carepath

Empowering public authorities and professionals towards trauma-informed leaving care support

TRAINING AND ASSESSMENT MATERIALS

WP3 / A3. / D3.1.2

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

Project information

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Prepared by

Name:	Luca Rollè, Eva Gerino, Andrea Cabiale, Antonella Ferrero, Joëlle Long, Laura Scomparin
Authoring partner:	UNITO
Position:	Responsible for the deliverable D3.1.2
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Name:	Alberto Zucconi
Partner:	IACP
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Training and assessment materials

Summary

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Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material MODULES – English Version

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UNIVERSITÀ DEGLI STUDI DI TORINO

IACP Eurochild ReadLab ERGO e-trikala

CarePath: Trauma-informed leaving care support empowering public authorities and professionals

CarePath - CP01x
Started - 16 gen 2020

View Course

CarePath: CP01x
CarePath: Trauma-informed leaving care support empowering public authorities and professionals

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Introduction

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Post course survey

Post course survey

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Pre-Course survey

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CarePath MOOC

Welcome to the CarePath Massive Open Online Course! Before you go further, let us know you better!

*Campo obbligatorio

Gender *

- ◯ Male
- ◯ Female

Email (MOOC email) *

La tua risposta

Country *

La tua risposta

Education level *

- ◯ High School Diploma
- ◯ Bachelor Degree
- ◯ Master Degree
- ◯ Altro: _____

Current profession or job description *

- ◯ Educator
- ◯ Social worker
- ◯ Psychologist
- ◯ Healthcare professional
- ◯ Student
- ◯ Psychiatrist
- ◯ Altro: _____

In which context do you work? *

- ◯ Local Public health Agency
- ◯ Social Service Agency
- ◯ Charity
- ◯ Non Governmental Organization-NGO
- ◯ Service for migrants and refugees
- ◯ Non Profit Organization
- ◯ For Profit Organization
- ◯ Organization focused on Immigrants and/or refugees
- ◯ Altro: _____

Have you ever had a specific training on trauma? *

- ◯ Yes
- ◯ No

How many years you been working with minors affected by trauma? *

- ◯ 1-2
- ◯ 3-5
- ◯ 6-9
- ◯ more than 10
- ◯ Never worked in this field

Invia

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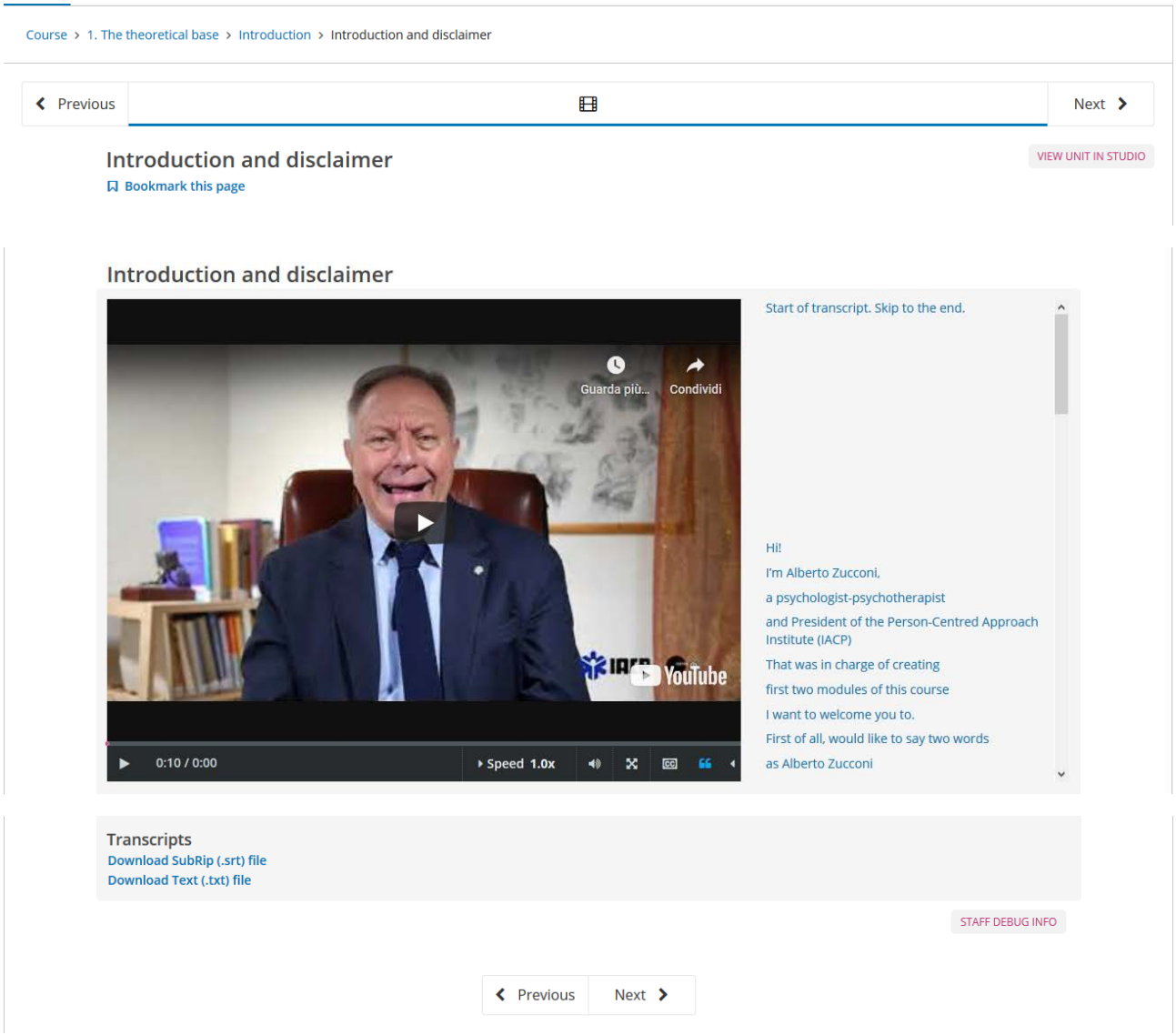


Transcript

Hi!

I'm Alberto Zucconi,

a psychologist-psychotherapist

and President of the Person-Centred Approach Institute (IACP)

That was in charge of creating

first two modules of this course

I want to welcome you to.

First of all, would like to say two words

as Alberto Zucconi

citizen

and they are words of gratitude.

A sincere thank you to each one of you that works to support and protect

of minors

traumatized

your work is very important

sensitive, delicate, but sometimes

also very heavy

We know well

that

that working with people that are suffering

at times can cause

pain and can lead to burn-out

Therefore

a sincere thank you because your

work protects

of

a precious reality for a nation and for a community; human capital.

Every traumatised person needs all the care possible

to be helped to reenter, with full rights, to be

an active member of the community

and to

be constructive for themselves and for the other members of the community.

I would like to add one other thing, which is perhaps obvious, but is better underlined:

this course

is addressed to all of you who are from different backgrounds, professions and skills

and who - as you know - are bound by the existing laws, the ethical/deontological

codes of various professions

and the internal rules of the various organizations to which you belong,

to do everything that you already know how to do and to whom you are responsible for doing and not to cross

borders and limits, because this would not be in favor of your clients.

I add another obvious thing

to complicate things the laws are not the same

in all European nations and this is a course

addressed to various nations and in various languages

therefore

Obviously the expectation to that of delivering a course to aware people

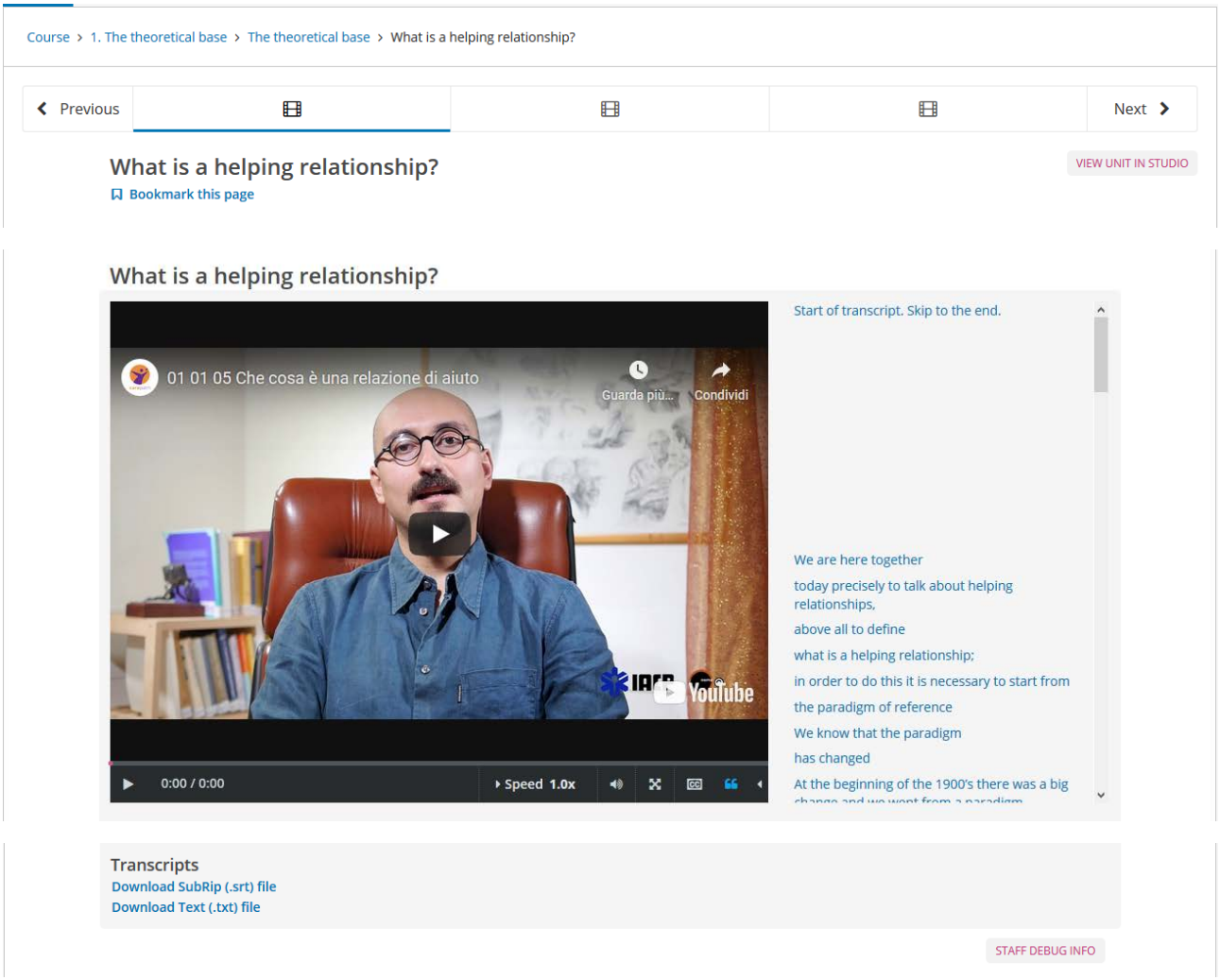
of the fact that also

respecting the limits means working effectively

And efficiently

Now thanks again for being on board this adventure and thanks for the daily work

that you do with passion.



Transcript

We are here together

today precisely to talk about helping relationships,

above all to define

what is a helping relationship;

in order to do this it is necessary to start from

the paradigm of reference

We know that the paradigm

has changed

At the beginning of the 1900's there was a big change and we went from a paradigm

reductionist mechanistic to a holistic and systemic .

The way of understanding a helping relationship has also changed, in fact in the mechanistic paradigm,

reductionist

a helping relationship was characterised by asymmetry; the professional was the agent of meaning

who imposed a reality onto his patient, his own vision of reality,

somehow making his patient passive.

And therefore passive with the professional

With the adoption of the new paradigm many things changed,

because we know that

relationships are central to our understanding: the importance is not in the single parts, but the relationships

in which these parts

make a whole.

With it to be qualified

So what is a helping relationship in the light of the new paradigm?

Which can be ?

To help us to define it let's read the words written by Carl Rogers in 1951, an author

who occupies a prominent place in helping us to understand the helping relationship in this new light.

Carl Rogers writes "A helping relationship is a relationship in which at least oneof the two

protagonists has the goal of promoting the growth, development,

maturity and achievement

of a more adequate and integrated way of acting of the other person.

Other in this sense could

be an individual or a group.

In other words, a helping relationship could be defined as a situation in which

one of the participants tries to favor, in one or others , a greater actualization

of the personal resources and a greater possibility of self-expression".

Here the words that stand out are valorization, promotion, resources

and therefore

this new light in which we see the helping relationships

is a light that places

the two protagonists

in a relation of parity,

in this way the professional will not be

the expert, the agent of meaning,

but will be the one that promotes the actualization of all the

resources that are intrinsic to the other person.

In doing so he will be able to facilitate a more functional process of co-construction of reality

for the client,

thus accompanying him in a process, accepting and respecting where the client is.

So today, what characteristics should a helping relationship professional have?

Certainly they should have knowledge, that is, must have a corpus to lean on

theoretical knowledge

must

moreover know how to apply this knowledge

and therefore the theories must be made concrete, be applied and know how to be applied in the relationship.

In addition to know how, given that the focus of the relationship is on the quality of the relationship itself,

it will be necessary for the professional also to know how to be, to know how to put into practice all of these conditions

and qualities that facilitate and make a helping relationship effective.

Among these, we know that surely authenticity is the first quality, that knowing how to see the world through the

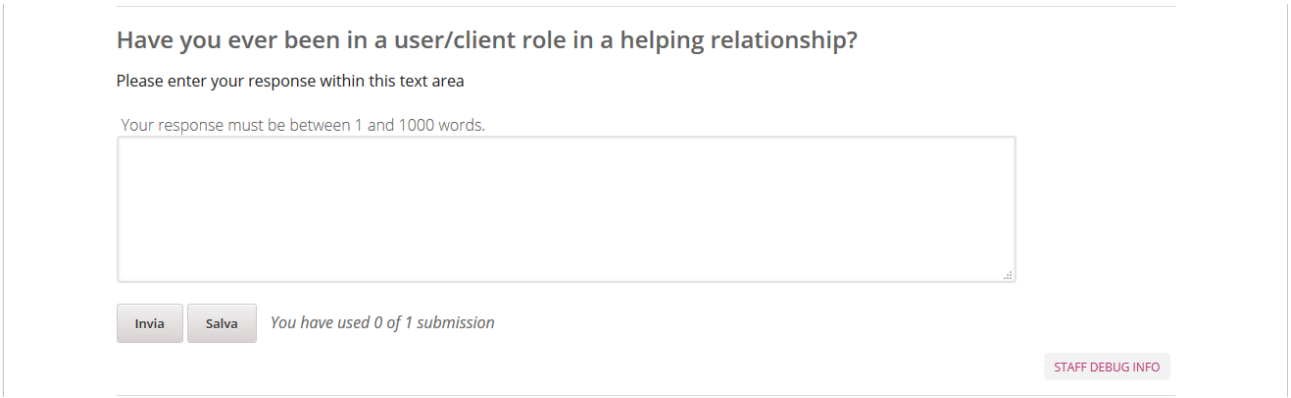
eyes of the other is the second, and the third is to not judge

the client, but to be able to respect and welcome them how they are.

If this is possible, if these three conditions are implemented by the professional,

this will facilitate a process of change

and improvement



If yes, what aspects of the helping relationship did you find particularly positive and facilitating?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

And which aspects didn't you find facilitating?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

If you have never been in a user/client role in a helping relationship, which aspects seem to you positive and facilitating and which aspects don't seem facilitating?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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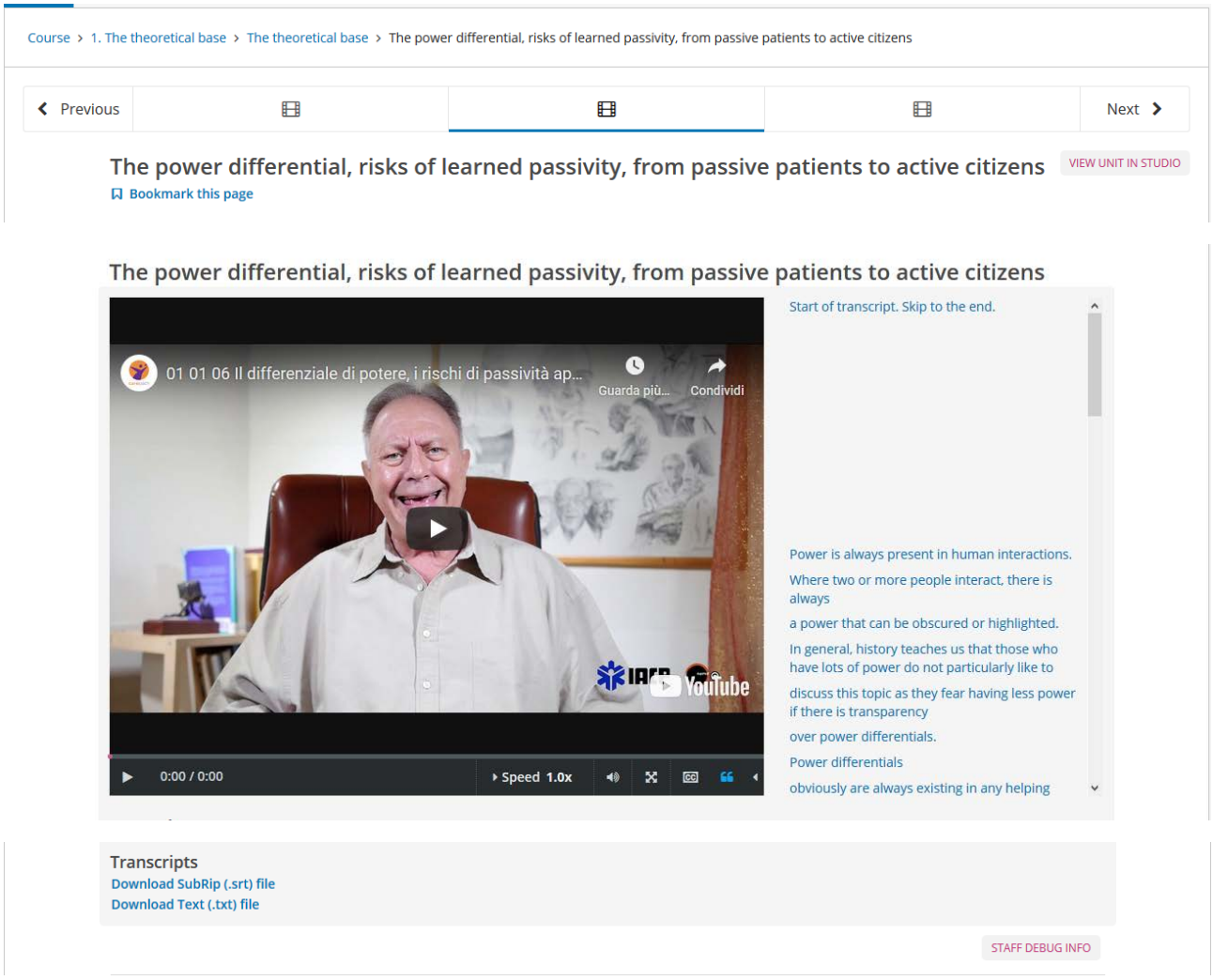

Transcript

Power is always present in human interactions.

Where two or more people interact, there is always

a power that can be obscured or highlighted.

In general, history teaches us that those who have lots of power do not particularly like to

discuss this topic as they fear having less power if there is transparency

over power differentials.

Power differentials

obviously are always existing in any helping relationships.

The professional, the expert,

those who offer a service have more power

over a service user, client, patient or how you want to define the person. Why?

Because the professional know something that the client doesn't exactly know,

and in addition the professional offers to their clients something they need.

They also design the rules

of the setting (i.e. the rules governing the design and management of the setting)

and can even suspend the provision of the service itself.

In short,

there is always a power difference between those who provide a service and those that receive it.

In the past, with the reductionist-mechanistic paradigm

power differences in the various helping relationships were very high.

We have seen, also in the light of the new paradigm of the Ottawa Charter and the biopsychosocial paradigm,

that this was not desirable as excessive

power differences can lead users of the service to assume a passive role that does not help to achieve

the objectives of the service itself.

Today, therefore, there is a tendency to focus on users, on the person of the client, and encourage

change through actions of empowerment that empower clients

to develop their skills, creativity and resilience.

This, the research highlights very clearly, is very useful

as the helping relationship facilitate better results in less time,

and for example in the field of health and wellbeing, secondary effects and relapses are lowered.

Therefore the world is increasingly orienting itself towards the evidence that everyone wins when

power is shared and if everyone contributes to achieving goals.

All of this is also true at a societal level, and therefore active, aware citizens

contribute much more to their social ecology and the communal construction of reality:

a sustainable reality for sustainable relationships.

This also true when providing services to children, who are small people, they are not children who don't understand or who are not responsible. This social construction of children as

"little cute things" is very obsolete.

In Depth Material

BPS Practice Guidelines (Third Edition)

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You can skip the following exercise in case you are not working in any role in the field of offering services to traumatized minors.

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What do you really think about the difference in power between operators of helping relationships and their clients?

Please enter your response within this text area

Your response must be between 1 and 10000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Can having too much power differential create undesirable effects? If so, what?

Please enter your response within this text area

Your response must be between 1 and 10000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

In your daily work, do you try to be actively aware to the level of power differential between you and your service users?

Please enter your response within this text area

Your response must be between 1 and 10000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

If you are attentive to the level of power difference, why are you paying attention to the power differentials in the helping relationship?

Please enter your response within this text area

Your response must be between 1 and 10000 words.

Invia Salva *You have used 0 of 1 submission*

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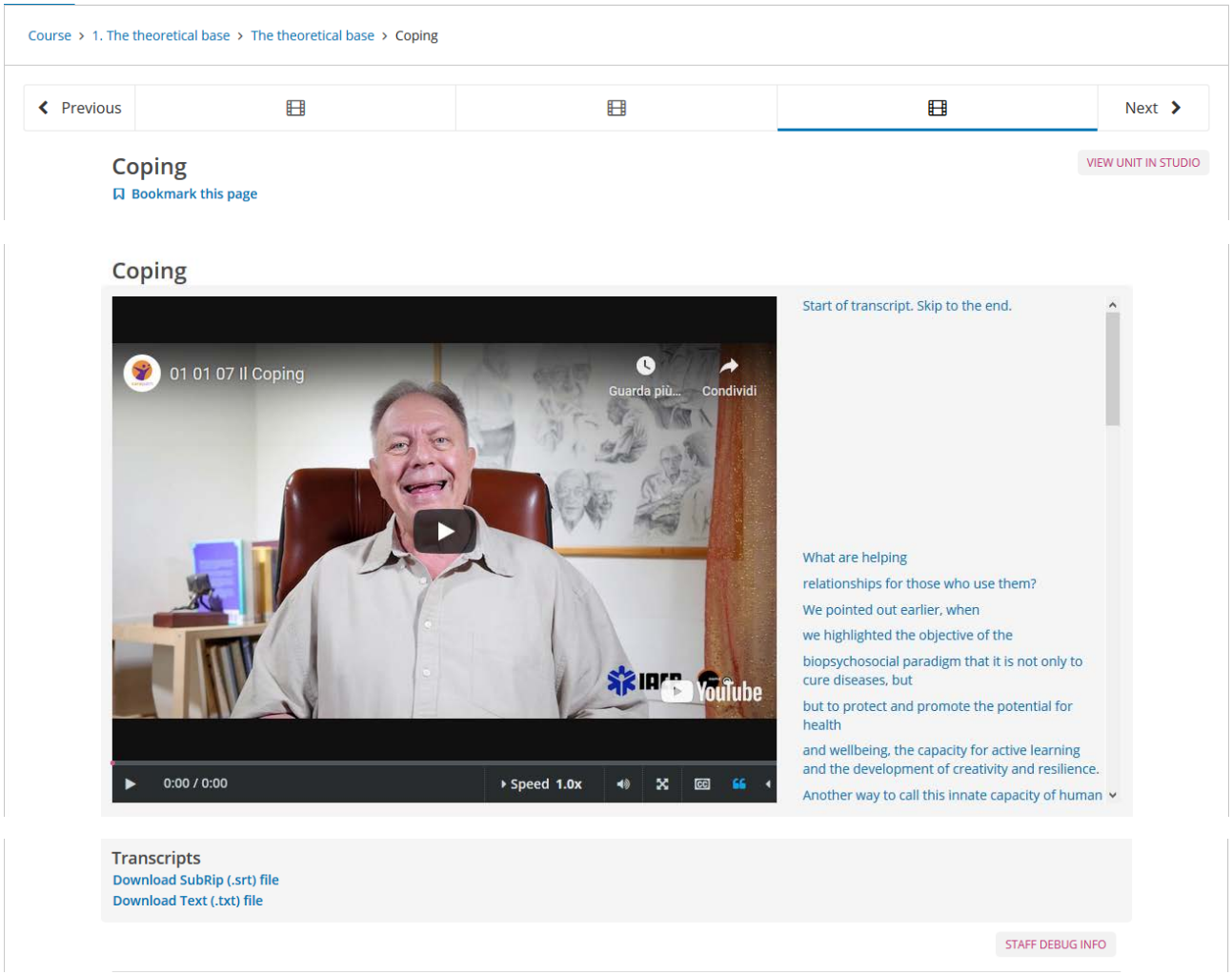


Transcript

What are helping

relationships for those who use them?

We pointed out earlier, when

we highlighted the objective of the

biopsychosocial paradigm that it is not only to cure diseases, but

but to protect and promote the potential for health

and wellbeing, the capacity for active learning and the development of creativity and resilience.

Another way to call this innate capacity of human organisms is

coping: An english term that in italian means knowing how to manage life's circumstances;

in other words, knowing how to better manage my relationship with myself,

with others and with the world around me.

We know that in helping relationships,

in regards to the qualities of the effective professional

regardless of the approach he uses, in order to to be effective they must know

how to relate with their clients with a high quality deep respect and without prejudice

to have an empathetic understanding not only of what the client says, but also what he feels, his

meanings, and relate to him honestly, authentically and transparently.

It is also necessary, however, for this process to work on the part of the user, client and patient to

actively get involved since this is a co-construed team game.

In helping relationships, clients that can be defined as “effective”

are clients that are sincere and motivated to change, perhaps because they are not feeling well

and want to stop suffering. They also need to have the ability to come

into psychological contact with the professional working with them and to perceive the relational qualities

that the professional puts into the relationship.

These capacities develop, as does the capacity to persevere, to be ready to learn from mistakes, with the courage that it takes to admit to errors, to let mistakes become teachers of wisdom.

ready to learn from mistakes, with the courage that it takes to admit to errors,

to let mistakes become teachers of wisdom

This underlines how coping is an optimal functioning process and the

result of the team work of the professional and their client to achieve the

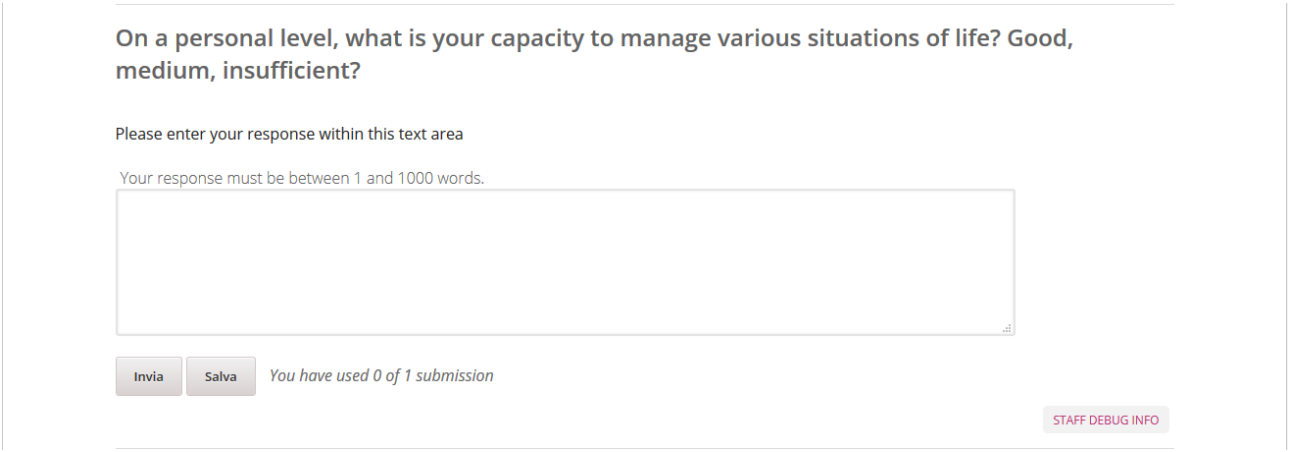
objectives of improved quality of life and greater realization of the intrinsic

potential

that each of us was born with and is written into our genetic code and then developed further,

more or less depending also by the environmental conditions in which we find ourselves, but also by the attitudes

that we have and by how we face life.



On a professional level, what is your capacity to manage various situations with clients, their families, colleagues and superiors? Good, medium, insufficient?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

What could you do, and would eventually like to do, to increase your capacity to cope on a personal and professional level?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

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Focusing on the illness or on the development of human potential

VIEW UNIT IN STUDIO

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Focusing on the illness or on the development of human potential

Start of transcript. Skip to the end.

To concentrate on disease or health?
Research shows us that it is much better
concentrate on health
because greater successes are obtained
and it lowers costs.
Why does this happen?
Because in the previous mechanistic reductionist paradigm
the person who needed help was in a passive state, in fact to label somebody a patient can make him in a sense too

Transcripts
Download SubRip (.srt) file
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STAFF DEBUG INFO

Transcript

You can skip the following exercise in case you are not working in any role in the field of helping relationships.

STAFF DEBUG INFO

According to you, does focusing on the person really give better results documented by research, or are they simply nice words spoken by idealistic, but not very concrete people?

(1 point possible)
Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Does your work style and everyday practice make it natural to focus on the person of the client or do so you have to make a big effort?

(1 point possible)
Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

When you are people centered, do you feel satisfaction in being able to do it? (1 point possible)

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

How do you self-evaluate your ability to be client centered and people-centered ? (1 point possible)

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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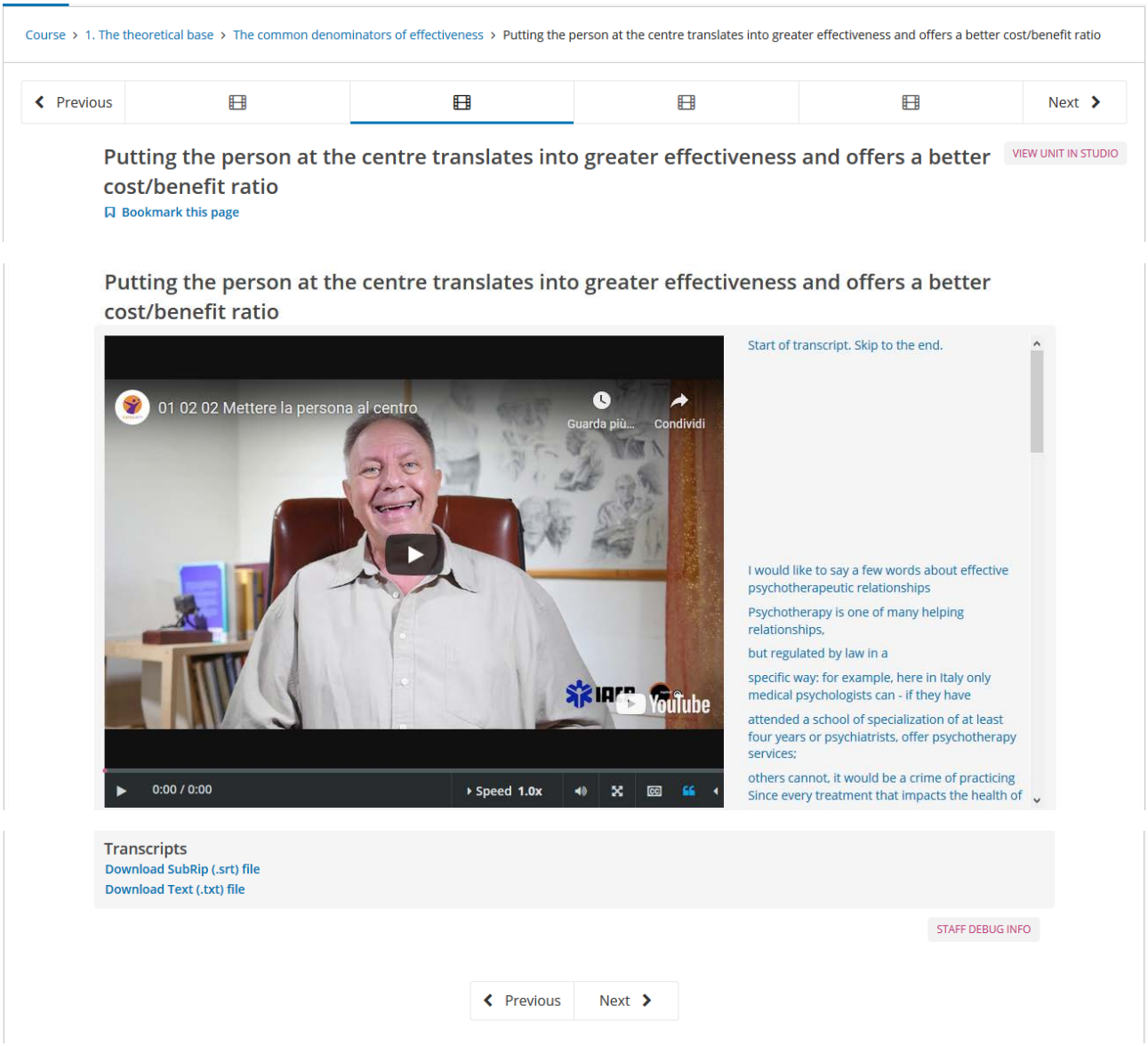


Transcript

I would like to say a few words about effective psychotherapeutic relationships

Psychotherapy is one of many helping relationships,

but regulated by law in a

specific way: for example, here in Italy only medical psychologists can - if they have

attended a school of specialization of at least four years or psychiatrists, offer psychotherapy services;

others cannot, it would be a crime of practicing Since every treatment that impacts the health of an organism

and therefore does good- can, if it is not properly understood how it is to be promoted, obviously do harm.

well

The vast body of research show that effectiveness in the field of psychotherapy does not derive from the belonging to the various psychotherapeutic approaches

specific theoretical approach; it derives much more from the relational qualities of psychotherapists

belonging to the various psychotherapeutic approaches and, as in any helping relationships,

the same variables, the same factors are operative.

A psychotherapist is effective not because he applies a certain theoretical model, but because

he or she have the ability to relate to his user with a large capacity of acceptance,

respect, not judging, with deep respect

and because he or she has

the capacity

the not only to listen to what his user / patient / customer say, but also empathy,

what meaning has for the specific client as an individual.

The professional is also able to relate to the client in a genuine, spontaneous and transparent way.

However, this is not enough because the psychotherapeutic relationship, as with any helping relationship, is a

team work, a co-construction in which the client, the user, the patient actively contributes,

otherwise it does not work.

And so?

The motivation is important, often provided by the client' feelings of discomfort - and therefore the motivation to change

and then the capacity for psychological contact with the psychotherapist 27

and, moreover,

the third condition: being able to perceive the quality of relationship offered by the professional possessing

the fundamental qualities of deep respect, empathic listening and the authenticity.

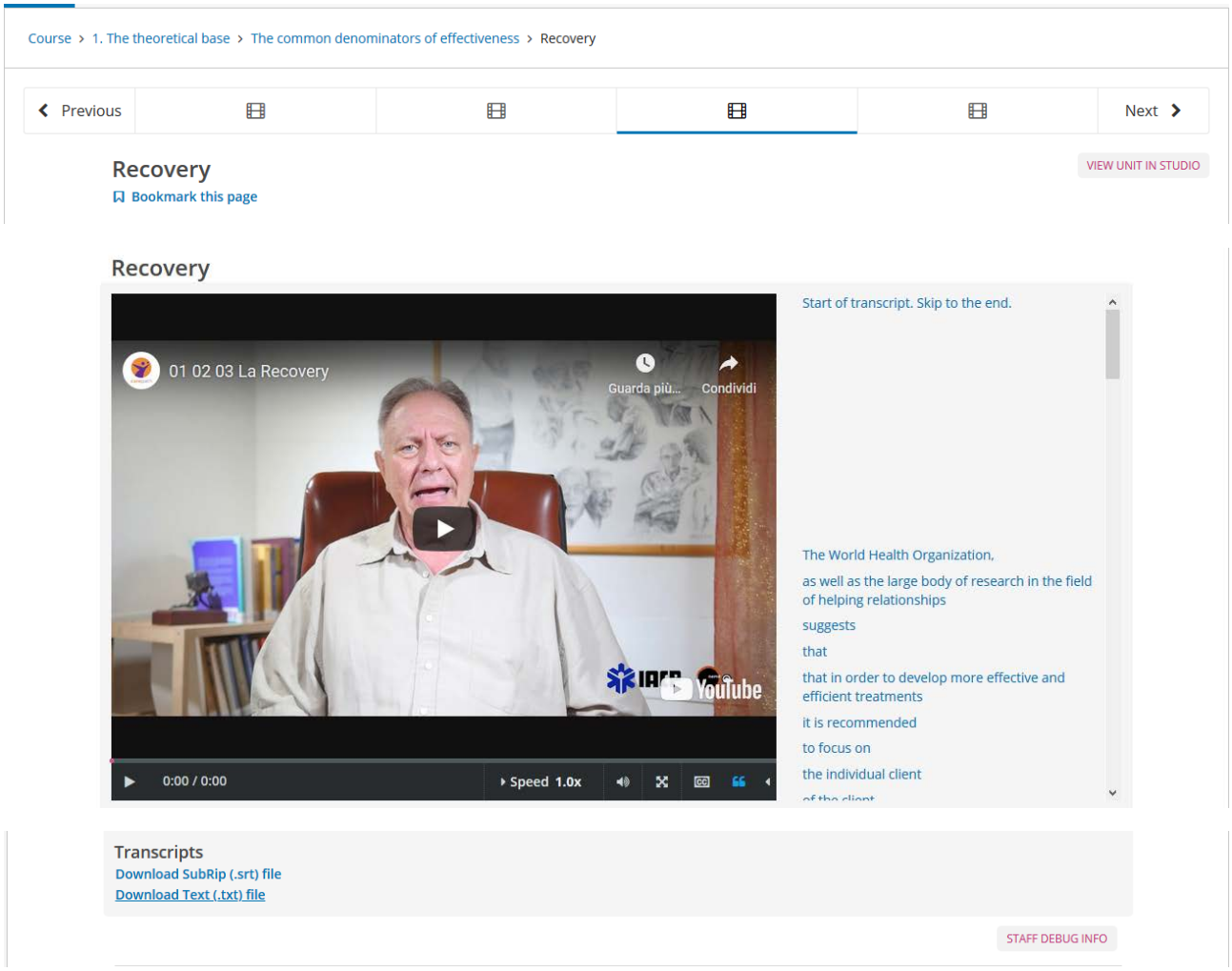
Of your psychotherapist

EIn this way the dyad can function with very positive and more effective results

than if the person with the same discomfort received only a drug treatment, or indeed.

no treatment.

In short, in the psychotherapeutic field and in the helping professions an effective relationship is good medicine



Transcript

The World Health Organization,

as well as the large body of research in the field of helping relationships

suggests

that

that in order to develop more effective and efficient treatments

it is recommended

to focus on

the individual client

of the client

we are taking care of.

In short, it is important to customize the treatments, not as if they were just a tin of white paint which allows us to paint white everybody, regardless of who the users are.

white paint which allows us to paint white everybody, regardless of who the users are.

Just as psychotherapy must be personalized, helping relationships must also be personalized

because this best helps Gino, Maria, Joseph, Mary, etc. .

Beacuse

We must

establish strong work alliances and engage in narratives

that sees the client as the protagonist in this adventure of change.

The Task Force 29 of the American Psychological Association

shows the importance of centering treatments on people

and

also recommends another important aspect:

that treatments and their philosophy must be

concepts of recovery

instead

of as was previously done

with a pessimistic

vision of pathology and chronicity

What is recovery?

In recent decades, recovery has developed a capacity –

of being more helpful by supporting and empowering clients -

and has dispelled some myths,

such as

that

schizophrenia

is a chronic pathology.

This was thought previously

but the very fact of thinking in this way also becomes to

a

certain extent a self-fulfilling prophecy

if we think about it - is rather obvious.

So true

Using the example of schizophrenia, we know that it

in every country, yet no culture treats it just the same way.

In some societies and cultures the schizophrenic is considered as a person

touched by the gods

and therefore the community treats them with respect, benevolence and offers

food and shelter

in other societies

they are instead treated as outcasts

banned from the community and chained to a tree in the forest.

In our western culture,

at different times, we treated

these people

in a very different way,

sometimes cruelly,

but obviously we did it for their own good, as when we believed

in turn that it was a phenomenon caused by a devil's possession and so we tortured these poor people

with hot irons, thinking that if their bodies are possessed by a devil,

if me make the body uncomfortable by torture the devil would come out.

or

We treated people by many other means,

but always making the prophecy of pathology and chronicity

and punctually these prophecies

come true

With a vision of recovery, which postulate that whatever your

situation, even as a serious one

as in schizophrenia, you can recover your capacities to function and be part of the community, in this way a positive prophecy

is formulated and realized: Like all prophecies, to some extent come true.

So today we see that when people are viewed with greater optimism, they satisfy these prophecies.

We therefore can witness people who still see things that others do not see, hear voices that

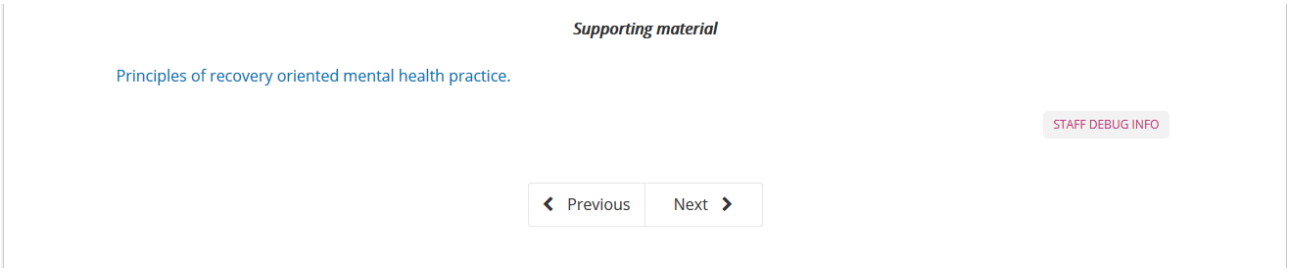
others do not hear, but nevertheless are working as paid consultants in an Local Health Agency advising how to treat

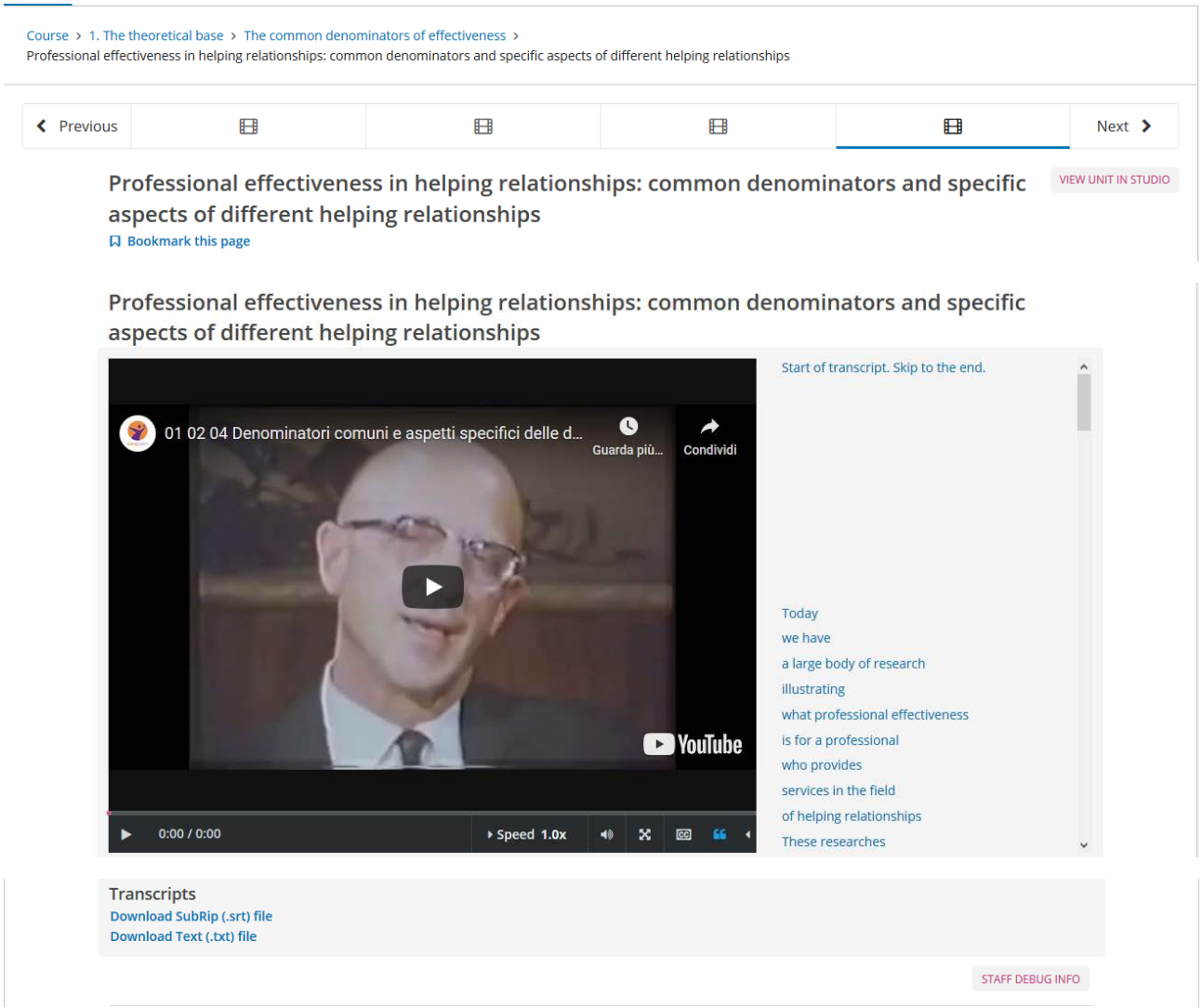
people with their afflictions in a more human and positive way, and to be able to realize

instead of negative prophecies - positive prophecies that are also

self-fulfilling

With prophecy, we must be careful what to choose and where this leads us.





Transcript

Today

we have

a large body of research

illustrating

what professional effectiveness

is for a professional

who provides

services in the field

of helping relationships

These researches

started long

time ago from the hypotheses formulated by Carl Rogers,

who is

the founder of the person-centered approach

and one of the fathers of humanistic psychology

Starting in 1942, Rogers scientifically formulated

hypotheses

and then moved on to his empirical

verification of what constituted the necessary and sufficient conditions for an effective professional to promote change.

These were and have been confirmed until today by research:

the ability to establish

a trusting relationship with the user/client,

with the professional having an attitude of non-judgement,

acceptance

and deep respect for the person of the client,

ability

a sensitive and accurate ability to listen empathetically - that is, to understand not only what the client says,

but also what it means for him/her

and also an attitude of authenticity, frankness

and honesty in the relationship.

These hypotheses, which were validated by research on psychotherapy ,

where later on proven effective

in all the helping relationships

none excluded

so in this

Rogers gave a great contribution made a significant

a step forward n the helping relationships, rooted them solidly

in science and not in metaphysics and made explicit the values that are at the base of any approach.

I think it will be clearer to listen directly to Carl Rogers in person,

who illustrates these three necessary and sufficient conditions in one of his famous films:

â€œFrom my own years of therapeutic experience I have come to feel that

If I can create the proper

climate, the proper relationship, the proper conditions,

the process of therapeutic movement will almost inevitably occur in my client.

You might ask, what is this climate?

What are these conditions?

Will they exist in the interview with the women Iâ€™m about to talk with whom I have

never seen before?

Well let me try to describe very briefly what these conditions are as I see them.

First of all, one question is,

can I be real in the relationship?

This has come to have an increasing amount of importance to me

over the years.

I feel that

the genuineness is another way of describing the quality I would like to have.

I like the term congruence, by which I mean, what Iâ€™m experiencing inside is present

in my awareness and comes out through in my communication.

In a sense,

when I have this quality,

Iâ€™m all in one piece in the relationship.

Thereâ€™s another word that describes it for me,

I feel that in the relationship

I would like to have a transparency, I would be quite willing for my client that sees all the way through me,

that there would be nothing hidden.

When Iâ€™m real in this fashion that Iâ€™m trying to describe then,

I know that my own feelings

will often bubble up into awareness and be expressed, but be expressed in ways

that wonâ€™t impose themselves on my client.

Then the

second question I would have is, will I find myself praising this person,

caring for this person.

I certainly donâ€™t want to pretend a caring that I donâ€™t feel.

In fact, if I dislike my client persistently, I feel itâ€™s better that I should express it.

But I know that the

process of therapy is much more likely to occur,

and constructive

change is much more likely,

if I feel a real spontaneous prising of this individual with whom I am working.

A prising of this person as a separate individual.

You can call it acceptance, you can call it caring,

you can call it a non-possessive love if you wish.

I think any of those terms tend to describe it.

I know that the relationship will prove more constructive if itâ€™s present.

And in the third quality, will I be able to understand the inner world of this individual,

from the inside,

will I be able to see it through her eyes,

will I be

sufficiently sensitive

to

move around inside the world of her feelings,

so that I know what it feels like to be her.

So that I can

sense not only the surface meanings but some of the meanings that lie

somewhat underneath the surface.

I know that If I can

let myself sensitively and accurately enter into her world of experience

than change and therapeutic change are much more likely.

Supporting material

Wampold BE. How important are the common factors in psychotherapy? An update. World Psychiatry. 2015;14(3):270–7.

STAFF DEBUG INFO

You can skip this exercise If you do not work in any role in the field of helping relationships.

STAFF DEBUG INFO

Of the common factors of all the helping relationships which you have just heard and seen, what qualities characterize you in your work with clients?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

What would you like to develop further?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

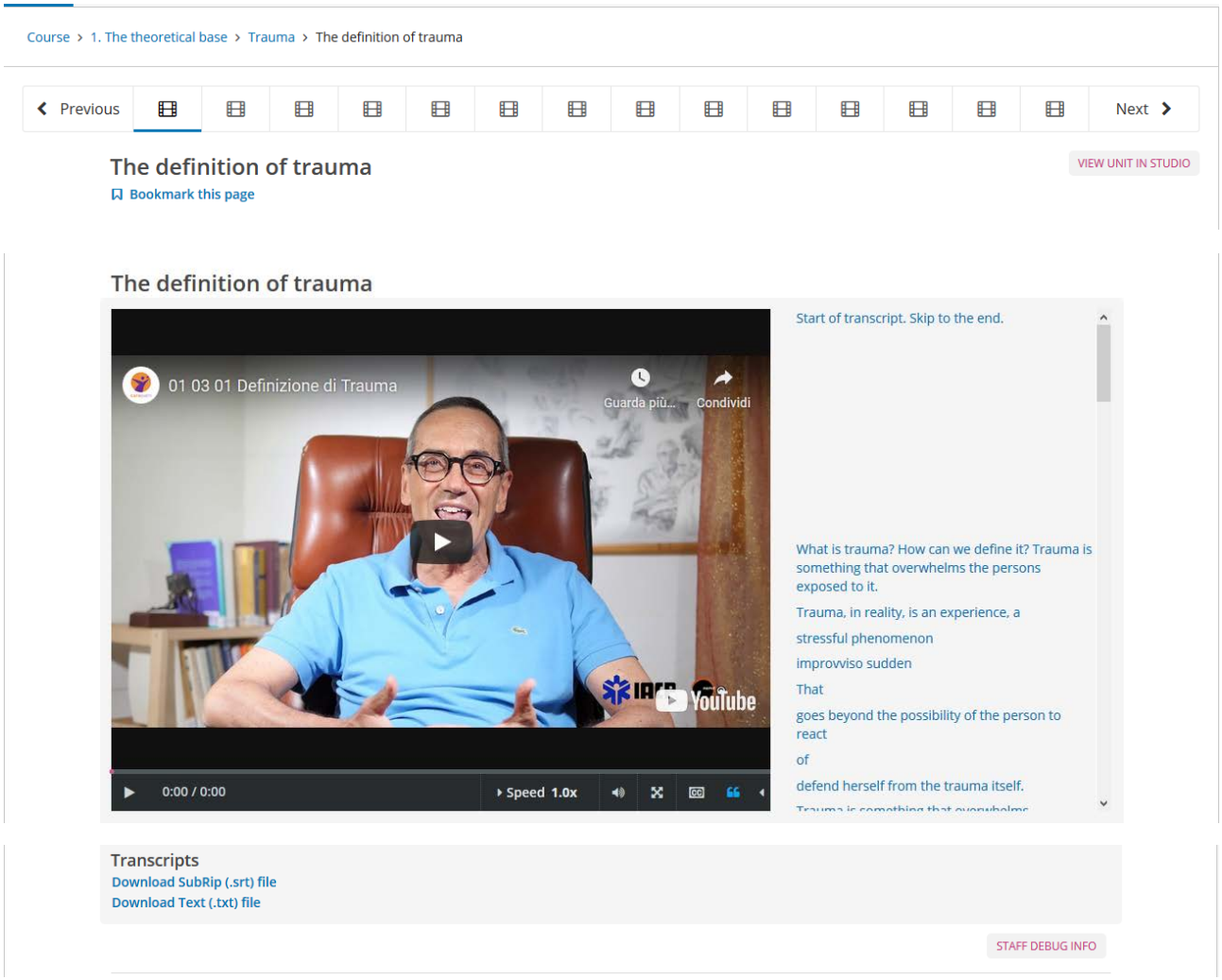
Does your workplace offer you the chance to become a better professional? And if so how?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO



Transcript

What is trauma? How can we define it? Trauma is something that overwhelms the persons exposed to it.

Trauma, in reality, is an experience, a

stressful phenomenon

improvviso sudden

That

goes beyond the possibility of the person to react

of

defend herself from the trauma itself.

Trauma is something that overwhelms

the persons exposed to it.

Trauma has been studied in various ways

in various ways

there are acute traumas for example due

to natural or technological catastrophes there are chronic/repeated situations of trauma -

such as children are often exposed to

But

what can be

said is that the history of trauma, from a clinical point of view, begins

precisely with the study of post-traumatic neuroses, which have also been studied by Freud - and therefore in the

context of psychoanalysis - and then taken up again by other others.

What psychoanalysis has studied, since its origins, is the fact that a trauma

to the first world war and to the successive wars - many exposure disorders have been noted

to war traumas which they then involved of the psychological consequences and that later

have been taken from the classification systems psychiatric, therefore of psychopathology

as a post-traumatic stress disorder. This post-traumatic stress disorder

Is the only disorder in psychiatry that is certainly and certainly due to an external factor;

This factor is precisely the trauma

It is no therefore necessary for a person

it is exposed, for example, to an earthquake or to a flood, to be bearer of

its weakness, fragility or vulnerability, beacuse is so important and

overwhelming force of the individual which in itself is able to induce

consequences at the psychological level and at the level also physical. At the physical level as between the

symptoms more important than today it's called post-traumatic stress disorder

there are, of course, type symptoms neurovegetativo:

symptoms of alert, of increased

arousal, or increase in vigilance and reactivity to external stimuli.

Therefore means that a person carries within itself also some objectives signs and,

Not only of subjective symptoms, of impact that the trauma has had on her

Trauma has also been studied from the point of view of psychological mechanisms

very important

which are

What psychoanalyst is has studied, since its origins

is the fact that a trauma

in particular if it occurs early in childhood

is subject to a removal process.

This removal does not mean, however, that the trauma is forgotten,

denied or buried. It can be reappear, be reactivated at another time

for example in adult life

Perhaps

due to another trauma that somehow

recalls the previous trauma. This is a two-stage mechanism that Freud carefully studied

according to which there is a first trauma which, in a certain sense, sensitises

and a second trauma that

reproduces in the subject the condition of being a victim

of powerlessness and fragility

reproducing the situation and leading

to new

symptoms

and a clinical situation where the client feels it as though it was the first time.

This said, the trauma of post-

traumatic stress disorder instead occurs in a

punctual manner that endangers the subjects life

It can be caused by war, tortue

technological or environmental causes

but this trauma is a punctual type and easily recognisable

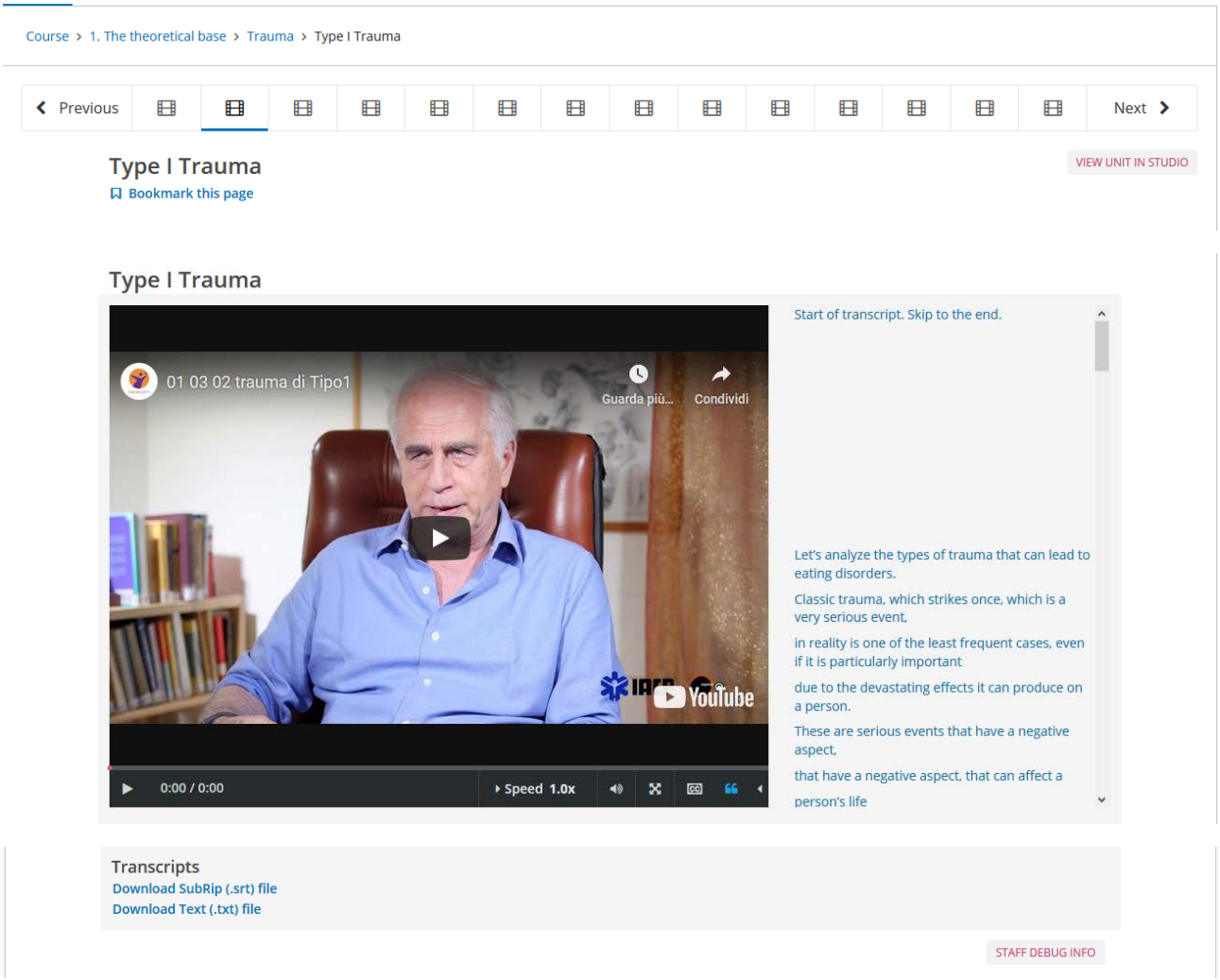
in the life of the subject

Supporting material

Kleber RJ. Trauma and Public Mental Health: A Focused Review. *Front Psychiatry*. 2019;10:451. Published 2019 Jun 25. doi:10.3389/fpsyt.2019.00451

STAFF DEBUG INFO

‹ Previous Next ›



Transcript

Let's analyze the types of trauma that can lead to eating disorders.

Classic trauma, which strikes once, which is a very serious event,

in reality is one of the least frequent cases, even if it is particularly important

due to the devastating effects it can produce on a person.

These are serious events that have a negative aspect,

that have a negative aspect, that can affect a

person's life

producing psychological or physical damage, or both of them,

and which can last

for several years in a person's life

Usually we find this trauma in what we call post-traumatic stress disorder,

but it is very common in eating disorders, in particular in some forms

of eating disorder.

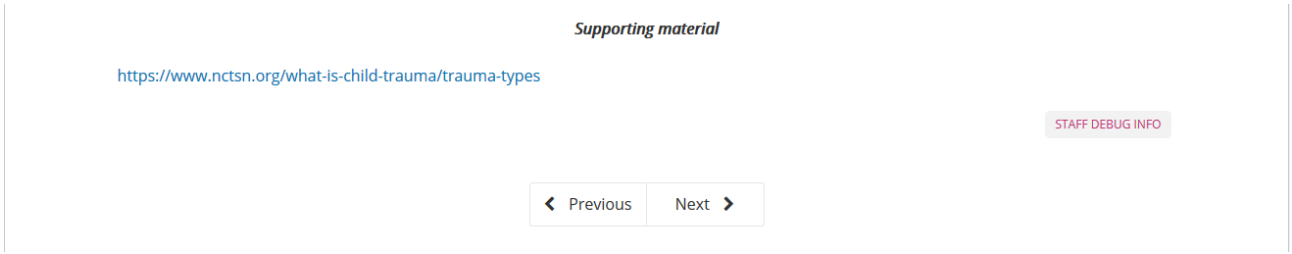
This can be divided into two parts: trauma, which can
can especially occur in particularly dramatic moments such
as rape, robbery, physical violence, wartime combat,
natural disasters (such as 18 00:01:12,820 --> 00:01:16,000 a tsunami or earthquake), a very serious car
or train accident.
Trauma of a predominantly psychological type: when someone's life is
under threat by someone, of a particular situation in which,
someone finds themself
where there are no physical injuries
physical injuries, but simply
a threat so extreme and strong that it is difficult for the person to erase it from their
mind in the near future.
For people subject to type I trauma, also called "focal trauma",
the trauma is called "single blow", that is,
that is, it strikes once,
but
leaves strong traces
and on symptoms
in eating-related symptoms,
has a very similar effect to post-traumatic stress disorder.
A trauma of the type I can have a series of consequences, among which eating disorders
are one of the most common,
and then a series of rather extensive symptoms
which can involve
that
a series
of traits
that are all present
in eating disorder behaviour.
That is to say that eating disorder behaviour isn't solely eating behaviour,
but the symptoms can accompany,
frequently

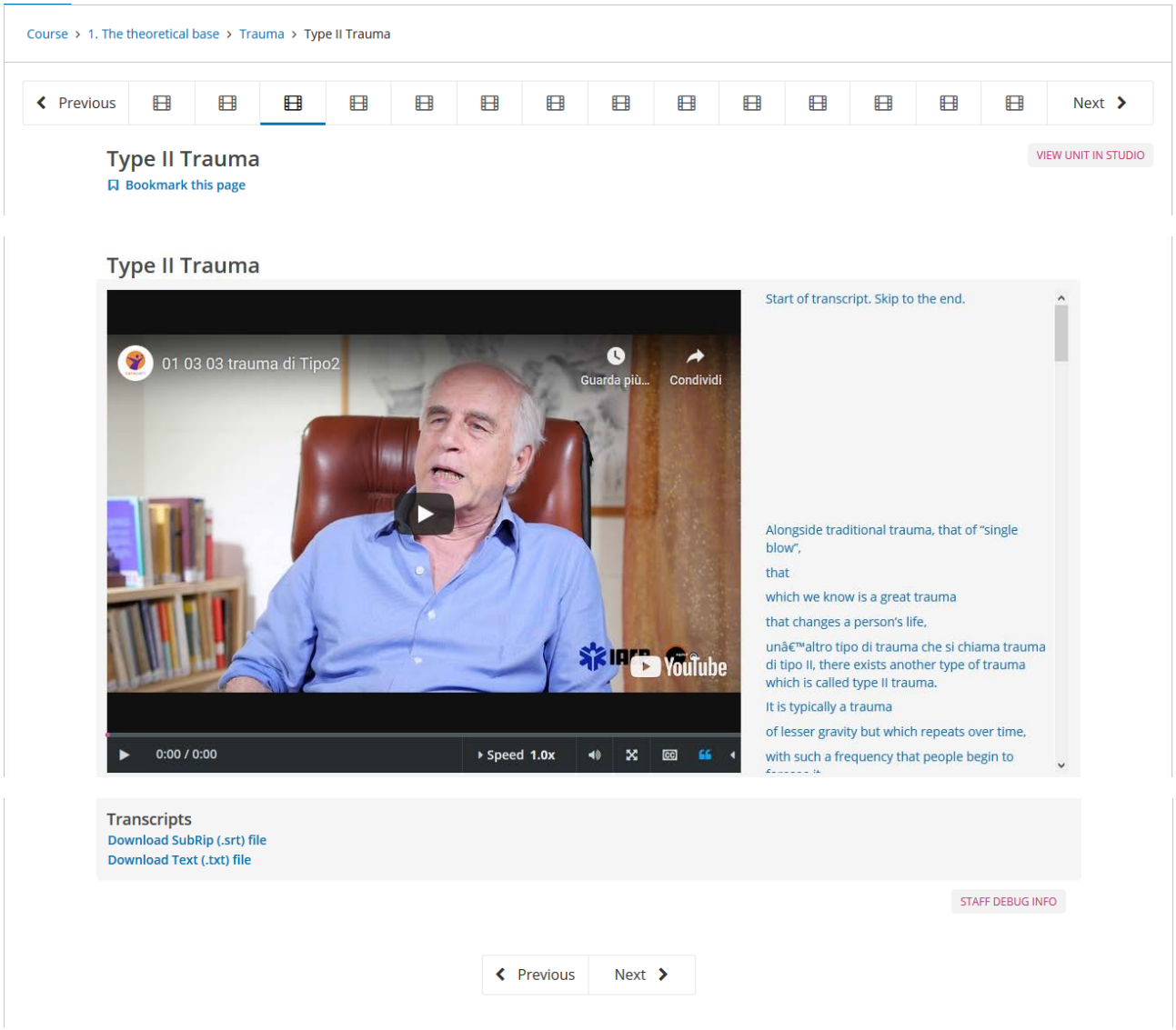
and in nearly all cases having this symptomatology,
each of the individual eating disorders. These traits are:
low self-esteem, a very strong tendency to depression,
a distorted image of one's body and sexuality
distorted peculiarites
high suicidal risk, anxiety disorders, alcohol abuse
sleep disorders, dissociative disorders, memory loss, aggressiveness and personality disorders.
It is a symptom logical procession that never surprises us
eating disorders never come alone, but are always accompanied by symptoms
of this kind or by real pathologies
that complete the picture of eating disorders
and
are rarely absent.
We have, in particular,
trauma that leaves a trace - as in this type I trauma
which occurs primarily
by producing alexithymia, which is an emotional disorder
that prevents a person from openly expressing their emotions
with words.
The tendency in this case, after a type I trauma, is to express emotions mainly
on a non-verbal level,
with one's own body,
and these sensations
can be 71 00:04:08,300 --> 00:04:09,320 very serious
and may involve
emotional dysregulation, also notable, to the point that the person
shows an impulse
at a certain level,
and
we know - because
this is one of the most
frequent feedback that we find

that there are some forms of bulimia nervosa in which this type of trauma
this type of trauma (for example abuse) are
are
of such gravity and magnitude as to produce
symptoms
that can lead to a considerable and widespread loss of control at
different levels.
In particular, what happens at an early stage of development,
when the trauma is dramatic
when there are serious variables in the family
to be sustained and supported,
in these cases
we run the risk of multi-impulsive bulimia:
form of bulimia
a very serious and dangerous
in which, together with bulimic behaviours,
alterations in the
character of eating behavior and above all impulsiveness,
which may concern
sexuality,
the
tendency
consume food in an uncontrolled manner, without tasting it,
which could, for example, lead to the
typical behaviours of those who carry
out thefts in supermarkets who consume food in the supermarket and cannot wait to
go back home to eat even if they could buy food.
A
A disinhibition of the impulses which we have seen regarding sexuality,
but above all, more importantly and more dangerously, self-injurious impulsiveness, self-injurious
behaviour such as cutting oneself or attempting suicide.
This type of bulimia, multicompulsive, is the most dangerous known, particularly

due to the high suicide rate

Concluding a type I trauma has the consequence, particularly if the environment is not supportive, of this form of bulimia which is certainly the most dangerous form known in particular for the very high suicide risk.





Transcript

Alongside traditional trauma, that of “single blow”,

that

which we know is a great trauma

that changes a person’s life,

unâ€™altro tipo di trauma che si chiama trauma di tipo II, there exists another type of trauma which is called type II trauma.

It is typically a trauma

of lesser gravity but which repeats over time,

with such a frequency that people begin to foresee it,

but cannot predict exactly when it will occur

This expectation has a wearying effect: it produces an extremely strong

feeling of powerlessness

in the subject that feels of not being able to master oneself.

able to master oneself.

In this type of trauma, where eating disorders are frequently found,

there may be a history

of violent conflicts in the home environment

which the

kid or adolescent,

sometimes the child, has been witness to for a long part of their life without knowing the

term. It may be that this violent conflict may lead to a real

violent behavior that can also produce

that can also produce serious damage or even loss

This type of repeating trauma

creates a very dramatic situation

a very dramatic situation where the person expects

there will be opposition even when its not necessarily the case.

even when it’s not necessarily the case.

Nevertheless the trauma is caused by such an extremely strong

and frequent repetition

that in the subsequent life of the person,

this same type of fear can occur

even after the trauma has ceased

In some cases, there is a tendency for people to repeat the type of trauma.

For example, in a

young woman

who has all her life witnessed the fighting between her parents

caused by them cheating on one another

in later life she only knew

how to choose

partners that expressed the same unfaithful behaviours

These betrayals increased her need to discover the cheating whether it had occurred or not. This type of

behaviour becomes,

in a certain way, a repetition of the prediction of a harmful event,

with the fear it could occur from one moment to the next,
as though the moment of childhood had never passed.
Type II trauma produces, among other things,
a tendency towards massive denial, affective numbness
as if the person tended to eliminate emotional feelings.
Therefore they tend to comport themselves as if they were “cooled”, as if they had no
other feelings
in certain moments of their lives.
This is called numbing, which is considered one
of the basic elements
of dissociative disorders: a disorder in which people lose the ability
to warn
to feel normal sensations
as if they had lost
significant sensory capacities
or as if they were absent or not
part of everyday life in certain moments
of their existence.
This is accompanied,
above all in eating disorders,
and even more
so in eating disorders
where there is a loss of control, therefore restricted anorexia
or anorexia and bulimic
behaviours
by a hidden and deep anger.
The subject is passive,
does not seem to react
but when they perform an action
you can perceive in them
a strong anger,
The manifestations of aggression towards the outside world

are very contained,

ma quando but when the subject feels strong emotions,

this strong anger can become explicit

and result in violent behaviour towards themselves and others.

The subject expresses an incessant sadness - not an intermittent type - which is stable

in the person

as if

there had been a childhood trauma that produces a constant pause

which in turn produces a sense of desperation

that extends

for the whole life

It is, as said, small traumas

that accumulate, but they have also been called

complex traumed or relational traumas because they depend on

a series of continuous relations one has with another.

Therefore it can happen that those who have experienced these traumas,

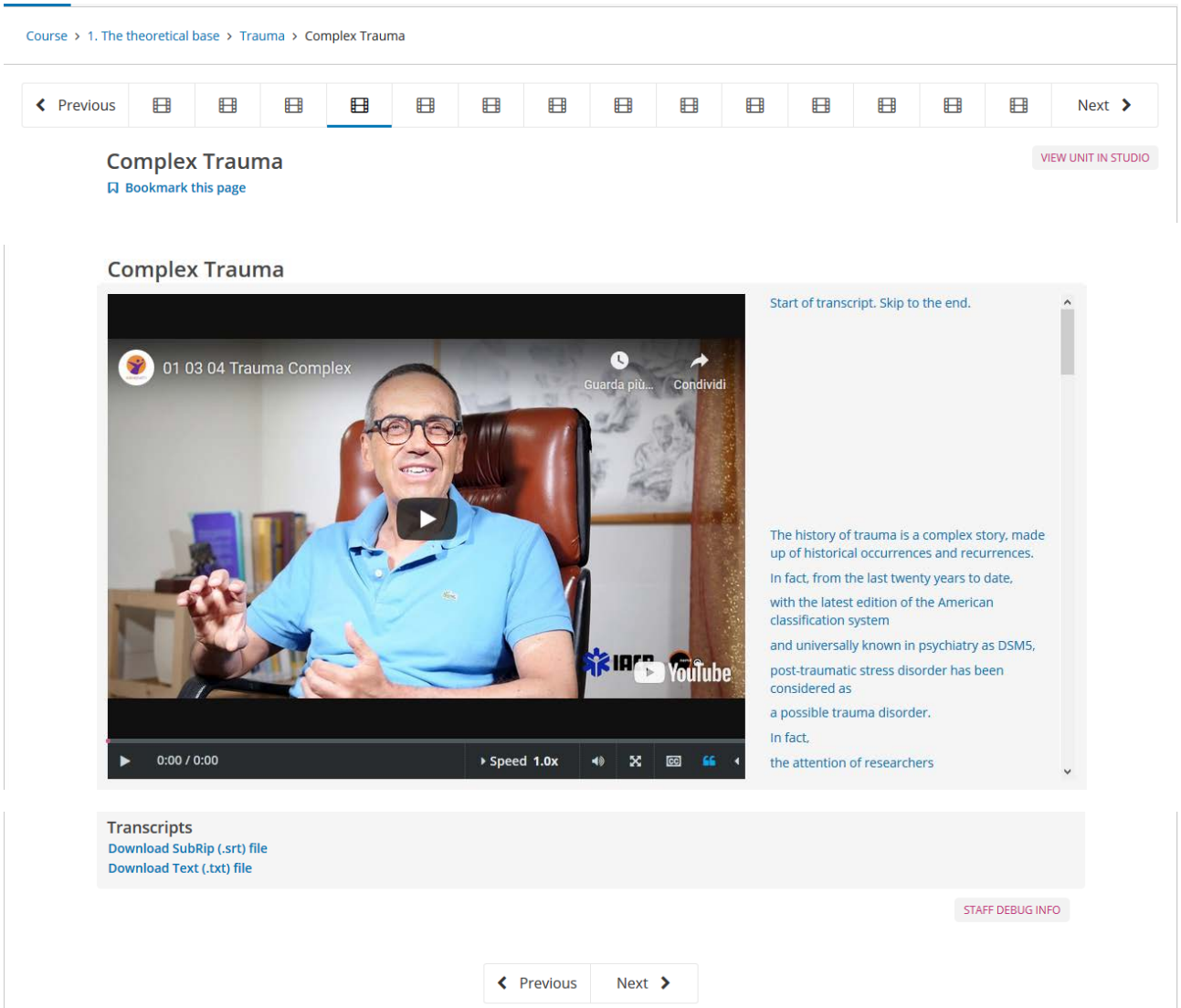
experience strong traumatic moments in the home environment, particularly

in the family environment

strong traumatic moments

They are, therefore, constant traumas that reappear and produce the dissociative symptoms

of which we have spoken or emotional regulation.



Transcript

The history of trauma is a complex story, made up of historical occurrences and recurrences.

In fact, from the last twenty years to date,

with the latest edition of the American classification system

and universally known in psychiatry as DSM5,

post-traumatic stress disorder has been considered as

a possible trauma disorder.

In fact,

the attention of researchers

primarily Van der Kolk, who launched the

question of complex trauma,

has turned to to childhood traumas.

Those which occurred at an age where the subject was in a

in which

these will be found in one

position of weakness, of inferiority - as children normally are.

This type of

of traumatic situation, of events that children are exposed to

from not only a psychopathological point of view,

but also a neurobiological one, are the possible causes of a predisposition to the development of psychiatric disorders

that go well beyond post-traumatic stress disorder.

These

phenomenons

of

childhood trauma

have different types: they can be acute,

they can be protracted and repeated during childhood

and go under the

name

abuses when traumatic phenomena are positive.

For example, when something is committed against the child, such as child abuse,

sexual or physical violence, or psychological violence.

Or they may be

emissive,

if they may be due to a type of neglect, neglect of both the psychological

and physical

of the child leading

to real events

and situations of abuse.

Thus maltreatment and abuse are the phenomena Therefore we are now dealing with

when we talk about complex trauma.

Complex trauma, or primary evolutionary trauma as some call it,

is often due to the failure

of the

primary

primary caregivers, parents for example, as well as cumulative trauma.

for example,

as well as cumulative trauma. The psychoanalyst Masud Khan deals precisely

with this type of trauma that is many small events or traumatic situations

of an omissive or commissive type that were repeated during childhood and which,

cumulatively, gives rise to a traumatic climate or dimension

that the subject will feel

during his adult life when they encounter difficulties,

problems, or another trauma that recalls the previous trauma.

However this previous trauma is a complex trauma which can be extended

over a very long

and important period of time, even a whole childhood.

Think of situations where there are families

that experience a

climate of fear or prolonged violence due to disturbances or problems affecting parents

of one or the other

and therefore do not guarantee that serenity, that sense

of security and protection that is very important for a child to develop basic trust

which is

necessary to encounter life and relationships

with others in a calm, open and confident way.

The subject may not notice this, because more or less all of these situations can

encounter phenomena of repression or forgetfulness,

and can

Therefore

Simply

work from within, in an underlying way,

until the “bill is presented” to the subject.

This is because these situations come to light, in a way

that can be explosive,

due to the effect of something in the environment of the subject that in adulthood helps

to deconstruct their emotional climate,

contributing to the discomfort of the subject and thus

reopening the scenario of the past trauma.

This is because, as previously mentioned, the current

trauma can attract and recall the past trauma, in a sort of fatal attraction

Re-victimisation in complex trauma

VIEW UNIT IN STUDIO

Bookmark this page

Re-victimisation in complex trauma

Start of transcript. Skip to the end.

What are the clinical manifestations of complex trauma? We have seen that complex trauma

leads to series of psychopathological consequences

that go far beyond the simple, so to speak, post-traumatic stress disorder.

so to speak, post-traumatic stress disorder.

These are evolutionary consequences that mature over time and, precisely because they have this

long gestation, which is different from post-traumatic stress disorder, they open up a much

Transcripts

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STAFF DEBUG INFO

What types of trauma characterise clients of the service where you work?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Do you feel that you have sufficient training to work effectively with your trauma affected clients?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

What role do you play in your workplace structure?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

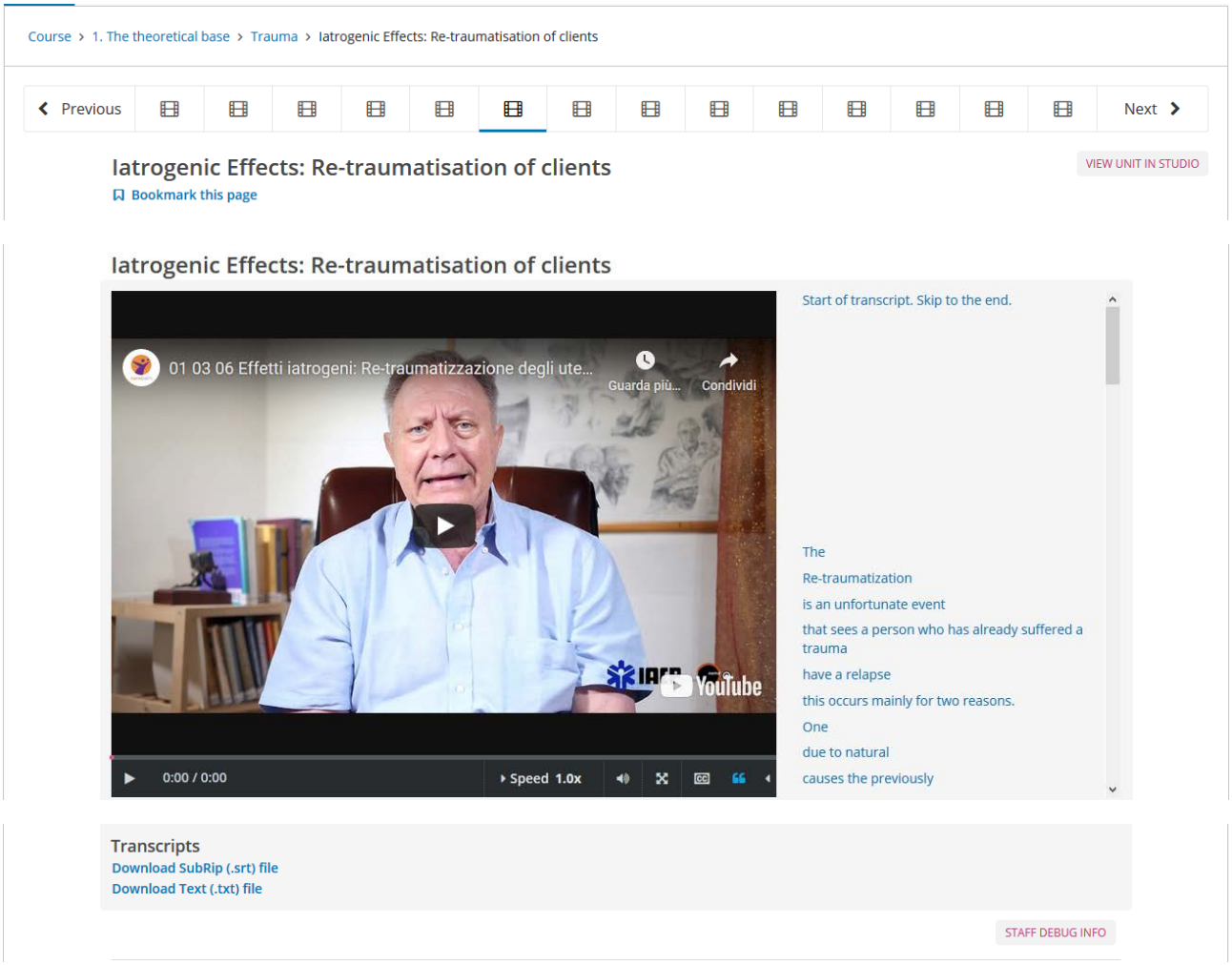
Would you like to receive further training and professional updating on trauma treatments and if so, on which issues specifically?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO



Transcript

The

Re-traumatization

is an unfortunate event

that sees a person who has already suffered a trauma

have a relapse

this occurs mainly for two reasons.

One

due to natural

causes the previously

traumatized person

is exposed

to images or events

where other people are victims of trauma and this makes

the subject re-live

the previously experienced trauma

The other is

is

instead

a type of re-traumatization

that

has

iatrogenic origin

That is,

are delivered

in which provided in manner

dysfunctional

Maybe

not necessarily due to the bad intentions of the professionals

but out of simple ignorance

the traumatized person

that instead of being helped

by the treatment and care facilities

it comes

traumatized

in short

it would be like

a

Person

that

who arrives at an emergency room

with a broken leg

and the doctors handle it badly,

dropping the patient from the stretcher

He then finds himself with two broken legs, thus doubling the damage;

a true tragedy.

The history and the sociology

treatments

of trauma

reveal that unfortunately,

this was not at all infrequent in the past

obviously not for bad will, but ignorance

to produce

such damages

iatrogenic results

The whole world of care,

because offers treatments that impact a complex and delicate system like a human being,

risks not only impacting people in a good way, but - without wanting to - further damaging people;

this is true for drugs, for surgical procedures

and for any type of helping relationship. A service If not delivered

effectively, it

becomes

Counterproductive

Within the specificity of trauma this is particularly serious, as a traumatized person

is particularly

sensitive and

can be significantly damaged by a second traumatization

Today we have learned

from these mistakes, research has become more numerous

and accurate

a

developed significant knowledge - which of course will continue to develop in the future - thanks

to which precautions have been drawn up so as not to run the risk of

re-traumatising already traumatized people

These precautions are called

trauma-informed practices

they centre on the person of the traumatized service user

and

pay attention to what causes further damages.

You can skip doing this exercise if you do not work in any role in the field of offering services to traumatized minors.

STAFF DEBUG INFO

In your nation, how high is the risk of re-traumatization of clients currently?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Is the risk of re-traumatisation of clients present in your workplace?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Which factors lead to the risk of re-traumatisation of clients?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Do you personally think you have received enough professional training to protect your clients from re-traumatisation following your work?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Would you like more training and updating on this preventive aspect?

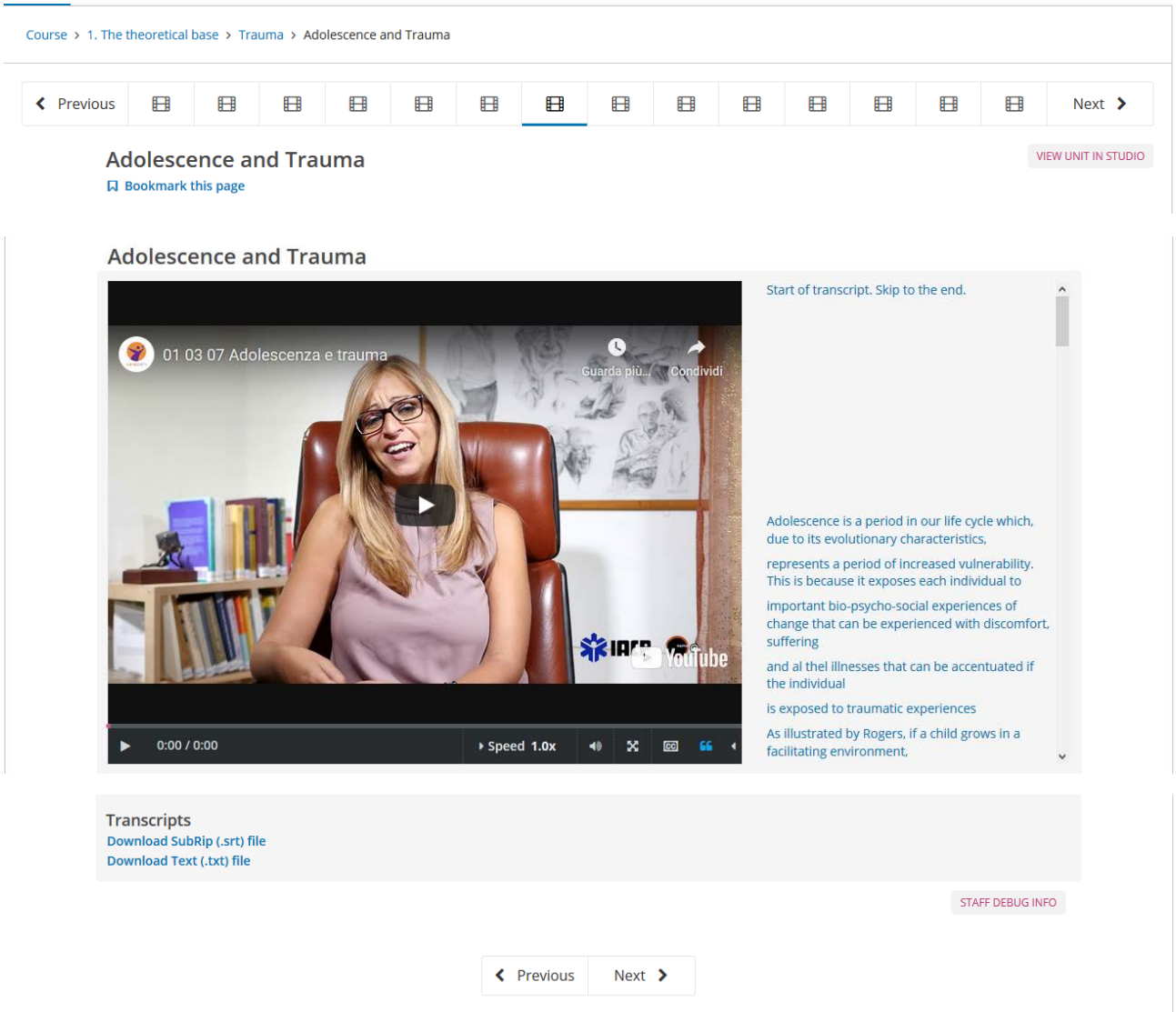
Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Previous Next



Transcript

Adolescence is a period in our life cycle which, due to its evolutionary characteristics,

represents a period of increased vulnerability. This is because it exposes each individual to

important bio-psycho-social experiences of change that can be experienced with discomfort, suffering

and al thel illnesses that can be accentuated if the individual

is exposed to traumatic experiences

As illustrated by Rogers, if a child grows in a facilitating environment,

this will allow him to be in touch with his/her feelings, not to block them or to freeze traumatic experiences,

but to move on in life, satisfying his needs and evaluating experiences

and evaluating experiences as pleasant or unpleasant depending

on whether they are favorable or unfavorable to one's own development, that Rogers

calls this innate capacity of self regulation the actualizing tendency, which is the capacity to understand oneself, self-regulate and actualize oneself.

If instead the child lives in an environment where he feels that the acceptance of his care takers

depends entirely on how well he adheres to their expectations,

to forcefully amputate a part of his own self

and therefore to relate

and build an ideal self with rigid constructs.

Constructs that will be even more rigid if

built on a constant sense of ambiguity, threats and fear, if the child grows in an

unpredictable environment

it is precisely in this deep core of estrangement between perceiving, experiencing, symbolizing

and act that is created and strengthens that sense of estrangement on its own which is then at the base

Of the pathogenesis

We therefore see that our teenager, who grows up and is nurtured in his relational context,

is thus exposed to the evolutionary changes mentioned earlier.

All these changes of determinants requires a kind of internal reorganization,

a re-tuning that involves the individual image of himself and his most important relationships

All this requires, therefore, a redefinition of one’s sense of identity.

to the life experiences, but also constant compared to the sense of identity that has been built

and all this requires, therefore, a redefinition of one's own concept

Of

Lets see what these changes facing the teenager are.

the first concerns the body: the adolescent's body is an evolving body, with

growth in size, the appearance of secondary sexual organs,

reproductive organ Therefore a body that requires a new type of relationship with itself.

The body becomes a primary and intermediary vehicle to

communicate the teenagers experiences externally.

A body, therefore, that you can choose to maintain and beautify,

but also to scratch, cut

or to forget; a body that chooses to be talked about.

At the same time, it is a body that is seen from the outside, that captures the gaze of others,

with desire or derision and therefore exposes the adolescent to new experiences,

new opportunities, but also new risks.

Then there are changes at an interpersonal level.

Within the family the teenager is asked to move from dependence - the care and attachment phase to autonomy and the search for balance between these two apparently opposite evolutionary thrusts, which has social repercussions. In fact in the external environment, the role of the teenager within their group of peers and other significant relational figures, changes have shown, there are also changes at the level of the brain.

As the latest researches

The brain undergoes modifications, both structural and functional, especially in those cortical areas that are involved in the decision-making processes.

All this causes great vulnerability which, as mentioned before, is further undermined if the subject experiences traumatic experiences harm or compromise that sense of internal security, the secure base described by Bowlby

This is our emotional place of safety in which needs can be felt, named, fulfilled, which we cannot. always return, but which therefore allows us to have that valuable experience of developing autonomy without losing love. Instead enriching ourselves through the meetings we have with other people.

The person, on the other hand, who has suffered trauma has low metallization capacity and is not able to self-regulate his/her emotional states, can do nothing - as Bromberg tells us

Bromberg tells us to isolate the traumatic experience and all the experiences and contents associated with it, by dissociating it. The pathological dissociation - as illustrated by Caretti - leads to the depletion of the subject and its resources, because it prevents him from reconstructing these traumatic experiences in a coherent narrative with his own life story.

For this reason, if we work with adolescents who have emotional stress, what we can offer is to work with them at an important relational depth, offering them relationships that are profound, based on listening, empathic listening, with deep respect for who they are. Trying to understand the experiences from their point of view, trying to grasp the meanings of what they experience what they experience and, therefore, to offer relational contexts in which adolescents can, slowly, reestablish contact with those parts of themselves - those needs denied up to that point. Not only allowing them to re-feel them, but also to re-tune parts of themselves

to the external experiences that before they experienced as excessively dissonant.

This is possible by offering the adolescents a relational contexts in which we have

a different look towards them. Not just a look that leads us to label

them as boys or girls in perennial revolution and struggle with the outside world, or as apathetic figures awakened

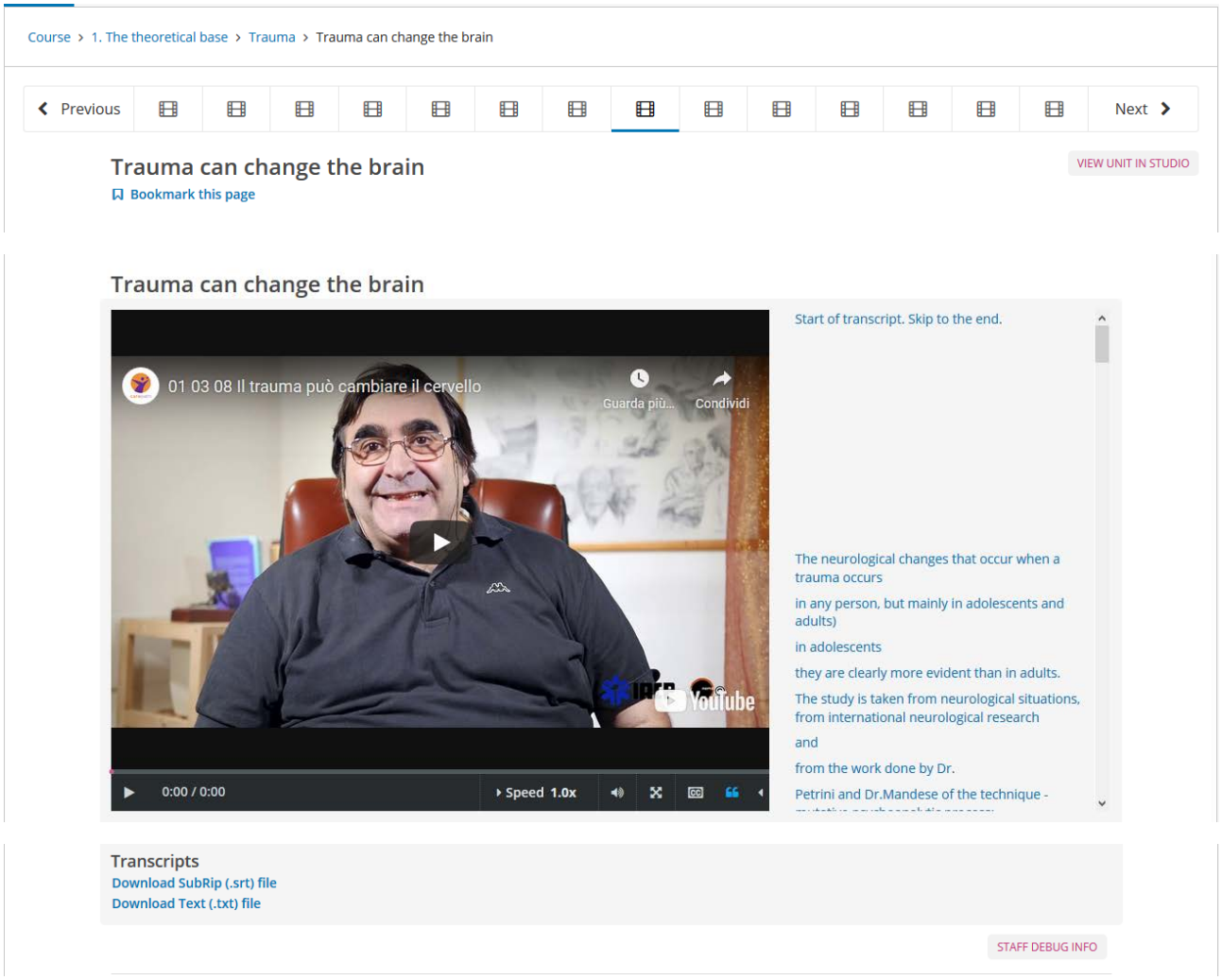
only by the world of social network, but to see them as children with characteristics

and tools typical of their evolutionary phases, that move around the world

ask questions, give answers, explore, try to give a personal meaning to their experiences.

Just as us we continue to act as adults for the rest of our lives

and therefore is very important that we will be rooting for them.



Transcript

The neurological changes that occur when a trauma occurs

in any person, but mainly in adolescents and adults)

in adolescents

they are clearly more evident than in adults.

The study is taken from neurological situations, from international neurological research

and

from the work done by Dr.

Petrini and Dr.Mandese of the technique - mutative psychoanalytic process:

a technique that clearly has

psychoanalytic and neurological parts, in

agreement

with the findings of

international neurological research and the relationship between neurology and psychoanalysis.

It is well known that every individual in a healthy

state develops 1400 new neurons

from estro- genic stem cells

on a daily basis, both at the hippocampus level

and at the olfactory level.

This is an important aspect because the hippocampus is the central part of the memory,

the organism

which recalls similar situations, thus in situations of trauma.

While at the

olfactory level

we observe our cerebral lobes

are nothing more than

an outlet of our olfactory lobe

the animals work with the sense of smell

we work with thought

therefore human being thought

no other than the olfactory

which has spread developed in these

brain cells

We believe that human beings have about 30,000 genes, too few to define all situations,

so family, sentimental, relational, cultural and religious situations come into play

Research shows that only 70% of genes are genetically determined

and only 30% are impacted by external factors.

The difference in genes

between a small man and a male bonobo is 5%,

however this

percentage is very important. A man and a bonobo are not comparable, at all.

comparable, at all. For humans,

culture, religion, all external situations, the family, the community

in which we live, are very important for the formation of an individual.

What happens

when stress occurs?

A stressful or neglectful situation neglect as we have seen is like a stress)
does nothing but block the activity of stem cells at the level of the hippocampus
and therefore it becomes impossible to replace neurons that are normally lost;
so there
is a loss of neurons
in the most important and deepest part of the brain which is the hippocampus
The cognitive emotion regulation that accompanies and sustains these
brain changes
is characterized
by anxiety and depression
related
to the amygdala:
a small cluster of nuclei inside the brain that supports
all our emotional-affective situations,
from love, to sexuality, to eating,
that is important from an emotional point of view.
An alteration occurs in the prefrontal cortex, which are the ones that direct our goals:
if I decide to go to the theater to see an actor it is the prefrontal cortex
that drives me to do this action, then the frontal cortex realizes it.
But the prefrontal cortex also drives impulses, for example when I have the impulse to leave or stay
in one place I owe it to the prefrontal cortex that the frontal then reacts and communicates
the need to remain, for instance due to a commitment.
The third part that will be damaged is
the hippocampus and memory (as we have already said,
the hippocampus is the seat of the memory).
Studies
Longitudinal studies have shown that traumas do not express themselves through a disorder
of DSM -5 or ICD - 10 which is called post traumatic stress disorder,
but is transmitted
through symptoms of anxiety and depression,
sometimes hallucination, but is highlighted
through changes in the sense of self in interpersonal relationships.

A person who has undergone a trauma
has behavioral limitations and mental limitations,
is the person seems unable
to express
herself in the world of work,
of affections
relationships, - it is
as if he or she have fallen to a lower level of functioning
This is
This is due to the HPA axis - hypothalamic-pituitary-adrenal axis.
At the brain-level there is a gland called
pituitary gland,
which all the hormones
of our body radiate from.
The connection between the hormonal (endocrine) parts
and the nervous part
is given by the
hypothalamic-
pituitary axis.
Everything that reaches the hypothalamus - an area of central importance, almost
a small brain
is transmitted to the pituitary gland and gives rise
to sensations, that is the nervous signal is transmitted with hormonal substances.
These hormonal substances
branch out throughout the body,
from the pituitary gland,
and control
the thyroid
sexuality through the genital glands, male
and female sexuality with the male hormone(which also determines female sexuality).
Then, especially,

the release of corticotrophin: the stress hormone, or rather the stress pre-hormone because the real stress hormone is ACTH

because the real stress hormone is ACTH,, the cortisol,

which is why cortisone is given to help the body react when there are physical malfunctions,

cortisol in fact has the same elements as cortin (POMC).

Even in the case of battles and wars the human organism is prepared, in fact cortisol - ACTH

to be precise - causes pain

to not be felt and gives rise to mechanisms of aggression (as happens in animals).

A clear situation of aggression

When this mechanism of activity

is repeated

it becomes chronic and protracted states of anxiety and anguish

occur

depending on the aforementioned amygdale.

The amygdale

is the chest of drawers

della nostra of our emotional memory, in the sense that it preserves all

our emotional memories, as if it were a camera of emotional reality.

So, for example, our first kiss, first work, first sensation of well-being

the first sporting victory - they are all photographed in the amygdale and re-emerge when

similar situations arise; when the hippocampus

begins

to secrete cortisol

This cortisol binds to the receptors of the hippocampus, amygdale and prefrontal area

and when it has reached a sufficient level, if the situation is not chronic,

it lowers the ACTH and CRF level.

In this way the hippocampus regulates our responses

to stress

When

we are well serotonin manages the area instead - serotonin is the hormone

of happiness, , when a person is depressed,

serotonergic drugs are prescribed.

Serotonin

inhibits aggressive behaviors and promotes socialization.

It is produced from tryptophan and is introduced into the diet.

Serotonin, together with oxytocin, which is the binding hormone, is the most positive

and useful hormone for the body, in the sense that while serotonin stimulates sociality

and relationship with others,

oxytocin - released after 5 seconds of hugging another person

is the hormone

that stimulates the bond.

The research is highlighting that loving activities,

important thoughts and feelings have

profound therapeutic effects on our bodies.

So

undoubtedly there exists,

in our way of being

a series of reactions that change the brain and modify the body,

in any situation where there are hormones related to neurohormones

and linked to nervous stimuli.

Supporting material

Bremner JD. Traumatic stress: effects on the brain. *Dialogues Clin Neurosci*. 2006;8(4):445–461.

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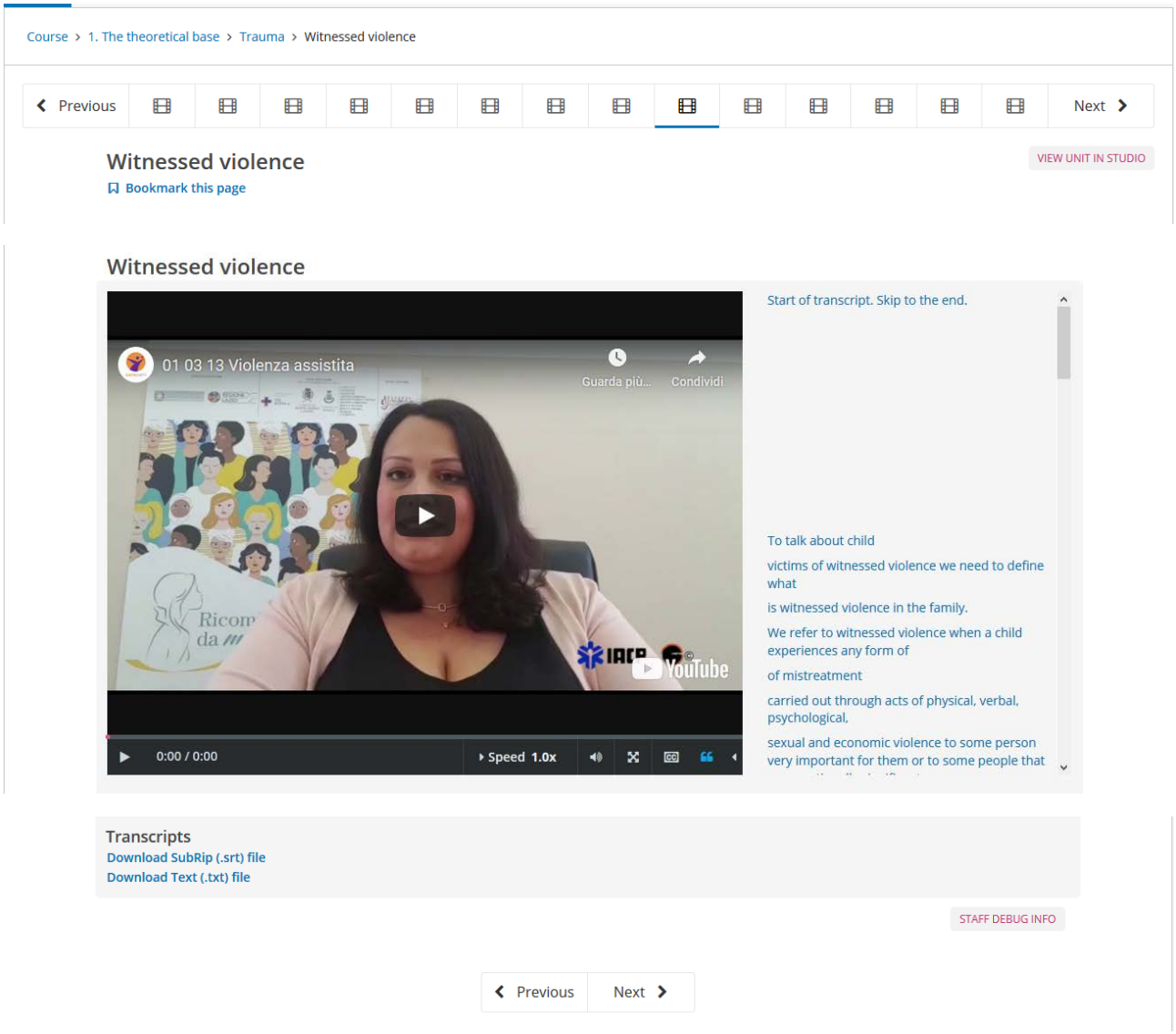


Transcript

To talk about child

victims of witnessed violence we need to define what

is witnessed violence in the family.

We refer to witnessed violence when a child experiences any form of

of mistreatment

carried out through acts of physical, verbal, psychological,

sexual and economic violence to some person very important for them or to some people that are emotionally significant

for them, an adult or minor

This type of violence also includes those inflicted by minors to other minors,

but also by other family members to pets; they all

are highly traumatizing experiences for children.

The characteristics of these experiences may be different.

Violence can be indirect: violence is perceived

so it is not just a question of seeing violence, but also just hearing it.

This should be emphasized because many women victims of violence report that the children,

when they were beaten, were in another room; in reality even in these cases

it is a form of direct violence even if the child do not see and only hears it.

The experience can be indirect

when the child is aware that the violence

has occurred or is about to happen; in this sense children have "antennas":

they understand when there is the typical

tension in a house that precedes the burst of an episode of violence.

The experience is sometimes perceived not directly or indirectly,

but the child can perceive its effects;

for example seeing the mother with bruises

or feeling this air of violence in the house, and so in these cases we are dealing with witnessed violence

There are some false beliefs about witnessed violence.

Children

are not impervious to violence that occurs within their own family;

even if the violent act does not occur in their presence, they can grasp its implementation

this because the child is never a passive and unconscious spectator.

Witnessed violence increases the risk of direct violence against children.

The child who tries to defend the mother, getting in the way,

can be hit by the father: in this case

Dr. Annibali uses a gender perspective to

talk about witnessed violence, as in most cases violence is perpetrated

by men against women

This does not exclude that violence can be perpetrated

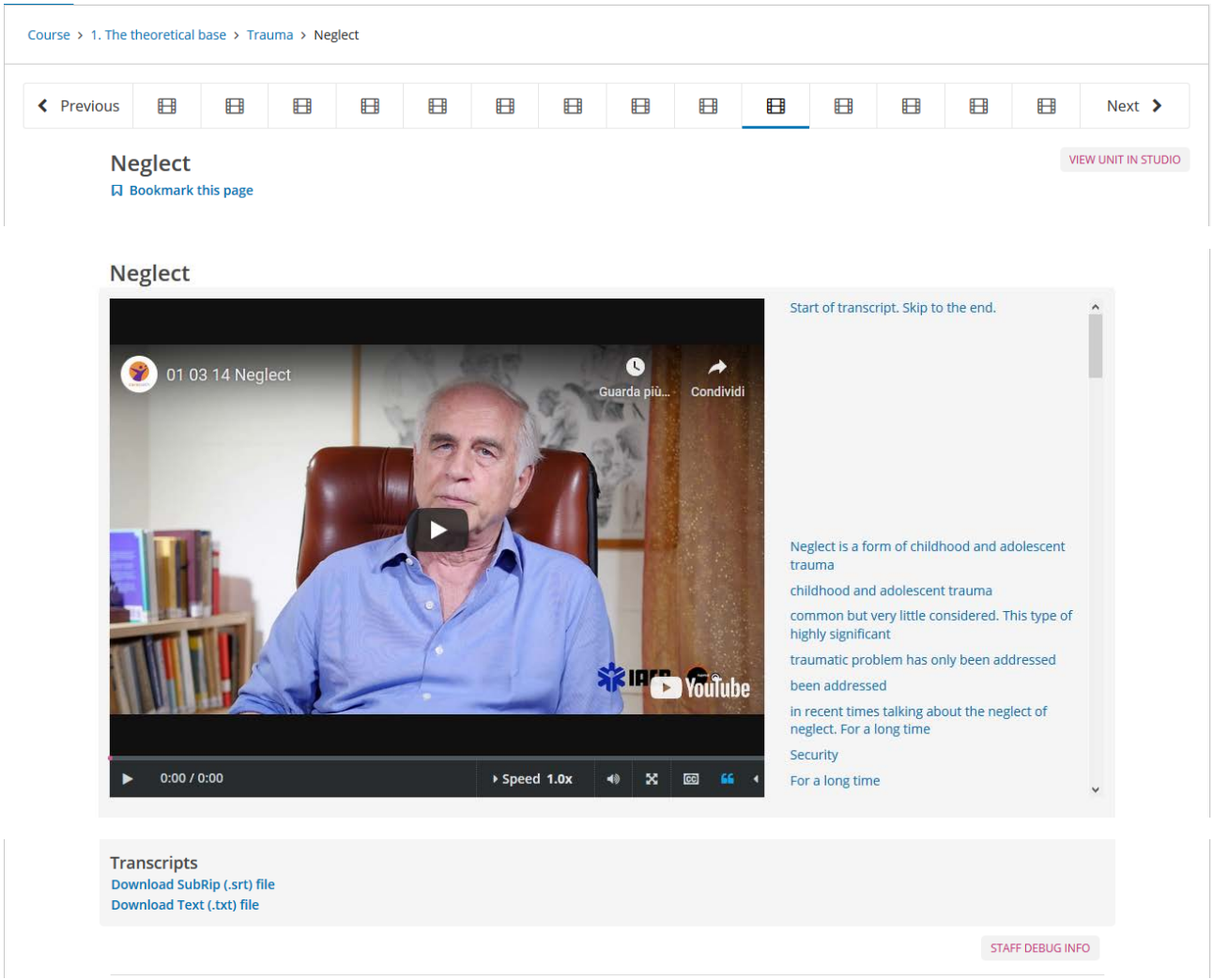
by a mother against the father, or at least by a woman

against a male, but statistically it occurs less frequently

Children exposed to violence are five times more at risk to become violent in adulthood compared to children

who have not witnessed violence.

The effects of witnessed violence are:
a feeling of fear, anxiety, overwhelmed, sadness,
serious depression, feelings of anger, guilt, inadequacy and shame.
Children lose confidence in them and in others, can develop
can develop psychosomatic disorders,
impulse control issues, academic difficulties, learning disabilities,
language,
loss of bowel control, relationship difficulties
and can also develop a post-traumatic stress
disorder if this traumatic experience occurs within a relationship of trust, such as the family.
At the biopsychosocial level,
the effects of witnessed violence are reflected in behavior,
emotions, cognition, the child's physicality, but also in relationships.
What the child experiences is a world in complete turmoil,
violence becomes normality
and consequently normality is violence
The child will recognize violent behavior
as normal and physiological
or, in this sense diminishing his dramatic experience and will probably repeat these
behaviors.
It is increasingly necessary to focus on witnessed violence and how it
affects children in the present and in their adult lives.



Neglect is a form of childhood and adolescent trauma

childhood and adolescent trauma

common but very little considered. This type of highly significant

traumatic problem has only been addressed

been addressed

in recent times talking about the neglect of neglect. For a long time

Security

For a long time

this aspect was not considered a true trauma

at most a small part of the existing trauma types

In reality today we think of this as the most widespread trauma, and the one

that has the worst consequences in terms of duration over time.

From this point of view, neglect indicates the perpetration of omission

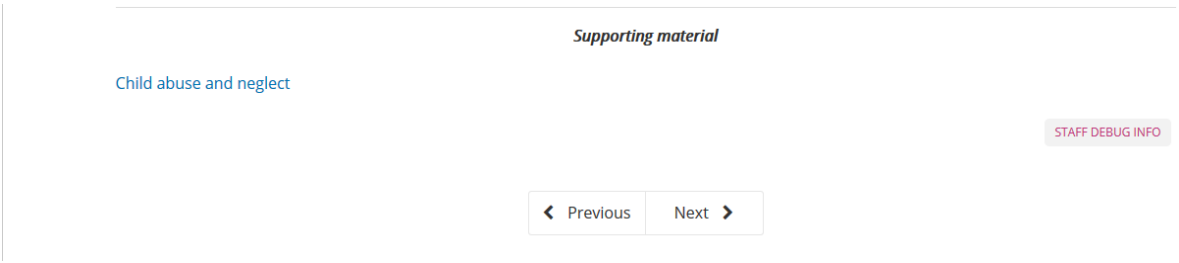
behaviors on the part of those who should be offering care.

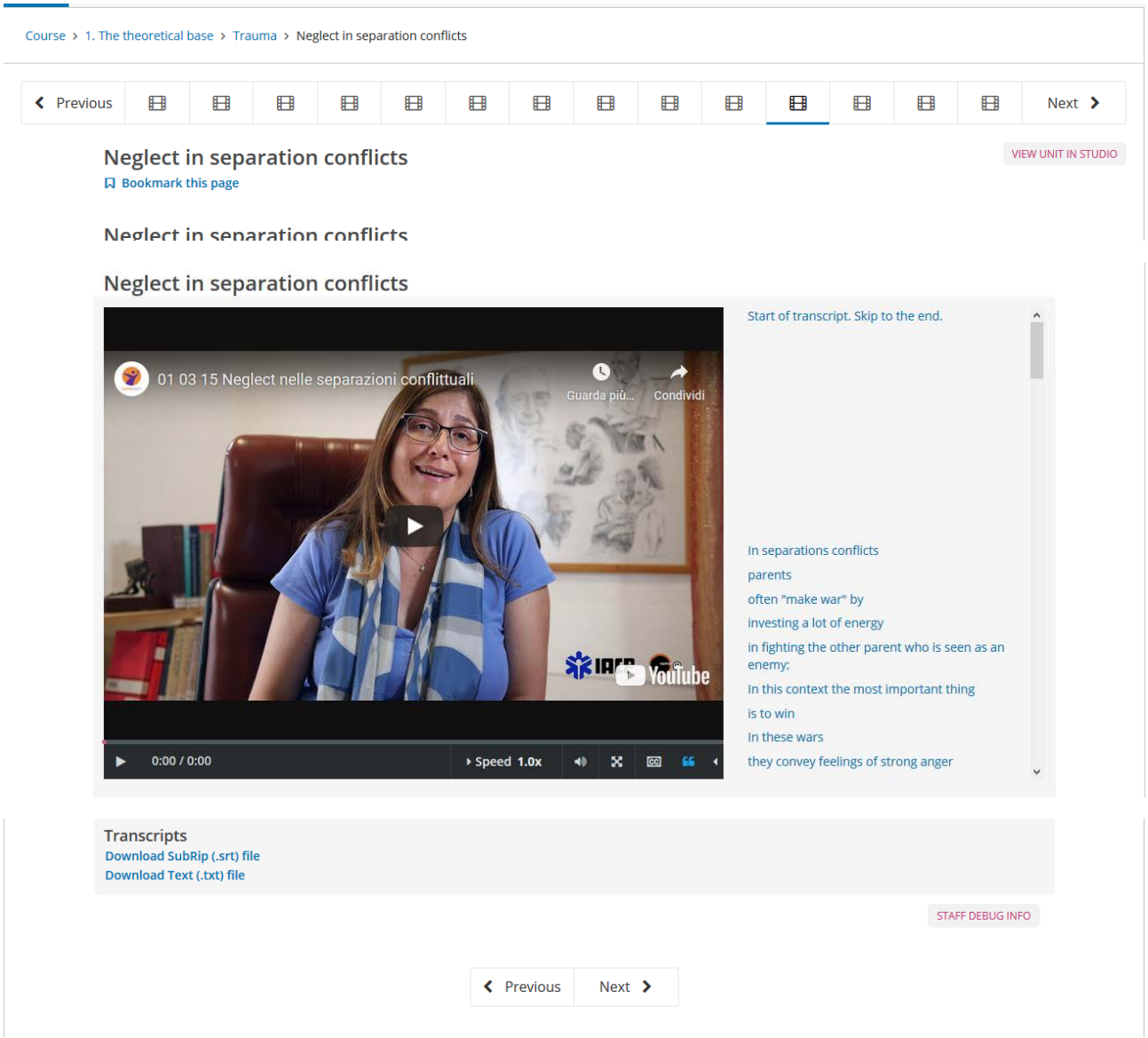
These omissions indicate, even if an imminent serious
risk of damage is missing, a series
of deficiencies that go on for a long period of time.
these are deficiencies that can, for example, accompany the presence of a type I trauma.
An abuse
could be well tolerated
or in a sufficiently adequate way,
but
much less so if you do not have a parent capable
of understanding
and helping, supporting and protecting
the child who has suffered this type of trauma.
to type I trauma
but also in of itself does real damage.
There are different types of neglect that can
concern healthcare,
education, child supervision,
protection with respect to environmental risks,
ai bisogni fisici, al sostegno emotivo physical needs, emotional
support that is given mainly by the family or at least
by those who take care of the child.
This kind of neglect

but in reality it
gives the person the feeling of having no protection from others
and therefore of living in a hostile environment that cannot guarantee them any kind of security.
Obviously
If we talk about the different types
of neglect, whether it is emotional or physical,
we find two completely different aspects.
In some situations the emotion is neglected as we are faced
with cold,

detached and poorly
involved caregivers. Physical neglect may instead concern
the strictly material aspect,
the basic needs,
and can also be extended to the educational needs
of the child who may not receive from parents
the information necessary
to live in a relational context.
There is also medical neglect,
which is when there is a need to treat an illness,
but those who should take care of the child do not
and consequently the illness can worsen
and become particularly dangerous
or harmful.
or harmful. There is moral neglect, or the lack of instructions for the ethical and moral aspects
of a person's ethical behavior.
The consequences of these types of neglect are damages to public health that has long been 64
underestimated.
Today we know
that long-term exposure
that long-term exposure
to neglect can involve
not only the aforementioned diseases, such as eating disorders
but also a reduction in the gray matter of the cortex
and therefore a much diminished
rispetto a soggetti normali.
capacity compared to normal subjects. This data thus reveals how important it is to deal with neglect
and
try to re-stabilize the familial and individual context
what kind of attention
to have that type of care
and attention that gives security to the individual and gives the feeling of being protected and understood.

At the conclusion of the overview of treated diseases, from eating disorders to neglect, 80
it is noted that the latter is particularly common in people who will develop an uncontrolled diet
that in the end advances to a complete loss of control.
It is necessary to think of a therapeutic relationship in which particular attention i
to the person - a sincere interest in them is manifested with an empathic attitude,
one of understanding., empathy
to understanding
This is one of the most important aspects to effectively deal
with this recently recognized, but particularly insidious trauma,
Importance compared to other major traumas.





Transcript

In separations conflicts

parents

often "make war" by

investing a lot of energy

in fighting the other parent who is seen as an enemy;

In this context the most important thing

is to win

In these wars

they convey feelings of strong anger

that actually indicate how complex it is for these people

to face the feelings

experienced and linked to the separation process;

feelings of disappointment, pain,

abandonment, a perception of emptiness, loneliness and

and a sense of failure

These people are actually communicating how complex it is for them to process

what is called psychological divorce.

In this context

the figure of the child emerges

as the one that should be protected;

unfortunately this does not always happen because in reality

the minor becomes the fulcrum of the conflict.

It becomes the central element

and therefore

the parents begin to communicate through the minor

the child becomes

the bridge between the parents,

the reason for discussion as each parent argues trying

from

Finding

to declare what is good

for their child

this case the well-being of the child becomes an excuse

behind which disappointments,

jealousies

and personal annoyances

are hidden

What is missing is the protection of the child, which must always be present, but it is essential in contexts of ruptures

but

it is essential in contexts

of ruptures

What parents could and should do is to collaborate and cooperate in all aspects related to the parenting function,

to collaborate and cooperate in all aspects related to the parenting

What parents

with the aim of lightening the burden on the child, in reality,

children are loaded with a heavy burden as they feel guilty for the separation of their parents,

they feel responsible for their happiness

as they are also feel guilty for being the cause of their parents quarrels

At this point what happens is that the child

in reality, is not seen.

Here is where the trauma arises

in the moment of greatest vulnerability

the child is not

seen and therefore his needs and feelings are not recognized, accepted and fulfilled.

Separation is always a traumatic

event because it is damaging,

A parental couple in the mind of

the child is a single nucleus, which in a certain way

has to split.

This external split

of the father and mother

will produce an internal split

however in the mind of the child.

the parental couple

does not cease to exist, but remains,

only that it loses strength,

identity,

dignity,

and function as a guide.

In this case there are other factors

that have a charge

very strong

negative burden

There are aspects that indicate the extent of the trauma,

for example the temperament of the child

and his ability

to tolerate frustration

the quality of the relationship and the type of attachment that parents were

able to create

before their separation.

The factor that

tells us most about the trauma and its size, is the age of the child:

the smaller the child the greater the trauma;

it will be the extent truma

and parents

even unknowingly,

implement a series of dysfunctional dynamics that lock the child in a

in a rigid role

from which he is unable to free himself

because

given his

young age

he does not yet have that level of awareness

or even a solid personality

capable of freeing himself from this trap

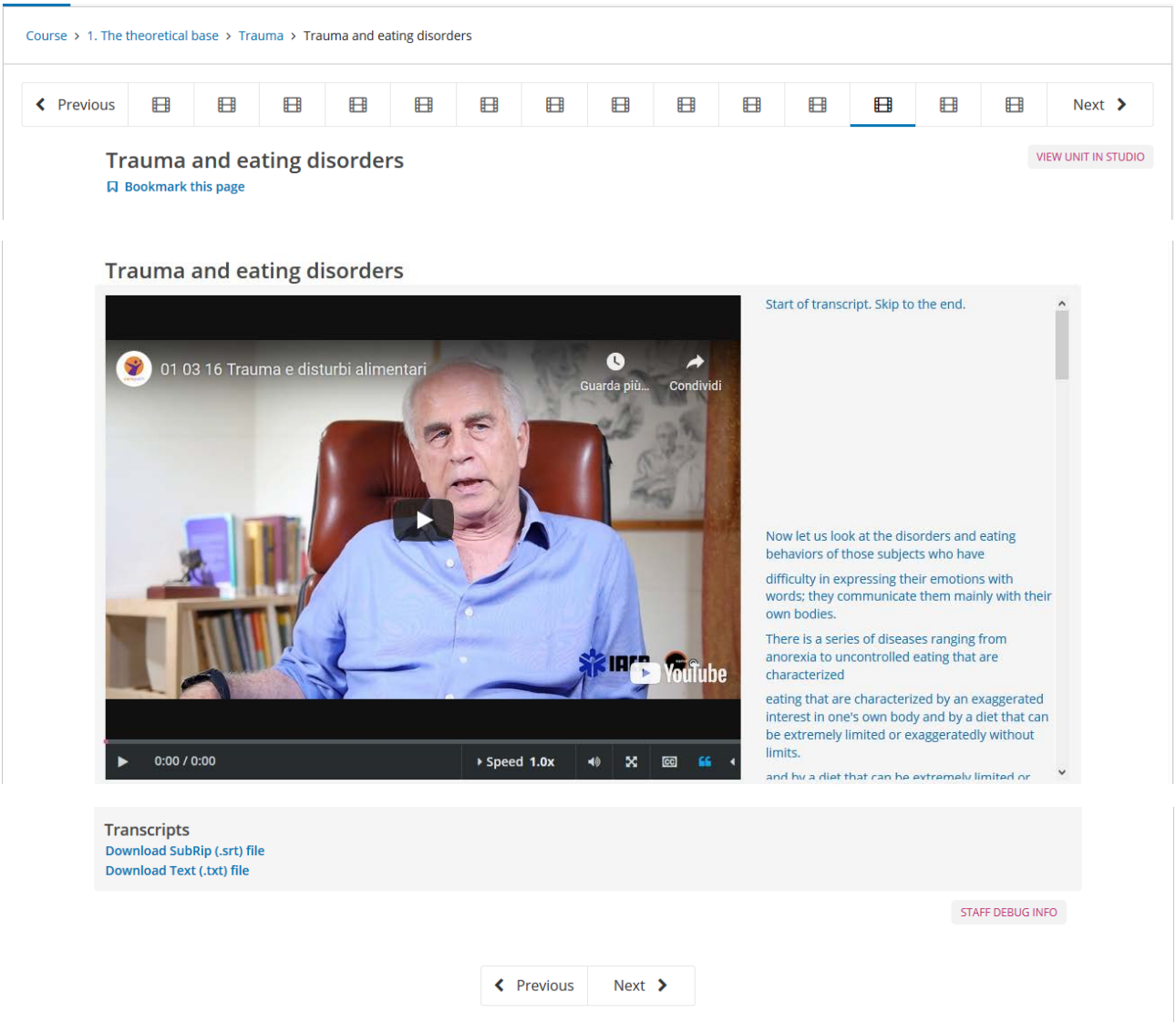
For this reason a technical consultant intervenes in these cases,

as he or she are able to identify

the type of dynamics that exists in the family

and to understand which interventions are needed to free the child

which interventions are needed to free the child.



Transcript

Now let us look at the disorders and eating behaviors of those subjects who have

difficulty in expressing their emotions with words; they communicate them mainly with their own bodies.

There is a series of diseases ranging from anorexia to uncontrolled eating that are characterized

eating that are characterized by an exaggerated interest in one's own body and by a diet that can be extremely limited or exaggeratedly without limits.

and by a diet that can be extremely limited or

Exaggeratedly

This type of patient,

in the case of anorexia, is

predominantly female

Anorexia nervosa is characterized by significant weigh

This weight loss is desired and sought after by the affected person who considers their body as having much larger proportions than is actually the case

In anorexia there may be a severe restriction. There is very limited food-intake, or

or the weight is kept low through food intake followed by strong elimination behaviors that lead

In anorexia there may be a severe restriction.

There is very limited food-intake

the weights come diverse after you inquire food

strong elimination behaviors that lead to

eliminating more than what was consumed

and consequently to lose weight.

Then comes

bulimia nervosa

a disease in which

diet is predominantly

conspicuous

Episodes of binge eating occur,

where the patient

the patient consumes a large quantity of food

great

this kind of patient has the ability to reduce

their body weight through the elimination

of food

especially by

resorting to inappropriate instruments or means such as vomiting

use of laxatives or diuretics,

the use of substances that eliminate appetite

or strenuous physical activity.

in this people balance of weight remains good

And physically it stays in shape

The opposite excess occurs

in the direction of uncontrolled eating also

called Bulimia nervosa or

binge eating disorder

Uncontrolled eating with constant food intake based on binge eating

the use of food on an ongoing basis for several hours of the day,

a diet without brakes

where the individual

or to reduce one's weight

to reduce food

Arriving at considerable weights, from 150 to 200 kg,

with all the related physical risks since

excessive body weight can.

cause serious physical illnesses

These diseases follow one another,

they have

the characteristic of

passing from one to the other as the control capacity decreases

In anorexia nervosa the

the control is very high

people are able to limit their diet

to maintain an extremely low body weight.

When control decreases,

we pass on to bulimia nervosa.

in which

Children or young people who have this

this problem feed themselves - even a lot

but maintain a good reward

but maintain a good reward

and have a capacity for control that emerges later after

food-intake, not before,

which allows them to keep

their weight at acceptable levels

In the third type, the uncontrolled diet, the day is spent eating,

the day is spent

eating,

often in front of the television, almost without awareness of

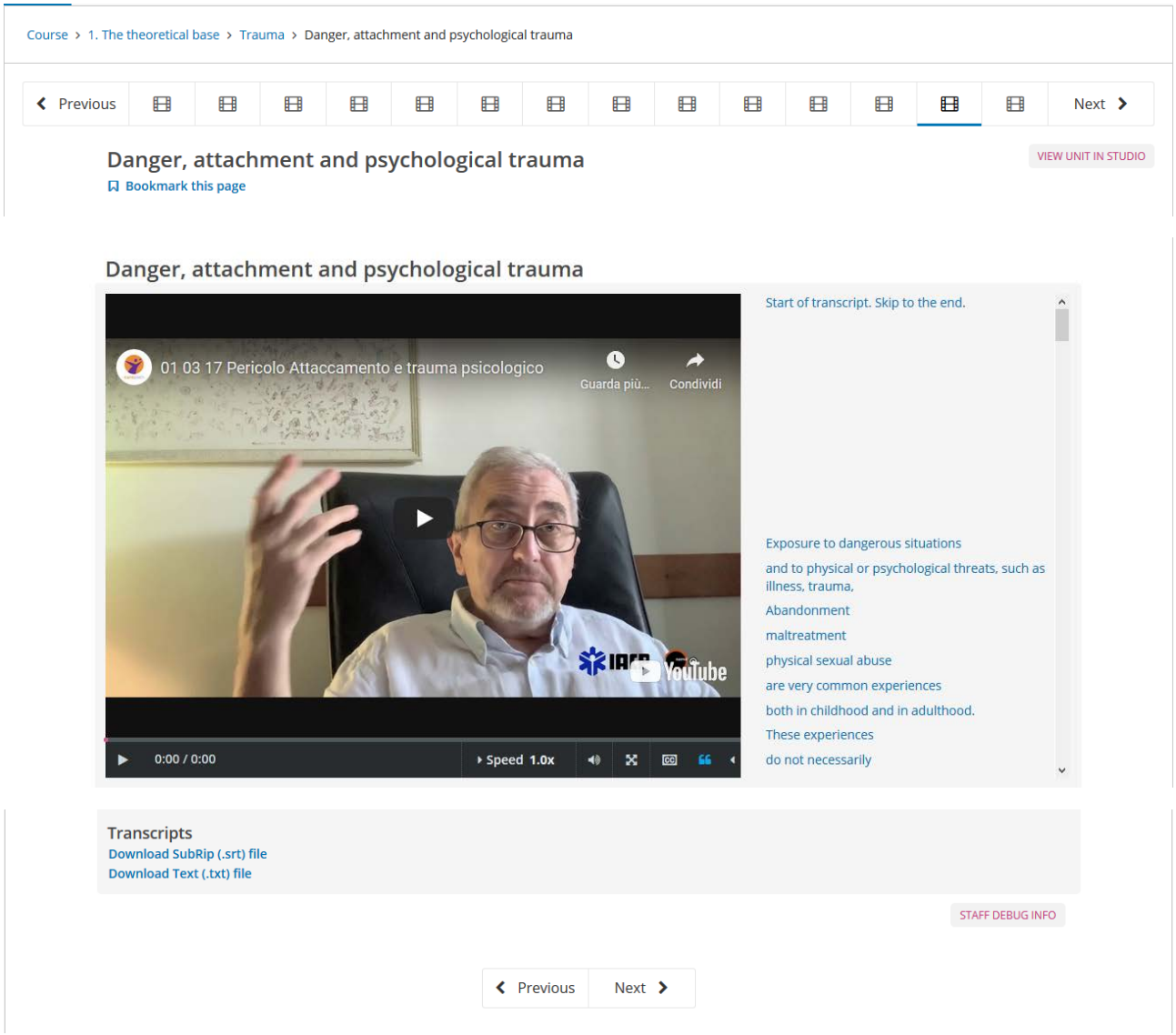
the repetitive and constant action of food intake

have a

any case, these diseases have a series of issues which concern the whole emotional

and the fact of exposing them to various types

of trauma that can occur in eating disorders.



Transcript

Exposure to dangerous situations

and to physical or psychological threats, such as illness, trauma,

Abandonment

maltreatment

physical sexual abuse

are very common experiences

both in childhood and in adulthood.

These experiences

do not necessarily

lead to the development of a psychological trauma

as the

human species has
extremely
sophisticated adaptive capacities
allowing us to face extreme situations
without necessarily
developing a condition of psychological trauma
If these dangerous situations are
dealt with effectively
they become
disarmed of their maladaptive potential
allowing
the individual to remain in a
healthy mental
and psychological condition
In particular, our species has developed
over time
the
interpersonal skills
and very sophisticated
behaviors that have the main function of protecting
us against dangers.
This
set of behaviors and attitudes
is defined
as our attachment system
The word attachment
comes from the attachment theory
that was first proposed in the 1950
by the English psychoanalyst John Bowlby.
Attachment theory holds that human
beings have an innate predisposition
to develop particular attachment relationships

with primary figures, often parents

who

perform the main

function of protecting against dangers.

In this theory we talk about attachment, whose main

but not sole

function is to protect us from dangerous conditions

when a person feels they are in sufficiently safe conditions

they are supported to explore the external

environment, discovering its resources

nd learning to prevent the

dangers that can be hidden in the environment

These attachment functions

have been studied in children of all ages

In this theory we talk about attachment

whose main, but not sole, function is to protect us from dangerous conditions:

when a person feels

in una condizione sufficientemente sicura they are in sufficiently safe conditions

they are supported

to

explore the external environment,

discovering

its resources

and learning to prevent the dangers that can be hidden in the environment.

These

attachment functions have been studied in children of all ages

particularly the relationship with their mother of one and two year-olds

and in primates, There are examples

of research from the 1950s on small

rhesus monkeys

that

that demonstrate how important

on small rhesus monkeys

how important the protective function

of the mother is

even more so than the nutritive function for primates

Attachment is usually divided into two categories: safe and insecure.

Safe attachment

is characterized by a sense

of security, trust in the environment

confidence in its resources

and the possibility of being helped and protected in the event of danger

Insecure attachment is

classically divided

Into

insecure-ambivalent and preoccupied attachment –

in children defined as type C -

characterized by

an overactivation of the body

with an emotional emphasis;

manifestations of anger

fear

complaints about

one's need for protection,

difficulties in separation from the mother

The other type of insecure attachment is the dismissive-

avoidant attachment - also known as type A

which

Un like the previous type, is characterized by hypoactivation. In particular

by distancing oneself from emotional

reactions that

occur in conditions of danger,

hence from one's fear,anger

sense of vulnerability

and
which are either inhibited in their expression
(for example with an attitude of apparent indifference)
or falsified and transformed
into expressions of opposing emotions (for example smiling when facing a frightening topic).
When these
modes of attachment are effective
they protect
against the dangers
that come from the environment
or from our relationships
If
these strategies are effective
and sufficiently protective,
conditions of psychological trauma do not occur
and the individual remains in a condition of relative safety.
The condition of psychological trauma manifests when these
strategies are
ineffective
for example when inhibiting the expression of fears, anger
or needs
is not sufficient to protect the individual
from environmental threats.
In the condition of psychological trauma, all mental processing
activities are negatively
affected by an experience of past or present danger.
This can come from a particularly intense and sudden event - for example
a physical trauma
or abuse
but it can also come from a repeated series of experiences
that cumulatively
traumatic value

In this case we are speaking of evolutionary trauma
a condition in which a child
for example, grows up in an
inadeguate
and neglecting family
environment and as a whole these prolonged experiences create a climate
of inadequate
development that can lead to a condition of psychological trauma.
The ability to adapt and rework a potentially traumatic situation of danger
depends on certain characteristics.
From the individual, his age, maturity,
personality
and the characteristics of his attachment, whether or not they are effective in protecting him;
his physical strength and state of health
as a sick person is more fragile
in the elaboration of a hazardous condition. 00:08:32,980 --> 00:08:34,840 It is very important, moreover,
the protective availability of the figures of attachment, which a person who does not have to
feel alone in the face of danger, but accompanied by protective relationships on the part of people
who are willing to make us feel like we're in the middle of something.
protégé
and accompanied in the elaboration
of a dangerous experience.
An important role is played from the social context: it is fundamental to find oneself
in a welcoming environment, with people who welcome and support
with
their culture,
rituals or personal presence (e.g. friends).
The process of adapting a traumatic condition is not immediate but needs time,
for instance
a significant bereavement - like that
of the spouse or parent -
usually requires

one or two years in order to be properly processed,

without turning into a condition

of traumatic grief.

When

an experience potentially traumatic is not processed,

usually, is accompanied by

excessive hyperactivation

emotional, with

dreams, nightmares,

fears,

I'm not sure I have a sense of threat,

uncontrolled reactions

- as in the case of post-traumatic stress disorder -

or from a situation of excessive hypoactivation, i.e. excessive distance being taken

from all that concerns the experience

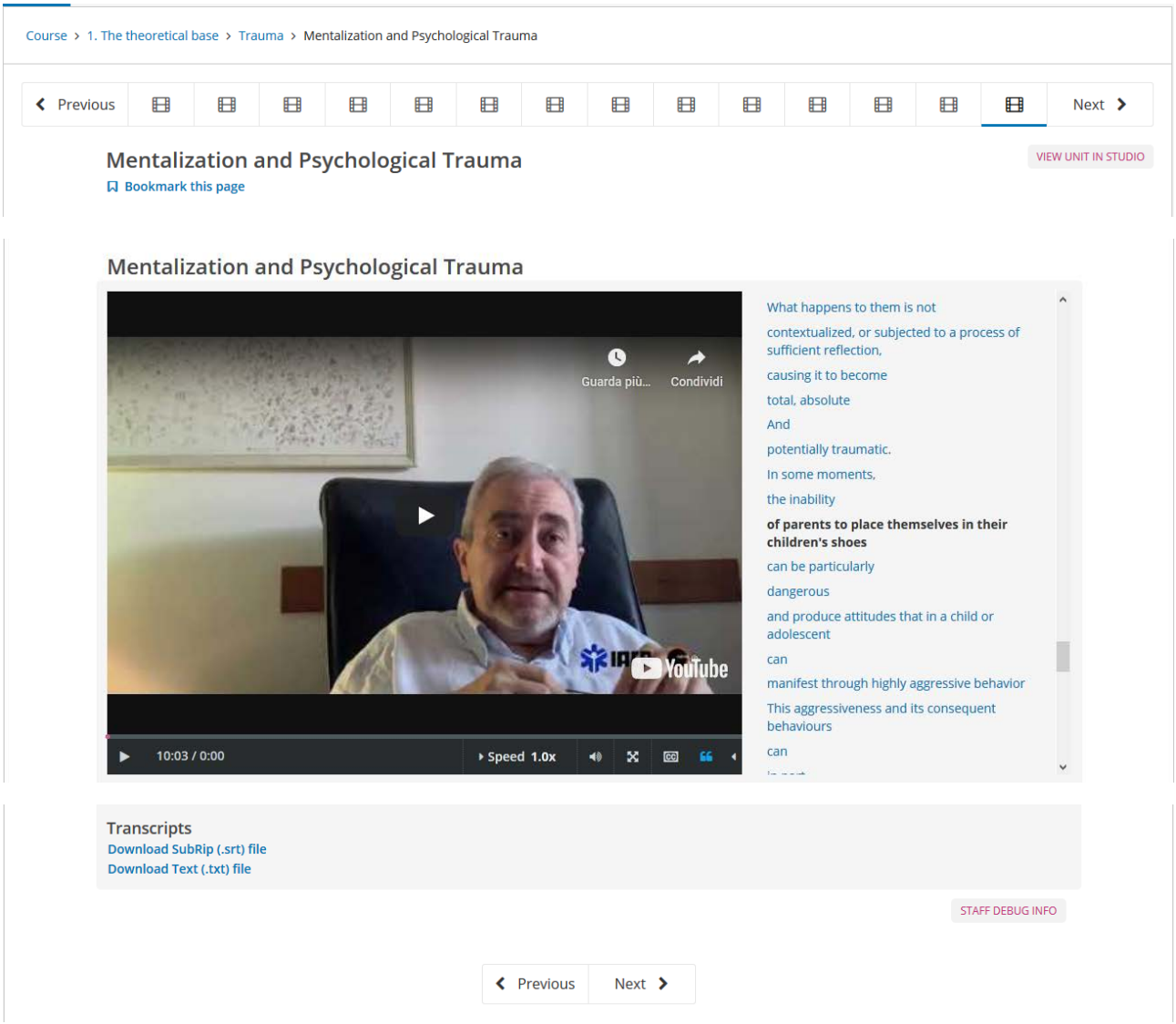
dangerous,

lack of memories,

affective inhibition,

avoid talking or places that are related to the traumatic experience.

In the presence of these two conditions we can speak of psychological trauma.



Transcript

When we talk about mentalization we talk about something that seems to be taken

for granted, which comes from far away

In fact every human being

even before

the

development of psychology,

faces mentalization problems at some point in their life.

That is

the problem of reflecting on oneself and others

of considering what we and others have

on our minds,

the thoughts,

the thoughts,

expectations and beliefs

that influence us

A simple way to understand the concept of

mentalization

Is to

Consider

oneself and others

in terms of mental states.

These abilities

begin to take shape in humans

at around 4 years of age

when a child becomes aware

that

what they think and feel

is not necessarily understood and shared by other people

for example that the mother may not know what is going on in the mind of the child

When children learn

his great novelty they also learn to use

a

very useful

and important

strategic mode of adaptation to problems

they

learn the importance of lying

Lying is possible if you think

that others minds have a different view of the world

and therefore cannot know the thoughts of another individual.

Mentalization

and its processes are based on a series

Of steps

The first regards our

relative

sensitivity to perceiving

Mental states

or of representing our own and others

of mental states (for example to understand being

cheerful, sad

having expectations

prejudices)

and

and the ability to interpret our own or others behavior

on the basis

of these mental states.

This is essential for our ability to be adaptive

(for example if a person is standing silently before us

we don’t think

they don’t have

we think their mind

is filled

with images and thoughts, that their silence is not an expression of emptiness, but of a series of mental states

that

are the basis of this silent behavior).

A second important aspect of mentalization is

that self-mentalization promotes

the regulation of our bodies

For example if

we realize we are

angry

and we begin to think

to think

the anger is related

to something that

was said

the very fact

of realizing it, of remembering

and making expectations and projections onto the consequences

of an action

opens up a psychological path to regulating the anger that has been activated in us.

The heart, our breathing, the production of hormones

linked to anger activation

begin to be regulated

by psychological mechanisms

For example, I could

feel guilty for having felt anger towards someone I love

this inhibits the expression of anger

and regulates the body

This is a fundamental function,

so much so that people with poor

mentalization skills are more exposed

to the dysregulation of the body

The heart

beats

faster and in an irregular way

emotional reactions are more uncontrolled,

and this can lead in the long term

to 100 00:05:32,000 --> 00:05:32,880 diseases

due to the constant dysregulation of the body).

One of the most important functions of the parents towards their children

Is to be

mentalizing:

To think

their children

also in relation to their needs

feelings, fears

putting

themselves - in a sense - in the shoes of their children

and perceiving things from their point of view

For example, a three year old child

will live certain topics

and interpret certain words or speeches within

their

childish abilities,

meaning it is important for the parent

to see things through their eyes.

This condition, which has been called (psychological) mindedness,

is one of the conditions most closely related

To the safe

development of children. It the condition of a

good parent

being

able to put themselves in the shoes of their children and perceive their needs

It is already observed in mothers of very young children

who, for example,

puts

themselves in the shoes of

their crying and agitated children, and therefore understand that they may be cold, or hungry, thus giving voice

to a child's state

if the son were able to have organized thoughts

and could express them.

The ability to represent the mental states of children

is a basic condition of being a parent.

Mentalization is also the basis of

the ability to cope with stress and potentially dangerous situations

by adapting

without developing conditions of psychological trauma.

for example
for a child faced with
the inconsistent behavior of the parent -
who perhaps acts angrily
or with physical violence
or says negative things towards the child -
the ability of this child to imagine the mental state of the parent
acts as a shock absorber and lets them consider
what the parent does
and says within a context. They can think, for example,
“father is
tired and what he says does not correspond to reality
father is usually
affectionate and loves me,
what is happening now
has value at this time and is linked to a particular
state of being, but it is not absolute the attitude described above protects against the mental states
of others
and makes the situation potentially less traumatic
It is clearly observed in adults with low
levels of mentalization
as in
people with borderline personality disorder
that they are much more exposed to continuous psychological trauma.
What happens to them is not
contextualized, or subjected to a process of sufficient reflection,
causing it to become
total, absolute
And
potentially traumatic.
In some moments,
the inability

of parents to place themselves in their children's shoes
can be particularly
dangerous
and produce attitudes that in a child or adolescent
can
manifest through highly aggressive behavior
This aggressiveness and its consequent behaviours
can
in part
Be interpreted
through the concept of mentalization.
If parents are constantly irritated
by the behavior of their child
for example, if the child
poses
a problem
or gives an attitude
the parent begins to turn
on the child in a negative way (perhaps stating that he is stupid, sick or worthless).
This leads the child
to have an image of themselves as a sick
disturbed
incapable person.
This attitude is kept at a distance
This attitude is kept at a distance from aggressive behaviors, meaning that every time an adult approaches
the child with the intention of getting to know them and getting them trust to him,
the child will probably have
a strong aggressive reaction
functioning to keep the adult
away as potentially traumatic
The case may be that for young people who are considered incapable
in the classroom and have to repeat,

the teachers consider

them

negative subjects

and at home these children have parents who reinforce

this negative idea of themselves.

Therefore these children have attitudes of strong reactivity and anger towards the adults who are trying

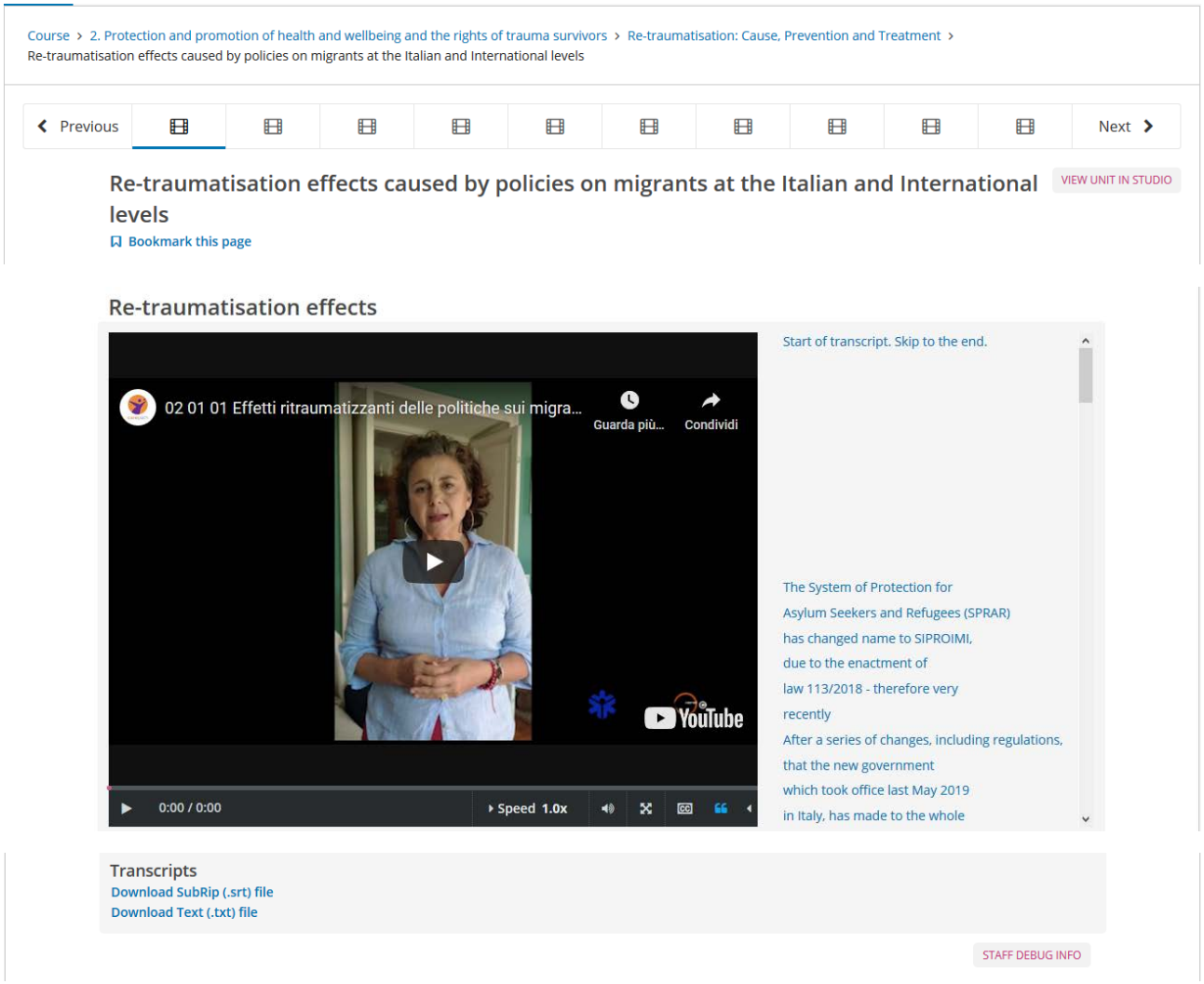
to help them (an educator, a teacher), aiming to keep

the other person

away

in order to not repeat the experience

of being painted as negative or incapable.



Transcript

The System of Protection for

Asylum Seekers and Refugees (SPRAR)

has changed name to SIPROIMI,

due to the enactment of

law 113/2018 - therefore very

recently

After a series of changes, including regulations,

that the new government

which took office last May 2019

in Italy, has made to the whole

issue of immigration, the right to asylum and

therefore hospitality. SPRAR was

SPRAR was established in 2002 and is composed of a

network of municipalities and local authorities,
which in collaboration with
third sector organisations and NGOs, manage on a
voluntary basis (therefore of their own choice)
hospitality and integration projects for
asylum seeker applicants and
refugees.
Over the years, this network has
undergone a progressive and positive
Evolution:
from the initial 1,500 hospitality
places to the current 35 thousand
There have been several phases
in the history of the SPRAR
that have led to a number of changes.
The first was the moment
institutionalization by means
of a law, making it stable and regular
as a central system of integrated
reception in Italy, whereas in
whereas in previous years there were
no structured hospitality systems
but only.
emergency interventions
Another important moment was in
2003 when, during the so-called
North Africa Emergency,
the effectiveness
and efficiency of the SPRAR model
in terms of achieving
social inclusion and
integration objectives emerged

also at the European level.
The last phase is the most recent one
in which the identity of the SPRAR
was modified, meaning it can
No longer
accommodate
asylum seekers or humanitarian cases
because humanitarian protection
has been abolished)
and by law we can only accommodate
unaccompanied foreign minors
holders of international protection
(which constitutes a small number compared
to asylum requests) and some
new types of residence permits,
the so-called special cases.
SPRAR, which is
now called SIPROIMI, will now be able to accommodate
special cases for medical treatment,
victims of trafficking
victims of labor exploitation,
domestic violence, natural disasters
and people who have
distinguished themselves for particular acts of heroism,
always referring to foreigners,
not Italian citizens,
who have other social protection systems.
It can be said that SPRAR
now has a
welfare identity directed towards foreigner
and is no longer a hospitality and protective system
for people related

to the theme of the right to asylum.
These changes to its identity
and could represent, on paper
a partially positive passage,
in the sense that it is turning
to the protection of people with
some type of vulnerability.
At the moment, the difficulty is the fact
that the person in need is required
to have a residence permit
but is not required
in the case of
a victim of trafficking, that can automatically acquire the permit
by as a victim of trafficking, the same can be said
for a victim of exploitation and so forth.
There are no precise criteria
for how these procedures
should be, or how to bring together all people
with this type of vulnerability under
the definition, even legal
of a special case. Only through the
F ormalization of a special-case
residence permit will
person have access to SPAR and
be able to take advantage of all
the protection services
that the
SPRAR can provide
The criteria and requirements
for which a person
may be entitled to
medical care have not yet been defined

what type of mental or physical

discomfort, what level of severity,

and what timing does this take into account?

We are therefore

in a critical transitional moment as

many people who,

up until a few months ago

had the right of access to SPRAR projects

now no longer have it.

While on the other hand,

those who on paper seem to be

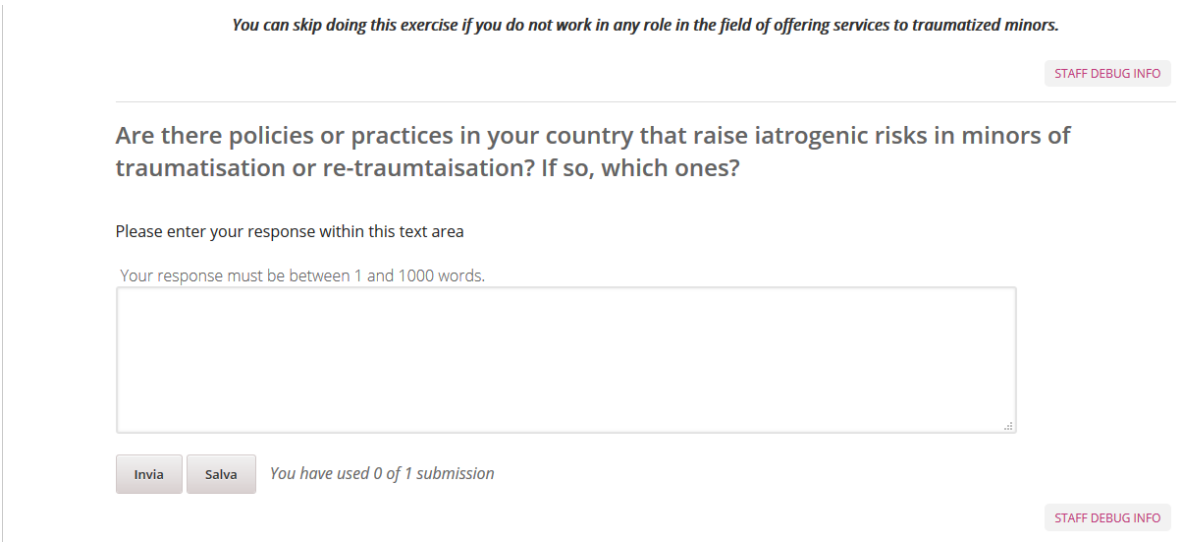
able to have the right to access to these services

in truth do not

know how to give the “supporting evidence”

to be able

use this right.



If you had the power to promote change in your country, what would you change in order to lower iatrogenic risks of traumtisation/re-traumatisation in policy level?

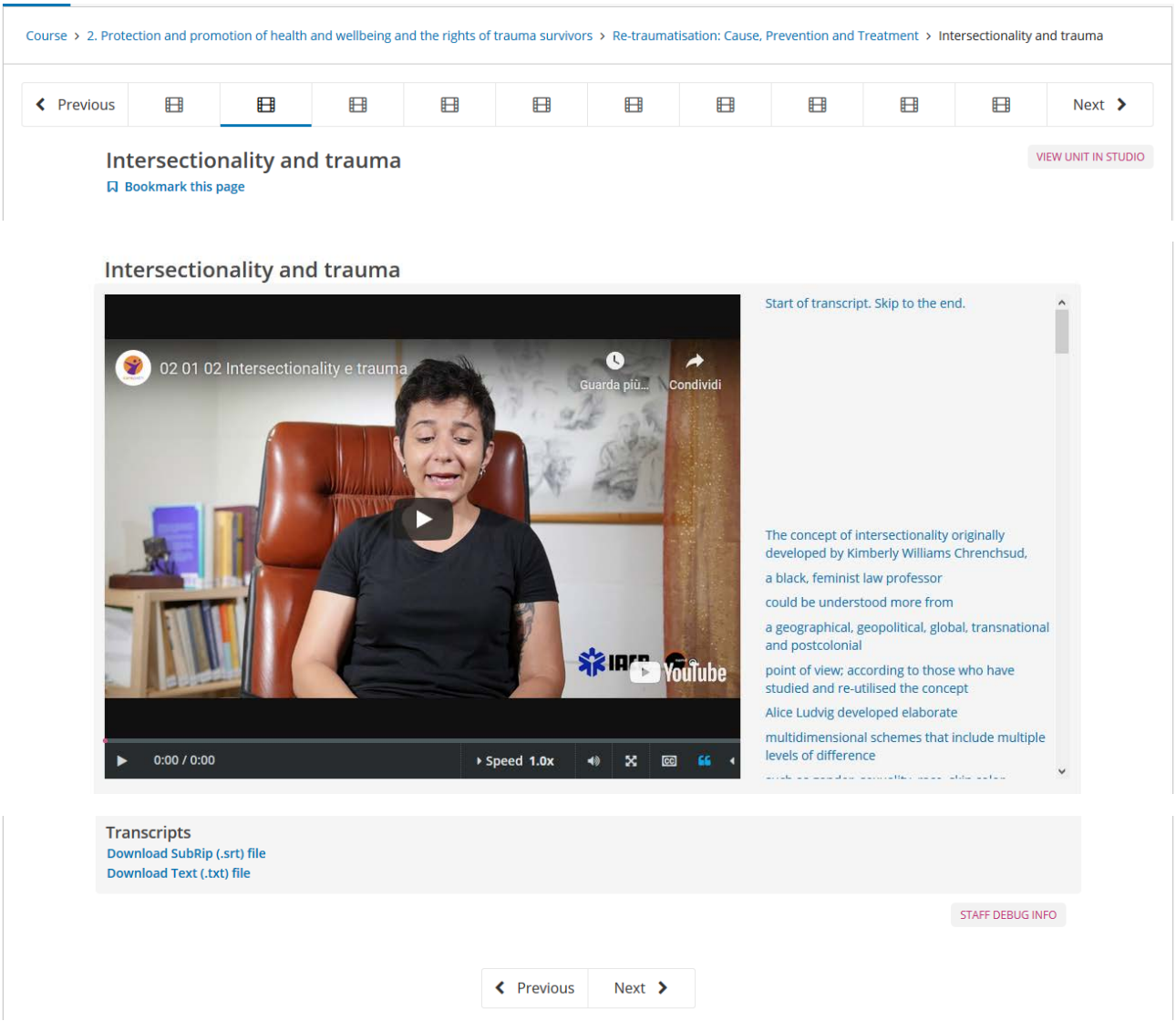
Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Previous Next



Transcript

The concept of intersectionality originally developed by Kimberly Williams Chrenchsud,

a black, feminist law professor

could be understood more from

a geographical, geopolitical, global, transnational and postcolonial

point of view; according to those who have studied and re-utilised the concept

Alice Ludvig developed elaborate

multidimensional schemes that include multiple levels of difference

such as gender, sexuality, race, skin color, ethnicity, status, class, culture, and so on.

This measures the innumerable levels

we should take into account and pay attention to when we are in a helping relationship with

people who come from what we commonly refer to as minority populations.

To quote Audre Lorde

we could say that there is no struggle to do
With one problem, because we don’ lives made of one dimension
Internationality is increasingly an element in the development
of equity policies
also thanks to the work of the United Nations and the European Union
Consider the directives to combat discrimination
and all the initiatives at national, regional and local levels,
and to the policies and diversity management
which are Western nations.
now adopted in all
and in many corporations
This does not, of course, cancel out the uncertainty and suffering of those who find
themselves living in conditions of multiple minority
perhaps after having experienced traumatic situations precisely because of being a minority
In the "daily paper" of May 17, 2018
a sentence from a boy from Cameroon is reported:
"one day we were in the kitchen and we were watching a TV program about LGBTQI migrants,
my African comrades started to say
- Italy is a shit country full of homosexuals -
once again I didn't feel free.”
Allen is 22 years old and has escaped from those who beat him and called him a demon,
leaving Cameroon behind
the newspaper reports
where being a homosexual is a crime
to ask for international protection in Italy.
However, the fear has remained the same
because homophobia has followed him to the hub of Mattea Street, Bologna
where he was welcomed along with his countrymen.
LGBTQI migrants, very often, are very young.
They cannot
count on the support of their own community of origin,
so they find themselves migrating,

but they are often culturally distinguished by the homophobia or transphobia that they have escaped from.
Nor can they be sure of coming into contact with multicultural realities
which allow them to live their sexual orientation or identity peacefully
As emphasized on several occasions in interviews by Vincenzo Bramato,
president of the Arcigay community of Bologna
in some European countries - such as Germany -
there are protected structures to welcome those who flee from persecution due to their sexual orientation
where the staff have received specific training
aimed at not reimposing judgmental or disparaging attitudes that would revive these people's stigma
And trauma
In Italy, at the moment, the hospitality model does not foresee these specificities,
but there are some positive examples such as the pilot experiment
launched in 2017 in Modena with a small six-person apartment
reserved just for LGBTQI asylum seekers
plus an LGBTQI migrant help desk in Verona.
For these
Migrant children
in a developmenting age in relation
to the LGBTQI community
to be part of an ethnic minority in a host country
it is only part of the problem
They are in fact, very often, a silent and frightened minority
even within their own community of reference
An invisible trauma, as Rogers puts it
is doubled.
Minority Stress - if we want to refer to Vittorio Lingiardi
there is a doubled
risk for the mental and physical health of
these people and thus a dramatic loss of human capital.
Getting trained in hospitality services means first of all training in human rights
and the specificities
that the

LGBTQI migrant brings with it to the helping relationship.

Training must therefore be centered on the person

and welcome and knowing these specificities in order to be truly inclusive.

Moreover the services addressed to migrants,

designed and provided very

often without considering the variable of sexual orientation and gender identity

can reduce their effectiveness,

both in regards to the relationship with the client

(and therefore these children that

cannot receive the welcome that they should have)

but also in regards to the usefulness of the training or preventive pathways

(for example, if we think of sexually transmitted diseases

and how

multidimensional formation is needed when we

have as clients adolescent migrants belonging to the LGBTQI community).

On the other hand, the services provided by the LGBT community

are strongly linked to a cultural model of Western gay men and lesbian women

and therefore very often these models

do not consider a model in which these youths who come from other cultures

can really recognize themselves.

The experience of the aforementioned realities

has proven that the support information

and counseling services provided by institutions, but also by non profit associations,

May not be effective for these children.

therefore

working with these populations of multiple minorities

will involve an interdisciplinary

reflection on the practice of the helping relations. Training in helping relationships

offered to these people should include the study of variables of homosexuality, bisexuality and transsexuality

in the history of psychiatry and psychology -

the concept of stigma,

homophobia, internalized homophobia,

but also to have a constant updating of the service providers

on the legislation

relating to these issues,

both in the host countries and in the countries of origin of the people you are going to serve.

In addition, everything

related to asylum-

related legislation should be continuously

deepened and learnt, because it

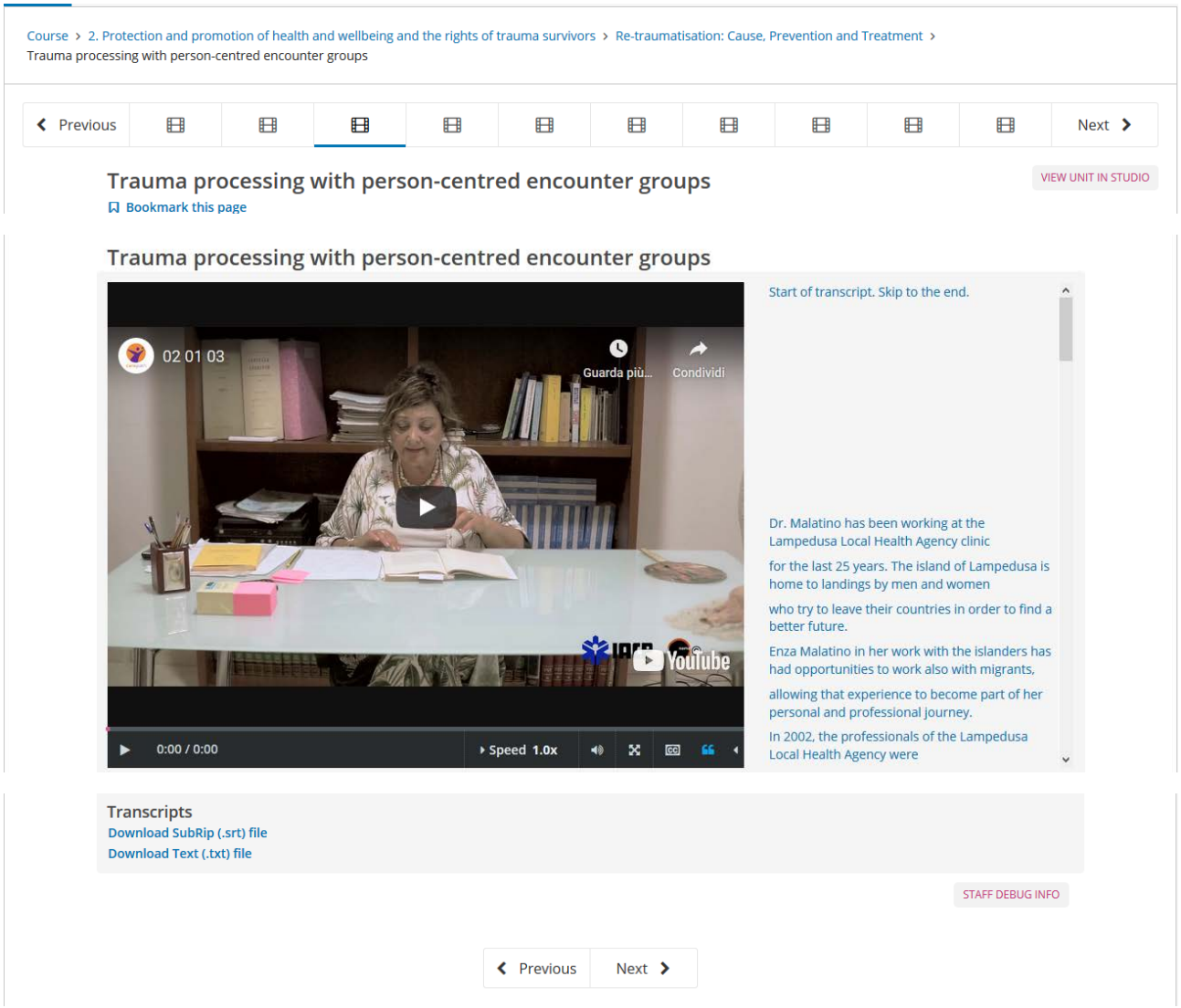
is constantly evolving and changing.

Together with the more technical skills, it will be necessary to develop and consolidate, from a more personal point of view,

a gender-sensitive approach and

maintaining, both within oneself and the working group

which offer services to these youths, a reflection on human rights.



Transcript

Dr. Malatino has been working at the Lampedusa Local Health Agency clinic

for the last 25 years. The island of Lampedusa is home to landings by men and women

who try to leave their countries in order to find a better future.

Enza Malatino in her work with the islanders has had opportunities to work also with migrants,

allowing that experience to become part of her personal and professional journey.

In 2002, the professionals of the Lampedusa Local Health Agency were

asked to offer support and therapy to the hospitality centre where people who had landed on the island after very difficult

long journeys, with severem l risk of death, needed treatment.

The head of the local Health Agency asked me to make a psychiatric evaluation of the subjects who landed on the island.

It was almost impossible to assess the psychiatric health

of subjects exposed and subjected to such serious traumatic events, as they came from different cultures

they did not request help or support of a pharmacological type, coming from contexts

which did not consider Western medicine as conventional medicine

What supported and helped these subjects in some cases

was to resort to magic rituals which were linked to the cultural beliefs that they held.

Offering help and support at the same time and people with all their sufferings was particularly complex

Thus I thought to organize some listening groups.

This was for me, a psychiatrist and psychotherapist trained in the person centered approach of Carl Rogers an extraordinary experience

In this type of group,

the encounter is characterized by people sitting in a circle

and listening to each other. The fundamental element is the total absence of judgment

and the profound respect for any topic that the group wants to discuss.

In this way, it is possible to create a climate of trust that greatly helps participants

even in very problematic emotional states to rework the experience

and at the same time find solidarity from the other participants:

becoming aware of one's personal experience is not necessarily only individual but can be shared and understood experience for the other people. 27 00:04:15,360 --> 00:04:23,360 This in of itself favors the resolution - sometimes - of suffering

conflict or painful event

That is what happened in these groups. An important and fundamental element was to find the balance with the cultural mediator

he translator - as the facilitator did not speak the participants' languages and the basic conditions

in which she was operating were absolutely prohibitive due to the lack

of materials (there were no chairs) or due to contingent situations (some groups had just escaped from the shipwreck

and some were only wearing rescue sheets).

Despite the unorthodox situation, to great surprise,

it was found that deep values live not in form but in substance.

Dealing with people who were sharing their stories

fter long and terrible journeys (crossing the desert in Libya, take the risk of drowning), the experiences

they shared were also highly traumatic for the professional who was listening to them,

experiencing the difficulty of getting out of this situation of suffering

and pain that had also become the daily experience of the professional

This experience for the professional reactivated of an event from childhood

- that had been forgotten - of when an aunt died and that loss had caused so much pain to me that this experience had been removed.

In light of all this, when you welcome

someone who has experienced drama like these, it is fundamental to offer empathic listening,

a fundamental element for offering some survivors the possibility of opening up

and sharing their experiences.It is also necessary to have a profound acceptance

of the person and an absence of judgment as this promotes trust.

Empathy is a balm for the soul, the feeling that another person puts

herself in your shoes and listens deeply and authentically feeling your own pain

These are the three basic conditions that Carl Rogers

research found necessary to facilitate change

in encounter groups and in helping relationships. At the conclusion of this reflection on the value of the Rogerian

encounter groups in the reworking of trauma with migrant people, it is possible to dwell on an interesting aspect: no one asked for pharmacological support

after participating in the listening groups.

The natural dimension of the group - its circular structure,

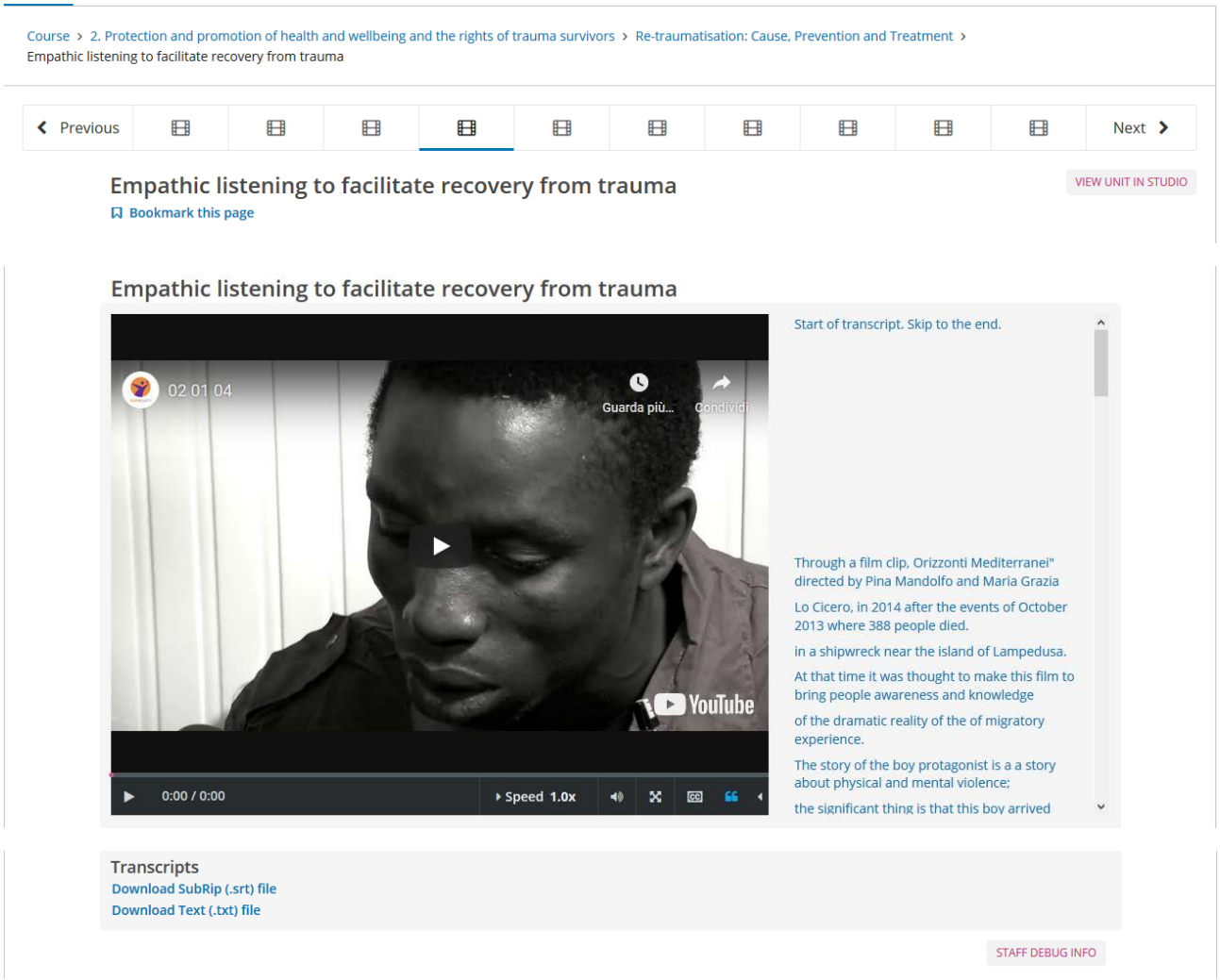
was quite appreciated. The circularity perhaps reproduced a little part of the experiences that the subjects live in their countries,

for example in Eritrea, where there is the custom of village

elders and males gathering in a circle around a large tree,

which is called the tree of words. In this meeting, the fabric of a torn narrative

is reconstructed through sharing words.



Transcript

Through a film clip, Orizzonti Mediterranei" directed by Pina Mandolfo and Maria Grazia

Lo Cicero, in 2014 after the events of October 2013 where 388 people died.

in a shipwreck near the island of Lampedusa.

At that time it was thought to make this film to bring people awareness and knowledge

of the dramatic reality of the of migratory experience.

The story of the boy protagonist is a a story about physical and mental violence;

the significant thing is that this boy arrived accompanied by his sister

and she was also a victim of of violence and rape - she'd never spoken to his brother...

about her experience, he had been raped as well but never talked about it

with his sister.

For him it was a source of shame to talk about this experience, so much so...

to request asked that his sister should not be present, because he didn't want her to...

learn about what had occurred to him, as he confessed afterwards- - feeling shame of being a man and being

a victim of such violence.

It should be noted that this boy was only 16 years old.

In the testimonial that the boy shares we learn about what happened to him

and to facilitate the flow of his sharing and to avoid the interruption of his emotional flow

he was simply listened to in order to not interrupt his narrative.

Only in a few instances, some nodding or exanging 20 00:02:15,160 --> 00:02:23,840 deeper glances , facilitated him in continuing to share

his story.

It is therefore observed that the empathic aspect takes the form of manifestation of empathy

that is more than situational than verbal, i.e. visual contact nods of the head, the body of the listener extending

towards him.

This is was necessary to help him sharing, without

touch him; for him the body contact was a source of shame, he was like a child.

unable to explore a difficult story and to endure it, he was younger

than his sister, but felt that he should nevertheless as a man, to be the one to offer support and encouragement to his sister.

Here, too, one observes how sensitivity, a respectful attitude, empathy and listening facilitate

the emergence of a sharing relationships.

The video has to do with the experience of

listening to two stories: one about a girl another of 33 00:08:23,080 --> 00:08:26,500 two brothers.

These two brothers, who left from Eritrea

and landed in Lampedusa in 2014, brought to the CARA center in Mineo...

they stayed at this facility to get their residence permits,

but when I tried to interview them in ordeer to have the opportunity to document ..

their experiences and stories we become aware that at the base of this kind of story 39 00:08:59,820 --> 00:09:08,360 there would have to be a lot of listening careful, delicate, because these two guys...

had been subjected to torture and very severe and dramatic violence.

Each of them had asked to speak without the presence of the other.

In the girl's story, her journey was motivated to give her brother

a chance of not to be forced at 16 years of age to do military service.

You can see in her narrative that she says... one fundamental thing: "I can't forget,

I can't find the strength to speak"; these are the keywords, and then the listening of her

was accompanied with a gentle contact between the the hands of the professional with the hands of the girl.

Using physical contact in the presence of these experiences is complex, indeed it is preferable

not to touch a traumatized person victim of trauma and physical violence; in this specific case

I somehow realized that the girl had the need to be deeply supported

in order to be able to share her story, so the professional he asked her if she could touch her hands.

Just the request, and not the action not accepted, has facilitated the possibility that she could give

her permission.

With this kind of contact you have created a strong channel of powerful energy was created , and every time

the girl had to talk about aspects particularly traumatic and painful she tended to stop and

so the professional would held her hands so the flow of sharing could continue

providing the necessary energy for the continuation of her story 57 00:11:39,760 --> 00:11:51,420 At the end of this experience one can say that never, listening to someone's story

that is a story of trauma, that can be minimalized trivialized or exaggerated

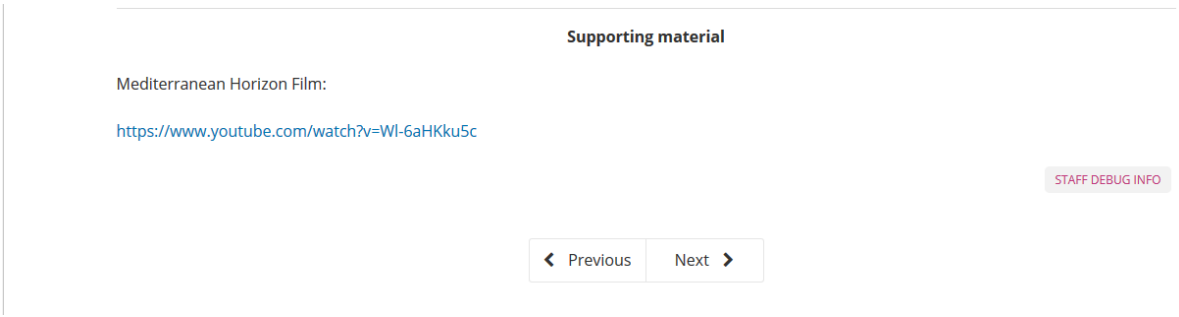
the most fundamental thing is listening to the story as it is told,

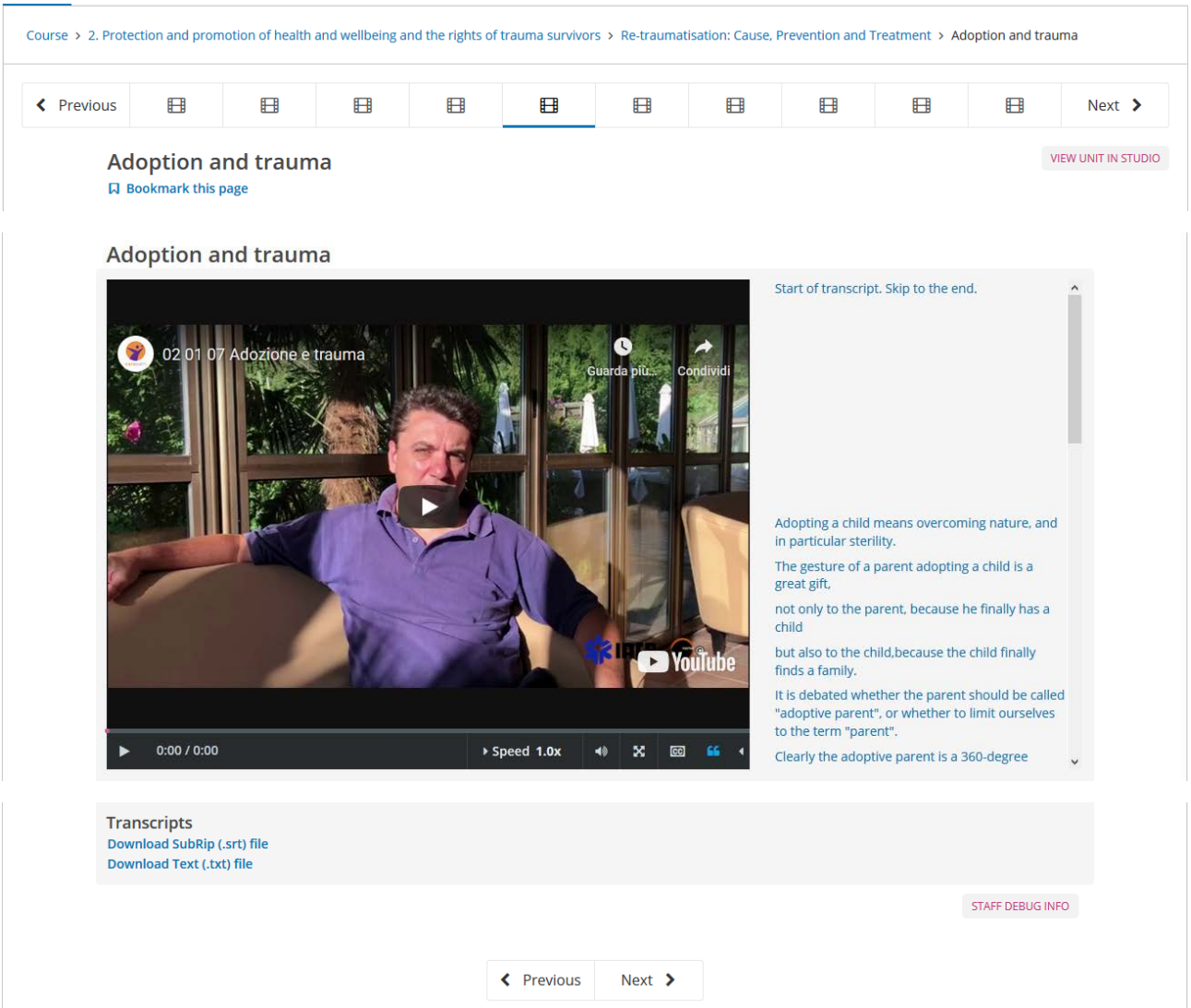
listening with great sensitivity and above all empathy and recognition of the suffering

other people's.

This was the fundamental element which gave access to the expression

more intense and deep emotionally in the sharing of this king of narratives.





Transcript

Adopting a child means overcoming nature, and in particular sterility.

The gesture of a parent adopting a child is a great gift,

not only to the parent, because he finally has a child

but also to the child,because the child finally finds a family.

It is debated whether the parent should be called "adoptive parent", or whether to limit ourselves to the term "parent".

Clearly the adoptive parent is a 360-degree parent

who is nothing less than a biological parent, as the research says, but above all as the relationship that is generated

between child and parent says.

Having an adopted child has many overlaps with having a biological child.

For an adoptive parent, hearing himself called father is always a surprise,

while for a biological parent it is a given.

This means that perhaps adoptive parenting

is more intense than biological

parenting can be. However, the parent must pay attention to this: the adopted child

has the right to be happy and to be happy,

he must also consider what his story has been. Which we might not always know,

because no one has told us and the child does not remember.

However, care must be taken with sensitivity to the problems that

the child may carry with them.

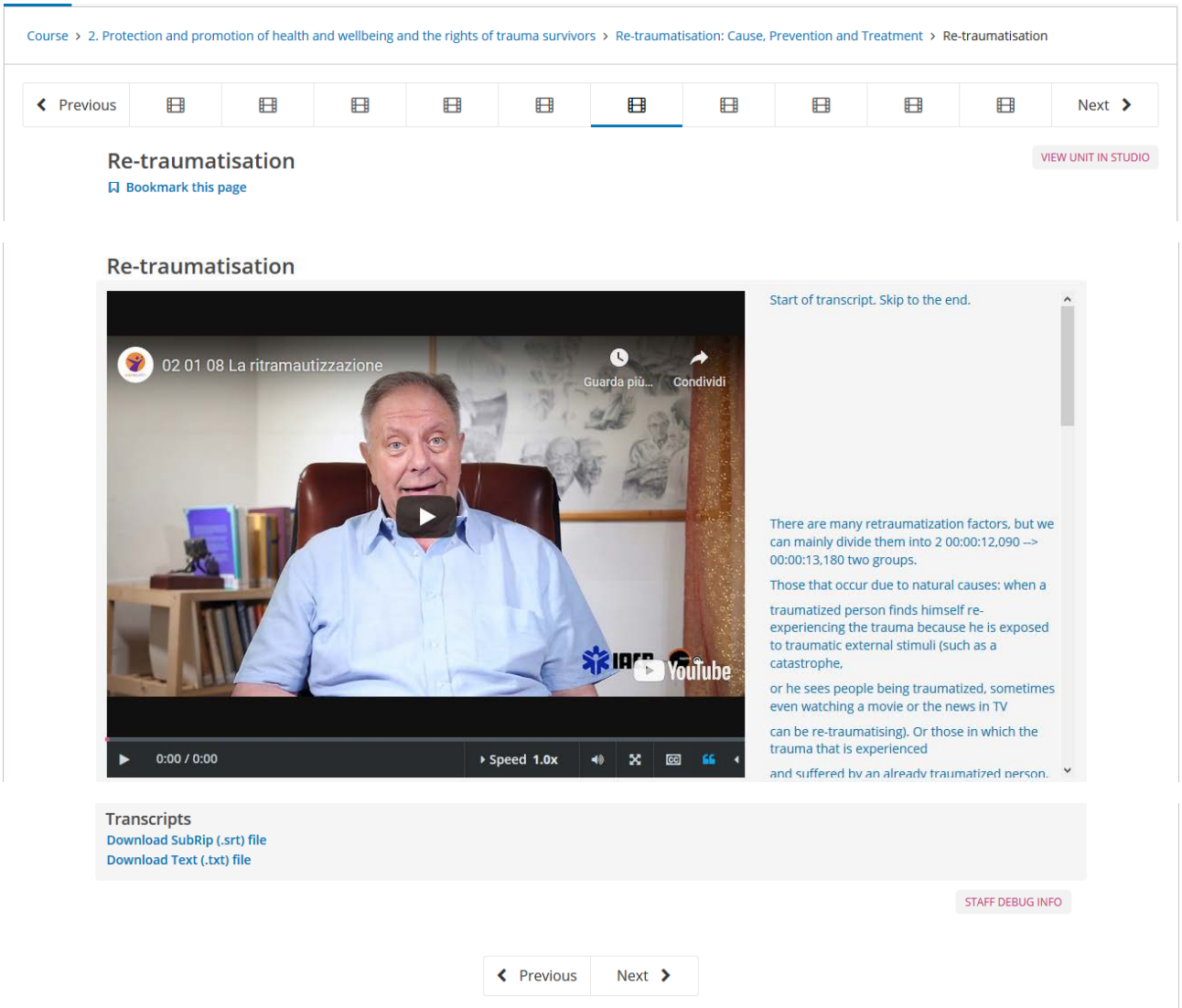
The adopted child, and then the adult, is often confronted with existential themes:

what are my origins?

Why was I abandoned?

These are answers that no one can give explanations to, but this does not exclude that life is beautiful

and we all have to strive to live better.



Transcript

There are many retraumatization factors, but we can mainly divide them into 2 00:00:12,090 --> 00:00:13,180 two groups.

Those that occur due to natural causes: when a

traumatized person finds himself re-experiencing the trauma because he is exposed to traumatic external stimuli (such as a catastrophe,

or he sees people being traumatized, sometimes even watching a movie or the news in TV

can be re-traumatising). Or those in which the trauma that is experienced

and suffered by an already traumatized person, is due to being offered services or care

by inexperienced people or in a non-trauma oriented organization, that even not wanting

to cause re-traumatizing still

not been trauma informed can damage the client. The safeguards and procedures that an operator, a professional

or an institution adopt to prevent the retraumatization of their clients is called trauma-informed care.

In the past, unfortunately, we have too often re-traumatized those who had already suffered a trauma, certainly not out

of a bad will, but out of ignorance.

It is thanks to the research and clinical evidence that we observed that these clients

if they were pressed to do things they did not want to do, if they were not respected

in their own times, if they were forced to remember their traumatic experiences -

obviously for a good cause - even without realizing it they received iatrogenic damage.

With the definition of informed trauma care we mean all those precautions,

that safety net developed through research, which have showed us how important

it is to protect already traumatised people against the danger of new traumatization.

To respect their pace to offer services centered on the person,

respecting their needs and sensitivity, and above all not forcing them to do something

they are not yet ready to do.

The reason is very simple: we have observed that already traumatised people need acceptance,

kindness and safe havens in which to regain their strength and resume

their rhythm of exploration which, precisely because they are traumatized, is necessarily cautious

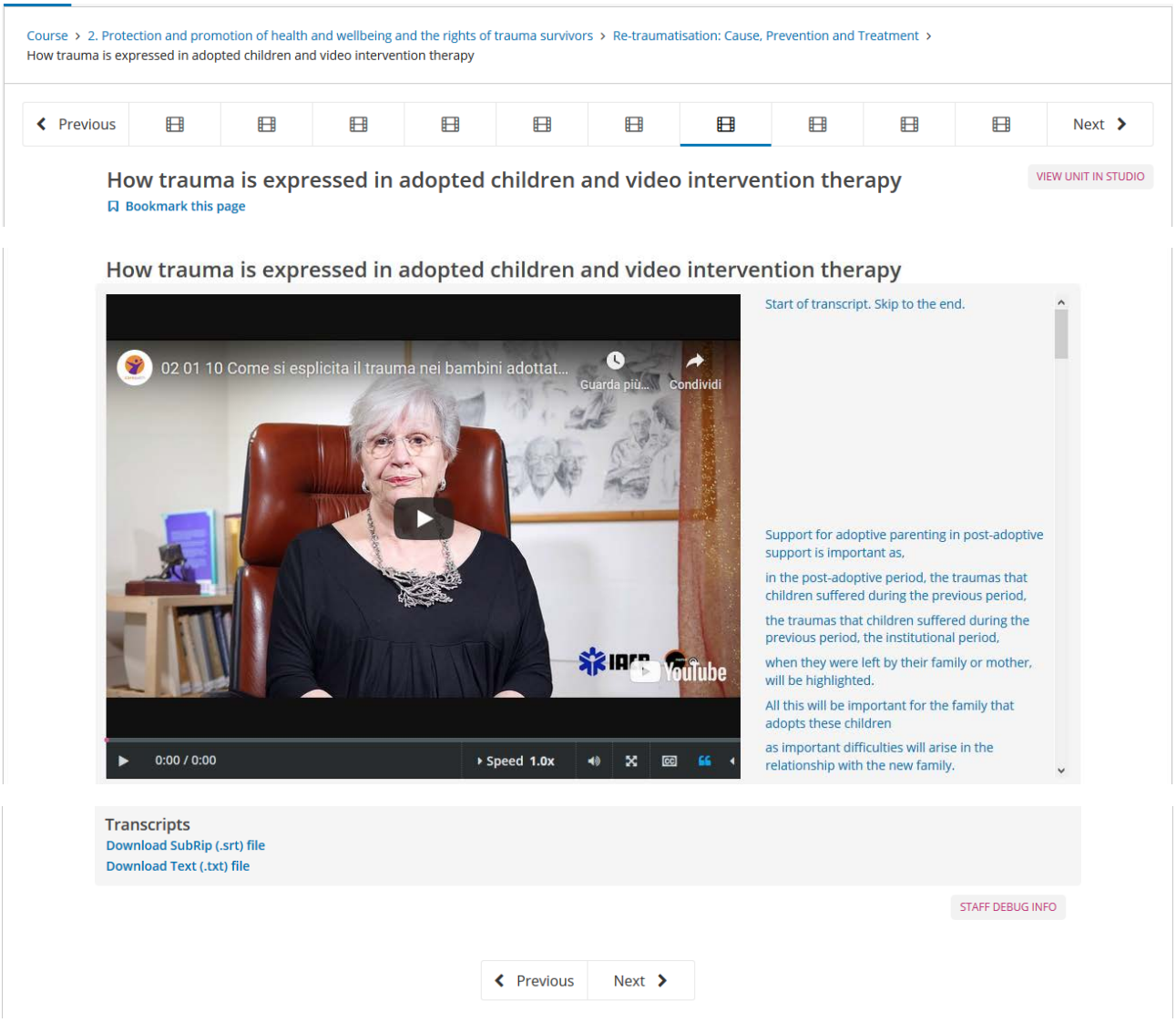
given their previous experience.

Therefore, trusting the self-regulating

abilities of

trauma survivors is essential aspect

of good care



Transcript

Support for adoptive parenting in post-adoptive support is important as,

in the post-adoptive period, the traumas that children suffered during the previous period,

the traumas that children suffered during the previous period, the institutional period,

when they were left by their family or mother, will be highlighted.

All this will be important for the family that adopts these children

as important difficulties will arise in the relationship with the new family.

From research we know that traumas have the ability to break relationships, 8 00:01:19,040 --> 00:01:24,540 to make them problematic and difficult, and children are no exception to this.

Becoming aware of the difficulty that the child finds in the new adoptive family

can make the path for parents easier -

- or at least more aware.

In the exchanges that make up the relationship, the interactive exchanges, children will be

difficult to manage, they can give confusing and unclear signs, seem not interested

Or absent

All these are aspects that will be analyzed point by point and that

will be part of the story of each adoption.

Accordingly we know, again from research, that every interactive

exchange is formed by micro events which, analyzed in detail,

influence the adult-to-child and child-to-adult response 20 00:02:49,100 --> 00:02:56,730 For this reason the use of videos becomes very important. Precisely in this situation

where the trauma has created conditions that make it difficult to read interactive micro-analytical aspects,

it becomes important to be able to film them, seeing them in exchanges and seeing where

and how the child moves in the interactive exchange and how the parent responds.

The use of video, therefore, is to be emphasized and recommended

It is a way to lay the foundations and look in detail in a specific way, moment

by moment, everything that happens in the exchange between child and parent.

The important thing to emphasize is that this particular use of the video must,

And should always be used and shown only by therapists specialized in this strategy;

it can not be used by those who do not have the specialization, given the particular

sensitivity of the subject.

It can be observed that, as has been said, adopted children have a way of sending signals

that are a little less evident, shorter and more confused than non- adopted children

In this sense, the use of video is extremely important as it allows the parent -

marking the interaction moment by moment - to see where and how the child

is able to relate to them.

This will be a milestone in the interactive exchange and begins the possibility

of constructing a new attachment bond.

Another important aspect is the child's hyper-vigilance

This is very important because it tells us about their history, fears, the lack

of care and neglect they have experienced, but especially if this child has suffered physical violence,

perhaps abuse, or at least witnessed violence.

Hyper-vigilance is where the child is extremely focused

on the adult's expression, monitoring him moment by moment to be able to read the adult's expression

to see if there is something that may be dangerous for him,

or if what they are doing may become dangerous or a source of threat.

Indica quindi chiaramente la mancanza di fiducia che il bambino presenta nei confronti dell'adulto, It therefore clearly indicates the lack of trust that the child has in the adult

will tend to slowly disappear by working on the adult-child relationship,

but not always permanently.

Another aspect that the child will present is an aspect of emotional clumsiness,

an aspect that will make the adoptive parents suffer greatly because he will feel this child is never

perfectly free to express his affection and emotional closeness to the adult.

This is not the responsibility of the child, this is also a fragment, which is expressed in

the report, of a particularly painful past story.

Children are used to not approaching adults, in order to make the adult

become less dangerous for them in the relationship.

So they are not used to touching them often, embracing them, which could happen in the new relationship.

We can therefore attend particularly closely to children, perhaps too close, sometimes clinging to themy,

but since they do not know how to modulate the way of approaching an adult,

do not know when it is too much or too little and are in complete disorientation and embarrassment.

Other times the child approaches with extreme clumsiness, in an almost false,

Unspontaneous way, which is immediately monitored by the parent who tends to label it

What is recommended is to always see it as the expression of a moment in the history of the child

- they were never free to approach as they would have liked and as they would have

felt to an adult, as such this still remains in an unspontaneous and rather clumsy way.

Another aspect that the parent will see will be fatigue and difficulties in sleeping...

an extremely restless sleep, not very restful and the difficulty to fall asleep.

A further aspect can be observed in the difficulty of concentration, often interpreted

as a learning disorder not better identified:

the child has no learning disability,

but his hypervigilance triggers such difficult, exhausting negative emotional traits...

and exhausting that distract him from the tasks assigned to him.

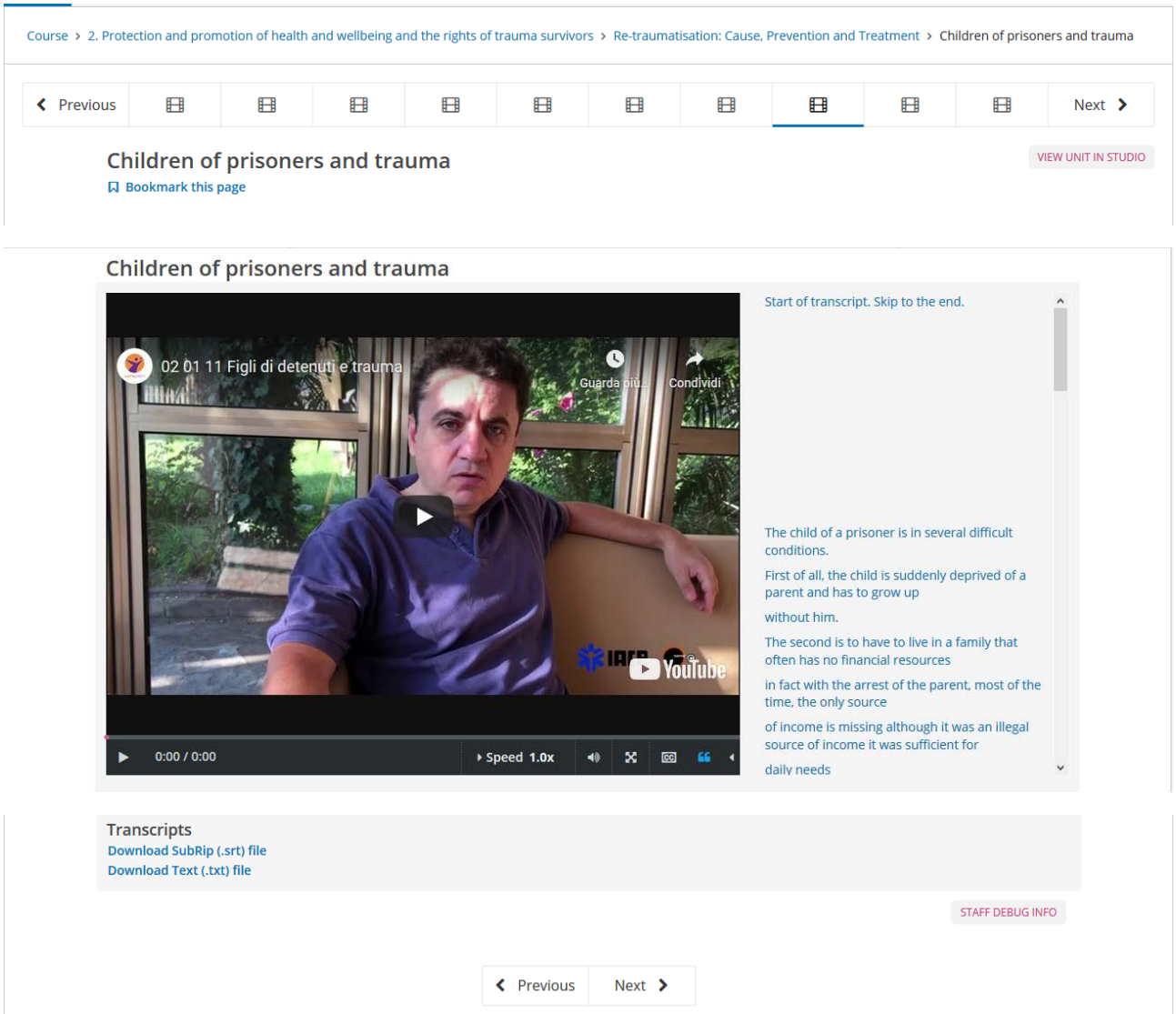
Once again we would see that the child is tuned to the face of the adult, his

expression, on what the adult expresses, about the danger he can pose;

all this will make it difficult for the child to be able to concentrate.

All these aspects however are extremely important, these behaviors are the narrative

of a past history, they'll tell the adoptive parent everything that is marked in the
child hystory that possibly this child can only express itself through
this kind of behaviors;
so maybe it's important to think that those are valuable information that
can put us in a position to understand that part of the child past, absolutely unknowable
for us, but who has created that change in that relationship as it is...
with the new foster parent.
More than situations to be corrected these are behaviors to be understood and accepted as
opportunities to understand what they can of a past history that could become,
along with this little child, today a shared narrative.
How the narrative of the past can create a bridge with the narrative of the present.



Transcript

The child of a prisoner is in several difficult conditions.

First of all, the child is suddenly deprived of a parent and has to grow up

without him.

The second is to have to live in a family that often has no financial resources

in fact with the arrest of the parent, most of the time, the only source

of income is missing although it was an illegal source of income it was sufficient for

daily needs

Another secondary tragedy, but no less important, is due to the fact that the child

finds himself victim of stigma

being children of prisoners means being

children of guilt

the child as he relates to this social pressure

makes his own judgment and may become convinced that he himself is a person worthy of punishment

Often the children of imprisoned parents are troubled children

this is also due to the fact that they do not have a parent - often the father - who educates and contains

in his excesses

They are children forced to live alone, as the mother cannot cope with all the problems 18 00:01:46,150 --> 00:01:54,200 and longer being able to rely on the support

of her husband

It is a whole new challenge to be managed, unfortunately even social workers sometimes fall into the trap

of stigmatizing the child that should be understood and facilitated even more than other children,

because living alone with a mother in difficulty is not a simple matter.

There is a discussion about how to tell the child that his or her parent has been

arrested

Many parents, out of shame or difficulty, tell the child the story of the absent parent

is not present since suddenly had to leave since he got hired for a new job

Clearly the lie quickly catches up with itself and the child is not convinced, because if up until

then the working father returned home every day, does not explain why he suddenly changed

job and left for so many days, months, years,

missing birthdays and holidays, so the child understands that it is a lie.

The best thing to say to the children in these cases is to tell the truth "...father has made some mistakes

and unfortunately must be in a place to answer for his behavior

but he's fine, stay calm

we will be able to visit him soon."

This is another issue related to the children of parents in prison

whether or not to show them the parent in prison

Some social workers say it is not appropriate because the prison environment

is not an environment tailored to the needs of the child

It is true that when you enter prison you have to deal with policemen, environments that are not always dignified

but it is also true that it is very important for a child

to be to see their parent

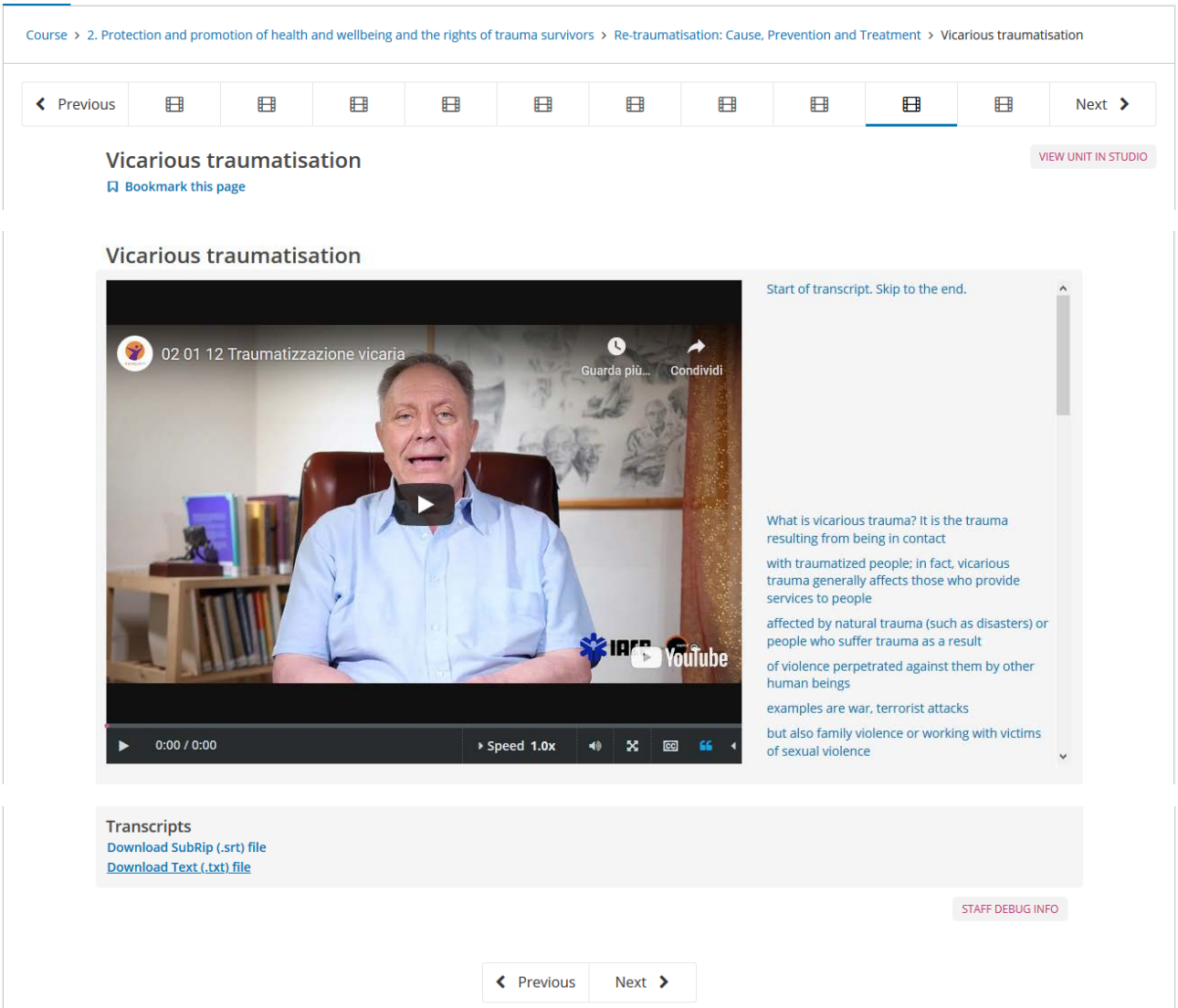
therefore, meetings between prisoners and their children should be facilitated.

Until a few years ago there were still walls that divided prisoners from visitors

today many things have changed: many prisons have a playroom or more colourful environments with games, and the same prison agents are much better prepared to welcome visiting children

However, this is not the primary topic, the issue is not whether the child goes into a suitable environment or not, but is to facilitate the meeting between parent and child

All this is said for all the cases were the parent is in prison not for a crime against his own child



Transcript

What is vicarious trauma? It is the trauma resulting from being in contact

with traumatized people; in fact, vicarious trauma generally affects those who provide services to people

affected by natural trauma (such as disasters) or people who suffer trauma as a result

of violence perpetrated against them by other human beings

examples are war, terrorist attacks

but also family violence or working with victims of sexual violence

In short, the operator relates daily to the trauma survivors with good will, offers assistance, support and psychological contact

but this, despite the profound significance of the openness, humanity

and the importance even at the existential level, can nevertheless affect the worker

mental health, and may develop in a source of real

trauma with all the consequences that trauma has on people.

Is very important to prevent and abate the impact of vicarious trauma that operators

and all those workers who are exposed to victims of trauma or violence

such as health personnel, policemen, firement, journalists, volunteers and all those people who for various reasons get in contact

with traumatized people.

It is important to prevent

vicarious trauma, also more generally termed burnout which also affects people

in helping relationships and that hits hard, in particular, when you cannot recharge

your batteries, or disconnect from work that is heavy and taxating as well as beautiful, and also is important to

have work -life balance, to keep to be an effective help worker one needs also to take care of personal life, spending time with family

friends and having some fun. In short, it is a challenge for all those who offer their

helping services with passion, generosity and empathy to also extend that kind of helping relationship

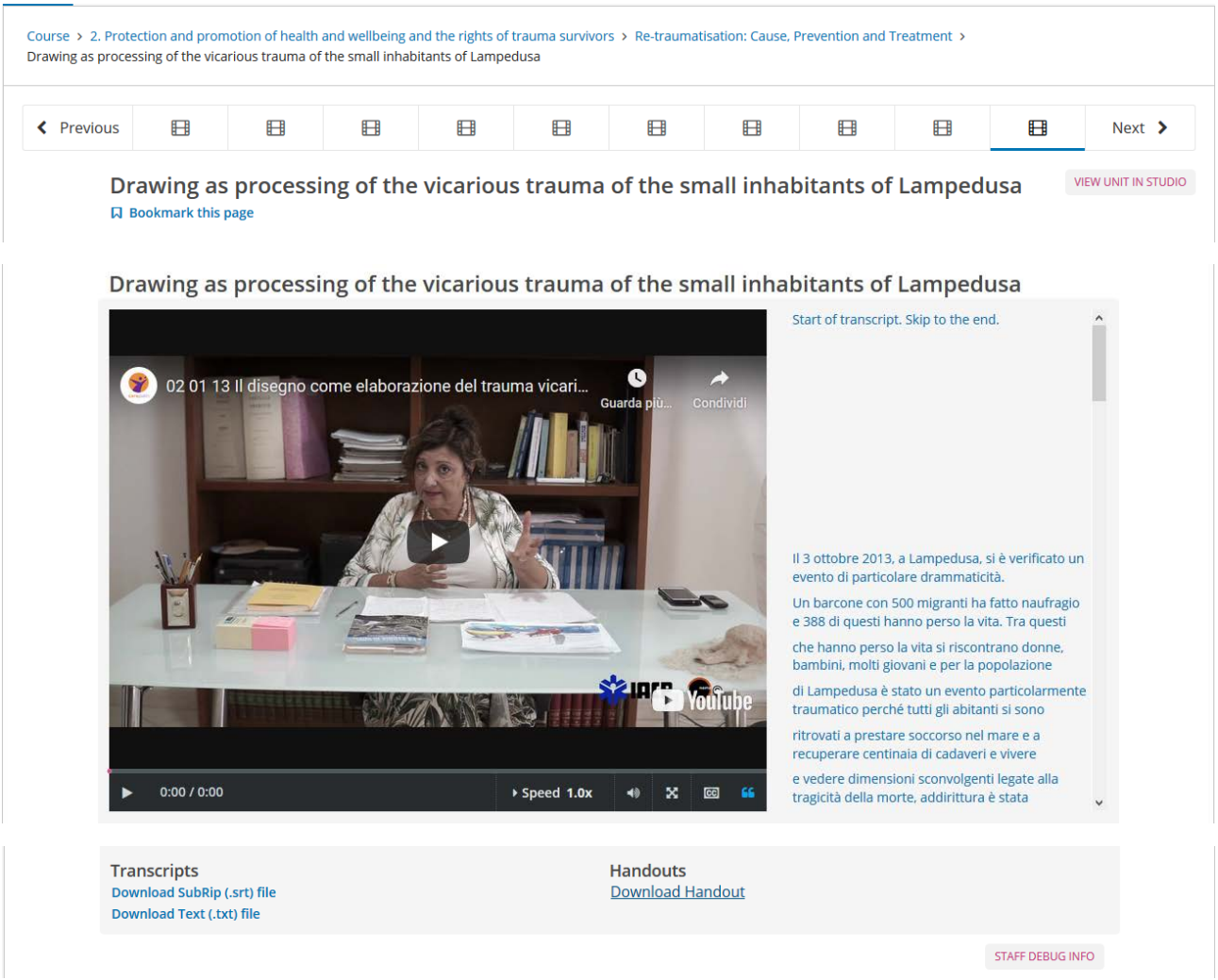
to themselves

because you can not give others what you do not have.

It is therefore morally, ethically and professionally necessary to promote our resilience, health and wellbeing,

because if we want to give a lot to people we help we must also relate generously with the person

with whom we will be spending each hour of our lives: ourselves.



Handout

Drawing as processing of the vicarious trauma of the small inhabitants of Lampedusa.

On October 3, 2013, a particularly dramatic event took place in Lampedusa. A boat with 500 migrants sank and 388 of them lost their lives. Among those who died there were women, children, many young people and for the population of the island of Lampedusa it was a particularly traumatic event because all the inhabitants found themselves rescuing people at sea and recovering hundreds of corpses and witnessing the shocking dimensions related to this tragedy. They even found a mother who was giving birth during the shipwreck with her son still attached to her umbilical cord.

An event of this kind produces a vicarious trauma on the population and therefore we tried, in some way, in the Local health Agency to offer help by listening and supporting people who had traumatic

experiences. One of the most difficult situations to handle was that related to the traumatic experience perceived by children, especially in primary schools.
Immigration in Lampedusa is a multi-year experience and everyone (including young people) knows that often journeys of hope end with the loss of life, but children 6 -7 years old are particularly sensitive to this type of experience and many of them have begun to have fears, anguish, phobias, all typical reactions of people exposed to traumatic experiences where lives are endangered and lost.

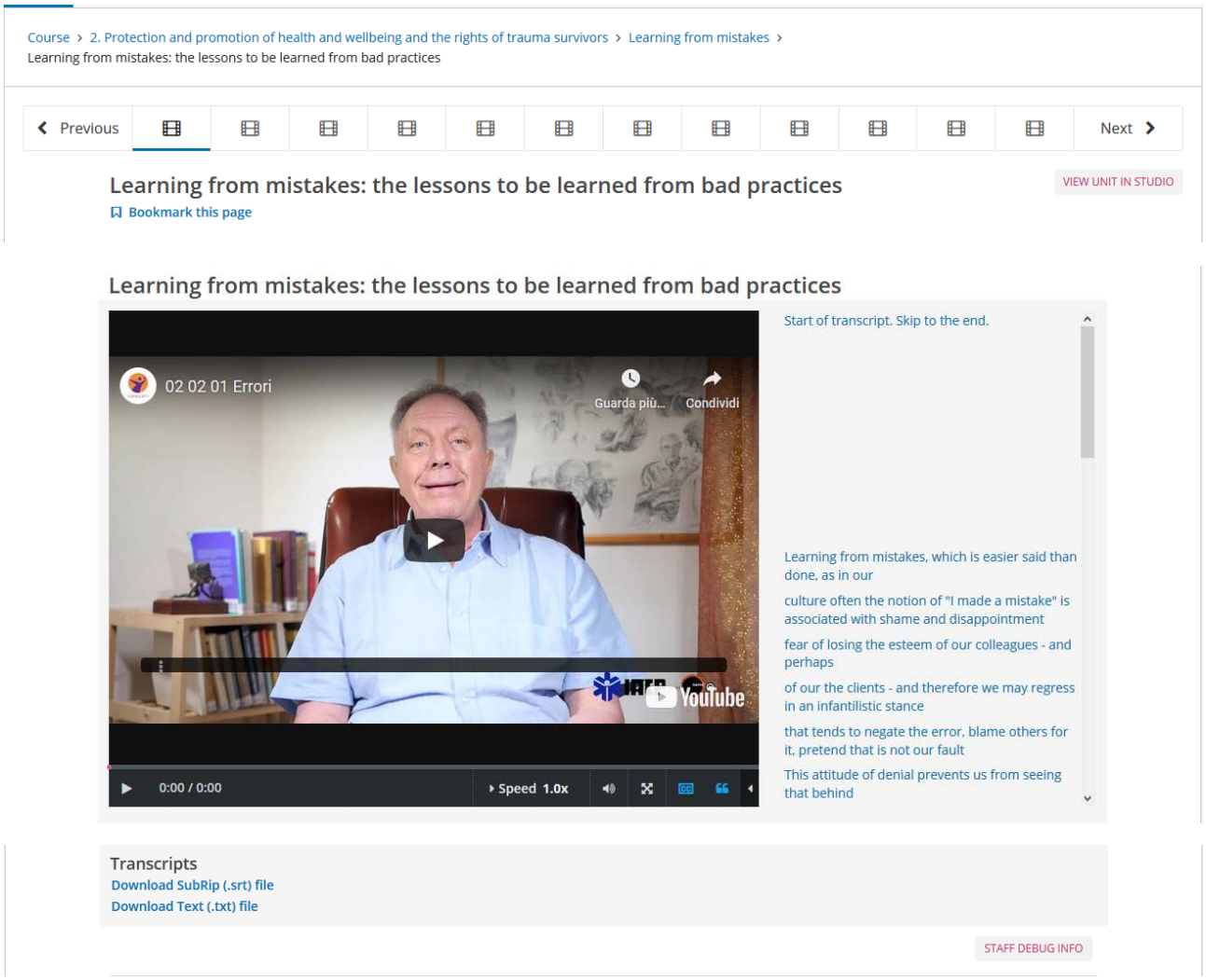
For the children of Lampedusa this tragic event had happened in their sea, a sea they experienced as a source of joy, play and fun; that sea that represented for them an element of joy and lightness suddenly turned into a sea of death. One of the possibilities that were put in place to deal with the processing of the children's vicarious trauma was to propose that they make drawings, these drawings now show how the children respond and react to this trauma.

A premise must be made: art is a powerful tool to make painful and frightening events tangible, in of itself art produces liberating effects and also reworks traumatic events. Next we must ask ourselves what is a traumatic event from the point of view of children. In this case it depends on the type of event, a traumatic event has different forms, it can be produced by humans (such as wars and terrorism) or by nature (hurricanes and earthquakes, tornados) and each of these events leaves specific traces and specific fears in the minds of children. From this point of view it was necessary, in the case of the shipwreck of Lampedusa, to recompose the emotional and internal fracture that the children had experienced, linked to the fact that this event could not only be resumed, but also affect their families, as for a child of 6 and 7 years it is difficult to understand the sense of death and we know how children bring everything back to themselves. These events and stories of death had the effect of producing in many children the fear of eating fish (the fish had eaten the dead children and mothers) or going to the sea side (in the sea there could be some corpses), it was necessary to rebuild this puzzle of their dimension of serenity in respect to the imagery that was being built on the island of Lampedusa.
As we said, this was possible with drawing.
Now I want to show you some of their drawing, here is the representation that the kids have made of their experiences: Here is the island of Lampedusa, a little distant from the sea that is full of dead bodies,
kids that died with their school back packs or mothers that lost their purses, the purses and back packs are the symbol of going to school. A mother that holds the hand of a little girl; the fathers are distant underwater and are going to die; the boat is a safety symbol.
In another drawing of another child there are only two subjects, like the mother and the father in danger of death and a big fire on the boat - in reality there was a boat that went on fire- and this father and mother are surrounded by a black sea and a sky full of crosses and of dead people.
This beautiful sea has become a sea of death.

Another child has the perception of death thought the very ordered sequence of coffins in the hangar of the Lampedusa airport, very often seen on television. What is noticeable, there are small coffins of different colors the adult coffins are brown but the death of a child is a blacker death and the sea is very dark sea.

This is another design where you can see the representation of anxiety is less intense, less strong ; may be due there is the possibility that the family, a family, can lose their child, so a death anxiety that is more personal, but this drawing is in some way cathartic may be due to the fact tin the sky there angels and stars like all the dead people and the children have been transformed.

Through the drawings it was possible to build a narrative of how each child individually perceived this event, because while the event was collective its perception was specific to each child. It was important not to offer elements of immediate consolation, but to let each child, by means of the graphic and verbal processing and the listening that followed the drawings, find personal solutions to what is anguished element such as the dimension of death and loss that at 6 - 7 years of age is the greatest anguish for a child.



Transcript

Learning from mistakes, which is easier said than done, as in our

culture often the notion of "I made a mistake" is associated with shame and disappointment

fear of losing the esteem of our colleagues - and perhaps

of our the clients - and therefore we may regress in an infantilistic stance

that tends to negate the error, blame others for it, pretend that is not our fault

This attitude of denial prevents us from seeing that behind

every error we can find a treasure of wisdom.

With the right attitude, being not defensive, we can open ourselves to learn from mistakes

mistakes becoming our as teachers that help us to become better professionals

by the way we often

facilitate this to our clients: to learn from experience.

It's funny and tragic: we helping professionals inspire

our clients to learn from their experiences and mistakes, but

we promote this awareness in our clients and less so for us; we are less enthusiastic

about not to defend ourselves and admit that the mistake is ours and in doing so

be open to learning.

A dysfunctional way of viewing errors generating loss of self esteem

when learning from mistakes should increase our self esteem: This is a little crazy,

like that those who feel afraid think they are a coward, ignoring that those who are brave experience fear but are not

frozen by it, and so those who are intelligent and wise accept their errors and learn from them.

We could learn from our clients that are sometimes more ready than us to humbly accept

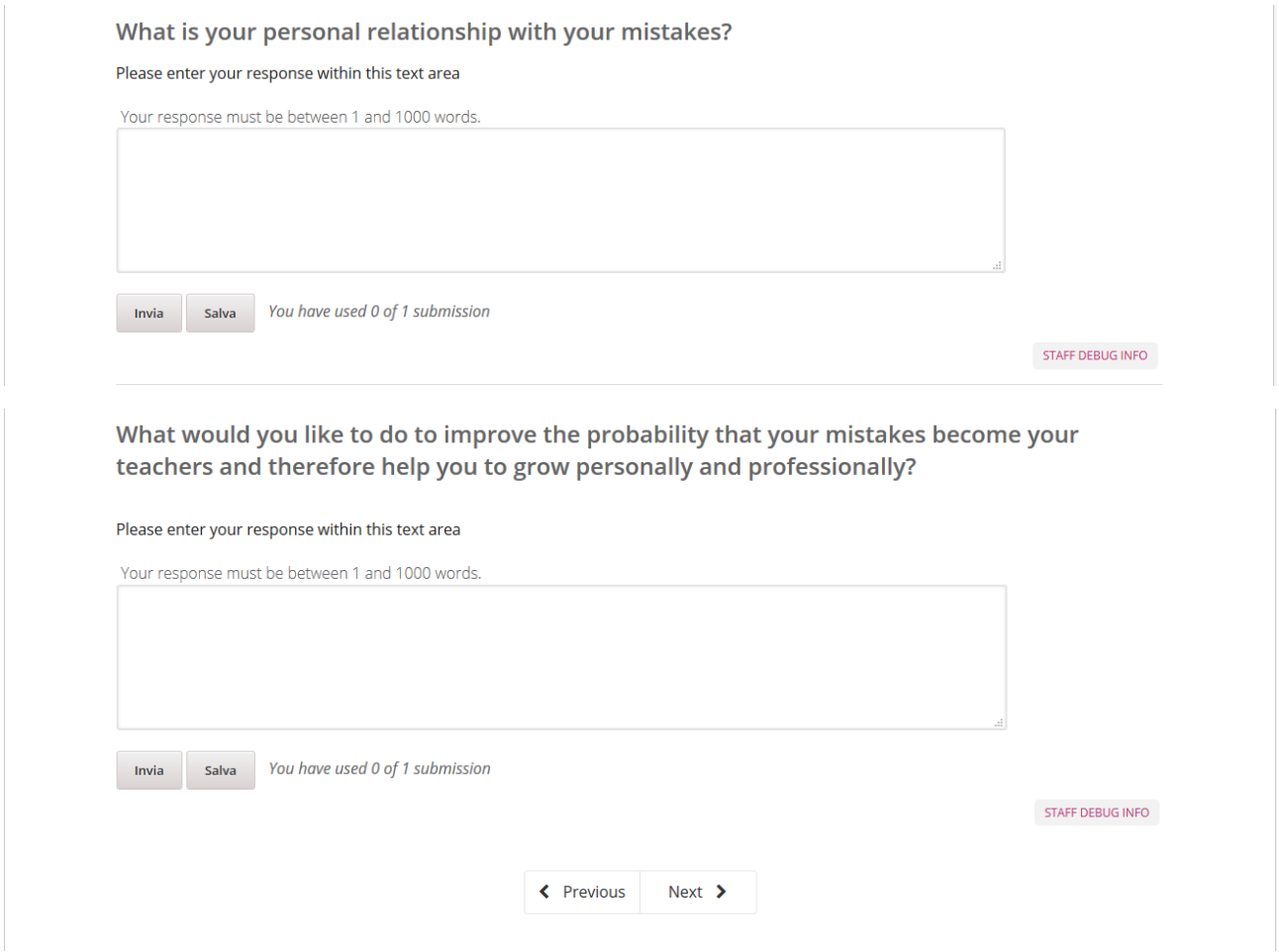
to learn from their experience and try to not make the same

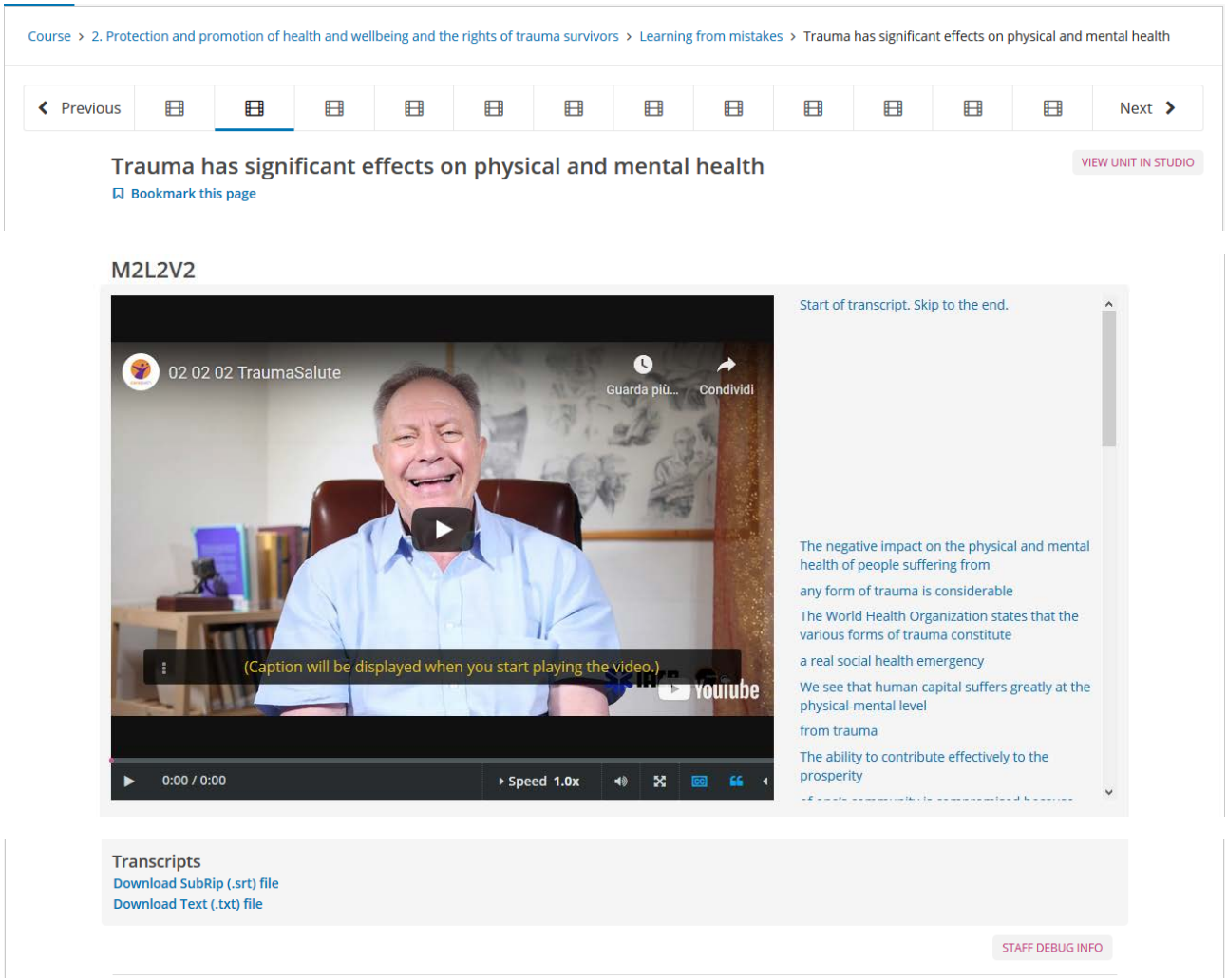
mistakes. However we are condemning ourselves to a compulsion to repeat our mistakes

if we refuse to admit that they are our mistakes, because by doing so we are describing ourselves as victims

and we create a situation of self-defined impotence.

Let's welcome our mistakes as masters of wisdom.





Transcript

The negative impact on the physical and mental health of people suffering from

any form of trauma is considerable

The World Health Organization states that the various forms of trauma constitute

a real social health emergency

We see that human capital suffers greatly at the physical-mental level

from trauma

The ability to contribute effectively to the prosperity

of one's community is compromised because those affected by trauma are in need of care

and this consume economic resources

and also by trauma is impaired the ability of trauma victims to produce prosperity

for themselves, their families, their communities and nations.

We can also observe another very worrying aspect for those who

That not only the victims of trauma

become a person with damage to their physical and mental health, but often,

especially for certain types of trauma (such as being victims of violence or sexual violence)

there is a high frequency of becoming perpetrators and thus traumatize other innocent people.

This shift from victims to perpetrators is a terrible thing that shows how trauma is like a virus

that expands if not combated, prevented and treated effectively in the community: a real pandemia.

One can speak of pandemics, that is, as something that is transmitted from individual to individual

quickly throughout the population which causes serious loss of human 21 00:02:45,390 --> 00:02:46,720 capital

In a bio-psycho-social approach we cannot leave the responsibility

of the prevention and treatment of trauma to the health sector alone, but it is a policy

task and therefore of all the institutions - families, schools, work organisations

the world of juvenile justice, legislation must become sensitive to these problems

and also become part of an effective network for the prevention and resolution of trauma

This is in the interest and for the good of all.

Support material

Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 3, Understanding the Impact of Trauma. Available from:

https://www.ncbi.nlm.nih.gov/books/NBK207191.

STAFF DEBUG INFO

Do you already know the concepts illustrated here? What the scientific community today knows about traumas and their effective treatment?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

In your opinion, would it be desirable to improve this Unit? If so, in what way?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Do you have sufficient periodic updates on the treatment of traumas and the accomplishment of your work?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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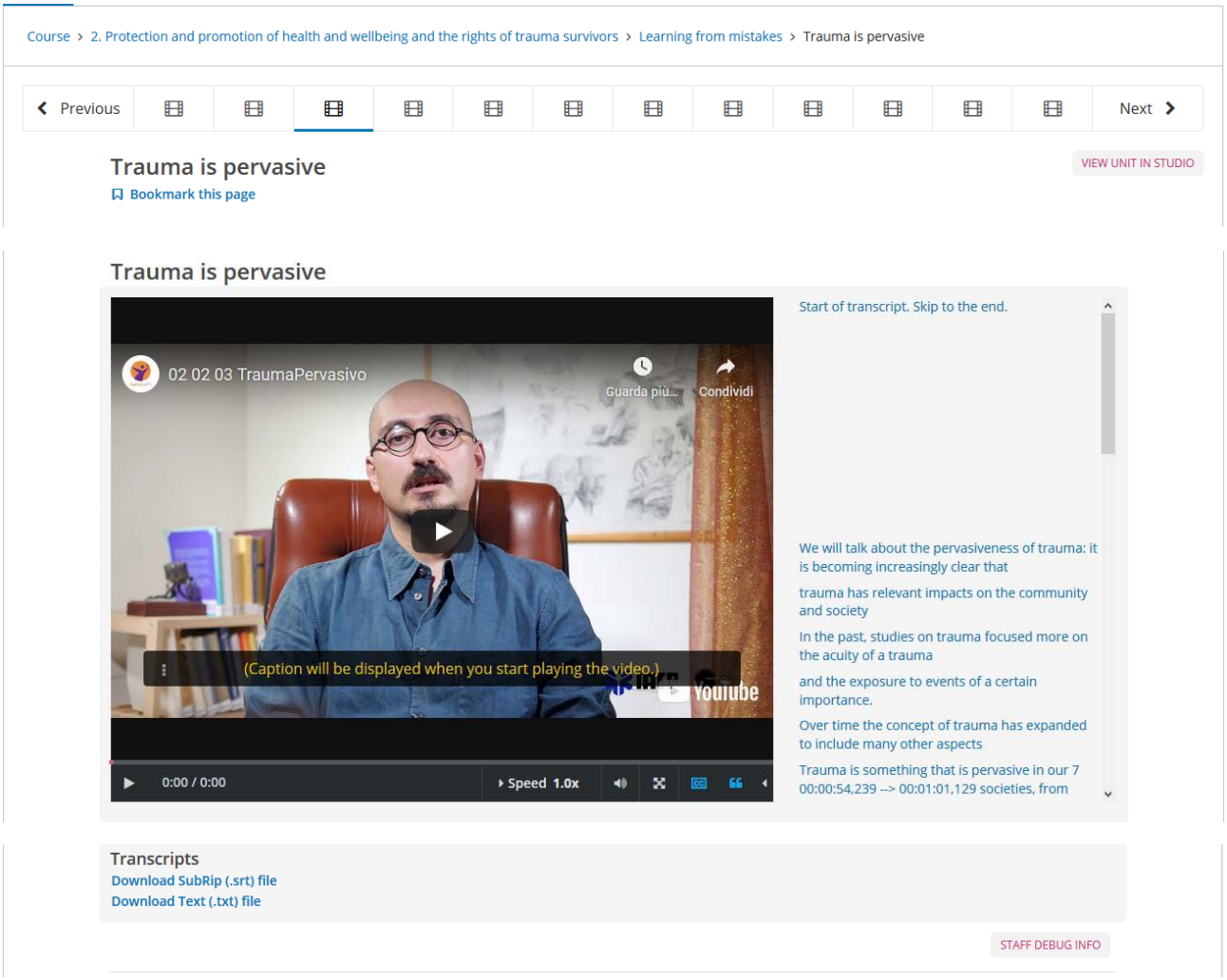
Previous Next



Transcript

We will talk about the pervasiveness of trauma: it is becoming increasingly clear that

trauma has relevant impacts on the community and society

In the past, studies on trauma focused more on the acuity of a trauma

and the exposure to events of a certain importance.

Over time the concept of trauma has expanded to include many other aspects

Trauma is something that is pervasive in our 7 00:00:54,239 --> 00:01:01,129 societies, from research we know that an adult person has been exposed, or will be exposed in the future,

at least once to a traumatic event

From some studies, like the in-depth study of Benguet, we

we know that worldwide the percentage of trauma in various countries is very high, with variations,

but always in high percentages

It is therefore important today to know what are the aspects that protect people from trauma and what will

increase the risk of trauma exposure.

We know from studies on the subject that trauma is also at the root of many 15 00:01:47,440 --> 00:01:54,780 of the chronic disorders that today have major repercussions on the economy

and on public health, but above all trauma impairs the ability of the individual

to express their potentialities and therefore to become a fully

and effective citizen of the community and society in which he lives

Trauma is even more important if we consider all those traumas that occur during the period

of individual development

when a person is developing 22 00:02:31,160 --> 00:02:40,069 their emotional and social capacities; trauma can powerfully affect

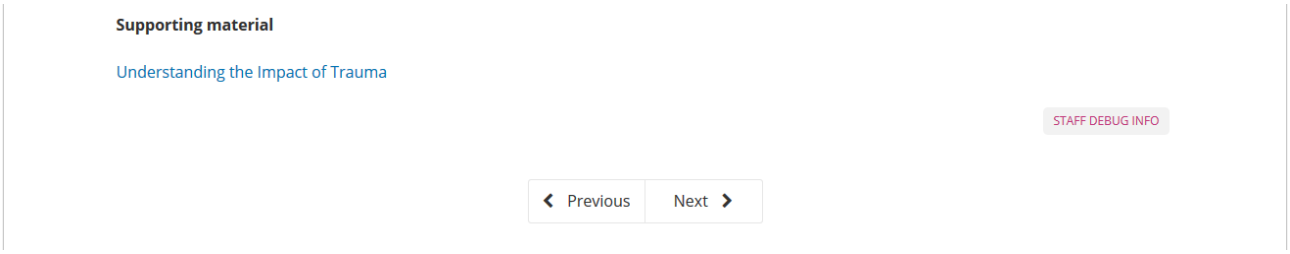
the development of these capabilities,

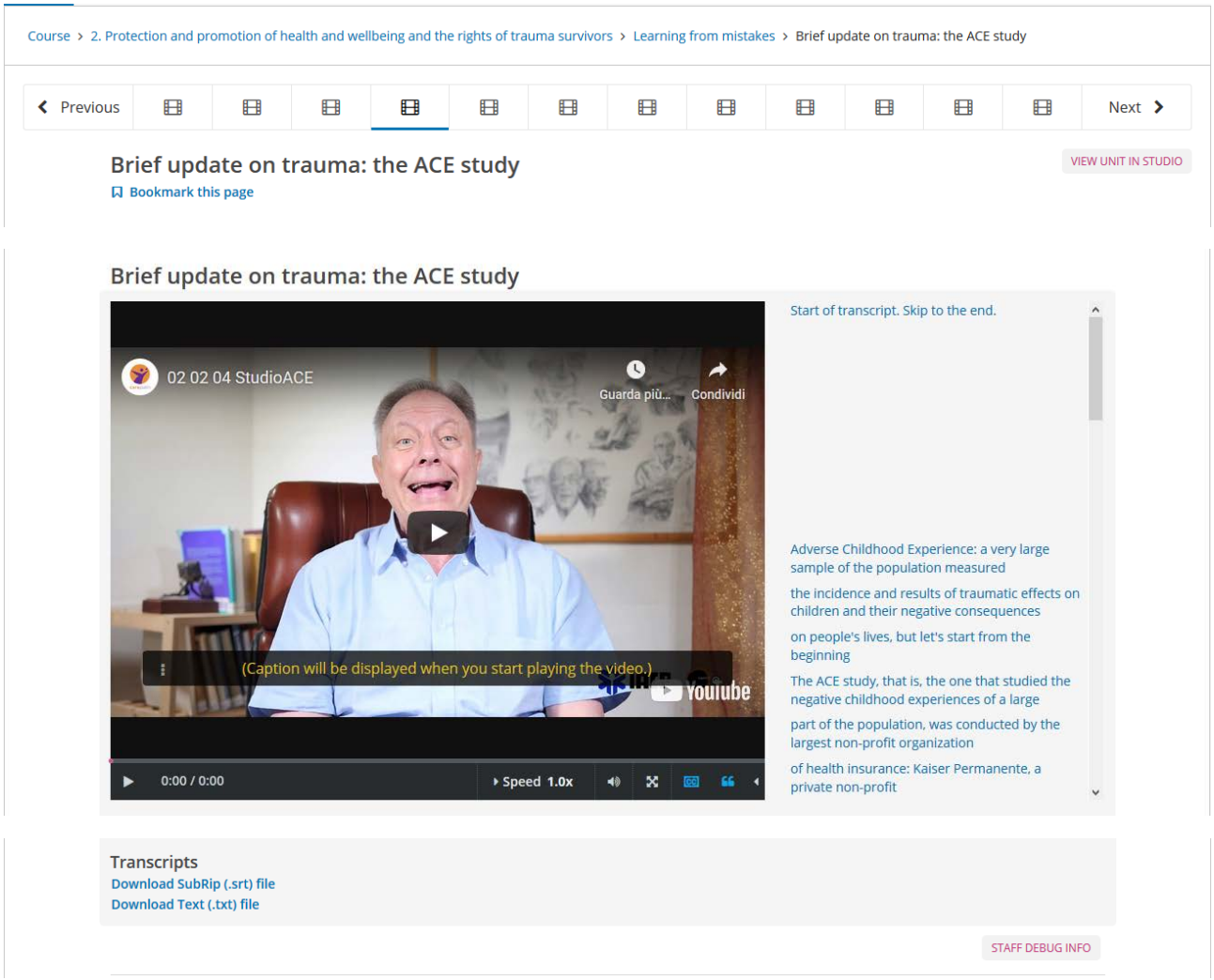
seriously undermining the

future development of the individual.

It will therefore be fundamental, and it is today, to deepen our knowledge of trauma

to be well informed about this topic, as we are doing through this course





Transcript

Adverse Childhood Experience: a very large sample of the population measured

the incidence and results of traumatic effects on children and their negative consequences

on people's lives, but let's start from the beginning

The ACE study, that is, the one that studied the negative childhood experiences of a large

part of the population, was conducted by the largest non-profit organization

of health insurance: Kaiser Permanente, a private non-profit

health insurance in California. They invested many millions of dollars 8 00:01:09,720 --> 00:01:16,970

to conduct this study that has benefited the entire scientific community, because we now know much more about this topic, replicas of this study have confirmed the original data

average in the population at least one third - therefore one third of citizens - is affected in their childhood

at least by experiencing an adverse episode, by a trauma

A smaller number of citizens is affected by two

types of trauma

and an even smaller number suffers a higher number of traumas

More a person is affected by multiple traumas, the more they suffer from the negative consequences

as if a knife stab will hurt a lot, but being stabbed several times is even worse

Traumas are worse than stab wounds, because they not only have negative consequences

such as stab wounds - on the physical and mental appearance of the victim of such violence

but they are also - in some way - a kind of virus that brings some people affected

by traumas

especially traumas in which you are a victim of violence, sexual abuse, etc

to become perpetrators in adulthood.

It has been said, then, of mental and physical problems

that often the two things are associated. To explain better: people

who are subject to trauma instinctively try to adjust to the trauma, that is to cope, to manage

the event, some aspects of this type of trauma management may be effective

but cost a lot in the long run. For example, some people

may - in order to manage the effects of trauma - mitigate their suffering with the use

of alcohol or drugs, this

creates another problem, aggravating

the situation, because they then become alcoholics or addicts. At the behavioural level

it is known that we tend to avoid contact with others, and by isolating ourselves we are cut off

from "recharging our batteries". Or becoming sexually promiscuous. In short,

adverse childhood experiences are a real social scourge and very costly, because the costs for

treatment and care alone are very expensive. Thus it is in the interest of everyone that we all strive to

prevent and treat the trauma we have suffered from childhood effectively

This not only

benefits the victims, but the whole society.

Supporting material

About the CDC-Kaiser ACE Study

STAFF DEBUG INFO

Did you know about the ACE study and its results?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Is the knowledge derived from the ACE study taken into account in your workplace? If so, which parts?

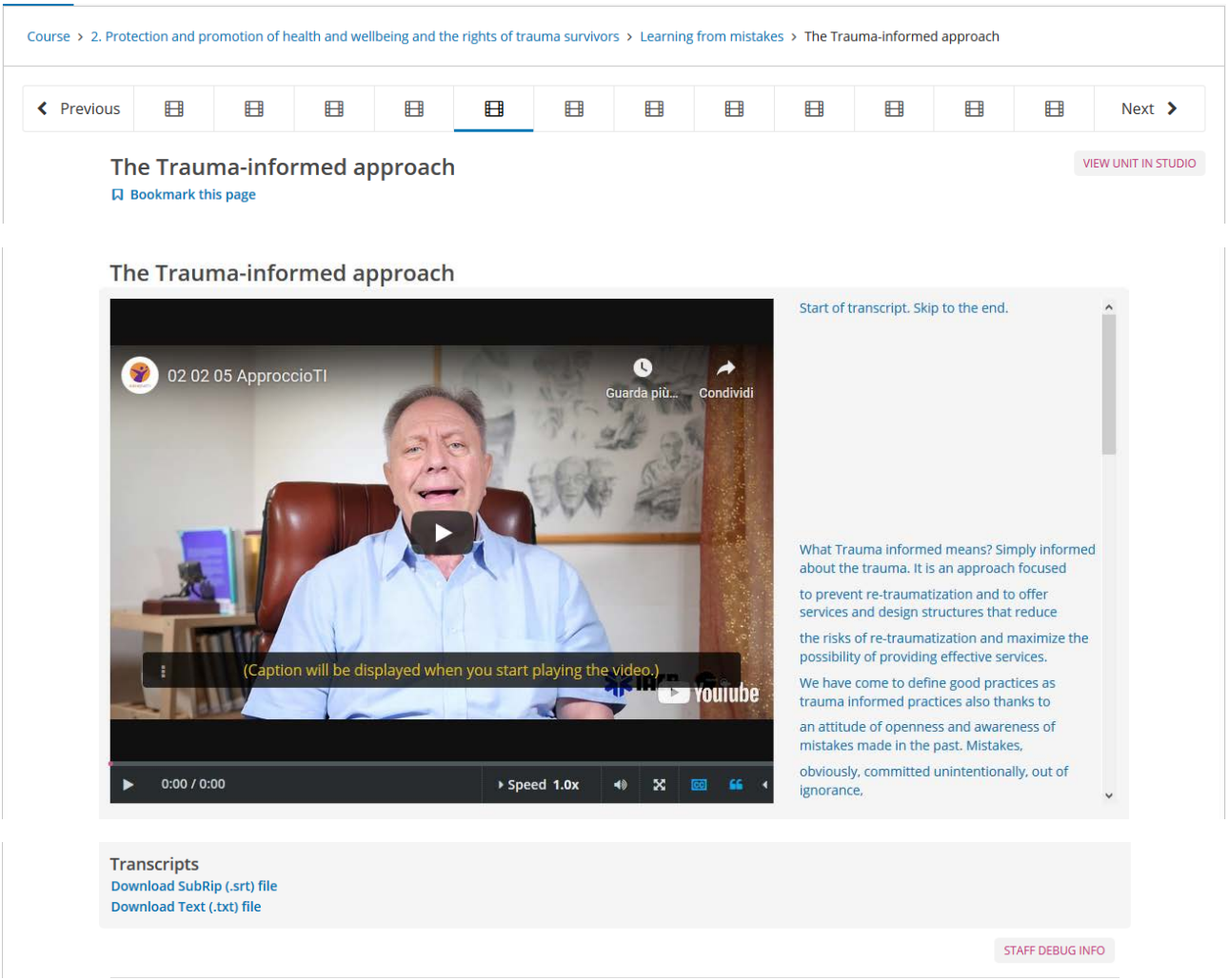
Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Previous Next



Transcript

What Trauma informed means? Simply informed about the trauma. It is an approach focused

to prevent re-traumatization and to offer services and design structures that reduce

the risks of re-traumatization and maximize the possibility of providing effective services.

We have come to define good practices as trauma informed practices also thanks to

an attitude of openness and awareness of mistakes made in the past. Mistakes,

obviously, committed unintentionally, out of ignorance,

because we didn't know

that some aspects of the treatments offered in the past were part of the problem and not the

solution: for example pushing clients against their will to remember and reexperience traumas

of the past, re-experiencing some traumatic moments and so on.. 11 00:01:31,660 --> 00:01:38,260 Today, thanks to what we've learned from our past mistakes,

we have a set of guidelines,

of parameters that help us prevent damage and maximize the benefits in service 14 00:01:53,310 --> 00:01:54,340 delivery;

this is not only in the field of healthcare, of mental health,

but in every area of intervention

- for example, schools, organizations, juvenile justice regulations

or even the laws - in other words a Trauma Informed School is a school sensitive to

trauma issues and therefore also the teachers will be aware that not always an unruly student

is just being mischievous, but may be expressing a discomfort due to trauma, and therefore knowing

this will have a rereferral tool for the psychologist so that student can

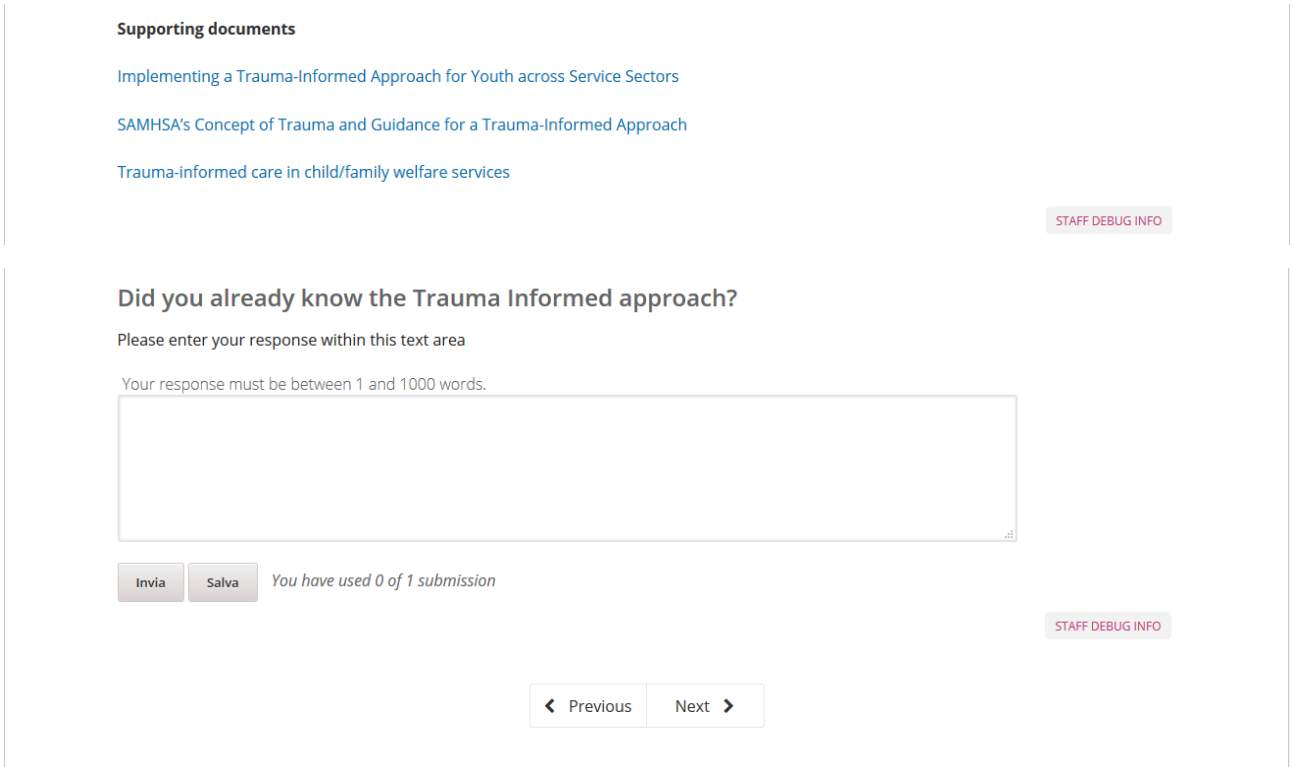
be helped if he/she needs to and the problem does not become more serious than it is already.

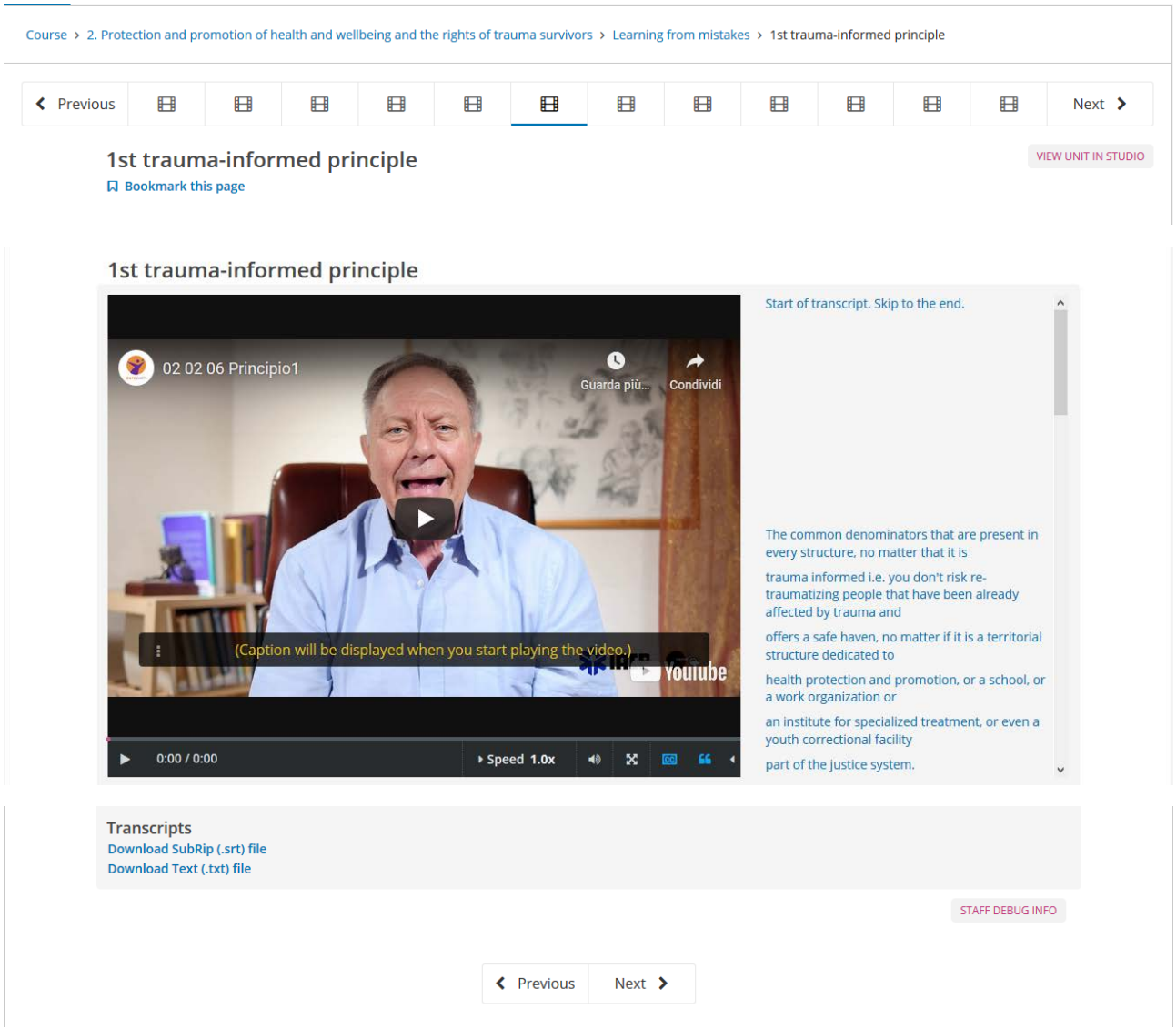
After all, having an informed trauma approach is not only dutiful, from one point of view

ethical, clinical and mental health perspectives, but it is cost-effective,

to deliver treatments that reduce the damage is in the interest not only of the victims

of trauma but of society as a whole.





Transcript

The common denominators that are present in every structure, no matter that it is

trauma informed i.e. you don't risk re-traumatizing people that have been already affected by trauma and

offers a safe haven, no matter if it is a territorial structure dedicated to

health protection and promotion, or a school, or a work organization or

an institute for specialized treatment, or even a youth correctional facility

part of the justice system.

Even a community, in order to be trauma informed, must have these common denominators that

have a red thread:

the common denominators are all focused in communicating 10 00:01:21,799 --> 00:01:26,340 and assuring to the traumatized person

a full sense of security,

physical and psychological, to be in a safe place.

The first trauma informed principle is that the structure must ensure the physical and emotional security and then the person will have the the certainty, because she knows about it, but also the experience that nothing will go wrong, no attack, can be aimed to damage her, it is a safe place where you do not have to to be on allert, in constant alarm, to live with axiety.

The trauma informed structure is also very comfortable, in all aspects of communication and metacommunication and therefore the service user is welcome, everybody say welcome, or welcome back and everybody that the client is a person is really welcomed. 22 00:02:50,780 --> 00:02:57,900 A structure to gain trust and giving security to service users must be coherent,

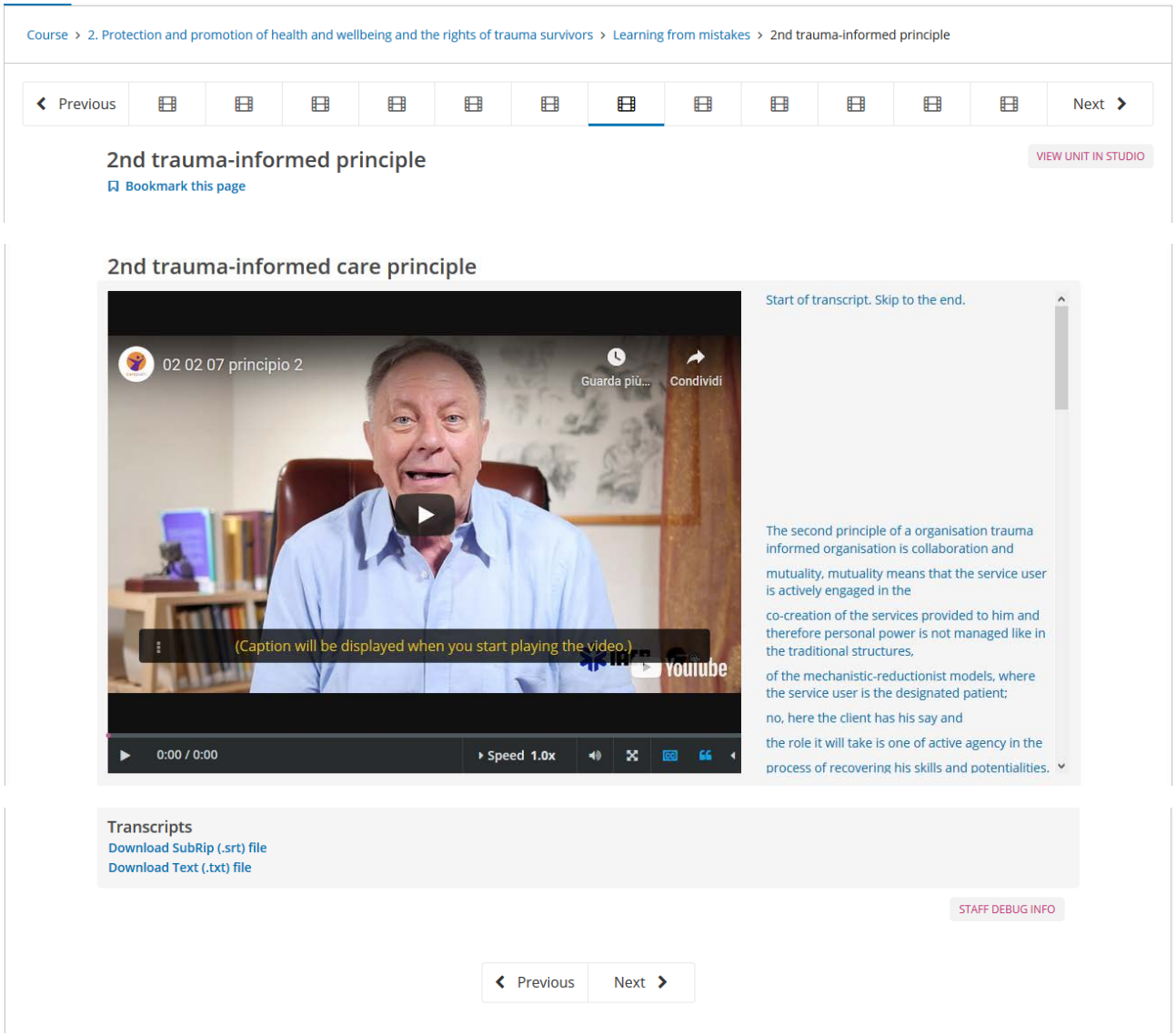
the messages at all levels must be congruent with the actions and constant in time.

Only in this way can the service user can develop real trust and feel that the structure is really welcoming and a safe place that can be relied on.

In a trauma informed facility there is no place, wheree violence, shame and guilt have space, very problematic aspects that can exacerbate or retraumatize those who have already suffered a trauma.

An informed trauma structure also ensures the confidentiality and professional secrecy, the privacy of the client, who will not be exposed to this kind of danger and violence.

In addition, the language of a trauma informed-person centered structure will speak clear, consistent language, that the client can understand and not any cryptic and professional language where one needs three university degrees to understand it.



Transcript

The second principle of a organisation trauma informed organisation is collaboration and

mutuality, mutuality means that the service user is actively engaged in the

co-creation of the services provided to him and therefore personal power is not managed like in the traditional structures,

of the mechanistic-reductionist models, where the service user is the designated patient;

no, here the client has his say and

the role it will take is one of active agency in the

process of recovering his skills and potentialities.

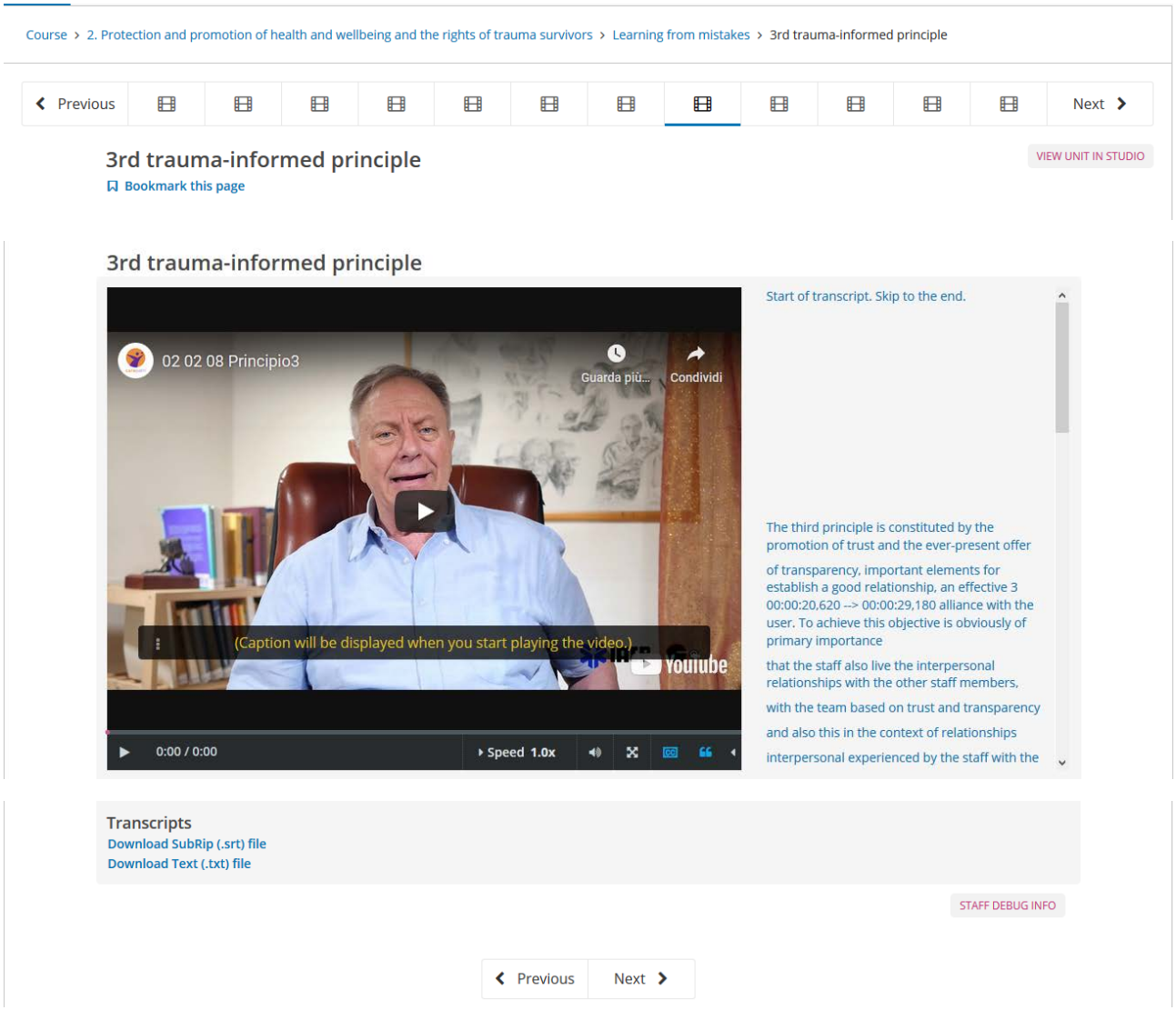
A trauma informed trauma structure will promote

the recovery of self-respect, a

crucial aspect for the victims of trauma,

and also recovery of hope, 12 00:01:17,040 --> 00:01:20,600 the recovery of one's potential.

A structure like this will always make clear, especially to itself, that the
recovery of health, functionality of a person with post 15 00:01:36,380 --> 00:01:37,909 traumatic stress,
from trauma, can only happen through effective relationships that staff members
of the structure can establish with the service user.
In short, good teamwork, a good working alliance.
Sharing the decision-making process is a central aspect to ensure the good functioning
of the services provided,
first of all we know well from the research of
Karasek about stress - if I have stressful stimuli but I also have a good deal of power of control,
the stress level will get lowered,
if I have little control on the situation the stress level rises; it's really
this principle at work.
So, to give decision-making power of control to the service user is already part of the cure,
in other words, the person with more control
is better able to overcome his condition.
A structure focused on providing trauma informed services is a structure that does not encourage
excessive disparity of power, excessive levels of power differential between structure
personnel and the clients, but takes active actions of empowerment and recognizes to the person
of the client the right to exercise control and a personal power in the co-construction
of a shared reality.
The trauma Informed structure is systemic and holistic in the sense
that is well aware
that what needs to work at is the social construction of a trauma informed reality;
all aspects contribute to making it as such
so everything, from alpha to omega,
from the beginning of the intake, from the welcoming
to the person of the client who will get treatment,
and how the client is accompanied and helped to live effectively
the aftercare phase.



Transcript

The third principle is constituted by the promotion of trust and the ever-present offer

of transparency, important elements for establish a good relationship, an effective 3 00:00:20,620 --> 00:00:29,180 alliance with the user. To achieve this objective is obviously of primary importance

that the staff also live the interpersonal relationships with the other staff members,

with the team based on trust and transparency

and also this in the context of relationships

interpersonal experienced by the staff with the users and their families.

Another important aspect is to respect the limits, keep the boundaries, because first and foremost

just by having clear boundaries we can create clear spaces, not respecting the boundaries

means polluting the settings and creating their dysfunction.

Transparency is fundamental and therefore the policies must be clear, formulated

not in bureaucratic language, but in a clear and transparent language

There is another reason

to be clear, everyone needs to know - especially the clients - in which place they are, which

are his rights and duties, what are the different aspect of the structure and of the staff

who works with him.

For this reason you also need to have a lot of clarity of roles and knowing that the various professionals that

work in a facility have various skills

and also provide various aspects of the treatment, none

is all-embracing and that therefore, as in an articulate society, the baker makes the bread, milkman

distributes the milk, the engineer makes his work and so on.

Essential for a trauma informed structure is respect for the rights, and the active promotion of the client rights, it is therefore fundamental

to ask and receive an real informed consent

explaining well to the client how they will be treated the procedures, service delivery and

doing everything possible to make sure that understanding and consent obtained

from the client are real and not mere formality.

4th trauma-informed principle

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4th trauma-informed principle

Start of transcript. Skip to the end.

The fourth principle of trauma informed structures is based on actions of empowerment,

by giving right of choice and also to Co-creation of realities dedicated to the service users.

Everything in the structure gives messages

and meta-messages focused on promoting strengths, the

resilience of clients, the choice is to promote the change

focusing on the strengths

and not on the weakness or dysfunction of the clients.

Transcripts

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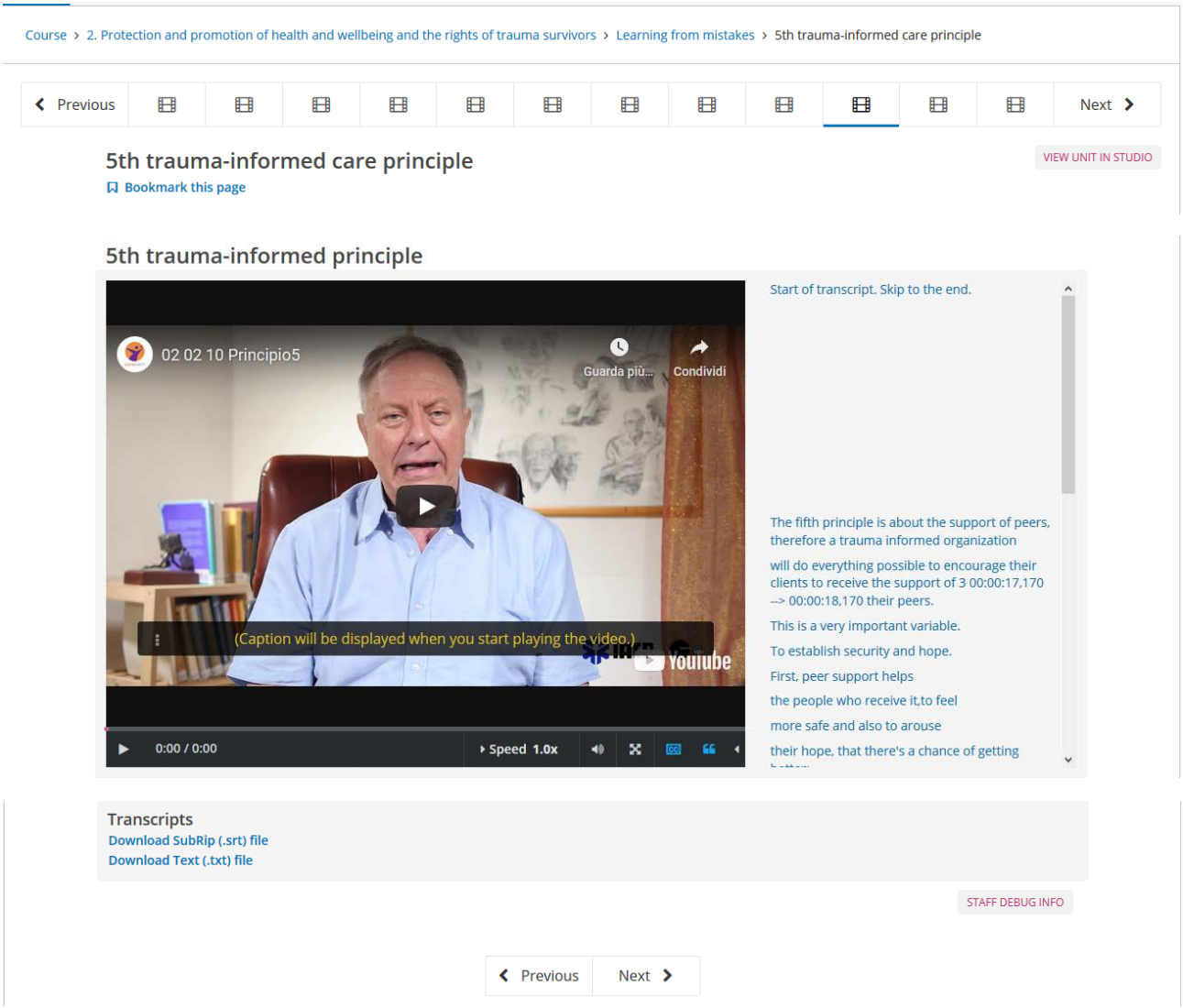


Transcript

The fifth principle is about the support of peers, therefore a trauma informed organization

will do everything possible to encourage their clients to receive the support of 3 00:00:17,170 --> 00:00:18,170 their peers.

This is a very important variable.

To establish security and hope.

First, peer support helps

the people who receive it,to feel

more safe and also to arouse

their hope, that there's a chance of getting better;

in short the support of peers is important to build greater self-confidence

in their own potential, also self-esteem.

Peer support also promotes possibilities of collaboration and therefore everything

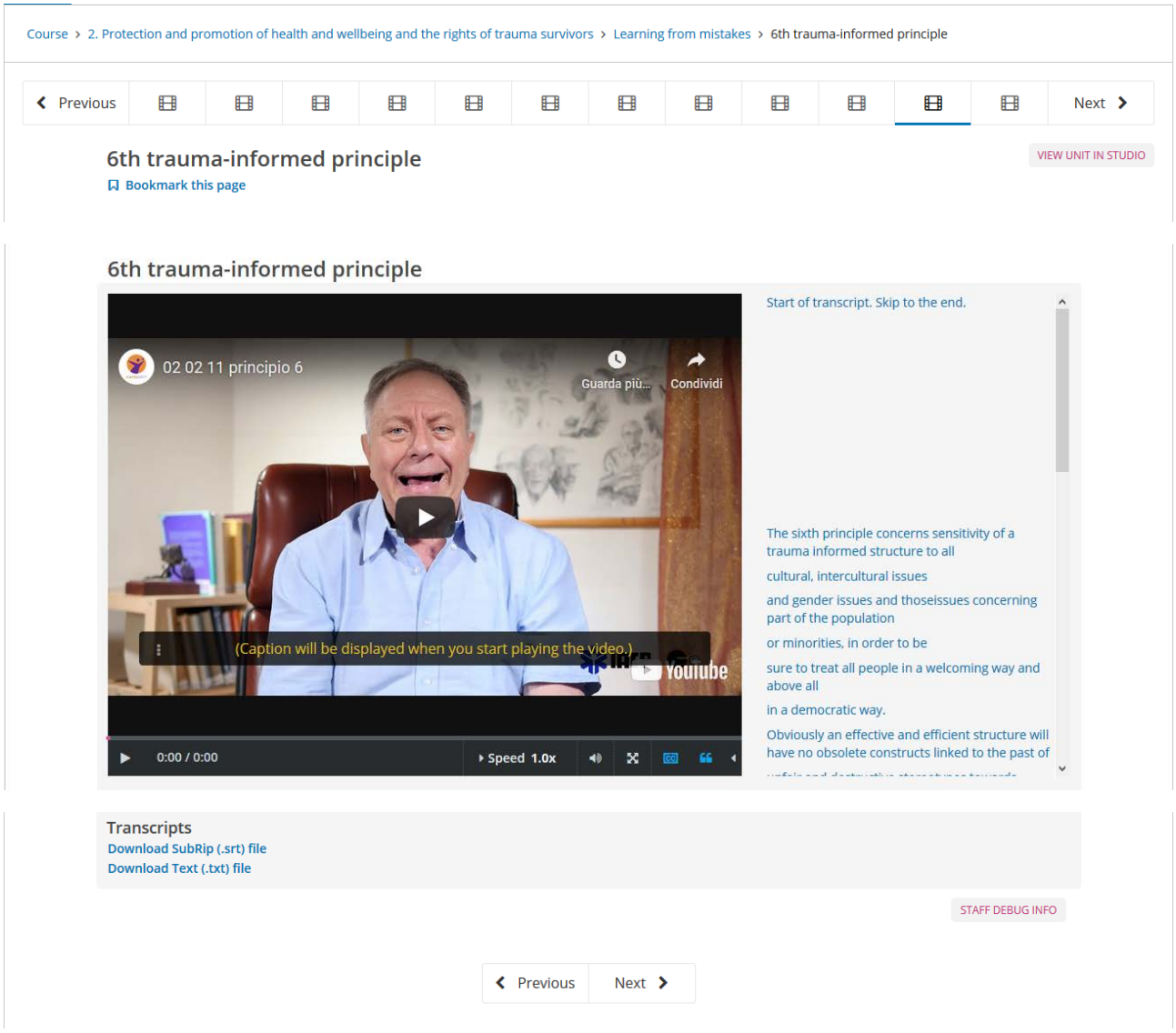
is positive in promoting the client social role and feel active.

It is undeniable that peer support brings an interpersonal communication that can

really take advantage of the construction of narratives

that I'm a part of a network

much richer and that can help the development of narratives of hope and healing.



Transcript

The sixth principle concerns sensitivity of a trauma informed structure to all

cultural, intercultural issues

and gender issues and thoseissues concerning part of the population

or minorities, in order to be

sure to treat all people in a welcoming way and above all

in a democratic way.

Obviously an effective and efficient structure will have no obsolete constructs linked to the past of

unfair and destructive stereotypes towards minorities.

The service provided will be, for example, realy

sensitive to gender diversity and respect

gender equality and then

such an effective approach will facilitate the use

of the cultural backgrounds, traditions,

of its clients cultures and countries of origin.

It will build a reality congruent to its own philosophy; the organization and the

procedures will all be

non-discriminatory and sensitive to diversity.

It will also be able to recognize and face efficiently the historical trauma. 19 00:01:43,060 --> 00:01:47,440 Historical traumas are made up of events

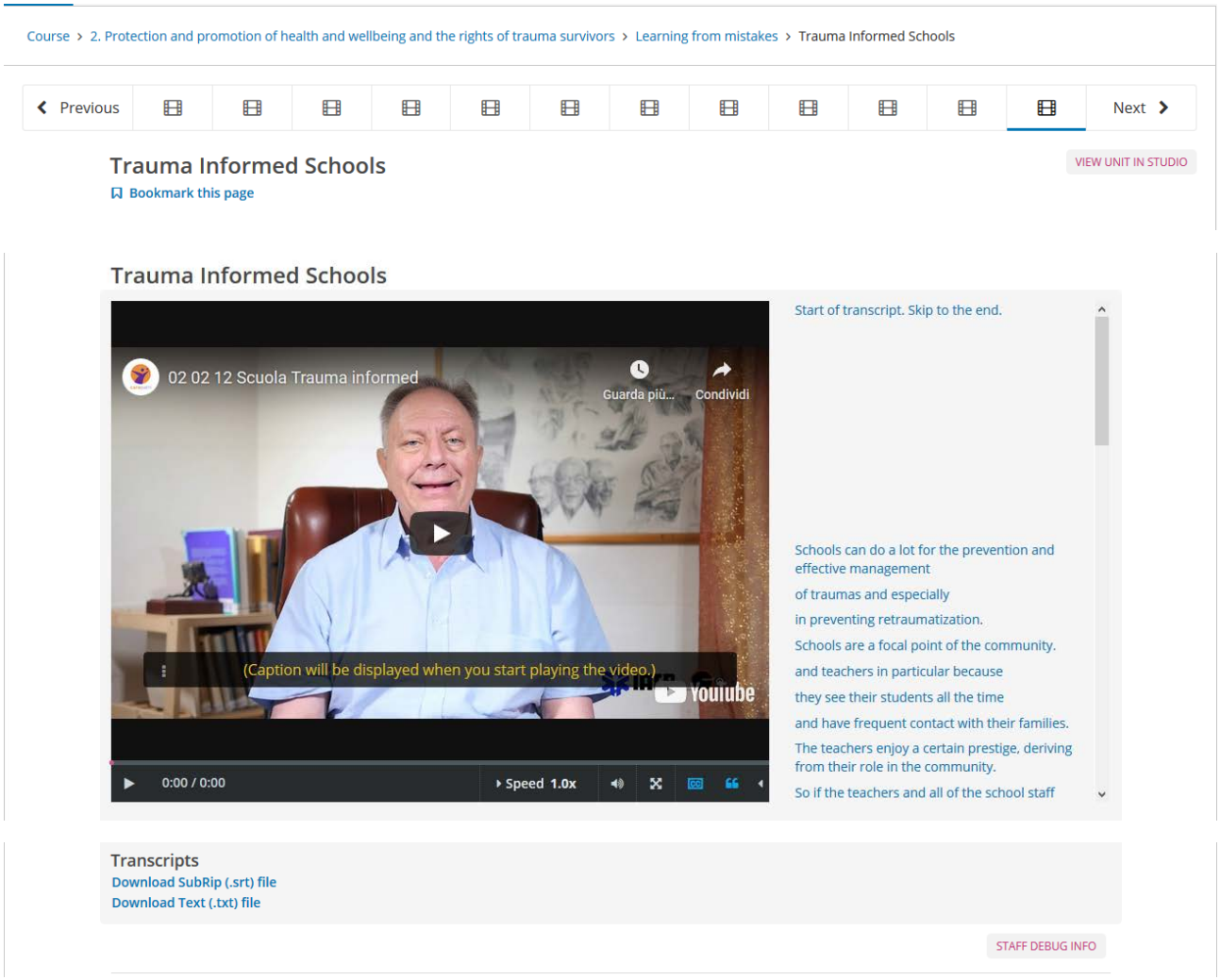
of mass trauma that also affect those

that have not experienced them directly, offering a dramatic example: the Holocaust; not only

millions of people have been victims

of the Nazi delirium, but also their children and grandchildren...

bear the burdens of the reverberation of such traumatic bestiality.



Transcript

Schools can do a lot for the prevention and effective management

of traumas and especially

in preventing retraumatization.

Schools are a focal point of the community.

and teachers in particular because

they see their students all the time

and have frequent contact with their families.

The teachers enjoy a certain prestige, deriving from their role in the community.

So if the teachers and all of the school staff

are sensitized to the

parameters of a trauma informed school , and also they have

available to them consultation services from

an expert who can help them make the improvements

that will make the school from a school ignorant

of the problem to school informed about trauma issues, well that school

will not be part of the problem, but part of the solution.

Not only because the teachers

sensitized to the issues of trauma may be

ready to pick up signals

that if they didn't have a trained eye they could interpret

as mere disciplinary problems, but instead - being trauma informed teachers - they will

be sensitive to refer to their

students to specialized professional and see if one

of their student needs professional support whether the student is or has been the victim of a

trauma.

Another significant influence teachers can exercise is with the parents,

that in that way could slowly become trauma-informed parents

and they can give a significant contribution

to this kind of problem.

In short, a trauma informed school

is the fullfilment of a school's vocation, which is to have

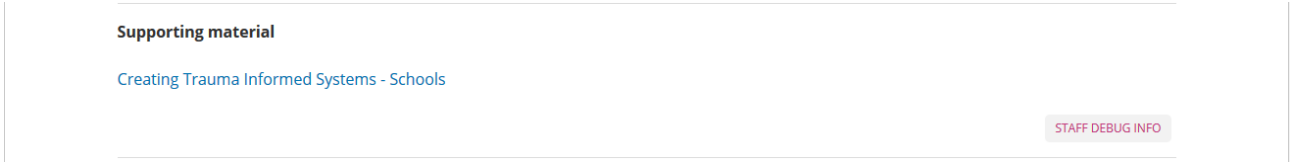
and effectively disseminate knowledge

that will allow their students to function as proactive citizens of the polis.

So, a trauma informed school

is fully prepared to fulfil its school' mission

in the best sense of the word.



Are there trauma-informed schools in your local community? In your nation?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Could you please help us improve the usefulness of this course for field practitioners by letting us know where we can find information about informed trauma schools, in your country or in EU and global level?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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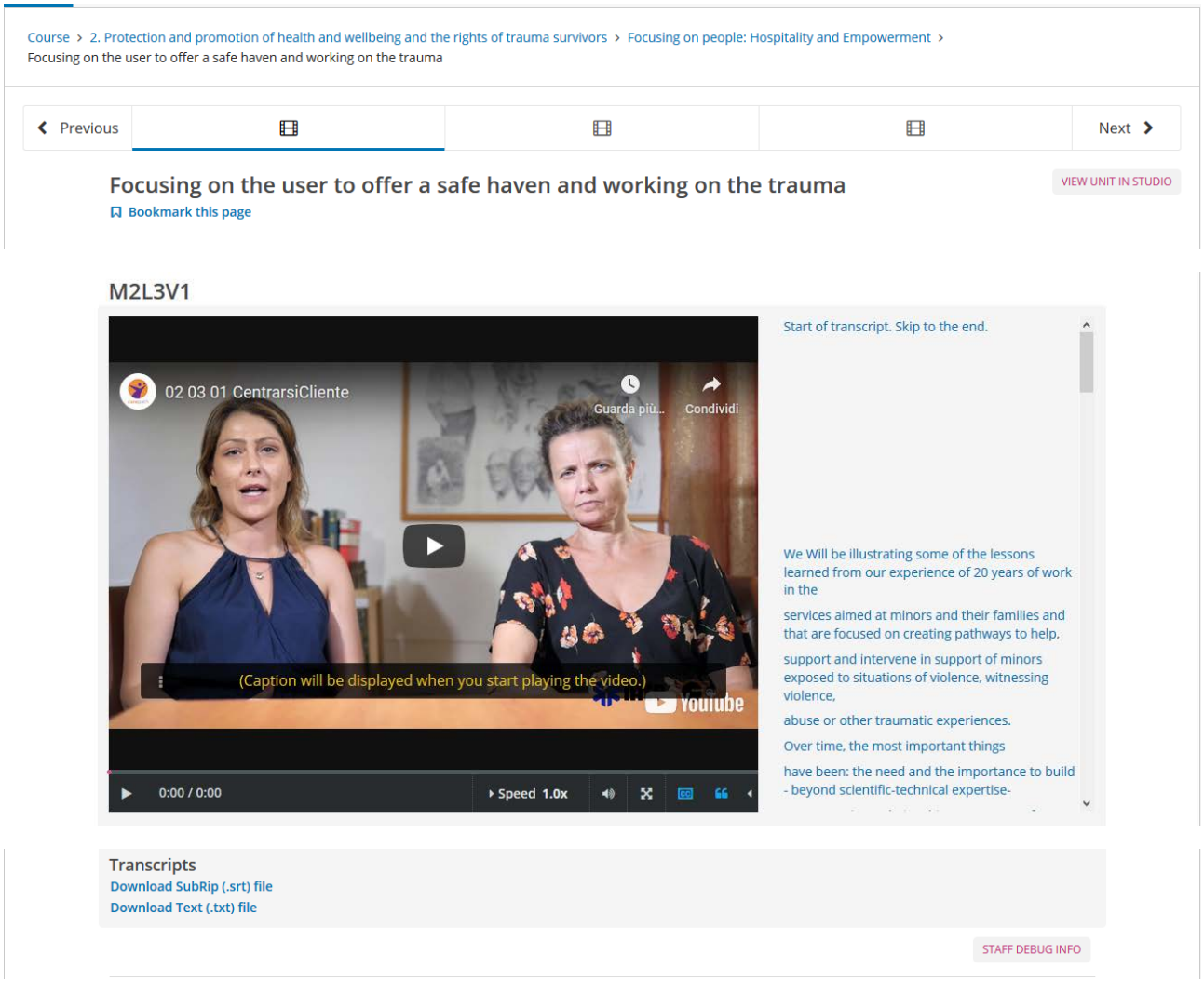

Transcript

We Will be illustrating some of the lessons learned from our experience of 20 years of work in the services aimed at minors and their families and that are focused on creating pathways to help, support and intervene in support of minors exposed to situations of violence, witnessing violence, abuse or other traumatic experiences.

Over time, the most important things

have been: the need and the importance to build - beyond scientific-technical expertise-

an appropriate relationship to create a safe environment for the child.

The term safe, should be declined in the dimension of listening

of needs and respect,

particularly important in situations in which the minor comes out of experiences that have violated the sense of security and respect and continuity of life, in these instances

a situation of profund respect is fundamental in order to resume an evolutionary path.

Wath means a dimension of respect? It means a real dimension of listening,

empathic listening and not centering
on protocols and operators' needs, but centering
on the inner world
of the minor, his needs, the pace of the child, which
must be respected since, often we find ourselves dealing with minors who have developed
a stance of self-defense and self-protection.
It is therefore important that the professional
does not try pry out defenses (wanting to know, asking questions)
but respecting the pace of the minor, being aware that the defense
are the best way found by the minor to cope with an impact that has been
overwhelming. So slowly, gently making the defenses less indispensable
we will be able to meet the core of the heart of that minor.
Experience shows us that it is important to be focused on the needs of the minor.
We will now discuss our experiences of our social assistance activities that
for eigth years we have spent at the Rome municipality dealing with prevention,
protection and support of minors and their families.
In accordance with the above mentioned importance to be focused on the needs
of the minor, we can broaden this reflection underlining the need to be centered on the characteristics
and the uniqueness of any situation, so... also centering on all those involved, in addition to
the minor definitely also his parents. In everyday work as a social assistant
is mainly focused on working with the parents, since the minors who suffer
or have suffered one or more traumas
are usually taken care of and followed up by some othe professionals
properly trained to support them.
With regard to the activity of the social worker, he or she is focused on accompanying the
families in the process of awareness
of their difficulties, criticalities, fragility,
but also the behaviors that have caused damage and suffering in their children, and also helping
to build support networks in order to support them in the acquisition and use
of adequate parental responsibility that guarantee
the child's right to grow up
quietly in his family,

in a context of protection and safeguard.

According to our experience, the elements preponderants one need as a professional

working in this area is with these clients are definitely the technical and scientific skills

schills of professionals, but surely also skills and abilities concerning

more the personal sphere, we refer to all that you can consider

of the "inner-world"of the professiona: his own emotions, prejudices,

resonances, projections that we tend to do and let's connect with each other;

as well as being helping professionals we are people

that encounter other people.

What happens when we work

with abusive parents? trying sometimes, even often,

feelings or emotions of anger, outrage, indignation and also sometimes

of fear; surely what

we want to say is that we don't have to pretend that these emotions don't exist, they're part

of us and they'd still be in the helping releshionship. the important thing is,

to know how to recognize them, so that we can manage and make sure that they don't affect

the reality in front of you, which is to do so that the personal subjectivity is not

the language through which one interprets what you have in front of you, confusing the

plans of reality or the roles. Sometimes the helping professional, confused by emotion, tends to assume the role

of the one who gives directives and the parent becomes simply the victim of the operator's decisions;

this certainly does not help the facilitation of the protection of minors, because

if you are not fully focused on the reality of the faced situation is not

possible to understand and perceive the needs of minors and thus effectively orienting the professional intervention.

for wat concerned the direct relationship with the minor, the intervention of the social worker

is in that case more reduced,

since there are strong emotional components

some times a social worker may want to respond to his personal need to give to the minors the affectivity

and the care they did not receive, other times attempting to overstep in the role of clinical professional helpers

who follow them and help them clinically in the processing of their own trauma.

Important note

You can skip doing this exercise if you do not work in any role in the field of helping professions.

STAFF DEBUG INFO

Do you have an attitude that makes it easier for you to put the person of the client at the centre of the professional relationship?se

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

If you don't work by centring on the person of the client, can you tell us why?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Do you think it would be useful to receive training to be able to, when you decide, to work by centring on the person of your clients?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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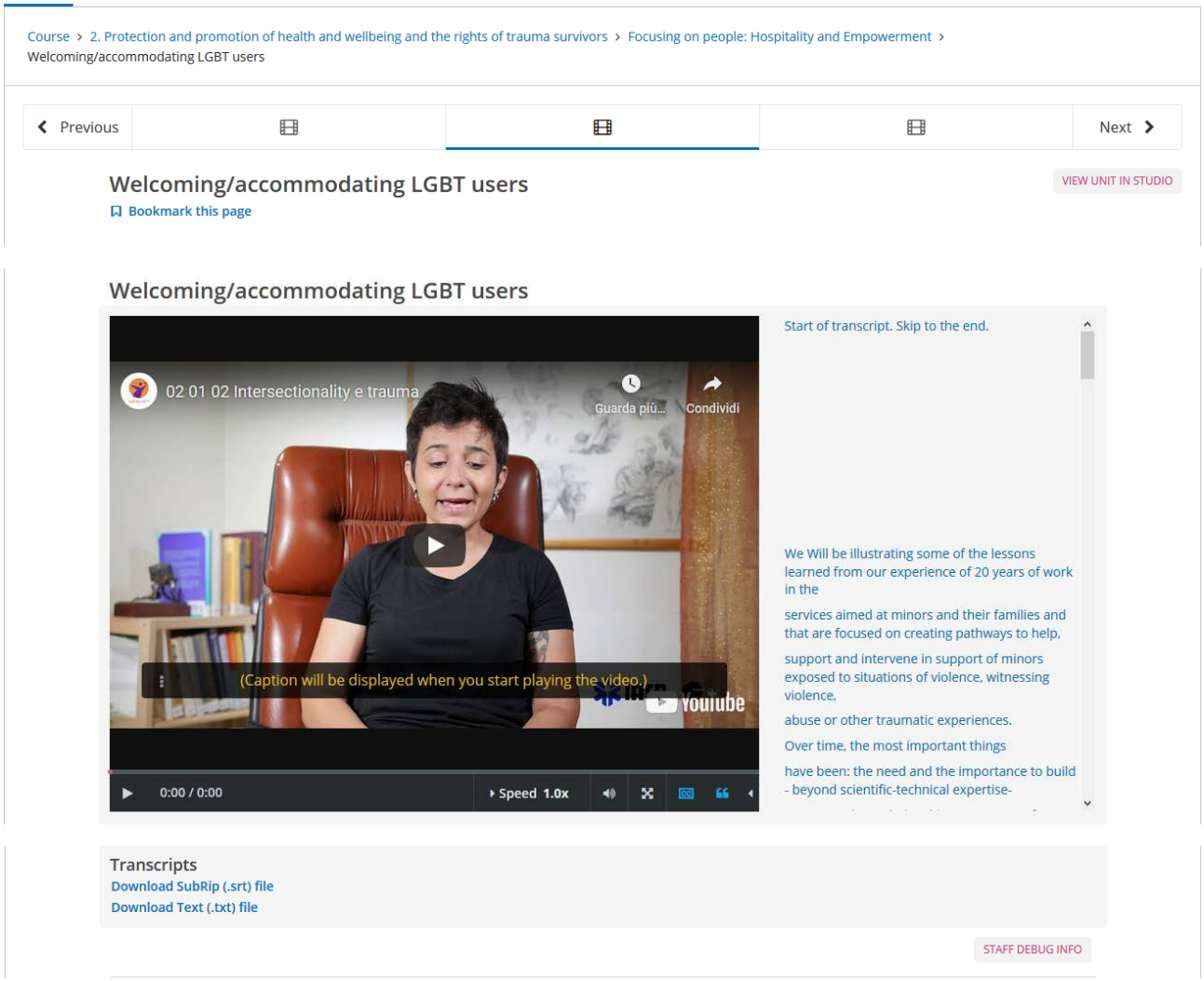

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risks guidelines issued by folds in 2012 compared to practice
psychological with people lgbt line non the importance of taking in
considering the attitudes of speaker of help towards homosexuality
and bisexuality intended not only like knowledge of the effects of
stigma about these people but also how awareness of how much one's own

implicit and explicit attitudes compared to the hours of sexuality, and therefore...

personal expertise on these thematic but also personal

personal look at these issues may affect

evaluation and intervention

The commonalities that can be extrapolated from

all documents produced so far can be so summarized.

Offer acceptance and support

by respectfully listening unjudged and

empathetic that helps the user to reduce the discomfort caused by minority stress

Take appropriate measures in the phase of getting to know these people

the assessment must be directed to the knowledge of the

girl and in all her complexity considering the interactions and

interconnections between minority stress mental health and dimension

spiritual interior as well as the position sexual orientation occupies in the

general functioning of the individual.

Encourage and support active ways of

coping we know that for teenagers in general it is very important to feel

active agents in particular when it comes to

stressful events the rapporteur to help will have to try to

help the user to favour developmental strategies

cognitive and emotional of the same appreciate the dimension again

foundational in adolescence

the role played by friendships of municipalities and

the lgbt community will see that the minority stress can result in

marginalization and isolation

a fundamental objective is to increase the

ability to use the support social.

Explore and develop identity

and identity dynamics constitute a very important aspect

and founding adolescence and in the adolescence of

lgbt people it is important that these people can explore and integrate

without necessarily having to choose an identity at the expense of the expense

the other as in the case of the dichotomy male female.

Understanding conflicts and promoting their integration

the aid report should favour

dialogue and integration between the parties of if possibly conflicting as

This can happen for example in the case of sexual orientation and belief

religious understand meaning underlying requests to modify

sexual orientation or to make a restorative therapy

in such cases you need one trained psychotherapist

world with a demand analysis appropriate welcoming means and

exploring that desire and by bringing it back to complex dynamics

family and social psychology that could lead the boy with the

girl to consider unacceptable a constituent part of one's own

identity.

You'll buy exploring the walking process.

Catch the minority levels stress in relation to the conditions of

double minority where the individual is discriminated against not only because

of bisexuality homosexuality but also other conditions covered by

social stigma

Take into account the weight that the lesser of stress minority stress a

in torque dynamics and important to remember that gay couples

and lesbians are neither recognized nor by the main religions nor

by the legal system of many countries connected this is to be considered

everything related to homogeneity and lack to the

poor legal regulation of this type of family formation

Supporting Material

Trauma-Informed Approaches for LGBQT* Survivors of Intimate Partner Violence: A Review of Literature and a Set of Practice Observations

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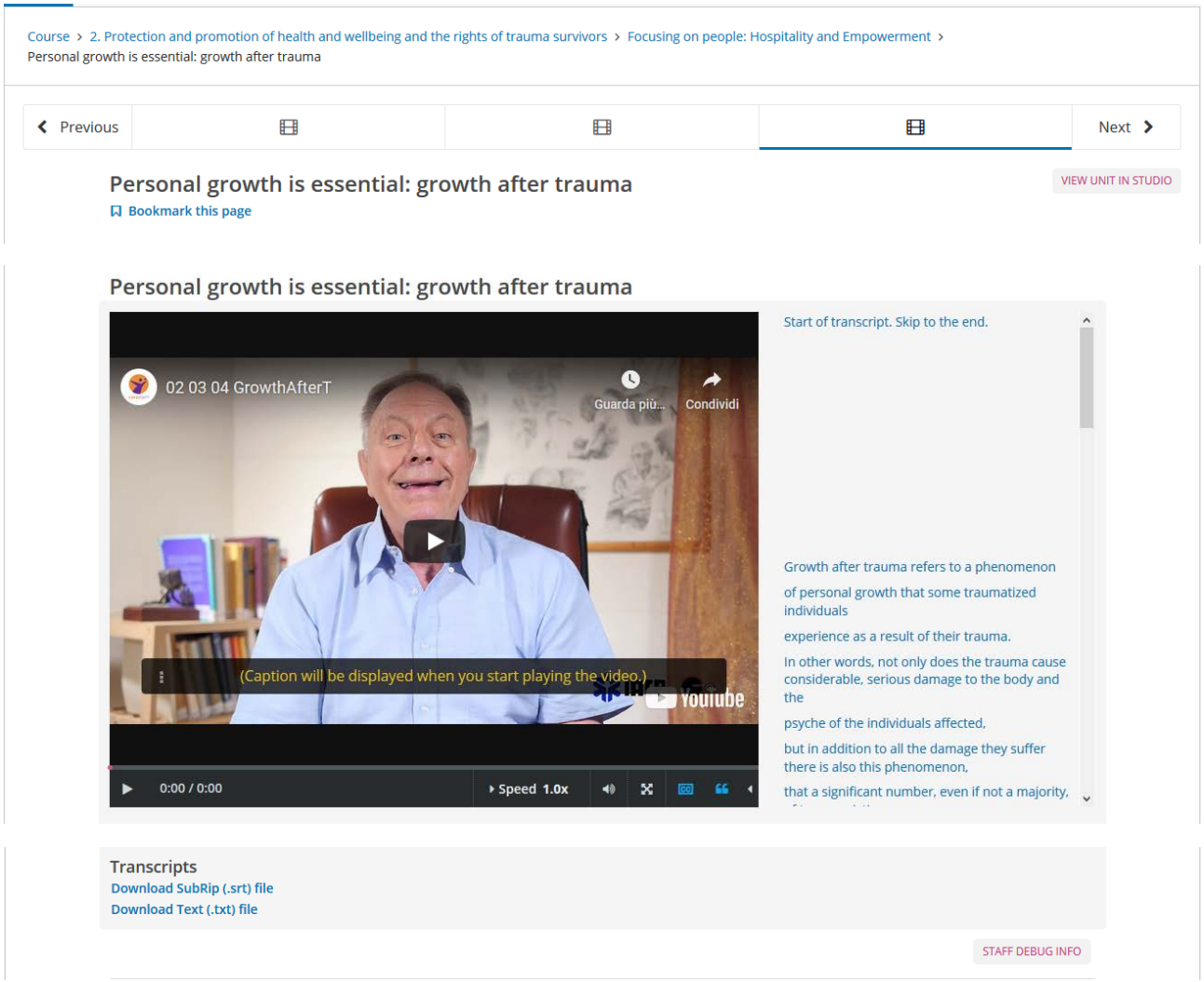


Transcript

Growth after trauma refers to a phenomenon

of personal growth that some traumatized individuals

experience as a result of their trauma.

In other words, not only does the trauma cause considerable, serious damage to the body and the

psyche of the individuals affected,

but in addition to all the damage they suffer there is also this phenomenon,

that a significant number, even if not a majority, of trauma victims

experience.

We want to underline that this, once again is a clear example of the wonderful resilience

of the human species, or maybe we should talk about the resilience

of all life forms that have developed

by the evolution of life on our planet.

No matter what, the tragedy of trauma impacts the person, is a severe "smackdown",

it hurts and offends the person,

and therefore, is a real earthquake, the tremors of which impact both the

psychic and physical plane of an individual.

However, in such upheaval, as is often the case,

not all the results are destructive

because when a person is overwhelmed by a trauma

he or she needs to cope 21 00:02:13,920 --> 00:02:17,540 with the new reality and some individuals

adapt by growing from that experience.

On an existential level they have

a growth experience, in other words

they become more open, more rooted in their values, their moral and spiritual aspects, living in a

more significant and life affirming ways,

with themselves, others and the world with new

and deeper meanings.

A personal example: I remember the emotions that I experienced reading a book written

by a colleague - Victor Frankl - who experienced the tragedy and all the related traumas

to be captured, as a Jew, during Nazism

and imprisoned in a Nazi extermination camp;

in the extermination camps, before to kill the people, they would attack

the prisoners in their dignity, however a number - even a small number of

people not only survived on a physical level, but in spite of all the traumas, also at the 36 00:04:01,970 --> 00:04:09,670 psychic level, they became better people and therefore, as Frankl reports in his

book "A psychologist in a lager" prisoners like him would take every effort,

depriving themselves of the little food they had, to give

loving support to unluckier inmates

that being sick or weak, were in danger of be sent to the famous showers in the gas

chambers to be exterminated.

The people that survived and was freed at the end of this Nazi madness

had become a better person, in spite of their physical weakness, and psych traumas

with a more significant relationship at the existential level with himself, others, the

world; an aspect that makes us meditate and perhaps it gives us some hope.

Supporting material

Growth after trauma

STAFF DEBUG INFO

You can skip doing this exercise If you do not work in any role in the field of helping professions.

STAFF DEBUG INFO

Have you had any traumatic experiences where despite the trauma, you experienced growth on a personal and existential level?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Have you witnessed any traumatised clients grow on a human and existential level?

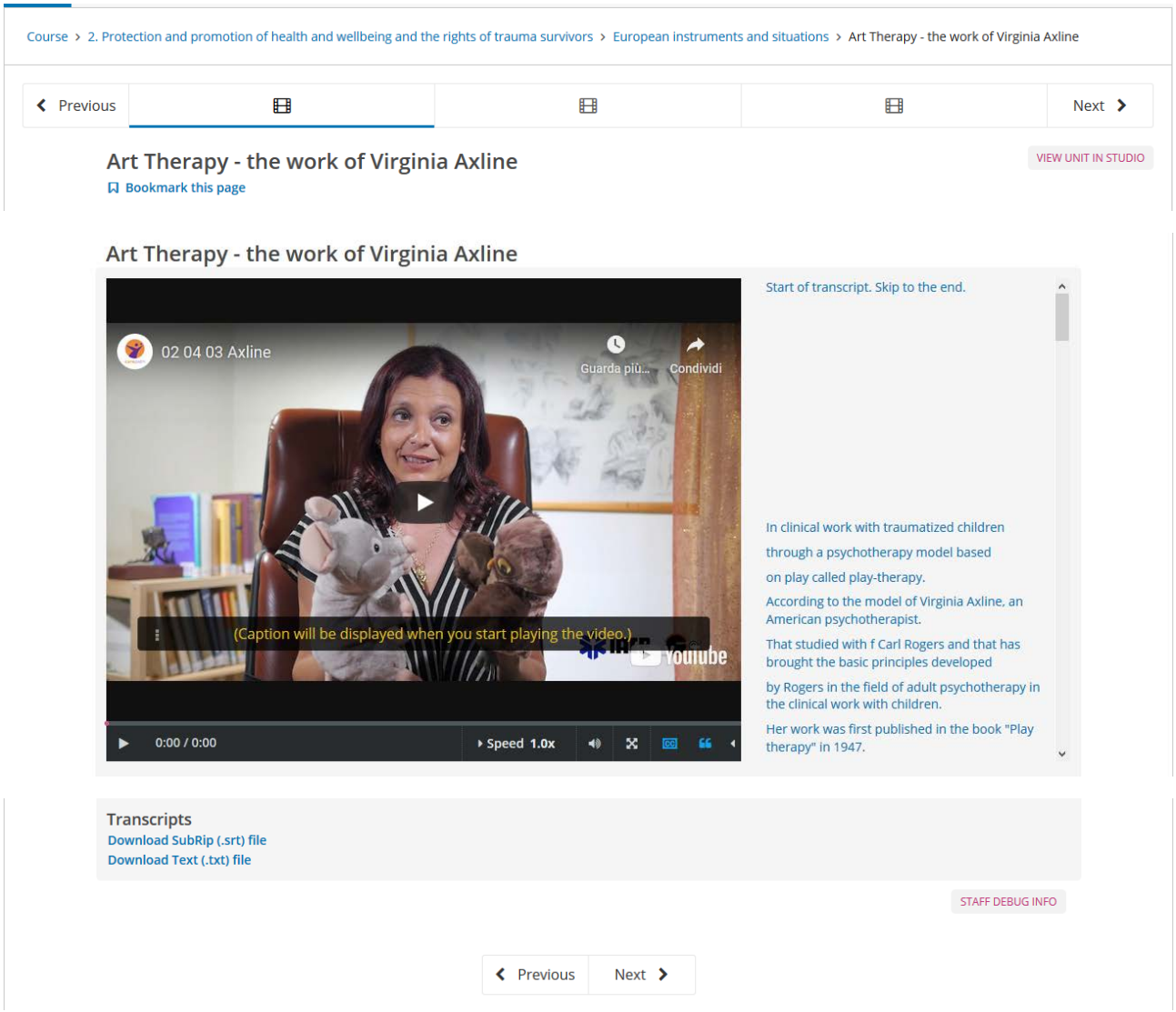
Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Previous Next



Transcript

In clinical work with traumatized children

through a psychotherapy model based

on play called play-therapy.

According to the model of Virginia Axline, an American psychotherapist.

That studied with f Carl Rogers and that has brought the basic principles developed

by Rogers in the field of adult psychotherapy in the clinical work with children.

Her work was first published in the book "Play therapy" in 1947.

The postulates highlighted and outlined by Rogers,

are the bases for understanding the inner world

of the child that Axline refers to, every child has an innate tendency

to actualize his inner potential 12 00:01:08,940 --> 00:01:10,890 and all his behaviors

are striving to achieve this goal.

A second postulate speaks of the child

Capacities for self-regulation, no one better than he knows what's best for himself.

A third postulate see the child

actively searching all those experiences

that may be conducive to his development, and the expression of his potential

while he will tend to refuse all those experiences that he consider unfavorable.

In this perspective, play therapy allows to the child to

express oneself in the best

possible conditions,

precisely because in a safe climate, containing and facilitating, the

child has better chances to express his potential.

The facilitating climate that

is provided by play therapy allows the child to grow stronger, to get to know himself

better and to correctly symbolize his experiences

in other words, to be able

to give expression to emotions and feelings.

Access to the child's inner world is

possible through so-called preferentials that are: The play, the drawing, the

fairy tale. Through these channels the child is able to express in a way

more spontaneous and free, as channels that belong to him , and that's the way it is...

able to express his needs, experiences and emotions.

In the play therapy process the therapist will be careful to

reflect to the child all that emerges through the play and then tuning in

with the child emotions.

This allows the child to broaden his awareness

Of his own behavior.

The availability of construction materials in play therapy

Is important because it is the way in which the child is involved. In that sense,

for example, to have a lot of material available of play allows the child to express himself

at liberty, to move at liberty inside

the environment, this becomes an experience for him...

highly significant:

the moment the child feels free is

facilitated in self-exploration

and, through this, does the change happen.

produces the use of personal power, the empowerment.

Returning to the construction of the setting, the

presence of many materials, for example, sheets of paper, various colors, plastiline

to model, sand trays for creating scenes or the presence of books,

fairy tales books that we can illustrate or read together;

along with the presence of puppets that allow

the child to express himself at his best: as an example, the use of two puppets that the child

and the therapist can wear, like puppets,

and wearing them the child makes them

parts of himself and can thus interact with the therapist, but making the puppet speak as a channel

of communication, which is important because by making the child can open up more

deeply and effectively.

In this sense the puppets can interact

as if they were autonomous entities, it's important for the therapist to look directly at the puppets

and not at the child, this facilitates

the use as a channel of expression that

he's not himself. The fact that they represent animals is a facilitating element because

for the child is easier to identify with the animal than with a human

figure. The therapist in this process with these

game materials will only accompany

the child in this path and - quoting

Axline - during a psychotherapy course the child will point the way

and the therapist won't direct it but follow it. In fact, the moment the child is free

to express himself, self-adjustment becames possible.

This is one of Rogers' earlier mentioned postulates.

In this perspective play therapy is effective in working with children who have undergone traumatic experiences

traumaticexperiences, since the creation of a climate of safety, containment and freedom

allows the traumatized client to express

himself at his best and start

processing his experience.

The importance of play 80 00:07:02,279 --> 00:07:10,349 is further underlined by research in the field neuroscience, particularly significant

is the contribution of Panksepp, which in its free "the ecology of the mind" identifies

seven basic emotional systems present in the mammals.

Among these systems the one that most

interests us is the identification of the circuit of play, a genetically determined circuit

which produces positive effects in the brain of mammals.

Panksepp found that

at the genetic level the play circuit is present in all mammals and therefore

they all have it in common. These researches enhance the importance of play for cognitive and emotional growth,

relational

and has proven itself that play facilitates coping skills,

e.g. social cooperation.

The fact that play has been confirmed

as a spontaneous, genetically rooted activity, allows us to do some thinking

when we're dealing with a child... who doesn't play. A child who doesn't play is

somehow indicative of a child who

at that moment it expressing a malaise.

Play therapy is a psychotherapeutic intervention highly effective with children

suffering,with discomfort, but

more with children who have 100 00:08:46,750 --> 00:08:48,840 ...traumatic experiences;

so play therapy underlines the point

that the child,

when is regarded as a person who

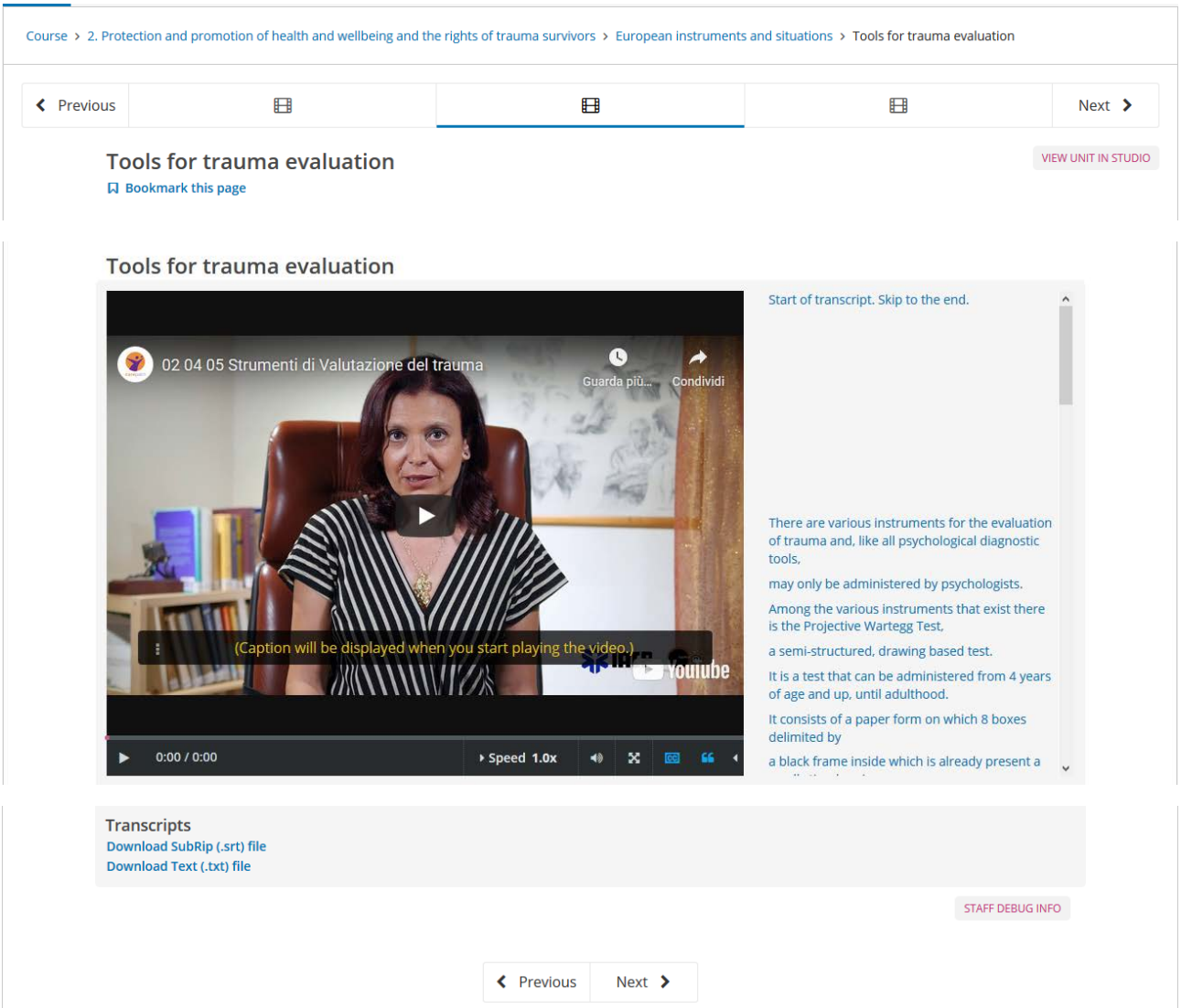
can tell, share and express all his emotions, feelings, anxieties.

and fears, but in a protected, secure environment. and respectful of the child himself and

his peculiarities.

All this can help the child to overcome the experience

traumatic experience and allow him to grow up in a way that is wholesome.



Transcript

There are various instruments for the evaluation of trauma and, like all psychological diagnostic tools, may only be administered by psychologists.

Among the various instruments that exist there is the Projective Wartegg Test,

a semi-structured, drawing based test.

It is a test that can be administered from 4 years of age and up, until adulthood.

It consists of a paper form on which 8 boxes delimited by

a black frame inside which is already present a small stimulus sign;

the person taking the test will have to complete a drawing inspired by what

is already present in the box, do it box to box and make eight drawings in total.

It is a very simple psychodiagnostic tool to administer, even in terms of timing,

and is based on drawing, a communication channel definitely preferential and facilitating for the child,

as mentioned earlier about play therapy.

Being a preferential channel for the child facilitates its realization.

The Wartegg test is based on a system of very accurate decoding and interpretation.

Despite the simplicity of administration the decoding system is very articulated

and accurate and refers to Crisis-Wartegg system: a procedure developed by the professor

Crisis, which, in general, allows to obtain a description of how personality works

of the individual to whom it was administered the test.

With respect to the specificity of the trauma the test allows, through the reading of certain

indexes, to identify in the presence of a trauma, in terms of its impact on the individual,

and everything that can come out of it... if you've been through a traumatic experience,

this on both a cognitive, emotional and a relational level.

The Wartegg test does not begin as a test specific for the assessment of the trauma, however

can make a significant contribution in this field

The report that comes out after decoding, which takes place through a first phase

where the drawings are translated into acronyms, the initials in indexes, and these read in configuration

of indexes that outline and describe aspects of functioning of the personality -

The strength of this test is in its simplicity. and immediacy and can give a description

of what the impact of the trauma was... on the psychological functioning of the individual

himself.

Next to Wartegg's test, which has a projective nature, there are also questionnaires

trauma assessment questionnaires, to name a few: the Hopkins Symptom Checklist - 2 which is a

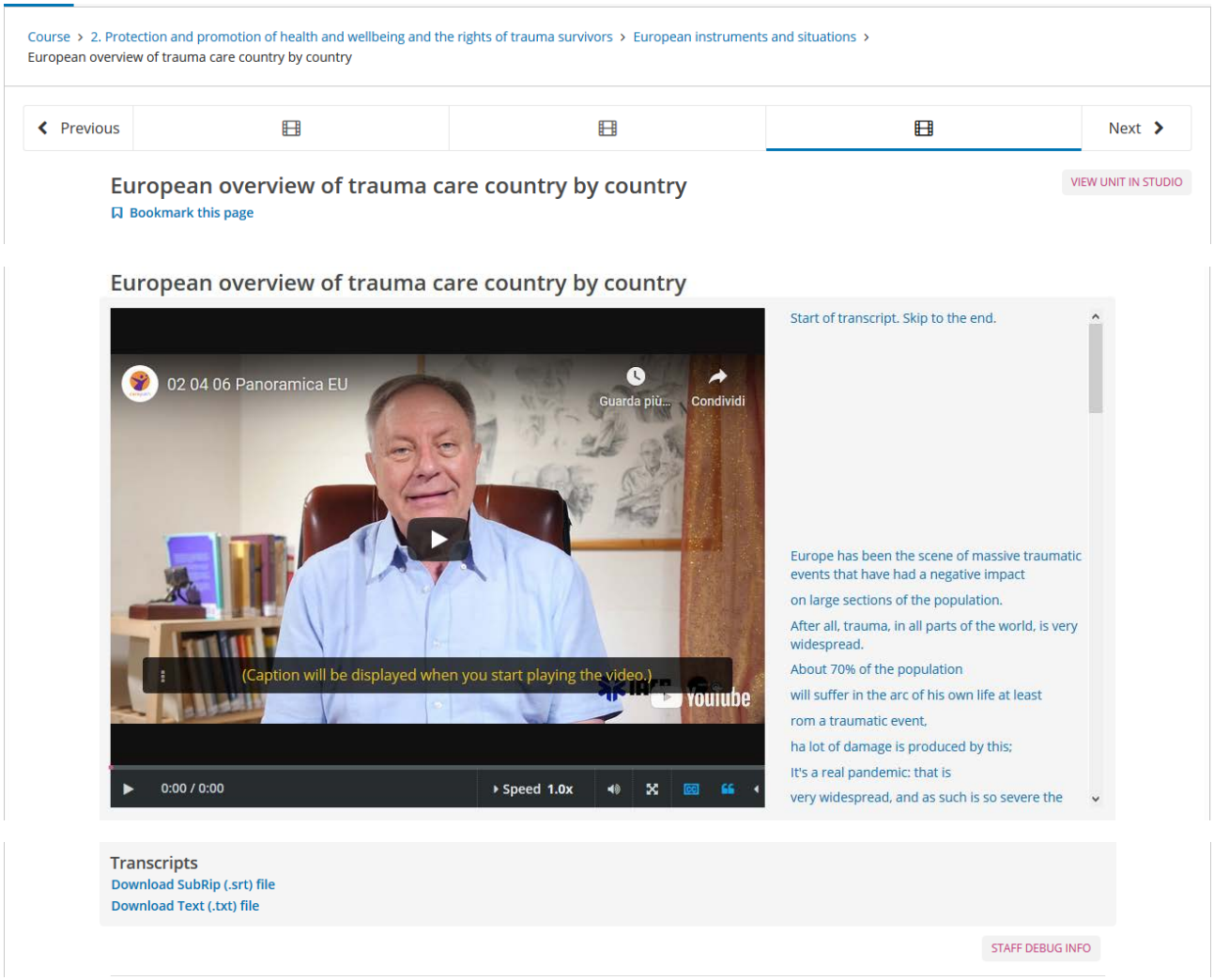
questionnaire developed by the University of Harvard and was created to 34 00:03:54,220 --> 00:04:03,470
assess the presence of symptoms in refugees children refugees (who have had this

experience), another questionnaire is the Trauma Symptoms Checklist for Young Children

a questionnaire which is not filled in directly by the subject but the caregiver, finally the Coping

Responses Inventory

which is administered from the age of 12 years and up and is a self report questionnaire



Transcript

Europe has been the scene of massive traumatic events that have had a negative impact

on large sections of the population.

After all, trauma, in all parts of the world, is very widespread.

About 70% of the population

will suffer in the arc of his own life at least

rom a traumatic event,

ha lot of damage is produced by this;

It's a real pandemic: that is

very widespread, and as such is so severe the damage at the mental,

physical, behavioral,

social, economic levels that trauma causes

that one would think this would have

alerted the nations of Europe,

among the most advanced countries in the world, to invest in research,

know-how, financing and skills development to manage effectively this pandemic - as we do

for many other phenomena -.

But, unfortunately, it's not the case; unbelievable. but true how little has been done.

There are exceptions to this , virtuos nations - like the Scandinavian countries- for example,

in Sweden they have equipped themselves not only at the level of of effective treatment of traumatized people, but

also at the social level, addressing with foresight

the problem; in every city there is present

a trauma task force;

professionals - such as social workers

- are well-trained on how to manage and prevent these

problems.

Many other European countries, however, have not been equally effective.

Suffice it to say that Belgium, where there is an excellent pro capita income, excellent capacities for

development, industry, services, etc, until a few years ago they had not developed

effective ways to train helping professionals with updated and effective skills.

At the university, the social construction of professional profiles was not sufficiently updated to help professionals to acquire the needed

skills to be really effective in dealing with this kind of problems. The situation, therefore, is not today absolutely satisfactory, with variables - such as

England and the Anglo-Saxon nations in general

which have developed in a

farsighted way the possibilities of training and investing resources in facility building

that can be of help and offer treatment to traumatized people, and also

carry out prevention.

However, in many countries, for example in Italy, there is still a long way to go

before we will have acceptable quality standard

to have the situation under control.

Positive work has been done, of course, by the trauma scientific societies that have been

created in recent decades; these have offered in part

a substitute for what would be the

task of the university educational process of the various health professions to create

and offer training, updates

and even the chances of obtaining qualifying diplomas

for the treatment of trauma.

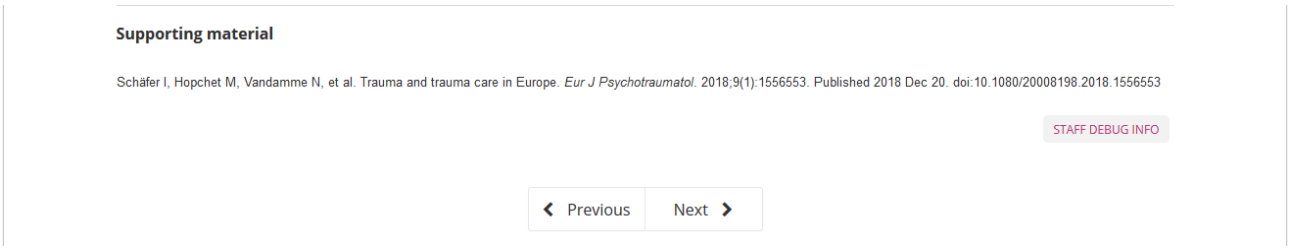
A lot is still is to be done and this is also an ethical, moral imperative, but

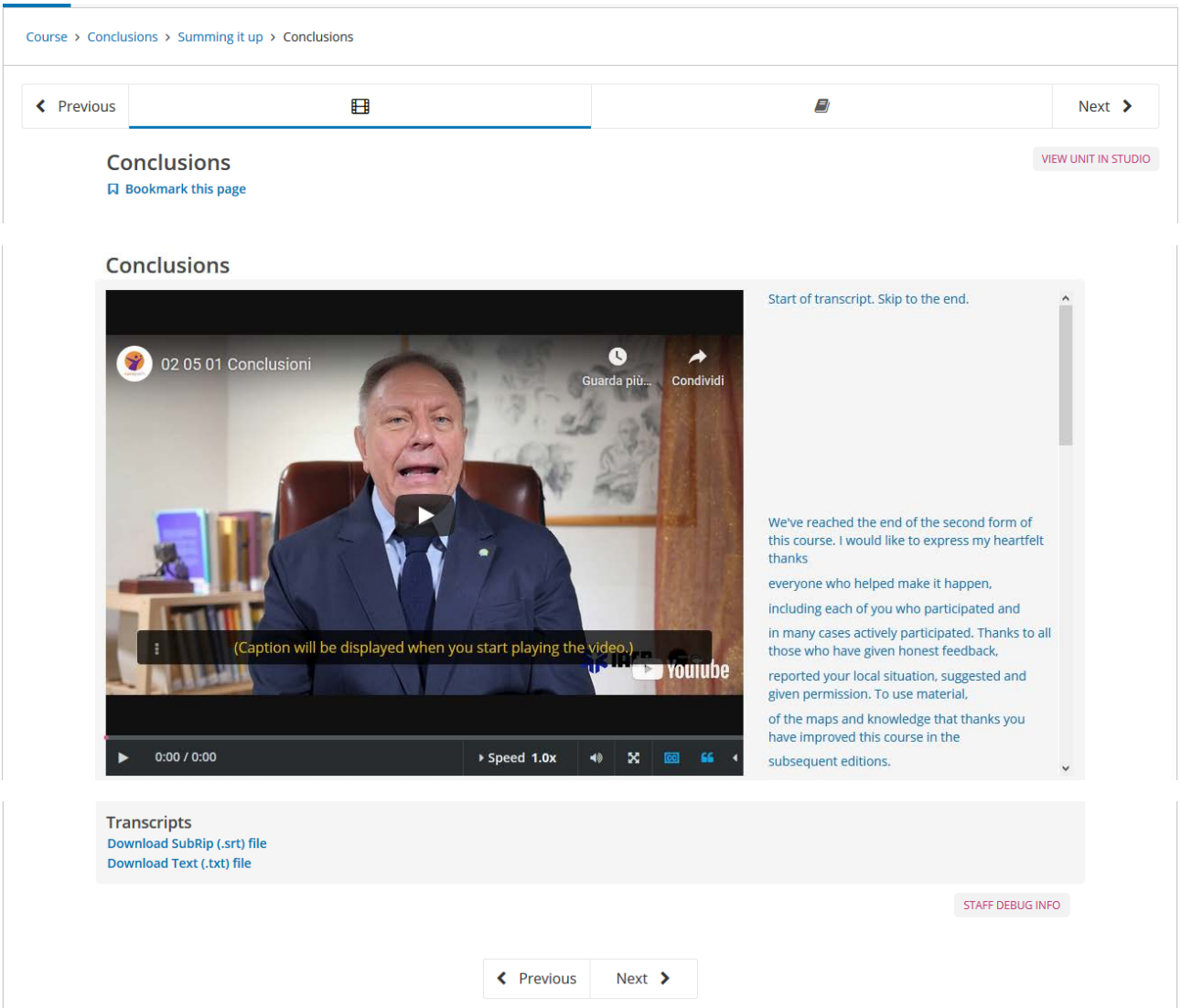
especially for social health and rights the health rights of individuals.

In Italy, art. 33 of the Constitution, like so many other European constitutions, says

that health is a right of every citizen, so we must protect and promote

Everyone's health: and this is a healthy imperative.





Transcript

We've reached the end of the second form of this course. I would like to express my heartfelt thanks

everyone who helped make it happen,

including each of you who participated and

in many cases actively participated. Thanks to all those who have given honest feedback,

reported your local situation, suggested and given permission. To use material,

of the maps and knowledge that thanks you have improved this course in the

subsequent editions.

A sincere thank you to the team that has worked

truly with great generosity and commitment to realize this work in which they believed,

in the aims and objectives.

Thanks to all colleagues outside the institute

who have agreed to work for free e

make your own image, your own contribution
and also your own material to be shared free of charge and disseminated through
the portal to this course.
Thanks to all the IACP staff who generously
has contributed as much with all their heart and their mind to share their
experiences in this difficult field of treatment of traumatized minors.
Thanks also to all the organizations who have collaborated with us and finally a
thanks to all Care project partners Path that have assisted us in every way and
even with their sympathy and affability.
Last thanks, icing on the cake,
is to the project manager and all colleagues of the University of Turin, Luca Rollè
is really is one of the best project managers that we have encountered in the various European projects
that we participated in;
also to his colleagues of the University of Turin, Faculty of
Psychology, they're wonderful and they've made
everything and more to facilitate our task.
So thank you, thank you all and good work. and good continuation with the other modules.

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This section is a prerequisite. You must complete this section in order to unlock additional content.

Quiz 1

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Quiz 1

15 points possible (graded)

1. What is a helping relationship?

- ○ An affective relationship based on the aid of one partner to another
- ○ A relationship established between a professional and a service user
- ○ A relationship that meets the needs of the professional and the service user
- ○ A doctor-patient relationship

2. The general systems theory was formulated by:

- ○ Wertheimer
- ○ Maslow
- ○ Rogers
- ○ Von Bertalanffy

3. What is the WHO?

- ○ World Science Organization
- ○ Social Medical Organization
- ○ World Health Organisation

4. The Person-centred Approach was founded by

- ○ C. Rogers
- ○ O. Rank
- ○ J. Bowlby
- ○ A. Maslow

5. Which of these conditions necessary for the establishment of an aid relationship was not theorized by C. Rogers?

- ○ Empathy
- ○ Unconditional positive acceptance
- ○ Resilience
- ○ Congruence

6. Working Alliance

- ○ It concerns the contractual arrangements between the worker and the employer.
- ○ does not concern the individual but only of the group
- ○ It is desirable form of collaboration in a helping relationship
- ○ This is the set of rules laid down by the professional and which the service user must comply with

7. Lack of empathy in the helping relationship

- ○ it is a professional quality
- ○ serves to better understand what the user is saying
- ○ is a recommended action to prevent burnout
- ○ it prevents a helping relationship from being effective

8. What is a complex post-traumatic stress disorder?

- ○ is an alternative term for post-traumatic stress disorder
- ○ is a disorder derived from chronically traumatic experiences
- ○ is a statement used when the symptoms of post-traumatic stress disorder persist for more than 6 months
- ○ it is a disturbance caused by a group trauma

9. Which of the following characteristics are not desirable in a "Trauma Informed Care" care system?

- ○ Valuing the patient in all aspects of care
- ○ Adopt neutral and supportive language
- ○ Make a correct screening on what experience can be defined as traumatic
- ○ Training staff on trauma and its effects

10. What is the most common etiopathogenic factor in the development of psychological trauma?

- ○ Repeated experience of physical and psychological neglect by caregivers
- ○ first-hand experience of natural disasters
- ○ First person experience of sudden death
- ○ Experience of child sexual abuse

11. Informed trauma care means:

- ○ A set of techniques that accompany the EMDR facilitates traumatic reworking
- ○ A type of psychotherapy
- ○ A systemic approach to the management and care of people with traumatic experiences
- ○ A specific hospital ward for people with traumatic experiences

12. Assisted violence is defined as:

- ○ Trauma from attending catastrophic events
- ○ Situation in which a minor assists, directly or indirectly, or perceives the effects of acts of violence committed on figures of reference affectively significant for him or her.
- ○ Type of violence inflicted by one parent to the other parent with the psychological and/or material support (obtained through psychological manipulation) of the child
- ○ The trauma derived from witnessing phenomena of general violence

13. What are the recommended intervention actions in case of witnessing violence?

- ○ Detection, Protection, Evaluation, Treatment
- ○ Observation, Evaluation, Treatment, Family Mediation
- ○ Detection, family accommodation, treatment, family mediation, family relocation
- ○ Removal from the family nucleus, Family mediation, family relocation

14. According to the WHO report published in 2013 on the prevention of child abuse in Europe, how many children under the age of 15 die from child abuse?

- ○ Between 800 and 900
- ○ Between 500 and 600
- ○ Between 900 and 1000
- ○ Between 400 and 500

15. The PTSD complex differs from the PTSD in that it:

- ○ the PTSD complex is typical of childhood
- ○ the PTSD complex is present in cases of violence within a relationship of trust
- ○ the PTSD complex is present if next to psychological symptoms there are motor symptoms
- ○ the c PTSD omplex is present exclusively in women and minors

Invia

Show Answer

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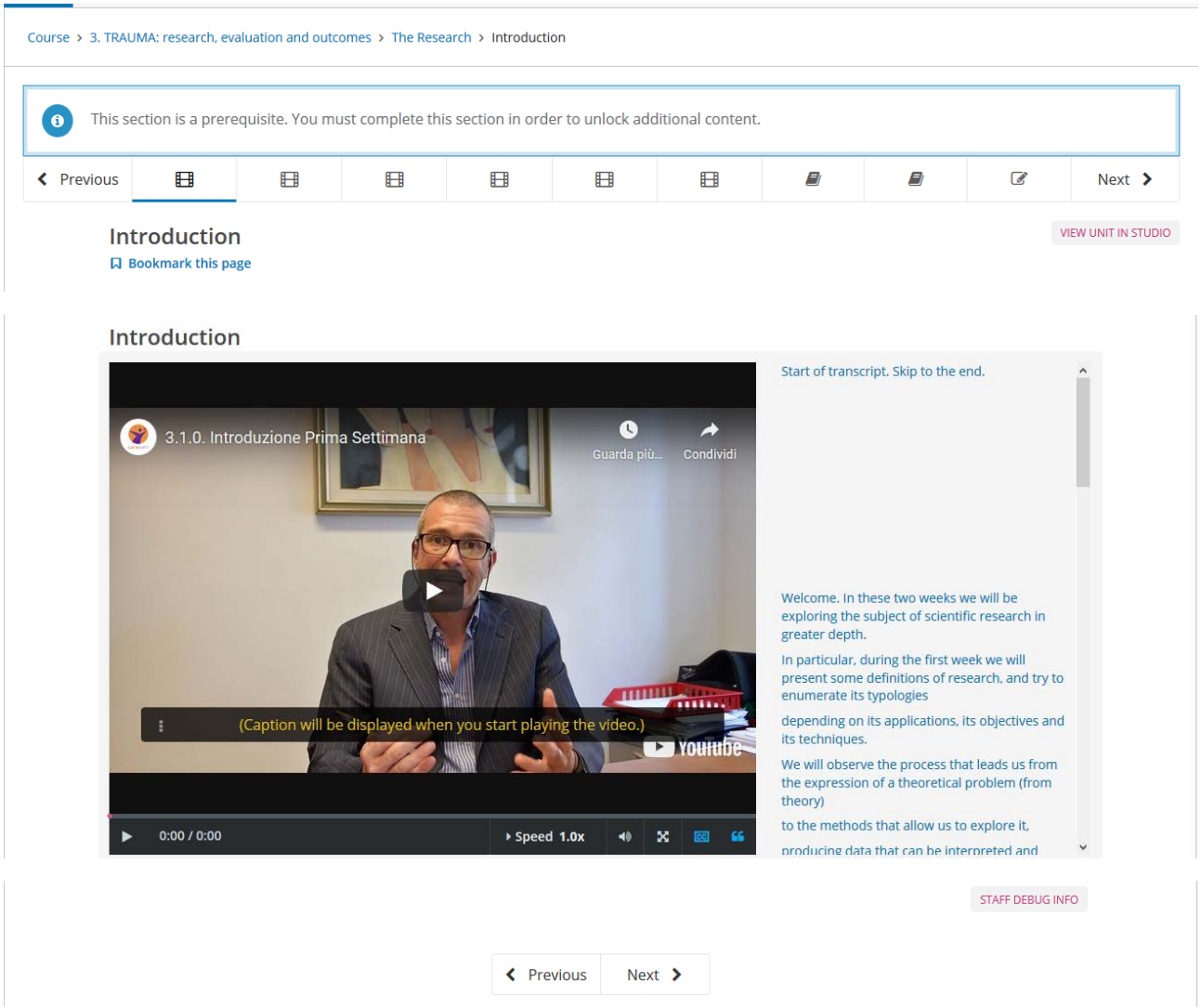


Transcript

Welcome. In these two weeks we will be exploring the subject of scientific research in greater depth.

In particular, during the first week we will present some definitions of research, and try to enumerate its typologies

depending on its applications, its objectives and its techniques.

We will observe the process that leads us from the expression of a theoretical problem (from theory)

to the methods that allow us to explore it,

producing data that can be interpreted and used. We will then integrate and examine in depth

the fundamental principles, limits and benefits of Action-Research, as a starting point

and my colleagues will explain the meaning of Action-Research,

to then get to explaining Evidence-Based Research.

After that, we will delve into advantages and challenges of the integration of

Evidence-Based Research in

Trauma-Informed Care. In particular, the international relevance of the topic provides us with a transversal perspective

on the critical points and strengths of

transforming research into clinical practice. Here we will analyze

the main and related elements of good practices in scientific literature,

some of which are informative. We will ask ourselves,

and we will try to understand the meaning of training needs,

and how these can in some ways be supported, taken into account, by the organization.

We must not forget that a Trauma-Informed Care approach certainly has an aspect,

an impact, that is fundamental in both the organization

and in the individual members of the organization. From here, we will take advantage of this space to go and discuss

scientific dissemination in the development and implementation of specific interventions

in Trauma-Informed Care. Arriving towards the end of our journey this week,

we will go into the evaluative aspects in organizations

that develop or attempt to develop Trauma-Informed procedures or processes.

In fact, they can offer their employees,

their collaborators, their volunteers, training and information on Trauma-Informed Care,

as well as offering possibly effective interventions related to

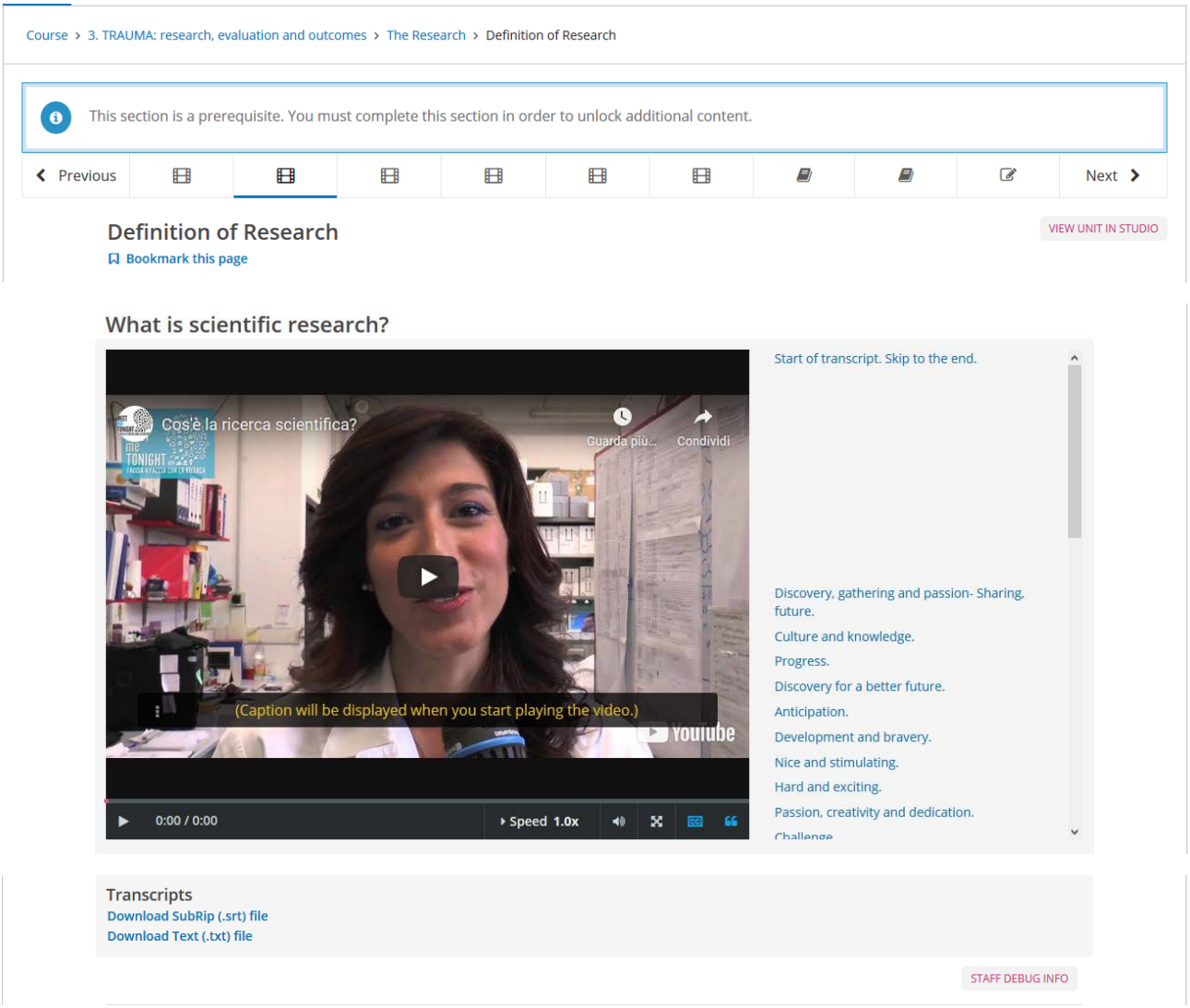
research evidence in psychotherapy, or rather in Evidence-Based therapy.

From here we will accompany each other and move on to the second week,

that will allow us to examine further issues related to research.

I wish all of you a pleasant course week and a good lesson,

on my behalf and on behalf of all my colleagues.



Transcript

Discovery, gathering and passion- Sharing, future.

Culture and knowledge.

Progress.

Discovery for a better future.

Anticipation.

Development and bravery.

Nice and stimulating.

Hard and exciting.

Passion, creativity and dedication.

Challenge.

Development.

Future. Innovation, perseverance.

Sacrifice, but a lot of satisfaction.

Opportunity.

Progress.

Comprehension.

Hard work, freedom and study.

Ambition.

Evolution.

Effort.

But also, fun.

Curiosity, innovation, prosperity.

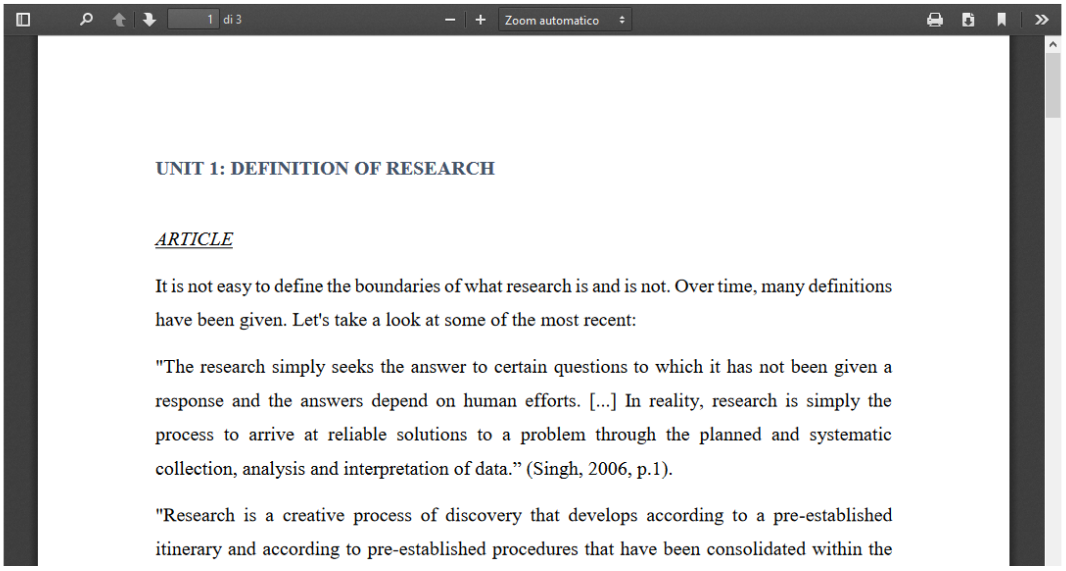
Research is human nature, a man who does not do

research is a man who does not solve problems, he is a man who does not exist.

Research is curiosity, it is desire to know reality, and most of all,

for those who have done it, it is the priceless joy of discovery.

Reading Material



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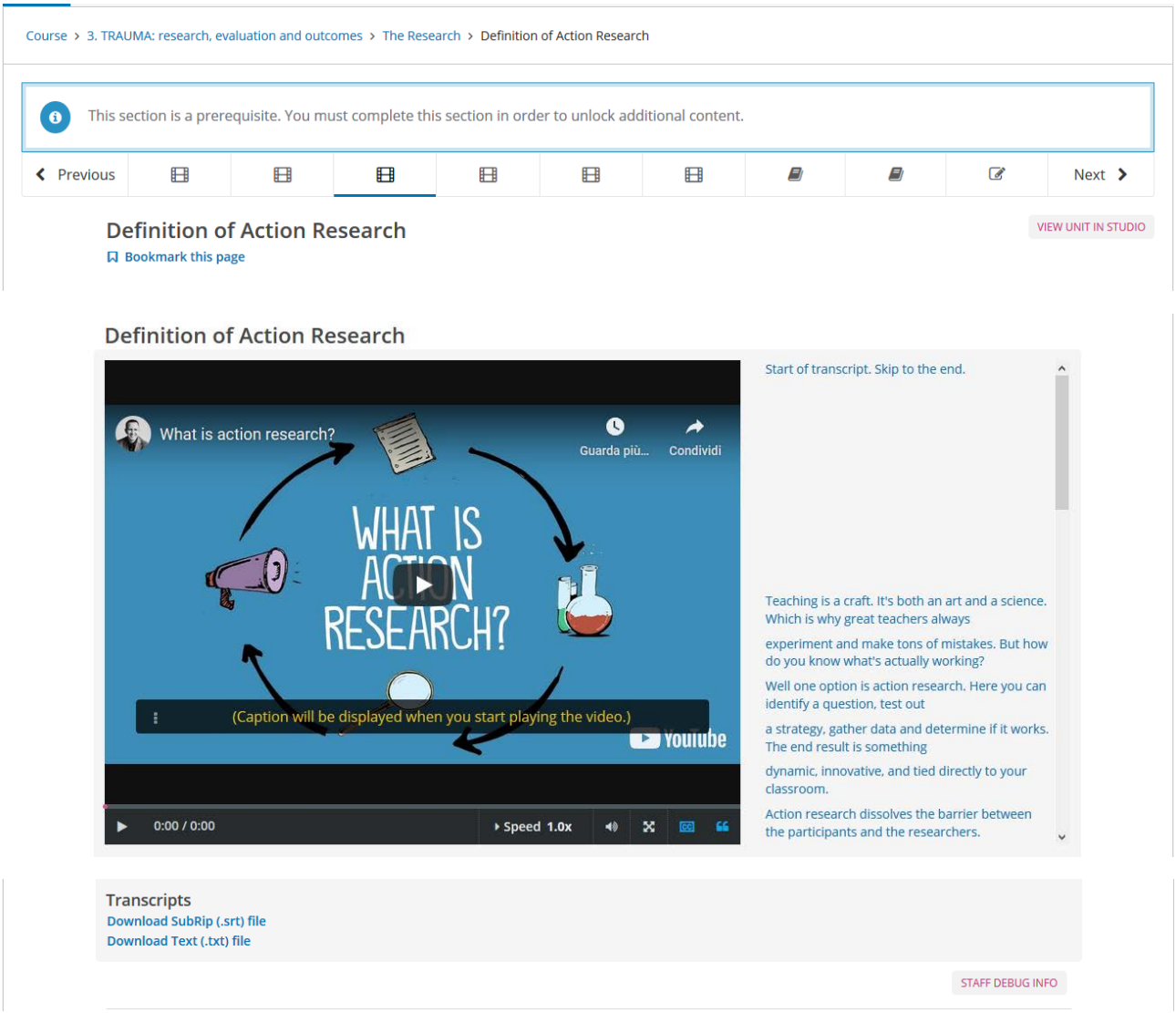


Transcript

Teaching is a craft. It's both an art and a science. Which is why great teachers always

experiment and make tons of mistakes. But how do you know what's actually working?

Well one option is action research. Here you can identify a question, test out

a strategy, gather data and determine if it works. The end result is something

dynamic, innovative, and tied directly to your classroom.

Action research dissolves the barrier between the participants and the researchers.

In other words, the teacher actively participates in the situation while also conducting the

research. There are many action research frameworks

but they generally follow a similar process. You start out in Phase 1, planning for research.

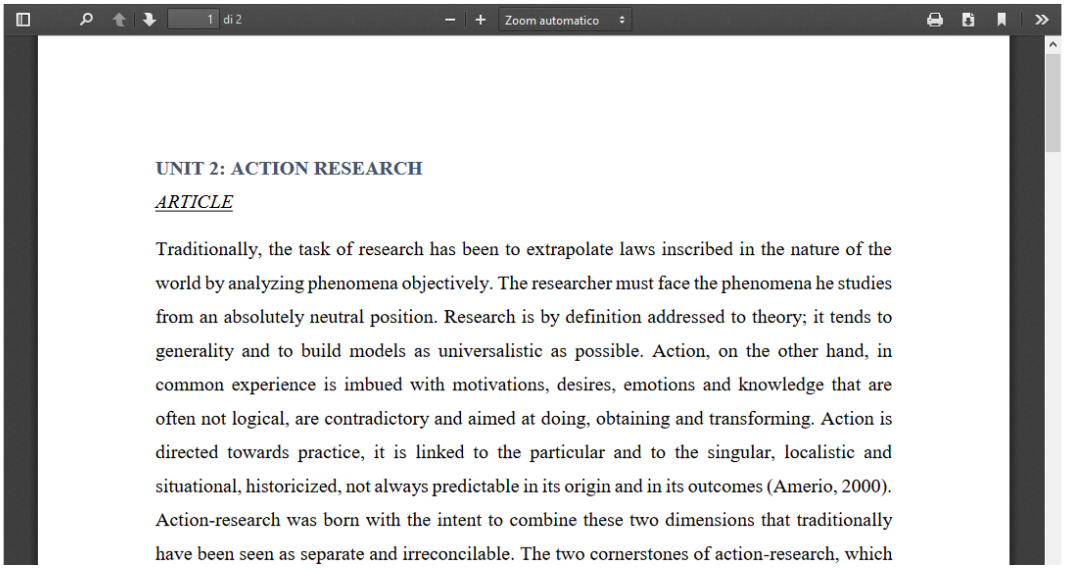
Here you begin with inquiry, where you define a specific research question.

It needs to be something that can actually be tested.

Next, you conduct a literature review to gain a deeper understanding of the topic.

Finally, you move into the design process where you determine your data methods, consider ethical issues, get the required permissions, create deadlines, and set up the systems.
Next you move into the action phase. This is where you engage in multiple cycles of experimentation and data collection. Your data collection might include qualitative data like observations, artifacts, and interviews or quantitative data like rubric scores surveys, or achievement data. After where you move to analysis. You'll often start by organizing the data with charts or graphs and looking for specific trends.
You might also discuss it with peers, free write in a journal, or create a cluster map before eventually writing out your results. Finally you have your conclusion.
This is where you share your research with the world and reflect on your own practice.
This will ultimately lead to newer questions and the cycle will continue as you refine your craft as a better, more creative teacher.

Reading material



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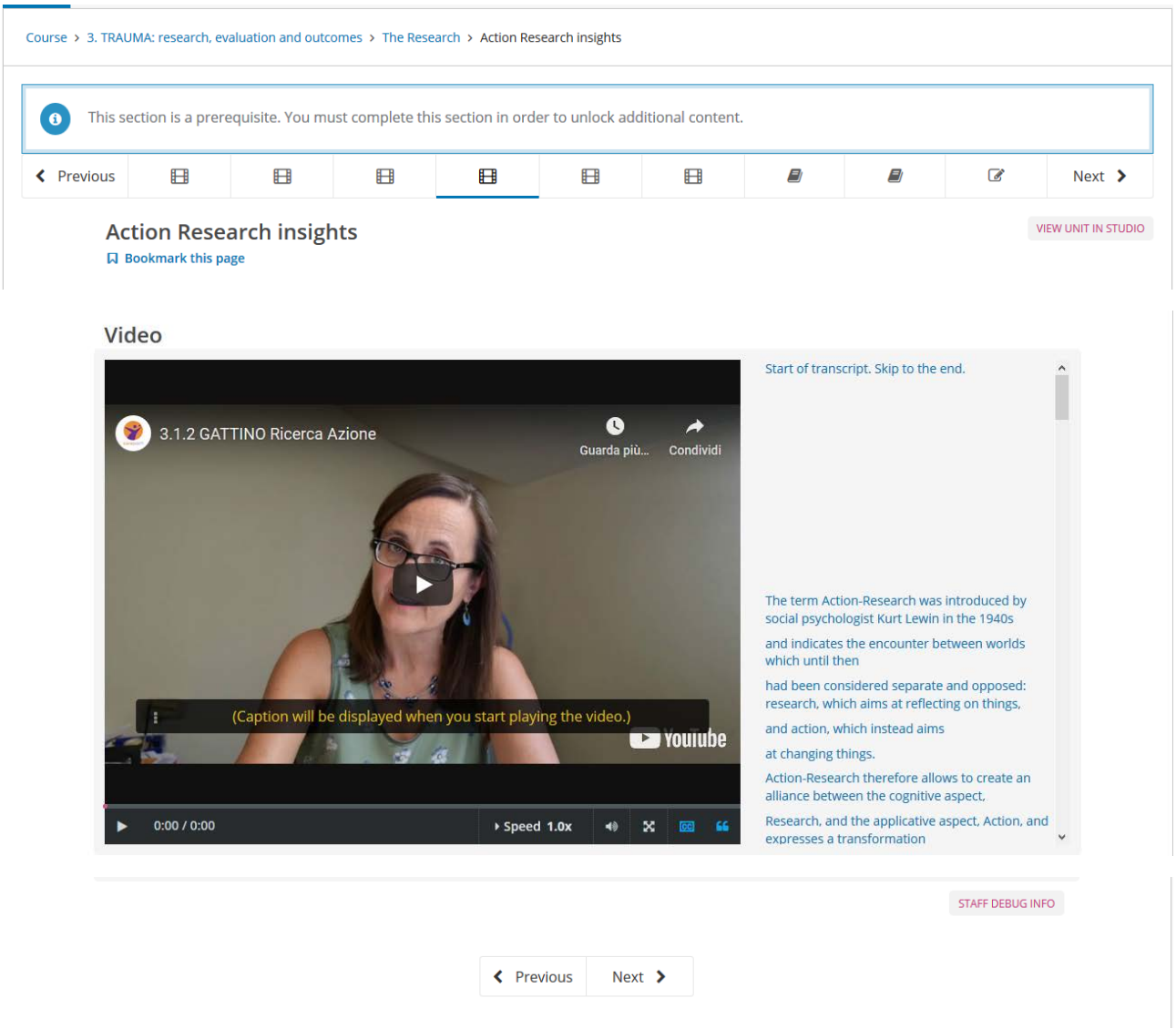

Transcript

The term Action-Research was introduced by social psychologist Kurt Lewin in the 1940s
and indicates the encounter between worlds which until then
had been considered separate and opposed: research, which aims at reflecting on things,
and action, which instead aims
at changing things.
Action-Research therefore allows to create an alliance between the cognitive aspect,
Research, and the applicative aspect, Action, and expresses a transformation
in the way of conceiving, planning and doing research in Human Sciences, in which the complexity
of the studied phenomena is not simplified but, on the contrary, accepted and taken in account.
Action-Research is always carried out by Lewin in a group setting
as the group is that psycho-social place
within which people build their actions and is also a tool that can facilitate

processes of change.

Action-Research can be described as a family of research methodologies whose objective,

as we have said, is to simultaneously activate a path of action

(in other words, of change) and of research (in other words, of understanding phenomena).

This path takes place through a flexible process that consists of a spiral of cycles,

each of which is structured into three consecutive stages: planning, execution

and reconnaissance/inquiry; the latter stage is aimed at assessing the results of each phase,

to prepare a rational basis for the next phase and to change, if necessary,

the original plan of action.

What happens after the first cycle of Action-Research?

Once the results have been analysed (and the potential change that has been produced

in relation to the initial situation has also been analysed), a new cycle of the process begins,

in which the new elements that emerged from the activity

carried out in the previous cycle are inserted; these cycles are repeated until the problematic situation is exhausted.

Planning, execution and inquiry are supported by a critical assessment

in which participants ask themselves what worked, what did not work, what was learned,

and what can be done differently.

The critical evaluation of each cycle allows action-researchers to correct any errors

and to re-adjust the actions to the actual needs that emerged in the course of the research itself.

What is the goal of Action-Research?

The objective of Action-Research is to generate change:

change in behaviour, habits,

contexts and so on.

The basic assumption is that the status quo does not enable the well-being

of individuals and that only through change can the situation improve.

Change, therefore, must be provoked, then analysed and understood,

and it must be lasting.

According to Lewin, for change to be lasting, it must go through three phases:

the ‘unfreezing phase’, which is obtained by acting on the factors of resistance to change

which are often linked to adherence to social norms;

the ‘moving phase’, for example changing and developing new beliefs,

values and attitudes on the basis of new information,and shifting
from an old situation to a new one;
then, there is the ‘reconstruction phase’ or ‘refreezing’, in which the new situation that has been created
stabilizes around a new balance, that is, the new values, attutudes,
and behaviours which are established and integrated into the rest of the system.
An important aspect of Action-Research is the active involvement
of the recipient, who in actual fact is both the recipient and actor
of the intervention and must be put in a position to share the aims of the research itself.
The basic assumption of Action-Research is that the people with whom we work are active individuals,
with skills and competences that must be involved in the research process.
When adopting the Action-Research approach, one cannot ignore the active involvement of the people
to whom the intervention is addressed, and one must create a situation of collaboration
and confrontation with the recipient-actors of the intervention.
Another characteristic element of this family of research methodologies
that is Action-Research is the absence of a predefined intervention method to be applied.
In fact, this method is constructed together with the group starting from some crucial principles
and on the basis of the responses observed during the course of the work.
It often happens that the initial model is modified, since the choice of methodology
and actions to be implemented are built during the process.
So far, we have illustrated the aspects that define Action-Research.
Let's now check the elements that differentiate it from the experimental method.
We have said before that in the Action-Research there is no fixed intervention.
Those who adopt this approach therefore allow the hypothesis to emerge during the process
and change its course through continuous monitoring.
Another element of difference is that, in Action-Research, we do not try to define causal relationships,
verify hypotheses from the literature or determine the results of treatments on representative samples
with the aim of confirming or falsifying
general theories.
In Action-Research, throughout each cycle, the phenomenon on which we are intervening comes more
into focus.
We do not care about the measurability of variables and the objective is to solve problems
by examining different paths that cannot be anticipated a priori, but that become the result and also

a tool of the group.

Finally, a further element of differentiation is the way in which the final results are presented;

in the case of Action-Research, they are illustrated to the entire group

or the entire community in participatory ways, using simplified,

accessible language rather than the technical-scientific jargon which characterizes experimental research reports.

The objective to be achieved through the presentation of data is to generate new evaluations

that allow the definition of possible opportunities for improvement.

Lastly, on the basis of what has been said so far, we can summarize the main assumptions underlying Action-Research:

The fact that it is practical and contextual.

Action-Research takes on as its target the problems of a group or a community;

therefore, it is contextual in its natures, or in other words, it is localized research which takes place within a context;

it is aimed at change and focuses on the group dimension

rather than on the individual, both when it comes to analysing

processes and defining of solutions and results that have emerged;

Moreover, Action-Research features multiple stages

and a cyclical nature which is given by the design of the research, which is configured as an alternation of phases

of knowledge and action; it places participation at the centre,

in terms of cooperation and interdependence

between researchers and the group, or researchers and the community.

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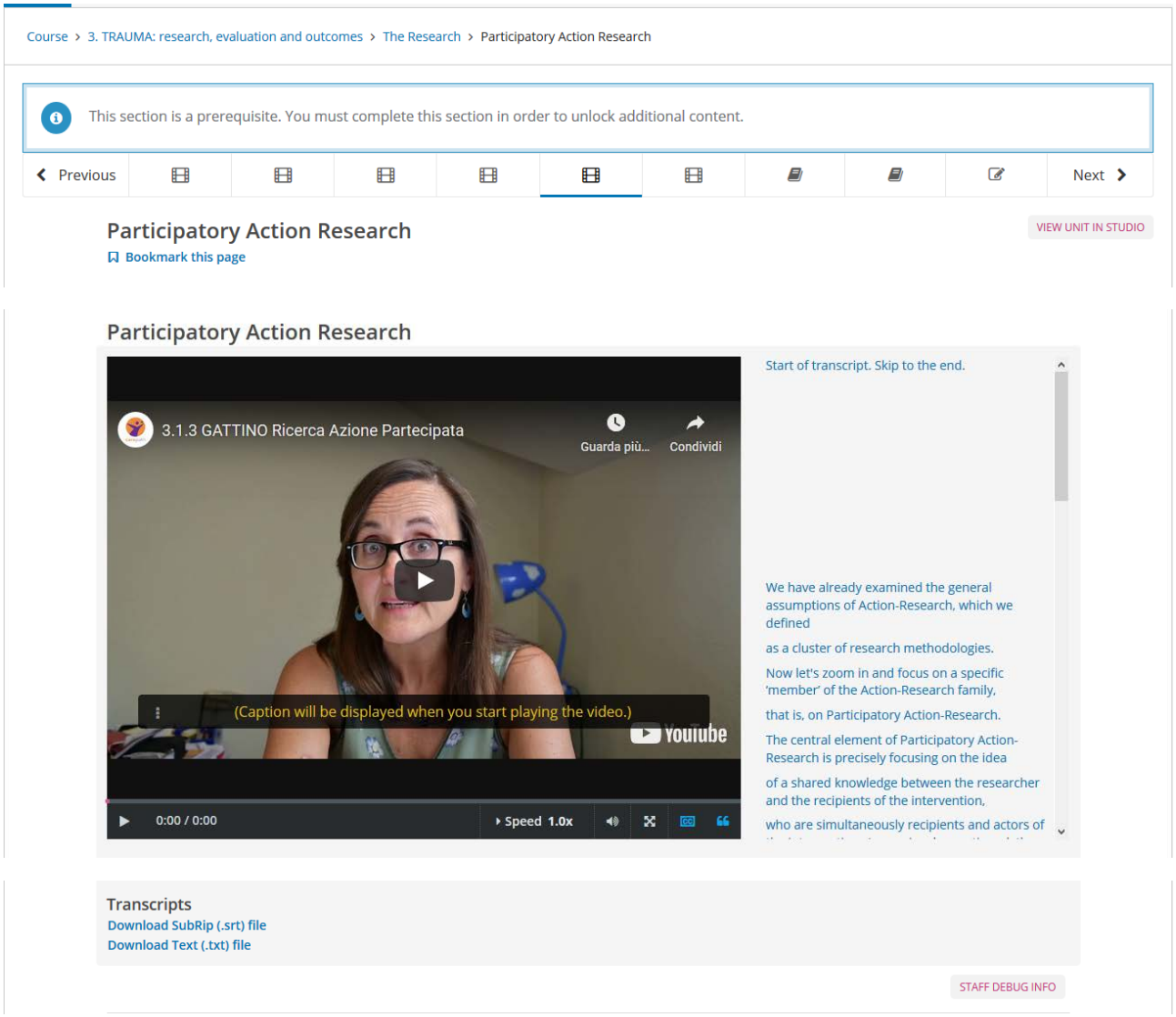


Transcript

We have already examined the general assumptions of Action-Research, which we defined

as a cluster of research methodologies.

Now let's zoom in and focus on a specific 'member' of the Action-Research family,

that is, on Participatory Action-Research.

The central element of Participatory Action-Research is precisely focusing on the idea

of a shared knowledge between the researcher and the recipients of the intervention,

who are simultaneously recipients and actors of the intervention. As previously mentioned, the focus of Participatory Action-Research

is to consider that there is a shared knowledge aimed to design and restore

the meaning of collective action.

Participatory Action-Research deems it important to design and conduct Action-Research

in a collective way through the participation of technical experts but also of people who belong to the context in which it intervenes,

and who are able to take advantage of local knowledge and expert knowledge by bringing out

the multiple points of view and perspectives that are present

within that specific context.

At the basis of Participatory Action-Research interventions there is the principle of participation,

intended as a tool and also as an objective of the social change of intervention.

Participatory Action-Research recognizes that a problem arises from a group that is in difficulty

in a specific context and at a precise and well-defined historical moment.

The researcher therefore notes the problem, he/she does not generate it, and his/her role is to help the group and the community

to identify the key aspects in order to be able

to continue with action.

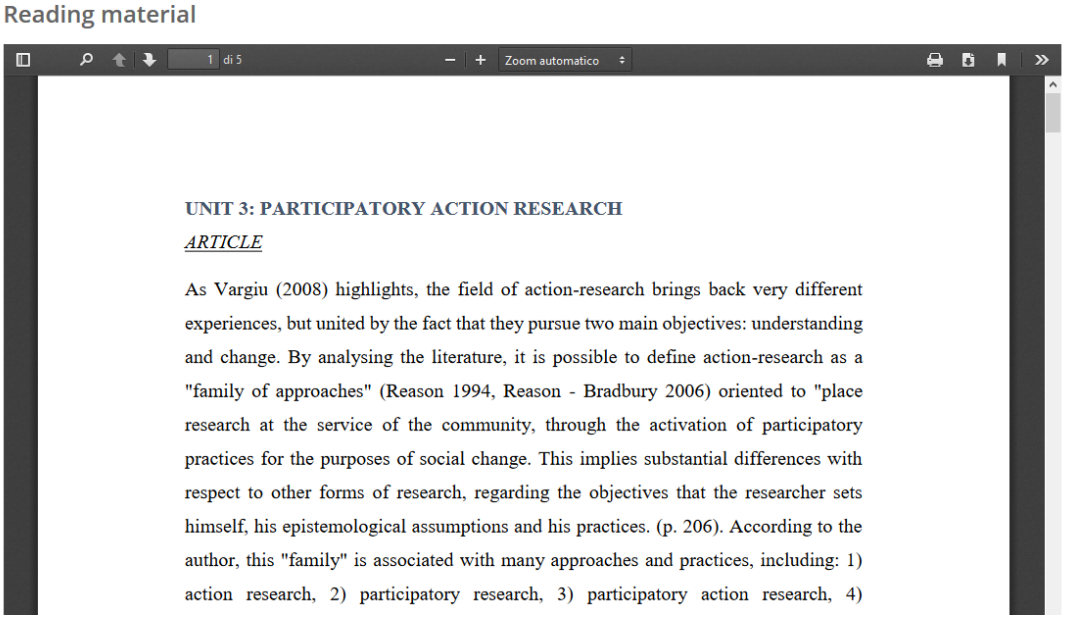
Those who adopt the Participatory Action-Research approach must therefore create a situation of collaboration and discussion with citizens

and operators regarding the definition of the problems

to be investigated, the conduct of research, and the

preparation of change.

Reading material



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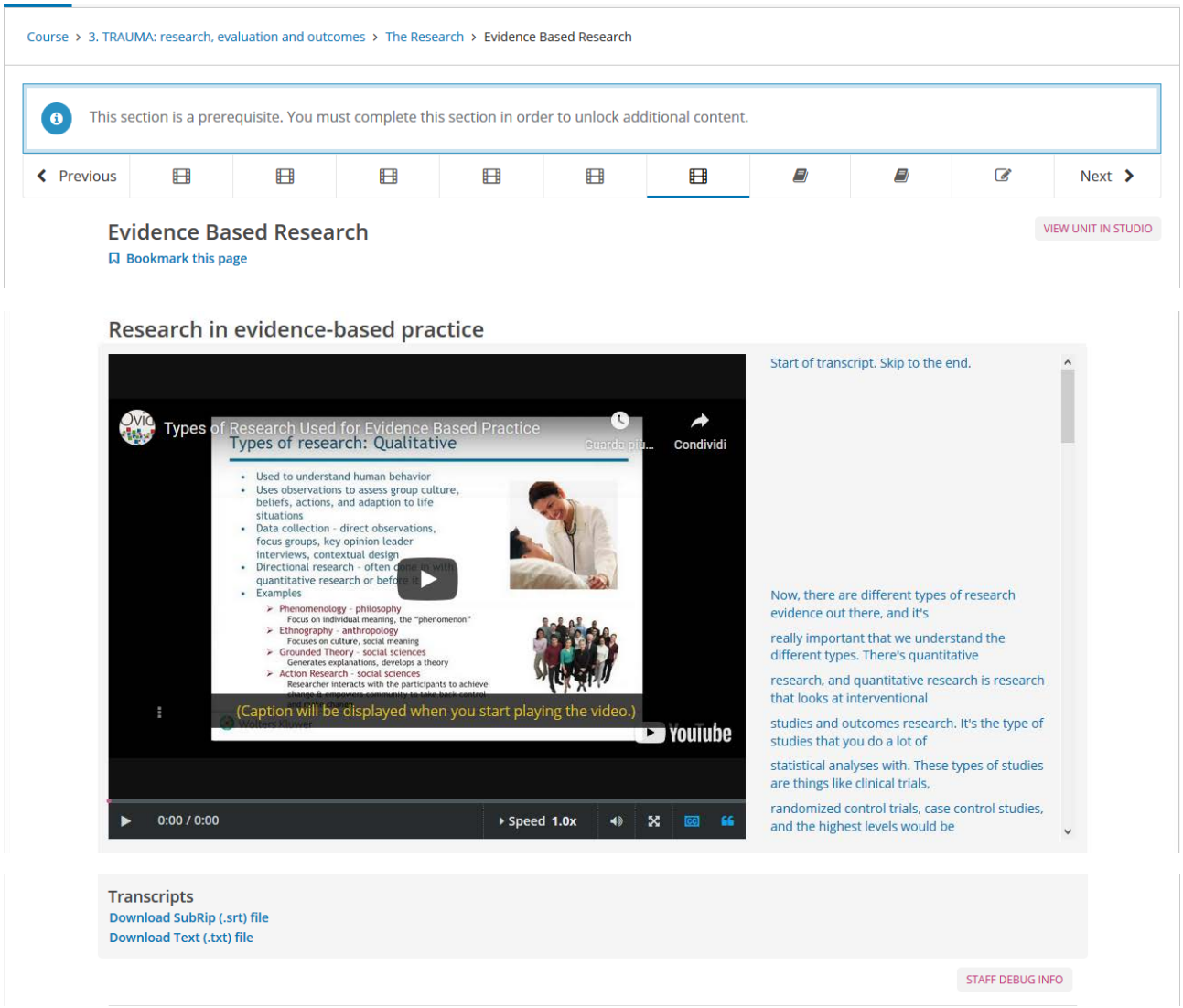


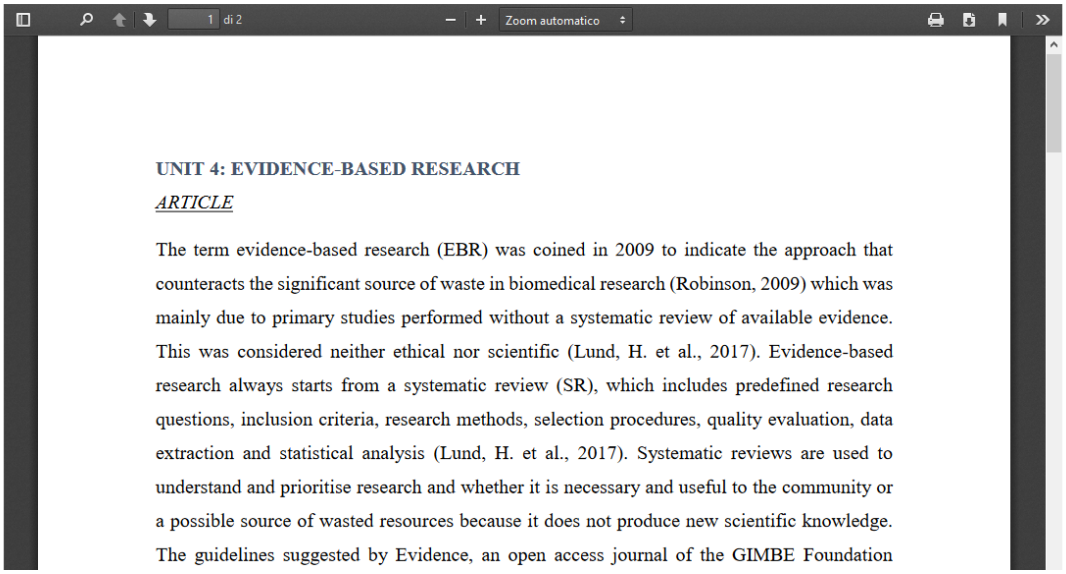
Transcript

Now, there are different types of research evidence out there, and it's really important that we understand the different types. There's quantitative research, and quantitative research is research that looks at interventional studies and outcomes research. It's the type of studies that you do a lot of statistical analyses with. These types of studies are things like clinical trials, randomized control trials, case control studies, and the highest levels would be meta-analyses and systematic reviews. Clinical practice guidelines for the most part are based off of quantitative research analysis. There's another type of research out there and it's called qualitative research, and qualitative research is really done to understand the human behavior, how people are responding to their situation. So the types of qualitative research you see done, and it's very often done in nursing and Social Sciences, are studies like

phenomenology, where you look at the phenomenon of being sick or having a certain condition. It also means looking at ethnographic groups, this is based out of anthropology, so we look at groups of people who have a certain condition. We know that qualitative research is very very important to how we deliver care today, because you need to make sure that your patients are having a good experience with the care they're receiving. Now, the highest level of research is considered secondary research and this is the thing that we call a systematic review or meta-analysis, and what is different about a systematic review and in meta-analyses is that it brings the same level of rigor to the review of all the research studies that have been done on a specific topic. It brings the same level of rigor to the analysis of all those studies. Here's another caveat: systematic reviews are very different than literature reviews because systematic reviews and meta-analyses actually have to be peer reviewed so that means two or more people have to be appraising all the studies that are included in a systematic review or a meta-analysis. When you do a systematic review you also need to look at a few other things to make sure that, it's important to how we provide care to our patients. You need to look at: is it really feasible the results of the systematic review? Can I really implement this with a specific patient population? Is it going to be appropriate? Is it meaningful to patient populations and to my practice as a health care provider? And is it going to be effective? Is it really going to make a difference? We do know though that research evidence is not created equal, so it's really important when healthcare providers take a look at the research that they get from a search, they need to determine what level of research they're looking at. At the base we have all the original research studies and these are the things like the randomized control studies and those type of things. The next level up would be the systematic reviews in the meta analyses: again, the systematic review meta analyses is done by a researcher looking at all the original research around a certain topic, doing a critical appraisal of it and a synthesis of it and then putting it together as a systematic review, so that's considered the higher level of research in the hierarchy of evidence. But at the very top is our clinical

decision support, and clinical decision support are tools that healthcare providers can use they read immediately and they go put into practice immediately. Now, why is this important? Because health care providers at the bedside do not have time to read a hundred, two-hundred, three-hundred-page systematic reviews or meta-analyses and then go make a decision about a patient: they have to read the evidence and put it into practice immediately and that's what clinical decision support tools do. All clinical decision support tools should be based on systematic reviews, meta analyses, evidence summaries or the best available evidence.

Evidence-based research



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Examples of research

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The following is an example of a survey method by Bean & Creswell (1980, p 321-322):

"The site of this study was a small (enrollment 1.000), religious, coeducational, liberal arts college in a Midwestern city with a population of 175.000 people. The dropout rate the previous year was 25%. Dropout rates tend to be highest among freshmen and sophomores, so an attempt was made to reach as many freshmen and sophomores as possible by distribution of the questionnaire through classes. Research on attrition indicates that males and females drop out of college for different reasons (Bean, 1978; Spady 1971). Therefore, only women were analyzed in this study. During April 1979, 169 women returned questionnaires. A homogeneous sample of 135 women who were 25 years old or younger, unmarried, full-time U.S. citizens, and Caucasian was selected for this analysis. Of these women, 71 were freshmen, 55 were sophomores, and 9 were juniors. Of the students, 95% were between the ages of 18 and 21. This sample is biased toward higher-ability students as indicated by scores on the ACT test. Data were collected by means of a questionnaire containing 116 items. [...] The majority of these were Likert-like items based on a scale from "a very small extent" to "a very great extent" Other questions asked for factual information, such as Act scores, high school grades, and parents' educational level. All information used in this analysis was derived from questionnaire data. This questionnaire ha benn developed and tested at three other institutions before its use at this college. [Authors discussed the instrument.] [...] Multiple regression and path analysis were used to analyze the data. [...]"

(Creswell, 2014, pp. 181-182)

The following is an example of a qualitative research (Cardano, Ortalda, pp. 242-243)

"The aim of the research was to study the initiation into smoking of pre-adolescents (Frohlich, Potvin, Chabot, Corin, 2002). After having reconstructed the prevalence of smoking among pre-adolescents in 32 territories of Quebec and having acquired relevant information on the constraints and "structural" resources that now hinder, now authorize the habit of smoking in this population - the presence of cigarette shops, the presence of public places where smoking is not allowed, the presence of subjects who monitor compliance with the rules governing the sale of cigarettes to adolescents and smoking in public places - the authors focus their attention on eight territories in which they lead focus groups. In each territory, the participants are recruited through the mediation of the teachers of the local school, thus putting them in charge of groups of boys and girls who - in all probability - knew each other and frequented each other before the focus group. In this study, the mutual knowledge of participants becomes a resource and not a limit, offering researchers the opportunity to access speeches that, perhaps less "domesticated", took shape in the context of the participants' lives. The latter, moreover, strengthened by mutual support, were able to deal with a topic - the habit of smoking - which was difficult to discuss in front of an adult interlocutor with greater serenity. Knowledge of the ethnographic context, of the linguistic codes of social practices widespread in the territories where the focus groups were anchored is what allowed the authors to face the difficulties commonly associated with the realization of a focus group with a natural group: the call to shared experiences not fully explained in the speech, the use of slang expressions, the use of index expressions."

(Cardano, Ortalda, pp. 242-243)

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Knowledge Check

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Quiz 3.1

4 points possible (graded)

1. A scientific research...

- ○ Should always take into account previously acquired knowledge
- ○ Starts with data collection
- ○ Always allows a faithful recording of reality
- ○ Always uses a single method

2. In Action-Research...

- ○ The researcher should be completely neutral towards the object of research
- ○ The participation and cooperation of researchers are encouraged
- ○ An attempt is made to extrapolate laws inscribed in nature through objective analysis of the phenomena
- ○ No social changes should be produced in the research context

3. Which of these steps is NOT part of every evidence-based research project?

- ○ Evaluation of the results
- ○ Validation of theory through practice
- ○ Formulation of research hypotheses
- ○ The systematic review of the literature

4. The central element of Participatory Action-Research is:

- ○ The focus on the idea of a knowledge not shared between the researcher and the beneficiary of the intervention
- ○ The clear and absolute separation between Action and Research
- ○ The a priori choice of the problems to be investigated and the tools to be used
- ○ The focus on the idea of a shared knowledge between the researcher and the beneficiary of the intervention

Invia

Show Answer

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Evidence Based Research in TIC/TIP: International Perspective

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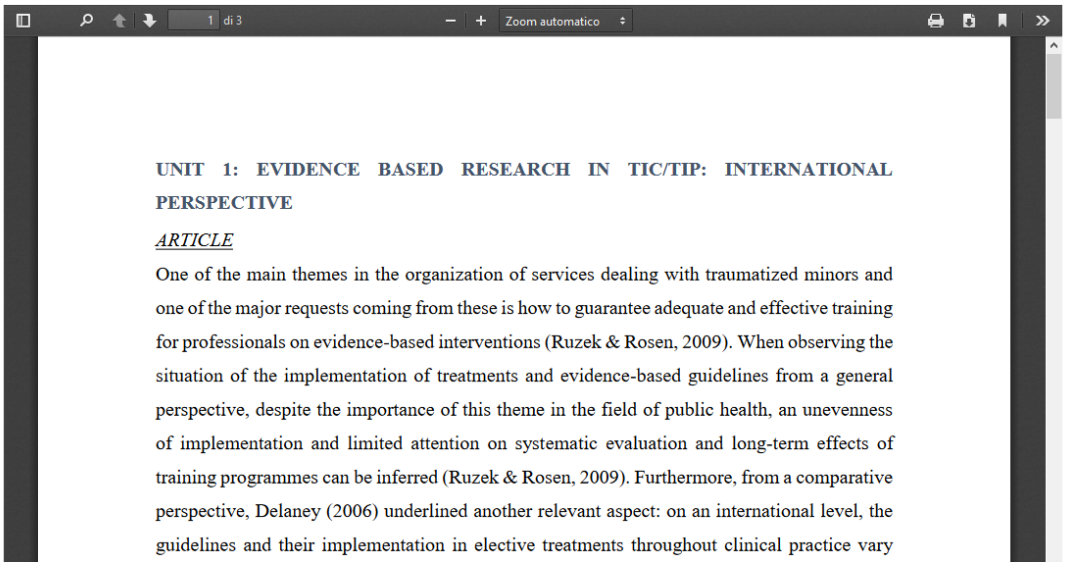
Reading Material



UNIT 1: EVIDENCE BASED RESEARCH IN TIC/TIP: INTERNATIONAL PERSPECTIVE

ARTICLE

One of the main themes in the organization of services dealing with traumatized minors and one of the major requests coming from these is how to guarantee adequate and effective training for professionals on evidence-based interventions (Ruzek & Rosen, 2009). When observing the situation of the implementation of treatments and evidence-based guidelines from a general perspective, despite the importance of this theme in the field of public health, an unevenness of implementation and limited attention on systematic evaluation and long-term effects of training programmes can be inferred (Ruzek & Rosen, 2009). Furthermore, from a comparative perspective, Delaney (2006) underlined another relevant aspect: on an international level, the guidelines and their implementation in elective treatments throughout clinical practice vary

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Training needs in organizations dealing with trauma

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Reading Material - ARTICLE

Bryson and colleagues (2017) lay an interesting premise that is useful for distinguishing two levels of reflection applicable to the analysis and evaluation of the themes of this module. The authors separate trauma-specific treatments (that is, intervention techniques aimed at the reduction of trauma-related symptoms) from TIC as a general perspective which aims at a transformation of the care system, including in TIC an understanding of trauma-related stress responses on every level and in all aspects of the organization of services. Despite widespread request for the application of TIC principles in services and despite the advantages that it might bring, scientific contributions on the implementation of TIC for underage clients is, unfortunately, limited (Bryson et al., 2017). Ruzek & Rosen, in 2009, already observed that the dissemination of evidence-based treatments focusing on PTSD-related symptoms was one of the key elements to which organizations supporting people affected by trauma were committed, and that, as a result, we witnessed an increase of scientific literature dealing with organizational factors linked to the implementation and dissemination of best practices. Despite this, in a previous analysis introduced by Delaney (2006), confirmed by Ruzek & Rosen (2009) and by Bryson and colleagues (2017) themselves, a high volatility of practice use rates emerged, such as restraint and isolation. Furthermore, as highlighted by Valenkamp and colleagues (2014) and also by Bryson and colleagues (2017), few studies tested the effectiveness of these interventions when compared to alternative methods of admission.

The volatility of intervention methods, according to Ruzek & Rosen (2009), would open up the necessity of proceeding to a comparative analysis of guidelines and international best practices in order to make them more based in the field of organizational change proposals and more evidence-based oriented on a policy level. Bryson & colleagues (2017) attempt, through a systematic review of scientific literature, to highlight what factors make the application of TIC work, for what kind of user, in what circumstances, in what direction and why. The strategies considered most widely shared in scientific contributions are: 1) a change-oriented leadership; 2) the use of research data to inform practice; 3) staff development; 4) the use of tools that prevent restraint and isolation; 5) the role of users in the context of their stay; 6) debriefing techniques. In the face of the need to analyse the operational complexity of these elements while also linking them to the territorial and organizational peculiarities, the authors' invitation for services dealing with TIC application is to advance in the attempt of demonstrating, through the process of scientific research and in a longitudinal perspective, the effectiveness of both efforts and changes applied for the betterment of the safety of patients, as well as the long-term outcomes of treatments. Coherently with this perspective, Lang and colleagues (2016) underline how important it is to reach a consensus on what constitutes a trauma-informed service and how to effectively measure the factors involved. First of all, central issues are: how to reach an optimal screening procedure; how to best operationalize the founding principles of TIC in daily work with subjects exposed to potentially or certainly traumatic events and what the best methods may be to enhance services dealing with this population. Currently, there is little research dealing with the efficacy of changes in the admission of patients in a TIC-based organizational level and how/how much these changes are useful to the health outcomes for participating users.

A challenge underlined by the researchers could in fact be the integration of EBPs research and best practices, in order to enhance the quality of the implementation these services offer (while also considering the analysis of the scope of economic impact of these initiatives), through the development of staff competences, of screening procedures, of policy change capabilities. A critical role in this direction can be played by the leadership, who should support a process of change, sometimes radical, even on the level of organizational culture (emphasis, for example, on the importance of TIC). Training on trauma is an essential component, but it is not sufficient for an organization to be trauma-informed. Another important aspect, as specified by Kramer and colleagues (2013), is the collaboration between different agencies dealing with assistance for minors and their families, who should possibly share the principles of TIC. On this last aspect, the authors analyzed the efficacy of training oriented towards the acquisition of specific knowledge with longitudinal administering of adequate survey tools (before and after training) as well as a follow-up survey in order to analyze how much these acquired competences result in changes in the relevant service. On this specific aspect, an interesting theme is the analysis of barriers met by the whole staff and the structuring of comparative research (with randomized groups) meant to examine the usefulness of different strategies employed and further training needs, also longitudinally.

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Dissemination of trauma research in organizational settings

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Reading Material - ARTICLE

When talking about the theme of dissemination of research in organizational settings, Ruzek & Rosen (2009) underline its complexity: the models dealing with dissemination highlighted how it depends on multiple factors interacting with each other on different levels (individual and organizational). Briggs and colleagues (2012) show how it is recognized that a change in knowledge represents the first step towards organizational change, but the verification of how much this is shown through or translates into an actual behavioral change is just as fundamental. Two aspects seem important: the systemic and multilevel complexity of the dissemination of scientific content in organizations, and the process that connects knowledge and practice through a complex mechanism of individual and organizational change. This process brings to the fore one of the most frequent resistances to the implementation of new best practices: the fact that the choice of their application in the organization is often experienced as "top-down" and, therefore, is not very well endorsed by clinicians (Rohrbach et al., 2006; Ruzek & Rosen, 2009). Indeed, in this case, the commitment of operators in changing their organizational praxis is a nodal dimension. As suggested by the scholars' contributions, an arrangement in which the agreement about change is negotiated by the leadership with subordinates, while keeping local needs in mind, contributes to success in its implementation (Durlak & DuPre, 2008; Ruzek & Rosen, 2009). Another central theme is the fact that healthcare organizations often do not have specialized personnel on their staff dedicated to EBP research, to studying of best practices and strategies for their application, and, in particular, to analysising and systematising continuous integration of scientific research's results (Berwick, 2003; Ruzek & Rosen, 2009).

With regard to this, Marvin & Volino Robinson (2018) highlight the need for organizations to have a vision that contemplates the analysis of the institution or service itself regarding the skill or the readiness in accomodating and sustaining interventions of change (literature calls it "organizational readiness", and it can be measured on an organizational, group or individual level). Dealing with this dimension in the planning phase is definitely relevant to sustaining the application of new practices, to analyzing the possible barriers in the process and sustaining the beliefs and positive attitudes towards organizational change. An across-the-board consideration for this theme is the centrality that should be assigned to the recommendation of building targeted strategies for change in a specific organization (Augustsson et al., 2017; Marvin & Volino Robinson, 2018). Research demonstrates the importance of leadership and of managerial vision in co-constructing the way of change in sync with professionals and in sharing a culture oriented towards the application of TIC, that is devoted, first of all, to the analysis of staff needs.

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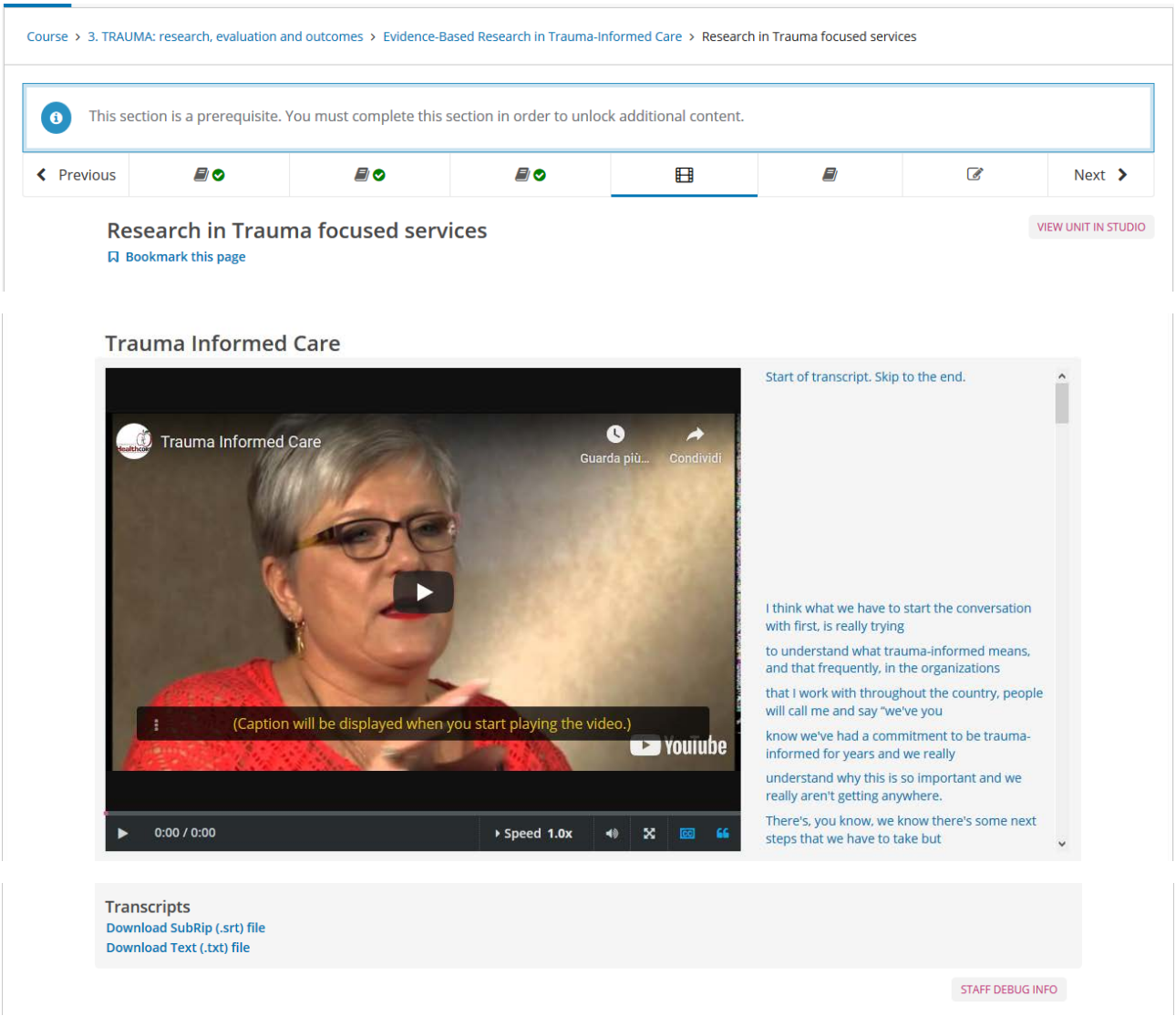


Transcript

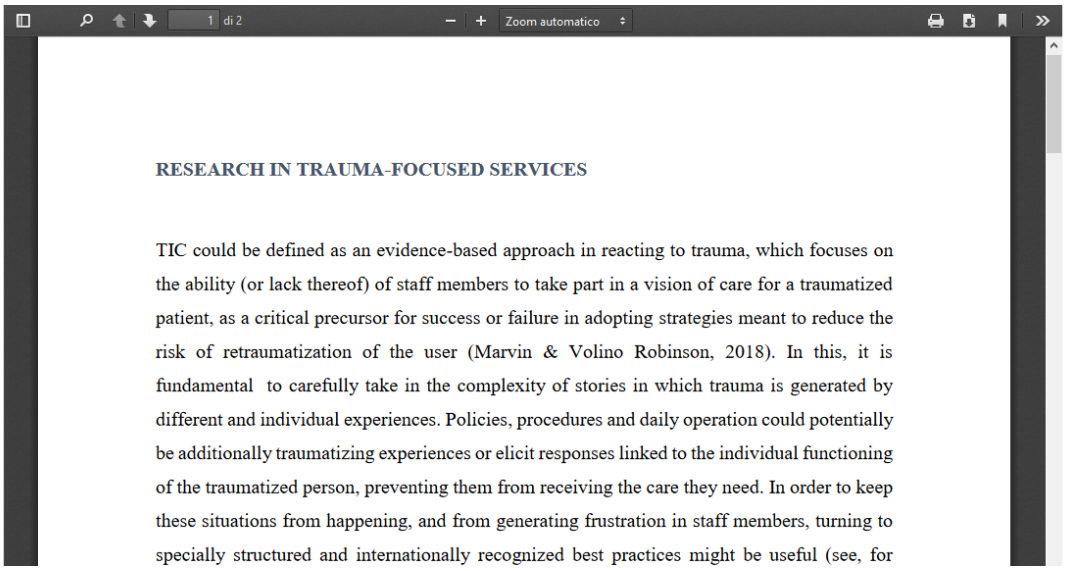
I think what we have to start the conversation with first, is really trying
to understand what trauma-informed means, and that frequently, in the organizations
that I work with throughout the country, people will call me and say "we've you
know we've had a commitment to be trauma-informed for years and we really
understand why this is so important and we really aren't getting anywhere.
There's, you know, we know there's some next steps that we have to take but
we've never really been able to get organized and never really begin able to
do that next thing", and what what we did at the National Council is, we developed
a tool called the "organizational self-assessment" and with that tool we
took the thoughts and the ideas from the leaders of the field, leaders in the
field such as Roger Fowler and Maxine Harris and Judith Herman and Sandy Blum,
and tried to synthesize their work in a way that expressed the practices and

principles of what it means to be trauma-informed, so for example “safety first” or transparency and, you know, mutuality and choice and voice and control and collaboration and giving people control back in their lives and, so, you know, what we did is we created an instrument called the “organizational self-assessment” using those those pieces of the practices and principles to operationalize what it looks like in an organization to move towards being trauma-informed, and it's, the OSA is a Likert scale of zero to four with a not applicable included, we took and created the seven domains of trauma-informed care and in those seven domains is where you capture those principles. Under each domain there are multiple standards and those standards are not the only standards, but the idea of the OSA is to get organizations to think a little bit differently about the work that they do. So, for example in the seven domains, the first domain is “screening and assessment”, so we want to to have an experience for
people upon entry into an agency where screening is done, but we also want to have people have the opportunity to talk about anything, any of their experiences, in a sensitive way and over time. If I'm someone coming into an organization and I may be very very scared or I may not trust you
if you're the intake coordinator but what I want to be at, what we want to be able to do is to to create an environment where people do feel comfortable answering some of those questions. And people need to be trained in how to ask the questions, they need to be trained in how to establish the relationship from the very very first time anybody walks through the door. The second domain is “consumer-driven care and services” and you know I'm so thrilled with Community HealthCore and the way they're thinking about the work they're doing and the numbers of peers that are being trained and are being utilized in really wonderful wonderful ways, and that's not the only piece. Peers are able to see services through a very very different lens: we know what it's like to go through a screening and assessment process, we know what it's like to be funneled into a group that really is not working for us, we know what it's like to be retraumatized by the system and being able to have that voice is part of all of the work, that's one piece of consumer

driven care and services, but it's looking at things from that real recovery-oriented perspective where it's consumer driven, it's person centered and that I have that if I'm the person receiving services I have an opportunity to say what works for me and what doesn't. I'm really bringing that voice and making sure that peers, consumers clients, but however you frame the language that people have an opportunity to really talk about what's working well in the organization and what doesn't work well. We also talked about workforce development in an educated trauma-informed workforce and that is including clinical training, clinicians need to have adequate training to do their jobs but if I'm the receptionist what does it mean for me to be a person working in a trauma-informed organization? Every person makes a difference, if I'm the van driver, if I'm the maintenance person, I make a difference in creating that community where people feel that they can begin to heal. And also thinking about compassion fatigue for staff, in our earlier work today we were talking about internal customer service, it's how every person in the organization treats each other. You cannot have a trauma-informed organization if staff is so overworked that they experience compassion fatigue, so you know, thinking about the needs of staff but also thinking about how that impacts if I'm not taking care of myself how can i really be there for another person? It's also about good clinical supervision are you supervising in a way that's trauma-informed rather than supervising in a punitive way? Domain 4 is evidence-based in emerging best practices, it's always looking at, it's not saying “this is the one thing that we're doing in is evidence-based and never looking at the new and emerging things that are happening”. It's always having an eye towards the good stuff, and really, you know, providing the training for staff, using peer delivered evidence-based best practices like “WHAM” Wellness, Whole Health Action Management, where peers are really helping other peers, you know, take control of their own physical health. Or “WRAP”, Wellness Recovery Action Planning, is a great trauma-informed tool to use that's evidence based, and then creating safe and secure environments. People cannot heal if they do not feel safe. If you're on hyper alert, if you feel like that you're walking into an

environment that does not welcome you where you do not feel safe,
nothing good is going to happen. I had somebody tell me, I was in a meeting, and
they repainted, they just repainted and updated their reception area, and one
of the clients came in and said “Are we moving?” and the person said “No, why?”
“Well we figured, if you were making it this
nice we were going to have to leave.” and that's an
indicator that people did not feel highly valued, it was a huge lesson for
them. People deserve to be treated in a place and in a way that says “I
respect you, you're valuable”, you can't begin to heal until you begin
to fill those things. And then domain six is about building community partnerships,
whoever we are in our community we have to work to make communities,
trauma-informed healing doesn't happen in a vacuum so if I receive great
services at your program but I go out to, you know, department whatever and they
treat me like I'm, you know, mud on the bottom of your shoe, it undoes all the
good work I did when I was working with you, so really really reaching out into
the community and help the community understand what it means to be
trauma-informed. And finally, domain seven is all about “Performance Improvement”:
How do you know what you're doing is making a difference?
If I do X is this going to work for me? Is this working for the people that we
serve? Am I doing client feedback surveys? Am I asking clients about the level of
safety that they feel? Am I surveying my staff? And then once I do the survey do I
do anything about what it was? I just surveyed so, you know, the way we use
the OSA is, we ask organizations, when they start the assessment, that's
their baseline, and then we ask them over a period of time to do it again, so they
can see the progress that they've made. And then we use a number of other tools,
a performance monitoring tool, and implementation guide to help
organizations move forward, but that's kind of the OSA in a snapshot, very quick
snapshot, because it's a long process, the OSA is not
designed for organizations to just say “okay we're done now”, it is not a
checklist, it's a way to guide conversations, to begin to make
significant change within the organization.

Reading material



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Knowledge check

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Quiz 3.2

3 points possible (graded)

1. A study by Ruzek and Rosen (2009) has shown that in the international context of trauma-related treatments:

- ○ The treatments were applied uniformly throughout various countries, highlighting the effectiveness of the approaches used
- ○ The needs of specific sub-groups were adequately addressed
- ○ The same treatments were equally effective in adults and children
- ○ The training programs were implemented in different ways, highlighting the need for the definition of core competencies

2. Trauma-Informed Care...

- ○ Aims to transform the care system, focusing on the ability of staff to participate in a vision of taking care of the traumatized patient
- ○ Aims to reduce only the symptoms related to trauma, focusing on intervention techniques
- ○ Implements techniques such as restraint and isolation
- ○ Is used exclusively with minors

3. One of the advantages of scientific dissemination in trauma-related organizations is:

- ○ The possibility of expressing exclusive interest in issues related to working groups
- ○ The implementation of evidence as a top-down decision by the leadership
- ○ The possibility of starting a process of implementation of the most recent evidence-based practices, aimed at improving the well-being of staff and patients
- ○ The transition to generic treatments that work for all patients

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Definition and premises

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Learning material

Guyadeen & Seasons (2018) highlight how, similarly to many other disciplines, "the field of planning has its own brand of evaluation" (p. 98) that can be classified into two branches: "plan evaluation and planning evaluation. Traditionally, evaluation in planning was considered independent of program evaluation and involved the use of specific evaluation approaches. The planning discipline currently argues that there is a benefit to building stronger links between program evaluation and evaluation in planning" (p. 98). In the public health system, evaluation plays an important role in the development of policies and programmatic planning. "Both processes follow a problem identification and definition phase" (p. 99), followed by phases of formulation, implementation and, finally, evaluation. The last phase aims to assess the success of the intervention and to identify areas for improvement of the program (Pal, 2014; Guyadeen & Seasons, 2018). As specified by Guyadeen and Seasons (2018): "It is a structured process that aims to create and synthesize information about interventions in order to make judgments regarding resulting changes, the desirability of an intervention, and the degree of adaptation between intended and unintended outcomes (McDavid & Hawthorn, 2006)" (p. 99). The process of evaluation can also be focused on the cost-effectiveness of programmes and plans and it can be considered of particular relevance in public sector organisations: reasons of political or legislative responsibility imply that planners should demonstrate the benefits of their actions or proposals to the public and to the community (Vedung, 2010; Guyadeen & Seasons, 2018).

Craig and colleagues (2008) highlight "how complex interventions are widely used in health services, in public health practices and in areas of social policy that have important consequences on health" (p. 1). These initiatives present challenges for operators dealing with evaluation, which go beyond the applicative and methodological difficulties that evaluation processes about the success of an initiative must address. As a matter of fact, "complex interventions are usually described as interventions that contain several interacting components" and have multiple "characteristics that evaluators should take into account" (Craig at al., 2008, p. 1). In this, for example, key questions in the evaluation of complex interventions could be: are such interventions effective in daily practice? Do the effects vary according to the target group or context? How does the intervention work? What are the key elements and how do they exert their effects?

In general, from a procedural and processual point of view, best practice consists in systematically developing interventions. This means that: "Best practice is to develop interventions systematically, using the best available evidence and appropriate theory, then to test them using a carefully phased approach, starting with a series of pilot studies targeted at each of the key uncertainties in the design, and moving on to an exploratory and then a definitive evaluation. The results should be disseminated as widely and persuasively as possible, with further research to assist and monitor the process of implementation" (Craig et al., 2008, p. 2).

To begin clarifying the elements involved in this complex process, Rychetnik, Frommer, Hawe & Shiell (2002) provide us with the following definitions:

INTERVENTION: it can be conceptualised as a set of actions aimed at an objective that involves a change or produces identifiable outcomes. To promote greater well-being or to protect health status are the main objectives of public health interventions, which are distinct from clinical interventions that, generally, have the aim of preventing or treating distress in individuals.

CONTEXT: it refers to the social, political and/or organizational setting in which the intervention is planned/designed, implemented and evaluated. The contextual features that are considered relevant for an intervention vary according to the type of intervention. For public health interventions, political, organisational, socio-economic, demographic and environmental factors are important.

EVALUATION: it is the process of determining the value of an intervention by comparing it with predetermined and defined standards.

EVIDENCE: it implies the interpretative reading of the data collected through formal research or specific investigations implemented according to the standards of the scientific method. The Evidence-based practice highlights and deals with the desired consequences of an intervention and considers central effectiveness (also in terms of cost) considering the data on the implementation and the outcomes of the intervention.

Moreover, PROGRAMMES are composed of sets of activities aimed at achieving a specific related result or set of objectives (McDavid & Hawthorn, 2006; Pal, 2014; Guyadeen & Seasons, 2018). Programs are generally designed as means for transforming resources into activities to produce a desired result (McDavid & Hawthorn, 2006; Guyadeen & Seasons, 2018). PLANS, which can assume the feature of a guide, a sort of programmatic and planning vision, have a predominant role in the organization of interventions or initiatives for a community (Baer 1997; Ryan, 2011; Guyadeen & Seasons, 2018). They may have overarching goals as they offer a vision oriented to future developments: they incorporate facts, objectives and policies that can be translated into a physical or tangible development model and address multiple community problems (Berke et al., 2006). Programmes can be part of the implementation strategies of a plan (Guyadeen & Seasons, 2018). As described by Guyadeen & Seasons (2018): "It is important to note that plans are evolving tools that need to be continually reviewed and updated to remain relevant to evolving needs, knowledge and experiences (Brody 2003). In this respect, evaluation should play a key role in ensuring the applicability and relevance of plans and programmes" (p. 99).

First, evaluation could be considered "an empirically oriented discipline that generates information about programs" (Guyadeen & Seasons, 2018, p. 99) with the aim of improving them and/or guiding future decisions. Secondly, there is an emphasis on both the functioning of the programme and the results. That is, the evaluation is not only about the effectiveness of the programme, but also about the process. As a matter of fact, it is focused on the way in which programs are administered; it includes an analysis of the organisational methodologies used to deliver the programme, the inputs used (e.g. Resources), the results (e.g., the tangible measures), and cost-effectiveness (Howlett, Ramesh & Perl, 2009; Guyadeen & Seasons, 2018). Finally, programme evaluation is used to try to make programmes more efficient and effective (Weiss, 1998; Guyadeen & Seasons, 2018), and as a means of ensuring accountability and assuring quality (Cousins et al., 2014; Pal, 2014; Guyadeen & Seasons, 2018).

For these reasons, decisions on interventions in the public health field should be based on a deep assessment of the strength points regarding the innovations proposed, but also of the gaps and weakness aspects in the evidence supporting their application (Rychetnik et al., 2002). Critical guides in the field of intervention assessment, which identify and assess multiple dimensions of evidence, allow adequate consideration to be given to issues such as relevance and transferability, providing specific and justified recommendations for practice (Rychetnik et al., 2002). However, it is equally important to balance rigorous evaluation and overarching purposes to distinguish between a systematic assessment of the available evidence and the complex socio-political process that determines political and practical decisions (Rychetnik et al., 2002).

In addition, Rychetnik, Frommer, Hawe and Shiell (2002) underline "the distinction between the assessment of evidence and the process of policy-making or operational decisions on the implementation of interventions. Research-based evidence is only one of several factors taken into account in these decisions" (p. 119). The authors further specify:

"Public health interventions tend to be complex, programmatic, and context dependent. The evidence for their effectiveness must be sufficiently comprehensive to encompass that complexity. The evaluation of evidence must distinguish between the fidelity of the evaluation process in detecting the success or failure of an intervention, and the relative success or failure of the intervention itself. Moreover, if an intervention is unsuccessful, the evidence should help in understanding whether the intervention was inherently faulty (that is, failure of intervention concept or theory), or badly delivered (failure of implementation). Furthermore, proper interpretation of the evidence depends upon the availability of adequate descriptive information on the intervention and its context, so that the transferability of the evidence can be determined" (p. 119)

As Craig and colleagues (2008) pointed out, in practice, evaluation is carried out through a wide number of approaches that impact on the possibility of choice between interventions and assessment methods. Moreover, in the field of complex interventions, various sources (e. g. political acceptability) can significantly inform researchers and influence the adoption of an ideal evaluation program. Furthermore, experimental methods are increasingly accepted as methodologies for evaluating policies, but political or ethical objections can limit their use. Evaluation should play a central role in the critical approach to intervention. If planners decide to apply non-experimental methods, they should be aware of their methodological limitations and, consequently, interpret and disseminate results with caution. In this, researchers "should be prepared to explain to decision-makers the need for adequate development work, the pros and cons of experimental and non-experimental approaches, and the trade-offs involved in settling for weaker methods. They should be prepared to challenge decision makers when interventions of uncertain effectiveness are being implemented in a way that would make strengthening the evidence through a rigorous evaluation difficult, or when a modification of the implementation strategy would open up the possibility of a much more informative evaluation" (Craig et al., 2008 p. 2).

More specifically, researchers (Craig et al., 2008) stress that, to develop a complex intervention, the evaluation process should follow a series of steps:

Identification of existing evidence on the subject: what is already published or disseminated in the scientific community about similar interventions (systematic and high-quality review of the relevant evidence including methods used to evaluate process and results);

Identification and development of the theory: the rationale of complex programs of intervention, the expected outcomes and the way in which the change is to be achieved may not be completely clear from the start. One of the first key tasks is "to develop a theoretical understanding of the likely process of change by drawing on existing evidence and theory, supplemented if necessary by new primary research. This should be done whether the researcher is developing the intervention or evaluating one that has already been developed" (p. 2);

Modelling process: Structuring an accurate model of a complex intervention before making a full assessment enables planners to include and collect information useful for both the intervention design and the assessment. More studies may be needed to progressively refine the project before a full evaluation is carried out. Another useful aspect in the preliminary design phase is economic evaluation, which can help project proposers to identify weaknesses and fill in gaps.

Finally, researchers should pay attention to general statements about which models are suitable for the type of intervention for the different questions and circumstances, and choose a study design based on the specific characteristics, such as the expected effect size and the probability of selection or bias of allocation. "Awareness of the whole range of experimental and non-experimental approaches should lead to more appropriate methodological choices" (Craig et al., 2008, p. 3).

In the field of programme evaluation the main types of evaluation are the formative and the summative ones. Evaluations focused on improving the performance of a program are considered formative because they provide feedback aimed at improving the results of programs or increasing efficiency (McDavid & Hawthorn, 2006; Posavac & Carey, 2007; Guyadeen & Seasons, 2018). Training assessments produce information useful for making immediate decisions about a program, such as improving some parts and/or modifying processes (Shadish, Cook & Leviton, 1991; Guyadeen & Seasons, 2018). Evaluations focused on results, that occur once a program is finalized or almost complete, provide information about whether a program has achieved its goals and/or whether the process is worth continuing (McDavid & Hawthorn, 2006; Posavac & Carey 2007; Shadish, Cook & Leviton, 1991; Guyadeen & Seasons, 2018).

To summarise, as indicated by Wandersman and colleagues in 2000, the evaluation process is complex and articulated (Figure 1).

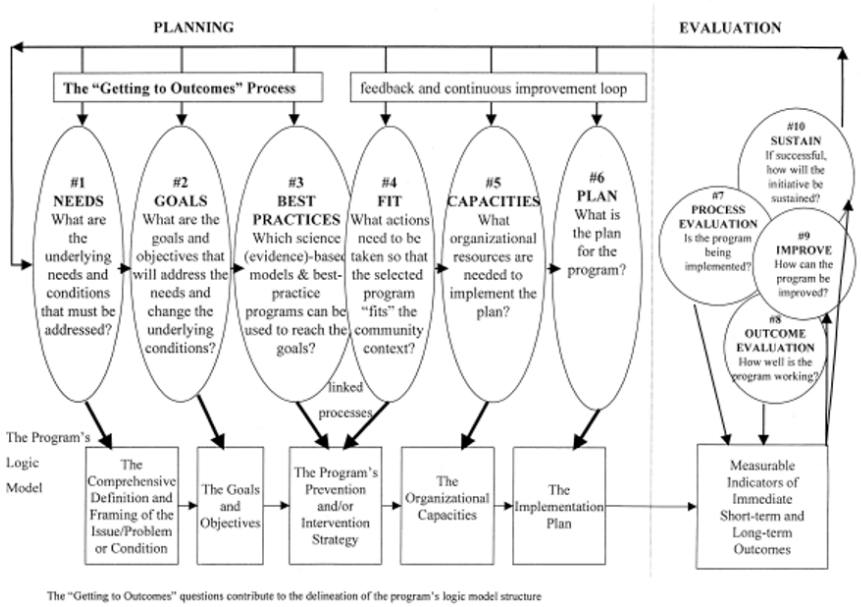

Fig. 1. The getting to outcomes framework.

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Efficiency and Experience Evaluation

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Reading material

According to Guyadeen & Seasons (2018), "the historically dominant evaluation model is science-driven and highly technical with a strong emphasis on quantitative methods". Scientific research methods and techniques such as systematic randomized research designs and experiments are considered integral to the evaluation process (Alkin 2013). This approach to evaluation focuses on measuring effectiveness and efficiency (Greene 1994)" (p. 100).

Scholars have been working for a long time and not without disagreements on how to evaluate it, its objectives and contents, and its indicators (Jacobson et al., 1999). For example, a widespread practice in the field of evaluation concerns the analysis of how (mainly in quantitative terms) programmes promote or hinder the achievement of objectives. This approach requires clearly identified objectives and congruent indicators. The evaluation of effectiveness is a complex process and it is not free from the responsibility of undertaking relevant decisions: as Craig and colleagues (2008) point out, in assessing the effectiveness of an intervention, randomisation must always be considered as the method of choice (e. g. to prevent selection errors). If a conventional randomised trial between parallel groups is not appropriate, other randomised methodological study designs should be considered or, if an experimental approach is not feasible, quasi-experimental or observational projects could be considered.

Regarding the analysis of the outcomes of the intervention, if the research plan is carried out in accordance with the scientific method, it aims to confirm or disconfirm the existence of a causal relationship between the intervention and its effects and understand the reasons behind its effectiveness or lack thereof. The study design also defines the level of evidence arising from it. The systematic review of randomised controlled trials (RCTs) is one of the most widely used and recognised methods for providing the best level of evidence on the effects of prevention and/or treatment interventions (Rychetnik, Frommer, Hawe & Shiell, 2002). Long-term follow-up may be necessary to determine whether expected results occur or whether short-term changes persist: "although uncommon, such studies may be highly informative" (Craig et al., 2008, p. 3).

About the levels of evidence in the evaluation of public health interventions, these are the subject of further study in the scientific literature because of their dependence on the criteria established to assess their credibility. In this regard, controversy continues to exist in the field of RCTs applied to the analysis of public health interventions; it mainly concerns the difficulty in conducting these studies due to the programmatic complexity of the interventions, the analysis of the results and the underestimation of the contribution of observational studies. Due to their nature, many public interventions require multiple and flexible analysis strategies to which studies based on "classical" RCT models - according to the authors - are difficult to adapt (especially because they require a very rigid standardization of the intervention and the assumption of randomization on the basis of individual units). An important point of the researchers' analysis is that it is stressed that applying non-randomized methodologies where these would be possible, instead, can lead to a significant and unsustainable loss of relevance; but, following the words of Rychetnik and colleagues (2002):

"the design of the study alone cannot be sufficient as the main criterion for the credibility of evidence about public health interventions" (p. 121).

Interpretation of results

The evaluation process is a central aspect of the design and implementation of an intervention regardless of whether the results obtained on effectiveness are negative or positive. In fact, the proof of an adequate implementation of the procedures foreseen by the intervention programme and the use of effective indicators in monitoring the process are recognized as central in the scientific literature (Rychetnik et al., 2002).

The theories underlying interventions, their specification (explanation and plausibility) in relation to the underlying assumptions (hypotheses), related to the effectiveness and functionality of the measures of result and impact, are key criteria for the evaluation and interpretation of its quality in terms of public health (Rychetnik et al., 2002).

Following the analysis of Rychetnik and colleagues (2002), multidimensional approaches are available in the literature to evaluate research on outcomes. In the evaluation of evidence on the effectiveness of intervention three dimensions are important:

1) "the strength of evidence, determined by a combination of study design (level), methodological quality and statistical precision" (p. 122);

2) "the magnitude of the measured effects" (p. 122);

3) the "relevance of the measured effects (as observed in the evaluation) to the implementation context" (p. 122).

Empirical quality assessments are important, as they can influence decisions at a political or practical level in the field of public healthcare. It should be carefully ensured that the use of inadequate evaluation protocols does not result in unrealistic or excessively costly demands. Evaluation criteria should support the decision-making process as they should help determine whether the measured results include (a) the interests of those who might be involved in the decision or proposal of the intervention and the target audience; (b) whether the unforeseen and expected effects of the intervention result in benefits or not; and (c) the efficiency of the intervention and its effectiveness. About the first dimension, the contribution of all stakeholders is crucial, given the social and political nature of public health. For these reasons, important actors in the evaluation process include decision-makers and target groups.

As Guyadeen & Seasons (2018) pointed out, there are evaluation models that place a strong emphasis on pluralism and on the analysis of the different stakeholders involved in an evaluation. Moreover, qualitative methods are often used to improve the vision of programmes from the perspectives of stakeholders directly involved (Greene, 1994); as a matter of fact, they could be considered critical as they have a direct involvement (e.g. money and personal interests) in the evaluation.

Participatory evaluation (Cousins, 2004), empowerment evaluation (Fetterman, 2004), collaborative evaluation (Rodriguez-Campos, 2012), and more recently, development evaluation (Patton, 2011) could be considered good examples of effective methodologies in this field (Guyadeen & Seasons, 2018).

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Evaluation of interventions' effectiveness and outcomes

Reading Material

As highlighted so far, the evaluation process should play a key role in ensuring that plans reflect the highest quality from both a conceptual and an applicational perspective (Guyadeen & Seasons, 2018; Berke and Godschalk, 2009; Baer, 1997). It can largely contribute to ensuring objectivity and systematization in the planning and analysis of the intervention, improving the process of programmatic preparation and giving the possibility of analyzing the congruence between the project's declaratory plan (declared objectives) and the results obtained (Guyadeen & Seasons, 2018). Through evaluation, it is also possible to document and empirically identify gaps and/or strengths (Berke, Smith & Lyles 2012; Guyadeen & Seasons, 2018). A basic premise is that, for plans to be effective and assessable, there must be a clear relationship between the main components of a plan (i.e. its objectives and policies) and the mechanisms of implementation (Oliveira & Pinho 2010b; Guyadeen & Seasons, 2018). Overall, there are two general forms of evaluation in planning: (a) evaluation of the plan (e.g. evaluation of the quality of the plan, evaluation of the implementation of the plan and evaluation of the results of the plan) and (b) evaluation of the planning (e.g. evaluation of the planning processes and planning practice) (Guyadeen & Seasons, 2018). While the evaluation of planning involves determining the effectiveness of the planning process, the evaluation of the intervention plan and its results involves evaluating the quality of the plan, the success of its implementation and the achievement of its objectives (Morckel, 2010; Guyadeen & Seasons, 2018). These forms of evaluation are similar to programme evaluation because they seek to improve decision-making, but differ because of their emphasis on the plan, how it was created, and the results generated by the activity of planning (Guyadeen & Seasons, 2018). In addition, there are generally three types of evaluation in planning: ex-ante (or a priori), ongoing and ex-post (Guyadeen & Seasons, 2018). According to Oliveira & Pinho (2010), these types of evaluation correspond to the different stages of planning, which include plan preparation, implementation and review (i.e., once implemented).

Evidence-based healthcare aims at taking into account efficiency and effectiveness, although until now efficiency issues have not been emphasized in evidence-based medicine. The assessment of evidence on public health interventions must inevitably determine whether efficiency has been assessed and, if so, the level of efficiency achieved (Rychetnik, Frommer, Hawe & Shiell, 2002). Furthermore, "evidence-based decisions on the value and applicability of an intervention drawn on knowledge of the effectiveness of identical, similar or analogous interventions, are usually carried out and evaluated in a different setting at a different time. To assess the transferability of evidence about an intervention, information is needed on (a) the intervention itself, (b) the evaluation context, and (c) interactions between the intervention and the context" (Rychetnik, Frommer, Hawe & Shiell, 2002, p. 123). In case of complex interventions, loyalty is not an easy issue. An element that adds complexity is the fact that rigorous standardisation of procedures sometimes undermines the specificity of the intervention when it is motivated by local needs (Craig et al., 2008). A key point that needs to be clarified is the amount of changes or adaptations allowed and the need to record changes in implementation so that fidelity can be assessed in relation to the degree of standardization required by the study protocol. Variability in implementation - whether planned or not - makes it all the more important that process and outcome evaluation procedures are fully reported and that a clear description of the intervention is provided to allow its replication (Craig et al., 2008).

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Knowledge check

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Quiz 3.3

3 points possible (graded)

1. According to Rychetnik, Frommer, Hawe and Shiell (2002), evaluation can be defined as:

- ○ A set of changes and outcomes that can be defined in advance
- ○ Interpretative reading of the data collected through formal research or specific surveys
- ○ The social, political and/or organisational setting within which the intervention is planned
- ○ The process of determining the value of an intervention through comparison with predetermined and explicit standards

2. When evaluating the effectiveness of an intervention, which of these does NOT seem to be a significant factor? (Rychetnik et al., 2002)

- ○ The number of interventions carried out by the organisation
- ○ The relevance of the measured effects in the implementation context
- ○ The magnitude of the measured effects
- ○ The strength of evidence, determined by a combination of study design, methodological quality and statistical accuracy

3. Evaluation...

- ○ Does not require integration between evaluation methods and the plan to be evaluated
- ○ Allows empirical documentation of the weaknesses and strengths of the intervention plans
- ○ Should avoid taking into account the interest of the people involved in decisions on interventions.
- ○ Should only be carried out on outcomes

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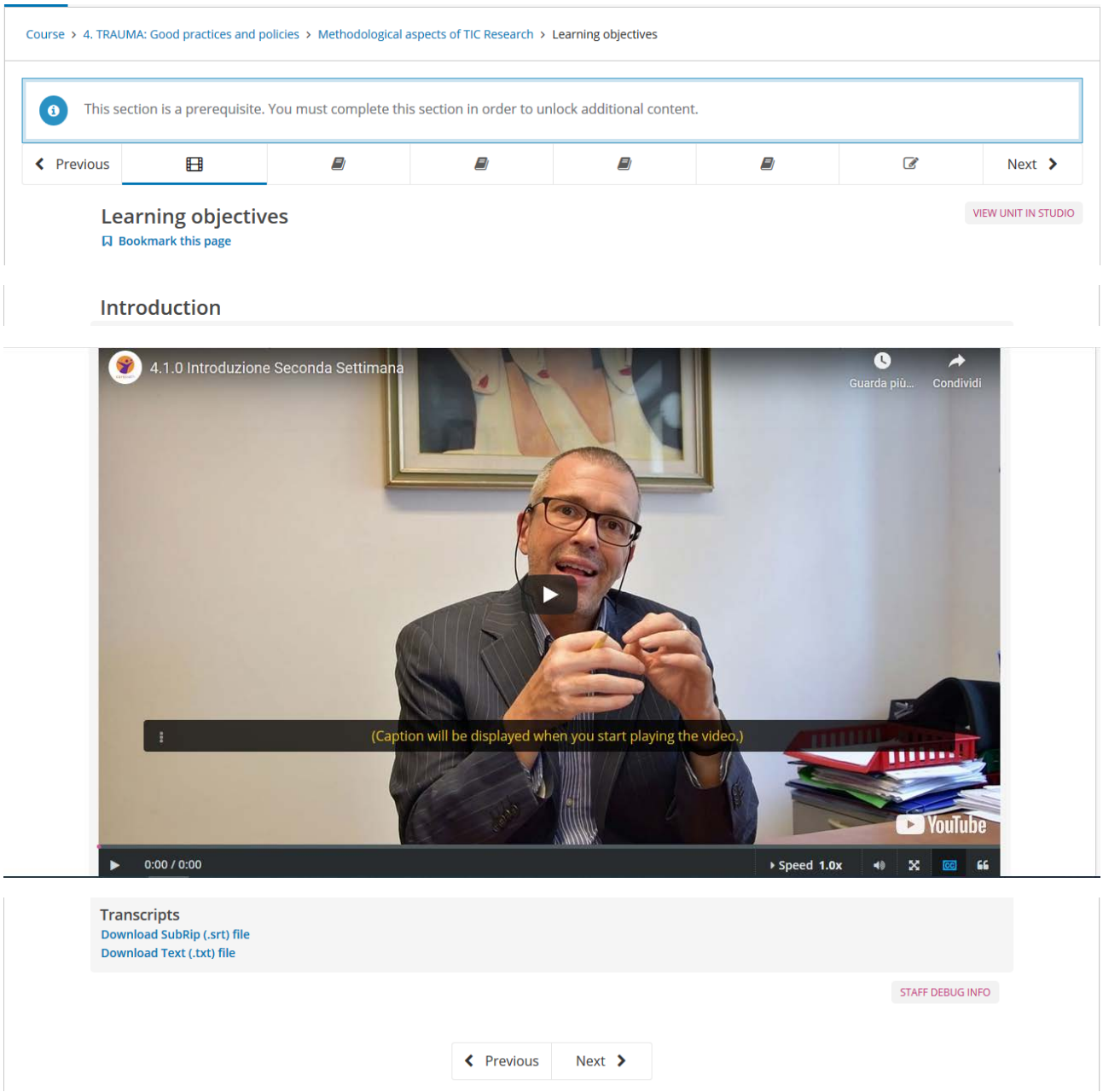

Transcript

Welcome. Here we are again in a new week, with new aspects, new insights.

In this week we will discuss aspects related to best practices,

aspects related to observation and aspects related to indicators of child abuse and maltreatment.

Let's start with the first element. Together we will investigate

the elements related to the intervention of research and practice with particular attention to

the development of best practices. After that we will examine the methodological aspects

of research in Trauma-Informed Care, which we have now learned

to understand and read, and we will have the opportunity to further understand how these apply

to research planning, how to use the Trauma-Informed Care format

in research, and then understand the link from theory to practice.

We will then try to identify the elements that constitute

a good research proposal by examining aspects related to a good technique such as observation.

Observation as a clinical tool, observation as a tool that can allow an operator

who collaborates or intends to work or (for a thousand other reasons)

is willing to know and examine in depth the theme of Trauma-Informed Care can use observation as a method,

and to understand the person brought into that context

(keep in mind the meaning of Trauma-Informed Care).

And here we will investigate the requirements and possible applications of clinical observation and more.

We will then continue with examples

and concepts previously discussed such as good practices, observation and how these

can be applied to child abuse and maltreatment, while also trying to identify indicators,

taking into account that an indicator is, as such, just an indicator, and is certainly not

a fundamental and certain element of abuse and maltreatment, but a set of indicators

may be interesting for us as an element to keep in mind as there may be something to investigate.

From here we will examine screening procedures

on assessment of trauma and we will try to understand with colleagues how important a screening

of trauma can be for knowledge.

We will then close with aspects related to Trauma-Informed Care and links with research,

and how there can be an organized system of processes that goes from theory to practice.

If in the first part, in the first two weeks we discussed and examined with colleagues

perhaps the most theoretical aspect of trauma, with us today,

with these two weeks, we discussed research in Evidence-Based or Action-Research in Trauma-Informed Care,

from now on you will move towards a new path that will always have trauma

and Trauma-Informed Care as a central theme but from a slightly different point of view,

specifically the legislative one, to then address issues related to legislation, research and policies.

We wish you, on my behalf and on behalf of all my colleagues,

a good progression of the path; you have now reached the half, perhaps more than half of the path,

and at this point you are heading towards the closure of your MOOC.

Again, we wish you a good continuation, and we will see each other again at the end of the MOOC.

This section is a prerequisite. You must complete this section in order to unlock additional content.

Introduction to core methodological aspects of research in TIC

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INTRODUCTION TO CORE METHODOLOGICAL ASPECTS OF RESEARCH IN TIC

As Newman & Ridenour (1998) suggested, the way in which researchers conduct a study and what conclusions they obtain from it are very different and depend on their approach to reality. Furthermore, epistemology concerns the study of how we know things while the method concerns the choice of the technique through which it is possible to proceed to the knowledge of phenomena (Bernard, 2006).

As Lastrucci (1963) pointed out, science is "an objective, logical and systematic method of analysing phenomena, designed to allow the accumulation of reliable knowledge" (p. 6). This is done through three objectives that guide the choices of the researcher (Bernard, 2006):

- Objectivity: this implies being explicit about measurements, attention to methodology and reference to peer review within the scientific community.
- The scientific method
- Reliability

The ethical dimension is part of the scientific method and, referring to research in the human sciences, a central question is how to operationalize phenomena that are complex by nature; this type of process is based on the definition of variables, on the search for associations or relationships between them and on the attempt to understand if and how the variation of one thing causes a variation in another (Bernard, 2006). In connection with these aspects, a founding element is the measurement and identification of valid and reliable indicators and is closely linked to the structuring of operational definitions that "consist of a set of instructions on how to measure a variable that has been conceptually defined" (p. 38).

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Research in TIC

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RESEARCH IN TIC

In TIC, one of the key concepts is to use scientifically-validated procedures and concepts. From this point of view, it is essential to promote a synergistic interaction between clinical work and research in order to investigate the outcomes of treatment and to evaluate the functioning models of services in terms of effectiveness and efficiency, also by formalizing these aspects in specific guidelines and/or paying attention to the adherence of the specific protocol to the established elements in international research in this field (Schäfer et al., 2018).

In this respect, the contribution of scientific research to the analysis of TIC definitions and their underlying factors is significant.

In this regard, Becker-Blease (2017), Hanson & Lang (2016) and Johnson (2017) highlight a number of critical aspects related to TIC and application problems, including, for example, the existence of a very present focus in the scientific literature on theoretical aspects and fundamental principles to the detriment of attention to the tangible elements and their applicability in practice: "there is a gap in how practitioners can transform theory and principles into everyday practice and therefore assess their effectiveness" (Becker-Blease, 2017, p.3). The focus on research is therefore useful for the evaluation of trauma-informed application initiatives, programmes and services and whether these are related to significant positive results.

In trying to implement a fruitful and functional exchange between conceptual and theoretical aspects and those related to application, a relevant focus should be dedicated to the analysis of the applicability of standardised procedures and indicators both in terms of the process elements and the results obtained. The scientific literature on the subject urges organizations and institutions to consider particularly relevant the structuring of research projects, both basic and applicative, aimed at dealing with screening procedures (evidence-based screening), the analysis of assessment procedures aimed at identifying traumatic events and their peculiarities. Moreover, to this end, it is important that randomized, controlled studies are implemented on an experimental basis to test the effectiveness of trauma-oriented interventions.

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Core elements to structure a good research proposal

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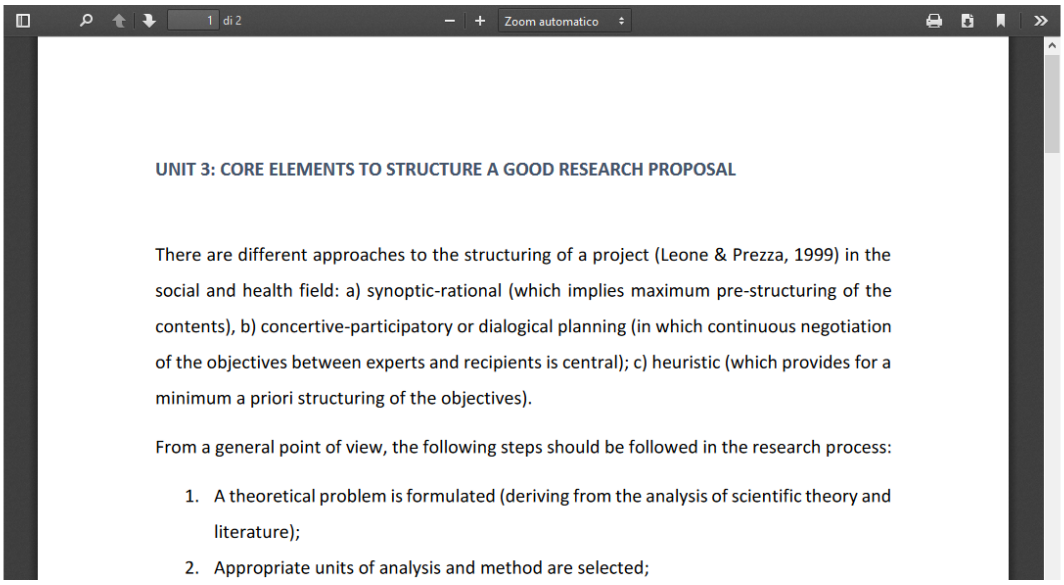
Core elements to structure a good research proposal



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Knowledge check

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Quiz 4.1

3 points possible (graded)

1. The operational definition:

- ○ Is carried out before the conceptual definition of a variable
- ○ Is carried out after the conceptual definition of a variable
- ○ Is processed during the measurement of a variable
- ○ Is not useful for measuring a variable

2. In the field of Trauma-Informed Care it is crucial to:

- ○ Impose a methodology of intervention on operators
- ○ Avoid taking into account the contributions of scientific research
- ○ Promote synergistic interaction between clinical work and research
- ○ Avoid taking into account critical aspects and application difficulties

3. At each stage of the design process:

- ○ The researcher should not ask himself important questions that also take into account the critical elements from a conceptual and practical point of view
- ○ The researcher should ask himself important questions that also take into account the critical elements from a conceptual and practical point of view
- ○ The data must always be analysed
- ○ There is need to plan for timing

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Good practice in TIC

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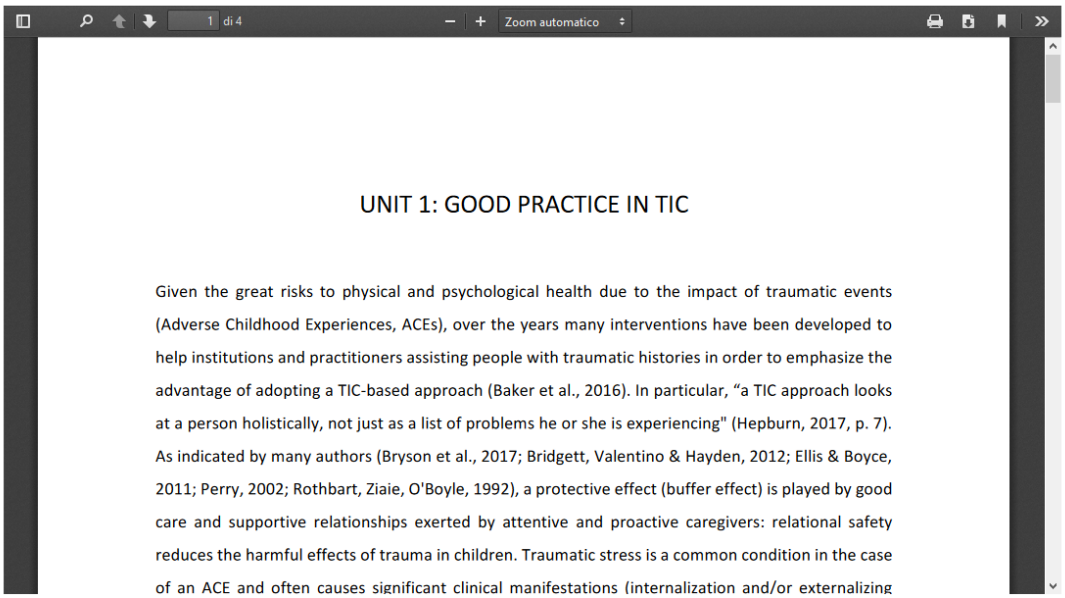

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Fundamental elements of good practices

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FUNDAMENTAL ELEMENTS OF GOOD PRACTICES

By analysing literature and protocols for the evaluation of TIC practices, it is therefore possible to conclude that good practices (potentially transferable in different contexts) should include:

1) permanent training of all staff members on trauma and its correlates. This training should not only be provided to professionals who work directly at the clinical level with users, but to all those who are included in various capacities and with different functions in the organization;

2) a constant update of the internal staff on evidence-based practices (EBP) in the treatment of trauma and a focus on the attitude of professionals towards EBPs;

3) collaboration with experts in the field in order to increase the availability of trained clinical providers;

4) the inclusion of standardized and evidence-based screening procedures in clinical practice and the use of specific and validated evaluation measures/tools to identify traumatic events (ACEs);

5) shared attention to the history of users and its association with symptoms or difficulties related to trauma;

6) in line with the previous point, the recognition of the specificity of the life history of each user guaranteed through an active and empathetic listening on behalf of all personnel;

7) the inclusion and careful sharing of the history of children's trauma in the planning of intervention or in the conceptualization of cases;

8) an in-depth evaluation and constant monitoring of the staff's skills (use of specifically designed procedures);

9) in-depth monitoring to maintain the standards set for good TIC service and, possibly, to improve the deficit elements;

10) the implementation of procedures to reduce secondary trauma stress and increase staff well-being;

11) building and maintaining a good network of cooperation not only within the services but also with other agencies in the field;

12) attention to the centrality of the communicative dimension: the highest level objective should be to have attentive and collaborative professionals in pursuing objectives and applying shared and co-constructed procedures;

13) attention to procedures to reduce the risk of re-traumatization for users;

14) encouraging the participation of patients in the design of the treatment plan;

15) involvement of users in the planning of the service: attention to their feedback and suggestions to improve the organization and the services offered;

16) a particular focus on providing services based on strengths, aimed at promoting factors for positive development (e.g. resilience, empowerment);

17) training on strategies aimed at organising a positive environment for users and staff;

18) special attention to the physical and structural dimensions of the service;

19) adherence to and promotion of TIC principles with specific and clear policies;

20) a central role assigned to the leadership dimension and its functions in the organisation of the service.

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Critical elements and challenges

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VIEW UNIT IN STUDIO

CRITICAL ELEMENTS AND CHALLENGES

Although a particularly highlighted topic in the recommendations for the implementation of best practices, the use of evidence-based practices is still today an element of resistance on behalf of some professionals, organizations and researchers (Gray, Elhai, Schmidt, 2007). This should be the subject of analysis, discussion and attention on behalf of organizations that deal with clinical intervention on trauma, in order to create a cooperative definition of standards as well.

In fact, although the TIC approach is assuming an important role in the organization of services and the provision of care for traumatised people at the moment, there are still some obstacles in its application and, even before that, in its conceptualization (Baker, 2016). In particular, there are shortcomings in this regard:

- a clear operational definition
- the presence of psychometrically validated tools to assess TIC dimensions.

To fill this gap, Baker and colleagues (2016), for example, built and validated a tool -Attitudes Related to Trauma-Informed Care (ARTIC) Scale - to assess the TIC-related attitudes of staff working in different areas of intervention or contexts dealing with individuals with traumatic histories. Previously in their publication Creating cultures of trauma-informed care (CCTIC): a self-assessment and planning protocol, Fallot and Harris (2009) structured a Self-Assessment and Planning Protocol that includes six domains that involve changes at the service, administrative or system level. Attention to the complexity of the TIC application situation is increasingly becoming a challenging objective from a propulsive point of view both for individual operators and for social and health services in their daily interaction and in their relationship with the scientific community of reference.

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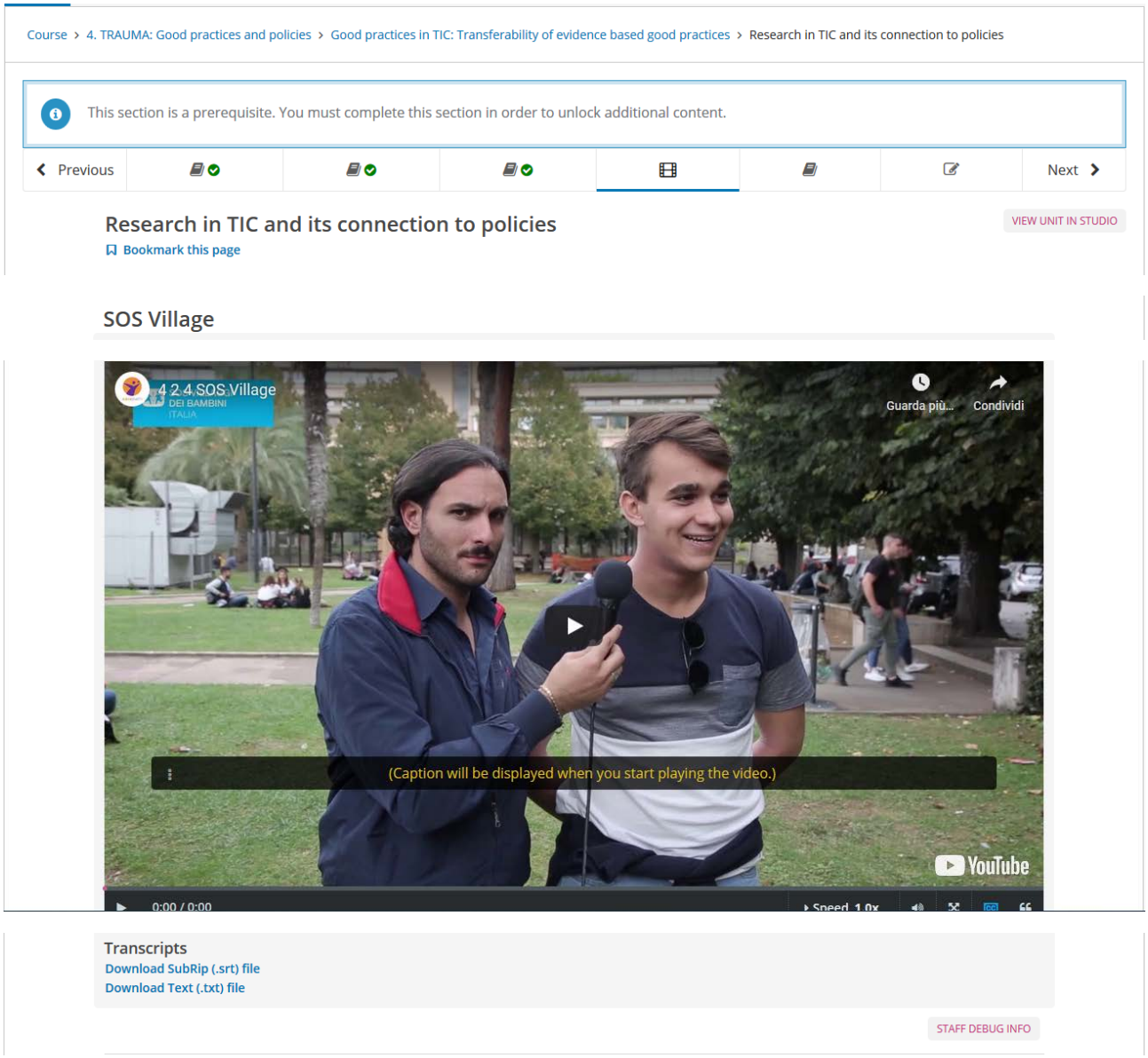

Transcript

[To become an adult is not simple. What are the everyday challenges?]

We're in Rome, interviewing people between 18 and 22 years-old

What is the TARI? [an Italian tax on garbage]

What is it?...

Oh, on savings...

A concept, like, about the economy...

The TARI is a thing, a political thing...

Yeah, right

What's the TARI?

The TARI? Is it a tax?

You need to look for a house: how do you do it?

What do you do? What's your move?

With public transport...

Giulia found it.

With an estate agency.

I live at home, with mom that's

always waiting for me

What kind of contract do you sign?

I mean, I just pay, I mean I gotta pay...

Contracts, ok, indefinite duration, long-term

contracts...

I mean, I just started law school...

but I just started! So...

You do the 4..? [4+4, a common housing contract]

4 Months?

Plus 5

Rent money is wasted money.

Like, water and electricity are included in the price

4?

The bank account

Like, a Latin interrogation is easier!

Eh, I dunno

Where you deposit..

If you want we can talk about Seneca

When you have any problem, who do you call?

Giulia

Dad

Seneca, who's dead.. so mom and

dad for now.

Some questions are hard to answer, but some young people turning 18 years

& one day old will have to face them alone.

Care Leavers

I don't know what that is

Health... needs?...

Who are they?

Liverpool players

I don't know what that is, never heard of them

I don't understand the question?

Clerics

They're young people that are turning 18,

they live in a foster home and need to leave their foster home and find an independent solution

Great!

[The future is built day by day]

What can we tell these young people, come on?!

What... Wish them well, what do we tell them?!

RESEARCH IN TIC AND ITS CONNECTION TO POLICIES

As a model that aims to structure the supply of services, TIC is implemented in a wide and varied contextual range; Bowen and Murshid (2016) underline how this paradigm can be applied equally, in its founding principles (security, reliability and transparency, collaboration, empowerment, choice and intersectionality), to social policies. This, according to the authors' proposal, since TIC offers mental health professionals (especially in the public sector) a path aimed at breaking the disparities through clinical-organizational action that, due to its ethical and deontological dimension, can also rise to a broader political dimension. Reeves (2015) had already highlighted how the widespread implementation of TIC-oriented care models can put at the centre of the intervention the response to the unique and peculiar needs of the people in charge of the rehabilitation services, reducing the welfare inequalities experienced by this vulnerable population.

Recently Levy-Carrick and colleagues (2019) have underlined the unequal treatment in the context of trauma as a critical issue in the national organization of health services to which the adoption of TIC can remedy, if not completely, at least widely. As a matter of fact, a central point stressed by the authors is that the effective application of this paradigm would be guaranteed by the full participation of carers in the planning and implementation of activities at each step. In their book "*Caring for the vulnerable: Perspectives in nursing theory, practice, and research*", De Chesnay and Anderson (2019) have also highlighted that mental health has a political and participatory nature (in particular on the part of users). In line with this, the World Health Organization has often urged policies in order to create a collaborative space in which practitioners and groups defending the rights of users of mental health services (advocacy groups) as well as a wide range of stakeholders can engage in the direction of a synergy attentive to mutual needs.

In addition, as is the case in some circumstances, it is important to make a political contribution to the decision to fund studies to analyse and promote evidence-based practices, to create and disseminate shared standards and to define the organisational ratio and community objectives of organisations and institutions involved in the provision of care models (Ko et al., 2008; Bateman & Anderson, 2013; Levy-Carrick et al., 2019).

What said thus far concerns the general dimension of health policy, but it also concerns the local dimension in response to specific territorial needs and, even more specifically, the policies of individual organisations or services. The literature dealing with TIC suggests that "to implement informed assistance on trauma, there is a need for preparation, evaluation and organizational change (Harris & Fallot, 2001, Rivard, Bloom, McCorkle, & Abramovitz, 2005) [...] The implementation of informed practices on trauma is therefore based on the use of individualized organizational data to inform planning and implementation" (Hummer et al., 2010, p. 82). The ability to support policies with data from effective research facilities is undoubtedly a priority and desirable strategic element (Levy-Carrick et al., 2019). For example, at the level of tools useful in analyzing how much organizational policies are oriented to the principles of TIC, the CCTIC protocol developed by Fallot and Harris (2009) could be particularly interesting to the extent that it enucleates domains and subdomains involved in the evaluation of organizational services and initiatives in the field of trauma care.

In conclusion, therefore, adopting a TIC-oriented perspective implies a sensitivity to what Levy-Carrick and colleagues stressed (2019): "Helping our patients and ourselves will require a critical change of perspective that must be introduced at the beginning of the training, strengthened in all, shaped by its older professionals and promoted by future generations" (p. 107).

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Previous Next

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Knowledge check

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Q4.2

3 points possible (graded)

1. The TIC approach:

- ○ Promotes caring for the person from a holistic point of view
- ○ Considers exclusively the psychological dimension of a person
- ○ Considers only the physical dimension of a person
- ○ Considers only the social dimension of a person

2. An intervention, in order to take into account best practices, should:

- ○ Avoid paying attention to the history of users and its association with symptoms or difficulties related to trauma
- ○ Avoid including standardized and evidence-based screening procedures in clinical practice
- ○ Make sure that the internal staff always continues to perform the procedures on which it was initially trained.
- ○ Promote an in-depth evaluation and a constant monitoring of the competences of the staff (use of specifically designed procedures)

3. A good research proposal...

- ○ Carries out a feasibility analysis and defines a timetable
- ○ Maintains its objectives as general as possible
- ○ Always formulates research hypotheses after data collection
- ○ Always provides for a stratified sample

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The importance of observation

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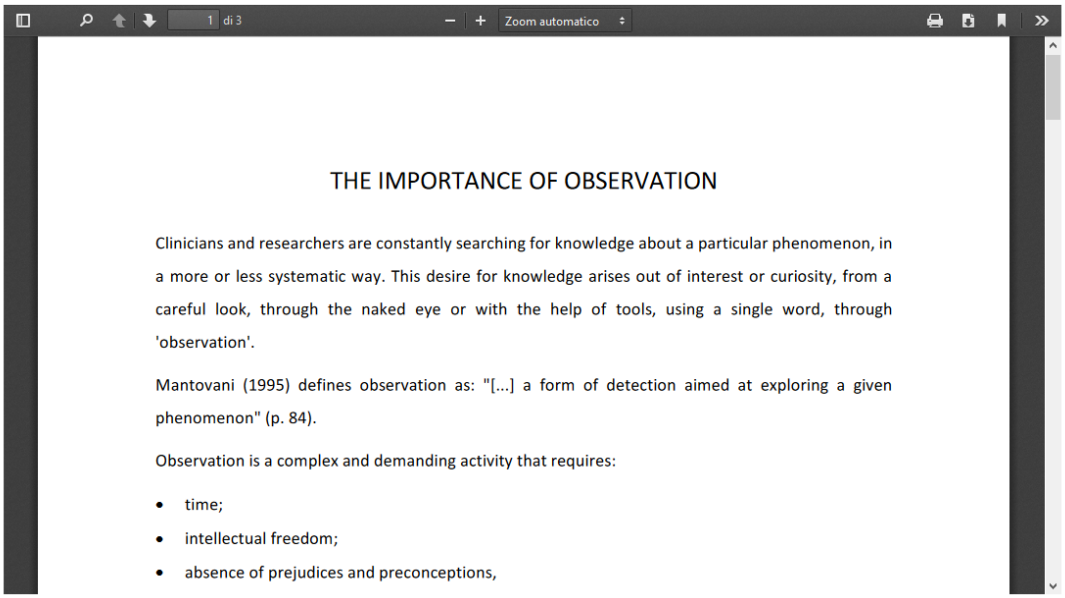

THE IMPORTANCE OF OBSERVATION

Clinicians and researchers are constantly searching for knowledge about a particular phenomenon, in a more or less systematic way. This desire for knowledge arises out of interest or curiosity, from a careful look, through the naked eye or with the help of tools, using a single word, through 'observation'.

Mantovani (1995) defines observation as: "[...] a form of detection aimed at exploring a given phenomenon" (p. 84).

Observation is a complex and demanding activity that requires:

- time;
- intellectual freedom;
- absence of prejudices and preconceptions,

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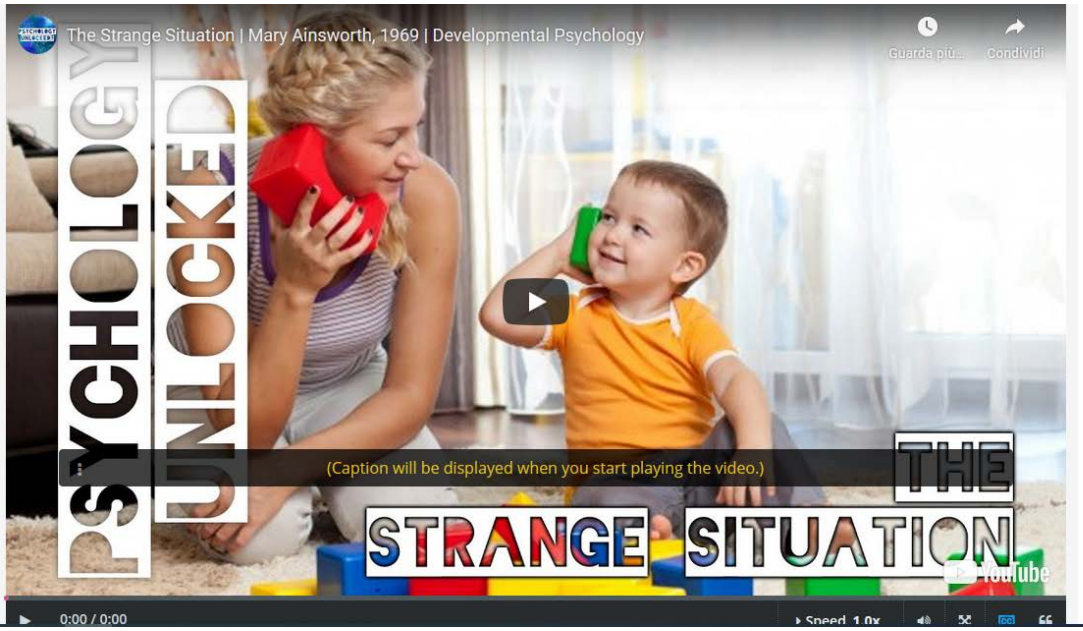
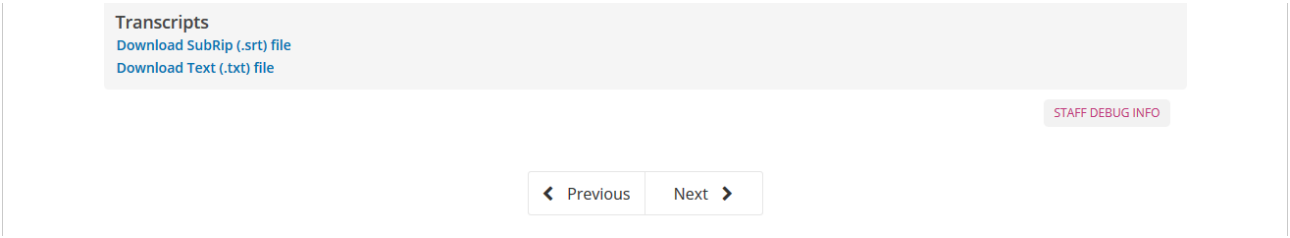
The importance of observation





Transcript

In 1969, american psychologist Mary Ainsworth gave developmental psychology
a new procedure for studying attachment in infants.
She called it the "Strange Situation classification" and it's widely referred to as simply "The
Strange Situation". As an adult, you know when you formed an attachment
with someone. You know how it feels, And you know how to express your feelings
in words. However, when it comes to babies and young
children, they haven't yet developed these skills
and therefore researchers must turn to more subtle techniques.
Such as the strange situation, which measures the security of an attachment
in one-to-two year olds. A 20-minute participatory observation during
which the researcher observes the infant's behavioral responses to a series of scenarios.
Ainsworth's Strange Situation includes eight stages, each lasting roughly three minutes.
To start with the mother, baby and researcher are all together in the room,
A small, neutrally colored space with some toys for the baby to play with.
The experimenter leaves after around a minute and the mother and baby are alone for approximately
three minutes. In this stage
researchers are watching to see whether the child is confident to explore the new environment
or whether she :01:41.280 A stranger joins the mother and baby in the
room. The researchers record the baby's response to this unfamiliar newcomer,
who is left alone with the baby when the mother leaves the room.
At this stage, the researchers are observing the baby's behavior for signs of separation
anxiety. Three minutes later, the mother returns, and
the researchers observe for the baby's reunion response. The stranger leaves the room.
A few minutes more and the mother leaves the room too - leaving the baby alone for the
first time in the experiment. The next person to enter the room is the stranger,
and finally, after three minutes, the mother returns and

the stranger leaves, all in all a perfectly strange situation for all involved.

So, what were the researchers measuring? When the mother was in the room with the baby, they scored the infant's behaviour on four measures:

"Proximity and contact seeking". "Contact maintaining".

"Avoidance of Proximity and contact" and "Resistance to contact and comforting".

The baby's exploratory behaviors were also recorded as she explored the environment.

Ainsworth reported that infants display one of three attachment types:

Securely attached infants showed distress when separated from their mother, were avoidant of the stranger when alone, but friendly in the presence of their mother and were happy when the mother returned from outside the room.

70% of children studied fell into this category. 15% of children demonstrated an ambivalent attachment with their mother. These children showed intense distress when the mother left the room and demonstrated a significant fear of the stranger.

When the mother returned to the room, ambivalent children approached the mother but rejected contact. Ainsworth reported that a final 15 percent had an avoidant attachment style. Such infants show no interest when the mother leaves the room and play happily with the stranger.

When the mother returns, avoidant children barely seem to notice.

In 1990, Maine and Solomon added that a very small percentage were Inconsistent in their behaviors and defined this attachment style as "disorganized".

Ainsworth's "caregiver sensitivity hypothesis" suggests that differences in infant attachment styles are dependent on the mother's behavior towards the baby during a critical period of development.

This section is a prerequisite. You must complete this section in order to unlock additional content.

Indicators of maltreatment and abuse

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INDICATORS OF MALTREATMENT AND ABUSE

Schimmenti (2018) underlines how trauma constitutes a deep laceration for individuals that can impact on their psychological processes of conditioning, at multiple levels, and their functioning. In particular, it has consequences with regard to the concept of self, relational modalities and belief systems. Furthermore, the author points out that scientific studies have highlighted how often events that can be defined as traumatic are interrelated and that exposure to multiple traumatic experiences increases the risk of developing a psychopathology (cumulative trauma), especially if this occurs during childhood and, especially, in the context of family relationships. Curran and colleagues (2018) also highlight this aspect in the scientific literature, pointing out how this involves:

1. for children who have been victims of multiple traumatic experiences, an increase in the risk of experiencing depression and impotence (Arata et al., 2007);
2. on a longitudinal level in adulthood for subjects with stories of physical and psychological abuse, a decrease in self-esteem and coping skills compared to emotions (especially anger and aggression), an increase in deviant sexual behavior and difficulty in psychosocial adaptation (Sesar et al., 2010);
3. for victims of sexual or physical abuse, a higher risk of having psychosocial difficulties and displaying asocial or antisocial behaviour, chronic physical symptoms, anxious or depressive disorders, symptoms related to trauma and dissociation (Higgins & McCabe, 2000).
4. In addition, in adolescence, scientific research also shows an increased risk of development of delinquent behavior, substance abuse and self-harm, especially in individuals with PTSD or poly-victimization histories.

In general, research suggests, from an epidemiological point of view, the connection between trauma and severity of impairment; moreover, if suffered during childhood, it can have serious and debilitating consequences on the development of cognitive, emotional and social skills (Curran et al., 2018). One aspect that seems to have a particularly significant impact on the development and outcomes of traumatic experiences in childhood is the emotional neglect of attachment figures - particularly those with parental functions - for the child (Schimmenti, 2018). An adequate understanding of the mechanisms underlying individual variability in the psychological response to trauma is important both to identify children at risk of long-term distress and to structure appropriate and effective interventions (Ozer et al., 2003; Alisic et al., 2011). In particular, it is important to emphasize that children react to trauma in different ways than adults, in part because of their level of development and their skills including the management of mnestic content and emotional responses to events. Lonigan and colleagues (1998) had already stressed the need for scientific research to focus on the analysis of childhood reactions to trauma and the factors associated with it. One of the questions they raised was the need to investigate indicators - specifically valid and reliable for the child population and not simply borrowed from the conditions found in adult subjects - on normal versus psychopathological reactions of children to adverse events. An interesting area of investigation is, in fact, that concerning the distinction between typical reactions to trauma and those conditions in which it is possible to find a psychopathological response with a particular focus on which symptoms allow a differential vision between the two conditions and an improvement of the possibilities of effective assessment by clinicians (Lonigan et al., 1998).

The literature provides a lot of information on indicators of mistreatment and abuse, pointing out that these are often non-specific signals that should be read with care and caution, since they do not always point to maltreatment exclusively. In fact, it is necessary for the operators to improve their ability to grasp the child's suffering in the contexts in which they find themselves, offering them the appropriate conditions so that they can feel welcomed and helped to express their emotions and difficulties. Coupled with observation techniques, the operators can use grids of indicators to investigate the problem as much as possible. As an example, see the link to a document drawn up by CE.S.P.IM (Centro Servizi per il volontariato Provincia di Imperia) entitled "*Il Silenzio dei Passerotti. Project for combating and recovering abuse and mistreatment of children*", in which some examples of indicators of abuse and maltreatment can be viewed.

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Different types of Child Abuse

Transcripts
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Transcript

There are many forms of child abuse. Online abuse: online abuse is any type of abuse that happens over the Internet. This can be in the form of cyber bullying, grooming, sexual abuse and exploitation or emotional abuse, from people they know as well as strangers. Online abuse can occur solely online or in addition to occurring in the real world. As technology is everywhere, children and young people suffering from this form of abuse may feel trapped with nowhere to turn as it follows them everywhere they, go like their bedroom which is meant to be a safe place for them. Grooming: grooming is when an adult builds a connection with a child for the purpose of abusing and/or exploiting them sexually. This can be done online, in the real world, by a stranger or someone they know. Sexual abuse: sexual abuse is where a child is forced or persuaded into participating in any sort of sexual act, and does not have to be physical. Sometimes the child may not be aware what is happening is abuse or that what is happening is wrong. Physical abuse: physical abuse is deliberately hurting a child, thus causing injuries such as broken ribs, burns or cuts. They could be kicked, punched, slapped, poisoned, burned or have objects thrown at them. Babies can be shaken sometimes so violently it leads to their death.

Neglect: neglect is a continuous failure to

provide the most basic needs to a child. Children left to go hungry, unbathed or adequately clothed, sheltered and supervised are all examples of neglected children. Neglect can also occur in the form of a parent or carer not protecting a child from other types of abuse. Bullying:
bullying is behavior that hurts someone else such as name-calling, hitting, pushing, spreading rumors, threatening or undermining someone. This can happen anywhere, even in their own home, and often over a long period of time.
Emotional abuse, also known as psychological abuse, when a parent or carer is constantly maltreating or neglecting
a child emotionally, which can involve deliberately trying to scare or humiliate a child or isolating or ignoring them. Harmful sexual behavior:
children and young people who develop harmful sexual behavior harm themselves and others by using sexually explicit words and phrases, inappropriate touching, using sexual violence and threats or engaging in full penetrative sex with other children or adults. Child sexual exploitation is another form of child abuse. Children and young people being sexually exploited are vulnerable people who have been tricked or manipulated into believing they're in a loving, safe relationship. They may be offered money or other rewards only to be trafficked into slavery. They may have been groomed online and become totally dependent on their abuser, making it even harder to leave.
Trafficking children is also child abuse. Children can be trafficked for cheap labor, sexual abuse, domestic servitude, benefit fraud and forced marriage.

Transcripts

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CORRIGENDUM: in the previous video, at 0:45, the lecturer says "psychological violence" while meaning "physical violence".

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Previous Next

Transcript

We are discussing child maltreatment and abuse, and before accessing what
the consequences of a traumatic event or exposure to specific forms of violence
according to behavioral indicators are, we will briefly mention the
categories of victimization in the area of abuse. Let's start from the international classifications:
first there's psychological abuse, also called "Emotional abuse" \ "Psychological abuse",
then there's physical abuse, and finally sexual abuse.
(CORRECTION: Physical) abuse is the exposure to forms of violence characterized
by physical harm which the child goes through; this is therefore
a very strong traumatic event, since it impacts on development; we will shortly see
which ones I'm referring to specifically. When speaking about forms of
psychological violence, we're referring to insults, denigrations, social isolation
and neglect; these are forms of violence that are less visible, but
which have a psychological impact nonetheless, and therefore constitute a traumatic event in the long term.

Finally, sexual abuse refers to all those acts related to victimization

which are linked to physical exposure to sexual violence, incest,

touching, or inappropriate touching on behalf of those who care for the child in a protected situation.

Let's analyse the consequences related to abuse

and violence against a child, taking into consideration both

behavioural and emotional indicators. The consequences that the child encounters

during his\her development are for example,

disturbances in the perception of the body, and therefore in his\her own body image;

the child cannot understand whether his\her body belongs to a child or an adult, because it has been eroticized

since a young age. Other consequences are chronic sleep-related difficulties; in other words, the traumatic event has

an impact on the regulation of the sleep-wake rhythm. Then there's attention disorders,

and difficulties in concentrating and paying attention when in school.

If the child is younger than 3-5 years old, there may also be evacuation disorders.

During adolescence, other manifestations of discomfort

that the child or young person may express are eating disorders,

including anorexia and bulimia, acts of explicit aggression towards

all subjects who tend to express a behavior of an attentional nature towards the child

(the child may defend himself with explicit aggression). Finally, acts of self-harm,

precisely because there is an inherent suffering, internal to the child

caused by the traumatic event; the child then reacts by causing harm to him/herself as well as other subjects.

These are some of the consequences of exposure to traumatic events in infancy,

childhood and adolescence, but many more are the ones investigated by literature:

learning difficulties, isolation and anti-social behavior

such as use and abuse of alcohol and drugs, promiscuous sexual behavior, exposure to

particular sexually transmitted diseases.

Therefore, this makes us understand how a normal developmental trajectory is not obtained

because those who care for the child and should have the function of child-carer

tend to express these forms of physical abuse previously established

linked to beating and voluntarily inflicting pain to the child, or sexual abuse,

that is, by eroticizing the body of the child for personal outbursts, or psychological abuse

such as humiliating, isolating and denigrating the child. All this has a traumatic impact on the child with the consequences we have just explored. These consequences are therefore indicators of a behavioral but also emotional nature and express a discomfort that the child experiences at a specific time and on which it is necessary to intervene early, before the consequences become increasingly traumatic and inherent in the development of the personality of the subject, with, of course, consequences of a psychopathological nature.

This section is a prerequisite. You must complete this section in order to unlock additional content.

Knowledge check

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VIEW UNIT IN STUDIO

Quiz 4.3

4 points possible (graded)

1. Observation is defined as (Mantovani, 1995):

- ○ An intermediate moment between a phenomenon and its interpretation
- ○ A form of detection aimed at exploring a given phenomenon
- ○ The description of a species in a catalogue
- ○ An objective and faithful way to record reality

2. During observation, an important factor is:

- ○ To avoid involvement in the interaction with the object of observation at all costs
- ○ To always use structured observation tools
- ○ To avoid being influenced by prejudices and preconceptions
- ○ The speed of judgment

3. In a minor, the presence of indicators and signs associated with maltreatment and abuse...

- ○ Should be considered without taking behaviors into account
- ○ Can be deduced through the observation of emotions and behaviors
- ○ Corresponds, in any case, to situations of maltreatment and abuse.
- ○ Results in the immediate forfeiture of parental responsibility.

4. According to Schimmenti (2018), traumatic experiences...

- ○ Increase the probability of developing mental illness, especially when the subject is subject to multiple exposures (cumulative trauma).
- ○ Are always easy to overcome by talking to friends and family about the event.
- ○ Do not cause any damage at all if they are experienced as a single event, thanks to neuroplasticity
- ○ Should be repressed by trying not to think about them.

Invia

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SUBMISSION HISTORY STAFF DEBUG INFO

This subsection is unlocked for learners when they meet the prerequisite requirements.

Learning objectives

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VIEW UNIT IN STUDIO

Learning objectives

- know briefly the socio-cultural and legal process that led to the worldwide and European recognition that children are subjects of rights and that States have an obligation to intervene promptly and effectively for their protection in case of violence, abuse or negligent treatment
- know the fundamental rights and principles set by the international and European legal framework on children's rights within which the Trauma Informed Care (ICT) can be applied. Specific attention will be devoted to the right of children to be informed and to take part in the decision affecting them, their care and their future after leaving care
- know and understand the legal instruments that guarantee the participation of traumatized children in proceedings (administrative and judicial) in which decisions are made for their protection (e.g. the right of the child capable of forming his or her own view to be heard and, in some cases, the duty to seek his or her consent)
- understand the operational effects of the children's rights based approach (and specifically of children's participation rights) on social and health policies
- know and master the legal terminology.

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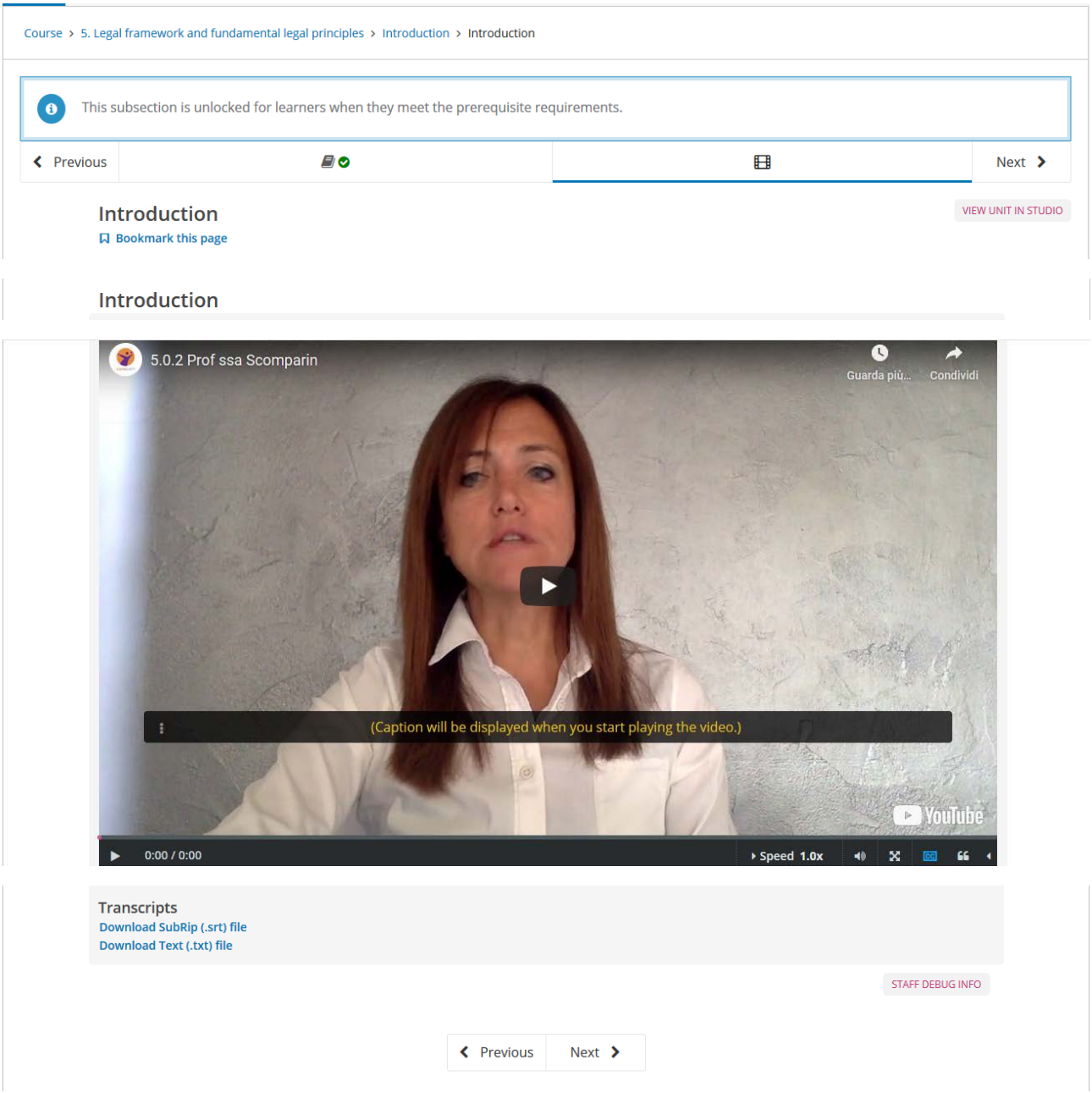

Transcript

The objective of this module is to examine the regulatory framework and the fundamental legal principles of Trauma Informed Care.

At the end of the module, it will be necessary to use correctly concepts such as abuse, mistreatment, prejudice, and abandonment.

The specific educational objective of this module is to understand the cultural and legal process that led, at global and European level, to the recognition that minors children are subjects of right and that there is there is an obligation for States to intervene promptly and effectively to protect them.

In this module, you will also learn the fundamental rights and principles established

by the international and European regulatory framework in the field of children's rights,

a framework that is fundamental for Trauma Informed Care.
In particular, you will focus on the right of children to be informed and
to be heard in proceedings concerning their assistance, care
their assistance, care the State has taken over.
You will also understand the measures
that guarantee the participation of minors, who have suffered abuse,
in decision-making procedures, whether administrative or judicial, concerning
their protection;
we will, therefore, focus on the right of the child
to be heard and on the duty, if necessary, to obtain his/her consent
to activate a protection measure.
The final part of the module will be dedicated
to the impact on social and health policies of the children's rights based approach,
through a general overview and some
case studies; for example, this part will focus on the analysis of the policies
against female genital mutilation and against the use of corporal punishment
in the family, or on the policies that many countries
have adopted to appoint a guardian for the care of abandoned foreign minors.

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Legal glossary on childhood trauma

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Legal glossary on childhood "trauma"

The term "trauma" is not commonly used in legal language.

The International Convention on the Rights of Children and Adolescents (CRC), for example, plans to "protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse" (Art. 19).

ABUSE and MALTREATMENT:

The Council of Europe defines as child abuse: "the acts and shortcomings that seriously disturb the child, threaten his bodily integrity, his physical, intellectual and moral development, whose manifestations are neglect and / or physical and / or mental and / or sexual injuries by a family member or others who care for the child" (IV Criminological Seminar - Strasbourg, 1978)

The World Health Organisation states that: "for child abuse and maltreatment (child abuse, maltreatment) all forms of physical and / or emotional ill-health, sexual abuse, neglect or negligence or commercial exploitation or anything else that involve a real or potential prejudice for the health of the child, for its survival, for its development or for its dignity in the context of a relationship characterized by responsibility, trust or power" (World Health Organisation, World Report on Violence and Health, 2002).

Both abuse and maltreatment can take the form of:

- active behaviour (for example, beatings, injuries, sexual acts, exploitation)
- omissive behaviour (for example, carelessness, negligence).

The absence of physical traumatic evidence does not exclude the hypothesis of mistreatment or abuse. For example, the conduct of the teacher / parent who humiliates, devalues, denigrates or psychologically violates a child or makes a threat may constitute abuse, when it consists of psychological violence that may cause damage to the child's psycho-physical health and may undermine their dignity.

The terms **VIOLENCE** and **EXPLOITATION** usually refer to active behaviours carried out against the child.

Exploitation, in particular, may be of economic or sexual nature

Article 32 (CRC): "States Parties recognise the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development."

Article 34, par. 1 (CRC): "States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse."

The United Nations Committee for the Rights of the Child determines that "violence" means "all forms of physical or mental violence, injury or abuse, negligent or neglectful treatment, abuse or exploitation, including sexual abuse". In common language the term violence is often used to designate only physical damage and/or intentional damage. However, the Committee places a strong emphasis on the fact that the choice of the term violence in this general comment should not be interpreted in any way as to minimise the impact or the need to deal with non-physical and/or unintentional forms of damage (such as, among others, abandonment and psychological mistreatment) (The right of the child to freedom from all forms of violence, General comment no. 13 (2011) CRC / C / GC / 13, 18 April 2011).

Finally, the expression **STATE OF ABANDONMENT** refers to a situation of serious and permanent inadequacy of the parents to take care of the child due to negligence, serious violence or exploitation.

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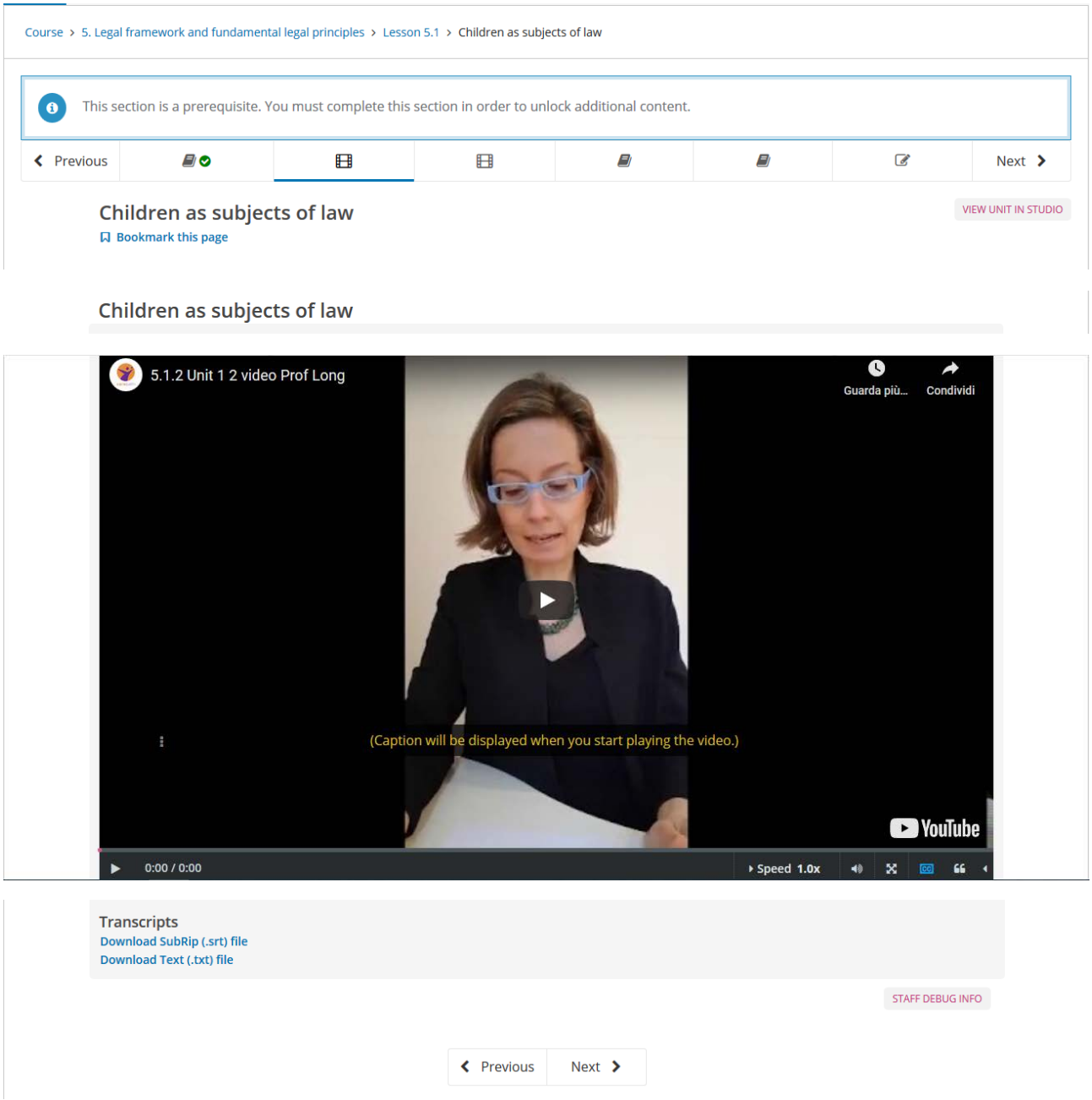

Transcript

Good morning. The objective of this video is to provide some elements of knowledge on

the cultural and legal process that led, on the one hand, to the recognition

that are also subjects of rights; they are holders

of the rights usually recognised to every human, as well as the rights

di essere soggetti in formazione; specifically granted to them;

secondly, the path that led to the recognition of the existence of a State duty

to intervene to protect and promote the rights of children who

are victims of violence and mistreatment. To contextualise the topic, I will read a few

lines from a 2006 book, entitled “Life and the Rules”, published by Feltrinelli

in Italy. Its author is Stefano Rodotà, an Italian jurist and politician, who was one of the authors of the European Charter of Fundamental Rights. Rodotà writes:

“the legal rule cannot be thought of as what removes pain from the world, but as one of the criteria that mark the tolerable pain threshold, personally and socially”.

I think that this text helps provide us with a background to the theme of the State's reaction to child abuse as highlights, above all, that law is not omnipotent. This means that even if there are legal rules that repress violence and abuse against children and that try to prevent them, this does not mean, unfortunately, that violence and mistreatment do not occur in practice. In addition to this, it must be admitted that in practice, when this violence and mistreatment do the State is not always able to activate a timely and efficient intervention.

In addition, the brief lines of Rodotà’s text help us to reflect on the threshold for State intervention, in general for the protection of subjects who are in serious hardship and then, specifically, in support of children who are victims of mistreatment. Here, this threshold can be identified in the attack itself, in the violation of human dignity. Therefore, the State must intervene when the pain threshold is so high as to compromise the very dignity of the human being and the rationale of State intervention in these cases must be identified in the general duty of social solidarity, protection of individual liberties and specific protection of vulnerable individuals.

Let us turn now to the fundamental stages of this journey which has seen us identify the child as a subject of rights and has led to the recognition of the State's duty to protect children who are victims of abuse.

An initial fundamental date can be identified as the year 1874. In that year in the city of New York, United States, a trial took place against the mother of a child named Mary Ellen Wilson.

The case of Mary Ellen Wilson was one which raised a great deal of uproar as it highlighted the lack of existence of a public child protection system system and it was precisely this case that led to the creation of the first charity specialising in the subject: the New York Society for the Prevention

of Cruelty to Children. What were the circumstances of this case?
Neighbours had
reported to a Methodist missionary named Etta Wheeler that a child thought to be
5 years old (Mary Ellen, who was, in fact, 10 years old) was a victim of abuse
by her mother. Etta Wheeler entered the house under the pretence of requesting help for a neighbour
with a chronic disability. Under the excuse of requesting help from a neighbour,
Etta Wheeler entered the home of Mary Ellen's parents and thus personally verified
the situation of the child, who was actually a victim of abuse,
both of physical nature, as she presented burns, bruises, cuts to her body and even clothing
not suitable for the season, and also of psychological mistreatment, as the child,
for example, was locked in a closet for many hours a day
and could not go out into the street, except into the building's courtyard at night time.
Etta Wheeler contacted the local authority and asked them to remove the child
from the family home. However, the the local authorities refused, in the absence of a legal framework
that allowed for such removal. Etta Wheeler did not, however, give up: she requested and obtained
assistance from a lawyer specialising in protecting animals from cruelty and,
using this regulatory framework, she achieved the aim of removing the
child from the house. In 1874, the trial took place which ended
with the mother being sentenced to one year's imprisonment for the mistreatment suffered by Mary Ellen.
Some time later, another significant date in the process of affirming
children’s rights arose: 1924. This time we move to Europe, to the city of Geneva.
The League of Nations proclaimed the Charter, known as the “Geneva” declaration,
the Declaration of the Rights of the Child. This was still a Charter which focused strongly
on the material and affective needs of children, in which children were essentially seen
as passive recipients of rights. To give an example, the Declaration stated:
“The hungry child must be fed; the sick child must be treated”.
We would have to wait a few decades to reach a new Charter, the Universal
Declaration of the Rights of the Child, New York Declaration of 1959, this time in the context
of the United Nations. In this document children are recognised as
legal subjects, and the concept is thus introduced that children, like
every human being, can hold rights directly. In the first principle,
for example, we read: “the child must enjoy all the rights set forth in

this declaration". The third principle states: "the child has the right,
from birth, to a name and a nationality". This formulation of rights
was then taken up worldwide in most famous document on Children's Rights,
the United Nations Convention of 1989.
I have emphasised the word "convention"
as this was the first important change compared to the documents of 1924 and
1959. The 1989 Convention is a document that is binding for the States that
ratified it, unlike a Declaration which is an act having merely
programmatic and, therefore, persuasive efficacy for its recipient states.
The 1989 Convention is also noted for establishing a monitoring and control mechanism
centring on the Committee on the Rights of the Child which is based in Geneva and which
examines the periodic reports presented by Member States on the implementation
of the Convention within their national legal systems. Insofar as the Convention is concerned,
the child is granted all rights generally recognised by international charters
to humans, in addition to some specific rights pertaining to children as subjects
in formation. In relation to child maltreatment, it is worth noting, in particular, Article 19,
which protects "the child against all forms of violence" within the family;
then, Article 34, "Protection against exploitation and sexual violence"; Article 35 "child protection
against kidnapping, sale and trafficking"; Article 37 "protection against torture, inhuman and cruel
treatment";
and then Article 39,
which is very significant as it establishes that:
"States Parties shall take all appropriate measures to promote physical and psychological recovery
and social reintegration of a child victim of abuse."

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The Mary Ellen case

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The case of Mary Ellen

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Reading material

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CASE OF Z AND OTHERS v. THE UNITED KINGDOM

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UN Convention on the Rights of the Child

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Knowledge check

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Quiz 5.1

5 points possible (graded)

Quiz 5.1

1. In legal language, which of the following is considered "trauma" to childhood?:

- ○ any form of physical and non-physical violence, even if not committed with the intention of procuring it
- ○ only physical violence, committed with the intention of procuring it
- ○ only physical violence, even if not committed with the intention of procuring it
- ○ any form of physical or non-physical violence, if committed with the intention of procuring it

2. In the case of Mary Ellen Wilson the victim of child abuse received protection in application of:

- ○ prohibition of animal cruelty
- ○ prohibition of inhuman and degrading treatment
- ○ prohibition of corporal punishment
- ○ ban on child abuse

3. Which of the following statements is true?

- ○ Children are not subject to rights
- ○ Children hold specific rights granted to them as trainees
- ○ Children have only rights recognised to every human person as such
- ○ Children are subject to rights if they have the ability to discern

4. Which of the following represents a specific instrument developed within the Council of Europe for the protection of the child?

- ECHR
- European Social Charter
- Charter of Nice
- Lanzarote Convention

5. In the judgment of the ECHR Z. AND OTHERS against UNITED KINGDOM, which of the following is recognised?

- Article 5 of the ECHR (Right to freedom and security)
- Article 6 of the ECHR (Right to a fair trial)
- Article 3 of the ECHR (Prohibition of Torture)
- Article 8 of the ECHR (Right to respect for private and family life)

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Legal glossary on international and UE's organisations and treaties

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Legal glossary on international and European Union organisations and treaties

United Nations (UN) = international organisation founded in 1945, with the aim of maintaining international peace and security, developing friendly relations among nations, cooperating in resolving international problems and promoting respect for human rights; it represents a centre for the harmonisation of the various national initiatives. The members of the UN are sovereign states; the United Nations is not a world government and does not legislate.

However, the UN provides the means to help resolve international conflicts and formulates appropriate policies on issues of common concern.

International Convention on the Rights of the Child (CRC) = international treaty approved by the General Assembly of the United Nations in 1989 which expresses a consensus on the obligations of States and of the international community towards children and recognises for the first time that children also enjoy civil, social, political, cultural and economic rights .

UN Committee on the Rights of the Child = established by the UN Convention on the Rights of the Child in order to examine the progress made by the States Parties in executing the obligations deriving from the treaty, it is composed of 18 experts of high morality and in possession of recognised expertise in the sector covered by the Convention. The task of the Committee is to analyse periodic reports on the implementation of the Convention which the States Parties are committed to presenting on the basis of the provisions of art. 44 of the Convention.

European Convention on Human Rights (ECHR) = international treaty by which the member states of the Council of Europe guarantee fundamental civil and political rights not only to their own citizens but also to anyone under their jurisdiction. Signed in Rome on 4 November 1950, the Convention entered into force in 1953.

European Court of Human Rights (Strasbourg Court) = International court established in 1959 with headquarters in Strasbourg. It rules on individual or state appeals concerning alleged violations of civil and political rights established by the European Convention on Human Rights. Since 1998, the Court has been a permanent body and can be approached directly by individuals.

Council of Europe = international organisation whose purpose is to promote democracy, human rights, European cultural identity and the search for solutions to social problems in Europe. Founded on 5 May 1949 with the Treaty of London, it is based in Strasbourg and includes 47 Member States, including the 28 members of the European Union.

Watch out! The Council of Europe is outside the European Union and should not be confused with its bodies.

Council of Europe Convention for the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention) = treaty by which member states agree to criminalise certain forms of sexual abuse of children. It is the first international treaty that deals with sexual abuse of children taking place within the family.

Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) = international treaty that aims to prevent violence, promote the protection of victims and prevent impunity for perpetrators. It is the first legally binding international instrument to create a comprehensive legal framework to protect women against any form of violence.

European Union = economic and political organisation between 28 countries of the European continent, created after the Second World War with the aim of promoting greater economic cooperation between Member States; over time, it has become an organisation aimed at establishing the foundations of a Union among the European peoples, safeguarding the countries and seeking political unity, guaranteeing, through joint action, economic and social progress, such as the creation of a single European market and the strengthening of social cohesion.

Charter of Fundamental Rights of the European Union (Charter of Nice) = proclaimed during the Nice European Council of 20 December 2000, it collects all civil, political, economic and social rights valid within the European Union and establishes the fundamental nature and scope of human rights for EU citizens. Although it became legally binding only following the entry into force of the Lisbon Treaty, it inspired, from its origins, the activity of the European Parliament. With the entry into force of the Lisbon Treaty, the *Charter of Nice* has the same legal value as the treaties and is therefore fully binding for the European institutions and the Member States.

Court of Justice of the European Union (CJEU - Luxembourg Court) = established in 1952, it is based in Luxembourg and interprets EU law to ensure that it is applied in the same way in all Member States and it settles legal disputes between national governments and EU institutions.

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CHILDREN'S RIGHTS

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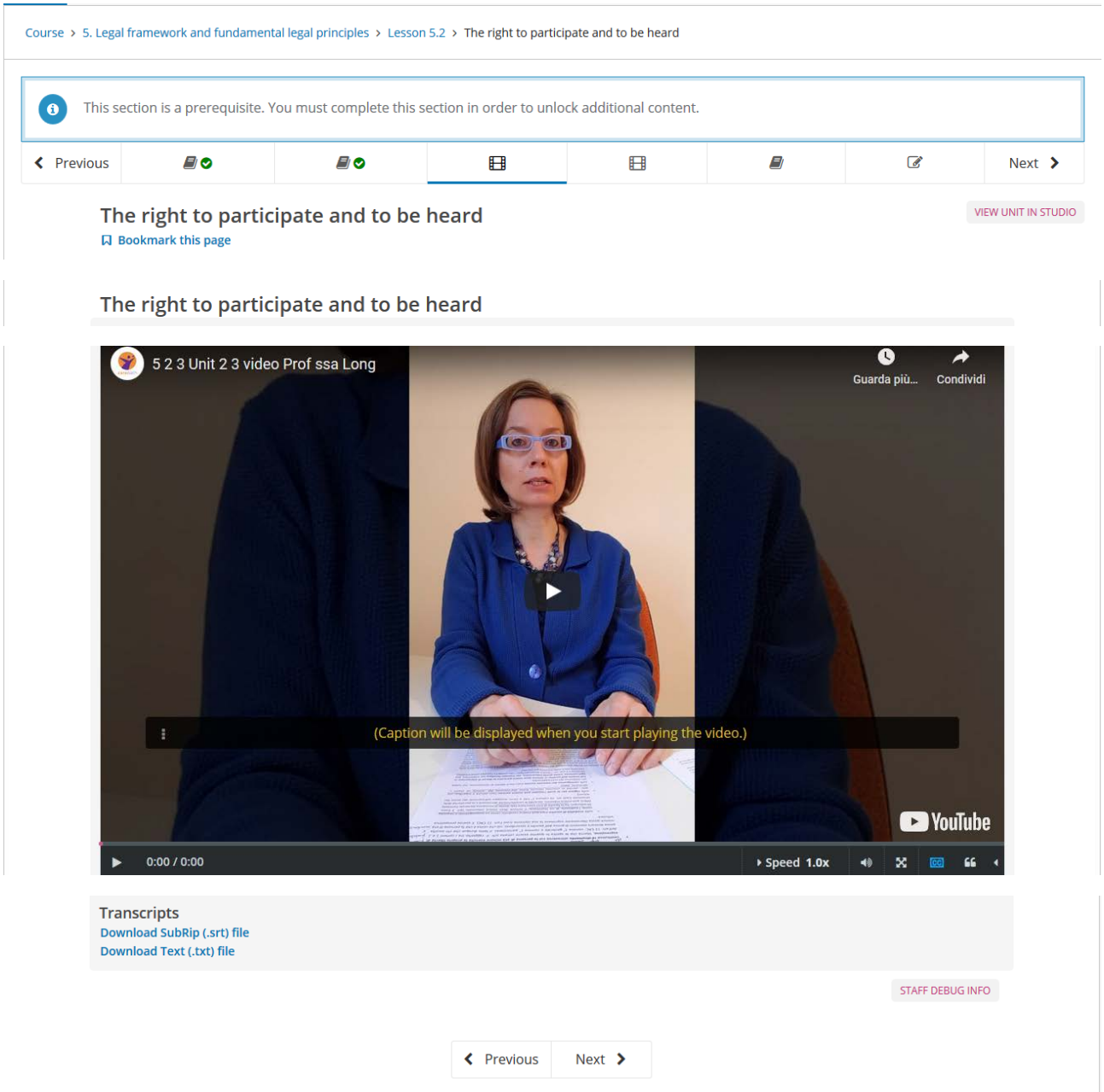

Transcript

Good morning.

One of the pillars of the United Nations Convention on the Rights of the Child and, more generally, one of the principles opening the way to the realisation of children's rights is the participation of children and young people in procedures which result in decisions that could influence significantly their lives.

The UN Convention on the Rights of the Child recognises the right of the child, as a human being, to freedom of expression in Article 12, paragraph 1; and, in the next paragraph, it identifies one of the instruments that guarantees the child's participation

in the procedures, in particular, the right to be heard, by the judge or by the other administrative authorities that are to make decisions in the interest of the child.

However, being heard is not the only tool that guarantees the child's participation in the decisions concerning him/her.

The European Convention on the Exercise of Children's Rights, which specifically concerns judicial procedures, at Article 3 recognises the right of the child to "receive all relevant information" and, at Article 4, recognises the right of the child to "request [...] the designation of a special representative" and "if there is a conflict of interest between the persons exercising parental responsibility and the child, who operates, precisely in the judicial procedures".

What does it mean in practice to refer the child's right to be heard heard to his freedom of expression?

It means that, while it may be true that the decision-maker when listening to the child could obtain useful information for the final decision, this preliminary process of being heard is subordinated to the main value of being heard, which is to guarantee to the person the possibility of expressing himself/herself on a theme that is so important to his/her life.

There are some practical consequences that concern, for example, the methods of being heard: this means that this process cannot be conducted as an interrogation or as a hearing of a witness.

It also means, for example, that the child may refuse to be heard by the judge

Since being heard is a right, the right holder may choose not to exercise it.

Well, as regards the reasons why it may be impossible to proceed with being heard: the fact of not having heard a child cannot be motivated by claiming that this hearing was superfluous in the specific case.

The only reason why hearing the child could be ruled out is that being heard being heard would be contrary to the interests of the minor

Another of the pillars of the UN Convention on the Rights of the Child is in fact the protection of the child and the protection pillar must be balanced with the rights of the child to participate in procedures concerning him/her.

We find this need for balancing also in the role played by the will expressed by the child when being heard in the final decision taken by the authority.

The authority, in fact, cannot be considered bound by the will expressed by the child.
In fact, the authority may believe that the will expressed by the child is actually
contrary to his/her interest.
Consider, for example, a minor who, in the context of a civil procedure
concerning family maltreatment, insists on seeing the parent or, more
generally, the abusing adult.
In this case the authority may well deny
the visits and continue suspending the same even if this is contrary to the will expressed by the child.
This is different, therefore, to what happens in the case of adults.
Adults have the right to refuse medical treatment
even if death may result from that refusal.
This is not the case for a minor because, as I have noted, the right to participate,
and in general the right to self-determination, must be balanced with the principle of
the best interests of the child.
However, the need for balance requires the judicial authority and, in general, the
authorities that make decisions about the child's life, to inform the child of the decision
taken and also to motivate specifically the reasons why it was not possible
to adhere to the will expressed by the child himself or herself when being heard.

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The children act

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INTRODUCTION TO THE FILM "THE CHILDREN ACT"

The main characters of the film are Adam, a seventeen year old boy who refuses a life-saving blood transfusion for religious reasons in agreement with his parents, and Fiona Maye, an English judge in the field of family and minors, called upon to decide whether to authorise the doctors to proceed with the blood transfusion regardless.

The film allows us to reflect on two distinctive features of the discipline of minor rights to hearing, found in Art. 12 of the United Nations Convention of Child Rights (CRC).

- **Hearing is the means through which the minor exercises his own freedom of expression**. In fact, Fiona meets Adam because she wants to "know" him and does not "hear" him through the method of an interrogation or a witness hearing. She does not limit their meeting to looking in-depth at the reasons for his decision to refuse the transfusion but chats with him touching upon different topics, such as music and poetry.
- **Moreover, the hearing does not bind the judge to the minor's will. In fact, in the film Fiona decides to act against Adam's will.** As opposed to the adult – who has the right to decide on his own life even if that decision leads to death (e.g. typical of the refusal of a life-saving blood transfusion for religious reasons) – the minor does not hold this right in all cases: Art. 12 of the United Nation Convention of Child Rights (CRC) establishes that whoever decides has to take into consideration the minor's opinion along with growth based upon their age and maturity level, but this is not binding for the judge. Indeed, if the judge or the person called upon to make a decision regarding a minor believes that the will expressed during the hearing does not conform to the minor's interest, not only has he the right, but he must decide in the opposite manner.

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The children act

Transcripts

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Handbook on European law relating to the rights of the child

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Handbook on European law rights relating to the rights of the child

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Knowledge check

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Q5.2

5 points possible (graded)

Quiz 5.2

1. Does corporal punishment to the detriment of the child include?

- ○ Also non-physical actions, such as threats, aimed at the humiliation of the child
- ○ Only physical punishment intended to cause pain to the child
- ○ Exclusively physical punishment intended to cause pain or discomfort to the child
- ○ Physical or non-physical actions, except those carried out to educate children

2. Which of the following statements is false?

- ○ Unjustified differentiation by age is prohibited
- ○ Underage people have the right, as such, to differentiated treatment based on age
- ○ The treatment of children must be inspired by the principle of the best interests of the child
- ○ All treatments differentiated by age are prohibited

3. Which of the following statements about the child being heard is true?

- ○ It may be conducted like the hearing of a witness, but not as an interrogation
- ○ It must be guaranteed only in judicial and administrative procedures that concern him/her
- ○ It may be excluded when the child's opinion is superfluous
- ○ It must be guaranteed only in judicial and not in administrative procedures that concern him/her

4. For the case where the child is heard, is the opinion of the child binding for those who decide?

- ○ No, but the decision maker must take this into account
- ○ Yes
- ○ No, the decision maker can disregard it
- ○ Yes if the child has a high degree of maturity

5. In the judgment of the ECHR Z. AND OTHERS against UNITED KINGDOM, which of the following is recognised?

- ○ Article 5 of the ECHR (Right to freedom and security)
- ○ Article 6 of the ECHR (Right to a fair trial)
- ○ Article 3 of the ECHR (Prohibition of Torture)
- ○ Article 8 of the ECHR (Right to respect for private and family life)

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Legal glossary on the participation of children

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Primary victimization = abuse or violence, which causes suffering and physical and/or psychological injuries.

Secondary victimization = further suffering caused by the stress of the proceedings itself, by the memory of the abuse suffered and by the possible contact with the author of the conduct, with the judge and with the lawyers.

Criminal proceeding = jurisdictional procedure through which the author of the conduct against the minor is punished, if his conduct is a crime.

Civil proceeding = jurisdictional procedure in which a judge assesses the adequacy of the child's family environment and takes any necessary measures.

Hearing of the minor = part of the civil/criminal proceedings in which the minor makes statements about the facts relevant to the judge's decision.

Consultation of the minor = part of the procedure (especially civil) in which the minor expresses his views, before the judge takes the decision.

Consent of the minor = further guarantee which consists in the obligation for the judge to obtain the favorable opinion of the minor in order to take a specific decision (for example, custody or adoption).

Representative = when parents are absent, unavailable, or in conflict of interest, representative is a person who identifies the interests of the child and protects them during the proceedings.

Lawyer = qualified person appointed to try to obtain a judge's decision as far as possible in accordance with the interests of the child. Social or health professional = expert in psychology, psychiatry or sociology, who assist the traumatized child during civil and criminal proceedings and help the judge to assess his psycho-physical conditions and his protection needs.

Precautionary measures = provisional measures, adopted by the judge, to protect the psycho-physical well-being of the minor, during the proceedings.

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Reading material

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The voice of traumatised child in civil and criminal proceedings

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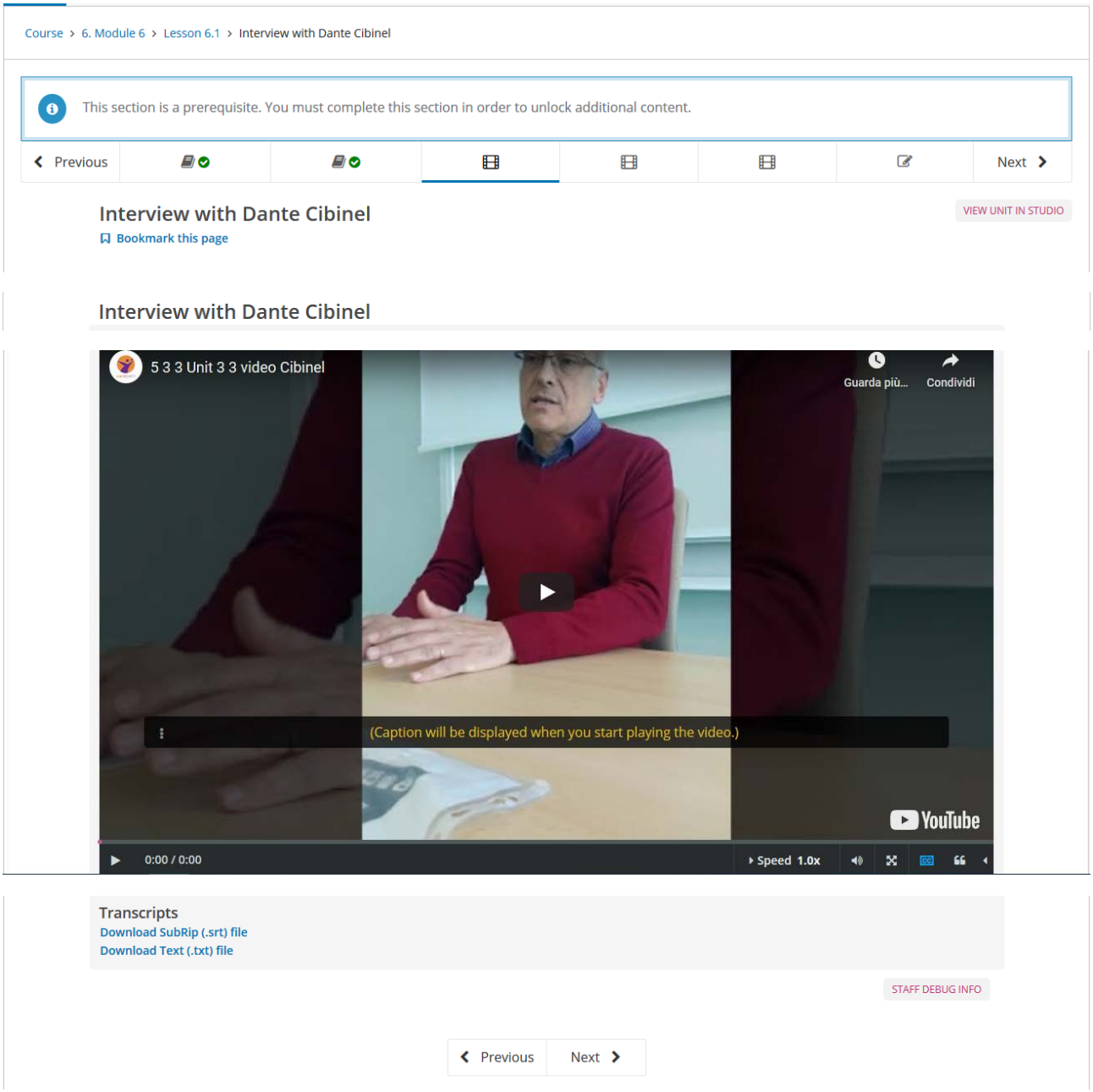


Transcript

The intervention of the Juvenile court for the protection of minors who are victims of abuse

takes place as follows: a request by the

public prosecutor is necessary, as the court does not act on its own;

the public prosecutor's request results from a report

by other persons of abuse suffered by a child

in the family environment.

These other persons, reporting the abuse to the public prosecutor,

are usually social services,

school authorities, or even police authorities

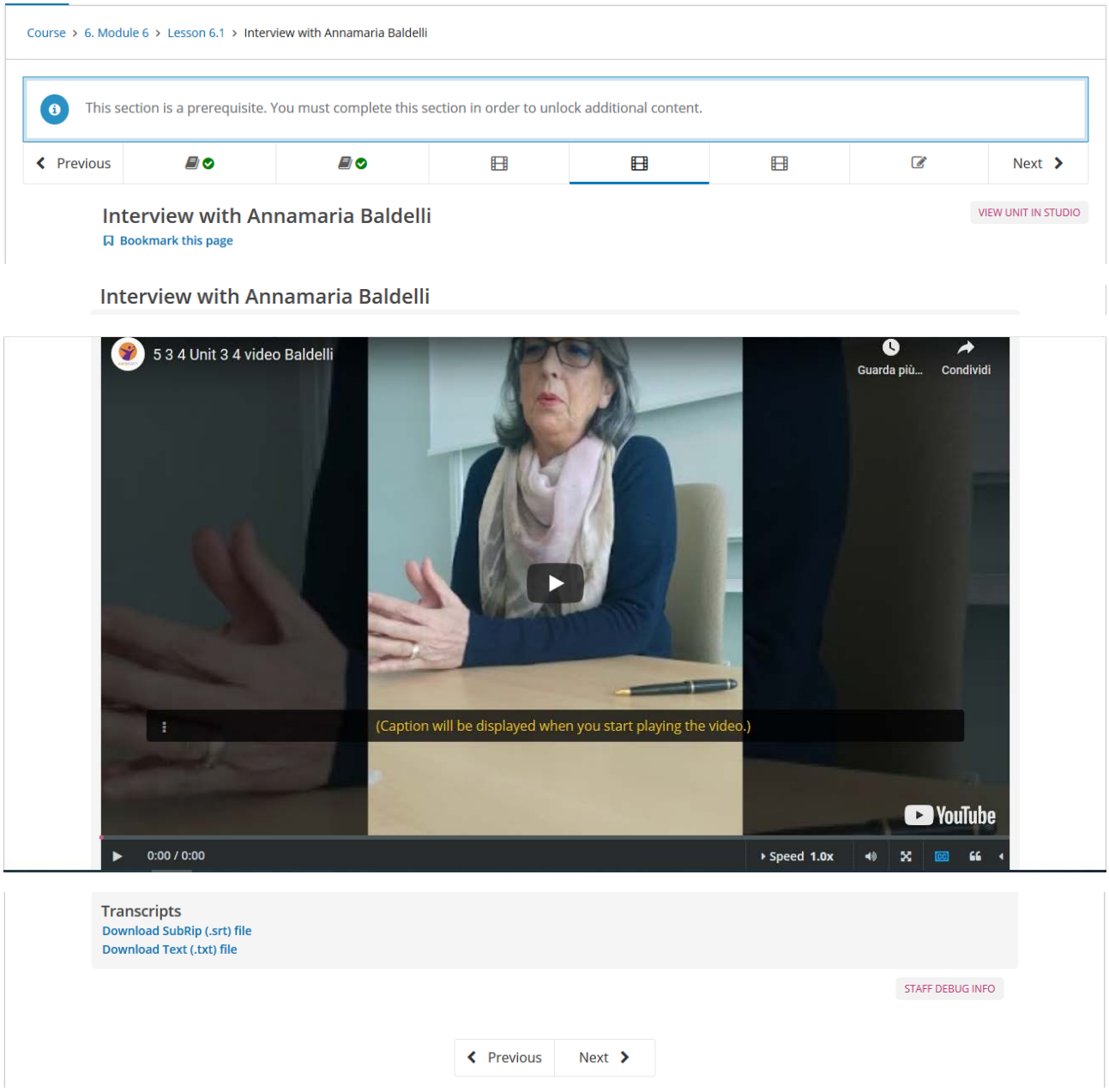
intervening when a crime is committed.
There is also then an intervention, obviously, by the criminal judicial authorities, but, very
often, when a crime has been committed, the interventions are simultaneous: the juvenile court
the interventions are simultaneous: the juvenile court and the criminal judicial authority
intervenes to ascertain the crime.
The Court's intervention is conditioned by the type of request by the public prosecutor.

There are situations in which the public prosecutor may request an immediate
and urgent intervention, in order to remove the child from his/her family environment;
or situations in which the public prosecutor
which the public prosecutor asks the court to carry out investigations to verify
the seriousness of the facts reported, their truthfulness
and gravity,and to identify the most appropriate measures to protect the child.
During these investigations,
or immediately after the removal order
- when the court found it essential to adopt it -
not only the reporting services are involved,
but also other services: the specialised psychology
services intervene and the parents themselves are necessarily involved,
although their intervention is obviously particular. However, the law states
that the parents must be heard prior to the court adopting definitive measures to protect
minors which would limit or
forfeit their parental responsibility,
if the public prosecutor has also requested this type
of decision.
has also requested this type of decision. these proceedings, if he/she is twelve years old or more,
or the judge considers him/her
capable of expressing his/her view.

Obviously it is an evaluation that the judge performs freely, in order to understand
the desires and also the real psychological situation of the minor.
I repeat: it is a real psychological situation of the child that is first

evaluated through the intervention of the specialised services which hear the child and report to the judge on what the child was able to say, also depending on his/her age.

This is a form of being heard which we can label mediated, performed by other persons having specific professional skills, which help the judge to take the decision.



Transcript

The juvenile public prosecutor has the task of activating the intervention of the

Family and Juvenile courts for the protection of minors.

Based upon this generic competence,

when a

crime involving the parents or other relatives of a minor is committed,

two problems immediately arise: the first problem is the coordination with the ordinary prosecutors,

who are responsible for the criminal proceedings, in order to avoid interference that

could damage the criminal investigations;

and the second problem is to collect information

about the prejudice suffered by the minor

and the

personal and family resources, possibly also of other relatives;

an appeal to the Family and Juvenile courts must then be prepared,

with adequate prospects for intervention.

The main difficulty is in containing the timescales,

as proceedings for the protection of the minor have their own timescales, but criminal proceedings also

have a duration that is not always governable. What we try to do

is to ask the police to report, simultaneously, both to the ordinary public prosecutor,

who is responsible for the criminal proceedings against the offender,

and to the juvenile public prosecutor, which holds the power to protect the victim of the crime,

in order to put these authorities in the position to coordinate promptly

and immediately, that is, from the very beginning of the investigation.

This method, also

supported by agreements between with the various prosecutors' offices, has allowed us to define

who does what, when and how, preserving the needs of

the criminal proceedings, but also the measures to protect the minor.

It may occur, especially when the child is admitted to hospital

and there is no disagreement between his/her parents on this admission,

that the protection intervention is delayed and therefore the intervention of the Family and Juvenile courts is delayed, as

the protection of the child is already ensured by

the hospitalisation, and the ordinary public prosecutor, responsible for theù

criminal proceedings against the offender, can carry out his/her own investigations

secretly and thus effectively.

If a decision

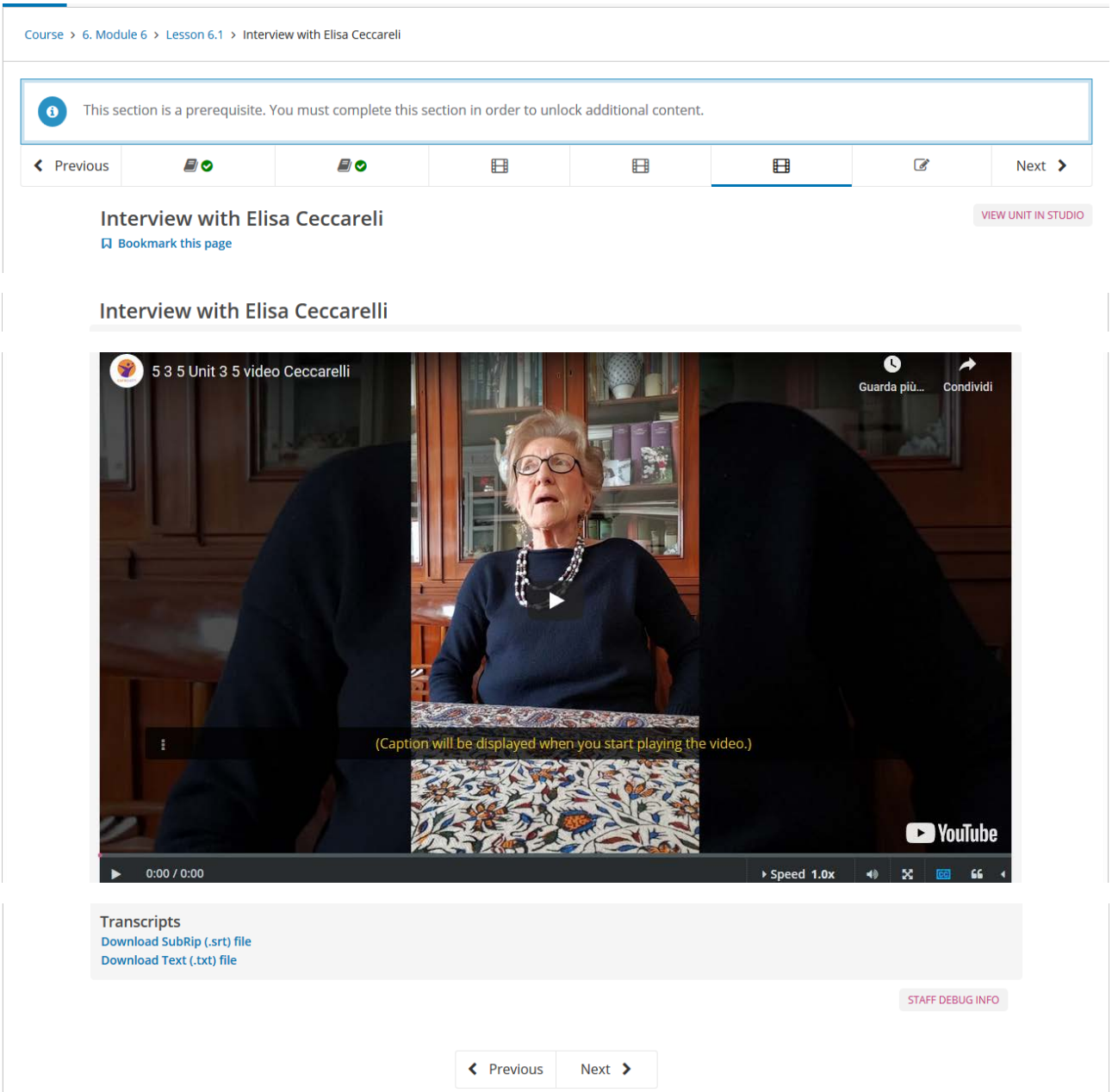
on the protection of the minor cannot be postponed, it may even be a colleague

at the office of the ordinary public prosecutor, responsible for the criminal proceedings, who issues an administrative protection order

through the police authorities, pursuant to article 403 of the civil code,

in order to protect the minor.

That temporary protection measure must then be ratified by the Family and Juvenile courts, with our appeal.



Transcript

I was a juvenile judge for many years and I often wondered what it meant

to hear children and teenagers.

I was never able to hear very young children, as I preferred their hearing to be conducted

in a different environment, by more competent people; in these cases, I only listened indirectly.

On the other hand, I heard many seven, eight, ten and eleven year old children.

They were, above all, children in extremely conflicting family environments, with parents who

did not decide to separate; separate, but in fact always united by conflicts

that had severe repercussions on their children.

What I always tried to communicate to the children
was first of all that there was a person
who was listening to them,
a person who had a specific task - to decide in the best way for them -
and that this decision
may even differ from what the children
wanted, from what they expressed.

The decision depends on the court, it depends on the judge. The judge has to decide;
so I will consider everything you tell me
and I will try to do
what is best for you.
However, the decision may not always
coincide with your wishes. This is something that always happens in life and
something you have to get used to.
I always tried to safeguard the positive aspects of the children's relationship with their parents.
In general, fathers are the
most aggressive in relationships with children
and they sometimes force children to do
things, thinking that this is useful in their conflicting relationship with their former partner.
I tried to
say: look at your father, he has nothing against you and it is right that you love your dad.
However, we know that he has some problems and that he does not accept the current situation.
In short, we must also be able to preserve the father figure.
Therefore, the judge must never adhere to the conflicting attitudes of the child;
however, it is also
necessary to safeguard
the possibility that the child may say
no, I can no longer stay with my father as he
does not understand.
I remember the case of a little girl who was ten years old with two parents;
her father was absolutely very pathological and the decision was:

okay we will wait for the dad to change, if he can change; and if he does not succeed in changing, it will certainly not be the child who will have to bear all this weight.

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Knowledge check

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Q6.1

7 points possible (graded)

1) Secondary victimization is caused by:

- ○ the stress resulting from minor's participation in the proceedings
- ○ the abuse that made necessary the intervention of the judicial authority
- ○ the stress resulting from the placement into a new family
- ○ the repetition of the abuse originally suffered

2) The principle of the best interests of the child:

- ○ applies only to criminal proceedings
- ○ implies that the judge must always take into consideration, above all other interests, the psycho-physical well-being of the child
- ○ applies only to civil proceedings
- ○ obliges the States to avoid the participation of the minor in the proceedings following the abuse suffered

3) The hearing of the child as a witness:

- ○ must always be performed by the judge
- ○ it is preferable that it is carried out in the last part of the proceedings
- ○ it is better that it is repeated at least twice, to test the reliability of the child
- ○ it is preferable that it is carried out at the beginning of the proceedings

4) The opinion expressed by the minor during the proceedings:

- ○ is not binding, but the judge must take it into consideration in order to decide
- ○ is always binding for the judge
- ○ is binding for the judge, but only if the minor is at least 14 years old
- ○ is binding for the judge, but only if the minor has a sufficient understanding

5) Criminal and civil proceedings following child's abuse:

- ○ are separate, but the civil one can start only after the penal one
- ○ are separate, but the civil one can only start if, in the criminal one, parents have been convicted
- ○ address different issues and have different purposes
- ○ have the same purpose and the same object

6) When does the judge order a precautionary measure?

- ○ at the end of the proceedings
- ○ before the beginning of the proceedings
- ○ during the proceedings, to protect the psycho-physical well-being of the child
- ○ during the proceedings, to ensure the reasonable duration of the proceedings

7) Extrajudicial procedures:

- ○ are applied when the relationship between the perpetrator of the abuse and the minor appears to be recoverable
- ○ are applied only when the abuse is serious
- ○ must always be applied
- ○ are applied only when the mistreatment isn't very serious

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Legal glossary on child policies

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Social services = range of services, provided by public or private bodies, which respond to collective and personal needs. While the term "services" means standardized services, universally provided to people as members of a category, "social services" respond to "specific needs" of the beneficiaries.

Social Services for children and families = series of measures and activities that meet the general or individual needs of a child and / or his family. These types of services are aimed at satisfying the different needs of children and families, such as specialized and intensive services .

Child-friendly social services = social services that respect, protect and realize the rights of every child, including the right of access to benefits, participation and protection and the principle of the best interests of the child. (Recommendation of the Council of Europe, November 16, 2011, No. 12, on the rights of children and social services for children and their families)

Child-friendly justice = judicial systems that guarantee the respect and effective implementation of all children's rights at the highest possible level, taking into account the degree of maturity and understanding of the child. It is an accessible justice, adapted to the age, rapid, diligent, adapted to the needs of the child and centered on them, in respect of the rights of the child, including the right to due process, participation and understanding of the proceedings, respect for private and family life, integrity and dignity. (See the Guidelines of the Committee of Ministers of the Council of Europe for child-friendly justice, adopted by the Committee of Ministers of the Council of Europe on 17 November 2010)

Early Childhood Education and Care (ECEC) = service offered to children from birth to primary education subject to a national regulatory framework and to compliance with a set of minimum standards and / or procedures for accreditation. The service includes private, public and volunteering services. European countries present different solutions to guarantee the education and care of children below the age of compulsory education. However, ECEC is increasingly becoming an integral part of education systems in Europe.

(See https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2011:0066:FIN:IT:PDF)

European Higher Education Area (European Higher Education Area - EHEA) = project that aims to achieve a process of convergence and strengthening of higher education or university studies in Europe. This process is in line with the strategies that the European Commission together with the Member States of the Union has launched in recent years to build a true Europe of knowledge and has the main purpose of promoting the mobility and employment of students, improving the quality and make education systems more competitive, attracting students (and teachers) from Europe and other parts of the world. The means to achieve this goal are the support for greater comparability and compatibility between the different systems and the different institutions of Higher Education in Europe, and the raising of their quality.(See https://ec.europa.eu/education/education-in-the-eu/european-education-area_en)

Child-friendly health care = health care policies and practices focused on children's evolving rights, needs, characteristics, resources and capacities, taking into account their opinion. (See https://rm.coe.int/168046ccef)

Child-friendly health care approach = integrated conceptual and operational framework that fully respects the rights and needs of children in the health sector.(See https://rm.coe.int/168046ccef)

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Reading material

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The impact of childrens' rights

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Role and functions of the Ombudsman

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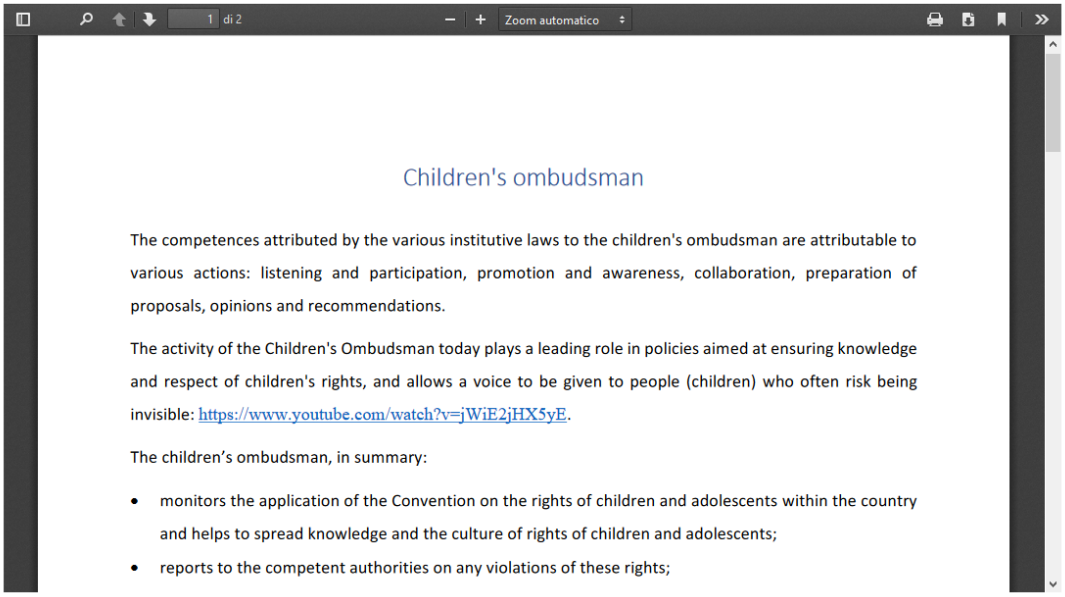
Children's Ombudsman



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Children's ombudsman

The competences attributed by the various institutive laws to the children's ombudsman are attributable to various actions: listening and participation, promotion and awareness, collaboration, preparation of proposals, opinions and recommendations.

The activity of the Children's Ombudsman today plays a leading role in policies aimed at ensuring knowledge and respect of children's rights, and allows a voice to be given to people (children) who often risk being invisible: https://www.youtube.com/watch?v=jWiE2jHX5yE.

The children's ombudsman, in summary:

- monitors the application of the Convention on the rights of children and adolescents within the country and helps to spread knowledge and the culture of rights of children and adolescents;
- reports to the competent authorities on any violations of these rights;

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External Video on participation

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External Video on participation

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The experience of a voluntary guardian of an unaccompagned child

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The volunteer guardian as the “voice” of the unaccompanied minor

Many minors are forced to leave their country and experience their childhood and adolescence away from home, separated from their families and with no family to ensure that their interests are being protected. The large majority of them have suffered traumatic experiences related to the migratory journey, to their life before it or to leaving their family.

In EU law, the *European Parliament and Council Directive, no. 2011/95/EU*, defines the unaccompanied minor (UM) as: *“‘unaccompanied minor’ means a minor who arrives on the territory of the Member States unaccompanied by an adult responsible for him or her whether by law or by the practice of the Member State concerned, and for as long as he or she is not effectively taken into the care of such a person; it includes a minor who is left unaccompanied after he or she has entered the territory of the Member States”.*

In many European judicial systems the figure of the volunteer guardian is becoming more prevalent. This is a private citizen, highly qualified, asked to legally represent minors who have arrived in the State territory alone and to ensure that their interests are protected, their needs listened to and their potential nurtured. The institution of the volunteer guardian represents, in other words, an example of active citizenship and thus a social policy instrument for minors.

Carlo Infuso, a lawyer from Turin, describes his experience as a volunteer guardian.

“I met V, my guardianee, in an absolutely ordinary situation: he was introduced to me by the Community who was hosting him. I met this boy and I must say that after the mutual introduction we did not know what to talk about. So, I got him on my motorbike and we went for a ride, we talked a little bit and we slowly started to build this relationship which has today evolved into something pleasant, full of mutual trust and enjoyable.

V. is finally starting his life here in Italy. He benefits from international protection and he will therefore have a residency permit when he turns eighteen and even later, as he has got a two year permit. We will ask permission for him to go on to finish his studies.

He is finally starting to understand the importance of learning the Italian language - which he did not realise before - for himself, his relationships with others and with me, with my friends, with the people he sees through me, who he is getting to know better. He is also learning the importance of studying to work as a waiter. He had thought that being a waiter just involved bringing food to the table but, instead, he is now learning to make cappuccino, the cappuccino with the drawing on top, to serve with double cutlery, from the left, from the right, to provide water glasses, glasses for wine, how to place the napkin, and so on. He is discovering little by little the pleasure of learning, learning for its own sake.

He is very funny. He is young, a teenager, and he is mad about music. He has an earring, a trendy haircut... just like any other boy.

Something that amazed me in my guardian role was the fact that he does not get involved with the guardian role. When a decision had to be made, for instance, about what to study and where, V. told me: “I don’t have any parents, you are my Italian father. You decide for me, because I know that what you decide for me will be fine”.

Today, after a few months, I’m glad that V can say: “I’m glad that we chose this study together, as I really like this school”.

The fact that I was able, perhaps through small daily things, to trigger in him a mechanism of confidence towards others, has allowed him to build some self-esteem and today V. is more able to make decisions that he would not have been able to make before, with more awareness, levity and so much more commitment than before.

It is a relationship that grows (between guardian and guardianee) and it is a relationship that can either go well or go badly. In our case, it went well and allowed us to build something.

I can happily say that V. is a guest in my home this weekend; tonight he will probably cook some food and we are all really happy.

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Knowledge check

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Q6.2

5 points possible (graded)

Quiz 6.2

1. In situations of domestic violence or in the case of conflict with parents, children and teenagers:

- ○ must have access to confidential medical advice and advice without parental consent if they are over 14 years old
- ○ must have access to confidential medical advice and advice without parental consent, regardless of their age
- ○ must have access to confidential medical advice and advice with the consent of their parents, regardless of their age
- ○ must have access to confidential medical advice and advice with the consent of their parents, if they have a high degree of maturity

2. The Bucharest Children's Declaration of the European Union is an instrument to mobilise the European institutions and the Member States to establish formal structures and mechanisms that promote the right of children and young people:

- ○ to be heard in any judicial or administrative procedure that concerns them
- ○ to receive or communicate information or ideas without interference from public authorities and without border restrictions
- ○ to benefit from particular protection and therefore to differentiated treatment on the basis of age
- ○ to participate in European Union decisions

3. When, according to the law, a child does not have capacity to give consent to a health intervention, this:

- ○ cannot be carried out
- ○ can be carried out even without the authorisation of his/her representative, authority, person or body designated by law
- ○ cannot be carried out without the authorisation of his/her representative, an authority, person or body designated by law
- ○ can be carried out even without the authorisation of his/her representative, authority, person or body designated by the law if it is possible to reconstruct the child's will

4. The video of the Council of Europe “Tell someone you trust” deals, through child-friendly methods, with the theme:

- ○ of sexual abuse
- ○ of bullying
- ○ of witness violence
- ○ of corporal punishment

5. The Children’s Ombudsman exercises:

- ○ incisive investigative powers
- ○ limitation and sanction powers
- ○ regulatory powers
- ○ powers of moral persuasion

Invia

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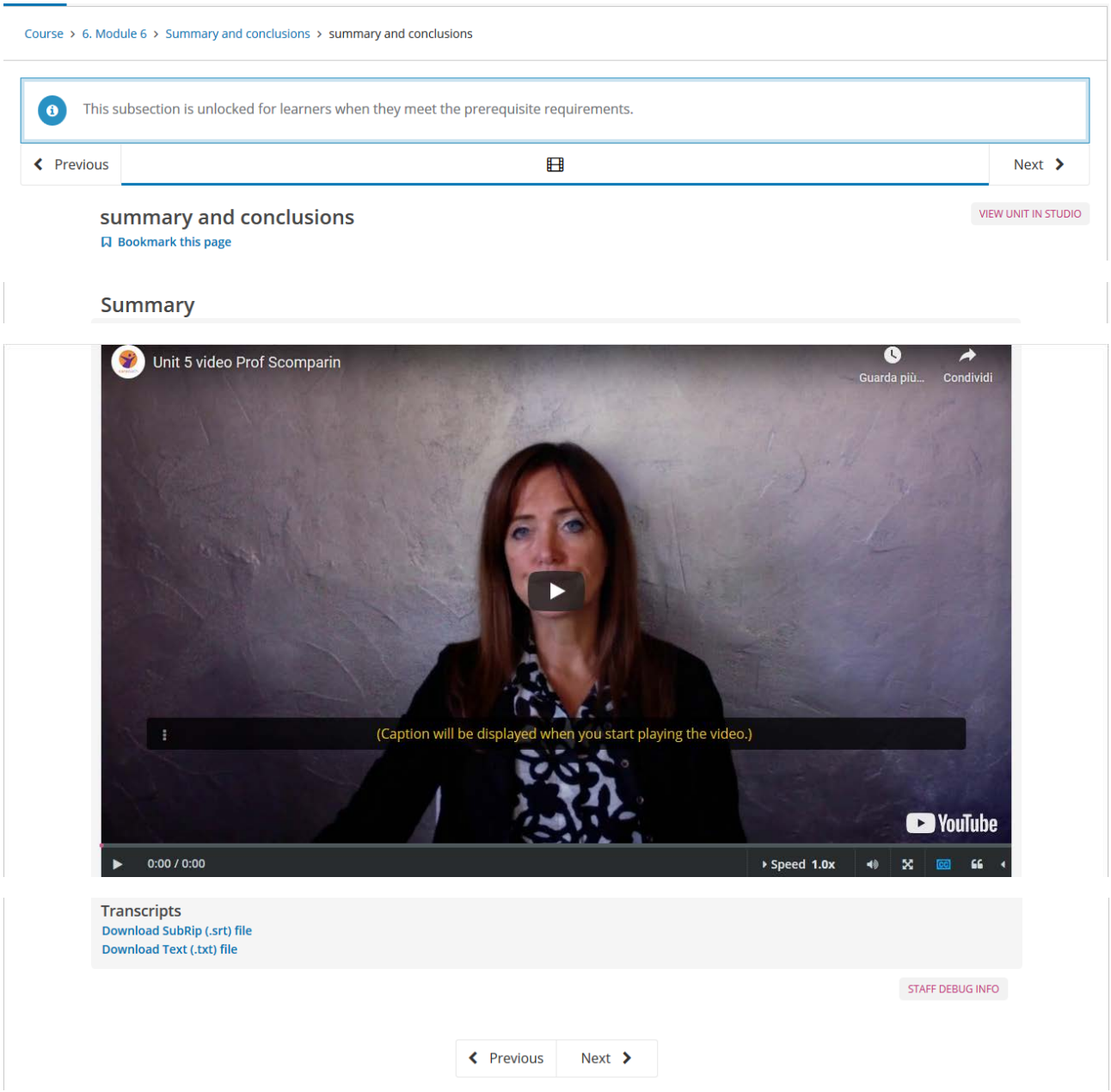


Transcript

You have reached the end of these two weeks of training,

in which we have attempted to identify

and describe the legal and social measures

for the protection of minors who have suffered a trauma.

Therefore, in this short final video, I would like to summarise our course journey,

identifying the most important issues that we have discussed.

Firstly, it is important to remember that achieving the consecration of children's rights

has been a troubled path.

A clear testimony of that is certainly the case of Mary Ellen Wilson,

which only ended positively thanks to the tenacity of a Methodist missionary

and the intuition of a lawyer:

to remove a child

from an inadequate family environment, it was necessary to apply the

law concerning animal cruelty.

hat is certainly astonishing.

Even more surprising, however,

is the context of the decision of the European Court of Human Rights in Z vs. United Kingdom,

also as it occurred over a hundred years later.

Even

in the early nineties, the idea of a State's obligation

to remedy problematic family situations for a child's well-being was

not deeply rooted in the legal system.

Therefore, the European Court judges derived

this duty from the European Convention of Human Rights, recognising

it as a corollary of the prohibition of inhuman or degrading treatments established in art. 3 of the European Convention.

We must then remember that

international and supranational law offered a decisive impulse for overcoming

the legal gaps that

were present in every State.

internazionale e dal diritto sovranazionale.

We must certainly recall the New York Convention

and then the many acts adopted by the Council

of Europe and, more recently, by the European Union.

It was only through these acts the awareness of the minor

as an autonomous subject of rights, holder of a legal position, independent

from that of his/her parents, definitely spread;

thus, today

we can say that this idea belongs to the common heritage of every legal system.

In the same way, it is also

well-established that there is a duty of the State's authorities to prevent
and punish any abuse against children
and to assist effectively those who have suffered abuse towards the complete
recovery of their psycho-physical well-being.
Moreover, it must be stressed that
the minor is an individual with
remarkable peculiarities:
his/her personality is still evolving and,
proportionally to his/her age, he/she certainly requires attention that adults do not usually require;
this special attention is even more
necessary when the child has been the victim of abuse and violence,
perhaps even within the family context.
In other words, it could be said
that, with regard to minors, the rights that generally belong to each
individual have required independent development, taking into account their particular
conditions.
It is therefore true that the child
has the right to be heard and to express his/her opinion on any matter that concerns him/her.
However, it is also true that, if his/her superior interest must be achieved,
the decision may
even differ from what he/she expressed as preferable; it may
also be completely different from the will expressed by the minor.
There is a fourth remarkable issue.
The path towards
recovering the well-being of the traumatised child
may be equally as painful as
the violence and abuse suffered.
Criminal or civil proceedings
are often essential
for achieving numerous and important objectives: to punish those who committed
the crime, if the conduct constitutes a crime;
to prevent the reiteration of the abuse;

to compensate the damage suffered;
and, when necessary, also to restore an adequate family environment.
It should not be forgotten that there is another side of the coin,
represented by
the numerous sacrifices the minor must make to face all
stages of the proceedings.
It is often crucial, for example, for the child to participate
in these proceedings;
and participation is not only one of his/her rights,
but also a fundamental device for ascertaining the truth:
by expressing his/her opinion and telling of his/her experience, the victim can always offer
to the judge important elements for making the final decision.
However, as we have seen,
there are also important risks of secondary victimisation,
as,
during the proceedings,
the minor will probably have to remember the facts and traumas suffered;
he/she will probably
suffer the public exposure related to the case;
in all likelihood,
during the trial, he/she will also have to come into direct contact with the perpetrator of the abuse.
All these are important and relevant risks.
Then, when it is necessary to order the adoption
or even the custody of the minor, it should certainly not be forgotten how
it can be to relate to a new family.
Paradoxically, we could say that the overcoming of the first trauma,
caused by the abuse,
requires the child to face a path in which there may be a risk
of suffering many other smaller traumas.
The most important consideration remains to be made.
It often happens that new rights and safeguards
require a great deal of time and energy to succeed;

and this, as we seen, has also happened with regard to minors.
However, now that
these guarantees exist,
a further step must be taken:
we must realise that law alone is not enough;
that international and supranational Conventions, European directives
and laws of the single States alone are not enough.
These acts are starting points,
a basis on
which everything else must be built.
What matters most - in this field probably
more than in others - is how the guarantees, which are contained in law, are implemented
through efficient social policies.
Central and local administrations
must certainly promote respect of
minors' rights with concrete measures.
At the same time, they must invest
in and create specific services for children and adolescents,
services such as help desks, support groups,
supervisory authorities.
We must not forget the important role
of volunteering and of the associations promoting and protecting
the rights of minors;
these associations are certainly a fundamental element
for implementing effective and efficient social policies.
Public administrations must have
adequate sensitivity and make appropriate investments
to limit the risks of secondary victimisation:
for example, they must certainly set up
special rooms for the hearing,
sensitise judges and lawyers,
ensure the best conditions for the hearing of the minor,

and provide continuous psychological assistance

during the proceedings.

Of course, the contribution of the first users

of this course, that is, the professionals, who interact

with the minor, is fundamental.

You

are

the guardians of minors outside the proceedings,

for overcoming the trauma caused by primary victimisation;

you are the guardians of the minor within the proceedings,

as you can make

more bearable something

that can never be ordinary;

and then you are the guardians of the minors even after the proceedings,

as you have to ensure that the difficult path

towards recovering serenity does not stop when it should

accelerate and finally achieves its goals.

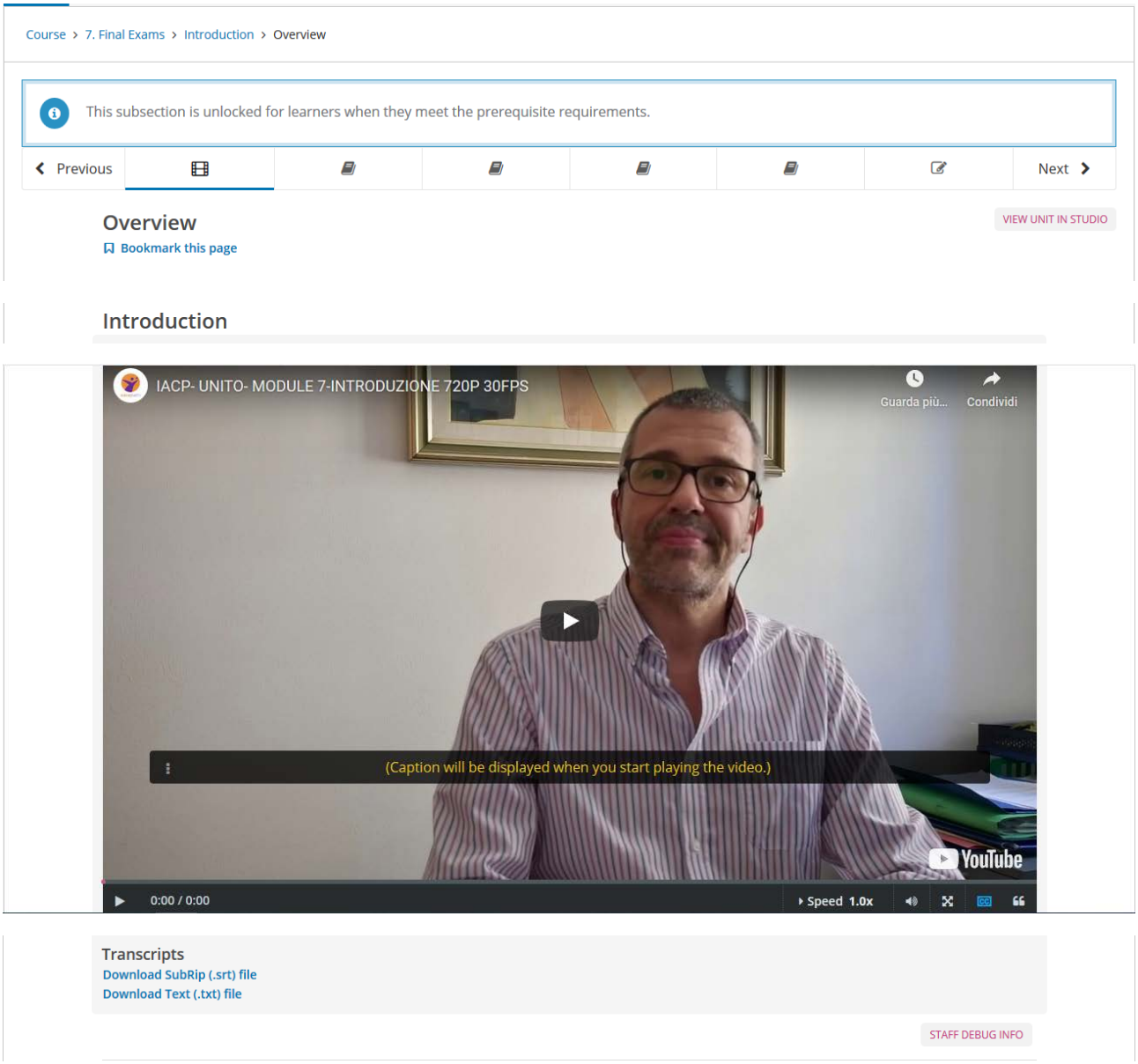
Ultimately, many difficulties await the child or adolescent victim

of abuse;

but, as we have tried to highlight, there are

also many devices to help him/her to face these challenges and to overcome them.

So I wish you all the best of luck in your careers.



Transcript

Welcome.

We are now in the last module, module 4.

This module was designed to evaluate and detect

the possible knowledge gained during the previous three modules.

How will this module work? We will propose three clinical cases, three scenarios.

You will have to choose one of these three scenarios and after that you have to

try to answer by putting together and integrating the skills learned in module one: the theory,

in module two: the research, and in module three, the legislative part; as well as

the relevant aspects of TIC, Trauma Informed Care, and how it can be applied to

the three scenarios.

How should you produce this short report?

You will have several options.

You may produce a PowerPoint file [NOTE: THIS IS NO LONGER SUPPORTED]; you may record a short video, so, you may use this format

or you may produce a Word document or a PDF file, or you may even use

other modes that come to mind.

The peculiarity of this last module

is that there will be a peer review, that is, you will evaluate the project made by another enrolled participant

and your project will be evaluated by a participant as well.

There will be a peer review. The last evaluation, however, will always be carried out

by a senior tutor, one of the project leaders.

This we could really call the last step that we ask of you in order to

obtain the certificate of participation of this MOOC.

Once you have finished your documents and your report, video or PowerPoint presentation [NO LONGER SUPPORTED],

you can submit it, there will be a random and anonymous match with another student,

after which you will be called to evaluate a document, a report or a video.

Then there will be the final submission of your work and after that

a senior will provide a further evaluation and decide whether or not to confirm the closure of your training.

We hope that this has been a pleasant path,

that you were able to learn something or otherwise confirm and value

additional knowledge about Trauma Informed Care. If you like, you can also leave short videos

at the end of your course, with your name and surname,

short documents where we will certify that you have been on this training course.

On my behalf, Luca Rollè, and on behalf of the entire Care Path project team, we would like to

thank you once again for being with us and we hope to see you again

in a future edition.

The PowerPoint (.ppt, .pptx) format is no longer supported due to technical issues. Please submit your final assignment directly in the form or in .pdf format. If your final assignment is a video, please upload your video on a streaming site of your choice and submit a link.

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This subsection is unlocked for learners when they meet the prerequisite requirements.

Instructions for peer assessment

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During this activity you are requested to analyze the case (Choosing the Scenario you prefer) from a legal, psychological and/or scientific research point of view. You answer should contain your reflections in the light of fundamental principles of Trauma Informed Care.

1. Your can prepare your contribution in

- text (simply enter your answer in the respective area) OR
- you can upload a file containing your contributions. **Important note - the file should be in pdf format up to 5mb.**

In case you have prepared a video you can simply enter the link of your published video so it can be accessed for evaluation.

2. Each learner upon submission of his own contribution has to assess at least 1 contribution from other learners. This is a necessary step, in order to finish the activity.

Important note - In case you need to evaluate a response that is contained into a file, you need to download the file and open it in your desktop/mobile device. make sure that the file has the .pdf extension. If not, please rename your file adding the .pdf suffix at the end.

3. The final step includes the Staff evaluation of your contribution. Upon completion, the final grade will be available to you straight away.

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Case Study 1

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Caro Clinico di Emanuela Tardioli

C.F. is 15 years old; she has been referred by the local hospitals to the local community service.

She irregularly attends high school with poor results and has been brought to the Hospital Emergency room for the ingestion of an excessive quantity of psychotropic drugs.

After the first-aid intervention, she was sent back home with the obligation for the whole family to follow a program of support and help.

The minor shows an angry attitude, she does not want to be at the interview or talk about her situation, she does not understand the reason for this referral. She claims to have done a stupid thing with her friend but certainly she will not repeat it.

After receiving empathic understanding of the fear, she experienced taking the overdose (she refers at the episode as doing a "bullshit") and receiving information of the terms of the services offered, the girl opens up, sharing her story and her fragility. She reports that her the parents have been separated-even if not officially- since few months ago and that the mother left their home.

C. reports that the mother leaving is a positive new development for her, since she has a very difficult relationship with her mother and the fact that mother is away from home makes her feel calmer; on the one hand, that entails not having any more around person who helped her to do things. For a long time, when C. went to elementary and high school, her mother was angry and beat and insulted her when C. did something wrong. The mother used psychological and physical violence to punish her; her typical insults where : " "stupid" "you're a bitch" However, in the last year C. began "finally" to no longer suffer passively this mistreatments, she started to respond to her mother attacks and sometimes she engaged in quarrels and even in physical fights with her mother. She experienced her new active behaviour with her mother as more satisfactory that the previous one. Her father is away all day for work, C. says that he is a good person, who nevertheless is returning at home only in the evening and does not seem interested in his family dynamics, probably because he comes home very tired from work. Things seem cold between her parents. In her family, people do not get together to carry out some common shared activities. Sundays are also spent at home or with her aunt (her father's sister). For C. the aunt is a significant adult and an important point of reference.

When C. was 13 years old, together with her friend started smoking tobacco and marijuana at school. She did like the feeling of relaxation and fun she experienced smoking marijuana and soon she started to hang out with a group of people who share the same "interest" in smoking grass.

After a few months of continuous difficulties at home, her mother started to be less present, every day in the afternoon her mother went out and this allowed C. to be free to invite her friends at home. Initially, she was happy with this new situation, she felt that it was an improvement of her life situation. Then one day she discovers, while travelling with a friend, that her mother is seeing another man and she see them sitting in a bar outside their neighbourhood in clear lovers' postures.

At this point, C. says, that she finally found herself in a position to get from her mother everything she wants, because her mother cannot escape her daughter' requests: C. wants to take her boyfriend home and be alone with him and asks her mother to leave her alone. Initially, the mother doesn't want to, but when C. tells her that she must, otherwise she will inform her father of her extramarital affair, her mother surrenders to her request. C.'s requests and her mother's concessions increase: C. takes whoever she wants home, smokes at home, and she is allowed to buy beer and to get all the money she asks for. The mother gives in to her requests, but C. receive from the mother her anger and insults and all her contempt.

The father's is not aware of all this. While talking about this C. shows an attitude of sad triumph and of great anger.

This state of affairs goes on for around a year, until in September, her father, discovers the wife's betrayal, ask her to leave their home.

At that point C. is even freer and she is alone until her father's return from work, she begins to be late at school or not to go to school at all, until, staying at her friend's house and finding a medicine of her friend's mother, they decide to try to take it together. After this episode, the father is called by the mother of the friend who has found C and her daughter deeply asleep on the bed and in a confusional state: "unfortunately" both girls are rushed to the hospital emergency room.

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This subsection is unlocked for learners when they meet the prerequisite requirements.

Case Study 2

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VIEW UNIT IN STUDIO

Case Study 2

B. is a 15 y.o. student, first of two; her mother is a businesswoman and her father is unemployed; the four of them live in a major city's suburb.

B. comes at consultation due to severe and invalidating physical pain, involving the lowest part of her body (legs and abdomen) that are not explained by any medical condition (her parents got her to examined by several professionals).

This pain impedes her from having a satisfying lifestyle, adequate for her age: going regularly to school is impossible for her, therefore she's risking to flunk and having to repeat the year; furthermore is really difficult for her going out with her friends or practicing some kind of sport because every plan could be shattered by this sudden, piercing pain.

At our first session she looks untidy, rather introverted (she lowers her gaze, whispers few words) and bent down (she spends all our time together crouched on her chair). She reports to have decided to ask for help because she's aware about the need to take care of this problem which "is shutting me in my house".

She possesses quite an extensive knowledge, great curiosity and a vivid intelligence, all of which seem to be the counterpart of her fix and folded body.

She says she has no idea of what may have started her symptoms, which appeared approximately at the time of her menarche.

She recounts she has wonderful relationships her family members, very few friends and to struggle a lot to be in groups, whether they be composed by peers or with adults. She loves to read and listen to music and studies several languages as an autodidact.

During our first year of psychotherapy, working on the invalidating meaning of her symptoms and focusing on empowering her, the pain is circumscribed and appeased: it appears just before her period and it makes her lose at most only 2 or 3 days of school. But there is still no consciousness about the origin of her symptoms and, moreover, she has frequent panic attacks.

In addition to B.'s individual sessions, periodically, I meet all the family which, even if they express concern about B.'s suffering, recognizes her great changes and the resources she was able to use to come back living a satisfying life.

After two years of psychotherapy, B. can manage her panic attacks, which had been becoming really sporadic and to use various strategies to manage pain (autogenous training, yoga, guided fantasies, breathing techniques).

However, while she's watching a movie in which there's a sexual assault scene, she experiences a sudden and intense anguish sensation, which she'll report to me at our next session as "an internal black out".

We begin to explore this feeling, trying to approach these "fragments of dream" as she initially refers to which later become blurry images hard to define as memories or fantasies borrowed from books or movies.

Working with respectful timing and modalities, not wanting to force her, her defensive strategies or her understandable fears, but meanwhile continuing to support her inner resources, slowly, B. recalls the memory of a person to whom she was entrusted while her parents were away (from age 3 to age 7) that sexually abused her.

Recalling the memory allows to start the process not only to report the abuser and to create a safe environment for herself (the abuser was still sporadically seeing her family) but also to make sense to her psychological suffering, up to that moment managed, but not signified or symbolized.

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Case study 3

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VIEW UNIT IN STUDIO

R, a minor of 13 years of age, is referred by the tribunal to a local health agency.

He attends elementary school and has been in a foster home since he was 9 years old.

At this first meeting he is accompanied by the educator of the family house and is open and interested in getting to know the people with whom he has an interview in order to have our service take him as a client. Initially he is sociable answers questions, interacts with people, jokes and is simpatico. When we start talking about the reasons of this colloquium he express confusion he doesn't understand why he is there, what he should do, what we want from him and he asks for answers to these questions giving voice to disorientation and different fears (of being obliged to be further away from his parents, of hurting them, of someone deciding that he won't be able to see them anymore, etc...).

His parents, after a period of separation now live together, just like when R. was removed from his family. The boy remembers several quarrels between his parents , they didn't get along very well, and several times the mother, from a different country than the country of residence, tried to return to her family of origins. When his mother left R. was sorry, but also happy because at the same time since his parents quarrels stopped for a while. He loves his parents and even now he is happy to spend time with them.

He speak with them everyday over the phone and sees them once a week when they visit him in the family house.

He's been there for a couple of years and he's fine, although he'd like to go back home, but he doesn't know if it's possible.

He doesn't remember well the day he entered the family home, but he knows that it was his father who accompanied him. Mom stayed home crying and he felt very sorry for her. Dad was stronger, because he accompanied him, and as always filled him with words, but he did not cry.

R. was scared when he entered the family home, but there he found some nice and funny people who made him feel less scared and it was easy to make friends with the rest of them too.

R. enters the foster home after a friend of his parents made sexual advances, violating him. He doesn't tell anyone, but at a certain point these things emerge (R. still doesn't know why) and he ended up in court. This man was a friend of his parents and he frequented his parents home quite often, he was fond of him and R. felt that he was important for him as well: In the evening this adult would read him some stories and sometimes R.' father would ask him to put R. to bed.

When those ugly things happened and came to light, his father accompanied R. to the foster home, wanting to protect him from this man.

R. doesn't really know how he feels about all this, maybe - he says - just a lot of confusion.

In the family home he's fine, but sometimes he feels a bit forced to obey to some hard rules, then he gets angry a lot and ends up acting out and damaging objects, but never people. In particular, R. can't stand the fact that in order to speak with his parents or to see them he has to follow rules that he doesn't understand; On the other hand, in this family home, he does interesting things (even practices sports), he feels good relating with the other people. He likes having friends around him even though, sometimes he wants to be left alone and would like to have space for himself.

R. has established a special relationship with and educator who takes care of him a lot and R. likes that quite a lot.

R. has many fears about what will happen when he leaves the foster home, not because he has to leave now, but he knows that eventually at some point this will happen and he doesn't want his parents to know that he experience these fears, since he is afraid they will feel sorry and think that he doesn't love them.

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This subsection is unlocked for learners when they meet the prerequisite requirements.

Open Response Assessment

VIEW UNIT IN STUDIO

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FINAL EXAM

This assignment has several steps. In the first step, you'll provide a response to the prompt. The other steps appear below the **Your Response** field.

IN PROGRESS

1 Your Response

Enter your response to the prompt. You can save your progress and return to complete your response at any time. **After you submit your response, you cannot edit it.**

The prompt for this section

> Analyze the case (Choosing the Scenario you prefer) from a legal, psychological and/or scientific research point of view
>
> Prepare a contribution (which can take different forms such as: text, video, presentation .ppt) that contains the reflections of the participant in the light of the fundamental principles
>
> of Trauma Informed Care, about the chosen case.
>
> **Important note: Please upload only pdf files up to 5 mb**

Your response (optional)

Enter your response to the prompt above.

Save your progress THIS RESPONSE HAS NOT BEEN SAVED.

Sfoglia... Nessun file selezionato. Upload files

You may continue to work on your response until you submit it.

Submit your response and move to the next step

NOT AVAILABLE

2 Assess Peers

NOT AVAILABLE

3 Staff Grade

Your Grade: Not Started

MANAGE INDIVIDUAL LEARNERS VIEW ASSIGNMENT STATISTICS GRADE AVAILABLE RESPONSES

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Post course survey

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VIEW UNIT IN STUDIO

POST COURSE SURVEY

	0. not at all	1	2	3	4. Very much	5. Not aware
01 - Are the contents consistent with educational aims?	○	○	○	○	○	○
02 - Are the contents of the lesson presented in an understandable way?	○	○	○	○	○	○
03 - Is there enough time to read, listen and watch the educational materials?	○	○	○	○	○	○
04 - How useful do you find the topics explored?	○	○	○	○	○	○
05 - How applicable do you think the themes of the lesson are?	○	○	○	○	○	○
06 - Would you suggest to a friend/colleague/friend/knower this lesson?	○	○	○	○	○	○
07 - How would you assess the experience of this online training?	○	○	○	○	○	○
08 - How would you rate the level of the CarePath course?	○	○	○	○	○	○
09 - Were the technical aspects (visuals, acoustics, subtitles, etc) of the CarePath course satisfactory?	○	○	○	○	○	○
10 - Was the online training platform of the CarePath course user-friendly?	○	○	○	○	○	○

Invia

View results

Export results to CSV Download CSV

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carepath

Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material
ANNEX 1
–
English Version

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

UNIT 1: DEFINITION OF RESEARCH

ARTICLE

It is not easy to define the boundaries of what research is and is not. Over time, many definitions have been given. Let's take a look at some of the most recent:

"The research simply seeks the answer to certain questions to which it has not been given a response and the answers depend on human efforts. [...] In reality, research is simply the process to arrive at reliable solutions to a problem through the planned and systematic collection, analysis and interpretation of data." (Singh, 2006, p.1).

"Research is a creative process of discovery that develops according to a pre-established itinerary and according to pre-established procedures that have been consolidated within the scientific community" (Corbetta, 2015, p.15).

In general, research is being carried out "whenever curiosity and intuition are applied with a systematic approach to answer questions about day-to-day phenomena, taking advantage of the experiences and knowledge already acquired" (Research Italy, 2013).

There are different types of research that differ according to its application, objectives and methods of investigation. Research can in fact be "applied" or "pure". Applied research aims to find a solution to an application problem that needs to be addressed, while pure research mainly concerns generalizations and the formulation of a theory (Kothary, 2004; Singh & Masuku, 2013). Depending on its objectives, research can be descriptive, exploratory, correlational or explanatory. Descriptive research aims to describe a phenomenon, a problem, a situation.

Correlational research aims to explore a relationship between two or more variables.

Explanatory research aims to explain why certain things happen.

Exploratory research aims to examine the feasibility of a study or to explore a little-known thematic area.

The investigation to be started needs a work plan determined by procedural steps that must be carried out in relation to the investigation itself; these phases are known as "research design".

Depending on the techniques used, research can be divided into:

- Quantitative research: it uses a structured approach, aims to quantify the variation or diversity of a phenomenon, situation or attitude through a well-structured research design, which provides quantitative data that can be analyzed to verify hypotheses and test relationships between variables.
- Qualitative research: it uses an unstructured approach, it is explanatory, descriptive and inductive in nature with particular attention to context and aims to identify and describe as many variations as possible in a phenomenon, situation or attitude, understanding the reasons underlying the variations. The latter implies an "interpretative and naturalistic approach to the world; it means that qualitative researchers study phenomena in their natural contexts, trying to give them meaning or interpret them in terms of the meaning that people bring them" (Denzin & Lincoln, 2011, p. 3). The aim of qualitative research is to describe and understand phenomena rather than predict and/or control them (Streubert & Carpenter, 2005).

The mixed approach, on the other hand, combines both quantitative and qualitative research methods. "Social research is based on the definition of variables, the search for associations between them and the attempt to understand if and how the variation of one thing causes a variation in another. Some common variables that you will find in social research are age, gender, ethnicity, race, education, income, marital status and employment" (Bernard, 2006, pp. 28-29). First, then, we find the concept of variable: something that can take on more than one value. Secondly, there is the concept of "measurement": in fact, the variables are measured by their indicators, which are defined by the values of the variable itself. Measurement implies which value to record. Any search must also respect the principles of validity and reliability. Validity means that the search must have accurate measuring instruments, data and results; while reliability means that the same results are obtained by measuring them several times with the same instrument.

Bernard (2006) explains the four fundamental points that the research process follows:

1. First, a theoretical problem is formulated (scientific theory and literature);
2. Then, appropriate units of analysis and method are selected;
3. Then, the data is collected and analyzed;
4. Finally, the theoretical proposition with which the research was started is either contested or supported.

(Bernard, 2006, p.69)

UNIT 2: ACTION RESEARCH

ARTICLE

Traditionally, the task of research has been to extrapolate laws inscribed in the nature of the world by analyzing phenomena objectively. The researcher must face the phenomena he studies from an absolutely neutral position. Research is by definition addressed to theory; it tends to generality and to build models as universalistic as possible. Action, on the other hand, in common experience is imbued with motivations, desires, emotions and knowledge that are often not logical, are contradictory and aimed at doing, obtaining and transforming. Action is directed towards practice, it is linked to the particular and to the singular, localistic and situational, historicized, not always predictable in its origin and in its outcomes (Amerio, 2000). Action-research was born with the intent to combine these two dimensions that traditionally have been seen as separate and irreconcilable. The two cornerstones of action-research, which differentiate it from traditional research, are participation and cooperation. Elliot would define it this way:

"Action-research could be defined as the study of a social situation with the aim of improving the quality of action within it. In other words, it aims to introduce a practical evaluation in concrete situations; the validity of the "theories" or hypotheses it generates depends not so much on "scientific" verifications of the truth as on their usefulness in helping people to act more intelligently and skilfully. In action research, "theories" are not independently validated and then applied to practice. They are validated through practice." (Elliott, 1994, p.97)

And again:

"The situation-problem must be diagnosed and remedial action must be planned and implemented, the effects of which must be controlled if improvements are to be made. This overall process of Analysis-Diagnosis-Planning-Actuation-Effects checking is called action-research [...]". (Elliott, 1994, p.96)

The original model of action-research was developed by Lewin (1946) with the aim of understanding the problems existing in specific contexts through the sharing of knowledge between people who are both researchers and experimental subjects. Action takes on more and more value because it becomes a moment in which knowledge about the problem is built up. The process of change takes place in three stages:

1. Unfreezing: the initial balance is broken by acting on resistance factors linked to adherence to social norms.
2. Moving: new and existing elements in the field move according to the forces acting within the field.
3. Refreezing: the new situation stabilises around a new balance.

Action-research is therefore a 'systematic collection and analysis of data for the purpose of taking action and bringing about change', generating shareable practical knowledge (Gillis & Jackson, 2002, p. 264).

The aim of any action-research is to produce social change through action (or actions), which is in turn the ultimate goal of the research (Greenwood & Levin, 1998; McNiff & Whitehead, 2006; MacDonald, 2012).

Researchers who start an action-research, have in mind the assumption that reality is created and recreated by a continuous social process. They recognize that, according to Argyris et al (1982), the crucial elements in a research approach that works within a specific social situation are: collaboration between researchers and reference communities; a critical investigation process; focus on social practice; and a reflective learning process. This necessarily implies a different type of research from the verification of hypotheses, which places more attention on the themes of the research, necessarily declared and discussed, to allow anyone interested to submit the research to critical examination (Checkland & Holwell, 1998).

UNIT 3: PARTICIPATORY ACTION RESEARCH

ARTICLE

As Vargiu (2008) highlights, the field of action-research brings back very different experiences, but united by the fact that they pursue two main objectives: understanding and change. By analysing the literature, it is possible to define action-research as a "family of approaches" (Reason 1994, Reason - Bradbury 2006) oriented to "place research at the service of the community, through the activation of participatory practices for the purposes of social change. This implies substantial differences with respect to other forms of research, regarding the objectives that the researcher sets himself, his epistemological assumptions and his practices. (p. 206). According to the author, this "family" is associated with many approaches and practices, including: 1) action research, 2) participatory research, 3) participatory action research, 4) participatory action research, 5) action science, 6) action inquiry, 7) sociology of action or *sociologie de l'action* (Bartoletto, 2006). Vargiu (2008) also adds those experiences that can be traced back to the Community Based Research to the Community Based (Participatory) Action Research and observes that "participatory research and participatory action research can be brought within the category of research that Capecchi (2006) defines as "con-ricerca"". (p. 209). According to the author, what allows useful differentiation is the level of participation foreseen in the research process and how much, in the definition of the objectives, the procedural elements and the instruments, space is given to the subjective and collective dimension.

Participatory research and action-research are increasingly becoming central paradigms in the social sciences (Brydon-Miller et al., 2004; Greenwood and Levin, 1998; Kindon, Pain and Kesby, 2007; Jason et al., 2004; Park et al., 1993; Reason and Bradbury, 2006; Selener, 1997; Taggart, 1997). As indicated by Kindon, Pain and Kesby (2007) and by Mackenzie and colleagues (2012), Participatory Action Research (PAR) involves researchers and participants in an overall project, aimed at examining a problematic condition or action with the aim of modifying it in a better direction (Wadsworth, 1998). It is a collaborative process of research, education and action (Hall, 1981) oriented towards social transformation (McTaggart, 1997), starting from the recognition of the existence of a plurality of knowledge in a variety of institutions and contexts (Kindon, Pain and Kesby, 2007). The process is cyclical (based on reflection-action cycles): researchers and participants identify a problem or situation that needs changing and

initiate research that draws on skills and resources to accelerate relevant action. Both researchers and participants reflect on this action, learn from it and move on to a new cycle of research/action/reflection. As Kindon, Pain and Kesby (2007) specify, they also cooperate in the development of context-specific methods to facilitate these cycles. In summary, PAR focuses on the dialogical engagement between co-researchers (Kindon, Pain and Kesby, 2007) and PAR is, therefore, an orientation in doing research (Reason 2004; Kesby et al, 2005), which requires methodological innovation and considers the research process as well as its products: its effectiveness is not only inherent in the quality of the information generated, but is also defined by the extent to which the participants' skills, knowledge and abilities are developed through research experience (Cornwall and Jewkes 1995; Kesby et al., 2005, 2007; Maguire 1987).

Reason and Bradbury (2006) argue for the need to adopt a participatory perspective or world view, which "asks us to be both situated and reflective, to be explicit about the perspective from which knowledge is created, to see investigation as a process of knowledge, to serve the democratic and practical ethos of action research" (p. 7). In line with Kindon and colleagues (2007), the key is an ontological view that implies that human beings are dynamic agents, endowed with reflective skills and personal change, and an epistemology that embraces those skills within the research process.

In accordance with a fundamentally participatory perspective, in PAR, the choices on the modes and levels of participation are not only made *a priori* by the researcher, but negotiated with co-researchers and participants. The most common methods used in PAR focus on dialogue, storytelling and collective action and the most commonly used are (Kindon, Pain and Kesby, 2007):

- Surveys
- Participant observation
- Secondary data analysis
- Learning by doing
- Dialogue
- Political action

- Group work and discussions
- Interviewing
- Storytelling
- Mapping
- Community art and media
- Diagramming
- Educational camps
- Exchange programmes
- Ranking and scoring
- Shared analysis, writing and presentations

As already highlighted, active research becomes participatory action research depending on who is involved in each phase and to what extent. Participants as collaborators can inform the design, propose methods, facilitate some activities and, above all, review and evaluate the process as a whole (Mackenzie et al., 2012). From the planning phase PAR tends to involve the use of established research techniques adapted to the situation and considers it essential to develop a strategy (before the action) to monitor and evaluate the effects of the action. This should allow the identification of the extent of the changes, but also to "articulate a robust epistemology against which to assess the validity and salience of new or emerging knowledge, similarly to a systemic thinking system (Ison, 2008). Effective monitoring and evaluation procedures provide the rigour of the process to assess the effectiveness, appropriateness and relevance of the action-research intervention. It also provides a framework to establishing causality in determining to what extent the research activity "caused" or "contributed" to desired changes in the situation" (McAllister and Vernooy, 1999)". (pp. 12-13). The evaluation of the process and outcomes by the participants provides a further avenue to consolidate stakeholder engagement and offers the opportunity, collectively, to co-construct an active and critical commitment, in which alternative voices are indispensable and enriching. The PAR therefore requires the

researcher to abandon control and take on the role of facilitator of the process (Kindon, Pain and Kesby, 2007; Janssen et al., 2013).

As highlighted by Kangovi and colleagues (2014), PAR in the field of mental health can be considered a good strategy to make the patient's involvement in the design operational. Its cooperative and iterative nature allows researchers, healthcare staff and patients to collaborate in the design of interventions validated by end users. It can also be used to adapt an existing intervention to specific needs and, when it is disseminated, to new settings and/or patient groups. About the field of application to young populations, as indicated by Shamrova and Cummings (2017), the children's rights paradigm has providedgreat impetus for researchers to recognize children as active participants in building meaning. In this, PAR is a mechanism through which agency is distributed to participants, supporting the implementation of children's rights (Checkoway, 2011; Quijada Cerecer, Cahill and Bradley, 2013; Shamrova and Cummings, 2017). In addition, throughout literature, results regarding its application are also reported at an organizational level; the most frequent were the changes in the organizational culture aimed at: increasing the possibilities of participation, increasing the level of inclusiveness towards the child, and spreading greater awareness to make the programs better adapted to the needs of children and youth (Shamrova and Cummings, 2017). In this, the authors (Shamrova and Cummings, 2017), have identified some methodological choices that could help to support the participation of children as meaningful:

- training

- the construction and use of child-friendly data collection tools

- the active involvement of children in the analysis of data and in the reading of results

- the choice of significant locations for the dissemination of the results of the research.

With regard to research with vulnerable groups, as indicated by Lushey and Munro (2015), PAR can promote the rights of children participation and those who lose their care and, at the same time, inform the empirical basis resulting from studies on these populations.

On a conceptual level, particularly interesting is the Youth Participatory Action Research (YPAR) (Anyon et al., 2018; Rodriguez and Brown, 2009), which includes the following founding principles:

1. it is based on investigation
2. the areas explored are the experiences just as they are lived by young people
3. it is participatory
4. has a transformative nature

Its key processes are:

a) the sharing of power between young people and adults during the whole process

b) training and application of research and advocacy methods

c) the critical use of strategic thinking on how social change can be created;

d) building alliances with all stakeholders.

Finally, an example of research according to the PAR paradigm is the one carried out by Törrönen and Vornanen (2014) with care-leavers. In line with the above principles, as indicated by the authors, the professionals and researchers involved took on a supporting role, while the young people conducted interviews, collected data from their peers and encouraged the expression of opinions about the experiences (Törrönen & Vauhkonen, 2012). The central aspect was, in fact, the attention to the vision of minors involved as co-researchers; therefore, they were fully involved in the research process.

UNIT 4: EVIDENCE-BASED RESEARCH

ARTICLE

The term evidence-based research (EBR) was coined in 2009 to indicate the approach that counteracts the significant source of waste in biomedical research (Robinson, 2009) which was mainly due to primary studies performed without a systematic review of available evidence. This was considered neither ethical nor scientific (Lund, H. et al., 2017). Evidence-based research always starts from a systematic review (SR), which includes predefined research questions, inclusion criteria, research methods, selection procedures, quality evaluation, data extraction and statistical analysis (Lund, H. et al., 2017). Systematic reviews are used to understand and prioritise research and whether it is necessary and useful to the community or a possible source of wasted resources because it does not produce new scientific knowledge. The guidelines suggested by Evidence, an open access journal of the GIMBE Foundation (Italian Group for Evidence-Based Medicine), to create an evidence-based research project are as follows:

1. Formulate the preliminary research question and identify relevant systematic reviews;
2. Assess the adequacy of the purpose, quality and updating of the research;
3. Evaluate the details of: population, intervention, comparison, outcomes, and time range (PICOT);
4. Evaluate the method used and the results.

Ultimately, researchers should use systematic reviews to formulate the final question of the study they wish to promote; justify the need for it during the application for funding and approval by the ethics committee; interpret the results of the new study in the context of the available evidence; and make recommendations for future research. Over time, there has been an exponential growth in evidence-based research, which has led to the publication of about two million articles in over twenty thousand journals. There are many reasons for this growth, on the one hand its educational vocation (JAMA, 1992) and the paradigm shift (Pagliaro & Colli, 2014) that led to this practice, and on the other hand, the strengths that evidence-based research presents:

- it allows to produce knowledge and guide professional practice in areas where there is greater uncertainty about the interventions carried out in clinical practice;

- it reduces waste because it defines the priorities of research questions taking into account previous systematic reviews;

- it allows a clear description of research designs (target population, interventions, comparisons, outcomes);

- it produces updates and disseminate systematic reviews;

- it integrates evidence into clinical practice;

- it allows a continuous re-evaluation of one's knowledge (GIMBE).

UNIT 1: EVIDENCE BASED RESEARCH IN TIC/TIP: INTERNATIONAL PERSPECTIVE

ARTICLE

One of the main themes in the organization of services dealing with traumatized minors and one of the major requests coming from these is how to guarantee adequate and effective training for professionals on evidence-based interventions (Ruzek & Rosen, 2009). When observing the situation of the implementation of treatments and evidence-based guidelines from a general perspective, despite the importance of this theme in the field of public health, an unevenness of implementation and limited attention on systematic evaluation and long-term effects of training programmes can be inferred (Ruzek & Rosen, 2009). Furthermore, from a comparative perspective, Delaney (2006) underlined another relevant aspect: on an international level, the guidelines and their implementation in elective treatments throughout clinical practice vary considerably on a national level and throughout different nations (including public health regulations). Weiner, Schneider & Lyons (2009) studied the analysis of evidence-based methods for the treatment of trauma in minors. As specified by the authors, some of these have been tested through experimental or quasi-experimental methods, but most methods were structured for adult populations despite being applied to minors as well, and were evaluated with little to no attention paid to cultural variables and differentiation of subgroups based on factors impacting outcomes. From these observations, an interesting solicitation on cross-cultural validation of treatments can be derived, which would allow not only an expansion of efficacy, but also an exploration of which barriers hinder their implementation and of flexible adaptation requirements relative to specific subgroups or application circumstances. Courtois & Gold (2009) and Layne & colleagues (2014) highlighted the need to include a specific focus on trauma and its consequences in operators' training, starting from an awareness of the fact that trauma and its effects impact all phases of treatment such as, specifically, the patient's engagement, the assessment, and the response to treatment. Furthermore, they underline how, in this respect, a relevant role is played by the creation of international standards and shared training methods for operators in Evidence-Based Practice (EBP; Lyon et al., 2011). EBP allows the operator to choose the best actionable choices, validated and appropriate for that specific situation, based on the specific needs of the client, their strengths and their circumstances (Layne et al., 2014). In order to guarantee adequate training in this regard, it is imperative for the scientific community to create a definition of core competencies, that is, a base of knowledge that those dealing with a history of trauma should possess. In particular, this

kind of attention should allow a good quality of provided services, increase operators' responsibility and disseminate knowledge that is shared and, often, manualized throughout protocols between different branches (psychology, psychotherapy, social sciences, psychiatry, etc). The National Child Traumatic Stress Network (NCTSN) is a web of professionals, family members, researchers and international partners dealing with the betterment of standards of care and the opportunity of access to services for children and families. The NCTSN has created a training protocol named CCCT (Core Curriculum on Childhood Trauma) (Layne et al., 2011) that clarifies the main elements of intervention (by including them in an integrated evidence-based matrix), the fundamental concepts in trauma and essential therapeutic skills for the planning and implementation of an effective intervention for children affected by trauma and their families. Two elements appear foundational: the goals of the intervention (objectives that are expected to be met through the intervention) and practical elements (the actual procedures meant to be applied in order to obtain results). This attention to operators' training on core competencies passes through the definition of specific "gold standards" relative to EBP training and evidence-based treatments (EBTT, Evidence-Based Trauma Treatments). The CCCT includes 5 levels: a) Empirical Evidence Base; b) 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families; c) intervention goals; d) practical elements (observable actions put in action to reach goals); e) therapeutic skills\abilities (two sub-levels: 1) procedural and process-oriented; 2) evaluative). The aforementioned model supports evidence-based practices and competences such as routine assessment and information gathering, theory of practice, application of results derived from scientific literature to individual patient situations, conceptualization of cases, and intervention planning. In the process of examining and implementing the CCCT model, a task force has planned a specific enhancement session of statistical analysis competences and structuring of study protocols that are useful for clinical practice validation. What gets most underlined about this is the invitation for development of both theoretical aspects and evaluation methods (multidimensional), as well as the empirical base accessible to evaluation and validation of interventions (in particular, for outcomes, intervening factors, and the efficacy of interventions centered on the specific situation of a person). Briggs & colleagues (2012) further identify as a priority the betterment of standards through "[...] evidence-based development, implementation and dissemination" (p. 1). The structuring of intervention guidelines - meant to identify optimal targets and identification methods (what the best intervention may be given specific circumstances) and outcomes evaluation - is fundamental and useful for operators and for those dealing with the structuring of services. Research designs that may be useful are the

ones that consider the interconnection between risk factors and different outcomes in order to clarify on what elements the intervention might be focused, as well as, recursively, to include new aspects in theoretical understanding of trauma and to complexify the scientific framework. Particularly interesting, as a matter of fact, is the observation that treatments targeting the reduction of PTSD-related symptoms are also effective in reducing functional difficulties not directly related to the object of treatment;this highlights how a trauma-focused treatment can generate positive, wide-ranging effects (Layne et al., 2010).

RESEARCH IN TRAUMA-FOCUSED SERVICES

TIC could be defined as an evidence-based approach in reacting to trauma, which focuses on the ability (or lack thereof) of staff members to take part in a vision of care for a traumatized patient, as a critical precursor for success or failure in adopting strategies meant to reduce the risk of retraumatization of the user (Marvin & Volino Robinson, 2018). In this, it is fundamental to carefully take in the complexity of stories in which trauma is generated by different and individual experiences. Policies, procedures and daily operation could potentially be additionally traumatizing experiences or elicit responses linked to the individual functioning of the traumatized person, preventing them from receiving the care they need. In order to keep these situations from happening, and from generating frustration in staff members, turning to specially structured and internationally recognized best practices might be useful (see, for example, the strategies promoted by SAMHSA in 2014). In synergy with this, the TIC perspective invites organizations to consider the impact of working with subjects bearing traumatic stories to members flowing into clinical services (SAMHSA, 2014; Knight, 2015) and how operators could be helped, through training and a trauma-informed leadership, in maintaining a good level of wellbeing and efficacy/efficiency in interventions when working (Manderscheid, 2009). Ruzek & Rosen (2009) examined in depth the factors influencing the way in which services receive research results on evidence-based practices linked to trauma treatment. A careful evaluation of both practice dissemination and research implies the inclusion of a field of analysis composed by multiple factors that can influence the evolution of the care process, the patients' or potential users' relationship with the services, the method clinicians use to learn new treatment techniques, the changes in the organizations linked to behavioral transformation. Surely, according to the vision of the authors, an increasingly urgent priority in the application of empirical research in this field is the validation or support for treatment methods applicable in an economically convenient way. The researchers, in particular, analyzed the role of factors concerning the operators that the research highlighted when linked to outcomes. They observe that evaluations made by operators specialized in trauma-related stress (specifically, those dealing with PTSD) about a specific practice, their competences and features (e. g. their self-efficacy level), their willingness to change in operational practices (e. g. adopting a specific best practice by integrating it in their daily functioning) are influencing factors, but they are scarcely studied on an empirical level. Accessibility to training programmes on EBPs and worries about the applicability of

innovations in the field of research relevant to their specific relevant population (problem of generalization of results) seem to be the most influential variables on their attitude towards evidence-based practices, independently of their theoretical framework. The training method that seems particularly efficient towards promoting change in caring behavior seems to be intensive training courses, especially when they call for the demonstration of necessary competences and when they require that those be put to the test throughout interactive participation in lessons (with availability of supervision on a regular basis and, therefore, beyond the training moment itself and training-the-trainers events). With regard to innovation factors, the authors highlight that patients' and operators' perceptions on treatments are an essential element in their adoption, particularly pertaining to their proved efficacy (even on a comparative level with other methods). With regard to systemic factors, they observe how particularly relevant the availability of spaces for supervision and administrative-organizational support is for a successful application of a good practice (Fixsen et al., 2005). Even more important is the need to empirically support the creation of trauma-informed care systems (Ko et al., 2008; Ruzek & Rosen, 2009). Furthermore, the monitoring of treatment implementation is another key aspect for dissemination, effects, and faithfulness to procedure for fulfillment of EBPs (Rosenheck, 2001b; DuFrene, Noell, Gilbertson & Duhon, 2005; Durlak & DuPre, 2008; Ruzek e Rosen, 2009). A particularly interesting aspect is the one analyzed by Rosenheck (2001a), who highlights the mutually recursive process of interaction between EBPs (in their general and prescriptive dimension) and local experiences/needs for implementation. The purpose of monitoring, even in the face of its cost in terms of economical and time investment resources for services, should therefore be allowing [services] to focus on crucial elements for treatment outcomes and treatment efficacy (Ruzek & Rosen, 2009). One of the key questions might be how the clinician's modifications in response to specific needs might undermine, increase or leave unaltered the intervention's effects (Ruzek & Rosen, 2009).

UNIT 3: CORE ELEMENTS TO STRUCTURE A GOOD RESEARCH PROPOSAL

There are different approaches to the structuring of a project (Leone & Prezza, 1999) in the social and health field: a) synoptic-rational (which implies maximum pre-structuring of the contents), b) concertive-participatory or dialogical planning (in which continuous negotiation of the objectives between experts and recipients is central); c) heuristic (which provides for a minimum a priori structuring of the objectives).

From a general point of view, the following steps should be followed in the research process:

1. A theoretical problem is formulated (deriving from the analysis of scientific theory and literature);
2. Appropriate units of analysis and method are selected;
3. Data is collected and analysed;
4. The theoretical proposition with which the research was started is either contested or supported.

As indicated by Lanzara (1985): "Every actor who presents himself the problem of innovation, or simply of intervening in a situation to modify it, has a design problem in front of him" (p. 336). Planning is a process of systematization; in fact, the structuring of a research project is a critical and fundamental phase that involves important choices that condition its outcomes. Moreover, Leone & Prezza (1999) underline that: "To articulate a project among different subjects, to think about the coherence between different parts (aims, times, available operators...) means problematizing the practice and dealing with the limit, with the partiality, and this is exactly what in some contexts tends to be removed" (p. 23) or considered too complex from an applicative point of view.

From a transversal point of view, the authors point out the fundamental stages in the structuring of a project in the social field:

1. Ideation: the phase in which a project is supposed to be carried out or proposed
2. Activation: verification of resources, roles, problems and strategies, possible analysis of demand (clients)

3. Planning: elaboration of the project and structuring of the phases that compose it, establishing the times and defining the methodological choices
4. Implementation: start of activities, first check of hypotheses, ongoing changes
5. Verification: final analysis of the results

In addition, in the field of scientific research, important elements from the application point of view are:

- Definition and analysis of the research object from the point of view of the scientific literature, explanation of the theoretical framework
- Identification and explanation of the general aims and specific objectives of the study (research question: exploratory, evaluative, explanatory)
- Structuring of hypotheses
- Identification of target population, recruitment of participants and sampling procedures
- Evaluation procedures, definition of indicators, tools and techniques for analysing the data collected
- Time planning (timeline) and feasibility analysis (including criticality and limitations)

In doing so, methodological installations of a quantitative, qualitative or mixed matrix can be used according to the research question.

Each phase of the design process entails that the researcher asks important questions that also take into account the critical elements from a conceptual and practical point of view. The context in which the research is carried out is one of these, as are the resources.

Given this complexity, it is of fundamental importance to pay attention to the training of staff in this dimension, as well as the constant interaction between professionals engaged in clinical work and researchers involved in research in and on the clinic.

Moreover, an important sector that shows its centrality is the structuring and validation of tools that can be used starting from both intervention and research objectives. These can have different forms and be applicable to specific targets, which is why it is essential that all actors involved in the design and implementation of a project synergistically establish each stage of the project plan, including methodological choices.

UNIT 1: GOOD PRACTICE IN TIC

Given the great risks to physical and psychological health due to the impact of traumatic events (Adverse Childhood Experiences, ACEs), over the years many interventions have been developed to help institutions and practitioners assisting people with traumatic histories in order to emphasize the advantage of adopting a TIC-based approach (Baker et al., 2016). In particular, “a TIC approach looks at a person holistically, not just as a list of problems he or she is experiencing" (Hepburn, 2017, p. 7). As indicated by many authors (Bryson et al., 2017; Bridgett, Valentino & Hayden, 2012; Ellis & Boyce, 2011; Perry, 2002; Rothbart, Ziaie, O'Boyle, 1992), a protective effect (buffer effect) is played by good care and supportive relationships exerted by attentive and proactive caregivers: relational safety reduces the harmful effects of trauma in children. Traumatic stress is a common condition in the case of an ACE and often causes significant clinical manifestations (internalization and/or externalizing symptoms) frequently found in hospitals or residential facilities dedicated to adults and children (Bryson et al., 2017; Greenwald et al, 2012; Hummer, Dollard & Robst, 2010; Ko et al., 2008). Quoting Elliott and colleagues (2005), who stated that "Trauma informed services are those where service delivery is influenced by an understanding of the impact of interpersonal violence and victimisation on an individual's life and development" (p. 462) and that "Many common procedures and practices in service settings reactivate traumatic reactions and are experienced as unsafe emotions and a source of weakness for trauma survivors" (p. 446).

It is possible to further emphasize that good practices should be evaluated on the basis of specific criteria that are identified and detailed in the scientific literature and that include a careful evaluation of the complex factors involved in the traumatic stories. As a matter of fact, in situations where the service or organisation deals with people who have suffered trauma, a perspective in which public health and social care are oriented towards risk prevention and reduction is recommended (Bryson et al., 2017). In this field, promoting trauma-informed approaches is a central issue: trauma-informed care (TIC) and trauma-informed practice (TIP) are the chosen treatment paradigms because they aim to transform entire care systems by including an understanding of stress in response to trauma in all aspects of the service and focus on the priority of safety and choice. In addition, this philosophy aims to create a treatment culture focused on non-violence, learning and collaboration in which the emphasis is on all environmental and interpersonal interactions (Bryson et al., 2017). In the systematic review of literature, Bryson and colleagues (2017) included some important findings:

- The “reduction of physical coercion in routine and residential psychiatric care" (p. 11) is emphasized as the reduction/elimination of isolation or control and coercion strategies;
- A key aspect of TIC is "the fundamental importance of senior leaders giving priority to TIC [...] especially when the staff is required to adapt to new ways of working" (p. 11);
- researchers stress the need to support staff through advanced training - in particular on trauma sequences - continuous supervision, coaching and debriefing;
- in this, it is essential to listen to patients and families, paying particular attention to their experiences, needs, priorities regarding the treatment process;
- the importance attributed to the area of constantly updating research data and to the analysis of outcome indicators are transversal dimensions aimed at motivating and informing the performance of services and improving effectiveness;
- the literature deals extensively with "the need to align formal and informal policy and practice with the general principles of trauma-informed practice" (p. 11).

Despite its increasingly frequent application, scientific research on the effectiveness of this type of approach is still lacking (Bryson et al., 2017); as pointed out by Valenkamp, Delaney & Verheij (2014) and Chandler (2008), there is a lack of randomised controlled studies that test interventions and explore the critical factors involved in implementing TIC-oriented treatments. With respect to what is currently indicated on an international level, empirical studies have shown how important training is in providing staff with a common language to be used regarding the patient's experience and particular interventions to be used with trauma patients (Bryson et al., 2017). The centrality of this issue has also been highlighted earlier by Le Bel, Huckshorn & Caldwell (2008) and by Brown, Baker & Wilcox (2012). In addition, specific training on best practices and patient participation in staff training activities (e.g. by reporting on their experiences) has proved useful (Holstead, Lamond, Dalton, Horne & Crick, 2010), as has the involvement of children in debriefing on critical aspects or stages in the provision of care (Lebel et al., 2008), data sharing and continuous monitoring of performance/processes (at individual, collective and unit level) (Bryson et al., 2017).

Another emerging focus of the scientific literature on effective TIC strategies is the ability of organisations to align policies and practices with the principles of informed trauma care (Bryson et al., 2017). According to this vision, the environment and culture of organizations are therapeutic tools themselves and both contribute to building a "therapeutic community". Of particular relevance are: 1) the focus on creating a safe treatment space for both patients and staff and 2) the inclusion of TIC principles in mission and vision statements. In summary, the main TIC strategies spotlighted by Bryson and colleagues (2017) are aligned with those underlying the NASMHPD (National Association of State Mental Health Program Directors) and both are presented in Table 1.

Bryson and colleagues (2017)
Community inclusion
Leadership commitment
Model selection
Workforce transformation
Outcome orientation
Shared maintenance
NASMHPD
Leadership towards organizational change
Use of data to inform practice
Use of restraint and seclusion reduction tools
Workforce development
Improve consumer's role in an in-patient setting
Thorough debriefing techniques

Table 1 Core strategies in TIC

In addition, in a study by Azeem and colleagues (2011), these strategic elements were tested longitudinally to analyse the reduction in the use of restraint and isolation. In particular, the authors stressed that:

- Leadership plays a key role in bringing about cultural change, particularly when a TIC-oriented vision is shared by all staff.
- data collection and sharing has "a key role in performance improvement projects" (p. 12) and in monitoring processes
- Training and continuing education of staff in the principles of recovery-oriented care, personal-centred care and TIC with the associated performance evaluations have been shown to have significant positive effects;
- an important focus should be dedicated to the principles of primary prevention using individual treatment plans that include the history of trauma and communication with the strategies of the patient, family and staff;
- a good principle for TIC practice is the involvement of the patient and the family;
- support debriefing activities - particularly with regard to emotional aspects and necessary changes in treatment plans - such as interventions to mitigate traumatisation and traumatisation impact were effectively implemented.

By examining different approaches to TIC, Hanson and Lang (2016) and Johnson (2017) identified some issues that could be considered important to explore the approaches of services for children and concluded that it is possible to identify 15 key TIC components.

The identified components were organised into three levels (Hanson & Lang, 2016, p. 98):

1. Workforce Development (WD):
    - Training required for all staff in awareness and knowledge of the impact of abuse or trauma;
    - Measurement of staff competence in defined criteria to demonstrate knowledge / practice on trauma;
    - Strategies / procedures to deal with / reduce the stress associated with secondary trauma among staff;
    - Knowledge/skills on how to access and refer to evidence-based best practices focused on trauma.
2. Trauma Focused Services (TFS):
    - Use of standardised measures of screening / evidence-based assessment to identify history and trauma-related symptoms or problems;
    - Inclusion of the child's trauma history in the documentation / files / case service plan;
    - Availability of qualified clinicians for and trained in evidence-based practices focused on trauma;
3. Organizational Delivery (ORG):
    - Collaboration, coordination of services and sharing of information between professionals within the agency related to trauma-informed services;
    - Collaboration, coordination of services and sharing of information between professionals of other agencies related to trauma-informed services;
    - Procedures to reduce the risk of user re-traumatization;
    - Procedures for user involvement and input into service planning and development of a trauma-informed system;
    - Providing services based on strengths and promoting positive development;
    - Providing a positive and safe physical environment;
    - Written policies that explicitly include and support trauma-informed principles;
    - Presence of a defined leadership position or a job function specifically related to TIC.

THE IMPORTANCE OF OBSERVATION

Clinicians and researchers are constantly searching for knowledge about a particular phenomenon, in a more or less systematic way. This desire for knowledge arises out of interest or curiosity, from a careful look, through the naked eye or with the help of tools, using a single word, through 'observation'.

Mantovani (1995) defines observation as: "[...] a form of detection aimed at exploring a given phenomenon" (p. 84).

Observation is a complex and demanding activity that requires:

- time;
- intellectual freedom;
- absence of prejudices and preconceptions,
- self-awareness;
- ability to not get involved;
- ability to suspend judgement.

In clinical and research contexts, observation acquires considerable importance, transforming itself from a simple and unscientific method into a flexible, structured and reliable one (Venuti, 2001). With the progress of studies on children, for example, the use of "child biographies" has been abandoned, to give space to systematic observation and experimentation (Bornstein, 2001). As a matter of fact, over time naturalistic observations have left room for standardized observations (Bornstein, 2001). One could argue, in the words of Venuti (2001), that observation "[...] acts as a bridge between an explanatory model of reference and a subsequent process of analysis and interpretation of data" (p. 58). To observe, therefore, it is no longer enough to look at a group of children interacting or recorded video of the behavior between mother and child, as observation must always refer to a theoretical and explanatory model, which will guide the researcher to formulate hypotheses and analyze the data (Venuti, 2001). What to observe, how, where and when to do it, will depend on the purpose of the research and the theoretical approach of reference.

There are different types of observations:

- psychoanalytic observation, which has psychoanalysis as its theoretical model;
- piagetian observation, which has as its theoretical model the psychology of development;
- ethological observation, which has ethology as its theoretical model.

Piagetian observation is a quasi-experimental type of observation. It lays its foundations on the theoretical approaches of interactionism, structuralism, cognitivism and deepens the study of the path of mental life in the course of development (Vigna, 2002). It is not limited to the recording of everything that the child does, but is guided by some hypotheses that form the basis of piagetian theory. The observer tries to establish an interaction with the observed in a natural context (Petter, 1984; Vigna, 2002). The basic principles of this observation are two:

1. The observer adapts to the child's stage of development and, by interacting, modifies the very conditions of the observation;
2. The observer repeatedly reproduces the same play situation during an observation to assess whether the child's reaction is repeated in the presence of the same stimulus and is not attributable to randomness.

The main application contexts of this type of observation are playschool and kindergarten.

The ethological approach, on the other hand, is inspired by Darwin's theory of evolution and the work of the ethologist Lorenz. The observation is defined as ethological when the observers do not influence in any way the behavior that they are interested in studying and cancel their subjectivity as much as possible. Usually this technique is applied in the natural environment in which a given behavior manifests itself spontaneously. However, it is possible to use the laboratory as an environment, provided that it is equipped in such a way as to reproduce a familiar environment for the child (e.g. a playroom).

It is useful in the investigation of the early years of life, where verbal language is still absent or poor, for two reasons:

1. it is easier to define the natural living environment of young children;
2. young children do not always realise that they are being observed and, in any case, do not react by changing their behaviour.

This type of observation aims at the exclusion of subjectivity and the achievement of objectivity that alone allows us to draw conclusions that are not misleading (Lis & Venuti, 1986). In this type of observation, procedures are used that allow the recording and the objective and systematic cataloguing of behaviors, so as to be able to interpret them later in the light of the initial hypotheses. Among the strengths of ethological observation emerge:

- an increase in descriptive studies of childhood behaviour;
- an attribution of importance to longitudinal research, considered the most suitable to grasp the process of change and its evolutionary meaning.

However, the emphasis on objective description can make us forget that when we observe, it is inevitable to make choices. Moreover, the importance of detecting micro-behaviours, which can be described objectively, cannot make us lose sight of the meaning that a certain behaviour assumes in a particular moment and context.

Psychoanalytic observation, on the other hand, is a type of direct observation, a method that does not make use of any instrument outside the observer himself. According to the psychoanalytic model, when there are no phenomena foreseen on the basis of a theory, "the unexpected" (Bion, 1962) becomes relevant. Observation in this case has the main function of creating a space where the unexpected can express itself. This picture does not involve any intentionality on the part of the observer to allow us to grasp the conscious and unconscious intentionality of the person observed. The fields of application are:

- psychological research;
- clinical work;
- training of child psychotherapists and analysts.

The observer is an integral part of the situation and observes both behaviors and verbalisations, as well as moods and emotions. He must also carefully evaluate his own psychological states as a source of information about the observed subject, using his own similarity to differentiate the latter from himself and accepting his own presence.

Finally, one can observe the entire family nucleus through structured tasks in the clinical context or in one's own natural environment. This type of observation can be associated with an interview with the family and has the intention of understanding how the members of the nucleus interact with each other and understanding communications at the verbal and preverbal level (forms of implicit intersubjectivity).

Ultimately, observation is one of the cornerstones of the professionalism of those who work in the field of education and training, helping to build a "basic attitude" that becomes an integral part of the way of acting professionally, as a basic element of educational competence. It is not a simple tool, but a set of attitudes, methodologies and tools. These can be structured (video recording, grids, checklists, etc.) or unstructured (e.g. logbook). The observer should then be trained through a training phase, acquire specific skills and knowledge to be able to use these tools and to detect the phenomenon he intends to study (Venuti, 2001). The data obtained from observation can be both qualitative and quantitative. Qualitative data have a narrative structure (Hilliard, 1993), while quantitative data can be used for various measurements and analyses (e.g. frequency and duration measurements, sequential analyses, etc.).

COUR EUROPÉENNE DES DROITS DE L'HOMME
EUROPEAN COURT OF HUMAN RIGHTS

CASE OF Z AND OTHERS v. THE UNITED KINGDOM

(Application no. 29392/95)

JUDGMENT

STRASBOURG

10 May 2001

In the case of Z and Others v. the United Kingdom,

The European Court of Human Rights, sitting as a Grand Chamber composed of the following judges:

Mr L. WILDHABER, *President*,
Mrs E. PALM,
Mr C.L. ROZAKIS,
Mr J.-P. COSTA,
Mr L. FERRARI BRAVO,
Mr L. CAFLISCH,
Mr P. KŪRIS,
Mr J. CASADEVALL,
Mr B. ZUPANČIČ,
Mrs N. VAJIĆ,
Mr J. HEDIGAN,
Mrs W. THOMASSEN,
Mrs M. TSATSA-NIKOLOVSKA,
Mr E. LEVITS,
Mr K. TRAJA,
Mr A. KOVLER,
Lady Justice ARDEN, ad hoc *judge*,

and also of Mr P.J. MAHONEY, *Deputy Registrar*,

Having deliberated in private on 28 June and 11 October 2000 and on 4 April 2001,

Delivers the following judgment, which was adopted on the last-mentioned date:

PROCEDURE

1. The case was referred to the Court, in accordance with the provisions applicable prior to the entry into force of Protocol No. 11 to the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention"), by the European Commission of Human Rights ("the Commission") on 25 October 1999 (Article 5 § 4 of Protocol No. 11 and former Articles 47 and 48 of the Convention).

2. The case originated in an application (no. 29392/95) against the United Kingdom of Great Britain and Northern Ireland lodged with the Commission under former Article 25 of the Convention by the applicants, Z, A, B, C and D, five British nationals, on 9 October 1995.

3. The applicants alleged that the local authority had failed to take adequate protective measures in respect of the severe neglect and abuse which they were known to be suffering due to their ill-treatment by their

parents and that they had no access to a court or effective remedy in respect of this. They relied on Articles 3, 6, 8 and 13 of the Convention.

4. The Commission declared the application admissible on 26 May 1998. On 6 September 1999, pursuant to the express wishes of D's adoptive parents, the Commission decided that D should no longer be an applicant. In its report of 10 September 1999 (former Article 31 of the Convention) [*Note by the Registry*. The report is obtainable from the Registry], it expressed the unanimous opinion that there had been a violation of Article 3 of the Convention, that no separate issue arose under Article 8, that there had been a violation of Article 6 and that no separate issue arose under Article 13.

5. Before the Court the applicants had been granted legal aid. The President of the Court acceded to their request not to have their names disclosed (Rule 47 § 3 of the Rules of Court).

6. On 6 December 1999 a panel of the Grand Chamber determined that the case should be decided by the Grand Chamber (Rule 100 § 1). The composition of the Grand Chamber was determined according to the provisions of Article 27 §§ 2 and 3 of the Convention and Rule 24. The President of the Court decided that in the interests of the proper administration of justice, the case should be assigned to the Grand Chamber that had been constituted to hear the case of *T.P. and K.M. v. the United Kingdom* ([GC], no. 28945/95, ECHR 2001-V) (Rules 24, 43 § 2, and 71). Sir Nicolas Bratza, the judge elected in respect of the United Kingdom, who had taken part in the Commission's examination of the case, withdrew from sitting in the Grand Chamber (Rule 28). The United Kingdom Government ("the Government") accordingly appointed Lady Justice Arden to sit as an *ad hoc* judge (Article 27 § 2 of the Convention and Rule 29 § 1).

7. The applicants and the Government each filed a memorial. Third-party comments were also received from Professor G. Van Bueren, Director of the Programme on International Rights of the Child, University of London, who had been given leave by the President to intervene in the written procedure (Article 36 § 2 of the Convention and Rule 61 § 3).

8. A hearing took place in public in the Human Rights Building, Strasbourg, on 28 June 2000 (Rule 59 § 2).

There appeared before the Court:

(a) *for the Government*

Ms S. McGRORY, Foreign and Commonwealth Office, *Agent*,
Mr D. ANDERSON QC, Foreign and Commonwealth Office,
Ms J. STRATFORD, Foreign and Commonwealth Office, *Counsel*,
Ms S. RYAN, Foreign and Commonwealth Office,
Ms J. GRAY, Foreign and Commonwealth Office,
Mr M. MURMANE, Foreign and Commonwealth Office, *Advisers*;

(b) *for the applicants*
Mr B. EMMERSON QC, *Counsel*,
Ms P. WOOD, Solicitor,
Mrs M. MAUGHAN, Solicitor,
Ms E. GUMBEL QC,
Ms N. MOLE, of the AIRE Centre, *Advisers*.

The Court heard addresses by Mr Emmerson and Mr Anderson.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

9. The applicants are four full siblings:
– Z, a girl born in 1982;
– A, a boy born in 1984;
– B, a boy born in 1986;
– C, a girl born in 1988.

10. The applicants' parents were married in November 1981.

11. The family was first referred to social services in October 1987 by their health visitor due to concerns about the children and marital problems. Z was reported to be stealing food at night. Following the referral, a professionals' meeting, involving the relevant agencies, was held on 24 November 1987, at which it was decided that a social worker and health visitor should visit. The family were reviewed at a further meeting in March 1988 and as it appeared that concerns had diminished, the file was closed.

12. In September 1988 a neighbour reported that the children were locked outside the house for most of the day.

13. In April 1989 the police reported that the children's bedrooms were filthy. The family's general practitioner also reported that the children's bedrooms were filthy and that their doors were locked. The children's head-teacher, Mrs Armstrong, expressed concern in May 1989 and requested a case conference. In June 1989 the NSPCC (National Society for the Prevention of Cruelty to Children) and the emergency team made a referral after complaints by neighbours that the house was filthy and that the children spent most of the day in their bedrooms, rarely being allowed out to play, and crying frequently. In August 1989 the maternal grandmother complained to the social services about the mother's care and discipline of the children.

14. At a professionals' meeting on 4 October 1989, at which the social services, the applicants' head-teacher, the applicants' general practitioner

and health visitor attended, it was decided that no social worker would be allocated to the family. The school was to monitor the older children's weight and the health visitor was to continue to visit the family regularly. It was agreed that the problem was one of limited and neglectful parenting rather than a risk of physical abuse, and that the parents should be assisted to manage their responsibilities better.

15. In October 1989, whilst the applicants were on holiday, their house was burgled. On entering, the police found it in a filthy state. Used sanitary towels and dirty nappies were discarded in a cupboard and the children's mattresses were sodden with urine. At a professionals' meeting on 13 December 1989, the health visitor requested that the four older children be placed on the Child Protection Register as she felt that their mother could not offer consistent care. This suggestion was rejected. However, a social-work assistant, Ms M., was assigned to the family. It was not considered appropriate to convene a case conference at this stage. Prior to the meeting, Z and A had mentioned to the head-teacher that A had been hit with a poker. It was decided that this statement would be investigated.

16. At a professionals' meeting on 23 March 1990, an improvement was noted in respect of the cleanliness of the house, the children's bedding being clean save on two occasions. However, it was reported that Z and A were taking food from bins at the school. There was still considered to be cause for concern, especially since the birth of another child was expected.

17. At a professionals' meeting on 11 July 1990, the applicants' headmistress reported a deterioration in the children's well-being; Z and A were still taking food from bins and A was soiling himself. Ms M. was visiting weekly at this stage and said that she was checking the children's bedrooms. She had noted that the children ate at 4 or 4.30 p.m. and then did not eat again until the morning. The children were also sent to bed at 6 p.m. It was planned to give the applicant's mother further assistance through a voluntary agency.

18. In or about September 1990, A and B were both reported to have bruising on their faces. The police investigated after neighbours had reported screaming at the applicants' home but apparently found no signs of bruising. They reported to the social services that "the conditions of the house were appalling and not fit for [the] children to live in".

19. At a further professionals' meeting on 3 October 1990, the assistant social worker, Ms M., stated that she was concerned about the applicants' soiling and their mother's lack of interest. Apparently, the children were defecating in their bedroom and smearing excrement on their windows. The head-teacher expressed concern, particularly concerning the boys A and B, and stated that the children had described blocks of wood being placed against their bedroom doors. It was decided to continue monitoring the children.

20. At a professionals' meeting on 5 December 1990, a decision was made to arrange a case conference for January 1991 as a result of concern regarding the applicants' care and the state of their bedroom. Ms M. considered that standards in the boys' bedroom had dramatically dropped. She found the room to be damp and smelly. A's bed was broken and had a metal bar protruding from it. The bedding was damp and grubby with soil marks.

21. In a report dated 24 January 1991, the headmistress stated that A was shabby, ill-kempt and often dirty and that he had been raiding the playground bins for apple cores. Z was pathetic, lacking in vitality and frequently and inexplicably tearful, becoming increasingly isolated from the other girls in her peer group with unfortunate incidents in which detrimental remarks were made about her appearance. B presented as withdrawn, pathetic and bedraggled. He regularly arrived cold, was frequently tearful and craved physical contact from adult helpers. He also appeared to crave for food. She concluded that they were still concerned that the children's needs were not being adequately met and that home conditions and family dynamics were giving reasons for concern.

22. At the case conference held on 28 January 1991, Ms M. stated that the boys' bedroom had no light, carpet or toys and that their bedding was wet, smelly and soil-stained. Their mother did not change the beds. Their head-teacher stated that Z was tearful and withdrawn, A had been raiding school bins and was often dirty, and B was very withdrawn, craved attention and was ravenously hungry. The chairman of the conference concluded that, despite the many concerns about the parenting of the applicants and the conditions in the home, there was little evidence to support going to court. It was felt that the parents were not wilfully neglecting their children and, bearing in mind their own poor upbringing, it was considered that the applicants' parents were doing what they could and that continued support was required to try and improve the situation. It was decided not to place the children on the Child Protection Register.

23. On 5 March 1991 B was found to have “unusual” bruises on his back.

24. At a later social services meeting in April 1991, no change to the children's living conditions was noted. The head-teacher stated that Z and A were still taking food from bins and that A was becoming more withdrawn. Ms M. reported that the mother had stated that the children were taking food from the park bins on the way to school.

25. In July 1991 the applicants' mother informed social services that the children would be better off living in care. On 12 August 1991 the social services received a phone call from a neighbour who stated that the children were frequently locked outside in a filthy back garden, that they constantly screamed and that they were kept for long periods in their bedrooms where they smeared faeces on their windows. The maternal grandparents later told

the guardian *ad litem* that Z, who was treated by her mother as a little servant, was expected to clean the excrement from the windows.

26. From 19 to 28 August 1991, the three older children spent some time with foster carers in respite care. The foster carers reported that A did not know how to wash, bathe or clean his teeth on arrival. He wet his bed every night and stole food from his brother. B was described as being "very frightened. He could not understand how he could play in the garden and the door was left open for him to come back in, he expected to be locked out". He also had to be taught to use the toilet properly and to clean himself.

27. At a professionals' meeting on 18 September 1991, Ms M. stated that the conditions in which the boys were sleeping were deteriorating. The mattresses in the boys' bedroom were ripped and the springs were coming through. The boys were stealing food, and C had also been seen to do this. Their mother stated that she could not control them. It was decided not to arrange a child-protection meeting but to carry out a monthly weight check on the three older children at school, and for the health visitor to check the weight of the two younger children. It was also decided to arrange respite care for Z, A and B in the holidays as well as on one weekend in four.

28. In November-December 1991 C was found to have developed a squint. His mother failed to keep appointments at the eye-clinic over the following months.

29. At a professionals' meeting on 21 November 1991, it was reported that the applicants' mother had said that she could not control the applicants' behaviour which consisted of refusing to go to bed when asked and stealing food. It was considered that the home was in an acceptable condition, though the boys' room still needed attention. The children's weights were recorded. It was noted that Z had put on 2 lb in the previous two months whereas she had only put on 2.5 lb in the preceding two years. A had only put on 3 lb in a year. B had put on 0.5 lb in a year and was on the 50th centile for height. C was on the 25th centile for weight. There was a discussion about the three elder children being accommodated by the local authority to allow the mother "to get back on her feet". The social services considered a six-week period whilst the general practitioner envisaged a period of eighteen to twenty-four months.

30. In December 1991 a social worker was introduced to the applicants' mother with a view to assisting her with shopping, budgeting and cooking.

31. Z, A and B were accommodated by volunteers between January and March 1992, and showed to have gained weight. In March and again in April, their mother asked if the boys, A and B, could be placed for adoption.

32. On 14 January 1992 C started to attend a nursery group at a family centre. She was noted to be unsocialised, lacking in confidence, unable to share, and with poor speech.

33. At a further professionals' meeting on 9 March 1992, it was decided that further respite care would be considered. The children's weights were noted, increases being seen for Z, A and B.

34. The children's parents divorced in April 1992.

35. At another professionals' meeting on 30 April 1992 it was decided that the applicants' mother's request that A and B be placed for adoption be followed up. The headmistress voiced concern over the fundamental pattern of the mother's care of the children, in particular in relation to Z's role in the home and the mothering role which she played. Ms M. reported that conditions were deteriorating for A and B.

36. On 10 June 1992 the applicants' mother demanded that the children be placed in care as she could not cope. She stated that if they were not removed from her care she would batter them. The applicants were placed in emergency foster care. The applicants were entered onto the Child Protection Register under the categories of neglect and emotional abuse after a child-protection meeting on 22 June 1992.

37. The applicants were all fostered separately. Initially, Z was noted to have dirty, ill-fitting clothes. She stated that she did not like living with her siblings as she did not like having to look after them all the time. A wet the bed every night, shunned physical contact and suffered from nightmares. B did not know how to use the toilet or toilet paper. C bonded very quickly with her foster parents.

38. On 8 October 1992 the local authority decided to seek care orders in respect of the children. Interim care orders were made on 7 December 1992.

39. A guardian *ad litem*, who was appointed on 18 January 1993, recommended that all the applicants should be the subject of care orders in order to protect them from further harm. She stated that there was "an abundance of evidence that the children have been subjected to physical and mental ill-treatment". She noted that their health had also been neglected by their parents who frequently missed appointments with opticians and doctors.

40. All the applicants were seen by Dr Dora Black, a consultant child psychiatrist, in January 1993. Dr Black stated that the three older children were all showing signs of psychological disturbance. Z was exhibiting signs of serious depressive illness and had assumed responsibility for her family and for its breakdown. Her mother's behaviour towards her was described as cruel and emotionally abusive. A and B, who suffered from nightmares, were both identified as showing signs of post-traumatic stress disorder and A was also chronically under-attached. Dr Black noted that all children had been deprived of affection and physical care. She described their experiences as "to put it bluntly, horrific", and added that the case was the worst case of neglect and emotional abuse that she had seen in her professional career. In her opinion, social services had "leaned over backwards to avoid putting these children on the Child Protection Register

and had delayed too long, leaving at least three of the children with serious psychological disturbance as a result".

41. Full care orders were made in respect of the applicants on 14 April 1993 by Judge Tyrer sitting at Milton Keynes County Court.

42. In June 1993 the Official Solicitor, acting as the applicants' next friend, commenced proceedings against the local authority claiming damages for negligence and/or breach of statutory duty arguing that the authority had failed to have regard to their welfare as was required by statute and should have acted more quickly and more effectively when apprised of their condition. It was argued that the local authority's failure to act had resulted in psychological damage. The application was struck out as revealing no cause of action, by Mr Justice Turner on 12 November 1993.

43. The applicants appealed to the Court of Appeal, which, on 28 February 1994, upheld the decision of Mr Justice Turner to strike out the application.

44. The applicants appealed to the House of Lords. On 29 June 1995 the House of Lords rejected their appeal, finding that no action lay against the local authority in negligence or breach of statutory duty concerning the discharge of their duties relating to the welfare of children under the Children Act 1989 in respect of child care. The case is reported as *X and Others v. Bedfordshire County Council* [1995] 3 All England Law Reports 353.

45. Lord Browne-Wilkinson gave the leading judgment. In respect of claims for breach of statutory duty, he stated, *inter alia*:

> "... My starting point is that the Acts in question are all concerned to establish an administrative system designed to promote the social welfare of the community. The welfare sector involved is one of peculiar sensitivity, involving very difficult decisions how to strike the balance between protecting the child from immediate feared harm and disrupting the relationship between the child and its parents. In my judgment in such a context it would require exceptionally clear statutory language to show a parliamentary intention that those responsible for carrying out these difficult functions should be liable in damages if, on subsequent investigation with the benefit of hindsight, it was shown that they had reached an erroneous conclusion and therefore failed to discharge their statutory duties. ...
>
> When one turns to the actual words used in the primary legislation to create the duties relied upon in my judgment they are inconsistent with any intention to create a private law cause of action."

46. As regards the claims that the local authority owed a duty of care to the applicants pursuant to the tort of negligence, Lord Browne-Wilkinson stated, *inter alia*:

> "I turn then to consider whether, in accordance with the ordinary principles laid down in *Caparo* [1990] 2 AC 605, the local authority ... owed a direct duty of care to the plaintiffs. The local authority accepts that they could foresee damage to the plaintiffs if they carried out their statutory duties negligently and that the relationship between the authority and the plaintiffs is sufficiently proximate. The third

requirement laid down in *Caparo* is that it must be just and reasonable to impose a common law duty of care in all the circumstances ...

The Master of the Rolls took the view, with which I agree, that the public policy consideration that has first claim on the loyalty of the law is that wrongs should be remedied and that very potent counter considerations are required to override that policy (see [1994] 4 AER 602 at 619). However, in my judgment there are such considerations in this case.

First, in my judgment a common law duty of care would cut across the whole statutory system set up for the protection of children at risk. As a result of the ministerial directions contained in 'Working Together' the protection of such children is not the exclusive territory of the local authority's social services. The system is inter-disciplinary, involving the participation of the police, educational bodies, doctors and others. At all stages the system involves joint discussions, joint recommendations and joint decisions. The key organisation is the Child Protection Conference, a multi-disciplinary body which decides whether to place the child on the Child Protection Register. This procedure by way of joint action takes place, not merely because it is good practice, but because it is required by guidance having statutory force binding on the local authority. The guidance is extremely detailed and extensive: the current edition of 'Working Together' runs to 126 pages. To introduce into such a system a common law duty of care enforceable against only one of the participant bodies would be manifestly unfair. To impose such liability on all the participant bodies would lead to almost impossible problems of disentangling as between the respective bodies the liability, both primary and by way of contribution, of each for reaching a decision found to be negligent.

Second, the task of the local authority and its servants in dealing with children at risk is extraordinarily delicate. Legislation requires the local authority to have regard not only to the physical well-being of the child but also to the advantages of not disrupting the child's family environment. ... In one of the child abuse cases, the local authority is blamed for removing the child precipitately; in the other for failing to remove the children from their mother. As the Report of the Inquiry into Child Abuse in Cleveland 1987 (Cmnd. 412) ('Cleveland Report 1987') said, at p. 244:

> '... It is a delicate and difficult line to tread between taking action too soon and not taking it soon enough. Social services whilst putting the needs of the child first must respect the rights of the parents; they also must work if possible with the parents for the benefit of the children. These parents themselves are often in need of help. Inevitably a degree of conflict develops between those objectives.'

Next, if liability in damages were to be imposed, it might well be that local authorities would adopt a more cautious and defensive approach to their duties. For example, as the Cleveland Report makes clear, on occasions the speedy decision to remove the child is sometimes vital. If the authority is to be made liable in damages for a negligent decision to remove a child (such negligence lying in the failure properly first to investigate the allegations) there would be a substantial temptation to postpone making such a decision until further inquiries have been made in the hope of getting more concrete facts. Not only would the child in fact being abused be prejudiced by such delay, the increased workload inherent in making such investigations would reduce the time available to deal with other cases and other children.

> The relationship between the social worker and the child's parents is frequently one of conflict, the parent wishing to retain care of the child, the social worker having to consider whether to remove it. This is fertile ground in which to breed ill-feeling and litigation, often hopeless, the cost of which both in terms of money and human resources will be diverted from the performance of the social service for which they were provided. The spectre of vexatious and costly litigation is often urged as a reason for not imposing a legal duty. But the circumstances surrounding cases of child abuse make the risk a very high one which cannot be ignored.
>
> If there were no other remedy for maladministration of the statutory system for the protection of children, it would provide substantial argument for imposing a duty of care. But the statutory complaints procedures contained in section 76 of the 1980 Act and the much fuller procedures now available under the 1989 Act provide a means to have grievances investigated though not to recover compensation. Further, it was submitted (and not controverted) that the local authorities Ombudsman would have power to investigate cases such as these.
>
> Finally, your Lordships' decision in *Caparo* [1990] 2 AC 605 lays down that in deciding whether to develop novel categories of negligence the court should proceed incrementally and by analogy with decided categories. We were not referred to any category of case in which a duty of care has been held to exist which is in any way analogous to the present cases. Here, for the first time, the plaintiffs are seeking to erect a common law duty of care in relation to the administration of a statutory social welfare scheme. Such a scheme is designed to protect weaker members of society (children) from harm done to them by others. The scheme involves the administrators in exercising discretion and powers which could not exist in the private sector and which in many cases bring them into conflict with those who, under the general law, are responsible for the child's welfare. To my mind, the nearest analogies are the cases where a common law duty of care has been sought to be imposed upon the police (in seeking to protect vulnerable members of society from wrongs done to them by others) or statutory regulators of financial dealing who are seeking to protect investors from dishonesty. In neither of these cases has it been thought appropriate to superimpose on a statutory regime a common law duty of care giving rise to a claim in damages for failure to protect the weak against the wrongdoer. ... In my judgment, the courts should proceed with great care before holding liable in negligence those who have been charged by Parliament with the task of protecting society from the wrong doings of others."

47. Z and C, the two girls, were meanwhile adopted. The boys, A and B, were initially in foster care. Following the breakdown of B's adoptive placement, he was placed in a therapeutic residential placement in July 1995. After two years, he was again placed with foster parents where he remained, attending school in a special-needs group. In January 1996, A was placed in a therapeutic community, where he stayed for two years. He apparently had a number of foster placements which broke down. Records indicated that he had been in twelve different placements in eight years. He is currently in a children's home.

48. In March 1996, applications were made to the Criminal Injuries Compensation Board (CICB) on behalf of all the children by the adoption society to whom the local authority had delegated certain responsibilities. It was claimed on behalf of Z that she had suffered severe neglect and chronic

deprivation which rendered it likely that specialist care would be necessary during her adolescence, a time where emotional repercussions of the abuse might become apparent; on behalf of A that he had suffered physical deprivation, emotional abuse, physical abuse and possible sexual abuse – he had suffered permanent physical scarring and was still receiving treatment from a child psychiatrist; on behalf of B that he had suffered extreme physical and emotional deprivation and shown signs of sexual abuse – he also had suffered permanent physical scarring and was receiving therapy; and on behalf of C that she had suffered extreme physical and emotional deprivation, and in addition that her need for eye treatment was not being met by her parents.

49. In February 1997, the CICB awarded 1,000 pounds sterling (GBP) to Z, GBP 3,000 to A and GBP 3,000 to B for injuries suffered between 1987 and 1992; it awarded GBP 2,000 to C for injuries suffered between 1988 and 1992. In a letter dated 20 May 1998 from the CICB to the Official Solicitor, it was stated:

> "The Board Member who assessed these cases recognised that the children were exposed to appalling neglect over an extended period but explained to their advisers that the Board could not make an award unless it was satisfied on the whole available evidence that an applicant had suffered an injury – physical or psychological – directly attributable to a crime of violence ... He was nevertheless satisfied, that setting aside 'neglect' the children had some physical and psychological injury inflicted upon them as enabled him to make an award to each child ..."

II. RELEVANT DOMESTIC LAW

A. Local authority's duties in respect of child care

50. Prior to the coming into force of the current legislation, the Children Act 1989, on 14 October 1991, the local authority's duty in respect of child care was governed by the Child Care Act 1980.

Sections 1 and 2 of the Child Care Act 1980 provided that:

> "1. It shall be the duty of every local authority to make available such advice, guidance and assistance as may promote the welfare of children by diminishing the need to receive or keep them in care.
>
> 2. (1) Where it appears to a local authority with respect to a child in their area appearing to them to be under the age of seventeen -
>
> (a) that he has neither parent nor guardian or has been and remains abandoned by his parents or guardian or is lost;
>
> (b) that his parents or guardian are, for the time being or permanently, prevented by reason of mental or bodily disease or infirmity or other incapacity or any other

circumstances from providing for his proper accommodation, maintenance and upbringing; and

(c) in either case, that the intervention of the local authority under this section is necessary in the interests of the welfare of the child, it shall be the duty of the local authority to receive the child into their care under this section."

51. Section 17 of the Children Act 1989 has since provided, *inter alia*:

"17. Provision of services for children in need, their families and others

(1) It shall be the general duty of every local authority (in addition to the other duties imposed on them by this Part) -

(a) to safeguard and promote the welfare of children within their area who are in need; and

(b) so far as is consistent with that duty, to promote the upbringing of such children by their families,

by providing a range and level of services appropriate to those children's needs.

(2) For the purpose principally of facilitating the discharge of their general duty under this section, every local authority shall have the specific duties and powers set out in Part I of Schedule 2.

...

(10) For the purposes of this Part a child shall be taken to be in need if -

(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him of services by a local authority under this Part;

(b) his health or development is likely to be significantly impaired or further impaired, without the provision for him of such services; or

(c) he is disabled ...

(11) ...; and in this Part

'development' means physical, intellectual, emotional, social or behavioural development; and

'health' means physical or mental health."

52. Part III of the Children Act 1989 deals with local authority support for children and families. The policy of the Act is made clear by paragraph 7 of Part I of Schedule 2, which requires local authorities to take reasonable steps designed to reduce the need to bring proceedings relating to children.

53. Section 20 provides that

"20(1) Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of -

(a) there being no person who has parental responsibility for him;

(b) his being lost or having been abandoned; or

(c) the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.

...

(4) A local authority may provide accommodation for any child within their area (even though a person who has parental responsibility for him is able to provide him with accommodation) if they consider that to do so would safeguard or promote the child's welfare."

54. Part V of the Children Act 1989 deals with the protection of children. Section 47 provides as follows:

"47(1) Where a local authority -

...

(b) have reasonable cause to suspect that a child who lives or is found, in their area is suffering, or is likely to suffer, significant harm,

the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

...

(8) Where, as a result of complying with this section, a local authority conclude that they should take action to safeguard or promote the child's welfare they shall take action (so far as it is within their power and reasonably practicable for them to do so)."

B. Complaints procedure

55. The complaints procedure is provided by section 26 of the Children Act 1989:

"Review of cases and inquiries into representations

...

(3) Every local authority shall establish a procedure for considering any representations (including any complaint) made to them by -

(a) any child ... who is not being looked after by them but is in need;

(b) a parent of his;

...

(e) such other person as the authority consider has a sufficient interest in the child's welfare to warrant his representations being considered by them,

about the discharge by the authority of any of their functions under this Part in relation to the child.

(4) The procedure shall ensure that at least one person who is not a member or officer of the authority takes part in -

(a) the consideration; and

(b) any discussions which are held by the local authority about the action (if any) to be taken in relation to the child in the light of this consideration.

...

(7) Where any representation has been considered under the procedure established by the local authority under this section, the authority shall -

(a) have due regard to the findings of those considering the representation; and

(b) take such steps as are reasonably practicable to notify (in writing) -

(i) the person making the representation;

(ii) the child (if the authority consider that he has sufficient understanding); and

(iii) such other persons (if any) as appear to the authority to be likely to be affected,

of the authority's decision in the matter and their reasons for taking that decision and of any action which they have taken, or propose to take.

(8) Every local authority shall give such publicity to their procedure for considering representations under this section as they consider appropriate."

56. The powers of the Secretary of State to investigate the actions of the local authority are set out in sections 81 and 84 of the Children Act 1989.

"81. (1) The Secretary of State may cause an inquiry to be held into any matter connected with -

(a) the function of the social services committee of a local authority, in so far as those functions relate to children;

...

84. Local authority failure to comply with statutory duty: default power of Secretary of State

(1) If the Secretary of State is satisfied that any local authority has failed, without reasonable excuse, to comply with any of the duties imposed on them by or under this Act he may make an order declaring that authority to be in default with respect to that duty.

...

(3) Any order under subsection (1) may contain such directions for the purpose of ensuring that the duty is complied with, within such period as may be specified in the order, as appears to the Secretary of State to be necessary.

(4) Any such directions shall, on the application of the Secretary of State, be enforceable by mandamus."

C. Actions for damages against the local authority

57. In England and Wales there is no single tort which imposes liability to pay compensation for civil wrongs. Instead there is a series of separate torts, for example, trespass, conversion, conspiracy, negligence and defamation.

58. Negligence arises in specific categories of situations. These categories are capable of being extended. There are three elements to the tort of negligence: a duty of care, breach of the duty of care, and damage. The duty of care may be described as the concept which defines the categories of relationships in which the law may impose liability on a defendant in damages if he or she is shown to have acted carelessly. To show a duty of care, the claimant must show that the situation comes within an existing established category of cases where a duty of care has been held to exist. In novel situations, in order to show a duty of care, the claimant must satisfy a threefold test, establishing:

– that damage to the claimant was foreseeable;

– that the claimant was in an appropriate relationship of proximity to the defendant; and,

– that it is fair, just and reasonable to impose liability on the defendant.

These criteria apply to claims against private persons as well as claims against public bodies. The leading case is *Caparo Industries plc v. Dickman* ([1990] 2 Appeal Cases 605).

59. If the courts decide that as a matter of law there is no duty of care owed in a particular situation, that decision will (subject to the doctrine of precedent) apply in future cases where the parties are in the same relationship.

60. The decision in *X and Others v. Bedfordshire County Council* ([1995] 3 All England Law Reports 353) is the leading authority in the United Kingdom in this area. It held that local authorities could not be sued for negligence or for breach of statutory duty in respect of the discharge of

their functions concerning the welfare of children. The leading judgment is reported at length in the facts above (see paragraphs 45-46 above).

61. Since *X and Others v. Bedfordshire County Council*, there have been two further significant judgments regarding the extent of liability of local authorities in child care matters.

62. The Court of Appeal gave judgment in *W. and Others v. Essex County Council* ([1998] 3 All England Law Reports 111). This case concerned the claims by a mother and father (first and second plaintiffs), who had agreed to act as foster parents, that the defendant local authority placed G., a 15-year-old boy, in their home although they knew that he was a suspect or known sexual abuser. During G.'s stay in their home, the plaintiffs' three children (fourth to sixth plaintiffs) were all sexually abused and suffered psychiatric illness. The plaintiffs brought an action against the local authority and the social worker involved, claiming damages for negligence and for negligent misstatement. On the defendants' application to strike out the statement of claim as disclosing no reasonable cause of action, the judges struck out the parents' claims but refused to strike out the claims of the children. The Court of Appeal upheld his decision. The headnote for the judgment summarised the Court of Appeal's findings as follows:

> "(1) Although no claim in damages lay in respect of decisions by a local authority in the exercise of a statutory discretion, if the decision complained of was so unreasonable that it fell outside the ambit of the discretion conferred, there was no *a priori* reason for excluding common law liability. In the instant case, the giving of information to the parents was part and parcel of the defendants' performance of their statutory powers and duties, and it had been conceded that it was arguable that those decisions fell outside the ambit of their discretion. Accordingly, since it had also been conceded that the damage to the children was reasonably foreseeable and that there was sufficient proximity, the question for the court was whether it was just and reasonable to impose a duty of care on the council or the social worker. Having regard to the fact that common law duty of care would cut across the whole statutory set up for the protection of children at risk, that the task of the local authority and its servants in dealing with such children was extraordinarily difficult and delicate, that local authorities might adopt a more defensive approach to their duties if liability in damages were imposed, that the relationship between parents and social workers was frequently one of conflict and that the plaintiff children's injuries were compensatable under the Criminal Injuries Compensation Scheme, it was not just and reasonable to do so. It followed that no duty of care was owed to the plaintiff parents who in any event were secondary victims in respect of their claim for psychiatric illness ...
>
> (2) (Stuart-Smith LJ dissenting) It was arguable that the policy considerations against imposing a common law duty of care on a local authority in relation to the performance of its statutory duties to protect children did not apply when the children whose safety was under consideration were those in respect of whom it was not performing any statutory duty. Accordingly, since in the instant case, the plaintiff children were not children for whom the council had carried out any immediate caring responsibilities under the child welfare system but were living at home with their parents, and express assurances had been given that a sexual abuser would not be placed in their home, their claim should proceed ..."

63. On further appeal by the parents, the House of Lords on 16 March 2000 held that it was impossible to say that the psychiatric injury allegedly suffered by the parents, flowing from a feeling that they had brought the abuser and their children together or from a feeling of responsibility for not having detected the abuse earlier, was outside the range of psychiatric injury recognised by the law, nor was it unarguable that the local authority had owed a duty of care to the parents. The parents' claim could not be said to be so certainly or clearly bad that they should be barred from pursuing it to trial and their appeal was allowed.

64. The House of Lords gave judgment on 17 June 1999 in *Barrett v. London Borough of Enfield* ([1999] 3 Weekly Law Reports 79). That case concerned the claims of the plaintiff, who had been in care from the age of ten months to 17 years, that the local authority had negligently failed to safeguard his welfare causing him deep-seated psychiatric problems. The local authority had applied to strike out the case as disclosing no cause of action. The House of Lords, upholding the plaintiff's appeal, unanimously held that the judgment in *X and Others v. Bedfordshire County Council* did not in the circumstances of this case prevent a claim of negligence being brought against a local authority by a child formerly in its care.

65. Lord Browne-Wilkinson, in his judgment in that case, commented as follows on the operation of the duty of care:

> "(1) Although the word 'immunity' is sometimes incorrectly used, a holding that it is not fair, just and reasonable to hold liable a particular class of defendants whether generally or in relation to a particular type of activity is not to give immunity from a liability to which the rest of the world is subject. It is a prerequisite to there being any liability in negligence at all that as a matter of policy it is fair, just and reasonable in those circumstances to impose liability in negligence. (2) In a wide range of cases public policy has led to the decision that the imposition of liability would not be fair and reasonable in the circumstances, e.g. some activities of financial regulators, building inspectors, ship surveyors, social workers dealing with sex abuse cases. In all these cases and many others the view has been taken that the proper performance of the defendant's primary functions for the benefit of society as a whole will be inhibited if they are required to look over their shoulder to avoid liability in negligence. In English law the decision as to whether it is fair, just and reasonable to impose a liability in negligence on a particular class of would-be defendants depends on weighing in the balance the total detriment to the public interest in all cases from holding such class liable in negligence as against the total loss to all would-be plaintiffs if they are not to have a cause of action in respect of the loss they have individually suffered. (3) In English law, questions of public policy and the question whether it is fair and reasonable to impose liability in negligence are decided as questions of law. Once the decision is taken that, say, company auditors though liable to shareholders for negligent auditing are not liable to those proposing to invest in the company (see *Caparo Industries plc v. Dickman* [1990] 1 All ER 568, [1990] 2 AC 605), that decision will apply to all future cases of the same kind. The decision does not depend on weighing the balance between the extent of the damage to the plaintiff and the damage to the public in each particular case."

D. Striking-out procedure

66. At the relevant time, Order 18, Rule 19 of the Rules of the Supreme Court provided that a claim could be struck out if it disclosed no reasonable cause of action. This jurisdiction has been described as being reserved for "plain and obvious cases", in which a claim was "obviously unsustainable".

67. In applications to strike out, the courts proceeded on the basis that all the allegations set out in the claimant's pleadings were true. The question for the courts was whether, assuming that the claimant could substantiate all factual allegations at trial, the claim disclosed a reasonable cause of action.

68. The striking out procedure, now contained in Part 3.4(2) of the Civil Procedure Rules in force since 1999, is regarded as an important feature of English civil procedure, performing the function of securing speedy and effective justice, *inter alia*, by allowing a court to decide promptly which issues need full investigation and trial, and disposing summarily of the others. By means of this procedure, it can be determined at an early stage, with minimal cost to the parties, whether the facts as pleaded reveal a claim existing in law.

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION

69. The applicants alleged that the local authority had failed to protect them from inhuman and degrading treatment contrary to Article 3 of the Convention, which provides:

> "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

70. In its report the Commission expressed the unanimous opinion that there had been a violation of Article 3 of the Convention. It considered that there was a positive obligation on the Government to protect children from treatment contrary to this provision. The authorities had been aware of the serious ill-treatment and neglect suffered by the four children over a period of years at the hands of their parents and failed, despite the means reasonably available to them, to take any effective steps to bring it to an end.

71. The applicants requested the Court to confirm this finding of a violation.

72. The Government did not contest the Commission's finding that the treatment suffered by the four applicants reached the level of severity prohibited by Article 3 and that the State failed in its positive obligation,

under Article 3 of the Convention, to provide the applicants with adequate protection against inhuman and degrading treatment.

73. The Court reiterates that Article 3 enshrines one of the most fundamental values of democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment. The obligation on High Contracting Parties under Article 1 of the Convention to secure to everyone within their jurisdiction the rights and freedoms defined in the Convention, taken in conjunction with Article 3, requires States to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman or degrading treatment, including such ill-treatment administered by private individuals (see *A. v. the United Kingdom*, judgment of 23 September 1998, *Reports of Judgments and Decisions* 1998-VI, p. 2699, § 22). These measures should provide effective protection, in particular, of children and other vulnerable persons and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge (see, *mutatis mutandis*, *Osman v. the United Kingdom*, judgment of 28 October 1998, *Reports* 1998-VIII, pp. 3159-60, § 116).

74. There is no dispute in the present case that the neglect and abuse suffered by the four applicant children reached the threshold of inhuman and degrading treatment (as recounted in paragraphs 11-36 above). This treatment was brought to the local authority's attention, at the earliest in October 1987. It was under a statutory duty to protect the children and had a range of powers available to them, including the removal of the children from their home. These were, however, only taken into emergency care, at the insistence of the mother, on 30 April 1992. Over the intervening period of four and a half years, they had been subjected in their home to what the consultant child psychiatrist who examined them referred as horrific experiences (see paragraph 40 above). The Criminal Injuries Compensation Board had also found that the children had been subject to appalling neglect over an extended period and suffered physical and psychological injury directly attributable to a crime of violence (see paragraph 49 above). The Court acknowledges the difficult and sensitive decisions facing social services and the important countervailing principle of respecting and preserving family life. The present case, however, leaves no doubt as to the failure of the system to protect these applicant children from serious, long-term neglect and abuse.

75. Accordingly, there has been a violation of Article 3 of the Convention.

II. ALLEGED VIOLATION OF ARTICLE 8 OF THE CONVENTION

76. The applicants alleged, in the alternative to their complaints under Article 3 of the Convention, that the circumstances in which they suffered

ill-treatment, causing them physical and psychological injury, disclosed a breach of Article 8 of the Convention, which under the principle of respect for private life, protected physical and moral integrity.

77. Having regard to its finding of a violation of Article 3, the Court considers that no separate issue arises under Article 8 of the Convention.

III. ALLEGED VIOLATION OF ARTICLE 6 OF THE CONVENTION

78. The applicants complained that they had been denied access to a court to determine their claims against the local authority in negligence. They relied on Article 6 of the Convention.

79. Article 6 § 1 provides in its first sentence:

> "In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law."

80. The Government denied that there was any civil right in issue in the case or any restriction on access, while the Commission found unanimously that there had been a breach of Article 6, in that the House of Lords had applied an exclusionary rule concerning the liability of local authorities in child care matters which constituted in the circumstances a disproportionate restriction on the applicants' access to a court.

A. Submissions of the parties

1. The applicants

81. The applicants submitted that their negligence claim was plainly arguable as a matter of domestic law, relying, *inter alia*, on *Osman*, cited above. The right to sue in negligence, a cause of action framed in general terms, was an established civil right in domestic law. The local authority had conceded that they could have foreseen damage to the applicants if they carried out their duties negligently and that there was a proximate relationship, thereby satisfying the first two limbs of the test for the duty of care. There was a strong argument that public policy considerations required a duty of care to be imposed and there was no prior decision excluding liability. The applicants also pointed to the fact that the judge who made the care orders specifically released the case papers to the Official Solicitor so that he could investigate and, if appropriate, pursue negligence claims; that the Official Solicitor considered that there were arguable claims in negligence; that the Legal Aid Board granted legal aid to pursue the claims to the House of Lords; and that the Court of Appeal which rejected the claims by a majority granted leave to appeal to the House of Lords, the precondition for such leave being that the claim was arguable in domestic

law; that the Master of the Rolls, in the Court of Appeal, found that there was duty of care, stating the contrary to be "an affront to common sense"; and that in previous cases, local authorities had paid settlements in negligence cases, on the basis that they were potentially liable. There was a serious dispute in domestic law, therefore, as to the existence of any exclusionary principle, which has continued since, and Article 6 was applicable.

82. The exclusionary rule applied by the House of Lords permitted the applicants' claims to be struck out without determining the facts and without a trial. This applied regardless of the merits or the seriousness of the harm suffered. Designed to protect local authorities from wasting resources on having to defend an action at all, this amounted in practical effect to an immunity and acted as a restriction on access to a court.

83. The application of a blanket rule which excluded the determination of the applicants' claims irrespective of the seriousness of the harm suffered, the nature and extent of negligence involved, or the fundamental rights which were at stake, constituted a disproportionate restriction on their right of access to a court. They emphasised the severity of the damage suffered by them due to prolonged exposure to abuse and neglect against which the public policy arguments against imposition of liability had little weight, namely, the alleged risk of frivolous litigation, the increased caution of social services in fulfilling their functions or the difficulty or sensitivity of the issues. Indeed, the requirement to investigate effectively cases of treatment contrary to Article 3 pointed strongly to the recognition of a right of access to a court where the State's responsibility had been engaged for inhuman or degrading treatment of vulnerable children. They referred to the Court's finding in *Osman* (cited above, p. 3170, § 151) that the domestic courts should be able to distinguish between degrees of negligence or harm and give consideration to the justice of a particular case. An exclusionary rule on that basis should be capable of yielding to competing human rights considerations on the facts of a particular case.

2. The Government

84. The Government submitted that Article 6 guaranteed a fair trial in the determination only of such civil rights and obligations as are (at least arguably) recognised in national law. It does not bear on the substantive question of whether a right to compensation exists in any given situation. The proceedings brought by the applicants established that no right existed. The decision to strike out their claim touched on the scope of the domestic law. By ruling that a right of action did not exist in a particular set of circumstances, the courts were applying substantive limits to tort liability, as the legislature might do in statute (see, for example, *Powell and Rayner v. the United Kingdom*, judgment of 21 February 1990, Series A no. 172,

pp. 16-17, § 36). There was no established cause of action which was restricted. Accordingly, they claimed that Article 6 § 1 was not applicable.

85. The Government argued in the alternative that there was no immunity applied which could be regarded as a restriction on access to a court. Even assuming that there was an arguable issue, there could in their view be no doubt that the dispute was subject to a fair and public hearing in compliance with the guarantees of Article 6. The striking-out procedure was an important way of securing the speedy and cost-effective determination of cases that were hopeless in law. It achieved those aims without inhibiting claimants' rights to present any arguments in their favour to a court. Thus, as factual matters were assumed to be those pleaded, the claimants were not prejudiced by the lack of hearing of evidence, while they could put forward any arguments in their favour to persuade the court that their claim was sustainable as a matter of law.

86. Assuming that their arguments on the above failed, the Government argued that any restriction on access to a court nonetheless pursued a legitimate aim and was proportionate. It aimed to preserve the efficiency of a vital sector of public service. The exclusion of liability was strictly limited in scope to the category of cases to which it applied, actions for misfeasance, vicarious liability for employees remaining unaffected. The domestic courts had themselves weighed up the public policy issues for and against liability in light of the principles of English tort law and the social and political philosophy underlying those principles. A very substantial margin of appreciation would therefore be appropriate in any international adjudication.

B. The Court's assessment

1. Applicability of Article 6 of the Convention

87. The Court recalls its constant case-law to the effect that "Article 6 § 1 extends only to '*contestations*' (disputes) over (civil) 'rights and obligations' which can be said, at least on arguable grounds, to be recognised under domestic law; it does not itself guarantee any particular content for (civil) 'rights and obligations' in the substantive law of the Contracting States" (see *James and Others v. the United Kingdom*, judgment of 21 February 1986, Series A no. 98, pp. 46-47, § 81; *Lithgow and Others v. the United Kingdom*, judgment of 8 July 1986, Series A no. 102, p. 70, § 192; and *The Holy Monasteries v. Greece*, judgment of 9 December 1994, Series A no. 301-A, pp. 36-37, § 80). It will however apply to disputes of a "genuine and serious nature" concerning the actual existence of the right as well as to the scope or manner in which it is exercised (see *Benthem v. the Netherlands*, judgment of 23 October 1985, Series A no. 97, pp. 14-15, § 32).

88. In the present case, the applicants were claiming damages on the basis of alleged negligence, a tort in English law which is largely developed through the case-law of the domestic courts. It is agreed by the parties that there was no previous court decision which indicated that liability existed in respect of damage caused negligently by a local authority in carrying out its child protection duties. It was in the applicants' case that the domestic courts were called on to rule whether this situation fell within one of the existing categories of negligence liability, or whether any of the categories should be extended to this situation (see paragraphs 57-65 above).

89. The Court is satisfied that at the outset of the proceedings there was a serious and genuine dispute about the existence of the right asserted by the applicants under the domestic law of negligence as shown, *inter alia*, by the grant of legal aid to the applicants and the decision of the Court of Appeal that their claims merited leave to appeal to the House of Lords. The Government's submission that there was no arguable (civil) "right" for the purposes of Article 6 once the House of Lords had ruled that no duty of care arose has relevance rather to any claims which were lodged or pursued subsequently by other plaintiffs. The House of Lords' decision did not remove, retrospectively, the arguability of the applicants' claims (see *Le Calvez v. France*, judgment of 29 July 1998, *Reports* 1998-V, pp. 1899-900, § 56). In such circumstances, the Court finds that the applicants had, on at least arguable grounds, a claim under domestic law.

90. Article 6 was, therefore, applicable to the proceedings brought by these applicants alleging negligence by the local authority. The Court must, therefore, examine whether the requirements of Article 6 were complied with in those proceedings.

2. Compliance with Article 6 of the Convention

91. The Court, in *Golder v. the United Kingdom* (judgment of 21 February 1975, Series A no. 18, pp. 13-18, §§ 28-36), held that the procedural guarantees laid down in Article 6 concerning fairness, publicity and expeditiousness would be meaningless if there were no protection of the pre-condition for the enjoyment of those guarantees, namely, access to a court. It established this as an inherent aspect of the safeguards enshrined in Article 6, referring to the principles of the rule of law and the avoidance of arbitrary power which underlie much of the Convention.

92. Article 6 § 1 "may ... be relied on by anyone who considers that an interference with the exercise of one of his (civil) rights is unlawful and complains that he has not had the possibility of submitting that claim to a tribunal meeting the requirements of Article 6 § 1" (see *Le Compte, Van Leuven and De Meyere v. Belgium*, judgment of 23 June 1981, Series A no. 43, p. 20, § 44). Where there is a serious and genuine dispute as to the lawfulness of such an interference, going either to the very existence or the scope of the asserted civil right, Article 6 § 1 entitles the individual "to have

this question of domestic law determined by a tribunal" (see *Sporrong and Lönnroth v. Sweden*, judgment of 23 September 1982, Series A no. 52, p. 30, § 81; see also *Tre Traktörer AB v. Sweden*, judgment of 7 July 1989, Series A no. 159, p. 18, § 40).

93. The right is not absolute, however. It may be subject to legitimate restrictions such as statutory limitation periods, security for costs orders, regulations concerning minors and persons of unsound mind (see *Stubbings and Others v. the United Kingdom*, judgment of 22 October 1996, *Reports* 1996-IV, pp. 1502-03, §§ 51-52; *Tolstoy Miloslavsky v. the United Kingdom*, judgment of 13 July 1995, Series A no. 316-B, pp. 80-81, §§ 62-67; and *Golder*, cited above, p. 19, § 39). Where the individual's access is limited either by operation of law or in fact, the Court will examine whether the limitation imposed impaired the essence of the right and, in particular, whether it pursued a legitimate aim and there was a reasonable relationship of proportionality between the means employed and the aim sought to be achieved (see *Ashingdane v. the United Kingdom*, judgment of 28 May 1985, Series A no. 93, pp. 24-25, § 57). If the restriction is compatible with these principles, no violation of Article 6 will arise.

94. It is contended by the applicants in this case that the decision of the House of Lords, finding that the local authority owed no duty of care, deprived them of access to a court as it was effectively an exclusionary rule, or an immunity from liability, which prevented their claims from being decided on the facts.

95. The Court observes, firstly, that the applicants were not prevented in any practical manner from bringing their claims before the domestic courts. Indeed, the case was litigated with vigour up to the House of Lords, the applicants being provided with legal aid for that purpose. Nor is it that any procedural rules or limitation periods had been relied on. The domestic courts were concerned with the application brought by the defendants to have the case struck out as disclosing no reasonable cause of action. This involved the pre-trial determination of whether, assuming the facts of the applicants' case as pleaded were true, there was a sustainable claim in law. The arguments before the courts were, therefore, concentrated on the legal issues, primarily whether a duty of care in negligence was owed to the applicants by the local authority.

96. Moreover, the Court is not persuaded that the House of Lords' decision that, as a matter of law, there was no duty of care in the applicants' case may be characterised as either an exclusionary rule or an immunity which deprived them of access to a court. As Lord Browne-Wilkinson explained in his leading speech, the House of Lords was concerned with the issue whether a novel category of negligence, that is a category of cases in which a duty of care had not previously been held to exist, should be developed by the courts in their law-making role under the common law

(see paragraph 46 above). The House of Lords, after weighing in the balance the competing considerations of public policy, decided not to extend liability in negligence into a new area. In so doing, it circumscribed the range of liability under tort law.

97. That decision did end the case, without the factual matters being determined on the evidence. However, if as a matter of law, there was no basis for the claim, the hearing of evidence would have been an expensive and time-consuming process which would not have provided the applicants with any remedy at its conclusion. There is no reason to consider the striking-out procedure which rules on the existence of sustainable causes of action as *per se* offending the principle of access to a court. In such a procedure, the plaintiff is generally able to submit to the court the arguments supporting his or her claims on the law and the court will rule on those issues at the conclusion of an adversarial procedure (see paragraphs 66-68 above).

98. Nor is the Court persuaded by the suggestion that, irrespective of the position in domestic law, the decision disclosed an immunity in fact or practical effect due to its allegedly sweeping or blanket nature. That decision concerned only one aspect of the exercise of local authorities' powers and duties and cannot be regarded as an arbitrary removal of the courts' jurisdiction to determine a whole range of civil claims (see *Fayed v. the United Kingdom*, judgment of 21 September 1994, Series A no. 294-B, pp. 49-50, § 65). As it has recalled above in paragraph 87, it is a principle of Convention case-law that Article 6 does not in itself guarantee any particular content for civil rights and obligations in national law, although other Articles such as those protecting the right to respect for family life (Article 8) and the right to property (Article 1 of Protocol No. 1) may do so. It is not enough to bring Article 6 § 1 into play that the non-existence of a cause of action under domestic law may be described as having the same effect as an immunity, in the sense of not enabling the applicant to sue for a given category of harm.

99. Furthermore, it cannot be said that the House of Lords came to its conclusion without carefully balancing the policy reasons for and against the imposition of liability on the local authority in the circumstances of the applicants' case. Lord Browne-Wilkinson, in his leading judgment in the House of Lords, acknowledged that the public policy principle that wrongs should be remedied required very potent counter-considerations to be overridden (see paragraph 46 above). He weighed that principle against the other public policy concerns in reaching the conclusion that it was not fair, just or reasonable to impose a duty of care on the local authority in the applicants' case. It may be noted that in subsequent cases the domestic courts have further defined this area of law concerning the liability of local authorities in child-care matters, holding that a duty of care may arise in other factual situations, where, for example, a child has suffered harm once

in local authority care, or a foster family has suffered harm as a result of the placement in their home by the local authority of an adolescent with a history of abusing younger children (see *W. and Others v. Essex County Council* and *Barrett*, both cited above, paragraphs 62-65 above).

100. The applicants, and the Commission in its report, relied on *Osman* (cited above) as indicating that the exclusion of liability in negligence, in that case concerning the acts or omissions of the police in the investigation and prevention of crime, acted as a restriction on access to a court. The Court considers that its reasoning in *Osman* was based on an understanding of the law of negligence (see, in particular, *Osman*, cited above, pp. 3166-67, §§ 138-39) which has to be reviewed in the light of the clarifications subsequently made by the domestic courts and notably by the House of Lords. The Court is satisfied that the law of negligence as developed in the domestic courts since the case of *Caparo Industries plc* (cited above) and as recently analysed in the case of *Barrett* (cited above, loc. cit.) includes the fair, just and reasonable criterion as an intrinsic element of the duty of care and that the ruling of law concerning that element in this case does not disclose the operation of an immunity. In the present case, the Court is led to the conclusion that the inability of the applicants to sue the local authority flowed not from an immunity but from the applicable principles governing the substantive right of action in domestic law. There was no restriction on access to a court of the kind contemplated in *Ashingdane* (cited above, loc. cit.).

101. The applicants may not, therefore, claim that they were deprived of any right to a determination on the merits of their negligence claims. Their claims were properly and fairly examined in light of the applicable domestic legal principles concerning the tort of negligence. Once the House of Lords had ruled on the arguable legal issues that brought into play the applicability of Article 6 § 1 of the Convention (see paragraphs 87-89 above), the applicants could no longer claim any entitlement under Article 6 § 1 to obtain any hearing concerning the facts. As pointed out above, such a hearing would have served no purpose, unless a duty of care in negligence had been held to exist in their case. It is not for this Court to find that this should have been the outcome of the striking-out proceedings since this would effectively involve substituting its own views as to the proper interpretation and content of domestic law.

102. It is nonetheless the case that the interpretation of domestic law by the House of Lords resulted in the applicants' case being struck out. The tort of negligence was held not to impose a duty of care on the local authority in the exercise of its statutory powers. Their experiences were described as "horrific" by a psychiatrist (see paragraph 40 above) and the Court has found that they were victims of a violation of Article 3 (see paragraph 74 above). Yet the outcome of the domestic proceedings they brought is that they, and any children with complaints such as theirs, cannot sue the local

authority in negligence for compensation, however foreseeable – and severe – the harm suffered and however unreasonable the conduct of the local authority in failing to take steps to prevent that harm. The applicants are correct in their assertions that the gap they have identified in domestic law is one that gives rise to an issue under the Convention, but in the Court's view it is an issue under Article 13, not Article 6 § 1.

103. The Court emphasises that the object and purpose underlying the Convention, as set out in Article 1, is that the rights and freedoms should be secured by the Contracting State within its jurisdiction. It is fundamental to the machinery of protection established by the Convention that the national systems themselves provide redress for breaches of its provisions, the Court exerting its supervisory role subject to the principle of subsidiarity. In that context, Article 13, which requires an effective remedy in respect of violations of the Convention, takes on a crucial function. The applicants' complaints are essentially that that they have not been afforded a remedy in the courts for the failure to ensure them the level of protection against abuse to which they were entitled under Article 3 of the Convention. The domestic courts referred to "the public-policy consideration that has first claim on the loyalty of the law" as being that "wrongs should be remedied" (see paragraph 46 above). As far as Convention wrongs are concerned, that principle is embodied in Article 13 (see, *inter alia*, *Kudła v. Poland* [GC], no. 30210/96, § 152, ECHR 2000-XI). It is under Article 13 that the applicants' right to a remedy should be examined and, if appropriate, vindicated.

104. Accordingly, the Court finds that there has been no violation of Article 6 of the Convention.

IV. ALLEGED VIOLATION OF ARTICLE 13 OF THE CONVENTION

105. The applicants submitted that they had not been afforded any remedy for the damage which they had suffered as a result of the failure of the local authority to protect them, relying on Article 13 of the Convention, which provides:

> "Everyone whose rights and freedoms as set forth in [the] Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."

106. The applicants argued that the exclusionary rule established by the House of Lords in their case deprived them of any effective remedy within the national legal system for the violation of Article 3 which they suffered. While the remedy required by Article 13 need not always be judicial in character, in their case a judicial determination was required. This was because the tort of negligence was the only remedy in national law capable of determining the substance of their complaint and which (but for the

alleged immunity) would closely match the requirements of the Convention. Also the accountability of public officials, central to both Articles 3 and 13, required a right of access to a court whereby the individual could hold the responsible officials to account in adversarial proceedings and obtain an enforceable order for compensation if the claim was substantiated. The wording of Article 13 also prohibited the creation of immunities for public officials and any such immunity must be regarded as contrary to the object and purpose of the Convention.

107. The Government pointed out that there were a number of remedies available to the applicants which went some way towards providing effective redress. This included the payment of compensation from the Criminal Injuries Compensation Board (CICB), the possibility of complaining to the Local Government Ombudsman, and the complaints procedure under the Children Act 1989. However, the Government accepted that in the particular circumstances of this case, the remedies were insufficient, alone or cumulatively, to satisfy the requirements of Article 13. They conceded that there had been a serious violation of one of the most important Convention rights, that the CICB could only award compensation for criminal acts, not for the consequences of neglect, and that any recommendation by the Ombudsman would not have been legally enforceable. They had been under the obligation, in this case, to ensure that some form of compensation was made available for damage caused by the breach of Article 3, whether by a broader statutory compensation scheme, an enforceable Ombudsman's award, or through the courts. They pointed out that from October 2000, when the Human Rights Act 1998 came into force, a victim would be able to bring proceedings in the courts against a public authority for a breach of a substantive right, and the courts would be empowered to award damages.

108. As the Court has stated on many occasions, Article 13 of the Convention guarantees the availability at the national level of a remedy to enforce the substance of the Convention rights and freedoms in whatever form they might happen to be secured in the domestic legal order. Article 13 thus requires the provision of a domestic remedy to deal with the substance of an "arguable complaint" under the Convention and to grant appropriate relief, although the Contracting States are afforded some discretion as to the manner in which they conform to their Convention obligations under this provision. The scope of the obligation under Article 13 also varies depending on the nature of the applicant's complaint under the Convention. Nevertheless, the remedy required by Article 13 must be "effective" in practice as well as in law (see, among other authorities, *Aydın v. Turkey*, judgment of 25 September 1997, *Reports* 1997-VI, pp. 1895-96, § 103).

109. The Court has previously held that where a right with as fundamental an importance as the right to life or the prohibition against torture, inhuman and degrading treatment is at stake, Article 13 requires, in

addition to the payment of compensation where appropriate, a thorough and effective investigation capable of leading to the identification and punishment of those responsible, including effective access for the complainant to the investigation procedure (see *Kaya v. Turkey*, judgment of 19 February 1998, *Reports* 1998-I, pp. 330-31, § 107). These cases, however, concerned alleged killings or infliction of treatment contrary to Article 3 involving potential criminal responsibility on the part of security force officials. Where alleged failure by the authorities to protect persons from the acts of others is concerned, Article 13 may not always require that the authorities undertake the responsibility for investigating the allegations. There should, however, be available to the victim or the victim's family a mechanism for establishing any liability of State officials or bodies for acts or omissions involving the breach of their rights under the Convention. Furthermore, in the case of a breach of Articles 2 and 3 of the Convention, which rank as the most fundamental provisions of the Convention, compensation for the non-pecuniary damage flowing from the breach should in principle be part of the range of available remedies.

110. The applicants have argued that in their case an effective remedy could only be provided by adversarial court proceedings against the public body responsible for the breach. The Court notes that the Government have conceded that the range of remedies at the disposal of the applicants was insufficiently effective. They have pointed out that in the future, under the Human Rights Act 1998, victims of human rights breaches will be able to bring proceedings in courts empowered to award damages. The Court does not consider it appropriate in this case to make any findings as to whether only court proceedings could have furnished effective redress, though judicial remedies indeed furnish strong guarantees of independence, access for the victim and family, and enforceability of awards in compliance with the requirements of Article 13 (see, *mutatis mutandis*, *Klass and Others v. Germany*, judgment of 6 September 1978, Series A no. 28, p. 30, § 67).

111. The Court finds that in this case the applicants did not have available to them an appropriate means of obtaining a determination of their allegations that the local authority failed to protect them from inhuman and degrading treatment and the possibility of obtaining an enforceable award of compensation for the damage suffered thereby. Consequently, they were not afforded an effective remedy in respect of the breach of Article 3 and there has, accordingly, been a violation of Article 13 of the Convention.

V. APPLICATION OF ARTICLE 41 OF THE CONVENTION

112. Article 41 of the Convention provides:

> "If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party."

A. Pecuniary damage

1. The applicants

113. The applicants submitted that they should be compensated for loss of future earnings and the costs of future medical expenses. Their experiences have, in different ways and to differing extents, blighted their lives. A substantial award should be made to enable them to enter life with a modicum of financial security, the potential to build an independent existence and the means to pay for therapeutic treatment and support.

114. The applicants provided updated medical reports dated 16 May 2000 by Dr Jean Harris-Hendriks concerning their progress and prognosis for the future.

(i) Z was described as having made a recovery from the serious depressive illness suffered at the time of her removal into care. While she was no longer suffering from any psychiatric illness, she had emotional, social and practical difficulties far beyond those normally affecting a girl of her age and was statistically vulnerable to anxiety and perhaps depressive illness in adult life. Her problems were classified as being of moderate severity. It was estimated that she would need psychotherapeutic treatment, outside the National Health Service, estimated at 60 to 100 sessions costing 70 to 90 pounds sterling (GBP) per session, to cope with her vulnerability, particularly at periods of transition. She was likely to remain vulnerable on the labour market, though it was anticipated that she would be able to take on further education, sustain her own mental health and enter the workforce. On her behalf, her representatives claimed GBP 9,000 for the cost of future psychiatric treatment, and GBP 40,000 to offset her handicap on the labour market, a total of GBP 49,000.

(ii) A had failed to appear for an interview with Dr Harris-Hendriks, who also commented on the lack of detailed information concerning periods spent by A in care. She had, however, interviewed him on behalf of the local authority in May 1993 and had some records concerning his past treatment and problems. On that basis, she concluded that he was suffering from long-term psychiatric illness and had a poor prognosis for recovery. His chances of fitting into the normal school system remained very poor. He

was prone to aggressiveness and had difficulty with everyday tasks. He was currently suffering from a reactive attachment disorder, resulting directly from severe parental neglect and abuse. The prognosis for the future was extremely bleak and he was likely to require intermittent hospitalisation. He was seriously handicapped on the labour market and was unlikely ever to be able to hold down a job. Assuming that he might otherwise have been able to obtain low-paid manual employment earning GBP 15,000 per year, and a normal working life to age 65, and taking into account uncertainties and early settlement, he claimed GBP 150,000 in loss of future earnings. As he had a substantial and continuing need for psychiatric treatment outside the National Health Service (NHS), he claimed GBP 50,000 as a minimum estimate for future treatment. This made a total of GBP 200,000.

(iii) B was still suffering from untreated post-traumatic stress disorder and a chronic, generalised anxiety disorder. He had horrific nightmares and, if left untreated, was likely to continue in the same disturbed emotional state. He required open-ended psychiatric treatment into adult life, outside the limited provision of the NHS. This was estimated at a cost of GBP 50,000 minimum. He is vulnerable in terms of both schooling and employment opportunities because of a chronic psychiatric disorder and limited social skills. His prospects of future employment were not as bleak as those of A, but he was likely to have substantial interruptions in his employment. On the assumption of six gaps of one year, on an average labourer's wage of GBP 15,000 per year, he claimed GBP 90,000. This made a total of GBP 140,000.

(iv) C was described as happy in her adoptive home, though carrying a substantial burden about her origins and reminders of them. She was recurrently angry and anxious about her natural mother. She had some remaining behavioural problems which were likely to be containable with good substitute parenting. She was, however, more liable than other children to anxiety and there was a statistical risk of depression in adult life. She did not currently require psychiatric treatment although provision should be made for treatment in adolescence and adulthood. At a recommended 30 to 50 sessions at GBP 70 to 90, a claim was made for GBP 4,500 for future psychiatric treatment. GBP 10,000 was claimed for loss of future earnings, making a total of GBP 14,500.

The reports commented that all the children would have benefited from compensation for their claims in 1994 as this would have allowed additional psychotherapeutic help, improving their prognosis. In A's case, his difficulties had been exacerbated by this lack of help while appropriate psychiatric, educational and environmental help might have substantially improved his prognosis. In B's case, more psychotherapeutic help could have reduced his current vulnerability and given a less gloomy prognosis. The reports also deplored that the psychotherapeutic referrals recommended for A and B in 1993 (for both) and 1998 (for B) had not been pursued by the

local authority on their behalf, and noted that one of the social workers had been told that there was no time or money for this work to be done.

2. The Government

115. The Government submitted that it was wrong to rely on domestic case-law and scales of assessment in just-satisfaction claims under Article 41 as the Court made its own assessment in accordance with principles in its own case-law. They emphasised that it must also be taken into account that the ill-treatment and neglect suffered by the applicants was not inflicted by the local authority but by their parents. It was also relevant that the breach of Article 3 arose only after there had been a failure to take effective steps when the situation in the home failed to show significant improvement – there was no ground for assuming that the children should have been removed from their home immediately. Nor should any award be made in respect of any alleged violation of Article 13 as that damage would be compensated by the award made under Article 3. In assessing what compensation would be equitable, it should also be taken into account that a number of compensatory remedies were available to the applicant, in particular, they received awards from the CICB.

116. As regards the recent medical reports, the Government considered that these were framed in largely identical terms with no attempt to distinguish the children's condition by reference to their age at the time of the violation, their sex and the duration of the treatment. No consideration was given either to what part was played by the temperament of the applicants, and by environmental factors including the care which they had received since 1992. Nor was any regard given to any harm which they might have suffered since being taken into care.

117. Turning to the specific claims made, the Government noted that Z had recovered from her depressive illness and had been doing remarkably well during her schooling, with no significant problems. There was nothing to substantiate the asserted claim for 60 to 100 sessions of psychotherapeutic treatment. Given her positive progress, the claim of statistical vulnerability to future anxiety and depressive illness was not substantiated either.

The report on A was in their view particularly unsatisfactory as it was issued without A having appeared for interview and without full information about his history. While he was not referred to a special clinic as suggested, he did receive therapeutic work in the community where he lived between 1996 and 1998. There was no or little basis for the assumption that his difficulties were exacerbated by the failure of his earlier compensation claim.

The report on B was similarly highly speculative and unsubstantiated, with regard to the alleged adverse impact of the lack of compensation. Its comments on his educational difficulties were inconsistent.

The report on C indicated that she was not psychiatrically ill and was coping well, rendering the conclusion that she had emotional and practical difficulties beyond the average girl of her age difficult to understand. The statements concerning likely future need and alleged impact of the failure of the compensation claim were unsupported by the evidence.

118. The Government submitted that in light of these considerations a reasonable sum of GBP 20,000 for Z, GBP 40,000 for A, GBP 30,000 for B, and GBP 10,000 for C would afford the applicants just satisfaction for both pecuniary and non-pecuniary damage.

3. The Court's assessment

119. As regards the applicants' claims for pecuniary loss, the Court's case-law establishes that there must be a clear causal connection between the damage claimed by the applicant and the violation of the Convention and that this may, in the appropriate case, include compensation in respect of loss of earnings (see, among other authorities, *Barberà, Messegué and Jabardo v. Spain* (Article 50), judgment of 13 June 1994, Series A no. 285-C, pp. 57-58, §§ 16-20, and *Çakıcı v. Turkey* [GC], no. 23657/94, § 127, ECHR 1999-IV).

120. A precise calculation of the sums necessary to make complete reparation (*restitutio in integrum*) in respect of the pecuniary losses suffered by the applicants may be prevented by the inherently uncertain character of the damage flowing from the violation (see *Young, James and Webster v. the United Kingdom* (Article 50), judgment of 18 October 1982, Series A no. 55, pp. 6-7, § 11). An award may still be made notwithstanding the large number of imponderables involved in the assessment of future losses, though the greater the lapse of time involved, the more uncertain the link becomes between the breach and the damage. The question to be decided in such cases is the level of just satisfaction, in respect of both past and future pecuniary losses, which it is necessary to award each applicant, the matter to be determined by the Court at its discretion, having regard to what is equitable (see The Sunday Times *v. the United Kingdom (no. 1)* (Article 50), judgment of 6 November 1980, Series A no. 38, p. 9, § 15, and *Smith and Grady v. the United Kingdom* (just satisfaction), nos. 33985/96 and 33986/96, §§ 18-19, ECHR 2000-IX). In that determination, the awards made in comparable domestic cases is a relevant but not decisive consideration.

121. Turning to the present case, the Court recalls that all four children suffered psychological and physical damage resulting from the abuse and neglect of their parents over a period of more than four years (see paragraphs 11-40 above). The breach of Article 3 concerned the failure of the local authority to take reasonable steps available to them to protect them from that damage. There is a direct causal link, therefore, between the breach and the damage suffered by the children. While it is correct, as

asserted by the Government, that there is no finding that the children should have immediately been taken into care and that they might have suffered damage even if effective steps had been taken at an earlier stage, the Court notes that the severity of the damage suffered by the children is inextricably linked to the long period of time over which the abuse persisted, which factor is also at the heart of the violation of Article 3 in this case.

122. The Court has taken into consideration the points made by the Government concerning the medical reports provided by the applicants, in particular, the lack of any attempt to compare the children's prospects in education and employment prior to their being taken into care. It cannot be excluded, for example, that A and B, who were identified as having educational difficulties, would have experienced some problems in any event. However, such assessments would inevitably be imprecise and based on some degree of speculation, as were the views expressed by Dr Harris-Hendriks concerning the future prognosis and effect on the educational and employment prospects. It may also be noted that the medical reports have not been tested in adversarial proceedings.

123. It is nonetheless possible, on the basis of the information available to the Court, to conclude that the four children will, in all probability, suffer from the effects of their experiences for the rest of their lives. Their capacity to cope with this past trauma will depend on their own personal abilities and the support to which they may have access.

124. It is clear that Z has made an excellent recovery from her depressive illness and, receiving support from her new family, is expected to do well at school and in the future in general. C, who, due to her young age, was less damaged by events, has also successfully integrated into a new family and is attending school without problem. In their case, the Court finds that it is not possible with any degree of certainty to draw conclusions as to future difficulties in the employment sphere. Notwithstanding their current positive prognosis, it may be considered as reasonably possible that in the future they will have some need of professional help in coping with problems which may arise as they grow older and in coming to terms with their childhood experience. An award to cover future psychotherapeutic care will assist in providing them with the support necessary to that process.

125. A was the most severely damaged of the children and suffers an ongoing psychiatric illness. Therapeutic care would help him now and will be necessary in the future. The Court is satisfied that the medical report may be relied on in this respect, Dr Harris-Hendriks having previously examined A and having access to sufficient information to support her opinion. Having integrated neither into a family nor into the education system, the prognosis for A may reasonably be described as bleak. In his case, it may be claimed that the damage suffered from the abuse will in all probability affect his prospects of gaining employment in the future. An award is appropriate to reflect this loss.

126. B is suffering from post-traumatic stress and anxiety disorders, which are likely to continue to affect him for some time to come. He requires both current and future psychiatric treatment. He is attending school, in a special-needs group. It is also probable, though to a lesser extent than A, that he will have problems in obtaining and sustaining employment in later life. An award is appropriate to reflect this.

127. Bearing in mind the uncertainties of the applicants' situations, and making an assessment on an equitable basis, the Court awards Z the sum of GBP 8,000 for future medical costs; A the sum of GBP 50,000 for future medical costs and GBP 50,000 for loss of employment opportunities; B the sum of GBP 50,000 for future medical costs and GBP 30,000 for loss of employment opportunities; and C the sum of GBP 4,000 for future medical costs.

B. Non-pecuniary damage

1. The applicants

128. The applicants claimed non-pecuniary damage in respect of the physical and psychiatric damage sustained. Z had suffered a serious depressive illness and severe malnutrition, and it was predicted that she would need long-term psychiatric care, probably into adulthood. A had suffered from post-traumatic stress disorder and was chronically under-attached. There was evidence to suggest that his father had hit him with a poker and that he had been sexually abused. He had suffered permanent scarring and was expected to require long-term psychiatric care. B had also suffered post-traumatic stress disorder, with some evidence of being beaten by a poker and being sexually abused. He suffered very bad nightmares and would wake up screaming. He was expected to require long-term psychiatric care. C had been less seriously damaged but was also expected to require some psychiatric treatment. Her health had been neglected by her mother and she had a squint as a result.

According to the assessment of Dr Black, Z, A and B had suffered psychiatric damage falling at the upper end of the severe bracket. They exhibited "marked problems" in their ability to cope with life and in their relationships with family, friends and those with whom they came into contact. A and B in particular had a poor prognosis and there was a likelihood of future vulnerability. C had suffered damage in the "moderately severe" bracket. Although she presented significant problems in the areas above, she had a more favourable prognosis.

Having regard to the levels of awards in such cases in the domestic courts, the applicants considered that a reasonable sum would be GBP 35,000 for Z, GBP 45,000 for A, GBP 40,000 for B, and GBP 25,000 for C.

2. The Government

129. As stated above, the Government considered that sums of GBP 20,000 for Z, GBP 40,000 for A, GBP 30,000 for B, and GBP 10,000 for C would afford the applicants just satisfaction for both pecuniary and non-pecuniary damage.

3. The Court's assessment

130. The children in this case suffered very serious abuse and neglect over a period of more than four years. Z, A and B suffered, and in the case of the two boys, still suffer psychiatric illness as a result. A and B also suffered physical injury and C suffered neglect in respect of an eye condition. The description of the conditions which they endured and the traumatic effects which this had on the children leave the Court with no doubt that a substantial award to reflect their pain and suffering is appropriate.

131. In making this assessment, the Court recalls that the rates applied in domestic cases, though relevant, are not decisive. It does not consider it appropriate or desirable to attempt to distinguish between the children in this context. Making an assessment on an equitable basis, the Court awards each child the sum of GBP 32,000.

C. Costs and expenses

132. The applicants claimed GBP 52,781.28 inclusive of value-added tax (VAT) by way of legal costs and expenses, which included fees for attendance at hearings before the Commission and the Court, fees for Dr Harris-Hendriks and submissions on Article 41 of the Convention.

133. The Government did not dispute the hourly rate or number of hours claimed by the applicants' principal legal advisers. They did query the involvement of a leading counsel as an expert on negligence law in addition to the leading counsel with human rights expertise. They also queried the involvement of the AIRE Centre in addition to an experienced counsel and solicitor, and noted that the AIRE Centre's fees for attending the hearing had also been billed in full in the second case, *T.P. and K.M. v. the United Kingdom* [GC], no. 28945/95, ECHR 2001-V, heard before the Court on the same day. They proposed that GBP 43,000 was a reasonable sum, taking these deductions into account. However, if no violation of Articles 6 and 8 of the Convention was found, they disputed the necessity for any of the fees incurred after April 2000 when the Government conceded a breach of Articles 3 and 13 of the Convention. In those circumstances, a reasonable sum would be GBP 36,000.

134. The Court recalls that only legal costs and expenses found to have been actually and necessarily incurred and which are reasonable as to

quantum are recoverable under Article 41 of the Convention (see, among other authorities, *Nikolova v. Bulgaria* [GC], no. 31195/96, § 79, ECHR 1999-II). It observes that the case involved important and complex issues, both concerning the facts which were established by the Commission, and the legal aspects. It does not consider that the costs incurred after April 2000 should be disallowed as such, as there were outstanding issues to be determined, including the claims of pecuniary and non-pecuniary damage arising out of the breaches conceded by the Government. As, however, the complaint made under Article 6, which was a significant part of the application, was unsuccessful, the costs and expenses allowed should be reduced. The Court has had regard to the fact that the Article 6 complaint was to some extent interconnected with the complaint about the inadequacy of remedies under Article 13.

135. In light of these matters, the Court awards the global sum of GBP 39,000 for legal costs and expenses, inclusive of VAT.

D. Default interest

136. According to the information available to the Court, the statutory rate of interest applicable in the United Kingdom at the date of adoption of the present judgment is 7.5% per annum.

FOR THESE REASONS, THE COURT

1. *Holds* unanimously that there has been a violation of Article 3 of the Convention.

2. *Holds* unanimously that no separate issue arises under Article 8 of the Convention.

3. *Holds* by twelve votes to five that there has been no violation of Article 6 of the Convention.

4. *Holds* by fifteen votes to two that there has been a violation of Article 13 of the Convention.

5. *Holds* unanimously
   (a) that the respondent State is to pay the applicants, within three months, the following amounts:
      (i) GBP 8,000 (eight thousand pounds sterling) to Z, GBP 100,000 (one hundred thousand pounds sterling) to A, GBP 80,000 (eighty

thousand pounds sterling) to B, and GBP 4,000 (four thousand pounds sterling) to C in respect of pecuniary damage;

(ii) GBP 32,000 (thirty-two thousand pounds sterling) to each applicant for non-pecuniary damage;

(iii) GBP 39,000 (thirty-nine thousand pounds sterling) in respect of costs and expenses, inclusive of VAT;

(b) that simple interest at an annual rate of 7.5% shall be payable from the expiry of the above-mentioned three months until settlement;

6. *Dismisses* unanimously the remainder of the applicants' claims for just satisfaction.

Done in English and in French, and delivered at a public hearing in the Human Rights Building, Strasbourg, on 10 May 2001.

Luzius WILDHABER
President

Paul MAHONEY
Deputy Registrar

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the following separate opinions are annexed to this judgment:

(a) concurring opinion of Lady Justice Arden as to Article 6;

(b) concurring opinion of Lady Justice Arden as to Article 41, joined by Mr Kovler;

(c) partly dissenting opinion of Mr Rozakis joined by Mrs Palm;

(d) partly dissenting opinion of Mrs Thomassen joined by Mr Casadevall and Mr Kovler.

L.W.
P.J.M.

CONCURRING OPINION OF LADY JUSTICE ARDEN AS TO ARTICLE 6

I agree that Article 6 of the Convention is applicable in this case and that it is not violated for the reasons given by the majority. I attach particular importance to the majority's affirmation of the well-established principle of Convention case-law that Article 6 does not guarantee any particular content for civil rights and obligations (see paragraphs 87, 98, 100 and 101 of the judgment). In the present case the applicants failed to obtain any remedy under the domestic law because the domestic courts held that they had no cause of action in English law (*X v. Bedfordshire County Council* [1995] 2 Appeal Cases 633).

Founding themselves upon the erroneous proposition as a matter of domestic law that they had some general right to sue in negligence where the defendant's act had caused damage and there was sufficient proximity, the applicants sought to argue that the decision of the English courts amounted to a sweeping or blanket immunity. I agree with the conclusion, in paragraph 98 of the judgment, that the facts of this case do not support that argument. In my view, when the courts in England, proceeding incrementally under the common law system of judicial law-making, hold that a hitherto unconsidered category of harm does not, as a matter of law, fall within the scope of the tort of negligence, they cannot properly be described as creating an "immunity", whether blanket or limited (see the speech of Lord Browne-Wilkinson in *Barrett v. the London Borough of Enfield* [1999] 3 Weekly Law Reports 79, paragraph 65 of the judgment in the present case). What the decision of the House of Lords in the present case did was to determine a legal issue fixing the limits on the substantive content of a domestic "civil right". In any event the decision was fully and carefully reasoned. It could not be regarded as the product of arbitrariness and it applied only to closely defined circumstances (see paragraphs 98-99 of the judgment).

Paragraph 98 of the judgment refers to *Fayed v. the United Kingdom* (judgment of 21 September 1994, Series A no. 294-B). In that case the Court contemplated the possibility that there might be a violation of the right of access to a court if, for example, a State could remove from the jurisdiction of the courts a whole range of civil claims, or confer immunities from civil liability on large groups or categories of persons (ibid., pp. 49-50, § 65). At the same time, however, the Court also stated that the Convention enforcement bodies could not create, by way of interpretation of Article 6, a substantive civil right which had no legal basis in the State concerned. Yet that is what the applicants are inviting the Court to do in the present case. Once the conclusion is reached that the right on which the applicants seek to rely has no legal basis in national law, the question of whether there was an

"immunity" such as to rely on the principle referred to in *Fayed* strictly does not arise.

In *Fayed* the Court did not settle the question whether the operation of a defence to a claim in defamation conferred by English law on a public officer was such as to attract the application of the right of access to a court under Article 6 § 1 or, rather, the substantive right to respect for one's private life under Article 8. Instead, it chose to "proceed on the basis that Article 6 § 1 [was] applicable to the facts of the case" (ibid., pp. 50-51, § 67). It explained that it did so as a matter of procedural convenience because the same central issues of legitimate aim and proportionality would have been raised under Article 8, and because the parties' arguments had been directed solely to Article 6 § 1. The result in that case does not, therefore, set any precedent for the applicability of Article 6 § 1 or detract from the principle to which, as stated, I attach particular importance, namely that Article 6 does not guarantee any particular content for civil rights and obligations (see paragraphs 87, 98, 100 and 101 of the present judgment).

CONCURRING OPINION OF LADY JUSTICE ARDEN AS TO ARTICLE 41, JOINED BY JUDGE KOVLER

Article 41 of the Convention enables the Court in appropriate cases to "afford just satisfaction to the injured party". The judgment of the Court awards two sums to each applicant by way of just satisfaction: one sum in respect of pecuniary damage and the other sum in respect of non-pecuniary damage. In the case of pecuniary damage, each applicant is awarded a different sum. However, in respect of non-pecuniary damage, each applicant is awarded an identical amount. Thus, with regard to non-pecuniary damage, the applicants' cases are not assessed individually. The applicants are treated as having suffered equal distress. In addition, no distinction is drawn between the suffering of any one applicant as against that of any other applicant, despite the differences between the cases of the applicants.

I agree that the just satisfaction which the Court awards to the applicants for the violation of Article 13 should include a sum on account of non-pecuniary damage in addition to the sums awarded in respect of pecuniary damage. I have no doubt that such an award is justified. However, in my opinion, the Court should not award the same sum to each applicant but rather should make a separate award to each applicant, reflecting the suffering of that applicant.

As paragraph 128 of the judgment shows, the applicants themselves have sought different amounts: GBP 35,000 for Z, GBP 45,000 for A, GBP 40,000 for B, and GBP 25,000 for C.

All the applicants endured suffering before they were taken into care. After they were taken into care they were assessed by consultant child psychiatrists: in 1993 by Dr Black, and in 2000 by Dr Harris-Hendriks. The diagnosis of A indicates that his case is the most serious. In 1993 he was diagnosed as suffering from post-traumatic stress disorder, and in 2000 he was diagnosed as suffering from a personality disorder for which the prognosis was unfavourable. B was considered to have a post-traumatic stress disorder in both 1993 and 2000, as well as social difficulties, and in addition in 2000 a generalised anxiety disorder, but the prognosis for him was uncertain rather than unfavourable. On the other hand, the initial diagnosis in 1993 of Z as suffering from a severe depressive illness has not been borne out, though it is considered that she may suffer anxiety and perhaps depressive illness in later life. In 2000 C's difficulties were described as moderate; she was regarded as vulnerable to anxiety and likely to need psychotherapeutic help in the future, but she had not suffered any psychiatric disorder.

In the circumstances my preferred course would have been to have performed a separate assessment of the amount to be awarded for non-pecuniary damage to each applicant. Having considered the evidence on the Article 41 issue, I consider that an appropriate amount would have been

GBP 25,000 for Z, GBP 40,000 for A, GBP 35,000 for B, and GBP 15,000 for C.

PARTLY DISSENTING OPINION OF JUDGE ROZAKIS JOINED BY JUDGE PALM

With great regret I am unable to follow the assessment and the conclusions of the majority of the Court that, in the instant case, there has been no violation of Article 6 § 1 of the Convention in so far as access of the applicants to a court of law is concerned. The reasons which have led me to depart from the majority's findings are as follows:

1. The majority is satisfied that the proceedings before the national courts, which culminated in a decision of the House of Lords, met the requirements of Article 6 § 1 as regards the applicants' right to have access to a court for the determination of their civil rights. As the Court observes in paragraph 101 of the judgment, the applicants may not "claim that they were deprived of any right to a determination on their merits of their negligence claims. Their claims were properly and fairly examined in the light of the applicable domestic principle concerning the tort of negligence". And, as it is also stated in paragraph 95, "[t]he arguments before the courts were, therefore, concentrated on the legal issues, primarily whether a duty of care in negligence was owed to the applicants by the local authority". It is difficult for one to accept this approach. The applicants' claims before the national courts did not, of course, refer to this preliminary issue. Their complaint was that the local authorities acted with gross negligence in a case involving a statutory duty of care and that, because of the damage inflicted on them by the failure of the authorities to properly discharge their responsibilities, compensation was due. They submitted this civil right to the courts and nurtured the legitimate expectation that it would be dealt with by the courts through an examination on the merits following an adversarial procedure that would enable them to prove the veracity of their claims. If it may be asserted that, as a general rule the question of access to a court is determined by the subject matter of the claims before the national courts, then the applicants never enjoyed access: at all stages of the domestic examination of their case, the national courts solely examined the jurisdictional problem of whether they could entertain the merits of the case before them, thus confining themselves to the preliminary question of whether an exclusionary rule exists, preventing them from examining the merits. An exclusionary rule which was eventually established by them, not on the basis of statutory requirements or specific precedents that were binding on them, but on the basis of a particular interpretation by them of the requirements of English law in the light of the circumstances of the case before them.

2. It is one matter, of course, to accept that there was no access to a court – which, unfortunately, the majority did not clearly accept – and another to say that, in the circumstances of a particular case, the absence of access is justified because it serves a particular purpose which is proportionate to the

damage done to an individual not enjoying the protection otherwise afforded to him by Article 6 of the Convention.

I am prepared to subscribe to this alternative approach, on which the majority has also embarked – without, however, making a clear distinction between the absence of access and the circumstances justifying a proportional denial of it. However, I am not prepared to accept that the facts of the case may lead us to the conclusion that the applicants were correctly and proportionately deprived of their right because the public-interest considerations prevailed over their legitimate expectation to have their claims examined on the merits.

First of all, it transpires clearly from the facts of the case that the right to sue in negligence was an established civil right in domestic law, that the public-care authorities accepted that they had been negligent in their behaviour, and that there was a proximate relationship in accordance with the criteria determined by national law. Further, the way that the judicial authorities dealt with the matter shows that the case presented serious issues that warranted serious examination: as the applicants pointed out, the judge who made the care orders specifically released the case papers to the Official Solicitor so that he could investigate and, if appropriate, pursue negligence claims; the Official Solicitor considered that there were arguable claims in negligence; the Legal Aid Board granted legal aid to pursue the claims to the House of Lords; and the Court of Appeal, which rejected the claims by a majority, granted leave to appeal to the House of Lords, the precondition for such leave being that the claim was arguable in domestic law; the Master of the Rolls in the Court of Appeal found that there was a duty of care, stating the contrary to be "an affront to common sense"; and, in previous cases, local authorities had settled negligence claims on the basis that they were potentially liable.

So, the only reason which eventually led to this case being struck out was an interpretation by the national courts, and particularly the House of Lords, based on an argument of expediency and as a matter of policy. Indeed, by applying the third test of the English law of torts on negligence – namely, whether it was fair, just and reasonable to impose liability on the public-care authorities in the circumstances of the case, the House of Lords found that it would be detrimental to the exercise of the duties of the public body in question to impose upon them the excessive burden of tortious liability for acts or omissions in the discharge of their duties. The position taken by the House of Lords in this matter was novel and tantamount to a refusal to extend tortious liability for civil wrongs arising out of a duty of care by local authorities for child care.

It is not the Court's task to enter into an examination of the social-policy considerations which led the national courts to interpret the third test in the way they did. Yet, it is its task to look at the circumstances surrounding the particular decisions taken and to assess their significance when applying its

own test of proportionality; and it seems difficult for me to accept that in view of the importance attached to the facts of the case by the various judicial and other bodies, and the novel character of the House of Lords' ruling, the creation of new case-law barring the examination of the case on its merits was proportionate to the need for adequate protection of individuals (and society generally) against negligence by public authorities.

Secondly, and more importantly, this Court has found a violation of Article 3 of the Convention on the basis of a finding that "the neglect and abuse suffered by the four applicant children reached the threshold of inhuman and degrading treatment" (see paragraph 74 of the judgment). Again it is difficult for me to accept that serious matters of public concern – as are all matters involving a violation of Article 3 – may be left outside the protection of independent and impartial tribunals established by law, and providing all the guarantees required by Article 6 of the Convention. The majority, however, holds a different view since it accepts that, even in circumstances where there has been a violation of the substance of Article 3, the Contracting States "are afforded some discretion as to the manner in which they conform to their Convention obligations ..." provided that some effective remedy exists to deal with individual complaints concerning inhuman and degrading treatment. Hence, they conclude that, in the present situation, Article 13, but not Article 6, has been violated.

It seems to me that the present case may be considered as the *locus classicus* of the limits afforded to States by the Convention to determine the modalities of access to domestic courts. Our case-law has repeatedly underlined the fact that the right to a tribunal is not unlimited – and rightly so. Yet, the Court is free to determine in which instances a Contracting State oversteps its freedom of choice and becomes liable under Article 6; and one criterion which can readily assist the Court in drawing the line between instances where a State retains its discretion, and instances where a State is bound to offer judicial guarantees to those falling under its jurisdiction, is the severity of the complaint before the national authorities. If the complaint may involve a violation of core Convention rights – such as Articles 2 and 3 – the Court is bound, to my mind, to find that the States are obliged not simply to offer an effective remedy (as required by Article 13), but a judicial remedy covering all the requirements of Article 6.

3. Most of the ideas put forward in the previous lines have as their source of inspiration *Osman v. the United Kingdom* (judgment of 28 October 1998, *Reports of Judgments and Decisions* 1998-VIII) which the majority has not followed in the present judgment. The main reason which has led the majority to depart from the established case-law is explained in paragraph 100 of the present judgment:

> "... The Court considers that its reasoning in *Osman* was based on an understanding of the law of negligence ... which has to be reviewed in the light of the clarifications subsequently made by the domestic courts and by notably the House of Lords. The

> Court is satisfied that the law of negligence as developed in the domestic courts since the case of *Caparo Industries plc* ... and as recently analysed in the case of *Barrett* ... includes the fair, just and reasonable criterion as an intrinsic element of the duty of care and that the ruling of law concerning that element in this case does not disclose the operation of an immunity. In the present case, the Court is led to the conclusion that the inability of the applicants to sue the local authority flowed not from an immunity but from the applicable principles governing the substantive right of action in domestic law. ..."

I do not think that in *Osman* the Court was very much concerned with this subtle issue raised by this judgment in the above-mentioned paragraph. The Court in *Osman* never said that the jurisdictional bar was an immunity to be distinguished from the applicable principles governing the substantive right of action in domestic law. It simply considered that "the application of the [exclusionary] rule in this manner without further enquiry into the existence of competing public interest considerations only serves *to confer a blanket immunity* on the police for their acts and omissions during the investigation and suppression of crime and amounts to an unjustifiable restriction on an applicant's right to have a determination on the merits of his or her claim against the police in deserving cases" (see *Osman*, cited above, p. 3170, § 151 – emphasis added). It went on to express the opinion that, in cases where the harm sustained by a complainant was of the most serious nature, examination of the merits could not be automatically excluded by the application of a rule which "*amounts to the grant of an immunity to the police*". In conclusion, the Court in *Osman* was mainly concerned with the fact that the applicants in a very serious case of possible substantive human-rights violations did not have the opportunity to air their grievances before a court of law; it was not concerned with whether the reason behind it being impossible to examine the case on the merits was or was not the result of an immunity provided for by national law acting as a procedural bar having such an effect. It simply found that the impossibility amounted to a grant of an immunity. Under these circumstances how can we distinguish between *Osman* and the present case?

For all the above reasons I believe that Article 6 (access to a court) has been violated and, hence, I consider that Article 13 does not raise a separate ground for violation, Article 6 being the *lex specialis* in this case.

PARTLY DISSENTING OPINION OF JUDGE THOMASSEN JOINED BY JUDGES CASADEVALL AND KOVLER

I am unable to agree with the majority that there has been no violation of Article 6 of the Convention in this case.

The Court is unanimous that the authorities failed to protect the applicants, young children, from inhuman and degrading treatment and its majority observes that the applicants were denied "a determination of their allegations that the local authority failed to protect them from inhuman and degrading treatment and the possibility of obtaining an enforceable award of compensation for the damage suffered thereby" (see paragraph 111 of the judgment).

Despite the severe negligence by the authorities, which allowed the ill-treatment of the applicants to continue for so many years and caused the applicants physical and psychiatric injuries amounting to a violation of Article 3, the applicants could not hold the authorities accountable in domestic court proceedings. By reference to policy factors (for example, difficulties of attributing responsibility between different agencies, sensitivity of decisions, risk of inculcating in local authorities a cautious and defensive approach to exercise of their duties, risk of costly and vexatious litigation) the domestic courts decided that the local authority could not be held liable in negligence in the exercise of their statutory powers to protect children. *De facto*, the local authority was thus declared to be immune for claims because they had acted in the exercise of their statutory powers to protect children.

In my view the applicants' rights under Article 6 were thereby violated as they had no access to a court in order to have a decision on their claims, which were arguable under national law. The facts of this case and the way in which domestic law operated are very similar to those in *Osman v. the United Kingdom* (judgment of 28 October 1998, *Reports of Judgments and Decisions* 1998-VIII) where the applicants' claims for negligence against the police were struck out for policy reasons relating to the perceived interests in preventing the efficiency of the police service being undermined by litigation. In *Osman* the Court found that the application of an exclusionary rule barring liability of the police for negligence in the exercise of their functions of investigating and preventing crime constituted a disproportionate restriction on access to a court for the applicants. The majority's reasons for not following the decisions in *Osman* (see paragraph 100 of the judgment) are not, to my mind, convincing. There seem to have been no striking or significant changes in the law of negligence since that case and all relevant matters concerning the content of domestic law had been brought to the attention of the Court by the parties in *Osman*. I am of the opinion that the conclusion under Article 6 in this case must be the same.

It is true that, as the majority observes in paragraph 95 of the judgment, the applicants were not prevented in any practical manner from bringing their claims before the domestic courts. The case was litigated up to the House of Lords, the applicants being provided with legal aid for that purpose. Nor is it the case that any procedural rules of limitation had been relied on. However, the notion of "access to a court" under Article 6 guarantees not only that the applicants have their claims brought before the courts, but implies also the right to have those claims examined on the basis of the facts before the courts and to have them decided on.

I agree with the majority saying in paragraph 98 that Article 6 does not in itself guarantee any particular content for civil rights and obligations in national law. But where there is an arguable claim under domestic tort law as in this case (see paragraph 89 of the judgment), requiring that the applicants obtain a decision by a court on the liability of those responsible for allowing their ill-treatment to continue for many years, cannot, in my opinion, be said to determine the content of domestic law.

I would observe that the Court's supervision of the activities of national courts in defining "access" or "liability" seems to take place on a wider basis. In *Fayed v. the United Kingdom* (judgment of 21 September 1994, Series A no. 294-B, pp. 49-50, § 65), the Court said:

> "Certainly the Convention enforcement bodies may not create by way of interpretation of Article 6 § 1 a substantive civil right which has no legal basis in the State concerned. However, it would not be consistent with the rule of law in a democratic society or with the basic principle underlying Article 6 § 1 – namely that civil claims must be capable of being submitted to a judge for adjudication – if, for example, a State could, without restraint or control by the Convention enforcement bodies, remove from the jurisdiction of the courts a whole range of civil claims or confer immunities from civil liability on large groups or categories of persons ..."

To reach its conclusion that the decision by the House of Lords did not amount to the granting of an immunity, the Court's majority observes, in paragraph 99, that in cases concerning the liability of local authorities in child-care matters brought after the applicants' case, the domestic courts have held that a duty of care may arise. But this does not change the fact that an immunity was conferred on the authorities in the applicants' case. Apparently the immunity applied in the applicants' case was found no longer appropriate in subsequent cases, the national courts taking into account, amongst other factors, the Court's approach in *Osman*, cited above.

While it has been alleged by the Government that a finding of a violation in this case would undermine the striking-out procedure used to avoid pointless litigation of baseless claims, I consider that this argument has not been substantiated by the material placed before the Court. The domestic courts have continued to strike cases out after the Court's judgment in *Osman*. A finding of a violation in this case would mean only that these applicants' claims, which involved serious ill-treatment contrary to a

fundamental human right, should not have been struck out on the basis of general policy arguments. This Court has found no denial of access to a court where judges have struck out cases where there has been no proximity or foreseeability (see, for example, *Powell v. the United Kingdom* (dec.), no. 45305/99, ECHR 2000-V, and *Bromiley v. the United Kingdom* (dec.), no. 33747/96, 23 November 1999, unreported).

The majority of the Court finds that the applicants were not afforded an effective remedy in respect of the breach of Article 3 and they conclude that Article 13, not Article 6, was violated.

My conclusion would be that the "remedy" to which the applicants were entitled should have been access to a court in order to have their damages settled. Restrictions to access to a court in order to protect the interests of the local authority exercising their powers to protect children may be necessary and justified under Article 6. However, I would say that in this case, where it is agreed that the child applicants were victims of the failure of the system to protect them from serious, long-term neglect and abuse, the immunity conferred on the local authority because of policy reasons cannot be seen as proportionate.

Therefore, I believe that Article 6 was violated.

I voted for a violation of Article 13 because I agree with the majority that the applicants, whose rights under Article 3 of the Convention were violated, had no effective remedy before the national authorities.

UN Convention on the Rights of the Child

In Child Friendly Language

"Rights" are things every child should have or be able to do. All children have the same rights. These rights are listed in the UN Convention on the Rights of the Child. Almost every country has agreed to these rights. All the rights are connected to each other, and all are equally important. Sometimes, we have to think about rights in terms of what is the best for children in a situation, and what is critical to life and protection from harm. As you grow, you have more responsibility to make choices and exercise your rights.

Article 1
Everyone under 18 has these rights.

Article 2
All children have these rights, no matter who they are, where they live, what their parents do, what language they speak, what their religion is, whether they are a boy or girl, what their culture is, whether they have a disability, whether they are rich or poor. No child should be treated unfairly on any basis.

Article 3
All adults should do what is best for you. When adults make decisions, they should think about how their decisions will affect children.

Article 4
The government has a responsibility to make sure your rights are protected. They must help your family to protect your rights and create an environment where you can grow and reach your potential.

Article 5
Your family has the responsibility to help you learn to exercise your rights, and to ensure that your rights are protected.

Article 6
You have the right to be alive.

Article 7
You have the right to a name, and this should be officially recognized by the government. You have the right to a nationality (to belong to a country).

Article 8
You have the right to an identity – an official record of who you are. No one should take this away from you.

Article 9
You have the right to live with your parent(s), unless it is bad for you. You have the right to live with a family who cares for you.

Article 10
If you live in a different country than your parents do, you have the right to be together in the same place.

Article 11
You have the right to be protected from kidnapping.

Article 12
You have the right to give your opinion, and for adults to listen and take it seriously.

Article 13
You have the right to find out things and share what you think with others, by talking, drawing, writing or in any other way unless it harms or offends other people.

Article 14
You have the right to choose your own religion and beliefs. Your parents should help you decide what is right and wrong, and what is best for you.

Article 15
You have the right to choose your own friends and join or set up groups, as long as it isn't harmful to others.

Article 16
You have the right to privacy.

Article 17
You have the right to get information that is important to your well-being, from radio, newspaper, books, computers and other sources. Adults should make sure that the information you are getting is not harmful, and help you find and understand the information you need.

Article 18
You have the right to be raised by your parent(s) if possible.

Article 19
You have the right to be protected from being hurt and mistreated, in body or mind.

Article 20
You have the right to special care and help if you cannot live with your parents.

Article 21
You have the right to care and protection if you are adopted or in foster care.

Article 22
You have the right to special protection and help if you are a refugee (if you have been forced to leave your home and live in another country), as well as all the rights in this Convention.

Article 23
You have the right to special education and care if you have a disability, as well as all the rights in this Convention, so that you can live a full life.

Article 24
You have the right to the best health care possible, safe water to drink, nutritious food, a clean and safe environment, and information to help you stay well.

Article 25
If you live in care or in other situations away from home, you have the right to have these living arrangements looked at regularly to see if they are the most appropriate.

Article 26
You have the right to help from the government if you are poor or in need.

Article 27
You have the right to food, clothing, a safe place to live and to have your basic needs met. You should not be disadvantaged so that you can't do many of the things other kids can do.

Article 28
You have the right to a good quality education. You should be encouraged to go to school to the highest level you can.

Article 29
Your education should help you use and develop your talents and abilities. It should also help you learn to live peacefully, protect the environment and respect other people.

Article 30
You have the right to practice your own culture, language and religion - or any you choose. Minority and indigenous groups need special protection of this right.

Article 31
You have the right to play and rest.

Article 32
You have the right to protection from work that harms you, and is bad for your health and education. If you work, you have the right to be safe and paid fairly.

Article 33
You have the right to protection from harmful drugs and from the drug trade.

Article 34
You have the right to be free from sexual abuse.Article 35No one is allowed to kidnap or sell you.

Article 36
You have the right to protection from any kind of exploitation (being taken advantage of).

Article 37
No one is allowed to punish you in a cruel or harmful way.

Article 38
You have the right to protection and freedom from war. Children under 15 cannot be forced to go into the army or take part in war.

Article 39
You have the right to help if you've been hurt, neglected or badly treated.

Article 40
You have the right to legal help and fair treatment in the justice system that respects your rights.

Article 41
If the laws of your country provide better protection of your rights than the articles in this Convention, those laws should apply.

Article 42
You have the right to know your rights! Adults should know about these rights and help you learn about them, too.

Articles 43 to 54
These articles explain how governments and international organizations like UNICEF will work to ensure children are protected with their rights.

unicef

QUEEN ALEXANDRA FOUNDATION FOR CHILDREN

Canadian Heritage Patrimoine canadien

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Empowering public authorities and professionals towards trauma-informed leaving care support

CHILDREN'S RIGHTS IN INTERNATIONAL AND EUROPEAN UNION LAW

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

UNIVERSITÀ DEGLI STUDI DI TORINO

REGIONE CALABRIA

IACP

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Putting children at the heart of Europe

ReadLab
Research Innovation and Development Lab

ERGO
EMPOWERING CHILDREN & YOUNG PEOPLE

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e-trikala

Learning objectives

02 unit

- ✓ Knowledge of the fundamental rights and principles established by the international and European legal framework on children's rights within which Trauma Informed Care (ICT) can be applied.
- ✓ Specific understanding of children's participation rights

Who is the child?

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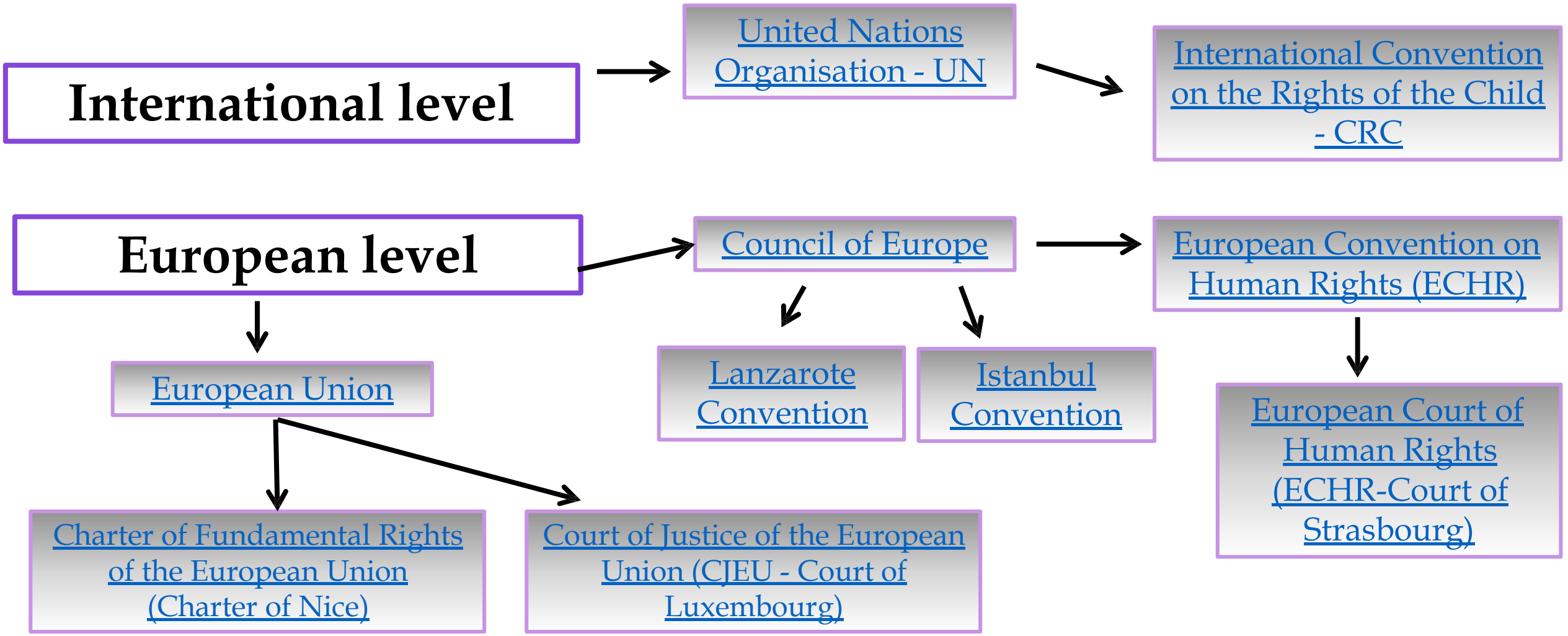
The International Convention on the Rights of the Child (CRC) establishes that “a child means every human being below the age of eighteen years” (article 1).

Similarly, most instruments of the Council of Europe concerning children adopt the definition established by the CRC.

Within the European Union there is no description of “child" and therefore the CRC definition is commonly used.

Legal framework



CHILDREN'S RIGHTS AND FREEDOMS

All individuals, including children, enjoy **freedoms and rights** recognised by legal instruments (conventions, treaties, declarations) on human rights, in particular, the European Union Charter of Fundamental Rights (*Charter of Nice*) and the European Convention of Human Rights (*ECHR*).

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FUNDAMENTAL RIGHTS AND FREEDOMS

CIVIL RIGHTS

ECONOMIC, SOCIAL AND CULTURAL RIGHTS

FREEDOMS AND FUNDAMENTAL CIVIL RIGHTS

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- They are called "first generation" rights and are considered fundamental as their violation profoundly damages the person's life.
- They require States both not to interfere in the private sphere of the individual, and to engage actively in an activity to secure the effective enjoyment of a fundamental right

For example, the right to respect for family life (art. 8 ECHR) calls for States not to separate children from their parents except when this is strictly necessary for the protection of the offspring themselves, but also to take measures to promote the development of relations between parents and children supporting the non-custodial parent in having access to his or her child and
overcoming the unjustified opposition of the other parent

Right to respect for family life

Everyone has the right to respect for "**family life**"

as experienced in practice

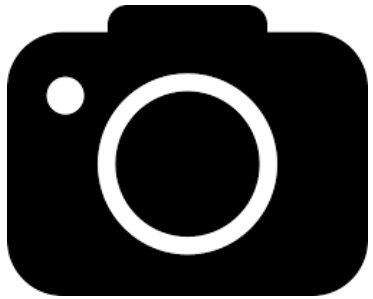
(for example, the child has the right to grow up in the family and to maintain contact with both parents after their separation)

Reference articles:

- Article 7 (right to respect for family life) Charter of Nice
- Article 8 (right to respect for family life) ECHR
- Articles 8 and 9 CRC

Right to respect for private life

The notion of "**private life**" developed by the case law of the Court of Strasbourg is broad and includes many aspects of an individual's identity
(for example, the physical and moral integrity of the person, the name, image, privacy and protection of personal data)

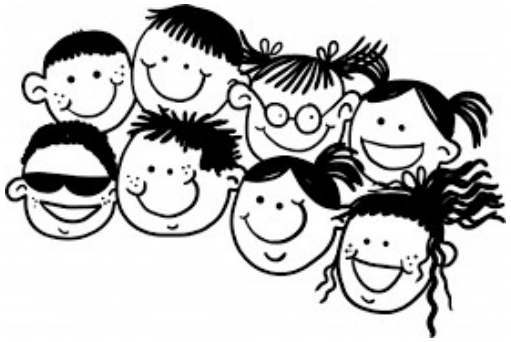


Reference articles:

- Article 7 (right to respect for private life) Charter of Nice
- Article 8 (right to respect for private life) ECHR
- Article 16 CRC

Non-discrimination

Different treatments based on gender, race, skin colour, ethnic or social origin, genetic characteristics, language, beliefs or religion, political or other opinions, belonging to a national minority, financial situation, birth, disability, age or sexual orientation **are considered discriminatory and prohibited** unless they serve a legitimate purpose



Reference articles:

- Article 7 (right to respect for private life), Articles 20 (equality before the law) and Article 21 (non-discrimination) Charter of Nice
- Article 14 ECHR; Article 1 of Protocol No. 12 of the ECHR (non-discrimination)
- Article E (non-discrimination) European Social Charter (ESC)
- Article 8 (right to respect for private life) ECHR
- Article 2 CRC

Principle of the best interests of the child

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Children and young people have the right, being minors, to benefit from special protection and therefore to benefit from differentiated treatment based on age

Reference article:

Article 3 CRC

EXAMPLE 1

The judge asked to decide upon the custody of children after the separation / divorce of the parents must decide solely on the basis of what is best for the child and not for the parents

Freedom of expression

Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and give information and ideas without interference by the public authority and regardless of borders.

(Article 10, paragraph 1 ECHR)

Reference articles:

- Article 11 and Article 24 paragraph 1 Charter of Nice
- Article 10 ECHR
- Article 12, paragraph 1 CRC

The right of the child to be heard

"The child shall be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law." (Article 12 CRC)

For more information on the child's right to be heard, see the contribution

Unit_2_3_video_Prof._Long

Reference articles:

- Article 12 CRC
- Articles 3 and 6 European Convention on the Exercise of Children's Rights

The right of the child to protection against violence and exploitation

"States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse" (Article 19, paragraph 1, International Convention on the Rights of the Child - CRC)

Case Z. and Others vs. U.K.

Reference articles:

- Articles 2 (right to life), 3 (inhuman or degrading treatment) and 8 (physical integrity) ECHR; Protocol no. 1 to the ECHR, article 2 (right to education)
- Articles 7 (right to special protection against physical and moral hazards) and 17 (right to protection) European Social Charter (CSE)
- Convention on the protection of children against sexual exploitation and abuse (Lanzarote Convention).
- Convention on preventing and combating violence against women and domestic violence (Istanbul Convention)
- Directive on the fight against sexual abuse and sexual exploitation of children and child pornography (2011/93/EU)

EXAMPLE 2: Witnessing violence

Violence does not only produce damage when it is acted out, but also when children become witnesses to it.

Watching, listening, experiencing anguish, being invested, infected and overwhelmed without being able to do anything. It means exposing a child to any form of mistreatment, carried out through acts of physical, verbal, psychological, sexual and economic violence, on reference figures or on other emotionally significant figures within domestic and family environments. This is witnessing violence.

It is a phenomenon that is still submerged, almost "invisible", characterised by multiple signals, whose effects can be devastating on the physical, cognitive and behavioural development of children

(Save the Children https://www.savethechildren.it/campagne/abbattiamo-il-muro-del-silenzio)

Children who witness an act of violence suffer it

https://www.youtube.com/watch?v=aNbVwD86JqU

Reference articles:

Article 19 CRC

Article 17 European Social Charter (ESC)

The story of a child witness

https://www.youtube.com/watch?v=hYX8cRkiklE

EXAMPLE 3 : Corporal punishment

The following are considered to be corporal punishment:

- any punishment for which physical strength is used to inflict a certain level of pain or affliction, no matter how slight
- equally cruel and degrading forms of non-physical punishment, for example, punishments that aim to denigrate the child, humiliate him, diminish him, despise him, make him a scapegoat, threaten him, scare him or taunt him (UN Committee on the Rights of the Child, General Comment n. 8 of 2006)

Raise your hand against smacking!

https://www.youtube.com/watch?v=FB6_Og-x6Cw

Reference articles:

Article 3 ECHR.

Articles 19, 28, paragraph 2, and 37 CRC

EXAMPLE 4 : Sexual abuse

It is considered "sexual abuse" to engage in sexual activities with a child where:

- use is made of coercion, force or threats; or abuse is made of a recognised position of trust, authority or influence over the child, including within the family;
- abuse is made of a particularly vulnerable situation of the child, notably because of a mental or physical disability or a situation of dependence.

(Article 18, paragraph 1, Convention of the Council of Europe on the protection of children from sexual exploitation and sexual abuse - Lanzarote Convention)

You can't touch here!
https://www.youtube.com/watch?v=ZNmu7plH5c8

Reference articles:

- Articles 32 and 34 CRC
- Lanzarote Convention

ECONOMIC, SOCIAL AND CULTURAL RIGHTS

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They represent the so-called “second generation” rights that each state is called upon to satisfy in order to overcome social inequalities, economic imbalances, disadvantages caused by nature, age, etc.

Their concrete realisation (unfortunately!) takes place gradually and compatibly with the economic-structural problems that every State faces.

Right to health

"Health is a state of complete physical, mental and social well-being and not simply an absence of disease or infirmity"

(World Health Organisation, 1948)

Reference articles:

- Article 35 (access to health care) Charter of Nice
- Article 25 Universal Declaration of Human Rights
- Articles 24, 25 and 26 CRC
- Article 2 (right to life) and article 3 (right to physical integrity) ECHR
- Article 11 (right to health protection) and article 13 (right to social and medical assistance) European Social Charter (CSE)
- Article 6 European Convention for the Protection of Human Rights and the Dignity of the Human Being with regard to the Applications of the biology and medicine, so-called “Oviedo Convention”

Right to education

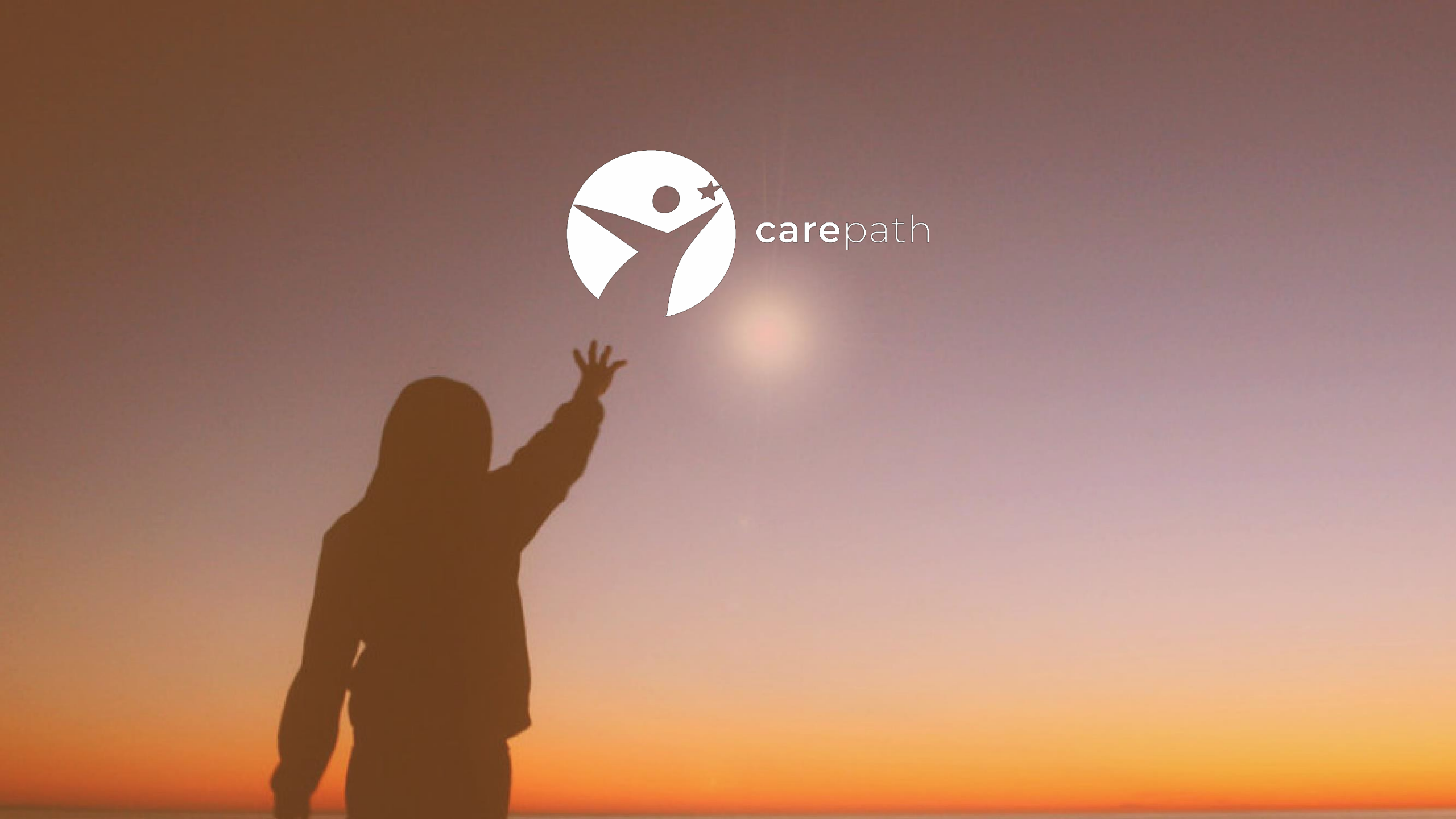
"Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit."

(Article 26, Universal Declaration of Human Rights)

The right to education does not just refer to the learning of basic school subjects but must be conceived in a broader sense. Education must seek to foster the development of the child's personality, his mental and physical qualities and attitudes. (Article 29 CRC)

Reference articles:

Article 14 Charter of Nice
Articles 28 and 29 CRC
Article 17 ECHR
Article 2 of Protocol No. 1 ECHR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HANDBOOK

Handbook on European law relating to the rights of the child

FRA
EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

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COUNCIL OF EUROPE
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Handbook on European law relating to the rights of the child

Foreword

This handbook on European law relating to the rights of the child is jointly prepared by the European Union Agency for Fundamental Rights (FRA) and the Council of Europe together with the Registry of the European Court of Human Rights. It is the fourth in a series of handbooks on European law jointly prepared by our organisations. Previous handbooks were dedicated to European law relating to non-discrimination law, asylum, borders and immigration, and data protection.

We embarked on this new joint project in the context of the celebrations of the 25th anniversary of the United Nations Convention on the Rights of the Child – which all European states have ratified – to shed light on the role of European legal standards in securing the enjoyment by children of their universal rights.

Children are full-fledged holders of rights. This handbook thus aims to raise awareness and improve the knowledge of the legal standards that protect and promote these rights in Europe. The Treaty on European Union (TEU) sets forth the Union's obligation to promote the protection of the rights of the child. The Charter of Fundamental Rights of the European Union (EU), EU regulations and directives, as well as the jurisprudence of the Court of Justice of the EU (CJEU), have contributed to further determining the protection of the rights of children. In the Council of Europe, a large number of conventions focus on specific aspects of the protection of the rights of the child, ranging from their rights and safety in cyberspace to the adoption of children. These conventions contribute to enriching the protection granted to children under the European Convention on Human Rights and the European Social Charter, including the jurisprudence of the European Court of Human Rights (ECtHR) and the decisions of the European Committee of Social Rights (ECSR).

This handbook is designed for non-specialist legal professionals, judges, public prosecutors, child protection authorities, and other practitioners and organisations responsible for ensuring the legal protection of the rights of the child.

We would like to thank Prof. Ton Liefaard, LL.M. Simona Florescu, JD. Margaret Fine, Prof. Karl Hanson, Prof. Ursula Kilkelly, Dr. Roberta Ruggiero, Prof. Helen Stalford and Prof. Wouter Vandenhole for their contribution in drafting this handbook. We would also like to thank all those who provided input and support throughout its preparation.

Snežana Samardžić-Marković

Director General of Democracy
Council of Europe

Michael O'Flaherty

Director of the European Union
Agency for Fundamental Rights

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Acronyms

CJEU	Court of Justice of the European Union (prior to December 2009, European Court of Justice, ECJ)
CoE	Council of Europe
CPT	European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment
CRC	United Nations Convention on the Rights of the Child
CRD	Consumer Rights Directive
CRPD	United Nations Convention on the Rights of Persons with Disabilities
ECHR	Convention for the Protection of Human Rights and Fundamental Freedoms (commonly known as European Convention on Human Rights, ECHR)
ECOSOC	United Nations Economic and Social Council
ECtHR	European Court of Human Rights
ECPT	European Convention for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment
ECSR	European Committee of Social Rights
EEA	European Economic Area
EEC	European Economic Community
ESC	European Social Charter
EU	European Union
FCNM	Council of Europe Framework Convention for the Protection of National Minorities
FRA	European Union Agency for Fundamental Rights
GC	Grand Chamber (of the European Court of Human Rights)
GPSD	Directive on General Product Safety
GRETA	Group of Experts on Action against Trafficking in Human Beings
ICCPR	United Nations International Covenant on Civil and Political Rights

ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
PACE	Parliamentary Assembly of the Council of Europe
TCN	Third-country nationals
TEU	Treaty on European Union
TFEU	Treaty on the Functioning of the European Union
TSD	Directive on the safety of toys
UCPD	Directive concerning unfair business-to-consumer commercial practices in the internal market
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees

How to use this handbook

This handbook provides an overview of the fundamental rights of children in the European Union (EU) and the Council of Europe (CoE) member states. It is broad in scope. It acknowledges children as beneficiaries of all human/fundamental rights, as well as subjects of special regulation given their specific characteristics. Children's rights is a cross-sectorial field of law. In this handbook the emphasis is on the areas of law which are of specific importance to children.

This handbook is designed to assist legal practitioners who are not specialised in the field of children's rights. It is intended for lawyers, judges, prosecutors, social workers and others working with national authorities, as well as non-governmental organisations (NGOs) and other bodies that may be confronted with legal questions relating to these subjects. It is a point of reference on both EU and CoE law related to these subject areas, explaining how each issue is regulated under EU law as well as under the European Convention on Human Rights (ECHR), the European Social Charter (ESC) and other instruments of the CoE. Each chapter first includes a single table of applicable law under the two separate European legal systems. Then the law under each system is presented consecutively in relation to each topic covered. This allows the reader to see where the two legal systems converge and where they differ. Where relevant, there are also references to the United Nations (UN) Convention on the Rights of the Child (CRC) and other international instruments.

Practitioners in non-EU states that are member states of the CoE and thereby parties to the ECHR can access the information relevant to their own country by going straight to the CoE sections. Practitioners in EU Member States will need to use both sections as those states are bound by both legal orders. For readers who need more information on a particular issue, a list of references to more specialised material can be found in the 'Further reading' section of the handbook.

ECHR law is presented through short references to selected European Court of Human Rights (ECtHR) cases related to the handbook topic covered. These have been chosen from existing ECtHR judgments and decisions on children's rights issues.

EU law is found in legislative measures that have been adopted, in relevant provisions of the Treaties and in particular in the Charter of Fundamental Rights

of the European Union, as interpreted in the case law of the Court of Justice of the European Union (CJEU – known before December 2009 as the European Court of Justice (ECJ)).

The case law described or cited in this handbook provides examples of an important body of both ECtHR and CJEU case law. The handbook includes, as far as possible given its limited scope and introductory nature, legal developments until 1 January 2015, although later developments have also been included when possible.

The handbook includes an introductory chapter, which briefly explains the role of the two legal systems as established by CoE and EU law, and contains 10 substantive chapters covering the following issues:

- civil rights and freedoms;
- equality;
- personal identity issues;
- family life;
- alternative care and adoption;
- child protection against violence and exploitation;
- economic, social and cultural rights;
- migration and asylum;
- consumer and data protection;
- children's rights within criminal justice and alternative proceedings.

Each chapter covers a distinct subject while cross-references to other topics and chapters provide a fuller understanding of the applicable legal framework. Key points are presented at the beginning of each section.

1 Introduction to European children's rights law: context and key principles

EU	Issues covered	CoE
Free Movement Directive (2004/38/EC), Article 2 (2) (c)	'Child' as a holder of rights	Convention on Action against Trafficking in Human Beings, Article 4 (d) Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention), Article 3 (a) ECtHR, *Marckx v. Belgium*, No. 6833/74, 1979 (the applicant child was six years old when the Court delivered judgment)
Young Workers Directive (94/33/EC), Article 3	Protection of young people at work	ESC (revised), Article 7 (right of children and young persons to protection)
Charter of Fundamental Rights, Article 14 (2) (right to education)	Right to receive free compulsory education	
Charter of Fundamental Rights, Article 21 (non-discrimination)	Prohibition of discrimination on grounds of age	
Charter of Fundamental Rights, Article 32 (prohibition of child labour and protection of young people at work) Directive on combating the sexual abuse and sexual exploitation of children and child pornography (2011/93/EU) Anti-Trafficking Directive (2011/36/EU)	Prohibition of exploitative child labour	ESC (revised), Article 7 (right of children and young persons to protection)

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 24 (rights of the child) Treaty on European Union, Article 3 (3)	Protection of children's rights (general)	
Charter of Fundamental Rights, Article 7 (respect for private and family life)	Right to respect for private and family life	ECHR, Article 8 (right to respect for private and family life) Convention on the Legal Status of Children born out of Wedlock Convention on the Adoption of Children (revised) Convention on Contact Concerning Children Convention on the Exercise of Children's Rights ECtHR, *Maslov v. Austria* [GC], No. 1638/03, 2008 (deportation of the applicant, convicted of criminal offences as a child)
CJEU, C-413/99, *Baumbast and R v. Secretary of State for the Home Department*, 2002 CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 2004 CJEU, C-148/02, *Carlos Garcia Avello v. Belgian State*, 2003 CJEU, C-310/08, *London Borough of Harrow v. Nimco Hassan Ibrahim and Secretary of State for the Home Department*, 2010 CJEU, C-480/08, *Maria Teixeira v. London Borough of Lambeth and Secretary of State for the Home Department*, 2010	Freedom of movement	

This introductory chapter explains how children's rights law has developed at the European level, which key principles guide its application, and which key aspects of children's rights European law addresses. It sets the background for the subject-specific analysis of the following chapters.

1.1. Core concepts

Key point

- European children's rights law builds on existing measures at the national and international level.

1.1.1. Scope of European children's rights law

In referring to 'European children's rights law', the focus is on primary sources of law (treaties, conventions, secondary legislation and case law) introduced by the Council of Europe (CoE) and the European Union (EU). Where relevant, reference is made to other European sources that influence the development of European children's rights law, including key policy documents, guidelines or other non-binding/soft-law instruments.

Children are holders of rights, rather than just objects of protection. They are beneficiaries of all human/fundamental rights and subjects of special regulations, given their specific characteristics. Much European case law derives from litigation initiated by parents or other legal representatives of children, given the limited legal capacity of children. While this handbook aims to illustrate how the law accommodates the specific interests and needs of children, it also illustrates the importance of parents/guardians or other legal representatives and makes reference, where appropriate, to where rights and responsibilities are most prominently vested in children's carers. In such instances, the United Nations (UN) Convention on the Rights of the Child (CRC)[1] approach is adopted, namely that parental responsibilities need to be exercised with the best interests of the child as their primary concern and in a manner consistent with the evolving capacities of the child.

1.1.2. 'Child' as a holder of rights

Under international law, the CRC establishes in its Article 1 that "a child means every human being below the age of eighteen years". This is the legal parameter currently used, also in Europe, to define what a child is.

1 UN, General Assembly (1989), Convention on the Rights of the Child, 20 November 1989.

Under EU law, there is no single, formal definition of 'child' set out in any of the treaties, their subordinate legislation or case law. The definition of a child can vary considerably under EU law, depending on the regulatory context. For example, EU law governing the free movement rights of EU citizens and their family members defines 'children' as "direct descendants who are under the age of 21 or are dependent",[2] essentially endorsing a biological and economic notion as opposed to one based on minority.

Some EU laws ascribe different rights to children according to their age. Directive 94/33/EC on the protection of young people at work (Young Workers Directive),[3] for example, which regulates children's access to and conditions of formal employment across the EU Member States, distinguishes between 'young people' (a blanket term for all persons under the age of 18 years), 'adolescents' (any young person of at least 15 years of age, but less than 18 years of age – who is no longer subject to compulsory full-time schooling) and 'children' (defined as those under the age of 15 – who are largely prohibited from undertaking formal employment).

Other areas of EU law, particularly those areas in which EU action complements that of Member States (such as social security, immigration and education), defer to national law to determine who is a child. In these contexts the CRC definition is generally adopted.

Under CoE law, most instruments relating to children adopt the CRC definition of a child. Examples include Article 4 (d) of the Council of Europe Convention on Action against Trafficking in Human Beings[4] or Article 3 (a) of the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention).[5]

2 Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States amending Regulation (EEC) No. 1612/68 and repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC and 93/96/EEC, OJ L 158, 30 April 2004 and OJ L 158, 29 April 2004, Art. 2 (2) (c).

3 Directive 94/33/EC of 20 August 1994 on the protection of young people at work, OJ 1994 L 216, Art. 3.

4 Council of Europe, Convention on Action against Trafficking in Human Beings, CETS No. 197, 15 May 2005.

5 Council of Europe, Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, CETS No. 201, 25 October 2007.

The European Convention on Human Rights (ECHR) does not contain a definition of a child, but its Article 1 obliges states to secure Convention rights to "everyone" within their jurisdiction. Article 14 of the ECHR guarantees the enjoyment of the rights set out in the Convention "without discrimination on any ground", including grounds of age.[6] The European Court of Human Rights (ECtHR) has accepted applications by and on behalf of children irrespective of their age.[7] In its jurisprudence, it has accepted the CRC definition of a child,[8] endorsing the "below the age of 18 years" notion.

The same applies to the European Social Charter (ESC) and its interpretation by the European Committee of Social Rights (ECSR).[9]

1.2. Background to European children's rights law

The majority of European children's rights law to date has been developed by the EU and the CoE. In addition to the UN, other international institutions, such as the Hague Conference on Private International Law, have also adopted important instruments that continue to inform the development of European law. Although these international frameworks have operated separately from one another, links are increasingly being drawn between them.[10] Inter-institutional cooperation is particularly strong between the CoE and the EU.

6 ECtHR, *Schwizgebel v. Switzerland*, No. 25762/07, 10 June 2010. See also FRA and ECtHR (2010), p. 102.

7 See, for example, ECtHR, *Marckx v. Belgium*, No. 6833/74, 13 June 1979, where the applicant child was six years old when the Court delivered the judgment.

8 ECtHR, *Güveç v. Turkey*, No. 70337/01, 20 January 2009; ECtHR, *Çoşelav v. Turkey*, No. 1413/07, 9 October 2012.

9 ECSR, *Defence for Children International (DCI) v. the Netherlands*, No. 47/2008, 20 October 2009, para. 25.

10 See, for instance, Chapter 5, which illustrates how EU family law regulating cross-border child abduction works with the Convention of 25 October 1980 on the Civil Aspects of International Child Abduction (Hague Child Abduction Convention).

1.2.1. European Union: development of children's rights law and the areas of protection covered

In the past, children's rights developed in the EU in a piecemeal fashion. Historically, European child law was largely aimed at addressing specific child-related aspects of broader economic and politically driven initiatives, for example in the field of consumer protection[11] and the free movement of persons.[12] More recently, however, children's rights have been addressed as part of a more coordinated EU agenda, based on three key milestones:

- the introduction of the Charter of Fundamental Rights of the European Union;
- the entry into force of the Treaty of Lisbon in December 2009;
- the adoption of the European Commission Communication on a special place for children in EU external action, and of the Council EU Guidelines for the promotion and protection of the rights of the child.

The first milestone was the introduction of the EU Charter of Fundamental Rights in 2000.[13] With the entry into force of the Treaty of Lisbon, on 1 December 2009, the Charter enjoys the same legal status as the EU treaties (Article 6 of the Treaty on European Union (TEU)). It obliges the EU and its Member States to protect the rights enshrined in it when implementing EU law. The EU Charter of Fundamental Rights contains the first detailed references to children's rights at the EU constitutional level, including through the recognition of children's right to receive free compulsory education (Article 14 (2)), a prohibition of discrimination on grounds of age (Article 21), and a prohibition of exploitative child labour (Article 32). Significantly, the Charter contains a dedicated provision on children's rights (Article 24). This articulates three key children's rights principles: the right to express their views freely in accordance with their age and maturity (Article 24 (1)); the right to have their best interests taken as

11 For example, Directive 2009/48/EC of the European Parliament and of the Council of 18 June 2009 on the safety of toys, OJ 2009 L 170, which enforces safety measures for children's toys.

12 For example, Directive 2004/38/EC.

13 EU (2012), Charter of Fundamental Rights of the European Union, OJ 2012 C 326.

a primary consideration in all actions relating to them (Article 24 (2)); and the right to maintain on a regular basis a personal relationship and direct contact with both parents (Article 24 (3)).

The second key milestone was the Lisbon Treaty, which, as noted above, entered into force on 1 December 2009.[14] This instrument made important institutional, procedural and constitutional changes to the EU by amending the TEU and the former European Community Treaty (now the Treaty on the Functioning of the European Union (TFEU)).[15] These changes enhanced the EU's potential to advance children's rights, not least by identifying the "protection of the rights of the child" as a general stated objective of the EU (Article 3 (3) of the TEU) and as an important aspect of the EU's external relations policy (Article 3 (5) of the TEU). More specific references to children are included within the TFEU as well, enabling the EU to enact legislative measures aimed at combating sexual exploitation and human trafficking (Article 79 (2) (d) and Article 83 (1)).

This has led to the adoption of the directives on combating child sexual abuse, child sexual exploitation and child pornography,[16] and on preventing and combating trafficking in human beings and protecting its victims,[17] which also contain provisions addressing specific needs of child victims. The more recent directive establishing minimum standards on the rights, support and protection of victims of crime similarly devotes many of its provisions to children.[18]

The third important milestone occurred at a more strategic, policy level, initially in the context of the EU's external cooperation agenda and latterly in relation to internal issue**s**. Specifically, the Council of the EU adopted 'EU Guidelines for the promotion and protection of the rights of the child'[19] and the European Commission adopted its Communication on *A special place*

14 EU (2007), Treaty of Lisbon amending the Treaty on European Union and the Treaty establishing the European Community, signed at Lisbon, OJ 2007 C 306, pp. 1–271.

15 See consolidated versions of European Communities (2012), Treaty on European Union (TEU) and Treaty on the Functioning of the European Union (TFEU), OJ 2012 C 326.

16 Directive 2011/93/EU, OJ 2011 L 335, p. 1.

17 Directive 2011/36/EU, OJ 2011 L 101, p. 1.

18 Directive 2012/29/EU, OJ 2012 L 315, p. 57.

19 Council of the European Union (2007), *EU Guidelines for the promotion and protection of the rights of the child*, Brussels, 10 December 2007.

for children in EU external action[20] to mainstream children's rights into all EU activities with non-EU Member States. Similarly, in 2011, the European Commission adopted the EU Agenda for the rights of the child, setting out key priorities for the development of children's rights law and policy across the EU Member States.[21] The agenda also included the targeting of the legislative processes relevant to child protection, such as the aforementioned adoption of the directive on victim's rights.

Most recently, this has been complemented with the Commission's adoption of a comprehensive strategy to support Member States in addressing poverty and social exclusion through a range of early-years interventions (for children of pre-school and primary school age).[22] While this particular initiative, like the agenda, is not legally binding, both are significant insofar as they establish the blueprint for the EU's normative and methodological approach to children's rights law – a blueprint that is firmly associated with the CRC and located within an ethic of child protection, participation and non-discrimination.

The EU may legislate only where it has been given competence under the treaties (Articles 2 to 4 of the TFEU). As children's rights is a cross-sectorial field, EU competence needs to be determined on a case-by-case basis. To date, areas relevant for children's rights where the EU has extensively legislated are:

- data and consumer protection;
- asylum and migration;
- cooperation in civil and criminal matters.

Articles 6 (1) of the TEU and 51 (2) of the EU Charter of Fundamental Rights provide that the Charter does not extend the competences of the EU, nor does it modify or establish a new power or task for the EU. The Charter provisions

20 European Commission (2008), *A special place for children in EU external action: Communication from the Commission to the Council, the European Parliament, the European Economic And Social Committee and the Committee of the Regions*, COM (2008) 55 final, Brussels, 5 February 2008.

21 European Commission (2011), *An EU agenda for the rights of the child: Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions*, COM (2011) 0060 final, Brussels, 15 February 2011.

22 European Commission (2013), *Investing in children: breaking the cycle of disadvantage*, Recommendation 2013/112/EU, Brussels.

are addressed to the EU institutions and to Member States only when they are implementing EU law. While always binding on the EU, the Charter provisions become legally binding for the Member States only where they act within the scope of EU law.

Each of the following chapters includes a brief overview of the EU's competence in areas dealt with under the respective chapter.

1.2.2. Council of Europe: development of children's rights law and the areas of protection covered

In contrast to the EU, ever since its establishment, the CoE has a clear mandate to protect and promote human rights. Its primary human rights treaty, ratified by all CoE member states, is the Convention for the Protection of Human Rights and Fundamental Freedoms, or European Convention on Human Rights (ECHR), which contains specific references to children. The main ones are as follows: Article 5 (1) (d) provides for the lawful detention of a child for the purposes of educational supervision; Article 6 (1) restricts the right to a fair and public hearing where this is in the interest of juveniles; Article 2 of Protocol No. 1 provides for the right to education and requires states to respect parents' religious and philosophical convictions in the education of their children. Moreover, all the other general provisions of the ECHR are applicable to everyone, including children. Some have been shown to have particular relevance to children, namely Article 8, which guarantees the right to respect for private and family life, and Article 3, which prohibits torture, inhuman and degrading treatment and punishment. By using interpretative approaches that focus on the positive obligations inherent in the ECHR provisions, the ECtHR has developed a large body of case law dealing with children's rights, including frequent references to the CRC. That said, the ECtHR analyses applications on a case-by-case basis and therefore does not offer a comprehensive overview of children's rights under the ECHR.

The CoE's other main human rights treaty, the European Social Charter (ESC[23] – revised in 1996[24]), provides for the protection of social rights, with specific

23 Council of Europe, European Social Charter, CETS No. 35, 18 October 1961.

24 Council of Europe, European Social Charter (revised), CETS No. 163, 3 May 1996.

provision for children's rights. It contains two provisions of particular importance for children's rights. Article 7 sets out the obligation to protect children from economic exploitation. Article 17 requires states to take all appropriate and necessary measures designed to ensure that children receive the care, assistance, education and training they need (including free primary and secondary education), to protect children and young persons from negligence, violence or exploitation and to provide protection for children deprived of their family's support. Implementation of the ESC is overseen by the European Committee of Social Rights (ECSR), which is composed of independent experts who rule on the conformity of national law and practice with the ESC either by way of a collective complaints procedure or a national reporting procedure.

In addition, the CoE has adopted a number of treaties that address a range of specific children's rights issues. These include the:

- Convention on the Legal Status of Children born out of Wedlock;[25]
- Convention on the Adoption of Children, revised in 2008;[26]
- Convention on Contact Concerning Children;[27]
- Convention on the Exercise of Children's Rights;[28]
- Council of Europe Convention on Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention).[29]

Finally, at the policy level it is important to note that in 2006, the CoE launched its programme 'Building a Europe for and with Children' – a transversal plan of action for addressing children's rights issues, including the adoption of

25 Council of Europe, European Convention on the Legal Status of Children born out of Wedlock, CETS No. 85, 15 October 1975.

26 Council of Europe, Convention on the Adoption of Children (Revised), CETS No. 202, 27 November 2008.

27 Council of Europe, Convention on Contact concerning Children, CETS No. 192, 15 May 2003.

28 Council of Europe, European Convention on the Exercise of Children's Rights, CETS No. 160, 25 January 1996.

29 Council of Europe, Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, CETS No. 201, 25 October 2007.

standard setting instruments across a range of areas.[30] Current priorities are focused on four key areas:[31]

- promoting child-friendly services and systems;
- eliminating all forms of violence against children;
- guaranteeing the rights of children in vulnerable situations;
- promoting child participation.

The principal aim of the CoE's children's rights programme is to support the implementation of international standards in the field of children's rights by all CoE member states, and in particular to promote the implementation of the CRC, highlighting its main principles: non-discrimination, the right to life and development, the best interests of the child as a primary consideration for decision-makers, and the right of children to be heard.[32]

The programme has overseen the adoption of several children's rights instruments offering practical guidance to complement binding European legal measures, including:

- Guidelines on child-friendly justice;[33]
- Guidelines on child-friendly healthcare;[34]
- Recommendation on integrated national strategies for the protection of children from violence;[35]

30 For more information, see http://www.coe.int/t/dg3/children/.

31 Council of Europe, Committee of Ministers (2011), Council of Europe Strategy for the Rights of the Child (2012–2015), CM (2011)171 final, 15 February 2012.

32 *Ibid.*

33 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010.

34 Council of Europe, Committee of Ministers (2011), *Guidelines on child-friendly health care*, 21 September 2011.

35 Council of Europe, Committee of Ministers (2009), Recommendation CM/Rec(2009)10 of the Committee of Ministers to member states on integrated national strategies for the protection of children from violence, 18 November 2009.

- Recommendation on children's rights and social services friendly to children and families;[36]

- Recommendation on participation of children and young people under the age of 18.[37]

In doing so, the programme has ensured that Europe is at the heart of standard-setting in children's rights and has also led the way, through various means, to ensure that children's voices are central to that process. The programme also aims to support the implementation of the ECHR and of the ESC and to promote other existing CoE legal instruments in relation to childhood (participation, protection and rights), youth and family.[38]

1.3. European children's rights law and the UN Convention on the Rights of the Child

Key point

- European children's rights law is largely based on the UN Convention on the Rights of the Child (CRC).

The fact that all EU and CoE member states are parties to the CRC gives the CRC important standing at the European level. It effectively imposes common legal obligations on European states with a knock-on effect on the way European institutions develop and apply children's rights.

In this way, the CRC has become the touchstone for the development of European children's rights law, with the result that the CoE and the EU increasingly draw on its influence. In particular, the integration of CRC principles and provisions into

36 Council of Europe, Committee of Ministers (2011), Recommendation Rec (2011)12 on children's rights and social services friendly to children and families, 16 November 2011.

37 Council of Europe, Committee of Ministers (2012), Recommendation Rec(2012)2 on the participation of children and young people under the age of 18, 28 March 2012.

38 Council of Europe, Committee of Ministers (2011), *Council of Europe Strategy for the Rights of the Child (2012–2015)*, CM (2011)171 final, 15 February 2012.

binding instruments and case law at the European level gives the CRC greater force, and opens up more effective channels of enforcement for those seeking to invoke children's rights in Europe. Specific examples of this are provided throughout this handbook.

The EU is not and cannot become a party to the CRC, since there is no legal mechanism within the CRC to allow entities other than states to accede to it. However, the EU relies on "general principles of EU law" (written and unwritten principles drawn from the common, constitutional traditions of the Member States) to supplement and guide interpretations of the EU Treaties (Article 6 (3) of the TEU). Court of Justice of the European Union (CJEU) rulings have confirmed that any obligation arising from EU membership should not conflict with Member States' obligations derived from their domestic constitutions and international human rights commitments.[39] As all EU Member States have ratified the CRC, the EU is bound to adhere to the principles and provisions enshrined therein, at least in relation to matters that fall within the scope of the EU's competence (as defined by the EU treaties).

This obligation is reinforced by other EU treaties and in particular by the EU Charter of Fundamental Rights. Article 24 of the Charter is directly inspired by CRC provisions, including some that have acquired the rank of 'CRC principles', notably the best interests of the child principle (Article 3 of the CRC), the child participation principle (Article 12 of the CRC) and the child's right to live with and/or enjoy a relationship with his or her parents (Article 9 of the CRC).

The importance of the CRC in guiding the development of EU children's rights is expressed in the Commission's Agenda for the Rights of the Child, which asserts that "the standards and principles of the UNCRC must continue to guide EU policies and actions that have an impact on the rights of the child".[40] In this spirit, child-related legislative instruments, almost without exception, are accompanied by either explicit reference to the CRC or more implicit reference to children's rights principles, such as 'best interests', the child's right to participate in decisions that affect him or her, or the right to be protected from discrimination.

39 For example CJEU, C-4/73, *J. Nold, Kohlen- und Baustoffgroßhandlung v. Commission of the European Communities*, 14 May 1974.

40 European Commission (2011), *An EU Agenda for the Rights of the Child*, COM (2011) 0060 final, Brussels.

The CoE, similarly to the EU, is not as an organisation legally bound to the CRC, although all CoE member states are individual parties to this convention. Nevertheless, the ECHR cannot be interpreted in a vacuum, but must instead be interpreted in harmony with the general principles of international law. Any relevant rules of international law applicable in the relations between the States Parties to the ECHR should be taken into account, in particular the rules concerning the universal protection of human rights. The obligations that the ECHR lays on its States Parties in the field of children's rights more specifically must be interpreted in light of the CRC.[41] The ECSR has also explicitly referred to the CRC in its decisions.[42] Moreover, the standard-setting and treaty-making activities of the CoE are influenced by CRC principles and provisions. For example, the *Guidelines on child friendly justice*[43] are directly informed by a range of CRC provisions, not to mention the accompanying General Comments of the UN Committee on the Rights of the Child.[44]

1.4. Role of the European courts in interpreting and enforcing European children's rights

1.4.1. The Court of Justice of the European Union

The CJEU issues decisions regarding many types of legal actions. In children's rights cases, the CJEU has so far mainly reviewed preliminary references (Article 267 of the TFEU).[45] These are procedures where a national court or tribunal asks the CJEU for an interpretation of primary EU law (i.e. treaties) or secondary

41 ECtHR, *Harroudj v. France*, No. 43631/09, 4 October 2012, para. 42.

42 ECSR, *World Organisation against Torture (OMCT) v. Ireland*, Complaint No. 18/2003, 7 December 2004, paras. 61–63; ECSR, *Defence for Children International (DCI) v. the Netherlands*, Complaint No. 47/2008, 20 October 2009.

43 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010.

44 See UN, Committee on the Rights of the Child (2007), *General Comment No. 10 (2007): Children's rights in juvenile justice*, CRC/C/GC/10, 25 April 2007; UN, Committee on the Rights of the Child (2009), *General Comment No. 12 (2009): The right of the child to be heard*, CRC/C/GC/12, 1 July 2009; and UN, Committee on the Rights of the Child (2013), *General Comment No. 14 (2013) on the right of the child to have his or her best interest taken as a primary consideration (art.3, para.1)*, CRC/C/GC/14, 29 May 2013.

45 The only exception is an action for annulment: CJEU, C-540/03, *European Parliament v. Council of the European Union* [GC], 27 June 2006.

EU law (i.e. decisions and legislation) that is of relevance to a national case pending before that national court or tribunal.

Until recent years, the CJEU had only adjudicated a few children's rights cases. With the adoption of more explicit children's rights legislative measures and a more prominent children's rights agenda, however, it is likely that children's rights will feature more regularly on the CJEU's listings in the future.

The CJEU has delivered most of its judgments concerning children's rights in the context of free movement and EU citizenship – areas in which the EU has enjoyed long-standing competence. Here the CJEU has expressly acknowledged that children enjoy the benefits associated with EU citizenship in their own right, thereby extending independent residence as well as both social and educational entitlement to children, on grounds of EU nationality.[46]

There is only one instance in which the CJEU directly used the CRC to determine how EU law should be interpreted in relation to children, namely in the *Dynamic Medien GmbH v. Avides Media AG* case. This case concerns the lawfulness of German labelling restrictions on imported DVDs and videos, which were already subject to similar controls in the United Kingdom. The CJEU concluded that the German labelling checks constituted a lawful restriction of the EU's free movement of goods provisions (which otherwise preclude double regulatory processes of this nature), given that they aimed to protect the welfare of children. The CJEU supported its decision by reference to Article 17 of the CRC, which encourages signatory states to develop appropriate guidelines for the protection of children from media-generated information and material injurious to their well-being.[47] Requirements of proportionality apply, however, with regard to the examination procedures established to protect children, which should be readily accessible, and possible to complete within a reasonable period.[48]

46 See CJEU, C-413/99, *Baumbast and R v. Secretary of State for the Home Department*, 17 September 2002; CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 19 October 2004; CJEU, C-148/02, *Carlos Garcia Avello v. Belgian State*, 2 October 2003; CJEU, C-310/08, *London Borough of Harrow v. Nimco Hassan Ibrahim and Secretary of State for the Home Department* [GC], 23 February 2010; CJEU, C-480/08, *Maria Teixeira v. London Borough of Lambeth and Secretary of State for the Home Department*, 23 February 2010. These cases are revisited in Chapters 8 and 9.

47 CJEU, C-244/06, *Dynamic Medien Vertriebs GmbH v. Avides Media AG*, 14 February 2008, paras. 42 and 52.

48 *Ibid.*, paras. 49 and 50.

In other cases, the CJEU has alluded to general children's rights principles also encapsulated in CRC provisions (such as the child's best interests and the right to be heard) to inform its judgments, particularly in the context of cross-border child abduction cases.[49]

That aside, the EU has traditionally been circumspect in attaching decisive force to the CRC, particularly in more politically sensitive areas such as immigration control,[50] although this is changing in recent jurisprudence, as discussed in the chapters that follow. Since the adoption of the EU Charter of Fundamental Rights, CJEU references to its articles on children's rights often resonate with references to the CRC, given the similarity between provisions.

1.4.2. The European Court of Human Rights

The ECtHR mainly decides on individual applications lodged in accordance with Articles 34 and 35 of the ECHR. ECtHR jurisdiction extends to all matters concerning the interpretation and application of the ECHR and its Protocols (Article 32 of the ECHR).

In contrast to the CJEU, the ECtHR has a vast jurisprudence on children's rights. Although many cases under Article 8 of the ECHR on the right to respect for private and family life are considered from a parents' rather than children's rights perspective, cases under other substantive provisions do not necessarily involve parents and have a clearer focus on the rights of the children concerned, such as the right to protection from inhuman and degrading treatment (Article 3 of the ECHR) or the right to a fair trial (Article 6 of the ECHR).

Although the ECtHR often refers to the CRC when addressing claims pursued either by or on behalf of children, it does not systematically attach decisive weight to it. In some cases, the children's rights principles, as articulated by the CRC, have had a profound influence on the ECtHR's reasoning, notably as concerns the Court's interpretation of Article 6 of the ECHR (right to a fair trial) in relation to the treatment of children in conflict with the law (see Chapter 11). In other areas, the approach of the ECtHR may vary slightly from that of the CRC,

49 CJEU, C-491/10 PPU, *Joseba Andoni Aguirre Zarraga v. Simone Pelz*, 22 December 2010. See further Chapter 5.

50 CJEU, C-540/03, *European Parliament v. Council of the European Union* [GC], 27 June 2006.

for example as regards hearing children in court (see Chapter 2). And in some cases, the ECtHR has explicitly relied on the CRC.

> Example: *Maslov v. Austria*[51] concerns the deportation of the applicant, who had been convicted of a number of criminal offences as a minor. The ECtHR held that where expulsion measures against a juvenile offender were concerned, the obligation to take the best interests of the child into account included an obligation to facilitate the child's reintegration, in line with Article 40 of the CRC. In the ECtHR's view, reintegration would not be achieved by severing the child's family or social ties through expulsion.[52] The CRC is thus one of the grounds used to find that the expulsion was a disproportionate interference with the applicant's rights under Article 8 of the ECHR (respect for family life).

1.5. European Committee of Social Rights

The ECSR comprises 15 independent and impartial experts who rule on the conformity of national law and practice with the ESC, either through the collective complaints procedure or the national reporting procedure.[53] Designated national and international organisations can engage in collective complaints against states that are party to the ESC and have accepted the complaints procedure. To date, complaints have involved whether states have violated children's rights under the ESC on issues including the economic exploitation of children,[54] the physical integrity of children,[55] the health rights of migrant children[56] and access to education by children with disabilities.[57]

51 ECtHR, *Maslov v. Austria* [GC], No. 1638/03, 23 June 2008.

52 *Ibid.*, para. 83.

53 For more information, see the ECSR website: www.coe.int/t/dghl/monitoring/socialcharter/ECSR/ECSRdefault_en.asp.

54 ESCR, *International Commission of Jurists (ICJ) v. Portugal*, Complaint No. 1/1998, 9 September 1999.

55 ESCR, *World Organisation Against Torture (OMCT) v. Greece*, Complaint No. 17/2003, 7 December 2004.

56 ESCR, *Defence for Children International (DCI) v. Belgium*, Complaint No. 69/2011, 23 October 2012.

57 ECSR, *Mental Disability Advocacy Center (MDAC) v. Bulgaria*, Complaint No. 41/2007, 3 June 2008, para. 35.

Example: In *International Commission of Jurists (ICJ) v. Portugal*,[58] it was alleged that although Portuguese legislation respected the minimum age of 15 years for admission to employment established by Article 7 (1) of the ESC, it was not adequately enforced. The ECSR held that the aim and purpose of the ESC was to protect rights not only in theory but also in fact, and thus that legislation must be applied effectively. Noting that a large number of children were employed illegally in Portugal, it found this situation to be in violation of Article 7 (1) of the ESC.

58 ESCR, *International Commission of Jurists (ICJ) v. Portugal*, Complaint No. 1/1998, 9 September 1999.

2 Basic civil rights and freedoms

EU	Issues covered	CoE
Charter of Fundamental Rights, Articles 10 (freedom of religion) and 14 (right to education)	**Freedom of thought, conscience and religion**	ECHR, Articles 9 (freedom of religion) and 14 (prohibition of discrimination); Article 2 of Protocol No. 1 (right of parents to ensure teaching of their children in conformity with their convictions) ECtHR, *Dogru v. France*, No. 27058/05, 2008 (wearing of Islamic headscarf at a state secondary school) ECtHR, *Kervanci v. France*, No. 31645/04, 2008 (wearing of Islamic headscarf at a state secondary school) ECtHR, *Grzelak v. Poland*, No. 7710/02, 2010 (alternatives to religious education in primary and secondary schools) ECtHR, *Lautsi and Others v. Italy* [GC], No. 30814/06, 2011 (display of crucifixes in state schools)
Charter of Fundamental Rights, Article 11 (freedom of expression)	**Freedom of expression and information**	ECHR, Article 10 (freedom of expression) ECtHR, *Handyside v. the United Kingdom*, No. 5493/72, 1976 (banning of a book for children) ECtHR, *Gaskin v. the United Kingdom*, No. 10454/83, 1989 (access to case-file kept during childhood)

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 24 (rights of the child) CJEU, C-491/10 PPU, *Joseba Andoni Aguirre Zarraga v. Simone Pelz*, 2010 (right to be heard, international child abduction)	**Right to be heard**	ECHR, Article 6 (fair trial) European Convention on the Exercise of Children's Rights, Articles 3, 4, 6 and 7 ECtHR, *Sahin v. Germany* [GC], No. 30943/96, 2003 (hearing a child in court in access proceedings)
Charter of Fundamental Rights, Article 12 (freedom of assembly and association)	**Right to freedom of assembly and of association**	ECHR, Article 11 (freedom of peaceful assembly and association) ECtHR, *Christian Democratic People's Party v. Moldova*, No. 28793/02, 2006 (attending gatherings in public space)

All persons enjoy the civil rights and freedoms laid down in various instruments, most notably the EU Charter of Fundamental Rights and the European Convention on Human Rights (ECHR) as interpreted by the European Court of Human Rights (ECtHR). Other than the Charter, no EU legal instrument deals specifically with the civil rights discussed in this chapter as they apply to children. At CoE level, however, the scope and interpretation of these civil rights have been developed extensively over the years, in particular through ECtHR case law.

This chapter presents an overview of the freedoms listed in Title II of the EU Charter of Fundamental Rights insofar as they have an impact on children's rights. It analyses the right of the child to freedom of thought, conscience and religion (Section 2.1), to freedom of expression and information (Section 2.3), the child's right to be heard (Section 2.4), and the right to freedom of assembly and of association (Section 2.5).

2.1. Freedom of thought, conscience and religion

Key points

- Freedom of thought, conscience and religion, as guaranteed under the EU Charter of Fundamental Rights and the ECHR, includes the right to change religion or belief and the freedom to manifest religion or belief in worship, teaching, practice and observance.
- Parents have the right to ensure the education and teaching of their children in conformity with their religious, philosophical and pedagogical convictions.
- Parents have the right and duty to provide direction to the child in the exercise of the child's right to freedom of thought, conscience and religion in a manner consistent with the evolving capacities of the child.

2.1.1. The child's right to freedom of religion

Under EU law, Article 10 of the EU Charter of Fundamental Rights guarantees to everyone the freedom of thought, conscience and religion. This right includes the freedom to change one's religion or belief and the freedom, either alone or in community with others and in public or in private, to manifest one's religion or belief in worship, teaching, practice and observance. The right to conscientious objection is recognised in accordance with the national laws (Article 10 (2) of the Charter).

Under CoE law, Article 9 of the ECHR provides the right to freedom of thought, conscience and religion. Three dimensions of the right to freedom of religion have been distilled from the ECtHR's case law: the internal dimension; the freedom to change one's religion or belief; and the freedom to manifest one's religion or belief. The first two dimensions are absolute, and states may not limit them under any circumstance.[59] The freedom to manifest one's religion or belief may be limited if such limitations are prescribed by law, pursue a legitimate aim and are necessary in a democratic society (Article 9 (2) of the ECHR).

In its case law, the ECtHR has dealt with children's freedom of thought, conscience and religion, mainly in relation to the right to education and the state school system. A topic of much public debate in European countries is religion in schools.

59 ECtHR, *Darby v. Sweden*, No. 11581/85, 23 October 1990.

Example: The cases of *Dogru v. France* and *Kervanci v. France*[60] concern the exclusion from the first year of a French state secondary school of two girls, aged 11 and 12 years, as a result of their refusal to remove their headscarves during physical education classes. The ECtHR observed that the purpose of the restriction on the applicants' right to manifest their religious convictions was to adhere to the requirements of secularism in state schools. According to the national authorities, wearing a veil, such as the Islamic headscarf, was incompatible with sports classes for health and safety reasons. The ECtHR deemed this reasonable, as the school balanced the applicants' religious convictions against the requirements of protecting the rights and freedoms of others and the public order. Accordingly, it concluded that the interference with the freedom of the pupils to manifest their religion was justified and proportionate to the aim pursued. It therefore found no violation of Article 9 of the ECHR.

Example: The case *Grzelak v. Poland*[61] concerns the failure to provide a pupil excused from religious instruction with ethics classes and associated marks. During his entire schooling at primary and secondary level (between the ages of seven and 18 years), the applicant did not receive religious instruction, in conformity with the wishes of his parents, who were declared agnostics. As too few pupils were interested, no class in ethics was ever organised, and he received school reports and certificates that contained a straight line instead of a mark for 'religion/ethics'. According to the ECtHR, the absence of a mark for 'religion/ethics' on the boy's school reports fell within the ambit of the negative aspect of freedom of thought, conscience and religion, as the reports could point to his lack of religious affiliation. It therefore amounted to a form of unwarranted stigmatisation. The difference in treatment between non-believers who wished to follow ethics classes and pupils who followed religious classes was thus not objectively and reasonably justified, nor was there a reasonable relationship of proportionality between the means used and the aim pursued. The state's margin of appreciation was exceeded in this matter, as the very essence of the applicant's right not to manifest his religion or convictions was infringed, in violation of Article 14 of the ECHR taken in conjunction with Article 9 of the ECHR.

60 ECtHR, *Dogru v. France*, No. 27058/05, 4 December 2008; ECtHR, *Kervanci v. France*, No. 31645/04, 4 December 2008 (available in French).

61 ECtHR, *Grzelak v. Poland*, No. 7710/02, 15 June 2010.

2.2. Parents' rights and the freedom of religion of their children

The rights of parents in the context of the freedom of religion of their children are addressed differently in European law compared to the CRC.

Under EU law, due respect must be given to the right of parents to ensure the education and teaching of their children in conformity with their religious, philosophical and pedagogical convictions, in particular in the context of the freedom to found educational establishments (Article 14 (3) of the Charter).

Under CoE law, in particular Article 2 of Protocol No. 1 to the ECHR, states must take into account the parent's (religious) convictions in the exercise of every function they undertake in the sphere of education and teaching. According to the ECtHR, this duty is broad, as it applies not only to the content and implementation of school curricula, but also to the performance of all functions a state assumes.[62] It includes the organisation and financing of public education, the setting and planning of the curriculum, the conveying of information or knowledge included in the curriculum in an objective, critical and pluralistic manner (hence forbidding the state to pursue an aim of indoctrination that might be considered as not respecting parents' religious and philosophical convictions), as well as the organisation of the school environment, including the presence of crucifixes in state-school classrooms.

Example: The case *Lautsi and Others v. Italy*[63] concerns the display of crucifixes in state-school classrooms. A parent complained that the presence of crucifixes in the classrooms of the state school attended by her children infringed the principle of secularism according to which she sought to educate her children. The ECtHR Grand Chamber found that it was up to the state, as part of its functions in relation to education and teaching, to decide whether or not crucifixes should be present in state-school classrooms, and that this fell within the scope of the second

62 See the relevant ECtHR case law: ECtHR, *Kjeldsen, Busk Madsen and Pedersen v. Denmark*, Nos. 5095/71, 5920/72 and 5926/72, 7 December 1976; ECtHR, *Valsamis v. Greece*, No. 21787/93, 18 December 1996; ECtHR, *Folgerø and Others v. Norway* [GC], No. 15472/02, 29 June 2007; ECtHR, *Hasan and Eylem Zengin v. Turkey*, No. 1448/04, 9 October 2007; ECtHR, *Lautsi and Others v. Italy* [GC], No. 30814/06, 18 March 2011.

63 ECtHR, *Lautsi and Others v. Italy* [GC], No. 30814/06, 18 March 2011.

sentence of Article 2 of Protocol No. 1 to the ECHR. The Court argued that in principle this decision falls within the margin of appreciation of the respondent state, and that there is no European consensus on the presence of religious symbols in state schools. It is true that the presence of crucifixes in state-school classrooms – a sign which undoubtedly refers to Christianity – gives visible prominence in the school environment to a country's majority religion. However, this is not in itself sufficient to denote a process of indoctrination on the respondent state's part. In the ECtHR's view, a crucifix on a wall is an essentially passive symbol that cannot be deemed to have an influence on pupils comparable to that of speech or participation in religious activities. Accordingly, the Grand Chamber concluded that, in deciding to keep crucifixes in the state-school classrooms the applicant's children attended, the authorities had acted within the limits of their margin of appreciation and thus respected the right of parents to ensure education and teaching in conformity with their own religious and philosophical convictions.

Under international law, Article 14 (2) of the CRC requires States Parties to respect the rights and duties of parents to provide direction to their child in the exercise of his/her right to freedom of thought, conscience and religion in a manner consistent with the evolving capacities of the child. Thus, as opposed to Article 14 (3) of the EU Charter of Fundamental Rights, the CRC focuses on the exercise of the freedom of the child him/herself. Under the CRC, parents have the right to provide guidance and direction not in accordance with their own convictions, but in accordance with the convictions held by the children. The wording of Article 14 (2) of the CRC is in line with the CRC's general conception of parental responsibilities: that parental responsibilities must be exercised consistently with the evolving capacities of the child (Article 5 of the CRC), and based on the best interests of the child (Article 18 (1) of the CRC).

2.3. Freedom of expression and information

Key points

- Both the EU Charter of Fundamental Rights and the ECHR guarantee the right to freedom of expression, which includes the freedom to hold opinions and to receive and impart information and ideas without interference by public authorities.
- The right to freedom of information does not include the right of access to childcare records.
- Making access to childcare records dependent on the consent of the contributor of the information may be compatible with Article 8 (the right to respect for private and family life) of the ECHR, provided that an independent authority has the final say in deciding whether access should be granted.

Under EU law, the right to freedom of expression includes the freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers (Article 11 of the EU Charter of Fundamental Rights).

Under CoE law, freedom of expression is guaranteed by Article 10 of the ECHR and may be limited only if the limitation is prescribed by law, pursues one of the legitimate aims listed in Article 10 (2) and is necessary in a democratic society.

In its case law, the ECtHR stressed that "[f]reedom of expression constitutes one of the essential foundations of [a democratic] society, one of the basic conditions for its progress and for the development of every man [...] it is applicable not only to 'information' or 'ideas' that are favourably received or regarded as inoffensive or as a matter of indifference, but also to those that offend, shock or disturb the State or any sector of the population".[64]

64 See, for example, ECtHR, *Handyside v. the United Kingdom*, No. 5493/72, 7 December 1976, para. 49.

Example: In *Handyside v. the United Kingdom*,[65] the ECtHR found that a ban imposed by the authorities on a book called *Little Red School Book* was in accordance with the exception laid down in Article 10 (2) of the ECHR on the protection of morals. The case deals with the right to receive information appropriate for a child's age and maturity – an aspect of the right to freedom of expression that is particularly relevant for children. The book, which was translated from Danish, was written for school-age children and questioned a series of social norms, including sexuality and drugs. Young people could interpret certain passages of the book at a critical stage of their development as an encouragement to indulge in precocious activities harmful for them or even to commit certain criminal offences. Therefore, according to the ECtHR, the competent English judges "were entitled, in the exercise of their discretion, to think at the relevant time that the book would have pernicious effects on the morals of many of the children and adolescents who would read it".[66]

Other child cases referencing Article 10 of the ECHR concern the right of access to information of children placed in care.

Example: The case *Gaskin v. the United Kingdom*[67] concerns a person who was placed in care for most of his childhood, during which period the local authority kept confidential records. These included various reports by medical practitioners, school teachers, police and probation officers, social workers, health visitors, foster parents and residential school staff. When the applicant sought access to those records for the purpose of proceeding for personal injuries against the local authority, he was refused. The confidentiality of such records had been warranted in the public interest for the proper operation of the childcare service, which would be jeopardised if contributors to the records were reluctant to be frank in their reports in the future. The ECtHR accepted that persons who were in state care as children had a vital interest "in receiving the information necessary to know and to understand their childhood and early development".[68] While the confidentiality of public records needs to be guaranteed, a system like the British one, which made access to records dependent on the consent of

65 *Ibid.*

66 *Ibid.*, para. 52.

67 ECtHR, *Gaskin v. the United Kingdom*, No. 10454/83, 7 July 1989.

68 *Ibid.*, para. 49.

the contributor, could in principle be compatible with Article 8 of the ECHR if the interests of the individual seeking access to records were secured when a contributor to the records was unavailable or improperly refused consent. In such a case, an independent authority should ultimately decide whether access should be granted. No such procedure was available to the applicant in the present case and the Court found a violation of the applicant's rights under Article 8 of the ECHR. The ECtHR, however, found no violation of Article 10 of the ECHR, reiterating that the right to freedom to receive information prohibits a government from restricting a person from receiving information that others wish or may be willing to impart, but does not oblige a state to impart the information in question to the individual.

2.4. Right to be heard

Key points

- Under EU law, children have the right to express their views freely. Their views shall be taken into consideration on matters which concern them in accordance with their age and maturity.
- Under the ECHR, there is no absolute requirement to hear a child in court. Whether or not to do so has to be assessed in light of the specific circumstances of each case and is dependent on the child's age and maturity.
- Under UN law, children's right to express their own views freely in all matters affecting them has been recognised as one of the general principles of the Convention on the Rights of the Child.

Under EU law, Article 24 (1) of the EU Charter of Fundamental Rights provides that children may express their views freely, and that such views shall be taken into consideration on matters which concern them in accordance with their age and maturity. This provision is of general applicability, and is not restricted to particular proceedings. The CJEU interpreted the meaning of this provision in conjunction with the Brussels II bis Regulation.

Example: *Joseba Andoni Aguirre Zarraga v. Simone Pelz*[69] concerns the removal of a minor child from Spain to Germany in breach of custody rulings. The CJEU was asked whether the German court (i.e. the court of the country the child was removed to) could oppose the enforcement order by the Spanish court (the country of origin) on the basis that the child had not been heard, thereby infringing Article 42 (2) (a) of Regulation No. 2201/2003 (Brussels II bis) and Article 24 of the EU Charter of Fundamental Rights. The child had opposed the return when she expressed her views within proceedings before the German court. The CJEU reasoned that hearing a child is not an absolute right, but that if a court decides it is necessary, it must offer the child a genuine and effective opportunity to express his or her views. It also held that the right of the child to be heard, as provided in the Charter and Brussels II bis Regulation, requires legal procedures and conditions which enable children to express their views freely to be available to them, and the court to obtain those views. The court also needs to take all appropriate measures to arrange such hearings, with regard to the children's best interests and the circumstances of each individual case. According to the CJEU's ruling, however, the authorities of the country the child had been removed to (Germany) could not oppose a return of the child on the basis of a breach of the right to be heard in the country of origin (Spain).

Under CoE law, the ECtHR does not interpret the right to respect for private and family life (Article 8 of the ECHR) as always requiring the child to be heard in court. As a general rule, it is for the national courts to assess the evidence before them, including the means used to ascertain the relevant facts. Domestic courts are not always required to hear a child in court on the issue of access to a parent who does not have custody rights. This issue has to be assessed in light of the specific circumstances of each case, having due regard to the age and maturity of the child concerned. Moreover, the ECtHR will often ensure, under the procedural limb of Article 8, that the authorities have taken appropriate steps to accompany their decisions with the necessary safeguards.

69 CJEU, C-491/10 PPU, *Joseba Andoni Aguirre Zarraga v. Simone Pelz*, 22 December 2010; see also Section 5.4, which discusses further details of this ruling and the operation of the Brussels II bis regulation.

Example: In the case of *Sahin v. Germany*,[70] the mother prohibited all contact between the applicant and his four-year old daughter. The German regional court decided that granting the father access to his daughter would be harmful to the child because of the serious tensions between the parents. It did so without hearing the child whether she wanted to continue seeing her father. On the question of hearing the child in court, the ECtHR referred to the expert's explanation before the regional court in Germany. After several meetings with the child, her mother and the applicant, the expert considered that the process of questioning the child could have entailed a risk for her, which could not have been avoided by special arrangements in court. The ECtHR found that, in these circumstances, the procedural requirements implicit in Article 8 of the ECHR – to hear a child in court – did not amount to obliging the direct questioning of the child on her relationship with her father.

Example: In *Sommerfeld v. Germany*,[71] the applicant's 13-year-old daughter had expressed a clear wish not to see the applicant and had done so for several years. The domestic courts were of the view that forcing her to see the applicant would seriously disturb her emotional and psychological balance. The ECtHR accepted that the decision-making process provided the applicant with the required protection of his interests.[72]

The European Convention on the Exercise of Children's Rights deals with the right of children to express their views freely.[73] This convention aims to promote children's rights by granting them specific procedural rights in family proceedings before a judicial authority, in particular for proceedings involving the exercise of parental responsibilities, such as residence and access to children. Article 3 of the convention grants children the right to be informed and to express their views in proceedings as a procedural right. In Article 4, the child is granted the right to apply for the appointment of a special representative in proceedings before a judicial authority affecting her or him. In line with Article 6, authorities must ensure that the child has received all relevant in-

70 ECtHR, *Sahin v. Germany* [GC], No. 30943/96, 8 July 2003, para. 73. On the specific aspect of national courts having to assess the evidence they have obtained, as well as the relevance of the evidence that defendants seek to adduce, see also ECtHR, *Vidal v. Belgium*, No. 12351/86, 22 April 1992, para. 33.

71 ECtHR, *Sommerfeld v. Germany* [GC], No. 31871/96, 8 July 2003.

72 *Ibid.*, paras. 72 and 88.

73 Council of Europe, European Convention on the Exercise of Children's Rights, CETS No. 160, 1996.

formation, consult her or him in person, if appropriate, and allow the child to express her or his views.

Under international law, Article 12 (1) of the CRC affirms that a child who is capable of forming her or his own views has the right to express these views freely in all matters affecting her or him. The child's views should be given due weight in accordance with her or his age and maturity. Article 12 (2) of the CRC furthermore prescribes that the child must be provided the opportunity to be heard in any judicial and administrative proceedings affecting her or him, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

The UN Committee on the Rights of the Child stressed that States Parties should either directly guarantee this right, or adopt or revise laws so that this right can be fully enjoyed by the child.[74] Furthermore, they must ensure that the child receives all necessary information and advice to make a decision in favour of her or his best interests. The committee also notes that a child has the right not to exercise this right; expressing views is a choice, not an obligation.

2.5. Right to freedom of assembly and association

Key points

- Both the EU Charter of Fundamental Rights and the ECHR guarantee the freedom of peaceful assembly and association.
- This right enables and protects individuals to further their causes together with others.

Under EU law, Article 12 of the EU Charter of Fundamental Rights provides that everyone has the right to freedom of peaceful assembly and association at all levels, in particular in political, trade union and civic matters. This implies the

74 UN, Committee on the Rights of the Child, *General Comment No. 14 (2013) on the right of the child to have his or her best interest taken as a primary consideration (art.3, para.1)*, CRC/C/GC/14, 29 May 2013.

right of everyone to form and to join trade unions for the protection of his or her interests.

Under CoE law, Article 11 (1) of the ECHR guarantees the right to freedom of assembly and association subject to the restrictions of Article 11 (2).

The ECtHR has explicitly asserted the right of children to attend gatherings in a public space. As the Court noted in *Christian Democratic People's Party v. Moldova*, it would be contrary to the parent's and children's freedom of assembly to prevent them from attending events, in particular to protest against government policy on schooling.

Under international law, individual children as well as children's organisations can rely on the protection offered by Article 15 of the CRC, which contains the right to freedom of association and of peaceful assembly. A large variety of associational forms in which children are engaged have been granted international protection based on this provision.

3 Equality and non-discrimination

EU	Issues covered	CoE
Charter of Fundamental Rights, Title III (Equality), including Articles 20 (equality before the law), 21 (non-discrimination) and 23 (equality between men and women)	Equality and non-discrimination	ECHR, Article 14; Protocol No. 12 to the ECHR, Article 1 (non-discrimination) ESC (revised), Article E (non-discrimination)
Racial Equality Directive (2000/43/EC)	Non-discrimination based on race and ethnic origin	ECtHR, *D.H. and Others v. the Czech Republic* [GC], No. 57325/00, 2007 (placement of Roma children in special schools) ECtHR, *Oršuš and Others v. Croatia*, No. 15766/03, 2010 (Roma-only classes in primary schools) Framework Convention for the Protection of National Minorities (FCNM), Articles 4 and 12
Charter of Fundamental Rights, Article 45 (freedom of movement and of residence) CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 2004 (residence rights of third-country national parents)	Non-discrimination based on nationality and immigration status	ECtHR, *Ponomaryovi v. Bulgaria*, No. 5335/05, 2011 (school fees for temporary residents) FCNM, Articles 4 and 12, para. 3
Employment Equality Directive (2000/78/EC)	Non-discrimination based on age	ECHR, Article 14; Protocol No. 12 to the ECHR, Article 1 (non-discrimination)
CJEU, C-303/06, *S. Coleman v. Attridge Law and Steve Law* [GC], 2008	Non-discrimination based on other protected grounds	ECtHR, *Fabris v. France* [GC], No. 16574/08, 2013 (inheritance rights for children born out of wedlock)

Freedom from discrimination is one of the basic principles of a democratic society. Both the EU and the CoE have been instrumental in interpreting this principle. EU institutions have adopted a series of directives which are highly relevant for children's issues. The European Court of Human Rights (ECtHR) has developed a substantial body of case law on the freedom from discrimination under Article 14 of the ECHR on the prohibition of discrimination, in conjunction with other Convention articles.

The European Committee of Social Rights (ECSR) considers the function of Article E of the European Social Charter (ESC) on non-discrimination to be similar to that of Article 14 of the European Convention on Human Rights (ECHR): it has no independent existence and must be combined with one of the ESC's substantive provisions.[75]

This chapter addresses the principles of equality and non-discrimination, with a focus on those grounds where child-specific case law has been developed. It first provides general information on European non-discrimination law (Section 3.1), and then presents the issue of equality and discrimination of children based on ethnic origin (Section 3.2), nationality and immigration status (Section 3.3), age (Section 3.4), and other protected grounds, including gender, language and personal identity (Section 3.5).

3.1. European non-discrimination law

Key points

- EU and CoE law prohibit discrimination on the grounds of sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age and sexual orientation.[76]
- When the ECtHR establishes that persons have been treated differently in a relevantly similar situation, it will investigate whether there is an objective and reasonable justification. If not, it will conclude that the treatment was discriminatory, in breach of Article 14 of the ECHR on the prohibition of discrimination.

75 ECSR, *Syndicat des Agrégés de l'Enseignement Supérieur (SAGES) v. France*, Complaint No. 26/2004, 15 June 2005, para. 34.

76 For an overview of European non-discrimination law, as constituted by the EU non-discrimination directives and Art. 14 of and Protocol 12 to the ECHR, see: FRA and ECtHR (2011), and its case law update July 2010–December 2011.

Under EU law, the prohibition of discrimination in Article 21 of the EU Charter of Fundamental Rights is a free-standing principle that also applies to situations not covered by any other Charter provision. The grounds on which discrimination is explicitly prohibited in this provision include sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age and sexual orientation. By contrast, Article 19 of the TFEU only covers the grounds of sex, racial or ethnic origin, religion or belief, disability, age and sexual orientation.

Several EU directives prohibit discrimination in the areas of employment, the welfare system and goods and services, all of which are potentially relevant to children. Council Directive 2000/78/EC, which establishes a general framework for equal treatment in employment and occupation (Employment Equality Directive),[77] prohibits discrimination on the grounds of religion or belief, disability, age and sexual orientation. Council Directive 2000/43/EC, implementing the principle of equal treatment between persons irrespective of racial or ethnic origin (Racial Equality Directive), prohibits discrimination on the basis of race or ethnicity not only in the context of employment and access to goods and services, but also in relation to the welfare system (including social protection, social security and healthcare) and to education.[78] Further directives implement the principle of equal treatment between men and women in matters of employment and occupation (Gender Equality Directive)[79] and in the access to and supply of goods and services (Gender Goods and Services Directive).[80]

Under CoE law, the prohibition of discrimination applies to the exercise of any of the substantive rights and freedoms set forth in the ECHR (Article 14), as well as to the exercise of any right guaranteed under domestic law or in any act by a public authority (Article 1 of Protocol No. 12 to the ECHR). Protocol 12, however, is of limited applicability, since it has only been ratified by a small number of countries and no child-related cases have yet been decided on its basis. The provisions set forth in both instruments include a non-exhaustive list of grounds on which discrimination is prohibited: sex, race, colour, language,

77 Council Directive 2000/78/EC, OJ 2000 L 303. All EU legal instruments are available on the EU's online portal providing access to EU law eur-lex: http://eur-lex.europa.eu/homepage.html.

78 Council Directive 2000/43/EC of 29 June 2000 implementing the principal of equal treatment between persons irrespective of racial or ethnic origin, OJ 2000 L 180, 29 June 2000.

79 Directive 2006/54/EC (recast), OJ 2006 L 204.

80 Council Directive 2004/113/EC, OJ 2004 L 373, p. 37.

religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status. Where the ECtHR finds that persons in relevantly similar positions have been treated differently, it will investigate whether this can be objectively and reasonably justified.[81]

Article E of the ESC also includes a non-exhaustive list of grounds on which discrimination is prohibited: race, colour, sex, language, religion, political or other opinion, national extraction or social origin, health, association with a national minority, or birth. The appendix to this article clarifies that differential treatment based on an objective and reasonable justification includes requiring a certain age or capacity for access to some forms of education[82] – and that this is therefore not discriminatory.

Under Article 4 of the Framework Convention for the Protection of National Minorities[83] (FCNM), States Parties guarantee to persons belonging to national minorities the right of equality before the law and equal protection by the law, and prohibit discrimination based on belonging to a national minority. They also undertake to adopt, where necessary, adequate measures to promote, in all areas of economic, social, political and cultural life, full and effective equality between persons belonging to a national minority and those belonging to the majority.

The following sections analyse specific grounds of discrimination which have proven of particular relevance for children.

81 For an overview of the ECtHR case law, see FRA and ECtHR (2011) and its case law update July 2010–December 2011.

82 Council of Europe, European Social Charter (revised) (1996), Explanatory report, para. 136.

83 Council of Europe, Framework Convention for the Protection of National Minorities (FCNM), CETS No. 157, 1995.

3.2. Non-discrimination based on race or ethnic origin

Key points

- Race and ethnic origin are prohibited grounds of discrimination.
- Both the EU and the CoE tackle discrimination of the Roma in the areas of education, employment, healthcare and housing.
- The over-representation or segregation of children belonging to a specific ethnic group in special schools or classes can only be objectively justified if appropriate safeguards for referring children to these schools or classes are put in place.

Under EU law, the Racial Equality Directive prohibits discrimination on the basis of race or ethnicity not only in the context of employment and goods and services, but also in accessing the welfare system, education and social security. The Roma, as a particularly sizeable and vulnerable ethnic group, fall squarely within the scope of the directive. A key element of the drive to tackle discrimination of the Roma at EU level was the adoption of an EU Framework for National Roma Integration Strategies up to 2020.[84] This has been followed by the European Commission's annual monitoring of the national strategies developed by EU Member States. The Racial Equality Directive covers at least four key areas that are important for Roma children: education, employment, healthcare and housing. Achieving full equality in practice may in certain circumstances warrant Roma-specific positive action, in particular in these four key areas.[85]

Under CoE law, the ECtHR has ruled in several landmark cases on the differential treatment of Roma children in the educational system. These cases were analysed under Article 14 taken together with Article 2 of Protocol No. 1 to the

84 European Commission (EC) (2011), *An EU framework for national Roma integration strategies up to 2020: Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions*, COM(2011) 173 final, Brussels, 5 April 2011.

85 European Commission (2014), *Joint Report on the application of Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin and of Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation*, Report from the Commission to the European Parliament and the Council, COM(2014) 2 final, Brussels, 17 January 2014.

ECHR. The ECtHR held that the over-representation or segregation of Roma children in special schools or classes could only be objectively justified by putting in place appropriate safeguards for referring children to these schools or classes, such as tests specifically designed for and sensitive to the needs of Roma children; appropriate evaluation and monitoring of progress so that integration in ordinary classes takes place as soon as learning difficulties have been remedied; and positive measures to address learning difficulties. In the absence of effective anti-segregationist measures, prolonging the educational segregation of Roma children in a mainstream school with a regular program could thus not be justified.[86]

Example: In *D.H. and Others v. the Czech Republic,*[87] the ECtHR found that a disproportionate number of Roma children were placed in special schools for children with learning difficulties without justification. The Court was concerned about the more basic curriculum offered in these schools and the segregation that the system caused. Roma children thus received an education that compounded their difficulties and compromised their subsequent personal development instead of helping them to integrate into the mainstream education system and develop the skills that would facilitate life among the majority population. Consequently, the ECtHR found a violation of Article 14 of the ECHR in conjunction with Article 2 of Protocol No. 1 to the ECHR.

Example: In *Oršuš and Others v. Croatia*,[88] the ECtHR examined the existence of Roma-only classes within ordinary primary schools. As a matter of principle, temporarily placing children in a separate class due to their inadequate command of the language of instruction is not discriminatory as such. Such a placement can be seen as adapting the educational system to the special needs of children with language difficulties. However, as soon as this placement disproportionally or exclusively affects members of a specific ethnic group, safeguards have to be put in place. For the initial placement in separate classes, the ECtHR noted that the placement was not part of a general practice to address the problems of children with an

86 ECtHR, *Lavida and Others v. Greece*, No. 7973/10, 30 May 2013 (available in French).

87 ECtHR, *D.H. and Others v. the Czech Republic* [GC], No. 57325/00, 13 November 2007, paras. 206–210.

88 ECtHR, *Oršuš and Others v. Croatia* [GC], No. 15766/03, 16 March 2010, para. 157.

inadequate command of the language, and that no specific testing of the children's command of the language had taken place. As to the curriculum offered to them, some children were not offered any specific programme (i.e., special language classes) to acquire the necessary language skills in the shortest time possible. There was neither a transferral nor a monitoring procedure in place to ensure the immediate and automatic transfer to the mixed classes as soon as the Roma children attained adequate language proficiency. Consequently, the Court found that this was in violation of Article 14 of the ECHR in conjunction with Article 2 of Protocol No. 1.

The ECSR holds that, even though educational policies of Roma children may be accompanied by flexible structures to meet the diversity of the group and may take into account the fact that some groups lead an itinerant or semi-itinerant lifestyle, there should be no separate schools for Roma children.[89]

Under Article 4 (2) and (3) FCNM, special measures adopted to promote the effective equality of persons belonging to national minorities shall not be regarded as discriminatory. In accordance with Article 12 (3) FCNM, States Parties moreover expressly undertake to promote equal opportunities for access to education at all levels for persons belonging to national minorities. The Advisory Committee on the FCNM has regularly examined the equal access to education of Roma children in line with this provision.[90]

89 ECSR, European Social Charter (revised) – Conclusions 2003 (Bulgaria), Art. 17, para. 2, p. 53.

90 See Council of Europe, Advisory Committee on the FCNM, *Commentary on Education under the Framework Convention for the Protection of National Minorities* (2006), ACFC/25DOC(2006)002.

3.3. Non-discrimination based on nationality and immigration status

Key points

- Protection against discrimination based on nationality is more limited in scope under EU law than under CoE law.
- Under EU law, protection against discrimination based on nationality is only granted to citizens of EU Member States, as enshrined in Article 45 (freedom of movement and of residence) of the EU Charter of Fundamental Rights.
- The ECHR guarantees the enjoyment of rights to all persons within the jurisdiction of a member state.

Under EU law, protection against discrimination based on nationality is particularly prominent in the context of the free movement of persons. Third-country nationals (i.e. persons who are citizens of a state that is not a member of the EU) enjoy a right to equal treatment in broadly the same areas as those covered by the non-discrimination directives when they qualify as 'long-term residents'. For qualifying as such, the Third-Country Nationals Directive requires, among other conditions, a period of five years of lawful residence.[91] In addition, Directive 2003/86/EC on the right to family reunification (Family Reunification Directive) [92] allows for third-country nationals lawfully residing in a Member State to be joined by family members, under certain conditions (see also Section 9.5).

Example: The *Chen* case[93] concerns the question of whether a child of a third-country national had the right to reside in one EU Member State when she was born in a different Member State and held the citizenship of the latter. Her mother, on whom she depended, was a third-country national. The CJEU determinedthat, when a Member State imposes require-

91 Directive 2003/109/EC of 23 January 2004 concerning the status of third-country nationals who are long-term residents, OJ 2004 L 16, p. 44.

92 Directive 2003/86/EC of 3 October 2003 on the right to family reunification, OJ 2003 L 251, p. 12.

93 CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 19 October 2004.

ments on individuals seeking citizenship, and these are met, it is not open to a different Member State to then challenge that entitlement when the mother and the child apply for residence. The CJEU confirmed that a Member State cannot refuse a right of residence to a parent who is the carer of a child who is an EU citizen, as this would deprive the child's right of residence of any useful effect.

Under CoE law, the ECHR guarantees the enjoyment of rights to all those living within the jurisdiction of a member state, whether they are citizens or not, including those living beyond the national territory, in areas under the effective control of a member state. Regarding education, the ECtHR therefore holds that differential treatment on grounds of nationality and immigration status could amount to discrimination.

Example: *Ponomaryovi v. Bulgaria*[94] concerns the issue of foreign nationals lacking permanent residence permits having to pay school fees for their secondary education. As a matter of principle, the normally wide margin of appreciation in cases of general measures of economic or social strategy needed to be qualified in the field of education, for two reasons:

- the right to education enjoys direct protection under the ECHR;
- education is a very particular type of public service, which serves broad societal functions.

According to the ECtHR, the margin of appreciation increases with the level of education, in inverse proportion to the importance of that education for those concerned and for society at large. So, while for primary schooling (higher) fees for foreigners are hard to justify, they may be fully justified at the university level. Given the importance of secondary education for personal development, and social and professional integration, a stricter scrutiny of the proportionality of the differential treatment applies for that level of education. The Court clarified that it did not take any position on whether or not a state is entitled to deprive all irregular migrants from the educational benefits it provides to nationals and certain limited categories of foreigners. In assessing the particular circumstances of the case, it found that no "considerations relating to the need to stem or reverse the flow of illegal immigration" applied. The applicants had not tried to abuse

94 ECtHR, *Ponomaryovi v. Bulgaria*, No. 5335/05, 21 June 2011, para. 60.

the Bulgarian educational system, as they had come to live in Bulgaria at a very young age following their mother's marriage with a Bulgarian, so they had no choice but to go to school in Bulgaria. There had accordingly been a violation of Article 14 of the ECHR in conjunction with Article 2 of Protocol No. 1 to the ECHR.

3.4. Non-discrimination based on age

Key point

- Under both EU law and the ECHR, discrimination on the grounds of age is prohibited.

Under EU law, the EU Charter of Fundamental Rights in Article 21 explicitly mentions 'age' as a ground on which discrimination is prohibited. Article 24 includes the rights of the child among the protected fundamental rights. Under current EU legislation on non-discrimination, protection from discrimination on the basis of age is more limited than protection on the basis of race and ethnicity or on the basis of sex. Age is currently only protected in the context of access to employment, similarly to sexual orientation, disability and religion or belief.

The Employment Equality Directive is applicable to children who are legally entitled to work. While the International Labour Organization Convention concerning Minimum Age for Admission to Employment,[95] ratified by all EU Member States, establishes a minimum age of 15 years, differences regarding this minimum age persist among the EU Member States.[96] According to Article 6 of the Employment Equality Directive, Member States may provide justifications for differences of treatment on grounds of age. These differences do not constitute discrimination if they are objectively and reasonably justified by a legitimate aim, and if the means of achieving that aim are appropriate and necessary. Concerning children and young people, such differences of treat-

95 International Labour Organization (ILO) (1973), Convention concerning Minimum Age for Admission to Employment, No. 138.

96 European Network of Legal Experts in the non-discrimination field, O'Dempsey, D. and Beale, A. (2011), *Age and employment*, European Commission, Directorate-General for Justice, Luxembourg, Publications Office.

ment may, for instance, include the setting of special conditions on access to employment and vocational training, employment and occupation, to promote their vocational integration or ensure their protection.

Under CoE law, Article 14 of the ECHR and Article 1 of Protocol 12 to the ECHR do not explicitly mention 'age' in the list of grounds on which discrimination is prohibited. The ECtHR, however, has examined issues of age discrimination in relation to various rights protected by the ECHR, and thereby implicitly analysed age as being included among 'other status'. In *D.G. v. Ireland*[97] and *Bouamar v. Belgium*,[98] for instance, the ECtHR found that there was a difference in treatment between adults and children in the countries' respective justice systems regarding detention, relevant to the application of the Convention. This difference in treatment stemmed from the punitive purpose of detention as regards adults and its preventive purpose in respect of children. Hence, the Court accepted 'age' as a possible ground for discrimination.

3.5. Non-discrimination based on other protected grounds

Key point

- Further grounds of discrimination, such as disability or birth, have been addressed in European jurisprudence pertaining to children.

Under EU law, Article 21 of the EU Charter of Fundamental Rights also prohibits discrimination based on other grounds particularly relevant to children, such as sex, genetic features, language, disability or sexual orientation. At least for disability, the CJEU has accepted that EU law also protects against so-called 'discrimination by association', i.e. discrimination against a person who is associated with another who has the protected characteristic (such as the mother of a child with disabilities).

97 ECtHR, *D.G. v. Ireland*, No. 39474/98, 16 May 2002 (see also Section 11.2.2).

98 ECtHR, *Bouamar v. Belgium*, No. 9106/80, 29 February 1988 (see also Section 11.2.2).

Example: In *S. Coleman v. Attridge Law and Steve Law*,[99] the CJEU noted that the Employment Equality Directive includes certain provisions designed to specifically accommodate the needs of persons with disabilities. This, however, does not lead to the conclusion that the principle of equal treatment enshrined in the directive must be interpreted strictly, as prohibiting only direct discrimination on the grounds of disability and relating exclusively to persons with disabilities. According to the CJEU, the directive applies not to a particular category of persons but to the very nature of the discrimination. An interpretation limiting its application to persons with disabilities wouldd**e**prive the directive of an important element of its effectiveness and reduce the protection that it is intended to guarantee. The CJEU concluded that the directive must be interpreted as meaning that the prohibition of direct discrimination laid down therein is not limited to persons with disabilities. Consequently, where an employer treated an employee who did not have a disability less favourably than another employee in a comparable situation, based on the disability of the former employee's child, whose care was provided primarily by that employee, such treatment was contrary to the prohibition of direct discrimination laid down by the directive.

Under CoE law, the ECtHR has dealt with discrimination against children in a variety of situations other than those already mentioned, such as discrimination based on language[100] or affiliation.[101]

Example: In *Fabris v. France*, [102] the applicant complained that he had been unable to benefit from a law introduced in 2001 granting children 'born of adultery' identical inheritance rights to those of legitimate children, a law passed following the ECtHR's judgment in *Mazurek v. France*[103] in 2000. The Court held that the legitimate aim of protecting the inheritance rights of the applicant's half-brother and half-sister did not outweigh his claim to a share of his mother's estate. In this case, the difference in treatment had

99 CJEU, C-303/06, *S. Coleman v. Attridge Law and Steve Law* [GC], 17 July 2008.

100 ECtHR, *Case "Relating to certain aspects of the laws on the use of languages in education in Belgium" v. Belgium*, Nos. 1474/62, 1677/62, 1691/62, 1769/63, 1994/63 and 2126/64, 23 July 1968.

101 ECtHR, *Fabris v. France* [GC], No. 16574/08, 7 February 2013.

102 *Ibid.*

103 ECtHR, *Mazurek v. France*, No. 34406/97, 1 February 2000.

been discriminatory, since it had no objective and reasonable justification. The Court found that it was in breach of Article 14 of the ECHR taken in conjunction with Article 1 of Protocol No. 1 to the ECHR.[104]

For children with disabilities, the ECSR holds that in the application of Article 17 (2) of the ESC it is acceptable to make a distinction between children with and without disabilities. It should, nevertheless, be the norm to integrate children with disabilities into mainstream schools, in which arrangements are made to cater for their special needs, and specialised schools should be the exception.[105] In addition, children attending special education schools that conform with Article 17 (2) of the ESC must be given sufficient instruction and training, so that proportionally an equivalent number of children in specialised schools and in mainstream schools complete their schooling.[106] The rights of children in relation to education are further addressed in Section 8.2.

Under UN law, Article 2 of the CRC prohibits discrimination against children on a non-exhaustive list of grounds, specifically listing 'birth' as one of them. Article 2 provides that:

> *1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.*
>
> *2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.*

104 ECtHR, *Fabris v. France* [GC], No. 16574/08, 7 February 2013.

105 ECSR, *International Association Autism Europe (IAAE) v. France*, Complaint No. 13/2002, 4 November 2003.

106 ECSR, *Mental Disability Advocacy Center (MDAC) v. Bulgaria*, Complaint No. 41/2007, 3 June 2008.

4 Personal identity issues

EU	Issues covered	CoE
	Birth registration and right to a name	ECtHR, *Johansson v. Finland*, No. 10163/02, 2007 (refusal to register a name previously granted to other persons) FCNM, Article 11 (right to use the surname in original language) European Convention on the Adoption of Children (Revised), Article 11 (3) (retaining the original name of an adopted child)
	Right to personal identity	ECHR, Articles 6 (fair trial) and 8 (right to respect for private and family life) ECtHR, *Gaskin v. the United Kingdom*, No. 10454/83, 1989 (refusal of access to child care records) ECtHR, *Mizzi v. Malta*, No. 26111/02, 2006 (inability to challenge paternity) ECtHR, *Mennesson v. France*, No. 65192/11, 2014 (surrogacy with biological father as intended father) ECtHR, *Godelli v. Italy*, No. 33783/09, 2012 (non-identifying information about birth mother) European Convention on the Adoption of Children (Revised), Article 22
	Identity theft	ECtHR, *K.U. v. Finland*, No. 2872/02, 2008 (advertisement placed on the internet without the knowledge of the victim)

EU	Issues covered	CoE
CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 2004 (residence right of the primary care giver of a child, citizen of the EU) CJEU, C-34/09, *Gerardo Ruiz Zambrano v. Office National de l'Emploi (ONEm)*, 2011 (residence rights of TCN with minor EU citizen children)	**Citizenship**	ECtHR, *Genovese v. Malta*, No. 53124/09, 2011 (arbitrary denial of citizenship to child born out of wedlock) European Convention on Nationality CoE Convention on the Avoidance of Statelessness in Relation to State Succession
	Identity as member of national minority	FCNM, Article 5 (1) (preservation of the essential elements of the identity)

Issues of personal identity have generally not been addressed at EU level, in view of the EU's limited competence in that area. However, the CJEU has incidentally ruled on the right to a name (particularly the right to have the name which has been recognised in one EU Member State also recognised in others) from the perspective of the freedom of movement principle. Citizenship and residency aspects have also been adjudicated in light of Article 20 of the TFEU. The CoE, on the other hand, in particular through the case law of the ECtHR, has interpreted and developed the application of several fundamental rights in the area of personal identity. Therefore, with the exception of several areas in which issues of personal identity have been addressed at EU level, the following sections deal only with CoE law.

This chapter does not refer to a specific fundamental right. Rather, it provides a cross-section of fundamental rights issues that are related to identity, such as birth registration and the right to a name (Section 4.1); the right to personal identity (Section 4.2); identity theft (Section 4.4); the right to citizenship (Section 4.5); and the identity of children belonging to national minorities (Section 4.6). Several related issues are dealt with in other chapters, in particular concerning sexual abuse (Section 7.1.3) or data protection (Chapter 10). Some of these rights, such as the right to a name, have mainly been claimed as parental rights, but the approach could easily be transposed to children themselves, given the implications for their own rights.

4.1. Birth registration and the right to a name

Key point

- Refusal to register a first name not unsuitable for a child which has already gained acceptance may be in breach of Article 8 of the ECHR (right to respect for private and family life).

Unlike UN treaties (e.g. Article 24 (2) of the International Covenant on Civil and Political Rights (ICCPR), Article 7 (1) of the CRC and Article 18 of the Convention on the Rights of Persons with Disabilities (CRPD)), the European instruments on fundamental rights do not explicitly provide for the right to birth registration immediately after birth or the right to a name from birth.

Under EU law, the right to a name has been addressed from the perspective of the freedom of movement. The CJEU holds that freedom of movement precludes an EU Member State from refusing to recognise a child's surname as registered in another Member State of which the child is a national or where the child was born and had resided.[107]

Under CoE law, refusal of birth registration of children may raise an issue under Article 8 of the ECHR.

First, the ECtHR found that the name as "a means of identifying persons within their families and the community" falls within the scope of the right to respect for private and family life as enshrined in Article 8 of the ECHR.[108] The parents' choice of their child's first name[109] and family name[110] is part of their private life. The Court has held that the refusal of state authorities to register a chosen forename based on the likely harm or prejudice that the name might cause the

107 See CJEU, C-148/02, *Carlos Garcia Avello v. Belgian State*, 2 October 2003; CJEU, C-353/06, *Stefan Grunkin and Dorothee Regina Paul* [GC], 14 October 2008.

108 ECtHR, *Guillot v. France*, No. 22500/93, 24 October 1993, para. 21.

109 ECtHR, *Johansson v. Finland*, No. 10163/02, 6 September 2007, para. 28; ECtHR, *Guillot v. France*, No. 22500/93, 24 October 1993, para. 22.

110 ECtHR, *Cusan and Fazzo v. Italy*, No. 77/07, 7 January 2014, para. 56.

child did not violate Article 8 of the ECHR.[111] Refusal to register a first name, however, that is not unsuitable for a child and that has already gained acceptance may be in breach of Article 8 of the ECHR.

> Example: In *Johansson v. Finland*,[112] the authorities refused to register the forename "Axl Mick", because the spelling did not comply with the Finnish naming practice. The ECtHR accepted that due regard had to be given to the child's best interests, and that the preservation of the national naming practice was in the public interest. It found, however, that the name had been accepted for official registration in other cases and could therefore not be considered unsuitable for a child. Since the name had already gained acceptance in Finland and it had not been contended that this name had negatively affected the cultural and linguistic identity of the state, the ECtHR concluded that the public-interest considerations did not outweigh the interest of having the child registered under the name chosen. The Court thus found that there had been a violation of Article 8 of the ECHR.

The ECtHR has also found that a rule stating that the husband's family name should be given to legitimate children at the moment of birth registration does not in itself violate the ECHR. However, the impossibility to derogate from this general rule was found to be excessively rigid and discriminatory for women, and therefore in violation of Article 14, taken in conjunction with Article 8 of the ECHR.[113]

Article 11 of the FCNM provides that every person belonging to a national minority has the right to use his or her surname (patronym) and first names in his or her minority language, as well as the right to have it officially recognised, albeit subject to modalities provided for in the legal system.

Article 11 (3) of the Revised European Convention on the Adoption of Children provides for the possibility for States Parties to keep the original surname of an adopted child (Adoption Convention).[114] This is an exception to the general principle that the legal relationship between the adopted child and his or her original family is severed.

111 ECtHR, *Guillot v. France*, No. 22500/93, 24 October 1993, para. 27.

112 ECtHR, *Johansson v. Finland*, No. 10163/02, 6 September 2007.

113 ECtHR, *Cusan and Fazzo v. Italy*, No. 77/07, 7 January 2014, para. 67.

114 Council of Europe, European Convention on the Adoption of Children (Revised), CETS No. 202, 2008.

4.2. Right to personal identity

Key points

- The right to know one's origins falls within the scope of a child's private life.
- The establishment of paternity requires carefully balancing the child's interest in knowing his or her identity with the interest of the presumed or alleged father, and with the general interest.
- Anonymous births may be permissible under Article 8 of the ECHR (right to respect for private and family life) provided that the child can at least obtain non-identifying information about the mother and that there is a possibility of seeking a confidentiality waiver by the mother.
- An adopted child has the right to access information concerning his or her origins. Biological parents may be granted a legal right not to disclose their identity, but this does not amount to an absolute veto.

Under CoE law, according to the ECtHR, Article 8 of the ECHR includes the right to identity and personal development. Details of a person's identity and the interest "in obtaining information necessary to discover the truth concerning important aspects of one's personal identity, such as the identity of one's parents"[115] have been considered relevant to personal development. Birth and the circumstances of birth form part of a child's private life. "[I]nformation concerning highly personal aspects of [one's] childhood, development and history" can constitute a "principal source of information about [one's] past and formative years",[116] so that lack of access to that information by the child raises an issue under Article 8 of the ECHR.

Under international law, Article 8 of the CRC provides for a high and rather detailed level of protection of the right to preserve a child's identity. It protects against unlawful interference with the preservation of identity, including nationality, name and family relations, as recognised by law. It also guarantees "appropriate assistance and protection" where a child is illegally deprived of some or all elements of his or her identity, with a view to speedily re-establish that identity.

115 ECtHR, *Odièvre v. France* [GC], No. 42326/98, 13 February 2003, para. 29.

116 ECtHR, *Gaskin v. the United Kingdom*, No. 10454/83, 7 July 1989, para. 36.

4.2.1. Establishing paternity

Under CoE law, children have complained to the ECtHR about the impossibility of determining the identity of their natural fathers. The ECtHR held that the determination of the legal relationship between a child and the alleged natural father was part of the scope of private life (Article 8 of the ECHR). Affiliation is a fundamental aspect of one's identity.[117] A child's interest in establishing paternity, however, must be balanced against the interests of the presumed father as well as the general interest. Indeed, a child's interest in having legal certainty about his or her paternal affiliation does not trump a father's interest in rebutting the legal presumption of paternity.

Example: In *Mikulić v. Croatia*,[118] the applicant was born out of wedlock and instituted proceedings for establishment of paternity against her presumed father. The respondent refused to appear on several occasions for court-ordered DNA testing, which led to unnecessary protraction of the paternity proceedings for about five years. The ECtHR held that if under domestic law alleged fathers could not be compelled to undergo medical testing, states had to provide for alternative means allowing for the swift identification of natural fathers by an independent authority. It found a violation of Article 8 of the ECHR in the applicant's case.

Example: In *Mizzi v. Malta*,[119] the presumed father was unable to deny paternity of a child born by his wife since the legally prescribed six-month time limit had elapsed. The ECtHR examined the case under both Articles 6 (right to a fair trial) and 8 (respect of private and family life) of the ECHR. It noted that introducing a time-limit within which a presumed father must take action to disavow a child aims to ensure legal certainty and protect the interest of the child to know his or her identity. These aims, however, do not outweigh the right of the father to have the opportunity to deny paternity. The practical impossibility of denying paternity since birth had in this case put an excessive burden on the presumed father, in violation of his right of access to a court and a fair trial as enshrined in Article 6 of

117 ECtHR, *Mennesson v. France*, No. 65192/11, 26 June 2014, para. 96.

118 ECtHR, *Mikulić v. Croatia*, No. 53176/99, 7 February 2002, paras. 64–65.

119 ECtHR, *Mizzi v. Malta*, No. 26111/02, 12 January 2006.

the ECHR. It had also disproportionately interfered with his rights under Article 8 of the ECHR.[120]

The interests of a child seeking to ascertain paternity and the interests of the biological father may sometimes coincide. This occurred in a situation where a father, due to his lack of legal capacity, was unable to institute proceedings at the domestic level to establish affiliation with his child. The ECtHR found that it was not in the best interests of a child born out of wedlock that his biological father was unable to institute proceedings to have his paternity established, and that the child was therefore entirely dependent on the discretion of state authorities to have its affiliation established.[121]

Authorities may have a positive obligation to intervene in proceedings to establish paternity in the best interests of the child when the legal representative (in this case the mother) of the child is unable to properly represent the child, for instance because of a serious disability.[122]

With regard to the specific case of recognition of affiliation between intended parents and children born out of surrogacy, the Court accepted in principle that states have a wide margin of appreciation, since there is no European consensus on allowing or recognising affiliation in surrogacy arrangements. The fact, however, that affiliation is a fundamental aspect of a child's identity reduces that margin of appreciation.

Example: *Mennesson v. France*[123] concerns the refusal of French authorities to register children born out of surrogacy in the United States in the French birth register on public policy grounds. The ECtHR found no violation of the applicants' right to respect for family life, concluding that they were in no way prevented from enjoying family life in France and that administrative obstacles they might have faced had not been insurmountable. With regard to the right to respect for the private life of the children, the Court attached great importance to their best interests. It particularly emphasised that the man who was intended to be registered as the children's father on the certificate was also their biological father. To deny a child

120 *Ibid.*, paras. 112–114.

121 ECtHR, *Kruškovic v. Croatia*, No. 46185/08, 21 June 2011, paras. 38–41.

122 ECtHR, *A.M.M. v. Romania*, No. 2151/10, 14 February 2012, paras. 58–65 (available in French).

123 ECtHR, *Mennesson v. France*, No. 65192/11, 26 June 2014.

legal affiliation when a biological affiliation is established and when the parent concerned claims full recognition cannot be held to be in conformity with the best interests of the children. The Court therefore found a violation of Article 8 of the ECHR in respect of the "private life" complaint of the children.[124]

4.2.2. Establishing maternity: anonymous birth

Under CoE law, a child's interest in knowing his or her origins, and in particular his or her mother, must be balanced with other private and public interests, such as the interests of the family or families involved, the public interest of preventing illegal abortions, child abandonment or the protection of health. Cases where the birth mother decides to remain anonymous, but the child can at least obtain non-identifying information about the birth mother and the child has the possibility to seek a confidentiality waiver from the mother, might be in conformity with Article 8 of the ECHR.[125]

Example: In *Godelli v. Italy*,[126] the applicant was abandoned at birth by her mother, who did not consent to being named on the birth certificate. The applicant could not access non-identifying information concerning her origins nor could she obtain disclosure of her mother's identity. The ECtHR found a violation of Article 8 of the ECHR, because the state did not strike a proper balance between the competing interests of birth mother and child.

4.3. Establishing one's origin: adoption

A child's right to know his or her origins has gained particular prominence in the context of adoption. The substantive guarantees related to adoption, outside the right to know one's origins, are dealt with in Section 6.3.

Under CoE law, Article 22 (3) of the European Convention on the Adoption of Children (revised) is a fairly robust provision on the adopted child's right to access information held by the authorities concerning his or her origins. It allows

124 *Ibid*., para. 100; see also ECtHR, *Labassee v. France*, No. 65941/11, 26 June 2014, para. 79.

125 ECtHR, *Odièvre v. France* [GC], No. 42326/98, 13 February 2003, paras. 48–49.

126 ECtHR, *Godelli v. Italy*, No. 33783/09, 25 September 2012, para. 58.

for States Parties to grant the parents of origin a legal right not to disclose their identity, as long as it does not amount to an absolute veto. The competent authority must be able to determine whether it overrides the parents of origin's right and can disclose identifying information in light of the circumstances and the respective rights at stake. In the case of full adoption, the adopted child must at least be able to obtain a document attesting the date and place of birth.[127]

Under international law, the Hague Convention on Inter-Country Adoption provides for the possibility for an adopted child to access information about the identity of his or her parents "under appropriate guidance", but leaves it to each State Party to allow for it, or not.[128]

4.4. Identity theft

Key point

- Practical and effective protection must be ensured against identity theft of children.

Identity theft concerns situations where a child's name is used without his or her knowledge.

Under CoE law, the ECtHR has dealt with identity theft under Article 8 of the ECHR on the right to respect for private and family life. It held that states are obliged to ensure the practical and effective protection of children against identity theft, and that states must take effective steps to identify and prosecute the perpetrator.[129]

127 Council of Europe, European Convention on the Adoption of Children (Revised), CETS No. 202, 2008, Art. 22.

128 Hague Conference on Private International Law, Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption, 29 May 1993, Art. 30 (2).

129 ECtHR, *K.U. v. Finland*, No. 2872/02, 2 December 2008, para. 49.

Example: In *K.U. v. Finland*,[130] an advertisement was placed on an internet dating website in the name of a 12-year-old boy, without his knowledge. It mentioned his age, telephone number, physical description and contained a link to a webpage containing his picture. The advertisement was of a sexual nature, suggesting that the boy was looking for an intimate relationship with a boy of his age or older, thus making him a target for paedophiles. The identity of the person who placed the advertisement could not be obtained from the internet provider due to the legislation in place. The ECtHR held that the positive obligation under Article 8 of the ECHR not only to criminalise offences but also to effectively investigate and prosecute them, assumes even greater importance when the physical and moral welfare of a child is threatened. In this case, the Court found that by being exposed as a target for paedophiliac approaches on the internet the child's physical and moral welfare was threatened. There was consequently a breach of Article 8 of the ECHR.

Aspects related to identity theft are closely related to child pornography and grooming. These are dealt with in Section 7.2.

4.5. Right to citizenship

Key points

- The right of residence within the EU of children who are EU citizens should not be deprived of any useful effect by refusing residence rights to their parent(s).
- The ECHR does not guarantee the right to citizenship, but an arbitrary refusal of citizenship may fall under Article 8 of the ECHR (right to respect for private and family life) due to its impact on an individual's private life.

Under EU law, Article 20 (1) of the TFEU grants the status of EU citizen to every Member State national of the EU. The CJEU ruled on the effectiveness of the right of residence of children who have EU citizenship but not the nationality of the EU Member State where they reside. At stake was the refusal of residence rights within the EU to a parent who was the carer of a child with EU citizenship. The CJEU held that the refusal of residence rights to a parent who is the

130 ECtHR, *K.U. v. Finland*, No. 2872/02, 2 December 2008.

primary caregiver of a child deprives the child's right of residence of any useful effect. Hence, the parent who is the primary caregiver has the right to reside with the child in the host state.[131] These aspects are addressed in more detail in Section 9.5.

Under CoE law, the ECHR does not guarantee the right to citizenship.[132] An arbitrary refusal of citizenship, however, may come within the scope of Article 8 of the ECHR because of its impact on an individual's private life, which embraces aspects of a child's social identity[133] – which here refers to the identity a child has in society.

> Example: In *Genovese v. Malta*, Maltese citizenship was denied to a child born out of wedlock outside of Malta to a non-Maltese mother and a judicially-recognised Maltese father. The refusal of citizenship as such did not violate Article 8 of the ECHR. The arbitrary denial of citizenship on the ground of birth out of wedlock, however, raised questions of discrimination. Arbitrary differential treatment on this ground requires weighty reasons by way of justification. In the absence of such reasons, a violation of Article 8 together with Article 14 of the ECHR was found.[134]

A key concern in treaty provisions on the right to acquire citizenship is the avoidance of statelessness. The European Convention on Nationality contains detailed provisions on children's legal acquisition of nationality, and restricts the possibilities for children to lose citizenship.[135] The CoE Convention on the Avoidance of Statelessness in Relation to State Succession contains an obligation to avoid statelessness at birth (Article 10) and provides for the right to the nationality of the successor state in case of statelessness (Article 2).[136] Article 12 of the Revised European Convention on Adoption also echoes the concern to avoid statelessness; states have to facilitate the acquisition of their nationality by a child adopted by one of their nationals, and loss of nationality

131 CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 19 October 2004, paras. 45–46.

132 ECtHR, *Slivenko and Others v. Latvia* [GC], Decision on admissibility, No. 48321/99, 23 January 2002, para. 77.

133 ECtHR, *Genovese v. Malta*, No. 53124/09, 11 October 2011, para. 33.

134 *Ibid.*, paras. 43–49.

135 Council of Europe, European Convention on Nationality, CETS No. 166, 1997, Arts. 6 and 7.

136 Council of Europe, Convention on the Avoidance of Statelessness in relation to State Succession, CETS No. 200, 2006.

as a consequence of adoption is conditional upon possession or acquisition of another nationality.

Under international law, Article 7 of the CRC guarantees the right to acquire a nationality, as does Article 24 (3) of the ICCPR.

4.6. Identity of children belonging to national minorities

Key point

- A child belonging to a national minority has the right to enjoy his or her own culture, profess and practice his or her own religion, and use his or her own language.[136]

Under EU law, no particular attention has been paid to the identity of children belonging to national minorities from a fundamental rights' perspective. Furthermore, there is no leading jurisprudence in the EU that adds to the CoE standards.

Under CoE law, Article 5 (1) of the FCNM explicitly mentions that States Parties undertake to preserve the essential elements of the identity of persons belonging to national minorities, i.e. their religion, language, traditions and cultural heritage. There is no child-specific provision in the FCNM. The question of language in education is dealt with in Section 8.2.

Under international law, Article 30 of the CRC guarantees to a child belonging to a national minority or an indigenous child the right "to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language" in community with other members of his or her group.

137 On other aspects of economic, social and cultural rights, see further Chapter 8.

5 Family life

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 7 (right to respect for family life)	Right to respect for family life	ECHR, Article 8 (right to respect for family life)
Charter of Fundamental Rights, Article 24 (rights of the child) Maintenance Regulation (4/2009)	Right to be cared for by parents	ECtHR, *R.M.S. v. Spain*, No. 28775/12, 2013 (deprivation of contact with daughter)
Charter of Fundamental Rights, Article 24 (3) (right to maintain contact with both parents) Brussels II bis Regulation (2201/2003) Mediation Directive (2008/52/EC)	Right to maintain contact with both parents	Convention on Contact concerning Children
Access to Justice Directive (2002/8/EC) (access to justice in cross border disputes)	Parental separation	ECtHR, *Levin v. Sweden*, No. 35141/06, 2012 (restriction of contact rights) ECtHR, *Schneider v. Germany*, No. 17080/07, 2011 (contact between a child and non-legally recognised father). ECtHR, *Sommerfeld v. Germany* [GC], No. 31871/96, 2003 (contact between father and daughter) ECtHR, *Mustafa and Armağan Akin v. Turkey*, No. 4694/03, 2010 (contact between siblings after custody award) ECtHR, *Vojnity v. Hungary*, No. 29617/07, 2013 (restriction on access on the ground of religious convictions)

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 24 (rights of the child) Brussels II bis Regulation (2201/2003) CJEU, C211/10 PPU, *Doris Povse v. Mauro Alpago*, 2010 (enforcement certificate)	**Child abduction**	Convention on Contact concerning Children ECtHR, *Neulinger and Shuruk v. Switzerland* [GC], No. 41615/07, 2010 (taking of child by mother) ECtHR, *X v. Latvia* [GC], No. 27853/09, 2013 (grave risk in case of child's return under Hague Convention)

European law – both EU and CoE – provides for the right to respect for family life (Article 7 of the EU Charter of Fundamental Rights; Article 8 of the ECHR). The EU's competence in matters of family life relates to cross-border disputes, including recognition and enforcement of judgments across Member States. The CJEU deals with matters such as the child's best interests and the right to family life as laid down in the EU Charter of Fundamental Rights, relative to the Brussels II bis Regulation. ECtHR case law relating to family life recognises interdependent rights, such as the right to family life and the right of the child to have their best interests, as a primary consideration. It acknowledges that children's rights are sometimes conflicting. The right of the child to respect for family life, for instance, may be limited to secure their best interests. Further, the CoE has adopted various other instruments which deal with matters related to contact, custody and exercise of children's rights.

This chapter examines the child's right to respect for family life and associated rights, especially the content and scope of these rights as well as the associated legal obligations and their interaction with other rights. Specific aspects addressed include the right to respect for family life and its limitations (Section 5.1), the right of the child to be cared for by his/her parents (Section 5.2), the right to maintain contact with both parents (Section 5.3) and child abduction (Section 5.4).

5.1. Right to respect for family life

Key points

- States have positive obligations to ensure children's effective enjoyment of their right to respect for family life.
- Under both EU and CoE law, judicial and administrative authorities should take into account the child's best interests in any decision related to the child's right to respect for his/her family life.

The child's right to respect for family life includes a number of composite rights, such as: the child's right to be cared for by his/her parents (Section 5.2); the right to maintain contact with both parents (Section 5.3); the right not to be separated from parents except where it is in the child's best interests (Section 5.4 and Chapter 6); and the right to family reunification (Chapter 9).

Under both EU law and CoE law, the right to respect for family life is not absolute, and subject to a number of limitations. These limitations, as the explanatory note to the EU Charter of Fundamental Rights[138] clarifies, are the same as for the corresponding provision of the ECHR, specifically Article 8 (2), that is: in accordance with the law and necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.[139]

The EU Charter of Fundamental Rights expressly incorporates within this right an obligation to consider the best interests of the child (Article 24 (2)).[140] Even though the obligation to observe the child's best interests is not expressly laid down under the ECHR, the ECtHR incorporates that obligation in its case law.[141]

138 European Parliament, Council of the European Union, European Commission (2007), "*Explanations relating to the Charter of Fundamental Rights*", 2007/C 303/02, OJ 2007 C 303, 14 December 2007, pp. 17–35, see explanation relating to Art. 7.

139 Council of Europe, Convention for the Protection of Human Rights and Fundamental Freedoms, CETS No. 5, 1950, Art. 8.

140 CJEU, C400/10 PPU, *J. McB. v. L.E.*, 5 October 2010.

141 See, for example, ECtHR, *Ignaccolo-Zenide v. Romania*, No. 31679/96, 25 January 2000, para. 94.

5.2. Right of the child to be cared for by his/her parents

Key points

- EU law regulates procedural aspects of the child's right to be cared for by his/her parents.
- Under the ECHR, states have negative and positive duties to respect children's and parents' rights to family life.

The right of children to know the identity of their parents and the right to be cared for by them are two core components of children's right to respect for family life. They are to an extent interdependent: children's right to know their parents is ensured through parental care. Sometimes, however, these rights are distinct - for example, for children who are adopted or born as a result of medically-assisted procreation. Here the right is more closely associated with the child's right to identity, as expressed by knowing his/her biological parentage, and is therefore considered in Chapter 4. The focus of this section is on the second right: the right of the child to be cared for by his/her parents.

Under EU law, there are no provisions dealing with the substantive scope of the right to be cared for by parents. EU instruments may deal with cross-border aspects, such as recognition and enforcement of judgements across Member States. Regulation 4/2009 on jurisdiction, applicable law, recognition and enforcement of decisions and cooperation in matters relating to maintenance (Maintenance Regulation), for instance, covers cross-border maintenance applications arising from family relationships.[142] It establishes common rules for the entire EU, aiming to ensure the recovery of maintenance claims even where the debtor or creditor is in another country.

Under CoE law, the ECtHR has underscored that Article 8 of the ECHR primarily establishes the duty of the state not to intervene in family life.[143] However, states

142 Council of the European Union (2008), Council Regulation (EC) No. 4/2009 of 18 December 2008 on jurisdiction, applicable law, recognition and enforcement of decisions and cooperation in matters relating to maintenance, OJ 2008 L 7 (Maintenance Regulation).

143 ECtHR, *R.M.S. v. Spain*, No. 28775/12, 18 June 2013, para. 69.

also have a positive obligation to take the necessary measures to both support parents and families and to protect children against potential abuse.[144] Children should only be separated from their parents in exceptional circumstances. In these cases, everything must be done to preserve personal relations and, when appropriate, to 'rebuild' the family. States enjoy a wide margin of appreciation when taking the initial decision to separate children from their parents.[145] However, stricter scrutiny is called for regarding any further limitations, such as restrictions placed on parental rights of access, and any legal safeguards designed to secure the effective protection of the right of parents and children to respect for their family life. Such further limitations entail the danger that the family relations between a young child and one or both parents would be effectively curtailed. Equally, when it comes to separating mothers from new-born babies, the reasons put forth by the state must be extraordinarily compelling.[146]

The margin of appreciation decreases with the amount of time children are separated from their parents, and state authorities should put forward strong reasons to support their decision to maintain the separation.[147] The ECtHR analyses whether the decision-making process was fair and whether all parties involved were given the opportunity to present their case.

Example: In *R.M.S. v. Spain*[148], the applicant argued that she had been deprived of all contact with her daughter from the age of three years and 10 months onwards on the basis of her socio-economic status. In finding a violation of Article 8 of the ECHR, the Court stressed that "the Spanish administrative authorities should have considered other less drastic measures than taking the child into care". It also stated that: "The role of the social welfare authorities is precisely to help persons in difficulty [...], to provide them with guidance and to advise them on matters such as the different types of benefits available, the possibility of obtaining social housing and other means of overcoming their difficulties, such as those originally sought by the applicant." Accordingly, the ECtHR held "that the Spanish authorities failed to undertake appropriate and sufficient efforts to secure the applicant's right to live with her child".[149]

144 *Ibid.*, para. 69 and following.

145 ECtHR, *Y.C. v. the United Kingdom*, No. 4547/10, 13 March 2012, para. 137.

146 ECtHR, *K. and T. v. Finland* [GC], No. 25702/94, 12 July 2001, para. 168.

147 ECtHR, *Y.C. v. the United Kingdom*, No. 4547/10, 13 March 2012, para. 137.

148 ECtHR, *R.M.S. v. Spain*, No. 28775/12, 18 June 2013.

149 *Ibid.*, paras. 86 and 93.

Under international law, Article 5 of the CRC provides that "States Parties shall respect the responsibilities, rights and duties of parents, [...] to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention". Furthermore, Article 9 of the CRC states that a child shall not be separated from his/her parents against his/her will, and that all parties must be given the opportunity to participate in any proceedings relating to this situation. The UN Guidelines on Alternative Care further substantiate the rights of children in these circumstances and the corresponding duties of states.[150]

5.3. Right to maintain contact with both parents

Key points

- The right of the child to maintain contact with both parents subsists in all forms of parental separation: family-related and state-sanctioned.
- The process of ensuring the right of the child to maintain contact with his/her parents and family reunification requires regard for the best interests of the child as a primary consideration, giving due weight to the views of the child in accordance with his/her age and maturity.

The scope of the right to maintain contact with parents differs depending on the context. In the event of a decision of the parents to separate from each other, the scope is broader and normally limited only by the best interests of the child. In the context of a state-sanctioned separation resulting from, for instance, expulsion or imprisonment of a parent, state authorities act in furtherance of a protected interest, and must strike a fair balance between the interests of the parties and the obligation to ensure the best interests of the child. The right of children to maintain contact with both parents is applicable in both instances.

Under EU law, Article 24 (3) of the EU Charter of Fundamental Rights expressly recognises every child's right to maintain contact with both parents. The

150 UN, Human Rights Council (2009), *UN Guidelines for the Alternative Care of Children*, UN Doc. A/HRC/11/L.13, 15 June 2009.

provision's wording clarifies the content of the right, particularly the meaning of contact, which must: occur on a *regular basis*; allow the development of a *personal relationship*; and be in the form of *direct contact*. There is, however, a caveat: the right of each child to maintain contact with her or his parents is expressly limited by their best interests. This provision, as the explanatory note to the Charter clarifies, is expressly informed by Article 9 of the CRC.

In line with EU competences (see Chapter 1), there has been a specific focus on judicial cooperation (with the objective of creating an area of freedom, security and justice in which the free movement of persons is ensured). Two EU instruments are of particular relevance: Council Regulation (EC) No. 2201/2003[151] (Brussels II bis), and European Parliament and Council Directive 2008/52/EC (Mediation Directive).[152] From a rights perspective, the Brussels II bis Regulation is significant. First, it applies to *all* decisions on parental responsibility, irrespective of marital status. Second, the rules relating to jurisdiction (determined for the most part by the child's habitual residence) are expressly informed by the best interests of the child; and third, there is particular regard for ensuring the respect of children's views.[153]

CJEU jurisprudence in cases of wrongful removal of a child following a decision taken unilaterally by one of the parents has primarily aimed to uphold the fundamental right of the child to maintain on a regular basis a personal relationship and direct contact with both parents (Article 24 (3) of the Charter), as the Court asserts that this right undeniably merges into the best interests of any child. In the CJEU's view, a measure that prevents the child to maintain on a regular basis a personal relationship and direct contact with both parents can be justified only by another interest of the child of such importance that it takes priority over the interest underlying that fundamental right.[154] This includes provisional, including protective, measures under Article 20 of the Brussels II bis Regulation. The Court ruled that a balanced and reasonable

151 Council of the European Union (2003), Council Regulation (EC) No. 2201/2003 of 27 November 2003 concerning jurisdiction and the recognition and enforcement of judgments in matrimonial matters and the matters of parental responsibility, repealing Regulation (EC) No 1347/2000, OJ 2003 L 338 (Brussels II bis).

152 European Parliament, Council of the European Union (2008), Directive 2008/52/EC of the European Parliament and the Council of 21 May 2008 on certain aspects of mediation in civil and commercial matters, OJ 2008 L 136/3 (*Mediation Directive*).

153 See, for example, Council Regulation (EC) No. 2201/2003, Preamble (paras. 5, 12, 13 and 19) and Articles 8, 41 (2) (c) and 42 (2) (a).

154 CJEU, C-403/09 PPU, *Jasna Detiček v. Maurizio Sgueglia*, 23 December 2009, para. 59.

assessment of all the interests involved, which must be based on objective considerations relating to the actual person of the child and his or her social environment, must in principle be performed in proceedings in accordance with the provisions of Brussels II bis Regulation.[155]

> Example: The case of *E. v. B.*[156] concerns proceedings between Mr. E. (the father) and Ms. B. (the mother), in relation to the jurisdiction of the courts of the United Kingdom to hear and determine the usual place of residence of their child, S., and the rights of access of the father. The parents had signed an agreement before a Spanish court whereby the mother had custody, and access was granted to the father. Subsequently, the mother sought to reduce the rights of access which had been granted to the father by that agreement. The father submitted an application before the High Court seeking the enforcement of the Spanish agreement. The mother submitted that she had prorogued the jurisdiction of the Spanish court and sought to transfer the prorogued jurisdiction to the courts of England and Wales. On the father's appeal, the Court of Appeal referred several questions to the CJEU concerning the interpretation of Article 12 (3) of the Brussels II bis Regulation. The CJEU held that where a court is seized of proceedings in accordance with Article 12 (3) of the Brussels II bis Regulation, the best interests of the child can only be safeguarded by a review, in each specific case, of the question of whether the prorogation of jurisdiction which is sought is consistent with the child's best interests. A prorogation of jurisdiction is valid only in relation to the specific proceedings for which the court whose jurisdiction is prorogued is seized. After the final conclusion of the proceedings from which the prorogation of jurisdiction derives, that jurisdiction comes to an end, in favour of the court benefiting from a general jurisdiction under Article 8 (1) of the Brussels II bis Regulation.

With regard to parental responsibility, Brussels II bis co-exists with the Hague Convention on jurisdiction, applicable law, recognition, enforcement and cooperation in respect of parental responsibility and measures for the protection of children.[157] Pursuant to Article 61, Brussels II bis shall take precedence over

155 *Ibid.*, para. 60.

156 CJEU, C-436/13, *E. v. B.*, 1 October 2014 (summary adjusted from http://cases.iclr.co.uk).

157 The World Organisation for Cross-border Cooperation in Civil and Commercial Matters (1996), Hague Conference on private international law, Convention on Jurisdiction, Applicable Law, Recognition, Enforcement and Co-Operation in respect of Parental Responsibility and Measures for the Protection of Children, 19 October 1996.

the Hague Convention: (a) if the child concerned has her or his habitual residence on the territory of a Member State or (b) as concerns the recognition and enforcement of a judgment rendered in a court of a Member State on the territory of another Member State, even if the child concerned has her or his habitual residence on the territory of a third state which is a contracting Party to the Hague Convention. Therefore, a key issue under the Brussels II bis Regulation is the determination of the habitual residence of the child.

Example: In *Mercredi v. Chaffe,*[158] the Court of Appeal of England and Wales referred a case to the CJEU concerning the removal of a two-month-old child from the United Kingdom to the French island of Réunion. The CJEU ruled that the concept of habitual residence, for the purposes of Articles 8 and 10 of the Brussels II bis Regulation corresponds to the place which reflects some degree of integration by the child in a social and family environment. Where the situation concerns an infant who has been staying with his/her mother only a few days in a Member State – other than that of his/her habitual residence – to which he/she was removed, the factors that must be taken into consideration include: first, the duration, regularity, conditions and reasons for the stay in the territory of that EU Member State and for the mother's move to that state; and second, with particular reference to the child's age, the mother's geographic and family origins, and the family and social connections which the mother and child have with that Member State.

Also of particular relevance for the enjoyment of the right to maintain contact with both parents in cross-border disputes are the instruments related to regulating access to justice that clarify how to handle complex disputes, such as Council Directive 2002/8/EC (Access to Justice Directive), which requires "improv[ing] access to justice in cross-border disputes by establishing minimum common rules relating to legal aid for such disputes".[159] The purpose of this directive is to: improve access to justice in cross-border civil cases by establishing common minimum rules relating to legal aid; ensure that appropriate legal aid is granted, under certain conditions, to persons who cannot meet the cost of proceedings on account of their financial situation; and facilitate compatibil-

158 CJEU, C-497/10 PPU, *Barbara Mercredi v. Richard Chaffe*, 22 December 2010.

159 Council of the European Union (2003), Council Directive 2002/8/EC of 27 January 2003 to improve access to justice in cross-border disputes by establishing minimum common rules relating to legal aid for such disputes, OJ 2003 L 026 (Access to justice directive).

ity of national laws in this matter and to provide for cooperation mechanisms between the authorities of the Member States.

Under CoE law, the right of each child to maintain contact with both parents is implicit in Article 8 of the ECHR. The ECtHR affirms that "the mutual enjoyment by parent and child of each other's company constitutes a fundamental element of family life".[160] It also emphasises, however, that this right may be limited by the best interests of the child (see Section 5.4 and Chapter 6). This right is at the centre of judicial decision-making about custody of and contact with children.

In a series of cases, the ECtHR has either expressly or implicitly referred to the best interests of the child within the context of custody and contact.

> Example: In *Schneider v. Germany*,[161] the applicant had a relationship with a married woman and claimed to be the biological father of her son, whose legally recognised father was the mother's husband. The applicant argued that the decision of the domestic courts to dismiss his application for contact with the child and information about the child's development on the basis that he was neither the child's legal father nor had a relationship with the child violated his rights under Article 8 of the ECHR. In finding a violation, the ECtHR focused on the failure of the domestic courts to give any consideration to the question of whether, in the particular circumstances of the case, contact between the child and the applicant would have been in the child's best interest.[162] As regards the applicant's request for information about the child's personal development, the Court held that the domestic courts failed to give sufficient reasons to justify their interference for the purposes of Article 8 (2)[163] and that, therefore, the interference had not been "necessary in a democratic society".

160 ECtHR, *K. and T. v. Finland* [GC], No. 25702/94, 12 July 2001, para. 151.

161 ECtHR, *Schneider v. Germany*, No. 17080/07, 15 September 2011.

162 See also ECtHR, *Anayo v. Germany*, No. 20578/07, 21 December 2010, paras. 67 and 71.

163 ECtHR, *Schneider v. Germany*, No. 17080/07, 15 September 2011, para. 104.

Example: In *Levin v. Sweden*[164] the applicant, a mother of three children in alternative non-family based care, argued that the restrictions on her right to maintain contact with her children violated her right to respect for family life. The ECtHR focused on the objective of the contact restrictions, i.e. protecting the best interests of the children. In that particular case, the children had been neglected while in the care of the applicant, and contact with her revealed strong negative reactions on the part of the children. In holding that there had been no violation of Article 8 of the ECHR, the Court found that the interference with the applicant's rights had been "proportionate to the legitimate aim pursued [the best interests of the children] and within the margin of the domestic authorities".

Example: In *Sommerfeld v. Germany*[165] the applicant complained about the restrictions on his right to maintain contact with his daughter, who had consistently expressed that she did not wish to remain in contact with him. In particular, the applicant argued that the failure of the domestic courts to obtain a psychological expert opinion constituted a flaw in the domestic proceedings. In finding no violation of Article 8 of the ECHR, the ECtHR concluded that the domestic court had been well placed to evaluate the daughter's statements and to establish whether or not she had been able to make up her own mind.

Example: In *Mustafa and Armağan Akin v. Turkey*,[166] the applicants – a father and a son – argued that the terms of a custody order by the domestic court had violated their rights under Article 8 of the ECHR. These terms prevented the son from having contact with his sister, who was in the custody of their mother. Moreover, the father could not have contact with both of his children together because his son's contact with his mother coincided with his own contact with his daughter. The ECtHR held that the decision of the domestic court separating the two siblings constituted a violation of the applicants' right to respect for their family life, as it not only prevented the two siblings from seeing each other, but also made it impossible for their father to enjoy the company of both his children at the same time.

164 ECtHR, *Levin v. Sweden*, No. 35141/06, 15 March 2012, paras. 57 and 69; ECtHR, *K. and T. v. Finland* [GC], No. 25702/94, 12 July 2001, para. 151.

165 ECtHR, *Sommerfeld v. Germany* [GC], No. 31871/96, 8 July 2003, para. 72.

166 ECtHR, *Mustafa and Armağan Akin v. Turkey*, No. 4694/03, 6 April 2010.

In the context of custody and contact decision-making, the ECtHR also prohibits discrimination incompatible with Article 14 of the ECHR.

Example: In the case of *Vojnity v. Hungary*,[167] the applicant argued that he had been denied access to his son due to his religious convictions.[168] In finding a violation of Article 14 in conjunction with Article 8 of the ECHR, the ECtHR observed that there was no evidence that the applicant's religious convictions involved dangerous practices or exposed his son to physical or psychological harm.[169] The domestic courts' decisions on the removal of the applicant's access rights rendered any form of contact and the establishment of any kind of further family life impossible, despite the fact that total severance of contact could be justified only in exceptional circumstances.[170] The ECtHR, therefore, held that there had been no reasonable relationship of proportionality between a total ban on the applicant's access rights and the aim pursued, namely the protection of the best interest of the child.[171]

Example: The case of *Salgueiro da Silva Mouta v. Portugal*[172] was brought by a father who claimed parental responsibility over his child. He alleged that, in the national proceedings, the Portuguese authorities had dismissed his claim and awarded parental responsibility to the mother on the basis of his sexual orientation. The ECtHR found that the domestic authorities indeed refused custody on the ground that he was homosexual – a decision that does not have an objective and reasonable justification. The Court concluded that Article 8 taken together with Article 14 of the ECHR were violated.

167 ECtHR, *Vojnity v. Hungary*, No. 29617/07, 12 February 2013; see also ECtHR, *P.V. v. Spain*, No. 35159/09, 30 November 2010 (available in French and Spanish).

168 ECtHR, *Vojnity v. Hungary*, No. 29617/07, 12 February 2013, para. 22.

169 *Ibid.*, para. 38.

170 *Ibid.*, para. 41.

171 *Ibid.*, para. 43.

172 ECtHR, *Salgueiro da Silva Mouta v. Portugal*, No. 33290/96, 21 December 1999.

Furthermore, the right of the child to maintain contact with both parents is expressly cited within the CoE Convention on Contact Concerning Children.[173] Article 4 (1) of this convention states that "a child and his or her parents shall have the right to obtain and maintain regular contact with each other". The general principles to be applied in jurisprudence about contact emphasise the right of a child to be informed, consulted and to express his or her views, and for these views to be given due weight. Article 6 of the CoE Convention on the Exercise of Children's Rights[174] further identifies requisites of judicial decision-making, including the legal obligations to: consider whether the judicial authority has sufficient information to determine the best interests of the child; ensure the right of the child to information about the process and outcomes; and open a safe space for affected children to freely express their views in an age/maturity appropriate manner.

Situations may arise in which children are otherwise separated from a parent, for example as a result of the parent's imprisonment. The ECtHR was faced with such a situation in *Horych v. Poland*,[175] where it addressed the issue of the conditions in which the applicant, categorised as a dangerous prisoner, had received visits from his minor daughters. It noted that "visits from children [...] in prison require special arrangements and may be subjected to specific conditions depending on their age, possible effects on their emotional state or well-being and on the personal circumstances of the person visited".[176] The Court went on to say that "positive obligations of the State under Article 8, [...] include a duty to secure the appropriate, as stress-free for visitors as possible, conditions for receiving visits from his children, regard being had to the practical consequences of imprisonment". [177]

Finally, the right of children deprived of the liberty to maintain contact with their parents is reinforced by selected provisions of the CoE Guidelines on

173 Council of Europe, Convention on Contact Concerning Children, CETS No. 192, 2003. See also The World Organisation for Cross-border Cooperation in Civil and Commercial Matters (1996), Hague Conference on private international law, Convention on Jurisdiction, Applicable Law, Recognition, Enforcement and Co-Operation in respect of Parental Responsibility and Measures for the Protection of Children.

174 Council of Europe, European Convention on the Exercise of Children's Rights, CETS No. 160, 1996.

175 ECtHR, *Horych v. Poland*, No. 13621/08, 17 April 2012.

176 *Ibid.*, para. 131.

177 *Ibid.*, para. 131.

child-friendly justice.[178] The guidelines expressly affirm the right of children deprived of their liberty "to maintain regular meaningful contact with parents [and] family" (Article 21 (a)) (see also Chapter 11).

Under international law, the right to maintain contact with both parents is affirmed in Article 9 (3) of the CRC: "State Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests."

5.4. Improper removal of children across borders — child abduction

Key points

- The ECtHR requires a child rights-based approach to improper removals in breach of custody arrangements: Article 8 of the ECHR (right to respect for private and family life) must be interpreted in connection with the Hague Convention and the CRC.
- EU law requires more specifically that the child be heard during the proceedings relating to his/her return following wrongful removal or retention.

Child abduction refers to a situation in which a child is removed or retained across national borders in breach of existing custody arrangements (Article 3 of the Hague Convention on the Civil Aspects of International Child Abduction[179] (Hague Convention)). Under the Hague Convention, wrongfully removed or retained children are to be returned speedily to their country of habitual residence (Article 11 (1)). The courts of the country of habitual residence determine the merits of the custody dispute. The courts of the country from which the child has been removed should order the return within six weeks from the date that the return application is made (Article 11). The Hague Convention is underpinned by the principle of the child's best interests. In the context of this convention, the presumption is that the unlawful removal of a child is in itself

178 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*.

179 The World Organisation for Cross-border Cooperation in Civil and Commercial Matters (1980), Hague conference on private international law, Hague Convention of 25 October 1980 on the civil aspects of international child abduction, 25 October 1980.

harmful and that the *status quo ante* should be restored as soon as possible to avoid the legal consolidation of wrongful situations. Issues of custody and access should be determined by the courts that have jurisdiction in the place of the child's habitual residence rather than those of the country to which the child has been wrongfully removed. There are several limited exceptions to the return mechanism, established in Articles 12, 13, and 20 of the Hague Convention. Article 13 includes the provisions that have generated most of the litigation, both at a domestic and at an international level. It establishes that the country the child has been removed to may refuse to return a child, where the return would expose him/her to a grave risk of harm or otherwise place him/her in an intolerable situation (Article 13 (b)). A return may equally be refused if the child objects to the return if he or she has attained the level of maturity to express his/her views (Article 13 (2)).

Under EU law, the most important instrument regulating child abduction between EU Member States is the Brussels II bis Regulation,[180] largely based on the provisions of the Hague Convention. This regulation complements and takes precedence over the Hague Convention in intra-EU abduction cases (Recital 17 of the Preamble and Article 60 (e)). Although the Hague Convention remains the main child-abduction instrument, in certain respects Brussels II bis has 'tightened' the jurisdictional rules in favour of the courts of origin/habitual residence. Similar to the Hague Convention, the courts of the state where the child was habitually resident immediately prior to improper removal/retention retain the jurisdiction in cases of child abduction. The regulation maintains the same exceptions to the return as those included in the Child Abduction Convention.

However, under Brussels II bis, as opposed to the Hague Convention, the state of habitual residence retains jurisdiction to adjudicate the merits of the custody dispute, even after a non-return order is issued in application of Article 13 (b) of the Hague Convention (Article 11 (6)–(8) of the Brussels II bis Regulation). The change of jurisdiction to the state the child has been removed to may only occur in two situations, provided for under Article 10 of the Brussels II bis Regulation. The first situation stipulates that the courts of the state of refuge shall have jurisdiction if the child has acquired habitual residence in that state

180 Council of the European Union (2003), Council Regulation (EC) No. 2201/2003 of 27 November 2003 concerning jurisdiction and the recognition and enforcement of judgments in matrimonial matters and the matters of parental responsibility, repealing Regulation (EC) No 1347/2000, OJ 2003) L 338.

and each person having right of custody has acquiesced in the removal or retention.[181] The second situation arises where the child: has acquired habitual residence in the state he/she has been removed to; a period of one year has elapsed since the parent left behind had or should have had knowledge of the whereabouts of the child; the child is settled into his new environment; and at least one of the four further conditions listed in Article 10 (b) of the Brussels II bis Regulation are met.[182]

As with all other EU legal instruments, Brussels II bis must be interpreted in accordance with the provisions of the EU Charter of Fundamental Rights, in particular Article 24. The CJEU has had the opportunity to clarify the interpretation of Article 24 in the context of child abductions. As discussed in Section 2.4, in the *Aguirre Zarraga Case*, the CJEU ruled that the right of the child to be heard, enshrined in Article 24 of the Charter, requires that the legal procedures and conditions which enable children to express their views freely be made available to them, and that those views be obtained by the court.[183] According to the CJEU however, it is only for the courts of the child's habitual residence to examine the lawfulness of their own judgments in the light of the EU Charter of Fundamental Rights and the Brussels II bis Regulation. According to the mutual trust principle, Member States' legal systems should provide effective and equivalent protection of fundamental rights. Therefore, the interested parties have to bring any human rights-based challenge before the courts which have jurisdiction over the merits of the custody dispute pursuant to the regulation. The CJEU ruled that the court of the Member State to which the child had been wrongfully removed could not oppose the enforcement of a certified judgement, ordering the return of the child, since the assessment of whether there was an infringement of these provisions fell exclusively within the jurisdiction of the state from which the child had been removed.

181 Art. 10 (a) of the Brussels II bis Regulation.

182 Art. 10 (b) of the Brussels II bis Regulation provides for four alternative conditions as follows: (i) within one year after the holder of rights of custody has had or should have had knowledge of the whereabouts of the child, no request for return has been lodged before the competent authorities of the Member State where the child has been removed to or is being retained; (ii) a request for return lodged by the holder of rights of custody has been withdrawn and no new request has been lodged within the time limit set in paragraph (i); (iii) a case before the court in the Member State where the child was habitually resident immediately before the wrongful removal or retention has been closed pursuant to Art. 11 (7); (iv) a judgment on custody that does not entail the return of the child has been issued by the courts of the Member State where the child was habitually resident immediately before the wrongful removal or retention.

183 CJEU, C-491/10 PPU, *Joseba Adoni Aguirre Zarraga v. Simone Pelz*, 22 December 2010. On aspects concerning child participation in this case, see further the analysis in Section 2.4.

Example: The case of *Povse v. Alpago*[184] concerns the unlawful removal of a girl to Austria by her mother. The Austrian courts dismissed the father's application for return of his daughter to Italy on the ground that there was a grave risk of harm to the child. Meanwhile, upon the request of the father, the Italian court ruled that it retained jurisdiction to adjudicate the merits of the custody dispute and issued an order for the return of the child to Italy and an enforcement certificate on the basis of Article 42 of Brussels II bis. The case was referred to the CJEU by an Austrian court following the mother's appeal against the application for enforcement of the certificate and the ensuing return order of the child to Italy. The CJEU ruled that once a certificate of enforcement has been issued there are no possibilities of opposing the return in the country the child has been removed to (in this case Austria), as the certificate is automatically enforceable. Further, the CJEU decided that, in this case, only the Italian courts were competent to adjudicate on the serious risk to the child's best interests entailed by the return. Assuming that these courts were to consider such a risk justified, they retained sole competence to suspend their own enforcement order[185].

Under CoE law, the CoE European Convention on Recognition and Enforcement of Decisions Concerning Custody of Children and on Restoration of Custody[186]and the Convention on Contact concerning Children[187] include safeguards to prevent the improper removal of children and ensure the return of children.[188]

The ECtHR often deals with child abduction cases, and is in such instances generally guided by provisions of the Hague Convention when interpreting Article 8 of the ECHR. However, the ECtHR inevitably conducts an analysis of the child's best interests in these cases. Two leading Grand Chamber judgments reflect the court's position on this matter.

184 CJEU, C-211/10, *Doris Povse v. Mauro Alpago*, 1 July 2010.

185 An application based on the same facts was later lodged with the ECtHR and declared inadmissible. See ECtHR, *Povse v. Austria*, Decision of inadmissibility, No. 3890/11, 18 June 2013.

186 Council of Europe, European Convention on Recognition and Enforcement of Decisions concerning Custody of Children and on Restoration of Custody of Children, CETS No. 105, 1980.

187 Council of Europe, Convention on Contact Concerning Children, CETS No. 192, 2003.

188 *Ibid.*, Arts. 10 (b) and 16, respectively; Council of Europe, European Convention on Recognition and Enforcement of Decisions concerning Custody of Children and on Restoration of Custody of Children, CETS No. 105, 1980, Art. 8.

Example: The case *Neulinger and Shuruk v. Switzerland*[189] was brought by a mother, who had removed her son from Israel to Switzerland in breach of existing guardianship arrangements. Upon the father's application under the Hague Convention, the Swiss authorities ordered the child's return to Israel. In the opinion of the national courts and experts, the child's return to Israel could be envisaged only if he was accompanied by his mother. The measure in question remained within the margin of appreciation afforded to national authorities in such matters. Nevertheless, to assess compliance with Article 8 of the ECHR, it was also necessary to take into account any developments since the Federal Court's judgment ordering the child's return. In the present case, the child was a Swiss national and had settled well in the country, where he had been living continuously for about four years. Although he was at an age where he still had a significant capacity for adaptation, being uprooted again would probably have serious consequences for him and had to be weighed against any benefit he was likely to gain from it. It was also noteworthy that restrictions had been imposed on the father's right of access before the child's removal. Moreover, the father had remarried twice since then and was now a father again, but failed to pay maintenance for his daughter. The ECtHR doubted that such circumstances would be conducive to the child's well-being and development. As to the mother, her return to Israel could expose her to a risk of criminal sanctions, such as a prison sentence. It was clear that such a situation would not be in the child's best interests, given that his mother was probably the only person to whom he related. The mother's refusal to return to Israel was not, therefore, totally unjustified. Moreover, the father had never lived alone with the child and had not seen him since the child's departure at the age of two. The ECtHR was thus not convinced that it would be in the child's best interests to return to Israel. As to the mother, a return to Israel would mean a disproportionate interference with her right to respect for her family life. Consequently, there would be a violation of Article 8 of the ECHR in respect of both applicants if the decision ordering the second applicant's return to Israel were to be enforced.

189 ECtHR, *Neulinger and Shuruk v. Switzerland* [GC], No. 41615/07, 6 July 2010.

Example: In *X v. Latvia*,[190] the mother argued that the return of her daughter to Australia, from where she had been wrongfully removed, would expose her to serious harm. In determining whether the decisions of the national courts had struck a fair balance between the competing interests at stake – within the margin of appreciation afforded to states in such matters – the best interests of the child had to be a primary consideration. To achieve a harmonious interpretation of the ECHR and the Hague Convention, the factors capable of constituting an exception to the child's immediate return under Articles 12, 13 and 20 of the Hague Convention had to be genuinely taken into account by the requested state, which had to issue a decision that was sufficiently reasoned on this point, and then evaluated in light of Article 8 of the ECHR. This Article imposed a procedural obligation on the domestic authorities, requiring that when assessing an application for a child's return, the courts had to consider arguable allegations of a "grave risk" for the child in the event of return and make a ruling giving specific reasons. As to the exact nature of the "grave risk", the exception provided for in Article 13 (b) of the Hague Convention concerned only situations which go beyond what a child could reasonably bear. In the present case, the applicant had submitted to the Latvian Appeal Court a psychologist's certificate concluding that there existed a risk of trauma for the child in the event of immediate separation from her mother. Although it was for the national courts to verify the existence of a "grave risk" for the child, and the psychological report was directly linked to the best interests of the child, the regional court refused to examine the conclusions of that report in light of the provisions of Article 13 (b) of the Hague Convention. At the same time, the national courts also failed to deal with the issue of whether it was possible for the mother to follow her daughter to Australia and to maintain contact with her. As the national courts had failed to carry out an effective examination of the applicant's allegations, the decision-making process under domestic law did not satisfy the procedural requirements inherent in Article 8 of the ECHR, and the applicant had therefore suffered a disproportionate interference with her right to respect for her family life.

190 ECtHR, *X v. Latvia* [GC], No. 27853/09, 26 November 2013, paras. 101, 106, 107 and 115–119.

6 Alternative care to family care and adoption

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 7 (family life) and Article 24 (rights of the child) Brussels II bis Regulation (2201/2003)	Alternative care to family care	ECHR, Article 8 (right to respect for private and family life) ESC (revised), Article 17 (right of children and young persons to social, legal and economic protection) ECtHR, *Wallová and Walla v. the Czech Republic*, No. 23848/04, 2006 (placement in care due to inadequate housing) ECtHR, *Saviny v. Ukraine*, No. 39948/06, 2008 (placement in care due to socio-economic reasons) ECtHR, *B. v. Romania (No. 2)*, No. 1285/03, 2013 (parents involvement in decision-making) ECtHR, *B.B. and F.B. v. Germany*, Nos. 18734/09 and 9424/11, 2013 (procedural flaws in decision-making process). ECtHR, *Olsson v. Sweden (No. 1),* No. 10465/83, 1988 (implementation of care order) ECtHR, *T. v. the Czech Republic*, No. 19315/11, 2014 (importance of contact).

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 24 (rights of the child)	**Adoption**	European Convention on the Adoption of Children (Revised) ECtHR, *Pini and Others v. Romania*, Nos. 78028/01 and 78030/01, 2004 (priority of child's interests in adoption) ECtHR, *Kearns v. France*, No. 35991/04, 2008 (parental consent to adoption). ECtHR, *E.B. v. France* [GC], No. 43546/02, 2008 (lesbian woman's eligibility to adopt). ECtHR, *Gas and Dubois v. France*, No. 25951/07, 2012 (gay couple's eligibility to adopt). ECtHR, *X and Others v. Austria* [GC], No. 19010/07, 2013 (second parent adoption for same sex couple). ECtHR, *Harroudj v. France*, No. 43631/09, 2012 (kafala and adoption).

Every child has the right to respect for family life, a right recognised under Article 7 of the EU Charter of Fundamental Rights and Article 8 of the European Convention on Human Rights (ECHR) (see Chapter 5). Both EU and Council of Europe law reflect the importance to the child of family relationships, and this includes the child's right not to be deprived of contact with his/her parents, except when this is contrary to the child's best interests.[191] Finding a balance between ensuring the child remains with his/her family – in line with the respect for family life – and ensuring the child is protected from harm is difficult. Where a child is removed from his/her family, he/she may be placed in either foster care or residential care. Family life does not end with this separation and requires that contact continues to support family reunification if it is in the child's best interests. In certain circumstances, permanent removal, through adoption, will take place. The finality of adoption means that stringent requirements must be followed.

The purpose of this chapter is to consider European law on alternative care. EU law, mainly through the Brussels II bis Regulation, deals with cross-border procedural aspects related to placing children in alternative care. This regulation should be interpreted according to the EU Charter of Fundamental Rights, in particular Article 24. The ECtHR has also developed an extensive body of case law dealing with both substantive and procedural matters of placing children into alternative care.

191 EU (2012), Charter of Fundamental Rights of the European Union, OJ 2012 C 326, Art. 24 (3).

Section 6.1 begins by introducing some of the general principles governing the situation of children deprived of family care, Section 6.2 outlines the law concerning the child's removal into alternative care and Section 6.3 considers the European standards on adoption.

6.1. Alternative care: general principles

Key points

- Alternative care is a temporary protective measure.
- International law confirms that family-based care should be preferred over residential care.
- Children have the right to information and to express their view with respect to placement into alternative care.

Under EU, CoE and international law, viewed together, six broad principles relating to alternative care emerge.

First, alternative care is a protective measure that ensures children's interim safety and facilitates children's return to their families where possible.[192] Ideally, it is thus a temporary solution. Sometimes, it is a protective measure pending family reunification, for example of unaccompanied or separated child migrants with their families.[193] Other times it is a protective measure pending developments in family life, for example, improvements in the health of a parent or provision of support to parents.

Second, international law confirms that family-based care (such as foster care) is the optimal form of alternative care for securing children's protection and development. This is affirmed by the UN Guidelines for the Alternative

192 UN, General Assembly (2010), *Guidelines for the alternative care of children*, A/RES/64/142, 24 February 2010, paras. 48–51; Committee on the Rights of the Child (2013), *General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3 para. 1)*, UN Doc. CRC/C/GC/14, 29 May 2013, paras. 58–70.

193 UN, General Assembly, Convention on the Rights of the Child, 20 November 1989, Art. 22; Committee on the Rights of the Child (2005), *General Comment No. 6 (2005): Treatment of unaccompanied and separated children outside their country of origin*, UN Doc. CRC/GC/2005/6, 1 September 2005, paras. 81–83.

Care of Children and the UN Convention on the Rights of Persons with Disabilities (CRPD), to which the EU is a party.[194] The CRPD expressly states that "States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting".[195] Non-family based care (e.g. residential care) "should be limited to cases where such a setting is specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests".[196]

Third, the child's right to a guardian or representative is key to securing his or her broader rights.[197] Although there is no explicit general obligation in EU law to appoint a guardian for children without parental care, at least seven EU directives require Member States to appoint a guardian for children within different contexts, some directly related to children without parental care.[198] Further, this body of law is substantiated by the UN Guidelines for the Alternative Care of Children (generally regarding children without parental care), the CRC (specifically regarding unaccompanied children) and the CoE Convention on Action against Trafficking in Human Beings.[199] Most often the mandate of a legal guardian is to safeguard the child's best interests, ensure his or her overall well-being and complement his/her limited legal capacity (and also sometimes to exercise legal representation).[200]

Fourth, implicit within Article 24 of the EU Charter of Fundamental Rights is the legal obligation to take positive measures to ensure that decision-making

194 UN, General Assembly (2010), *Guidelines for the alternative care of children*, A/RES/64/142, 24 February 2010, paras. 20–22; UN, Committee on the Rights of the Child (2006), *General Comment No. 7 (2005): Implementing child rights in early childhood*, UN Doc. CRC/C/GC/7/Rev.136 (b), 20 September 2006, para. 18. UN, Convention on the rights of persons with disabilities (CRPD), 13 December 2006, Art. 23 (5) (see also Art. 7).

195 UN, Convention on the Rights of Persons with Disabilities (CRPD), 13 December 2006, Art. 23 (5).

196 UN, General Assembly (2010), *Guidelines for the alternative care of children*, 24 February 2010, A/RES/64/142, para. 21.

197 FRA (2014a), p. 31.

198 *Ibid.*, p. 14.

199 UN, General Assembly (2010), *Guidelines for the alternative care of children*, 24 February 2010, A/RES/64/142, paras. 100–103; UN, Committee on the Rights of the Child, *General Comment No. 6, (2005): Treatment of unaccompanied and separated children outside their country of origin*, UN Doc. CRC/GC/2005/6, 1 September 2005, paras. 33–38; Council of Europe, Convention on Action against Trafficking in Human Beings, CETS No. 197, 2005, Art. 10 (4).

200 FRA (2014a), p. 15.

about a child's placement is guided by his/her best interests[201] and views.[202] General Comments No. 5 and 14 of the Committee on the Rights of the Child[203] as well as the UN Guidelines for the Alternative Care of Children emphasise the need to ensure the child's right to information, including on his/her rights and options, as well as the child's right "to be consulted and to have his/her views duly taken into account in accordance with his/her evolving capacities".[204]

Fifth, children's broader rights within the EU Charter of Fundamental Rights, the ECHR and the CRC remain applicable to cases of alternative care (foster or residential care). This includes their civil and political rights (e.g. their rights to privacy, freedom of expression and freedom of religion and protection from all forms of violence) and their socio-economic rights (including their rights to education, healthcare and participation in cultural life).[205]

Finally, Article 4 of the CRC requires states to take "all appropriate legislative, administrative, and other measures" to implement the convention. This applies equally to the context of alternative care. Article 17 (1) (c) of the revised European Social Charter (ESC) similarly requires states to take all appropriate and necessary measures designed to provide protection and special aid for children and young persons temporarily or definitively deprived of their family's support.

Under EU law, the CJEU ruled that the Brussels II bis Regulation applies to decisions to place a child in alternative care. As noted in Chapter 5, Brussels II bis incorporates children's rights principles in its approach, emphasising that the equality of all children, the best interests of the child and the right to be heard, amongst others, should be taken into account.[206] Here the

201 UN, Committee on the Rights of the Child (2013), *General Comment No. 14 (2013) on the right to have his/her best interest taken as a primary consideration (art.3 para.1),* UN Doc. CRC/C/GC/14, 29 May 2013.

202 UN, Committee on the Rights of the Child (2009), *General Comment No. 12 (2009): The right of the child to be heard*, UN Doc. CRC/C/GC/12, 20 July 2009, para. 97.

203 UN, Commitee on the Rights of the Child, *General Comment No. 14*, para. 15 (g), 29 May 2013; *General Comment No. 5*, para. 24, 27 November 2003.

204 UN, General Assembly (2010), *Guidelines for the alternative care of children*, 24 February 2010, A/RES/64/142, para. 6.

205 EU Charter of Fundamental Rights, Arts. 3–4, 7, 10–11, 14 and 24; ECHR, especially Art. 8; and CRC, Arts. 13–14, 16, 19, 28, 29, 24, 31 and 37; UN, General Assembly (2010), *Guidelines for the alternative care of children*, 24 February 2010, A/RES/64/142, Sec. 2.

206 Brussels II bis, Preamble. See also Chapter 5.

"grounds of non-recognition for judgments relating to parental responsibility", as expressed in Article 23 of the Brussels II bis Regulation, are instructive. Article 23 states that judgments shall not be recognised:

> *"(a) if such recognition is manifestly contrary to the public policy of the Member State in which recognition is sought taking into account the best interests of the child;*
> *(b) if it was given, except in case of urgency, without the child having been given an opportunity to be heard, in violation of fundamental principles of procedure of the Member State in which recognition is sought […]."*

Under the regulation, jurisdiction is determined on the basis of the child's habitual residence, with several limited exceptions, including the child's best interests (Articles 8, 12 and 15 of Brussels II bis).

Under CoE law, the ECtHR affirms that the family is the natural environment for the growth and well-being of children. However, where the family cannot provide the child with the requisite care and protection, removal to an alternative care setting may be required. Such removal interferes with the respect for family life. The ECtHR has explained that in most cases the placement of a child in alternative care should be intended as a temporary measure and that the child must ultimately be reunited with his/her family in fulfilment of the right to respect for private and family life under Article 8 of the ECHR.[207]

Although the ECHR does not impose any specific duty on states to provide children with care and protection, Article 17 of the ESC requires that states "take all appropriate and necessary measures designed to provide protection and special aid from the state for children and young persons temporarily or definitively deprived of their family's support".[208]

207 ECtHR, *K.A. v. Finland*, No. 27751/95, 14 January 2003. The Committee of Ministers of the Council of Europe has endorsed this approach in its Recommendation on the rights of children living in residential institutions, adopted on 16 March 2005.

208 Council of Europe, European Social Charter (revised), CETS No. 163, 1996, Art. 17 (1) c.

6.2. Placing children in alternative care

Key points

- Under the CoE law, placing a child in alternative care should be provided for by law, pursue a legitimate aim and be necessary in a democratic society. Relevant and sufficient reasons must be put forward by the competent authority.
- Under CoE law, the decision-making process must follow certain procedural safeguards.

Under CoE law,[209] the child's placement in alternative care is only compatible with Article 8 of the ECHR when it is in accordance with the law, pursues a legitimate aim (such as the protection of the child's best interests) and is considered necessary in a democratic society. This last aspect requires that the courts give reasons that are both relevant and sufficient to support the means used to pursue the desired aim.

Example: In *Olsson v. Sweden (No. 1)*,[210] the applicants complained about the decision to place their three children into care. Finding that the care decision fell within the state's margin of appreciation, the ECtHR focused on the manner in which the care order was implemented. According to the Court, the care decision should have been regarded as a temporary measure, to be discontinued as soon as circumstances permitted, given that adoption was not being considered. Measures taken should thus have been consistent with the ultimate aim of reuniting the natural family. In this light, the ECtHR noted that the national authorities had placed the children in separate foster homes, at a significant distance from each other and their parents. Although the authorities had acted in good faith in implementing the care order, the Court noted that it was unacceptable for administrative difficulties, such as the lack of appropriate foster families or placements, to determine where the children would be placed. In such a fundamental area as respect for family life, such considerations could not be allowed to play more than a secondary role. Thus, in finding a violation

209 The placement of children in alternative care has also been a topic of political debate in the CoE for many years. See for instance the Committee of Ministers Resolution (77) 33 on the placement of children, adopted on 3 November 1977.

210 ECtHR, *Olsson v. Sweden (No. 1)*, No. 10465/83, 24 March 1988.

of Article 8 of the ECHR, the ECtHR stated that the measures taken by the authorities in the implementation of the care order were not supported by sufficient reasons to render them proportionate to the legitimate aim pursued under Article 8.

More recently, the ECtHR considered the merits of decisions to place children in alternative care under Article 8 of the ECHR.

Example: In *Wallová and Walla v. the Czech Republic*[211] the applicants complained about the placement of their five children in two separate children's homes due to their poor housing situation. Custody of the children was given to the children's homes in 2002 on the basis of the parents' economic instability and the care orders were later lifted when their economic and housing situation improved. The ECtHR found that the underlying reason for the decision to place the children in care had been a lack of suitable housing and as such a less drastic measure could have been used to address their situation. Under Czech law, there was a possibility to monitor the family's living and hygiene conditions, and to advise them on how to improve their situation, but this option was not used. While the reasons given for placing the children in care were relevant, they were not sufficient, and the authorities did not make enough efforts to help the applicants overcome their difficulties through alternative measures. In concluding that there had been a violation of Article 8 of the ECHR, the Court also took note of the conclusions of the UN Committee on the Rights of the Child, which observed that the principle of primary consideration of the best interests of the child was still not adequately defined and reflected in all Czech legislation, court decisions and policies affecting children.

Example: In *Saviny v. Ukraine*,[212] the applicants' children were placed in care due to the parents' lack of financial means and the domestic court's conclusion that their personal qualities endangered their children's lives, health and moral upbringing. In assessing the case, the ECtHR questioned the adequacy of the evidence on which the domestic authorities had based their findings and considered that there was insufficient information available on the extent of social assistance made available. This would

211 ECtHR, *Wallová and Walla v. the Czech Republic*, No. 23848/04, 26 October 2006 (available in French).

212 ECtHR, *Saviny v. Ukraine*, No. 39948/06, 18 December 2008.

have been pertinent in evaluating whether the authorities had discharged the duty to keep the family together and whether they had sufficiently explored the effectiveness of less drastic alternatives before seeking to separate the children from their parents. Furthermore, at no stage of the proceedings had the children been heard by the judges. In sum, although the reasons given by the national authorities for removal of the applicants' children were relevant, they were not sufficient to justify such a serious interference with the applicants' family life. Therefore, the Court found that there had been a violation of Article 8 of the ECHR.

The ECtHR requires under Article 8 of the ECHR that decision-making concerning respect for family life must adhere to certain procedural safeguards. It states that the decision-making process (administrative and judicial proceedings) leading to measures of interference with family life must be fair and afford due respect to the interests protected by Article 8. What is considered under Article 8 is whether "the parents have been involved in the decision-making process [...] to a degree sufficient to provide them with [a] requisite protection of their interests".[213] This includes keeping them informed about developments, ensuring that they can participate in decisions made about them[214] and, in certain circumstances, hearing from the children concerned.[215]

Example: In *B. v. Romania (No. 2)*,[216] the applicant had been diagnosed with paranoid schizophrenia and taken by the police on a number of occasions to psychiatric institutions for treatment. Her children no longer lived with her and were placed in a care home because of their mother's illness. The ECtHR had to examine whether, having regard to the serious nature of the decisions to be taken as regards placing children into care, the decision-making process, seen as a whole, provided the parents to a sufficient degree with the requisite protection of their interests. In that connection, the Court observed that the applicant, who was suffering from a severe mental disorder, had not been assigned either a lawyer or a guardian *ad litem* to represent her during the proceedings, so that it had been impossible for her to take part in the decision-making process concerning her

213 ECtHR, *W. v. the United Kingdom*, No. 9749/82, 8 July 1987, para. 64.

214 ECtHR, *McMichael v. the United Kingdom*, No. 16424/90, 24 February 1995.

215 ECtHR, *B. v. Romania (No. 2)*, No. 1285/03, 19 February 2013; ECtHR, *B.B. and F.B. v. Germany*, Nos. 18734/09 and 9424/11, 14 March 2013.

216 ECtHR, *B. v. Romania (No. 2)*, No. 1285/03, 19 February 2013.

minor children. In addition, the applicant's situation and the situation of her children had been examined by a court on only two occasions over a period of 12 years before both children had reached majority, and there was no evidence of regular contact between social workers and the applicant, which may otherwise have provided suitable means of representing her views to the authorities. In light of these facts, the Court concluded that the decision-making process around her children's placement in care had not adequately protected her interests, and that there had thus been a violation of her rights under Article 8 of the ECHR.

Example: In *B.B. and F.B. v. Germany*,[217] following allegations from the applicants' 12-year-old daughter that she and her eight-year-old brother had been repeatedly beaten by their father, the parental rights in respect of the two children were transferred to the Youth Court and the children were placed in a children's home. The District Court made a full order transferring parental authority from the applicants to the Youth Office, reaching its decision on the basis of direct evidence from the children. About a year later, at the first subsequent meeting with their parents, the daughter admitted that she had lied about having been beaten, and the children were eventually returned to their parents. In considering the applicants' complaint that the authorities had failed to adequately examine the relevant facts, the ECtHR emphasised that mistaken assessments by professionals did not necessarily mean that measures taken would be incompatible with Article 8 of the ECHR. The placement decision could only be assessed in light of the situation as presented to the domestic authorities at the time. In the ECtHR's assessment, the fact that the District Court had relied only on the statements of the children, while the applicants had submitted statements from medical professionals who had not noticed any signs of ill-treatment, combined with the fact that the Court of Appeal had not re-examined the children, were significant. As the children were in a safe placement at the time of the full hearing, there had been no need for haste, and the courts could have established an investigation into the facts of their own motion, which they failed to do. In sum, the German courts failed to give sufficient reasons for their decision to withdraw the applicants' parental authority, in breach of Article 8 of the ECHR.

217 ECtHR, *B.B. and F.B. v. Germany*, Nos. 18734/09 and 9424/11, 14 March 2013.

Even when placed in alternative care, children retain the right to maintain contact with their parents. This right has been recognised under the ECHR,[218] as the ECtHR holds that mutual contact between parents and children is a fundamental part of family life under Article 8. Given that placement in alternative care should normally be a temporary measure, maintaining family relationships is essential to ensure the successful return of the child to his/her family.[219] Under the ECHR, positive duties flow from these principles, as illustrated by the following cases.

Example: In *T. v. the Czech Republic*,[220] the ECtHR considered whether the rights of a father and daughter (applicants) had been violated by the placement of the child in care and the failure of the authorities to support contact between them. The child had been placed in a specialist institution after the death of her mother and after the father's applications for custody of his daughter had been denied due to concerns about his personality. Further requests to spend holidays with his daughter were denied and a therapeutic centre concluded that the visits were not beneficial to the child as she was afraid of him, at which time all contact was terminated. Later on, the courts decided that contact between the two applicants should only take place in writing, in accordance with the wishes of the child. The ECtHR emphasised *inter alia* a child's interests in maintaining ties with his/her family, except in particularly extreme cases where this would not be in the child's best interest. In examining the decision to place the child into care, the ECtHR noted with approval that the domestic authorities had given careful consideration to their decision, which was made after hearing expert psychological and psychiatric opinions as well as taking into account the wishes of the child. There had thus been no violation of Article 8 of the ECHR in relation to the decision to place the child in care. However, the Court went on to find that Article 8 had been violated as a result of the restrictions imposed on the contact between the applicants, in particular due to the lack of oversight of decisions by the child's residential institution to deny contact, given that these decisions ultimately reduced the chances of family reunification.

218 ECtHR, *Olsson v. Sweden (No. 1)*, No. 10465/83, 24 March 1988.

219 ECtHR *Eriksson v. Sweden*, No. 11373/85, 22 June 1989.

220 ECtHR, *T. v. the Czech Republic*, No. 19315/11, 17 July 2014 (available in French).

Example: In *K.A. v. Finland*,[221] the applicant's children were placed in alternative care due to allegations that they were being sexually abused. During the children's placement in care, little contact took place between them and their parents and little effort was made to plan for their reunification. Examining the case, the ECtHR noted that the state has a positive duty to facilitate family reunification as soon as reasonably feasible, taking into account the duty to protect the best interests of the child. According to the ECtHR, the severe restrictions on the applicant's right to visit his children reflected the social welfare authority's intention to strengthen the ties between the children and the foster family, rather than to reunite the original family. This was made notwithstanding a noted improvement in the father's circumstances. Accordingly, there was a violation of Article 8 of the ECHR.

6.3. Adoption

Key points

- Adoption ensures alternative care for children who cannot remain with their biological families.
- The best interests of the child must be the paramount consideration in adoption.
- There is no right to adopt under EU or CoE law, but the adoption process must adhere to certain criteria to ensure that it is in the best interests of the child.[220]

Under international law, the best interests of the child must be the paramount consideration in cases of adoption. Aside from the best interests principle, other general principles of the CRC also guide and inform its implementation in the context of adoption: non-discrimination, the right to life, survival and development and respect for children's views.[223] Of particular relevance is

221 ECtHR, *K.A. v. Finland*, No. 27751/95, 14 January 2003.

222 On the interest of the child to know his/her origins in the context of adoption, see Chapter 4.

223 CRC, Arts. 2, 3, 6 and 12. See also, UN, Committee on the Rights of the Child (2010), Treaty-specific guidelines regarding the form and content of periodic reports to be submitted by States Parties under Article 44, paragraph 1 (b), of the Convention on the Rights of the Child, UN Doc. CRC/C/58/Rev.2, 23 November 2010, paras. 23–27.

the UN Committee on the Rights of the Child's General Comment No. 14 on the "right of the child to have his or her best interests taken as a primary consideration".[224]

Similarly, one of the objectives of the Hague Convention on Protection of Children and Co-operation in respect of Intercountry Adoption is to "to establish safeguards to ensure that intercountry adoptions take place in the best interests of the child and with respect for his or her fundamental rights as recognised in international law".[225]

Under EU law, the rights and associated legal obligations in Article 24 of the EU Charter of Fundamental Rights are applicable to adoption in so far as it is addressed by the EU.

Under CoE law, the right to respect for family life as expressed in Article 8 of the ECHR is applicable and relied on in adoption cases. There are also two specific CoE conventions on this subject: the European Convention on the Adoption of Children[226] and the European Convention on the Adoption of Children (revised).[227] These instruments require a child rights-based approach to adoption. The European Convention on the Adoption of Children (revised), for instance, states that "[t]he competent authority shall not grant an adoption unless it is satisfied that the adoption will be in the best interests of the child".[228] Likewise, the ECtHR emphasises that the best interests of the child may override those of the parent in certain circumstances, including in adoption.[229] The European Convention on the Adoption of Children (revised) also requires that adoption should not be granted by the competent authority without "the consent of the child considered by law as having sufficient understanding".[230] Moreover, the child not deemed to understand this shall "as far as possible, be consulted

224 UN Committee on the Rights of the Child (2013), *General comment No. 14 (2013) on the right of the child to have his/her best interests taken as a primary consideration*, CRC /C/GC/14, Art. 3, para. 1.

225 Hague Conference on private international law, The Hague Convention on Protection of Children and Cooperation in respect of Intercountry Adoption, 29 May 1993, Art. 1(a).

226 Council of Europe, European Convention on the Adoption of Children (Revised), CETS No. 202, 2008.

227 *Ibid.* This Convention opened for signature in 2008 and came into force in 2011.

228 *Ibid.*, Art. 4 (1).

229 ECtHR, *Pini and Others v. Romania*, Nos. 78028/01 and 78030/01, 22 June 2004.

230 Council of Europe, European Convention on the Adoption of Children (Revised), CETS No. 202, 2008, Art. 5 (1) b.

and his or her views and wishes shall be taken into account having regard to his or her degree of maturity".[231]

Example: In *Pini and Others v. Romania*,[232] two Italian couples complained about the failure of the Romanian authorities to execute the decision of a Romanian court concerning their adoption of two Romanian children. In breach of court orders, the private institution in which the children resided in Romania had refused to hand them over to the applicants. The ECtHR held that the relationship between the applicants and their adopted children fell within the scope of family life under Article 8 of the ECHR, even though they had never lived together or established emotional ties. Considering the case, the ECtHR interpreted Article 8 in light of the CRC and the Hague Convention in finding that the positive obligation on the authorities to enable the applicants to establish family ties with their adopted children was circumscribed by the best interests of the child.[233] In this regard, it held that the child's interests may, depending on their nature and seriousness, override those of the parent. Furthermore, in finding that there was no violation of Article 8, the Court emphasised that in a relationship based on adoption it is important that the child's interests should prevail over those of the parents, since adoption meant providing a child with a family, not a family with a child.[234]

Example: In *Kearns v. France*,[235] the ECtHR found it compatible with the ECHR that an Irish woman, who had placed her child for adoption in France, could not revoke her formal consent to adoption after the expiry of a two-month period. The ECtHR first underlined that the national authorities' refusal of the request for the child's return pursued the legitimate aim of protecting the rights and freedoms of others, in this case the child.[236] In relation to the imposition of a time-limit for the withdrawal of consent, the French law sought to strike a fair balance and ensure proportionality between the conflicting interests of the biological mother, the child and the adoptive family. In this process, the child's best interests

231 *Ibid.*, Art. 6.

232 ECtHR, *Pini and Others v. Romania*, Nos. 78028/01 and 78030/01, 22 June 2004.

233 *Ibid.*, para. 155.

234 *Ibid.*, para. 156.

235 ECtHR, *Kearns v. France*, No. 35991/04, 10 January 2008.

236 *Ibid.*, para. 73.

had to be paramount.[237] From the evidence presented to the Court, it was in the child's best interests to enjoy stable relations within a new family as quickly as possible and all of the necessary steps had been taken to ensure that the applicant understood the precise implications of her action. In light of these considerations, the Court held that France had not failed in its positive obligations towards the applicant under Article 8 of the ECHR.

The ECtHR also affirms that decision-making about adoption must take place in a manner consistent with the prohibition of discrimination established in Article 14 of the ECHR. In particular, the ECtHR considered whether the applicants' exclusion from eligibility to adopt on the grounds of either sexual orientation or age was compatible with Article 14, in conjunction with Article 8. In doing so, it reaffirms that the duty to take proportionate action with a view to protecting the best interests of the child is of central importance.

Example: In *Schwizgebel v. Switzerland*,[238] the applicant, a single 47-year-old woman, was unable to adopt a second child given the age gap between her and the child she wished to adopt. The applicant claimed to be a victim of discrimination on the grounds of age. The ECtHR considered that the denial of authorisation to receive a child with a view to adoption in the applicant's case pursued the legitimate aim of protecting the well-being and rights of the child.[239] Given the lack of European consensus concerning the right to adopt as a single parent, the lower and upper age-limits for adopters and the age-difference between the adopter and the child, and the state's consequent broad margin of appreciation in this area as well as the need to protect children's best interests, the refusal to authorise the placement of a second child did not contravene the proportionality principle.[240] The Court therefore found that the justification given by the government appeared objective and reasonable and that the difference in treatment complained of had not been discriminatory within the meaning of Article 14 of the ECHR.

237 *Ibid.*, para. 79.

238 ECtHR, *Schwizgebel v. Switzerland*, No. 25762/07, 10 June 2010.

239 *Ibid.*, para. 86.

240 *Ibid.*, para. 97.

Example: The case of *E.B. v. France*[241] concerns the refusal of the national authorities to grant approval for the purposes of adoption to the applicant, a lesbian living with her partner who sought to adopt as a single person.[242] The Court reiterated that Article 8 of the ECHR did not in itself confer a right to found a family or adopt. However, a discrimination complaint could fall within the broader scope of a particular right, even if the issue in question did not relate to a specific entitlement granted by the ECHR.[243] Given that French law allowed single persons to adopt, such a right could not be denied to an individual on discriminatory grounds. As established by domestic courts, the applicant presented undoubted personal qualities and an aptitude for bringing up children, which were assuredly in the child's best interests, a key notion in the relevant international instruments.[244] The Court formed the view that the applicant's sexual orientation played a determinative role in the refusal of the authorities to allow her to adopt, amounting to discriminatory treatment by comparison to other single individuals who were entitled to adopt under national law.[245]

Example: The case of *Gas and Dubois v. France*[246] concerns the question of whether same-sex couples should have an equal right to second-parent adoption as heterosexual couples. The applicants were a same-sex couple who had entered into a civil partnership. Together they had brought up a daughter, who was conceived by artificial insemination and borne by one of them in 2000. The other partner's application for a simple adoption was rejected on the grounds that the adoption would deprive the child's biological mother of her parental rights, which would run counter to both the applicant's intentions and the child's best interests. Under French law, the only situation in which a simple adoption does not result in the removal of the biological parents' rights in favour of the adoptive parent is when an individual adopts his/her spouse's child. The applicants alleged that they had been discriminated against compared with both married and unmarried heterosexual couples. Examining whether they had been discriminated against compared with a married couple, the

241 ECtHR, *E.B. v. France* [GC], No. 43546/02, 22 January 2008.

242 *Ibid.*, para. 49.

243 *Ibid.*, paras. 41–48.

244 *Ibid.*, para. 95.

245 *Ibid.*, para. 96.

246 ECtHR, *Gas and Dubois v. France*, No. 25951/07, 15 March 2012.

ECtHR concluded that marriage conferred a special status, giving rise to social, personal and legal consequences; for that reason, the applicants could not be said to be in a relevantly similar situation to married couples. Concerning the comparison with unmarried couples of opposite sex, the Court concluded that a comparable heterosexual couple in a civil partnership would also have their application for a simple adoption refused under the provisions of French law. The ECtHR consequently concluded that there had been no difference in treatment based on sexual orientation and thus no violation of the applicants' Convention rights.

Example: The case of *X and Others v. Austria*[247] concerns a complaint from a same-sex couple that it had been discriminated against in comparison with different-sex couples as regards second-parent adoption. The first and third applicants were in a stable relationship and the first applicant sought to adopt the second applicant, who was the son of the third applicant. As in *Gas and Dubois*, the ECtHR rejected the notion that the applicants were in an analogous position to a married couple in which one spouse wants to adopt the child of the other spouse. However, the ECtHR accepted that the applicants were in a comparable situation to an unmarried heterosexual couple. While second-parent adoption for unmarried heterosexual couples is permissible under Austrian law, the Austrian Civil Code provides that anyone who adopts a child would replace the biological parent of the same sex, meaning that second-parent adoption for same-sex couples is a legal impossibility. The Court concluded that in such circumstances there had been a difference in treatment of the applicants on the grounds of their sexual orientation and that no sufficiently weighty and convincing reasons had been advanced by the Government, in breach of Article 14 in conjunction with Article 8 of the ECHR.

Finally, the ECtHR also focuses its attention on the merits of abiding by the spirit and purpose of international law with respect to decision-making about adoption.

247 ECtHR, *X and Others v. Austria* [GC], No. 19010/07, 19 February 2013.

Example: In *Harroudj v. France*,[248] the French authorities refused the applicant's request for the full adoption of an Algerian girl who had been abandoned at birth and placed in the applicant's care under *kafala* – guardianship under Islamic law. The reasons for such a refusal were the fact that the French Civil Code does not allow for the adoption of a child whose adoption would be prohibited under the law of his/her country of origin (which is the case for Algerian law), and the fact that *kafala* already gave the applicant parental authority allowing her to take decisions in the child's best interests. A subsequent appeal was rejected on the basis that the domestic law was consistent with the Hague Convention on the Protection of Children and Co-operation in Respect of Intercountry Adoption and that Article 20 of the CRC recognised *kafala* as being on a par with adoption in preserving the child's best interests. In examining the applicant's complaint, the ECtHR recalled the principle that, once a family tie is established, the state has to act in a manner calculated to enable that tie to be developed and establish legal safeguards that render possible the child's integration in the family, as well as the need to interpret the ECHR harmoniously with the general principles of international law. In its assessment, the ECtHR underlined the French courts' concern to abide by the spirit and purpose of international conventions, including the UN Convention on the Rights of the Child. *Kafala* was recognised under French law and the applicant was allowed to exercise parental authority and take decisions in the child's interest. It was open to her, for example, to draw up a will in the child's favour, overcoming difficulties stemming from the restriction on adoption. In conclusion, by gradually obviating the prohibition of adoption in this manner, the respondent state, which sought to encourage the integration of children of foreign origin without cutting them off immediately from the rules of their country of origin, showed respect for cultural pluralism and struck a fair balance between the public interest and that of the applicant. The ECtHR thus found no violation of the applicant's rights.

248 ECtHR, *Harroudj v. France*, No. 43631/09, 4 October 2012.

7 Child protection against violence and exploitation

EU	Issues covered	CoE
Directive on combating the sexual abuse and sexual exploitation of children and child pornography (2011/93/EU)	**Violence in schools, at home and other settings**	ECHR, Articles 2 (right to life), 3 (inhuman and degrading treatment), and 8 (physical integrity); Protocol No. 1 to the ECHR, Article 2 (right to education) ECtHR, *Kayak v. Turkey*, No. 60444/08, 2012 (stabbing in the vicinity of a school) ECtHR, *O'Keeffe v. Ireland* [GC], No. 35810/09, 2014 (sexual abuse in school) ECtHR, *Campbell and Cosans v. the United Kingdom*, Nos. 7511/76 and 7743/76, 1982 (corporal punishment) ESC (revised), Articles 7 (right to special protection against physical and moral hazards) and 17 (right to protection) ECSR, *World Organisation against Torture (OMCT) v. Belgium*, Complaint No. 21/2003, 2004 (prohibition of corporal punishment in Belgium) Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention) Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention)

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 5 (2) (forced or compulsory labour) Young Workers Directive (94/33/EC) Anti-Trafficking Directive (2011/36/EU)	**Forced labour**	ECHR, Article 4 (freedom from servitude, forced and compulsory labour) ECtHR, *C.N. and V. v. France*, No. 67724/09, 2012 (servitude; positive obligations of the state) ESC (revised), Article 7 (10) (protection of children against physical and moral dangers) CoE Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention)
Charter of Fundamental Rights, Article 5 (3) (prohibition of trafficking) Anti-Trafficking Directive (2011/36/EU)	**Child trafficking**	ECHR, Article 4 (freedom from servitude) ECtHR, *Rantsev v. Cyprus and Russia*, No. 25965/04, 2010 (failure of the state to investigate alleged accusations of trafficking) CoE Convention on Action against Trafficking in Human Beings
Anti-Trafficking Directive (2011/36/EU)	**Child pornography**	ECHR, Article 8 (right to respect for private life) ECtHR, *Söderman v. Sweden* [GC], No. 5786/08, 2013 (secret filming of a child) ESC (revised), Article 7 (10) (special protection against physical and moral dangers) Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention) Convention on Cybercrime
	Children belonging to a minority	ECtHR, *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], No. 47848/08, 2014 (death of a severely disabled young man in a state institution)
Council Decision 2010/48/EC	**Children with disabilities**	ECtHR, *Nencheva and Others v. Bulgaria*, No. 48609/06, 2013 (death of children in a state institution)
Commission Decision 2007/698/EC	**Missing children**	ECtHR, *Zorica Jovanović v. Serbia*, No. 21794/08, 2013 (right to information)

Child protection in the broad sense relates to all measures designed to ensure the exercise of children's rights. In the narrow sense, it relates to the rights of children to be free from all forms of violence. Under international law, states must take measures to ensure children benefit from adequate protection and their rights to physical integrity and dignity are effectively observed. The duty of the state to protect may take various forms, depending on the specific risk of violence a child is exposed to and the perpetrator thereof. Thus, states' duties are more evident where children are under the authority and control of the state, for example where they are placed in public institutions. This happens when the risk of violence is high. The state's duty to protect may prove more difficult in cases where children are exposed to violence by private actors, such as their family members.

The European Union's main competence in the area relates to cross-border crimes (Article 83 of the Treaty on the Functioning of the European Union (TFEU)). Particular legislative measures have therefore been enacted with respect to child pornography and human trafficking. The EU has also passed legislation requiring Member States to criminalise several forms of sexual abuse. At the Council of Europe (CoE) level, the European Convention on Human Rights (ECHR) – mainly under Articles 2, 3 and 8 – has elaborated on states' duties in relation to a wide range of acts constituting violence against children. The ECSR has also been active in the field, both through its reporting procedure and its collective complaint mechanism. Further, specific CoE conventions, most notably the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention),[249] are now in place and monitoring bodies in charge of supervising their implementation.

This chapter analyses specific aspects of violence against children and the response of the international community. Section 7.1 looks at violence at home, school and other settings and focuses on issues such as corporal punishment, child abuse and neglect, and sexual violence. Section 7.2 looks at cases of child exploitation which have a marked cross-border dimension, including human trafficking (for the purposes of forced labour or sexual exploitation), child pornography and grooming. Finally, Section 7.3 deals with instances of abuse where children are in particularly vulnerable situations.

249 Council of Europe, Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, CETS No. 201, 2007.

7.1. Violence at home, in schools or other settings

Key points

- States have the duty to ensure that children are effectively protected against violence and harm in all settings.
- States have the duty to provide an adequate legal framework for child protection.
- States must conduct effective investigations into arguable allegations of child abuse, violence against children and harm to children.

Under EU law,[250] the main legal instrument in this field, enacted on the basis of Articles 82 and 83 of the TFEU, is Directive 2011/93/EU on combating sexual abuse and sexual exploitation of children and child pornography.[251]

Under CoE law, the ECtHR and the ECSR have developed a substantial body of case law regarding the protection of children against violence in all settings. In addition, specific CoE conventions (e.g. the Lanzarote Convention) provide detailed guarantees to protect children against specific forms of violence.

7.1.1. Scope of state responsibility

Under CoE law, the ECtHR has analysed the most severe forms of violence against children under various articles of the ECHR, most notably Articles 2 and 3. The Court has identified clear duties incumbent on states whenever children are placed in institutions under their authority.[252] Likewise, if a certain conduct or situation reaches the level of severity after which it qualifies as inhuman or degrading treatment under Article 3, the state has positive obligations to protect children against ill-treatment, including treatment administered by private individuals. Situations such as long-term neglect by parents,[253] repeated sexual

250 Directive 2011/93/EU of the European Parliament and of the Council of 13 December 2011 on combating the sexual abuse and sexual exploitation of children and child pornography, OJ 2011 L 335/1.

251 *Ibid*.

252 ECtHR, *Nencheva and Others v. Bulgaria*, No. 48609/06, 18 June 2013 (available in French).

253 ECtHR, *Z and Others v. the United Kingdom* [GC], No. 29392/95, 10 May 2001.

abuse by school teachers,[254] rape,[255] or corporal punishments[256] have all been found to fall within the scope of Article 3 of the ECHR.

In the case of a death, a state may be held responsible under Article 2 of the ECHR, even if the death was inflicted by a private person, and not by an agent of the state. States' positive obligations vary from case to case, the core duty being to secure the *effective* protection of children against violence. In cases of serious forms of ill-treatment, positive obligations include the duty to enact effective criminal law provisions which are backed by the law-enforcement machinery.[257] States must also adopt special measures and safeguards for protecting children.[258]

The ECHR was faced on several occasions with cases concerning violence against children administered by private individuals in schools, private homes or other establishments which were ran by non-state actors, where it was questionable whether state responsibility could arise. More importantly, the ECtHR ruled that a state may not absolve itself of the duty to protect children by delegating the administration of important public services – such as education – to private individuals.[259] In cases concerning the determination of state responsibility, the ECtHR generally distinguished between the states' general obligation to protect, when the risk was not clearly identifiable, and a specific obligation to protect, in cases where the victim was clearly identifiable. In the former case, the ECtHR analysed whether the absence of state intervention resulted in a real risk of violence for the child victim.

Example: The case of *Kayak v. Turkey*[260] concerns the stabbing to death of a 15-year-old boy by another teenager, in the vicinity of a school. The ECtHR found that schools have an obligation to protect those enrolled from all forms of violence. In this specific case the ECtHR ruled that Turkey was responsible under Article 2 of the ECHR for failing to protect the right to life

254 ECtHR, *O'Keeffe v. Ireland* [GC], No. 35810/09, 28 January 2014.

255 ECtHR, *M.C. v. Bulgaria*, No. 39272/98, 4 December 2003.

256 ECtHR, *Tyrer v. the United Kingdom*, No. 5856/72, 25 April 1978.

257 ECtHR, *M.C. v. Bulgaria*, No. 39272/98, 4 December 2003, para. 150.

258 ECtHR, *O'Keeffe v. Ireland* [GC], No. 35810/09, 28 January 2014, para. 146.

259 *Ibid.*, para. 150; ECtHR, *Costello-Roberts v. the United Kingdom*, No. 13134/87, 25 March 1993, para. 27.

260 ECtHR, *Kayak v. Turkey*, No. 60444/08, 10 July 2012 (available in French).

of the applicants' son and brother, as there was no effective surveillance system in place at the time. In the absence of such a system, it was possible for a teenager to take a knife from the kitchen school, which he used to stab the victim.

Example: The case of *O'Keeffe v. Ireland*[261] concerns acts of abuse committed in the 1970s in an Irish National School. At the time, national schools in Ireland were recognised and paid for by the state, whereas the management and administration was entrusted to the Church. The applicant, a pupil at the time, was subjected to approximately 20 acts of sexual abuse by one of the school teachers. She only complained to the state authorities about these acts in 1998, after finding out about other acts of sexual abuse committed by the same teacher. The ECtHR had to determine whether the state could be held liable for acts of abuse which were not reported at the time to the authorities. The Court first found that the acts of abuse to which the applicant had been subjected fell within the scope of Article 3 of the ECHR. Then, based on various reports, the ECtHR found that the state should have been aware of the potential risks of sexual abuse in schools. At the time, there was no adequate procedure in place which would have allowed a child or a parent to complain directly to the state about acts of abuse. There was also no supervision mechanisms of the teachers' treatment of children. The ECtHR therefore concluded that Ireland had failed to fulfil its positive obligations under Article 3 of the ECHR, since it did not provide an effective protection mechanism for acts of abuse against minors in schools.

Pursuant to the ECtHR, states must also conduct effective investigations into allegations of ill-treatment or loss of life, irrespective of whether the acts were perpetrated by state agents[262] or by private persons. An investigation is effective if, upon the receipt of complaints from victims or their successors, states put in place a procedure capable of leading to the identification and punishment of those responsible for acts of violence contrary to either Articles 2 or 3 of the ECHR.

Under the ESC, children's rights to protection from abuse and ill-treatment fall mainly under Articles 7 and 17.

261 ECtHR, *O'Keeffe v. Ireland* [GC], No. 35810/09, 28 January 2014.

262 ECtHR, *Assenov and Others v. Bulgaria*, No. 24760/94, 28 October 1998.

Further, under the Lanzarote Convention, states are required to criminalise various forms of sexual abuse and sexual exploitation against children.[263] This convention also requires states to take legislative or other measures to prevent sexual abuse of children, by organising awareness-raising campaigns, training specialist staff, informing children on the risks of abuse, and providing specialist help to individuals who risk committing child abuse crimes. Furthermore, under Articles 4 and 5 of the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention),[264] states undertake to enact special legislative measures and to investigate acts of violence against women. Under Article 22 of the Istanbul Convention, states are obliged to ensure specialist support services to women and children who are victims of domestic violence.

Under international law, the CRC is the key legal instrument for ensuring child protection at state level. Pursuant to Article 19, States Parties have the duty to take legislative, administrative, social and educational measures to protect children against all forms of violence. The UN Committee on the Rights of the Child has issued an important number of General Comments and recommendations interpreting states' obligations under the CRC. For instance, General Comment No. 13 describes measures to protect children against all forms of violence.[265] General Comment No. 5 refers to measures to implement and monitor the CRC in national laws and policies.[266]

263 Council of Europe, Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, CETS No. 201, 2007.

264 Council of Europe, Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, CETS No. 210, 2011.

265 UN, Committee on the Rights of the Child (2011), *General comment No. 13*, CRC/C/GC/13, 18 April 2011.

266 UN, Committee on the Rights of the Child (2003), *General comment No. 5*, CRC/GC/2003/5, 27 November 2003.

7.1.2. Corporal punishment

Corporal punishment is generally defined as any form of physical punishment intended to cause someone pain or discomfort. It mostly relates to hitting children with the hand or with an object, but it may also involve non-physical acts, such as threats, which have the same end result – the humiliation of the child.[267]

Under CoE law, the ECtHR has analysed complaints about corporal punishment as a form of disciplinary measure mainly under Article 3 of the ECHR. Where the measure reached the level of severity required under Article 3, the ECtHR found that the treatment violated that provision.[268] Where measures of corporal punishment do not reach the threshold of severity required under Article 3, they may nevertheless fall under Article 8 as part of the right to physical and moral integrity. However, the ECtHR has to date not found a violation on the merits of Article 8 in corporal punishment cases. The use of corporal punishment in state schools may also breach the rights of the parents to raise their children according to their philosophical convictions, as provided for under Article 2 of Protocol No. 1 to the ECHR.[269]

Example: The cases of *Campbell and Cosans v. the United Kingdom*[270] concern the suspension from school of two boys for refusing to accept corporal punishment. The ECtHR found no violation of Article 3 of the ECHR as the children had not actually been subjected to corporal punishment. It found, however, a violation of Article 2 of Protocol No. 1 to the ECHR on the grounds that, by allowing for corporal punishment, the respondent state had failed to respect the parents' philosophical convictions. The ECtHR also found a violation of one of the boys' right to education provided for under Article 2 of Protocol No. 1 to the ECHR, on account of his suspension from school.

267 UN, Committee on the Rights of the Child (2007), *General Comment No. 8 (2006): The right of the child to protection from corporal punishment and other cruel or degrading forms of punishment' (Arts. 19; 28, para. 2; and 37 inter alia)*, CRC/C/GC/8, 2 March 2007.

268 ECtHR, *Tyrer v. the United Kingdom*, No. 5856/72, 25 April 1978.

269 ECtHR, *Campbell and Cosans v. the United Kingdom*, Nos. 7511/76 and 7743/76, 25 February 1982, para. 38.

270 ECtHR, *Campbell and Cosans v. the United Kingdom*, Nos. 7511/76 and 7743/76, 25 February 1982.

The ESC does not include any direct prohibition against corporal punishment. Nevertheless, the ECSR has read such an obligation into Article 17 of the ESC.[271] By virtue of its supervision, both through the reporting procedure and the collective complaints procedure of states' compliance with Article 17, the ECSR has found that several contracting states breach this provision by not prohibiting all forms of corporal punishment. In three similar cases filed by the Association for the Protection of All Children (APPROACH) Ltd. against Belgium,[272] the Czech Republic,[273] and Slovenia[274] respectively, the ECSR found a violation of Article 17 of the ESC, as these states lacked legislation setting out "an express and comprehensive prohibition on all forms of corporal punishment of children that is likely to affect their physical integrity, dignity, development or psychological well-being".[275] The ECSR also established that laws prohibiting the corporal punishment of children must be applicable to such forms of alternative care as institutional care, foster care and kindergartens. It should also be recalled in this regard that the Council of Europe's Parliamentary Assembly issued in 2004 a recommendation requesting all contracting states to ban corporal punishment.[276]

Under international law, corporal punishment is indirectly considered a form of violence against children falling under Articles 19, 28 (2) and 37 of the CRC. Moreover, the Committee on the Rights of the Child has issued General Comment No. 8/2006, calling on states to take appropriate measures against all forms of corporal punishment.[277]

271 See, for example, ECSR, *World Organisation against Torture (OMCT) v. Belgium*, Complaint No. 21/2003, 7 December 2004; ECSR, Conclusions XVI-2, Poland, Art. 17, p. 65.

272 ECSR, *Association for the Protection of All Children (APPROACH) v. Belgium*, Complaint No. 98/2013, 29 May 2015, para. 49.

273 ECSR, *Association for the Protection of All Children (APPROACH) v. Czech Republic*, Complaint No. 96/2013, 29 May 2015.

274 ECSR, *Association for the Protection of All Children (APPROACH) v. Slovenia*, Complaint No. 95/2013, 27 May 2015.

275 ECSR, *Association for the Protection of All Children (APPROACH) v. Slovenia*, Complaint No. 95/2013, 27 May 2015, para. 51.

276 Council of Europe, Parliamentary Assembly (2004), Recommendation 1666 (2004) on a Europe-wide ban on corporal punishment of children, 23 June 2004.

277 UN, Committee on the Rights of the Child (2007), *General Comment No. 8 (2006): The right of the child to protection from corporal punishment and other cruel or degrading forms of punishment (arts. 19; 28, para. 2; and 37, inter alia)*, CRC/C/GC/8, 2 March 2007.

7.1.3. Sexual abuse

Human trafficking and child pornography is dealt with in Sections 7.2.2 and 7.2.3 respectively.

Child sexual abuse may take many forms, including harassment, touching, incest or rape. Child sexual abuse can take place in various settings, including homes, schools, care-institutions, churches, etc. Children are particularly vulnerable to sexual abuse, as they often find themselves under the authority and control of adults and have less access to complaint mechanisms.

Under EU law, Directive 2011/93/EU – largely reflecting the approach of the Lanzarote Convention – seeks to harmonise minimum criminal sanctions for various child sexual abuse offences between Member States.[278] Under Article 3 of this directive, Member States must take criminal law measures to ensure the sanctioning of various forms of sexual abuse, including causing children to witness sexual activities or sexual abuse, and engaging in sexual activities with children. The directive provides for increased penalties if the acts are committed by persons in a position of trust against particularly vulnerable children and/or through the use of coercion. Further, Member States must ensure that the prosecution of suspects of child abuse takes place automatically and that persons convicted of sexual abuse crimes are prevented from exercising any professional activities involving direct or regular contact with children. The directive also includes provisions on child-friendly proceedings and ensures the protection of child victims in courts.

Directive 2011/93/EU is linked to the Framework Decision 2009/315/JHA[279] on the organisation and content of the exchange of information extracted from the criminal record between Member States. Despite not being child-specific, this Framework Decision fills an important gap in the protection system, ensuring that Member States' authorities have access to the criminal records of convicted persons. This facilitates the identification of individuals convicted of sexual abuse looking for a job in institutions working with children in other Member States.

278 Directive 2011/93/EU of the European Parliament and of the Council of 13 December 2011 on combating the sexual abuse and sexual exploitation of children and child pornography, OJ 2011 L 335/1.

279 Council Framework Decision 2009/315/JHA of 26 February 2009 on the organisation and content of the exchange of information extracted from the criminal record between Member States, OJ 2009 L 93, pp. 23–32.

Under CoE law, the ECtHR has examined cases of sexual abuse under Articles 3 and 8 of the ECHR. Complaints generally concern the failure of states to take appropriate measures to protect children from abuse. In the context of Article 3, the ECtHR has also examined whether states conducted effective investigations into allegations of sexual abuse. Child-abuse claims made under Article 8 concern the impact of such acts on the physical integrity of the victim and on the right to respect for family life. At times, the distinction between states' obligations under Articles 3 and 8 is rather blurred, the ECtHR using similar reasoning for finding violations of both Articles. It should be noted, however, that Article 8 cases have been more common in situations concerning undue removal/taking into care and the impact of allegations of child abuse on the family. These situations are analysed in Chapter 5.

Example: In *M.C. v. Bulgaria*[280] the applicant was a 14-year-old girl, who claimed to have been raped by two individuals after she had gone out one evening. Her complaint before the domestic authorities had been dismissed mainly as no form of physical violence had been found. The ECtHR noted that allegations of rape fell under Article 3 of the ECHR and that the respondent state had to conduct an effective investigation into such allegations. In finding that the Bulgarian authorities failed to conduct such an investigation, the ECtHR relied on evidence that the authorities generally dismissed cases where the victim could not show physical opposition to the act of rape. The Court found that such a standard of proof was not in accordance with factual realities concerning victims of rape and was therefore capable of rendering the authorities' investigation ineffective in breach of Article 3 of the ECHR.

Further, the Lanzarote Convention regulates in detail the right of children to be protected from sexual abuse. This convention adopted in the framework of the CoE, is open to ratification by states outside Europe. This binding instrument is backed by a plethora of non-legally binding instruments aimed at further ensuring that states enact effective measures against child sexual abuse.[281]

280 ECtHR, *M.C. v. Bulgaria*, No. 39272/98, 4 December 2003.

281 Examples include: Council of Europe, Committee of Ministers (2001), Recommendation Rec (2001) 16 on the protection of children against sexual exploitation, 31 October 2001; Council of Europe, Parliamentary Assembly (1996), Resolution 1099 (1996) on the sexual exploitation of children, 25 September 1996; Council of Europe, Parliamentary Assembly (2000), Resolution 1212 (2000) on rape in armed conflicts, 3 April 2000; Council of Europe, Parliamentary Assembly (2002), Resolution 1307 (2002) on sexual exploitation of children: zero tolerance, 27 September 2002.

7.1.4. Domestic violence and child neglect

Many cases of domestic violence include allegations of sexual abuse. In this sense, states' obligations under international law are similar to those listed in Section 7.1.3 above.

Under CoE law, it has usually been mothers who have complained to the ECtHR that the state has failed to adequately discharge its obligation – established by the ECHR – to protect against harm. Domestic violence cases raised issues under Articles 2, 3 and 8 of this Convention. States must comply with their positive obligation to take effective measures against domestic violence and conduct an effective investigation into arguable allegations of domestic violence or child neglect.

Example: In the case of *Kontrová v. Slovakia*,[282] the applicant had on several occasions been physically assaulted by her husband. She complained to the police, but later withdrew her complaint. Her husband subsequently threatened to murder their children. A relative reported this incident to the police. Nevertheless, several days after the incident, the applicant's husband shot himself and their two children dead. The ECtHR held that a state's positive obligations arise in the sphere of Article 2 of the ECHR whenever the authorities know or ought to know of the existence of a real and immediate risk to the life of an identified individual. In this case, the Slovak authorities should have known of such a risk by virtue of the pre-existing communications between the applicant and the police. The positive obligations of the police should have entailed registering the applicant's criminal complaint, launching a criminal investigation and initiating criminal proceedings, keeping a proper record of the emergency calls and taking action in respect of the allegations that the applicant's husband had a shotgun. The police, however, failed to meet its obligations and the direct consequence of those failures was the death of the applicant's children, in breach of Article 2 of the ECHR.

282 ECtHR, *Kontrová v. Slovakia*, No. 7510/04, 31 May 2007.

Example: The case of *Eremia v. the Republic of Moldova*[283] concerns the complaint of a mother and her two daughters about the authorities' failure to protect them from the violent and abusive behaviour of their husband and father. The ECtHR held that, despite their knowledge of the abuse, the authorities failed to take effective measures to protect the mother from further domestic violence. It also considered that, despite the detrimental psychological effects on the daughters witnessing their father's violence against their mother in the family home, little or no action had been taken to prevent the recurrence of such behaviour. The Court found that the Moldovan authorities had not properly complied with their obligations under Article 8 of the ECHR.

Cases of child neglect, either in state institutions or at home, have also been raised under the ECHR. The obligations of the authorities in situations of parental child neglect are similar to those in the cases presented previously. On the one hand, the state needs to put in place effective mechanisms for child protection, while on the other, state authorities must take action for protecting children in cases of reported child neglect, or where there is enough evidence of child neglect at their disposal, be it in homes or in privately-run institutions.[284] Cases of neglect in state institutions impose direct obligations on the authorities to protect children by ensuring that they receive adequate (medical) care, that the facilities where they are placed are adequate and/or the staff is trained to deal with the needs of children.[285]

The Istanbul Convention is also relevant.[286] Though not child-specific, it includes several references to children. First, under Article 3 (f), girls below the age of 18 are to be considered 'women', therefore, all the provisions of the convention apply to them. Secondly, under Article 2 (2), States Parties are encouraged to apply the convention to all victims of domestic violence, which can include children. In fact, in most cases children are witnesses to and are severely affected by domestic violence within the home.[287] Finally, child-specific provisions of the convention include obligations for states to take measures to address the needs of child victims, raise awareness among children, and protect child witnesses.

283 ECtHR, *Eremia v. the Republic of Moldova*, No. 3564/11, 28 May 2013.

284 ECtHR, *Z and Others v. the United Kingdom* [GC], No. 29392/95, 10 May 2001.

285 ECtHR, *Nencheva and Others v. Bulgaria,* No. 48609/06, 18 June 2013 (available in French).

286 Council of Europe, Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, CETS No. 210, 2011.

287 FRA (2014c), pp. 134–135. See also UNICEF (2006).

In the same vein, under Article 17 of the ESC, states are obliged to prohibit all forms of violence against children and to adopt adequate criminal and civil law provisions.

The issues of domestic violence and child neglect have been addressed in various non-legally binding instruments of the CoE.[288]

7.2. Child exploitation, pornography and grooming

Key points

- State authorities have a duty to cooperate and effectively work together to protect children against violence, including in the conduct of investigations.

7.2.1. Forced labour

Under EU law, slavery, servitude, forced or compulsory labour are prohibited (Article 5 (2) of the EU Charter of Fundamental Rights). The employment of children is also prohibited (Article 32 of the Charter). Directive 94/33/EC is the main legal instrument prohibiting child labour.[289] Only in exceptional circumstances are states allowed to set the minimum age for employment below the minimum school leaving age (Article 4 (2)). States have to ensure that young people admitted to work benefit from appropriate working conditions (Articles 6 and 7). Furthermore, children can only be employed for certain activities, such as light domestic work or social and cultural activities (Articles 2 (2) and 5). The directive also sets out specific protection measures to be taken in cases of child labour (Section III).

288 Examples include: Council of Europe, Committee of Ministers (1985), Recommendation No. R (85) 4 on violence in the family, 26 March 1985; Council of Europe, Committee of Ministers (1990), Recommendation No. R (90) 2 on social measures concerning violence in the family, 15 January 1990; Council of Europe, Parliamentary Assembly (1998), Recommendation 1371 (1998) on abuse and neglect of children, 23 April 1998.

289 Council Directive 94/33/EC of 22 June 1994 on the Protection of Young People at Work, OJ 1994 L 216.

In many instances, forced child labour cases involve trafficked children.[290] Directive 2011/36/EU on preventing and combating trafficking in human beings recognises forced labour as a form of child exploitation (Article 2 (3)).[291] Children trafficked for the purposes of forced labour are protected under the directive in the same way as victims of trafficking for other purposes (such as sexual exploitation, see Section 7.1.3).[292]

Under CoE law, Article 4 of the ECHR prohibits in absolute terms all forms of slavery, servitude, forced and compulsory labour. The ECtHR defines "forced or compulsory labour" as "work or service which is exacted from any person under the menace of any penalty against the will of the person concerned and for which the said person has not offered himself voluntarily".[293] Servitude includes, in addition, "the obligation for the 'serf' to live on another person's property and the impossibility of altering his condition".[294] Servitude is therefore an aggravated form of compulsory labour.

In cases concerning allegations of forced labour, the ECtHR first determines whether the allegations fall within the scope of Article 4 of the ECHR.[295] It then analyses whether states have complied with their positive obligations to put in place a legislative and administrative framework that prohibits, punishes and effectively prosecutes cases of forced or compulsory labour, servitude and slavery.[296] As regards the procedural aspect of Article 4, the ECtHR examines whether the domestic authorities conducted an effective investigation into arguable allegations of forced labour or servitude.[297]

290 Recital 11, Directive 2011/36/EU of the European Parliament and of the Council of 15 April 2011 on preventing and combating trafficking in human beings and protecting its victims, OJ 2011 L 101/1.

291 Directive 2011/36/EU of the European Parliament and of the Council of 15 April 2011 on preventing and combating trafficking in human beings and protecting its victims, OJ 2011 L 101/1.

292 See further FRA (2015c), pp. 40–41.

293 ECtHR, *Siliadin v. France*, No. 73316/01, 26 July 2005, para. 116.

294 *Ibid.*, para. 123.

295 ECtHR, *C.N. and V. v. France*, No. 67724/09, 11 October 2012, para. 70.

296 *Ibid.*, para. 104 and following.

297 ECtHR, *C.N. v. the United Kingdom*, No. 4239/08, 13 November 2012, paras. 70–82.

Example: The case of *C.N. and V. v. France*[298] concerns the forced-labour claims of two sisters of Burundian origin. After the death of their parents, they were taken to live with their aunt and her family in France. They were accommodated for four years in the basement of the house in allegedly very bad conditions. The older sister did not attend school and spent all her time doing household chores and taking care of her aunt's disabled son. The younger sister attended school and worked for the aunt and her family after school and after having been given time to do her homework. Both sisters lodged a complaint with the ECtHR that they had been held in servitude and subjected to forced labour. The ECtHR found that the first applicant had indeed been subject to forced labour as she had to work seven days a week with no remuneration and no holiday. Moreover, she had been held in servitude because she had the feeling that her situation was permanent, with no likelihood of change. The ECtHR further found that the state did not meet its positive obligations, since the legal framework in place did not offer effective protection to victims of compulsory labour. Concerning the procedural obligation to investigate, the ECtHR held that the requirements of Article 4 of the ECHR had been met, as the authorities had conducted a prompt independent investigation capable of leading to the identification and punishment of those responsible. The ECtHR dismissed the second applicant's allegations of forced labour, reasoning that she had been able to go to school and was given time to do her homework.

The ESC guarantees the right of children to be protected against physical and moral dangers within and outside the working environment (Article 7 (10)). The ECSR observed that domestic/labour exploitation of children, including trafficking for the purposes of labour exploitation, must be prohibited at state level.[299] States Parties to the ESC must ensure not only that they have the necessary legislation to prevent exploitation and protect children and young persons, but also that this legislation is effective in practice.[300]

The Lanzarote Convention also stipulates that states should criminalise all forms of child sexual exploitation.

298 ECtHR, *C.N. and V. v. France*, No. 67724/09, 11 October 2012.

299 ECSR Conclusions 2004, Bulgaria, p. 57.

300 ECSR Conclusions 2006, Albania, p. 61; ECSR Conclusions 2006, Bulgaria, p. 113.

7.2.2. Child trafficking

Under EU law, Article 83 of the TFEU identifies trafficking in human beings as a field where the EU Parliament and Council have legislative powers. Article 5 (3) of the EU Charter of Fundamental Rights contains an express prohibition of trafficking in human beings. The contribution of the EU is valued here, as this is an area with cross-border dimensions.

Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting its victims is the first instrument passed by the European Parliament and the Council based on Article 83 of the TFEU.[301] Under Article 2 (1) of this directive, trafficking is defined as "the recruitment, transportation, transfer, harbouring or reception of persons, including the exchange or transfer of control over those persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation". The purpose of the directive is to set out minimum rules for the definition and sanctioning of human trafficking-related offences (Article 1). The directive as a whole is relevant for children, and it also includes several child-specific provisions relating to assistance and support of child victims of trafficking and protection in criminal investigations (Articles 13–16).[302] Specific support measures are to be taken pursuant to a specialist assessment of each individual victim (Article 14 (1)). States should appoint a guardian to represent the child's best interests (Article 14 (2)) and provide support to the family of the child (Article 14 (3)). During criminal proceedings, children have the right to a representative, free legal counselling, and the right to be heard in adequate premises and by trained professionals (Article 15 (1)–(3)). Further protection measures include the possibility to conduct hearings without the presence of the public and the possibility to hear the child indirectly via communication technologies (Article 15 (5)).[303]

301 Directive 2011/36/EU of the European Parliament and of the Council of 15 April 2011 on preventing and combating trafficking in human beings and protecting its victims, OJ 2011 L 101/1.

302 Provisions detailed in FRA and ECtHR (2014), p. 222.

303 See FRA (2015b), p. 79.

Directive 2004/81/EC is also relevant for trafficked children.[304] Under this instrument, victims of trafficking may be issued residence permits by the host Member States, provided they cooperate in the criminal investigation. Nevertheless, the directive only applies to children to the extent decided by Member States.[305]

When it comes to enforcement, the EU's law enforcement agency (Europol) and the EU's Judicial Cooperation Unit (Eurojust) play important roles in ensuring cooperation between Member States to identify and prosecute organised trafficking networks. The relevant provisions for the protection of child victims at EU level are addressed in Section 11.3 of this handbook.

Under CoE law, the ECHR does not include any express provision on trafficking. Nevertheless, the ECtHR interprets Article 4 of the ECHR as including a prohibition of trafficking.[306] The Court has adopted the same definition of trafficking as laid down in Article 3 (a) of the Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the UN Convention against Transnational Organized Crime (Palermo Protocol) and Article 4 (a) of the CoE Convention on Action against Trafficking in Human Beings.[307] The ECtHR first identifies whether a particular situation involves a credible allegation of trafficking and thus falls under the scope of Article 4. If it does, the ECtHR's analysis will follow the patterns described in Section 7.2.1: the Court looks into whether the legal framework of the respondent state offers effective protection against trafficking, whether the state has discharged its positive obligations in the particular circumstances of the case and whether the authorities have conducted an effective investigation into arguable allegations of trafficking.

304 Council Directive 2004/81/EC of 29 April 2004 on the residence permit issued to third-country nationals who are victims of trafficking in human beings or who have been the subject of an action to facilitate irregular immigration, who cooperate with the competent authorities, OJ 2004 L 261, pp. 19–23.

305 *Ibid.*, Art. 3.

306 ECtHR, *Rantsev v. Cyprus and Russia*, No. 25965/04, 7 January 2010, para. 282.

307 UN, Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (UNCTOC), New York, 15 November 2000; Council of Europe, Council of Europe Convention on Action against Trafficking in Human Beings, CETS No. 197, 2005.

Example: The case of *Rantsev v. Russia and Cyprus*[308] was lodged by the father of a young Russian girl who died under suspicious circumstances in Cyprus. She had entered Cyprus on a cabaret artist visa. After what appeared to be an escape attempt, she died by falling off the balcony of an apartment belonging to acquaintances of her employer. Her father lodged a complaint against both Russia and Cyprus, essentially claiming that the authorities had not appropriately investigated the death of his daughter. The ECtHR held for the first time that trafficking in human beings falls under the scope of Article 4 of the ECHR. Although Cyprus had an adequate legal framework to combat trafficking, Article 4 was violated, as the administrative practice of requiring employers to issue financial guarantees for cabaret dancers did not offer effective protection against trafficking and exploitation. Further, in the particular circumstances of the case, the Cypriot authorities should have known that the applicant's daughter was at risk of being trafficked. The Court ruled that the police failed to take measures to protect Ms Rantseva against exploitation. Finally, it found a violation of Article 4 by Russia, since the Russian authorities did not appropriately investigate the allegations of trafficking.

The ECSR considers trafficking in human beings to constitute a grave violation of human rights and human dignity, and to amount to a new form of slavery.[309] Under Article 7 (10), states must enact legislation to criminalise it.[310] This legislation must be backed by an adequate supervisory mechanism, sanctions, and an action plan to combat child trafficking and sexual exploitation. [311]

At treaty level, the CoE Convention on Action against Trafficking in Human Beings is the key instrument addressing human trafficking.[312] In view of the broader membership of the CoE and the fact that the Anti-Trafficking Convention is open to accession by non-CoE member states,[313] it complements the

308 ECtHR, *Rantsev v. Cyprus and Russia*, No. 25965/04, 7 January 2010. The case does not concern the death of a child; however, this case is worth mentioning in absence of ECtHR child-specific trafficking cases and in view of the particular threat of trafficking to children.

309 ECSR, *Federation of Catholic Family Associations in Europe (FAFCE) v. Ireland*, No. 89/2013, 12 September 2014, para. 56.

310 ECSR, Conclusions XVII-2 (2005), Poland, p. 638.

311 ECSR, *Federation of Catholic Family Associations in Europe (FAFCE) v. Ireland*, No. 89/2013, 12 September 2014, para. 57.

312 Council of Europe, Council of Europe Convention on Action against Trafficking in Human Beings, CETS No. 197, 2005.

313 For example, Belarus acceded to the convention on 26 November 2013.

EU Directive 2011/36/EU and is instrumental in combating trafficking in states party to the convention, whether EU members or not, on the basis of common standards and obligations. The implementation of the convention is monitored by a group of independent experts (the Group of Experts on Action against Trafficking in Human Beings GRETA), who periodically assess the situation in each country and publish reports. On the basis of these reports, the Committee of the Parties to the Convention, the political pillar of the monitoring mechanism under the convention, adopts recommendations to States Parties concerning measures to be taken to implement GRETA's conclusions and follows up on progress.

7.2.3. Child pornography and grooming

Under EU law, Directive 2011/93/EU is the main legal instrument addressing child pornography.[314] Pornography is defined as: "(i) any material that visually depicts a child engaged in real or simulated sexually explicit conduct; (ii) any depiction of the sexual organs of a child for primarily sexual purposes; (iii) any material that visually depicts any person appearing to be a child engaged in real or simulated sexually explicit conduct or any depiction of the sexual organs of any person appearing to be a child, for primarily sexual purposes; or (iv) realistic images of a child engaged in sexually explicit conduct or realistic images of the sexual organs of a child, for primarily sexual purposes."[315] Article 5 of this directive introduces an obligation for EU Member States to take all necessary measures to ensure that the intentional production, acquisition, possession, distribution, dissemination, transmission, offering, supplying or making available of child pornography as well as knowingly obtaining access to this type of content is punishable.

Under CoE law, the ECtHR has on several occasions analysed cases concerning child pornography under Article 8 of the ECHR.

Example: The case of *Söderman v. Sweden* was brought by a girl whose stepfather attempted to film her while she was taking a shower.[316] She alleged that the Swedish legislative framework did not adequately protect

314 Directive 2011/93/EU of the European Parliament and of the Council of 13 December 2011 on combating the sexual abuse and sexual exploitation of children and child pornography, OJ 2011 L 335/1, pp. 1–14.

315 *Ibid.*, Art. 2 (c).

316 ECtHR, *Söderman v. Sweden* [GC], No. 5786/08, 12 November 2013.

her private life. The ECtHR held that the state has positive obligations to set up a legislative framework offering adequate protection to victims such as the applicant. As this case concerns only an attempt to film the applicant, the ECtHR held that such legislative framework does not necessarily have to include criminal sanctions. The remedies offered to a victim – either civil or criminal – have to be effective. On the facts of the case, the ECtHR held that the applicant did not benefit from effective criminal or civil remedies against her stepfather's attempt to film her, in breach of Article 8 of the ECHR.

Article 9 of the CoE Convention on Cybercrime[317] requires States Parties to criminalise the conduct of offering, making available, distributing, transmitting, procuring or possessing child pornography or producing such material through a computer system. An important requirement is that this conduct must be intentional. The Explanatory Report of the Convention states that the term 'pornographic material' is dependent on national standards concerning materials classified as "obscene, inconsistent with public morals or similarly corrupt".[318] Nevertheless, this obligation to criminalise should not only apply to material if it visually depicts a child, but also if it depicts a person appearing to be one or realistic images representing a child who is engaged in sexually explicit conduct.[319]

Further, pursuant to Articles 21 to 23 of the Lanzarote Convention, states are required to take legislative measures to criminalise various forms of child pornography. Under Article 21, recruiting, coercing and participating in child pornography activities should be criminalised. Under Article 22, causing children to witness sexual (abuse) acts must equally be criminalised. Finally, Article 23 requires that criminal legislation be enacted in relation to acts of solicitation of children for sexual purposes through information and communication technologies. The Lanzarote Committee has adopted an opinion on this provision, which invites the States Parties to the convention to consider extending the criminalisation of solicitation to cases when the sexual abuse is not the result of a meeting in person but committed online.[320]

317 Council of Europe, Convention on Cybercrime, CETS No. 185, 2001.

318 Explanatory report to the Council of Europe, Council of Europe Convention on Cybercrime, para. 99.

319 Council of Europe, Convention on Cybercrime, CETS No. 185, 2001, Art. 9 (2).

320 Lanzarote Committee Opinion on Art. 23 of the Lanzarote Convention and its explanatory note, 17 June 2015.

7.3. High risk groups

Key point

- Children victims of forced disappearance (known as 'enforced disappearance' in international law) have the right to preserve or to re-establish their identity.

7.3.1. Children belonging to a minority

Under CoE law, ECtHR cases dealing specifically with violence against minority children – outside the context of human trafficking and forced labour – are rather sparse. They mainly concern segregation in schools and discrimination, which is analysed in Section 3.2.

Example: In the case of *Centre of Legal Resources on behalf of Valentin Câmpeanu v. Romania*, an NGO lodged an application in the name of a young Roma boy who died in a state institution.[321] He was HIV-positive and had a severe intellectual disability. The conditions in the institution where he lived were appalling: there was no heating, no bedding or clothes, no support from staff, etc. In the absence of any close relative of the victim, an NGO alleged on his behalf the infringement of the rights established by Articles 2, 3, 5, 8, 13 and 14 of the ECHR. The Grand Chamber decided that, in the exceptional circumstances of the case (the extreme vulnerability and lack of any known next-of-kin of the young Roma), the NGO had standing to represent the deceased applicant. On the merits, the ECtHR found a violation of the substantive limb of Article 2. The domestic authorities were found liable for the death of Mr. Câmpeanu as they had placed him in an institution where he died due to the lacked adequate food, accommodation and medical care. The ECtHR also found a violation of Article 2 due to the fact that the Romanian authorities did not conduct an effective investigation into the death of Mr. Câmpeanu.

321 ECtHR, *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], No. 47848/08, 17 July 2014.

With respect to children living in institutions, the CoE Recommendation Rec(2005)5 supports the decision that the placement of a child should not be based on discriminatory grounds.[322]

7.3.2. Children with disabilities

Under EU law, the EU has become a party to the CRPD, the first international treaty in the field of human rights to which the EU has acceded.[323] The CRPD includes specific provisions related to children. EU Member States and the EU have undertaken to ensure the enjoyment of human rights by children with disabilities on an equal basis with other children. Under Article 16 of the CRPD, they must take specific measures to protect children with disabilities from abuse and exploitation.[324]

Under CoE law, ECtHR cases concerning children with disabilities have raised several issues, including consent, states' positive obligations to protect from death and ill-treatment, and living conditions in state-run facilities.

Example: The case of *Nencheva and Others v. Bulgaria*[325] concerns the death of 15 children and young adults in a home for people with mental and psychical disabilities. The ECtHR held that the children had been placed in a specialised public institution under the sole control of the state. The living conditions of the children in the institution were appalling: they lacked food, medicine, clothing and heating. The competent authorities had been alerted to this situation on several occasions, and were consequently aware or should have been aware of the risks of death. The ECtHR found a violation of the substantive limb of Article 2 of the ECHR, as the authorities did not take measures to protect the lives of children placed under their control. Further, the Bulgarian authorities did not conduct an effective investigation into the deaths of the applicants' children. In the particular circumstances of the case, the Bulgarian authorities should have launched an *ex officio* criminal investigation. The investigation was

322 Council of Europe, Committee of Ministers (2005), Recommendation Rec (2005)5 on the rights of children living in residential institutions, 16 March 2005.

323 Council of the European Union (2009), Council Decision 2010/48/EC of 26 November 2009 concerning the conclusion, by the European Community, of the United Nations Convention on the Rights of Persons with Disabilities, OJ 2010 L 23/35.

324 See also Section 3.5.

325 ECtHR, *Nencheva and Others v. Bulgaria*, No. 48609/06, 18 June 2013 (available in French).

deemed ineffective for several reasons: it had started two years after the death of the children, it had lasted unreasonably long, it did not cover the death of all the children and it did not clarify all the relevant factors in the matter.

7.4. Missing children

Under EU law, the EU Commission has launched a hotline number (116000) for missing children.[326] This service takes calls reporting missing children and passes them on to the police authorities, offers guidance to and supports the persons responsible for the missing child, and supports the investigation.

Under CoE law, the enforced disappearance of children has been addressed under Article 8 of the ECHR.

Example: In *Zorica Jovanović v. Serbia*,[327] a new-born baby allegedly died in hospital shortly after birth, but his body was never transferred to the parents. The mother complained that the state had failed to provide her with any information about the fate of her son, including the cause of his alleged death or time and place of his burial. The ECtHR held that a state's "continuing failure to provide [the mother] with credible information as to the fate of her son" amounted to a violation of her right to respect for family life.[328]

Under UN law, Article 25 (1) (b) of the International Convention for the Protection of All Persons from Enforced Disappearance[329] stipulates that states must prevent and punish the "falsification, concealment or destruction of documents attesting to the true identity" of children that are themselves or whose parents are subjected to enforced disappearance. States must also take the necessary measures to search for and identify these children, and to return them to their families of origin. In light of these children's right to preserve,

326 Commission Decision (2007), Commission Decision 2007/698/EC of 29 October 2007 amending Decision 2007/116/EC as regards the introduction of additional reserved numbers, OJ 2007, L 284/31.

327 ECtHR, *Zorica Jovanović v. Serbia*, No. 21794/08, 26 March 2013.

328 *Ibid.*, para. 74.

329 UN, International Convention for the Protection of All Persons from Enforced Disappearance, 20 December 2006.

or to have re-established, their identity, including their nationality, name and family relations as recognised by law, states need to have legal procedures in place to review and annul any adoption or placement of children involved in enforced disappearances (Article 25 (4)). The convention reiterates two of the general principles underpinning children's rights: the best interests of the child as a primary consideration and the right of the child to express his/her views (Article 25 (5)). Whereas a relatively low number of European states have ratified this convention, its relevance to the European normative framework should not be dismissed.[330]

330 As at 19 February 2015, nine out of the 28 EU Member States had ratified this convention (Austria, Belgium, Spain, France, Germany, Lithuania, Netherlands, Portugal and Slovakia). In addition, the following CoE member states have ratified the convention: Serbia, Montenegro, Bosnia and Herzegovina, Armenia and Albania.

8 Economic, social and cultural rights and adequate standard of living

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 14 (education) Qualification Directive (2011/95/EU) CJEU, C-413/99, *Baumbast and R v. Secretary of State for the Home Department*, 2002 (education of migrant children)	**Right to education**	ECHR, Protocol No. 1, Article 2 (right to education) ESC (revised), Article 17 (right to education) ECtHR, *Catan and Others v. Moldova and Russia* [GC], Nos. 43370/04, 8252/05 and 18454/06, 2012 (language in schools) ECtHR, *D.H. and Others v. the Czech Republic* [GC], No. 57325/00, 2007; ECtHR, *Oršuš and Others v. Croatia* [GC], No. 15766/03, 2010 (discrimination in school of Roma children) ECtHR, *Ponomaryovi v. Bulgaria*, No. 5335/05, 2011 (discrimination on ground of immigration status) FCNM, Articles 12 (3) and 14 European Convention on the Legal Status of Migrant Workers
Charter of Fundamental Rights, Article 35 (access to health care) Qualification Directive (2011/95/EU), Article 29 (core benefits for migrant children)	**Right to health**	ESC (revised), Articles 11 (right to protection of health) and 13 (right to social and medical assistance) ECHR, Articles 2 (right to life) and 8 (right to physical integrity) ECtHR, *Oyal v. Turkey*, No. 4864/05, 2010 (HIV infection of a newborn) ECtHR, *Iliya Petrov v. Bulgaria*, No. 19202/03, 2012 (injury in an electricity substation) ECtHR, *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], No. 47848/08, 2014 (death in an institution)

EU	Issues covered	CoE
		ECtHR, *Glass v. the United Kingdom*, No. 61827/00, 2004 (informed consent) ECtHR, *M.A.K and R.K. v. the United Kingdom*, Nos. 45901/05 and 40146/06, 2010 (test without parental consent) ECSR, *International Federation of Human Rights Leagues (FIDH) v. France*, Complaint No. 14/2003, 2004, (medical care for migrant children) ECSR, *Defence for Children International (DCI) v. Belgium*, Complaint No. 69/2011, 2012 (children in an irregular situation) Convention on Human Rights and Biomedicine (Oviedo Convention), Articles 6 and 8
Charter of Fundamental Rights, Article 34 (3) (right to social and housing assistance)	**Right to housing**	ESC (revised), Articles 16 (right of the family to social, legal and economic protection), 17 (right of children and young persons to social, legal and economic protection) and 31 (right to housing) ECtHR, *Bah v. the United Kingdom*, No. 56328/07, 2011 ECtHR, *Connors v. the United Kingdom*, No. 66746/01, 2004.
Charter of Fundamental Rights, Article 34 (social security and social assistance)	**Right to an adequate standard of living and right to social security**	ESC (revised), Articles 12–14 (rights to social security, social and medical assistance, and to benefit from social welfare services), 16 (right of the family to social, legal and economic protection) and 30 (right to protection against poverty and exclusion) ECSR, *European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) v. France*, Complaint No. 82/2012, 2013 (suspension of family allowances for truancy) ECtHR, *Konstantin Markin v. Russia* [GC], No. 30078/06, 2012 (parental leave)

Economic, social and cultural rights (ESC rights), more often referred to as socio-economic rights or social rights in a European context, include work-related rights as well as the right to education, health, housing, social security and, more generally, an adequate standard of living. Cultural rights have remained largely underdeveloped and unaddressed in scholarship and litigation. Aspects of them are addressed in Section 4.6 on the identity of children belonging to a minority and in Section 8.2 under the right to education.

Explicit standards on ESC rights in the European context can mainly be found in the European Social Charter and the EU Charter of Fundamental Rights, although the ECHR and its protocols also include several relevant provisions, for instance the prohibition of forced labour and the right to education. Moreover, the ECtHR has argued that there is "no water-tight division separating [the] sphere [of social and economic rights] from the field covered by the Convention"[331] and has read ESC rights into the civil rights guaranteed by the ECHR. In that way, for example, access to health care has been dealt with under the prohibition of torture, inhuman and degrading treatment and punishment (Article 3 of the ECHR).[332]

This chapter analyses ESC rights that are of specific relevance to children: the right to education (Section 8.2); the right to health (Section 8.3); the right to housing (Section 8.4); and the right to an adequate standard of living and social security (Section 8.5).

8.1. Approaches to economic, social and cultural rights

Key points

- Securing the availability of adequate resources is key to ensure the protection of social rights.
- Essential elements of social rights are availability, accessibility, adaptability and acceptability.

Under EU law, ESC rights have been included in the EU Charter of Fundamental Rights on par with civil and political rights. However, Article 52 of the Charter distinguishes between rights and principles, with the latter being limited in the way they are "judicially cognisable".

331 ECtHR, *Airey v. Ireland*, No. 6289/73, 9 October 1979, para. 26.

332 See, for example, ECtHR, Factsheet on Prisoners' health-related rights, February 2015, and Factsheet on Health, April 2015.

Under CoE law, the ECSR notes that when the realisation of a right is "exceptionally complex and particularly expensive to resolve", it assesses progressive realisation against three criteria: measures must be taken "to achieve the objectives of the Charter within a reasonable time, with measurable progress and to an extent consistent with the maximum use of available resources".[333] It also introduces a prioritisation, in that it reminds states of "the impact that their choices will have for groups with heightened vulnerabilities as well as for others persons affected".[334]

The ECSR, albeit in the specific context of the right to social security, argues that retrogressive steps "in order to ensure the maintenance and sustainability of the existing social security system" are permissible provided they do not "undermine the core framework of a national social security system or deny individuals the opportunity to enjoy the protection it offers against serious social and economic risk".[335] The ECtHR also accepts the possibility of retrogressive steps, but examines whether the method chosen is reasonable and suitable to the achievement of the legitimate aim pursued.[336]

In the context of the right to education, the ECSR, in line with the approach of the UN Committee on Economic, Social and Cultural Rights, has adopted the analytical framework of availability, accessibility, acceptability and adaptability.[337] The distinction between availability and accessibility also features in the case law of the ECtHR. The criteria or essential elements of availability, accessibility, acceptability and adaptability guide the analysis that follows, to the extent that relevant case law is available.

333 ECSR, *International Association Autism Europe (IAAE) v. France*, Complaint No. 13/2002, 4 November 2003, para. 53; applied in ECSR, *European Action of the Disabled (AEH) v. France*, Complaint No. 81/2012, 11 September 2013, paras. 94–99.

334 ECSR, *International Association Autism Europe (IAAE) v. France*, Complaint No. 13/2002, 4 November 2003, para. 53.

335 ECSR, *General Federation of Employees of the National Electric Power Corporation (GENOP-DEI) and Confederation of Greek Civil Servants' Trade Unions (ADEDY) v. Greece*, Complaint No. 66/2011, 23 May 2012, para. 47.

336 ECtHR, *Markovics and Others v. Hungary*, Decision of inadmissibility, Nos. 77575/11, 19828/13 and 19829/13, 24 June 2014, paras. 37 and 39.

337 ECSR, *Mental Disability Advocacy Center (MDAC) v. Bulgaria*, Complaint No. 41/2007, 3 June 2008, para. 37.

8.2. Right to education

Key points

- Limitations to the accessibility of education must be foreseeable, pursue a legitimate aim and must be justified and non-discriminatory.
- Acceptability of education, which requires respect for the religious and philosophical convictions of parents, does not exclude the possibility of religious or sexual education in schools.
- Adaptability requires special measures for children with disabilities and the possibility for children belonging to a minority to learn and be taught in their own language.
- Children have the right to education regardless of their nationality or migration status.

Under EU law, Article 14 (2) of the EU Charter of Fundamental Rights guarantees the right to education, including "the possibility to receive free compulsory education". In its third paragraph, Article 14 ensures the freedom to found educational establishments and the right of parents to ensure the education and teaching of their children in conformity with their religious, philosophical and pedagogical convictions.

Under CoE law, Article 2 of Protocol No. 1 to the ECHR guarantees the right to education. The ECtHR clarifies that this article does not oblige states to make education available; it provides "a right of access to educational institutions existing at a given time".[338] In addition, the right to education also includes "the possibility of drawing profit from the education received, that is to say, the right to obtain, in conformity with the rules in force in each state, and in one form or another, official recognition of the studies [...] completed".[339] However, this is not an absolute right; limitations must be foreseeable for those concerned and must pursue a legitimate aim. Disciplinary measures, including suspension or expulsion from an educational institution, are allowed, provided they meet the conditions for permissible limitations. To assess whether these forms of exclusion from education result in a denial of the right to ed-

338 ECtHR, *Case "Relating to certain aspects of the laws on the use of languages in education in Belgium" v. Belgium*, Nos. 1474/62, 1677/62, 1691/62, 1769/63, 1994/63 and 2126/64, 23 July 1968, para. 4.

339 *Ibid.*

ucation, factors such as the procedural safeguards, duration of the exclusion, reintegration efforts and adequacy of alternative education provided will be considered.[340]

> Example: In *Catan and Others v. Moldova and Russia*,[341] the ECtHR looked into the language policy introduced in schools by the separatist authorities in Transdniestria. The objective of this language policy was Russification. Following the forced closure of Moldovan-language schools (using the Latin alphabet), parents had to choose between sending their children to schools where they were taught in an artificial combination of language and Cyrillic alphabet and with teaching materials produced in Soviet times, or to sending their children to schools that were less well equipped and less conveniently situated, on their way to which they were subjected to harassment and intimidation. The forced closure of schools and subsequent harassment was held to be an unjustified interference with the children's right to education that amounted to a violation of Article 2 of Protocol No. 1 to the ECHR.[342]

As part of the right to education, parents have the right to respect for their religious and philosophical convictions. However, "the setting and planning of the curriculum fall in principle within the competence" of the state.[343] They can also integrate information or knowledge of a religious or philosophical kind in the school curriculum, on condition that it is "conveyed in an objective, critical and pluralistic manner".[344] To safeguard pluralism, quantitative and qualitative differences in teaching a particular religion or philosophy must be balanced by offering parents the possibility of either partially or fully exempting their children from such teaching, namely the possibility not to attend certain classes or the religious course as a whole.[345] For the ECtHR's way of dealing with the issue from a non-discrimination angle, see Section 2.1.[346]

340 ECtHR, *Ali v. the United Kingdom*, No. 40385/06, 11 January 2011, para. 58.

341 ECtHR, *Catan and Others v. Moldova and Russia* [GC], Nos. 43370/04, 8252/05 and 18454/06, 19 October 2012.

342 *Ibid.*, paras. 141–144.

343 ECtHR, *Folgerø and Others v. Norway* [GC], No. 15472/02, 29 June 2007, para. 84.

344 *Ibid.*, para. 84.

345 *Ibid.*, paras. 85–102 and Dissenting opinion.

346 ECtHR, *Grzelak v. Poland*, No. 7710/02, 15 June 2010.

Pursuant to Article 17 (2) of the revised ESC, states undertake "to take all appropriate and necessary measures designed [...] to provide to children and young persons a free primary and secondary education as well as to encourage regular attendance at schools".[347] Additionally, the ECSR ruled that under this provision, contracting states should ensure that children unlawfully present in their territory also have access to education.[348]

Furthermore, educational institutions have to be accessible to everyone without discrimination.[349] The ESCR held that the "integration of children with disabilities into mainstream schools [...] should be the norm and teaching in specialised schools must be the exception".[350] States do not enjoy a wide margin of appreciation regarding the choice of the type of school for persons with disabilities; it must be a mainstream school.[351]

Situations concerning differential treatment in education on grounds such as nationality, immigration status or ethnic origin are dealt with in Chapter 3.

Under the ECSR case law, sexual and reproductive health education must be part of the ordinary curriculum.[352] Whereas states enjoy a wide margin of appreciation in determining the cultural appropriateness of the educational material used, they must ensure non-discriminatory sexual and reproductive health education "which does not perpetuate or reinforce social exclusion and the denial of human dignity". Educational materials must not "reinforce demeaning stereotypes", for instance concerning persons of non-heterosexual orientation.[353]

347 The ESC of 1961 does not contain a provision on the right to education.

348 ECSR, *Médecins du Monde – International v. France*, Complaint No. 67/2011, 11 September 2012.

349 On the issue of children with disabilities, see further Chapters 3 and 7.

350 ECSR, *Mental Disability Advocacy Center (MDAC) v. Bulgaria*, Complaint No. 41/2007, 3 June 2008, para. 35.

351 ECSR, *European Action of the Disabled (AEH) v. France*, Complaint No. 81/2012, 11 September 2013, para. 78.

352 ECSR, *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia*, Complaint No. 45/2007, 30 March 2009, para. 47.

353 *Ibid.*, paras. 59 and 61.

Finally, adaptability of education requires, for example, that for children with disabilities who are integrated into mainstream schools, "arrangements are made to cater for their special needs"[354] (see also Section 3.5).

In addition, under Article 12 (3) of the FCNM, States Parties undertake to promote equal opportunities for access to education at all levels for persons belonging to national minorities (see also Chapter 3).[355] For children belonging to national minorities, Article 14 of the FCNM contains the right to learn and be taught one's own language.[356] The ECtHR has confirmed that the right to education implies the right to be educated in (one of) the national language(s).[357]

8.2.1. Right to education of migrant children

Under EU law, children's fundamental right to education, regardless of their migration status, is recognised in virtually all aspects of EU migration law.[358] That said, the EU does not have the competence to determine the content or scope of national educational provisions. Rather, the EU protects migrant children's right to access education on the same or, depending on their status, similar basis as nationals. The Students Directive (2004/114/EC) regulates the conditions of admission of third-country nationals for the purposes of studies, pupil exchange, unremunerated training or voluntary service.[359] This admission

354 ECSR, *Mental Disability Advocacy Center (MDAC) v. Bulgaria*, Complaint No. 41/2007, 3 June 2008, para. 35.

355 See further Council of Europe, Advisory Committee on the Framework Convention for the Protection of National Minorities (FCNM), Commentary on Education under the Framework Convention for the Protection of National Minorities, 2006, ACFC/25DOC(2006)002, Part 2.1.

356 For further clarification, see Council of Europe, Advisory Committee on the Framework Convention for the Protection of National Minorities (FCNM), Commentary on Education under the Framework Convention for the Protection of National Minorities, 2006, ACFC/25DOC(2006)002, Part 2.3, and Thematic Commentary No. 3: The language rights of persons belonging to national minorities under the Framework Convention, 2012, ACFC/44DOC(2012)001 rev, Part VI, Language Rights and Education.

357 ECtHR, *Catan and Others v. Moldova and Russia* [GC], Nos. 43370/04, 8252/05 and 18454/06, 19 October 2012, para. 137.

358 E.g. Art. 27 Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (Recast) (Qualification Directive), OJ 2011 L 337/9, pp. 9–268.

359 Council Directive 2004/114/EC on the conditions of admission of third-country nationals for the purposes of studies, pupil exchange, unremunerated training or voluntary service (Students Directive).

covers the entry and residence of the third-country national for a period exceeding three months. The general conditions of admission for children include the presentation of a valid travel document, parental authorisation for the planned stay, sickness insurance and, if the Member State so requests, the payment of a fee for processing the application for admission.[360] School pupils for instance are required to provide evidence of participation in a pupil exchange scheme operated by an organisation recognised by the Member State.[361] Unremunerated trainees are subject to providing the evidence the Member State requires to ensure that during their stay they will have sufficient resources to cover their subsistence, training and return travel costs.[362] Access to economic activities, including employment, by higher education students are subject to restrictions.[363]

The children of EU migrants who move to another EU Member State under free movement law benefit from the most favourable entitlement in this context. They have a right to be admitted to that state's general educational, apprenticeship and vocational training courses under the same conditions as nationals.[364] This includes public and private, and compulsory and non-compulsory education. The CJEU has always interpreted this entitlement broadly to ensure equal access to education, but also to broader, education-related social benefits, as well as to any benefits intended to facilitate educational attendance. For example, in the *Casagrande* case, the child of a migrant worker was able to access a means-tested educational grant under EU free movement law.[365]

360 *Ibid.*, Art, 6.

361 *Ibid.*, Art. 7.

362 *Ibid.*, Art. 10.

363 *Ibid.*, Art. 17.

364 Regulation (EU) 492/2011 of the European Parliament and of the Council of 5 April 2011 on freedom of movement for workers within the Union, OJ 2011 L 141/1, pp. 1–12, Art. 10; and Directive 2004/38 of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States amending Regulation (EEC) No. 1612/68 and repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC and 93/96/EEC (Free Movement Directive), OJ 2004 L 158, pp. 77–123, Art. 24 (1).

365 CJEU, C-9/74, *Donato Casagrande v. Landeshauptstadt München*, 3 July 1974. Subsequently confirmed in cases such as CJEU, C-3/90, *M.J.E. Bernini v. Minister van Onderwijs en Wetenschappen*, 26 February 1992.

Moreover, legislation introduced in the 1970s requires Member States to provide supplementary language tuition for children of EU migrant workers, in both the host state language and in their mother tongue, with a view to facilitate their integration in the host state and in their country of origin should they subsequently return.[366] While this seems to offer quite generous and valuable supplementary support to children following their admission to a school in the host state, its implementation across different countries has been notoriously patchy and increasingly impractical given the range of different languages to accommodate.[367]

Example: The issue in *Baumbast and R v. Secretary of State for the Home Department*[368] was whether the two daughters of a German migrant worker who moved to the United Kingdom with his Colombian wife and daughters, could continue to attend school there after he left the United Kingdom for a non-EU Member State, leaving his wife and daughters behind. The CJEU was faced with the question of whether his wife and daughters could remain in the host state independently, notwithstanding the fact that Mr Baumbast (from whom the family derived their residence rights) had effectively relinquished his status as an EU migrant worker. The decisive factor for the CJEU was that the children were integrated into the education system of the host state and it would have been both harmful and disproportionate to uproot them at such a crucial point in their education. The Court confirmed that such is the importance of achieving continuity in children's education that it can effectively 'anchor' the (otherwise non-qualifying) family's residence in the host state for the duration of a migrant child's studies.

366 Council Directive 77/486/EEC on the education of the children of migrant workers, OJ 1977 L 199, pp. 32–33. Note that third-country national migrant children are excluded from its scope.

367 Commission reports on the implementation of Directive 77/486/EEC, COM(84) 54 final and COM(88) 787 final.

368 CJEU, C-413/99, *Baumbast and R v. Secretary of State for the Home Department*, 17 September 2002.

The *Baumbast* decision was followed in successive cases[369] and has been codified in Article 12 (3) of Directive 2004/38/EC (Free Movement Directive).[370]

Third-country national children can generally only access *publicly-funded* education under the same conditions as nationals, and are excluded from associated benefits such as maintenance grants.[371] Some EU immigration instruments, however, go further than granting mere equality of access, requiring Member States to implement mechanisms to ensure due recognition and transferability of foreign qualifications, even in the absence of documentary evidence (Article 28 of the Qualification Directive).[372]

The educational rights of asylum-seeking children are weaker still; they must be granted access to the host state's education system on *similar,* but not necessarily the *same* terms as those that apply to nationals.[373] As such, education may be provided in accommodation centres rather than schools, and the authorities can postpone asylum-seeking children's full access to a school for up to three months from the date of application for asylum. Where access to the education system is impossible due to the specific situation of the child, Member States are obliged to offer alternative education arrangements (Article 14 (3) of the Reception Conditions Directive).[374]

369 CJEU, C-480/08, *Maria Teixeira v. London Borough of Lambeth and Secretary of State for the Home Department*, 23 February 2010; CJEU, C-310/08, *London Borough of Harrow v. Nimco Hassan Ibrahim and Secretary of State for the Home Department* [GC], 23 February 2010.

370 Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States amending Regulation (EEC) No. 1612/68 and repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC and 93/96/EEC, OJ 2004 L 158, Art. 2 (2) (c) and Art. 12 (3).

371 Refugee Qualification Directive 2011/95/EU, Art. 11; Long-Term Residents Directive (Directive 2003/109/EC), Art. 14; Directive 2003/86/EC on the right to family reunification, Art. 14; Temporary Protection Directive (2001/55/EC); Reception Directive (2013/33/EU), Art 14(c); and Return Directive (2008/115/EC).

372 Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (Recast) (Qualification Directive), OJ 2011 L 337/9.

373 Reception Conditions Directive (2013/33/EU). Note that, under the Refugee Qualification Directive (2011/95/EU, Art. 27), child refugees (who have acquired longer term residence rights) can access education under the same conditions as nationals.

374 Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (Recast) (Reception Directive), OJ 2013 L 180/96, pp. 96–116.

Under CoE law, Article 2, Protocol No. 1 has been used in conjunction with Article 14 to secure migrant children's access to education (see also Section 3.3).

> Example: In *Ponomaryovi v. Bulgaria*,[375] the ECtHR considered the requirement for two Russian school children without permanent residence to pay secondary school fees. The Court concluded that imposing fees for secondary school in their case had been discriminatory and thus contrary to Article 14 of the ECHR taken together with Article 2 of Protocol No. 1 to the ECHR.[376].

The ESC protects migrant children's educational rights both directly (Article 17, paragraph 2) and indirectly, imposing restrictions on children's employment rights with a view to enabling them to obtain the full benefits of compulsory education (Article 7).

Furthermore, the European Convention on the Legal Status of Migrant Workers[377] endorses migrant children's right to access "on the same basis and under the same conditions as nationals", general education and vocational training in the host state (Article 14 (1)).

Under international law, migrant children's equality of access to education is supported by the International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families (Article 30).[378]

Article 28 of the CRC provides that all children have the right to free compulsory education. According to Article 29 (1) (c), this right extends far beyond equality of access to education and includes provisions concerning the development of the child's cultural identity, language and values of the child's country of origin.

375 ECtHR, *Ponomaryovi v. Bulgaria*, No. 5335/05, 21 June 2011.

376 See also Section 3.3.

377 Council of Europe, European Convention on the Legal Status of Migrant Workers, CETS No. 93, 1977.

378 UN, Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 18 December 1990.

8.3. Right to health

Key points

- States have positive obligations to take measures against life-endangering health risks that the authorities are or ought to be aware of.
- State authorities must undertake an effective investigation in case of a person's death.
- Under the ESC, children who are unlawfully in the country are entitled to healthcare beyond urgent medical assistance.
- Acceptability of healthcare requires informed consent or authorisation.
- Under EU law and the ESC, subject to several limitations, migrant children are entitled to access social assistance and healthcare.

Under EU law, Article 35 of the EU Charter of Fundamental Rights guarantees a right of access to healthcare.

Children of EU migrant nationals can access social welfare and health support on the same basis as nationals, following three months of residence in the host state.[379] Similar rights are extended to the children of third-country nationals who have acquired permanent residence in a Member State, although these may be restricted to so-called 'core benefits'.[380] As far as refugee and asylum-seeking children are concerned, Member States have to provide access to appropriate social assistance on an equal basis as nationals of the host state, but, again, this can be limited to 'core benefits' (Article 29 of the Qualification Directive). The legislation requires Member States to provide vulnerable migrant children with access to sufficient healthcare support. For instance, children who have suffered violence or torture must be provided with sufficient support to address their physical and mental needs (Chapter IV Recast Reception Directive, Articles 21, 23 (4) and 25). The Qualification Directive contains similar provisions for vulnerable child migrants.

379 Free Movement Directive, Art. 24.

380 Council Directive 2003/109/EC of 25 November 2003 concerning the status of third-country nationals who are long-term residents, OJ L 16, 23.1.2004, Art. 11 (4)).

Under CoE law, the ECHR does not expressly guarantee a right to healthcare or a right to health. However, the ECtHR has dealt with a number of health-related cases in a variety of circumstances. First, the Court examines life-endangering health issues for children. It identifies positive obligations incumbent on the state to take preventive measures against life-endangering health risks that it knows or should know about.

Example: In *Oyal v. Turkey*, the state failed to take preventive measures against the spread of HIV through blood transfusions. As a consequence, a new-born baby was infected with the HIV virus during blood transfusions at a state hospital. While some redress was offered, the ECtHR found that, in the absence of full medical cover for treatment and medication during the lifetime of the child concerned, the state had failed to offer satisfactory redress and thereby violated the right to life (Article 2 of the ECHR).[381] In addition, it ordered the Turkish State to provide free and full medical cover during the lifetime of the victim.

Example: In *Iliya Petrov v. Bulgaria*,[382] a 12-year old boy got seriously injured in an electricity substation. The substation was located in an outdoor park where children and young people often met, and the door was not locked. The ECtHR held that the exploitation of an electricity grid is an activity that poses a heightened risk to persons who are close to the installations. The state has an obligation to put adequate regulation in place, including a system to control the proper application of security rules. The Court ruled that the failure of the state to ensure that the electricity substation was secured, although it knew about the safety problems, amounted to a violation of the right to life (Article 2 of the ECHR).[383]

Moreover, states have positive obligations to account for the treatment of children in a vulnerable situation who are in the care of state authorities (see also Chapter 6 and Section 7.3).

381 ECtHR, *Oyal v. Turkey*, No. 4864/05, 23 March 2010, paras. 71–72.

382 ECtHR, *Iliya Petrov v. Bulgaria*, No. 19202/03, 24 April 2012 (available in French).

383 *Ibid.*

Example: The case of *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania*[384] concerned an HIV-positive Roma teenager who had a severe intellectual disability and also suffered from tuberculosis, pneumonia and hepatitis, and died at the age of 18. He had been in state care throughout his life. The ECtHR found serious shortcomings in the decision-making concerning the provision of medication and care, and a continuous failure of the medical staff to provide him with appropriate care and treatment. Article 2 of the ECHR had therefore been violated.[385]

Furthermore, in the absence of an emergency, the ECtHR found that medical treatment without parental consent is in breach of Article 8 of the ECHR.

Example: In *Glass v. the United Kingdom*,[386] diamorphine had been administered to a child with severe disability, notwithstanding firm objections by his mother. The ECtHR found that the decision of the hospital authorities to override the mother's objection to the proposed treatment in the absence of authorisation by a Court resulted in a breach of Article 8 of the ECHR.[387]

Example: In *M.A.K. and R.K. v. the United Kingdom*,[388] a nine year old girl underwent a blood test and photographs without parental consent, notwithstanding her father's express instructions not to carry out any further tests while the girl was alone in the hospital. In the absence of any medical urgency, these medical interventions without parental consent were held to be in violation of her right to physical integrity under Article 8 of the ECHR.[389]

In accordance with Articles 6 and 8 of the Convention on Human Rights and Biomedicine,[390] when a child does not have the legal capacity to consent to

384 ECtHR, *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], No. 47848/08, 17 July 2014. See further the description of this ECHR ruling in Chapter 7.

385 See also Section 7.

386 ECtHR, *Glass v. the United Kingdom*, No. 61827/00, 9 March 2004.

387 *Ibid.*, para. 83.

388 ECtHR, *M.A.K. and R.K. v. the United Kingdom*, Nos. 45901/05 and 40146/06, 23 March 2010.

389 *Ibid.*, para. 79.

390 Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, CETS No. 164, 1997.

a medical intervention, that intervention may only be carried out with the authorisation of his or her representative, save in an emergency situation. Whereas this convention does not require the consent of the child if he or she is legally incapable of consenting, it does hold that the opinion of the child must be taken into consideration "as an increasingly determining factor in proportion to his or her age and degree of maturity" (Article 6 (2)).

Furthermore, under Article 11 of the ESC, States Parties agree to take appropriate measures to provide for advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health.[391] Medical assistance and care is guaranteed under Article 13 of the ESC to those who are without adequate resources and unable to secure those resources by their own efforts or from other sources. Finally, in 2011 the Committee of Ministers adopted child-specific guidelines on child-friendly healthcare.[392]

As indicated in the following examples, the ECSR holds that migrant children staying irregularly in a country are entitled to healthcare beyond urgent medical assistance. The ESC includes many references to children's rights to social welfare and health services (Articles 11, 12, 13, 14, 16 and 17), which apply regardless of their migration status.

Example: The ECSR decision in *International Federation of Human Rights Leagues (FIDH) v. France*[393] concerns France passing a law which ended the exemption of immigrants in an irregular situation with very low incomes from paying for medical treatment, and imposed health care charges. The ECSR ruled that individuals who have not reached the age of majority, including unaccompanied children, must be provided with free medical care.

391 On sexual and reproductive health education, see also under education (Section 8.2).

392 Council of Europe, Committee of Ministers (2011), Guidelines on child-friendly health care, 21 September 2011.

393 ECSR, *International Federation of Human Rights Leagues (FIDH) v. France*, Complaint No. 14/2003, 8 September 2004, paras. 35–37.

Example: In *Defence for Children International (DCI) v. Belgium*,[394] the ECSR found a violation of Article 17 of the ESC because of restrictions on medical assistance to undocumented migrant children. The Committee confirmed "the right of migrant minors unlawfully in a country to receive health care extending beyond urgent medical assistance and including primary and secondary care, as well as psychological assistance".[395] It also stated that the lack of reception facilities for foreign minors unlawfully in the country made access to health care difficult. Moreover, it found that causes of ill-health can only be removed to the extent that children are provided with housing and foster homes. Accordingly, it held that there was a violation of Article 11 (1) and (3) of the ESC due to the lack of housing and foster homes.[396]

The European Convention on the Legal Status of Migrant Workers[397] similarly provides that migrant workers who are lawfully employed in the territory of another state, as well as their families, should receive equal access to social and medical assistance (Article 19).

Under international law, more comprehensive provisions on the right to health can be found in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)[398] and in Article 24 of the CRC. These instruments emphasise prevention and treatment. The UN Committee on the Rights of the Child emphasises the importance of access to the highest attainable standard of healthcare and nutrition during early childhood,[399] and access for adolescents to sexual and reproductive information.[400] It has also clarified that children's right to health entails "the right to control one's health and body,

394 ECSR, *Defence for Children International (DCI) v. Belgium*, Complaint No. 69/2011, 23 October 2012.

395 *Ibid.*, para. 128.

396 *Ibid.*, paras. 116–118.

397 Council of Europe, European Convention on the Legal Status of Migrant Workers, CETS No. 93, 1977.

398 UN, General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, Vol. 993, p. 3.

399 UN, Committee on the Rights of the Child (2006), *General Comment No. 7 (2005): Implementing child rights in early childhood* , UN Doc. CRC/C/GC/7/Rev.1, para. 27.

400 UN, Committee on the Rights of the Child (2003), *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, UN Doc. CRC/GC/2003/4, para. 28.

including sexual and reproductive freedom to make responsible choices".[401] It encourages states to "consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion".[402]

8.4. Right to housing

Key points

- The right to adequate housing is guaranteed in Article 31 of the ESC.
- The ECSR holds that adequate shelter is to be provided to children residing irregularly in a country and that the living conditions in shelters must be in keeping with human dignity.
- According to the ECtHR, inadequate housing does not justify placement into public care.

Under EU law, Article 34 (3) of the EU Charter of Fundamental Rights contains a reference to the right to housing assistance as part of the struggle against social exclusion and poverty. The Racial Equality Directive highlights housing among the goods and services available to the public to which non-discriminatory access and supply should be granted.[403] Non-differential treatment regarding housing benefits applies to long-term residents. However, EU law tries to ensure, regarding family reunification for instance, that family members will not constitute a burden for the Member States' social assistance systems.[404] The Family Reunification Directive requires applications for family reunification to provide evidence that a valid sponsor of family reunification (i.e. a third-country national allowed to reside for a period of one year or more and with a reasonable prospect of obtaining the right of permanent residence)

401 UN, Committee on the Rights of the Child (2013), *General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, UN Doc. CRC/C/GC/15, para. 24.

402 *Ibid.*, para. 31.

403 Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin, Art. 3.

404 See further FRA and ECtHR (2014), p. 201.

has accommodation regarded as normal for a comparable family in the same region. The accommodation should meet the general health and safety standards in force in the Member State concerned.[405]

Under CoE law, there is no right to be provided with housing under the ECHR, but if a state decides to provide housing, it must do so in a non-discriminatory way.

> Example: In *Bah v. the United Kingdom*[406] the applicant, who was lawfully residing in the UK, was allowed to be joined by her son on the condition that he did not have recourse to public funds. Shortly after her son's arrival, the applicant sought assistance in finding accommodation. However, because her son was subject to immigration control, she was refused the priority to which her status as an unintentionally homeless person with a minor child would ordinarily have entitled her. The authorities ultimately helped her find new accommodation and later provided her with social housing. The applicant complained that the refusal to grant her priority had been discriminatory. The ECtHR held that it was legitimate to put in place criteria for the allocation of limited resources such as social housing, provided that such criteria were not arbitrary or discriminatory. There had been nothing arbitrary in the denial of priority to the applicant, who had brought her son into the country in full awareness of the condition attached to his leave to enter. Moreover, the applicant had never in fact been homeless and there were other statutory duties which would have required the local authority to assist her and her son had the threat of homelessness actually manifested itself. Consequently, there had been no violation of Article 14 taken in conjunction with Article 8 of the ECHR.

The ECtHR also examines cases of eviction of Roma families from caravan sites.[407] The ECtHR has indirectly dealt with the issue of the quality of housing, stating that inadequate housing does not justify placing children into public care[408] (see also Sections 5.2. and 6.2.).

405 Council Directive 2003/86/EC on the right to family reunification of 22 September 2003 (Family Reunification Directive) Art. 7 (1) (a).

406 ECtHR, *Bah v. the United Kingdom*, No. 56328/07, 27 September 2011.

407 ECtHR, *Connors v. the United Kingdom*, No. 66746/01, 27 May 2004.

408 ECtHR, *Wallová and Walla v. the Czech Republic*, No. 23848/04, 26 October 2006, paras. 73–74 (available in French); ECtHR, *Havelka and Others v. the Czech Republic*, No. 23499/06, 21 June 2007, paras. 57–59 (available in French).

The right to adequate housing is guaranteed in Article 31 of the ESC. The ECSR holds that "[a]dequate housing under Article 31 (1) means a dwelling which is safe from a sanitary and health point of view, i.e. it must possess all basic amenities, such as water, heating, waste disposal, sanitation facilities and electricity and must also be structurally secure, not overcrowded and with secure tenure supported by the law".[409] Evictions are permissible if justified, carried out in conditions that respect dignity, and if alternative accommodation is made available.[410] Living conditions in a shelter "should be such as to enable living in keeping with human dignity [...] [and] must fulfil the demands for safety, health and hygiene, including basic amenities, i.e. clean water, sufficient lighting and heating. The basic requirements of temporary housing include also security of the immediate surroundings."[411]

With regard to housing for foreign children in an irregular situation, the ECSR holds that both the failure to provide any form of accommodation and the provision of inappropriate accommodation in hotels amount to a violation of Article 17 (1) of the ESC.[412] Moreover, under Article 31 (2) of the ESC on the prevention of homelessness, states are required to provide adequate shelter to children in an irregular situation without resorting to detention.[413]

409 ECSR, *Defence for Children International (DCI) v. the Netherlands*, Complaint No. 47/2008, 20 October 2009, para. 43.

410 ECSR, *European Roma Rights Centre (ERRC) v. Italy*, Complaint No. 27/2004, 7 December 2005, para. 41; ECSR, *Médecins du Monde – International v. France*, Complaint No. 67/2011, 11 September 2012, paras. 74–75 and 80.

411 ECSR, *Defence for Children International (DCI) v. the Netherlands*, Complaint No. 47/2008, 20 October 2009, para. 62.

412 ECSR, *Defence for Children International (DCI) v. Belgium*, Complaint No. 69/2011, 23 October 2012, paras. 82–83. See also FRA (2010), p. 30.

413 ECSR, *Defence for Children International (DCI) v. the Netherlands*, Complaint No. 47/2008, 20 October 2009, para. 64.

8.5. Right to an adequate standard of living and right to social security

Key points

- Access to child allowances and parental leave must be non-discriminatory.
- Under EU law, the social security coverage of young workers in apprenticeship contracts should not be so low that it excludes them from the general range of protection.
- Under the ESC, the suspension of family allowances in case of truancy is a disproportionate limitation to the right of the family to economic, social and legal protection.

Under EU law, Article 34 (1) of the EU Charter of Fundamental Rights stipulates that the "Union recognises and respects the entitlement to social security benefits and social services" in cases that correspond to the traditional branches of social security (maternity, illness, industrial accidents, dependency or old age, and loss of employment). Entitlement extends to everyone residing and moving legally within the EU. The right to social assistance is recognised to ensure a decent existence for those who lack sufficient resources and to combat social exclusion and poverty. All these aspects are qualified by the "rules laid down by Union Law and national laws and practices" (Article 34 (1) of the Charter).

The CJEU holds that, where a Member State's own nationals are only required to reside in the Member State to access a child-raising allowance, nationals of other EU Member States cannot be made to produce a formal residence permit to access the same benefits.[414] The refusal of parental leave to certain categories of persons, such as commissioning mothers who have a baby through a surrogacy arrangement, is discriminatory.[415] The same applies to male civil servants who are refused parental leave if their wives do not work or exercise any profession, unless the wives are unable to meet the needs related to the upbringing of the child due to serious illness or injury.[416] Similarly, Member States have to establish a parental leave regime in the event of the birth of

414 CJEU, C-85/96, *María Martínez Sala v. Freistaat Bayern*, 12 May 1998, paras. 60–65.

415 CJEU, C363/12, *Z v. A Government Department, The Board of Management of a Community School* [GC], 18 March 2014.

416 CJEU, C-222/14, *Konstantinos Maïstrellis v. Ypourgos Dikaiosynis, Diafaneias kai Anthropinon Dikaiomaton*, 16 July 2015, para. 53.

twins that ensures these parents receive treatment particular to their needs. This can be ensured through basing the length of parental leave on the number of children born, and providing for other measures, such as material assistance or financial aid.[417]

Under CoE law, the ECtHR examined alleged discrimination in the granting of parental leave and parental allowances in Russia.

> Example: In *Konstantin Markin v. Russia*,[418] parental leave was refused to a serviceman in the Russian army, while servicewomen were entitled to such leave. In the Court's view, the exclusion of servicemen from the entitlement to parental leave could not be reasonably justified. Neither the special armed forces context and assertions about the risk to operational effectiveness, nor the arguments about the special role of women in raising children or the prevailing traditions in the country were found to justify the differential treatment. The Court found that Article 14 in conjunction with Article 8 of the ECHR had been violated.

More extensive provisions on the right to social security, the right to social and medical assistance, and the right to benefit from social welfare services can be found in Articles 12–14 of the ESC. Article 16 of the ESC explicitly mentions social and family benefits as a way the economic, legal and social protection of the family life can be promoted. Article 30 of the ESC provides for a right to protection against poverty and social exclusion. Certain social security claims may fall within the scope of Article 1, Protocol No. 1 to the ECHR, provided that national legislation generates a proprietary interest by providing for the payment as of right of a welfare benefit, whether conditional or not on the prior payment of contributions.[419]

Article 12 of the ESC requires states to establish or maintain a social security system, and to endeavour to raise it progressively to a higher level.

Article 16 of the ESC requires states to ensure the economic, legal and social protection of the family by appropriate means. The primary means should be family or child benefits, provided as part of social security and available either

417 CJEU, C-149/10, *Zoi Chatzi v. Ypourgos Oikonomikon*, 16 September 2010, paras. 72–75.

418 ECtHR, *Konstantin Markin v. Russia* [GC], No. 30078/06, 22 March 2012.

419 ECtHR, *Stummer v. Austria* [GC], No. 37452/02, 7 July 2011, para. 82.

universally or subject to a means-test. These benefits must constitute an adequate income supplement for a significant number of families. The ECSR assesses the adequacy of family (parental) benefits with respect to the median equivalised income (Eurostat).[420] The ECSR finds that the absence of any general system of family benefits is not in conformity with the ESC.[421]

The ECSR accepts, however, that the payment of child benefits may be made conditional based on the child's residence.[422] It holds that the introduction of only very limited protection against social and economic risks given to children (15–18 years old) in special apprenticeship contracts (they were only entitled to sickness benefits in kind and to occupational accident coverage at a rate of 1 %) effectively excludes a distinct category of (minor) workers from the "general range of protection offered by the social security system at large". It is hence in violation of the state's obligation to progressively raise the system of social security.[423]

The suspension of family allowances in cases of truancy is also a disproportionate limitation on the right of the family to economic, social and legal protection.

Example: In a complaint against France, the European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) argued that suspending family allowances as a measure to address truancy was a violation of the right of families to social, legal and economic protection under Article 16 of the ESC. In finding the measure disproportionate to the aim pursued, the Committee noted that "the contested measure of suspending and possibly suppressing family allowances makes parents exclusively responsible for pursuing the aim of reducing truancy and increases the economic and social vulnerability of the families concerned".[424]

420 ECSR, Conclusions 2006, Estonia, p. 215

421 ECSR, Conclusions 2011, Turkey, Art. 16.

422 ECSR (2007), Conclusions XVIII-1 – General Introduction, p. 11.

423 ECSR, *General Federation of Employees of the National Electric Power Corporation (GENOP-DEI) and Confederation of Greek Civil Servants' Trade Unions (ADEDY) v. Greece*, Complaint No. 66/2011, 23 May 2012, para. 48.

424 ECSR, *European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) v. France*, Complaint No. 82/2012, 19 March 2013, para. 42.

The European Convention on the Legal Status of Migrant Workers[425] provides that migrant workers lawfully employed in another state as well as their families should receive equal access to social security (Article 18), and other "social services" that facilitate their reception in the host state (Article 10). Similarly, the European Convention on Social Security protects refugees and stateless persons' rights to access social security provision in the host state (including family benefits for children).[426]

Under international law, the right to an adequate standard of living is guaranteed in Article 11 of the ICESCR and Article 27 of the CRC.

425 Council of Europe, European Convention on the Legal Status of Migrant Workers, CETS No. 93, 1977.

426 Council of Europe, European Convention on Social Security, CETS No. 78, 1972.

9 Migration and asylum

EU	Issues covered	CoE
TFEU, Article 21 Charter of Fundamental Rights, Article 45 (freedom of movement) Reception Conditions Directive (2013/33/EU) Return Directive (2008/115/EC) Asylum Procedures Directive (2013/32/EU) Dublin Regulation (No. 604/2013) Qualification Directive (2011/95/EU) Freedom of Movement Directive (2004/38/EC) CJEU, C-648/11, *The Queen, on the application of MA and Others v. Secretary of State for the Home Department*, 2013 (Dublin transfers) Schengen Borders Code Regulation (562/2006), Annex VII, 6	Entry and residence	ECHR, Article 8 (family life)
Asylum Procedures Directive (2013/32/EU), Article 25(5)	Age assessment	
TFEU, Articles 67, 73 and 79 (2) (a) Family Reunification Directive (2003/86/EC) Qualification Directive (2011/95/EU), Article 31 Reception Conditions Directive (2013/33/EU) Temporary Protection Directive (2001/55/EC) Dublin Regulation (No. 604/2013) Return Directive (2008/115/EC), Article 13	Family reunification and separated children	ECHR, Article 8 (right to respect for private and family life) ECtHR, *Şen v. the Netherlands*, No. 31465/96, 2001 (balancing rights) ECtHR, *Jeunesse v. the Netherlands* [GC], No. 12738/10, 2014 (family life, child's best interests)

EU	Issues covered	CoE
Reception Conditions Directive, (2013/33/EU), Article 11 Return Directive (2008/115/EC), Article 17	Detention of children	ECtHR, *Mubilanzila Mayeka and Kaniki Mitunga v. Belgium*, No. 13178/03, 2006 (detention in view of expulsion) ECtHR, *Popov v. France*, Nos. 39472/07 and 39474/07, 2012 (detention in view of expulsion) ECtHR, *Kanagaratnam and Others v. Belgium*, No. 15297/09, 2011 (detention in view of expulsion)
Freedom of Movement Directive (2004/38/EC), Preamble (para. 24), Articles 7, 12, 13 and 28 (3) (b)	Expulsion	ECtHR, *Gül v. Switzerland*, No. 23218/94, 1996 (deportation of family) ECtHR, *Boultif v. Switzerland*, No. 54273/00, 2001 (deportation of childen) ECtHR, *Tarakhel v. Switzerland* [GC], No. 29217/12, 2014 (deportation of children)
Charter of Fundamental Rights, Articles 47–48 (right to an effective remedy and to a fair trial, presumption of innocence and right of defence) Asylum Procedures Directive (2013/32/EU), Article 7 and 25 Victims' Directive (2012/29/EU), Article 8	Access to justice	ECHR, Article 13 (right to an effective remedy) ECtHR, *Rahimi v. Greece*, No. 8687/08, 2011 (effective remedies to challenge conditions of detention)

The EU has clear competence to legislate in the area of migration and asylum. Provisions covering migrant children govern a range of migration situations, including long-term work-related migration, asylum, and subsidiary protection, and also addresses the situation of migrants in an irregular situation. In addition to the protection migrant children are entitled to under Article 24 of the EU Charter of Fundamental Rights, Articles 18 and 19 of the Charter deal with the right to asylum and protection in the event of removal, expulsion or

extradition. The EU has also paid attention to the specific needs of unaccompanied children, including regarding legal aspects such as legal guardianship and legal representation, age assessment, family tracing and reunification, asylum procedures, detention, and expulsion, as well as aspects relating to the living conditions of the children, including accommodation, healthcare, education and training, religion, cultural norms and values, recreation and leisure and social interaction and experiences of racism.[427]

Within the CoE system, four conventions in particular support the rights of migrant children in different contexts: the ECHR, the ESC, the European Convention on the Legal Status of Migrant Workers and the European Convention on Nationality. This chapter mainly focuses on the implementation of ECHR provisions, notably Article 3 (protection against inhuman, degrading treatment), Article 5 (deprivation of liberty), and Article 8 (right to respect for private and family life), taken alone or in conjunction with Article 14 (non-discrimination). These provisions are used to support migrant, refugee and asylum seeking children's and their family members' rights to family reunification, access to justice and ongoing residence in the host state.

At the international level, a number of CRC provisions uphold children's rights in the context of migration and asylum and have informed the development of legal measures at the European level. Specifically, Article 7 protects children's right to birth registration, nationality, and parental care; Article 8 protects the child's right to identity, including nationality, name and family relations; Article 9 ensures that separated children should maintain contact with both parents where it is in their best interests; and Article 22 provides refugee children with the right to special protection and help. Further, the UN Convention Relating to the Status of Refugees[428] along with its 1967 Protocol are universally regarded as the centrepiece of international refugee protection.

The following sections focus on entry and residence (Section 9.1); age assessment (Section 9.2); family reunification for separated children (Section 9.3); detention (Section 9.4); expulsion (Section 9.5) and access to justice (Section 9.6).

427 See further, FRA (2010); FRA (2011a), pp. 27–38; FRA (2011b), pp. 26–30.

428 UN, General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, Vol. 189, p. 137.

9.1. Entry and residence

Key points

- EU nationals enjoy the right to freedom of movement within the EU.
- Decisions on child entry and residence should be taken in the framework of appropriate mechanisms and procedures and in the child's best interests.

Under EU law, the nature and scope of children's rights differs largely according to the nationality of the child and the child's parents and according to whether the child is migrating with his/her parents or independently.

The migration of EU nationals is regulated by various legal instruments. The rights granted to EU nationals are far-reaching and aim to stimulate optimum mobility across the EU. First, Article 21 of the TFEU provides that EU citizens and their family members have a right to move and reside freely within the territory of any EU Member State. Moreover, once they arrive in the host state, they have a right to be treated equally to nationals of that state in relation to their access to and conditions of work, social and welfare benefits, school, healthcare, etc.[429] Article 45 of the EU Charter of Fundamental Rights equally guarantees the freedom of movement of EU citizens.

Further, the rights of children who move with EU-national parents/carers are also governed by the Free Movement Directive.[430]This stipulates that family members have a right to enter and reside in the host state either with or following the primary EU migrant's move there (Article 5 (1)). Family members, for the purposes of this instrument, include any biological children of either the EU migrant or their spouse or partner, provided they are under the age of 21 or are "dependent" (Article 2 (2)). They may be both EU and non-EU nationals, provided the primary migrant with whom they have moved is an EU

429 Some restrictions have been imposed on migrants from Croatia, the most recent country to accede to the EU, for a transitional period up until June 2015, with the possibility for Member States of extending the period in which restrictions will be imposed until 2020.

430 Please note that relevant provisions of the directive also apply in the EEA. See further Agreement on the European Economic Area, 2 May 1992, Part III, Free Movement of Persons, Services and Capital and Agreement between the European Community and its Member Sates, on the one part, and the Swiss Confederation, on the other, on the free movement of persons, signed in Luxembourg on 21 June 1999, entered into force on 1 June 2002, OJ 2002 L 114/6.

national. For the first three months following their move, the family's right of residence is unconditional, but thereafter EU citizens who wish their children to remain with them in the host state must demonstrate that they have sufficient financial resources and comprehensive sickness insurance to support them (Article 7). Children and other family members automatically acquire permanent residence after a period of five consecutive years of residence in the host state with the EU citizen (Articles 16 (2) and 18). At that point, they are no longer subject to any resources/sickness insurance conditions.

The freedom of movement of third-country nationals who do not belong to the family of an EU migrant is subject to more restrictions. This area is partially regulated by EU law and partially regulated by national immigration laws.

In the context of international protection procedures, children are regarded as "vulnerable persons" whose specific situation Member States are required to take into account when implementing EU law.[431] This requires states to identify and accommodate any special provision that asylum-seeking children in particular might need when they enter the host state. Article 24 of the EU Charter of Fundamental Rights applies to the entry and residence requirements of the EU asylum *acquis* as it relates to children. It requires that in all actions relating to children, whether taken by public authorities or private institutions, EU Member States ensure that the best interests of the child are a primary consideration. More specifically, the best interests principle underpins the implementation of Directive 2013/32/EU on common procedures for granting and withdrawing international protection (Asylum Procedures Directive)[432] and the Regulation establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person (Dublin Regulation) as they relate to children.[433] Both texts also contain specific guarantees for unaccompanied children, including their legal representation. The Regulation (562/2006) on the Schengen Borders Code

431 See specifically Reception Conditions Directive 2013/33/EU, Art. 21 and Return Directive 2008/115/EC, Art. 3 (9).

432 Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection (recast), 29 June 2013, L 180/60, Art. 25(6).

433 Regulation (EU) No. 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person (recast), OJ 2013 L. 180/31-180/59, Art. 6.

requires border guards to check that the persons accompanying children have parental care over them, especially where children are accompanied by only one adult and there are serious grounds for suspecting that the children may have been unlawfully removed from the custody of their legal guardian(s). In this case, the border guard must investigate further to detect any inconsistencies or contradictions in the information given. If children are travelling unaccompanied, border guards must ensure, by means of thorough checks on travel and supporting documents, that the children are not leaving the territory against the wishes of the person(s) responsible for their parental care.[434]

Under CoE law, states have the right, as a matter of well-established international law and subject to their treaty obligations, including the ECHR, to control the entry, residence and expulsion of aliens. The right to respect for private and family life in Article 8 of the ECHR is often invoked as a safeguard against expulsion in cases concerning children who otherwise would have been assessed as not in need of international protection, including subsidiary protection. Article 8 violations have been found in cases involving children, as forced separation from close family members is likely to have an acute impact on their education, social and emotional stability and identity.[435]

9.2. Age assessment[436]

Key points

- Age assessment procedures must take account of the child's rights.
- Age assessment refers to the procedures through which authorities seek to establish the legal age of a migrant to determine which immigration procedures and rules need to be followed.

Under EU law, Article 25 (5) of the Asylum Procedures Directive allows Member States to resort to medical examinations, but requires that these be performed

434 Regulation (562/2006) of the European Parliament and the Council of 15 March 2016 establishing a Community Code on the rules governing the movement of persons across borders (Schengen Borders Code) Annex VII, 6.

435 ECtHR, *Şen v. the Netherlands*, No. 31465/96, 21 December 2001 (available in French); ECtHR, *Tuquabo-Tekle and Others v. the Netherlands*, No. 60665/00, 1 December 2005.

436 See also FRA and ECtHR (2014), Section 9.1.2.

"with full respect for the individual's dignity, shall be the least invasive examination, and shall be carried out by qualified medical professionals". This provision also requires that individuals are informed in a language they can understand that such an assessment may be carried out and their consent to examination should be obtained. The refusal to undergo age assessment cannot result in a rejection of the application for international protection.

There is significant variation in the nature and scope of age assessment methods applied across the EU.[437] In the UK for instance, the judiciary has reviewed domestic procedures on age assessment, and in the case of *Merton* it determined the minimum procedural requirements for assessing age when an individual claims to be an unaccompanied child.[438] Such requirements include, among others, the right of the asylum seeker to be informed about the reasons for rejection or objections of the interviewer.[439] National courts have also stated the need to apply the benefit of doubt in age assessment cases, although this has been interpreted by some national courts as a mere "sympathetic assessment of evidence" rather than a formal "benefit of doubt" principle.[440]

Under CoE law, there is no specific provision or ECtHR case law relating to children's rights in the context of age assessment procedures. However, particularly invasive practices used to this end might raise an issue under Articles 3 or 8 of the ECHR. Article 3 has been interpreted to include a broad range of scenarios that might be considered inhumane or degrading, including invasive physical examinations of children.[441] Under Article 8, applied to an immigration context, the authorities could legitimately interfere with a child's right to privacy and conduct age assessments if in accordance with the law and necessary to protect one of the legitimate aims listed in Article 8 (2) of the ECHR.

Under international law, Article 8 of the CRC obliges states to respect the child's right to identity. This implies an obligation to assist a child in asserting

437 For an overview of the various methods applied in each country, see the European Asylum Support Office Guidelines on Age Assessment Practice in Europe, Luxembourg, 2014. See further, FRA (2010), pp. 53–55.

438 United Kingdom, Court of Appeal, *R (on the application of B) v. The Mayor and Burgesses of the London Borough of Merton* [2003] EWHC 1689, 14 July 2003.

439 See FRA (2010), pp. 61–66.

440 United Kingdom, Court of Appeal, *R (on the application of CJ) v. Cardiff County* Council [2011] EWCA Civ 1590, 20 December 2011, reaffirmed in United Kingdom, Upper Tribunal, *R (on the application of MK) v. Wolverhampton City Council* [2013] UKUT 00177 (IAC), 26 March 2013.

441 ECtHR, *Yazgül Yilmaz v. Turkey*, No. 36369/06, 1 February 2011 (available in French).

his or her identity, which may involve confirming the child's age. Age assessment procedures, however, should be a last resort.

In any case, the best interests principle should underpin national procedures on age assessment. The UN Committee on the Rights of the Child affirms that age assessment should take into account the physical appearance of the child and his or her psychological maturity. The assessment must be conducted in a scientific, safe, child- and gender-sensitive and fair manner, avoiding any risk of violation of the physical integrity of the child, and giving due respect to human dignity.[442]

9.3. Family reunification for separated children[443]

Key points

- European-level provisions focus mainly on reuniting children safely with their parents, either in the host country or their country of origin.
- Preference will be given to the child's parents and/or primary carers when determining which family members should be reunited with the family.
- The child's best interests must guide family reunification cases.

Under EU law, the most notable instrument is the Family Reunification Directive, which requires Member States to authorise the entry and residence of the unaccompanied child's parents who are third-country nationals – in those situations where it is not in the child's best interest to join his/her parents abroad instead. In the absence of a parent, Member States have the discretion to authorise the entry and residence of the child's legal guardian or any other member of the family.[444] The definition and rights attached to 'family' are therefore more generous in the context of unaccompanied children than for most other categories of child migrants.

442 UN, Committee on the Rights of the Child, *General Comment No. 6 (2005): Treatment of unaccompanied and separated children outside their country of origin*, UN Doc. CRC/GC/2005/6, 1 September 2005, (V)(a)(31)(A).

443 See also FRA and ECtHR (2014), Section 5.3 on family reunification.

444 Arts. 10 (3) (a) and (b), respectively.

As to asylum-seeking children, the Qualification Directive emphasises the need to ensure, where possible, that an unaccompanied child is placed with adult relatives in the host state, that he or she remains with any siblings, and that absent family members are located in a sensitive and safe manner as soon as practicable (Article 31). The Reception Conditions Directive makes similar provisions for unaccompanied children who have not yet acquired refugee status (Article 24).

Council Directive 2001/55/EC on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof (Temporary Protection Directive) also seeks to expedite the reunification of family members (including children) who have been separated from one another following a sudden evacuation from their country of origin (Article 15).[445] However, this directive has to date not been applied; for it to be 'triggered', a Council decision is required – and such a decision has not yet been taken.

Article 24.3 of the Reception Conditions Directive (Recast) also requires that Member States start tracing the members of the unaccompanied child's family, where necessary. This is done with the assistance of international or other relevant organisations as soon as possible after an application for international protection is made, whilst protecting the child's best interests. In cases of a possible threat to the life or integrity of a child or his/her close relatives, particularly if they have remained in the country of origin, care must be taken to ensure that the collection, processing and circulation of information concerning them is undertaken on a confidential basis to avoid jeopardising their safety. Further, in accordance with Article 31 (5) of the Qualifications Directive (Recast), the granting of international protection to the child should not interfere with the start or continuation of the tracing process.

The Dublin Regulation provides, in addition, that if an unaccompanied child has a relative or relatives living in another Member State who can take care of him or her, Member States are obliged, where possible, to unite the child with them, unless this is contrary to the child's best interests (Article 8). In addition,

445 Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof, OJ 2001 L 212.

the Regulation contains an obligation to trace the relatives on the territory of Member States, while protecting the best interests of the child (Article 6). Furthermore, the Reception Conditions Directive contains an obligation to start tracing the members of the child's family, where necessary with the assistance of international or other relevant organisations (Article 24). The latter type of assistance is also envisaged under the Dublin Regulation (Article 6).

The best interests principle must always be applied when considering a decision concerning family reunification. For example, parents must be able to prove that they are capable of exercising their parental duties to the benefit of the child. National courts will find a child's return to his or her country of origin unlawful when authorities have failed to gather evidence that there are adequate arrangements for the child's reception and care in that country (Return Directive, Article 10 (2)).

Under CoE law, Article 8 of the ECHR does not allow migrant parents and their children an absolute right to choose where they want to live. National authorities can legitimately deport or refuse entry to family members provided there are no insurmountable obstacles to establishing family life elsewhere.[446] Such decisions must always be a proportionate response to wider public policy concerns, including the desire to deport or prevent the entry of a parent who has been involved in criminal activity.

Example: In *Şen v. Netherlands* the ECtHR confirmed that in striking a balance between the rights of the child/family and wider public policy interests, three key factors must be taken into account: the age of the children; their situation in the country of origin; and the degree to which they actually depend on their parents.

Example: The case of *Jeunesse v. the Netherlands*[447] concerns the Dutch authorities' refusal to allow a Surinamese woman married to a Dutch national, with whom she had three children, to reside in the Netherlands on the basis of her family life in the country. The ECtHR considered that the authorities had not paid enough attention to the impact of their re-

446 ECtHR, *Bajsultanov v. Austria*, No. 54131/10, 12 June 2012; ECtHR, *Latifa Benamar and Others v. the Netherlands*, Decision of inadmissibility, No. 43786/04, 5 April 2005.

447 ECtHR, *Jeunesse v. the Netherlands* [GC], No. 12738/10, 3 October 2014.

fusal on the applicant's children and their best interests. The ECtHR found a violation of Article 8 of the ECHR on account that a fair balance had not been struck between the personal interests of the applicant and her family in maintaining their family life in the Netherlands and the public order interests of the Government in controlling immigration.

Under international law, a child has the right not to be separated from his or her family unless separation is deemed to be in the child's best interests (Article 9 (1) CRC). Article 10 of the CRC provides that a child whose parents live in different countries should be allowed to move between those countries to stay in contact with them both, or to reunify, subject to national immigration law. The best interests principle, as enshrined in Article 3 of the CRC, underpins all decisions relating to family reunification with a child or unaccompanied child.[448]

9.4. Detention

Key points

- European law authorises the detention of children in an immigration context only as a measure of last resort.
- National authorities are obliged to place children in appropriate alternative accommodation.

Under EU law, Article 11 of the Reception Conditions Directive (Recast) requires that children should only be detained as a last measure and only if less coercive measures cannot be applied effectively. Such detention should be for the shortest period of time possible, and all efforts made to release those detained and to place them in a suitable accommodation. Where children are detained, they should have the possibility to engage in leisure activities, including play and recreational activities appropriate to their age. According to the same article, unaccompanied children too should only be detained in exceptional circumstances, and all efforts should be made to release them as soon as

448 According to UNICEF, in relation to claims to reunite the child with his/her family in the host state, national courts must also ensure that parents are not exploiting their children in order to obtain residence permits for that country. See UNICEF, Judicial implementation of Art. 3 of the CRC in Europe, p. 104. See also UNHCR (2008), *Guidelines on Determining the Best Interests of the Child*, May 2008.

possible. They should never be detained in prison accommodation, but rather be provided with accommodation in institutions equipped with personnel and age-appropriate facilities. Their accommodation should be separate from adults.

Article 17 of the Return Directive envisages the detention of children and families whose asylum application has been rejected subject to certain conditions. With regard to unaccompanied children, however, it requires that they be placed in institutions provided with staff and facilities which respond to the needs of persons of their age. There is as of yet no CJEU case law relating specifically to the detention of children.

Under CoE law, the detention of migrant children has been addressed in the context of Articles 3 and 5 of the ECHR.

> Example: *Mubilanzila Mayeka and Kaniki Mitunga v. Belgium*,[449] concerns an unaccompanied child held in detention. A five year old child was detained in a transit centre for adults for two months without appropriate support. The child had travelled from the Democratic Republic of Congo without the necessary travel papers in the hope of being reunited with her mother, who had obtained refugee status in Canada. The child was subsequently returned to the Democratic Republic of Congo, despite the fact that she had no family members waiting there to care for her. The ECtHR ruled that in the absence of any risk of the child seeking to evade the supervision of the Belgian authorities, detaining her in a closed centre for adults had been unnecessary. The ECtHR also noted that other measures – such as placing her in a specialised centre or with foster parents – could have been taken that would have been more conducive to the best interest of the child as enshrined in Article 3 of the CRC. The ECtHR found violations of Articles 3, 5 and 8 of the ECHR.

Other cases have highlighted the illegality of detention, even where the child in question was accompanied by a parent.

449 ECtHR, *Mubilanzila Mayeka and Kaniki Mitunga v. Belgium*, No. 13178/03, 12 October 2006.

Example: In *Muskhadzhiyeva and Others v. Belgium*,[450] the ECtHR ruled that the month-long detention in a closed transit centre of a mother and her four children, aged between seven months and seven years, constituted a violation of Article 3 of the ECHR. In reaching its conclusions, the Court drew attention to the fact that the centre was "ill-equipped to receive children", with serious consequences for their mental health.

Example: *Popov v. France*[451] concerns the administrative detention of a family for two weeks pending their deportation to Kazakhstan, confirms this ruling. The ECtHR found a violation of Article 3 of the ECHR insofar as the French authorities had not measured the inevitably harmful effects on the two children (who were five months and three years old) of being held in a detention centre in conditions that were "ill-adapted to the presence of children".[452] The Court also found a violation of Article 5 and Article 8 in respect of the whole family and referred to Article 37 of the CRC, which provides that "[e]very child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age".[453]

Example: Similarly, in *Kanagaratnam and Others v. Belgium*,[454] the detention of an asylum-seeking mother and her three children in a closed centre for aliens in an irregular situation for four months amounted to a breach of Articles 3 and 5 of the ECHR. Despite the fact that the children were accompanied by their mother, the Court considered that, by placing them in a closed centre, the Belgian authorities had exposed them to feelings of anxiety and inferiority and had, in full knowledge of the facts, risked compromising their development. [455]

450 ECtHR, *Muskhadzhiyeva and Others v. Belgium*, No. 41442/07, 19 January 2010 (available in French).

451 ECtHR, *Popov v. France*, Nos. 39472/07 and 39474/07, 19 January 2012.

452 *Ibid.*, para. 95.

453 *Ibid.*, para. 90.

454 ECtHR, *Kanagaratnam and Others v. Belgium*, No. 15297/09, 13 December 2011 (available in French).

455 The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), in its 19th General Report has described safeguards for irregular migrants deprived of their liberty, and additional safeguards for children; see further: *20 years of combating torture, 19th General Report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)*, 1 August 2008 to 31 July 2009.

Under international law, Article 9 (4) of the CRC provides that when a child is detained, state authorities must inform the child's parents of his or her whereabouts.[456]

9.5. Expulsion[457]

Key points

- The vulnerability of migrant children to expulsion is intrinsically linked with their parents' residence status in the host state.
- The best interests principle should guide all decisions relating to the expulsion of immigrant children and their family/primary carers.
- Under EU law, there are circumstances in which migrant children can remain in a host state notwithstanding their parents' legal status, particularly with a view to completing their education or where establishing family life elsewhere would be difficult.

Under EU law, as with other areas of EU migration law, rules governing the expulsion of children differ according to their nationality, their parents' nationality and the context of their migration. Once a child obtains access to a Member State under EU free movement law, he/she is likely to be able to remain there, even if the EU migrant parent he/she originally moved with no longer qualifies for ongoing residence or decides to leave.

Specifically, under the Free Movement Directive**,** children and other family members can remain in the host state following the death of the EU citizen parent they initially moved with (Article 12 (2)), provided they lived in the host state for at least 12 months before their parent's death. Similarly, they can, in principle, remain in the host state following their parent's departure. However, in both cases, if the child/family member is a third-country national, their ongoing residence is contingent on their being able to demonstrate they have

456 On international safeguards for children in situation of detention see *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, 5 March 2015, A/HRC/28/68.

457 Otherwise referred to as return, removal, repatriation, extradition, or deportation, depending on the legal context. For the purposes of this chapter, the term expulsion will be used to define the lawful removal of a non-national or other person from a state. See also FRA and ECtHR (2014), Section 5.4 on maintaining the family – protection from expulsion.

enough money to support themselves. They must also have sickness insurance (Article 7).

The rules are even more permissive for children enrolled in education facilities in the host state. In such cases, they and their custodial parent or carer are entitled to remain in the host state following the death or departure of the primary EU migrant citizen, irrespective of the child's nationality (Article 12 (3)). While originally it was thought that this education-related concession only applied to children in families with sufficient money to support themselves,[458] later case law has confirmed that it extends to children in education who may be dependent on social welfare support.[459]

Furthermore, family members and particularly third-country national parents also enjoy a right to remain in the host state following divorce from the partner who was an EU citizen, if they have primary custody of the couple's children or have been awarded rights of access to the children that must be exercised in the host state (Articles 13 (2) (b) and 13 (2) (d)).

The CJEU has referred to a child's status as an EU citizen under Article 20 of the TFEU to grant the child's third-country national parents a permit to work and reside in the EU Member State of the child's citizenship. This enables the child to enjoy the rights attached to his/her status as an EU citizen, in so far as the child would otherwise have to leave the EU to accompany his/her parents.[460] Subsequent CJEU jurisprudence indicates, however, that "the mere fact that it might appear desirable to a national of a Member State, for economic reasons or in order to keep his family together in the territory of the Union, for the members of his family who do not have the nationality of a Member State to be able to reside with him in the territory of the Union, is not sufficient in itself to support the view that the Union citizen will be forced to leave Union territory if such a right is not granted".[461]

458 CJEU C-413/99, *Baumbast and R v. Secretary of State for the Home Department*, 17 September 2002.

459 CJEU C-480/08, *Maria Teixeira v. London Borough of Lambeth and Secretary of State for the Home Department*, 23 February 2010; CJEU C-310/08, *London Borough of Harrow v. Nimco Hassan Ibrahim and Secretary of State for the Home Department* [GC], 23 February 2010. The education of migrant children is considered further in Section 8.2.

460 CJEU, C-34/09, *Gerardo Ruiz Zambrano v. Office National de l'Emploi (ONEm)*, 8 March 2011.

461 CJEU, C-256/11, *Murat Dereci and Others v. Bundesministerium für Inneres* [GC], 15 November 2011, para. 68. See also CJEU, C-40/11, *Yoshikazu Iida v. Stadt Ulm*, 8 November 2012. See further, FRA and ECtHR (2014), pp. 125–127.

The Free Movement Directive explicitly provides that any exceptional expulsion of children should be in line with the provisions of the CRC (Recital 24). Moreover, Article 28 (3) (b) endorses children's immunity from expulsion unless it is deemed to be in their best interests and in accordance with the CRC.

As far as asylum seeking children whose claim has been rejected are concerned, the Return Directive specifies that the best interests of the child should inform decisions relating to the return of unaccompanied children (Article 10). Moreover, before removing an unaccompanied child from a Member State, the authorities of that Member State must be satisfied that the child will be returned to a member of his/her family, a nominated guardian or adequate reception facilities in the state of return (Article 10 (2)).

In circumstances where asylum seeking children are returned to another Member State to have their asylum claim assessed, the Dublin Regulation stipulates that the best interests principle must guide the application of such decisions (Article 6). Furthermore, the regulation provides a checklist of factors to assist the authorities' determination of what is in the child's best interests. This includes due account for the child's family reunification possibilities; the child's well-being and social development; safety and security considerations, in particular where there is a risk of the child being a victim of human trafficking; and the views of the child, in accordance with his or her age and maturity.

Example: In *The Queen, on the application of MA and Others v. Secretary of State for the Home Department*,[462] the CJEU had to determine which state was responsible in the case of an unaccompanied child who had submitted asylum applications in different EU Member States and who had no family or relatives in other EU Member States. The CJEU clarified that in the absence of a family member legally present in a Member State, the state in which the child is physically present is responsible for examining such a claim. In doing so, it relied on Article 24 (2) of the EU Charter of Fundamental Rights, whereby in all actions relating to children, the child's best interests are to be a primary consideration.

Under CoE law, states are, in principle, permitted to interfere with the right to respect for family life in accordance with Article 8 (2) of the ECHR.

462 CJEU, C-648/11, *The Queen, on the application of MA and Others v. Secretary of State for the Home Department*, 6 June 2013.

Example: *Gül v. Switzerland*[463] concerns an applicant who lived in Switzerland with his wife and daughter, who were all granted residence permits on humanitarian grounds. He also wished to bring to Switzerland their minor son, whom they had left behind in Turkey, but the Swiss authorities refused to grant him this request, mainly on the grounds that he had insufficient means to provide for his family. The ECtHR held that by leaving Turkey the applicant had himself caused the separation with his son. His recent visits to Turkey showed that his initial reasons for applying for political asylum in Switzerland were no longer valid. There were no obstacles preventing the family from establishing themselves in their country of origin, where their minor son had always lived. While acknowledging that their family's situation was very difficult from the human point of view, the Court found no breach of Article 8 of the ECHR.

Example: In *Üner v. The Netherlands*[464] it was confirmed that consideration should be given to the impact that expulsion would have on any children in a family when determining whether it was a proportionate response. This involved considering: "the best interests and well-being of the children, in particular the seriousness of the difficulties which any children [...] are likely to encounter in the country to which the applicant is to be expelled; and the solidity of social, cultural and family ties with the host country and with the country of destination".

Example: The case of *Tarakhel v. Switzerland*[465] concerns the refusal of the Swiss authorities to examine the asylum application of an Afghan couple and their six children, and their decision to send them back to Italy. The ECtHR found that, in view of the current situation regarding the reception system in Italy, and in the absence of detailed and reliable information concerning the specific facility of destination, the Swiss authorities did not possess sufficient assurances that, if returned to Italy, the applicants would be taken charge of in a manner adapted to the age of the children. The ECtHR therefore found that there would be a violation of Article 3 of the ECHR if the Swiss authorities were to send the applicants back to Italy under the Dublin II Reg-

463 ECtHR, *Gül v. Switzerland*, No. 23218/94, 19 February 1996.

464 *ECtHR*, *Üner v. The Netherlands* [GC], No. 46410/99, 18 October 2006, paras. 57–58. See also *Boultif v. Switzerland*, No. 54273/00, 2 August 2001.

465 ECtHR, *Tarakhel v. Switzerland* [GC], No. 29217/12, 4 November 2014.

ulation without having first obtained individual assurances from the Italian authorities that the applicants would be taken charge of in a manner adapted to the age of the children and that the family would be kept together.

Under international law, a state shall upon request provide the parent(s) or the child with essential information concerning the whereabouts of the absent family member(s) in instances of detention, imprisonment, exile, deportation or death, unless it would be detrimental to the well-being of the child (Article 9 (4) of the CRC).

9.6. Access to justice[466]

Key point

- Migrant children have the right to an effective remedy.

Under EU law, children's rights to access justice in an immigration context are set out in a range of different instruments. First, the right to an effective legal remedy and to a fair trial is set out in Article 47 of the EU Charter of Fundamental Rights. This includes a right to a fair and public hearing within a reasonable time by an independent and impartial tribunal, including having the possibility of advice, a defence and appropriate legal representation under Article 48. For child migrants, this is reinforced by a range of secondary legislative provisions. In particular, the Dublin Regulation obliges Member States to ensure that an unaccompanied child is represented by an appropriately qualified professional who has access to all of the relevant information in the child's file (Article 6). Parallel provisions are found in the Qualification Directive (Article 31) and in the Asylum Procedures Directive (Article 25). Children's right to legal representation is also supported by their right to access victim services and special confidential support services under Article 8 of Directive 2012/29/EU establishing minimum standards on the rights, support and protection of victims of crime (Victims' Directive).[467]

466 See also FRA and ECtHR (2014), Section 4.5 on legal assistance in asylum and return procedures.

467 Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, OJ 2012 L 315/55.

Rights associated with access to justice are not without their limitations, however, and may be subject to certain age conditions. For example, the Asylum Procedures Directive allows Member States to "refrain from appointing a [legal] representative where the unaccompanied minor will in all likelihood reach the age of 18 before a decision at first instance is taken" (Article 25 (2)).

Under CoE law, the ECtHR ruled out the applicability of Article 6 (right to a fair trial) in cases concerning decisions on entry, stay and deportation of aliens.[468] However, Article 13 of the ECHR (the right to an effective remedy) may be relied on in certain circumstances.

Example: *Rahimi v. Greece*[469] concerns the conditions in which a migrant child from Afghanistan, who had entered Greece irregularly, was held in a detention centre and subsequently released with a view to his expulsion. In finding a violation of Article 13 of the ECHR, the ECtHR noted that the information brochure provided to the applicant did not indicate the procedure to be followed to make a complaint to the chief of police. Moreover, the applicant was not informed in a language which he understood of the available remedies he could use to complain about the conditions of his detention. Relying on the reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), the ECtHR noted the absence in Greece of an independent authority for the inspection of detention facilities of the law-enforcement agencies. It also noted that there was no impartial authority to make the remedy effective. Accordingly, it found violations of Article 3, Article 5 paragraphs 1 and 4, and Article 13 of the ECHR.

The ESC requires states to promote the legal (as well as social and economic) development of the family (Article 16). Moreover, Article 19 (1) requires states to maintain "adequate and free services" and to ensure that migrant workers and their families receive accurate information relating to emigration and immigration. A similar 'information' requirement (central to migrants' access to justice) is contained in Article 6 of the European Convention on the legal status of migrant workers, but the more extensive provisions governing "right

468 ECtHR, *Maaouia v. France* [GC], No. 39652/98, 5 October 2000.

469 ECtHR, *Rahimi v. Greece*, No. 8687/08, 5 April 2011 (available in French).

of access to the courts and administrative authorities" (Article 26) are directed exclusively at migrant workers rather than their family members.[470]

In addition, it is worth noting that the CoE has developed very comprehensive guidelines on child-friendly justice, which set out how all justice and administrative proceedings, including immigration proceedings, should be adapted to meet the needs of children.[471]

Under international law, Article 37 of the CRC is particularly relevant for migrant children deprived of their liberty, as it ensures these children the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of their liberty before a court or other competent, independent and impartial authority, whose decision must furthermore be prompt.

470 Council of Europe, European Convention on the Legal Status of Migrant Workers, CETS No. 93, 1977.

471 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010.

10 Consumer and personal data protection

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 38 TFEU, Article 169 Consumer Rights Directive (2011/83/EU) Unfair Business-to-Consumer Commercial Practices Directive (2005/29/EC) General Product Safety Directive (2001/95/EC) Clinical Trials Directive (2001/20/EC) CJEU, C-244/06, *Dynamic Medien Vertriebs GmbH v. Avides Media AG*, 2008 (sale over the internet of DVDs) CJEU, C-36/02, *Omega Spielhallen- und Automatenaufstellungs-GmbH v. Oberbürgermeisterin der Bundesstadt Bonn*, 2004 (licence for playing a game) Regulation 536/2014 on clinical trials on medicinal products for human use Directive on foodstuffs intended for particular nutritional uses (2009/39/EC) Toy Safety Directive (2009/48/EC) Directive concerning products which, appearing to be other than they are, endanger the health or safety of consumers (87/357/EEC) Television Without Frontiers Directive (89/552/EEC) Audiovisual Media Services Directive (2010/13/EU)	Protection of children as consumers	European Convention on Transfrontier Television

EU	Issues covered	CoE
Charter of Fundamental Rights, Articles 7 (respect for private and family life), 8 (protection of personal data) and 52 (scope and interpretation of rights and principles) TFEU, Article 16 Data Protection Directive (95/46/EC)	Children and data protection	ECHR, Article 8 (right to respect for private and family life) ECtHR, *K.U. v. Finland*, No. 2872/02, 2008 (advertisement on the internet) ECtHR, *Avilkina and Others v. Russia*, No. 1585/09, 2013 (disclosure of medical records) Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data

This chapter addresses European legislation and case law in the field of consumer and data protection. There is an abundance of legislation and case law at the EU level, as the TFEU expressly lays down the EU's competence in these matters. The CoE's contribution in this field is more limited. At treaty level there are two main conventions on media and data protection. The ECtHR has also decided on a number of cases concerning the data protection of individuals.

The following sections shall concentrate on specific aspects of consumer law relating to children (Section 10.1) and data protection (Section 10.2). For each of these issues, the general legal framework and its applicability for children is analysed, as well as the specific norms for the protection of children, where relevant.

10.1. Protection of children as consumers

Key points

- According to the CJEU, child consumers' best interests and the protection of their rights override requirements of public interest justifying limits to the free movement of goods, persons, services and capital.
- Children as consumers should be provided with relevant information so as to be able to consider all relevant facts and make an informed choice.
- Unfair commercial practices are those that do not comply with the principle of professional diligence and may influence adult and child consumers' transactional decisions.
- Children can be included in clinical trials only if the administered medicinal product is expected to be of direct benefit to them, thereby outweighing the risks.
- EU and CoE law limit the amount of marketing children may be exposed to, without banning it as such.
- Children are entitled to specific protection, which implies protection against any advertising as well as tele-shopping programmes which could cause moral or physical harm to them.
- The placement of products advertisements in children's programmes is forbidden.

10.1.1. Consumer rights

Under EU law, the main pillars of consumer protection are laid down in Article 169 (1) of the TFEU and Article 38 of the EU Charter of Fundamental Rights. The CJEU has recognised that the best interests of the child override requirements of public interest, justifying limits to the common market freedoms.

Example: The case of *Dynamic Medien*[472] concerns the sale over the internet in Germany of DVDs of Japanese cartoons. The cartoons had been approved for children over 15 years of age in the United Kingdom. They had not been rated as appropriate by the relevant German authority. The main question before the CJEU was whether the prohibition in Germany was contrary to the freedom of movement principle. The CJEU found that the

472 CJEU, C-244/06, *Dynamic Medien Vertriebs GmbH v. Avides Media AG*, 14 February 2008.

main purpose of the German law was to protect children from information that would be detrimental to their well-being. It ruled that the restriction on the freedom of movement of goods was not disproportionate as long as it did not go beyond what was necessary to attain the objective of protecting children pursued by the Member State concerned.

Example: The case of *Omega*[473] concerns the operation of a 'laserdrome' in Germany. The game played in the 'laserdrome' included hitting sensory targets placed on the jackets worn by players. The equipment for the game was supplied by a British company and both the game and the equipment had been lawfully marketed in the United Kingdom. The game was prohibited in Germany on the ground that it was contrary to fundamental values such as human dignity. The CJEU found that the restriction imposed by the German authorities was not contrary to EU law, as it had been duly justified on public policy grounds.

The most recent review process of the EU consumer law resulted in the adoption of the Consumer Rights Directive 2011/83/EU (CRD), which aims to fully harmonise national laws on distance-selling and off-premises contracts, as well as other types of consumer contracts.[474] The intention is to balance a high level of consumer protection and the competitiveness of enterprises. As per Article 3 (3) (a), the CRD is not applicable to contracts for social services, including social housing, childcare and support of families and persons permanently or temporarily in need, including of long-term care. Social services include services for children and youth, assistance services for families, single parents and older persons, and services for migrants. The CRD dedicates specific attention to pre-contractual information. It bases its 'information requirements' on the assumption that if consumers, including children, are provided with due information, they will be able to consider all relevant facts and make an informed choice.

473 CJEU, C-36/02, *Omega Spielhallen- und Automatenaufstellungs-GmbH v. Oberbürgermeisterin der Bundesstadt Bonn*, 14 October 2004.

474 Directive 2011/83/EU of the European Parliament and the Council of 25 October 2011 on consumer rights, amending Council Directive 93/13/EEC and Directive 1999/44/EC of the European Parliament and of the Council and repealing Council Directive 85/577/EEC and Directive 97/7/EC of the European Parliament and of the Council, OJ 2011 L 304/64 (it should have been implemented by 13 December 2013).

10.1.2. Unfair commercial practices on children

Under EU law, Directive 2005/29/EC, concerning unfair business-to-consumer commercial practices in the internal market (UCPD),[475] covers the totality of business-to-consumer transactions (whether operated offline or online, involving both goods and services). Children are included in the UCPD in the category of 'vulnerable consumers' (Article 5 (3)). Transactional decisions cannot be taken following harassment, coercion or undue influence or misleading information, and child consumers have the right to make these decisions freely. The directive prohibits product marketing and advertising activities which create confusion with another product or with a competitor's trademark, and requires that all the necessary information for consumers be provided to them in a clear and comprehensible manner, and at a suitable time to enable them to make a transactional decision (Articles 6 and 7).

10.1.3. Products' safety

Under EU law, there is a comprehensive framework to ensure that only safe and otherwise compliant products find their way on to the market. In particular, Directive 2001/95/EC on general product safety (GPSD) dedicates specific attention to the safety of children by including them in the category of consumers who can be particularly vulnerable to the risks posed by the products under consideration (Recital 8 of the GPSD). Therefore, the safety of the product needs to be assessed, taking into account all the relevant aspects, in particular the categories of consumers to which the product is destined.

Council Directive 87/357/EEC is a specific product safety directive on the approximation of the laws of the Member States concerning products which, appearing to be other than they are, endanger the health or safety of consumers.[476] It prohibits the marketing, importing and manufacturing of products that look like foodstuffs, but that are not edible. Member States must carry out checks to ensure that no such products are marketed. If a Member State bans

475 Directive 2005/29/EC of European Parliament and of the Council of 11 May 2005 concerning unfair business-to-consumer commercial practices in the internal market and amending Council Directive 84/450/EEC, Directives 97/7/EC, 98/27/EC and 2002/65/EC of the European Parliament and of the Council and Regulation (EC) No. 2006/2004 of the European Parliament and of the Council, OJ 2005 L 149/22.

476 Council Directive 87/357/EEC of 25 June 1987 on the approximation of the laws of the Member States concerning products which, appearing to be other than they are, endanger the health or safety of consumers, OJ 1987 L 192/49.

a product under the terms of this directive, it must inform the Commission and provide details to inform the other Member States. The question of toy safety in particular is discussed in more detail under Section 10.1.6.

10.1.4. Clinical trials on children

Under EU law, Directive 2001/20/EC[477] on the approximation of national provisions relating to the implementation of 'good clinical practice' in the conduct of clinical trials on medicinal products for human use includes children among vulnerable persons who are incapable of giving legal consent to clinical trials (Recital 3). Children may only be included in clinical trials if they directly benefit from receiving the medicinal product and if such benefits outweigh the risks (Recital 3). Clinical trials should afford subjects the best possible protection (Article 4).

Similarly, Regulation (EU) No. 536/2014 on clinical trials on medicinal products for human use includes specific provisions for children in the vulnerable population category (Article 10 (1)). This regulation aims to gradually replace Directive 2001/20/EC.[478] It requires that applications for the authorisation of clinical trials involving children be carefully assessed. A child's legal representative must consent to a clinical trial taking place, as must the child if he/she is capable of forming an opinion (Article 29 (1) and (8)). The regulation lays down specific conditions for conducting safe clinical trials on children and ensuring their informed consent (Article 32). These conditions are that: no incentives are given to the subject except for compensation for expenses and loss of earnings directly related to the participation in the clinical trial; the clinical trial is intended to investigate treatments for a medical condition that only occurs in children; and there are scientific grounds for expecting that participation in the clinical trial will produce: a direct benefit for the minor concerned outweighing the risks and burdens involved; or some benefit for the population represented by the minor concerned and such a clinical trial will pose only minimal risk to, and will impose minimal burden on, the minor concerned in comparison with the standard treatment of the minor's condition. Only in emergency situations may

477 Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use, OJ 2001 L 121/34.

478 Regulation (EU) 536/2014 of the European Parliament and the Council of 16 April 2014 on clinical trials on medicinal products for human use, and repealing Directive 2001/20/EC, OJ 2014 L 158/1.

clinical trials be performed on children without having previously obtained their consent or the consent of their legal representatives (Article 35 (1)).

10.1.5. Food intended for infants and young children

Under EU law, Directive 2009/39/EC on foodstuffs intended for particular nutritional uses[479] focuses on the nutritional composition and safety of foods specifically manufactured for infants and young children under the age of 12 months. Its rules concern infant and follow-on formulae, processed cereal-based foods and baby foods and additives in foods for infants and young children. The directive aims to guarantee product safety and to provide the consumer with suitable products and appropriate information. It specifies, amongst other things, that a particular nutritional use shall fulfil the particular nutritional requirements of certain categories of persons, including those of infants or young children in good health (Article 1 (3) (c)).

10.1.6. Toy safety

Under EU law, Directive 2009/48/EC on the safety of toys (TSD)[480] defines toys in its Article 2 as "products designed or intended, whether or not exclusively, for use in play by children under 14 years of age".[481] Annex I provides a non-exhaustive list of items that are not considered toys, but that could be subject to confusion. Article 2 (2) also lists some toys that are excluded from its range of action. The TSD also reinforces health and safety standards by limiting the amounts of certain chemicals that may be contained in the material used for toys (Article 10).[482]

479 Directive 2009/39/EC of the European Parliament and of the Council of 6 May 2009 on foodstuffs intended for particular nutritional uses, OJ 2009 L 124/21.

480 Directive 2009/48/EC of the European Parliament and of the Council of 18 June 2009 on the safety of toys, OJ 2009 L 170.

481 *Ibid.*, Art. 2 (1).

482 The European Commission has also concluded 'voluntary agreements' with European toys industries/traders in order to improve toy safety. See further: http://ec.europa.eu/growth/sectors/toys/safety/index_en.htm.

10.1.7. Children and advertising

Under EU law, Directive 2010/13/EU on Audiovisual Media Services (AVMS Directive)[483] expanded the scope of legal regulation of the Directive 89/552/EEC on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the pursuit of television broadcasting activities (Television Without Frontiers (TWF) Directive). The AVMS Directive deals with the limitation of the amount, quality and content of marketing children may be exposed to, regulating the duration of advertisement (Articles 20, 24 and 27). It forbids product placement in children's programmes (Article 11) and authorises Member States to prohibit the display of sponsorship logos during programmes for children (Article 10 (4)).[484] The AVMS Directive balances the protection of children with other important democratic values, such as the freedom of expression, supporting the idea that such protection is possible through the essential involvement of parental responsibility (Recitals 48 and 59).

The effective implementation of the AVMS Directive is supplemented by the 1998[485] and 2006[486] recommendations on the protection of children and human dignity.

483 Directive 2010/13/EU of the European Parliament and the Council of 10 March 2010 on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the provision of audiovisual media services (Audiovisual Media Services Directive), OJ 2010 L 95/1.

484 For a more general overview of the functioning of the AMS Directive, please refer to: COM(2012) 203 final, Report from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, on the application of Directive 2010/13/EU ('Audiovisual Media Service Directive'), Brussels, 4 May 2012 and SWD(2012) 125 final, Commission Staff Working Document attached to the First Report from the Commission to the European Parliament, the Council, The European Economic And Social Committee And The Committee of the Regions on the Application of Directive 2010/13/EU 'Audiovisual Media Services' accompanying the document, Brussels, 4 May 2012.

485 Council Recommendation 98/560/EC of 24 September 1998 on the development of the competitiveness of the European audiovisual and information services industry by promoting national frameworks aimed at achieving a comparable and effective level of protection of minors and human dignity, OJ 1998 L 270.

486 Recommendation 2006/952/EC of the European Parliament and of the Council of 20 December 2006 on the protection of minors and human dignity and on the right of reply in relation to the competitiveness of the European audiovisual and on-line information services industry, OJ 2006 L 378.

Under CoE law, the European Convention on Transfrontier Television[487] was the first international treaty to create a legal framework for the free circulation of transfrontier television programmes in Europe. It specifically protects children and youth (Article 7 (2)), for instance forbidding the screening of pornographic and violent material and of programmes inciting to racial hatred. It identifies advertising standards and regulates advertising time and advertising breaks.

10.2. Children and personal data protection

Key points

- Under EU and CoE law, personal data protection has been acknowledged as a fundamental right.
- The right to respect for private and family life, home and correspondence (Article 8 of the ECHR) includes the right to protection of personal data.
- Children have, among other rights relating to their personal data, the right to object to the processing of their data, except on compelling legitimate grounds.

10.2.1. European data protection law

Under EU law, the EU has competence to legislate on data protection matters (Article 16 of the TFEU).[488] Article 8 (2) of the EU Charter of Fundamental Rights contains key data protection principles (fair processing, consent or legitimate aim prescribed by law, right to access and rectification), whereas Article 8 (3) requires that compliance with data protection rules be subject to control by an independent authority. The right to the protection of personal data established in Article 8 may be limited in accordance with the law and for the respect of the principles of a democratic society such as the freedoms and rights of others (Article 52 of the Charter).[489]

487 Council of Europe, European Convention on Transfrontier Television, CETS No. 132, 1989. Amended according to the provisions of the Protocol, CETS No. 171, 2002.

488 For a general overview of European data protection law, see: FRA and CoE (2014).

489 CJEU, Joined cases C-468/10 and C-469/10, *Asociación Nacional de Establecimientos Financieros de Crédito (ASNEF) and Federación de Comercio Electrónico y Marketing Directo (FECEMD) v. Administración del Estado*, 24 November 2011, para. 48; CJEU, C-275/06, *Productores de Música de España (Promusicae) v. Telefónica de España SAU* [GC], 29 January 2008, para. 68.

Personal data protection has emerged as one of the key areas of European law relating to privacy. Directive 95/46/EC on the protection of individuals with regard to the processing of personal data and on the free movement of such data (Data Protection Directive)[490] is the main instrument in this field.

Because data processing is operated in closed spaces not open to the public, children as well as other data subjects are usually unaware of the processing of their own personal data. To counteract the vulnerability of data subjects, European law guarantees children (and other data subjects) specific individual rights, such as the right to be informed that their data are being collected, the right to access the stored data and to learn about the details of the processing operation, the right to object in case of unlawful processing, the rights to rectification, erasure and blocking of data.

Controllers of processing operations must provide adequate information with regard to processing of data (Articles 10 and 11 of the Data Protection Directive). Interpreted in a child-friendly manner, this implies that the language and the form of the information need to be adapted to the level of maturity and understanding of children. As a minimum requirement, the information must include the purpose of processing, as well as the identity and contact details of the controller (Articles 10 (a) and (b) of the Data Protection Directive).

The Data Protection Directive provides for the consent of data subjects, regardless of the sensitivity of the data processed (Articles 7, 8 and 14). A child-friendly consent procedure would entail taking into account the child's evolving capacities, progressively involving him or her. The first step entails a child being consulted by his/her legal representative prior to providing consent, before moving on to a parallel consent of the child and his or her legal representative, to the sole consent of the adolescent child.

Data subjects have the right to erasure of data, which entails the possibility of having their personal data removed or deleted upon their request, and also the right to object to the processing of their personal data. The latter has become increasingly important for children because of the massive amount of children's personal data circulated and available through social networking. Although the CJEU has not yet addressed cases concerning children, in a recent

490 Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data (Data Protection Directive), OJ 1995 L 281.

case concerning an adult applicant, it held that the right to object applies to data and information, "in particular where they appear to be inadequate, irrelevant or no longer relevant, or excessive in relation to those purposes and in the light of the time that has elapsed".[491] The CJEU also held that the applicability of the right to object needs to be balanced against other fundamental rights.

Under CoE law, the ECtHR has read the right to protection of personal data into Article 8 of the ECHR. The Court examines situations where the issue of data protection arises, including the interception of communications,[492] various forms of surveillance[493] and the protection against storage of personal data by public authorities.[494] Furthermore, the ECtHR ruled that national law must set out appropriate measures to ensure judicial remedies against infringements of data protection rights.

Example: In *K.U. v. Finland*,[495] the applicant was a child who complained that an advertisement of a sexual nature had been posted in his name on an internet dating site. The service provider refused to reveal the identity of the person who had posted the information because of confidentiality obligations under Finnish law. The applicant claimed that domestic law did not provide sufficient protection against the actions of a private person placing incriminating data about the applicant on the internet. The ECtHR held that states have positive obligations which involve adopting measures designed to secure respect for private life even in the sphere of relations between individuals. In the applicant's case, his practical and effective protection required that effective steps be taken to identify and prosecute the perpetrator. However, such protection was not afforded by the state, and the Court found a violation of Article 8 of the ECHR.[496]

491 CJEU, C-131/12, *Google Spain SL and Google Inc. v. Agencia Española de Protección de Datos (AEPD) and Mario Costeja González* [GC], 13 May 2014, para. 93.

492 See, for example: ECtHR, *Malone v. the United Kingdom*, No. 8691/79, 2 August 1984; ECtHR, *Copland v. the United Kingdom*, No. 62617/00, 3 April 2007.

493 See, for example: ECtHR, *Klass and Others v. Germany*, No. 5029/71, 6 September 1978; ECtHR, *Uzun v. Germany*, No. 35623/05, 2 September 2010.

494 See, for example: ECtHR, *Leander v. Sweden*, No. 9248/81, 26 March 1987; ECtHR, *S. and Marper v. the United Kingdom* [GC], Nos. 30562/04 and 30566/04, 4 December 2008.

495 ECtHR, *K.U. v. Finland*, No. 2872/02, 2 December 2008. See further Chapter 4.

496 FRA and CoE (2014), p. 122.

Example: *Avilkina and Others v. Russia*[497] concerns the disclosure of a two year old girl's medical files to the prosecutor, following his request to be informed about all refusals by Jehovah's Witnesses concerning blood transfusions. Acknowledging that the interests of a patient and the community as a whole in protecting the confidentiality of medical data might be outweighed by the interests of investigating crime, the Court noted that the applicant was not a suspect or accused in any criminal proceedings. In addition, the medical professionals providing treatment to the applicant could have applied for judicial authorisation for a blood transfusion, had they believed her to be in a life-threatening situation. In the absence of any pressing social need for requesting the disclosure of the confidential medical information concerning the applicant, the ECtHR found a violation of Article 8 of the ECHR.

Example: In *S. and Marper v. the United Kingdom*,[498] an eleven year old's fingerprints and DNA taken in relation with the suspicion of attempted robbery were retained without a time limit, even though he was ultimately acquitted. Given the nature and amount of personal information contained in cellular samples and DNA profiles, their retention in itself amounted to an interference with the first applicant's right to respect for private life. The core principles of the relevant instruments of the Council of Europe and the law and practice of the other contracting states require the retention of data to be proportionate in relation to the purpose of collection and limited in time, particularly in the police sector. The protection afforded by Article 8 of the ECHR would be unacceptably weakened if the use of modern scientific techniques in the criminal justice system were allowed at any cost and without carefully balancing their potential benefits against important private-life interests. In that respect, the blanket and indiscriminate nature of the power of retention in England and Wales was particularly striking, since it allowed data to be retained for an unlimited period of time and irrespective of the nature or gravity of the offence or of the age of the suspect. Retention could be especially harmful in the case of minors, given their special situation and the importance of their development and integration in society. In conclusion, the retention of data constituted a disproportionate interference with the applicant's right to respect for private life.

497 ECtHR, *Avilkina and Others v. Russia*, No. 1585/09, 6 June 2013.

498 ECtHR, *S. and Marper v. the United Kingdom* [GC], Nos. 30562/04 and 30566/04, 4 December 2008.

The Council of Europe Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data[499] (Convention 108) applies to all data processing carried out both in the private and public sectors, and protects the individual, children included, against abuses which may accompany the processing of personal data. Convention 108 has an additional protocol which regulates the establishment of supervisory authorities and cross-border flow of personal data to non-Parties to the convention.[500]

The principles laid down in Convention 108 related to the processing of personal data concern fair and lawful collection and automatic processing of data, stored for specified legitimate purposes and not for use for ends incompatible with those purposes, nor kept for longer than is necessary. They also concern the quality of the data. In the absence of proper legal safeguards, the processing of 'sensitive' data, such as on a person's race, politics, health, religion, sexual life or criminal record, is prohibited. The convention also enshrines the individual's right, children included, to know that information is stored on him or her and, if necessary, to have it corrected. Restrictions on the rights laid down in the convention are possible only when overriding interests, such as state security or defence, are at stake.

Under international law, the right to data protection is part of the child's right to privacy contained in Article 16 of the CRC. This article provides that a child shall not be subject to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation. This right must be respected by everybody, including the child's legal representative.

499 Council of Europe, Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data, CETS No. 108, 1981.

500 Council of Europe, Additional Protocol to the Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data, regarding supervisory authorities and transborder data flows, CETS No. 181, 2001.

11 Children's rights within criminal justice and alternative (non-judicial) proceedings

EU	Issues Covered	CoE
Charter of Fundamental Rights, Articles 47 (right to an effective remedy and to fair trial), 48 (presumption of innocence and right of defence) and 49 (principles of legality and proportionality of criminal offences and penalties) Right to Interpretation and Translation Directive (2010/64/EU) Right to Information Directive (2012/13/EU) Access to a Lawyer Directive (2013/48/EU)	**Fair trial guarantees**	ECHR, Article 6 (fair trial) ECtHR, *T. v. the United Kingdom* [GC], No. 24724/94, 1999 (children in court) ECtHR, *Panovits v. Cyprus*, No. 4268/04, 2008 (access to a lawyer)
Charter of Fundamental Rights, Articles 4 (torture, inhuman and degrading treatment) and 6 (right to liberty)	**Detention**	ECHR, Articles 3 (torture, inhuman and degrading treatment) and 5 (right to liberty) ECtHR, *Bouamar v. Belgium*, No. 9106/80, 1988 (detention for educational supervision) ECtHR, *D.G. v. Ireland*, No. 39474/98, 2002 (detention for educational supervision) ECtHR, *Nart v. Turkey*, No. 20817/04, 2008 (pre-trial detention) ECtHR, *Güveç v. Turkey*, No. 70337/01, 2009 (conditions of detention)

EU	Issues Covered	CoE
Victims' Directive (2012/29/EU) CJEU, C-105/03, *Criminal proceedings against Maria Pupino* [GC], 2005 (standing of child witnesses in court)	**Child witnesses and victims**	ECHR, Articles 3 (torture, inhuman and degrading treatment) and 8 (private life) ECtHR, *Kovač v. Croatia*, No. 503/05, 2007 (child witness) ECtHR, *S.N. v. Sweden*, No. 34209/96, 2002 (child witness) ECtHR, *R.R. and Others v. Hungary*, No. 19400/11, 2012 (exclusion of family from the witness protection programme)

Children's rights in the context of juvenile justice proceedings concern children accused of, prosecuted for or sentenced for having committed criminal offences, as well as children who participate in justice or related proceedings as victims and/or witnesses. The position of children in the context of juvenile justice is regulated by general human rights provisions relevant to both adults and children.

This chapter presents an overview of the European norms relevant to children involved in judicial and alternative proceedings. It addresses fair trial guarantees, including effective participation and access to a lawyer, the rights of detained young offenders, including pre-trial detention (substantive and procedural safeguards), conditions of detention and protection against ill-treatment, and the protection of child witnesses and victims. Protection aspects are especially relevant for non-adversarial, alternative proceedings, which should be used whenever these may best serve the child's best interests.[501] In the case of children, objectives of criminal justice, such as social integration, education and prevention of re-offending, are basic principles that are valued.[502]

501 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010, para. 24.

502 See further, Council of Europe, Committee of Ministers (2008), Recommendation CM/Rec (2008)11 of the Committee of Ministers to member states on the European Rules for juvenile offenders subject to sanctions or measures, 5 November 2008, Part I.A.2.

11.1. Fair trial guarantees

Key points

- Children in criminal proceedings are entitled to be treated fairly and in a child-friendly manner.
- Court proceedings should be adjusted to children's needs to ensure their effective participation.
- Children have the right to access a lawyer from the initial stages of the criminal proceedings and from the first police interrogation.

While briefly outlining the general requirements for a fair trial at both the EU and CoE level, this section places particular emphasis on child-specific fair trial guarantees.

The right to a fair trial is a core pillar of a democratic society. Children suspected or accused of a crime have the right to a fair trial, and they benefit from the same guarantees as any other person in conflict with the law. Fair trial guarantees apply from the child's first interrogation and subsist during the trial. Children in conflict with the law are, however, particularly vulnerable and may therefore need additional protection. European bodies have developed specific requirements to ensure that these children's needs are effectively met.

Under EU law, several provisions of the EU Charter of Fundamental Rights establish basic rights of access to justice which sustain fair trial guarantees for both adults and children. Article 47 deals specifically with the right to an effective remedy and to fair trial, establishing requirements of particular relevance for children, such as the reasonability of time in having a fair and public hearing, and the rights to be defended, represented and advised as well as to legal aid. Similarly, the principles of legality and proportionality of criminal offences and penalties established in Article 49 are particularly relevant for children. In addition, several EU directives lay down specific fair trial guarantees in criminal proceedings: the Right to Interpretation and Translation Directive,[503] the Right

503 Directive 2010/64/EU of the European Parliament and of the Council of 20 October 2010 on the right to interpretation and translation in criminal proceedings, OJ 2010 L 280/1.

to Information Directive,[504] and the Access to a Lawyer Directive.[505] The first two directives do not include child-specific guarantees, although the Right to Information Directive contains provisions addressing the situation of vulnerable suspects or accused persons more generally. The child-related provisions of the Access to a Lawyer Directive are elaborated upon in Section 11.2.2.

Even in the absence of child-specific provisions, Member States must observe the EU Charter of Fundamental Rights when implementing the provisions of the aforementioned directives. Therefore, principles such as the child's best interests, enshrined in Article 24, should be given due weight in cases where children are the subject of any of the provisions of the directives. To date, no cases have been brought to the CJEU concerning the interpretation of Article 24 of the Charter in conjunction with one the mentioned directives.[506]

Of specific importance is the European Commission proposal for a directive on procedural safeguards for criminally suspected or accused children,[507] which aims to provide children mandatory access to a lawyer at all stages of criminal proceedings. It also provides that children should benefit from prompt information about their rights, the assistance of parents (or other appropriate persons) and questioning behind closed doors. In addition, children deprived of liberty should be entitled to receive appropriate education, guidance, training, and medical care, and to be kept separate from adults.[508]

Under CoE law, the ECHR fair trial guarantees are laid down in Article 6, which generates the most extensive case law of the ECtHR. Article 6 (1) of the ECHR includes some express fair trial guarantees: the right to a fair public hearing/

504 Directive 2012/13/EU of the European Parliament and of the Council of 22 May 2012 on the right to information in criminal proceedings, OJ 2012 L 142/1.

505 Directive 2013/48/EU of the European Parliament and of the Council of 22 October 2013 on the right of access to a lawyer in criminal proceedings and in European arrest warrant proceedings, and on the right to have a third party informed upon deprivation of liberty and to communicate with third persons and with consular authorities while deprived of liberty, OJ 2013 L 294/1.

506 The CJEU has dealt with the interpretation of Art. 24 in proceedings relating to international child abduction (see Section 5.4).

507 European Commission (2013), Proposal for a Directive of the European Parliament and of the Council on procedural safeguards for children suspected or accused in criminal proceedings, COM(2013) 822 final, Brussels, 27 November 2013.

508 See further Section 11.2. Of relevance for child protection can also be the European Commission (2013), Proposal for a Directive of the European Parliament and of the Council on provisional legal aid for suspects or accused persons deprived of liberty and legal aid in European arrest warrant proceedings, COM(2013) 824 final, Brussels, 27 November 2013.

pronouncement (unless it is contrary to, among others, the interests of juveniles); the right to a trial within reasonable time; the right to a trial by an independent and impartial tribunal; [509] and the right to a trial by a tribunal established by law. Inherent in the concept of a fair trial, the ECtHR has developed guarantees: equality of arms and adversarial proceedings; the right to remain silent; access to a lawyer; effective participation; presence at the hearing; and reasoned decisions. In addition, everyone must be presumed innocent until proven guilty, according to law (Article 6 (2) of the ECHR).

Everyone charged with a criminal offence shall have the following minimum rights: the right to be informed promptly about the charges in a language she/he understands (Article 6 (3) (a) of the ECHR); the right to have adequate time and facilities for the preparation of her/his defence (Article 6 (3) (b) of the ECHR); the right to have legal assistance of her/his own choosing (Article 6 (3) (c) of the ECHR); the right to examine or have witnesses examined (Article 6 (3) (d) of the ECHR); and the right to have the free assistance of an interpreter (Article 6 (3) (e) of the ECHR). These guarantees apply to adults and children alike. However, aspects of particular importance to children which have generated child-specific case law include the right to effective participation, as well as the right to access a lawyer. These two specific fair trial guarantees are therefore further elaborated upon in this chapter.

Of high importance for child suspects/accused are the CoE's *Guidelines on child friendly justice*.[510] Even if the guidelines are not legally binding, they represent a stepping stone in ensuring that justice proceedings, including those part of the criminal justice system, take into account the specific needs of children. They are built on existing ECtHR case law and other European and international legal standards, such as the UN Convention on the Rights of the Child. They are a useful tool for professionals dealing with children. According to Section I (1), the guidelines apply to children in judicial (criminal or non-criminal) proceedings or in alternatives to such proceedings. Of specific importance for children in criminal proceedings is the right to have the information on criminal charges explained to both the child and the parents in a way that they understand the exact charge (Section IV.A.1.5); the right to be questioned only in the presence of the lawyer/parents or a person of trust (Section C (30)); the right to

509 ECtHR, *Nortier v. the Netherlands*, No. 13924/88, 24 August 1993; ECtHR, *Adamkiewicz v. Poland*, No. 54729/00, 2 March 2010.

510 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010.

speedy proceedings (Section D (4)) and the right to child-sensitive interviews or hearings (Section D (5)).

In June 2014, PACE adopted a resolution on child-friendly juvenile justice, with which it underscores the need for a rights-based and child-specific treatment of children in conflict with the law.[511] PACE calls upon Member States to implement international human right standards regarding juvenile justice, including the CoE's Guidelines on child friendly justice, and to bring national laws and practice in conformity with these standards. PACE suggests using liberty deprivation only as a measure of last resort and for the shortest possible period of time, setting the minimum age of criminal responsibility at 14 years old, without allowing for exceptions in cases of serious offences, and establishing a specialised juvenile justice system, including diversion mechanisms, non-custodial measures and specialised professionals.

Under international law, Article 40 of the CRC acknowledges that every child alleged as, accused of, or recognised as having infringed penal law is entitled to be treated fairly and in a manner that takes into account his/her age. The key objective of juvenile justice according to Article 40 of the CRC is to reintegrate children in society, in which they can play a constructive role. Article 40 (2) of the CRC recognises children's right to a fair trial and that children have some additional entitlements, including the right to be assisted by parents, the right to appeal and the right to have their privacy fully protected at all stages of the proceedings.

Further, other instruments have developed the CRC principles of fair trial and the right to be treated in a child-specific way, including the use of liberty deprivation as a measure of last resort and only for the shortest appropriate period of time (see Article 37 (b) of the CRC). Of particular importance are the UN Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules),[512] the UN Guidelines for the Prevention of Juvenile Delinquency (Riyadh Guidelines)[513] and the UN Rules for the Protection of Juveniles Deprived

511 Parliamentary Assembly of the Council of Europe, Resolution 2010 (2014), "Child-friendly juvenile justice: from rhetoric to reality".

512 UN, General Assembly (1985), *UN Standard Minimum Rules for the Administration of Juvenile Justice*, UN Doc. GA Res. 40/33,19 November 1985.

513 UN, General Assembly (1990), *UN Guidelines for the Prevention of Juvenile Delinquency*, UN Doc. GA Res. 45/112, 14 December 1990.

of their Liberty (also known as the 'Havana Rules').[514] The Beijing Rules provide detailed guidance on the implementation of Article 40 of the CRC's fair trial requirements and child-specific treatment, including the aims of juvenile justice, protection of privacy, investigation and prosecution, pre-trial detention, adjudication and disposition, and institutional and non-institutional treatment. The Havana Rules concern the treatment of juveniles deprived of their liberty and include rules regarding the definition of liberty deprivation, police custody and pre-trial detention, juvenile institution conditions, disciplinary procedures, screening methods and the use of force or restraint, complaint mechanisms, inspection and monitoring mechanisms and the reintegration of juveniles. Finally, the Riyadh Guidelines provide detailed guidelines regarding policies aiming at the prevention of juvenile delinquency.

The UNCRC issued one General Comment (No. 10)[515] on children and juvenile justice, which offers detailed guidance on how to interpret and implement the CRC as far as juvenile justice is concerned. This comment deals with important juvenile justice principles, including the right to effective participation as part of the right to a fair trial (see further in Section 11.1.1), the use of deprivation of liberty as a measure of last resort and for the shortest appropriate period of time, the use of diversion and prevention of juvenile delinquency, the embedment of the best interests of the child principle and the principle of non-discrimination in the juvenile justice system, and age limits. The UNCRC recommends to set the minimum age of criminal responsibility at 12, or preferably higher. It also recommends to grant all children the right to be dealt with in the context of juvenile justice and prohibits transferring 16 and 17 year olds to the adult criminal system in cases of serious offences. Other general comments, e.g. regarding the right to be heard (which is connected to the right to participate effectively in justice proceedings), and the protection against all forms of violence, are also relevant for juvenile justice.[516]

514 UN, General Assembly (1990), UN Rules for the Protection of Juveniles Deprived of their Liberty, UN Doc. GA Res. 45/113, 14 December 1990.

515 UN, Committee on the Rights of the Child (2007), *General Comment No. 10 on Children's rights in juvenile justice*, CRC/C/GC/07, 25 April 2007.

516 UN, Committee on the Rights of the Child (CRC) (2009), *General Comment No. 12 (2009): The right of the child to be heard*, CRC/C/GC/12, 1 July 2009; UN, Committee on the Rights of the Child (2011), *General Comment No. 13 (2011) – The right of the child to freedom from all forms of violence,* CRC/C/GC/13, 18 April 2011.

11.1.1. Effective participation

Under EU law, Article 47 of the EU Charter of Fundamental Rights lays down similar guarantees to those provided under Article 6 of the ECHR, including the right to a fair and public hearing within a reasonable time by an independent and impartial tribunal, the right to legal representation and the right to effective remedies. The proposed directive on procedural safeguards for criminally suspected or accused children includes the right to effective participation, as well as the right to legal representation.[517]

Under CoE law, the ECtHR has elaborated under Article 6 specific requirements for ensuring children's effective participation in criminal trials. As a general rule, proceedings should ensure that account is taken of the child's age, level of maturity and emotional capacities.[518] Concrete examples of 'effective participation' requirements include the child's presence during the hearings, holding of *in camera* hearings, limited publicity, ensuring that the child understands what is at stake and limited formality of court sessions. So far the ECtHR has not held that setting the age of criminal responsibility too low constitutes in itself a violation of Article 6 of the ECHR. When assessing whether a child was able to participate effectively in the national proceedings the ECtHR looks at the concrete circumstances of each case.

Example: The case of *T. v. the United Kingdom*[519] concerns the murder of a two year old by two ten year olds. They were committed to public trial under big media attention. The court procedure was partly modified, in that shorter sessions were held, the applicant's parents were placed close to him, a playing area was available during breaks, etc. Nevertheless, the applicant and his co-accused were tried in an adult court, and most of the rigors of a criminal trial were preserved. The ECtHR held that the applicant had not been able to participate effectively in the proceedings due to the publicity of the sessions combined with the high level of media attention and to his limited capacity to instruct his lawyers and to provide adequate testimonies. His rights under Article 6 of the ECHR were therefore violated.

517 European Commission (2013), Proposal for a Directive of the European Parliament and of the Council on procedural safeguards for children suspected or accused in criminal proceedings, COM(2013) 822 final, Brussels, 27 November 2013.

518 ECtHR, *T. v. the United Kingdom* [GC], No. 24724/94, 16 December 1999, para. 61.

519 ECtHR, *T. v. the United Kingdom* [GC], No. 24724/94, 16 December 1999.

The recognition of the right to effective participation is also at the core of the Council of Europe's Guidelines on child-friendly justice. Justice for children, including juvenile justice, should be "accessible, age appropriate, speedy, diligent, adapted to and focused on the needs and rights of the child, respecting the rights of the child including the right to due process, to participate in and to understand the proceedings, to respect for private and family life and to integrity and dignity".[520] The guidelines provide specific guidance on how children should be treated during juvenile justice or other justice proceedings. Children should have access to court and judicial proceedings, and their rights to legal counsel and representation and to be heard and express their views should be safeguarded; undue delay should be avoided, proceedings should be organised in a child-friendly way (which affects the environment and language) and special safeguards should be in place to take and respond to evidence/statements provided by children.[521]

11.1.2. Access to a lawyer

Under EU law, the Access to a Lawyer Directive 2013/48/EU[522] – to be implemented by 27 November 2016 – includes direct references to children in Recitals 52 and 55 of its preamble, as well as in Article 5 (2)–(4). Pursuant to Recital 55 and Article 5 (2), if a child is deprived of liberty, the holder of parental responsibility shall be notified and be given reasons thereof, unless this would be contrary to the child's best interests. In the latter case, another appropriate adult shall be informed. According to Article 2, the directive applies from the moment suspects or accused are made aware of having committed a criminal offence until the conclusion of the proceedings by a final determination of guilt or innocence. Further, Article 3 (3) lays down that access to a lawyer includes the right of suspects/accused to meet and communicate with the lawyer in private, including before the first interrogation, the presence and effective participation of the lawyer during questioning and the lawyer's presence during several investigative or evidence gathering acts.

520 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010, para. II. C.

521 *Ibid.*, Section D.

522 Directive 2013/48/EU of the European Parliament and of the Council of 22 October 2013 on the right of access to a lawyer in criminal proceedings and in European arrest warrant proceedings, and on the right to have a third party informed upon deprivation of liberty and to communicate with third persons and with consular authorities while deprived of liberty, OJ 2013 L 294/1.

Under CoE law, the ECtHR considers access to a lawyer to be one of the fundamental elements of the right to a fair trial.[523] Individuals charged with a criminal offence have the right to access a lawyer from the early stages of a police investigation. That right may be limited in exceptional circumstances, provided that the limitation does not unduly prejudice the rights of the accused. The ECtHR has found that this could occur when statements given without having had access to a lawyer are used for conviction.[524] The ECtHR's scrutiny of whether an applicant had effective access to a lawyer is stricter in cases involving children.[525]

Example: The case of *Panovits v. Cyprus*[526] concerns a 17 year old who was charged with murder and robbery. He was brought to the police station, accompanied by his father. He was then arrested and taken to a separate room for questioning, in the absence of the father or a lawyer. While the applicant was being questioned, his father was informed of the applicant's right to contact a lawyer. Several minutes later, the father was told that his son had meanwhile confessed to having committed the crime. The ECtHR found that, in view of his age, the applicant could not have been considered to be aware of his right to legal representation before making any statement. It was also unlikely that he could reasonably have appreciated the consequences of him being questioned without the assistance of a lawyer in criminal proceedings concerning a murder. Even though the authorities appeared to have at all times been willing to allow the applicant to be assisted by a lawyer if he so requested, they had failed to make him aware of his right to request the assignment of a lawyer free of charge if necessary. There was no evidence that the applicant or his father expressly and unequivocally waived their right to legal assistance. Consequently, the Court found a violation of Article 6 (3) (c) in conjunction with Article 6 (1) of the ECHR.

523 ECtHR, *Salduz v. Turkey* [GC], No. 36391/02, 27 November 2008, para. 51.

524 *Ibid.*, para. 62.

525 *Ibid.*, para. 60.

526 ECtHR, *Panovits v. Cyprus*, No. 4268/04, 11 December 2008.

11.2. Rights of young offenders in relation to detention

Key points

- Children may only be deprived of their liberty as a last resort and for the shortest appropriate period of time.
- If detained, children are to be treated age-appropriately and with respect for their dignity.
- Children should not be detained together with adults.

Every person has the right to liberty. Deprivation of liberty therefore constitutes an exception and includes any form of placement in an institution by decision of a judicial or administrative authority, from which the juvenile is not permitted to leave at will.[527] Given the importance of safeguarding the rights of the child, including their best interests, situations of liberty-deprivation should be considered from that particular angle when concerning children.

While detention occurs in various circumstances, this section focuses on children in contact with the criminal justice systems.

International instruments universally affirm that detention must be a measure of last resort. This means that state authorities faced with the question of placing a child in detention should first give adequate consideration to alternatives to protect the best interests of the child, as well as to further the reintegration of the child (Article 40 (1) of the CRC). Alternatives can include, for example: "care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes" (Article 40 (4) of the CRC). Only where alternatives are not feasible should detention be considered. Moreover, detention should only be ordered for the shortest period of time and under appropriate substantive and procedural guarantees. In view of their age and vulnerability, children benefit from special rights and guarantees when placed in detention.

527 Rule 21.5 of Council of Europe, Committee of Ministers (2008), Recommendation CM/Rec(2008)11 on the European Rules for juvenile offenders subject to sanctions or measures, 5 November 2008.

11.2.1. Forms of detention (substantive and procedural guarantees)

Under EU law, the current legal framework for criminal justice proceedings does not include a binding instrument regarding the detention of children.

Under CoE law, Article 5 of the ECHR provides that everyone has the right to liberty. Detention is an exception which should be provided for by national law and should not be arbitrary. In addition, detention has to be justified under one of the six exhaustive situations listed under Articles 5 (1) (a) to (f). Detention of children in contact with the criminal justice system can be justified under paragraphs (a) detention after conviction by a competent court; (c) pre-trial detention; or (d) detention for the purpose of educational supervision in particular. The latter two shall be analysed, as they have given rise to specific duties on the part of the state authorities.

Pre-trial detention

'Pre-trial detention' refers to situations where individuals are taken into police custody on suspicion of having committed a criminal offence, or are held in remand. It starts when an individual is taken into custody and ends with the determination on the merits of the case by a court of first instance.[528] While children benefit from the same guarantees as adults, the ECtHR has laid down several additional principles to strengthen the position of children in domestic criminal proceedings.

The ECtHR has generally interpreted Article 5 (1) (c) and Article 5 (3) as requiring that a person be placed in pre-trial detention only if there is a reasonable suspicion of him/her having committed a criminal offence. Further, pre-trial detention should not exceed a reasonable time and should be reviewed at reasonable intervals. The longer the period of detention, the stronger the reasons put forward by the authorities to justify it need to be. According to ECtHR case law, a person charged with an offence must always be released pending trial, unless the state can show that there are "relevant and sufficient" reasons to justify the continued detention.[529]

528 ECtHR, *Idalov v. Russia* [GC], No. 5826/03, 22 May 2012, para. 112.

529 ECtHR, *Smirnova v. Russia*, No. 46133/99 and 48183/99, 24 July 2003, para. 58.

The ECtHR developed four basic acceptable reasons for refusing bail to the detainee in cases of pre-trial detention: the risks of absconding, of prejudicing the administration of justice, of committing further offences or of causing public disorder. In addition, the continuation of pre-trial detention should be strictly necessary, and the state must examine all the facts arguing for or against the existence of a genuine requirement of public interest justifying a continued deprivation of liberty.[530]

In cases involving children, the ECtHR mandates that state authorities should pay particular attention to the child's age when balancing the relevant arguments for and against pre-trial detention; it should be used as a measure of last resort and for the shortest possible period.[531] This implies that the authorities should consider alternatives to pre-trial detention.[532]Furthermore, state authorities should display special diligence in bringing children to trial within a reasonable time.[533]

Example: In *Nart v. Turkey*,[534] the 17 year old applicant was arrested on suspicion of having robbed a grocery shop. He was placed in pre-trial detention, in an adult prison, for 48 days. With particular reference to the fact that the applicant was a child, the ECtHR stated that "pre-trial detention of minors should be used only as a measure of last resort; it should be as short as possible and, where detention is strictly necessary, minors should be kept apart from adults".[535] In this particular case the authorities attempted to justify the pre-trial detention on the basis of the 'state of evidence', but the ECtHR found that this reason alone could not justify the length of the applicant's detention. Consequently, the ECtHR found a violation of Article 5 (3) of the ECHR.

530 *Ibid.*, paras. 58–59; ECtHR, *Ladent v. Poland*, No. 11036/03, 18 March 2008, para. 55.

531 ECtHR, *Korneykova v. Ukraine*, No. 39884/05, 19 January 2012, paras. 43–44. See also ECtHR, *Selçuk v. Turkey*, No. 21768/02, 10 January 2006, paras. 35–36; ECtHR, *J.M. v. Denmark*, No. 34421/09, 13 November 2012, para. 63.

532 ECtHR, *Dinç and Çakır v. Turkey*, No. 66066/09, 9 July 2013, para. 63 (available in French); ECtHR, *Güveç v. Turkey*, No. 70337/01, 20 January 2009, para. 108.

533 ECtHR, *Kuptsov and Kuptsova v. Russia*, No. 6110/03, 3 March 2011, para. 91.

534 ECtHR, *Nart v. Turkey*, No. 20817/04, 6 May 2008.

535 *Ibid.*, para. 31.

Detention for the purpose of educational supervision

This form of detention has been ordered in situations where the child has a particular need for educational supervision because of a disturbed personality and violent behaviour. Article 5 (1) (d) of the ECHR primarily targets forms of detention outside the scope of the juvenile justice system.

Example: The case of *Bouamar v. Belgium*[536] concerns the placement of a child in a remand prison on nine occasions for periods of around 15 days. The applicant was an adolescent considered to have a disturbed personality and violent behaviour. The Belgian Government submitted that he had been placed in the remand prison for the purpose of educational supervision. The ECtHR noted that interim placements in a remand prison are not in themselves contrary to Article 5 (1) (d), as long as the authorities pursue the purpose of placing the juvenile under educational supervision. However, the ECtHR found that in the applicant's case the authorities failed to show that they had the intention or possibility to place him in an institution where he could benefit from educational supervision. Consequently, the ECtHR found a violation of Article 5 (1) (d) of the ECHR.

Example: *D.G. v. Ireland*[537] concerns the placement of a violent child in a detention centre. The ECtHR held that the notion of 'educational supervision' should not be equated strictly with classroom teaching. Educational supervision entails many aspects of the exercise of parental rights by the local authority for the benefit and protection of the person concerned. The ECtHR held that it is permissible for domestic authorities to place juveniles in detention facilities on a temporary basis until suitable accommodation is found, as long as this happens speedily. In the applicant's case the speediness requirement was not met as he was only placed in a suitable accommodation more than six months after his release from detention. The ECtHR therefore found a violation of Article 5 (1) (d) of the ECHR.

536 ECtHR, *Bouamar v. Belgium*, No. 9106/80, 29 February 1988.

537 ECtHR, *D.G. v. Ireland*, No. 39474/98, 16 May 2002.

Appeals to detention, speediness of review and access to a lawyer

The ECtHR requires particular diligence from national authorities in cases involving children in detention. In addition to the guarantees mentioned above, state authorities must ensure that children have the right to challenge the lawfulness of the detention at reasonable intervals, and that they have access to a lawyer during the proceedings determining the lawfulness of their detention. Furthermore, these legal challenges need to be decided speedily by domestic courts. The ECtHR derives these procedural guarantees from the text of Article 5 (4) of the ECHR.

> Example: In *Bouamar v. Belgium*,[538] the ECtHR found a violation of Article 5 (4) because: the hearings for the determination of the applicant's detention took place in the absence of his lawyers; they were not decided speedily; there was no actual decision on the 'lawfulness of the detention', since the domestic courts dismissed the applicant's appeals as devoid of purpose.

11.2.2. Conditions of detention

Under EU law, Article 4 of the EU Charter of Fundamental Rights prohibits torture and inhuman or degrading treatment. However, as the Charter only applies within the scope of EU law, this provision has to be linked to another EU legal instrument dealing with detention in order to bind Member States in this respect. So far, there have not been any cases before the CJEU in relation to Article 4 of the Charter.

Under CoE law, the ECtHR found that detaining children together with adults might lead to a breach of Article 3[539] or Article 5 of the ECHR.[540] Further, lack of adequate medical care in detention could also raise issues under Article 3.[541] Other aspects which may potentially raise issues under Article 3 include available cell space, lighting, and recreational activities.[542] In assessing the compatibility of conditions of detention with the standards of Article 3 of

538 ECtHR, *Bouamar v. Belgium*, No. 9106/80, 29 February 1988.

539 ECtHR, *Güveç v. Turkey*, No. 70337/01, 20 January 2009.

540 ECtHR, *Nart v. Turkey*, No. 20817/04, 6 May 2008.

541 ECtHR, *Güveç v. Turkey*, No. 70337/01, 20 January 2009; ECtHR, *Blokhin v. Russia*, No. 47152/06, 14 November 2013 (referred to the GC on 24 March 2014).

542 ECtHR, *Kuptsov and Kuptsova v. Russia*, No. 6110/03, 3 March 2011, para. 70.

the ECHR, the ECtHR often relies on the set of standards developed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), which monitors prison conditions under the umbrella of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment by conducting site visits to CoE member states.[543]

Example: In *Güveç v. Turkey*,[544] a fifteen year old boy was arrested on suspicion of membership of the Kurdistan Working Party (PKK). He was detained by the State Security Court in a prison for adults for five years. The ECtHR observed that his detention contravened Turkish regulations and obligations under international treaties, including, among others, Article 37 (c) of the CRC, which requires that children are kept separately from adults. The Court also noted that the applicant began to have psychological problems in prison, as a result of which he repeatedly attempted to commit suicide. In addition, the authorities failed to provide the applicant with adequate medical care. Consequently, given the applicant's age, the length of his detention in prison together with adults, the failure of the authorities to provide adequate medical care for his psychological problems, and their failure to take steps to prevent his repeated attempts to commit suicide, the ECtHR had no doubt that the applicant was subjected to inhuman and degrading treatment. There had accordingly been a violation of Article 3 of the ECHR.

The ECSR has consistently interpreted Article 17 of the ESC to the effect that if children are detained or imprisoned, they should be separated from adults.

The CoE European Rules for juvenile offenders subject to sanctions or measures provide detailed guidance on conditions of detention. They also provide that juveniles should not be held in institutions for adults, but in institutions specially designed for them.[545]

543 See, for example, ECtHR, *Güveç v. Turkey*, No. 70337/01, 20 January 2009.

544 *Ibid*.

545 Council of Europe, Committee of Ministers (2008), CM/Rec(2008)11 on the European Rules for juvenile offenders subject to sanctions or measures, 5 November 2008, Rule 59.1.

Under international law, the CRC contains a separate provision on deprivation of liberty of children. which states that children must be separated from adults, unless it is not in their best interest to do so (Article 37 (c) of the CRC). This article also stipulates that children, in principle, have the right to maintain contact with their family through correspondence or visits.

11.2.3. Protection against abuse and ill-treatment

Under CoE law, the ECtHR has repeatedly held that domestic authorities are responsible for protecting persons in detention from death, abuse or ill-treatment caused by other inmates or the authorities themselves. States' obligations in this respect are particularly strong, since detainees are under the authority and control of the state.[546] In addition to taking reasonable measures to protect inmates, state authorities must also conduct effective investigations into arguable allegations of ill-treatment or death.

Example: The case of *Çoşelav v. Turkey* concerns the suicide of an adolescent in prison,[547] who had previously unsuccessfully attempted to commit suicide on several occasions. Following those attempts, the authorities transferred him from a wing for juveniles to a detention facility for adults. Having first established that the authorities knew or ought to have known of the existence of a real and immediate risk to the life of the applicants' son, the Court then noted that the authorities failed to take reasonable measures to prevent the risk of suicide. The ECtHR placed a strong emphasis on the age of the deceased and the fact that he had been detained together with adults. Consequently, the ECtHR found a violation of the substantive aspect of Article 2 of the ECHR. In addition, the Court also found a violation of the procedural limb of Article 2 due to the authorities' failure to conduct an effective investigation into the death of the applicants' son. The reasons supporting these findings include: the failure of the authorities to promptly inform the applicants of their son's death; the failure of the prosecution to examine the alleged failures in preventing the suicide; and the excessive length of the ensuing administrative proceeding.

546 ECtHR, *Anguelova v. Bulgaria*, No. 38361/97, 13 June 2002; ECtHR, *H.Y. and Hü.Y. v. Turkey*, No. 40262/98, 6 October 2005.

547 ECtHR, Çoşelav v. Turkey, No. 1413/07, 9 October 2012.

11.3. Protection of child victims and witnesses

Key point

- Child victims and witnesses are entitled to protection against further victimisation, to recovery and reintegration and to effective participation in criminal and alternative proceedings.

Under both EU and CoE law, the position of child victims and witnesses has been recognised.

Under EU law, the Victim's Rights Directive 2012/29/EU[548] explicitly recognises the position of child victims. It provides that, when the victim is a child, his or her best interests are a primary consideration and must be assessed on an individual basis. In addition, a child-sensitive approach must prevail, which means the child's age, maturity, views, needs and concerns must be taken into account. Moreover, the directive aims to ensure that the child and the holder of parental responsibility (or another legal representative) will be informed of any measures or rights specifically focused on the child (Article 1 (2)). Child victims also have the right to be heard during criminal proceedings, and Member States must ensure that they can also provide evidence. Due account must be taken of the child's age and maturity (Article 10 (1)). Furthermore, the directive aims to protect the privacy and identity of child victims during criminal proceedings, to prevent secondary victimisation, among other reasons (Article 21 (1), see also Article 26). Moreover, the directive establishes a special provision on the right to protection of child victims during criminal proceedings (Article 24), which deals with the audiovisual recording of interviews with child victims and its use as evidence in criminal proceedings, the appointment of special representatives, and the right to legal representation in the child's own name if there is a conflict of interests between the child victim and the holders of parental responsibility. The directive furthermore contains various provisions for the protection of victims in general, such as access to victim support services. In the case of children or other vulnerable groups, specialist support

548 Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, OJ 2012 L 315/55.

services should be made available (see Section 38 of the resolution accompanying the directive).[549]

Before being replaced by the Victims' Directive, Framework Decision 2001/220/JHA on the standing of victims in criminal proceedings covered among other things the participation of victims, their rights and fair treatment. It recognised the special position of vulnerable victims, although it did not explicitly refer to children. Pursuant to this framework decision, the CJEU has ruled that children can be qualified as vulnerable when taking into account their age and the offences of which they consider themselves to have been victims. This consequently entitles them to special measures of protection, such as hearing them outside the trial court and before the trial takes place.[550] The CJEU has also ruled that all measures taken to protect victims must be designed in a way that the accused still receives a fair trial. In other words, the protection of victims and witnesses may not jeopardise the right of the accused person to a fair trial (see also the examples of case law of the ECtHR).[551]

Example: In the *Pupino* case,[552] an Italian school teacher was prosecuted for maltreating a pupil. Under the Italian Code of Criminal Procedure, witnesses must, as a rule, testify in court during the trial. In certain circumstances, however, their evidence may be taken before a judge ahead of trial through a special procedure (*incidente probatorio*). In this case, the public prosecutor asked the national court to allow the testimonies of the young children given in advance as evidence, but the national court refused. For the first time, the CJEU gave its interpretation of some of the provisions relevant to the standing of children as victims and witnesses in criminal proceedings. It underscored that the Framework Decision 2001/220/JHA requires Member States to ensure the specific protection of vulnerable victims, which means that the national court must be able to authorise vulnerable victims to testify in a way that guarantees their protection, for example outside the trial and before it takes place. The CJEU stated: "However, independently of whether a victim's minority is as a general rule sufficient to classify such a victim as particularly vulnerable

549 See FRA (2014b), p. 36.

550 CJEU, C-105/03, *Criminal proceedings against Maria Pupino* [GC], 16 June 2005, para. 53.

551 CJEU, C-105/03, *Criminal proceedings against Maria Pupino* [GC], 16 June 2005. See also CJEU, C-507/10, *Criminal proceedings against X*, 21 December 2011.

552 CJEU, C-105/03, *Criminal proceedings against Maria Pupino* [GC], 16 June 2005.

within the meaning of the Framework Decision, it cannot be denied that where, as in this case, young children claim to have been maltreated, and maltreated, moreover, by a teacher, those children are suitable for such classification, having regard in particular to their age and to the nature and consequences of the offences of which they consider themselves to be a victim".[553] Furthermore, the CJEU ruled that all measures concerning the protection and prevention of secondary victimisation must be designed in such a way that the defendant is still granted a fair trial.[554]

Under CoE law, the ECtHR ruled that there is a duty of the state to protect victims' interests. This is true for victims who participate as witnesses in criminal proceedings. Their interests under ECHR provisions, such as Article 2 and Article 8, must be balanced against the interests of the defence.[555] The ECtHR has a number of rulings concerning sexual offences in which children testified against the alleged perpetrators. This case law shows that the Court recognised that criminal proceedings concerning sexual offences "are often conceived of as an ordeal by the victim, in particular when the latter was unwillingly confronted with the defendant" and that this was even more prominent when children were concerned.[556] Consequently, the Court accepted that in such cases certain measures may be taken for the purpose of protecting the child victims. However, it also noted that such measures may not jeopardise the adequate and effective exercise of the rights of the defence, and the judicial authorities may therefore be required to take measures which counterbalance the handicaps under which the defence operates.[557]

Example: In *Kovač v. Croatia*,[558] a 12 year old girl testified before an investigating judge that the applicant had committed indecent acts on her. The applicant had not been present or represented during the said testimony, nor was he given the opportunity to contest the victim's statement The ECtHR reiterated that, as a rule, all evidence must be provided in

553 *Ibid.*, para. 53.

554 *Ibid.*, para. 59.

555 ECtHR, *Doorson v. the Netherlands*, No. 20524/92, 26 March 1996.

556 ECtHR, *S.N. v. Sweden*, No. 34209/96, 2 July 2002, para. 47.

557 ECtHR, *Bocos-Cuesta v. the Netherlands*, No. 54789/00, 10 November 2005; ECtHR, *A.L. v. Finland*, No. 23220/04, 27 January 2009; ECtHR, *W. v. Finland*, No. 14151/02, 24 April 2007; ECtHR, *Kovač v. Croatia*, No. 503/05, 12 July 2007.

558 ECtHR, *Kovač v. Croatia*, No. 503/05, 12 July 2007.

the presence of the accused at a public hearing with a view to adversarial arguments. If statements at the stage of the police inquiry or the judicial investigation are used as evidence, this is not in itself inconsistent with Article 6 of the ECHR, provided that the defendant is given an adequate and proper opportunity to challenge and question the witness concerned, either at the time of making the statements or at a later stage of the proceedings. In the applicant's case, the victim's statements were the only direct evidence of the facts held against the applicant, and this evidence was decisive in the court's decision to issue a guilty verdict. However, the applicant had been unable to contest or obtain a reply from the domestic courts concerning his complaint in that respect. What is more, the victim's actual statement had never been read out before the trial court. Instead, the judge merely noted that the victim upheld her statement made before the investigating judge. Therefore, the ECtHR concluded that the applicant had not been afforded a fair trial, a breach of Article 6 (1) in conjunction with Article 6 (3) (d) of the ECHR.

Example: In *S.N. v. Sweden*,[559] a ten-year-old boy testified to the police that he was sexually abused by the applicant. The boy was interviewed twice by a police inspector with significant experience in child abuse cases. The first interview was videotaped, the second audiotaped. The lawyer of the applicant did not attend the second interview, but agreed with the police-inspector on the issues that needed to be discussed. During the trial, the District Court played the recordings of the child's interviews, but did not examine him in person. The court ultimately convicted the applicant, relying almost entirely on the child's testimonies. The Court of Appeal upheld the conviction. It found that the police interviews provided sufficient evidence for the applicant's guilt to be established, even though it acknowledged that there was no technical evidence supporting the child's allegations, which were sometimes imprecise. The ECtHR accepted that, in sexual offence cases, cross-examination of a witness is not always possible and that, in such cases, witness testimonies should be treated with extreme care. Although the statements made by the child were virtually the sole evidence against the accused, the proceedings as a whole were fair. The videotape was shown during the trial and appeal hearings and the transcript of the second interview was read out before the District Court; the audiotape was also played before the Court of Appeal. This gave the

559 ECtHR, *S.N. v. Sweden*, No. 34209/96, 2 July 2002.

applicant sufficient opportunity to challenge the child's testimony and his credibility in the course of the criminal proceedings. Consequently, there had been no violation of Article 6 (3) (d) of the ECHR.

The case law of the ECtHR is not only about balancing the protection of child victims and the right of the defendant to a fair trial, but also about the protection of the right to life of witnesses and their families, including children, under Article 2 of the ECHR, as shown by the following example.

Example: *R.R. and Others v. Hungary*[560] concerns a prisoner who testified in open court about his drug-trafficking activities and who was, along with his wife and two children, put in the official witness-protection programme for risk of retribution. When the authorities realised that the prisoner was still in contact with criminal circles, they removed him and his family from the witness protection programme for having breached its terms. Under Article 2 of the ECHR, the family claimed that their exclusion from the witness-protection programme had put their lives at risk of mafia retribution. The Court accepted that the applicants' inclusion in the witness protection programme and the father's collaboration with the authorities meant that the applicants' lives had been at risk when the measure was originally put in place. As the cancellation of their protection by the programme was not motivated by a reduction of that risk, but by a breach of its terms, the Court was not persuaded that the authorities had proven that the risk had ceased to exist. Furthermore, it was not unreasonable to suppose that, following the withdrawal of the family's cover identities, their identities and whereabouts became accessible to anyone wishing to harm them. In that way, the authorities potentially exposed the family to a life-threatening danger, in breach of Article 2 of the ECHR.

Article 31 of the Lanzarote Convention indicates which general measures of protection Member States should take to protect the rights and interests of victims, including their special needs as witnesses, at all stages of investigations and criminal proceedings (Article 31 (1)). These measures include information about their rights as victims, the availability of services and the general progress of the investigation or proceedings, the protection of their privacy and safety (including information on the release of the person prosecuted or convicted) and the avoidance of contact between victims and perpetrators in

560 ECtHR, *R.R. and Others v. Hungary*, No. 19400/11, 4 December 2012.

court and law enforcement agency premises. In addition, Article 31 provides that victims must have access to legal aid (Article 31 (3)). The information provided must be adapted to children's age and maturity and be in a language he or she understands (Article 31 (6)).

The CoE's *Guidelines on child friendly justice*[561] also pay attention to the position of the child victim and witness, particularly when he or she gives evidence in judicial proceedings. The guidelines call upon member states to make "'[e]very effort […] for children to give evidence in the most favourable settings and under the most suitable conditions, having regard to their age, maturity and level of understanding and any communication difficulties they may have".[562] To this end, trained professionals should be involved, and, for example, audiovisual statements encouraged. Children should also have the opportunity to give evidence in criminal cases without the presence of the alleged perpetrator. The guidelines also recognise that this child-friendly approach should respect the right of other parties to contest the content of the child's statements. In addition, the guidelines provide that the privacy and family life of child witnesses should be protected (Section IV (a) (9)) and proceedings should preferably be held *in camera*.

Under international law, the position of child victims has been explicitly recognised in Article 39 of the CRC. This provision stipulates that States Parties must take all appropriate measures to promote physical and psychological recovery and social reintegration of child victims. This recovery and reintegration must take place in an environment which fosters the health, self-respect and dignity of the child.

It is also important to note that the UN has adopted the Guidelines on Justice in Matters involving Child Victims and Witnesses of Crime.[563] These guidelines call for child victims and witnesses to be treated in a "child-sensitive manner", which "denotes an approach that balances the child's right to protection and that takes into account the child's individual needs and views".[564] The guide-

561 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010. See also FRA (2015b).

562 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010, para. 64.

563 UN Economic and Social Council (ECOSOC), Resolution 2005/20, *Guidelines on Justice in Matters involving Child Victims and Witnesses of Crime*, 22 July 2005.

564 *Ibid.*, para. 9 (d).

lines provide very detailed guidance on how to implement these aspects. The UN Committee on the Rights of the Child has also underscored the relevance of these UN Guidelines under Article 12 of the CRC (right to be heard) in its General Comment.[565] According to the committee, child victims and child witnesses of a crime must be given an opportunity to fully exercise their rights to freely express their views, which in particular "means that every effort has to be made to ensure that a child victim and/or witness is consulted on the relevant matters with regard to involvement in the case under scrutiny, and enabled to express freely, and in her or his own manner, views and concerns regarding her or his involvement in the judicial process".[566] The Committee also argues that "the right of the child victim and witness is [...] linked to the right to be informed about issues such as availability of health, psychological and social services, the role of a child victim and/or witness, the ways in which 'questioning' is conducted, existing support mechanisms in place for the child when submitting a complaint and participating in investigations and court proceedings, the specific places and times of hearings, the availability of protective measures, the possibilities of receiving reparation, and the provisions for appeal".[567]

565 UN, Committee on the Rights of the Child (2009), *General Comment no. 12 (2009): The right of the child to be heard*, CRC/C/GC/12, 1 July 2009, paras. 62–64.

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How to find case law of the European Courts

European Court of Human Rights: HUDOC case law database

The **HUDOC database** provides free access to ECtHR case law: http://HUDOC.echr.coe.int.

The database is available in English and French and provides a user-friendly search engine that makes it easy to find case law.

Video tutorials and user manuals are available on the HUDOC **Help** page. For details and examples of how to use filters and search fields, the user can place the mouse pointer on the ? at the right of every search tool in the Hudoc interface.

The case law references in this handbook provide the reader with comprehensive information that will enable them to easily find the full text of the judgment or decision cited.

Before starting a search, please note that the default settings show the Grand Chamber and Chamber judgments in the order of the latest judgment published. To search in other collections such as decisions, the user should tick the appropriate box in the **Document Collections** field appearing on the upper left side of the screen.

The simplest way to find cases is by entering the application number into the **Application Number** field under the **Advanced Search** on the upper right side of the screen and then clicking the blue 'Search' button.

To access further case law pertaining to other issues, for example, children-related issues, the user can use the **Search field** indicated with a magnifying glass on the top right part of the screen. In the search field, the user can search in the text using a:

- single word (e.g. child)
- phrase (e.g. "migrant children")
- case title
- State
- Boolean phrase (e.g. child IN alternative care)

To help the user perform a text search, the **Simple Boolean search** is available by clicking on the arrow appearing inside the **Search field**. The Simple Boolean search offers six search possibilities: this exact word or phrase, all of these words, any of these words, none of these words, near these words, free Boolean search.

Once the search results appear, the user can easily narrow the results using the filters appearing in the **Filters** field on the left side of the screen, for example, "Language" or "State". Filters can be used individually or in combination to further narrow the results. The "Keywords" filter can be a useful tool, as it often comprises terms extracted from the text of the ECHR and is directly linked to the Court's reasoning and conclusions.

Example: Finding the Court's case law on the issue of expulsion of asylum seekers putting them at risk of torture or inhuman or degrading treatment or punishment under Article 3 ECHR

1) The user first enters the phrase "asylum seekers" into the **Search field** and clicks the blue **Search button**.

2) After the search results appear, the user then selects the "3" under the **Violation filter** in the **Filters field** to narrow the results to those related to a violation of Article 3.

3) The user can then select the relevant keywords under the **Keywords filter** to narrow the results to those relevant to Article 3, such as the keyword "(Art. 3) Prohibition of torture".

For more significant cases, a legal summary is available in HUDOC. The summary comprises a descriptive head note, a concise presentation of the facts and the law, with emphasis on points of legal interest. If a summary exists, a link **Legal Summaries** will appear in the results together with the link to the judgment text or decision. Alternatively, the user can search exclusively for legal summaries by ticking the "Legal Summaries" box in the **Document Collections** field.

If non-official translations of a given case have been published, a link **Language versions** will appear in the results together with the link to the judgment text or decision. HUDOC also provides links to third-party internet sites that host other translations of ECtHR case law. For more information, see "Language versions" under the HUDOC "Help" section.

Court of Justice of the European Union: CURIA case law database

The **CURIA case law database** provides free access to ECJ/CJEU case law: http://curia.europa.eu.

The search engine is available in all official EU languages.[568] The **language** can be selected on the upper right side of the screen. The search engine can be used to search for information in all documents related to concluded and pending cases by the Court of Justice, the General Court and the Civil Service Tribunal.

There is a **Help** section available at http://curia.europa.eu/common/juris/en/aideGlobale.pdf#. Each search box also has a help page that can be accessed by clicking the icon and contains useful information to help the user make the best possible use of the tool.

The simplest way to find a specific case is to enter the full case number into the search box entitled **Case number** and then clicking the green 'Search' button. It is also possible to search for a case using a part of the case number. For example, entering 122 in the 'Case number' field will find Case No. 122 for

568 Available since 30 April 2004: Spanish, Danish, German, Greek, English, French, Italian, Dutch, Portuguese, Finnish and Swedish; since 1 May 2004: Czech, Estonian, Latvian, Lithuanian, Hungarian, Polish, Slovak and Slovene; since 1 January 2007: Bulgarian and Romanian; since 30 April 2007: Maltese; since 31 December 2011: Irish; temporary derogations have been laid down by Regulation (EC) No. 920/2005 and Regulation (EU) No. 1257/2010. Secondary legislation in force at the date of accession is being translated into Croatian and will gradually be published in the Special edition of the Official Journal of the European Union.

cases from any year and before any of the three courts: Court of Justice, the General Court and/or the Civil Service Tribunal.

Alternatively, one can also use the **Name of parties** field to search with the common name of a case. This is usually the simplified form of the names of the parties to the case.

There are a total of 16 multi-functional search fields available to help narrow the search results. The different search fields are user-friendly and can be used in various combinations. The fields often have search lists that can be accessed by clicking the icon and selecting available search terms.

For more general searches, using the **Text** field produces results based on keyword searches in all documents published in the European Court Reports since 1954, and since 1994 for the European Court Reports – Staff Cases (ECR-SC).

For more subject-specific searches, the **Subject-matter** field can be used. This requires clicking the icon to the right of the field and selecting the relevant subject(s) from the list. The search results will then produce an alphabetised list of selected documents related to the legal questions dealt with in the decisions of the Court of Justice, the General Court, the Civil Service Tribunal and in the Opinions of the Advocates General.

The CURIA website also has additional case law tools:

Numerical access: this section is a collection of case information for any case brought before one of the three courts. The cases are listed by their case number and in the order in which they were lodged at the relevant registry. Cases can be consulted by clicking on their case number. The 'Numerical access' section is available at: http://curia.europa.eu/jcms/jcms/Jo2_7045/.

Digest of the case-law: this section offers a systematic classification of case law summaries on the essential points of law stated in the decision in question. These summaries are based as closely as possible on the actual wording of that decision. The 'Digest' section is available at: http://curia.europa.eu/jcms/jcms/Jo2_7046/.

Annotation of judgments: this section contains references to annotations by legal commentators relating to the judgments delivered by the three courts

since they were first established. The judgments are listed separately by court or tribunal in chronological order according to their case number, while the annotations by legal commentators are listed in chronological order according to their appearance. References appear in their original language. The 'Annotation of judgments' section is available at: http://curia.europa.eu/jcms/jcms/Jo2_7083/.

National case-law database: this external database can be accessed through the CURIA website. It offers access to relevant national case law concerning EU law. The database is based on a collection of case law from EU Member State national courts and/or tribunals. The information has been collected by a selective trawl of legal journals and direct contact with numerous national courts and tribunals. The 'National case-law database' is available in English and in French and is available at: http://curia.europa.eu/jcms/jcms/Jo2_7062/.

Legal instruments referenced

UN legal instruments

On core UN treaties, including the CRC and their monitoring bodies see: www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx.

On the Hague Conference on Private International Law Conventions relating to the International Protection of Children family and property relations see: https://www.hcch.net/en/instruments/conventions.

CoE legal instruments

All CoE legal instruments are available online at http://conventions.coe.int/Treaty/.

For information about the status of acceptance of CoE legal instruments by EU Member States, see 'International obligations' on the FRA website at: http://fra.europa.eu/en/publications-and-resources/data-and-maps/int-obligations.

	Title
Children's rights/civil rights	
European Convention on Human Rights	Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocols No. 11 and No. 14, CETS No.: 005, Rome, 4.11.1950, pp. 1–15.
Protocol to the European Convention on Human Rights	Protocol to the Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocol No. 11, CETS No.: 009, Paris, 20.3.1952, pp. 1–3.
Protocol No. 12 to the European Convention on Human Rights	Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms, CETS No.: 177, Rome, 4.11.2000, pp. 1–3.
European Convention on the Exercise of Children's Rights	European Convention on the Exercise of Children's Rights, CETS No.: 160, Strasbourg, 25.1.1996, pp. 1–10.
European Convention on the Legal Status of Children born out of Wedlock	European Convention on the Legal Status of Children born out of Wedlock, CETS No.: 085, Strasbourg, 15.10.1975, pp. 1–5.
Convention on Human Rights and Biomedicine (Oviedo Convention)	Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, CETS No.: 164, Oviedo, 4.4.1997, pp. 1–12.
Personal identity issues	
Framework Convention for the Protection of National Minorities	Framework Convention for the Protection of National Minorities, CETS No.: 157, Strasbourg, 1.2.1995, pp. 1–10.
European Convention on Nationality	European Convention on Nationality, CETS No.: 166, Strasbourg, 6.11.1997, pp. 1–13.
Convention on the Avoidance of Statelessness in relation to State Succession	Council of Europe Convention on the Avoidance of Statelessness in relation to State Succession, CETS No.: 200, Strasbourg, 19.5.2006, pp. 1–7.
Family life and parental care	
Convention on Contact concerning Children	Convention on Contact concerning Children, CETS No.: 192, Strasbourg, 15.5.2003, pp. 1–13.
European Convention on the Adoption of Children (revised)	European Convention on the Adoption of Children (revised), CETS No.: 202, Strasbourg, 27.11.2008, pp. 1–11.
European Convention on Recognition and Enforcement of Decisions concerning Custody of Children and on Restoration of Custody of Children	European Convention on Recognition and Enforcement of Decisions concerning Custody of Children and on Restoration of Custody of Children, CETS No.: 105, Luxembourg, 20.5.1980, pp. 1–12.

Child protection against violence and exploitation	
Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention)	Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, CETS No.: 201, Lanzarote, 25.10.2007, pp. 1–21.
European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment	European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, CETS No.: 126, Strasbourg, 26.11.1987, pp. 1–9.
Convention on Cybercrime	Convention on Cybercrime, CETS No.: 185, Budapest, 23.11.2001, pp. 1–27.
Council of Europe Convention on Action against Trafficking in Human Beings	Council of Europe Convention on Action against Trafficking in Human Beings, CETS No.: 197, Warsaw, 16.5.2005, pp. 1–21.
Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention)	Council of Europe Convention on preventing and combating violence against women and domestic violence, CETS No.: 210, Istanbul, 11.5.2011, pp. 1–31.
Economic, social and cultural rights	
European Social Charter	European Social Charter, CETS No. 035, Turin, 18.10.1961, pp. 1–18.
European Social Charter (revised)	European Social Charter (revised), CETS No. 163, Strasbourg, 3.5.1996, pp. 1-29.
Issues on migration and asylum	
European Convention on the Repatriation of Minors	European Convention on the Repatriation of Minors, CETS No.: 071, The Hague, 28.5.1970, pp. 1–9.
European Convention on the Legal Status of Migrant Workers	European Convention on the Legal Status of Migrant Workers, CETS No.: 093, Strasbourg, 24.11.1977, pp. 1–14.
European Convention on Social Security	European Convention on Social Security, CETS No.: 078, Paris, 14.12.1972, pp. 1–42.
European Code of Social Security	European Code of Social Security, CETS No.: 048, Strasbourg, 16.4.1964, pp. 1–33.
Consumer and data protection	
Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data	Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data, CETS No.: 108, Strasbourg, 28.1.1981, pp. 1–10.
European Convention on Transfrontier Television	European Convention on Transfrontier Television, CETS No.: 132, Strasbourg, 5.5.1989, pp. 1–20.

EU legal instruments

All EU legal instruments are available online at http://eur-lex.europa.eu.

Short-hand name	Title
Non-discrimination	
Racial Equality Directive (2000/43/EC)	Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin, OJ L 180, 19.7.2000, pp. 22–26.
Employment Equality Directive (2000/78/EC)	Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation, OJ L 303, 2.12.2000, pp. 16–22.
Gender Goods and Services Directive (2004/113/EC)	Council Directive 2004/113/EC of 13 December 2004 implementing the principle of equal treatment between men and women in the access to and supply of goods and services, OJ L 373, 21.12.2004, pp. 37–43.
Family life and parental care	
Brussels II bis Regulation (EC) No. 2201/2003	Council Regulation (EC) No. 2201/2003 of 27 November 2003 concerning jurisdiction and the recognition and enforcement of judgments in matrimonial matters and the matters of parental responsibility, repealing Regulation (EC) No. 1347/2000, OJ L 338, 23.12.2003, pp. 1–29.
Maintenance Regulation (EC) No. 4/2009	Council Regulation (EC) No. 4/2009 of 18 December 2008 on jurisdiction, applicable law, recognition and enforcement of decisions and cooperation in matters relating to maintenance obligations, OJ L 7, 10.1.2009, pp. 1–79.
Mediation Directive (2008/52/EC)	Directive 2008/52/EC of the European Parliament and of the Council of 21 May 2008 on certain aspects of mediation in civil and commercial matters, OJ L 136, 24.5.2008, pp. 3–8.
Access to Justice Directive (2002/8/EC)	Council Directive 2002/8/EC of 27 January 2003 to improve access to justice in cross-border disputes by establishing minimum common rules relating to legal aid for such disputes, OJ L 26, 31.1.2003, pp. 41–47.
Child protection against violence and exploitation	
Young Workers Directive (94/33/EC)	Council Directive 94/33/EC of 22 June 1994 on the protection of young people at work, OJ L 216, 20.8.1994, pp. 12–20.
Anti-Trafficking Directive (2011/36/EU)	Directive 2011/36/EU of the European Parliament and of the Council of 5 April 2011 on preventing and combating trafficking in human beings and protecting its victims, and replacing Council Framework Decision 2002/629/JHA, OJ L 101, 15.4.2011, pp. 1–11.

Directive on combating the sexual abuse and sexual exploitation of children and child pornography (2011/93/EU)	Directive 2011/93/EU of the European Parliament and of the Council of 13 December 2011 on combating the sexual abuse and sexual exploitation of children and child pornography, and replacing Council Framework Decision 2004/68/JHA, OJ L 335, 17.12.2011, pp. 1–14.
Victims' Directive (2012/29/EU)	Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA, OJ L 315, 14.11.2012, pp. 57–73.
Residence Permits for Victims of Anti-Trafficking Directive (2004/81/EC)	Council Directive 2004/81/EC of 29 April 2004 on the residence permit issued to third-country nationals who are victims of trafficking in human beings or who have been the subject of an action to facilitate illegal immigration, who cooperate with the competent authorities, OJ L 261, 6.8.2004, pp. 19–23.
Commission Decision 2007/698/EC	Commission Decision of 29 October 2007 amending Decision 2007/116/EC as regards the introduction of additional reserved numbers beginning with 116 (notified under document number C(2007) 5139) (Text with EEA relevance), OJ L 284, 30.10.2007, pp. 31–32.
Migration and asylum, including social rights of migrant children	
Asylum Procedures Directive (2013/32/EU)	Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection, OJ L 180, 29.6.2013, pp. 60–95.
Dublin Regulation (EU) No. 604/2013	Regulation (EU) No. 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person, OJ L 180, 29.6.2013, pp. 31–59.
Qualification Directive (2011/95/EU)	Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted, OJ L 337, 20.12.2011, pp. 9–26.
Regulation (EU) No. 492/2011	Regulation (EU) No. 492/2011 of the European Parliament and of the Council of 5 April 2011 on freedom of movement for workers within the Union Text with EEA relevance, OJ L 141, 27.5.2011, pp. 1–12.

Free Movement Directive (2004/38/EC)	Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States amending Regulation (EEC) No. 1612/68 and repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC and 93/96/EEC (Text with EEA relevance), OJ L 158, 30.4.2004, pp. 77–123.
Council Directive 77/486/EEC on the education of the children of migrant workers	Council Directive 77/486/EEC of 25 July 1977 on the education of the children of migrant workers, OJ L 199, 6.8.1977, pp. 32–33.
Family Reunification Directive (2003/86/EC)	Council Directive 2003/86/EC of 22 September 2003 on the right to family reunification, OJ L 251, 3.10.2003, pp. 12–18.
Temporary Protection Directive (2001/55/EC)	Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof, OJ L 212, 7.8.2001, pp. 12–23.
Reception Conditions Directive (2013/33/EU)	Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection, OJ L 180, 29.6.2013, pp. 96–116.
Return Directive (2008/115/EC)	Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals, OJ L 348, 24.12.2008, pp. 98–107.
Long-Term Residents Directive (2003/109/EC)	Council Directive 2003/109/EC of 25 November 2003 concerning the status of third-country nationals who are long-term residents, OJ L 16, 23.1.2004, pp. 44–53.
Schengen Borders Code Regulation (EC) No. 562/2006	Regulation (EC) No. 562/2006 of the European Parliament and of the Council o f15 March 2006 establishing a Community Code on the rules governing the movement of persons across borders (Schengen Borders Code), OJ L 105, 13.4.2006, pp. 1–32.
Consumer and personal data protection	
Consumer Rights Directive (2011/83/EU)	Directive 2011/83/EU of the European Parliament and of the Council of 25 October 2011 on consumer rights, amending Council Directive 93/13/EEC and Directive 1999/44/EC of the European Parliament and of the Council and repealing Council Directive 85/577/EEC and Directive 97/7/EC of the European Parliament and of the Council Text with EEA relevance, OJ L 304, 22.11.2011, pp. 64–88.

Directive 87/357/EEC concerning products which, appearing to be other than they are, endanger the health or safety of consumers	Council Directive 87/357/EEC of 25 June 1987 on the approximation of the laws of the Member States concerning products which, appearing to be other than they are, endanger the health or safety of consumers, OJ L 192, 11.7.87, pp. 49–50.
Distance Selling Directive (97/7/EC)	Directive 97/7/EC of the European Parliament and of the Council of 20 May 1997 on the protection of consumers in respect of distance contracts – Statement by the Council and the Parliament re Article 6 (1) – Statement by the Commission re Article 3 (1), first indent, OJ L 144, 4.6.1997, pp. 19–27.
General Product Safety Directive (2001/95/EC)	Directive 2001/95/EC of the European Parliament and of the Council of 3 December 2001 on general product safety (Text with EEA relevance), OJ L 11, 15.1.2002, pp. 4–17.
Directive 2009/39/EC on foodstuffs intended for particular nutritional uses	Directive 2009/39/EC of the European Parliament and of the Council of 6 May 2009 on foodstuffs intended for particular nutritional uses (recast) (Text with EEA relevance), OJ L 124, 20.5.2009, pp. 21–29.
Toy Safety Directive (2009/48/EC)	Directive 2009/48/EC of the European Parliament and of the Council of 18 June 2009 on the safety of toys (Text with EEA relevance), OJ L 170, 30.6.2009, pp. 1–37.
Television Without Frontiers Directive (89/552/EEC)	Council Directive 89/552/EEC of 3 October 1989 on the coordination of certain provisions laid down by Law, Regulation or Administrative Action in Member States concerning the pursuit of television broadcasting activities, OJ L 298, 17.10.1989, pp. 23–30.
Audiovisual Media Services Directive (2010/13/EU)	Directive 2010/13/EU of the European Parliament and of the Council of 10 March 2010 on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the provision of audiovisual media services (Text with EEA relevance), OJ L 95, 15.4.2010, pp. 1–24.
Data Protection Directive (95/46/EC)	Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data, OJ L 281, 23.11.95, pp. 31–50.
Directive 2002/58/EC concerning the processing of personal data and the protection of privacy in the electronic communications sector	Directive 2002/58/EC of the European Parliament and of the Council of 12 July 2002 concerning the processing of personal data and the protection of privacy in the electronic communications sector (Directive on privacy and electronic communications), OJ L 201, 31.7.2002, pp. 37–47.

Unfair Business-to-Consumer Commercial Practices Directive (2005/29/EC)	Directive 2005/29/EC of the European Parliament and of the Council of 11 May 2005 concerning unfair business-to-consumer commercial practices in the internal market and amending Council Directive 84/450/EEC, Directives 97/7/EC, 98/27/EC and 2002/65/EC of the European Parliament and of the Council and Regulation (EC) No. 2006/2004 of the European Parliament and of the Council ('Unfair Commercial Practices Directive') (Text with EEA relevance), OJ L 149, 11.6.2005, pp. 22–39.
Clinical Trials Directive (2001/20/EC)	Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use, OJ L 121, 1.5.2001, pp. 34–44.
Regulation 536/2014 on clinical trials on medicinal products for human use	Regulation (EU) No. 536/2014 of the European Parliament and of the Council of 16 April 2014 on clinical trials on medicinal products for human use, and repealing Directive 2001/20/EC (Text with EEA relevance), OJ L 158, 27.5.2014, pp. 1–76.
Criminal justice and alternative proceedings	
Right to Interpretation and Translation Directive (2010/64/EU)	Directive 2010/64/EU of the European Parliament and of the Council of 20 October 2010 on the right to interpretation and translation in criminal proceedings, OJ L 280, 26.10.2010, pp. 1–7.
Right to Information Directive (2012/13/EU)	Directive 2012/13/EU of the European Parliament and of the Council of 22 May 2012 on the right to information in criminal proceedings, OJ L 142, 1.6.2012, pp. 1–10.
Access to a Lawyer Directive (2013/48/EU)	Directive 2013/48/EU of the European Parliament and of the Council of 22 October 2013 on the right of access to a lawyer in criminal proceedings and in European arrest warrant proceedings, and on the right to have a third party informed upon deprivation of liberty and to communicate with third persons and with consular authorities while deprived of liberty, OJ L 294, 6.11.2013, pp. 1–12.
Charter of Fundamental Rights	Charter of Fundamental Rights of the European Union, OJ C 326, 26.10.2012, pp. 391–407.
Children with disabilities	
Council Decision 2010/48/EC	Council Decision 2010/48/EC concerning the conclusion, by the European Community, of the United Nations Convention on the Rights of Persons with Disabilities, OJ L 23, 27.1.2010, pp. 35–61.

A great deal of information on the European Union Agency for Fundamental Rights is available on the internet. It can be accessed through the FRA website at fra.europa.eu.

Further information on the case law of the European Court of Human Rights is available on the Court's website: echr.coe.int. The HUDOC search portal provides access to judgments and decisions in English and/or French, translations into additional languages, legal summaries, press releases and other information on the work of the Court.

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EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

Children are full-fledged holders of rights. They are beneficiaries of all human and fundamental rights and subjects of special regulations, given their specific characteristics. This handbook aims to illustrate how European law and case law accommodate the specific interests and needs of children. It also illustrates the importance of parents and guardians or other legal representatives and makes reference, where appropriate, to where rights and responsibilities are most prominently vested in children's carers. This handbook aims to raise awareness and improve the knowledge of the legal standards that protect and promote children's rights in Europe. It is a point of reference on both European Union (EU) and Council of Europe (CoE) law related to these subjects, explaining how each issue is regulated under EU law, including the Charter of Fundamental Rights of the European Union, as well as under the European Convention on Human Rights (ECHR), the European Social Charter (ESC) and other CoE instruments. The handbook is designed for non-specialist legal professionals, judges, public prosecutors, child protection authorities, and other practitioners and organisations responsible for ensuring the legal protection of the rights of the child. It explains key jurisprudence, summarising major rulings of both the Court of Justice of the European Union (CJEU) and the European Court of Human Rights (ECtHR).

EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS
Schwarzenbergplatz 11 – 1040 Vienna – Austria
Tel. +43 (1) 580 30-60 – Fax +43 (1) 580 30-693
fra.europa.eu – info@fra.europa.eu

COUNCIL OF EUROPE
67075 Strasbourg Cedex – France

EUROPEAN COURT OF HUMAN RIGHTS
Tel. +33 (0) 3 88 41 20 18 – Fax +33 (0) 3 88 41 27 30
echr.coe.int – publishing@echr.coe.int

CHILDREN'S RIGHTS DIVISION
Tel. +33 (0) 388 41 25 07 – Fax +33 (0) 90 21 52 85
coe.int/children – children@coe.int

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carepath

Empowering public authorities and professionals towards trauma-informed leaving care support

The voice of the traumatised child in civil and criminal proceedings

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

UNIVERSITÀ DEGLI STUDI DI TORINO · REGIONE CALABRIA · IACP · Eurochild Putting children at the heart of Europe · ReadLab Research Innovation and Development Lab · ERGO EMPOWERING CHILDREN & YOUNG PEOPLE · CORDELIA ALAPÍTVÁNY CORDELIA FOUNDATION · e-trikala

Unit 03

Learning objectives

To describe the participatory powers of the traumatised child in civil and criminal proceedings concerning him/her
and the measures that aim to ensure his/her
safety and psycho-physical well-being

Main international and European sources

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COUNCIL OF EUROPE

CONSEIL DE L'EUROPE

- Convention on the Rights of the Child (CRC)
- European Convention on the Exercise of Children's Rights (Strasbourg Conv.)
- Lanzarote Convention
- European Convention on Human Rights (ECHR)

- Charter of Fundamental Rights of the European Union
- Directive 2011/36/EU on trafficking in human beings
- Directive 2012/29/EU on the rights of victims of crime
- Directive 2011/93/EU on combating the sexual abuse and sexual exploitation of children and child pornography

Proceedings in which the child may be involved

1. Criminal proceedings

State's obligation to prevent and punish violence and abuse against minors (primary victimisation) *Art. 3-7 CRC; Art. 3 ECHR; Art. 18 Lanzarote; Art. 2-10 Directive 36; Art. 3-17 Directive 93*

Prevention

Introduction of criminal offences related to violence and abuse against children

Punishment

Punishment of perpetrators of violence and abuse against minors

2. Civil Proceedings

When one or both parents are direct perpetrators of the abuse, or have otherwise allowed it

To guarantee a safe and peaceful family environment

Art. 9 CRC; Art. 8 ECHR

Restrictions for parents

Custody of the child to another family

Placement in facilities for traumatised children

Adoption of the minor

- Video Baldelli
- Video Ceccarelli
- Video Cibinel

- Video Cibinel
- Video Baldelli

Relations between criminal and civil proceedings

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Criminal proceedings

objective → to identify and punish the perpetrator of conduct against the minor, if that conduct is a crime

Civil proceedings

objective → to verify the adequacy of the child's family and to prevent any further injury

These proceedings are separate and independent → conduct that is not a crime can compromise the family environment, justifying the judge's intervention

3. Extrajudicial procedures

When the relationship between the perpetrator of the abuse and the minor appears to be recoverable

Art. 13 Strasbourg Conv.; Art. 12 Directive 29

The aim is to avoid intrusive procedures, which could definitively compromise the recovery of the relationship

- Mediation
- Conciliation attempt
- Additional measures for rapprochement

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The best interests of the child

This principle applies to every proceeding and requires the child's psycho-physical wellbeing to be put before any other interest worthy of protection

Art. 3 CRC; Art. 6 Strasbourg Conv.

The Judge must gather all information necessary to know the facts at issue and the child's family environment

The Judge's decision must always be oriented towards protecting the minor's interests

- Video Ceccarelli
- Video Long

Child's right to be consulted

The child's views must be known by the judge and taken into account in the decision

Art. 12 CRC; Art. 3 Conv. Strasbourg

Participatory guarantees for the child

BUT

Protection measures to avoid "secondary victimisation"

Participatory guarantees for the child

1. The right to be informed

Art. 31 Lanzarote; Art. 3 Strasbourg Conv.; Art. 3-4 Directive 29

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Only a child with adequate knowledge can profitably participate in the decision-making process

About What?

- meaning of the proceedings
- facts at issue
- rights and protections
- child's role
- possible consequences of his/her views

Who?

- judicial authority
- lawyer
- representative
- expert

How?

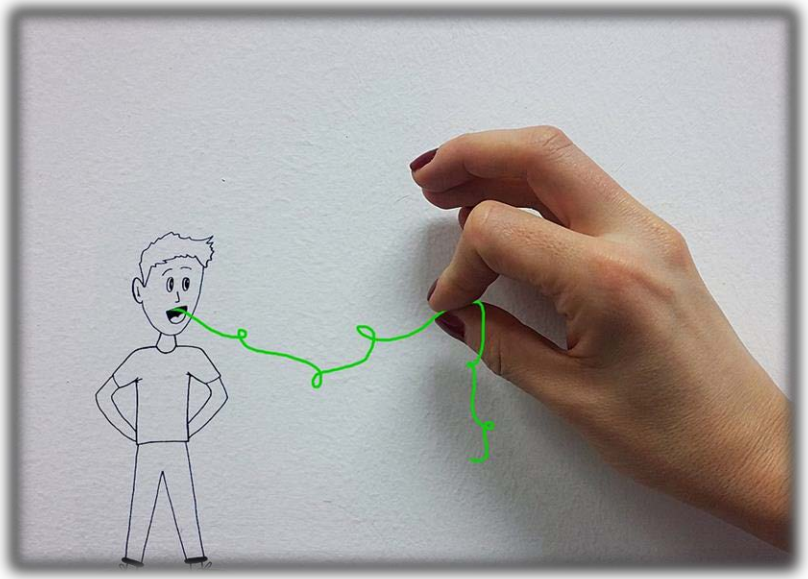
use of language and concepts suitable to the age and understanding of the child

2. Right to be heard about facts at issue

The minor may be asked to testify about facts relevant for the decision

Criminal proceedings

Child as witness of violence and abuse suffered, in order to ascertain the guilt of the accused



Civil proceedings

Child as witness of violence and abuse suffered, in order to assess the adequacy of the family

High risk of secondary victimisation

- Video Ceccarelli
- Video Cibinel
- Video Long

3. Right to be consulted before judge's decision

Before the decision, the child has the right to express his/her views on the issues addressed in the proceedings

Art. 12 CRC; Art. 3 Strasbourg Conv.

Criminal proceedings

- beginning of the proceedings
- precautionary measures
- probation and other special proceedings
- assessment of evidence

Civil proceedings

- removal from the family
- removal of one of the parents
- child custody
- adoption

Often opinion is replaced by the stronger guarantee of consent

Extrajudicial procedures

Consent for mediation or conciliation attempt

The weight of opinion depends on the child's understanding

Protection tools in the proceedings

1. Support persons

Art. 12 CRC; Art. 31 Lanzarote; Art. 9-10 Strasbourg Conv.; Art. 24 Directive 29

Representative (if parents are unavailable, or in conflict of interest)

He identifies and protects the child's interests

Lawyer

He adopts the most appropriate legal strategy to obtain a decision in accordance with the child's interests

Social or health professionals (psychologists, psychiatrists, social workers)

- protection against secondary victimisation
- support to the judge, parents and lawyers, to understand the needs and fragility of the child
- contribution to overcoming the trauma resulting from the violence suffered

These figures may be designated by the Judge

2. Privacy

Art. 16 CRC; Art. 8 ECHR; Art. 21 Directive 29

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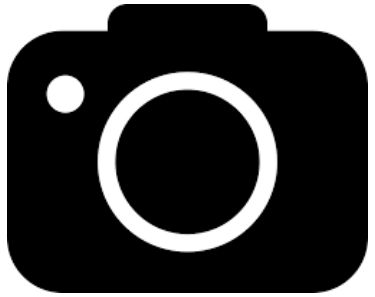
Hearing in closed session, without presence of the public

Limits to the dissemination of images and information



Limits to the questions about private life that can be addressed to the child during the hearing

3. Reasonable duration of the proceedings

Secondary victimisation is also linked to the length of the proceedings *Art. 7 Strasbourg Conv.*

conflict between different values

the decision must be taken as soon as possible to avoid prolonged stress

the other interests of the minor and of the other persons involved in the decision cannot be completely sacrificed

need for balancing

4. Protection measures during the hearing (part I)

When the child testifies about the abuse, about his relations with the perpetrator, about his family *Art. 31 Lanzarote; Art. 18 Directive 29; ECHR, 2.7.2002, S.N. c. Sweden*

⇩

Measures to avoid the risk of secondary victimisation

Venue of the hearing

hearing may take place outside the courtroom

⇩

Minor's house, judge's office, lawyer's office, special room

Who asks the questions?

the questions may not be addressed directly by the lawyers of the parties, but by the judge, or by an expert

⇩

Lawyers could be aggressive, or more simply they might not have experience in examining minors

4. Protection measures during the hearing (part II)

carepath

It is necessary to proceed as soon as possible to the hearing and to avoid repetitions

The wait for the hearing and repetitions increase stress

⇩

The hearing of the child must take place in the early stages of the procedure, and then it must no longer be repeated

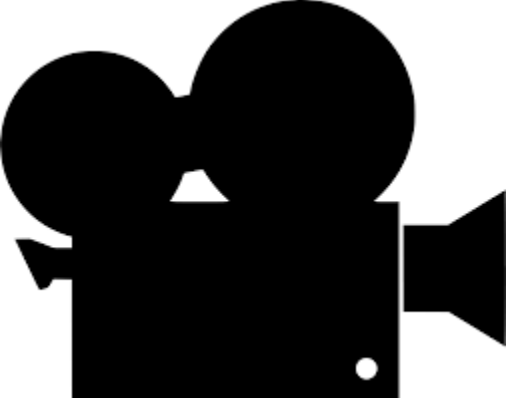
No contact with the accused, parents in conflict of interest and their lawyers

Eye contact can stress and intimidate the child

⇩

- intercom system with mirrored glass
- video conference
- questions prepared by the lawyers but addressed by the judge or by an expert in a special room

need to balance the interests of the child with the rights of the defence



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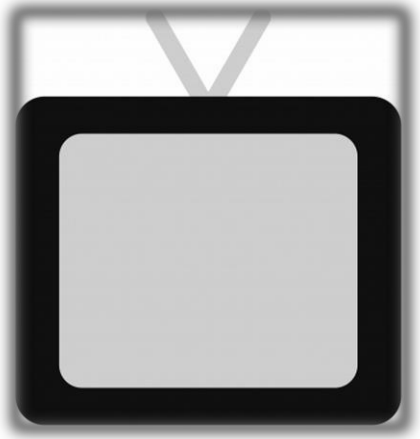
Videos of child's hearing



Example of a special room in Italy

Preparation of the child before testifying
(video 1 and video 2)

A child's testimony about his sister's murder

5. Protection measures for the expression of the child's views or consent

Art. 6 Strasbourg Conv.

Free expression of opinion or consent could be affected by the presence of other persons such as parents, accused and lawyers

The Judge can hear what the child wants to say outside the courtroom, or not in the presence of those persons

- Video Ceccarelli
- Video Long

- Video Baldelli
- Video Cibinel

6. Well-being protection during the proceedings

Art. 20-21 CRC; Art. 31 Lanzarote; Art. 18 Directive 29

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Before the final decision is taken, provisional precautionary measures can be adopted in order to protect the child

Measures against the perpetrator

- precautionary detention/house arrest
- restrictions against parents
- removal from the family home
- prohibition on approaching the child

Measures for the minor

- provisional custody with another family
- removal from the family home

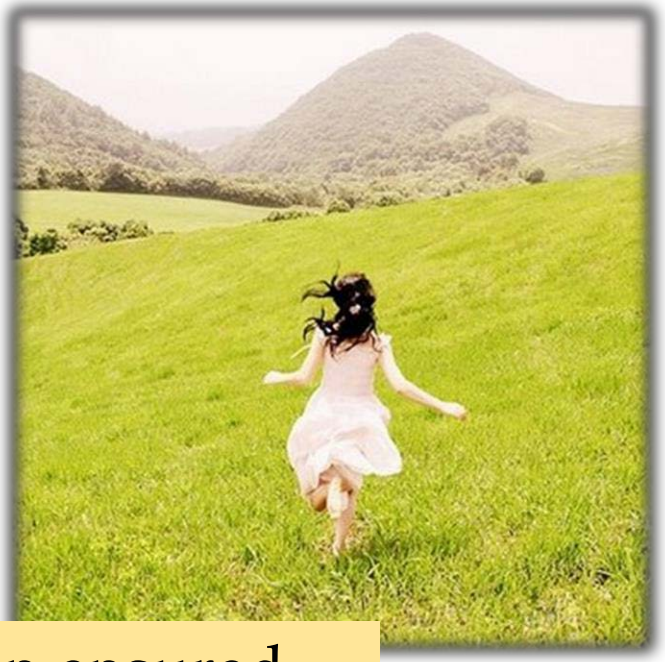
7. Assistance outside the proceedings

Art. 39 CRC; Art. 31 Lanzarote; Art. 8-9 Directive 29

Video Cibinel

Psychological and emotional support outside the proceedings

Secondary victimisation must be combated also before and after the hearing



These needs are often ensured through the work of social services

The punishment of the guilty and the recovery of family serenity are not enough

it is necessary to support the child to overcome the trauma resulting from the abuse suffered (primary victimisation)

Summary on the role of social or health professionals

carepath

Inside the proceedings

- Individual assessment of specific protection needs
- assistance during the child's participation in procedural activities
- assessment of the child's reliability
- participation in conciliation attempts
- assessment of the understanding
- evaluation of the family conditions

main objective → to prevent secondary victimisation and to provide the judge with useful knowledge for his decision

Outside the proceedings

- psychological and emotional support for the child
- checks on the conditions of the new family

main objective → to overcome the trauma caused by the violence and the abuse suffered and to restore family serenity

carepath

Other useful learning materials

Guidelines on child-friendly justice
(Council of Europe)

Handbook for professionals and policymakers on justice in matters involving child victims and witnesses of crime
(United Nations)

Guidelines on children in contact with the justice system
(International Association of Youth and Family Judges and Magistrates)

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Empowering public authorities and professionals towards trauma-informed leaving care support

The impact of a children's rights based approach on social and health policies

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

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Unit 04

Learning objectives

To understand the operational effects on social and health policies of an approach centred on the fundamental rights of children and in particular on their participation rights

Legal framework vs. policies

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Policies are an essential part of the framework for combating violence against children: the presence of adequate legislation that prohibits such violence is NOT sufficient!

"Too often, we see that legislation is on the books but that many children remain on the margins of society (...), all the more vulnerable to violence and abuse
(Rima Salah, Deputy Executive Director, UNICEF. cit., in United Nations Secretary-General's Study on Violence against Children)"

Social and health policies & participation rights

carepath

Children contribute to policies:

- ✓ actively participating in the decision-making process **in their specific case** (e.g. through interviews/letters to the social worker or judge responsible for their case, direct participation in meetings where decisions are made about their case, presence of a special representative)

- ✓ participating **as a group** in the definition of priorities and actions to combat violence against children (e.g. the establishment of advisory councils for children, involvement of young people in the training of childcare professionals, involvement of children in studies and research on the functioning of childcare services)

In the family

"A family where children can freely express views and be taken seriously from the earliest ages… **plays a preventive role against all forms of violence in the home and family**"

Parent education programmes addressing:
- the relationship of mutual respect between parents and children;
- the involvement of children in decision-making;
- ways of dealing with conflicting views within the family

Source: General Comment No. 12 (2009) *The right of the child to be heard*

EXAMPLE NO. 1

At global and European level there are multiple awareness-raising initiatives, several specifically aimed at parents, to affirm the illegitimacy of any corporal punishment of children

In alternative care

carepath

"Mechanisms must be introduced to ensure that children in all forms of alternative care, including in institutions, are able to express their views and that those views be given due weight in matters of their placement, the regulations of care in foster families or homes and their daily lives" (General Comment No. 12 (2009) *The right of the child to be heard*)

For instance, they must be heard in decisions concerning:

- the choice of the time and place of their placement in alternative care
- family members with whom to maintain contact during alternative care, the frequency and methods of such contacts
- projects about their future
- periodic reviews of their situation

(See SOS, Children's Villages International/ISS, Guidelines for the Alternative Care of Children: A UN Framework, Geneva, 2009)

General mechanisms could include:

- a **monitoring institution** (such as *ombudsman* for children) with unimpeded access to care facilities to hear the views and concerns of the child directly
- a **representative council** for children in the residential care facility, with a mandate to participate in the development and implementation of the policy and rules of the institution
- specific **training of professionals**, also involving children as trainers

Source: General Comment No. 12 (2009) *The right of the child to be heard*

Example No. 2

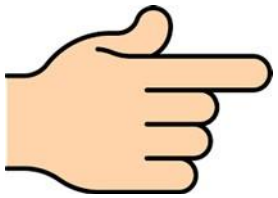
In several European countries, **informal networks of care leavers and former care leavers** placed in care facilities or foster families promote participation and active citizenship:

- creating moments of aggregation, discussion and mutual enrichment among the participants
- contributing to the improvement of social policies related to alternative care and to the need to specifically support young people leaving State care.

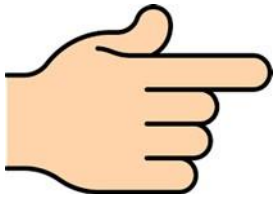
A *European Care Leavers Network* is currently being established.

Source: *http://www.agevolando.org/leavecare-livelife/*

One of the most recurrent concerns of children in alternative care is **the future after the coming of age**, which is often followed by the end of the State's specific obligation to care for them



For a concrete action of the Italian Care Leavers Network to raise awareness on the difficulty of care leavers becoming autonomous at the age of majority: see the video "18 years and (not) feeling it"



For the concrete action of an ombudsman, see the video of the Irish Ombudsman "Young person in residential care makes complaint to Ombudsman for Children"

Healthcare

carepath

Children should always be involved in discussions and decisions related to their health

(Unicef- Save The Children, *Every child's right to be heard* , 2009)

They have the "right to be **informed** in a manner appropriate to age and understanding" (art. 4 EACH – European Association for Children in Hospital – Charter)

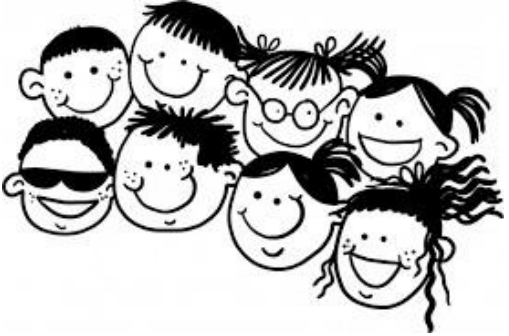
carepath

"Where, according to law, a minor does not have the capacity to consent to an intervention, the intervention may only be carried out with the **authorisation of his or her representative** or an authority or a person or body provided for by law.
The **opinion of the minor** shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity."

(art. 6 par. 2 Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine)

When they are experiencing violence or abuse at home, children may need "access to **confidential medical counselling and advice** without parental consent, irrespective of the child's age"

General Comment No. 12 (2009) *The right of the child to be heard*



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The child's participation in decisions concerning his or her health not only promotes his or her personal well-being, but also improves health polices and health and safety practices

General mechanisms can include:

- feedback systems for all users of services
- research and consultative processes with children as respondents and/or researchers
- participation of children's councils in the development of standards and indicators for health services that respect children's rights
- involvement of children in inspections and monitoring

[Unicef- Save The Children, *Every child's right to be heard* , 2009, p.98]

In situations of violence

States are encouraged to:

- consult with children, including marginalised and disadvantaged groups, in the development and implementation of legislative, policy, educational and other measures to address all forms of violence. (General Comment No. 12 (2009) *The right of the child to be heard*)
- ease access to individuals or organisations to which children can report in confidence and safety (General Comment No. 12 (2009) *The right of the child to be heard*)
- establish independent authorities to guarantee the rights of all minors and in particular those who have suffered violence (General comment No. 13 (2011) The right of the child to freedom from all forms of violence)

EXAMPLE NO. 3

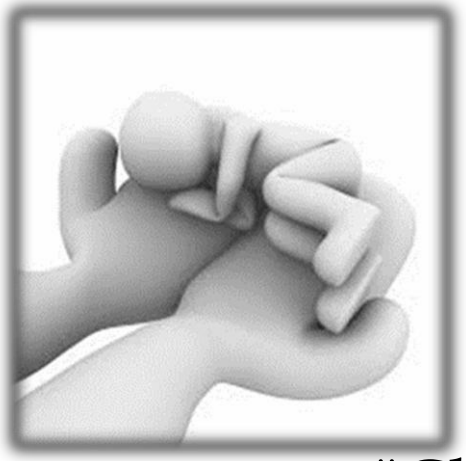
The video of the Council of Europe "Tell someone you trust" deals with sexual abuse using a language and methods suitable for children, **encouraging them to report the violence they have suffered**

EXAMPLE NO. 4

The Italianaire is a video cartoon made with the participation of five young adults living in Italy and originating from Egypt, facilitated by Save the Children, aimed at informing and raising awareness among Egyptian children living in areas with a high rate of child emigration about the **real living conditions in Italy** of Egyptian migrant children

EXAMPLE NO. 5

The Council of Europe's video "Beat Bullying" shows the effects of bullying using child-friendly contents and language and encourages children to take a leading role in combating bullying



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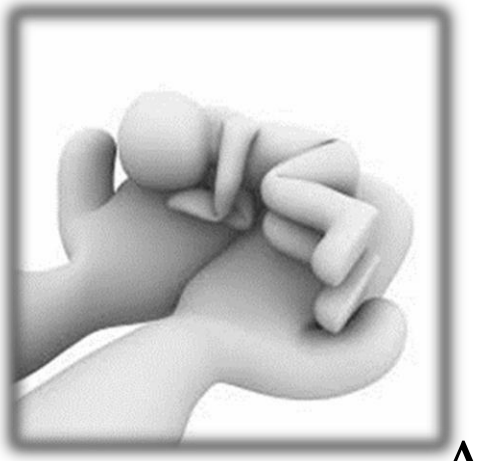
"Children and young people's right to be heard can also play a preventive role against all forms of violence in the home, family, schools and institutions"

(European Network of Ombudspersons for Children (ENOC), *Position Statement on 'Violence against Children'*, 2015)



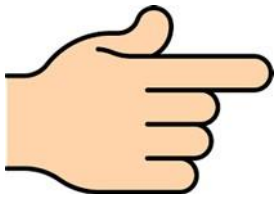
Adults should guarantee the child's participation in decision-making processes, taking every precaution to minimise the risk of violence or any other negative consequence that may derive from the participation itself

(General Comment No. 12 (2009) *The right of the child to be heard*)

Conclusions

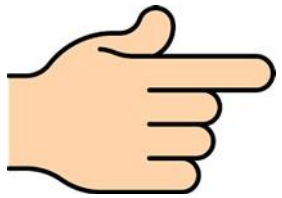
An **integrated approach** is needed and should include:

- ✓ not only contrast but **prevention** of violence against children
- ✓ promoting a **culture of respect** for children's rights
- ✓ **specific training** for professionals working in contact with children on protection and participation rights
- ✓ children's services created and managed on a **child-friendly basis**
- ✓ **help desks/help lines** easily accessible to children who experience violence

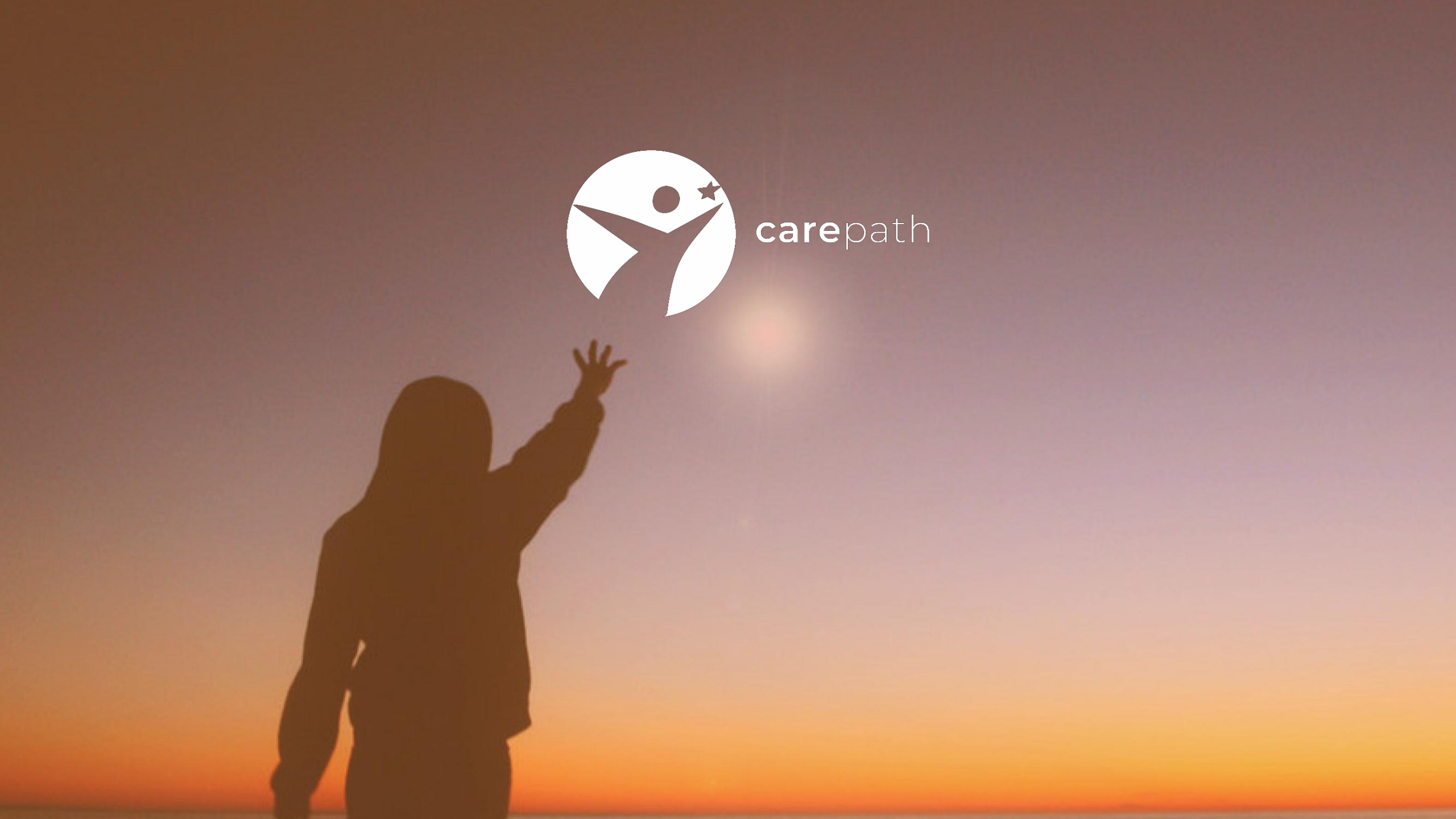


Source: Council of Europe, *Policy Guidelines on Integrated National Strategies for the Protection of Children from Violence*, 2009. See also European Network of Ombudspersons for Children (ENOC), *Position Statement on 'Violence against Children"*, 2015.

"Children have a unique body of knowledge about their lives, needs and concerns, together with ideas and views derive from their direct experience... **Decisions that are fully informed by children's own perspectives will be more relevant, more effective and more sustainable"**



Source: The Save the Children Found, *Every Child's Right To Be Heard, a resource guide on the UN Committee on the Rights of the Child general comment no.12*, London, 2011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Children's ombudsman

The competences attributed by the various institutive laws to the children's ombudsman are attributable to various actions: listening and participation, promotion and awareness, collaboration, preparation of proposals, opinions and recommendations.

The activity of the Children's Ombudsman today plays a leading role in policies aimed at ensuring knowledge and respect of children's rights, and allows a voice to be given to people (children) who often risk being invisible: https://www.youtube.com/watch?v=jWiE2jHX5yE.

The children's ombudsman, in summary:

- monitors the application of the Convention on the rights of children and adolescents within the country and helps to spread knowledge and the culture of rights of children and adolescents;
- reports to the competent authorities on any violations of these rights;
- verifies that persons of minor age have full access to their rights;
- expresses opinions on regulatory proposals concerning minors and on the protection of the rights and development of subjects in the developmental age.

More specifically, the functions and powers of the Guarantor Authorities (children's ombudsmen) can be divided into two main areas:

- The first is of general nature and can be identified as interventions to promote children's rights. The children's ombudsman, for example, promotes the knowledge and affirmation of the individual and the social and political rights of childhood and adolescence, taking forward every initiative aimed at concretely realising the same; monitors the application within the country of the Convention on the Rights of the Child; expresses, at the request of the competent local bodies, opinions, proposals and observations on draft laws, regulations and administrative acts concerning the possible impact on children and young people.
- The second area of intervention is specific and concerns responses to reports of situations of individual children in difficulty. The children's ombudsman, in fact, accepts notifications even originating from underage people (for an example, see here), from families, from schools, from associations and institutions, in relation to cases of violation of rights; reports to the competent public administrations any cases of violation of rights, consequent to deeds or facts delayed, omitted or otherwise irregularly performed, of which it has obtained knowledge from public and private subjects, or from individual persons, including children.

As for its *modus operandi*, the children's ombudsman is not granted direct and incisive powers of investigation, prescription and sanction. The action of the Guarantors is essentially expressed by way of so-

called moral suasion, that is, in the persuasion exercised towards public subjects (political decision-makers, local administrations, social-assistance territorial services, judicial authorities) and private entities (conflicting parents, third sector bodies) based on its status as a guarantee authority. Thus, for example, the children's ombudsman can recommend to the competent administrations the adoption of aid and support interventions, as well as the adoption, in the case of their omissive conduct, of specific measures; to promote, within the competent administrations, the modification or reform of measures deemed prejudicial to children and young people; to call upon the competent administrations to consider as preeminent the superior interest of the child.

The children's ombudsman can exist both nationally and locally.

In Europe we find The European Network of Child and Adolescent Guarantors (European Network of Ombudsman for Children - website: https://enoc.eu/?page_id=174) which meets at least once a year to discuss issues of common interest at European level and to identify lines of shared intervention.

The national supervisory authorities constantly collaborate with the international network of children's guarantors, with international organisations and institutions for the protection and promotion of children's rights and with non-profit organisations.

The exchange with different subjects allows the authorities to develop proposals in line with the times and with the needs of young people.

One of the areas of intervention of the Guarantors concerns the phenomena of violence and maltreatment to the detriment of underage people (psychological mistreatment, physical abuse, violence, sexual behaviour, neglect, assisted violence). On this point see the ENOC contribution Position Statement on "Violence against Children",

http://enoc.eu/wp-content/uploads/2014/12/ENOC-position-statement-on-Violence-against-children-2015-FV.pdf

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Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material
ANNEX 2
–
English Version

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

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The British
Psychological Society
Promoting excellence in psychology

Practice Guidelines

Third edition

August 2017

If you have problems reading this document and would like it in a different format, please contact us with your specific requirements.

Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.

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Preface

This Third Edition of the Practice Guidelines replaces the second edition published in 2009. Legislation, practice and technology have moved on since then and these changes are captured in the new guidance.

This edition of the guidelines was produced through the British Psychological Society's Professional Practice Board by a working group drawn from the range of Member Networks across The Society whose members are engaged in professional practice, as well as representatives from relevant expert reference groups of The Society, in particular areas of practice. Further information is available in ***Appendix 3: How this document has been developed.***

These Practice Guidelines aim to define good practice for all psychologists whether registered, chartered or in training and offer guidance for decision making. The Guidelines have been designed for broad application across the full range of applied psychology.

The first part of the guidance (sections 1–3) set out considerations for psychologists on different contexts of practice. The second part of the guidance (sections 4–8) sets out guidance for psychologists on how to manage work with clients.

It is recognised that in addition psychologists may require more detailed guidance for some particular roles and responsibilities or for particular situations in which they work. Further information is available in the ***Appendices***.

The Society expects that the guidelines will be used to form a basis for consideration, with the principles being taken into account in the process of decision-making, together with the needs of others and the specific circumstances. No guidance can replace the need for psychologists to use their own professional judgement. Effective practice means exercising this professional judgement in a defensible way that does not put clients or the public at risk, or undermine, or call into question the reputation of the profession as a whole.

The Guidelines will be reviewed in accordance with Society policy within a maximum period of five years in order to reflect current legislation, evidence and practice contexts. Psychologists using the Practice Guidelines should do so in conjunction with the ***BPS Code of Ethics and Conduct*** and the ***BPS Code of Human Research Ethics***, as necessary.

Glossary of terms

Client

The Society's *Code of Ethics and Conduct* uses the term person or people throughout, this is in recognition of the fact that the document is generic and may be used by all psychologists; academics, researchers, students and practitioners alike.

Throughout this Practice Guidelines document the term 'client' is used and refers to any person or persons with whom a psychologist interacts on a professional basis.

For example, the 'client' may be a couple, a family group, an educational institution, a community organisation or group or a private or public organisation including a court, an individual (sometimes referred to as, for example, athlete, child/young person, patient, prisoner, coachee, service user, stakeholder, leader, or student), who are in receipt of the services of the psychologist.

Psychologist

Throughout this Practice Guidelines document the term 'psychologist' is used and refers to all psychologists whether registered, chartered or in training who provide psychological services across the full range of applied psychology, in any context of practice.

1. How psychologists work

1.1 Legal and professional obligations of psychologists

Psychologists' professional practice is impacted upon and governed by a range of legislation and regulation. Particular psychological disciplines may also need to consider additional legislation, regulation and guidelines. It is the psychologist's responsibility to ensure they are aware of the legislation and guidelines that govern their particular area of practice as well as the terms of their employment or terms contracted with a commissioner of their services.

Psychologists are also advised to consider membership of a union or similar body to ensure they have access to appropriate representation, support and legal advice should they be subject to a complaint or disciplinary action, or require support for example with an employment grievance, which may be related to concerns over quality and standards of psychological service provision.

Further information is available in the ***Appendices***. Important examples to note are:

Health and Care Professions Council (HCPC) Registration

It is a statutory requirement for all psychologists wishing to practice using one of the titles protected by the HCPC to register with the HCPC. Unregistered psychologists offering services to the public in any of the domains regulated by the HCPC may commit an offence by doing so, even if they refrain from using protected titles, provided intent to deceive can be proved. The Society's position is that it is in the interests of both the public and the profession for all psychologists providing services in a regulated domain to be registered with the HCPC.

Professional competence

Psychologists should value the continuing development and maintenance of high standards of competence in their practice and the importance of working within the recognised limits of their knowledge, skill, training, education, and experience. Psychologists should consider advances in the evidence base, the need to maintain technical and practical skills and knowledge and the limits of their competence. This is stipulated in both the ***BPS Code of Ethics and Conduct*** and the ***HCPC Standards of Proficiency***.

Professional indemnity insurance

The UK Government has introduced legislation (The Health Care and Associated Professions (Indemnity Arrangements) Order 2014) which now makes it mandatory for health professionals to have a professional indemnity arrangement in place. The HCPC has made having such an arrangement in place a condition of registration.

This may be achieved either through the employer or through a privately arranged policy. An employer's insurance may provide cover only for a negligence claim but not for the costs of a disciplinary hearing. It is the psychologist's responsibility to check carefully that

they have cover in place that meets their personal/professional needs. Further information is available in the ***Society document: Career Support and Development***

Disclosure and Barring Service (DBS) Checks

Psychologists working in certain fields, for example with children or in healthcare, will need to demonstrate they have had a satisfactory criminal records check at the appropriate level for the nature of the work undertaken.

Applicants will be provided with a certificate to demonstrate this. Applicants cannot request a check personally, this can be requested by a psychologist's employer. For psychologists practising independently the Society offers this as a service to members. Further information is available on the ***Society Website: https://beta.bps.org.uk/Practice-Guidelines***

Equality Act 2010

This Act protects people against unfair treatment, promotes equality and prevents discrimination against any of nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. Respect is a core ethical value for psychologists and a commitment to equality of opportunity is embedded in all aspects of psychological practice. Psychologists, where they operate in an organisational context, must also seek to encourage and influence others in ensuring that equality of opportunity is embedded in all thinking and all practice relating to access to services for client groups and recruitment and employment practices.

Providers of service to the public must also make reasonable adjustments for people who have a disability under the Act. This requirement is anticipatory so requires consideration, and adjustment where reasonable, of any barriers which may prevent a person with a disability from using a service.

Data Protection Act 1998

The Data Protection Act defines personal and sensitive personal data, and data must be processed in accordance with eight principles. It gives individuals the right to know what information is held about them and provides a framework to ensure that personal information is handled properly.

Good information governance is at the heart of safe practice. It encompasses physical data security, access controls and acceptable use, data quality, and records management, among other things. Psychologists must have appropriate security to prevent any personal data held from being accidentally or deliberately compromised. In most circumstances, independent practitioners will also need to register as a data controller with the Information Commissioner's Office.

Further information is available in ***Section 7.1: Information governance, Appendix 1: Relevant legislation*** and ***Society Document: Data Protection Act 1998 – Guidelines for Psychologists.***

Freedom of Information Act 2000

The Freedom of Information Act 2000 provides public access to information held by public authorities. Public authorities include government departments, local authorities, the NHS, State schools and police forces.

It does this in two ways:

- public authorities are obliged to publish certain information about their activities; and
- members of the public are entitled to request information from public authorities.

The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland, and by UK-wide public authorities based in Scotland. Information held by Scottish public authorities is covered by Scotland's own Freedom of Information (Scotland) Act 2002.

This legislation permits information to be withheld from disclosure in certain prescribed circumstances, for example information provided in confidence, related to law enforcement or where it relates to personal matters.

Health and Safety at Work Act 1974

This Act places a duty on all employers 'to ensure, so far as is reasonably practicable, the health, safety and welfare at work' (Part 1, Section 2.1) of all their employees. Employees themselves also have obligations under the legislation.

Working together to safeguard children guidance

The Government website provides statutory guidance on inter-agency working to safeguard and promote the welfare of children. Statutory guidance is issued by law; it must be followed unless there is a good reason not to. All organisations, including charities, are expected to comply with this government inter-agency statutory guidance. Psychologists have a duty of care to both their clients and the public. Any allegations of abuse, either ongoing or historic, must be taken seriously and consideration must be given about breaking confidentiality especially in cases where other vulnerable people may be at risk. Further information is available in ***Section 4: Safeguarding***.

Mental Capacity Act 2005

The Mental Capacity Act (2005) provides a clear and comprehensive framework with regard to capacity and consent for all individuals aged 16 years and above in England and Wales.

There are five key principles set out in the Act which underpin practice (quoted from legislative source):

(i) A person must be assumed to have capacity unless it is established that he lacks capacity.

(ii) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(iii) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(iv) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
(v) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

In Scotland the Adults with Incapacity (Scotland) Act 2000 applies and in Northern Ireland the Mental Capacity Act (Northern Ireland) 2016 is used.

Mental Health Act 1983 as amended 2007

The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

The Act sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients. The Code of Practice[1] provides statutory guidance for mental health professionals on how they should carry out their responsibilities in practice under the MHA. Although the Act allows for people to be compulsorily detained and treated without their consent if required, empowerment and involvement of patients as far as is possible is required by the Code of Practice.

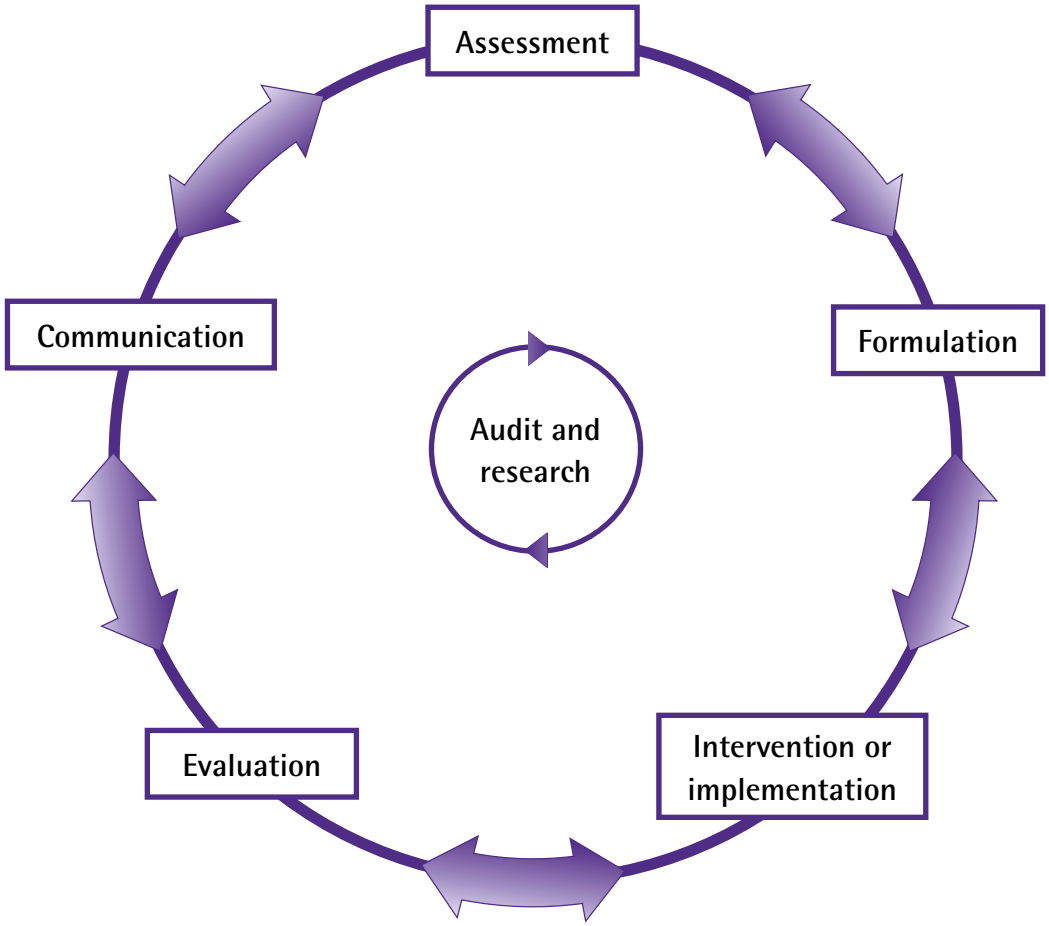
Those involved in working with people subject to provisions of the MHA, including psychologists, must understand and give consideration to the five key principles set out in the Code:
(i) least restrictive option and maximising independence;
(ii) empowerment and involvement;
(iii) respect and dignity;
(iv) purpose and effectiveness; and
(v) efficiency and equity.

1.2 Cycle of professional practice

The professional practice of psychologists is underpinned by four key ethical values – Respect, Competence, Responsibility and Integrity – and five core skills:

- **assessment** and establishment of agreements with the client;
- **formulation** of client needs and problems;
- **intervention or implementation** of solutions;
- **evaluation** of outcomes; and
- **communication** through reporting and reflecting on outcomes.

These core competencies flow and inform each other as illustrated below.



Assessment and establishment of agreements with the client

Assessment of psychological processes and behaviour is derived from the theory and practice of both academic and applied psychology. It includes both assessing change and stability, and comparison with others. Assessment procedures used will depend heavily on the practice context and may include:

- the development and use of psychometric tests following best practice;
- the application of systematic observation and measurement of behaviour in a range of contexts and settings;
- devising structured assessment strategies for individual clients, teams and organisations; and
- the use of a range of interview processes with clients, carers, other stakeholders and other professionals.

Results of these assessments are integrated within the context of the historical, dynamic and developmental processes that will have shaped the client as well as future aspirations or needs. Psychologists have the ability to assess the suitability of different measurement procedures, depending on the purpose for which the assessment is needed, as well as being competent to devise and use context-specific procedures.

Formulation of client needs and problems

Formulation is the summation and integration of the knowledge that is acquired by the assessment process. This will draw on psychological theory and research to provide a framework for describing a client's needs. Because of their particular training in the relationship of theory to practice, psychologists will be able to draw on a number of models to meet needs or support decision-making. This process provides the foundation from which actions derive. What makes this activity unique to psychologists is the knowledge base, experience and information on which they draw. The ability to access, review, critically evaluate, analyse and synthesise data and knowledge from a psychological perspective is one that is distinct to psychologists, both academic and applied.

Intervention or implementation of solutions

This will be the stage where the client's needs, as described by formulation, begin to be met. This may involve the use of psychological models or approaches to, for example, facilitate change, solve a problem or improve the quality of a relationship. All these interventions, or implementation of solutions, are tests of the provisional hypotheses contained in the formulation, and are subject to repeated modification in the light of experience and new data.

Evaluation of and reflecting on outcomes

Evaluation is used to measure the effectiveness of activities and interventions both during and after their implementation. The results of any evaluation and reflection will impact the next steps taken by a psychologist.

Although employers and others may demand certainty about outcomes, psychologists should always be careful to make it clear that they are able to provide only interpretations of behaviour, and advice and guidance, rather than necessarily predicting future behaviours.

Communication through reporting

Communication skills are integral to all aspects of a psychologist's role. Effective communication skills are essential in relation to all aspects of work with others. Communication skills include communication with clients, all forms of electronic and verbal communication, professional letters and reports, and the dissemination of research findings.

Audit and research

Audit and research underpin the cycle, as they help to inform all stages of professional practice.

Audit aims to evaluate how close assessment, formulation, intervention and implementation are against a set of previously given standards of practice. Audit also evaluates how protocols and procedures, for example related to consent or recording of activity, have been followed.

Research provides the evidence base for the practice of psychology. Research methods in psychology vary from qualitative observation to quantitative scientific method, so it is important to distinguish the nature and quality of the evidence underpinning any knowledge or techniques being applied. In general, basic research develops theories, models and data to describe and explain psychological processes and structures, while primary research develops and evaluates ways of using psychological knowledge to intervene with people, organisations, processes or technologies to achieve desired effects. Secondary research consolidates other research to identify higher order trends and directions.

1.3 Reflective practice

One of the key processes that should be encouraged for psychologists is having a complex understanding of self in the context of others. The HCPC requires reflection in the record of continued professional development in order to retain continued registration.

Psychologists will need to make decisions about clients which may have a profound impact on their lives. Decision-making is often subject to various competing biases. Psychologists should be aware of the possibility that they may be influenced by considerations which are not driven by professional knowledge, skills or experience. Maintaining awareness of these biases is important when trying to think through dilemmas.

Sources of influence and bias may include:

- **Cognitive Biases –** Over 150 have been described[2,3,4] including salience (how readily something comes to mind), confirmation bias (the human tendency to look for evidence that confirms their belief and to ignore other evidence), loss aversion (risky behaviour to avoid loss), beliefs about disclosure (tendency to be more honest when they believe their actions will be known by others), and dissonance reduction (justifying actions if consequences are considered worth it).
- **Personal Experience –** the experience of the psychologist may affect how they view or treat a client or situation. This may include current or historical trauma, or the kind of organisation and culture with which they are most familiar. Interventions which may be appropriate in one context may be ineffective and cause distress in another.
- **Motivation –** the original reasons for undertaking the profession may change or be challenged due to fatigue or experience within the profession which may affect the psychologist's viewpoint.
- **Health –** psychologists should be mindful of the potential effect of health conditions or medications which they may be taking, on their practice.
- **Control over the psychologist's own practice –** this refers to clarity and openness in the management of the psychologist's business and maintaining the professional's autonomy in their interactions with clients.
- **Pro bono public work –** psychologists are encouraged, and personally motivated to

engage with such work, while being mindful of impact on the value that is placed on the profession as a whole.

- **An unethical environment –** maintaining self-recognition of what the appropriate ethical standard should be, irrespective of the prevailing situation.
- **Environment –** political realities may lead the psychologist to make compromises; while there is nothing wrong with compromises, their constant use may mean a decline in overall standards.

The literature is generally pessimistic about the ability of practitioners to overcome some of these biases, considering them to be inherent in human thinking patterns. By being aware of and acknowledging them, it can be possible to manage their influence. For example, biases can be levelled out by presenting information in different ways, by engaging the perspectives of people with different experiences and expectations, or by priming thinking with different examples.

A key factor in developing and maintaining these skills is the use of consultation or supervision and having a space where it is possible to open up thinking to the mind of another with a view to extending knowledge about the self.

It is important that psychologists from all disciplines look after their own wellbeing. This is not only important for them as individuals, but also for the quality of the care they give their clients. In their practice and, for example, within their CPD plans and supervision psychologists should consider self-care and how they can maintain their own wellbeing.

It is also important for psychologists to evaluate effectiveness of practice, by welcoming feedback from clients. This can be difficult due to fears of criticism but reflective practitioners are eager to improve and welcome any feedback that will support this process.

1.4 Continuing professional development

Continuing professional development (CPD) is the professional and work-related aspect of lifelong learning. It is an integral part of the process of adapting to change, and essential for maintaining and enhancing professionalism and competence. The Society provides an online facility to record CPD, further information is available on the ***Society website: http://beta.bps.org.uk/Practice-Guidelines***.

- CPD is both a professional expectation and an individual responsibility to taking a structured and self-managed approach to further learning through:
  - actively engaging in a range of CPD
  - maintaining a record of CPD
  - applying learning from CPD to professional practice.
- There is a range of formal and informal learning activities that may be used for CPD and it is recommended that psychologists engage in a mix of CPD activities.
- Professional development is not purely about inputs (i.e. undertaking CPD activities); it also requires a reflective, outcomes-based approach which focuses on the learning gained from CPD and its application to current or future practice, together with the associated benefits for clients and the services provided.

- All members who are registered with the HCPC are required to comply with their CPD requirements as a condition of continued professional registration. Further information is available in ***Appendix 2: Websites and further information***

Mentoring

Psychologists may seek a mentoring relationship with colleagues in order to focus their attention on skills to add to their competencies. Psychologists taking on the role of mentor often support the psychologist with their career path. Early career psychologists may find it beneficial to be mentored by a more experienced psychologist.

1.5 Consultation/supervision

Consultation or supervision is considered an essential part of good practice as a psychologist. There is no legal requirement for supervision, although it is considered an ethical and professional expectation to engage in appropriate consultation in order to support effective practice. Provision of this is therefore an important underpinning to good quality service delivery. The Society's position is, for safe and effective practice in clinical and mental health settings, or with other vulnerable groups, supervision is a requirement of practice.

The objectives of consultation/supervision are:

- to provide practitioners with consultation on their work with clients;
- to enhance the quality and competence of practice offered to all clients;
- to offer psychologists intellectual challenge enabling reflection, transformational learning and psychological support to maximise their responsibility for appropriate self-care; and
- to contribute to the CPD of both psychologist and supervisor by developing competence in the use and practise of supervision.

All aspects of practice are appropriate for discussion in supervision, including research activity, administrative and managerial work, service developments, team working, teaching and the process of supervising others. Supervision is not personal therapy and nor is it a form of, or substitute for, line management or appropriate training.

For psychologists working in a wide range of settings such as therapeutic and organisational settings, supervision is a core component of the psychologist's CPD. For some areas of practice, the nature of supervision changes over time. This may be unique to each psychologist and the context of their application. Expectations should be agreed from the outset and reviewed at appropriate intervals.

Forms of consultation/supervision

Supervision may take the form of clinical supervision, mentoring, coaching, supervision on placement/work setting, tutorials and peer support. Psychologists may engage in one to one supervision; group supervision (facilitated or non-facilitated) or peer supervision and any of these may be face to face or virtual. Whilst it should not be a substitute for line management, a psychologist's supervisor may also be their line manager.

Those working in independent practice, or in the absence of service-based supervision, should seek supervision from appropriately qualified and experienced personnel as appropriate. Peer supervision (individual or group) may be an appropriate way to find collegial support.

Psychologists may select different supervisors, depending on their preferred supervisory style, nature, orientation and their needs at the time. Particularly for experienced psychologists, this may be from an experienced colleague from outside their profession, professional specialty or organisation. Psychologists could also invite supervision from experts by experience for whom they provide services, where appropriate to the context of practice.

The Society maintains the Register of Applied Psychology Practice Supervisors (RAPPS), which recognises psychologists with special expertise in supervision and supervisory practice. Further information is available on the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines***.

Amount of supervision

While there is a specified number of supervision sessions for trainees (e.g. for their Chartered status) which varies across different sub-disciplines of psychology, no definitive amount of supervision is specified as part of CPD. To determine both the quantity and nature of the supervision, the psychologist may consider their need for supervision from various perspectives: their own assessment of need, the competencies required for their practice; the context of their work; organisational requirements; and the support available. For psychologists in employment the arrangements for consultation/supervision should be agreed after considering these factors in consultation with the employer.

Roles and responsibilities of the supervisor

Psychologists undertaking supervision should ensure that they are sufficiently experienced, competent and appropriately trained to provide supervision. Psychologists are often called upon to supervise non-psychologists, in which case these guidelines would also apply.

In supervision, the psychologist as supervisor needs be aware of their own competence in relation to the work of the psychologist and, where necessary, recommend additional supervisors who may have the appropriate level of expertise. Psychologists may offer consultancy supervision to professional colleagues, organisations and stakeholders in line with their competencies.

Psychologists should avoid personal relationships between the supervisor and psychologist which could adversely affect integrity and objectivity.

Psychologists providing consultation/supervision should do so in line with the guidance in other relevant sections of these Practice Guidelines.

Issues of power and control

The nature of supervision itself creates a power imbalance, even between peers. Both the person providing supervision and the person receiving it need to be aware of this.

The supervisory leadership relationship should be both informative and reflective. Psychologists in leadership roles as supervisors should provide regular, informative feedback to the psychologist as well as motivating them to reflect on their own practice, continue to self-assess and improve self-awareness.

1.6 Leadership

Psychologists at any stage of their career are likely to find themselves in a position where they are required to demonstrate or model leadership. This may be an integral part of their practitioner work or may arise through being a leader of a team, including leading in Society work. Leadership is widely quoted and described in the context of leading change as, *'accepting responsibility to create conditions that enable others to achieve shared purpose in the face of uncertainty'*[5]. Furthermore, leaders 'can create conditions interpersonally, structurally, and/or procedurally'[6]. These descriptors highlight the often complex process of psychological change through clinical intervention and also through leading others.

Contemporary leadership styles are generally more aligned to working *within* a team or a system rather than being directive. Leading as a psychologist is likely to include dealing with highly complex information and systems whatever the context. Leading in this way demands high levels of skill in developing, managing and maintaining professional relationships. This may include communicating complex and sensitive information, and reflexivity to enable individuals and teams to co-formulate around difficulty and challenge.

2. Where psychologists work

2.1 Working environment

When undertaking work with clients, psychologists need to give consideration to providing an environment which is welcoming, accessible, safe, and offers privacy. Although choice of workspace is not always available, it is important wherever work takes place with clients that psychologists consider:

- whether lighting, acoustics, heating and seating are comfortable;
- whether confidential conversations may be audible to others;
- whether there are arrangements to ensure client and practitioner safety, for example through easy access to another member of staff if a difficulty arises;
- whether access and exits are safe, well-lit and in areas which are likely to be overseen;
- that reasonable adjustments can be made to support effects of special needs and/or disability;
- whether the setting is culturally acceptable to clients; and
- whether there are facilities and equipment suitable for the clients, for example lavatories, play materials for children.

Where context of practice allows, psychologists could seek the assistance of relevant workplace representatives, for example their trade union representative or human resources staff, in situations where appropriate workplace conditions are not being provided. However, it is acknowledged that sometimes the ideal workspace may not be available or that psychologists may not have access to these workplace representatives due to their context of practice and psychologists should, within the limits of safe practice, be able to adapt to situations within local constraints in order to provide the best service for clients.

Sometimes, it is important to work with clients in representative environments in order to understand behavioural drivers. This will apply if the psychologist's task is to understand behaviours in such environments and provide support, for example through the use of technology, design of procedures, training or team design. Psychologists should consider carefully how to create representative conditions without causing harm. Equally it may sometimes be necessary for psychologists to work in a client's own context as that is where any intervention may be formulated or put in place. Psychologists should ensure they follow the relevant health and safety guidelines in place at their working location even if that location is not their usual place of work.

There may be a temptation to make assumptions about what sort of environment is most suitable, comfortable and culturally appropriate for clients, however it is helpful to ask them and endeavour to make appropriate adjustments to meet their needs.

Lone working

Many psychologists practise in a lone worker workplace and on occasion visit clients in their own homes. When working at home, it is necessary to ensure the proper insurance

and protocols for this type of work, as well as manage boundaries between personal and private space. When working alone, the Suzy Lamplugh Trust recommends always ensuring that someone else has access to schedules and contact details for clients. Psychologists may also want to put in place a 'code word call', where should they fail to answer or speak the correct code word, the police are alerted. This is just an example of an additional safety practice, and there may be different ideas for ensuring personal safety when lone working. However, the important point is to think about keeping safe, have a plan and stick to it. Further information is available in ***Appendix 2: Websites and further information.***

Harassment and bullying

Bullying is behaviour that may take the form of actions or comments that are offensive, which are intended to humiliate, undermine, demean or injure the recipient. It may target an individual or group of individuals and is a form or abuse that may be explicit and therefore obvious, or it may be insidious, an experience recognised only by the recipient and harder to notice by others. Bullying may be vertical (i.e. between managers/supervisors and staff) or horizontal (i.e. between colleagues). Clients may also experience bullying by professionals. While bullying may involve a misuse of power and be committed in the workplace by a manager, supervisor or senior colleagues (sometimes known as downwards bullying), it should be borne in mind that it is not uncommon for senior staff to be bullied by those whose work they oversee.[7] What can be legitimately classified as bullying may take into account the particular personal sensitivities and characteristics of the person suffering the alleged bullying.

Harassment can be defined as actions or comments that are unwanted and which may be related to age, disability, gender reassignment, race, sex, sexual orientation, religion or belief or any other personal characteristic of the recipient. Harassment occurs when someone engages in unwanted conduct in relation to the aforementioned characteristics and that conduct has the purpose or effect of violating the other person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for the other person.

The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Psychologists with concerns over the above behaviour should seek the support of their supervisor, line manager or other appropriate senior staff member, accredited trade union workplace representative or human resources department. Further information is available in ***Appendix 2: Websites and further information.***

Whistleblowing

Whistleblowing is the disclosure of wrong doing (beyond normal managerial channels) and is important as it is a critical way not only of seeking justice for the individual or individuals affected, but also of developing inside information within organisations about incorrect or unfair practices,[8] thereby increasing the evidence required for corrective action to take place.

A whistle-blower is protected by law (the Public Interest (Disclosure) Act 1998) if:

1. They are a worker (this includes trainees and can include self-employed personnel servicing an organisation in certain circumstances).
2. They are acting in the public interest.
3. The disclosure relates to past, present or likely future wrongdoing which involves one or more of the following:
    - criminal offences (which may include fraudulent actions);
    - a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
    - a miscarriage of justice has occurred, is occurring or is likely to occur;
    - the health or safety of any individual has been, is being or is likely to be endangered;
    - the environment has been, is being or is likely to be damaged; or
    - information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

If the individual has been victimised or if they have lost their job due to whistleblowing, the legislation provides them with the right to take a case to an employment tribunal. Whistleblowing is a complex legal area and it is important that anyone considering it considers appropriate advice, for example from an accredited trade union workplace representative or helpline. The relevant human resources department which will have a policy relating to this, or it may be appropriate to seek formal legal advice. Some organisations such as NHS Trusts have a nominated Director responsible for dealing with disclosure issues who may be contacted directly. The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Further information is available in ***Appendix 2: Websites and further information.***

Psychologists can inform on all aspects of the establishment of workplace cultural norms that promote positive managerial and leadership behaviour and can help facilitate the development of cultures that support the disclosure of inappropriate practices. Psychologists are also appropriately qualified to support workers who have been subject to bullying or harassment or who are contemplating or indeed have already 'blown the whistle'. Whistleblowing, and even the prospect of such, can create traumatic responses in workers[9] and can lead to retaliation as a consequence. Empirical evidence highlights the link between whistleblowing and the devastating effects on health that may follow, such as depression, anxiety and symptoms relating to post-traumatic stress[10]. Psychologists are able to work with affected employees and in a consultative capacity with organisations to manage work-related stress disorders caused by these incidents of bullying, harassment and whistleblowing to lessen the risk of absenteeism and to facilitate a return to work following a period of absence. Further information is available in ***Section 8: How to respond when things go wrong.***

2.2 Working in the digital age

Digital media continues to advance in terms of choice and functionality. It is becoming increasingly common for psychologists in particular when working with clients to make use of the internet and/audio-visual technology. These technologies require the psychologist to ensure that the network used is as secure as reasonably possible and, as far as is feasible, assures privacy to their clients.

There can be no guarantee of security when using the internet, and voice over internet protocol (VOIP) services such as 'Skype' or 'FaceTime' are no different, as they use the same data infrastructure as the rest of the internet.

Most, if not all, VOIP systems encrypt the voice into waveforms during digital transit across the internet, and it would be impossible to eavesdrop on these data packets in real time. However, the information is potentially vulnerable to eavesdropping/compromise before encryption by the speaker's system, and after decryption by the listener's system. This will depend upon the security measures in place for the end user's (speaker and listener) own networking infrastructures, be that a company, institution or home user. If an end user's computer has been compromised by any form of malware, then there will be a risk of eavesdropping, data theft and/or denial of service.

The risk for eavesdropping on VOIP systems is no more or less than that of traditional analogue phone systems, and both would require specialist knowledge, equipment and software to be achieved. However, it is recommended that only fit-for-purpose VOIP systems are used, and that public networks, such as Social Media sites, are avoided for VOIP communications. Further information is available on the ***Society website: http://beta.bps.org.uk/Practice-Guidelines***.

Some employers may have their own rules about which media are acceptable to use. The USA has the Health Insurance Portability and Accountability Act (HIPAA) which sets standards for security for electronic data. There is no such provision in the UK to date, and so psychologists must satisfy themselves that any media used to communicate personal data is secure. This is a rapidly changing area and so technology-specific guidance has not been provided in this document. Further information is available in ***Section 7.1: Information governance*** and ***Appendix 2: Websites and further information.***

The use of online 'Apps', computer assisted decision-making and artificial intelligence in psychological practice and research is evolving rapidly. When recommending or using computerised systems psychologists should pay due regard to peoples' health, wellbeing and safety being mindful of Clinical Safety Evaluations, Medical Device Evaluations and other relevant guidance such as NICE.

Use of social media

Many psychologists are using social media, networking sites or blogs to communicate with friends, family, professionals, colleagues and clients. This specific guidance therefore addresses the use of social media by psychologists, and provides practical advice for using them responsibly. Further information is available in ***Appendix 2: Websites and further information.***

Psychologists should:

- Remember that social networking sites are generally public and permanent. Once something is posted online, it remains traceable even if it is later deleted.
- Keep their professional and personal life as separate as possible. This may be best achieved by having separate accounts for work-related communications to those for friends/family.
- Consider whether, in their context of practice, it is appropriate to accept 'friend' requests from current or past clients, if necessary, decline the request via more formal means of communication. It is highly unlikely to be appropriate to accept in a clinical or forensic context.
- Be minded to act responsibly at all times and uphold the reputation of the profession, whether identified as a psychologist or not on the social media platform.
- Be aware that social networking sites may update their services and that privacy settings can be reset to a default that deletes personalised settings.
- Remember that images posted online by family or friends may be accessible, as they may not have set privacy settings as tightly.
- Be minded that social networking sites can make it easier to engage (intentionally or unintentionally) in professional misconduct.
- Report the misconduct of other psychologists on such social networking sites to any relevant parties (such as the employer or the HCPC).
- Be aware of their employer's social media policy.

Psychologists should not:

- Establish inappropriate relationships with clients online.
- Discuss work-related or confidential issues online in any non-secure medium.
- Publish pictures of clients online, where they are classified as clinical records.
- Use social networking sites for whistle-blowing or raising concerns.
- Post defamatory comments about individuals or institutions. Defamation law can apply to any comments posted on the web, irrespective of whether they are made in a personal or professional capacity.

2.3 Working for the court

Psychologists may be asked to act as professional or expert witnesses in court. The main difference between an expert witness and an ordinary witness (i.e. a witness to fact), is that the former are able to give an opinion, whereas ordinary witnesses can give only factual evidence. A professional witnesses' remit can cross the boundary of both fact and opinion.

Psychologists are responsible for ensuring they are sufficiently competent and expert in offering an opinion. It is not appropriate for trainee or assistant psychologists to act as expert witnesses. Indications of competence in respect of the knowledge required by the court, and expertise within a specialised field, may include:

- qualifications and/or degree(s) in the areas(s) in question;
- a number of years of post-doctoral/post-qualification experience;
- academic, professional and scientific publications in relevant areas;
- demonstrations of professional practice, competence, specialist knowledge and expertise with a bearing upon the issues in the case; and

- current experience in applying psychology in the area of claimed expertise.

It follows that a psychologist with trainee or assistant status is unlikely to have the necessary experience and qualifications to be retained as an expert witness by a legal firm. However, trainees or assistants who have written reports on individuals in the course of their employment may be required to give evidence (for example, at a tribunal). If so, they should bear in mind that only qualified psychologists should give evidence of opinion, and that their supervisor is responsible for the professional quality of their work in this situation as in all others.

Psychologists instructed as experts need to ensure that they can provide an independent and impartial opinion, and that their independence is clear to all. Any potential conflicts of interest should be made explicit and should be reported as soon as they arise. This can extend to being asked to provide an expert report on someone the psychologist is providing with therapy as an 'Applicant', 'Claimant' or 'Complainer'. This dual relationship is an unacceptable conflict.

When lawyers seek to introduce expert psychological evidence, it is the judge in the case who decides whether an individual has the requisite expertise to give evidence with the potential to be relevant to the case. The judge also decides whether what the expert asserts is relevant and, therefore, admissible in law.

Expert evidence in civil court proceedings is governed by Part 35 of the Civil Procedure Rules 1998, and its associated practice direction. This rule makes clear that an expert's overriding duty is to help the court on matters within their expertise and that this duty overrides the expert's duty to the person from whom they are receiving instructions. Any report must be written in accordance with the criteria in Practice Direction 35.

Further information is available in ***Society documents: Psychologists as Expert Witnesses: Guidelines and Procedure*** and ***Psychologists as Expert Witnesses in the Family courts in England and Wales.***

2.4 Working for defence and security organisations

Psychologists may work with defence and security interests in many different capacities. This may include supporting military or security personnel to perform their roles through the development of skills and behaviours, supporting the mental health and wellbeing of people affected by threats, activities and events in this context, and offering advice and consultancy. It is also UK Defence practice to enlist uniformed psychologists for roles associated with psychology. However, in general, psychologists in defence will be in a civilian role and therefore not under military command.

While there is a strong sense of common culture within the defence and security sectors, there are also important variations. For example, each of the armed forces has its own organisational culture resulting in different attitudes and behaviours. There are also differences within different sectors of each organisation. All these differences are very important to the individuals concerned, forming a large part of their sense of identity.

Psychologists working with these populations should ensure they investigate and acknowledge cultural differences, particularly when working with other national cultures. They should also take careful account of the environments in which people are living and working. Psychologists can be working with civilians and/or members of the armed forces who are operating in life threatening environments and are required to make decisions under extraordinary pressure. It is usually invalid to extrapolate from behaviour in benign conditions to behaviour under threat, hardship and stress.

3. Who psychologists work with

3.1 Working with Experts by Experience

In relevant services it is best practice for psychologists to work collaboratively with clients and Experts by Experience in developing and delivering all aspects of psychological services. In mental health, the Government is committed to shared decision-making and the principle 'no decision about me without me'[11]. This applies from work with an individual client through to changes in government policy relevant to the services provided by psychologists. Psychologists should develop services, policies and guidelines in collaboration with the people who use their services.

In professional practice it is important and helpful to work collaboratively with clients and, where relevant, others in order to ensure that the application of psychological research and theory is understood by and adapted appropriately to the client group and context, which may differ from the populations on which the research was based.

3.2 Working with assistants/interns

Many graduate psychologists take up assistant psychologist positions on either a paid or an unpaid basis.

The following (non-exhaustive) list provides examples of activities which can be carried out by assistant psychologists/interns. This list can guide those who are working as assistant psychologists/interns to request or refuse a task or assignment, as well as assist those who are practising and supervising to observe boundaries and limitations:

- research, audit and service evaluation;
- literature searches, developing and maintaining training packs, information leaflets, libraries of equipment, and other tasks necessary to the efficient running of the service;
- assessment of individuals and groups, for example, direct observations, formal psychometric testing, semi-structured interviews, and writing appropriate reports;
- delivery of interventions with individuals, groups and organisations;
- undertaking supportive work with carers, family members, employers, human resources professionals, team members, health staff and other professionals;
- delivering training for other professionals (if and when competent to do so); or
- promoting applied psychology services by providing relevant information to referrers, commissioners and others.

An assistant psychologist/intern should not be employed to:

- substitute for qualified applied psychologists; or
- undertake solely administrative or clerical duties for which a clerical assistant should be employed.

In occupational settings, the issue of appropriate supervision and guidance is of particular importance when the needs of individuals and organisational demands need to be balanced. Appropriate mechanisms need to be in place to ensure that no assistant psychologist/intern is, for instance, put in a position where they have to design or decide on any materials or processes which could have a potential harmful impact on individuals or groups or to an organisation (such as potential loss of profit or revenue).

In clinical and forensic settings, there are some additional limitations, related to the clear delineation between qualified and assistant psychologist/intern, as follows:

- An assistant psychologist should carry out only prescribed interventions with individuals or in groups, and should write reports only when under close supervision of the primary, qualified psychologist. Any report should be signed as having been written 'under the supervision of' followed by the name, registration status and job title of the qualified psychologist.
- When an assistant psychologist is called to give evidence in a legal setting, such as a tribunal, the qualified psychologist remains responsible for the professional quality of the assistant's work. This means the qualified psychologist should attend the hearing also, as there may be questions which an assistant cannot answer. Both should bear in mind that an assistant is not qualified to give evidence of opinion.
- An assistant psychologist should not undertake tasks in areas where there is not a competent supervisor.
- An assistant psychologist should not carry out the duties of a care assistant.

The managing or supervising psychologist has a responsibility to ensure that assistant psychologists are not given work to do that is over and above their level of competence. Further information is available in ***Society Document: Applied practitioner psychologist internship programmes and unpaid voluntary assistant psychologist posts.***

3.3 Working with trainee psychologists

The Society's standards related to working with trainees across the domains of applied psychology are set out in the Standards for accreditation of training programmes. These set out: the required core competencies that trainees need to develop, the curriculum and assessment requirements that programme providers need to deliver against, and the requirements of supervised practice; expectations around trainees' understanding of and ability to work ethically and legally; selection and recruitment of trainees; personal and professional development of trainees whilst in training; academic staffing and leadership for accredited programmes; and expectations in relation to quality management. Psychologists working with trainees as practice educators should familiarise themselves with these standards and adhere to them in their work with trainees. Further information is available on the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines.***

3.4 Working with multiple clients

Psychologists will sometimes be in situations where their client will not be one clear individual or group, for example, a psychologist may be employed by an organisation to

provide assessment or psychological support for employees. Psychologists need to consider and be mindful of the demands that this might place on their ethical practice and how this might lead to conflicts of interest.

Identification of the following client hierarchy may be considered[12],[13]:

- Primary client – the person or persons with whom the psychologist is interacting directly: the recipient of a psychological service.
- Commissioning stakeholders – the organisation or overall commissioning body that has sought the psychologist.
- Others affected by the primary client's actions – the customers of the organisation or service, or the personal acquaintances, friends and family of the primary client. In some circumstances, this will be the general public or larger groups interested in the outcomes of the intervention.

The psychologist's role will be mainly to the primary client and then the commissioning stakeholder. It is paramount that issues around boundaries and sharing of information are made explicit and addressed appropriately through a clear contracting agreement. Further information is available in ***Section 3.5: Working with other professionals***, ***Section 5: Making and maintaining agreements*** and ***Section 7: Managing data and confidentiality.***

Within each of the levels of the hierarchy, varying allegiances to associates (friends, family, acquaintances, colleagues) will need to be attended to, as will consideration of the impact of professional activity on the reputation of the profession and all those concerned.

3.5 Working with other professionals (including in multi-agency settings)

In order to meet the complex needs of clients fully, psychologists will often be required to work collaboratively with other professionals from their own or other agencies.

Such collaborative working will be for the benefit of clients and/or the promotion of the safety and protection of the public or the benefit of the organisation, and is required by national policy and legislation in a number of areas in which psychologists work. Engaging in partnerships drawing on a wide range of services and agencies enables psychologists to address identified community issues with the optimum use of resources.

Where appropriate to their context of practice, and consistent with the requirements of psychological practice, psychologists should:

- Work together with colleagues to develop a shared view of the aims and objectives of work at all levels. They should respect the professional standing and views of other colleagues and commit themselves to joint working.
- Make it clear to other professional colleagues what can be expected of them in collaborative work, the work that will be done, and the point at which the work will be terminated.
- Ensure that there are explicit agreements about information-sharing and confidentiality and its limits, and that these are adhered to.

- Practise and encourage in others full and open communication with colleagues/ agencies to support effective collaboration within the boundaries of the agreed limits on information-sharing and confidentiality,
- Demonstrate their commitment to involving clients in multi-agency work, finding ways to engage them and retaining the central principle of better outcomes for clients as the rationale for multi-professional and multi-agency work, as long as this is consistent with public safety.
- Be sensitive to the effects of clients receiving contradictory advice from different professionals or agencies and should work towards a co-ordinated view wherever possible.

3.6 Boundaries in professional relationships

Psychologists seek to establish good relationships and trust with their clients, other professionals, organisations and the community. They are aware of the complexity of professional relationships and the need to observe their boundaries. Multiple relationships occur when a psychologist is in a professional role with a client or colleague and at the same time is in another role with the same person or group e.g. as a supervisor, sports club member or co-author in a publication or where a psychologist is asked to work at a school where their child is a pupil.

Psychologists should:

- Ensure that the relationship reflects the appropriate context within which the practice is taking place.
- Be aware of the issues of multiple relationships and professional boundaries which may lead to (real or perceived) conflicts of interest or ethical considerations.
- Clarify for clients and other relevant stakeholders when these issues might arise.

When acting as leaders in practitioner or managerial roles, psychologists should maintain an awareness of the importance of respect for boundary and power issues within leadership relationships. In particular, an awareness of the possible abuse of these relationships should be maintained at all times. It is important that psychologists explicitly define the boundary of the relationship and negotiate and respect the responsibility that each holds in relation to it. Where psychologists are in a position of power/leadership with individuals, it is particularly important that they exercise caution and consider the possible issues which may arise from developing a personal relationship with these individuals. It may be necessary to seek further supervision where appropriate, with additional peers as necessary.

Psychologists have a duty of care towards their clients, who may be vulnerable, and should maintain a professional emotional distance from clients, services users or relatives and should not enter into an intimate or sexual relationship with any clients, service users or relatives they come into contact with as part of practice. Psychologists should also be aware that their duty of care can continue after a client practitioner relationship has ended.

As far as is reasonably practical, psychologists should not enter into a professional relationship with someone with whom they already have, or have had, a close personal

relationship. This includes family members and friends. Where there is no reasonable alternative, such as a lack of availability of other professionals, and it is acceptable in the particular context of practice, the psychologist should make every effort to remain professional and objective while working with the individual they know or have known. In such circumstances, at the earliest possible opportunity, this should be disclosed and discussed with a manager, where there is one, and supervisor and a note should be made in client records.

A range of psychologists work with people who initially have accessed the services in a dependent position, and have then transitioned to becoming partners and colleagues in service and policy development and design. The nature of the work becomes more collegiate and the psychologist holds multiple roles including facilitating participation, adapting communication and advocacy.

3.7 Working with children and young people

When seeking to work with children and young people, psychologists should consider how they can develop ways of communicating with the child or young person that will be most effective in ensuring they can express their views and feelings.

In most instances psychologists will use their specialist professional training and experience working with children, young people and families in order to understand the developmental needs of the child or young person in question; where a psychologist does not have specialist training that has included children and young people then there would be an expectation that advice or supervision should be sought before working with a child, young person, or their family. Similarly, work with children, young people and their families should take account of wider systemic factors outside of the child or young person; this will usually involve the child's family and may also include their school, and other settings.

As with adult clients, there can be misunderstandings and confusions about the role of a psychologist, the nature of the work being undertaken, and the possible outcomes of the work. It is essential to ask the children and young people about their understanding of what is happening on a regular basis (this may be appropriate at each session) and address any confusion that has arisen.

When working with children and young people, psychologists are advised to ensure that they have ascertained who has parental responsibility and that those with parental responsibility are aware of their planned involvement, if this is appropriate. Psychologists working with children, young people and families need to be aware that young people who are deemed to be competent to make their own decisions: 'Gillick competent'[14] can give their own consent to involvement with a psychologist, and that if a young person gives consent under these circumstances, then parental consent is not required. Similarly, a young person who is 'Gillick competent' can give consent even if parents have declined to give consent; such young people can also ask that parents are not informed of any involvement, and this should be respected by the psychologist; an example here would be in a school setting where a young person may give their own consent to see a psychologist

and may ask for parents not to be informed. Psychologists also need to be aware that where separated or divorced parents share parental responsibility, one parent can give consent.

3.8 Working with people with intellectual disabilities and impaired cognitive abilities

Psychologists are likely to work at some point with a range of people whose cognitive abilities are either temporarily or permanently altered, either by organic or developmental changes. Appropriate assessment of the abilities and skills is required, so that adaptions can be made to further interventions, treatments or management. The implications of the cognitive abilities on the person, their family and the reason for psychology involvement, will need to be considered.

Psychologists working with people with intellectual (learning) disabilities will need to consider adaptations to their approach to ensure the service they are offering is clearly understood, and is adapted to the individual's preferences, strengths and needs. This can include considering adaptations to oral or written communication, psychological assessment, intervention, and outcome evaluation.

Psychologists will need to be flexible and to make reasonable adjustments to their usual practice to ensure an appropriate service is offered. Psychologists should ensure their work is person-centred and respectful of the individual's needs, whether that work involves working with the individual with intellectual disabilities directly, or whether it also includes, or even may predominantly involve, working indirectly with family, carer or professional systems around the individual.

Psychologists will need to be mindful of the range of complex factors that often affect people with intellectual disabilities (e.g. communication needs, poorer mental and physical health outcomes and healthcare service experiences, unemployment, disempowerment, social isolation and exclusion, including experiences of bullying, abuse and hate crime, being overrepresented in the prison population, among others) and, therefore, the specific policy and practice guidance that applies. Further information is available in ***Section 4.2: Safeguarding adults at risk of harm*** and ***Section 6.3: Informed consent with people who may lack capacity.***

3.9 Working with detained people

Where clients are detained involuntarily there will always be a legal framework within which professionals must practise, and they should be aware of how their work fits into that framework. Involuntary detention is not only covered by professional rules and national legislation, but also by international agreements.

Psychologists should be aware that having the approval of one's employer is not necessarily a guarantee that practice is either ethical or legal, as described for example in the Hoffman report[15]. Where practitioners have doubts about the legal or ethical acceptability of employer demands, they should seek advice from an accredited workplace trade union representative, a human resources department, or appropriate helpline. They should

follow their organisation's guidelines on raising concerns at work. Seeking advice outside the immediate setting is helpful as colleagues within the workplace may be subject to the same pressures as they are.

Under the headings below, the role of the practitioner can be seen to be key to the way that detained persons are understood, and this can have a great impact on the way that their cases are handled by the detaining authority. The practitioner therefore has considerable power, whereas the client has very little. This power imbalance should always be borne in mind by practitioners dealing with detained persons. They should also bear in mind that the imbalance can be implicit as well as explicit.

Prisoners

Putting psychological pressure on detained persons to obtain a confession to an offence is illegal under the UN Convention on Torture[16]. In this context, 'psychological pressure' could well include such things as telling indeterminate-sentence prisoners who maintain innocence that they are unlikely to be released unless they engage with an intervention that relies on acknowledgement of guilt. Decisions about release are not the role of the practitioner, unless they are directly involved with, or are a member of the release authority, with a delegated role in the formal decision-making process. An approach to engagement such as this would not be considered beneficial to the client. However, those instructed by any party to the formal Parole Board decision-making process may properly be asked to give an opinion on suitability for release.

Practitioners dealing with detained offenders who have committed violent or sexual offences should guard against being morally judgemental. It is routine for practitioners in this field to encounter offenders who have committed very unpleasant acts with whose victims they can readily identify. Psychologists should be mindful that their own views about a client do not impact on their work.

Care should be taken when working with detained persons whose literacy is poor or whose first language is not English, and who cannot read a report which has been written about them. Even clients who are literate in English will probably not be familiar with psychological terminology, and may need considerable time to read and fully digest a report. People who are detained can also have cognitive challenges or intellectual disabilities which might make this process more difficult.

Persons detained under immigration legislation

Detained people may be afraid of raising a particular topic in case it is misunderstood, or too embarrassed because of cultural standards. For example, in some cultures it is difficult or unacceptable to discuss sexual matters, but sexual violence has been suffered by many asylum seekers in conflict zones, and some discussion of it may be essential in assessing their case. Even within the same culture there can be considerable generational differences.

Psychologists should guard against unwarranted interpretations of psychological evidence by commissioners or authority figures. For example, reporting that someone's story shows inconsistencies may give the impression that they are lying. This may be the case, but inconsistencies alone are insufficient proof of this. It is commonplace for evidence to be

inconsistently reported when people have been through traumatising experiences in areas of conflict, as is often the case with persons detained under immigration legislation.

Practitioners should take particular care in dealing with detained persons whose first language is not English. The opportunities for misunderstanding in both directions should be obvious, and in many cases the correct procedure will be to interview with the help of an interpreter. Failing to use interpreters when it was clearly appropriate to do so could inappropriately compromise the quality of the psychologist's work.

Mental Health Detentions

Mental Health Act 1983 as amended 2007 (England and Wales)
Under the Mental Health Act (MHA) a person can only be detained for treatment if that person is suffering from a mental disorder of a nature of degree that makes it appropriate for them to receive medical treatment in hospital. In the Act 'mental disorder' is defined as 'any disorder or disability of mind'. This definition is very broad but the *Code of Practice* provides guidance on clinically recognised conditions that fall within its meaning. Major categories of mental illness (e.g. affective disorders, schizophrenia and organic mental disorders) are included along with personality disorders, autistic spectrum disorders and learning disabilities (the latter only if accompanied by abnormally aggressive or seriously irresponsible behaviour). Dependence on alcohol or drugs is not considered a mental disorder under the MHA.

In the Act, all 'medical treatment' including psychological interventions is for the purpose of alleviating, or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations. The medical treatment must be required for the health and safety of the client or for the protection of others. This means that the primary purpose of psychological interventions offered and provided to detained persons has to be to reduce the risks that their mental disorder presents to the detained person or others; as once those risks are reduced or minimised the client will no longer require detention and can progress to a less restrictive environment. This requirement points to the importance of an individualised formulation of a client's treatment needs that includes a careful assessment of the risks to self and others (see section on Risk Assessment, p.32).

Under the MHA appropriate medical treatment must be available. This is described as the 'appropriate medical treatment test' in the *Code of Practice*. Such treatment must have the *purpose* of alleviating or preventing a worsening of the disorder or its symptoms or manifestations, even if it cannot be shown in advance that the treatment is likely to have an effect for a particular patient. Thus, appropriate medical treatment need not be likely to achieve those purposes. That is, purpose is not the same as likelihood. The nature and degree of the patient's mental disorder and all the patient's particular circumstances are all relevant to whether the treatment is appropriate.

The appropriate medical treatment test is designed to ensure that patients are not detained for treatment unless they are actually to be offered appropriate treatment for their mental disorder. Thus, the MHA requires only that appropriate treatment is available to a detained patient. The patient's refusal to accept treatment is not an obstacle to detention, so long as appropriate treatment is available.

This has particular relevance for psychological therapies. The Code at chapter 23.20 states:

> *In particular, psychological therapies and other forms of medical treatments which, to be effective, require the patient's cooperation are not automatically inappropriate simply because a patient does not currently wish to engage with them. Such treatments can potentially remain appropriate and available as long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to engage.*

Whilst the availability test of appropriate medical treatment applies to psychological interventions in the same way as for other forms of treatment, it is important for psychologists to avoid placing pressure on clients to participate in such treatment. In order for there to be an effective therapeutic alliance there needs to be trust and this only develops in the absence of coercion. Psychological therapy works when the client decides they are ready for therapy and freely consents to it. There is an inevitable power differential in favour of the clinician. Thus, every attempt should be made to emphasise patient involvement and choice and to avoid coercion in a manner consistent with the *Code of Practice* empowerment and involvement and respect and dignity principles. Further information is available in ***Section 6: Obtaining informed consent.***

The Mental Health Act 2007, which amended the MHA 1983, introduced approved clinicians (AC) who may be drawn from a defined group of professions, including practitioner psychologists listed in the register maintained by the Health and Care Professions Council. ACs are approved by the appropriate national authority to act as an approved clinician for the purposes of the MHA 1983. Responsible clinicians (RC) are ACs who have overall responsibility for an allocated patient's case. The Code of Practice at chapter 36.3 says that a patient's RC should be the available AC with the most appropriate expertise to meet the patient's main assessment and treatment needs. At chapter 36.5 the Code says that where psychological therapies are central to a patient's treatment then it may be appropriate for a professional with particular expertise in this area to act as the RC.

Chapter 39 of the *Code of Practice* provides guidance on the circumstances in which potential conflicts of interest may prevent designated professionals from making an application for or recommendations supporting a patient's detention or guardianship. The potential conflicts of interest dealt with in the Code involve financial, business, professional and personal issues.

The Mental Health (Scotland) Act 2015.

This act, together with the Mental Health (Care and Treatment) (Scotland) Act 2003 sets out the law for detaining patients and restricting patients. For patients to be detained, this has to be considered by the Mental Health Tribunal for Scotland. This applies, for example, to those detained in the NHS who are not subject to a court (forensic) decision.

Restricted patients are 'detained in hospital under a compulsion order with a restriction order'. They have usually committed an offence punishable by imprisonment but as a result of mental disorder are not imprisoned but ordered to be detained in hospital for treatment, without limit of time. They are dealt with through a programme of treatment and rehabilitation – the aim being to prevent recurrence of offending by dealing with the mental disorder'.

Risk assessment

When dealing with detained people seeking release, such as parole applicants or patients seeking release from a mental health tribunal, risk assessment (usually for violence risk) will be a prime consideration. Psychologists should bear in mind that risk assessment is not prediction. Risk assessment instruments are rarely more than about 70 per cent accurate when predicting reconviction and many items on commonly used risk-assessment schedules are of poor predictive value.[17] Psychologists should also bear in mind that risk-assessment instruments are better at identifying low-risk than high-risk individuals[18],[19]. A statement of risk is not a prediction about an individual, but a statement based on the behaviour of a criterion group with which that individual is being compared. Risk is statistical by its very nature, and the value of such comparisons depends upon the individual's similarity to the criterion group upon which the risk assessment instrument was developed. Accuracy may be greatly reduced if the similarity is low[20]. It may be better to think of risk assessment as a process of identifying those risk factors which need to be monitored and controlled if supervision of the individual is to be reduced or withdrawn.

3.10 Working with people who are, or would like to be employed

Psychologists are sometimes commissioned to deliver psychological assessment or training with employees and potential employees. Psychologists should take particular care over the advice provided in follow-up reports, as employers are not trained professionals and may misinterpret advice or psychometric testing results. For example, citing a reading ability level using age is misleading, and could be interpreted as incompetent for the role, when in reality the role does not require a high reading level or a reasonable adjustment could be provided.

Similarly, psychologists should ensure that the tools they are using to assess competence or suitability are appropriate for the role, and have good reliability and validity. Any tools devised by the psychologist are likely to be interpreted by the employer as professional and authoritative, where there is ambiguity or multiple interpretations, this must be made clear, so that decisions about peoples' employment are not made in error.

There are people who work or who would like to work, who may experience cognitive difficulties caused by a range of factors, for example intellectual disabilities, dementia, acquired brain injury. Sometimes this information is known and needs to be considered when assessing and advising. At other times, this possibility of a cognitive or intellectual impairment needs to be considered. The impact of this can be far reaching, in terms of ongoing or future employment, access to benefits and of course associated psychological adjustments for the person and the people around them. Further information is available in ***Section 7: Managing data and confidentiality*** and ***Society Document: Psychological Assessment of Adults with Specific Performance Difficulties at Work.***

3.11 Working with cultural difference

It is expected that all psychologists will have the necessary skills and abilities to work with all sections of the community.

Psychologists need to be aware of stereotypical beliefs and assumptions which manifest in thinking about culture and ethnic groups. Psychologists should bear in mind the history of racism and the early development of Western psychology[21] and culturally biased testing in favour of white, middle-class children. Psychologists need to recognise that multi-ethnic groups are not homogenous groups and there are wide regional and local differences among these groups which can be split by language, dialect and regional variations. Each ethnic community has a distinct identity and religious focus may also vary within and across communities.

Race is not a biologically meaningful concept to apply to people, and even the artificial divisions between the so-called racial groups are nebulous and unstable, biologically, socially and physically.[22]

Psychologists need to understand the discrimination suffered by people from diverse and/or minority ethnic and religious backgrounds as a result of:

- the interchangeable use of the terms race, culture and ethnicity leading either to the perception of black and minority culture, race and ethnicity as unitary or an assumption that knowing about these cultures solves the problem of equality, fairness and availability of services;
- the maintenance of the colour-blind approach in service where 'one size fits all', resulting in a lack of formal recognition of the varied diverse needs as well as these needs being ignored, unacknowledged or assumed to be the same;
- the lack of appropriate culturally relevant psychological therapy available to certain Black and Minority Ethnic (BME) communities;
- being discriminated against on grounds of 'special' needs, effectively considered as 'cultural pathology'; and
- experiencing instances of indirect, subtle, or unintentional discrimination often called 'micro-aggressions'.

It would be expected that all practising psychologists should develop a productive working relationship with culturally and linguistically diverse groups of people by:

- avoiding different types of biases and find new ways (verbally and non-verbally) to build rapport and respect;
- using and working with trained interpreters in assessment, formulation and intervention work as well as research work;
- being aware of the impact of culture, ethnicity and religion in assessment, formulation and intervention processes and the use of norm-referenced tests which do not include minority ethnic groups as part of their standardisation;
- pre-assessing and pre-incorporating ethnic identity (including its fine gradations, region, class and generation) which can have impacts on processes and outcomes of psychological work;
- acknowledging their own ethnocentricity and possible underlying socially conditioned prejudice to people who are 'different'; psychologists need to acknowledge that people can change, irrespective of their differences and psychological distress;
- relooking at current models of mental health which traditionally reflect Western

constructions, and incorporating other world views of psychological wellbeing; and
- understanding and respecting the different concepts of health and illness that exist within different ethnicities, including newly arrived people from Europe and refugees from Syria, Turkey, Somalia etc.

Psychologists need to: address the different life situations and life circumstances experienced by users who wish to use mental health services; hear their voices based on their personal experiences; and act and respond accordingly in a human way.

3.12 Working with people of faith, religion and spirituality

In working with clients who hold a variety of values and religious and spiritual beliefs which may be different from their own, psychologists should consider the following:

- Psychologists should respect clients' values and spiritual beliefs and need to be mindful that their personal beliefs should not be an impediment to engaging with the client.
- Spiritual beliefs are very often beneficial to the client's wellbeing and may be helpful to be incorporated into any intervention to achieve a positive impact where appropriate.
- In some circumstances the client's faith belief may be harmful or detrimental to themselves or others.

3.13 Working with sexual and gender minorities

Psychologists are committed to the fair treatment and inclusion of people who are intersex, people who do not identify as heterosexual and/or people who do not identify with their natally-assigned sex. This section provides guidance to address specific issues in support of these heterogeneous populations. In these guidelines we use the term 'sexual minority(ies)' to refer to individuals whose romantic attraction or sexual attraction is other than heterosexual (different from the majority in the surrounding society), and the term 'gender minorities' to refer to transgender, genderqueer and intersex individuals.

When working with gender and sexual minorities, psychologists are encouraged to:

- remember that sexual and gender minority identities are not indicative of mental health disorders;
- understand that attitudes towards sex, sexuality and gender are located in a changing social, cultural, and political context, and to reflect on their own understanding of these concepts and how it may impact their practice;
- reflect on the limits of their practice when working with certain sexual and gender minority clients, and to consider appropriate referral and training when necessary;
- understand how social stigmatisation (e.g. prejudice, discrimination and violence) poses risks to gender and sexual minority clients;
- consider engaging with the wider socio-political context regarding sexual and gender minorities in order to reduce social stigma;
- be knowledgeable about the diversity of sexual and gender minority identities and practices;

- use the preferred language of the sexual and gender minority individuals;
- understand the unique and particular circumstances and challenges facing clients with diverse gender and sexual identities and practices;
- understand the diversity of forms of relationships and families in gender and sexual minority clients;
- be aware of the potential challenges facing sexual and gender minority clients in their relationships and families;
- be mindful of the intersections between sexual and gender minority and socio-cultural/economic status;
- recognise the particular challenges experienced by gender and sexual minorities with physical and/or mental health difficulties;
- recognise the diversity of developmental pathways for sexual and gender minority children and adults;
- recognise the needs and issues of young people from gender and sexual minorities, and their particular vulnerabilities;
- support the self-determination of their clients in the development of their identities and practices; and
- avoid attempting to change gender or sexual minorities on the basis that they can be 'cured' or because of stigmatising theory, personal, religious and/or socio-cultural beliefs.

Working with racially and ethnically diverse Lesbian, Bisexual, Gay, Trans*, Queer (LGBTQ) populations

Black and minority ethnic (BME) LGBTQ people have to negotiate between the values and beliefs of the mainstream and minority ethnic cultures. Cultural differences in norms, beliefs, and values can be a source of psychological stress[23],[24],[25]. There may be no particular sexual and ethnic minority group to which a BME LGBTQ person can anchor their identity and obtain acceptance and support. This may be a particular issue for BME LGBTQ youth who are exploring their sexuality and sexual identity.

When offering psychological services to racially and ethnically diverse LGBTQ populations, it is not sufficient for a psychologist simply to identify the racial and ethnic identity and background of the client. Ethnic minority status can complicate and exacerbate the issues, challenges and difficulties the client experiences. The client can be affected by the way their ethno-culture community view and understand sex, sexuality and gender. The issue of racism within the LGBTQ community is also an important issue to consider[26],[27],[28],[29]. Sensitivity to the complex dynamics associated with factors such as cultural values about gender roles, religious and procreative beliefs, degree of individual and family acculturation, and the personal and cultural history of discrimination or oppression is also important. All of these factors may have a significant impact on identity integration and psychological and social functioning[30],[31],[32],[33],[34].

Further information is available in ***Society Document: Guidelines and Literature Review for Psychologists Working Therapeutically with Sexual and Gender Minority Clients.***

3.14 Working with people who may be socially excluded

Social exclusion refers to the extent to which individuals are denied access to the prevailing social system and the right to participate in key areas of social, economic and cultural life. This exclusion occurs due to constraints and restrictions rather than as a matter of choice. Exclusion is typically a result of poverty and/or belonging to a social minority group. The impact of social exclusion has been well documented and leads to the perpetuation of cycles of inequality for individuals and groups. These cycles of inequality are perpetuated in terms of income, health, opportunity, relationships and life-span. Further information is available in ***Society Document: Socially inclusive practice.***

Social inclusion is the process where the needs of all members of communities and the groups which constitute them are recognised, prioritised and met, resulting in these individuals feeling valued and respected. Promoting social inclusion is a broader task than promoting equality and tackling discrimination and stigma. It requires psychology professionals to address wider structural issues in society which maintain excluding processes and power differentials.

The range of individuals and groups who may experience disadvantage and exclusion is not limited to the protected characteristics outlined in the Equality Act. For example, people may also experience exclusion because of their age, they are a carer or are in care, they have a low income or low educational achievement, or their cognitive ability is compromised.

When working towards social inclusion psychologists are encouraged to:

- acknowledge, understand and respect the diversity of the communities in which they practise;
- make adjustments where possible and needed, to enable people to fully participate, e.g. to communication, access to services, adaptation to materials and psychological assessment and interventions;
- recognise that they have a professional duty actively to promote equality and opportunity;
- recognise the shame and distress caused by discrimination, and the impact of discrimination on wellbeing;
- acknowledge and respond to the trauma and distress caused by exclusion;
- move beyond the level of the individual and recognise that social exclusion is a structural issue, and that inclusion will be achieved only by structural changes in society and broad policy initiatives;
- acknowledge that there is a responsibility to highlight the links between structural societal factors and mental health problems;
- make employers, policy-makers, clients and the general public aware of situations where policies, practice and the distribution of resources are oppressive, unfair, harmful or illegal;
- challenge social conditions, both as individuals and collectively, that contribute to social exclusion and stigmatisation;
- make services accessible in terms of time, space, familiarity and comfort; make reasonable adjustments to services to meet individuals' needs; people need to be able

to get to places, get into places, feel welcomed to places and feel that they belong in places;

- recognise that inclusive services reflect the communities they serve in terms of the identities and diversity of the staff team;
- recognise the range of interventions that can improve clinical and social outcomes and use influence to ensure these services are commissioned;
- emphasise social outcomes and participation alongside clinical outcomes;
- maintain an emphasis on empowering clients to achieve their social goals; and
- identify natural sources of support and reciprocal relationships for individuals within their communities, and seek out opportunities to help individuals transition out of formal mental health services.

4. Safeguarding

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect[35]. This guidance addresses safeguarding of both children and adults.

Abuse takes many forms and cuts through various domains of life. The categories below are often referred to in investigation/legislation context and are not mutually exclusive with e.g. emotional abuse featuring in the other domains of abuse. Abuse can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

- Physical abuse – is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This could include hitting, poisoning, deprivation of food, water or liberty, rough handling or exposure to heat or cold, amongst other things.
- Sexual violence and abuse – sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding. Sexual violence and abuse can take many forms and may include non-contact sexual activities such as: indecent exposure, stalking, grooming or being made to look at, or be involved in the production of sexually abusive material, or being made to watch sexual activities.
- Psychological/emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, blaming, controlling, intimidation or coercion amongst other things.
- Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not, or could not, consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property of inheritance.
- Institutional abuse is the mistreatment or neglect by a regime or individuals, in settings which people who may be at risk reside in or use. Institutional abuse may occur when routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. It may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services and includes a failure to ensure the necessary preventative and/or protective measures are in place.
- Neglect is the persistent failure to meet basic physical and/or psychological needs. It may involve a parent or carer failing to provide adequate food, clothing and shelter, failing to provide or unresponsiveness to, basic emotional needs or failing to protect from physical harm.

Psychologists are in a particularly relevant position to identify interactions or circumstances that affect health and development. This applies not only to psychologists who undertake direct work with children and vulnerable adults in a variety of settings; but also to those who work with clients, seen for instance in clinics, hospitals or prisons, who may make historical disclosures of abuse or raise concerns about child protection or the welfare of people within their families or communities. Safeguarding is thus the responsibility of all psychologists whatever their role.

4.1 Safeguarding children

The Society endorses *Working Together to Safeguard Children* – A guide to inter-agency working to safeguard and promote the welfare of children[36]. Safeguarding children is the responsibility of everyone.

The guidance defines safeguarding children as protecting children from maltreatment and preventing impairment of children's physical or mental health or development (physical, intellectual, emotional, social and behavioural). Promotion of welfare is defined as ensuring that children grow up in circumstances consistent with the provision of safe and effective care, and taking action to enable all children to have the best life chances.

Child protection within safeguarding refers to the activity that is undertaken to protect specific children who are suffering or likely to suffer significant harm. For the purposes of child protection legislation children are those who have not yet reached their 18th birthday. The child's needs are paramount, and the needs and wishes of each child be they a baby or infant or an older child, should be put first, so every child receives the support they need before a problem escalates.

The policy of Working Together is underpinned by two key principles: (a) safeguarding is everyone's responsibility and for services to be effective each professional and organisation should play their full part; and (b) safeguarding requires a child-centred approach based on a clear understanding of the needs and views of children.

Where there are concerns that a child is at risk of harm, such concerns should normally be communicated following the psychologist's work-place safeguarding protocol. Where this is not applicable, concerns about a child's welfare can be made directly to the local authority children's social care team.

Psychologists should:

- be alert to the heightened vulnerability/possible need for early intervention support for a child who: has a disability, has additional needs (including special educational needs), is a young carer, is showing signs of engaging in anti-social or criminal behaviour, has returned home from care and/or is showing early signs of abuse and/or neglect.
- be alert to heightened vulnerability where a child is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence.
- consider the potential impacts of parental/carer ill-health on the family and whether this creates any significant negative impacts or risks for children within that family;

- be aware that if an adult has responsibilities for children outside the home setting, such as working with children, their mental ill-health and/or their health more generally upon the adult's capacity to work safely;
- be aware that children within the same family can be treated differently (one child may be singled out for abuse);
- be aware/seek to understand how children can come to abuse other children;
- recognise that some professionals use their position to abuse children and vulnerable people; and
- challenge institutional abuse in its many forms.

Psychologists should be aware of situations of risk which require additional consideration, notably:

- sexual exploitation, which involves exploitative situations, contexts and relationships without the child recognising the harm on account of their age/understanding, social/economic and/or emotional vulnerability;
- internet abuse, which can involve cyber bullying, exposure to pornography or violence and exploitation of young people;
- domestic violence which may expose a child to violence directly or indirectly;
- shame-based abuse where children or young people may be physically assaulted or murdered because of bringing perceived 'shame' to their families or breaking cultural expectations of 'honour'; and
- Trafficking, any child transported for exploitative reasons is considered to be a trafficking victim, whether or not they have been forced or deceived. This is partly because it is not considered possible for children to give informed consent. Even when a child understands what has happened they may still appear to submit willingly to what they believe to be the will of their parents or accompanying adults.

Psychologists should have a knowledge and understanding of services for children in need and how to access them. Psychologists confronted with child abuse in any form should contribute to whatever actions are needed to safeguard children and promote their welfare. The needs/interests of adults should not be allowed to take precedence ahead of the needs of the child. Psychologists should work co-operatively with parents/carers unless this is inconsistent with ensuring the child's safety and ensure that the child's view is sought, heard and communicated. Psychologists should share appropriate information in a timely way, discuss any concerns and help analyse information so that an assessment can be made of the child's needs and circumstances. Psychologists should contact the children's services or social services department at the appropriate local authority (in some cases this role has been delegated to a multi-agency safeguarding hub) if they are concerned about a child or a vulnerable adult.

Managing cases of alleged historical abuse

There is a growing recognition that a disclosure of non-recent abuse may reveal current risks to others from an alleged perpetrator. Psychologists have a duty of care to their clients, and in the safeguarding of others. This may place psychologists in complex positions when trying to negotiate and balance their duties and responsibilities.

Psychologists who work with adult clients who disclose non-recent sexual abuse, should recognise that there may be current and ongoing risks posed by the alleged perpetrator to others. Not sharing concerns beyond the consulting room could mean that other children and young people could be at risk.

A client's allegations should be taken seriously, regardless of their presenting problems or mental health diagnosis.

Lack of access to children identified through familial relationships, work or volunteering roles should not eliminate concerns about risk, given opportunities for abuse to occur within communities.

It is crucial that psychologists seek advice from colleagues, particularly colleagues in safeguarding services, within the organisation and also from other agencies tasked with leading on safeguarding (i.e. social services). Psychologists working with clients without a referral and where no stakeholder agency is involved should seek advice from senior experienced colleagues on how to proceed. Psychologists need to be alert to the possibility that abuse may be organised, severe and complex.

There may be times when, in the interests of supporting a client's psychological readiness for disclosure, consultation may continue without requiring identifying details to be provided to the psychologist. It is important that a clients' lack of readiness to disclose does not become an obstacle to receiving psychological help. Further information is available in ***Society Document: Guidance document on the management of disclosures of non-recent (historic) child sexual abuse.***

Where the disclosure is made by the perpetrator of the abuse, risk assessment should be made regarding the context of the setting of the disclosure but there may be a professional obligation to disclose the criminal offence in order to safeguard other potential victims as above.

4.2 Safeguarding adults at risk of harm

The Care Act 2014 brought in new legislation regarding the safeguarding of all vulnerable adults. In some regions there is a move away from the term 'vulnerable adult' towards the concept of an adult at risk of harm.

An adult at risk of harm is a person aged 18 or over with need for care or support, who is experiencing, or is at risk of, abuse or neglect, and as a result of their needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The needs referred to here may cover a variety of personal or life circumstances including (but not limited to) cognitive impairment, age, disability, illness, injury or mental health condition.

The legal context

There is no set piece of legislation for adult safeguarding. It is a mix of criminal law, case law and welfare law. The Care Act 2014, updated in 2016, brought in the first legal framework for safeguarding adults in a single act. It contains a range of regulations and statutory guidance, which form the base upon how social care will develop in the future.

It enshrines the new statutory principle of wellbeing and it makes it the responsibility of local authorities to promote wellbeing when carrying out any of their care and support functions. The act specifies the rights of those who need care and support, their carers, and the funding system for care and support. It recognises that this cannot be achieved by any single agency. Every organisation and person who comes into contact with a child or adult has a responsibility and a role to play to help to keep children and adults safe. Further information is available in ***Appendix 1: Relevant legislation.***

Modern slavery

An important area of concern is modern slavery. The Government website provides details about the government's work to end modern slavery, including details about how to refer victims into the national referral mechanism (NRM). Modern slavery is a serious crime. It encompasses slavery, servitude, and forced or compulsory labour and human trafficking. Modern slavery victims can often face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation.

A person is trafficked if they are brought to (or moved around) a country by others who threaten, frighten, hurt and force them to do work or other things they don't want to do.

A victim of slavery is entitled to help and protection from the UK Government (this is called the National Referral Mechanism), all support is provided on a confidential basis, and support to talk to the police. The National Referral Mechanism has been put in place to identify victims of trafficking and refer them to organisations that will offer help and support. Further information is available in ***Appendix 2: Websites and further information.***

Responding to concerns

Safeguarding adults means:

- Protecting the rights of adults to live in safety, free from abuse and neglect.
- People and organisations working together to prevent and stop both the risks and experience of abuse or neglect.
- People and organisations making sure that the adult's wellbeing is promoted including, where appropriate, taking fully into account their views, feelings and beliefs in deciding on any action.
- Recognising that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances and therefore potential risks to their safety and wellbeing.

Providers' safeguarding arrangements should always promote the adult's wellbeing. Being safe is only one of many things that adults want for themselves and there can be challenges in balancing safety and freedom in a way which protects and fulfils human rights. Providers, and other professionals where relevant, should work with the adult to establish what being safe means to them and how that can be best achieved.

Care and support means different things in every case. The fundamental standard on safeguarding is that children and adults using services must be protected from abuse and improper treatment. Providers should establish and operate systems and processes

effectively to ensure this protection and to investigate allegations of abuse as soon as they are aware of them.

The standard states that care or treatment must not:

- Discriminate on the grounds of any of the protected characteristics of the Equality Act 2010;
- Include acts intended to control or restrain an adult or a child that are not necessary to prevent, or not a proportionate response to, a risk of harm to them or another person if the adult or child was not subject to control or restraint;
- Be degrading to the adult or the child;
- Significantly disregard the needs of the adult or the child for care or treatment.

The standard goes on to state that no adult or child must be deprived of their liberty for the purposes of receiving care or treatment without lawful authority.

Safeguarding Adults Boards were established to help and safeguard adults with care and support needs The Safeguarding Adult Board must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies, according to the values of 'Making Safeguarding Personal' Guide 2014[37]. Making safeguarding personal is not just for people with capacity, it is just as important for people who lack capacity. The Guide specifies outcomes that people might want including to be and to feel safe, to maintain or get friends, to know that this won't happen to anyone else or to be able to protect self in the future.

The following are not outcomes:

- Harm or abuse is substantiated/unsubstantiated.
- The person is receiving increased monitoring or care.

The role of the Care Quality Commission[38] is to monitor, inspect and regulate services to make sure that they meet the fundamental standards of quality and care. The Commission works alongside Safeguarding Adults Boards and Safeguarding Children Boards to share information and intelligence where appropriate to help them identify risks. This includes providing appropriate advice and support to people at risk of radicalisation in sectors such as healthcare and education.

4.3 Terrorism and extremism

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ('specified authorities' listed in Schedule 6 to the Act), in the exercise of their functions, to have 'due regard to the need to prevent people from being drawn into terrorism'. Depending on where the psychologist works, these duties may have relevance in the course of their employment. The term 'due regard' as used in the Act means that the authorities should place an appropriate amount of weight on the need to prevent people being drawn into terrorism when they consider all the other factors relevant to how they carry out their usual functions.

The current UK definition of 'terrorism' is given in the Terrorism Act 2000. In summary, this defines terrorism as an action that endangers or causes serious violence to a person/ people; causes serious damage to property; or seriously interferes or disrupts an electronic system. The use or threat must be designed to influence the government or to intimidate the public and is made for the purpose of advancing a political, religious or ideological cause. People suspected of being involved in such activity must be referred to the police.

'Extremism' is defined in the Prevent Strategy[39] as vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty, and mutual respect and tolerance of different faiths and beliefs. Definitions of extremism can also include calls for the death of members of our armed forces, whether in this country or overseas.

While it is recognised there is no single profile associated with extremism, identity is considered to be central, and risk screening is based on assessment in relation to two general pathways into extremism – criminal and non-criminal. Disengagement follows a similar process. This is a contentious area of practice. Psychologists should ensure they focus on their core role, working in a non-stigmatising way, and avoiding profiling based on characteristics such as race, religion, ethnicity or any other aspect. The psychologist should carefully weigh relevant professional obligations and seek and follow appropriate local and employer guidance. Further information is available in ***Appendix 2: Websites and further information.***

5. Making and maintaining agreements

Both client and psychologist benefit by having arrangements for the work clearly set out from the start. Psychologists should be aware that all professional engagements are ultimately governed by the law of contract. A legally enforceable contract can arise as a result of the parties' entering into a written agreement, but can also arise as a result of a verbal agreement between the contracting parties.

A contract arises if the following are present:

- one of the parties (the offeror) had made an offer to the other party (the offeree);
- the offeree accepts the offeror's offer;
- there is consideration (i.e. something of value) passing from each party to the other, e.g. the offeror provide services to the offeree; the offeree pays the offeror;
- the parties intended to create a legal binding arrangement; and
- the terms of the contract are sufficiently certain.

While this does not mean that all client engagements are made subject to an agreed contract document, it does mean that in the worst-case scenario of a complaint against a psychologist being made, it will be very helpful for the psychologist to be able to demonstrate that they have met their professional obligations to their client. This will be best done by demonstrating that an agreement was made by both parties who knew what they were agreeing to, that the parties had the legal capacity to make such an agreement and that what they were agreeing to is permitted under the law. Where the client does not have the capacity, best interest decisions need to be made in accordance with the Mental Capacity Act. Further information is available in ***Section 6: Obtaining informed consent***.

Psychologists may wish to include the following when making agreements:

- the role and function of the psychologist;
- the psychologist's relevant qualifications, areas of expertise and ways of working;
- relevant limitations of the psychologist's practice, e.g. assessments not accepted or types of activity not undertaken;
- where the psychologist is appointed to work with a third party, the psychologist should make clear their obligations to each of the clients concerned and each client's obligations under the agreement and ensure that there are no conflicts or ambiguities;
- the extent of the psychologist's power and responsibilities when acting on behalf of other agencies;
- obligations in relation to duty of care and safeguarding, and related limitations to confidentiality;
- how confidentiality of client information and data is assured and any limitations to that confidentiality;
- how conflicts of interest will be managed if applicable;
- the client's, or other party's, rights of access to stored information;
- the use of any one-way viewing screens or video or audio recording and the security of any recorded material;

- the nature of psychological activities involved, the reasons for undertaking them and information about the likely outcomes;
- the availability of the psychologist to the client;
- details of fees, together with application of VAT if non-clinical services, or expenses to be billed in connection with the work undertaken;
- what is expected from the client as their contribution to the engagement with the psychologist, expectations for payment and consequences of non-payment;
- ownership of intellectual property rights;
- what might cause a breach of the agreement;
- the rights of each party to withdraw from the agreement and the consequences to any financial agreement;
- recourse to dispute resolution or law;
- the equality and justice aspects of social policies and their possible impact;
- external ethical scrutiny and approval of the engagement, where appropriate; and
- arrangements to terminate the retainer.

In advance of any psychological assessment, the client should be made aware of the availability of services, and the existence of any waiting lists for intervention.

For some approaches, intervention follows an evolving path, unique to each client and his or her life circumstances, which cannot be precisely predicted in advance. Clients should be made aware of this uncertainty, and predictions should be made on the best judgments. It is recognised that it is sometimes unrealistic and undesirable to provide detailed information on all aspects of psychological intervention, and consent should be obtained to a general strategy rather than specific procedures. Further information is available in this document or the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines.***

5.1 The practitioner's right to withdraw their service

There are circumstances in which a psychologist may decide to terminate the agreement for provision of psychological services. The circumstances may be personal or professional.

The personal circumstances may include but will not be restricted to leaving employment in a psychological service, incidences of illness or family commitments.

The professional issues may relate to service structural changes, safety, or provision of most appropriate service.

In these circumstances, psychologists will, as far as possible, work to ease the transition of service provision and give as much notice as is practical in the particular situation.

5.2 Referrals

Where a psychologist finds themselves unable to come to an agreement with a client, the psychologist may refer the client to a suitably qualified colleague. Psychologists will both make and receive referrals when working in services with other professionals.

In making referrals, psychologists should consider the needs of the client and to the best of their knowledge refer to another professional with the appropriate skills and experience.

In receiving referrals, the psychologist should consider whether the referral is appropriate for psychology, establish the client's understanding of the purpose of the referral, and consider as far as possible prior to meeting the client whether the referral falls appropriately within their own areas of practice.

5.3 Representation of the qualifications and status of the psychologist

HCPC registration and BPS Chartered Status

Psychologists are encouraged to state their registration with the HCPC and protected title(s). This will provide assurance that the psychologist meets national standards of training and professional skills.

Use of the 'consultant' title

The term 'consultant' generally does not have a formal definition. Within the medical field it is used by doctors who have considerable experience and proven expertise demonstrated through examination within their respective Royal Colleges.

While there is no clear comparable grading structure for psychologists outside the NHS (within the NHS, the consultant title is used by psychologists who are employed in Band 8C, 8D and 9 positions), the use of this title would be seen to reflect both seniority and specialist expertise.

There is a difference between a 'consultant' psychologist and a psychologist who provides consultations in their context of practice. The Society expects that psychologists should be honest and accurate in representing their professional affiliations and qualifications, including such matters as knowledge, skill, training, education and experience.

The Society's position is that this would be applicable in any situation where expert knowledge or skills is being marketed or promoted, whether or not this is for financial gain. Further information is available in ***Society Document: Guidance on the use of the title 'Consultant Psychologist'.***

6. Obtaining informed consent

Psychologists should always ensure that they have sought and received the consent of those they work with, given of their own free will, without undue influence.

The concept of informed consent relates to the client's right to choose whether to receive psychological services, and to make this choice on the basis of the best information available presented in the most appropriate way. The principles apply, whether the psychologist works in the public, private or voluntary sector or in independent practice.

Psychologists should obtain the informed consent of the client in an appropriate manner prior to undertaking any assessment, intervention or research activities. In all circumstances, common sense and ethical practice should apply when considering the approach to gaining informed consent from those with whom the psychologist is working.

This section refers, in the main, to consent with adults with capacity. Further information on informed consent with discrete communities where further consideration may be needed is available in ***Sections 6.1 to 6.4***.

Obtaining informed consent involves a process which is dynamic and is relevant to the specific assessment, intervention or decision being made at that time. When there are substantive changes in the intervention or when the psychologist has reason to consider the client may no longer consent, consent should be reviewed. Psychologists should ensure that their clients are enabled to play an active role in this process. Clients should be encouraged to ask questions whenever they are in doubt.

Psychologists should be aware that a client's desire for help, and the immediate impact of the psychologist's supportive listening, may affect the client's ability to make informed choices about the help they wish to receive. They should also be aware that their own desires to help a client may bias their presentation of information, such as the probability of successful outcomes.

Psychologists should be aware of the complexities of obtaining informed consent to treatment due to the perceived power, status and authority of the professional psychologist. It may not be clear if the consent given is freely given by the client or, for example, is part of a pattern of compliance towards authority figures. Equally, a client may say that they understand the explanation given by the psychologist, and accept a plan for intervention, in order to avoid the discomfort of being seen not to understand the psychologist's complex language and ideas.

Obtaining informed consent is particularly difficult when the client is obliged to undertake the psychological intervention as part of an employment process or performance measure where they may have obligations under their employment contract; or when detained.

There should ideally be an ongoing dialogue between client and psychologist, as part of the process of joint decision-making. At any point, the client should feel free to ask questions about the impact of the treatment and withdraw consent to continue.

Psychologists should attempt to intervene against the express wish of a client only after careful consideration and in line with relevant legislation, policies and professional practice.

Provision of information for informed consent

In order to ensure that the client has all the information necessary to make an informed decision about whether to take part or not in a psychological activity, they must be provided with relevant information, such as that listed below, in a format that is designed to meet their specific needs.

The psychologist should consider providing information about the following:

- what the psychological activity involves, as far as this is consistent with the model of interaction, e.g. there will be limits in the use of some non-directive therapies and psychometric assessments;
- the benefits of the activity, either directly to the client in the case of assessment or intervention, or indirectly in the case of systemic intervention, or to potential theoretical advances or service improvement;
- any alternative assessment or treatment options and their known availability;
- foreseeable risks and how minor or serious they may be, for example the potential to feel worse at stages during therapeutic interventions;
- what might be the benefits and potential costs and risks to them of engaging or not engaging in the proposed psychological activity; and
- the client's right to withdraw their consent from assessment, treatment or intervention at any stage, along with information about any likely consequences of such withdrawal.

Consent to involvement of others

Psychologists have an obligation to ensure that prospective clients are informed of the extent and limitations of confidentiality with respect to anticipated services, the purposes of any assessment, the nature of the procedures to be employed or the intended uses of any product such as notes or recordings, before the assessment or intervention starts. Further information is available in ***Section 7: Managing data and confidentiality.***

The psychologist should ask the prospective client: whom they would wish to be informed of their assessment or treatment, if anyone; and the information they are willing to share where communication is essential, for example to the referring agent or organisation, management or court. Wherever appropriate, including in the law, the client should have copies of reports or letters or be given feedback so that they are kept fully informed.

If it is deemed necessary to move from individual contact to include others this should where possible be done with the client's prior consent.

Psychologists may be asked to provide consultancy or advice to colleagues about an identified client, without that person's knowledge or when the client has indicated that they do not want to have direct contact with the psychologist. In these circumstances, the psychologist will need to consider their potential involvement and the need for consent.

A psychologist who draws upon the work of other professionals in preparing a report, should seek their consent, where possible and if not already in disclosed records, to include that material and should acknowledge its source in the report.

If a report is requested which draws upon previous or concurrent investigations of a client in other contexts, for example NHS records in the preparation of a report for the court, the client's consent or relevant authority's consent for that information to be used should be sought.

If psychologists wish to use reports on clients which have been compiled by other professionals, they should do so only with the consent of those professionals and use the reports only in the context for which the report was specifically provided.

Information on and consent to record-keeping

Express consent must be sought in advance for the use of video, audio recording or one-way screens, with a clear explanation of the purpose of these. Further information is available in ***Section 7.1: Information governance***

6.1 Informed consent for court

When a psychologist is instructed to give evidence in court, it is the court that should be informed and whose authority should be sought for the work undertaken. When serving as a witness in the legal arena, the psychologist is responsible to the court, rather than to either party.

6.2 Informed consent with children and young people

All children and young people, whatever their age or status, have a right to express their views freely and be involved in any decision-making that affects their lives, which includes judicial and administrative proceedings[40]. Therefore, psychologists who seek to work with children or young people must gain their informed consent. This applies whether the child or young person or another agent with legitimate responsibility for the child or young person has made the request for involvement. Any direction or guidance provided by parents or other caregivers must be 'in accordance with the child's evolving capabilities' and support the 'exercise by the child of his or her rights'[41]. The onus is then on the adults to provide appropriate support to enable the child or young person to express their views and contribute to decision-making.

Every psychologist should consider how they can:

- provide an accessible explanation to the child or young person about their work as a psychologist;
- offer a clear reason for their possible involvement;
- provide an opportunity for the child or young person to talk about what working with the psychologist might involve.
- discuss and agree how information is recorded and possibly shared with others with an awareness that young people who are 'Gillick competent' can consent to information not being shared with parents;

- discuss how the child or young person will be kept safe;
- ensure that the child or young person has understood the psychologist's role and has given their informed consent;
- ensure the child or young person understands they can withdraw their consent at any point;
- ensure their practice acknowledges and respects the culture, community and context of the child or young person.

Occasionally, a disagreement over consent may arise between parent/carer and child or young person and/or between parents/carers. The psychologist would make every effort to resolve the difference of views, perhaps seeking, with agreement, involvement of an appropriate family member and/or a colleague, although as discussed above, a young person who is 'Gillick competent' can legitimately request that family members (including parents) are not involved or informed of any involvement. If the disagreement is not resolved, the psychologist should draw on their professional experience to act in the best interest of the child or young person seeking consultation and support through appropriate channels, including safeguarding and legal departments, and consultation with appropriate colleagues including other professionals.

6.3 Informed consent with people who may lack capacity

It is likely that psychologists at some stage within their careers will be working with people who lack capacity to consent to assessment or treatment. This could be because of a wide range of difficulties such as intellectual disability, brain injury, dementia, severe mental health difficulties, and neurological conditions. As a result, it will often be necessary to make a judgment about a client's ability to give informed consent. This should include whether the person is able to:

- understand the information relevant to the decision (e.g. psychological treatment);
- retain that information;
- use or weigh that information as part of the process of making the decision; and
- communicate their decision (whether by talking, using sign language or any other means.)

The Mental Capacity Act 2005 contains 5 key principles which it is important to understand:

1. A presumption of capacity;
2. Individuals being supported to make their own decisions;
3. Individuals have the right to make 'unwise' decisions;
4. Anything done on behalf of a person with a mental capacity issue should be in their best interests; and
5. An intervention should be on the basis of the 'less restrictive option' weighed up in the particular circumstances of the case.

The Mental Capacity Act Code of Practice[42] expands upon these points (and indeed all aspects of the Act), highlighting the need to assist a client in making a decision for

themselves (with the use, for example, of memory aids, simplified resources, etc.). It should also be noted that the fact that a person is able to retain the information relevant to a decision for a short period does not prevent them from being regarded as able to make the decision.

The Mental Capacity Act (2005) provides a clear framework for what to do if a person lacks capacity to make a range of decisions, including consenting to treatment. The principle of 'best interest' must be followed, and the Act states clearly who needs to be consulted in relation to making such a decision and ensuring that the individual's wishes are considered.

It is good practice to give full information (possibly using adapted resources) to clients even when they are not deemed able to give informed consent. The psychologist must, so far as reasonably practicable, permit and encourage the client to participate, or to improve their clients' ability to participate, as fully as possible in any act done for the client and in any decision affecting them.

In some circumstances, it is possible that there may be others who have been given legal authority for decision-making on behalf of others, such as Power of Attorney for Health and Welfare or Deputyships for Health and Welfare. It is important to note that patients might also have created Property and Affairs Lasting Powers of Attorney. Those acting under a Property and Affairs power alone will not have authority to make decisions in relation to a patient's treatment. If someone is a Health and Welfare Attorney or Deputy, those persons will be able to make those decisions on behalf of others. It is also necessary to ensure that the client has not made an Advance Decision to refuse treatment prior to the loss of capacity, although this is unusual in relation to psychological treatment.

In some clinical contexts, particularly relating to brain injury, intellectual disabilities and dementia, issues related to capacity and best interest are particularly prevalent. Psychologists practising in these areas need to ensure sufficient knowledge and expertise. Further information is available in ***Society Document: Guidance on determining the best interests of adults who lack the capacity to make a decision for themselves.***

6.4 Informed consent with people as employees

Tripartite arrangements where an employer commissions and pays for an assessment or intervention, such as diagnostic assessments for neurodiversity and cognitive functioning return to work assessments, or coaching, potentially give the employer access to data that they will struggle to interpret, or may misinterpret, for example test scores and details of personal life. It is important that the psychologist protects the employee by giving the employer only what they need to know and can reasonably require for the purpose of employment.

The Psychologist should consider whether they will be gathering information that is not usually held by an employer, or is not held routinely for all employees, for example IQ scores and childhood experiences. If so, the psychologist should consider abridging documentation so that the employer receives only the information they 'need to know',

and the employee can if necessary hold a full copy for future reference. This prevents discrimination against employees who are subject to in depth assessment for reasons related to illness, neurodiversity or disability from being unfairly compared to their peers. It also prevents complex psychological information from being held by those who are not qualified to interpret it.

Agreements should be made explicitly about the information which can be shared with the commissioning organisation. In order to aid transparency, information should normally be sent to the client prior to being shared with the organisation.

6.5 Informed consent with detained persons

Prisoners

Informed consent may be harder to obtain when a client is detained. Psychologists working with detained persons should be aware that, as well as UK law, the UK is signatory to a number of conventions on the treatment of detained persons. These conventions not only outlaw physical ill-treatment, but also certain kinds of psychological pressure. For example, it is contrary to the UN Convention on Torture to apply psychological pressure to elicit a confession, or compliance with a regime. In this context, 'psychological pressure' could include making progression contingent on compliance with a particular aspect of the regime. Practitioners should be particularly mindful of the power imbalance in forensic contexts, which is far more acute than is generally found in non-justice system based settings. Only offenders detained in secure hospitals can be required to comply with assessments or treatments under involuntary detention sections of the Mental Health Act.

Mental Health Detentions

For psychologists there can be potential conflicts of interest or what could be better termed 'competing duties of care' between the roles of Responsible Clinician (RC) (for further information on this role see Section 3.5) (including the duty to detain or otherwise compel participation in treatment) and that of psychologist (including, principally, the duty to establish freely-given consent wherever possible to enhance the efficacy of the therapeutic intervention). The MHA Code at chapter 24.34 (medical treatment) states that permission given by a patient to a particular treatment 'under any unfair or undue pressure' is not consent (p.257).

Good outcomes for psychological therapies are associated with positive therapeutic alliances and good working relationships between therapists and patients. The potential for even perceived abuse of power and the inherent power differential between an RC and a detained patient subject to the MHA runs a risk of rupturing this relationship or it becoming coercive. Psychologist RCs must therefore remain aware of and give full consideration to any potential competing duties of care between the RC and psychological therapist roles when providing psychological treatments to patients over whom they have compulsory powers.

The main issues to be considered by psychologist RCs when addressing potential competing duties of care in this context include the following:

1. Psychological treatments (with the possible exception of indirect interventions delivered by proxies such as paid staff and carers) are more likely to be effective when informed consent is obtained. As such, RCs acting as psychological therapists should utilise all reasonable and ethical attempts to obtain consent from patients before proceeding with psychological treatment. The *Code* at chapter 24.34–24.39 (p.257) provides guidance on obtaining consent.
2. The Act permits psychological treatment to be given without consent and the Code provides guidance on how to proceed with treatment in these circumstances (chapter 24.40–24.44, pp.257–258). There may be circumstances, especially when significant risks to others or self have been identified, when it is considered to be necessary for a psychologist RC to proceed with providing psychological treatment without consent. In such circumstances then there should be, where practicable, prior discussion with the MDT involved in the patient's treatment and care about the risks involved. Careful consideration should be given to the availability and merits of another suitably qualified member of the team providing the psychological treatment required with the RC remaining in overall charge of the client's care.
3. There may be situations where it is judged that informed consent cannot be clearly obtained, or where it would appear another available practitioner would be more likely to achieve a more effective outcome (perhaps due to the power differential between patient and RC). In such situations the psychologist RC is advised to refer on to other members of the treatment team who are able to provide the psychological treatment needed, while the RC remains in charge of overall care.

7. Managing data and confidentiality

7.1 Information governance

Psychologists should follow local and national guidance and statutory responsibilities regarding management of data. Psychologists should make, keep and disclose information in records only in accordance with national policy and legislation, and the policies and procedures of the organisation(s) they are employed by/working in collaboration with. Further information is available in ***Section 1.1: Legal and professional obligations of psychologists, Appendix 1: Relevant legislation*** and ***Appendix 2: Websites and further information.***

Psychologists must bear in mind the potential impact of the information in their records on all who may have access to such records, for example, the client, other professionals, managers, authorised carers, etc. Where possible, distinction should be made between fact, observation and opinion, and judgemental comments should be avoided. Psychologists are responsible for holding their records securely to ensure the confidentiality of the information contained within them and to control access to them. Further information is available in ***Society Guidance: Guidelines on the use of Electronic Health Records.***

This guidance applies to all record-keeping on clients, their relatives, carers and/or associates, and their organisations, regardless of the media in which information is held, e.g. written notes and reports, audio- and video-recordings, paper and electronic records, etc.

Records made, kept or accessed by psychologists should be:

- systematic and appropriately detailed;
- in clear language/format;
- accurate;
- up to date; and
- relevant to professional work and to the purpose for which they were collected.

Clients have a legal right to access records concerning them, and this right is enshrined in legislation. Additionally, it is good practice for clients to be given feedback on their content. Sharing records with clients supports the collaborative approach of psychologists and enables clients to have full and effective involvement. Client access to records will be restricted to information about themselves and not third parties. Restrictions will also apply when disclosure would place the clients or others at risk of serious harm.

In tripartite arrangements involving an employer access to information should be governed by agreements made explicitly about the information which can be shared with the commissioning organisation.

Shared records

In some organisations in which psychologists work single, multi-professional, client-based records are held. Such records are designed as shared documents (paper or electronic),

the function of which is primarily to facilitate inter-professional communication to ensure the safe and effective delivery of high quality services. Such records may be shared among organisations/agencies to facilitate care and/or exceptionally, to safeguard the client or others, including the general public. In some contexts, clients have the right to object to their data being disclosed to a third party even someone who might provide essential healthcare. Psychologists should be aware of local codes and policies. Further information is available in ***Section 3.5: Working with other professionals***, ***Section 7: Managing data and confidentiality*** and ***Appendix 2: Websites and further information.***

Psychologists should include in the shared record all information about their work with clients and related others which is required to ensure appropriate multi-professional care and to safeguard the client and relevant others, including the general public.

Third-party and sensitive material should be clearly marked. There should be clarity/clear communication within the multi-professional team about what is and is not shared with the client if there are safeguarding concerns. A system needs to be established about how suspicions and causes of concern are recorded and/or shared.

Where shared records are held, other professionals involved with the clients will have access to such records. This should be explained to the clients at the onset of engagement with them.

The use of sealed envelopes is no longer considered good practice following the findings from serious untoward incident investigations where the existence of sealed envelopes compromised care.

Assessment materials

Psychologists should be mindful at all times of the confidential nature of assessment materials. Many assessment measures are invalidated by prior knowledge of their specific content and objectives. Psychologists who use these materials are required to respect their confidentiality and to avoid their release into the public domain (unless this is explicitly allowed in the nature of the instrument and by the test publisher). Psychologists should, therefore, take reasonable steps to prevent misuse of test data and materials by others. Further information is available from ***Appendix 2: Websites and further information.***

In many organisations, there is only one shared records system. In these cases, it is necessary for psychologists to be able to use the shared records system to hold raw data from psychometric assessment. The results of psychometric assessment will be incorporated into reports which explain their context and appropriate interpretation, and which are included in the shared institutional record. In relation to the visibility of the psychometric instrument and the raw data to other members of the multidisciplinary team who are not psychologists, the onus is on the other professionals not to interpret information where they are unqualified to do so, just as the psychologist would not interpret, for example, physical healthcare test results they are unqualified to interpret. Psychologists may consider whether it is appropriate to mark assessment materials so their nature is clear.

Additional data

Psychologists may wish to keep separate notes to aid their work but which are not intended for sharing with others or to be part of the permanent client record. These notes, often called process notes, which are written for the purposes of reflection on practice, should be anonymised with no other identifying links e.g. initials, appointment time, so that these notes therefore are clearly not part of the client record. Process notes may, for example, be used for reflection and supervision. If process notes are made to assist in compilation of a report, the material should be incorporated, as relevant, into the final report and the process notes then destroyed.

Long-term illness, incapacity or death of a psychologist

Most organisations will have procedures in place in the event of illness, incapacity or death of a psychologist. Psychologists in independent practice are advised to make a professional will and to appoint a professional executor, probably an experienced colleague, whose role it would be to take charge of client records, to inform the clients involved and, where appropriate and practicable, to make provision for continuity of the service provided.

Retention and destruction of records

Psychologists' records should be held securely for as long as they are required for the purpose of psychological work. Psychologists must follow legal requirements, national and local policy frameworks and procedures regarding the retention or disposal of records after the psychologist's work is concluded. Psychologists should ensure that they keep up to date with requirements.

For independent practitioners general guidance is that many independent psychologists keep records relating to contact with adults for 7 years, and follow NHS guidance in relation to children. Where the records derive from work undertaken within an organisation, the maintenance of these records is determined by the organisation's policies and legal requirements.

Retention and destruction of health records, both paper and electronic, is covered in the NHS code of practice for records management. Generally speaking, retention is until age 26 for people seen as children; 20 years after the last contact for adults, and 8 years after death if the death occurred while the person was in the care of the NHS. There are specific requirements for mental health services depending on the nature of the contact.

In education settings, Local authorities generally retain Education Health and Care Plans for 35 years after the case has been closed. Other records are retained until the child is 25.

All records must be destroyed under confidential conditions following organisational procedures or for independent practitioners using a destruction service or process which meets industry standards for document management and can provide the appropriate certification.

7.2 Confidentiality

Clients are entitled to expect that the information they give to psychologists about themselves and others will remain confidential. Psychologists have a duty not to disclose

such information except as discussed below and to bring their confidentiality practice to the attention of their clients, employers, managers and any other professionals involved.

Psychologists have a duty to inform involved parties of their confidentiality standards and practice at the point of first contact. Clients should be informed of the limits of confidentiality where information about them may be shared and confidentiality breached, for example for reasons of safeguarding, requirements of the law, and public protection.

Psychologists have a duty to be aware of the content of any other relevant guidelines and of any other policy guidelines which set out local expectations.

Use of client data for audit must follow the Caldicott principles, which, designed for the NHS, provide helpful guidance for any setting in terms of when it is appropriate to use with client-identifiable data and when anonymised data should be used[43]. Generally under data protection legislation, it is necessary to obtain specific informed consent for the use of client data for particular purposes, and to inform clients of the purposes for which their data is being collected and how it will be used. Further information is available in ***Appendix 2: Websites and further information.***

Disclosure of information

If disclosure of information is deemed necessary, psychologists should obtain specific informed consent from their clients, making the consequences of disclosure as clear and unbiased as possible. There are a number of circumstances where this might not be possible or may not apply: for example where the health, safety, security or welfare of the client or someone else may otherwise be put at risk; and if there are legal or safeguarding responsibilities, such as the need to avoid 'tipping off'. If confidentiality is broken without consent, the client should be told what has been said and to whom, unless such disclosure may expose the client or others to serious harm or is contrary to legal or safeguarding obligations.

Psychologists who are faced with the difficult decision as to whether to disclose information without a client's consent must weigh carefully the arguments for and against disclosure. The responsibility for this decision lies with the individual psychologist although they may seek advice and guidance from appropriate sources such as their employing organisation's Information Governance or Data Protection Lead, Clinical Governance Lead, Caldicott Guardian, Safeguarding named and designated professionals, or legal departments. These other professionals can be the most helpful sources of advice in difficult disclosure situations. Independent practitioners may wish to consult the legal helpline of their professional indemnity insurer.

Circumstances may emerge where clients may present a risk to others or to themselves, or be at risk from others whom they wish to protect. It is then necessary to discuss the importance of disclosure and to encourage it, for example to partners of HIV positive clients, and to employers if a client's mental health status presents a risk to others via driving, handling machinery or interaction in a working situation, for example, flight deck crew. Disclosure without consent, or against the client's expressed wish may be necessary in situations in which failure to disclose appropriate information would expose the client, or

someone else, to a risk of serious harm (including physical or sexual abuse) or death.

The psychologist must weigh up the needs and interests of their own client against the wider welfare, protection and safeguarding of the public.

Disclosure to clients' employers, insurance companies and others

Psychologists have a duty to ensure, at first contact, that clients understand the purpose of any assessment undertaken at the request of employers, the DVLA or insurance companies, and of the psychologist's obligation to disclose the results of that assessment. In the case of assessment for fitness to work or to drive, they should obtain the client's written consent.

Psychologists should consider what each party involved needs to know, gaining understanding and agreement on which aspects will be fed back, in advance. For example, the full detailed and raw scores obtained by a psychologist in recruitment assessment processes may be unsuitable for an employer to receive in full. The commissioning body should be made aware of the decision-making data that they originally requested, in the case of an employer this could include strengths and weaknesses, and recommendations for employer actions, for example.

Primary clients should be advised about and able to preview, with opportunity to ask questions first, any data that will be sent to an employer about them. Bear in mind that the informed consent difficulties still stand and that an employee or potential employee can withdraw consent for the employer to be informed of any part of their results.

This can be very difficult to manage in practice, and requires psychologists to make these agreements with their commissioners before they start the work, so that all are informed of the risks in the service delivery. Further information is available in ***Section 3.4: Working with multiple clients.***

Disclosure after a client's death

After a client's death, relatives or other authorities may seek access to the psychologist's records. In the first instance, the psychologist is advised to follow organisational procedures where they exist which usually deal with the administrative proofs required such as proof of death, proof of kinship and right to access the material requested.

A psychologist's duty of confidentiality continues after a client has died. The psychologist will need to weigh up the circumstances around the request for disclosure and what personal information is being sought. If there has been a specific request by the client for their information to remain confidential, their wishes should usually be respected. If the psychologist is unaware of any instructions from the client, when considering requests for information the following should be taken into account:

- the purpose of the disclosure;
- whether the disclosure of information is likely to cause distress to, or be of benefit to, the client's partner or families;
- the permission of a surviving relative or next of kin is not required, and does not authorise disclosure of confidential information, although the views of those who were close to the client may help the psychologist decide if disclosure is appropriate;

- whether the disclosure will also disclose information about the client's family or anyone else; and
- whether the information is already public knowledge or can be anonymised or coded.

There may be circumstances where the disclosure of information is required, for example:
- to support an inquest or fatal accident inquiry;
- where the disclosure is required by law, is authorised under section 251 of the NHS Act 2006, or is justified in the public interest, such as for education or research;
- in the case of national confidential inquiries or for local clinical audit; and
- when a person has a right of access to records under the Access to Health Records Act 1990 or Access to Health Records (Northern Ireland) Order 1993.

7.3 Confidentiality when safeguarding

In exceptional circumstances it may be necessary to breach the client's confidentiality with or without their immediate knowledge or consent. This would be the case where there are significant risks to the client's psychological wellbeing; where the alleged perpetrator may be a current risk to others or where there is risk of jeopardising a potential investigation. Any decision to breach confidentiality cannot be taken lightly, but can be justified and accounted for if made in good faith because of safeguarding concerns. This is supported by professional guidance. The focus of any intervention including any breach of confidentiality must be on promoting a proportionate, measured approach to balancing the risk of harm with respecting the client's capacity to consent, their choices and preferred outcome for their own life circumstances.

Specified authorities may need to share personal information to ensure, for example, that a person at risk of radicalisation is given appropriate support. When considering sharing personal information, the specified authority should take account of the following:
- necessity and proportionality: personal information should be shared only where it is strictly necessary to the intended outcome and proportionate to it. Key to determining the necessity and proportionality of sharing information will be the professional judgement of the risks to an individual or the public;
- consent: wherever possible the consent of the person concerned should be obtained before sharing any information about them;
- power to share: the sharing of data by public sector bodies requires the existence of the power to do so, in addition to satisfying the requirements of the Data Protection Act 1998 and the Human Rights Act 1998; and
- Data Protection Act and the Common Law Duty of Confidentiality: in engaging with non-public bodies, the specified authority should ensure that they are aware of their own responsibilities under the Data Protection Act and any confidentiality obligations that exist.

In relation to health sector staff, government guidance states it is important that staff understand how to balance client confidentiality with the duty to report. They should also be made aware of the information-sharing agreements in place for sharing information with other sectors, and get advice and support on confidentiality issues when responding

to potential evidence that someone is being drawn into terrorism, either during informal contact or consultation and treatment.

7.4 Confidentiality for the court

Psychologists acting as expert or professional witnesses have a duty to disclose all of the evidence used to reach their opinion where directed by the court to do so.

This could include:

- the details of any tests and assessments administered with professional colleagues;
- notes made during report writing; and
- referenced academic articles or studies.

No information relating to an assessment or report should be disclosed outside the relevant proceedings without agreement. Psychologists should normally seek permission from the instructing party to disclose any information to another health care professional.

Where instructed directly by the court, the Crown Prosecution Service, Procurator Fiscal or a solicitor, the psychologist is required to report or comment on any or all aspects of the case that appear to the psychologist, as an expert in the field, to be relevant or pertinent. In such circumstances, the psychologist is not in a position to offer confidentiality to any person, and should make this position clear to any party with whom they have contact during psychological investigations or assessment.

In these circumstances, it will be important that the psychologist makes sure they are up to date with the legislation and policy guidance regarding public and media access to information available to whichever court or tribunal their instruction arises from. The psychologist will need this awareness so that they can explain to the adult or child concerned what the limits of privacy are in these legal circumstances. They will need to make clear to the client which information needs to be made accessible, by whom and under what circumstances. Only when the client understands this, can they give informed consent.

There are different levels of access to sensitive information in different legal contexts; this will include testimony, documents and professional and expert reports. Many proceedings typically take place in open court, to which the public has access. In these cases, there is a presumption in favour of providing information and documents to third parties which were relied upon by the court in reaching its decision, though not the entire court file.

Where court papers and other materials are received in electronic format, psychologists should ensure that these are stored in a secure, password-protected format. This may require the addition of additional security for documents that arrive in an unsecured form. Where psychologists submit reports in an electronic format they should ensure that these are in a secure, password-protected format.

Psychologists working with clients who are the subject of court proceedings may need to be careful to ensure that they keep all records which may be of relevance to the court process until it is clear that the court has reached a final conclusion, including any appeal that may have been heard.

With few exceptions, applications in the family court are heard in private, with only those immediately involved being allowed to attend and access information. It is possible, however, for duly accredited members of the media to attend hearings in the family court, subject to the power to exclude them on specified grounds.

In most family court proceedings, media representatives have no entitlement to receive or peruse court documents referred to in the course of evidence, submissions or judgment. If media representatives wish to see documents referred to in the family court they may apply to the judge for disclosure but they are subject to strict guidance in terms of what information they can divulge into the public domain.

7.5 Confidentiality with children and young people

When beginning direct work with a child or young person, the psychologist should discuss and agree who will have access to the information arising from the work, with direct reference to principles of 'Gillick competence'. In undertaking this discussion it is helpful to acknowledge that there may be those adults (e.g. parents/carers, other relevant professionals such as teachers, social workers, counsellors) who may have a supportive interest in the work and may wish to have appropriate access to information but the wishes of a 'Gillick competent' young person should take precedence unless there are safeguarding concerns.

Parents or those with legal responsibility may be made aware of this agreement if appropriate, although a young person deemed to be Gillick competent is able to agree to work with a psychologist independently. Those with parental responsibility do not have an automatic right of access to the psychologist's records by making a subject access request under data protection legislation.

The nature and purposes of any work will vary and this will determine how and to whom information will be shared, however the child or young person should always be made aware of who will have access to what and for what purpose and due consideration given to the wishes of a 'Gillick competent' young person about who can have access to information about any involvement with a psychologist. The child or young person should be fully aware of the content of any shared information, including as appropriate, copies of the documents. Whatever is agreed about information sharing including work where information is confidential, the psychologist must ensure the child or young person knows and understands that if there is a risk of harm the psychologist must follow safeguarding procedures.

7.6 Confidentiality with detained persons

When detained persons give informed consent to the collection of information, they do so for a specific purpose and for use by specific people. The use of such information for a different purpose or for use by different people would require separate consent. Thus, although a psychologist may interview and write a report on a detained person, consent for that purpose cannot be taken as allowing a third party access to the psychologist's records on that person, such as notes on (or recordings of) the interview. If psychologists are

put under pressure to reveal such information, they should seek the advice of colleagues including for example those responsible for governance or data protection. They should bear in mind that they have a legal duty to be aware of and comply with data protection legislation and professional confidentiality rules.

7.7 Confidentiality obligations during training

During training, no academic/training documents should identify clients to whom they relate (even by means for example of initials, service name or date of appointment) as any such potential identifiers could be used to trace the client and therefore make the document a part of the clinical record and subject to the relevant provisions of data protection legislation. This includes published reports, case studies prepared for trainee assessments and any articles or publications. Tutors and supervisors should communicate this to their trainees. Trainees should be clearly instructed to both make and keep separately those records which are part of the provision of psychological service and which belong to the service organisation and are subject to its policies and procedures; and papers which are anonymised and are part of the trainee's academic learning, and belong to the trainee and are subject to the training provider's policies and procedures.

Express consent should be obtained by trainees before audio- or video-recording their interactions with clients. If the client is unable to give informed consent, it is unlikely to be appropriate for the recording to be made. Careful consideration should be given before any material is recorded if the client is party to any legal proceedings or family or employment disputes. If material is to be used for purposes other than client care (including teaching and research), the client should be informed of the purposes of the recording. It should be made clear to clients how the material will be used and to whom it will be disclosed, for example, trainee students, other researchers, and supervisors.

The trainee and the client should come to an agreement about how long recorded material should be kept. The general principle is that recordings will be kept for as long as needed to fulfil the purpose for which the client has given consent and no longer. The security of the material must be maintained, and it must be destroyed at the agreed time limit if no longer required.

Informed consent is required before client material in an identifiable format may be published in case studies, presentations or other research reports. It is becoming common practice for clinical material in professional doctorate portfolios to be stripped out before the thesis is placed in online institutional repositories.

8. How to respond when things go wrong

8.1 Managing conflict with a client

Conflict with a client suggests that someone's expectations are not being met. The first objective should be to restore agreement or agree to make changes. The well prepared psychologist will have a client agreement in place and will be able to review the experience against the agreement with the client to address this question. Further information is available in ***Section 5: Making and maintaining agreements***. Even in the absence of an agreement, the psychologist would be advised to enquire with the client where their expectations are unmet or raise their own unmet expectations with the client. This can be an opportunity to put a belated agreement in place.

It may be that the parties agree to set aside the agreement and bring it to an early close. Agreeing to disagree may be a better outcome for psychologist and client who cannot restore agreement. Take account of any need for onward referral either within the service or elsewhere or back to the original referrer, and depending on the nature of the work setting, any financial obligations in closing the work.

The psychologist may find it helpful to consult with appropriate colleagues in preparation for the conversations with the client, such as line or service managers, those with other relevant organisational responsibilities, and supervisors. There may be more general lessons to be drawn as part of reflective practice in relation to the quality of the client agreement for future use.

8.2 Transparency and duty of candour

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 duty of candour (regulation 20) requires all health and adult social care providers registered with the Care Quality Commission to be open with people when things go wrong. Psychologists need to be aware of the terminology relating to this regulation including:

- openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered;
- transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators; and
- candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Psychologists also have a responsibility to ensure that they engage in open and transparent communications with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. Guidance from the Care Quality Commission on duty of candour outlines the specific requirements that providers must follow when things go wrong with care and treatment, including informing people about

the incident, providing reasonable support, providing truthful information, and making an apology. Psychologists are instrumental in supporting organisations to promote a culture that encourages candour, openness and honesty at all levels. Further information is available in ***Appendix 2: Websites and further information.***

8.3 Managing conflict in team settings

Dealing with breakdowns in working relationships, professional disagreements and fitness to practise concerns

As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues (including relating to consultation/supervision or line management) by clear communication, relevant evidence and collaboratively working through the issues in reasoned argument within the context of respectful relationships.

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

Where there is serious or continual disagreement, both parties need to take whatever action is appropriate in their professional context, consulting other experienced professionals as necessary.

Supervisors and line managers have professional obligations concerning professional standards, ethical practice and 'fitness to practise' issues. If line managers or supervisors have any concerns regarding performance in these areas, they have a duty to discuss these with the psychologist and, if necessary, address the matters by in the first instance following appropriate employment policies and procedures, or in the case of an independent practitioner, making a report to the HCPC.

Working in multi-professional or multi-agency contexts

Psychologists may find themselves in conflict with the approaches to work taken by other individual colleagues or by the multi-professional team or agency.

Psychologists should bring to the awareness of the multi-professional team or agency any difficulty in the group working together which may impact on the psychologist's ability to function effectively and ethically in their role. Such issues are best addressed when guided by national and local policy and current legislation before proceeding with multi-professional/multi-agency collaboration. Further information is available in ***Appendix 1: Relevant legislation.***

The psychologist may also have cause for concern about the ability of the team to provide for the needs of the client owing to interpersonal difficulties between members of the multi-agency or multidisciplinary team that might have an indirect impact on the client. As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues by clear communication, relevant evidence and collaboratively

working through the issues in reasoned argument within the context of respectful relationships.

If the situation remains unresolved for any reason, for example because it is judged not to be an issue for active management, the psychologist must make a judgement about whether their involvement in the team is helpful to the client or the working of the team. If not, the psychologist should consult with an appropriate colleague about whether they should disengage from that team.

A psychologist may also experience concerns about the competence or ethical practice of individual colleagues involved in joint working. These concerns may relate to the competence of the colleague to carry out a particular intervention, the appropriateness of an intervention for a particular client or problem, the nature of the relationship between a colleague and his or her client (e.g. potential abuses of power).

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

If they conclude that misconduct has occurred, psychologists should bring the matter to the attention of those charged with the responsibility to investigate such concerns, generally in the first instance an employer or in the case of an independent practitioner, the HCPC. Further information is available in ***Section 2.1: Working environment.***

8.4 Supporting a colleague when a complaint has been made

The receipt of a complaint or allegation can be distressing for all concerned, not least for the person who is the subject of the complaint or allegation. It is important that they receive advice and support from appropriate persons. Any potential conflicts of interest should be considered. It may be that a psychologist is not best placed to offer support and guidance as they may be called as a witness in the complaints process. Encourage colleagues to seek advice from an experienced colleague or supervisor where appropriate.

The psychologist should also be encouraged to seek the support of an accredited workplace trade-union representative who is skilled at supporting people in these situations and can access legal advice if necessary. Legal advice can also be obtained from the professional indemnity insurance broker, and sometimes from household insurance policies where the householder has taken out the legal advice additional option.

Complaints are an increasingly normal occurrence and must be handled in a professional manner. The complaint investigator or professional body will need the psychologist's version of events and any evidence before any conclusions are reached. Psychologists should support colleagues to respond promptly, objectively, factually and honestly to the complaint. The content of the complaint should always be held in confidence.

8.5 If the client remains unhappy

If any conflict or issue as referred to in this section cannot be resolved, it may be appropriate to advise a client or other individual that that they have a right to raise any concerns about a psychologist with the Health and Care Professions Council, further details of which can be found at www.hcpc-uk.org

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Role	Name
Chair of the Practice Guidelines Working Group	Nicola Gale
Academics, Researchers and Teachers in Psychology	Simon Goodson
Children, Young People and their Families	Katie Hunt
Clinical Psychology	Tejinder Kondel and Ste Weatherhead
Coaching Psychology	Paul Philipps
Community Psychology	Ho Law
Counselling Psychology	Helen Nicholas
Crisis, Disaster & Trauma	John Durkin
Defence and Security	Fiona Butcher and Karen Carr
Education and Child Psychology	Charmian Hobbs
Ethics	Martin Fisher
Expert Witness Advisory Group	David Crighton
Forensic Psychology	Robert Forde
Health Psychology	Andrew Haig-Ferguson
Independent Practice	Sonya Wallbank and Jill Wilkinson
Informatics	Graham Fawcett
Intellectual Disabilities	Kate Theodore
Mental Capacity Advisory Group	Gemma Gray

Role	Name
Mental Health Act Advisory Group	John Taylor
Neuropsychology	Katherine Carpenter
Northern Ireland	Alison Clarke
Occupational Psychology	Nancy Doyle, Julie Freeborn, Almuth McDowell and Rainer Kurtz
Older People	Carolien Lamers
Prevent	Clare Fuller
Psychology of Sexualities	Jimmy Couzens
Psychotherapy	Ho Law
Race and Culture	Zenobia Nadirshaw
Safeguarding Advisory Group	Gill Evans, Liz McMonagle and Anne Peake
Scotland	Louise Richards
Social Inclusion	Anna Daiches
Sport and Exercise Psychology	Lee Ann Sharp
Wales	Nicola Massie
Experts by Experience	Joanne Hemmingfield and Simon Mudie
Legal Support	Stephen Pearson, Freeths LLP
Administrator	Emma Smith
Editorial Support	Sally Anderson
Policy Advisor (Professional Practice)	Hannah Farndon

Appendix 1 – Relevant legislation

Unless otherwise stated, Acts can be found on the government website http://www.legislation.gov.uk/

United Kingdom and England

Care Act 2014

An Act to make provision to reform the law relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding adults from abuse or neglect; to make provision about care standards; to establish and make provision about Health Education England; to establish and make provision about the Health Research Authority; to make provision about integrating care and support with health services; and for connected purposes.

Care Standards Act 2000

An Act to establish a National Care Standards Commission; to make provision for the registration and regulation of children's homes, independent hospitals, independent clinics, care homes, residential family centres, independent medical agencies, domiciliary care agencies, fostering agencies, nurses agencies and voluntary adoption agencies; to make provision for the regulation and inspection of local authority fostering and adoption services; to make provision for the registration, regulation and training of those providing child minding or day care' to make provision for the protection of children and vulnerable adults; to amend the law about children looked after in schools and colleges.

Children Act 1989

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Children and Families Act 2014

An Act to make provision about children, families, and people with special educational needs or disabilities; to make provision about the right to request flexible working; and for connected purposes.

Data Protection Act 1998

An Act to make new provision for the regulation of the processing of information relating to individuals, including the obtaining, holding, use or disclosure of such information. The Act states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- fairly and lawfully processed;

- processed for limited purposes;
- adequate, relevant and not excessive;
- accurate and up to date;
- not kept for longer than is necessary;
- processed in line with your rights;
- secure; and
- not transferred to other countries without adequate protection.

Equality Act 2010

An Act to make provision to require Ministers of the Crown and others when making strategic decisions about the exercise of their functions to have regard to the desirability of reducing socio-economic inequalities; to reform and harmonise equality law and restate the greater part of the enactments relating to discrimination and harassment related to certain personal characteristics; to enable certain employers to be required to publish information about the differences in pay between male and female employees; to prohibit victimisation in certain circumstances; to require the exercise of certain functions to be with regard to the need to eliminate discrimination and other prohibited conduct; to enable duties to be imposed in relation to the exercise of public procurement functions; to increase equality of opportunity; to amend the law relating to rights and responsibilities in family relationships; and for connected purposes.

Health and Social Care Act 2012

An Act to establish and make provision about a National Health Service Commissioning Board and clinical commissioning groups and to make other provision about the National Health Service in England; to make provision about public health in the United Kingdom; to make provision about regulating health and adult social care services; to make provision about regulating health and social care workers; to make provision about public involvement in health and social care matters, scrutiny of health matters by local authorities and co-operation of health care services; to make other provision about information relating to health or social care to make other provision about health care; and for connected purposes.

Mental Capacity Act 2005

An Act to make new provision relating to persons who lack capacity; to establish a superior court of record called the Court of Protection in place of the office of the Supreme Court called by that name; to make provision in connection with the Convention on the International Protection of Adults signed at the Hague on 13th January 2000; and for connected purposes.

Mental Health Act 1983 as amended 2007

An Act to consolidate the law relating to mentally disordered persons. The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

Offender Rehabilitation Act 2014

An Act to make provision about the release, and supervision after release, of offenders; to make provision about the extension period for extended sentence prisoners; to make provision about community orders and suspended sentence orders; and for connected purposes.

Official Secrets Act 1989

An Act to replace section 2 of the Official Secrets Act 1911 by provisions protecting more limited classes of official information.

Regulation of Investigatory Powers Act (RIPA) 2000/Investigatory Powers Act 2016

An Act to make provision for and about the interception of communications, the acquisitions and disclosure of data relating to communications, the carrying out of surveillance, the use of human intelligence sources and acquisitions of the means by which electronic data protected by encryption or passwords may be decrypted or accessed; equipment interference, bulk personal datasets and other information; to make provision about the treatment of material held as a result of such interception, equipment interference or acquisition or retention; to establish the Investigatory Powers Commissioner and other Judicial Commissioners and make provision about them and other oversight arrangements; to make further provision about investigatory powers and national security; to amend sections 3 and 5 of the Intelligence Services Act 1994.

Safeguarding Vulnerable Groups Act 2006

An Act to make provision in connection with the protection of children and vulnerable adults. Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.

Northern Ireland

Children Act 1989 – NI has a Criminal Justice Children's Order 1998

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Criminal Justice (Northern Ireland) Act 2013

An Act to amend the law relating to sex offender notification, sexual offences prevention orders and human trafficking; to provide for the destruction, retention, use and other regulation of certain fingerprints and DNA samples and profiles; to provide for the release on license of persons detained under Article 45(2) of the Criminal Justice (Children) (Northern Ireland) Order 1998.

Criminal Justice (Northern Ireland) Order 2008 and Public Protection Arrangements in Northern Ireland (PPANI)

The Criminal Justice (NI) Order 2008 introduced a new sentencing framework, including extended and indeterminate sentences for public protection to reduce the risk of dangerous sexual and violent offenders being released into the community until the risk they pose is considered by the parole commissioners to be at a manageable level. The Public Protection Arrangements in Northern Ireland (PPANI) contained within the Criminal Justice (NI) Order 2008, place a duty on a number of agencies, within the criminal justice sector and elsewhere, to cooperate in the interest of better assessment and management of risk posed by serious sexual and violent offenders.

Justice Act (Northern Ireland) 2015

An Act to provide for a single jurisdiction for county courts and magistrates' courts; to amend the law on committal for trial; to provide for prosecutorial fines; to make provision in relation to victims and witnesses in criminal proceedings and investigations; to amend the law on criminal records and live links; to provide for violent offences prevention orders; to make other amendments relating to the administration of civil and criminal justice; and for connected purposes.

Mental Capacity Act (Northern Ireland) 2016

This Act fused mental health and mental capacity law into a single piece of legislation. The Act provides a framework for broader decision-making which includes: a statutory presumption of capacity, a requirement to support decision-making, mechanisms to allow individuals to plan for times that they do not have capacity, and safeguards to protect the rights of individuals when compulsory interventions or substitute decisions are required. It will remove the ability for someone to be treated for a mental health condition against his or her wishes if he or she retains the capacity to refuse such treatment, thus putting it on a par with the rights that individuals currently enjoy to make decisions regarding physical health treatment.

The Parole Commissioners' Rules (Northern Ireland) 2009

The Parole Commissioners for Northern Ireland are an independent body responsible for making decisions on the release and recall of prisoners sentenced to life, indeterminate custodial sentences, and extended custodial sentences, as well as the recall of prisoners serving determinate sentences.

The Sexual Offences (Northern Ireland) Order 2008

The Sexual Offences (Northern Ireland) Order 2008 lowered the age of sexual consent from 17 to 16 and incorporated significant changes to the law in relation to sexual offences in Northern Ireland; better protection for young people and people with a mental disorder from sexual abuse and exploitation; and sought to clarify issues surrounding consent in sexual assault cases and rape.

Scotland

Adoption and Children (Scotland) Act 2007

An Act of the Scottish Parliament to restate and amend the law relating to adoption; to make other provision in relation to the care of children; to enable provision to be made in relation to allowances in respect of certain children; and for connected purposes.

Adults with Incapacity (Scotland) Act 2000

An Act of the Scottish Parliament to make provision as to the property, financial affairs and personal welfare of adults who are incapable by reason of mental disorder or inability to communicate; and for connected purposes.

Adult Support and Protection (Scotland) Act 2007

An Act of the Scottish Parliament to make provision for the purposes of protecting adults from harm; to require the establishment of committees with functions relating to the safeguarding of adults who are at risk of harm; to amend the law relating to incapable adults; to allow the Public Guardian to intervene in court proceedings; to amend the law relating to mentally disordered persons; and for connected purposes

Children (Scotland) Act 1995

An Act to reform the law of Scotland relating to children, to the adoption of children and to young persons who as children have been looked after by a local authority; to make new provision as respects the relationship between parent and child and guardian and child in the law of Scotland; to make provision as respects residential establishments for children and certain other residential establishments; and for connected purposes.

Children and Young People (Scotland) Act 2014

An Act of the Scottish Parliament to make provision about the rights of children and young people; to make provision about investigations by the Commissioner for Children and Young People in Scotland; to make provision for and about the provision of services and support for or in relation to children and young people; to make provision for an adoption register; to make provision about children's hearings, detention in secure accommodation and consultation on certain proposals in relation to schools; and for connected purposes.

Mental Health (Scotland) Act 2015

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

Mental Health (Care and Treatment) (Scotland) Act 2003

An Act of the Scottish Parliament to restate and amend the law relating to mentally disordered persons; and for connected purposes.

Protection from Abuse (Scotland) Act 2001

An Act of the Scottish Parliament to enable a power of arrest to be attached to interdicts

granted to protect individuals from abuse; to regulate the consequences of such attachment; and for connected purposes.

Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005

An Act of the Scottish Parliament to make it an offence to meet a child following certain preliminary contact and to make other provision for the purposes of protecting children from harm of a sexual nature, including provision for implementing in part Council Framework Decision 2004/68/JHA; and to make further provision about the prevention of sexual offences.

Protection of Vulnerable Groups (Scotland) Act 2007

An Act of the Scottish Parliament to bar certain individuals from working with children or certain adults; to require the Scottish Ministers to keep lists of those individuals; to make further provision in relation to those lists; to establish a scheme under which information about individuals working or seeking to work with children or certain adults is collated and disclosed; to amend Part 5 of the Police Act 1997; to amend the meaning of school care accommodation service in the Regulation of Care (Scotland) Act 2001; and for connected purposes

Public Bodies (Joint Working) (Scotland) Act 2014

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

Regulation of Care (Scotland) Act 2001

An Act of the Scottish Parliament to establish the Scottish Commission for the Regulation of Care and the Scottish Social Services Council; to make provision for the registration and regulation of care services and for the registration, regulation and training of social service workers; to enable local authorities to provide and maintain residential accommodation in which nursing is provided; to make further provision as respects persons who have been looked after by local authorities; to amend the definition of 'place of safety' in the Children (Scotland) Act 1995.

Smoking, Health and Social Care (Scotland) Act 2005

To amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council, the provision of information to the Council and the minimum frequency of inspection of care services by the Commission to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to amend the Public Health (Scotland) Act 1897 to introduce a right of appeal in certain cases under that Act; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland

Social Care (Self-directed Support) (Scotland) Act 2013

An Act of the Scottish Parliament to enable local authorities to provide support to certain carers; to make provision about the way in which certain social care services are provided by local authorities; and for connected purposes.

Vulnerable Witnesses (Scotland) Act 2004

An Act of the Scottish Parliament to make provision for the use of special measures for the purpose of taking the evidence of children and other vulnerable witnesses in criminal or civil proceedings; to make provision about the admissibility of expert psychological or psychiatric evidence as to subsequent behaviour of the complainer in criminal proceedings in respect of certain offences to make provision about the admissibility of certain evidence bearing on the character, conduct or condition of witnesses in proceedings before a sheriff relating to the establishment of grounds of referral to children's hearings; to abolish the competence test for witnesses in criminal and civil proceedings; and for connected purposes.

Wales

The Mental Health (Wales) Measure 2010

This measure places new legal duties on local health boards and local authorities in Wales in relation to the assessment and treatment of mental health problems. The Measure became law in December 2010 and there are 4 parts to it which are as follows:

- Part 1 ensures that there are more mental health services are available within primary care.
- Part 2 makes sure all patients in secondary services have a Care and Treatment plan.
- Part 3 enables all adults discharged from secondary services to refer themselves back to those services.
- Part 4 supports every in-patient to have help from an independent mental health advocate if wanted.

Social Services and Well-being (Wales) Act 2014

An Act of the National Assembly for Wales to reform social services law; to make provision about improving the wellbeing outcomes for people who need care and support and carers who need support; to make provision about co-operation and partnership by public authorities with a view to improving the wellbeing of people; to make provision about complaints relating to social care and palliative care; and for connected purposes.

Violence against women, Domestic Abuse and Sexual Violence (Wales) Act 2015

An Act of the National Assembly for Wales to improve arrangements for the prevention of gender-based violence, domestic abuse and sexual violence; to improve arrangements for the protection of victims of such abuse and violence; to improve support for people affected by such abuse and violence; and to require the appointment of a National Adviser on gender-based violence, domestic abuse and sexual violence.

Well-being of Future Generations (Wales) Act 2015

An Act of the National Assembly for Wales to make provision requiring public bodies to do things in pursuit of the economic, social, environmental and cultural wellbeing of Wales in

a way that accords with the sustainable development principle; to require public bodies to report on such action; to establish a Commissioner for Future Generations to advise and assist public bodies in doing things in accordance with this Act; to establish public services boards in local authority areas; to make provision requiring those boards to plan and take action in pursuit of economic, social, environmental and cultural wellbeing in their area; and for connected purposes.

Appendix 2 – Websites and further information

British Psychological Society – www.bps.org.uk

The Society website has guidance, advice and further information on many topics not covered in these guidelines as well as those mentioned.

Psychologists working in clinical fields will also need to take account of Clinical Guidelines produced by NICE in England and Wales https://www.nice.org.uk/ or SIGN in Scotland http://www.sign.ac.uk/

1.1 Legal and professional obligations of psychologists

HCPC – http://hcpc-uk.org
The Health and Care Professions Council website has lots of information about professional registration including the standards of proficiency for the seven protected titles and information about indemnity insurance

Information Commissioner's Office – https://ico.org.uk/
The ICO website contains lots of useful information for organisations, private practitioners and the public regarding the rights and responsibilities under the data protection and Freedom of Information Acts.

DBS Checks – https://www.gov.uk/disclosure-barring-service-check
The government website provides helpful information for employers regarding these checks.

1.2 Continuing professional development

The HCPC has provided guidance regarding CPD for registrants. http://www.hcpc-uk.org/cpd

2.1 Working environment

Lone Working

Suzy Lamplugh Trust – http://www.suzylamplugh.org/

The Suzy Lamplugh Trust campaigns for personal safety and has lots of advice for people working alone to help to keep safe. They have some good advices and resources available.

Harassment and Bullying

ACAS – http://www.acas.org.uk/
The Advisory, Conciliation and Arbitration Service (ACAS) is a statutory organisation providing help and advice for employers and employees. They have produced guidance on several topics including harassment and bullying aimed separately at employers and employees.

Whistleblowing

Whistleblowing for employees – https://www.gov.uk/whistleblowing

The government has produced some guidance for employees surrounding whistleblowing including what to do and what to expect.

2.2 Working in the digital age

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – http://www.hhs.gov/hipaa/

This American act makes provisions for health information privacy. The government website provides information for professionals regarding this act.

N.B This Act is ONLY law for practice in America.

Social Media

The HCPC has provided guidance regarding the use of social media by professional psychologists.

http://www.hcpc-uk.org/Assets/documents/100035B7Social_media_guidance.pdf

3. Safeguarding

Statutory guidance Working together to safeguard children – https://www.gov.uk/government/publications/working-together-to-safeguard-children–2
Statutory guidance on inter-agency working to safeguard and promote the welfare of children.

Getting it Right for Every Child (GIRFEC) and the Early Years Framework – http://www.maternal-and-early-years.org.uk/getting-it-right-for-every-child-principles-and-values
This is an NHS Scotland approach which establishes the principle of giving all children and young people the best possible start in life as a priority for all services.

UK Government Guidance – https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care
No Secrets sets out a code of practice for the protection of vulnerable adults.

It explains how commissioners and providers of health and social care services should work together to produce and implement local policies and procedures. They should collaborate with the public, voluntary and private sectors and they should also consult clients, their carers and representative groups. Local authority social services departments should co-ordinate the development of policies and procedures.

Protection of vulnerable adults scheme (POVA) – http://www.scie.org.uk/publications/guides/guide03/law/adults.asp
Individuals should be referred to, and included on, the POVA list if they have abused, neglected or otherwise harmed vulnerable adults in their care or placed vulnerable adults

in their care at risk of harm. By making statutory checks against the list, providers of care must ensure they do not offer such individuals employment in care positions. POVA checks are requested as part of disclosures from the Criminal Records Bureau.

Prevention and Protection in Partnership 2015 – https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf

This policy from Northern Ireland is for all organisations working with, or providing services to, adults across the statutory, voluntary, community, independent and faith sectors. It sets clear and proportionate safeguarding expectations across the range of organisations.

Modern Slavery and the national referral mechanism (NRM) – https://www.gov.uk/government/collections/modern-slavery
These pages provide details about the government's work to end modern slavery, including details about how to refer victims into the NRM.

Let's talk about it – http://www.ltai.info/about/
Let's Talk About It is an initiative designed to provide practical help and guidance to the public in order to stop people becoming terrorists or supporting terrorism.

4. Managing data and confidentiality

Information Commissioners Office – https://ico.org.uk/
The Information Commissioners Office produces guidance with regards to data sharing and the Data protection and Freedom of information Acts.

HCPC guidance on confidentiality – http://www.hcpc-uk.co.uk/assets/documents/100023F1GuidanceonconfidentialityFINAL.pdf
The HCPC has provided guidance on confidentiality for registrants.

NHS – https://digital.nhs.uk/article/402/Information-Governance
The NHS has produced guidance regarding Information Governance and security for NHS and partner organisations. The NHS has codes of practice for Records management and Confidentiality.

Caldicott Report – https://www.gov.uk/government/publications/the-information-governance-review
A review was commissioned in 1997 by the Chief Medical Officer of England owing to increasing concern about the ways in which patient information is being used in the NHS in England and Wales and the need to ensure that confidentiality is not undermined. Such concern was largely due to the development of information technology in the service, and its capacity to disseminate information about patients rapidly and extensively. A committee was established under the chairmanship of Dame Fiona Caldicott. The Caldicott Report highlighted six key principles, and made 16 specific recommendations. In 2012 Dame Caldicott produced a follow up report which made 26 further recommendations including the addition of a seventh principle.

Psychological Testing Centre – http://ptc.bps.org.uk/ptc/guidelines-and-information

The PTC website contains lots of guidance about psychometric testing and the management of data generated from those tests.

5. Transparency and duty of candour

Care Quality Commission – http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
The CQC has produced Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare with regards to duty of candour.

Appendix 3 – How this document has been developed

In developing these guidelines, the overall aim and scope of the guidelines was considered at length, and the decision arrived at that they should be applicable to all psychologists irrespective of registration status or practice context. The guidelines have therefore been written in a way which it is hoped is inclusive of the various contexts of practice. Drawing on a broad stakeholder group for the development work, the guidelines aim to cover all the important considerations for practice. It is however recognised they cannot cover every circumstance and also that new issues arise which will require careful consideration by the individual psychologist.

The Practice Guidelines development Working Group was constituted to include all of the member networks of the Society whose members engage in practice, including the HCPC registered practitioners. It included representatives of the Society's national branches in Scotland, Wales and Northern Ireland, in order to ensure applicability to the different national contexts. It also included representation from the expert working groups of the Society's Professional Practice Board and others on specialist topics of practice.

The content of the guidelines has been developed from a combination of revision of the previous edition in the light of professional consensus on current expectations of a good standard of practice of psychology; inclusion of key points from other Society guidance on specific topics with reference to further guidance; and in some cases development of new material drawing on the professional experience of our members or outside professionals in the field. The working group has not used systematic methods to search for or assess the evidence for the material included. Recommendations have been included based on working group consensus. Where there are known areas of professional difference of opinion this has been stated.

A draft of the guidelines was circulated for Society wide consultation and one month allowed for comment. This included circulation to Experts by Experience (psychology service user representatives) with whom the Society works in various contexts. The Guidelines were also sent for comment to the Health and Care Professions Council as the statutory regulator for practitioner psychologists. Comments received were considered carefully by the Working Group and changes made to the text of the guidelines where considered necessary. The annotated audit sheet of the comments received and disposal was provided to a meeting of the Society's Professional Practice Board to assist its consideration of the draft guidelines, by way of final peer scrutiny. The guidelines were reviewed by the Society's legal advisers prior to publication. Final approval of the guidelines was given by the Society's Board of Trustees.

The guidelines will be reviewed and updated in accordance with Society policy after five years or sooner if circumstances indicate this is needed.

To ensure clarity and presentation in a user friendly format, the Guidelines have been edited by professional staff within the Society and the format designed by the Society's Preparation for Print specialists. Where considered helpful, links have been made to

additional web based resources, both to assist practitioner development and to provide up to date information in areas where there is frequent change. Organisational providers of psychological services are encouraged to review how these guidelines are used in practice and feed back to the Society any barriers to application.

In ensuring an appropriate level of independence in the production of these Guidelines, the Society has ensured its conflict of interest policy has been complied with and that no member of the working group's input has been compromised by a conflict of interest. No member has received any form of remuneration other than reimbursement of travel and subsistence expenses in accordance with Society policy. The large size of the working group and peer scrutiny and challenge, as well as the robust consultation process, guards against the potential for any one member or small group of members inappropriately to bias the Guidelines.

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel: 0116 254 9568 Fax 0116 247 0787 E-mail: mail@bps.org.uk Website: www.bps.org.uk

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Principles of recovery oriented mental health practice

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.

> *It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment and connection—and external conditions that facilitate recovery—implementation of human rights, a positive culture of healing, and recovery-oriented services. (Jacobson and Greenley, 2001 p. 482)*

The purpose of principles of recovery oriented mental health practice is to ensure that mental health services are being delivered in a way that supports the recovery of mental health consumers.

1. UNIQUENESS OF THE INDIVIDUAL

Recovery oriented mental health practice:

- recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community
- accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life
- empowers individuals so they recognise that they are at the centre of the care they receive.

2. REAL CHOICES

Recovery oriented mental health practice:

- supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored
- supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time
- ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.

3. ATTITUDES AND RIGHTS

Recovery oriented mental health practice:

- involves listening to, learning from and acting upon communications from the individual and their carers about what is important to each individual
- promotes and protects individual's legal, citizenship and human rights
- supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual
- instils hope in an individual's future and ability to live a meaningful life.

4. DIGNITY AND RESPECT

Recovery oriented mental health practice:

- consists of being courteous, respectful and honest in all interactions
- involves sensitivity and respect for each individual, particularly for their values, beliefs and culture
- challenges discrimination and stigma wherever it exists within our own services or the broader community.

5. PARTNERSHIP AND COMMUNICATION

Recovery oriented mental health practice:

- acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them
- values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement
- involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

6. EVALUATING RECOVERY

Recovery oriented mental health practice:

- ensures and enables continuous evaluation of recovery based practice at several levels
- individuals and their carers can track their own progress
- services demonstrate that they use the individual's experiences of care to inform quality improvement activities
- the mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships as well as health and well being measures.

These Recovery Principles have been adapted from the Hertfordshire Partnership NHS Foundation Trust Recovery Principles in the UK.

SPECIAL ARTICLE

How important are the common factors in psychotherapy? An update

Bruce E. Wampold

Department of Counseling Psychology, University of Wisconsin, Madison, WI, USA; Modum Bad Psychiatric Center, Vikersund, Norway

The common factors have a long history in the field of psychotherapy theory, research and practice. To understand the evidence supporting them as important therapeutic elements, the contextual model of psychotherapy is outlined. Then the evidence, primarily from meta-analyses, is presented for particular common factors, including alliance, empathy, expectations, cultural adaptation, and therapist differences. Then the evidence for four factors related to specificity, including treatment differences, specific ingredients, adherence, and competence, is presented. The evidence supports the conclusion that the common factors are important for producing the benefits of psychotherapy.

Key words: Common factors, contextual model, psychotherapy, alliance, empathy, expectations, cultural adaptation, therapist differences, specific ingredients

(World Psychiatry 2015;14:270–277)

The so-called common factors have a long history in psychiatry, originating with a seminal article by S. Rosenzweig in 1936 (1) and popularized by J. Frank in the various editions of his book *Persuasion and Healing* (2-4). During this period, the common factors have been both embraced and dismissed, creating some tension (5-9). The purpose of this paper is not to review or discuss the debate, but to provide an update, summarizing the evidence related to these factors.

To understand the evidence for the common factors, it is important to keep in mind that these factors are more than a set of therapeutic elements that are common to all or most psychotherapies. They collectively shape a theoretical model about the mechanisms of change in psychotherapy.

A particular common factor model, called the contextual model, has been recently proposed (8,10). Although there are other common factor models (e.g., 4,11), based on different theoretical propositions, the predictions made about the importance of various common factors are similar and the choice of the model does not affect conclusions about the impact of these factors. The contextual model is presented below, followed by a review of the evidence for the common factors imbedded in the model.

THE CONTEXTUAL MODEL

The contextual model posits that there are three pathways through which psychotherapy produces benefits. That is, psychotherapy does not have a unitary influence on patients, but rather works through various mechanisms. The mechanisms underlying the three pathways entail evolved characteristics of humans as the ultimate social species; as such, psychotherapy is a special case of a social healing practice.

Thus, the contextual model provides an alternative explanation for the benefits of psychotherapy to ones that emphasize specific ingredients that are purportedly beneficial for particular disorders due to remediation of an identifiable deficit (8).

The three pathways of the contextual model involve: a) the real relationship, b) the creation of expectations through explanation of disorder and the treatment involved, and c) the enactment of health promoting actions. Before these pathways can be activated, an initial therapeutic relationship must be established.

Initial therapeutic relationship

Before the work of therapy can begin, an initial bond between therapist and patient needs to be created. E. Bordin stated in 1979 that "some basic level of trust surely marks all varieties of therapeutic relationships, but when attention is directed toward the more protected recesses of inner experience, deeper bonds of trust and attachment are required and developed" (12, p. 254). The initial meeting of patient and therapist is essentially the meeting of two strangers, with the patient making a determination of whether the therapist is trustworthy, has the necessary expertise, and will take the time and effort to understand both the problem and the context in which the patient and the problem are situated.

The formation of the initial bond is a combination of bottom-up and top-down processing. Humans make very rapid determination (within 100 ms), based on viewing the face of another human, of whether the other person is trustworthy or not (13), suggesting that patients make very rapid judgments about whether they can trust their therapist. More than likely, patients make rapid judgments about the dress of the therapist, the arrangement and decorations of the room (e.g., diplomas on the wall), and other features of the therapeutic setting (14). However, patients come to therapy with expectations about the nature of psychotherapy as

well, due to prior experiences, recommendations of intimate or influential others, cultural beliefs, and so forth. The initial interaction between patient and therapist is critical, it seems, because more patients prematurely terminate from therapy after the first session than at any other point (15).

Pathway 1: The real relationship

The real relationship, defined psychodynamically, is "the personal relationship between therapist and patient marked by the extent to which each is genuine with the other and perceives/experiences the other in ways that befit the other" (16, p. 119). Although the psychotherapeutic relationship is influenced by general social processes, it is an unusual social relationship in that: a) the interaction is confidential, with some statutory limits (e.g., child abuse reporting), and b) disclosure of difficult material (e.g., of infidelity to a spouse, of shameful affect, and so forth) does not disrupt the social bond. Indeed, in psychotherapy, the patient is able to talk about difficult material without the threat that the therapist will terminate the relationship.

The importance of human connection has been discussed for decades, whether is it called attachment (17), belongingness (18), social support (19), or the lack of loneliness (20,21). In fact, perceived loneliness is a significant risk factor for mortality, equal to or exceeding smoking, obesity, not exercising (for those with chronic cardiac disease or for healthy individuals), environmental pollution, or excessive drinking (22-24). Psychotherapy provides the patient a human connection with an empathic and caring individual, which should be health promoting, especially for patients who have impoverished or chaotic social relations.

Pathway 2: Expectations

Research in a number of areas documents that expectations have a strong influence on experience (25). Indeed, the purported price of a bottle of wine influences rating of pleasantness as well as neural representations (26). The burgeoning research on the effects of placebos documents the importance of expectations, as placebos have robustly shown to alter reported experience as well as demonstrating physiological and neural mechanisms (27,28).

Expectations in psychotherapy work in several possible ways. Frank (4) discussed how patients present to psychotherapy demoralized not only because of their distress, but also because they have attempted many times and in many ways to overcome their problems, always unsuccessfully. Participating in psychotherapy appears to be a form of remoralization.

However, therapy has more specific effects on expectations than simple remoralization. According to the contextual model, patients come to therapy with an explanation for their distress, formed from their own psychological beliefs, which is sometimes called "folk psychology" (29-31). These beliefs, which are influenced by cultural conceptualizations of mental disorder but also are idiosyncratic, are typically not adaptive, in the sense that they do not allow for solutions. Psychotherapy provides an explanation for the patient's difficulties that is adaptive, in the sense that it provides a means to overcome or cope with the difficulties. The patient comes to believe that participating in and successfully completing the tasks of therapy, whatever they may be, will be helpful in coping with his or her problems, which then furthers for the patient the expectation that he or she has ability to enact what is needed. The belief that one can do what is necessary to solve his or her problem has been discussed in various ways, including discussions of mastery (4,32), self-efficacy (33), or response expectancies (25).

Critical to the expectation pathway is that patients believe that the explanation provided and the concomitant treatment actions will be remedial for their problems. Consequently, the patient and therapist will need to be in agreement about the goals of therapy as well as the tasks, which are two critical components of the therapeutic alliance (34,35). Hatcher and Barends described the alliance as "the degree to which the therapy dyad is engaged in collaborative, purposive work" (36, p. 293). Creating expectations in psychotherapy depends on a cogent theoretical explanation, which is provided to the patient and which is accepted by the patient, as well as on therapeutic activities that are consistent with the explanation, and that the patient believes will lead to control over his or her problems. A strong alliance indicates that the patient accepts the treatment and is working together with the therapist, creating confidence in the patient that the treatment will be successful.

Pathway 3: Specific ingredients

The contextual model stipulates that there exists a treatment, particularly one that the patient finds acceptable and that he or she thinks will be remedial for his or her problems, creating the necessary expectations that the patient will experience less distress. Every treatment that meets the conditions of the contextual model will have specific ingredients, that is, each cogent treatment contains certain well-specified therapeutic actions.

The question is how the specific ingredients work to produce the benefits of psychotherapy. Advocates of specific treatments argue that these ingredients are needed to remediate a particular psychological deficit. The contextual model posits that the specific ingredients not only create expectations (pathway 2), but universally produce some salubrious actions. That is, the therapist induces the patient to enact some healthy actions, whether that may be thinking about the world in less maladaptive ways and relying less on dysfunctional schemas (cognitive-behavioral treatments), improving interpersonal relations (interpersonal psychotherapy and some dynamic therapies), being more accepting

of one's self (self-compassion therapies, acceptance and commitment therapy), expressing difficult emotions (emotion-focused and dynamic therapies), taking the perspective of others (mentalization therapies), and so forth. The effect of lifestyle variables on mental health has been understated (37). A strong alliance is necessary for the third pathway as well as the second, as without a strong collaborative work, particularly agreement about the tasks of therapy, the patient will not likely enact the healthy actions.

According to the contextual model, if the treatment elicits healthy patient actions, it will be effective, whereas proponents of specific ingredients as remedial for psychological deficits predict that some treatments – those with the most potent specific ingredients – will be more effective than others (8).

EVIDENCE FOR VARIOUS COMMON FACTORS

Now that the contextual model has been briefly presented, attention is turned toward an update of the evidence for the common factors. Each factor reviewed is imbedded in the contextual model, although each of them is more generically considered atheoretically as an important one. As will be apparent, many of the common factors are not theoretically or empirically distinct.

To present the evidence succinctly and with as little bias and error as possible, we rely on meta-analyses of primary studies. Studies that examine the association of levels of a common factor and outcome are typically reported by some type of correlation statistic (such as Pearson's product-moment correlation), whereas studies that experimentally manipulate and compare conditions typically report some standardized mean difference (such as Cohen's d). For comparison purposes, correlational statistics are converted to Cohen's d. All meta-analyses reported aggregate statistics, corrected for bias, based on the effects of individual studies appropriated weighted. To understand the importance of effects, Cohen (38) classified a d of 0.2 as small, 0.5 as medium, and 0.8 as large. The evidence is summarized in Figure 1, where the effects of various common factors are compared to those of various specific factors.

Alliance

The alliance is composed of three components: the bond, the agreement about the goals of therapy, and the agreement about the tasks of therapy (12). As discussed above, alliance is a critical common factor, instrumental in both pathway 2 and pathway 3.

Alliance is the most researched common factor. Typically the alliance is measured early in therapy (at session 3 or 4) and correlated with final outcome. The most recent meta-analysis of the alliance included nearly 200 studies involving over 14,000 patients and found that the aggregate correlation between alliance and outcome was about .27, which is equivalent to a Cohen's d of 0.57 (39), surpassing the threshold for a medium sized effect.

There have been a number of criticisms of the conclusion that alliance is an important factor in psychotherapy (40), most of which have focused on the correlational nature of alliance research. However, each of the criticisms has been considered and has been found not to attenuate the importance of the alliance (see 8).

First, it could well be that early symptom relief causes a strong alliance at the third or fourth session – that is, early responders report better alliances and have better outcomes. To address this threat, early therapy progress must be statistically controlled or longitudinal research is needed to examine the association of alliance and symptoms over the course of therapy. The studies that have examined this question have found evidence to support either interpretation, but the better designed and more sophisticated studies are converging on the conclusion that the alliance predicts future change in symptoms after controlling for already occurring change.

Second, it could be that the correlation between alliance and outcome is due to the patients' contributions to the alliance. According to this line of thinking, some patients may come to therapy well prepared to form a strong alliance and it is these patients who also have a better prognosis, so the alliance-outcome association is due to the characteristics of the patients rather than to something that therapists provide to the patients. Disentangling the patient and therapist contributions involves the use of multilevel modeling. Recently, Baldwin et al (41) performed such an analysis and found that it was the therapist contribution which was important: more effective therapists were able to form a strong alliance across a range of patients. Patients' contribution did not predict outcome: patients who are able to form better alliances, perhaps because they have secure attachment histories, do not have better prognoses. Indeed, patients with poor attachment histories and chaotic interpersonal relationships may well benefit from a therapist who is able to form alliances with difficult patients. These results have been corroborated by meta-analyses (42).

Third, there may be a halo effect if the patient rates both the alliance and the outcome. However, meta-analyses have shown that the alliance-outcome association is robust even when alliance and outcome are rated by different people. It also appears that the alliance is equally strong for cognitive-behavioral therapies as it is for experiential or dynamic treatments, whether a manual is used to guide treatment or not, and whether the outcomes are targeted symptoms or more global measures.

There are other threats to validity of the alliance as a potent therapeutic factor, but the evidence for each of them is nonexistent or weak (8). The research evidence, by and large, supports the importance of the alliance as an important aspect of psychotherapy, as predicted by the contextual model.

As mentioned above, distinctions between certain common factors are difficult to make. A distinction has been

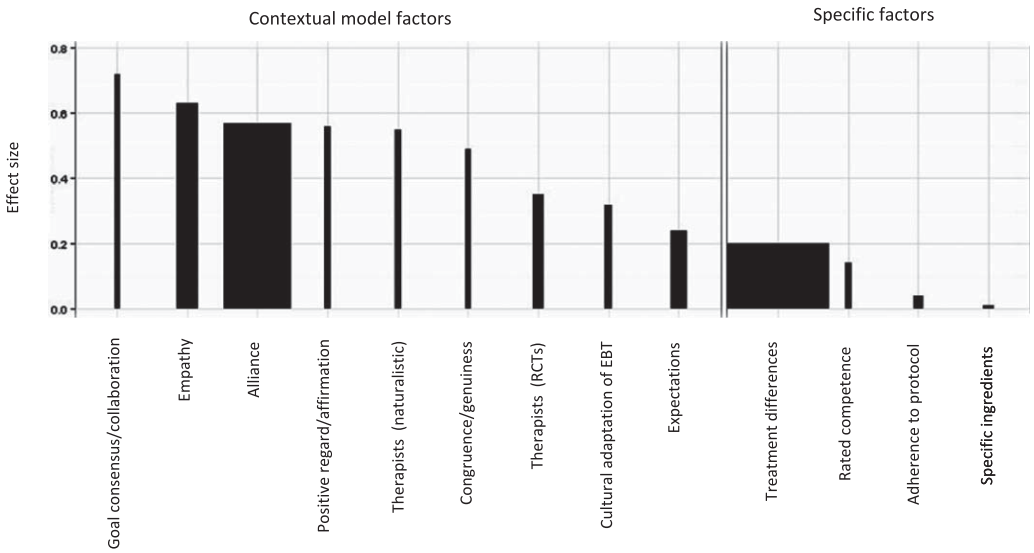

Figure 1 Effect sizes for common factors of the contextual model and specific factors. Width of bars is proportional to number of studies on which effect is based. RCTs – randomized controlled trials, EBT – evidence-based treatments

made between the bond, as defined as a component of the alliance, which is related to purposeful work, and the real relationship, which is focused on the transference-free genuine relationship (8,16). There is some evidence that the real relationship is related to outcome, after controlling for the alliance (16), and, although the evidence is not strong, it does support the first pathway of the contextual model.

A second construct related for the alliance is labeled goal consensus/collaboration. Although related to agreement about the goals and tasks for therapy, goal consensus/collaboration is measured with different instruments. As shown in Figure 1, the effect for goal consensus and collaboration is strong (d=0.72), based on a meta-analysis of 15 studies (43).

Empathy and related constructs

Empathy, a complex process by which an individual can be affected by and share the emotional state of another, assess the reasons for another's state, and identify with the other by adopting his or her perspective, is thought to be necessary for the cooperation, goal sharing, and regulation of social interaction. Such capacities are critical to infant and child rearing, as children, who are unable to care for themselves, signal to the caregiver that care is needed, a process that is then put to use to manage social relations among communities of adult individuals. Therapist expressed empathy is a primary common factor, critical to pathway 1 of the contextual model, but which also augments the effect of expectations.

The power of the empathy in healing was beautifully revealed in a study of placebo acupuncture for patients with irritable bowel syndrome (44). Patients with this syndrome were randomly assigned to a limited interaction condition, an augmented relationship condition, or treatment as usual (waiting list for acupuncture). In the limited interaction condition, the acupuncturist met with the patient briefly, but was not allowed to converse with him or her, and administered the sham acupuncture (a device that gives the sensation of having needles pierce the skin, but they do not). In the augmented relationship condition, the practitioner conversed with the patient about the symptoms, the relevance of lifestyle and relationships to irritable bowel syndrome, as well as the patient's understanding of the cause and meaning of her disorder. All this was done in a warm and friendly manner, using active listening, appropriate silences for reflection, and a communication of confidence and positive expectation. For the four dependent variables (global improvement, adequate relief, symptom severity, and quality of life), the two sham acupuncture conditions were superior to treatment as usual. However, the augmented relationship condition was superior to the limited interaction condition, particularly for quality of life.

The above study is noteworthy because it was an experimental demonstration of the importance of a warm, caring, empathic interaction within a healing setting. Unfortunately, experimental manipulation of empathy in psychotherapy studies is not possible, for design and ethical reasons. Nonetheless, there have been numerous studies (n=59) that have correlated ratings of therapist empathy with outcome, which have been meta-analytically summarized (45), resulting in a relatively large effect (d=0.63; see Figure 1). Constructs related to empathy have also been meta-analyzed and found to be related to outcome, including positive regard/affirmation (d=0.56, n=18; see Figure 1) (46) and congruence/genuineness (d=0.49, n=18; see Figure 1) (47).

It should be recognized that several of the threats to validity for the alliance are also present with regard to empathy. For example, it is clearly easier for a therapist to be warm and

caring toward a motivated, disclosing and cooperative patient than to one who is interpersonally aggressive, and the former types of patients will most likely have better outcomes than the latter, making the empathy/outcome correlation an artifact of patient characteristics rather than therapist action. Unfortunately, studies such as the ones conducted to rule out these threats to validity for the alliance have not been conducted for empathy and related constructs.

Expectations

Examining the role of expectations in psychotherapy is difficult. In medicine, expectations can be induced verbally and then physicochemical agents or procedures can be administered or not, making the two components (creation of expectations and the treatment) independent. In psychotherapy, creating the expectations, through explanation of the patient's disorder, presenting the rationale for the treatment, and participating in the therapeutic actions, is part of therapy. It is difficult to design experimental studies of expectations in psychotherapy (not impossible, but not yet accomplished in any important manner).

The typical way to assess the effect of expectations in psychotherapy is to correlate patient ratings of their expectations with outcomes, but we have seen that such correlational studies produce threats to validity. Furthermore, in many studies, expectations are measured *prior* to when the rationale for the treatment is provided to the patient, when it is the explanation given to the patient that is supposed to create the expectations. Assessing expectations after the explanation has been given (i.e., during the course of treatment) is also problematic, as those patients who have made significant progress in therapy will naturally respond that they think therapy will be helpful.

Despite the difficulties with investigating expectations in psychotherapy, this is a topic of much interest (48-50). Recently, a meta-analysis of expectations showed that there was a relatively small, but statistically significant, relationship between rated expectations and outcome ($d=0.24$, $n=46$; see Figure 1) (49). The best evidence for expectations in the context of healing is derived from studies of the placebo effect, where exquisite care has been taken to experimentally manipulate variables of interest and to control for threats to validity, by using physiological and neurological variables as well as subjective reports. A summary of this literature is beyond the scope of this article, but many excellent reviews are available (8,27,28).

Cultural adaptation of evidence-based treatments

The contextual model emphasizes that the explanation given for the patient's distress and the therapy actions must be acceptable to the patient. Acceptance is partly a function of consistency of the treatment with the patient's beliefs, particularly beliefs about the nature of mental illness and how to cope with the effects of the illness. This suggests that evidence-based treatments that are culturally adapted will be more effective for members of the cultural group for which the adapted treatment is designed. There are many ways to adapt treatments, including those involving language, cultural congruence of therapist and patient, cultural rituals, and explanations adapted to the "myth" of the group.

A recent meta-analysis demonstrated that adapting evidence-based treatments by using an explanation congruent with the cultural group's beliefs (i.e., using the cultural "myth" as the explanation) was more effective than unadapted evidence-based treatments, although the effect was modest ($d=0.32$, $n=21$; see Figure 1) (51).

Therapist effects

Therapist effects are said to exist if some therapists consistently achieve better outcomes with their patients than other therapists, regardless of the nature of the patients or the treatment delivered. Therapist effects have been studied in clinical trials and in naturalistic settings. In both designs, the measure of therapist effects is an intraclass correlation coefficient. Technically, this coefficient indexes the degree to which two patients from the same therapist have similar outcomes relative to two patients from two different therapists. To compare therapist effects to other common factors, the intraclass correlation coefficient is converted to Cohen's d.

The contextual model predicts that there will be differences among therapists *within* a treatment. That is, even though the therapists are delivering the same specific ingredients, some therapists will do so more skillfully and therefore achieve better outcomes than other therapists delivering the same treatment. Evidence for this conjecture is found in clinical trials. A meta-analysis of therapist effects in clinical trials found modest therapist effects ($d=0.35$, $n=29$; see Figure 1) (52). Keep in mind that the therapists in clinical trials generally are included because of their competence and then they are given extra training, supervised, and monitored. Moreover, the patients in such trials are homogeneous, as they have a designated diagnosis and are selected based on various inclusionary/exclusionary criteria. In such designs, patients are randomly assigned to therapists. Consequently, consistent differences among therapists in such trials, although modest, are instructive.

Not surprisingly, therapist effects in naturalistic settings are greater than in clinical trials. In the former settings, therapists are more heterogeneous, patients may not be randomly assigned to therapists, patients are heterogeneous, and so forth. A meta-analysis of therapist effects in such settings found a relatively large effect ($d=0.55$, $n=17$; see Figure 1) (52).

The finding of robust therapist effects raises the question about what are the characteristics or actions of more effective therapists. Recent research has begun to address this

question. Studies have shown that effective therapists (vis-à-vis less effective therapists) are able to form stronger alliances across a range of patients, have a greater level of facilitative interpersonal skills, express more professional self-doubt, and engage in more time outside of the actual therapy practicing various therapy skills (8).

SPECIFIC EFFECTS

Evidence for the common factors is also collected by examining the evidence for specific aspects of psychotherapy. The contextual model makes several predictions about specific effects, which will be discussed as each specific effect is considered.

Treatment differences

When pathway 3 of the contextual model was discussed earlier, it was emphasized that the model contends that all therapies with structure, given by empathic and caring therapists, and which facilitate the patient's engagement in behaviors that are salubrious, will have approximately equal effects. That is, the specific ingredients, discussed in pathway 3, are not critical because they remediate some psychological deficit.

The question of whether some treatments are superior to others has long been debated, with origins at the very beginning of the practice of psychotherapy (think about the disagreements amongst Freud, Adler and Jung, for example). Today, there are claims that some treatments, in general or for specific disorders, are more effective than others. Others, however, claim that there are no differences among psychotherapies, in terms of their outcomes.

The literature addressing this issue is immense and summarizing the results of relative efficacy is not possible. Nevertheless, the various meta-analyses for psychotherapies in general or for specific disorders, if they do find differences among various types of treatment, typically find at most differences of approximately d=0.20, the value shown in Figure 1.

Specific effects from dismantling studies

To many, the dismantling design is the most valid way to identify the effects of specific ingredients. In this design, a specific ingredient is removed from a treatment to determine how much more effective the treatment is in total compared to the treatment without the ingredient that is purportedly remedial for the psychological deficit.

Two meta-analyses have examined dismantling designs and both found minimal differences between the total treatment and the treatment without one or more critical ingredients (d=0.01, n=30, see Figure 1) (53,54). The most recent of these meta-analyses did find that adding an ingredient to an existing treatment increased the effect for targeted variables by a small amount (d=0.28) (53).

Adherence and competence

In clinical trials, it is required that adherence to the protocol and the competence at delivering the treatment are rated. This makes sense: if the goal is to make inferences about a particular treatment, then it is necessary to ensure that the treatment was delivered with the necessary components and not with extraneous components (i.e., with *adherence* to the protocol) and that the treatment components were delivered skillfully (i.e., given *competently*).

It would seem logical theoretically that adherence to the protocol and competence would be related to outcome. That is, for cases where the therapist followed the protocol and did so skillfully, there should be better outcomes. However, this is not the case. In a meta-analysis of adherence and competence (55), effects were small (d=0.04, n=28 for adherence; d=0.14, n=18 for competence; see Figure 1).

The results for adherence and competence demand further explanation. If the specific ingredients of a treatment are critical, then adherence should make a difference – actually delivering those ingredients should be related to outcome. There is evidence that rigid adherence to a protocol can attenuate the alliance and increase resistance to the treatment (i.e., failing to accept the treatment, a contextual model tenet) (8), and that flexibility in adherence is related to better outcomes (56), results consistent with prediction of the contextual model.

The findings for competence are a bit more difficult to understand. Competence in these trials typically is rated by experts in the treatment being given, based on watching therapy sessions. Why can't experts differentiate between "good" therapy and "bad" therapy? If this were indicative of experts' abilities to judge competence, then the notion of psychotherapy supervision would be turned upside down, because what is observed and evaluated would have no relation to outcomes – how could the supervisor then make a case for providing input to the supervisee? But the clue to the resolution of this mystery is found in the definition of competence. Most psychotherapy trials rate the competence *for a specific treatment*. That is, what is rated is the skill in providing the elements of the treatment protocol, rather than common factors, such as empathy, alliance, affirmation, and so forth – aspects of therapy that do predict outcome and seem to differentiate more effective therapists from less effective therapists.

CONCLUSIONS

Although the common factors have been discussed for almost a century, the focus of psychotherapy is typically on the development and dissemination of treatment models. If

not discounted, then the common factors are thought of as perhaps necessary, but clearly not sufficient. The evidence, however, strongly suggests that the common factors must be considered therapeutic and attention must be given to them, in terms of theory, research and practice.

One of the criticisms of the common factors is that they are an atheoretical collection of commonalities. In this paper, the contextual model was presented to convey a theoretical basis for these factors.

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REVIEW
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Trauma and Public Mental Health: A Focused Review

Rolf J. Kleber[1,2]*

[1] Utrecht University, Utrecht, Netherlands, [2] Arq Psychotrauma Expert Group, Diemen, Netherlands

Psychological trauma has developed into a very common concept in the scientific community, in mental health care, as well as in popular language and mass media. The purpose of this article is to show the relevance of the discipline of traumatic stress studies to the field of public mental health by examining central concepts and findings concerning trauma and its aftermath and examining implications for public mental health. Attention is paid to the diagnosis of posttraumatic stress disorder (PTSD) and the construct of resilience as well as to specific areas of public mental health activities. A public mental health perspective will help to develop preventive approaches to trauma and extend the impact of various forms of interventions. It will also make clear that trauma care will have to consider the community and the society at large.

Keywords: trauma, posttraumatic stress disorder, resilience, public mental health, war, disasters, violence

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Jutta Lindert,
University of Applied Sciences Emden Leer, Germany

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Aikaterini Arvaniti,
Democritus University of Thrace, Greece
Eva-Maria Pichler,
University of Zurich, Switzerland

***Correspondence:**
Rolf J. Kleber
r.kleber@uu.nl

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INTRODUCTION

Psychological trauma has developed into a very popular concept in the scientific community, in the world of mental health care, as well as in common language and mass media. The consequences of various shocking events—violence, disasters, acts of terrorism, accidents, and war—receive frequent and enduring attention. The number of scientific and clinical publications has increased enormously and in many media programs ample attention is paid to victims and others affected by these events. The purpose of this article is to show the relevance of the discipline of traumatic stress studies to the field of public mental health by examining central concepts and findings concerning trauma and its aftermath and examining implications for public mental health.

WHAT IS A TRAUMATIC EVENT?

Traumatic events involve the confrontation with war, violence, disasters, sudden loss, serious illness, and other overwhelming and disturbing events. According to the psychiatric classifications [of the *International Classification of Diseases* of the World Health Organization (ICD-11) and the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5)], a traumatic event is defined as the exposure to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (1, 2).

Phenomenologically such an event can be characterized by an extreme sense of powerlessness as well as a disruption of beliefs and expectations. The individual has lost control over the situation and is to a large extent a victim of the circumstances and/or other people (i.e. the perpetrator). In "Jenseits des Lustprinzips" (1920), Freud already posed: "the essence of a traumatic situation is an experience of helplessness that is brought about either externally or internally." At the same time, he or she is confronted with a shattering of basic assumptions. The self-evidence of one's life is gone. The sense of invulnerability,

the idea of the benevolence of the world, and the idea that other people can be trusted are devastated. The obvious certainties of life have disappeared. The images one holds of oneself and the environment no longer adequately fit the new situation. In the words of Janoff-Bulman (3), basic assumptions have been shattered.

Exposure to traumatic events is not rare, as has been consistently found in epidemiological studies. The World Mental Health Surveys of adults were carried out among nearly 70,000 participants from 24 countries ranging in economic status from low to high (4). These data showed that at some time in their life 70.4% of the respondents had experienced at least one type of a traumatic event. The specific rates were: 14% had experienced intimate partner or sexual violence, 34.3% accidents or injuries, 22.9% physical violence, 13.1% war-related events, 34.1% the unexpected or traumatic death of a loved one, and 35.7% experienced traumas that happened to loved ones (e.g., serious illness of a child). As Kessler et al. (4) stated, these findings make clear that it is rather normal to be exposed to a very upsetting event in one's lifetime.

RISE AND BLOOM OF THE CONCEPT OF POST-TRAUMATIC STRESS DISORDER

The concept of *posttraumatic stress disorder* (PTSD) is nowadays so much used that it dominates most thinking about the consequences of violence, disaster, and being a refugee. That development is quite unique as the attention for trauma was very meager just 40, 50 years ago. In the 1970s, the United States became increasingly confronted with the psychological and social difficulties of the nearly three million veterans who had fought in Vietnam. They suffered from nightmares, depression, relationship problems, et cetera. However, because of the ambivalent perspective on the Vietnam War, authorities and professionals were rather reluctant to acknowledge these difficulties, but the increasing concern led to the introduction of the term post-traumatic stress disorder in the anxiety disorders section of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) (5).

The diagnosis of PTSD is directly linked to experiencing or witnessing a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape, or other violent assault (criterion A). According to DSM-5 (1), PTSD consists of four categories of symptoms. Re-experiencing the traumatic event (criterion B) is manifested in symptoms such as intrusive memories, distressing dreams, flashbacks, or distress or physiological reactions upon exposure to cues of the trauma. The other categories are symptoms of avoidance of the reminders of the trauma (criterion C), alterations in memories or mood associated with the trauma (criterion D), and finally clear alterations in physiological arousal and reactivity [criterion E; see further Ref. (1)].

Recently a relatively different definition of PTSD has been introduced in the new version of the International Classification of Diseases of the World Health Organization (2018). It consists of three categories (reexperiencing, avoidance, hyperarousal) with only two core symptoms in each category. The definition may be more flexible to use (allowing for cultural variation and clinical judgment) but is less detailed and comprehensive. Empirical studies have found that prevalence rates may vary between the two classifications and there is often a lack of overlap (i.e., not the same individuals are classified as PTSD patients by the two classifications). This is a major concern for the field of traumatic stress studies. It is a challenge for future research to unravel the differences and to create order (6), as most research is conducted with the DSM definition while most countries in the world use instead ICD.

Prevalence figures for PTSD vary enormously, according to the nature of the events, various risk factors, the time of measurement, and the instruments used. In general, PTSD occurs more when an aggressor is involved (in the case interpersonal violence), for persistent and extended events (e.g., internment, sexual abuse) and for socially charged events (e.g., rape). Among Dutch veterans who were confronted with war violence during deployment in Iraq, the figures of current prevalence varied between 3 and 4% (7). Nine percent of American Vietnam veterans had current PTSD 20 years after the war (8). Figures on PTSD in studies of disasters (man-made, technological, as well as natural) varied mostly around 5% to 15% (9). The prevalence findings also fluctuated strongly in studies of sexual violence, although the rates are generally higher than after other events: between 3.7% and 65%. The already mentioned World Mental Health Surveys (4, 10) determined that intimate partner or sexual violence (such as rape) was a very frequent cause of PTSD. Nevertheless, the unexpected death of loved ones represented the most frequent cause of event-related psychopathology within the general population because of the high frequency with which people experience such a loss. About this last mentioned finding, it is relevant to remark that there is a close relationship between trauma and loss and consequently between PTSD and complicated grief, but they are not similar (11). The concepts of Persistent Complex Bereavement Disorder (1) and Prolonged Grief Disorder (2) as result of the death of a family member or a close friend are included in DSM-5 and ICD-11, respectively.

In a comprehensive and systematic analysis (12) prevalence rates of PTSD and depression were identified from 181 surveys comprising 81,866 refugees and other conflict-affected persons from 40 countries exposed to humanitarian emergencies. Again, rates of reported PTSD and depression showed large inter-survey variability. The prevalence estimates derived from the methodologically most robust surveys provided rates between 13% and 25% for PTSD, as assessed by Steel et al. (12). The risk of PTSD among refugees was increased by experiencing torture and sexual violence, having a higher age, being a woman, and through a long stay in different asylum seekers centers.

Despite the increased knowledge about PTSD and despite the positive results of therapeutic treatments for PTSD, there are various dilemmas and challenges. First, there is a large comorbidity, as most patients also suffer from depression, substance abuse, or other disorders (6). Furthermore, defining the borderline between normal and abnormal behavior after trauma is difficult. Moreover, although this is matter of heavy debate among researchers and clinicians, PTSD is sometimes an overstretched concept in the sense that normal responses to stressful life events are labelled as disorder. Difficulties of diverse groups—from refugees to veterans—are attributed too much or too easily to traumatic events and their resilience is underestimated (13).

IMPACT ON THE INDIVIDUAL

Regarding a public mental health perspective, it is highly relevant to understand that the majority of people exposed to serious live events does not develop disorders. However, this does not mean that they will not suffer from symptoms and difficulties. Most people will experience responses such as intrusions, nightmares, startle reactions, and numbness (14). Findings from large epidemiological studies of disaster victims have made this clear. In 2000 the Netherlands were confronted with a disastrous explosion of a fireworks container area in the middle of a neighborhood. A comprehensive and longitudinal study was conducted among the inhabitants. In the investigation of post-disaster reactions (15) it was found that most inhabitants suffered from various serious symptoms (especially depression, fears, re-experiences, physical symptoms) in the first 2 to 3 weeks after the explosion. At least 87% of the affected residents were highly affected in those first weeks after the disaster.

These responses can be considered functional and normal, as has been made clear in emotion theories (16). People are afraid that it will happen again. They do not feel safe anymore and are constantly alert for danger. They are angry because of the neglect of the responsible authorities or they feel rage in the direction of the perpetrator. They react easily irritated at remarks of other people. They blame themselves for being there at the moment of the disaster or having not done anything to prevent the situation. They feel despaired because of the death of loved ones and the loss of material goods. They have the impression that other people do not understand their distress and sorrow and feel estranged from others. Nevertheless, the intensity and frequency of these distressing and painful responses do not reach the level of disorder.

Although DSM-5 recognizes the possibility of the occurrence of Acute Stress Disorder (ASS) in the first days after an event, a diagnosis that overlaps with PTSD, this diagnosis is rarely used in clinical practice as well as research. Patients with ASS usually report numbness, problems with memory, sleep and concentration, irritability, fears, or anxiety and have frequent re-experiences of the event. The usefulness of acute stress disorder as a classification is controversial in the literature (17). The difference with normal reactions to a major life event and with PTSS, apart from the time criterion (ASS can only be used for disturbances in the first 4 weeks after the experience), is not yet confirmed adequately.

As mentioned above, the world does not make sense any more after such a traumatic experience. Already in the 1940s the psychiatrist and concentration camp survivor Victor Frankl stated that the search for meaning played a crucial role in adaptation to threatening events (18). Cognitive approaches to trauma (e.g., 19) state that successful processing of the traumatic experience takes place when new information (e.g., the implication of the traumatic experience) is assimilated into existing structures or models. Unsuccessful processing occurs when the trauma-related information is not integrated into existing beliefs concerning self-image and world views (20). In low control situations not amenable to direct repair or problem-solving, such as trauma, loss, and serious illness, meaning-making is often the most adaptive strategy. As Schok et al. (20) have argued, meaning can be created by answering the question why an event occurred and why it happened to the person. It can also be operationalized as considering the ways in which one's life changed because of the event and assessing the extent to which one has "made sense of" the experience. Research findings have indicated that these two processes of finding a cause for the extreme event and finding personal benefits in the traumatic experience play independent roles in adjustment after trauma (21, 22). Therefore, the attempt to find meaning discloses itself twofold: in searching for an answer to the question why it happened as well as in rethinking one's attitudes and priorities to restructure one's life along more satisfying lines (23).

IMPACT ON THE COMMUNITY

Violence, disasters, accidents, and war are also stressful events for the community. Consequently, the impact of traumatic events goes beyond those who are directly exposed to the event and affects close relationships, the social environment, and the society at large. A human being does not live in a vacuum. He or she is surrounded by others. And those others will be confronted with the traumatic event and its aftermath too. This holds true for an event that struck an individual, such as a rape. Others hear about the event, perceive the suffering of the victims, and must cope with the implications. Naturally, it holds also true for events that struck a large group of people. For instance, a disaster undermines the social fabric of a community. It can lead to dissolution of social networks and to forced or voluntary migration. Regarding the health care system, it can lead to a disruption of the provision of social services and an erosion of the health care infrastructure (24, 25).

On the other hand, the social environment can stimulate recovery after trauma. The perception of social support has been found to be an influential factor for the effects of traumatic events on the individual as well as the community. For instance, studies undertaken after disasters have shown that social support had a significant stress-buffering effect for post-traumatic problems. Furthermore, a comprehensive meta-analysis (26) has shown that lack of social support systems and lack of sharing of emotions are significant risk factors for mental health disturbances.

THE OTHER SIDE OF TRAUMA: RESILIENCE

The finding that most people confronted with extreme life events did not develop disturbances like PTSD created interest in the phenomenon of *resilience*. This concept has been widely used in recent years in the scientific and clinical world. Resilience refers to a dynamic process involving positive adaptation to one's circumstances in the face of significant adversity, as defined by Luthar and Cicchetti (27). However, there are various understandings of resilience [see Ref. (28)]. Resilience may be treated as a quality, a personal trait, a process, and an outcome. While, for example, some researchers conceive of resilience

as a multiply determined developmental process that is not fixed, others use measures of trait resilience, which favors the assumption that resilience is a personality attribute [see for the different views Ref. (29)].

Investigation of resilience can lead to useful avenues for intervention. The concept offers a different perspective on risk and protection. Focusing on what makes individuals strong rather that what makes them weak may aid to understand what helps them to maintain their mental health. Sleijpen and colleagues examined strategies of young refugees in dealing with negative experiences (28). Their findings revealed that young refugees living in the Netherlands were affected by memories of traumatic events experienced in their country of origin or during the flight, but that current stressors, especially for young people without a residence permit, played a more significant role in determining their psychological well-being. The participants in this study used the following four strategies to deal with traumatic experiences and current stressors: (1) acting autonomously, (2) performing at school, (3) perceiving support from peers and parents, and (4) participating in the new society. These strategies helped the young refugees to strengthen their sense of power and control, they gave them some distraction, and they supported or sustained their spirit within the family unit and the new society [see Ref. (28)].

PROLONGED AFTERMATH

For public mental health initiatives, it is important to realize on the one hand the significance of the resilience of people affected, but at the other hand also the fact that disturbances can last for a very long period. Difficulties do not always disappear in time. Sometimes they may last for a very long time. 10 years after the Enschede Fireworks disaster still 6.7% of a representative sample of the inhabitants of the neighborhood had an indication of chronic disaster-related PTSD (30). 40 years after the Vietnam War (31), prevalence rates of PTSD were 4.5% (male USA veterans) and 6.1% (female veterans). In the World Mental Health Surveys (4), it was also found that PTSD symptoms typically were quite persistent.

The long-term aftermath of trauma can be illustrated with the following research finding. A large community-based sample of child survivors from World War II was compared with a reference group from the Dutch population as well as with clinical groups (32). These children survived internment in the Japanese camps in the former colony of the Dutch East Indies (now Indonesia) during the period 1942–1945 (and afterwards). Most of them were forced to migrate to the Netherlands in the 1940s and 1950s. Long-term sequelae of the persecution were studied by standardized questionnaires on posttraumatic responses, general health, and dissociation. Compared with control individuals of the same age that lived through the German occupation in the Netherlands during World War II, the child survivors from the former Dutch Indies reported significantly more traumatic experiences and mental health disturbances approximately 50 years after the war. 23 percent of these now adult child survivors in the community sample had an indication of PTSD related to the events in World War II [see Ref. (32)].

These results underline the long-term aftermath of traumatic experiences. This conclusion is also relevant for the many war refugees who migrated to Europe in recent years. In the field of psychotraumatology, there has been a continuing debate about the extent to which diagnostic criteria for PTSD adequately cover the posttraumatic symptomatology experienced by individuals exposed to prolonged, repeated, and interpersonal traumatic events, such as occurring in situations of domestic violence, war, and torture (33). This symptomatology is more complex, more severe, and more invasive than that captured by the classic PTSD diagnosis. This manifestation of psychopathology is referred to as *complex PTSD* (CPTSD). In the 11th version of the ICD (2), this concept is added as a formal diagnosis comorbid to PTSD. It consists of impairments in three domains: difficulties in emotion regulation, negative beliefs about oneself, and difficulties in sustaining relationships. The concept is attractive as it focuses on personal changes due to the confrontation with enduring violence and oppression, but it is as such also rather (too) close to personality disorders while it is not clear whether the addition of this new diagnostic concept is really required beyond PTSD. Research is also still indecisive about these matters. Because of these reasons, a concept such as complex PTSD was not included in DSM-5.

PUBLIC HEALTH STRATEGIES

Public health strategies are aimed at preventing or diminishing mental health problems and addressing the causes of these conditions (see also 10). These strategies are active on multiple levels: individual, family, community, and society. Unfortunately, public health care of trauma is a rather underdeveloped area (see Magruder et al., 2107), especially in contrast to the field of treatment of trauma-related disorders, in particular PTSD. Psychotherapies of PTSD have been found successful, as has been shown by many RCT's (randomized controlled trials) and meta-analyses, in comparison with control groups and placebo treatments [e.g., Ref. (34)]. Most evidence has been found for trauma-focused cognitive behavioral therapy and Eye Movement Desensitization and Reprocessing (EMDR), and to a somewhat lesser extent Narrative Exposure Therapy and Brief Eclectic Psychotherapy for PTSD [e.g., Ref. (35)]. However, here we focus only on public health strategies relevant to trauma care. They are all explicitly aimed at preventing the emergence of health problems or preventing the aggravation of these difficulties.

Preventing adversity. First, although it is a truism, one should bear in mind that stopping or avoiding exposure to events that can be experienced as traumatic is a sensible public health strategy. If disasters, accidents, or wars can be prevented by concrete measures, the chance on traumatic experiences and on their negative consequences is, by definition, taken away.

Creating awareness and recognition. Secondly, creating awareness and acknowledgment concerning the impact of trauma on the population is a strategy by which difficulties can be prevented. Psycho-education with the help of brochures is an obvious example of this. Similarly, so-called silent journeys by a community after a violent crime in their neighborhood

and creating monuments ("lieux de memoire") are just as exemplary regarding recognition and appreciation for the people affected by trauma.

The increase of awareness through public health campaigns has been suggested for combatting child sexual abuse (36). Public health campaigns serve to help the identification of affected children and to facilitate the recognition of their difficulties by adults. Such services imply the awareness of the impact of traumatic experiences in diverse domains (individual, societal), the recognition of signs and symptoms, the integration of knowledge about trauma in public health programs, and the prevention of re-traumatization for their users. In this respect, technology-based interventions (e.g., online platforms, social media, mobile applications) can be advantageous. Such campaigns of awareness and recognition should be accompanied by mental health services with adequate interventions for abused persons looking for care. Nevertheless, despite their positive aims and effects, at the same time, all these campaigns may have a downside: they can lead to complications, such as the risks of promoting an unnecessary victim status and medicalizing complaints of the affected persons, resulting in a reduction of the potential for spontaneous recovery (36, 37).

Strengthening resilience. The third group of strategies is focused on bolstering resilience and stimulating self-efficacy. For example, training programs have been developed in the armies of the USA and several European countries to allow military soldiers to deal with the stress of war and to be more resistant to the intense and overwhelming events they will be confronted with.

Counseling. Fourth, counseling people confronted with traumatic events is a well-known intervention in the field of trauma care. Various forms of secondary preventive interventions providing practical care, support, and information have been designed for employees of organizations confronted with extreme events in the work setting, such as the police and banks, but also for victims of large-scale acts of terrorism. These interventions consist of a couple of protocolled sessions in the first 2 or 3 months after a calamity [see for an overview Ref. (38)]. They are considered as quite helpful, although controlled research is mostly lacking. This intervention should not be confused with so-called psychological debriefing, a typically single session of group counseling directly after a disaster or an act of violence. If this form of support is focused too much on the ventilation of emotions, debriefing has been found to have a negative impact: posttraumatic reactions and depressive feelings are worsened and very early exposure to the trauma material may interfere with natural recovery processes (9, 38).

Reconciliation. A related form of post-trauma care are large-scale programs to reconcile people after large-scale conflicts. For instance, a civil war divides families, communities, and nations, often pitting one neighbor against another. Distrust, resentment, and anger dominate post-war society, just as much as passivity and emotional numbness. That is why programs are designed to reconcile people (perpetrators and victims) and to restore trust, connectedness, and social cohesion.

Such truth and reconciliation efforts were conducted in Sierra Leone (39). Community-level forums in 200 villages were set up in which victims detailed war atrocities and perpetrators confessed to war crimes. Research using a randomized control trial among more than 2,000 individuals showed that reconciliation led to greater forgiveness of perpetrators and strengthened social capital: social networks were larger, and people contributed more to public goods in treated villages. However, there were also negative psychological costs next to the positive societal benefits. The reconciliation intervention also worsened psychological health, increasing depression, anxiety, and PTSD in the same villages. For a subset of villages, outcomes were measured 9 months and 31 months after the intervention. Results showed that both positive and negative effects persisted into the longer time horizon. These findings suggest that policy-makers should be careful with reconciliation processes and must find ways to restrict the emphasis on emotions.

Policy making. Finally, there is the overarching field of policy making, a rather underdeveloped topic in trauma care. As Magruder et al. (40) stated, public policies should be formulated to prevent traumatic events, to understand risk and protective factors, to provide early intervention services for individuals and communities at risk of post-trauma maladjustment, and to shape societal norms to eliminate stigma. Extra priorities for improving mental health include a focus on adequately training researchers and professionals, supporting international collaborations, and encouraging scientists to share their expertise with policymakers. Furthermore, integration of physical and mental health care is especially important, as trauma-exposed individuals often seek help in primary care rather than mental health settings. Consequently, posttraumatic disturbances may go undiagnosed.

FINALLY

A public mental health perspective will help to develop preventive approaches to trauma and extend the impact of various forms of interventions. It will also make clear that trauma care will have to consider the community and the society at large. The concept of trauma is an attractive concept. It refers to both spectacular and shocking events that receive huge attention, such as acts of terrorism and large-scale calamities. Something dramatic happens that could happen to anyone: the cause appears to be clear and the responsibility appears to lay elsewhere. One could argue that traumatic experiences show us the limits of our abilities to master our lives and that they defy our efforts to control the circumstances. However, the concept of trauma is also a dangerous concept. It is often used too easy and too quick. Not every stressful event is a traumatic experience and not every person confronted with war, disaster, or terror is traumatized. Overstretching the concept may create the risk of medicalization of regular difficulties of the afflicted people and ignoring the self-reliance and the adaptive skills of them.

AUTHOR CONTRIBUTIONS

I am the sole author. I designed and wrote the manuscript.

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Traumatic stress: effects on the brain

J. Douglas Bremner, MD

Brain areas implicated in the stress response include the amygdala, hippocampus, and prefrontal cortex. Traumatic stress can be associated with lasting changes in these brain areas. Traumatic stress is associated with increased cortisol and norepinephrine responses to subsequent stressors. Antidepressants have effects on the hippocampus that counteract the effects of stress. Findings from animal studies have been extended to patients with post-traumatic stress disorder (PTSD) showing smaller hippocampal and anterior cingulate volumes, increased amygdala function, and decreased medial prefrontal/anterior cingulate function. In addition, patients with PTSD show increased cortisol and norepinephrine responses to stress. Treatments that are efficacious for PTSD show a promotion of neurogenesis in animal studies, as well as promotion of memory and increased hippocampal volume in PTSD.

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Author affiliations: Departments of Psychiatry and Behavioral Sciences and Radiology, and the Emory Center for Positron Emission Tomography, Emory University School of Medicine, Atlanta, Ga, and the Atlanta VAMC, Decatur, Ga, USA

Address for correspondence: J Douglas Bremner, MD, Emory University, 1256 Briarcliff Rd, Room 308e, Atlanta, GA 30306, USA
(e-mail: jdbremn@emory.edu)

Effects of traumatic stress

Traumatic stressors such as early trauma can lead to post-traumatic stress disorder (PTSD), which affects about 8% of Americans at some time in their lives,[1] as well as depression,[2,3] substance abuse,[1,4] dissociation,[5] personality disorders,[6,7] and health problems.[8] For many trauma victims, PTSD can be a lifelong problem.[9] The President's New Freedom Commission Report highlights the importance of providing services for mental disorders related to early trauma.[10-12] However, the development of effective treatments is limited by gaps in knowledge about the underlying neurobiological mechanisms that mediate symptoms of trauma-related disorders like PTSD. This paper reviews preclinical and clinical studies on the effects of traumatic stress on the brain.

Normal development of the brain across the lifespan

To understand how traumatic stress occurring at different stages of the life cycle interacts with the developing brain, it is useful to review normal brain development. The normal human brain undergoes changes in structure and function across the lifespan from early childhood to late life. Understanding these normal developmental changes is critical for determining the difference between normal development and pathology, and how normal development and pathology interact.

Although the bulk of brain development occurs in utero, the brain continues to develop after birth. In the first 5 years of life there is an overall expansion of brain volume related to development of both gray matter and white

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Selected abbreviations and acronyms

ACTH	*adrenocorticotropic hormone*
BDNF	*brain-derived neurotropic factor*
BPD	*bipolar disorder*
CRF	*corticotropin-releasing factor*
CS	*conditioned stimulus*
FDG	*fluorodeoxyglucose*
HPA	*hypothalamic-pituitary-adrenal*
MRI	*magnetic resonance imaging*
mRNA	*messenger ribonucleic acid*
NAA	N-*acetyl aspartate*
PET	*positron emission tomography*
PTSD	*post-traumatic stress disorder*
US	*unconditioned stimulus*

matter structures; however, from 7 to 17 years of age there is a progressive increase in white matter (felt to be related to ongoing myelination) and decrease in gray matter (felt to be related to neuronal pruning) while overall brain size stays the same.[13-16] Gray matter areas that undergo the greatest increases throughout this latter developmental epoch include frontal cortex and parietal cortex.[17,18] Basal ganglia decrease in size, while corpus callosum,[19,20] hippocampus, and amygdala[21-23] appear to increase in size during childhood, although there may be developmental sex-laterality effects for some of these structures.[24] Overall brain size is 10% larger in boys than girls during childhood.[24]

During the middle part of life (from age 20 to 70) there is a gradual decrease in caudate,[25] diencephalon,[25] and gray matter,[25,26] which is most pronounced in the temporal[27] and frontal cortex,[26] with enlargement of the ventricles[26,27] and no change in white matter.[25,26] Studies have not been able to document changes in hippocampal volume in normal populations during this period.[27] After menopause in women at about the age of 50, however, there are changes in reproductive hormones, such as decreased levels of estrogen. Since estrogen promotes neuronal branching in brain areas such as the hippocampus,[28] a loss of estrogen may lead to changes in neuronal structure. Although the effects of menopause on the brain have not been well studied, it is known that sex hormones also affect brain function and circuitry[29]; therefore, the changes in sex hormones with menopause will presumably affect brain function, as well as possibly structure. There is some evidence in super-elderly individuals (age >70) for modest reductions in hippocampal volume with late stages of aging.[27,30] More robust findings have included increased ventricular volume and reduction in gray matter, temporal lobe, and cerebellum volumes with normal aging, that begins before the age of 70.[25,27,31-33]

Therefore, trauma at different stages in life will presumably have different effects on brain development. The few studies that have looked at this issue do suggest that there are differences in the effects of trauma on neurobiology, depending on the stage of development at which the trauma occurs. Studies in this area, however, have been limited.

Neurobiology of PTSD

PTSD is characterized by specific symptoms, including intrusive thoughts, hyperarousal, flashbacks, nightmares, and sleep disturbances, changes in memory and concentration, and startle responses. Symptoms of PTSD are hypothesized to represent the behavioral manifestation of stress-induced changes in brain structure and function. Stress results in acute and chronic changes in neurochemical systems and specific brain regions, which result in long-term changes in brain "circuits," involved in the stress response.[34-37] Brain regions that are felt to play an important role in PTSD include hippocampus, amygdala, and medial prefrontal cortex. Cortisol and norepinephrine are two neurochemical systems that are critical in the stress response *(Figure 1)*.

The corticotropin-releasing factor (CRF)/hypothalamic-pituitary-adrenal (HPA) axis system plays an important role in the stress response. CRF is released from the hypothalamus, with stimulation of adrenocorticotropic hormone (ACTH) release from the pituitary, resulting in glucocorticoid (cortisol in man) release from the adrenal, which in turn has a negative feedback effect on the axis at the level of the pituitary, as well as central brain sites including hypothalamus and hippocampus. Cortisol has a number of effects which facilitate survival. In addition to its role in triggering the HPA axis, CRF acts centrally to mediate fear-related behaviors,[38] and triggers other neurochemical responses to stress, such as the noradrenergic system via the brain stem locus coeruleus.[39] Noradrenergic neurons release transmitter throughout the brain; this is associated with an increase in alerting and vigilance behaviors, critical for coping with acute threat.[40-42]

Studies in animals showed that early stress has lasting effects on the HPA axis and norepinephrine. A variety of early stressors resulted in increased glucocorticoid

response to subsequent stressors.[43-45] Maternally deprived rats had decreased numbers of glucocorticoid receptors in the hippocampus, hypothalamus, and frontal cortex.[46] Stressed animals demonstrated an inability to terminate the glucocorticoid response to stress,[47,48] as well as deficits in fast-feedback of glucocorticoids on the HPA axis, which could be related to decreased glucocorticoid receptor binding in the hippocampus.[49] Early postnatal adverse experiences increase hypothalamic CRF messenger ribonucleic acid (mRNA), median eminence CRF content, and stress-induced glucocorticoid[50] and ACTH release.[46] These effects could be mediated by an increase in synthesis of CRH mRNA following stress.[51] In nonhuman primates, adverse early experiences resulted in long-term effects on behaviors, as well as elevated levels of CRF in the cerebrospinal fluid.[52] Exposure to chronic stress results in potentiation of noradrenergic responsiveness to subsequent stressors and increased release of norepinephrine in the hippocampus and other brain regions.[42]

Preclinical and clinical studies have shown alterations in memory function following traumatic stress,[53] as well as changes in a circuit of brain areas, including hippocampus, amygdala, and medial prefrontal cortex, that mediate alterations in memory.[54] The hippocampus, a brain area involved in verbal declarative memory, is very sensitive to the effects of stress. Stress in animals is associated with damage to neurons in the CA3 region of the hippocampus (which may be mediated by hypercortisolemia, decreased brain-derived neurotrophic factor (BDNF), and/or elevated glutamate levels) and inhibition of neurogenesis.[55-60] High levels of glucocorticoids seen with stress were also associated with deficits in new learning.[61,62]

Antidepressant treatments have been shown to block the effects of stress and/or promote neurogenesis.[58,63-66] Animal studies have demonstrated several agents with

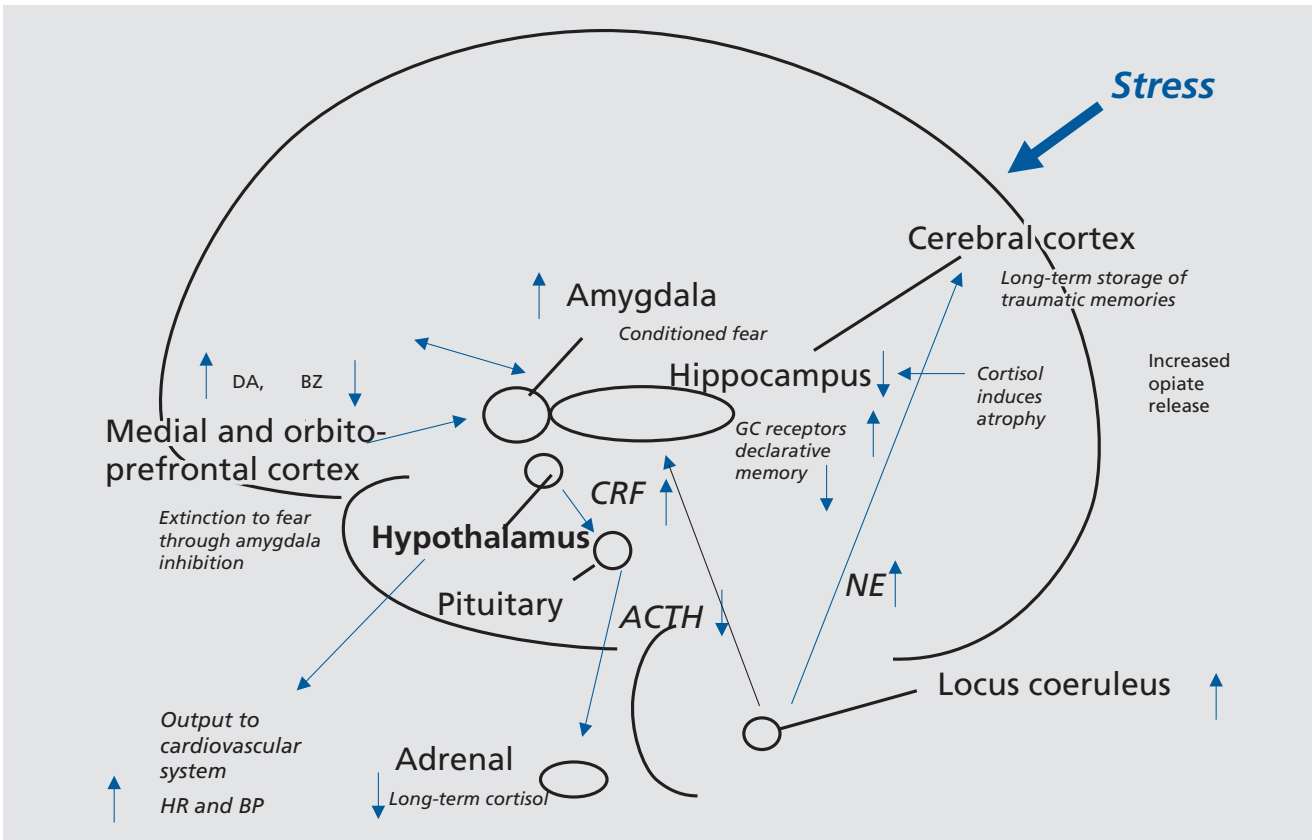

Figure 1. Lasting effects of trauma on the brain, showing long-term dysregulation of norepinephrine and cortisol systems, and vulnerable areas of hippocampus, amygdala, and medial prefrontal cortex that are affected by trauma. GC, glucocorticoid; CRF, corticotropin-releasing factor; ACTH, adrenocorticotropin hormone; NE, norepinephrine; HR, heart rate; BP, blood pressure; DA, dopamine; BZ, benzodiazapine; GC, glucocorticoid

potentially beneficial effects on stress-induced hippocampal damage. It has been found that phenytoin blocks the effects of stress on the hippocampus, probably through modulation of excitatory amino acid-induced neurotoxicity.[67] Other agents, including tianeptine, dihydroepiandosterone (DHEA), and fluoxetine have similar effects.[63,64,66,68-73] These medications may share a common mechanism of action through upregulation of cyclic adenosine monophosphate (cAMP) response element binding protein (CREB) that may lead to regulation of expression of specific target genes involved in structural modeling of the hippocampus. Such treatment effects on BDNF and trkB messenger ribonucleic acid (mRNA), can have long-term effects on brain structure and function. There is new evidence that neurogenesis is necessary for the behavioral effects of antidepressants,[74,75] although this continues to be a source of debate.[72,76]

The hippocampus demonstrates an unusual capacity for neuronal plasticity and regeneration. In addition to findings noted above related to the negative effects of stress on neurogenesis, it has recently been demonstrated that changes in the environment, eg, social enrichment or learning, can modulate neurogenesis in the dentate gyrus of the hippocampus, and slow the normal age-related decline in neurogenesis.[77,78] Rat pups that are handled frequently within the first few weeks of life (picking them up and then returning them to their mother) had increased type II glucocorticoid receptor binding which persisted throughout life, with increased feedback sensitivity to glucocorticoids, and reduced glucocorticoid-mediated hippocampal damage in later life.[79] These effects appear to be due to a type of "stress inoculation" from the mothers' repeated licking of the handled pups.[80] Considered together, these findings suggest that early in the postnatal period there is a naturally occurring brain plasticity in key neural systems that may "program" an organism's biological response to stressful stimuli. These findings may have implications for victims of childhood abuse.

Long-term dysregulation of the HPA axis is associated with PTSD, with low levels of cortisol found in chronic PTSD in many studies[81-86] and elevations in CRF.[82,87] Not all studies, however, have found lower cortisol levels in PTSD.[88-91] Exposure to a traumatic reminder appears to be associated with a potentiated release of cortisol in PTSD.[92]

The few studies of the effects of early stress on neurobiology conducted in clinical populations of traumatized children have generally been consistent with findings from animal studies. Research in traumatized children has been complicated by issues related to psychiatric diagnosis and assessment of trauma.[93] Some studies have not specifically examined psychiatric diagnosis, while others have focused on children with trauma and depression, and others on children with trauma and PTSD. Sexually abused girls (in which effects of specific psychiatric diagnosis were not examined) had normal baseline cortisol and blunted ACTH response to CRF,[94] while women with childhood abuse-related PTSD had hypercortisolemia.[95] Another study of traumatized children in which the diagnosis of PTSD was established showed increased levels of cortisol measured in 24-hour urines.[96] Emotionally neglected children from a Romanian orphanage had elevated cortisol levels over a diurnal period compared with controls.[97] Maltreated school-aged children with clinical-level internalizing problems had elevated cortisol compared with controls.[98] Depressed preschool children showed increased cortisol response to separation stress.[99] Adult women with a history of childhood abuse showed increased suppression of cortisol with low-dose (0.5 mg) dexamethasone.[100] Women with PTSD related to early childhood sexual abuse showed decreased baseline cortisol based on 24-hour diurnal assessments of plasma, and exaggerated cortisol response to stressors (traumatic stressors[101] more than neutral cognitive stressors).[102] We also found that patients with PTSD had less of an inhibition of memory function with synthetic cortisol (dexamethasone) than normal subjects.[103] Adult women with depression and a history of early childhood abuse had an increased cortisol response to a stressful cognitive challenge relative to controls,[104] and a blunted ACTH response to CRF challenge.[105] These findings show long-term changes in stress responsive systems. Early in development, stress is associated with increased cortisol and norepinephrine responsiveness, whereas with adulthood, resting cortisol may be normal or low, but there continues to be increased cortisol and norepinephrine responsiveness to stressors. In addition, early stress is associated with alterations in hippocampal morphology which may not manifest until adulthood, as well as increased amygdala function and decreased medial prefrontal function.

Cognitive function and brain structure in PTSD

Studies in PTSD are consistent with changes in cognition and brain structure. Multiple studies have demonstrated verbal declarative memory deficits in PTSD.[53,106-108]

Patients with PTSD secondary to combat[109-113] and childhood abuse[114,115] were found to have deficits in verbal declarative memory function based on neuropsychological testing. Studies, using a variety of measures (including the Wechsler Memory Scale, the visual and verbal components of the Selective Reminding Test, the Auditory Verbal Learning Test, Paired Associate Recall, the California Verbal New Learning Test, and the Rivermead Behavioral Memory Test), found specific deficits in verbal declarative memory function, with a relative sparing of visual memory and IQ.[109-113,115-124] These studies have been conducted in both patients with PTSD related to Vietnam combat,[109-113,116,119-121,123] rape,[117] the Holocaust,[124-126] adults with early childhood abuse,[115] and traumatized children.[118] One study in adult rape survivors showed that verbal declarative memory deficits are specifically associated with PTSD, and are not a nonspecific effect of trauma exposure.[117] Another study of women with early childhood sexual abuse in which some, but not all, of the patients had PTSD, showed no difference between abused and nonabused women,[127] while another study was not able to show a difference between Vietnam veterans with and without PTSD.[128] Other types of memory disturbances studied in PTSD include gaps in memory for everyday events (dissociative amnesia),[129] deficits in autobiographical memory,[130] an attentional bias for trauma-related material,[131-140] and frontal lobe-related impairments.[141] These studies suggest that traumas such as early abuse with associated PTSD result in deficits in verbal declarative memory. It is not clear if cognitive deficits in early abuse survivors are specific to PTSD and are not related to the nonspecific effects of abuse.

These effects were specific to verbal (not visual) memory, and were significant after controlling for IQ. Some of these studies used neuropsychological tests of declarative memory, such as the Wechsler Memory Scale (WMS) and Selective Reminding Test (SRT), that have been validated as sensitive to loss of neurons in the CA3 region of the hippocampus in epileptics who underwent hippocampal resection.[142,143] Vietnam veterans with PTSD were originally shown by us to have 8% smaller right hippocampal volume based on magnetic resonance imaging (MRI) relative to controls matched for a variety of factors such as alcohol abuse and education ($P<0.05$); smaller volume was correlated with deficits in verbal declarative memory function as measured with the Wechsler Memory Scale.[144] A second study from our group showed a 12% reduction in left hippocampal volume in 17 patients with childhood abuse-related PTSD compared with 17 case-matched controls, that was significant after controlling for confounding factors.[145] Smaller hippocampal volume was shown to be specific to PTSD within the anxiety disorders, and was not seen in panic disorder.[146] Gurvits et al[147] showed bilateral hippocampal volume reductions in combat-related PTSD compared with combat veterans without PTSD and normal controls. Combat severity was correlated with volume reduction. Stein et al[148] found a 5% reduction in left hippocampal volume. Other studies in PTSD have found smaller hippocampal volume and/or reductions in *N*-acetyl aspartate (NAA), a marker of neuronal integrity.[149-153] Studies in childhood[154-156] and new-onset[157,158] PTSD did not find hippocampal volume reduction, although reduced NAA (indicating loss of neuronal integrity) was found in medial prefrontal cortex in childhood PTSD.[159] In a recent meta-analysis we pooled data from all of the published studies and found smaller hippocampal volume for both the left and the right sides, equally in adult men and women with chronic PTSD, and no change in children.[160] More recent studies of holocaust survivors with PTSD did not find a reduction in hippocampal volume, although PTSD patients who developed PTSD in response to an initial trauma had smaller hippocampal volume compared with those who developed PTSD after repeated trauma, suggesting a possible vulnerability of smaller hippocampal volume.[161] Two independent studies have shown that PTSD patients have deficits in hippocampal activation while performing a verbal declarative memory task,[149,162] although it is unclear if this is a deficit in activation or higher hippocampal blood flow at baseline. Both hippocampal atrophy and hippocampal-based memory deficits reversed with treatment with the selective serotonin reuptake inhibitor (SSRI) paroxetine, which has been shown to promote neurogenesis (the growth of neurons) in the hippocampus in preclinical studies.[163] In addition, treatment with the anticonvulsant phenytoin led to an improvement in PTSD symptoms[164] and an increase in right hippocampal and right cerebral volume.[165] We hypothesize that stress-induced hippocampal dysfunction may mediate many of the symptoms of PTSD which are related to memory dysregulation, including both explicit memory deficits as well as fragmentation of memory in abuse survivors. It is unclear at the current time whether these changes are specific to PTSD, whether certain common environmental events (eg, stress) in different disorders lead to similar brain changes, or whether common genetic traits lead to similar outcomes.

The meaning of findings related to deficits in memory and the hippocampus in PTSD, and questions related to the relative contribution of genetic and environmental factors, has become an important topic in the field of PTSD and stress research. There are three possible models, taking into account genetic or environmental factors, which have been proposed to explain smaller hippocampal volume in PTSD: Model A (Environment), Model B (Environment and Genetic), and Model C (Genetic).[166-169] In Model C (Genetic), smaller hippocampal volume represents a premorbid risk factor for PTSD. In support of this model Pitman and colleagues[170] have demonstrated that lower premilitary IQ is associated with combat-related PTSD, as well as finding a correlation between PTSD symptoms and hippocampal volume in twin brothers.[151] Model A (Environment) states that stress leads to damage or inhibition of neurogenesis via hypercortisolemia, decreased BDNF, or increased glutamate. Model B (Environment/Genetic) states that a combination of environmental and genetic factors leads to deficits in hippocampal function and structure. Showing that an intervention like medication changes hippocampal volume and cognition would provide support for at least a partial contribution of the environment to the outcomes of interest.

In addition to the hippocampus, other brain structures have been implicated in a neural circuitry of stress, including the amygdala and prefrontal cortex. The amygdala is involved in memory for the emotional valence of events, and plays a critical role in the acquisition of fear responses. The medial prefrontal cortex includes the anterior cingulate gyrus (Brodmann's area [BA] 32) and subcallosal gyrus (area 25) as well as orbitofrontal cortex. Lesion studies demonstrated that the medial prefrontal cortex modulates emotional responsiveness through inhibition of amygdala function. Conditioned fear responses are extinguished following repeated exposure to the conditioned stimulus in the absence of the unconditioned (aversive, eg, electric shock) stimulus. This inhibition appears to be mediated by medial prefrontal cortical inhibition of amygdala responsiveness.

Animal studies also show that early stress is associated with a decrease in branching of neurons in the medial prefrontal cortex.[171] Rauch and colleagues found smaller volume of the anterior cingulate based on MRI measurements in PTSD[172]; we have replicated these findings in women with abuse and PTSD.[160] An important question is whether these effects are reversible with treatment.

Neural circuits in PTSD

Brain imaging studies have shown alterations in a circuit including medial prefrontal cortex (including anterior cingulate), hippocampus, and amygdala in PTSD. Many of these studies have used different methods to trigger PTSD symptoms (eg, using traumatic cues) and then look at brain function. Stimulation of the noradrenergic system with yohimbine resulted in a failure of activation in dorsolateral prefrontal, temporal, parietal, and orbitofrontal cortex, and decreased function in the hippocampus.[173] Exposure to traumatic reminders in the form of traumatic slides and/or sounds or traumatic scripts was associated with an increase in PTSD symptoms, decreased blood flow, and/or failure of activation in the medial prefrontal cortex/anterior cingulate, including Brodmann's area 25, or subcallosal gyrus, area 32 and 24, as measured with positron emission tomography (PET) or functional MRI (fMRI).[174-183] Other findings in studies of traumatic reminder exposure include decreased function in hippocampus,[176] visual association cortex,[176,180] parietal cortex,[176,179,180,184] and inferior frontal gyrus,[176,179,180,184] and increased function in amygdala,[181,184] posterior cingulate,[174,176,177,180] and parahippocampal gyrus.[174,176,178] Shin and colleagues found a correlation between increased amygdala function and decreased medial prefrontal function with traumatic reminders,[181] indicating a failure of inhibition of the amygdala by the medial prefrontal cortex that could account for increased PTSD symptoms with traumatic reminders. Other studies found increased amygdala and parahippocampal function and decreased medial prefrontal function during performance of an attention task,[182] increased posterior cingulate and parahippocampal gyrus and decreased medial prefrontal and dorsolateral prefrontal function during an emotional Stroop paradigm,[185] and increased amygdala function with exposure to masked fearful faces.[186] Retrieval of emotionally valenced words[187] (eg "rape-mutilate") in women with PTSD from early abuse resulted in decreases in blood flow in an extensive area which included orbitofrontal cortex, anterior cingulate, and medial prefrontal cortex (BA 25, 32, and 9), left hippocampus, and fusiform gyrus/inferior temporal gyrus, with increased activation in posterior cingulate, left inferior parietal cortex, left middle frontal gyrus, and visual association and motor cortex.[188] Another study found a failure of medial prefrontal cortical/anterior cingulate activation, and decreased visual association and parietal

cortex function, in women with abuse and PTSD relative to women with abuse without PTSD, during performance of the emotional Stroop task (ie, naming the color of a word such as "rape").[189] We recently found increased amygdala activation with classical fear conditioning (pairing a shock and a visual stimulus), and decreased medial prefrontal cortex function with extinction, in abuse-related PTSD.[190] The findings described above point to a network of related regions mediating symptoms of PTSD, including medial prefrontal cortex, anterior cingulate, hippocampus, amygdala, posterior cingulate, parietal, visual association, and dorsolateral prefrontal cortex.[191]

Fewer brain imaging studies have been performed in children with PTSD. Several studies have shown alterations in electroencephalogram (EEG) measures of brain activity in children with a variety of traumas who were not selected for diagnosis compared with healthy children. About half of the children in these studies had a psychiatric diagnosis. Abnormalities were located in the anterior frontal cortex and temporal lobe and were localized to the left hemisphere.[192,193] Two studies have found reductions in brain volume in children with trauma and PTSD symptoms.[154,155] One group did not find reductions in hippocampal volume, either at baseline or over a longitudinal period,[154,156] while another group found an 8.5% reduction in hippocampal volume that was not significant after controlling for smaller brain volumes in the PTSD group.[155] One study used single-voxel proton magnetic resonance spectroscopy (proton MRS) to measure relative concentration of NAA and creatinine (a marker of neuronal viability) in the anterior cingulate of 11 children with maltreatment-related PTSD and 11 controls. The authors found a reduction in the ratio of NAA to creatinine in PTSD relative to controls.[159] Studies have also found smaller size of the corpus callosum in children with abuse and PTSD relative to controls.[154] as well as larger volume of the superior temporal gyrus.[194] In a study of abused children in whom diagnosis was not specified, there was an increase in T2 relaxation time in the cerebellar vermis, suggesting dysfunction in this brain region.[195] The reason for differences in findings between adults and children are not clear; however, factors such as chronicity of illness or interaction between trauma and development may explain findings to date.

In summary, dysfunction of a circuit involving the medial prefrontal cortex, dorsolateral prefrontal cortex, and possibly hippocampus and amygdala during exposure to traumatic reminders may underlie symptoms of PTSD. These studies have primarily assessed neural correlates of traumatic remembrance, while little has been done in the way of utilizing cognitive tasks as probes of specific regions, such as memory tasks as probes of hippocampal function.

MRI assessment of brain abnormalities in PTSD and trauma spectrum disorders

Findings of smaller hippocampal volume appear to be associated with a range of trauma related psychiatric disorders, as long as there is the presence of psychological trauma. We have used MRI to show smaller hippocampal volume in PTSD,[144,145,149,196] depression,[197] depression with early abuse,[198] borderline personality disorder (BPD) with early abuse,[199] and Dissociative Identity Disorder (DID) with early abuse.[200] The greatest magnitude of difference was seen in the DID patients, who had unusually severe early childhood sexual abuse histories. We did not find changes in hippocampal volume in patients with panic disorder without a history of abuse (suggesting that findings are not generalized to other anxiety disorders).[201] We found smaller amygdala volume in BPD with early abuse[199] and increased amygdala volume in depression.[197,202] Patients with depression had smaller orbitofrontal cortex volume with no changes in anterior cingulate (BA 32) or medial prefrontal cortex (BA 25).[203] More recently, we found smaller anterior cingulate volume in women with abuse and PTSD relative to controls.[204]

Neural circuits in women with abuse and PTSD

We have used PET to study neural circuits of trauma-related disorders in women with early abuse and a variety of trauma spectrum mental disorders. Initially we studied women with abuse and PTSD.[54,205-208] We initially measured brain activation with a paragraph-encoding task in conjunction with PET O-15 water measurement of brain blood flow. Women with abuse and PTSD showed a failure of hippocampal activation during the memory task relative to controls.[149] Women with abuse and PTSD in this study also had smaller hippocampal volume measured with MRI relative to both women with abuse without PTSD and nonabused non-PTSD women. The failure of hippocampal activation was significant

after controlling differences in hippocampal volume as well as accuracy of encoding. In another study we measured neural correlates of exposure to a personalized script of childhood sexual abuse. Women with abuse and PTSD showed a failure of medial prefrontal and hippocampal activation relative to abused women without PTSD.[176] Women with abuse and PTSD also showed a failure of medial prefrontal and hippocampal function during recall of paired word associates with traumatic-emotional content (eg, "rape-mutilate"),[188] and decreased medial prefrontal function during an emotional Stroop task with trauma-content words.[209] Other studies showed a failure of medial prefrontal activation in women with BPD and early abuse during an abandonment script.[210] Women with BPD and abuse had increased psychophysiological responses to abandonment scripts relative to trauma scripts, while women with PTSD and abuse had the opposite pattern,[211] indicating differential responding in those two disorders in spite of the common exposure to early abuse.

In another project we studied 19 physically healthy women including women with a history of severe childhood sexual abuse and the diagnosis of current PTSD (N=8) and women without childhood abuse or PTSD (N=11).[212] All subjects underwent PET measurement of cerebral blood flow and psychophysiology measurement of heart rate and skin conductance during habituation, acquisition, and extinction conditions, on a single day, with scanning during a control condition on another day separated by 1 week from the active condition. Subjects were randomly assigned to undergo either the active condition or the control condition first (ie, active-control or control-active). Subjects were told at the beginning of the study that they would be exposed to electric shocks and viewing images on a screen during collection of PET and psychophysiology data. During habituation subjects were exposed to a blue square on a screen (conditioned stimulus [CS]), 4 seconds in duration, followed by 6 seconds of a blank screen. CS exposure was repeated eight times at regular intervals over 80 seconds in two separate blocks separated by 8 minutes. One PET image of brain blood flow was obtained starting from the beginning of each of the blocks. During active fear acquisition exposure to the blue square (CS) was paired with an electric shock to the forearm (unconditioned stimulus [UCS]). Subjects had 8 paired CS-UCS presentations at 10-second intervals for each of two blocks. With extinction subjects were again exposed to the blue squares (CS) without shock ("active" extinction). On a second day subjects went through the same procedure with electric shocks delivered randomly when the blue square was not present (unpaired CS-UCS) (an equal number as on day 1) during scans 3 and 4, which served as a control for active fear acquisition.

PTSD subjects had increased symptoms of anxiety, fear, dissociation, distress, substance use disorders (SUDs), and PTSD at all time points during both study days relative to non-PTSD. Acquisition of fear was associated with increased skin conductance (SC) responses to CS exposure during the active versus the control conditions in all subjects. There was increased SC for PTSD during the first CS-UCS presentation. Extinction of fear was associated with increased skin conductance (SC) responses to CS exposure during the active versus the control conditions in all subjects. When PTSD and non-PTSD subjects were examined separately, SC levels were significantly elevated in non-PTSD subjects undergoing extinction following the active compared with the control condition during session one.

PTSD subjects showed activation of the bilateral amygdala during fear acquisition compared with the control condition. Non-PTSD subjects showed an area of activation in the region of the left amygdala. When PTSD subjects and control subjects were directly compared, PTSD subjects showed greater activation of the left amygdala during the fear conditioning condition (pairing of US and CS) relative to the random shock control than healthy women. Other areas that showed increased activation with fear acquisition in PTSD included bilateral superior temporal gyrus (BA 22), cerebellum, bilateral inferior frontal gyrus (BA 44, 45), and posterior cingulate (BA 24). Fear acquisition was associated with decreased function in medial prefrontal cortex, visual association cortex, and medial temporal cortex, inferior parietal lobule function, and other areas. Extinction of fear responses was associated with decreased function in the orbitofrontal and medial prefrontal cortex (including subcallosal gyrus, BA 25, and anterior cingulate BA 32), visual association cortex, and other areas, in the PTSD subjects, but not in the controls. Amygdala blood flow with fear acquisition was negatively correlated with medial prefrontal blood flow with fear extinction (increased blood flow in amygdala correlated with decreased blood flow in medial prefrontal cortex) in all subjects (r=-0.48; P<0.05). Increased amygdala blood flow with fear acquisition was positively correlated with PTSD (r=0.45), anxiety (r=0.44) and disso-

ciative (r=0.80) symptom levels in PTSD (but not non-PTSD) subjects. There was a negative correlation between medial prefrontal blood flow during extinction and anxiety as measured with the Panic Attack Symptom Scale (PASS) during extinction in the PTSD group only, which was significant after correction for multiple comparisons (r=-0.90; P=0.006).[190] This study was consistent with increased amygdala function with fear acquisition, and decreased medial prefrontal (anterior cingulate) function during extinction in PTSD. This is consistent with the model of an overactive amygdala and a failure of medial prefrontal cortex to extinguish, or shut off, the amygdala, when the acute threat is no longer present.

Treatment of PTSD

Intervening soon after the trauma is critical for long-term outcomes, since with time traumatic memories become indelible and resistant to treatment.[213] Early treatments are not necessarily effective. For instance, studies have shown that Critical Incident Stress Debriefing (CISD) can be associated with a worsening of outcome relative to no treatment at all.[214] Pharmacological treatment of chronic PTSD has shown efficacy originally for imipramine,[215] amitriptyline,[216] and phenalzine,[215] and later for brofaramine,[217] paroxetine,[218,219] and sertraline.[220] Selective serotonin reuptake inhibitors (SSRIs) and tianeptine are now recommended as first-line treatment for PTSD.[221-226]

The utility of early treatment is also demonstrated by animal studies showing that pretreatment before stress with antidepressants reduces chronic behavioral deficits related to stress.[227,228] Antidepressants, including both norepinephrine and serotonin reuptake inhibitors, as well as gabapentine and phenytoin, promote nerve growth (neurogenesis) in the hippocampus, while stress inhibits neurogenesis.[63,64,66,69,71,75,229] This is important because hippocampal neurogenesis has been shown to be required for antidepressant response.[74]

Few studies have examined the effects of pharmacological treatment on brain structure and function in patients with trauma-related mental disorders. We studied a group of patients with depression and found no effect of fluoxetine on hippocampal volume, although there were increases in memory function[230] and hippocampal activation measured with PET during a memory encoding task. Depressed patients with a history of childhood trauma were excluded, and we subsequently have found hippocampal volume reductions at baseline in women with early abuse and depression but not in women with depression without early abuse;[198] this suggests that the study design of excluding patients with early trauma may account for the negative result. Other studies in depression showed that smaller hippocampal volume was a predictor of resistance to antidepressant treatment.[231] Smaller orbitofrontal cortex volume is associated with depression; one study in geriatric depression found smaller orbitofrontal cortex volume, while length of antidepressant exposure was correlated with larger orbitofrontal volume.[232]

Several studies have looked at functional brain imaging response to antidepressants in depression. Single photon-emission computed tomography (SPECT) blood flow studies in depression showed that antidepressants increased anterior cingulate, right putamen, and right thalamus function.[233] SPECT Xenon-133 studies showed reduced prefrontal function at baseline in depression, with treatment responders showing reduced perfusion in prefrontal cortex compared with nonresponders after treatment.[234] In a fluorodeoxyglucose (FDG) PET study of brain function patients with depression treated with fluoxetine who had a positive response to treatment had limbic and striatal decreases (subgenual cingulate, hippocampus, insula, and pallidum) and brain stem and dorsal cortical increases (prefrontal, parietal, anterior, and posterior cingulate) in function. Failed response was associated with a persistent 1-week pattern and absence of either subgenual cingulate or prefrontal changes.[235] Sertraline resulted in an increase in middle frontal gyrus activity in depression measured with PET FDG, as well as increased function in right parietal lobe and visual association cortex.[236] Successful paroxetine therapy of depression was associated with increased glucose metabolism measured with PET in dorsolateral, ventrolateral, and medial aspects of the prefrontal cortex, parietal cortex, and dorsal anterior cingulate. Areas of decreased metabolism were noted in both anterior and posterior insular regions (left) as well as right hippocampal and parahippocampal regions.[237] In another PET FDG study, at baseline, subjects with depression had higher normalized metabolism than controls in the prefrontal cortex (and caudate and thalamus), and lower metabolism in the temporal lobe. With treatment with paroxetine, subjects with depression had metabolic changes in the direction of normalization in these regions.[238] A PET FDG study of patients with depression and controls showed that at baseline, the mean metabolism was increased in the left and right lateral orbital cortex/ventrolateral prefrontal cortex (PFC), left amygdala,

and posterior cingulate cortex, and decreased in the subgenual anterior cingulate cortex (ACC) and dorsal medial/dorsal anterolateral PFC in depressives relative to controls. Following treatment with antidepressants, metabolism significantly decreased in the left amygdala and left subgenual ACC. The metabolic reduction in the amygdala and right subgenual ACC appeared largely limited to those subjects who both responded to treatment and remained well at 6 months' follow-up.[239] Another study showed that antidepressant treatment of depression resulted in a decrease in amygdala activation with emotional faces as measured with fMRI.[240] In summary, studies show changes in limbic and prefrontal cortical regions with successful antidepressant treatment of depression.

Fewer studies have looked at the effects of pharmacological treatment on the brain in anxiety disorders. One PET FDG study showed that caudate function decreased with treatment of obsessive compulsive disorder with antidepressants.[241] Paroxetine resulted in a decrease in glutamate/glutamine measured with magnetic resonance spectroscopy (MRS) in children with obsessive-compulsive disorder (OCD).[242] Patients with PTSD were shown to have an increase in hippocampal volume and memory function with paroxetine,[163] and increased right hippocampal and right cerebral volume with phenytoin.[165] No published studies have looked at the effects of pharmacological treatment on brain function in PTSD, or on sensitive markers of brain chemistry like NAA.

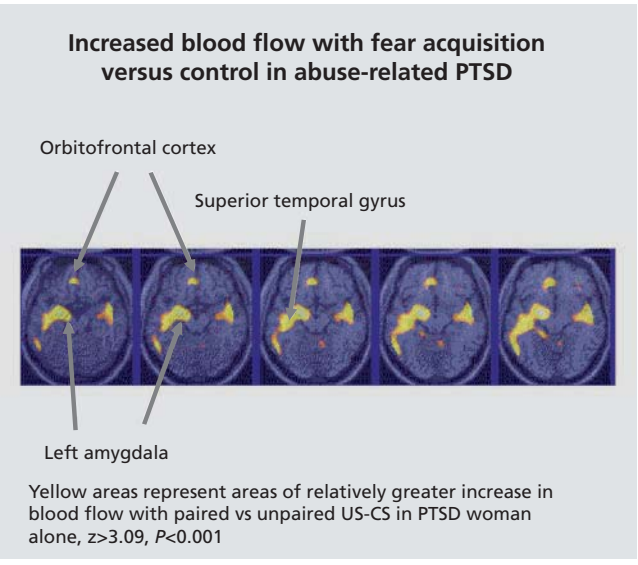

Figure 2. Neural correlates of fear conditioning in women with abuse and PTSD. There was increased amygdala activation with fear acquisition using a classical conditioning paradigm relative to non-PTSD abused women. PTSD, post-traumatic stress disorder

Brain biomarkers like NAA represent an objective marker of neural plasticity. To date psychiatry has relied on subjective reports as the gold standard. However, this is limited by self-reporting and the subjective interpretations of symptoms and response to treatment. Brain markers of antidepressant response may provide a complementary approach to assessing response to treatment, as well as providing insight into the mechanisms of treatment response. Our group is trying to look at mechanisms in the brain underlying treatment response in PTSD.

Effects of pharmacotherapy on brain function and structure in PTSD

We have begun to assess the effects of pharmacotherapy on brain structure and function in PTSD.[243] We recently assessed the effects of phenytoin on brain structure and function. Studies in animals show that phenytoin, which is used in the treatment of epilepsy and is known to modulate glutamatergic function, blocks the effects of stress on the hippocampus.[67] We studied nine patients with PTSD in an open-label function before and after treatment with phenytoin. Phenytoin resulted in a significant improvement in PTSD symptoms.[164] Phenytoin also resulted in increases in both right hippocampal volume and right hemisphere volume.[165] These findings indicate that phenytoin has an effects on PTSD symptoms as well as brain structure in PTSD patients.

We have assessed the effects of open-label paroxetine on memory and the hippocampus in PTSD. Male and female patients with symptoms of PTSD were medication-free for at least 4 weeks before participation in the study. Twenty-eight patients were found to be eligible and started the medication phase. Of the total patient sample five patients did not finish due to noncompliance; 23 patients completed the study.

Before patients started the medication phase, neuropsychological tests were administered, including the *Wechsler Adult Intelligence Scale – Revised*, WAIS-R (arithmetic, vocabulary, picture arrangement, and block design test), two subtests of the *Wechsler Memory Scale-Revised*, WMS-R, including logical memory (free recall of two story narratives, which represents verbal memory) and figural memory (which represents visual memory and involved reproduction of designs after a 6-second presentation); and the verbal and visual components of

the *Selective Reminding Test*, SRT.

Paroxetine was prescribed in the first visit after the pre-treatment assessments. All patients started open-label with a dose of 10 mg daily and were titrated up to 20 mg in 4 days.

Paroxetine treatment resulted in a mean 54% reduction in PTSD symptoms as measured with mean changes from baseline on the CAPS total score ($P<0.005$) among study completers. Improvement was equally strong on all symptom cluster scores (Re-experiencing, Avoidance/Numbing, Hyperarousal). Treatment also resulted in significant improvements in verbal declarative memory as measured with the WMS-R paragraph recall for delayed recall ($P<0.005$) and percent retention (80.2 to 91.1; $P=0.003$), but not immediate recall. Improvements were significant on all subscales of the Verbal Component of the SRT; including long-term recall and delayed recall.

Repeated measures ANOVA with side as the repeated measure showed a main effect for treatment related to a 4.6% increase in mean hippocampal volume (1857.3 mm^3 [SD 225.6] to 1906.2 mm^3, [SD 243.2]) with treatment (F=8.775 df=1. 36; $P=0.005$). Increased hippocampal volume was seen for both left (5.6%) (1807.6 mm^3 [SD 255.5] to 1909.3 mm^3 [SD 236.9]) and right (3.7%) (1906.9 mm^3 [SD 195.8] to 1976.7 mm^3 (SD 249.6]) hippocampus. There was no change in whole brain volume with treatment. Increase in hippocampal volume was significant after adding whole brain volume before and after treatment to the model.

Discussion

Traumatic stress has a broad range of effects on brain function and structure, as well as on neuropsychological components of memory. Brain areas implicated in the stress response include the amygdala, hippocampus, and prefrontal cortex. Neurochemical systems, including cortisol and norepinephrine, play a critical role in the stress response. These brain areas play an important role in the stress response. They also play a critical role in memory, highlighting the important interplay between memory and the traumatic stress response. Preclinical studies show that stress affects these brain areas. Furthermore, antidepressants have effects on the hippocampus that counteract the effects of stress. In fact, promotion of nerve growth (neurogenesis) in the hippocampus may be central to the efficacy of the antidepressants. Studies in patients with PTSD show alterations in brain areas implicated in animal studies, including the amygdala, hippocampus, and prefrontal cortex, as well as in neurochemical stress response systems, including cortisol and norepinephrine. Treatments that are efficacious for PTSD show a promotion of neurogenesis in animal studies, as well as promotion of memory and increased hippocampal volume in PTSD. Future studies are needed to assess neural mechanisms in treatment response in PTSD. ❑

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Estrés traumático: efectos en la cerebro

El estrés traumático surte efectos muy diversos sobre la función y la estructura cerebrales. Las regiones cerebrales implicadas en la respuesta al estrés son la amígdala (núcleo amigdalino), el hipocampo y la corteza prefrontal. Los sistemas neuroquímicos, como el cortisol y la noradrenalina, desempeñan una misión crítica en la respuesta al estrés. Estas regiones cerebrales influyen sobre la respuesta al estrés y sobre la memoria, lo que subraya la interrelación entre la memoria y la respuesta al estrés traumático. Los antidepresivos actúan sobre el hipocampo y contrarrestan el efecto del estrés. Los estudios sobre pacientes con trastorno por estrés postraumático (TEPT) revelan alteraciones en las regiones cerebrales implicadas en los estudios con animales como la amígdala, el hipocampo y la corteza prefrontal, así como en los sistemas neuroquímicos de respuesta al estrés, entre ellos el cortisol y la noradrenalina. Los tratamientos con eficacia frente al TEPT promueven la neurogénesis en los estudios con animales y también aumentan la memoria, y el volumen hipocámpico en el TEPT. Se requieren nuevos estudios para evaluar los mecanismos neurales de la respuesta terapéutica en el TEPT.

Effets du stress traumatique sur le cerveau

Le stress traumatique exerce une grande variété d'effets sur la fonction et la structure cérébrales. Les aires cérébrales impliquées dans la réponse au stress comprennent l'amygdale, l'hippocampe et le cortex préfrontal. Les systèmes neurochimiques, incluant le cortisol et la norépinéphrine, jouent un rôle critique dans la réponse au stress. Ces aires cérébrales influent sur la mémoire et sur la réponse au stress traumatique, soulignant ainsi les interactions existant entre les deux. Les effets des antidépresseurs sur l'hippocampe compensent les effets du stress. Les études chez les patients atteints de trouble stress post-traumatique (ESPT) montrent des modifications des aires cérébrales impliquées au cours des études animales, telles l'amygdale, l'hippocampe et le cortex préfrontal, ainsi que des modifications des systèmes neurochimiques de réponse au stress comme le cortisol et la noradrénaline. Les traitements efficaces dans l'ESPT entraînent une activation de la neurogenèse chez l'animal de même qu'une amélioration de la mémoire et une augmentation du volume de l'hippocampe dans l'ESPT. Il faudra d'autres études pour évaluer les mécanismes neuronaux dans la réponse thérapeutique au cours de l'ESPT.

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Trauma-Informed Care in Behavioral Health Services

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

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Consensus Panel

Note: Each panelist's information reflects his or her affiliation at the time of the Consensus Panel meeting and may not reflect that person's most current affiliation.

Chair

Lisa M. Najavits, Ph.D.
Research Psychologist
Veterans Affairs Boston Healthcare System
Professor of Psychiatry
Boston University School of Medicine
Boston, MA

Co-Chair

Linda B. Cottler, Ph.D., M.P.H.
Professor of Epidemiology in Psychiatry
Department of Psychiatry
Washington University–St. Louis
St. Louis, MO

Workgroup Leaders

Stephanie S. Covington, Ph.D., LCSW, MFCC
Co-Director
Center for Gender and Justice
Institute for Relational Development
La Jolla, CA

Margaret Cramer, Ph.D.
Clinical Psychologist/Clinical Instructor
Harvard Medical School
Boston, MA

Anne M. Herron, M.S.
Director
Treatment Programming
New York State Office of Alcoholism and Substance Abuse Services
Albany, NY

Denise Hien, Ph.D.
Research Scholar
Social Intervention Group
School of Social Work
Columbia University
New York, NY

Dee S. Owens, M.P.A.
Director
Alcohol-Drug Information
Indiana University
Bloomington, IN

Panelists

Charlotte Chapman, M.S., LPC, CAC
Training Director
Division of Addiction Psychiatry
Mid-Atlantic Addiction Technology Transfer Center
Virginia Commonwealth University
Richmond, VA

Scott F. Coffey, Ph.D.
Associate Professor
Department of Psychiatry and Human Behavior
University of Mississippi Medical Center
Jackson, MS

Renee M. Cunningham-Williams, M.S.W., M.P.E., Ph.D.
Research Assistant/Professor of Social Work
Department of Psychiatry
Washington University
St. Louis, MO

Chad D. Emrick, Ph.D.
Administrative Director
Substance Abuse Treatment Program
Denver VA Medical Center (116A1)
Denver, CO

Charles R. Figley, Ph.D.
Professor
Director of the Traumatology Institute
Florida State University
Tallahassee, FL

Larry M. Gentilello, M.D., FACS
Professor and Chairman
Division of Burn, Trauma, and Critical Care
University of Texas Southwestern Medical School
Dallas, TX

Robert Grant, Ph.D.
Trauma Consultant
Oakland, CA

Anthony (Tony) Taiwai Ng, M.D.
Disaster Psychiatrist
Washington, DC

Pallavi Nishith, Ph.D.
Associate Research Professor
Center for Trauma
Department of Psychology
University of Missouri–St. Louis
St. Louis, MO

Joseph B. Stone, Ph.D., CACIII, ICADC
Program Manager and Clinical Supervisor
Confederated Tribes of Grand Ronde Behavioral Health Program
Grand Ronde, OR

Michael Villanueva, Ph.D.
Research Professor
Center on Alcoholism, Substance Abuse, and Addiction
Albuquerque, NM

KAP Expert Panel and Federal Government Participants

Barry S. Brown, Ph.D.
Adjunct Professor
University of North Carolina–Wilmington
Carolina Beach, NC

Jacqueline Butler, M.S.W., LISW, LPCC, CCDC III, CJS
Professor of Clinical Psychiatry
College of Medicine
University of Cincinnati
Cincinnati, OH

Deion Cash
Executive Director
Community Treatment and Correction Center, Inc.
Canton, OH

Debra A. Claymore, M.Ed.Adm.
Owner/Chief Executive Officer
WC Consulting, LLC
Loveland, CO

Carlo C. DiClemente, Ph.D.
Chair
Department of Psychology
University of Maryland–Baltimore County
Baltimore, MD

Catherine E. Dube, Ed.D.
Independent Consultant
Brown University
Providence, RI

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief, Services
Division of Clinical and Services Research
National Institute on Drug Abuse
Bethesda, MD

Michael Galer, D.B.A.
Independent Consultant
Westminster, MA

Renata J. Henry, M.Ed.
Director
Division of Alcoholism, Drug Abuse and Mental Health
Delaware Department of Health and Social Services
New Castle, DE

Joel Hochberg, M.A.
President
Asher & Partners
Los Angeles, CA

Jack Hollis, Ph.D.
Associate Director, Center for Health Research
Kaiser Permanente
Portland, OR

Mary Beth Johnson, M.S.W.
Director
Addiction Technology Transfer Center
University of Missouri–Kansas City
Kansas City, MO

Eduardo Lopez
Executive Producer
EVS Communications
Washington, DC

Holly A. Massett, Ph.D.
Academy for Educational Development
Washington, DC

Diane Miller
Chief
Scientific Communications Branch
National Institute on Alcohol Abuse and Alcoholism
Bethesda, MD

Harry B. Montoya, M.A.
President/Chief Executive Officer
Hands Across Cultures
Española, NM

Richard K. Ries, M.D.
Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, WA

Gloria M. Rodriguez, D.S.W.
Research Scientist
Division of Addiction Services
New Jersey Department of Health and Senior Services
Trenton, NJ

Everett Rogers, Ph.D.
Center for Communications Programs
Johns Hopkins University
Baltimore, MD

Jean R. Slutsky, P.A., M.S.P.H.
Senior Health Policy Analyst
Agency for Healthcare Research & Quality
Rockville, MD

Nedra Klein Weinreich, M.S.
President
Weinreich Communications
Canoga Park, CA

Clarissa Wittenberg
Director
Office of Communications and Public Liaison
National Institute of Mental Health
Bethesda, MD

Consulting Members of the KAP Expert Panel

Paul Purnell, M.A
Social Solutions, LLC
Potomac, MD

Scott Ratzan, M.D., M.P.A., M.A.
Academy for Educational Development
Washington, DC

Thomas W. Valente, Ph.D.
Director
Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Los Angeles, CA

Patricia A. Wright, Ed.D.
Independent Consultant
Baltimore, MD

What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://store.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

Pamela S. Hyde, J.D.
Administrator
Substance Abuse and Mental Health Services Administration

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Frances M. Harding
Director
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

How This TIP Is Organized

This Treatment Improvement Protocol (TIP) is divided into three parts:

- Part 1: *A Practical Guide for the Provision of Behavioral Health Services*
- Part 2: *An Implementation Guide for Behavioral Health Program Administrators*
- Part 3: *A Review of the Literature*

Part 1 is for behavioral health service providers and consists of six chapters. Recurring themes include the variety of ways that substance abuse, mental health, and trauma interact; the importance of context and culture in a person's response to trauma; trauma-informed screening and assessment tools, techniques, strategies, and approaches that help behavioral health professionals assist clients in recovery from mental and substance use disorders who have also been affected by acute or chronic traumas; and the significance of adhering to a strengths-based perspective that acknowledges the resilience within individual clients, providers, and communities.

Chapter 1 lays the groundwork and rationale for the implementation and provision of trauma-informed services. It provides an overview of specific trauma-informed intervention and treatment principles that guide clinicians, other behavioral health workers, and administrators in becoming trauma informed and in creating a trauma-informed organization and workforce. Chapter 2 provides an overview of traumatic experiences. It covers types of trauma; distinguishes among traumas that affect individuals, groups, and communities; describes trauma characteristics; and addresses the socioecological and cultural factors that influence the impact of trauma. Chapter 3 broadly focuses on understanding the impact of trauma, trauma-related stress reactions and associated symptoms, and common mental health and substance use disorders associated with trauma. Chapter 4 provides an introduction to screening and assessment as they relate to trauma and is devoted to screening and assessment processes and tools that are useful in evaluating trauma exposure, its effects, and client intervention and treatment needs. Chapter 5 covers clinical issues that counselors and other behavioral health professionals may need to know and address when treating clients who have histories of trauma. Chapter 6 presents information on specific treatment models for trauma, distinguishing integrated models (which address substance use disorders, mental disorders, and trauma simultaneously) from those that treat trauma alone.

Advice to Counselors and/or Administrators boxes in Part 1 provide practical information for providers. Case illustrations, exhibits, and text boxes further illustrate information in the text by offering practical examples.

Part 2 provides an overview of programmatic and administrative practices that will help behavioral health program administrators increase the capacity of their organizations to deliver

trauma-informed services. Chapter 1 examines the essential ingredients, challenges, and processes in creating and implementing trauma-informed services within an organization. Chapter 2 focuses on key development activities that support staff members, including trauma-informed training and supervision, ethics, and boundaries pertinent to responding to traumatic stress, secondary trauma, and counselor self-care.

Advice to Administrators and/or Supervisors boxes in Part 2 highlight more detailed information that supports the organizational implementation of trauma-informed care (TIC). In addition, case illustrations, organizational activities, and text boxes reinforce the material presented within this section.

Part 3 is a literature review on TIC and behavioral health services and is intended for use by clinical supervisors, interested providers, and administrators. Part 3 has three sections: an analysis of the literature, links to select abstracts of the references most central to the topic, and a general bibliography of the available literature. To facilitate ongoing updates (performed periodically for up to 3 years from first publication), the literature review is only available online at the Substance Abuse and Mental Health Services Administration (SAMHSA) Publications Ordering Web page (http://store.samhsa.gov).

Terminology

Behavioral health: Throughout the TIP, the term "behavioral health" is used. Behavioral health refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illness and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used in this TIP to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use and related problems, treatments and services for mental and substance use disorders, and recovery support. Because behavioral health conditions, taken together, are the leading causes of disability burden in North America, efforts to improve their prevention and treatment will benefit society as a whole. Efforts to reduce the impact of mental and substance use disorders on America's communities, such as those described in this TIP, will help achieve nationwide improvements in health.

Client/consumer: In this TIP, the term "client" means anyone who seeks or receives mental health or substance abuse services. The term "consumer" stands in place of "client" in content areas that address consumer participation and determination. It is not the intent of this document to ignore the relevance and historical origin of the term "consumer" among individuals who have received, been subject to, or are seeking mental health services. Instead, we choose the word "client," given that this terminology is also commonly used in substance abuse treatment services. Note: This TIP also uses the term "participant(s)" instead of "client(s)" for individuals, families, or communities seeking or receiving prevention services.

Complex trauma: This manual adopts the National Child Traumatic Stress Network (NCTSN) definition of complex trauma. The term refers to the pervasive impact, including developmental

consequences, of exposure to multiple or prolonged traumatic events. According to the NCTSN Web site (http://www.nctsn.org/trauma-types), complex trauma typically involves exposure to sequential or simultaneous occurrences of maltreatment, "including psychological maltreatment, neglect, physical and sexual abuse, and domestic violence…. Exposure to these initial traumatic experiences—and the resulting emotional dysregulation and the loss of safety, direction, and the ability to detect or respond to danger cues—often sets off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood" (NCTSN, 2013).

Co-occurring disorders: When an individual has one or more mental disorders as well as one or more substance use disorders (including substance abuse), the term "co-occurring" applies. Although people may have a number of health conditions that co-occur, including physical problems, the term "co-occurring disorders," in this TIP, refers to substance use and mental disorders.

Cultural responsiveness and cultural competence: This TIP uses these terms interchangeably, with "responsiveness" applied to services and systems and "competence" applied to people, to refer to "a set of behaviors, attitudes, and policies that…enable a system, agency, or group of professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 13). Culturally responsive behavioral health services and culturally competent providers "honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services…. [C]ultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time" (U.S. Department of Health and Human Services, 2003, p. 12).

Evidence-based practices: There are many different uses of the term "evidence-based practices." One of the most widely accepted is that of Chambless and Hollon (1998), who say that for a treatment to be considered evidence based, it must show evidence of positive outcomes based on peer-reviewed randomized controlled trials or other equivalent strong methodology. A treatment is labeled "strong" if criteria are met for what Chambless and Hollon term "well-established" treatments. To attain this level, rigorous treatment outcome studies conducted by independent investigators (not just the treatment developer) are necessary. Research support is labeled "modest" when treatments attain criteria for what Chambless and Hollon call "probably efficacious treatments." To meet this standard, one well-designed study or two or more adequately designed studies must support a treatment's efficacy. In addition, it is possible to meet the "strong" and "modest" thresholds through a series of carefully controlled single-case studies. An evidence-based practice derived from sound, science-based theories incorporates detailed and empirically supported procedures and implementation guidelines, including parameters of applications (such as for populations), inclusionary and exclusionary criteria for participation, and target interventions.

Promising practices: Even though current clinical wisdom, theories, and professional and expert consensus may support certain practices, these practices may lack support from studies that are scientifically rigorous in research design and statistical analysis; available studies may be limited in number or sample size, or they may not be applicable to the current setting or population. This TIP refers to such practices as "promising."

Recovery: This term denotes a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Major dimensions that support a life in recovery, as defined by SAMHSA, include:

- ***Health:*** overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.
- ***Home:*** a stable and safe place to live.
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- ***Community:*** relationships and social networks that provide support, friendship, love, and hope.

Resilience: This term refers to the ability to bounce back or rise above adversity as an individual, family, community, or provider. Well beyond individual characteristics of hardiness, resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events. This TIP applies the term "resilience" and its processes to individuals across the life span.

Retraumatization: In its more literal translation, "retraumatization" means the occurrence of traumatic stress reactions and symptoms after exposure to multiple events (Duckworth & Follette, 2011). This is a significant issue for trauma survivors, both because they are at increased risk for higher rates of retraumatization, and because people who are traumatized multiple times often have more serious and chronic trauma-related symptoms than those with single traumas. In this manual, the term not only refers to the effect of being exposed to multiple events, but also implies the process of reexperiencing traumatic stress as a result of a current situation that mirrors or replicates in some way the prior traumatic experiences (e.g., specific smells or other sensory input; interactions with others; responses to one's surroundings or interpersonal context, such as feeling emotionally or physically trapped).

Secondary trauma: Literature often uses the terms "secondary trauma," "compassion fatigue," and "vicarious traumatization" interchangeably. Although compassion fatigue and secondary trauma refer to similar physical, psychological, and cognitive changes and symptoms that behavioral health workers may encounter when they work specifically with clients who have histories of trauma, vicarious trauma usually refers more explicitly to specific cognitive changes, such as in worldview and sense of self (Newell & MacNeil, 2010). This publication uses "secondary trauma" to describe trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event. Secondary trauma can occur among behavioral health service providers across all behavioral health settings and among all professionals who provide services to those who have experienced trauma (e.g., healthcare providers, peer counselors, first responders, clergy, intake workers).

Substance abuse: Throughout the TIP, the term "substance abuse" has been used to refer to both substance abuse and substance dependence. This term was chosen partly because behavioral health professionals commonly use the term substance abuse to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs to determine what possible range of meanings it covers; in most cases, it will refer to all varieties of substance-related

disorders as found in *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (American Psychiatric Association, 2013a).

Trauma: In this text, the term "trauma" refers to experiences that cause intense physical and psychological stress reactions. It can refer to "a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Although many individuals report a single specific traumatic event, others, especially those seeking mental health or substance abuse services, have been exposed to multiple or chronic traumatic events. See the "What Is Trauma" section in Part 1, Chapter 1, for a more indepth definition and discussion of trauma.

Trauma-informed: A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. In May 2012, SAMHSA convened a group of national experts who identified three key elements of a trauma-informed approach: "(1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice" (SAMHSA, 2012, p 4).

Trauma-informed care: TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.

Trauma-specific treatment services: These services are evidence-based and promising practices that facilitate recovery from trauma. The term "trauma-specific services" refers to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.

Trauma survivor: This phrase can refer to anyone who has experienced trauma or has had a traumatic stress reaction. Knowing that the use of language and words can set the tone for recovery or contribute to further retraumatization, it is the intent of this manual to put forth a message of hope by avoiding the term "victim" and instead using the term "survivor" when appropriate.

Part 1: A Practical Guide for the Provision of Behavioral Health Services

1 Trauma-Informed Care: A Sociocultural Perspective

IN THIS CHAPTER

- Scope of the TIP
- Intended Audience
- Before You Begin
- Structure of the TIP
- What Is Trauma?
- Trauma Matters in Behavioral Health Services
- Trauma Informed Intervention and Treatment Principles
- As You Proceed

Many individuals who seek treatment in behavioral health settings have histories of trauma, but they often don't recognize the significant effects of trauma in their lives; either they don't draw connections between their trauma histories and their presenting problems, or they avoid the topic altogether. Likewise, treatment providers may not ask questions that elicit a client's history of trauma, may feel unprepared to address trauma-related issues proactively, or may struggle to address traumatic stress effectively within the constraints of their treatment program, the program's clinical orientation, or their agency's directives.

By recognizing that traumatic experiences and their sequelae tie closely into behavioral health problems, front-line professionals and community-based programs can begin to build a trauma-informed environment across the continuum of care. Key steps include meeting client needs in a safe, collaborative, and compassionate manner; preventing treatment practices that retraumatize people with histories of trauma who are seeking help or receiving services; building on the strengths and resilience of clients in the context of their environments and communities; and endorsing trauma-informed principles in agencies through support, consultation, and supervision of staff.

This Treatment Improvement Protocol (TIP) begins by introducing the scope, purpose, and organization of the topic and describing its intended audience. Along with defining trauma and trauma-informed care (TIC), the first chapter discusses the rationale for addressing trauma in behavioral health services and reviews trauma-informed intervention and treatment principles. These principles serve as the TIP's conceptual framework.

Scope of the TIP

Many individuals experience trauma during their lifetimes. Although many people exposed to trauma demonstrate few or no lingering symptoms, those individuals who have experienced repeated, chronic, or multiple traumas are more likely to exhibit pronounced symptoms and consequences, including substance abuse, mental illness, and health problems. Subsequently, trauma can significantly affect how an individual engages in major life areas as well as treatment.

This TIP provides evidence-based and best practice information for behavioral health service providers and administrators who want to work more effectively with people who have been exposed to acute and chronic traumas and/or are at risk of developing traumatic stress reactions. Using key trauma-informed principles, this TIP addresses trauma-related prevention, intervention, and treatment issues and strategies in behavioral health services. The content is adaptable across behavioral health settings that service individuals, families, and communities—placing emphasis on the importance of coordinating as well as integrating services.

Intended Audience

This TIP is for behavioral health service providers, prevention specialists, and program administrators—the professionals directly responsible for providing care to trauma survivors across behavioral health settings, including substance abuse and mental health services. This TIP also targets primary care professionals, including physicians; teams working with clients and communities who have experienced trauma; service providers in the criminal justice system; and researchers with an interest in this topic.

Before You Begin

This TIP endorses a trauma-informed model of care; this model emphasizes the need for behavioral health practitioners and organizations to recognize the prevalence and pervasive impact of trauma on the lives of the people they serve and develop trauma-sensitive or trauma-responsive services. This TIP provides key information to help behavioral health practitioners and program administrators become trauma aware and informed, improve screening and assessment processes, and implement science-informed intervention strategies across settings and modalities in behavioral health services. Whether provided by an agency or an individual provider, trauma-informed services may or may not include trauma-specific services or trauma specialists (individuals who have advanced training and education to provide specific treatment interventions to address traumatic stress reactions). Nonetheless, TIC anticipates the role that trauma can play across the continuum of care—establishing integrated and/or collaborative processes to address the needs of traumatized individuals and communities proactively.

Individuals who have experienced trauma are at an elevated risk for substance use disorders, including abuse and dependence; mental health problems (e.g., depression and anxiety symptoms or disorders, impairment in relational/social and other major life areas, other distressing symptoms); and physical disorders and conditions, such as sleep disorders. This TIP focuses on specific types of prevention (Institute of Medicine et al., 2009): selective prevention, which targets people who are at risk for developing social, psychological, or other conditions as a result of trauma or who are at greater risk for experiencing trauma due to behavioral health disorders or conditions; and indicated prevention, which targets people who display early signs of trauma-related

symptoms. This TIP identifies interventions, including trauma-informed and trauma-specific strategies, and perceives treatment as a means of prevention—building on resilience, developing safety and skills to negotiate the impact of trauma, and addressing mental and substance use disorders to enhance recovery.

This TIP's target population is adults. Beyond the context of family, this publication does not examine or address youth and adolescent responses to trauma, youth-tailored trauma-informed strategies, or trauma-specific interventions for youth or adolescents, because the developmental and contextual issues of these populations require specialized interventions. Providers who work with young clients who have experienced trauma should refer to the resource list in Appendix B. This TIP covers TIC, trauma characteristics, the impact of traumatic experiences, assessment, and interventions for persons who have had traumatic experiences. Considering the vast knowledge base and specificity of individual, repeated, and chronic forms of trauma, this TIP does not provide a comprehensive overview of the unique characteristics of each type of trauma (e.g., sexual abuse, torture, war-related trauma, murder). Instead, this TIP provides an overview supported by examples. For more information on several specific types of trauma, please refer to TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (Center for Substance Abuse Treatment [CSAT], 2000b), TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b), TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d), and the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (Substance Abuse and Mental Health Services Administration [SAMHSA], planned f).

This TIP, *Trauma-Informed Care in Behavioral Health Services*, is guided by SAMHSA's Strategic Initiatives described in *Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014* (SAMHSA, 2011b). Specific to Strategic Initiative #2, Trauma and Justice, this TIP addresses several goals, objectives, and actions outlined in this initiative by providing behavioral health practitioners, supervisors, and administrators with an introduction to culturally responsive TIC.

Specifically, the TIP presents fundamental concepts that behavioral health service providers can use to:

- Become trauma aware and knowledgeable about the impact and consequences of traumatic experiences for individuals, families, and communities.
- Evaluate and initiate use of appropriate trauma-related screening and assessment tools.
- Implement interventions from a collaborative, strengths-based approach, appreciating the resilience of trauma survivors.
- Learn the core principles and practices that reflect TIC.
- Anticipate the need for specific trauma-informed treatment planning strategies that support the individual's recovery.
- Decrease the inadvertent retraumatization that can occur from implementing standard organizational policies, procedures, and interventions with individuals, including clients and staff, who have experienced trauma or are exposed to secondary trauma.
- Evaluate and build a trauma-informed organization and workforce.

The consensus panelists, as well as other contributors to this TIP, have all had experience as substance abuse and mental health counselors, prevention and peer specialists, supervisors, clinical directors, researchers, or administrators working with individuals, families, and

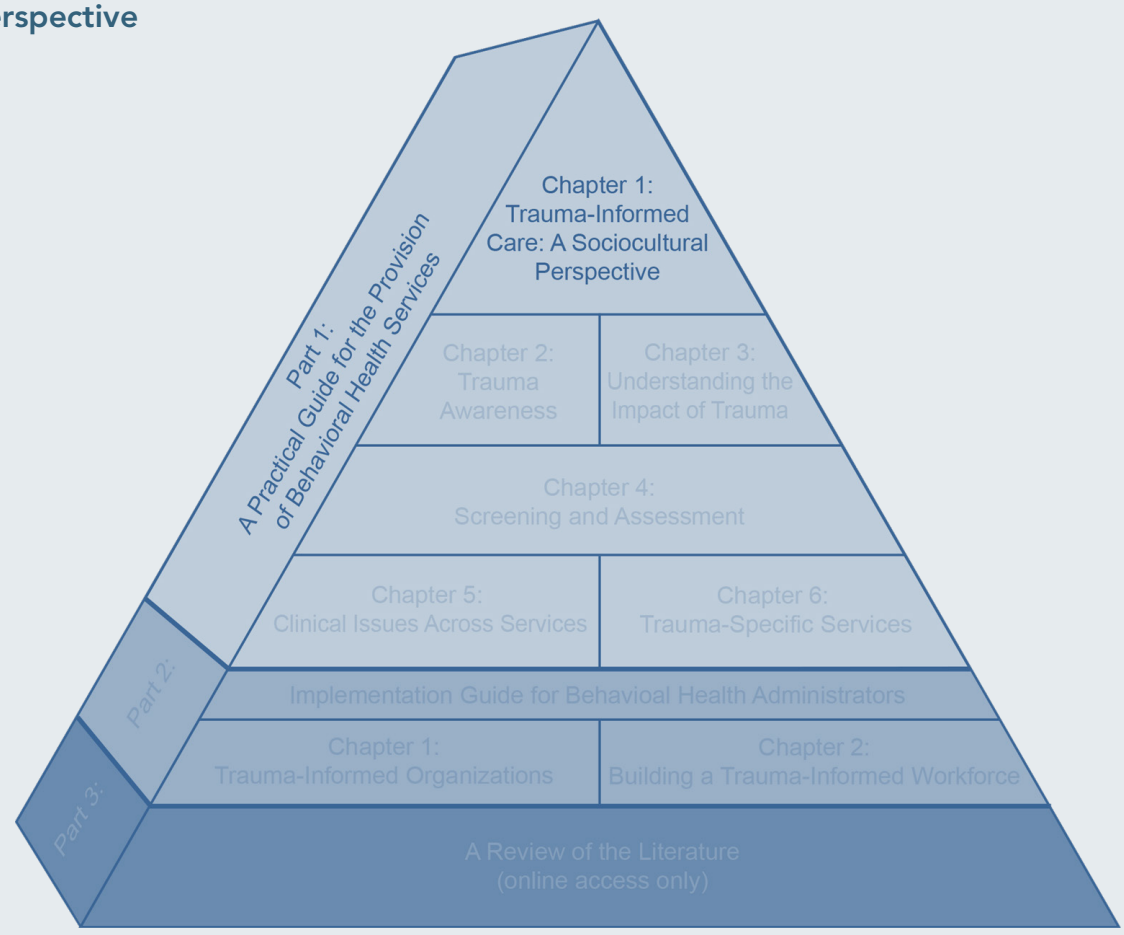
communities who have experienced trauma. The material presented in this TIP uses the wealth of their experience in addition to the available published resources and research relevant to this topic. Throughout the consensus process, the panel members were mindful of the strengths and resilience inherent in individuals, families, and communities affected by trauma and the challenges providers face in addressing trauma and implementing TIC.

Structure of the TIP

Using a TIC framework (Exhibit 1.1-1), this TIP provides information on key aspects of trauma, including what it is; its consequences; screening and assessment; effective prevention, intervention, and treatment approaches; trauma recovery; the impact of trauma on service providers; programmatic and administrative practices; and trauma resources.

Note: To produce a user-friendly but informed document, the first two parts of the TIP include minimal citations. If you are interested in the citations associated with topics covered in Parts 1 and 2, please consult the review of the literature provided in Part 3 (available online at http://store.samhsa.gov). Parts 1 and 2 are easily read and digested on their own, but it is highly recommended that you read the literature review as well.

Exhibit 1.1-1: TIC Framework in Behavioral Health Services—Sociocultural Perspective



What Is Trauma?

According to SAMHSA's Trauma and Justice Strategic Initiative, "trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Trauma can affect people of every race, ethnicity, age, sexual orientation, gender, psychosocial background, and geographic region. A traumatic experience can be a single event, a series of events, and/or a chronic condition (e.g., childhood neglect, domestic violence). Traumas can affect individuals, families, groups, communities, specific cultures, and generations. It generally overwhelms an individual's or community's resources to cope, and it often ignites the "fight, flight, or freeze" reaction at the time of the event(s). It frequently produces a sense of fear, vulnerability, and helplessness.

See Appendix C to read about the history of trauma and trauma interventions.

Often, traumatic events are unexpected. Individuals may experience the traumatic event directly, witness an event, feel threatened, or hear about an event that affects someone they know. Events may be human-made, such as a mechanical error that causes a disaster, war, terrorism, sexual abuse, or violence, or they can be the products of nature (e.g., flooding, hurricanes, tornadoes). Trauma can occur at any age or developmental stage, and often, events that occur outside expected life stages are perceived as traumatic (e.g., a child dying before a parent, cancer as a teen, personal illness, job loss before retirement).

It is not just the event itself that determines whether something is traumatic, but also the individual's experience of the event. Two people may be exposed to the same event or series of events but experience and interpret these events in vastly different ways. Various biopsychosocial and cultural factors influence an individual's immediate response and long-term reactions to trauma. For most, regardless of the severity of the trauma, the immediate or enduring effects of trauma are met with resilience—the ability to rise above the circumstances or to meet the challenges with fortitude.

For some people, reactions to a traumatic event are temporary, whereas others have prolonged reactions that move from acute symptoms to more severe, prolonged, or enduring mental health consequences (e.g., posttraumatic stress and other anxiety disorders, substance use and mood disorders) and medical problems (e.g., arthritis, headaches, chronic pain). Others do not meet established criteria for posttraumatic stress or other mental disorders but encounter significant trauma-related symptoms or culturally expressed symptoms of trauma (e.g., somatization, in which psychological stress is expressed through physical concerns). For that reason, even if an individual does not meet diagnostic criteria for trauma-related disorders, it is important to recognize that trauma may still affect his or her life in significant ways. For more information on traumatic events, trauma characteristics, traumatic stress reactions, and factors that heighten or decrease the impact of trauma, see Part 1, Chapter 2, "Trauma Awareness," and Part 1, Chapter 3, "Understanding the Impact of Trauma."

Trauma Matters in Behavioral Health Services

The past decade has seen an increased focus on the ways in which trauma, psychological distress, quality of life, health, mental illness,

and substance abuse are linked. With the attacks of September 11, 2001, and other acts of terror, the wars in Iraq and Afghanistan, disastrous hurricanes on the Gulf Coast, and sexual abuse scandals, trauma has moved to the forefront of national consciousness.

Trauma was once considered an abnormal experience. However, the first National Comorbidity Study established how prevalent traumas were in the lives of the general population of the United States. In the study, 61 percent of men and 51 percent of women reported experiencing at least one trauma in their lifetime, with witnessing a trauma, being involved in a natural disaster, and/or experiencing a life-threatening accident ranking as the most common events (Kessler et al., 1999). In Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions, 71.6 percent of the sample reported witnessing trauma, 30.7 percent experienced a trauma that resulted in injury, and 17.3 percent experienced psychological trauma (El-Gabalawy, 2012). For a thorough review of the impact of trauma on quality of life and health and among individuals with mental and substance use disorders, refer to Part 3 of this TIP, the online literature review.

Rationale for TIC

Integrating TIC into behavioral health services provides many benefits not only for clients, but also for their families and communities, for behavioral health service organizations, and for staff. Trauma-informed services bring to the forefront the belief that trauma can pervasively affect an individual's well-being, including physical and mental health. For behavioral health service providers, trauma-informed practice offers many opportunities. It reinforces the importance of acquiring trauma-specific knowledge and skills to meet the specific needs of clients; of recognizing that individuals may be affected by trauma regardless of its acknowledgment; of understanding that trauma likely affects many clients who are seeking behavioral health services; and of acknowledging that organizations and providers can retraumatize clients through standard or unexamined policies and practices. TIC stresses the importance of addressing the client individually rather than applying general treatment approaches.

TIC provides clients more opportunities to engage in services that reflect a compassionate perspective of their presenting problems. TIC can potentially provide a greater sense of safety for clients who have histories of trauma and a platform for preventing more serious consequences of traumatic stress (Fallot & Harris, 2001). Although many individuals may not identify the need to connect with their histories, trauma-informed services offer clients a chance to explore the impact of trauma, their strengths and creative adaptations in managing traumatic histories, their resilience, and the relationships among trauma, substance use, and psychological symptoms.

Two Influential Studies That Set the Stage for the Development of TIC

The Adverse Childhood Experiences Study (Centers for Disease Control and Prevention, 2013) was a large epidemiological study involving more than 17,000 individuals from United States; it analyzed the long-term effects of childhood and adolescent traumatic experiences on adult health risks, mental health, healthcare costs, and life expectancy.

The Women, Co-Occurring Disorders and Violence Study (SAMHSA, 2007) was a large multisite study focused on the role of interpersonal and other traumatic stressors among women; the interrelatedness of trauma, violence, and co-occurring substance use and mental disorders; and the incorporation of trauma-informed and trauma-specific principles, models, and services.

Implementing trauma-informed services can improve screening and assessment processes, treatment planning, and placement while also decreasing the risk for retraumatization. The implementation may enhance communication between the client and treatment provider, thus decreasing risks associated with misunderstanding the client's reactions and presenting problems or underestimating the need for appropriate referrals for evaluation or trauma-specific treatment. Organizational investment in developing or improving trauma-informed services may also translate to cost effectiveness, in that services are more appropriately matched to clients from the outset. TIC is an essential ingredient in organizational risk management; it ensures the implementation of decisions that will optimize therapeutic outcomes and minimize adverse effects on the client and, ultimately, the organization. A key principle is the engagement of community, clients, and staff. Clients and staff are more apt to be empowered, invested, and satisfied if they are involved in the ongoing development and delivery of trauma-informed services.

An organization also benefits from work development practices through planning for, attracting, and retaining a diverse workforce of individuals who are knowledgeable about trauma and its impact. Developing a trauma-informed organization involves hiring and promotional practices that attract and retain individuals who are educated and trained in trauma-informed practices on all levels of the organization, including board as well as peer support appointments. Trauma-informed organizations are invested in their staff and adopt similar trauma-informed principles, including establishing and providing ongoing support to promote TIC in practice and in addressing secondary trauma and implementing processes that reinforce the safety of the staff. Even though investing in a trauma-informed workforce does not necessarily guarantee trauma-informed practices, it is more likely that services will evolve more proficiently to meet client, staff, and community needs.

Advice to Counselors: The Importance of TIC

The history of trauma raises various clinical issues. Many counselors do not have extensive training in treating trauma or offering trauma-informed services and may be uncertain of how to respond to clients' trauma-related reactions or symptoms. Some counselors have experienced traumas themselves that may be triggered by clients' reports of trauma. Others are interested in helping clients with trauma but may unwittingly cause harm by moving too deeply or quickly into trauma material or by discounting or disregarding a client's report of trauma. Counselors must be aware of trauma-related symptoms and disorders and how they affect clients in behavioral health treatment.

Counselors with primary treatment responsibilities should also have an understanding of how to recognize trauma-related reactions, how to incorporate treatment interventions for trauma-related symptoms into clients' treatment plans, how to help clients build a safety net to prevent further trauma, how to conduct psychoeducational interventions, and when to make treatment referrals for further evaluations or trauma-specific treatment services. All treatment staff should recognize that traumatic stress symptoms or trauma-related disorders should not preclude an individual from mental health or substance abuse treatment and that all co-occurring disorders need to be addressed on some level in the treatment plan and setting. For example, helping a client in substance abuse treatment gain control over trauma-related symptoms can greatly improve the client's chances of substance abuse recovery and lower the possibility of relapse (Farley, Golding, Young, Mulligan, & Minkoff, 2004; Ouimette, Ahrens, Moos, & Finney, 1998). In addition, assisting a client in achieving abstinence builds a platform upon which recovery from traumatic stress can proceed.

Trauma and Substance Use Disorders

Many people who have substance use disorders have experienced trauma as children or adults (Koenen, Stellman, Sommer, & Stellman, 2008; Ompad et al., 2005). Substance abuse is known to predispose people to higher rates of traumas, such as dangerous situations and accidents, while under the influence (Stewart & Conrod, 2003; Zinzow, Resnick, Amstadter, McCauley, Ruggiero, & Kilpatrick, 2010) and as a result of the lifestyle associated with substance abuse (Reynolds et al., 2005). In addition, people who abuse substances and have experienced trauma have worse treatment outcomes than those without histories of trauma (Driessen et al., 2008; Najavits et al., 2007). Thus, the process of recovery is more difficult, and the counselor's role is more challenging, when clients have histories of trauma. A person presenting with both trauma and substance abuse issues can have a variety of other difficult life problems that commonly accompany these disorders, such as other psychological symptoms or mental disorders, poverty, homelessness, increased risk of HIV and other infections, and lack of social support (Mills, Teesson, Ross, & Peters, 2006; Najavits, Weiss, & Shaw, 1997). Many individuals who seek treatment for substance use disorders have histories of one or more traumas. More than half of women seeking substance abuse treatment report one or more lifetime traumas (Farley, Golding, Young, Mulligan, & Minkoff, 2004; Najavits et al., 1997), and a significant number of clients in inpatient treatment also have subclinical traumatic stress symptoms or posttraumatic stress disorder (PTSD; Falck, Wang, Siegal, & Carlson, 2004; Grant et al., 2004; Reynolds et al., 2005).

Trauma and Mental Disorders

People who are receiving treatment for severe mental disorders are more likely to have histories of trauma, including childhood physical and sexual abuse, serious accidents, homelessness, involuntary psychiatric hospitalizations, drug overdoses, interpersonal violence, and other forms of violence. Many clients with severe mental disorders meet criteria for PTSD; others with serious mental illness who have histories of trauma present with psychological symptoms or mental disorders that are commonly associated with a history of trauma, including anxiety symptoms and disorders, mood disorders (e.g., major depression, dysthymia, bipolar disorder; Mueser et al., 2004), impulse control disorders, and substance use disorders (Kessler, Chiu, Demler, & Walters, 2005).

Traumatic stress increases the risk for mental illness, and findings suggest that traumatic stress increases the symptom severity of mental illness (Spitzer, Vogel, Barnow, Freyberger & Grabe, 2007). These findings propose that traumatic stress plays a significant role in perpetuating and exacerbating mental illness and suggest that trauma often precedes the development of mental disorders. As with trauma and substance use disorders, there is a bidirectional relationship; mental illness increases the risk of experiencing trauma, and trauma increases the risk of developing psychological symptoms and mental disorders. For a more comprehensive review of the interactions among traumatic stress, mental illness, and substance use disorders, refer to Part 3 of this TIP, the online literature review.

Trauma-Informed Intervention and Treatment Principles

TIC is an intervention and organizational approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health services from prevention through treatment. There are many definitions of TIC and various models for incorporating it across organizations, but a "trauma-informed approach incorporates three key elements: (1) *realizing* the prevalence of trauma; (2) *recognizing* how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) *responding* by putting this knowledge into practice" (SAMHSA, 2012, p. 4).

TIC begins with the first contact a person has with an agency; it requires all staff members (e.g., receptionists, intake personnel, direct care staff, supervisors, administrators, peer supports, board members) to recognize that the individual's experience of trauma can greatly influence his or her receptivity to and engagement with services, interactions with staff and clients, and responsiveness to program guidelines, practices, and interventions. TIC includes program policies, procedures, and practices to protect the vulnerabilities of those who have experienced trauma and those who provide trauma-related services. TIC is created through a supportive environment and by redesigning organizational practices, with consumer participation, to prevent practices that could be retraumatizing (Harris & Fallot, 2001c; Hopper et al., 2010). The ethical principle, "first, do no harm," resonates strongly in the application of TIC.

> "A program, organization, or system that is trauma informed realizes the widespread impact of trauma and under stands poten tial paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings."
>
> (SAMHSA, 2012, p. 4)

TIC involves a commitment to building competence among staff and establishing programmatic standards and clinical guidelines that support the delivery of trauma-sensitive services. It encompasses recruiting, hiring, and retaining competent staff; involving consumers, trauma survivors, and peer support specialists in the planning, implementation, and evaluation of trauma-informed services; developing collaborations across service systems to streamline referral processes, thereby securing trauma-specific services when appropriate; and building a continuity of TIC as consumers move from one system or service to the next. TIC involves reevaluating each service delivery component through a trauma-aware lens.

The principles described in the following subsections serve as the TIP's conceptual

Advice to Counselors: Implementing Trauma-Informed Services

Recognizing that trauma affects a majority of clients served within public health systems, the National Center for Trauma-Informed Care (NCTIC) has sought to establish a comprehensive framework to guide systems of care in the development of trauma-informed services. If a system or program is to support the needs of trauma survivors, it must take a systematic approach that offers trauma-specific diagnostic and treatment services, as well as a trauma-informed environment that is able to sustain such services, while fostering positive outcomes for the clients it serves. NCTIC also offers technical assistance in the implementation of trauma-informed services. For specific administrative information on TIC implementation, refer to Part 2, Chapters 1 and 2, of this TIP.

framework. These principles comprise a compilation of resources, including research, theoretical papers, commentaries, and lessons learned from treatment facilities. Key elements are outlined for each principle in providing services to clients affected by trauma and to populations most likely to incur trauma. Although these principles are useful across all prevention and intervention services, settings, and populations, they are of the utmost importance in working with people who have had traumatic experiences.

Promote Trauma Awareness and Understanding

Foremost, a behavioral health service provider must recognize the prevalence of trauma and its possible role in an individual's emotional, behavioral, cognitive, spiritual, and/or physical development, presentation, and well-being. Being vigilant about the prevalence and potential consequences of traumatic events among clients allows counselors to tailor their presentation styles, theoretical approaches, and intervention strategies from the outset to plan for and be responsive to clients' specific needs. Although not every client has a history of trauma, those who have substance use and mental disorders are more likely to have experienced trauma. Being trauma aware does not mean that you must assume everyone has a history of trauma, but rather that you anticipate the possibility from your initial contact and interactions, intake processes, and screening and assessment procedures.

Even the most standard behavioral health practices can retraumatize an individual exposed to prior traumatic experiences if the provider implements them without recognizing or considering that they may do harm. For example, a counselor might develop a treatment plan recommending that a female client—who has been court mandated to substance abuse treatment and was raped as an adult—attend group therapy, but without considering the implications, for her, of the fact that the only available group at the facility is all male and has had a low historical rate of female participation. Trauma awareness is an essential strategy for preventing this type of retraumatization; it reinforces the need for providers to reevaluate their usual practices.

> "Trauma informed care embraces a perspective that highlights adaptation over symptoms and resilience over pathology."
>
> (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005, p. 467)

Becoming trauma aware does not stop with the recognition that trauma can affect clients; instead, it encompasses a broader awareness that traumatic experiences as well as the impact of an individual's trauma can extend to significant others, family members, first responders and other medical professionals, behavioral health workers, broader social networks, and even entire communities. Family members frequently experience the traumatic stress reactions of the individual family member who was traumatized (e.g., angry outbursts, nightmares, avoidant behavior, other symptoms of anxiety, overreactions or underreactions to stressful events). These repetitive experiences can increase the risk of secondary trauma and symptoms of mental illness among the family, heighten the risk for externalizing and internalizing behavior among children (e.g., bullying others, problems in social relationships, health-damaging behaviors), increase children's risk for developing posttraumatic stress later in life, and lead to a greater propensity for traumatic stress reactions across generations of the family. Hence, prevention and intervention services can provide education and age-appropriate programming tailored to develop coping skills and support systems.

So too, behavioral health service providers can be influenced by exposure to trauma-related affect and content when working with clients. A trauma-aware workplace supports supervision and program practices that educate all direct service staff members on secondary trauma, encourages the processing of trauma-related content through participation in peer-supported activities and clinical supervision, and provides them with professional development opportunities to learn about and engage in effective coping strategies that help prevent secondary trauma or trauma-related symptoms. It is important to generate trauma awareness in agencies through education across services and among all staff members who have any direct or indirect contact with clients (including receptionists or intake and admission personnel who engage clients for the first time within the agency). Agencies can maintain a trauma-aware environment through ongoing staff training, continued supervisory and administrative support, collaborative (i.e., involving consumer participation) trauma-responsive program design and implementation, and organizational policies and practices that reflect accommodation and flexibility in attending to the needs of clients affected by trauma.

Recognize That Trauma-Related Symptoms and Behaviors Originate From Adapting to Traumatic Experiences

A trauma-informed perspective views trauma-related symptoms and behaviors as an individual's best and most resilient attempt to manage, cope with, and rise above his or her experience of trauma. Some individuals' means of adapting and coping have produced little difficulty; the coping and adaptive strategies of others have worked in the past but are not working as well now. Some people have difficulties in one area of life but have effectively negotiated and functioned in other areas.

Individuals who have survived trauma vary widely in how they experience and express traumatic stress reactions. Traumatic stress reactions vary in severity; they are often measured by the level of impairment or distress that clients report and are determined by the multiple factors that characterize the trauma itself, individual history and characteristics, developmental factors, sociocultural attributes, and available resources. The characteristics of the trauma and the subsequent traumatic stress reactions can dramatically influence how individuals respond to the environment, relationships, interventions, and treatment services, and those same characteristics can also shape the assumptions that clients/consumers make about their world (e.g., their view of others, sense of safety), their future (e.g., hopefulness, fear of a foreshortened future), and themselves (e.g., feeling resilient, feeling incompetent in regulating emotions). The breadth of these effects may be observable or subtle.

Once you become aware of the significance of traumatic experiences in clients' lives and begin to view their presentation as adaptive, your identification and classification of their presenting symptoms and behaviors can shift from a "pathology" mindset (i.e., defining clients strictly from a diagnostic label, implying that something is wrong with them) to one of resilience—a mindset that views clients' presenting difficulties, behaviors, and emotions as responses to surviving trauma. In essence, you will come to view traumatic stress reactions as *normal* reactions to *abnormal* situations. In embracing the belief that trauma-related reactions are adaptive, you can begin relationships with clients from a hopeful, strengths-based stance that builds upon the belief that their responses to traumatic experiences reflect creativity, self-preservation, and determination.

This will help build mutual and collaborative therapeutic relationships, help clients identify what has worked and has not worked in their attempts to deal with the aftermath of trauma from a nonjudgmental stance, and develop intervention and coping strategies that are more likely to fit their strengths and resources. This view of trauma prevents further retraumatization by not defining traumatic stress reactions as pathological or as symptoms of pathology.

View Trauma in the Context of Individuals' Environments

Many factors contribute to a person's response to trauma, whether it is an individual, group, or community-based trauma. Individual attributes, developmental factors (including protective and risk factors), life history, type of trauma, specific characteristics of the trauma, amount and length of trauma exposure, cultural meaning of traumatic events, number of losses associated with the trauma, available resources (internal and external, such as coping skills and family support), and community reactions are a few of the determinants that influence a person's responses to trauma across time. Refer to the "View Trauma Through a Sociocultural Lens" section later in this chapter for more specific information highlighting the importance of culture in understanding and treating the effects of trauma.

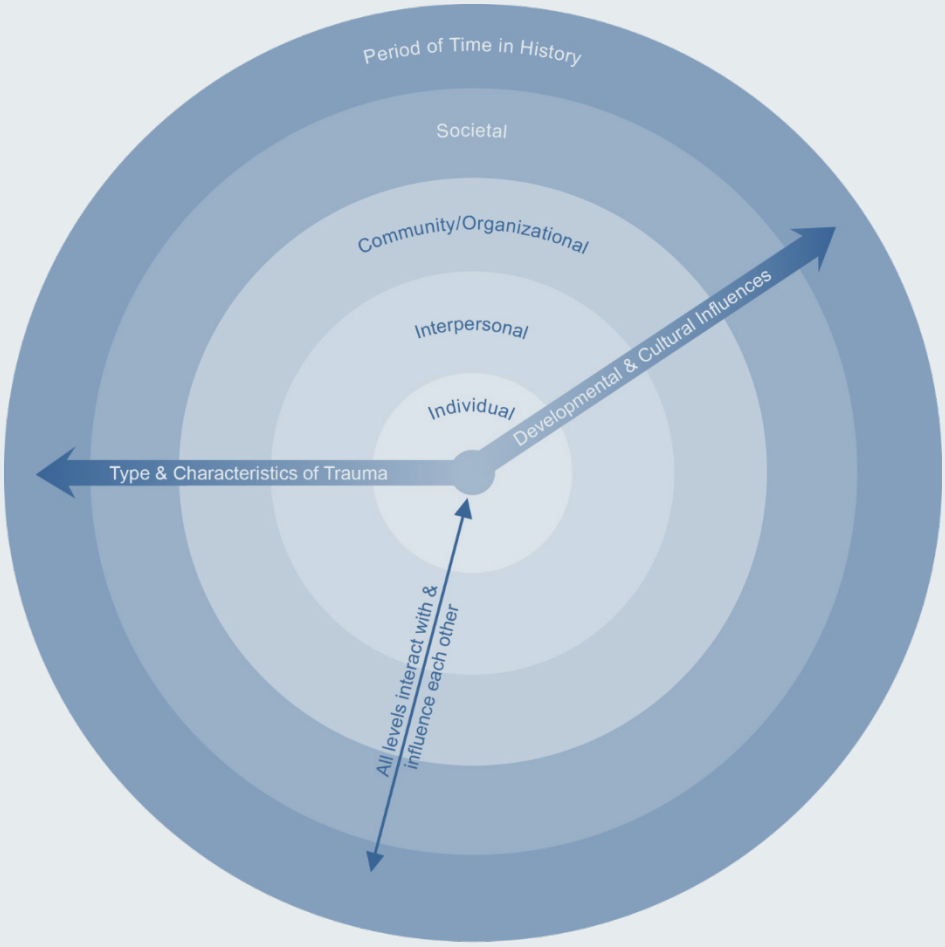
Trauma cannot be viewed narrowly; instead, it needs to be seen through a broader lens—a contextual lens integrating biopsychosocial, interpersonal, community, and societal (the degree of individualistic or collective cultural values) characteristics that are evident preceding and during the trauma, in the immediate and sustained response to the event(s), and in the short- and long-term effects of the traumatic event(s), which may include housing availability, community response, adherence to or maintenance of family routines and structure, and level of family support.

To more adequately understand trauma, you must also consider the contexts in which it occurred. Understanding trauma from this angle helps expand the focus beyond individual characteristics and effects to a broader systemic perspective that acknowledges the influences of social interactions, communities, governments, cultures, and so forth, while also examining the possible interactions among those various influences. Bronfenbrenner's (1979) and Bronfenbrenner and Ceci's (1994) work on ecological models sparked the development of other contextual models. In recent years, the social-ecological framework has been adopted in understanding trauma, in implementing health promotion and other prevention strategies, and in developing treatment interventions (Centers for Disease Control and Prevention, 2009). Here are the three main beliefs of a social-ecological approach (Stokols, 1996):

- Environmental factors greatly influence emotional, physical, and social well-being.
- A fundamental determinant of health versus illness is the degree of fit between individuals' biological, behavioral, and sociocultural needs and the resources available to them.
- Prevention, intervention, and treatment approaches integrate a combination of strategies targeting individual, interpersonal, and community systems.

This TIP uses a social-ecological model to explore trauma and its effects (Exhibit 1.1-2). The focus of this model is not only on negative attributes (risk factors) across each level, but also on positive ingredients (protective factors) that protect against or lessen the impact of trauma. This model also guides the inclusion of certain targeted interventions in this text, including selective and indicated

Exhibit 1.1-2: A Social-Ecological Model for Understanding Trauma and Its Effects



prevention activities. In addition, culture, developmental processes (including the developmental stage or characteristics of the individual and/or community), and the specific era when the trauma(s) occurred can significantly influence how a trauma is perceived and processed, how an individual or community engages in help-seeking, and the degree of accessibility, acceptability, and availability of individual and community resources.

Depending on the developmental stage and/or processes in play, children, adolescents, and adults will perceive, interpret, and cope with traumatic experiences differently. For example, a child may view a news story depicting a traumatic event on television and believe that the trauma is recurring every time they see the scene replayed. Similarly, the era in which one lives and the timing of the trauma can greatly influence an individual or community response. Take, for example, a pregnant woman who is abusing drugs and is wary of receiving medical treatment after being beaten in a domestic dispute. She may fear losing her children or being arrested for child neglect. Even though a number of States have adopted policies focused on the importance of treatment for pregnant women who are abusing drugs and of the accessibility of prenatal care, other States have approached this issue from a criminality standpoint (e.g., with child welfare and criminal laws) in the past few decades. Thus, the traumatic event's timing is a significant

component in understanding the context of trauma and trauma-related responses.

The social-ecological model depicted in Exhibit 1.1-2 provides a systemic framework for looking at individuals, families, and communities affected by trauma in general; it highlights the bidirectional influence that multiple contexts can have on the provision of behavioral health services to people who have experienced trauma (see thin arrow). Each ring represents a different system (refer to Exhibit 1.1-3 for examples of specific factors within each system). The innermost ring represents the individual and his or her biopsychosocial characteristics. The "Interpersonal" circle embodies all immediate relationships including family, friends, peers, and others. The "Community/Organizational" band represents social support networks, workplaces, neighborhoods, and institutions that directly influence the individual and his/her relationships. The "Societal" circle signifies the largest system—State and Federal policies and laws, such as economic and healthcare policies, social norms, governmental systems, and political ideologies. The outermost ring, "Period of Time in History," reflects the significance of the period of time during which the event occurred; it influences each other level represented in the circle. For example, making a comparison of society's attitudes and responses to veterans' homecomings across different wars and conflicts through time shows that homecoming environments can have either a protective or a negative effect on healing from the psychological and physical wounds of war, depending on the era in question. The thicker arrows in the figure represent the key influences of culture, developmental characteristics, and the type and characteristics of the trauma. All told, the context of traumatic events can significantly influence both initial and sustained responses to trauma; treatment needs; selection of prevention, intervention, and other treatment

Exhibit 1.1-3: Understanding the Levels Within the Social-Ecological Model of Trauma and Its Effects

Individual Factors	Interpersonal Factors	Community and Organizational Factors	Societal Factors	Cultural and Developmental Factors	Period of Time in History
Age, biophysical state, mental health status, temperament and other personality traits, education, gender, coping styles, socioeconomic status	Family, peer, and significant other interaction patterns, parent/family mental health, parents' history of trauma, social network	Neighborhood quality, school system and/or work environment, behavioral health system quality and accessibility, faith-based settings, transportation availability, community socioeconomic status, community employment rates	Laws, State and Federal economic and social policies, media, societal norms, judicial system	Collective or individualistic cultural norms, ethnicity, cultural subsystem norms, cognitive and maturational development	Societal attitudes related to military service members' homecomings, changes in diagnostic understanding between DSM-III-R* and DSM-5**

**Diagnostic and Statistical Manual of Mental Disorders,* Third Edition, Revised (American Psychiatric Association [APA], 1987)

***Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (APA, 2013a)

Case Illustration: Marisol

Marisol is a 28-year-old Latina woman working as a barista at a local coffee shop. One evening, she was driving home in the rain when a drunk driver crossed into her lane and hit her head on. Marisol remained conscious as she waited to be freed from the car and was then transported to the hospital. She sustained fractures to both legs. Her recovery involved two surgeries and nearly 6 months of rehabilitation, including initial hospitalization and outpatient physical therapy.

She described her friends and family as very supportive, saying that they often foresaw what she needed before she had to ask. She added that she had an incredible sense of gratitude for her employer and coworkers, who had taken turns visiting and driving her to appointments. Although she was able to return to work after 9 months, Marisol continued experiencing considerable distress about her inability to sleep well, which started just after the accident. Marisol describes repetitive dreams and memories of waiting to be transported to the hospital after the crash. The other driver was charged with driving under the influence (DUI), and it was reported that he had been convicted two other times for a DUI misdemeanor.

Answering the following questions will help you see how the different levels of influence affect the impact and outcome of the traumatic event Marisol experienced, as well as her responses to that event:

1. Based on the limited information provided in this illustration, how might Marisol's personality affect the responses of her family and friends, her coworkers, and the larger community?
2. In what ways could Marisol's ethnic and cultural background influence her recovery?
3. What societal factors could play a role in the car crash itself and the outcomes for Marisol and the other driver?

Explore the influence of the period of time in history during which the scenario occurs—compare the possible outcomes for both Marisol and the other driver if the crash occurred 40 years ago versus in the present day.

strategies; and ways of providing hope and promoting recovery.

Minimize the Risk of Retraumatization or Replicating Prior Trauma Dynamics

Trauma-informed treatment providers acknowledge that clients who have histories of trauma may be more likely to experience particular treatment procedures and practices as negative, reminiscent of specific characteristics of past trauma or abuse, or retraumatizing—feeling as if the past trauma is reoccurring or as if the treatment experience is as dangerous and unsafe as past traumas. For instance, clients may express feelings of powerlessness or being trapped if they are not actively involved in treatment decisions; if treatment processes or providers mirror specific behavior from the clients' past experiences with trauma, they may voice distress or respond in the same way as they did to the original trauma. Among the potentially retraumatizing elements of treatment are seclusion or "time-out" practices that isolate individuals, mislabeling client symptoms as personality or other mental disorders rather than as traumatic stress reactions, interactions that command authority, treatment assignments that could humiliate clients (such as asking a client to wear a sign in group that reflects one of their treatment issues, even if the assignment centers on positive attributes of the client), confronting clients as resistant, or presenting treatment as conditional upon conformity to the provider's beliefs and definitions of issues.

Clients' experiences are unique to the specific traumas they have faced and the surrounding

circumstances before, during, and after that trauma, so remember that even seemingly safe and standard treatment policies and procedures, including physical plant operations (e.g., maintenance, grounds, fire and safety procedures), may feel quite the contrary for a client if one or more of those elements is reminiscent of his or her experience of trauma in some way. Examples include having limited privacy or personal space, being interviewed in a room that feels too isolating or confining, undergoing physical examination by a medical professional of the same sex as the client's previous perpetrator of abuse, attending a group session in which another client expresses anger appropriately in a role play, or being directed not to talk about distressing experiences as a means of deescalating traumatic stress reactions.

Although some treatment policies or procedures are more obviously likely to solicit distress than others, *all* standard practices should be evaluated for their potential to retraumatize a client; this cannot be done without knowing the specific features of the individual's history of trauma. Consider, for instance, a treatment program that serves meals including entrees that combine more than one food group. Your client enters this program and refuses to eat most of the time; he expresses anger toward dietary staff and claims that food choices are limited. You may initially perceive your client's refusal to eat or to avoid certain foods as an eating disorder or a behavioral problem. However, a trauma-aware perspective might change your assumptions; consider that this client experienced neglect and abuse surrounding food throughout childhood (his mother forced him to eat meals prepared by combining anything in the refrigerator and cooking them together).

Advice to Counselors and Administrators: Sending the Right Message About Trauma

How often have you heard "We aren't equipped to handle trauma" or "We don't have time to deal with reactions that surface if traumatic experiences are discussed in treatment" from counselors and administrators in behavioral health services? For agencies, staff members, and clients, these statements present many difficulties and unwanted outcomes. For a client, such comments may replicate his or her earlier encounters with others (including family, friends, and previous behavioral health professionals) who had difficulty acknowledging or talking about traumatic experiences with him or her. A hands-off approach to trauma can also reinforce the client's own desire to avoid such discussions. Even when agencies and staff are motivated in these sentiments by a good intention—to contain clients' feelings of being overwhelmed—such a perspective sends strong messages to clients that their experiences are not important, that they are not capable of handling their trauma-associated feelings, and that dealing with traumatic experiences is simply too dangerous. Statements like these imply that recovery is not possible and provide no structured outlet to address memories of trauma or traumatic stress reactions.

Nevertheless, determining how and when to address traumatic stress in behavioral health services can be a real dilemma, especially if there are no trauma-specific philosophical, programmatic, or procedural processes in place. For example, it is difficult to provide an appropriate forum for a client to address past traumas if no forethought has been given to developing interagency and intra-agency collaborations for trauma-specific services. By anticipating the need for trauma-informed services and planning ahead to provide appropriate services to people who are affected by trauma, behavioral health service providers and program administrators can begin to develop informed intervention strategies that send a powerful, positive message:

- Both clients and providers can competently manage traumatic experiences and reactions.
- Providers are interested in hearing clients' stories and attending to their experiences.
- Recovery is possible.

As a treatment provider, you cannot consistently predict what may or may not be upsetting or retraumatizing to clients. Therefore, it is important to maintain vigilance and an attitude of curiosity with clients, inquiring about the concerns that they express and/or present in treatment. Remember that certain behaviors or emotional expressions can reflect what has happened to them in the past.

Foremost, a trauma-informed approach begins with taking practical steps to reexamine treatment strategies, program procedures, and organizational polices that could solicit distress or mirror common characteristics of traumatic experiences (loss of control, being trapped, or feeling disempowered). To better anticipate the interplay between various treatment elements and the more idiosyncratic aspects of a particular client's trauma history, you can:

- Work with the client to learn the cues he or she associates with past trauma.
- Obtain a good history.
- Maintain a supportive, empathetic, and collaborative relationship.
- Encourage ongoing dialog.
- Provide a clear message of availability and accessibility throughout treatment.

In sum, trauma-informed providers anticipate and respond to potential practices that may be perceived or experienced as retraumatizing to clients; they are able to forge new ways to respond to specific situations that trigger a trauma-related response, and they can provide clients with alternative ways of engaging in a particularly problematic element of treatment.

Create a Safe Environment

The need to create a safe environment is not new to providers; it involves an agency-wide effort supported by effective policies and procedures. However, creating safety within a trauma-informed framework far exceeds the standard expectations of physical plant safety (e.g., facility, environmental, and space-related concerns), security (of staff members, clients, and personal property), policies and procedures (including those specific to seclusion and restraint), emergency management and disaster planning, and adherence to client rights. Providers must be responsive and adapt the environment to establish and support clients' sense of physical and emotional safety.

Beyond anticipating that various environmental stimuli within a program may generate strong emotions and reactions in a trauma survivor (e.g., triggers such as lighting, access to exits, seating arrangements, emotionality within a group, or visual or auditory stimuli) and implementing strategies to help clients cope with triggers that evoke their experiences with trauma, other key elements in establishing a safe environment include consistency in client interactions and treatment processes, following through with what has been reviewed or agreed upon in sessions or meetings, and dependability. Mike's case illustration depicts ways in which the absence of these key elements could erode a client's sense of safety during the treatment process.

Neither providers nor service processes are always perfect. Sometimes, providers

Case Illustration: Mike

From the first time you provide outpatient counseling to Mike, you explain that he can call an agency number that will put him in direct contact with someone who can provide further assistance or support if he has emotional difficulty after the session or after agency hours. However, when he attempts to call one night, no one is available despite what you've described. Instead, Mike is directed by an operator to either use his local emergency room if he perceives his situation to be a crisis or to wait for someone on call to contact him. The inconsistency between what you told him in the session and what actually happens when he calls makes Mike feel unsafe and vulnerable.

unintentionally relay information inaccurately or inconsistently to clients or other staff members; other times, clients mishear something, or extenuating circumstances prevent providers from responding as promised. Creating safety is not about getting it right all the time; it's about how consistently and forthrightly you handle situations with a client when circumstances provoke feelings of being vulnerable or unsafe. Honest and compassionate communication that conveys a sense of handling the situation together generates safety. It is equally important that safety extends beyond the client. Counselors and other behavioral health staff members, including peer support specialists, need to be able to count on the agency to be responsive to and maintain their safety within the environment as well. By incorporating an organizational ethos that recognizes the importance of practices that promote physical safety and emotional well-being, behavioral health staff members may be more likely to seek support and supervision when needed and to comply with clinical and programmatic practices that minimize risks for themselves and their clients.

Beyond an attitudinal promotion of safety, organizational leaders need to consider and create avenues of professional development and assistance that will give their staff the means to seek support and process distressing circumstances or events that occur within the agency or among their clientele, such as case consultation and supervision, formal or informal processes to debrief service providers about difficult clinical issues, and referral processes for client psychological evaluations and employee assistance for staff. Organizational practices are only effective if supported by unswerving trauma awareness, training, and education among staff. Jane's case illustration shows the impact of a minor but necessary postponement in staff orientation for a new hire—not an unusual circumstance in behavioral health programs that have heavy caseloads and high staff turnover.

Identify Recovery From Trauma as a Primary Goal

Often, people who initiate or are receiving mental health or substance abuse services don't identify their experiences with trauma as a significant factor in their current challenges or problems. In part, this is because people who have been exposed to trauma, whether once or repeatedly, are generally reluctant to revisit it. They may already feel stuck in repetitive memories or experiences, which may add to their existing belief that any intervention will make matters worse or, at least, no better. For some clients, any introduction to their trauma-related memories or minor cues reminiscent of the trauma will cause them to experience strong, quick-to-surface emotions, supporting their belief that addressing trauma is dangerous and that they won't be able to handle the

Case Illustration: Jane

Jane, a newly hired female counselor, had a nephew who took his own life. The program that hired her was short of workers at the time; therefore, Jane did not have an opportunity to engage sufficiently in orientation outside of reviewing the policies and procedure manual. In an attempt to present well to her new employer and supervisor, she readily accepted client assignments without considering her recent loss. By not immersing herself in the program's perspective and policies on staff well-being, ethical and clinical considerations in client assignments, and how and when to seek supervision, Jane failed to engage in the practices, heavily supported by the agency, that promoted safety for herself and her clients. Subsequently, she felt emotionally overwhelmed at work and would often abruptly request psychiatric evaluation for clients who expressed any feelings of hopelessness out of sheer panic that they would attempt suicide.

emotions or thoughts that result from attempting to do so. Others readily view their experiences of trauma as being in the past; as a result, they engage in distraction, dissociation, and/or avoidance (as well as adaptation) due to a belief that trauma has little impact on their current lives and presenting problems. Even individuals who are quite aware of the impact that trauma has had on their lives may still struggle to translate or connect how these events continue to shape their choices, behaviors, and emotions. Many survivors draw no connection between trauma and their mental health or substance abuse problems, which makes it more difficult for them to see the value of trauma-informed or trauma-specific interventions, such as creating safety, engaging in psychoeducation, enhancing coping skills, and so forth.

As a trauma-informed provider, it is important that you help clients bridge the gap between their mental health and substance-related issues and the traumatic experiences they may have had. All too often, trauma occurs before substance use and mental disorders develop; then, such disorders and their associated symptoms and consequences create opportunities for additional traumatic events to occur. If individuals engage in mental health and substance abuse treatment without addressing the role that trauma has played in their lives, they are less likely to experience recovery in the long run. For example, a person with a history of trauma is more likely to have anxiety and depressive symptoms, use substances to self-medicate, and/or relapse after exposure to trauma-related cues. Thus, collaboration within and between behavioral health agencies is necessary to make integrated, timely, trauma-specific interventions available from the beginning to clients/consumers who engage in substance abuse and mental health services.

Support Control, Choice, and Autonomy

Not every client who has experienced trauma and is engaged in behavioral health services wants, or sees the need for, trauma-informed or trauma-specific treatment. Clients may think that they've already dealt with their trauma adequately, or they may believe that the effects of past trauma cause minimal distress for them. Other clients may voice the same sentiments, but without conviction—instead using avoidant behavior to deter distressing symptoms or reactions. Still others may struggle to see the role of trauma in their presenting challenges, not connecting their past traumatic experiences with other, more current difficulties (e.g., using substances to self-medicate strong emotions). Simply the idea of acknowledging trauma-related experiences and/or stress reactions may be too frightening or overwhelming for some clients, and others may fear that their reactions will be dismissed. On the other hand, some individuals want so much to dispense with their traumatic experiences and reactions that they hurriedly and repeatedly disclose their experiences before establishing a sufficiently safe environment or learning effective coping strategies to offset distress and other effects of retraumatization.

As these examples show, not everyone affected by trauma will approach trauma-informed services or recognize the impact of trauma in their lives in the same manner. This can be challenging to behavioral health service providers who are knowledgeable about the impact of trauma and who perceive the importance of addressing trauma and its effects with clients. As with knowing that different clients may be at different levels of awareness or stages of change in substance abuse treatment services, you should acknowledge that people affected by trauma

present an array of reactions, various levels of trauma awareness, and different degrees of urgency in their need to address trauma.

Appreciating clients' perception of their presenting problems and viewing their responses to the impact of trauma as adaptive—even when you believe their methods of dealing with trauma to be detrimental—are equally important elements of TIC. By taking the time to engage with clients and understand the ways they have perceived, adjusted to, and responded to traumatic experiences, providers are more likely to project the message that clients possess valuable personal expertise and knowledge about their own presenting problems. This shifts the viewpoint from "Providers know best" to the more collaborative "Together, we can find solutions."

How often have you heard from clients that they don't believe they can handle symptoms that emerge from reexperiencing traumatic cues or memories? Have you ever heard clients state that they can't trust themselves or their reactions, or that they never know when they are going to be triggered or how they are going to react? How confident would you feel about yourself if, at any time, a loud noise could initiate an immediate attempt to hide, duck, or dive behind something? Traumatic experiences have traditionally been described as exposure to events that cause intense fear, helplessness, horror, or feelings of loss of control. Participation in behavioral health services should not mirror these aspects of traumatic experience. Working collaboratively to facilitate clients' sense of control and to maximize clients' autonomy and choices throughout the treatment process, including treatment planning, is crucial in trauma-informed services.

For some individuals, gaining a sense of control and empowerment, along with understanding traumatic stress reactions, may be pivotal ingredients for recovery. By creating opportunities for empowerment, counselors and other behavioral health service providers help reinforce, clients' sense of competence, which is often eroded by trauma and prolonged traumatic stress reactions. Keep in mind that treatment strategies and procedures that prioritize client choice and control need not focus solely on major life decisions or treatment planning; you can apply such approaches to common tasks and everyday interactions between staff and consumers. Try asking your clients some of the following questions (which are only a sample of the types of questions that could be useful):

- What information would be helpful for us to know about what happened to you?
- Where/when would you like us to call you?
- How would you like to be addressed?
- Of the services I've described, which seem to match your present concerns and needs?
- From your experience, what responses from others appear to work best when you feel overwhelmed by your emotions?

Likewise, organizations need to reinforce the importance of staff autonomy, choice, and sense of control. What resources can staff members access, and what choices are available to them, in processing emotionally charged content or events in treatment? How often do administrators and supervisors seek out feedback on how to handle problematic situations (e.g., staff rotations for vacations, case consultations, changes in scheduling)? Think about the parallel between administration and staff members versus staff members and clients; often, the same philosophy, attitudes, and behaviors conveyed to staff members by administrative practices are mirrored in staff–client interactions. Simply stated, if staff members do not feel empowered, it will be a challenge for them to value the need for client empowerment. (For more information on administrative and workforce development issues, refer to Part 2, Chapters 1 and 2.)

Case Illustration: Mina

Mina initially sought counseling after her husband was admitted to an intensive outpatient drug and alcohol program. She was self-referred for low-grade depression, resentment toward her spouse, and codependency. When asked to define "codependency" and how the term applied to her, she responded that she always felt guilty and responsible for everyone in her family and for events that occurred even when she had little or no control over them.

After the intake and screening process, she expressed interest in attending group sessions that focused primarily on family issues and substance abuse, wherein her presenting concerns could be explored. In addition to describing dynamics and issues relating to substance abuse and its impact on her marriage, she referred to her low mood as frozen grief. During treatment, she reluctantly began to talk about an event that she described as life changing: the loss of her father. The story began to unfold in group; her father, who had been 62 years old, was driving her to visit a cousin. During the ride, he had a heart attack and drove off the road. As the car came to stop in a field, she remembered calling 911 and beginning cardiopulmonary resuscitation while waiting for the ambulance. She rode with the paramedics to the hospital, watching them work to save her father's life; however, he was pronounced dead soon after arrival.

She always felt that she never really said goodbye to her father. In group, she was asked what she would need to do or say to feel as if she had revisited that opportunity. She responded in quite a unique way, saying, "I can't really answer this question; the lighting isn't right for me to talk about my dad." The counselor encouraged her to adjust the lighting so that it felt "right" to her. Being invited to do so turned out to be pivotal in her ability to address her loss and to say goodbye to her father on her terms. She spent nearly 10 minutes moving the dimmer switch for the lighting as others in the group patiently waited for her to return to her chair. She then began to talk about what happened during the evening of her father's death, their relationship, the events leading up to that evening, what she had wanted to say to him at the hospital, and the things that she had been wanting to share with him since his death.

Weeks later, as the group was coming to a close, each member spoke about the most important experiences, tools, and insights that he or she had taken from participating. Mina disclosed that the group helped her establish boundaries and coping strategies within her marriage, but said that the event that made the most difference for her had been having the ability to adjust the lighting in the room. She explained that this had allowed her to control something over which she had been powerless during her father's death. To her, the lighting had seemed to stand out more than other details at the scene of the accident, during the ambulance ride, and at the hospital. She felt that the personal experience of losing her father and needing to be with him in the emergency room was marred by the obtrusiveness of staff, procedures, machines, and especially, the harsh lighting. She reflected that she now saw the lighting as a representation of this tragic event and the lack of privacy she had experienced when trying to say goodbye to her father. Mina stated that this moment in group had been the greatest gift: "…to be able to say my goodbyes the way I wanted… I was given an opportunity to have some control over a tragic event where I couldn't control the outcome no matter how hard I tried."

Create Collaborative Relationships and Participation Opportunities

This trauma-informed principle encompasses three main tenets. First, **ensure that the provider–client relationship is collaborative**, regardless of setting or service. Agency staff members cannot make decisions pertaining to interventions or involvement in community services autocratically; instead, they should develop trauma-informed, individualized care plans and/or treatment plans collaboratively with the client and, when appropriate, with family and caregivers. The nonauthoritarian approach that characterizes TIC views clients

as the experts in their own lives and current struggles, thereby emphasizing that clients and providers can learn from each other.

The second tenet is to **build collaboration beyond the provider–client relationship**. Building ongoing relationships across the service system, provider networks, and the local community enhances TIC continuity as clients move from one level of service to the next or when they are involved in multiple services at one time. It also allows you to learn about resources available to your clients in the service system or community and to connect with providers who have more advanced training in trauma-specific interventions and services.

The third tenet emphasizes the need to **ensure client/consumer representation and participation in behavioral health program development, planning, and evaluation as well as in the professional development of behavioral health workers**. To achieve trauma-informed competence in an organization or across systems, clients need to play an active role; this starts with providing program feedback. However, consumer involvement should not end there; rather, it should be encouraged throughout the implementation of trauma-informed services. So too, clients, potential clients, their families, and the community should be invited to participate in forming any behavioral health organization's plans to improve trauma-informed competence, provide TIC, and design relevant treatment services and organizational policies and procedures.

Trauma-informed principles and practices generated without the input of people affected by trauma are difficult to apply effectively. Likewise, staff trainings and presentations should include individuals who have felt the impact of trauma. Their participation reaches past the purely cognitive aspects of such education to offer a personal perspective on the strengths and resilience of people who have experienced trauma. The involvement of trauma survivors in behavioral health education lends a human face to subject matter that is all too easily made cerebral by some staff members in an attempt to avoid the emotionality of the topic.

Consumer participation also means giving clients/consumers the chance to obtain State training and certification, as well as employment in behavioral health settings as peer specialists. Programs that incorporate peer support services reinforce a powerful message—that provider–consumer partnership is important, and that consumers are valued. Peer support specialists are self-identified individuals who have progressed in their own recovery from alcohol dependence, drug addiction, and/or a mental disorder and work within behavioral health programs or at peer support centers to assist others with similar disorders and/or life experiences. Tasks and responsibilities may include leading a peer support group; modeling effective coping, help-seeking, and self-care strategies; helping clients practice new skills or monitor progress; promoting positive self-image to combat clients' potentially negative feelings about themselves and the discrimination they may perceive in the program or community; handling case management tasks; advocating for program changes; and representing a voice of hope that views recovery as possible.

Familiarize the Client With Trauma-Informed Services

Without thinking too much about it, you probably know the purpose of an intake process, the correct way to complete a screening device, the meaning of a lot of the jargon specific to behavioral health, and your program's expectations for client participation; in fact, maybe you're already involved in facilitating these processes in behavioral health services every day, and they've become almost

automatic for you. This can make it easy to forget that nearly everything clients and their families encounter in seeking behavioral health assistance is new to them. Thus, introducing clients to program services, activities, and interventions in a manner that *expects* them to be unfamiliar with these processes is essential, regardless of their clinical and treatment history. Beyond addressing the unfamiliarity of services, educating clients about each process—from first contact all the way through recovery services—gives them a chance to participate actively and make informed decisions across the continuum of care.

Familiarizing clients with trauma-informed services extends beyond explaining program services or treatment processes; it involves explaining the value and type of trauma-related questions that may be asked during an intake process, educating clients about trauma to help normalize traumatic stress reactions, and discussing trauma-specific interventions and other available services (including explanations of treatment methodologies and of the rationale behind specific interventions). Developmentally appropriate psychoeducation about trauma-informed services allows clients to be informed participants.

Incorporate Universal Routine Screenings for Trauma

Screening universally for client histories, experiences, and symptoms of trauma at intake can benefit clients and providers. Most providers know that clients can be affected by trauma, but universal screening provides a steady reminder to be watchful for past traumatic experiences and their potential influence upon a client's interactions and engagement with services across the continuum of care. Screening should guide treatment planning; it alerts the staff to potential issues and serves as a valuable tool to increase clients' awareness of the possible impact of trauma and the importance of addressing related issues during treatment.

Nonetheless, screenings are only as useful as the guidelines and processes established to address positive screens (which occur when clients respond to screening questions in a way that signifies possible trauma-related symptoms or histories). Staff should be trained to use screening tools consistently so that all clients are screened in the same way. Staff members also need to know how to score screenings and when specific variables (e.g., race/ethnicity, native language, gender, culture) may influence screening results. For example, a woman who has been sexually assaulted by a man may be wary of responding to questions if a male staff member or interpreter administers the screening or provides translation services. Likewise, a person in a current abusive or violent relationship may not acknowledge the interpersonal violence in fear of retaliation or as a result of disconnection or denial of his or her experience, and he or she may have difficulty in processing and then living between two worlds—what is acknowledged in treatment versus what is experienced at home.

In addition, staff training on using trauma-related screening tools needs to center on how and when to gather relevant information after the screening is complete. Organizational policies and procedures should guide staff members on how to respond to a positive screening, such as by making a referral for an indepth assessment of traumatic stress, providing the client with an introductory psychoeducational session on the typical biopsychosocial effects of trauma, and/or coordinating care so that the client gains access to trauma-specific services that meet his or her needs. Screening tool selection is an important ingredient in incorporating routine, universal screening practices into behavioral health services. Many screening tools are available, yet they differ in format

and in how they present questions. Select tools based not just on sound test properties, but also according to whether they encompass a broad range of experiences typically considered traumatic and are flexible enough to allow for an individual's own interpretation of traumatic events. For more information on screening and assessment of trauma and trauma-related symptoms and effects, see Chapter 4, "Screening and Assessment," in this TIP.

View Trauma Through a Sociocultural Lens

To understand how trauma affects an individual, family, or community, you must first understand life experiences and cultural background as key contextual elements for that trauma. As demonstrated in Exhibit 1.1-2, many factors shape traumatic experiences and individual and community responses to it; one of the most significant factors is culture. It influences the interpretation and meaning of traumatic events, individual beliefs regarding personal responsibility for the trauma and subsequent responses, and the meaning and acceptability of symptoms, support, and help-seeking behaviors. As this TIP proceeds to describe the differences among cultures pertaining to trauma, remember that there are numerous cross-cutting factors that can directly or indirectly influence the attitudes, beliefs, behaviors, resources, and opportunities within a given culture, subculture, or racial and/or ethnic group (Exhibit 1.1-4). For an indepth

Exhibit 1.1-4: Cross-Cutting Factors of Culture

Culture and Trauma

- Some populations and cultures are more likely than others to experience a traumatic event or a specific type of trauma.
- Rates of traumatic stress are high across all diverse populations and cultures that face military action and political violence.
- Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma.
- Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life.
- Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behavior, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased.
- Traumatic stress symptoms vary according to the type of trauma within the culture.
- Culture affects what qualifies as a legitimate health concern and which symptoms warrant help.
- In addition to shaping beliefs about acceptable forms of help-seeking behavior and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.

exploration of these cross-cutting cultural factors, refer to the planned TIP, *Improving Cultural Competence* (SAMHSA, planned c).

When establishing TIC, it is vital that behavioral health systems, service providers, licensing agencies, and accrediting bodies build culturally responsive practices into their curricula, standards, policies and procedures, and credentialing processes. The implementation of culturally responsive practices will further guide the treatment planning process so that trauma-informed services are more appropriate and likely to succeed.

Use a Strengths-Focused Perspective: Promote Resilience

Fostering individual strengths is a key step in prevention when working with people who have been exposed to trauma. It is also an essential intervention strategy—one that builds on the individual's existing resources and views him or her as a resourceful, resilient survivor. Individuals who have experienced trauma develop many strategies and/or behaviors to adapt to its emotional, cognitive, spiritual, and physical consequences. Some behaviors may be effective across time, whereas others may eventually produce difficulties and disrupt the healing process. Traditionally, behavioral health services have tended to focus on presenting problems, risk factors, and symptoms in an attempt to prevent negative outcomes, provide relief, increase clients' level of functioning, and facilitate healing. However, focusing too much on these areas can undermine clients' sense of competence and hope. Targeting only presenting problems and symptoms does not provide individuals with an opportunity to see their own resourcefulness in managing very stressful and difficult experiences. It is important for providers to engage in interventions using a balanced approach that targets the strengths clients have

> "Trauma informed care recognizes symptoms as originating from adaptations to the traumatic event(s) or context. Validating resilience is important even when past coping behaviors are now causing problems. Understanding a symptom as an adaptation reduces a survivor's guilt and shame, increases their self esteem and provides a guideline for developing new skills and resources to allow new and better adaptation to the current situation."
>
> (Elliot et al., 2005, p. 467)

Advice to Counselors and Administrators: Using Strengths-Oriented Questions

Knowing a client's strengths can help you understand, redefine, and reframe the client's presenting problems and challenges. By focusing and building on an individual's strengths, counselors and other behavioral health professionals can shift the focus from "What is wrong with you?" to "What has worked for you?" It moves attention away from trauma-related problems and toward a perspective that honors and uses adaptive behaviors and strengths to move clients along in recovery.

Potential strengths-oriented questions include:

- The history that you provided suggests that you've accomplished a great deal since the trauma. What are some of the accomplishments that give you the most pride?
- What would you say are your strengths?
- How do you manage your stress today?
- What behaviors have helped you survive your traumatic experiences (during and afterward)?
- What are some of the creative ways that you deal with painful feelings?
- You have survived trauma. What characteristics have helped you manage these experiences and the challenges that they have created in your life?
- If we were to ask someone in your life, who knew your history and experience with trauma, to name two positive characteristics that help you survive, what would they be?
- What coping tools have you learned from your _____ (fill in: cultural history, spiritual practices, athletic pursuits, etc.)?
- Imagine for a moment that a group of people are standing behind you showing you support in some way. Who would be standing there? It doesn't matter how briefly or when they showed up in your life, or whether or not they are currently in your life or alive.
- How do you gain support today? (Possible answers include family, friends, activities, coaches, counselors, other supports, etc.)
- What does recovery look like for you?

developed to survive their experiences and to thrive in recovery. A strengths-based, resilience-minded approach lets trauma survivors begin to acknowledge and appreciate their fortitude and the behaviors that help them survive.

Foster Trauma-Resistant Skills

Trauma-informed services build a foundation on which individuals can begin to explore the role of trauma in their lives; such services can also help determine how best to address and tailor interventions to meet their needs. Prevention, mental health, and substance abuse treatment services should include teaching clients about how trauma can affect their lives; these services should also focus on developing self-care skills, coping strategies, supportive networks, and a sense of competence. Building trauma-resistant skills begins with normalizing the symptoms of traumatic stress and helping clients who have experienced trauma connect the dots between current problems and past trauma when appropriate.

Nevertheless, TIC and trauma-specific interventions that focus on skill-building should not do so at the expense of acknowledging individual strengths, creativity in adapting to trauma, and inherent attributes and tools clients possesses to combat the effects of trauma. Some theoretical models that use skill-building strategies base the value of this approach on a deficit perspective; they assume that some individuals lack the necessary tools to manage specific situations and, because of this deficiency, they encounter problems that others with effective skills would not experience. This type of perspective further assumes that, to recover, these individuals must learn new coping skills and behavior. TIC, on the other hand, makes the assumption that clients

Advice to Administrators: Self-Assessment for Trauma-Informed Systems

NCTIC has developed a self-assessment package for trauma-informed systems to help administrators structurally incorporate trauma into programs and services. The self-assessment can be used by systems of care to guide quality improvement with the goal of establishing fully trauma-informed treatment and recovery efforts (NCTIC, Center for Mental Health Services, 2007). Behavioral health treatment program administrators can use these materials and NCTIC as resources for improvement in delivering TIC.

are the experts in their own lives and have learned to adapt and acquire skills to survive. The TIC approach honors each individual's adaptations and acquired skills, and it helps clients explore how these may not be working as well as they had in the past and how their current repertoire of responses may not be as effective as other strategies.

Demonstrate Organizational and Administrative Commitment to TIC

Becoming a trauma-informed organization requires administrative guidance and support across all levels of an agency. Behavioral health staff will not likely sustain TIC practices without the organization's ongoing commitment to support professional development and to allocate resources that promote these practices. An agency that wishes to commit to TIC will benefit from an organizational assessment of how staff members identify and manage trauma and trauma-related reactions in their clients. Are they trauma aware—do they recognize that trauma can significantly affect a client's ability to function in one or more areas of his or her life? Do the staff members understand that traumatic experiences and trauma-related reactions can greatly influence clients' engagement, participation, and response to services?

Agencies need to embrace specific strategies across each level of the organization to create trauma-informed services; this begins with staff education on the impact of trauma among clients. Other agency strategies that reflect a trauma-informed infrastructure include, but are not limited to:

- Universal screening and assessment procedures for trauma.
- Interagency and intra-agency collaboration to secure trauma-specific services.
- Referral agreements and networks to match clients' needs.
- Mission and value statements endorsing the importance of trauma recognition.
- Consumer- and community-supported committees and trauma response teams.
- Workforce development strategies, including hiring practices.
- Professional development plans, including staff training/supervision focused on TIC.
- Program policies and procedures that ensure trauma recognition and secure trauma-informed practices, trauma-specific services, and prevention of retraumatization.

TIC requires organizational commitment, and often, cultural change. For more information on implementing TIC in organizations, see Part 2, Chapter 1 of this TIP.

Develop Strategies To Address Secondary Trauma and Promote Self-Care

Secondary trauma is a normal occupational hazard for mental health and substance abuse professionals, particularly those who serve populations that are likely to include survivors of trauma (Figley, 1995; Klinic Community Health Centre, 2008). Behavioral health staff members who experience secondary trauma present a range of traumatic stress reactions

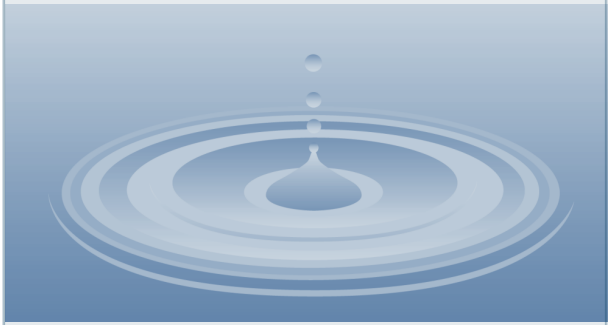
and effects from providing services focused on trauma or listening to clients recount traumatic experiences. So too, when a counselor has a history of personal trauma, working with trauma survivors may evoke memories of the counselor's own trauma history, which may increase the potential for secondary traumatization.

The range of reactions that manifest with secondary trauma can be, but are not necessarily, similar to the reactions presented by clients who have experienced primary trauma. Symptoms of secondary trauma can produce varying levels of difficulty, impairment, or distress in daily functioning; these may or may not meet diagnostic thresholds for acute stress, posttraumatic stress, or adjustment, anxiety, or mood disorders (Bober & Regehr, 2006). Symptoms may include physical or psychological reactions to traumatic memories clients have shared; avoidance behaviors during client interactions or when recalling emotional content in supervision; numbness, limited emotional expression, or diminished affect; somatic complaints; heightened arousal, including insomnia; negative thinking or depressed mood; and detachment from family, friends, and other supports (Maschi & Brown, 2010).

Working daily with individuals who have been traumatized can be a burden for counselors and other behavioral health service providers, but all too often, they blame the symptoms resulting from that burden on other stressors at work or at home. Only in the past 2 decades have literature and trainings begun paying attention to secondary trauma or compassion fatigue; even so, agencies often do not translate this knowledge into routine prevention practices. Counselors and other staff members may find it difficult to engage in activities that could ward off secondary trauma due to time constraints, workload, lack of agency resources, and/or an organizational culture that disapproves of help-seeking or provides inadequate staff support. The demands of providing care to trauma survivors cannot be ignored, lest the provider become increasingly impaired and less effective. Counselors with unacknowledged secondary trauma can cause harm to clients via poorly enforced boundaries, missed appointments, or even abandonment of clients and their needs (Pearlman & Saakvitne, 1995).

Essential components of TIC include organizational and personal strategies to address

The Impact of Trauma



Trauma is similar to a rock hitting the water's surface. The impact first creates the largest wave, which is followed by ever-expanding, but less intense, ripples. Likewise, the influence of a given trauma can be broad, but generally, its effects are less intense for individuals further removed from the trauma; eventually, its impact dissipates all around. For trauma survivors, the impact of trauma can be far-reaching and can affect life areas and relationships long after the trauma occurred. This analogy can also broadly describe the recovery process for individuals who have experienced trauma and for those who have the privilege of hearing their stories. As survivors reveal their trauma-related experiences and struggles to a counselor or another caregiver, the trauma becomes a shared experience, although it is not likely to be as intense for the caregiver as it was for the individual who experienced the trauma. The caregiver may hold onto the trauma's known and unknown effects or may consciously decide to engage in behaviors that provide support to further dissipate the impact of this trauma and the risk of secondary trauma.

Advice to Counselors: Decreasing the Risk of Secondary Trauma and Promoting Self-Care

- **Peer support.** Maintaining adequate social support will help prevent isolation and depression.
- **Supervision and consultation.** Seeking professional support will enable you to understand your own responses to clients and to work with them more effectively.
- **Training.** Ongoing professional training can improve your belief in your abilities to assist clients in their recoveries.
- **Personal therapy.** Obtaining treatment can help you manage specific problems and become better able to provide good treatment to your clients.
- **Maintaining balance.** A healthy, balanced lifestyle can make you more resilient in managing any difficult circumstances you may face.
- **Setting clear limits and boundaries with clients.** Clearly separating your personal and work life allows time to rejuvenate from stresses inherent in being a professional caregiver.

secondary trauma and its physical, cognitive, emotional, and spiritual consequences. In agencies and among individual providers, it is key for the culture to promote acceptability, accessibility, and accountability in seeking help, accessing support and supervision, and engaging in self-care behaviors in and outside of the agency or office. Agencies should involve staff members who work with trauma in developing informal and formal agency practices and procedures to prevent or address secondary trauma. Even though a number of community-based agencies face fiscal constraints, prevention strategies for secondary trauma can be intertwined with the current infrastructure (e.g., staff meetings, education, case consultations and group case discussions, group support, debriefing sessions as appropriate, supervision). For more information on strategies to address and prevent secondary trauma, see Part 2, Chapter 2 of this TIP.

Provide Hope—Recovery Is Possible

What defines recovery from trauma-related symptoms and traumatic stress disorders? Is it the total absence of symptoms or consequences? Does it mean that clients stop having nightmares or being reminded, by cues, of past trauma? When clients who have experienced trauma enter into a helping relationship to address trauma specifically, they are often looking for a cure, a remission of symptoms, or relief from the pain as quickly as possible. However, they often possess a history of unpredictable symptoms and symptom intensity that reinforces an underlying belief that recovery is not possible. On one hand, clients are looking for a message that they can be cured, while on the other hand, they have serious doubts about the likely success of any intervention.

Clients often express ambivalence about dealing with trauma even if they are fully aware of trauma's effects on their lives. The idea of living with more discomfort as they address the past or as they experiment with alternative ways of dealing with trauma-related symptoms or consequences is not an appealing prospect, and it typically elicits fear. Clients may interpret the uncomfortable feelings as dangerous or unsafe even in an environment and relationship that is safe and supportive.

How do you promote hope and relay a message that recovery is possible? First, maintain consistency in delivering services, promoting and providing safety for clients, and showing respect and compassion within the client–provider relationship. Along with clients' commitment to learning how to create safety for themselves, counselors and agencies need

to be aware of, and circumvent, practices that could retraumatize clients. Projecting hope and reinforcing the belief that recovery is possible extends well beyond the practice of establishing safety; it also encompasses discussing what recovery means and how it looks to clients, as well as identifying how they will know that they've entered into recovery in earnest.

Providing hope involves projecting an attitude that recovery is possible. This attitude also involves viewing clients as competent to make changes that will allow them to deal with trauma-related challenges, providing opportunities for them to practice dealing with difficult situations, and normalizing discomfort or difficult emotions and framing these as manageable rather than dangerous. If you convey this attitude consistently to your clients, they will begin to understand that discomfort is not a signal to avoid, but a sign to engage—and that behavioral, cognitive, and emotional responses to cues associated with previous traumas are a normal part of the recovery process. It's not the absence of responses to such triggers that mark recovery, but rather, how clients experience and manage those responses. Clients can also benefit from interacting with others who are further along in their recovery from trauma. Time spent with peer support staff or sharing stories with other trauma survivors who are well on their way to recovery is invaluable—it sends a powerful message that recovery is achievable, that there is no shame in being a trauma survivor, and that there is a future beyond the trauma.

As You Proceed

This chapter has established the foundation and rationale of this TIP, reviewed trauma-informed concepts and terminology, and provided an overview of TIC principles and a guiding framework for this text. As you proceed, be aware of the wide-ranging responses to trauma that occur not only across racially and ethnically diverse groups but also within specific communities, families, and individuals. Counselors, prevention specialists, other behavioral health workers, supervisors, and organizations all need to develop skills to create an environment that is responsive to the unique attributes and experiences of each client. As you read this TIP, remember that many cross-cutting factors influence the experiences, help-seeking behaviors, intervention responses, and outcomes of individuals, families, and populations who have survived trauma. Single, multiple, or chronic exposures to traumatic events, as well as the emotional, cognitive, behavioral, and spiritual responses to trauma, need to be understood within a social-ecological framework that recognizes the many ingredients prior to, during, and after traumatic experiences that set the stage for recovery.

2 Trauma Awareness

IN THIS CHAPTER

- Types of Trauma
- Characteristics of Trauma
- Individual and Sociocultural Features

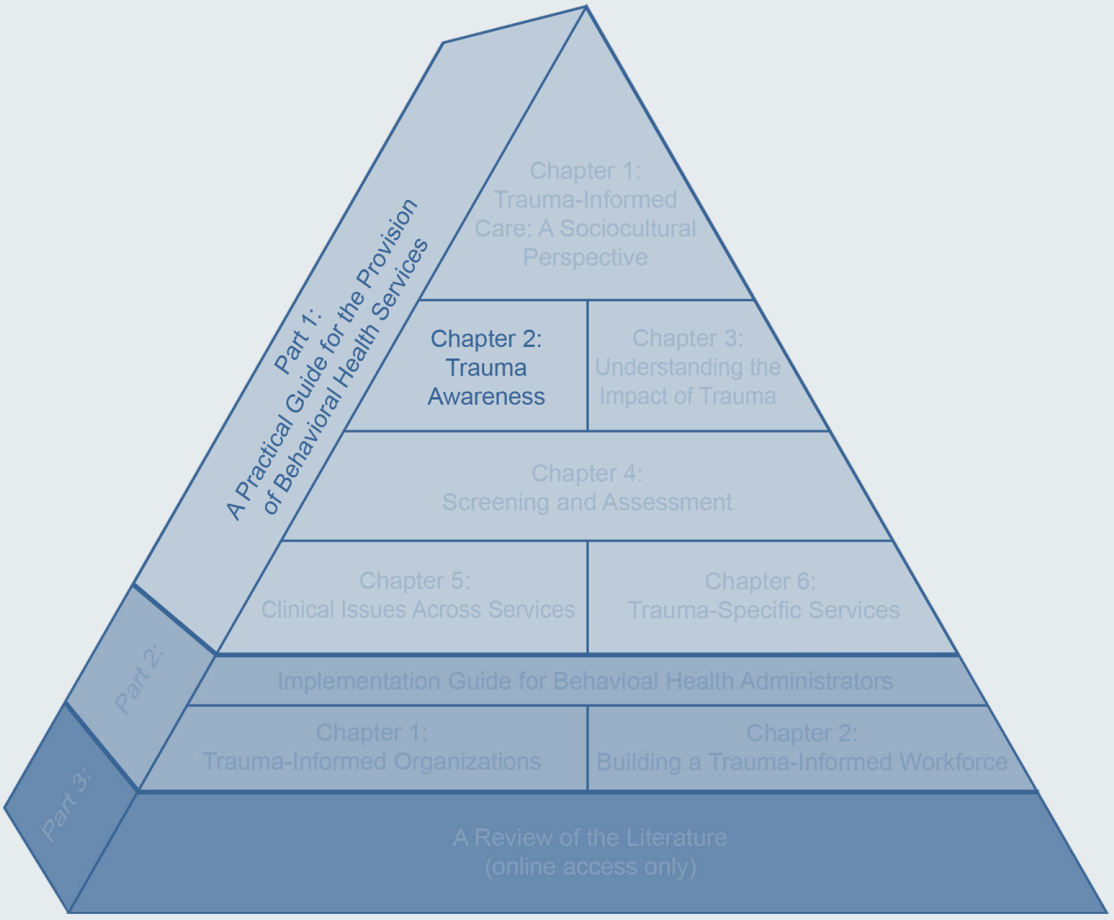
Traumatic experiences typically do not result in long-term impairment for most individuals. It is normal to experience such events across the lifespan; often, individuals, families, and communities respond to them with resilience. This chapter explores several main elements that influence why people respond differently to trauma. Using the social-ecological model outlined in Part 1, Chapter 1, this chapter explores some of the contextual and systemic dynamics that influence individual and community perceptions of trauma and its impact. The three main foci are: types of trauma, objective and subjective characteristics of trauma, and individual and sociocultural features that serve as risk or protective factors.

This chapter's main objective is to highlight the key characteristics of traumatic experiences. Trauma-informed behavioral health service providers understand that many influences shape the effects of trauma among individuals and communities—it is not just the event that determines the outcome, but also the event's context and the resultant interactions across systems.

Types of Trauma

The following section reviews various forms and types of trauma. It does not cover every conceivable trauma that an individual, group, or community may encounter. Specific traumas are reviewed only once, even when they could fit in multiple categories of trauma. Additionally, the order of appearance does not denote a specific trauma's importance or prevalence, and there is no lack of relevance implied if a given trauma is not specifically addressed in this Treatment Improvement Protocol (TIP). The intent is to give a broad perspective of the various categories and types of trauma to behavioral health workers who wish to be trauma informed.

TIC Framework in Behavioral Health Services—Trauma Awareness



Natural or Human-Caused Traumas

The classification of a trauma as natural or caused by humans can have a significant impact on the ways people react to it and on the types of assistance mobilized in its aftermath (see Exhibit 1.2-1 for trauma examples). Natural traumatic experiences can directly affect a small number of people, such as a tree falling on a car during a rainstorm, or many people and communities, as with a hurricane. Natural events, often referred to as "acts of God," are typically unavoidable. Human-caused traumas are caused by human failure (e.g., technological catastrophes, accidents, malevolence) or by human design (e.g., war). Although multiple factors contribute to the severity of a natural or human-caused trauma, traumas perceived as intentionally harmful often make the event more traumatic for people and communities.

For information on resources to prepare States, Territories, and local entities to deliver effective mental health and substance abuse responses during disasters, contact the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Disaster Technical Assistance Center:

4350 East West Hwy, Suite 1100
Bethesda, MD 20814 6233
Phone: 1 800 308 3515
Fax: 1 800 311 7691
Email: DTAC@samhsa.hhs.gov

Exhibit 1.2-1: Trauma Examples

Caused Naturally	Caused by People	
	Accidents, Technological Catastrophes	Intentional Acts
Tornado	Train derailment	Arson
Lightning strike	Roofing fall	Terrorism
Wildfire	Structural collapse	Sexual assault and abuse
Avalanche	Mountaineering accident	Homicides or suicides
Physical ailment or disease	Aircraft crash	Mob violence or rioting
Fallen tree	Car accident due to malfunction	Physical abuse and neglect
Earthquake	Mine collapse or fire	Stabbing or shooting
Dust storm	Radiation leak	Warfare
Volcanic eruption	Crane collapse	Domestic violence
Blizzard	Gas explosion	Poisoned water supply
Hurricane	Electrocution	Human trafficking
Cyclone	Machinery-related accident	School violence
Typhoon	Oil spill	Torture
Meteorite	Maritime accident	Home invasion
Flood	Accidental gun shooting	Bank robbery
Tsunami	Sports-related death	Genocide
Epidemic		Medical or food tampering
Famine		
Landslide or fallen boulder		

How survivors of natural trauma respond to the experience often depends on the degree of devastation, the extent of individual and community losses, and the amount of time it takes to reestablish daily routines, activities, and services (e.g., returning to school or work, being able to do laundry, having products to buy in a local store). The amount, accessibility, and duration of relief services can significantly influence the duration of traumatic stress reactions as well as the recovery process.

Alongside the disruption of daily routines, the presence of community members or outsiders in affected areas may add significant stress or create traumatic experiences in and of themselves. Examples include the threat of others stealing what remains of personal property, restrictions on travel or access to property or living quarters, disruption of privacy within shelters, media attention, and subsequent exposure to repetitive images reflecting the devastation. Therefore, it isn't just the natural disaster or event that can challenge an individual or community; often, the consequences of the event and behavioral responses from others within and outside the community play a role in pushing survivors away from effective coping or toward resilience and recovery.

Human-caused traumas are fundamentally different from natural disasters. They are either intentional, such as a convenience store robbery at gunpoint, or unintentional, such as the technological accident of a bridge collapse (as occurred in Minneapolis, Minnesota, in 2007; U.S. Fire Administration, 2007). The subsequent reactions to these traumas often depend on their intentionality. However, a person or group of people is typically the target of the survivors' anger and blame. Survivors of an unintentionally human-caused traumatic event may feel angry and frustrated because of the lack of protection or care offered by the responsible party or government, particularly if there has been a perceived act of omission. After intentional human-caused acts, survivors often struggle to understand the

Case Illustrations: Quecreek Mine Flood and Greensburg's Tornado

Quecreek Mine Flood

The year following the rescue of nine miners from the Quecreek mine in western Pennsylvania in 2002 was a difficult one for residents of Somerset County. The dazzle of publicity surrounding a handful of workers from a small town, tension between miners and rescuers, and animosity over money for movie and book deals, in addition to the trauma itself, resulted in a rescuer's suicide, a number of miners having trauma-related symptoms, and several rescuers needing to seek treatment for posttraumatic stress disorder (PTSD; Goodell, 2003).

Greensburg's Tornado

Greensburg, a small town in southern Kansas, was hit by a large tornado in 2007 that killed 11 residents and leveled 95 percent of the town while causing severe damage to the remaining 5 percent. Families and community members experienced significant grief and traumatic stress after the disaster. Yet today, Greensburg is rebuilding with a focus on being "green"—that is, environmentally responsible—from design to construction and all the way through demolition. This town has the highest number of Leadership in Energy and Environmental Design–certified buildings in the world. A reality television show about the town's reinvention ran for three seasons, demonstrating the town's residents and business owners working with local government and various corporations to make their home an even better place than it was before the tornado.

motives for performing the act, the calculated or random nature of the act, and the psychological makeup of the perpetrator(s).

Individual, Group, Community, and Mass Traumas

In recognizing the role of trauma and understanding responses to it, consider whether the trauma primarily affected an individual and perhaps his or her family (e.g., automobile accident, sexual or physical assault, severe illness); occurred within the context of a group (e.g., trauma experienced by first responders or those who have seen military combat) or community (e.g., gang-related shootings); transpired within a certain culture; or was a large-scale disaster (e.g., hurricane, terrorist attack). This context can have significant implications for whether (and how) people experience shame as a result of the trauma, the kinds of support and compassion they receive, whether their experiences are normalized or diminished by others, and even the kinds of services they are offered to help them recover and cope.

Individual trauma

An individual trauma refers to an event that only occurs to one person. It can be a single event (e.g., mugging, rape, physical attack, work-related physical injury) or multiple or prolonged events (e.g., a life-threatening illness, multiple sexual assaults). Although the trauma directly affects just one individual, others who know the person and/or are aware of the trauma will likely experience emotional repercussions from the event(s) as well, such as recounting what they said to the person before the event, reacting in disbelief, or thinking that it could just as easily have happened to them, too.

Survivors of individual trauma may not receive the environmental support and concern that members of collectively traumatized groups and communities receive. They are less likely to reveal their traumas or to receive validation of their experiences. Often, shame distorts their perception of responsibility for the trauma. Some survivors of individual traumas, especially those who have kept the trauma secret, may not receive needed comfort and

Advice to Counselors: Working With Clients Who Have Experienced Individual Traumas

In working with clients who have histories of individual trauma, counselors should consider that:

- Empathy, or putting oneself in the shoes of another, is more potent than sympathy (expressing a feeling of sorrow for another person).
- Some clients need to briefly describe the trauma(s) they have experienced, particularly in the early stages of recovery. Strategies that focus on reexperiencing the trauma, retrieving feelings related to the trauma, and bringing past experiences to the forefront should only be implemented if trauma-specific treatment planning and services are available.
- Understanding the trauma, especially in early recovery, should begin with educating the client about and normalizing trauma-related symptoms, creating a sense of safety within the treatment environment, and addressing how trauma symptoms may interfere with the client's life in the present.
- It is helpful to examine how the trauma affects opportunities to receive substance abuse and/or mental health treatment as well as treatment for and recovery from the trauma itself (e.g., by limiting one's willingness to share in or participate in group counseling).
- Identifying and exploring strengths in the client's history can help the client apply those strengths to his or her ability to function in the present.

acceptance from others; they are also are more likely to struggle with issues of causation (e.g., a young woman may feel unduly responsible for a sexual assault), to feel isolated by the trauma, and to experience repeated trauma that makes them feel victimized.

Physical injuries

Physical injuries are among the most prevalent individual traumas. Millions of emergency room (ER) visits each year relate directly to physical injuries. Most trauma patients are relatively young; about 70 percent of injury-related ER cases are people younger than 45 years old (McCaig & Burt, 2005). Dedicated ER hospital units, known as "trauma centers," specialize in physical traumas such as gunshot wounds, stabbings, and other immediate physical injuries. The term "trauma" in relation to ERs does not refer to psychological trauma, which is the focus of this TIP, yet physical injuries can be associated with psychological trauma. Sudden, unexpected, adverse health-related events can lead to extensive psychological trauma for patients and their families.

Excessive alcohol use is the leading risk factor for physical injuries; it's also the most promising target for injury prevention. Studies consistently connect injuries and substance use (Gentilello, Ebel, Wickizer, Salkever, & Rivara, 2005); nearly 50 percent of patients admitted to trauma centers have injuries attributable to alcohol abuse and dependence (Gentilello et al., 1999). One study found that two thirds of ambulatory assault victims presenting to an ER had positive substance use urinalysis results; more than half of all victims had PTSD 3 months later (Roy-Byrne et al.,

Acute stress disorder (ASD) prevalence among patients at medical trauma centers is very high, making trauma related disorders some of the most common complications seen in physically injured patients. Clients who have sustained serious injuries in car crashes, fires, stabbings, shootings, falls, and other events have an increased likelihood of developing trauma related mental disorders. Research suggests that PTSD and/or problem drinking is evident in nearly 50 percent of patients 1 year after discharge from trauma surgical units.

(Zatzick, Jurkovich, Gentilello, Wisner, & Rivara, 2002)

2004). Nearly 28 percent of patients whose drinking was identified as problematic during an ER visit for a physical injury will have a new injury within 1 year (Gentilello et al., 2005). For further information, see TIP 16, *Alcohol and Other Drug Screening of Hospitalized Trauma Patients* (Center for Substance Abuse Treatment [CSAT], 1995a).

Group trauma

The term "group trauma" refers to traumatic experiences that affect a particular group of people. This TIP intentionally distinguishes group trauma from mass trauma to highlight the unique experiences and characteristics of trauma-related reactions among small groups. These groups often share a common identity and history, as well as similar activities and concerns. They include vocational groups who specialize in managing traumas or who routinely place themselves in harm's way—for example, first responders, a group including police and emergency medical personnel. Some examples of group trauma include crews and their families who lose members from a commercial fishing accident, a gang whose members experience multiple deaths and injuries, teams of firefighters who lose members in a roof collapse, responders who attempt to save flood victims, and military service members in a specific theater of operation.

Survivors of group trauma can have different experiences and responses than survivors of individual or mass traumas. Survivors of group trauma, such as military service members and first responders, are likely to experience repeated trauma. They tend to keep the trauma experiences within the group, feeling that others outside the group will not understand; group outsiders are generally viewed as intruders. Members may encourage others in the group to shut down emotionally and repress their traumatic experiences—and there are some occupational roles that necessitate the repression of reactions to complete a mission or to be attentive to the needs at hand. Group members may not want to seek help and may discourage others from doing so out of fear that it may shame the entire group. In this environment, members may see it as a violation of group confidentiality when a member seeks assistance outside the group, such as by going to a counselor.

Group members who have had traumatic experiences in the past may not actively support traumatized colleagues for fear that acknowledging the trauma will increase the risk of repressed trauma-related emotions surfacing. However, groups with adequate resources for helping group members can develop a stronger and more supportive environment for handling subsequent traumas. These main group features influence the course of short- and long-term adjustments, including the development of traumatic stress symptoms associated with mental and substance use disorders.

Certain occupational groups are at greater risk of experiencing trauma—particularly multiple traumas. This TIP briefly reviews two main groups as examples in the following sections: first responders and military service members. For more detailed information on the impact of trauma and deployment, refer to the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (SAMHSA, planned f).

First responders

First responders are usually emergency medical technicians, disaster management personnel, police officers, rescue workers, medical and behavioral health professionals, journalists, and volunteers from various backgrounds. They also include lifeguards, military personnel, and clergy. Stressors associated with the kinds of traumatic events and/or disasters first responders are likely to experience include

exposure to toxic agents, feeling responsible for the lives of others, witnessing catastrophic devastation, potential exposure to gruesome images, observing human and animal suffering and/or death, working beyond physical exhaustion, and the external and internal pressure of working against the clock.

Military service members

Military personnel are likely to experience numerous stressors associated with trauma. Service members who have repeatedly deployed to a war zone are at a greater risk for traumatic stress reactions (also known as combat stress reaction or traumatic stress injury), other military personnel who provide support services are also at risk for traumatic stress and secondary trauma (refer to the glossary portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP). So too, service members who anticipate deployment or redeployment may exhibit psychological symptoms associated with traumatic stress. Some stressors that military service members may encounter include working while physically exhausted, exposure to gunfire, seeing or knowing someone who has been injured or killed, traveling in areas known for roadside bombs and rockets, extended hypervigilance, fear of being struck by an improvised explosive device, and so forth.

Trauma affecting communities and cultures

Trauma that affects communities and cultures covers a broad range of violence and atrocities that erode the sense of safety within a given community, including neighborhoods, schools, towns, and reservations. It may involve violence in the form of physical or sexual assaults, hate crimes, robberies, workplace or gang-related violence, threats, shootings, or stabbings—for example, the school shooting at Virginia Polytechnic Institute and State University in 2007. It also includes actions that attempt to dismantle systemic cultural practices, resources, and identities, such as making boarding school attendance mandatory for Native American children or placing them in non-Native foster homes. Cultural and/or community-based trauma can also occur via indifference or limited responsiveness to specific communities or cultures that are facing a potential catastrophe. Cultural traumas are events that, whether intentionally or not, erode the heritage of a culture—as with prejudice, disenfranchisement, and health inequities (e.g., late prenatal care, inability to afford medications, limited access to culturally appropriate health education, vicinity and quality of affordable medical services), among other examples.

"The excitement of the season had just begun, and then, we heard the news, oil in the water, lots of oil killing lots of water. It is too shocking to understand. Never in the millennium of our tradition have we thought it possible for the water to die, but it is true."

—Chief Walter Meganack, Port Graham, 1989

Of all the groups negatively affected by the Exxon Valdez oil spill, in many ways Alaska Natives were the most devastated. The oil spill destroyed more than economic resources; it shook the core cultural foundation of Native life. Alaska Native subsistence culture is based on an intimate relationship with the environment. Not only does the environment have sacred qualities for Alaska Natives; their survival also depends on the well-being of the ecosystem and the maintenance of cultural norms of subsistence. The spill directly threatened the well-being of the environment, disrupted subsistence behavior, and severely disturbed the sociocultural milieu of Alaska Natives.

Source: Gill & Picou, 1997, pp. 167–168.

Historical trauma

Historical trauma, known also as generational trauma, refers to events that are so widespread as to affect an entire culture; such events also have effects intense enough to influence generations of the culture beyond those who experienced them directly. The enslavement, torture, and lynching of African Americans; the forced assimilation and relocation of American Indians onto reservations; the extermination of millions of Jews and others in Europe during World War II; and the genocidal policies of the Hutus in Rwanda and the Khmer Rouge in Cambodia are examples of historical trauma.

In the past 50 years, research has explored the generational effects of the Holocaust upon survivors and their families. More recent literature has extended the concept of historical or generational trauma to the traumatic experiences of Native Americans. Reduced population, forced relocation, and acculturation are some examples of traumatic experiences that Native people have endured across centuries, beginning with the first European presence in the Americas. These tragic experiences have led to significant loss of cultural identity across generations and have had a significant impact on the well-being of Native communities (Whitbeck, Chen, Hoyt, & Adams, 2004). Data are limited on the association of mental and substance use disorders with historical trauma among Native people, but literature suggests that historical trauma has repercussions across generations, such as depression, grief, traumatic stress, domestic violence, and substance abuse, as well as significant loss of cultural knowledge, language, and identity (Gone, 2009). Historical trauma can increase the vulnerability of multiple generations to the effects of traumas that occur in their own lifetimes.

Mass trauma

Mass traumas or disasters affect large numbers of people either directly or indirectly. It is beyond the scope of this TIP to cover any specific disaster in detail; note, however, that mass traumas include large-scale natural and human-caused disasters (including intentional acts and accidents alike). Mass traumas may involve significant loss of property and lives as well as the widespread disruption of normal routines and services. Responding to such traumas often requires immediate and extensive resources that typically exceed the capacity of the affected communities, States, or countries in which they occur. Recent examples of such large-scale catastrophes include:

- In January 2010, a massive earthquake hit Haiti, killing hundreds of thousands of people and leaving over a million homeless.
- A nuclear reactor meltdown in the Ukraine in 1986 resulted in a technological and environmental disaster that affected tens of millions of people.
- The tsunami in the Indian Ocean in 2005 left hundreds of thousands dead in nine countries.

One factor that influences an individual's response to trauma is his or her ability to process one trauma before another trauma occurs. In mass traumas, the initial event causes considerable destruction, the consequences of which may spawn additional traumas and other stressful events that lead to more difficulties and greater need for adjustments among survivors, first responders, and disaster relief agencies. Often, a chain reaction occurs. Take, for example, Hurricane Katrina and its impact on the people of Louisiana and other coastal States. After the initial flooding, people struggled to obtain basic needs, including food, drinking water, safe shelter, clothing, medicines, personal hygiene items, and so forth, all as concern mounted about the safety of children and

other relatives, friends, and neighbors. In this and similar cases, the destruction from the initial flooding led to mass displacement of families and communities; many people had to relocate far from New Orleans and other badly affected areas, while also needing to gain financial assistance, reinitiate work to generate income, and obtain stable housing. People could not assimilate one stressor before another appeared.

Nevertheless, mass traumas can create an immediate sense of commonality—many people are "in the same boat," thus removing much of the isolation that can occur with other types of trauma. People can acknowledge their difficulties and receive support, even from strangers. It is easier to ask for help because blame is often externalized; large-scale disasters are often referred to as "acts of God" or, in cases of terrorism and other intentional events, as acts of "evil." Even so, survivors of mass trauma often encounter an initial rally of support followed by quickly diminishing services and dwindling care. When the disaster fades from the headlines, public attention and concern are likely to decrease, leaving survivors struggling to reestablish or reinvent their lives without much outside acknowledgment.

The experience of mass trauma can lead to the development of psychological symptoms and substance use at either a subclinical or a diagnostic level (refer to Part 3 of this TIP, available online, for more information highlighting the relationship between trauma and behavioral health problems). Likewise, one of the greatest risks for traumatic stress reactions after a mass tragedy is the presence of preexisting mental and co-occurring disorders, and individuals who are in early recovery from substance use disorders are at greater risk for such reactions as well. Nonetheless, people are amazingly resilient, and most will not develop long-term mental or substance use disorders after an event; in fact, most trauma-related symptoms will resolve in a matter of months (Keane & Piwowarczyk, 2006).

Interpersonal Traumas

Interpersonal traumas are events that occur (and typically continue to reoccur) between people who often know each other, such as spouses or parents and their children. Examples include physical and sexual abuse, sexual assault, domestic violence, and elder abuse.

Intimate partner violence

Intimate partner violence (IPV), often referred to as domestic violence, is a pattern of actual or threatened physical, sexual, and/or emotional abuse. It differs from simple assault in that multiple episodes often occur and the perpetrator is an intimate partner of the victim. Trauma associated with IPV is normally ongoing. Incidents of this form of violence are rarely isolated, and the client may still be in contact with and encountering abuse from the perpetrator while engaged in treatment.

Intimate partners include current and former spouses, boyfriends, and girlfriends. The majority of all nonfatal acts of violence and intimate partner homicides are committed against women; IPV accounts for over 20 percent of nonfatal violence against women but only 3.6 percent of that committed against men (Catalano, 2012). Children are the hidden casualties of IPV. They often witness the assaults or threats directly, within earshot, or by being exposed to the aftermath of the violence (e.g., seeing bruises and destruction of property, hearing the pleas for it to stop or the promises that it will never happen again).

Substance abuse, particularly involving alcohol, is frequently associated with IPV. It is the presence of alcohol-related problems in either partner, rather than the level of alcohol consumption itself, that is the important factor.

Drinking may or may not be the cause of the violence; that said, couples with alcohol-related disorders could have more tension and disagreement within the relationship in general, which leads to aggression and violence. The consumption of alcohol during a dispute is likely to decrease inhibitions and increase impulsivity, thus creating an opportunity for an argument to escalate into a physical altercation. More information on domestic violence and its effects on partners and families, as well as its connection with substance use and trauma-related disorders, is available in TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b), and from the National Online Resource Center on Violence Against Women (http://www.vawnet.org/).

Developmental Traumas

Developmental traumas include specific events or experiences that occur within a given developmental stage and influence later development, adjustment, and physical and mental health. Often, these traumas are related to adverse childhood experiences (ACEs), but they can also result from tragedies that occur outside an expected developmental or life stage (e.g., a child dying before a parent, being diagnosed with a life-threatening illness as a young adult) or from events at any point in the life cycle that create significant loss and have life-altering consequences (e.g., the death of a significant other in the later years that leads to displacement of the surviving partner).

Adverse childhood experiences

Some people experience trauma at a young age through sexual, physical, or emotional abuse and neglect. The Adverse Childhood Experiences Study (Felitti et al., 1998) examined the effects of several categories of ACEs on adult health, including physical and emotional abuse; sexual abuse; a substance-dependent parent; an incarcerated, mentally ill, or suicidal household member; spousal abuse between parents; and divorce or separation that meant one parent was absent during childhood. The National Comorbidity Studies examined the prevalence of trauma and defined childhood adversities as parental death, parental divorce/separation, life-threatening illness, or extreme economic hardship in addition to the childhood experiences included in the Adverse Childhood Experiences Study (Green et al., 2010).

ACEs can negatively affect a person's well-being into adulthood. Whether or not these experiences occur simultaneously, are time-limited, or recur, they set the stage for increased vulnerability to physical, mental, and substance use disorders and enhance the risk

Child Neglect

Child neglect occurs when a parent or caregiver does not give a child the care he or she needs according to his or her age, even though that adult can afford to give that care or is offered help to give that care. Neglect can mean not providing adequate nutrition, clothing, and/or shelter. It can mean that a parent or caregiver is not providing a child with medical or mental health treatment or is not giving prescribed medicines the child needs. Neglect can also mean neglecting the child's education. Keeping a child from school or from special education can be neglect. Neglect also includes exposing a child to dangerous environments (e.g., exposure to domestic violence). It can mean poor supervision for a child, including putting the child in the care of someone incapable of caring for children. It can mean abandoning a child or expelling him or her from home. Lack of psychological care, including emotional support, attention, or love, is also considered neglect—and it is the most common form of abuse reported to child welfare authorities.

Source: dePanfilis, 2006.

for repeated trauma exposure across the life span. Childhood abuse is highly associated with major depression, suicidal thoughts, PTSD, and dissociative symptoms. So too, ACEs are associated with a greater risk of adult alcohol use. When a person experiences several adverse events in childhood, the risk of his or her heavy drinking, self-reported alcohol dependence, and marrying a person who is alcohol dependent is two to four times greater than that of a person with no ACEs (Dube, Anda, Felitti, Edwards, & Croft, 2002).

A detailed examination of the issues involved in providing substance abuse treatment to survivors of child abuse and neglect is the subject of TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT, 2000b).

Political Terror and War

Political terror and war are likely to have lasting consequences for survivors. In essence, anything that threatens the existence, beliefs, well-being, or livelihood of a community is likely to be experienced as traumatic by community members. Whether counselors are working with an immigrant or refugee enclave in the United States or in another country, they should be aware of local events, local history, and the possibility that clients have endured trauma. (For international information about the clinical, historical, and theoretical aspects of trauma and terrorism, see Danieli, Brom, & Sills, 2005.) Terrorism is a unique subtype of human-caused disasters. The overall goal of terrorist attacks is to maximize the uncertainty, anxiety, and fear of a large community, so the responses are often epidemic and affect large numbers of people who have had direct or indirect exposure to an event (Silver et al., 2004; Suvak, Maguen, Litz, Silver, & Holman, 2008). Terrorism has a variety of results not common to other disasters, such as reminders of the unpredictability of terrorist acts; increases in security measures for the general population; intensified suspicion about a particular population, ethnicity, or culture; and heightened awareness and/or arousal.

Refugees

According to the World Refugee Survey, there are an estimated 12 million refugees and asylum seekers, 21 million internally displaced people, and nearly 35 million uprooted people (U.S. Committee for Refugees and Immigrants, 2006). Many of these people have survived horrendous ordeals with profound and lasting effects for individuals and whole populations. In addition to witnessing deaths by execution, starvation, or beatings, many survivors have experienced horrific torture.

Refugees are people who flee their homes because they have experienced or have a reasonable fear of experiencing persecution. They

Torture and Captivity

Torture traumatizes by taking away an individual's personhood. To survive, victims have to give up their sense of self and will. They become the person the torturer designs or a nonperson, simply existing. Inevitably, the shame of the victim is enormous, because the focus of torture is to humiliate and degrade. As a result, victims often seek to hide their trauma and significant parts of their selfhood long after torture has ended and freedom has been obtained. According to Judith Herman, "the methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma. They are organized techniques of disempowerment and disconnection. Methods of psychological control are designed to instill terror and helplessness and to destroy the victim's sense of self in relation to others."

Source: Herman, 1997, p. 77.

differ from immigrants who willingly leave their homes or homeland to seek better opportunities. Although immigrants may experience trauma before migrating to or after reaching their new destination, refugees will often have greater exposure to trauma before migration. Refugees typically come from war-torn countries and may have been persecuted or tortured. Consequently, greater exposure to trauma, such as torture, before migrating often leads to more adjustment-related difficulties and psychological symptoms after relocation (Steel et al., 2009).

Refugees typically face substantial difficulties in assimilating into new countries and cultures. Moreover, the environment can create a new set of challenges that may include additional exposure to trauma and social isolation (Miller et al., 2002). These as well as additional factors influence adjustment, the development of mental illness (including PTSD), and the occurrence of substance use disorders. Additional factors that influence outcomes after relocation include receptivity of the local community, along with opportunities for social support and culturally responsive services.

Among refugee populations in the United States, little research is available on rates of mental illness and co-occurring substance use disorders and traumatic stress among refugee populations. Substance use patterns vary based on cultural factors as well as assimilation, yet research suggests that trauma increases the risk for substance use among refugees after war-related experiences (Kozarić-Kovačić, Ljubin, & Grappe, 2000). Therefore, providers should expect to see trauma-related disorders among refugees who are seeking treatment for a substance use disorder and greater prevalence of substance use disorders among refugees who seek behavioral health services.

Vietnamese Refugees

"Wars always have consequences, both immediate and remote, and the consequences are often tragic. One tragic circumstance often caused by war is the forceful, disorganized, and uncontrollable mass movement of both civilians and soldiers trying to escape the horrors of the wars or of an oppressive regime.…

"Vietnamese communists, by taking power in the North in 1954 and then in the South in 1975, caused two major upheavals in the Land of the Small Dragon, as Vietnam was once called. The first Vietnam War led to the 1954 exodus during which 1 million people fled from the North to the South. The second Vietnam War resulted in the dispersion, from 1975-1992, of approximately 2 million Vietnamese all over the world. These significant, unplanned, and uncoordinated mass movements around the world not only dislocated millions of people, but also caused thousands upon thousands of deaths at sea.…

"The second and third wave of refugees from 1976 onward went through a more difficult time. They had to buy their way out and to hide from soldiers and the police who hunted them down. After catching them, the police either asked for brides or threw the escapees into jails. Those who evaded police still had to face engine failures, sea storms, pirates…They then had to survive overcrowded boats for days or weeks, during which food and water could not be replenished and living conditions were terrible… Many people died from exhaustion, dehydration, and hunger. Others suffered at the hands of terrifying pirates… After the sea ordeal came the overcrowded camps where living conditions were most often substandard and where security was painfully lacking.…

"In the United States, within less than 3 decades, the Vietnamese population grew from a minority of perhaps 1,000 persons to the second largest refugee group behind Cubans."

Source: Vo, 2006, pp. 1–4.

System-Oriented Traumas: Retraumatization

Retraumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma. Unfortunately, treatment settings and clinicians can create retraumatizing experiences, often without being aware of it, and sometimes clients themselves are not consciously aware that a clinical situation has actually triggered a traumatic stress reaction. Agencies that anticipate the risk for retraumatization and actively work on adjusting program policies and procedures to remain sensitive to the histories and needs of individuals who have undergone past trauma are likely to have more success in providing care, retaining clients, and achieving positive outcomes.

Staff and agency issues that can cause retraumatization include:

- Being unaware that the client's traumatic history significantly affects his or her life.
- Failing to screen for trauma history prior to treatment planning.
- Challenging or discounting reports of abuse or other traumatic events.
- Using isolation or physical restraints.
- Using experiential exercises that humiliate the individual.
- Endorsing a confrontational approach in counseling.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling behavior/feelings as pathological.
- Failing to provide adequate security and safety within the program.
- Limiting participation of the client in treatment decisions and planning processes.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate setting.

Advice to Counselors: Addressing Retraumatization

- Anticipate and be sensitive to the needs of clients who have experienced trauma regarding program policies and procedures in the treatment setting that might trigger memories of trauma, such as lack of privacy, feeling pushed to take psychotropic medications, perceiving that they have limited choices within the program or in the selection of the program, and so forth.
- Attend to clients' experiences. Ignoring clients' behavioral and emotional reactions to having their traumatic memories triggered is more likely to increase these responses than decrease them.
- Develop an individual coping plan in anticipation of triggers that the individual is likely to experience in treatment based on his or her history.
- Rehearse routinely the coping strategies highlighted in the coping plan. If the client does not practice strategies prior to being triggered, the likelihood of being able to use them effectively upon triggering is lessened. For example, it is far easier to practice grounding exercises in the absence of severe fear than to wait for that moment when the client is reexperiencing an aspect of a traumatic event. (For more information on grounding exercises, refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*; Najavits, 2002a, pp. 125–131.)
- Recognize that clinical and programmatic efforts to control or contain behavior in treatment can cause traumatic stress reactions, particularly for trauma survivors for whom being trapped was part of the trauma experience.
- Listen for the specific trigger that seems to be driving the client's reaction. It will typically help both the counselor and client understand the behavior and normalize the traumatic stress reactions.
- Make sure that staff and other clients do not shame the trauma survivor for his or her behavior, such as through teasing or joking about the situation.
- Respond with consistency. The client should not get conflicting information or responses from different staff members; this includes information and responses given by administrators.

- Having clients undress in the presence of others.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Imposing agency policies or rules without exceptions or an opportunity for clients to question them.
- Enforcing new restrictions within the program without staff–client communication.
- Limiting access to services for ethnically diverse populations.
- Accepting agency dysfunction, including lack of consistent, competent leadership.

Characteristics of Trauma

The following section highlights several selected characteristics of traumatic experiences that influence the effects of traumatic stress. Objective characteristics are those elements of a traumatic event that are tangible or factual; subjective characteristics include internal processes, such as perceptions of traumatic experiences and meanings assigned to them.

Objective Characteristics

Was it a single, repeated, or sustained trauma?

Trauma can involve a single event, numerous or repeated events, or sustained/chronic experiences. A *single trauma* is limited to a single point in time. A rape, an automobile accident, the sudden death of a loved one—all are examples of a single trauma. Some people who experience a single trauma recover without any specific intervention. But for others—especially those with histories of previous trauma or mental or substance use disorders, or those for whom the trauma experience is particularly horrific or overwhelming—a single trauma can result in traumatic stress symptoms and trauma- and stress-related disorders. Single traumas do not necessarily have a lesser psychological impact than repeated traumas. After the terrorist attacks on September 11, 2001—a significant single trauma—many Manhattan residents experienced intrusive memories and sleep disruption whether they were at the site of the attacks or watched television coverage of it (Ford & Fournier, 2007; Galea et al., 2002).

A series of traumas happening to the same person over time is known as *repeated trauma*. This can include repeated sexual or physical assaults, exposure to frequent injuries of others, or seemingly unrelated traumas. Military personnel, journalists covering stories of mass tragedies or prolonged conflicts, and first responders who handle hundreds of cases each year typify repeated trauma survivors. Repetitive exposure to traumas can have a cumulative effect over one's lifetime. A person who was assaulted during adolescence, diagnosed with a life-threatening illness in his or her thirties, and involved in a serious car accident later in life has experienced repeated trauma.

Some repeated traumas are sustained or chronic. Sustained trauma experiences tend to wear down resilience and the ability to adapt. Some examples include children who endure ongoing sexual abuse, physical neglect, or emotional abuse; people who are in violent relationships; and people who live in chronic poverty. Individuals in chronically stressful, traumatizing environments are particularly susceptible to traumatic stress reactions, substance use, and mental disorders.

Bidirectional relationships exist between trauma and substance use as well as trauma and mental illness. For example, abuse of alcohol and drugs increases the risk of a traumatic experience and creates greater vulnerability to the effects of trauma; substance abuse reduces a person's ability to take corrective and remedial actions that might reduce the impact of the trauma. Likewise, traumatic stress leads to a greater likelihood of

Case Illustration: Yourself

Think of a time that was particularly stressful (but not traumatic) in your life. Revisit this period as an observer watching the events unfold and then ask yourself, "What made this time particularly stressful?" It is likely that a part of your answer will include the difficulty of managing one situation before another circumstance came along demanding your time. Stressful times denote being bombarded with many things at one time, perceived or actual, without sufficient time or ability to address them emotionally, cognitively, spiritually, and/or physically. The same goes for trauma—rapid exposure to numerous traumas one after another lessens one's ability to process the event before the next onslaught. This creates a cumulative effect, making it more difficult to heal from any one trauma.

substance abuse that, in turn, increases the risk for additional exposure to trauma. Paralleling this bidirectional relationship, mental illness increases vulnerability to the effects of trauma and raises the risk for substance use disorders and for encountering additional traumatic events. So too, early exposure to ACEs is associated with traumatic stress reactions and subsequent exposure to trauma in adult years.

People who have encountered multiple and longer doses of trauma are at the greatest risk for developing traumatic stress. For example, military reservists and other military service members who have had multiple long tours of duty are at greater risk for traumatic stress reactions (see the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families;* SAMHSA, planned f). In addition, people are more likely to encounter greater impairment and distress from trauma if that trauma occurs with significant intensity and continues sporadically or unceasingly for extended periods.

Was there enough time to process the experience?

A particularly severe pattern of ongoing trauma, sometimes referred to as "cascading trauma," occurs when multiple traumas happen in a pattern that does not allow an individual to heal from one traumatic event before another occurs. Take, for example, California residents—they repeatedly face consecutive and/or simultaneous natural disasters including fires, landslides, floods, droughts, and earthquakes. In other cases, there is ample time to process an event, but processing is limited because people don't have supportive relationships or environments that model preventive practices. This can lead to greater vulnerability to traumas that occur later in life.

How many losses has the trauma caused?

Trauma itself can create significant distress, but often, the losses associated with a trauma have more far-reaching effects. For instance, a child may be forced to assume adult responsibilities, such as serving as a confidant for a parent who is sexually abusing him or her, and lose the opportunity of a childhood free from adult worries. In another scenario, a couple may initially feel grateful to have escaped a house fire, but they may nevertheless face significant community and financial losses months afterward. In evaluating the impact of trauma, it is helpful to access and discuss the losses associated with the initial trauma. The number of losses greatly influences an individual's ability to bounce back from the tragedy.

In the case illustration on the next page, Rasheed's losses cause him to disconnect from his wife, who loves and supports him. Successful confrontation of losses can be difficult if the losses compound each other, as with Rasheed's loss of his friend, his disability, his employment struggles, and the threats to his marriage and liberty. People can cite a specific

Case Illustration: Rasheed

Rasheed was referred to an employee assistance program by his employer. He considered quitting his job, but his wife insisted he talk to a counselor. He is a 41-year-old auto mechanic who, 4 years ago, caused a head-on collision while attempting to pass another vehicle. A close friend, riding in the passenger's seat, was killed, and two young people in the other vehicle were seriously injured and permanently disabled. Rasheed survived with a significant back injury and has only been able to work sporadically. He was convicted of negligent homicide and placed on probation because of his physical disability. He is on probation for another 4 years, and if he is convicted of another felony during that time, he will have to serve prison time for his prior offense.

While still in the hospital, Rasheed complained of feeling unreal, numb, and disinterested in the care he received. He did not remember the crash but remembers waking up in the hospital 2 days later. He had difficulty sleeping in the hospital and was aware of feelings of impending doom, although he was unaware of the legal charges he would later face. He was diagnosed with ASD.

He was discharged from the hospital with a variety of medications, including pain pills and a sleep aid. He rapidly became dependent on these medications, feeling he could not face the day without the pain medication and being unable to sleep without sleep medicine in larger doses than had been prescribed. Within 3 months of the accident, he was "doctor shopping" for pain pills and even had a friend obtain a prescription for the sleeping medication from that friend's doctor. In the 4 intervening years, Rasheed's drug use escalated, and his blunted emotions and detachment from friends became more profound. He became adept at obtaining pain pills from a variety of sources, most of them illegal. He fears that if he seeks treatment for the drug problem, he will have to admit to felony offenses and will probably be imprisoned. He also does not believe he can manage his life without the pain pills.

In the past 2 years, he has had recurring dreams of driving a car on the wrong side of the road and into the headlights of an oncoming vehicle. In the dream, he cannot control the car and wakes up just before the vehicles crash. At unusual times—for instance, when he is just awakening in the morning, taking a shower, or walking alone—he will feel profound guilt over the death of his friend in the accident. He becomes very anxious when driving in traffic or when he feels he is driving faster than he should. His marriage of 18 years has been marked by increasing emotional distance, and his wife has talked about separating if he does not do something about his problem. He has been unable to work consistently because of back pain and depression. He was laid off from one job because he could not concentrate and was making too many mistakes.

The counselor in the employee assistance program elicited information on Rasheed's drug use, although she suspected Rasheed was minimizing its extent and effects. Knowledgeable about psychological trauma, the counselor helped Rasheed feel safe enough to talk about the accident and how it had affected his life. She was struck by how little Rasheed connected his present difficulties to the accident and its aftermath. The counselor later commented that Rasheed talked about the accident as if it had happened to someone else. Rasheed agreed to continue seeing the counselor for five additional visits, during which time a plan would be made for Rasheed to begin treatment for drug dependence and PTSD.

event as precipitating their trauma, or, in other cases, the specific trauma can symbolize a series of disabling events in which the person felt his or her life was threatened or in which he or she felt emotionally overwhelmed, psychologically disorganized, or significantly disconnected from his or her surroundings. It will be important for Rasheed to understand how his losses played a part in his abuse of prescription medications to cope with symptoms associated with traumatic stress and loss, (e.g., guilt, depression, fear). If not addressed, his trauma could increase his risk for relapse.

Was the trauma expected or unexpected?

When talking about a trauma, people sometimes say they didn't see it coming. Being unprepared, unaware, and vulnerable often increases the risk of psychological injury, but these are common components of most traumas, given that most traumatic events do occur without warning (e.g., car crashes, terrorist attacks, sexual assaults). People with substance use disorders, mental illness, and/or cognitive disabilities may be especially vulnerable in that they may attend less or have competing concerns that diminish attention to what is going on around them, even in high-risk environments. However, most individuals attempt to gain some control over the tragedy by replaying the moments leading up to the event and processing how they could have anticipated it. Some people perseverate on these thoughts for months or years after the event.

Sometimes, a trauma is anticipated but has unexpected or unanticipated consequences, as in the case of Hurricane Katrina. Learning about what is likely to happen can reduce traumatization. For instance, training military personnel in advance of going to combat overseas prepares them to handle traumas and can reduce the impact of trauma.

Were the trauma's effects on the person's life isolated or pervasive?

When a trauma is isolated from the larger context of life, a person's response to it is more likely to be contained and limited. For instance, military personnel in combat situations can be significantly traumatized by what they experience. On return to civilian life or noncombat service, some are able to isolate the traumatic experience so that it does not invade ordinary, day-to-day living. This does not mean that the combat experience was not disturbing or that it will not resurface if the individual encounters an experience that triggers memories of the trauma; it just means that the person can more easily leave the trauma in the past and attend to the present.

Conversely, people who remain in the vicinity of the trauma may encounter greater challenges in recovery. The traumatic event intertwines with various aspects of the person's daily activities and interactions, thus increasing the possibility of being triggered by surrounding cues and experiencing subsequent psychological distress. However, another way to view this potential dilemma for the client is to reframe it as an opportunity—the repetitive exposure to trauma-related cues may provide vital guidance as to when and which treatment and coping techniques to use in the delivery of trauma-informed and trauma-specific behavioral health services.

Who was responsible for the trauma and was the act intentional?

If the severity of a trauma is judged solely by whether the act was intentional or not, events that reflect an intention to harm would be a primary indicator in predicting subsequent difficulties among individuals exposed to this form of trauma. For most survivors, there is an initial disbelief that someone would conceivably intend to harm others, followed by considerable emotional and, at times, behavioral investment in somehow making things right again or in making sense of a senseless, malicious act. For instance, in the wake of the World Trade Center attacks in New York City, people responded via renewed patriotism, impromptu candlelight vigils, attacks on people of Arab and Muslim descent, and unprecedented donations and willingness to wait in long lines to donate blood to the Red Cross. Each example is a response that in some way attempts to right the perceived wrong or attach new meaning to the event and subsequent consequences.

When terrible things happen, it is human nature to assign blame. Trauma survivors can become heavily invested in assigning blame or finding out who was at fault, regardless of the type of trauma. Often, this occurs as an attempt to make sense of, give meaning to, and reestablish a sense of predictability, control, and safety after an irrational or random act. It is far easier to accept that someone, including oneself, is at fault or could have done something different than it is to accept the fact that one was simply in the wrong place at the wrong time.

For some trauma survivors, needing to find out why a trauma occurred or who is at fault can become a significant block to growth when the individual would be better served by asking, "What do I need to do to heal?" Behavioral health professionals can help clients translate what they have learned about responsibility in recovery to other aspects of their lives. For instance, someone in treatment for co-occurring disorders who has internalized that becoming depressed or addicted was not his or her fault, but that recovery *is* a personal responsibility, can then apply the same principle to the experience of childhood abuse and thereby overcome negative judgments of self (e.g., thinking oneself to be a bad person who deserves abuse). The individual can then begin to reassign responsibility by attaching the blame to the perpetrator(s) while at the same time assuming responsibility for recovery.

Was the trauma experienced directly or indirectly?

Trauma that happens to someone directly seems to be more damaging than witnessing trauma that befalls others. For example, it is usually more traumatic to be robbed at gunpoint than to witness someone else being robbed or hearing someone tell a story about being robbed. Yet, sometimes, experiencing another's pain can be equally traumatic. For instance, parents often internalize the pain and suffering of their children when the children are undergoing traumatic circumstances (e.g., treatments for childhood cancer).

There are two ways to experience the trauma of others. An individual may witness the event, such as seeing someone killed or seriously injured in a car accident, or may learn of an event that happened to someone, such as a violent personal assault, suicide, serious accident, injury, or sudden or unexpected death. For many people, the impact of the trauma will depend on a host of variables, including their proximity to the event as eyewitnesses, the witnesses' response in the situation, their relationship to the victims, the degree of helplessness surrounding the experience, their exposure to subsequent consequences, and so on.

Case Illustration: Frank

Frank entered substance abuse treatment with diagnoses of co-occurring PTSD and substance use disorder. While on a whitewater kayak trip with his wife, her kayak became pinned on a rock, and Frank could only watch helplessly as she drowned. His drinking had increased markedly after the accident. He acknowledged a vicious cycle of sleep disturbance with intrusive nightmares followed by vivid memories and feelings of terror and helplessness after he awoke. He drank heavily at night to quiet the nightmares and memories, but heavy alcohol consumption perpetuated his trouble sleeping. He withdrew from contact with many of his old "couple friends" and his wife's family, with whom he had been close. At treatment entry, he described his life as "going to work and coming home." The trauma occurred 3 years before he sought treatment, but Frank continued to feel numb and disconnected from the world. His only emotion was anger, which he tried to keep in check. Integrated treatment for PTSD and substance abuse helped him sleep and taught him coping skills to use when the memories arose; it fostered his engagement and retention in long-term care for both disorders.

The effects of traumas such as genocide and internment in concentration camps can be felt across generations—stories, coping behaviors, and stress reactions can be passed across generational lines far removed from the actual events or firsthand accounts. Known as historical trauma, this type of trauma can affect the functioning of families, communities, and cultures for multiple generations.

What happened since the trauma?

In reviewing traumatic events, it is important to assess the degree of disruption after the initial trauma has passed, such as the loss of employment, assets, community events, behavioral health services, local stores, and recreational areas. There is typically an initial rally of services and support following a trauma, particularly if it is on a mass scale. However, the reality of the trauma's effects and their disruptiveness may have a more lasting impact. The deterioration of normalcy, including the disruption of day-to-day activities and the damage of structures that house these routines, will likely erode the common threads that provide a sense of safety in individual lives and communities. Hence, the degree of disruption in resuming normal daily activities is a significant risk factor for substance use disorders, subclinical psychological symptoms, and mental disorders. For example, adults displaced from their homes because of Hurricanes Katrina or Rita had significantly higher rates of past-month cigarette use, illicit drug use, and binge drinking than those who were not displaced (Office of Applied Studies, 2008).

Subjective Characteristics

Psychological meaning of trauma

An important clinical issue in understanding the impact of trauma is the meaning that the survivor has attached to the traumatic experience. Survivors' unique cognitive interpretations of an event—that is, their beliefs and assumptions—contribute to how they process, react to, cope with, and recover from the trauma. Does the event represent retribution for past deeds committed by the individual or his or her family? How does the individual attach meaning to his or her survival? Does he or she believe that it is a sign of a greater purpose not yet revealed? People who attempt to share their interpretation and meaning of the event can feel misunderstood and sometimes alienated (Paulson & Krippner, 2007; Schein, Spitz, Burlingame, & Muskin, 2006).

> It is important to remember that what happened is not nearly as important as what the trauma means to the individual.

People interpret traumatic events in vastly different ways, and many variables shape how an individual assigns meaning to the experience (framing the meaning through culture, family beliefs, prior life experiences and learning, personality and other psychological features, etc.). Even in an event that happens in a household, each family member may interpret the experience differently. Likewise, the same type of event can occur at two different times in a person's life, but his or her interpretation of the events may differ considerably because of developmental differences acquired between events, current cognitive and emotional processing skills, availability of and access to environmental resources, and so forth.

Disruption of core assumptions and beliefs

Trauma often engenders a crisis of faith (Frankl, 1992) that leads clients to question basic assumptions about life. Were the individual's core or life-organizing assumptions (e.g., about safety, perception of others, fairness, purpose of life, future dreams) challenged or disrupted during or after the traumatic event? (See the seminal work,

Resilience: Connection and Continuity

Research suggests that reestablishing ties to family, community, culture, and spiritual systems is not only vital to the individual, but it also influences the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of survivors of Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents directly affected by the purge experienced fewer negative effects than those who were emotionally or physically severed from their grandparents. Whether the grandparents survived was less important than the connection the grandchildren felt to their pasts.

Shattered Assumptions, by Janoff-Bulman, 1992.) For example, some trauma survivors see themselves as irreparably wounded or beyond the possibility of healing. The following case illustration (Sonja) explores not only the importance of meaning, but also the role that trauma plays in altering an individual's core assumptions—the very assumptions that provide meaning and a means to organize our lives and our interactions with the world and others.

Cultural meaning of trauma

Counselors should strive to appreciate the cultural meaning of a trauma. How do cultural interpretations, cultural support, and cultural responses affect the experience of trauma? It is critical that counselors do not presume to understand the meaning of a traumatic experience without considering the client's cultural context. Culture strongly influences the perceptions of trauma. For instance, a trauma involving shame can be more profound for a person from an Asian culture than for someone from a European culture. Likewise, an Alaska Native individual or community, depending upon their Tribal ancestry, may believe that the traumatic experience serves as a form of retribution. Similarly, the sudden death of a family member or loved one can be less traumatic in a culture that has a strong belief in a positive afterlife. It is important for counselors to recognize that their perceptions of a specific trauma could be very different from their clients' perceptions. Be careful not to judge a client's beliefs in light of your own value system. For more information on culture and how to achieve cultural competence in providing behavioral health services, see SAMHSA's planned TIP, *Improving Cultural Competence* (SAMHSA, planned c).

Individual and Sociocultural Features

A wide variety of social, demographic, environmental, and psychological factors influence a person's experience of trauma, the severity of traumatic stress reactions following the event, and his or her resilience in dealing with the short- and long-term environmental, physical, sociocultural, and emotional consequences. This section addresses a few known factors that influence the risk of trauma along with the development of subclinical and diagnostic traumatic stress symptoms, such as mood and anxiety symptoms and disorders. It is not meant to be an exhaustive exploration of these factors, but rather, a brief presentation to make counselors and other behavioral health professionals aware that various factors influence risk for and protection against traumatic stress and subsequent reactions. (For a broader perspective on such factors, refer to Part 1, Chapter 1.)

Individual Factors

Several factors influence one's ability to deal with trauma effectively and increase one's risk for traumatic stress reactions. Individual factors pertain to the individual's genetic, biological, and psychological makeup and history as they influence the person's experience and

Case Illustration: Sonja

Sonja began to talk about how her life was different after being physically assaulted and robbed in a parking lot at a local strip mall a year ago. She recounts that even though there were people in the parking lot, no one came to her aid until the assailant ran off with her purse. She sustained a cheekbone fracture and developed visual difficulties due to the inflammation from the fracture. She recently sought treatment for depressive symptoms and reported that she had lost interest in activities that typically gave her joy. She reported isolating herself from others and said that her perception of others had changed dramatically since the attack.

Sonja had received a diagnosis of major depression with psychotic features 10 years earlier and received group therapy at a local community mental health center for 3 years until her depression went into remission. She recently became afraid that her depression was becoming more pronounced, and she wanted to prevent another severe depressive episode as well as the use of psychotropic medications, which she felt made her lethargic. Thus, she sought out behavioral health counseling.

As the sessions progressed, and after a psychological evaluation, it was clear that Sonja had some depressive symptoms, but they were subclinical. She denied suicidal thoughts or intent, and her thought process was organized with no evidence of hallucinations or delusions. She described her isolation as a reluctance to shop at area stores. On one hand, Sonja was self-compassionate about her reasons for avoidance, but on the other hand, she was concerned that the traumatic event had altered how she saw life and others. "I don't see people as very caring or kind, like I used to prior to the event. I don't trust them, and I feel people are too self-absorbed. I don't feel safe, and this bothers me. I worry that I'm becoming paranoid again. I guess I know better, but I just want to have the freedom to do what I want and go where I want."

Two months after Sonja initiated counseling, she came to the office exclaiming that things can indeed change. "You won't believe it. I had to go to the grocery store, so I forced myself to go the shopping center that had a grocery store attached to a strip mall. I was walking by a coffee shop, quickly browsing the items in the front window, when a man comes out of the shop talking at me. He says, 'You look like you need a cup of coffee.' What he said didn't register immediately. I looked at him blankly, and he said it again. 'You look like you need a cup of coffee. I'm the owner of the shop, and I noticed you looking in the window, and we have plenty of brewed coffee left before we close the shop. Come on in, it's on the house.' So I did! From that moment on, I began to see people differently. He set it right for me—I feel as if I have myself back again, as if the assault was a sign that I shouldn't trust people, and now I see that there is some goodness in the world. As small as this kindness was, it gave me the hope that I had lost."

For Sonja, the assault changed her assumptions about safety and her view of others. She also attached meaning to the event. She believed that the event was a sign that she shouldn't trust people and that people are uncaring. Yet these beliefs bothered her and contradicted how she saw herself in the world, and she was afraid that her depressive symptoms were returning.

For an inexperienced professional, her presentation may have ignited suspicions that she was beginning to present with psychotic features. However, it is common for trauma survivors to experience changes in core assumptions immediately after the event and to attach meaning to the trauma. Often, a key ingredient in the recovery process is first identifying the meaning of the event and the beliefs that changed following the traumatic experience. So when you hear a client say "I will never see life the same," this expression should trigger further exploration into how life is different, what meaning has been assigned to the trauma, and how the individual has changed his or her perception of self, others, and the future.

(Continued on the next page.)

Case Illustration: Sonja (continued)

Sometimes, reworking the altered beliefs and assumptions occurs with no formal intervention, as with Sonja. In her situation, a random stranger provided a moment that challenged an assumption generated from the trauma. For others, counseling may be helpful in identifying how beliefs and thoughts about self, others, and the world have changed since the event and how to rework them to move beyond the trauma. It is important to understand that the meaning that an individual attaches to the event(s) can either undermine the healing process (e.g., believing that you should not have survived, feeling shame about the trauma, continuing to engage in high-risk activities) or pave the road to recovery (e.g., volunteering to protect victim rights after being sexually assaulted). The following questions can help behavioral health staff members introduce topics surrounding assumptions, beliefs, interpretations, and meanings related to trauma:

- In what ways has your life been different since the trauma?
- How do you understand your survival? (This is an important question for clients who have been exposed to ACEs or cumulative trauma and those who survived a tragedy when others did not.)
- Do you believe that there are reasons that this event happened to you? What are they?
- What meaning does this experience have for you?
- Do you feel that you are the same person as before the trauma? In what ways are you the same? In what ways do you feel different?
- How did this experience change you as a person? Would you like to return to the person you once were? What would you need to do, or what would need to happen, for this to occur?
- Did the traumatic experience change you in a way that you don't like? In what ways?
- How do you view others and your future differently since the trauma?
- What would you like to believe now about the experience?

interpretation of, as well as his or her reactions to, trauma. However, many factors influence individual responses to trauma; it is not just individual characteristics. Failing to recognize that multiple factors aside from individual attributes and history influence experiences during and after trauma can lead to blaming the victim for having traumatic stress.

History of prior psychological trauma

People with histories of prior psychological trauma appear to be the most susceptible to severe traumatic responses (Nishith, Mechanic, & Resick, 2000; Vogt, Bruce, Street, & Stafford, 2007), particularly if they have avoided addressing past traumas. Because minimization, dissociation, and avoidance are common defenses for many trauma survivors, prior traumas are not always consciously available, and when they are, memories can be distorted to avoid painful affects. Some survivors who have repressed their experiences deny a history of trauma or are unable to explain their strong reactions to present situations.

Remember that the effects of trauma are cumulative; therefore, a later trauma that outwardly appears less severe may have more impact upon an individual than a trauma that occurred years earlier. Conversely, individuals who have experienced earlier traumas may have developed effective coping strategies or report positive outcomes as they have learned to adjust to the consequences of the trauma(s). This outcome is often referred to as posttraumatic growth or psychological growth.

Clients in behavioral health treatment who have histories of trauma can respond negatively to or seem disinterested in treatment efforts. They may become uncomfortable in groups that emphasize personal sharing; likewise, an individual who experiences brief bouts of dissociation (a reaction of some trauma survivors) may be misunderstood by others in treatment and seen as uninterested. Providers need to

attend to histories, adjust treatment to avoid retraumatization, and steer clear of labeling clients' behavior as pathological.

History of resilience

Resilience—the ability to thrive despite negative life experiences and heal from traumatic events—is related to the internal strengths and environmental supports of an individual. Most individuals are resilient despite experiencing traumatic stress. The ability to thrive beyond the trauma is associated with individual factors as well as situational and contextual factors. There are not only one or two primary factors that make an individual resilient; many factors contribute to the development of resilience. There is little research to indicate that there are specific traits predictive of resilience; instead, it appears that more general characteristics influence resilience, including neurobiology (Feder, Charney, & Collins, 2011), flexibility in adapting to change, beliefs prior to trauma, sense of self-efficacy, and ability to experience positive emotions (Bonanno & Mancini, 2011).

History of mental disorders

The correlations among traumatic stress, substance use disorders, and co-occurring mental disorders are well known. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (American Psychiatric Association, 2013a), traumatic stress reactions are linked to higher rates of mood, substance-related, anxiety, trauma, stress-related, and other mental disorders, each of which can precede, follow, or emerge concurrently with trauma itself. A co-occurring mental disorder is a significant determinant of whether an individual can successfully address and resolve trauma as it emerges from the past or occurs in the present. Koenen, Stellman, Stellman, and Sommer (2003) found that the risk of developing PTSD following combat trauma was higher for individuals with preexisting conduct disorder, panic disorder, generalized anxiety disorder, and/or major depression than for those without preexisting mental disorders. For additional information on comorbidity of trauma and other mental disorders, see TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c).

Sociodemographic Factors

Demographic variables are not good predictors of who will experience trauma and subsequent traumatic stress reactions. Gender, age, race and ethnicity, sexual orientation, marital status, occupation, income, and education can all have some influence, but not enough to determine who should or should not receive screening for trauma and traumatic stress symptoms. The following sections cover a few selected variables. (For more information, please refer to Part 3 of this TIP, the online literature review.)

Gender

In the United States, men are at greater risk than women for being exposed to stressful events. Despite the higher prevalence among men, lifetime PTSD occurs at about twice the rate among women as it does in men. Less is known about gender differences with subclinical traumatic stress reactions. There are also other gender differences, such as the types of trauma experienced by men and women. Women are more likely to experience physical and sexual assault, whereas men are most likely to experience combat and crime victimization and to witness killings and serious injuries (Breslau, 2002; Kimerling, Ouimette, & Weitlauf, 2007; Tolin & Foa, 2006). Women in military service are subject to the same risks as men and are also at a greater risk for military sexual trauma. Men's traumas often occur in public; women's are more likely to take place in private settings. Perpetrators of traumas against men are often strangers, but women are more likely to know the perpetrator.

Age

In general, the older one becomes, the higher the risk of trauma—but the increase is not dramatic. Age is not particularly important in predicting exposure to trauma, yet at no age is one immune to the risk. However, trauma that occurs in the earlier and midlife years appears to have greater impact on people for different reasons. For younger individuals, the trauma can affect developmental processes, attachment, emotional regulation, life assumptions, cognitive interpretations of later experiences, and so forth (for additional resources, visit the National Child Traumatic Stress Network; http://www.nctsn.org/). For adults in midlife, trauma may have a greater impact due to the enhanced stress or burden of care that often characterizes this stage of life—caring for their children and their parents at the same time. Older adults are as likely as younger adults to recover quickly from trauma, yet they may have greater vulnerabilities, including their ability to survive without injury and their ability to address the current trauma without psychological interference from earlier stressful or traumatic events. Older people are naturally more likely to have had a history of trauma because they have lived longer, thus creating greater vulnerability to the effects of cumulative trauma.

Race, ethnicity, and culture

The potential for trauma exists in all major racial and ethnic groups in American society, yet few studies analyze the relationship of race and ethnicity to trauma exposure and/or traumatic stress reactions. Some studies show that certain racial and ethnic groups are at greater risk for specific traumas. For example, African Americans experienced higher rates of overall violence, aggravated assault, and robbery than Whites but were as likely to be victims of rape or sexual assault (Catalano, 2004). Literature reflects that diverse ethnic, racial, and cultural groups are more likely to experience adverse effects from various traumas and to meet criteria for posttraumatic stress (Bell, 2011).

Sexual orientation and gender identity

Lesbian, gay, bisexual, and transgender individuals are likely to experience various forms of trauma associated with their sexual orientation, including harsh consequences from families and faith traditions, higher risk of assault from casual sexual partners, hate crimes, lack of legal protection, and laws of exclusion (Brown, 2008). Gay and bisexual men as well as transgender people are more likely to experience victimization than lesbians and bisexual women. Dillon (2001) reported a trauma exposure rate of 94 percent among lesbian, gay,

Resilience: Cultural, Racial, and Ethnic Characteristics

The following list highlights characteristics that often nurture resilience among individuals from diverse cultural, racial, and ethnic groups:

- Strong kinship bonds
- Respect for elders and the importance of extended family
- Spirituality and religious practices (e.g., shrine visitations or the use of traditional healers)
- Value in friendships and warm personal relationships
- Expression of humor and creativity
- Instilling a sense of history, heritage, and historical traditions
- Community orientation, activities, and socialization
- Strong work ethic
- Philosophies and beliefs about life, suffering, and perseverance

"Fortune owes its existence to misfortune, and misfortune is hidden in fortune."

–Lao-Tzu teaching, Taoism (Wong & Wong, 2006)

and bisexual individuals; more than 40 percent of respondents experienced harassment due to their sexual orientation. Heterosexual orientation is also a risk for women, as women in relationships with men are at a greater risk of being physically and sexually abused.

People who are homeless

Homelessness is typically defined as the lack of an adequate or regular dwelling, or having a nighttime dwelling that is a publicly or privately supervised institution or a place not intended for use as a dwelling (e.g., a bus station). The U.S. Department of Housing and Urban Development (HUD) estimates that between 660,000 and 730,000 individuals were homeless on any given night in 2005 (HUD, 2007). Two thirds were unaccompanied persons; the other third were people in families. Adults who are homeless and unmarried are more likely to be male than female. About 40 percent of men who are homeless are veterans (National Coalition for the Homeless, 2002); this percentage has grown, including the number of veterans with dependent children (Kuhn & Nakashima, 2011).

Rates of trauma symptoms are high among people who are homeless (76 to 100 percent of women and 67 percent of men; Christensen et al., 2005; Jainchill, Hawke, & Yagelka, 2000), and the diagnosis of PTSD is among the most prevalent non-substance use Axis I disorders (Lester et al., 2007; McNamara, Schumacher, Milby, Wallace, & Usdan, 2001). People who are homeless report high levels of trauma (especially physical and sexual abuse in childhood or as adults) preceding their homeless status; assault, rape, and other traumas frequently happen while they are homeless. Research suggests that many women are homeless because they are fleeing domestic violence (National Coalition for the Homeless, 2002). Other studies suggest that women who are homeless are more likely to have histories of childhood physical and sexual abuse and to have experienced sexual assault as adults. A history of physical and/or sexual abuse is even more common among women who are homeless and have a serious mental illness.

Youth who are homeless, especially those who live without a parent, are likely to have experienced physical and/or sexual abuse. Between 21 and 42 percent of youth runaways report having been sexually abused before leaving their homes; for young women, rates range from 32 to 63 percent (Administration on Children, Youth and Families, 2002). Additionally, data reflect elevated rates of substance abuse for youth who are homeless and have histories of abuse.

More than half of people who are homeless have a lifetime prevalence of mental illness and substance use disorders. Those who are homeless have higher rates of substance abuse (84 percent of men and 58 percent of women), and substance use disorders, including alcohol and drug abuse/dependence, increase with longer lengths of homelessness (North, Eyrich, Pollio, & Spitznagel, 2004).

For more information on providing trauma-informed behavioral health services to clients who are homeless, and for further discussion of the incidence of trauma in this population, see TIP 55-R, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2013b).

3 Understanding the Impact of Trauma

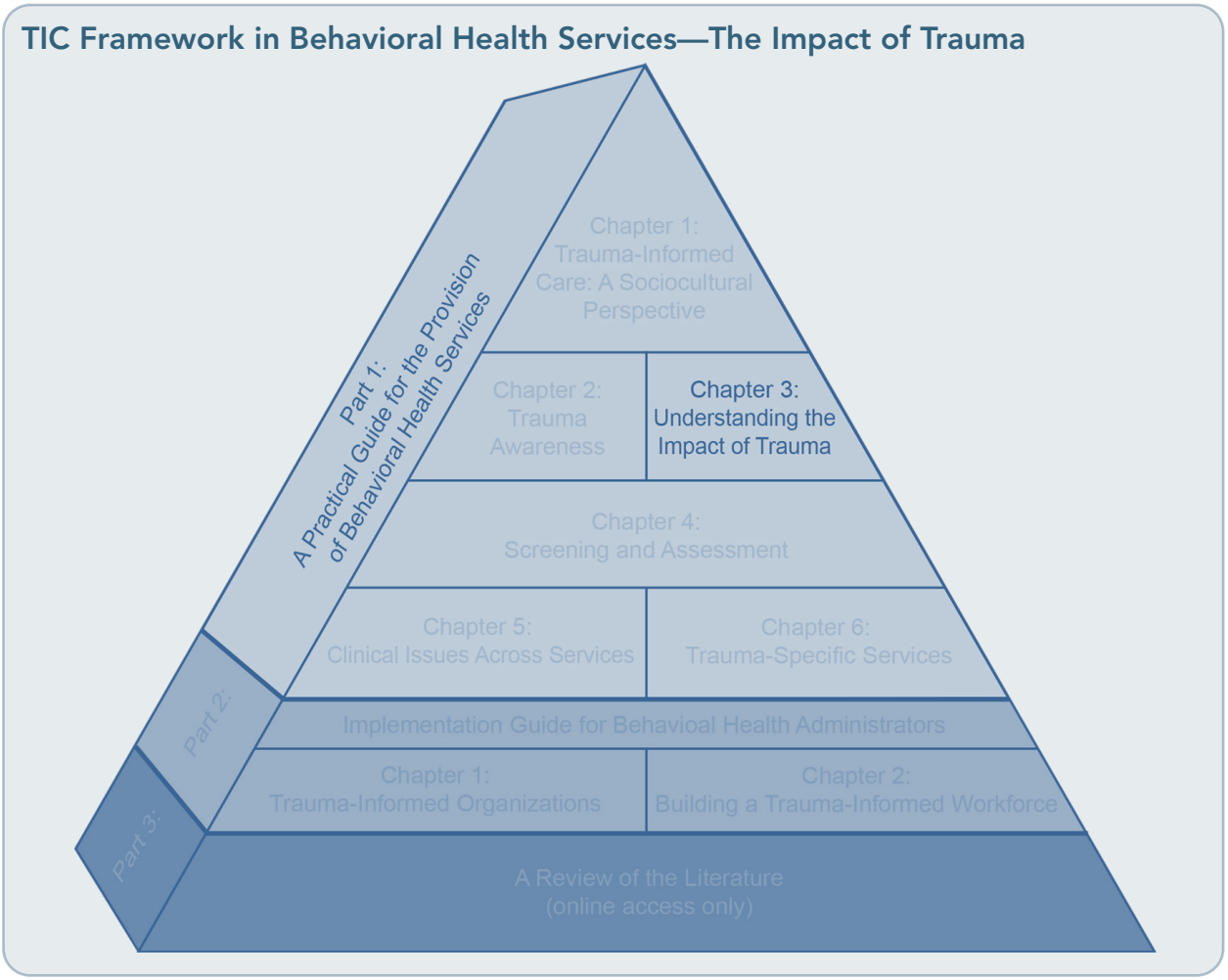
IN THIS CHAPTER

- Sequence of Trauma Reactions
- Common Experiences and Responses to Trauma
- Subthreshold Trauma Related Symptoms
- Specific Trauma Related Psychological Disorders
- Other Trauma Related and Co Occurring Disorders

Trauma-informed care (TIC) involves a broad understanding of traumatic stress reactions and common responses to trauma. Providers need to understand how trauma can affect treatment presentation, engagement, and the outcome of behavioral health services. This chapter examines common experiences survivors may encounter immediately following or long after a traumatic experience.

Trauma, including one-time, multiple, or long-lasting repetitive events, affects everyone differently. Some individuals may clearly display criteria associated with posttraumatic stress disorder (PTSD), but many more individuals will exhibit resilient responses or brief subclinical symptoms or consequences that fall outside of diagnostic criteria. The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors.

This chapter begins with an overview of common responses, emphasizing that traumatic stress reactions are normal reactions to abnormal circumstances. It highlights common short- and long-term responses to traumatic experiences in the context of individuals who may seek behavioral health services. This chapter discusses psychological symptoms not represented in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), and responses associated with trauma that either fall below the threshold of mental disorders or reflect resilience. It also addresses common disorders associated with traumatic stress. This chapter explores the role of culture in defining mental illness, particularly PTSD, and ends by addressing co-occurring mental and substance-related disorders.



Sequence of Trauma Reactions

Survivors' immediate reactions in the aftermath of trauma are quite complicated and are affected by their own experiences, the accessibility of natural supports and healers, their coping and life skills and those of immediate family, and the responses of the larger community in which they live. Although reactions range in severity, even the most acute responses are natural responses to manage trauma—they are not a sign of psychopathology. Coping styles vary from action oriented to reflective and from emotionally expressive to reticent. Clinically, a response style is less important than the degree to which coping efforts successfully allow one to continue necessary activities, regulate emotions, sustain self-esteem, and maintain and enjoy interpersonal contacts. Indeed, a past error in traumatic stress psychology, particularly regarding group or mass traumas, was the assumption that all survivors need to express emotions associated with trauma and talk about the trauma; more recent research indicates that survivors who choose not to process their trauma are just as psychologically healthy as

Foreshortened future: Trauma can affect one's beliefs about the future via loss of hope, limited expectations about life, fear that life will end abruptly or early, or anticipation that normal life events won't occur (e.g., access to education, ability to have a significant and committed relationship, good opportunities for work).

those who do. The most recent psychological debriefing approaches emphasize respecting the individual's style of coping and not valuing one type over another.

Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect. Most responses are normal in that they affect most survivors and are socially acceptable, psychologically effective, and self-limited. Indicators of more severe responses include continuous distress without periods of relative calm or rest, severe dissociation symptoms, and intense intrusive recollections that continue despite a return to safety. Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely. Exhibit 1.3-1 outlines some common reactions.

Common Experiences and Responses to Trauma

A variety of reactions are often reported and/or observed after trauma. Most survivors exhibit immediate reactions, yet these typically resolve without severe long-term consequences. This is because most trauma survivors are highly resilient and develop appropriate coping strategies, including the use of social supports, to deal with the aftermath and effects of trauma. Most recover with time, show minimal distress, and function effectively across major life areas and developmental stages. Even so, clients who show little impairment may still have subclinical symptoms or symptoms that do not fit diagnostic criteria for acute stress disorder (ASD) or PTSD. Only a small percentage of people with a history of trauma show impairment and symptoms that meet criteria for trauma-related stress disorders, including mood and anxiety disorders.

The following sections focus on some common reactions across domains (emotional, physical, cognitive, behavioral, social, and developmental) associated with singular, multiple, and enduring traumatic events. These reactions are often normal responses to trauma but can still be distressing to experience. Such responses are not signs of mental illness, nor do they indicate a mental disorder. Traumatic stress-related disorders comprise a specific constellation of symptoms and criteria.

Emotional

Emotional reactions to trauma can vary greatly and are significantly influenced by the individual's sociocultural history. Beyond the initial emotional reactions during the event, those most likely to surface include anger, fear, sadness, and shame. However, individuals may encounter difficulty in identifying any of these feelings for various reasons. They might lack experience with or prior exposure to emotional expression in their family or community. They may associate strong feelings with the past trauma, thus believing that emotional expression is too dangerous or will lead to feeling out of control (e.g., a sense of "losing it" or going crazy). Still others might deny that they have any feelings associated with their traumatic experiences and define their reactions as numbness or lack of emotions.

Emotional dysregulation

Some trauma survivors have difficulty regulating emotions such as anger, anxiety, sadness, and shame—this is more so when the trauma occurred at a young age (van der Kolk, Roth, Pelcovitz, & Mandel, 1993). In individuals who are older and functioning well

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma

Immediate Emotional Reactions	Delayed Emotional Reactions
Numbness and detachment Anxiety or severe fear Guilt (including survivor guilt) Exhilaration as a result of surviving Anger Sadness Helplessness Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself) Disorientation Feeling out of control Denial Constriction of feelings Feeling overwhelmed	Irritability and/or hostility Depression Mood swings, instability Anxiety (e.g., phobia, generalized anxiety) Fear of trauma recurrence Grief reactions Shame Feelings of fragility and/or vulnerability Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
Immediate Physical Reactions	**Delayed Physical Reactions**
Nausea and/or gastrointestinal distress Sweating or shivering Faintness Muscle tremors or uncontrollable shaking Elevated heartbeat, respiration, and blood pressure Extreme fatigue or exhaustion Greater startle responses Depersonalization	Sleep disturbances, nightmares Somatization (e.g., increased focus on and worry about body aches and pains) Appetite and digestive changes Lowered resistance to colds and infection Persistent fatigue Elevated cortisol levels Hyperarousal Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
Immediate Cognitive Reactions	**Delayed Cognitive Reactions**
Difficulty concentrating Rumination or racing thoughts (e.g., replaying the traumatic event over and over again) Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes) Memory problems (e.g., not being able to recall important aspects of the trauma) Strong identification with victims	Intrusive memories or flashbacks Reactivation of previous traumatic events Self-blame Preoccupation with event Difficulty making decisions Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma Belief that feelings or memories are dangerous Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day) Suicidal thinking
Immediate Behavioral Reactions	**Delayed Behavioral Reactions**
Startled reaction Restlessness Sleep and appetite disturbances Difficulty expressing oneself Argumentative behavior Increased use of alcohol, drugs, and tobacco Withdrawal and apathy Avoidant behaviors	Avoidance of event reminders Social relationship disturbances Decreased activity level Engagement in high-risk behaviors Increased use of alcohol and drugs Withdrawal

(Continued on the next page.)

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma (continued)

Immediate Existential Reactions	Delayed Existential Reactions
Intense use of prayer	Questioning (e.g., "Why me?")
Restoration of faith in the goodness of others (e.g., receiving help from others)	Increased cynicism, disillusionment
Loss of self-efficacy	Increased self-confidence (e.g., "If I can survive this, I can survive anything")
Despair about humanity, particularly if the event was intentional	Loss of purpose
Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)	Renewed faith
	Hopelessness
	Reestablishing priorities
	Redefining meaning and importance of life
	Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)

Sources: Briere & Scott, 2006b; Foa, Stein, & McFarlane, 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011.

prior to the trauma, such emotional dysregulation is usually short lived and represents an immediate reaction to the trauma, rather than an ongoing pattern. Self-medication—namely, substance abuse—is one of the methods that traumatized people use in an attempt to regain emotional control, although ultimately it causes even further emotional dysregulation (e.g., substance-induced changes in affect during and after use). Other efforts toward emotional regulation can include engagement in high-risk or self-injurious behaviors, disordered eating, compulsive behaviors such as gambling or overworking, and repression or denial of emotions; however, not all behaviors associated with self-regulation are considered negative. In fact, some individuals find creative, healthy, and industrious ways to manage strong affect generated by trauma, such as through renewed commitment to physical activity or by creating an organization to support survivors of a particular trauma.

Traumatic stress tends to evoke two emotional extremes: feeling either too much (overwhelmed) or too little (numb) emotion. Treatment can help the client find the optimal level of emotion and assist him or her with appropriately experiencing and regulating difficult emotions. In treatment, the goal is to help clients learn to regulate their emotions without the use of substances or other unsafe behavior. This will likely require learning new coping skills and how to tolerate distressing emotions; some clients may benefit from mindfulness practices, cognitive restructuring, and trauma-specific desensitization approaches, such as exposure therapy and eye movement desensitization and reprocessing (EMDR; refer to Part 1, Chapter 6, for more information on trauma-specific therapies).

Numbing

Numbing is a biological process whereby emotions are detached from thoughts, behaviors, and memories. In the following case illustration, Sadhanna's numbing is evidenced by her limited range of emotions associated with interpersonal interactions and her inability to associate any emotion with her history of abuse. She also possesses a belief in a foreshortened future. A prospective longitudinal study (Malta, Levitt, Martin, Davis, & Cloitre, 2009) that followed the development of PTSD in disaster workers highlighted the importance of understanding and appreciating numbing as a traumatic stress reaction. Because numbing

Case Illustration: Sadhanna

Sadhanna is a 22-year-old woman mandated to outpatient mental health and substance abuse treatment as the alternative to incarceration. She was arrested and charged with assault after arguing and fighting with another woman on the street. At intake, Sadhanna reported a 7-year history of alcohol abuse and one depressive episode at age 18. She was surprised that she got into a fight but admitted that she was drinking at the time of the incident. She also reported severe physical abuse at the hands of her mother's boyfriend between ages 4 and 15. Of particular note to the intake worker was Sadhanna's matter-of-fact way of presenting the abuse history. During the interview, she clearly indicated that she did not want to attend group therapy and hear other people talk about their feelings, saying, "I learned long ago not to wear emotions on my sleeve."

Sadhanna reported dropping out of 10th grade, saying she never liked school. She didn't expect much from life. In Sadhanna's first weeks in treatment, she reported feeling disconnected from other group members and questioned the purpose of the group. When asked about her own history, she denied that she had any difficulties and did not understand why she was mandated to treatment. She further denied having feelings about her abuse and did not believe that it affected her life now. Group members often commented that she did not show much empathy and maintained a flat affect, even when group discussions were emotionally charged.

symptoms hide what is going on inside emotionally, there can be a tendency for family members, counselors, and other behavioral health staff to assess levels of traumatic stress symptoms and the impact of trauma as less severe than they actually are.

Physical

Diagnostic criteria for PTSD place considerable emphasis on psychological symptoms, but some people who have experienced traumatic stress may present initially with physical symptoms. Thus, primary care may be the first and only door through which these individuals seek assistance for trauma-related symptoms. Moreover, there is a significant connection between trauma, including adverse childhood experiences (ACEs), and chronic health conditions. Common physical disorders and symptoms include somatic complaints; sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders.

Somatization

Somatization indicates a focus on bodily symptoms or dysfunctions to express emotional distress. Somatic symptoms are more likely to occur with individuals who have traumatic stress reactions, including PTSD. People from certain ethnic and cultural backgrounds may initially or solely present emotional distress via physical ailments or concerns. Many individuals who present with somatization are likely unaware of the connection between their emotions and the physical symptoms that they're experiencing. At times, clients may remain resistant to exploring emotional content and remain focused on bodily complaints as a means of avoidance. Some clients may insist that their primary problems are physical even when medical evaluations and tests fail to confirm ailments. In these situations, somatization may be a sign of a mental illness. However, various cultures approach emotional distress through the physical realm or view emotional and physical symptoms and well-being as one. It is important not to assume that clients with physical complaints are using somatization as a means to express emotional pain; they may have specific conditions or disorders that require medical attention. Foremost, counselors need to refer for medical evaluation.

Advice to Counselors: Using Information About Biology and Trauma

- Educate your clients:
  - Frame reexperiencing the event(s), hyperarousal, sleep disturbances, and other physical symptoms as physiological reactions to extreme stress.
  - Communicate that treatment and other wellness activities can improve both psychological and physiological symptoms (e.g., therapy, meditation, exercise, yoga). You may need to refer certain clients to a psychiatrist who can evaluate them and, if warranted, prescribe psychotropic medication to address severe symptoms.
  - Discuss traumatic stress symptoms and their physiological components.
  - Explain links between traumatic stress symptoms and substance use disorders, if appropriate.
  - Normalize trauma symptoms. For example, explain to clients that their symptoms are not a sign of weakness, a character flaw, being damaged, or going crazy.
- Support your clients and provide a message of hope—that they are not alone, they are not at fault, and recovery is possible and anticipated.

Biology of trauma

Trauma biology is an area of burgeoning research, with the promise of more complex and explanatory findings yet to come. Although a thorough presentation on the biological aspects of trauma is beyond the scope of this publication, what is currently known is that exposure to trauma leads to a cascade of biological changes and stress responses. These biological alterations are highly associated with PTSD, other mental illnesses, and substance use disorders. These include:

- Changes in limbic system functioning.
- Hypothalamic–pituitary–adrenal axis activity changes with variable cortisol levels.
- Neurotransmitter-related dysregulation of arousal and endogenous opioid systems.

As a clear example, early ACEs such as abuse, neglect, and other traumas affect brain development and increase a person's vulnerability to encountering interpersonal violence as an adult and to developing chronic diseases and other physical illnesses, mental illnesses, substance-related disorders, and impairment in other life areas (Centers for Disease Control and Prevention, 2012).

Hyperarousal and sleep disturbances

A common symptom that arises from traumatic experiences is hyperarousal (also called hypervigilance). Hyperarousal is the body's way of remaining prepared. It is characterized by sleep disturbances, muscle tension, and a lower threshold for startle responses and can persist years after trauma occurs. It is also one of the primary diagnostic criteria for PTSD.

Hyperarousal is a consequence of biological changes initiated by trauma. Although it

Case Illustration: Kimi

Kimi is a 35-year-old Native American woman who was group raped at the age of 16 on her walk home from a suburban high school. She recounts how her whole life changed on that day. "I never felt safe being alone after the rape. I used to enjoy walking everywhere. Afterward, I couldn't tolerate the fear that would arise when I walked in the neighborhood. It didn't matter whether I was alone or with friends—every sound that I heard would throw me into a state of fear. I felt like the same thing was going to happen again. It's gotten better with time, but I often feel as if I'm sitting on a tree limb waiting for it to break. I have a hard time relaxing. I can easily get startled if a leaf blows across my path or if my children scream while playing in the yard. The best way I can describe how I experience life is by comparing it to watching a scary, suspenseful movie—anxiously waiting for something to happen, palms sweating, heart pounding, on the edge of your chair."

serves as a means of self-protection after trauma, it can be detrimental. Hyperarousal can interfere with an individual's ability to take the necessary time to assess and appropriately respond to specific input, such as loud noises or sudden movements. Sometimes, hyperarousal can produce overreactions to situations perceived as dangerous when, in fact, the circumstances are safe.

Along with hyperarousal, sleep disturbances are very common in individuals who have experienced trauma. They can come in the form of early awakening, restless sleep, difficulty falling asleep, and nightmares. Sleep disturbances are most persistent among individuals who have trauma-related stress; the disturbances sometimes remain resistant to intervention long after other traumatic stress symptoms have been successfully treated. Numerous strategies are available beyond medication, including good sleep hygiene practices, cognitive rehearsals of nightmares, relaxation strategies, and nutrition.

Cognitive

Traumatic experiences can affect and alter cognitions. From the outset, trauma challenges the just-world or core life assumptions that

Cognitions and Trauma

The following examples reflect some of the types of cognitive or thought-process changes that can occur in response to traumatic stress.

Cognitive errors: Misinterpreting a current situation as dangerous because it resembles, even remotely, a previous trauma (e.g., a client overreacting to an overturned canoe in 8 inches of water, as if she and her paddle companion would drown, due to her previous experience of nearly drowning in a rip current 5 years earlier).

Excessive or inappropriate guilt: Attempting to make sense cognitively and gain control over a traumatic experience by assuming responsibility or possessing survivor's guilt, because others who experienced the same trauma did not survive.

Idealization: Demonstrating inaccurate rationalizations, idealizations, or justifications of the perpetrator's behavior, particularly if the perpetrator is or was a caregiver. Other similar reactions mirror idealization; traumatic bonding is an emotional attachment that develops (in part to secure survival) between perpetrators who engage in interpersonal trauma and their victims, and Stockholm syndrome involves compassion and loyalty toward hostage takers (de Fabrique, Van Hasselt, Vecchi, & Romano, 2007).

Trauma-induced hallucinations or delusions: Experiencing hallucinations and delusions that, although they are biological in origin, contain cognitions that are congruent with trauma content (e.g., a woman believes that a person stepping onto her bus is her father, who had sexually abused her repeatedly as child, because he wore shoes similar to those her father once wore).

Intrusive thoughts and memories: Experiencing, without warning or desire, thoughts and memories associated with the trauma. These intrusive thoughts and memories can easily trigger strong emotional and behavioral reactions, as if the trauma was recurring in the present. The intrusive thoughts and memories can come rapidly, referred to as flooding, and can be disruptive at the time of their occurrence. If an individual experiences a trigger, he or she may have an increase in intrusive thoughts and memories for a while. For instance, individuals who inadvertently are retraumatized due to program or clinical practices may have a surge of intrusive thoughts of past trauma, thus making it difficult for them to discern what is happening now versus what happened then. Whenever counseling focuses on trauma, it is likely that the client will experience some intrusive thoughts and memories. It is important to develop coping strategies before, as much as possible, and during the delivery of trauma-informed and trauma-specific treatment.

help individuals navigate daily life (Janoff-Bulman, 1992). For example, it would be difficult to leave the house in the morning if you believed that the world was not safe, that all people are dangerous, or that life holds no promise. Belief that one's efforts and intentions can protect oneself from bad things makes it less likely for an individual to perceive personal vulnerability. However, traumatic events—particularly if they are unexpected—can challenge such beliefs.

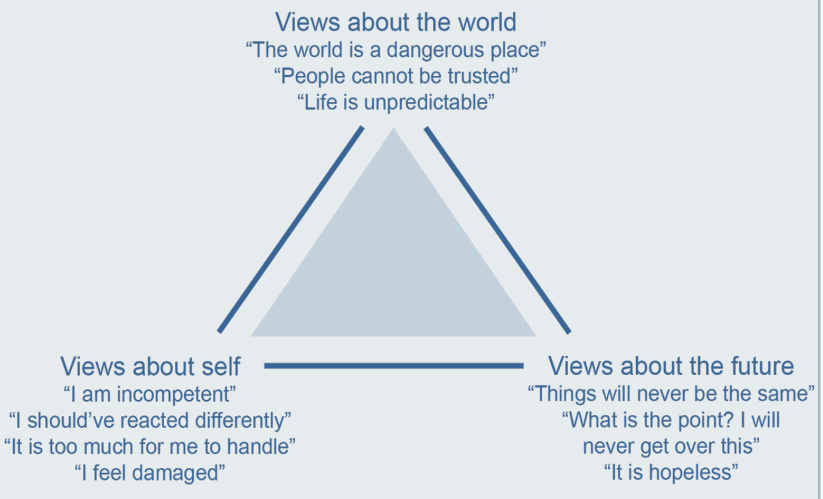
Let's say you always considered your driving time as "your time"—and your car as a safe place to spend that time. Then someone hits you from behind at a highway entrance. Almost immediately, the accident affects how you perceive the world, and from that moment onward, for months following the crash, you feel unsafe in any car. You become hypervigilant about other drivers and perceive that other cars are drifting into your lane or failing to stop at a safe distance behind you. For a time, your perception of safety is eroded, often leading to compensating behaviors (e.g., excessive glancing into the rearview mirror to see whether the vehicles behind you are stopping) until the belief is restored or reworked. Some individuals never return to their previous belief systems after a trauma, nor do they find a way to rework them—thus leading to a worldview that life is unsafe. Still, many other individuals are able to return to organizing core beliefs that support their perception of safety.

Many factors contribute to cognitive patterns prior to, during, and after a trauma. Adopting Beck and colleagues' cognitive triad model (1979), trauma can alter three main cognitive patterns: thoughts about self, the world (others/environment), and the future. To clarify, trauma can lead individuals to see themselves as incompetent or damaged, to see others and the world as unsafe and unpredictable, and to see the future as hopeless—believing that personal suffering will continue, or negative outcomes will preside for the foreseeable future (see Exhibit 1.3-2). Subsequently, this set of cognitions can greatly influence clients' belief in their ability to use internal resources and external support effectively. From a cognitive–behavioral perspective, these cognitions have a bidirectional relationship in sustaining or contributing to the development of depressive and anxiety symptoms after trauma. However, it is possible for cognitive patterns to help protect against debilitating psychological symptoms as well. Many factors contribute to cognitive patterns prior to, during, and after a trauma.

Feeling different

An integral part of experiencing trauma is feeling different from others, whether or not the trauma was an individual or group experience. Traumatic experiences typically feel surreal and challenge the necessity and value of mundane activities of daily life. Survivors

Exhibit 1.3-2: Cognitive Triad of Traumatic Stress



often believe that others will not fully understand their experiences, and they may think that sharing their feelings, thoughts, and reactions related to the trauma will fall short of expectations. However horrid the trauma may be, the *experience* of the trauma is typically profound.

The type of trauma can dictate how an individual feels different or believes that they are different from others. Traumas that generate shame will often lead survivors to feel more alienated from others—believing that they are "damaged goods." When individuals believe that their experiences are unique and incomprehensible, they are more likely to seek support, if they seek support at all, only with others who have experienced a similar trauma.

Triggers and flashbacks

Triggers

A trigger is a stimulus that sets off a memory of a trauma or a specific portion of a traumatic experience. Imagine you were trapped briefly in a car after an accident. Then, several years later, you were unable to unlatch a lock after using a restroom stall; you might have begun to feel a surge of panic reminiscent of the accident, even though there were other avenues of escape from the stall. Some triggers can be identified and anticipated easily, but many are subtle and inconspicuous, often surprising the individual or catching him or her off guard. In treatment, it is important to help clients identify potential triggers, draw a connection between strong emotional reactions and triggers, and develop coping strategies to manage those moments when a trigger occurs. A trigger is any sensory reminder of the traumatic event: a noise, smell, temperature, other physical sensation, or visual scene. Triggers can generalize to any characteristic, no matter how remote, that resembles or represents a previous trauma, such as revisiting the location where the trauma occurred, being alone, having your children reach the same age that you were when you experienced the trauma, seeing the same breed of dog that bit you, or hearing loud voices. Triggers are often associated with the time of day, season, holiday, or anniversary of the event.

Flashbacks

A flashback is reexperiencing a previous traumatic experience as if it were actually happening in that moment. It includes reactions that often resemble the client's reactions during the trauma. Flashback experiences are very brief and typically last only a few seconds, but the emotional aftereffects linger for hours or longer. Flashbacks are commonly initiated by a trigger, but not necessarily. Sometimes, they occur out of the blue. Other times, specific physical states increase a person's vulnerability to reexperiencing a trauma, (e.g., fatigue, high

Advice to Counselors: Helping Clients Manage Flashbacks and Triggers

If a client is triggered in a session or during some aspect of treatment, help the client focus on what is happening in the here and now; that is, use grounding techniques. Behavioral health service providers should be prepared to help the client get regrounded so that they can distinguish between what is happening now versus what had happened in the past (see Covington, 2008, and Najavits, 2002b, 2007b, for more grounding techniques). Offer education about the experience of triggers and flashbacks, and then normalize these events as common traumatic stress reactions. Afterward, some clients need to discuss the experience and understand why the flashback or trigger occurred. It often helps for the client to draw a connection between the trigger and the traumatic event(s). This can be a preventive strategy whereby the client can anticipate that a given situation places him or her at higher risk for retraumatization and requires use of coping strategies, including seeking support.

Source: Green Cross Academy of Traumatology, 2010.

stress levels). Flashbacks can feel like a brief movie scene that intrudes on the client. For example, hearing a car backfire on a hot, sunny day may be enough to cause a veteran to respond as if he or she were back on military patrol. Other ways people reexperience trauma, besides flashbacks, are via nightmares and intrusive thoughts of the trauma.

Dissociation, depersonalization, and derealization

Dissociation is a mental process that severs connections among a person's thoughts, memories, feelings, actions, and/or sense of identity. Most of us have experienced dissociation—losing the ability to recall or track a particular action (e.g., arriving at work but not remembering the last minutes of the drive). Dissociation happens because the person is engaged in an automatic activity and is not paying attention to his or her immediate environment. Dissociation can also occur during severe stress or trauma as a protective element whereby the individual incurs distortion of time, space, or identity. This is a common symptom in traumatic stress reactions.

Dissociation helps distance the experience from the individual. People who have experienced severe or developmental trauma may have learned to separate themselves from distress to survive. At times, dissociation can be very pervasive and symptomatic of a mental disorder, such as dissociative identity disorder (DID; formerly known as multiple personality disorder). According to the DSM-5, "dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (APA, 2013a, p. 291). Dissociative disorder diagnoses are closely associated with histories of severe childhood trauma or pervasive, human-caused, intentional trauma, such as that experienced by concentration camp survivors or victims of ongoing political imprisonment, torture, or long-term isolation. A mental health professional, preferably with significant training in working with dissociative disorders and with trauma, should be consulted when a dissociative disorder diagnosis is suspected.

Potential Signs of Dissociation

- Fixed or "glazed" eyes
- Sudden flattening of affect
- Long periods of silence
- Monotonous voice
- Stereotyped movements
- Responses not congruent with the present context or situation
- Excessive intellectualization

(Briere, 1996a)

The characteristics of DID can be commonly accepted experiences in other cultures, rather than being viewed as symptomatic of a traumatic experience. For example, in non-Western cultures, a sense of alternate beings within oneself may be interpreted as being inhabited by spirits or ancestors (Kirmayer, 1996). Other experiences associated with dissociation include depersonalization—psychologically "leaving one's body," as if watching oneself from a distance as an observer or through derealization, leading to a sense that what is taking place is unfamiliar or is not real.

If clients exhibit signs of dissociation, behavioral health service providers can use grounding techniques to help them reduce this defense strategy. One major long-term consequence of dissociation is the difficulty it causes in connecting strong emotional or physical reactions with an event. Often, individuals may believe that they are going crazy because they are not in touch with the nature of their reactions. By educating clients on the resilient qualities of dissociation while also emphasizing that it prevents them from addressing or

validating the trauma, individuals can begin to understand the role of dissociation. All in all, it is important when working with trauma survivors that the intensity level is not so great that it triggers a dissociative reaction and prevents the person from engaging in the process.

Behavioral

Traumatic stress reactions vary widely; often, people engage in behaviors to manage the aftereffects, the intensity of emotions, or the distressing aspects of the traumatic experience. Some people reduce tension or stress through avoidant, self-medicating (e.g., alcohol abuse), compulsive (e.g., overeating), impulsive (e.g., high-risk behaviors), and/or self-injurious behaviors. Others may try to gain control over their experiences by being aggressive or subconsciously reenacting aspects of the trauma.

Behavioral reactions are also the consequences of, or learned from, traumatic experiences. For example, some people act like they can't control their current environment, thus failing to take action or make decisions long after the trauma (learned helplessness). Other associate elements of the trauma with current activities, such as by reacting to an intimate moment in a significant relationship as dangerous or unsafe years after a date rape. The following sections discuss behavioral consequences of trauma and traumatic stress reactions.

Reenactments

A hallmark symptom of trauma is reexperiencing the trauma in various ways. Reexperiencing can occur through reenactments (literally, to "redo"), by which trauma survivors repetitively relive and recreate a past trauma in their present lives. This is very apparent in children, who play by mimicking what occurred during the trauma, such as by pretending to crash a toy airplane into a toy building after seeing televised images of the terrorist attacks on the World Trade Center on September 11, 2001. Attempts to understand reenactments are very complicated, as reenactments occur for a variety of reasons. Sometimes, individuals reenact past traumas to master them. Examples of reenactments include a variety of behaviors: self-injurious behaviors, hypersexuality, walking alone in unsafe areas or other high-risk behaviors, driving recklessly, or involvement in repetitive destructive relationships (e.g., repeatedly getting into romantic relationships with people who are abusive or violent), to name a few.

Self-harm and self-destructive behaviors

Self-harm is any type of intentionally self-inflicted harm, regardless of the severity of injury or whether suicide is intended. Often, self-harm is an attempt to cope with emotional or physical distress that seems overwhelming or to cope with a profound sense of dissociation or being trapped, helpless, and "damaged" (Herman, 1997; Santa Mina & Gallop, 1998). Self-harm is associated with past childhood sexual abuse and other forms of trauma as well as substance abuse. Thus,

Resilient Responses to Trauma

Many people find healthy ways to cope with, respond to, and heal from trauma. Often, people automatically reevaluate their values and redefine what is important after a trauma. Such resilient responses include:

- Increased bonding with family and community.
- Redefined or increased sense of purpose and meaning.
- Increased commitment to a personal mission.
- Revised priorities.
- Increased charitable giving and volunteerism.

Case Illustration: Marco

Marco, a 30-year-old man, sought treatment at a local mental health center after a 2-year bout of anxiety symptoms. He was an active member of his church for 12 years, but although he sought help from his pastor about a year ago, he reports that he has had no contact with his pastor or his church since that time. Approximately 3 years ago, his wife took her own life. He describes her as his soulmate and has had a difficult time understanding her actions or how he could have prevented them.

In the initial intake, he mentioned that he was the first person to find his wife after the suicide and reported feelings of betrayal, hurt, anger, and devastation since her death. He claimed that everyone leaves him or dies. He also talked about his difficulty sleeping, having repetitive dreams of his wife, and avoiding relationships. In his first session with the counselor, he initially rejected the counselor before the counselor had an opportunity to begin reviewing and talking about the events and discomfort that led him to treatment.

In this scenario, Marco is likely reenacting his feelings of abandonment by attempting to reject others before he experiences another rejection or abandonment. In this situation, the counselor will need to recognize the reenactment, explore the behavior, and examine how reenactments appear in other situations in Marco's life.

addressing self-harm requires attention to the client's reasons for self-harm. More than likely, the client needs help recognizing and coping with emotional or physical distress in manageable amounts and ways.

Among the self-harm behaviors reported in the literature are cutting, burning skin by heat (e.g., cigarettes) or caustic liquids, punching hard enough to self-bruise, head banging, hair pulling, self-poisoning, inserting foreign objects into bodily orifices, excessive nail biting, excessive scratching, bone breaking, gnawing at flesh, interfering with wound healing, tying off body parts to stop breathing or blood flow, swallowing sharp objects, and suicide. Cutting and burning are among the most common forms of self-harm.

Self-harm tends to occur most in people who have experienced repeated and/or early trauma (e.g., childhood sexual abuse) rather than in those who have undergone a single adult trauma (e.g., a community-wide disaster or a serious car accident). There are strong associations between eating disorders, self-harm, and substance abuse (Claes &Vandereycken, 2007; for discussion, see Harned, Najavits, & Weiss, 2006). Self-mutilation is also associated with (and part of the diagnostic criteria for) a number of personality disorders, including borderline and histrionic, as well as DID, depression, and some forms of schizophrenia; these disorders can co-occur with traumatic stress reactions and disorders.

It is important to distinguish self-harm that is suicidal from self-harm that is not suicidal and to assess and manage both of these very serious dangers carefully. Most people who engage in self-harm are not doing so with the intent to kill themselves (Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003)—although self-harm can be life threatening and can escalate into suicidality if not managed therapeutically. Self-harm can be a way of getting attention or manipulating others, but most often it is not. Self-destructive behaviors such as substance abuse, restrictive or binge eating, reckless automobile driving, or high-risk impulsive behavior are different from self-harming behaviors but are also seen in clients with a history of trauma. Self-destructive behaviors differ from self-harming behaviors in that there may be no immediate negative impact of the behavior on the individual; they differ from suicidal behavior in that there is no intent to cause death in the short term.

Advice to Counselors: Working With Clients Who Are Self-Injurious

Counselors who are unqualified or uncomfortable working with clients who demonstrate self-harming, self-destructive, or suicidal or homicidal ideation, intent, or behavior should work with their agencies and supervisors to refer such clients to other counselors. They should consider seeking specialized supervision on how to manage such clients effectively and safely and how to manage their feelings about these issues. The following suggestions assume that the counselor has had sufficient training and experience to work with clients who are self-injurious. To respond appropriately to a client who engages in self-harm, counselors should:

- Screen the client for self-harm and suicide risk at the initial evaluation and throughout treatment.
- Learn the client's perspective on self-harm and how it "helps."
- Understand that self-harm is often a coping strategy to manage the intensity of emotional and/or physical distress.
- Teach the client coping skills that improve his or her management of emotions without self-harm.
- Help the client obtain the level of care needed to manage genuine risk of suicide or severe self-injury. This might include hospitalization, more intensive programming (e.g., intensive outpatient, partial hospitalization, residential treatment), or more frequent treatment sessions. The goal is to stabilize the client as quickly as possible, and then, if possible, begin to focus treatment on developing coping strategies to manage self-injurious and other harmful impulses.
- Consult with other team members, supervisors, and, if necessary, legal experts to determine whether one's efforts with and conceptualization of the self-harming client fit best practice guidelines. See, for example, Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT], 2005c). Document such consultations and the decisions made as a result of them thoroughly and frequently.
- Help the client identify how substance use affects self-harm. In some cases, it can increase the behavior (e.g., alcohol disinhibits the client, who is then more likely to self-harm). In other cases, it can decrease the behavior (e.g., heroin evokes relaxation and, thus, can lessen the urge to self-harm). In either case, continue to help the client understand how abstinence from substances is necessary so that he or she can learn more adaptive coping.
- Work collaboratively with the client to develop a plan to create a sense of safety. Individuals are affected by trauma in different ways; therefore, safety or a safe environment may mean something entirely different from one person to the next. Allow the client to define what safety means to him or her.

Counselors can also help the client prepare a safety card that the client can carry at all times. The card might include the counselor's contact information, a 24-hour crisis number to call in emergencies, contact information for supportive individuals who can be contacted when needed, and, if appropriate, telephone numbers for emergency medical services. The counselor can discuss with the client the types of signs or crises that might warrant using the numbers on the card. Additionally, the counselor might check with the client from time to time to confirm that the information on the card is current.

TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a), has examples of safety agreements specifically for suicidal clients and discusses their uses in more detail. There is no credible evidence that a safety agreement is effective in preventing a suicide attempt or death. Safety agreements for clients with suicidal thoughts and behaviors should only be used as an adjunct support accompanying professional screening, assessment, and treatment for people with suicidal thoughts and behaviors. Keep in mind that safety plans or agreements may be perceived by the trauma survivor as a means of controlling behavior, subsequently replicating or triggering previous traumatic experiences.

All professionals—and in some States, anyone—could have ethical and legal responsibilities to those clients who pose an imminent danger to themselves or others. Clinicians should be aware of the pertinent State laws where they practice and the relevant Federal and professional regulations.

However, as with self-harming behavior, self-destructive behavior needs to be recognized and addressed and may persist—or worsen—without intervention.

Consumption of substances

Substance use often is initiated or increased after trauma. Clients in early recovery—especially those who develop PTSD or have it reactivated—have a higher relapse risk if they experience a trauma. In the first 2 months after September 11, 2001, more than a quarter of New Yorker residents who smoked cigarettes, drank alcohol, or used marijuana (about 265,000 people) increased their consumption. The increases continued 6 months after the attacks (Vlahov, Galea, Ahern, Resnick, & Kilpatrick, 2004). A study by the Substance Abuse and Mental Health Services Administration (SAMHSA, Office of Applied Studies, 2002) used National Survey on Drug Use and Health data to compare the first three quarters of 2001 with the last quarter and reported an increase in the prevalence rate for alcohol use among people 18 or older in the New York metropolitan area during the fourth quarter.

Interviews with New York City residents who were current or former cocaine or heroin users indicated that many who had been clean for 6 months or less relapsed after September 11, 2001. Others, who lost their income and could no longer support their habit, enrolled in methadone programs (Weiss et al., 2002). After the Oklahoma City bombing in 1995, Oklahomans reported double the normal rate of alcohol use, smoking more cigarettes, and a higher incidence of initiating smoking months and even years after the bombing (Smith, Christiansen, Vincent, & Hann, 1999).

Self-medication

Khantzian's self-medication theory (1985) suggests that drugs of abuse are selected for their specific effects. However, no definitive pattern has yet emerged of the use of particular substances in relation to PTSD or trauma symptoms. Use of substances can vary based on a variety of factors, including which trauma symptoms are most prominent for an individual and the individual's access to particular substances. Unresolved traumas sometimes lurk behind the emotions that clients cannot allow themselves to experience. Substance use and abuse in trauma survivors can be a way to self-medicate and thereby avoid or displace difficult emotions associated with traumatic experiences. When the substances are withdrawn, the survivor may use other behaviors to self-soothe, self-medicate, or avoid emotions. As likely, emotions can appear after abstinence in the form of anxiety and depression.

Avoidance

Avoidance often coincides with anxiety and the promotion of anxiety symptoms. Individuals begin to avoid people, places, or situations to alleviate unpleasant emotions, memories, or circumstances. Initially, the avoidance works, but over time, anxiety increases and the perception that the situation is unbearable or dangerous increases as well, leading to a greater need to avoid. Avoidance can be adaptive, but it is also a behavioral pattern that reinforces perceived danger without testing its validity, and it typically leads to greater problems across major life areas (e.g., avoiding emotionally oriented conversations in an intimate relationship). For many individuals who have traumatic stress reactions, avoidance is commonplace. A person may drive 5 miles longer to avoid the road where he or she had an accident. Another individual may avoid crowded places in fear of an assault or to circumvent strong emotional memories about an earlier assault that took place in a crowded area. Avoidance can come in many forms. When people can't tolerate strong affects associated with traumatic memories, they avoid, project,

deny, or distort their trauma-related emotional and cognitive experiences. A key ingredient in trauma recovery is learning to manage triggers, memories, and emotions without avoidance—in essence, becoming desensitized to traumatic memories and associated symptoms.

Social/Interpersonal

A key ingredient in the early stage of TIC is to establish, confirm, or reestablish a support system, including culturally appropriate activities, as soon as possible. Social supports and relationships can be protective factors against traumatic stress. However, trauma typically affects relationships significantly, regardless of whether the trauma is interpersonal or is of some other type. Relationships require emotional exchanges, which means that others who have close relationships or friendships with the individual who survived the trauma(s) are often affected as well—either through secondary traumatization or by directly experiencing the survivor's traumatic stress reactions. In natural disasters, social and community supports can be abruptly eroded and difficult to rebuild after the initial disaster relief efforts have waned.

Survivors may readily rely on family members, friends, or other social supports—or they may avoid support, either because they believe that no one will be understanding or trustworthy or because they perceive their own needs as a burden to others. Survivors who have strong emotional or physical reactions, including outbursts during nightmares, may pull away further in fear of being unable to predict their own reactions or to protect their own safety and that of others. Often, trauma survivors feel ashamed of their stress reactions, which further hampers their ability to use their support systems and resources adequately.

Many survivors of childhood abuse and interpersonal violence have experienced a significant sense of betrayal. They have often encountered trauma at the hands of trusted caregivers and family members or through significant relationships. This history of betrayal can disrupt forming or relying on supportive relationships in recovery, such as peer supports and counseling. Although this fear of trusting others is protective, it can lead to difficulty in connecting with others and greater vigilance in observing the behaviors of others, including behavioral health service providers. It is exceptionally difficult to override the feeling that someone is going to hurt you, take advantage of you, or, minimally, disappoint you. Early betrayal can affect one's ability to develop attachments, yet the formation of supportive relationships is an important antidote in the recovery from traumatic stress.

Developmental

Each age group is vulnerable in unique ways to the stresses of a disaster, with children and the elderly at greatest risk. Young children may display generalized fear, nightmares, heightened arousal and confusion, and physical symptoms, (e.g., stomachaches, headaches). School-age children may exhibit symptoms such as aggressive behavior and anger, regression to behavior seen at younger ages, repetitious traumatic play, loss of ability to concentrate, and worse school performance. Adolescents may display depression and social withdrawal, rebellion, increased risky activities such as sexual acting out, wish for revenge and action-oriented responses to trauma, and sleep and eating disturbances (Hamblen, 2001). Adults may display sleep problems, increased agitation, hypervigilance, isolation or withdrawal, and increased use of alcohol or drugs. Older adults may exhibit increased withdrawal and isolation, reluctance to leave home, worsening of chronic illnesses, confusion, depression, and fear (DeWolfe & Nordboe, 2000b).

Neurobiological Development: Consequences of Early Childhood Trauma

Findings in developmental psychobiology suggest that the consequences of early maltreatment produce enduring negative effects on brain development (DeBellis, 2002; Liu, Diorio, Day, Francis, & Meaney, 2000; Teicher, 2002). Research suggests that the first stage in a cascade of events produced by early trauma and/or maltreatment involves the disruption of chemicals that function as neurotransmitters (e.g., cortisol, norepinephrine, dopamine), causing escalation of the stress response (Heim, Mletzko, Purselle, Musselman, & Nemeroff, 2008; Heim, Newport, Mletzko, Miller, & Nemeroff, 2008; Teicher, 2002). These chemical responses can then negatively affect critical neural growth during specific sensitive periods of childhood development and can even lead to cell death.

Adverse brain development can also result from elevated levels of cortisol and catecholamines by contributing to maturational failures in other brain regions, such as the prefrontal cortex (Meaney, Brake, & Gratton, 2002). Heim, Mletzko et al. (2008) found that the neuropeptide oxytocin—important for social affiliation and support, attachment, trust, and management of stress and anxiety—was markedly decreased in the cerebrospinal fluid of women who had been exposed to childhood maltreatment, particularly those who had experienced emotional abuse. The more childhood traumas a person had experienced, and the longer their duration, the lower that person's current level of oxytocin was likely to be and the higher her rating of current anxiety was likely to be.

Using data from the Adverse Childhood Experiences Study, an analysis by Anda, Felitti, Brown et al. (2006) confirmed that the risk of negative outcomes in affective, somatic, substance abuse, memory, sexual, and aggression-related domains increased as scores on a measure of eight ACEs increased. The researchers concluded that the association of study scores with these outcomes can serve as a theoretical parallel for the effects of cumulative exposure to stress on the developing brain and for the resulting impairment seen in multiple brain structures and functions.

The National Child Traumatic Stress Network (http://www.nctsn.org) offers information about childhood abuse, stress, and physiological responses of children who are traumatized. Materials are available for counselors, educators, parents, and caregivers. There are special sections on the needs of children in military families and on the impact of natural disasters on children's mental health.

Subthreshold Trauma-Related Symptoms

Many trauma survivors experience symptoms that, although they do not meet the diagnostic criteria for ASD or PTSD, nonetheless limit their ability to function normally (e.g., regulate emotional states, maintain steady and rewarding social and family relationships, function competently at a job, maintain a steady pattern of abstinence in recovery). These symptoms can be transient, only arising in a specific context; intermittent, appearing for several weeks or months and then receding; or a part of the individual's regular pattern of functioning (but not to the level of DSM-5 diagnostic criteria). Often, these patterns are termed "subthreshold" trauma symptoms. Like PTSD, the symptoms can be misdiagnosed as depression, anxiety, or another mental illness. Likewise, clients who have experienced trauma may link some of their symptoms to their trauma and diagnose themselves as having PTSD, even though they do not meet all criteria for that disorder.

Combat Stress Reaction

A phenomenon unique to war, and one that counselors need to understand well, is combat stress reaction (CSR). CSR is an acute anxiety reaction occurring during or shortly after participating in military conflicts and wars as well as other operations within the war zone, known as the theater. CSR is not a formal diagnosis, nor is it included in the DSM-5 (APA, 2013a). It is similar to acute stress

Case Illustration: Frank

Frank is a 36-year-old man who was severely beaten in a fight outside a bar. He had multiple injuries, including broken bones, a concussion, and a stab wound in his lower abdomen. He was hospitalized for 3.5 weeks and was unable to return to work, thus losing his job as a warehouse forklift operator. For several years, when faced with situations in which he perceived himself as helpless and overwhelmed, Frank reacted with violent anger that, to others, appeared grossly out of proportion to the situation. He has not had a drink in almost 3 years, but the bouts of anger persist and occur three to five times a year. They leave Frank feeling even more isolated from others and alienated from those who love him. He reports that he cannot watch certain television shows that depict violent anger; he has to stop watching when such scenes occur. He sometimes daydreams about getting revenge on the people who assaulted him.

Psychiatric and neurological evaluations do not reveal a cause for Frank's anger attacks. Other than these symptoms, Frank has progressed well in his abstinence from alcohol. He attends a support group regularly, has acquired friends who are also abstinent, and has reconciled with his family of origin. His marriage is more stable, although the episodes of rage limit his wife's willingness to commit fully to the relationship. In recounting the traumatic event in counseling, Frank acknowledges that he thought he was going to die as a result of the fight, especially when he realized he had been stabbed. As he described his experience, he began to become very anxious, and the counselor observed the rage beginning to appear.

After his initial evaluation, Frank was referred to an outpatient program that provided trauma-specific interventions to address his subthreshold trauma symptoms. With a combination of cognitive–behavioral counseling, EMDR, and anger management techniques, he saw a gradual decrease in symptoms when he recalled the assault. He started having more control of his anger when memories of the trauma emerged. Today, when feeling trapped, helpless, or overwhelmed, Frank has resources for coping and does not allow his anger to interfere with his marriage or other relationships.

reaction, except that the precipitating event or events affect military personnel (and civilians exposed to the events) in an armed conflict situation. The terms "combat stress reaction" and "posttraumatic stress injury" are relatively new, and the intent of using these new terms is to call attention to the unique experiences of combat-related stress as well as to decrease the shame that can be associated with seeking behavioral health services for PTSD (for more information on veterans and combat stress reactions, see the planned TIP, *Reintegration-Related Behavioral Health Issues for Veterans and Military Families*; SAMHSA, planned f).

Although stress mobilizes an individual's physical and psychological resources to perform more effectively in combat, reactions to the stress may persist long after the actual danger has ended. As with other traumas, the nature of the event(s), the reactions of others, and the survivor's psychological history and resources affect the likelihood and severity of CSR. With combat veterans, this translates to the number, intensity, and duration of threat factors; the social support of peers in the veterans' unit; the emotional and cognitive resilience of the service members; and the quality of military leadership. CSR can vary from manageable and mild to debilitating and severe. Common, less severe symptoms of CSR include tension, hypervigilance, sleep problems, anger, and difficulty concentrating. If left untreated, CSR can lead to PTSD.

Common causes of CSR are events such as a direct attack from insurgent small arms fire or a military convoy being hit by an improvised explosive device, but combat stressors encompass a diverse array of traumatizing events, such as seeing grave injuries, watching others

Advice to Counselors: Understanding the Nature of Combat Stress

Several sources of information are available to help counselors deepen their understanding of combat stress and postdeployment adjustment. Friedman (2006) explains how a prolonged combat-ready stance, which is adaptive in a war zone, becomes hypervigilance and overprotectiveness at home. He makes the point that the "mutual interdependence, trust, and affection" (p. 587) that are so necessarily a part of a combat unit are different from relationships with family members and colleagues in a civilian workplace. This complicates the transition to civilian life. *Wheels Down: Adjusting to Life After Deployment* (Moore & Kennedy, 2011) provides practical advice for military service members, including inactive or active duty personnel and veterans, in transitioning from the theater to home.

The following are just a few of the many resources and reports focused on combat-related psychological and stress issues:

- *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Tanielian & Jaycox, 2008)
- *On Killing* (Grossman, 1995), an indepth analysis of the psychological dynamics of combat
- *Haunted by Combat* (Paulson & Krippner, 2007), which contains specific chapters on Reserve and National Guard troops and female veterans
- *Treating Young Veterans: Promoting Resilience Through Practice and Advocacy* (Kelly, Howe-Barksdale, & Gitelson, 2011)

die, and making on-the-spot decisions in ambiguous conditions (e.g., having to determine whether a vehicle speeding toward a military checkpoint contains insurgents with explosives or a family traveling to another area). Such circumstances can lead to combat stress. Military personnel also serve in noncombat positions (e.g., healthcare and administrative roles), and personnel filling these supportive roles can be exposed to combat situations by proximity or by witnessing their results.

Specific Trauma-Related Psychological Disorders

Part of the definition of trauma is that the individual responds with intense fear, helplessness, or horror. Beyond that, in both the short term and the long term, trauma comprises a range of reactions from normal (e.g., being unable to concentrate, feeling sad, having trouble sleeping) to warranting a diagnosis of a trauma-related mental disorder. Most people who experience trauma have no long-lasting disabling effects; their coping skills and the support of those around them are sufficient to help them overcome their difficulties, and their ability to function on a daily basis over time is unimpaired. For others, though, the symptoms of trauma are more severe and last longer. The most common diagnoses associated with trauma are PTSD and ASD, but trauma is also associated with the onset of other mental disorders—particularly substance use disorders, mood disorders, various anxiety disorders, and personality disorders. Trauma also typically exacerbates symptoms of preexisting disorders, and, for people who are predisposed to a mental disorder, trauma can precipitate its onset. Mental disorders can occur almost simultaneously with trauma exposure or manifest sometime thereafter.

Acute Stress Disorder

ASD represents a normal response to stress. Symptoms develop within 4 weeks of the trauma and can cause significant levels of distress. Most individuals who have acute stress reactions never develop further impairment or PTSD. Acute stress disorder is highly associated with the experience of one specific trauma rather than the experience of long-term exposure to chronic traumatic stress. Diagnostic criteria are presented in Exhibit 1.3-3.

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). **Note:** This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks), during which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood:
   5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms:
   6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
   7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors, such as head injury, alcohol, or drugs).

Avoidance Symptoms:
   8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   9. Efforts to avoid external reminders (e.g., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms:
   10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
   11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   12. Hypervigilance.
   13. Problems with concentration.
   14. Exaggerated startle response.

(Continued on the next page.)

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD (continued)

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure. **Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

Source: APA, 2013a, pp. 280–281.

The primary presentation of an individual with an acute stress reaction is often that of someone who appears overwhelmed by the traumatic experience. The need to talk about the experience can lead the client to seem self-centered and unconcerned about the needs of others. He or she may need to describe, in repetitive detail, what happened, or may seem obsessed with trying to understand what happened in an effort to make sense of the experience. The client is often hypervigilant and avoids circumstances that are reminders of the trauma. For instance, someone who was in a serious car crash in heavy traffic can become anxious and avoid riding in a car or driving in traffic for a finite time afterward. Partial amnesia for the trauma often accompanies ASD, and the individual may repetitively question others to fill in details. People with ASD symptoms sometimes seek assurance from others that the event happened in the way they remember, that they are not "going crazy" or "losing it," and that they could not have prevented the event. The next case illustration demonstrates the time-limited nature of ASD.

Differences between ASD and PTSD

It is important to consider the differences between ASD and PTSD when forming a diagnostic impression. The primary difference is the amount of time the symptoms have been present. ASD resolves 2 days to 4 weeks after an event, whereas PTSD continues beyond the 4-week period. The diagnosis of ASD can change to a diagnosis of PTSD if the condition is noted within the first 4 weeks after the event, but the symptoms persist past 4 weeks.

ASD also differs from PTSD in that the ASD diagnosis requires 9 out of 14 symptoms from five categories, including intrusion, negative mood, dissociation, avoidance, and arousal. These symptoms can occur at the time of the trauma or in the following month. Studies indicate that dissociation at the time of trauma is a good predictor of subsequent PTSD, so the inclusion of dissociative symptoms makes it more likely that those who develop ASD will later be diagnosed with PTSD (Bryant & Harvey, 2000). Additionally, ASD is a transient disorder, meaning that it is present in a person's life for a relatively short time and then passes. In contrast, PTSD typically becomes a primary feature of an individual's life. Over a lengthy period, PTSD can have profound effects on clients' perceptions of safety, their sense of hope for the future, their relationships with others, their physical health, the appearance of psychiatric symptoms, and their patterns of substance use and abuse.

There are common symptoms between PTSD and ASD, and untreated ASD is a possible predisposing factor to PTSD, but it is unknown whether most people with ASD are likely to develop PTSD. There is some suggestion that, as with PTSD, ASD is more

Case Illustration: Sheila

Two months ago, Sheila, a 55-year-old married woman, experienced a tornado in her home town. In the previous year, she had addressed a long-time marijuana use problem with the help of a treatment program and had been abstinent for about 6 months. Sheila was proud of her abstinence; it was something she wanted to continue. She regarded it as a mark of personal maturity; it improved her relationship with her husband, and their business had flourished as a result of her abstinence.

During the tornado, an employee reported that Sheila had become very agitated and had grabbed her assistant to drag him under a large table for cover. Sheila repeatedly yelled to her assistant that they were going to die. Following the storm, Sheila could not remember certain details of her behavior during the event. Furthermore, Sheila said that after the storm, she felt numb, as if she was floating out of her body and could watch herself from the outside. She stated that nothing felt real and it was all like a dream.

Following the tornado, Sheila experienced emotional numbness and detachment, even from people close to her, for about 2 weeks. The symptoms slowly decreased in intensity but still disrupted her life. Sheila reported experiencing disjointed or unconnected images and dreams of the storm that made no real sense to her. She was unwilling to return to the building where she had been during the storm, despite having maintained a business at this location for 15 years. In addition, she began smoking marijuana again because it helped her sleep. She had been very irritable and had uncharacteristic angry outbursts toward her husband, children, and other family members.

As a result of her earlier contact with a treatment program, Sheila returned to that program and engaged in psychoeducational, supportive counseling focused on her acute stress reaction. She regained abstinence from marijuana and returned shortly to a normal level of functioning. Her symptoms slowly diminished over a period of 3 weeks. With the help of her counselor, she came to understand the link between the trauma and her relapse, regained support from her spouse, and again felt in control of her life.

prevalent in women than in men (Bryant & Harvey, 2003). However, many people with PTSD do not have a diagnosis or recall a history of acute stress symptoms before seeking treatment for or receiving a diagnosis of PTSD.

Effective interventions for ASD can significantly reduce the possibility of the subsequent development of PTSD. Effective treatment of ASD can also reduce the incidence of other co-occurring problems, such as depression, anxiety, dissociative disorders, and compulsive behaviors (Bryant & Harvey, 2000). Intervention for ASD also helps the individual develop coping skills that can effectively prevent the recurrence of ASD after later traumas.

Although predictive science for ASD and PTSD will continue to evolve, both disorders are associated with increased substance use and mental disorders and increased risk of relapse; therefore, effective screening for ASD and PTSD is important for all clients with these disorders. Individuals in early recovery—lacking well-practiced coping skills, lacking environmental supports, and already operating at high levels of anxiety—are particularly susceptible to ASD. Events that would not normally be disabling can produce symptoms of intense helplessness and fear, numbing and depersonalization, disabling anxiety, and an inability to handle normal life events. Counselors should be able to recognize ASD and treat it rather than attributing the symptoms to a client's lack of motivation to change, being "dry drunk" (for those in substance abuse recovery), or being manipulative.

Posttraumatic Stress Disorder

The trauma-related disorder that receives the greatest attention is PTSD; it is the most

Case Illustration: Michael

Michael is a 62-year-old Vietnam veteran. He is a divorced father of two children and has four grandchildren. Both of his parents were dependent on alcohol. He describes his childhood as isolated. His father physically and psychologically abused him (e.g., he was beaten with a switch until he had welts on his legs, back, and buttocks). By age 10, his parents regarded him as incorrigible and sent him to a reformatory school for 6 months. By age 15, he was using marijuana, hallucinogens, and alcohol and was frequently truant from school.

At age 19, Michael was drafted and sent to Vietnam, where he witnessed the deaths of six American military personnel. In one incident, the soldier he was next to in a bunker was shot. Michael felt helpless as he talked to this soldier, who was still conscious. In Vietnam, Michael increased his use of both alcohol and marijuana. On his return to the United States, Michael continued to drink and use marijuana. He reenlisted in the military for another tour of duty.

His life stabilized in his early 30s, as he had a steady job, supportive friends, and a relatively stable family life. However, he divorced in his late 30s. Shortly thereafter, he married a second time, but that marriage ended in divorce as well. He was chronically anxious and depressed and had insomnia and frequent nightmares. He periodically binged on alcohol. He complained of feeling empty, had suicidal ideation, and frequently stated that he lacked purpose in his life.

In the 1980s, Michael received several years of mental health treatment for dysthymia. He was hospitalized twice and received 1 year of outpatient psychotherapy. In the mid-1990s, he returned to outpatient treatment for similar symptoms and was diagnosed with PTSD and dysthymia. He no longer used marijuana and rarely drank. He reported that he didn't like how alcohol or other substances made him feel anymore—he felt out of control with his emotions when he used them. Michael reported symptoms of hyperarousal, intrusion (intrusive memories, nightmares, and preoccupying thoughts about Vietnam), and avoidance (isolating himself from others and feeling "numb"). He reported that these symptoms seemed to relate to his childhood abuse and his experiences in Vietnam. In treatment, he expressed relief that he now understood the connection between his symptoms and his history.

commonly diagnosed trauma-related disorder, and its symptoms can be quite debilitating over time. Nonetheless, it is important to remember that PTSD symptoms are represented in a number of other mental illnesses, including major depressive disorder (MDD), anxiety disorders, and psychotic disorders (Foa et al., 2006). The DSM-5 (APA, 2013a) identifies four symptom clusters for PTSD: presence of intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. Individuals must have been exposed to actual or threatened death, serious injury, or sexual violence, and the symptoms must produce significant distress and impairment for more than 4 weeks (Exhibit 1.3-4).

Certain characteristics make people more susceptible to PTSD, including one's unique personal vulnerabilities at the time of the traumatic exposure, the support (or lack of support) received from others at the time of the trauma and at the onset of trauma-related symptoms, and the way others in the person's environment gauge the nature of the traumatic event (Brewin, Andrews, & Valentine, 2000).

People with PTSD often present varying clinical profiles and histories. They can experience symptoms that are activated by environmental triggers and then recede for a period of time. Some people with PTSD who show mostly psychiatric symptoms (particularly depression and anxiety) are misdiagnosed and go untreated for their primary condition. For many people, the trauma experience and diagnosis

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled "Posttraumatic Stress Disorder for Children 6 Years and Younger" (APA, 2013a).

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
   5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
   2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
   3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
   4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
   5. Markedly diminished interest or participation in significant activities.
   6. Feelings of detachment or estrangement from others.
   7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

(Continued on the next page.)

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD (continued)

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   2. Reckless or self-destructive behavior.
   3. Hypervigilance.
   4. Exaggerated startle response.
   5. Problems with concentration.
   6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify whether:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Source: APA, 2013a, pp. 271–272.

are obscured by co-occurring substance use disorder symptoms. The important feature of PTSD is that the disorder becomes an orienting feature of the individual's life. How well the person can work, with whom he or she associates, the nature of close and intimate relationships, the ability to have fun and rejuvenate, and the way in which an individual goes about confronting and solving problems in life are all affected by the client's trauma experiences and his or her struggle to recover.

Posttraumatic stress disorder: Timing of symptoms

Although symptoms of PTSD usually begin within 3 months of a trauma in adulthood, there can be a delay of months or even years before symptoms appear for some people. Some people may have minimal symptoms after a trauma but then experience a crisis later in life. Trauma symptoms can appear suddenly, even without conscious memory of the original trauma or without any overt provocation. Survivors of abuse in childhood can have a delayed response triggered by something that happens to them as adults. For example, seeing a movie about child abuse can trigger symptoms related

Advice to Counselors: Helping Clients With Delayed Trauma Responses

Clients who are experiencing a delayed trauma response can benefit if you help them to:

- Create an environment that allows acknowledgment of the traumatic event(s).
- Discuss their initial recall or first suspicion that they were having a traumatic response.
- Become educated on delayed trauma responses.
- Draw a connection between the trauma and presenting trauma-related symptoms.
- Create a safe environment.
- Explore their support systems and fortify them as needed.
- Understand that triggers can precede traumatic stress reactions, including delayed responses to trauma.
- Identify their triggers.
- Develop coping strategies to navigate and manage symptoms.

to the trauma. Other triggers include returning to the scene of the trauma, being reminded of it in some other way, or noting the anniversary of an event. Likewise, combat veterans and survivors of community-wide disasters may seem to be coping well shortly after a trauma, only to have symptoms emerge later when their life situations seem to have stabilized. Some clients in substance abuse recovery only begin to experience trauma symptoms when they maintain abstinence for some time. As individuals decrease tension-reducing or self-medicating behaviors, trauma memories and symptoms can emerge.

Culture and posttraumatic stress

Although research is limited across cultures, PTSD has been observed in Southeast Asian, South American, Middle Eastern, and Native American survivors (Osterman & de Jong, 2007; Wilson & Tang, 2007). As Stamm and Friedman (2000) point out, however, simply observing PTSD does not mean that it is the "best conceptual tool for characterizing posttraumatic distress among non-Western individuals" (p. 73). In fact, many trauma-related symptoms from other cultures do not fit the DSM-5 criteria. These include somatic and psychological symptoms and beliefs about the origins and nature of traumatic events. Moreover, religious and spiritual beliefs can affect how a survivor experiences a traumatic event and whether he or she reports the distress. For example, in societies where attitudes toward karma and the glorification of war veterans are predominant, it is harder for war veterans to come forward and disclose that they are emotionally overwhelmed or struggling. It would be perceived as inappropriate and possibly demoralizing to focus on the emotional distress that he or she still bears. (For a review of cultural competence in treating trauma, refer to Brown, 2008.)

Methods for measuring PTSD are also culturally specific. As part of a project begun in 1972, the World Health Organization (WHO) and the National Institutes of Health (NIH) embarked on a joint study to test the cross-cultural applicability of classification systems for various diagnoses. WHO and NIH identified apparently universal factors of psychological disorders and developed specific instruments to measure them. These instruments, the Composite International Diagnostic Interview and the Schedules for Clinical Assessment in Neuropsychiatry, include certain criteria from the DSM (Fourth Edition, Text Revision; APA, 2000a) as well as criteria from the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10; Exhibit 1.3-5).

Exhibit 1.3-5: ICD-10 Diagnostic Criteria for PTSD

A. The patient must have been exposed to a stressful event or situation (either brief or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.

B. There must be persistent remembering or "reliving" of the stressor in intrusive "flashbacks," vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.

D. Either of the following must be present:
   1. Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor.
   2. Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
      a. Difficulty in falling or staying asleep.
      b. Irritability or outbursts of anger.
      c. Difficulty in concentrating.
      d. Exaggerated startle response.

E. Criteria B, C, and D must all be met within 6 months of the stressful event or at the end of a period of stress. (For some purposes, onset delayed more than 6 months can be included, but this should be clearly specified.)

Source: WHO, 1992.

Complex trauma and complex traumatic stress

When individuals experience multiple traumas, prolonged and repeated trauma during childhood, or repetitive trauma in the context of significant interpersonal relationships, their reactions to trauma have unique characteristics (Herman, 1992). This unique constellation of reactions, called complex traumatic stress, is not recognized diagnostically in the DSM-5, but theoretical discussions and research have begun to highlight the similarities and differences in symptoms of posttraumatic stress versus complex traumatic stress (Courtois & Ford, 2009). Often, the symptoms generated from complex trauma do not fully match PTSD criteria and exceed the severity of PTSD. Overall, literature reflects that PTSD criteria or subthreshold symptoms do not fully account for the persistent and more impairing clinical presentation of complex trauma. Even though current research in the study of traumatology is prolific, it is still in the early stages of development. The idea that there may be more diagnostic variations or subtypes is forthcoming, and this will likely pave the way for more client-matching interventions to better serve those individuals who have been repeatedly exposed to multiple, early childhood, and/or interpersonal traumas.

Other Trauma-Related and Co-Occurring Disorders

The symptoms of PTSD and other mental disorders overlap considerably; these disorders often coexist and include mood, anxiety,

The term "**co occurring disorders**" refers to cases when a person has one or more mental disorders as well as one or more substance use disorders (including sub stance abuse). Co occurring disorders are common among individuals who have a history of trauma and are seeking help.

Advice to Counselors: Universal Screening and Assessment

Only people specifically trained and licensed in mental health assessment should make diagnoses; trauma can result in complicated cases, and many symptoms can be present, whether or not they meet full diagnostic criteria for a specific disorder. Only a trained assessor can distinguish accurately among various symptoms and in the presence of co-occurring disorders. However, behavioral health professionals without specific assessment training can still serve an important role in screening for possible mental disorders using established screening tools (CSAT, 2005c; see also Chapter 4 of this TIP). In agencies and clinics, it is critical to provide such screenings systematically—for each client—as PTSD and other co-occurring disorders are typically underdiagnosed or misdiagnosed.

substance use, and personality disorders. Thus, it's common for trauma survivors to be underdiagnosed or misdiagnosed. If they have not been identified as trauma survivors, their psychological distress is often not associated with previous trauma, and/or they are diagnosed with a disorder that marginally matches their presenting symptoms and psychological sequelae of trauma. The following sections present a brief overview of some mental disorders that can result from (or be worsened by) traumatic stress. PTSD is not the only diagnosis related to trauma nor its only psychological consequence; trauma can broadly influence mental and physical health in clients who already have behavioral health disorders.

People With Mental Disorders

MDD is the most common co-occurring disorder in people who have experienced trauma and are diagnosed with PTSD. A well-established causal relationship exists between stressful events and depression, and a prior history of MDD is predictive of PTSD after exposure to major trauma (Foa et al., 2006).

Many survivors with severe mental disorders function fairly well following trauma, including disasters, as long as essential services aren't interrupted. For others, additional mental health supports may be necessary. For more information, see *Responding to the Needs of People With Serious and Persistent Mental Illness in Times of Major Disaster* (Center for Mental Health Services, 1996).

Co-occurrence is also linked with greater impairment and more severe symptoms of both disorders, and the person is less likely to experience remission of symptoms within 6 months.

Generalized anxiety, obsessive–compulsive, and other anxiety disorders are also associated with PTSD. PTSD may exacerbate anxiety disorder symptoms, but it is also likely that preexisting anxiety symptoms and anxiety disorders increase vulnerability to PTSD. Preexisting anxiety primes survivors for greater hyperarousal and distress. Other disorders, such as personality and somatization disorders, are also associated with trauma, but the history of trauma is often overlooked as a significant factor or necessary target in treatment.

The relationship between PTSD and other disorders is complex. More research is now examining the multiple potential pathways among PTSD and other disorders and how various sequences affect clinical presentation. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c), is valuable in understanding the relationship of substance use to other mental disorders.

People With Substance Use Disorders

There is clearly a correlation between trauma (including individual, group, or mass trauma) and substance use as well as the presence of posttraumatic stress (and other trauma-related disorders) and substance use disorders. Alcohol and drug use can be, for some, an effort to

Co-Occurring PTSD and Other Mental Disorders

- Individuals with PTSD often have at least one additional diagnosis of a mental disorder.
- The presence of other disorders typically worsens and prolongs the course of PTSD and complicates clinical assessment, diagnosis, and treatment.
- The most common co-occurring disorders, in addition to substance use disorders, include mood disorders, various anxiety disorders, eating disorders, and personality disorders.
- Exposure to early, severe, and chronic trauma is linked to more complex symptoms, including impulse control deficits, greater difficulty in emotional regulation and establishing stable relationships, and disruptions in consciousness, memory, identity, and/or perception of the environment (Dom, De, Hulstijn, & Sabbe, 2007; Waldrop, Back, Verduin, & Brady, 2007).
- Certain diagnostic groups and at-risk populations (e.g., people with developmental disabilities, people who are homeless or incarcerated) are more susceptible to trauma exposure and to developing PTSD if exposed but less likely to receive appropriate diagnosis and treatment.
- Given the prevalence of traumatic events in clients who present for substance abuse treatment, counselors should assess all clients for possible trauma-related disorders.

manage traumatic stress and specific PTSD symptoms. Likewise, people with substance use disorders are at higher risk of developing PTSD than people who do not abuse substances. Counselors working with trauma survivors or clients who have substance use disorders have to be particularly aware of the possibility of the other disorder arising.

Timeframe: PTSD and the onset of substance use disorders

Knowing whether substance abuse or PTSD came first informs whether a causal relationship exists, but learning this requires thorough assessment of clients and access to complete data on PTSD; substance use, abuse, and dependence; and the onset of each. Much current research focuses solely on the age of onset of substance use (not abuse), so determining causal relationships can be difficult.

The relationship between PTSD and substance use disorders is thought to be bidirectional and cyclical: substance use increases trauma risk, and exposure to trauma escalates substance use to manage trauma-related symptoms. Three other causal pathways described by Chilcoat and Breslau's seminal work (1998) further explain the relationship between PTSD and substance use disorders:

1. The "self-medication" hypothesis suggests that clients with PTSD use substances to manage PTSD symptoms (e.g., intrusive memories, physical arousal). Substances such as alcohol, cocaine, barbiturates, opioids, and amphetamines are frequently abused in attempts to relieve or numb emotional pain or to forget the event.
2. The "high-risk" hypothesis states that drug and alcohol use places people who use substances in high-risk situations that increase their chances of being exposed to events that lead to PTSD.
3. The "susceptibility" hypothesis suggests that people who use substances are more susceptible to developing PTSD after exposure to trauma than people who do not. Increased vulnerability may result from failure to develop effective stress management strategies, changes in brain chemistry, or damage to neurophysiological systems due to extensive substance use.

PTSD and substance abuse treatment

PTSD can limit progress in substance abuse recovery, increase the potential for relapse, and complicate a client's ability to achieve success in various life areas. Each disorder can mask or hide the symptoms of the other, and both need

Case Illustration: Maria

Maria is a 31-year-old woman diagnosed with PTSD and alcohol dependence. From ages 8 to 12, she was sexually abused by an uncle. Maria never told anyone about the abuse for fear that she would not be believed. Her uncle remains close to the family, and Maria still sees him on certain holidays. When she came in for treatment, she described her emotions and thoughts as out of control. Maria often experiences intrusive memories of the abuse, which at times can be vivid and unrelenting. She cannot predict when the thoughts will come; efforts to distract herself from them do not always work. She often drinks in response to these thoughts or his presence, as she has found that alcohol can dull her level of distress. Maria also has difficulty falling asleep and is often awakened by nightmares. She does not usually remember the dreams, but she wakes up feeling frightened and alert and cannot go back to sleep.

Maria tries to avoid family gatherings but often feels pressured to go. Whenever she sees her uncle, she feels intense panic and anger but says she can usually "hold it together" if she avoids him. Afterward, however, she describes being overtaken by these feelings and unable to calm down. She also describes feeling physically ill and shaky. At these times, she often isolates herself, stays in her apartment, and drinks steadily for several days. Maria also reports distress pertaining to her relationship with her boyfriend. In the beginning of their relationship, she found him comforting and enjoyed his affection, but more recently, she has begun to feel anxious and unsettled around him. Maria tries to avoid sex with him, but she sometimes gives in for fear of losing the relationship. She finds it easier to have sex with him when she is drunk, but she often experiences strong feelings of dread and disgust reminiscent of her abuse. Maria feels guilty and confused about these feelings.

to be assessed and treated if the individual is to have a full recovery. There is a risk of misinterpreting trauma-related symptoms in substance abuse treatment settings. For example, avoidance symptoms in an individual with PTSD can be misinterpreted as lack of motivation or unwillingness to engage in substance abuse treatment; a counselor's efforts to address substance abuse–related behaviors in early recovery can likewise provoke an exaggerated response from a trauma survivor who has profound traumatic experiences of being trapped and controlled. Exhibit 1.3-6 lists important facts about PTSD and substance use disorders for counselors.

Sleep, PTSD, and substance use

Many people have trouble getting to sleep and/or staying asleep after a traumatic event; consequently, some have a drink or two to help them fall asleep. Unfortunately, any initially helpful effects are likely not only to wane quickly, but also to incur a negative rebound effect. When someone uses a substance before going to bed, "sleep becomes lighter and more easily disrupted," and rapid eye movement sleep (REM) "increases, with an associated increase in dreams and nightmares," as the effects wear off (Auerbach, 2003, p. 1185).

People with alcohol dependence report multiple types of sleep disturbances over time, and it is not unusual for clients to report that they cannot fall asleep without first having a drink. Both REM and slow wave sleep are reduced in clients with alcohol dependence, which is also associated with an increase in the amount of time it takes before sleep occurs, decreased overall sleep time, more nightmares, and reduced sleep efficiency. Sleep during withdrawal is "frequently marked by severe insomnia and sleep fragmentation…a loss of restful sleep and feelings of daytime fatigue. Nightmares and vivid dreams are not uncommon" (Auerbach, 2003, pp. 1185–1186).

Confounding changes in the biology of sleep that occur in clients with PTSD and substance use disorders often add to the problems of

Exhibit 1.3-6: PTSD and Substance Use Disorders: Important Treatment Facts

Profile Severity

- PTSD is one of the most common co-occurring mental disorders found in clients in substance abuse treatment (CSAT, 2005c).
- People in treatment for PTSD tend to abuse a wide range of substances, including opioids, cocaine, marijuana, alcohol, and prescription medications.
- People in treatment for PTSD and substance abuse have a more severe clinical profile than those with just one of these disorders.
- PTSD, with or without major depression, significantly increases risk for suicidality (CSAT, 2009a).

Gender Differences

- Rates of trauma-related disorders are high in men and women in substance abuse treatment.
- Women with PTSD and a substance use disorder most frequently experienced rape or witnessed a killing or injury; men with both disorders typically witnessed a killing or injury or were the victim of sudden injury or accident (Cottler, Nishith, & Compton, 2001).

Risk of Continued Cycle of Violence

- While under the influence of substances, a person is more vulnerable to traumatic events (e.g., automobile crashes, assaults).
- Perpetrators of violent assault often are under the influence of substances or test positive for substances at the time of arrest.

Treatment Complications

- It is important to recognize and help clients understand that becoming abstinent from substances does not resolve PTSD; in fact, some PTSD symptoms become worse with abstinence for some people. Both disorders must be addressed in treatment.
- Treatment outcomes for clients with PTSD and a substance use disorder are worse than for clients with other co-occurring disorders or who only abuse substances (Brown, Read, & Kahler, 2003).

recovery. Sleep can fail to return to normal for months or even years after abstinence, and the persistence of sleep disruptions appears related to the likelihood of relapse. Of particular clinical importance is the vicious cycle that can also begin during "slips"; relapse initially improves sleep, but continued drinking leads to sleep disruption. This cycle of initial reduction of an unpleasant symptom, which only ends up exacerbating the process as a whole, can take place for clients with PTSD as well as for clients with substance use disorders. There are effective cognitive–behavioral therapies and nonaddictive pharmacological interventions for sleep difficulties.

4 Screening and Assessment

IN THIS CHAPTER

- Screening and Assessment
- Barriers and Challenges to Trauma Informed Screening and Assessment
- Cross Cultural Screening and Assessment
- Choosing Instruments
- Trauma Informed Screening and Assessment
- Concluding Note

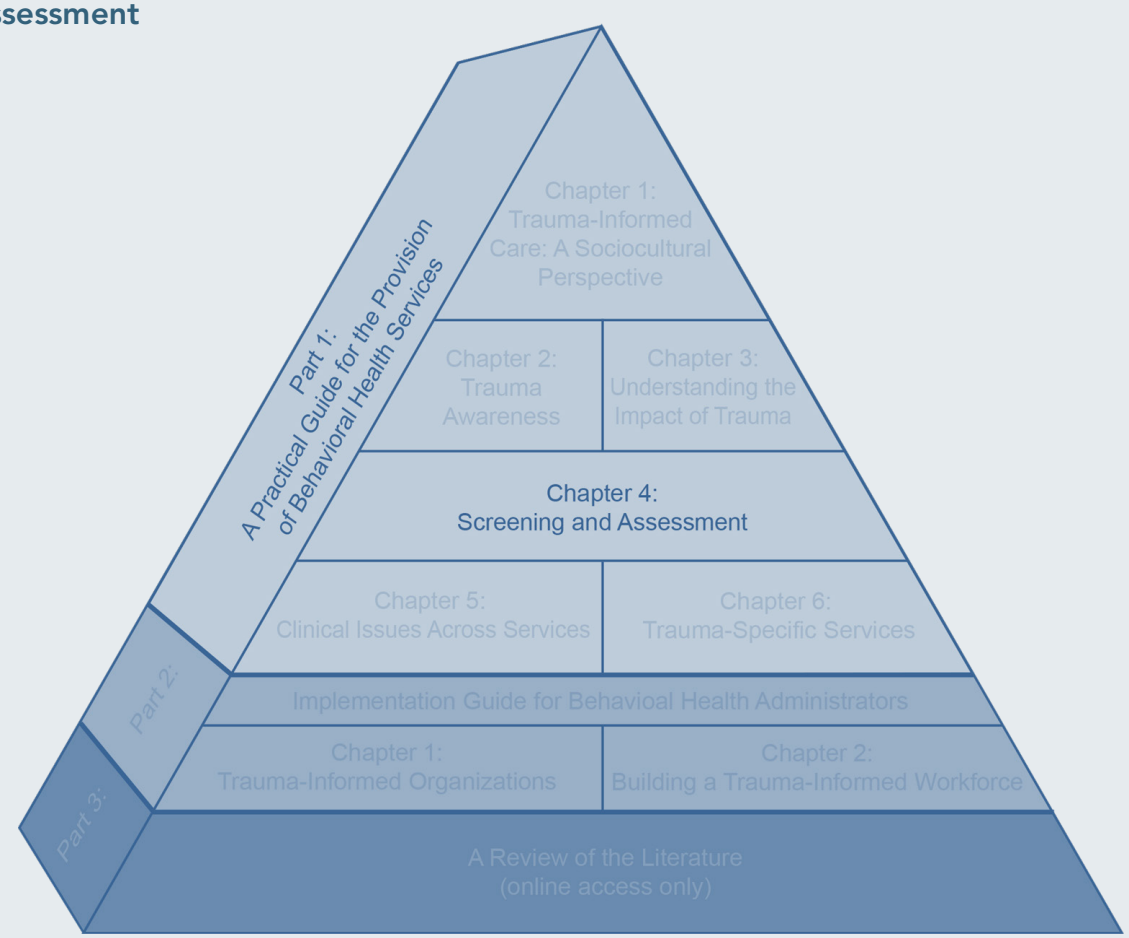
Why screen universally for trauma in behavioral health services? Exposure to trauma is common; in many surveys, more than half of respondents report a history of trauma, and the rates are even higher among clients with mental or substance use disorders. Furthermore, behavioral health problems, including substance use and mental disorders, are more difficult to treat if trauma-related symptoms and disorders aren't detected early and treated effectively (Part 3, Section 1, of this Treatment Improvement Protocol [TIP], available online, summarizes research on the prevalence of trauma and its relationship with other behavioral health problems).

Not addressing traumatic stress symptoms, trauma-specific disorders, and other symptoms/disorders related to trauma can impede successful mental health and substance abuse treatment. Unrecognized, unaddressed trauma symptoms can lead to poor engagement in treatment, premature termination, greater risk for relapse of psychological symptoms or substance use, and worse outcomes. Screening can also prevent misdiagnosis and inappropriate treatment planning. People with histories of trauma often display symptoms that meet criteria for other disorders.

Without screening, clients' trauma histories and related symptoms often go undetected, leading providers to direct services toward symptoms and disorders that may only partially explain client presentations and distress. Universal screening for trauma history and trauma-related symptoms can help behavioral health practitioners identify individuals at risk of developing more pervasive and severe symptoms of traumatic stress. Screening, early identification, and intervention serves as a prevention strategy.

Screening to identify clients who have histories of trauma and experience trauma related symptoms is a prevention strategy.

Trauma-Informed Care Framework in Behavioral Health Services—Screening and Assessment



The chapter begins with a discussion of screening and assessment concepts, with a particular focus on trauma-informed screening. It then highlights specific factors that influence screening and assessment, including timing and environment. Barriers and challenges in providing trauma-informed screening are discussed, along with culturally specific screening and assessment considerations and guidelines. Instrument selection, trauma-informed screening and assessment tools, and trauma-informed screening and assessment processes are reviewed as well. For a more research-oriented perspective on screening and assessment for traumatic stress disorders, please refer to the literature review provided in Part 3 of this TIP, which is available online.

Screening and Assessment

Screening

The first two steps in screening are to determine whether the person has a history of trauma and whether he or she has trauma-related symptoms. Screening mainly obtains answers to "yes" or "no" questions: "Has this client experienced a trauma in the past?" and "Does this client at this time warrant further assessment regarding trauma-related symptoms?" If someone acknowledges a trauma history, then further screening is necessary to determine whether trauma-related symptoms are present. However, the presence of such symptoms does not necessarily say anything about their severity, nor does a positive screen indicate that a disorder actually exists. Positive

Screening is often the first contact between the client and the treatment provider, and the client forms his or her first impression of treatment during this intake process. Thus, how screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client.

screens only indicate that assessment or further evaluation is warranted, and negative screens do not necessarily mean that an individual doesn't have symptoms that warrant intervention.

Screening procedures should always define the steps to take after a positive or negative screening. That is, the screening process establishes precisely how to score responses to screening tools or questions and clearly defines what constitutes a positive score (called a "cut-off score") for a particular potential problem. The screening procedures detail the actions to take after a client scores in the positive range. Clinical supervision is helpful—and sometimes necessary—in judging how to proceed.

Trauma-informed screening is an essential part of the intake evaluation and the treatment planning process, but it is not an end in itself. Screening processes can be developed that allow staff without advanced degrees or graduate-level training to conduct them, whereas assessments for trauma-related disorders require a mental health professional trained in assessment and evaluation processes. The most important domains to screen among individuals with trauma histories include:

- Trauma-related symptoms.
- Depressive or dissociative symptoms, sleep disturbances, and intrusive experiences.
- Past and present mental disorders, including typically trauma-related disorders (e.g., mood disorders).
- Severity or characteristics of a specific trauma type (e.g., forms of interpersonal violence, adverse childhood events, combat experiences).
- Substance abuse.
- Social support and coping styles.
- Availability of resources.
- Risks for self-harm, suicide, and violence.
- Health screenings.

Assessment

When a client screens positive for substance abuse, trauma-related symptoms, or mental disorders, the agency or counselor should follow up with an assessment. A positive screening calls for more action—an assessment that determines and defines presenting struggles to develop an appropriate treatment plan and to make an informed and collaborative decision about treatment placement. Assessment determines the nature and extent of the client's problems; it might require the client to respond to written questions, or it could involve a clinical interview by a mental health or substance abuse professional qualified to assess the client and arrive at a diagnosis. A clinical assessment delves into a client's past and current experiences, psychosocial and cultural history, and assets and resources.

Assessment protocols can require more than a single session to complete and should also use multiple avenues to obtain the necessary clinical information, including self-assessment tools, past and present clinical and medical records, structured clinical interviews, assessment measures, and collateral information from significant others, other behavioral health professionals, and agencies. Qualifications for conducting assessments and clinical interviews are more rigorous than for screening. Advanced degrees, licensing or certification, and special training in administration, scoring, and interpretation of specific assessment instruments and interviews are often

Advice to Counselors: Screening and Assessing Clients

- Ask all clients about any possible history of trauma; use a checklist to increase proper identification of such a history (see the online Adverse Childhood Experiences Study Score Calculator [http://acestudy.org/ace_score] for specific questions about adverse childhood experiences).
- Use only validated instruments for screening and assessment.
- Early in treatment, screen all clients who have histories of exposure to traumatic events for psychological symptoms and mental disorders related to trauma.
- When clients screen positive, also screen for suicidal thoughts and behaviors (see TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*; Center for Substance Abuse Treatment [CSAT], 2009a).
- Do not delay screening; do not wait for a period of abstinence or stabilization of symptoms.
- Be aware that some clients will not make the connection between trauma in their histories and their current patterns of behavior (e.g., alcohol and drug use and/or avoidant behavior).
- Do not require clients to describe emotionally overwhelming traumatic events in detail.
- Focus assessment on how trauma symptoms affect clients' current functioning.
- Consider using paper-and-pencil instruments for screening and assessment as well as self-report measures when appropriate; they are less threatening for some clients than a clinical interview.
- Talk about how you will use the findings to plan the client's treatment, and discuss any immediate action necessary, such as arranging for interpersonal support, referrals to community agencies, or moving directly into the active phase of treatment. It is helpful to explore the strategies clients have used in the past that have worked to relieve strong emotions (Fallot & Harris, 2001).
- At the end of the session, make sure the client is grounded and safe before leaving the interview room (Litz, Miller, Ruef, & McTeague, 2002). Readiness to leave can be assessed by checking on the degree to which the client is conscious of the current environment, what the client's plan is for maintaining personal safety, and what the client's plans are for the rest of the day.

required. Counselors must be familiar with (and obtain) the level of training required for any instruments they consider using.

For people with histories of traumatic life events who screen positive for possible trauma-related symptoms and disorders, thorough assessment gathers all relevant information necessary to understand the role of the trauma in their lives; appropriate treatment objectives, goals, planning, and placement; and any ongoing diagnostic and treatment considerations, including reevaluation or follow-up.

Overall, assessment may indicate symptoms that meet diagnostic criteria for a substance use or mental disorder or a milder form of symptomatology that doesn't reach a diagnostic level—or it may reveal that the positive screen was false and that there is no significant cause for concern. Information from an assessment is used to plan the client's treatment. The plan can include such domains as level of care, acute safety needs, diagnosis, disability, strengths and skills, support network, and cultural context. Assessments should reoccur throughout treatment. Ongoing assessment during treatment can provide valuable information by revealing further details of trauma history as clients' trust in staff members grows and by gauging clients' progress.

Timing of Screening and Assessment

As a trauma-informed counselor, you need to offer psychoeducation and support from the outset of service provision; this begins with explaining screening and assessment and with proper pacing of the initial intake and evaluation process. The client should understand the screening process, why the specific questions are important, and that he or she may choose to delay a response or to not answer a question

at all. Discussing the occurrence or consequences of traumatic events can feel as unsafe and dangerous to the client as if the event were reoccurring. It is important not to encourage avoidance of the topic or reinforce the belief that discussing trauma-related material is dangerous, but be sensitive when gathering information in the initial screening. Initial questions about trauma should be general and gradual. Taking the time to prepare and explain the screening and assessment process to the client gives him or her a greater sense of control and safety over the assessment process.

Clients with substance use disorders

No screening or assessment of trauma should occur when the client is under the influence of alcohol or drugs. Clients under the influence are more likely to give inaccurate information. Although it's likely that clients in an active phase of use (albeit not at the assessment itself) or undergoing substance withdrawal can provide consistent information to obtain a valid screening and assessment, there is insufficient data to know for sure. Some theorists state that no final assessment of trauma or posttraumatic stress disorder (PTSD) should occur during these early phases (Read, Bollinger, & Sharkansky, 2003), asserting that symptoms of withdrawal can mimic PTSD and thus result in overdiagnosis of PTSD and other trauma-related disorders. Alcohol or drugs can also cause memory impairment that clouds the client's history of trauma symptoms. However, Najavits (2004) and others note that underdiagnosis, not overdiagnosis, of trauma and PTSD has been a significant issue in the substance abuse field and thus claim that it is essential to obtain an initial assessment early, which can later be modified if needed (e.g., if the client's symptom pattern changes). Indeed, clinical observations suggest that assessments for both trauma and PTSD—even during active use or withdrawal—appear robust (Coffey, Schumacher, Brady, & Dansky, 2003). Although some PTSD symptoms and trauma memories can be dampened or increased to a degree, their overall presence or absence, as assessed early in treatment, appears accurate (Najavits, 2004).

Conduct Assessments Throughout Treatment

Ongoing assessments let counselors:

- Track changes in the presence, frequency, and intensity of symptoms.
- Learn the relationships among the client's trauma, presenting psychological symptoms, and substance abuse.
- Adjust diagnoses and treatment plans as needed.
- Select prevention strategies to avoid more pervasive traumatic stress symptoms.

The Setting for Trauma Screening and Assessment

Advances in the development of simple, brief, and public-domain screening tools mean that at least a basic screening for trauma can be done in almost any setting. Not only can clients be screened and assessed in behavioral health treatment settings; they can also be evaluated in the criminal justice system, educational settings, occupational settings, physicians' offices, hospital medical and trauma units, and emergency rooms. Wherever they occur, trauma-related screenings and subsequent assessments can reduce or eliminate wasted resources, relapses, and, ultimately, treatment failures among clients who have histories of trauma, mental illness, and/or substance use disorders.

Creating an effective screening and assessment environment

You can greatly enhance the success of treatment by paying careful attention to how you approach the screening and assessment process. Take into account the following points:

- ***Clarify for the client what to expect in the screening and assessment process.*** For example, tell the client that the screening and assessment phase focuses on identifying issues that might benefit from treatment. Inform him or her that during the trauma screening and assessment process, uncomfortable thoughts and feelings can arise. Provide reassurance that, if they do, you'll assist in dealing with this distress—but also let them know that, even with your assistance, some psychological and physical reactions to the interview may last for a few hours or perhaps as long as a few days after the interview, and be sure to highlight the fact that such reactions are normal (Read et al., 2003).
- ***Approach the client in a matter-of-fact, yet supportive, manner.*** Such an approach helps create an atmosphere of trust, respect, acceptance, and thoughtfulness (Melnick & Bassuk, 2000). Doing so helps to normalize symptoms and experiences generated by the trauma; consider informing clients that such events are common but can cause continued emotional distress if they are not treated. Clients may also find it helpful for you to explain the purpose of certain difficult questions. For example, you could say, "Many people have experienced troubling events as children, so some of my questions are about whether you experienced any such events while growing up." Demonstrate kindness and directness in equal measure when screening/assessing clients (Najavits, 2004).
- ***Respect the client's personal space.*** Cultural and ethnic factors vary greatly regarding the appropriate physical distance to maintain during the interview. You should respect the client's personal space, sitting neither too far from nor too close to the client; let your observations of the client's comfort level during the screening and assessment process guide the amount of distance. Clients with trauma may have particular sensitivity about their bodies, personal space, and boundaries.
- ***Adjust tone and volume of speech to suit the client's level of engagement and degree of comfort in the interview process.*** Strive to maintain a soothing, quiet demeanor. Be sensitive to how the client might hear what you have to say in response to personal disclosures. Clients who have been traumatized may be more reactive even to benign or well-intended questions.
- ***Provide culturally appropriate symbols of safety in the physical environment.*** These include paintings, posters, pottery, and other room decorations that symbolize the safety of the surroundings to the client population. Avoid culturally inappropriate or insensitive items in the physical environment.
- ***Be aware of one's own emotional responses to hearing clients' trauma histories.*** Hearing about clients' traumas may be very painful and can elicit strong emotions. The client may interpret your reaction to his or her revelations as disinterest, disgust for the client's behavior, or some other inaccurate interpretation. It is important for you to monitor your interactions and to check in with the client as necessary. You may also feel emotionally drained to the point that it interferes with your ability to accurately listen to or assess clients. This effect of exposure to traumatic stories, known as secondary traumatization, can result in symptoms similar to those experienced by the client (e.g., nightmares, emotional numbing); if necessary, refer to a colleague for assessment (Valent, 2002). Secondary traumatization is addressed in greater detail in Part 2, Chapter 2, of this TIP.
- ***Overcome linguistic barriers via an interpreter.*** Deciding when to add an interpreter requires careful judgment. The interpreter should be knowledgeable of behavioral

health terminology, be familiar with the concepts and purposes of the interview and treatment programming, be unknown to the client, and be part of the treatment team. Avoid asking family members or friends of the client to serve as interpreters.

- ***Elicit only the information necessary for determining a history of trauma and the possible existence and extent of traumatic stress symptoms and related disorders.*** There is no need to probe deeply into the details of a client's traumatic experiences at this stage in the treatment process. Given the lack of a therapeutic relationship in which to process the information safely, pursuing details of trauma can cause retraumatization or produce a level of response that neither you nor your client is prepared to handle. Even if a client wants to tell his or her trauma story, it's your job to serve as "gatekeeper" and preserve the client's safety. Your tone of voice when suggesting postponement of a discussion of trauma is very important. Avoid conveying the message, "I really don't want to hear about it." Examples of appropriate statements are:
  - "Your life experiences are very important, but at this early point in our work together, we should start with what's going on in your life currently rather than discussing past experiences in detail. If you feel that certain past experiences are having a big effect on your life now, it would be helpful for us to discuss them as long as we focus on your safety and recovery right now."
  - "Talking about your past at this point could arouse intense feelings—even more than you might be aware of right now. Later, if you choose to, you can talk with your counselor about how to work on exploring your past."
  - "Often, people who have a history of trauma want to move quickly into the details of the trauma to gain relief. I understand this desire, but my concern for you at this moment is to help you establish a sense of safety and support before moving into the traumatic experiences. We want to avoid retraumatization—meaning, we want to establish resources that weren't available to you at the time of the trauma before delving into more content."
- ***Give the client as much personal control as possible during the assessment by:***
  - Presenting a rationale for the interview and its stress-inducing potential, making clear that the client has the right to refuse to answer any and all questions.
  - Giving the client (where staffing permits) the option of being interviewed by someone of the gender with which he or she is most comfortable.
  - Postponing the interview if necessary (Fallot & Harris, 2001).
- ***Use self-administered, written checklists rather than interviews when possible to assess trauma.*** Traumas can evoke shame, guilt, anger, or other intense feelings that can make it difficult for the client to report them aloud to an interviewer. Clients are more likely to report trauma when they use self-administered screening tools; however, these types of screening instruments only guide the next step. Interviews should coincide with self-administered tools to create a sense of safety for the client (someone is present as he or she completes the screening) and to follow up with more indepth data gathering after a self-administered screening is complete. The Trauma History Questionnaire (THQ) is a self-administered tool (Green, 1996). It has been used successfully with clinical and nonclinical populations, including medical patients, women who have experienced domestic violence, and people with serious mental illness (Hooper, Stockton,

Krupnick, & Green, 2011). Screening instruments (including the THQ) are included in Appendix D of this TIP.

- ***Interview the client if he or she has trouble reading or writing or is otherwise unable to complete a checklist.*** Clients who are likely to minimize their trauma when using a checklist (e.g., those who exhibit significant symptoms of dissociation or repression) benefit from a clinical interview. A trained interviewer can elicit information that a self-administered checklist does not capture. Overall, using both a self-administered questionnaire and an interview can help achieve greater clarity and context.
- ***Allow time for the client to become calm and oriented to the present if he or she has very intense emotional responses when recalling or acknowledging a trauma.*** At such times, avoid responding with such exclamations as "I don't know how you survived that!" (Bernstein, 2000). If the client has difficulty self-soothing, guide him or her through grounding techniques (Exhibit 1.4-1), which are particularly useful—perhaps even critical—to achieving a successful

Exhibit 1.4-1: Grounding Techniques

Grounding techniques are important skills for assessors and all other behavioral health service providers who interact with traumatized clients (e.g., nurses, security, administrators, clinicians). Even if you do not directly conduct therapy, knowledge of grounding can help you defuse an escalating situation or calm a client who is triggered by the assessment process. Grounding strategies help a person who is overwhelmed by memories or strong emotions or is dissociating; they help the person become aware of the here and now. A useful metaphor is the experience of walking out of a movie theater. When the person dissociates or has a flashback, it's like watching a mental movie; grounding techniques help him or her step out of the movie theater into the daylight and the present environment. The client's task is not only to hold on to moments from the past, but also to acknowledge that what he or she was experiencing is from the past. Try the following techniques:

1. **Ask the client to state what he or she observes.**
   Guide the client through this exercise by using statements like, "You seem to feel very scared/angry right now. You're probably feeling things related to what happened in the past. Now, you're in a safe situation. Let's try to stay in the present. Take a slow deep breath, relax your shoulders, put your feet on the floor; let's talk about what day and time it is, notice what's on the wall, etc. What else can you do to feel okay in your body right now?"
2. **Help the client decrease the intensity of affect.**
   - "Emotion dial": A client imagines turning down the volume on his or her emotions.
   - Clenching fists can move the energy of an emotion into fists, which the client can then release.
   - Guided imagery can be used to visualize a safe place.
   - Distraction (see #3 below).
   - Use strengths-based questions (e.g., "How did you survive?" or "What strengths did you possess to survive the trauma?").
3. **Distract the client from unbearable emotional states.**
   - Have the client focus on the external environment (e.g., name red objects in the room).
   - Ask the client to focus on recent and future events (e.g., "to do" list for the day).
   - Help the client use self-talk to remind himself or herself of current safety.
   - Use distractions, such as counting, to return the focus to current reality.
   - Somatosensory techniques (toe-wiggling, touching a chair) can remind clients of current reality.
4. **Ask the client to use breathing techniques.**
   - Ask the client to inhale through the nose and exhale through the mouth.
   - Have the client place his or her hands on his or her abdomen and then watch the hands go up and down while the belly expands and contracts.

Source: Melnick & Bassuk, 2000.

interview when a client has dissociated or is experiencing intense feelings in response to screening and/or interview questions.

- ***Avoid phrases that imply judgment about the trauma.*** For example, don't say to a client who survived Hurricane Katrina and lost family members, "It was God's will," or "It was her time to pass," or "It was meant to be." Do not make assumptions about what a person has experienced. Rather, listen supportively without imposing personal views on the client's experience.
- ***Provide feedback about the results of the screening.*** Keep in mind the client's vulnerability, ability to access resources, strengths, and coping strategies. Present results in a synthesized manner, avoiding complicated, overly scientific jargon or explanations. Allow time to process client reactions during the feedback session. Answer client questions and concerns in a direct, honest, and compassionate manner. Failure to deliver feedback in this way can negatively affect clients' psychological status and severely weaken the potential for developing a therapeutic alliance with the client.
- ***Be aware of the possible legal implications of assessment.*** Information you gather during the screening and assessment process can necessitate mandatory reporting to authorities, even when the client does not want such information disclosed (Najavits, 2004). For example, you can be required to report a client's experience of child abuse even if it happened many years ago or the client doesn't want the information reported. Other legal issues can be quite complex, such as confidentiality of records, pursuing a case against a trauma perpetrator and divulging information to third parties while still protecting the legal status of information used in prosecution, and child custody issues (Najavits, 2004). It's essential that you know the laws in your State, have an expert legal consultant available, and access clinical supervision.

Barriers and Challenges to Trauma-Informed Screening and Assessment

Barriers

It is not necessarily easy or obvious to identify an individual who has survived trauma without screening. Moreover, some clients may deny that they have encountered trauma and its effects even after being screened or asked direct questions aimed at identifying the occurrence of traumatic events. The two main barriers to the evaluation of trauma and its related disorders in behavioral health settings are clients not reporting trauma and providers overlooking trauma and its effects.

Concerning the first main barrier, some events will be experienced as traumatic by one person but considered nontraumatic by another. A history of trauma encompasses not only the experience of a potentially traumatic event, but also the person's responses to it and the meanings he or she attaches to the event. Certain situations make it more likely that the client will not be forthcoming about traumatic events or his or her responses to those events. Some clients might not have ever thought of a particular event or their response to it as traumatic and thus might not report or even recall the event. Some clients might feel a reluctance to discuss something that they sense might bring up uncomfortable feelings (especially with a counselor whom they've only recently met). Clients may avoid openly discussing traumatic events or have difficulty recognizing or articulating their experience of trauma for other reasons, such as feelings of shame, guilt, or fear of retribution by others associated with the event (e.g., in cases of interpersonal or

Common Reasons Why Some Providers Avoid Screening Clients for Trauma

Treatment providers may avoid screening for traumatic events and trauma-related symptoms due to:

- A reluctance to inquire about traumatic events and symptoms because these questions are not a part of the counselor's or program's standard intake procedures.
- Underestimation of the impact of trauma on clients' physical and mental health.
- A belief that treatment of substance abuse issues needs to occur first and exclusively, before treating other behavioral health disorders.
- A belief that treatment should focus solely on presenting symptoms rather than exploring the potential origins or aggravators of symptoms.
- A lack of training and/or feelings of incompetence in effectively treating trauma-related problems (Salyers, Evans, Bond, & Meyer, 2004).
- Not knowing how to respond therapeutically to a client's report of trauma.
- Fear that a probing trauma inquiry will be too disturbing to clients.
- Not using common language with clients that will elicit a report of trauma (e.g., asking clients if they were abused as a child without describing what is meant by abuse).
- Concern that if disorders are identified, clients will require treatment that the counselor or program does not feel capable of providing (Fallot & Harris, 2001).
- Insufficient time for assessment to explore trauma histories or symptoms.
- Untreated trauma-related symptoms of the counselor, other staff members, and administrators.

domestic violence). Still others may deny their history because they are tired of being interviewed or asked to fill out forms and may believe it doesn't matter anyway.

A client may not report past trauma for many reasons, including:

- Concern for safety (e.g., fearing more abuse by a perpetrator for revealing the trauma).
- Fear of being judged by service providers.
- Shame about victimization.
- Reticence about talking with others in response to trauma.
- Not recalling past trauma through dissociation, denial, or repression (although genuine blockage of all trauma memory is rare among trauma survivors; McNally, 2003).
- Lack of trust in others, including behavioral health service providers.
- Not seeing a significant event as traumatic.

Regarding the second major barrier, counselors and other behavioral health service providers may lack awareness that trauma can significantly affect clients' presentations in treatment and functioning across major life areas, such as relationships and work. In addition, some counselors may believe that their role is to treat only the presenting psychological and/or substance abuse symptoms, and thus they may not be as sensitive to histories and effects of trauma. Other providers may believe that a client should abstain from alcohol and drugs for an extended period before exploring trauma symptoms. Perhaps you fear that addressing a clients' trauma history will only exacerbate symptoms and complicate treatment. Behavioral health service providers who hold biases may assume that a client doesn't have a history of trauma and thus fail to ask the "right" questions, or they may be uncomfortable with emotions that arise from listening to client experiences and, as a result, redirect the screening or counseling focus.

Challenges

Awareness of acculturation and language

Acculturation levels can affect screening and assessment results. Therefore, indepth discussions may be a more appropriate way to gain an understanding of trauma from the client's point of view. During the intake, prior to trauma screening, determine the client's history of

Common Assessment Myths

Several common myths contribute to underassessment of trauma-related disorders (Najavits, 2004):

- ***Myth #1: Substance abuse itself is a trauma.*** However devastating substance abuse is, it does not meet the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), criteria for trauma per se. Nevertheless, high-risk behaviors that are more likely to occur during addiction, such as interpersonal violence and self-harm, significantly increase the potential for traumatic injury.
- ***Myth #2: Assessment of trauma is enough.*** Thorough assessment is the best way to identify the existence and extent of trauma-related problems. However, simply identifying trauma-related symptoms and disorders is just the first step. Also needed are individualized treatment protocols and action to implement these protocols.
- ***Myth #3: It is best to wait until the client has ended substance use and withdrawal to assess for PTSD.*** Research does not provide a clear answer to the controversial question of when to assess for PTSD; however, Najavits (2004) and others note that underdiagnosis of trauma and PTSD has been more significant in the substance abuse field than overdiagnosis. Clinical experience shows that the PTSD diagnosis is rather stable during substance use or withdrawal, but symptoms can become more or less intense; memory impairment from alcohol or drugs can also cloud the symptom picture. Thus, it is advisable to establish a tentative diagnosis and then reassess after a period of abstinence, if possible.

migration, if applicable, and primary language. Questions about the client's country of birth, length of time in this country, events or reasons for migration, and ethnic self-identification are also appropriate at intake. Also be aware that even individuals who speak English well might have trouble understanding the subtleties of questions on standard screening and assessment tools. It is not adequate to translate items simply from English into another language; words, idioms, and examples often don't translate directly into other languages and therefore need to be adapted. Screening and assessment should be conducted in the client's preferred language by trained staff members who speak the language or by professional translators familiar with treatment jargon.

Awareness of co-occurring diagnoses

A trauma-informed assessor looks for psychological symptoms that are associated with trauma or simply occur alongside it. Symptom screening involves questions about past or present mental disorder symptoms that may indicate the need for a full mental health assessment. A variety of screening tools are available, including symptom checklists. However, you should only use symptom checklists when you need information about how your client is currently feeling; don't use them to screen for specific disorders. Responses will likely change from one administration of the checklist to the next.

Basic mental health screening tools are available. For example, the Mental Health Screening Form-III screens for present or past symptoms of most mental disorders (Carroll & McGinley, 2001); it is available at no charge from Project Return Foundation, Inc. and is also reproduced in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c). Other screening tools, such as the Beck Depression Inventory II and the Beck Anxiety Inventory (Beck, Wright, Newman, & Liese, 1993), also screen broadly for mental and substance use disorders, as well as for specific disorders often associated with trauma. For further screening information and resources on depression and suicide, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008), and TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a).

For screening substance use disorders, see TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT, 1994); TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT, 1997a); TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT, 1999c); TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c); and TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d).

A common dilemma in the assessment of trauma-related disorders is that certain trauma symptoms are also symptoms of other disorders. Clients with histories of trauma typically present a variety of symptoms; thus, it is important to determine the full scope of symptoms and/or disorders present to help improve treatment planning. Clients with trauma-related and substance use symptoms and disorders are at increased risk for additional Axis I and/or Axis II mental disorders (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Cottler, Nishith, & Compton, 2001). These symptoms need to be distinguished so that other presenting subclinical features or disorders do not go unidentified and untreated. To accomplish this, a comprehensive assessment of the client's mental health is recommended.

Misdiagnosis and underdiagnosis

Many trauma survivors are either misdiagnosed (i.e., given diagnoses that are not accurate) or underdiagnosed (i.e., have one or more diagnoses that have not been identified at all). Such diagnostic errors could result, in part, from the fact that many general instruments to evaluate mental disorders are not sufficiently sensitive to identify posttraumatic symptoms and can misclassify them as other disorders, including personality disorders or psychoses. Intrusive posttraumatic symptoms, for example, can show up on general measures as indicative of hallucinations or obsessions. Dissociative symptoms can be interpreted as indicative of schizophrenia. Trauma-based cognitive symptoms can be scored as evidence for paranoia or other delusional processes (Briere, 1997). Some of the most common misdiagnoses in clients with PTSD and substance abuse are:

- ***Mood and anxiety disorders.*** Overlapping symptoms with such disorders as major depression, generalized anxiety disorder, and bipolar disorder can lead to misdiagnosis.
- ***Borderline personality disorder.*** Historically, this has been more frequently diagnosed than PTSD. Many of the symptoms, including a pattern of intense interpersonal relationships, impulsivity, rapid and unpredictable mood swings, power struggles in the treatment environment, underlying anxiety and depressive symptoms, and transient, stress-related paranoid ideation or severe dissociative symptoms overlap. The effect of this misdiagnosis on treatment can be particularly negative; counselors often view clients with a borderline personality diagnosis as difficult to treat and unresponsive to treatment.
- ***Antisocial personality disorder.*** For men and women who have been traumatized in childhood, "acting out" behaviors, a lack of empathy and conscience, impulsivity, and self-centeredness can be functions of trauma and survival skills rather than true antisocial characteristics.
- ***Attention deficit hyperactivity disorder (ADHD).*** For children and adolescents, impulsive behaviors and concentration problems can be diagnosed as ADHD rather than PTSD.

It is possible, however, for clients to legitimately have any of these disorders in addition to trauma-related disorders. Given the overlap of posttraumatic symptoms with those of other disorders, a wide variety of diagnoses often needs to be considered to avoid misidentifying

other disorders as PTSD and vice versa. A trained and experienced mental health professional will be required to weigh differential diagnoses. TIP 42 (CSAT, 2005c) explores issues related to differential diagnosis.

Cross-Cultural Screening and Assessment

Many trauma-related symptoms and disorders are culture specific, and a client's cultural background must be considered in screening and assessment (for review of assessment and cultural considerations when working with trauma, see Wilson & Tang, 2007). Behavioral health service providers must approach screening and assessment processes with the influences of culture, ethnicity, and race firmly in mind. Cultural factors, such as norms for expressing psychological distress, defining trauma, and seeking help in dealing with trauma, can affect:

- How traumas are experienced.
- The meaning assigned to the event(s).
- How trauma-related symptoms are expressed (e.g., as somatic expressions of distress, level of emotionality, types of avoidant behavior).
- Willingness to express distress or identify trauma with a behavioral health service provider and sense of safety in doing so.
- Whether a specific pattern of behavior, emotional expression, or cognitive process is considered abnormal.
- Willingness to seek treatment inside and outside of one's own culture.
- Response to treatment.
- Treatment outcome.

When selecting assessment instruments, counselors and administrators need to choose,

Culture-Specific Stress Responses

Culture-bound concepts of distress exist that don't necessarily match diagnostic criteria. Culture-specific symptoms and syndromes can involve physical complaints, broad emotional reactions, or specific cognitive features. Many such syndromes are unique to a specific culture but can broaden to cultures that have similar beliefs or characteristics. Culture-bound syndromes are typically treated by traditional medicine and are known throughout the culture. Cultural concepts of distress include:

- ***Ataques de nervios.*** Recognized in Latin America and among individuals of Latino descent, the primary features of this syndrome include intense emotional upset (e.g., shouting, crying, trembling, dissociative or seizure-like episodes). It frequently occurs in response to a traumatic or stressful event in the family.
- ***Nervios.*** This is considered a common idiom of distress among Latinos; it includes a wide range of emotional distress symptoms including headaches, nervousness, tearfulness, stomach discomfort, difficulty sleeping, and dizziness. Symptoms can vary widely in intensity, as can impairment from them. This often occurs in response to stressful or difficult life events.
- ***Susto.*** This term, meaning "fright," refers to a concept found in Latin American cultures, but it is not recognized among Latinos from the Caribbean. *Susto* is attributed to a traumatic or frightening event that causes the soul to leave the body, thus resulting in illness and unhappiness; extreme cases may result in death. Symptoms include appetite or sleep disturbances, sadness, lack of motivation, low self-esteem, and somatic symptoms.
- ***Taijin kyofusho.*** Recognized in Japan and among some American Japanese, this "interpersonal fear" syndrome is characterized by anxiety about and avoidance of interpersonal circumstances. The individual presents worry or a conviction that his or her appearance or social interactions are inadequate or offensive. Other cultures have similar cultural descriptions or syndromes associated with social anxiety.

Sources: APA, 2013, pp. 833–837; Briere & Scott, 2006b.

whenever possible, instruments that are culturally appropriate for the client. Instruments that have been normed for, adapted to, and tested on specific cultural and linguistic groups should be used. Instruments that are not normed for the population are likely to contain cultural biases and produce misleading results. Subsequently, this can lead to misdiagnosis, overdiagnosis, inappropriate treatment plans, and ineffective interventions. Thus, it is important to interpret all test results cautiously and to discuss the limitations of instruments with clients from diverse ethnic populations and cultures. For a review of cross-cultural screening and assessment considerations, refer to the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration, planned c).

Choosing Instruments

Numerous instruments screen for trauma history, indicate symptoms, assess trauma-related and other mental disorders, and identify related clinical phenomena, such as dissociation. One instrument is unlikely to meet all screening or assessment needs or to determine the existence and full extent of trauma symptoms and traumatic experiences. The following sections present general considerations in selecting standardized instruments.

Purpose

Define your assessment needs. Do you need a standardized screening or assessment instrument for clinical purposes? Do you need information on a specific aspect of trauma, such as history, PTSD, or dissociation? Do you wish to make a formal diagnosis, such as PTSD? Do you need to determine quickly whether a client has experienced a trauma? Do you want an assessment that requires a clinician to administer it, or can the client complete the instrument himself or herself? Does the instrument match the current and specific diagnostic criteria established in the DSM-5?

Population

Consider the population to be assessed (e.g., women, children, adolescents, refugees, disaster survivors, survivors of physical or sexual violence, survivors of combat-related trauma, people whose native language is not English); some tools are appropriate only for certain populations. Is the assessment process developmentally and culturally appropriate for your client? Exhibit 1.4-2 lists considerations in choosing a screening or assessment instrument for trauma and/or PTSD.

Instrument Quality

An instrument should be psychometrically adequate in terms of sensitivity and specificity or reliability and validity as measured in several ways under varying conditions. Published research offers information on an instrument's psychometric properties as well as its utility in both research and clinical settings. For further information on a number of widely used trauma evaluation tools, see Appendix D and Antony, Orsillo, and Roemer's paper (2001).

The DSM-5 and Updates to Screening and Assessment Instruments

The recent publication of the DSM-5 (APA, 2013a) reflects changes to certain diagnostic criteria, which will affect screening tools and criteria for trauma-related disorders. Criterion A2 (specific to traumatic stress disorders, acute stress, and posttraumatic stress disorders), included in the fourth edition (text revision) of the DSM (DSM-IV-TR; APA, 2000a), has been eliminated; this criterion stated that the individual's response to the trauma needs to involve intense fear, helplessness, or horror. There are now four cluster symptoms, not three: reexperiencing, avoidance, arousal, and persistent negative alterations in cognitions and mood. Changes to the DSM-5 were made to symptoms within each cluster. Thus, screening will need modification to adjust to this change (APA, 2012b).

Exhibit 1.4-2: Key Areas of Trauma Screening and Assessment

Trauma
Key question: Did the client experience a trauma?

Examples of measures: Life Stressor Checklist-Revised (Wolfe & Kimerling, 1997); Trauma History Questionnaire (Green, 1996); Traumatic Life Events Questionnaire (Kubany et al., 2000).

Note: A good trauma measure identifies events a person experienced (e.g., rape, assault, accident) and also evaluates other trauma-related symptoms (e.g., presence of fear, helplessness, or horror).

Acute Stress Disorder (ASD) and PTSD
Key question: Does the client meet criteria for ASD or PTSD?

Examples of measures: Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990); Modified PTSD Symptom Scale (Falsetti, Resnick, Resnick, & Kilpatrick, 1993); PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993); Stanford Acute Stress Reaction Questionnaire (Cardena, Koopman, Classen, Waelde, & Spiegel, 2000).

Note: A PTSD diagnosis requires the person to meet criteria for having experienced a trauma; some measures include this, but others do not and require use of a separate trauma measure. The CAPS is an interview; the others listed are self-report questionnaires and take less time.

Other Trauma-Related Symptoms
Key question: Does the client have other symptoms related to trauma? These include depressive symptoms, self-harm, dissociation, sexuality problems, and relationship issues, such as distrust.

Examples of measures: Beck Depression Inventory II (Beck, 1993; Beck et al., 1993); Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993); Impact of Event Scale (measures intrusion and avoidance due to exposure to traumatic events; Horowitz, Wilner, & Alvarez, 1979; Weiss & Marmar, 1997); Trauma Symptom Inventory (Briere, 1995); Trauma Symptom Checklist for Children (Briere, 1996b); Modified PTSD Symptom Scale (Falsetti et al., 1993).

Note: These measures can be helpful for clinical purposes and for outcome assessment because they gauge *levels* of symptoms. Trauma-related symptoms are broader than diagnostic criteria and thus useful to measure, even if the patient doesn't meet criteria for any specific diagnoses.

Other Trauma-Related Diagnoses
Key question: Does the client have other disorders related to trauma? These include mood disorders, anxiety disorders besides traumatic stress disorders, and dissociative disorders.

Examples of measures: Mental Health Screening Form III (Carroll & McGinley, 2001); The Mini-International Neuropsychiatric Interview (M.I.N.I.) Structured Clinical Interview for DSM-IV-TR, Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011); Structured Clinical Interview for DSM-IV-TR, Non-Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011a).

Note: For complex symptoms and diagnoses such as dissociation and dissociative disorders, interviews are recommended. Look for measures that incorporate DSM-5 criteria.

Sources: Antony et al., 2001; Najavits, 2004.

Practical Issues

Is the instrument freely and readily available, or is there a fee? Is costly and extensive training required to administer it? Is the instrument too lengthy to be used in the clinical setting? Is it easily administered and scored with accompanying manuals and/or other training materials? How will results be presented to or used with the client? Is technical support available for difficulties in administration, scoring, or interpretation of results? Is special equipment required such as a microphone, a video camera, or a touch-screen computer with audio?

Trauma-Informed Screening and Assessment

The following sections focus on initial screening. For more information on screening and assessment tools, including structured interviews, see Exhibit 1.4-2. Screening is only as good as the actions taken afterward to address a positive screen (when clients acknowledge that they experience symptoms or have encountered events highlighted within the screening). Once a screening is complete and a positive screen is acquired, the client then needs referral for a more indepth assessment to ensure development of an appropriate treatment plan that matches his or her presenting problems.

Establish a History of Trauma

A person cannot have ASD, PTSD, or any trauma-related symptoms without experiencing trauma; therefore, it is necessary to inquire about painful, difficult, or overwhelming past experiences. Initial information should be gathered in a way that is minimally intrusive yet clear. Brief questionnaires can be less threatening to a client than face-to-face interviews, but interviews should be an integral part of any screening and assessment process. If the client initially denies a history of trauma (or minimizes it), administer the questionnaire later or delay additional trauma-related questions until the client has perhaps developed more trust in the treatment setting and feels safer with the thoughts and emotions that might arise in discussing his or her trauma experiences.

The Stressful Life Experiences (SLE) screen (Exhibit 1.4-3) is a checklist of traumas that also considers the client's view of the impact of those events on life functioning. Using the SLE can foster the client–counselor relationship. By going over the answers with the client, you can gain a deep understanding of your client, and the client receives a demonstration of your sensitivity and concern for what the client has experienced. The National Center for PTSD Web site offers similar instruments (http://www.ptsd.va.gov/professional/pages/assessments/assessment.asp).

In addition to broad screening tools that capture various traumatic experiences and symptoms, other screening tools, such as the Combat Exposure Scale (Keane et al., 1989) and the Intimate Partner Violence Screening Tool (Exhibit 1.4-4), focus on acknowledging a specific type of traumatic event.

Screen for Trauma-Related Symptoms and Disorders in Clients With Histories of Trauma

This step evaluates whether the client's trauma resulted in subclinical or diagnosable disorders. The counselor can ask such questions as, "Have you received any counseling or therapy? Have you ever been diagnosed or treated for a psychological disorder in the past? Have you ever been prescribed medications for your emotions in the past?" Screening is typically conducted by a wide variety of behavioral health service providers with different levels of training and education; however, all

Exhibit 1.4-3: SLE Screening

Please fill in the number that best represents how much the following statements describe your experiences. You will need to use two scales, one for how well the statement describes your experiences and one for how stressful you found this experience. The two scales are below.

Describes your Experience:

0	1	2	3	4	5	6	7	8	9	10
Did not experience this	a little like my experiences				somewhat like my experiences					exactly like my experiences

Stressfulness of Experience:

0	1	2	3	4	5	6	7	8	9	10
Not at all stressful	not very stressful				somewhat stressful					extremely stressful

Describes your Experience	Life Experience	Stressfulness Then		Stressfulness Now
	I have witnessed or experienced a natural disaster; like a hurricane or earthquake.			
	I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.			
	I have witnessed or experienced a serious accident or injury.			
	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.			
	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.			
	I have witnessed or experienced the death of my spouse or child.			
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).			
	I or a close friend or family member has been kidnapped or taken hostage.			
	I or a close friend or family member has been the victim of a terrorist attack or torture.			
	I have been involved in combat or a war or lived in a war affected area.			
	I have seen or handled dead bodies other than at a funeral.			
	I have felt responsible for the serious injury or death of another person.			
	I have witnessed or been attacked with a weapon other than in combat or family setting			
	As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury			
	As an adult, I was hit, choked or pushed hard enough to cause injury.			
	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.			
	As a child/teen I was forced to have unwanted sexual contact.			
	As an adult I was forced to have unwanted sexual contact.			
	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact			
	I have witnessed or experienced an extremely stressful event not already mentioned. Please Explain:_____ _____			

Sources: Hudnall Stamm, 1996, 1997. Used with permission.

Exhibit 1.4-4: STaT Intimate Partner Violence Screening Tool

1. Have you ever been in a relationship where your partner has pushed or **Slapped** you?
2. Have you ever been in a relationship where your partner **Threatened** you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken, or punched **Things**?

Source: Paranjape & Liebschutz, 2003. Used with permission

individuals who administer screenings, regardless of education level and experience, should be aware of trauma-related symptoms, grounding techniques, ways of creating safety for the client, proper methods for introducing screening tools, and the protocol to follow when a positive screen is obtained. (See Appendix D for information on specific instruments.) Exhibit 1.4-5 is an example of a screening instrument for trauma symptoms, the Primary Care PTSD (PC-PTSD) Screen. Current research (Prins et al., 2004) suggests that the optimal cutoff score for the PC-PTSD is 3. If sensitivity is of greater concern than efficiency, a cutoff score of 2 is recommended.

Exhibit 1.4-5: PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…

1. Have had nightmares about it or thought about it when you did not want to?
   YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES NO
3. Were constantly on guard, watchful, or easily startled?
   YES NO
4. Felt numb or detached from others, activities, or your surroundings?
   YES NO

Source: Prins et al., 2004. Material used is in the public domain.

Another instrument that can screen for traumatic stress symptoms is the four-item self-report SPAN, summarized in Exhibit 1.4-6, which is derived from the 17-item Davidson Trauma Scale (DTS). SPAN is an acronym for the four items the screening addresses: startle, physiological arousal, anger, and numbness. It was developed using a small, diverse sample of adult patients (N=243; 72 percent women; 17.4 percent African American; average age = 37 years) participating in several clinical studies, including a family study of rape trauma, combat veterans, and Hurricane Andrew survivors, among others.

The SPAN has a high diagnostic accuracy of 0.80 to 0.88, with sensitivity (percentage of true positive instances) of 0.84 and specificity (percentage of true negative instances) of 0.91 (Meltzer-Brody, Churchill, & Davidson, 1999). SPAN scores correlated highly with the full DTS (r = 0.96) and other measures, such as the Impact of Events Scale (r = 0.85) and the Sheehan Disability Scale (r = 0.87).

The PTSD Checklist (Exhibit 1.4-7), developed by the National Center for PTSD, is in the public domain. Originally developed for combat veterans of the Vietnam and Persian

Exhibit 1.4-6: The SPAN

The SPAN instrument is a brief screening tool that asks clients to identify the trauma in their past that is most disturbing to them currently. It then poses four questions that ask clients to rate the frequency and severity with which they have experienced, in the past week, different types of trauma-related symptoms (startle, physiological arousal, anger, and numbness).

To order this screening instrument, use the following contact information:
Multi-Health Systems, Inc.
P.O. Box 950
North Tonawanda, NY
14120-0950
Phone: 800-456-3003

Source: Meltzer-Brody et al., 1999.

Exhibit 1.4-7: The PTSD Checklist

Instructions to Client: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully and circle the number that indicates how much you have been bothered by that problem *in the past month*.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
2. Repeated, disturbing dreams of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
4. Feeling very upset when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
7. Avoiding activities or situations because they reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
8. Trouble remembering important parts of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
9. Loss of interest in activities that you used to enjoy?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
10. Feeling distant or cut off from other people?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
12. Feeling as if your future will somehow be cut short?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
13. Trouble falling or staying asleep?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
14. Feeling irritable or having angry outbursts?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
15. Having difficulty concentrating?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
16. Being "super-alert" or watchful or on guard?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
17. Feeling jumpy or easily startled?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Source: Weathers et al., 1993. Material used is in the public domain.

Gulf Wars, it has since been validated on a variety of noncombat traumas (Keane, Brief, Pratt, & Miller, 2007). When using the checklist, identify a specific trauma first and then have the client answer questions in relation to that one specific trauma.

Other Screening and Resilience Measures

Along with identifying the presence of trauma-related symptoms that warrant assessment to determine the severity of symptoms as well as whether or not the individual possesses subclinical symptoms or has met criteria for a trauma-related disorder, clients should receive other screenings for symptoms associated with trauma (e.g., depression, suicidality). It is important that screenings address both external and internal resources (e.g., support systems, strengths, coping styles). Knowing the client's strengths can significantly shape the treatment planning process by allowing you to use strategies that have already worked for the client and incorporating strategies to build resilience (Exhibit 1.4-8).

Exhibit 1.4-8: Resilience Scales

A number of scales with good psychometric properties measure resilience:

- Resilience Scale (Wagnild & Young, 1993)
- Resilience Scale for Adults (Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003)
- Connor Davidson Resilience Scale, 25-,10-, and 2-Item (Connor & Davidson, 2003; Campbell-Sills & Stein, 2007; Vaishnavi, Connor, & Davidson, 2007, respectively)
- Dispositional Resilience Scale, 45-,30-, 15-item forms (Bartone, Roland, Picano, &Williams, 2008)

Preliminary research shows improvement of individual resilience through treatment interventions in other populations (Lavretsky, Siddarth, & Irwin, 2010).

Screen for suicidality

All clients—particularly those who have experienced trauma—should be screened for suicidality by asking, "In the past, have you ever had suicidal thoughts, had intention to commit suicide, or made a suicide attempt? Do you have any of those feelings now? Have you had any such feelings recently?" Behavioral health service providers should receive training to screen for suicide. Additionally, clients with substance use disorders and a history of psychological trauma are at heightened risk for suicidal thoughts and behaviors; thus, screening for suicidality is indicated. See TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a). For additional descriptions of screening processes for suicidality, see TIP 42 (CSAT, 2005c).

Concluding Note

Screenings are only beneficial if there are follow-up procedures and resources for handling positive screens, such as the ability to review results with and provide feedback to the individual after the screening, sufficient resources to complete a thorough assessment or to make an appropriate referral for an assessment, treatment planning processes that can easily incorporate additional trauma-informed care objectives and goals, and availability and access to trauma-specific services that match the client's needs. Screening is only the first step!

5 Clinical Issues Across Services

IN THIS CHAPTER

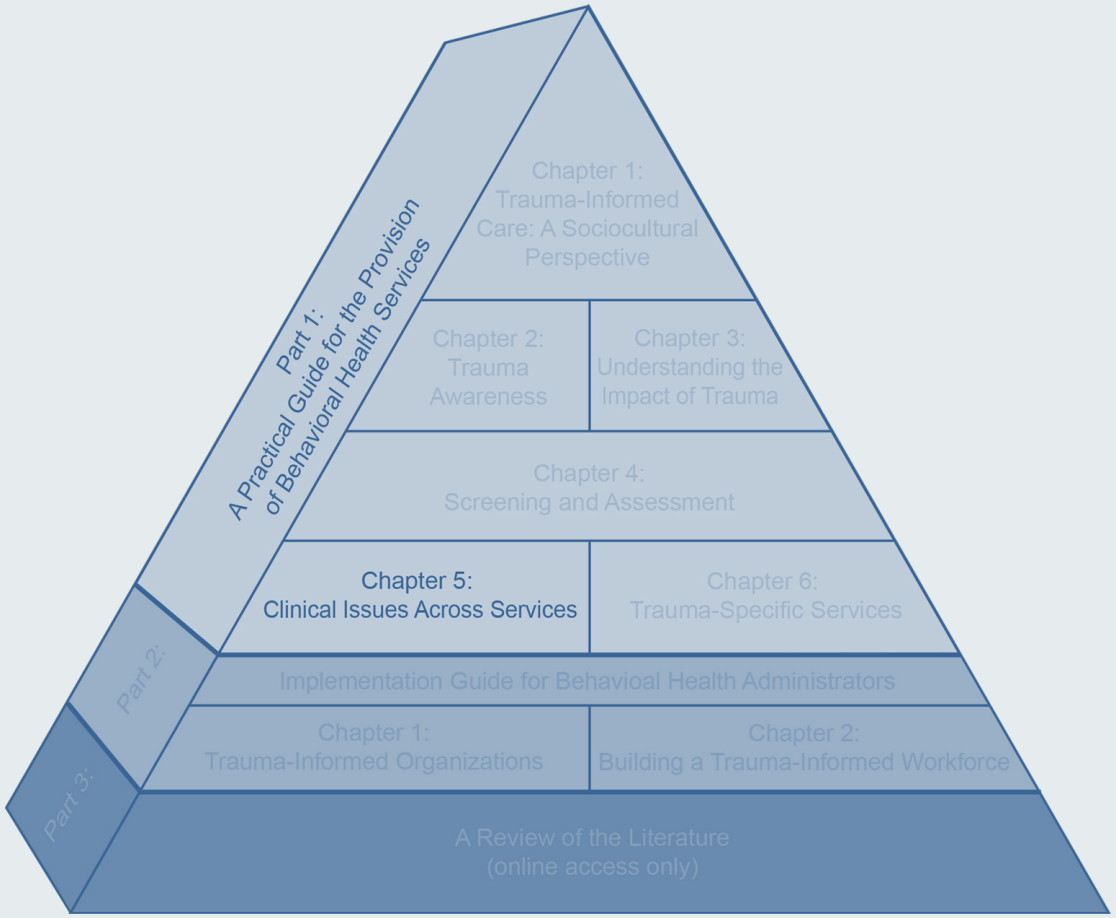
- Trauma Informed Prevention and Treatment Objectives
- Treatment Issues
- Making Referrals to Trauma Specific Services

Many clients in behavioral health treatment may have histories of trauma, so counselors should be prepared to help them address issues that arise from those histories. This chapter begins with a thorough discussion of trauma-informed prevention and treatment objectives along with practical counselor strategies. Specific treatment issues related to working with trauma survivors in a clinical setting are discussed as well, including client engagement, pacing and timing, traumatic memories, and culturally appropriate and gender-responsive services. The chapter ends with guidelines for making referrals to trauma-specific services.

Trauma-Informed Prevention and Treatment Objectives

Trauma-informed care (TIC) not only focuses on identifying individuals who have histories of trauma and traumatic stress symptoms; it also places considerable effort in creating an environment that helps them recognize the impact of trauma and determine the next course of action in a safe place. For some individuals, psychoeducation and development or reinforcement of coping strategies will be the most suitable and effective strategy, whereas others may request or warrant a referral for more trauma-specific interventions (see Part 1, Chapter 6, of this Treatment Improvement Protocol [TIP]). Although research is limited in the area of building resilience to prevent exacerbation of trauma symptoms and traumatic stress disorders, TIC also focuses on prevention strategies to avoid retraumatization in treatment, to promote resilience, and to prevent the development of trauma-related disorders. The following sections highlight key trauma-informed prevention and treatment objectives.

TIC Framework in Behavioral Health Services—Clinical Issues Across Services



Establish Safety

Beyond identifying trauma and trauma-related symptoms, the initial objective of TIC is establishing safety. Borrowing from Herman's (1992) conceptualization of trauma recovery, safety is the first goal of treatment. Establishing safety is especially crucial at the outset of trauma-informed treatment and often becomes a recurrent need when events or therapeutic changes raise safety issues, such as a change in treatment staffing due to vacations.

In the context of TIC, safety has a variety of meanings. Perhaps most importantly, the client has to have some degree of ***safety from trauma symptoms***. Recurring intrusive nightmares; painful memories that burst forth seemingly without provocation; feelings of sadness, anger, shame, or being overwhelmed; or not having control over sudden disconnections from others make moment-to-moment living feel unsafe. Clients might express feeling unsafe through statements such as, "I can't control my feelings," or, "I just space out and disconnect from the world for no reason," or, "I'm afraid to go to sleep because of the nightmares." The intense feelings that accompany trauma can also make clients feel unsafe. They may wake up in the morning feeling fine but become immobilized by depression as the day progresses. Clients with histories of trauma may experience panicky feelings of being trapped or abandoned. An early effort in trauma treatment is thus helping the client

Advice to Counselors: Strategies To Promote Safety

Strategy #1: Teach clients how and when to use grounding exercises when they feel unsafe or overwhelmed.

Strategy #2: Establish some specific routines in individual, group, or family therapy (e.g., have an opening ritual or routine when starting and ending a group session). A structured setting can provide a sense of safety and familiarity for clients with histories of trauma.

Strategy #3: Facilitate a discussion on safe and unsafe behaviors. Have clients identify, on paper, behaviors that promote safety and behaviors that feel unsafe for them today.

Strategy #4: Refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (Najavits, 2002a). This menu-based manual covers an array of treatment topics, including the core concept of safety. Each topic consists of several segments, including preparing for the session, session format, session content, handouts, and guidelines.

Strategy #5: Encourage the development of a safety plan. Depending on the type of trauma, personal safety can be an issue; work with the client to develop a plan that will help him or her feel in control and prepared for the unexpected. If the trauma was a natural or human-caused disaster, encourage thinking about how family and friends will respond and connect in the event of another crisis. If sexual abuse or rape was the event, encourage thinking about future steps that could help make the client safer. There is a delicate balance between preparation and the realization that one cannot prepare for all possible traumatic events. Nonetheless, an action plan can help the client regain a sense of environmental balance.

gain more control over trauma symptoms (and be able to label them as such) by learning more about the client and helping him or her develop new coping skills to handle symptoms when they arise and stay more grounded when flooded with feelings or memories.

A second aspect is ***safety in the environment***. Trauma reactions can be triggered by sudden loud sounds (e.g., television at high volume, raised voices), tension between people, certain smells, or casual touches that are perceived as invasions of physical boundaries. The vulnerability of exposing one's history in the treatment setting can manifest in the client as feeling physically vulnerable and unsafe in the treatment environment. Sudden or inadequately explained treatment transitions, such as moving from one level of treatment to another or changing counselors, can also evoke feelings of danger, abandonment, or instability. Early in treatment, trauma survivors generally value routine and predictability. The counselor should recognize these needs and respond appropriately by offering information in advance, providing nonshaming responses to a client's reactions to stimuli in his or her environment, and helping the client build a daily structure that feels safe.

A third aspect of safety is ***preventing a recurrence of trauma***. People with histories of trauma and substance abuse are more likely to engage in high-risk behaviors and to experience subsequent traumas. Early treatment should focus on helping clients stop using unsafe coping mechanisms, such as substance abuse, self-harm, and other self-destructive behaviors, and replacing them with safe and healthy coping strategies. Helping clients learn to protect themselves in reasonable ways is a positive goal of treatment.

Prevent Retraumatization

A key objective in TIC is to prevent retraumatization generated by intervention and treatment practices and policies. Unfortunately, treatment settings and clinicians can

Advice to Counselors: Strategies To Prevent Retraumatization

Strategy #1: Be sensitive to the needs of clients who have experienced trauma regarding behaviors in the treatment setting that might trigger memories of the trauma.

Strategy #2: Do not ignore clients' symptoms and demands when clients with trauma histories act out in response to triggered trauma memories; doing so may replicate the original traumatic experience.

Strategy #3: Be mindful that efforts to control and contain a client's behaviors in treatment can produce an abnormal reaction, particularly for trauma survivors for whom being trapped was part of the trauma experience.

Strategy #4: Listen for specific triggers that seem to be driving the client's reaction. An important step in recovery is helping the client identify these cues and thereby reach a better understanding of reactions and behaviors.

unintentionally create retraumatizing experiences (for a review of traumas that can occur when treating serious mental illness, see Frueh et al., 2005). For instance, compassionate inquiry into a client's history can seem similar to the interest shown by a perpetrator many years before. Direct confrontation by counselors about behaviors related to substance abuse can be seen, by someone who has been repeatedly physically assaulted, as provocation building up to assault. Counselor and program efforts to help clients constrain destructive behaviors can be interpreted as efforts to control and dominate the individual. Intrusive shaming or insensitive behavior demonstrated by another client in the program can threaten a trauma survivor whose boundaries have been disregarded in the past—thus making the experience of treatment feel dangerous rather than safe. Some staff and agency issues that can result in retraumatization include:

- Disrespectfully challenging reports of abuse or other traumatic events.
- Discounting a client's report of a traumatic event.
- Using isolation.
- Using physical restraints.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling intense rage and other feelings as pathological.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate and/or disrespectful manner.
- Having clients undress in the presence of others.
- Being insensitive to a client's physical or emotional boundaries.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Applying rigid agency policies or rules without an opportunity for clients to question them.
- Accepting agency dysfunction, including a lack of consistent, competent leadership.

Provide Psychoeducation

Trauma-informed education informs clients about traumatic stress and trauma-related symptoms and disorders as well as the related consequences of trauma exposure. It focuses on giving information to clients to help normalize presenting symptoms, to highlight potential short-term and long-term consequences of trauma and various paths to recovery, and to underscore the message that recovery is possible. Education frequently takes place prior to or immediately following an initial screening as a way to prepare clients

Advice to Counselors: Strategies To Implement Psychoeducation

Strategy #1: Remember that this may be the client's first experience with treatment. It's easy to use program or clinical jargon when you're around it every day, but most individuals who seek help are unfamiliar with clinical language, how the program works, and treatment objectives. Psychoeducation begins with understanding the client's expectations and reasons for seeking help, followed by educating the client and other family members about the program. Remember that this is all new for them.

Strategy #2: After obtaining acknowledgment of a trauma history, provide an overview of common symptoms and consequences of traumatic stress, regardless of whether the client affirms having trauma-related symptoms. It is equally important to educate the client on resilience factors associated with recovery from trauma (Wessely et al., 2008). A trauma-informed perspective provides a message that trauma reactions are normal responses to an abnormal situation.

Strategy #3: Develop a resource box that provides an array of printed or multimedia educational materials that address the program, specific symptoms and tools to combat trauma-related symptoms, treatment options and therapy approaches, advantages of peer support, and steps in developing specific coping strategies.

Strategy #4: Develop a rotating educational group that matches services and client schedules to complement treatment. Remember that education can play a pivotal role in enhancing motivation, in normalizing experiences, and in creating a sense of safety as individuals move further into treatment. For some survivors, education can be a powerful intervention or prevention strategy.

for hearing results or to place the screening and subsequent assessment findings in proper context. Education in and of itself, however, does not necessarily constitute a stand-alone treatment; rather, it can be conceptualized as a first step and/or component of more comprehensive treatment. Nonetheless, education may be a prevention and intervention strategy for individuals who have histories of trauma without current consequences or symptoms and/or those who have reported a resolution of past trauma(s). For example, some clients may have significantly delayed onset of traumatic stress symptoms. In this scenario, earlier education can enhance recognition of symptoms and ease the path of seeking treatment.

Some clients do not recognize the link between their current difficulties and their trauma histories; education can help them understand the possible origin of their difficulties. Psychoeducation presents trauma-related symptoms that follow a trauma as normal reactions. By identifying the source of clients' current difficulties and framing them as normal thoughts, emotions, and behaviors in response to trauma, many trauma survivors report a reduction in the intensity of the difficulties or symptoms. Often, a client will express relief that his or her reactions are normal. You may find the U.S. Department of Veterans Affairs (VA) National Center on PTSD's educational handouts on traumatic stress reactions useful.

Psychoeducation goes beyond the identification of traumatic stress symptoms and/or learning about the psychological, cognitive, and physical impacts of trauma. Numerous curricula are available that use psychoeducation as a first-line or complementary approach to trauma-specific therapies to enhance coping strategies in key areas, including safety, emotional regulation, help-seeking, avoidant behavior, and so forth. An example is S.E.L.F., a trauma-informed psychoeducational group curriculum with educational components related to trauma recovery in the following

Case Illustration: Linda

Linda served as an Army nurse in an evacuation hospital in Vietnam. She reported her postdeployment adjustment as difficult and isolating but denied any significant symptoms of traumatic stress throughout her life. Four years ago, Linda sought treatment for alcohol dependence; during the intake, she recalls denying trauma-related symptoms. "I distinctly remember the session," she recounts. "The counselor first took my history but then gave information on typical symptoms and reactions to trauma. I thought, 'Why do I need to hear this? I've survived the worst trauma in my life.' I didn't see the value of this information. Then 3 weeks ago, I began to have recurrent nightmares, the same graphic type I occasionally had when I was in Vietnam. Since then, I've been very anxious, reliving horrible scenes that I'd experienced as a nurse and postponing going to bed in fear of having the dreams again. I didn't understand it. I am 70 years old, and the war happened a long time ago. Then I began putting it together. Recently, the emergency helicopter flight pattern and approach to the area's hospital changed. I began hearing the helicopter periodically in my living room, and it reminded me of Vietnam. I knew then that I needed help; I couldn't stop shaking. I felt as if I was losing control of my emotions. I remembered how the intake counselor took the time to explain common symptoms of trauma. That's why I'm here today."

"This might not sound like a big deal, but for many people relationships have become all about getting: telling your problem story and then getting help with it. There is little, if any, emphasis placed on giving back. That's a big deal!!! Service relationships are like a one way street and both people's roles are clearly defined. But in 'regular' relationships in your community, people give and take all the time. No one is permanently on the taking side or the giving side. This exchange contributes to people feeling ok about being vulnerable (needing help) as well as confident about what they're offering. For many of us, being the role of 'getter' all the time has shaken our confidence, making us feel like we have nothing worthwhile to contribute. Peer support breaks that all down. It gets complicated somewhat when one of us is paid, but modeling this kind of relationship in which both of us learn, offers us the real practice we need to feel like a 'regular' community member as opposed to an 'integrated mental patient'."

(Mead, 2008, p.7)

areas: creating **S**afety, regulating **E**motions, addressing **L**oss, and redefining the **F**uture (Bloom, Foderaro, & Ryan, 2006).

Offer Trauma-Informed Peer Support

Living with a history of trauma can be isolating and consuming. The experience of trauma can reinforce beliefs about being different, alone, and marred by the experience. At times, behavioral health treatment for trauma-related effects can inadvertently reinforce these beliefs. Simply engaging in treatment or receiving specialized services (although warranted) can further strengthen clients' beliefs that there is something wrong with them. Formalized peer support can enhance the treatment experience. Treatment plus peer support can break the cycle of beliefs that reinforce traumatic stress (e.g., believing that one is permanently damaged; that nobody could understand; that no one should or could tolerate one's story). Peer support provides opportunities to form mutual relationships; to learn how one's history shapes perspectives of self, others, and the future; to move beyond trauma; and to mirror and learn alternate coping strategies. Peer support defines recovery as an

Advice to Counselors: Strategies To Enhance Peer Support

Strategy #1: Provide education on what peer support is and is not. Roles and expectations of peer support can be confusing, so providing clarification in the beginning can be quite useful. It is important to provide initial education about peer support and the value of using this resource.

Strategy #2: Use an established peer support curriculum to guide the peer support process. For example, *Intentional Peer Support: An Alternative Approach* (Mead, 2008) is a workbook that highlights four main tasks for peer support: building connections, understanding one's worldview, developing mutuality, and helping each other move toward set desires and goals. This curriculum provides extensive materials for peer support staff members as well as for the individuals seeking peer support.

interactive process, not as a definitive moment wherein someone fixes the "problem."

Normalize Symptoms

Symptoms of trauma can become serious barriers to recovery from substance use and mental disorders, including trauma-related ones. Counselors should be aware of how trauma symptoms can present and how to respond to them when they do appear. A significant step in addressing symptoms is normalizing them. People with traumatic stress symptoms need to know that their symptoms are not unique and that their reactions are common to their experience(s). Often, normalizing symptoms gives considerable relief to clients who may have thought that their symptoms signified some pervasive, untreatable mental disorder.

Advice to Counselors: Strategies To Normalize Symptoms

Strategy #1: Provide psychoeducation on the common symptoms of traumatic stress.

Strategy #2: Research the client's most prevalent symptoms specific to trauma, and then provide education to the client. For example, an individual who was conscious and trapped during or as a result of a traumatic event will more likely be hypervigilant about exits, plan escape routes even in safe environments, and have strong reactions to interpersonal and environmental situations that are perceived as having no options for avoidance or resolution (e.g., feeling stuck in a work environment where the boss is emotionally abusive).

Strategy #3: First, have the client list his or her symptoms. After each symptom, ask the client to list the negative and positive consequences of the symptom. Remember that symptoms serve a purpose, even if they may not appear to work well or work as well as they had in the past. Focus on how the symptoms have served the client in a positive way (see Case Illustration: Hector). This exercise can be difficult, because clients as well as counselors often don't focus on the value of symptoms.

Case Illustration: Hector

Hector was referred to a halfway house specializing in co-occurring disorders after inpatient treatment for methamphetamine dependence and posttraumatic stress disorder (PTSD). In the halfway house, he continued to feel overwhelmed with the frequency and intensity of flashbacks. He often became frustrated, expressing anger and a sense of hopelessness, followed by emotional withdrawal from others in the house. Normalization strategy #3 was introduced in the session. During this exercise, he began to identify many negative aspects of flashbacks. He felt that he couldn't control the occurrence of flashbacks even though he wanted to, and he realized that he often felt shame afterward. In the same exercise, he was also urged to identify positive aspects of flashbacks. Although this was difficult, he realized that flashbacks were clues about content that he needed to address in trauma-specific treatment. "I realized that a flashback, for me, was a billboard advertising what I needed to focus on in therapy."

Identify and Manage Trauma-Related Triggers

Many clients who have traumatic stress are caught off guard with intrusive thoughts, feelings, sensations, or environmental cues of the trauma. This experience can be quite disconcerting, but often, the individual does not draw an immediate connection between the internal or external trigger and his or her reactions. At other times, the trigger is so potent that the individual is unable to discern the present trigger from the past trauma and begins to respond as if the trauma is reoccurring.

Key steps in identifying triggers are to reflect back on the situation, surroundings, or sensations prior to the strong reaction. By doing so, you and your client may be able to determine the connections among these cues, the past trauma(s), and the client's reaction. Once the cue is identified, discuss the ways in which it is connected to past trauma. For some cues, there will be an obvious and immediate connection (e.g., having someone say "I love you" in a significant relationship as an adult and connecting this to an abuser who said the same thing prior to a sexual assault). Other

Advice to Counselors: Strategies To Identify and Manage Trauma-Related Triggers

Strategy #1: Use the Sorting the Past From the Present technique for cognitive realignment (Blackburn, 1995) to help separate the current situation from the past trauma. Identify one trigger at a time, and then discuss the following questions with the client:

- When and where did you begin to notice a reaction?
- How does this situation remind you of your past history or past trauma?
- How are your reactions to the current situation similar to your past reactions to the trauma(s)?
- How was this current situation different from the past trauma?
- How did you react differently to the current situation than to the previous trauma?
- How are you different today (e.g., factors such as age, abilities, strength, level of support)?
- What choices can you make that are different from the past and that can help you address the current situation (trigger)?

After reviewing this exercise several times in counseling, put the questions on a card for the client to carry and use outside of treatment. Clients with substance use disorders can benefit from using the same questions (slightly reworded) to address relapse triggers.

Strategy #2: After the individual identifies the trigger and draws connections between the trigger and past trauma, work with him or her to establish responses and coping strategies to deal with triggers as they occur. Initially, the planned responses will not immediately occur after a trigger, but with practice, the planned responses will move closer to the time of the trigger. Some strategies include an acronym that reflects coping strategies (Exhibit 1.5-1), positive self-talk generated by cognitive–behavioral covert modeling exercises (rehearsal of coping statements), breathing retraining, and use of support systems (e.g., calling someone).

Strategy #3: Self-monitoring is any strategy that asks a client to observe and record the number of times something happens, to note the intensity of specific experiences, or to describe a specific behavioral, emotional, or cognitive phenomenon each time it occurs. For individuals with histories of trauma, triggers and flashbacks can be quite frightening, intense, and powerful. Even if the client has had just one or two triggers or flashbacks, he or she may perceive flashbacks as happening constantly. Often, it takes time to recover from these experiences. Using self-monitoring and asking the client to record each time a trigger occurs, along with describing the trigger and its intensity level (using a scale from 1–10), clients and counselors will gain an understanding of the type of triggers present and the level of distress that each one produces. Moreover, the client may begin to see that the triggers don't actually happen all the time, even though they may seem to occur frequently.

Exhibit 1.5-1: The OBSERVATIONS Coping Strategy

- Take a moment to just ***Observe*** what is happening. Pay attention to your body, your senses, and your environment.
- Focus on your ***Breathing***. Allow your feelings and sensations to wash over you. Breathe.
- Name the ***Situation*** that initiated your response. In what way is this situation familiar to your past? How is it different?
- Remember that ***Emotions*** come and go. They may be intense now, but later they will be less so. Name your feelings.
- ***Recognize*** that this situation does not define you or your future. It does not dictate how things will be, nor is it a sign of things to come. Even if it is familiar, it is only one event.
- ***Validate*** your experience. State, at least internally, what you are feeling, thinking, and experiencing.
- ***Ask*** for help. You don't have to do this alone. Seek support. Other people care for you. Let them!
- ***This*** too shall pass. Remember: There are times that are good and times that are not so good. This hard time will pass.
- ***I*** can handle this. Name your strengths. Your strengths have helped you survive.
- Keep an ***Open*** mind. Look for and try out new solutions.
- ***Name*** strategies that have worked before. Choose one and apply it to this situation.
- Remember you have survived. You are a ***Survivor***!

cues will not be as obvious. With practice, the client can begin to track back through what occurred immediately before an emotional, physical, or behavioral reaction and then examine how that experience reminds him or her of the past.

Draw Connections

Mental health and substance abuse treatment providers have historically underestimated the effects of trauma on their clients for many reasons. Some held a belief that substance

Advice to Counselors: Strategies To Help Clients Draw Connections

Strategy #1: Writing about trauma can help clients gain awareness of their thoughts, feelings, and current experiences and can even improve physical health outcomes (Pennebaker, Kiecolt-Glaser, & Glaser, 1988; Smyth, Hockemeyer, & Tulloch, 2008). Although this tool may help some people draw connections between current experiences and past traumas, it should be used with caution; others may find that it brings up too much intense trauma material (especially among vulnerable trauma survivors with co-occuring substance abuse, psychosis, and current domestic violence). Journal writing is safest when you ask clients to write about present-day specific targets, such as logging their use of coping strategies or identifying strengths with examples. Writing about trauma can also be done via key questions or a workbook that provides questions centered upon trauma experiences and recovery.

Strategy #2: Encourage clients to explore the links among traumatic experiences and mental and substance use disorders. Recognition that a mental disorder or symptom developed after the trauma occurred can provide relief and hope that the symptoms may abate if the trauma is addressed. Ways to help clients connect substance use with trauma histories include (Najavits, 2002b; Najavits, Weiss, & Shaw, 1997):

- Identifying how substances have helped "solve" trauma or PTSD symptoms in the short term (e.g., drinking to get to sleep).
- Teaching clients how trauma, mental, and substance use disorders commonly co-occur so that they will not feel so alone and ashamed about these issues.
- Discussing how substance abuse has impeded healing from trauma (e.g., by blocking feelings and memories).
- Helping clients recognize trauma symptoms as triggers for relapse to substance use and mental distress.
- Working on new coping skills to recover from trauma and substance abuse at the same time.
- Recognizing how both trauma and substance abuse often occur in families through multiple generations.

abuse should be addressed before attending to any co-occurring conditions. Others did not have the knowledge and training to evaluate trauma issues or were uncomfortable or reluctant to discuss these sensitive issues with clients (Ouimette & Brown, 2003). Similarly, in other behavioral health settings, clinicians sometimes address trauma-related symptoms but do not have experience or training in the treatment of substance abuse.

So too, people who have histories of trauma will often be unaware of the connection between the traumas they've experienced and their traumatic stress reactions. They may notice depression, anger, or anxiety, or they may describe themselves as "going crazy" without being able to pinpoint a specific experience that produced the trauma symptoms. Even if clients recognize the events that precipitated their trauma symptoms, they may not understand how others with similar experiences can have different reactions. Thus, a treatment goal for trauma survivors is helping them gain awareness of the connections between their histories of trauma and subsequent consequences. Seeing the connections can improve clients' ability to work on recovery in an integrated fashion.

Teach Balance

You and your clients need to walk a thin line when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session whereby the client dissociates, shuts down, or becomes emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma. Several trauma-specific theories offer guidelines on acceptable levels of distress associated with the traumatic content that the therapy addresses. For example, some traditional desensitization processes start at a very low level of subjective distress, gradually working up through a hierarchy of trauma memories and experiences until those experiences produce minimal reactions when paired with some coping strategy, such as relaxation training. Other desensitization processes start at a higher level of intensity to provide more rapid extinction of traumatic associations and to decrease the risk of avoidance—a behavior that reinforces traumatic stress.

> The Subjective Units of Distress Scale (SUDS) uses a 0 10 rating scale, with 0 representing content that causes no or minimal distress and 10 representing content that is exceptionally distressing and overwhelming.
>
> (Wolpe & Abrams, 1991)

Working with trauma is a delicate balancing act between the development and/or use of coping strategies and the need to process the traumatic experiences. Individuals will choose different paths to recovery; it's a myth that every traumatic experience needs to be expressed and every story told. For some individuals, the use of coping skills, support, and spirituality are enough to recover. Regardless of theoretical beliefs, counselors must teach

Advice to Counselors: Strategy To Teach Balance

Strategy #1: Teach and use the SUDS in counseling. This scale can be useful from the outset as a barometer for the client and counselor to measure the level of distress during and outside of sessions. It provides a common language for the client and counselor, and it can also be used to guide the intensity of sessions. SUDS can tangibly show a client's progress in managing experiences. Without a scale, it is more difficult to grasp that a distressing symptom or circumstance is becoming less and less severe without some repeated measure.

coping strategies as soon as possible. Retraumatization is a risk whenever clients are exposed to their traumatic histories without sufficient tools, supports, and safety to manage emotional, behavioral, and physical reactions.

Build Resilience

Survivors are resilient! Often, counselors and clients who are trauma survivors focus on the negative consequences of trauma while failing to recognize the perseverance and attributes that have helped them survive. It is natural to focus on what's not working rather than what has worked. To promote growth after trauma and establish a strengths-based approach, focus on building on clients' resilience. Current resilience theories claim that building or reinforcing resilience prevents further development of trauma-related symptoms and disorders. The following *Advice to Counselors* box is adapted from the American Psychological Association's 2003 statement on resilience.

Advice to Counselors: Strategies To Build Resilience

Strategy #1: Help clients reestablish personal and social connections. Access community and cultural resources; reconnect the person to healing resources such as mutual-help groups and spiritual supports in the community.

Strategy #2: Encourage the client to take action. Recovery requires activity. Actively taking care of one's own needs early in treatment can evolve into assisting others later on, such as by volunteering at a community organization or helping military families.

Strategy #3: Encourage stability and predictability in the daily routine. Traumatic stress reactions can be debilitating. Keeping a daily routine of sleep, eating, work, errands, household chores, and hobbies can help the client see that life continues. Like exercise, daily living skills take time to take hold as the client learns to live through symptoms.

Strategy #4: Nurture a positive view of personal, social, and cultural resources. Help clients recall ways in which they successfully handled hardships in the past, such as the loss of a loved one, a divorce, or a major illness. Revisit how those crises were addressed.

Strategy #5: Help clients gain perspective. All things pass, even when facing very painful events. Foster a long-term outlook; help clients consider stress and suffering in a spiritual context.

Strategy #6: Help maintain a hopeful outlook. An optimistic outlook enables visions of good things in life and can keep people going even in the hardest times. There are positive aspects to everyone's life. Taking time to identify and appreciate these enhances the client's outlook and helps him or her persevere.

Strategy #7: Encourage participation in peer support, 12-Step, and other mutual-help programs.

Source: American Psychological Association, 2003.

Address Sleep Disturbances

Sleep disturbances are one of the most enduring symptoms of traumatic stress and are a particularly common outcome of severe and prolonged trauma. Sleep disturbances increase one's risk of developing traumatic stress; they significantly alter physical and psychological processes, thus causing problems in daytime functioning (e.g., fatigue, cognitive difficulty, excessive daytime sleepiness). People with sleep disturbances have worse general health and quality of life. The cardiovascular and immune systems, among others, may be affected as well. Sleep disturbances can worsen traumatic stress symptoms and interfere with healing by impeding the brain's ability to process and consolidate traumatic memories (Caldwell & Redeker, 2005).

Sleep disturbances vary among trauma survivors and can include decreased ability to stay asleep, frequent awakenings, early morning unintentional awakening, trouble falling asleep, poor quality of sleep, and disordered

Advice to Counselors: Strategies To Conduct a Sleep Intervention

Strategy #1: Conduct a sleep history assessment focused first on the client's perception of his or her sleep patterns. Assess whether there is difficulty initiating or staying asleep, a history of frequent or early morning awakenings, physically restless sleep, sleepwalking, bedtime aversion, and/or disruptive physical and emotional states upon awakening (e.g., confusion, agitation, feeling unrested). Also determine total sleep time, pattern of nightmares, and use of medications, alcohol, and/or caffeine (see Moul, Hall, Pikonis, & Buysse, 2004, for a review of self-report measures).

Strategy #2: Use a sleep hygiene measure to determine the presence of habits that typically interfere with sleep (e.g., falling asleep while watching television). The National Sleep Foundation Web site (http://www.sleepfoundation.org) provides simple steps for promoting good sleep hygiene.

Strategy #3: Provide education on sleep hygiene practices. Introduce clients to the idea that practicing good sleep hygiene is one step toward gaining control over their sleep disturbances.

Strategy #4: Reassess sleep patterns and history during the course of treatment. Sleep patterns often reflect current client status. For example, clients who are struggling are more likely to have disturbed sleep patterns; sleep disturbances significantly influence clients' mental health status.

Strategy #5: Use interventions such as nightmare rehearsals to target recurrent nightmares. There are numerous examples of imagery-based nightmare rehearsals. Clients may be instructed to rehearse repetitively the recurrent nightmare a few hours before bedtime. In this instruction, the client either rehearses the entire nightmare with someone or visualizes the nightmare several times to gain control over the material and become desensitized to the content. Other strategies involve imagining a change in the outcome of the nightmare (e.g., asking the client to picture getting assistance from others, even though his or her original nightmare reflects dealing with the experience alone).

breathing during sleep (Caldwell & Redeker, 2005). Most traumatic stress literature focuses on nightmares, insomnia, and frequent awakenings. These disturbances are connected to two main symptoms of traumatic stress: hyperarousal (which causes difficulty in falling and remaining asleep) and reexperiencing the trauma (e.g., through recurrent nightmares). Other sleep disturbances trauma survivors report include sleep avoidance or resistance to sleep (see Case Illustration: Selena), panic awakenings, and restless or unwanted body movements (e.g., hitting your spouse unintentionally in bed while asleep; Habukawa, Maeda, & Uchimura, 2010).

Case Illustration: Selena

Selena initially sought treatment for ongoing depression (dysthymia). During treatment, she identified being sexually assaulted while attending a party at college. At times, she blames herself for the incident because she didn't insist that she and her girlfriends stay together during the party and on the way back to their dorm afterward. Selena reported that she only had two drinks that night: "I could never manage more than two drinks before I wanted to just sleep, so I never drank much socially." She was assaulted by someone she barely knew but considered a "big brother" in the brother fraternity of her sorority. "I needed a ride home. During that ride, it happened," she said. For years thereafter, Selena reported mild bouts of depression that began lasting longer and increasing in number. She also reported nightmares and chronic difficulty in falling asleep. In therapy, she noted avoiding her bed until she's exhausted, saying, "I don't like going to sleep; I know what's going to happen." She describes fear of sleeping due to nightmares. "It's become a habit at night. I get very involved in playing computer games to lose track of time. I also leave the television on through the night because then I don't sleep as soundly and have fewer nightmares. But I'm always exhausted."

Build Trust

Some traumatic experiences result from trusting others (e.g., interpersonal trauma). In other cases, trust was violated during or after the traumatic experience, as in cases when help was late to arrive on the scene of a natural disaster. This lack of trust can leave individuals alienated, socially isolated, and terrified of developing relationships. Some feel that the trauma makes them different from others who haven't had similar experiences. Sometimes, a client's trust issues arise from a lack of trust in self—for instance, a lack of trust in one's perceptions, judgment, or memories. People who have also experienced severe mental or substance use disorders may have difficulty trusting others because, during the course of their illness, they felt alienated or discriminated against for behaviors and emotions generated by or associated with the disorders.

Some client groups (e.g., gay, lesbian, and bisexual clients; people from diverse cultures; those with serious mental illness) evidence significant mistrust because their trust has been repeatedly violated in the past. Traumatic experiences then compound this mistrust. Mistrust can come from various sources, is usually unstated, and, if left unaddressed, can impede treatment. For example, some clients leave treatment early or do not engage in potentially beneficial treatments. Others avoid issues of trust and commitment by leaving treatment when those issues begin to arise.

Establishing a safe, trusting relationship is paramount to healing—yet this takes time in the counseling process. Counselors and other behavioral health professionals need to be consistent throughout the course of treatment; this includes maintaining consistency in the parameters set for availability, attendance, and level of empathy. Trust is built on behavior shown inside and outside of treatment; you should immediately address any behavior that may even slightly injure the relationship (e.g., being 5 minutes late for an appointment, not responding to a phone message in a timely manner, being distracted in a session).

Advice to Counselors: Strategies To Build Trust

Strategy #1: Clients can benefit from a support or counseling group composed of other trauma survivors. By comparing themselves with others in the group, they can be inspired by those who are further along in the recovery process and helpful to those who are not faring as well as they are. These groups also motivate clients to trust others by experiencing acceptance and empathy.

Strategy #2: Use conflicts that arise in the program as opportunities. Successful negotiation of a conflict between the client and the counselor is a major milestone (van der Kolk, McFarlane, & Van der Hart, 1996). Helping clients understand that conflicts are healthy and inevitable in relationships (and that they can be resolved while retaining the dignity and respect of all involved) is a key lesson for those whose relationship conflicts have been beset by violence, bitterness, and humiliation.

Strategy #3: Prepare clients for staff changes, vacations, or other separations. Some clients may feel rejected or abandoned if a counselor goes on vacation or is absent due to illness, especially during a period of vulnerability or intense work. A phone call to the client during an unexpected absence can reinforce the importance of the relationship and the client's trust. You can use these opportunities in treatment to help the client understand that separation is part of relationships; work with the client to view separation in a new light.

Strategy #4: Honor the client–counselor relationship, and treat it as significant and mutual. You can support the development of trust by establishing clear boundaries, being dependable, working with the client to define explicit treatment goals and methods, and demonstrating respect for the client's difficulty in trusting you and the therapeutic setting.

Support Empowerment

Strong feelings of powerlessness can arise in trauma survivors seeking to regain some control of their lives. Whether a person has survived a single trauma or chronic trauma, the survivor can feel crushed by the weight of powerlessness. Mental illness and substance abuse, too, can be disempowering; clients may feel that they've lost control over their daily lives, over a behavior such as drug use, or over powerful emotions such as fear, sadness, or anger. Empowerment means helping clients feel greater power and control over their lives, as long as such control is within safe and healthy bounds. A key facet of empowerment is to help clients build on their strengths. Empowerment is more than helping clients discover what they "should" do; it is also helping them take the steps they feel ready to take.

Case Illustration: Abby

Abby, a 30-year-old, nervous-looking woman, is brought by her parents to a community mental health clinic near their home in rural Indiana. During the intake process, the counselor learns that Abby is an Army Reservist who returned from 12 months of combat duty 3 years ago. The war experience changed her in many ways. Her deployment pulled her away from veterinary school as well as the strong emotional support of family, friends, and fellow classmates. She got along with her unit in Iraq and had no disciplinary problems. While there, she served as a truck driver in the Sunni Triangle. Her convoy was attacked often by small arms fire and was once struck by an improvised explosive device. Although Abby sustained only minor injuries, two of her close friends were killed. With each successive convoy, her level of fear and foreboding grew, but she continued performing as a driver.

Since returning to the United States, she has mostly stayed at home and has not returned to school, although she is helping out on the farm with various chores. Abby has isolated herself from both family members and lifelong friends, saying she doesn't think others can understand what she went through and that she prefers being alone. She reports to her parents and the counselor that she is vaguely afraid to be in cars and feels most comfortable in her room or working alone, doing routine tasks, at home. Abby also says that she now understands how fragile life can be.

She has admitted to her parents that she drinks alcohol on a regular basis, something she did not do before her deployment, and that on occasion, she has experienced blackouts. Abby feels she needs a drink before talking with strangers or joining in groups of friends or family. She confided to her father that she isolates herself so that she can drink without having to explain her drinking to others.

The counselor recognizes Abby's general sense of lacking internal control and feeling powerless over what will happen to her in the future. He adopts a motivational interviewing style to establish rapport and a working alliance with Abby. During sessions, the counselor asks Abby to elaborate on her strengths; he reinforces strengths that involve taking action in life, positive self-statements, and comments that deal with future plans. He also introduces Abby to an Iraq War veteran who came home quite discouraged about putting his life together but has done well getting reintegrated. The counselor urges Abby go to the local VA center so that she can meet and bond with other recently returned veterans. He also encourages Abby to attend Alcoholics Anonymous meetings, emphasizing that she won't be pressured to talk or interact with others more than she chooses to.

The counselor continues to see Abby every week and begins using cognitive–behavioral techniques to help her examine some of her irrational fears about not being able to direct her life. He asks Abby to keep a daily diary of activities related to achieving her goals of getting back to school and reestablishing a social network. In each session, Abby reviews her progress using the diary as a memory aid, and the counselor reinforces these positive efforts. After 4 months of treatment, Abby reenrolls in college and is feeling optimistic about her ability to achieve her career plans.

Advice to Counselors: Strategies To Support Empowerment

Strategy #1: Offer clients information about treatment; help them make informed choices. Placing appropriate control for treatment choices in the hands of clients improves their chances of success.

Strategy #2: Give clients the chance to collaborate in the development of their initial treatment plan, in the evaluation of treatment progress, and in treatment plan updates. Incorporate client input into treatment case consultations and subsequent feedback.

Strategy #3: Encourage clients to assume an active role in how the delivery of treatment services occurs. An essential avenue is regularly scheduled and structured client feedback on program and clinical services (e.g., feedback surveys). Some of the most effective initiatives to reinforce client empowerment are the development of peer support services and the involvement of former clients in parts of the organizational structure, such as the advisory board or other board roles.

Strategy #4: Establish a sense of self-efficacy in clients; their belief in their own ability to carry out a specific task successfully—is key. You can help clients come to believe in the possibility of change and in the hope of alternative approaches to achieving change. Supporting clients in accepting increasing responsibility for choosing and carrying out personal change can facilitate their return to empowerment (Miller & Rollnick, 2002).

Acknowledge Grief and Bereavement

The experience of loss is common after traumas, whether the loss is psychological (e.g., no longer feeling safe) or physical (e.g., death of a loved one, destruction of community, physical impairment). Loss can cause public displays of grief, but it is more often a private experience. Grieving processes can be emotionally overwhelming and can lead to increased substance use and other impulsive behaviors as a way to manage grief and other feelings associated with the loss. Even for people who experienced trauma years prior to treatment, grief is still a common psychological issue. Delayed or absent reactions of acute grief can cause exhaustion, lack of strength, gastrointestinal symptoms, and avoidance of emotions.

Risk factors of chronic bereavement (grief lasting more than 6 months) can include:

- Perceived lack of social support.
- Concurrent crises or stressors (including reactivation of PTSD symptoms).
- High levels of ambivalence about the loss.
- An extremely dependent relationship prior to the loss.
- Loved one's death resulting from disaster: unexpected, untimely, sudden, and shocking (New South Wales Institute of Psychiatry & Centre for Mental Health, 2000).

Advice to Counselors: Strategies To Acknowledge and Address Grief

Strategy #1: Help the client grieve by being present, by normalizing the grief, and by assessing social supports and resources.

Strategy #2: When the client begins to discuss or express grief, focus on having him or her voice the losses he or she experienced due to trauma. Remember to clarify that losses include internal experiences, not just physical losses.

Strategy #3: For a client who has difficulty connecting feelings to experiences, assign a feelings journal in which he or she can log and name each feeling he or she experiences, rate the feeling's intensity numerically, and describe the situation during which the feeling occurred. The client may choose to share the journal in an individual or group session.

Strategy #4: Note that some clients benefit from developing a ritual or ceremony to honor their losses, whereas others prefer offering time or resources to an association that represents the loss.

Monitor and Facilitate Stability

Stability refers to an ongoing psychological and physical state whereby one is not overwhelmed by disruptive internal or external stimuli (Briere & Scott, 2006b). It's common for individuals to have an increase in symptoms, distress, or impairment when dealing with the impact of their trauma or talking about specific aspects of their trauma. There is a thin line that the client and counselor need to negotiate and then walk when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session that causes the client to dissociate, shut down, or become emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma.

Advice to Counselors: Strategies To Monitor and Facilitate Stability

Strategy #1: If destabilization occurs during the intake process or treatment, stop exploring the material that triggered the reaction, offer emotional support, and demonstrate ways for the client to self-soothe.

Strategy #2: Seek consultation from supervisors and/or colleagues (e.g., to explore whether a new case conceptualization is needed at this point).

Strategy #3: Refer the client for a further assessment to determine whether a referral is necessary for trauma-specific therapy or a higher level of care, or use of multiple levels of care (e.g., intensive outpatient care, partial hospitalization, residential treatment).

Strategy #4: Focus on coping skills and encourage participation in a peer support program.

Strategy #5: When a client becomes agitated and distressed, carefully explore with the client what is causing this state. When such feelings arise because of current threats in the client's life or environment, it is dangerous to halt or soothe away responses that act as warning signals (Pope & Brown, 1996). When a client is in a situation involving domestic violence, lives in a dangerous neighborhood, or has run out of money for food, he or she requires direct and concrete assistance rather than simple emotional support.

Source: Briere & Scott, 2006b.

Managing Destabilization

When a client becomes destabilized during a session, you can respond in the following manner: "Let's slow down and focus on helping you be and feel safe. What can we do to allow you to take care of yourself at this moment? Then, when you feel ready, we can decide what to focus on next."

Clients should have some psychological stability to engage in trauma-related work. An important distinction can be made between a normative increase in symptoms (e.g., the typical up-and-down course of traumatic stress reactions or substance abuse) and destabilization (dangerous, significant decrease in functioning). Signs of destabilization include (Green Cross Academy of Traumatology, 2007; Najavits, 2002b):

- Increased substance use or other unsafe behavior (e.g., self-harm).
- Increased psychiatric symptoms (e.g., depression, agitation, anxiety, withdrawal, anger).
- Increased symptoms of trauma (e.g., severe dissociation).
- Helplessness or hopelessness expressed verbally or behaviorally.
- Difficulty following through on commitments (e.g., commitment to attend treatment sessions).
- Isolation.
- Notable decline in daily activities (e.g., self-care, hygiene, care of children or pets, going to work).

Treatment Issues

The treatment environment itself can significantly affect how clients experience traumatic stress and how the client responds to treatment. Some specific issues related to working with trauma survivors in a clinical setting are discussed in the following sections.

Client Engagement

A lack of engagement in treatment is the client's inability to make progress toward treatment goals, deal with important topics in treatment, or complete treatment. Clients who have histories of trauma will express ambivalence about treatment similarly to others, except that clients who have traumatic stress can feel more "stuck" and perceive themselves as having fewer options. In addition, clients may be avoiding engagement in treatment because it is one step closer to addressing their trauma. You should attend to the client's motivation to change, implement strategies that address ambivalence toward treatment, and use approaches that help clients overcome avoidant behavior.

Advice to Counselors: Strategies To Foster Engagement

Strategy #1: According to Mahalik (2001), the standard method of handling clients' lack of engagement is exploring it with them, clarifying the situation through discussion with them, reinterpreting (e.g., from "can't" to "won't" to "willing"), and working through the situation toward progress.

Strategy #2: To improve engagement into treatment, try motivational interviewing and enhancement techniques. For additional information on such techniques, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT], 1999b).

Pacing and Timing

Although your training or role as a counselor may prohibit you from providing trauma-specific services, you must still be prepared for the fact that clients are not as focused on when or where it is most appropriate to address trauma—they want relief, and most lay and professional people have been taught that the only path to recovery is disclosure. Some clients are reluctant to talk about anything associated with their histories of trauma. Other clients immediately want to delve into the memories of their trauma without developing a safe environment. The need to gain any relief for the traumatic stress pushes some individuals to disclose too quickly, without having the necessary support and coping skills to manage the intensity of their memories. Clients who enter treatment and immediately disclose past trauma often don't return because the initial encounter was so intense or because they experienced considerable emotional distress for several days afterward and/or in anticipation of the next session.

Proper pacing of sessions, disclosure, and intensity is paramount. Clients who immediately disclose without proper safety nets are actually retraumatizing themselves by reliving the experience without adequate support—often placing themselves in the same circumstances that occurred during the actual traumas they experienced. Although you should not adamantly direct clients not to talk about what happened, it is important to discuss with the clients, even if you have to interrupt them empathically and respectfully, the potential consequences of disclosing too soon and too fast. Ask whether they have done this before, and then inquire about the outcome. Reinforce with clients that trauma heals when there are support, trust, and skills in place to manage the memories of the traumatic experiences. Ideally, disclosure begins after these elements are secured, but realistically, it is a

Advice to Counselors: Strategies To Establish Appropriate Pacing and Timing

Strategy #1: Frequently discuss and request feedback from clients about pacing and timing. Moving too quickly into discussion of the trauma can increase the risk of dissociation, overactivation of memories, and feeling overwhelmed.

Strategy #2: Use the SUDS as a barometer of intensity to determine the level of work.

Strategy #3: Slowly increase the speed of interventions and continually adjust the intensity of interventions; move in and out of very intense work, or use strategies that decrease the intensity when necessary. One approach that typically decreases the intensity of traumatic memories is to ask the individual to imagine that he or she is seeing the scene through a window or on a television screen. This helps decrease intensity and the risk of dissociation. It provides an opportunity for the client to view the trauma from a different perspective and a strategy to use outside of treatment to shift from reliving the trauma to observing it from a neutral position.

Strategy #4: Monitor clients to ensure that treatment does not overwhelm their internal capacities, retraumatize them, or result in excessive avoidance; make sure therapy occurs in the "therapeutic window" (Briere & Scott, 2006b).

Strategy #5: Be alert to signs that discussions of trauma, including screening, assessment, and intake processes, are going too fast. Mild to moderate signs are:
- Missing counseling appointments after discussions of important material.
- Periods of silence.
- Dissociation.
- Misunderstanding what are usually understandable concepts.
- Redirecting the focus of the discussion when certain issues arise.

Strategy #6: Observe the client's emotional state. Slow down; seek consultation if the client exhibits:
- Persistent resistance to addressing trauma symptoms.
- Repetitive flashbacks.
- Increase in dissociation.
- Regression.
- Difficulty in daily functioning (e.g., trouble maintaining everyday self-care tasks).
- Substance use relapses.
- Self-harm or suicidal thoughts/behaviors (e.g., talking about suicide).

Strategy #7: Use caution and avoid (Briere, 1996b, p. 115):
- Encouraging clients to describe traumatic material in detail before they can deal with the consequences of disclosure.
- Using overly stressful interventions (e.g., intensive role-plays, group confrontation, guided imagery).
- Confrontations or interpretations that are too challenging given the client's current functioning.
- Demanding that the client work harder and stop resisting.

Source: Strategies 1–6: Green Cross Academy of Traumatology, 2001. Adapted with permission.

balancing act for both the counselor and client as to when and how much should be addressed in any given session. Remember not to inadvertently give a message that it is too dangerous to talk about trauma; instead, reinforce the importance of addressing trauma without further retraumatization.

Length of Treatment

Many factors influence decisions regarding the length of treatment for a given client. Severity of addiction, type of substance abused, type of trauma, age at which the trauma occurred, level of social support, and the existence of

mental disorders all influence length of treatment. External factors, such as transportation and childcare, caps on insurance coverage, and limitations in professional resources, can also affect length of treatment. In general, longer treatment experiences should be expected for clients who have histories of multiple or early traumas, meet diagnostic criteria for multiple Axis I or Axis II diagnoses, and/or require intensive case management. Most of the empirically studied and/or manual-based models described in the next chapter are short-term models (e.g., lasting several months); however, ongoing care is indicated for clients with more complex co-occurring trauma disorders.

Traumatic Memories

One of the most controversial issues in the trauma field is the phenomenon of "recovered memories" or "traumatic amnesia" (Brewin, 2007). Practitioners working with traumatized individuals are particularly concerned about the possibility of new memories of the traumatic event emerging during the course of therapy and the possibility of these memories being induced by the clinician. Scientific reviews indicate that people can experience amnesia and delayed recall for some memories of a wide variety of traumas, including military combat and prisoner of war experiences, natural disasters and accidents, childhood sexual abuse, and political torture (Bowman & Mertz, 1996; Brewin, 2007; Karon & Widener, 1997; McNally, 2005). In some cases, the survivor will not remember some of what happened, and the counselor may need to help the client face the prospect of never knowing all there is to know about the past and accept moving on with what is known.

Legal Issues

Legal issues can emerge during treatment. A client, for instance, could seek to prosecute a perpetrator of trauma (e.g., for domestic violence) or to sue for damages sustained in an accident or natural disaster. The counselor's role is not to provide legal advice, but rather, to offer support during the process and, if needed, refer the client to appropriate legal help (see Advice to Counselors box on p. 131). A legal matter can dominate the treatment atmosphere for its duration. Some clients have difficulty making progress in treatment until most or all legal matters are resolved and no longer act as ongoing stressors.

Memories of Trauma

Points for counselors to remember are:

- Some people are not able to completely remember past events, particularly events that occurred during high-stress and destabilizing moments.
- In addition to exploring the memories themselves, it can be beneficial to explore how a memory of an event helps the client understand his or her feeling, thinking, and behaving in the present.
- Persistently trying to recall all the details of a traumatic event can impair focus on the present.

Forgiveness

Clients may have all sorts of reactions to what has happened to them. They may feel grateful for the help they received, joy at having survived, and dedication to their recovery. At the other extreme, they may have fantasies of revenge, a loss of belief that the world is a good place, and feelings of rage at what has happened. They may hold a wide variety of beliefs associated with these feelings.

One issue that comes up frequently among counselors is whether to encourage clients to forgive. The issue of forgiveness is a very delicate one. It is key to allow survivors their feelings, even if they conflict with the counselor's own responses. Some may choose to forgive the perpetrator, whereas others may remain angry or seek justice through the courts and other legal means. Early in recovery from

Advice to Counselors: Strategies To Manage Traumatic Memories

Strategy #1: Most people who were sexually abused as children remember all or part of what happened to them, although they do not necessarily fully understand or disclose it. Do not assume that the role of the clinician is to investigate, corroborate, or substantiate allegations or memories of abuse (American Psychiatric Association [APA], 2000b).

Strategy #2: Be aware that forgotten memories of childhood abuse can be remembered years later. Clinicians should maintain an empathic, nonjudgmental, neutral stance toward reported memories of sexual abuse or other trauma. Avoid prejudging the cause of the client's difficulties or the veracity of the client's reports. A counselor's prior belief that physical or sexual abuse, or other factors, are or are not the cause of the client's problems can interfere with appropriate assessment and treatment (APA, 2000b).

Strategy #3: Focus on assisting clients in coming to their own conclusions about the accuracy of their memories or in adapting to uncertainty regarding what actually occurred. The therapeutic goal is to help clients understand the impact of the memories or abuse experiences on their lives and to reduce their detrimental consequences in the present and future (APA, 2000b).

Strategy #4: Some clients have concerns about whether or not a certain traumatic event did or did not happen. In such circumstances, educate clients about traumatic memories, including the fact that memories aren't always exact representations of past events; subsequent events and emotions can have the effect of altering the original memory. Inform clients that it is not always possible to determine whether an event occurred but that treatment can still be effective in alleviating distress.

Strategy #5: There is evidence that suggestibility can be enhanced and pseudomemories can develop in some individuals when hypnosis is used as a memory enhancement or retrieval strategy. Hypnosis and guided imagery techniques can enhance relaxation and teach self-soothing strategies with some clients; however, use of these techniques is not recommended in the active exploration of memories of abuse (Academy of Traumatology, 2007).

Strategy #6: When clients are highly distressed by intrusive flashbacks of delayed memories, help them move through the distress. Teach coping strategies and techniques on how to tolerate strong affect and distress (e.g., mindfulness practices).

trauma, it is best to direct clients toward focusing on stabilization and a return to normal functioning; suggest that, if possible, they delay major decisions about forgiveness until they have a clearer mind for making decisions (Herman, 1997). Even in later stages of recovery, it's not essential for the client to forgive in order to recover. Forgiveness is a personal choice independent of recovery. Respect clients' personal beliefs and meanings; don't push clients to forgive or impose your own beliefs about forgiveness onto clients.

In the long-term healing process, typically months or years after the trauma(s), forgiveness may become part of the discussion for some people and some communities. For example, in South Africa, years after the bitter and bloody apartheid conflicts, a Truth and Reconciliation Commission was established by the Government. Public hearings created dialog and aired what had been experienced as a means, ultimately, to promote forgiveness and community healing. By addressing very difficult topics in public, all could potentially benefit from the discourse. Similarly, a parental survivor of the Oklahoma City bombing was, at first, bitter about his daughter's early, unfair, and untimely death. Today, he gives talks around the world about the abolition of the death penalty. He sat with convicted

Advice to Counselors: Strategies To Manage Legal Proceedings

Strategy #1: If you're aware of legal proceedings, you can play a key role in helping your client prepare emotionally for their impact, such as what it might be like to describe the trauma to a judge or jury, or how to cope with seeing the perpetrator in court. When helping a client prepare, however, be careful not to provide legal advice.

Strategy #2: Help clients separate a successful legal outcome from a successful treatment outcome. If clients connect these two outcomes, difficulties can arise. For example, a client may discontinue treatment after his or her assailant is sentenced to serve prison time, believing that the symptoms will abate without intervention.

Strategy #3: If clients express interest in initiating a civil or criminal suit, encourage them to consider the ways in which they are and are not prepared for this, including their own mental states, capacity for resilience, and inevitable loss of confidentiality (Pope & Brown, 1996). Inform clients coping with legal issues that involvement in the legal process can be retraumatizing.

Strategy #4: Emphasize, for trauma survivors who are involved in legal proceedings against an assailant, that "not guilty" is a legal finding—it is based on the degree of available evidence and is not a claim that certain events in question did not occur. They should also receive, from an attorney or other qualified individual, information on:

- The nature of the legal process as it pertains to the clients' specific cases.
- The estimated duration and cost of legal services, if applicable.
- What to expect during police investigations.
- Court procedures.
- Full information on all possible outcomes.
- What to expect during cross-examination.

Strategy #5: Counselors can be called on to assist with a legal case involving trauma. The court may require you to provide treatment records, to write a letter summarizing your client's progress, or to testify at a trial. Always seek supervisory and legal advice in such situations and discuss with the client the possible repercussions that this might have for the therapeutic relationship. As a general rule, it is best practice to avoid dual roles or relationships.

bomber Timothy McVeigh's father while the man's son was executed in Indiana at a Federal prison several years after the bombing. For this man, forgiveness and acceptance helped him attain personal peace. Other trauma survivors may choose never to forgive what happened, and this, too, is a legitimate response.

Culturally and Gender Responsive Services

Culture is the lens through which reality is interpreted. Without an understanding of culture, it is difficult to gauge how individuals organize, interpret, and resolve their traumas. The challenge is to define how culture affects individuals who have been traumatized.

Increased knowledge of PTSD (Wilson & Tang, 2007), mental illness, and substance use disorders and recovery (Westermeyer, 2004) requires behavioral health practitioners to consider the complicated interactions between culture, personality, mental illness, and substance abuse in adapting treatment protocols. This section offers some general guidelines for working with members of cultures other than one's own. Treatment for traumatic stress, mental illness, substance use disorders, and co-occurring trauma-related symptoms is more effective if it is culturally responsive.

The U.S. Department of Health and Human Services (2003) has defined the term "cultural competence" as follows:

> Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time (p. 12).

Cultural competence is a process that begins with an awareness of one's own culture and beliefs and includes an understanding of how those beliefs affect one's attitudes toward people of other cultures. It is rooted in respect, validation, and openness toward someone whose social and cultural background is different from one's own. For a thorough review of cultural competence, see the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration [SAMHSA], planned c).

Cultural Competence

Cultural competence includes a counselor's knowledge of:

- Whether the client is a survivor of cultural trauma (e.g., genocide, war, government oppression, torture, terrorism).
- How to use cultural brokers (i.e., authorities within the culture who can help interpret cultural patterns and serve as liaisons to those outside the culture).
- How trauma is viewed by an individual's sociocultural support network.
- How to differentiate PTSD, trauma-related symptoms, and other mental disorders in the culture.

For more specific information on cultural competence in trauma therapy, see Brown (2008).

In some cultures, an individual's needs take precedence over group needs (Hui & Triandis, 1986), and problems are seen as deriving from the self. In other cultures, however, complex family, kin, and community systems take precedence over individual needs. Considerable heterogeneity exists within and across most ethnic subcultures and across lines of gender, class, age, and political groups (CSAT, 1999b). Subcultures abound in every culture, such as gangs; populations that are homeless or use substances; orphaned or disenfranchised people; religious, ethnic, and sexual minorities; indigenous people; and refugee and immigrant populations. Some subcultures have more in common with similar subcultures in other countries than with their own cultures (e.g., nonheterosexual populations).

Trauma and substance abuse can themselves be a basis for affiliation with a subculture. De Girolamo (1993) reports that "disaster subcultures" exist within many cultures. These cultures of victimization, like all subcultures, have unique worldviews, codes of conduct, and perceptions of the larger society. In a disaster subculture, people are, to some extent, inured to disaster and heedless of warnings of impending disaster. For example, riverbank erosion in Bangladesh displaces thousands of people each year, yet few believe that it is a serious problem or that the displacement will be permanent (Hutton, 2000). Israelis who have lived with unpredictable violence for many years behave differently in public areas and have adapted to different norms than people who don't commonly experience violence (Young, 2001).

Many people identify with more than one subculture. Some identify with a particular culture or subculture, but not with all of its values. Individual identities are typically a mosaic of factors, including developmental achievements, life experiences, behavioral health histories, traumatic experiences, and

alcohol and illicit drug use; levels of acculturation and/or assimilation vary from one individual to the next as well.

Importance of the trauma aftermath

Counselors working in the immediate aftermath of trauma—whether individual, group, or community in nature—face many challenges. For example, survivors may be forced to adjust without access to other health services, employment, support, or insurance. In these instances, counselors must often work with individuals and communities coping with the trauma while struggling daily to meet basic needs. Research suggests that reestablishing ties to family, community, culture, and spiritual systems can not only be vital to the individual, but can also influence the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of people victimized by Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents affected by the purge experienced fewer negative effects than did those who were emotionally or physically severed from their grandparents. The researchers also found that whether the grandparents survived was less important than the connection the grandchildren managed to keep to their past. Ties to family and community can also have an adverse effect, especially if the family or community downplays the trauma or blames the victim. Counselors need to have a full understanding of available support before advocating a particular approach.

Treatment strategies

Many traditional healing ways have been damaged, forgotten, or lost—yet much wisdom remains. Drawing on the best traditional and contemporary approaches to human distress and defining culturally competent curricula regarding identity and healing (Huriwai, 2002; Wilson & Tang, 2007) both require respect and appreciation for the many ways in which various people characterize and resolve trauma and how they use addictive substances to bear the burdens of human distress.

Community-Based Treatment for Native American Historical Trauma

Key beliefs in community healing:

- Clients carry childhood pain that has led to adult dysfunction.
- Childhood pain must be confronted, confessed, and addressed, if relief is to be obtained.
- Cathartic expression is the initial step in the healing journey toward a lifelong pursuit of introspection and self-improvement.
- The healing journey entails reclamation of indigenous heritage, identity, spirituality, and practices to remedy the pathogenic effects of colonization and other sources of historical trauma.

Source: Gone, 2009.

It is not yet known how well existing PTSD treatments work for individuals who identify primarily with cultures other than mainstream American culture. It is possible that such treatments do work for clients of other cultures, though some cultural adaptation and translation may be required. For example, some PTSD treatments that have been used with subculture groups without adaptation other than language translation and that appear to be effective across cultures include eye movement desensitization and reprocessing (Bleich, Gelkopf, & Solomon, 2003) and Seeking Safety (Daouest et al., 2012).

Gender

Gender differences exist in traumatic stress, mental disorders, and substance use disorders. For example, women have higher rates of PTSD, whereas men have higher rates of substance abuse (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Stewart, Ouimette, & Brown, 2002; Tolin & Foa, 2006).

Working With Clients From Diverse Cultures: Trauma and Substance Abuse

- In socially appropriate ways, educate clients, their loved ones, and possibly members of their extended community about the relationship between substance abuse and PTSD, how substance abuse is often used to cope with trauma, and what treatment entails.
- Make serious efforts to connect clients to supportive and understanding people (preferably within culturally identified groups).
- Help clients understand that many who have not experienced trauma or do not have substance use disorders will not understand the psychological, spiritual, and interpersonal insights that they have gained during their recovery processes.

The types of interpersonal trauma experienced by men and by women are often different. A number of studies (Kimerling, Ouimette, & Weitlauf, 2007) indicate that men experience more combat and crime victimization and women experience more physical and/or sexual assault—implying that men's traumas often occur in public, whereas the traumatization of women is more likely to take place in a private setting, such as a home. Men's abusers are more often strangers. Those who abuse women, on the other hand, are more often in a relationship with them. Women (and girls) often are told, "I love you," during the same time period when the abuse occurs. However, women now serve in the military and thus are increasingly subject to some of the same traumas as men and also to military sexual trauma, which is much more common for women to experience. Similarly, men can be subject to domestic violence or sexual abuse.

In treatment, gender considerations are relevant in a variety of ways, including, but not limited to, the role and impact of societal gender stereotypes upon assessment processes, treatment initiation, and engagement of services (e.g., peer support systems); the selection and implementation of gender-specific and gender-responsive approaches for both men and women at each level of intervention; and the best selection of trauma-related interventions that account for gender-specific differences related to traumatic stress. For an extensive review and discussion of gender-specific and gender-responsive care for traumatic stress and substance use, see the TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d), and TIP 56, *Addressing the Specific Behavioral Health Needs of Men* (SAMHSA, 2013a).

Beyond the complexities of gender considerations, one must also consider whether clients should be given the choice of working with a male or a female counselor. Some clients who have been traumatized have no preference, particularly if their trauma wasn't associated with gender (e.g., a natural disaster, act of terrorism, fire, serious accident). If gender did play a role in trauma (e.g., childhood sexual abuse), clients can have strong fears of working with a counselor who is the same gender as the perpetrator. Many women who experienced sexual abuse (whose perpetrators are typically men) feel uncomfortable being treated by men because of the intense emotions that can be evoked (e.g., anger, fear). Men who experienced sexual abuse (whose perpetrators are also typically men) can feel uncomfortable for the same reasons, or they may feel shame when talking to men due to feelings evoked about masculinity, homosexuality, and so forth. However, not all clients with trauma histories prefer female therapists.

Discuss with clients the possible risks (e.g., initial emotional discomfort) and benefits of being treated by a woman or man (e.g., developing a therapeutic relationship with a man might challenge a client's belief that all men are dangerous), and, if possible, let them then choose the gender of their counselor. Tell

them that if they experience initial emotional discomfort, and the discomfort does not decrease, they can switch to a counselor of the opposite gender. For group therapy that focuses on trauma, similar considerations apply. Generally, gender-specific groups are recommended when possible, but mixed-gender groups also work. Gender also comes into play in substance abuse treatment. Research and clinical observation indicate that significant gender differences occur in many facets of substance abuse and its treatment. For example, men and women experience different physical repercussions of substance use (e.g., women have more health problems), different trajectories (e.g., women become addicted more quickly), and different treatment considerations (e.g., traditional substance abuse treatment was designed for men).

Sexual orientation

Lesbian, gay, bisexual, and transgender (LGBT) clients face specific issues in behavioral health treatment settings, including histories of abuse and discrimination relating to sexual orientation, homophobia in treatment on the part of counselors or other clients, potential difficulty addressing traumatic experiences related to their sexuality or sexual orientation, and often, a significant lack of trust toward others. LGBT people sometimes think that others can't understand them and their specific needs and thus are reluctant to engage in treatment programs in which the clientele is predominantly heterosexual. Some clients react with judgment, anger, or embarrassment when an LGBT client attempts to describe sexual trauma relating to homosexual behavior, making it even harder for LGBT clients to describe their experiences.

Often, individual counseling can address issues the LGBT client isn't comfortable discussing in group treatment. "Providing one-on-one services may decrease the difficulty of mixing heterosexual and LGBT clients in treatment groups and decrease the likelihood that heterosexism or homophobia will become an issue" (CSAT, 2001, p. 56). For more on treating LGBT individuals, see *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT, 2001).

Making Referrals to Trauma-Specific Services

Many people who experience trauma do not exhibit persistent traumatic stress symptoms. In fact, people do recover on their own. So how do you determine who is at higher risk for developing more persistent symptoms of traumatic stress, trauma-related disorders, and traumatic stress disorders? One main factor is the severity of symptoms at the time of screening and assessment. Other factors, beyond trauma characteristics and pretrauma individual characteristics, to consider in making referrals include (Ehlers & Clark, 2003):

- Cognitive appraisals that are excessively negative regarding trauma sequelae, including consequences, changes after the event(s), responses of other people to the trauma, and symptoms.
- Acknowledgment of intrusive memories.
- Engagement in behaviors that reinforce or prevent resolution of trauma, including avoidance, dissociation, and substance use.
- History of physical consequences of trauma (e.g., chronic pain, disfigurement, health problems).
- Experiences of more traumas or stressful life events after the prior trauma.
- Identification of co-occurring mood disorders or serious mental illness.

The next chapter provides an overview of trauma-specific services to complement this chapter and to provide trauma-informed counselors with a general knowledge of trauma-specific treatment approaches.

6 Trauma-Specific Services

IN THIS CHAPTER

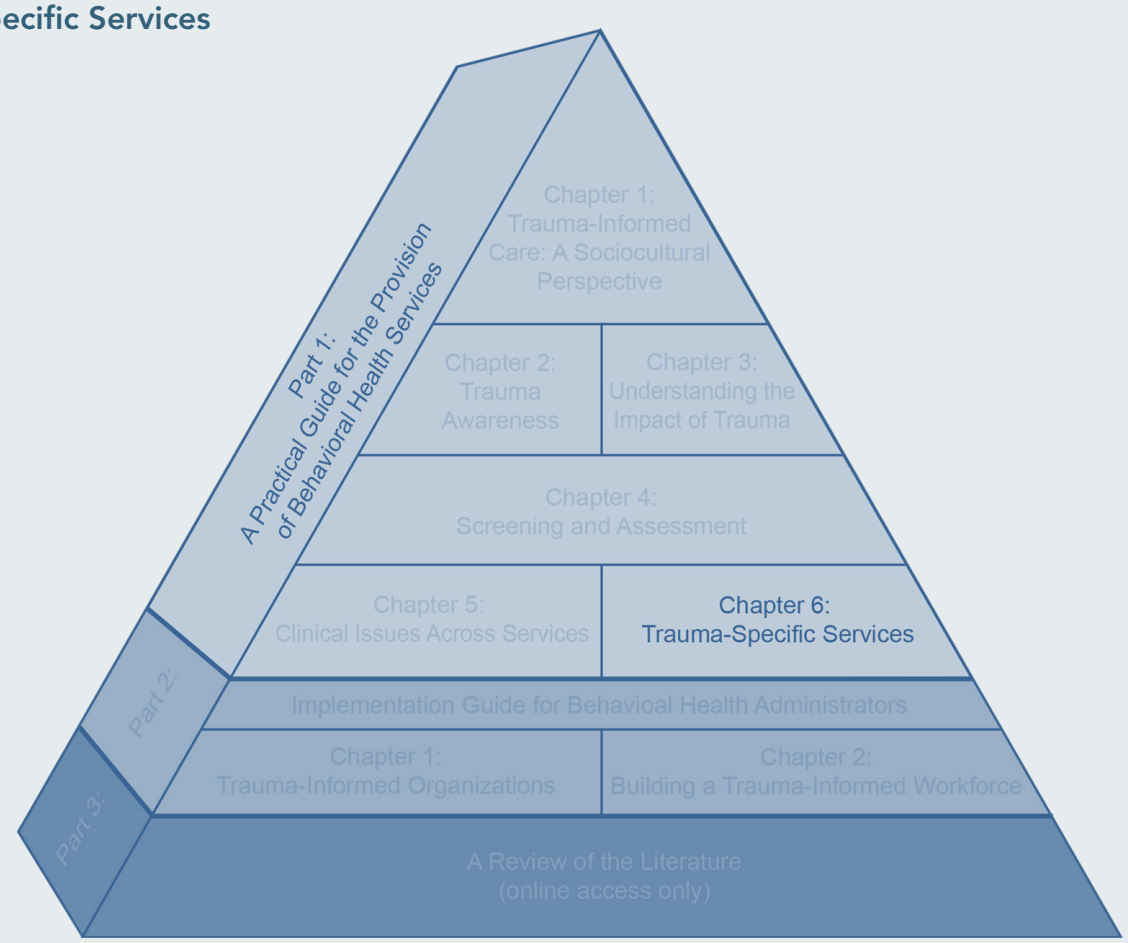
- Introduction
- Trauma Specific Treatment Models
- Integrated Models for Trauma
- Emerging Interventions
- Concluding Note

This chapter covers various treatment approaches designed specifically to treat trauma-related symptoms, trauma-related disorders, and specific disorders of traumatic stress. The models presented do not comprise an exhaustive list, but rather, serve as examples. These models require training and supervised experience to be conducted safely and effectively. The chapter begins with a section on trauma-specific treatment models, providing a brief overview of interventions that can be delivered immediately after a trauma, as well as trauma-specific interventions for use beyond the immediate crisis. The second segment focuses on integrated care that targets trauma-specific treatment for mental, substance use, and co-occurring disorders. Even though entry-level, trauma-informed behavioral health service providers are unlikely to be in a position to use these interventions, having some knowledge of them is nevertheless important. Currently, more research is needed to tease out the most important ingredients of early interventions and their role in the prevention of more pervasive traumatic stress symptoms. More science-based evidence is available for trauma-specific treatments that occur and extend well beyond the immediate reactions to trauma. The last part of the chapter provides a brief review of selected emerging interventions that have not been covered elsewhere in this Treatment Improvement Protocol (TIP).

Introduction

Trauma-specific therapies vary in their approaches and objectives. Some are present focused, some are past focused, and some are combinations (Najavits, 2007a). Present-focused approaches primarily address current coping skills, psychoeducation, and managing symptoms for better functioning. Past-focused approaches primarily focus on telling the trauma story to understand the impact of the trauma on how the person functions today, experiencing emotions that were too overwhelming to experience in the past, and helping clients more effectively cope in the present with their

Trauma-Informed Care Framework in Behavioral Health Services—Trauma-Specific Services



traumatic experiences. Clients participating in present-focused approaches may reveal some of their stories; past-focused approaches emphasize how understanding the past influences current behavior, emotion, and thinking, thereby helping clients cope more effectively with traumatic experiences in the present.

The distinction between these approaches lies in the primary emphasis of the approach. Depending on the nature of the trauma and the specific needs of the client, one approach may be more suitable than the other. For instance, in short-term treatment for clients in early recovery from mental illness and/or substance abuse, present-focused, cognitive–behavioral, or psychoeducational approaches are generally more appropriate. For clients who are stable in their recovery and have histories of developmental trauma where much of the trauma has been repressed, a past-focused orientation may be helpful. Some clients may benefit from both types, either concurrently or sequentially.

This chapter discusses a number of treatment models, general approaches, and techniques. A treatment model is a set of practices designed to alleviate symptoms, promote psychological well-being, or restore mental health. Treatment techniques are specific procedures that can be used as part of a variety of models. Some models and techniques described in this chapter can be used with groups, some with individuals, and some with both. This chapter is selective rather than comprehensive; additional models are described in the literature. See, for example, the PILOTS database on the Web site of the National Center for PTSD

(NCPTSD; http://www.ptsd.va.gov) for treatment literature related to trauma and posttraumatic stress disorder (PTSD). For an overview of models for use with both adult and child populations, refer to *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services* (Center for Mental Health Services, 2008).

Some treatments discussed in this chapter are described as evidence based. Because research on integrated treatment models is so new, many have only been examined in a few studies. Given these circumstances and the fact that an outcome study provides only limited evidence of efficacy, the term "evidence based" should be interpreted cautiously. Additional scientific study is needed to determine whether some treatments discussed herein are, in fact, evidence based. A good resource for evaluating evidence-based, trauma-specific treatment models is *Effective Treatments for PTSD* (Foa, Keane, Friedman, & Cohen, 2009). Although evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with symptoms of trauma that co-occur with mental and substance use disorders (see Allen, 2001, for an indepth discussion of trauma and serious mental illness), other factors must also be weighed, including the specific treatment needs of the client; his or her history of trauma, psychosocial and cultural background, and experiences in prior trauma treatment; the overall treatment plan for the client; and the competencies of the program's clinical staff. Although behavioral health counselors can prepare to help their clients address some of the issues discussed in Chapter 5, specialized training is necessary to provide treatment for co-occurring substance use and mental disorders related to trauma.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has created the National Registry of Evidence-Based Programs and Practices (NREPP) as a resource for reviewing and identifying effective treatment programs. Programs can be nominated for consideration as co-occurring disorders programs or substance abuse prevention or treatment programs, and their quality of evidence, readiness for dissemination, and training considerations are then reviewed. For more detailed information, including details about several evidence-based co-occurring trauma treatment programs, visit the NREPP Web site (http://www.nrepp.samhsa.gov). Program models for specialized groups, such as adolescents, can also be found on the NREPP Web site. For specific research-oriented information on trauma-specific treatments, refer to Part 3 of this TIP, which provides a literature review and links to select abstracts (available online).

Federal Agencies

Both the American Red Cross and the Federal Emergency Management Agency (FEMA) respond to disasters. Behavioral health service providers should understand the basics about these major emergency response agencies. For example, the Red Cross can respond rapidly with funding for food, shelter, and immediate needs, whereas FEMA assistance requires a period of gearing up but provides for longer-term needs. SAMHSA, along with other Federal agencies, assists FEMA in a number of areas of emergency response planning activities. See also SAMHSA's Disaster Technical Assistance Center Web site (http://www.samhsa.gov/dtac) and Technical Assistance Publication 34, *Disaster Planning Handbook for Behavioral Health Treatment Programs* (SAMHSA, 2013).

Trauma-Specific Treatment Models

Immediate Interventions

Intervention in the first 48 hours

The acute intervention period comprises the first 48 hours after a traumatic event. In a

"One day I was called out of bed at 5:00 a.m. to go to a town approximately 30 miles away because a levee had broken…. By 6:00 a.m., my colleagues and I were there with many of the townspeople, with helicopters flying overhead, with trucks going in and out by the main road trying to empty the factories. When we got there, as far as you could see was farmland. By 11 a.m., you could see a 'lake' in the distance. By 2 p.m., the water was on the edge of the town. Being there, at that town, before, during, and after the water came was probably the most valuable function we performed. We were able to share in the grief of the hundreds of people as we stayed with them while their fields, houses, and workplaces were flooded. We witnessed the death of a town, and the people reacted with disbelief, anger, sadness, and numbness. Each person had a different story, but all grieved, and we provided many an opportunity to express it. People cried as the water started rising into their houses. Some had to watch. Some had to leave. At times it was utterly silent as we all waited. There was a woman whose parents sent her away during the floods of '43 and she had been angry for 50 years about it. She was determined that her children and grandchildren would see everything. I spent 12 hours that day just giving support, listening, giving information, and sometimes shedding a tear or two myself."

—Rosemary Schwartzbard, Ph.D., responder to floods along the Mississippi River in 1993

Source: Schwartzbard, 1997.

disaster, rescue operations usually begin with local agencies prior to other organizations arriving on the scene. Law enforcement is likely to take a primary role on site. Whether it is a disaster, group trauma, or individual trauma (including a trauma that affects an entire family, such as a house fire), a hierarchy of needs should be established: survival, safety, security, food, shelter, health (physical and mental), orientation of survivors to immediate local services, and communication with family, friends, and community (National Institute of Mental Health, 2002). In this crucial time, appropriate interventions include educating survivors about resources; educating other providers, such as faith-based organizations and social service groups, to screen for increased psychological effects including use of substances; and use of a trauma response team that assists clients with their immediate needs. No formal interventions should be attempted at this time, but a professionally trained, empathic listener can offer solace and support (Litz & Gray, 2002).

Basic needs

Basic necessities, such as shelter, food, and water, are key to survival and a sense of safety. It is important to focus on meeting these basic needs and on providing a supportive environment. Clients' access to prescribed medications may be interrupted after a trauma, particularly a disaster, so providers should identify clients' medication needs for preexisting physical and mental disorders, including methadone or other pharmacological treatment for substance use. For example, after September 11, 2001, substance abuse treatment program administrators in New York had to seek alternative methadone administration options (Frank, Dewart, Schmeidler, & Demirjian, 2006).

Psychological first aid

The psychological first aid provided in the first 48 hours after a disaster is designed to ensure safety, provide an emotionally supportive environment and activities, identify those with high-risk reactions, and facilitate communication, including strong, reassuring leadership immediately after the event. The primary helping response of psychological first aid is to provide a calm, caring, and supportive environment to set the scene for psychological recovery. It is also essential that all those first responding to a trauma—rescue workers, medical professionals, behavioral health workers (including substance abuse counselors), journalists, and volunteers—be familiar with relevant aspects of traumatic stress. Approaching

Advice to Counselors: Core Actions in Preparing To Deliver Psychological First Aid

- Contact and engagement
- Safety and comfort
- Stabilization
- Information gathering: Current needs and concerns
- Practical assistance
- Connection with social supports
- Information on coping
- Linkage with collaborative services

Source: National Child Traumatic Stress Network & NCPTSD, 2012.

survivors with genuine respect, concern, and knowledge increases the likelihood that the caregiver can (NCPTSD, 2002):

- Answer questions about what survivors may be experiencing.
- Normalize their distress by affirming that what they are experiencing is normal.
- Help them learn to use effective coping strategies.
- Help them be aware of possible symptoms that may require additional assistance.
- Provide a positive experience that will increase their chances of seeking help if they need it in the future.

Clinical experience suggests that care be taken to respect a survivor's individual method of coping; some may want information, for example, whereas others do not. Similarly, some may want to talk about the event, but others won't. An excellent guide to providing psychological first aid is available online from the Terrorism and Disaster Branch of the National Child Traumatic Stress Network (http://www.nctsn.org/content/psychological-first-aid).

Critical incident stress debriefing

Initially developed for work with first responders and emergency personnel, critical incident stress debriefing (CISD; Mitchell & Everly, 2001) is now widely used and encompasses various group protocols used in a variety of settings. This facilitator-led group intervention is for use soon after a traumatic event with exposed people. The goal is to provide psychological closure by encouraging participants to talk about their experiences and then giving a didactic presentation on common stress reactions and management.

The widespread use of CISD has occurred despite the publication of conflicting results regarding its efficacy. Claims that single-session psychological debriefing can prevent development of chronic negative psychological sequelae are not empirically supported (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Some controlled studies suggest that it may impede natural recovery from trauma (McNally, Bryant, & Ehlers, 2003). Other research suggests emphasizing screening to determine the need for early interventions. Mitchell and Everly (2001) point out that many of the studies showing negative

Advice to Counselors: Evidence Related to Immediate Interventions

Evidence related to immediate interventions suggests that:

- Early, brief, focused psychotherapeutic intervention provided in an individual or group format can reduce distress in bereaved spouses, parents, and children.
- Selected cognitive–behavioral approaches may help reduce the incidence, duration, and severity of acute stress disorder (ASD), PTSD, and depression in trauma survivors.
- A one-session individual recital of events and expression of emotions evoked by a traumatic event does not consistently reduce risk of later developing PTSD. In fact, it may increase the risk for adverse outcomes. Perhaps CISD hinders the natural recovery mechanisms that restore pretrauma functioning (Bonanno, 2004).
- The focus initially should be upon screening with follow-up as indicated.

results were not conducted with first responders; that is, CISD may be appropriate for some, but not all, groups. A recent study of 952 U.S. peacekeepers and CISD by the U.S. Army Research Unit–Europe (Adler et al., 2008) found mixed results.

Interventions Beyond the Initial Response to Trauma

In the interest of increasing your overall familiarity with relevant approaches, the following sections review several traumatic stress treatment approaches that counselors will most likely encounter when collaborating with clinicians or agencies that specialize in trauma-specific services and treating traumatic stress.

Cognitive–behavioral therapies

Most PTSD models involve cognitive–behavioral therapy (CBT) that integrates cognitive and behavioral theories by incorporating two ideas: first, that cognitions (or thoughts) mediate between situational demands and one's attempts to respond to them effectively, and second, that behavioral change influences acceptance of altered cognitions about oneself or a situation and establishment of newly learned cognitive–behavioral interaction patterns. In practice, CBT uses a wide range of coping strategies.

There are many different varieties of CBT. CBT originated in the 1970s (Beck, Rush, Shaw & Emery, 1979; Ellis & Harper, 1975) and has expanded since then to address various populations, including people who use substances, people who experience anxiety, people with PTSD or personality disorders, children and adolescents, individuals involved in the criminal justice system, and many others. CBT has also been expanded to include various techniques, coping skills, and approaches, such as dialectical behavior therapy (DBT; Linehan, 1993), Seeking Safety (Najavits, 2002a), and mindfulness (Segal, Williams, & Teasdale, 2002). Traditional CBT emphasizes symptom reduction or resolution, but recent CBT approaches have also emphasized the therapeutic relationship, a particularly important dynamic in trauma treatment (Jackson, Nissenson, & Cloitre, 2009).

A widely accepted framework in treating trauma, substance use disorders, and mental illness categorizes therapies as single (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treatment of multiple disorders delivered by separate clinicians or in separate programs that do not necessarily address the interactions between symptoms and disorders).

CBT has been applied to the treatment of trauma and has also been widely and effectively used in the treatment of substance use. A review of efficacy research on CBT for PTSD is provided by Rothbaum, Meadows, Resick, and Foy (2000). Najavits and colleagues (2009) and O'Donnell and Cook (2006) offer an overview of CBT therapies for treating PTSD and substance abuse. In addition, a free online training resource incorporating CBT for traumatized children within the community, Trauma-Focused CBT, is available from the Medical University of South Carolina (http://tfcbt.musc.edu/).

Cognitive processing therapy

Cognitive processing therapy (CPT) is a manualized 12-session treatment approach that can be administered in a group or individual setting (Resick & Schnicke, 1992, 1993). CPT was developed for rape survivors and combines elements of existing treatments for PTSD, specifically exposure therapy (see the "Exposure Therapy" section later in this chapter) and cognitive therapy. The exposure therapy component of treatment consists of

Advice to Counselors: Relaxation Training, Biofeedback, and Breathing Retraining Strategies

Relaxation training, biofeedback, and breathing retraining strategies may help some clients cope with anxiety, a core symptom of traumatic stress. However, no evidence supports the use of relaxation and biofeedback as effective standalone PTSD treatment techniques (Cahill, Rothbaum, Resick, & Follete, 2009). Both are sometimes used as complementary strategies to manage anxiety symptoms elicited by trauma-related stimuli. Breathing retraining uses focused or controlled breathing to reduce arousal. Breathing retraining and relaxation, along with other interventions when necessary, can help clients with ASD. An important caution in the use of breath work with trauma clients is that it can sometimes act as a trigger—for example, given its focus on the body and its potential to remind them of heavy breathing that occurred during assault. Biofeedback, which requires specialized equipment, combines stress reduction strategies (e.g., progressive muscle relaxation, guided imagery) with feedback from biological system measures (e.g., heart rate, hand temperature) that gauge levels of stress or anxiety reduction. Relaxation training, which requires no specialized equipment, encourages clients to reduce anxiety responses (including physiological responses) to trauma-related stimuli; it is often part of more comprehensive PTSD treatments (e.g., prolonged exposure and stress inoculation training [SIT]).

clients writing a detailed account of their trauma, including thoughts, sensations, and emotions that were experienced during the event. The client then reads the narrative aloud during a session and at home. The cognitive therapy aspect of CPT uses six key PTSD themes identified by McCann and Pearlman (1990): safety, trust, power, control, esteem, and intimacy. The client is guided to identify cognitive distortions in these areas, such as maladaptive beliefs.

Results from randomized, placebo-controlled trials for the treatment of PTSD related to interpersonal violence (Resick, 2001; Resick, Nishith, Weaver, Astin, & Feuer, 2002) support the use of CPT. CPT and prolonged exposure therapy models are equally and highly positive in treating PTSD and depression in rape survivors; CPT is superior in reducing guilt (Nishith, Resick, & Griffin, 2002; Resick et al., 2002; Resick, Nishith, & Griffin, 2003). CPT has shown positive outcomes with refugees when administered in the refugees' native language (Schulz, Marovic-Johnson, & Huber, 2006) and with veterans (Monson et al., 2006). However, CPT has not been studied with high-complexity populations such as individuals with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. CPT requires a 3-day training plus consultation (Karlin et al., 2010). Resick and Schicke (1996) published a CPT treatment manual, *Cognitive Processing Therapy for Rape Victims: A Treatment Manual*.

Exposure therapy

Exposure therapy for PTSD asks clients to directly describe and explore trauma-related memories, objects, emotions, or places. Intense emotions are evoked (e.g., sadness, anxiety) but eventually decrease, desensitizing clients through repeated encounters with traumatic material. Careful monitoring of the pace and appropriateness of exposure-based interventions is necessary to prevent retraumatization (clients can become conditioned to fear the trauma-related material even more). Clients must have ample time to process their memories and integrate cognition and affect, so some sessions can last for 1.5 hours or more. For simple cases, exposure can work in as few as 9 sessions; more complex cases may require 20 or more sessions (Foa, Hembree, & Rothbaum, 2007). Various techniques can

Advice to Counselors: Steps for Introducing a Breathing Exercise

Use the following statements to lead clients through a breathing exercise:

- Place your hands on your stomach. As you inhale, breathe deeply but slowly so that your hands rise with your stomach. As you exhale slowly, practice breathing so that your hands drop with your stomach.
- Inhale slowly through your nose with your mouth closed; don't rush or force in the air.
- Exhale slowly through your mouth with your lips in the whistling position.
- Breathe out for twice as long as you breathe in.

expose the client to traumatic material. Two of the more common methods are exposure through imagery and in vivo ("real life") exposure.

The effectiveness of exposure therapy has been firmly established (Rothbaum et al., 2000); however, adverse reactions to exposure therapy have also been noted. Some individuals who have experienced trauma exhibit an exacerbation of symptoms during or following exposure treatments. Even so, the exacerbation may depend on counselor variables during administration. Practitioners of exposure therapy need comprehensive training to master its techniques (Karlin et al., 2010); a counselor unskilled in the methods of this treatment model can not only fail to help his or her clients, but also cause symptoms to worsen.

Exposure therapy is recommended as a first-line treatment option when the prominent trauma symptoms are intrusive thoughts, flashbacks, or trauma-related fears, panic, and avoidance. However, counselors should exercise caution when using exposure with clients who have not maintained stability in managing mental illness symptoms or abstinence from substance use disorders. Studies and routine use of exposure have consistently excluded high-complexity clients such as those with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. The only trial of exposure therapy with a substance dependence sample found that it did not outperform standard substance abuse treatment on most variables (Mills et al., 2012).

Prolonged exposure therapy for PTSD is listed in SAMHSA's NREPP. For reviews of exposure therapy, also see Najavits (2007a) and Institute of Medicine (2008). In addition to prolonged exposure therapy, other therapies incorporate exposure and desensitization techniques, including eye movement desensitization and reprocessing (EMDR; Shapiro, 2001), cognitive processing, and systematic desensitization therapies (Wolpe, 1958).

Eye movement desensitization and reprocessing

EMDR (Shapiro, 2001) is one of the most widely used therapies for trauma and PTSD. The treatment protocols of EMDR have evolved into sophisticated paradigms requiring training and, preferably, clinical supervision. EMDR draws on a variety of theoretical

A Brief Description of EMDR Therapy

Treatment involves three main concentrations (past memories, present disturbances, future actions) and eight phases. Counselors may work with several phases in one session. Each phase is meant to be revisited either in every session or when appropriate (e.g., the closure process is meant to be conducted at the end of every session, in preparation for the next).

- Phase 1: History and Treatment Planning (1-2 sessions)
- Phase 2: Preparation
- Phase 3: Assessment and Reprocessing
- Phase 4: Desensitization
- Phase 5: Installation
- Phase 6: Body Scan
- Phase 7: Closure
- Phase 8: Reevaluation

Source: EMDR Network, 2012.

frameworks, including psychoneurology, CBT, information processing, and nonverbal representation of traumatic memories. The goal of this therapy is to process the experiences that are causing problems and distress. It is an effective treatment for PTSD (Seidler & Wagner, 2006) and is accepted as an evidence-based practice by the U.S. Department of Veterans Affairs (VA), the Royal College of Psychiatrists, and the International Society for Traumatic Stress Studies (Najavits, 2007a); numerous reviews support its effectiveness (e.g., Mills et al., 2012). EMDR values the development of "resource installation" (calming procedures) and engages in exposure work to desensitize clients to traumatic material, using external tracking techniques across the visual field to assist in processing distressing material. Training in EMDR, available through the EMDR Institute, is required before counselors use this treatment. It is listed in SAMHSA's NREPP (EMDR Network, 2012). Thus far, there is no study examining the use of EMDR with clients in substance abuse treatment. See Part 3 of this TIP, available online, to review empirical work on EMDR.

Narrative therapy

Narrative therapy is an emerging approach to understanding human growth and change; it is founded on the premise that individuals are the experts on their own lives and can access their existing intrapsychic and interpersonal resources to reduce the impact of problems in their lives. Developed for the treatment of PTSD resulting from political or community violence, narrative therapy is based on CBT principles, particularly exposure therapy (Neuner, Schauer, Elbert, & Roth, 2002; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). This approach views psychotherapy not as a scientific practice, but as a natural extension of healing practices that have been present throughout human history. For a trauma survivor, the narrative, as it is told and retold, expresses the traumatic experience, puts the trauma in the context of the survivor's life, and defines the options he or she has for change. Narrative structure helps clients connect events in their lives, reveals strings of events, explores alternative expressions of trauma, evokes explanations for clients' behaviors, and identifies their knowledge and skills. The use of stories in therapy, with the client as the storyteller, generally helps lessen suffering (McLeod, 1997; White, 2004).

In the substance abuse treatment field, many clients will see a connection between narrative therapy and the process of telling their stories in 12 Step programs, in which reframing life stories of feeling trapped, despairing, and hopeless leads to stories of strength, joy, and hope. Key storytelling points at a 12 Step speaker meeting include describing what an experience was like, what happened, and what it is like now.

Skills training in affective and interpersonal regulation

Skills training in affective and interpersonal regulation (STAIR) is a two-phase cognitive–behavioral model that adapts therapies developed by others into a new package (Cloitre, Koenen, Cohen, & Han, 2002). Phase 1 consists of eight weekly sessions of skills training in affect and interpersonal regulation derived from general CBT and DBT (Linehan, 1993) and adapted to address trauma involving childhood abuse. Session topics are labeling and identifying feelings, emotion management, distress tolerance, acceptance of feelings, identifying trauma-based interpersonal schemas, identifying conflict between trauma-generated feelings and current interpersonal goals, role-plays on issues of power and control, and role-plays on developing flexibility in interpersonal situations. Phase 2 features eight

STAIR Steps

Phase 1, tailored to individual clients, is called Skills Training in Affect Regulation and consists of the following components:

- Psychoeducation: Describe the symptoms of PTSD and explain the treatment rationale.
- Training in experiencing and identifying feelings, triggers, and thoughts, as well as training in mood regulation strategies.
- Learning history: Ask the client the following questions—How did the client deal with traumas past and present? How did the client's family deal with feelings? How did the client's family life affect his or her present difficulty experiencing and identifying feeling?
- Emotion regulation skills: Identify the cognitive, behavioral, and social support modalities for coping. Use data gathered with self-monitoring forms to identify strengths and weaknesses in each coping modality. Teach skills such as breathing retraining, self-statements to reduce fear, and social skill training to improve social support.
- Acceptance and tolerance of negative affect: Motivate clients to face distressing situations related to the trauma that are important to them. Review negative repercussions of avoidance. Discuss tolerating negative affect as a step toward achieving specific goals.
- Schema therapy for improved relationships: Identify relevant schemas learned in childhood. Suggest alternative ways of viewing self and others in current relationships. Use role-playing to teach assertiveness, emphasizing response flexibility based on relative power in each relationship.

Once Phase 1 of STAIR is well learned, clients move to Phase 2, which involves exposure therapy.

Source: Mollick & Spett, 2002.

sessions of modified prolonged exposure using a narrative approach.

Cloitre and colleagues (2002) assigned women with PTSD related to childhood abuse randomly to STAIR or a minimal attention waitlist, excluding clients with current substance dependence as well as other complexities. STAIR participants showed significantly greater gains in affect regulation, interpersonal skills, and PTSD symptoms than the control participants. These gains were maintained through follow-up at 3 and 9 months. However, it is not clear from this study whether DBT and exposure were both needed. Phase 1 therapeutic alliance and negative mood regulation skills predicted Phase 2 exposure success in reducing PTSD, suggesting the importance of establishing a strong therapeutic relationship and emotion regulation skills before conducting exposure work with people who have chronic PTSD.

Stress inoculation training

SIT was originally developed to manage anxiety (Meichenbaum, 1994; Meichenbaum & Deffenbacher, 1988). Kilpatrick, Veronen, and Resick (1982) modified SIT to treat rape survivors based on the idea that the anxiety and fear that rape survivors experience during their trauma generalizes to other objectively safe situations. SIT treatment components include education, skills training (muscle relaxation training, breathing retraining, role-playing, guided self-talk, assertiveness training, and thought stopping [i.e., actively and forcefully ending negative thoughts by thinking

SIT has been used to help individuals cope with the aftermath of exposure to stressful events and on a preventative basis to "inoculate" individuals to future and ongoing stressors (Meichenbaum, 1996). This practice as a preventive strategy is similar to promoting disease resistance through immunizations.

Advice to Counselors: SIT Phases

SIT is a prevention and treatment approach that has three overlapping phases. It is often seen as a complementary approach to other interventions for traumatic stress.

Phase 1: Conceptualization and education. This phase has two main objectives. The initial goal is to develop a collaborative relationship that supports and encourages the client to confront stressors and learn new coping strategies. The next objective is to increase the client's understanding of the nature and impact of his or her stress and awareness of alternative coping skills. Many cognitive strategies are used to meet these objectives, including self-monitoring activities, Socratic questioning, identifying strengths and evidence of resilience, and modeling of coping strategies.

Phase 2: Skill acquisition and rehearsal. This phase focuses on developing coping skills and using coping skills that the individual already possesses. This process includes practice across settings, so that the individual begins to generalize the use of his or her skills across situations through rehearsal, rehearsal, and more rehearsal.

Phase 3: Implementation and following through. The main objective is to create more challenging circumstances that elicit higher stress levels for the client. By gradually increasing the challenge, the client can practice coping strategies that mimic more realistic circumstances. Through successful negotiation, the client builds a greater sense of self-efficacy. Common strategies in this phase include imagery and behavioral rehearsal, modeling, role-playing, and graded in vivo exposure.

Source: Meichenbaum, 2007.

"STOP" and then redirecting thoughts in a more positive direction]), and skills application. The goal is to help clients learn to manage their anxiety and to decrease avoidant behavior by using effective coping strategies. Randomized controlled clinical trials have indicated that SIT reduces the severity of PTSD compared with waitlist controls and shows comparable efficacy to exposure therapy. At follow-up (up to 12 months after treatment), gains were maintained (Foa et al., 1999; Foa, Rothbaum, Riggs, & Murdock, 1991).

Other therapies

Numerous interventions introduced in the past 20 years focus on traumatic stress. For some interventions, the evidence is limited, and for other others, it is evolving. One example is the traumatic incident reduction (TIR) approach. This brief memory-oriented intervention is designed for children, adolescents, and adults who have experienced traumatic stress (Valentine & Smith, 2001). Listed in SAMHSA's NREPP, the intervention is designed to process specific traumatic incidents or problematic themes related to the trauma, including specific feelings, emotions, sensations, attitudes, or pain. It involves having clients talk through the traumatic incident repeatedly with the anticipation that changes in affect will occur throughout the repetitions. TIR is a client-centered approach.

Integrated Models for Trauma

This section covers models specifically designed to treat trauma-related symptoms along with either mental or substance use disorders at the same time. Integrated treatments help clients work on several presenting problems simultaneously throughout the treatment, a promising and recommended strategy (Dass-Brailsford & Myrick, 2010; Najavits, 2002b; Nixon & Nearmy, 2011). Thus far, research is limited, but what is available suggests that integrated treatment models effectively reduce

substance abuse, PTSD symptoms, and other mental disorder symptoms. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment, 2005c), offers a detailed description of integrated treatment. In contrast with integrated models, other model types include single (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treatment of multiple disorders delivered by separate clinicians or in separate programs that do not necessarily address the interactions between symptoms and disorders).

Similar to single models, integrated treatment models are designed for use in a variety of settings (e.g., outpatient, day treatment, and/or residential substance abuse and mental health clinics/programs). Most models listed are manual-based treatments that address trauma-related symptoms, mental disorders, and substance use disorders at the same time. Additional approaches and further details on the selected approaches can be found at NREPP (http://www.nrepp.samhsa.gov).

Addiction and Trauma Recovery Integration Model

The Addiction and Trauma Recovery Integrated Model (ATRIUM; Miller & Guidry, 2001) integrates CBT and relational treatment through an emphasis on mental, physical, and spiritual health. This 12-week model for individuals and groups blends psychoeducational, process, and expressive activities, as well as information on the body's responses to addiction and traumatic stress and the impact of trauma and addiction on the mind and spirit. It helps clients explore anxiety, sexuality, self-harm, depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection. It was designed primarily for women and focuses on developmental (childhood) trauma and interpersonal violence, but it recognizes that other types of traumatic events occur.

The ATRIUM model consists of three phases of treatment. The first stage, or "outer circle," consists of the counselor collecting data from the client about his or her trauma history, offering psychoeducation on the nature of trauma, and helping the client assess personal strengths. ATRIUM actively discourages the evocation of memories of abuse or other trauma events in this phase. The second stage, or "middle circle," allows clients and counselors to address trauma symptoms more directly and specifically encourages clients to reach out to and engage with support resources in the community. The middle circle also emphasizes learning new information about trauma and developing additional coping skills. The third stage of the program, the "inner circle," focuses on challenging old beliefs that arose as a result of the trauma. For instance, the concept of "nonprotecting bystander" is used to represent the lack of support that the traumatized person experienced at the time of the trauma. This representation is replaced with the "protective presence" of supportive others today.

ATRIUM was used in one of the nine study sites of SAMHSA's Women, Co-Occurring Disorders and Violence Study. Across all sites, trauma-specific models achieved more favorable outcomes than control sites that did not use trauma-specific models (Morrissey et al., 2005). There has not yet been a study of ATRIUM per se, however. A manual describing the theory behind this model in greater depth, as well as how to implement it, is published under the title *Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit* (Miller & Guidry, 2001).

Beyond Trauma: A Healing Journey for Women

Beyond Trauma (Covington, 2003) is a curriculum for women's services based on theory, research, and clinical experience. It was developed for use in residential, outpatient, and correctional settings; domestic violence programs; and mental health clinics. It uses behavioral techniques and expressive arts and is based on relational therapy. Although the materials are designed for trauma treatment, the connection between trauma and substance abuse in women's lives is a theme throughout. Beyond Trauma has a psychoeducational component that defines trauma by way of its process as well as its impact on the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). Coping skills are emphasized; specific exercises develop emotional wellness.

Concurrent Treatment of PTSD and Cocaine Dependence

Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD) is a 16-session, twice-weekly individual outpatient psychotherapy model designed to treat women and men with co-occurring PTSD and cocaine dependence (Coffey, Schumacher, Brimo, & Brady, 2005). CTPCD combines imagery and in vivo exposure therapy (in which the client becomes desensitized to anxiety-producing stimuli through repeated exposure to them) for the treatment of PTSD with elements of CBT for substance dependence. To balance the dual needs of abstinence skill building and prompt trauma treatment, the first five sessions focus on coping skills for cocaine dependence. Session six transitions into exposure therapy, which begins in earnest in session seven and is combined with CBT for the treatment of substance abuse.

CTPCD helps reduce substance use and PTSD symptoms. The use of any illicit drug, as measured by urine screens, was quite low during the 16-week treatment trial and didn't escalate during the second half of treatment—when most exposure sessions occurred. PTSD symptoms dropped significantly over the course of treatment, as did self-reported depressive symptoms; however, the dropout rate was high (Coffey, Dansky, & Brady, 2003). CTPCD was reformulated into Concurrent Prolonged Exposure (COPE; Mills et al., 2012), which was compared with treatment as usual in a high-complexity clinical sample of individuals who had PTSD and substance dependence. Both treatment conditions resulted in improvements in PTSD with no difference at 3 months (though COPE showed significantly greater improvement at 9 months); moreover, the two conditions did not differ in impact on substance use outcomes, depression, or anxiety.

Integrated CBT

Integrated CBT is a 14-session individual therapy model designed for PTSD and substance use. It incorporates elements such as psychoeducation, cognitive restructuring, and breathing retraining (McGovern, Lamber-Harris, Alterman, Xie, & Meier, 2011). A randomized controlled trial showed that both integrated CBT and individual addiction treatment achieved improvements in substance use and other measures of psychiatric symptom severity with no difference between the treatments.

Seeking Safety

Seeking Safety is an empirically validated, present-focused treatment model that helps clients attain safety from trauma and substance abuse (Najavits, 2002a). The Seeking Safety manual (Najavits, 2002b) offers clinician guidelines and client handouts and is available in

several languages. Training videos and other implementation materials are available online (http://www.seekingsafety.org). Seeking Safety is flexible; it can be used for groups and individuals, with women and men, in all settings and levels of care, by all clinicians, for all types of trauma and substance abuse.

Seeking Safety covers 25 topics that address cognitive, behavioral, interpersonal, and case management domains. The topics can be conducted in any order, using as few or as many as are possible within a client's course of treatment. Each topic represents a coping skill relevant to both trauma and substance abuse, such as compassion, taking good care of yourself, healing from anger, coping with triggers, and asking for help. This treatment model builds hope through an emphasis on ideals and simple, emotionally evocative language and quotations. It attends to clinician processes and offers concrete strategies that are thought to be essential for clients dealing with concurrent substance use disorders and histories of trauma.

More than 20 published studies (which include pilot studies, randomized controlled trials, and multisite trials representing various investigators and populations) provide the evidence base for this treatment model. For more information, see SAMHSA's NREPP Web site (http://www.nrepp.samhsa.gov) as well as the "Outcomes" section of the Seeking Safety Web site (http://www.seekingsafety.org/3-03-06/studies.html). Study samples included people with chronic, severe trauma symptoms and substance dependence who were diverse in ethnicity and were treated in a range of settings (e.g., criminal justice, VA centers, adolescent treatment, homelessness services, public sector). Seeking Safety has shown positive outcomes on trauma symptoms, substance abuse, and other domains (e.g., suicidality, HIV risk, social functioning, problem-solving, sense of meaning); consistently outperformed treatment as usual; and achieved high satisfaction ratings from both clients and clinicians. It has been translated into seven languages, and a version for blind and/or dyslexic individuals is available.

The five key elements of Seeking Safety are:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
2. Integrated treatment (working on trauma and substance abuse at the same time).
3. A focus on ideals to counteract the loss of ideals in both trauma and substance abuse.
4. Four content areas: cognitive, behavioral, interpersonal, and case management.
5. Attention to clinician processes (addressing countertransference, self-care, and other issues).

Substance Dependence PTSD Therapy

Substance Dependence PTSD Therapy (Triffleman, 2000) was designed to help clients of both sexes cope with a broad range of traumas. It combines existing treatments for PTSD and substance abuse into a structured, 40-session (5-month, twice-weekly) individual therapy that occurs in two phases. Phase I is "Trauma-Informed, Addictions-Focused Treatment" and focuses on coping skills and cognitive interventions as well as creating a safe environment. Phase I draws on CBT models, anger management, relaxation training, HIV risk reduction, and motivational enhancement techniques. Phase II, "Trauma-Focused, Addictions-Informed Treatment," begins with psychoeducation about PTSD followed by "Anti-Avoidance I," in which a modified version of stress inoculation training is taught in two to four sessions. Following this is "Anti-Avoidance II," lasting 6 to 10 sessions, in which in vivo exposure is used.

Trauma Affect Regulation: Guide for Education and Therapy

Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford & Russo, 2006; Frisman, Ford, Lin, Mallon, & Chang, 2008) uses emotion and information processing in a present-focused, strengths-based approach to education and skills training for trauma survivors with severe mental, substance use, and co-occurring disorders across diverse populations. TARGET helps trauma survivors understand how trauma changes the brain's

TARGET: The Seven-Step FREEDOM Approach

Focus: Being focused helps a person pay attention and think about what's happening right now instead of just reacting based on alarm signals tied to past trauma. This step teaches participants to use the SOS skill (Slow down, Orient, Self-check) to pay attention to body signals and the immediate environment and to use a simple scale to measure stress and control levels.

Recognize triggers: Recognizing trauma triggers enables a person to anticipate and reset alarm signals as he or she learns to distinguish between a real threat and a reminder. This step helps participants identify personal triggers, take control, and short-circuit their alarm reactions.

Emotion self-check: The goal of this skill is to identify two types of emotions. The first are "alarm" or reactive emotions such as terror, rage, shame, hopelessness, and guilt. Because these emotions are the most noticeable after trauma, they are the alarm system's way of keeping a person primed and ready to fend off further danger. The second type of emotion, "main" emotions, include positive feelings (e.g., happiness, love, comfort, compassion) and feelings that represent positive strivings (e.g., hope, interest, confidence). By balancing both kinds of emotions, a person can reflect and draw on his or her own values and hopes even when the alarm is activated.

Evaluate thoughts: When the brain is in alarm mode, thinking tends to be rigid, global, and catastrophic. Evaluating thoughts, as with identifying emotions, is about achieving a healthier balance of positive as well as negative thinking. Through a two-part process, participants learn to evaluate the situation and their options with a focus on how they choose to act—moving from reactive thoughts to "main" thoughts. This is a fundamental change from the PTSD pattern, which causes problems by taking a person straight from alarm signals to automatic survival reactions.

Define goals: Reactive goals tend to be limited to just making it through the immediate situation or away from the source of danger. These reactive goals are necessary in true emergencies but don't reflect a person's "main" goals of doing worthwhile things and ultimately achieving a good and meaningful life. This step teaches one how to create "main" goals that reflect his or her deeper hopes and values.

Options: The only options that are available when the brain's alarm is turned on and won't turn off are automatic "flight/fight" or "freeze/submit" reactive behaviors that are necessary in emergencies but often unhelpful in ordinary living. This step helps identify positive intentions often hidden by the more extreme reactive options generated by the alarm system. This opens the possibility for a greater range of options that take into consideration one's own needs and goals as well as those of others.

Make a contribution: When the brain's alarm is turned on and reacting to ordinary stressors as if they were emergencies, it is very difficult for a person to come away from experiences with a feeling that they have made a positive difference. This can lead to feelings of alienation, worthlessness, or spiritual distress. The ultimate goal of TARGET is to empower adults and young people to think clearly enough to feel in control of their alarm reactions and, as a result, to be able to recognize the contribution they are making not only to their own lives, but to others' lives as well.

Source: Advanced Trauma Solutions, 2012.

normal stress response into an extreme survival-based alarm response that can lead to PTSD, and it teaches them a seven-step approach to making the PTSD alarm response less distressing and more adaptive (summarized by the acronym FREEDOM: Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution).

TARGET can be presented in individual therapy or gender-specific psychoeducational groups, and it has been adapted for individuals who are deaf; it has also been translated into Spanish and Dutch. TARGET is a resilience-building and recovery program not limited to individual or group psychotherapy; it is also designed to provide an educational curriculum and milieu intervention that affects all areas of practice in school, therapeutic, or correctional programs. TARGET is listed in SAMHSA's NREPP (http://www.nrepp.samhsa.gov).

Trauma Recovery and Empowerment Model

The trauma recovery and empowerment model (TREM) of therapy (Fallot & Harris, 2002; Harris & Community Connections Trauma Work Group, 1998) is a manualized group intervention designed for female trauma survivors with severe mental disorders. TREM addresses the complexity of long-term adaptation to trauma and attends to a range of difficulties common among survivors of sexual and physical abuse. TREM focuses mainly on developing specific recovery skills and current functioning and uses techniques that are effective in trauma recovery services. The model's content and structure, which cover 33 topics, are informed by the role of gender in women's experience of and coping with trauma.

TREM can be adapted for shorter-term residential settings and outpatient substance abuse treatment settings, among others. Adaptations of the model for men and adolescents are available. The model was used in SAMHSA's Women, Co-Occurring Disorders and Violence Study for three of the nine study sites and in SAMHSA's Homeless Families program, and it is listed in SAMHSA's NREPP. This model has been used with clients in substance abuse treatment; research by Toussaint, VanDeMark, Bornemann, and Graeber (2007) shows that women in a residential substance abuse treatment program showed significantly better trauma treatment outcomes using TREM than they did in treatment as usual, but no difference in substance use.

TREM Program Format

Each session includes an experiential exercise to promote group cohesiveness. The 33 sessions are divided into the following general topic areas:

- **Part I–empowerment** introduces gender identity concepts, interpersonal boundaries, and self-esteem.
- **Part II–trauma recovery** concentrates on sexual, physical, and emotional abuse and their relationship to psychiatric symptoms, substance abuse, and relational patterns and issues.
- **Part III–advanced trauma recovery issues** addresses additional trauma issues, such as blame and the role of forgiveness.
- **Part IV–closing rituals** allows participants to assess their progress and encourages them to plan for their continued healing, either on their own or as part of a community of other survivors.
- **Part V–modifications or supplements for special populations** provides modifications for subgroups such as women with serious mental illness, incarcerated women, women who are parents, women who abuse substances, and male survivors.

Source: Mental Health America Centers for Technical Assistance, 2012.

Triad Women's Project

The Triad Project was developed as a part of SAMHSA's Women, Co-Occurring Disorders and Violence Study. It is a comprehensive, trauma-informed, consumer-responsive integrated model designed for female trauma survivors with co-occurring substance use and mental disorders who live in semirural areas. Triad integrates motivational enhancement for substance use disorders, DBT, and intensive case management techniques for co-occurring mental disorders. This program is a 16-week group intervention for women that uses integrated case management services, a curriculum-based treatment group, and a peer support group (Clark & Fearday, 2003).

Emerging Interventions

New interventions are emerging to address traumatic stress symptoms and disorders. The following sections summarize a few interventions not highlighted in prior chapters; this is not an exhaustive list. In addition to specific interventions, technology is beginning to shape the delivery of care and to increase accessibility to tools that complement trauma-specific treatments. Numerous applications are available and evolving. For more information on the role of technology in the delivery of care, see the planned TIP, *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (SAMHSA, planned g).

Couple and Family Therapy

Trauma and traumatic stress affects significant relationships, including the survivor's family. Although minimal research has targeted the effectiveness of family therapy with trauma survivors, it is important to consider the needs of the individual in the context of their relationships. Family and couples therapy may be key to recovery. Family members may experience secondary traumatization silently, lack understanding of traumatic stress symptoms or treatment, and/or have their own histories of trauma that influence their willingness to support the client in the family or to talk about anything related to trauma and its effects. Family members can engage in similar patterns of avoidance and have their own triggers related to the trauma being addressed at the time. A range of couple and family therapies have addressed traumatic stress and PTSD, but few studies exist that support or refute their value. Current couple or family therapies that have some science-based evidence include behavioral family therapy, behavioral marital therapy, cognitive–behavioral couples treatment, and lifestyle management courses (Riggs, Monson, Glynn, & Canterino, 2009).

Mindfulness Interventions

Mindfulness is a process of learning to be present in the moment and observing internal experience (e.g., thoughts, bodily sensations) and external experience (e.g., interactions with others) in a nonjudgmental way. Mindfulness challenges limiting beliefs that arise from trauma, quells anxiety about future events, and simply helps one stay grounded in the present. It plays a significant role in helping individuals who have been traumatized observe their experiences, increase awareness, and tolerate uncomfortable emotions and cognitions.

To date, mindfulness-based interventions appear to be valuable as an adjunct to trauma-specific interventions and in decreasing arousal (Baer, 2003). It may also help individuals tolerate discomfort during exposure-oriented and trauma processing interventions. Overall, mindfulness practices can help clients in managing traumatic stress, coping, and resilience. In a study of firefighters, mindfulness was associated with fewer PTSD symptoms, depressive symptoms, physical symptoms, and alcohol problems when controlling for other variables (Smith et al., 2011).

Becoming an Observer and Learning To Tolerate Discomfort: The Leaf and Stream Metaphor

The following exercise, "leaves floating on a stream," is a classic. Many clinicians and authors provide renditions of this mindfulness practice. The main objectives are to stand back and observe thoughts rather than get caught up in them. Simply stated, thoughts are just thoughts. Thoughts come and go like water flowing down a stream. We don't need to react to the thoughts; instead, we can just notice them.

Conduct the mindfulness exercise for about 10 minutes, then process afterward. Take time to allow participants to visualize each sense as they imagine themselves sitting next to the stream. For example, what does it look like? What do they hear as they sit next to the stream? Don't rush the exercise. As you slowly make the statements detailed in the following two paragraphs, take time in between each statement for participants to be in the exercise without interruption; simply offer gentle guidance.

Begin to sit quietly, bringing your attention to your breath. If you feel comfortable, close your eyes. As you focus on breathing in and out, imagine that you are sitting next to a stream. In your imagination, you may clearly see and hear the stream, or you may have difficulty visualizing the stream. Follow along with the guided exercise; either way, it will work just as well.

Now begin to notice the thoughts that come into your mind. Some thoughts rush by, while others linger. Just allow yourself to notice your thoughts. As you begin to notice each thought, imagine putting those words onto a leaf as it floats by on the stream. Just let the thoughts come, watching them drift by on the leaves. If your thoughts briefly stop, continue to watch the water flow down the stream. Eventually, your thoughts will come again. Just let them come, and as they do, place them onto a leaf. Your attention may wander. Painful feelings may arise. You may feel uncomfortable or start to think that the exercise is "stupid." You may hook onto a thought—rehashing it repeatedly. That's okay; it's what our minds do. As soon as you notice your mind wandering or getting stuck, just gently bring your focus back to your thoughts, and place them onto the leaves. Now, bring your attention back to your breath for a moment, then open your eyes and become more aware of your environment.

Facilitated Questions:

- What was it like for you to observe your thoughts?
- Did you get distracted? Stuck?
- Were you able to bring yourself back to the exercise after getting distracted?
- In what ways was the exercise uncomfortable?
- In what ways was the exercise comforting?

For clients and practitioners who want to develop a greater capacity for mindfulness, see Kabat-Zinn's books *Wherever You Go, There You Are: Mindfulness Meditation In Everyday Life* (1994) and *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* (1990). For clinical applications of mindfulness, see *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse* (Segal et al., 2002) and *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors* (Marlatt & Donovan, 2005).

Pharmacological Therapy

Pharmacotherapy for people with mental, substance use, and traumatic stress disorders needs to be carefully managed by physicians who are well versed in the treatment of each condition. Medications can help manage and control symptoms; however, they are only a part of a comprehensive treatment plan. There

are no specific "antitrauma" drugs; rather, certain drugs target specific trauma symptoms. Clients receiving pharmacotherapy need careful assessment. Some clients with preexisting mental disorders may need further adjustment in medications due to the physiological effects of traumatic stress. In addition, sudden withdrawal from a pattern of self-administered substances can not only lead to dangerous levels of physical distress, but also exacerbate the emergence of more severe PTSD symptoms. Distress after trauma often lessens over time, which can sometimes make the use of medications unnecessary for some individuals. Some trauma survivors do not develop long-term psychological problems from their experiences that require medication; others may simply refuse the initiation of pharmacotherapy or the use of additional medications.

Concluding Note

Behavioral health counselors can best serve clients who have experienced trauma by providing integrated treatment that combines therapeutic models to target presenting symptoms and disorders. Doing so acknowledges that the disorders interact with each other. Some models have integrated curricula; others that address trauma alone can be combined with behavioral health techniques with which the counselor is already familiar.

In part, the choice of a treatment model or general approach will depend on the level of evidence for the model, the counselor's training, identified problems, the potential for prevention, and the client's goals and readiness for treatment. Are improved relationships with family members a goal? Will the client be satisfied if sleep problems decrease, or is the goal resolution of broader issues? Are there substance use or substance-related disorders? Is the goal abstinence? Collaborating with clients to decide on goals, eliciting what they would like from treatment, and determining what they expect to happen can provide some clues as to what treatment models or techniques might be successful in keeping clients engaged in recovery.

Part 2: An Implementation Guide for Behavioral Health Program Administrators

1 Trauma-Informed Organizations

IN THIS CHAPTER

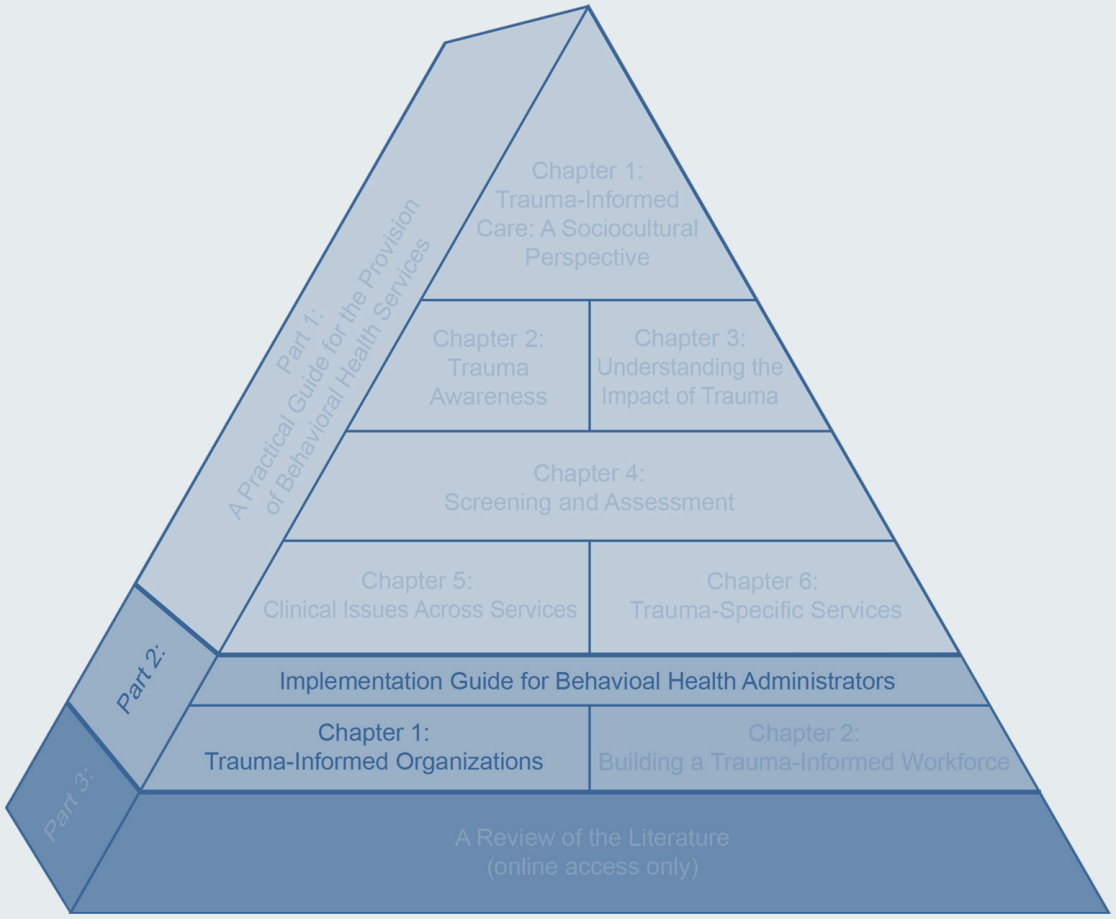
- Show Organizational and Administrative Commitment to TIC
- Use Trauma Informed Principles in Strategic Planning
- Review and Update Vision, Mission, and Value Statements
- Assign a Key Staff Member To Facilitate Change
- Create a Trauma Informed Oversight Committee
- Conduct an Organizational Self Assessment of Trauma Informed Services
- Develop an Implementation Plan
- Develop Policies and Procedures To Ensure Trauma Informed Practices and To Prevent Retraumatization
- Develop a Disaster Plan
- Incorporate Universal Routine Screenings
- Apply Culturally Responsive Principles
- Use Science Based Knowledge
- Create a Peer Support Environment
- Obtain Ongoing Feedback and Evaluations
- Change the Environment To Increase Safety
- Develop Trauma Informed Collaborations

Part 2 provides a broad overview of how to create and implement an institutional framework for trauma-informed services in program delivery and staff development, policies and procedures, administrative practices, and organizational infrastructure in behavioral health services. Chapter 1, "Trauma-Informed Organizations," focuses on specific organizational strategies that will help develop a trauma-informed culture in behavioral health settings. Numerous strategies are presented, including organizational commitment to trauma-informed care (TIC), trauma-informed organizational assessment, implementation of universal screening for trauma, and creation of a peer support environment.

Chapter 2, "Building a Trauma-Informed Workforce," focuses on organizational activities that foster the development of a trauma-informed workforce, including recruiting, hiring, and retaining trauma-informed staff; providing training on evidence-based and emerging trauma-informed best practices; developing competencies specific to TIC; addressing ethical considerations; providing trauma-informed supervision; and preventing and treating secondary trauma in behavioral health service providers.

The strategies described in the following sections can help supervisors and other administrative staff members create a trauma-informed behavioral health environment. As a starting point, the administration should identify key personnel and consumers to guide the organizational change process and the organizational assessment. Administrators and supervisors need to plan for and demonstrate an ongoing commitment to these strategies, or staff may perceive development activities as comprising yet another idea or demand from the agency that is short-lived beyond the initial thrust of training.

TIC Framework in Behavioral Health Services—Trauma-Informed Organizations



Creating a trauma-informed organization is a fluid, ongoing process; it has no completion date. Consumer demographics change across time, exposure to specific types of trauma may become more prevalent, and knowledge of best and evidence-based practices (EBPs) will continue to advance. A trauma-informed organization continues to demonstrate a commitment to compassionate and effective practices and organizational reassessments, and it changes to meet the needs of consumers with histories of trauma. It is encouraging that recent Substance Abuse and Mental Health Services Administration (SAMHSA) data indicates that the majority of over 10,000 programs they surveyed state that they provide trauma-related care (Capezza & Najavits, 2012). However, there remains a major need to make TIC consistently high-quality, routine, and pervasive across treatment systems.

The following stages form the basis of creating a trauma-informed organization:

1. Commit to creating a trauma-informed agency.
2. Create an initial infrastructure to initiate, support, and guide changes.
3. Involve key stakeholders, including consumers who have histories of trauma.
4. Assess whether and to what extent the organization's current policies, procedures, and operations either support TIC or interfere with the development of a trauma-informed approach.
5. Develop an organizational plan to implement and support the delivery of TIC within the agency.

Trauma-Informed Services and Service Systems

"A trauma-informed service system and/or organization is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence and trauma play in the lives of people seeking mental health and addiction services. A 'trauma-informed' organizational environment is capable of supporting and sustaining 'trauma-specific' services as they develop. A trauma-informed system recognizes that trauma results in multiple vulnerabilities and affects many aspects of a survivor's life over the lifespan, and therefore coordinates and integrates trauma-related activities and training with other systems of care serving trauma survivors. A basic understanding of trauma and trauma dynamics…should be held by all staff and should be used to design systems of services in a manner that accommodates the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid retraumatization and facilitate consumer participation in treatment. A trauma-informed service system is knowledgeable and competent to recognize and respond effectively to adults and children traumatically impacted by any of a range of overwhelming adverse experiences, both interpersonal in nature and caused by natural events and disasters. There should be written plans and procedures to develop a trauma-informed service system and/or trauma-informed organizations and facilities with methods to identify and monitor progress. Training programs for this purpose should be implemented."

Source: Jennings, 2009, pp. 111–112.

6. Create collaborations between providers and consumers and among service providers and various community agencies.
7. Put the organizational plan into action.
8. Reassess the implementation of the plan and its ability to meet the needs of consumers and to provide consistent TIC on an ongoing basis.
9. Implement quality improvement measures as needs and problem areas are identified.
10. Institute practices that support sustainability, such as ongoing training, clinical supervision, consumer participation and feedback, and resource allocation.

Strategy #1: Show Organizational and Administrative Commitment to TIC

Foremost, administrators need to understand the impact that trauma can have on people's lives. The consistent delivery of TIC is only as effective as the organization's commitment, which must extend to administrative practices with staff members, program policies and procedures, program design, staffing patterns, use of peer support, staff and peer training and supervision, organizational assessment and consumer feedback, and resources to uphold trauma-informed principles and practices. Even short-term change is not sustainable without the agency's continual commitment.

Typically, desirable organizational change doesn't occur by accident. It comes from steadfast leadership, a convincing message that change is necessary and beneficial for staff and consumers, and resources that support change. Many people naturally resist change; thus, an organization's commitment includes a willingness to discuss with staff members the impact and role of trauma in their service setting, patience in planning and implementation, and

Seminal Resource for Administrators

As you investigate how best to implement or improve trauma informed services within your organization or across systems, review the influential work, *Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services.*

(Harris & Fallot, 2001c)

Advice to Administrators: Managing Staff Reactions to Implementation of New Processes or Ideas

A common hurdle for administrators after introducing a new process or idea is the staff assumption that it will require more work. Frontline staff members are often inundated with many responsibilities beyond face-to-face time with clients. In addition, a common misperception is that if you begin to address trauma, you will have difficulty containing it.

In addition to administrative buy-in, administrators must promote rather than simply announce the implementation of trauma-informed services. Promotion includes educating staff about the rationale for trauma-informed services, offering opportunities for discussion and input from staff and consumers, providing training focused on trauma-informed skills, and so forth. For example, the San Diego Trauma-Informed Guide Team (2012) created a promotional brochure on how TIC can make staff jobs easier:

- Focuses on root problem
- Is preventative
- Increases support system
- Facilitates collaboration
- Shares workload
- Empowers client
- Provides consistency in agencies/systems
- Uses evidence-based best practices

TIC may be cost-effective, lead to less intensive services and less use of services, prevent undue stress for staff members and clients, and prevent client crises caused by old policies that could retraumatize trauma survivors.

the ability to tolerate the uncertainty that naturally accompanies transitions.

Strategy #2: Use Trauma-Informed Principles in Strategic Planning

Strategic planning provides an opportunity to explore and develop short- and long-term goals. The planning process often begins with reevaluating the organizations' values, mission, and vision, yet agencies cannot adequately develop a trauma-informed strategic plan without obtaining specific information about internal (staff, resources, processes) and external environmental (referral constellation, changes in health care, funding sources, State and Federal standards, community needs, consumer demographics, etc.) factors and influences. Data gathered through staff, consumer, organizational, and community assessments shapes the direction of the plan, including projected demands, challenges, obstacles, strengths, weaknesses, and resources. At the conclusion of this planning process, the organization will have specific goals, objectives, and tasks to meet the needs of their stakeholders and to address any anticipated challenges. Ideally, strategic planning should define key steps in developing or refining trauma-informed services within the organization.

Strategy #3: Review and Update Vision, Mission, and Value Statements

Vision, mission, and value statements provide a conceptual framework for TIC development and delivery. They should not be created in isolation; they should reflect voices from the community, populations, and other stakeholders that the organization serves. These statements develop through input, discussion, and assessment. They are not static; they evolve as needs, populations, or environments change.

Statement Example

As behavioral health service providers, we strive to be trauma aware—to understand the dynamics and impact of trauma on the lives of individuals, families, and communities. We strive to create a trauma-sensitive culture by demonstrating, through consumer empowerment, program design, and direct care, an understanding of the relationships among trauma, substance abuse, and mental illness.

Advice to Administrators: How To Create Vision, Value, and Mission Statements

Define the organization's vision, values, and mission to be compatible with TIC. Emphasize the organizational culture needed to provide TIC. An outgrowth of that cultural shift may include an enhanced working environment for employees and consumers that is noncoercive and reduces conflicts, restraint, and seclusion. Even if the current mission statement is appropriate, change it anyway to symbolize intended change within the organization. To define or redefine the vision, values, and mission:

- Involve consumers, all levels of staff, and leadership, including the director/CEO.
- Review:
  - Organizational priorities to identify and manage conflicting priorities.
  - Resources to assess whether reallocation is necessary for change (e.g., to hire peer support specialists, to furnish comfort rooms).
- Operationalize the vision, values, and mission at the level of individual departments
- Evaluate progress at regular staff meetings to ensure that changing the culture of care stays on the agenda.

Source: New Logic Organizational Learning, 2011.

Strategy #4: Assign a Key Staff Member To Facilitate Change

Prior to the development of an oversight committee, a senior staff member with the authority to initiate and implement changes should be assigned to oversee the developmental process. By assigning a trauma-aware senior staff member who is committed to trauma-informed services, it is more likely that the organization's and committee's goals, objectives, and plans will remain in focus. This senior staff member is responsible for ongoing development and facilitation of the oversight committee; management of the initial organizational assessment, reassessments, and other evaluative and feedback processes; and facilitation and oversight of the implementation plan and subsequent changes, including policies and procedures to ensure delivery of TIC.

Strategy #5: Create a Trauma-Informed Oversight Committee

The role of the oversight committee includes providing ongoing input and direction in the initial organizational assessment, strategic plan, plan implementation, reevaluation and development of trauma-informed policies and procedures, and future reassessments. The committee monitors progress and uses real-time data to forge a clear pathway to new processes that support TIC. The committee should involve stakeholders from the community, consumers, specialists, staff members, and administrators. Leadership involvement is necessary. Stakeholders may be alumni, family members, community-based organizations, and other institutions that interact with the agency or would benefit from trauma-informed services.

Initially, the agency must educate the committee on the organization's mission, values, and vision as well as the task at hand—developing trauma-informed services. To ease potential conflicts or confusion about the organization's structure, the guidelines, expectations, and roles of the committee need to be communicated directly to committee members as well as the organization as a whole, including board members, support and professional staff, supervisors, and so forth. The committee also needs to know the extent of their power and the necessary lines of communication before, during, and after evaluating and implementing changes in the organization.

Including consumers and/or those who have lived through trauma is vital. They have unique knowledge, experiences, and perspectives on the impact of treatment design, delivery, policies, and procedures. They offer firsthand information on practices that can potentially retraumatize clients in behavioral health settings and can suggest preventive, alternative practices and solutions. Consumer committee members keep staff and administrators aware of the goal of achieving TIC.

Strategy #6: Conduct an Organizational Self-Assessment of Trauma-Informed Services

An organizational self-assessment evaluates the presence and/or the effectiveness of current trauma-informed practices across each service and level of the organization. This assessment allows an organization to see how it functions within the context of trauma-informed principles and provides feedback to inform the development or revision of the implementation plan for TIC. In essence, this assessment process can serve as a blueprint for change and as a benchmark of compliance with and progress in implementing trauma-informed practices across time. Overall, it is a process of identifying organizational strengths, weaknesses, opportunities, and threats related to the implementation and maintenance of TIC. Refer to Appendix F for sample organizational assessment tools for the organization and the consumer.

The self-assessment should obtain feedback from key stakeholders, particularly consumers, family members, referral sources, community organizations, and all levels of the organization's staff, including nonclinical and clinical staff, supervisors, and administrative personnel. Similar to the universal screening process, an organizational self-assessment is only as effective as the steps taken after data are gathered and analyzed. From this assessment, an implementation plan should be established that highlights the goals, objectives, steps, timeframe, and personnel responsible in overseeing the specific objective. Assessment shouldn't be a once-and-done project. Timely and regularly scheduled organizational assessments should follow to assist in quality improvement. For an explanation of more detailed steps to take in conducting an organizational self-assessment, see Chapter 4 of the planned Treatment Improvement Protocol (TIP), *Improving Cultural Competence* (SAMHSA, planned c).

Advice to Administrators: Ten Steps to Quality Improvement

1. Identify new goals or problems.
2. Gather input from each level of the organization, including consumers and other key stakeholders.
3. Analyze the feedback.
4. Explore improvement options and the potential barriers associated with each.
5. Select the overall approach and specific strategies to address barriers (anticipate barriers, and try to address them before they occur).
6. Develop an implementation plan, and then present the plan to staff members and other key stakeholders not directly involved in the quality improvement process.
7. Implement the plan.
8. Reassess the new plan.
9. Evaluate the results and determine if new goals or additional problems or issues need to be addressed.
10. Repeat the first nine steps.

Strategy #7: Develop an Implementation Plan

Implementation plans should evolve from consumer participation, demographic profiles

Advice to Administrators: Implementation Plan Content

1. **Introduction and overview:** This includes the organization's history, the demographics that characterize its client base, the rationale for the implementation plan, and the incorporation of TIC. Focus on identification of strengths, weaknesses, opportunities, and threats. Provide an overview of goals and objectives.
2. **Specific goals and objectives:** Goals and objectives should address:
   - Workforce development strategies for recruiting, hiring, retaining, training, supervising, and promoting wellness of clinical and nonclinical staff members to support TIC.
   - Consumer participation and peer support development and implementation strategies.
   - Policies, procedures, and practices to support TIC and culturally responsive services, to promote safety, and to prevent retraumatization.
   - Specific evidence-based or best practice adoptions to support TIC.
   - Strategies to amend facility design or environment (plant) operations to reinforce safety.
   - Fiscal planning to ensure sustainability of the steps initiated in the organization.
3. **Guidelines for implementation:** Guidelines should highlight the specific steps, roles, responsibilities, and timeframes for each activity to meet TIC objectives.

of populations served, data from organizational self-assessment, and research on promising and evidence-based trauma-informed practices. Using the framework proposed in this TIP, the oversight committee is responsible for designing a plan that outlines the purpose, goals, objectives, timeframes, and personnel responsible for each objective (Exhibit 2.1-1).

Exhibit 2.1-1: TIC Planning Guidelines

The following publications provide samples of organizational guidelines for implementing TIC.

- Fallot, R. D. & Harris, M. (2009). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.* Washington, DC: Community Connections, 2009.
- Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-informed organizational toolkit.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W. K. Kellogg Foundation.
- Huckshorn, K. (2009). Transforming cultures of care toward recovery oriented services: Guidelines toward creating a trauma informed system of care. In *Trauma informed care (TIC) planning guidelines for use in developing an organizational action plan.* Alexandria, VA: National Association of State Mental Health Program Directors.
- Jennings, A. (2009). *Criteria for building a trauma-informed mental health service system.* Retrieved on May 21, 2013, from http://www.theannainstitute.org/CBTIMHSS.pdf
- Ohio Legal Rights Service (2007). *Trauma-informed treatment in behavioral health settings.* Columbus, OH: Ohio Legal Rights Service.
- Prescott, L., Soares, P., Konnath, K., & Bassuk, E. (2008). *A long journey home: A guide for creating trauma-informed services for mothers and children experiencing homelessness* [draft]. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W.K. Kellogg Foundation.

The following resource is a systemwide set of guidelines for implementing TIC.

- U.S. Department of Health and Human Services, Health Resources and Services Administration (2006). *Model trauma system: Planning and evaluation.* Rockville, MD: Health Resources and Services Administration.

Strategy #8: Develop Policies and Procedures To Ensure Trauma-Informed Practices and To Prevent Retraumatization

In the early stage of evaluating current services and planning for TIC, the committee needs to assess practices, procedures, and policies that may have been or could be retraumatizing to any individual, at any level of the organization, from consumers to administrators. Programs that are not trauma informed are as likely to be unaware of the impact of trauma on staff as they are to be unaware of its influence on consumers. In the initial review, careful scrutiny should be used to eliminate any practice that is potentially harmful, including seclusion and restraint practices, therapeutic activities that are shaming, treatment planning without collaboration, any medical inquiry without privacy, and so forth.

Policies and procedures are the building blocks of each agency. They guide the service process and, if followed, they provide an opportunity for the agency to deliver consistent responses and care. Policies and procedures must incorporate trauma-informed practices across all domains and standards, such as admissions, plant/environmental standards, screening and assessment processes, referrals (to other services, including hospitalization, or for further evaluations), treatment planning, confidentiality, discharge, and more. They also need to be updated periodically to incorporate new science and to meet the changing needs of consumers. By regularly reviewing and adapting administrative and clinical policies and procedures in response to ever-changing needs and evidence, the agency can provide staff members with good guidelines for providing trauma-informed services that are consistent yet flexible.

Program Curriculum: Roadmap to Seclusion-Free and Restraint-Free Mental Health Services

This curriculum, written from consumer perspectives, provides behavioral health staff with education, strategies, and hands-on tools to prevent and ultimately eliminate the use of seclusion and restraint. It includes many handouts for participants and consumers. This training package, available online (http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055), is divided into seven modules plus a resources section:

- Module 1: The Personal Experience of Seclusion and Restraint
- Module 2: Understanding the Impact of Trauma
- Module 3: Creating Cultural Change
- Module 4: Understanding Resilience and Recovery from the Consumer Perspective
- Module 5: Strategies to Prevent Seclusion and Restraint
- Module 6: Sustaining Change Through Consumer and Staff Involvement
- Module 7: Review and Action Plan
- Resource Section

Source: Center for Mental Health Services (CMHS), SAMHSA, 2005.

Strategy #9: Develop a Disaster Plan

Facilities are often required to develop disaster plans, but specific requirements vary from State to State. From the outset, developing a disaster plan in behavioral health services is essential. Many clients in behavioral health services have lived with trauma, so proactive steps that reduce the impact of a new trauma may prevent worsening of symptoms and decrease the risk for more pervasive effects. (See also Technical Assistance Publication 34, *Disaster Planning Handbook for Behavioral Health Treatment Programs* [SAMHSA, 2013].)

Most disaster events cannot be accurately anticipated. Even so, behavioral health organizations can take steps to reduce the impact of a disaster event on program functioning and on the lives of clients. Each service or program should develop a disaster response committee that meets regularly to develop, maintain, and adapt policies and procedures to respond to disasters affecting the program. Committee planning efforts may include:

1. Creating a disaster response team of program staff members tasked with coordinating program administration and services in a disaster event.
2. Establishing a communication process for informing staff and clients of the status of program functioning and for coordinating staff assignments during and shortly after the disaster event.
3. Outlining a process to inform clients and their families of available services, their location, and contact information for accessing services to meet clients' critical needs.
4. Developing plans for service provision during a disaster event and service implementation after the event.
5. Creating special plans for high-risk or special needs clients who need services during and shortly after the disaster. Examples of this are clients who are homeless, in detoxification services or methadone programs, on prescribed psychopharmaceuticals, or at risk for suicide.
6. Making plans for maintaining the security of client records, program records, and facilities during and shortly after the event.
7. Coordinating ahead with other community resources and services to ensure that clients at high risk or with special needs get the services they require as soon as possible.
8. Prioritizing how services will start back up after a disaster event.
9. Providing special services after the event to clients at high risk for trauma reactions and symptoms.
10. Establishing a postdisaster debriefing process to review disaster responses, services, and outcomes.

Some specific disaster events, such as hurricanes, may sometimes offer opportunities for planning and preparation in advance of the disaster event. This preparation time is usually just a few days, but it allows programs to make advance preparations and take advance action to establish lines of communication, stockpile resources, prepare for evacuation of clients, and protect client and program records.

Strategy #10: Incorporate Universal Routine Screenings

A key element of trauma-informed services is the institution of universal routine screening across all services, regardless of the individual's path in accessing services (e.g., primary care, hospitalization, outpatient). Considering the prevalence of trauma among individuals who seek services for mental and substance use disorders, the implementation of screening is paramount. Without screening, clients are not identified as trauma survivors. Subsequently, they miss recovery opportunities and treatment services that would be more likely to meet their needs, while also running a higher risk of being retraumatized by unexamined organizational policies, procedures, and practices. For more information on the rationale, processes, and instruments of universal screening for trauma, refer to Part 1, Chapter 4.

Strategy #11: Apply Culturally Responsive Principles

Providers must be culturally competent when incorporating evidence-based and best practices as well as trauma-informed treatment

models within the organization. Clients' views of behavioral health differ according to race, ethnicity, and culture (refer to the planned Treatment Improvement Protocol [TIP], *Improving Cultural Competence* [SAMHSA, planned c]). Likewise, cultures attach different meanings to trauma, and responses to trauma will vary considerable across cultures (see Part 3, the online literature review, for more information). For example, trauma survivors who come from a collective society or culture, in which the goals of the group take precedence over the goals of the individual, may be more focused on the well-being of their family or the family's response to the trauma survivors' experience. Often, this view runs in opposition to the individualistic perspective of many behavioral health services. Subsequently, treatment providers who are not culturally competent may interpret collective values as a sign of resistance or avoidance in dealing with traumatic stress. CMHS (2003) outlines principles of cultural competence in disaster work applicable across all forms of trauma:

1. ***Recognize the importance of culture and respect diversity.*** Those who value culture and diversity understand their own cultures, attitudes, values, and beliefs, and they work to understand the cultures of others. This includes being able to communicate effectively with those from other cultures, respecting others' feelings about personal space, knowing about others' social organization, understanding how time is viewed, and being aware of others' beliefs about the effects of their behaviors.
2. ***Maintain a current profile of the cultural composition of the community.*** This includes describing the community's population in terms of race and ethnicity, age, gender, religion, refugee and immigrant status, housing status, income levels, rural/urban balance, unemployment, languages spoken, literacy, schools, and businesses.
3. ***Recruit workers who are representative of the community or service area.*** If the workers who are available do not match the community, they should have the personal attributes, knowledge, and skills to develop cultural competence.
4. ***Provide ongoing cultural competence training to staff.*** Topics should include cultural values and traditions, family values, linguistics and literacy, immigration experiences and status, help-seeking behaviors, techniques and strategies for cross-cultural outreach, and the avoidance of stereotypes and labels (DeWolfe & Nordboe, 2000b).
5. ***Ensure that services are accessible, appropriate, and equitable.*** In planning disaster work or TIC, community associations and organizations are invaluable. Gaining their acceptance requires time and energy.
6. ***Recognize the role of help-seeking behaviors, traditions, and natural support networks.*** Culture includes traditions that dictate whom, or which groups, to seek in times of need; how to handle suffering and loss; and how healing takes place. These customs and traditions are respected by a culturally responsive disaster relief program.
7. ***Involve community leaders and organizations representing diverse cultural groups as "cultural brokers."*** Collaborating with community leaders is an effective means of learning about the community, establishing program credibility, and ensuring that services are culturally responsive.
8. ***Ensure that services and information are culturally and linguistically responsive.*** Communication with individuals who do not speak English, who are illiterate in all languages or have limited literacy, and who are deaf or hard of hearing is essential to service provision. Local radio stations, television outlets, and newspapers that are multicultural are an excellent venue for educational information after a disaster.

Using survivors' friends or relatives as interpreters is not recommended, as survivors may be uncomfortable discussing personal matters with family members or friends. Asking children to interpret can place too heavy a responsibility on them and reverses parents' and children's roles.

9. ***Assess and evaluate the program's level of cultural responsiveness.*** Self-assessment and process evaluation can help keep a program on track. A variety of strategies can be used for collecting data and communicating findings to stakeholders.

Strategy #12: Use Science-Based Knowledge

Along with culturally responsive services, trauma-informed organizations must use science-based knowledge to guide program development and the implementation of services, policies, procedures, and practices. This includes the adoption of EBPs (see Part 1, Chapter 6, and Part 3, Section 1, to review definition, treatments, and resources for EBPs). TIC research is quite new; interpret these limited studies and information cautiously. Chambless and Hollon's (1998) criteria, which are still the benchmark for EBPs, are valuable resources for administrators. Look closely at who was included—and excluded—from treatment studies. Often, the types of severe, chronic, and unstable cases seen in community settings are excluded from treatment studies. Evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with mental illness, substance use disorders, and co-occurring psychological trauma. Nonetheless, other variables must also be contemplated before adopting EBPs in an organization, including the cultural appropriateness of the practice; the strength of its clinical focus on strengths-based strategies; training and competence of clinical staff; the cost of training, materials, and implementation; and the ease of maintaining EBP fidelity amidst staff turnover.

For more detailed information on EBPs, visit the National Registry of Evidence Based Programs and Practices (NREPP) Web site (http://nrepp.samhsa.gov). For more specific research oriented information on trauma and trauma specific treatments, refer to the literature review in Part 3 of this TIP, available online.

Strategy #13: Create a Peer-Support Environment

The main purpose of peer support services is to provide consumer mentoring, support, and care coordination for clients with histories of mental illness or substance abuse. The goals are to help others deal with personal and environmental barriers that impede recovery and achieve wellness. Peer support accomplishes this through many activities, including advocacy, support during crises and recovery activities, modeling, education, and assistance in accessing available resources. Peer support programs send a powerful message to staff members, consumers, and the community—that recovery is possible through support, collaboration, and empowerment. These programs reinforce the trauma-informed premise that organizations need to reflect the populations that they serve and involve consumers in planning, implementing, monitoring, and delivering recovery services.

For an introduction to peer support services, see *What Are Peer Recovery Support Services?* (Center for Substance Abuse Treatment, 2009e).

Notably, peer support services have the potential to be considerably flexible to meet client needs at each stage of recovery. Specifically, peer support services can be incorporated

across the continuum of care, starting with outreach services and extending into long-term recovery services. Peer support specialists can enhance consumer motivation to change, to initiate services, and/or to engage in recovery activities. They can play powerful liaison roles by supporting clients entering treatment and explaining what to expect from services. They can ease the transition into treatment, from one service to the next, from one modality to another (e.g., inpatient group to outpatient group), and beyond formal treatment. Moreover, peer support services create an atmosphere focused on mutuality rather than pathology. They provide living models of resilience and promote hope—that recovery is possible and attainable.

Administrators should familiarize themselves with how other organizations have implemented peer support programs, current curricula, certifications and training processes, competencies and ethics, and peer support service State standards or recommendations, if applicable. The Carter Center's Summit in 2009, The Pillars of Peer Support Services, supported in part by SAMHSA and CMHS, highlighted the numerous elements necessary to develop a strong, vital peer workforce (Daniels et al., 2010). These elements include:

- Clear job and service descriptions.
- Job-related competencies and competence-based testing processes.
- Peer support certifications.
- Ongoing continuing education.
- Media and technology access for peer specialists.
- Sustainable funding.
- Research and evaluation components.
- Code of ethics and conduct.
- Competence-based training for supervisors.
- Multilevel support and program support teams.

> "Peer recovery support services are evidence based and have been demonstrated to promote positive health outcomes and control the cost of healthcare. These services are offered by a trained individual with lived experience and recovery from a mental illness, substance use and/or chronic health conditions. Peer recovery support services minimally include chronic illness self management, whole health and wellness promotion and engagement, relapse prevention, life skill coaching, and insurance and health systems navigation."
>
> (Daniels et al., 2012, p. 22)

Advice to Administrators: Sample Peer Support Staff Tasks

- Use active listening skills help peers identify areas of dissatisfaction and benefits of changing beliefs, thoughts, and behavior.
- Use problem-solving skills to help peers identify barriers to recovery and develop plans to meet peer-determined goals.
- Facilitate recovery support groups.
- Link clients with community resources.
- Work with the treatment team to advocate for clients and to remove recovery barriers.
- Participate in consumer panels to educate staff about the consumer perspective and about peer support.
- Participate in hospital-wide committees and workgroups

Source: New Logic Organizational Learning, 2011.

Strategy #14: Obtain Ongoing Feedback and Evaluations

Obtain feedback on and evaluations of organizational performance on a regular basis. Give consumers a clear avenue for offering feedback at any time, and make evaluations assessing the organization's progress toward providing trauma-informed services standard practice. Without feedback and further evaluation, organizations cannot assess whether they are

meeting trauma-informed objectives. A routine monitoring process for TIC implementation gives the organization additional information necessary to combat new obstacles and threats and to understand what works. Regular monitoring equips organizations with the ability to formulate different strategies to meet objectives as well as to respond to the changing needs of the population. Ongoing evaluation and consumer feedback are essential in improving the quality of services.

Strategy #15: Change the Environment To Increase Safety

Practices that generate emotional and physical safety are necessary. Another aspect of creating safety is reevaluating the physical facilities and environment to enhance safety and to circumvent preventable retraumatization. Think how traumatizing it would be if you were a female rape survivor and a night counselor was conducting a room check at 2:00 a.m., or a male security guard was walking the women's residential wing. What would it be like if you were sitting with your back to the door in a small office during an intake interview, if your history included a physical assault and robbery? For most, it would at least increase anxiety; for others it would be retraumatizing. Trauma-informed providers must carefully assess environmental safety. Although you are likely to identify some facility issues that could erode safety for trauma survivors, a safe environment will only be established if regular feedback is obtained from consumers about their experiences with the program.

Strategy #16: Develop Trauma-Informed Collaborations

TIC is about collaboration with consumers, staff members, key stakeholders, and other agencies. Collaborative relationships provide opportunities for consumers to access the most appropriate services as needs arise. Rather than waiting for a crisis or a dire need for a service to investigate available resources, it is far more efficient and compassionate to establish relationships within the agency and with other community resources before these needs arise. No agency can meet the needs of every client; referral agreements and/or collaborative arrangements that integrate the delivery of TIC, including support services (e.g., housing, legal, medical), are important.

Creating Sanctuary

The sanctuary model is a trauma-based therapeutic approach that has been used in inpatient, residential, therapeutic community, and outpatient settings with children, adolescents, and adults. It provides a template for changing social service delivery systems so that they are better equipped to respond to the complex needs of trauma survivors. Sanctuary is informed by four knowledge areas: "the psychobiology of trauma, the active creation of nonviolent environments, principles of social learning, and an understanding of the ways in which complex adaptive systems grow, change, and alter their course" (Bloom et al., 2003, p. 174).

The sanctuary model describes a stage-based approach to healing that is referred to as SAGE: safety, affect modulation, grieving, and emancipation. This model is nonlinear; an individual does not necessarily move from one stage to another in a straight path, but progress in one area does affect progress in other areas (Bloom, 1997; Bloom et al., 2003). SAGE is a cognitive–behavioral translation of the sanctuary model (Bills, 2003). Early in treatment, the focuses are typically on safety and affect management. Safety encompasses four domains: physical, psychological, social, and moral (Bloom, 1997; see http://www.sanctuaryweb.com for further details and a curriculum).

2 Building a Trauma-Informed Workforce

IN THIS CHAPTER

- Introduction
- Workforce Recruitment, Hiring, and Retention
- Training in TIC
- Trauma Informed Counselor Competencies
- Counselor Responsibilities and Ethics
- Clinical Supervision and Consultation
- Secondary Traumatization
- Counselor Self Care

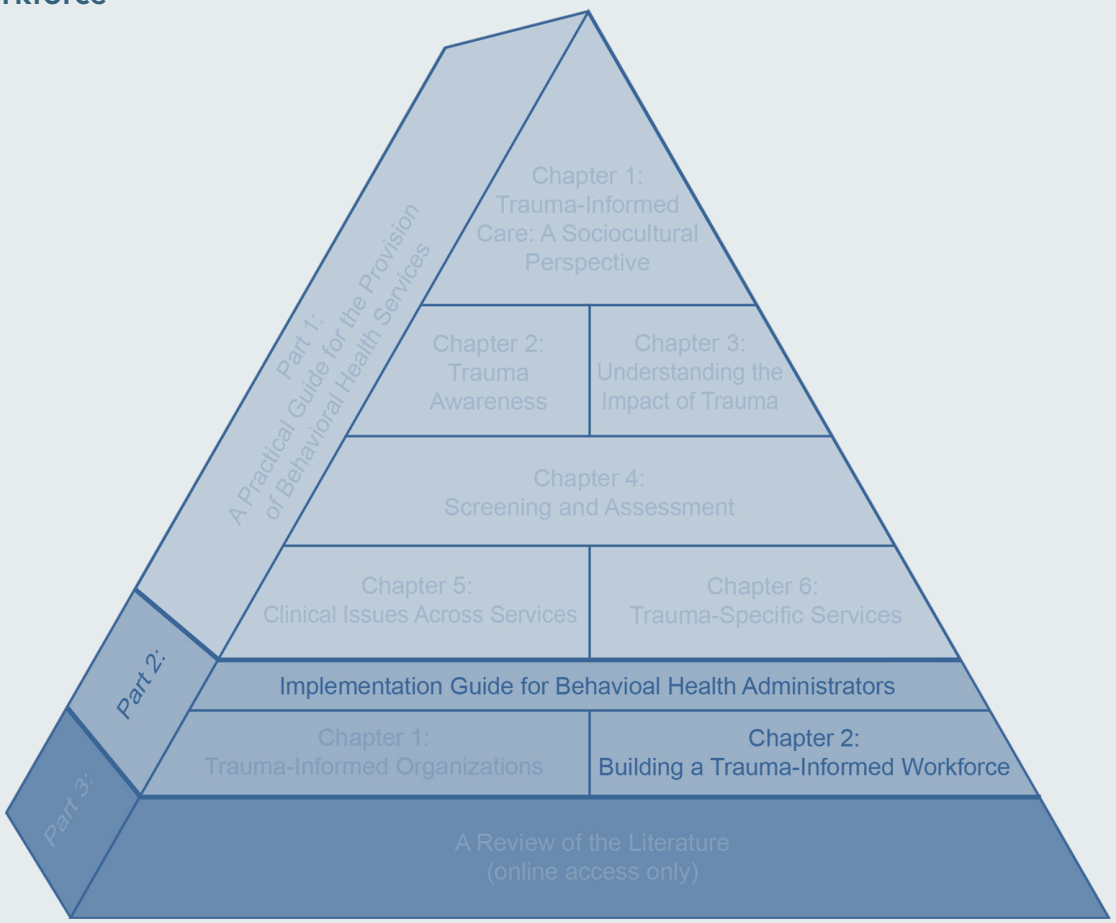
Introduction

For an organization to embrace a trauma-informed care (TIC) model fully, it must adopt a trauma-informed organizational mission and commit resources to support it. This entails implementing an agency-wide strategy for workforce development that is in alignment with the values and principles of TIC and the organization's mission statement. Without a fully trained staff, an organization will not be able to implement the TIC model. However, simply training behavioral health professionals in TIC is not enough. Counselors will not be able to sustain the kind of focus required to adopt and implement a trauma-informed philosophy and services without the ongoing support of administrators and clinical supervisors.

An organizational environment of care for the health, well-being, and safety of, as well as respect for, its staff will enhance the ability of counselors to provide the best possible trauma-informed behavioral health services to clients. This culture of care must permeate the organization from top to bottom. Behavioral health program administrators should aim to strengthen their workforce; doing so "requires creating environments that support the health and well-being, not only of persons with mental and substance use conditions, but of the workforce as well" (Hoge, 2007, p. 58). An organizational culture of care, safety, and respect demands activities that foster the development of trauma-informed counselors. This chapter focuses on key workforce development activities, such as:

- Recruiting, hiring, and retaining trauma-informed staff.
- Training behavioral health service providers on the principles of, and evidence-based and emerging best practices relevant to, TIC.
- Developing and promoting a set of counselor competencies specific to TIC.

TIC Framework in Behavioral Health Services—Building a Trauma-Informed Workforce



- Delineating the responsibilities of counselors and addressing ethical considerations specifically relevant to promoting TIC.
- Providing trauma-informed clinical supervision.
- Committing to prevention and treatment of secondary trauma of behavioral health professionals within the organization.

Addressing each of these areas is essential to building a trauma-informed workforce and an organizational culture that supports TIC.

Workforce Recruitment, Hiring, and Retention

An Action Plan for Behavioral Health Workforce Development (Hoge et al., 2007) emphasizes the importance of organization-wide support and active involvement in workforce recruitment, hiring, and retention in behavioral health systems. One of the key findings of this report is that the work environment itself in many behavioral health settings can be toxic to the workforce and may hinder the delivery of individualized, respectful, collaborative, and client-centered care to service recipients. Factors such as the downward pressure on organizations for higher productivity of counselors increase caseloads and decrease wages of behavioral health staff members and may create a high-stress environment that contributes to low morale and worker dissatisfaction. Other factors that often contribute to low retention of qualified counselors in behavioral health settings include the lack of professional career

ladders, fragile job security, the lack of clinical supervision, and an inability to influence the organization in which they are working (Hoge et al., 2007).

Added to this mix is the intensity of working with people with the co-occurring conditions of trauma-related mental and substance use disorders and the risk of secondary traumatization of counselors. In creating and sustaining a trauma-informed workforce, organizations need to foster a work environment that parallels the treatment philosophy of a trauma-informed system of care. Doing so allows counselors to count on a work environment that values safety, endorses collaboration in the making of decisions at all levels, and promotes counselor well-being.

Recruitment and Hiring in a Trauma-Informed System of Care

In a 2007 technical report (Jennings, 2007b), the National Center for Trauma-Informed Care identified several priorities for organizations with regard to recruitment and hiring trauma-informed staff, including:

- Active recruitment of and outreach to prospective employees who are trauma-informed or have formal education in providing trauma-informed or trauma-specific services in settings such as universities, professional organizations, professional training and conference sites, peer support groups, and consumer advocacy groups.
- Hiring counselors and peer support staff members with educational backgrounds and training in trauma-informed and/or trauma-specific services and/or lived experience of trauma and recovery.
- Providing incentives, bonuses, and promotions for staff members during recruitment and hiring that take into consideration prospective employees' trauma-related education, training, and job responsibilities.

In addition to hiring behavioral health professionals with formal professional education and training, organizations should also "routinely survey the demographics and other characteristics of the population served and recruit a workforce of similar composition" (Hoge et al., 2007, p. 297). Essentially, this means actively engaging in outreach to consumer advocacy groups, recovery-oriented programs, community and faith-based organizations, and former clients/consumers with the intention of recruiting potential employees whose knowledge and expertise comes from their lived experience of trauma, resilience, and recovery. Support staff members, peer support workers, counselors in training, and apprentices can be recruited from this population and offered incentives, such as tuition reimbursement, training stipends, and professional mentoring with the goal of developing a trauma-informed workforce from within the demographic served. Jennings (2007b) calls these staff members "trauma champions" who can provide needed expertise in a trauma-informed organization to promote trauma-informed policies, staff development, and trauma-based services consistent with the mission of the organization (p. 135).

Who Is a Trauma Champion?

"A champion understands the impact of violence and victimization on the lives of people seeking mental health or addiction services and is a front-line worker who thinks 'trauma first.' When trying to understand a person's behavior, the champion will ask, 'is this related to abuse and violence?' A champion will also think about whether his or her own behavior is hurtful or insensitive to the needs of a trauma survivor. The champion is there to do an identified job—he is a case manager or a counselor or a residential specialist—but in addition to his or her job, a champion is there to shine the spotlight on trauma issues."

Source: Harris & Fallot, 2001a, p. 8.

As with hiring behavioral health professionals who are in recovery from substance use disorders, the organization should be transparent and explicit in its recruitment and hiring practices of trauma survivors in recovery. The organization can be transparent by advertising the mission statement of the organization as part of the recruitment process and inviting applicants who are in recovery from trauma to apply. The needs of behavioral health staff members who are in recovery from both substance use and trauma-related conditions and working in a trauma-informed system of care should be addressed in the organization's ongoing training, clinical supervision, and staff development policies and practices.

Workforce Retention

Staff turnover is rampant in behavioral health settings. It is costly to the organization, and as a result, it is costly to clients. A strong therapeutic relationship with a counselor is one of the largest factors in an individual's ability to recover from the overwhelming effects of trauma. When behavioral health professionals leave an organization prematurely or in crisis as a result of chronic levels of high stress or secondary traumatization, clients must deal with disruptions in their relationships with counselors. Some of the organizational factors that contribute to chronic levels of high stress and often lead to high staff turnover include expecting counselors to maintain high caseloads of clients who have experienced trauma; not providing trauma-informed clinical supervision and training to counselors; and failing to provide adequate vacation, health insurance, and other reasonable benefits that support counselors' well-being. Other factors that may have a more profound impact on staff retention include failing to acknowledge the reality of secondary traumatization, promoting the view that counselors' stress reactions are a personal failure instead of a normal response to engaging with clients' traumatic material, and not supporting personal psychotherapy for counselors (Saakvitne, Pearlman, & Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy, 1996).

Research on promoting counselor retention in behavioral health settings demonstrates that

Advice to Administrators: Preventing Turnover and Increasing Workforce Retention

To prevent behavioral health staff turnover and increase retention of qualified, satisfied, and highly committed trauma-informed counselors, consider:

- Offering competitive wages, benefits, and performance incentives that take into account education, training, and levels of responsibility in providing trauma-informed or trauma-specific services.
- Creating a safe working environment that includes both the physical plant and policies and procedures to prevent harassment, stalking, and/or violence in the workplace and to promote respectful interactions amongst staff at all levels of the organization.
- Establishing an organizational policy that normalizes secondary trauma as an accepted part of working in behavioral health settings and views the problem as systemic—not the result of individual pathology or a deficit on the part of the counselor.
- Instituting reasonable, manageable caseloads that mix clients with and without trauma-related concerns.
- Letting staff offer input into clinical and administrative policies that directly affect their work experience.
- Providing vacation, health insurance (which includes coverage for psychotherapy/personal counseling), and other benefits that promote the well-being of the staff.
- Implementing regular, consistent clinical supervision for all clinical staff members.
- Providing ongoing training in trauma-informed services offered by the organization.

behavioral health staff members are interested in the same kind of work environment and benefits as employees in many other fields. They include a "living wage with healthcare benefits; opportunities to grow and advance; clarity in a job role; some autonomy and input into decisions; manageable workloads; administrative support without crushing administrative burden; basic orientation and training for assigned responsibilities; a decent and safe physical work environment; a competent and cohesive team of coworkers; the support of a supervisor; and rewards for exceptional performance" (Hoge et al., 2007, p. 18).

When an organization's administration values its staff by providing competitive salaries and benefits, a safe working environment, a reasonable and manageable workload, input into the making of clinical and administrative policy decisions, and performance incentives, it helps behavioral health workers feel connected to the mission of the organization and become dedicated to its sustainability and growth. This type of work environment demonstrates both a level of respect for counselors (similar to the level of respect a trauma-informed organization displays toward clients) and an appreciation for the complexity of their job responsibilities and the stress they face when working with people who have experienced trauma in their lives. To retain behavioral health professionals working in a trauma-informed setting, wages and performance incentives should be tied not only to education, training, and work experience, but also to levels of responsibility in working with clients who have experienced trauma.

Training in TIC

Training for all staff members is essential in creating a trauma-informed organization. It may seem that training should simply focus on new counselors or on enhancing the skill level of those who have no prior experience in working with trauma, but training should, in fact, be more systematic across the organization to develop fully sustainable trauma-informed services. All employees, including administrative staff members, should receive an orientation and basic education about the prevalence of trauma and its impact on the organization's clients. To ensure safety and reduction of harm, training should cover dynamics of retraumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. Training for all employees must also educate them "about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socioeconomic status on individuals' experiences of trauma" (Jennings, 2007a, p. 5).

All clinical and direct service staff members, regardless of level of experience, should receive more indepth training in screening and assessment of substance use and trauma-related disorders; the relationships among trauma, substance use disorders, and mental disorders; how to understand difficult client behaviors through a trauma-informed lens; how to avoid retraumatizing clients in a clinical setting; the development of personal and professional boundaries unique to clinical work with traumatized clients; how to identify the signs of secondary traumatization in themselves; and how to develop a comprehensive personal and professional self-care plan to prevent and/or ameliorate the effects of secondary traumatization in the workplace. All clinical staff members who work with traumatized clients should receive additional training in evidence-based and promising practices for the treatment of trauma (for information on locating training, see Appendix B.) This might include training done within the agency by experts in the field or training received by attending advanced trauma trainings. Administrators

should provide the time and financial resources to clinical staff members for this professional development activity. Jennings (2007a) suggests that, whenever possible, "trainings should be multi-system, inclusive of staff in mental health and substance abuse, health care, educational, criminal justice, social services systems and agencies, and promoting systems integration and coordination" (p. 5).

Moreover, criminal justice settings, schools, military/veteran programs, and other places in which behavioral health services are provided may benefit from approaches that are sensitive to the special circumstances and cultures of these environments. For example, in exploring trauma-informed correctional care, Miller and Najavits (2012, p. 1) observe:

> Prisons are challenging settings for trauma-informed care. Prisons are designed to house perpetrators, not victims. Inmates arrive shackled and are crammed into overcrowded housing units; lights are on all night, loud speakers blare without warning and privacy is severely limited. Security staff is focused on maintaining order and must assume each inmate is potentially violent. The correctional environment is full of unavoidable triggers, such as pat downs and strip searches, frequent discipline from authority figures, and restricted movement….This is likely to increase trauma-related behaviors and symptoms that can be difficult for prison staff to manage….Yet, if trauma-informed principles are introduced, all staff can play a major role in minimizing triggers, stabilizing offenders, reducing critical incidents, deescalating situations, and avoiding restraint, seclusion or other measures that may repeat aspects of past abuse.

The Need for Training

Behavioral health service providers working with clients who have mental, substance use, and trauma-related disorders need to have the best knowledge, skills, and abilities. Substance abuse counselors, in particular, require additional training and skill development to be able to extend trauma-informed services (within the

Case Illustration: Larry

Larry is a 28-year-old clinical social worker who just finished his master's program in social work and is working in a trauma-informed outpatient program for people with substance use disorders. He is recovering from alcohol use disorder and previously worked in a residential rehabilitation program as a recovery support counselor. There, his primary responsibilities were to take residents to Alcoholics Anonymous (AA) meetings, monitor their participation, and confront them about their substance use issues and noncompliance with the program's requirement of attendance at 12-Step meetings.

In Larry's new position as a counselor, he confronts a client in his group regarding her discomfort with attending AA meetings. The client reports that she feels uncomfortable with the idea that she has to admit that she is powerless over alcohol to be accepted by the group of mostly men. She was sexually abused by her stepfather when she was a child and began drinking heavily and smoking pot when she was 11 years old. The client reacts angrily to Larry's intervention.

In supervision, Larry discusses his concerns regarding the client's resistance to AA and the feedback that he provided to her in group. Beyond focusing supervision on Larry's new role as a counselor in a trauma-informed program, the clinical supervisor recommends that Larry take an interactive, multisession, computer-assisted training on the 12-Step facilitation (TSF) model. The TSF model introduces clients to and assists them with engaging in 12-Step recovery support groups. The agency has the computer-based training available in the office, and Larry agrees to use follow-up coaching sessions with his supervisor to work on implementation of the approach. The supervisor recognizes that Larry is falling back on his own recovery experience and the strategies he relied on in his previous counseling role. He will benefit from further training and coaching in an evidence-based practice that provides a nonaggressive, focused, and structured way to facilitate participation in recovery support groups with clients who have trauma histories.

limits of their professional licensure and scope of practice) to clients who have co-occurring substance use, trauma-related, or mental disorders. Many clinical practice issues in traditional substance abuse treatment are inconsistent with trauma-informed practice, which needs to be addressed with further training. Similarly, mental health clinicians often need training in substance abuse treatment, as they typically do not have backgrounds or experience in that domain. Moreover, several surveys indicate that clinicians consistently perceive the combination of trauma and substance abuse as harder to treat than either one alone (Najavits, Norman, Kivlahan, & Kosten, 2010). It is thus key to emphasize cross-training as part of TIC. Exhibit 2.2-1 addresses these issues and offers suggestions for additional training.

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings

- Some substance abuse counseling strategies commonly used to work through clients' denial and minimization of their substance use issues may be inappropriate when working with trauma survivors (e.g., highly confrontational models can remind trauma survivors of emotional abuse).

  Training: The Stages of Change model of addiction treatment can help counselors shift from the traditional confrontation of denial to conceptualizing clients' ambivalence about changing substance use patterns as a normal part of the precontemplation stage of change. This method is a respectful cognitive–behavioral approach that helps counselors match counseling strategies to their assessment of where each client is in each stage of change, with the ultimate goal of helping clients make changes to health risk behaviors. (Connors, Donovan, & DiClemente, 2001).

- The 12-Step concept of powerlessness (Step 1) may seem unhelpful to trauma survivors for whom the emotional reaction to powerlessness is a major part of their trauma (particularly for victims of repetitive trauma, such as child abuse or intimate partner violence). It can be confusing and counterproductive to dwell on this concept of powerlessness regarding trauma when the therapeutic objective for trauma-informed counseling methods should be to help clients empower themselves. For people in recovery, powerlessness is a paradox, sometimes misunderstood by both counselors and clients, in that the acknowledgment of powerlessness often creates a sense of empowerment. Most clients, with support and respectful guidance from a counselor, will come to understand that powerlessness (as used in 12-Step programs) is not an inability to stand up for oneself or express a need, and it does not mean for one to be powerless in the face of abuse. With this understanding, clients may become more open to participating in 12-Step groups as a resource for their recovery from substance use disorders. When clients continue to struggle with this concept and decline to participate in 12-Step recovery efforts, they may benefit from referral to other forms of mutual-help programs or recovery support groups in which the concept of powerlessness over the substance of abuse is not such a significant issue.

  Training: The TSF model can help counselors develop a more supportive and understanding approach to facilitating clients' involvement in 12-Step recovery groups (if this is a client-generated recovery goal). "Although based on standard counseling models, TSF differs from them in several ways. These differences include TSF's strong emphasis on therapist support, discouragement of aggressive 'confrontation of denial' and therapist self-disclosure, and highly focused and structured format" (Sholomskas & Carroll, 2006, p. 939).

  Another well-intentioned, but often misguided, approach by counselors who have not had formal or extensive training is "digging" for trauma memories without a clear therapeutic rationale or understanding of client readiness. In doing so, the counselor may unintentionally retraumatize the client or produce other harmful effects. In early intervention, it is sufficient simply to acknowledge and validate the pain and suffering of the client without uncovering or exploring specific trauma memories. The counselor who is insufficiently trained in trauma-informed clinical

(Continued on the next page.)

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings (continued)

practice may also press agendas that are ultimately unhelpful, such as insisting that the client forgive an abuser, pursue a legal case against a perpetrator, or engage in trauma treatment, even when the client may not be ready for such steps. These efforts are particularly inappropriate for clients in early recovery from substance use disorders. The first goal in treatment is stabilization

Training: The Seeking Safety model of treating substance abuse and posttraumatic stress disorder (PTSD) can help counselors focus on the primary goal of stabilization and safety in TIC. This model emphasizes safety as the target goal, humanistic themes such as honesty and compassion, and making cognitive–behavioral therapy accessible and interesting to clients who may otherwise be difficult to engage (Najavits, 2002a).

- Treatment should be client-centered; it should acknowledge the client's right to refuse counseling for trauma-related issues. It is important to discuss the advantages and disadvantages of exploring trauma-related concerns, and then, following an open discussion, to allow clients the right to choose their path. This discussion should be part of the informed consent process at the start of treatment. Clients also have the right to change their minds.

  Training: Motivational interviewing, a client-centered, nonpathologizing counseling method, can aid clients in resolving ambivalence about and committing to changing health risk behaviors including substance use, eating disorders, self-injury, avoidant and aggressive behaviors associated with PTSD, suicidality, and medication compliance (Arkowitz, Miller, Westra, & Rollnick, 2008; Kress & Hoffman, 2008). Training in MI can help counselors remain focused on the client's agenda for change, discuss the pros and cons of treatment options, and emphasize the personal choice and autonomy of clients.

In addition to the training needs of substance abuse counselors, all direct care workers in mental health settings, community-based programs, crisis intervention settings, and criminal justice environments should receive training in TIC. Guidelines for training in assisting trauma-exposed populations are presented in Exhibit 2.2-2.

Continuing Education

Research on the effectiveness of single-session didactic and/or skill-building workshops

Exhibit 2.2-2: Guidelines for Training in Mental Health Interventions for Trauma-Exposed Populations

After a year of collaboration in 2002, the Task Force on International Trauma Training of the International Society for Traumatic Stress Studies published a consensus-based set of recommendations for training. Core curricular elements of the recommended training include:

- Competence in listening.
- Recognition of psychosocial and mental problems to promote appropriate assessment.
- Familiarity with established interventions in the client population.
- Full understanding of the local context, including help-seeking expectations, duration of treatment, attitudes toward intervention, cost-effectiveness of intervention, and family attitudes and involvement.
- Strategies for solving problems on the individual, family, and community levels.
- Treatment approaches for medically unexplained somatic pain.
- Collaboration with existing local resources and change agents (e.g., clergy, traditional healers, informal leaders).
- Self-care components.

Source: Weine et al., 2002.

Advice to Administrators: Trauma-Informed Staff Training

- Establish training standards for the evidence-based and promising trauma-informed practice models (such as Seeking Safety) adopted by your organization.
- Bring expert trainers with well-developed curricula in TIC and trauma-specific practices into your organization.
- Select a core group of clinical supervisors and senior counselors to attend multisession training or certification programs. These clinicians can then train the rest of the staff.
- Use sequenced, longitudinal training experiences instead of single-session seminars or workshops.
- Emphasize interactive and experiential learning activities over purely didactic training.
- Provide ongoing mentoring/coaching to behavioral health professionals in addition to regular clinical supervision to enhance compliance with the principles and practices of TIC and to foster counselor mastery of trauma-specific practice models.
- Build organization-wide support for the ongoing integration of new attitudes and counselor skills to sustain constructive, TIC-consistent changes in practice patterns.
- Provide adequate and ongoing training for clinical supervisors in the theory and practice of clinical supervision and the principles and practices of TIC.
- Include information and interactive exercises on how counselors can identify, prevent, and ameliorate secondary traumatic stress (STS) reactions in staff trainings.
- Offer cross-training opportunities to enhance knowledge of trauma-informed processes throughout the system.

demonstrates that immediate gains in counselor knowledge and skills diminish quickly after the training event (Martino, Canning-Ball, Carroll, & Rounsaville, 2011). Consequently, organizations may be spending their scarce financial resources on sending counselors to this kind of training but may not be reaping adequate returns with regard to long-lasting changes in counselor skills and the development of trauma-informed and trauma-specific counselor competencies. Hoge et al. (2007) suggest the implementation of training strategies for behavioral health professionals that have proven to be effective in improving counselor skills, attitudes, and practice approaches. These strategies include: "interactive approaches; sequenced, longitudinal learning experiences; outreach visits, known as academic detailing; auditing of practice with feedback to the learner; reminders; the use of opinion leaders to influence practice; and patient-mediated interventions, such as providing information on treatment options to persons in recovery, which in turn influences the practice patterns of their providers" (p. 124).

Trauma-Informed Counselor Competencies

Hoge et al. (2007) identified a number of counselor competencies in behavioral health practices that are consistent with the skills needed to be effective in a trauma-informed system of care. They include person-centered planning, culturally competent care, development of therapeutic alliances, shared responsibility for decisions, collaboratively developed recovery plans, evidence-based practices, recovery- and resilience-oriented care, interdisciplinary- and team-based practice, and consumer/client advocacy. In addition, counselor competencies critical to the effective delivery of services to clients with trauma-related disorders include:

- Screening for and assessment of trauma history and trauma-related disorders, such as mood and anxiety disorders.
- Awareness of differences between trauma-informed and trauma-specific services.

- Understanding the bidirectional relationships among substance use and mental disorders and trauma.
- Engagement in person-centered counseling.
- Competence in delivering trauma-informed and trauma-specific evidence-based interventions that lessen the symptoms associated with trauma and improve quality of life for clients.
- Awareness of and commitment to counselor self-care practices that prevent or lessen the impact of secondary traumatization on behavioral health workers.

Exhibit 2.2-3 provides a checklist of competencies for counselors working in trauma-informed behavioral health settings. Administrators and clinical supervisors can use this checklist to assess behavioral health professionals' understanding of trauma awareness and counseling skills and determine the need for additional training and clinical supervision.

Counselor Responsibilities and Ethics

Treating all clients in an ethical manner is an expectation of all healthcare providers. It is of special importance when working with clients who have trauma-related disorders, as their trust in others may have been severely shaken. Counselors who work with traumatized individuals on a regular basis have special responsibilities to their clients because of the nature of this work. Administrators and clinical supervisors in trauma-informed organizations should develop policies that clearly define the counselors' job and should provide education about the role of counselors in the organization and their responsibilities to clients.

General Principles Regarding Counselor Responsibilities

The following are some general principles governing the responsibilities of counselors who provide behavioral health services for clients with histories of trauma:

- Counselors are responsible for routinely screening clients for traumatic experiences and trauma-related symptoms (Ouimette & Brown, 2003; see also Treatment Improvement Protocol [TIP] 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Center for Substance Abuse Treatment [CSAT], 2005c).
- Counselors should offer clients with substance use and trauma-related disorders continuing mental health services if it is within their professional license and scope of practice to do so.
- Counselors are responsible for referring clients with substance use disorders and co-occurring trauma-related disorders to treatment that addresses both disorders when the treatment falls outside of the counselor's professional license and scope of practice (Ouimette & Brown, 2003).
- Counselors should refer clients with substance use disorders and co-occurring trauma-related disorders to concurrent participation in mutual-help groups if appropriate (Ouimette & Brown, 2003).
- Counselors have a responsibility to practice the principles of confidentiality in all interactions with clients and to respect clients' wishes not to give up their right to privileged communication.
- Counselors are responsible for educating clients about the limits of confidentiality and what happens to protected health information, along with the client's privilege, when the client signs a release of information or agrees to assign insurance benefits to the provider.
- Counselors must inform clients that treatment for trauma-related disorders is always voluntary.
- Counselors are responsible for being aware of their own secondary trauma and

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist

Trauma Awareness

___ Understands the difference between trauma-informed and trauma-specific services

___ Understands the differences among various kinds of abuse and trauma, including: physical, emotional, and sexual abuse; domestic violence; experiences of war for both combat veterans and survivors of war; natural disasters; and community violence

___ Understands the different effects that various kinds of trauma have on human development and the development of psychological and substance use issues

___ Understands how protective factors, such as strong emotional connections to safe and nonjudgmental people and individual resilience, can prevent and ameliorate the negative impact trauma has on both human development and the development of psychological and substance use issues

___ Understands the importance of ensuring the physical and emotional safety of clients

___ Understands the importance of not engaging in behaviors, such as confrontation of substance use or other seemingly unhealthy client behaviors, that might activate trauma symptoms or acute stress reactions

___ Demonstrates knowledge of how trauma affects diverse people throughout their lifespans and with different mental health problems, cognitive and physical disabilities, and substance use issues

___ Demonstrates knowledge of the impact of trauma on diverse cultures with regard to the meanings various cultures attach to trauma and the attitudes they have regarding behavioral health treatment

___ Demonstrates knowledge of the variety of ways clients express stress reactions both behaviorally (e.g., avoidance, aggression, passivity) and psychologically/emotionally (e.g., hyperarousal, avoidance, intrusive memories)

Counseling Skills

___ Expedites client-directed choice and demonstrates a willingness to work within a mutually empowering (as opposed to a hierarchical) power structure in the therapeutic relationship

___ Maintains clarity of roles and boundaries in the therapeutic relationship

___ Demonstrates competence in screening and assessment of trauma history (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Shows competence in screening and assessment of substance use disorders (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Demonstrates an ability to identify clients' strengths, coping resources, and resilience

___ Facilitates collaborative treatment and recovery planning with an emphasis on personal choice and a focus on clients' goals and knowledge of what has previously worked for them

___ Respects clients' ways of managing stress reactions while supporting and facilitating taking risks to acquire different coping skills that are consistent with clients' values and preferred identity and way of being in the world

___ Demonstrates knowledge and skill in general trauma-informed counseling strategies, including, but not limited to, grounding techniques that manage dissociative experiences, cognitive–behavioral tools that focus on both anxiety reduction and distress tolerance, and stress management and relaxation tools that reduce hyperarousal

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Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist (continued)

___ Identifies signs of STS reactions and takes steps to engage in appropriate self-care activities that lessen the impact of these reactions on clinical work with clients

___ Recognizes when the needs of clients are beyond his or her scope of practice and/or when clients' trauma material activates persistent secondary trauma or countertransference reactions that cannot be resolved in clinical supervision; makes appropriate referrals to other behavioral health professionals

Source: Abrahams et al., 2010.

countertransference reactions and seeking appropriate help in responding to these reactions so that they do not interfere with the best possible treatment for clients.

TIC organizations have responsibilities to clients in their care, including:

- Protecting client confidentiality, particularly in relation to clients' trauma histories. Organizations should comply with the State and Federal laws that protect the confidentiality of clients being treated for mental and substance use disorders.
- Providing clients with an easy-to-read statement of their rights as consumers of mental health and substance abuse services, including the right to confidentiality (Exhibit 2.2-4).
- Providing quality clinical supervision to all counselors and direct-service workers, with an emphasis on TIC. Organizations should, at minimum, comply with State licensing requirements for the provision of clinical supervision to behavioral health workers.
- Establishing and maintaining appropriate guidelines and boundaries for client and counselor behavior in the program setting.
- Creating and maintaining a trauma-informed treatment environment that respects the clients' right to self-determination and need to be treated with dignity and respect.
- Maintaining a work environment that reinforces and supports counselor self-care.

All behavioral health professionals are responsible for abiding by professional standards of care that protect the client. Breaches of confidentiality, inappropriate conduct, and other violations of trust can do further harm to clients who already have histories of trauma. Many treatment facilities have a Client Bill of Rights (or a similar document) that describes the rights and responsibilities of both the counselors and the participants; it often is part of the orientation and informed consent process when a client enters treatment. However, simply reading and acknowledging the receipt of a piece of paper is not a substitute for the dialog that needs to happen in a collaborative therapeutic partnership. Administrators are responsible for providing clients with easy-to-read information describing counselor responsibilities and client rights. Clinical supervisors are responsible for helping counselors engage in a respectful dialog with clients about those rights and responsibilities as part of a comprehensive informed consent process.

Exhibit 2.2-4 is an excerpt from a Client Bill of Rights that outlines clients' right to confidentiality in plain language that is readable and easily understood.

Exhibit 2.2-4: Sample Statement of the Client's Right to Confidentiality From a Client Bill of Rights

Tri-County Mental Health Services is a trauma-informed mental health and substance abuse treatment agency in Maine. Below is a statement regarding clients' right to confidentiality and staff responsibility to protect that privilege; this statement is provided in a brochure outlining consumer rights that is easily accessible to service recipients at the agency and online.

Confidentiality

We will not give out information about you to anyone without your knowledge and permission. This includes written information from your record and verbal information from your providers. Additionally, we will not request any information about you without your knowledge and permission. A Release of Information Form allows you to say what information can be shared and with whom. You determine the length of time this is valid, up to one year.

Tri-County policies prevent any employee of the agency who does not have a direct need to know from having access to any information about you. The penalty for violation can include immediate dismissal.

Exceptions to this rule of confidentiality include times when a client is at immediate risk of harm to self or others, or when ordered by the court. We will make every effort to notify you in these instances.

Source: Tri-County Mental Health Services, 2008, pp. 6-7.

Ethics in Treating Traumatized Clients

All behavioral health professionals must conform to the ethical guidelines established by their profession's State licensing boards and/or certifying organizations. State licensing boards for substance abuse counseling, psychiatry, social work, psychology, professional counseling, and other behavioral health professions provide regulatory standards for ethical practice in these professions. These boards also have specific procedures for responding to complaints regarding the actions of professional caregivers. Additionally, national professional societies have standards for ethical practices. Members of these organizations are expected to practice within the boundaries and scope of these standards. Some of these standards are quite explicit, whereas others are more general; most approach professional ethics not as a rigid set of rules, but rather, as a process of making ethical decisions.

Clinical supervisors are responsible for informing counselors of their ethical responsibilities with regard to their own organization's policies and procedures, monitoring supervisees' reading and understanding the codes of ethics of professional organizations and State licensing boards, and promoting counselor understanding of ethics and how to make decisions ethically as a regular part of clinical supervision, team meetings, and counselor training. Administrators can support high ethical standards by creating an organization-wide ethics task group consisting of counselors, supervisors, and administrators who meet regularly to review and revise clinical policies in line with State and Federal law and professional codes of ethics. Administrators may also act as a support mechanism for counselors who need additional consultation regarding potential ethical dilemmas with clients. The Green Cross Academy of Traumatology provides ethical guidelines for the treatment of clients who have experienced trauma; these guidelines are adapted in Exhibit 2.2-5.

Exhibit 2.2-5: Green Cross Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized

Respect for the dignity of clients

- Recognize and value the personal, social, spiritual, and cultural diversity present in society, without judgment. As a primary ethical commitment, make every effort to provide interventions with respect for the dignity of those served.

Responsible caring

- Take the utmost care to ensure that interventions do no harm.
- Have a commitment to the care of those served until the need for care ends or the responsibility for care is accepted by another qualified service provider.
- Support colleagues in their work and respond promptly to their requests for help.
- Recognize that service to survivors of trauma can exact a toll in stress on providers. Maintain vigilance for signs in self and colleagues of such stress effects, and accept that dedication to the service of others imposes an obligation to sufficient self-care to prevent impaired functioning.
- Engage in continuing education in the appropriate areas of trauma response. Remain current in the field and ensure that interventions meet current standards of care.

Integrity in relationships

- Clearly and accurately represent your training, competence, and credentials. Limit your practice to methods and problems for which you are appropriately trained and qualified. Readily refer to or consult with colleagues who have appropriate expertise; support requests for such referrals or consultations from clients.
- Maintain a commitment to confidentiality, ensuring that the rights of confidentiality and privacy are maintained for all clients.
- Do not provide professional services to people with whom you already have either emotional ties or extraneous relationships of responsibility. The one exception is in the event of an emergency in which no other qualified person is available.
- Refrain from entering other relationships with present or former clients, especially sexual relationships or relationships that normally entail accountability.
- Within agencies, ensure that confidentiality is consistent with organizational policies; explicitly inform individuals of the legal limits of confidentiality.

Responsibility to society

- Be committed to responding to the needs generated by traumatic events, not only at the individual level, but also at the level of community and community organizations in ways that are consistent with your qualifications, training, and competence.
- Recognize that professions exist by virtue of societal charters in expectation of their functioning as socially valuable resources. Seek to educate government agencies and consumer groups about your expertise, services, and standards; support efforts by these agencies and groups to ensure social benefit and consumer protection.
- If you become aware of activities of colleagues that may indicate ethical violations or impairment of functioning, seek first to resolve the matter through direct expression of concern and offers of help to those colleagues. Failing a satisfactory resolution in this manner, bring the matter to the attention of the officers of professional societies and of governments with jurisdiction over professional misconduct.

Clients' universal rights

All clients have the right to:

- Not be judged for any behaviors they used to cope, either at the time of the trauma or after the trauma.
- Be treated at all times with respect, dignity, and concern for their well-being.
- Refuse treatment, unless failure to receive treatment places them at risk of harm to self or others.

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Exhibit 2.2-5: Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized (continued)

- Be regarded as collaborators in their own treatment plans.
- Provide their informed consent before receiving any treatment.
- Not be discriminated against based on race, culture, sex, religion, sexual orientation, socioeconomic status, disability, or age.
- Have promises kept, particularly regarding issues related to the treatment contract, role of counselor, and program rules and expectations.

Procedures for introducing clients to treatment

Obtain informed consent, providing clients with information on what they can expect while receiving professional services. In addition to general information provided to all new clients, clients presenting for treatment who have histories of trauma should also receive information on:

- The possible short-term and long-term effects of trauma treatment on the client and the client's relationships with others.
- The amount of distress typically experienced with any particular trauma treatment.
- Possible negative effects of a particular trauma treatment.
- The possibility of lapses and relapses when doing trauma work, and the fact that these are a normal and expected part of healing.

Reaching counseling goals through consensus

Collaborate with clients in the design of a clearly defined contract that articulates a specific goal in a specific time period or a contract that allows for a more open-ended process with periodic evaluations of progress and goals.

Informing clients about the healing process

- Clearly explain to clients the nature of the healing process, making sure clients understand.
- Encourage clients to ask questions about any and all aspects of treatment and the therapeutic relationship. Provide clients with answers in a manner they can understand.
- Encourage clients to inform you if the material discussed becomes overwhelming or intolerable.
- Inform clients of the necessity of contacting you or emergency services if they feel suicidal or homicidal, are at risk of self-injury, or have a sense of being out of touch with reality.
- Give clients written contact information about available crisis or emergency services.
- Inform clients about what constitutes growth and recovery and about the fact that some trauma symptoms may not be fully treatable.
- Address unrealistic expectations clients may have about counseling and/or the recovery process.

Level of functioning

- Inform clients that they may not be able to function at the highest level of their ability—or even at their usual level—when working with traumatic material.
- Prepare clients to experience trauma-related symptoms, such as intrusive memories, dissociative reactions, reexperiencing, avoidance behaviors, hypervigilance, or unusual emotional reactivity.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

Boundaries in therapeutic relationships

Maintaining appropriate therapeutic boundaries is a primary ethical concern for behavioral health professionals. Counselors working with clients who have substance use, trauma-related, and other mental disorders may feel challenged at times to maintain boundaries that create a safe therapeutic container. Some clients, especially those with longstanding disorders, bring a history of client–counselor relationships to counseling. Clients who have been traumatized may need help understanding the roles and responsibilities of both the counselor and the client. Clients with trauma-related conditions may also have special needs

Advice to Clinical Supervisors: Recognizing Boundary Confusion

Clinical supervisors should be aware of the following counselor behaviors that can indicate boundary confusion with clients:

- The counselor feels reluctant or embarrassed to discuss specific interactions with a client or details of the client's treatment in supervision or team meetings.
- The counselor feels possessive of the client, advocates with unusual and excessive vehemence for the client, or expresses an unreasonable sense of overresponsibility for the client.
- The counselor becomes defensive and closed to hearing ideas from the supervisor or the treatment team members about approaches to working with a client and/or exploring his or her own emotional reactions to a client.
- The clinician begins or increases personal self-disclosure to the client and is not able to identify legitimate clinical reasons for the self-disclosure.

in establishing appropriate boundaries in the counseling setting; they may be particularly vulnerable and not understand or appreciate the need for professional boundaries, including not engaging in dual relationships. For example, some clients might experience a counselor's boundary around not giving the client his or her personal phone number for emergency calls as a rejection or abandonment. Cultural considerations also influence therapeutic boundaries.

Administrators, in collaboration with clinical supervisors, are responsible for creating policies regarding counselor and client boundaries for various issues (e.g., giving and receiving gifts, counselor personal disclosure, and counselor roles and responsibilities when attending the same 12-Step meetings as clients); policies should be specific to their organization and conform to State and Federal law and behavioral health professional codes of ethics. Clinical supervisors are responsible for training counselors in the informed consent process and effective ways to discuss boundaries with clients when they enter treatment.

Guidelines for establishing and maintaining boundaries in therapeutic relationships, adapted from the Green Cross Academy of Traumatology, are given in Exhibit 2.2-6.

Clients with trauma histories may be especially vulnerable to counselor behaviors that are inconsistent or that are experienced by the client as boundary violations. Examples of such behavior include: being late for appointments, ending counseling sessions early, repeatedly and excessively extending the session time, canceling or "forgetting" appointments multiple times, spending time in the session talking about their own needs and life experiences, exploring opportunities for contact outside the therapeutic relationship (including making arrangements to meet at AA or other 12-Step recovery group meetings), and enforcing rules differently for one client than for another.

Due to the complex dynamics that can arise in the treatment of clients with trauma histories, regularly scheduled clinical supervision, where issues of ethics and boundaries can be discussed, is recommended for counselors. For more information on how clinical supervision can be effectively used, see TIP 52, *Clinical Supervision and the Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Boundary crossing and boundary violation

Although guidelines and codes of ethics are useful tools in helping clinical supervisors and counselors understand the boundaries between counselors and clients, they are open to interpretation and are context-bound. Given these limitations, it is crucial to educate counselors

Exhibit 2.2-6: Boundaries in Therapeutic Relationships

Procedures for Establishing Safety

Roles and boundaries
Counselor roles and boundaries should be established at the start of the counseling relationship and reinforced periodically, particularly at times when the client is experiencing high stress.

Ongoing Relationships and the Issue of Boundaries

Dual relationships
Dual relationships and inappropriate interactions with clients are to be avoided. It is important to tell clients at the beginning of counseling that contact between the counselor and the client can only occur within the boundaries of the professional relationship. This information is part of the informed consent process. Relationships outside these boundaries include sexual or romantic relationships, a counselor also serving as a client's sponsor in 12-Step programs, and any kind of relationship in which the counselor exploits the client for financial gain.

Sexual contact
- Never engage in any form of sexual contact with clients.
- Do not reward sexualized behaviors with attention or reactivity.
- Directly clarify the boundaries of the therapeutic relationship, and address the underlying motivations of persisting sexualized behavior.
- Set limits on a client's inappropriate behaviors while maintaining an ethos of care. Maintain respect for the dignity and worth of the client at all times.
- Understand that a client's attempt to sexualize a therapeutic relationship may reflect an early history of abuse, difficulty understanding social norms, or a variety of psychological problems.
- Readdress the absolute inappropriateness of sexual and/or romantic behavior in a nonlecturing, nonpunitive manner.
- If sexual behavior between clients occurs in a treatment program, counselors should consult with a clinical supervisor. Document the nature of the contact and how the issue is addressed.
- If a counselor has sexual contact with a client, he or she should take responsibility by ceasing counseling practice, referring clients to other treatment providers, and notifying legal and professional authorities. If a counselor is at risk for engaging with a client sexually but has not acted on it, the counselor should immediately consult with a supervisor, colleague, or psychotherapist.

Boundaries
Counselors should use care with self-disclosure or any behaviors that may be experienced as intrusive by the client, including:
- Personal disclosures made for the counselor's own gratification.
- Sexualized behavior with the client.
- Excessively intrusive questions or statements.
- Interrupting the client frequently.
- Violating the client's personal space.
- Interpersonal touch, which might activate intrusive memories or dissociative reactions or be experienced as a boundary violation by the client.
- Being consistently late for appointments or allowing outside influences (such as telephone calls) to interrupt the client's time in a counseling session.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

in TIC settings regarding the boundary issues that may arise for clients who have been traumatized and to give counselors a conceptual framework for understanding the contextual nature of boundaries. For example, it would be useful for clinical supervisors to discuss with

counselors the distinction between boundary crossings and boundary violations in clinical practice. Gutheil and Brodsky (2008) define boundary crossing as a departure from the customary norms of counseling practice in relation to psychological, physical, or social space "that are harmless, are nonexploitative, and may even support or advance the therapy" (p. 20). Examples of boundary crossings include taking phone calls from a client between sessions if the client is in crisis or telling a client a story about the counselor's recovery from trauma (without offering specific personal information or graphic/detailed description of the trauma) with the intention of offering hope that it is possible to recover.

Gutheil and Brodsky (2008) define boundary violations as boundary crossings that are unwanted and dangerous and which exploit the client, stating that "some boundary crossings are inadvisable because of their intent (i.e., they are not done in the service of the patient's well-being and growth, involve extra therapeutic gratification for the therapist) and/or their effect (i.e., they are not likely to benefit the patient and entail a significant risk of harming the patient)" (pp. 20–21). An example of a boundary violation would be when a counselor invites a client to attend the same AA meetings the counselor attends or shares drinking and drugging "war stories" for the counselor's own gratification. Two key elements in understanding when a boundary crossing becomes a boundary violation are the intent of the counselor and the damaging effect on the client. Maintaining a standard of practice of nonexploitation of the client is the primary focus for clinical supervisors and counselors in determining when boundary crossings become boundary violations.

Context is also an important consideration in determining the acceptability of boundary crossings. For example, it may be acceptable for a counselor in a partial hospitalization program for serious mental illness to have a cup of coffee at the kitchen table with a resident, whereas for a counselor in an outpatient mental health program, having a cup of coffee with a client at the local coffee shop would be a much more questionable boundary crossing.

Case Illustration: Denise

Denise is a 40-year-old licensed professional counselor working in an inpatient eating disorder program. She has had extensive training in trauma and eating disorder counseling approaches and has been working as a clinician in mental health settings for 15 years. Denise is usually open to suggestions from her supervisor and other treatment team members about specific strategies to use with clients who have trauma histories and eating disorders. However, in the past week, her supervisor has noticed that she has become defensive in team meetings and individual supervision when discussing a recently admitted young adult who was beaten and raped by her boyfriend; subsequently, the client was diagnosed with PTSD and anorexia. When the clinical supervisor makes note of the change in Denise's attitude and behavior in team meetings since this young woman was admitted, initially Denise becomes defensive, saying that the team just doesn't understand this young woman and that the client has repeatedly told Denise, "You're the only counselor I trust."

The clinical supervisor recognizes that Denise may be experiencing secondary traumatization and boundary confusion due to working with this young woman and to the recent increase in the number of clients with co-occurring trauma-related disorders on her caseload. After further exploration, Denise reveals that her own daughter was raped at the same age as the young woman and that hearing her story has activated an STS reaction in Denise. Her way of coping has been to become overly responsible for and overprotective of the young woman. With the nonjudgmental support of her supervisor, Denise is able to gain perspective, recognize that this young woman is not her daughter, and reestablish boundaries with her that are appropriate to the inpatient treatment setting.

Clinical Supervision and Consultation

Organizational change toward a TIC model doesn't happen in isolation. Ongoing support, supervision, and consultation are key ingredients that reinforce behavioral health professionals' training in trauma-informed and trauma-specific counseling methods and ensure compliance with practice standards and consistency over time. Often, considerable energy and resources are spent on the transition to new clinical and programmatic approaches, but without long-range planning to support those changes over time. The new treatment approach fades quickly, making it hard to recognize and lessening its reliability.

Advice to Clinical Supervisors and Administrators: Adopting an Evidence-Based Model of Clinical Supervision and Training

Just as adopting evidence-based clinical practices in a trauma-informed organization is important in providing cost-effective and outcome-relevant services to clients, adopting an evidence-based model of clinical supervision and training clinical supervisors in that model can enhance the quality and effectiveness of clinical supervision for counselors. This will ultimately enhance client care.

One of the most commonly used and researched integrative models of supervision is the discrimination model, originally published by Janine Bernard in 1979 and since updated (Bernard & Goodyear, 2009). This model is considered a competence-based and social role model of supervision; it includes three areas of focus on counselor competencies (intervention, conceptualization, and personalization) and three possible supervisor roles (teacher, counselor, and consultant).

Counselor competencies:

- Intervention: The supervisor focuses on the supervisee's intervention skills and counseling strategies used with a particular client in a given session.
- Conceptualization: The supervisor focuses on how the supervisee understands what is happening in a session with the client.
- Personalization: The supervisor focuses on the personal style of the counselor and countertransference responses (i.e., personal reactions) of the counselor to the client.

Supervisor roles:

- Teacher: The supervisor teaches the supervisee specific counseling theory and skills and guides the supervisee in the use of specific counseling strategies in sessions with clients. The supervisor as teacher is generally task-oriented. The supervisor is more likely to act as a teacher with beginning counselors.
- Counselor: The supervisor does not act as the counselor's therapist, but helps the counselor reflect on his or her counseling style and personal reactions to specific clients. The supervisor as counselor is interpersonally sensitive and focuses on the process and relational aspects of counseling.
- Consultant: The supervisor is more of a guide, offering the supervisee advice on specific clinical situations. The supervisor as consultant invites the counselor to identify topics and set the agenda for the supervision. The supervisor is more likely to act as a consultant with more advanced counselors.

This model of supervision may be particularly useful in working with counselors in TIC settings, because the supervisor's response to the supervisee is flexible and specific to the supervisee's needs. In essence, it is a counselor-centered model of supervision in which the supervisor can meet the most relevant needs of the supervisee in any given moment.

For a review of other theories and methods of clinical supervision, refer to TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Ongoing supervision and consultation supports the organizational message that TIC is the standard of practice. It normalizes secondary traumatization as a systemic issue (not the individual pathology of the counselor) and reinforces the need for counselor self-care to prevent and lessen the impact of secondary traumatization. Quality clinical supervision for direct care staff demonstrates the organization's commitment to implementing a fully integrated, trauma-informed system of care.

Supervision and Consultation

Historically, there was an administrative belief that counselors who had extensive clinical experience and training would naturally be the best clinical supervisors. However, research does not support this idea (Falender & Shafranske, 2004). Although a competent clinical supervisor needs to have an extensive clinical background in the treatment of substance use, trauma-related, and other mental disorders, it is also essential for any counselor moving into a supervisory role to have extensive training in the theory and practice of clinical supervision before taking on this role. In particular, clinical supervisors in trauma-informed behavioral health settings should be educated in how to perform clinical supervision (not just administrative supervision) of direct service staff and in the importance of providing continuous clinical supervision and support for staff members working with individuals affected by trauma. Clinical

Case Illustration: Arlene

Arlene is a 50-year-old licensed substance abuse counselor who has a personal history of trauma, and she is actively engaged in her own recovery from trauma. She is an experienced counselor who has several years of training in trauma-informed and trauma-specific counseling practices. Her clinical supervisor, acting in the role of consultant, begins the supervision session by inviting her to set the agenda. Arlene brings up a clinical situation in which she feels stuck with a client who is acting out in her Seeking Safety group (for more information on Seeking Safety, see Najavits, 2002a).

Arlene reports that her client gets up suddenly and storms out of the group room two or three times during the session. The supervisor, acting in the role of the counselor and focusing on personalization, asks Arlene to reflect on the client's behavior and what feelings are activated in her in response to the client's anger. Arlene is able to identify her own experience of hyperarousal and then paralysis as a stress reaction related to her prior experience of domestic violence in her first marriage. The supervisor, acting in the role of teacher and focusing on conceptualization, reminds Arlene that her client is experiencing a "fight-or-flight" response to some experience in the group that reminds her of her own trauma experience. The supervisor then suggests to Arlene that her own reactions are normal responses to her previous history of trauma, and that when her client is angry, Arlene is not reexperiencing her own trauma but is being activated by the client's traumatic stress reaction to being in group. In this way, the supervisor highlights the parallel process of the client–counselor's stress reactions to a perceived threat based on prior trauma experiences.

The supervisor, acting again as a consultant and focusing on personalization this time, invites Arlene to reflect on the internal and external resources she might be able to bring to this situation that will help remind her to ground herself so she can lessen the impact of her stress reactions on her counseling strategy with this client. Arlene states that she can create a list of safe people in her life and place this list in her pocket before group. She can use this list as a touchstone to remind her that she is safe and has learned many recovery skills that can help her stay grounded, maintain her boundaries, and deal with her client's behavior. The clinical supervisor, acting as a consultant and now focusing on intervention, asks Arlene if she has some specific ideas about how she can address the client's behavior in group. Arlene and the clinical supervisor spend the remainder of the session discussing different options for addressing the client's behavior and helping her feel safer in group.

supervision in a TIC organization should focus on the following priorities:

- General case consultation
- Specialized consultation in specific and unusual cases
- Opportunities to process clients' traumatic material
- Boundaries in the therapeutic and supervisory relationship
- Assessment of secondary traumatization
- Counselor self-care and stress management
- Personal growth and professional development of the counselor

Supervision of counselors working with traumatized clients should be regularly scheduled, with identified goals and with a supervisor who is trained and experienced in working with trauma survivors. The styles and types of supervision and consultation may vary according to the kind of trauma work and its context. For instance, trauma counseling in a major natural disaster would require a different approach to supervision and consultation than would counseling adults who experienced childhood developmental trauma or counseling clients in an intensive early recovery treatment program using a manualized trauma-specific counseling protocol.

Competence-based clinical supervision is recommended for trauma-informed organizations. Competence-based clinical supervision models identify the knowledge and clinical skills each counselor needs to master, and they use targeted learning strategies and evaluation procedures, such as direct observation of counselor sessions with clients, individualized coaching, and performance-based feedback. Studies on competence-based supervision approaches have demonstrated that these models improve counselor treatment skills and proficiency (Martino et al., 2011).

Whichever model of clinical supervision an organization adopts, the key to successful trauma-informed clinical supervision is the recognition that interactions between the supervisor and the counselor may parallel those between the counselor and the client. Clinical supervisors need to recognize counselors' trauma reactions (whether they are primary or secondary to the work with survivors of trauma) and understand that a confrontational or punitive approach will be ineffective and likely retraumatize counselors.

Clinical supervisors should adopt a respectful and collaborative working relationship with counselors in which role expectations are clearly defined in an informed consent process similar to that used in the beginning of the counselor–client relationship and in which exploring the nature of boundaries in both client–counselor and counselor–supervisor relationships is standard practice. Clear role boundaries, performance expectations, open dialog, and supervisor transparency can go a long way toward creating a safe and respectful relationship container for the supervisor and supervisee and set the stage for a mutually enhancing, collaborative relationship. This respectful, collaborative supervisory relationship is the main source of training and professional growth for the counselor and for the provision of quality care to people with behavioral health disorders.

Secondary Traumatization

The demands of caregiving exact a price from behavioral health professionals that cannot be ignored; otherwise, they may become ineffective in their jobs or, worse, emotionally or psychologically impaired. In a study of Master's level licensed social workers, 15.2 percent of respondents to a survey reported STS as a result of indirect exposure to trauma material at a level that meets the diagnostic criteria for PTSD. This rate is almost twice the rate of PTSD in the general population. The author

STS is a trauma related stress reaction and set of symptoms resulting from exposure to another individual's traumatic experiences rather than from exposure directly to a traumatic event.

concluded that behavioral health professionals' experience of STS is a contributing factor in staff turnover and one reason why many behavioral health service professionals leave the field (Bride, 2007). Secondary traumatization of behavioral health workers is a significant organizational issue for clinical supervisors and administrators in substance abuse and mental health treatment programs to address.

To prevent or lessen the impact of secondary traumatization on behavioral health professionals, clinical supervisors and administrators need to understand secondary trauma from the ecological perspective described in Part 1, Chapter 1 of this TIP. The organization itself creates a social context with risk factors that can increase the likelihood of counselors experiencing STS reactions, but it also contains protective factors that can lessen the risk and impact of STS reactions on staff members. Organizations can lessen the impact of the risk factors associated with working in trauma-informed organizations by mixing caseloads to contain clients both with and without trauma-related issues, supporting ongoing counselor training, providing regular clinical supervision, recognizing counselors' efforts, and offering an empowering work environment in which counselors share in the responsibility of making decisions and can offer input into clinical and program policies that affect their work lives.

When organizations support their counselors in their work with clients who are traumatized, counselors can be more effective, more productive, and feel greater personal and professional satisfaction. In addition, counselors develop a sense of allegiance toward the organization, thus decreasing staff turnover. If organizations do not provide this support, counselors can become demoralized and have fewer emotional and psychological resources to manage the impact of clients' traumatic material and outward behavioral expressions of trauma on their own well-being. Providing counselors with the resources to help them build resilience and prevent feeling overwhelmed should be a high priority for administrators and clinical supervisors in TIC organizations.

Risk and Protective Factors Associated With Secondary Traumatization

Clinical and research literature on trauma describes a number of factors related to the development of secondary trauma reactions and psychological distress in behavioral health professionals across a wide range of practice settings, as well as individual and organizational factors that can prevent or lessen the impact of STS on staff. The risk and protective factors model of understanding secondary trauma is based on the ecological perspective

Advice to Clinical Supervisors: Recognizing Secondary Traumatization

Some counselor behaviors that demonstrate inconsistency to clients may be outward manifestations of secondary traumatization, and they should be discussed with counselors through a trauma-informed lens. It is imperative that clinical supervisors provide a nonjudgmental, safe context in which counselors can discuss these behaviors without fear of reprisal or reprimand. Clinical supervisors should work collaboratively with supervisees to help them understand their behavior and engage in self-care activities that lessen the stress that may be contributing to these behaviors.

outlined in Part 1, Chapter 1 of this TIP. The terms "compassion fatigue," "vicarious traumatization," "secondary traumatization," and "burnout" are used in the literature, sometimes interchangeably and sometimes as distinct constructs. As stated in the terminology portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP, the term "secondary traumatization" refers to traumatic stress reactions and psychological distress from exposure to another individual's traumatic experiences; this term will be used throughout this section, although the studies cited may use other terms.

Risk factors

Individual risk factors that may contribute to the development of STS in behavioral health professionals include preexisting anxiety or mood disorders; a prior history of personal trauma; high caseloads of clients with trauma-related disorders; being younger in age and new to the field with little clinical experience or training in treating trauma-related conditions; unhealthy coping styles, including distancing and detachment from clients and co-workers; and a lack of tolerance for strong emotions (Newall & MacNeil, 2010). Other negative coping strategies include substance abuse, other addictive behaviors, a lack of recreational activities not related to work, and a lack of engagement with social support. A recent study of trauma nurses found that low use of support systems, use of substances, and a lack of hobbies were among the coping strategies that differed between nurses with and without STS (Von Rueden et al., 2010). Other researchers found that clinicians who engaged in negative coping strategies, such as alcohol and illicit drug use, were more likely to experience intrusive trauma symptoms (Way, Van Deusen, Martin, Applegate, & Janle, 2004).

Numerous organizational factors can contribute to the development of STS in counselors who work with clients with trauma-related disorders. These risk factors include organizational constraints, such as lack of resources for clients, lack of clinical supervision for counselors, lack of support from colleagues, and lack of acknowledgment by the organizational culture that secondary traumatization exists and is a normal reaction of counselors to client trauma (Newall & MacNeil, 2010). In a study of 259 individuals providing mental health counseling services, counselors who spent more time in session with clients with trauma-related disorders reported higher levels of traumatic stress symptoms (Bober & Regehr, 2006). Counselors may be more at risk for developing secondary traumatization if the organization does not allow for balancing the distribution of trauma and nontrauma cases amongst staff members.

Protective factors

Much of the clinical and research literature focuses on individual factors that may lessen the impact of STS on behavioral health professionals, including male gender, being older, having more years of professional experience,

Advice to Clinical Supervisors: Recognizing STS in Counselors Who Are In Recovery

For counselors who are in recovery from a substance use or mental disorder, the development of STS may be a potential relapse concern. As Burke, Carruth, and Prichard (2006) point out, "a return to drinking or illicit drug use as a strategy for dealing with secondary trauma reactions would have a profoundly detrimental effect on the recovering counselor" (p. 292). So too, secondary trauma may ignite the reappearance of depressive or anxiety symptoms associated with a previous mental disorder. Clinical supervisors can address these risk factors with counselors and support them in engaging with their own recovery support network (which might include a peer support group or an individual counselor) to develop a relapse prevention plan.

having specialized training in trauma-informed and trauma-specific counseling practices, lacking a personal trauma history, exhibiting personal autonomy in the workplace, using positive personal coping styles, and possessing resilience or the ability to find meaning in stressful life events and to rebound from adversity (Sprang, Clark, & Whitt-Woosley, 2007). Some of these factors, like positive personal coping styles and the ability to find meaning in adversity, can be developed and enhanced through personal growth work, psychotherapy, engagement with spiritual practices and involvement in the spiritual community, and stress reduction strategies like mindfulness meditation. A recent multimethod study of an 8-week workplace mindfulness training group for social workers and other social service workers found that mindfulness meditation increased coping strategies, reduced stress, and enhanced self-care of the participants; findings suggested that workers were more likely to practice stress management techniques like mindfulness at their place of work than at home (McGarrigle & Walsh, 2011). Organizations can support counselors' individual efforts to enhance positive personal coping styles, find meaning in adversity, and reduce stress by providing time for workers during the workday for personal self-care activities, like mindfulness meditation and other stress reduction practices.

One of the organizational protective factors identified in the literature that may lessen the negative impact of secondary traumatization on behavioral health professionals is providing adequate training in trauma-specific counseling strategies, which increases providers' sense of efficacy in helping clients with trauma-related disorders and reduces the sense of hopelessness that is often a part of the work (Bober & Regehr 2006). One study found that specialized trauma training enhanced job satisfaction and reduced levels of compassion fatigue, suggesting that "knowledge and training might provide some protection against the deleterious effects of trauma exposure" (Sprang et al., 2007, p. 272). Another protective factor that may lessen the chances of developing secondary traumatization is having a diverse caseload of clients. Organizations "must determine ways of distributing workload in order to limit the traumatic exposure of any one worker. This may not only serve to reduce the impact of immediate symptoms but may also address the potential longitudinal effects" (Bober & Regehr, 2006, p. 8).

Emotional support from professional colleagues can be a protective factor. A study of substance abuse counselors working with clients who were HIV positive found that workplace support from colleagues and supervisors most effectively prevented burnout (Shoptaw, Stein, & Rawson, 2000). This support was associated with less emotional fatigue and depersonalization, along with a sense of greater personal accomplishment. In a study of domestic violence advocates, workers who received more support from professional peers were less likely to experience secondary traumatization (Slattery & Goodman, 2009).

In addition, counselor engagement in relationally based clinical supervision with a trauma-informed supervisor acts as a protective agent. Slattery and Goodman (2009) note that "for the trauma worker, good supervision can normalize the feelings and experiences, provide support and information about the nature and course of the traumatic reaction, help in the identification of transference and countertransference issues, and reveal feelings or symptoms associated with the trauma" (p. 1362). Workers who reported "engaging, authentic, and empowering relationships with their supervisors" were less likely to experience STS (p. 1369). Thus, it is not simply the frequency and regularity of clinical supervision,

but also the quality of the supervision and the quality of the supervisor–counselor relationship that can lessen the impact of STS on behavioral health professionals.

Engagement with a personal practice of spirituality that provides a sense of connection to a larger perspective and meaning in life is another protective factor that can lessen the impact of STS on counselors (Trippany, Kress, & Wilcoxon, 2004). Although recovering counselors may look to support groups for connection to a spiritual community, other behavioral health professionals might find support for enhancing spiritual meaning and connection in church, a meditation group, creative endeavors, or even volunteer work. The key is for counselors to develop their own unique resources and practices to enhance a sense of meaningful spirituality in their lives. Clinical supervisors should be aware of spiritual engagement as a protective factor in preventing and lessening the impact of STS and should support clinicians in including it in their self-care plans, but they should take care not to promote or reject any particular religious belief system or spiritual practice.

Another protective factor that may lessen the impact of workers' STS is a culture of empowerment in the organization that offers counselors a sense of autonomy, a greater ability to participate in making decisions about clinical and organizational policies, and obtaining support and resources that further their professional development. Slattery & Goodman (2009) surveyed 148 domestic violence advocates working in a range of settings. The authors found that those workers "who reported a high level of shared power were less likely to report posttraumatic stress symptoms, despite their own personal abuse history or degree of exposure to trauma" (p. 1370). To the degree that organizations can provide a cultural context within which behavioral health professionals have autonomy and feel empowered, they will be able to lessen the impact of STS on their professional and personal lives. Self-efficacy and empowerment are antidotes to the experience of powerlessness that often accompanies trauma.

Strategies for Preventing Secondary Traumatization

The key to prevention of secondary traumatization for behavioral health professionals in a trauma-informed organization is to reduce risk and enhance protective factors. Organizational strategies to prevent secondary traumatization include:

- Normalize STS throughout all levels of the organization as a way to help counselors feel safe and respected, enhancing the likelihood that they will talk openly about their experiences in team meetings, peer supervision, and clinical supervision.
- Implement clinical workload policies and practices that maintain reasonable standards for direct-care hours and emphasize balancing trauma-related and nontrauma-related counselor caseloads.
- Increase the availability of opportunities for supportive professional relationships by promoting activities such as team meetings, peer supervision groups, staff retreats, and counselor training that focuses on understanding secondary traumatization and self-care. Administrators and clinical supervisors should provide time at work for counselors to engage in these activities.
- Provide regular trauma-informed clinical supervision that is relationally based. Supervisors should be experienced and trained in trauma-informed and trauma-specific practices and provide a competence-based model of clinical supervision that promotes counselors' professional and personal development. Supervision limited to case consultation or case management is insufficient to

reduce the risk for secondary traumatization and promote counselor resilience.

- Provide opportunities for behavioral health professionals to enhance their sense of autonomy and feel empowered within the organization. Some of these activities include soliciting input from counselors on clinical and administrative policies that affect their work lives, including how to best balance caseloads of clients with and without histories of trauma; inviting representatives of the counseling staff to attend selected agency board of directors and/or management team meetings to offer input on workforce development; and inviting counselors to participate in organizational task forces that develop trauma-informed services, plan staff retreats, or create mechanisms to discuss self-care in team meetings. Administrators and clinical supervisors should assess the organization's unique culture and develop avenues for counselor participation in activities that will enhance their sense of empowerment and efficacy within the organization.

Exhibit 2.2-7 highlights some specific strategies that individual counselors can engage in to prevent secondary traumatization.

Assessment of Secondary Traumatization

Counselors with unacknowledged STS can harm clients, self, and family and friends by becoming unable to focus on and attend to their needs or those of others. They may feel helpless or cynical and withdraw from support systems. Exhibit 2.2-8 describes some emotional, cognitive, and behavioral signs that may indicate that a counselor is experiencing secondary traumatization. Clinical supervisors should be familiar with the manifestations of STS in their counselors and should address signs of STS immediately.

Stamm (2009–2012) has developed and revised a self-assessment tool, the Professional Quality of Life Scale (ProQOL), that measures indicators of counselor compassion fatigue and compassion satisfaction. Compassion fatigue "is best defined as a syndrome consisting of a combination of the symptoms

Exhibit 2.2-7: Counselor Strategies To Prevent Secondary Traumatization

Strategies that counselors can use (with the support and encouragement of supervisors and administrators) to prevent secondary traumatization include:

- ***Peer support*:** Maintaining adequate social support, both personally and professionally, helps prevent isolation and helps counselors share the emotional distress of working with traumatized individuals.
- ***Supervision and consultation*:** Professional consultation will help counselors understand secondary traumatization, their own personal risks, the protective factors that can help them prevent or lessen its impact, and their countertransference reactions to specific clients.
- ***Training*:** Ongoing professional training can improve counselors' understanding of trauma and enhance a sense of mastery and self-efficacy in their work.
- ***Personal psychotherapy or counseling*:** Being in counseling can help counselors become more self-aware and assist them in managing the psychological and emotional distress that often accompanies working with clients who have trauma histories in a number of behavioral health settings.
- ***Maintaining balance in one's life*:** Balancing work and personal life, developing positive coping styles, and maintaining a healthy lifestyle can enhance resilience and the ability to manage stress.
- ***Engaging in spiritual activities that provide meaning and perspective*:** Connection to a spiritual community and spiritual practices (such as meditation) can help counselors gain a larger perspective on trauma and enhance resilience.

Exhibit 2.2-8: Secondary Traumatization Signs

The following are some indicators that counselors may be experiencing secondary traumatization.

Psychological distress
- Distressing emotions: grief, depression, anxiety, dread, fear, rage, shame
- Intrusive imagery of client's traumatic material: nightmares, flooding, flashbacks of client disclosures
- Numbing or avoidance: avoidance of working with client's traumatic material
- Somatic issues: sleep disturbances, headaches, gastrointestinal distress, heart palpitations, chronic physiological arousal
- Addictive/compulsive behaviors: substance abuse, compulsive eating, compulsive working
- Impaired functioning: missed or canceled appointments, decreased use of supervision, decreased ability to engage in self-care, isolation and alienation

Cognitive shifts
- Chronic suspicion about others
- Heightened sense of vulnerability
- Extreme sense of helplessness or exaggerated sense of control over others or situations
- Loss of personal control or freedom
- Bitterness or cynicism
- Blaming the victim or seeing everyone as a victim
- Witness or clinician guilt if client reexperiences trauma or reenacts trauma in counseling
- Feeling victimized by client

Relational disturbances
- Decreased intimacy and trust in personal/professional relationships
- Distancing or detachment from client, which may include labeling clients, pathologizing them, judging them, canceling appointments, or avoiding exploring traumatic material
- Overidentification with the client, which may include a sense of being paralyzed by one's own responses to the client's traumatic material or becoming overly responsible for the client's life

Frame of reference
- Disconnection from one's sense of identity
- Dramatic change in fundamental beliefs about the world
- Loss or distortion of values or principles
- A previous sense of spirituality as comfort or resource decreases or becomes nonexistent
- Loss of faith in something greater
- Existential despair and loneliness

Sources: Figley, 1995; Newall & MacNeil, 2010; Saakvitne et al., 1996.

of secondary traumatic stress and professional burnout" (Newall & MacNeil, 2010, p. 61). Although secondary traumatization as a reaction to exposure to clients' trauma material is similar to PTSD, burnout is a more general type of psychological distress related to the pressures of working in high-stress environments over time. Burnout may be a result of secondary traumatization and/or a contributing factor in the development of secondary traumatization. The ProQOL includes STS and burnout scales that have been validated in research studies (Adams, Figley, & Boscarino, 2008; Newall & MacNeil, 2010).

This tool can be used in individual and group clinical supervision, trainings on self-care, and team meetings as a way for counselors to check in with themselves on their levels of stress and potential signs of secondary traumatization.

Case Illustration: Gui

Gui is a 48-year-old licensed substance abuse counselor who has worked in a methadone maintenance clinic for 12 years. He originally decided to get his degree and become a counselor because he wanted to help people and make a difference in the world. Over the past 6 months, he has felt fatigued a great deal, gets annoyed easily with both clients and coworkers, and has developed a cynical attitude about the world and the people who come to the clinic for help. During this time, the clinic has been forced to lay off a number of counselors due to funding cutbacks. As a result, Gui and the remaining counselors have had a 20 percent increase in the number of weekly client contact hours required as part of their job duties. In addition, the level and severity of clients' trauma-related and other co-occurring disorders, poverty, joblessness, and homelessness has increased.

Gui is a valued employee, and when Gui discusses his thoughts that he might want to leave the clinic with his clinical supervisor, the supervisor listens to Gui's concerns and explores the possibility of having him fill out the ProQOL to get a pulse on his stress level. Gui agrees and is willing to discuss the results with his supervisor. He is not surprised to see that he scores above average on the burnout scale of the instrument but is very surprised to see that he scores below average on the secondary traumatic stress scale and above average on the compassion satisfaction scale. He begins to feel more hopeful that he still finds satisfaction in his job and sees that he is resilient in many ways that he did not acknowledge before.

Gui and the clinical supervisor discuss ways that the supervisor and the organization can lessen the impact of the stress of the work environment on Gui and support the development of a self-care plan that emphasizes his own ability to rebound from adversity and take charge of his self-care.

The compassion satisfaction scale allows counselors to reflect on their resilience and reminds them of why they choose to work with people with substance use and trauma-related disorders, despite the fact that this work can lead to secondary traumatization. The compassion satisfaction subscale reminds counselors that they are compassionate, that one of the reasons they are in a helping profession is that they value service to others, and that helping brings meaning and fulfillment to their lives. Exhibits 2.2-9 through 2.2-11 present the most recent version of the ProQOL.

Addressing Secondary Traumatization

If a counselor is experiencing STS, the organization should address it immediately. Clinical supervisors can collaborate with counselors to devise an individualized plan that is accessible, acceptable, and appropriate for each counselor and that addresses the secondary stress reactions the counselor is experiencing, providing specific self-care strategies to counteract the stress. Decisions about strategies for addressing secondary traumatization should be based on the personal preferences of the counselor, the opportunity for an immediate intervention following a critical incident, and the counselor's level of awareness regarding his or her experience of STS. Counselors may need to talk about what they are experiencing, feeling, and thinking. These experiences can be processed in teams, in consultations with colleagues, and in debriefing meetings to integrate them effectively (Myers & Wee, 2002).

If a critical incident evokes secondary traumatization among staff—such as a client suicide, a violent assault in the treatment program, or another serious event—crisis intervention should be available for workers who would like to participate. Any intervention should be voluntary and tailored to each worker's individual needs (e.g., peer, group, or individual sessions); if possible, these services should be offered continuously instead of just one time.

Exhibit 2.2-9: PRoQOL Scale

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PRoQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *past 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I *[help]*.
___ 3. I get satisfaction from being able to *[help]* people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I *[help]*.
___ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
___ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
___ 10. I feel trapped by my job as a *[helper]*.
___ 11. Because of my *[helping]*, I have felt "on edge" about various things.
___ 12. I like my work as a *[helper]*.
___ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
___ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a *[helper]*.
___ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
___ 21. I feel overwhelmed because my case [work] load seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
___ 24. I am proud of what I can do to *[help]*.
___ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a *[helper]*.
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.

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Exhibit 2.2-10: Your Scores on the ProQOL: Professional Quality of Life Screening

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental healthcare professional.

Compassion Satisfaction _____
Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____
Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____
The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a healthcare professional.

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Exhibit 2.2-11: What Is My Score and What Does It Mean?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

*You Wrote	Change to
1	5
2	4
3	3
4	2
5	1

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____
Total : _____

The sum of my Compassion Satisfaction questions is	So my score equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score.

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____
Total : _____

The sum of my Burnout questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add the[m] up. When you have added them up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____
Total : _____

The sum of my Secondary Trauma questions is	So my score equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

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The objective of debriefing a critical incident that evokes STS reactions in counselors is to help them dissipate the hyperarousal associated with traumatic stress and prevent long-term aftereffects that might eventually lead to counselor impairment. Because clinical supervisors may also be experiencing secondary traumatization, it is advisable for administrators to invite an outside trauma consultant into the organization to provide a safe space for all staff members (including clinical supervisors) to address and process the critical stress incident. For noncrisis situations, secondary traumatization should be addressed in clinical supervision. Clinical supervisors and counselors should work collaboratively to incorporate regular screening and self-assessment of STS into supervision sessions.

Advice to Clinical Supervisors: Advantages and Disadvantages of Using Psychometric Measures

Using a psychometric measure such as the ProQOL has advantages and disadvantages. It is important to understand that all tests measure averages and ranges but do not account for individual circumstances.

If you use the ProQOL in clinical supervision, present it as a self-assessment tool. Let counselors opt out of sharing their specific results with you and/or your team if it is administered in a group. If counselors choose to share scores on specific items or scales with you, work collaboratively and respectfully with them to explore their own understanding of and meanings attached to their scores. If this tool is not presented to supervisees in a nonjudgmental, mindful way, counselors may feel as if they have failed if their scores on the secondary traumatization scale are above average or if their scores on the compassion satisfaction scale are below average. High scores on the compassion fatigue and burnout scales do not mean that counselors don't care about their clients or that they aren't competent clinicians. The scores are simply one way for you and your supervisees to get a sense of whether they might be at risk for secondary traumatization, what they can do to prevent it, how to address it, and how you can support them.

The potential benefits of using a self-assessment tool like the ProQOL in clinical supervision are that it can help counselors:

- Reflect on their emotional reactions and behaviors and identify possible triggers for secondary traumatization.
- Assess their risk levels.
- Examine alternative coping strategies that may prevent secondary traumatization.
- Understand their own perceptions of themselves and their job satisfaction, affirming what they already know about their risk of secondary traumatization and their compassion satisfaction.
- Reflect on different factors that might contribute to unexpected low or high scores, such as the day of the week, the intensity of the workload, whether they have just come back from the weekend or a vacation, and so forth.
- Increase self-awareness and self-knowledge, because scores on specific items or scales bring to consciousness what is often outside of awareness.
- Realize how resilient they are emotionally, mentally, physically, and spiritually.
- Become aware of and open up conversations about self-care and self-care activities and resources, such as supportive coworkers, team members, and social networks outside of work.

If used regularly, self-assessment tools can help counselors and clinical supervisors monitor STS levels, indicate significant positive and negative changes, and suggest action toward self-care in specific areas. Clinical supervisors should fill out the ProQOL and review results with their own supervisors, a peer supervisor, or a colleague before administering it to supervisees. Doing so enables supervisors to gauge their own reactions to the self-assessment and anticipate potential reactions from supervisees.

Advice to Clinical Supervisors: Is it Supervision or Psychotherapy?

Although there are some aspects of clinical supervision that can be therapeutic and parallel the therapeutic and emotional support that occurs between the counselor and the client, clinical supervision is not therapy. As a result, it is important for clinical supervisors to maintain appropriate boundaries with supervisees when addressing their STS reactions at work.

When does the process in supervision cross over into the realm of practicing therapy with a supervisee? One clear indicator is if the supervisor begins to explore the personal history of the counselor and reflects directly on that history instead of bringing it back to how the counselor's history influences his or her work with a particular client or with clients with trauma histories in general. Clinical supervisors should focus only on counselor issues that may be directly affecting their clinical functioning with clients. If personal issues arise in clinical supervision, counselors should be encouraged to address them in their own counseling or psychotherapy.

Exhibit 2.2-12: Clinical Supervisor Guidelines for Addressing Secondary Traumatization

1. Engage counselors in regular screening/self-assessment of counselors' experience of STS.
2. Address signs of STS with counselors in clinical supervision.
3. Work collaboratively with counselors to develop a comprehensive self-care plan and evaluate its effectiveness on a regular basis.
4. Provide counselors a safe and nonjudgmental environment within which to process STS in individual and group supervision or team meetings.
5. Provide counselors with a safe and nonjudgmental place within which to debrief critical stress incidents at work; bring in an outside consultant if needed.
6. Support and encourage counselors to engage in individual counseling or psychotherapy, when needed, to explore personal issues that may be contributing to secondary traumatization at work.

When STS issues arise, the clinical supervisor should work with counselors to review and revise their self-care plans to determine what strategies are working and whether additional support, like individual psychotherapy or counseling, may be warranted.

Exhibit 2.2-12 outlines some guidelines for clinical supervisors in addressing secondary trauma in behavioral health professionals working with clients who have substance use, mental, and trauma-related disorders.

Counselor Self-Care

In light of the intensity of therapeutic work with clients with co-occurring substance use, mental, and trauma-related disorders and the vulnerability of counselors to secondary traumatization, a comprehensive, individualized self-care plan is highly recommended. Balance is the key to the development of a self-care plan—a balance between home and work, a balance between focusing on self and others, and a balance between rest and activity (Saakvitne, Perlman, & Traumatic Stress Institute/ Center for Adult & Adolescent Psychotherapy 1996). Counselor self-care is also about balancing vulnerability, which allows counselors to be present and available when clients address intensely painful content, with reasonable efforts to preserve their sense of integrity in situations that may threaten the counselors' faith or worldview (Burke et al., 2006). A comprehensive self-care plan should include activities that nourish the physical, psychological/mental, emotional/relational, and spiritual aspects of counselors' lives.

The literature on counselor self-care advocates for individual, team, and organizational strategies that support behavioral health professionals working with clients who have

Case Illustration: Carla

Carla is a 38-year-old case manager working in an integrated mental health and substance abuse agency. She provides in-home case management services to home-bound clients with chronic health and/or severe mental health and substance abuse problems. Many of her clients have PTSD and chronic, debilitating pain.

Both her parents had alcohol use disorders, and as a result, Carla became the caretaker in her family. She loves her job; however, she often works 50 to 60 hours per week and has difficulty leaving her work at work. She often dreams about her clients and wakes up early, feeling anxious. She sometimes has traumatic nightmares, even though she was never physically or sexually abused, and she has never experienced the trauma of violence or a natural disaster. She drinks five cups of coffee and three to four diet sodas every day and grabs burgers and sweets for snacks while she drives from one client to the next. She has gained 20 pounds in the past year and has few friends outside of her coworkers. She has not taken a vacation in more than 2 years. She belongs to the Catholic church down the street, but she has stopped going because she says she is too busy and exhausted by the time Sunday rolls around.

The agency brings in a trainer who meets with the case management department and guides the staff through a self-assessment of their current self-care practices and the development of a comprehensive self-care plan. During the training, Carla acknowledges that she has let her work take over the rest of her life and needs to make some changes to bring her back into balance. She writes out her self-care plan, which includes cutting back on the caffeine, calling a friend she knows from church to go to a movie, going to Mass on Sunday, dusting off her treadmill, and planning a short vacation to the beach. She also decides that she will discuss her plan with her supervisor and begin to ask around for a counselor for herself to talk about her anxiety and her nightmares. In the next supervision session, Carla's supervisor reviews her self-care plan with her and helps Carla evaluate the effectiveness of her self-care strategies. Her supervisor also begins to make plans for how to cover Carla's cases when she takes her vacation.

substance use and trauma-related disorders. Counselors are responsible for developing comprehensive self-care plans and committing to their plans, but clinical supervisors and administrators are responsible for promoting counselor self-care, supporting implementation of counselor self-care plans, and modeling self-care. Counselor self-care is an ethical imperative; just as the entire trauma-informed organization must commit to other ethical issues with regard to the delivery of services to clients with substance use, mental, and trauma-related disorders, it must also commit to the self-care of staff members who are at risk for secondary traumatization as an ethical concern. Saakvitne and colleagues (1996) suggest that when administrators support counselor-self-care, it is not only cost-effective in that it reduces the negative effects of secondary traumatization on counselors (and their clients), but also promotes "hope-sustaining behaviors" in counselors, making them more motivated and open to learning, and thereby improving job performance and client care.

A Comprehensive Self-Care Plan

A self-care plan should include a self-assessment of current coping skills and strategies and the development of a holistic, comprehensive self-care plan that addresses the following four domains:

1. Physical self-care
2. Psychological self-care (includes cognitive/mental aspects)
3. Emotional self-care (includes relational aspects)
4. Spiritual self-care

Activities that may help behavioral health workers find balance and cope with the stress

Advice to Clinical Supervisors: Spirituality

The word "spiritual" in this context is used broadly to denote finding a sense of meaning and purpose in life and/or a connection to something greater than the self. Spiritual meanings and faith experiences are highly individual and can be found within and outside of specific religious contexts.

Engaging in spiritual practices, creative endeavors, and group/community activities can foster a sense of meaning and connection that can counteract the harmful effects of loss of meaning, loss of faith in life, and cognitive shifts in worldview that can be part of secondary traumatization. Counselors whose clients have trauma-related disorders experience fewer disturbances in cognitive schemas regarding worldview and less hopelessness when they engage in spiritually oriented activities, such as meditation, mindfulness practices, being in nature, journaling, volunteer work, attending church, and finding a spiritual community (Burke et al., 2006). Clinical supervisors can encourage counselors to explore their own spirituality and spiritual resources by staying open and attuned to the multidimensional nature of spiritual meaning of supervisees and refraining from imposing any particular set of religious or spiritual beliefs on them. A strong sense of spiritual connection can enhance counselors' resilience and ability to cope with the sometimes overwhelming effects of clients' trauma material and trauma-related behavior (including suicidality) on counselors' faith in life and sense of meaning and purpose.

Modeling Self-Care

"Implementing interventions was not always easy, and one of the more difficult coping strategies to apply had to do with staff working long hours. Many of the staff working at the support center also had full-time jobs working for the Army. In addition, many staff chose to volunteer at the Family Assistance Center and worked 16- to 18-hour days. When we spoke with them about the importance of their own self-care, many barriers emerged: guilt over not working, worries about others being disappointed in them, fear of failure with respect to being unable to provide what the families might need, and a 'strong need to be there.' Talking with people about taking a break or time off proved problematic in that many of them insisted that time off was not needed, despite signs of fatigue, difficulty concentrating, and decreased productivity. Additionally, time off was not modeled. Management, not wanting to fail the families, continued to work long hours, despite our requests to do otherwise. Generally, individuals could see and understand the reasoning behind such endeavors. Actually making the commitment to do so, however, appeared to be an entirely different matter. In fact, our own team, although we kept reasonable hours (8 to 10 per day), did not take a day off in 27 days. Requiring time off as part of membership of a Disaster Response Team might be one way to solve this problem."

—Member of a Disaster Response Team at the Pentagon after September 11

Source: Walser, 2004, pp. 4–5.

of working with clients with trauma-related disorders include talking with colleagues about difficult clinical situations, attending workshops, participating in social activities with family and friends, exercising, limiting client sessions, balancing caseloads to include clients with and without trauma histories, making sure to take vacations, taking breaks during the workday, listening to music, walking in nature, and seeking emotional support in both their personal and professional lives (Saakvitne et al., 1996). In addition, regular clinical supervision and personal psychotherapy or counseling can be positive coping strategies for lessening the impact of STS on counselors. Still, each counselor is unique, and a self-care approach that is helpful to one counselor may not be helpful to another. Exhibits 2.2-13 and 2.2-14 offer tools for self-reflection to help counselors discover which specific self-care activities might best suit them. The worksheet can be used privately by counselors or by clinical supervisors as an exercise in individual supervision, group supervision, team meetings, or trainings on counselor self-care.

Exhibit 2.2-13: Comprehensive Self-Care Plan Worksheet

Name: Date:	Personal	Professional/Workspace
Physical		
Psychological/Mental		
Emotional/Relational		
Spiritual		

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Review the questions in Exhibit 2.2-14, and then write down specific self-care strategies in the form (given in Exhibit 2.2-13) that you're confident you will practice in both personal and professional realms.

The *Comprehensive Self-Care Worksheet* is a tool to help counselors (and clinical supervisors) develop awareness of their current coping strategies and where in the four domains they need to increase their engagement in self-care activities. Once completed, clinical supervisors should periodically review the plan with their supervisees for effectiveness in preventing and/or ameliorating secondary traumatization and then make adjustments as needed.

Essential Components of Self-Care

Saakvitne and colleagues (1996) describe three essential components, the "ABCs," of self-care that effectively address the negative impact of secondary traumatization on counselors:

1. **Awareness** of one's needs, limits, feelings, and internal/external resources. Awareness involves mindful/nonjudgmental attention to one's physical, psychological, emotional, and spiritual needs. Such attention requires quiet time and space that supports self-reflection.
2. **Balance** of activities at work, between work and play, between activity and rest, and between focusing on self and focusing on others. Balance provides stability and helps counselors be more grounded when stress levels are high.
3. **Connection** to oneself, to others, and to something greater than the self. Connection decreases isolation, increases hope, diffuses stress, and helps counselors share the burden of responsibility for client care. It provides an anchor that enhances counselors' ability to witness tremendous suffering without getting caught up in it.

Exhibit 2.2-14: Comprehensive Self-Care Plan Worksheet Instructions

Use the following questions to help you engage in a self-reflective process and develop your comprehensive self-care plan. Be specific and include strategies that are accessible, acceptable, and appropriate to your unique circumstances. Remember to evaluate and revise your plan regularly.

Physical
What are non-chemical things that help my body relax?
What supports my body to be healthy?

Psychological/Mental
What helps my mind relax?
What helps me see a bigger perspective?
What helps me break down big tasks into smaller steps?
What helps me counteract negative self-talk?
What helps me challenge negative beliefs?
What helps me build my theoretical understanding of trauma and addictions?
What helps me enhance my counseling/helping skills in working with traumatized clients?
What helps me become more self-reflective?

Emotional/Relational
What helps me feel grounded and able to tolerate strong feelings?
What helps me express my feelings in a healthy way?
Who helps me cope in positive ways and how do they help?
What helps me feel connected to others?
Who are at least three people I feel safe talking with about my reactions/feelings about clients?
How can I connect with those people on a regular basis?

Spiritual
What helps me find meaning in life?
What helps me feel hopeful?
What sustains me during difficult times?
What connects me to something greater?

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Clinical supervisors can help counselors review their self-care plans through the ABCs by reflecting on these questions:

1. Has the counselor accurately identified his or her needs, limits, feelings, and internal and external resources in the four domains (physical, psychological/mental, emotional/relational, spiritual)?
2. Has the counselor described self-care activities that provide a balance between work and leisure, activity and rest, and a focus on self and others?
3. Has the counselor identified self-care activities that enhance connection to self, others, and something greater than self (or a larger perspective on life)?

Supervisors should make their own self-care plans and review them periodically with their clinical supervisors, a peer supervisor, or a colleague.

Commitment to Self-Care

One of the major obstacles to self-care is giving in to the endless demands of others, both at work and at home. It is therefore essential for counselors with the support of clinical supervisors to become "guardians of [their] boundaries and limits" (Saakvitne et al., 1996, p 136). Creating a daily schedule that includes breaks for rest, exercise, connection with coworkers, and other self-care activities can support counselors in recognizing that they are valuable individuals who are worthy of taking the time to nourish and nurture themselves, thus increasing commitment to self-care. Another way to support counselors in committing to self-care is for supervisors and administrators to model self-care in their own professional and personal lives.

Understanding that counselor self-care is not simply a luxury or a selfish activity, but rather, an ethical imperative (Exhibit 2.2-15) can foster counselors' sense of connection to their own values and accountability to the people they serve as competent and compassionate caregivers. Clinical supervisors and administrators can reinforce this sense of accountability while supporting counselors by providing a caring, trauma-informed work environment

Exhibit 2.2-15: The Ethics of Self-Care

The Green Cross Academy of Traumatology was originally established to serve a need in Oklahoma City following the April 19, 1995, bombing of the Alfred P. Murrah Federal Building. Below are adapted examples of the Academy's code of ethics with regard to worker self-care.

Ethical Principles of Self-Care in Practice
These principles declare that it is unethical not to attend to your self-care as a practitioner, because sufficient self-care prevents harming those we serve.

Standards of self-care guidelines:
- Respect for the dignity and worth of self: A violation lowers your integrity and trust.
- Responsibility of self-care: Ultimately it is your responsibility to take care of yourself—and no situation or person can justify neglecting this duty.
- Self-care and duty to perform: There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care.

Standards of humane practice of self-care:
- Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self-care.
- Physical rest and nourishment: Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
- Emotional rest and nourishment: Every helper deserves emotional and spiritual renewal both in and outside the work context.
- Sustenance modulation: Every helper must utilize self-restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since improper consumption can compromise their competence as a helper.

Commitment to self-care:
- Make a formal, tangible commitment: Written, public, specific, measurable promises of self-care.
- Set deadlines and goals: The self-care plan should set deadlines and goals connected to specific activities of self-care.
- Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care.

Source: Green Cross Academy of Traumatology, 2010. Adapted with permission.

that acknowledges and normalizes secondary traumatization and by offering reasonable resources that make it possible for counselors to do their work and take care of themselves at the same time. Preventing secondary traumatization and lessening its impact on counselors once it occurs is not only cost-effective with regard to decreasing staff turnover and potential discontinuity of services to clients; it is also the ethical responsibility of a trauma-informed organization.

Appendices

Appendix A—Bibliography

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Substance Abuse and Mental Health Services Administration. (planned f). *Reintegration-related behavioral health issues in veterans and military families.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (planned g). *Using technology-based therapeutic tools in behavioral health services.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.

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Appendix B—Trauma Resource List

Introduction

As it would be difficult to include every organization focused on trauma, the list of resources in this appendix is not exhaustive; consequently, this list does not include books or other materials concerning the vast nature of this topic, but rather, it concentrates solely on online resources accessible to the public for free or as part of an organization membership. The inclusion of selected resources does not necessarily signify endorsement by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Following these resources for adults is a list of resources focused on children and adolescents and a list of training opportunities.

Technology and Trauma: Using the Web To Treat PTSD

The role of the Internet in helping those who are experiencing posttraumatic stress disorder (PTSD) has expanded rapidly; there are numerous Web sites with toolkits and research publications for clinicians who treat clients with PTSD, as well as Web sites aimed at providing information and support for these individuals. The U.S. military has contributed to the field in developing these avenues—specifically, with interactive Web applications for use on home computers and smartphones.

- PTSD Coach is a smartphone application from the U.S. Department of Veterans Affairs (VA) to help people experiencing PTSD learn about and manage their symptoms (http://www.ptsd.va.gov/public/pages/ptsdcoach.asp).
- Afterdeployment.org is a Web site developed by the Defense Centers of Excellence project led by the National Center for Telehealth & Technology, with interactive workshops about PTSD, traumatic brain injury (TBI), anxiety, and depression, aimed at returning veterans (http://www.afterdeployment.org).
- T2 Virtual PTSD Experience, also developed by the National Center for Telehealth & Technology, is an application to be used within the popular online game Second Life as an interactive way of simulating how PTSD can be acquired within a combat environment, how PTSD may present itself to the person experiencing it, and how to seek effective treatment (http://www.t2health.org/vwproj).

Resources for Adults

Academy of Cognitive Therapy

http://www.academyofct.org
260 South Broad Street
18th Floor
Philadelphia, PA 19102
Phone: 267-350-7683
Email: info@academyofct.org

The Academy of Cognitive Therapy, a nonprofit organization, supports continuing education and research in cognitive therapy, provides a valuable resource in cognitive therapy for professionals and the public at large,

and actively works toward the identification and certification of clinicians skilled in cognitive therapy. Certification is awarded to those individuals who, based on an objective evaluation, have demonstrated an advanced level of expertise in cognitive therapy. The Academy includes physicians, psychologists, social workers, and other mental health professionals from around the world. The Academy formed a Trauma Task Force after September 11, 2001, to disseminate information (available on their Web site) to help people around the world receive the best help possible following trauma.

Addiction Technology Transfer Center Network

http://www.attcnetwork.org/index.asp
5100 Rockhill Road
Kansas City, MO 64110
Phone: 816-235-6888
Email: networkoffice@attcnetwork.org

The Addiction Technology Transfer Center (ATTC) Network serves as a resource for students and professionals to identify international distance education opportunities for the substance abuse treatment field and as a free marketing venue for ATTC-approved sponsors of distance education courses. The ATTC Web site provides trauma-related resources that include case studies, information on working with returning veterans who have been exposed to trauma, and links to various publications on PTSD and secondary traumatic stress.

Agency for Healthcare Research and Quality

http://www.innovations.ahrq.gov/index.aspx
540 Gaither Road
Suite 2000
Rockville, MD 20850
Phone: 301-427-1104

The Agency for Healthcare Research and Quality (AHRQ) is the research arm of HHS, specializing in patient safety and quality improvement, outcomes and effectiveness of care, clinical practice and technology assessment, and healthcare organization and delivery systems. AHRQ also provides funding and technical assistance to health research and research training programs at many universities and institutions. AHRQ's Web site provides links to research publications on PTSD and to other government publications and toolkits dealing with trauma-informed care.

The American Academy of Experts in Traumatic Stress

http://www.aaets.org
203 Deer Road
Ronkonkoma, NY 11779
Phone: 631-543-2217
Email: info@aaets.org

The American Academy of Experts in Traumatic Stress is a multidisciplinary network of professionals who are committed to the advancement of intervention for survivors of trauma. The Academy aims to identify expertise among professionals and across disciplines and to provide meaningful standards for those who work regularly with survivors. The Academy is committed to fostering a greater appreciation of the effects of common traumatic experiences (e.g., chronic illness, accidents, domestic violence, loss) in addition to large-scale disasters and catastrophes. The group's aim is to help all victims to become survivors and, ultimately, to thrive.

American Red Cross Disaster Services

http://www.redcross.org/what-we-do/disaster-relief
American Red Cross National Headquarters
2025 E Street, NW

Washington, DC 20006
Phone: 202-303-4498

Red Cross disaster relief focuses on meeting people's immediate emergency disaster-caused needs. When a disaster threatens or strikes, the Red Cross provides shelter, food, and health and mental health services to address basic human needs. In addition to these services, the core of Red Cross disaster relief is the assistance given to individuals and families affected by disaster to enable them to resume their normal daily activities independently. Training opportunities are also provided.

Anxiety and Depression Association of America

http://www.adaa.org
8701 Georgia Avenue #412
Silver Spring, MD 20910
Phone: 240-485-1001

The Anxiety and Depression Association of America (ADAA) is the only national, nonprofit membership organization dedicated to informing the public, healthcare professionals, and legislators that anxiety disorders are real, serious, and treatable. ADAA promotes the early diagnosis, treatment, and cure of anxiety disorders and is committed to improving the lives of the people who have them. The ADAA Web site provides information about the symptoms of PTSD and how it can be treated, in addition to offering a PTSD self-screening tool.

Association for Behavioral and Cognitive Therapies

http://www.abct.org
305 7th Avenue
16th Floor
New York, NY 10001
Phone: 212-647-1890
Fax: 212-647-1865

The Association for Behavioral and Cognitive Therapies is a professional, interdisciplinary organization concerned with the application of behavioral and cognitive science to understanding human behavior, developing interventions to enhance the human condition, and promoting the appropriate use of these interventions. The association's Web site includes resources for the public and for professionals on trauma and disaster-related problems, a clinical referral directory, and other resources and training opportunities in behavioral therapy.

Association of Traumatic Stress Specialists

http://www.atss.info
88 Pompton Avenue
Verona, NJ 07044
Phone: 973-559-9200
Email: Admin@atss.info

The Association of Traumatic Stress Specialists is an international membership organization that offers three distinct board certifications to qualified individuals who provide services, intervention, response, and/or treatment in the field of traumatic stress. The Association is dedicated to improving the quality of life of all individuals throughout the world who have been affected by traumatic events. Membership represents those who serve survivors of natural disasters, terrorist attacks, injuries and deaths related to serving in the line of duty or to school and workplace violence; veterans; refugees; victims of crime; Holocaust survivors; those affected and exploited by political persecution; and others who have experienced traumatic stress injuries.

Center for Anxiety and Related Disorders

http://www.bu.edu/card
648 Beacon Street
6th Floor

Boston, MA 02215
Phone: 617-353-9610

The Center for Anxiety and Related Disorders (CARD) at Boston University is a clinical and research center dedicated to advancing knowledge and providing care for anxiety, mood, eating, sleep, and related disorders. CARD's Web site offers information regarding PTSD and research publications on trauma and anxiety, in addition to linking to toolkits from the National Child Traumatic Stress Network's Adolescent Traumatic Stress and Substance Abuse Program.

Center for the Study of Traumatic Stress

http://www.cstsonline.org
Uniformed Services University of the Health Sciences
Department of Psychiatry
4301 Jones Bridge Road
Bethesda, MD 20814-4799
Phone: 301-295-2470
Fax: 301-319-6965

The Center for the Study of Traumatic Stress (CSTS) is a federally funded organization established by the Military Health System in 1987 to address Department of Defense concerns regarding health risks and concerns resulting from the traumatic impact of the use of weapons of mass destruction in combat, acts of terrorism and hostage events, combat and peacekeeping operations, natural disasters, and assaults or accidents occurring in both uniformed and civilian communities. CSTS primarily serves members of the armed forces, along with their children and families.

Center for Culture, Trauma and Mental Health Disparities

http://www.semel.ucla.edu/cctmhd
UCLA Semel Institute of Neuroscience & Biobehavioral Sciences
760 Westwood Plaza
Los Angeles, CA 90024
Phone: 310-794-9929

The Collaborative Center for Trauma and Mental Health Disparities at the University of California Los Angeles is a multiethnic and multidisciplinary group that focuses on conducting research and providing training that pertains to trauma in minority populations.

Council of State Governments Justice Center—Mental Health

http://csgjusticecenter.org/jc/category/mental-health
100 Wall Street
20th Floor
New York, NY 10005
Phone: 212-482-2320
Fax: 212-482-2344
Email: consensusproject@csg.org

The Consensus Project is part of the Council of State Governments Justice Center and partners with other organizations, such as SAMHSA's GAINS Center, working to improve outcomes for people, including juveniles, with mental illnesses involved with the criminal justice system. The Consensus Project offers a webinar on trauma services in the criminal justice system and on child trauma and juvenile justice, as well as a local programs database.

Dart Center for Journalism and Trauma

http://www.dartcenter.org
Columbia University
Graduate School of Journalism
2950 Broadway
New York, NY 10027
Phone: 212-854-8056

The Dart Center is dedicated to improving media coverage of trauma, conflict, and

tragedy. The Center also addresses the consequences of such coverage for those working in journalism and provides training and education via seminars, newsroom briefings and consultation on trauma issues, in addition to training for journalism educators and other trainers. The Dart Center Web site offers fact sheets, publications, and DVDs on request for use by journalists, educators, and clinicians.

David Baldwin's Trauma Information Pages

http://www.trauma-pages.com
Phone: 541-686-2598
Email: dvb@trauma-pages.com

This Web site focuses primarily on emotional trauma and traumatic stress, including PTSD and dissociation, whether following individual traumatic experience(s) or a large-scale disaster. The site's purpose is to provide information for clinicians and researchers in the traumatic stress field. Specifically, the focus is on both clinical and research aspects of trauma responses and their resolution.

Disaster Technical Assistance Center

http://www.samhsa.gov/dtac
9300 Lee Highway
Fairfax, VA 22031
Phone: 800-308-3515
Fax: 703-225-2338

SAMHSA has created the Disaster Technical Assistance Center (DTAC) to help States prepare for and respond to a wide range of potential catastrophes—both natural and human-caused disasters. DTAC primarily serves individuals and communities who are recovering from natural and human-caused disasters. It works in conjunction with the Federal Emergency Management Agency (FEMA) and SAMHSA's Emergency Mental Health and Traumatic Stress Services Branch, using strengths-based, outreach-oriented principles conducted in nontraditional settings, as a supplement to programs already in place on a local level.

EMDR Institute, Inc.

http://www.emdr.com
P.O. Box 750
Watsonville, CA 9507
Phone: 831-761-1040
Fax: 831-761-1204
Email: inst@emdr.com

Eye Movement Desensitization and Reprocessing (EMDR) is an information-processing therapy that uses an eight-phase approach. (See the description in Part 1, Chapter 6.) The Web site presents background and descriptive information about this approach to treatment and lists training opportunities, references, and networking groups.

The Federal Emergency Management Agency

http://www.fema.gov
500 C Street SW
Washington, DC 20472
Phone: 202-646-2500

The Federal Emergency Management Agency, a formerly independent agency that became part of the Department of Homeland Security in March 2003, is tasked with responding to, planning for, recovering from, and mitigating against disasters. FEMA can trace its beginnings to the Congressional Act of 1803. This Act, generally considered the first piece of disaster legislation, provided assistance to a New Hampshire town following an extensive fire. In the century that followed, ad hoc legislation was passed more than 100 times in response to hurricanes, earthquakes, floods, and other natural disasters.

The International Critical Incident Stress Foundation, Inc.

http://www.icisf.org
3290 Pine Orchard Lane
Suite 106
Ellicott City, MD 21042
Phone: 410-750-9600
Fax: 410-750-9601
Email: info@icisf.org

The International Critical Incident Stress Foundation, Inc., is a nonprofit, open-membership foundation dedicated to the prevention and mitigation of disabling stress through the provision of education, training, and support services for all emergency services professions; continuing education and training in emergency mental health services for psychologists, psychiatrists, social workers, and licensed professional counselors; and consultation in the establishment of crisis and disaster response programs for varied organizations and communities worldwide.

International Society for the Study of Trauma and Dissociation

http://www.issd.org
8400 Westpark Drive
Second Floor
McLean, VA 22102
Phone: 703-610-9037
Fax: 703-610-0234
Email: info@isst-d.org

The Society is a nonprofit professional association organized for the purposes of information sharing and international networking of clinicians and researchers; providing professional and public education; promoting research and theory about dissociation; and promoting research and training in the identification, treatment, and prevention of dissociative disorders. The Society offers courses in its Dissociative Disorders Psychotherapy Training Program.

The International Society for Traumatic Stress Studies

http://www.istss.org
111 Deer Lake Road
Suite 100
Deerfield, IL 60015
Phone: 847-480-9028
Fax: 847-480-9282

The International Society for Traumatic Stress Studies (ISTSS) was founded in 1985 for professionals to share information about the effects of trauma. ISTSS is dedicated to the discovery and dissemination of knowledge about policy, program, and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences. ISTSS provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma in the United States and around the world.

National Alliance on Mental Illness

http://www.nami.org
3803 N. Fairfax Dr.
Suite 100
Arlington, VA 22203
Phone: 703-524-7600
Fax: 703-524-9094

The National Alliance on Mental Illness (NAMI) is a nonprofit advocacy group founded in 1979 to raise awareness and provide essential and free education, advocacy, and support group programs for people living with mental illness and their loved ones. NAMI operates at the local, State, and national levels, with each level of the organizations providing education, information, support, and advocacy for those with mental illness and their support system. NAMI has developed a Trauma Toolkit and includes a series of lectures for mental health professionals about trauma.

National Association of State Alcohol and Drug Abuse Directors, Inc.

http://www.nasadad.org
1025 Connecticut Ave NW
Suite 605
Washington, DC 20036
Phone: 202-293-0090
Fax: 202-293-1250
Email: dcoffice@nasadad.org

The National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) is a private, not-for-profit educational, scientific, and informational organization. NASADAD's basic purpose is to foster and support the development of effective alcohol and drug abuse prevention and treatment programs throughout every State. NASADAD offers a policy brief with regards to trauma and substance use/abuse in the wake of natural or human-made disasters.

National Association of State Mental Health Program Directors

http://www.nasmhpd.org
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 703-739-9333
Fax: 703-548-9517

The National Association of State Mental Health Program Directors (NASMHPD; pronounced "NASH-pid") is a nonprofit organization dedicated to serving the needs of the Nation's public mental health system through policy development, information dissemination, and technical assistance. NASMHPD represents the $23 billion public mental health service delivery system. As a private, not-for-profit 501(c)(3) membership organization, NASMHPD helps set the agenda and determine the direction of State mental health agency interests across the country, historically including State mental health planning, service delivery, and evaluation. The principal programs operated, funded, and/or regulated by NASMHPD members serve people who have serious mental illnesses, developmental disabilities, and/or substance use disorders. NASMPHD has launched a Technical Assistance Coordinating Center in response to the Alternatives to Restraint and Seclusion State Infrastructure Grant Project, an initiative of SAMHSA's Center for Mental Health Services, designed to promote the implementation and evaluation of best practice approaches to preventing and reducing the use of seclusion and restraint in mental health settings.

National Center for Injury Prevention and Control

http://www.cdc.gov/injury
1600 Clifton Road
Atlanta, GA 30333
Phone: 800-232-4636
Email: cdcinfo@cdc.gov

The National Center for Injury Prevention and Control (NCIPC) was established by the Centers for Disease Control and Prevention in 1992. Through research, surveillance, implementation of evidence-based strategies, capacity building, and communication activities, NCIPC works to reduce morbidity, disability, mortality, and costs associated with injuries and violence. NCIPC is the lead U.S. Federal agency for nonoccupational injury prevention.

National Center for PTSD

http://www.ptsd.va.gov
810 Vermont Avenue NW
Washington, DC 20420
Phone: 802-296-6300
Email: ncptsd@va.gov

The National Center for PTSD (NCPTSD) was created within the Department of

Veterans Affairs in 1989 in response to a Congressional mandate to address the needs of veterans with military-related PTSD. Its mission is to advance the clinical care and social welfare of America's veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders. Its Web site is provided as an educational resource concerning PTSD and other enduring consequences of traumatic stress. The NCPTSD Web site has information about instruments to measure trauma exposure, risk and resilience factors for PTSD, self-report instruments, and interview schedules. Training opportunities are listed at http://www.ptsd.va.gov/about/training/training-programs.asp.

National Center for Telehealth and Technology

http://www.t2health.org
9933C West Hayes Street
Joint Base Lewis-McChord, WA 98431
Phone: 253-968-1914
Fax: 253-968-4192
Email: AskUs@t2health.org

The National Center for Telehealth and Technology is a Federal agency founded by the Department of Defense as part of the Military Health System. It primarily serves veterans and active-duty military personnel who are experiencing adverse health effects due to TBI and PTSD, as well as military children who are coping with their parents' deployment, through the use of technology (e.g., mobile phone applications, deployable telehealth centers).

National Center for Trauma-Informed Care

http://www.samhsa.gov/nctic
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 866-254-4819
Fax: 703-548-9517
Email: NCTIC@NASMHPD.org

The National Center for Trauma-Informed Care (NCTIC) is a Federal center established by SAMHSA in 2005 to offer consultation, technical assistance, education, outreach, and resources to support trauma-informed care in publicly-funded systems and programs. NCTIC primarily serves those who are already receiving services from the behavioral health system and is focused on helping behavioral health services and programs to become more aware of the impact of trauma among consumers, to adapt services to incorporate trauma-informed practices, and to help raise awareness of practices or processes that are more likely to retraumatize consumers.

National Center for Victims of Crime

http://www.victimsofcrime.org
2000 M Street NW
Suite 480
Washington, DC 20036
Phone: 202-467-8700
Fax: 202-467-8701
Email: webmaster@ncvc.org

The National Center for Victims of Crime (NCVC) is a nonprofit organization funded partially by Federal grants from the Department of Justice. It was founded in 1985 and originally known as the Sunny Von Bulow National Victim Advocacy Center. NCVC is a resource center for those affected by violent crimes and also provides training and education for behavioral health service providers.

National Center on Domestic Violence, Trauma & Mental Health

http://www.nationalcenterdvtraumamh.org/
Phone: 312-726-7020
Fax: 312-726-7022

The National Center on Domestic Violence, Trauma & Mental Health was established in 2005 through a grant from the Family Violence Prevention and Services Program, HHS. The Center's mission is to promote accessible, culturally relevant, and trauma-informed responses to domestic violence and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being; this is achieved by providing training and online resources to mental health and substance abuse treatment providers and developing policies to improve system responses to domestic violence survivors and their children.

National Center on Elder Abuse

http://www.ncea.aoa.gov
University of California–Irvine
Program in Geriatric Medicine
101 The City Drive South, 200 Building
Orange, CA 92868
Phone: 855-500-3537
Email: ncea-info@aoa.hhs.gov

The National Center on Elder Abuse (NCEA), part of the U.S. Administration on Aging, serves as a national resource center dedicated to the prevention of elder mistreatment. NCEA provides information to both mental health professionals and the general public and also provides technical assistance and training to States and community-based organizations.

National Center on Family Homelessness

http://www.familyhomelessness.org
200 Reservoir Street
Suite 200
Needham, MA 02494
Phone: 617-964-3834
Fax: 617-244-1758
Email: info@familyhomelessness.org

The National Center on Family Homelessness (NCFH) was founded in 1988 and is a nonprofit organization that conducts research and creates public awareness about the special needs of families experiencing homelessness. NCFH primarily serves veterans who are homeless and their families and young mothers who are homeless with their children. NCFH has developed a Trauma-Informed Organizational Toolkit for Homeless Services.

National Coalition Against Domestic Violence

http://www.ncadv.org
1 Broadway
Suite B210
Denver, CO 80203
Phone: 303-839-1852
Fax: 303-831-9251
Email: mainoffice@ncadv.org

The National Coalition Against Domestic Violence (NCADV) is an advocacy group founded in 1978 and acts as a national information and referral center for the general public, media, survivors of domestic violence and their children, and allied and member agencies and organizations. NCADV also works to influence legislation that would provide protection for survivors of domestic violence and their families and provide funding to shelters, healthcare centers, and other organizations.

National Council for Behavioral Health

http://www.thenationalcouncil.org
1701 K Street NW
Suite 400
Washington, DC 20006
Phone: 202-684-7457
Email: communications@thenationalcouncil.org

The National Council for Behavioral Health is a national community behavioral health

advocacy organization, formed in 1970, to conduct Federal advocacy activities, representing the industry on Capitol Hill and before Federal agencies. It also offers a national consulting service program, various publications, and an annual training conference. The National Council Magazine, 2011, Issue 2, focuses on trauma-informed behavioral health services. The National Council has offered a Learning Community for Adoption of Trauma-Informed Practices, funded by SAMHSA.

National Institute on Drug Abuse

http://drugabuse.gov
National Institute on Drug Abuse
National Institutes of Health
6001 Executive Boulevard
Room 5213, MSC 9561
Bethesda, MD 20892-9561
Phone: 301-443-1124
Email: information@nida.nih.gov

The National Institute on Drug Abuse's (NIDA) mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. NIDA's goal is to ensure that science, not ideology or anecdote, forms the foundation for all of the Nation's drug abuse reduction efforts. NIDA was established in 1974, and in October 1992 it became part of the National Institutes of Health (NIH), HHS. The Institute is organized into divisions and offices, each of which plays an important role in programs of drug abuse research. NIDA has an ongoing research program on women's health and sex/gender differences, including the gathering of information on trauma and substance abuse.

National Institute of Mental Health

http://www.nimh.nih.gov
National Institute of Mental Health
Science Writing, Press, and Dissemination Branch
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: 301-443-4513
Fax: 301-443-4279
Email: nimhinfo@mail.nih.gov

The National Institute of Mental Health (NIMH) is one of the 27 component institutes of NIH, the Federal Government's principal biomedical and behavioral research agency that is part of HHS. NIMH's mission is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior. This public health mandate demands that NIMH use science to achieve better understanding, treatment, and eventually, prevention of these disabling conditions that affect millions of Americans. NIMH offers publications and podcasts related to traumatic events and PTSD.

National Registry for Evidence-Based Programs and Practices

http://www.nrepp.samhsa.gov
Phone: 866-436-7377
Email: nrepp@samhsa.hhs.gov

SAMHSA's National Registry for Evidence-Based Programs and Practices (NREPP) is a searchable online registry of more than 300 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. NREPP offers several interventions that address trauma and PTSD.

National Sexual Violence Resource Center

http://www.nsvrc.org
123 North Enola Drive
Enola, PA 17025
Phone: 717-909-0710
Fax: 717-909-0714

The National Sexual Violence Resource Center (NSVRC) was founded by the Pennsylvania Coalition Against Rape in 2000 and is partially federally funded by grants from the Centers for Disease Control and Prevention. NSVRC advocates for changes in Federal and State legislation to further the goal of ending sexual violence in all communities, in addition to collecting and disseminating a wide range of resources on sexual violence, including statistics, research, position statements, statutes, training curricula, prevention initiatives and program information. NSVRC does not provide direct services to survivors of sexual violence but acts as a resource to support these services.

National Trauma Consortium

http://www.nationaltraumaconsortium.org
520 Ralph Street
Sarasota, FL 34242
Phone: 941-312-9795

The National Trauma Consortium (NTC) is a clearinghouse for information about trauma and emerging best practices in trauma treatment and services and, in addition, offers training and consultation services. NTC also provides resources in the form of downloadable publications and links to other organizations related to mental health and trauma.

National Voluntary Organizations Active in Disasters

http://www.nvoad.org
1501 Lee Highway
Suite 170
Arlington, VA 22209-1109
Phone: 703-778-5088
Fax: 703-778-5091
Email: info@nvoad.org

National Voluntary Organizations Active in Disasters (NVOAD) coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective service and less duplication by getting together before disasters strike. Once disasters occur, NVOAD or an affiliated State VOAD encourages members and other voluntary agencies to convene on site. This cooperative effort has proven to be the most effective way for a wide variety of volunteers and organizations to work together in a crisis. NVOAD's principles are cooperation, coordination, communication, education, mitigation, convening mechanisms, and outreach.

Office for Victims of Crime Training and Technical Assistance Center

https://www.ovcttac.gov/
9300 Lee Highway
Fairfax, VA 22031-6050
Phone: 866-682-8822
TTY: 866-682-8880
Fax: 703-279-4673
Email: TTAC@ovcttac.org

The Office for Victims of Crime Training and Technical Assistance Center provides comprehensive, quality technical assistance and training resources to victims' service providers and allied professionals. Its mission is to support the development of the field by increasing the Nation's capacity to provide crime victims with skilled, capable, and sensitive assistance. Its core functions are needs assessment, capacity building, evaluation, and reporting.

Rape, Abuse & Incest National Network

http://www.rainn.org
1220 L Street NW
Suite 505
Washington, DC 20005
Phone: 202-544-1034
Email: info@rainn.org

The Rape, Abuse & Incest National Network (RAINN) is a nonprofit organization, founded in 1994, that is partially funded by a grant from the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. RAINN provides support for survivors of sexual assault via a telephone hotline and an online hotline and works with the Department of Defense (DoD) to provide a hotline for members of the DoD community who have experienced sexual assault.

SAMHSA's Tribal Training and Technical Assistance Center

http://beta.samhsa.gov/tribal-ttac
201 Corporate Drive
Suite 800
Landover, MD 20785
Phone: 240-650-0257
Email: TA-Request@tribaltechllc.com

SAMHSA's Tribal Training and Technical Assistance Center (Tribal TTAC) is committed to providing comprehensive broad, focused, and/or intensive training and technical assistance to federally recognized Tribes and other American Indian and Alaska Native communities seeking to address and prevent mental and substance use disorders and suicide while promoting mental health. The goal of the Tribal TTAC is to use a culturally relevant, evidence-based, holistic approach to support Native communities in their self-determination efforts through infrastructure development, capacity building, and program planning and implementation.

Sanctuary Model

http://www.sanctuaryweb.com
Phone: 888-538-3124

The goals of the Sanctuary Model include increasing the perceived sense of community/cohesiveness; the degree of social immunity to the spread of violence; the capacity for social learning; the making of decisions democratically and the sharing of responsibility in solving problems and resolving conflicts; the ability to deal with complexity; opportunities for all clients and staff members to experience a truly safe and connected community; opportunities for troubled clients to have corrective emotional, relational, and environmental experiences; and recovery, healing, and growth.

Seeking Safety

http://www.seekingsafety.org
Treatment Innovations
28 Westbourne Road
Newton Centre, MA 02459
Phone: 617-299-1610
Fax: 617-701-1295
Email: info@seekingsafety.org

This Web site provides information about Seeking Safety, a psychotherapeutic intervention for treating trauma, PTSD, and substance abuse. Seeking Safety is a present-focused therapy to help people attain safety from both PTSD and substance abuse. The treatment is also available as a book, which provides both client handouts and guidance for clinicians. The site includes topics included in the treatment program, sample materials, relevant empirical studies, and supplementary articles.

Sidran Institute

http://www.sidran.org
P.O. Box 436
Brooklandville, MD 21022-0436
Phone: 410-825-8888
Fax: 410-560-0134
Email: info@sidran.org

The Sidran Institute is a nationally focused nonprofit organization devoted to helping people who have experienced traumatic life events through education and advocacy. The Institute's education and advocacy focuses on:

- The early recognition and treatment of trauma-related stress in children.
- The understanding of trauma and its long-term effect on adults.
- The strategies in engaging in mutual-help recovery for trauma survivors.
- The clinical methods and practices leading in aiding trauma victims.
- The development of public policy initiatives responsive to the needs of adult and child survivors of traumatic events.

Substance Abuse and Mental Health Services Administration

http://www.samhsa.gov
1 Choke Cherry Lane
Rockville, MD 20857
Phone: 877-726-4727
Fax: 240-221-4292
Email: SAMHSAInfo@samhsa.hhs.gov

SAMHSA is the Federal agency within HHS charged with improving the quality and availability of prevention, treatment, and rehabilitative services to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness. The Emergency Mental Health and Traumatic Stress Services Branch, a branch of SAMHSA's Center for Mental Health Services, works with FEMA to provide crisis counseling training and technical assistance to State and local mental health professionals. SAMHSA offers several publications regarding trauma and PTSD, as well as a publication focusing on creating a seclusion-free and restraint-free environment.

Traumatic Stress Institute

http://www.traumaticstressinstitute.org
Klingberg Family Centers
370 Linwood Street
New Britain, CT 06052
Phone: 860-224-9113

The Traumatic Stress Institute (TSI) works to increase understanding of the psychological impact of trauma and to help victims of violence restore meaning and wholeness to their lives. In meeting these goals, TSI is involved in clinical service, professional training, community education, and research. TSI offers forensic assessment and expert testimony, professional education, training opportunities, and publications. TSI developed the "Risking Connections" trauma treatment program and provides training in the use of this model.

Tulane University Traumatology Institute

http://sites.google.com/site/charlesfigley/Home/traumatologyinstitute
Tulane School of Social Work
6823 St. Charles Ave., Building 9
New Orleans, LA 70118
Phone: 800-631-8234
Email: figley@tulane.edu

The Traumatology Institute, founded in 1996, brings together health and mental health professionals from a wide array of disciplines from throughout the United States and around the world to develop cutting-edge research, treatment approaches, and training programs in the field of traumatology. The Institute facilitates the development of knowledge about the traumatization experience of victims, survivors, and the professionals who serve them. The Traumatology Institute conducts research, education, and service activities toward reducing the deleterious effects of trauma on individuals, families, communities, and entire societies.

Veterans Affairs PTSD Support Services

http://www.ptsdsupport.net/va.html
P.O. Box 5574
Woodland Park, CO 80866
Email: russ@ptsdsupport.net

The Department of Veterans Affairs Medical Centers provide a network of more than 100 specialized programs for veterans with PTSD, working closely in conjunction with the Veterans Web Site (http://www.vetcenter.va.gov) operated by VA's Readjustment Counseling Service. Each specialized PTSD program offers veterans education, evaluation, and treatment conducted by mental health professionals from a variety of disciplines (such as psychiatry, psychology, social work, counseling, and nursing). See also: National Center for PTSD.

White Bison Wellbriety Training Institute

http://www.whitebison.org
701 N. 20th Street
Colorado Springs, CO 80904
Phone: 877-871-1495
Email: info@whitebison.org

White Bison is an American Indian nonprofit charitable organization that focuses on offering sobriety, recovery, addictions prevention, and wellness/Wellbriety learning resources to the Native American community nationwide. White Bison's Wellbriety Training Institute provides training, tools, and resources for historical and intergenerational trauma to trainers and mental health professionals.

Resources for Children and Adolescents

The following section provides resources that address the needs of children and adolescents who are affected by traumatic stress.

American Academy of Child & Adolescent Psychiatry

http://www.aacap.org
3615 Wisconsin Avenue NW
Washington, DC 20016-3007
Phone: 202-966-7300
Fax: 202-966-2891

The American Academy of Child & Adolescent Psychiatry (AACAP) is a national professional medical association dedicated to treating and improving the quality of life for children, adolescents, and families affected by mental, behavioral, and developmental disorders. AACAP distributes information to promote an understanding of mental illnesses and remove the shame associated with them, to advance efforts in prevention of mental illnesses, and to ensure proper treatment and access to services for children and adolescents.

American Professional Society on the Abuse of Children

http://www.apsac.org
350 Poplar Avenue
Elmhurst, IL 60126
Phone: 630-941-1235
Fax: 630-359-4274
E-mail: apsac@apsac.org

The mission of the American Professional Society on the Abuse of Children (APSAC) is to enhance the ability of professionals to respond to children and families affected by abuse and violence. Among other initiatives, APSAC provides education and other sources of information to professionals who work in the child maltreatment and related fields.

Anna Institute

http://www.theannainstitute.org
21 Ocean Street
Rockland, ME 04841
Email: afj@gwi.net

The Anna Institute was founded in memory of artist Anna Caroline Jennings; it focuses on educating both the public and mental health professionals about the effects of sexual abuse and trauma on children. The Anna Institute's Web site provides articles on incorporating

trauma-informed care into existing behavioral health models, presentations on childhood trauma and retraumatization, and handouts for teachers at primary and secondary schools.

Caring for Every Child's Mental Health Campaign

http://www.samhsa.gov/children
P.O. Box 2345
Rockville, MD 20847-2345
Email: nmhic-info@samhsa.hhs.gov

SAMHSA's Caring for Every Child's Mental Health communications campaign is a national public information and education operation. Its goals are to increase public awareness about the importance of protecting the mental health of young people; foster the recognition that many children have mental health problems; and encourage caregivers to seek early, appropriate treatment and services. It also strives to reduce discrimination associated with mental health problems. The campaign is a technical assistance program that is part of the Comprehensive Community Mental Health Services Program for Children and Their Families.

Child Study Center

http://www.aboutourkids.org
One Park Avenue
7th Floor
New York, NY 10016
Phone: 212-263-6622
Email: webmaster@aboutourkids.org

The New York University Child Study Center Web site offers information to parents of children and adolescents with learning, behavioral, and emotional disorders, including PTSD and substance use disorders. An online newsletter is available. Its research initiatives advance understanding of the causes and treatments of child mental disorders, and these findings are integrated into clinical care to provide state-of-the-art service.

Child Trauma Academy

http://www.childtrauma.org
5161 San Felipe
Suite 320
Houston, TX 77056
Phone: 866-943-9779
Email: cta@childtrauma.org

The mission of the Child Trauma Academy is to help improve the lives of traumatized and maltreated children. Through education, service delivery, and program consultation, the academy seeks to advance systems that educate, nurture, protect, and enrich these children.

Child Trauma Institute

http://www.childtrauma.com
P.O. Box 544
Greenfield, MA 01302-0544
Phone: 413-774-2340
Email: cti@childtrauma.com

The Child Trauma Institute provides training, consultation, information, and resources for those who work with trauma-exposed children, adolescents, and adults. The Web site has information for parents, publications for parents and professionals, and links to other child trauma Web sites.

Child Welfare Information Gateway

http://www.childwelfare.gov
Children's Bureau/ACYF
1250 Maryland Avenue SW
Eighth Floor
Washington, DC 20024
Phone: 800-394-3366
Email: info@childwelfare.gov

The Child Welfare Information Gateway (CWIG) is a service of the Children's Bureau in the Administration for Children and Families, part of HHS, which provides information

to child welfare and mental health professionals about programs, research, laws and policies, training approaches, and statistics regarding child welfare, child abuse and neglect, and adoption. CWIG offers educators' toolkits for preventing and responding to child abuse and neglect, a function to search State statutes about child abuse and neglect, and logic model builder toolkits for program administrators.

Child Welfare League of America

http://www.cwla.org
1726 M Street NW
Suite 500
Washington DC, 20036
Phone: 202-688-4200
Fax: 202-833-1689

Through its member child welfare agencies, the Child Welfare League of America develops and disseminates practice standards as benchmarks for high-quality services that protect children and youth; promotes high-quality services through training, consultation, conferences, and publications; formulates and promotes public policies that contribute to the well-being of children and youth; ensures that all child welfare services are provided in a manner that demonstrates respect for cultural and ethnic diversity; and promotes open exchange of data, resources, and ideas within and across systems that serve children, youth, and families.

Eunice Kennedy Shriver National Institute of Child Health and Human Development

http://www.nichd.nih.gov/Pages/index.aspx
31 Center Drive
Building 31, Room 2A32
Bethesda, MD 20892-2425
Phone: 800-370-2943

Established in 1962, NIH's National Institute of Child Health and Human Development (NICHD) focuses on human development processes from conception to later years. The Institute implements, conducts, and supports laboratory research, clinical trials, epidemiological research, and other studies that explore health processes and the impact of disabilities, diseases, and variations on the lives of individuals. NICHD sponsors training for scientists and healthcare providers to promote the goals of the Institute.

National Center for Children Exposed to Violence

http://www.nccev.org
Yale Child Study Center
230 South Frontage Road
P.O. Box 207900
New Haven, CT 06520-7900
Phone: 877-496-2238
Email: colleen.vadala@yale.edu

The National Center for Children Exposed to Violence (NCCEV) seeks to increase the capacity of individuals and communities to reduce the incidence and impact of violence on children and families; to train and support the professionals who provide intervention and treatment; and to increase professional and public awareness of the effects of violence on children, families, communities, and society. The Center's Web site is a rich source of information. NCCEV is supported by grants from the Office of Juvenile Justice and Delinquency Prevention, the Department of Justice, SAMHSA, and the Department of Education.

National Center on Substance Abuse and Child Welfare

http://www.ncsacw.samhsa.gov
P.O. Box 2345
Rockville, MD 20847-2345
Phone: 866-493-2758
Email: ncsacw@cffutures.org

The National Center on Substance Abuse and Child Welfare (NCSACW) is an initiative of HHS and is jointly funded by SAMHSA's Center for Substance Abuse Treatment and the Administration on Children, Youth and Families, Children's Bureau's Office on Child Abuse and Neglect. NCSACW seeks to develop and implement a comprehensive program of information gathering and dissemination, to provide technical assistance, and to develop knowledge that promotes effective practical, organizational, and systemic changes at the local, State, and national levels. Its Web site includes PowerPoint presentations, online tutorials and training, technical assistance presentations, and additional print resources.

National Child Traumatic Stress Network

http://www.nctsnet.org
NCTSN—University of California, Los Angeles
11150 W. Olympic Boulevard
Suite 650
Los Angeles, CA 90064
Phone: 310-235-2633
Fax: 310-235-2612

The National Child Traumatic Stress Network (NCTSN), currently comprising 54 treatment centers nationwide, is funded by SAMHSA's Center for Mental Health Services through the Donald J. Cohen National Child Traumatic Stress Initiative and coordinated by Duke University and the University of California, Los Angeles. The purpose of this congressionally mandated initiative is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. NCTSN works with SAMHSA to raise public awareness of the effects of traumatic stress on children and families, and with other systems of care (including the health, mental health, education, law enforcement, child welfare, juvenile justice, and military family service systems) to ensure that there is a comprehensive trauma-informed continuum of accessible care. Additionally, NCTSN offers a list of evidence-based and promising practices.

National Institute for Trauma and Loss in Children

http://www.starrtraining.org/trauma-and-children
42855 Garfield Road
Suite 111
Clinton Township, MI 48038
Phone: 877-306-5256
Fax: 586-263-4915
Email: TLC@starrtraining.org

The National Institute for Trauma and Loss in Children provides school professionals, crisis intervention teams, medical and mental health professionals, child care professionals, and clinicians with trauma education, training, consultation, referral services, and trauma-specific intervention programs and resource materials needed to help those traumatized by violent or nonviolent trauma-inducing incidents.

National Native Children's Trauma Center

http://iers.umt.edu/National_Native_Childrens_Trauma_Center
Institute for Educational Research and Service
McGill Hall 026
The University of Montana
Missoula, MT 59812-6376
Phone: 406-243-5344
Fax: 406-243-2197
Email: iers@mso.umt.edu

The National Native Children's Trauma Center (NNCTC) is a federally funded organization created by SAMHSA and affiliated with the National Child Traumatic Stress Network. It

is run by the University of Montana. NNCTC offers trauma interventions and trainings to address trauma in American Indian/Alaska Native children, primarily through clinicians, Tribal programs, school systems, and community agencies.

Training Opportunities

The following resources highlight various training and credentialing opportunities for behavioral health professionals interested in gaining more education in treating and providing services to those affected by trauma. It is not an exhaustive list, but provides a starting place for service providers looking for further training.

The Web site of the ISTSS has posted a directory of trauma-related academic and training opportunities (http://www.istss.org/LearningAboutTrauma.htm). It includes links to the institutions providing the programs. The Association for Traumatic Stress Specialists (http://www.atss.info) offers three levels of recognition for education and experience:

- Certified Trauma Specialist (CTS)—designed for counselors, clinicians, and treatment specialists who provide intervention services or individual, group, and/or family counseling. This certification requires 240 hours of education and training in trauma treatment, plus 2,000 hours of trauma counseling and intervention experience.
- Certified Trauma Responder (CTR)—designed for those who provide immediate trauma interventions. It requires a minimum of 40 hours of experience on a crisis or critical incident response team, an associate degree or a high school diploma with successful completion of disaster or critical incident stress debriefing training, and 72 hours of crisis response training.
- Certified Trauma Services Specialist (CTSS)—designed for those who provide immediate trauma intervention, crisis support, advocacy, or victim assistance. It requires 1 year of experience in a trauma-related field, plus specific training.

Some colleges and universities, such as the International Trauma Studies Program at New York University and the Center for Anxiety and Related Disorders at Boston University, provide specialty trauma training for mental health practitioners. The University of Missouri at St. Louis offers specialized training in trauma therapy or research at its Center for Trauma Recovery to students in its Clinical Psychology graduate program. The Center for the Treatment and Study of Anxiety at the University of Pennsylvania provides training for health professionals. The Department of Counseling at the University of Nevada, Las Vegas offers a graduate and undergraduate course on Trauma and Addiction; graduate students can receive training in trauma and addictions as part of the Advanced Graduate Certificate in Addiction Studies. The Medical University of South Carolina offers Web-based courses in trauma-focused cognitive–behavioral therapy (TF-CBT) and in using TF-CBT for childhood traumatic grief. Many universities have faculty members with expertise in trauma and trauma-related subjects, so that training can be accessed through many graduate programs.

The Addiction Technology Transfer Center (ATTC) Network, a resource established in 1993 by the SAMHSA's Center for Substance Abuse Treatment, is a network of 14 independent regional centers with a national office. One of its programs provides long-distance education for clinicians on various topics. Among hundreds of self-paced, self-directed, and supervised courses available online (http://www.attcnetwork.org/learn/education/

dasp.asp) are Substance Abuse Treatment for Trauma Survivors, Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues, Chemical Dependency and Posttraumatic Stress Disorder, Clinical Self-Care for Addiction Counselors and Clinical Supervisors, Eye Movement Desensitization and Reprocessing, Battered Women and Addictions, and Posttraumatic Stress Disorder. ATTC training and educational opportunities are based on empirical research and are intended to bring science to service. Undoubtedly, more distance-learning courses in this specialized area of interest will be developed as professional attention to co-occurring disorders increases.

SAMHSA's Center for Mental Health Services provides training for FEMA-approved crisis counseling programs using Stafford Act funding. These funding resources are available to select agencies designated to provide crisis counseling in the wake of a Presidential Disaster Declaration. Other funding for trauma training may be found through special programs of funding for target groups, such as those who provide mental health services and case management for victims of crime (e.g., Office for Victims of Crime in the U.S. Department of Justice; see p. 257).

The American Red Cross provides limited disaster mental health training. The focus of this training is to orient licensed mental health professionals to the Red Cross Disaster services system and their roles as volunteers.

The National Center for Post-Traumatic Stress Disorder was originally created in 1989 within the U.S. Department of Veterans Affairs (VA) to address the needs of veterans with military-connected PTSD. Its focus has since broadened to include trauma in general. The Center provides a variety of training opportunities for both VA and non-VA mental health personnel, including a PTSD 101 course developed specifically for clinicians who provide services to clients who have experienced trauma (see http://www.ptsd.va.gov/professional/index.asp).

Seeking Safety offers training in trauma, PTSD, and co-occurring disorders to mental health professionals on all levels, from counselors to nurses to administrators. The EMDR International Association (EMDRIA) provides training to clinicians for certification in EMDR via a curriculum including instruction, supervised practicum, and consultation; EMDRIA additionally provides basic training in the field, separate from the certification process. EMDR training is also provided by the EMDR Humanitarian Assistance Program, a nonprofit organization with a training-focused model to assist clinicians in treating trauma.

ISTSS was founded in 1985 to bring attention to the study, assessment, and treatment of traumatized people (http://www.istss.org). ISTSS is a professional society and provides face-to-face training during its annual meeting, especially through the preconference institutes. The ISTSS Web site offers numerous video and audio trainings for continuing education credits. ISTSS and the Figley Institute (http://www.figleyinstitute.com) have established best practice standards. The American Academy of Experts in Traumatic Stress provides training and certification in several different areas (http://www.aaets.org). Similarly, the International Society for the Study of Dissociation (http://www.issd.org) specializes in promoting therapies for dissociative disorders. In 2002, the Green Cross Academy of Traumatology (http://www.greencross.org) established a Commission on Accreditation of Traumatology Education Programs to increase and maintain the high standards in the education and training of traumatologists.

Appendix C—Historical Account of Trauma

Historically, symptoms of traumatic stress have been recorded in both military and civilian populations (Lasiuk & Hegadoren, 2006). Early accounts described the effect of battle conditions on soldiers; "soldier's heart" and "nostalgia" were the terms for traumatic stress reactions used during the American Civil War. As warfare techniques and strategies changed, so did the depiction of soldiers' traumatic stress reactions. The advent of heavy explosives in World War I led to the attribution of symptoms to "shell shock," giving a more physiological description of the effects from explosions (Benedek & Ursano, 2009). On the civilian side, the industrial revolution gave rise to larger and more dramatic catastrophes, including industrial and railway accidents. These, as well as other disasters, are noted in occupational health histories, newspapers, and contemporary literature.

Even with a more physical explanation of traumatic stress (i.e., shell shock), a prevailing attitude remained that the traumatic stress response was due to a character flaw. For instance, a soldier's pain at that time was often seen as a symptom of homesickness. In spite of the efforts of Charcot, Janet, and Freud, who described the psychogenic origin of symptoms as a response to psychological trauma (Lasiuk & Hegadoren, 2006), World War II military recruits were screened in attempt to identify those "who were afflicted with moral weakness," which would prevent them from entering military service.

At the same time, there were new treatment innovations for war-related trauma during World War II. One approach treated soldiers in the field for what was then called "battle fatigue" by allowing some time for rest before returning to battle. During the Korean and Vietnam wars, approaches began to focus more on the use of talk therapy. It was not until the post-Vietnam era that interest in developing treatment alternatives started to take hold. During this time, the U.S. Department of Veterans Affairs (then called the Veterans Administration) developed group therapy for posttraumatic stress disorder (PTSD). Beyond being cost-effective, the technique was well suited to the symptoms of the veterans and fostered socialization and reintegration (Greene et al., 2004).

The publication of the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition (DSM-III), in 1980 marked the introduction of PTSD as a diagnosis, inspired by symptoms presented by veterans of the Vietnam War (Benedek & Ursano, 2009). The diagnosis in this iteration required the identification of a specific stressor—a catastrophic stressor that was outside the range of usual human experience (APA, 1980)—and classified PTSD as

Historical Approaches to Trauma Healing and Recovery

First Generation of Approaches to Trauma Healing and Recovery
The first generation approaches to trauma healing and recovery focused on individual and clinical interventions to address the symptoms of PTSD and moved toward integration of trauma effects into ongoing life activities. The rapidly developing recognition of additional groups with violence and trauma histories—beyond those with war and captivity experiences (e.g., survivors of natural disasters and terrorism, refugees and immigrants fleeing homeland violence and persecution)—presented issues and needs that incited a second generation of approaches to trauma healing and recovery.

Second Generation of Approaches to Trauma Healing and Recovery
The second generation approaches focused on psychosocial education and empowerment models designed to tap into self-healing forces to energize personal and social movement. These approaches often are based on group and peer support models, and provide both support and education on the management of trauma and its affects. These approaches are not designed to replace clinical or alternative therapies; rather, they provide a social context for care.

Concurrent to the development of psychosocial educational empowerment approaches, we also learned that if the approaches are not implemented in organizations or programs that are trauma-informed, they will not take root and may lose effectiveness.

Trauma-Informed Care: A New Paradigm for Public Health Services
Trauma-informed care is a new paradigm for organizing public mental health and human services. Trauma-informed care changes the opening question for those seeking services from "What is wrong with you?" (patient or consumer) to "What has happened to you?" (survivor). Trauma-informed care is initiated by assumption that every person seeking services is a trauma survivor who designs his or her own path to healing, facilitated by support and mentoring from the service provider.

In a trauma-informed environment, survivors are empowered to proactively set goals and to manage progress toward those goals. For most existing organizations or programs, that requires movement from a traditional "top down" hierarchical clinical model to a psychosocial empowerment partnership that embraces all possible tools and paths to healing. In a pluralistic public health system with many levels and types of services and treatment, this is coming to be accepted as a "sine qua non," or "without which not," for humane, dignified, cost-effective, genuinely person-centered support and assistance in moving forward.

Source: Salasin, 2011, p. 18.

an anxiety disorder (Lasiuk & Hegadoren, 2006). Beginning with this definition, the body of research grew, and the scope of application began to broaden, but not without considerable debate on what constituted a trauma.

The social revolution that began in the 1960s, combined with the women's movement and the call for more attention to diverse and disenfranchised groups, set the stage for an increase in the acknowledgement and treatment of victims of interpersonal violence and crime-related trauma (Figley, 2002). The introduction of rape trauma syndrome as a condition highlighted the psychological consequences of sexual assault and the subsequent lack of support from society and the social services system (Kramer & Green, 1997). Subsequently, research began to focus more on interpersonal violence, thus leading to the identification of risk factors and treatment approaches unique to this form of violence and trauma (Olff, Langeland, Drajer, & Gersons, 2007).

With input from international and national mental health organizations and research, the DSM-IV further modified the definition of trauma to include a broader interpretation of the identified stressor (Andreasen, 2010). DSM-5 has maintained the modified definition of trauma, but the criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly (APA, 2013b).

Paralleling the change in DSM criteria, cognitive–behavioral therapy for traumatic stress was developed along with other skills-based approaches (Greene et al., 2004).

Researchers, such as Foa, Resick, D'Zurilla, and Michenbaum, added to the body of knowledge and gave clinicians a variety of tools; these approaches continue to develop and show efficacy even today. There was also renewed interest in the long- and short-term effects of childhood sexual abuse and domestic violence. Interest in documenting the effects of trauma expanded further, including traumatic brain injury, significant orthopedic injuries, and multiple traumas (Starr et al., 2004). So too, the consumer movement in health care began. Consumers insisted on patient rights, humane treatment, and involvement in the treatment process; as a result, the paternalistic approach to health care began to change. As consumers set the initial stage and Federal agencies (e.g., the Substance Abuse and Mental Health Services Administration and its centers) and national organizations promoted the need for trauma-informed policies and care, national studies began to demonstrate the prevalence of traumatic experiences. Research including the Adverse Childhood Experiences and the Women, Co-Occurring, and Violence studies clearly demonstrated the pervasive long-term impact of trauma, reinforcing the call for trauma-informed policies and care. (For more information on the development of trauma-informed care, see Harris and Fallot, 2001b, as well as Jennings, 2004.)

Appendix D—Screening and Assessment Instruments

This appendix provides a selected sample of available tools for screening and assessment of traumatic events and trauma-related symptoms. This is not an exhaustive list, nor does this list focus on screening instruments that capture a broader range of symptoms related to trauma (such as sleep hygiene and dissociation) or other features important in providing trauma-informed care (e.g., resilience level, coping skill style, resource availability). For more information on a broad range of available instruments, refer back to Part 1, Chapter 4. Many of the instruments listed below use criteria found in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000), but with the release of the DSM-5 (APA, 2013a), instruments will evolve, and new versions will be available under the same contact information.

Screening and Assessment Measures

- Clinician Administered PTSD Scale (CAPS)
- Davidson Trauma Scale (DTS)
- Distressing Event Questionnaire (DEQ)
- Evaluation of Lifetime Stressors (ELS)
- Impacts of Event Scale Revised (IES-R)
- Mississippi Scale for Combat-Related PTSD (M-PTSD)
- Penn Inventory for Posttraumatic Stress Disorder
- Posttraumatic Diagnostic Scale (PDS)
- PTSD Symptom Scale-Interview (PSS-I)
- PTSD Symptom Scale: Self-Report Version (MPSS-SR)
- Screen for Posttraumatic Stress Symptoms (SPTSS)
- Structured Interview for PTSD (SI-PTSD)
- Trauma Assessment for Adults (TAA)
- Trauma Assessment for Adults (TAA)–Self Report
- Trauma History Questionnaire (THQ)
- Trauma Symptom Inventory (TSI)
- Traumatic Stress Schedule

Screening and Assessment Measures

Clinician Administered PTSD Scale (CAPS)

Domains:	Posttraumatic stress disorder (PTSD), acute stress disorder (ASD)
Timeframe:	CAPS-Sx: Lifetime and current (past week) CAPS-Dx: Current (past month)
Response format:	Other
Format of administration:	Structured
Number of items:	30
Completion time:	30–60 minutes
Qualifications to administer:	Administered by clinicians and clinical researchers who have a working knowledge of PTSD and by appropriately trained paraprofessionals
How to obtain scale:	Contact Danny G. Kaloupek, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: veterans, car accident survivors Reliability: alpha = .94, test-retest = .90–.98 Validity: sensitivity = .85, specificity = .95 (compared with Structured Clinical Interview for DSM Disorders [SCID]), r = .91 (with MS Scale for Combat-related PTSD) kappa = .77 against the SCID diagnosis; item-total correlations = .49–.82; internal consistency = .94
Author(s):	Dudley David Blake, Frank W. Weathers, Linda M. Nagy, Danny G. Kaloupe, Dennis S. Charney, and Terence M. Keane
Contact:	Danny G. Kaloupek, Ph.D. National Center for PTSD Boston VA Medical Center, 11B 150 South Huntington Avenue Boston, MA 02130
Relevant citations:	Blake, D. D. (1994). Rationale and development of the clinician-administered PTSD scales. *PTSD Research Quarterly, 5,* 1–2. Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8*, 75–90.

Gray, M., Litz, B., Hsu, J., & Lombardo, T. (2004). Psychometric properties of the Life Events Checklist. *Assessment, 11*, 330–341.

Weathers, F. W., Keane, T. M., & Davidson, J. R. (2001). Clinician-Administered PTSD Scale: A review of the first ten years of research. *Depression and Anxiety, 13*, 132–156.

Davidson Trauma Scale (DTS)

Domains:	PTSD symptoms
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument. Education/training requirements may be waived for those granted the right to administer tests at this level (B) in their jurisdiction.
How to obtain scale:	Contact Mental Health Systems, Inc.
Cost or public domain:	Cost: $15.00
Psychometrics:	Populations sampled: rape victims, veterans, hurricane victims, miscellaneous traumas Reliability: alpha = .99, test-retest = .86
Author(s):	Jonathan R.T. Davidson
Contact:	Mental Health Systems, Inc. 908 Niagara Falls Boulevard North Tonawanda, NY, 14120-2060 800-456-3003
Relevant citations:	Davidson, J. R. T., Book, S. W., Colket, J. T., Tupler, L. A., Roth, S., David, D., Hertzberg, M., Mellman, T., Beckham, J.C., Smith, R., Davison, R. M., Katz, R., & Feldman, M. (1997). Assessment of a new self-rating scale for posttraumatic stress disorder. *Psychological Medicine, 27,* 153–160. Davidson, J. R., Tharwani, H. M., & Connor, K. M. (2002). Davidson Trauma Scale (DTS): Normative scores in the general population and effect sizes in placebo-controlled SSRI trials. *Depression and Anxiety, 15*, 75–78.

Distressing Event Questionnaire (DEQ)

Domains:	Posttraumatic Stress Disorder (PTSD) for multiple events
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact Edward Kubany, Ph.D.
How to obtain scale:	Contact Edward Kubany, Ph.D.
Cost or public domain:	Contact Edward Kubany, Ph.D.
Psychometrics:	Population sampled: veterans, battered women Reliability: inter-item r = .93, test-retest = .95; validity: Pearson's r reliability coefficient = .83 (with Penn Inventory, Pearson's r reliability coefficient = .76 (with Beck Depression Inventory)
Author(s):	Edward Kubany, Mary Beth Leisen, Aaron S. Kaplan, Martin P. Kelly
Contact:	Edward Kubany, Ph.D. National Center for PTSD Pacific Islands Division Department of VA Suite 307 Honolulu, HI 96813 Kubany.Edward@honolulu.va.gov
Relevant citations:	Kubany, E. S., Leisen, M. B., Kaplan, A. S., & Kelly, M. P. (2000). Validation of a brief measure of posttraumatic stress disorder: The distressing event questionnaire (DEQ). *Psychological Assessment, 12*, 197–209.

Evaluation of Lifetime Stressors (ELS)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	56
Completion time:	10–20 minutes for screening, 1–3 hours for complete interview
Qualifications to administer:	Should be administered by trained clinicians only

How to obtain scale:	Contact Karen Krinsley, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: male veterans, female sexual abuse survivors Reliability: r = .4–1.0
Author(s):	Karen Krinsley, Frank W. Weathers, Elana Newman, Edward A. Walker, Danny G. Kaloupek, Rachel Kimerling
Relevant citations:	Corcoran, C. B., Green, B. L., Goodman, L. A., & Krinsley, K. E. (2000). Conceptual and methodological issues in trauma history assessment. In A. Y. Shalev, R. Yehuda, & A. C. McFarlane (Eds.), *International handbook of human response to trauma* (pp. 22–232). Dordrecht, Netherlands: Kluwer Academic Publishers. Krinsley, K. (1996). Psychometric review of the Evaluation of Lifetime Stressors (ELS) Questionnaire and Interview. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation (*pp. 160–162). Lutherville, MD: Sidran Press.

Impact of Event Scale Revised (IES-R)

Domains:	PTSD for a single event
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	22
Completion time:	5–10 minutes for screening
Qualifications to administer:	None
How to obtain scale:	http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: earthquake survivors, emergency disaster workers, Vietnam veterans, violence and sexual assault victims Reliability: alpha = .79–.92, test-retest = .89–.94, Pearson's r reliability coefficient = .74–.87
Author(s):	Daniel Weiss and Charles R. Marmar
Relevant citations:	Sundin, E. C. & Horowitz, M. J. (2002). Impact of Event Scale: Psychometric properties. *British Journal of Psychiatry, 180,* 205–209. Weiss, D. S. & Marmar, C. R. (1996).The Impact of Event Scale-Revised. In J. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399–411). New York: Guilford Press. (Includes measure in its entirety.)

Mississippi Scale for Combat-Related PTSD (M-PTSD)

Domains:	PTSD for multiple events
Timeframe:	Contact National Center for PTSD at ncptsd@ncptsd.org
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact National Center for PTSD at ncptsd@va.gov
How to obtain scale:	To order the scale contact the National Center for PTSD
Cost or public domain:	Free (ncptsd@va.gov)
Psychometrics:	Population sampled: veterans Reliability: inter-item r = .94, test-retest = .97 Validity: sensitivity = .93, specificity = .89
Author(s):	Terence M. Keane
Contact:	National Center for PTSD (116D) VA Medical Center 215 N. Main St. White River Junction, VT 05009 http://www.ptsd.va.gov/
Relevant citations:	Engdahl, B. & Eberly, R. (1994). Assessing PTSD among veterans exposed to war trauma 40–50 years ago. *NCP Clinical Quarterly, 4,* 13–14. Keane, T. M., Caddell, J. M., & Taylor, K. L. (1988). Mississippi Scale for Combat-Related Posttraumatic Stress Disorder: Three studies in reliability and validity. *Journal of Consulting and Clinical Psychology, 56,* 85–90.

Penn Inventory for Posttraumatic Stress Disorder

Domains:	PTSD for multiple events
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	26
Completion time:	5–15 minutes

Qualifications to administer:	Contact Melvyn Hammarberg, Ph.D.
How to obtain scale:	Contact Melvyn Hammarberg, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans, oil-rig disaster survivors Reliability: alpha = .94, test-retest = .96
Author(s):	Melvyn Hammarberg
Contact:	Melvyn Hammarberg, Ph.D. Department of Anthropology University of Pennsylvania 325 University Museum 33rd and Spruce Street Philadelphia, PA 19104-6398
Relevant citations:	Hammarberg, M. (1996). Psychometric review of the Penn Interview for Post Traumatic Stress Disorder. In B. H, Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 231–235). Lutherville, MD: Sidran Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Posttraumatic Diagnostic Scale (PDS)

Domains:	DSM-IV PTSD symptom clusters
Timeframe:	Current (past month)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	49
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact National Computer Systems (NCS)
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: accident/fire, disaster, assault, sexual assault, sexual abuse, major illness Reliability: alpha = .92, test-retest = .83 Validity: sensitivity = .89, specificity = .75

Author(s):	Edna B. Foa, Ph.D.
Contact:	National Computer Systems (NCS) 5605 Green Circle Drive Minnetonka, MN 55343
Relevant citations:	Foa, E. (1996). *Post-traumatic Diagnostic Scale manual*. Minneapolis, MN: National Computer Systems. Foa, E., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of PTSD: The Post-traumatic Diagnostic Scale (PDS). *Psychological Assessment, 9*, 445–451. Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

PTSD Symptom Scale-Interview (PSS-I)

Domains:	PTSD single event
Timeframe:	Current (past 2 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17
Completion time:	20 minutes
Qualifications to administer:	Can be administered by a master's level interviewer after a few hours of training.
How to obtain scale:	Contact Edna B. Foa, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: female sexual assault victims, female assault victims Reliability: alpha = .85, test-retest = .80; validity: sensitivity = .88, specificity = .96 (compared with SCID); Pearson's r reliability coefficient = .48–.80 (with Impact of Events intrusion and avoidance, State portion of State-Trait Anxiety Inventory, and MPSS-SR)
Author(s):	Edna B. Foa and Gregory A. Leskin
Contact:	Edna B. Foa, Ph.D. Medical College of Pennsylvania Department of Psychiatry 3200 Henry Avenue Philadelphia, PA 19129-1137

Relevant citations:	Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6*, 459–474. Foa, E. & Tolin, D. F. (2005). Comparison of the PTSD Symptom Scale-Interview Version and the clinician administered PTSD Scale. *Journal of Traumatic Stress, 13*, 181–191. Leskin, G. A. (1999). Screening for trauma and PTSD in a primary care clinic. *NC-PTSD Clinical Quarterly, 8*, 68–69.

PTSD Symptom Scale: Self-Report Version (MPSS-SR)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Contact Sherry Falsetti, Ph.D.
How to obtain scale:	Contact Sherry Falsetti, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: alpha = .96–.97 Validity: sensitivity = .89, specificity = .65
Author(s):	Sherry Falsetti, Patricia A. Resick, Heidi S. Resnick, Dean G. Kilpatrick
Contact:	Sherry Falsetti, Ph.D. University of Illinois College of Medicine Department of Family and Community Medicine 1601 Parkview Avenue Rockford, IL 61107-1897
Relevant citations:	Bonin, M. F., Norton, G. R., Asmundson, G. J., Dicurzio, S., & Pidlubney, S. (2000). Drinking away the hurt: The nature and prevalence of PTSD in substance abuse patients attending a community-based treatment program. *Journal of Behavior Therapy and Experimental Psychiatry, 31*, 55–66. Coffey, S. F., Dansky, B. S., Falsetti, S. A., Saladin, M. E., & Brady, K. T. (1998). Screening for PTSD in a substance abuse sample:

Psychometric properties of a modified version of the PTSD Symptom Scale Self-Report. *Journal of Traumatic Stress, 11,* 393–399.

Falsetti, S. A., Resnick, H. S., Resick, P. A., & Kilpatrick, D. (1993). The Modified PTSD Symptom Scale: A brief self-report measure of post-traumatic stress disorder. *The Behavioral Therapist, 16*, 161–162.

Screen for Posttraumatic Stress Symptoms (SPTSS)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	5 minutes
Qualifications to administer:	Contact Eve Carlson, Ph.D.
How to obtain scale:	Contact Eve Carlson, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: psychiatric inpatients Reliability: split half reliability = .91, test-retest = .82
Author(s):	Eve Carlson, Ph.D.
Contact:	Eve Carlson, Ph.D. National Center for PTSD (352-117-MP) Palo Alto Health Care System 795 Willow Road Menlo Park, CA 94025
Relevant citations:	Carlson, E. (2001). Psychometric study of a brief screen for PTSD: Assessing the impact of multiple traumatic events. *Assessment*, *8*, 431–441.

Structured Interview for PTSD (SI-PTSD)

Domains:	PTSD single event
Timeframe:	Current (past 4 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17

Completion time:	20–30 minutes
Qualifications to administer:	Can be administered by mental health professionals or by paraprofessionals after some training.
How to obtain scale:	Contact Jonathan Davidson, M.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans Reliability: alpha = .94, test-retest = .71, intraclass r = .97 Validity: sensitivity = .96, specificity = .80 (compared with SCID), Pearson's r reliability coefficient = .61 (with IES), Pearson's r reliability coefficient = .51 (with Hamilton Anxiety Scale)
Author(s):	Jonathan Davidson
Contact:	Jonathan Davidson, M.D. Department of Psychiatry Box 3812 Duke University Medical Center Durham, NC 27710-3812
Relevant citations:	Davidson, J. R. T., Kudler, H. S., & Smith, R. D. (1990). Assessment and pharmacotherapy of posttraumatic stress disorder. In J. E. L. Giller (Ed.), *Biological assessment and treatment of post-traumatic stress disorder* (pp. 205–221). Washington, DC: American Psychiatric Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Trauma Assessment for Adults (TAA)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	13
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain

Psychometrics:	Populations sampled: adult mental health center clients; face validity established; feasible; validity established via archival records
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Cusack, K. J., Frueh, B. C., & Brady, K. T. (2004). Trauma history screening in a community mental health center. *Psychiatric Services, 55,* 157–162. Resnick, H. S. (1996). Psychometric review of Trauma Assessment for Adults (TAA). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 362–365). Lutherville, MD: Sidran Press.

Trauma Assessment for Adults (TAA)–Self Report

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	None to date
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Resnick, H. S., Falsetti, S. A., Kilpatrick, D. G., & Freedy, J. R. (1996). Assessment of rape and other civilian trauma-related posttraumatic stress disorder: Emphasis on assessment of potentially traumatic events. In T. W. Miller (Ed.), *Stressful life events* (pp. 231–266). Madison, WI: International Universities Press.

Trauma History Questionnaire (THQ)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured

Number of items:	24
Completion time:	5–15 minutes
Qualifications to administer:	Contact Bonnie L. Green, Ph.D.
How to obtain scale:	Contact Bonnie L. Green, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: psychiatric outpatients, college students, women with breast cancer Reliability: r = 0.7–0.9, intraclass = .76
Author(s):	Bonnie L. Green
Relevant citations:	Hooper, L., Stockton, P., Krupnick, J., & Green, B., (2011). Development, use, and psychometric properties of the Trauma History Questionnaire. *Journal of Loss and Trauma, 16*, 258–283. Muesser, K. T., Salyers, M. P., Rosenberg, S. D., Ford, J. D., Fox, L., & Carty, P. (2001). Psychometric evaluation of trauma and posttraumatic stress disorder assessments in persons with severe mental illness. *Psychological Assessment, 13*, 110–117. Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Trauma Symptom Inventory (TSI)

Domains:	Trauma-related symptoms
Timeframe:	Current (last 6 months)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	100
Completion time:	20 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and courses in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact Psychological Assessment Resources
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: general population Reliability: alpha = .84–.87

Author(s):	John Briere
Contact:	Psychological Assessment Resources Box 998 Odessa, FL 33556
Relevant citations:	Briere, J. (1996). Psychometric review of Trauma Symptom Inventory (TSI). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 381–383). Lutherville, MD: Sidran Press. Briere, J. (1995). *Trauma Symptom Inventory professional manual.* Odessa, FL: Psychological Assessment Resources. Orsillo, S. M. (2001). Measures for acute stress disorder and post-traumatic stress disorder. In M. M. Antony & S. M. Orsillo (Eds.), *Practitioner's guide to empirically based measures of anxiety* (pp. 255–307). New York: KluwerAcademic/Plenum.

Traumatic Stress Schedule

Domains:	Trauma history
Timeframe:	Current (but author suggests any period)
Response format:	Other
Format of administration:	Semi-structured
Number of items:	10 (with 12 probes)
Completion time:	5–30 minutes
Qualifications to administer:	Can be administered by lay interviewer with training
How to obtain scale:	Contact Fran Norris, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: test-retest = .88, frequency of events equal to National Women's Study PTSD Module
Author(s):	Fran Norris
Relevant citations:	Norris, F. H. (1990). Screening for traumatic stress: A scale of use in the general population. *Journal of Applied Social Psychology*, *20*, 1704–1718. (Includes measure in its entirety.) Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Appendix E—Consumer Materials

The following are samples of available consumer materials relating to trauma-informed care and traumatic stress. There is a plethora of consumer information available to meet the immediate and long-term needs of consumers of behavioral health services affected by trauma. In order to not waste effort creating new materials for your client's concerns, it is advisable to explore current science-informed resources. In most cases, consumer materials are already available and easily accessible for free.

AfterDeployment.org (2010). *Just the Facts: Resilience*. Available: http://afterdeployment.org/sites/default/files/pdfs/client-handouts/resilience-understanding.pdf

This Web site provides resources to address symptoms related to traumatic stress in addition to other postdeployment adjustment issues. This site provides information and handouts on resilience, triggers, and other trauma-related topics. It is appropriate for service members as well as civilians.

Blanch, A., Filson, B., & Penny, D. (2012). *Engaging Women in Trauma-Informed Peer Support: A Guidebook*. Available: http://www.nasmhpd.org/publications/engagingwomen.aspx

This draft technical assistance guide was created by the National Center for Trauma-Informed Care (NCTIC) and developed under contract with the National Association of State Mental Health Program Directors. This publication is designed to help make trauma-informed peer support available to women who are trauma survivors and who receive or have received behavioral health services. It is a resource for peers providing support in these or other settings who want to learn how to use trauma-informed principles in supporting women or in the peer support groups. It has been a resource used in the delivery of technical assistance through NCTIC.

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., et al. (2006). Appendix E: Handouts. *Psychological First Aid: Field Operations Guide.* Available: http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_Appx_E_handouts.pdf

Developed jointly with the National Child Traumatic Stress Network and the National Center for PTSD, this curriculum provides a science-informed approach to psychological first aid for response workers. The goals of this module are to assist survivors in the immediate aftermath of disaster and/or terrorism, reduce initial distress, and foster short- and long-term adaptive functioning. This link provides specific survivor-oriented material, such as strategies in seeking and giving support, education on common immediate reactions, and parental tips for children across developmental stages.

Center for Mental Health Services (2002). *Dealing with the Effects of Trauma-A Self-Help Guide.* Available: http://store.samhsa.gov/shin/content//SMA-3717/SMA-3717.pdf

This self-help guide gives practical information and tools to address and manage symptoms and other consequences of traumatic stress. It provides education on a variety of topics, including trauma-related symptoms, advice on the key ingredients of quality care, barriers to recovery, and practical strategies to enhance recovery and manage difficult emotions.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2005). *Roadmap to Seclusion and Restraint Free Mental Health Services*. Available: http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055

This curriculum concerns the elimination of seclusion and restraint. It provides numerous handouts for consumers as well as staff. Several consumer handouts include common reactions to trauma, a trauma screening tool, and strategies to de-escalate agitation and distress.

Mead, S. (2008). *Intentional Peer Support: An Alternative Approach*. Sherry Mead Consulting. Available: http://www.intentionalpeersupport.org/apps/webstore/products/show/3408520

This interactive workbook is designed for individuals who are in peer support roles and those who use peer support services. It provides goals, tasks, competencies, and skills associated with peer support relationships and guidelines for first interviews.

Najavits, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

This evidence-based practice for individuals who have a history of trauma and a substance use disorder provides not only guidelines for clinicians but handouts for individuals. The consumer materials include information on PTSD and substance abuse and their interrelationship, key principles of the Seeking Safety program, coping skills to support safety, and grounding exercises. For additional information and resources, go to http://www.seekingsafety.org.

National Center for PTSD, U.S. Department of Veterans Affairs (2010). *Understanding PTSD*. Available: http://www.ptsd.va.gov/public/understanding_ptsd/booklet.pdf

This booklet provides consumer information on posttraumatic stress, common traumatic stress symptoms, effective treatments, and resources. The National Center for PTSD also provides additional professional and public resources specific to trauma for veterans and civilians.

Sidran Institute (2012). *Healing Self-Injury*. Available: http://healingselfinjury.org/about.html

This Web site provides numerous resources for consumers and professionals to understand self-inflicted violence. It offers publication links, archived newsletters, and a current blog focused on self-harm.

Appendix F—Organizational Assessment for Trauma-Informed Care

The following two resources are organizational assessments, which represent a key strategy in developing or re-evaluating trauma-informed services. The first assessment, presented by the University of South Florida, College of Behavioral and Community Sciences (2012), is designed for staff or key stakeholders. The second assessment comes from the *Trauma-Informed Organizational Toolkit for Homeless Services* (Guarino, Soares, Konnath, Clervil & Bassuk, 2009) and is a consumer version. There are several other assessment tools available, including Fallot and Harris's *Creating Cultures of Trauma-Informed Care (CCTIC): A Self Assessment and Planning Protocol* (2009).

Staff or Key Stakeholder Organizational Assessment Tool
University of South Florida, College of Behavioral and Community Sciences (2012). *Creating Trauma-Informed Care Environments: An Organizational Self-Assessment*. Available: http://www.cfbhn.org/assets/TIC/youthresidentialself%20assess%20Fillable%20FORM%20%282%29.pdf

Consumer Version: Organizational Assessment Tool
Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-Informed Organizational Toolkit for Homeless Services*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. See: pp. 82–93. Available: http://www.familyhomelessness.org/media/90.pdf

Appendix G—SAMHSA Resource Panel

John Bailey
Special Expert
Office of Policy, Planning, and Budget
Office of the Administrator
Substance Abuse and Mental Health Services Administration
Rockville, MD

Shirley Beckett, NCAC II
Certification Administrator
National Association of Alcohol and Drug Abuse Counselors
Washington, DC

Danny Brom, Ph.D.
Director
The Israel Center for the Treatment of Psychotrauma
Latner Institute for the Study of Social Psychiatry and Psychotherapy
Israel

Ling Chin, M.D.
Chief, Clinical Science
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Carol Coley, M.S., USPHS
Senior Program Management Officer
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Christina Currier
Public Health Analyst
Office of Evaluation, Scientific Analysis and Synthesis
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Marlene EchoHawk, Ph.D.
Health Science Administrator
Division of Health
Indian Health Service
U.S. Department of Health and Human Services
Rockville, MD

Jill Shepard Erickson, M.S.W., ACSW
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Angela M. Gonzalez, Ph.D., CDR, USPHS
Special Programs Development Branch-Refugee Mental Health Program
Division of Prevention, Traumatic Stress, and Special Programs
Substance Abuse and Mental Health Services Administration
Rockville, MD

Jacqueline Hendrickson, M.S.W., LCSW-C
Public Health Advisor
Division of Pharmacologic Therapies
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Michael Hilton, Ph.D.
Health Science Administrator
Division of Clinical and Prevention Research
National Institute of Alcohol Abuse and Alcoholism
National Institutes of Health
Bethesda, MD

Kenneth J. Hoffman, M.D., M.P.H.
Medical Director
TRICARE Management Activity
Military Health System-Population Health Programs
Department of Defense, Health Affairs
Falls Church, VA

Kirk E. James, M.D.
Special Expert
Systems Improvement Branch
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Hendree E. Jones, Ph.D.
Assistant Professor
Department of Psychiatry and Behavioral Sciences
Johns Hopkins University Center
Baltimore, MD

Cindy Kleppinger, M.D.
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

David Liu, M.D.
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Richard E. Lopez, J.D., Ph.D.
Social Science Analyst
Co-Occurring and Homeless Branch
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Sue Martone, M.P.A.
Public Health Advisor
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
Washington, DC

Dee S. Owens, M.P.A.
Director
Alcohol-Drug Information Center
Indiana University
Bloomington, IN

Harold I. Perl, Ph.D.
Chief, Health Services Research Branch
Division of Clinical and Prevention Research
National Institute of Alcohol Abuse and Alcoholism
National Institutes of Health
Bethesda, MD

Melissa V. Rael, USPHS
Senior Program Management Officer
Division of State and Community Assistance
Co-Occurring and Homeless Branch
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Lawrence D. Rickards, Ph.D.
Co-Occurring Disorders Program Manager
Homeless Programs Branch
Division of Knowledge Development and Systems Change
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Cecilia Rivera-Casale, Ph.D.
Senior Project Officer
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Terrence Schomburg, Ph.D.
Team Leader
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Richard T. Suchinsky, M.D.
Associate Chief for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC

Beth A. Weinman, M.A.
Coordinator
National Drug Abuse Programs
Correctional Programs Division-Services Branch
U.S. Department of Justice
Washington, DC

Penelope P. Ziegler, M.D.
Head, Treatment Section
American Academy of Addiction Psychiatry
Williamsburg, VA

Appendix H—Field Reviewers

Carol Ackley
Owner/Director
River Ridge Treatment Center
Burnsville, MN

Rosie Anderson-Harper, M.A.
Mental Health Manager
Division of Alcohol and Drug Abuse
Missouri Department of Mental Health
Jefferson City, MO

Reba Architzel
Director
Federal Relations and Policy Analysis
New York State Office of Alcoholism and Substance Abuse Services
Albany, NY

Larry L. Ashley, Ed.S., M.A.
Addictions Specialist
Department of Counseling
University of Nevada, Las Vegas
Las Vegas, NV

G.T. (Gigi) Belanger
Public Health Advisor
Homeless Programs Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Charles H. Bombardier, Ph.D.
Associate Professor
Department of Rehabilitation Medicine
Harborview Medical Center
University of Washington School of Medicine
Seattle, WA

Patricia T. Bowman
Probation Counselor
Fairfax Alcohol Safety Action Program
Fairfax, VA

Patricia Allen Bradford, LISW, LMFT, CTS
Program Manager
Health Care for Homeless Veterans
Columbia, SC

Kathy Brock
Director
Polytechnic University Counseling Center
Brooklyn, NY

Vivian B. Brown, Ph.D.
Chief Executive Officer
Mental Health and Social Services Centers for Innovation in Health
PROTOTYPES
Culver City, CA

Wilma J. Calvert, R.N., Ph.D.
Post-Doctoral Fellow
Department of Psychiatry
Washington University School of Medicine
St. Louis, MO

Jerome F.X. Carroll, Ph.D.
Consultant in private practice
Chair, Columbia University's Drugs & Society Seminar
Brooklyn, NY

Steven J. Chen, Ph.D.
Associate Director
Division of Substance Abuse and Mental Health
Utah Department of Human Services
Salt Lake City, UT

Colleen Clark, M.A., Ph.D.
Research Assistant Professor
Licensed Clinical Psychologist
Triad Women's Project
University of South Florida
Tampa, FL

R.T. Codd, III., Ed.S.
Certified Member of the Academy of Cognitive Therapy
Director/Owner
Cognitive–Behavioral Therapy Center of Western North Carolina
Asheville, NC

Carol Coley, M.S.
Senior Program Management Advisor
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Carol J. Colleran, CAP, ICADC
Director of Primary Programs
Center of Recovery for Older Adults
Hanley-Hazelden Center
West Palm Beach, FL

Stephanie S. Covington, M.S.W., Ph.D.
Co-Director
Center for Gender and Justice
Institute for Relational Development
La Jolla, CA

David A. Deitch, Ph.D.
Professor of Clinical Psychiatry
Director, CCARTA
Department of Clinical Psychiatry
University of California, San Diego
La Jolla, CA

Gail D. Dixon, M.A., CAPP
NIDA Project Manager
Southern Coast Addiction Technology Transfer Center
Tallahassee, FL

Jill Shepard Erickson, M.S.W., ACSW
Public Health Advisor
Child and Family Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Phil Erickson
Substance Abuse Program Manager
Loudoun County Community Services Board
Leesburg, VA

Kathleen J. Farkas, Ph.D., LISW
Mandel School of Applied Social Sciences
Case Western Reserve University
Cleveland, OH

Norma B. Finkelstein, M.S.W., Ph.D.
Executive Director
W.E.L.L. Project
Institute for Health and Recovery
Cambridge, MA

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief
Services Research Branch
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Judith Ford, M.A., MFT
Director of Women's Services
Community Services and Hospitals
Connecticut Department of Mental Health and Addiction Services
Hartford, CT

Julian D. Ford, Ph.D.
Associate Professor
Department of Psychiatry
University of Connecticut Health Center
Farmington, CT

Matthew Friedman, M.D., Ph.D.
Professor of Psychiatry and Pharmacology
Executive Director, National Center for PTSD
Dartmouth Medical School
VA Medical Center
White River Junction, VT

John Galea, M.A.
Deputy Director, New York City Relations
New York State Office of Alcoholism and Substance Abuse Services
New York, NY

Angela M. Gonzalez, Ph.D., CAPT., USPHS
Scientist Officer
Special Programs Development Branch-Refugee Mental Health Program
Division of Prevention, Traumatic Stress, and Special Programs
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Maya D. Hennessey
Women's Specialist
Supervisor, Quality Assurance, Technical Assistance & Training
Office of Special Programs
Division of Substance Abuse
Illinois Department of Human Services and Substance Abuse
Chicago, IL

Michael W. Herring, LCSW
Licensed Clinical Social Worker
Wayne Psychiatric Associates, P.A.
Goldsboro, NC

Nancy J. Hirzel
Clinic Director
Adult Services Division
Jefferson Addictive Disorders Clinic
Jefferson Parish Human Services Authority
Metairie, LA

Robert Holden, M.A.
Program Director
Partners in Drug Abuse Rehabilitation Counseling (PIDARC)
Washington, DC

Kay M. Johnson
Crime Victims Treatment Center - HIV Project
St. Luke's Roosevelt Hospital Center
New York, NY

Kimberly A. Johnson, M.A., NCAC II
Director
Augusta Mental Health Complex
Maine Office of Substance Abuse
Augusta, ME

Sharon D. Johnson, M.S.W., M.P.E., Ph.D.
Assistant Professor
Department of Social Work
University of Missouri-St. Louis
St. Louis, MO

Lorene Lake, M.A., Ed.D.
Executive Director
Chrysalis House, Inc.
Crownsville, MD

Michael S. Levy, Ph.D.
Director of Clinical Treatment Services
CAB Health and Recovery Services
Danvers, MA

T.K. Logan, Ph.D.
Associate Professor
Center on Drug & Alcohol Research
Department of Behavioral Science
University of Kentucky
Lexington, KY

James J. Manlandro, D.O., FAOAAM, FACOFP
Medical Director
Family Addiction Treatment Services, Inc.
Somers Point, NJ

Rozanne Marel, Ph.D.
Head of Epidemiology & Needs Assessment
New York State Office of Alcoholism and Substance Abuse Services
New York, NY

Pamela Martin, Ph.D.
Director
Behavioral Health Services Division
New Mexico Department of Health
Santa Fe, NM

Ruby J. Martinez, Ph.D., R.N., CS
Assistant Professor
School of Nursing
University of Colorado Health Sciences Center
Denver, CO

Sue Martone, M.P.A.
Public Health Advisor
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
Washington, DC

Beth Marty, M.S., LPC
Clinical Program Manager
WYSTAR
Sheridan, WY

Lisa A. Melchior, Ph.D.
Vice President
The Measurement Group, LLC
Culver City, CA

Candace Merritt
Social Worker
Veterans Administration Medical Center
Denver, CO

Pamela A. Mumby, C.N.S., F.N.P., M.S.N.
Adult Psychiatric Nurse Practitioner
Substance Abuse Treatment Program
Veterans Administration Medical Center
Denver, CO

Briana S. Nelson-Goff, Ph.D.
Associate Professor
Family Studies and Human Service
Kansas State University
Manhattan, KS

Sarah Niemeyer
Clinical Director
Amethyst, Inc.
Columbus, OH

Thomas A. Peltz, M.Ed.
Therapist/Licensed Mental Health Counselor
Certified Addiction Specialist
Private Practice
Beverly Farms, MA

Karen Pressman, M.S.W., CADAC, LACDI
Director, Planning and Development
Bureau of Substance Abuse Services
Massachusetts Department of Public Health
Boston, MA

Melissa V. Rael, USPHS
Senior Program Management Officer
Co-Occurring and Homeless Branch
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Lawrence D. Rickards, Ph.D.
Public Health Advisor
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Alice F. Roeling
OAD Inpatient Facility Manager
The Springs of Recovery Adolescent Program
Greenwall Springs, LA

James Rowan, M.A.
Program Manager
Case Management and Offender Services
Arapahoe House, Inc.
Thornton, CO

JoAnn Y. Sacks, Ph.D.
Deputy Director, CIRP
National Development and Research Institutes, Inc.
New York, NY

Darren C. Skinner, M.S.W., Ph.D., LSW
Division Director
Co-Occurring Program
Gaudenzia, Inc.
Philadelphia, PA

Mickey J.W. Smith, M.S.W.
Senior Policy Associate, Behavioral Health
Program, Policy & Practice Unit
Division of Professional Development & Advocacy
National Association of Social Workers
Washington, DC

Richard T. Suchinsky, M.D.
Associate Chief for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC

Wilbur Woodis, M.A.
Management Analyst
Office of Clinical and Preventive Services
Division of Behavioral Health
Indian Health Service
Office of Public Health
U.S. Department of Health and Human Services
Rockville, MD

Appendix I: Cultural Competency and Diversity Network Participants

Charles H. Bombardier, Ph.D.
Associate Professor
Department of Rehabilitation Medicine
Harborview Medical Center
University of Washington School of Medicine
Seattle, WA
Disability Workgroup

Carol S. D'Agostino, CSW, CASAC
Director
Geriatric Addictions Program
LIFESPAN of Greater Rochester, Inc.
Rochester, NY
Aging Workgroup

Thomas L. Geraty, M.S.W., Ph.D., LICSW
Private Practice
Jamaica Plain, MA
LGBT Workgroup

Wayne Lee Mitchell, M.D.
Indian Health Service
Phoenix, AZ
Aging Workgroup

Ann S. Yabusaki, M.Ed., M.A., Ph.D.
Substance Abuse Director
Psychologist
Substance Abuse Programs and Training
Coalition for a Drug-Free Hawaii
Kaneohe, HI
Asian and Pacific Islanders Workgroup and Aging Workgroup

Appendix J: Acknowledgments

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CDM KAP personnel included Rose M. Urban, M.S.W., J.D., LCSW, LCAS, KAP Executive Deputy Project Director; Jessica L. Culotta, M.A., KAP Managing Project Co-Director; Susan Kimner, former Managing Project Co-Director; Elizabeth Marsh, former KAP Deputy Project Director; Claudia Blackburn, M.S., Psy.D., Expert Content Director; Sheldon Weinberg, KAP Senior Researcher/Applied Psychologist; Bruce Carruth, Ph.D., Expert Content Director; Raquel Witkin, M.S., former Deputy Project Manager; Janet G. Humphrey, M.A., former Editor/Writer; Virgie D. Paul, M.L.S., Librarian; Angela T. Fiastro, KAP Junior Editor; Sonja Easley and Elizabeth Plevyak, former Editorial Assistants; and Elizabeth Pratt, Ph.D., Carol Schober, Psy.D., M.S.N., and Patricia A. Burke, M.S.W., LCSW, BCD, C-CATODSW, CCS, contributing authors. Special thanks to Stephanie Perry, M.D., for providing a content review of the TIP, and to John P. Allen, Ph.D., for writing draft material and contributing information on combat stress.

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under the Substance Abuse and Mental Health Services Administration's Knowledge Application Program (KAP) to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

What Are KAP Keys?

Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening instruments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted frequently. The Keys allow you, the busy clinician or program administrator, to locate information easily and to use this information to enhance treatment services.

Ordering Information

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TIP 2 **Pregnant, Substance-Using Women**—*Replaced by TIP 51*

TIP 3 **Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents**—*Replaced by TIP 31*

TIP 4 **Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents**—*Replaced by TIP 32*

TIP 5 **Improving Treatment for Drug-Exposed Infants**

TIP 6 **Screening for Infectious Diseases Among Substance Abusers**—*Archived*

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TIP 10 **Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients**—*Replaced by TIP 43*

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TIP 14 **Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment**

TIP 15 **Treatment for HIV-Infected Alcohol and Other Drug Abusers**—*Replaced by TIP 37*

TIP 16 Alcohol and Other Drug Screening of Hospitalized Trauma Patients
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 17 Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System—*Replaced by TIP 44*

TIP 18 The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers—*Archived*

TIP 19 Detoxification From Alcohol and Other Drugs—*Replaced by TIP 45*

TIP 20 Matching Treatment to Patient Needs in Opioid Substitution Therapy—*Replaced by TIP 43*

TIP 21 Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System
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Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers
Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 26 Substance Abuse Among Older Adults
Substance Abuse Among Older Adults: A Guide for Treatment Providers
Substance Abuse Among Older Adults: A Guide for Social Service Providers
Substance Abuse Among Older Adults: Physician's Guide
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 27 Comprehensive Case Management for Substance Abuse Treatment
Case Management for Substance Abuse Treatment: A Guide for Treatment Providers
Case Management for Substance Abuse Treatment: A Guide for Administrators
Quick Guide for Clinicians
Quick Guide for Administrators

TIP 28 Naltrexone and Alcoholism Treatment—*Replaced by TIP 49*

TIP 29 Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities
Quick Guide for Clinicians
Quick Guide for Administrators
KAP Keys for Clinicians

TIP 30 Continuity of Offender Treatment for Substance Use Disorders From Institution to Community
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 31 Screening and Assessing Adolescents for Substance Use Disorders
See companion products for TIP 32.

TIP 32 Treatment of Adolescents With Substance Use Disorders
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TIP 33 Treatment for Stimulant Use Disorders
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TIP 45 Detoxification and Substance Abuse Treatment
Quick Guide for Clinicians
Quick Guide for Administrators
KAP Keys for Clinicians

TIP 46 Substance Abuse: Administrative Issues in Outpatient Treatment
Quick Guide for Administrators

TIP 47 Substance Abuse: Clinical Issues in Outpatient Treatment
Quick Guide for Clinicians
KAP Keys for Clinicians

TIP 48 Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery

TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice
Quick Guide for Counselors
Quick Guide for Physicians
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TIP 50 Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment
Quick Guide for Clinicians
Quick Guide for Administrators

TIP 51 Substance Abuse Treatment: Addressing the Specific Needs of Women
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TIP 53 Addressing Viral Hepatitis in People With Substance Use Disorders
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TIP 54 Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders
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KAP Keys for Clinicians
You Can Manage Your Chronic Pain To Live a Good Life: A Guide for People in Recovery From Mental Illness or Addiction

TIP55-R Behavioral Health Services for People Who Are Homeless

TIP 56 Addressing the Specific Behavioral Health Needs of Men

TIP 57 Trauma-Informed Care in Behavioral Health Services

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Implementing a Trauma-Informed Approach for Youth across Service Sectors

This brief is based on a webinar, ***Implementing a Trauma-Informed Approach for Youth Across Service Sectors***, held Tuesday, May 21, 2013, 2:00 p.m. to 3:30 p.m. EDT. The webinar was sponsored by the Interagency Working Group on Youth Programs (IWGYP), a collaboration of 18 Federal departments and agencies that support programs and services focusing on youth and promote the goal of positive, healthy outcomes for youth. The webinar was planned jointly by the IWGYP and the Substance Abuse and Mental Health Services Administration (SAMHSA). The webinar slides are housed on the IWGYP website, FindYouthInfo.gov, under the Mental Health Youth Topic. The webinar featured three content experts nationally known in their field: Eugene Griffin, J.D., Ph.D., Northwestern University, Feinberg School of Medicine; Julian Ford, Ph.D., University of Connecticut, School of Medicine; and Charles Wilson, MSSW, Chadwick Center for Children and Families Rady Children's Hospital - San Diego, California; all of whom have been supported by SAMHSA trauma-focused grants. Additionally, the webinar included two youth presenters, NC and LS, who spoke about their own lived experience and the importance of trauma-informed care. Both youth are referred to only by initials to protect their privacy. NC is a peer specialist and LS is a law student.

Introduction

Trauma affects youth in all communities, and responses to those experiences by child-serving systems are critical. It is important for providers serving youth to understand how best to respond and support healing.

Service providers and policymakers in the youth-serving field are continually learning more from research[i] about trauma, traumatic experiences, and the various responses to traumatic events. It is important for youth serving systems to develop a greater understanding of the association between trauma and mental health and substance use disorders, and how it can derail the healthy development of youth. The field recognizes the importance of addressing trauma and using a trauma-informed approach in prevention, treatment, and recovery efforts.

This brief discusses the concept and prevalence of trauma; techniques for coping with, and recovering from trauma at an individual and systems level; the core principles for building a framework for understanding trauma; and implementation of elements essential for a trauma-informed system as presented by the featured experts.

Recognizing the effects of trauma and understanding how to address trauma are fundamental to the Trauma and Justice Strategic Initiative at the Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services (HHS). The focus of SAMHSA's Trauma and Justice Strategic Initiative is on integrating a trauma-informed approach throughout health, behavioral health, and related systems to reduce the harmful effects of trauma and violence on individuals, families, and communities and using innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.

As part of this Initiative, with the help of experts, SAMHSA will be releasing a concept paper outlining a framework for trauma and guidance for developing and implementing a trauma-informed approach.

What Do We Mean by Trauma?

After an introduction by Dr. Larke Huang from the Substance Abuse and Mental Health Services Administration (SAMHSA), Dr. Eugene Griffin provided a framework for understanding trauma.

Trauma is a complex experience that affects youth and the systems that serve them in a variety of ways. The experience of trauma can be described through some common elements: event, experience, and effects, also known as "Three E's."[ii] These elements address the uniqueness of an individual's response to an event and how an event affects one's future behavior and well-being.

An **Event** is objective and measurable. Traumatic events include abuse (physical, emotional, sexual); domestic or community violence; an accident or natural disaster; and war or terrorism.

1. An **Experience** is subjective and difficult to measure because it relates to how someone reacts to an event. It is often thought to be life threatening or physically or emotionally overwhelming, and intensity can vary among people and over time. The way one person experiences an event might differ from the way another person does; culture, gender, and age all influence one's experience of the event. Additionally, people experience events in different ways. Resilience, risk and protective factors, and supports may contribute to this experience.
2. **Effects** are the reactions a person has to an event and the ways an experience changes or alters that person's ongoing and future behavior. Classic symptoms include experiencing hyperarousal, such as overreacting or being hypervigilant; re-experiencing an event as nightmares or flashbacks; and avoiding a situation by having a fight, flight, or freeze reaction. The effects of a traumatic event can have a long-term impact on neurobiological development and contribute to negative physical, hormonal, and chemical changes due to stress responses.

Building on this "Three E's" concept of trauma, SAMHSA frames its concept of trauma as: an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[iii] Researchers[iv] report that traumatic stress occurs when an extreme experience overwhelms and alters an individual's stress-related physiological systems and compromises the functioning of stress-response systems (e.g., neuroimmune, neuroendocrine, autonomic, and central nervous system networks).

"What I found worked best is when I was surrounded by people who really got it, who really understood trauma." — LS

Prevalence of Trauma

Many youth are exposed to traumatic events, including those in the juvenile justice and child welfare systems, as well as those who experience homelessness. Building on the three E's concept, we know that the experience of trauma is complex and particular to each individual's life circumstances, which can make quantifying the extent difficult. Some people experience multiple traumas; for example, a youth who has been separated from his or her family and then experiences assault or abuse in a foster home. As many as half of all children that have been involved with the mental health, child welfare, and juvenile justice systems have experienced multiple traumas.[v] LS and NC, two young people formerly involved with the foster care system, comment in the box above on their experiences with multiple traumas.

"When I was seven years old…my brothers and I were placed in foster care…We were immediately separated, and so I felt like that was probably the first traumatic event that I experienced." — LS

"While I was at my foster home, I had gotten into altercations with my foster brother and before he hit me, I felt scared…" — NC

Coping with and Reactions to Trauma

Dr. Julian Ford provided an overview of strategies for youth, families, and communities to recover from trauma. Recovery from the adverse effects of trauma begins with the recognition that the experience of survival threat caused by traumatic events has caused some major changes in the way a person now copes with stress. These ways of coping are necessary and effective in emergencies such as traumatic events, but they interfere with ordinary day-to-day life. Youth who have experienced trauma may develop coping strategies to help them survive.

Chronic Survival Coping

Trauma affects a youth's relationships, sense of survival, and sense of trust and security with people. The reaction to terrible shock, stressors, challenges, and loss is chronic survival coping. An individual trying to cope or recover from serious challenges and stressors will learn techniques to survive, such as staying on edge; being vigilant, watchful, or even distrustful (hypervigilance); or using indifference to mask hopelessness.

Posttraumatic Survival Coping

Physically, posttraumatic survival coping reflects a change in the body, not just a mental and psychological change. It changes how a person's brain works. The brain helps a person learn, explore, try activities, and experience different ways of living. However, a person cannot experience life freely when trying to survive trauma. Instead, that person must put everything else aside and concentrate only on basic survival needs. Some common survival modes or hypervigilance practices are scanning the environment and being on guard for danger; attempting to block out or not think about upsetting things; being ready to fight or flee; experiencing elevated heart rate and adrenalin rush; and being unable to regulate aggression or use anger management techniques.

"I wish that the people who I was working with in my school were more trauma informed and that they were focused - instead of on the disruptive behavior - on what was causing the disruptive behavior." — LS

Hypervigilance can make it difficult to set and accomplish goals even for the most persistent and high achieving person; all goals are trumped by the larger objective of staying safe. This type of coping can lead to difficulties trusting, including parents, caregivers, friends, teachers, and other adults.

Neurobiological Brain Research

Neuroscience indicates that a person's response to stress and use of coping techniques have three components. Dr. Ford provided a metaphor for understanding these complex brain processes:

- The ***"alarm"*** in the brain tells a person to wake up and pay attention. It also tells the body when there is a crisis and to be ready to react and survive.
- The ***"librarian"*** and ***"search engine"*** file and retrieve memories. When the alarm goes off, the memory filing center pulls information from all parts of the brain to figure out what is going on.
- The ***"computer hard drive"*** is the thinking center where all the information is put together and decisions are made.

If the three above components are working well, the thinking center is activated and a person can handle the stressful situation, not worry about survival, and come up with good ideas and plans for handling the situation, thus the alarm is turned off. However, if the alarm is so strong because of extreme stress (e.g., a threat to survival), it can crash the memory filing center and the hard drive in the brain. At that point, survival coping tactics take over. These activities take place in the part of the brain that helps a person survive and be safe. Operating in survival mode is not the ideal way to live because it leads to difficulty relaxing, trusting, focusing, and handling things appropriately.

Recovery from Trauma

A trauma-informed approach is a framework for providing services that should be integrated into everything that a program and system does. Dr. Ford noted that the goal of recovery from trauma is to tap into an existing strength to reset the brain's alarm to not be in persistent survival mode. Resetting the alarm requires strategies to resume thinking clearly. Evidence-based trauma-informed and trauma-specific therapy programs provide youth and their caregivers with strategies to focus their minds and deal with not feeling safe. Learning the strategies for regulating emotions and controlling anxiety is vital to everyday functioning in society. A trauma-informed approach includes youth and caretakers

in future planning. Trauma takes away control of a person's body or life. Reintroducing some control can tap into resiliency, and planning for the future provides hope.[vi]

Strategies for recovery from trauma include recognizing one's own and others' alarm reactions, sweeping one's mind clear before judging and acting, focusing on what is most important and positive, and being aware of stress and personal control levels. These strategies activate the thinking center and reset the alarm.

Many Paths to Recovery: Evidence-Based Models

- Cognitive-behavioral therapies
- Emotion regulation therapies
- Relational-interpersonal therapies
- Psychotherapies for dissociation
- Parent-child and family system therapies
- Social/helping network therapies
- Peer-to-peer support programs

The webinar presenters acknowledged that there are many paths to recovery and recommended common therapeutic approaches implemented by mental health professionals that can assist individuals who have experienced trauma. It is important to understand that trauma-informed care principles can be implemented by people who are not mental health professionals and work in various systems that provide services for individuals who have experienced trauma.

Trauma at the Systems Level

Mr. Charles Wilson provided a discussion of the child welfare system, and its role in addressing youth and families who have experienced trauma. The experience of trauma is complex and personal, and youth and families who have experienced trauma receive services within a variety of community systems. Providers and systems have the ability to help or potentially re-traumatize. A trauma-informed system aligns interactions among youth-serving agencies, such as the child protection systems, lawyers, juvenile judges, law enforcement, schools, and mental health providers so that they better understand how youth, families, and adults respond to trauma.

A trauma-informed system is not just about raising awareness, but changing behavior, actions, and responses. The approach requires doing things differently so as not to re-traumatize or introduce additional trauma. Systems need to support the natural resiliency of children and youth and assist them in identifying their unique strengths.

In a trauma-informed system, caregivers play a central role in recovery, help promote youth's natural resiliency, and give youth tools for managing stress. A strengths-based approach considers and includes the assistance given to caregivers within the system. This approach considers how the system helps caregivers deal with both current and past traumatic stress. The trauma-informed system assists caregivers understand the significant trauma histories of the children and youth that are in their care. Child welfare workers, mental health therapists, foster parents, juvenile judges, and all those working with children who have experienced significant traumatic events are influenced and touched by the trauma and can experience secondary or vicarious traumatic reactions. Therefore, the trauma-informed system responds to the varying impacts of traumatic stress on children, caregivers, and all those who are in contact with the system. Practitioners take this thinking and awareness about trauma and use it in everyday practice.

"The aftercare team also took a lot of time to do safety planning and future planning with me, and that is important because a lot of young people who experience trauma, they express feelings of hopelessness and they are in a constant state of anxiety, and so their ability to project into the future and plan for the future can be seriously impaired." — LS

Core Principles of a Trauma-Informed Approach

Given the presence of trauma in the lives of many youth and the need for systems and providers to support healing, a trauma-informed approach to providing services is critical. According to SAMHSA's concept of trauma[vii], a program, an organization, or a system that is trauma informed is based on four key assumptions:

- ***Realizes*** the widespread impact of trauma and understands potential paths for recovery.
- ***Recognizes*** the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
- ***Responds*** by fully integrating knowledge about trauma into policies, procedures, practices, and settings.
- ***Resists re-traumatization*** of clients as well as staff***.***

The Chadwick Trauma-Informed Systems Project (CTISP)[viii] National Advisory Committee says that in a trauma-informed child welfare system, all parties recognize and respond to the varying impact of traumatic stress on children, caregivers, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and skill into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery.

"I was 13 years old in my first foster home, and I must admit I did not want to be there at first because I was at home with people who I was unfamiliar with…" — NC

SAMHSA's six principles[ix] support a framework for understanding trauma and developing a trauma-informed approach:

- ***Safety:*** Throughout the organization, the staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.
- ***Trustworthiness and transparency:*** Organizational operations and decisions are conducted with transparency and with the goal of building and maintaining trust among clients, family members, staff, and others involved with the organization.
- ***Collaboration and mutuality:*** There is true partnering and leveling of power differences between staff and clients and among organizational staff, from direct care staff to administrators; they recognize that healing happens in relationships and in the meaningful sharing of power and decision making.
- ***Empowerment:*** Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills are developed as needed.
- ***Voice and choice:*** The organization aims to strengthen the experience of choice for clients, family members, and staff and recognizes that every person's experience is unique and requires an individualized approach.
- ***Culture, historical and gender issues:*** The organization incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; are gender-responsive; and incorporate a focus on historical trauma.

These principles underlie the values, beliefs, and attitudes of individuals and organizations offering a trauma-informed approach. Using this approach, organizations foster a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. Trauma-informed organizations build on strengths and assets of clients, staff, and communities instead of responding only to their perceived deficits. They recognize that everyone has a role to play. They address cultural, historical, and gender issues; actively move past cultural stereotypes and biases; offer gender-responsive services; promote the value of cultural connections; and recognize and address historical trauma. In the words of Dr. Ford, "A person does not have to be a therapist to be therapeutic."

Implementation

In his presentation, Mr. Charles Wilson shared the following central elements of providing trauma-informed care within programs, policies, services, and systems as outlined by the child welfare committee of the National Child Traumatic Stress Network. Sources with additional information are provided in the resources section of this brief.

Element 1: Maximize Physical and Psychological Safety for Children and Families

- Safety is a priority. Children and families who have experienced trauma may still feel unsafe even when they are no longer in danger. In addition to ensuring physical safety, it is important to help children and families feel psychologically safe.
- Sometimes even a noise or smell can trigger the feeling of being unsafe and elicit a reaction that a caretaker might not expect or understand. Being aware of and understanding these triggers and changing something seemingly small or insignificant in a daily routine can change behavior from negative to positive.

Element 2: Identify the Trauma-Related Needs of Children

- One of the first steps in helping trauma-exposed children and families is to understand how they have been impacted by trauma.
- Trauma-related needs can be identified through trauma screening and assessment.
- It is important to consider the type(s) of trauma children have experienced when making service referrals and developing service plans. All children need individualized services that are based on their unique circumstances, strengths, and challenges.

"I had reported a child abuse and neglect incident with social services and they did not come and take us out of our home. It was a form of betrayal of trust because you are expecting someone to help you and when that help does not come, then your relationship with the institutions that you need to rely on in order to get out of a bad situation, the relationship is broken." — LS

Element 3: Enhance Child Well-Being and Resilience

- Many children are naturally resilient.
- Systems must recognize and build on children's existing strengths.
- Both individual caseworkers and overall agency policies should support the continuity of children's relationships.
- Staff and agencies should also ensure that children who have been traumatized have access to evidence-based treatments and services.

Element 4: Enhance Family Well-Being and Resilience

- Families are a critical part of both protecting children from harm and enhancing their natural resilience.
- Providing trauma-informed education and services to parents and other caregivers enhances protective capacities.
- Agencies should recognize and assist caregivers to understand the significant trauma histories of the children and youth that are in their care.
- Agencies should assist caregivers to understand their own trauma histories.

"We need to do some self-esteem building and work with young people to acknowledge their strengths. I think when you have experienced trauma, you have a lot of thoughts, beliefs, or feelings of being unworthy or ashamed and you feel a lot of guilt and sometimes that leads to hopelessness. You are not going to work hard to achieve goals if you do not believe you can achieve them, if you do not believe you are worthy of achieving them…" — LS

Element 5: Enhance the Well-Being and Resilience of Those Working in the System

- Staff play important roles in supporting children, but working with people who have experienced abuse, neglect, violence, and other trauma can cause staff to develop secondary traumatic stress reactions.
- Agencies should collect information about trauma and secondary trauma experienced by staff, implement strategies and practices that build resilience and help staff manage stress, and address the impact of secondary traumatic stress on both individuals and on the system as a whole.

> **"The aftercare team was most useful because they worked across the systems…I did not have to do the work that a lot of young people are burdened with, which is finding a way to get our systems to work with one another." — LS**

Element 6: Partner with Youth and Families

- Youth and families should have choices and an active voice in decision making on individual, agency, and systemic levels.
- Youth and family members who have been in the system have a unique perspective and can provide valuable feedback.
- Partnerships with youth and families should occur at all levels.

Element 7: Partner with Agencies and Systems That Interact with Children and Families

- Agencies need to establish strong partnerships with other child- and family-serving systems.
- Service providers should develop common protocols and frameworks.
- Cross-system collaboration enables all helping professionals to see the child as a whole person, thus preventing potentially competing priorities and messages.
- Collaboration between systems promotes cohesive care and better outcomes.

Conclusion

This brief provides an overview of the webinar content as presented by experts in the field regarding the concepts and prevalence of trauma, principles for understanding trauma, and practices for addressing trauma and working with youth who have experienced trauma.

LS and NC, two young people formerly involved with the foster care system, provided much insight on their experiences with multiple traumas. Their shared comments provide important information and practice-based evidence and strategies that child and youth serving systems could incorporate into their work with children and youth who have experienced trauma. Some of the practical applications they described as beneficial to them include:

- Staff working in schools need to be aware of, educated and informed on the effects of trauma for children and youth, and trained in the causes of disruptive behaviors and ways to address these behaviors that do not re-traumatize children and youth;
- Aftercare teams need to provide consistent and ongoing planning with youth to address the after effects of trauma, (e.g., anxiety, sadness, depressions, feelings of hopelessness, anger, shame, guilt) and to build upon their strengths to instill good self-esteem and a belief that they are worthy of and can achieve goals in their life;

- Aftercare teams need to provide ongoing assistance for children and youth to learn skills for daily life, safety planning to address potential re-traumatization, and development of goals for the "here and now" and in their future;
- Aftercare teams need to provide quick response for children and youth who have been traumatized when reports or incidents of child abuse and/or neglect occur. Teams need to remember that these children and youth have been placed in unfamiliar surroundings and they do not feel safe or trust the people or environment immediately. They must rely on the aftercare teams to provide a trusting relationship with staff that will provide safety, protection and security in their lives;
- Aftercare teams need to work across systems to advocate for children and youth who have experienced trauma, and to assist them with the work needed for their daily care and consistent planning for life transitions.

Many strategies for coping with trauma have been noted in this brief, as well as the experiences of LS and NC which can inform child and youth serving systems on the successful practices and strategies that could improve the experience of children and youth who are coping with and healing from trauma. The resources noted below offer a starting point for deeper understanding of trauma and trauma-informed approaches.

Resources

Helping Children and Adolescents Cope with Violence and Disasters: What Community Members Can Do, National Institute of Mental Health, 2013 website information
http://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-violence-and-disasters-community-members/index.shtml

National Child Traumatic Stress Network, Learning Center for Child and Adolescent Trauma, Resources and Training
http://learn.nctsn.org/index.php

National Council for Behavioral Health; Trauma Informed Care
http://www.thenationalcouncil.org/topics/trauma-informed-care/

National Council for Behavioral Health; How to Manage Trauma
http://www.thenationalcouncil.org/wp-content/uploads/2013/05/Trauma-infographic.pdf

Cady, D., & Lulow, E. (2012.) Trauma-Informed Method of Engagement [Flyer]. Washington, DC: National Technical Assistance Center for Children's Mental Health.

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Green, J. G., McLaughlin, K. A., Kessler, R. C., et al. (2010). Childhood adversities and adult psychopathology in the National Comorbidity Survey Replication (NCS-R) III: Associations with functional impairment related to DSM-IV disorders;

McLaughlin, K. A., Green, J. G., Kessler R. C., et al. (2010). Childhood adversity and adult psychiatric disorder in the U.S. National Comorbidity Survey;

Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2009). Collaborative treatment of traumatized children and teens: The Trauma Systems Therapy Approach;

Mollica, R. F. (2006). Healing invisible wounds: Paths to hope and recovery in a violent world.

[ii] Griffin, G. & Sallen, S. (2013) Considering Child Trauma Issues in Juvenile Court Sentencing. Children's Legal Rights Journal, 34, 1 - 22.

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Center for Advanced Studies in Child Welfare. (2013). Trauma-informed child welfare practice. Retrieved from http://cascw.umn.edu/wp-content/uploads/2013/12/CW360-Ambit_Winter2013.pdf.

[vi] Ford, J.D., Courtois, C.A. (Eds.) (2013). Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models. New York: Guilford Press.

[vii] SAMHSA (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.

[viii] Chadwick Trauma-Informed Systems Project. (2013). Creating trauma-informed child welfare systems: A guide for administrators (2nd ed.). San Diego, CA: Chadwick Center for Children and Families. Retrieved from http://www.chadwickcenter.org/CTISP/images/CTISPTICWAdminGuide2ndEd2013.pdf

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SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

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Introduction

Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. ***In order to maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.***

The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.[1,2,3,4,5] Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences.[6,7,8,9] However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical diseases.[1,10,11]

With appropriate supports and intervention, people can overcome traumatic experiences.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.[12,13] Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems.[5,14] Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.[15,16,17]

In addition, the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

Thus, the pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing "business as usual." In public institutions and service systems, there is increasing recognition that many of the individuals have extensive histories of trauma that, left unaddressed, can get in the way of achieving good health and well-being. For example, a child who suffers from maltreatment or neglect in the home may not be able to concentrate on school work and be successful in school; a women victimized by domestic violence may have trouble performing in the work setting; a jail inmate repeatedly exposed to violence on the street may have difficulty refraining from retaliatory violence and re-offending; a sexually abused homeless youth may engage in self-injury and high risk behaviors to cope with the effects of sexual abuse; and, a veteran may use substances to mask the traumatic memories of combat. The experiences of these individuals are compelling and, unfortunately, all too common. Yet, until recently, gaining a better understanding of how to address the trauma experienced by these individuals and how to mitigate the re-traumatizing effect of many of our public institutions and service settings was not an integral part of the work of these systems. Now, however, there is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their "business" under the framework of a trauma-informed approach.

There is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their business under the framework of a trauma-informed approach.

Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach

PURPOSE

The purpose of this paper is to develop a working concept of trauma and a trauma-informed approach and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups. SAMHSA puts forth a framework for the behavioral health specialty sectors, that can be adapted to other sectors such as child welfare, education, criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual's capacity to cope with traumatic experiences. In fact, many people with behavioral health problems receive treatment and services in these non-specialty behavioral health systems. SAMHSA intends this framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families and communities. The desired goal is to build a framework that helps systems "talk" to each other, to understand better the connections between trauma and behavioral health issues, and to guide systems to become trauma-informed.

APPROACH

SAMHSA approached this task by integrating three significant threads of work: trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors

of traumatic experiences who have had involvement in multiple service sectors. It was expected that this blending of the research, practice and survivor knowledge would generate a framework for improving the capacity of our service systems and public institutions to better address the trauma-related issues of their constituents.

To begin this work, SAMHSA conducted an environmental scan of trauma definitions and models of trauma informed care. SAMHSA convened a group of national experts who had done extensive work in this area. This included trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of trauma-specific interventions; and policymakers in the field of behavioral health.

From this meeting, SAMHSA developed a working document summarizing the discussions among these experts. The document was then vetted among federal agencies that conduct work in the field of trauma. Simultaneously, it was placed on a SAMHSA website for public comment. Federal agency experts provided rich comments and suggestions; the public comment site drew just over 2,000 respondents and 20,000 comments or endorsements of others' comments. SAMHSA reviewed all of these comments, made revisions to the document and developed the framework and guidance presented in this paper.

The key questions addressed in this paper are:

- **What do we mean by trauma?**
- **What do we mean by a trauma-informed approach?**
- **What are the key principles of a trauma-informed approach?**
- **What is the suggested guidance for implementing a trauma-informed approach?**
- **How do we understand trauma in the context of community?**

SAMHSA's approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA's trauma-focused grants and initiatives, such as SAMHSA's National Child Traumatic Stress Initiative, SAMHSA's National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA's: Jail Diversion Trauma Recovery grant program; Children's Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Reentry and Adult Treatment Drug Court Programs.

Background: Trauma — Where We Are and How We Got Here

The concept of traumatic stress emerged in the field of mental health at least four decades ago. Over the last 20 years, SAMHSA has been a leader in recognizing the need to address trauma as a fundamental obligation for public mental health and substance abuse service delivery and has supported the development and promulgation of trauma-informed systems of care. In 1994, SAMHSA convened the Dare to Vision Conference, an event designed to bring trauma to the foreground and the first national conference in which women trauma survivors talked about their experiences and ways in which standard practices in hospitals re-traumatized and often, triggered memories of previous abuse. In 1998, SAMHSA funded the Women, Co-Occurring Disorders and Violence Study to generate knowledge on the development and evaluation of integrated services approaches for women with co-occurring mental and substance use disorders who also had histories of physical and or sexual abuse. In 2001, SAMHSA funded the National Child Traumatic Stress Initiative to increase understanding of child trauma and develop effective interventions for children exposed to different types of traumatic events.

The American Psychiatric Association (APA) played an important role in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the recently released DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970's.[18,19,20,21] National trauma research and practice centers have conducted significant work in the past few decades, further refining the concept of trauma, and developing effective trauma assessments and treatments.[22,23,24,25] With the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.[3,25]

Simultaneously, an emerging trauma survivors movement has provided another perspective on the understanding of traumatic experiences. Trauma survivors, that is, people with lived experience of trauma, have powerfully and systematically documented their paths to recovery.[26] Traumatic experiences complicate a child's or an adult's capacity to make sense of their lives and to create meaningful consistent relationships in their families and communities.

Trauma survivors have powerfully and systematically documented their paths to recovery.

The convergence of the trauma survivor's perspective with research and clinical work has underscored the central role of traumatic experiences in the lives of people with mental and substance use conditions. The connection between trauma and these conditions offers a potential explanatory model for what has happened to individuals, both children and adults, who come to the attention of the behavioral health and other service systems.[25,27]

People with traumatic experiences, however, do not show up only in behavioral health systems. Responses to these experiences often manifest in behaviors or conditions that result in involvement with the child welfare and the criminal and juvenile justice system or in difficulties in the education, employment or primary care system. Recently, there has also been a focus on individuals in the military and increasing rates of posttraumatic stress disorders.[28,29,30,31]

With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed. Federal research agencies, academic institutions and practice-research partnerships have generated empirically-supported interventions. In SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) alone there are over 15 interventions focusing on the treatment or screening for trauma.

These interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough. Building on lessons learned from SAMHSA's Women, Co-Occurring Disorders and Violence Study; SAMHSA's National Child Traumatic Stress Network; and SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions in which services are provided played a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served. SAMHSA's National Center for Trauma-Informed Care has continued to advance this effort, starting first in the behavioral health sector, but increasingly responding to technical assistance requests for organizational change in the criminal justice, education, and primary care sectors.

FEDERAL, STATE AND LOCAL LEVEL TRAUMA-FOCUSED ACTIVITIES

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

States are elevating a focus on trauma. For example, Oregon Health Authority is looking at different types of trauma across the age span and different population groups. Maine's "Thrive Initiative" incorporates a trauma-informed care focus in their children's systems of care. New York is introducing a trauma-informed initiative in the juvenile justice system. Missouri is exploring a trauma-informed approach for their adult mental health system. In Massachusetts, the Child Trauma Project is focused on taking trauma-informed care statewide in child welfare practice. In Connecticut the Child Health and Development Institute with the state Department of Children and Families is building a trauma-informed system of care throughout the state through policy and workforce development. SAMHSA has supported the further development of trauma-informed approaches through its Mental Health Transformation Grant program directed to State and local governments.

Increasing examples of local level efforts are being documented. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the wellbeing of the community. The Family Policy Council in Washington State convened groups to focus on the impact of adverse childhood experiences on the health and well-being of its local communities and tribal communities. Philadelphia held a summit to further its understanding of the impact of trauma and violence on the psychological and physical health of its communities.

SAMHSA continues its support of grant programs that specifically address trauma.

At the federal level, SAMHSA continues its support of grant programs that specifically address trauma and technical assistance centers that focus on prevention, treatment and recovery from trauma.

Other federal agencies have increased their focus on trauma. The Administration on Children Youth and Families (ACYF) has focused on the complex trauma of children in the child welfare system and how screening and assessing for severity of trauma and linkage with trauma treatments can contribute to improved well-being for these youth. In a joint effort among ACYF, SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the three agencies developed and issued through the CMS State Directors' mechanism, a letter to all State Child Welfare Administrators, Mental Health Commissioners, Single State Agency Directors for Substance Abuse and State Medicaid Directors discussing trauma, its impact on children, screening, assessment and treatment interventions and strategies for paying for such care. The Office of Juvenile Justice and Delinquency Prevention has specific recommendations to address trauma in their Children Exposed to Violence Initiative. The Office of Women's Health has developed a curriculum to train providers in primary care on how to address trauma issues in health care for women. The Department of Labor is examining trauma and the workplace through a federal interagency workgroup. The Department of Defense is honing in on prevention of sexual violence and trauma in the military.

As multiple federal agencies representing varied sectors have recognized the impact of traumatic experiences on the children, adults, and families they serve, they have requested collaboration with SAMHSA in addressing these issues. The widespread recognition of the impact of trauma and the burgeoning interest in developing capacity to respond through trauma-informed approaches compelled SAMHSA to revisit its conceptual framework and approach to trauma, as well as its applicability not only to behavioral health but also to other related fields.

SAMHSA's Concept of Trauma

Decades of work in the field of trauma have generated multiple definitions of trauma. Combing through this work, SAMHSA developed an inventory of trauma definitions and recognized that there were subtle nuances and differences in these definitions.

Desiring a concept that could be shared among its constituencies — practitioners, researchers, and trauma survivors, SAMHSA turned to its expert panel to help craft a concept that would be relevant to public health agencies and service systems. SAMHSA aims to provide a viable framework that can be used to support people receiving services, communities, and stakeholders in the work they do. A review of the existing definitions and discussions of the expert panel generated the following concept:

> ***Individual trauma results from an* event*, series of events, or set of circumstances that is* experienced *by an individual as physically or emotionally harmful or life threatening and that has lasting adverse* effects *on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.***

THE THREE "E'S" OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as "trauma and stressor-related disorders" to include exposure to a traumatic or stressful event as a diagnostic criterion.

The individual's **experience** of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one's country differently from another refugee; one military veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of "why me?" The individual's experience of these events or circumstances is shaped in the context of this powerlessness and questioning. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When a person experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal, shattering a person's trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

How the event is experienced may be linked to a range of factors including the individual's cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure), or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty).[1]

The long-lasting adverse **effects** of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one's neurobiological make-up and ongoing health and well-being. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.[1,3] Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

SAMHSA's Trauma-Informed Approach: Key Assumptions and Principles

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to influence how service systems conduct their business.

The context in which trauma is addressed or treatments deployed contributes to the outcomes for the trauma survivors, the people receiving services, and the individuals staffing the systems. Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.[22,32,33] SAMHSA's concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles.

A program, organization, or system that is trauma-informed* realizes *the widespread impact of trauma and understands potential paths for recovery;* recognizes *the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and* responds *by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively* resist re-traumatization*.

A trauma informed approach is distinct from trauma-specific services or trauma systems. A trauma informed approach is inclusive of trauma-specific interventions, whether assessment, treatment or recovery supports, yet it also incorporates key trauma principles into the organizational culture.

Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.

THE FOUR "R'S: KEY ASSUMPTIONS IN A TRAUMA-INFORMED APPROACH

In a trauma-informed approach, all people at all levels of the organization or system have a basic **realization** about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People's experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional).There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in prevention, treatment, and recovery settings. Similarly, there is a realization that trauma is not confined to the behavioral health specialty service sector, but is integral to other systems (e.g., child welfare, criminal justice, primary health care, peer–run and community organizations) and is often a barrier to effective outcomes in those systems as well.

People in the organization or system are also able to **recognize** the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

The program, organization, or system **responds** by applying the principles of a trauma-informed approach to all areas of functioning. The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma practices. Policies of the organization, such as mission statements, staff handbooks and manuals promote a culture based on beliefs about resilience, recovery, and healing from trauma. For instance, the agency's mission may include an intentional statement on the organization's commitment to promote trauma recovery; agency policies demonstrate a commitment to incorporating perspectives of people served through the establishment of client advisory boards or inclusion of people who have received services on the agency's board of directors; or agency training includes resources for mentoring supervisors on helping staff address secondary traumatic stress. The organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes trust, fairness and transparency. The program's, organization's, or system's response involves a universal precautions approach in which one expects the presence of trauma in lives of individuals being served, ensuring not to replicate it.

A trauma-informed approach seeks to **resist re-traumatization** of clients as well as staff. Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission.[27] Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories. For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

1. **Safety**
2. **Trustworthiness and Transparency**
3. **Peer Support**
4. **Collaboration and Mutuality**
5. **Empowerment, Voice and Choice**
6. **Cultural, Historical, and Gender Issues**

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

The six key principles fundamental to a trauma-informed approach include:[24,36]

1. **Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. **Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.

3. **Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term "Peers" refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as "trauma survivors."

4. **Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: "one does not have to be a therapist to be therapeutic."[12]

5. **Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.[34] Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.

6. **Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Guidance for Implementing a Trauma-Informed Approach

Developing a trauma-informed approach requires change at multiples levels of an organization and systematic alignment with the six key principles described above. The guidance provided here builds upon the work of Harris and Fallot and in conjunction with the key principles, provides a starting point for developing an organizational trauma-informed approach.[20] While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives. Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a "checklist" or a prescriptive step-by-step process. These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care.[35,36,37,38] What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content.

TEN IMPLEMENTATION DOMAINS

1. **Governance and Leadership**
2. **Policy**
3. **Physical Environment**
4. **Engagement and Involvement**
5. **Cross Sector Collaboration**
6. **Screening, Assessment, Treatment Services**
7. **Training and Workforce Development**
8. **Progress Monitoring and Quality Assurance**
9. **Financing**
10. **Evaluation**

GOVERNANCE AND LEADERSHIP: The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within the organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

POLICY: There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be "hard-wired" into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

PHYSICAL ENVIRONMENT OF THE ORGANIZATION: The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of a trauma informed approach through openness, transparency, and shared spaces.

ENGAGEMENT AND INVOLVEMENT OF PEOPLE IN RECOVERY, TRAUMA SURVIVORS, PEOPLE RECEIVING SERVICES, AND FAMILY MEMBERS RECEIVING SERVICES: These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach that differentiates it from the usual approaches to services and care.

CROSS SECTOR COLLABORATION: Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization's mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

SCREENING, ASSESSMENT, AND TREATMENT SERVICES: Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach. Trauma screening and assessment are an essential part of the work. Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

TRAINING AND WORKFORCE DEVELOPMENT: On-going training on trauma and peer-support are essential. The organization's human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals with complex trauma.

PROGRESS MONITORING AND QUALITY ASSURANCE: There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments and treatment.

FINANCING: Financing structures are designed to support a trauma-informed approach which includes resources for: staff training on trauma, key principles of a trauma-informed approach; development of appropriate and safe facilities; establishment of peer-support; provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and development of trauma-informed cross-agency collaborations.

EVALUATION: Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

To further guide implementation, the chart on the next page provides sample questions in each of the ten domains to stimulate change-focused discussion. The questions address examples of the work to be done in any particular domain yet also reflect the six key principles of a trauma-informed approach. Many of these questions and concepts were adapted from the work of Fallot and Harris, Henry, Black-Pond, Richardson, & Vandervort, Hummer and Dollard, and Penney and Cave.[39, 40, 41,42]

While the language in the chart may seem more familiar to behavioral health settings, organizations across systems are encouraged to adapt the sample questions to best fit the needs of the agency, staff, and individuals being served. For example, a juvenile justice agency may want to ask how it would incorporate the principle of safety when examining its physical environment. A primary care setting may explore how it can use empowerment, voice, and choice when developing policies and procedures to provide trauma-informed services (e.g. explaining step by step a potentially invasive procedure to a patient at an OBGYN office).

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

KEY PRINCIPLES					
Safety	**Trustworthiness and Transparency**	**Peer Support**	**Collaboration and Mutuality**	**Empowerment, Voice, and Choice**	**Cultural, Historical, and Gender Issues**
10 IMPLEMENTATION DOMAINS					
Governance and Leadership	• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? • How do the agency's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? • How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?				
Policy	• How do the agency's written policies and procedures include a focus on trauma and issues of safety and confidentiality? • How do the agency's written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery? • How do the agency's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training? • How do human resources policies attend to the impact of working with people who have experienced trauma? • What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?				

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Physical Environment	• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? • In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this? • How has the agency provided space that both staff and people receiving services can use to practice self-care? • How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).
Engagement and Involvement	• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services? • How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information? • How is transparency and trust among staff and clients promoted? • What strategies are used to reduce the sense of power differentials among staff and clients? • How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
Cross Sector Collaboration	• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions? • Are collaborative partners trauma-informed? • How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services? • What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?
Screening, Assessment, Treatment Services	• Is an individual's own definition of emotional safety included in treatment plans? • Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? • Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? • How are peer supports integrated into the service delivery approach? • How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women? • Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding? • How are these trauma-specific practices incorporated into the organization's ongoing operations?

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Training and Workforce Development	• How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences? • How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? • How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? • How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety? • How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors. • What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? • What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?
Progress Monitoring and Quality Assurance	• Is there a system in place that monitors the agency's progress in being trauma-informed? • Does the agency solicit feedback from both staff and individuals receiving services? • What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency? • How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes? • What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?
Financing	• How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? • What funding exists for cross-sector training on trauma and trauma-informed approaches? • What funding exists for peer specialists? • How does the budget support provision of a safe physical environment?
Evaluation	• How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach? • How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? • What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality? • What measures or indicators are used to assess the organizational progress in becoming trauma-informed?

Next Steps: Trauma in the Context of Community

Delving into the work on community trauma is beyond the scope of this document and will be done in the next phase of this work. However, recognizing that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process.

Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.

Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not. The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

Conclusion

As the concept of a trauma-informed approach has become a central focus in multiple service sectors, SAMHSA desires to promote a shared understanding of this concept. The working definitions, key principles, and guidance presented in this document represent a beginning step toward clarifying the meaning of this concept. This document builds upon the extensive work of researchers, practitioners, policymakers, and people with lived experience in the field. A standard, unified working concept will serve to advance the understanding of trauma and a trauma-informed approach for public institutions and service sectors.

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Trauma-informed care in child/family welfare services

Liz Wall, Daryl Higgins and Cathryn Hunter

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This paper aims to define and clarify what trauma-informed service delivery means in the context of delivering child/family welfare services in Australia. Exposure to traumatic life events such as child abuse, neglect and domestic violence is a driver of service need. Policies and service providers must respond appropriately to people who are dealing with trauma and its effects in order to ensure best outcomes for individuals and families using these services. In addition to evidence-based programs or clinical interventions that are specific to addressing trauma symptoms, such as trauma-focused cognitive behaviour therapy, there is a need for broader organisational- or service-level systems of care that respond to the needs of clients with a lived experience of trauma that go beyond a clinical response. Some of the challenges identified in implementing and embedding trauma-informed care across services and systems are discussed.

KEY MESSAGES

- Traumatic experiences are common, with people often having multiple adverse experiences across their life. There are many serious and deleterious outcomes associated with exposure to them.
- Clients often present to child/family welfare services with a complex range of symptoms and behaviours related to prior and/or past trauma, which neither they nor those working with them have linked to this previous trauma exposure. As a result they may face an uninformed and fragmented response that is potentially re-traumatising.
- There are a small number of trauma-specific interventions that have been evaluated using a rigorous scientific standard and been shown to be effective—however, the research is often based on populations who have experienced a single traumatic event rather than complex trauma.
- Trauma-informed care is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.
- With the lack of an overarching framework in Australia, there is a danger of inconsistent or piecemeal development of trauma-informed models and practices that do not share a consistent language or framework for implementing trauma-informed systems of care in child/family services.
- As trauma affects a large proportion of the population, survivors are clients in a broad range of human services, and organisations across all settings should consider how a trauma-informed approach could benefit stakeholders, regardless of whether or not the organisation also provides evidence-based trauma-specific interventions.
- Challenges to implementing a trauma-informed approach to care include: a lack of clearly articulated definitions (e.g. of trauma-specific interventions vs the concept and principles of trauma-informed care); translating trauma-informed care to specific practice and service settings; consistency across service settings and systems; care-coordination; a lack of guidance for facilitating complex system change; and a lack of evaluation of models of trauma-informed care.
- Research is needed to explore whether different trauma-informed approaches are required for different population groups, including children, adolescents and adults, or for males and females.

Understanding the experiences of adversity in childhood such as sexual or other abuse as trauma is now recognised to be an important concept for human service delivery sectors. The USA has led efforts to incorporate trauma theory into mental health and other service delivery, largely driven by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA funds two major trauma-related resources, the National Center for Trauma-Informed Care (NCTIC) and the National Child Traumatic Stress Initiative (NCTSI), to provide a focus for developing a shared language and evidence base around trauma and trauma-informed approaches to service. Emerging

efforts in Australia are now contributing to our knowledge of effective practice for children, young people and adults who have experienced trauma from events such as child maltreatment, sexual assault, military service, forced adoption and past family separation practices.

This paper aims to define and clarify what trauma-informed service delivery means in an Australian context. Australia is not as far down the track as the USA in terms of implementing a trauma-informed approach to human service provision in systems such as mental health and child and family services. There is, however, a recognition that exposure to traumatic life events is a driver of service need and that policies and service providers must address and respond to trauma appropriately to ensure best outcomes for individuals and families using these services.

Trauma terminology

There has been extensive debate around the classification and terminology for describing the effects of trauma, as well as the relationship to specific diagnostic terms such as post-traumatic stress disorder (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005; Wall & Quadara, 2014). The latest iteration of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), an international classification system for mental health disorders, has taken a broad approach to the terminology with a category of "Trauma and Stressor Related Disorders" rather than specifically including complex trauma as a diagnostic term.

Any discussion of trauma-informed service delivery requires consideration of the vast array of definitions and terminology that arises around trauma. This section explains some of the different terms, phrases and concepts that are used in the literature to describe trauma and trauma-related service provision.

Recently, there have been attempts to provide consistency in definitions and a shared language around trauma and a trauma-informed approach to care. SAMHSA's (2014) *Concept of Trauma and Guidance for a Trauma-Informed Approach* puts forward definitions and a working concept of trauma and a trauma-informed approach in order to develop a shared understanding of these concepts for service systems and stakeholders. SAMHSA is a key resource for trauma-informed approaches to care and these definitions are likely to be widely adopted.

What is trauma?

Traumatic events have been described as those that "overwhelm the ordinary human adaptations to life [and] … generally involve threats to life or bodily integrity, or a close personal encounter with violence and death" (Herman, 1992, p. 33). SAMHSA's concept of trauma provides a comprehensive definition that encompasses trauma related to one-off events as well as ongoing adversity:

> Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing. (SAMHSA, 2014, p. 7)

Although not diagnostic terms, *complex trauma* and *complex post-traumatic stress disorder* are often used to describe trauma that is the result of stressors that are interpersonal—usually severe, sustained and perpetrated by one human being on another—and where clients may not meet all of the specific diagnostic criteria for post-traumatic stress disorder (PTSD) or where the primary clinical presentation is the associated features due to the global effects of trauma on the person's functioning (Connor & Higgins, 2008a, 2008b). Trauma is particularly damaging when it occurs in childhood. Complex, interpersonally generated trauma is severely disruptive of a person's capacity to manage internal states (Kezelman & Stavropoulos, 2012). Complex trauma symptoms include problems with mood regulation, impulse control, self-perception, attention, memory and somatic disorders (Briere & Jordan, 2004; Burstow, 2003; van der Kolk et al., 2005).

Trauma-informed interventions occur at two levels: trauma-specific interventions and trauma-informed models of care. Organisational responses to trauma tend to occur on a continuum from basic trauma awareness, to trauma sensitivity, trauma responsivity and through to trauma-informed and/or trauma-specific interventions. We argue here that it is helpful for organisations providing services in the child/family welfare domain, and human services more broadly, to think about their organisational responses to trauma based on their particular service and client needs.

Trauma-specific interventions

Trauma-specific interventions refer to clinical services or programs designed to treat and ameliorate the actual symptoms and presentations of trauma. While it is possible for individual practitioners to deliver trauma-specific interventions (such as trauma-focused cognitive behaviour therapy [CBT]) within the context of a service delivery model or agency that is not trauma-informed at a system level, this is far from ideal. Elements of a service may not be consistent with a trauma-informed approach—such as the waiting room design and operation, interactions with administrative staff or the absence of adjunct services to address other presenting issues for which the trauma-specific intervention might not be effective. Trauma-specific services are best delivered as part of a trauma-informed system of care operating within a trauma-aware organisational context (Elliot, Bjelajac, Fallor, Markoff, & Reed, 2005; Kezelman & Stavropoulos, 2012).

Funded by the Department of Veterans' Affairs, Phoenix Australia (previously known at the Australian Centre for Posttraumatic Mental Health) has developed a database that summarises the evidence for effective trauma-specific interventions related to military and veteran families and communities (see *What Emerging Interventions are Effective for the Treatment of Adults with PTSD?* <www.evidencecompass.dva.gov.au/home/question/10>). Regarding adults suffering from PTSD, they found a paucity of evidence in relation to the efficacy of emerging therapies.[1] Phoenix Australia have also published a variety of resources for practitioners working with people affected by trauma, including fact sheets, clinical guidelines, booklets for clients and a smartphone app for clients with post-traumatic stress symptoms <phoenixaustralia.org/for-practitioners/practitioner-resources>.

Trauma-focused cognitive behaviour therapy (TF-CBT) is an evidence-based treatment approach for children who have experienced sexual abuse, exposure to domestic violence or similar traumas.[2] TF-CBT features on a range of databases of evidence-based practices, including the California Evidence-Based Clearinghouse for Child Welfare (CEBC) Program Registry: <www.cebc4cw.org>. Training in TF-CBT is available online from the Medical University of South Carolina website: <tfcbt.musc.edu>. However, a full discussion of evidence-based trauma-specific interventions is beyond the scope of this paper.[3]

Similarly, in relation to adults affected by childhood trauma, Connor and Higgins (2008a, 2008b) outlined a model of trauma-specific intervention for clients who experience complex trauma (who may not meet the criteria for PTSD). Evaluating the model, they found qualitative and quantitative evidence from a small-scale pilot study of the effectiveness of their combined individual and group therapy approach focused on the following elements (using the mnemonic "HEALTH"):

- having a supportive therapist;
- ensuring personal safety;
- assisting with daily functioning;
- learning to manage core PTSD symptoms (self-regulation);
- treating complex PTSD symptoms; and
- having patience and persistence to enable "ego strengthening".

1 The emerging interventions included in their review were: mindfulness, acceptance and commitment therapy, meditation, transcendental meditation, acupuncture, power therapies, and experiential psychotherapies including adventure therapy, art therapy, music therapy, and canine- and equine-assisted psychotherapy. See: <evidencecompass.dva.gov.au/home/question/10>.

2 See: *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma* (Child Welfare Information Gateway, 2012) <www.childwelfare.gov/pubpdfs/trauma.pdf>.

3 See *Approaches Targeting Outcomes for Children Exposed to Trauma Arising From Abuse and Neglect: Evidence, Practice and Implications* (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2014) for a discussion of the evidence of the effectiveness of trauma-specific and trauma-informed practices pertaining specifically to children who have experienced abuse and neglect.

However, there have been criticisms made of trauma-specific interventions. For example:

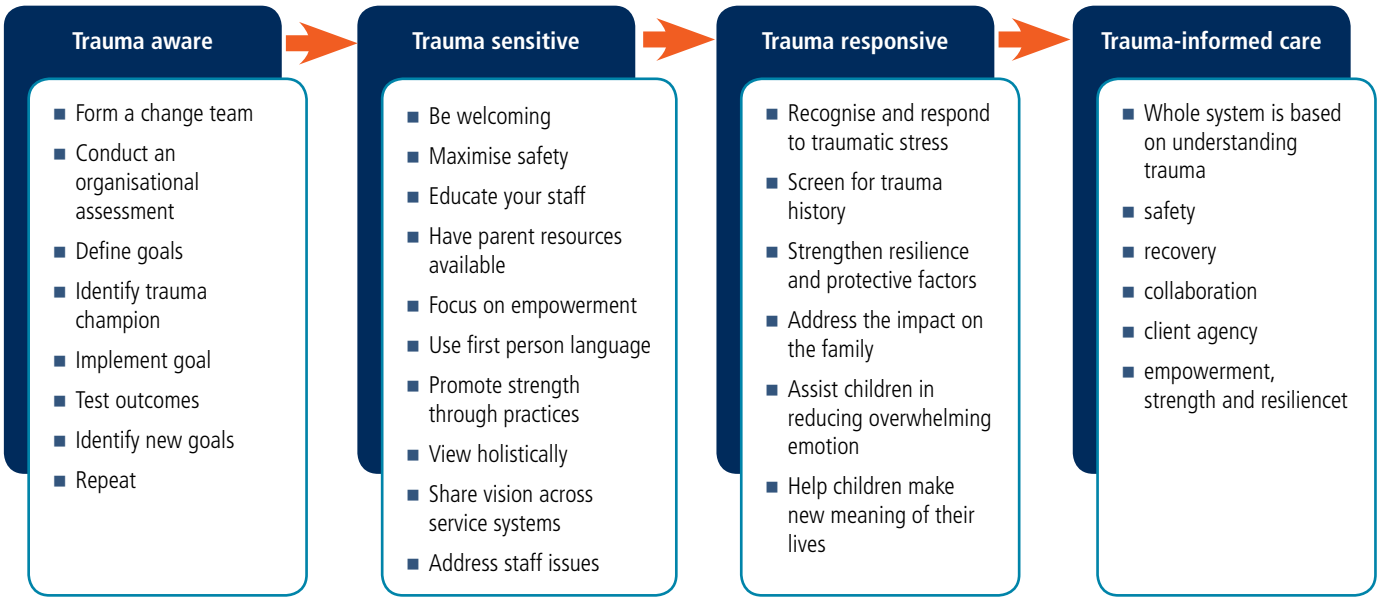
- complex trauma is often inter-relational in nature, so the degree to which research on the treatment of combat-related PSTD applies in these circumstances has been questioned (e.g. for those exposed to prolonged child sexual abuse, particularly if it has resulted in personality or dissociative disorders and is associated with disturbances to affect regulation, self-concept and interpersonal relationships);
- treatment sessions may need to be more frequent and over a longer duration than typical structured programs;
- evaluations of cognitive-based interventions often focus on statistically significant effect sizes rather than clinically meaningful symptom reduction; and
- the value of non-cognitively based interventions, which have been poorly evaluated or not evaluated, are easily overlooked (see: van der Kolk, 2014).

The primary purpose of the paper is not to review the effectiveness—or limitations—of trauma-specific interventions, or even to look specifically at complex trauma and complex PTSD (see: Wall & Quadara, 2014); but rather to explore the broader issue of the value and role of trauma-informed care in child and family welfare service provision.

Trauma-informed model of care

The available literature suggests that there is a continuum from being *trauma aware* (seeking information out about trauma and its implications for organisations) to being *trauma-informed* (a cultural shift at the systemic level). One useful resource sets out the progression in four stages (see Figure 1):

- *trauma aware*: seek information out about trauma;[4]
- *trauma sensitive*: operationalise concepts of trauma within the organisation's work practice;
- *trauma responsive*: respond differently, making changes in behaviour;
- *trauma informed*: entire culture has shifted to reflect a trauma approach in all work practices and settings.



Source: Adapted by Antonia Quadara from Mieseler & Myers (2013)

Figure 1: Practical steps to get from trauma aware to trauma informed

4 At its most basic level, organisations that are trauma aware incorporate trauma awareness into their work. Staff have an understanding of trauma and how symptoms and behavioural presentations in individuals may be responses to traumatic experiences so that behaviours that appear self-destructive or self-defeating can be acknowledged as being adaptive behaviours to trauma that have become maladaptive over time (Hopper, Bassuk, & Olivet, 2010; Markoff, Fallot, Reed, & Elliot, 2005). This applies particularly to broader human service delivery agencies (beyond child/family welfare), particularly if they are not primarily focused on delivering trauma-specific interventions and/or trauma-informed models of care.

SAMHSA's definition of a trauma-informed approach to service is:

> A program, organisation or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff and others involved with the system and responds by fully integrating knowledge about trauma into policies, procedures and practices and seeks to actively resist retraumatisation (SAMHSA, 2014, p. 9)

The main aim of this paper is to explore trauma-informed approaches to care and service delivery specifically in the child and family welfare sectors. While the focus is on how child/family welfare services can be trauma informed, the need extends to other service delivery areas. The trauma literature indicates that trauma survivors are clients in a very broad range of human services such as:

- homelessness (Hopper et al., 2010; Morrison 2009);
- mental health (Kezelman & Stavropoulos, 2012; Muskett, 2014);
- substance abuse treatment; and
- correctional systems (Stathopoulos, 2012).

These types of services have a clear connection to the impacts of trauma, particularly trauma arising from interpersonal victimisation, which has been identified as a driver of human service use (Huntington, Moses, & Veysey, 2005). The term "complex needs" is sometimes used to describe the span of need for an array of services required over a lifetime (Wall & Quadara, 2014). These agencies and services would benefit from being—at a minimum—"trauma aware".

What is the evidence that a trauma-informed approach is needed?

Research suggests that exposure to adverse, potentially traumatic events in childhood is not uncommon (Anda et al., 2006). For example, the Adverse Childhood Experiences (ACE) study in the USA showed that of 17,337 respondents, 64% had experienced at least one adverse experience[5] and approximately 12% had experienced four or more in the first 18 years of life (Anda et al., 2006). Further to this, a recent report suggested that childhood trauma affects an estimated five million Australian adults (Kezelman, Hossack, Stavropoulos, & Burley, 2015). There is also a great deal of evidence associating traumatic experiences with a broad range of deleterious outcomes in childhood, adolescence and adulthood (e.g. Anda et al., 2006; CFCA, 2014a, 2014b; Dube et al., 2001; Hahn Fox, Perez, Cass, Baglivio, & Epps, 2015; Johnson-Reid, Kohl, & Drake, 2012; Nurius, Green, Logan-Greene, & Borja, 2015).

Individual responses to traumatic experiences vary widely, with not all exposure leading to negative outcomes. It is the individual response to the experience that determines whether it is considered traumatic or not (SAMHSA, 2014). If effects occur they can be short- or long-term and may occur immediately following exposure to adversity or have a delayed onset (SAMHSA, 2014).

Multiple studies have reported negative effects associated with experiencing trauma across all facets of life. Mental ill-health, physical illness, social and relational difficulties, and poor academic and employment outcomes have all been linked to previous traumatic experiences. Anda and colleagues (2006) found a strong relationship between increased numbers of adverse childhood experiences and increased prevalence and risk of:

- affective disturbances (e.g. panic attacks, anxiety, hallucinations);
- somatic disturbances (e.g. sleep disturbance, severe obesity);
- smoking, illicit drug use, injected drug use, alcoholism (for people with four or more adverse childhood experiences);
- early intercourse, promiscuity and sexual dissatisfaction;
- impaired memory of childhood; and

5 The adverse childhood experiences measured were three types of childhood abuse: emotional abuse, physical abuse, and contact sexual abuse; and five measures of household dysfunction during childhood: exposure to alcohol or other substance abuse, mental illness, violent treatment of mother or step-mother, criminal behaviour in the household, and parental separation or divorce (Anda et al., 2006, p. 176).

- high perceived stress, difficulty controlling anger and risk of perpetrating intimate partner violence (for people with four or more adverse childhood experiences).

Further to this, the study found that as the number of adverse childhood experiences increased so too did the average number of co-occurring negative outcomes (Anda et al., 2006). There is strong evidence to indicate that certain types of trauma rarely occur in isolation. Research suggests, for example, that the different child maltreatment types are interrelated: sexual abuse, physical abuse, psychological maltreatment, neglect and exposure to domestic and family violence typically occur in combination with each other. A large proportion of children and young people who experience childhood abuse or neglect are exposed to more than one type of abuse (known as "multi-type maltreatment"; Price-Robertson, Higgins, & Vasallo, 2013). Further to this, other forms of victimisation such as bullying or assault by a peer have often been found to co-occur with child maltreatment (known as "poly-victimisation"; see Finkelhor, Ormrod, & Turner, 2007).

Multiple victimisation experiences across different domains are consistently associated with poorer outcomes than a single adverse or maltreatment experience. Those who experience multi-type maltreatment or poly-victimisation are more likely to experience high levels of trauma symptoms and worse outcomes than those who are exposed to no maltreatment or only one type (Finkelhor et al., 2007; Higgins & McCabe, 2001). Supporting these findings, a recent large scale US study of children in the Illinois child welfare system found that children who experienced both violent interpersonal *and* attachment-based ("non-violent") traumas within the caregiver system experienced greater difficulties across several areas of impairment (including attention/behavioural dysregulation and self/relational dysregulation) and were significantly more likely to exhibit PTSD-like symptoms compared to children who had experienced neither type of trauma, violent trauma only or non-violent trauma only (Kisiel et al., 2014).

Co-occurring mental health issues and disorders such as conduct disorder and oppositional defiant disorder (in children), PTSD, depression and other affective disorders, borderline personality disorder, somatoform disorders, psychotic and dissociative disorders have commonly been associated with traumatic experiences (Bateman, Henderson, & Kezelman, 2013; Breslaue, 2009; CFCA, 2014a, 2014b; Nurius et al., 2015; van der Kolk et al., 2005). Self-harm and suicide attempts have also been linked with previous traumatic experiences (Bateman et al., 2013; Cozolino, 2010; Dube et al., 2001; Herman, 1992; Johnson-Reid et al., 2012). In one study, Dube and colleagues (2001) reported that any adverse childhood experience increased the risk of attempted suicide by 2–5 fold with the relationship being partially mediated by illicit drug use, depressed affect and self-reported alcoholism.

Those who have had previous traumatic experiences also commonly report physical health issues. For example, in summarising research on the potential effects of trauma exposure, Bateman and colleagues (2013) found that "survivors of child maltreatment were at increased risk of hepatitis, diabetes, heart disease, cancer, a stroke, are more likely to have surgery and are at increased risk of having one or more chronic pain symptoms" (p. 19). The same authors also noted a range of conditions that child sexual abuse survivors were at increased risk of, including irritable bowel syndrome, asthma, arthritis and digestive problems.

In addition, childhood trauma exposure has been linked to involvement with the criminal justice system. A large study exploring adverse childhood experiences of serious, chronic and violent juvenile offenders and juveniles referred to the justice system for single non-violent offences found that every additional adverse childhood event experienced increased the risk of becoming a serious, chronic and violent juvenile offender by more than 35%, even when other known risk factors for violent behaviour were accounted for (Hahn Fox et al., 2015).

Lastly, difficulties in interpersonal relationships are often reported as a result of experiencing trauma (Bateman et al., 2013; Briere & Spinazzola, 2005; Evans & Coccoma, 2014; van der Kolk, 2005).

Although individual responses to traumatic experiences may vary widely, research has found a strong relationship between the degree of risk of experiencing multiple and complex negative outcomes following traumatic experiences and factors such as the age at which the experience/s occurred, the nature of the experience/s (with negative effects being particularly associated with

trauma of an interpersonal nature such as child abuse and neglect), and the severity and chronicity of the experiences (Cozolino, 2010; Herman, 1992; Kisiel et al., 2014; National Scientific Council on the Developing Child, 2014 [NSCDC]; Resick et al., 2012; van der Kolk et al., 2005). As noted by Cozolino (2010):

> The impact of trauma depends on a complex interaction of the physical and psychological stages of development during which it occurs, the length and degree of the trauma, and the presence of vulnerabilities or past traumas. The impact of chronic trauma becomes woven into the structure of personality and is hidden behind other symptoms, making it difficult to identify, diagnose and treat. (p. 266)

Traumatic events experienced early in life can be extremely damaging to the developing brain. Neural development relies on the interplay of genes and environmental inputs (particularly interaction with primary carers) and early adversity or disrupted attachment relationships that lead to chronic high levels of stress can interfere with key neurobiological development (NSCDC, 2014). Pamela Alexander (2013) suggested that "affective synchronization between mother and child" (p. 45) in carer–infant interactions is crucial for brain development, social development and stress regulation. Early onset, sustained trauma that interferes with this can lead to deficits in multiple domains: dysfunction in fear extinction; affect or emotional regulation; behaviour regulation; learning, cognition and attention; and self and relational dysregulation (Cook et al., 2005; Courtois & Ford, 2009; Evans & Coccoma, 2014; Kisiel et al., 2014; NSCDC, 2014; van der Kolk et al., 2005).

Research has also highlighted that experiencing traumatic events tends to increase the chances of experiencing further traumatic events across the life course. Cozolino (2010) argued that:

> Enduring personality traits and coping strategies that emerge in these situations [experiencing early onset, sustained trauma] tend to decrease positive adaptation and increase an individual's vulnerability to future trauma. This can manifest through engagement in abusive relationships, poor judgement, or a lack of self-protection. (pp. 268–9)

Finally, in examining the need for a trauma-informed approach to care it is pertinent to note that in many cases, due to the co-occurrence of problems resulting from experiencing trauma, individuals may find themselves in multiple systems, cycling in and out of specific services over many years to access, for example, treatment for drug and alcohol addictions, support for employment opportunities and therapeutic services for mental illness.

Historically, the underlying factor often linking a constellation of needs together—the history of abuse and its impacts—has not been adequately acknowledged or integrated into these service systems' service responses to individuals (Harris & Fallot, 2001). Further, populations with complex needs are at high risk of falling through the gaps of service delivery systems due to a lack of service co-ordination and the related barriers to service integration (Whiteford & McKeon, 2012). This can mean that clients: are deemed ineligible for services (e.g. cannot engage in mental health treatment until they have "dealt with" their substance abuse issue or vice versa); are expected to separate out their trauma experiences from their service or treatment needs ("we don't deal with trauma in this parenting class"); and experience services systems' responses as re-traumatising.

The SAMHSA-funded *Women With Co-Occurring Disorders and Violence Study* was a comprehensive 5-year project (1998–2003) across multiple sites, which provided evidence that integrating different services, such as mental health and substance abuse services where there was client need for both, was effective. This study showed that trauma-informed approaches could enhance the effectiveness of mental health and substance abuse services for women with co-occurring mental health and substance abuse disorders (Huntington et al., 2005; Morrisey et al., 2005). A trauma committee for this study also developed an understanding of trauma-informed principles and ways in which mental health and substance abuse service providers could use the approach (Elliot et al., 2005). In the years since the study, further development, debate and discussion has resulted in an expanded evidence base about the effects of trauma and appropriate approaches for services.

What is trauma-informed care?

Trauma-informed care could be described as a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs (Harris & Fallot, 2001). This requires consideration of a person's environment beyond the immediate service being provided and of how their symptoms and presentations may be seen as adaptations to trauma rather than as pathologies (Herman, 1992). At the broadest level, trauma-informed care means that services have an awareness and sensitivity to the way in which clients' presentation and service needs can be understood in the context of their trauma history (Knight, 2015). Kezelman and Stavropoulos (2012) noted that trauma-informed health and welfare settings and systems contrast dramatically with traditional settings and systems as they require different ways of operating, and without this understanding, risk re-traumatising service users. Trauma-informed approaches to care could be described as a strengths-based framework that is responsive to the effects of trauma (Bateman et al., 2013).

Principles of trauma-informed care

Principles of trauma-informed care have been articulated in a range of academic literature and guidance publications (Elliot et al., 2005; Hopper et al., 2010; Jennings, 2004; Kezelman & Stavropoulos, 2012; SAMHSA, 2014). These principles vary in length and number depending on the publication but essentially have the same underlying philosophies, that trauma-informed care means services are trauma aware, safe, strengths-based and integrated.

At the very minimum, trauma-informed services aim to do no further harm through re-traumatising individuals by acknowledging that usual operations may be an inadvertent trigger for exacerbating trauma symptoms. SAMHSA's (2014) approach to trauma-informed care makes four key assumptions that must be present as a basis of implementation for trauma-informed care, with a further six key principles to then be applied.

The key assumptions that SAMHSA has identified as needing to be inherent in any trauma-informed approach are based on four "R"s:

- *Realisation* at all levels of an organisation or system about trauma and its impacts on individuals, families and communities;
- *Recognition* of the signs of trauma;
- *Response*—program, organisation or system responds by applying the principles of a trauma-informed approach; and
- *Resist* re-traumatisation—of clients as well as staff.

In addition to these assumptions, SAMHSA (2014) then described six key principles of a trauma-informed approach:

- *Safety*—Staff and the people they serve feel physically and psychologically safe.
- *Trustworthiness and transparency*—Organisational operations and decisions are transparent and trust is built.
- *Peer support*—Peers is the terminology SAMHSA use for individuals with lived experience of trauma or their caregivers. Peers are also known as "trauma survivors".
- *Collaboration and mutuality*—This principle is about levelling power differentials between staff and clients and amongst organisational staff to ensure a collaborative approach to healing.
- *Empowerment, voice and choice*—This principle emphasises the strengths-based nature of trauma-informed care. The organisation—and ideally the whole service delivery system—fosters recovery and healing.
- *Cultural, historical and gender issues*—A trauma-informed approach incorporates processes that move past cultural stereotypes and biases, and incorporates policies, protocols and processes that are responsive to the cultural needs of clients.

For an example of an Australian model of trauma-informed care, see Tucci and Mitchell's (2015) outline of the basic understanding of trauma that informs appropriate care underpinning the services and training provided by the Australian Childhood Foundation: *9 Plain English Principles of Trauma Informed Care* <www.childhood.org.au/blog/home/2015/april/trauma-informed-care>.

The Berry Street Childhood Institute also provides a number of resources and training on trauma-informed care for children: <www.childhoodinstitute.org.au/Resources>.

Achieving trauma-informed services: Reflection questions for service managers

- What is the likelihood of clients who have experienced trauma accessing our service?
- Do we provide access to trauma-specific evidence-based treatments for current psychological difficulties that result from that trauma (e.g. Trauma-focused cognitive-behaviour therapy)?
  - See *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma* <www.childwelfare.gov/pubpdfs/trauma.pdf>
- Do we provide access to effective treatments for complex trauma and complex PTSD (for which trauma-specific treatments may not be as effective)?
  - (See: Connor & Higgins, 2008a, 2008b; Kezelman & Stavropoulos, 2012).
- Are these trauma-specific interventions provided inhouse, in collaboration with other agencies, or via referral to an external agency (and if so, do we provide active/warm referral)? See:
  - *Interagency collaboration: Part A. What is it, what does it look like, when is it needed and what supports it?* <aifs.gov.au/cfca/publications/interagency-collaboration-part-what-it-what-does-it>
  - *Interagency collaboration: Part B. Does collaboration benefit children and families? Exploring the evidence.* <aifs.gov.au/cfca/publications/interagency-collaboration-part-b-does-collaboration-benefi>
  - *Effective practices for service delivery coordination in Indigenous communities*. <www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2011/ctgc-rs-08.pdf>
- How do we incorporate restorative justice principles?
  - According to Higgins et al. (2014), restorative justice activities might include:
    - addressing trauma and other mental health consequences through evidence-based therapeutic interventions;
    - repairing the injuries caused to relationships, especially between sons/daughters and parents;
    - providing opportunities for truth-telling, storytelling and acknowledgement; and
    - overcoming shame and recognising past actions through public activities and community awareness campaigns.
  - See: Higgins et al., 2014, pp. 41–46: *Forced Adoption Support Services Scoping Study* <www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/forced-adoption-support-services-scoping-study>
- Who in the organisation is likely to come into contact with individuals who have experienced trauma, or be providing information to, or receiving communications from clients experiencing trauma? Thinking from a "client journey" perspective, this might include:
  - phone/intake staff;
  - web/staff with online monitoring;
  - reception;
  - office manager;
  - media and communications staff;
  - other staff or contractors on the premises (e.g. catering, cleaning, security); and
  - project/service delivery professionals and support staff.

- Who is less likely to be interacting with trauma survivors but who need to understand, and who need to support "front-line" workers and other support staff who do?
  - executive staff (who create the authorising environment);
  - managers and team leaders; and
  - mentors and supervisors.

This suggests the value of whole-of-organisation approaches to trauma-informed service delivery, directed at every level to ensure a focus on what helps clients feel safe.

- What should training encompass? Training should include:
  - skills in de-escalation or "holding" clients who are experiencing an acute episode of trauma or re-traumatisation;
  - debriefing and staff protocols for responding to difficult situations and clients presenting with complex circumstances and trauma histories;
  - information on staff care and preventing/responding to secondary or vicarious trauma—the psychological term for changes that can occur to people when they are repeatedly exposed to traumatic material (see <aifs.gov.au/publications/feeling-heavy>);
  - organisational supports to prevent or address vicarious trauma for staff including: clinician self-care skills and reflective practice, caseload management, supervision, debriefing, staff and peer support, workplace safety, comfort and supportive work culture that acknowledges the reality of vicarious trauma (Morrison, 2007);
  - types of events/circumstances in clients' lives that may be traumatising;
  - typical modes of reacting—events/triggers for re-traumatisation; and
  - understanding the impacts of trauma (such as behavioural symptoms typical of PTSD, as well as the developmental impacts of victimisation and trauma on an individual's beliefs—about the self, the world, and the future—e.g. see: Janoff-Bulman & Frieze, 1983).

Further to this, SAMHSA also provide a range of sample questions to consider when implementing a trauma-informed approach <store.samhsa.gov/shin/content//SMA14–4884/SMA14–4884.pdf> (p.14–16).

Which services should be delivering trauma-informed care?

Most of the US literature about trauma-informed care is directed at change in behavioural health services. In Australia there appears to be an emphasis on driving change in the mental health sector. This has the potential to cause confusion about the pathway to providing trauma-informed care in the child, family and community sectors and about what being trauma-informed actually means. One aspect of clarifying these questions is to understand which services should be adopting a trauma-informed approach to human service delivery.

In addition, there are communities and populations for whom violence and intergenerational trauma are a constant reality. Some Indigenous communities, for example, experience the phenomenon of trans-generational trauma whereby trauma is transmitted across a number of generations (Atkinson, 2002). The historical impacts of colonisation on Aboriginal people in Australia have played out in a history of disadvantage and discrimination as traditional Aboriginal life was gradually disrupted and dismantled (Atkinson, 2002; Keel, 2004). The effectiveness of the full range of health and human services in such communities could be enhanced by a trauma-informed approach (Atkinson, 2013).

As outlined in the earlier discussion on principles of trauma-informed care, it is important for services to be culturally attuned and relevant (Atkinson, 2013). This is described by SAMHSA as the principle that the trauma-informed organisation actively moves past cultural and gendered stereotypes and incorporates policies and processes that are responsive to the cultural needs of individuals served, including addressing historical trauma (SAMHSA, 2014) or collective trauma (Atkinson, 2013).

Building on the work of Harris and Fallot, SAMHSA's (2014) *Concept of Trauma and Guidance for a Trauma-Informed Approach* outlined ten implementation domains:

- governance and leadership;
- policy;
- physical environment;
- engagement and involvement;
- cross-sector collaboration;
- screening, assessment, treatment services;
- training and workforce development;
- progress monitoring and quality assurance;
- financing; and
- evaluation (p. 12).

This guidance information is designed to provide a starting point for an organisational approach to implementing trauma-informed care. It also indicates that organisations across *all* settings should consider how trauma-informed approaches could benefit stakeholders regardless of whether they deal with trauma in their day-to-day business. The reality of the prevalence of traumatic experiences in the general population indicates that trauma is not confined to prevention, treatment and recovery settings but is integral in other systems as well (SAMHSA, 2014).

It is important to note that many practices that service providers currently use are likely to already be consistent with a trauma-informed approach, such as conveying empathy and validating the client's experiences (Knight, 2015). What is different about identifying as a trauma-informed service is that there is a paradigm shift in service delivery culture to acknowledge and clearly articulate the importance of trauma in understanding and responding to client presentation.

With the lack of an overarching framework in Australia, there is a danger of developing trauma-informed models and practices that are not sharing a consistent language about what being trauma-informed entails. This issue is discussed in more depth in the section about challenges to implementation later in this paper.

The need for a systems approach to trauma-informed care

Following the lead of the USA, Australian health agencies are moving towards a trauma-informed paradigm for considering health and human service delivery systems (Kezelman & Stavropoulos, 2012) in preference to a medical model of individual illness (DeCanandia, Guarino, & Clervil, 2014).

The effects of traumatic experience often manifest in behaviours that result in people being involved in human service systems that go beyond mental health, such as the criminal justice system (SAMHSA, 2014). A systems approach to trauma-informed care means that implementation goes beyond individual practitioner and service organisation change to extend to whole systems that people who have experienced trauma are likely to interact with. A system, for example, could include the justice, homelessness or child welfare systems. These systems may not include treatment settings but can still affect the people who experience them. In the USA, a range of systems are in the process of adopting a cross-sectoral approach to implementing trauma-informed care and trauma-specific services to support service users (DeCanandia et al., 2014). For example, the behavioural health and health care, veterans' administration, homelessness and education sectors are just a few of the systems that are shifting to a trauma-informed approach (DeCanandia et al., 2014).

The differences between trauma-informed services and trauma-specific services are described in the definitions outlined earlier. It is important to distinguish between them but acknowledge the intersection of the two types. Trauma-specific services are designed to treat the symptoms or manifestations of the effect of a trauma on an individual but these interventions must be delivered in a trauma-informed context. This emphasises an overall philosophy of trauma as a central concept in understanding the presentation of clients within a range of health and welfare settings (Kezelman & Stavropoulos, 2012).

Challenges in implementing a trauma-informed approach to care

As noted previously, implementing trauma-informed care requires a paradigm shift in service delivery (Hopper et al., 2010; Jennings, 2004). The literature around trauma-informed care indicates that there are still some challenges to implementing this approach for systems and services, as well as the need for research to evaluate the approach's effect on client wellbeing and other service delivery outcomes (Ashmore, 2013; Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Hopper et al., 2010; Muskett, 2014). These challenges are discussed in the following sections.

Inconsistent understandings of what it means to be trauma-informed

The most identifiable challenges across the literature are in the need to create shared understandings, and current inconsistencies in education regarding trauma-informed care (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Hopper et al., 2010). It is difficult to align organisational change to a specific practice without a shared understanding or vision of what trauma-informed care actually is. In a comparative study of trauma-informed care in acute mental health inpatient units, Ashmore (2013) identified this as an issue in the implementation of trauma-informed care in an acute patient environment. A lack of definition and of a shared framework, as well as a lack of information specific to an acute mental health inpatient setting, were associated with challenges and inconsistency in implementation.

In their review of the literature, the Parenting Research Centre and the Australian Centre for Post-traumatic Health (2013, now Phoenix Australia) found that although participants within the child and family services sector who worked with children exposed to trauma were familiar with terminology such as "trauma-informed care", they argued that:

- the field still lacked clear definitions or understandings of concepts;
- there were assumptions that children's social and behavioural difficulties were necessarily trauma-related without clear assessment; and
- there was a lack of guidelines for assessment and treatment of trauma.

SAMHSA's (2014) recent guidance document is clearly aimed at addressing this lack of consistency in definitions and the 2012 document by Adults Surviving Child Abuse provides some practice guidelines (Kezelman & Stavropoulos, 2012). However, an aspect of trauma-informed care is that it must be culturally relevant to the populations it serves (Elliot et al., 2005; Jennings, 2004) and any broad level articulation of policy approaches or frameworks must be applicable in a range of systems and settings and for a variety of cohorts.

Translating trauma-informed care to specific practice and service settings

In addition to the array of terminology and concepts that are sometimes used interchangeably and inconsistently, there is a lack of evidence-based guidance for specific settings and systems to assist with coordinating how trauma-informed practice should be provided for particular service settings and specific populations of service users. This issue was identified by Muskett (2013) and Ashmore (2013) in relation to mental health nursing, where the need to remove the use of seclusion and restraint is emphasised but, beyond this, little has been articulated to support the use of specific practices for service settings to adopt to improve service delivery consistent with principles of trauma-informed care. Dealing with survivors of trauma, particularly in a mental health or child protection setting, may require individuals to use their prior experience to respond to specific situations. In such stressful and potentially dangerous settings, crisis management could lead to a de-prioritisation of trauma-informed responses (Conners-Burrow et al., 2013). Training and guidance for staff on how to respond to acute situations appropriately and feel confident that they are acting in accordance with the principles of trauma-informed care is recommended (Knight, 2015; Muskett, 2014).

Facilitating complex system change

As noted by the American Institute for Research, in order to build a trauma-informed system, commitment at all system levels is required. This includes a commitment to ongoing training and service transformation (DeCanandia et al., 2014). Australia is behind the USA and Canada in developing models and systemwide responses to children and other service users impacted by trauma (Bateman et al., 2013). For example, the USA has the National Child Traumatic Stress Network, funded by SAMHSA, which brings a singular and comprehensive focus to responding to childhood trauma. Australia is arguably still at the stage of requiring policy change to articulate a clear direction for moving towards systems of trauma-informed care in a range of different service delivery areas relating to child/family wellbeing (Bateman et al., 2013).

Systemic change is important because it enables people to receive services that are sensitive to the impact of trauma regardless of whether they enter through any particular service setting or intervention.

Large-scale systems change is also logistically difficult and time-consuming and requires commitment and resources (Hopper et al., 2010). Philosophical differences between sectors that need to work together to integrate care can also impede systemic change (Hopper et al., 2010). Ashmore (2013) identified particular features of systems change for systems such as mental health that are challenging. These challenges include that hierarchical systems such as health may encounter resistance and that there is an inherent power inequality between service users and professionals in such environments.

Creating change at a systemic level is more than providing practitioners and organisations with tools. It requires changes to funding models to support outcomes rather than outputs, and changes to education for mental health practitioners, social workers and other specialists. Essentially, this is about a move towards a more holistic understanding of the inter-related biological, psychological and social dimensions of trauma.

Evaluating a trauma-informed approach to care

Studies from the USA, particularly following the Women With Co-Occurring Disorders Study, have found that trauma-informed, integrated services are judged to be cost-effective when compared with treatment as usual in the comparison sites of that particular study (Domino, Morrisey, Chung, Huntington, & Larson, 2005). Although this study is regularly cited in the literature as evidence of the cost-effectiveness of trauma-informed care (DeCanandia et al., 2014, Hopper et al., 2010; Kezelman & Stavropoulos, 2012); in reality, there is a lack of evaluation about cost-effectiveness and other aspects of trauma-informed care approaches, including its effectiveness in improving outcomes for service users (Quadara, 2015). There is also a lack of evaluation tools to measure the extent to which an organisation is trauma-informed, and the lack of consistent definitions further translates into difficulties in identifying a clear method to indicate the degree to which a service or program is trauma-informed (Hopper et al., 2010).

Other challenges identified in evaluating trauma-informed care, highlighted by Hopper et al. (2010), include the difficulty in measuring cultural change and sustainability of change and whether changes in outcome are attributable to trauma-informed environments or trauma-specific interventions. In addition, the need for cross-system collaboration and assessing human service interactions to establish the extent of trauma-informed care practice implementation further complicates evaluation in this area (Kramer et al., 2015).

Applying trauma-informed care principles

To illustrate how trauma-informed care principles can be applied to respond to different trauma issues, we briefly look at service delivery in the context of people affected by the policies that created the Stolen Generation, past adoption practices and humanitarian migration.

The Stolen Generation

In their program logic, the Aboriginal and Torres Strait Islander Healing Foundation (2014, p. 25) explain how a collective healing process for members of the Stolen Generation and their descendants can occur, and the mechanisms that underlie this process. Central to this model is an understanding of an Aboriginal world view and the pervasive trauma of colonisation, and the need for specific strategies to address ongoing, collective trauma. A common element of collective healing projects is that they are based on a trauma-informed or recovery framework. According to the Healing Foundation (2014):

> Trauma-informed practice is a strengths-based approach to healing that: is based on an understanding of, and responsiveness to, the impact of trauma; emphasises physical, psychological, and emotional safety for people seeking help and for the helpers; and creates opportunities for people affected by trauma to rebuild a sense of control and empowerment. It recognises the prevalence of trauma and is sensitive to and informed by the impacts of trauma on the wellbeing of individuals and communities. (p. 47)

Forced adoption and past family removal practices

An example of an issue that has only recently received public acknowledgement of its role in traumatising a large number of Australians is the former practice of forced adoption, or separation from family due to past family removal practices. In their exploration of good practice principles for services addressing the needs of people affected by forced adoption and past family removal practices, Kenny, Higgins, and Morley (2015) noted:

> There is increasing recognition of the potential for trauma for individuals who have been subjected to forced adoption policies and practices, and the value of a "trauma-informed" or "trauma-aware" approach to service delivery. Good practice suggests that service providers should approach all clients with a forced adoption experience as if they might be trauma survivors (p. 8).

In their overview of good practice principles, Kenny et al. (2015, p. 8) outlined the key elements of trauma-informed service delivery. Being a trauma-informed service ensures the provision of:

- a safe and supportive environment that protects against physical harm and re-traumatisation;
- an understanding of clients and their symptoms in relation to their overall life background, experiences and culture;
- continued collaboration between service provider and client throughout all stages of service delivery and treatment;
- an emphasis on skill building rather than managing symptoms;
- an understanding of the symptoms and survival responses required to cope;
- a view of trauma as a fundamental experience that influences an individual's identity rather than a single discrete event; and
- a focus on what has happened to a person rather than what is wrong with a person.[6]

Humanitarian migrants surviving torture and trauma

The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) outline the program logic for their service model as systemic and based on an ecological model of factors that influence and support healing for survivors (see *How We Work* <www.startts.org.au/about-us/how-we-work>).

They aim to provide a range of services that reflect the bio-psycho-social model, such as:

- complementary therapies or neurofeedback to address biological impacts;
- counselling to address psychological impacts; and
- community development projects to support social changes.

6 See Forced Adoptions Community of Practice <aifs.gov.au/projects/forced-adoptions-community-practice>.

"There is nothing more practical than a good theory": The theoretical basis of trauma-informed models of care

(a) Attachment—developing a secure base

Attachment theory (Bowlby, 1988) has been used by developmental psychologists to explain positive, secure relationships between infants and caregivers, and how this forms the template for secure adult interpersonal relationships. Disruption to the relationship or insecure attachment is seen as a fundamental mechanism by which childhood trauma affects adult self-concept, wellbeing and interpersonal relationships. Trauma-informed care systems provide a safe environment to expose disruption to the attachment relationship, and build new internal models and "scripts" of the self and relationships.

(b) Self-regulation and control

Social cognitive theories of self-regulation help explain how individuals respond to threatening events. Key components of many trauma-specific treatments are to help individuals to improve self-regulation, safety, security, sense of control and mastery of their environment, and modulate their emotional reactions to traumatic stimuli. Trauma-informed systems of care are aware of the ways in which programs and organisations can trigger traumatic reactions—or even inadvertently replicate the dynamics of the traumatic events/relationships—and seek to minimise them, and promote environments that facilitate positive affect regulation or "modulation".

(c) Fundamental attribution error—overestimating the personal characteristics, underestimating situational factors

Theories of social psychology have identified that humans often make what is termed the "fundamental attribution error", whereby we over-emphasise a person's personality, or internal characteristics, in explaining their behaviour, and underestimate the environmental, or situational factors, that are external influences on their behaviours (e.g. see: Jones & Harris, 1967). For clients who have experienced trauma—particularly complex trauma involving multiple injuries in the interpersonal domain—it is likely that those around them, including their families, their work colleagues and even their health/mental health professionals, are likely to attribute their interpersonal difficulties and deficits in functioning and wellbeing to an inherent personality flaw, rather than having been shaped by their environment (i.e. the external traumatic events they have endured). Creating new environments of support, and opportunities for "reprograming" life scripts are important. But practitioners need to be open to seeing the external influences and specifically target intervention strategies to remediate the long-standing negative consequences.

Source: The title is a quote from Lewin (1952, p. 169)

Moving forward

Much of the literature identified that the paradigm shift towards implementation of a trauma-informed approach to care needed to include commitment from political leadership at all levels (Ashmore, 2013; Bateman et al., 2013; Kramer et al., 2015).

In Australia, the Mental Health Coordinating Council (Bateman et al., 2013) has articulated the requirement for a policy statement from national and state leaders endorsing the concept of trauma as a priority mental health issue and supporting the transition to a trauma-informed service system. This would ensure that there is an identifiable commitment from governments to support the need for trauma-informed service systems.

The broad dissemination of information about trauma-informed, evidence-based best practice has been identified as an important feature of developing the evidence base around trauma (Kramer et al., 2015). Development of a nationally based resource, such as SAMHSA's National Center for Trauma-Informed Care and the National Child Traumatic Stress Network, would provide an Australian-based network of information to support policy development and service delivery and to enable the use of what is currently known about trauma-informed services in different health and human service sectors. Having central resources such as these, is instrumental in shifting human service systems towards a trauma-informed approach to service delivery.[7] Australia does not yet have a body with such a specific focus but extensive work has been undertaken by organisations such as the Mental Health Coordinating Council and Adults Surviving Child Abuse, among others, to help shape behavioural health policy towards incorporating an understanding of the damaging effects of trauma into policy and service delivery approaches.

Although there are some resources and tools now available to support guidance towards trauma-informed systems of care in Australia (Bateman et. al., 2013), there does not appear to be an overarching trauma framework to support a shift in a consistent way. As noted earlier, organisations in Australia have recognised the need for trauma-informed services and

7 See National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint <www.samhsa.gov/nctic>

interventions but the current array of methods, models and interventions on offer and in use do not support a coordinated and common approach that would ensure trauma-informed has a consistent meaning and interpretation in service delivery.

Conclusion

There is growing awareness of the need, and a strong rationale for the value, of implementing a trauma-informed approach to human service delivery. Such an approach has been adopted and implemented extensively in the USA. In Australia, there is a strong push towards trauma-informed approaches to care, and recognition of the impacts of child abuse and other traumas as a driver of service need. However, there is confusion with the array of terminology used and a lack of reference to specific trauma-informed frameworks to guide the introduction of trauma-informed care in a systemic way. Despite the need, and the conceptual/theoretical rationale, it is important to acknowledge that there is limited empirical evidence to show that working systemically to be trauma aware and providing trauma-informed systems of care leads to reductions in trauma symptoms or other positive outcomes for clients.

Currently, there is no overarching policy to mandate trauma-informed care and no framework to guide evidence-based practice to transition in a systematic way to trauma-informed care in Australia. In addition, improvements to collection of research data and adoption of standardised outcome measures for evaluation would support a more systemic approach to evaluating the implementation of trauma-informed care.

There is value in capturing practice-based evidence; however, this is beyond the scope of the current paper, and would be best carried out via a systematic and rigorous approach to gathering and synthesising information from practitioners working with traumatised clients in a variety of fields—as well as the views of those in service delivery systems that are not yet trauma-informed to examine the barriers and enablers of system change. Similarly, there is a need to articulate findings from the emerging field of trauma-informed practice into concrete policy statements or frameworks that can be applied to different client groups within and across a range of service systems and settings.

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At the time of writing **Liz Wall** was a Senior Research Officer at the Australian Institute of Family Studies. **Daryl Higgins** is Deputy Director (Research) and **Cathryn Hunter** is a Senior Research Officer with the Child Family Community Australia information exchange at the Australian Institute of Family Studies.

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Australian Institute of Family Studies
Level 20, 485 La Trobe Street, Melbourne VIC 3000 Australia
Phone: (03) 9214 7888 Fax: (03) 9214 7839 Internet: <www.aifs.gov.au>

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GLBTQDVP

GLBTQ Domestic Violence Project

TRAUMA-INFORMED APPROACHES FOR LGBQT* SURVIVORS OF INTIMATE PARTNER VIOLENCE

A Review of Literature and a Set of Practice Observations

June 2016

Authors:

Erin C. Miller, M.P.S., M.D.V.
Domestic Violence/ Sexual Assault Programs; Newton-Wellesley Hospital

Lisa A. Goodman, Ph.D.
Boston College

Kristie A. Thomas, Ph.D.
Simmons College

Alex Peterson
University of British Columbia

Jillian R. Scheer, M.A.
Boston College

Julie M. Woulfe, M.A.
Boston College

Carole Warshaw, M.D.
National Center on Domestic Violence, Mental Health, and Trauma

Principal Investigator:

Curt Rogers, M.P.A.
GLBTQ Domestic Violence Project

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Produced by
The GLBTQ Domestic Violence Project

For more information on supporting LGBQT* survivors of intimate partner violence, contact one of the organizations below:

The LGBTQ DV Capacity Building Learning Center
c/o The Northwest Network
A program focused on improving research, practice and policy regarding domestic violence in LGBTQ communities.
1-206-568-777 | info@nwnetwork.org | www.nwnetwork.org

FORGE
A transgender anti-violence organization, specializing in technical assistance for victim service agencies, with a focus on domestic violence, sexual assault, dating violence, stalking, and hate crimes.
1-414-559-2123 | AskFORGE@forge-forward.org | www.forge-forward.org

If you would like more information about accessible, culturally relevant trauma-informed approaches for survivors, contact:

The National Center on Domestic Violence, Trauma & Mental Health
A program providing training, support, and consultation to advocates, clinicians, attorneys and policymakers as they work to improve agency and systems-level responses to survivors and their children.
1-312-726-7020 | info@nationalcenterdvtraumamh.org | www.nationalcenterdvtraumamh.org

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Executive Summary

In 2013, the Administration for Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services, awarded a grant to the GLBTQ Domestic Violence Project in Boston, Massachusetts to help improve trauma-informed work with lesbian, gay, bisexual, queer and transgender (LGBQT*) survivors of intimate partner violence (IPV). The following document is a literature review that sets the context for thinking about trauma-informed practice (TIP) for these communities. We developed this review over the course of 2015, supported along the way by an Advisory Board comprised of the NorthEast Two-Spirit Society, Queer Muslims of Boston, Fenway Community Health, the Hispanic Black Gay Coalition, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, and Massachusetts Asian & Pacific Islanders for Health.

This document helps inform a set of practice-based observations that are included in the Appendix (page 40) and are also available as a separate document. At present, there are few, if any, documented LGBQT*-specific models of trauma-informed practice. This literature review and the accompanying practice observations make a clear case for the need for such models, and for the implementation of culturally competent LGBQT* trauma-informed services.

Key takeaways from the literature review include:

- IPV occurs in LGBQT* relationships at rates equal to or higher than rates in heterosexual relationships. Different subgroups within the community may experience different rates or types of IPV, with bisexual and transgender individuals at particularly high risk.

- Although LGBQT* IPV shares many underlying dynamics with IPV in heterosexual couples, it also has unique characteristics, including the types of abusive tactics used and the context of discrimination and social stigma faced by LGBQT* individuals. Within LGBQT* subgroups, there may be additional complexities.

- LGBQT* survivors who are also part of other oppressed groups often face homophobia within their own cultural communities as well as racism, ableism, xenophobia, and colonialism in mainstream communities. Moreover, LGBQT* IPV often occurs in a landscape that includes other forms of abuse and trauma, including family violence, sexual violence, hate crimes, and police brutality. Such overlapping forms of trauma are often interrelated, rendering some members of the LGBQT* communities subject to abuse by more than one person at a time and at more than one point in their lifespans. In the face of these overlapping forms of oppression, LGBQT* survivors are forced to make particularly constrained choices about safety, often trading one kind of safety for another.

- Mental health difficulties are major concerns among LGBQT* people in general. LGBQT* individuals experience higher rates of traumatic events, and may be at greater risk for developing symptoms of PTSD, depression, and anxiety as well as experiencing suicidality and isolation. These concerns are amplified for LGBQT* survivors of IPV, especially transgender individuals and survivors of color. Nonetheless, LGBQT* survivors find strength and resilience through identity affirmation and social support.

- LGBQT* survivors exhibit unique help-seeking behaviors. Overall, they are less likely to seek services from law enforcement and mainstream providers and more likely to rely on informal social support and LGBQT*-focused programs. There also are differences in help-seeking *within* LGBQT* subgroups. For instance, trans individuals may have an especially difficult time accessing culturally competent and non-traumatizing services. For LGBQT* people of color, stigma, economic constraints, and the absence of community outreach are barriers to services.

- Service provision that is not rooted in an expansive understanding of the intersecting oppressions that LGBQT* survivors face may do more harm than good. The kind of harm done by those in a social service system designed to help has been referred to as *sanctuary harm*, which is antithetical to trauma-informed practice.

- Despite growing awareness of the impact of sanctuary harm on clients who experience multiple forms of oppression and of the unique needs of LGBQT* survivors, trauma-informed approaches tailored to LGBQT* communities have been slow to develop. To our knowledge, there are none in the academic literature. It was our Advisory Board that pointed to an alternative model of trauma-informed practice – transformative justice.[1] While the roots of trauma-informed practice grew out of mental health and substance abuse services, transformative justice emerged from activist communities and seeks to uproot the conditions that created traumatic experiences, ending oppression even (if not especially) within helping systems.

We hope that this document will facilitate thinking about how the core principles of trauma-informed practice can be applied to working with LGBQT* survivors and to ameliorating vicarious traumatization among service providers who do their best in difficult circumstances.
Although this document is intended primarily for staff in domestic and sexual violence organizations, it has broad applicability. The information provided can be used to enhance the work of practitioners, advocates, and administrators in other anti-abuse disciplines, homelessness services, mental health and healthcare circles, criminal legal systems, youth services, and an array of other human services disciplines and social change initiatives that seek to serve and ensure the inclusion of LGBQT* communities. The practice-based observations in the Appendix provide further framing for this important endeavor.

[1] The authors wish to thank Hales Burton, at the Fenway Violence Recovery Program, for first suggesting this conceptual shift.

Introduction

IPV refers to the physical and/or emotional abuse of an individual by a current or former intimate partner. It includes the full range of tactics used to create and maintain power and control over another person, including financial abuse, verbal abuse and intimidation, and cultural abuse. In this document, the phrases *intimate partner violence* and *domestic violence* are used interchangeably to denote partner violence. However, it is important to note that domestic violence (DV) is sometimes defined more broadly to include violence and abuse perpetrated by relatives. Although many LGBQT* individuals experience abuse and/or rejection from family and relatives, the dynamics of partner violence versus family violence may differ dramatically. When we discuss the latter, we use the term *family violence* to distinguish it from violence by an intimate partner.

Following a note on language, the literature review is organized into five sections. Section One focuses on the prevalence and dynamics of IPV in LGBQT* communities. Section Two focuses on trauma, mental health, and resilience among LGBQT* individuals to contextualize the critical need for trauma-informed practices for these survivors. Section Three focuses on the range of systemic, institutional, and individual-level barriers that thwart LGBQT* peoples' access to informal and formal support services. Finally, the last section reviews the core principles of a trauma-informed approach to practice, with attention to the needs of service providers who work with LGBQT* survivors, and provides examples of community-specific approaches to trauma.

A Note on Language

The authors wish to acknowledge at the outset the deep complexities of language. LGBQT* stands for lesbian, gay, bisexual, queer, and transgender. It is often used interchangeably with GLBTQ, LGBQT-TS, and similar acronyms to broadly refer to sexual and gender minorities. This document honors the current practice of including an asterisk after the "T" to signify the broad diversity of trans communities, including trans women – transgender individuals who identify as women, though assigned male at birth; trans men – transgender individuals who identify as men, though assigned female at birth; those transitioning from female to male (FTM); those transitioning from male to female (MTF); cross dressers; gender non-conforming individuals; and others who might self-identify as being members of trans communities. In this paper, transgender and trans are used interchangeably.

These definitions belie the complexity of the terms, however. The words *lesbian*, *gay*, *bisexual*, *transgender*, and *queer* all carry particular historical, political and cultural meanings. To a great extent, these words have been shaped in white, Western contexts. Words such as lesbian, gay, and bisexual, for example, are uniquely English. There are seldom translations into other languages that carry the same understanding of LGBQT* identity as being an identity rather than a set of behaviors. Literal translations, into Spanish or Haitian Creole as but two examples, carry few if any of the presumptions that are inherent in English. In many parts of the Latin and Spanish-speaking world, men who engage in sex with

same sex partners are only considered "gay" in the English sense of the word if they are the receptive partner. It is not engaging in the acts that is the determinant of identity, so much as the role that an individual plays (traditionally read as *masculine* or *feminine*) in the conduct of that act. Similarly, men who marry women, but engage in same sex acts with other men, are frequently identified as heterosexual. In short, they are defined by their social role, rather than by their private, intimate acts. Hence the conception of *gay*, as defined in U.S. contexts, frequently fails to apply.

Precisely because identifiers such as LGBQT* were defined in white middle class and academic contexts, the limitations of LGBQT* labels and identifiers may be particularly acute in communities of color, Indigenous communities, and immigrant communities, among others. During the course of crafting this literature review, members of our Advisory Board taught us a tremendous amount. The Hispanic Black Gay Coalition (HBGC) suggested use of the term *same gender loving*, a community-specific phrase coined by Cleo Manago to distinguish African Americans, and in particular African American men, who do not self-identify as being part of the predominantly white gay movement in the U.S., but who nonetheless wish to affirm their same sex intimate relationships. Corey Yarbrough, one of the founding Executive Directors of HBGC, suggested that, for some same gender loving people, this language may be a form of racialized resistance to the racism of the mainstream LGBQT* movement in the U.S. In the alternative, Corey stated, some members of African American communities may be on the *down low*, engaging in same sex sexual activity, but rejecting LGBQT* identifiers as a result of internalized homo- and bi-phobia.

The NorthEast Two-Spirit Society (NETSS) in part echoed Corey's thoughts about the racism of the mainstream LGBQT* movement. In addition, Harlan Pruden, one of co-founders of NETSS, spoke about an "internal muddiness" that some Native peoples may experience when seeking to find language for their experience. Speaking of his own Cree inheritance as a registered member of the Saddle Indian Reservation, Harlan said that when he asked something of an elder, he knew to offer them tobacco, but never understood the spiritual dimension of the ceremony. Having been separated from too much of their own history by colonialism, genocide, and forced assimilation, Harlan stated, many Native people may use the words *Two-Spirit* when what they really mean is gay Indian.[2]

Harlan also spoke at length about the contextual nature of Native Two-Spirit identities. As Harlan put it, "When I am out on a Friday night in a gay club, I am a gay man. Yet when I am in rural Oklahoma at a Two-Spirit gathering, I am a proud Two-Spirit man." Alluding to the unique role and cultural responsibilities that Two-Spirit people often held (and may still hold) in the life of Native communities, Harlan pointed out the obvious differences in the spiritual role of Two-Spirit peoples, and

[2] Two-spirit is a contemporary term, adopted from the Northern Algonquin, and meant to signify the embodiment of both masculine and feminine within one person. Now embraced by many Native peoples as a pan-Indigenous umbrella term connoting both diverse gender expressions and sexual orientations, two-spirit (TS) generally speaks to the respect that Native peoples held for diversity, and the unique sacred and ceremonial roles that TS people held (and may still hold) within their own communities. Herein the phrase TS speaks not simply to a third gender, or to same gender attraction, but more broadly to the history of compulsory Christianization that sought to erase two-spirit peoples within their own nations. Notably, there is no single consensus definition of two-spirit, and the term means different things to different Native peoples.

the political and social function of people claiming LGBQT* identities in mainstream communities. Several members of the project's advisory board echoed this point,
speaking about the complex layering of cultural and spiritual value systems that accompanied their choice to self-identify in, with, and outside of their own communities.

These same Advisory Board members also acknowledged the landscape in which such decisions are made, and stated that individuals in their communities may shift how they self identify as a means of preserving their safety. As the rest of this literature review discusses, LGB, transgender, same gender loving, Two-Spirit, and queer-identified peoples make choices about how, when, and if to "out" themselves in a complex social and political landscape that is too often unsafe, if not violent. Hence, how any individual self-identifies may shift depending on who is asking, why, and in what context. As one Advisory Board member stated, "identities have to be fluid in order to be protective."

Finally, the leadership of HarborCOV, an LGBQT*-affirming DV organization in Boston that specializes in serving communities facing cultural or linguistic barriers, has noted that some cultures may not have the variety or depth of language that words such as LGB, transgender, same gender loving, and Two-Spirit convey. Indeed, Kourou Pich, Co-Executive Director of HarborCOV has observed that people from some cultures and communities may have difficulty finding language for themselves in their own communities, and that that invisibility is intentional – a function both of denial of the existence of sexual minorities in those communities, but also perhaps protectiveness of gender queer and same gender attracted people.

Language is power. We authors, therefore, have put a great deal of thought into the words we use to name peoples' experiences. At the same time, we know that we can never be as inclusive or sensitive as we want to be. We have done our best to honor the range of experiences we are writing about in this document.

Intimate Partner Violence in LGBQT* Communities

Prevalence of IPV in LGBQT Communities*

Historically, DV has been seen primarily as a problem of cisgender[3], heterosexual men abusing cisgender, heterosexual women. Because of this limited framework, research on the prevalence of DV and IPV among LGBQT* and non-female-identified individuals has been scarce and often limited by the use of non-probability sampling, cross-sectional data that precludes causal inference, and inconsistent definitions of IPV and sexual orientation (Brown & Herman, 2015; Finneran & Stephenson, 2012). Recently, however, there has been an increase in studies that provide more rigorous estimates of IPV in LGBQT* communities. The majority of these studies suggest that IPV occurs in LGBQT* relationships at rates equal to or higher than heterosexual, cisgender relationships (Balsam, Rothblum, & Beauchaine, 2005; Duke & Davidson, 2009; Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016; Messinger, 2011; Walters, Chen, & Breiding, 2013). Herein, we briefly present prevalence estimates of LGB IPV before turning to the limited research on prevalence among trans individuals. For a more detailed review of IPV prevalence in LGBQT* communities, see Brown and Herman (2015).

Currently, the best prevalence estimates on partner abuse in LGB communities come from the nationally representative 2010 National Intimate Partner and Sexual Violence Survey (NISVS) conducted by the U.S. Center for Disease Control & Prevention (Walters et al., 2013). Findings suggest higher rates of lifetime IPV experiences (defined as physical violence, sexual violence, or stalking) among lesbians (43.8%), bisexual women (61.1%), and bisexual men (37.3%) – but not gay men (26%) – compared to heterosexual women (35.0%) and heterosexual men (29%). In addition, findings from the California Health Interview warrant mention. Based on a probability sample of California residents ages 18 to 70, this study found that lifetime and 1-year IPV prevalence was higher in sexual minorities compared with heterosexuals, but this was significant only for bisexual women and gay men.

Determining IPV prevalence based on gender identity is difficult due to a lack of studies with representative or even large samples. The National Transgender Discrimination Survey is one of the largest studies of transgender individuals' experience of discrimination with 6,456 participants (Grant, Mottet, & Tanis, 2011). This study did not focus on IPV in particular, but did measure related phenomena. The researchers found that 19% of respondents reported experiences of violence at the hands of a family member specifically due to their gender identity. This statistic is likely an underestimate because it excluded DV perpetrated by non-family intimate partners as well as DV unrelated to gender identity. A much higher percentage of participants reported experiencing actions that may or may not be part of abusive behavior: 29% reported an ex-partner limiting their contact with their children, 45% reported having a relationship end when they came out as trans to their partner, and 57% experienced family rejection (Grant et al., 2011). However, these are unreliable proxies for IPV.

[3] Cisgender is a term that refers to individuals for whom the gender they were assigned at birth matches their gender identity. It can be thought of as meaning "not transgender."

Only one study to date has compared IPV among transgender to IPV among cisgender individuals. Analysis of data from One Colorado's anonymous 2011 LGBT Health Survey (n= 1,193) found that 31.1% of trans respondents reported experiencing IPV, compared to 20.4% of cisgender respondents (Langenderfer-Magruder et al., 2016) – findings that suggest transgender individuals experience higher rates of IPV than their cisgender, LGB counterparts. Furthermore, preliminary evidence suggests that different subgroups within transgender communities experience different rates or types of IPV (Chestnut, Jindasurat, & Varathan, 2012; Clements, Katz, & Marx, 1999). Future studies should examine these differences, particularly with regard to differences between trans men and trans women and with attention to intersecting identities for all participants (e.g., race, sexual orientation, disability, socioeconomic status).

Similarities of LGBQT and Heterosexual IPV*

In general, IPV experienced by LGBQT* individuals follows patterns similar to heterosexual and cisgender individuals (Ristock, 2005). Specifically, abuse can take the form of physical or sexual violence as well as emotional, financial, or verbal abuse. Messinger's (2011) analysis of the National Violence Against Women Survey revealed that the prevalence of various types of abuse in GLB communities mirrored prevalence rates among heterosexuals: Both groups reported prevalence rates that went in descending order from verbal abuse to controlling behavior to physical violence to sexual abuse. However, as described next, there are also unique aspects of IPV in LGBQT* communities, and potentially important differences among LGBQT* subgroups.

Unique Characteristics of IPV in LGB communities

IPV occurs in a larger societal and systemic context of homo-, bi-, and transphobia, heterosexism, misogyny, and patriarchy. These factors can influence abuse tactics and relationship dynamics for LGBQT* survivors, making their experiences different from those of heterosexual survivors. For example, sexual minority victims of IPV may be subject to abusive tactics that leverage systemic and cultural discrimination (i.e., identity abuse; Ard & Makadon, 2011; Balsam, 2001; Balsam & Szymanski, 2005; FORGE, 2014; Gay Men's Domestic Violence Project, 2014; National Center on Domestic & Sexual Violence, 2014; West, 2012). Examples of identity abuse include denying or belittling an individual's LGBQT* identity (e.g., refusing to use preferred gender pronouns), restricting access to a supportive LGBQT* community (NCDSV, 2014), or threatening to disclose a survivor's sexual orientation, gender identity, or HIV/AIDS status (Ristock, 2005). People who use violence against their LGBQT* partners may also use threats to authenticity as a method of control, making survivors feel that they are not "queer enough" or do not understand how LGBQT* relationships are supposed to be (Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thornton, 2006). Controlling behavior, in general, may be a particularly important aspect of DV among LGBQT* couples, and may result in even higher levels of psychological harm than physical abuse alone (Frankland & Brown, 2014).

IPV in LGBQT* survivors can also be minimized in a variety of ways: For example, common portrayals of DV in the media – usually depicting heterosexual relationships, specifically men abusing women – can render invisible even to themselves experiences of underrepresented survivors (Holt, 2011). Pervasive beliefs that LGBQT* relationships are more egalitarian or that gay and lesbian individuals are better able to defend themselves against partners who use violence also serve to render IPV invisible in these communities (Bornstein et al., 2006; Holt, 2011; Walters, 2011).

Finally, although isolation is a commonly used tactic in heterosexual as well as in LGBQT* relationships, it may be more difficult to overcome in tight-knit LGBQT* communities in which relationships and resources are often shared with the abusive partner (Bornstein et al., 2006). The level of isolation is even more pronounced for LGBQT* survivors from rural and immigrant communities (Ristock, 2005).

Unique Characteristics of IPV among Transgender People

There is limited research on the characteristics of IPV in transgender communities. The National Coalition of Anti-Violence Programs 2014 annual survey of its member programs reported that, compared to people who did not identify as transgender, transgender survivors were two times more likely to face threats/intimidation, nearly two times more likely to experience harassment, and over four times more likely to face police violence in response to reporting IPV (National Coalition of Anti-Violence Program, 2015b). Transgender women were at highest risk of experiencing threats/intimidation, harassment, and injury (NCAVP, 2015a), and transgender people of color were the most likely to report experiencing threats of intimidation in their intimate partnerships.

Generally high rates of violence, trauma, and discrimination in the lives of transgender individuals may have a compounding effect, influencing transgender IPV survivors' willingness to identify abuse or seek help. FORGE's safety planning guide remarks that transgender individuals may feel unwanted, or "believe that they are lucky to ever find love, even if that love turns violent" (Guadalupe-Diaz, 2013, p. 3). In a study of transgender relationship violence, some participants could not even conceptualize their trans partner's behavior as abusive because they viewed these partners as being so oppressed themselves (Ristock, 2011).

Multiple Experiences of Violence in LGBQT Communities*

Because of the fragmented nature of research on violence and abuse in the lives of LGBQT* individuals, the prevalence of "polyvictimization"[4] – that is, multiple kinds of violence and abuse committed by different people – in this community is still unknown. However, evidence suggests that LGBQT* individuals are more likely to experience multiple types of violence (e.g. sexual abuse, physical abuse, and exposure to domestic violence during childhood; sexual assault, physical assault, and stalking during adulthood) at the hands of many different types of individuals (family, partners, community members, legal actors, strangers) and at multiple points in their lifetime (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Grant et al., 2011; Stotzer, 2009).

Specific subgroups of LGBQT* survivors are at especially high risk for multiple forms of victimization. One notable example is LGBQT* homeless youth, highly overrepresented among homeless populations (Durso & Gates, 2012; Grant et al., 2011; Hunter, 2008). Evidence indicates that family and partner violence are major drivers of such homelessness (Cochran et al., 2002; Durso & Gates, 2012; Grant et al., 2011; Risser & Shelton, 2002). Homelessness in turn may render LGBQT* peoples increasingly vulnerable to other forms of violence including harassment, hate crimes, police brutality, and sexual exploitation (Amnesty International, 2005; Durso & Gates, 2012; Keuroghlian et al., 2014; Mogul, Ritchie, & Whitlock, 2012; NCAVP, 2015a; NCAVP, 2015b; Reck, 2009). Layered onto these experiences are other types of oppression such as housing, employment, and healthcare, which are themselves traumatogenic and which also act as barriers to help seeking (D'Augelli, 1998; Durso & Gates, 2012; Grant et al., 2011; Tyler, 2008).

Unique Experiences of IPV among Specific Subgroups of LGBQT Survivors*

The experience of IPV for specific subgroups may be quite different than that of White, middle-class LGBQT* survivors (Chavis & Hill, 2009). The intersections of various identities result in unique social contexts shaped by multiple systems of power and oppression (Chavis & Hill, 2009; Feltey, 2001). These systems may shape the way that IPV is enacted and experienced, and the way it is addressed by service providers. Although attention to all intersections would be beyond the scope of this document, here we focus on three subgroups that have received especially scant attention: sexual minorities in Native communities, immigrant and refugee communities, and faith-based communities. Although there is virtually no research on IPV within these subgroups, it is nevertheless instructive to understand this context when considering the experience of IPV for people within these communities. Later sections touch on specific aspects of the help-seeking experience of African-American and Latin@ LGBQT* survivors.

[4] "Polyvictimization" refers to experiences of multiple kinds of violence and abuse, at the hands of multiple people at multiple points in the lifespan. The authors have chosen to put this word in quotes because some have understood it to imply that the victim is somehow responsible for for these experiences. This would obviously be inaccurate and inappropriate. Indeed, there is now a rich literature on the ways that people who use abusive behaviors target individuals with prior trauma histories.

Two-Spirit and LGBT Native Peoples. In general, there is scant research on the experiences of Two-Spirit and LGBT Native individuals. However, the fact that rates of violence and abuse against cisgender, heterosexual Native women are so high suggests that Two-Spirit Native women might be at especially high risk compared to their non-Native sexual minority counterparts (Lehavot, Walters, Simoni, 2009). Consistent with this view, one study showed that 78% of Two-Spirit women reported experiencing physical assault and 85% reported experiencing sexual assault (Lehavot et al. 2009).

These statistics are all the more alarming given that Native women, regardless of Two-Spirit or LBT status, are more likely to experience physical brutality, and therefore injury, during rapes and sexual assaults (Amnesty International, 2007). Further, some Native researchers have noted the disproportionate impact of homo/transphobia that occurs within the Native community given that Two-Spirit survivors may need cultural support from their own people in the face of violence and trauma (Frazer, Somjen, & Pruden, 2010). Not surprisingly then, violence against Two-Spirit and Native LGBQT* individuals also contributes to the development of a range of health and mental health conditions, such as liver disease, substance abuse, PTSD, as well as to behaviors that increase the risk for HIV (Balsam, Huang, Fieland, Simoni, & Walters, 2004; Centers for Disease Control and Prevention, 2001; Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Simoni, Seghal, Walters, 2004). Clearly, more research is needed on IPV in the lives of Two-Spirit and LGBQT* Native peoples.

Immigrants and Refugees. The experiences of LGBQT* immigrant and refugee survivors of IPV are largely invisible in the academic literature. The broader research on DV in heterosexual, cisgender immigrant communities is complex, indicating that they experience lower rates of IPV, but higher rates of IPV homicide compared to non-immigrants (Bohn, 2003; Tjaden & Thoennes, 1998).

Although there is a need for more prevalence research, it is well documented that sexual minority immigrants face challenges resulting from historically homophobic immigration policies (Chung & Lee, 1999). Under the Immigration and Nationality Act of 1917, LGBQT* immigrants were strictly prohibited from entering the United States on the grounds that they were "mentally or physically defective." The Immigration & Naturalization Act of 1952 similarly prevented LGBQT* immigrants from entering the U.S. based on the idea that they were "afflicted with psychopathic personality" (Foss, 1994). Even up to 1990, Public Health Service physicians barred entrance to those immigrants suspected to be LGBQT*, labeling them as "sexual psychopaths." In addition to contending with these oppressive policies, LGBQT* immigrants were also isolated within their own communities and shunned by white, non-immigrant LGBQT* communities because of their immigration status (Cantú, Hurtado, & Anzaldúa, 2012; Moraga & Anzaldúa, 1981). Even today these interpersonal and institutional challenges echo in the lives of sexual minority immigrants and likely create unique challenges for LGBQT* immigrant and refugee survivors of IPV.

Religious or Spiritual LGBQT Survivors*. LGBQT* people have both positive and negative experiences of faith, possibly even simultaneously. Researchers and practitioners highlight the healing value of religious communities and practices for this community (e.g., Queer Muslims of Boston,

FaithTrust Institute; Ryan, Huebner, Diaz, & Sanchez, 2009). Yet, institutionalized religious policies and principles continue to be a major source of social oppression for many LGBQT* people (Clarke, Brown, & Hochstein, 1989; Davidson, 2000; Hilton, 1992; McNeill, 1993; Morrow & Gill, 2003; Spong, 1991; Spong, 1998). For example, many religious practices condemn non-heterosexual behavior (Bouhdiba, 1998; Jaspal & Cinnirella, 2010) and view LGBQT* people as immoral and spiritually corrupt (Morrow & Gill, 2003). For many religious LGBQT* people, family and societal rejection is therefore compounded by the loss of religious communities (Mahaffy, 1996).

Sources of conflict for religious LGBQT* people include anti-gay religious teachings and scriptural interpretations, homo/bi/transphobic church atmospheres, fear of being "outed" in non-affirming religious settings, and microaggressions (i.e., subtle forms of oppression) from people within their religious communities (Brown & Pantalone, 2011; Shuck & Liddle, 2001). Not surprisingly, receiving homophobic messages through a religious medium has been found to be associated with internalized shame among LGBQT* individuals (Herek, 1987; Ream, 2001).

The challenges of participating in a faith community that is not LGBQT*-affirming may be particularly acute for LGBQT* individuals of color and immigrants since the support role of faith-institutions is particularly crucial in these communities due to the lack of other available social supports. For example, Christian religious institutions have served a range of healing functions within African American communities, where faith has been an important source of strength in the face of ongoing racialized violence and oppression (Billingsley, 2003; Cone, 1997; Cone, 2010; Higginbotham, 1994; Lincoln & Mamiya, 1990). Yet, for African American young men, churches are the primary source of anti-gay messages in their communities (Stokes & Peterson, 1998). The loss of access to one's faith community under such circumstances may be particularly wounding. These challenges are real and ongoing, but their effects on LGBQT* survivors of IPV remain unexplored. Most research on the experience of IPV survivors in relation to their faith communities focuses on the spiritual lives of heterosexual, cisgender women. Clearly, more research is needed in this area.

In sum, violence – be it by intimate partners, family and community members, or society at large – is a common occurrence in the lives of many LGBQT* individuals. Because such polyvictimization is rooted in and exacerbated by the larger context of homophobia and transphobia, the experiences of LGBQT* survivors differ in many ways from those of heterosexual, cisgender survivors. Given that experiences differ, so too does the impact of experiencing IPV. We turn next to the research on the mental health consequences of IPV among LGBQT* survivors as well as protective factors that promote resilience.

Trauma and Mental Health in LGBQT* Communities

The emerging literature on how IPV affects the mental health of LGBQT* survivors is mixed, with some studies indicating that the impact is similar for LGBQT* and non-LGBQT* survivors, and others indicating that adverse effects are more common among LGBQT* survivors (Edwards, Sylaska, & Neal, 2015). This section reviews that literature, focusing especially on depression and PTSD – two common mental effects of abuse. As this section will show, emerging research indicates that bisexual and transgender survivors may be at particularly high risk for experiencing adverse mental health effects.

Depression. LGBQT* survivors of IPV, similar to their heterosexual and cisgender counterparts, are particularly at risk of depression. One longitudinal study examining data from a nationally representative survey of adolescents between the ages of 18 and 27 (227 gay and lesbian, 345 bisexual, and 13,490 heterosexual) found that across all three groups, exposure to IPV was significantly related to increased depression – even after controlling for exposure to childhood physical or sexual abuse and homelessness or expulsion from one's home by caregivers (McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012). This is consistent with a more recent meta-analysis examining 19 studies, which found that men who are victims of IPV at the hands of other men are more likely to use substances, suffer from depressive symptoms, have an HIV positive diagnosis, and engage in unprotected sex (Buller, Devries, Howard, & Bacchus, 2014). As a whole, this body of literature suggests that LGBQT* IPV survivors are at greater risk for experiencing depression than LGBQT* individuals without IPV experience.

Looking more closely within the LGBQT* community, there is some evidence indicating that bisexual individuals may have disproportionately high rates of depression as compared to gay and lesbian individuals (Bostwick, Boyd, Hughes, & McCabe, 2010). Interestingly, theoretical work has posited that the relatively high mental health difficulties within the bisexual community may be attributable to the additional stressors of experiencing bi-negative attitudes from both heterosexual and LGTQ communities. The National Epidemiologic Survey on Alcohol and Related Conditions, which compared rates of major depression among lesbian, gay, bisexual and heterosexual adults (*n*=34,653), found that both male and female individuals who reported bisexual behavior had higher lifetime rates of all mood disorders, including depression (Bostwick et al., 2010). By extension, one might expect bisexual survivors of IPV to be at particular risk for depression.

Likewise, there is scant research on depression and other mental health effects of IPV for transgender survivors. There is, however, literature on the relationship between interpersonal violence more generally and symptoms of depression in this community. For example, in one cross-sectional study of over 591 MTF participants from the New York City area, 63% had depression scores in the clinical range. Further, in this same sample, violence that was related to one's gender identity, or gender abuse, was predictive of depression (Nuttbrock et al., 2014). These findings are consistent with another study of 6,436 transgender-identified individuals, in which 19% of respondents had experienced violence at the hands of a family member because of their chosen gender identity. This exposure was associated with over twice the rate of suicidality, with 65% of those who experienced family violence also reporting

having attempted suicide, compared to 32% of those who did not experience family violence (Grant et al., 2011). Overall, though the literature remains inconclusive, it raises questions about whether transgender survivors of IPV could be at increased risk for depression.

PTSD. IPV exposure also increases the risk of PTSD symptoms in the LGBQT* community. According to the CDC's 2010 IPV report described previously (i.e., NISVS) 19.5% of lesbian women, 46.2% of bisexual women and 22.1% of heterosexual women report experiencing at least one symptom of PTSD – defined as having nightmares and intrusive thoughts of the traumatic experience; feeling constantly on guard, watchful or easily startled; and feeling numb or detached in response to an experience of IPV (Walters et al., 2013). Data from bisexual, gay, and heterosexual men were excluded from the analysis due to small sample sizes. Evidence from other research, however, suggests that that the relationship between IPV and PTSD may extend to gay and bisexual male survivors (Pantalone, Hessler, & Simoni, 2010).

Consistent with the findings on IPV and depression, there is initial evidence that bisexual survivors of IPV have higher rates of PTSD than gay and lesbian survivors. According the CDC's NISVS, more than half of bisexual women (57.4%) who experienced physical or sexual violence or stalking reported at least some form of negative impact (e.g., experiencing PTSD symptoms, missing a day of school or work, feeling fearful or concerned for their safety) as compared to a third of lesbian women (33.5%), and a fourth of heterosexual women (28.2%) (Walters et al., 2013). Significantly more bisexual women (46.2%) reported experiencing at least one symptom of PTSD as compared to lesbian (19.5%) and heterosexual women (22.1%) (Walters et al., 2013). These results suggest that bisexual women may be at disproportionately high risk for developing PTSD after experiencing IPV.

Again, literature on the relationship between IPV and PTSD in transgender communities is limited. As noted earlier, transgender individuals are especially likely to experience violence and discrimination in the domains of education, health, family life, and work which may shape their responses to partner violence (Grant et al., 2011). These risks are not equally distributed among trans individuals. Trans women experience higher rates of violence than trans men, probably because they are less able to "pass" (i.e., be perceived as the gender they identify as) (Dean et al., 2000; Mizock & Lewis, 2008). The risks may also be explained by the concept of trans-misogyny: the idea that there is a particular brand of discrimination that combines transphobia with sexism and applies specifically to trans women (Serano, 2007).

In addition, trans people of color are at particularly high risk (Richmond, Burnes, & Carroll, 2012). In a study of MTF youth of color in Chicago, major life stressors included lack of transportation, difficulty finding a job, sex in exchange for resources, being frequently bothered by police, forced sexual activity, difficulty finding a safe place to sleep, difficulty accessing healthcare, and history of incarceration and homelessness (Stieglitz, 2010). Given that multiple experiences of trauma are more likely to result in the development of clinical PTSD (Scott, 2007), it is not surprising that in one study of MTF transgender individuals, 17.8% reported clinically significant symptoms of PTSD (Shipherd, Maguen, Skidmore, &

Abramovitz, 2011). As a whole, the literature on bisexual and transgender communities makes clear the need for researchers to continue to investigate the distinct experiences of subgroups of the LGBQT* community.

The mental health consequences of IPV among LGBQT* survivors must also be understood within the broader context of historical trauma. Historical trauma is a term used to describe repeated communal traumatic events that exist across time, are embedded throughout culture, and can result in an intergenerational cycle of traumatic stress (Sotero, 2007). Oppressed communities subjected to historical trauma are at heightened risk for mental and physical health consequences compared to communities not exposed to such trauma (Danieli, 1998; McMichael, 1999; Sotero, 2007). Not only have LGBQT* people endured such historical trauma as a group, but many such individuals have also experienced intergenerational trauma originating from other identities such as those based on race or religion (DeGruy, 2005; Franklin, Boyd-Franklin, & Kelly, 2006; Jaimes & Halsey, 1992). Studies have shown that cumulative historical traumatic events actually increase survivors' risk for lifetime trauma and interpersonal violence (Chae & Walters, 2009). These forces are critical to understand when considering the mental health impact of violence against various subgroups of the LGBQT* communities.

Resilience in LGBQT Communities*

Research has identified several important factors that contribute to strength and resilience among LGBQT* survivors. In particular, a positive LGBQT* identity, or *identity affirmation,* and social support from friends can profoundly influence survivors' mental health.

Regarding the first of these two factors, LGBQT* identity affirmation has been well documented as critical to positive mental health outcomes. For example, one study investigating 165 lesbian, gay, and bisexual youth found that family support and self-acceptance mediated the relationship between victimization and mental health (Hershberger & D'Augelli. 1995). Another study surveyed 613 lesbian, gay, and bisexual individuals and found that LGB individuals who have positive appraisals of their LGB identity and do not anticipate rejection from others had lower psychological distress (Balsam & Mohr, 2007). In a subsequent study, the same authors found that higher identity acceptance negatively correlated with measures of depression, guilt, fear, hostility, and sadness, and positively correlated with measures of general life satisfaction, self-assurance, and social self-esteem (Mohr & Kendra, 2011). Finally, in a study of trans people of color who were survivors of traumatic events, participants named pride in one's gender and ethnic identity as critical to resilience (Singh & McKleroy, 2011). In short, LGBQT* individuals who feel more positive about being LGBQT* or their ethnicity are able to cope more successfully with the challenges they face.

Social support from friends and family also serves a critical protective role. Moody and Smith (2013), for example, found that perceived support from friends was associated with reduced suicidality among trans individuals. For transgender youth of color, identifying other youth and adults with similar identities helped to validate their experiences of racism within the LGBQT* community (Singh, 2013).

And in one study of MTF youth of color, friends were the most frequently cited source of support, and physicians or case managers were perceived as at least somewhat helpful (Stieglitz, 2010).

Social media has become a critical conduit for accessing social support within the LGBQT* community (Singh, 2013). Online communities have become sites of community organizing, cultural empowerment, and education for LGBQT* people, enhancing both a sense of identity and a sense of social support and community (Mehra, Merkel, & Bishop, 2004). Religion and spirituality may also contribute to resilience, particularly as these become sources of social support (Potter, 2007).

In sum, there is a clear need for supportive mental health and trauma-informed approaches for LGBQT* individuals. Furthermore, these services must recognize the societal factors that contribute to individual mental health concerns. LGB individuals, and transgender individuals in particular, experience high rates of traumatic experiences that stem from social isolation, prejudice, and discrimination. These experiences can have many negative mental health outcomes, and are exacerbated by multiple forms of oppression. Nonetheless, LGBQT* individuals show remarkable resilience by developing strong social support networks, creating and engaging with online and activist LGBQT* communities, and developing a positive LGBQT* identity. Trauma-informed approaches must allow providers to understand the context in which survivors have experienced abuse, identify sources of individual and communal strength and resilience, and support healing. Unfortunately, the current reality for sexual minorities who seek help from informal and formal supports is far different.

Help-Seeking Among LGBQT* Survivors

A range of systemic, institutional, and individual-level barriers uniquely thwart LGBQT* peoples' access to informal and formal support services (Edwards, Sylaska, & Neal, 2015; Helfrich & Simpson, 2006). At the broadest level, pervasive heterosexism renders violence between same sex partners invisible. The myth that IPV occurs only between men and women contributes to the profound difficulty that service professionals have even identifying IPV among LGBQT* couples (Blasko, Winek, & Bieschke, 2007; Brown & Groscup, 2008; Helfrich & Simpson, 2006; Seelau & Seelau, 2005). Brown and Groscup (2008) studied 120 crisis center workers' perceptions of same-sex DV by presenting scenarios in which only the gender of the abuser and survivor were changed, and found that participants ranked same-sex DV as less severe and less likely to get worse than the same scenario among heterosexual pairs. Although service providers may recognize that LGBQT* survivors deserve protection from IPV just as heterosexual survivors do (Sorenson & Thomas, 2009), these kinds of biases may affect their ability even to identify IPV in this community (Basow & Thompson, 2012).

Beyond the invisibility of LGBQT* IPV, a range of factors cause well-meaning social services systems to harm members of marginalized communities, including sexual minorities. Forms of oppression such as racism, colonialism, ableism, heterosexism, sexism, and transphobia that are often implicit in our helping systems can render these systems traumatogenic, especially when these oppressive dynamics are not acknowledged (Buzawa & Buzawa, 2003; Dirks, 2004; Herman, 2003; Walters, Simoni, & Evans-Campbell, 2002). The kind of harm done by institutions designed to provide support has been termed "sanctuary harm" (Bloom 2011; Bloom 2013).

A primary example of a system that causes this kind of sanctuary harm is the healthcare system. Historically, medicine and the health sciences were central to the effort to pathologize same sex relationships and transgenderism. Being gay or lesbian was classified as a mental disorder by the American Psychological Association until 1973, and conceptions of gender dysphoria as a mental health condition did not undergo a similar revolution until 2013 (Bayer, 1987; Drescher & Merlino, 2007).

The continuing impact of this history is evident in the experiences of LGBQT* patients in healthcare settings. Lambda Legal (2010) found that more than half of all sexual minority survey participants had experienced at least one of the following types of discrimination in a healthcare setting: being refused needed care; being blamed for their health status; seeing healthcare professionals refuse to touch them or use excessive precautions; hearing healthcare professionals use harsh or abusive language; or experiencing healthcare professionals being physically rough or abusive. Similarly, Shires and Jaffee (2015) found that over 40 percent of transgender men reported verbal harassment, physical assault, or denial of equal treatment in a doctor's office or hospital. Grant et al. (2011) reported that over one-quarter of respondents in a survey for the National Center for Transgender Equality experienced verbal harassment in medical settings, and that the likelihood of discrimination, abuse, or assault of transgender patients by their provider actually increased with the provider's awareness of their patient's transgender status. Such experiences of discrimination are far more likely to affect

LGBQT* patients of color, financially-oppressed patients, and undocumented patients (Grant et al., 2011; Lambda Legal, 2010).

Other examples of sanctuary harm abound across systems. For example, between 2010 and 2011, LGBQT* survivors reported an increase of incidences in which the police arrested both the abuser and victim when called (28.4% up from 21.9%), an increase in the percentage of LGBQT* survivors seeking shelter who were denied (61.6% up from 44.6%), and a decrease in the percentage of LGBQT* survivors who received requested orders of protection (78.1% down from 83.7%; NCAVP, 2015b). The same study found that transgender IPV survivors were over six times more likely to experience physical violence while interacting with the police than other survivors, and more likely to experience hate violence in shelters than other survivors (notably, trans men were 3.5 times more likely; whereas, trans women 1.3 times more likely) (NCAVP, 2015b). In short, transgender survivors may experience even more re-traumatization and less access to formal support systems than LGB survivors.

Mainstream programs may use heterosexist language in program materials, or have ambiguous or poorly defined policies regarding service provision for LGBQT* survivors (Helfrich & Simpson, 2006). LGBQT* survivors may well anticipate discrimination both from staff members and the heterosexual survivors using these services and may worry that their sexual orientation (and one could assume, gender identity) will be revealed should they actually seek help (Bornstein et al., 2006; McClennen, 2005; Helfrich & Simpson, 2006).

Low-income LGBQT* survivors of color experience another set of barriers: A community needs assessment of Black and Latin@ LGBQT* communities in the greater Boston area (Tod@s, The Hispanic Black Gay Coalition, The Violence Recovery Program at Fenway Health, The Network/La Red, & Renewal House, 2013) found that a lack of outreach to these communities limited their knowledge of IPV resources. In addition, geographic isolation, lack of transportation options, and the cost of making phone calls were major challenges to finding formal help. Similar to Black and Latin@ communities, Two-Spirit individuals identified lack of financial resources, transportation, and geographic inaccessibility as barriers to seeking support (Walters, Horwath, & Simoni, 2001). In addition, the lack of programming specifically aimed at Two-Spirit people and fear of what other Native community members might think were consistently ranked as barriers.

In the context of these institutional barriers, sexual minority survivors describe a range of personal reasons for not seeking support. Many feel that the need to educate a provider about one's identity and experiences would be overwhelming, particularly during a time of crisis (Turrell & Herrmann, 2008). Others worry about further victimization by providers who lack training on LGBQT* issues, and by other clients accessing the same services (Bornstein et al., 2006). Talking about abuse in one's intimate relationship almost always means coming out about one's sexual orientation or possibly one's gender identity. Further, gossip in insular or tight-knit communities raises concerns of confidentiality and retaliation – not just by the abuser but also by the community at large. Gay male survivors may keep silent about abuse and be more reluctant to seek help because they do not see doing so as consistent

with notions of masculinity (Seidler, 2006). According to Spiegel (2003), the abuse thrusts male survivors into "confrontation between two disparate psychosocial processes: the realities of abuse and the mythology of masculinity" (p. 133). Notably, although LGBQT* individuals may be hesitant to contact mainstream domestic violence programs, one survey reported that 86.2% of LGBQT* respondents *would* contact a domestic violence program if it was LGBQT*-specific (Holt, 2011).

Although the majority of LGBQT* survivors do not immediately seek help from the formal service system, they do rely on their informal social support systems; that is, their friends and families (Edwards et al., 2015). And yet, here too, LGBQT* survivors face a range of barriers to support. For example, LGBQT* survivors may be reluctant to seek help from friends and family given their own or their community's gendered beliefs about violence (e.g., women cannot be violent and men cannot be victimized) (Seelau & Seelau, 2005; Walters, 2011). They may be particularly hesitant to seek help from heterosexual friends or family members if they have had previous experiences of heterosexism and cissexism from their peers (Ard & Makadon, 2011). Survivors may have received messages that LGBQT* relationships themselves are "wrong" or "sick." Consequently, they may feel that admitting violence will only confirm these messages, conferring a sense of stigma on the victim, the relationship, and the LGBQT* community in general. Alternately, survivors who feel as though they are representing the LGBQT* community may feel that admitting IPV will harm the LGBQT* community at large (Balsam, 2001). Also, friends and resources may be shared between the survivor and perpetrator to an even greater degree than in heterosexual relationships, further making it difficult to access support (Bornstein et al., 2006).

In sum, a range of factors hinder LGBQT* survivors from seeking formal and informal assistance. Some survivors choose not to seek help from anyone; however, many survivors will make at least an initial attempt, and how they are treated can affect likelihood of seeking help in the future. Formal systems such as DV programs, hospitals, and law enforcement have a responsibility to ensure that they are facilitating help-seeking, not preventing it. To that end, the next section reviews the literature on a trauma-informed approach to practice, with attention to the needs of service providers who work with LGBQT* survivors, and provides examples of community-specific approaches to trauma.

Trauma-Informed Practices

A growing body of literature suggests that incorporating trauma-informed approaches into work with survivors is beneficial for the participant, staff, and overall organization. In this section we review the definition and core principles of a trauma-informed approach. Next, we discuss the need for LGBQT*-specific trauma-informed models and the role of transformative justice in developing such models.[5]

The term trauma-informed services was first used by Maxine Harris and Roger Fallot (2001a) in the context of mental health and addictions treatment programs. They noticed that many individuals seeking these services had experienced high rates of physical and sexual abuse, yet few providers were knowledgeable about trauma and the effects of such violence. As a result, services were not designed with trauma survivors in mind, increasing the possibility of retraumatization by the very services that were supposed to help them.

In response, Harris and Fallot (2001b) proposed creating trauma-informed service systems. This meant recognizing that the majority of people seeking services are likely to have experienced trauma; and that the effects of trauma impact many life domains, including people's experience of services. Thus, they argued, services had to be redesigned to incorporate an understanding of the pervasiveness of trauma and its impact on every aspect of their work. That is, programs and practices needed to be welcoming and appropriate for individuals with a history of trauma; and they needed to minimize retraumatization and promote healing and recovery. This, in turn, required an organizational commitment to trauma-informed practice, and ensuring that the necessary training for staff was in place.

In their initial work, Harris and Fallot (2001a) identified five requirements for creating trauma-informed services: (1) administrative commitment to change; (2) universal screening for trauma history among participants/clients;[6] (3) training and education on trauma for all staff; (4) hiring staff with a deep knowledge of trauma, referred to as "trauma champions;" and (5) reviewing policies and procedures to ensure they do not replicate abusive dynamics.

Although Harris and Fallot's approach was developed in the context of mental health and addictions services, its underlying principles have been adapted and applied to several different service contexts. These contexts include correctional facilities (Hodas, 2006), psychiatric and hospital settings (Jennings, 2004), homelessness services (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009), addiction

[5] While the terms trauma-informed care and a trauma-informed approach are sometimes used interchangeably, the use of these terms has evolved over time. Trauma-informed care while perhaps still applicable in settings that provide health or mental health care, is actually inconsistent with the spirit/principles of a trauma-informed approach which involves service relationships that are fully collaborative rather than one person providing and the other receiving care.

[6] The requirement for universal trauma screening emerged in the context of mental health and addictions treatment services and are not necessarily applicable to other service settings such as DV programs.

services (Covington, 2008), services for children who have experienced abuse (Hodas, 2006; Ko et al., 2008), and DV organizations (Warshaw, Sullivan, & Rivera, 2013; Warshaw 2014; Wilson, Fauci, & Goodman, 2015).

These adaptations have not fundamentally altered the original principles, but have offered more expanded and nuanced interpretations of how they work in practice. In their excellent review, Hopper, Bassuk, and Olivet (2010) identified core principles that cut across different service contexts. These include: trauma awareness (e.g., staff training, consultation, supervision and self-care); safety (e.g., physical and emotional safety for all, awareness of potential triggers, clear roles and boundaries, and cultural diversity); opportunities to rebuild control (e.g., predictable environments, rebuilding efficacy, and personal control over lives); and a strengths-based approach (e.g., focus on future and skills-building).

Furthermore, Elliot, Bjelajac, Fallot, Markoff and Reed (2005) placed trauma-informed principles in the context of the entire service system and environment. For example, in a trauma-informed system, survivors engage with staff as collaborative partners rather than as passive recipients of services, and organizations actively solicit survivor input. In trauma-informed organizations, providers also strive to understand each survivor within the context of their background and life experiences and in terms of what is meaningful to them. Such contextualizing is essential. Because survivors experience trauma and seek support in a social, historical, and political context, healing must also include recognition of this context.

In order to do this difficult work, staff must themselves be supported. A fundamental aspect of a trauma-informed approach, therefore, involves creating an organizational environment that facilitates providers' capacity to do their work well. Clients interact with individual providers, who themselves interact with supervisors and the organization. When providers are subject to stressful organizational dynamics, those stresses interfere with their ability to be effective (Bloom, 2010). One consequence of problematic organizational dynamics is vicarious traumatization (synonymous with secondary traumatic stress or compassion fatigue) among service providers. Vicarious traumatization has been defined by Charles Figley (1995) as "the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7), and symptoms may mimic those of PTSD. Vicarious traumatization has been linked to burnout in several studies (Bemiller & Williams, 2011; Brown & O'Brien, 1998; Ortlepp & Friedman, 2002; Ullman & Townsend, 2007).

Vicarious traumatization is widespread. Findings from a study of 148 advocates working in a range of types of DV organizations indicate that 47.3% of participants met criteria for clinical levels of PTSD symptoms (Slattery & Goodman, 2009). Organizational factors that may contribute to vicarious traumatization include a lack of involvement or influence on decision making, feeling like one's abilities are not being used, being exposed to danger at work, and too much focus on fixed regulations, procedures, and paperwork (Brown & O'Brien, 1998). Indeed, Slattery and Goodman (2009) found that lack of access to power (i.e., equality, voice, representation, shared leadership, and respect) in the

workplace significantly predicted vicarious traumatization above and beyond individual factors (e.g., personal history of trauma and exposure to traumatized clients). They recommended creating a workplace that emphasizes support, cooperation, effective communication, and conflict resolution skills and asserted that efforts to "flatten the hierarchy" and address power differences at the organization may also help minimize vicarious traumatization.

Creating a trauma-informed service system, then, occurs on three levels. The first is focused on the needs of survivors. The second is focused on changing an organization's culture to support staff and fully integrate trauma-informed practices into its service delivery; and the third level acknowledges the larger societal context in which survivors seek services and organizations operate. This level emphasizes not only engagement with the individual as part of a community, but also with community change itself in order to transform the conditions that produce abuse, violence, and trauma in the first place (Warshaw, 2014; Wilson et al., 2015).

These overarching principles have been applied across trauma-informed service systems. However, the particular language used to describe specific practices that arise from them may vary substantially depending on the service setting. The appendix provides a table of six trauma-informed models that have been identified as having some relevance for this project either because of the communities being served (LGBQT* or IPV survivors), the popularity of the model, or the credibility of the organization. See also Wilson and colleagues' (2015) recent qualitative content analysis of key documents – publications, manuals, and training guides – that describe an emerging consensus on trauma-informed practices in the domestic violence context, as well as points of difference and tension.

It is important to note that trauma-*informed* services are different from, but related to, trauma-*specific* services. Whereas trauma-informed services are designed to be implemented at all levels of an organization and focus on limiting the potential for retraumatization among participants, trauma-specific services are aimed at treating actual trauma symptoms (Harris & Fallot, 2001a). Examples of trauma-specific services include grounding techniques, psychoeducation, mind-body approaches and body-based therapies, cognitive behavioral therapy, and complex trauma treatment (Courtois & Ford, 2009; Courtois & Ford, 2015; Jennings, 2004; Resick, 2003; Warshaw & Brashler, 2009). A number of trauma-specific interventions have been tested in experimental or quasi-experimental research designs. Several studies have also attempted to document the effectiveness of trauma-specific services for female survivors of domestic violence. For a systematic review of evidence-based, trauma-specific services for survivors of domestic violence, see Warshaw et al. (2013). It is important to note, however, that none of these studies focused on LGBQT* survivors.

Trauma-informed service models are inherently more difficult to study because they focus less on specific practices and more on general principles, and they rely on change at the organizational level. Nonetheless, the Women, Co-Occurring Disorders, and Violence Study (WCDVS) attempted to evaluate the impact of this approach. As the only longitudinal study of a trauma-informed approach, the WCVDS indicated that women who received trauma-informed services showed small but significant

improvements on mental health outcomes and trauma symptoms relative to treatment as usual, but no effect for substance abuse (e.g., Morrissey et al., 2005). Since then, researchers have developed several tools to measure the presence of trauma-informed principles and practices as experienced by survivors (see, Accessing Safety and Recovery Initiative & the National Center on Domestic Violence, Trauma, & Mental Health, 2012; Goodman et al., in press;), and are testing new measures of the effects of trauma-informed practices on survivor wellbeing (National Center on Domestic Violence, Trauma, & Mental Health, in development), yielding new possibilities for exploring this important approach.

Trauma-Informed Practices with LGBQT Survivors of IPV*

Despite the high rates of IPV and trauma in LGBQT* communities, trauma-informed approaches tailored to LGBQT* communities have been slow to develop. Some non-IPV trauma-specific interventions have been designed with input from LGBQT* individuals and with concern for LGBQT* cultural competence (e.g., de Arrellano, Ko, Danielson, & Sprague, 2008; Real Life Heroes and Target-A). In addition, the Technical Assistance Partnership for Child and Family Mental Health created a webinar that discusses trauma-informed care for LGBQT* homeless youth. However, there are few well developed trauma-informed approaches for LGBQT* clients in service settings generally, and none in the field of IPV services.

Because of the barriers and difficulties faced by LGBQT* survivors, providers who work with these particular communities may face unique challenges, including lack of resources both within and outside of the service organization, exposure to homo-, bi-, and transphobia through hotline prank callers, experiences of discrimination while attempting to connect survivors with resources, and the possibility of increased vicarious trauma through shared LGBQT* identities.

At the same time, advocates may find strength and resiliency through a shared LGBQT* identity, a strong sense of LGBQT* community, and increased work satisfaction in serving marginalized community members. Advocates who identify as LGBQT* also may be able to draw upon their own experiences of discrimination as a source of resilience in the face of hardship. However, these hypotheses, which are informed by the authors' extensive practice experiences, have not been explored in the literature; considerable research is needed to determine the strengths and job stressors for providers who work with LGBQT* survivors.

Examples of Community-Specific Approaches to Trauma

Although there are no well-developed LGBQT*-specific practices, several community-specific approaches that have been developed by members of culturally-specific communities that have experienced multiple and overlapping forms of oppression may serve as guides.

One example, "Indigenist coping," which was first posited by Walters and colleagues (2002), is a Native-specific model that asks providers to abandon a focus on individual pathology, and instead center the historical trauma, ongoing discrimination, and experiences as a colonized people within a first world nation that are the norm for Native peoples in the U.S. (Walters et al., 2002). The multiple traumas experienced by Native peoples both individually and collectively are the foundation of service provision.

Walters and colleagues interpret the disproportionate rates of substance use, mental health challenges, and HIV risk behaviors among Native people, as conditions that might best be addressed and healed within the context of reconnection to the history and spiritual and healing practices of the Native community. Perhaps the most interesting aspect of the Indigenist coping model is its focus on uprooting internalized colonization and integrating identity along political, ethnic, racial, cultural, and spiritual dimensions. Although this model is not specific to Two-Spirit peoples, it is Two-Spirit-inclusive, and provides a conceptual framework that is responsive to the layered traumas experienced by too many Two-Spirit individuals (Walters, et al., 2002).

Similarly, the National Latin@ Network for Healthy Families and Communities has long used human rights and social justice frameworks to interpret trauma. Specifically, they view trauma through an understanding of multiple kinds of historical & collective trauma, the traumatogenic impact of "non-traditional" traumas such as racism, nativism, poverty, and discrimination and unjust denial of services from helping systems currently and historically experienced by Latin peoples. The National Latin@ Network correspondingly looks to identity cultural traditions and collective knowledge and wisdom, as sources of resilience and post-traumatic growth, both for individuals and for entire communities. Much like the Indigenist coping model (Walters et al., 2002), the approach of the National Latin@ Network looks to the community for both healing and leadership (Serrata, 2012).

Transformative Justice as a Trauma-Informed Practice

Transformative justice analyses recognize systemic oppression as contributing to and exacerbating the impact of interpersonal and community violence and seeks justice at every level (Hairston & Oliver, 2006; Generation Five, 2007). Whereas trauma-informed practice was conceptualized in clinical and academic contexts, transformative justice grew out of a community-based intervention model. It moves away from criminalizing and pathologizing those who use violence and toward transforming organizations, conditions, and systems that perpetuate violence. It is critical that trauma-informed practices include transformative justice as an additional lens in service delivery and system reform.

Generation Five (2007), an advocacy-based project working to end childhood sexual abuse, has helped shape a practice-oriented understanding of transformative justice by offering several goals and principles needed to build greater capacity of communities to challenge traumatogenic systems. According to Generation Five, there are four specific goals of transformative justice: safety, healing, and agency for survivors; accountability and transformation for people who use violence; community action,

healing, and accountability among those in positions of power; and, transformation of the social conditions that perpetuate violence. Notably, these goals build on a set of core principles: 1) liberation, 2) shifting power, 3) safety, 4) accountability, 5) collective action, 6) honoring diversity and 7) sustainability. Here, we explain these principles by providing possible ways in which they could be applied to work with LGBQT* survivors.

Liberation refers to ending long-standing intergenerational cycles of systemic and family violence, which can be partly achieved by shifting power away from those whose power has been achieved through domination, oppression, and violence. In the case of LGBQT* survivors, shifting power includes listening and responding to survivors' articulation of their stories and needs in order to promote self-determination. Liberation and shifting power also applies to LGBQT* individuals who use violence: To end intergenerational cycles of violence, it is important to understand their violent behaviors within the context of institutions and norms that perpetuate violence against them. For example, DV organizations can adopt more fluid and nuanced definitions of "victim" and "perpetrator"; that is, definitions that allow for someone to be (or have been) both a victim of violence and someone who used violence. Doing so invites people's full trauma history into the conversation for consideration and healing.

Safety is conceptualized on three intersecting levels. First, on an individual level, LGBQT* survivors must be protected from immediate and future acts of violence via intervention and prevention efforts. Second, within individual communities, action must be taken to foster norms and practices that condemn violence and support conditions for healing. Finally, at the macro level, communities must be accountable to one other in order to challenge institutional power. Part of that accountability includes acknowledging the prevalence and impact of interpersonal and historical trauma on individuals and communities as well as committing to survivor empowerment and healing. For example, mainstream DV programs can develop relationships with LGBQT* community members and programs to work toward long-term accountability of culturally sensitive service provision. They also can engage in ongoing program evaluation, including open discussion of policies, procedures, and staff profiles, in an effort to transform trauma-inducing organizational norms. Futures Without Violence (n.d.) has developed a series of "Program Personnel Policy Questions" for DV organizations to assess their readiness to work with children and teens; many of these questions can be amended to assess readiness to work with LGBQT* survivors. The National Center on Domestic Violence, Trauma & Mental Health's Accessible, Culturally Relevant, DV & Trauma-Informed (ACDVTI) Agency Self-Assessment Tool also provides guidance on organizational readiness and LGBTQ* inclusiveness.

Collective action highlights the need to address cycles of isolation and shame resulting from traumatic experiences by building alliances with communities to transform structures that perpetuate abuse. Additionally, honoring diversity includes creating and implementing interventions that respond to the unique needs of each community. Finally, sustainability refers to building internal capacity of intimate and community networks to support and maintain survivor-centered safety and healing. These last three principles highlight how social service organizations must incorporate advocacy efforts into

their work and cannot operate in isolation. Instead, they must learn from and collaborate with other organizations, specifically culturally specific organizations. Such collaboration includes not only LGBQT* organizations but also organizations that reflect the range of identities that LGBQT* survivors possess. Incorporating a diversity of expertise and perspective into programs and policies is critical for providing a more trauma-informed approach.

Conclusion

This literature review documents the need for LGBQT*-specific trauma-informed practices with survivors of IPV. IPV is at least as common among LGBQT* individuals as heterosexuals, and may be highest in bisexual and transgender communities. Furthermore, although LGBQT* IPV shares many underlying dynamics with IPV in heterosexual couples, it also has unique characteristics, including the types of abusive tactics used and the context of discrimination and social stigma faced by LGBQT* individuals. Moreover, there are additional complexities within LGBQT* subgroups.

LGBQT* survivors also face unique barriers to help-seeking. Overall, LGBQT* individuals are less likely to seek services from law enforcement and mainstream providers and more likely to rely on informal social support and LGBQT*-focused programs. There are also differences in help-seeking *within* LGBQT* subgroups. For instance, trans individuals may have an especially difficult time accessing culturally competent and non-traumatizing services. For LGBQT* people of color, stigma, economic constraints, and the absence of community outreach are barriers to accessing services.

Trauma and mental health are major concerns in LGBQT* communities in general, and for LGBQT* survivors specifically. LGBQT* individuals experience higher rates of traumatic events, and may be more susceptible to developing symptoms of PTSD, depression, isolation, suicidality, and anxiety. These concerns, which must be viewed in the context of historical trauma, are amplified for LGBQT* people of color and transgender individuals. Nonetheless, LGBQT* individuals find strength and resilience through identity affirmation and social support. More research focused on the strengths and sources of resilience of LGBQT* people is needed to complement and inform existing research on pathology and barriers.

Despite the high rates of IPV and trauma that LGBQT* communities experience, trauma-informed approaches tailored to LGBQT* survivors have been slow to develop. We hope that this document will facilitate thinking about how the core principles of trauma-informed practice can be applied to working with this community and to ameliorating vicarious traumatization among service-providers who do their best in difficult circumstances. The practice-based observations in the Appendix provide further framing for this important endeavor.

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Appendix A: Existing Trauma-Informed Approaches

Trauma-informed Approach	Trauma-informed Care with LGBQT* Homeless Youth
Community	LGBQT* Homeless Youth

Principles	Examples of Practices
• Recovery is possible • Healing happens in relationships • Sharing power and governance • Understanding trauma and its impact • Promoting safety • Supporting client control, choice, autonomy • Focus on strengths • Integrating cultural awareness	• Organizational commitment to nondiscrimination and cultural competence • Involve LGBQT* youth in decisions about services • Provide positive LGBQT* role models • Coordinate with LGBQT* service and advocacy organizations • Collaborate with other organizations • Outreach to change public awareness • Include LGBQT* youth in outreach • Assess staff for knowledge, attitudes, skills

Poirier, J., Murphy, C., Shelton, J., & Costello, S. (2013). Ending LGBT youth homelessness: A call to action. Retrieved from http://tapartnership.org/events/webinars/webinarArchives/presentationSlides/20130710_LGBThomelessness_FINAL.pdf

Trauma-informed Approach	Trauma-Informed or Trauma-Denied
Community	Female Survivors of Trauma

Principles	Examples of Practices
• Recognize the impact of violence and victimization on development and coping • Identify recovery from trauma as primary goal • Employ an empowerment model • Strive to maximize women's choice and control over recovery • Services are based in relational collaboration • Create an atmosphere respectful of survivors' need for safety, respect and acceptance • Emphasize women's strengths, adaptations and resiliency • Minimize retraumatization • Services are culturally competent and understand each woman in context • Solicit participant input and involve participants in designing and evaluating services	• Outreach and Engagement: prioritize safety, ask permission, follow client's lead • Screening and Assessment: screen all clients for trauma history, understand survivor's unwillingness to answer certain questions, only ask for necessary information, balance usefulness of information against client needs, clearly communicate reason for asking questions • Resource Coordination and Advocacy: focus on empowering clients, identify strengths, emphasize skill-building • Crisis Intervention: plan for crises in advance, avoid using restraints or forced hospitalizations, make sure clients know their options • Trauma-Specific Services: offered in trauma-informed environment by individuals trained in trauma and its treatment • Parenting Services: build on parents' strengths • Mental Health and Substance Abuse: treat trauma and substance abuse in integrated way, emphasize physical and emotional safety, collaborate on treatment • Healthcare: prepare clients for medical appointments that might be triggering, debrief and review information provided during exam

Elliot, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477.

Trauma-informed Approach	The Sanctuary Model
Community	Originally for adults who experienced abuse as children, adapted to domestic violence settings

Principles	Examples of Practices
• Core Concepts: nonviolence, viewing organization as whole entity, parallel processes • 7 Commitments: • Nonviolence: physical and psychological nonviolence at all organizational levels • Emotional Intelligence: staff must cultivate awareness of emotional responses and be able to manage and talk about them • Social Learning: organization must be dynamic and constantly identify and respond to changing needs of communities being served • Open Communication: organization should espouse transparency, nonviolent language, and effectively manage conflicts • Democracy: everyone at the agency, clients and staff, should have a voice that is heard • Social Responsibility: create a just and safe organization • Growth and Change: focus should be on the future, with goal of changing and growing over time	

The Sanctuary Model. Accessed 7/2014, from http://www.sanctuaryweb.com/

Trauma-informed Approach	National Center for Domestic Violence, Trauma & Mental Health's Accessible, Culturally Relevant, Domestic Violence-and Trauma-Informed (ACDVTI) Agency Self-Assessment Tool
Community	Domestic violence survivors and programs

Principles	Examples of Practices
• ACDVTI Approach • Be sensitive to the pervasiveness of trauma and its impact on survivors, staff and organizations including historical trauma and ongoing experiences of discrimination and oppression • Recognize the role of coercive control and DV-related safety and confidentiality concerns • Ensure services are welcoming, inclusive, accessible and culturally responsive • Work to minimize retraumatization • Support resilience, healing and well-being • Employ a collaborative strength-based approach • Attend to the quality of interactions for people using services and staff • Involve people using services and communities being served in shaping and evaluating services • Maintain a commitment to changing the conditions that contribute to abuse, violence, discrimination & oppression • Key tenets include recognizing the importance of • Physical and emotional safety • Relationship & connection • Respect, empowerment, transparency, collaboration & choice • Hope & resilience • A survivor-defined approach	The ACDVTI tool provides guidance on engaging in a reflective organization-wide self-assessment process. It is structured to walk agencies through a process of considering what an ACDVTI approach would look like in each of the following 7 domains. • Organizational Commitment and Infrastructure • Staff Support • Physical, Sensory and Relational Environment • Intake Process • Programs and Services • Community Partnership • Evaluation and Feedback It also includes a section on organizational readiness.

National Center on Domestic Violence, Trauma & Mental Health. *Becoming Accessible, Culturally Relevant, Domestic Violence- and Trauma-Informed Organizations: An Organizational Reflection Tool*. National Center on Domestic Violence, Trauma & Mental Health. Chicago, IL. 2015 in press. National Coalition of Anti-Violence Programs.(2012). Hate Violence Against Lesbian, Gay, Bisexual, Transgender, Queer, and HIV- affected Communities In the United States in 2011: A Report from the National Coalition of Anti-Violence Programs. New York City: NCAVP. Retrieved 8/22/2015 from: http://www.cuav.org/wp-content/uploads/2012/08/4379_NCAVPHVReport2011Final_Updated.pdf.

Trauma-informed Approach	SAMHSA TIC in Behavioral Health Services Guide	
Community	Behavioral health service organizations	
Principles		**Examples of Practices**
6 Initial Chapters: • Trauma-informed care: A sociocultural perspective • Trauma awareness • Understanding the impact of trauma • Screening and assessment • Clinical issues across services • Trauma-specific services		• Show organizational and administrative commitment to TIC • Use trauma-informed principles in strategic planning • Review and update vision, mission and value statements • Assign a key staff member to facilitate change • Create a TIC oversight committee • Conduct and organizational self-assessment • Develop an implementation plan • Develop policies and procedures to ensure trauma-informed practices and prevent retraumatization • Develop a disaster plan • Incorporate universal routine screenings • Apply culturally responsive principles • Use science-based knowledge • Create a peer-support environment • Obtain ongoing feedback and evaluations • Change the environment to increase safety • Develop trauma-informed collaborations
Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioral health services*. Rockville, MD: Substance Abuse and Mental Health Services Administration.		

Trauma-informed Approach	Developing Trauma-Informed Organizations Toolkit	
Community	Women with co-occurring disorders and histories of violence	
Principles		**Examples of Practices**
• A comprehensive, continuous, integrated service system • Person-centered services • Trauma • Safety • Family-focused • Diversity		• Establish open dialogue among providers, recipients, and systems • Increase capacity through cross-training, modification and addition of services as necessary • Increase access to peer support • Use respectful, gender-neutral, non-violent language • Recognize and understand cultural differences and how they impact the healing process • Provide co-ed and gender specific services • Staff should be knowledgeable about trauma • Provide access to trauma-specific services • Work with participants to develop calming skills • Validate participant experiences • Allow participant to define their family and support them in their role as parent • Cultural differences should be viewed as community resources and incorporated into service planning
Institute for Health and Recovery. (2012). *Developing Trauma-Informed Organizations: A Tool Kit* (Second ed.). Cambridge, MA: Institute for Health and Recovery.		

Appendix B: A Set of Practice-Based Observations for Trauma-Informed Practice with LGBQT* Survivors of Intimate Partner Violence

GLBTQDVP

GLBTQ Domestic Violence Project

TRAUMA-INFORMED APPROACHES FOR LGBQT* SURVIVORS OF INTIMATE PARTNER VIOLENCE

A Set of Practice Observations
June 2016

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Authors:

Erin C. Miller, M.P.S., M.D.V.
Domestic Violence/ Sexual Assault Programs;
Newton-Wellesley Hospital

Lisa A. Goodman, Ph.D.
Boston College

Kristie A. Thomas, Ph.D.
Simmons College

Carole Warshaw, M.D.
National Center on Domestic Violence, Mental Health, and Trauma

Principal Investigator:

Curt Rogers, M.P.A.
GLBTQ Domestic Violence Project

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Produced by
The GLBTQ Domestic Violence Project

GLBTQDVP

For more information on supporting LGBQT* survivors of intimate partner violence, contact one of the organizations below:

The LGBTQ DV Capacity Building Learning Center
c/o The Northwest Network
A program focused on improving research, practice and policy regarding domestic violence in LGBTQ communities.
1-206-568-777 | info@nwnetwork.org | www.nwnetwork.org

FORGE
A transgender anti-violence organization, specializing in technical assistance for victim service agencies, with a focus on domestic violence, sexual assault, dating violence, stalking, and hate crimes.
1-414-559-2123 | AskFORGE@forge-forward.org | www.forge-forward.org

If you would like more information about accessible, culturally relevant trauma-informed approaches for survivors, contact:

The National Center on Domestic Violence, Trauma & Mental Health
A program providing training, support, and consultation to advocates, clinicians, attorneys and policymakers as they work to improve agency and systems-level responses to survivors and their children.
1-312-726-7020 | info@nationalcenterdvtraumamh.org | www.nationalcenterdvtraumamh.org

Introduction and Project Overview

This document contains a set of preliminary practice observations from the field, which are intended to inform the development of a trauma-informed transformative justice approach specific to lesbian, gay, bisexual, queer, and transgender (LGBQT*) survivors of intimate partner violence (IPV). These observations are the result of a research project that was led by the GLBTQ Domestic Violence Project (GLBTQ-DVP) and funded by the Administration for Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services.

The goal of the project was to help develop a culturally-specific, trauma-informed approach to working with LGBQT* survivors with support and input from a range of stakeholders. To meet this goal, the following activities[1] were conducted over the course of two years (2013-2015):

- A substantive literature review on intimate partner violence in the LGBQT* communities (page 1), which is intended to be read in tandem with the observations
- Input from an advisory committee that included Queer Muslims of Boston, the Hispanic Black Gay Coalition, the Northeast Two Spirit Society, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, Massachusetts Asian & Pacific Islanders for Health, and Fenway Health
- Two focus groups with survivors participating in one GLBTQ DVP program, the goal of which was to explore their experiences seeking help
- Three separate focus groups and multiple individual conversations with staff of one GLBTQ DVP program to assess their perceptions, experiences, and ideas about trauma-informed organizations and providing trauma-informed services
- Surveys of the program's staff as well as LGBQT* practitioners nationally to assess knowledge and experience of trauma-informed practices
- Informal conversations with staff and leadership of LGBQT* culturally-specific organizations across the country
- The authors' own collective experience working with LGBQT* organizations and communities over the past 30 years
- Considerable guidance from the National Center on Domestic Violence, Trauma, & Mental Health

From these multiple sources of data, a set of six observations emerged, which then were simplified and distilled in the hopes that they will be broadly applicable. They are listed here and explained in detail in the subsequent pages.

- Observation 1: The majority of LGBQT* survivors have experienced multiple forms of violence and abuse in their lives. Experiences of historical trauma and ongoing discrimination can compound these multiple experiences of victimization.

[1] The Simmons College Institutional Review Board approved the research activities involving human subjects (i.e., interviews and focus groups with practitioners and program participants).

- Observation 2: Organizations that work with LGBQT* survivors must operate from a place of understanding that perceived "challenges" may actually be creative strengths.

- Observation 3: Organizations that work with LGBQT* survivors must operate from the premise that if LGBQT* communities, staff, board members, organizations, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their family of choice, not merely as a service provider or colleague.

- Observation 4: If practitioners are to truly be of service, a social justice and anti-oppression framework must become the cornerstone of their individual work, their organization's work, and their organization's interactions with the community.

- Observation 5: Staff self-care (and organizational support for self-care) is critical.

- Observation 6: There is a profound need for transformative justice[2] approaches to working with LGBQT* and other multiply oppressed communities.

It is important to note that the authors view these observations as dynamic and evolving, and we are hopeful that LGBQT*organizations, practitioners, activists, and researchers will expand upon them as part of their own trauma-informed, anti-oppression, transformative justice work. Some sections of this addendum tie directly to the literature review (e.g., observations 1 and 5), and others do not. Also, although these observations grew in tandem with the literature review – and should be read together – some of the ideas are not yet supported by a body of literature. Rather, they reflect the practice wisdom and lived experience of LGBQT* practitioners and LGBQT* survivors who contributed to this project.

The practice observations and companion literature review are intended primarily for staff in domestic and sexual violence organizations; however, they are applicable to practitioners in other anti-abuse disciplines, homelessness services, mental health and healthcare circles, criminal legal systems, youth services, and an array of other human services disciplines and social change endeavors that seek to serve and ensure the inclusion of LGBQT* communities.

[2] The authors wish to thank Hales Burton at the Fenway Violence Recovery Program for first suggesting this conceptual shift.

A Note on Language[3]

Before describing the observations, the authors wish to acknowledge the deep complexities of language. In this document, IPV refers to the physical and/or emotional abuse of an individual by a current or former intimate partner. It includes the full range of tactics used to create and maintain power and control over another person, including financial abuse, verbal abuse and intimidation, and cultural abuse. In this document, the phrases *intimate partner violence* and *domestic violence* are used interchangeably to denote partner violence. However, it is important to note that domestic violence (DV) is sometimes defined more broadly to include violence and abuse perpetrated by relatives. Although many LGBQT* individuals experience abuse and/or rejection from family and relatives, the dynamics of partner violence versus family violence may differ dramatically. When we discuss the latter, we use the phrase *family violence* to distinguish it from violence by an intimate partner.

LGBQT* stands for lesbian, gay, bisexual, queer, and transgender. It is often used interchangeably with GLBTQ, LGBQT-TS, and similar acronyms to broadly refer to sexual and gender minorities. This document honors the current practice of including an asterisk after the "T" to signify the broad diversity of trans communities, including trans women – transgender individuals who identify as women, though assigned male at birth; trans men – transgender individuals who identify as men, though assigned female at birth; those transitioning from female to male (FTM); those transitioning from male to female (MTF); cross dressers; gender non-conforming individuals; and others who might self-identify as being members of trans communities. In this paper, transgender and trans are used interchangeably.

These definitions belie the complexity of the terms, however. The words *lesbian*, *gay*, *bisexual*, *transgender*, and *queer* all carry particular historical, political and cultural meanings. To a great extent, these words have been shaped in white, Western contexts. Words such as lesbian, gay, and bisexual, for example, are uniquely English. There are seldom translations into other languages that carry the same understanding of LGBQT* identity as being an identity rather than a set of behaviors. Literal translations, into Spanish or Haitian Creole as but two examples, carry few if any of the presumptions that are inherent in English. In many parts of the Latin and Spanish-speaking world, men who engage in sex with same sex partners are only considered "gay" in the English sense of the word if they are the receptive partner. It is not engaging in the acts that is the determinant of identity, so much as the role that an individual plays (traditionally read as *masculine* or *feminine*) in the conduct of that act. Similarly, men who marry women, but engage in same sex acts with other men, are frequently identified as heterosexual. In short, they are defined by their social role, rather than by their private, intimate acts. Hence the conception of *gay*, as defined in U.S. contexts, frequently fails to apply.

Precisely because identifiers such as LGBQT* were defined in white middle class and academic contexts, the limitations of LGBQT* labels and identifiers may be particularly acute in communities of

[3] For those of you who are reading the literature and practice observations in tandem, please note that this "note on language" section is identical to the "note on language" section in the literature review.

color, Indigenous communities, and immigrant communities, among others. During the course of crafting this literature review, members of our Advisory Board taught us a tremendous amount. The Hispanic Black Gay Coalition (HBGC) suggested use of the term *same gender loving*, a community-specific phrase coined by Cleo Manago to distinguish African Americans, and in particular African American men, who do not self-identify as being part of the predominantly white gay movement in the U.S., but who nonetheless wish to affirm their same sex intimate relationships. Corey Yarbrough, one of the founding Executive Directors of HBGC, suggested that for some same gender loving people this language may be a form of racialized resistance to the racism of the mainstream LGBQT* movement in the U.S. In the alternative, Corey stated, some members of African American communities may be on the *down low*, engaging in same sex sexual activity, but rejecting LGBQT* identifiers as a result of internalized homo and biphobia.

The NorthEast Two-Spirit Society (NETSS) in part echoed Corey's thoughts about the racism of the mainstream LGBQT* movement. In addition, Harlan Pruden, one of co-founders of NETSS, spoke about an "internal muddiness" that some Native peoples may experience when seeking to find language for their experience. Speaking of his own Cree inheritance as a registered member of the Saddle Indian Reservation, Harlan said that when he asked something of an elder, he knew to offer them tobacco, but never understood the spiritual dimension of the ceremony. Having been separated from too much of their own history by colonialism, genocide and forced assimilation, Harlan stated, many Native people may use the words *Two-Spirit* when what they really mean is gay Indian.[4]

Harlan also spoke at length about the contextual nature of Native Two-Spirit identities. As Harlan put it, "When I am out on a Friday night in a gay club, I am a gay man. Yet when I am in rural Oklahoma at a Two-Spirit gathering, I am a proud Two-Spirit man." Alluding to the unique role and cultural responsibilities that Two-Spirit people often held (and may still hold) in the life of Native communities, Harlan pointed out the obvious differences in the spiritual role of Two-Spirit peoples, and the political and social function of people claiming LGBQT* identities in mainstream communities. Several members of the project's advisory board echoed this point,
speaking about the complex layering of cultural and spiritual value systems that accompanied their choice to self-identify in, with, and outside of their own communities.

These same Advisory Board members also acknowledged the landscape in which such decisions are made, and stated that individuals in their communities may shift how they self identify as a means of preserving their safety. As the rest of this literature review discusses, LGB, transgender, same gender loving, Two-Spirit, and queer-identified peoples make choices about how, when, and if to "out" themselves in a complex social and political landscape that is too often unsafe, if not violent. Hence how

[4] Two-Spirit is a contemporary term, adopted from the Northern Algonquin, and meant to signify the embodiment of both masculine and feminine within one person. Now embraced by many Native peoples as a pan-Indigenous umbrella term connoting both diverse gender expressions and sexual orientations, Two-Spirit generally speaks to the respect that Native peoples held for diversity, and the unique sacred and ceremonial roles that Two-Spirit people held (and may still hold) within their own communities. Herein the phrase Two Spirit speaks not simply to a third gender, or to same gender attraction, but more broadly to the history of compulsory Christianization that sought to erase Two-Spirit peoples within their own nations. Notably, there is no single consensus definition of Two-Spirit, and the term means different things to different Native peoples.

any individual self-identifies may shift depending on who is asking, why, and in what context. As one Advisory Board member stated, "identities have to be fluid in order to be protective."

Finally, the leadership of HarborCOV, an LGBQT*-affirming DV organization in Boston that specializes in serving communities facing cultural or linguistic barriers, has noted that some cultures may not have the variety or depth of language that words such as LGB, transgender, same gender loving, and Two-Spirit convey. Indeed, Kourou Pich, Co-Executive Director of HarborCOV has observed that people from some cultures and communities may have difficulty finding language for themselves in their own communities, and that that invisibility is intentional – a function both of denial of the existence of sexual minorities in those communities, but also perhaps protectiveness of gender queer and same gender attracted people.

Language is power. We authors, therefore, have put a great deal of thought into the words we use to name peoples' experiences. At the same time, we know that we can never be as inclusive or sensitive as we want to be. We have done our best to honor the range of experiences we are writing about in this document.

Notes from the Field: A Set of Practice-Base Observations

Observation 1: The majority of LGBQT survivors have experienced multiple forms of violence and abuse in their lives. Experiences of historical trauma and ongoing discrimination can compound these multiple experiences of victimization.*

A trauma-informed approach, at its core, asks that practitioners assume that everyone they serve has experienced some form of violence, abuse, or other trauma in their lives and to see these experiences as the norm, rather than the exception (Felitti et al., 1998; Harris & Fallot, 2001).

Given the prevalence and overlapping nature of violence and abuse in the lives of LGBQT* peoples, it might be more prudent to suggest that practitioners build practices and systems that presume *multiple* forms of victimization among the people they serve. It is not unusual for LGBQT* peoples to be targets of many different forms of violence and abuse at the hands of multiple individuals, at numerous points throughout the lifespan (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Grant, Mottet, & Tanis, 2011; Stotzer, 2009).[5] Indeed, traumatic experiences such as intimate partner

[5] To date, the fragmented nature of the research into violence and abuse in the lives of LGBQT* individuals means that, although there is a broad practice consensus about the prevalence of "polyvictimization" in the lives of LGBQT* peoples, there is little peer-reviewed research examining the phenomenon. However, there is abundant evidence that LGBQT* people, and in particular LGBQT* people of color, are more likely to be targeted for multiple forms of violence and abuse, in multiple contexts (family, partnerships, community) over the course of their lifetime. For example, LGBQT* peoples are disproportionately subject to childhood sexual abuse, bullying by peers, sexual violence in adolescence and adulthood, intimate partner violence, hate crimes, and police brutality (Roberts et al., 2010; Grant et al., 2011; Stotzer, 2009). Again, the authors wish to encourage individuals to read these observations in tandem with the literature review to learn more about these siloed areas of research.

violence, family violence, and other types of trauma that occur over the course of the lifespan, including childhood sexual assault, bullying, hate crimes, or police brutality, may intersect and compound each other in the lives of LGBQT* survivors in ways that create unique challenges for survivors themselves, and unique opportunities for control by future perpetrators.

These interpersonal traumas are often further compounded by experiences of oppression and historical trauma in LGBQT* communities. LGBQT* peoples have historically experienced discrimination at the hands of helping professionals in a range of systems (e.g., healthcare, mental health, criminal-legal, child protection, public assistance, and sexual and domestic violence organizations) – if LGBQT* peoples have been visible in those systems at all.[6] In addition, many of these systems (in particular mental health and criminal-legal systems) have not only pathologized, labeled, isolated, and detained LGBQT* individuals, but also intentionally fractured LGBQT* partnerships, families, and communities. Such treatment is especially the case for multiply marginalized LGBQT* communities, such as communities of color, immigrants and refugees, Two Spirit communities, and people with disabilities.

It is important to understand, however, that these forms of oppression are not merely historical artifact in the lives of LGBQT* survivors, but ongoing and continuing realities, especially for those who are multiply marginalized. This ongoing oppression then exacerbates experiences of current and historical trauma.

A trauma-informed approach encourages practitioners, and indeed entire systems, to minimize the possibilities for retraumatization by creating an atmosphere that prioritizes survivor's need for safety, respect, and acceptance (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Jennings, 2004; Substance Abuse and Mental Health Services Administration, 2014; Warshaw, 2014; Wilson, Fauci & Goodman, 2015). In short, a trauma-informed approach asks first and foremost that practitioners – as well as the systems in which they work – do no harm.

However, for LGBQT* survivors in particular, the mandate to do no harm requires that practitioners understand the concept of *sanctuary harm* – the idea that institutions and institutional gatekeepers can inflict enormous damage on the very people whose healing, empowerment, and safety they are supposed to nurture and protect (Bloom & Farragher, 2011; Smith & Freyd, 2014). Survivors who participated in the focus groups for this project spoke of blatant discrimination, noting, for example, institutions and practitioners who had at times openly refused services to male and LGBQT* survivors. And, in the staff focus groups, participants spoke about the challenges of advocating with organizations that had a funder mandate to be LGBQT* inclusive, but who were still actively resistant to accepting some members of this diverse community.

[6] The authors are mindful that historical trauma means different things in different communities. Many members of First Nation communities frame historical trauma in terms of colonization, genocide, and boarding-school trauma. Members of Jewish communities may frame historical trauma in terms of the intergenerational impact of the Holocaust. And members of the African Diaspora may think of the Middle Passage and the enslavement of African peoples when referencing historical traumas. The specific nature of the historical influences the way it continues to affect the lives of individuals and entire communities.

Conversations with LGBQT* practitioners across the country, especially those from mainstream organizations, surfaced deep ethical tensions over their own roles as institutional actors in organizations and agencies that they believed too often inflicted sanctuary harm. Consciousness of the harm they were doing – and the good they were prevented from doing – was a significant source of mental, emotional, and ethical distress for many practitioners, especially when contrasted with their larger awareness of the needs of the communities and people they were serving.

Observation 2: Organizations that work with LGBQT survivors must operate from a place of understanding that perceived "challenges" may actually be creative strengths.*

Recognizing the potentially significant impact of violence and abuse on development and coping strategies, a trauma-informed approach aims to contextualize coping strategies such as substance use, cutting, eating disorders, "promiscuous" sex, and dissociation as adaptive responses to otherwise intolerable situations (Elliot et al, 2005; Guarino et al., 2009; Jennings, 2004; SAMHSA, 2014, Warshaw 2014). Because it is rooted in clinical frameworks, trauma-informed practice approaches often frame such strategies as necessary within the context of abuse, but no longer adaptive once relative safety had been achieved. Following the examples of Kate Bornstein and Sylvia Rivera, the LGBQT*-specific practitioners who participated in the survey and informal conversations spoke about celebrating survivors' coping strategies as not merely adaptive, but indeed creative, even when such strategies are not on the surface immediately conducive to health or perceived well-being. Given the multiple forms of victimization, ongoing discrimination, and historical trauma that shape the LGBQT* experience, it may be that there is no safety anywhere. In that context, any strategy that allows people to survive – internally or externally – is to be celebrated. As one practitioner put it, "It isn't about coping, it is about surviving. We celebrate survival, because it is so uncertain." Such a response should not preclude practitioners from expressing concern or helping survivors to develop alternative survival strategies in parallel; however, it does require that practitioners fully embrace survivors and honor and respect their own strategies.

Observation 3: Organizations that work with LGBQT survivors must operate from the premise that if LGBQT* communities, staff, board members, organizations, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their family of choice, not merely as a service provider or colleague.*

A trauma-informed approach asks that practitioners base everything they do in relational collaboration. In fact, one of the core principles of a trauma-informed approach is to ensure that goals and strategies are collaboratively defined, and that the partnership between survivor and practitioner is itself a place of healing (Elliot, et al, 2005; SAMHSA, 2014; Warshaw, 2014; Davies & Lyon, 2014; Wilson et al., 2015).

Just as with other historically oppressed communities, the complexities of the LGBQT* experience may be such that a traditional relationship between service provider and client is not sufficient to fully support the person's healing. Instead, a different and more porous set of boundaries may be required – or at least expected. As several LGBQT* practitioners put it, when LGBQT* communities, staff, co-workers, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their "family of choice," not merely as a service provider. Program participants supported this sentiment, describing how one of the most important and helpful aspects of the services they received was the staff's willingness to go "above and beyond their job descriptions." Providing the sort of attention that a friend might provide (e.g., calling to check in or going along to doctor's appointments) was important because, as one survivor expressed, "I had never been treated that way in my life, not even by my family." Although this can raise complex ethical issues for both survivors and practitioners in navigating this important but complicated terrain, recognizing it is critical in working with LGBQT* survivors and working within LGBQT* communities.

Observation 4: If practitioners are to truly be of service, a social justice and anti-oppression framework must become the cornerstone of their individual work, their organization's work, and their organization's interactions with the community.

Another principle of trauma-informed practice is to respond to all people in ways that are sensitive to their individual social locations and contexts (Wilson et al., 2015; see also Elliot, et al, 2005; Jennings, 2004; Guarino et al., 2009; SAMHSA, 2014; National Center on Domestic Violence, Trauma & Mental Health, in press). At a minimum, this principle sets forth an expectation of cultural sensitivity across multiple aspects of identity. Given the chronic and cascading traumas, ongoing oppression and historical trauma referenced above, cultural sensitivity is essential but not sufficient for responding to the experiences of LGBQT* survivors. Instead, attention to individual social locations and contexts must be situated within a broader anti-oppression framework.

LGBQT* practitioners from across the country observed that the broader movements against sexual and domestic violence sometimes minimized the ways in which violence and abuse intersect with other forms of oppression. They took note not simply of the ways in which this lack of proactive attention shaped direct services, but also how it shaped their organization's hiring practices, the tokenization of staff members from historically marginalized communities, the narrow makeup of their organization's governing board, the focus on quantity over holistic quality of services, and the lack of input particularly from transgender community members and community members of color in strategic planning and other organizational activities.

By contrast, they called on practitioners to build organizations that are integrated into and learn from the historically marginalized communities they serve (or should be serving) and that center the knowledge and experiences of those communities. Historically oppressed communities, including LGBQT* communities, are at the leading edge of anti-violence work, not a set of "minority communities" requiring special logistics or uniquely special care. What organizations learn from historically oppressed communities should serve as the foundation of their organizational philosophy, practices, and policies.

Observation 5: Staff self-care (and organizational support for self-care) is critical.

Empathic engagement and bearing witness to other people's pain can affect us deeply. To be effective, it is important for service providers and activists serving people in pain and crisis to be mindful of how they have been affected by their own experiences of trauma *and* how they are affected when they open themselves up to other people's experiences (Saakvitne, Gamble, Pearlman, & Lev, 2000; Hopper, Bassuk, & Olivet, 2010; Bloom & Farragher, 2013; SAMHSA, 2014). Hence, an understanding of vicarious trauma and encouragement to develop strong habits of self-care have become foundational principles in trauma-informed practice (Bloom & Farragher, 2011; Bloom & Farragher, 2013). Thus, to be truly trauma-informed, organizations need to institute programmatic supports for self-care at all levels of the organization (Bloom & Farragher, 2011; Bloom & Farragher, 2013, Warshaw 2014).

Conversations with LGBQT* practitioners across the country led to an additional observation: There is a particular weight that accompanies serving LGBQT* people experiencing violence, abuse, and discrimination while simultaneously identifying with those same communities. Trauma, vicarious trauma, organizational trauma, and historical trauma compounded one another in the lives of the LGBQT* practitioners who contributed to this project, just as they do for the survivors who participate in their programs. Moreover, the impact of compounding trauma was one each group articulated virtually unanimously. Their experiences underscore the need for self-care at the individual level. They also point to need for organizational policies that enable self-care, provide LGBQT*-affirming workspaces, and facilitate connection with the larger community of providers and activists that support and depend upon the work and health of that organization. Essentially, caring for each other individually and as a collective is a critical element of any trauma-informed approach.

Observation 6: There is a profound need for transformative justice[7] approaches to working with LGBQT and other multiply oppressed communities.*

Because the companion literature review focused largely on peer-reviewed, published literature, it did not consider the enormous array of activist literature and art that historically oppressed communities have often used to express their communal strategies for survival and resistance. The work of Incite!, Creative Interventions, Black & Pink, and Break Out, along with broader bodies of art, music, dance, autobiography, fiction, and oral history attest to this creative communal drive.

One innovation that has emerged from this kind of activist energy is the concept of *transformative justice* (Generation Five, 2007; Creative Interventions, 2012). Transformative justice recognizes the profound harm and trauma that mainstream approaches have inflicted on LGBQT* peoples, particularly those who face multiple forms of oppression. Its practitioners argue for an approach that understands these historical harms and seeks to create new and innovative responses that avoid replicating them. Rather than work within the framework of social services, it aims for the liberation of oppressed people as communities not just as individuals, under the fundamental

[7] The authors wish to thank Hales Burton at the Fenway Violence Recovery Program for first suggesting this conceptual shift.

assumption that “individual justice and collective liberation are equally important, mutually supportive, and fundamentally intertwined” (Generation Five, 2007, p.1). In other words, transformative justice seeks to transform the political and cultural conditions that allow violence, abuse and oppression to exist in the first place. It is critical that trauma-informed practices include transformative justice as an additional lens in service delivery and system reform.

Conclusion

In summary, these six observations underscore the ways in which individual, interpersonal, and structural factors coalesce in the lives of LGBQT* survivors of domestic violence, creating a unique context, that affects their experiences and needs. Future trauma-informed approaches for LGBQT* survivors of domestic violence should consider the multi-layered context that surrounds LGBQT* survivors and use that knowledge to inform not only client-level practices, but also organizational-level policies.

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REVIEW ARTICLE

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Trauma and trauma care in Europe

Ingo Schäfer[a], Manoëlle Hopchet[b], Naomi Vandamme[c], Dean Ajdukovic[d], Wissam El-Hage[e], Laurine Egreteau[f], Jana Darejan Javakhishvili[g], Nino Makhashvili[h], Astrid Lampe[i], Vittoria Ardino[j], Evaldas Kazlauskas[k], Joanne Mouthaan[l], Marit Sijbrandij[*m], Małgorzata Dragan[n], Maja Lis-Turlejska[o], Margarida Figueiredo-Braga[p,q], Luísa Sales[r], Filip Arnberg[s], Tetiana Nazarenko[t], Natalia Nalyvaiko[u], Cherie Armour[v] and Dominic Murphy[w]

[a]Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany; [b]Belgian Institute for Psychotraumatology, Brussels, Belgium; [c]Belgian Institute for Psychotraumatology, Trauma Center Limburg, Hasselt, Belgium; [d]Department of Psychology, Faculty of Humanities and Social Sciences, University of Zagreb, Zagreb, Croatia; [e]UMR 1253, iBrain, Université de Tours, CHRU de Tours, Inserm, Tours, France; [f]Laurine Egreteau, CHRU de Tours, Clinique Psychiatrique Universitaire, Tours, France; [g]Institute of Addiction Studies, Faculty of Arts and Science, ILia State University, Tbilisi, Georgia; [h]Business School, ILia State University, Tblisi, Georgia; [i]Department of Medical Psychology and Psychotherapy, University Medical Hospital Innsbruck, Innsbruck, Austria; [j]Dipartimento di Scienze dell'Uomo, Urbino University, Urbino, Italy; [k]Center for Psychotraumatology, Institute of Psychology, Vilnius University, Vilnius, Lithuania; [l]Department Clinical Psychology, Institute of Psychology, Leiden University, Leiden, The Netherlands; [m]Faculty of Behavioural and Movement Sciences, VU University Amsterdam, Amsterdam, The Netherlands; [n]Faculty of Psychology, University of Warsaw, Warsaw, Poland; [o]Faculty of Psychology, SWPS University of Social Sciences and Humanities, Warsaw, Poland; [p]Faculty of Medicine, University of Porto, Porto, Portugal; [q]Centre for Social Studies (CES) of the University of Coimbra, Coimbra, Portugal; [r]Department of Psychiatry of the Military Hospital of Coimbra, Centre of Trauma (CES) of the University of Coimbra, Coimbra, Portugal; [s]National Centre for Disaster Psychiatry, Department of Neuroscience, Psychiatry, Uppsala University, Uppsala, Sweden; [t]Non-Governmental organization 'Ukrainian Society of Overcoming the Consequences of Traumatic Events' (USOCTE), Kyiv, Ukraine; [u]International Institute of Depth Psychology, Non-Governmental organization 'Ukrainian Society of Overcoming the Consequences of Traumatic Events' (USOCTE), Kyiv, Ukraine; [v]School of Psychology, Institute of Mental Health Sciences, Faculty of Life & Health Sciences, Ulster University, Coleraine, Northern Ireland, UK; [w]Research Department, Combat Stress, Leatherhead, UK & King's Centre for Military Health Research, Department of Psychological Medicine, King's College London, London, UK

ABSTRACT

The European countries have a long history of exposure to large-scale trauma. In the early 1990s the increasing awareness of the consequences of trauma within the mental health community led to the foundation of local societies for psychotraumatology across Europe and the European Society of Traumatic Stress Studies (ESTSS), which celebrated its 25th anniversary in 2018. The focus of this article is to describe the current state of care for survivors of trauma in the 15 European countries where ESTSS member societies have been established. Brief descriptions on the historical burden of trauma in each country are followed by an overview of the care system for trauma survivors in the countries, the state-of-the-art of interventions, current challenges in caring for survivors and the topics that need to be most urgently addressed in the future. The reports from the different countries demonstrate how important steps towards a better provision of care for survivors of trauma have been made in Europe. Given the cultural and economic diversity of the continent, there are also differences between the European countries, for instance with regard to the use of evidence-based treatments. Strategies to overcome these differences, like the new ESTSS training curricula for care-providers across Europe, are briefly discussed.

Trauma y Atenciones de Trauma en Europa

Los países Europeos tienen una larga historia de exposición a traumas de larga escala. A principios de la década de 1990, la creciente conciencia de las consecuencias del trauma dentro de la comunidad de salud mental condujo a la fundación de las sociedades locales para la psicotraumatología en Europa y la Sociedad Europea de Estudios de Estrés Traumático (ESTSS), la cual celebra en el 2018 su 25° aniversario. El enfoque de este artículo es describir el estado actual de la atención de los sobrevivientes de traumas en los 15 países Europeos, donde las sociedades miembros de la ESTSS se han establecido. Las descripciones breves sobre la carga histórica de trauma en cada país son seguidas por una descripción general del sistema de atención para sobrevivientes de trauma en el país, el estado de la técnica de las intervenciones, los desafíos actuales en el cuidado de sobrevivientes y los temas que necesitan ser abordados con mayor urgencia en el futuro. Los reportes de los diferentes países demuestran los pasos importantes que se han dado en Europa en la entrega de atención para los sobrevivientes de trauma. Dada la diversidad cultural y económica del continente, hay también diferencias entre los países Europeos, por ejemplo en relación al uso de tratamientos basados en la evidencia. Las estrategias para

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关键词
心理创伤学; 历史; ESTSS; 欧洲; 创伤; 治疗; 护理; 心理治疗

HIGHLIGHTS

- Important steps towards a better provision of care for victims of trauma were made in the European countries.
- In 2018, ESTSS celebrates its 25th anniversary.
- Strategies to promote a better practice include new ESTSS curricula for professionals across Europe.

CONTACT Ingo Schäfer i.schaefer@uke.de Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany

[*]In close collaboration with fellow NtVP Board members Miriam Lommen, Marie-Louise Meewisse, Trudy Mooren and Maartje Schoorl.

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resolver estas diferencias, como el nuevo curriculum de entrenamiento de la ESTSS para los proveedores de atención a lo largo de Europa son discutidas brevemente.

欧洲的创伤和创伤护理

欧洲国家有遭受大规模创伤的久远历史。在20世纪90年代早期，精神卫生界内越来越意识到创伤的后果，导致了在欧洲各个地区性创伤心理学会和欧洲创伤应激研究学会（European Society of Traumatic Stress Studies；ESTSS）的成立，该学会将于2018年庆祝其成立25周年。本文旨在描述在已建立ESTSS子协会的15个欧洲国家中创伤幸存者护理的当前状况。首先是对每个国家创伤的历史负担的简要描述，之后概述了各国创伤幸存者的护理系统的概述，干预措施的最新技术，护理幸存者面临的的当前挑战以及将来最迫切需要解决的问题。来自不同国家的报告展示了，在欧洲是如何实现为创伤幸存者提供更好的护理。鉴于大陆的文化和经济多样性，欧洲国家之间也存在差异，例如在循证治疗的使用上。我们简要讨论了克服这些差异的策略，例如为跨欧洲的护理服务提供者的新ESTSS培训课程。

1. Introduction

Exposure to trauma is common (Kessler et al., 2017) and its consequences on the individuals and communities affected can hardly be overestimated. In Europe, as in other regions of the world, a high burden of trauma is related to human-made events. In the twentieth century, military conflict took place during every single year in the European region and many of them affected numerous countries (see Table 1). Mass traumatization was also related to military conflicts associated with European colonialism, or conflicts in other continents where European military forces were involved in conflicts (see Table 2). Another massive burden of trauma across Europe resulted from the Holocaust and, throughout most of the twentieth century, from the political oppression by the Soviet communism. Trauma has occurred and still occurs in many societal contexts. For example, these include the familial and institutional abuse of children, different forms of gender-based violence in the European societies, various forms of institutional violence (i.e. in detention facilities of some countries) and also large-scale disasters and terror attacks that struck individual countries. Finally, over the last decades, an increasing number of migrants have reached the European countries, due to war and violence in their homeland (Hall & Olff, 2016; Kartal & Kiropoulos, 2016; Knaevelsrud, Stammel, & Olff, 2017; Munz & Melcop, 2018).

In the last two decades of the twentieth century, the increasing awareness of the consequences of trauma in the mental health community led to the foundation of local working groups and societies for psychotraumatology in several European countries. The European Society of Traumatic Stress Studies (ESTSS), which celebrated its 25th anniversary this year, was founded in 1993. Over two decades, ESTSS was an organization that included both member societies and individual members, which in the first years mainly came from western European countries. Recently, ESTSS has developed into an umbrella organization of the European societies for traumatic stress. This change is the result of a strategic plan that has been pursued over a longer period of time (Gersons, 2013). The ESTSS board consists of representatives from all member societies, which facilitates the work towards common strategic aims, such as promoting a standard curriculum for training in psychotrauma across Europe. In 2018, ESTSS com-

Table 1. Examples of military conflicts in Europe.

Year	Military conflict	Countries affected
1914–1918	First World War	Paneuropean
1917–1922	Soviet revolution	Former Soviet countries
1936–1939	Spanish civil war	Spain
1939–1945	Second World War	Paneuropean
1944–1953	Lithuanian partisan war against Soviet occupation	Lithuania
1968–1998	The Northern Ireland Troubles	UK, Republic of Ireland
1991–2000	Wars following the dissolution of former Yugoslavia	Slovenia, Croatia, Bosnia and Herzegovina Serbia, Montenegro, Kosovo
Since 1990	Military conflicts/wars in the South and North Caucasus	Georgia, Armenia, Azerbaijan and Russia (including North Caucasian region of Russia)
2008	Russian-Georgian war	Georgia, Russia
Since 2014	Conflict in East Ukraine	Ukraine, Russia

The list of military conflicts and countries involved is not all inclusive.

Table 2. Examples of military conflicts outside of Europe.

Year	Military conflict	European countries affected
1945–1949	War in the former Dutch East Indies	The Netherlands
1946–1954	Vietnam war	France
1954–1962	Algeria war	France
1950–1953	Korean war	Belgium, France, Greece, Luxembourg, Netherlands, UK
1961–1974	Portuguese Colonial War in Africa	Portugal
1979–1987	Afghanistan war	Former Soviet countries, UK
1990–1991	Gulf war	Belgium, Denmark, France, Germany, Greece, Hungary, Italy, Netherlands, Norway, Poland, Portugal, Romania, Spain, Sweden, UK
2001–2014	Afghanistan war	Albania, Belgium, Croatia, Czech Republic, Denmark, France, Georgia, Germany, Italy, Lithuania, Norway, Poland, Portugal, Romania, Russia, Spain, Sweden, UK, etc.

The list of military conflicts and countries involved is not all inclusive.

prised of 13 member societies that included 15 European countries and regions. These included Austria, Belgium, Croatia, Georgia, Germany, Lithuania, Italy, The Netherlands, Poland, Portugal, Sweden, the German-speaking and the French-speaking part of Switzerland, Ukraine and the UK (www.estss.org). Moreover, ESTSS had 12 additional affiliated societies and institutions in 2018. The society is constantly working towards the inclusion of further European societies and actively supports the formation of new societies in countries where they do not exist yet, as currently happened in Finland where the Finish Society for Psychotraumatology was launched in 2018.

While a series of articles at the occasion of ESTSS' twentieth anniversary focused on the inspiring and often also entertaining recollections of former presidents on the development of ESTSS (Lueger-Schuster, 2013b), the focus of this article is on the current member societies of ESTSS and on the development of trauma care in the respective countries. After some reflections on the historical burden of trauma in each country, representatives from all the national societies describe the structure of care organizations for trauma survivors, the state-of-the-art of interventions, current challenges in caring for survivors and the topics that need to be most urgently addressed in their countries in the future.

2. Psychotraumatology in Belgium

Five to eight million deaths, perhaps even 10: this was the devastating toll of the conquest and colonial exploitation of the Belgian Congo with King Leopold II, between the 1880s and the First World War (Hochshild, 1998). All traces of this Genocide remained secret until the early 1980s. Concerning the historical burden of the two World Wars (Manfred, 2015), it is the First World War more than the Second World War which, in the collective memory, constitutes a great trauma because of the looting of the country and the massacre of more than six thousand civilians. Recent events that stay more broadly in the mind of the Belgian people include the Heysel Drama in 1985 and the Dutroux affair with the sexual abuse, sequestration and death of young children and adolescents in 1996. In March 2016, the terrorist attacks at the national airport and in the metro of Brussels caused the death of 35 persons (Deschepper et al., 2018). Psychosocial structures vary across the country and have little or no coordination between them. One of the reasons is a difference between the functioning of French- and Flemish-speaking communities. Some structures can be found in both the French- and the Flemish-speaking communities. For instance, Public Welfare Centres and police victim services can be found in both of them. The integration of a psychosocial dimension into emergency and intervention plans was formalized in 2006. For the last 20 years, psychotherapists and other clinicians working in private practices started to specialize in trauma care for survivors. More and more specifically trained psychologists are working in hospitals and mental health centres. Recently, the development of outpatient trauma treatment centres linked to hospitals is evident. Some centres for the provision of trauma care for refugees were established in Brussels and cover the Dutch- as well as the French-speaking part of the country. In 2017, the High Council on Health received a Ministerial request for an opinion on the psychological care and support of persons following terrorist incidents or related disasters.

Until recently, there were no trauma-focused intervention methods in use in Belgium. The main therapeutic currents, for instance cognitive behavioural therapy (CBT) and psychodynamic therapies, were putting their own accents on working with trauma. In 2006, the BIP (Belgian Institute for Psychotraumatology) started the first psychotraumatology course. More trauma centres were created in the following years in principle cities, mainly Antwerp and Brussels. The course is organized in collaboration with two Universities. BIP organizes conferences in collaboration with other institutes or centres in Belgium. An independent Belgian trauma society needs to be created in the near future.

Current challenges in caring for trauma survivors concern the coordination of different support services. The political system in Belgium involves varying responsibilities at several levels, which makes decision-making complex. More visibility through studies on the positive impact and benefits of qualified trauma-focused care will be important. Finally, a well-structured national accreditation system should be put in place in order to continue provision of quality care for trauma survivors.

Among the topics to be most urgently addressed in the future is accessibility of services which is limited due to long waiting lists before survivors get access to psychological care in the Belgium mental health care system. Moreover, new ways of thinking about specialized trauma-care structures are needed.

3. Psychotraumatology in Croatia

The still living burden of the Second World War psychotrauma in Croatia has merged with the trauma of the Homeland War (1991–1995). Throughout the whole post-World War period there was no awareness of the consequences of trauma exposure, the issue was present neither in the health nor in public discourse. Consequently, no specific care was developed and provided. In contrast, the war in the 1990s brought about a high level of awareness of trauma and posttraumatic stress disorder (PTSD). Decades later the war-affected population reports 18% prevalence of PTSD (Priebe et al., 2010). This may be

partly due to lack of effective early trauma interventions and a number of hindering social factors, such as the prolonged economic crisis that affected more the vulnerable populations. The spin-off effect of massive trauma at the social level is a new understanding of the impact of traumatic events on physical and psychological health, as well as on communities (Corkalo Biruski, Ajdukovic, & Löw Stanic, 2014; Lončar & Henigsberg, 2007), which in turn facilitates access to specialized services by people exposed to trauma in everyday life.

Trauma survivors have access to psychiatric services in major hospitals, while veterans receive help within the three specialized regional centres and the National Centre for Psychotrauma. The cost of services are covered by universal national health insurance. Several non-governmental organizations with qualified staff provide supportive therapy to survivors of sexual assault, traffic accidents and other life threatening incidents, as well as domestic violence. The Polyclinic for the Protection of Children based in Zagreb specializes in working with traumatized children. Other facilities focus on prevention and support in the immediate aftermath of traumatic incidents, such as the Crisis Response Network maintained by the Society for Psychological Assistance (SPA).

The psychiatrists' first treatment choice is psychopharmacology. The prevalent therapeutic approach in psychiatric services for veterans is group therapy. Some veterans have been attending such groups for over 25 years. Low use of evidence-based trauma-focused therapies reflects (Schnyder et al., 2015) the prevailing traditional approach in Croatian psychiatry. Hence, traumatized populations still have poor access to effective, evidence-based trauma treatments. Training in trauma-focused CBT and EMDR is offered to practitioners, but this is not fully integrated into the helping system. With the existing high level of competencies in dynamic psychotherapy and psychopharmacology (Britvić et al., 2012), the challenge remains to develop a more stepwise approach to trauma-informed services, increase public awareness of risk and resilience factors, and to expand treatment choices to include evidence-based trauma-focused therapies and make them more available to the general populations in need. The Croatian Society for Traumatic Stress (CSTS) has been working on this challenge since it was founded in 2011 by organizing training workshops. It is currently promoting the ESTSS certified training in psychotrauma for mental health providers. One of the ambitions is to further integrate such training into university curricula so that future generations of mental health professionals are able to provide state-of-the-art care to traumatized people. Similarly, basic and intermediate levels of trauma-related knowledge and skills will be made more available to first responders and other health professionals.

4. Psychotraumatology in France

According to the World Mental Health survey, 72.7% of the French population has been exposed to traumatic events in their lifetime (Husky, Lépine, Gasquet, & Kovess-Masfety, 2015). Intimate partner violence, serious illness of a child and rape were the events associated with highest risk of PTSD. While rape is underreported in France, each year nearly 100,000 individuals claim to be survivors of rape or attempted rape and 500,000 claim to be survivors of intimate partner violence. A fifth of the French population was exposed to war-related events (mainly the Second World War). The twenty-first century was scarred by numerous Islamism extremist attacks, of which the November 2015 Paris attacks have been the bloodiest to date, resulting in more than 264 dead and 914 injured individuals. Traffic fatalities decreased in the past decades, reaching 5.1 per 100,000 inhabitants per year.

Since 1995, medico-psychological emergency units (CUMP for 'Cellules d'Urgence Médico-Psychologiques') are deployed in the case of mass casualty situations and provide immediate psychological support and care. These units were very effective after terror attacks in Paris and Nice, supporting thousands of survivors over many weeks (Hirsch et al., 2015). Psychological assistance aims at providing survivors with an entry point to psychological health care and giving them a first sense of relief, even though they do not provide psychological follow-up care (Vandentorren et al., 2018). In order to ensure long-term high-quality trauma care to all survivors in need across the country, President Emmanuel Macron in November 2017 announced the creation of about 10 ambulatory services specialized in trauma care. These services are aimed at providing medical and psychological care to survivors (minors or adults) that have experienced violence or any traumatic event during their lifetime.

The traditional psychodynamic approach is gradually but slowly replaced by structured trauma-focused psychotherapies, such as CBT or EMDR, and also new technologies (e-PTSD) are being introduced (Bourla, Mouchabac, El Hage, & Ferreri, 2018). However, the provision and access to treatment remain limited by the fact that there is a limited number of experienced trained trauma therapists and that care centres are not always clearly identified or equitably distributed across the country.

The challenges in caring for survivors are to achieve universal access to prevention, improve access to trauma-focused psychotherapies and ensure coordination of specialized care and support. One major challenge is to expand public funding of structured psychotherapies by trained psychologists. It is advisable to ease access to structured trauma-focused

therapies as part of mental health care programmes in compliance with international guidelines. In the end, patients should benefit from personalized treatment strategies for their trauma-related disorders, based on objective information.

The future ambulatory care services specialized in trauma will have to structure the organization of care, to establish a single French umbrella society (involving the national trauma centre and psychotrauma societies such as AFORCUMP-SFP, ALFEST and ABC des Psychotraumas), to be involved in qualifying training curricula, and to set up a French certification committee connected to the ESTSS accreditation committee, in order to meet modern European and international standards.

5. Psychotraumatology in Georgia

Georgia is a post-Soviet country, with a population of approximately 3.3 million. Since becoming independent in the early 1990s, it went through a prolonged series of civil war and ethnic-political conflicts followed by a war with Russia in 2008 and loss of control over more than 20% of the country's territory. Ongoing social, political and economic crises create pressure on the population, 20.6% of whom live under the poverty level and 7.3% of whom are internally displaced. Among the conflict-affected population, 23.3% suffer from PTSD symptoms, 14.0% from depression, 10.4% from anxiety and 12.4% have more than one mental health condition (Makhashvili et al., 2014). In addition, the population still suffers from the inter-generational effects of trauma related to the Soviet invasion and totalitarian past (Javakhishvili, 2014, 2018).

The large proportion of conflict-affected population led to the build-up of trauma care capacities and corresponding institutional developments, i.e. trauma-focused torture victim rehabilitation centres (GCRT), functional since 2000, with the head office in the capital city Tbilisi and branches in eastern and western Georgia. The multidisciplinary teams provide free of charge care for their clients that include forced migrants, ex-prisoners and others. There are a number of non-governmental organizations providing trauma-informed psychosocial services to socially disadvantaged groups, including forced migrants, domestic violence survivors and other target groups.

The Georgian Society of Psychotrauma (GSP) was founded in 2007 with the support of ESTSS. GSP builds capacity within the local professional community and has introduced such evidence-based treatment methods as Trauma-Focused CBT, Brief Eclectic Psychotherapy for PTSD (BEPP) and EMDR, as well as other relevant psychosocial interventions. Since 2008, GSP regularly conducts an annual international multidisciplinary conference 'Trauma and Society'. To assure capacity building and good quality care, an innovative Master Program in Mental Health was founded in 2012 at Ilia State University in Tbilisi, under the lead and with a main perspective on psychotraumatology.

The mental health treatment gap is about 90% in the country. There is a predominant focus on hospital care; community-based services are under-developed. Common mental disorders are under-recognized and under-treated by the state services. There is a need to develop a trauma-informed primary health care system, enlarge the trauma care infrastructure and establish corresponding referral pathways. Another challenge is low awareness of one's own mental health condition. According to a recent study, of those who suffered from mental health symptoms, only 24.8% sought care, 19.6% acknowledge mental health problems but did not seek care, and 54% did not acknowledge mental health problems (Chikovani et al., 2015).

Since most trauma survivors belong to socially disadvantaged groups who are often exposed to multiple traumatization as well as a series of everyday life stressors, we rarely find among these patients simple PTSD. The most widespread trauma-related condition are complex posttraumatic disorders. Therefore, the most urgent need is to evaluate effective methods of addressing complex trauma conditions. From 2016 to 2018, within the framework of an Erasmus Plus cooperation, the Trauma-Focused Cognitive-Behavioural Therapy Train of Trainers (ToT) module was developed, piloted and adapted to the Georgian cultural context in cooperation with Cardiff University. It has proved its effectiveness in the treatment of not only simple but also complex trauma-related disorders. There is a need to collect strong evidence to further prove the effectiveness of these approaches.

6. Psychotraumatology in the German-speaking countries

As in many European countries, the largest historical burden of trauma in Austria, Germany and Switzerland comes from the two twentieth century World Wars and the Holocaust. Over the decades, the different roles of the three countries in these catastrophic events had an influence on the perception of their traumatic impact. In contrast to Switzerland, discourses in Germany and Austria had been more focused on their role as perpetrators and their responsibility for these events. In general, Switzerland has been much less concerned by the two twentieth century World Wars than Germany and Austria. It took a longer time before the trans-generational consequences of war and displacement on parts of the German and Austrian population were also discussed (e.g. Glück, Tran, & Lueger-Schuster, 2012,

Kuwert, Brähler, Glaesmer, Freyberger, & Decker, 2009). Another population that requires expertise on psychotraumatology in the three countries is that of the refugees (e.g. Knaevelsrud et al., 2017; Spiller et al., 2017).

Services for trauma survivors are organized in a similar way in the three German-speaking countries. Non-governmental organizations play an important role in the psychosocial response to disaster and other mass incidents. Some of them also provide care for survivors of individual trauma in the form of local 'crisis intervention units' that closely collaborate with other emergency services. Specialized counselling agencies, usually funded by the local municipal authorities, offer low-threshold services for survivors of childhood abuse, sexual assault and domestic violence. In all three countries, there are also growing networks of clinical outpatient services for survivors of interpersonal violence that are frequently located at psychiatric hospitals. Psychotherapists in private practice play an important role for the treatment of posttraumatic disorders in both children and adults. Moreover, in each of the three German-speaking countries, a larger number of hospitals offer specialized inpatient care for patients with posttraumatic disorders.

The German-speaking Society for Psychotraumatology (DeGPT), the common trauma society of the three German-speaking countries (Germany, Austria and Switzerland), has developed curricula for the training of professionals in different settings (e.g. staff in counselling services, psychotherapists for children and adults) in trauma-related practices. The curricula for psychotherapists have been recognized by important national bodies, like the national chambers of physicians and psychotherapists in Germany. At present, about 50 training institutes in Germany, Austria and Switzerland offer the curricula. The society also coordinates the national German guideline for the treatment of PTSD. Such activities have contributed to the dissemination of evidence-based practices in different settings. However, as in other European countries (Kazlauskas et al., 2016), many psychotherapists still do not feel competent to deal with traumatized populations. As a result, patients can face substantial problems to find adequate help, for instance in the form of trauma-focussed interventions for individuals with PTSD.

The prevention of trauma in different settings remains a challenge. Recently, initiatives in all three German-speaking countries addressed the problem of institutional violence, e.g. in foster care settings, but more efforts are needed to sustainably implement preventive efforts and bodies like the independent commissioner into childhood sexual abuse in Germany (Bergmann, 2011). The dissemination of trauma-informed practices in all parts of the health care system and the social sector is another urgent issue. Finally, the provision of adequate care for the considerable number of migrants from contexts of war and persecution in the German-speaking countries is a challenge for the years to come.

7. Psychotraumatology in Italy

Trauma permeates the history of Italy: war, terrorism, major mass disasters, abuse and maltreatment deeply affected the Italian society across time and generations. During the Second World War, many Italians experienced the effects of torture and deportation leaving a scattered society (Favaro, Rodella, Colombo, & Santonastaso, 1999). In the 1970s, the Italian society faced the 'dark period' of *Brigate Rosse*, a terroristic group who caused many deaths and created a deep sense of fear in the population. Domestic violence is the most common crime against children; indeed, child abuse and maltreatment is a major public health problem. A recent report (Autorità Garante per l'Infanzia, CISMAI and Terre des Hommes, 2016) revealed that each year 950 children are exposed to sexual abuse. In the past year, the percentage of maltreatment and abuse increased by 6%. Italy has also experienced a significant number of natural disasters, like floods and earthquakes, that potentially increased the prevalence of post-traumatic syndromes in the communities. There are no robust data about the actual burden of such traumatic experiences and their effects on the society today.

Italian health and social care systems have not yet fully embraced a trauma-informed approach. This led to fragmented responses to the needs of survivors, especially in terms of preventive initiatives. There is some resistance to implement routine screening and assessment tools for the early detection and prevention of post-traumatic syndromes. For this reason, the system responds late and mainly to traumatization that became complex as a result of missed accurate diagnoses. It is a challenge to acquire a systemic vision of care for traumatized populations, with shared policies and protocols.

Exposure-based therapies are rarely used; EMDR is the only widely implemented intervention in the social care system at all levels. Other trauma-focused therapies (Ehring et al., 2014) – such as trauma-focused CBT or Narrative Exposure Therapy (NET; Schauer, Neuner, & Elbert, 2011) – struggle to be disseminated. Clinicians are asked to integrate different treatment approaches with a good understanding of assessment and psychoeducation techniques. Training of health and social care professionals is a key issue. In Italy, trauma is still seen as a 'psychologist/psychotherapist business', undermining the importance of multidisciplinarity. Furthermore, a synergy between clinical work and research should be

promoted to investigate the outcomes of treatment and to adapt service models accordingly.

There are a few important strategic points the Italian Society of Traumatic Stress Studies (SISST) should consider for the future. Highly traumatized migrants and refugees are one of the priorities requiring a long-term preventive plan to fight longer-term consequences for the society. The second point is the promotion of a more articulated reasoning about the implementation of evidence-based therapies. Furthermore, epidemiological studies are warranted to determine the actual prevalence and incidence of traumatic events in Italian society. Finally, another crucial issue is a comprehensive training in psychotraumatology. The new ESTSS certification represents a good opportunity for trauma-informed capacity building initiatives in the near future.

8. Psychotraumatology in Lithuania

The burden of trauma in Lithuania was largely influenced by the political situation in Europe in the twentieth century. Large-scale traumas associated with the two World Wars, the Holocaust and the prolonged Soviet occupation had a significant impact on the Lithuanian population, marked with suffering and oppression for several generations. Interest in trauma and trauma research in Lithuania was started soon after the collapse of the Soviet Union in the 1990s and several studies explored posttraumatic effects of political violence in the country (Kazlauskas & Zelviene, 2016).

Survivors of traumatic events can seek treatment for mental disorders in the public mental health care system, which includes about 100 primary mental health centres spread across the country, and in more severe cases in psychiatric hospitals. Several non-governmental organizations and crisis centres in the biggest cities in Lithuania are providing help for survivors of interpersonal violence, including psychosocial support and psychotherapy. Additionally, psychotherapists in private practice are also available for trauma survivors. Despite these positive developments, care organizations for trauma survivors are not developed in Lithuania and evidence-based trauma-focused treatments for trauma survivors are not available in the public mental health care system.

Mental health professionals are increasingly aware of the negative effects of trauma on individuals and are interested in learning new ways to help trauma survivors. There is significant progress regarding the implementation of evidence-based trauma-focused treatments, such as EMDR and BEPP, in Lithuania recently. The numbers of therapists trained in trauma-focused treatments are growing, but these treatments are not offered in the public health care system and are available predominantly in private practice which is expensive and not covered by national health care insurance.

Despite the high prevalence of traumatic experiences in Lithuania (Kazlauskas & Zelviene, 2016), it was reported that PTSD is not identified in the Lithuanian national health care system (Kazlauskas, Zelviene, & Eimontas, 2017). The lack of acknowledgment of trauma and PTSD in Lithuania is a major barrier for the development of treatments for trauma survivors in the country.

Future directions of the trauma field in Lithuania include ensuring access to evidence-based treatments for trauma survivors. There is a need of trainings for practitioners to update their knowledge about the impact of trauma, with a particular focus on how to diagnose stress-related disorders and how to provide trauma-focused treatments. Finally, health care and social policy changes on the national level are needed to acknowledge trauma survivors and include evidence-based treatments in the health care of survivors exposed to various traumas, particularly children and adolescents. The Lithuanian trauma society is taking an active role in raising awareness about the effects of trauma to facilitate the further development of care for trauma survivors.

9. Psychotraumatology in the Netherlands

The Second World War marks the largest historical burden and the starting point for psychotrauma care in the Netherlands. Occupation by German and Japanese (in the former Dutch East Indies) armed forces and subsequent post-colonial wars led to over 250,000 military and civilian lives lost. Public awareness for the psychological effects of wartime and other traumatic experiences started around 1975, with the awareness of the Holocaust. In response, Foundation Center ’45 was funded, first focusing on Second World War concentration camp survivors, but soon extending their services to other traumatized populations. The focus on post-war reconstruction, tensions between interest groups and an emphasis on heroics and the resistance, together with a poorly developed mental health care, contributed to this late societal response (Vermetten & Olff, 2013). Subsequent national and international disasters, such as the 1992 Bijlmermeer airplane disaster and the 2000 Enschede fire explosion, further increased professional and public awareness of psychotrauma, and fuelled the establishment of the Dutch Society of Psychotraumatology in 2006.

Mental health care for trauma-related disorders is covered by health insurance at little or no additional personal costs. Facilities for trauma care have been integrated at many levels of health care. Routinely, the first step for individuals with trauma-related symptoms is to consult their general practitioner for referral to secondary health care organizations.

A national standard of care for trauma- and stressor-related disorders is currently underway (Kwaliteitsontwikkeling GGZ, 2018).

Trauma-focused treatment is increasingly offered next to interventions directed at emotion regulation, day-night structure and social support (Vermetten & Olff, 2013). Examples are EMDR, CBT, NET, BEPP and Imagery Rescripting. There is a growing role for E-health interventions (e.g. Olff, 2015). Some institutions use treatment intensification (EMDR or CBT), with preliminary positive effects (Van Woudenberg et al., 2018; Zepeda Méndez, Nijdam, Ter Heide, van der Aa, & Olff, 2018). Although not yet implemented, other treatment innovations include hormonal enhancers (D-cycloserin, cortisol, oxytocin; e.g. Thomaes et al., 2016).

Effective treatment for PTSD due to events in adulthood in fairly well functioning patients seems available, as well as special services and care for the military and the police. One of the greatest practical challenges are the long waiting lists in secondary mental health care, limiting accessibility to care for vulnerable patient groups, such as individuals with multiple (childhood) traumatization, patients with severe physical, neurocognitive and/or psychiatric comorbidities or severe psychosocial problems, and (asylum seeking) refugees. The latter in particular experience difficulties accessing evidence-based care due to stigma, requirement of referral by general practitioners, and language and cultural barriers. Moreover, research on the (cost-)effectiveness of treatments for these target groups is relatively lacking (e.g. Sijbrandij et al., 2017), as well as on improving symptom recovery and treatment adherence of current PTSD treatments.

Topics which should be urgently addressed in the future include improving treatment outcome for specific target groups, i.e. patients with childhood trauma; implementing treatment for target groups that are currently excluded from regular PTSD treatments; family- or system-oriented interventions to prevent inter-generational consequences of trauma and enhance opportunities for social support; evaluation of e-mental health interventions for PTSD and comorbid disorders, including blended treatment options administered within routine clinical practice; increased use of transdiagnostic treatment options for trauma-exposed patients targeting a variety of psychopathology limiting psychosocial functioning; and the use of low-intensity interventions, carried out by non-professional helpers to increase coverage of mental health interventions.

10. Psychotraumatology in Poland

The recognition of the socio-psychological consequences of the Second World War in Poland is an extremely important issue. Poland belongs to the part of Europe which Snyder (2010) called the 'Bloodlands'. The number of ethnic Poles and Polish Jews who died or were murdered in connection to the Second World War amounted to about six million. Poland lost about 17% of its pre-war population (Materski & Szarota, 2009). Moreover, the Soviet invasion and the subsequent imposition of a communist regime led to large groups of people being persecuted. Many survivors of the war (e.g. resistance movement members, people deported to Siberia) were not even recognized as survivors, and speaking about many aspects of war experiences could lead to prosecution. Very little attention has been paid to Second World War issues in medicine and psychology, in comparison to the volume of analogous research in western countries (Lis-Turlejska, Szumiał, & Drapała, 2018). Psychological help for survivors of the war was practically absent, and the need is still not recognized today. Since the collapse of communism, neither war nor other traumas have been recognized on a broader scale. Research has been conducted on the consequences of the great flood of 1997 (Strelau & Zawadzki, 2005), however, other traumatic events, including the death of the president and other governmental officials in the Smolensk plane crash in 2010, have not yet been the subject of psychological research.

There is no coherent care system in Poland for survivors of various traumatic events. A number of crisis intervention centres provide help for 'families in crisis' – mainly for survivors of domestic violence (www.spoleczenstwoobywatelskie.gov.pl). There are non-governmental organizations working with survivors of trauma (e.g. battered women, abused children, survivors of crime). However, they are all underfunded and their capacity is limited. Access to psychotherapy under national health insurance is also limited. Despite the fact that there are many psychotherapists working privately, mainly in larger cities, there are still very few professionals who are specialized in psychotraumatology.

Crisis intervention is probably the most widely offered help to trauma survivors. Practitioners have the opportunity to be trained in different approaches in psychotherapy, including CBT, prolonged exposure therapy and EMDR. However, there is no clear emphasis on evidence-based treatments and they are not widely used in practice. There is also a lack of research on the effectiveness of trauma therapy. The issue of prevention is neglected in general, except training for professional groups (e.g. flight crews, emergency services).

Currently, the most important challenge is to increase access to professional care, specifically increasing access to therapists who offer evidence-based interventions. However, education of the general population about the importance of help seeking and potential benefits out of it is also crucial. It is necessary to further develop research on the

psychosocial consequences of both the Second World War and other large-scale traumatic events. It is also important to encourage the teaching of contemporary curricula on abnormal psychology, including content specific to trauma. This seems to be the most urgent task, alongside further development of the trauma care system and promotion of good practices in psychological care and psychotherapies for trauma survivors.

11. Psychotraumatology in Portugal

A colonial war of 13 years has left to Portugal an individual and collective traumatic heritage (Maia, McIntyre, Pereira, & Ribeiro, 2011). The consequences remain to this day through the intergenerational transmission of trauma (Dias, Sales, Cardoso, & Kleber, 2014). Throughout the years, clinicians, academics and other professionals discussed the psychosocial consequences and reactions to this trauma. Later, the coordinated response to two major accidents promoted a national approach to survivors of crisis and disaster. In 2009, the Centre for Social Studies of the University of Coimbra created the Centre of Trauma (CT), a society that brings together the country's leading organizations who directly deal with potentially traumatic events. Since 2010, CT is a full member of ESTSS.

In Portugal, the National Authority for Civil Protection provides central technical guidance to the organizations who deliver services to survivors of disasters or catastrophes. It is a governmental entity which coordinates the interventions developed and implemented by the different professional groups and organizations (fire fighters, medical emergency services, etc.). Clinical care to trauma survivals is provided by the National Health Service in the first place, but in cooperation with organizations (both non-governmental and governmental) who are specialized in trauma therapies and relevant psychosocial interventions. There is a core team of trained and certificated psychotherapists within CT whose service is accessible to people in need.

The most widespread therapy methods in Portugal are CBT, EMDR, Psychodrama and brief supportive psychotherapeutic strategies. Psychopharmacotherapy is also frequently used alone or in combination with psychological interventions. Treatment takes place in public and private health institutions. A number of governmental and non-governmental organizations currently invests in building the capacity of their staff in trauma care and designing and implementation of preventive interventions. CT is responsible for regular organization of conferences, seminars and the delivery of a biannual psychotrauma course. The course equips professionals from different fields with relevant knowledge and skills.

Professional and organizational preparation and knowledge to treat trauma consequences at the individual, family and social level needs to be optimized and updated. Minorities and refugees at risk may benefit from more integrated assistance. The ability to effectively respond to disasters and catastrophes through the provision of acute trauma care and coordination among the different organizations that are involved in disaster management has to be improved. There is room for improvement regarding the identification of populations at risk, screening for trauma related disorders and responding to the needs of the health care system. Family doctors and nurses, firemen and other professional groups have to be trained to assure their trauma-informed professional performance.

The topics to be addressed in the near future include creating a national plan for PTSD prevention and psychosocial interventions in case of crisis and disaster, as well as founding a network for specific treatment responses to trauma-related disorders, namely PTSD. Good practices have to be disseminated and young researchers and clinicians need to be motivated to work in the field of psychotraumatology. Finally, more effective and organized strategies to address potentially traumatic contexts such as unemployment, marital violence, cyber bulling and road accidents need to be developed, and the cooperative and coordinated work with national and European entities needs to be further increased.

12. Psychotraumatology in Sweden

The Swedish population has enjoyed peace for over 200 years. For a long time, the country did not experience the same increase in attention to psychotraumatology as other European countries with afflicted veteran soldiers from the nineteenth century wars. The impetus for trauma-informed services has instead come from disasters, large accidents and the increased attention to interpersonal abuse. A harrowing bus crash involving 12-year-olds on a school trip in 1988 (Arnberg et al., 2011) became the initiating event for the public organization of crisis support after large-scale events. Events such as the 1994 Estonia ferry disaster in the Baltic sea (e.g. Arnberg, Hultman, Michel, & Lundin, 2013) and the 2004 Southeast Asia tsunami (e.g. Michélsen, Therup-Svedenlöf, Backheden, & Schulman, 2017), both leading to hundreds of Swedish casualties, as well as the recent deployment of Swedish peacekeeping forces around the world, have highlighted the psychosocial consequences of trauma. More recently, the refugee crisis has set off many activities related to culturally informed trauma services.

In Sweden, every municipality has a psychosocial crisis team and there are psychosocial disaster contingency teams at the larger hospitals. A major step forward was the legislation passed in 2000 that

mandates employers to ensure that they have adequate knowledge of and plans for crisis support for their employees. Beyond the acute crisis support, however, access to qualified treatment of chronic traumatization varies across the country. In some regions there are dedicated trauma clinics; in others, there are trauma teams within the psychiatric services. Some regions lack both dedicated trauma clinics and teams.

The acute crisis interventions that are available in Sweden include Psychological First Aid, various forms of unstructured crisis support and a variety of debriefing methods including psychological debriefing (Witteveen et al., 2012). As for the treatment of PTSD, the Swedish National Board of Health and Welfare issues guidelines for public health care. In their latest guidelines from 2017 (The Swedish National Board of Health and Welfare, 2017), trauma-focused psychological treatments were given the highest priority; selective serotonin reuptake inhibitors (SSRIs) were prioritized as a potential but not necessary option for adults with PTSD, although they probably are the most widely used treatment in the country.

Several challenges lie ahead. The use of ineffective preventative interventions remains and the provision of psychosocial support beyond the acute phase is very limited, partly due to compartmentalized organizations. Further development of acute interventions in health care would benefit from robust evidence for early interventions. Trauma-related problems in patients too often go undetected in health care assessments (Al-Saffar, Borgå, & Hällström, 2002). In addition, access to prioritized treatments is underdeveloped in many parts of Sweden: the concentration of relevant competence in metropolitan areas is a salient issue in this country due to its large rural areas.

Another challenge related to the treatment of PTSD is that a large proportion of therapists are due for retirement in the next five years. It will become important for the field to continue to attract younger professionals. It is hoped that a stronger professional community, aided by the Swedish Society for Psychotrauma, can prevent fragmentation of the many regional initiatives, particularly in light of the many refugees across the country, and serve as a force for increasing the quality of and access to trauma treatments.

13. Psychotraumatology in Ukraine

The historical burden of trauma in Ukraine mainly consists of man-made catastrophes. They include the famines in the years 1933 and 1947, the Second World War, the explosion of the Chernobyl nuclear power station, and the current military conflict with Russia, which is officially called 'Anti Terrorist Operation (ATO)'. All events that happened during the Soviet times were hushed up and psychological support has never been provided to the people in need. It was not until the Maidan revolution and the beginning of the current war that psychological services in Ukraine were organized for victims of mass violence.

In Ukraine, care organizations for trauma survivors are currently under development. It presupposes an effective coordination of governmental and non-governmental organizations and professional institutions. The non-governmental organization Ukrainian Society for Overcoming the Consequences of Traumatic Events (USOCTE) was created to reach that aim. This professional organization aims at the development of crisis intervention services as well as capacity for provision of trauma-focused psychological therapies in Ukraine, in accordance with the international standards. Currently, USOCTE provides psychological help to wounded ATO soldiers and veterans, as well as other people who suffer from consequences of the ATO: those living in the ATO zone, internally displaced persons, families of killed soldiers and participants of the Maidan revolution. USOCTE is also engaged in developing training programmes for psychologists and psychoeducational materials for the general population. The methods used in trauma care are EMDR, CBT and the SEE FAR CBT treatment protocol of the Israeli coalition of trauma.

These treatments are offered in a strictly structured way. All clients sign an agreement, which determines the focus of the therapy. According to that agreement, a client has a right to attend 12 free-of-charge sessions. The first sessions are devoted to a detailed diagnostic interview, psycho-education on the signs and nature of posttraumatic disorders and providing information on therapeutic approaches. The following stabilization phase is intended to create a sense of safety by means of different techniques. It is followed by the trauma-focused interventions mentioned above. The final phase of treatment has the aim to integrate the experiences into daily life, assess the results and adapt to the achieved changes.

Challenges in this work are the very high level of psychological disturbance among the people living close to the conflict zone, and their reluctance to acknowledge this and to ask for psychological support (Roberts et al., 2017). It should also be mentioned that women are especially vulnerable on the front-line territory, and suffer multiple problems including high levels of psychological violence. These problems are often not recognized and the population has a tendency to believe that the end of military activities will solve all problems.

To overcome the consequences of the current military conflict in Ukraine, USOCTE is confronted with a number of tasks. They include building up a multilevel system of psychological assistance with the support of governmental and non-governmental organizations as well as monitoring and evaluating the activities of specialists in the psychological field on a regular basis. Moreover, the local communities need to be involved in supporting the aggrieved. Finally, there is a need for a more intensive cooperation and sharing of experiences with international organizations.

14. Psychotraumatology in the UK and Northern Ireland

The 2014 Adult Psychiatric Morbidity Study (APMS) provides the most comprehensive estimates of PTSD within the UK, although the sample is of English residents only (Fear, Bridges, Hatch, Hawkins, & Wessely, 2014). APMS found a PTSD prevalence of 4.4%, with similar rates observed between men and women. PTSD rates in women declined with increasing age; 12.5% of 16–24-year-old women had PTSD. In contrast, in men PTSD remained roughly consistent until declining from age 65. Northern Ireland (NI) has historically experienced a sustained period of political conflict known as the Troubles. The NI Study of Health and Stress identified that NI has one of the highest global rates of PTSD with lifetime and 12 month prevalence rates of 8.8 and 5.1%, respectively (Bunting et al. 2013). Lifetime prevalence in NI females (11%) was substantially higher than the rates in NI men (6.4%). Although there is no specific information on prevalence rates in Scotland and Wales, it is anticipated they are similar to English rates.

The UK's mental health services are provided by the National Health Service (NHS). Although regional variations exist, the first point of access is via family doctors. Community services, often available via self-referral, typically treat survivors of single incident traumas where a diagnosis of PTSD is present without co-morbid problems (e.g. substance misuse). Treatment of more complex cases (e.g. survivors of child abuse, refugees, etc.) is via specialist mental health teams. NHS treatment complies with best practice guidelines compiled by the National Institute for Health Care and Excellence. A range of other non-governmental organizations exist that are staffed by qualified health professionals and offer support to sub-populations of trauma survivors (e.g. survivors of domestic abuse, veterans, etc.). In NI, a Regional Trauma Service is under development to address the mental health legacy of the Troubles.

Interventions to treat PTSD in the UK are typically trauma-focused psychological therapies such as, but not limited to, trauma-focused CBT, EMDR and prolonged exposure (NICE, 2005). In addition, psychopharmacology support is given to manage co-morbid mental health presentations. Increasingly, e-technologies are being developed to help provide cost-effect support that also promote accessibility. For example, an online guided self-help tool for PTSD has been developed and internet-based video technologies have been successfully used to deliver PTSD treatments with much reduced therapist time required. Some providers also utilize compressed therapy where 16–-20 hours of TF-CBT are delivered over a week.

Currently, whilst there is often some delay in accessing specialist mental health assessment services, the biggest bottleneck is in the provision of specialist services for more complex cases of PTSD. Also, whilst APMS has shown that help-seeking for PTSD is improving, the majority of people with PTSD in the UK still do not seek any help.

Whilst, the UK has made considerable efforts to improve the public understanding of mental health, more needs to be done. Additionally, organizations which routinely expose staff to trauma (such as the emergency services, military and child social workers) need to address the issue of PTSD as a result of chronic trauma exposure as there has been limited work done on this topic.

15. Conclusion

The perspectives above show that important steps towards a better provision of care for survivors of trauma have been taken in the European countries. Given the cultural and economic diversity of the continent, there are still some differences between the countries, for instance with regard to the use of evidence-based treatments. Effective treatments have many elements in common (Schnyder et al., 2015) and the treatment of choice is often based on culture and history. The dissemination of evidence-based knowledge and skills has always been a priority of ESTSS (Ajdukovic, 2013, Bisson, 2013, Olff, 2013) and further strategic steps towards this aim have been made recently. In 2018, the first of a series of new ESTSS curricula, the 'Advanced Training in Treating Posttraumatic Disorders in Adults', was approved by the board. The curriculum comprises 120 hours of training and 20 hours of case supervision. It has a strong focus on evidence-based approaches and provides knowledge and skills for the treatment of acute stress disorder, non-complex PTSD and complex posttraumatic disorders (for more detail see www.estss.org). The curriculum has already been adopted by several member societies who are building up local structures to offer the trainings or adopt their national curricula to meet the requirements of the ESTSS curriculum. Other

curricula, for instance for the treatment of trauma-related disorders in children and adolescents, and more basic curricula to promote the idea of trauma-informed care among different groups of professionals, are currently being developed.

The country reports presented in this paper show that many countries share similar challenges and have topics in common that need to be addressed. These topics include, among others, the prevention of trauma, the promotion of trauma-informed practices in the whole health care system and standards of care for groups with special needs, including refugees and internally displaced people. Of increasing importance in the field of mental health is the involvement of trauma survivors in mental health care teams (Van der Schrieck-De Loos, 2013). It was beyond the scope of this paper to describe the large amount of research in the field of psychotraumatology in the European countries, which represents a significant proportion of the global research activities in this field (Olff, 2018). However, similar to the differences with regard to the use of evidence-based treatments, these activities are not evenly distributed between the different European countries. It is part of ESTSS's mission to stimulate and promote research Europe wide.

The current structure of ESTSS allows for a more direct exchange between the member societies and thereby provides the opportunity to effectively address such common issues. It has always been the aim of the society to provide a platform for all professionals in Europe in the field of psychotraumatology to connect, to develop together training and research, guidelines and actions where needed. ESTSS is constantly working towards this aim, for instance by identifying successful models in individual countries or regions and disseminating these experiences among all others. A recent example of this exchange is a series of movies providing information on the consequences of trauma and effective treatments tailored to the needs of the public, professionals from the health care system and trauma survivors that can be downloaded from the ESTSS website. They were developed by a national society (DeGPT) and translated into 10 European languages with the help of other member societies.

ESTSS can look back on 25 years of advocacy for the field of psychotraumatology in Europe. The first European Conference on Traumatic Stress, which can be considered one of the roots of ESTSS, was held three decades ago (Ørner, 2013). During these years, ESTSS has developed a unique profile as a truly international professional society that integrates the diversity of the European countries and greatly benefits from their cultural richness (Lueger-Schuster, 2013a; Olff, 2013). An important part of the society's success story are the ESTSS conferences that attract delegates from all parts of the world. Other important activities included projects like the European Network of Traumatic Stress (TENTS; Bisson, 2013) and the *European Journal of Psychotraumatology* (EJPT). EJPT has become an important platform for the dissemination of knowledge related to psychological trauma and, thanks to the relentless efforts of its founding editor Miranda Olff, has become one of the journals with the highest impact in the field (Olff, 2018).

Over the years, ESTSS had fruitful collaborations with large societies from other regions of the world. There is also a strong involvement of ESTSS in the global collaboration of trauma societies, an initiative that had initially been proposed by the International Society for Traumatic Stress Studies (ISTSS; Schnyder et al., 2017) and developed to a collaboration of all large trauma societies on an equal basis. It already has the function of a global umbrella for defined projects and holds promise to become a more formal global structure.

Only about half of the more than 40 countries on the European continent have established local trauma societies so far, most of which are members of ESTSS. In the coming decades, it will remain one of the most important aims of ESTSS to support the formation of new societies in countries where they do not exist yet, and to provide a common platform and a professional home for trauma specialists from the whole European region.

In their articles at the occasion of the twentieth anniversary of ESTSS, several former presidents described what some of them called the 'infancy and adolescence' of the society (Schnyder, 2013, Turner, 2013). At the age of 25 years, ESTSS has become a young adult. The society has 'grown up' and, with the latest change of its structure, has completed a developmental process that made it stronger and prepared it for the tasks ahead. This would not have been possible without the enthusiasm of a large number of dedicated colleagues from all over Europe. They invested their time and energy over the last 25 years to make the society what it is today. We congratulate ESTSS on its 25th birthday and strongly believe that it will successfully continue its 'adult life' for the good of psychotraumatology in Europe.

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ORCID

Evaldas Kazlauskas http://orcid.org/0000-0002-6654-6220
Marit Sijbrandij http://orcid.org/0000-0001-5430-9810
Małgorzata Dragan http://orcid.org/0000-0001-8221-2012
Margarida Figueiredo-Braga http://orcid.org/0000-0003-2374-4371
Filip Arnberg http://orcid.org/0000-0002-1317-2093
Cherie Armour http://orcid.org/0000-0001-7649-3874
Dominic Murphy http://orcid.org/0000-0002-9596-6603

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Violence Prevention
A Public Health Issue
Child Abuse & Neglect
Fast Facts
Risk and Protective Factors
Prevention Strategies
Adverse Childhood Experiences
Fast Facts
CDC-Kaiser ACE Study
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Suicide
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Data Sources
Communication Resources

About the CDC-Kaiser ACE Study

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being.

The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors.

More detailed information about the study can be found in the links below or in the article, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults ,".

Open All Close All

The ACE Pyramid +

Study Questionnaires +

Data and Statistics +

Major Findings +

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Child abuse and neglect

CHILD ABUSE AND NEGLECT

In Western Australia, under the *Children and Community Services Act 2004,* a child is a person under the age of 18 years.

There are generally five types of child abuse and neglect, which may co-exist:

- physical abuse
- sexual abuse
- emotional abuse
- psychological abuse
- child neglect.

Publication: How do I recognise when a child is at risk of abuse or neglect?

Child development and trauma guide

The *Child development and trauma guide* has been developed to assist practitioners to understand typical developmental pathways of children and recognise indicators of trauma at different ages and stages.

Importantly, the resource offers practical, age appropriate advice as to the needs of children, parents and carers when trauma has occurred, and ways in which children and families can be assisted in healing and recovery.

The *Child development and trauma guide* covers the following age groups:

- 0 to 12 months
- 12 months to 3 years
- 3 to 5 years
- 7 to 9 years
- 9 to 12 years
- 12 to 18 years.

Resources

What to do... when you are concerned that a child is being abused or neglected
A3 poster

How do I recognise when a child is at risk of abuse or neglect?
Outlines the five main types of child abuse and neglect.

What does it mean?
A guide for families and carers about how the Department for Child Protection helps keep children safe.

Protecting children
Information for parents, families and friends.

Keeping our kids safe
For aboriginal families and communities.

FEATURE

Growth after trauma

Why are some people more resilient than others—and can it be taught?

By Lorna Collier
November 2016, Vol 47, No. 10
Print version: page 48

As Kay Wilson struggled to make her way through a Jerusalem forest after being repeatedly stabbed by a Palestinian terrorist, she distracted herself from her agony by playing the song "Somewhere Over the Rainbow" in her mind, composing a new piano arrangement while she fought for breath and forced herself to put one bare foot in front of the other.

Wilson, then 46, had been working as a tour guide when, on Dec. 18, 2010, she and a friend were ambushed by terrorists. Wilson witnessed her friend's murder and was herself viciously stabbed with a machete, ultimately playing dead as her attacker plunged his knife into her chest a final time.

She eventually recovered from her severe physical wounds and is healing from her psychological trauma. She now speaks to global audiences about her survival, hoping to "dispel hatred, whether toward Arabs or Jews."

The work "helps me make meaning out of something so senseless," says Wilson, who is also writing a book about her experiences.

After the attack, Wilson had flashbacks and deep survivor's guilt. But like many people who have survived trauma, she has found positive change as well—a new appreciation for life, a newfound sense of personal strength and a new focus on helping others.

Post-traumatic growth (PTG) is a theory that explains this kind of transformation following trauma. It was developed by psychologists Richard Tedeschi, PhD, and Lawrence Calhoun, PhD, in the mid-1990s, and holds that people who endure psychological struggle following adversity can often see positive growth afterward.

"People develop new understandings of themselves, the world they live in, how to relate to other people, the kind of future they might have and a better understanding of how to live life," says Tedeschi.

How can clinicians use PTG theory to help patients? How has new research helped refine understanding of it? Here's a look at developments in the field.

Signs of post-traumatic growth

PTG can be confused with resilience, but the two are different constructs (see "The post-traumatic growth inventory" below).

"PTG is sometimes considered synonymous with resilience because becoming more resilient as a result of struggle with trauma can be an example of PTG—but PTG is different from resilience, says Kanako Taku, PhD, associate professor of psychology at Oakland University, who has both researched PTG and experienced it as a survivor of the 1995 Kobe earthquake in Japan.

"Resiliency is the personal attribute or ability to bounce back," says Taku. PTG, on the other hand, refers to what can happen when someone who has difficulty bouncing back experiences a traumatic event that challenges his or her core beliefs, endures psychological struggle (even a mental illness such as post-traumatic stress disorder), and then ultimately finds a sense of personal growth. It's a process that "takes a lot of time, energy and struggle," Taku says.

Someone who is already resilient when trauma occurs won't experience PTG because a resilient person isn't rocked to the core by an event and doesn't have to seek a new belief system, explains Tedeschi. Less resilient people, on the other hand, may go through distress and confusion as they try to understand why this terrible thing happened to them and what it means for their world view.

To evaluate whether and to what extent someone has achieved growth after a trauma, psychologists use a variety of self-report scales. One that was developed by Tedeschi and Calhoun is the Post-Traumatic Growth Inventory (PTGI) (*Journal of Traumatic Stress*

, 1996). It looks for positive responses in five areas:

- Appreciation of life.
- Relationships with others.
- New possibilities in life.
- Personal strength.
- Spiritual change.

The scale is being revised to add new items that will expand the "spiritual change" domain, says Tedeschi. This is being done "to incorporate more existential themes that should resonate with those who are more secular" as well as reflect cross-cultural differences in perceptions of spirituality.

A predisposition for growth?

How many people experience PTG? Tedeschi prefers not to put a hard number on it.

"It all depends on the trauma, the circumstances, the timing of the measurement ... [and] on how you define growth using the PTGI, looking at total score, means, factors or individual items," he says. However, he estimates that about one-half to two-thirds of people show PTG.

Some PTG researchers have tried to corroborate self-reported growth by questioning friends and family members about whether growth "sticks."

"We are getting more studies that show that PTG is generally stable over time, with a few people showing increases and a few showing decreases," Tedeschi says. "It is now up to us to learn what is going on with those who change over time, but the evidence is for stability in general, and also corroboration by others."

There appear to be two traits that make some more likely to experience PTG, says Tedeschi: openness to experience and extraversion. That's because people who are more open are more likely to reconsider their belief systems, says Tedeschi, and extroverts are more likely to be more active in response to trauma and seek out connections with others.

Women also tend to report more growth than men, says Tedeschi, but the difference is relatively small.

Age also can be a factor, with children under 8 less likely to have the cognitive capacity to experience PTG, while those in late adolescence and early adulthood—who may already be trying to determine their world view—are more open to the type of change that such growth reflects, says Tedeschi.

There also may be genetic underpinnings for PTG, but researchers are just beginning to tease this out. In a 2014 study in the *Journal of Affective Disorders*, for example, Harvard social and psychiatric epidemiologist Erin Dunn, ScD, and a team of researchers examined data previously collected from over 200 Hurricane Katrina survivors and found that variants in the gene RGS2 significantly interacted with levels of exposure to the hurricane to predict PTG. RGS2 is linked to fear-related disorders, such as post-traumatic stress disorder, panic disorder and anxiety.

Dunn calls the results "very interesting" but notes that "we have to be somewhat cautious in interpreting it because we were unable to find a similar sample to replicate that finding."

Sarah Lowe, PhD, of Montclair State University, who worked with Dunn on the research, says one difficulty with gene studies for PTG is the concept's complexity. "If you look at what predicts PTG, it is often psychological stress and dysfunction—but also more positive personality traits like optimism and future orientation, which you'd expect would have a very different genetic basis," she says.

Theory into practice

Is it possible to prepare people for PTG, to pave the way should tragedy or trauma strike? Yes, says Tedeschi, noting that psychologists can "allow people to understand that this may be a possibility for themselves" and is a "fairly normal process" if and when trauma occurs.

More often, though, therapists will become involved not before adversity has occurred, but afterward. In this context, they can introduce PTG concepts but need to take care doing so.

H'Sien Hayward, PhD, cautions that therapists should not "jump right into the possibility of growth," which she says can "often be construed as minimizing someone's pain and suffering and minimizing the impact of the loss."

Hayward, who works with veterans at VA Long Beach Medical Center in Long Beach, California, knows about such growth firsthand: She was paralyzed in a car accident when she was 16, ending a competitive athletic career. She overcame that trauma through the help of supportive family and friends, went on to study social psychology at Harvard and has traveled to more than 42 countries, often on humanitarian missions providing counseling and other support to trauma victims. Today, she credits the accident for increasing her strength of character "exponentially" by forcing her to overcome challenges. She also appreciates life and relationships with others—including the near-daily support in the small tasks of daily living that she gets from friends and strangers alike: "those interactions warm my heart."

Yet Hayward is careful not to preach the potential for upside to her patients before they are ready. Instead, she waits for them to express "some positive reaction to the event."

She also helps patients discover what's meaningful in their lives and then helps them schedule activities involving these interests, such as spending more time with family members or doing volunteer work.

Tedeschi says sometimes traditional therapy for trauma patients gives people short-fix solutions to help them resume daily functions, such as sleep or work, but may not provide them with a way of living "beyond just getting by ... We've got to attend to their experience of life and how meaningful, satisfied and fulfilling it is."

One veterans' care facility that takes a nontraditional, PTG approach to trauma treatment is Boulder Crest Retreat in Bluemont, Virginia. The private, donor-supported institute provides free, weeklong nonclinical exercises and activities for vets seeking recovery from combat stress. The treatment is led primarily by veterans who have themselves gone through trauma and achieved growth. Vets are encouraged to deal with past traumas while also discovering their underlying strengths, as well as forging connections with others and ultimately finding ways to give back.

After the intensive program, vets are followed for 18 months with regular Skype check-ins.

Kevin Sakaki, a former Marine and intelligence/special operations veteran, entered Boulder Crest's Warrior program last September and found it transformative. He's noticed such changes in himself as better communication with his family, less anger ("Things don't get to me as much"), a deeper appreciation of "the little things," more generosity and a stronger connection to other people.

Tedeschi is among the psychologists studying the Boulder Crest program's efficacy as part of a research grant funded by the Marcus Foundation.

He hopes that as vets go through the process at Boulder Crest, they "develop new principles for living that involve altruistic behavior, having a mission in life and purpose that goes beyond oneself, so that trauma is transformed into something that's useful not only for oneself but for others."

For further references go to our digital edition to connect directly to the research cited in this article: www.apa.org/monitor/digital.

The post-traumatic growth inventory

To evaluate whether and to what extent someone has achieved growth after a trauma, psychologists look for positive responses in five areas.

1: Appreciation of life

2: Relationships with others

3: New possibilities in life

4: Personal strength

5: Spiritual change

Source: Richard Tedeschi, PhD, and Lawrence Calhoun, PhD, *Journal of Traumatic Stress*, 1996

RELATED ARTICLES

- How to foster resilience

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TRAUMA TYPES

ABOUT CHILD TRAUMA

TRAUMA TYPES

- Bullying
- Community Violence
- Complex Trauma
- Disasters
- Early Childhood Trauma
- Intimate Partner Violence
- Medical Trauma
- Physical Abuse
- Refugee Trauma
- Sexual Abuse
- Terrorism and Violence
- Traumatic Grief

POPULATIONS AT RISK

When a child feels intensely threatened by an event he or she is involved in or witnesses, we call that event a trauma. There is a range of traumatic events or trauma types to which children and adolescents can be exposed.

Bullying

Bullying is a deliberate and unsolicited action that occurs with the intent of inflicting social, emotional, physical, and/or psychological harm to someone who often is perceived as being less powerful.

view

Community Violence

Community violence is exposure to intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim.

view

Complex Trauma

Complex trauma describes both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure.

view

Disasters

Natural disasters include hurricanes, earthquakes, tornadoes, wildfires, tsunamis, and floods, as well as extreme weather events such as blizzards, droughts, extreme heat, and wind storms.

view

Early Childhood Trauma

Early childhood trauma generally refers to the traumatic experiences that occur to children aged 0-6.

view

Intimate Partner Violence

Intimate Partner Violence (IPV), also referred to as domestic violence, occurs when an individual purposely causes harm or threatens the risk of harm to any past or current partner or spouse.

view

Medical Trauma

Pediatric medical traumatic stress refers to a set of psychological and physiological responses of children and their families to single or multiple medical events.

view

Physical Abuse

Physical abuse occurs when a parent or caregiver commits an act that results in physical injury to a child or adolescent.

view

Refugee Trauma

Many refugees, especially children, have experienced trauma related to war or persecution that may affect their mental and physical health long after the events have occurred.

view

Sexual Abuse

Child sexual abuse is any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer.

view

Terrorism and Violence

Families and children may be profoundly affected by mass violence, acts of terrorism, or community trauma in the form of shootings, bombings, or other types of attacks.

view

Traumatic Grief

While many children adjust well after a death, other children have ongoing difficulties that interfere with everyday life and make it difficult to recall positive memories of their loved ones.

view

The NCTSN is funded by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services and jointly coordinated by UCLA and Duke University.

SCHOOLS

TRAUMA-INFORMED SYSTEMS

Child Welfare

Schools

Essential Elements

NCTSN Resources

Justice

Healthcare

CULTURE AND TRAUMA

FAMILIES AND TRAUMA

FAMILY-YOUTH-PROVIDER-PARTNERSHIPS

SECONDARY TRAUMATIC STRESS

Children's reactions to trauma can interfere considerably with learning and behavior at school. Schools serve as a critical system of support for children who have experienced trauma. Administrators, teachers, and staff can help reduce the effects of trauma on children by recognizing trauma responses, accommodating and responding to traumatized students within the classroom, and referring children to outside professionals when necessary. The National Child Traumatic Stress Network has developed tools and materials to help educators, school staff, and administrators understand and respond to the specific needs of traumatized children.

Essential Elements

The primary mission of schools is to support students in educational achievement. To reach this goal, children must feel safe, supported, and ready to learn.

view

NCTSN Resources

The following resources on Schools were developed by the NCTSN.

view

The NCTSN is funded by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services and jointly coordinated by UCLA and Duke University.

carepath

Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material MODULES – French Version

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CarePath: Trauma-informed leaving care support empowering public authorities and professionals

CarePath - CP01-FRx
Started - 3 feb 2020

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CarePath: Trauma-informed leaving care support empowering public authorities and professionals

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- Pre-course survey
  - Au propos de vous
    - Pre-course survey
- 1. La base theorique
  - Introduction
    - Introduction et clause de non-responsabilité
  - La base theorique
    - Qu'entend-on par "une relation d'aide"
    - le différentiel de pouvoir, les risques de la passivité apprise
    - S'adapter
  - Les denominateurs communs de l'efficacite
    - Se concentrer sur la maladie ou sur le développement du potentiel humain ?
    - Mettre la personne au centre pour une plus grande efficacité et un meilleur rapport coût/bénéfice
    - Rétablissement
    - L'efficacité professionnelle dans les relations d'aide
  - Traumatisme
    - La définition du traumatisme
    - Traumatisme de type I
    - Traumatisme de type II
    - Traumatisme complexe

Course Tools

Bookmarks

Important Course Dates

Today is 4 mar 2020 17:00 CET

Course End
in 4 mesi - 2 lug 2020

To earn a certificate, you must complete all requirements before this date.

- Revictimisation dans un traumatisme complexe
- Effets iatrogènes : Retraumatisation des clients
- Adolescence et traumatisme
- Un traumatisme peut toucher le cerveau
- Violence subie
- Négligence
- La négligence dans les conflits liés à une séparation
- Traumatismes et troubles alimentaires
- Danger, attachement et traumatisme psychologique
- Mentalisation et traumatisme psychologiques

2. Protection et promotion de la santé des survivants d'un traumatisme

Nouveaux traumatismes: Cause, prevention et traitement

- Conséquences des nouveaux traumatismes causés par les politiques migratoires en Italie et sur la scène internationale
- Intersectionnalité et traumatismes
- Traitement des traumatismes dans les groupes de rencontre centrés sur la personne
- Une écoute empathique pour faciliter la guérison d'un traumatisme.
- Adoption et traumatismes
- Les nouveaux traumatismes
- Comment les traumatismes s'expriment-ils chez les enfants adoptés ? La thérapie par vidéo-intervention
- Enfants de détenus et traumatismes
- Traumatismes vicariants
- Le dessin dans le traitement des traumatismes vicariants chez les habitants de Lampedusa

Tirer les lecons des erreurs

- Tirer les leçons des erreurs : les enseignements à tirer des mauvaises pratiques
- Les traumatismes ont des effets graves sur la santé physique et mentale
- Le traumatisme est omniprésent
- Quelques informations sur le traumatisme : l'étude ACE
- L'approche sensible aux traumatismes
- Les premiers principes de l'approche sensible aux traumatismes
- Deuxième principe des soins sensibles aux traumatismes
- 3ème principe de soins sensibles aux traumatismes
- 4ème principe des soins sensibles aux traumatismes
- 5ème principe de soins sensibles aux traumatismes
- 6ème principe des soins sensibles aux traumatismes
- Les écoles sensibles aux traumatismes

- Se concentrer sur la personne: Accueil et responsabilisation
  - Se concentrer sur l'usager
  - Accueil / hébergement des usagers LGBT
  - L'épanouissement personnel est essentiel : l'épanouissement après le traumatisme
- Les situations et les instruments Europeens
  - Art Thérapie - l'œuvre de Virginia Axline
  - Les outils d'évaluation des traumatismes
  - Un aperçu européen des traitements de traumatismes, pays par pays
- En résumé
  - Conclusions
  - Bibliographie
- Quiz 1&2
  - Quiz
  - Quiz 1

3. TRAUMA: research, evaluation and outcomes

- La recherche
  Prerequisite: Quiz 1&2
  Quiz
- La recherche factuelle
  Prerequisite: La recherche
  Quiz
- The Intervention evaluation process
  Prerequisite: La recherche factuelle
  Quiz

4. TRAUMA: Good practices and policies

- Aspects méthodologiques d'une recherche sur l'accompagnement sensible aux traumatismes
  Prerequisite: La recherche factuelle
  Quiz
- Bonnes pratiques dans le domaine de l'accompagnement sensible aux traumatismes
  Prerequisite: Aspects méthodologiques d'une recherche sur l'accompagnement sensible aux traumatismes
  Quiz
- Observation / Indicateurs de maltraitance et d'abus
  Prerequisite: Bonnes pratiques dans le domaine de l'accompagnement sensible aux traumatismes
  Quiz

- 5. Legal framework and fundamental legal principles
  - Introduction
    Prerequisite: Observation / Indicateurs de maltraitance et d'abus
  - Leçon 5.1
    Prerequisite: Observation / Indicateurs de maltraitance et d'abus
    Quiz
  - Leçon 5.2
    Prerequisite: Leçon 5.1
    Quiz
- 6. Module 6
  - Leçon 6.1
    Prerequisite: Leçon 5.2
    Quiz
  - Leçon 6.2
    Prerequisite: Leçon 6.1
    Quiz
  - En résumé
    Prerequisite: Leçon 6.2
- 7. Final exams
  - Introduction
    Prerequisite: Leçon 6.2
    Final Exam
- Post-course Questionnaire
  - Questionnaire
    Questionnaire

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Pre-course survey

Bookmark this page

CarePath MOOC

Bienvenue dans le cours en ligne ouvert et ouvert de CarePath! Avant d'aller plus loin, faites-nous mieux connaissance!

*Campo obbligatorio

Le sexe *

- ◯ Mâle
- ◯ Femelle

Email (MOOC email) *

La tua risposta

Pays *

Niveau d'éducation *

- ◯ Baccalauréat
- ◯ Licence
- ◯ Master
- ◯ Altro:

Profession actuelle ou description de poste *

- ◯ Éducateur/éducatrice
- ◯ Travailleur social
- ◯ Psychologue
- ◯ Professionnel de la Santé
- ◯ Étudiant/Étudiante
- ◯ Psychiatre
- ◯ Altro:

Dans quel contexte travaillez-vous? *

- ◯ Agence locale de santé publique
- ◯ Agence de services sociaux
- ◯ Charité / Association
- ◯ Organisation non gouvernementale - ONG
- ◯ Service pour migrants et réfugiés
- ◯ Organisation à but non lucratif
- ◯ Pour l'organisation à but lucratif
- ◯ Organisation centrée sur les immigrants et / ou les réfugiés
- ◯ Altro: _____

Avez-vous déjà suivi une formation spécifique sur les traumatismes? *

- ◯ Oui
- ◯ Non

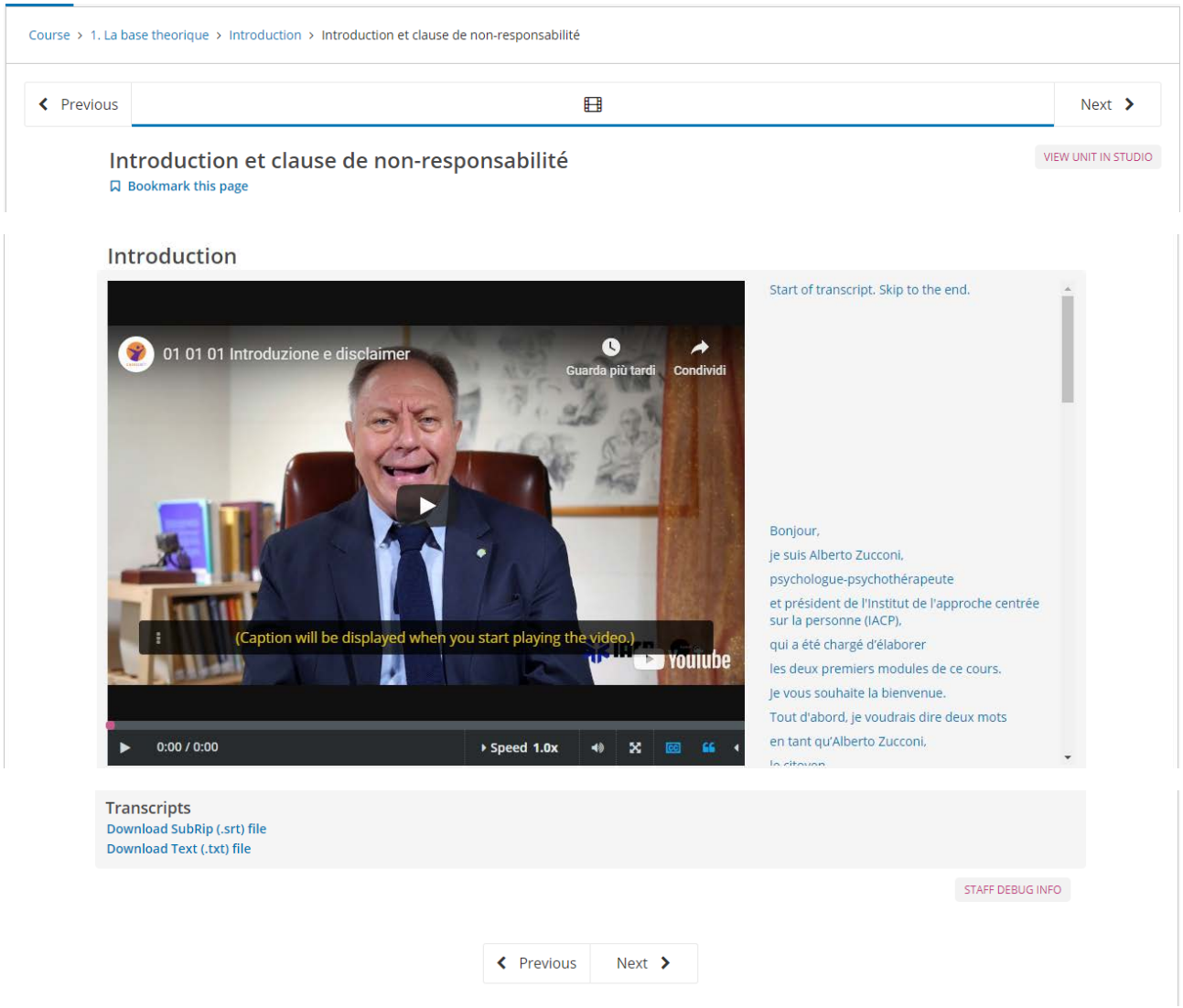
Depuis combien d'années travaillez-vous avec des mineurs touchés par un traumatisme? *

- ◯ 1-2
- ◯ 3-5
- ◯ 6-9
- ◯ plus que 10
- ◯ Jamais travaillé dans ce domaine

Invia

STAFF DEBUG INFO

‹ Previous Next ›



Transcript

Bonjour,

je suis Alberto Zucconi,

psychologue-psychothérapeute

et président de l'Institut de l'approche centrée sur la personne (IACP),

qui a été chargé d'élaborer

les deux premiers modules de ce cours.

Je vous souhaite la bienvenue.

Tout d'abord, je voudrais dire deux mots

en tant qu'Alberto Zucconi,

le citoyen.

Et ce sont des mots de gratitude.

Un sincère merci à chacun d'entre vous qui faites tant et tant d'efforts pour soutenir et protéger

les mineurs

victimes de traumatisme.

Votre travail est très important,

sensible, délicat, mais il peut

s'avérer extrêmement lourd.

Nous savons

que

s'occuper de personnes qui souffrent

risque de causer

de la douleur et de mener à l'épuisement.

Donc,

un sincère merci à vous tous et vous toutes,

dont le travail oeuvre à protéger

une réalité précieuse pour toute nation et pour toute communauté : le capital humain.

Chaque personne traumatisée doit recevoir tous les soins possibles

pour qu'elle puisse se réinsérer, exercer tous ses droits,

redevenir un membre actif de la communauté

et

contribuer tant à son propre développement qu'à celui de la communauté.

J'aimerais ajouter une autre chose, qui peut paraître évidente, mais mérite d'être soulignée:

ce cours

s'adresse à vous tous et vous toutes, qui venez d'horizons, de professions et de compétences divers

et qui - comme vous le savez – êtes tenus, par les lois existantes, les codes éthiques/déontologiques

des différentes professions

et les règles internes des différentes organisations auxquelles vous appartenez,

d'utiliser toutes vos connaissances et compétences pour ceux et celles dont vous avez la responsabilité, sans jamais franchir

les limites, car cela serait certainement en défaveur de vos clients.

Je voudrais ajouter une remaque évidente.

Pour compliquer les choses, les lois ne sont pas les mêmes

dans toutes les nations européennes et c'est un cours

adressé à différentes nations et dans des langues diverses

par conséquent

De toute evidence, l’objectif de cela est d’offrir un cours aux personnes conscientes

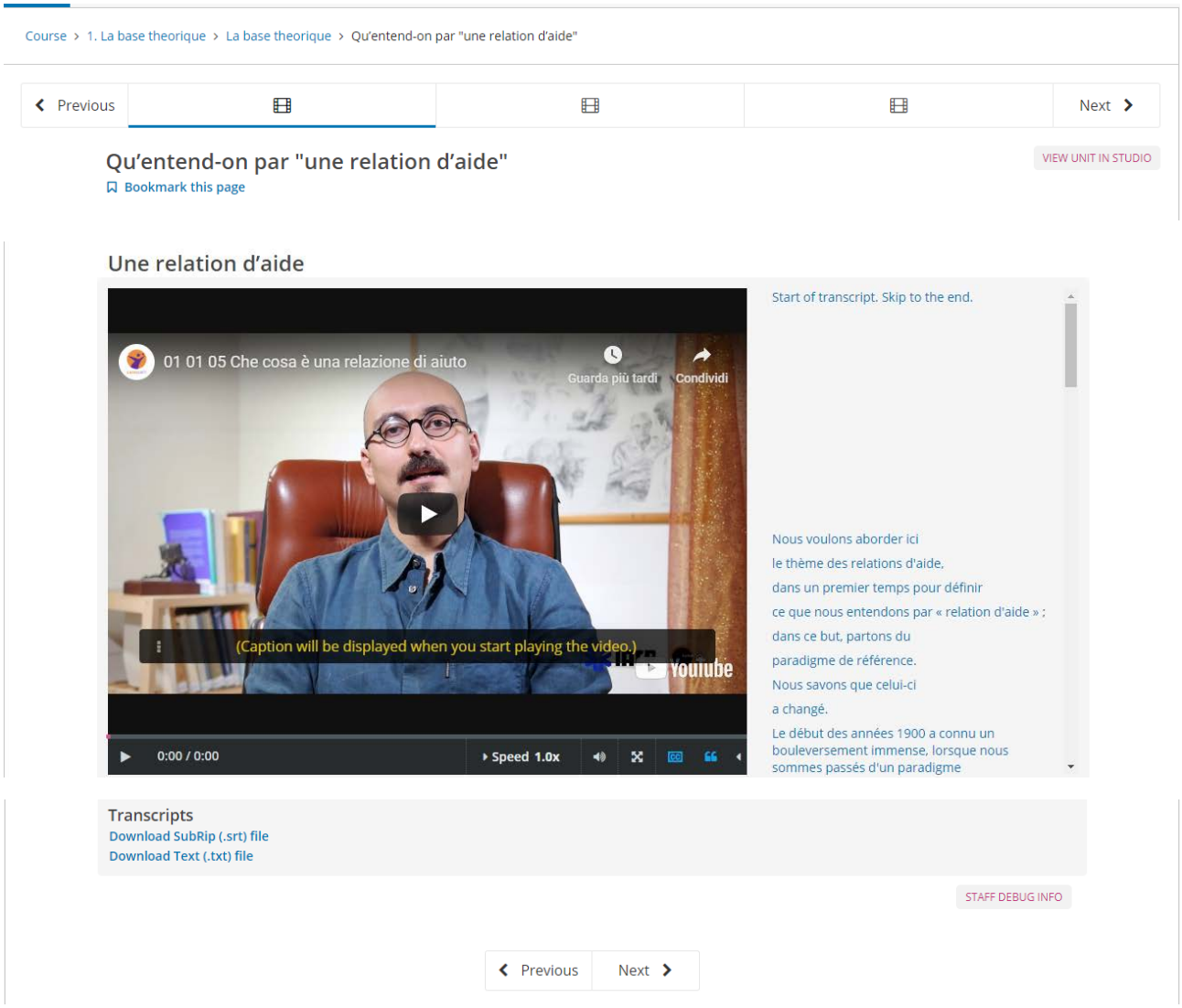
du fait que également

le respect les limites signifie travailler de manière effective

et efficace.

Merci encore de vous être embarqués dans cette aventure et merci pour le travail

que vous accomplissez tous les jours avec passion.



Transcript

Nous voulons aborder ici

le thème des relations d'aide,

dans un premier temps pour définir

ce que nous entendons par « relation d'aide » ;

dans ce but, partons du

paradigme de référence.

Nous savons que celui-ci

a changé.

Le début des années 1900 a connu un bouleversement immense, lorsque nous sommes passés d'un paradigme

mécaniste réductionniste à un paradigme holistique et systémique.

La façon de comprendre la relation d'aide a également changé ; dans le paradigme mécaniste

réductionniste,

elle se caractérisait par son asymétrie : le professionnel était l'agent de sens

imposant une réalité à son patient, sa propre vision de la réalité,

rendant en quelque sorte son patient passif.

L'adoption du nouveau paradigme a modifié la donne ;

nous plaçons maintenant

les relations au centre de l'approche : la priorité n'est plus donnée aux composantes individuelles, mais aux relations

qui font de ces composantes

un tout.

With it to be qualified

Alors, qu'est-ce qu'une relation d'aide à la lumière du nouveau paradigme ?

Pour nous aider à la définir, relisons les écrits de Carl Rogers de 1951, un auteur

qui occupe une place centrale pour tout qui veut comprendre la nouvelle vision de la relation d'aide.

Carl Rogers écrit : « Une relation d'aide est une relation dans laquelle au moins un des deux

protagonistes a pour but de promouvoir la croissance, le développement,

la maturité et l'adoption

d'un comportement plus adéquat et intégré chez l'autre personne.

Dans ce sens,

l'autre peut être un individu ou un groupe.

En d'autres termes, une relation d'aide pourrait être définie comme une situation dans laquelle

l'un des participants essaie de favoriser, chez l'un ou l'autre, un plus grand épanouissement

des ressources personnelles et une plus grande possibilité d'expression de soi ».

Les mots qui ressortent ici sont valorisation, promotion, ressources ;

cette

nouvelle vision des relations d'aide

place donc

les deux protagonistes

dans une relation de parité ;

ainsi, le professionnel ne sera pas

l'expert, l'agent de sens,

mais plutôt celui qui favorise l'épanouissement de toutes les

ressources propres à l'autre.

Ce faisant, il pourra faciliter un processus plus fonctionnel de co-construction de la réalité

pour le patient,

l'accompagnant ainsi dans un processus, en acceptant et en respectant l'endroit où se trouve le patient.

Aujourd'hui, quelles sont les caractéristiques que doit avoir un professionnel de la relation d'aide ?

Il ou elle doit certainement posséder des connaissances, c'est-à-dire un corpus

de savoirs théoriques

sur

lesquelles s'appuyer ;

il ou elle doit, en outre, savoir comment appliquer ces connaissances (les théories doivent être concrétisées, appliquées)

et savoir comment les appliquer dans la relation. Mais savoir comment appliquer ne suffit pas. L'accent de la relation étant mis sur sa propre qualité,

le professionnel devra également savoir comment être, comment mettre en pratique toutes les conditions

et qualités qui facilitent et rendent efficace une relation d'aide.

Parmi celles-ci, nous savons que l'authenticité est sûrement la première qualité, que voir le monde à travers les

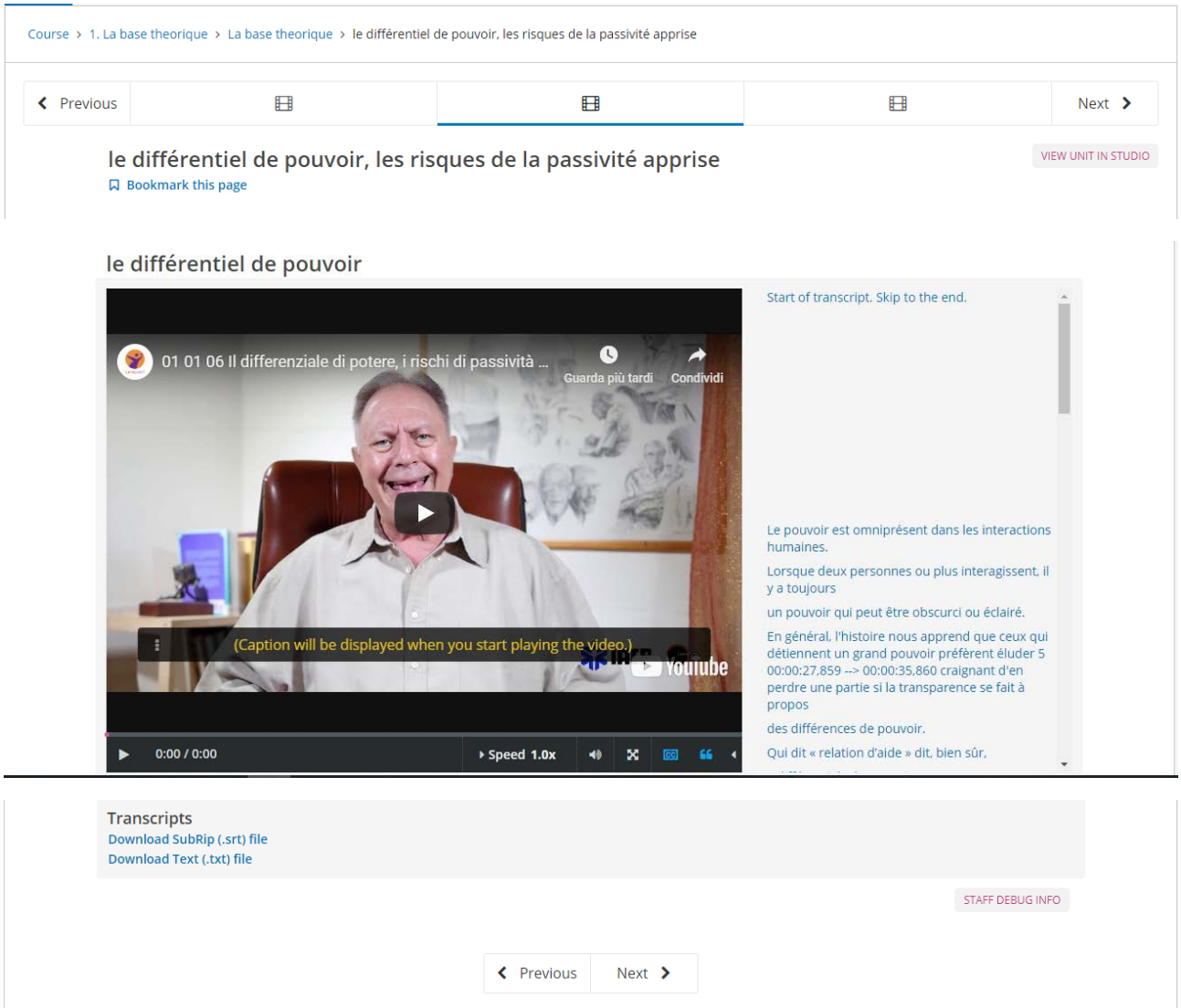
yeux de l'autre est la deuxième, et la troisième est de ne pas juger

le patient, mais de pouvoir le respecter et l'accueillir tel qu'il est.

Si cela est possible, si ces trois conditions sont remplies par le professionnel,

un processus de changement

et d'auto-épanouissement chez le patient s’en trouvera facilité.



Transcript

Le pouvoir est omniprésent dans les interactions humaines.

Lorsque deux personnes ou plus interagissent, il y a toujours

un pouvoir qui peut être obscurci ou éclairé.

En général, l'histoire nous apprend que ceux qui détiennent un grand pouvoir préfèrent éluder 5 00:00:27,859 --> 00:00:35,860 craignant d'en perdre une partie si la transparence se fait à propos

des différences de pouvoir.

Qui dit « relation d'aide » dit, bien sûr,

« différentiels de pouvoir ».

Le professionnel, l'expert,

celui ou celle qui offre un service aura plus de pouvoir

que l'utilisateur du service, le client, le patient, quel que soit la façon dont vous voulez définir cette personne. Pourquoi ?

Parce que le professionnel sait quelque chose que le patient ignore en partie,

et parce que le professionnel offre au patient quelque chose dont il a besoin.

C’est également lui ou elle qui conçoit les règles

du cadre (c'est-à-dire les règles qui régissent la conception et la gestion du cadre)

et qui a le pouvoir de suspendre la prestation du service.

En bref,

il y a toujours une différence de pouvoir entre ceux qui fournissent un service et ceux qui le reçoivent.

Lorsque s’appliquait le paradigme réductionniste-mécaniste,

les différentiels de pouvoir dans les relations d'aide étaient très élevées.

Nous avons constaté, à la lumière du nouveau paradigme de la Charte d'Ottawa et du paradigme bio-psychosocial,

que ces différentiels de pouvoir sont à éviter,

que, s’il sont excessifs, ils peuvent amener les usagers du service à assumer un rôle passif contreproductif.

Nous constatons aujourd'hui une tendance à se concentrer sur les utilisateurs, sur la personne du patient, et à encourager

le changement par des actions d'empowerment (de mise en capacité)

qui permettent aux patients de développer leurs propres compétences, leur créativité et leur résilience.

Ceci, comme la recherche le souligne très clairement, s’avère très utile,

la relation d'aide offrant de meilleurs résultats dans un délai plus court ;

par exemple dans le domaine de la santé et du bien-être, nous remarquons une diminution des effets secondaires et des rechutes.

On en conclut donc que tout le monde est gagnant lorsque le pouvoir est partagé et lorsque chacun

contribue à la poursuite des objectifs.

Cette vérité s’applique également au niveau sociétal, les citoyens actifs et conscients

contribuant davantage à leur écologie sociale et à la construction communautaire de la réalité :

une réalité durable pour des relations durables.

La remarque s’applique également à la prestation de services pour enfants, who are small people, compris comme individus petits et non pas comme enfants incapables

de comprendre ni de répondre. La construction sociale des enfants en tant que

« charmantes petites choses » n’est plus d’actualité.

Matériau de support

BPS Practice Guidelines (Third Edition)

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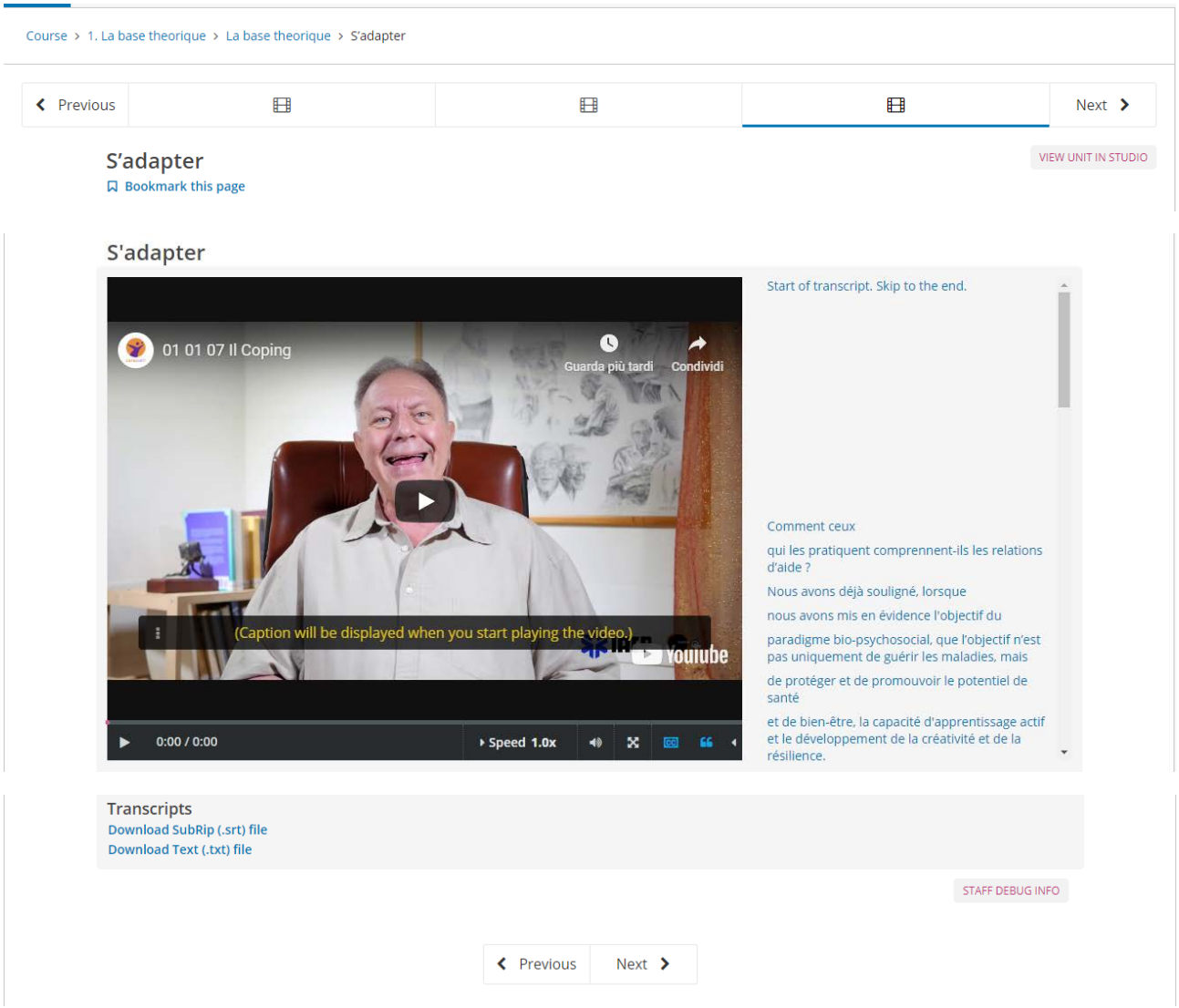


Transcript

Comment ceux

qui les pratiquent comprennent-ils les relations d'aide ?

Nous avons déjà souligné, lorsque

nous avons mis en évidence l'objectif du

paradigme bio-psychosocial, que l'objectif n'est pas uniquement de guérir les maladies, mais

de protéger et de promouvoir le potentiel de santé

et de bien-être, la capacité d'apprentissage actif et le développement de la créativité et de la résilience.

Un autre terme décrivant cette capacité innée des organismes humains est

« coping ». Un terme anglais qui, en français, peut se traduire par « savoir gérer les circonstances de la vie » :

savoir mieux gérer son propre rapport avec soi-même,

avec les autres et avec le monde qui nous entoure.

Nous savons que, dans les relations d'aide,

les qualités recherchées chez un professionnel efficace,

quelle que soit son approche, concernent son comportement

avec ses patients, un profond respect et l'absence de préjugés,

une compréhension empathique non seulement de ce que dit le patient, mais également de ce qu'il ressent, de ses

significations, une attitude honnête, authentique et transparente.

Par ailleurs, il est également nécessaire, si l'on veut que ce processus fonctionne, que l'utilisateur, le client ou le patient

s'implique activement, puisqu'il s'agit ici d'un jeu d'équipe co-construit.

Dans les relations d'aide, les patients que l'on peut définir comme « efficaces »

sont sincères et motivés à changer, fut-ce parce qu'ils ne se sentent pas bien

et veulent arrêter de souffrir. Ils doivent également avoir la capacité d'entrer

en contact psychologique avec le professionnel qui travaille avec eux et de percevoir les qualités

que le professionnel met dans la relation.

Ces capacités évoluent, tout comme la capacité de persévérer, d'être prêt à apprendre de ses erreurs,

avec le courage qu'il faut pour admettre ses propres erreurs,

pour transformer les erreurs en enseignants de sagesse.

Il en ressort que l'adaptation (coping) est un processus de fonctionnement optimal et le

résultat d'un travail d'équipe entre le professionnel et son patient visant à atteindre

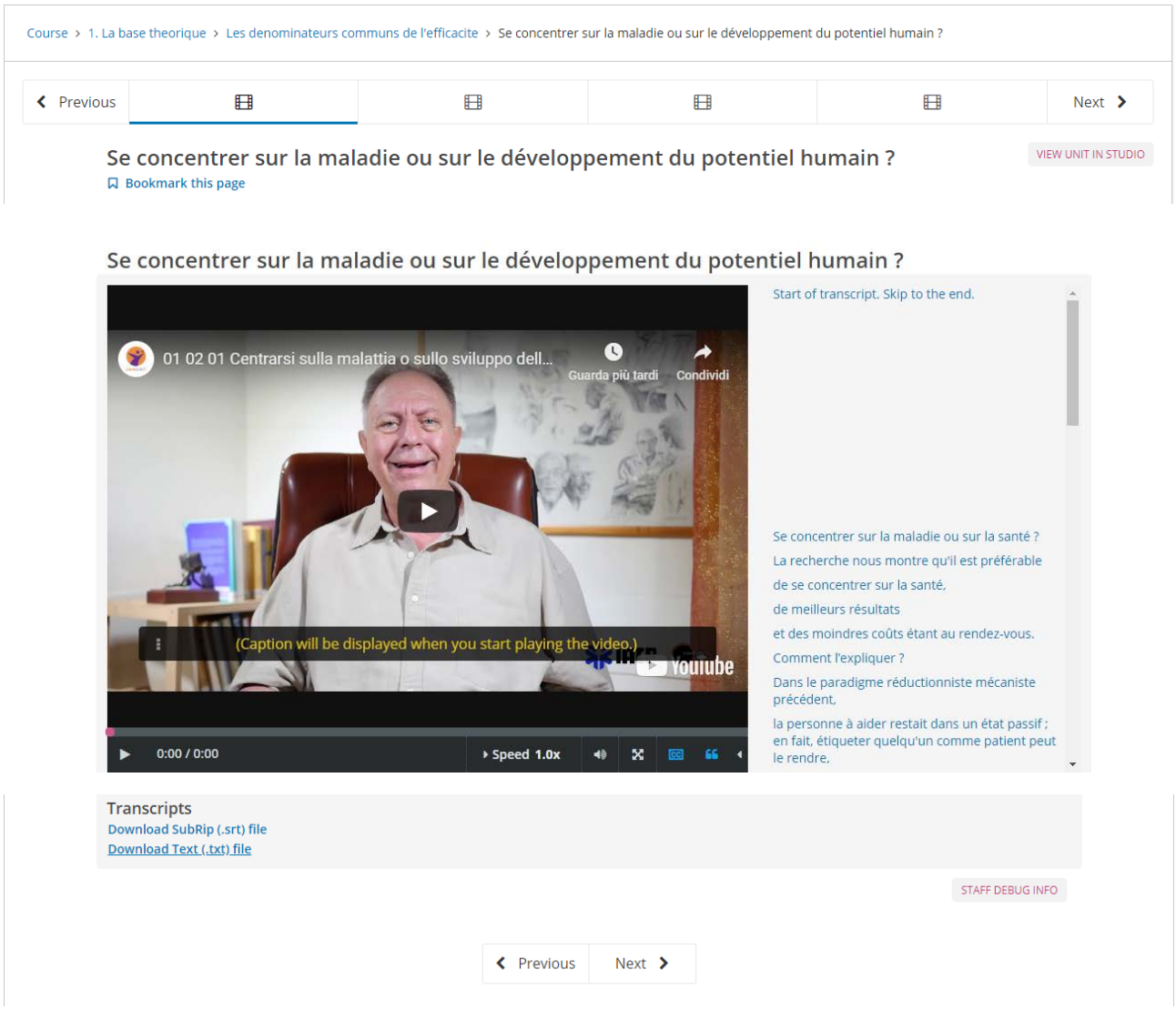
les objectifs d'une meilleure qualité de vie et d'une plus grande réalisation du potentiel

intrinsèque

intrinsèque avec lequel chacun d'entre nous sommes nés et qui est inscrit dans notre code génétique. Ce potentiel

inné s'est ensuite développé avec plus ou moins d'amplitude en fonction des conditions environnementales dans lesquelles nous nous trouvons, mais également des attitudes

que nous avons et de la façon dont nous faisons face à la vie.



Transcript

Se concentrer sur la maladie ou sur la santé ?

La recherche nous montre qu'il est préférable

de se concentrer sur la santé,

de meilleurs résultats

et des moindres coûts étant au rendez-vous.

Comment l'expliquer ?

Dans le paradigme réductionniste mécaniste précédent,

la personne à aider restait dans un état passif ; en fait, étiqueter quelqu'un comme patient peut le rendre,

dans un certain sens, trop patient,

c'est-à-dire trop passif ; porteur

d'une passivité acquise. Le risque est moindre dans le

nouveau paradigme qui encourage la personne à utiliser son propre pouvoir dans le but d'être et

d’entrer dans un partenariat basé sur un partage du pouvoir décisionnel entre le professionnel

et son patient.

De plus, la recherche nous montre qu'une approche de protection et de promotion de la santé

et du bien-être

peut

donner de meilleurs résultats pour les mêmes catégories d'utilisateurs de services.

Citons comme exemple

une

relation proactive des patients avec a good relationship le personnel de l'hôpital,

au cas où ils viendraient à subir une opération chirurgicale. Dans le nouveau modèle,

nous constatons moins de jours d'hospitalisation

et moins de negative conséquences négatives après la chirurgie,

un meilleur développement des défenses immunitaires

et une meilleure conformité

(entendez « une meilleure collaboration du client avec les médecins et les infirmières pour se conformer à leurs prescriptions,

comme de prendre des médicaments régulièrement »).

Le nouveau modèle se caractérise également par moins de plaintes déposées par les usagers

contre les établissements de santé et

un meilleur taux de rétention des médecins.

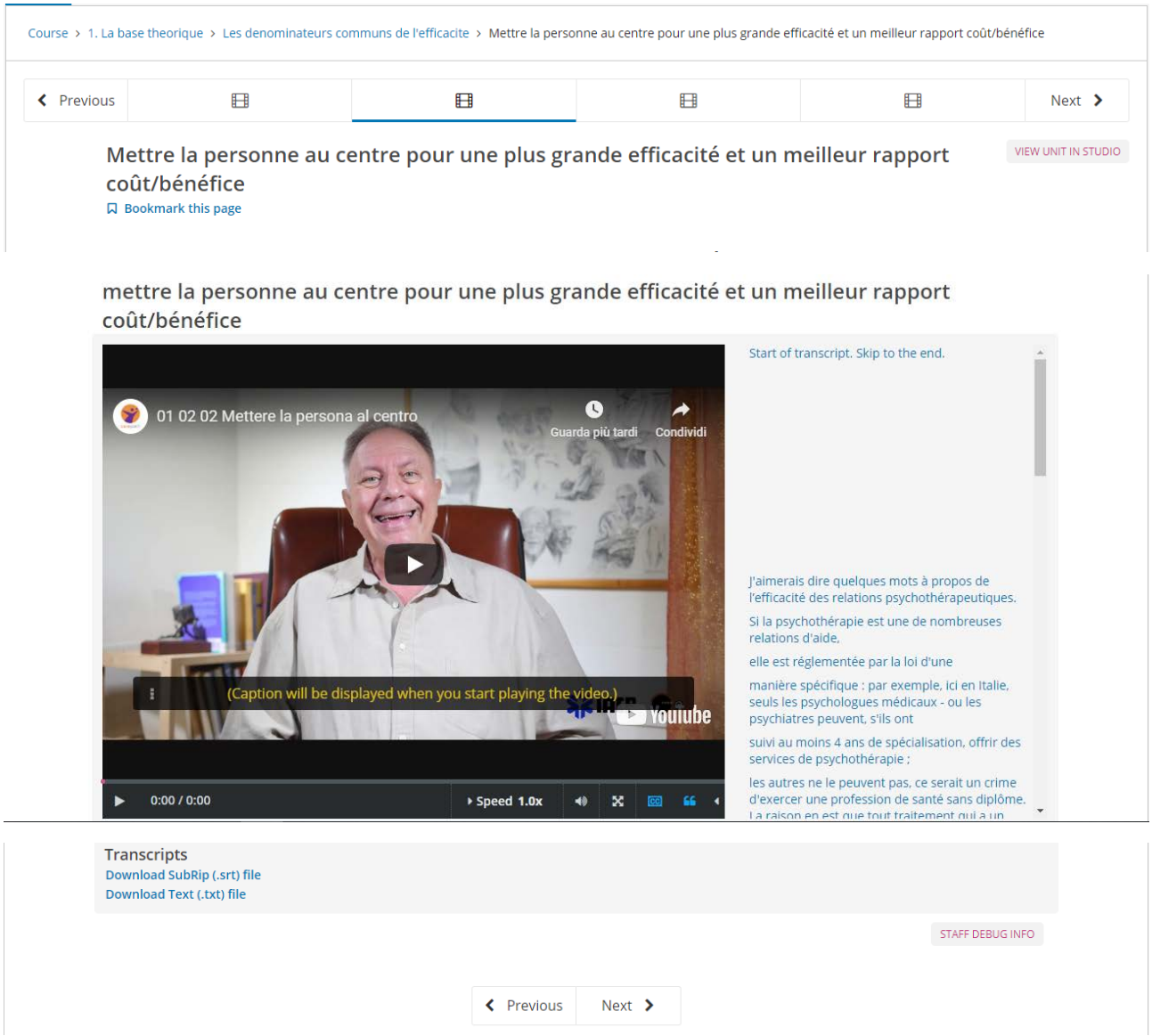
Ce nouveau paradigme favorise les résultats non seulement pour l'utilisateur et sa famille,

mais également pour la société dans son ensemble, car une société où les gens peuvent mieux développer leur potentiel

est une société où ils seront moins malades, où ils vivront plus vieux et seront moins sujets aux maladies ; en résumé, c'est une société plus prospère.

En bref, quand il y a promotion de la santé et du bien-être, il n’y a que des gagnants,

chacun s'en sort mieux et les résultats parlent d'eux-mêmes.



Transcript

J'aimerais dire quelques mots à propos de l’efficacité des relations psychothérapeutiques.

Si la psychothérapie est une de nombreuses relations d'aide,

elle est réglementée par la loi d'une

manière spécifique : par exemple, ici en Italie, seuls les psychologues médicaux - ou les psychiatres peuvent, s'ils ont

suivi au moins 4 ans de spécialisation, offrir des services de psychothérapie ;

les autres ne le peuvent pas, ce serait un crime d'exercer une profession de santé sans diplôme. La raison en est que tout traitement qui a un impact sur la santé d'un organisme

- et donc qui fait du bien - peut, s'il n'est pas bien pratiqué,

faire du mal.

Le vaste corpus de recherches montre que l'efficacité dans la psychothérapie n’est pas le simple résultat d’une

« approche théorique spécifique », mais plutôt des qualités relationnelles des psychothérapeutes,

quelles que soient leurs démarches ; ajoutons que, comme dans toute relation d'aide,

les mêmes variables et les mêmes facteurs interviennent.

Un psychothérapeute sera efficace, non pas parce qu'il appliquera un certain modèle théorique, mais parce

qu'il aura la capacité de se mettre en relation avec le patient, de l'accepter et

de le respecter, sans le juger,

mais avec un profond respect,

et parce qu'il sera en mesure non seulement

d'écouter ce que son usager / patient / client dira, mais également de faire preuve d'empathie,

c'est à dire tout ce qui fera sens pour le patient en tant qu'individu.

Le professionnel est également capable d'établir une relation authentique, spontanée et transparente avec le patient.

Pourtant, tout cela ne suffira pas. En effet la relation psychothérapeutique, comme toute relation d'aide, est un

travail d'équipe, une co-construction à laquelle le client, l'usager, le patient contribuera activement,

au risque qu'elle ne fonctionne pas.

Et donc ?

La motivation, qui vient souvent du sentiment de malaise vécu par le patient - et donc de sa motivation à changer –

est également importante, tout comme la relation psychologique avec le psychothérapeute

et,

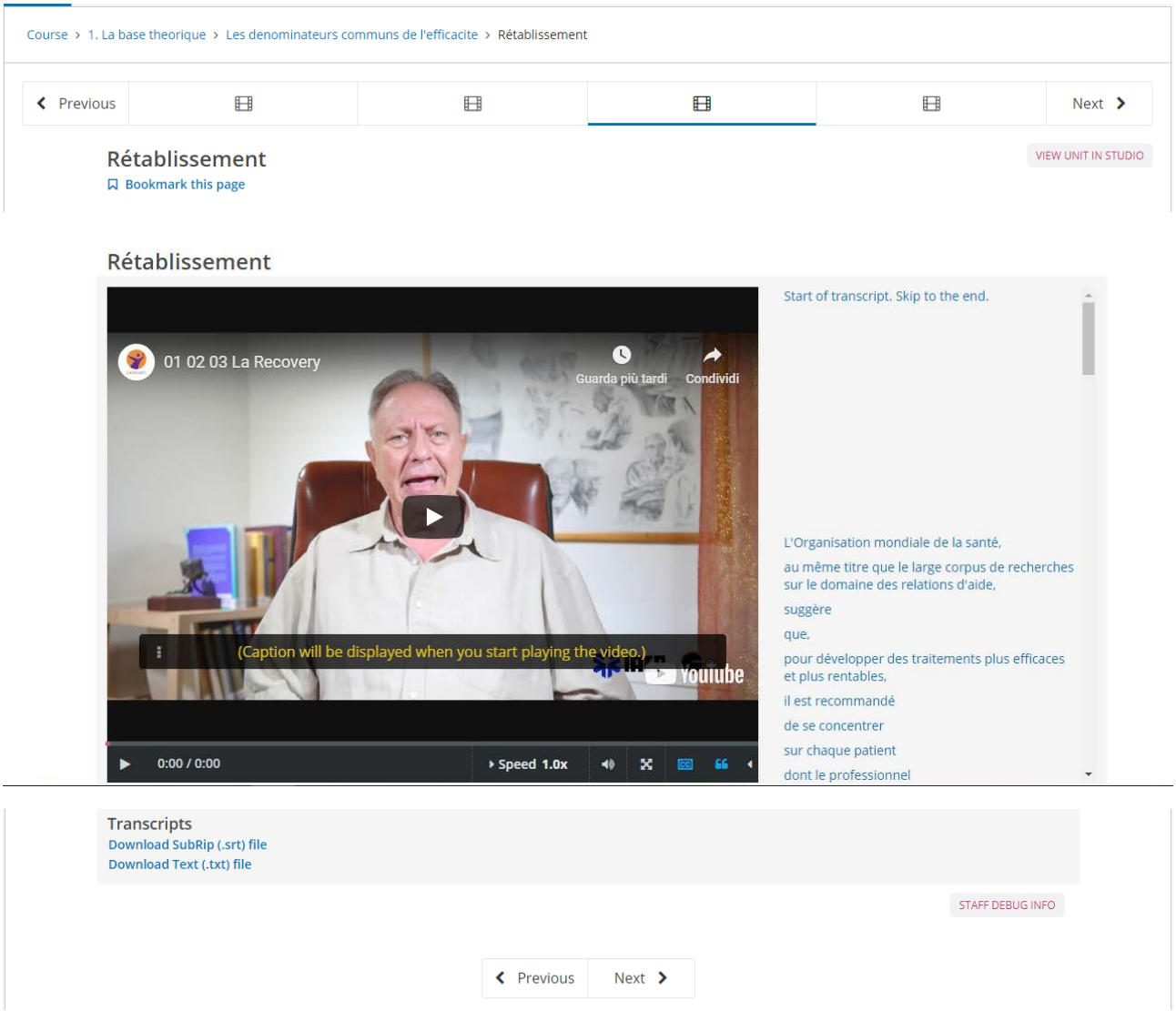
troisième condition, la capacité de percevoir la qualité de relation établie par le professionnel qui possède

les qualités fondamentales de respect profond, d'écoute empathique et d'authenticité.

C'est ainsi que la dyade pourra fonctionner et donner des résultats très positifs,

plus efficaces que si la personne souffrant du malaise ne recevait qu'un traitement médicamenteux ou, pire,

aucun traitement.



Transcript

L'Organisation mondiale de la santé,

au même titre que le large corpus de recherches sur le domaine des relations d'aide,

suggère

que,

pour développer des traitements plus efficaces et plus rentables,

il est recommandé

de se concentrer

sur chaque patient

dont le professionnel

prend soin.

En bref, il est important de personnaliser les traitements, et donc de ne pas utiliser

un pot de peinture blanche qui nous permettrait de peindre en blanc tout le monde, peu importe qui en seraient les utilisateurs.

Tout comme la psychothérapie doit être personnalisée, les relations d'aide doivent également l'être,

car c'est cela qui aidera au mieux Gino, Maria, Joseph, etc.

En effet,

nous devons

nouer des relations de travail solides et nous lancer dans des récits

qui considèrent le client comme un acteur dans l'aventure du changement.

La Task Force 29 de l'American Psychological Association (APA)

montre combien il est important de centrer les traitements sur les personnes,

et

ajoutant:

que les traitements et leur philosophie doivent se baser

sur les concepts de rétablissement

et

de développement du potentiel,

à mille lieues de la vision pessimiste

de la pathologie et de la chronicité qui dominait auparavant.

Qu'entend-on par rétablissement ?

Au cours des dernières décennies, le concept de « rétablissement » a gagné des galons,

une capacité à soutenir des patients et à en accroître l'autonomie,

tout en dissipant certains mythes,

comme celui

selon

lequel la schizophrénie

est une pathologie chronique.

C'est ce que l'on pensait auparavant,

mais le fait même de penser de cette manière devient aussi,

dans une

certaine mesure, une prophétie auto-réalisatrice,

un phénomène de construction sociale qui - si l'on y réfléchit -

est assez évident.

Prenons l'exemple de la schizophrénie, si on sait

qu'elle existe dans tous les pays, aucune culture ne la traite de la même manière.

Dans certaines sociétés et cultures, le schizophrène est considéré comme une personne

touchée par les dieux qui sera,

par conséquent, traitée avec respect et bienveillance par une communauté qui lui offrira

nourriture et abri ;

Dans d'autres sociétés,

par contre, ils seront plutôt traités comme des parias,

bannis de la communauté et enchaînés à un arbre dans la forêt.

Dans notre culture occidentale,

selon les époques, nous

les traitions

différemment,

parfois avec cruauté,

mais toujours « pour leur propre bien »,

in turn that it was a phenomenon caused by a devil's possession and so we tortured these poor people

comme lorsque nous avons cru qu'il s'agissait d'un phénomène causé par une possession diabolique

et que nous avons torturé ces pauvres gens avec des fers chauds, pensant que,si leur corps était possédé par un diable,

il fallait rendre le corps inconfortable par la torture pour que le diable en sorte.

Nous avons essayé d'autres traitements,

mais en faisant toujours en sorte que la prophétie

de la pathologie et de la chronicité

se réalise.

Dans une vision axée sur le rétablissement, qui postule que, indépendamment de votre situation,

fût-elle aussi grave que la schizophrénie,

vous pourrez récupérer vos capacités et reprendre place au sein de la communauté, nous formulons une prophétie positive qui,

comme toutes les prophéties, finit, dans une certaine mesure, par se réaliser.

Ainsi, nous constatons aujourd'hui que, lorsque les gens sont perçus avec un plus grand optimisme, ils réalisent ces prophéties.

Nous rencontrons des gens qui voient des choses que d'autres ne voient pas, entendent des voix que

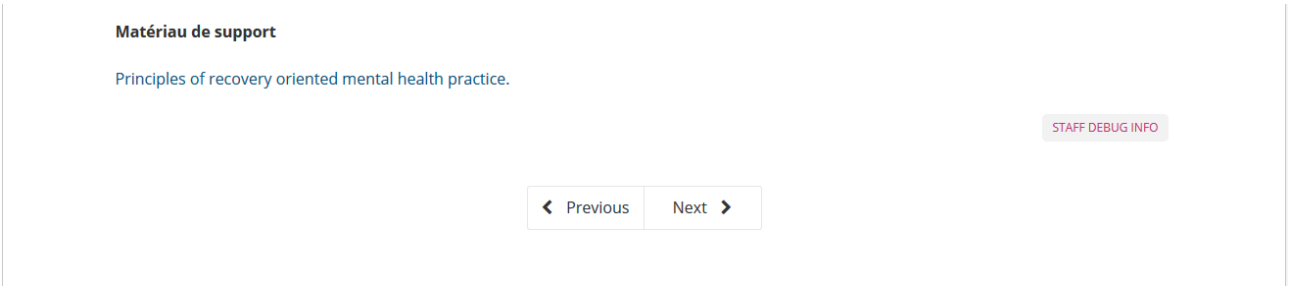
d'autres n'entendent pas, mais qui travaillent néanmoins comme consultants rémunérés dans une Agence de Santé Locale pour conseiller sur la manière

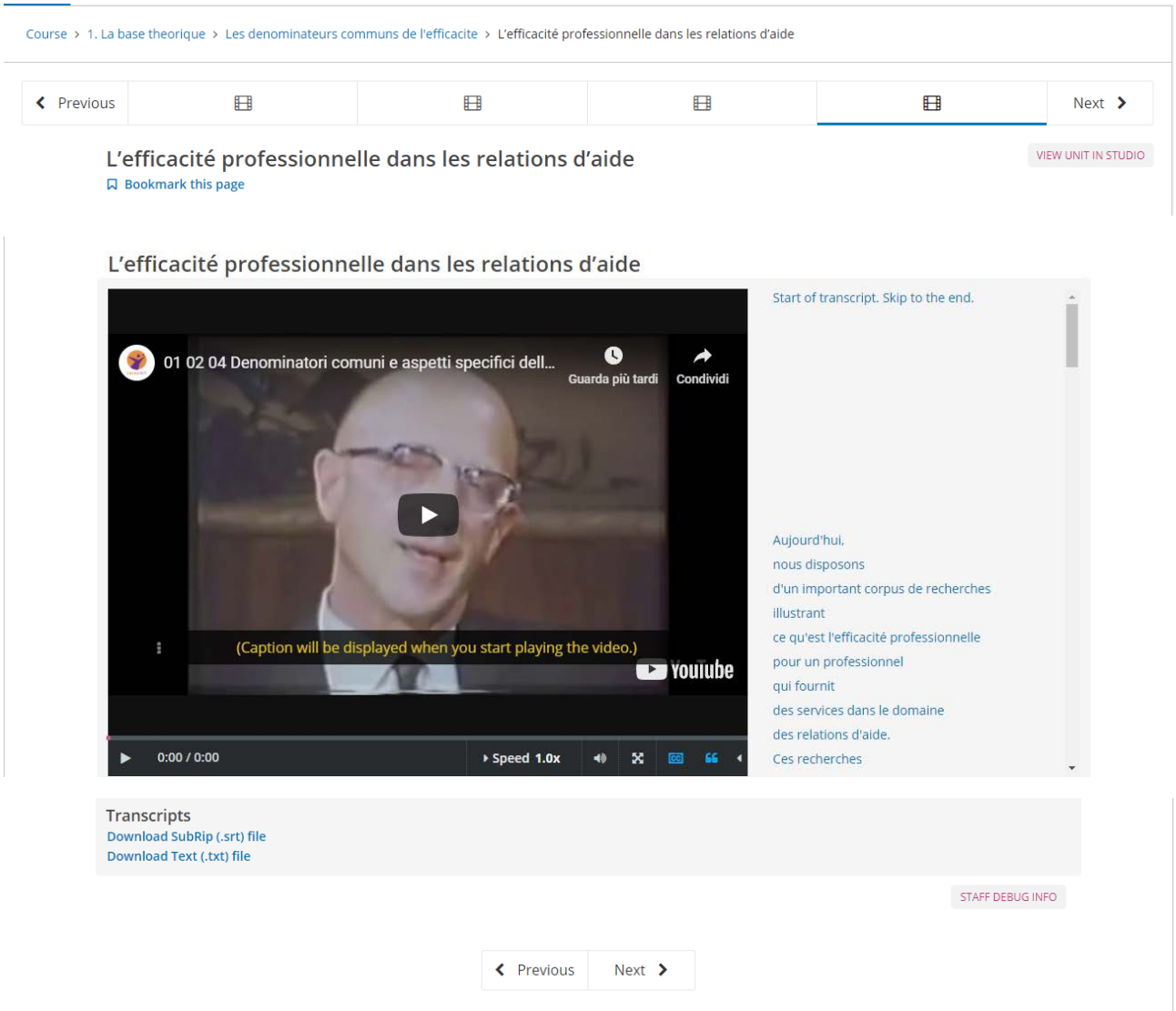
de traiter des afflictions d'une manière plus humaine et positive, afin de réaliser –

non pas des prophéties négatives –

mais des prophéties positives.

Dans le monde des prophéties, nous devons faire attention à laquelle choisir et où elle nous mènera.





Transcript

Aujourd'hui,

nous disposons

d'un important corpus de recherches

illustrant

ce qu'est l'efficacité professionnelle

pour un professionnel

qui fournit

des services dans le domaine

des relations d'aide.

Ces recherches

ont commencé il y a longtemps

partir des hypothèses formulées par Carl Rogers,

à

le fondateur de l'approche centrée sur la personne

et l'un des pères de la psychologie humaniste.

À partir de 1942, Rogers a formulé

une série d'hypothèses scientifiques,

avant de passer à la vérification empirique

de ce qui constituait les conditions nécessaires et suffisantes pour qu'un professionnel

efficace opère un changement.

Ces conditions ont été et sont encore confirmées aujourd'hui par la recherche :

l'établissement

d'une relation de confiance avec l'usager / le patient,

l'absence de jugement dans le chef du professionnel,

une capacité d'acceptation

et de respect profond de la personne du patient,

une écoute

empathique sensible et précise (comprendre non seulement ce que dit le patient,

mais également ce que cela signifie pour lui),

sans oublier une attitude d'authenticité, de franchise

et d'honnêteté dans la relation.

Ces hypothèses, qui ont été validées par des recherches sur la psychothérapie,

ont prouvé leur efficacité

dans toutes les relations d'aide.

Rogers a révolutionné l'approche,

en l'enracinant solidement dans

la science, et non plus dans la métaphysique, et en explicitant les valeurs qui la fondent.

Je pense qu'il est préférable de donner la parole à Carl Rogers en personne,

qui illustre ces trois conditions nécessaires et suffisantes dans un de ses célèbres films :

« De mes années d'expérience thérapeutique, je suis venu à penser que,

si je peux créer le bon

climat, la bonne relation, les bonnes conditions,

un processus de mouvement thérapeutique se produira presque inévitablement chez mon patient.

Vous vous demandez peut-être ce qu'est ce climat ?

Quelles en sont les conditions ?

Existeront-elles dans une entrevue avec des femmes que je n'ai

jamais vues auparavant ?

Laissez-moi essayer de décrire très brièvement ces conditions telles que je les perçois.

Tout d'abord, la question se pose de savoir

si je peux être réel dans la relation.

Cela a pris une importance croissante pour moi

au fil des ans.

Je pense qu'authenticité

est une autre façon de décrire la qualité que j'aimerais posséder.

J'aime le terme de congruence, qui signifie pour moi que ce que je vis à l'intérieur est présent

dans ma conscience et s'exprime par ma communication.

Dans un sens,

quand j'ai cette qualité,

je suis tout entier dans la relation.

Un autre mot décrit cet état :

je sens que

j'aimerais mettre de la transparence dans la relation, je serais tout à fait disposé à ce que mon client voit tout à travers moi,

qu'il n'y ait rien de caché.

Quand j'atteins ce niveau de réalité,

je sais que mes propres sentiments

vont prendre conscience et s'exprimer,

mais pas d'une façon qui s'imposera à mon patient.

Ensuite,

la deuxième question que je me pose est de savoir si je vais me retrouver

à faire l'éloge de cette personne,à prendre soin d'elle.

Je ne veux certainement pas tomber dans une fausse empathie.

En fait, si je n'aime pas mon client de façon persistante, je pense qu'il vaut mieux que je le dise.

Mais je sais que le

processus de thérapie est beaucoup plus susceptible de réussir,

et que le changement constructif

est plus envisageable,

si je ressens une véritable appréciation spontanée de l'individu avec lequel je travaille.

Une appréciation de cette personne comme individu à part entière.

Vous pouvez l'appeler « acceptation », vous pouvez l'appeler « attention »,

vous pouvez l'appeler « amour non possessif » si vous le souhaitez.

Je pense que tous ces termes décrivent bien mon propos.

Je sais que la relation sera plus constructive si tout cela est présent.

Pour ce qui est de la troisième qualité, serai-je capable de comprendre le monde intérieur de cet individu,

de l'intérieur ?

Serai-je capable de le voir à travers ses yeux ?

Serai-je suffisamment

sensible

pour

me transporter dans le monde de ses sentiments,

de sorte que je sache ce que l'on ressent en étant lui ?

Pour que je puisse

sentir non seulement le sens superficiel, mais également certaines

significations cachées sous la surface.

Je sais que si je peux

me laisser entrer avec sensibilité et précision dans le monde de son expérience,

le changement et le changement thérapeutique seront beaucoup plus probables. »

Matériau de support

Wampold BE. How important are the common factors in psychotherapy? An update. World Psychiatry. 2015;14(3):270–7.

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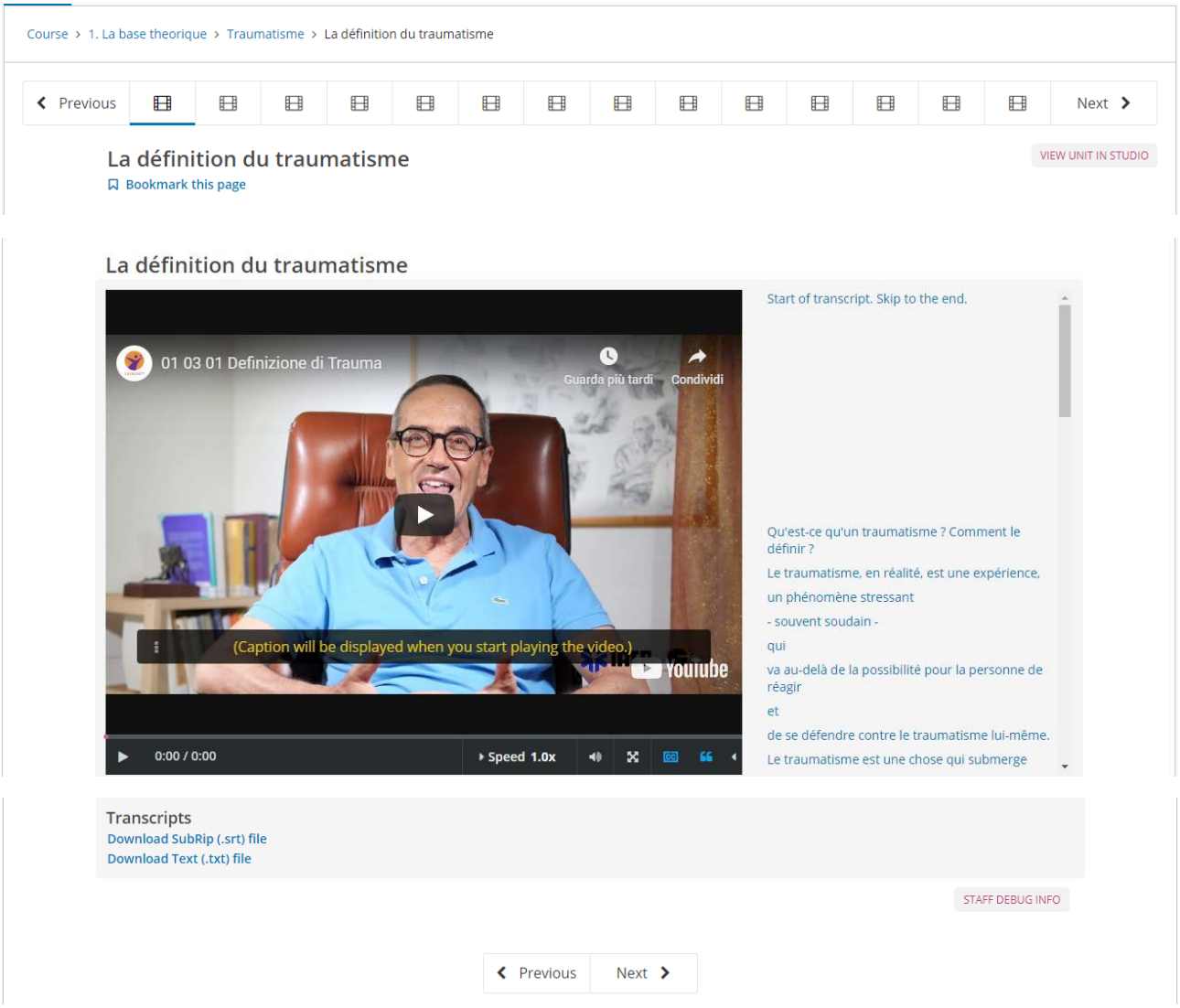

Transcript

Qu'est-ce qu'un traumatisme ? Comment le définir ?

Le traumatisme, en réalité, est une expérience,

un phénomène stressant

- souvent soudain -

qui

va au-delà de la possibilité pour la personne de réagir

et

de se défendre contre le traumatisme lui-même.

Le traumatisme est une chose qui submerge

les personnes qui y sont exposées.

Les traumatismes ont été étudiés

de diverses manières.

Il y a des traumatismes aigus

pouvant être causés par des catastrophes naturelles ou technologiques, des situations chroniques/répétées de traumatisme

(comme celles auxquelles les enfants sont souvent exposés).

Toutefois,

nous pouvons affirmer

que l'histoire des traumatismes, d'un point de vue clinique, commence

avec l'étude des névroses post-traumatiques, qui ont également été étudiées par Freud (et donc dans le cadre

de la psychanalyse), puis reprises par d'autres.

Le traumatisme a également été étudié du point de vue des mécanismes psychologiques, dont l'importance

est indéniable.

Depuis ses origines, la psychanalyse prétend qu'un traumatisme,

en particulier

s'il se produit dans la petite enfance,

subit un processus de suppression.

Cette suppression ne signifie pas pour autant que le traumatisme est oublié,

nié ou enterré. Il peut réapparaître, être réactivé à un autre moment,

par exemple à l'âge adulte,

parfois

suite à un nouveau traumatisme qui rappelle en quelque sorte

le traumatisme précédent. Il s'agit d'un mécanisme en deux étapes, que Freud a étudié attentivement,

selon lequel se produit un premier traumatisme qui, dans un certain sens, sensibilise,

puis un second traumatisme qui

reproduit chez le sujet la victimisation,

l'impuissance et la fragilité. Ainsi,

la répétition de la situation conduit

à de nouveaux

symptômes et

à un état clinique qui suscite le ressenti comme si c'était la première fois.

Ceci dit, le traumatisme du syndrome

de stress post-traumatique se produit plutôt

de manière ponctuelle et met en danger la vie des sujets.

S’il peut être causé par la guerre, la torture,

des facteurs technologiques ou environnementaux,

il est de type ponctuel et facilement reconnaissable

in the life of the subjectdans la vie du sujet.

Matériau de support

Kleber RJ. Trauma and Public Mental Health: A Focused Review. *Front Psychiatry*. 2019;10:451. Published 2019 Jun 25. doi:10.3389/fpsyt.2019.00451

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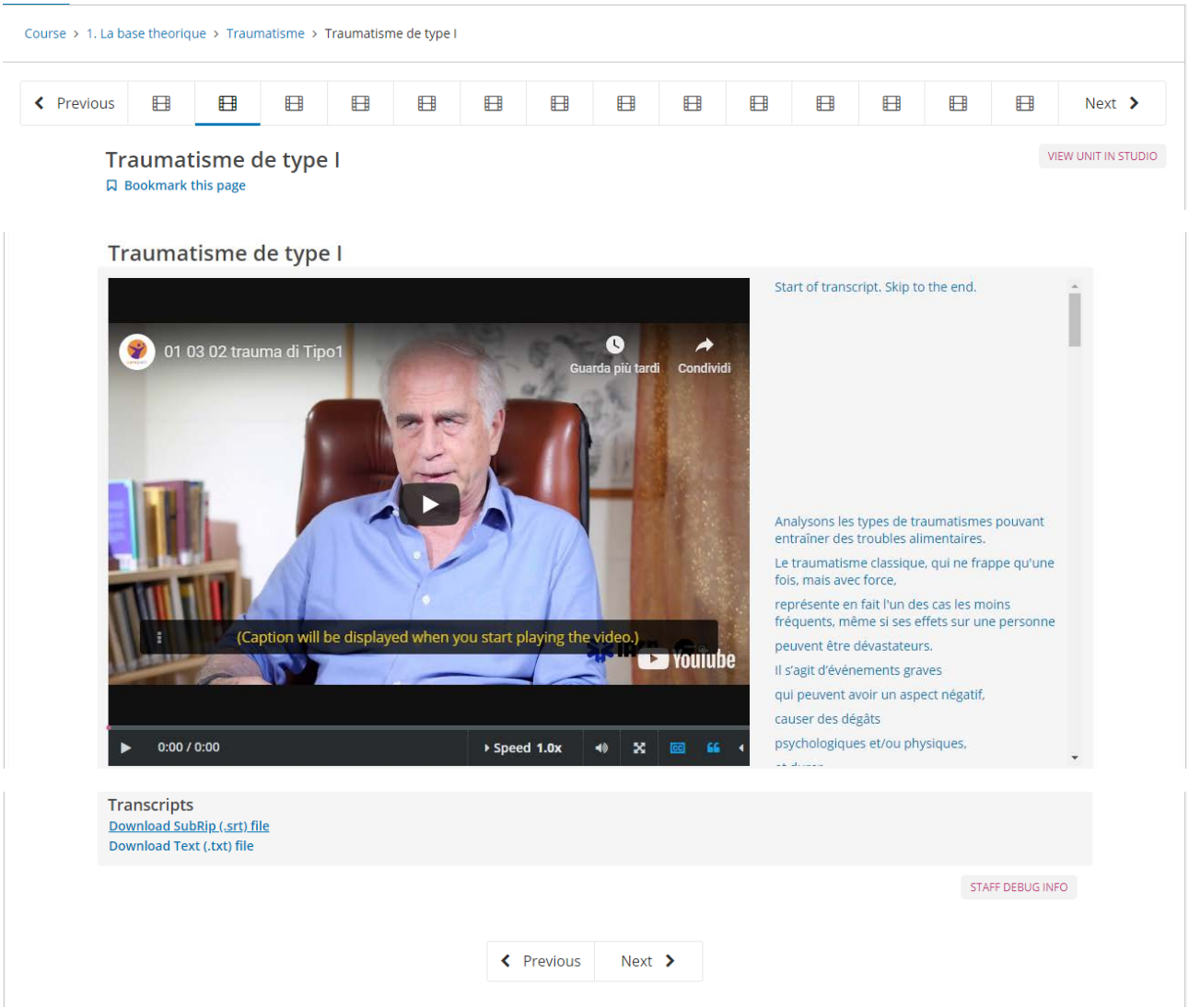

Transcript

Analysons les types de traumatismes pouvant entraîner des troubles alimentaires.

Le traumatisme classique, qui ne frappe qu'une fois, mais avec force,

représente en fait l'un des cas les moins fréquents, même si ses effets sur une personne

peuvent être dévastateurs.

Il s'agit d'événements graves

qui peuvent avoir un aspect négatif,

causer des dégâts

psychologiques et/ou physiques,

et durer

plusieurs années.

Habituellement, si on retrouve ce traumatisme dans ce qu'on appelle le syndrome de stress post-traumatique,

il est également très courant dans les troubles de l'alimentation, en particulier dans certaines formes de troubles de l'alimentation.

On peut les répartir en deux catégories : 1. le traumatisme physique, susceptible de se produire principalement dans des moments particulièrement dramatiques, comme un viol, un vol, un acte de violence physique, des combats en temps de guerre, des catastrophes naturelles (comme un tsunami ou un tremblement de terre), un très grave accident de voiture ou de train ;

2. le traumatisme de type essentiellement psychologique :lorsque la vie d'une personne est mise en danger par quelqu'un d'autre, dans une situation particulière où, même en l'absence de blessures physiques, physical injuries, but simply la menace est à ce point extrême et forte qu'il est difficile pour la personne de l'effacer rapidement de son esprit.

Pour les personnes ayant subi un traumatisme de type I, également appelé « traumatisme focal », il s'agit d'un « coup unique », c'est-à-dire que le traumatisme frappe une fois, mais laisse des traces durables et dans les symptômes liés à l'alimentation, a un effet semblable au trouble de stress post-traumatique.

Un traumatisme du type I peut avoir une série de conséquences, parmi lesquelles les troubles alimentaires sont l'une des plus fréquentes, ainsi que des symptômes assez étendus pouvant se manifester par une série de traits tous présents dans le comportement du trouble alimentaire.

C'est-à-dire que le trouble alimentaire n'est pas seulement un comportement alimentaire,

mais les symptômes peuvent accompagner,

fréquemment

et dans presque tous les cas de cette symptomatologie,

chacun des troubles alimentaires individuels. Quels sont ces traits ?

Une faible estime de soi, une très forte tendance à la dépression,

a distorted image of one's body and sexuality

une image déformée de son propre corps et

de sa sexualité,n risque suicidaire élevé, des troubles anxieux, un abus d'alcool,

des troubles du sommeil, des troubles dissociatifs, des pertes de mémoire, de l'agressivité et des troubles de la personnalité.

C'est un cortège symptomologique qui ne nous surprend jamais :

les troubles alimentaires ne surviennent jamais seuls, mais sont toujours accompagnés de symptômes

de ce genre ou de véritables pathologies

qui complètent le tableau des troubles alimentaires

et

en sont rarement absents.

Nous pouvons citer en exemple

un traumatisme qui laisse une trace - comme dans le cas d'un traumatisme de type I

– et qui se produit principalement

en produisant une alexithymie, soit un trouble émotionnel empêchant

la personne d'exprimer ouvertement ses émotions

avec des mots.

La tendance dans ce cas, après un traumatisme de type I, est d'exprimer ses émotions

de manière non verbale,

avec son propre corps ;

ces sensations peuvent

s'avérer

très graves

et entraîner

une forte dysrégulation émotionnelle, également notable, au point que la personne

montre une impulsion

à un certain niveau,

et

nous savons - parce que c'est

l'une des réactions les

plus fréquentes que nous constatons

- qu'il existe certaines formes de boulimie dans lesquelles ce type de traumatisme

(par exemple la maltraitance) est

d'une gravité

et d'une ampleur telles qu'il produit des

symptômes

pouvant entraîner une perte de contrôle considérable et

généralisée à différents niveaux.

En particulier, ce qui se passe à un stade précoce du développement,

lorsque le traumatisme est dramatique

et qu'il y a des variables sérieuses dans la famille

à soutenir,

dans ces cas,

le risque existe d'une boulimie multi-impulsive :

une forme très grave et

dangereuse de boulimie

qui peut entraîner, en plus des comportements boulimiques,

des altérations du comportement alimentaire,

et surtout de l'impulsivité,

parfois

sexuelle,

the

une tendance

à consommer de la nourriture de manière incontrôlée, sans la goûter,

ce qui peut, par exemple, conduire aux

comportements typiques de ceux qui commettent

des vols dans les supermarchés ou qui y consomment de la nourriture sans pouvoir

attendre de rentrer chez eux pour manger,

même s'ils peuvent payer leur nourriture.

Il s’agit d’une désinhibition des pulsions, constatée dans le champs de la sexualité,

mais également, ce qui est plus important et plus dangereux, d’une auto-mutilation impulsive,

de comportements d'auto-mutilation pouvant aller jusqu’à se couper ou tenter de se suicider.

Ce type de boulimie, multi-compulsive, est la plus dangereuse,

notamment en raison du taux de suicide élevé.

En conclusion, un traumatisme de type I peut entraîner,

of this form of bulimia which is certainly the most dangerous form known in particular surtout si l'environnement n'est pas favorable,

cette forme de boulimie, qui est certainement la plus dangereuse, notamment en raison d’un risque très élevé de suicide.

matériau de support

https://www.nctsn.org/what-is-child-trauma/trauma-types

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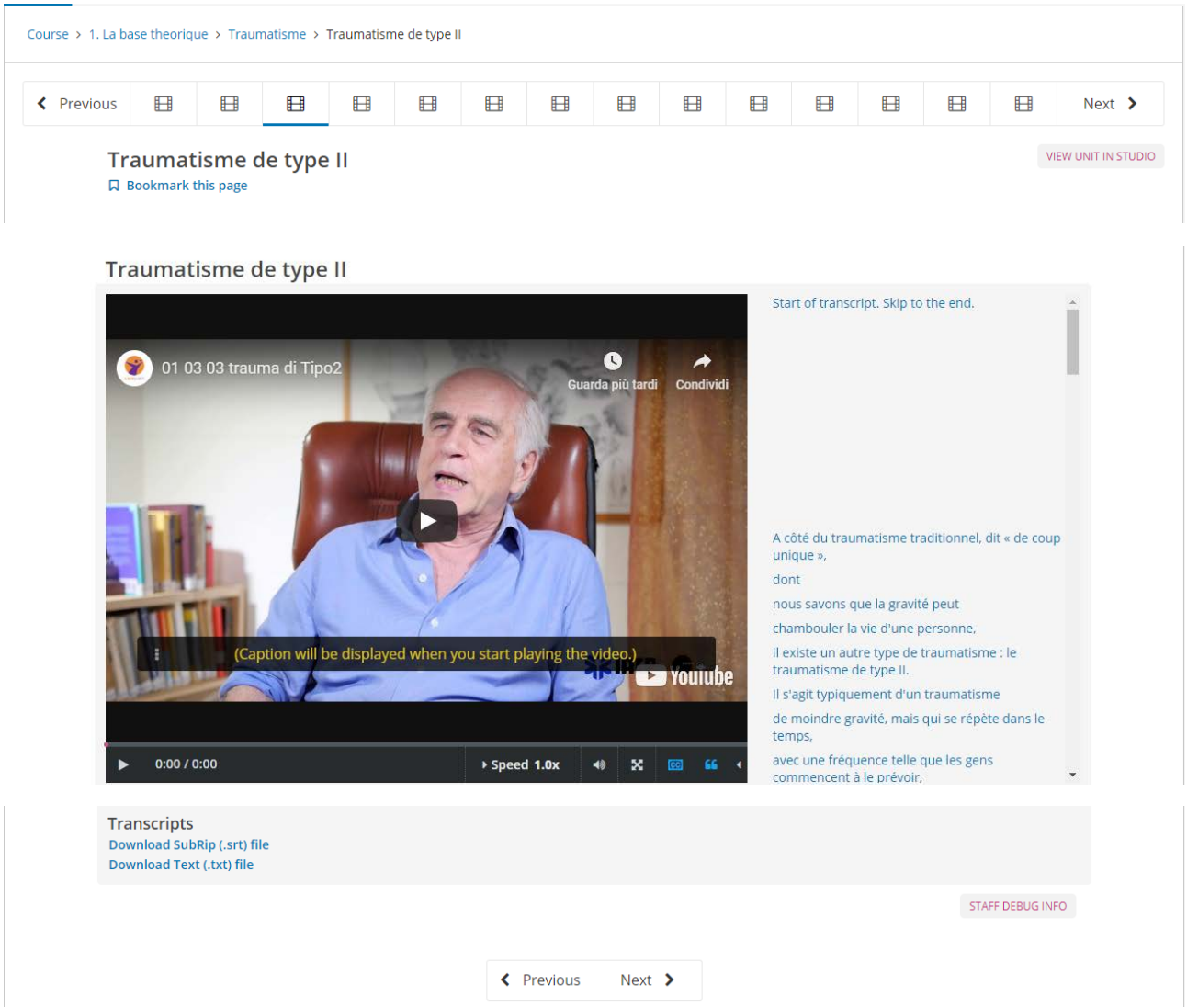


Transcript

A côté du traumatisme traditionnel, dit « de coup unique »,

dont

nous savons que la gravité peut

chambouler la vie d'une personne,

il existe un autre type de traumatisme : le traumatisme de type II.

Il s'agit typiquement d'un traumatisme

de moindre gravité, mais qui se répète dans le temps,

avec une fréquence telle que les gens commencent à le prévoir,

même s’ils ne peuvent pas en prédire le moment exact de la survenance.

Cette attente a un effet lassant : elle produit

un sentiment d'impuissance extrêmement fort

in the chez le sujet qui a l'impression de ne

pas pouvoir se maîtriser.
Ce type de traumatisme, qui cause fréquemment des troubles alimentaires,
peut résulter
de conflits violents dans le milieu familial
dont
l'adolescent,
ou parfois l'enfant, a été témoin pendant une longue partie de sa vie sans pouvoir les nommer.
Ces conflits violents peuvent mener à un comportement réellement
violent qui risque de causer de graves dommages
ou même des pertes.
Ce type de traumatisme répétitif crée une situation
d'attente dramatique :
la personne s'attend à rencontrer une opposition
même si ce n'est
pas nécessairement le cas.
Néanmoins, le traumatisme est causé par une répétition si forte
et si fréquente que,
dans la vie ultérieure de la personne,
la peur qu'il suscitait peut réapparaitre
une fois le traumatisme disparu.
Dans certains cas, les gens ont tendance à répéter ce type de traumatisme.
Par exemple, une
jeune femme
qui toute sa vie a été témoin de disputes entre ses parents
causées par des infidélités,
risque de ne choisir, plus tard,
que des partenaires
susceptibles de reproduire les mêmes comportements infidèles.
Les trahisons passées la poussent à chercher une tricherie, qu'elle ait eu lieu ou non.
Ce type de comportement devient,
d'une certaine façon, la répétition d'une prédiction d'un événement négatif,
avec la crainte qu'il puisse se produire d'un moment à l'autre,

comme si le moment de l'enfance n'était jamais passé.

Le traumatisme de type II produit, entre autres,

une tendance au déni massif, un engourdissement affectif,

comme si la personne voulait réprimer ses sentiments émotionnels.

Elle aura tendance à se comporter comme si elle était « refroidie », comme si elle n'éprouvait

que ce seul et unique sentiment

à certains moments de sa vie.

C'est ce qu'on appelle l'engourdissement, qui est considéré comme

l'une des composantes de base

des troubles dissociatifs : un trouble qui fait perdre la capacité

de ressentir

des sensations normales,

comme si on avait perdu

des capacités sensorielles importantes,

ou comme si on était absent ou s'éclipsait

de la vie quotidienne à certains moments

de l'existence.

Cela s'accompagne,

surtout dans le cas de troubles alimentaires

(d'autant plus

s'il y a perte de contrôle,

anorexie restreinte ou anorexie avec comportements boulimiques ou boulimie),

d'une colère

cachée

et profonde.

Le sujet est passif,

semble incapable de réagir,

même si, lorsqu'il accomplit une action,

on perçoit en lui .

une forte colère

Les manifestations d'agression envers le monde extérieur

sont très contenues,

mais lorsque le sujet ressent des émotions fortes,

la colère peut devenir explicite

et se traduire par un comportement violent rs lui-même ou envers les autres.

Le sujet exprime une tristesse incessante - et non intermittente -

qui se stabilise,

comme s'il

avait connu un traumatisme de l'enfance qui s’est mis en pause constante,

nt de produire un sentiment de désespoir qui,

ava lui,

se prolonge toute la vie.

Ce sont, comme on dit, des petits traumatismes

qui s'accumulent. On les définit également

comme des traumatismes complexes ou relationnels, parce qu'ils dépendent

d'une série de relations mutuelles continues.

Il peut donc arriver que la personne qui a vécu ces traumatismes

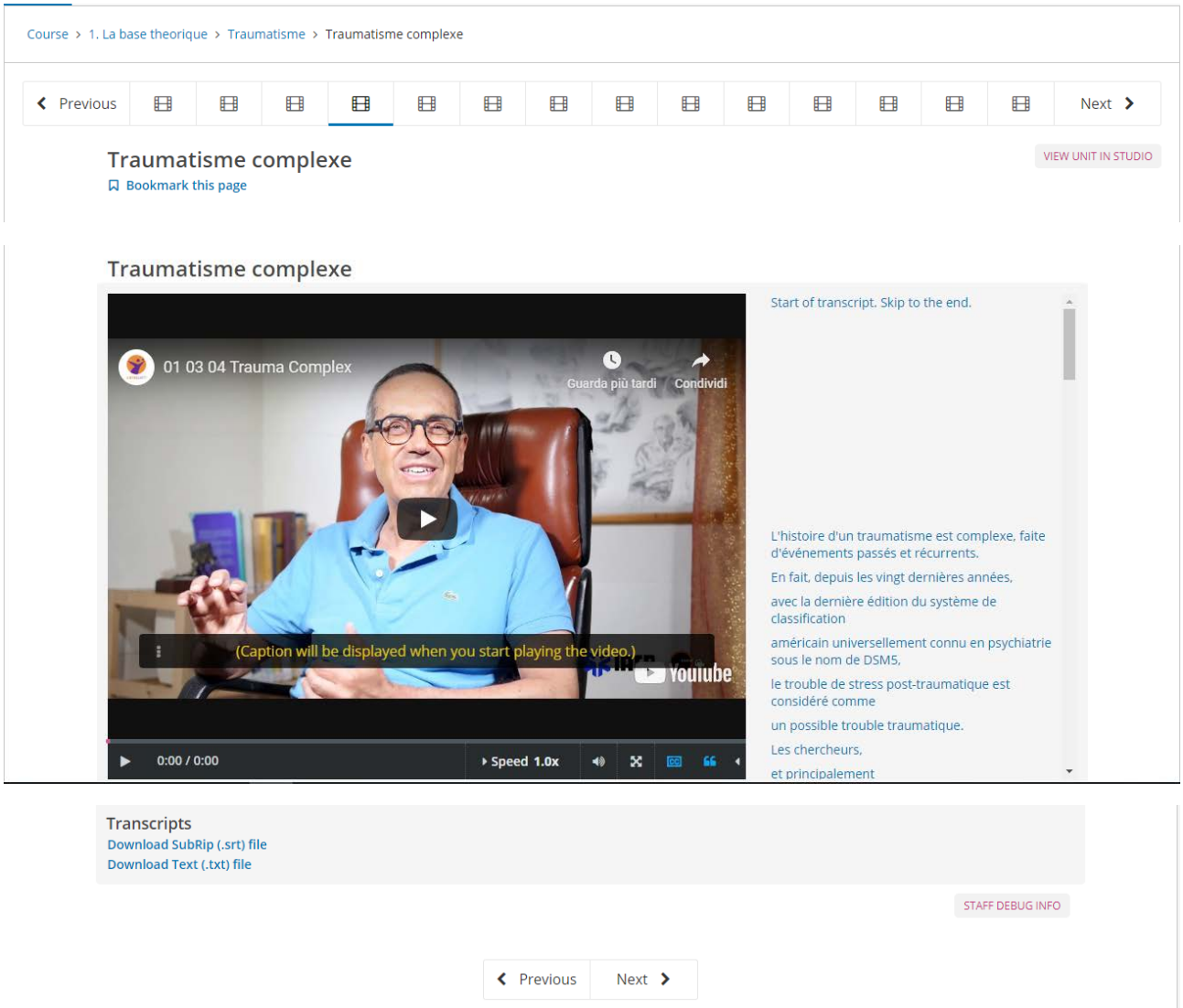
vive des moments fortement traumatisants dans son lieu de vie, et plus précisément

dans son environnement familial.

Il s'agit

donc de traumatismes constants qui réapparaissent et produisent les symptômes dissociatifs

mentionnés précédemment ou, en d’autres termes, une régulation émotionnelle.



Transcript

L'histoire d'un traumatisme est complexe, faite d'événements passés et récurrents.

En fait, depuis les vingt dernières années,

avec la dernière édition du système de classification

américain universellement connu en psychiatrie sous le nom de DSM5,

le trouble de stress post-traumatique est considéré comme

un possible trouble traumatique.

Les chercheurs,

et principalement

Van der Kolk, à la base

du questionnement sur les traumatismes complexes,

se sont tournés vers les traumatismes de l'enfance,

ceux qui se sont produits à un âge où le sujet se trouvait dans une

position de faiblesse,

d'infériorité -

comme le sont normalement les enfants.

Ce type de

situation traumatique, d'événements auxquels les enfants sont exposés,

d'un point de vue non seulement psychopathologique,

mais également neurobiologique, peuvent expliquer une prédisposition au développement de troubles psychiatriques

qui vont bien au-delà du syndrome de stress post-traumatique.

Ces

phénomènes

de

traumatismes de l'enfance

se présentent de diverses manière : ils peuvent être aigus,

prolongés et répétés pendant l'enfance

et assimilés à

des formes

de maltraitance lorsque les phénomènes traumatiques sont positifs.

Par exemple, lorsqu'un acte est commis contre l'enfant, comme des mauvais traitements,

de la violence sexuelle ou physique, ou de la violence psychologique.

Ils peuvent,

par ailleurs,

être omissifs, c'est-à-dire qu'ils peuvent être dus à une forme de négligence,

à une absence des soins tant psychologique se physiques

qu de l'enfant conduisant

à des événements

et des situations réelles de maltraitance.

Ainsi, la maltraitance et l'abus sont les phénomènes auxquels nous nous confrontons aujourd'hui

lorsque nous parlons de traumatismes complexes.

Le traumatisme complexe, ou traumatisme évolutif primaire comme certains l'appellent,

est souvent dû à l'échec

des

soignants primaires,

les parents

par exemple

ainsi qu'à un traumatisme cumulatif. Le psychanalyste Masud Khan s'occupe précisément 48 00:03:12,380 --> 00:03:19,080 de ce type de traumatisme, constitué d'un grand nombre de petits événements

ou de situations traumatiques omissives ou commissives, qui

se sont répétés pendant l'enfance et qui, cumulativement, créent un climat ou une dimension traumatiques

que le sujet ressentira pendant

sa vie adulte chaque fois qu'il rencontrera des difficultés,

des problèmes ou un autre traumatisme qui lui rappellera le traumatisme précédent.

Cependant, ce traumatisme antérieur est complexe et risque de se prolonger

sur une période très longue

et importante, voire sur toute une enfance.

Pensez aux familles qui vivent

dans un climat de

peur ou de violence prolongée en raison de nuisances ou de problèmes affectant les parents

et qui rendent impossible la sérénité,

le sentiment de sécurité

et de protection indispensable pour qu'un enfant puisse développer une confiance de base,

affronter la vie

et les relations

avec les autres de manière calme, ouverte et confiante.

Le phénomène peut passer inaperçu aux yeux du sujet, car presque toutes ces situations peuvent

être réprimées ou oubliées,

et

donc

se développer

de manière intérieure, sous-jacente,

jusqu'à ce que le sujet doive «régler la note ».

La raison en est que ces situations se révèlent subitement,

d'une manière parfois explosive,

sous l'effet d'un événement survenu dans l'environnement du sujet et qui,

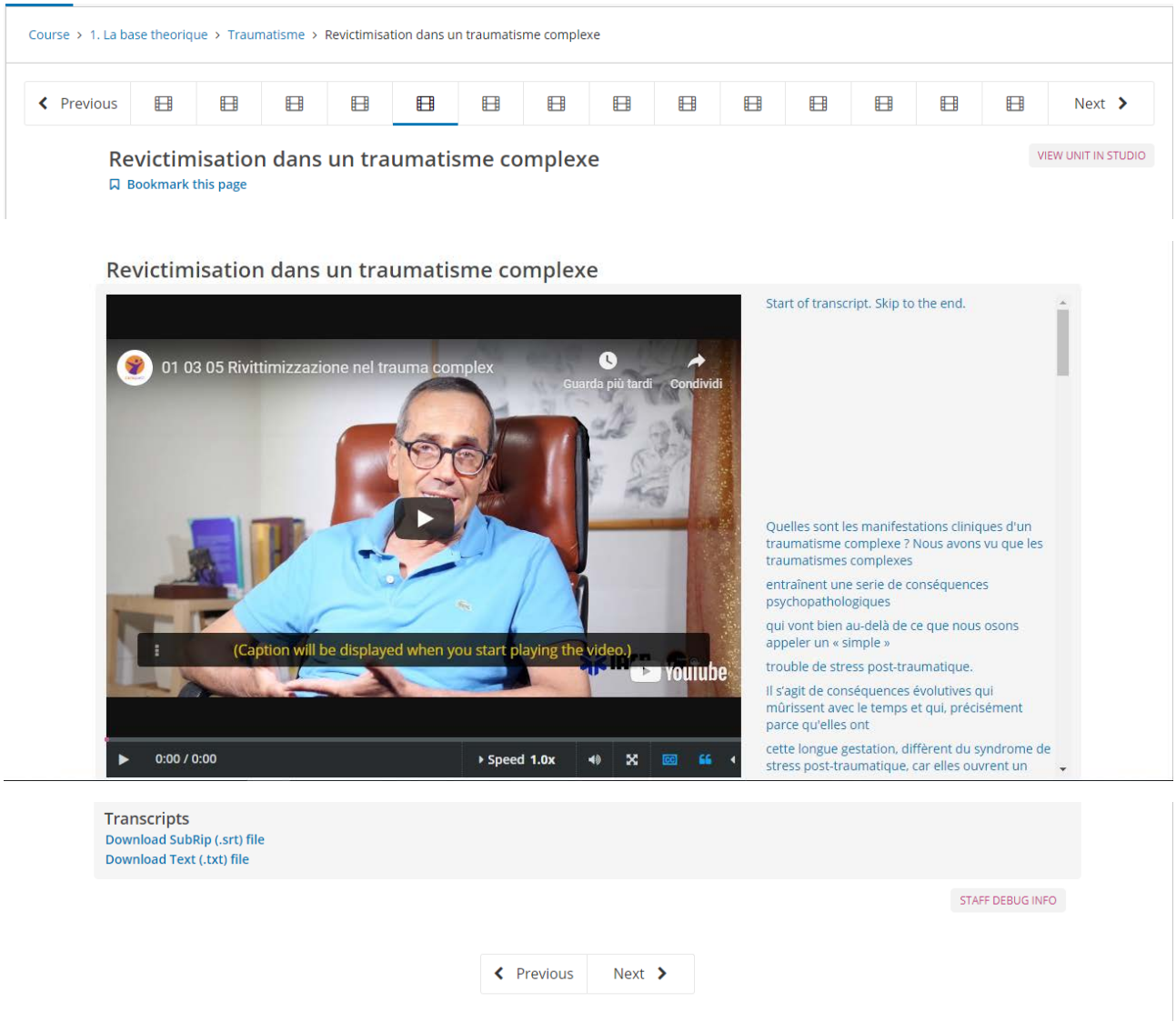
une fois celui-ci arrivé à l'âge adulte,

l’aide à déconstruire son climat émotionnel, contribuant à son

inconfort et rouvrant ainsi le scénario du traumatisme passé.

Il en va de cette manière parce que, comme nous l'avons déjà mentionné,

le traumatisme actuel peut attirer et rappeler le traumatisme passé, dans une sorte d'attraction fatale.



Transcript

Quelles sont les manifestations cliniques d'un traumatisme complexe ? Nous avons vu que les traumatismes complexes

entraînent une serie de conséquences psychopathologiques

qui vont bien au-delà de ce que nous osons appeler un « simple »

trouble de stress post-traumatique.

Il s'agit de conséquences évolutives qui mûrissent avec le temps et qui, précisément parce qu'elles ont

cette longue gestation, diffèrent du syndrome de stress post-traumatique, car elles ouvrent un éventail beaucoup

plus large de pathologies.

Commençons par les troubles

de la régulation affective,

de l'émotion

et

du comportement.

Il arrive donc souvent que les personnes,

quand elles ont été soumises à un traumatisme complexe,

développent une impulsivité qui n'est pas seulement

de caractère, mais d'un trouble, un trouble qui contrôle les impulsions. Elle peut

se manifester et

s'exprimer dans des comportements violents,

envers les autres et envers soi-même,

dans une consommation impulsive de substances

(toxicomanie ou alcoolisme).

Un autre aspect très important

est celui de l'autorégulation émotionnelle dans le sens

de l'estime de soi. Il s'agit de la possibilité pour un sujet d'établir

une confiance de base

en lui-même

et, partant, des éventuels sentiments de culpabilité que,

de façon plus ou moins latente, il porte en lui depuis l'enfance. N'oublions pas

qu'un enfant soumis à des abus, sexuels ou autres, se sent souvent coupable d'avoir fait

quelque chose de sale et ne pourra donc pas attribuer correctement

a responsabilité de ce qui est arrivé à l'adulte, auteur de l'abus.

Ces sentiments de culpabilité peuvent se développer,

se prolonger et déboucher sur une forme dépressive de vulnérabilité.

La dépression peut ainsi être l'une des conséquences

d'un traumatisme complexe à l'âge adulte.

Parmi les autres conséquences,

citons les troubles psychosomatiques ; en effet les conséquences d'un traumatisme peuvent également se manifester sur le plan

physique : réactivité physiologique, hyperréactivité physiologique, conséquences sur le système

cardiovasculaire (phénomènes cardiotoniques, hypertensifs), problèmes

de régulation de la douleur et de son seuil

(diffusion de la douleur dans le corps),

hypersensibilité à des stimuli douloureux
et divers troubles sexuels,
qui
d'un point de vue psychosomatique, sont liés à des troubles du contrôle
des impulsions pouvant déboucher sur des formes de perversion et donc
des pertes de contrôle des impulsions sexuelles.
Enfin, nous constatons des troubles dissociatifs,
par exemple la dépersonnalisation et la déréalisation, des phénomènes aujourd'hui reconnus
ec une certaine difficulté intuitive, qui se manifestent par un sentiment d'extranéit
avé que le sujet ressent face à la réalité et face à lui-même.
Il s'agit
de mécanismes de défense contre
une réalité que le sujet ressent comme intolérable,
qu'il ne peut pas ressentir
comme revivifiée, la dissociation permettant de s'en éloigner.
Freud a mis en évidence
le mécanisme fondamental
de la compulsion de répétition, par lequel un sujet tente de retrouver le traumatisme,
non pas tant pour
en subir
à nouveau les effets négatifs, mais plutôt pour tenter de le surmonter.
Cette tentative de surmonter le traumatisme fait que certains comportements du sujet
le conduisent
à revivre des situations données : le cas classique est celui de l'enfant,
victime d'un agresseur, qui peut répéter l’agression, une fois à l'âge adulte,
tantôt dans le rôle
de l’agresseur, tantôt dans celui de l’agressé.
L'adulte peut tenter de se re-légitimer,
en créant une situation où
il revit en tant que victime l’acte
d’un autre,
ou il peut

adopter un comportement qui fait de lui

l'auteur d'une agression.

Cela pourrait survenir, par exemple,

dans des situations de violence sexuelle subies dans l'enfance et susceptibles

de se reproduire avec une plus grande fréquence à l'âge adulte ou à l'adolescence,

soit une situation qui se reproduit.

Prenons l'exemple d'un viol,

une violence sexuelle

à l'encontre d'une femme

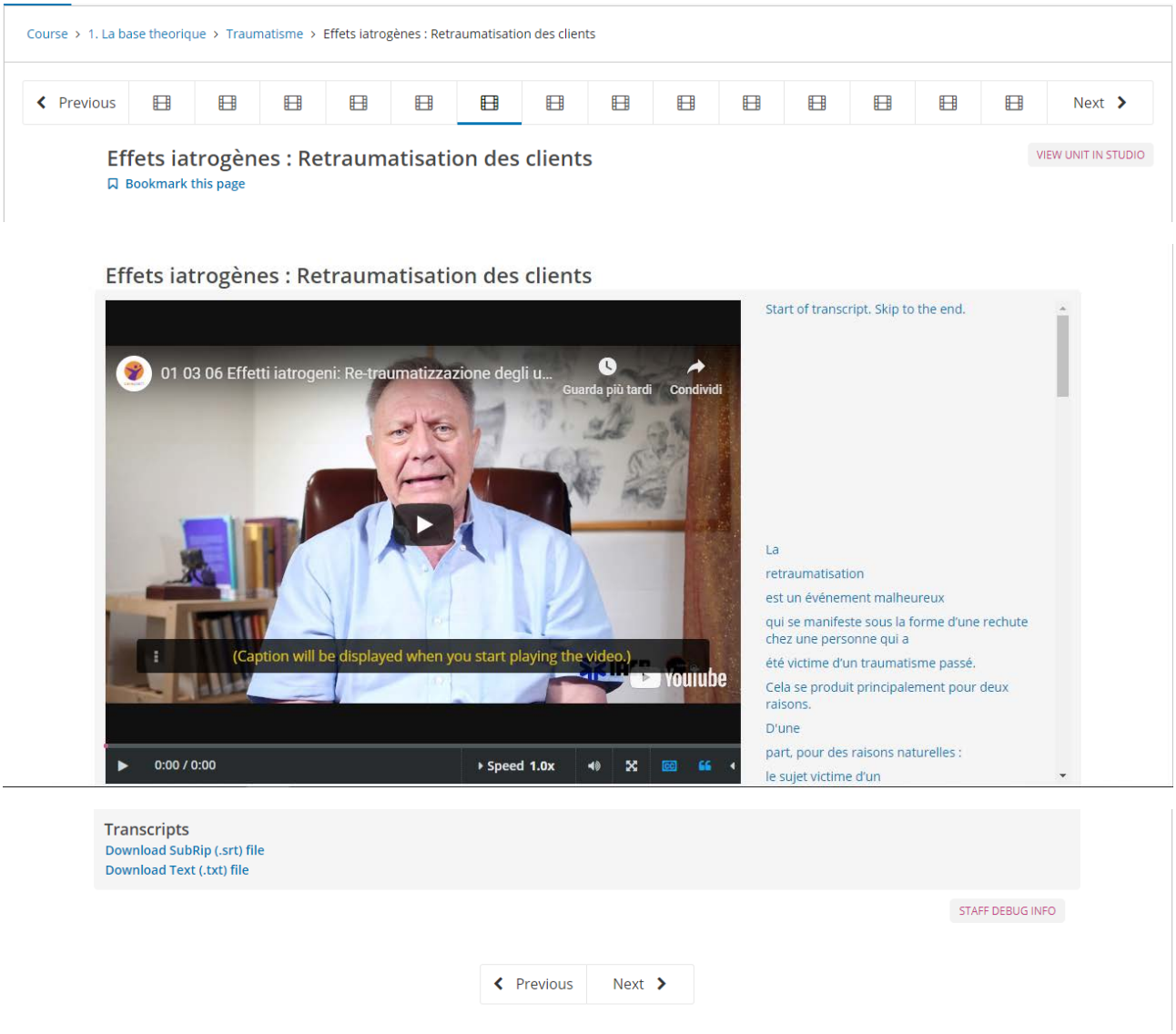
qui peut être vécue

à la première personne (en tant que bourreau)

ou recréée en tant que victime,

soit une situation qui fait revivre le traumatisme,

dans chacun des rôles pour essayer de le surmonter, dans ce que Freud appelle la « compulsion de répétition ».



Transcript

La

retraumatisation

est un événement malheureux

qui se manifeste sous la forme d'une rechute chez une personne qui a

été victime d'un traumatisme passé.

Cela se produit principalement pour deux raisons.

D'une

part, pour des raisons naturelles :

le sujet victime d'un

traumatisme passé

est exposé

à des images ou des événements
qui causent un traumatisme chez d’autres,
et revit le traumatisme vécu.
Autre
raison :
une
forme
de retraumatisation 20 00:00:58,840 --> 00:00:59,340 dont
les
origines sont iatrogènes.
traitements ont
été dispensés
de manière dysfonctionnelle,
pas nécessairement
en raison
des mauvaises intentions des professionnels
ou des administrateurs
de l'établissement de soins,
mais par simple ignorance,
de sorte qu'au lieu de recevoir l’aide souhaitée,
le sujet
traumatisé
subit un
nouveau traumatisme.
En bref,
cela s’assimile
au cas d’une personne
arrivant
aux urgences avec une jambe cassée,
qui tombe de la civière,
par la faute
d’une mauvaise manipulation par les soignants.

Le sujet se retrouve alors avec deux jambes cassées, doublant ainsi les dommages ;

une véritable tragédie.

L'histoire et la sociologie

des traitements

de traumatismes

révèlent que, malheureusement,

il n'était pas rare dans le passé –

non pas en raison d'une mauvaise volonté, mais par ignorance -

de produire

des

résultats iatrogènes.

Puisque les traitements

touchent le système complexe et délicat qu'est l'être humain,

le secteur des soins peut non seulement avoir un impact positif sur les patients, mais également – et sans le vouloir – risque de leur causer des dommages supplémentaires ;

cela est vrai pour les médicaments, pour les interventions chirurgicales

et pour tout type de relation d'aide. Un service, s'il n'est pas fourni de manière

efficace, peut

s'avérer

contre-productif.

Dans le cas spécifique d'un traumatisme, ce risque est particulièrement grave, car la victime d'un traumatisme sera ,

de facto,

plus sensible

et risque donc d'être considérablement « abîmée » par le second traumatisme.

Aujourd'hui, nous avons tiré

les enseignements des erreurs du passé, les recherches

sont non seulement

plus nombreuses,

mais également plus précises, et nous avons développé un corpus suffisant (et non encore épuisé)

de connaissances qui nous permettent de réduire le risque de

« retraumatiser » des personnes déjà traumatisées,

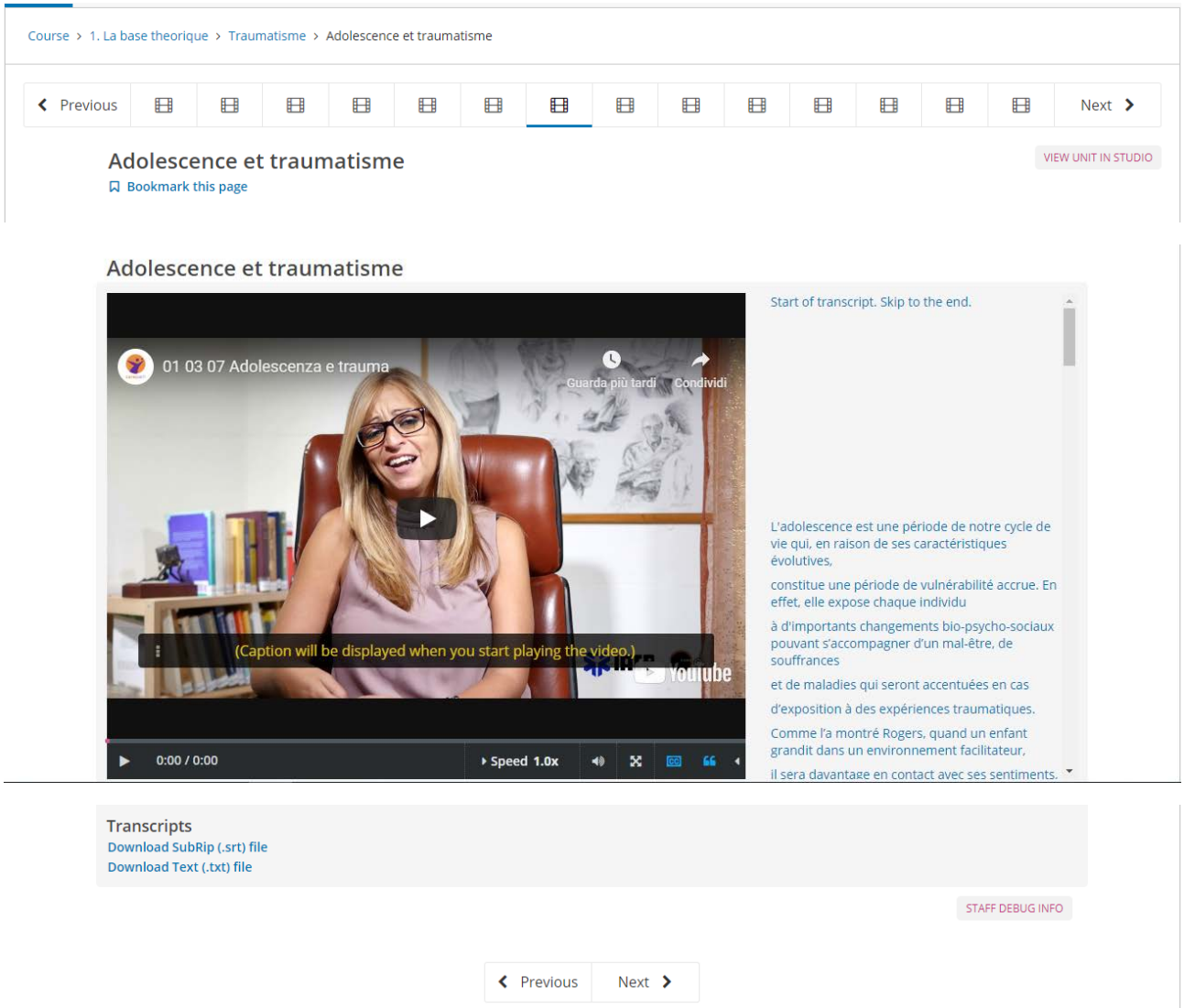
grâce à ce qu’on appelle des

« pratiques sensibles au traumatisme »,

centrées sur la personne de l'usager traumatisé

et

attentive aux causes éventuelles de dommages supplémentaires.



L'adolescence est une période de notre cycle de vie qui, en raison de ses caractéristiques évolutives,

constitue une période de vulnérabilité accrue. En effet, elle expose chaque individu

à d'importants changements bio-psycho-sociaux pouvant s'accompagner d'un mal-être, de souffrances

et de maladies qui seront accentuées en cas

d'exposition à des expériences traumatiques.

Comme l'a montré Rogers, quand un enfant grandit dans un environnement facilitateur,

il sera davantage en contact avec ses sentiments, sans risque de bloquer ni de figer les expériences traumatisantes,

et il pourra avancer dans la vie, en satisfaisant ses besoins et

en évaluant les expériences comme agréables ou désagréables

selon qu'elles seront favorables ou défavorables à son propre développement.

Rogers appelle cette capacité innée d'autorégulation la tendance actualisante, soit la capacité de se comprendre, de s'autoréguler et de s'actualiser.

Si, au contraire, l'enfant vit dans un environnement où il ne sentira accepté par les personnes qui s'occupent de lui uniquement

si lui-même est en mesure de répondre à leurs attentes,

il risque une introjection de ces attentes,

d'amputer de force une partie de son propre soi

et de construire un soi idéal avec des constructions rigides.

Des constructions qui seront encore plus rigides si

elles se construisent sur un sentiment constant d'ambiguïté, de menaces et de peur, si l'enfant grandit dans

un environnement imprévisible.

Nous constatons que notre adolescent, qui grandit et se nourrit dans son contexte relationnel,

est ainsi exposé aux changements évolutifs mentionnés plus haut.

Toutes ces modifications de déterminants imposent une sorte de réorganisation interne,

un réajustement qui implique l'image individuelle de lui-même et de ses relations les plus importantes...

Tout cela exige donc une redéfinition du sens de sa propre identité.

Voyons quels sont les changements auxquels l'adolescent est confronté.

Le premier touche son corps : le corps de l'adolescent est un corps en évolution, avec

une croissance en taille, l'apparition d'organes sexuels secondaires,

d'organes reproducteurs. Il s'agit donc d'un corps qui nécessite un nouveau type de relation avec lui-même.

Le corps devient un véhicule primaire et intermédiaire par

lequel l'adolescent communique ses expériences vers l'extérieur.

Un corps, dès lors, que vous pouvez choisir d'entretenir et d'embellir,

mais également de gratter, de couper ou d'ignorer

; un corps qui veut que l'on parle de lui.

En même temps, c'est un corps qui est vu de l'extérieur, qui capte le regard des autres,

avec désir ou dérision, et qui expose l'adolescent à de nouvelles expériences,

à de nouvelles opportunités, mais également à de nouveaux risques.

Ensuite, viennent des changements au niveau interpersonnel.

Au sein de la famille, on demande à l'adolescent de passer de la dépendance - la phase de soins et d'attachement

- à l'autonomie et à la recherche d'un équilibre entre ces deux axes

évolutifs apparemment opposés, avec les répercussions sociales que cela induit. En effet, dans l'environnement extérieur,

le rôle de l'adolescent au sein de son groupe de pairs et d'autres figures relationnelles significatives, change

Comme l'ont montré les dernières recherches, des changements se produisent également au niveau du cerveau

Celui-ci subit des modifications,

à la fois structurelles et fonctionnelles, notamment

dans les zones corticales qui participent aux processus de décision.

Tout cela entraîne une grande vulnérabilité qui, comme nous l'avons déjà mentionné, est encore plus aigüe

si le sujet subit des traumatismes ou compromet

ce sentiment de sécurité interne, la base de sécurité décrite par Bowlby.

toujours réciproquer, mais qui nous permet donc de vivre cette précieuse expérience

ddu développement de l'autonomie sans perte de l'amour. Au lieu de cela, nous nous enrichissons par les rencontres que 58 00:04:38,190 --> 00:04:39,500 nous entretenons avec d'autres.

Par contre, la victime d'un traumatisme a une faible capacité de mentalisation et n'est pas

capable d'auto-réguler ses états émotionnels ; comme nous le dit Bromberg,

elle ne peut rien faire pour isoler l'expérience traumatique et toutes les expériences et tous les contenus

qui lui sont associés, en la dissociant. La dissociation pathologique - comme l'illustre Caretti - conduit

à l'épuisement du sujet et de ses ressources, car elle l'empêche de reconstruire

ces expériences traumatiques dans un récit qui serait cohérent avec sa propre histoire de vie.

Pour cette raison, si

nous travaillons avec des adolescents en situation

de stress émotionnel, nous pouvons travailler avec eux à une profondeur relationnelle importante,

en leur offrant des relations profondes, basées sur l'écoute,

une écoute empathique, avec un profond respect pour ce qu'ils sont. Essayer de comprendre

les expériences de leur point de vue, essayer de saisir le sens de ce qu'ils vivent et, par conséquent,

offrir des contextes relationnels dans lesquels les adolescents peuvent,

lentement, rétablir le contact avec ces parties d'eux-mêmes - ces besoins qui leur ont été refusés jusqu'alors.

Non seulement en leur permettant de les ressentir à nouveau, mais également en les aidant à reconnecter des parties d'eux-mêmes

aux expériences extérieures qu'ils vivaient auparavant comme excessivement dissonantes.

Nous y parviendrons en proposant aux adolescents un contexte relationnel qui pose

un regard différent sur eux. Pas uniquement un regard qui nous amène à les étiqueter

comme des garçons ou des filles en révolution perpétuelle et en lutte avec le monde extérieur, ou comme des figures apathiques réveillées

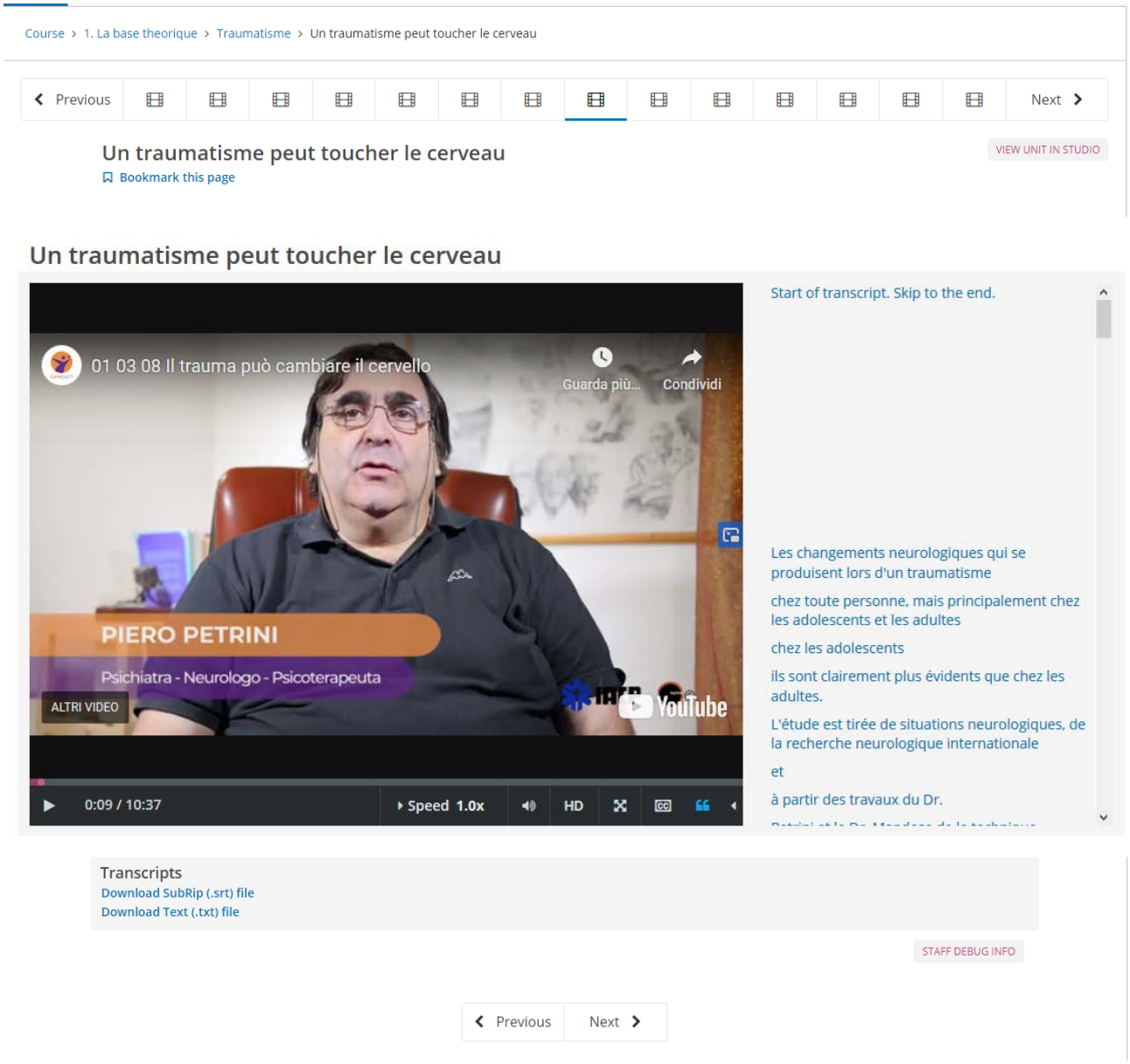
uniquement par l'univers du réseau social, mais plutôt un regard qui les voit comme des enfants dotés de caractéristiques

et d'outils typiques à leurs phases d'évolution, qui se déplacent dans le monde,

posent des questions, apportent des réponses, explorent, essaient de donner un sens personnel à leurs expériences.

A l'image de ce que nous faisons lorsque nous continuons à agir comme des adultes pour le reste de notre vie ;

l'affection que nous leur portons est donc très importante.



Transcript

Les changements neurologiques qui se produisent lors d'un traumatisme

chez toute personne, mais principalement chez les adolescents et les adultes

chez les adolescents

ils sont clairement plus évidents que chez les adultes.

L'étude est tirée de situations neurologiques, de la recherche neurologique internationale

et

à partir des travaux du Dr.

Petrini et le Dr. Mandese de la technique - processus psychanalytique mutatif :

une technique qui a clairement

les parties psychanalytiques et neurologiques, en

accord

avec les conclusions de

la recherche neurologique internationale et la relation entre la neurologie et la psychanalyse.

Il est bien connu que tout individu en bonne santé

l'état développe 1400 nouveaux neurones

à partir de cellules souches oestrogéniques

au quotidien, tant au niveau de l'hippocampe

et au niveau olfactif.

C'est un aspect important car l'hippocampe est la partie centrale de la mémoire,

l'organisme

qui rappelle des situations similaires, donc dans des situations de traumatisme.

Lors de la

niveau olfactif

nous observons nos lobes cérébraux

ne sont rien d'autre que

un exutoire de notre lobe olfactif

les animaux travaillent avec l'odorat

nous travaillons avec la pensée

donc la pensée de l'être humain

rien d'autre que l'olfactif

qui s'est répandu s'est développé dans ces

les cellules du cerveau

Nous pensons que les êtres humains ont environ 30.000 gènes, trop peu pour définir toutes les situations,

pour que les situations familiales, sentimentales, relationnelles, culturelles et religieuses entrent en jeu

La recherche montre que seulement 70% des gènes sont déterminés génétiquement

et seulement 30 % sont touchés par des facteurs externes.

La différence entre les gènes

entre un petit homme et un bonobo masculin est de 5%,

Toutefois, cette

Le pourcentage est très important. Un homme et un bonobo ne sont pas du tout comparables.

comparable, tout au plus. Pour les humains,

la culture, la religion, toutes les situations extérieures, la famille, la communauté

dans lequel nous vivons, sont très importants pour la formation d'un individu.

Ce qui se passe

quand le stress se produit ?

Comme nous l'avons vu, une situation stressante ou négligente est comme un stress

ne fait rien d'autre que de bloquer l'activité des cellules souches au niveau de l'hippocampe

et il devient donc impossible de remplacer les neurones qui sont normalement perdus ;

donc là

est une perte de neurones

dans la partie la plus importante et la plus profonde du cerveau qui est l'hippocampe

La régulation cognitive des émotions qui accompagne et soutient ces

changements dans le cerveau

est caractérisé

par l'anxiété et la dépression

en rapport avec

à l'amygdale :

un petit groupe de noyaux à l'intérieur du cerveau qui supporte

toutes nos situations émotionnelles et affectives,

de l'amour, à la sexualité, à l'alimentation,

qui est important d'un point de vue émotionnel.

Une altération se produit dans le cortex préfrontal, qui sont ceux qui orientent nos objectifs :

si je décide d'aller au théâtre pour voir un acteur, c'est le cortex préfrontal

qui me pousse à faire cette action, puis le cortex frontal la réalise.

Mais le cortex préfrontal donne également des impulsions, par exemple lorsque j'ai l'impulsion de partir ou de rester

à un endroit, je dois au cortex préfrontal le fait que le frontal réagit et communique

la nécessité de rester, par exemple en raison d'un engagement.

La troisième partie qui sera endommagée est

l'hippocampe et la mémoire (comme nous l'avons déjà dit,

l'hippocampe est le siège de la mémoire).

Des études longitudinales

ont montré que les traumatismes ne s'expriment pas à travers un trouble

de DSM -5 ou ICD - 10 qui est appelé trouble de stress post-traumatique,

mais est transmis

par des symptômes d'anxiété et de dépression,

parfois une hallucination, mais elle est mise en évidence

par des changements dans le sens du moi dans les relations interpersonnelles.

Une personne qui a subi un traumatisme

a des limitations comportementales et mentales,

est que la personne semble incapable

pour exprimer

elle-même dans le monde du travail,

d'affections

les relations, - c'est

comme s'il était tombé à un niveau de fonctionnement inférieur

Il s'agit de

Cela est dû à l'axe HPA - axe hypothalamo-hypophyso-surrénalien.

Au niveau du cerveau, il existe une glande appelée

l'hypophyse,

que toutes les hormones

de notre corps rayonnent.

Le lien entre les parties hormonales (endocriniennes)

et la partie nerveuse

est donné par le

hypothalamique -

l'axe pituitaire.

Tout ce qui atteint l'hypothalamus - une zone d'importance centrale, presque

un petit cerveau

est transmise à l'hypophyse et donne lieu

aux sensations, c'est-à-dire que le signal nerveux est transmis avec des substances hormonales.

Ces substances hormonales

se ramifient sur tout le corps,

de la glande pituitaire,

et le contrôle

la thyroïde

la sexualité par les glandes génitales, chez l'homme

et la sexualité féminine avec l'hormone mâle (qui détermine également la sexualité féminine).

Alors, surtout,

la libération de corticotrophine : l'hormone du stress, ou plutôt la pré-hormone du stress car la véritable hormone du stress est l'ACTH

parce que la véritable hormone du stress est l'ACTH, le cortisol,

C'est pourquoi la cortisone est administrée pour aider le corps à réagir en cas de dysfonctionnement physique,

Le cortisol possède en fait les mêmes éléments que la cortine (POMC).

Même dans le cas de batailles et de guerres, l'organisme humain est préparé, en fait le cortisol - ACTH

pour être précis - provoque la douleur

de ne pas être ressentie et donne lieu à des mécanismes d'agression (comme cela se produit chez les animaux).

Une situation d'agression claire

Lorsque ce mécanisme d'activité

est répétée

elle devient des états chroniques et prolongés d'anxiété et d'angoisse

se produire

en fonction de l'amygdale susmentionnée.

L'amygdale

est la commode

de notre mémoire émotionnelle, en ce sens qu'elle préserve tout

nos souvenirs émotionnels, comme s'il s'agissait d'une caméra de la réalité émotionnelle.

Ainsi, par exemple, notre premier baiser, notre premier travail, notre première sensation de bien-être

la première victoire sportive - ils sont tous photographiés dans l'amygdale et réapparaissent lorsque

des situations similaires se présentent ; lorsque l'hippocampe

commence

pour sécréter du cortisol

Ce cortisol se lie aux récepteurs de l'hippocampe, de l'amygdale et de la zone préfrontale

et lorsqu'elle a atteint un niveau suffisant, si la situation n'est pas chronique,

il abaisse le taux d'ACTH et de CRF.

Ainsi, l'hippocampe régule nos réponses

pour souligner

Quand

nous sommes bien la sérotonine gère la zone à la place - la sérotonine est l'hormone

de bonheur, lorsqu'une personne est déprimée,

des médicaments sérotoninergiques sont prescrits.

Sérotonine

inhibe les comportements agressifs et favorise la socialisation.

Il est produit à partir du tryptophane et est introduit dans l'alimentation.

La sérotonine, avec l'ocytocine, qui est l'hormone de liaison, est la plus positive

et hormone utile pour l'organisme, en ce sens que si la sérotonine stimule la socialité

et la relation avec les autres,

Ocytocine - libérée après 5 secondes d'étreinte d'une autre personne

est l'hormone

qui stimule le lien.

La recherche met en évidence que les activités d'amour,

les pensées et les sentiments importants ont

des effets thérapeutiques profonds sur notre corps.

Alors

Il existe sans aucun doute,

dans notre façon d'être

une série de réactions qui changent le cerveau et modifient le corps,

dans toute situation où il existe des hormones liées aux neurohormones

et liés à des stimuli nerveux.

Matériau de support

Bremner JD. Traumatic stress: effects on the brain. *Dialogues Clin Neurosci*. 2006;8(4):445–461.

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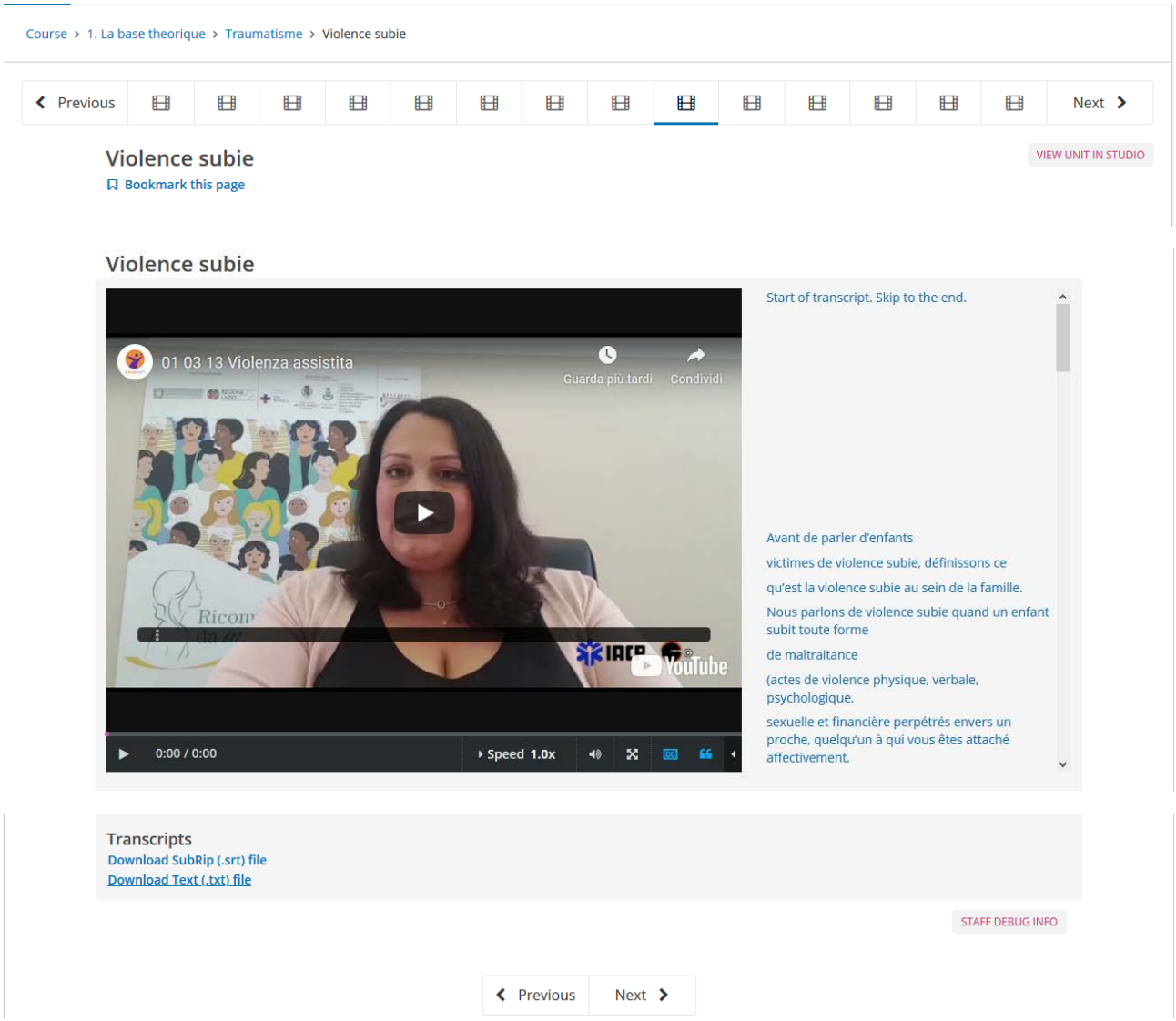


Transcript

Avant de parler d'enfants

victimes de violence subie, définissons ce

qu'est la violence subie au sein de la famille.

Nous parlons de violence subie quand un enfant subit toute forme

de maltraitance

(actes de violence physique, verbale, psychologique,

sexuelle et financière perpétrés envers un proche, quelqu'un à qui vous êtes attaché affectivement,

que ce soit un adulte ou un mineur).

Ce type de violence englobe la violence infligée par des mineurs à d'autres mineurs,

mais également par des membres de la famille envers des animaux domestiques ; il s'agit

d'expériences très traumatisantes pour les enfants.

Les caractéristiques de ces expériences peuvent varier.

La violence peut être indirecte : elle est ressentie,

ce qui signifie qu'elle peut être vue, mais également entendue.

C'est un aspect important, car de nombreuses femmes victimes de violence signalent que,

lorsque l'acte violent survient, leurs enfants se trouvent parfois dans une autre pièce;

on parle tout de même ici de violence directe, même si l'enfant ne fait qu'entendre l'acte violent, sans le voir.

L'expérience peut être indirecte,

lorsque l'enfant est conscient que l'acte violent

a déjà eu lieu ou est sur le point de se produire ; dans ce cas, on pourrait dire que les enfants possèdent des « antennes » :

ils comprennent lorsque règne dans la maison

la tension caractéristique et précurseur d'un épisode de violence.

Parfois, si l'expérience n'est vécue ni directement ni indirectement,

l'enfant en ressent les effets ; par exemple,

il voit des hématomes

sur la peau de sa mère ou sent un vent de violence dans la maison.

Dans de telles situations, on parle de violence dont l'enfant a été le témoin (witnessed violence).

Des fausses croyances circulent à propos de la violence dont l'enfant est le témoin.

Il n'est pas imperméables à la violence qui se produit au sein de leur propre famille ;

même s'il n'assiste pas à l'acte violent, il prend conscience de sa réalité,

l'enfant n'étant jamais un spectateur passif et inconscient.

Cette forme de violence augmente le risque de violence directe à l'encontre des enfants.

L'enfant, qui s'interpose pour défendre sa mère, risque de recevoir

des coups de la part du père : dans ce cas,

le Dr. Annibali applique l'approche genrée

lorsqu'elle aborde la violence dont l'enfant est le témoin, puisque, dans la plupart des cas,

la violence est exercée par les hommes à l'encontre des femmes.

Cela n'exclut en rien la violence

des mères à l'encontre des pères, ou du moins d'une femme

à l'encontre d'un homme, mais d'un point de vue statistique, celle-ci est moins fréquente.

Les enfants exposés à la violence courent cinq fois plus de risques de devenir violents à l'âge adulte que les enfants qui n'ont pas été témoins de violence.

Les conséquences de la violence dont l'enfant

est le témoin sont :

un sentiment de peur, d'anxiété, de surcharge, de tristesse,

de dépression grave, des sentiments de colère, de culpabilité, d'inaptitude et de honte.

Les enfants perdent confiance en eux et dans les autres, ils peuvent développer

des troubles psychosomatiques,

des difficultés à contrôler leurs impulsions, des problèmes scolaires,

des troubles de l'apprentissage et du langage,

une perte de maîtrise intestinale, des difficultés relationnelles

et un syndrome de stress post-traumatique

disosi l'expérience traumatisante se produit dans le cadre d'une relation de confiance, comme le cadre familial.

Au niveau bio-psychosocial,

quand l'enfant est témoin de violence, les conséquences se

manifestent dans les comportements, les émotions, les capacités cognitives, sur sa condition physique, mais également dans ses relations.

L'enfant vit un bouleversement total, la violence devient normale et en conséquence,

La normalité, c'est la violence.

and consequently normality is violence

Soit, l'enfant va considérer le comportement violent comme

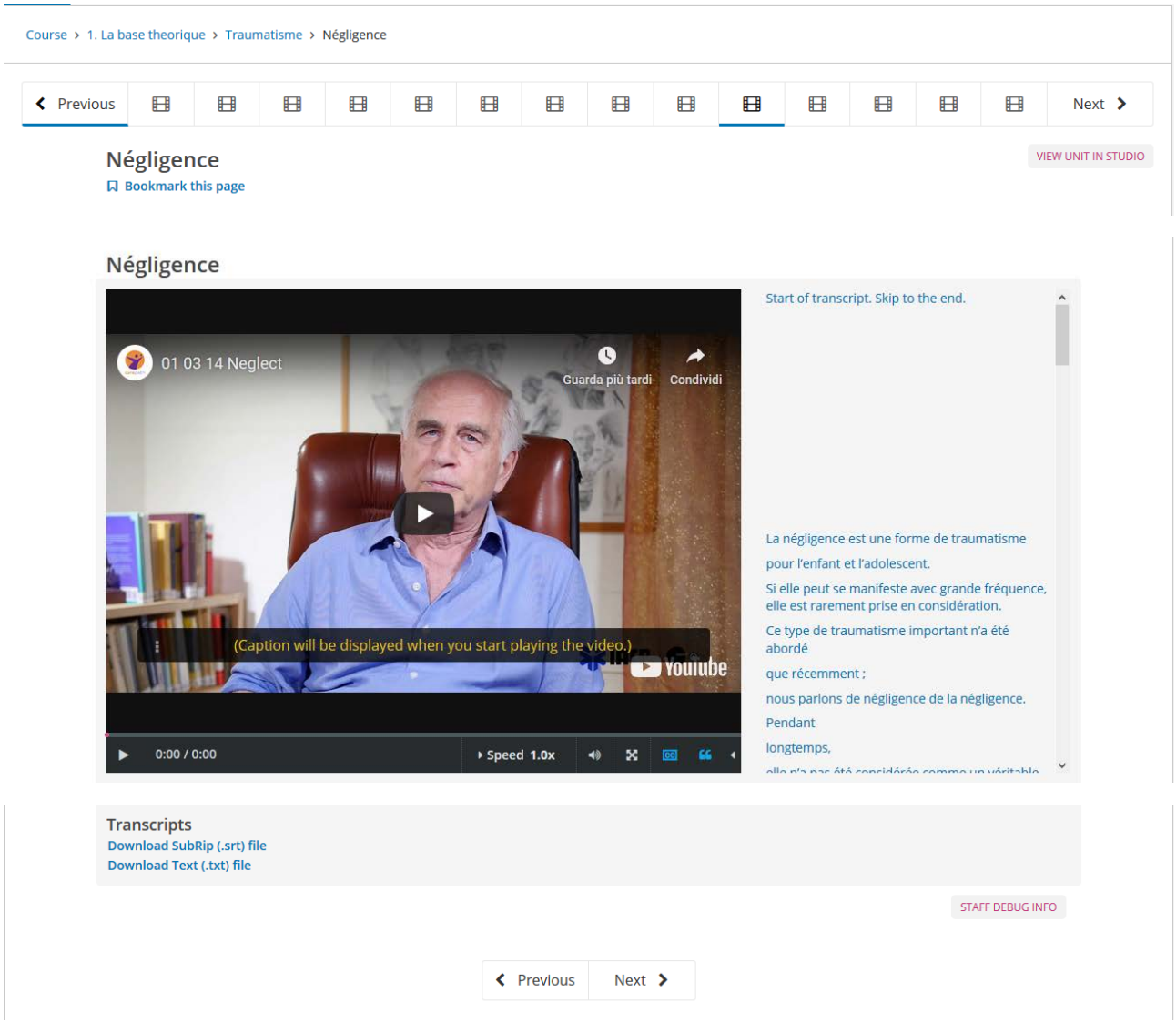
normal et physiologique,

it il va atténuer le côté dramatique de l'expérience au risque de probablement répéter

ces mêmes comportements.

Nous devons donc mettre l'accent sur la violence dont l'enfant est le témoin,

et sur son impact présent et futur.



Transcript

La négligence est une forme de traumatisme

pour l'enfant et l'adolescent.

Si elle peut se manifeste avec grande fréquence, elle est rarement prise en considération.

Ce type de traumatisme important n'a été abordé

que récemment ;

nous parlons de négligence de la négligence.

Pendant

longtemps,

elle n'a pas été considérée comme un véritable traumatisme,

mais au mieux comme une partie congrue dans la typologie des traumatismes existants.

En réalité, nous pensons aujourd'hui qu'il s'agit du traumatisme le plus répandu

et celui qui a les conséquences les plus graves sur le long terme.

Par « négligence », on entend l'adoption de comportements d'omission
de la part des personnes susceptibles d'offrir des soins.
Ces omissions désignent, même
s'il n'y a pas de risque grave et imminent de préjudice,
une série de manquements qui s'étirent sur une longue période de temps.
Ils peuvent, par exemple, accompagner un traumatisme de type I.
Il est probable
qu'un abus susceptible d'être bien
ou suffisamment toléré,
le sera moins
e l'absence d'un parent capable
de comprendre
et d'aider, de soutenir et de protéger
l'enfant victime du traumatisme.
En conséquence, si la négligence peut accompagner un traumatisme de type I,
elle peut également être la cause d'un véritable dommage.
Il existe plusieurs types de négligence,
dans les soins de santé,
l'éducation, l'accueil de l'enfant,
la protection face aux risques environnementaux,
les besoins physiques, le soutien affectif qui
vient principalement de la famille ou,
du moins, des personnes qui s'occupent de l'enfant.
Si on peut accorder moins d'importance
à ce type de négligence,
dans les faits,
il inculque chez la personne concernée le sentiment de ne pas être protégée
et donc de vivre dans un environnement hostile où elle ne jouit d'aucune garantie de sécurité.
Concernant
les types de négligence,
affective ou physique,
on distingue deux aspects totalement opposés.

Dans certains cas, l'émotion est négligée quand nous sommes confrontés

à des personnes responsables froides,

détachées et peu impliquées.

Par contre, la négligence physique

peut se limiter aux aspects purement matériels,

les besoins fondamentaux,

ou s'étendre aux besoins éducatifs de l'enfant,

qui peut ne pas recevoir de ses parents

les informations nécessaires

dans un contexte relationnel.

On parle également de négligence médicale

quand les personnes responsables de l'enfant omettent de soigner une maladie,

quand celle-ci s'aggrave

et devient particulièrement dangereuse ou néfaste.

Il y a également négligence

morale quand on n'éduque

pas l'enfant aux aspects éthiques

et moraux des comportements.

Alors que ces types de négligence peuvent peser sur la santé publique, ses conséquences

ont été longtemps minimisées.

De nos jours,

nous sommes conscients

qu'une longue exposition

à la négligence peut non seulement causer des maladies,

telles que les troubles de l'alimentation,

mais également une diminution de la quantité de matière grise dans le cortex.

En conséquence, les victimes présentent

des capacités cognitives très inférieures

à celles des sujets normaux.

Ainsi, les données montrent combien il est important de traiter la négligence et d'essayer de stabiliser le contexte familial et individuel.

Il s'agit d'offrir des soins ainsi que

l’attention qui suscite

un sentiment

de sécurité chez l’individu et le sentiment d’être protégé et compris.

Pour conclure cet aperçu des troubles traités, des troubles alimentaires jusqu’à la négligence,

soulignions la fréquence des troubles de négligence chez les personnes susceptibles de développer un régime alimentaire déséquilibré et,

in fine, de perdre totalement le contrôle de leur alimentation.

Il est nécessaire d’envisager une relation thérapeutique qui accorde une attention particulière à la personne

– un intérêt sincère pour elle grâce à

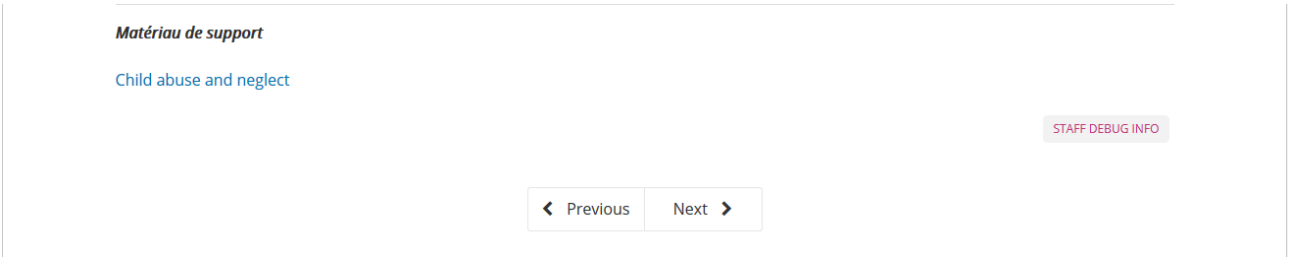
une attitude empathique

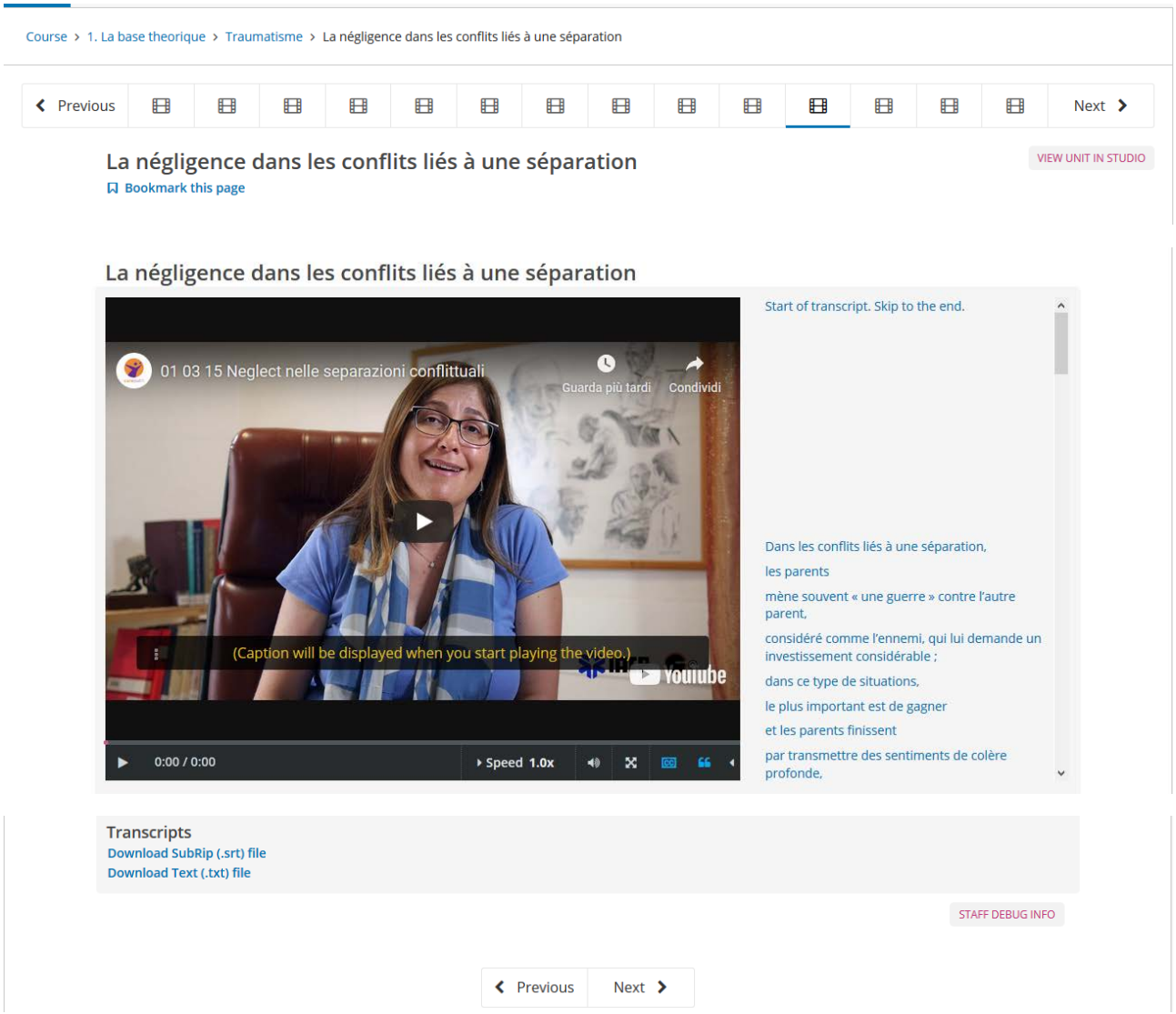
et compréhensive.

Depuis peu, c’est l’un ds aspects les plus importants pour gérer

un traumatisme insidieux qui, s’il n’ été découvert que récemment,

rivalise de gravité avec les autres grands traumatismes.





Transcript

Dans les conflits liés à une séparation,

les parents

mène souvent « une guerre » contre l'autre parent,

considéré comme l'ennemi, qui lui demande un investissement considérable ;

dans ce type de situations,

le plus important est de gagner

et les parents finissent

par transmettre des sentiments de colère profonde,

qui montrent

combien il leur

est difficile d'affronter les sentiments propres

au processus de séparation :

déception,
douleur, abandon, vide, solitude
et sentiment d'échec.
En fait, ces personnes ont du mal à gérer
ce qu'on appelle le divorce psychologique.
Dans ce contexte,
l'enfant apparaît comme la
personne à protéger ;
malheureusement, ce n'est pas toujours le cas,
Il devient
le pivot et
les parents commencent
à communiquer à travers le mineur –
the child becomes
l'enfant qui devient une passerelle entre les parents,
un motif de discussion,
chacun des parents
déclarant ne vouloir
que son
bien.
Le bien-être de l'enfant devient une excuse
derrière laquelle se cachent les déceptions,
les jalousies
et les contrariétés personnelles.
La protection de l'enfant
disparaît alors qu'elle devrait toujours être présente.
Elle est même essentielle
dans les situations
de ruptures.
Ce que les parents pourraient et devraient faire,
c'est collaborer et coopérer sur tous les aspects liés à la parentalité,
afin de soulager

le fardeau qui pèse sur l’enfant. En effet,

childrles enfants, « responsables du bonheur des parents », se sentent coupables de leur séparation 47 00:03:06,540 --> 00:03:09,120 et d’être la cause de leurs disputes.

A ce stade, l’enfant est oublié,

moment choisi par le traumatisme pour apparaître :

alors qu’il est très vulnérable,

l’enfant est ignoré par son entourage,

in the moment of greatest vulnerability

ses besoins et ses sentiments

ne sont pas reconnus, acceptés ni rencontrés.

La séparation est toujours traumatisante,

car elle cause des dégâts,

elle crée une division.

Dans l’esprit d’un enfant, le couple formé

par ses parents est un noyau unique qui,

d’une certaine manière, va se diviser.

Cette division extérieure du père et de la mère risque

de créer une fracture interne.

Cependant, dans la tête de l’enfant,

le couple parental

ne cesse pas d’exister,

il perd juste sa force,

son identité,

sa dignité

et sa fonction de guide.

Il existe d’autres facteurs très

lourds

à

porter.

D’autres aspects expliquent l’ampleur du traumatisme,

comme le tempérament de l’enfant

et son aptitude

à tolérer la frustration,

la qualité de la relation et le type d'attachement que les parents

ont pu créer

avant leur séparation.

C'est l'âge de l'enfant qui s'avère

le meilleur indicateur du traumatisme et de son ampleur :

plus l'enfant est jeune, plus

grand sera le traumatisme ;

les parents,

parfois inconsciemment,

enclenchent une série de dynamiques dysfonctionnelles qui enferment l'enfant

dans un rôle strict dont,

en raison de son jeune âge,

il ne parviendra pas

à se

libérer.

he does not yet have that level of awareness

Lui manque encore le niveau de conscience ou une personnalité

assez forte pour se libérer du piège.

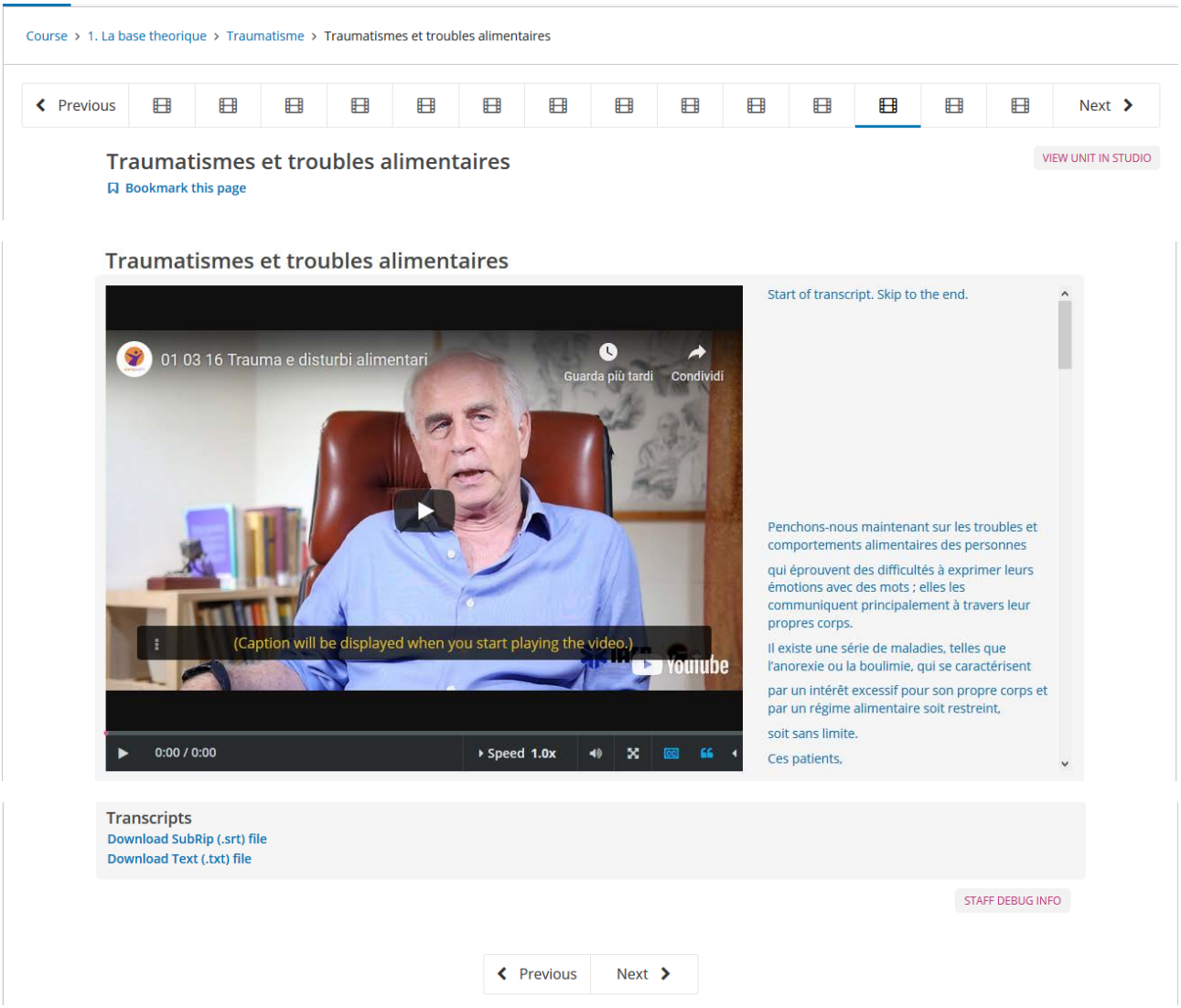
Voilà pourquoi un consultant technique pourrait intervenir dans ces processus,

car il ou elle est capable

de repérer la dynamique familiale

et saura comment

libérer l'enfant.



Transcript

Penchons-nous maintenant sur les troubles et comportements alimentaires des personnes

qui éprouvent des difficultés à exprimer leurs émotions avec des mots ; elles les communiquent principalement à travers leur propres corps.

Il existe une série de maladies, telles que l'anorexie ou la boulimie, qui se caractérisent

par un intérêt excessif pour son propre corps et par un régime alimentaire soit restreint,

soit sans limite.

Ces patients,

surtout s'ils

souffrent d'anorexie,

sont principalement des femmes.

L'anorexie mentale est caractérisée par une perte considérable de poids, qui peut s'avérer très dangereuse, voire mortelle.

Cette perte de poids est souhaitée et recherchée par la personne, qui voit son corps beaucoup plus volumineux qu'il ne l'est réellement.

L'anorexie peut s'accompagner de restrictions sévères. Les prises alimentaires sont très réduites ou

le poids est maintenu à un niveau bas, les ingestions d'aliments étant suivies

de comportements violents d'élimination.

On élimine plus que

ce que l'on absorbe,

ce qui provoque

une perte

de poids.

La boulimie nerveuse,

bulimia nervosa

pour sa part,

est une maladie

où le régime alimentaire est surtout ostentatoire.

Des épisodes de compulsion alimentaire

peuvent se produire,

pendant lesquels le patient consomme de grandes quantités de nourriture.

Ils

peuvent limiter leur poids

corporel en éliminant

la nourriture

grâce à

des instruments inadéquats ou en se faisant vomir,

ou des substances

qui coupent l'appétit,

ou encore grâce à une activité physique intense.

Il s'agit d'une compulsion

alimentaire excessive,

qu'on appelle boulimie nerveuse

ou trouble

de la compulsion alimentaire.

Le comportement
alimentaire n'est plus maîtrisé,
la personne mange sans arrêt
et souffre de compulsion alimentaire ;
elle mange tout le temps pendant plusieurs
heures chaque jour,
c'est un régime alimentaire illimité.
La personne ne parvient plus à réduire ses ingestions alimentaires ni à perdre du poids.
Quand elle atteint un poids considérable,
de 150 à 200 kg,
apparaissent des risques physiques,
l'excès de poids pouvant provoquer
des maladies physiques graves.
Ces pathologies se succèdent, l'individu pouvant passer de l'une à l'autre
au fur et à mesure que sa capacité de contrôle diminue.
Dans le cas de l'anorexie mentale,
le niveau de contrôle reste très élevé
et les personnes sont capables de limiter leur régime alimentaire
pour garder un poids corporel très faible.
Lorsque le contrôle diminue,
elles passent à la boulimie nerveuse.
Les enfants
et les jeunes,
qui souffrent de ce problème,
se nourrissent
- parfois avec excès – pour
garder un bon système de récompense.
Ils possèdent une capacité de contrôle qui se manifeste longtemps après
l'ingestion alimentaire et pas avant et cela leur permet de garder
un poids acceptable.
Concernant le troisième type de maladie, le régime alimentaire incontrôlé,
la personne passe sa journée

à manger,

souvent en regardant la télévision.

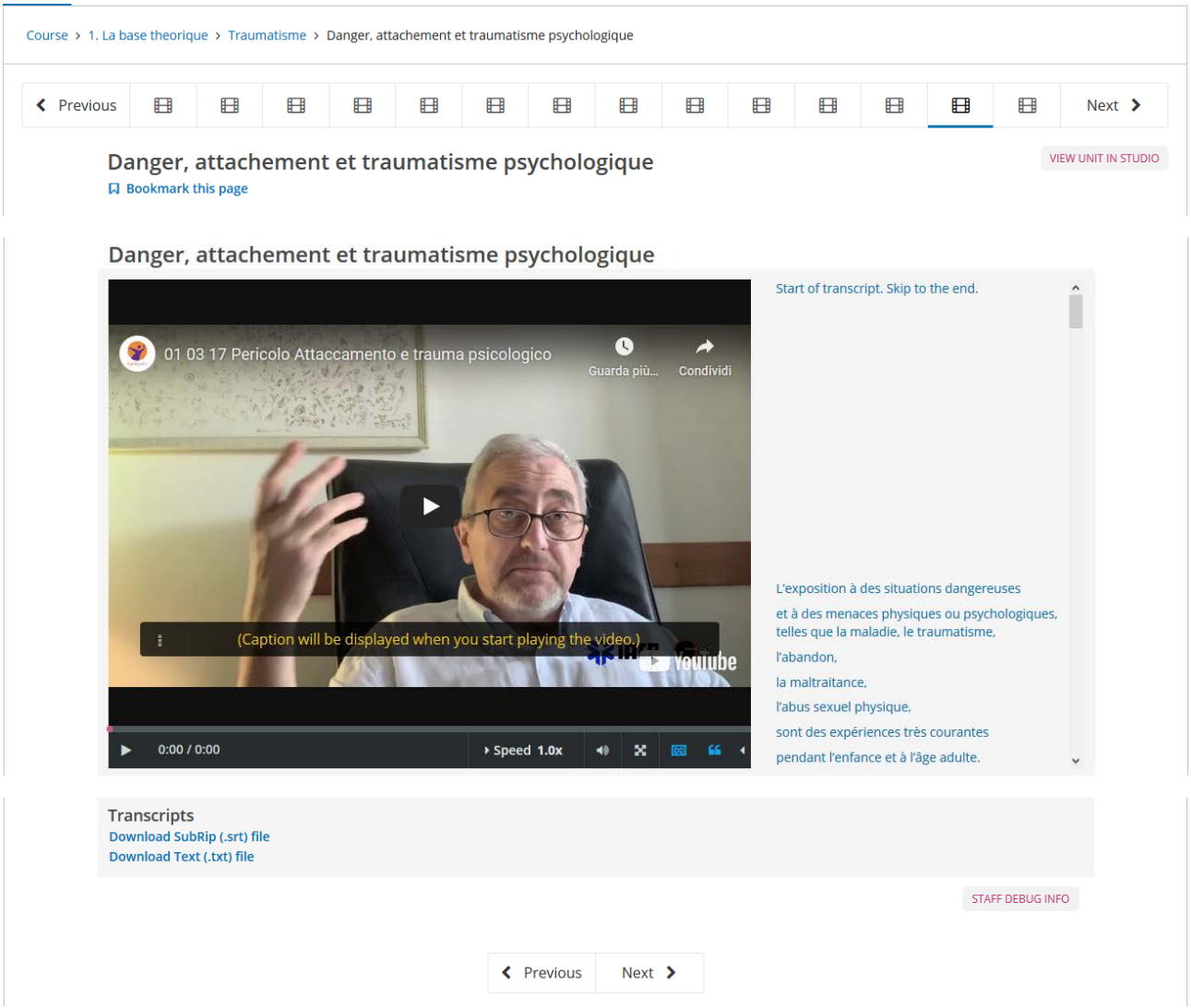
Elle perd conscience de

l'action constante et répétitive que constitue l'ingestion d'aliments.

Quoiqu'il en soit, ces maladies posent une série de questions concernant

le domaine affectif et l'exposition aux traumatismes,

qui peut mener à des troubles alimentaires.



Transcript

L'exposition à des situations dangereuses

et à des menaces physiques ou psychologiques, telles que la maladie, le traumatisme,

l'abandon,

la maltraitance,

l'abus sexuel physique,

sont des expériences très courantes

pendant l'enfance et à l'âge adulte.

Ces expériences

ne débouchent pas nécessairement

sur des traumatismes psychologiques,

les êtres

humains étant

dotés
de capacités d'adaptation
extrêmement sophistiquées,
qui leur permettent d'affronter
des situations extrêmes sans développer nécessairement un traumatisme psychologique.
Si ces situations dangereuses
sont traitées efficacement,
elles perdent leur
potentiel et
perturbateur
et l'individu parvient à rester
en bonne santé mentale
psychologique.
Au fil du temps, notre espèce a développé
des
compétences
interpersonnelles
et des comportements
très sophistiqués, qui servent essentiellement à nous protéger
contre les dangers.
Cet ensemble
de comportements et d'attitudes
constitue
notre système d'attachement.
Le terme « attachement »
vient d'une théorie élaborée
dans les années 50 par
un psychanalyste anglais, John Bowlby.
La théorie de l'attachement
dit que les êtres humains possèdent une prédisposition
à nouer des relations d'attachement
avec des personnalités primaires, souvent les parents,

censées
les protéger
des éventuels dangers.
Dans le cadre de cette théorie, on parle d'attachement dont
la fonction principale,
mais pas unique, est de nous protéger contre les situations dangereuses :
quand une personne se sent suffisamment en sécurité,
elle est encouragée à explorer
l'environnement extérieur, à découvrir ses ressources
et à apprendre à éviter
les dangers qui peuvent se cacher dans leur entourage.
Ces fonctions d'attachement
ont été étudiées chez les enfants de tous âges –
principalement au niveau de la relation que les enfants de 1 à 2 ans entretiennent avec leur mère –
et chez les primates.
Dans les années 50,
des recherches effectuées sur des petits singes
rhésus ont
montré
that demonstrate how important
on small rhesus monkeys
l'importance de la fonction protectrice
de la mère. Chez les primates,
cette fonction est même plus importante que la fonction alimentaire.
L'attachement se subdivise habituellement en deux catégories : sûr et précaire.
L'attachement sûr
est caractérisé par un sentiment de sécurité,
de confiance dans l'entourage
et dans ses propres ressources
et par la possibilité d'être aidé et protégé en cas de danger.
L'attachement précaire
présente

généralement deux types

– attachement précaire-ambivalent et attachement inquiet –

chez les enfants de type C

– et se manifeste par une hyper-activation

du corps avec un accent affectif ;

des manifestations

de colère,

de crainte,

des plaintes concernant

son besoin de protection,

des difficultés de séparation avec la mère.

Le deuxième type d'attachement précaire est l'attachement dédaigneux-évitant

– aussi connu sous le nom d'attachement de type A -

qui,

qui, contrairement au type précédent, est caractérisé par une hypo-activation.

Il s'agit ici d'un détachement par rapport

à ses propres émotions

suscitées par un danger,

donc d'un détachement par rapport à sa peur,

sa colère, son sentiment de vulnérabilité.

On observe

soit un inhibition de leur expression

(par exemple, grâce à une attitude d'indifférence apparente)

soit une expression fausse,

qui devient l'expression d'une émotion opposée (par exemple, sourire lorsqu'on est confronté à quelque chose d'effrayant).

Lorsque ces

modes d'attachement sont efficaces,

ils nous protègent

contre les dangers

émanant de notre entourage

ou de nos relations.

Si
ces stratégies sont efficaces
et suffisamment protectrices,
les conditions nécessaires à l'apparition d'un traumatisme psychologique
ne sont pas remplies et la personne reste dans une situation de sécurité relative.
Les conditions d'un traumatisme psychologique ne se manifestent que si ces
stratégies sont
inefficaces.
Par exemple, quand l'inhibition de l'expression des peurs,
de la colère ou
des besoins ne suffit plus à protéger la personne
face aux menaces environnantes.
En situation de traumatisme psychologique, toutes les activités de traitement mental
subissent l'impact négatif
Il peut s'agir d'un événement soudain et particulièrement intense -
This can come from a particularly intense and sudden event - par exemple,
une maltraitance ou
un traumatisme physique –
ou d'une série d'expériences répétées
qui, ensemble,
prennent une valeur traumatique.
Dans ce cas, on parle de traumatisme évolutif :
l'enfant grandit
dans un cadre familial négligent et néfaste,
inadeguate
toutes ces expériences prolongées
créant un climat propice à un développement inadéquat,
pouvant mener
à un traumatisme psychologique.
La capacité à s'adapter et à retravailler une situation de danger potentiellement traumatisante
dépend de certaines caractéristiques.
De l'individu, de son âge, de sa maturité,

personnalité

et les caractéristiques de son attachement, qu'elles soient ou non efficaces pour le protéger ;

sa force physique et son état de santé

car une personne malade est plus fragile

dans l'élaboration d'une condition dangereuse. C'est d'ailleurs très important,

la disponibilité protectrice des figures de rattachement, qu'une personne qui n'a pas à

se sentir seul face au danger, mais accompagné de relations protectrices de la part des personnes

qui sont prêts à nous faire sentir que nous sommes au milieu de quelque chose.

protégé

et accompagné dans l'élaboration

d'une expérience dangereuse.

Un rôle important est joué par le contexte social : il est fondamental de se retrouver

dans un environnement accueillant, avec des personnes qui accueillent et soutiennent

avec

leur culture

les rituels ou la présence personnelle (par exemple des amis).

Le processus d'adaptation d'un état traumatique n'est pas immédiat mais nécessite du temps,

par exemple

un deuil important - comme ça

du conjoint ou d'un parent -

exige généralement

un ou deux ans afin d'être traité correctement,

sans se transformer en condition

de deuil traumatique.

Quand

une expérience potentiellement traumatisante n'est pas traitée,

est généralement accompagné de

une hyperactivation excessive

émotionnel, avec

des rêves, des cauchemars,

les craintes,

Je ne suis pas sûr d'avoir un sentiment de menace,

des réactions incontrôlées

- comme dans le cas du syndrome de stress post-traumatique -

ou d'une situation d'hypoactivation excessive, c'est-à-dire d'une distance excessive à parcourir

de tout ce qui concerne l'expérience

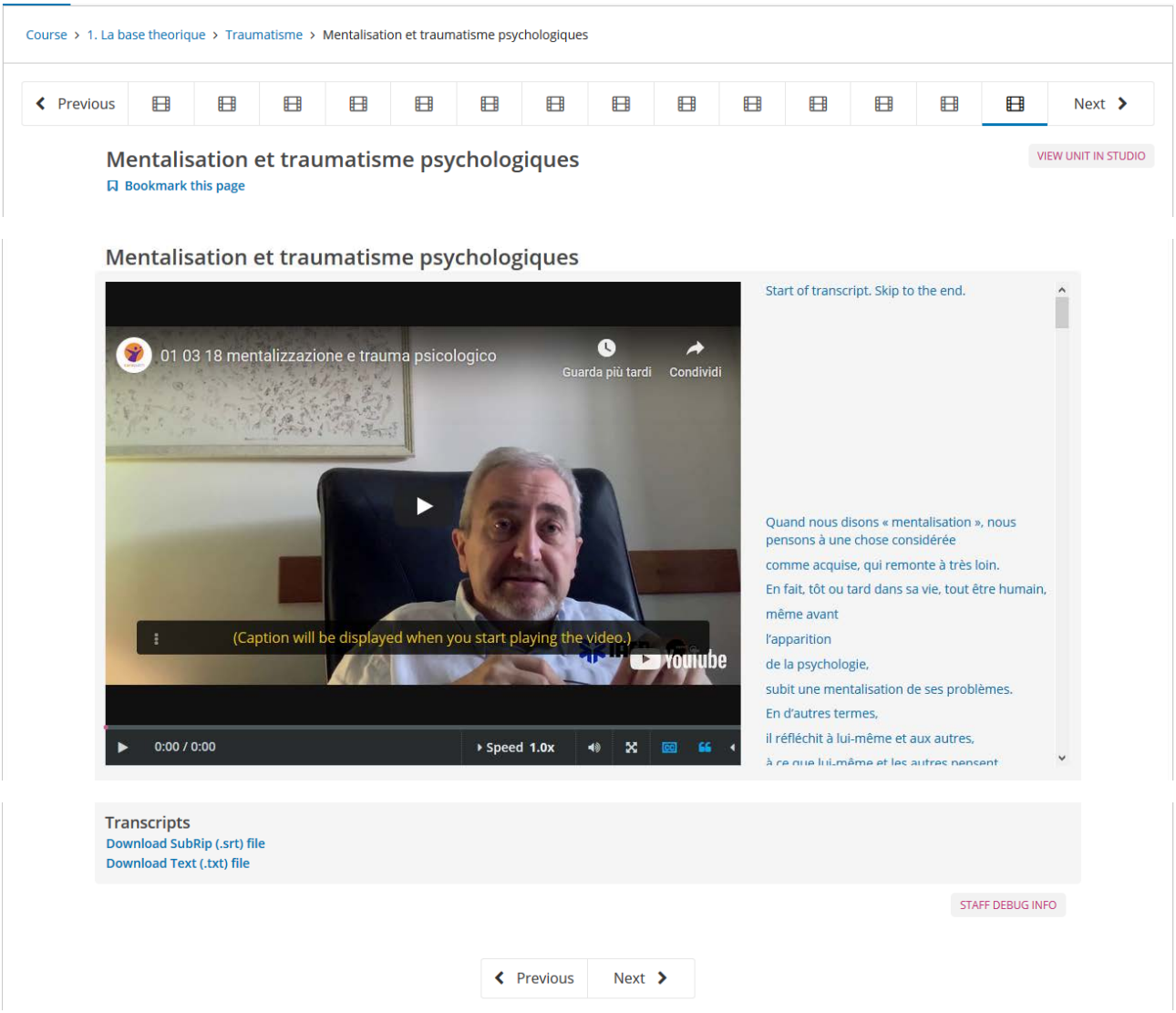
dangereux,

manque de souvenirs,

inhibition affective,

éviter de parler ou de se rendre dans des lieux liés à l'expérience traumatisante.

En présence de ces deux conditions, on peut parler de traumatisme psychologique.



Transcript

Quand nous disons « mentalisation », nous pensons à une chose considérée

comme acquise, qui remonte à très loin.

En fait, tôt ou tard dans sa vie, tout être humain,

même avant

l'apparition

de la psychologie,

subit une mentalisation de ses problèmes.

En d'autres termes,

il réfléchit à lui-même et aux autres,

à ce que lui-même et les autres pensent,

aux réflexions,

sentiments,

besoins,
attentes et croyances
qui nous influencent.
Pour comprendre le concept de
mentalisation,
il suffit
de s'envisager
soi-même et d'envisager
les autres comme des états mentaux.
Ces aptitudes apparaissent
chez les humains aux alentours
de l'âge de 4 ans,
lorsque l'enfant prend conscience
que
ses pensées et sentiments
ne sont pas nécessairement
compris et partagés par les autres. Par exemple, la mère peut parfaitement ignorer
ce qui se passe dans la tête de son enfant.
Quand les enfants s'en rendent compte,
ils apprennent également à
utiliser un mode stratégique
très important
et utile d'adaptation aux problèmes ;
ils
apprennent l'importance du mensonge.
Le mensonge est possible si on accepte
que les autres peuvent avoir un point de vue différent
sur le monde et qu'en conséquence, ils ignorent ce que vous pensez.
Le processus de mentalisation
repose sur une succession
d'étapes.
La première concerne

notre sensibilité
relative
à la perception des états mentaux,
ou à la représentation
de notre état mental ou de celui des autres
(par exemple, comprendre qu'on est joyeux,
triste, qu'on a des attentes, des préjugés)
prejudices)
et
et notre aptitude à interpréter
nos comportements
et ceux des autres sur base de ces états mentaux.
C'est une étape essentiele à notre capacité d'adaptation
(par exemple, si la personne face à nous reste silencieuse,
nous ne pensons pas qu'elle
n'a rien à dire,
nous pensons que son esprit est rempli
d'images et d'idées
et que son silence n'est pas l'expression d'un vide, mais bien un succession d'états mentaux
sur
lesquels repose ce comportement silencieux).
Le deuxième aspect important de la mentalisation
est que l'auto-mentalisation encourage
la régulation du corps.
nous constatons que
nous sommes en colère et si nous pensons
que la cause en est quelque
chose qui
a été dit,
le
fait d'en
prendre

conscience,
de s’en rappeler
les conséquences
d’une action,
enclenche chez nous un mécanisme de régulation de cette colère.
Notre rythme cardiaque, notre respiration, la production d’hormones
déclenchée par la colère,
seront régulés par
des mécanismes psychologiques.
Par exemple, se sentir
coupable d’avoir été en colère contre
un être cher inhibe l’expression
de colère et régule le corps.
Il s’agit d’une fonction de base,
à tel point qu’une personne,
dont les capacités à mentaliser sont faibles,
sera plus exposée aux dérèglements du corps
(pulsations
cardiaques
plus rapides et moins régulières,
réactions émotionnelles incontrôlées
et à long terme,
peut-être les
maladies inhérentes
aux dérèglements constants du corps).
L’une des fonctions principales de la parentalité concerne la mentalisation :
Is to be
penser
aux
enfants
en fonction de leurs besoins,
de leurs sentiments,

de leurs craintes et,
dans une certaine mesure,
se mettre à leur place et percevoir les choses de leur point de vue.
Par exemple, un enfant de trois ans
vit certaines choses
et interprète certains mots ou discours
en fonction
de ses aptitudes d'enfant.
Il est donc essentiel que 116 00:06:17,540 --> 00:06:19,840 les parents
Cette fonction s'appelle la conscience (psychologique)
et fait partie des conditions essentielles au développement
et à la sécurité
des enfants. Un bon parent doit
pouvoir
mettre à la place
se de ses enfants et percevoir leurs besoins.
On a déjà observé chez les mères de très jeunes
enfants qu'elle se mettent
à la place
d'un enfant agité et en pleurs et comprennent
ainsi qu'il a froid ou faim.
Elles donnent une voix
à l'état mental de l'enfant comme si celui-ci
était capable d'organiser ses pensées et de les exprimer.
La capacité à se représenter les états mentaux des enfants
est une condition essentielle pour devenir parent.
La mentalisation permet également de gérer
le stress et les situations potentiellement dangereuses,
en s'adaptant
sans créer les conditions d'un traumatisme psychologique.
Par exemple,
quand un enfant est confronté

au comportement incohérent de son parent
(colère, violence physique ou insultes verbales),
sa capacité d'imaginer l'état
mental du parent sert
d'amortisseur et lui permet d'envisager le contexte dans lequel le parent
agit de cette manière.
Par exemple,
il peut penser : « papa est fatigué et
ce qu'il dit n'est pas vrai ;
il est d'habitude affectueux et il m'aime,
son attitude
a une valeur maintenant
et est du à
un état particulier chez lui,
mais cette valeur n'est pas absolue. » L'attitude décrite ici
le protège
contre les états mentaux des autres
et rend la situation potentiellement moins traumatisante.
On voit clairement chez les adultes à faibles capacités de mentalisation,
ainsi que
chez les personnes souffrant d'un trouble de la personnalité,
qu'ils sont davantage exposés aux traumatismes psychologiques continus.
s ne parviennent pas à contextualiser
ce qui leur arrive. Il le processus de réflexion n'est pas suffisant,
et l'événement
survenu devient
absolu
et potentiellement traumatisant.
Par moment,
l'incapacité
des parents à se mettre dans la peau de leurs
enfants peut s'avérer

dangereuse et provoquer

des attitudes qui, chez l'enfant et l'adolescent,

prendront

peut-être la forme de comportements très agressifs.

Cette agressivité et les comportements qui

les

comportements

qui en découlent peuvent

être interprétés partiellement à travers le prisme du concept de mentalisation.

Si les parents sont constamment irrités

par le comportement de leur enfant,

par exemple quand il

pose

problème ou

est insolent,

les parents commenceront

à lui renvoyer une image négative (par exemple en le traitant d'idiot, de malade ou de nul). 189
00:11:10,260 --> 00:11:12,700 Dès lors, l'enfant

risque de se voir comme une personne malade,

perturbée,

incapable.

Pour combattre cette image négative,

il adoptera des comportements agressifs et chaque fois qu'un adulte s'approchera

de lui pour mieux le connaître,

il risque de réagir très agressivement

afin de maintenir

à distance l'adulte

potentiellement traumatisant.

Lorsque des jeunes sont considérés comme des incapables en classe,

qu'ils doublent,

que les enseignants

ont

une opinion négative d'eux,

il est fréquent qu'à la maison,

leurs parents renforcent cette image négative.

En conséquence, ces enfants réagissent violemment et expriment de la colère

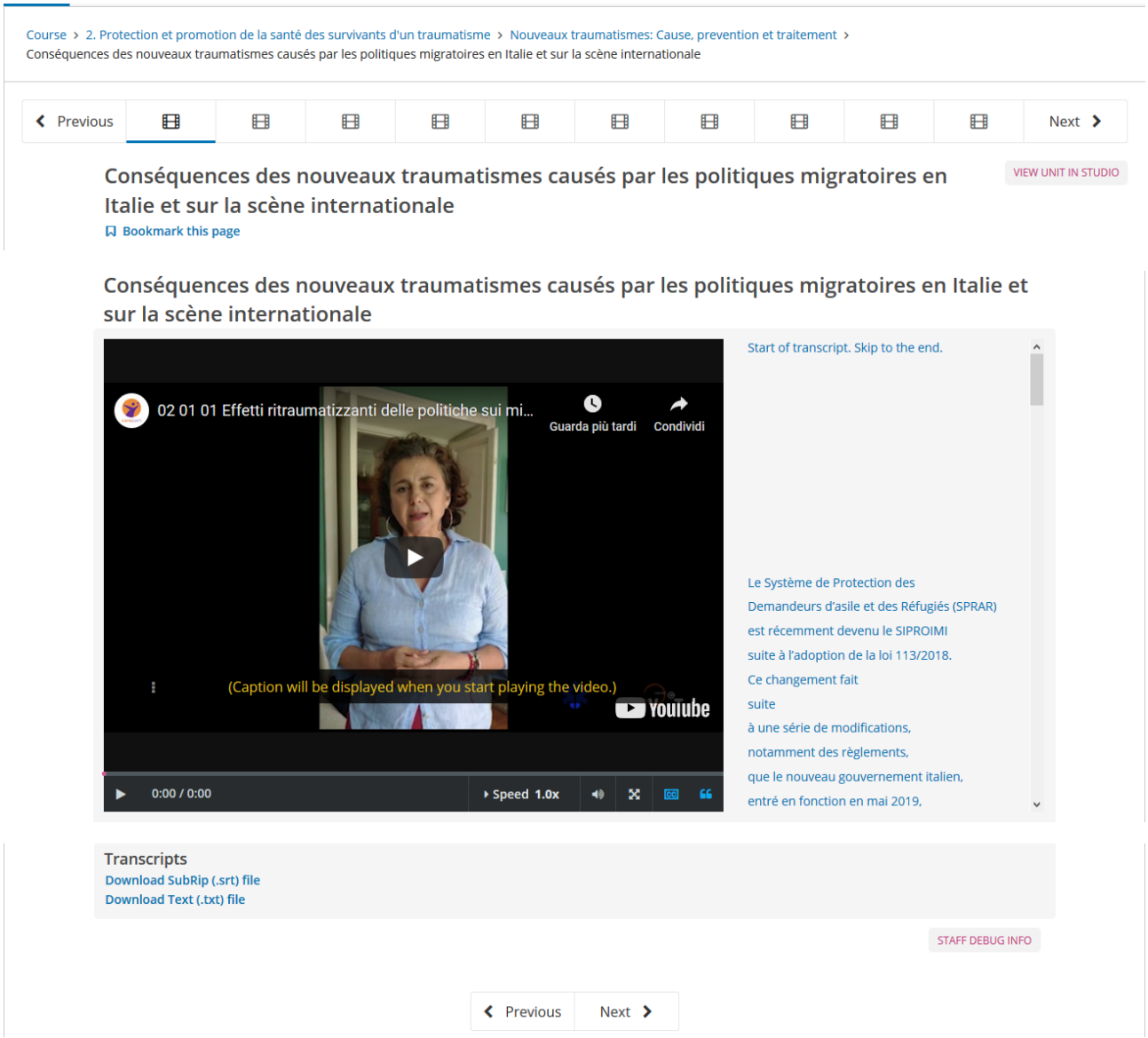
vis-à-vis des adultes qui tentent de les aider

(éducateurs, enseignants),

afin de les tenir

à distance et d'éviter d'être à nouveau perçus

comme des personnes négatives et incapables.



Transcript

Le Système de Protection des

Demandeurs d'asile et des Réfugiés (SPRAR)

est récemment devenu le SIPROIMI

suite à l'adoption de la loi 113/2018.

Ce changement fait

suite

à une série de modifications,

notamment des règlements,

que le nouveau gouvernement italien,

entré en fonction en mai 2019,

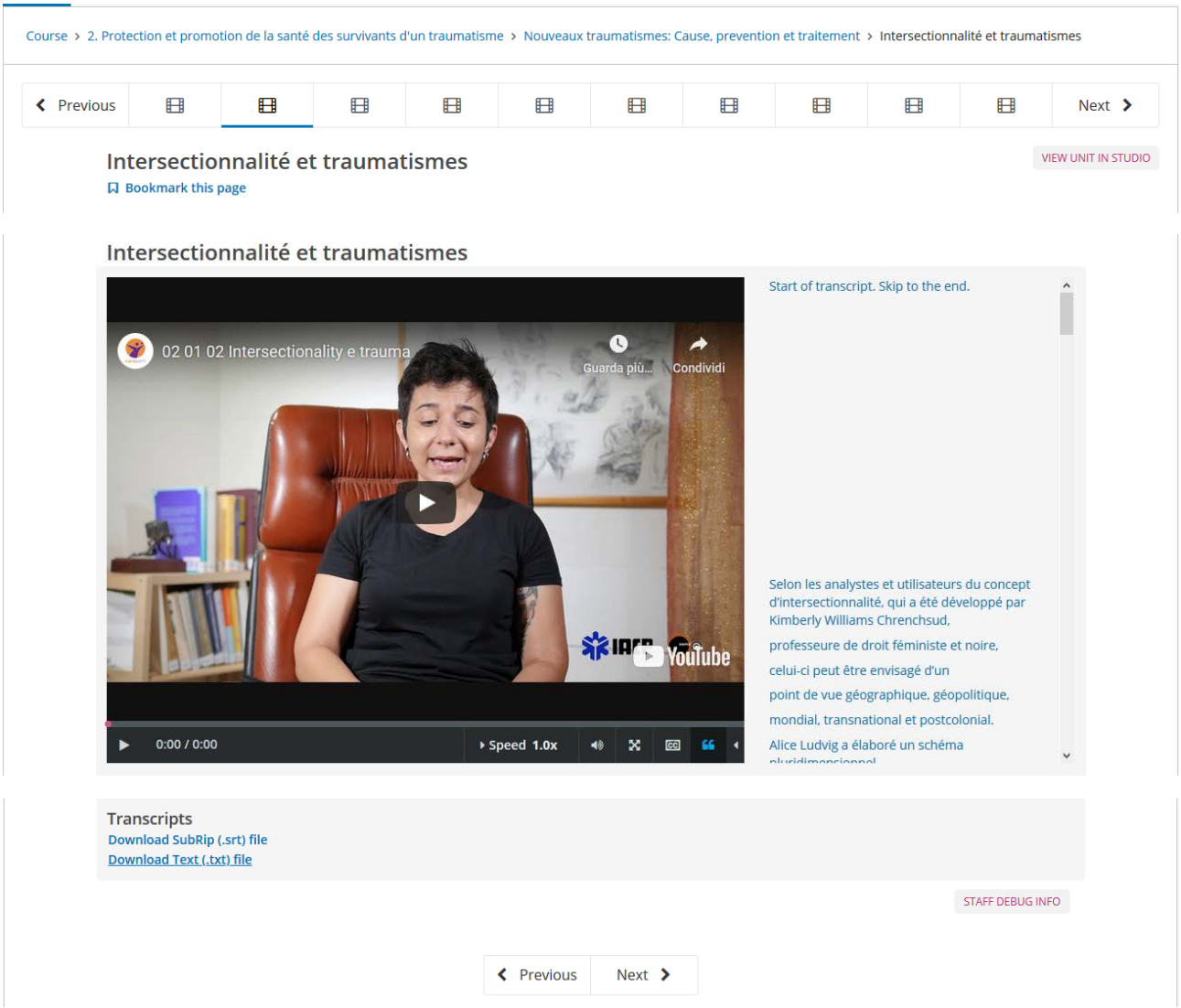
a apportées à la problématique migratoire,

au droit d'asile et donc à l'accueil. Le SPRAR,
mis en place en 2002, s'applique sur
un réseau de municipalités et d'autorités locales qui,
en collaboration avec
les ONG et les associations du troisième secteur,
a choisi de gérer bénévolement les projets d'accueil
et d'intégration des demandeurs d'asile
et des
réfugiés.
Au fil des ans, ce réseau a subi
une évolution progressive et
positive :
de 1.500 places d'accueil au départ,
il est passé à 35.000 aujourd'hui.
L'histoire du SPRAR est marquée
par plusieurs étapes
de changements successifs.
Le premier fut son
institutionnalisation par la loi,
qui en a fait un système central
d'accueil intégré en Italie
stable et officiel.
Auparavant, l'Italie
n'avait aucun système
d'accueil structuré, mais dépendait
exclusivement d'interventions d'urgence.
Un autre changement important remonte
à 2003, when, au moment de la crise
en Afrique du Nord,
lorsque le
modèle du SPRAR
a été reconnu au niveau européen comme

un acteur efficace
d'intégration et
d'inclusion sociale.
Lors de la dernière phase,
la plus récente, le statut
du SPRAR a été modifié :
il ne peut plus
accueillir
les demandeurs d'asile ni gérer
les dossiers humanitaires,
la protection humanitaire
ayant été supprimée.
La loi ne l'autorise plus qu'à accueillir
les mineurs étrangers non accompagnés,
les titulaires d'un droit à la protection internationale (qui ne concerne que peu de
personnes en comparaison avec les demandeurs d'asile).
Il peut également s'occuper de quelques nouveaux
types de permis de séjour,
les « dossiers spéciaux ». Le SPRAR,
devenu désormais le SIPROIMI, pourra à présent prendre en charge
les dossiers spéciaux concernant les traitements médicaux,
les victimes de traite,
les victimes d'exploitation au travail,
de violence intrafamiliale,
de catastrophes naturelles et les personnes
qui se sont distinguées par des actes d'héroïsme.
Il doit toujours s'agir d'étrangers,
et non pas de citoyens italiens
qui bénéficient, pour leur part, d'autres mécanismes de protection sociale.
On peut dire que le SPRAR
possède désormais une composante
« protection sociale » pour les étrangers.

Ce n’est plus un système d’accueil et de protection
pour les personnes concernées
par le droit à l’asile.
Son nouveau statut peut,
sur papier,
sembler relativement positif
dans la mesure où il devient un mécanisme
de protection pour
des personnes vulnérables.
Pour l’instant, la difficulté réside dans
l’obligation pour la personne vulnérable
d’avoir un permis de séjour,
sauf lorsqu’il
s’agit de victimes de traite ou d’abis…
qui reçoivent
automatiquement ce permis
en raison de leur statut de victimes.
Il n’y a aucun critère précis quant
au déroulement des procédures 95 00:03:59,269 --> 00:04:05,480 ni à la désignation
de ces personnes vulnérables
sous la définition,
même juridique, des dossiers spéciaux.
Le seul moyen
d’accéder au SPRAR
et de bénéficier
de tous les services
de protection
qu’il offre
reste l’obtention
d’un permis de séjour
dans le cadre
des dossiers spéciaux.

Les critères et exigences d'accès aux soins
médicaux n'ont pas encore été définis
(typologie de maladie mentale ou physique,
niveau de gravité et calendrier ?).
La période
actuelle est critique :
de nombreuses personnes,
qui avaient accès aux projets du
SPRAR jusqu'il y
a quelques mois, l'ont perdu.
Par ailleurs,
ceux et celles qui ont théoriquement
le droit d'accéder à ces services
ignorent quel
type de preuves
fournir pour
pouvoir l'exercer.



Transcript

Selon les analystes et utilisateurs du concept d'intersectionnalité, qui a été développé par Kimberly Williams Chrenchsud,

professeure de droit féministe et noire,

celui-ci peut être envisagé d'un

point de vue géographique, géopolitique,

mondial, transnational et postcolonial.

Alice Ludvig a élaboré un schéma pluridimensionnel,

comportant plusieurs niveaux de différenciation :

genre, sexualité, race, couleur de peau, origine ethnique, statut, classe, culture…

Le schéma évalue

les innombrables niveaux à envisager

lorsqu'on aide

une personne considérée comme
appartenant à une population minoritaire.
Les politiques pour l'égalité
s'élaborent de plus en plus
sur un plan international,
notamment grâce au travail des Nations Unies et de l'Union européenne.
Pour s'en convaincre, Il suffit d'étudier les directives de lutte contre la discrimination,
l'ensemble des initiatives nationales, régionales et locales,
ainsi que les politiques pour la diversité
et la gestion de la diversité,
actuellement adoptées dans tous
les pays occidentaux et dans de nombreuses entreprises.
Bien sûr, ces politiques n'ont pas pour effet
de lever les doutes et les souffrances des personnes en situation de minorités multiples,
qui peuvent avoir vécu des évènements traumatisants en raison de leur appartenance à une minorité.
Dans le « daily paper » du 17 mai 2018,
on peut lire une citation d'un jeune Camerounais :
« nous étions dans la cuisine en train de regarder une émission télévisée sur les migrants LGBTQI ;
mes amis africains ont commencé à dire
que l'Italie est un pays de merde rempli d'homosexuels
et, à nouveau, je ne me sentais plus libre.
Allen a 22 ans et a fui le Cameroun où il subissait quotidiennement coups et insultes,
Al où il était diabolisé parce que,
dans ce pays, d'après la presse,
l'homosexualité est un délit.
S'il a demandé la protection internationale à l'Italie,
il continue à vivre dans la crainte,
l'homophobie l'ayant suivi jusqu'à la rue Mattea à Bologne
où il a trouvé refuge avec d'autres compatriotes.
Les migrants LGBTQI sont souvent très jeunes.
Faute de pouvoir compter
sur le soutien de leur communauté d'origine,

ils décident de migrer,

mais gardent le stigma culturel de l'homophobie ou de la transphobie.

Rien ne leur garantit qu'une fois en Italie,

ils pourront se frotter aux réalités multiculturelles qui leur permettraient de vivre paisiblement leur orientation et leur identité sexuelles.

Comme l'a souvent souligné Vincenzo Bramato,

président de la communauté Arcigay de Bologne,

lors de nos entretiens, certains pays européens, comme l'Allemagne,

se sont dotés de structures protégées d'accueil des victimes de persécution sur base de leur orientation sexuelle.

Le personnel y reçoit une formation 53 00:03:38,220 --> 00:03:43,680 pour leur éviter d'adopter des attitudes subjectives ou méprisantes,

susceptibles de reproduire la stigmatisation et le traumatisme que les victimes ont vécus.

Si, en Italie, le mécanisme d'accueil ne prévoit pas pour l'instant ce type de structure,

il existe des exemples de bonnes pratiques,

comme l'expérience pilote menée en 2017 à Modène (un petit appartement pour six personnes

a été réservé à des demandeurs d'asile LGBTQI)

ou encore le guichet d'information pour les migrants LGBTQI, à Vérone.

Pour ces

jeunes migrants,

qui sont en pleine phase de développement

de leurs premières relations avec la communauté LGBTQI,

l'appartenance à une minorité ethnique

dans le pays d'accueil est un élément du problème.

En fait, ils appartiennent souvent à une

minorité effrayée et silencieuse, au sein même de leur communauté de référence.

Comme Rogers le souligne, 69 00:04:31,840 --> 00:04:32,620 le traumatisme invisible est multiplié par deux.

Dans le cas du stress minoritaire - si l'on veut reprendre les termes de Vittorio Lingiardi

– il existe un double risque

pour la santé physique et mentale des personnes concernées,

et donc un risque considérable de perte de capital humain.

Former aux services d'accueil équivaut à former aux droits humains

et aux spécificités propres

aux migrants

LGBTQI dans les relations d'aide.

Training must therefore be centered on the person

La formation, pour être véritablement inclusive,

doit se concentrer sur la personne, sur l'accueil et sur la connaissance de ces spécificités.

De plus, les services pour les migrants,

car très souvent ils sont conçus et offerts sans tenir compte de leur orientation

sexuelle et de leur identité de genre,

peuvent perdre en efficacité, tant au niveau de la relation avec le patient

(les jeunes ne reçoivent pas

l'accueil qu'ils devraient)

qu'au niveau de la formation ou des parcours préventifs

(par exemple, pour les maladies sexuellement transmissibles,

une formation pluridimensionnelle est

nécessaire lorsqu'on traite avec des migrants adolescents

appartenant à la communauté LGBTQI).

D'autre part, les services offerts par la communauté LGBT

s'inscrivent solidement dans un modèle culturel de lesbiennes ou gays occidentaux ;

dès lors, les jeunes en

provenance d'autres cultures risquent

de ne pas s'y retrouver.

Les expériences citées précédemment

montrent que les services d'informations,

de soutien et de conseil offerts par les institutions, mais également par les associations but non-lucratif,

peuvent s'avérer inefficaces. En conséquence,

lorsqu'on

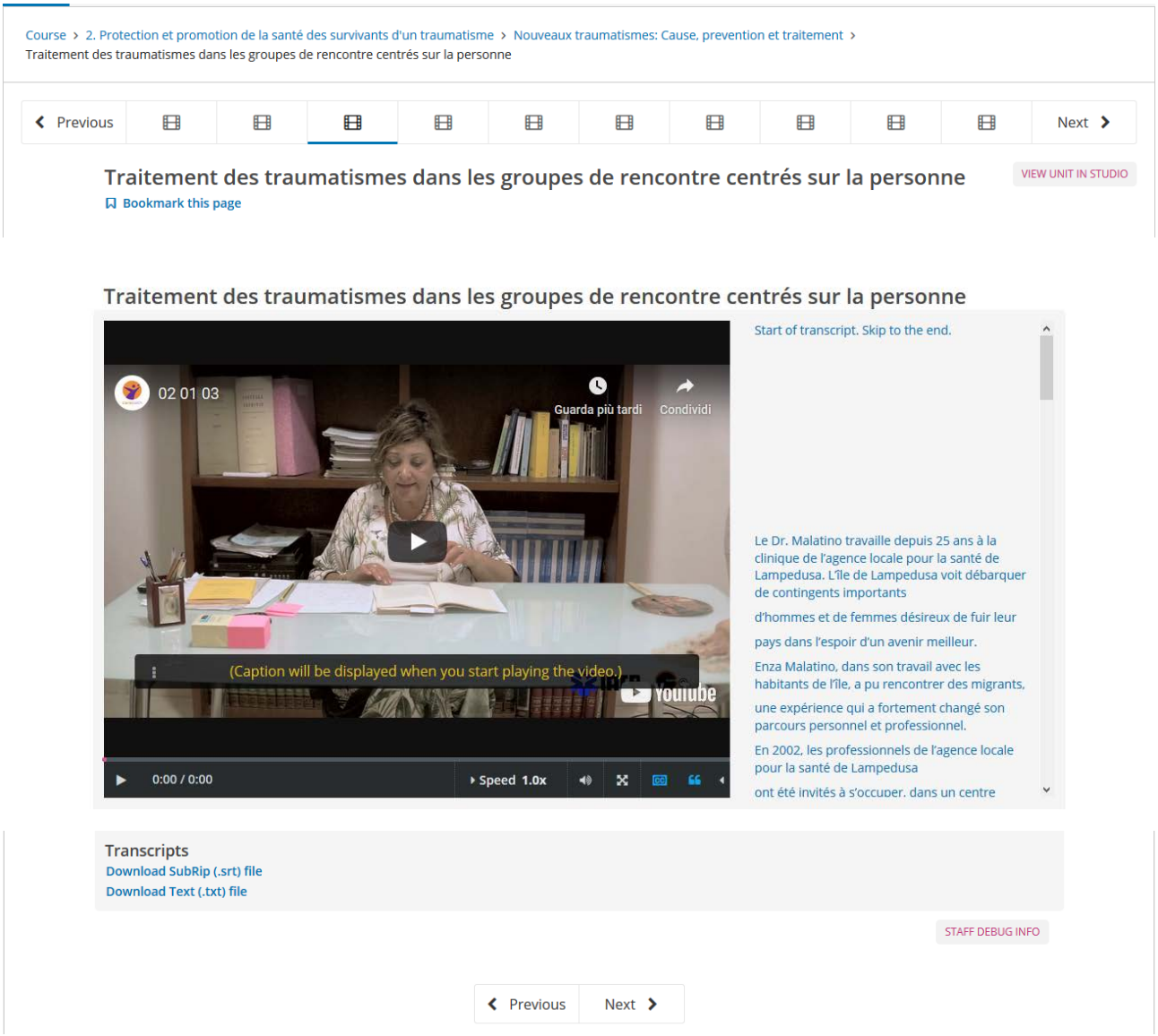
travaille avec des populations en situation de minorités multiples,

une réflexion pluridisciplinaire

s'impose sur la pratique de la relation d'aide.

La formation aux relations d'aide à offrir à ces personnes doit s'inspirer des différentes 106 00:06:54,460 --> 00:06:56,800 - variables d'homosexualité, de bisexualité et transsexualité dans l'histoire

de la psychiatrie et de la psychologie ainsi que des concepts de stigmatisation,
d'homophobie et homophobie intériorisée.
Les prestataires de services doivent recevoir une
information régulière
sur la législation concernant ces questions,
aussi bien dans le pays d'accueil que dans le pays d'origine des personnes concernées.
De plus, il faut
apprendre et approfondir
ses connaissances de la
législation sur l'asile,
car celle-ci change continuellement.
Outre les compétences techniques, il conviendra, au niveau personnel, de développer et d'approfondir une
démarche sensible au genre
et de poursuivre une réflexion sur les droits humains.
Cette exigence s'applique également aux groupes de travail qui offrent des services à ces jeunes.



Transcript

Le Dr. Malatino travaille depuis 25 ans à la clinique de l'agence locale pour la santé de Lampedusa. L'île de Lampedusa voit débarquer de contingents importants

d'hommes et de femmes désireux de fuir leur

pays dans l'espoir d'un avenir meilleur.

Enza Malatino, dans son travail avec les habitants de l'île, a pu rencontrer des migrants,

une expérience qui a fortement changé son parcours personnel et professionnel.

En 2002, les professionnels de l'agence locale pour la santé de Lampedusa

ont été invités à s'occuper, dans un centre d'accueil, de personnes qui avaient effectué un long et pénible voyage

au péril de leur vie. La direction de l'agence locale pour la santé m'a invitée à mener une évaluation psychiatrique des personnes qui avaient

débarqué sur l'île. Il s'est 10 00:01:48,360 --> 00:01:56,569 quasiment impossible d'évaluer leur santé mentale,

avéré au-delà des graves évènements traumatiques qu'elles avaient vécus, car elles provenaient d'une autre culture

et ne demandaient aucune aide ni soutien pharmacologique,

dans leur culture la médecine occidentale n'est pas conventionnelle.

En effet, Le recours à des rites magiques liés

à leurs croyances culturelles pouvait aider certaines d'entre elles.

Il était difficile d'offrir de l'aide et du soutien à ces personnes en souffrance.

J'ai donc envisagé d'organiser des groupes d'écoute.

Pour moi, psychiatre et psychothérapeute formée à l'approche centrée sur la personne de Carl Rogers, l'expérience fut incroyable.

Dans ce genre de groupes,

les personnes s'asseyent en cercle

pour se mettre à l'écoute. L'élément fondamental est l'absence totale de jugement

et le respect profond pour tous les thèmes dont le groupe souhaite discuter.

Ainsi, il est possible de créer un climat de confiance, favorable aux participants,

même si leur état psychique est très problématique, qui pourront ainsi retravailler

leur expérience dans un espace de solidarité collective :

la prise de conscience de son expérience personnelle n'est pas nécessairement individuelle, elle peut être partagée et comprise par les autres.

Cela facilite parfois la résolution de la souffrance,

du conflit ou de l'évènement douloureux.

C'est exactement ce qui s'est passé dans le groupe. Il était essentiel de dégager un équilibre entre le médiateur culturel,

le traducteur (l'animateur ne parlait pas les langues des participants) et

les conditions spartiates : il n'y avait pas de chaises,

certains groupes venaient d'échapper à un naufrage et d'autres ne portaient que des draps de sauvetage.

Malgré cette situation peu orthodoxe,

à ma grande surprise,

nous avons découvert que les valeurs profondes ne se retrouvent pas dans la forme mais dans le fond.

A force d'entendre les témoignages de voyages longs et pénibles

(traverser le désert en Lybie, prendre le risque de se noyer),

les expériences, parfois à ce point traumatiques qu'elles affectaient

le professionnel, les difficultés causées par tant de souffrance et de douleur,

sont devenues le quotidien du professionnel.

Cette expérience a réveillé chez lui un événement qui remontait

à son enfance et qu'il avait oublié : la mort d'une de ses tantes, qui avait été à tellement douloureuse pour lui qu'elle avait disparu de sa mémoire.

Ainsi, lorsqu'on accueille une personne qui a vécu des drames de ce type,

il est essentiel d'offrir une écoute empathique.

C'est la seule manière d'offrir aux victimes la possibilité de s'ouvrir

et de partager leurs expériences. Il importe également d'accepter

la personne sans la juger, afin de créer un sentiment de confiance.

L'empathie est un baume pour l'âme, c'est le signe qu'une autre personne

se met dans votre peau, qu'elle écoute attentivement et qu'elle ressent véritablement votre douleur.

Voilà les trois conditions de base que la recherche de Carl Rogers

estime nécessaires pour susciter un vrai changement dans les groupes de rencontre

Au bout de la réflexion, par Rogers, sur la valeur des groupes de rencontre

pour aider les migrants à reformuler leurs traumatismes, on insiste sur un aspect intéressant :

aucun participant au groupe d'écoute n'a sollicité,

en fin de parcours, d'aide pharmacologique.

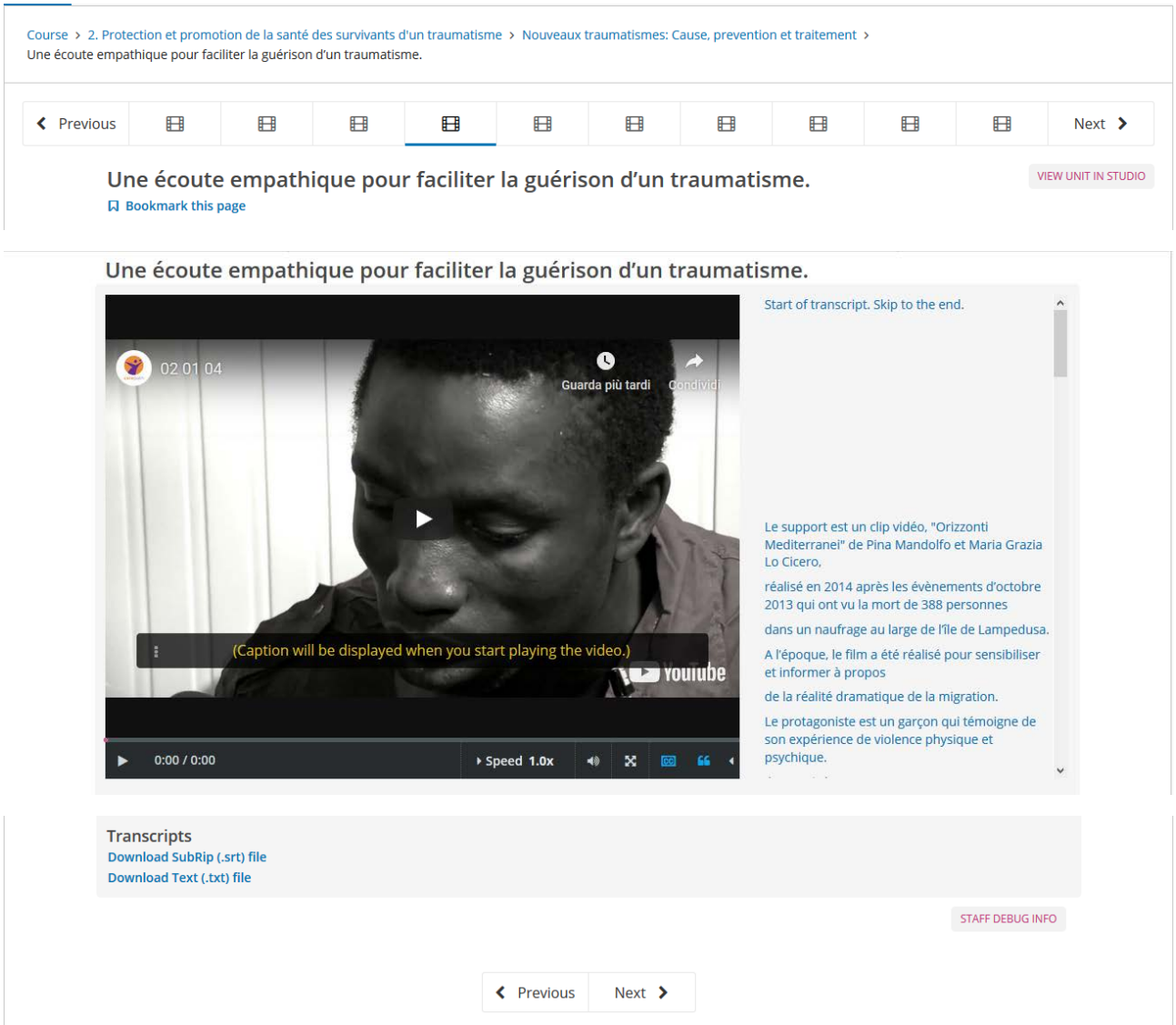
La configuration naturelle du groupe, en cercle, a été appréciée. Peut-être parce que la circularité reproduit dans une moindre mesure

les expériences vécues dans les pays d'origine : en Erythrée par exemple,

il est de coutume que les hommes et les aînés du village se regroupent

en cercle autour d'un grand arbre, qu'ils nomment l'arbre des mots.

Lors de cette rencontre, le tissu déchiré du récit est reconstitué grâce au partage de mots.



Transcript

Le support est un clip vidéo, "Orizzonti Mediterranei" de Pina Mandolfo et Maria Grazia Lo Cicero,

réalisé en 2014 après les évènements d'octobre 2013 qui ont vu la mort de 388 personnes

dans un naufrage au large de l'île de Lampedusa.

A l'époque, le film a été réalisé pour sensibiliser et informer à propos

de la réalité dramatique de la migration.

Le protagoniste est un garçon qui témoigne de son expérience de violence physique et psychique.

Il est arrivé avec sa sœur,

qui a également été victime de violence et de viol. La sœur n'avait jamais parlé de cette expérience horrible à son frère,

qui, lui-même, avait subi le même traumatisme, sans

jamais en parler à sa sœur non plus.

Il avait tellement honte d'en parler qu'il avait demandé que sa sœur ne soit pas présente

car il ne voulait pas qu'elle le sache (il le lui a dit plus tard).

Il avait honte d'être un homme victime de violence.

Ce garçon n'avait que 16 ans.

Dans son témoignage, le garçon raconte ce qui s'est passé pendant son voyage.

Pour éviter de briser son flux émotionnel, nous n'avons jamais interrompu son récit.

Seuls quelques hochements de tête et des regards profonds

l'ont encouragé à poursuivre son témoignage.

La manifestation d'empathie s'est faite par le biais de contacts visuels,

de hochements de tête, d'inclinaisons du corps vers lui,

mais pas de manière verbale ni situationnelle.

C'était nécessaire pour le pousser à parler sans le toucher ;

il voyait tout contact comme source de honte, comme s'il était un enfant

incapable d'avoir une histoire pénible et de la supporter.

Même s'il était plus jeune que sa sœur, il pensait devoir venir à son aide.

A nouveau, nous pouvons observer comment faire preuve de délicatesse,

comment écouter avec empathie pour créer des relations de partage.

CETTE PARTIE DE LA VIDEO EST DIFFICILE A TRANSCRIRE CAR ELLE CONTIENT DES VOIX DE NARRATEURS, DES ENTRETIENS ET DES IMAGES.

La vidéo présente un moment d'écoute de deux récits :

celui d'une fille et celui d'un garçon –

qui sont frère et soeur.

Ils quittent l'Erythrée et arrivent à

Lampedusa en 2014 où ils sont placés dans le centre CARA de Mineo.

Ils y restent en attendant l'obtention d'un permis de séjour.

Lorsque nous tentons de les interroger, de leur offrir une chance de témoigner

de leurs expériences, nous savons qu'il faut leur offrir

une écoute attentive et empathique, un lieu sûr où partager leur récit.

La tâche est délicate car frère et sœur ont survécu à des violences

et à des actes de torture particulièrement graves et tragiques.

Chacun a demandé à s'exprimer en l'absence de l'autre.

Le récit de la fille – de son voyage - commence par sa volonté d'éviter à son frère

de devoir faire son service militaire à 16 ans. Dans son histoire, elle souligne un élément fondamental :

« Je ne parviens pas à oublier, je ne trouve pas la force de parler. »

Lorsqu'elle prononce ces mots, un contact, lors de l'écoute, s'établit entre la fille et le professionnel qui lui prend les mains.

Normalement, il est difficile de recourir au moindre contact physique face à ce type

d'expérience, il est donc préférable de ne pas toucher la victime de traumatismes et de violence physique.

Toutefois, dans le cas qui nous occupe, le professionnel a estimé que la fille avait besoin

d'un soutien plus fort pour continuer à partager son histoire. Le professionnel lui demande donc s'il peut lui tenir les mains.

La demande verbale, préalable à l'action, a suffi pour la convaincre d'accepter.

Grâce à ce contact, un canal puissant et solide d'énergie s'est libéré.

Chaque fois que la fille doit aborder un aspect particulièrement douloureux et traumatisant,

elle a tendance à s'arrêter et le professionnel lui tient les mains pour maintenir

le flux d'énergie nécessaire

à la poursuite du récit.

En conclusion de cet exercice, nous pouvons affirmer que, confronté à des témoignages,

on ne peut ni banaliser, ni minimiser, ni amplifier le récit.

Il importe de l'écouter avec empathie, avec la plus grande attention

pour la manière dont il est raconté. Ecouter en faisant preuve d'une grande sensibilité,

mais surtout d'empathie, et reconnaître la souffrance vécue par autrui.

Voilà l'élément déterminant qui nous a donné accès à l'expression la plus profonde

et la plus intense des émotions dans ce partage poignant.

Matériau de support

Mediterranean Horizon Film:

https://www.youtube.com/watch?v=Wl-6aHKku5c

STAFF DEBUG INFO

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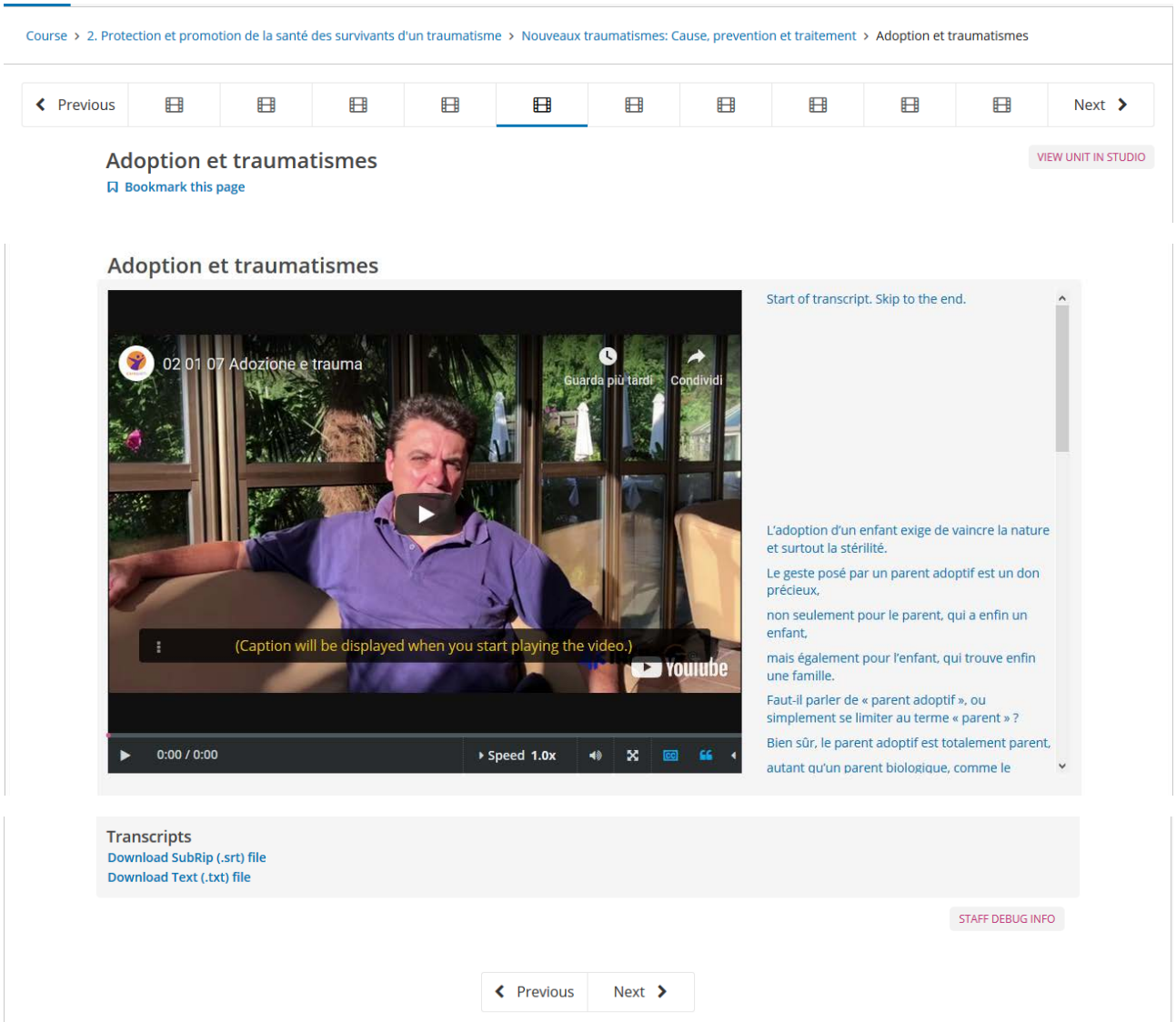


Transcript

L'adoption d'un enfant exige de vaincre la nature et surtout la stérilité.

Le geste posé par un parent adoptif est un don précieux,

non seulement pour le parent, qui a enfin un enfant,

mais également pour l'enfant, qui trouve enfin une famille.

Faut-il parler de « parent adoptif », ou simplement se limiter au terme « parent » ?

Bien sûr, le parent adoptif est totalement parent,

autant qu'un parent biologique, comme le montre la recherche, mais également comme le prouvent les relations nouées entre l'enfant et le parent.

Adopter un enfant et avoir un enfant biologique sont des expériences similaires à plus d'un titre.

Pourtant, si le parent adoptif sera surpris lorsque l'enfant l'appellera papa

(ou maman), cela sera une évidence pour le parent biologique.

En d'autres termes, la parentalité adoptive

est peut-être plus intense que la parentalité

biologique. Cependant, le parent doit tenir compte de ceci :

l'enfant adopté a le droit d'être heureux et, pour être heureux,

il a besoin qu'on tienne compte de son histoire.

Ou, elle peut nous être inconnue si personne ne nous l'a racontée ou

si l'enfant l'a oubliée.

Malgré tout, nous devons faire preuve de sensibilité face aux problèmes

que l'enfant peut porter en lui.

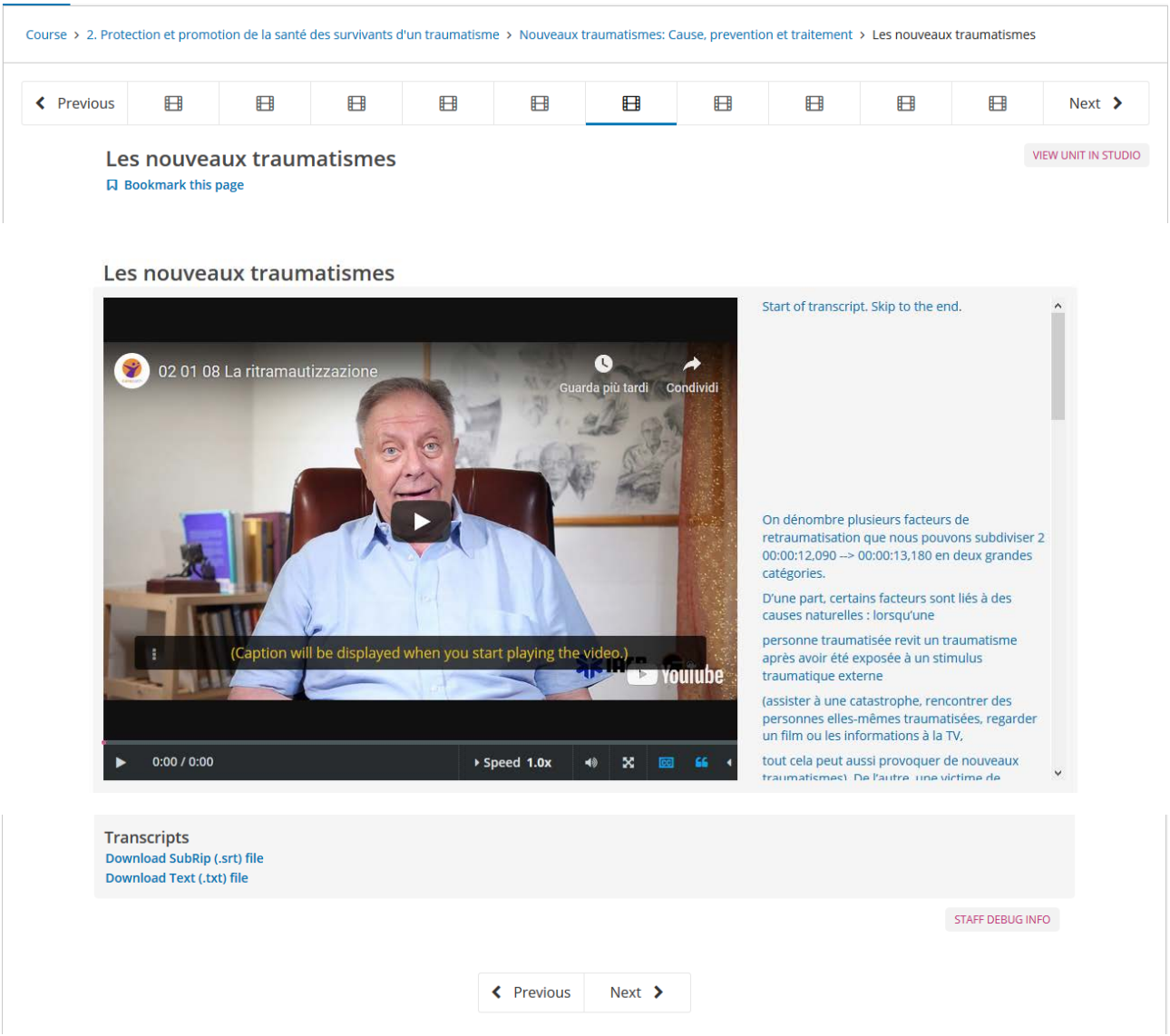
L'enfant adopté, au même titre que l'adulte qu'il deviendra, est souvent confronté à des questions existentielles :

qu'en est-il de mes origines ?

Pourquoi m'a-t-on abandonné ?

Personne ne peut répondre à ces questions, et pourtant la vie est belle et nous devons

continuer à aspirer à une vie meilleure.



Transcript

On dénombre plusieurs facteurs de retraumatisation que nous pouvons subdiviser en deux grandes catégories.

D'une part, certains facteurs sont liés à des causes naturelles : lorsqu'une

personne traumatisée revit un traumatisme après avoir été exposée à un stimulus traumatique externe

(assister à une catastrophe, rencontrer des personnes elles-mêmes traumatisées, regarder un film ou les informations à la TV,

tout cela peut aussi provoquer de nouveaux traumatismes). De l'autre, une victime de traumatismes peut vivre

un nouveau traumatisme causé par le processus d'accompagnement lorsque

celui-ci est assuré par une personne inexpérimentée ou par une organisation

qui n'est pas sensible aux traumatismes.

Même si le problème est fortuit, ne pas être sensible aux traumatismes peut être néfaste pour le patient.

Les garanties et les procédures qu'un prestataire, un professionnel ou une institution mettent en place sensibles aux traumatismes.

pour éviter les nouveaux traumatismes chez les clients s'appellent les soins

Malheureusement, dans le passé, il est trop souvent arrivé que nous provoquions de nouveaux

traumatismes chez des personnes déjà traumatisées, certainement pas par mauvaise foi,

mais par simple ignorance. C'est grâce à la recherche et aux preuves cliniques que nous avons observé que ces patients,

s'ils sont obligés de faire ce qu'ils ne veulent pas, s'ils ne sont pas respectés

dans leur temporalité, s'ils sont obligés de se remémorer des expériences traumatisantes

– pour un motif valable bien sûr – subissent, même à leur insu, des dommages iatrogènes.

Par accompagnement sensible aux traumatismes, nous entendons toutes les précautions, le filet de sécurité développé grâce à la recherche,

qui montre combien il est important de protéger les personnes traumatisées contre le danger des nouveaux traumatismes.

Il s'agit de respecter leur rythme, d'offrir des services centrés sur la personne,

de respecter leurs besoins et leurs sensibilités, mais surtout de ne pas les forcer à faire quoi que ce soit

si elles ne sont pas encore prêtes.

La raison est très simple : nous avons observé que les personnes traumatisées ont besoin d'acceptation,

de gentillesse et d'un lieu sûr pour reprendre des forces avant de se relancer,

avec la vitesse et la prudence dues aux traumatismes vécus,

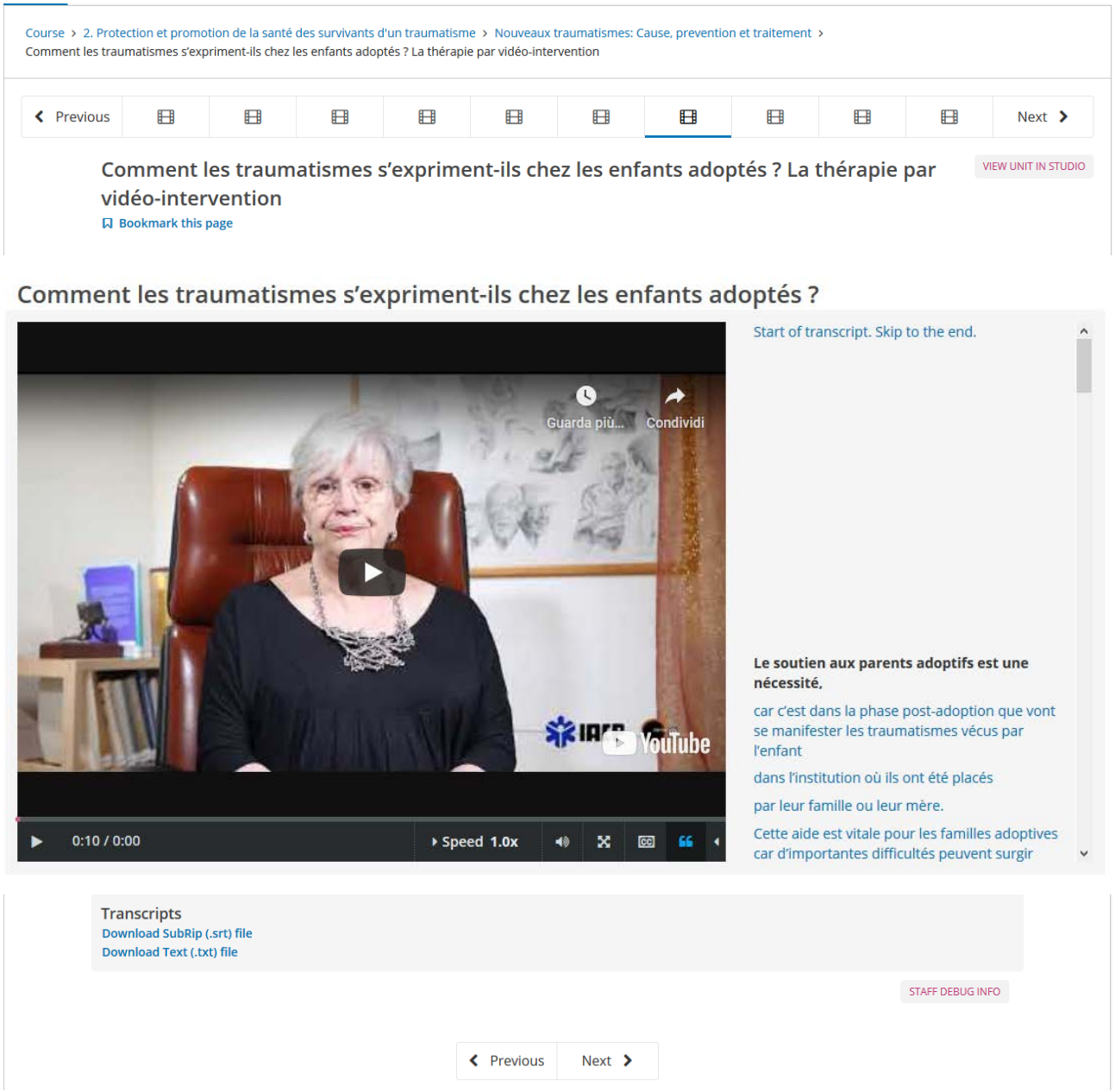
dans leur exploration.

En conséquence, son nous voulons offrir un accompagnement de qualité,

nous devons nous fier

aux capacités autorégulatrices

des victimes de traumatismes.



Transcript

Le soutien aux parents adoptifs est une nécessité,

car c'est dans la phase post-adoption que vont se manifester les traumatismes vécus par l'enfant

dans l'institution où ils ont été placés

par leur famille ou leur mère.

Cette aide est vitale pour les familles adoptives car d'importantes difficultés peuvent surgir

dans la relation entre l'enfant et sa nouvelle famille.

La recherche montre que les traumatismes peuvent briser les relations,

les rendre problématiques et difficiles et les enfants n'échappent pas à la règle.

Etre informés des difficultés rencontrées par l'enfant dans la nouvelle famille

adoptive peut faciliter la tâche des parents ou

du moins les sensibiliser.

Dans les échanges créateurs d'une relation, les échanges interactifs,

les enfants sont difficiles à gérer ; ils peuvent envoyer des signaux déroutants et imprécis,

paraître absents ou désintéressés.

Nous allons analyser chacun de ces aspects, qu'on retrouve

dans toutes les histoires d'adoption.

Par conséquent, et toujours grâce à la recherche, nous savons que chaque échange

interactif est constitué de micro-évènements qui,

analysés dans les détails, influencent les réactions adulte-enfant et enfant-adulte.

Voilà pourquoi il est très important d'utiliser les vidéos.

where the trauma has created conditions that make it difficult to read interactive micro-analytical aspects,

En effet, dans les situations où les traumatismes compliquent la lecture des aspects micro-analytiques interactifs,

il sera utile de les filmer,

de les observer lors des échanges et de voir où

et comment l'enfant se déplace

dans l'échange interactif et comment le parent réagit.

Ainsi, il convient de recommander et d'insister sur l'utilisation de l'outil - vidéo.

La vidéo permet de jeter les bases et d'analyser dans les détails chaque moment,

chaque action dans l'échange entre l'enfant et le parent. Soulignons que cet usage particulier de la vidéo doit être réservé et partagé uniquement avec les thérapeutes spécialisés ;

il ne peut pas être pratiqué par les personnes qui ne possèdent pas cette expertise vu le degré de sensibilité des personnes concernées.

On observe que les enfants adoptés envoient des signaux moins évidents,

plus brefs et moins précis que les enfants non adoptés.

A cet égard, l'utilisation de la vidéo revêt une grande importance car elle permet au parent –

qui filme chaque moment de l'interaction – de voir quand et comment l'enfant parvient à entrer en relation avec lui.

Cette étape dans

l'échange interactif permettra

de nouer un nouveau lien d'attachement.

L'hypervigilance de l'enfant est un autre élément important, essentiel même,

car elle nous raconte l'histoire de l'enfant, ses craintes, l'absence de soins et les moments de négligence.

Mais surtout, elle nous dit si l'enfant a subi de la violence physique, des abus peut-être,

ou s'il a été le témoin de violence.

L'hypervigilance désigne le moment où l'enfant se concentre

plus attentivement sur l'expression de l'adulte,

il en surveille chaque instant pour tenter de décrypter

ce qu'elle signifie et s'assurer que rien de dangereux ne va lui arriver,

ou veiller à ce qu'il n'y ait ni danger ni aucune source de menace dans cette expression.

Cela dénote clairement un manque de confiance de la part de l'enfant envers l'adulte.

Si cette méfiance va s'atténuer par le travail sur la relation adulte-enfant, il peut arriver qu'elle ne disparaisse jamais.

L'enfant peut également faire preuve d'une maladresse affective,

qui risque de blesser profondément les parents adoptifs car ils auront le sentiment

que cet enfant ne se sentira jamais libre d'exprimer son affection et sa proximité affective avec eux.

La responsabilité n'incombe pas à l'enfant mais, comme le montre le rapport,

c'est un fragment de son histoire passée particulièrement douloureux.

Les enfants sont habitués à ne pas s'approcher des adultes pour éviter tout danger.

Ils n'ont donc pas l'habitude de les toucher, ni de les étreindre, même quand la nouvelle relation le permet.

En conséquence, on peut avoir tendance à trop s'occuper de ces enfants,

en exagérant la proximité, en s'accrochant à eux ;

or puisqu'ils ne parviennent pas à moduler leurs contacts avec

l'adulte, ils ne sauront pas quand c'est trop ou trop peu, ils sont en plein désarroi et embarras.

Parfois, l'enfant s'approche de façon très maladroite, de manière presque forcée ;

le parent va le remarquer immédiatement et aura tendance à y coller une étiquette.

Nous préconisons d'envisager ce comportement comme l'expression d'un moment de l'histoire de l'enfant –

il n'a jamais été libre de se rapprocher spontanément d'un

adulte et c'est ce qui explique son comportement plutôt maladroit.

Un autre aspect que le parent verra sera la fatigue et les difficultés à dormir ...

un sommeil extrêmement agité, peu reposant et la difficulté à s'endormir.

Un autre aspect peut être observé dans la difficulté de concentration, souvent interprétée

comme trouble d'apprentissage pas mieux identifié:

l'enfant n'a pas de trouble d'apprentissage,

mais son hypervigilance déclenche des traits émotionnels négatifs si difficiles et épuisants...

et épuisant qui le distrait des tâches qui lui sont assignées.

Une fois de plus, nous verrions que l'enfant est à l'écoute du visage de l'adulte, son

l'expression, sur ce que l'adulte exprime, du danger qu'il peut représenter;

tout cela empêchera l'enfant de se concentrer.

Tous ces aspects sont cependant extrêmement importants, ces comportements sont le récit

d'une histoire passée, ils diront au parent adoptif tout ce qui est marqué dans le

histoire de l'enfant que cet enfant ne peut éventuellement s'exprimer à travers

ce genre de comportements;

alors peut-être qu'il est important de penser que ce sont des informations précieuses qui

peut nous mettre en position de comprendre cette partie du passé de l'enfant, absolument inconnaissable

pour nous, mais qui a créé ce changement dans cette relation telle qu'elle est ...

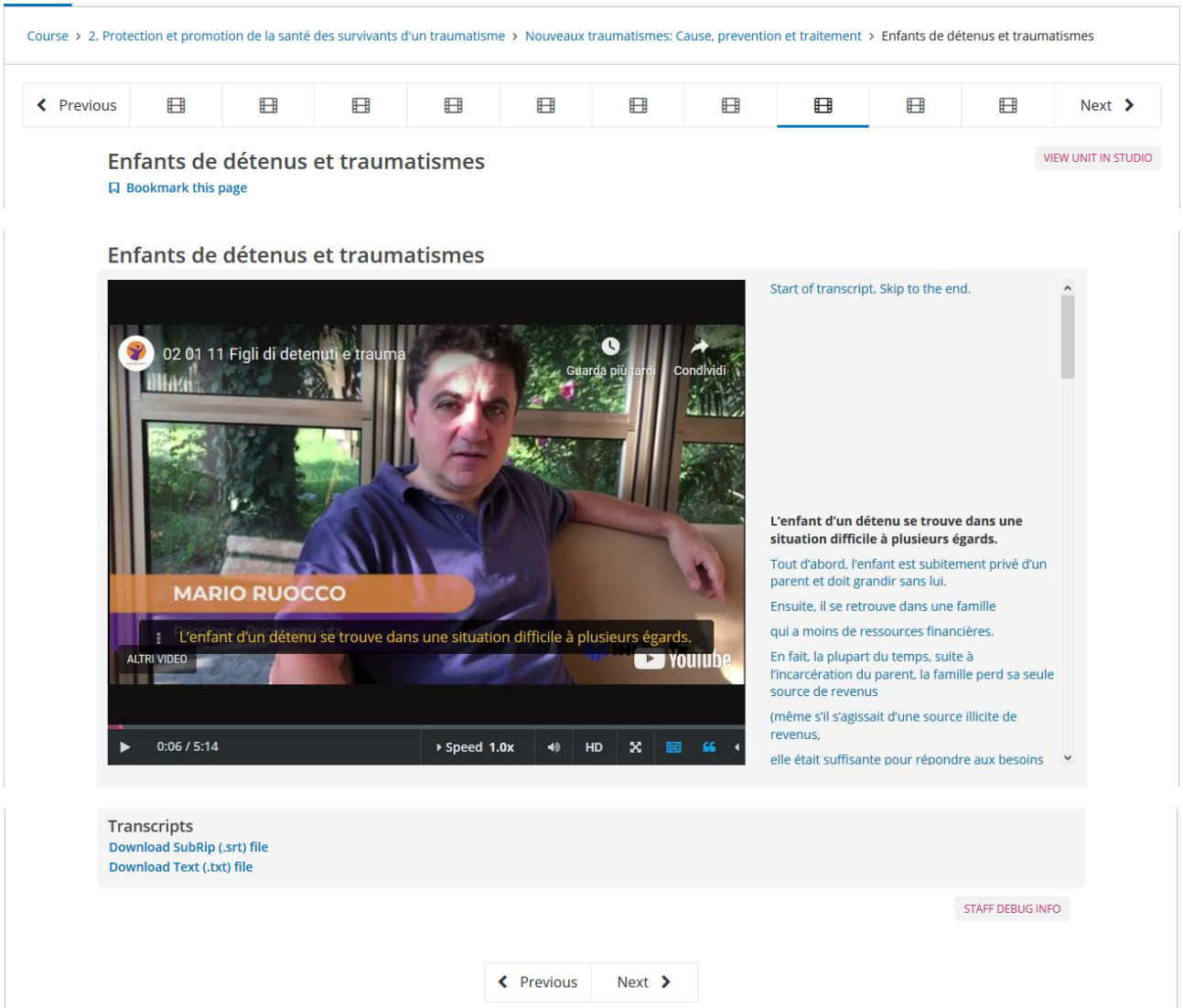
avec le nouveau parent nourricier.

Plus que des situations à corriger, ce sont des comportements à comprendre et à accepter comme

des occasions de comprendre ce qu'ils peuvent d'une histoire passée qui pourrait devenir,

avec ce petit enfant, aujourd'hui un récit partagé.

Comment le récit du passé peut créer un pont avec le récit du présent.



Transcript

L'enfant d'un détenu se trouve dans une situation difficile à plusieurs égards.

Tout d'abord, l'enfant est subitement privé d'un parent et doit grandir sans lui.

Ensuite, il se retrouve dans une famille

qui a moins de ressources financières.

En fait, la plupart du temps, suite à l'incarcération du parent, la famille perd sa seule source de revenus

(même s'il s'agissait d'une source illicite de revenus,

elle était suffisante pour répondre aux besoins quotidiens).

Une des autres conséquences tragiques, et non des moindres,

est que l'enfant devient victime de stigmatisation :

être enfant de détenu équivaut à être enfant de la culpabilité ;

l'enfant, face à la pression sociale,

se forge sa propre opinion et se convainc qu'il

mérite d'être puni. Souvent, les enfants de parents détenus sont des enfants perturbés,

notamment parce qu'il leur manque un parent

– souvent le père – pour les éduquer et leur poser

des limites.

Ce sont des enfants obligés de vivre seuls, la mère devant gérer tous les problèmes

sans plus compter sur l'aide

de son mari.

C'est un tout nouveau défi à relever et, malheureusement, il arrive que même des travailleurs sociaux tombent

dans le piège de la stigmatisation de l'enfant alors qu'ils devraient essayer

de le comprendre et de l'aider davantage que les autres enfants.

En effet, vivre seul avec une mère en difficulté n'est pas une mince

affaire. Comment annoncer à l'enfant qu'un de ses parents est incarcéré ?

Beaucoup de parents, par honte ou par difficulté, disent à l'enfant que l'autre parent

a du partir précipitamment car on lui a offert un nouvel emploi.

Evidemment, le mensonge ne tient pas face aux doutes de l'enfant puisque,

jusque-là, le père rentrait du travail tous les jours.

Pourquoi, alors, partir tellement de jours, de mois, d'années,

manquer tant d'anniversaires et de vacances pour la seule raison qu'on a accepté

un nouvel emploi ? L'enfant comprend vite que c'est un mensonge.

Le mieux à faire est de dire la vérité

à l'enfant :

« …ton père a commis des erreurs et, malheureusement, il doit répondre de ses actes ; mais il va bien, ne t'inquiète pas,

nous pourrons lui rendre visite bientôt. »

Voilà un autre problème dans la vie d'un enfant de détenus :

faut-il lui montrer le parent emprisonné ? Certains travailleurs sociaux

estiment qu'il est préférable d'éviter, le milieu carcéral n'étant pas adapté

aux besoins de l'enfant. Il n'est pas faux que, la porte d'une prison franchie,

on se retrouve face à des policiers, à des endroits pas toujours décents.

Par ailleurs, il est essentiel pour l'enfant de voir son parent.

Il est donc impératif d'organiser des rencontres entre les détenus et leurs enfants.

Si, jusqu'à récemment, des parois séparaient le détenu de ses visiteurs,

aujourd'hui les temps ont changé : de nombreuses prisons sont équipées de salles de jeu ou de pièces plus colorées,

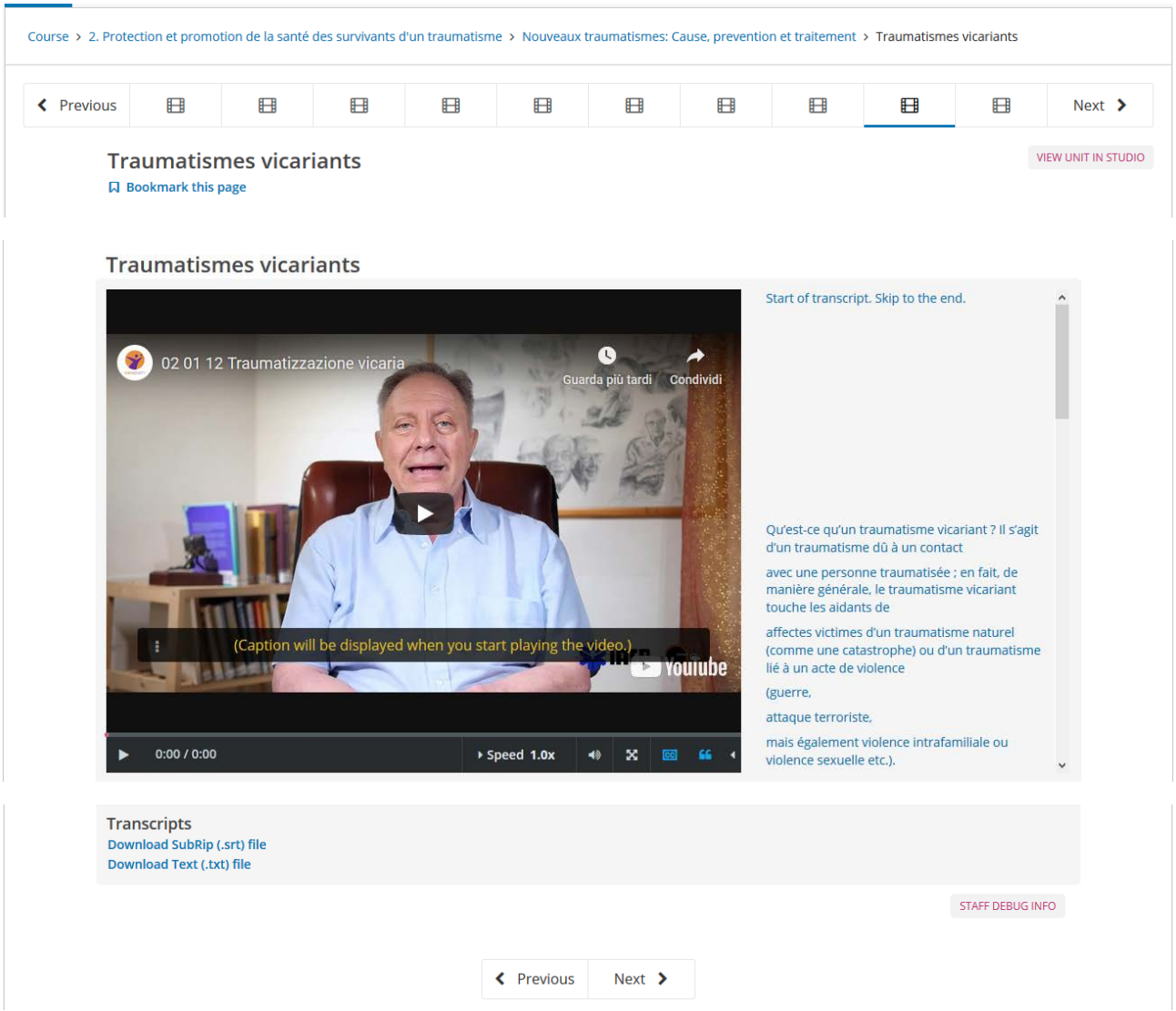
avec des jeux, et les agents pénitentiaires sont mieux préparés à l'accueil des enfants.

Toutefois, ce n'est pas le premier souci ;

il importer surtout d'organiser une rencontre entre le parent et l'enfant,

peu importe si l'enfant se rend dans un milieu adapté ou pas.

Ce n'est bien sûr pas le cas lorsque le parent est en prison pour avoir commis un délit contre son propre enfant.



Transcript

Qu'est-ce qu'un traumatisme vicariant ? Il s'agit d'un traumatisme dû à un contact

avec une personne traumatisée ; en fait, de manière générale, le traumatisme vicariant touche les aidants de

affectes victimes d'un traumatisme naturel (comme une catastrophe) ou d'un traumatisme lié à un acte de violence

(guerre,

attaque terroriste,

mais également violence intrafamiliale ou violence sexuelle etc.).

En résumé, le prestataire est en contact journalier avec les victimes

de traumatismes et leur offre, avec bienveillance, aide,

soutien et contact psychologique...

Mais malgré le sens

profond d'ouverture, d'humanité et l'importance existentielle de son travail, ces traumatismes peuvent peser sur sa santé mentale.

Le prestataire peut alors développer un véritable traumatisme

avec toutes les conséquences que cela implique pour lui.

Il est extrêmement important de prévenir et de limiter l'impact des traumatismes vicariants chez les prestataires et professionnels

susceptibles d'entrer en contact avec des victimes de traumatismes ou de violence. Il s'agit souvent de professionnels de la santé, d'agents de police, de pompiers, de journalistes, de bénévoles et de tout qui,

qui pour une raison ou pour une autre, entrent en contact avec des personnes traumatisées.

Il est tout aussi essentiel de prévenir les traumatismes vicariants, ou plus communément « épuisement professionnel »

(burnout), qui touchent les personnes impliquées dans des relations d'aide.

Ces traumatismes frappent durement ceux et celles qui ne parviennent pas à recharger leurs batteries,

à se déconnecter d'un travail lourd et prenant, mais aussi magnifique.

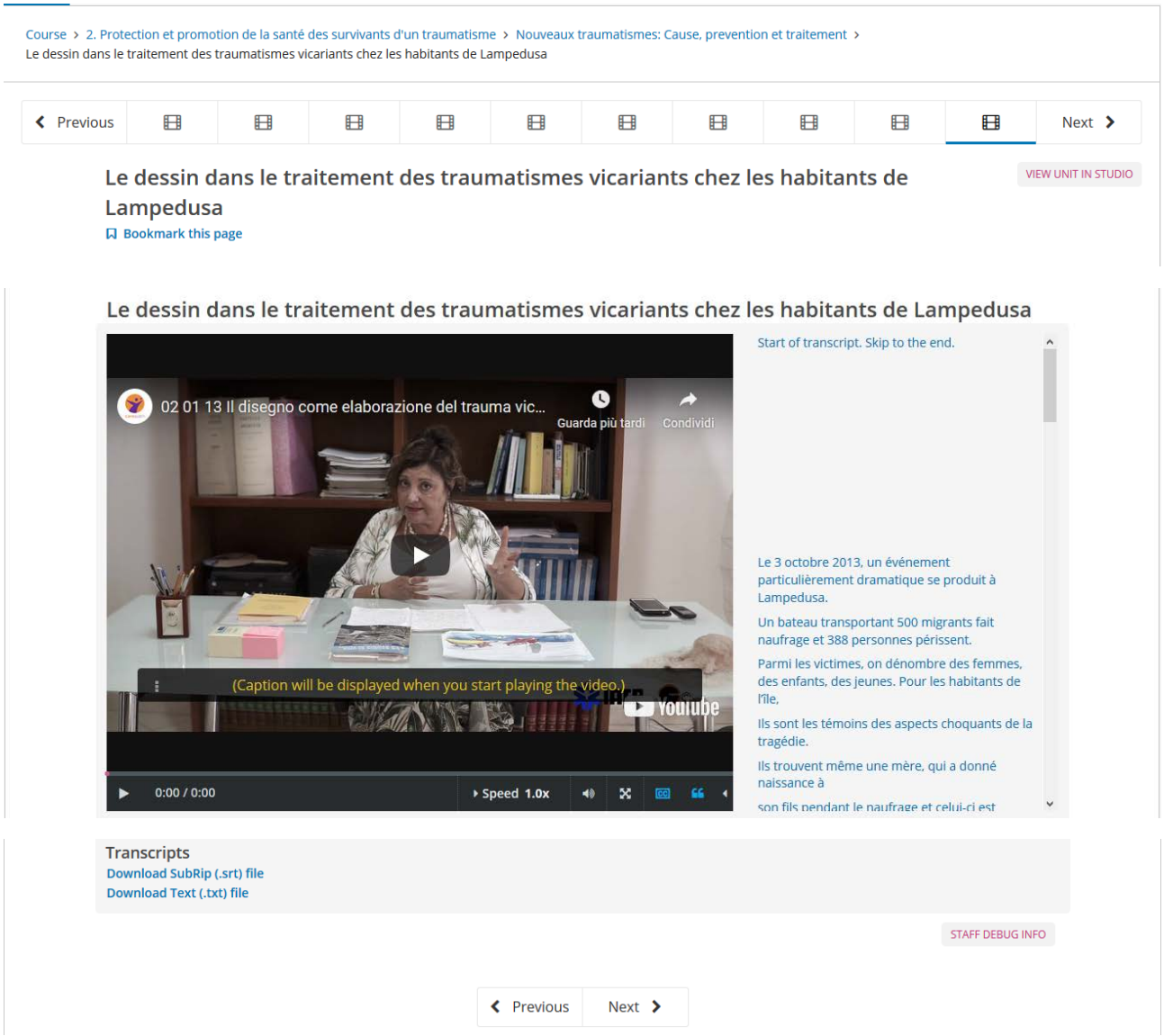
Il est également important d'assurer un équilibre entre la vie familiale et la vie professionnelle car,

pour être efficace dans son travail d'aide, le professionnel devra prendre soin de sa vie privée,

passer du temps avec sa famille, ses amis et s'amuser. En résumé, il est difficile pour les prestataires de services d'aide, animés par la passion, la générosité et l'empathie, de s'aider eux-mêmes.

Ou on ne peut pas donner aux autres ce qu'on ne possède pas. D'un point de vue moral, éthique et professionnel, il est donc nécessaire de stimuler notre résilience, de protéger notre santé et notre bien-être.

En effet, si nous voulons donner le maximum aux personnes que nous aidons, il est essentiel de s'occuper également de la personne avec laquelle nous allons passer chaque minute de notre vie: nous-mêmes.



Transcript

Le 3 octobre 2013, un événement particulièrement dramatique se produit à Lampedusa.

Un bateau transportant 500 migrants fait naufrage et 388 personnes périssent.

Parmi les victimes, on dénombre des femmes, des enfants, des jeunes. Pour les habitants de l'île,

Ils sont les témoins des aspects choquants de la tragédie.

Ils trouvent même une mère, qui a donné naissance à

son fils pendant le naufrage et celui-ci est toujours attaché au cordon ombilical.

l'événement est traumatisant car ils participent tous au sauvetage en mer

et à la récupération de centaines de cadavres.

Cet événement provoque un traumatisme

vicariant au sein de la population.

Nous tentons donc, au sein de l'agence locale pour la santé,

d’offrir une aide d’écoute et de soutien aux personnes qui

ont vécu des expériences traumatisantes.

Les expériences traumatisantes vécues par les enfants,

surtout s’ils sont encore en âge de l’école primaire, sont les plus difficiles à gérer.

A Lampedusa, l’immigration est une expérience de plusieurs années.

Tous les habitants (notamment les jeunes) savent que, souvent,

les voyages de l’espoir se soldent par des pertes humaines. Cependant, les enfants de 6-7 ans sont plus sensibles à ce type

d’expériences et la plupart éprouvent de la peur, de l’angoisse, des phobies.

Ils adoptent les réactions typiques de quelqu’un exposé à une expérience traumatisante,

lorsque la vie est mise en danger ou perdue.

Pour les enfants de Lampedusa, ce tragique événement s’est déroulé dans leur mer,

qu’ils associent à la joie, au jeu et au plaisir ; Cette mer est pour eux un espace de joie et de légèreté,

qui tout à coup devient un espace de mort.

Afin de traiter

les traumatismes vicariants chez ces enfants,

nous leur proposons de réaliser des dessins qui illustrent

comment les enfants répondent et réagissent au traumatisme.

Si deve fare una piccola premessa: l’arte

è uno strumento potente per rendere tangibili eventi dolori e spaventosi, in sé l’arte

Posons une hypothèse : l’art est un instrument efficace pour rendre concrets des événements douloureux et effrayants.

L’art, en tant que tel,

a un effet libérateur et permet de repenser les évènements traumatisants.

Ensuite,

la question se pose du sens d’un événement traumatisant pour les enfants.

Tout dépend du type d’évènements. En effet, un événement traumatisant peut prendre différentes formes :

être provoqué par les humains (par exemple, les guerres et le terrorisme) ou par la nature

(les ouragans, les tremblements de terre et les tornades).

Chacun de ces évènements laisse des traces et des craintes spécifiques dans l’esprit des enfants. A cet égard, il est nécessaire, dans le cas du naufrage survenu à Lampedusa,

de reconstruire la fracture affective et interne vécue par les enfants, qui a aussi touché leur famille.

Ajoutons que des enfants de 6 et 7 ans auront du mal à

comprendre le sens de la mort et nous savons combien les enfants ramènent tout à eux.

A cause de ces évènements et de ces histoires de mort,

les enfants ont maintenant peur de manger du poisson (les poissons se sont nourris des enfants et des mères décédés)

ou de nager dans la mer

(où ils pourraient rencontrer des cadavres).

Il faut donc reconstruire leur

sérénité en utilisant l'imagerie développée sur l'île de Lampedusa.

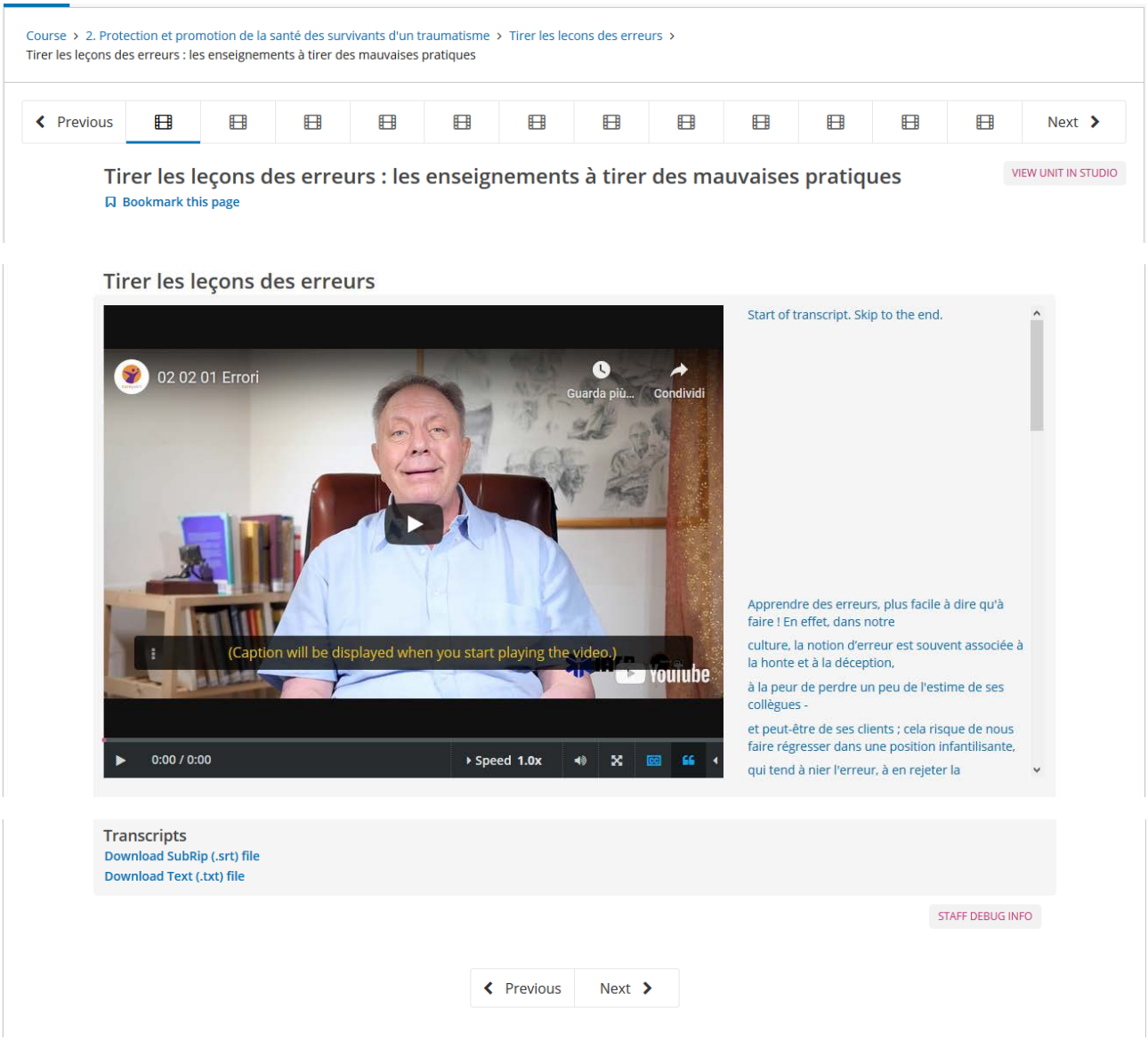
Comme on dit, tout est possible grâce au dessin.

Grâce au dessin, il est possible de construire un récit expliquant comment chaque enfant ressent l'événement car,

même si l'expérience de l'évènement est collective, sa perception variera selon chaque enfant.

Il faut éviter d'offrir immédiatement des mots de consolation,

mais laisser chaque enfant développer une solution personnelle aux angoisses liées au décès et à la disparition (la plus grande angoisse chez les enfants de 6-7 ans), par un soutien verbal et graphique, et par l'écoute qui fait suite à chaque phase de dessin.



Transcript

Apprendre des erreurs, plus facile à dire qu'à faire ! En effet, dans notre

culture, la notion d'erreur est souvent associée à la honte et à la déception,

à la peur de perdre un peu de l'estime de ses collègues -

et peut-être de ses clients ; cela risque de nous faire régresser dans une position infantilisante,

qui tend à nier l'erreur, à en rejeter la responsabilité sur les

autres, à prétendre que ce n'est pas notre faute, etc. Cette attitude de négation nous empêche de voir que, derrière chaque erreur,

se cache un trésor de sagesse.

En adoptant la bonne attitude, en refusant de rester sur la défensive,

nous pouvons nous ouvrir et apprendre de nos erreurs : elles deviennent ainsi nos professeurs et nous aident à

devenir de meilleurs professionnels ; qui plus est, ce faisant,

nous aidons nos patients à apprendre de leurs expériences.

C'est à la fois drôle et tragique : tous nous voulons aider les professionnels à inciter

leurs patients à apprendre de leurs expériences et de leurs erreurs,

tout en favorisant cette prise de conscience davantage chez eux que chez nous ;

nous rechignons à admettre nos erreurs et, ainsi, refusons d'être

ouverts à l'apprentissage.

Une perception dysfonctionnelle des erreurs, comme si elles généraient

une perte d'estime de soi lorsqu'on en tire les leçons, serait censée augmenter notre confiance :

c'est un peu fou. Tentons une image : ceux qui ont peur pensent qu'ils sont lâches,

ignorant que les braves éprouvent de la peur mais décident de la surmonter ;

les intelligents et sages acceptent leurs erreurs et en tirent les leçons.

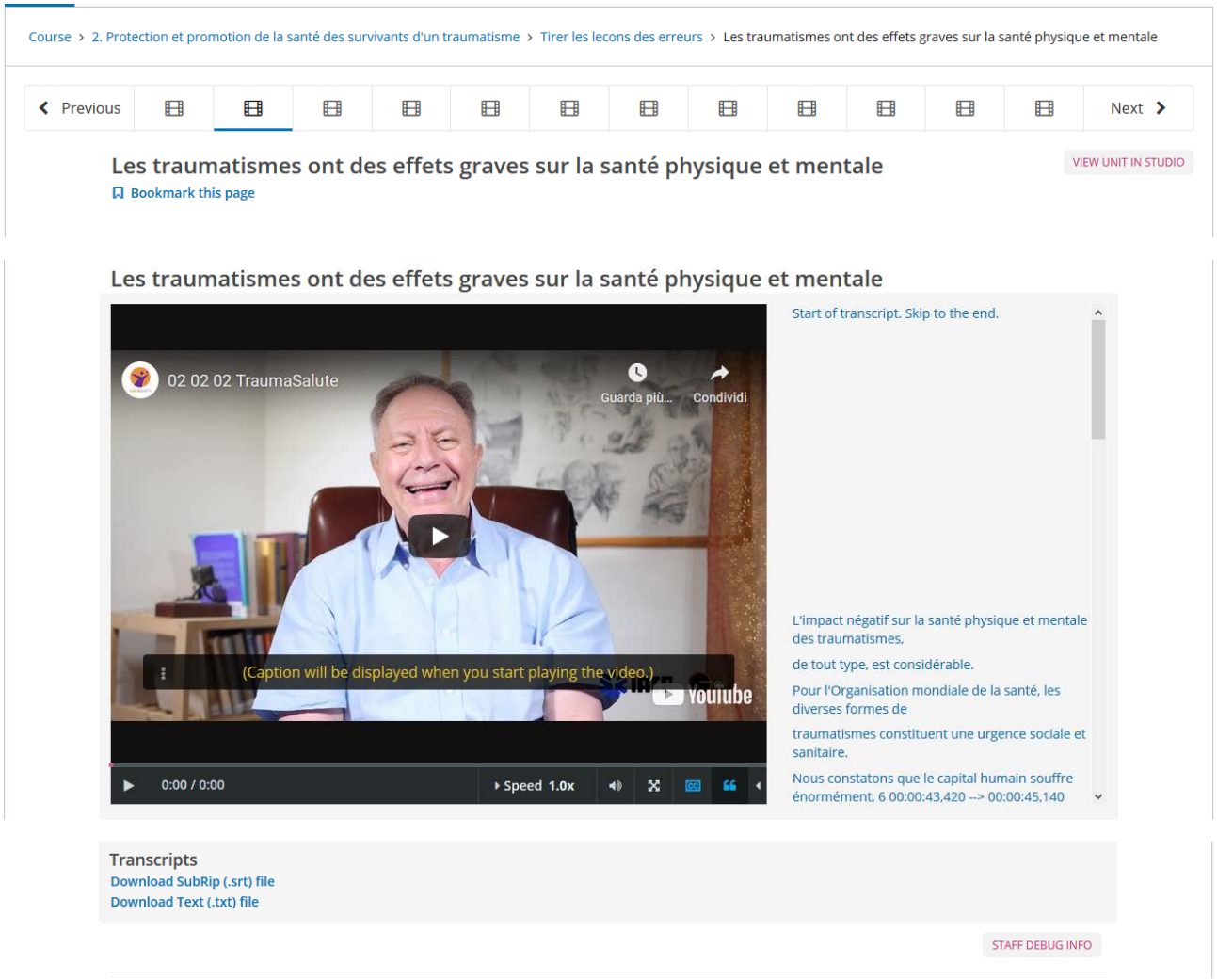
Nous pourrions apprendre beaucoup de nos patients qui sont, davantage que nous,

prêts à tirer humblement les leçons de de leurs expériences pour éviter de répéter les mêmes erreurs.

Au contraire, nous nous condamnons à répéter nos erreurs lorsque nous refusons de les admettre ;

en effet, dans cette hypothèse, nous nous décrivons comme des victimes susceptibles de nous mettre en situation d’impuissance.

Accueillons nos erreurs pour ce qu’elles sont : des maîtres de la sagesse.



Transcript

L'impact négatif sur la santé physique et mentale des traumatismes,

de tout type, est considérable.

Pour l'Organisation mondiale de la santé, les diverses formes de

traumatismes constituent une urgence sociale et sanitaire.

Nous constatons que le capital humain souffre énormément, tant au niveau physique que mental, des traumatismes.

Collectivement, nous contribuons moins efficacement à la prospérité, lorsque

les victimes de traumatismes nécessitent des soins et donc consomment une partie

de nos ressources économiques ; qui plus est, le traumatisme les empêche,

individuellement, de produire de la prospérité pour elles-mêmes,

pour leur famille, pour leur collectivité et pour leur pays.

Nous observons un autre aspect très préoccupant chez la victime de traumatismes :

non seulement souffre-t-elle de dommages au

niveau de sa santé physique et mentale,

mais, principalement dans certains types de traumatismes (violence ou violence sexuelle),

elle risque de passer du statut de victime à celui d'auteur et donc de traumatiser,

à son tour, d'autres personnes innocentes.

Ce glissement horrible montre à quel point le traumatisme est assimilable à un virus qui se propage d'un corps

à l'autre s'il n'est pas combattu, prévenu et traité efficacement dans la communauté.

On peut parler de pandémie, c'est-à-dire d'un problème qui se transmet rapidement d'un individu

à l'autre dans la population, entraînant une grave perte de capital humain.

Dans une approche bio-psychosociale, nous ne pouvons laisser

la responsabilité de la prévention et du traitement des traumatismes au seul secteur de la santé ;

il s'agit d'une tâche politique qui nécessite que toutes les institutions - familles, écoles, organisations professionnelles, monde de la justice des mineurs, législatif –

se sensibilisent à la problématique et s'intègrent dans

un réseau efficace de prévention et de résolution des traumatismes.

C'est dans l'intérêt et pour le bien de tous et de toutes.

Matériau de support

Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 3, Understanding the Impact of Trauma. Available from:

https://www.ncbi.nlm.nih.gov/books/NBK207191.

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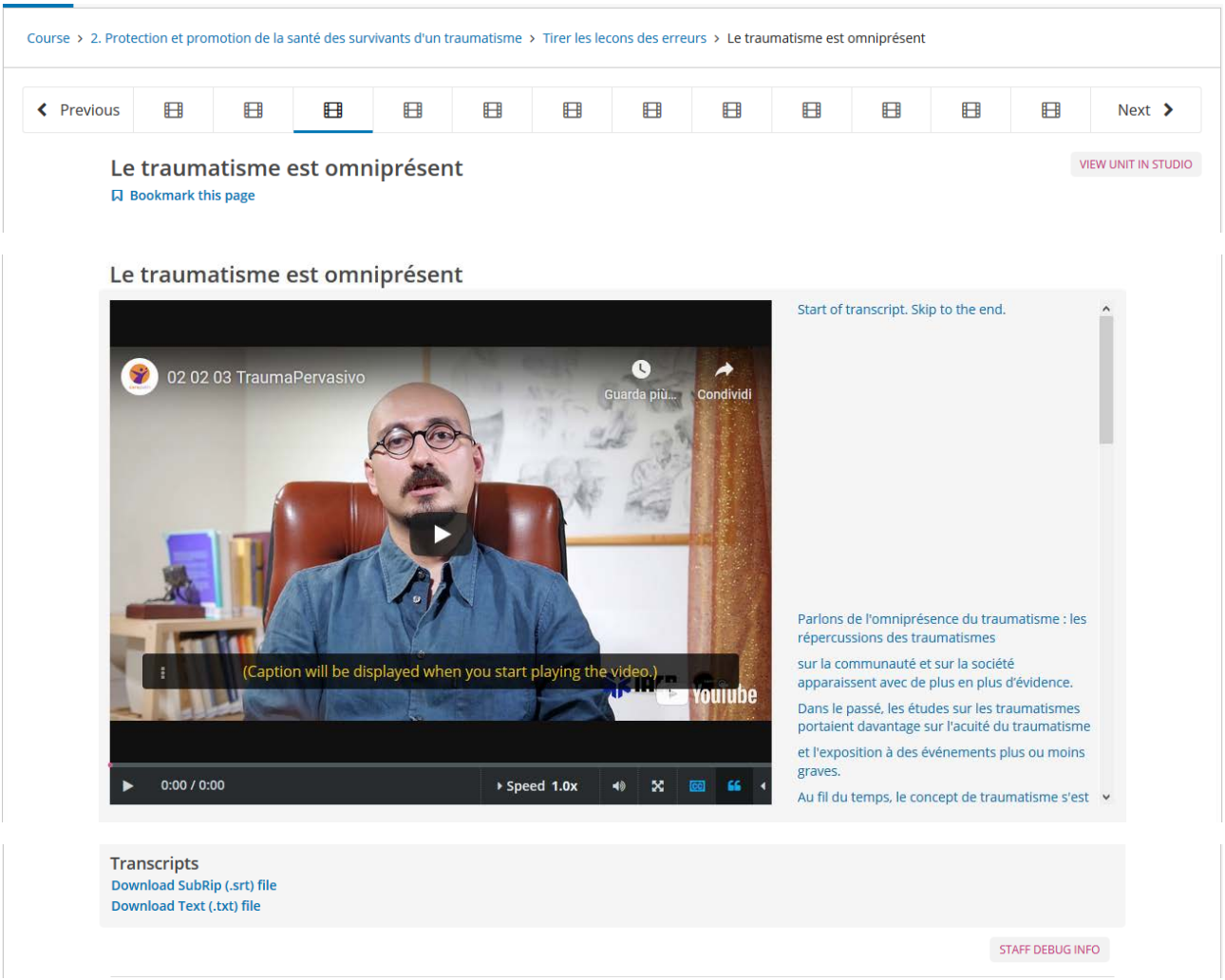


Transcript

Parlons de l'omniprésence du traumatisme : les répercussions des traumatismes

sur la communauté et sur la société apparaissent avec de plus en plus d'évidence.

Dans le passé, les études sur les traumatismes portaient davantage sur l'acuité du traumatisme

et l'exposition à des événements plus ou moins graves.

Au fil du temps, le concept de traumatisme s'est élargi à de nombreux autres aspects.

Le traumatisme est un phénomène omniprésent dans nos sociétés : la recherche nous indique

qu'une personne adulte a été exposée,

ou sera exposée dans l'avenir, au moins une fois à un événement traumatique.

D'après certaines études, comme celle de Benguet, nous savons que, dans le monde entier,

le pourcentage d'occurence de traumatismes est très élevé,

malgré quelques variations. Nous devons donc aujourd'hui tout faire pour découvrir

quels aspects protègent le mieux les gens contre

les traumatismes et lesquels risquent d'augmenter l'exposition aux traumatismes.

Les études sur le sujet nous ont appris que le traumatisme est collectivement à

l'origine de nombreux troubles chroniques aux répercussions majeures sur l'économie et la santé publique,

mais surtout qu'individuellement, un traumatisme empêche la personne concernée d'exprimer

ses potentialités et donc de devenir un citoyen pleinement conscient et efficace de la communauté et de la société dans laquelle elle vit.

Le concept de traumatisme sera encore plus important

si on envisage tous les traumatismes

survenant pendant la période

de développement de l'individu,

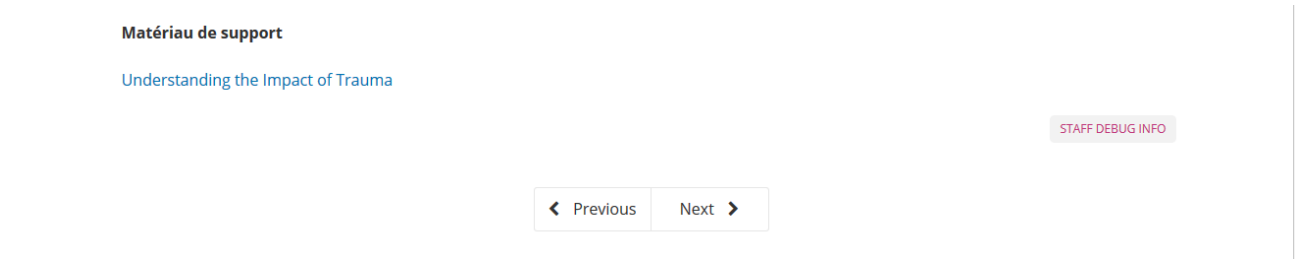
lorsqu'il développe ses

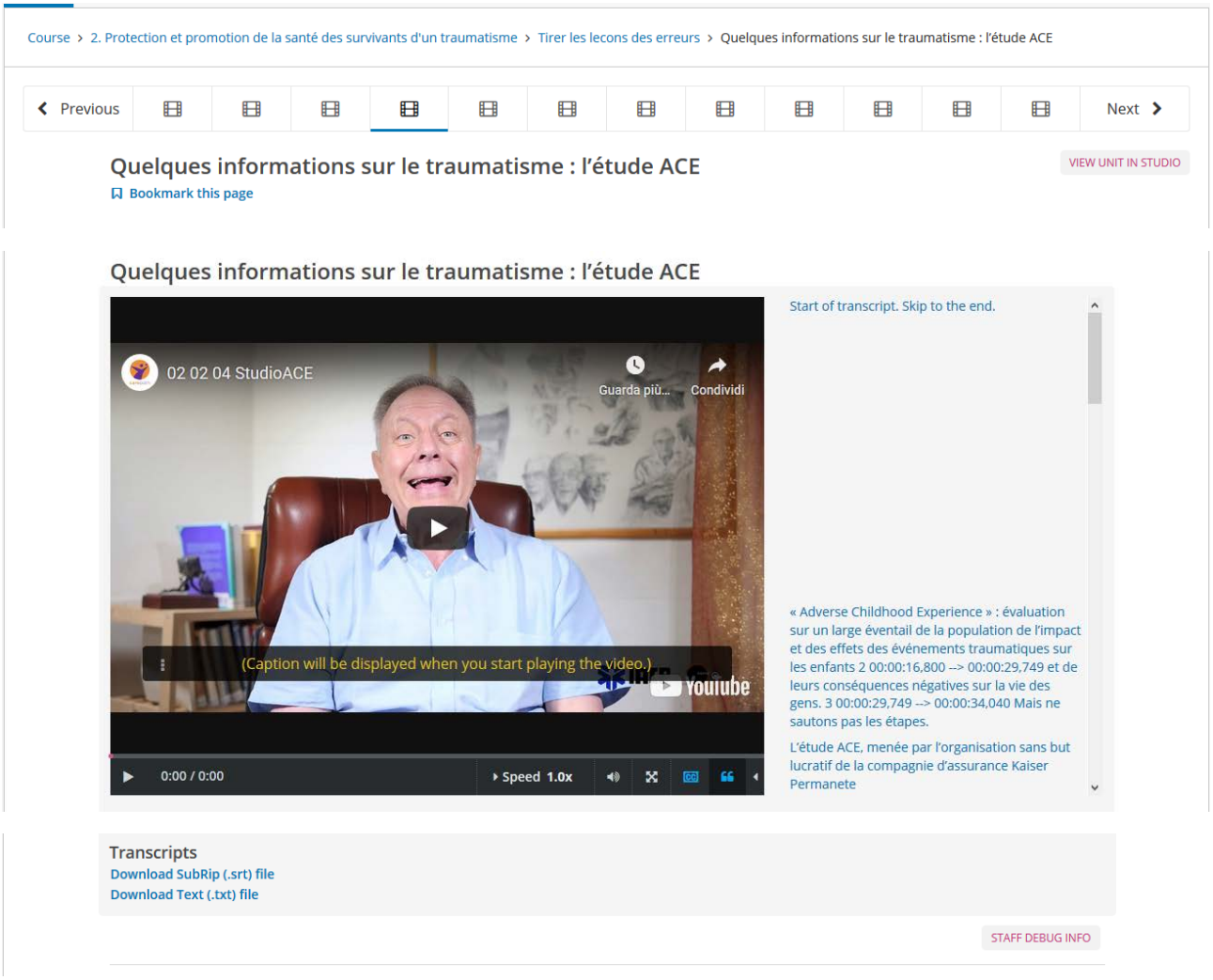
capacités émotionnelles et sociales ;

Il est donc crucial, comme nous

le faisons aujourd'hui à travers ce cours,

d'approfondir notre connaissance du traumatisme.





Transcript

« Adverse Childhood Experience » : évaluation sur un large éventail de la population de l'impact et des effets des événements traumatiques sur les enfants et de leurs conséquences négatives sur la vie des gens. Mais ne sautons pas les étapes.

L'étude ACE, menée par l'organisation sans but lucratif de la compagnie d'assurance Kaiser Permanete

(basée en Californie), s'est penchée sur les expériences négatives vécues au cours de l'enfance.

L'organisation a investi plusieurs millions de dollars pour mener à bien une étude

qui a porté des fruits pour l'ensemble de la communauté scientifique ;

en effet, nous en savons maintenant beaucoup plus sur le sujet ;

qui plus est, chaque répétition de l'étude en a confirmé les données initiales :

en moyenne, au moins un tiers de la population, soit un tiers des citoyens, a connu dans son enfance au moins un épisode indésirable,

un traumatisme. Un plus petit nombre de citoyens est affecté par

deux occurrences traumatiques et un nombre encore

plus petit souffre d'un plus

grand nombre de traumatismes.

La gravité des conséquences est proportionnelle au nombre de traumatismes vécus,

tout comme recevoir plusieurs coups de poignard est pire qu'en recevoir un seul.

Qui plus est, un traumatisme fait plus de dégâts qu'un coup de couteau,

car non seulement il laisse des séquelles négatives – au même titre qu'un coup de couteau -

sur l'apparence physique et mentale de la victime, mais, d'une certaine manière,

il agit comme un virus et pousse

certaines victimes de traumatismes – principalement quand elles ont subi des actes de violences, d'abus sexuels, etc. -

à en devenir elles-mêmes des auteurs une fois à l'âge adulte.

On a donc dit des problèmes mentaux et physiques qu'ils sont souvent associés.

Précisons : les victimes d'un traumatisme essaient instinctivement

de s'adapter à celui-ci, c'est-à-dire de s'en sortir, de gérer l'événement.

Si ce type de gestion d'un traumatisme peut être efficace dans un premier temps,

il finit par coûter cher sur le long terme.

Par exemple, certaines personnes peuvent, afin de gérer les effets du traumatisme, atténuer

leur souffrance par la consommation d'alcool ou de drogues,

ce qui crée un autre problème,

aggrave la situation et les fait sombrer dans l'alcoolisme ou la toxicomanie.

Au niveau comportemental, nous savons que nous avons tendance à éviter

le contact avec les autres, mais, en nous isolant, nous sommes empêchés de « recharger nos batteries ».

Ou d'entretenir des relations sexuelles. Bref, les expériences négatives de l'enfance sont un véritable fléau social

qui coûte très cher, les seuls coûts des traitements et des soins étant déjà très élevés.

Il est donc dans l'intérêt général que nous nous efforcions de prévenir et de traiter efficacement les traumatismes

que nous avons subis dans notre enfance.

C'est tout bénéfice non seulement pour les victimes, mais également pour l'ensemble de la société.

Matériau de support

About the CDC-Kaiser ACE Study

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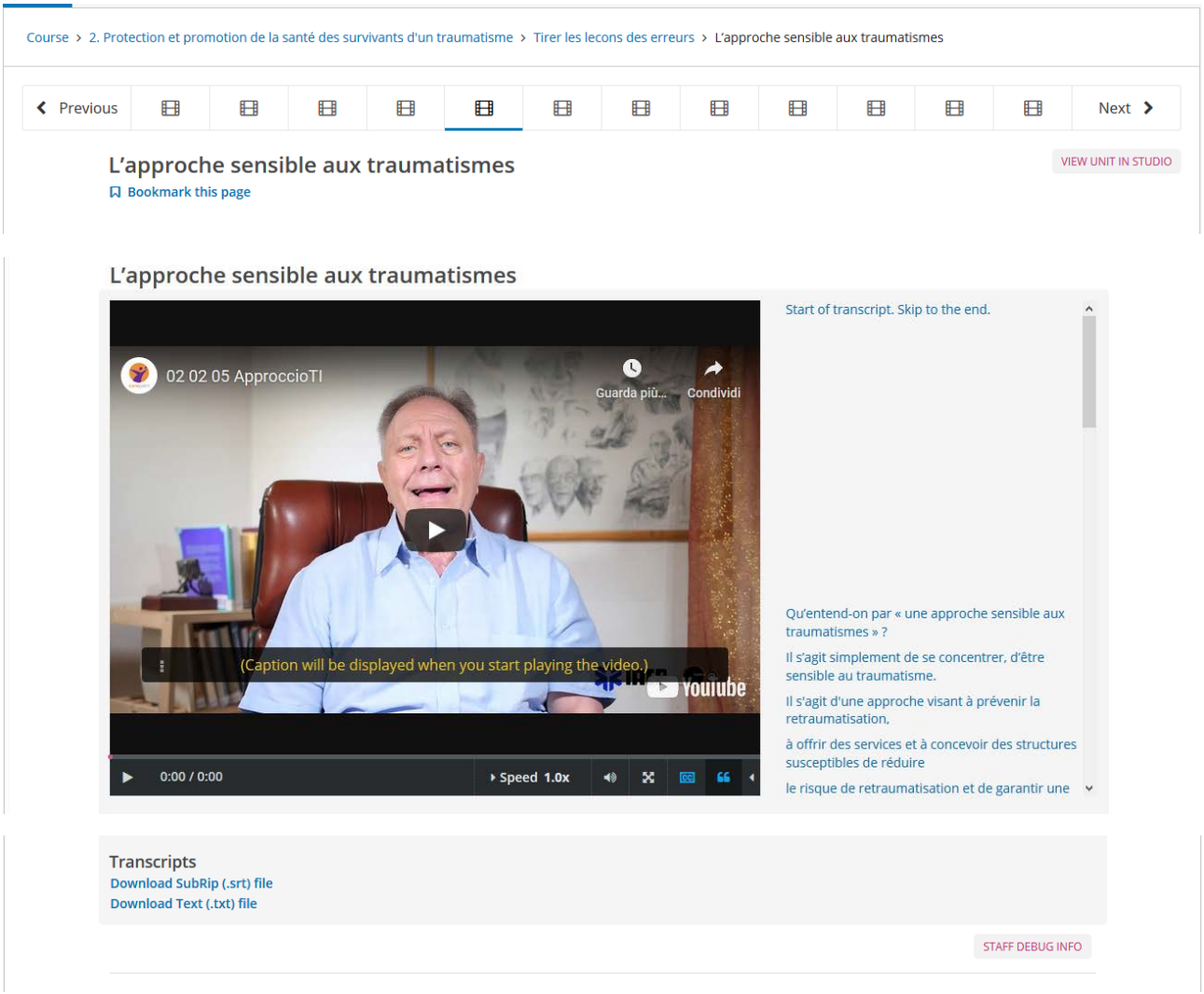


Transcript

Qu'entend-on par « une approche sensible aux traumatismes » ?

Il s'agit simplement de se concentrer, d'être sensible au traumatisme.

Il s'agit d'une approche visant à prévenir la retraumatisation,

à offrir des services et à concevoir des structures susceptibles de réduire

le risque de retraumatisation et de garantir une efficacité maximale des services.

Nous en sommes également arrivés à définir les bonnes pratiques comme des pratiques

sensibles aux traumatismes

par une attitude d'ouverture aux erreurs commises dans le passé.

Il s'agissait, bien sûr d'erreurs commises non pas intentionnellement,

mais par ignorance, parce que, justement, nous ne savions pas que certains aspects des traitements offerts

à l'époque contribuaient au problème et non à la solution : par exemple,

nous ignorions que susciter chez le patient

un souvenir non souhaité des traumatismes passés, un retour sur les moments traumatisants,

était iatrogène.

Aujourd'hui, grâce aux leçons des erreurs passées, nous disposons d'une série de directives

et de paramètres qui nous aident à prévenir

les dommages et à tirer un maximum des offres de services.

C’est vrai non seulement dans le domaine de la santé et de la santé mentale,

mais dans tous les autres domaines, comme l’enseignement, la vie associative,

la justice pour mineurs ou même le législatif.

Par exemple, dans un enseignement sensible aux traumatismes, les enseignants sauront que l’élève « indiscipliné » ne l’est pas automatiquement parce qu’il ne respecte pas les règles

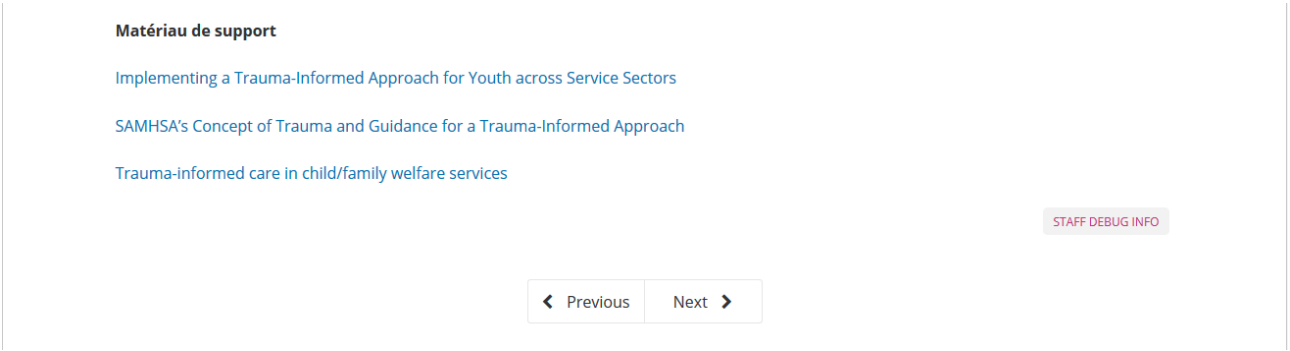
mais il est envisageable qu’il exprime, par son indiscipline, un problème sous-jacent dû à un traumatisme. En être conscient permettra à l'enseignant de gérer

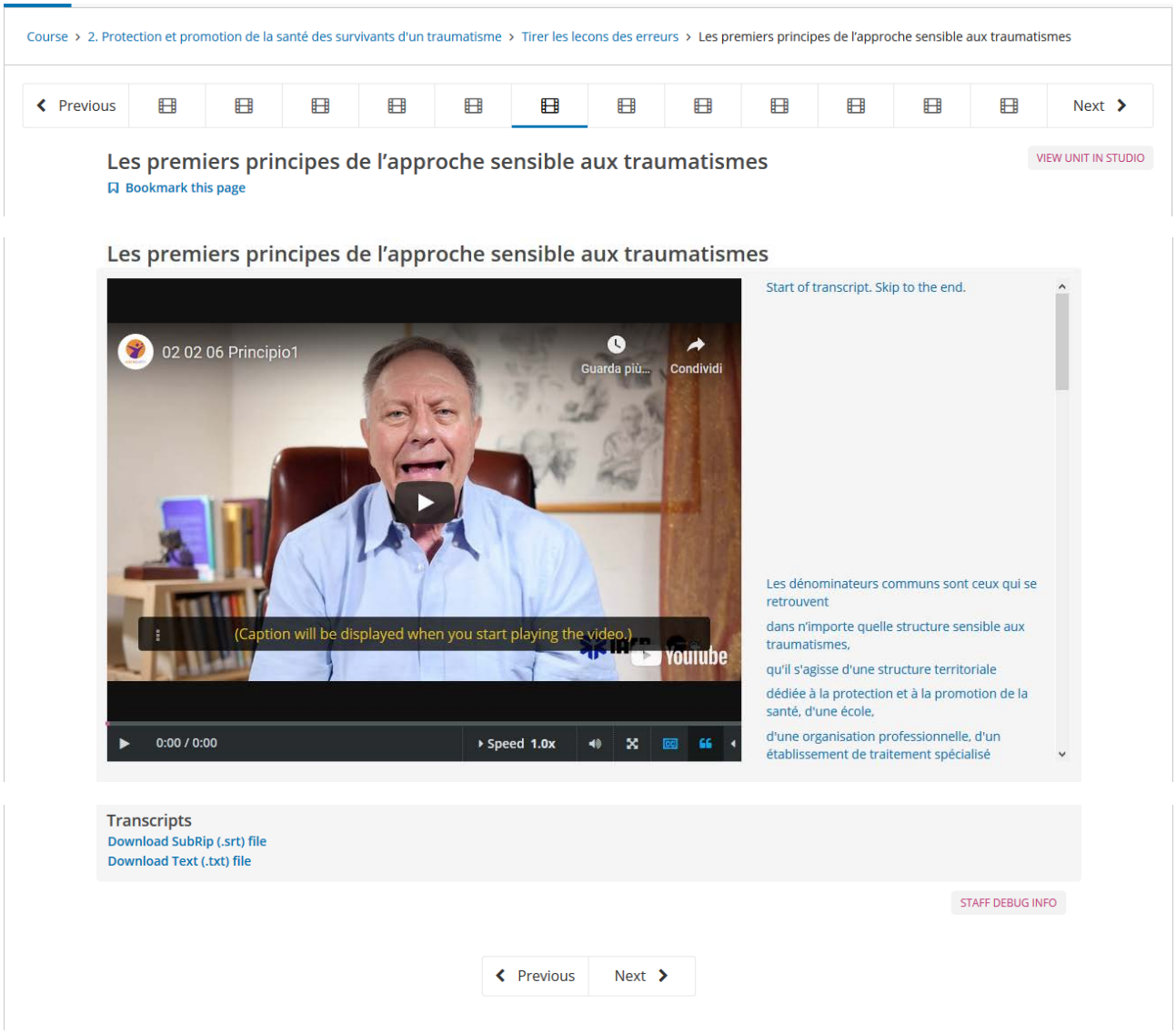
plus efficacement son rôle et d’orienter l'élève problématique vers un psychologue afin que l'élève, s'il a besoin d'aide, puisse être aidé,

et afin d’éviter une aggravation de son problème. Après tout, adopter une approche sensible au traumatisme n'est pas seulement une obligation éthique,

clinique pour les professionnels de la santé mentale, mais c'est également un choix rentable,

car fournir des traitements qui atténuent les dommages est dans l'intérêt non seulement des victimes d’un traumatisme mais de l’ensemble de la société.





Transcript

Les dénominateurs communs sont ceux qui se retrouvent

dans n'importe quelle structure sensible aux traumatismes,

qu'il s'agisse d'une structure territoriale

dédiée à la protection et à la promotion de la santé, d'une école,

d'une organisation professionnelle, d'un établissement de traitement spécialisé

ou même d'un établissement correctionnel dans le système judiciaire.

Une communauté, pour être sensible aux traumatismes, doit posséder ces dénominateurs communs,

qui partagent un même fil conducteur :

ils se retrouvent autour de la volonté de

communiquer aux survivants de traumatismes

un sentiment de sécurité,

physique et psychologique - d'être pour eux un refuge.

Le premier principe fondé sur le traumatisme est que les

établissements doivent offrir une sécurité physique et émotionnelle

permettant à la personne traumatisée de vivre en sécurité,

de sentir que rien de mal ne peut lui arriver,

qu'elle ne subira pas d'attaques,

que rien de mal ne lui sera fait : C'est un endroit sûr où elle ne devra pas être sur le qui-vive, en alerte permanente, en état d'anxiété.

La structure « sensible aux traumatismes » sera accueillante pour tout ce qui concerne

la communication et la méta-communication. Dès lors,

le patient se sentira le bienvenu ; vous lui souhaitez la « bienvenue » et

êtes réellement convaincu que le patient est une personne que vous souhaitez réellement accueillir.

Une structure, pour qu'elle suscite la confiance et un sentiment

de sécurité aux utilisateurs du service, doit transmettre,

à tous les niveaux, un message qui correspondra aux activités qui y sont menées.

C'est seulement dans ces conditions que le client pourra éprouver

une réelle confiance et voir dans la structure un port accueillant, sûr et fiable.

Une structure sensible aux traumatismes ne laissera aucun espace pour la violence,

la honte ni la culpabilité, qui risqueraient d'exacerber

ou de retraumatiser ceux et celles qui ont déjà subi un traumatisme.

Une structure sensible aux traumatismes garantira également la totale confidentialité et le secret professionnel,

la vie privée de l'individu, qui sera ainsi protégé de cette forme de violence.

De plus, le langage qui y sera parlé se concentrera sur la personne,

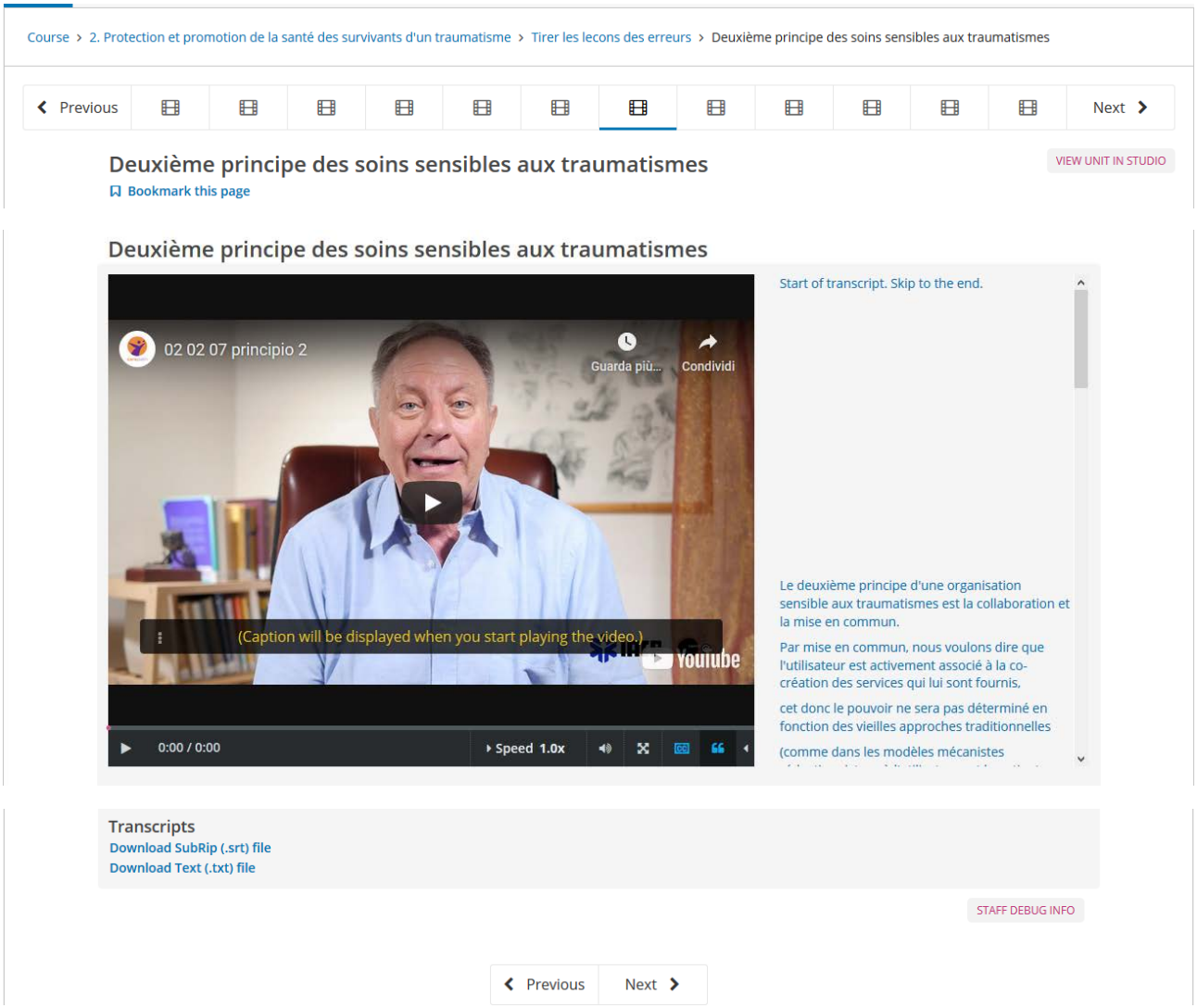
c'est-à-dire qu'elle parlera un langage clair et cohérent que l'usager pourra comprendre,

et non un langage

professionnel cryptique qui

exigera, pour le comprendre,

d'avoir au moins 3 diplômes.



Transcript

Le deuxième principe d'une organisation sensible aux traumatismes est la collaboration et la mise en commun.

Par mise en commun, nous voulons dire que l'utilisateur est activement associé à la co-création des services qui lui sont fournis,

cet donc le pouvoir ne sera pas déterminé en fonction des vieilles approches traditionnelles

(comme dans les modèles mécanistes réductionnistes où l'utilisateur est le patient désigné).

Non, ici, les clients ont leur mot à dire,

et le rôle qu'ils vont jouer est celui d'un acteur du changement,

désireux de retrouver ses capacités et potentialités.

Une structure sensible aux traumatismes fera tout pour que

le patient retrouve son respect de soi,

un objectif crucial pour toute victime de traumatismes ;

mais également de l'espoir ; qui dit « rétablissement »

dit rétablissement de son propre potentiel.

Pareille structure montrera toujours clairement, surtout à elle-même,

que le rétablissement de la santé et de la fonctionnalité d'une personne souffrant

de stress post-traumatique ou

de traumatismes ne peut se faire que par le biais de relations

réelles entre les membres de son personnel et l'usager.

En bref, un bon travail d'équipe, une alliance de travail.

Le partage des décisions est essentiel pour le bon fonctionnement du service fourni.

Tout d'abord, comme le montre la recherche de Karasek sur le stress,

nous savons que, si je subis des stimuli stressants,

mais que je garde un grand pouvoir de contrôle,

le stress en sera réduit.

Par contre, si j'ai peu de contrôle sur la situation, le stress augmentera.

C'est précisément ce principe qui est à l'œuvre ici.

Par conséquent, donner le pouvoir de décision et de contrôle à l'utilisateur du service est déjà une partie de la solution.

En d'autres mots, un patient, une personne avec plus de contrôle sera

capable de mieux surmonter ses problèmes

et d'améliorer sa condition.

La structure sensible aux traumatismes

est systémique et holistique,

en ce sens qu'elle

est bien consciente que ce

sur quoi elle doit opérer s’avère

précisément la construction

sociale d'une réalité traumatisée.

Tous les aspects se combinent

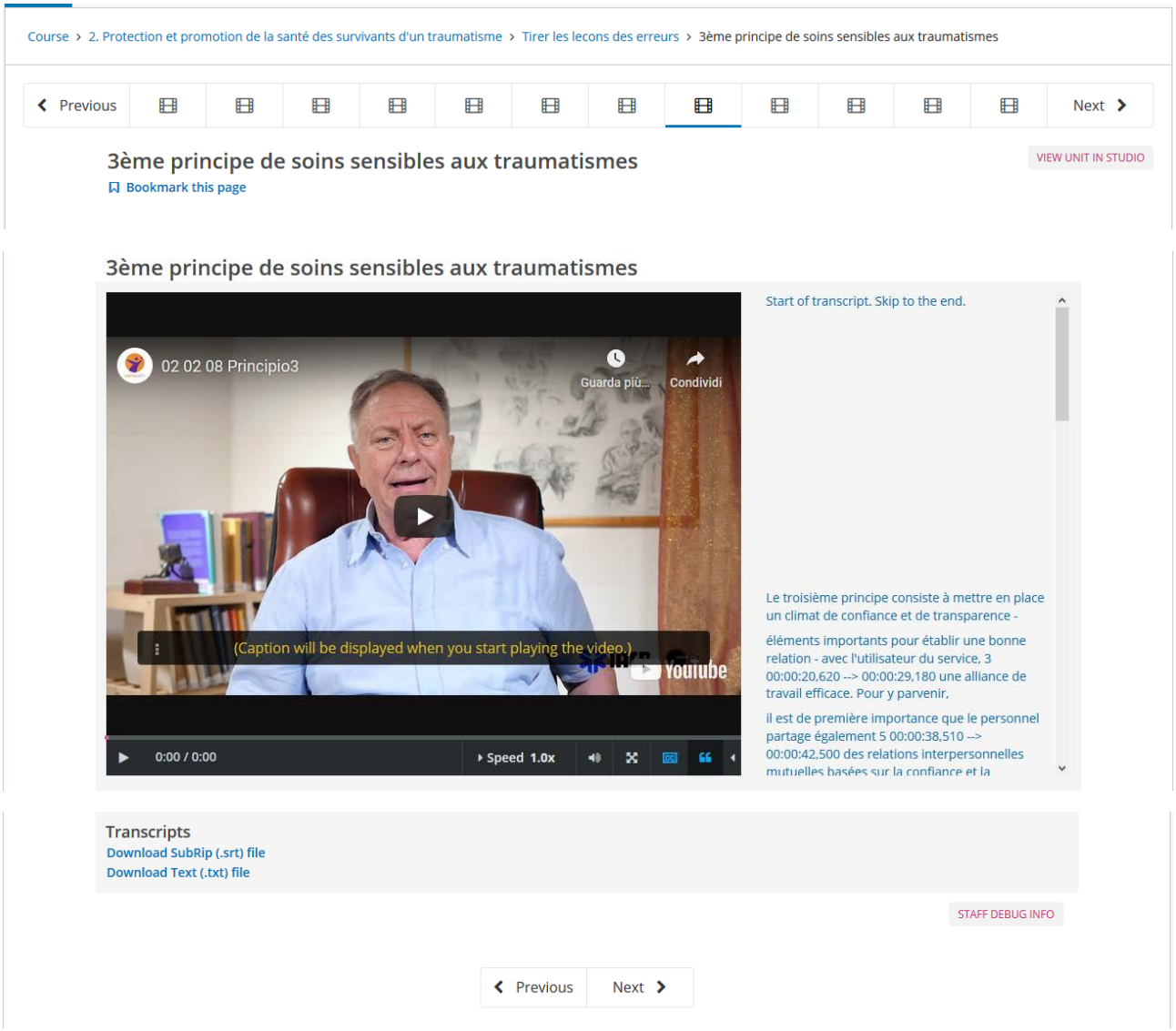
pour faire un tout et, ainsi,

elle prendra soin de l'alpha à l'oméga,

depuis les premiers contacts,

jusqu'à l’accueil,

l'offre de service et tout le processus de suivi.



Transcript

Le troisième principe consiste à mettre en place un climat de confiance et de transparence -

éléments importants pour établir une bonne relation - avec l'utilisateur du service, une alliance de travail efficace. Pour y parvenir,

il est de première importance que le personnel partage également des relations interpersonnelles mutuelles basées sur la confiance et la transparence,

avec toute l'équipe et tout l'équipage, et également des relations interpersonnelles

de qualité avec les usagers et leurs familles.

N’oublions pas le respect des limites et des barrières à maintenir.

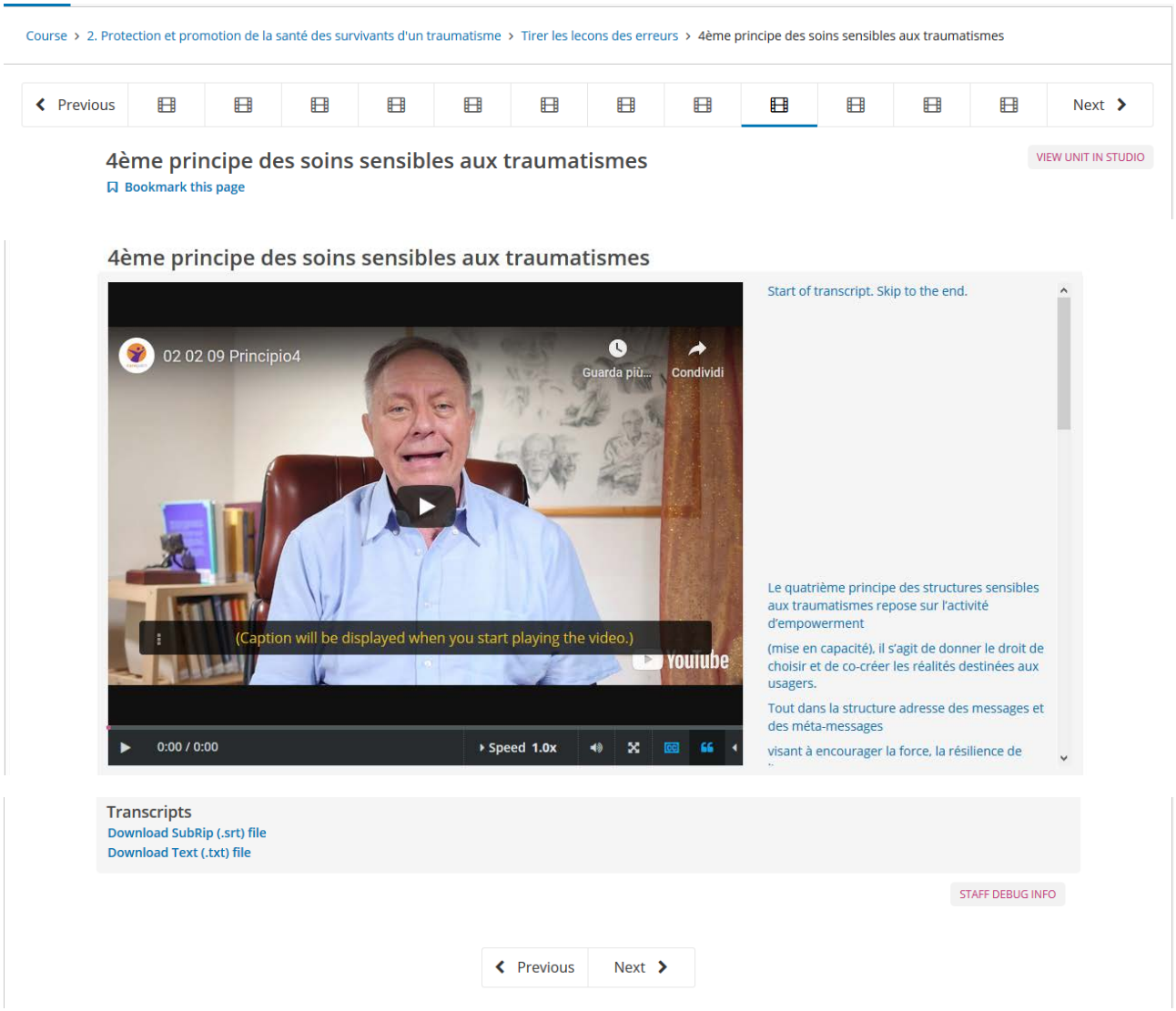
La principale raison en est qu'en ayant des frontières claires,

on crée des espaces de liberté. Ou, ne pas respecter les frontières équivaut à polluer l’espace de travail et à diminuer l’efficacité de l’intervention.

La transparence étant fondamentale, les politiques doivent être formulées dans un langage

clair et transparent, à mille lieues du jargon bureaucratique.

La clarté permet également à tout un chacun, mais surtout aux usagers du service,
à comprendre dans quelle situation ils se trouvent,
quels sont leurs droits et leurs devoirs,
ainsi que tous les aspects de la structure et du personnel avec lesquels ils vont travailler.
De la clarté s'impose également au niveau des rôles de chacun,
sans oublier que les différents professionnels actifs au sein d'une
même structure ont des compétences diverses et s'occupent de différents aspects du traitement ;
personne n'est généraliste et, donc, comme dans une société articulée,
le boulanger fait le pain, le laitier distribue le lait, l'ingénieur dessine des plans et ainsi de suite.
Au centre d'une structure sensible aux traumatismes,
nous retrouvons le respect des droits de l'utilisateur et leur promotion active.
Il est donc essentiel d'obtenir du patient un véritable consentement éclairé et de lui expliquer
dans les détails quelles sont les procédures prévues,
comment le service se déroulera,
pour que le consentement soit authentique et non une simple formalité.



Transcript

Le quatrième principe des structures sensibles aux traumatismes repose sur l'activité d'empowerment (mise en capacité), il s'agit de donner le droit de choisir et de co-créer les réalités destinées aux usagers.
Tout dans la structure adresse des messages et des méta-messages
visant à encourager la force, la résilience de l'usager.
Le choix consiste à promouvoir le changement en
se concentrant sur les forces du patient,
et non sur ses faiblesses ni sur ses dysfonctionnements.
L'objectif est de faire comprendre comment l'usager
a traversé les différentes situations dans le passé,
parfois sans doute pas de la manière la plus efficace,
en bref comment il s'est adapté (coping).
Il s'agit donc de mener une mission, d'appliquer une philosophie d'offre de services

mettant l'accent sur la force des personnes.

En d'autres termes, si on privilégiait, dans le passé,

les pathologies et leur atténuation, aujourd'hui un nouveau paradigme est apparu,

basé sur la santé et les atouts, paradigme que nous essayons d'essaimer.

Les rôles sociaux sont également valorisés ;

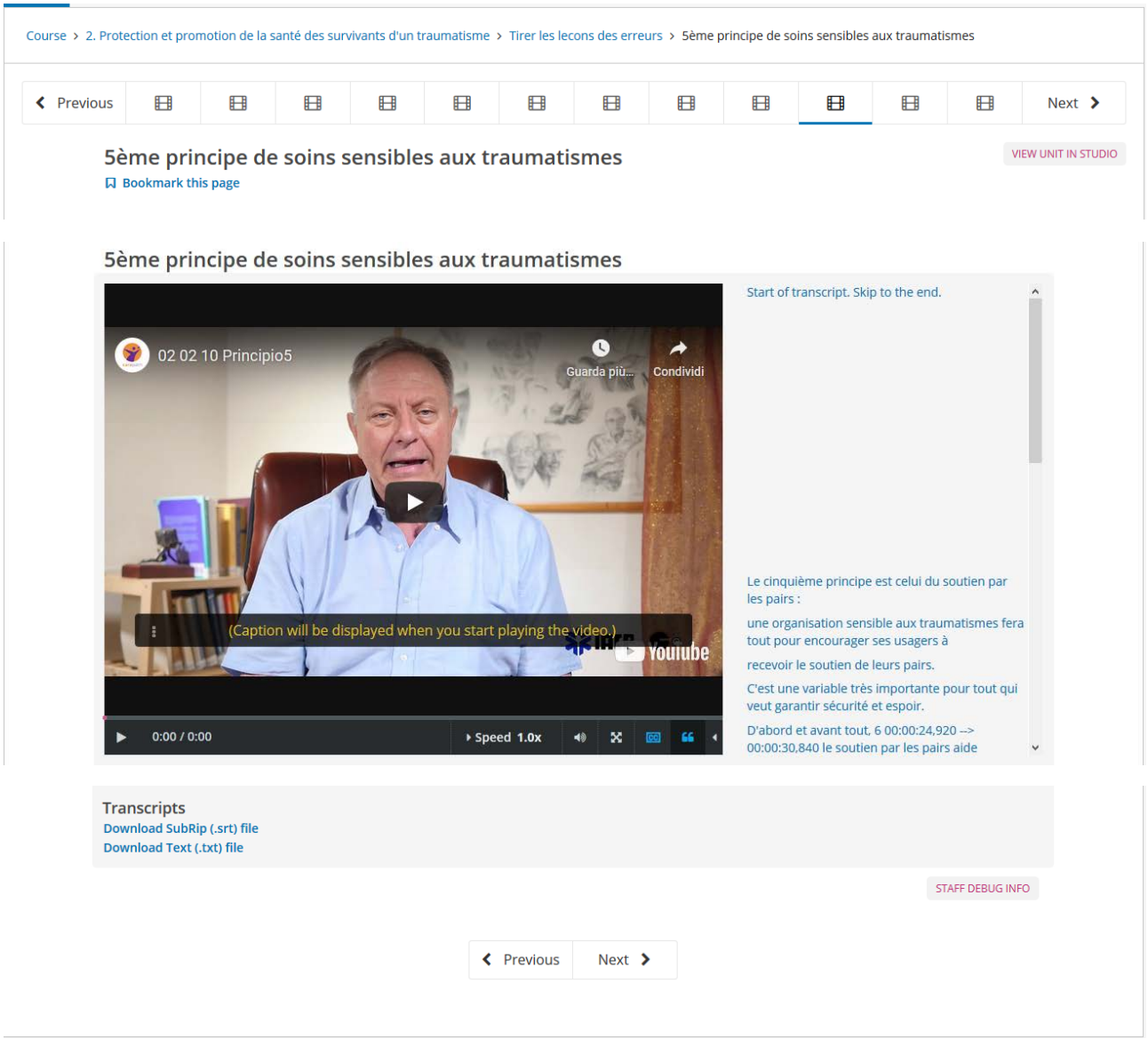
puisque que nous sommes des mammifères sociaux, ils revêtent donc une importance vitale pour notre identité et le développement de notre potentiel.

L'objectif déclaré et poursuivi est de promouvoir l'autorégulation, l'autonomie et les compétences d'autogestion des utilisateurs.

Ainsi la possibilité de se développer également à partir d'expériences traumatiques n'équivaut

pas à mettre en avant chez la personne son statut de pauvre victime,

mais sa capacité de résilience.



Transcript

Le cinquième principe est celui du soutien par les pairs :

une organisation sensible aux traumatismes fera tout pour encourager ses usagers à

recevoir le soutien de leurs pairs.

C'est une variable très importante pour tout qui veut garantir sécurité et espoir.

D'abord et avant tout, le soutien par les pairs aide

les gens à se sentir bienvenus et

suscite chez eux

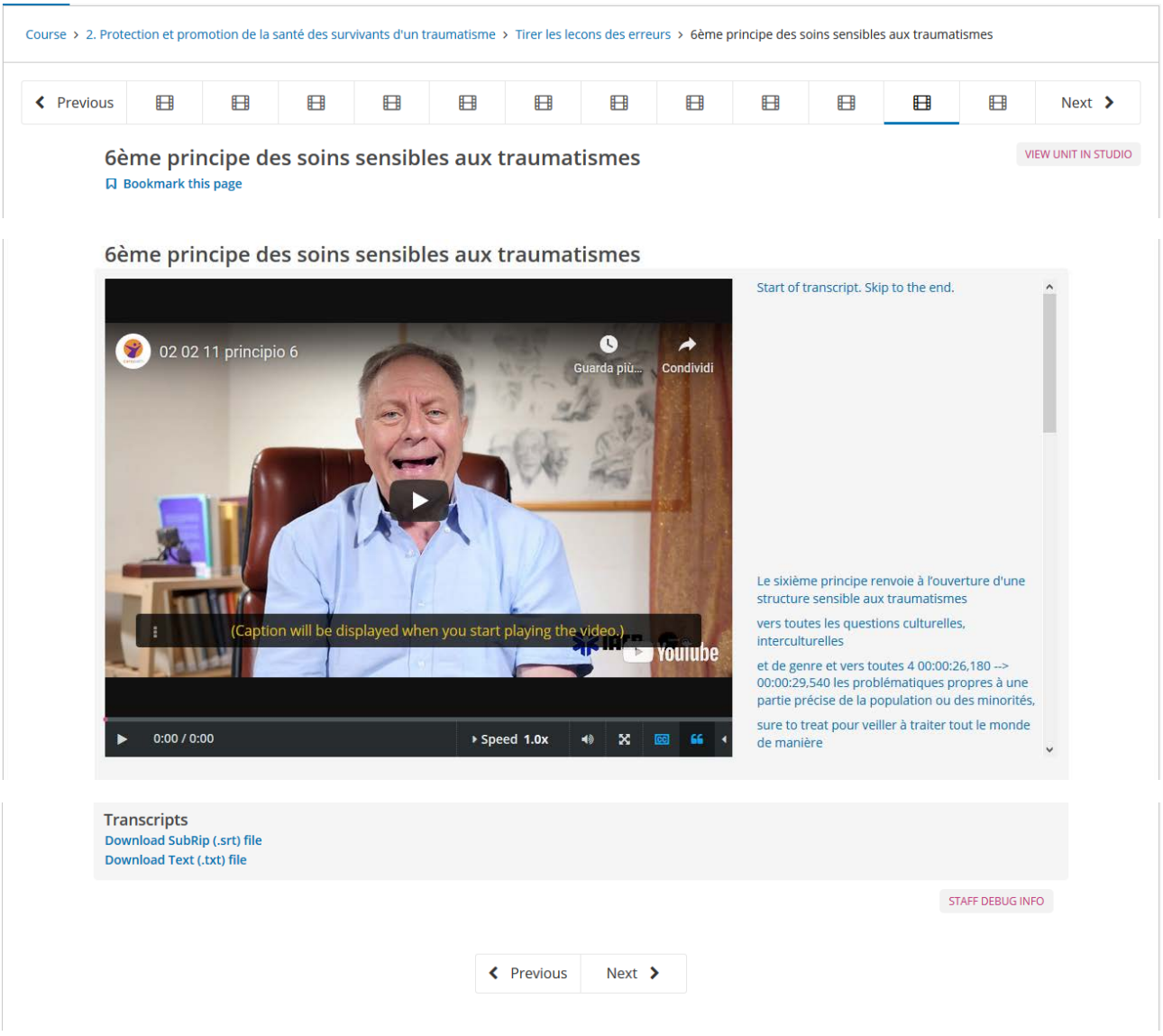
l’espoir de pouvoir s'améliorer.

Bref, il est important d'obtenir le soutien de ses pairs afin de

gagner en confiance en soi, de renforcer son propre potentiel et même d’accroître son estime de soi.

Le soutien par les pairs favorise également les possibilités de

collaboration et donc tout ce qui est positif pour promouvoir son propre rôle social et se sentir actif. Il est indéniable que le soutien par les pairs encourage une communication interpersonnelle favorable à la construction de récits intégrés dans un puzzle beaucoup plus riche et porteur d’autres récits d'espoir et de guérison.



Transcript

Le sixième principe renvoie à l'ouverture d'une structure sensible aux traumatismes

vers toutes les questions culturelles, interculturelles

et de genre et vers toutes les problématiques propres à une partie précise de la population ou des minorités,

sure to treat pour veiller à traiter tout le monde de manière

accueillante et, surtout, démocratique.

Il va sans dire qu'une structure efficace et efficiente évitera toute construction du passé,

gangrénée par des stéréotypes injustes et destructeurs envers les minorités.

Le service fourni sera, par exemple,

sensible aux différences entre

les genres et au respect

de la diversité des genres,

ce qui aidera à utiliser les contextes culturels, les traditions,

les cultures et les origines de chacun des utilisateurs.

La structure construira une réalité fidèle à sa propre philosophie,

afin que toutes les procédures

soient non discriminatoires et sensibles à la diversité.

En outre, elle sera également en mesure de

reconnaître et de traiter efficacement les traumatismes historiques.

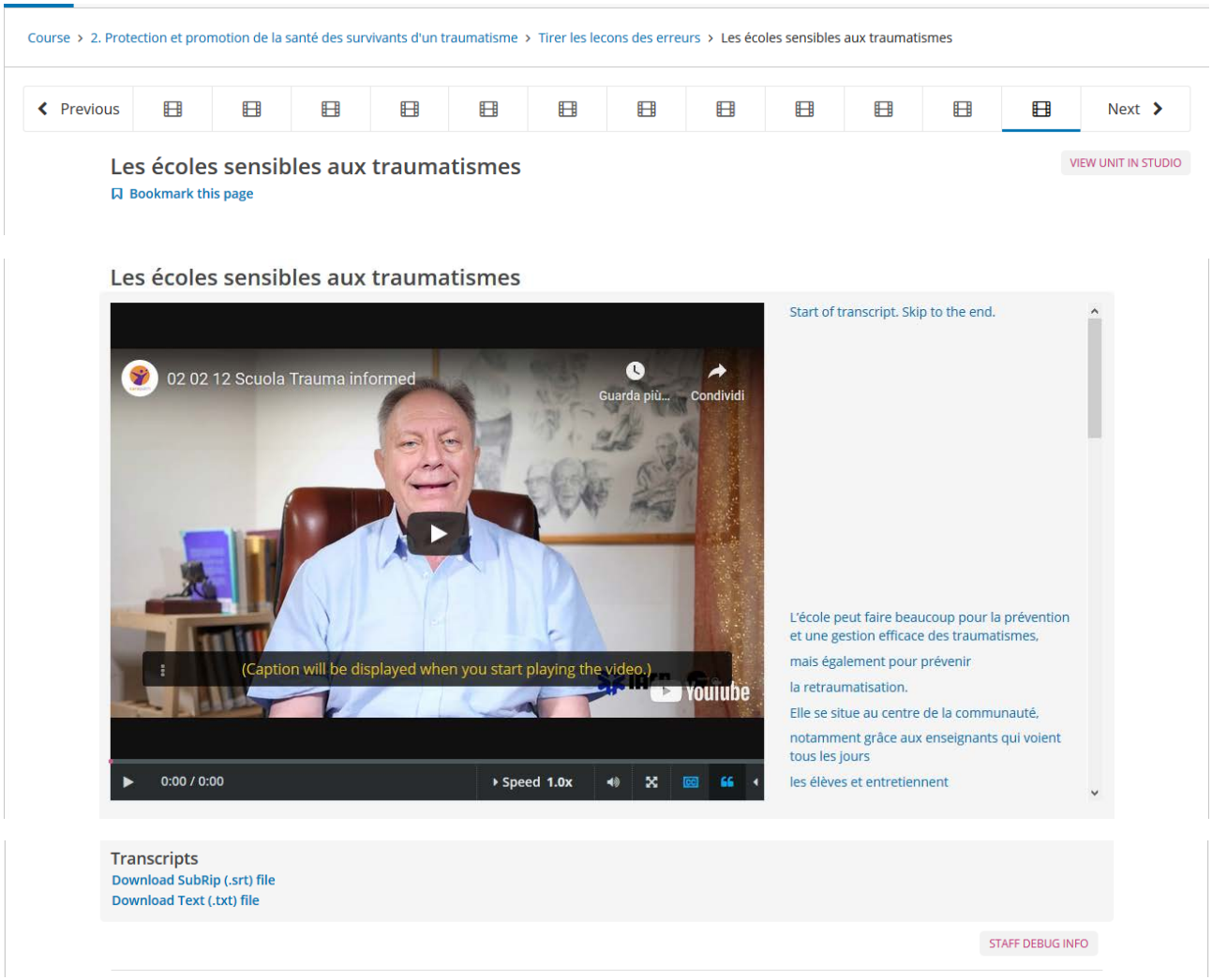
Nous entendons par là les traumatismes de masse qui vont jusqu'à affecter

ceux et celles qui n'en ont pas fait l'expérience directe.

Donnons un exemple dramatique : l'holocauste ;

non seulement des millions de malheureux ont été victimes du délire nazi,

mais également leurs enfants et petits-enfants qui ont subi l'écho de cette bestialité.



Transcript

L'école peut faire beaucoup pour la prévention et une gestion efficace des traumatismes,

mais également pour prévenir

la retraumatisation.

Elle se situe au centre de la communauté,

notamment grâce aux enseignants qui voient tous les jours

les élèves et entretiennent

des contacts fréquents avec leurs familles.

Qui plus est, les enseignants jouissent d'un prestige social,

en raison de leur rôle dans la communauté.

Ainsi, si les enseignants et le personnel

scolaire sont ouverts aux éléments constitutifs

d'une école sensible aux traumatismes,

peut-être pourraient-ils demander à un expert

de les aider à lever le voile sur les problèmes et accepter l’existence des traumatismes.

Dans ce cas, cette école ne serait plus une partie du problème,

mais une partie de la solution,

notamment parce que les enseignants

sensibilisés aux problèmes des traumatismes seront

en mesure de capter les signaux.

S'ils n'ont pas un œil exercé,

ils risquent d’interpréter certains des comportements de leurs élèves comme

de simples manifestations d’un

manque de discipline.

Par contre, s’ils sont sensibles aux traumatismes,

ils pourraient servir de

référence aux élèves et déterminer si l'un

de leurs élèves a besoin d’un soutien en tant que victime d'un traumatisme. Les enseignants peuvent avoir une influence importante sur les parents,

afin qu’ils se sensibilisent eux-mêmes aux traumatismes

et puissent ainsi contribuer de manière significative à la solution.

En bref, la sensibilisation aux traumatismes s’ajoute à la vocation d'une école,

dont le propos est déjà de diffuser les connaissances pour

aider les gens à fonctionner comme des

citoyens volontaristes dans la ville.

Donc, une école sensible aux traumatismes

est pleinement équipée pour remplir sa

mission d'école dans le meilleur sens du terme.

Matériau de support

Creating Trauma Informed Systems - Schools

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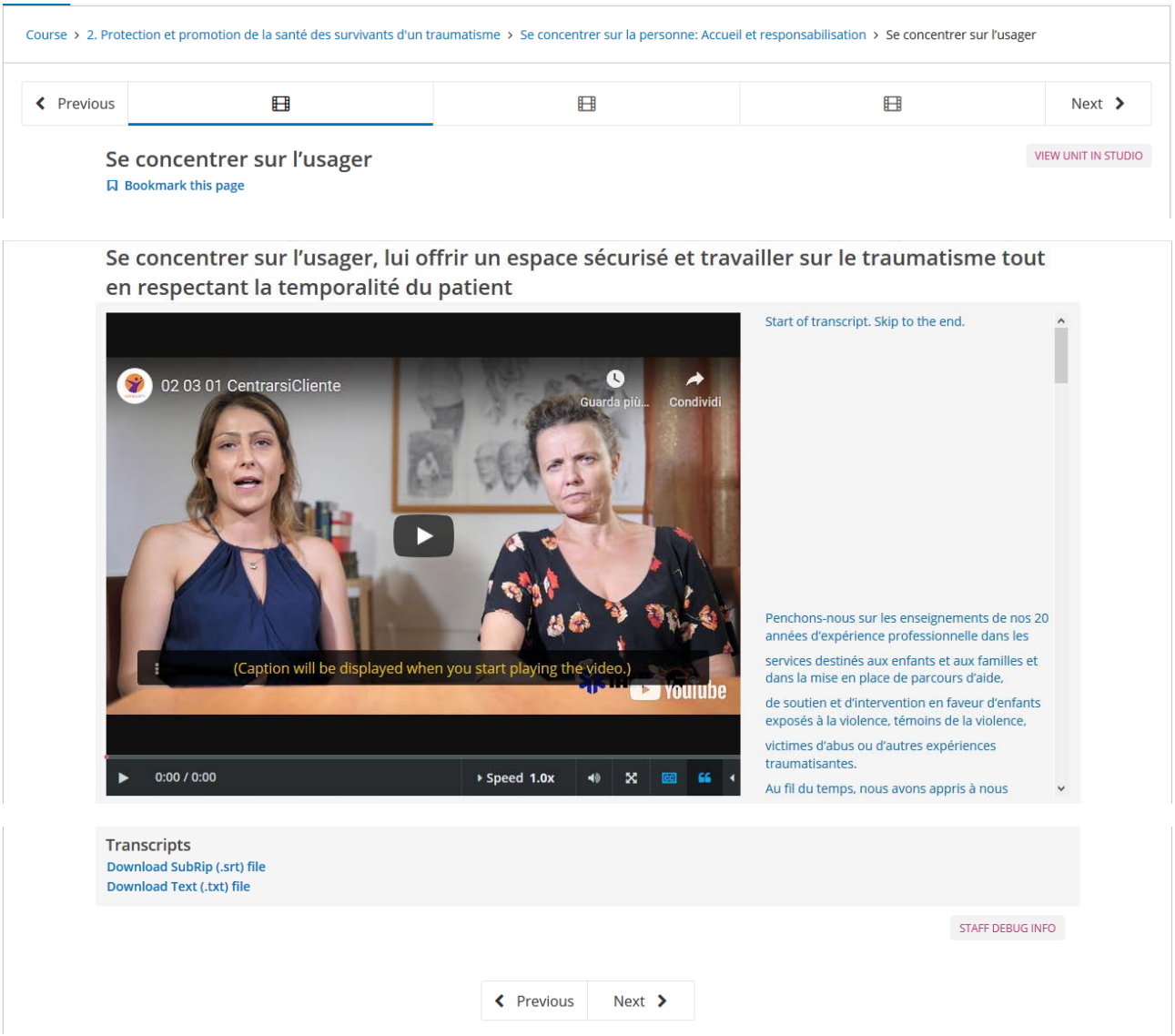


Transcript

Penchons-nous sur les enseignements de nos 20 années d'expérience professionnelle dans les services destinés aux enfants et aux familles et dans la mise en place de parcours d'aide, de soutien et d'intervention en faveur d'enfants exposés à la violence, témoins de la violence, victimes d'abus ou d'autres expériences traumatisantes.

Au fil du temps, nous avons appris à nous concentrer principalement sur :

la nécessité et l'importance de nouer une relation adéquate

afin de créer un cadre sûr pour l'enfant, qui dépasse les compétences et techniques scientifiques.

Par « sûr », nous entendons un espace propice à

une écoute respectueuse des besoins et exigences du patient.

C'est essentiel lorsque l'enfant a vécu des expériences destructrices de son sentiment de sécurité et d'estime de soi et dangereuses pour sa vie. Dans pareilles situations,

il est nécessaire de garantir e plus grand respect afin que le client reprenne son processus de développement.

Qu'entend-t-on par respect ? Il s'agit d'une véritable écoute - une écoute empathique –

qui ne se focalise pas sur les protocoles et les besoins des professionnels,

mais veut plutôt privilégier le monde intérieur du mineur,

ses besoins, sa temporalité ; autant d'éléments

qu'il convient de respecter car,

souvent, nous rencontrons des mineurs sur la défensive,

susceptibles d'adopter une attitude d'autoprotection.

Il est donc essentiel que le professionnel concerné

ne tente pas de mettre à bas les défenses du patient (en voulant savoir, en s'emparant, en posant des questions),

mais qu'il respecte le rythme de l'enfant,

qu'il soit conscient que la défense est la meilleure manière que l'enfant a trouvée

pour gérer une force oppressante. En rendant progressivement ces défenses inutiles,

on pourra atteindre le cœur de l'enfant.

L'expérience montre combien il est important de se concentrer sur les besoins de l'enfant.

Passons à l'exemple d'une assistante sociale,

qui a travaillé pendant 8 ans au service de la ville de Rome.

Elle s'occupe de la prévention, de la protection et du soutien aux enfants et à leurs familles.

Comme nous l'avons dit, il faut se focaliser non seulement sur les besoins de l'enfant,

mais également sur les caractéristiques et la singularité de chaque situation,

and the uniqueness of any situation, so... also centering on all those involved, in addition to

en tenant compte de toutes les personnes concernées, au-delà de l'enfant et de ses parents.

Dans son travail quotidien, un travailleur social sera principalement en relation avec les parents,

les enfants victimes d'un ou de plusieurs traumatismes

étant le plupart du temps pris en charge et suivis par des spécialistes

formés pour les aider dans ce processus.

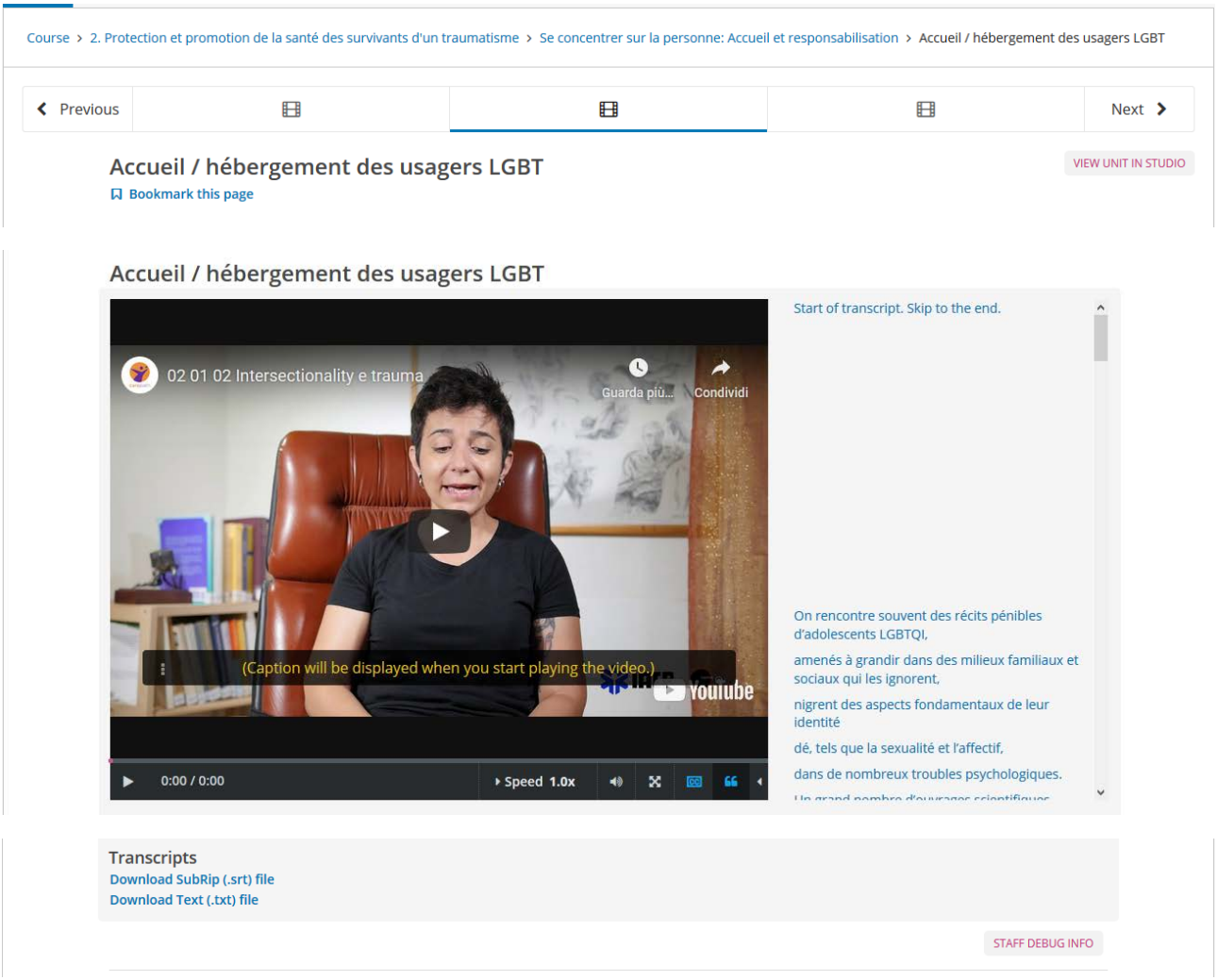
Dans leur travail, les assistants sociaux accompagnent les familles et essayent de se familiariser avec difficultés, leur gravité, leur vulnérabilité,

mais également ce qui a provoqué le préjudice

et le malaise chez leurs enfants.

Ensuite, ils créent des réseaux de soutien, pour les aider à

acquérir et à s'approprier les responsabilités
parentales, garantie que l'enfant aura le droit de grandir paisiblement au sein de sa famille,
dans un cocon protecteur.
En fonction de expériences, quels sont les éléments essentiels permettant aux professionnels
d'agir dans ce sens ? Des compétences professionnelles techniques et scientifiques,
mais également des compétences et des aptitudes liées davantage à la sphère personnelle.
Nous parlons ici de tout ce qui relève
du « monde intérieur » du professionnel : ses émotions, ses préjugés,
ses raisonnements, les hypothèses qu'il pose lorsqu'il entre en relation.
En outre, en tant que professionnels impliqués dans les relations d'aide,
nous sommes des personnes allant à la rencontre de l'autre.
Que se passe-t-il lorsqu'on travaille avec des parents abusifs ou négligents ?
Ne nous voilons pas la face,
il arrive que nous ressentions de la colère,
de l'indignation et même de la crainte ; nous ne devons pas ignorer ces émotions,
qui font partie de nous et s'insinueraient de
toute manière dans la relation thérapeutique. Le plus important est de les reconnaître,
de façon à pouvoir les gérer et à éviter qu'elles
affectent la réalité concrète ou la voilent de subjectivité.
Parfois, le professionnel, troublé par ses propres émotions,
risque d'agir de manière directive ;
le parent devient alors la victime des décisions prises par le professionnel ;
ce n'est pas ainsi qu'on garantira la protection des mineurs, puisque,
faute de se concentrer sur la réalité de la situation,
il sera impossible de comprendre ou de percevoir les besoins des mineurs, et donc de gérer efficacement les interventions.
Concernant la relation directe avec l'enfant, l'intervention du travailleur social est plus limitée.
Elle peut néanmoins contenir une forte composante affective, le travailleur social risquant de combler
ses besoins personnels par l'offre d'affection et d'accompagnement aux enfants traumatisés.
Le travailleur social risque également de se substituer
aux professionnels chargés de suivre et d'aider les enfants à gérer leurs traumatismes.



Transcript

On rencontre souvent des récits pénibles d'adolescents LGBTQI,

amenés à grandir dans des milieux familiaux et sociaux qui les ignorent,

nigrent des aspects fondamentaux de leur identité

dé, tels que la sexualité et l'affectif,

dans de nombreux troubles psychologiques.

Un grand nombre d'ouvrages scientifiques montrent

qu'au sein d'une population non-clinique, ces populations souffrent beaucoup plus

de trouble anxieux, de toxicomanie, de troubles de stress post-traumatique et d'un risque accru de suicide.

Les chercheurs établissent une corrélation entre cette incidence accrue de la souffrance mentale,

le stress lié à l'appartenance à une minorité et l'homophobie sociale ;

ainsi il apparaît que l'invisibilité et le silence

sont les causes et les conséquences d'expériences traumatisantes.

Lorsqu'elles vivent ces réalités traumatisantes, les personnes concernées souffrent de traumatismes cumulatifs,

de traumatismes relationnels et de troubles traumatiques complexes.

Nous constatons donc une relation circulaire entre le préjudice 16 00:01:08,409 --> 00:01:09,820 social,

le sentiment de dissociation,

l'invisibilité, mais également la résilience au

sein d'une population chez qui on nie ces aspects et à qui on refuse,

de surcroît, la citoyenneté, l'appartenance et l'inclusion.

En conséquence, les responsables de l'accueil et de l'aide

aux enfants doivent impérativement

s'interroger sur la manière d'aider ces personnes à accéder plus facilement au droit d'exister,

au droit à la dignité et au droit à l'amour. Les relations réciproques qui durent depuis plus de 50 ans,

les documents, le vademecum, les orientations, qui découlent de

ces recherches font référence

aux dimensions suivantes :

l'homosexualité est une variante normale et positive de la

sexualité humaine et elle n'est nullementun indicateur des troubles mentaux ou du développement :

l'homosexualité et la bisexualité font l'objet d'une stigmatisation sociale,

avec une influence très négative les processus et parcours d'évolution ;

les effets et les comportements homosexuels peuvent apparaître

dans de nombreuses orientations sexuelles ;

les personnes LGBT peuvent mener des vies heureuses et satisfaisantes,

nouer des relations durables dans un couple, fonder une

famille aussi solide que celle des personnes hétérosexuelles ;

aucune recherche scientifique n'établit de lien entre l'homosexualité

et les traumatisme ou les dysfonctionnements ;

rien ne prouve que les essais thérapeutiques visant à modifier

l'ordre sexuel soient efficaces ou dénués de risques.

Les orientations sur la pratique psychologique auprès de personnes LGBTIQ,

publiées par l'APA en 2012, soulignent qu'il est important de tenir compte des

attitudes du responsable de la relation

d'aide envers l'homosexualité et la bisexualité. Non seulement celui-ci doit-il connaître

l'impact de la stigmatisation sur les personnes concernées,
mais également être sensibilisé aux attitudes
implicites et explicites envers l'homosexualité ou la bisexualité.
L'expérience et le point de vue personnels sur ces
questions peuvent peser sur l'évaluation et sur l'intervention.
Les dénominateurs communs préconisés, pouvant être extrapolés à
partir du corpus de documents, peuvent se résumer comme suit :
accepter et accompagner en écoutant avec respect,
sans jugement et avec empathie pour aider l'usager à
surmonter le malaise provoqué par le stress lié à l'appartenance à une minorité ;
prendre des mesures adéquates lors de la prise de contact avec ces personnes :
l'évaluation devrait aider à comprendre la personne dans toute sa complexité, à
prendre en compte les interactions et interconnexions entre le stress
lié à l'appartenance à une minorité, la santé mentale et la dimension spirituelle et intérieure,
ainsi que la place qu'occupe l'orientation sexuelle dans le fonctionnement général de la personne ;
encourager et soutenir les stratégies d'adaptation actives :
nous savons qu'en général,
il est important pour les adolescents de se sentir acteurs de leur vie,
surtout lorsqu'ils doivent gérer des évènements traumatisants.
Le responsable de la relation d'aide devrait aider l'usager et favoriser les stratégies
qui facilitent le traitement cognitif et affectif du facteur de stress ;
comprendre le rôle important
de l'amitié dans la communauté LGBTIQ.
Ne pas oublier que le stress lié à l'appartenance
à une minorité peut mener
à la marginalisation et à l'isolement.
Il est donc essentiel de
renforcer l'accès à l'aide sociale ;
examiner et développer l'identité.
Les dynamiques identitaires sont essentielles et vitales lors de
l'adolescence et chez les personnes LGBTIQ.
Elle doivent donc explorer et intégrer

leurs identités diverses sans nécessairement devoir en privilégier l'une sur l'autre

(par exemple, entre l'identité féminine et masculine) ;

comprendre et intégrer les conflits. La relation d'aide encourage

le dialogue et l'intégration de tout conflit

entre les parties concernant par exemple,

l'orientation sexuelle et les croyances religieuses ;

comprendre la signification sous-jacente des

demandes de changement d'orientation sexuelle

ou des souhaits de suivre un traitement curatif. Dans de telles situations,

il est essentiel qu'un thérapeute expérimenté réalise une analyse des véritables enjeux,

en accepte le sens et analyse ce souhait, qui renvoie à la dynamique sociale et familiale complexe,

et qui a poussé la personne à

considérer qu'une facette de son identité était

inacceptable ;

comprendre et examiner le processus qui consiste à « sortir du placard ».

saisir les niveaux de stress liés à l'appartenance

à une minorité lorsqu'il y a double minorité :

la personne est victime de discrimination en raison de son homosexualité ou de sa bisexualité,

mais également en raison d'autres sources de stigmatisation sociale ;

tenir compte de l'importance du stress lié à l'appartenance à une minorité

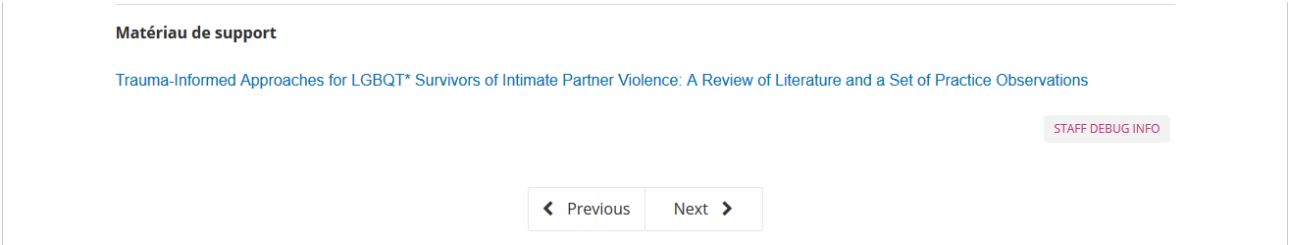
dans la dynamique de couple.

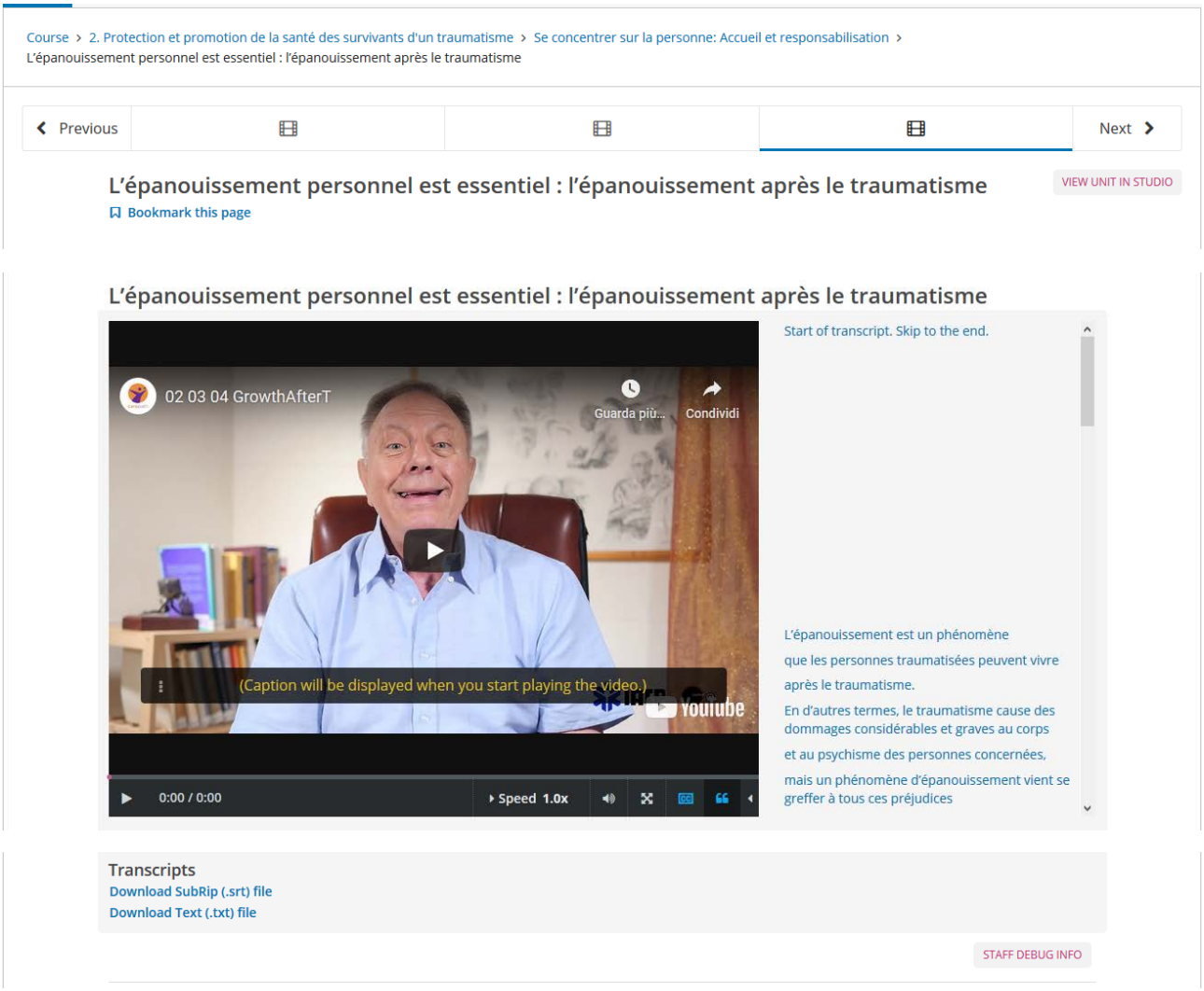
N'oublions pas que les couples gays

et lesbiens ne sont pas reconnus par les principales religions ni par le système

juridique de nombreux pays. Ainsi, il est nécessaire de prendre en compte tout ce qui relève de l'homogénéité

et de l'absence de cadre légal pour ce type de composition familiale.





Transcript

L'épanouissement est un phénomène

que les personnes traumatisées peuvent vivre

après le traumatisme.

En d'autres termes, le traumatisme cause des dommages considérables et graves au corps

et au psychisme des personnes concernées,

mais un phénomène d'épanouissement vient se greffer à tous ces préjudices

chez un nombre considérable de victimes de traumatismes

(avec des exceptions).

Cela montre l'incroyable résilience de l'espèce humaine,

ou peut-être de toutes les formes de vie qui

sont apparues au fil de

l'évolution du vivant sur notre planète.

Quoiqu'il en soit, la tragédie du traumatisme fait basculer la personne,

« détruit », insulte et blesse la victime d'un traumatisme,

comme le ferait un tremblement de terre dont les secousses ébranleraient

jusqu'aux composantes psychiques et physiques de la personne.

Toutefois, dans cette tourmente, le mal n'étant souvent pas a sens unique,

la victime du traumatisme doit s'adapter à une nouvelle réalité.

Certaines personnes parviendront à s'adapter, à se reconstruire, à s'épanouir suite au traumatisme.

D'un point de vue existentiel, elles vivent un épanouissement.

En d'autres termes, elles sont plus ouvertes,

plus enracinées dans les valeurs morales et spirituelles,

elles vivent avec plus de pertinence

et sont davantage connectées à elles-mêmes,

aux autres et au monde ;

elles trouvent

un sens nouveau

et plus profond.

Prenons un exemple personnel :

Je me souviens de l'émotion ressentie à la lecture d'un livre écrit par un collègue,

Victor Frankl, à propos de la tragédie et de tous les traumatismes que pouvait vivre un juif à l'époque du nazisme lorsqu'il se retrouvait interné dans un camp d'extermination nazi.

Dans ces camps, avant de tuer, on humiliait

et on tentait de tuer la dignité humaine,

de manière assez efficace. Cependant, un petit groupe de personnes

est parvenu à survivre physiquement au camp, malgré les traumatismes, et, au niveau psychique,

à devenir meilleur. Comme Frankl le raconte dans son ouvrage « Découvrir un sens à sa vie »",

lui et quatre autres personnes du camp se sont privées du peu de nourriture

qu'ils recevaient pour offrir une aide bienveillante à des personnes plus malheureuses qu'eux

(les malades ou les faibles). Ils ont ainsi pris un risque supplémentaire d'être

envoyé dans les fameuses douches, les chambres à gaz, et d'être exterminés.

Les membres du groupe ont survécu, avant d'être libérés à la chute du nazisme,

et malgré leur faiblesse physique et les traumatismes vécus, ils sont devenus de meilleures personnes.

Ils entretenaient une relation existentielle, plus pertinente, avec eux-mêmes,

avec les autres et avec le monde. C'est un aspect à méditer, qui pourrait nous insuffler un peu d'espoir.

Matériau de support

Growth after trauma

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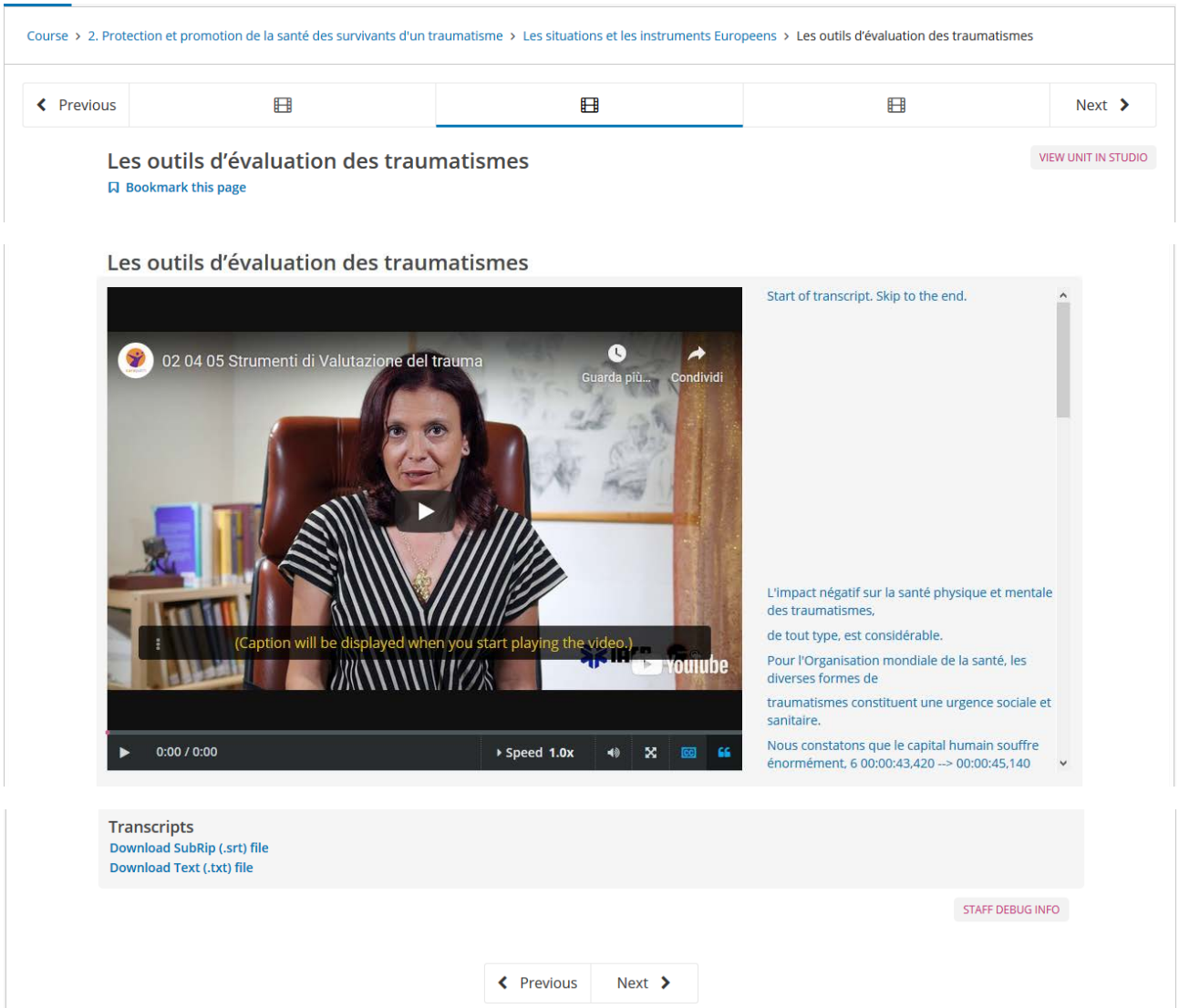


Transcript

L'impact négatif sur la santé physique et mentale des traumatismes,

de tout type, est considérable.

Pour l'Organisation mondiale de la santé, les diverses formes de

traumatismes constituent une urgence sociale et sanitaire.

Nous constatons que le capital humain souffre énormément, 6 00:00:43,420 --> 00:00:45,140 tant au niveau physique que mental, des traumatismes.

Collectivement, nous contribuons moins efficacement à la prospérité, lorsque

les victimes de traumatismes nécessitent des soins et donc consomment une partie

de nos ressources économiques ; qui plus est, le traumatisme les empêche,

individuellement, de produire de la prospérité pour elles-mêmes,

pour leur famille, pour leur collectivité et pour leur pays.

Nous observons un autre aspect très préoccupant chez la victime de traumatismes :

non seulement souffre-t-elle de dommages au

niveau de sa santé physique et mentale,

mais, principalement dans certains types de traumatismes (violence ou violence sexuelle),

elle risque de passer du statut de victime à celui d'auteur et donc de traumatiser,

à son tour, d'autres personnes innocentes.

Ce glissement horrible montre à quel point le traumatisme est assimilable à un virus qui se propage d'un corps

à l'autre s'il n'est pas combattu, prévenu et traité efficacement dans la communauté.

On peut parler de pandémie, c'est-à-dire d'un problème qui se transmet rapidement d'un individu

à l'autre dans la population, entraînant une grave perte de capital humain.

Dans une approche bio-psychosociale, nous ne pouvons laisser

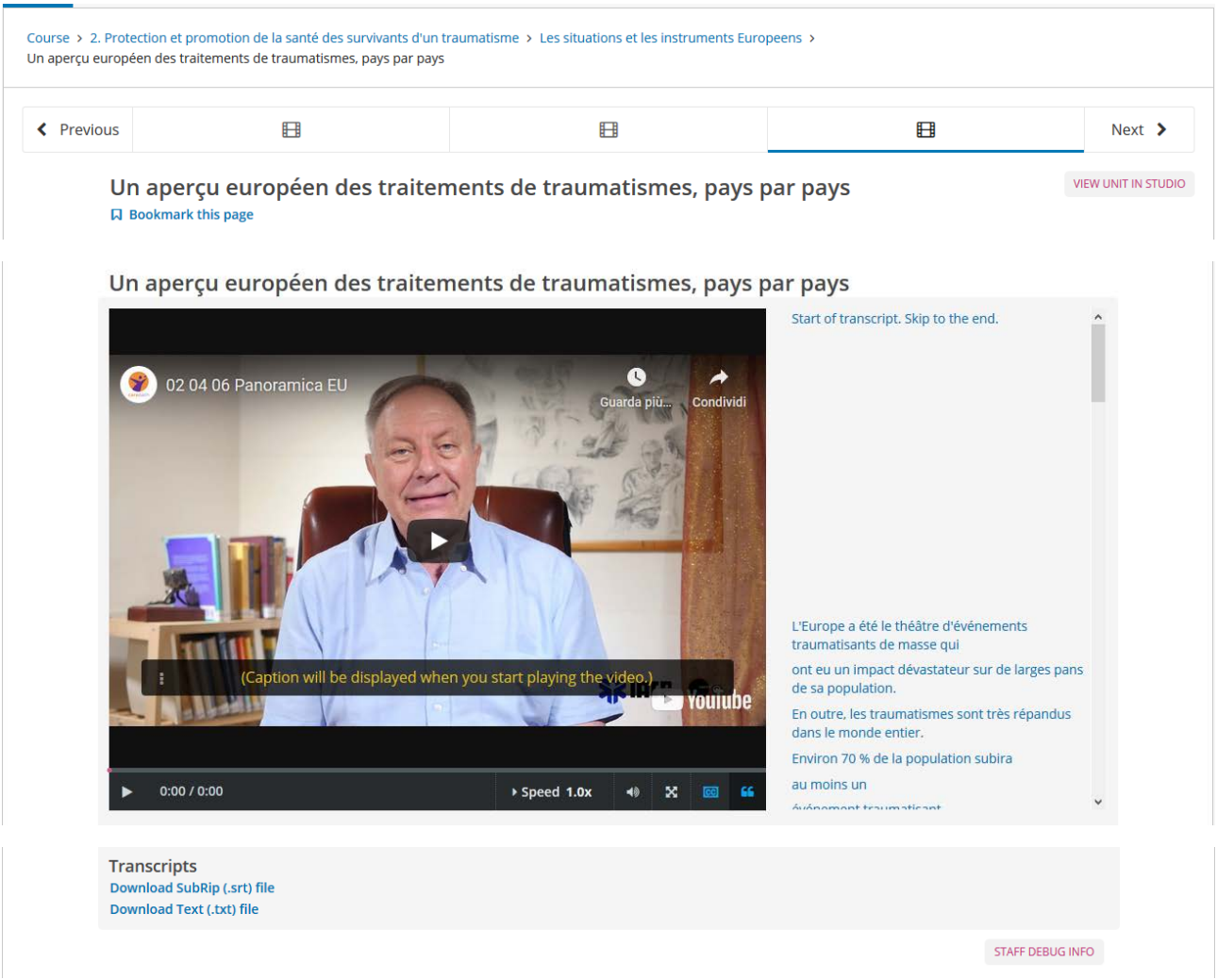
la responsabilité de la prévention et du traitement des traumatismes au seul secteur de la santé ;

il s'agit d'une tâche politique qui nécessite que toutes les institutions - familles, écoles, organisations professionnelles, monde de la justice des mineurs, législatif –

se sensibilisent à la problématique et s'intègrent dans

un réseau efficace de prévention et de résolution des traumatismes.

C'est dans l'intérêt et pour le bien de tous et de toutes.



Transcript

L'Europe a été le théâtre d'événements traumatisants de masse qui

ont eu un impact dévastateur sur de larges pans de sa population.

En outre, les traumatismes sont très répandus dans le monde entier.

Environ 70 % de la population subira

au moins un

événement traumatisant

au cours de la vie.

Il s'agit d'une véritable pandémie : une épidémie généralisée,

et à ce titre les dégâts que causent les traumatismes aux niveaux mental,

physique, comportemental,

social, économique

atteignent une telle gravité que

l'ensemble des nations européennes

– qui sont parmi les plus avancées au monde –

se sont mises en mode alerte, afin d'investir dans la recherche,

le savoir-faire, le financement et afin de développer les compétences nécessaires pour gérer efficacement -

comme nous le faisons déjà pour de nombreux autres phénomènes - cette pandémie. Malheureusement, tout cela n'est qu'un rêve ; incroyable mais vrai :

peu a été fait. Nous voyons quelques rares exceptions ; quelques nations -

comme les pays scandinaves et l'exemple de la Suède - ont étoffé l'offre de traitements

aux victimes de traumatismes, et, au niveau social,

ont investi dans la prévention afin d'anticiper le problème.

Chaque ville s'y est dotée d'un groupe de travail dédié aux traumatismes,

et les professionnels – comme les travailleurs sociaux – reçoivent une formation

universitaire correcte sur la manière de gérer et de prévenir les traumatismes

au niveau individuel, communautaire et national.

Malheureusement, nombreux sont les autres pays européens qui n'ont pas été aussi efficaces.

Prenons le seul exemple de la Belgique, un pays caractérisé par un excellent revenu

par habitant, une capacité de développement de l'industrie et des services hors pair,

mais qui, jusqu'à il y a quelques années, n'était pas en mesure de former les aidants

At professionnels aux compétences modernes et efficaces. A l'université, la construction sociale des profils

des aidants professionnels était trop dépassée pour leur permettre d'acquérir les compétences nécessaires pour une gestion efficace de ce genre de problèmes.

Dès lors, la situation en Europe est loin d'être satisfaisante,

même si les pays scandinaves – au même titre que l'Angleterre et les pays anglo-saxons -

ont eu la clairvoyance de développer une offre correcte de formations et d'investir

thadans la création d'institutions capables d'offrir une aide et un traitement

efficaces aux personnes traumatisées, ainsi que dans la prévention.

Toutefois, dans de nombreux autres pays, comme en Italie,

il reste encore beaucoup de chemin à parcourir avant

que nous puissions maîtriser la situation.

S'il faut admettre le travail remarquable accompli par les instituts de formation en traumatologie

created in créés ces dernières décennies, force est de constater qu'ils ont simplement

a substitutfait ce qui aurait dû être normalement la tâche de l'université :

task of theformer efficacement les différentes professions de la santé, actualiser les techniques de formation,

les services de supervision et de conseil,

et même proposer des diplômes professionnels

pour le traitement des traumatismes.

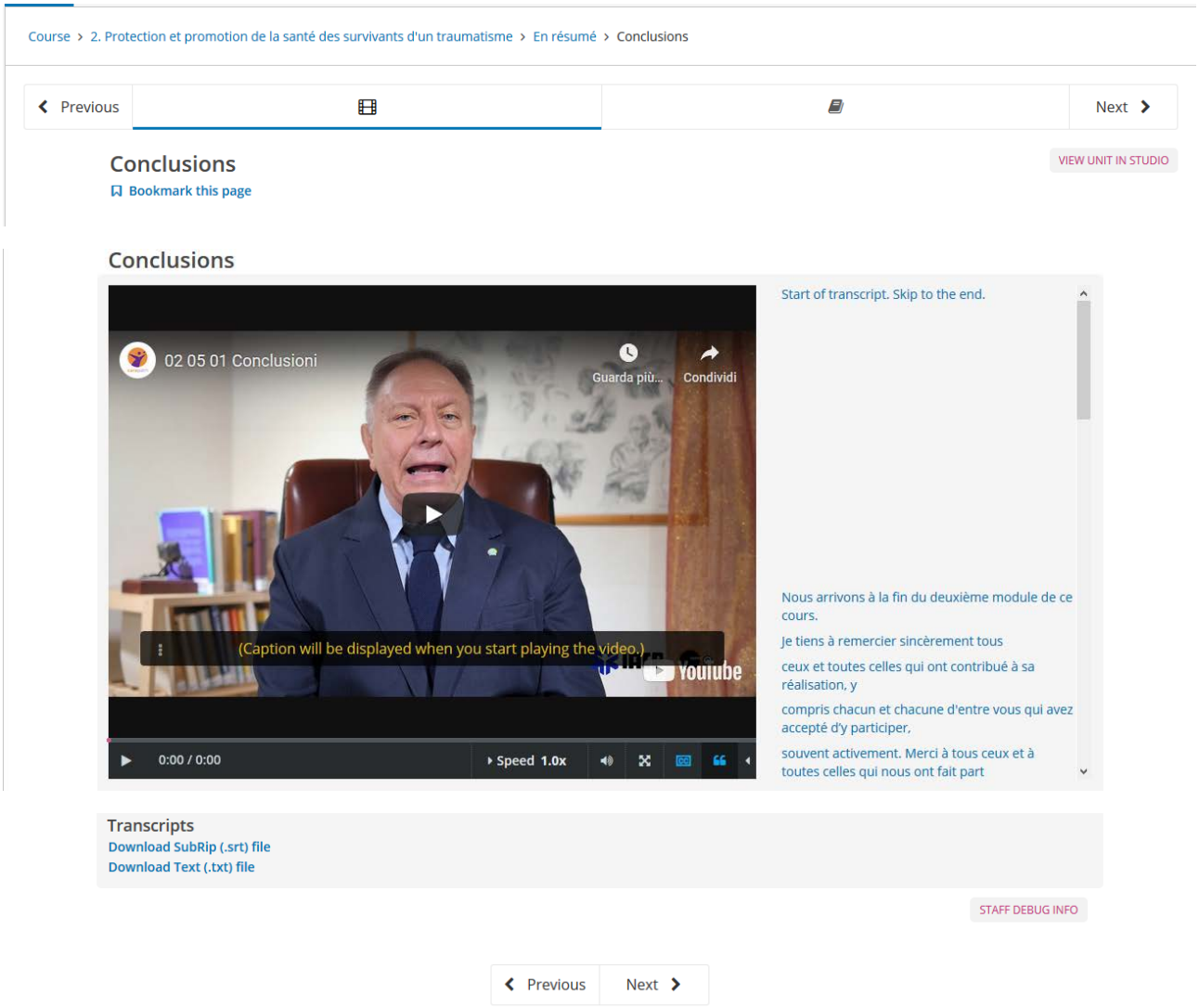
Il reste beaucoup à faire - c'est un impératif éthique et moral -

pour protéger et promouvoir, dans la science et dans la conscience,

les droits des individus et la santé sociale. L'article 33 de la Constitution italienne, comme beaucoup d'autres constitutions européennes,

stipule que la santé est un droit pour chaque citoyen ;

nous devons donc protéger et promouvoir la santé de tous et de toutes : c'est un impératif.



Transcript

Nous arrivons à la fin du deuxième module de ce cours.

Je tiens à remercier sincèrement tous

ceux et toutes celles qui ont contribué à sa réalisation, y

compris chacun et chacune d'entre vous qui avez accepté d'y participer,

souvent activement. Merci à tous ceux et à toutes celles qui nous ont fait part

de leurs commentaires, qui nous ont expliqué leur situation locale,

qui nous ont proposé des solutions et qui nous ont donné la permission d'utiliser

documents, cartes et matériel qui, grâce à vous, amélioreront les éditions ultérieures de ce cours.

Mes sincères remerciements à chaque membre de l'équipe qui a travaillé avec beaucoup de générosité et d'engagement pour atteindre un but dans lequel ils croyaient fermement

et qu'ils partageaient.

Merci à tous les collègues extérieurs à l'institut

qui ont accepté de travailler gratuitement,

de nous laisser utiliser leur image,

et de partager et de diffuser leur contribution

et leur matériel sur le portail de ce cours.

Merci à tous les professionnels de l'IACP pour avoir eu la générosité de partager,

avec tout leur cœur et leur intelligence,

leurs expériences dans le domaine difficile de l'aide aux jeunes victimes de traumatismes.

Merci également à toutes les organisations qui ont travaillé avec nous, et enfin,

merci à tous les partenaires du projet CarePath qui n'ont eu de cesse de nous

aider avec sympathie et amabilité.

Last thanks, icing on the cake,

Mes derniers remerciements iront au chef de projet et à tous ses collègues de l'Université de Turin. Luca Rollè est vraiment

l'un des meilleurs chefs de projet avec lesquels j'ai eu la chance de travailler

dans le cadre d'un projet européen ; j'adresse également

un merci chaleureux à ses collègues de l'Université de Turin,

de la Faculté de Psychologie, tous et toutes sont merveilleux et

ont fait tant et plus pour nous faciliter la tâche.

Merci, merci à tous et à toutes ; bon travail ! Et aux participants de ce cours, nous souhaitons une bonne continuation avec les autres modules. Ciao! Alberto Zucconi et tous les professionnels de l'équipe IACP

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Quiz 1

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VIEW UNIT IN STUDIO

Q.1

15 points possible (graded)

1. Qu'est-ce qu'une relation d'aide?

- ○ Une relation affective basée sur l'aide d'un partenaire à un autre
- ○ Une relation établie entre un professionnel et un utilisateur de services
- ○ Une relation qui répond aux besoins du professionnel et de l'utilisateur de services
- ○ Une relation médecin-patient

2) La théorie générale des systèmes a été formulée par:

- ○ Wertheimer
- ○ Maslow
- ○ Rogers
- ○ Von Bertalanffy

3. Qu'est-ce que l'OMS?

- ○ Organisation mondiale de la science
- ○ Organisation médico-sociale
- ○ Organisation mondiale de la santé

4) L'approche centrée sur la personne a été fondée par

- ○ C. Rogers
- ○ O. Rank
- ○ J. Bowlby
- ○ A. Maslow

5) Laquelle de ces conditions nécessaires à l'établissement d'une relation d'aide n'a pas été théorisée par C. Rogers?

- ○ Empathie
- ○ Acceptation positive inconditionnelle
- ○ Résilience
- ○ Congruence

6) Alliance de travail

- ○ Elle concerne les dispositions contractuelles entre le travailleur et l'employeur
- ○ Elle ne concerne pas l'individu mais uniquement le groupe
- ○ Il est souhaitable de collaborer dans une relation d'aide
- ○ Il s'agit de l'ensemble de règles établies par le professionnel et auxquelles l'utilisateur du service doit se conformer

7) Le manque d'empathie dans la relation d'aide

- ○ Est une qualité professionnelle
- ○ Permet de mieux comprendre ce que dit l'utilisateur
- ○ Est une action recommandée pour éviter l'épuisement professionnel
- ○ Empêche une relation d'aide d'être efficace

8) Qu'est-ce qu'un trouble de stress post-traumatique complexe?

- ○ C'est un terme alternatif pour le trouble de stress post-traumatique
- ○ C'est un trouble dérivé d'expériences traumatisantes chroniques
- ○ C'est une terminologie utilisée lorsque les symptômes du trouble de stress post-traumatique persistent pendant plus de 6 mois
- ○ Il s'agit d'une perturbation causée par un traumatisme de groupe

9) Laquelle des caractéristiques suivantes n'est pas souhaitable dans un système de soins "Trauma Informed Care"?

- ○ Valoriser le patient dans tous les aspects des soins
- ○ Adopter un langage neutre et favorable
- ○ Faire un dépistage correct sur quelle expérience peut être définie comme traumatisante
- ○ Former le personnel au traumatisme et à ses effets

10) Quel est le facteur étiopathogène le plus courant dans le développement d'un traumatisme psychologique?

- ○ Expérience répétée de négligence physique et psychologique de la part des soignants
- ○ Expérience directe de catastrophes naturelles
- ○ Expérience directe de mort subite
- ○ Expérience d'abus sexuels sur des enfants

11) Les soins informés des traumatismes signifient:

- ○ Un ensemble de techniques qui accompagnent l'EMDR et qui facilite le re-travail traumatique
- ○ Un type de psychothérapie
- ○ Une approche systémique de gestion et de soins des personnes ayant vécu des expériences traumatisantes
- ○ Une salle d'hôpital spécifique pour les personnes ayant vécu des expériences traumatisantes

12) La violence assistée est définie comme:

- ○ Un traumatisme lié à la participation à des événements catastrophiques
- ○ Une situation dans laquelle un mineur assiste, directement ou indirectement, ou perçoit les effets d'actes de violence commis sur des figures de référence affectivement significatives pour lui
- ○ Un type de violence infligée par un parent à l'autre parent avec le soutien psychologique et / ou matériel (obtenu par manipulation psychologique) de l'enfant
- ○ Le traumatisme dérivé du fait d'être témoin de phénomènes de violence générale

13) Quelles sont les actions d'intervention recommandées en cas de témoin de violence?

- ○ Détection, protection, évaluation, traitement
- ○ Observation, évaluation, traitement, médiation familiale
- ○ Détection, hébergement familial, traitement, médiation familiale, réinstallation familiale
- ○ Éloignement du noyau familial, médiation familiale, relocalisation familiale

14) Selon le rapport de l'OMS publié en 2013 sur la prévention de la maltraitance des enfants en Europe, combien d'enfants de moins de 15 ans meurent-ils de maltraitances?

- ○ Entre 800 et 900
- ○ Entre 500 et 600
- ○ Entre 900 et 1000
- ○ Entre 400 et 500

15) Le complexe du PTSD diffère du PTSD en ce qu'il:

- ○ Est typique de l'enfance
- ○ Est présent en cas de violence dans une relation de confiance
- ○ Est présent si à côté des symptômes psychologiques, il y a des symptômes moteurs
- ○ Est présent exclusivement chez les femmes et les mineurs

Invia You have used 0 of 2 attempts

Salva Show Answer

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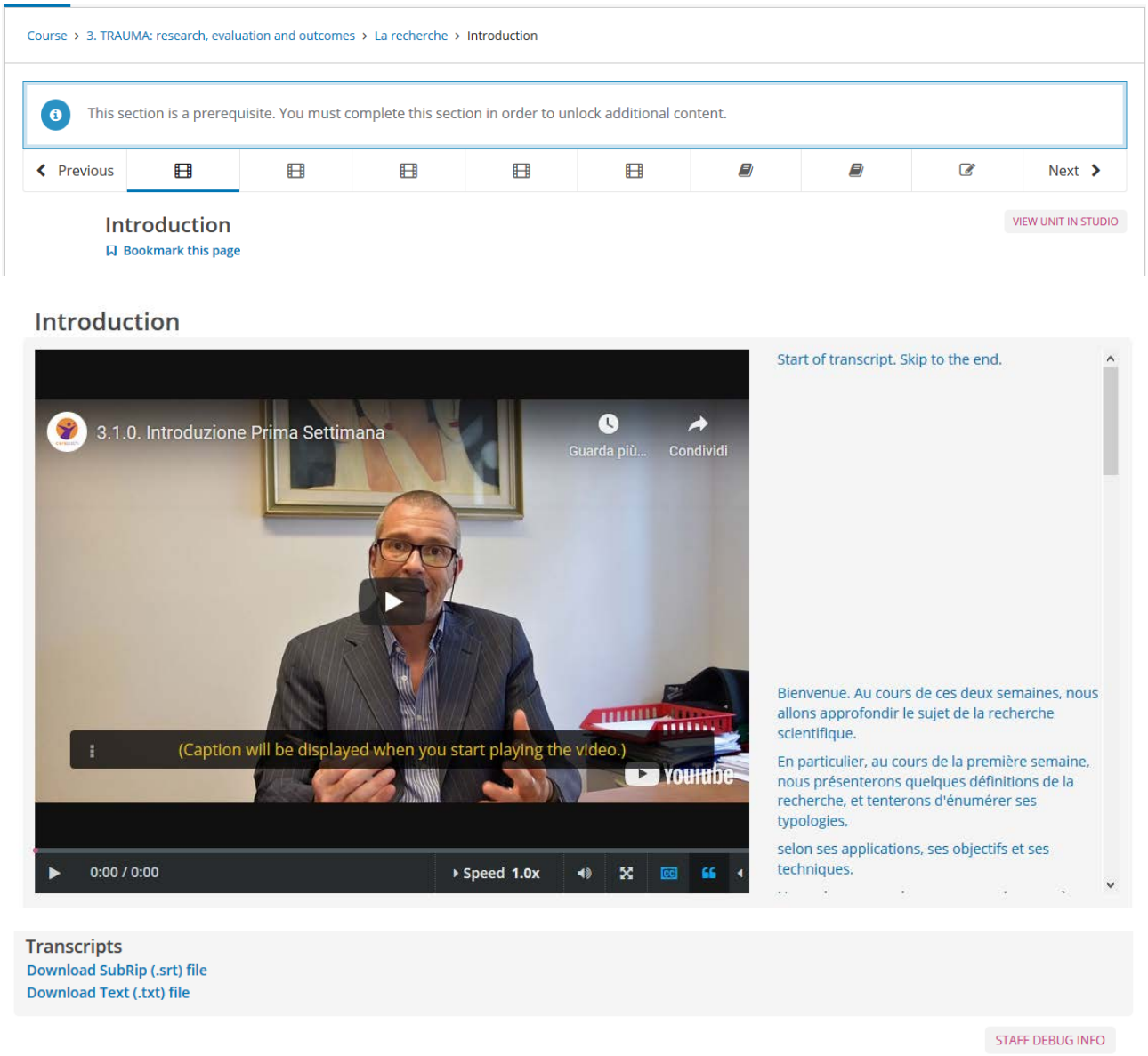

Transcript

Bienvenue. Au cours de ces deux semaines, nous allons approfondir le sujet de la recherche scientifique.

En particulier, au cours de la première semaine, nous présenterons quelques définitions de la recherche, et tenterons d'énumérer ses typologies,

selon ses applications, ses objectifs et ses techniques.

Nous observerons le processus qui nous mène de l'expression d'un problème théorique (de la théorie)

aux méthodes qui nous permettent de l'explorer

et de produire des données qui peuvent être interprétées et utilisées. Nous allons ensuite intégrer et examiner en profondeur

les principes fondamentaux, les limites et les avantages de la Recherche-Action, comme point de départ,

et mes collègues expliqueront la signification de la Recherche-Action,

pour ensuite expliquer la recherche factuelle.

Après cela, nous explorerons les avantages et les défis de l'intégration

de la recherche factuelle dans les soins

fondés sur les traumatismes. En particulier, la pertinence internationale du sujet nous fournit une perspective transversale

sur les points critiques et les forces

de la transformation de la recherche en pratique clinique. Ici, nous analyserons

les éléments principaux et connexes des bonnes pratiques dans la littérature scientifique,

dont certains sont informatifs. Nous nous questionnerons,

et nous essaierons de comprendre la signification des besoins de formation,

et comment ceux-ci peuvent être soutenus et pris en compte par l'organisation.

Nous ne devons pas oublier qu'une approche de soins adaptées aux traumatismes implique un aspect

et un impact qui sont fondamentaux à la fois au sein de l'organisation

et parmi les membres individuels de l'organisation. A partir de là, nous en profiterons pour discuter de la diffusion scientifique dans l'élaboration

et la mise en œuvre d'interventions spécifiques concernant les soins adaptés

sur les traumatismes. Pour conclure cette semaine, nous aborderons

les aspects évaluatifs dans les organisations

qui développent ou tentent de développer des procédures ou des processus basés sur les traumatismes.

En fait, ils peuvent offrir à leurs employés, 27 00:02:33,950 --> 00:02:40,290 leurs collaborateurs et leurs bénévoles, une formation et une séance d'information à propos des soins adaptés aux traumatismes,

ainsi que des interventions efficaces liées aux

données de recherche en psychothérapie, ou dans la thérapie fondée sur des preuves.

De là, nous passerons ensemble à la deuxième semaine,

ce qui nous permettra d'examiner d'autres questions liées à la recherche.

Je vous souhaite à tous une semaine de cours agréable et une bonne leçon,

en mon nom et au nom de tous mes collègues.

This section is a prerequisite. You must complete this section in order to unlock additional content.

Description de la recherche

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VIEW UNIT IN STUDIO

ARTICLE

Il est difficile de distinguer ce qui relève de la recherche et ce qui n'en relève pas. Au fil du temps, plusieurs définitions sont apparues. Penchons-nous sur les plus récentes :

« La recherche vise simplement à trouver une réponse à certaines questions auxquelles on n'a jamais répondu et les réponses dépendent des efforts humains consentis. [...] En fait, la recherche est simplement le processus permettant de trouver des solutions fiables à un problème grâce à un recueil systématique et planifié, à une analyse et à une interprétation de données. » (Singh, 2006, p.1).

« La recherche est un processus créatif de découverte qui évolue au fil d'un itinéraire et de procédures pré-déterminés, qui ont fait l'objet d'une consolidation au sein de la communauté scientifique. » (Corbetta, 2015, p.15).

En règle générale, une recherche est menée « lorsqu'on applique la curiosité et l'intuition dans le cadre d'une démarche systématique visant à répondre à des questions relatives à des phénomènes quotidiens en s'inspirant des expériences et des connaissances déjà acquises. » (Research Italy, 2013).

On distingue plusieurs types de recherche en fonction de son application, de ses objectifs et de ses méthodes d'analyse. En réalité, la recherche peut être « appliquée » ou « pure ». La recherche appliquée vise à trouver une solution à un problème d'application alors que la recherche pure concerne les généralisations et la formulation d'une théorie (Kothary, 2004; Singh & Masuku, 2013). En fonction de ses objectifs, on parle de recherche descriptive, exploratoire, corrélationnelle ou explicative. La recherche descriptive vise à décrire un phénomène, un problème, une situation.

La recherche corrélationnelle analyse la relation entre deux ou plusieurs variables.

La recherche explicative explique pourquoi certaines choses se produisent.

La recherche exploratoire examine la faisabilité d'une étude ou analyse un domaine de recherche peu connu.

Avant de démarrer l'analyse, il convient d'élaborer un plan de travail reprenant les différentes phases de la procédure de réalisation de l'analyse en question; on appelle ces phases les « plans de recherche ».

Selon les techniques utilisées, on distingue :

- la recherche quantitative : il s'agit d'une démarche structurée visant à quantifier la variation ou la diversité d'un phénomène, d'une situation ou d'une attitude grâce à un plan de recherche bien structuré, qui fournit des données quantitatives. Celles-ci peuvent être analysées pour vérifier des hypothèses et tester des relations entre les variables ;

- la recherche qualitative : il s'agit d'une démarche non structurée, explicative, descriptive et inductive par nature, qui prête une attention particulière au contexte. Elle entend identifier et décrire autant de variations que possible dans un phénomène, une situation ou une attitude afin de comprendre les raisons sous-jacentes à leur manifestation. D'où « une vision interprétative et naturaliste du monde; en d'autres termes, les chercheurs étudient les phénomènes dans leurs milieux naturels et essaient de leur donner un sens ou de les interpréter à la lumière du sens que les personnes leur attribuent » (Denzin & Lincoln, 2011, p. 3). L'objectif de la recherche qualitative consiste à décrire et à comprendre les phénomènes plutôt qu'à les prédire et/ou les contrôler (Streubert & Carpenter, 2005).

D'autre part, l'approche mixte mélange les méthodes de la recherche quantitative à celles de la recherche qualitative. « La recherche sociale repose sur la définition des variables, la recherche d'associations entre elles et la volonté de comprendre si et comment la variation d'un élément provoque la variation dans un autre élément. Les variables courantes dans la recherche sociale sont l'âge, le genre, l'origine ethnique, la race, l'éducation, le revenu, l'état civil et l'emploi » (Bernard, 2006, pp. 28-29). Dans un premier temps, nous nous penchons sur le concept de variable :

un élément qui peut adopter plusieurs valeurs. Ensuite, vient le concept de « mesure »: les variables sont mesurées grâce à leurs indicateurs, définis par la variable en tant que telle. La mesure représente la valeur à enregistrer. Toute recherche se doit également de respecter les principes de validité et de fiabilité. La validité implique que la recherche présente des instruments de mesure, des données et des résultats précis ; quant à la fiabilité, elle signifie qu'on obtient les mêmes résultats après avoir procédé à plusieurs mesures avec le même instrument.

Bernard (2006) explique les quatre points fondamentaux qu'un processus de recherche doit suivre :

1. premièrement, la formulation d'un problème théorique (théorie et littérature scientifiques) ;

2. deuxièmement, le choix d'une méthode et d'unités d'analyse adéquates ;

3. troisièmement, le recueil et l'analyse des données ;

4. enfin, la contestation ou la validation de la proposition théorique, qui a servi de point de départ à la recherche.

(Bernard, 2006, p.69)

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What is research?

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Découverte. Collaboration. Passion. Partage, avenir.

Culture et savoir.

Le progrès.

Découverte pour un avenir meilleur.

Anticipation.

Développement et bravoure.

Agréable et stimulant.

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Découverte. Collaboration. Passion. Partage, avenir.

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Développement et bravoure.

Agréable et stimulant.

Difficile et excitant.

Passion, créativité et dévouement.

Défi.

Développement.

L'avenir. Innovation. Persévérance.

Sacrifice, mais grande satisfaction.

Opportunité.

Progrès.

Compréhension.

Un dur labeur. Liberté et étude.

Ambition.

Évolution.

Effort

(mais aussi plaisir).

Curiosité. Innovation. Prospérité.

La recherche est la nature humaine.

Ne pas faire de recherche signifie ne pas résoudre les problèmes. Ca signifie ne pas exister.

La recherche est la curiosité. C'est le désir de connaître la réalité,

et surtout, pour ceux qui l'ont fait, c'est la joie inestimable de la découverte.

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VIEW UNIT IN STUDIO

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Recherche-action

ARTICLE

Traditionnellement, la tâche de la recherche a toujours été d'extrapoler des lois inscrites dans la nature du monde par une analyse objective des phénomènes. Le chercheur doit étudier les phénomènes à partir d'une position absolument neutre. La recherche s'attaque par définition à la théorie ; elle tend à la généralité et à la construction de modèles aussi universels que possible. L'action, en revanche, est, dans l'expérience commune, imprégnée de motivations, de désirs, d'émotions et de connaissances souvent illogiques, contradictoires et qui visent à faire, à obtenir et à transformer. L'action est orientée vers la pratique, elle est liée au particulier et au singulier, localiste et situationnelle, historicisée, pas toujours prévisible dans son origine et dans ses résultats (Amerio, 2000). La recherche-action est née avec l'intention de combiner ces deux dimensions traditionnellement considérées comme distinctes et inconciliables. Les deux pierres angulaires de la recherche-action, qui la différencient de la recherche traditionnelle, sont la participation et la coopération. C'est ainsi qu'Elliot la définirait :

« La recherche-action pourrait se définir comme l'étude d'une situation sociale visant à améliorer la qualité de l'action en son sein. En d'autres termes, elle a pour propos d'introduire une évaluation pratique dans des situations concrètes ; la validité des « théories » ou des hypothèses qu'elle génère dépend moins des vérifications « scientifiques » de la vérité que de leur pertinence pour aider les gens à agir de façon plus intelligente et plus compétente. Dans la recherche-action, les « théories » ne sont pas validées de façon indépendante avant d'être appliquées à la pratique. Elles sont validées par la pratique ». (Elliott, 1994, p.97)

Ou encore...

« Il convient de diagnostiquer la situation-problème et de planifier, puis appliquer des mesures correctives, dont les effets doivent être contrôlés, si l'objectif est d'apporter des améliorations. Ce processus global d'analyse-diagnostic-planification-action-vérification des effets s'appelle la recherche-action [...] ». (Elliott, 1994, p.96)

C'est Lewin (1946) qui a développé le modèle original de recherche-action dans le but de comprendre les problèmes existant dans des contextes spécifiques par le partage de connaissances entre des personnes qui sont à la fois chercheurs et sujets d'expérience. L'action prend de plus en plus de valeur parce qu'elle devient un moment de construction des connaissances sur le problème. Le changement se produit en trois étapes :

1. Unfreezing (dégel) : rompre l'équilibre initial en agissant sur les facteurs de résistance liés à l'adhésion aux normes sociales.

2. Moving (changement) : les éléments nouveaux et existants dans le champ se déplacent en fonction des forces agissant en son sein.

3. Refreezing (regel) : la nouvelle situation se stabilise autour d'un nouvel équilibre.

La recherche-action est donc « un recueil et une analyse systématiques de données visant à prendre des mesures et à apporter des changements », générant des connaissances pratiques et susceptibles d'être partagées (Gillis & Jackson, 2002, p. 264).

L'objectif de toute recherche-action est de produire un changement social par l'action (ou les actions), qui est à son tour le but ultime de la recherche (Greenwood & Levin, 1998; McNiff & Whitehead, 2006; MacDonald, 2012).

Les chercheurs, quand ils entreprennent une recherche-action, ont à l'esprit l'hypothèse que la réalité est créée et recréée par un processus social continu. Ils reconnaissent que, selon Argyris et al (1982), les éléments cruciaux d'une approche de recherche menée dans une situation sociale spécifique sont : la collaboration entre les chercheurs et les communautés de référence ; un processus d'investigation critique ; l'accent placé sur la pratique sociale ; et un processus d'apprentissage réfléchi. Cela implique nécessairement un type de recherche différent de la vérification des hypothèses, qui accorde plus d'attention aux thèmes de la recherche, nécessairement déclarés et discutés, pour permettre à toute personne intéressée de soumettre la recherche à un examen critique (Checkland & Holwell, 1998).

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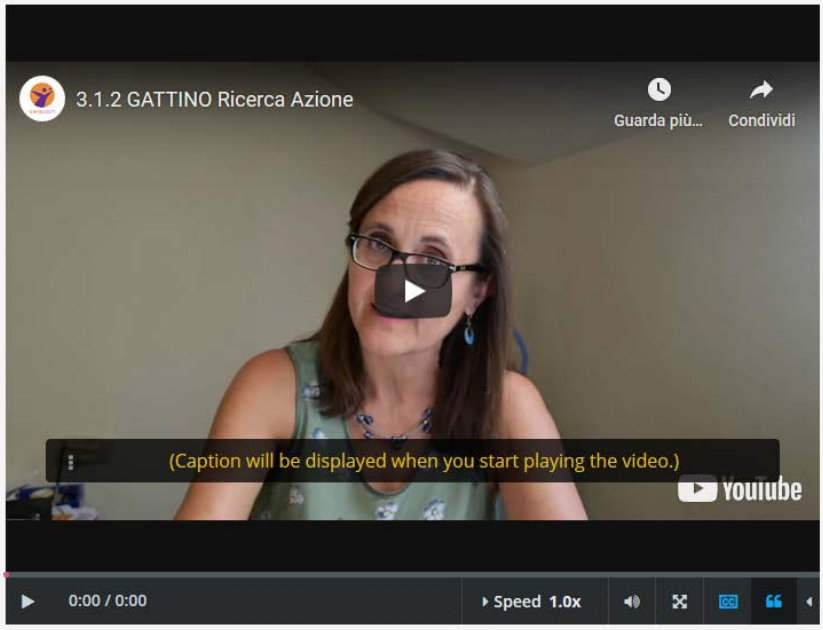
Recherche-action



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Le terme “Action-Recherche” a été introduit par le psychologue social Kurt Lewin dans les années 40

et indique la rencontre entre des mondes jusque-là

considérés comme séparés et opposés: la recherche, qui vise à réfléchir sur les choses,

et l'action, qui vise plutôt à changer

les choses.

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Transcript

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considérés comme séparés et opposés: la recherche, qui vise à réfléchir sur les choses,

et l'action, qui vise plutôt à changer

les choses.

L’Action-Recherche permet donc de créer une alliance entre l'aspect cognitif,

Recherche, et l'aspect applicatif, Action ; et exprime une transformation

dans la manière de concevoir, planifier et faire des recherches en Sciences Humaines, dans lesquelles la complexité

des phénomènes étudiés n'est pas simplifiée mais, au contraire, acceptée et prise en compte.

La recherche-action est toujours menée par Lewin dans un cadre de groupe

car le groupe est ce lieu psychosocial dans

lequel les gens construisent leurs actions

et est également un outil qui peut faciliter les processus de changement.

La recherche-action peut être décrite comme une famille de méthodologies de recherche dont l'objectif,

comme nous l'avons dit, est d'activer simultanément une voie d'action

(en d'autres termes, de changement) et de recherche (en d'autres termes, de compréhension des phénomènes).

Ce chemin se déroule à travers un processus flexible qui consiste en une spirale de cycles,

chacun étant structuré en trois étapes consécutives: planification, exécution

et reconnaissance / enquête. Cette dernière étape vise à évaluer les résultats de chaque phase,

préparer une base rationnelle pour la phase suivante et modifier, si nécessaire,

le plan d'action initial.

Que se passe-t-il après le premier cycle de recherche-action?

Une fois les résultats (ainsi que le changement potentiel produit

par rapport à la situation initiale) analysés, un nouveau cycle du processus commence,

dans lequel les nouveaux éléments qui ont émergé de l'activité

menée dans le cycle précédent sont intégrés; ces cycles se répètent jusqu'à épuisement de la situation problématique.

La planification, l'exécution et l'enquête sont soutenues par une évaluation critique

dans laquelle les participants se demandent ce qui a fonctionné, ce qui n'a pas fonctionné,

ce qui a été appris et ce qui peut être fait différemment.

L'évaluation critique de chaque cycle permet aux chercheurs d'action de corriger les erreur

et de réajuster les actions aux besoins réels qui sont apparus au cours de la recherche elle-même.

Quel est l'objectif de la recherche-action?

L'objectif d'Action-Recherche est de générer du changement :

changement de comportement, d'habitudes,

de contextes, etc.

L'hypothèse de base est que le statu quo ne permet pas le bien-être des individus

et que ce n'est que par le changement que la situation peut s'améliorer.

Le changement doit donc être provoqué, puis analysé et compris,

et cela doit être durable.

Selon Lewin, pour que le changement soit durable, il doit passer par trois phases : l

a « phase de dégel », qui s’obtient en agissant sur les facteurs de résistance au changement,

qui sont souvent liés à l'adhésion aux normes sociales ;

la « phase mouvante », par exemple changer et développer de nouvelles croyances,

valeurs et attitudes sur la base de nouvelles informations et passage

d'une ancienne situation à une nouvelle;

il y a ensuite la « phase de reconstruction » ou « recongélation », dans laquelle la nouvelle situation créée

se stabilise autour d'un nouvel équilibre, c'est-à-dire les nouvelles valeurs, attitudes

et comportements qui sont établis et intégrés dans le reste du système.

Un aspect important de la recherche-action est la participation active

du bénéficiaire, qui est en réalité à la fois le destinataire et l'acteur

de l'intervention et doit être en mesure de partager les objectifs de la recherche elle-même.

L'hypothèse de base de la recherche-action est que les personnes avec lesquelles nous travaillons sont des individus actifs,

avec des aptitudes et des compétences qui doivent être impliquées dans le processus de recherche.

Lors de l'adoption de l'approche de la Recherche-Action, on ne peut ignorer l'implication active des personnes

à qui s'adresse l'intervention, et il faut créer une situation de collaboration

et de confrontation avec les acteurs-destinataires de l'intervention.

Un autre élément caractéristique de cette famille de méthodologies

de recherche qui est la recherche-action est l'absence d'une méthode d'intervention prédéfinie à appliquer.

En fait, cette méthode est construite avec le groupe à partir de quelques principes cruciaux

et sur la base des réponses observées au cours du travail.

Il arrive souvent que le modèle initial soit modifié, car le choix de la méthodologie

et des actions à mettre en œuvre se construit au cours du processus.

Jusqu'à présent, nous avons illustré les aspects qui définissent la recherche-action.

Vérifions maintenant les éléments qui la différencient de la méthode expérimentale.

Nous avons déjà dit que dans la recherche-action, il n'y a pas d'intervention fixe.

Ceux qui adoptent cette approche permettent donc à l'hypothèse d'émerger au cours du processus

et de changer de cap grâce à un suivi continu.

Un autre élément de différence est que, dans la recherche-action, nous n'essayons pas de définir les relations causales,

vérifier les hypothèses de la littérature ou déterminer les résultats des traitements sur des échantillons représentatifs

dans le but de confirmer ou de falsifier

des théories générales.

En Recherche-Action, tout au long de chaque cycle, le phénomène sur lequel nous intervenons est davantage

mis en avant.

Nous ne nous soucions pas de la mesurabilité des variables et l'objectif est de résoudre les problèmes

en examinant différents parcours qui ne peuvent être anticipés a priori, mais qui deviennent

le résultat et aussi l'outil du groupe.

Enfin, un autre élément de différenciation est la manière dont les résultats finaux sont présentés;

dans le cas de la recherche-action, ils sont illustrés à l'ensemble du groupe

ou à l'ensemble de la communauté de manière participative, utiliser un langage simplifié

et accessible plutôt que le jargon technico-scientifique qui caractérise les rapports de recherche expérimentale.

L'objectif à atteindre par la présentation des données est de générer de nouvelles évaluations

qui permettent de définir les possibilités d'amélioration possibles.

Enfin, sur la base de ce qui a été dit jusqu'à présent, nous pouvons résumer les principales hypothèses sous-jacentes à la recherche-action:

Le fait qu'elle soit pratique et contextuelle.

La recherche-action prend pour cible les problèmes d'un groupe ou d'une communauté ;

par conséquent, elle est contextuelle dans sa nature, ou en d'autres termes, c'est une recherche localisée qui se déroule dans un contexte ;

- elle vise le changement et se concentre sur la dimension de groupe plutôt

que sur l'individu, à la fois lorsqu'il s'agit d'analyser les processus

et de définir les solutions et les résultats qui ont émergé;

De plus, la recherche-action comporte plusieurs étapes

et un caractère cyclique qui est donné par la conception de la recherche,

qui se configure comme une alternance de phases de connaissance et d'action ;

- elle place la participation au centre du sujet, en termes de coopération et de l'interdépendance

entre les chercheurs et le groupe, ou les chercheurs et la communauté.

Definition of Action Research

Start of transcript. Skip to the end.

L'enseignement est un métier. C'est à la fois un art et une science. C'est pourquoi les meilleurs professeurs

expérimentent toujours et font beaucoup d'erreurs. Mais comment savez-vous ce qui fonctionne réellement?

L'une des options est la recherche-action. Ici, vous pouvez identifier une question, tester une stratégie,

Transcripts

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L'une des options est la recherche-action. Ici, vous pouvez identifier une question, tester une stratégie,

collecter des données et déterminer si cela fonctionne. Le résultat final est

dynamique, innovant et lié directement à votre classe.

La recherche-action fait disparaître la barrière entre les participants et les chercheurs.

En d'autres termes, l'enseignant participe activement à la situation tout en menant la recherche.

Il existe de nombreux cadres de recherche-action

mais ils suivent généralement un processus similaire. Dans la phase 1, vous initiez la planification de la recherche.

Vous commencez par l'enquête, où vous définissez une question de recherche spécifique.

Celle-ci doit pouvoir être réellement testée.

Ensuite, vous effectuez une revue de la littérature pour mieux comprendre le sujet.

Enfin, vous entrez dans le processus de conception où vous déterminez vos méthodes de données,

tenez compte des problèmes éthiques, obtenez les autorisations requises, créez des délais et configurez les systèmes.

Puis, vous passez à la phase d'action. C'est là que vous vous engagez dans plusieurs cycles

d'expérimentation et de collecte de données. Cette dernière peut inclure

des données qualitatives telles que des observations, des artefacts et des entretiens ou

des données quantitatives telles que des enquêtes sur les scores des rubriques ou des données sur les résultats. Vous passez ensuite

à l'analyse. Vous commencerez souvent par organiser les données avec des tableaux

ou des graphiques et à rechercher des tendances spécifiques.

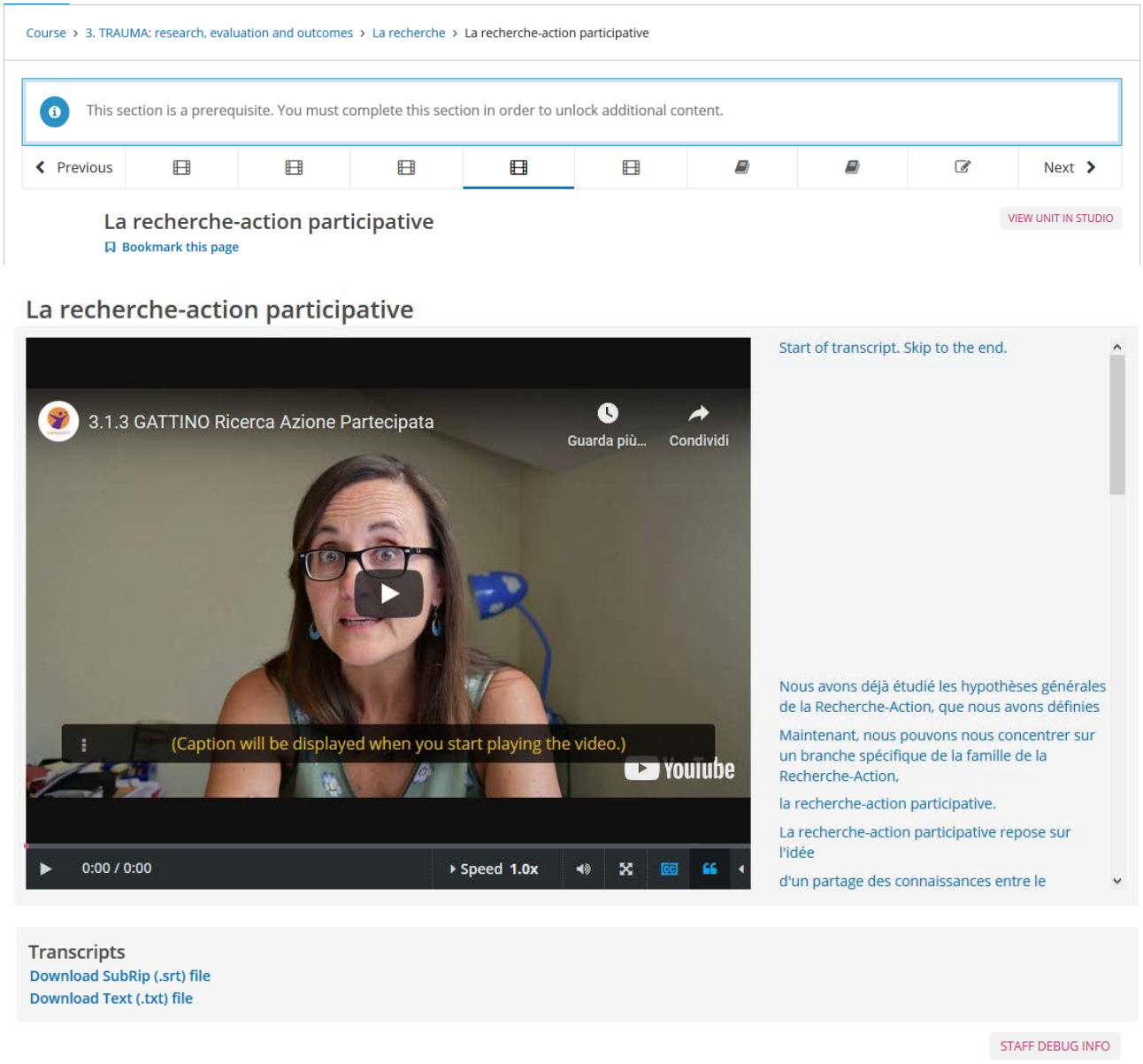
Vous pourrez également en discuter avec des pairs, tenir des notes dans un journal ou créer une carte à points

avant d'écrire vos résultats. Finalement, vous aurez votre conclusion.

C'est à ce moment-là que vous partagerez vos recherches avec le monde et réfléchirez à votre propre pratique.

Cela conduira finalement à de nouvelles questions et le cycle se poursuivra au fur et à mesure que

vous affinerez votre art pour devenir un meilleur enseignant, plus créatif.



Transcript

Nous avons déjà étudié les hypothèses générales de la Recherche-Action, que nous avons définies

Maintenant, nous pouvons nous concentrer sur un branche spécifique de la famille de la Recherche-Action,

la recherche-action participative.

La recherche-action participative repose sur l'idée

d'un partage des connaissances entre le chercheur et les bénéficiaires de l'intervention,

qui en sont aussi les acteurs. Comme nous l'avons déjà mentionné, l'objectif de la recherche-action participative

est le partage des connaissances, afin de concevoir et de redonner

un sens à l'action collective.

La recherche-action participative met en avant la collectivité en encourageant les échanges entre experts et

entre les personnes appartenant au contexte dans lequel elle intervient,

qui sont capables de tirer parti des connaissances locales et des connaissances des experts en faisant ressortir

les multiples points de vue et perspectives qui sont présents

dans ce contexte spécifique.

Ces interventions reposent sur le principe de participation,

comme un outil mais aussi comme un objectif du changement social de l'intervention.

La recherche-action participative établit qu'un problème provient d'un groupe qui est en difficulté

dans un contexte spécifique à un moment historique précis et bien défini.

Le chercheur note donc le problème, il ne le génère pas, et son rôle est d'aider le groupe et la communauté

à identifier les éléments clés afin de pouvoir

poursuivre l'action.

Les personnes qui adoptent l'approche de recherche-action participative doivent donc créer une situation de collaboration et de discussion avec les citoyens

et les opérateurs, lorsqu'ils définissent les problèmes

à étudier, la réalisation des recherches et la préparation

du changement.

ARTICLE

Comme le souligne Vargiu (2008), le domaine de la recherche-action redonne vie à expériences à la fois différentes, mais également unies par deux grands objectifs : la compréhension et le changement. La littérature existante définit la recherche-action comme étant une « famille de démarches » (Reason 1994, Reason - Bradbury 2006) visant à « mettre la recherche au service de la communauté, par l'activation de pratiques participatives dans le but de réaliser la transformation sociale. Ce qui suppose de grandes différences par rapport aux autres formes de recherche au niveau des objectifs que le chercheur se fixe, de ses hypothèses épistémologiques et de ses pratiques. » (p. 206). Selon l'auteur, on peut associer cette « famille » à de nombreuses démarches et pratiques, notamment : 1) la recherche-action, 2) la recherche participative, 3) la recherche-action participative, 4) la recherche-action participative , 5) la science-action, 6) l'enquête-action, 7) la sociologie de l'action (Bartoletto, 2006). Vargiu (2008) y ajoute les expériences qui remontent à la recherche communautaire, à la recherche-action communautaire et participative. Il observe que « la recherche participative et la recherche-action participative peuvent rejoindre la catégorie de recherche que Capecchi (2006) qualifie de « con-ricerca » ». (p. 209). Selon l'auteur, le niveau de participation prévu dans le processus de recherche et l'espace réservé à la dimension subjective et collective dans la définition des objectifs, des éléments de procédure et des instruments qui font toute la différence.

La recherche participative et la recherche-action participative (RAP) prennent une place de de plus en plus centrale dans les sciences sociales (Brydon-Miller et al., 2004; Greenwood et Levin, 1998; Kindon, Pain et Kesby, 2007; Jason et al., 2004; Park et al., 1993; Reason et Bradbury, 2006; Selener, 1997; Taggart, 1997). Comme le signalent Kindon, Pain et Kesby (2007) ainsi que Mackenzie et collègues (2012), la recherche-action participative implique les chercheurs et les participants dans un projet global, qui vise à analyser une condition ou une action problématique dans le but de corriger une situation (Wadsworth, 1998). Il s'agit d'un processus de recherche, d'éducation et d'action basé sur la collaboration (Hall, 1981) visant la transformation sociale (McTaggart, 1997), et dont le point de départ est la reconnaissance de l'existence d'une pluralité de connaissances dans un éventail d'institutions et de contextes (Kindon, Pain et Kesby, 2007). Le processus est cyclique (basé sur des cycles de réflexion-action) : les chercheurs et les participants identifient un problème ou une situation à modifier et entament une recherche basée sur les compétences et les ressources afin de susciter une action pertinente. Les chercheurs et les participants réfléchissent à cette action, en tirent les leçons et passent à un nouveau cycle de recherche/action/réflexion. Comme Kindon, Pain et Kesby (2007) le précisent, ils collaborent également à la définition de méthodes spécifiques au contexte susceptible de simplifier ces cycles. En résumé, la RAP repose sur un processus de participation-dialogue entre les co-chercheurs (Kindon, Pain et Kesby, 2007). Dès lors, la RAP privilégie l'orientation par l'action, qui exige une innovation méthodologique et envisage le processus de recherche ainsi que ses productions : son efficacité est non seulement inhérente à la qualité de l'information générée, mais également au processus de développement des compétences, des connaissances et des aptitudes des participants au fil de l'expérience de recherche (Cornwall et Jewkes 1995; Kesby et al., 2005, 2007; Maguire 1987).

Reason et Bradbury (2006) plaident pour l'adoption d'une approche participative ou d'une vision du monde, qui « exige de nous qu'on se positionne et qu'on réfléchisse, qu'on précise le point de vue instigateur de la connaissance, qu'on envisage la recherche comme un processus de connaissance, qu'on se mettre au service de l'éthique démocratique et pratique de la recherche-action » (p. 7). En phase avec Kindon et collègues (2007), la solution est une vision ontologique, qui suppose que les êtres humains sont des agents dynamiques, dotés d'aptitudes à la réflexion et au changement personnel, ainsi qu'une épistémologie, qui intègre ces aptitudes dans le processus de recherche.

Conformément à l'optique intrinsèquement participative, dans la RAP, le choix des modes et des niveaux de participation ne sont pas opérés à priori par le chercheur, mais font l'objet d'une négociation avec les co-chercheurs et les participants. Les méthodes les plus couramment utilisées dans la RAP se concentrent sur le dialogue, le récit et l'action collective. On utilise principalement (Kindon, Pain et Kesby, 2007) :

- les enquêtes ;
- l'observation par les participants ;
- l'analyse des données secondaires ;
- l'apprentissage par la pratique ;
- le dialogue ;
- l'action politique ;
- le travail et les discussions en groupes ;
- les entrevues ;
- le récit ;
- la cartographie ;
- l'art et les médias communautaires ;
- les diagrammes ;
- les camps éducatifs ;
- les programmes d'échange ;
- les classements et les notations ;
- les analyses, l'écriture et les présentations partagées.

Comme nous l'avons déjà souligné, la recherche active devient de la recherche-action participative en fonction des personnes qui participent à chaque phase et de leur degré de participation. Les participants, en tant que collaborateurs, peuvent influencer la phase de conception, proposer des méthodes, animer des activités et avant tout, réexaminer et évaluer le processus dans son ensemble (Mackenzie et al., 2012). Dès la phase de planification, la RAP tend à recourir aux techniques de recherche bien établies en les adaptant à la situation et cherchant à mettre au point une stratégie (avant l'action) de suivi et d'évaluation de l'incidence de l'action. Cela permet de définir l'ampleur des changements, mais également « d'articuler une épistémologie solide permettant d'évaluer la validité et la pertinence des nouvelles connaissances et du savoir naissant, tout comme une démarche de réflexion systémique » (Ison, 2008). Les procédures efficaces de suivi et d'évaluation offrent une évaluation rigoureuse de l'efficacité, de l'importance et de la pertinence de l'intervention de la recherche-action. Elles proposent également un cadre de causalité en déterminant dans quelle mesure l'activité de recherche a « causé » ou « contribué » au changement souhaité de la situation » (McAllister et Vernooy, 1999)" (pp. 12-13). L'évaluation du processus et des résultats par les participants permet de consolider la participation des parties prenantes et offre la possibilité de co-construire ensemble une participation active et critique, où les voix discordantes sont indispensables et enrichissantes. En conséquence, la RAP exige du chercheur qu'il lâche prise, et qu'il endosse le rôle d'animateur du processus (Kindon, Pain et Kesby, 2007; Janssen et al., 2013).

Comme le soulignent Kangovi et collègues (2014), dans le champ de la santé mentale, la RAP s'avère être une bonne stratégie en ceci qu'elle associe le patient à la conception opérationnelle. Grâce à son caractère coopératif et itératif, les chercheurs, le personnel de la santé et les patients peuvent collaborer à la conception d'interventions validées par les utilisateurs finaux. Elle peut également servir à adapter une intervention existante aux besoins spécifiques et, une fois diffusée, à de nouvelles configurations et/ou groupes de patients. Concernant l'application aux populations jeunes, comme le précisent Shamrova et Cummings (2017), le paradigme des droits de l'enfant a fortement poussé les chercheurs à reconnaître les enfants comme des participants actifs à la construction de sens. Dans ce cadre, la RAP, en tant que mécanisme, permet aux participants de devenir acteurs et d'accompagne l'application des droits de l'enfant (Checkoway, 2011; Quijada Cerecer, Cahill et Bradley, 2013; Shamrova et Cummings, 2017). Qui plus est, la littérature montre que son application produit des résultats également au niveau organisationnel ; la plupart du temps, il s'agit d'une transformation de la culture organisationnelle dans le but : d'augmenter les possibilités de participation ; d'améliorer le niveau d'inclusion de l'enfant ; et de sensibiliser davantage à une meilleure adaptation des programmes aux besoins des enfants et des jeunes (Shamrova et Cummings, 2017). A ce propos, les auteurs (Shamrova et Cummings, 2017), ont identifié une série de choix méthodologiques susceptibles de soutenir une participation pertinente de enfants :

- la formation ;

- la construction et l'utilisation d'outils de recueil de données adaptés aux enfants ;

- la participation active des enfants dans l'analyse des données et dans la lecture des résultats ;

- le choix de lieux pertinents pour la diffusion des résultats de la recherche.

Dans le cadre de recherches auprès de groupes vulnérables, comme le soulignent Lushey et Munro (2015), la RAP peut promouvoir les droits à la participation des enfants et des personnes ayant perdu leur charge, tout en contribuant à la base empirique qui découle des études réalisées sur ces populations.

Sur un plan conceptuel, la recherche-action participative des jeunes est particulièrement intéressante (Anyon et al., 2018; Rodriguez et Brown, 2009). Elle associe les principes de base suivants :

1. elle repose sur une enquête ;

2. les domaines examinés sont les expériences telles que vécues par les jeunes ;

3. elle est participative ;

4. elle présente un caractère transformateur.

Ses principaux processus sont :

a) le partage de pouvoir entre les jeunes et les adultes pendant tout le processus ;

b) la formation et l'application des méthodes de recherche et de plaidoyer ;

c) l'utilisation critique de la réflexion stratégique sur les outils de transformation sociale ;

d) la constitution d'alliances avec les parties prenantes.

Enfin, citons comme exemple de recherches menées sur base du paradigme de la RAP la recherche par Törrönen et Vornanen (2014) auprès de jeunes quittant les structures d'accueil. En accord avec les principes ci-dessus, et comme le soulignent les auteurs, les professionnels et chercheurs se contentaient d'accompagner les jeunes, alors que ceux-ci s'occupaient de mener les entrevues, de recueillir les données auprès de leurs pairs et d'encourager l'expression d'opinions sur les expériences (Törrönen & Vauhkonen, 2012). En fait, priorité était donnée au point de vue des mineurs associés au processus en tant que co-chercheurs ; ces derniers participent donc pleinement au processus de recherche.

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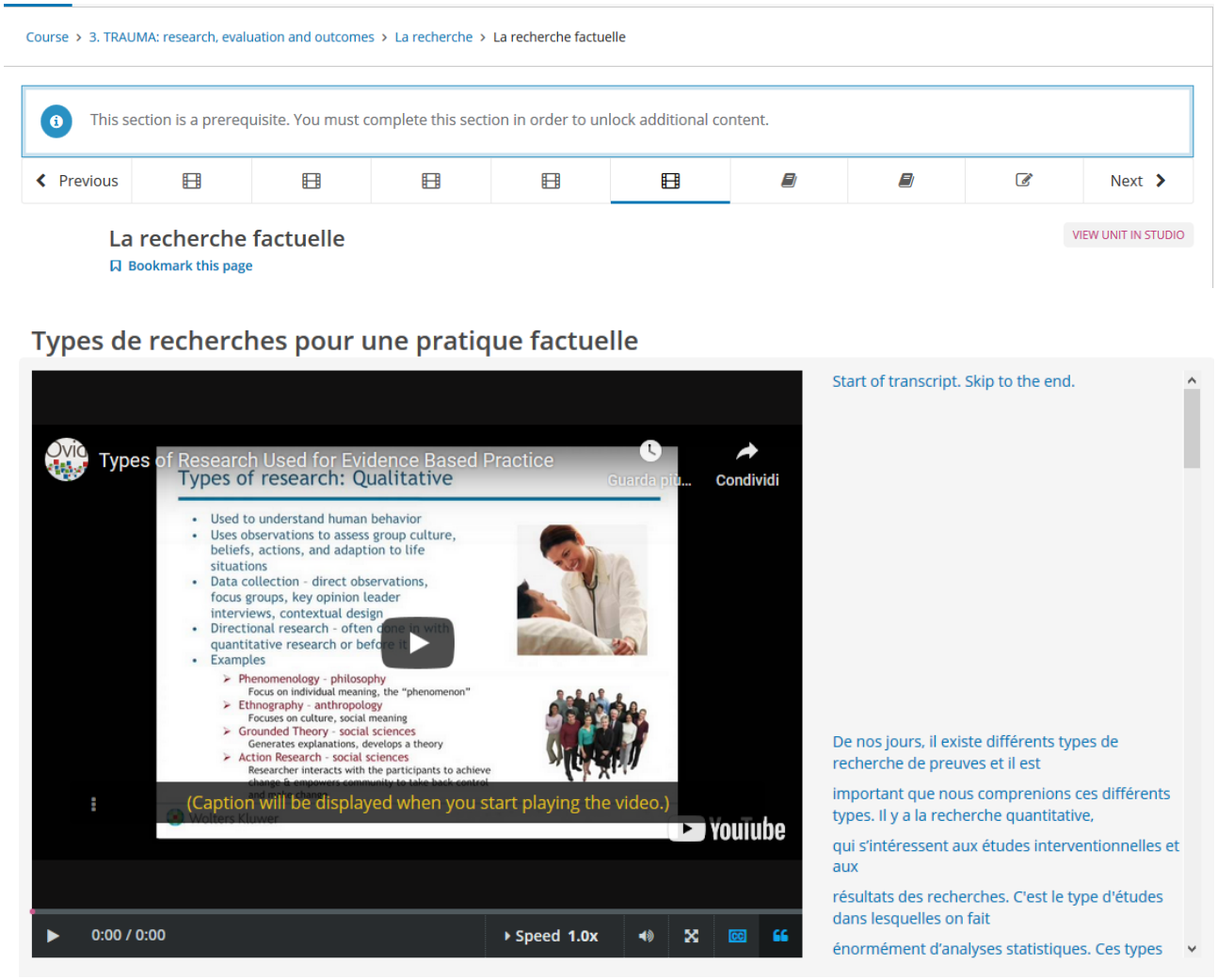

Transcript

De nos jours, il existe différents types de recherche de preuves et il est
important que nous comprenions ces différents types. Il y a la recherche quantitative,
qui s'intéressent aux études interventionnelles et aux
résultats des recherches. C'est le type d'études dans lesquelles on fait
énormément d'analyses statistiques. Ces types d'études peuvent être des essais cliniques,
des essais contrôlés randomisés, des études de cas témoins, et le niveau le plus élevé
serait la méta-analyse et la revue systématique. Les lignes directrices des pratiques clinique sont,
pour la plupart, basées sur la recherche quantitative analytique. Il existe un autre type
de la recherche, appelé la recherche qualitative et la recherche qualitative est vraiment
faite pour comprendre le comportement humain, sur comment les gens répondent

par rapport à leur situation. Donc le type de recherche qualitative que vous voyez, souvent utilisé en soins infirmiers et en science sociale, sont des études comme la phénoménologie, où vous regardez le phénomène d'être malade ou d'avoir une certaine condition. Cela signifie également devoir regarder les groupes ethnographique, basé sur l'anthropologie, nous regardons donc des groupes de personnes qui ont une certaine condition. Nous savons que la recherche qualitative est extrêmement importante pour la façon dont nous dispensons les soins aujourd'hui, parce que vous devez vous assurer que votre patient ait une bonne expérience avec les soins qu'il reçoit. Maintenant le le plus haut niveau de recherche est considéré comme étant de la recherche secondaire et c'est ce que nous appelons la revue systématique ou la méta-analyse, et ce qui est différent à propos de la revue systématique et de la méta-analyses c'est que ca apporte le même niveau de rigueur à l'examen de toutes les recherches qui ont été faites sur un sujet spécifique. Cela apporte le même niveau de rigueur à l'analyse de toute les études. Voici un point d'attention: les revues systématiques sont très différentes des revues de la littérature car les revues systématique et les méta-analyses doivent être évalué par les pairs, ce qui signifie deux personnes ou plus doivent évaluer les études comprises dans la revue systématique ou méta-analyse. Lorsque vous effectuez une revue systématique, vous avez besoin de regarder d'autres point afin de vous assurer qu'il est important de savoir comment nous prodiguons des soins aux patients. Vous devez regarder: est-ce que les résultats de la revue systématique sont réellement faisable? Puis-je vraiment mettre en œuvre cela avec une population de patients spécifique? Est-ce que ce sera approprié? Est-ce significatif pour les populations de patients et ma pratique en tant que fournisseur de soins? Est-ce que ce sera être efficace? Est-ce Que ca fera vraiment une différence? Nous savons cependant que les preuves de recherche sont pas créée égales, donc c'est vraiment important lorsque les fournisseurs de soins de santé s'informent sur la recherche qu'ils obtiennent à partir d'une recherche, ils doivent déterminer quel niveau de recherche ils veulent. À la base, nous avons tous les originaux des études de recherche et ce sont des choses comme le contrôle aléatoire des études et ce genre de choses.

Le niveau suivant serait la revue systématique dans la méta-analyse: encore une fois, la Revue systématique de la méta-analyse est effectuée par un chercheur qui regarde

toutes les recherches originales autour d'un certain sujet,
en faisant une évaluation critique de celui-ci et une synthèse, puis de mettre le tout
ensemble pour une revue systématique, donc c'est ce qui est considéré comme le niveau supérieur de recherche dans la hiérarchie des preuves. Mais tout en haut se trouve notre aide à la décision clinique,
et cette aide à la décision clinique est un outil que les prestataires de santé peuvent utiliser,
ils lisent immédiatement et ils mettent en pratique immédiatement.
Maintenant, pourquoi est-ce important? Parce que les prestataires de soins aux chevet
n'ont pas le temps de lire cent, deux cents, trois cents pages d'une revue systématique ou d'une méta-analyse et ensuite prendre une décision pour un patient: ils doivent
lire la preuve et la mettre en pratique immédiatement et c'est ce que
font les outils d'aide à la décision clinique. Tous les outils d'aide à la décision clinique
doivent être basés sur les revues systématiques, les méta-analyses, le résumé des preuves
ou les meilleurs preuves disponibles.

ARTICLE

Le terme « recherche factuelle » (EBR, evidence-based research) apparaît en 2009 pour désigner la démarche visant à mettre un terme au gaspillage considérable constaté dans la recherche biomédicale (Robinson, 2009), où les études primaires étaient réalisées sans examen systématique des preuves disponibles. Cette approche n'était considérée comme ni éthique ni scientifique (Lund, H. et al., 2017). La recherche factuelle, pour sa part, commence par un examen systématique, qui englobe des questions de recherche prédéfinies, des critères d'inclusion, des méthodes de recherche, des procédures de sélection, une évaluation de la qualité, une extraction des données et une analyse statistique (Lund, H. et al., 2017). L'examen systématique permet de comprendre et de sérier les recherches, d'envisager si elles sont nécessaires et utiles à la communauté, ou si elles représentent un gaspillage éventuel de ressources lorsqu'elles ne débouchent pas sur de nouvelles connaissances scientifiques. « Evidence », une revue en libre accès de la fondation GIMBE (Italian Group for Evidence-Based Medicine – groupement italien pour une médecine factuelle), propose une série de lignes directrices pour la conception d'un projet de recherche factuelle :

1. formuler la question de recherche préliminaire et identifier des examens systématiques pertinents ;
2. évaluer l'intérêt de l'objet, de la qualité et de l'actualisation de la recherche ;
3. évaluer, dans les détails, la population, l'intervention, la comparaison, les conclusions et l'intervalle de temps (PICOT) ;
4. évaluer la méthode utilisée et les résultats.

Enfin, les chercheurs devraient procéder à des examens systématiques afin de définir la question qu'envisagera l'étude, en justifier la nécessité pendant la demande de financement et l'approbation par la commission éthique, interpréter les résultats de la nouvelle étude dans le contexte des preuves disponibles, et formuler une série de recommandations en vue d'une future recherche. Au fil du temps, on a assisté à une croissance exponentielle du nombre de recherches factuelles, qui ont abouti à la publication d'environ deux millions d'articles dans plus de vingt mille revues. Plusieurs raisons expliquent cette croissance : la vocation pédagogique (JAMA, 1992) et le glissement de paradigme (Pagliaro & Colli, 2014) qui ont conduit à cette pratique d'une part et les atouts que présente la recherche factuelle d'autre part :

- elle permet de produire des connaissances et d'orienter la pratique professionnelle dans des domaines où une plus grande incertitude règne autour des interventions menées dans la pratique clinique ;

- elle limite le gaspillage en définissant les priorités des sujets de recherche et en tenant compte des précédents examens systématiques ;

- elle permet une description claire des plans de recherche (public cible, interventions, comparaisons, conclusions) ;

- elle produit des mises à jour et diffuse les examens systématiques ;

- elle intègre les preuves dans la pratique clinique ;

- elle permet une réévaluation continue de nos connaissances (GIMBE).

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Exemples de recherche

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VIEW UNIT IN STUDIO

Ci-après un exemple de méthode d'analyse utilisée par Bean & Creswell (1980, p 321-322):

« L'étude porte sur un petit collège (1000 inscrits – arts et lettres) mixte et religieux dans une ville du Midwest dont la population est de 175.000 habitants. L'année précédant l'étude, le taux de décrochage s'élevait à 25%. Les élèves de première et de deuxième année présentant les taux les plus élevés, la distribution des questionnaires se fait dans le but d'atteindre un nombre maximum de ces étudiants. Une analyse des taux de défection montre que les filles et les garçons décrochent pour des raisons différentes (Bean, 1978; Spady 1971). Il est donc décidé de n'examiner que le décrochage de la population féminine. Dans le courant du mois d'avril 1979, 169 filles répondent au questionnaire. La recherche porte sur un échantillon homogène de 135 femmes de 25 ans ou moins, célibataires, citoyennes américaines et caucasiennes. 71 de ces femmes sont en première année, 55 en deuxième et 9 sont des élèves du cycle moyen. Parmi ces étudiantes, 95% ont entre 18 et 21 ans. L'échantillon est biaisé en faveur des étudiantes dont les aptitudes sont plus élevées, comme le montrent les résultats au test ACT. Les données sont recueillies via un questionnaire reprenant 116 points, dont [...] la majorité utilise l'échelle Likert de « très peu » à « beaucoup ». D'autres questions concernent des informations factuelles telles que les scores Act, les notes scolaires les plus élevées et le niveau d'éducation des parents. Toutes les informations utilisées dans l'analyse étaient recueillies via le questionnaire, qui avait été élaboré et testé dans trois autres institutions avant d'être diffusé au collège. [Les auteurs ont discuté de l'instrument.] [...] Plusieurs analyses de régression et de trajectoires ont été effectuées en vue de l'examen des données. [...] »

(Creswell, 2014, pp. 181-182)

Ci-après un exemple de recherche qualitative (Cardano, Ortalda, pp. 242-243)

« L'objectif de la recherche consiste à analyser les raisons pour lesquelles les pré-adolescents commencent à fumer (Frohlich, Potvin, Chabot, Corin, 2002). Après avoir retracé la prévalence du tabagisme chez les pré-adolescents sur 32 territoires du Québec et recueilli des informations pertinentes sur les contraintes et les ressources « structurelles » qui tantôt entravent, tantôt favorisent le tabagisme au sein de cette population – la présence de bureaux de tabac, de places publiques où il est interdit de fumer, d'agents chargés du respect des règles en matière de vente de cigarettes aux adolescents et de tabagisme dans les lieux publics – les auteurs se concentrent sur huit territoires et y organisent des groupes de discussion. Sur chaque territoire, les participants sont recrutés grâce aux enseignants de l'école locale, ce qui permet de constituer des groupes de garçons et de filles qui, selon toute probabilité, se connaissent et se fréquentent préalablement à la constitution du groupe de discussion. Dans le cadre de l'étude, la connaissance préalable des participants est une ressource et non pas une limite, car elle permet aux chercheurs d'accéder à des discours moins « formatés » et plus en phase avec la vie des participants. En outre, ces derniers, confortés par le soutien de leurs pairs, peuvent aborder plus sereinement un thème – le tabagisme – qu'il serait plus compliqué de traiter face à un interlocuteur adulte. Grâce à leur connaissance du contexte ethnographique, des codes linguistiques, des pratiques sociales répandues sur les territoires où se déroulent les groupes de discussion, les auteurs sont peuvent surmonter les difficultés propres à l'organisation de discussions au sein d'un groupe naturel : le recours à des expériences communes rarement explicitées dans le discours, le recours à des expressions argotiques, etc. »

(Cardano, Ortalda, pp. 242-243)

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Les références

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Quiz 3.1

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Q3.1

4 points possible (graded)

1. Une recherche scientifique...

- ○ commence par un recueil de données ;
- ○ devrait toujours prendre en compte les connaissances déjà acquises ;
- ○ permet toujours un relevé fidèle de la réalité ;
- ○ utilise toujours une méthode unique.

2. Dans une recherche-action...

- ○ le chercheur doit entretenir une neutralité parfaite envers l'objet de la recherche ;
- ○ on tente d'extrapoler les lois inscrites dans la nature par une analyse objective des phénomènes ;
- ○ aucun changement social ne devrait être produit dans le contexte de la recherche.
- ○ on encourage la participation et la coopération des chercheurs ;

3. Parmi les étapes suivantes, laquelle NE S'INSCRIT PAS dans un projet de recherche factuelle ?

- ○ Validation de la théorie par la pratique
- ○ Evaluation des résultats
- ○ Formulation d'hypothèses de recherche
- ○ Examen systématique de la littérature existante

4. L'élément central d'une Recherche-Action Participative est :

- ○ l'accent placé sur l'idée d'une connaissance non partagée entre le chercheur et le bénéficiaire de l'intervention ;
- ○ la séparation claire et absolue entre l'action et la recherche
- ○ le choix a priori des problèmes à étudier et des outils à utiliser
- ○ l'accent placé sur l'idée d'un partage des connaissances entre le chercheur et le bénéficiaire de l'intervention ;

Invia You have used 0 of 2 attempts

Salva Show Answer

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Recherche factuelle en AST/PAT, un point de vue international

ARTICLE

Quiconque organise des services à destination de mineurs victimes de traumatismes se demande notamment comment garantir une formation adéquate et efficace des professionnels en vue d'interventions fondées sur des preuves ou factuelles (Ruzek & Rosen, 2009). Une observation globale du niveau d'application des traitements et des directives fondées sur des données probantes laisse constater, malgré l'importance du thème dans le domaine de la santé publique, des disparités d'application et un intérêt limité pour l'évaluation systématique et les effets à long terme des programmes de formation (Ruzek et Rosen, 2009). De plus, d'un point de vue comparatif, Delaney (2006) a souligné un autre aspect pertinent : au niveau international, les lignes directrices et leur application lors de traitements électifs tout au long de la pratique clinique varient considérablement au niveau national et entre les différents pays (y compris pour ce concerne les réglementations de santé publique). Weiner, Schneider & Lyons (2009) se sont penchés sur les méthodes factuelles (fondées sur des données probantes) de traitement des traumatismes chez les mineurs. Comme le précisent les auteurs, si certaines de ces méthodes ont été mises à l'essai de manière expérimentale ou quasi-expérimentale, la plupart ont été structurées pour des populations adultes, même si elles ont également été appliquées à des mineurs ; par ailleurs, elles ont été évaluées indépendamment des variables culturelles et des différences entre sous-groupes basées sur des facteurs pouvant en influencer les résultats.

A partir de ces observations, on peut se poser une question intéressante sur la validation interculturelle des traitements, ce qui permettrait non seulement d'en accroître l'efficacité, mais également d'explorer les obstacles qui entravent leur mise en œuvre, ainsi que les adaptations que l'on pourrait appliquer à certains sous-groupes ou situations spécifiques. Pour Courtois & Gold (2009) et Layne & co (2014), force est de mettre en avant le traumatisme et ses conséquences lors de la formation des professionnels, en les sensibilisant, dans un premier temps, aux conséquences qu'ont les traumatismes et leurs effets sur toutes les phases du traitement, telles que, et spécifiquement, la participation du patient, l'évaluation et la réponse au traitement. En outre, ils soulignent l'importance, dans ce but, de fixer des normes internationales et des méthodes communes de formation des professionnels aux pratiques factuelles (EBP ; Lyon et al., 2011). Pareilles pratiques (EBP) permettent aux professionnels de poser les meilleurs choix réalisables, validés et adaptés à la situation, en fonction des besoins spécifiques du client, de ses forces et de sa situation (Layne et al., 2014).

Afin de garantir une formation adéquate, la communauté scientifique doit impérativement définir une série de compétences de base, soit le minimum de connaissances que devraient posséder ceux et celles qui travaillent avec des victimes de traumatismes. Plus précisément, pareille intervention devrait améliorer la qualité des services fournis, accroître la responsabilité des professionnels et diffuser une base de connaissances partagées et, souvent, consignées dans des protocoles propres aux différentes branches (psychologie, psychothérapie, sciences sociales, psychiatrie, etc). Le "National Child Traumatic Stress Network" (NCTSN) est un réseau de professionnels, de membres de familles concernées par la problématique, de chercheurs et de partenaires internationaux désireux d'améliorer les normes de soins et l'accès aux services pour les enfants et les familles. Le NCTSN a mis au point un protocole de formation appelé CCCT (Core Curriculum on Childhood Trauma ou Programme de base pour Traumatismes de l'Enfance) (Layne et al., 2011), qui définit les principaux éléments d'intervention (en les incluant dans une matrice intégrée et fondée sur des preuves), les concepts fondamentaux propres aux traumatismes et les compétences thérapeutiques essentielles pour planifier et mettre en œuvre une intervention efficace pour les enfants victimes de traumatismes et pour leurs familles. Deux éléments apparaissent fondamentaux : les objectifs de l'intervention (ce que l'on s'attend à atteindre grâce à l'intervention) et les éléments pratiques (les procédures à appliquer afin d'obtenir les résultats visés). La formation des professionnels s'articule autour de compétences de base, via la définition de "normes d'excellence" en matière de formation aux pratiques et traitements fondés sur des données probantes (EBTT, Evidence-Based Trauma Treatments).

Le CCCT (Programme de base) comprend cinq niveaux : a) Base de données empiriques ; b) 12 concepts de base pour comprendre les réactions au stress traumatique chez les enfants et les familles ; c) objectifs d'intervention ; d) éléments pratiques (actions observables mises en œuvre pour atteindre les objectifs) ; e) aptitudes thérapeutiques (avec deux sous-niveaux : 1) procédures et processus ; et 2) évaluation). Le modèle susmentionné s'appuie sur des pratiques et des compétences factuelles, comme l'évaluation systématique et la collecte d'informations, la théorie de la pratique, l'application de résultats tirés de la documentation scientifique aux situations individuelles des patients, la conceptualisation des cas et la planification des interventions. Dans le cadre de l'examen et de la mise en œuvre du modèle CCCT, un groupe de travail a prévu une séance spécifique de perfectionnement des compétences en analyse statistique et de structuration des protocoles d'étude utiles pour la validation des pratiques cliniques. Ce qui ressort ici est l'intention de développer à la fois des aspects théoriques et des méthodes d'évaluation (multidimensionnelles), ainsi que la base empirique accessible pour l'évaluation et la validation des interventions (en particulier, au niveau des résultats, les facteurs entrant en ligne de compte et l'efficacité des interventions axées sur la situation particulière d'une personne). Briggs & collègues (2012) identifient ensuite comme priorité l'amélioration des normes par « [...] l'élaboration, la mise en œuvre et la diffusion fondées sur des preuves » (p. 1). La structuration des lignes directrices d'intervention - destinées à identifier les meilleurs objectifs et méthodes optimales d'identification (quelle est la meilleure intervention dans des circonstances spécifiques ?), tout en évaluant les résultats - est fondamentale pour les professionnels et pour ceux et celles qui sont chargé.e.s de la structuration des services.

Les modèles de recherche s'avèrent utiles quand ils tiennent compte de l'interconnexion entre les facteurs de risque et les différents résultats afin d'identifier les éléments sur lesquels l'intervention pourrait être axée et, de façon récursive, d'inclure de nouveaux aspects dans la compréhension théorique du traumatisme et de complexifier le cadre scientifique. En fait, il est particulièrement intéressant de noter que les traitements visant à atténuer les symptômes post-traumatiques permettent également de réduire les difficultés fonctionnelles non directement liées à l'objet du traitement ; on peut en déduire qu'un traitement axé sur le traumatisme peut avoir des effets larges et positifs (Layne et coll., 2010).

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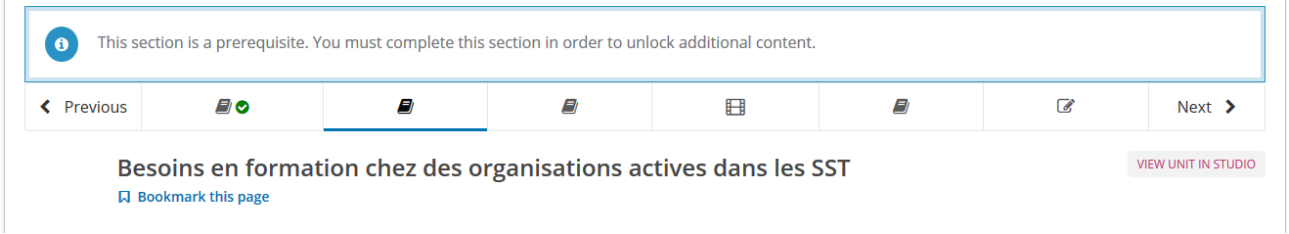

ARTICLE

Bryson et ses collaborateurs (2017) posent un préalable intéressant qui permet de distinguer deux niveaux de réflexion applicables à l'analyse et à l'évaluation des thèmes du présent module. Les auteurs établissent une distinction entre les traitements spécifiques aux traumatismes d'une part (c'est-à-dire les techniques d'intervention visant à réduire les symptômes liés aux traumatismes) et, d'autre part, les soins sensibles aux traumatismes (SST ou TIC) en tant qu'approche globale visant une transformation du système de soins, y compris, lorsqu'il s'agit de SST, une meilleure compréhension des réponses au stress lié aux traumatismes à tous les niveaux et dans tous les aspects de l'organisation des services. Malgré les nombreuses demandes d'appliquer les principes des SST (TIC) aux services et en dépit des avantages éventuels de pareille décision, les contributions scientifiques sur la mise en œuvre de soins sensibles aux traumatismes pour les patients mineurs sont, malheureusement, limitées (Bryson et al., 2017). Ruzek & Rosen, dès 2009, observaient que les organisations d'aide aux victimes de traumatismes privilégiaient la diffusion de traitements fondés sur des données probantes axés sur les symptômes post-traumatiques et constataient, par conséquent, une augmentation de la documentation scientifique portant sur les facteurs organisationnels liés à l'application et la diffusion des bonnes pratiques.

Cependant, une analyse préalable réalisée par Delaney (2006), confirmée par Ruzek & Rosen (2009) et par Bryson et co (2017) eux-mêmes, indiquait une forte volatilité des taux d'utilisation des pratiques, comme la contention et l'isolement. Qui plus est, comme l'ont souligné Valenkamp et co (2014), puis Bryson et co (2017), peu d'études ont testé l'efficacité de ces interventions par rapport aux autres méthodes d'admission. La volatilité des méthodes d'intervention, selon Ruzek & Rosen (2009), imposerait de procéder à une analyse comparative des lignes directrices et des meilleures pratiques internationales afin de les ancrer davantage, d'un point de vue politique, dans le champ des propositions de changement organisationnel et des pratiques factuelles. Bryson et co (2017) tentent, par un examen systématique de la littérature scientifique, de mettre en évidence les facteurs qui expliquent l'efficacité des soins sensibles aux traumatismes, pour quel type d'utilisateur, dans quelles circonstances, dans quelle direction et pourquoi. Les stratégies les plus largement partagées dans les contributions scientifiques sont : 1) un leadership axé sur le changement ; 2) l'utilisation des données de recherche pour éclairer la pratique ; 3) la formation approfondie du personnel ; 4) l'utilisation d'outils qui empêchent la contention et l'isolement ; 5) le rôle des usagers lors de leur séjour ; 6) les techniques de verbalisation. Face à la nécessité d'analyser la complexité opérationnelle de ces éléments tout en les reliant aux particularités territoriales et organisationnelles, les auteurs choisissent de solliciter des services permettant l'application de soins sensibles aux traumatismes afin de démontrer, à travers le processus de recherche scientifique et dans une perspective longitudinale, l'efficacité des efforts et des changements appliqués pour améliorer la sécurité des patients, ainsi que les résultats à long terme des traitements. Dans le droit de fil de cette approche, Lang et co (2016) soulignent l'importance d'un consensus sur les éléments constitutifs d'un service sensible aux traumatismes et sur la façon de mesurer efficacement les facteurs correspondants. Tout d'abord, les questions centrales sont les suivantes : comment mettre en place une procédure de dépistage optimale ? Comment opérationnaliser au mieux les principes fondateurs des soins sensibles aux traumatismes dans le traitement quotidien de sujets exposés à des événements potentiellement ou certainement traumatisants ? Et quelles peuvent être les meilleures méthodes pour améliorer les services offerts à ceux-ci ? À l'heure actuelle, peu de recherches portent sur l'efficacité des changements apportés aux méthodes d'admission des patients dans les organisations qui appliquent les principes des soins sensibles aux traumatismes, ou sur la pertinence et l'utilité de ces changements au niveau de la santé des usagers participants. Un défi souligné par les chercheurs pourrait, en fait, être l'intégration des recherches sur les pratiques factuelles (EBP) et des meilleures pratiques en la matière afin d'améliorer la qualité de mise en œuvre propres à ces services (tout en analysant l'ampleur de l'impact économique de ces initiatives), par le développement des

compétences du personnel, des procédures de dépistage et des capacités de changement politique. Dans ce processus, un rôle crucial peut être joué par les dirigeants, qui devraient soutenir un processus de changement, parfois radical, même au niveau de la culture organisationnelle (en mettant, par exemple, l'accent sur l'importance des soins sensibles aux traumatismes).

Si une formation sur les traumatismes est un élément essentiel, elle ne suffit pas pour certifier qu'une organisation est réellement sensible aux traumatismes. Un autre aspect important, comme le précisent Kramer et co (2013), est la collaboration entre les différentes agences chargées de l'aide aux mineurs et à leurs familles, qui devraient éventuellement adopter les principes des soins sensibles aux traumatismes. Sur ce dernier aspect, les auteurs ont analysé l'efficacité d'une formation visant l'acquisition de connaissances spécifiques relatives à l'administration longitudinale d'outils d'enquête adéquats (avant et après la formation), ainsi qu'une enquête de suivi analysant dans quelle mesure ces compétences acquises entraînent des changements dans le service concerné. Sur ce point spécifique, soulignons l'intérêt d'une analyse des obstacles rencontrés par l'ensemble du personnel et de la structuration d'une recherche comparative (auprès de groupes aléatoires) afin d'examiner l'utilité des différentes stratégies employées et les besoins de formation continue, également de manière longitudinale.

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Diffusion de recherches sur la traumatismes en milieu organisationnel

ARTICLE

Dans un exposé sur la diffusion des recherches en milieu organisationnel, Ruzek et Rosen (2009) en soulignent la complexité : les modèles traitant de la diffusion ont mis en évidence sa dépendance à de multiples facteurs interagissant entre eux à différents niveaux (individuel et organisationnel). Pour Briggs et co (2012), s'il est reconnu qu'un changement dans les connaissances représente le premier pas vers un changement organisationnel, il est tout aussi fondamental de vérifier dans quelle mesure cela se traduit par un changement de comportement réel. Deux aspects semblent importants : la complexité systémique et verticale de la diffusion d'un contenu scientifique au sein des organisations et le processus liant les connaissances et la pratique par un mécanisme complexe de changements individuels et organisationnels. Ce processus met en évidence l'une des résistances les plus fréquentes à la mise en œuvre de nouvelles pratiques exemplaires : la perception que le choix de leur application dans l'organisation est imposé « par le sommet », sans que les cliniciens ne le soutiennent suffisamment (Rohrbach et al., 2006 ; Ruzek & Rosen, 2009). En effet, et dans ce cas, la motivation des professionnels à changer leur pratique organisationnelle est un aspect central.

Comme le suggèrent les contributions des chercheurs, lorsqu'un changement repose sur un accord négocié entre les dirigeants et leurs subordonnés, tenant compte des besoins locaux, il est plus susceptible de réussir (Durlak et DuPre, 2008 ; Ruzek et Rosen, 2009). Un autre thème central est le fait que les organisations de soins de santé n'ont souvent, dans leur personnel, aucune personne chargée spécifiquement de mener des recherches sur des pratiques factuelles (BPE), ni d'étudier les meilleures pratiques et stratégies pour leur application, ni, plus précisément, d'analyser ou d'intégrer de manière systématique et continue les résultats de recherches scientifiques (Berwick, 2003 ; Ruzek & Rosen, 2009). A cet égard, Marvin et Volino Robinson (2018) soulignent que les organisations doivent se doter d'une vision qui envisagerait l'analyse de l'institution ou du service lui-même à la lumière de sa capacité ou de sa préparation à accueillir et à soutenir des interventions de changement (la littérature parle de « préparation organisationnelle », qui peut être mesurée à l'échelle organisationnelle, collective ou individuelle). Prendre en compte cette dimension lors de la phase de planification peut certainement contribuer à pérenniser les nouvelles pratiques, à analyser les obstacles éventuels dans le processus et à conserver une attitude positive envers le changement organisationnel. Dans ce cadre, force est de constater l'importance centrale à accorder à la recommandation visant à élaborer des stratégies ciblées vers le changement dans une organisation donnée (Augustsson et coll., 2017 ; Marvin et Volino Robinson, 2018). La recherche démontre l'importance du leadership et d'une vision managériale dans la co-construction du processus de changement en phase avec les professionnels et dans le partage d'une culture orientée vers l'application des soins sensibles aux traumatismes, qui se concentrerait en tout premier lieu sur l'analyse des besoins du personnel.

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Recherches dans les services axés sur les traumatismes

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Des soins sensibles aux traumatismes

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ARTICLE

On pourrait définir les TIC (soins sensibles aux traumatismes) comme une approche factuelles permettant de réagir à un traumatisme, mettant l'accent sur la capacité (ou l'incapacité) des membres du personnel à s'inscrire dans une vision des soins d'un patient victime de traumatismes susceptible ou non de déboucher sur des stratégies d'atténuation des risques de retraumatisme de l'usager concerné (Marvin & Volino Robinson, 2018). Dans ce contexte, il est fondamental de prendre soigneusement en compte la complexité des cas de traumatismes générés par des expériences différentes et individuelles. Les politiques, les procédures et le fonctionnement quotidien des soins pourraient constituer de nouvelles expériences traumatisantes ou susciter des réactions liées au fonctionnement individuel de la personne traumatisée, l'empêchant de recevoir les soins dont elle a besoin. Pour éviter ces situations et d'éventuelles frustrations dans le chef des membres du personnel, il pourrait être utile de recourir à des bonnes pratiques spécialement structurées et reconnues à l'échelle internationale (voir, par exemple, les stratégies préconisées par la SAMHSA en 2014). En phase avec cet objectif, les organisations qui appliquent l'approche des soins sensibles aux traumatismes sont invitées à envisager l'impact que peuvent avoir les soins apportés à des sujets porteurs d'histoires traumatisantes sur les membres du personnel dans les services cliniques (SAMHSA, 2014 ; Knight, 2015) et comment aider les professionnels, par la formation et un leadership sensibilisé aux traumatismes, à conserver un bon niveau de bien-être et d'efficacité dans leurs interventions (Manderscheid, 2009). Ruzek et Rosen (2009) ont examiné dans les détails les facteurs qui déterminent la prise en compte, par les services, des résultats de recherches menées sur les pratiques factuelles de traitements des traumatismes. Lorsqu'on évalue de manière attentive les processus de diffusion des pratiques et des recherches, le champ d'analyse se compose de multiples facteurs pouvant influencer l'évolution du processus de soins, la relation des patients ou des usagers potentiels avec les services, la méthode utilisée par les cliniciens pour apprendre de nouvelles techniques de traitement, les changements de type "transformation comportementale" au sein des organisations. Certes, selon les auteurs, il est de plus en plus urgent, dans l'application de la recherche empirique à ce domaine, de valider ou de soutenir les méthodes de traitement applicables d'une manière économiquement pratique. Les chercheurs, en particulier, ont analysé le rôle des facteurs propres aux professionnels et liés aux résultats que la recherche a mis en évidence. Ils observent que, si les évaluations réalisées par des professionnels spécialisés dans le stress traumatique (en particulier ceux ou celles s'occupant de stress post-traumatique) à propos d'une pratique spécifique, de leurs compétences et caractéristiques (par exemple leur niveau d'auto-efficacité), de leur volonté de changer les pratiques opérationnelles (par exemple, adopter une meilleure pratique spécifique en l'intégrant dans leur fonctionnement quotidien) sont autant de facteurs déterminants, elles ne font l'objet que d'études empiriques limitées. Parmi les variables pesant le plus sur leur acceptation de pratiques factuelles, indépendamment de leur cadre théorique, les professionnels citent principalement l'accessibilité aux programmes de formation aux pratiques fondées sur des données probantes (EBP) et leurs questionnements à propos de l'applicabilité des innovations dans les domaines de recherche propres à leur population spécifique (problème de la généralisation des résultats). La méthode de formation qui semble particulièrement efficace pour promouvoir un changement comportemental lors d'une prise en charge semble être la formation intensive, surtout lorsqu'elle exige la démonstration des compétences nécessaires et une mise à l'épreuve par le biais d'une participation interactive aux cours (avec une supervision régulière et donc au-delà des moments de formation et de formation des formateurs).

A propos des facteurs d'innovation, les auteurs soulignent que la perception qu'ont les patients et les professionnels des traitements est un élément essentiel de leur adoption, notamment pour tout ce qui concerne leur efficacité prouvée (même en cas de comparaison avec d'autres méthodes). Pour ce qui est des facteurs systémiques, ils observent que l'existence d'espaces de supervision et d'un soutien administratif et organisationnel conditionne l'application réussie d'une bonne pratique (Fixsen et al., 2005). Plus important encore, il est nécessaire d'apporter une aide empirique à la création de systèmes de soins sensibles aux traumatismes (Ko et coll., 2008 ; Ruzek et Rosen, 2009). De plus, évaluer la mise en œuvre du traitement permet de déterminer dans quelle mesure une pratique factuelle répond aux exigences de diffusion, d'efficacité et de respect des procédures (Rosenheck, 2001b ; DuFrene, Noell, Gilbertson et Duhon, 2005 ; Durlak et DuPre, 2008 ; Ruzek et Rosen, 2009). Citons comme aspect particulièrement intéressant l'analyse menée par Rosenheck (2001a) sur le processus d'interaction mutuellement récursif entre les pratiques fondées sur des preuves (dans leur dimension générale et prescriptive) et les expériences et exigences locales de leur mise en œuvre. L'objectif de suivi, même en dépit du coût des investissements en ressources économiques et en temps consacrés aux services, devrait donc permettre aux [services] de se concentrer sur des éléments cruciaux pour garantir les résultats et l'efficacité du traitement (Ruzek et Rosen, 2009). L'une des questions clés à se poser serait la suivante : comment les modifications apportées par le clinicien en réponse à des besoins spécifiques pourraient-elles réduire, augmenter ou ne pas modifier les effets de l'intervention (Ruzek et Rosen, 2009) ?

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Quiz 3.2

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VIEW UNIT IN STUDIO

Q3.2

3 points possible (graded)

1. Une étude de Ruzek et Rosen (2009) a montré que, dans le contexte international des traitements liés aux traumatismes :

- ○ les traitements ont été appliqués uniformément dans différents pays, ce qui souligne l'efficacité des approches utilisées ;
- ○ la mise en oeuvre des programmes variait grandement, d'où l'impérieuse nécessité de définir les compétences de base ;
- ○ les besoins de sous-groupes spécifiques ont été adéquatement pris en compte ;
- ○ les mêmes traitements avaient le même niveau d'efficacité chez les adultes et chez les enfants.

2. Des soins sensibles aux traumatismes...

- ○ visent à atténuer les seuls symptômes liés au traumatisme, en mettant l'accent sur les techniques d'intervention ;
- ○ mettent en œuvre des techniques telles que la contention et l'isolement ;
- ○ sont exclusivement utilisés avec des mineurs.
- ○ visent à transformer le système de soins en mettant l'accent sur la capacité du personnel à participer à un projet de prise en charge du patient victime de traumatismes ;

3. L'un des avantages de la diffusion de données scientifiques dans les organisations sensibles aux traumatismes est :

- ○ la possibilité d'entamer un processus de mise en œuvre des pratiques factuelles les plus récentes, pour améliorer le bien-être du personnel et des patients;
- ○ la possibilité d'exprimer un intérêt exclusif pour les questions relatives aux groupes de travail ;
- ○ l'application des principes de données probantes suite à une décision imposée par la direction ;
- ○ la transition vers des traitements génériques efficaces pour tous les patients.

Invia You have used 0 of 2 attempts

Salva Show Answer

SUBMISSION HISTORY STAFF DEBUG INFO

This subsection is unlocked for learners when they meet the prerequisite requirements.

Definitions et prealables

ARTICLE

Guyadeen & Seasons (2018) soulignent que, comme bien d'autres disciplines, « la planification possède son propre système d'évaluation » (p. 98). Elle se subdivise en deux parties : « l'évaluation du plan et l'évaluation de la planification. Traditionnellement, l'évaluation de la planification était indépendante de l'évaluation du programme et nécessitait l'utilisation d'approches d'évaluation spécifiques. Actuellement, la discipline de la planification estime préférable de nouer des liens solides entre l'évaluation du programme et l'évaluation de la planification » (p. 98). Dans le système de santé publique, l'évaluation joue un rôle essentiel dans la conception des politiques et de la planification programmatique. « Les deux processus prévoient l'identification d'un problème et une phase de définition » (p.99), suivie de phases de formulation, de mise en œuvre et enfin d'évaluation. La dernière phase vise à évaluer la réussite de l'intervention et à identifier des points à améliorer dans le programme (Pal, 2014; Guyadeen & Seasons, 2018). Comme le précisent Guyadeen et Seasons (2018): « Il s'agit d'un processus structuré qui vise à générer et à synthétiser des informations sur les interventions afin de porter des jugements sur les changements qui en résultent, sur la pertinence d'une intervention et sur le degré d'adaptation entre les résultats escomptés et les résultats inattendus (McDavid & Hawthorn, 2006) » (p. 99). Le processus d'évaluation peut également se concentrer sur le rapport coût-efficacité des programmes et des plans et peut être considéré comme particulièrement pertinent pour les organisations du secteur public : des raisons liées à la responsabilité politique et juridique obligent les gestionnaires à prouver les avantages de leurs actions ou propositions à l'opinion publique et à la communauté (Vedung, 2010; Guyadeen & Seasons, 2018).

Craig et collègues (2008) signalent « que les interventions complexes sont largement répandues dans les services de santé, dans les pratiques de santé publique et dans les domaines de la politique sociale qui pèsent lourdement sur la santé » (p. 1). Ces initiatives sont autant de défis pour les responsables de l'évaluation, Au-delà des difficultés d'application et de méthodologie que les processus d'évaluation de la réussite d'une initiative doivent normalement aborder. En effet, « les interventions complexes sont généralement définies comme des interventions comportant plusieurs composantes en interaction » et présentent « des caractéristiques multiples que les évaluateurs doivent prendre en compte » (Craig et al., 2008, p. 1). Voici des exemples de questions à poser lors de l'évaluation d'interventions complexes : ces interventions sont-elles efficaces dans la pratique quotidienne ? Les effets varient-ils en fonction du groupe cible ou du contexte ? Comment fonctionne l'intervention ? Quelles en sont les composantes principales et comment agissent-elles ?

En général, sous l'angle des procédures et des processus, les meilleures pratiques consistent à créer des interventions systématiques. En d'autres termes : « les meilleures pratiques consistent à élaborer des interventions de manière systématique en utilisant les meilleures preuves disponibles et une théorie adaptée. Et, ensuite, à les tester en utilisant une approche soigneusement échelonnée. Il convient de commencer par une série d'études pilotes ciblant chacune les principales incertitudes de la conception et d'enchaîner sur une évaluation d'abord exploratoire et ensuite définitive. Les résultats doivent être diffusés aussi largement et de manière aussi persuasive que possible et une future recherche envisagée afin de soutenir et de suivre le processus de mise en oeuvre » (Craig et al., 2008, p. 2).

Afin de préciser les éléments constitutifs de ce processus complexe, Rychetnik, Frommer, Hawe & Shiell (2002) nous proposent les définitions suivantes :

INTERVENTION : elle peut être conçue comme un ensemble d'actions visant un objectif de transformation ou de production de résultats identifiables. Les interventions dans la santé publique visent principalement à promouvoir un plus grand bien-être ou à protéger l'état de santé alors que les interventions cliniques ont généralement pour but la prévention ou le traitement de la souffrance chez les individus.

CONTEXTE : il fait référence au milieu social, politique et/ou organisationnel dans lequel l'intervention est prévue/conçue, réalisée et évaluée. Les caractéristiques contextuelles pertinentes pour une intervention varient selon le type d'intervention. Pour les interventions dans la santé publique, les facteurs politiques, organisationnels, socio-économiques, démographiques et environnementaux sont importants.

EVALUATION : il s'agit du processus qui définit la valeur d'une intervention en la comparant à des normes prédéterminées et définies.

PREUVE : elle suppose une lecture interprétative des données recueillies grâce à la recherche officielle ou à des enquêtes spécifiques réalisées selon des normes relevant de la méthode scientifique. La pratique factuelle souligne et traite les conséquences voulues d'une intervention et mesure l'efficacité décisive (aussi en matière de coûts) sur base des données relatives à la mise en œuvre et des résultats de l'intervention.

En outre, les PROGRAMMES comportent une série d'activités visant un résultat connexe spécifique ou une série d'objectifs (McDavid & Hawthorn, 2006; Pal, 2014; Guyadeen & Seasons, 2018). En règle générale, les programmes sont conçus pour transformer les ressources en activités afin d'arriver au résultat escompté (McDavid & Hawthorn, 2006; Guyadeen & Seasons, 2018). Les PLANS, qui peuvent présenter les caractéristiques d'un guide, d'un projet de programmation ou de planification, peuvent jouer un rôle prépondérant dans l'organisation des interventions ou des initiatives en faveur d'une communauté (Baer 1997; Ryan, 2011; Guyadeen & Seasons, 2018). Ils peuvent viser des objectifs globaux car ils présentent une vision basée sur les futurs développements : ils comportent des faits, des objectifs et des politiques pouvant se traduire en un modèle de développement physique ou tangible et s'attaquer à plusieurs problématiques de la communauté (Berke et al., 2006). Les programmes peuvent s'inscrire dans des stratégies de réalisation d'un plan (Guyadeen & Seasons, 2018). Comme l'expliquent Guyadeen & Seasons (2018): « Il est essentiel de signaler que les plans sont des outils évolutifs, à réexaminer et à actualiser sans cesse en fonction de l'évolution des besoins, des connaissances et des expériences (Brody 2003). A ce propos, l'évaluation est essentielle pour garantir l'applicabilité et la pertinence des plans et des programmes » (p. 99).

Premièrement, l'évaluation peut être envisagée comme « une discipline empirique qui génère des informations sur des programmes » (Guyadeen & Seasons, 2018, p. 99) afin de les améliorer et/ou d'orienter les futures décisions. Deuxièmement, l'accent est placé sur le fonctionnement ainsi que sur les résultats du programme. Nous entendons par là que l'évaluation ne concerne pas uniquement l'efficacité du programme, mais s'étend au processus. En effet, elle se concentre sur la manière dont sont gérés les programmes ; elle prévoit une analyse des méthodologies organisationnelles appliquées dans la réalisation du programme, les informations utilisées (par exemple, les ressources), les résultats (par exemple, les mesures concrètes) et le rapport coût-efficacité (Howlett, Ramesh & Perl, 2009; Guyadeen & Seasons, 2018). Enfin, l'évaluation du programme est utilisée pour tenter de rendre les programmes plus efficients et efficaces (Weiss, 1998; Guyadeen & Seasons, 2018), garantir la responsabilité et la qualité (Cousins et al., 2014; Pal, 2014; Guyadeen & Seasons, 2018).

Par conséquent, les décisions concernant les interventions dans le domaine de la santé publique devraient reposer sur une évaluation approfondie des points forts des innovations proposées, mais également des lacunes et des points faibles liés aux éléments probants qui sous-tendent leur application (Rychetnik et al., 2002). Des guides critiques sur l'évaluation des interventions, qui définissent et évaluent les différentes facettes des éléments probants, permettent de tenir suffisamment compte des questions telles que la pertinence et la transférabilité, et présentent des recommandations spécifiques et légitimes concernant la pratique (Rychetnik et al., 2002). Toutefois, il importe également de dégager un équilibre entre l'évaluation rigoureuse et les principaux objectifs si l'on veut maintenir une distinction entre l'évaluation systématique des preuves disponibles et le processus socio-économique complexe qui détermine les décisions politiques et pratiques (Rychetnik et al., 2002).

En outre, Rychetnik, Frommer, Hawe et Shiell (2002) soulignent « la différence entre l'évaluation des preuves et le processus de prise de décisions politiques et opérationnelles concernant la mise en œuvre des interventions. Les faits établis de façon scientifique figurent parmi les éléments pris en considération dans ces décisions » (p. 119). Les auteurs précisent en outre que :

"...les interventions dans le domaine de la santé publique sont généralement complexes, programmatiques et contextualisées. Les preuves de leur efficacité doivent être suffisamment complètes pour englober cette complexité. L'évaluation des preuves doit faire la différence entre la fiabilité du processus d'évaluation du degré de réussite ou d'échec d'une intervention et le succès ou l'échec relatif de la dite intervention. De plus, si une intervention échoue, les preuves doivent aider à comprendre si l'intervention était fondamentalement déficiente (concept ou théorie de l'intervention erroné) ou si elle a été mal réalisée (échec de la mise en oeuvre). Par ailleurs, pour bien interpréter les preuves, il convient de disposer d'informations descriptives adéquates sur l'intervention et son contexte afin de pouvoir déterminer la transférabilité des preuves » (p. 119).

Comme Craig et collègues (2008) le font remarquer, dans la pratique, l'évaluation se fait au prix de nombreuses démarches, qui influencent le choix entre les interventions et les méthodes d'évaluation. De plus, dans le cas d'interventions complexes, plusieurs sources (par exemple, l'acceptation politique) peuvent renseigner les chercheurs et influencer le choix d'un programme d'évaluation idéal. Par ailleurs, si les méthodes expérimentales sont de plus en acceptées pour évaluer les politiques, des objections politiques et éthiques peuvent en limiter l'utilisation. L'évaluation devrait jouer un rôle essentiel dans l'approche critique d'une intervention. Si les gestionnaires décident d'appliquer des méthodes non-expérimentales, ils devraient être au fait de leurs limites méthodologiques et dès lors, interpréter et diffuser les résultats avec prudence. Dans ce contexte, les chercheurs « devraient être prêts à expliquer aux décideurs qu'il faut mener un travail de développement adéquat, à leur présenter les avantages et les inconvénients des méthodes expérimentales et non-expérimentales, ainsi que les compromis nécessaires si on opte pour des méthodes moins satisfaisantes. Ils devraient être prêts à contester le choix des décideurs lorsque ceux-ci privilégient des interventions dont l'efficacité incertaine risque de compliquer la consolidation des preuves par une évaluation rigoureuse ou lorsqu'un changement de la stratégie de mise en œuvre pourrait déboucher sur une évaluation plus informative » (Craig et al., 2008 p. 2).

Plus concrètement, les chercheurs (Craig et al., 2008) soulignent que pour développer une intervention complexe, le processus d'évaluation doit suivre une séquence d'actions précise :

1. identifier les preuves existantes - analyses déjà publiées ou diffusées dans la communauté scientifique sur des interventions similaires (examen systématique et rigoureux des preuves pertinentes, notamment des méthodes utilisées pour évaluer le processus et les résultats) ;

2. définir et développer une théorie - la logique de programmes complexes d'intervention, les résultats escomptés et la manière dont sera réalisée la transformation doivent parfois être explicités. L'une des premières tâches à accomplir consiste à « développer une compréhension théorique de l'éventuel processus de transformation en s'inspirant des preuves et théories existantes et, si nécessaire, en menant une nouvelle recherche primaire complémentaire. Cette tâche doit être réalisée indépendamment du propos (mise au point ou évaluation d'une intervention par le chercheur) » (p. 2) ;

3. modéliser le processus - structurer un modèle précis d'intervention complexe avant de réaliser une évaluation complète permet aux gestionnaires d'intégrer et de recueillir des informations utiles pour la conception de l'intervention et pour son évaluation. Il pourrait s'avérer nécessaire de réaliser d'autres études pour affiner progressivement le projet avant la réalisation d'une évaluation globale. L'évaluation financière constitue un autre aspect intéressant de la phase de conception primaire, car elle peut aider les porteurs de projets à repérer et corriger les points faibles.

Enfin, les chercheurs devraient prêter attention aux énoncés généraux sur les modèles pouvant convenir aux types d'intervention en fonction des différentes questions et circonstances, puis choisir un modèle d'étude basé sur les caractéristiques spécifiques telles que l'effet de taille attendu et la probabilité d'une sélection ou d'un biais de répartition. « Une connaissance de tout l'éventail d'approches expérimentales et non-expérimentales devrait permettre des choix méthodologiques plus judicieux » (Craig et al., 2008, p. 3).

Les processus d'évaluation des programmes peuvent se répartir dans deux catégorie distinctes : l'évaluation formative et l'évaluation récapitulative. On considère comme formatives les évaluations visant l'amélioration des performances d'un programme, car elles permettent d'améliorer les résultats des programmes ou leur efficacité (McDavid & Hawthorn, 2006; Posavac & Carey, 2007; Guyadeen & Seasons, 2018). Les bilans de formation donnent des informations utiles pour des décisions rapides sur le programme (comme l'amélioration de certaines parties et/ou la modification de processus) (Shadish, Cook & Leviton, 1991; Guyadeen & Seasons, 2018). Les évaluations axées sur les résultats, menées après ou tout juste avant la fin d'un programme, donnent des informations sur la réalisation des objectifs du programme et/ou sur la pertinence de la poursuite du processus (McDavid & Hawthorn, 2006; Posavac & Carey 2007; Shadish, Cook & Leviton, 1991; Guyadeen & Seasons, 2018).

En résumé, comme le signalent Wandersman et collègues en 2000, le processus d'évaluation est complexe et articulé (Figure 1).

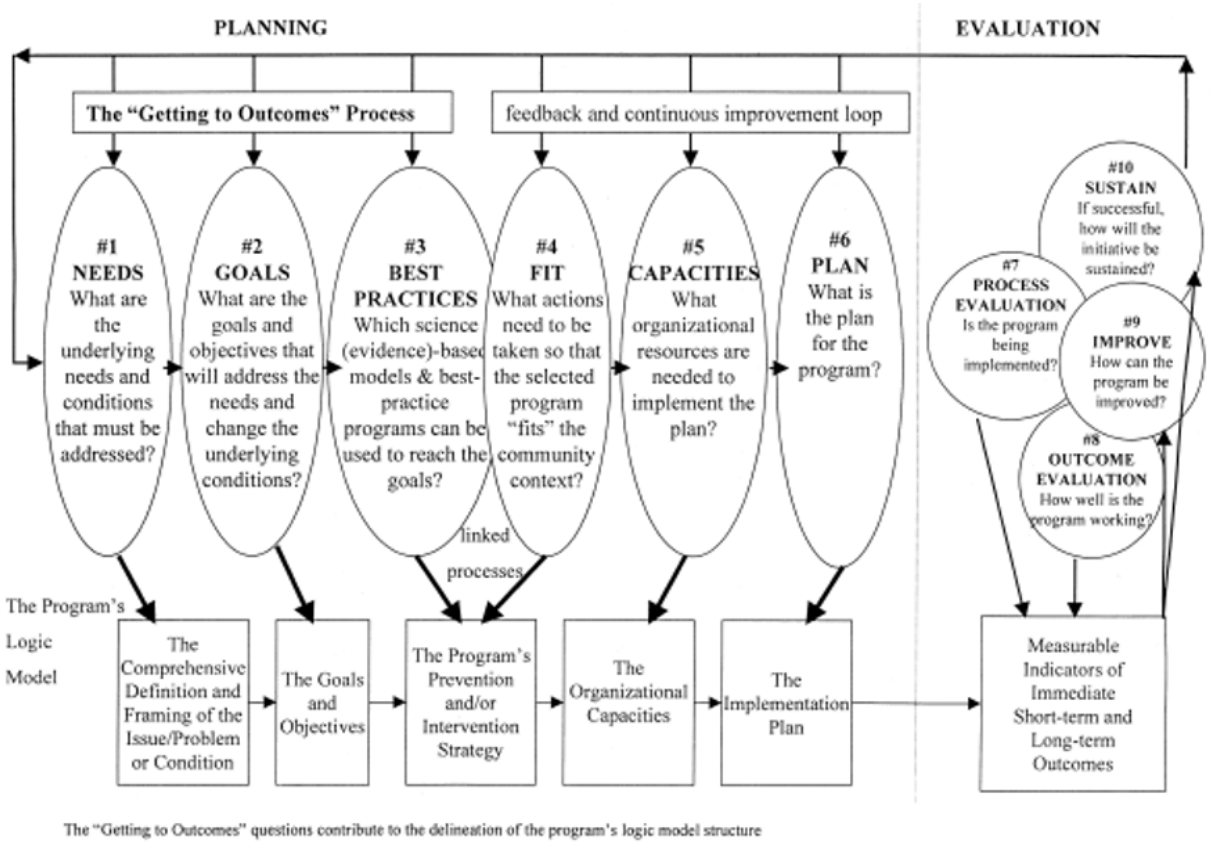

Fig. 1. The getting to outcomes framework.

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Evaluation de l'efficacite et de l'experience

ARTICLE

Selon Guyadeen & Seasons (2018), « le modèle d'évaluation historiquement dominant est le modèle scientifique à grande technicité, axé sur les méthodes quantitatives ». Les méthodes et techniques de recherche scientifiques, comme les plans et expériences de recherche systématiques et alléatoires font partie intégrante du processus d'évaluation (Alkin 2013). Cette approche de l'évaluation se concentre sur la mesure de l'efficacité et de l'efficience (Greene 1994) » (p. 100).

Depuis longtemps, les intellectuels travaillent, non sans désaccord, sur son évaluation, ses objectifs, son contenu et ses indicateurs (Jacobson et al., 1999). Par exemple, une des pratiques d'évaluation courantes consiste à évaluer la manière (surtout en termes quantitatifs) dont les programmes encouragent ou entravent la réalisation des objectifs. Cette méthode exige de fixer des objectifs clairs et des indicateurs conformes. L'évaluation de l'efficacité est un processus complexe, qui ne dispense pas de la prise de décisions pertinentes : comme Craig et collègues (2008) le soulignent à propos de l'évaluation de l'efficacité d'une intervention, la randomisation reste une méthode de choix (car, par exemple, elle évite les erreurs de sélection). Si un essai randomisé conventionnel entre groupes parallèles ne convient pas, d'autres plans d'étude méthodologique randomisée doivent être envisagés ou, si une approche expérimentale est impossible, des projets quasi-expérimentaux ou d'observation sont envisageables.

Lors de l'analyse des résultats d'une intervention, si le plan de recherche suit une méthode scientifique, il vise à confirmer ou infirmer l'existence d'un lien de causalité entre l'intervention et ses effets, et à comprendre les raisons de son efficacité ou de son inefficacité. Le plan d'étude définit également le niveaux des preuves qui en découlent. L'examen systématique des essais randomisés contrôlés (RCTs) est l'une des méthodes reconnues la plus communément utilisée pour fournir les éléments probants les plus solides sur les effets des interventions de prévention et/ou de traitement (Rychetnik, Frommer, Hawe & Shiell, 2002). Il peut s'avérer nécessaire d'assurer un suivi sur le long terme afin de déterminer si les résultats escomptés sont avérés ou si des modifications sur le court terme persistent : « bien qu'atypiques, de telles études peuvent être extrêmement informatives » (Craig et al., 2008, p. 3).

Par ailleurs, les niveaux de preuves lors de l'évaluation d'interventions dans la santé publique font l'objet d'analyses approfondies dans la littérature scientifique car ils dépendent du critère utilisé pour évaluer leur crédibilité. A ce propos, l'utilisation des essais randomisés contrôlés dans l'examen des interventions de santé publique continue à susciter la controverse ; notamment en raison de la difficulté de ces études causée par la complexité programmatique des interventions, l'analyse des résultats et à tendance à sous-estimer l'apport des études d'observation. En raison de leur nature, de nombreuses interventions publiques exigent des stratégies d'analyse flexibles et multiples et, selon les auteurs, leur appliquer des études basées sur des modèles d'essais randomisés contrôlés classiques s'avère difficile (principalement parce qu'ils demandent une normalisation très stricte de l'intervention et reposent sur l'hypothèse d'une randomisation basée sur des unités individuelles). Dans leur analyse, les chercheurs soulèvent un point important : l'application de méthodologies non randomisées, lorsque cela est possible, risque de déboucher sur une perte considérable et insoutenable de pertinence ; mais, comme le soulignent Rychetnik et collègues (2002) :

« le seul plan d'une étude n'est pas un critère suffisant pour définir la crédibilité des preuves liées aux interventions dans la santé publique » (p. 121).

Interprétation des résultats

Le processus d'évaluation est un des aspects centraux lors de la conception ou de la mise en oeuvre d'une intervention, indépendamment de ses résultats positifs ou négatifs. En effet, la littérature scientifique (Rychetnik et al., 2002) considère essentielles l'application correcte des procédures prévues dans le programme de l'intervention et l'utilisation de bons indicateurs dans le suivi du processus.

Les théories sur lesquelles reposent les interventions, leur cahier des charges (explication et plausibilité) en lien avec les hypothèses de base concernant l'efficacité et la fonctionnalité des mesures de résultats et d'incidence sont autant de critères importants pour l'évaluation et l'interprétation de la qualité de leur impact sur la santé publique (Rychetnik et al., 2002).

Dans le droit fil de l'analyse de Rychetnik et co (2002), la littérature propose d'autres démarches pluridimensionnelles pour l'évaluation des recherches sur les résultats. Lorsqu'il s'agit d'évaluer les preuves de l'efficacité d'une intervention, on distingue trois dimensions importantes :

1) « la robustesse des preuves, déterminée à la fois par le plan d'étude (niveau), la qualité de la méthodologie et la précision statistique » (p. 122) ;

2) « l'ampleur des effets mesurés » (p. 122) ;

3) « la pertinence des effets mesurés (tels qu'observés dans l'évaluation) par rapport au contexte de la mise en oeuvre » (p. 122).

Les évaluations qualitatives empiriques sont essentielles car elles peuvent influencer les décisions politiques et pratiques dans le domaine des soins de santé. Il faut éviter que l'utilisation de protocoles d'évaluation inadéquats ne donne des exigences irréalistes ou trop onéreuses. Les critères d'évaluation doivent soutenir le processus décisionnel dans la mesure où ils doivent aider à déterminer si les résultats mesurés englobent (a) les intérêts des personnes susceptibles de décider ou de proposer l'intervention et le public cible ; (b) la pertinence ou l'inutilité des effets imprévus ou attendus de l'intervention ; et (c) l'efficacité et l'efficience de l'intervention. La contribution des parties prenantes est essentielle pour la première dimension étant donné la nature sociale et politique de la santé publique. C'est pourquoi, les décideurs et les groupes cibles s'avèrent des intervenants importants lors du processus d'évaluation.

Comme le signalent Guyadeen & Seasons (2018), des modèles d'évaluation insistent fortement sur le pluralisme et sur l'étude des différentes parties prenantes impliquées dans un exercice d'évaluation. De plus, il arrive souvent que des méthodes qualitatives soient utilisées pour mieux comprendre le point de vue des intervenants directement impliqués (Greene, 1994); en effet, ces derniers peuvent jouer un rôle essentiel vu qu'ils sont directement impliqués (par exemple, à cause d'intérêts personnels et financiers) dans l'évaluation.

L'évaluation participative (Cousins, 2004), l'évaluation du degré d'empowerment (Fetterman, 2004), l'évaluation collaborative (Rodriguez-Campos, 2012), et plus récemment, l'évaluation du développement (Patton, 2011) sont de bons exemples de méthodologies efficaces dans ce domaine (Guyadeen & Seasons, 2018).

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Evaluation de l'efficacite des interventions: evaluation du processus

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ARTICLE

Comme nous l'avons souligné, un des rôles essentiels du processus d'évaluation devrait être de garantir la grande qualité de la conceptualisation et de l'application des plans. (Guyadeen & Seasons, 2018; Berke et Godschalk, 2009; Baer, 1997). Il peut également confirmer le caractère objectif et systématique des processus de planification et d'analyse de l'intervention, améliorant ainsi la phase préparatoire et permettant d'analyser la cohérence entre les dispositions déclaratoires du projet (objectifs déclarés) et les résultats engrangés (Guyadeen & Seasons, 2018). L'évaluation donne également les outils pour documenter et identifier de façon empirique les lacunes et/ou les atouts (Berke, Smith & Lyles 2012; Guyadeen & Seasons, 2018). L'hypothèse de base est que, pour que les plans soient efficaces et évaluables, une relation évidente doit exister entre les principales composantes du plan (par exemple, ses objectifs et ses politiques) et les mécanismes de mise en oeuvre (Oliveira & Pinho 2010b; Guyadeen & Seasons, 2018). En général, nous pouvons identifier deux grandes formes d'évaluation de la planification : (a) l'évaluation du plan (par exemple, l'évaluation de la qualité du plan, l'évaluation de sa mise en oeuvre et l'évaluation de ses résultats du plan), et (b) l'évaluation de la planification (par exemple, l'évaluation des processus et des pratiques de planification) (Guyadeen & Seasons, 2018). Si l'évaluation de la planification suppose de mesurer l'efficacité du processus de planification, l'évaluation du plan de l'intervention et de ses résultats implique l'évaluation de la qualité du plan, de la réussite de sa mise en oeuvre et de la réalisation de ses objectifs (Morckel, 2010; Guyadeen & Seasons, 2018). Ces processus d'évaluation ressemblent à l'évaluation de programmes en cela qu'ils visent à améliorer les prises de décisions, mais s'en écartent en cela qu'ils mettent l'accent sur le plan, sur la manière dont il a été conçu et sur les résultats induit par l'activité de planification (Guyadeen & Seasons, 2018). En outre et en règle générale, nous distinguons trois types d'évaluation de la planification : l'évaluation ex-ante (ou a priori), l'évaluation continue et l'évaluation ex-post (Guyadeen & Seasons, 2018). Selon Oliveira & Pinho (2010), ces types d'évaluation correspondent aux différents stades de la planification, notamment la préparation du plan, sa mise en oeuvre et son réexamen (par exemple, une fois réalisé).

Bien que, jusqu'à présent, la médecine factuelle ignore la question de son efficacité, le domaine des soins de santé factuels, par contre, cherche à s'en emparer. L'évaluation des preuves dans le cadre des interventions de santé publique doit absolument déterminer si l'efficacité a été mesurée et si le niveau d'efficience a été atteint (Rychetnik, Frommer, Hawe & Shiell, 2002). Qui plus est, « les décisions fondées sur des preuves à propos de la valeur et de l'applicabilité d'une intervention fondée sur le niveau de connaissance de l'efficacité d'interventions identiques, similaires ou analogues, sont habituellement prises et évaluées dans un autre contexte et à un autre moment. Afin d'évaluer la transférabilité des preuves d'une intervention, nous devons disposer d'informations sur (a) l'intervention en tant que telle, (b) le contexte de son évaluation, et (c) les interactions entre l'intervention et le contexte » (Rychetnik, Frommer, Hawe & Shiell, 2002, p. 123). Dans le cas d'interventions complexes, la question de la fidélité n'est pas simple à trancher. Ajoutons un niveau de complexité : une normalisation stricte des procédures peut mettre à mal la spécificité d'une intervention lorsqu'elle est motivée par des besoins locaux (Craig et al., 2008). Pour évaluer la fidélité en lien avec le degré de normalisation requis par le protocole de l'étude, il faut également préciser le nombre de modifications ou d'adaptations autorisées et la nécessité d'enregistrer les changements opérés lors de la mise en oeuvre. Les variations dans la mise en oeuvre – qu'elles soient prévues ou pas – exigent d'autant plus un rapport complet des procédures d'évaluation des résultats et du processus et une description claire de l'intervention pour permettre de la reproduire (Craig et al., 2008).

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Quiz 3.3

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Q3.3

3 points possible (graded)

1. D'après Rychetnik, Frommer, Hawe and Shiell (2002), l'évaluation se définit comme :

- ○ un ensemble de modifications et de résultats pouvant être prédéfinis ;
- ○ la lecture interprétative des données recueillies dans le cadre de recherches formelles ou d'enquêtes spécifiques ;
- ○ le contexte social, politique et/ou organisationnel de l'intervention.
- ○ le processus permettant de déterminer la valeur d'une intervention par le biais d'une comparaison avec des normes prédéterminées et explicites ;

2. Lors de l'évaluation de l'efficacité d'une intervention, lequel de ces facteurs NE semble PAS être un facteur significatif ? (Rychetnik et al., 2002)

- ○ La pertinence des effets mesurés dans le contexte de la mise en œuvre
- ○ Le nombre d'interventions réalisées par l'organisation.
- ○ L'ampleur des effets mesurés
- ○ La force de la preuve, déterminée par une combinaison de la conception de l'étude, de la qualité méthodologique et de l'exactitude statistique

3. L'évaluation...

- ○ permet la documentation empirique des faiblesses et des forces des plans d'intervention ;
- ○ n'exige pas d'intégration entre les méthodes d'évaluation et le plan à évaluer ;
- ○ doit éviter de prendre en compte l'intérêt des personnes associées aux décisions sur les interventions ;
- ○ ne devrait porter que sur les résultats

Invia | You have used 0 of 2 attempts

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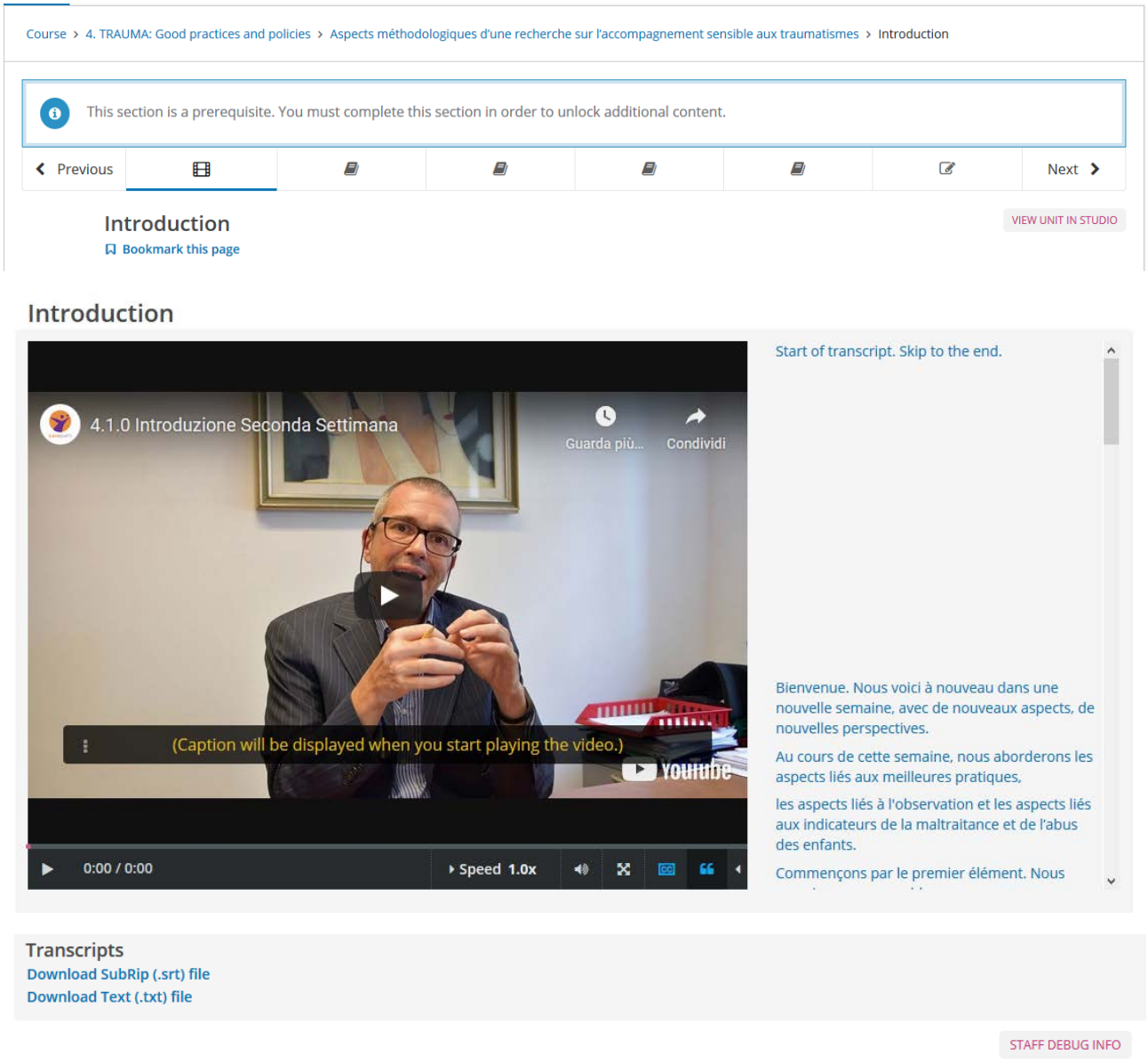

Transcript

Bienvenue. Nous voici à nouveau dans une nouvelle semaine, avec de nouveaux aspects, de nouvelles perspectives.

Au cours de cette semaine, nous aborderons les aspects liés aux meilleures pratiques,

les aspects liés à l'observation et les aspects liés aux indicateurs de la maltraitance et de l'abus des enfants.

Commençons par le premier élément. Nous examinerons ensemble

quels sont les éléments liés à l'intervention de la recherche et de la pratique,

en accordant une attention particulière au développement des meilleures pratiques.

Ensuite, nous examinerons quels sont les aspects méthodologiques de la recherche en matière de Trauma-Informed Care,

que nous avons maintenant appris à comprendre et à lire, et nous aurons l'occasion de mieux comprendre

comment ces principes s'appliquent à la planification d'une recherche, comment utiliser le format de Trauma-Informed Care

dans la recherche, donc le canal de la théorie à la pratique.

Nous allons ensuite essayer d'identifier

les éléments qui constituent une bonne proposition de recherche en allant voir quels sont les aspects liés, par exemple, à une bonne technique qu'est l'observation.

L'observation comme outil clinique, l'observation comme outil pouvant permettre à un opérateur

qui collabore ou a l'intention de travailler ou (pour mille autres raisons)

est disposé à connaître et à approfondir le thème de Trauma-Informed Care peut utiliser l'observation comme méthode,

l'outil d'observation, qui peut à son tour être un outil important pour comprendre le contexte,

et pour comprendre la personne placée dans ce contexte (gardez à l'esprit le sens de Trauma-Informed Care).

Et nous allons ici étudier les exigences et les applications possibles de l'observation clinique et au-delà.

Nous poursuivrons ensuite sur les exemples

et les concepts évoqués ci-dessus en tant que bonnes pratiques, l'observation et la manière dont celles-ci

peuvent être appliquées à l'abus et à la maltraitance des enfants, tout en essayant également d'identifier les indicateurs,

en tenant compte du fait qu'un indicateur est, en tant que tel, juste un indicateur, et n'est certainement pas

un élément fondamental et certain de l'abus et de maltraitance, mais qu'un ensemble d'indicateurs

peut être intéressant pour nous en tant qu'élément à garder à l'esprit qu'il peut y avoir quelque chose à étudier.

À partir de là, nous examinerons les procédures

de contrôle sur l'évaluation des traumatismes et nous essaierons de comprendre avec mes collègues

combien le dépistage des traumatismes peut être important pour la connaissance.

Nous terminerons ensuite avec les aspects liés aux Trauma-Informed Care et les liens avec la recherche,

et comment il peut y avoir un système organisé de processus qui va de la théorie à la pratique.

Si dans la première partie, au cours des deux premières semaines, nous avons discuté et examiné avec des collègues

l'aspect peut-être le plus théorique du traumatisme, avec nous aujourd'hui,

avec ces deux semaines, nous avons discuté de la recherche dans recherche fondée sur des données probantes ou sur l'action dans les Trauma-Informed Care,

à partir de maintenant vous vous dirigerez désormais vers une nouvelle voie qui aura toujours les traumatismes

et les Trauma-Informed Care comme thème central, mais d'un point de vue légèrement différent, notamment le législatif,

pour ensuite aborder les questions liées à la législation, à la recherche et aux politiques.

Nous vous souhaitons, à mon nom et au nom de tous mes collègues,

une bonne progression sur ce chemin; puisque vous en avez maintenant atteint la moitié, peut-être même plus de la moitié,

et qu'à ce stade, vous vous dirigez vers la fermeture de votre MOOC.

Encore une fois, nous vous souhaitons une bonne continuation, et nous nous reverrons à la fin du MOOC.

This section is a prerequisite. You must complete this section in order to unlock additional content.

Introduction aux principaux aspects méthodologiques de la recherche dans l'accompagnement sensible aux traumatismes

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Comme l'ont suggéré Newman & Ridenour (1998), la manière dont des chercheurs mènent une étude et les conclusions qu'ils en tirent peuvent fortement différer en fonction de leur approche de la réalité. Par ailleurs, si l'épistémologie étudie comment nous savons les choses, la méthode, pour sa part, renvoie au choix de la technique permettant de procéder à la connaissance des phénomènes (Bernard, 2006).

Comme l'a souligné Lastrucci (1963), la science est « une méthode objective, logique et systématique d'analyse des phénomènes, conçue pour permettre l'accumulation de connaissances fiables » (p. 6). Cela se fait à travers trois objectifs qui guident les choix du chercheur (Bernard, 2006) :

- objectivité : nécessité d'expliciter les mesures, de veiller à la méthodologie et de se référer aux examens par les pairs au sein de la communauté scientifique ;
- application d'une méthode scientifique
- fiabilité

La dimension éthique s'inscrit dans la méthode scientifique. Quand le propos de la recherche est les sciences humaines, une question centrale se pose : comment opérationnaliser des phénomènes complexes par nature ? Ce type de processus repose sur la définition de variables, sur la recherche d'associations ou de relations entre elles et sur la question de savoir si et comment la variation d'une chose provoque une variation dans une autre (Bernard, 2006). Dans ce contexte, un élément fondateur est la mesure et l'identification d'indicateurs valides et fiables, en vue de l'établissement de définitions opérationnelles qui « consistent en un ensemble d'instructions sur la façon de mesurer une variable ayant fait l'objet d'une définition conceptuelle » (p. 38).

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Recherche dans l'accompagnement sensible aux traumatismes

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Dans le cadre de l'accompagnement sensible aux traumatismes, l'un des concepts clés consiste à utiliser des procédures et des concepts scientifiquement validés. De ce point de vue, une interaction synergique s'impose entre le travail clinique et la recherche afin d'étudier les résultats des traitements et d'évaluer l'efficacité et l'efficience des modèles de fonctionnement des services, notamment par leur formalisation dans des directives et/ou par la garantie que le protocole en question respecte les éléments établis dans la recherche internationale du domaine (Schäfer et al., 2018).

À cet égard, la contribution de la recherche scientifique à l'analyse des définitions dans l'accompagnement sensible aux traumatismes et de ses facteurs sous-jacents conserve toute son importance.

Ainsi, Becker-Blease (2017), Hanson & Lang (2016) et Johnson (2017) signalent un certain nombre d'aspects critiques liés à l'accompagnement sensible aux traumatismes et aux problèmes d'application, comme, notamment, la tendance dans la littérature scientifique à se focaliser sur les aspects théoriques et les principes fondamentaux au détriment des éléments tangibles et de leur applicabilité dans la pratique : « un fossé se creuse lorsque les praticiens doivent transformer la théorie et les principes en pratique quotidienne et, donc, évaluer leur efficacité » (Becker-Blease, 2017, p.3). L'accent placé sur la recherche permet d'évaluer les initiatives, les programmes et les services sensibles aux traumatismes et de déterminer s'ils contribuent à des résultats positifs significatifs.

Lorsqu'on souhaite réaliser un échange fructueux et fonctionnel entre les aspects conceptuels-théoriques et pratiques, l'accent devrait se mettre sur l'analyse de l'applicabilité des procédures et des indicateurs normalisés, tant au niveau des étapes du processus que des résultats obtenus. La littérature scientifique sur le sujet nous incite à envisager plus précisément une structuration de projets de recherche, tant fondamentaux qu'applicatifs, visant à traiter des procédures de dépistage (en fonction de preuves accumulées), et à analyser des procédures d'évaluation dont le but serait d'identifier les événements traumatisants et leurs particularités. En outre et à cette fin, il est important que des études randomisées et contrôlées soient mises en œuvre sur une base expérimentale, afin de tester l'efficacité des interventions sensibles aux traumatismes.

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Structurer un projet dans le domaine social et de la santé peut se faire selon trois approches différentes (Leone & Prezza, 1999) : a) synoptique-rationnelle (qui implique une pré-structuration maximale des contenus), b) collaborative - participative ou dialogique (qui privilégie la négociation continue des objectifs entre experts et bénéficiaires) ; c) heuristique (qui prévoit une structuration minimale a priori des objectifs).

Dans l'absolu, un processus de recherche devrait suivre quatre étapes :

1. formulation d'un problème théorique (découlant de l'analyse de la théorie et de la littérature scientifiques) ;
2. sélection des unités d'analyse et de la méthode appropriée ;
3. collecte et analyse des données ;
4. contestation ou soutien de la proposition théorique sous-tendant la recherche.

Comme l'avance Lanzara (1985), « ...tout acteur qui se pose le problème de l'innovation, ou qui choisit d'intervenir dans une situation pour la modifier, a devant lui un problème de conception » (p. 336). La planification est un processus de systématisation ; en fait, la structuration d'un projet de recherche est une phase critique et fondamentale qui implique des choix importants qui conditionneront les résultats. En outre, Leone & Prezza (1999) soulignent que « ...tout qui articule un projet entre différents sujets et réfléchit à la cohérence entre différentes éléments (objectifs, temporalité, opérateurs disponibles...) doit se poser la question de la pratique, ainsi que de la limite et des parties, et c'est exactement, ce qui dans certains contextes, tend à être oublié » (p. 23) ou considéré comme trop complexe et donc impossible à appliquer.

D'un point de vue transversal, les auteurs rappellent les étapes fondamentales de la structuration d'un projet dans le domaine social :

1. idéation : la phase de réalisation ou de proposition du projet ;
2. activation : vérification des ressources, des rôles, des problèmes et des stratégies, analyse éventuelle de la demande (clients) ;
3. planification : élaboration du projet et structuration des phases qui le composent, établissement des délais et définition des choix méthodologiques ;
4. mise en œuvre : début des activités, première vérification des hypothèses, modifications ;
5. vérification : analyse finale des résultats.

En outre, dans une recherche scientifique, une série d'éléments opérationnels sont à épingler :

- définition et analyse de l'objet de la recherche sur base de la littérature scientifique, explication du cadre théorique ;
- identification et explication des buts généraux et des objectifs spécifiques de l'étude (propos de la recherche : exploratoire, évaluative, explicative) ;
- structuration des hypothèses ;
- identification de la population cible, sélection des participants et échantillonnage ;
- procédures d'évaluation, définition d'indicateurs, outils et techniques d'analyse des données collectées ;
- planification (calendrier) et analyse de faisabilité (y compris des aspects critiques et limites).

Par ce biais, le thème de la recherche conditionnera les éléments méthodologiques d'une matrice quantitative, qualitative ou mixte.

Lors de chaque phase du processus de conception, le chercheur pose des questions importantes qui reposent sur les aspects conceptuels et pratiques les plus critiques. Citons parmi ceux-ci le contexte dans lequel la recherche est menée, ainsi que les ressources dont elle dispose.

Le processus étant complexe, il est fondamental de privilégier la formation du personnel, ainsi que l'interaction constante entre les professionnels actifs dans les opérations cliniques et les chercheurs impliqués dans la recherche clinique.

En outre, un autre aspect central est la structuration et la validation d'outils à utiliser en fonction des objectifs tant d'intervention que de recherche. Ceux-ci pouvant prendre différentes formes et s'appliquer à des cibles spécifiques, il est essentiel que tous les acteurs impliqués dans la conception et la mise en œuvre d'un projet collaborent à la formulation de chaque étape du plan de projet, y compris lors des choix méthodologiques.

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Quiz 4.1

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Q4.1

3 points possible (graded)

1. La définition opérationnelle :

- ○ est formulée avant la définition conceptuelle d'une variable.
- ○ n'est pas utile pour mesurer une variable.
- ○ est formulée après la définition conceptuelle d'une variable.
- ○ est activée lors de la mesure d'une variable.

2. Lors d'un accompagnement sensible aux traumatismes, il est crucial :

- ○ d'imposer une méthodologie d'intervention aux opérateurs.
- ○ d'ignorer les contributions de la recherche scientifique.
- ○ d'ignorer les aspects critiques et les difficultés d'application.
- ○ d'encourager une interaction synergique entre le travail clinique et la recherche.

3. A chaque étape du processus de conception :

- ○ le chercheur ne doit pas se poser de questions importantes basées sur les aspects conceptuels et pratiques les plus critiques.
- ○ le chercheur doit se poser des questions importantes qui reposent sur les aspects conceptuels et pratiques les plus critiques.
- ○ les données doivent toujours être analysées.
- ○ il est nécessaire de prévoir un calendrier

Invia You have used 0 of 2 attempts

Salva Show Answer

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Bonnes pratiques dans l'accompagnement sensible aux traumatismes

Compte tenu des risques importants que font peser des événements traumatiques (Adverse Childhood Experiences, ACE) sur la santé physique et psychologique, de nombreuses interventions ont été développées au fil des ans pour aider les institutions et les aidants professionnels de personnes à antécédents traumatiques à adopter une approche orientée sur les TIC (Baker et al., 2016). En particulier, « une approche basée sur un accompagnement sensible aux traumatismes considère la personne de manière holistique, et non pas seulement comme une liste de problèmes qu'elle rencontre » (Hepburn, 2017, p. 7). Comme l'indiquent de nombreux auteurs (Bryson et al., 2017 ; Bridgett, Valentino & Hayden, 2012 ; Ellis & Boyce, 2011 ; Perry, 2002 ; Rothbart, Ziaie, O'Boyle, 1992), il y a un effet protecteur (effet tampon) lorsque des soignants attentifs et volontaristes entretiennent de bonnes relations lors des soins et de l'accompagnent : la sécurité relationnelle réduit les effets néfastes des traumatismes chez les enfants. On rencontre souvent des situations de stress traumatique dans les cas d'expériences négatives vécues durant l'enfance (ACE), qui se manifestent souvent dans des problèmes cliniques importants (internalisation et/ou externalisation des symptômes), comme on en retrouve fréquemment dans les hôpitaux ou les établissements résidentiels pour adultes et enfants (Bryson et al., 2017 ; Greenwald et al, 2012 ; Hummer, Dollard & Robst, 2010 ; Ko et al., 2008). Citant Elliott et ses collègues (2005) qui ont déclaré que « des services sont sensibles aux traumatismes lorsque le personnel comprend l'impact de la violence interpersonnelle et de la victimisation sur la vie et le développement d'un individu » (p. 462) et que « de nombreuses procédures et pratiques courantes dans le domaine des services réactivent les réactions traumatiques et sont, partant, vécues comme des émotions dangereuses et un obstacle supplémentaire chez les survivants de traumatismes » (p. 446). Soulignons que les bonnes pratiques devraient être évaluées sur la base de critères spécifiques identifiés et détaillés dans la littérature scientifique et comprenant un moment d'évaluation minutieuse des facteurs complexes interagissant dans les événements traumatisants. En fait, dans les situations où le service ou l'organisation s'occupe de victimes d'un traumatisme, on recommande d'orienter l'offre de soins et l'accompagnement social vers la prévention et la réduction des risques (Bryson et al., 2017). Dans ce cadre, il est crucial d'encourager des approches sensibles aux traumatismes : on choisit un accompagnement sensible aux traumatismes (TIC) et une pratique sensible aux traumatismes (TIP) comme paradigmes de traitement, car ils visent à transformer totalement les systèmes de soins en privilégiant dans tous les aspects du service une prise en comte du stress vécu en réponse aux traumatismes, ainsi que les aspects de sécurité et de libre-choix. En outre, pareille approche vise à créer une culture du traitement axée sur la non-violence, l'apprentissage et la collaboration, qui mettra l'accent sur l'ensemble des interactions environnementales et interpersonnelles (Bryson et al., 2017). Après un examen systématique de la littérature, Bryson et ses collègues (2017) ont tiré quelques conclusions importantes :

- - qui dit « réduction de la coercition physique dans les soins psychiatriques de routine et en établissement » (p. 11) dit réduction/élimination de l'isolement ou des stratégies de contrôle et de coercition ;
- - dans le cadre de l'accompagnement sensible aux traumatismes, il est « primordial que les hauts responsables donnent la priorité à un accompagnement sensible aux traumatismes [...], surtout lorsque le personnel doit s'adapter à de nouvelles méthodes de travail » (p. 11) ;
- - les chercheurs soulignent la nécessité de soutenir le personnel par une formation avancée - en particulier sur les séquences de traumatismes - une supervision continue, un coaching et un débriefing ;
- - En cela, il est essentiel d'être à l'écoute des patients et des familles, en accordant une attention particulière à leurs expériences, à leurs besoins, à leurs priorités lors du traitement ;
- - il importe d'assurer une mise à jour constante des données de recherche et une analyse des indicateurs de résultats afin de motiver et de soutenir des services performants et d'améliorer leur efficacité ;
- - la littérature traite abondamment de « la nécessité d'aligner les politiques et les pratiques formelles et informelles sur les principes généraux d'une sensible aux traumatismes » (p. 11).

Bien que ce soit un domaine de plus en plus appliqué, l'efficacité de ce type d'approche n'a pas encore fair l'objet d'assez de recherches scientifiques(Bryson et al., 2017) ; comme le soulignent Valenkamp, Delaney & Verheij (2014) et Chandler (2008), on manque d'études contrôlées randomisées pour tester les interventions et explorer les facteurs critiques dans la mise en œuvre de traitements axés sur l'accompagnement sensible aux traumatismes. Au niveau international, des études empiriques ont montré l'importance de la formation pour que le personnel dispose d'un langage commun à utiliser lorsqu'il doit discuter de l'expérience du patient, et d'interventions à privilégier avec les patients traumatisés (Bryson et al., 2017). L'importance de cette question a également été soulignée par Le Bel, Huckshorn & Caldwell (2008) et par Brown, Baker & Wilcox (2012). Qui plus est, une formation spécifique sur les meilleures pratiques et sur la participation des patients aux activités de formation du personnel (par exemple lorsqu'il s'agit de rendre compte de leurs expériences) s'est révélée utile (Holstead, Lamond, Dalton, Horne & Crick, 2010), au même titre la participation des enfants au débriefing sur les aspects ou les étapes critiques de la prestation de soins (Lebel et al., 2008), le partage des données et le suivi continu des performances/processus (au niveau individuel, collectif et de l'unité) (Bryson et al., 2017). La littérature scientifique sur des stratégies efficaces dans le domaine de l'accompagnement sensible aux traumatismes met également l'accent sur la capacité des organisations à aligner leurs politiques et leurs pratiques sur les principes d'un accompagnement sensible aux traumatismes (Bryson et al., 2017). Dans cette optique, l'environnement et la culture des organisations constituent en soi des outils thérapeutiques et contribuent à la construction d'une « communauté thérapeutique ». Les aspects suivants revêtent une importance particulière : 1) l'objectif de créer un espace de traitement sûr pour les patients et le personnel et 2) la prise en compte des principes de l'accompagnement sensible aux traumatismes dans les déclarations de mission et de vision. En résumé, les principales stratégies en matière d'accompagnement sensible aux traumatismes mises en avant par Bryson et ses collègues (2017) s'alignent sur celles qui sous-tendent la NASMHPD (National Association of State Mental Health Program Directors) ; vous les trouverez au tableau 1.

Tab. 1 Principales stratégies dans l'accompagnement sensible aux traumatismes

Bryson et collègues (2017)
Inclusion communautaire
Implication des dirigeants
Choix du modèle
Transformation de la main-d'œuvre
Orientation axée sur les résultats
Mise en œuvre partagée

NASMHPD
Leadership vers le changement organisationnel
Utilisation des données pour orienter la pratique
Utilisation d'outils de réduction de la contrainte et de l'isolement
Formation du personnel
Amélioration du rôle de consommateur en milieu hospitalier
Techniques de débriefing approfondi

En outre, dans une étude réalisée par Azeem et ses collègues (2011), ces éléments stratégiques ont été testés de manière longitudinale dans le but d'analyser les effets d'une moindre utilisation des techniques de contention et à l'isolement. Les auteurs ont notamment insisté sur les quelques constats suivants :

✓ le leadership joue un rôle clé dans la mise en place d'un changement culturel, en particulier lorsque l'ensemble du personnel partage une même vision de l'accompagnement sensible aux traumatismes ;

✓ la collecte et le partage des données jouent « un rôle clé dans les projets d'amélioration des performances » (p. 12) et dans les processus de suivi ;

✓ il a été démontré que la formation et la formation continue du personnel aux principes des soins axés sur le rétablissement, des soins axés sur la personne et de l'accompagnement sensible aux traumatismes, couplées à des évaluations de performance correspondantes, ont des effets positifs significatifs ;

✓ priorité devrait être donnée aux principes de la prévention primaire via des programmes de traitement individuels tenant compte du passé traumatique et des stratégies du patient, de la famille et du personnel ;

✓ un bon principe pour appliquer un accompagnement sensible aux traumatismes est d'associer le patient et sa famille ;

✓ des activités de débriefing à propos du soutien apporté - notamment pour tous les aspects émotionnels et les changements prévus lors du traitement - telles que les interventions visant à atténuer les traumatismes et l'impact des traumatismes ont été efficacement mises en œuvre.

Lors de leur examen de différentes approches d'accompagnement sensible aux traumatismes, Hanson et Lang (2016) et Johnson (2017) ont identifié une série de questions pouvant avoir de l'importance dans l'analyse des services aux enfants et ont conclu qu'il est possible d'identifier 15 composantes clés dans un accompagnement sensible aux traumatismes.

Les éléments identifiés ont été organisés en trois niveaux (Hanson & Lang, 2016, p. 98) :

1. Formation du personnel :

- Formation requise pour tout le personnel en matière de sensibilisation et de connaissance de l'impact des abus ou des traumatismes ;

- évaluation des compétences du personnel selon des critères définis pour démontrer les connaissances / la pratique en matière de traumatismes ;

- Stratégies / procédures pour traiter / réduire le stress associé aux traumatismes secondaires chez le personnel ;

- Connaissances/compétences sur la manière d'accéder et de se référer aux meilleures pratiques fondées sur des données probantes et axées sur les traumatismes.

2. Services centrés sur les traumatismes :

- utilisation de mesures normalisées de dépistage / d'évaluation basées sur des preuves, afin d'identifier les antécédents et les symptômes ou problèmes liés au traumatisme ;

- prise en compte des traumatismes passés de l'enfant dans la documentation / les dossiers / le plan de service ;

- disponibilité de cliniciens qualifiés et formés aux pratiques fondées sur des données probantes et sensibles aux traumatismes ;

3. Application organisationnelle

- Collaboration, coordination des services et partage d'informations entre les professionnels de l'agence liée aux services sensibles aux traumatismes ;

- Collaboration, coordination des services et partage d'informations entre les professionnels d'autres organismes liés aux services sensibles aux traumatismes ;

- Procédures visant à réduire le risque de re-traumatisation du patient ;

- Procédures garantissant la participation et la contribution des patients lors de la planification des services et de la mise en place d'un système sensible aux traumatismes ;

- offre de services basés sur les points forts et promotion d'un développement positif ;

- mise en place d’un environnement physique positif et sûr ;

- des politiques écrites qui incluent et soutiennent explicitement des principes sensibles aux traumatismes ;

- présence d'un poste de direction défini ou d'un profil de poste spécifiquement dédié à l’accompagnement sensible aux traumatismes.

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Éléments essentiels des bonnes pratiques

L'analyse de la littérature et des protocoles d'évaluation des pratiques appliquées au domaine de l'accompagnement sensible aux traumatismes permet de conclure que, pour qu'il y ait bonnes pratiques (potentiellement transférables dans différents contextes), les éléments suivants doivent être garantis :

1) la formation permanente de tous les membres du personnel aux traumatismes et à leurs corrélats. Cette formation devrait être dispensée non seulement aux professionnels travaillant directement au niveau clinique avec les utilisateurs, mais également à tout qui participe à l'organisation à divers titres et aux différentes fonctions ;

2) une formation continuée du personnel interne aux pratiques fondées sur des preuves (EBP) pour le traitement des traumatismes, avec un accent placé sur le comportement des professionnels face aux EBP ;

3) la collaboration avec des experts du domaine afin d'augmenter le nombre de professionnels cliniques formés ;

4) la prise en compte des procédures de dépistage normalisées et fondées sur des preuves dans la pratique clinique et l'utilisation de mesures/outils d'évaluation spécifiques et validés pour identifier les événements traumatiques (ACE) ;

5) une même prise en compte du passé des patients, des symptômes et difficultés rencontrées suite à un traumatisme ;

6) dans le droit fil du point précédent, la reconnaissance de la spécificité du parcours de vie de chaque utilisateur grâce à une écoute active et empathique par l'ensemble du personnel ;

7) la prise en compte minutieuse de l'histoire des traumatismes des enfants lors de la planification de l'intervention ou de sa conceptualisation ;

8) une évaluation approfondie et un contrôle constant des compétences du personnel (utilisation de procédures spécialement conçues) ;

9) un contrôle approfondi du respect des normes fixées pour un bon service d'accompagnement sensible aux traumatismes, afin de pallier d'éventuels manquements ;

10) la mise en œuvre de procédures visant à réduire le stress lié aux traumatismes secondaires et à accroître le bien-être du personnel ;

11) la création et le maintien d'un bon réseau de coopération, non seulement au sein des services mais également avec d'autres agences locales ;

12) un accent placé sur l'importance de la communication : l'objectif premier devrait être de disposer d'un personnel attentif et collaboratif dans la poursuite des objectifs et l'application de procédures partagées et co-construites ;

13) un accent placé sur des procédures visant à réduire le risque de retraumatisme pour les utilisateurs ;

14) encourager la participation des patients à la conception du traitement ;

15) la participation des usagers à la planification du service : veiller à leurs réactions et suggestions pour améliorer l'organisation et les services offerts ;

16) un accent particulier placé sur la fourniture de services basés sur les points forts, pour promouvoir les facteurs de développement positif (par exemple, la résilience, l'empowerment) ;

17) une formation aux stratégies d'organisation d'un environnement positif pour les utilisateurs et pour le personnel ;

18) une attention particulière aux dimensions physiques et structurelles du service ;

19) l'adhésion aux principes de l'accompagnement sensible aux traumatismes et leur promotion via des politiques spécifiques et claires ;

20) un rôle central attribué à la direction et à ses fonctions dans l'organisation du service.

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Éléments critiques et défis

Bien qu'il s'agisse d'un point particulièrement mis en avant dans les recommandations de mise en œuvre des meilleures pratiques, l'utilisation de pratiques fondées sur des données probantes fait encore aujourd'hui l'objet de résistance de la part de certains professionnels, organisations et chercheurs (Gray, Elhai, Schmidt, 2007). Les organisations qui réalisent des interventions cliniques suite à des traumatismes ne devraient pas faire l'économie d'une analyse ou, pour le moins, d'une discussion à ce propos, afin de jeter les bases d'une définition coopérative des normes.

En fait, Si l'approche basée sur l'accompagnement sensible aux traumatismes joue actuellement un rôle important dans l'organisation des services et la fourniture de soins aux personnes traumatisées, plusieurs obstacles compliquent encore son application et, même lors d'une phase préalable, sa conceptualisation (Baker, 2016). Que manque-t-il ?

- une définition opérationnelle claire
- la présence d'outils validés psychométriquement permettant d'évaluer les diverses dimensions d'un accompagnement sensible aux traumatismes.

Pour combler cette lacune, Baker et co (2016), par exemple, ont construit et validé un outil - l'échelle ARTIC (Attitudes favorables à un accompagnement sensible aux traumatismes) – afin d'évaluer la présence d'attitudes favorables à un accompagnement sensible aux traumatismes chez le personnel travaillant dans différents domaines d'intervention ou dans divers contextes en lien avec des personnes ayant connu des incidents traumatiques. Dans une publication précédente, « Creating cultures of trauma-informed care (CCTIC) : a self-assessment and planning protocol », Fallot et Harris (2009) ont formalisé un protocole d'auto-évaluation et de planification comprenant six champs susceptibles de connaître des changements au niveau des services, de l'administration ou du système. Tant les opérateurs individuels que les services sociaux et de santé doivent, de plus en plus, prendre en compte la complexité des programmes d'accompagnement sensible aux traumatismes dans leur interaction quotidienne et dans leur relation avec la communauté scientifique de référence.

Transcript

[Devenir adulte n'est pas simple. Quels sont les défis quotidiens?]

Nous sommes à Rome, interviewant des personnes entre 18 et 22 ans

Qu'est-ce que le TARI? [une taxe italienne sur les ordures]

Qu'Est-ce que c'est?...

Oh, sur les économies ...

Un concept, comme, sur l'économie ...

Le TARI est une chose, une chose politique ...

Oui en effet

Qu'est-ce que le TARI?

Le TARI? Est-ce une taxe?

Vous devez chercher une maison: comment faites-vous?

Que faire? Quelle est votre décision?

Avec les transports publics ...

Giulia l'a trouvé.

Avec une agence immobilière.

Je vis à la maison, avec maman qui m'attend toujours

Quel type de contrat signez-vous?

Je veux dire, je paye tout simplement, je veux dire que je dois payer les contrats,

ok, d'une durée indéterminée,

des contrats à long terme ...

Je veux dire, je viens de commencer l'école de droit ...

mais je viens de commencer! Donc...

Vous faites les 4 ..? [4 + 4, un contrat de logement commun]

4 mois?

Plus 5

L'argent du loyer est de l'argent gaspillé.

Par exemple, l'eau et l'électricité sont incluses dans le prix

4?

Le compte bancaire

Comme, un interrogatoire en latin est plus facile!

Eh, je ne sais pas

Où vous déposez ..

Si vous voulez, nous pouvons parler de Seneca

En cas de problème, qui appelez-vous?

Giulia

Papa

Seneca, qui est mort ... alors maman et

papa pour le moment.

Il est difficile de répondre à certaines questions, mais certains jeunes de tout juste 18 ans

devront les affronter seuls.

Sortants de soins

Je ne sais pas ce que c'est

La Santé … Les besoins? ...

Qui sont-ils?

Les Joueurs de Liverpool

Je ne sais pas ce que c'est, je n'en ai jamais entendu parler

Je ne comprends pas la question?

Clercs

Ce sont des jeunes qui viennent d'avoir 18 ans,

ils vivent dans une famille d'accueil et doivent quitter leur famille d'accueil et trouver une solution d'indépendance

Génial!

[L'avenir se construit de jour en jour]

Que pouvons-nous dire à ces jeunes, allez?!

Que ... Je leur souhaite bonne chance, que peut-on leur dire ?!

En tant que modèle visant à structurer l'offre de services, l'accompagnement sensible aux traumatismes est utilisé dans un contexte large et varié ; Bowen et Murshid (2016) soulignent combien ce paradigme peut tout autant s'appliquer, dans ses principes fondateurs (sécurité, fiabilité et transparence, collaboration, autonomisation, choix et intersectionnalité), aux politiques sociales. Selon la proposition des auteurs, le constat est d'autant plus vrai que l'accompagnement sensible aux traumatismes permet aux professionnels de la santé mentale (en particulier dans le secteur public) de faire tomber les disparités par une action clinique-organisationnelle qui, en raison de sa dimension éthique et déontologique, peut également s'ouvrir à une dimension politique plus large. Reeves (2015) avait déjà souligné comment l'application généralisée de modèles de soins axés sur un accompagnement sensible aux traumatismes pouvait placer au centre de l'intervention la réponse aux besoins uniques et particuliers des responsables des services de réadaptation, réduisant ainsi les inégalités sociales dont souffre cette population vulnérable.

Récemment, Levy-Carrick et ses collègues (2019) ont souligné que l'inégalité de traitement dans le contexte des traumatismes constitue un problème critique dans l'organisation nationale des services de santé, auquel l'adoption d'une approche d'accompagnement sensible aux traumatismes peut remédier, sinon complètement, du moins largement. En fait, au centre du propos des auteurs s'articule le constat que l'application efficace de ce paradigme serait garantie par la pleine participation des soignants à la planification et à la mise en œuvre des activités, et ce à chaque étape. Dans leur livre "Caring for the vulnerable : Perspectives in nursing theory, practice, and research", De Chesnay et Anderson (2019) ajoutent que la santé mentale revêt un caractère politique et participatif (en particulier dans le chef des usagers). Dans cette optique, l'Organisation mondiale de la santé a souvent préconisé des politiques visant à créer un espace de collaboration dans lequel les praticiens et les groupes de défense des droits des usagers des services de santé mentale (groupes de défense), ainsi qu'un large éventail d'autres parties prenantes, peuvent encourager une synergie attentive aux besoins de chacun.

En outre, comme nous le constatons parfois, il est important de fonder sur des considérations politiques la décision de financer des études d'analyse et de promotion des pratiques fondées sur des données probantes, d'établir et de diffuser des normes communes, de définir la proportion organisationnelle et les objectifs communautaires des organisations et des institutions impliquées dans la fourniture de soins (Ko et al., 2008 ; Bateman & Anderson, 2013 ; Levy-Carrick et al., 2019).

Les propos ci-dessus concernent non seulement la dimension générale de la politique de santé, mais également la dimension locale en réponse à des besoins territoriaux spécifiques et, plus spécifiquement, aux politiques de chaque organisation ou de chaque service. La littérature sur l'accompagnement sensible aux traumatismes suggère que, "pour appliquer une assistance sensible aux traumatismes, s'imposent les étapes de préparation, d'évaluation et de changement organisationnel (Harris & Fallot, 2001, Rivard, Bloom, McCorkle, & Abramovitz, 2005) [...] La mise en œuvre de pratiques sensibles aux traumatismes repose donc sur l'utilisation des données de chaque organisation individuelle pour illustrer les phases de planification et d'application" (Hummer et al., 2010, p. 82). Accompagner les politiques via des données issues de centres de recherche constitue incontestablement une priorité et un avantage stratégique (Levy-Carrick et al., 2019). Par exemple, parmi les outils pouvant servir à analyser dans quelle mesure les politiques organisationnelles reposent sur les principes d'un accompagnement sensible aux traumatismes, le protocole CCTIC développé par Fallot et Harris (2009) pourrait être particulièrement intéressant dans la mesure où il éliminerait les domaines et sous-domaines liés à l'évaluation des services et initiatives organisationnels dans le domaine des soins aux traumatisés.

En conclusion, qui dit perspective basée sur un accompagnement sensible aux traumatismes dit une sensibilité accrue à ce que Levy-Carrick et co ont défini comme important (2019) : "aider nos patients et nous-mêmes nécessitera un changement de perspective critique dès le début de la formation, renforcé dans tous ses aspects, mis en place par des professionnels plus âgés et porté par les générations futures" (p. 107).

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Knowledge check

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Q4.2

3 points possible (graded)

1. L'approche de l'accompagnement sensible aux traumatismes :

- ○ ne prend en compte que la dimension psychologique d'une personne.
- ○ favorise un accompagnement global de la personne.
- ○ ne prend en compte que la dimension physique d'une personne.
- ○ ne prend en compte que la dimension sociale d'une personne.

2. Une intervention, afin de prendre en compte les meilleures pratiques, devrait :

- ○ encourager une évaluation approfondie et un contrôle constant des compétences du personnel (utilisation de procédures spécialement conçues).
- ○ ignorer l'histoire des patients et les éventuels symptômes ou difficultés liés à un traumatisme.
- ○ exclure de la pratique clinique des procédures de dépistage normalisées et fondées sur des preuves.
- ○ veiller à ce que le personnel interne continue à exécuter les procédures auxquelles il a été initialement formé.

3. Une bonne proposition de recherche

- ○ fixe des objectifs aussi généraux que possible
- ○ formule toujours des hypothèses de recherche après la collecte des données
- ○ prévoit toujours un échantillon stratifié
- ○ effectue une analyse de faisabilité et définit un calendrier

Invia You have used 0 of 2 attempts

Salva Show Answer

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L'importance de l'observation

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Cliniciens et chercheurs sont constamment à la recherche de nouvelles connaissances phénoménologiques, de manière plus ou moins systématique. Ce désir de connaissance naît de l'intérêt ou de la curiosité, d'un regard attentif, à l'œil nu ou à l'aide d'outils, en résumé il nait de « l'observation ».

Mantovani (1995) définit l'observation comme : « [...] une forme de détection visant à explorer un phénomène donné » (p. 84).

L'observation est une activité complexe et exigeante qui nécessite :

- du temps ;
- une liberté intellectuelle ;
- une absence de préjugés et d'idées préconçues ;
- de la conscience de soi ;
- la capacité de ne pas s'impliquer ;
- la capacité de suspendre son jugement.

Dans les contextes de la pratique clinique ou de la recherche, l'observation acquiert une importance considérable, cessant d'être une méthode simple et non scientifique pour se transformer en une méthode flexible, structurée et fiable (Venuti, 2001). Vu les progrès accomplis dans le domaine des études sur les enfants, par exemple, l'utilisation des « biographies d'enfants » a été abandonnée, pour laisser place à l'observation et à l'expérimentation systématiques (Bornstein, 2001). En fait, au fil du temps, les observations naturalistes ont été remplacées par des observations standardisées (Bornstein, 2001). On pourrait soutenir, comme le dit Venuti (2001), que l'observation « [...] sert de pont entre un modèle explicatif de référence et un processus consécutif d'analyse et d'interprétation des données » (p. 58). Pour observer, il ne suffit donc plus de regarder un groupe d'enfants en interaction ou une vidéo illustrant le comportement d'une mère et de son enfant, l'observation devant toujours se référer à un modèle théorique et explicatif, qui guidera le chercheur dans la formulation des hypothèses et l'analyse des données (Venuti, 2001). Ce qu'il faut observer, comment, où et quand, dépendra de l'objectif de la recherche et de l'approche théorique de référence.

Il existe différents types d'observations :

- l'observation psychanalytique, qui a pour modèle théorique la psychanalyse ;
- l'observation selon Piaget, qui a pour modèle théorique la psychologie du développement ;
- l'observation éthologique, qui a pour modèle théorique l'éthologie.

L'observation piagétienne est un type d'observation quasi-expérimental. Il s'appuie sur les approches théoriques de l'interactionnisme, du structuralisme, du cognitivisme et approfondit l'étude du cheminement de la vie mentale au cours du développement (Vigna, 2002). Elle ne se limite pas à l'enregistrement de tout ce que fait l'enfant, mais est guidée par certaines hypothèses qui constituent la base de la théorie piagétienne. L'observateur tente d'établir une interaction avec l'observé dans un contexte naturel (Petter, 1984 ; Vigna, 2002). Les principes de base de cette observation sont au nombre de deux :

1. l'observateur s'adapte au stade de développement de l'enfant et, en interagissant, modifie les conditions mêmes de l'observation ;

2. l'observateur reproduit à plusieurs reprises une même situation de jeu lors de l'observation pour évaluer si la réaction de l'enfant se répète en réaction au même stimulus et n'est pas attribuable au hasard.

Cette forme d'observation a principalement lieu à l'école maternelle ou au jardin d'enfants.

L'approche éthologique, en revanche, s'inspire de la théorie de l'évolution de Darwin et des travaux de l'éthologue Lorenz. L'observation se définit comme éthologique lorsque les observateurs n'influencent en aucune façon le comportement qu'ils souhaitent étudier et annulent autant que possible leur subjectivité. Cette technique est généralement appliquée dans l'environnement naturel où un comportement donné se manifeste spontanément. Toutefois, il est possible d'utiliser le laboratoire comme environnement, à condition qu'il soit équipé de manière à reproduire un contexte familier pour l'enfant (par exemple une salle de jeux).

Elle est particulièrement utile lorsqu'il s'agit d'analyser les premières années de la vie, lorsque le langage verbal est encore absent ou pauvre, et ce pour deux raisons :

1. il est plus facile de définir le cadre de vie naturel des jeunes enfants ;

2. les jeunes enfants ne se rendent pas toujours compte qu'ils sont observés et, en tout cas, ne modifient pas leur comportement en réaction.

L'objectif, dans ce type d'observation, est d'exclure toute subjectivité et d'atteindre un niveau d'objectivité qui permet de tirer des conclusions fiables (Lis & Venuti, 1986). Dans ce cadre, le chercheur utilise des procédures qui permettent l'enregistrement et le catalogage objectif et systématique des comportements, afin de pouvoir les interpréter ultérieurement à la lumière des hypothèses initiales. Parmi les atouts de l'observation éthologique, citons

- un nombre accru d'études descriptives sur le comportement des enfants ;
- la priorité donnée à la recherche longitudinale, considérée comme la plus apte à appréhender correctement le processus de changement et sa signification évolutive.

Cependant, lorsque l'accent est mis sur la description objective, le risque existe d'oublier que l'observation s'accompagne automatiquement de choix. En outre, l'importance de la détection des micro-comportements, qui peuvent être décrits objectivement, ne peut nous faire perdre de vue le sens que revêt un certain comportement à un moment et dans un contexte particuliers.

L'observation psychanalytique, en revanche, est un type d'observation directe, une méthode qui n'utilise aucun instrument en dehors de l'observateur lui-même. Selon le modèle psychanalytique, lorsque la théorie ne permet de prévoir aucun phénomène, « l'inattendu » (Bion, 1962) prend toute sa pertinence. L'observation a, dans ce cas, pour fonction principale de créer un espace où l'inattendu peut s'exprimer. Cela exclut toute intentionnalité de la part de l'observateur, et permet de saisir l'intentionnalité consciente et inconsciente de la personne observée. Les domaines d'application sont les suivants :

- la recherche psychologique ;
- le travail clinique ;
- la formation de psychothérapeutes et d'analystes pour enfants.

L'observateur fait partie intégrante de la situation et observe à la fois les comportements et les verbalisations, ainsi que les humeurs et les émotions. Il doit également évaluer soigneusement ses propres états psychologiques, comme source d'information sur le sujet observé, en utilisant sa propre ressemblance pour différencier ce dernier de lui-même et accepter sa propre présence.

Enfin, on peut observer l'ensemble du noyau familial à travers des tâches structurées dans un contexte clinique ou dans son propre environnement naturel. Ce type d'observation peut se faire lors d'un entretien avec la famille et a pour but de comprendre comment les membres du noyau interagissent entre eux et comment ils communiquent au niveau verbal et préverbal (formes d'intersubjectivité implicite).

Enfin, l'observation est l'une des pierres angulaires des professions dans les domaines de l'éducation et de la formation, car elle permet de construire une « attitude de base » qui devient partie intégrante du comportement professionnel, en tant qu'élément de base de la compétence éducative. Il ne s'agit pas d'un simple outil, mais d'un ensemble d'attitudes, de méthodologies et d'outils. Ceux-ci peuvent être structurés (enregistrement vidéo, grilles, listes de contrôle, etc.) ou non structurés (par exemple, journal de bord). L'observateur doit ensuite suivre une formation qui le dotera des compétences et des connaissances permettant d'utiliser ces outils pour détecter le phénomène qu'il entend étudier (Venuti, 2001). Les données obtenues à partir de l'observation peuvent être à la fois qualitatives et quantitatives. Les données qualitatives ont une structure narrative (Hilliard, 1993), tandis que les données quantitatives peuvent être utilisées pour diverses mesures et analyses (par exemple, mesures de fréquence et de durée, analyses séquentielles, etc.)

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External video

Start of transcript. Skip to the end.

En 1969, la psychologue américaine Mary Ainsworth a donné à la psychologie du développement

une nouvelle procédure pour étudier l'attachement chez les nourrissons.

Elle l'a appelé la "classification de situation étrange" et on l'appelle souvent simplement

En tant qu'adulte, on sait quand on a formé un lien d'attachement avec quelqu'un.

Transcripts

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Transcript

En 1969, la psychologue américaine Mary Ainsworth a donné à la psychologie du développement

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Elle l'a appelé la "classification de situation étrange" et on l'appelle souvent simplement

En tant qu'adulte, on sait quand on a formé un lien d'attachement avec quelqu'un.

On sait ce que l'on ressent et on sait exprimer ses sentiments avec

des mots. Cependant, les bébés et les jeunes enfants

n'ont pas encore développé ces compétences

et les chercheurs doivent donc se tourner vers des techniques plus subtiles.

"La situation étrange", qui mesure la sécurité d'un attachement

chez les enfants de un à deux ans, en est une. C'est une observation participative de 20 minutes au cours

de laquelle le chercheur observe les réponses comportementales du nourrisson à une série de scénarios.

"La situation étrange" d'Ainsworth comprend huit étapes et chacune dure environ trois minutes.

Pour commencer, la mère, le bébé et le chercheur sont tous ensemble dans la pièce,

un petit espace aux couleurs neutres avec des jouets pour bébés.

L'expérimentatrice part après environ une minute et la mère et le bébé

sont seuls pendant environ trois minutes.

Un étranger rejoint la mère et le bébé dans la pièce.

Les chercheurs enregistrent la réponse du bébé à ce nouveau venu, inconnu,

qui est ensuite laissé seul avec le bébé lorsque la mère quitte la pièce.

À ce stade, les chercheurs observent alors le comportement du bébé pour

déceler des signes d'anxiété suite à la séparation.

Trois minutes plus tard, la mère revient

et les chercheurs observent la réponse du bébé suite aux retrouvailles.

L'étranger quitte la pièce. Quelques minutes de plus et la mère quitte également la pièce - laissant le bébé seul pour la première fois dans l'expérience.

La prochaine personne à entrer dans la pièce est l'étranger, et enfin,

au bout de trois minutes, la mère revient et l'inconnu s'en va.

C’est finalement une situation parfaitement étrange pour toutes les personnes impliquées.

Alors, que mesuraient les chercheurs?

Lorsque la mère était dans la pièce avec le bébé, ils ont évalué le comportement du nourrisson selon quatre mesures:

"Proximité et recherche de contacts". "Maintien du contact".

"Évitement de la proximité et du contact" et "Résistance au contact et zone de confort".

Les comportements exploratoires du bébé ont également été enregistrés alors qu'il explorait l'environnement.

Ainsworth a rapporté que les nourrissons affichent l'un des trois types d’attachements:

Les nourrissons fort attachés à leur mère montraient des signes de détresse lorsqu'ils étaient séparés d’elle,

évitaient l'étranger lorsqu'ils étaient seuls, étaient amical en présence de leur mère

et heureux quand elle revenait de l'extérieur dans la pièce.

70% des enfants étudiés entraient dans cette catégorie. 15% des enfants ont démontré un attachement ambivalent

avec leur mère. Ces enfants ont montré une détresse intense lorsque

la mère a quitté la pièce et manifesté une peur importante de l'étranger.

Lorsque la mère est revenue dans la chambre, des enfants ambivalents se sont approchés de la mère mais ont

refusé tout contact.

Ainsworth a rapporté qu'un dernier 15% avait un style d'attachement évitant.

Ces enfants ne manifestent aucun intérêt lorsque la mère quitte la pièce et joue joyeusement avec l'étranger.

Lorsque la mère revient, les enfants évitants semblent à peine s'en apercevoir.

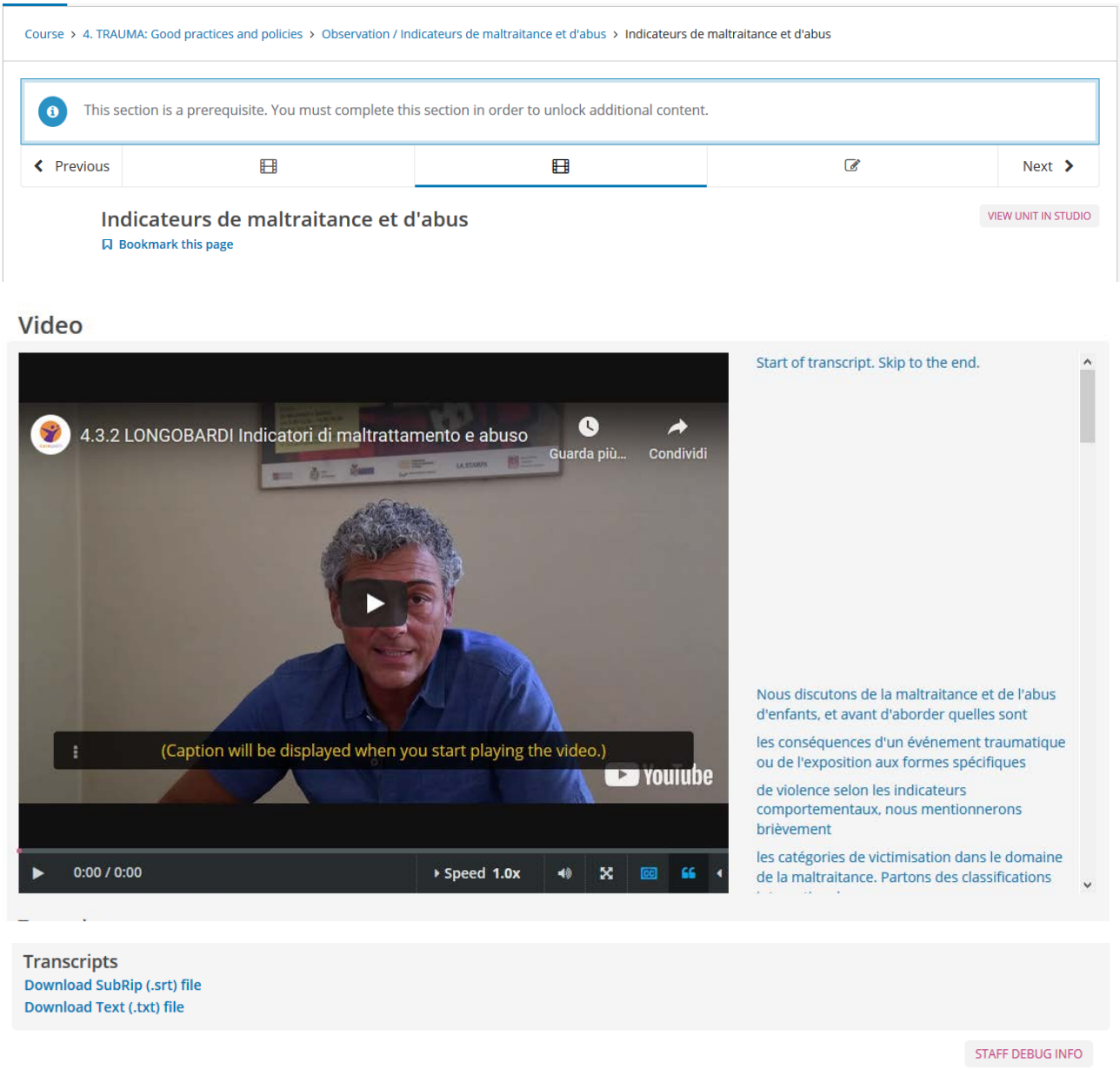
En 1990, le Maine et Salomon ont ajouté qu’un très faible pourcentage était

incohérent dans leurs comportements et défini ce style d'attachement comme "désorganisé".

Il'hypothèse d'Ainsworth sur la sensibilité des soignants suggère que les différences dans les styles d'attachement des nourrissons

dépendent du comportement de la mère envers

le bébé pendant une période critique de développement.



Transcript

Nous discutons de la maltraitance et de l'abus d'enfants, et avant d'aborder quelles sont

les conséquences d'un événement traumatique ou de l'exposition aux formes spécifiques

de violence selon les indicateurs comportementaux, nous mentionnerons brièvement

les catégories de victimisation dans le domaine de la maltraitance. Partons des classifications internationales :

il y a d'abord la violence psychologique, aussi appelée "abus émotionnel" / "abus psychologique",

puis il y a les abus physiques, et enfin les abus sexuels.

En ce qui concerne la violence psychologique, il s'agit de l'exposition à des formes de

violence caractérisée par des dommages physiques que l'enfant subit,

il s'agit donc d'un événement traumatisant très fort puisqu'il a des conséquences sur le développement de l'enfant,

nous verrons sous peu de quels pays je parle. Lorsque nous parlons

de violence psychologique, nous faisons référence aux insultes, le dénigrement, l'isolement social de l'enfant et la négligence ;

ce sont des formes de violence moins visibles,

mais qui ont néanmoins un impact psychologique et constituent donc un événement traumatisant à long terme.

La violence physique est l'exposition formes de violence caractérisées par des dommages physiques ; il s'agit donc d'un événement traumatique très fort, puisqu'il a un impact sur le développement ;

nous verrons bientôt ce à quoi je fais spécifiquement référence. Enfin, les abus sexuels se réfèrent à tous les actes liés à la victimisation qui sont lié à une exposition physique à la violence sexuelle, à l'inceste,

aux attouchements ou à une situation inappropriée qui touche au nom de ceux qui s'occupent de l'enfant dans une situation protégée.

Analysons les conséquences liées aux abus

et à la violence contre un enfant, en tenant compte

à la fois des indicateurs comportementaux et émotionnels. Les conséquences que l'enfant rencontre au cours

de son développement sont par exemple,

troubles de la perception du corps, et donc de son image corporelle;

l'enfant ne peut pas comprendre si son corps appartient à un enfant ou à un adulte, car il est érotisé depuis son plus jeune âge.

Les autres conséquences sont des difficultés chroniques liées au sommeil; en d'autres termes,

l'événement traumatique a un impact sur la régulation du rythme veille-sommeil. Ensuite, il y a des

troubles de l'attention et des difficultés à se concentrer et à faire attention à l'école.

Si l'enfant a moins de 3 à 5 ans, il peut également y avoir des troubles d'évacuation.

Pendant l'adolescence, d'autres manifestations d'inconfort

que l'enfant ou le jeune peut ressentir sont des troubles de l'alimentation, notamment l'anorexie et la boulimie,

des actes d'agression explicites envers tous les sujets qui ont tendance à afficher un

comportement de nature attentionnelle envers l'enfant

(l'enfant peut se défendre lui-même / elle-même avec une agression explicite).

Enfin, les actes d'automutilation, précisément parce qu'il existe une souffrance intrinsèque,

interne à l'enfant, causée par l'événement traumatisant; l'enfant réagit alors en se faisant du mal ainsi qu'à d'autres sujets.

Ce sont quelques-unes des conséquences de l'exposition à des événements traumatisants pendant la petite enfance,

l'enfance et l'adolescence, mais beaucoup plus sont étudiés par la littérature:

difficultés d'apprentissage, isolement et comportements antisociaux tels que l'utilisation

et abus d'alcool et de drogues, comportement sexuel liberé,

exposition à certaines maladies sexuellement transmissibles.

Par conséquent, cela nous fait comprendre comment une trajectoire de développement normale

n'est pas obtenu parce que ceux qui s'occupent de l'enfant et devraient avoir la fonction de garde d'enfants,

maltraitent l'enfant de manière physique,

en battant et en infligeant volontairement de la douleur à l'enfant, de manière sexuelle,

c'est-à-dire en érotisant le corps de l'enfant, ou d'une manière psychologique,

c'est-à-dire en humiliant, en isolant et en dénigrant l'enfant. Ces formes de maltraitance ont un impact traumatisant sur l'enfant avec

les conséquences que nous venons d'explorer. Ces conséquences sont donc des indicateurs d'un comportement

mais aussi la nature émotionnelle et expriment un inconfort que l'enfant éprouve

à un moment précis et sur lequel il est nécessaire d'intervenir tôt,

avant que les conséquences deviennent de plus en plus traumatisantes et inhérentes à la développement de la personnalité du sujet, avec, bien entendu, des conséquences de nature psycho-pathologique.

Schimmenti (2018) souligne combien un traumatisme constitue une lacération profonde pour les individus, pouvant avoir un impact sur leurs processus psychologiques de conditionnement, à de multiples niveaux, et sur leur fonctionnement. Il a notamment des conséquences sur le concept de soi, sur les modalités relationnelles et sur les systèmes de croyance. En outre, l'auteur souligne que de nombreuses études scientifiques ont souligné la fréquence des connexions entre des événements pouvant être définis comme traumatiques et ont montré que l'exposition à des expériences traumatiques multiples augmente le risque de développer une psychopathologie (traumatisme cumulatif), principalement si elle se produit pendant l'enfance et, surtout, dans le cadre des relations familiales. Curran et ses collègues (2018) soulignent également cet aspect dans la littérature scientifique, en ajoutant que :

1. chez les enfants victimes de multiples expériences traumatiques, cela renforce les risques de dépression et d'impuissance (Arata et al., 2007) ;

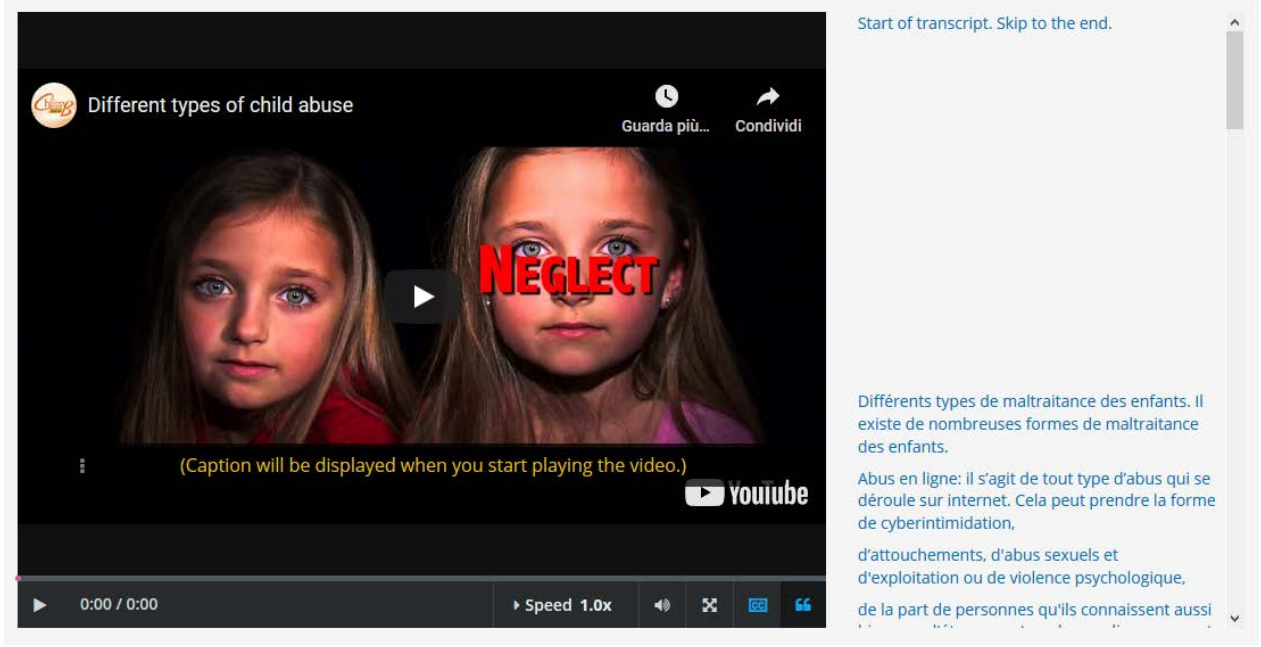
2. sur un plan longitudinal à l'âge adulte pour les sujets ayant connu des épisodes de violence physique et psychologique, cela entraîne une diminution de l'estime de soi et des capacités d'adaptation aux émotions (en particulier la colère et l'agression), une augmentation des comportements sexuels déviants et des difficultés d'adaptation psychosociale (Sesar et al., 2010) ;

3. chez les victimes d'abus sexuels ou physiques, cela augmente le risque d'éprouver des difficultés psychosociales et de présenter un comportement asocial ou antisocial, des symptômes physiques chroniques, des troubles anxieux ou dépressifs, des symptômes liés à un traumatisme et une dissociation (Higgins & McCabe, 2000).

4. En outre, à l'adolescence, les recherches scientifiques montrent également un risque accru de développement de comportements délinquants, d'abus de substances et d'automutilation, en particulier chez les personnes souffrant de SSPT ou ayant des antécédents de poly-victimisation.

En général, la recherche suggère, d'un point de vue épidémiologique, qu'il existe un lien entre le traumatisme et la gravité de l'altération ; de plus, s'il a été subi pendant l'enfance, il peut avoir des conséquences graves et débilitantes sur le développement des compétences cognitives, émotionnelles et sociales (Curran et al., 2018). Un aspect pouvant influencer le développement et les résultats des expériences traumatisantes de l'enfance est la négligence émotionnelle des figures d'attachement - en particulier celles qui ont des fonctions parentales - pour l'enfant (Schimmenti, 2018). Il est préférable de bien comprendre les mécanismes qui sous-tendent la variabilité individuelle de la réponse psychologique aux traumatismes à la fois pour identifier quels enfants risquent d'éprouver une détresse à long terme et afin de structurer des interventions efficaces appropriées (Ozer et al., 2003 ; Alisic et al., 2011). Plus précisément, soulignons que les enfants réagissent aux traumatismes de manière différente des adultes, en partie en raison de leur niveau de développement et de leurs compétences, notamment quand il s'agit de gérer le contenu mnésique et les réactions émotionnelles aux événements. Lonigan et ses collègues (1998) avaient déjà souligné combien la recherche scientifique devrait se concentrer sur l'analyse des réactions des enfants aux traumatismes et sur les facteurs qui y sont associés. L'une des questions posées portait sur la nécessaire analyse d'indicateurs - pouvant directement s'appliquer à la population enfantine et non pas simplement extrapolés en fonction de conditions rencontrées chez les sujets adultes – relatifs aux réactions normales et psychopathologiques des enfants aux événements indésirables. Un domaine d'investigation intéressant concerne la distinction à établir entre les réactions typiques à un traumatisme et les conditions susceptibles d'induire une réponse psychopathologique en se concentrant particulièrement sur les symptômes qui permettent de distinguer l'un de l'autre et de procéder à une évaluation efficace par les cliniciens (Lonigan et al., 1998). La littérature fournit de nombreuses informations sur les indicateurs de mauvais traitements et d'abus, soulignant qu'il s'agit souvent de signaux non spécifiques devant être lus avec prudence et précaution, car ils ne désignent pas toujours exclusivement la maltraitance. En effet, les opérateurs doivent être en mesure de mieux comprendre la souffrance de l'enfant dans les contextes où il se trouve, afin de bénéficier des meilleures conditions pour qu'il se sente accueilli et aidé à exprimer ses émotions et ses difficultés. En les complétant de techniques d'observation, les opérateurs peuvent utiliser des grilles d'indicateurs pour une étude optimale du problème. À titre d'exemple, veuillez consulter le lien vers un document élaboré par le CE.S.P.IM (Centro Servizi per il volontariato Provincia di Imperia) et intitulé « Il Silenzio dei Passerotti - Projet pour combattre et atténuer les abus et la maltraitance des enfants », où vous trouverez quelques exemples d'indicateurs d'abus et de maltraitance.

external video - Different types of Child Abuse



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Transcript

Différents types de maltraitance des enfants. Il existe de nombreuses formes de maltraitance des enfants.

Abus en ligne: il s’agit de tout type d’abus qui se déroule sur internet. Cela peut prendre la forme de cyberintimidation,

d’attouchements, d'abus sexuels et d'exploitation ou de violence psychologique,

de la part de personnes qu'ils connaissent aussi bien que d'étrangers. Les abus en ligne peuvent

se produire uniquement en ligne ou également aussi dans le monde réel.

La technologie étant omniprésente, les enfants et les jeunes souffrant de cette forme d'abus peuvent se sentir piégés,

sans issue de secours, puisque cela les poursuit où qu’ils aillent, même dans leur chambre,

censée pourtant être un endroit sûr pour eux. Attouchement: les attouchements se produisent quand un adulte

établit une connection avec un enfant dans l’objectif de les exploiter ou d’abuser

d’eux sexuellement. Cela peut se faire en ligne, dans le monde réel, par un étranger ou une personne qu'il connaît.

Abus sexuels: l’abus sexuel se produit quand un enfant est forcé ou se fait

persuader de prendre part à tout type d’acte sexuel, et ca ne doit pas être physique.

Parfois, l'enfant peut ne pas avoir conscience que ce qu’il se passe est de la maltraitance,

ou que ce qu’on lui impose est mal. Violence physique : la violence physique consiste à blesser délibérément un enfant,

lui causant ainsi des blessures telles que des côtes cassées, des brûlures ou des coupures.

Ils peuvent recevoir des coups de pied, des coups de poing, des gifles, être empoisonnés, brulés ou se faire jeter des objets sur eux.

Les bébés peuvent être secoués parfois si violemment que cela conduit à leur mort.

Négligence : la négligence est un manquement continu à fournir

les besoins les plus élémentaires à un enfant. Les enfants laissés affamés, sans hygiène, non habillés de manière adéquate,

laissés sans abris ou sans surveillance sont autant d'exemples d'enfants négligés.

La négligence peut également prendre la forme d'un parent ou d'un soignant qui ne protège

pas l'enfant contre d'autres types d’abus. Harcèlement:

les harcèlements sont des comportements qui blessent quelqu'un d'autre, comme par exemple

via des injures, ou par le fait de frapper, pousser, répandre des rumeurs, de menacer ou de rabaisser quelqu'un.

Cela peut se produire n'importe où, même dans leur propre maison, et souvent sur une longue période de temps.

La violence émotionnelle, également appelée violence psychologique, lorsqu'un parent

ou une personne qui s'occupe d'un enfant le maltraite ou le néglige constamment

sur le plan émotionnel, ce qui peut impliquerdélibérément d'effrayer ou

d'humilier un enfant ou en l'isolant ou en l'ignorant. Comportement sexuel préjudiciable :

les enfants et les jeunes qui développent un comportement sexuel préjudiciable se nuisent à eux-mêmes

et d'autres en utilisant des mots et des phrases sexuellement explicites, des attouchements inappropriés,

en utilisant la violence et les menaces sexuelles ou en ayant des relations

sexuelles avec pénétration totale avec d'autres enfants ou adultes.

L'exploitation sexuelle des enfants est une autre forme de maltraitance des enfants.

Les enfants et les jeunes personnes exploitées sexuellement

sont des personnes vulnérables qui ont été trompées ou manipulées

en croyant qu'ils sont dans une relation aimante et sûre. On peut leur proposer

de l'argent ou d'autres récompenses pour être ensuite réduits en esclavage. Il se peut qu'elles aient été préparées en ligne et qu'elles deviennent totalement dépendantes de leur agresseur,

ce qui rend le départ encore plus difficile. La traite des enfants est également un abus d'enfants.

Les enfants peuvent être victimes de la traite à des fins de main-d'œuvre bon marché, d'abus sexuels, de servitude domestique, de fraude aux allocations et de mariage forcé.

This section is a prerequisite. You must complete this section in order to unlock additional content.

Knowledge check

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VIEW UNIT IN STUDIO

Q4.3

4 points possible (graded)

1. L'observation se définit comme (Mantovani, 1995) :

- ○ une étape entre un phénomène et son interprétation ;
- ○ une forme de détection visant à explorer un phénomène donné ;
- ○ la description d'une espèce dans un catalogue ;
- ○ une façon objective et fidèle de rendre compte de la réalité.

2. Lors de l'observation, il est important :

- ○ d'éviter d'être influencé par des préjugés et des idées préconçues ;
- ○ d'éviter à tout prix de participer à l'interaction avec l'objet de l'observation ;
- ○ de toujours utiliser des outils d'observation structurés ;
- ○ de veiller à la rapidité du jugement.

3. Chez un mineur, la présence d'indicateurs et de signes associés à des mauvais traitements et à des abus...

- ○ doit être envisagée sans tenir compte des comportements ;
- ○ correspond, dans tous les cas, à des situations de maltraitance et d'abus ;
- ○ entraîne la déchéance immédiate de la responsabilité parentale.
- ○ peut se déduire par l'observation des émotions et des comportements ;

4. Selon Schimmenti (2018), les expériences traumatisantes...

- ○ sont toujours faciles à surmonter (il suffit de parler de l'événement à des amis et à la famille) ;
- ○ ne causent aucun dommage si elles sont vécues comme un événement unique, par le fait de la neuroplasticité ;
- ○ augmentent la probabilité de développer une maladie mentale, en particulier lorsque le sujet est soumis à des expositions multiples (traumatismes cumulés) ;
- ○ doivent être réprimées (il suffit de ne pas y penser).

Invia | You have used 0 of 2 attempts

Salva | Show Answer

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This subsection is unlocked for learners when they meet the prerequisite requirements.

Objectifs d'apprentissage

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VIEW UNIT IN STUDIO

1. Se familiariser avec les processus socioculturels et juridiques par lesquels les instances mondiales et européennes ont reconnu les enfants comme sujets de droits et l'obligation, pour les Etats, d'intervenir rapidement et efficacement pour leur protection en cas de violence, de maltraitance ou de traitement négligent ;

2. connaître les droits fondamentaux et les principes établis par le cadre juridique international et européen sur les droits de l'enfant permettant l'application d'une approche fondée sur les soins sensibles aux traumatismes (Trauma Informed Care - TIC). Une attention particulière sera accordée au droit des enfants à l'information et à la participation aux décisions les concernant, concernant leur prise en charge et leur avenir après avoir quitté les structures de prise en charge ;

3. connaître et comprendre les instruments juridiques qui garantissent la participation des enfants victimes de traumatismes aux procédures (administratives et judiciaires) nécessitant des décisions concernant leur protection (par exemple, le droit de l'enfant capable de discernement d'être entendu et, dans certains cas, le devoir de demander son consentement) ;

4. comprendre les effets opérationnels de l'approche basée sur les droits de l'enfant (et spécifiquement des droits de participation des enfants) sur les politiques sociales et de santé ;

5. connaître et maîtriser la terminologie juridique.

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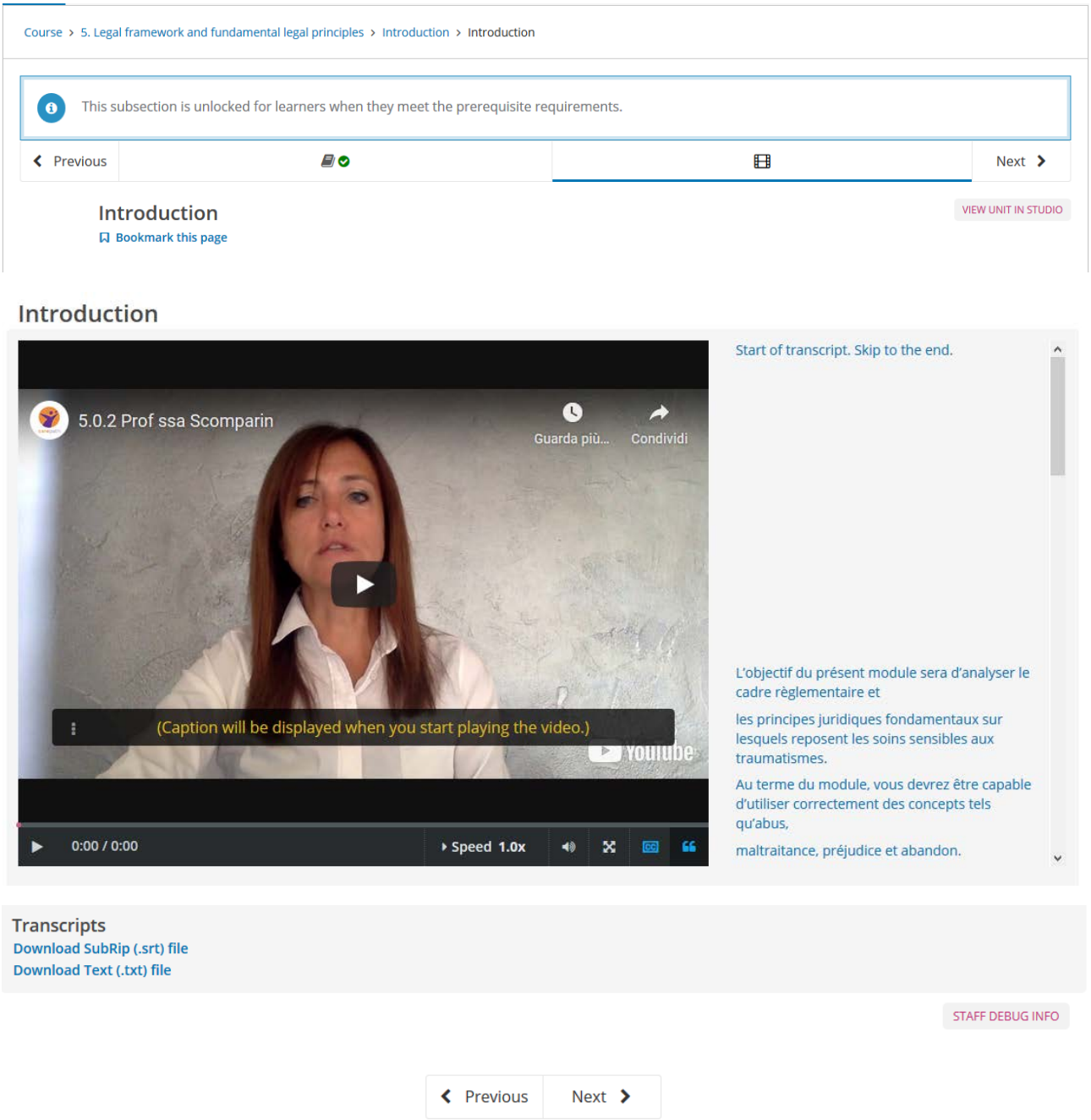


Transcript

L'objectif du présent module sera d'analyser le cadre règlementaire et

les principes juridiques fondamentaux sur lesquels reposent les soins sensibles aux traumatismes.

Au terme du module, vous devrez être capable d'utiliser correctement des concepts tels qu'abus,

maltraitance, préjudice et abandon.

L'objectif pédagogique de ce module est de comprendre le processus juridique

et culturel qui a mené, au niveau international et européen, à la reconnaissance des enfants mineurs

are subjects of right and that there is there is an obligation for States to intervene promptly

and effectively to protect them.

comme sujets de droit. Il s'agira également de comprendre que l'état à l'obligation d'intervenir rapidement

et efficacement pour assurer leur protection.

Dans le présent module, vous apprendrez aussi les droits et les principes fondamentaux, établis par le cadre règlementaire international et européen dans le domaine des droits de l'enfant.

a framework that is fundamental for Trauma Informed Care.

Ce cadre est essentiel pour un accompagnement sensible aux traumatismes.

Nous insisterons tout particulièrement sur le droit de l'enfant à être informé et entendu lors des procédures concernant l'aide

et les soins à leur apporter ainsi que leur avenir, et ce même après l'intervention de l'état.

Vous vous familiariserez également avec les mesures

garantissant la participation des mineurs victimes d'abus

aux processus décisionnels relatifs à leur protection,

qu'ils soient administratifs ou juridiques ; ainsi, vous insisterez sur

le droit de l'enfant à être entendu et,

si nécessaire, sur l'obligation d'obtenir son consentement pour la mise

en place d'une mesure de protection.

La dernière partie du module sera consacrée

à l'impact sur les politiques sociales et de santé d'une approche basée sur les droits de l'enfant,

par le biais d'un aperçu général suivi

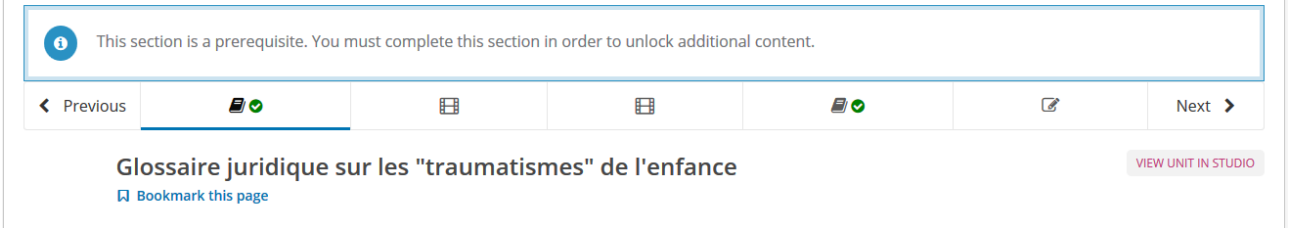
de quelques études de cas ; par exemple, cette partie se penchera sur les politiques

de lutte contre les mutilations génitales, contre les châtiments corporels

au sein de la famille ou sur les politiques de désignation

d'un tuteur pour les mineurs étrangers abandonnés,

qui ont été adoptées par de nombreux pays.



Glossaire juridique sur les "traumatismes" de l'enfance

Le terme « traumatisme » n'est pas couramment utilisé dans le langage juridique.

La Convention internationale relative aux droits de l'enfant (CRC), par exemple, veut « protéger l'enfant contre toute forme de violence, d'atteinte ou de brutalités physiques ou mentales, d'abandon ou de négligence, de mauvais traitements ou d'exploitation, y compris la violence sexuelle » (Art. 19).

Abus et maltraitance

Le Conseil de l'Europe définit la maltraitance des enfants en ces termes : « les actes et insuffisances qui perturbent gravement l'enfant, menacent son intégrité physique, son développement physique, intellectuel et moral, qui se manifestent sous la forme de négligence et / ou de blessures physiques et / ou mentales et / ou sexuelles par un membre de la famille ou d'autres personnes qui prennent soin de l'enfant". (IV Criminological Seminar - Strasbourg, 1978)

Pour l'Organisation mondiale de la Santé : « la maltraitance de l'enfant s'entend de toutes les formes de mauvais traitements physiques et/ ou affectifs, de sévices sexuels, de négligence ou de traitement négligent, ou d'exploitation commerciale ou autre, entraînant un préjudice reél ou potentiel pour la santé de l'enfant, sa survie, son développement ou sa dignité dans le contexte d'une relation de responsabilité, de confiance ou de pouvoir." (Organisation mondiale de la Santé, Rapport mondial sur la Violence et la Santé, 2002).

Tant un abus qu'une maltraitance peut prendre la forme :

- d'un comportement actif (par exemple, coups, blessures, actes sexuels, exploitation)
- d'une omission (par exemple, un manque de vigilance, de la négligence).

L'absence de preuves physiques traumatisantes n'exclut pas l'hypothèse de mauvais traitements ou d'abus. Par exemple, la conduite de l'enseignant / du parent qui humilie, dévalorise, dénigre ou viole psychologiquement un enfant ou le menace peut constituer un abus, lorsqu'il s'agit d'une violence psychologique pouvant porter atteinte à la santé psychophysique de l'enfant et à sa dignité.

Les termes **VIOLENCE et EXPLOITATION** désignent généralement des comportements actifs envers l'enfant.

L'exploitation, en particulier, peut être de nature économique ou sexuelle

- *Article 32 (CDE) : « Les Etats parties reconnaissent le droit de l'enfant d'être protégé contre l'exploitation économique et de n'être astreint à aucun travail comportant des risques ou susceptible de compromettre son éducation ou de nuire à sa santé ou à son développement physique, mental, spirituel, moral ou social. »*

- *Article 34, par. 1 (CDE) : « Les Etats parties s'engagent à protéger l'enfant contre toutes les formes d'exploitation sexuelle et de violence sexuelle. »*

Le Comité des droits de l'enfant des Nations Unies définit la « violence » comme « toute forme de violence, d'atteinte ou de brutalités physiques ou mentales, d'abandon ou de négligence, de mauvais traitements ou d'exploitation, y compris la violence sexuelle ». Dans le langage de tous les jours, le terme de violence est souvent utilisé pour désigner uniquement les dommages physiques et/ou les dommages intentionnels. Toutefois, le Comité insiste fortement sur le fait que le choix du terme « violence » dans l'Observation générale ne doit en aucun cas être interprété comme une tentative de minimiser l'impact ou la nécessité de traiter des formes non physiques et/ou non intentionnelles de dommages (telles que, entre autres, l'abandon et la maltraitance psychologique). (Le droit de l'enfant d'être protégé contre toutes les formes de violence, Observation générale n° 13 (2011) CRC / C / GC / 13, 18 avril 2011).

Enfin, l'expression **ÉTAT D'ABANDON** désigne une situation d'incapacité grave et permanente des parents à s'occuper de l'enfant en raison de négligence, de violence grave ou d'exploitation.

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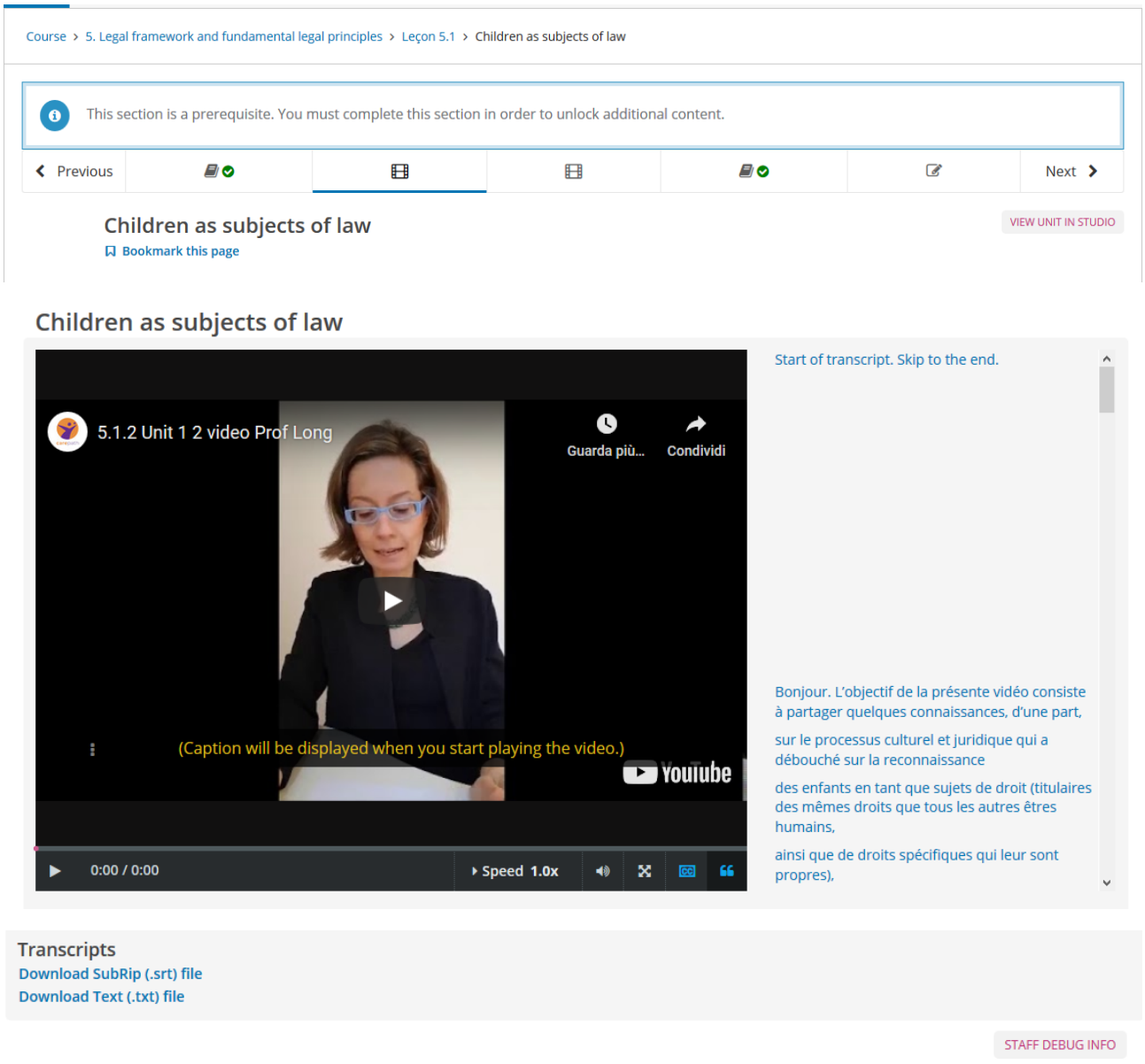

Transcript

Bonjour. L'objectif de la présente vidéo consiste à partager quelques connaissances, d'une part,

sur le processus culturel et juridique qui a débouché sur la reconnaissance

des enfants en tant que sujets de droit (titulaires des mêmes droits que tous les autres êtres humains,

ainsi que de droits spécifiques qui leur sont propres),

et d'autre part, sur le parcours vers la reconnaissance

de l'obligation qui impose à l'état de s'ingérer

pour défendre et protéger les droits

des enfants victimes de violence et de maltraitance. Pour contextualiser mes propos,

je lirai quelques lignes d'un livre de 2006 intitulé « La vie et les règles », publié chez Feltrinelli en Italie,

dont l'auteur, Stefano Rodot, juriste et politicien italien, fut l'un des auteurs de la Charte européenne des droits fondamentaux.

Rodot écrit : « la règle juridique ne peut pas être envisagée comme

une manière de supprimer la souffrance dans le monde,

mais bien comme un critère permettant de définir un seuil de souffrance

tolérable d'un point de vue social et personnel ».

Je pense que ce texte peut nous servir de base dans notre analyse de la réaction de l'état face à la maltraitance des enfants

en cela qu'il souligne l'omnipotence de la loi.

En d'autres termes, même s'il existe des règles juridiques visant à réprimer

la violence et les abus envers les enfants et tenter de les éviter,

malheureusement, la violence et la maltraitance peuvent toujours se produire au quotidien.

De plus, quand il y a actes de violence ou de maltraitance,

l'état n'est pas toujours en mesure d'intervenir de manière opportune et efficace.

J'ajouterai que ces quelques lignes écrites par Rodot posent la question du seuil justifiant

une intervention générale de l'état en protection de personnes confrontée

à de grandes difficultés et une intervention plus spécifique d'aide aux enfants victimes de maltraitance.

Dans ce cas, on peut fixer le seuil quand il y a atteinte et violation du droit à

la dignité humaine. En conséquence, l'état doit intervenir quand le seuil de souffrance

est tel qu'il risque de compromettre la dignité de l'être humain.

Ainsi, le motif d'une intervention de l'état découle de

son obligation générale à assurer la solidarité sociale, la protection des libertés individuelles

et la protection particulière des personnes vulnérables.

Passons maintenant aux étapes essentielles du parcours qui nous a permis de définir

l'enfant comme sujet de droit et de reconnaître l'obligation de l'état à protéger les enfants victimes

d'abus.

L'année 1874 est la première date marquante.

En effet, c'est cette année que se déroule se déroule dans la ville de New York

aux Etats-Unis le procès de la mère d'une enfant appelée Mary Ellen Wilson. L'affaire Mary Ellen Wilson fut l'une des premières à faire la une des journaux

car elle montrait l'absence totale d'un système public de protection de l'enfant.

C'est d'ailleurs suite à cette affaire que fut créée

la première organisation caritative en la matière : la New York Society for the Prevention of

Cruelty to Children (organisation new yorkaise pour la prévention de la cruauté à l'égard des enfants). Retraçons les événements de ce cas particulier ?

Les voisins dénoncent auprès

d'une missionnaire méthodiste, Etta Wheeler, la maltraitance, par sa mère,

d'une enfant censée avoir 5 ans (Mary Ellen, qui est en fait âgée

de 10 ans). Etta Wheeler parvient à entrer dans la maison sous prétexte de venir chercher de l'aide

En invoquant cette excuse, Etta Wheeler parvient donc à entrer

Etta Wheeler entered the home of Mary Ellen's parents and thus personally verified

the situation of the child, who was actually a victim of abuse,

chez les parents de Mary Ellen et constate la situation dans laquelle vit l'enfant : celle-ci est victime de maltraitance physique (elle présente des brûlures, des ecchymoses,

des entailles sur le corps et les vêtements qu'elle porte ne sont pas adaptés à la saison) et psychologique

(l'enfant est enfermée dans une armoire plusieurs heures par jour

et ne peut pas sortir de la maison, si ce n'est quelques minutes en soirée, dans la cour de l'immeuble).

Etta Wheeler contacte les autorités locales et leur demande de retirer l'enfant

du foyer familial. Malheureusement, les autorités locales refusent faute de cadre juridique permettant de retirer un enfant à sa famille.

Etta Wheeler ne renonce pas : elle sollicite et obtient

l'aide d'un avocat spécialisé dans la protection des animaux contre la cruauté.

Et c'est en invoquant ce cadre règlementaire qu'elle obtient le retrait de l'enfant du foyer familial.

En 1874 le procès se termine par la condamnation

de la mère à un an de prison pour maltraitance à l'encontre de Mary Ellen.

Quelques années plus tard, en 1924, le processus d'affirmation

des droits de l'enfant connaît une avancée remarquable. Cette fois, nous nous rendons en Europe dans la ville de Genève.

La Ligue des nations proclame une charte, connue sous le nom de déclaration de « Genève »

ou Déclaration des droits de l'enfant. Encore aujourd'hui, il s'agit d'une charte axée principalement sur les

besoins matériels et affectifs de l'enfant. Elle considère en premier lieu les enfants comme

des bénéficiaires passifs de droits. Par exemple, la Déclaration stipule que

« L'enfant qui a faim doit être nourri ; l'enfant malade doit être soigné ».

Nous devrons encore attendre quelques décennies pour obtenir une nouvelle charte, la Déclaration universelle

des droits de l'enfant, déclaration proclamée à New York en 1959 par l'Organisation des Nations-Unies.

comme des titulaires

directs de droits au même titre que

n'importe quel autre être humain. Par exemple,

le premier principe dit que « L'enfant doit jouir de tous les droits énoncés dans

la présente Déclaration ». Le troisième principe ajoute que « L'enfant a droit,

dès sa naissance, à un nom et à une nationalité. » Cette formulation des droits a ensuite été reprise

au niveau mondial dans le fameux document sur les droits de l'enfant,

la Convention de l'ONU de 1989.

J'insiste sur le mot « convention »

car il s'agir là du premier changement important par rapport aux documents de 1924

et 1959. La Convention de 1989 est un document contraignant pour les Etats

qui l'ont ratifié, contrairement à une déclaration,

qui est un texte purement programmatique. Ainsi, elle a un effet persuasif pour les états bénéficiaires.

La Convention de 1989 est également connue pour son mécanisme de suivi et de contrôle,

qui repose sur la Commission des droits de l'enfant, un organisme basée à Genève et

chargé d'examiner les rapports périodiques des Etats membres sur la transposition

de la Convention dans leurs systèmes juridiques nationaux. La Convention octroie à l'enfant tous les droits que les

chartes internationales accordent aux êtres

humains, ainsi qu'une série de droits spécifiques en tant que personnes en devenir.

Dans le cadre de la maltraitance des enfants, signalons l'Article 19,

qui protège « l'enfant contre toutes les formes de violence » au sein de la famille ;

ainsi que l'Article 34, "Protection contre toutes les formes d'exploitation sexuelles et de violence sexuelle »,

l'Article 35 « protection de l'enfant contre l'enlèvement, la vente ou la traite », l'Article 37 « protection contre la torture, des peines ou traitements cruels, inhumains ou dégradants »,

et enfin l' Article 39,

très important car il établit que : « Les Etats parties prennent toutes les mesures appropriées pour faciliter la réadaptation

physique et psychologique et la réinsertion sociale de tout enfant victime de toute forme de négligence, d'exploitation ou de sévices ».

and social reintegration of a child victim of abuse."

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The Mary Ellen Case

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The Mary Ellen case

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Supporting material

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VIEW UNIT IN STUDIO

1. **AFFAIRE Z ET AUTRES c. ROYAUME-UNI**
2. UN Convention on theRights of the Child In Child Friendly Language (English)
3. La Convention des Nations Unies relatives aux droits de l'enfants (texte intégral)

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Quiz 5.1

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VIEW UNIT IN STUDIO

Q5.1

5 points possible (graded)

1) Dans le langage juridique, lequel des éléments suivants est considéré comme un « traumatisme » de l'enfance ?

- ○ Toute forme de violence physique et non physique, même quand l'acte n'est pas commis dans l'intention de la causer
- ○ La seule violence physique, si l'acte a été commis dans l'intention de la causer
- ○ La seule violence physique, même si l'acte n'a pas été commis dans l'intention de la causer
- ○ Toute forme de violence physique ou non physique, si l'acte a été commis dans l'intention de la causer

2) Dans le cas de Mary Ellen Wilson, la victime de maltraitance a bénéficié d'une protection en application de :

- ○ l'interdiction des traitements inhumains et dégradants
- ○ l'interdiction de la cruauté envers les animaux
- ○ l'interdiction des châtiments corporels
- ○ l'interdiction de la maltraitance des enfants

3) Lequel des énoncés suivants est vrai ?

- ○ Les enfants ne sont pas sujets de droits
- ○ Les enfants n'ont que des droits reconnus à toute personne humaine en tant que telle
- ○ Les enfants jouissent de droits spécifiques qui leur sont accordés en tant que mineurs (trainees)
- ○ Les enfants sont sujets de droits s'ils ont la capacité de discernement

4) Lequel des éléments suivants représente un instrument spécifique développé au sein du Conseil de l'Europe pour la protection de l'enfant ?

- ○ La Convention de Lanzarote
- ○ La CEDH
- ○ La Charte sociale européenne
- ○ La Charte de Nice

5) Dans l'arrêt de la Cour européenne des droits de l'homme "Z. ET AUTRES contre le ROYAUME-UNI", lequel des éléments suivants est reconnu ?

- ○ Article 5 de la CEDH (Droit à la liberté et à la sécurité)
- ○ Article 6 de la CEDH (Droit à un procès équitable)
- ○ Article 8 de la CEDH (Droit au respect de la vie privée et familiale)
- ○ Article 3 de la CEDH (Interdiction de la torture)

[explanation Commentaires : la Cour a soutenu à l'unanimité qu'il y avait violation de l'article 3 de la Convention ; qu'aucune question distincte ne se posait en vertu de l'article 8 de la Convention ; avec douze voix contre cinq, qu'il n'y avait pas violation de l'article 6 de la Convention ; enfin, avec quinze voix contre deux, qu'il y avait violation de l'article 13 de la Convention. [explanation]

Invia You have used 0 of 2 attempts

Salva Show Answer

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Glossaire juridique sur les organisations et traités internationaux et de l'Union européenne

Organisation des Nations Unies (ONU) = organisation internationale fondée en 1945 dans le but de maintenir la paix et la sécurité internationales, de développer des relations amicales entre les nations, de coopérer pour résoudre les problèmes internationaux et promouvoir le respect des droits de l'homme ; elle est au centre des efforts d'harmonisation des diverses initiatives nationales. Les membres de l'ONU sont des États souverains ; les Nations Unies ne sont pas un gouvernement mondial et ne légifèrent pas.

Toutefois, l'ONU fournit aux Etats les outils nécessaires pour résoudre les conflits internationaux et formule des politiques appropriées sur des questions d'intérêt commun.

Convention internationale relative aux droits de l'enfant (CDE) = traité international approuvé par l'Assemblée générale des Nations Unies en 1989 qui exprime un consensus sur les obligations des États et de la communauté internationale envers les enfants et reconnaît pour la première fois que les enfants jouissent également de droits civils, sociaux, politiques, culturels et économiques.

Comité des droits de l'enfant des Nations Unies = établi par la Convention des Nations Unies relative aux droits de l'enfant afin d'examiner les progrès réalisés par les États parties dans l'exécution des obligations découlant du traité, il est composé de 18 experts de haute moralité et possédant une expertise reconnue dans le secteur visé par la Convention. Le Comité a pour tâche d'analyser les rapports périodiques sur la mise en œuvre de la Convention que les États parties se sont engagés à présenter conformément aux dispositions de son article 44.

Convention européenne des droits de l'homme (CEDH) = traité international en vertu duquel les Etats membres du Conseil de l'Europe garantissent les droits civils et politiques fondamentaux non seulement à leurs propres citoyens mais aussi à toute personne relevant de leur juridiction. Signée à Rome le 4 novembre 1950, la Convention est entrée en vigueur en 1953.

Cour européenne des droits de l'homme (Cour de Strasbourg) = Cour internationale instituée en 1959 et ayant son siège à Strasbourg. Elle statue sur les recours individuels ou étatiques concernant des violations alléguées des droits civils et politiques établis par la Convention européenne des droits de l'homme. Depuis 1998, la Cour est un organe permanent et peut être saisie directement par des particuliers.

Conseil de l'Europe = organisation internationale dont le but est de promouvoir la démocratie, les droits de l'homme, l'identité culturelle européenne et la recherche de solutions aux problèmes sociaux en Europe. Fondée le 5 mai 1949 par le traité de Londres, elle a son siège à Strasbourg et compte 47 États membres, dont les 28 membres de l'Union européenne.

Attention ! Le Conseil de l'Europe est une organisation distincte de l'Union européenne et ne doit pas être confondu avec ses organes.

Convention du Conseil de l'Europe pour la protection des enfants contre l'exploitation et les abus sexuels (Convention de Lanzarote) = traité par lequel les Etats membres conviennent d'ériger en infraction pénale certaines formes d'abus sexuels perpétrées contre des enfants. Il s'agit du premier traité international qui traite des abus sexuels d'enfants commis au sein de la famille.

Convention du Conseil de l'Europe sur la prévention et la lutte contre la violence à l'égard des femmes et la violence domestique (Convention d'Istanbul) = traité international qui vise à prévenir la violence, à promouvoir la protection des victimes et à prévenir l'impunité des auteurs. C'est le premier instrument international juridiquement contraignant qui crée un cadre juridique complet pour protéger les femmes contre toute forme de violence.

Union Européenne = organisation économique et politique entre 28 pays du continent européen, créée après la Seconde Guerre mondiale dans le but de promouvoir une plus grande coopération économique entre les États membres ; elle est devenue au fil du temps une organisation visant à jeter les bases d'une Union entre les peuples européens, à sauvegarder les pays et à rechercher l'unité politique, garantissant, par une action commune, le progrès économique et social, comme la création d'un marché unique européen et le renforcement de la cohésion sociale.

Charte des droits fondamentaux de l'Union européenne (Charte de Nice) = proclamée lors du Conseil européen de Nice du 20 décembre 2000, elle rassemble tous les droits civils, politiques, économiques et sociaux valables dans l'Union européenne et établit la nature et la portée fondamentales des droits de l'homme pour les citoyens européens. Bien qu'elle ne soit devenue juridiquement contraignante qu'après l'entrée en vigueur du traité de Lisbonne, elle a inspiré, dès son origine, l'activité du Parlement européen. Avec l'entrée en vigueur du traité de Lisbonne, la Charte de Nice a acquis la même valeur juridique que les traités et est donc pleinement contraignante pour les institutions européennes et les États membres.

Cour de justice de l'Union européenne (CJUE - Cour de Luxembourg) = créée en 1952, elle a son siège à Luxembourg et interprète la législation communautaire afin d'en garantir l'application uniforme dans tous les États membres et de statuer sur les différends juridiques entre les gouvernements des Etats membres et les institutions européennes.

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Les droits de l' enfant

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Les droits de l'enfant

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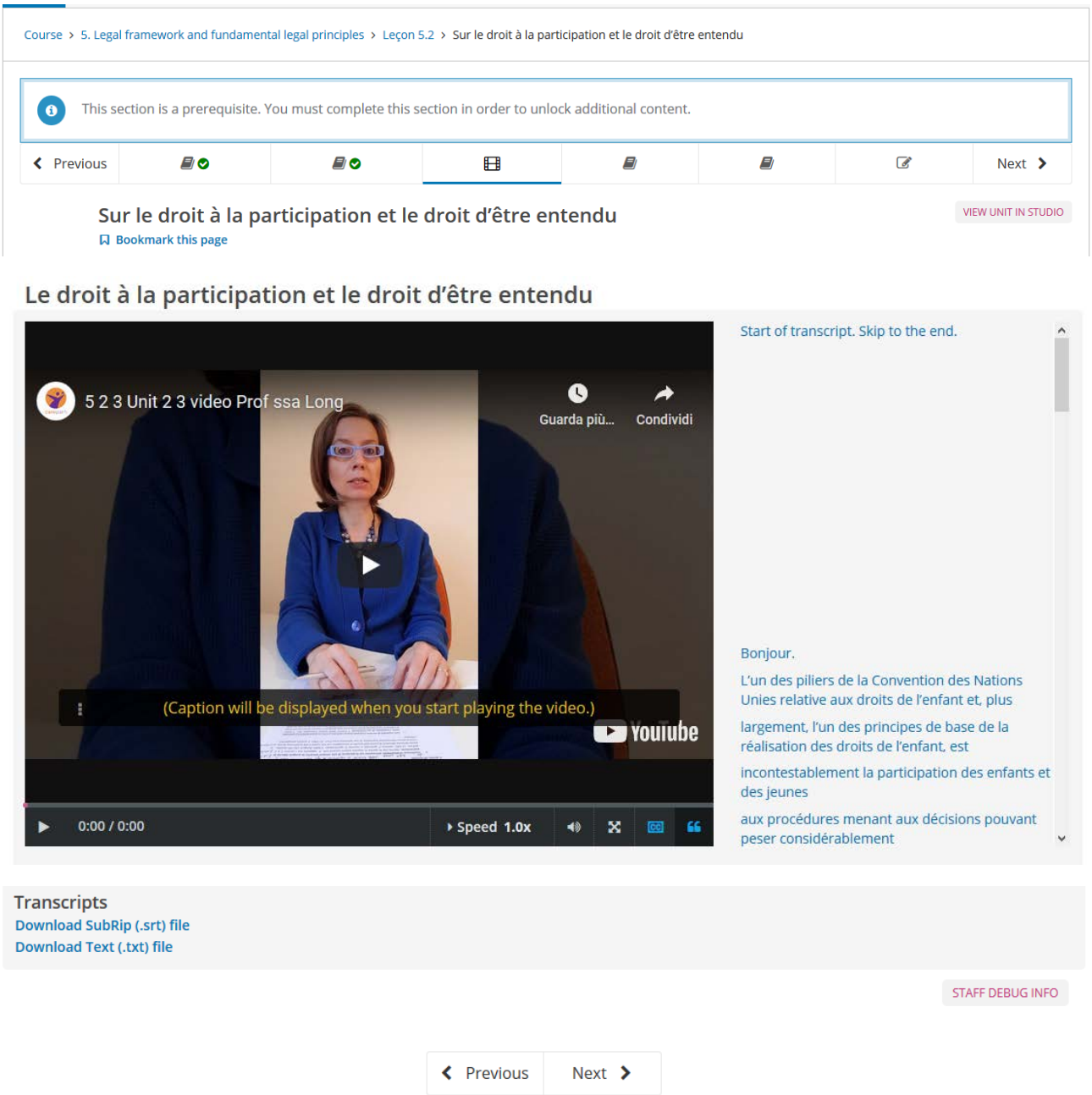

Transcript

Bonjour.

L'un des piliers de la Convention des Nations Unies relative aux droits de l'enfant et, plus largement, l'un des principes de base de la réalisation des droits de l'enfant, est incontestablement la participation des enfants et des jeunes aux procédures menant aux décisions pouvant peser considérablement sur leur vie.

La Convention de l'ONU relative aux droits de l'enfant reconnaît le droit de l'enfant, en tant qu'être humain, à la liberté d'expression dans son Article 12, paragraphe 1; et dans le paragraphe suivant,

elle détermine les instruments garantissant la participation de l'enfant

dans les procédures. Il s'agit principalement du droit à être entendu par le juge ou

par d'autres autorités administratives susceptibles de prendre des décisions dans l'intérêt de l'enfant.

Cependant, le droit à être entendu n'est pas le seul à garantir la participation de l'enfant

dans les décisions qui le concernent.

La Convention européenne sur l'exercice des droits de l'enfant, qui porte plus précisément

sur les procédures judiciaires, reconnaît, dans son Article 3, le droit de l'enfant à « recevoir toute information pertinente » ;

dans son Article 4, elle reconnaît le droit de l'enfant à « demander [...] la

désignation d'un représentant spécial » et « la désignation d'un représentant spécial dans les procédures l'intéressant devant une autorité judiciaire, lorsque le droit interne prive

les détenteurs des responsabilités parentales de la faculté de représenter l'enfant en

raison d'un conflit d'intérêts avec celui-là ».

What does it mean in practice to refer the child's right to be heard heard to his freedom of expression?

Comment la référence au droit de l'enfant à être entendu et à sa liberté d'expression

se traduit-elle dans la pratique ?

Ce processus préliminaire d'écoute de l'enfant vise

avant tout à garantir la possibilité de s'exprimer sur une question très importante

pour sa vie.

On relève des conséquences pratiques sur, par exemple, les méthodes d'écoute : le

processus ne peut pas être mené comme un interrogatoire ou comme l'audition

d'un témoin.

De plus, l'enfant peut refuser d'être entendu

par le juge.

Le droit à être entendu étant un droit, son titulaire peut décider de ne pas l'exercer.

Quelles sont les raisons pouvant être invoquées pour ne pas réaliser ce droit à être entendu ?

On ne peut motiver la non application en déclarant que l'audition est

superflue dans ce cas particulier.

La seule raison permettant d'écarter l'application du droit à être entendu

est que cette écoute pourrait nuire aux intérêts du mineur.

La protection de l'enfant est l'un des autres piliers de la Convention de l'ONU relative aux droits de l'enfant, qui doit

être mis en regard du droit de l'enfant à participer

aux procédures qui le concernent.

Un autre exemple en est la volonté

exprimée par l'enfant lorsqu'il est entendu par l'autorité décisionnelle.

En fait, l'autorité n'est pas tenue de respecter la volonté exprimée par l'enfant.

Elle peut en effet considérer que celle-ci va

à l'encontre de son intérêt.

Prenons l'exemple d'un mineur d'âge qui dans le cadre d'une procédure civile relative à

un cas de maltraitance familiale, insiste pour continuer à le parent

ou l'adulte maltraitant.

Dans ce cas, l'autorité peut refuser

les visites et maintenir sa décision même si elle est contraire à la volonté exprimée par l'enfant.

Il en va différemment des affaires concernant des adultes.

En effet, les adultes ont le droit, par exemple, de refuser un traitement médical même

si cela risque de causer leur décès.

Ce n'est pas le cas pour les mineurs car dans leur cas, comme 54 00:05:43,930 --> 00:05:49,740 je l'ai signalé, le droit à la participation, principalement le droit à l'auto-détermination, doit être mis en balance

avec l'intérêt supérieur de l'enfant.

However, the need for balance requires the judicial authority and, in general, the

Toutefois, l'autorité judiciaire, et les autorités en général, chargée de décider du sort

d'un enfant, doit informer ce dernier de leur décision et lui expliquer pourquoi il n'a pas

été possible de respecter la volonté qu'il/elle a exprimée pendant les audiences.

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"THE CHILDREN ACT"

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PRESENTATION DU FILM "THE CHILDREN ACT" (My Lady dans sa version française)

La film a pour principaux personnages Adam, un garçon de dix-sept ans qui, en accord avec ses parents, refuse une transfusion sanguine pour des raisons religieuses, et Fiona Maye, une juge anglaise spécialisée dans le droit de la famille et des mineurs, appelée à décider s'il faut autoriser ou non les médecins à procéder à la transfusion de sang.

Le film nous donne à réfléchir sur deux aspects distincts de la discipline des droits des mineurs à être entendu, que l'on retrouve dans l'art. 12 de la Convention des Nations Unies relative aux droits de l'enfant (CDE).

1) **C'est en étant « entendu » que le mineur exerce sa liberté d'expression**. Dans le film, Fiona rencontre Adam parce qu'elle souhaite le « connaître » et non pas simplement « l'entendre » au sens de la méthode d'interrogation ou d'une audition de témoin. Elle ne se limite pas, durant leur rencontre, à examiner en profondeur les raisons de la décision de refuser la transfusion, mais discute avec lui de différents sujets, tels que la musique et la poésie.

2) **Qui plus est, l'audience ne lie pas le juge à la volonté du mineur**. En fait, dans le film, Fiona décide d'agir contre la volonté d'Adam. Contrairement à l'adulte - qui a le droit de décider de sa propre vie, même si cette décision entraîne la mort (par exemple, le refus d'une transfusion sanguine pour des raisons religieuses) - le mineur ne détient pas ce droit de manière absolue : l'art. 12 de la Convention des Nations Unies relative aux droits de l'enfant (CDE) stipule que quiconque décide doit prendre en considération l'opinion du mineur ainsi que son développement eu égard à son âge et à son degré de maturité, sans que cela ne soit contraignant pour le ou la juge. En effet, si le ou la juge ou la personne appelée à prendre une décision à l'égard d'un mineur estime que la volonté exprimée lors de l'audition n'est pas conforme à l'intérêt du mineur, non seulement il / elle en a le droit, mais il / elle doit décider dans le sens contraire.

The Children Act - Official Trailer

STAFF DEBUG INFO

The Children Act Official Trailer #1 (2018) Emma Thompson, Stanley Tucci Drama Movie HD

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Supporting material

VIEW UNIT IN STUDIO

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Manuel de droit européen en matière de droits de l'enfant

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Quiz 5.2

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VIEW UNIT IN STUDIO

Q5.2

6 points possible (graded)

1) Qu'entend-on par « châtiments corporels infligés à un enfant » ?

- ○ Uniquement les châtiments corporels destinés à causer de la douleur à l'enfant.
- ○ Les châtiments corporels exclusivement destinés à causer de la douleur ou de l'inconfort à l'enfant.
- ○ Des actes physiques ou non physiques, à l'exception d'actes posés pour éduquer les enfants.
- ○ des actes non physiques, tels que les menaces, visant à humilier l'enfant.

2) Parmi les énoncés suivants, lequel est faux ?

- ○ La différenciation injustifiée selon l'âge est interdite
- ○ Les mineurs ont le droit, en tant que tels, d'être traités différemment en fonction de leur âge.
- ○ Tous les traitements différenciés selon l'âge sont interdits
- ○ Le traitement des enfants doit s'inspirer du principe de l'intérêt supérieur de l'enfant

3) Parmi les énoncés suivants sur le droit d'un enfant à être entendu, lequel est vrai ?

- ○ L'audition peut se dérouler comme l'audition d'un témoin, mais pas comme un interrogatoire.
- ○ Il ne doit être garanti que dans les procédures judiciaires et administratives qui le concernent
- ○ Il peut être exclu lorsque l'opinion de l'enfant est superflue.
- ○ Il ne doit être garanti que dans les procédures judiciaires et non dans les procédures administratives qui le ou la concernent.

Commentaire : l'enfant a le droit d'être entendu dans toute procédure judiciaire ou administrative l'intéressant, soit directement, soit par l'intermédiaire d'un représentant ou d'une organisation approprié (Article 12 de la Convention internationale relative aux droits de l'enfant - CDE). L'audition ne peut se dérouler comme une interrogation ni comme l'audition d'un témoin. (Voir la video de la contribution du Prof. Long)

4) Dans le cas où l'enfant est entendu, son avis est-il contraignant pour ceux qui décident ?

- ○ Non, mais le décideur doit en tenir compte.
- ○ Oui.
- ○ Non, le décideur peut ne pas en tenir compte.
- ○ Oui si l'enfant a un degré élevé de maturité.

5) Lequel des instruments suivants est un instrument spécifique développé au sein du Conseil de l'Europe sur la violence domestique ?

- ○ Convention d'Istanbul
- ○ Convention de Lanzarote
- ○ Convention internationale relative aux droits de l'enfant (CDE)
- ○ Convention sur les relations personnelles relatives aux enfants

You can use this template as a guide to the simple editor markdown and OLX markup to use for multiple choice problems. Edit this component to replace this template with your own assessment.

Add the question text, or prompt, here. This text is required. You can add an optional tip or note related to the prompt like this.

- ○ an incorrect answer
- ○ the correct answer
- ○ an incorrect answer

Invia You have used 0 of 2 attempts

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Glossaire juridique sur la participation des enfants traumatisés aux procédures civiles et pénales

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Victimisation primaire = maltraitance ou violence, qui cause des souffrances et des blessures physiques et/ou psychologiques.

Victimisation secondaire = souffrances supplémentaires causées par le stress de la procédure elle-même, par le souvenir de la maltraitance subie et par le contact possible avec l'auteur du comportement, avec le juge et avec les avocats.

Procédure pénale = procédure juridictionnelle par laquelle l'auteur du comportement contre le mineur est puni, si son comportement est un crime.

Procédure civile = procédure juridictionnelle par laquelle un juge évalue le caractère adéquat de l'environnement familial de l'enfant et prend les mesures nécessaires.

Audition du mineur = partie de la procédure civile/pénale au cours de laquelle le mineur fait des déclarations sur les faits ayant une pertinence pour la décision du juge.

Consultation du mineur = partie de la procédure (notamment civile) au cours de laquelle le mineur exprime son opinion, avant que le juge ne prenne la décision.

Consentement du mineur = garantie supplémentaire qui consiste en l'obligation pour le juge d'obtenir l'avis favorable du mineur afin de prendre une décision spécifique (par exemple, garde ou adoption).

Représentant = lorsque les parents sont absents, indisponibles ou en conflit d'intérêts, le représentant est une personne qui identifie l'intérêt de l'enfant et le défend tout au long de la procédure.

Avocat = personne qualifiée désignée pour tenter d'obtenir une décision du juge dans la mesure du possible en fonction de l'intérêt de l'enfant.

Professionnel social ou professionnel de la santé = expert en psychologie, psychiatrie ou sociologie, qui assiste l'enfant victime de traumatismes lors des procédures civiles et pénales et aide le juge à évaluer ses conditions psychophysiques et une éventuelle protection nécessaire.

Mesures conservatoires = mesures provisoires, adoptées par le juge, pour protéger le bien-être psychophysique du mineur pendant la procédure.

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La parole de l'enfant traumatisé dans les procédures civiles et pénales

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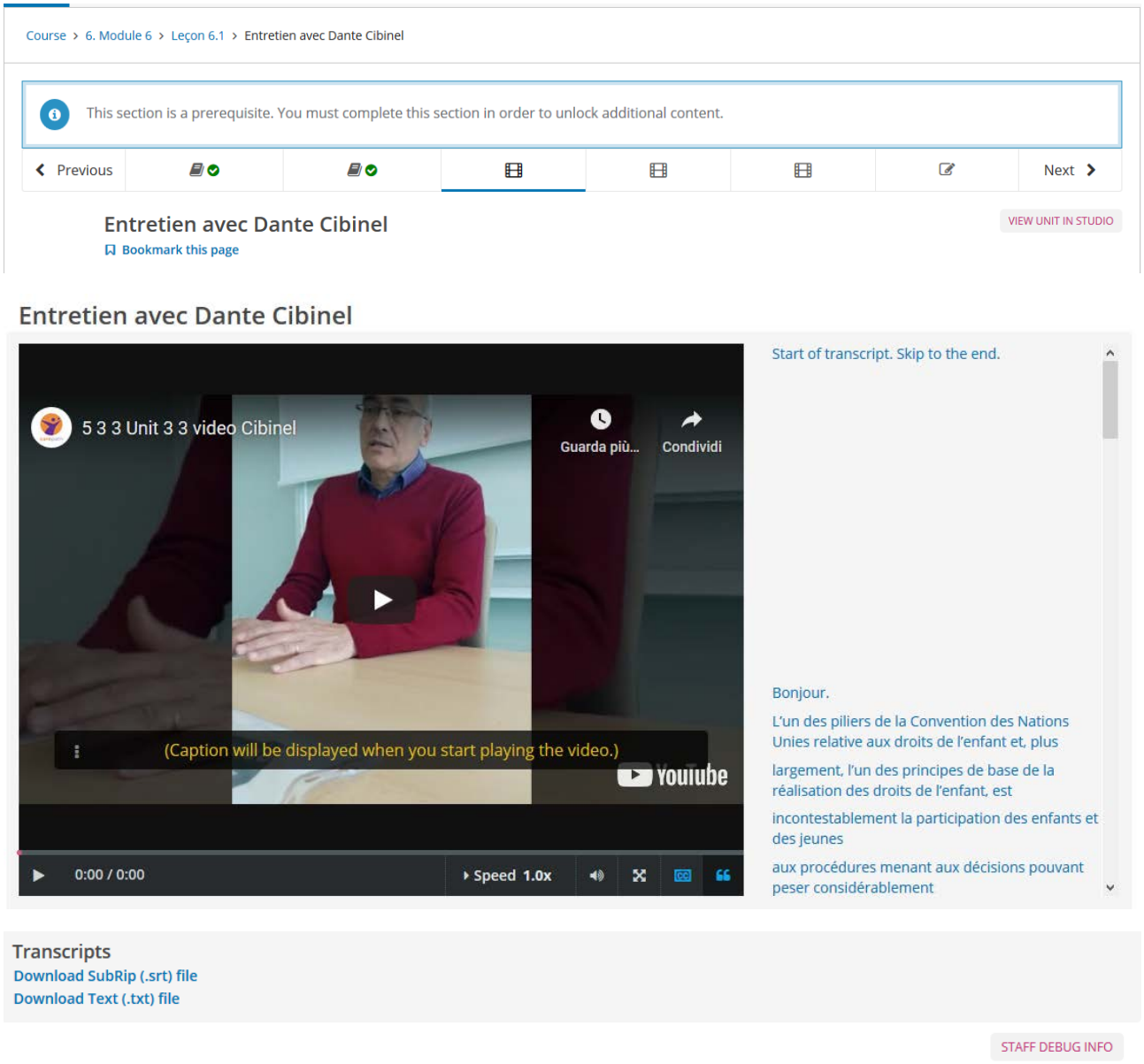


Transcript

Bonjour.

L'un des piliers de la Convention des Nations Unies relative aux droits de l'enfant et, plus largement, l'un des principes de base de la réalisation des droits de l'enfant, est incontestablement la participation des enfants et des jeunes aux procédures menant aux décisions pouvant peser considérablement sur leur vie.

La Convention de l'ONU relative aux droits de l'enfant reconnaît le droit de l'enfant, en tant qu'être humain, à la liberté d'expression dans son Article 12, paragraphe 1; et dans le paragraphe suivant,

elle détermine les instruments garantissant la participation de l'enfant

dans les procédures. Il s'agit principalement du droit à être entendu par le juge ou

par d'autres autorités administratives susceptibles de prendre des décisions dans l'intérêt de l'enfant.

Cependant, le droit à être entendu n'est pas le seul à garantir la participation de l'enfant

dans les décisions qui le concernent.

La Convention européenne sur l'exercice des droits de l'enfant, qui porte plus précisément

sur les procédures judiciaires, reconnaît, dans son Article 3, le droit de l'enfant à « recevoir toute information pertinente » ;

dans son Article 4, elle reconnaît le droit de l'enfant à « demander [...] la

désignation d'un représentant spécial » et « la désignation d'un représentant spécial dans les procédures l'intéressant devant une autorité judiciaire, lorsque le droit interne prive

les détenteurs des responsabilités parentales de la faculté de représenter l'enfant en

raison d'un conflit d'intérêts avec celui-là ».

What does it mean in practice to refer the child's right to be heard heard to his freedom of expression?

Comment la référence au droit de l'enfant à être entendu et à sa liberté d'expression

se traduit-elle dans la pratique ?

Ce processus préliminaire d'écoute de l'enfant vise

avant tout à garantir la possibilité de s'exprimer sur une question très importante

pour sa vie.

On relève des conséquences pratiques sur, par exemple, les méthodes d'écoute : le

processus ne peut pas être mené comme un interrogatoire ou comme l'audition

d'un témoin.

De plus, l'enfant peut refuser d'être entendu

par le juge.

Le droit à être entendu étant un droit, son titulaire peut décider de ne pas l'exercer.

Quelles sont les raisons pouvant être invoquées pour ne pas réaliser ce droit à être entendu ?

On ne peut motiver la non application en déclarant que l'audition est

superflue dans ce cas particulier.

La seule raison permettant d'écarter l'application du droit à être entendu

est que cette écoute pourrait nuire aux intérêts du mineur.

La protection de l'enfant est l'un des autres piliers de la Convention de l'ONU relative aux droits de l'enfant, qui doit

être mis en regard du droit de l'enfant à participer

aux procédures qui le concernent.

Un autre exemple en est la volonté

exprimée par l'enfant lorsqu'il est entendu par l'autorité décisionnelle.

En fait, l'autorité n'est pas tenue de respecter la volonté exprimée par l'enfant.

Elle peut en effet considérer que celle-ci va

à l'encontre de son intérêt.

Prenons l'exemple d'un mineur d'âge qui dans le cadre d'une procédure civile relative à

un cas de maltraitance familiale, insiste pour continuer à le parent

ou l'adulte maltraitant.

Dans ce cas, l'autorité peut refuser

les visites et maintenir sa décision même si elle est contraire à la volonté exprimée par l'enfant.

Il en va différemment des affaires concernant des adultes.

En effet, les adultes ont le droit, par exemple, de refuser un traitement médical même

si cela risque de causer leur décès.

Ce n'est pas le cas pour les mineurs car dans leur cas, comme 54 00:05:43,930 --> 00:05:49,740 je l'ai signalé, le droit à la participation, principalement le droit à l'auto-détermination, doit être mis en balance

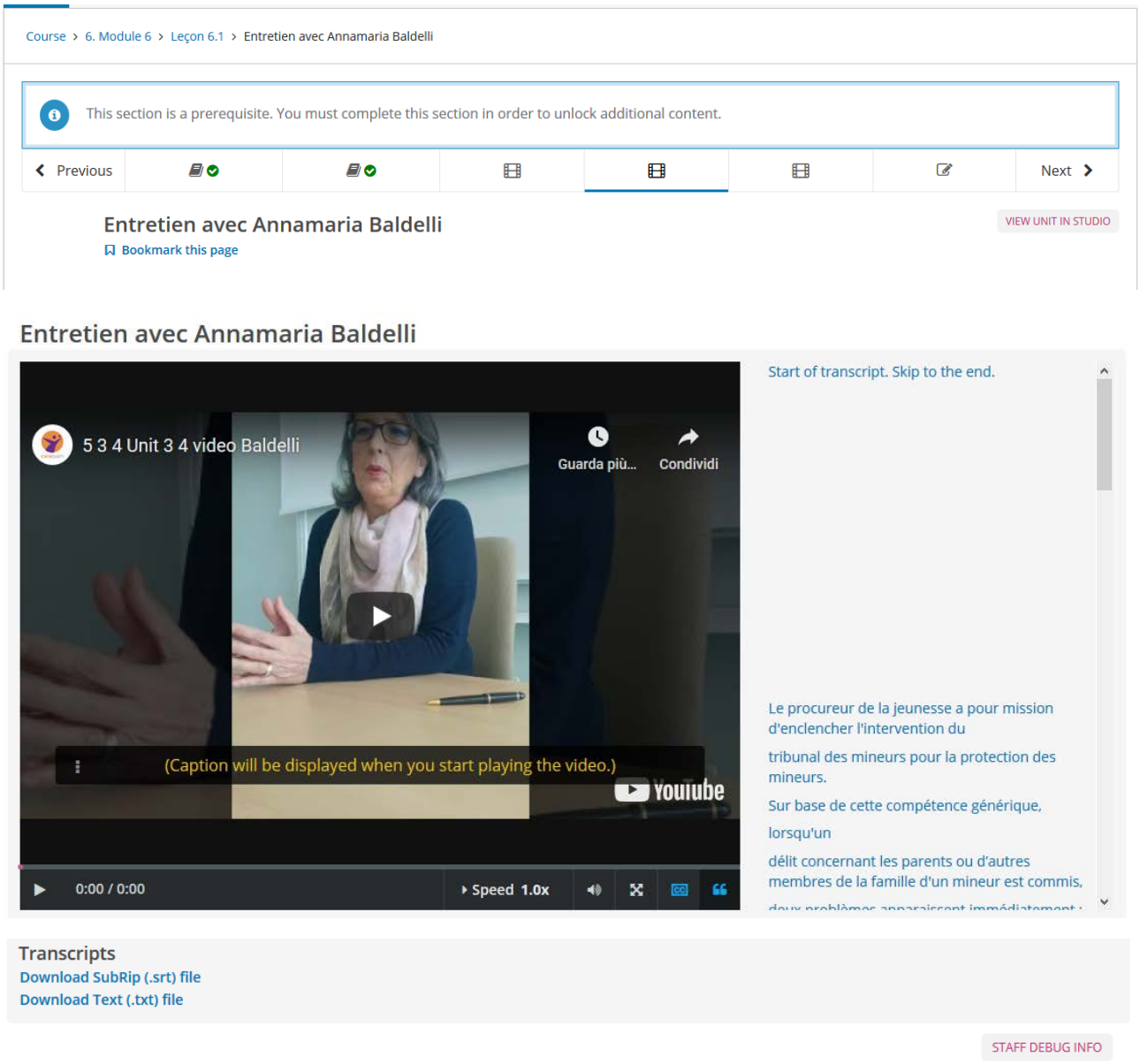
avec l'intérêt supérieur de l'enfant.

However, the need for balance requires the judicial authority and, in general, the

Toutefois, l'autorité judiciaire, et les autorités en général, chargée de décider du sort

d'un enfant, doit informer ce dernier de leur décision et lui expliquer pourquoi il n'a pas

été possible de respecter la volonté qu'il/elle a exprimée pendant les audiences.



Transcript

Le procureur de la jeunesse a pour mission d'enclencher l'intervention du

tribunal des mineurs pour la protection des mineurs.

Sur base de cette compétence générique,

lorsqu'un

délit concernant les parents ou d'autres membres de la famille d'un mineur est commis,

deux problèmes apparaissent immédiatement : quid de la coordination avec les procureurs ordinaires

(en charge de de la procédure pénale), afin d'éviter toute ingérence

susceptible de nuire aux enquêtes pénales ?

Comment recueillir des informations

sur le préjudice subi par le mineur

et les

ressources personnelles et familiales, éventuellement d'autres membres de la famille ?

si la procédure de protection du mineur a ses propres temps, il en est de même de la procédure pénale

dont la durée n'est pas toujours contrôlable.

Ce que nous essayons de faire, c'est de demander

à la police de signaler l'éventuelle infraction, simultanément au procureur ordinaire,

en charge de la procédure

pénale contre l'auteur de l'infraction,

et au procureur des mineurs,

en charge de protéger la victime de l'infraction, afin de garantir

une juste coordination rapide et immédiate entre ces autorités,

soit dès le tout début de l'enquête.

Cette façon d'agir,

également soutenue par des accords entre les différents parquets, nous a permis de définir

qui fait quoi, quand et comment, tout en préservant le bon déroulement de la

procédure pénale, mais également les mesures de protection du mineur.

Il arrive parfois, principalement lorsqu'un enfant est admis à l'hôpital

et que les parents ne s'y opposent pas, que l'acte de protection soit retardée et,

donc, que l'intervention du tribunal pour enfants soit également retardée,

la protection de l'enfant étant déjà garantie par

l'hospitalisation ; dans ce cas, le procureur général ordinaire, en charge des

poursuites pénales contre l'auteur, peut enquêter en secret

et de manière efficace.

Si une décision

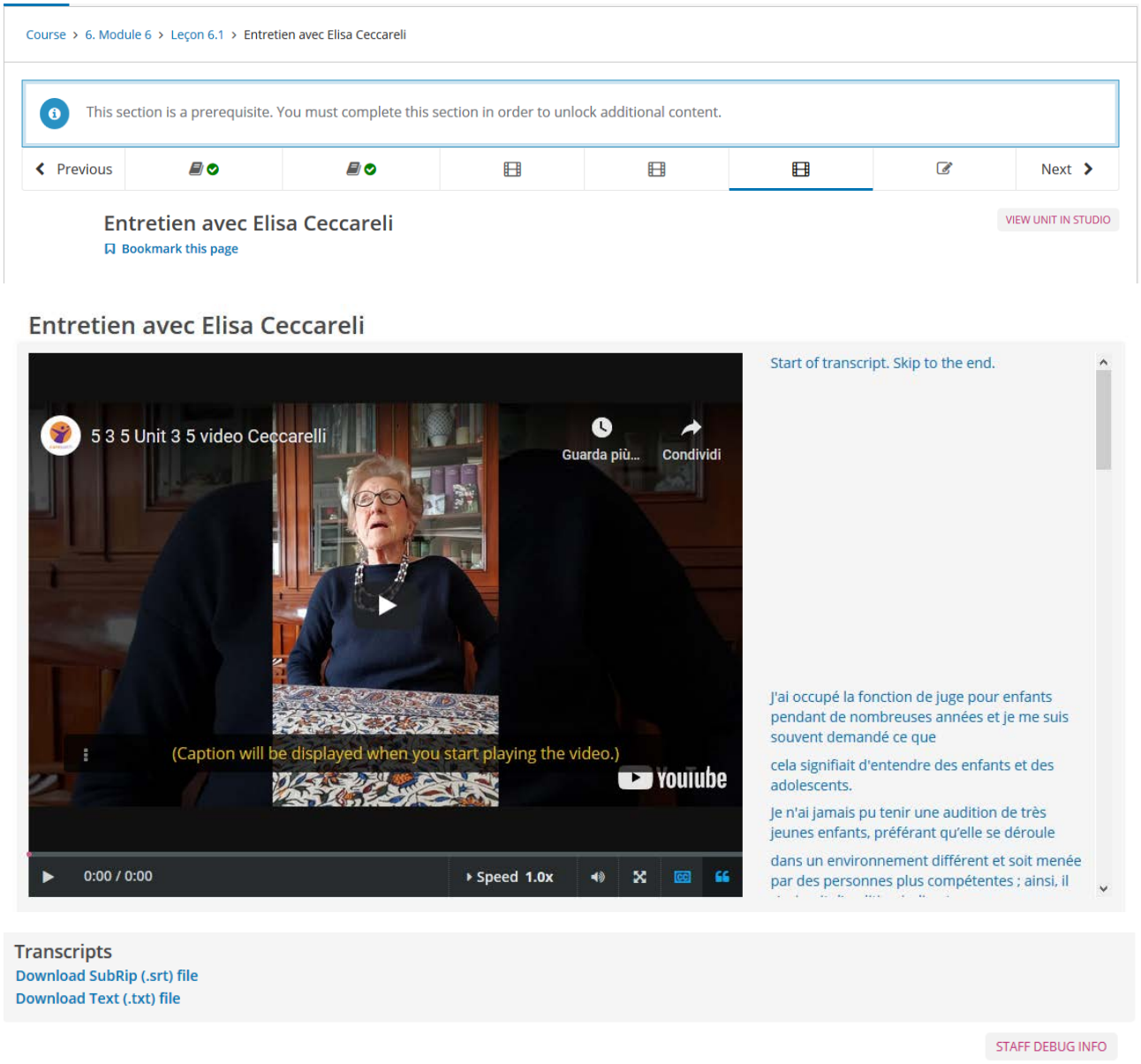
sur la protection d'un mineur ne peut être différée,

il est possible qu'un collègue du procureur, en charge de la procédure pénale, rende une ordonnance de protection administrative

par l'intermédiaire des autorités de police, conformément à l'article 403 du code civil,

afin de protéger le mineur,

en attendant que, par notre recours, le tribunal pour enfants ratifie cette mesure de protection temporaire.



Transcript

J'ai occupé la fonction de juge pour enfants pendant de nombreuses années et je me suis souvent demandé ce que

cela signifiait d'entendre des enfants et des adolescents.

Je n'ai jamais pu tenir une audition de très jeunes enfants, préférant qu'elle se déroule

dans un environnement différent et soit menée par des personnes plus compétentes ; ainsi, il s'agissait d'audition indirecte.

Au lieu de cela, j'ai entendu beaucoup d'enfants de sept, huit, dix, onze ans.

Il s'agissait principalement

d'enfants vivant dans des milieux familiaux extrêmement conflictuels, dont les parents

n’avaient pas choisi de se séparer, mais avaient été séparés et étaient, en fait, toujours été unis par des conflits

qui avaient de lourdes répercussions sur leurs enfants.

Ce que j'ai toujours essayé de communiquer aux enfants,

c'est d'abord qu'il y avait une personne

qui les écoutait, une personne

qui avait une tâche précise : décider de ce qui serait le mieux pour eux ;

and that this decision

cette décision pouvait différer de ce que les enfants

eux-mêmes voulaient, de ce qu'ils avaient exprimé comme souhait.

La décision dépend du tribunal,

elle dépend du juge. C’est le juge qui doit décider ;

donc je prends en compte tout ce que vous me dites,

je vais essayer de faire ce

qui est bon pour vous et,

pourtant, la décision ne coïncidera pas toujours

avec votre désir. C'est quelque chose qui peut arriver au cours d’une vie,

il faut s'y habituer.

J'ai toujours essayé de préserver les aspects positifs de la relation des enfants avec leurs parents.

En général, les pères sont

les plus agressifs dans les relations avec les enfants

et parfois ils forcent les enfants à penser que ces choses

sont utiles dans leur relation conflictuelle avec l'ancien partenaire.

J'ai essayé de

dire : regarde le père, il ne t’en veut pas et tu as raison de l’aimer ;

mais nous savons qu'il a des problèmes, qu'il n'accepte pas la situation actuelle. 32 00:03:12,860 --> 00:03:18,140 En somme, nous devons aussi être capables de préserver la figure du père.

Alors, comment dire ?, si le juge ne doit jamais s’approprier les attitudes conflictuelles de l'enfant,

il doit donner

à l'enfant

la possibilité de dire non,

« je ne peux plus rester avec ce père,

car il ne me comprend pas ».

Je me souviens du cas d'une petite fille de dix ans qui avait deux parents ;

son père avait une attitude extrêmement pathologique et la décision fut :

d'accord, attendons que le père change, s'il peut changer ;

et s'il ne réussit pas à changer, ce ne sera certainement pas l'enfant qui devra supporter tout ce poids.

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Quiz 6.1

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Q6.1

7 points possible (graded)

1) La victimisation secondaire est causée par :

- ○ le stress induit par la participation d'un mineur à la procédure ;
- ○ les cas de maltraitance qui ont rendu nécessaire l'intervention de l'autorité judiciaire ;
- ○ le stress induit par le placement dans une nouvelle famille ;
- ○ la répétition de la maltraitance initiale.

2) Le principe de l'intérêt supérieur de l'enfant :

- ○ ne s'applique qu'aux procédures pénales ;
- ○ ne s'applique qu'aux procédures civiles ;
- ○ signifie que le juge doit toujours prendre en considération, au-dessus de tout autre intérêt, le bien-être psychophysique de l'enfant ;
- ○ oblige les Etats à éviter que le mineur ne participe à la procédure menée à la suite des maltraitances subies

3) L'audition de l'enfant comme témoin :

- ○ doit toujours être exécutée par le juge ;
- ○ doit, de préférence, être effectuée dans la dernière partie de la procédure ;
- ○ doit, de préférence, être répété au moins deux fois, pour vérifier la fiabilité de l'enfant.
- ○ doit, de préférence, effectuée au début de la procédure ;

4) L'opinion exprimée par le mineur au cours de la procédure :

- ○ n'est pas exécutoire, mais le juge doit en tenir compte pour prendre sa décision ;
- ○ est toujours obligatoire pour le juge ;
- ○ est obligatoire pour le juge, mais seulement si le mineur est âgé d'au moins 14 ans ;
- ○ est obligatoire pour le juge, mais seulement si le mineur a une capacité de compréhension suffisante.

5) Les procédures pénales et civiles consécutives à des sévices infligés à un enfant :

- ○ sont distinctes, mais la procédure civile ne peut commencer qu'après la procédure pénale ;
- ○ abordent des questions différentes et poursuivent des objectifs différents ;
- ○ sont distinctes, mais la procédure civile ne peut commencer que si les parents ont été condamnés au pénal ;
- ○ poursuivent le même but et le même objet.

6) Quand le juge ordonne-t-il une mesure conservatoire ?

- ○ Au cours de la procédure, pour protéger le bien-être psychophysique de l'enfant.
- ○ A la fin de la procédure.
- ○ Avant le début de la procédure.
- ○ En cours de procédure, pour garantir que la procédure ait une durée raisonnable.

7) Des procédures extrajudiciaires :

- ○ ne sont appliquées que lorsque le cas de maltraitance est grave ;
- ○ doivent toujours être appliquées ;
- ○ sont appliquées lorsque la relation entre l'auteur de la maltraitance et le mineur semble pouvoir être rétablie ;
- ○ ne sont appliquées que lorsque les cas de maltraitance sont d'une gravité mineure.

Invia You have used 0 of 2 attempts

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Legal glossary on child policies

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Social services = range of services, provided by public or private bodies, which respond to collective and personal needs. While the term "services" means standardized services, universally provided to people as members of a category, "social services" respond to "specific needs" of the beneficiaries.

Social Services for children and families = series of measures and activities that meet the general or individual needs of a child and / or his family. These types of services are aimed at satisfying the different needs of children and families, such as specialized and intensive services .

Child-friendly social services = social services that respect, protect and realize the rights of every child, including the right of access to benefits, participation and protection and the principle of the best interests of the child. (Recommendation of the Council of Europe, November 16, 2011, No. 12, on the rights of children and social services for children and their families)

Child-friendly justice = judicial systems that guarantee the respect and effective implementation of all children's rights at the highest possible level, taking into account the degree of maturity and understanding of the child. It is an accessible justice, adapted to the age, rapid, diligent, adapted to the needs of the child and centered on them, in respect of the rights of the child, including the right to due process, participation and understanding of the proceedings, respect for private and family life, integrity and dignity. (See the Guidelines of the Committee of Ministers of the Council of Europe for child-friendly justice, adopted by the Committee of Ministers of the Council of Europe on 17 November 2010)

Early Childhood Education and Care (ECEC) = service offered to children from birth to primary education subject to a national regulatory framework and to compliance with a set of minimum standards and / or procedures for accreditation. The service includes private, public and volunteering services. European countries present different solutions to guarantee the education and care of children below the age of compulsory education. However, ECEC is increasingly becoming an integral part of education systems in Europe.

(See https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2011:0066:FIN:IT:PDF)

European Higher Education Area (European Higher Education Area - EHEA) = project that aims to achieve a process of convergence and strengthening of higher education or university studies in Europe. This process is in line with the strategies that the European Commission together with the Member States of the Union has launched in recent years to build a true Europe of knowledge and has the main purpose of promoting the mobility and employment of students, improving the quality and make education systems more competitive, attracting students (and teachers) from Europe and other parts of the world. The means to achieve this goal are the support for greater comparability and compatibility between the different systems and the different institutions of Higher Education in Europe, and the raising of their quality.(See https://ec.europa.eu/education/education-in-the-eu/european-education-area_en)

Child-friendly health care = health care policies and practices focused on children's evolving rights, needs, characteristics, resources and capacities, taking into account their opinion. (See https://rm.coe.int/168046ccef)

Child-friendly health care approach = integrated conceptual and operational framework that fully respects the rights and needs of children in the health sector.(See https://rm.coe.int/168046ccef)

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L'impact d'une approche fondée sur les droits de l'enfant

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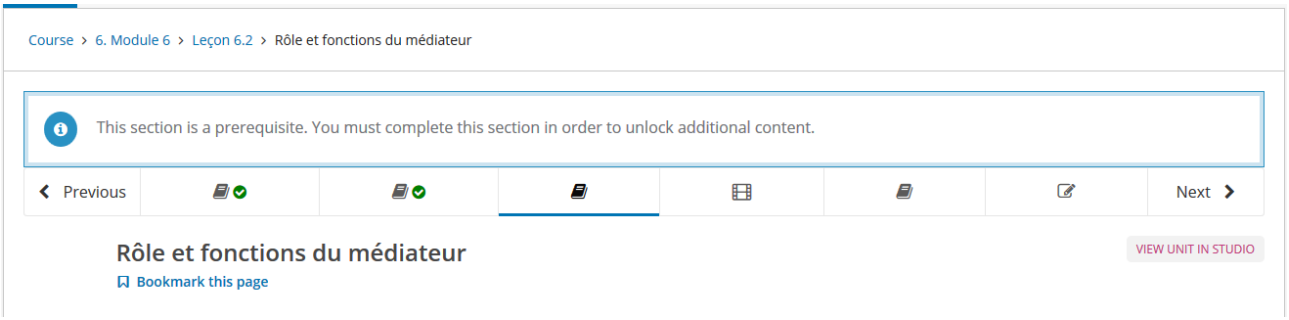

Les compétences attribuées par les différents cadres législatifs aux médiateurs / médiatrices pour enfants concernent diverses actions : écoute et participation, promotion et sensibilisation, collaboration, élaboration de propositions, d'avis et de recommandations.

L'activité d'un médiateur / d'une médiatrice pour enfants joue aujourd'hui un rôle de premier plan dans les politiques visant à assurer la connaissance et le respect des droits des enfants, et permet de donner une voix aux personnes (enfants) qui risquent souvent d'être invisibles :

https://www.youtube.com/watch?v=jWiE2jHX5yE.

En résumé, le médiateur / la médiatrice pour enfants :

- surveille l'application de la Convention relative aux droits de l'enfant et de l'adolescent au niveau national et contribue à faire connaître et à promouvoir la culture des droits des enfants et des adolescents ;
- informe les autorités compétentes de toute violation de ces droits ;
- vérifie que les personnes mineures ont pleinement accès à leurs droits ;
- émet des avis sur les propositions réglementaires concernant les mineurs et sur la protection de leurs droits et de leur développement.

Plus précisément, on peut classer les fonctions et pouvoirs des médiateurs / des médiatrices pour enfants dans deux principales catégories.

1) La première, de type générale, concerne les interventions visant à promouvoir les droits des enfants. Par exemple, le médiateur / la médiatrice pour enfants promeut la connaissance et l'affirmation de l'individu et des droits sociaux et politiques de l'enfance et de l'adolescence, en faisant avancer toute initiative visant à les réaliser concrètement ; surveille l'application, au niveau national, de la Convention relative aux droits de l'enfant ; exprime, à la demande des organes locaux compétents, des avis, des propositions et des observations sur les projets de lois, de règlements et d'actes administratifs et leur l'impact éventuel sur les enfants et les jeunes.

2) Le deuxième domaine d'intervention est plus spécifique et englobe les réponses à apporter aux situations particulières d'enfants en difficulté. En effet, le médiateur / la médiatrice pour enfants reçoit les signalements, même lorsqu'ils proviennent de personnes mineures (par exemple, voir ici), de familles, d'écoles, d'associations et d'institutions, à propos de cas de violation des droits ; il.elle signale aux administrations publiques compétentes tous les cas de violation des droits, à la suite d'actes ou de faits retardés, omis ou exécutés de façon irrégulière, dont il.elle a eu connaissance de la part de sujets publics et privés, ou de personnes individuelles, y compris des enfants.

Quant à son modus operandi, le médiateur / la médiatrice pour enfants ne dispose pas de pouvoirs directs d'enquête, de prescription ou de sanction. Son action s'exprime essentiellement par la voie d'une persuasion morale, c'est-à-dire une force de persuasion exercée à l'égard des sujets publics (décideurs politiques, administrations locales, services territoriaux d'aide sociale, autorités judiciaires) et des entités privées (parents en conflit, organismes du tiers secteur) sur base de son statut d'autorité garante. Ainsi, par exemple, le médiateur / la médiatrice pour enfants peut recommander aux administrations compétentes d'adopter des interventions d'aide et de soutien, ainsi que, en cas d'omission d'agir, des mesures spécifiques ; susciter, au sein des administrations compétentes, la modification ou la révision de mesures jugées préjudiciables aux enfants et aux jeunes ; inviter les administrations compétentes à considérer comme prioritaire l'intérêt supérieur de l'enfant.

L'activité du médiateur / de la médiatrice pour enfants peut s'exercer tant au niveau national que local.

En Europe, a été créé le Réseau européen des défenseurs des enfants (European Network of Ombudsman for Children - site web : https://enoc.eu/?page_id=174) qui se réunit au moins une fois par an pour discuter de questions d'intérêt commun au niveau européen et pour identifier des lignes d'intervention communes.

Les autorités nationales de contrôle collaborent en permanence avec le Réseau international des défenseurs des enfants, avec les organisations et institutions internationales de protection et de promotion des droits de l'enfant et avec une série d'organisations sans but lucratif.

Grâce aux échanges fréquents avec les différents acteurs concernés, les autorités peuvent élaborer des propositions en accord avec les rythmes et les besoins des jeunes.

Un des domaines d'intervention des médiateurs englobe les actes de violence et de maltraitance à l'égard des mineurs (maltraitance psychologique et physique, violence, abus sexuels, négligence, violence assistée). A ce propos, vous pouvez consulter le document de position de l'ENOC sur la violence à l'encontre des enfants :

http://enoc.eu/wp-content/uploads/2014/12/ENOC-position-statement-on-Violence-against-children-2015-FV.pdf

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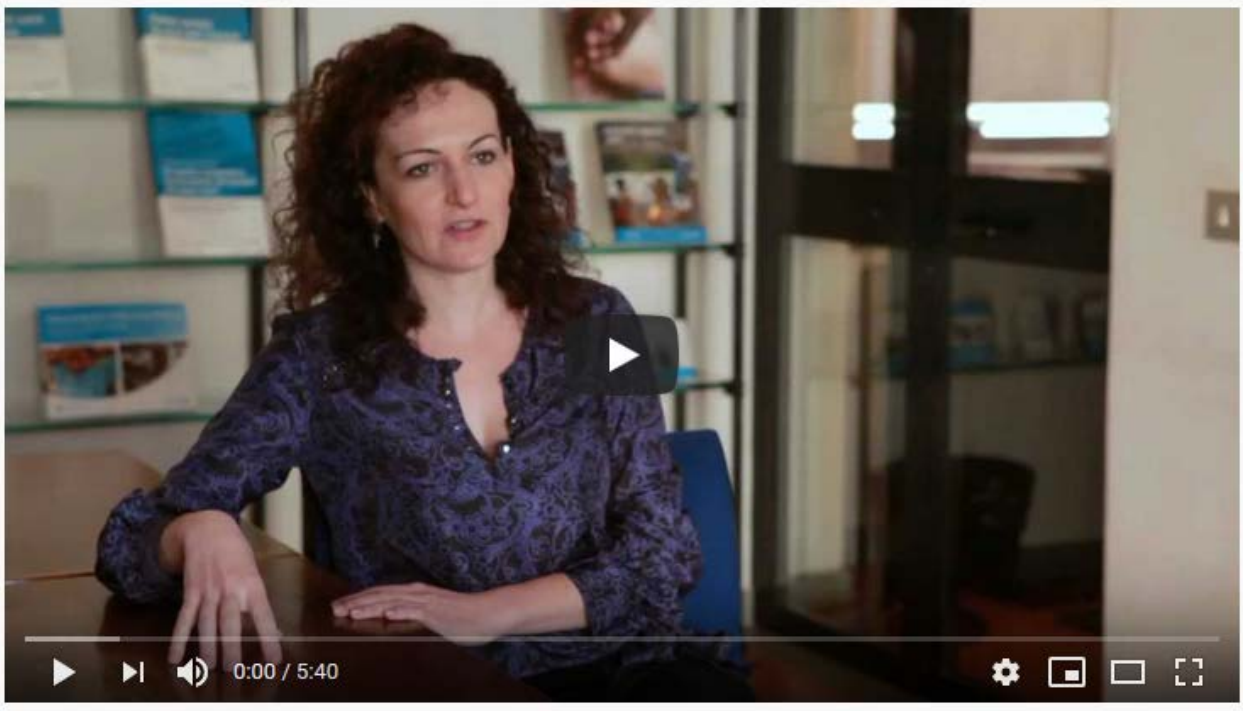

The Importance of Ombudsmen for Children

565 visualizzazioni • 29 ott 2013 3 1 CONDIVIDI SALVA ...

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l'expérience d'un médiateur bénévole pour un enfant non accompagné

De nombreux mineurs sont contraints de quitter leur pays et de vivre leur enfance et leur adolescence loin de chez eux, de leurs parents et sans leur famille pour veiller à la protection de leurs intérêts. La plupart d'entre eux ont vécu des expériences traumatisantes avant et pendant leur trajectoire migratoire ou au moment de devoir quitter leur famille.

Dans le droit européen, la Directive du Conseil européen et du Parlement européen, n° 2011/95/EU, définit le mineur non accompagné (MENA) de la manière suivante : « *un mineur qui entre sur le territoire des États membres sans être accompagné d'un adulte qui est responsable de lui, de par le droit ou la pratique en vigueur dans l'État membre concerné, et tant qu'il n'est pas effectivement pris en charge par une telle personne; cette expression couvre aussi le mineur qui a été laissé seul après être entré sur le territoire des États membre*. »

Dans de nombreux systèmes judiciaires européens, le tuteur bénévole est une figure qui gagne en importance. Il s'agit d'un citoyen ordinaire, très compétent, qui est invité à devenir le représentant légal d'un mineur arrivé seuls sur le territoire du pays et à veiller à la protection de ses intérêts, à l'écoute de ses besoins et à développer son potentiel. En d'autres termes, l'institution d'un tuteur bénévole constitue un exemple de citoyenneté active et donc un instrument de politique sociale pour les mineurs.

Carlo Infuso, juriste à Turin, nous parle de son expérience en tant que tuteur bénévole :

« J'ai rencontré V, le mineur dont je suis tuteur, par hasard : il m'a été présenté par la communauté qui l'accueillait. J'ai rencontré ce garçon et je dois avouer qu'après les présentations, nous ne savions pas quoi nous dire. Je l'ai donc embarqué sur ma moto et nous sommes partis faire un tour, nous avons un peu discuté et petit à petit, nous avons noué une relation, qui a débouché aujourd'hui sur une relation agréable, conviviale, marquée par le respect mutuel.

V. démarre enfin sa vie, ici en Italie. Il jouit d'une protection internationale et à son dix-huitième anniversaire, il recevra un permis de séjour dont il pourra bénéficier pendant deux ans. Il pourra alors demander l'autorisation de terminer ses études.

Il a enfin compris combien il est important qu'il apprenne la langue italienne – il ne s'en rendait pas bien compte avant – pour lui, pour approfondir ses relations avec les autres et avec moi, mes amis et les personnes qu'il rencontre grâce à moi. Il comprend aussi qu'il est important qu'il étudie s'il veut travailler comme serveur. Il pensait que ce métier se limitait à servir de la nourriture à table alors que maintenant, il apprend à faire le cappuccino, avec un dessin dans la mousse, à servir en utilisant deux couverts, en se plaçant à gauche et à droite, à disposer les verres à eau, les verres à vin, une nappe... Petit à petit, il découvre le plaisir d'apprendre, apprendre pour le plaisir d'apprendre.

Il est très drôle. Il est jeune, c'est un ado fou de musique. Il porte une boucle d'oreille, il a une coupe de cheveux tendance ... comme tous les jeunes.

En tant que tuteur, ce qui m'étonne, c'est qu'il ne se mêle pas de mon rôle. Par exemple, quand il a fallu choisir le type et le lieu de ses études, V. m'a dit : « Je n'ai pas de parents, tu es mon père italien. Tu décides à ma place parce que je sais que tu prendras la bonne décision ».

Après plusieurs moi, je suis heureux que V puisse dire : « Je suis content qu'on ait choisi ces études ensemble parce que j'adore cette école ».

Le fait que j'ai pu, grâce à des petites choses du quotidien, susciter chez lui de la confiance envers les autres, lui a permis de gagner en estime de soi. Aujourd'hui, V. prend plus facilement des décisions qu'il n'aurait pas pu prendre avant. Il les prend en plus grande conscience, avec plus de légèreté et s'impliquant davantage qu'auparavant.

La relation (tuteur/ mineur) grandit et peut évoluer en bien ou en mal. Dans notre cas, elle a bien évolué et elle nous a permis de construire quelque chose.

Je me réjouis de pouvoir dire que V. vient passer le week-end chez moi ; ce soir, il va probablement préparer quelque chose à manger et on est vraiment très heureux.

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Quiz 6.2

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Q6.2

5 points possible (graded)

1) Dans des situations de violence domestique ou en cas de conflits avec les parents, les enfants et les adolescents :

- ○ doivent avoir accès à des avis et des conseils médicaux confidentiels sans le consentement de leurs parents s'ils ont plus de 14 ans ;
- ○ doivent avoir accès à des avis et des conseils médicaux confidentiels avec le consentement de leurs parents, sans considération de leur âge ;
- ○ doivent avoir accès à des avis et des conseils médicaux confidentiels avec le consentement de leurs parents, s'ils ont un degré de maturité élevé ;
- ○ doivent avoir accès à des avis et conseils médicaux confidentiels sans le consentement des parents, sans considération de leur âge ;

2) La Déclaration européenne de Bucarest sur les enfants est un instrument dont le propos est d'encourager les institutions européennes et les États membres à mettre en place des structures et des mécanismes formels de promotion du droit des enfants et des jeunes :

- ○ à participer aux décisions de l'Union européenne ;
- ○ à être entendus dans toute procédure judiciaire ou administrative les concernant ;
- ○ à recevoir ou communiquer des informations ou des idées sans ingérence des autorités publiques et sans restrictions aux frontières ;
- ○ à bénéficier d'une protection particulière et donc d'un traitement différencié en fonction de l'âge ;

3) Lorsque, selon la loi, un mineur n'a pas la capacité de consentir à une intervention de santé, celle-ci :

- ○ ne peut être effectuée sans l'autorisation de son représentant, d'une autorité, d'une personne ou instance désignée par la loi ;
- ○ ne peut être effectuée ;
- ○ peut être effectuée, même sans l'autorisation de son représentant, de son autorité, de la personne ou instance désignée par la loi ;
- ○ peut être exécutée, même sans l'autorisation de son représentant, de son autorité, de la personne ou instance désignée par la loi, s'il est possible de reconstituer la volonté de l'enfant.

4) La vidéo du Conseil de l'Europe "Parle à quelqu'un de confiance" traite, par des méthodes adaptées aux enfants, du thème :

- ○ du harcèlement ;
- ○ des abus sexuels ;
- ○ des témoins de violence ;
- ○ de châtiments corporels ;

5) Le médiateur / la médiatrice des enfants exerce :

- ○ des pouvoirs d'investigation ;
- ○ des pouvoirs de limitation et de sanction ;
- ○ des pouvoirs de persuasion morale ;
- ○ des pouvoirs réglementaires.

Invia You have used 0 of 2 attempts

Salva Show Answer

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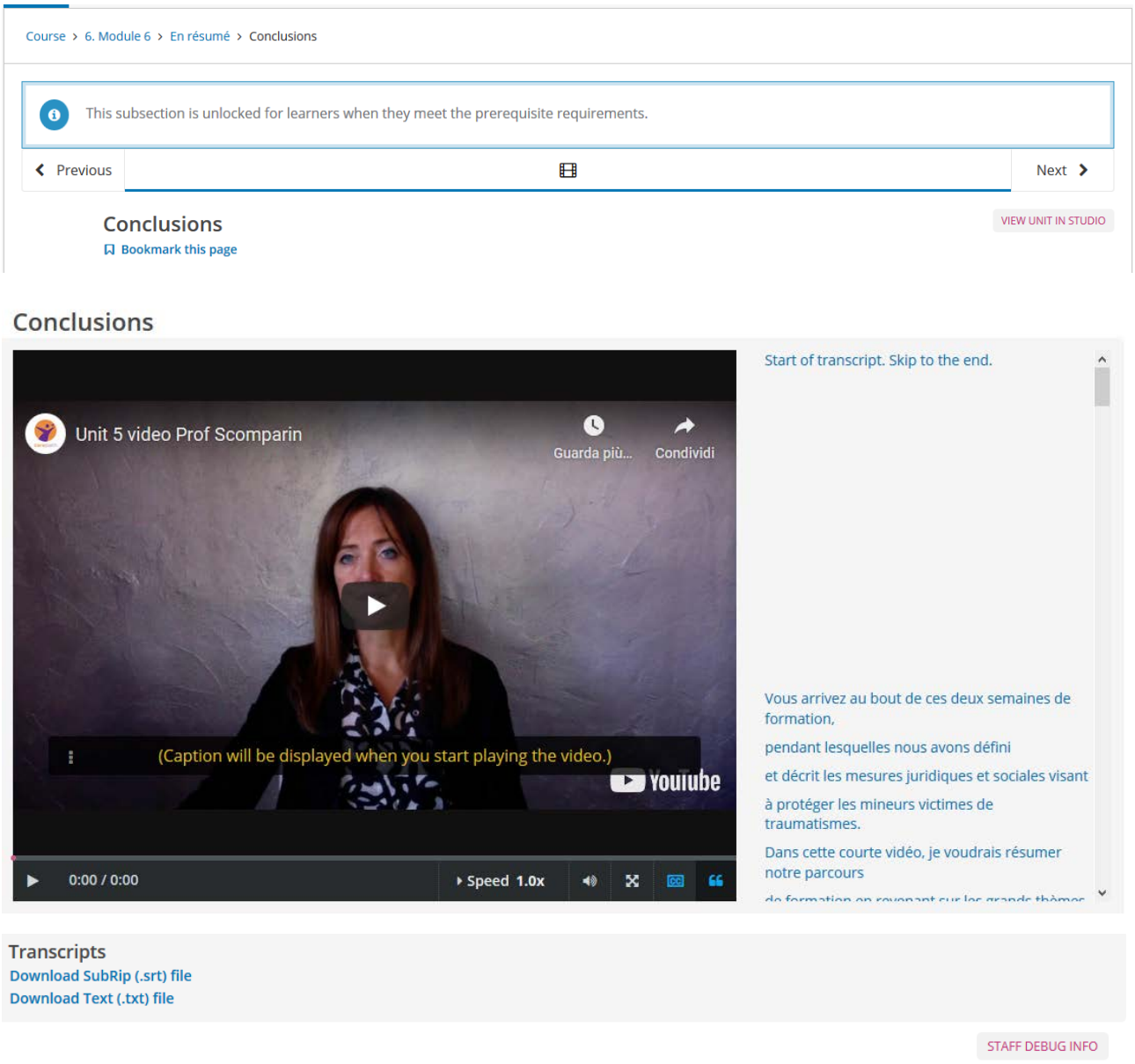


Transcript

Vous arrivez au bout de ces deux semaines de formation,

pendant lesquelles nous avons défini

et décrit les mesures juridiques et sociales visant

à protéger les mineurs victimes de traumatismes.

Dans cette courte vidéo, je voudrais résumer notre parcours

de formation en revenant sur les grands thèmes abordés.

Premièrement, rappelons-nous que le chemin vers la consécration des droits de l'enfant

a été semé d'embuches.

J’en prends pour preuve le dossier de Mary Ellen Wilson,

qui a connu une fin heureuse uniquement grâce à la ténacité d’une missionnaire méthodiste

et à l’intuition d’un juriste :

pour séparer un enfant

d’un milieu familial néfaste, il a fallu appliquer la loi sur

la cruauté envers les animaux.

Voilà qui est, pour le moins, étonnant.

Toutefois, près d’un siècle plus tard,

le contexte de l’arrêt de la Cour européenne des droits humains dans

l’affaire Z contre le Royaume-Uni

est encore plus surprenant. A la fin des années 1900, le concept de l’obligation d’un état

de corriger une situation familiale problématique pour

protéger le bien-être

d’un enfant n’était pas encore profondément ancrée

dans le système juridique.

En conséquence, la Cour européenne a tiré cette obligation

de la Convention européenne sur les droits humains en la reconnaissant comme un corollaire de

l’interdiction des traitements dégradants et inhumains établie dans son article 3.

N’oublions pas que

le droit international et supranational a permis de combler 29 00:02:02,480 --> 00:02:05,400 les vides juridiques présents

dans chaque Etat.

Nous devons également nous souvenir

de la Convention de New York et des autres nombreuses lois adoptées

par le Conseil de l’Europe et plus récemment,

par l’Union européenne.

C’est uniquement grâce à ces lois que s’est répandue la conscience du mineur

en tant que sujet autonome de droits, titulaire d’un statut juridique,

indépendant de ses parents ;

ainsi,

nous pouvons affirmer aujourd’hui que cette idée s’inscrit enfin dans le patrimoine commun de chaque système juridique.

De la même manière,

il est établi que les autorités de l'État ont l'obligation de prévenir et de sanctionner

les abus envers les enfants et d'aider,

de manière efficace, les victimes d'abus à retrouver

complètement leur bien-être psychophysique.

En outre, soulignons que

le mineur est une personne présentant

des spécificités particulières :

sa personnalité est en devenir et,

en fonction de son âge, il ou elle a certainement besoin d'une attention spécifique dont les adultes peuvent généralement se passer ;

cette attention particulière est d'autant plus

vitale lorsque l'enfant a été victime d'abus et de violence,

y compris parfois dans son entourage familial.

En d'autres termes, dès qu'il s'agit de mineurs, on pourrait dire que

les droits acquis par chaque individu ont exigé des avancées indépendantes,

qui tenaient compte de leur situation

particulière.

Il est avéré que l'enfant

possède le droit d'être entendu et d'exprimer son opinion sur les questions qui le concernent.

Toutefois, s'il en va de son intérêt supérieur,

la décision peut

s'écarter de sa volonté exprimée ;

elle peut même en être aux antipodes.

Quatrièmement, le processus

aidant l'enfant traumatisé

à retrouver son bien-être

peut s'avérer aussi douloureux

que la violence ou l'abus subi.

Des procédures civiles ou pénales

s'imposent souvent :

sanctionner l'auteur du délit,

si le comportement incriminé en est un ;
éviter que l'abus ne se reproduise ;
prévoir des indemnités pour les dommages causés ;
et, si nécessaire, rétablir un contexte familial adéquat.
Il ne faut pas oublier le revers de la médaille :
le mineur doit
faire de nombreux sacrifices pour surmonter toutes
les étapes des procédures.
Par exemple, il sera souvent indispensable pour l'enfant de participer
à ces procédures ;
sa participation n'est pas uniquement une question de droit,
mais également un outil pour de découvrir la vérité :
en exprimant son opinion et son expérience, la victime peut fournir
des éléments importants qui permettront au juge de trancher.
Néanmoins, comme nous l'avons vu précédemment,
le risque de victimisation secondaire persiste,
car,
lors des procédures,
le mineur devra probablement revivre les faits et les traumatismes subis ;
il ou elle souffrira peut-être
de l'exposition publique de l'affaire ;
selon toute vraisemblance,
pendant le procès, il ou elle se retrouvera face à l'auteur de l'abus.
Tous ces risques sont importants et doivent être pris en compte.
Ensuite, s'il s'avère nécessaire d'ordonner une procédure d'adoption
ou même de garde du mineur, n'oublions jamais combien
il peut être difficile de nouer des liens avec une nouvelle famille.
Assez paradoxalement, pour surmonter le premier traumatisme
causé par l'abus,
l'enfant risque, dans son parcours,
de connaître de nombreux autres petits traumatismes.
Reste à aborder l'élément le plus important.

La route vers de nouveaux droits et de nouvelles protections
est souvent long et difficile ;
comme nous l'avons vu, ce constat s'applique également aux mineurs.
Cependant, maintenant que
ces garanties existent,
nous devons poursuivre le chemin
et comprendre que la loi seule ne suffit pas ;
les conventions internationales et supranationales, les directives européennes
et les droits nationaux ne suffisent pas.
Il s'agit en fin d'un point de départ,
d'une base sur
laquelle tout le reste doit reposer.
Le plus important – dans ce domaine
- ci plus que dans d'autres – est d'appliquer les garanties prévues par la loi par
le biais de politiques sociales efficaces.
Les administrations centrales et locales doivent
impérativement promouvoir le respect
des droits des mineurs par l'adoption de mesures concrètes.
Parallèlement,
elles doivent financer et mettre en place des services spécifiques destinés aux enfants et aux adolescents,
comme des guichets d'information, des groupes de soutien,
des instances de contrôle.
Signalons par ailleurs le rôle essentiel joué par le bénévolat et
par le milieu associatif, dans la défense et la protection
des droits des mineurs ;
ces associations sont vitales pour la mise
en œuvre de politiques sociales efficaces.
Les administrations publiques doivent être suffisamment
sensibilisées et procéder à des investissement adaptés afin de limiter
les risques de victimisation secondaire :
par exemple, elles doivent absolument prévoir
des salles spéciales pour les auditions,

sensibiliser les juges et les avocats,

ensure the best conditions for the hearing of the minor,

garantir les meilleures conditions pour les audiences du mineur et assurer un soutien psychologique permanent pendant les procédures.

Evidemment, la contribution des premiers utilisateurs de notre formation, à savoir les professionnels qui travaillent avec les mineurs, est primordiale.

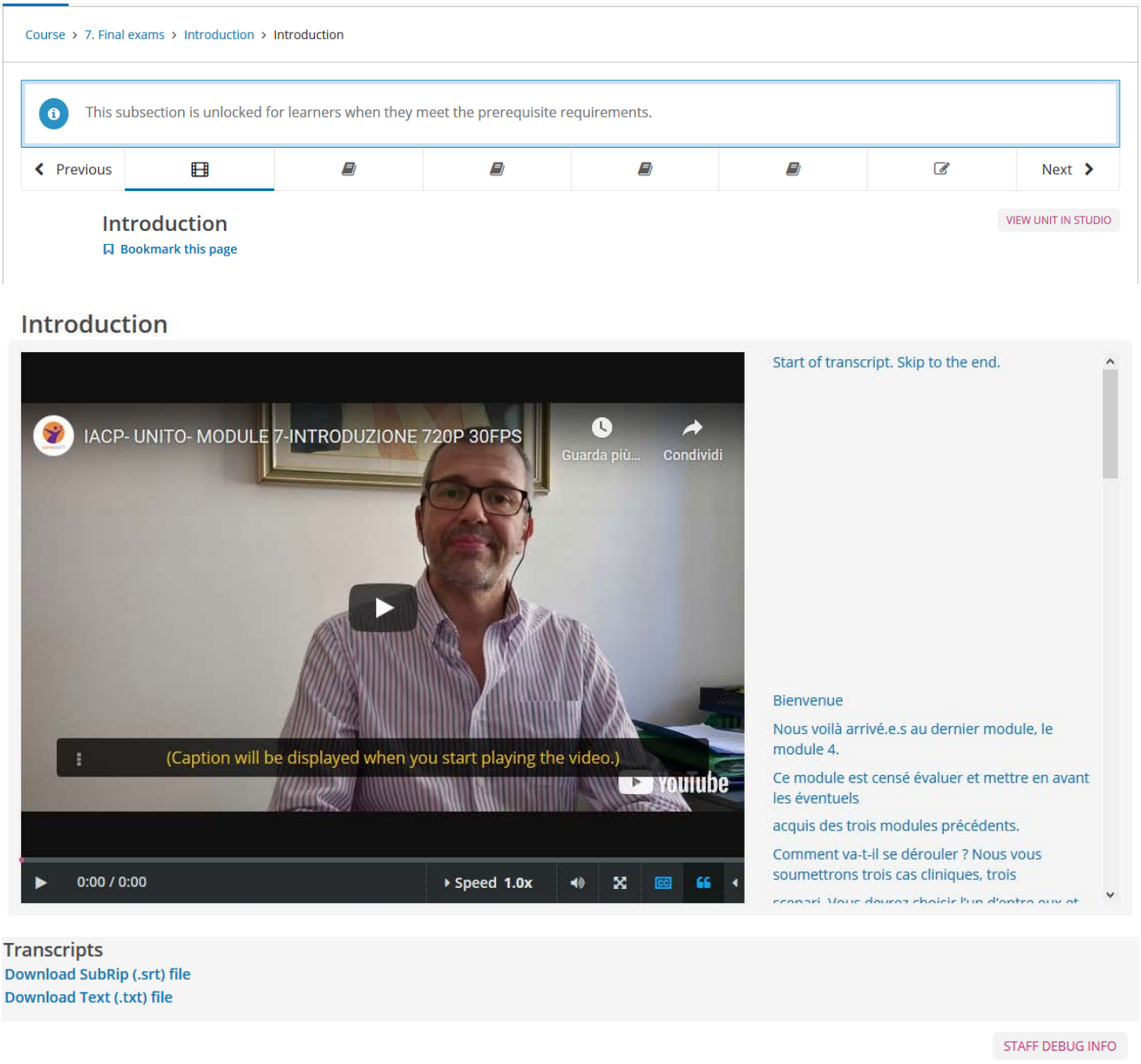
Vous êtes les tuteurs des mineurs en dehors des procédures, qui les aidez à surmonter le traumatisme causé par la victimisation primaire ;

vous êtes les tuteurs des mineurs pendant les procédures puisque vous pouvez rendre supportable un fait, qu'on ne pourra jamais banaliser ; et

vous restez les tuteurs des mineurs après les procédures car vous devrez veiller à la poursuite du difficile chemin vers la sérénité retrouvée lorsqu'il faudra aider le mineur à passer à la vitesse supérieure et atteindre enfin ses objectifs.

Enfin, l'enfant ou l'adolescent victime d'abus devra affronter de nombreuses difficultés, mais comme nous avons tenté de le montrer, nombreux sont les dispositifs qui les aideront à affronter et à surmonter ces défis.

Je vous souhaite donc bonne chance dans vos carrières respectives.



Transcript

Bienvenue

Nous voilà arrivé.e.s au dernier module, le module 4.

Ce module est censé évaluer et mettre en avant les éventuels

acquis des trois modules précédents.

Comment va-t-il se dérouler ? Nous vous soumettrons trois cas cliniques, trois

scenari. Vous devrez choisir l'un d'entre eux et tenter ensuite

de répondre, en mobilisant et en intégrant toutes les compétences acquises dans le module 1 (la théorie),

dans le module 2 (la recherche), dans le module 3 (la partie législative), aux questions suivantes

quels sont les aspects relevant d'un accompagnement sensible aux traumatismes

et comment appliquer ses principes aux trois scenarii?

Comment devrez-vous rédiger ce bref rapport, ce bref compte-rendu ?

Plusieurs alternatives s'offriront à vous. Vous pourrez créer un fichier Power Point,

et donc préparer une présentation ; vous pourrez réaliser une petite vidéo, donc utiliser

ce format ou créer un document Word ou un fichier PDF, ou vous pourrez choisir d'autres

modalités qui vous viendront à l'esprit.

La particularité, la spécificité de ce dernier module

réside dans le fait qu'il s'agira d'une révision par les pairs

votre projet sera évalué par deux participants à la formation parallèlement.

L'évaluation sera réalisée par les pair.e.s. Toutefois, la dernière évaluation relèvera toujours de la responsabilité d'un.e

tuteur/tutrice ou d'une personne responsable du projet.

Il s'agit véritablement de la dernière étape que nous vous invitons à franchir pour obtenir

l'attestation de participation à ce parcours de formation en ligne.

Dès que votre dossier sera complet et que vous aurez terminé votre rapport, vidéo,

présentation Power Point, vous pourrez les envoyer et vous serez associé.e, de manière aléatoire et anonyme,

à un autre étudiant. Ensuite, vous serez, à votre tour, invité.e à évaluer un document, un rapport ou une vidéo.

Enfin, vous procèderez au dépôt final de votre travail,

un.e tuteur /tutrice réalisera une évaluation supplémentaire de celui-ci et validera, ou pas, la clôture de votre parcours de formation

Nous espérons que le parcours aura été agréable, que vous avez appris quelque chose ou

qu'il vous a permis de consolider et de valoriser un nouveau savoir sur

l'accompagnement sensible aux traumatismes. Si vous le souhaitez, à la fin de votre parcours,

vous pourrez envoyer des petites vidéos avec votre nom, votre prénom et quelques brèves

fiches qui nous permettront de certifier que vous avez bien participé à cette formation.

En mon nom, Luca Rollè, et au nom de toute l'équipe du projet Care Path, je vous remercie

encore une fois d'avoir participé et nous espérons vous revoir lors d'une

prochaine édition de la formation.

This subsection is unlocked for learners when they meet the prerequisite requirements.

Instructions

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During this activity you are requested to analyze the case (Choosing the Scenario you prefer) from a legal, psychological and/or scientific research point of view. You answer should contain your reflections in the light of fundamental principles of Trauma Informed Care.

1. Your can prepare your contribution in

- text (simply enter your answer in the respective area) OR
- you can upload a file containing your contributions. **Important note - the file should be in pdf format up to 5mb.**

In case you have prepared a video you can simply enter the link of your published video so it can be accessed for evaluation.

2. Each learner upon submission of his own contribution has to assess at least 1 contribution from other learners. This is a necessary step, in order to finish the activity.

Important note - In case you need to evaluate a response that is contained into a file, you need to download the file and open it in your desktop/mobile device. make sure that the file has the .pdf extension. If not, please rename your file adding the .pdf suffix at the end.

3. The final step includes the Staff evaluation of your contribution. Upon completion, the final grade will be available to you straight away.

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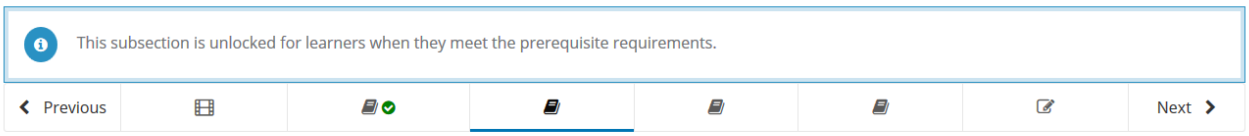

Cas 1

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C. F. est une jeune fille de 15 ans envoyée à un service spécialisé par l'hôpital.

Elle fréquente irrégulièrement le lycée ayant notes médiocres.

Elle a été accompagnée aux urgences en raison de l'ingestion d'une quantité excessive de psychotropes. Après l'intervention du service d'urgence, elle a été renvoyée chez elle avec l'obligation pour toute la famille de suivre un parcours d'aide et de soutien.

La jeune fille montre une attitude un peu colérique, ne veut pas assister à l'entretien ni parler de ses affaires et ne comprend pas la raison de cet envoi. Elle prétend avoir fait une “connerie” avec son amie mais elle ne va certainement pas le répéter.

Reconnue la peur imaginable avec laquelle elle a vécu la "connerie" à laquelle elle fait référence, et clarifiée les termes de l'interview, la jeune fille s'ouvre et, exprimant la fragilité de son histoire, se raconte :

Les parents sont séparés, même si pas officiellement, depuis quelques mois et la mère n’est pas à la maison. C. trouve cela positif pour elle-même, elle a une relation très difficile avec sa mère et le fait qu'elle soit loin de chez elle la rend plus calme, même si cela lui a fait perdre une personne qui l'a aidée à faire certaines choses.

Pendant longtemps, à l'école primaire et dans une partie du collège, cette mère a été colérique, elle l’a battue et insultée lorsqu'elle était confrontée à des erreurs ou à des choses que la fille devait faire différemment.

Pour la corriger, la mère la frappait, l’insultait en disant "tu es une conne", "stupide", pour arriver dans la dernière période à des disqualifications plus importantes "tu es une chienne".

Cependant, dans la dernière année de sa vie, C. a commencé "finalement" à ne plus souffrir, mais à répondre à sa mère. Parfois, elles se battaient, ce qui permettait à la jeune fille de faire face aux querelles. Le père est absent toute la journée pour le travail et C. dit qu’il est gentil, il rentre à la maison le soir et ne semblait pas intéressé par le ménage, probablement à cause de la fatigue du jour. Les choses semblent un peu froides entre les parents et il n'y a pas de moments dans la vie de famille où ils font des choses ensemble. Les dimanches sont également passés à la maison ou chez la tante (sœur du père), qui est un point de référence pour C.

Lorsqu'elle a 13 ans, elle commence à fumer à l'école et, avec une copine, elles connaissent la marijuana et la fument. Elle aime le sentiment de détente et d'amusement qu'elle ressent quand elle fume et commence bientôt à fréquenter un groupe de personnes partageant le même "intérêt".

Après quelques mois de difficultés continues à la maison, sa mère commence à être moins présente et l'après-midi, elle sort tous les jours, ce qui permet à C. d'être libre de ramener à la maison qui elle veut et de disposer de l'espace nécessaire. Au début, elle en est satisfaite et ne s'informe pas de ce changement ni des raisons. Elle considère plutôt que cela constitue un avantage pour sa vie. Puis elle découvre un jour, que sa mère va voir un autre homme parce qu’il les trouve assis dans un bar loin de chez eux dans des attitudes amoureuses.

À ce stade, dit-elle, elle trouve enfin le moyen d'obtenir tout ce qu'elle veut, alors qu'elle entre dans un jeu de requêtes avec la mère à laquelle la femme ne peut pas s’échapper : C. veut ramener son petit ami à la maison et demande à la mère de la laisser seule. Au début, la femme ne veut pas mais elle est obligée pour éviter que la fille raconte tout au père. Les demandes de C. et les concessions de la mère augmentent : C. emmène à la maison qui elle veut, fume à la maison, elle est autorisée à acheter de la bière et elle obtient de l'argent pour ce qu'elle demande. Elle paye tout cela avec la colère et les insultes de la femme, qui cède à toutes les demandes même si elle lui fait sentir tout son mépris.

Le père ignore tout cela. En parlant de ça, C. à une attitude de triomphe triste et de grande colère.

Cela dure jusqu'en septembre (environ un an), lorsque son père, ayant découvert la trahison de sa femme, la chasse. À ce stade, C. est encore plus libre et reste seule jusqu'au retour du père, elle commence à être en retard à l'école ou elle ne va pas du tout. Un jour, chez son amie, elles trouvent un médicament que la mère prend et elles décident de l'essayer ensemble. Exactement à la suite de cet épisode, le père est appelé par la mère de l'amie qui trouve les filles endormies sur le lit et dans un état confus et qui sont "malheureusement" emmenées aux urgences.

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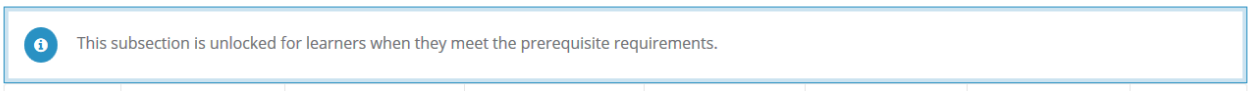

Cas 2

B. est une étudiante de 15 ans, l'aînée d'une fratrie de deux ; sa mère est entrepreneuse et son père sans-emploi ; les quatre membres de la famille vivent dans la banlieue d'une grande ville.

B. vient à la consultation en raison de douleurs graves et invalidantes, principalement au niveau de la partie inférieure de son corps (jambes et abdomen), qu'aucun problème de santé ne peut expliquer (ses parents l'ont fait examiner par plusieurs professionnels).

Les douleurs lui interdisent de mener un train de vie satisfaisant, approprié à son âge : il lui est impossible de fréquenter régulièrement l'école, d'où un risque d'échec et de redoublement ; qui plus est, il lui est extrêmement difficile de sortir avec ses amis ou de pratiquer quelqu'activité sportive que ce soit, tous ses projets de vie risquant à tout moment d'être anéantis par cette douleur soudaine et perçante.

Lors de notre première session, elle nous apparaît négligée, relativement introvertie (elle baisse sans cesse le regard et chuchote quelques mots) et voutée (elle passe toute notre première rencontre racrapotée sur sa chaise). Elle nous dit avoir décidé de demander de l'aide, car elle est consciente qu'elle doit résoudre un problème qui "la maintient cloitrée à la maison".

Elle montre une connaissance étendue, une grande curiosité et une vive intelligence, à l'opposé de son langage corporel, celui d'une jeune fille pliée en deux et apathique.

Elle explique n'avoir aucune idée de ce qui pourrait avoir déclenché les symptômes, qui sont approximativement apparus au moment de sa puberté.

Elle ajoute entretenir d'excellentes relations avec les membres de sa famille, n'avoir que très peu d'amis et se sentir mal à l'aise dans un groupe, qu'il soit composé de pair.e.s ou d'adultes. Elle adore lire et écouter de la musique, et étudie en autodidacte plusieurs langues.

Au cours de la première année de psychothérapie, pendant laquelle j'ai examiné pourquoi ses symptômes étaient invalidants et me suis efforcée de la rendre plus autonome, j'ai pu circonscrire et apaiser les douleurs : elles apparaissaient un peu avant ses menstruations et ne lui faisaient plus perdre que deux ou trois jours d'école. Malheureusement, l'origine des symptômes restait inconnue et la jeune fille a commencé à connaître de fréquentes crises de panique.

En plus des sessions individuelles de B., je rencontre régulièrement sa famille dans sa totalité, qui, tout en continuant à s'inquiéter de la souffrance de B., reconnaît les grands changements réalisés et les ressources que B. est capable d'activer pour retrouver une vie satisfaisante.

Après deux années de psychothérapie, B. parvient à gérer ses crises de panique, qui sont de plus en plus rares, et utilisent diverses stratégies pour gérer ses douleurs (formation autogène, yoga, fantasmes guidés, techniques de respiration).

Toutefois, lorsqu'elle regarde un film qui contient une scène montrant une agression sexuelle, elle ressent une angoisse soudaine et intense, qu'elle me décrira, lors de sa session suivante, comme un "blackout interne".

Nous commençons à explorer ce sentiment, dans un effort de comprendre ces "fragments de rêve", comme elle les définit dans un premier temps, qui deviennent ensuite des images floues qu'elle a du mal à définir comme des souvenirs ou des fantasmes empruntés d'un livre ou d'un film.

Alors que nous travaillons à son rythme et à sa guise, pour ne pas la forcer ni trop épuiser sur ses stratégies de défense ou ses craintes bien compréhensibles, tout en continuant à soutenir ses ressources internes, B. se rappelle petit à petit d'une personne à qui elle avait été confiée en l'absence de ses parents (et alors qu'elle avait de 3 à 7 ans) et qui l'a agressée sexuellement.

Ce souvenir enclenche un processus qui permet non seulement de signaler l'abuseur, mais également de créer pour B. un espace sécurisée (en effet l'abuseur rendrait de temps en temps visite à sa famille) et de mieux comprendre sa souffrance psychologique, qu'elle ne faisait jusque-là que gérer.

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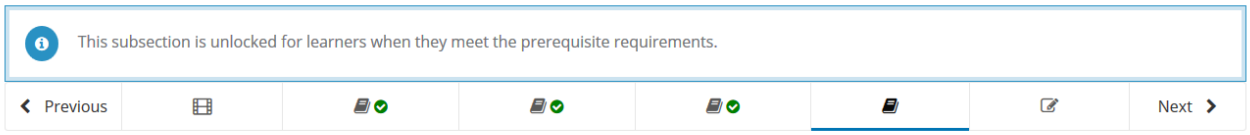

Cas 3

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VIEW UNIT IN STUDIO

R, mineur âgé de 13 ans, est signalé au service territorial suite à un renvoi par le Tribunal.

Il fréquente l'école primaire et vit dans une maison d'accueil depuis l'âge de 9 ans.

Lors du rendez-vous, il est accompagné par l'éducatrice de la maison d'accueil. Il fait preuve d'ouverture et veut connaître les personnes qu'il rencontre lors de l'entrevue dont le but est une prise en charge.

Dans un premier temps, il est sociable, répond aux questions, interagit avec les personnes, blague et se montre sympathique.

Lorsqu'on aborde le but de l'entrevue, il exprime toute sa confusion : il ne comprend pas la raison de sa présence, il ne sait ni quoi faire ni ce qu'on attend de lui ; il demande des réponses à ses questions qui expriment son désarroi et ses craintes (d'être éloigné davantage de ses parents, de les faire souffrir, que quelqu'un décide qu'il ne pourra plus les voir, etc....).

Après une période de séparation, les parents vivent à nouveau ensemble, exactement comme à l'époque où R. a fait l'objet d'un éloignement. Le garçon se rappelle des disputes entre ses parents, ils ne s'entendaient plus vraiment, et à plusieurs reprises, la mère, qui est originaire d'un autre pays, a tenté de retourner dans sa famille d'origine.

A chaque départ de la maman, R. était envahi de tristesse, mais également de soulagement, car les disputes cessaient pour un temps. Il aime ses parents et cela lui fait toujours plaisir de passer du temps avec eux.

Il leur parle tous les jours et les voit une fois par semaine lorsqu'ils lui rendent visite au siège de la maison d'accueil.

Cela fait deux ans qu'il y vit et il s'y sent bien même s'il souhaiterait rentrer à la maison ; il ignore si c'est possible.

Il ne se rappelle pas du jour où il a intégré la maison d'accueil, mais il sait que c'est son père qui l'y a accompagné.

La maman est restée à la maison, en pleurs, et cela lui a fait énormément de peine.

Son père s'est montré plus fort, il l'a accompagné et, comme toujours, il l'a abreuvé de paroles, mais sans verser de larmes.

A son arrivé à la maison d'accueil, R., malgré sa peur, a rencontré des gens amusants et sympathiques, qui ont apaisé ses craintes et il s'est facilement lié d'amitié.

R. intègre la famille d'accueil après qu'un ami de ses parents lui ait fait des avances sexuelles et l'ait violé.

Si, dans un premier temps, il ne l'a dit à personne, un jour, la vérité est sortie.

R. (qui en ignore toujours la raison) se retrouve au Tribunal. Cet homme, un ami de ses parents, fréquentait la maison assez souvent, et lui s'y était attaché et savait qu'il comptait pour cet ami : le soir, il lui racontait des histoires et parfois, papa lui demandait de le mettre au lit.

Lorsque de vilaines choses se sont produites et que cela s'est su, le père a accompagné R. à la maison d'accueil afin de le protéger de cet homme.

R. ne sait pas très bien ce qu'il ressent, si ce n'est – dit-il – une énorme confusion.

S'il se sent bien en maison d'accueil, il est obligé d'y respecter des règles strictes et, parfois, il se met en colère et finit par causer des dégâts, aux objets, mais pas aux personnes. Ce qui l'agace tout particulièrement, c'est qu'on lui impose des règles qu'il ne comprend pas lors de ses rencontres ou discussions avec ses parents.

Du reste, à la maison d'accueil, il fait des choses intéressantes (en l'occurrence du sport) et s'entend bien avec son entourage. Il aime être entouré d'amis même si, parfois, il souhaite être seul et préfèrerait qu'on lui fiche la paix.

Il apprécie d'avoir pu nouer une relation spéciale avec une éducatrice qui s'occupe beaucoup de lui.

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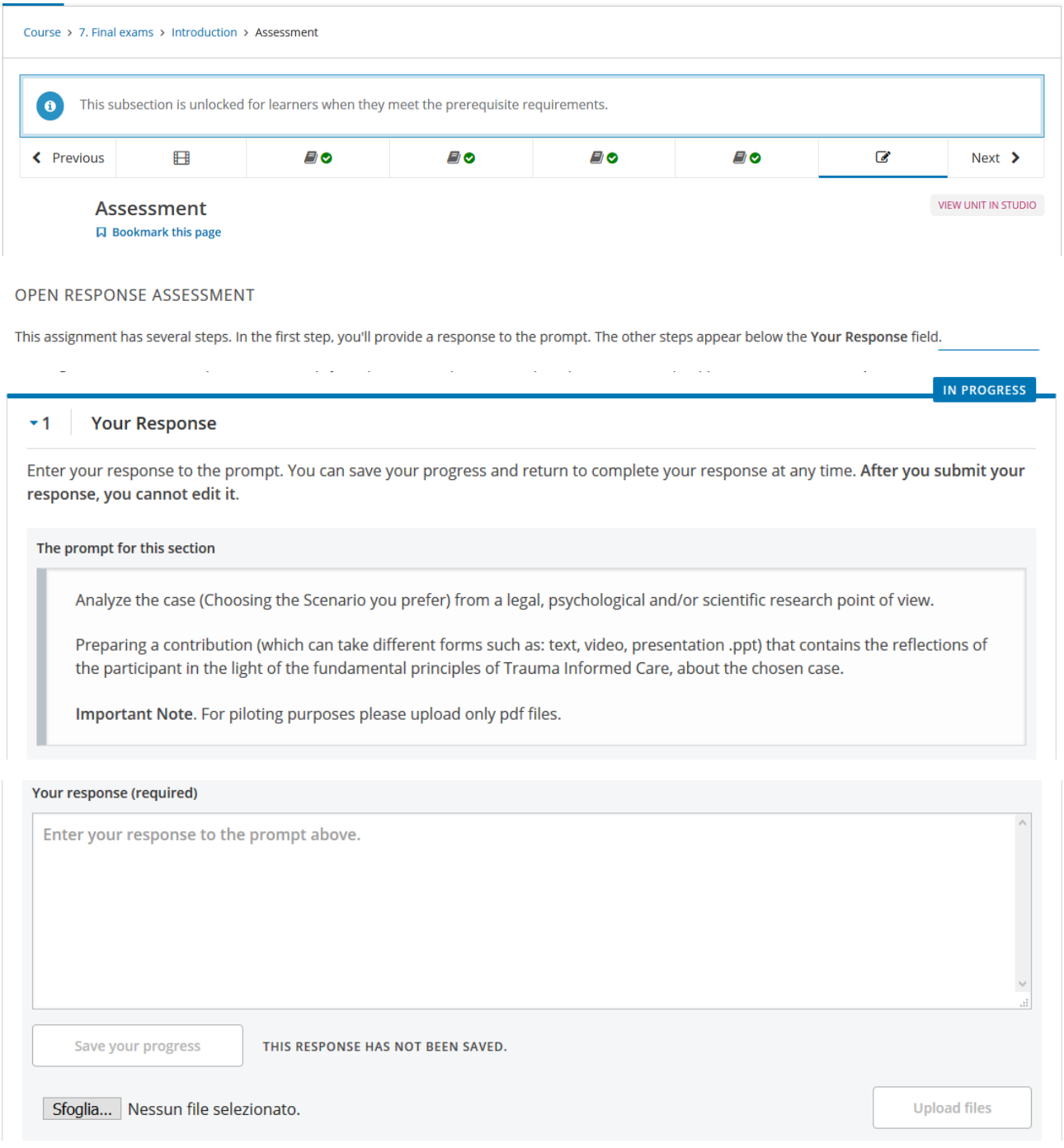
Course › 7. Final exams › Introduction › Assessment
This subsection is unlocked for learners when they meet the prerequisite requirements.
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Assessment
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VIEW UNIT IN STUDIO
OPEN RESPONSE ASSESSMENT
This assignment has several steps. In the first step, you'll provide a response to the prompt. The other steps appear below the Your Response field.
IN PROGRESS
1
Your Response
Enter your response to the prompt. You can save your progress and return to complete your response at any time. After you submit your response, you cannot edit it.
The prompt for this section
Analyze the case (Choosing the Scenario you prefer) from a legal, psychological and/or scientific research point of view.
Preparing a contribution (which can take different forms such as: text, video, presentation .ppt) that contains the reflections of the participant in the light of the fundamental principles of Trauma Informed Care, about the chosen case.
Important Note. For piloting purposes please upload only pdf files.
Your response (required)
Enter your response to the prompt above.
Save your progress
THIS RESPONSE HAS NOT BEEN SAVED.
Sfoglia...
Nessun file selezionato.
Upload files

You may continue to work on your response until you submit it.

Submit your response and move to the next step

NOT AVAILABLE

2 | Assess Peers

Your Grade: Not Started

MANAGE INDIVIDUAL LEARNERS VIEW ASSIGNMENT STATISTICS

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Questionnaire

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QUESTIONNAIRE

	0 Not at all	1	2	3	4 Very much	5 I do not know
01 - Are the contents consistent with educational aims?	○	○	○	○	○	○
02 - Are the contents of the lesson presented in an understandable way?	○	○	○	○	○	○
03 - Is there enough time to read, listen and watch the educational materials?	○	○	○	○	○	○
04 - How useful do you find the topics explored?	○	○	○	○	○	○
06 - Would you suggest to a friend/colleague/friend/knower this lesson?	○	○	○	○	○	○
07 - How would you assess the experience of this online training?	○	○	○	○	○	○
08 - How would you rate the level of the CarePath course?	○	○	○	○	○	○
09 - Were the technical aspects (visuals, acoustics, subtitles, etc) of the CarePath course satisfactory?	○	○	○	○	○	○
10 - Was the online training platform of the CarePath course user-friendly?	○	○	○	○	○	○
Are the contents of the lesson presented in an understandable way?	○	○	○	○	○	○

View results

Export results to CSV Download CSV

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Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material
ANNEX 1
–
French Version

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

UNIVERSITÀ DEGLI STUDI DI TORINO

IACP Eurochild ReadLab ERGO e-trikala

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Empowering public authorities and professionals towards trauma-informed leaving care support

LES DROITS DE L'ENFANT DANS LA LEGISLATION INTERNATIONALE ET LA LEGISLATION DE L'UNION EUROPÉENNE

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

02

unité

Objectifs d'apprentissage

✓ Acquérir un corpus de connaissances sur les droits fondamentaux et principes établis par le cadre juridique international et européen sur les droits de l'enfant dans lequel l’approche des soins sensibles aux traumatismes (Trauma Informed Care - TIC) peut s’appliquer.

✓ Mieux comprendre la question spécifique des droits de participation des enfants.

Qu’entend-on par « enfant » ?

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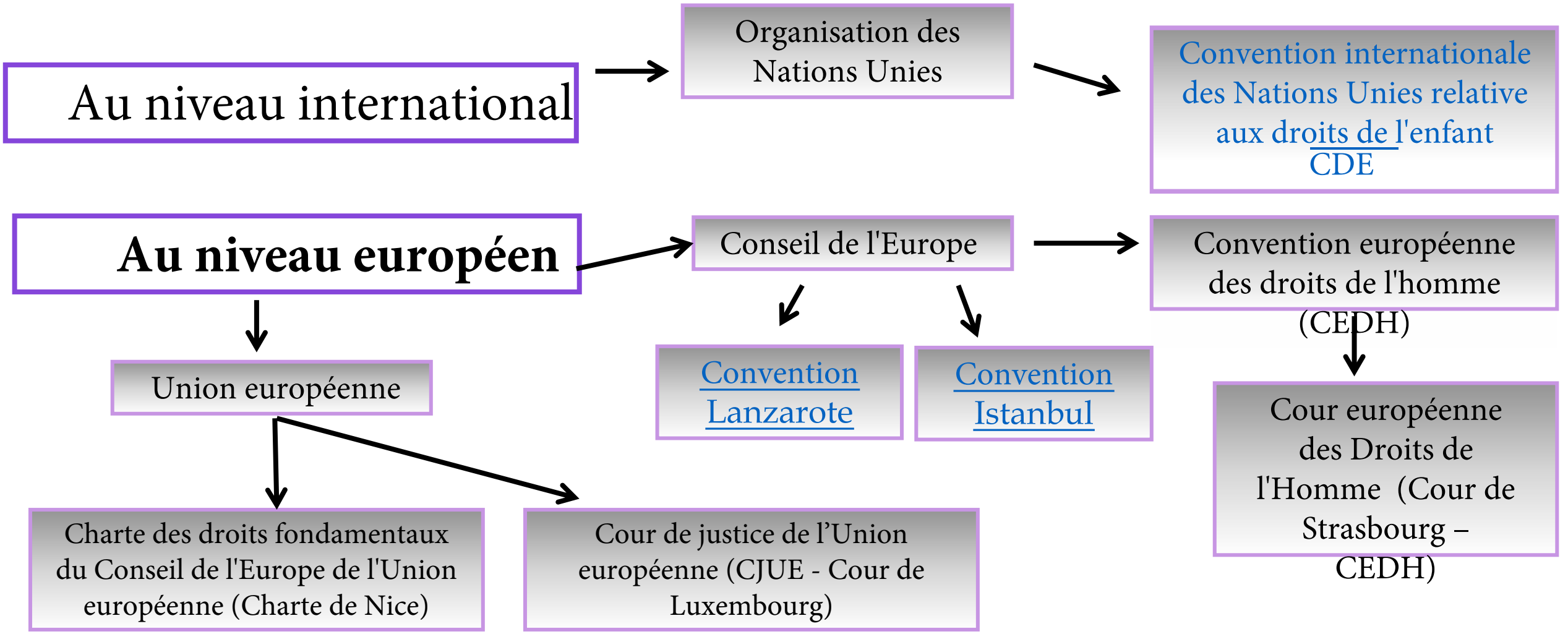
La Convention internationale relative aux droits de l'enfant (CDE) établit que « un enfant s'entend de tout être humain âgé de moins de dix-huit ans » (article premier).

De même, la plupart des instruments du Conseil de l'Europe concernant les enfants adoptent la définition établie par la CDE.

Puisqu’au sein de l'Union européenne, il n'existe aucune description du terme « enfant », la définition de la CDE est couramment utilisée.

Cadre juridique



DROITS ET LIBERTES DE L’ENFANT

Tous les individus, y compris les enfants, jouissent des libertés et des droits reconnus par les instruments juridiques (conventions, traités, déclarations) relatifs aux droits de l'homme, en particulier la Charte des droits fondamentaux de l'Union européenne (Charte de Nice) et la Convention européenne des droits de l'homme (CEDH).

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DROITS FONDAMENTAUX ET LIBERTES FONDAMENTALES

DROITS CIVILS

DROITS ECONOMIQUES, SOCIAUX ET CULTURELS

LIBERTES ET DROITS CIVILS FONDAMENTAUX

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• On les appelle droits de « première génération » et ils sont considérés comme fondamentaux parce que leur violation porte profondément atteinte à la vie des personnes.
- Ils exigent des États que ceux-ci n'interfèrent pas dans la sphère privée de l'individu et qu'ils s'efforcent activement d’assurer l'exercice effectif d'un droit fondamental

Par exemple, le droit au respect de la vie privée et familiale (art. 8 CEDH) demande aux Etats de ne pas séparer les enfants de leurs parents sauf lorsque cela est strictement nécessaire pour la protection des enfants eux-mêmes, mais également, dans le cadre des mesures prises pour promouvoir le développement des relations entre les parents et les enfants, d’aider le parent qui n’en a pas la garde à avoir accès à son enfant et à surmonter l'opposition injustifiée de l'autre parent.

Droit au respect de la vie familiale

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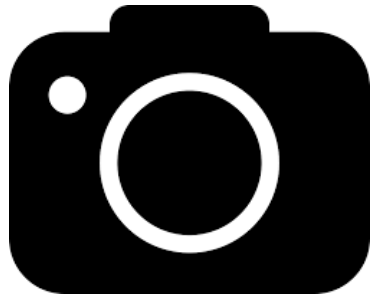
Toute personne a droit au respect de la « vie familiale » telle qu'elle est vécue dans la pratique (l'enfant a, par exemple, le droit de grandir dans la famille et de rester en contact avec ses deux parents après leur séparation).

Articles de référence :

- Article 7 (droit au respect de la vie privée et familiale) – Charte de Nice
- Article 8 (droit au respect de la vie privée et familiale) - CEDH
- Articles 8 et 9 de la CDE

Droit au respect de la vie privée

La notion de " vie privée " développée par la jurisprudence de la Cour de Strasbourg est large et comprend de nombreux aspects de l'identité d'un individu
(par exemple l'intégrité physique et morale de la personne, le nom, l'image, la vie privée et la protection des données personnelles)

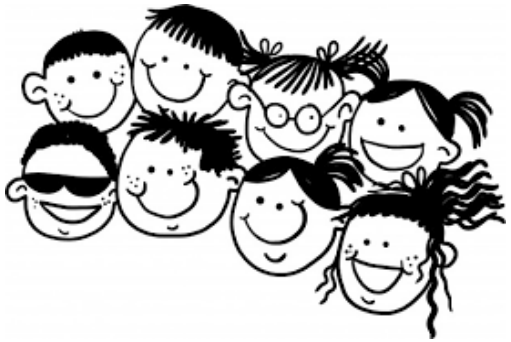


Articles de référence :

Article 7 (droit au respect de la vie privée) Charte de Nice
- Article 8 (droit au respect de la vie privée) CEDH
- Article 16 de la CDE

Non-discrimination

Les différents traitements fondés sur le sexe, la race, la couleur de la peau, les origines ethniques ou sociales, les caractéristiques génétiques, la langue, les croyances ou la religion, les opinions politiques ou toute autre opinion, l'appartenance à une minorité nationale, la fortune, la naissance, le handicap, l'âge ou l'orientation sexuelle sont considérés comme discriminatoires et interdits à moins qu'ils ne servent un but légitime



Articles de référence :

- Article 7 (droit au respect de la vie privée et familiale), Article 20 (Egalité en droit) et Article 21 (non-discrimination) – Charte de Nice
- Article 14 CEDH ; Article 1 du Protocole 12 de la CEDH (non-discrimination)
- Article E (non-discrimination) Charte sociale européenne (CSE)
- Article 8 (droit au respect de la vie privée) CEDH
- Article 2 CDE

Principe de l’intérêt supérieur de l’enfant

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Les enfants et les jeunes ont le droit, en tant que mineurs, de bénéficier d'une protection spéciale et donc d'un traitement différencié en fonction de l'âge

Article de référence :

Article 3 CDE

EXEMPLE 1
Le juge appelé à décider de la garde des enfants après la séparation / le divorce des parents doit décider sur la seule base de ce qui est le mieux pour l'enfant et non pour les parents

Liberté d'expression

Toute personne a droit à la liberté d'expression. Ce droit comprend la liberté d'opinion et la liberté de recevoir ou de communiquer des informations ou des idées sans qu'il puisse y avoir ingérence d'autorités publiques et sans considération de frontières. (Article 11, paragraphe 1 CEDH)

Articles de référence :

- Article 11 et article 24 paragraphe 1 Charte de Nice
- Article 10 CEDH
- Article 12, paragraphe 1 CDE

Le droit de l'enfant à être entendu

« On donnera notamment à l'enfant la possibilité d'être entendu dans toute procédure judiciaire ou administrative l'intéressant, soit directement, soit par l'intermédiaire d'un représentant ou d'une organisation approprié, de façon compatible avec les règles de procédure de la législation nationale (Article 12 - CDE)

Pour de plus amples informations sur le droit de l'enfant à être entendu, voir Unit_2_3_video_Prof.ssa_Long

Articles de référence :

- Article 12 CDE
- Articles 3 et 6 Convention européenne sur l'exercice des droits des enfants

Le droit de l'enfant à la protection contre la violence et l'exploitation

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« Les Etats parties prennent toutes les mesures législatives, administratives, sociales et éducatives appropriées pour protéger l'enfant contre toute forme de violence, d'atteinte ou de brutalités physiques ou mentales, d'abandon ou de négligence, de mauvais traitements ou d'exploitation, y compris la violence sexuelle... » (Article 19, paragraphe 1, Convention internationale sur les droits de l'enfant - CDE)

Case Z. et Autres vs. RU.

Articles de référence :

- Articles 2 (droit à la vie), 3 (traitements inhumains ou dégradants) et 8 (intégrité physique) CEDH; Protocole 1 de la CEDH, article 2 (droit à l'éducation)
- Articles 7 (droit à une protection spéciale contre les risques physiques et moraux) et 17 (droit à la protection) Charte sociale européenne (CSE)
- Convention sur la protection des enfants contre l'exploitation et les abus sexuels (Convention de Lanzarote).
- Convention sur la prévention et la lutte contre la violence à l'égard des femmes et contre la violence domestique (Convention d'Istanbul)
- Directive relative à la lutte contre les abus sexuels et l'exploitation sexuelle des enfants, ainsi que la pédopornographie (2011/93 / EU)

EXEMPLE 2 : Être témoin de la violence

La violence ne produit pas seulement des dommages lorsqu'elle est exercée, mais également lorsque les enfants en sont témoins.

Voir, entendre, éprouver de l'angoisse, être infecté et accablé sans pouvoir rien faire. Tout cela équivaut à exposer un enfant à une forme de maltraitance, réalisée par des actes de violence physique, verbale, psychologique, sexuelle et économique, sur des figures de référence ou sur d'autres personnes pouvant avoir un importance émotionnelle dans le cadre familial et domestique. C'est cela, être témoin de la violence. Un phénomène encore caché, presque « invisible », caractérisé par de multiples signaux, dont les effets peuvent être dévastateurs sur le développement physique, cognitif et comportemental des enfants

(Save the Children, https://www.savethechildren.it/campagne/abbattiamo-il-muro-del-silenzio)

Articles de référence :

Article 19 CDE

Article 17 Charte sociale européenne (CSE)

Les enfants qui sont témoins d'un acte de violence en sont aussi des victimes https://www.youtube.com/watch?v=aNbVwD86JqU

L'histoire d'un enfant témoin
https://www.youtube.com/watch?v=hYX8cRkiklE

EXEMPLE 3 : Châtiment corporel

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On considère comme châtiment corporel :

- tous châtiments impliquant l'usage de la force physique et visant à infliger un certain degré de douleur ou de désagrément, aussi léger soit-il
- certaines formes non physiques cruelles et dégradantes, par exemple: les châtiments tendant à rabaisser, humilier, dénigrer, prendre pour bouc émissaire, menacer, effrayer ou ridiculiser l'enfant. (Comité des droits des enfants de l'ONU, Observation générale 8, 2006)

Levez la main contre la fessée ! https://www.youtube.com/watch?v=Aj1fWgCeo-o

Articles de référence :

Article 3 CEDH

Articles 19, 28, paragraphe 2, et 37 CDE

EXEMPLE 4 : Abus sexuels

On considère comme « abus sexuel » le fait de se livrer à des activités sexuelles avec un enfant :

- en faisant usage de la contrainte, de la force ou de menaces; en abusant d'une position reconnue de confiance, d'autorité ou d'influence sur l'enfant, y compris au sein de la famille ;
- en abusant d'une situation de particulière vulnérabilité de l'enfant, notamment en raison d'un handicap physique ou mental ou d'une situation de dépendance.

(Article 18, paragraphe 1, Convention du Conseil de l'Europe sur la protection des enfants contre l'exploitation et les abus sexuels – Convention de Lanzarote)

You can't touch here!
https://www.youtube.com/watch?v=ZNmu7plH5c8

Articles de référence :

- Articles 32 et 34 CDE
- Convention de Lanzarote

DROITS ECONOMIQUES, SOCIAUX ET CULTURELS

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Ils représentent les droits dits de « deuxième génération » que chaque État est appelé à satisfaire afin de surmonter les inégalités sociales, les déséquilibres économiques, les désavantages causés par la nature, l'âge, etc.

Leur exercice concret se fait (malheureusement !) progressivement et de manière compatible avec les problèmes économico-structurels auxquels chaque État est confronté.

Droit à la santé

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« La santé est un état de complet bien-être physique, mental et social et ne consiste pas seulement en une absence de maladie ou d'infirmité.»

(Organisation mondiale de la Santé, 1948)

Articles de référence :

- Article 35 (accès aux soins de santé) Charte de Nice
- Article 25 Déclaration universelle des droits de l'homme
- Articles 24, 25 et 26 CDE
- Article 2 (droit à la vie) et article 3 (droit à l'intégrité physique) CEDH
- Article 11 (droit à la protection de la santé) et article 13 (droit à l'assistance sociale et médicale) Charte sociale européenne (CSE)
- Article 6 Convention européenne pour la protection des droits de l'homme et de la dignité de l'être humain en rapport avec les applications de la biologie et de la médicine, « Convention d'Oviedo »

Droit à l'éducation

« Toute personne a droit à l'éducation. L'éducation doit être gratuite, au moins en ce qui concerne l'enseignement élémentaire et fondamental. L'enseignement élémentaire est obligatoire. L'enseignement technique et professionnel doit être généralisé; l'accès aux études supérieures doit être ouvert en pleine égalité à tous en fonction de leur mérite. »

(Article 26, Déclaration universelle des droits de l'homme)

Le droit à l'éducation ne se réfère pas uniquement à l'apprentissage des matières scolaires de base mais doit être conçu dans un sens plus large. L'éducation doit chercher à favoriser l'épanouissement de la personnalité de l'enfant, de ses dons et aptitudes mentales et physiques. (Article 29 CDE)

<u>Articles de référence</u>

Article 14 Charte de Nice

Articles 28 et 29 CDE

Article 17 CEDH

Article 2 du protocole 1 CEDH

carepath

MANUEL

Manuel de droit européen en matière de droits de l'enfant

FRA
EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

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CONSEIL DE L'EUROPE

Manuel de droit européen en matière de droits de l'enfant

Avant-propos

Ce manuel de droit européen en matière de droits de l'enfant a été préparé conjointement par l'Agence des droits fondamentaux de l'Union européenne (FRA) et le Conseil de l'Europe, avec l'aide du Greffe de la Cour européenne des droits de l'homme. Il est le quatrième d'une série de manuels de droit européen élaborés conjointement par nos organisations. Les manuels précédents étaient consacrés au droit européen en matière de non-discrimination, d'asile, de frontières et d'immigration et de protection des données.

Nous avons lancé ce nouveau projet conjoint dans le cadre des célébrations du 25e anniversaire de la Convention des Nations Unies relative aux droits de l'enfant – que tous les États européens ont ratifiée – afin de mettre en lumière le rôle des normes juridiques européennes pour assurer aux enfants l'exercice de leurs droits universels.

Les enfants sont des titulaires de droits à part entière. Ce manuel entend donc sensibiliser le lecteur et approfondir ses connaissances des normes juridiques qui protègent et promeuvent ces droits en Europe. Le traité sur l'Union européenne (TUE) impose à l'Union l'obligation de promouvoir la protection des droits de l'enfant. La Charte des droits fondamentaux de l'Union européenne, les règlements et directives de l'Union européenne (UE) ainsi que la jurisprudence de la Cour de justice de l'UE (CJUE) ont contribué à encadrer plus précisément la protection des droits de l'enfant. Au niveau du Conseil de l'Europe, de multiples conventions portent sur des aspects spécifiques de la protection des droits de l'enfant, depuis leurs droits et leur sécurité dans le cyberespace jusqu'à l'adoption d'enfants. Ces conventions contribuent au renforcement de la protection que confèrent aux enfants la Convention européenne des droits de l'homme et la Charte sociale européenne, y compris la jurisprudence de la Cour européenne des droits de l'homme (CEDH) et les décisions du Comité européen des droits sociaux (CEDS).

Le présent manuel est destiné aux juristes non spécialisés, aux juges, aux procureurs, aux autorités chargées de la protection de l'enfance, ainsi qu'à d'autres praticiens et organisations chargés d'assurer la protection juridique des droits de l'enfant.

Nous tenons à remercier le professeur Ton Liefaard, LL.M. Simona Florescu, JD. Margaret Fine, le professeur Karl Hanson, le professeur Ursula Kilkelly, le docteur Roberta Ruggiero, le professeur Helen Stalford et le professeur Wouter Vandenhole pour leur contribution à la rédaction de cet ouvrage. Nous souhaitons également remercier toutes les personnes qui nous ont apporté leur contribution et leur soutien tout au long de la préparation de ce manuel.

Snežana Samardžić-Marković

Directrice générale de la Démocratie Conseil de l'Europe

Michael O'Flaherty

Directeur de l'Agence des droits fondamentaux de l'Union européenne

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Acronymes

APCE	Assemblée parlementaire du Conseil de l'Europe
CCPMN	Convention-cadre du Conseil de l'Europe pour la protection des minorités nationales
CdE	Conseil de l'Europe
CEDH	Convention européenne de sauvegarde des droits de l'homme et des libertés fondamentales (communément appelée « Convention européenne des droits de l'homme »)
CEDS	Comité européen des droits sociaux
CEE	Communauté économique européenne
CEPT	Convention européenne pour la prévention de la torture et des peines ou traitements inhumains ou dégradants
CJUE	Cour de Justice de l'Union européenne (avant décembre 2009, Cour de Justice des Communautés européennes, CJCE)
CouEDH	Cour européenne des droits de l'homme
CPT	Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants
CRC	Convention des Nations Unies relative aux droits de l'enfant
CRPD	Convention des Nations Unies relative aux droits des personnes handicapées
CSE	Charte sociale européenne
EEE	Espace économique européen
FRA	Agence des droits fondamentaux de l'Union européenne
GC	Grande Chambre (de la Cour européenne des droits de l'homme)
GRETA	Groupe d'experts sur la lutte contre la traite des êtres humains
HCR	Haut-Commissariat des Nations Unies pour les réfugiés
ICCPR	Pacte international des Nations Unies relatif aux droits civils et politiques

ICERD	Convention internationale sur l'élimination de toutes les formes de discrimination raciale
ICESCR	Pacte international relatif aux droits économiques, sociaux et culturels
OIT	Organisation internationale du travail
ONU	Organisation des Nations Unies
RPT	Ressortissants de pays tiers
TFUE	Traité sur le fonctionnement de l'Union européenne
TUE	Traité sur l'Union européenne
UE	Union européenne

Comment utiliser ce manuel ?

Le présent manuel donne une vue d'ensemble des droits fondamentaux des enfants dans les États membres de l'Union européenne (UE) et du Conseil de l'Europe (CdE). Le domaine qu'il couvre est large. Les enfants sont reconnus en tant que bénéficiaires de tous les droits fondamentaux/de l'homme, mais aussi en tant que sujets de réglementations particulières compte tenu de leurs caractéristiques spécifiques. Les droits des enfants constituent un domaine intersectoriel du droit. Dans le présent manuel, l'accent est mis sur les domaines du droit qui revêtent une importance particulière pour les enfants.

Le manuel a été conçu pour aider les praticiens du droit qui ne sont pas spécialisés dans le domaine des droits de l'enfant ; il s'adresse aux avocats, aux juges, aux procureurs, aux travailleurs sociaux et aux autres collaborateurs des autorités nationales, ainsi qu'aux organisations non gouvernementales (ONG) et autres organes susceptibles d'être confrontés pour la première fois à des questions juridiques dans ce domaine. Il s'agit d'un premier ouvrage de référence sur le droit de l'UE et du Conseil de l'Europe en la matière, qui présente point par point les règles du droit de l'UE, de la Convention européenne des droits de l'homme (CEDH), de la Charte sociale européenne (CSE) et d'autres instruments du Conseil de l'Europe. Chaque chapitre débute par un tableau récapitulant les règles applicables en vertu des deux ordres juridiques européens distincts. Ensuite, les dispositions de chaque ordre juridique sont présentées successivement pour chacun des questions envisagées. Cela permet au lecteur d'identifier les points de convergence ou de divergence entre les deux systèmes juridiques. Le cas échéant, référence est également faite à la Convention des Nations Unies relative aux droits de l'enfant (CRC) et à d'autres instruments internationaux.

Les praticiens du droit des États qui ne sont pas membres de l'UE mais membres du Conseil de l'Europe, et, à ce titre, parties à la CEDH, peuvent accéder aux informations pertinentes pour leur propre pays en consultant directement les sections consacrées à la CEDH. Les praticiens du droit des États membres de l'UE devront consulter les deux sections, étant donné que ces États sont soumis aux deux ordres juridiques. Les lecteurs qui souhaitent de plus amples informations sur une question particulière pourront se reporter à la partie « lectures complémentaires » du manuel, où ils trouveront des références bibliographiques plus spécialisées.

Le droit issu de la CEDH est présenté sous la forme de brèves références à des affaires dans lesquelles la Cour européenne des droits de l'homme (CouEDH) a eu

à connaître de sujets liés aux questions traitées dans le manuel, choisies parmi l'abondante jurisprudence de la Cour relative aux droits de l'enfant.

Le droit de l'UE est constitué des mesures législatives adoptées et des dispositions pertinentes des traités, en particulier de celles de la Charte des droits fondamentaux de l'Union européenne telles qu'interprétées par la jurisprudence de la Cour de Justice de l'Union européenne (CJUE, dénommée Cour de Justice des Communautés européennes (CJCE) avant décembre 2009).

La jurisprudence décrite ou citée dans le manuel fournit des exemples tirés de l'important corpus de jurisprudence de la CouEDH et de la CJUE. Le manuel intègre, dans la mesure du possible compte tenu de son champ d'application restreint et de sa nature introductive, les évolutions du droit intervenues jusqu'au 1er janvier 2015, bien que des évolutions plus récentes aient également été incluses lorsque cela était possible.

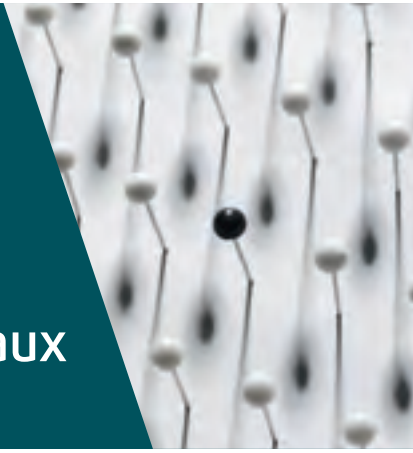
Le manuel comprend une introduction, qui explique brièvement le rôle des deux systèmes juridiques correspondant l'un au droit issu de la CEDH et l'autre à celui de l'UE, ainsi que dix chapitres de fond couvrant les questions suivantes :

- droits civils et libertés ;
- égalité ;
- identité des personnes ;
- vie familiale ;
- modes de garde alternatifs et adoption ;
- protection des enfants contre la violence et l'exploitation ;
- droits économiques, sociaux et culturels ;
- migration et asile ;
- protection des consommateurs et des données à caractère personnel ;
- droits de l'enfant dans le cadre de la justice pénale et des procédures de remplacement.

Chaque chapitre traite d'un sujet distinct et comprend des renvois à d'autres sujets et à d'autres chapitres qui permettent d'offrir au lecteur une meilleure compréhension du cadre juridique applicable. Des points clé sont présentés au début de chaque section.

1

Introduction aux droits de l'enfant : contexte et principes fondamentaux du droit européen



UE	Questions traitées	CdE
Directive relative à la liberté de circulation (2004/38/CE), article 2, paragraphe 2, point c)	L'« enfant » en tant que titulaire de droits	Convention du Conseil de l'Europe sur la lutte contre la traite des êtres humains, article 4, point d) Convention du Conseil de l'Europe sur la protection des enfants contre l'exploitation et les abus sexuels (Convention de Lanzarote), article 3, point a) CouEDH, *Marckx c. Belgique*, n° 6833/74, 1979 (le requérant avait six ans quand la Cour a rendu son arrêt)
Directive « Jeunes travailleurs » (94/33/CE), article 3	Protection des jeunes au travail	CSE (révisée), article 7 (droit des enfants et des adolescents à la protection)
Charte des droits fondamentaux, article 14, paragraphe 2 (droit à l'éducation)	Droit à bénéficier d'une éducation obligatoire gratuite	
Charte des droits fondamentaux, article 21 (non-discrimination)	Interdiction de la discrimination fondée sur l'âge	

UE	Questions traitées	CdE
Charte des droits fondamentaux, article 32 (interdiction du travail des enfants et protection des jeunes au travail) Directive relative à la lutte contre les abus sexuels et l'exploitation sexuelle des enfants, ainsi que la pédopornographie (2011/93/UE) Directive concernant la prévention de la traite des êtres humains (2011/36/UE)	**Interdiction de l'exploitation des enfants par le travail**	CSE (révisée), article 7 (droit des enfants et des adolescents à la protection)
Charte des droits fondamentaux, article 24 (droits de l'enfant) TUE, article 3, paragraphe 3	**Protection des droits de l'enfant (général)**	
Charte des droits fondamentaux, article (droit au respect de la vie privée et familiale)	**Droit au respect de la vie privée et familiale**	CEDH, article 8 (droit au respect de la vie privée et familiale) Convention européenne sur le statut juridique des enfants nés hors mariage Convention européenne en matière d'adoption des enfants (révisée) Convention sur les relations personnelles concernant les enfants Convention européenne sur l'exercice des droits des enfants CouEDH, *Maslov c. Autriche* [GC], n° 1638/03, 2008 (expulsion du requérant condamné pénalement en tant qu'enfant)

UE	Questions traitées	CdE
CJUE, C-413/99, *Baumbast et R c. Secretary of State for the Home Department*, 2002 CJUE, C-200/02, *Kunqian Catherine Zhu et Man Lavette Chen c. Secretary of State for the Home Department*, 2004 CJUE, C-148/02, *Carlos Garcia Avello c. État belge*, 2003 CJUE, C-310/08, *London Borough of Harrow c. Nimco Hassan Ibrahim et Secretary of State for the Home Department*, 2010 CJUE, C-480/08, *Maria Teixeira c. London Borough of Lambeth et Secretary of State for the Home Department*, 2010	Liberté de circulation	

Ce chapitre liminaire expose l'évolution du cadre juridique relatif aux droits de l'enfant au niveau européen, les principes fondamentaux qui guident son application et les aspects principaux des droits de l'enfant abordés par le droit européen. Il présente le contexte dont relève l'analyse thématique des chapitres suivants.

1.1. Concepts fondamentaux

Point clé

- Le cadre juridique européen relatif aux droits de l'enfant s'appuie sur des mesures existantes au niveau national et international.

1.1.1. Champ d'application des droits de l'enfant

En ce qui concerne « le cadre juridique européen relatif aux droits de l'enfant », l'accent est mis sur les sources de droit primaire (traités, conventions, législation dérivée et jurisprudence) introduites par le Conseil de l'Europe (CdE) et l'Union européenne (UE). Le cas échéant, il est fait référence aux autres sources européennes qui influencent son évolution, y compris les documents stratégiques clés, les lignes directrices ou les autres instruments non contraignants/de droit souple.

Les enfants ne sont pas exclusivement objets d'une protection, ils sont détenteurs de droits. Ils sont bénéficiaires de tous les droits fondamentaux et de l'homme, et sont sujets de réglementations particulières compte tenu de leurs caractéristiques spécifiques. La majeure partie de la jurisprudence européenne provient de poursuites intentées par des parents ou d'autres représentants légaux d'enfants compte tenu de la capacité juridique limitée des enfants. Si l'objectif du présent manuel est d'illustrer comment le droit s'adapte aux intérêts et besoins particuliers des enfants, le manuel illustre également l'importance des parents/tuteurs ou autres représentants légaux et fait référence, le cas échéant, aux principaux droits et responsabilités conférés aux personnes ayant la charge des enfants. Dans ces cas, l'approche de la Convention des Nations Unies relative aux droits de l'enfant (CRC)[1] est adoptée, c'est-à-dire que les parents doivent exercer leurs responsabilités avec pour principale préoccupation l'intérêt supérieur de l'enfant, et d'une manière qui respecte l'évolution de ses capacités.

1.1.2. L'« enfant » en tant que titulaire de droits

En ce qui concerne le droit international, la CRC dispose, en son article 1er, qu'« un enfant s'entend de tout être humain âgé de moins de dix-huit ans. » Il s'agit du paramètre juridique actuellement utilisé, en Europe également, pour définir un enfant.

Dans le droit de l'UE, il n'existe aucune définition unique officielle de l'« enfant » dans les traités, la législation dérivée ou la jurisprudence. La définition de l'enfant au sens du droit de l'UE peut considérablement varier en fonction du contexte réglementaire. À titre d'exemple, le droit de l'UE régissant les droits relatifs à la libre circulation des citoyens de l'UE et des membres de leur famille définit les enfants comme « les descendants directs qui sont âgés de moins de vingt-et-un ans ou qui sont à charge »[2], adoptant, pour l'essentiel, une notion biologique et économique par opposition à une notion fondée sur la minorité.

1 Organisation des Nations Unies (ONU), Assemblée générale (1989), Convention relative aux droits de l'enfant, 20 novembre 1989.

2 Directive 2004/38/CE du Parlement européen et du Conseil du 29 avril 2004 relative au droit des citoyens de l'Union et des membres de leurs familles de circuler et de séjourner librement sur le territoire des États membres, modifiant le règlement (CEE) n° 1612/68 et abrogeant les directives 64/221/CEE, 68/360/CEE, 72/194/CEE, 73/148/CEE, 75/34/CEE, 75/35/CEE, 90/364/CEE, 90/365/CEE et 93/96/CEE, JO L 158 du 30.4.2004 et JO L 158 du 29.04.2004, art. 2, para. 2, point c).

Certains actes législatifs de l'UE confèrent des droits différents aux enfants en fonction de leur âge. Ainsi, la directive 94/33/CE relative à la protection des jeunes au travail (directive « Jeunes travailleurs »[3]), qui régit l'accès des enfants au travail officiel et les conditions y afférentes dans les États membres de l'UE, établit une distinction entre les « jeunes » (un terme générique désignant toute personne âgée de moins de 18 ans), les « adolescents » (tout jeune âgé de 15 ans au moins et de moins de 18 ans et qui n'est plus soumis à l'obligation scolaire à temps plein) et les « enfants » (tout jeune de moins de 15 ans, pour qui l'emploi officiel est largement interdit).

D'autres domaines du droit de l'UE, en particulier ceux dans lesquels l'action de l'UE complète celle des États membres (tels que la sécurité sociale, l'immigration et l'éducation) se reportent au droit national pour déterminer qui est un enfant. Dans ces contextes, la définition de la CRC est généralement adoptée.

Dans le droit du CdE, la majorité des instruments relatifs aux enfants adoptent la définition de l'enfant de la CRC. On citera par exemple l'article 4, point d), de la Convention du Conseil de l'Europe sur la lutte contre la traite des êtres humains[4] ou l'article 3, point a), de la Convention du Conseil de l'Europe sur la protection des enfants contre l'exploitation et les abus sexuels (Convention de Lanzarote)[5].

La Convention européenne de droits de l'homme (CEDH) ne comprend pas de définition de l'enfant, mais, en vertu de son article 1er, les États sont tenus de garantir à « toute personne » relevant de leur juridiction les droits définis dans la Convention. L'article 14 de la CEDH garantit la jouissance des droits définis dans cette convention, « sans distinction aucune », notamment sans distinction d'âge[6]. La Cour européenne des droits de l'homme (CouEDH) a accepté les requêtes déposées par des enfants et pour le compte d'enfants quel que soit leur âge[7]. Dans

3 Directive 94/33/CE du 22 juin 1994 relative à la protection des jeunes au travail, JO 1994 L 216, art. 3.

4 Conseil de l'Europe (CdE), Convention sur la lutte contre la traite des êtres humains, STCE n° 197, 15 mai 2005.

5 CdE, Convention sur la protection des enfants contre l'exploitation et les abus sexuels, STCE n° 201, 25 octobre 2007.

6 CouEDH, *Schwizgebel c. Suisse*, n° 25762/07, 10 juin 2010. Voir également FRA et CouEDH (2011), section 4.5.

7 Voir par exemple, CouEDH, *Marckx c. Belgique*, n° 6833/74, 13 juin 1979 (le requérant avait six ans quand la Cour a rendu son arrêt).

sa jurisprudence, elle a accepté la définition de l'enfant contenue dans la CRC[8], adoptant la notion de « personne âgée de moins de 18 ans ».

Il en va de même pour la Charte sociale européenne (CSE) et son interprétation par le Comité européen des droits sociaux (CEDS)[9].

1.2. Contexte du droit européen relatif aux droits de l'enfant

À ce jour, la majeure partie du droit européen relatif aux droits de l'enfant a été élaborée par l'UE et le CdE. Outre les Nations Unies, d'autres institutions internationales telles que la Conférence de La Haye de droit international privé ont également adopté plusieurs instruments importants qui continuent de guider le développement du droit européen. Bien que ces cadres internationaux opèrent séparément les uns des autres, des liens sont de plus en plus souvent établis entre eux.[10] La coopération interinstitutionnelle est particulièrement étroite entre le CdE et l'UE.

1.2.1. Union européenne : évolution des droits de l'enfant et domaines de protection couverts

Dans le passé, les droits de l'enfant se sont développés de manière fragmentaire dans l'UE. D'un point de vue historique, la législation relative aux enfants visait, dans une large mesure, à couvrir des aspects concernant les enfants dans le cadre d'initiatives politiques et économiques plus larges, par exemple dans le domaine de la protection des consommateurs[11] et de la libre circulation des personnes[12].

8 CouDEH, *Güveç c. Turquie*, n° 70337/01, 20 janvier 2009 ; CouEDH, *Çoşelav c. Turquie*, n° 1413/07, 9 octobre 2012.

9 CEDS, *Défense des Enfants International (DEI) c. Pays-Bas*, n° 47/2008, 20 octobre 2009, para. 25.

10 Voir, par exemple, le chapitre 5, qui illustre la manière dont le droit de l'UE relatif à la famille régissant les enlèvements internationaux d'enfants s'articule avec la Convention du 25 octobre 1980 sur les aspects civils de l'enlèvement international d'enfants (convention de la Haye sur l'enlèvement d'enfants).

11 Par exemple, la directive 2009/48/CE du Parlement européen et du Conseil du 18 juin 2009 relative à la sécurité des jouets, JO 2009 L 170, qui met en œuvre des mesures de sécurité pour les jouets pour enfants.

12 Par exemple, la directive 2004/38/CE.

Toutefois, plus récemment, les droits des enfants ont été abordés dans le cadre d'un programme plus coordonné de l'UE, fondé sur trois étapes importantes :

- l'adoption de la Charte des droits fondamentaux de l'Union européenne ;
- l'entrée en vigueur du Traité de Lisbonne en décembre 2009 ;
- l'adoption de la communication de la Commission européenne intitulée « Une place à part pour les enfants dans l'action extérieure de l'UE » et des « Orientations de l'UE concernant la promotion et la protection des droits de l'enfant » du Conseil.

La première étape importante a été l'adoption de la Charte des droits fondamentaux de l'Union européenne en 2000[13]. Avec l'entrée en vigueur du Traité de Lisbonne, le 1er décembre 2009, la Charte a la même valeur juridique que les traités de l'UE (article 6 du Traité sur l'Union européenne, TUE). Elle oblige l'UE et ses États membres à protéger les droits qui y sont consacrés lorsqu'ils mettent en œuvre le droit de l'UE. La Charte des droits fondamentaux de l'UE est le premier texte de niveau constitutionnel à l'échelle de l'UE qui contient des dispositions précises relatives aux droits de l'enfant, notamment la reconnaissance du droit des enfants de suivre gratuitement l'enseignement obligatoire (article 14, paragraphe 2), l'interdiction de la discrimination en raison notamment de l'âge (article 21) et une interdiction de l'exploitation des enfants par le travail (article 32). De manière significative, la Charte contient une disposition spécifique sur les droits de l'enfant (article 24). Celle-ci énonce trois principes fondamentaux des droits de l'enfant : le droit d'exprimer leur opinion librement, en fonction de leur âge et leur maturité (article 24, paragraphe 1), le droit de voir leur intérêt supérieur constituer une considération primordiale dans tous les actes qui les concernent (article 24, paragraphe 2) et le droit d'entretenir régulièrement des relations personnelles et des contacts directs avec leurs deux parents (article 24, paragraphe 3).

La deuxième étape importante a été l'adoption du Traité de Lisbonne, qui, comme indiqué ci-dessus, est entré en vigueur le 1er décembre 2009[14]. Cet instrument a fortement modifié l'UE sur le plan institutionnel, procédural et constitutionnel, en modifiant le TUE et l'ancien traité instituant la Communauté européenne

13 UE (2012), Charte des droits fondamentaux de l'Union européenne, JO 2012 C 326.

14 UE (2007), Traité de Lisbonne modifiant le traité sur l'Union européenne et le traité instituant la Communauté européenne, signé à Lisbonne, JO 2007 C 306, p. 1.

(désormais devenu le Traité sur le fonctionnement de l'Union européenne, TFUE).[15] Cette évolution a renforcé la capacité de l'UE à faire progresser les droits de l'enfant, notamment en inscrivant la « protection des droits de l'enfant » parmi les objectifs généraux de l'UE (article 3, paragraphe 3, du TUE) et en en faisant un aspect important de la politique extérieure de l'UE (article 3, paragraphe 5, du TUE). Le TFUE également contient des références plus spécifiques aux enfants, permettant à l'UE d'adopter des mesures législatives visant à lutter contre l'exploitation sexuelle et la traite des êtres humains (article 79, paragraphe 2, point d), et article 83, paragraphe 1).

Cela a conduit à l'adoption de la directive relative à la lutte contre les abus sexuels et l'exploitation sexuelle des enfants, ainsi que la pédopornographie[16], et de la directive concernant la prévention de la traite des êtres humains et la lutte contre ce phénomène ainsi que la protection des victimes[17], qui contiennent également des dispositions répondant aux besoins spécifiques des enfants victimes. La directive établissant des normes minimales concernant les droits, le soutien et la protection des victimes de la criminalité[18], plus récente, consacre une grande partie de ses dispositions aux enfants.

La troisième étape importante s'est déroulée à un niveau plus stratégique, à l'origine dans le cadre du programme de coopération extérieure de l'UE et, par la suite, pour les questions internes. Concrètement, le Conseil de l'UE a adopté les « Orientations de l'UE concernant la promotion et la protection des droits de l'enfant »[19] et la Commission européenne, sa communication intitulée *Une place à part pour les enfants dans l'action extérieure de l'UE*[20], pour intégrer les droits de l'enfant dans toutes les activités de l'UE avec des États qui n'en sont pas membres. De même, en 2011, la Commission européenne a adopté un programme de l'UE en matière de droits de l'enfant, définissant les grandes priorités en vue de l'élaboration de la politique et de la législation relatives aux droits de

15 Voir versions consolidées des Communautés européennes (2012), Traité sur l'Union européenne (TUE) et Traité sur le fonctionnement de l'Union européenne (TFUE), JO 2012 C 326.

16 Directive 2011/93/UE, JO 2011 L 335, p. 1.

17 Directive 2011/36/UE, JO 2011 L 101, p. 1.

18 Directive 2012/29/UE, JO 2012 L 315, p. 57.

19 Conseil de l'UE (2007), *Orientations de l'UE concernant la promotion et la protection des droits de l'enfant*, Bruxelles, 10 décembre 2007.

20 Commission européenne (2008), *Une place à part pour les enfants dans l'action extérieure de l'UE : communication de la Commission au Conseil, au Parlement européen, au Comité économique et social et au Comité des régions*, COM(2008) 55 final, Bruxelles, 5 février 2008.

l'enfant dans tous les États membres de l'UE.[21] Le programme portait également sur le ciblage du processus législatif ayant trait à la protection des enfants, telles que l'adoption de la directive précitée sur les droits des victimes.

Plus récemment, le programme a été complété par une stratégie globale, adoptée par la Commission européenne, pour soutenir les États membres à lutter contre la pauvreté et l'exclusion sociale au moyen d'une série d'interventions dès la petite enfance (pour les enfants d'âge préscolaire et en âge de fréquenter l'enseignement primaire).[22] Bien que cette stratégie et le programme précité ne soient pas juridiquement contraignants, l'un et l'autre sont importants dans la mesure où ils établissent une référence pour l'approche normative et méthodologique de l'UE en matière des droits de l'enfant. Cette orientation stratégique est fortement liée à la CRC et s'inscrit dans une éthique de protection, de participation et de non-discrimination des enfants.

L'UE ne peut légiférer que dans les domaines où des compétences lui ont été attribuées par les traités (articles 2 à 4 du TFUE). Les droits de l'enfant étant un domaine intersectoriel, les compétences de l'UE doivent être déterminées au cas par cas. À ce jour, les domaines pertinents pour les droits de l'enfant dans lesquels l'UE a largement légiféré sont les suivants :

- protection des données et des consommateurs ;
- asile et migration ;
- coopération en matière civile et pénale.

L'article 6, paragraphe 1, du TUE et l'article 51, paragraphe 2, de la Charte des droits fondamentaux de l'UE prévoient que la Charte n'étend pas les compétences de l'UE et qu'elle ne modifie ou ne crée aucune compétence ni aucune tâche nouvelles pour l'UE. Les dispositions de la Charte s'adressent aux institutions de l'UE et aux États membres uniquement lorsqu'ils mettent en œuvre le droit de l'Union. Si les dispositions de la Charte sont toujours contraignantes pour l'UE, elles ne le sont pour les États membres uniquement lorsqu'ils agissent dans le champ d'application du droit de l'UE.

21 Commission européenne (2011), *Programme de l'Union européenne en matière de droits de l'enfant : communication de la Commission au Parlement européen, au Conseil, au Comité économique et social européen et au Comité des régions*, COM(2011) 60 final, Bruxelles, 15 février 2011.

22 Commission européenne (2013), *Investir dans l'enfance pour briser le cercle vicieux de l'inégalité*, Recommandation 2013/112/UE, Bruxelles.

Chaque chapitre suivant dresse un bref aperçu des compétences de l'UE dans les domaines concernant le chapitre.

1.2.2. Conseil de l'Europe : évolution des droits de l'enfant et domaines de protection couverts

À la différence de l'UE, le Conseil de l'Europe détient depuis sa création un mandat clair pour protéger et promouvoir les droits de l'homme. Son principal traité sur les droits de l'homme, ratifié par tous les États membres du CdE, est la Convention de sauvegarde des droits de l'homme et des libertés fondamentales, également appelée Convention européenne des droits de l'homme (CEDH), qui contient plusieurs mentions spécifiques relatives aux enfants. Les principales sont les suivantes : l'article 5, paragraphe 1, point d), prévoit la détention légale d'un enfant aux fins de son éducation surveillée ; l'article 6, paragraphe 1, limite le droit à une audience publique et équitable lorsque l'intérêt des mineurs l'exige ; l'article 2 du protocole n° 1, prévoit le droit à l'éducation et exige des États qu'ils respectent les convictions religieuses et philosophiques des parents dans le cadre de l'éducation de leurs enfants. En outre, toutes les autres dispositions générales de la CEDH sont applicables à tous, y compris aux enfants. Certaines se sont révélées présenter un intérêt particulier pour les enfants, à savoir l'article 8, qui garantit le droit au respect de la vie privée et familiale, et l'article 3, qui interdit la torture et les peines et traitements inhumains ou dégradants. En recourant à des approches interprétatives qui mettent l'accent sur les obligations positives inhérentes à la CEDH, la CouEDH a développé une jurisprudence abondante traitant des droits de l'enfant, qui comprend de nombreuses références à la CRC. Cela étant dit, la CouEDH analyse les recours au cas par cas et, par conséquent, n'offre pas une vue d'ensemble exhaustive des droits de l'enfant au titre de la CEDH.

L'autre grand traité du CdE relatif aux droits de l'homme, la Charte sociale européenne (CSE,[23] révisée en 1996[24]), prévoit la protection des droits sociaux, avec des dispositions spécifiques pour les droits de l'enfant. Elle contient deux dispositions qui revêtent une importance particulière pour les droits de l'enfant. L'article 7 prévoit l'obligation de protéger les enfants contre l'exploitation économique. L'article 17 exige des États qu'ils prennent toutes les mesures nécessaires

23 CdE, Charte sociale européenne, STE n° 35, 18 octobre 1961.

24 CdE, Charte sociale européenne (révisée), STE n° 163, 3 mai 1996.

et appropriées en vue d'assurer aux enfants les soins, l'assistance, l'éducation et la formation dont ils ont besoin (y compris un enseignement primaire et secondaire gratuit), de protéger les enfants et les adolescents contre la négligence, la violence ou l'exploitation et d'assurer la protection des enfants privés de leur soutien familial. La mise en œuvre de la CSE est supervisée par le Comité européen des droits sociaux (CEDS), qui se compose d'experts indépendants statuant sur la conformité du droit et de la pratique des États parties à la CSE, soit dans le cadre de la procédure des réclamations collectives, soit dans le cadre du système de rapports nationaux.

En outre, le CdE a adopté des traités portant sur une série de questions spécifiques relatives aux droits de l'enfant. Parmi eux figurent :

- la Convention européenne sur le statut juridique des enfants nés hors mariage[25] ;
- la Convention européenne en matière d'adoption des enfants, révisée en 2008[26] ;
- la Convention sur les relations personnelles concernant les enfants[27] ;
- la Convention européenne sur l'exercice des droits des enfants[28] ;
- la Convention du Conseil de l'Europe sur la protection des enfants contre l'exploitation et les abus sexuels (Convention de Lanzarote)[29].

Enfin, au niveau stratégique, il est important de noter qu'en 2006, le CdE a lancé son programme « Construire une Europe pour et avec les enfants », un plan d'action transversal consacré aux questions portant sur les droits de l'enfant, y compris l'adoption d'instruments normatifs dans différents domaines.[30] Les objectifs actuels sont axés sur quatre domaines clés[31] :

25 CdE, Convention européenne sur le statut juridique des enfants nés hors mariage, STE n° 85, 15 octobre 1975.

26 CdE, Convention européenne en matière d'adoption des enfants (révisée), STCE n° 202, 27 novembre 2008.

27 CdE, Convention sur les relations personnelles concernant les enfants, STE n° 192, 15 mai 2003.

28 CdE, Convention européenne sur l'exercice des droits des enfants, STE n° 160, 25 janvier 1996.

29 CdE, Convention sur la protection des enfants contre l'exploitation et les abus sexuels, STCE n° 201, 25 octobre 2007.

30 Pour plus d'informations, voir www.coe.int/t/dg3/children/default_FR.asp?.

31 CdE, Comité des Ministres (2011), Stratégie du Conseil de l'Europe sur les droits de l'enfant (2012-2015), CM(2011)171 final, 15 février 2012.

- promouvoir des services et systèmes adaptés aux enfants ;
- supprimer toutes les formes de violence à l'encontre des enfants ;
- garantir les droits de l'enfant en situation de vulnérabilité ;
- encourager la participation des enfants.

Le but principal du programme du CdE en faveur des droits de l'enfant est de soutenir la mise en œuvre des normes internationales dans le domaine des droits de l'enfant par tous les États membres du CdE et, en particulier, de promouvoir la mise en œuvre de la CRC, en mettant en lumière ses principes essentiels, que sont la non-discrimination, le droit à la vie et au développement, la priorité donnée à l'intérêt supérieur de l'enfant dans la prise de décision et le droit des enfants à être entendus.[32]

Le programme a supervisé l'adoption de plusieurs instruments en matière de droits de l'enfant fournissant des lignes directrices pratiques pour compléter les mesures juridiques européennes contraignantes ; il s'agit notamment des instruments suivants :

- Lignes directrices sur une justice adaptée aux enfants[33] ;
- Lignes directrices sur les soins de santé adaptés aux enfants[34] ;
- Recommandation sur les stratégies nationales intégrées de protection des enfants contre la violence[35] ;
- Recommandation sur les droits de l'enfant et les services sociaux adaptés aux enfants et aux familles[36] ;

32 *Ibid.*

33 CdE, Comité des Ministres (2010), *Lignes directrices sur une justice adaptée aux enfants*, 17 novembre 2010.

34 CdE, Comité des Ministres (2011), *Lignes directrices sur les soins de santé adaptés aux enfants*, 21 septembre 2011.

35 CdE, Comité des Ministres (2009), Recommandation CM/Rec(2009)10 du Comité des Ministres aux États membres sur les stratégies nationales intégrées de protection des enfants contre la violence, 18 novembre 2009.

36 CdE, Comité des Ministres (2011), Recommandation Rec(2011)12 sur les droits de l'enfant et les services sociaux adaptés aux enfants et aux familles, 16 novembre 2011.

- Recommandation du Comité des Ministres aux États membres sur la participation des enfants et des jeunes de moins de 18 ans[37].

De ce fait, le programme a permis de faire en sorte que l'Europe soit au cœur des efforts normatifs dans le domaine des droits de l'enfant et a montré la voie à suivre, par divers moyens, pour veiller à ce que la voix des enfants soit au cœur de ce processus. Le programme vise également à soutenir la mise en œuvre de la CEDH et de la CSE et à promouvoir d'autres instruments juridiques existants du CdE concernant l'enfance (la participation, la protection et les droits de l'enfant), la jeunesse et la famille.[38]

1.3. Le droit européen relatif aux droits de l'enfant et la Convention des Nations Unies relative aux droits de l'enfant

Point clé

- Le droit européen relatif aux droits de l'enfant est largement fondé sur la Convention des Nations Unies relative aux droits de l'enfant.

Le fait que tous les États membres de l'Union européenne et du Conseil de l'Europe sont en même temps parties à la CRC donne à cette dernière une position importante au niveau européen. Elle impose effectivement des obligations juridiques communes aux États de l'Europe, ce qui a des répercussions sur la manière dont les institutions européennes définissent et appliquent les droits de l'enfant.

Ainsi, la CRC est devenu la pierre de touche de l'élaboration du droit européen relatif aux droits de l'enfant, de sorte que le CdE et l'UE font de plus en plus appel à son influence. En particulier, l'intégration des principes et dispositions de la CRC dans des instruments contraignants et dans la jurisprudence au niveau européen confère plus de force à la CRC et ouvre des voies d'exécution plus efficaces pour

37 CdE, Comité des Ministres (2012), Recommandation CM/Rec(2012)2 du Comité des Ministres aux États membres sur la participation des enfants et des jeunes de moins de 18 ans, 28 mars 2012.

38 CdE, Comité des Ministres (2011), *Stratégie du Conseil de l'Europe sur les droits de l'enfant (2012-2015)*, CM(2011)171 final, 15 février 2012.

ceux qui cherchent à invoquer les droits de l'enfant en Europe. Des exemples spécifiques concernant cet aspect sont présentés tout au long de ce manuel.

L'Union européenne n'est pas et ne peut pas devenir partie à la CRC, dans la mesure où cette dernière ne prévoit pas mécanisme juridique permettant à des entités autres que des États d'y adhérer. Toutefois, elle se fonde sur les « principes généraux du droit de l'Union » (principes écrits et non écrits, issus des traditions constitutionnelles communes aux États membres), pour compléter et orienter l'interprétation des traités de l'UE (article 6, paragraphe 3, du TUE). La Cour de justice de l'Union européenne (CJUE) a confirmé que toute obligation découlant de l'adhésion à l'UE ne doit pas entrer en conflit avec les obligations des États membres découlant des Constitutions nationales et des engagements internationaux relatifs aux droits de l'homme[39]. Étant donné que tous les États membres de l'UE ont ratifié la CRC, l'Union est tenue de respecter les dispositions et les principes qui y sont consacrés, du moins en ce qui concerne les questions relevant de sa compétence (définie par les traités).

Cette obligation est renforcée par d'autres traités de l'UE, et en particulier par la Charte des droits fondamentaux de l'UE. L'article 24 de la Charte s'inspire directement des dispositions de la CRC, y compris certaines qui ont acquis le rang de « principes », notamment l'intérêt supérieur de l'enfant (article 3 de la CRC), la participation de l'enfant (article 12 de la CRC) et le droit de l'enfant de vivre avec ses parents et/ou de jouir d'une relation avec eux (article 9 de la CRC).

L'importance de la CRC s'agissant d'orienter la définition des droits de l'enfant au niveau de l'UE est exprimée dans le programme de la Commission en matière de droits de l'enfant, qui indique que « [l]es normes et principes établis par [la CRC] doivent continuer à guider les politiques et les actions de l'Union européenne qui ont une incidence sur les droits de l'enfant »[40]. Dans cet esprit, les instruments législatifs concernant les enfants s'accompagnent, presque sans exception, d'une référence explicite à la CRC ou d'une référence davantage implicite aux principes en matière de droits de l'enfant, tels que l'intérêt supérieur de l'enfant, le droit de l'enfant à participer aux décisions qui ont une incidence sur lui ou son droit d'être protégé contre la discrimination.

39 Par exemple, CJUE, C-4/73, *J. Nold, Kohlen- und Baustoffgroßhandlung c. Commission des Communautés européennes*, 14 mai 1974.

40 Commission européenne (2011), *Programme de l'Union européenne en matière de droits de l'enfant*, COM(2011) 0060 final, Bruxelles.

Le Conseil de l'Europe, à l'instar de l'UE, n'est pas, en tant qu'organisation, légalement tenu par la CRC, bien que tous les États membres du CdE soient, individuellement, parties à cette Convention. Néanmoins, la CEDH ne peut être interprétée isolément. Elle doit, au contraire, être interprétée en harmonie avec les principes généraux du droit international. Il convient de tenir compte de toute règle pertinente de droit international applicable dans les relations entre les États parties à la CEDH, en particulier les règles relatives à la protection universelle des droits de l'homme. En ce qui concerne plus précisément les obligations que la CEDH impose aux États qui y sont parties dans le domaine des droits de l'enfant, celles-ci doivent être interprétées à la lumière de la CRC[41]. Le CEDS a lui aussi explicitement fait mention de la CRC dans ses décisions[42]. En outre, les activités du CdE liées à l'établissement de normes et à l'élaboration de traités sont influencées par les principes et dispositions de la CRC. Par exemple, les *Lignes directrices sur une justice adaptée aux enfants*[43] sont directement aiguillées par une série de dispositions de la CRC, sans oublier les observations générales du Comité des droits de l'enfant des Nations Unies[44].

1.4. Rôle des Cours européennes dans l'interprétation et l'application des droits européens de l'enfant

1.4.1. La Cour de justice de l'Union européenne

La CJUE peut statuer sur la base de nombreux types d'actions en justice. Dans les affaires concernant les droits de l'enfant, la CJUE a jusqu'ici principalement statué dans le cadre de renvois préjudiciels (article 267 du TFUE)[45]. Il s'agit de procédures

41 CouEDH, *Harroudj c. France*, n° 43631/09, 4 octobre 2012, point 42.

42 CEDS, *Organisation mondiale contre la Torture (OMCT) c. Irlande*, n° 18/2003, 7 décembre 2004, paras. 61-63 ; CEDS, *Défense des Enfants International (DEI) c. Pays-Bas*, n° 47/2008, 20 octobre 2009.

43 CdE, Comité des Ministres (2010), *Lignes directrices sur une justice adaptée aux enfants*, 17 novembre 2010.

44 Voir ONU, Comité des droits de l'enfant (2007), *Observation générale n° 10 (2007), Les droits de l'enfant dans le système de justice pour mineurs*, 25 avril 2007 ; (2009), *Observation générale n° 12 (2009), Le droit de l'enfant d'être entendu,* CRC/C/GC/12, 1er juillet 2009 ; et (2013), *Observation générale n° 14 (2013) sur le droit de l'enfant à ce que son intérêt supérieur soit une considération primordiale (art. 3, para. 1),* CRC/C/GC/14, 29 mai 2013.

45 La seule exception concerne un recours en annulation : CJUE, C-540/03, *Parlement européen c. Conseil de l'Union européenne* [GC], 27 juin 2006.

dans lesquelles une juridiction nationale demande à la CJUE d'interpréter le droit primaire (c'est-à-dire les traités) ou le droit dérivé (c'est-à-dire les décisions ou la législation) de l'UE concerné par une affaire nationale pendante devant une juridiction nationale.

Jusqu'à ces dernières années, la CJUE n'avait statué que dans quelques affaires concernant les droits de l'enfant. Toutefois, à la suite de l'adoption de plusieurs mesures législatives concernant explicitement les droits de l'enfant et l'importance accrue de cette question, il est probable que la CJUE ait plus souvent à connaître d'affaires concernant les droits de l'enfant à l'avenir.

La Cour a rendu la majeure partie de ses arrêts au sujet des droits de l'enfant dans le contexte de la libre circulation et de la citoyenneté de l'UE, domaines dans lesquels l'Union jouit d'une compétence de longue date. À cet égard, la CJUE a expressément reconnu que les enfants bénéficient des avantages associés à la citoyenneté de l'UE de manière autonome, étendant ainsi le séjour autonome et les droits sociaux et éducatifs aux enfants, sur la base de la nationalité de l'UE[46].

Il n'y a qu'un seul exemple dans lequel la CJUE a directement utilisé la CRC pour déterminer la manière dont le droit de l'UE devait être interprété en ce qui concerne les enfants, à savoir l'affaire *Dynamic Medien*. Cette affaire portait sur la légalité de restrictions en matière d'étiquetage imposées par l'Allemagne en ce qui concerne des DVD et vidéos qui avaient déjà fait l'objet de contrôles similaires au Royaume-Uni. La CJUE a conclu que les contrôles allemands concernant l'étiquetage constituaient une restriction légale aux dispositions de l'UE relatives à la libre circulation des marchandises (qui, autrement, s'opposent à toute double procédure réglementaire de ce type), étant donné qu'ils visaient à protéger le bien-être des enfants. La CJUE a étayé sa décision en se référant à l'article 17 de la CRC, qui encourage les États signataires à élaborer des principes directeurs appropriés destinés à protéger l'enfant contre l'information et les matériels médiatiques qui nuisent à son bien-être[47]. Les exigences en matière de proportionnalité

46 Voir CJUE, C-413/99, *Baumbast et R c. Secretary of State for the Home Department*, 17 septembre 2002 ; CJUE, C-200/02, *Kunqian Catherine Zhu et Man Lavette Chen c. Secretary of State for the Home Department*, 19 octobre 2004 ; CJUE, C-148/02, *Carlos Garcia Avello c. État belge*, 2 octobre 2003 ; CJUE, C-310/08, *London Borough of Harrow c. Nimco Hassan Ibrahim et Secretary of State for the Home Department* [GC], 23 février 2010 ; CJUE, C-480/08, *Maria Teixeira c. London Borough of Lambeth et Secretary of State for the Home Department*, 23 février 2010. Ces affaires sont examinées aux chapitres 8 et 9.

47 CJUE, C-244/06, *Dynamic Medien Vertriebs GmbH c. Avides Media AG*, 14 février 2008, points 42 et 52.

s'appliquent toutefois en ce qui concerne les procédures d'examen mises en place pour protéger les enfants, qui doivent être facilement accessibles et réalisables dans un délai raisonnable [48].

Dans les autres affaires, la CJUE a fait allusion aux principes généraux en matière de droits de l'enfant, qui sont également consacrés dans les dispositions de la CRC (tels que l'intérêt supérieur de l'enfant et le droit d'être entendu) pour guider ses arrêts, notamment dans le cadre des affaires d'enlèvement transfrontaliers d'enfants[49].

Mis à part cela, l'UE a toujours fait preuve de circonspection s'agissant de conférer un caractère décisif à la CRC, notamment dans les domaines politiquement sensibles tels que le contrôle de l'immigration[50], même si la situation est en train d'évoluer dans la jurisprudence récente, comme nous le verrons dans les chapitres qui suivent. Depuis l'adoption de la Charte des droits fondamentaux de l'Union européenne, les références de la CJUE aux articles de la Charte concernant les droits de l'enfant trouvent souvent écho dans des références à la CRC, étant donné les similitudes entre les dispositions.

1.4.2. La Cour européenne des droits de l'homme

La Cour européenne des droits de l'homme (CouEDH) statue principalement sur des demandes individuelles déposées conformément aux articles 34 et 35 de la Convention européenne des droits de l'homme (CEDH). La compétence de la CouEDH s'étend à toutes les questions concernant l'interprétation et l'application de la CEDH et de ses protocoles (article 32 de la CEDH.).

Contrairement à la CJUE, la CouEDH dispose d'une vaste jurisprudence sur les droits de l'enfant. Bien que de nombreuses affaires relevant de l'article 8 de la CEDH, relatif au respect de la vie privée et familiale, soient considérées du point de vue des droits des parents plutôt que des droits de l'enfant, des affaires relevant d'autres dispositions de fond ne concernent pas nécessairement les parents et sont plus clairement axées sur les droits des enfants concernés, telles que

48 *Ibid.*, points 49 et 50.

49 CJUE, C-491/10 PPU, *Joseba Andoni Aguirre Zarraga c. Simone Pelz*, 22 décembre 2010. Voir le chapitre 5.

50 CJUE, C-540/03, *Parlement européen c. Conseil de l'Union européenne* [GC], 27 juin 2006.

celles liées à la protection contre les peines ou traitements inhumains ou dégradants (article 3 de la CEDH) ou le droit à un procès équitable (article 6 de la CEDH).

Bien que la CouDEH se réfère souvent à la CRC lors de l'examen des requêtes déposées par des enfants ou au nom de ceux-ci, elle n'y accorde pas systématiquement un poids décisif. Dans certaines affaires, les principes en matière de droits de l'enfant tels qu'ils sont exposés par la CRC ont eu une profonde influence sur le raisonnement de la CouDEH, notamment en ce qui concerne l'interprétation que la Cour a donnée de l'article 6 de la CEDH (droit à un procès équitable) en ce qui concerne le traitement des enfants en conflit avec la loi (voir le chapitre 11). Dans d'autres domaines, l'approche de la CouEDH peut varier légèrement de celle de la CRC, par exemple en ce qui concerne l'audition des enfants devant les tribunaux (voir le chapitre 2). Dans certains cas enfin, la CouEDH a explicitement invoqué la CRC.

Exemple : L'affaire *Maslov c. Autriche*[51] concerne l'expulsion du requérant, qui avait été condamné pour un certain nombre d'infractions pénales en tant que mineur. La CouEDH a estimé que, en ce qui concerne les mesures d'expulsion à l'égard d'un délinquant juvénile, l'obligation de prendre en considération l'intérêt de l'enfant exigeait aussi de faciliter la réintégration de celui-ci, conformément à l'article 40, de la CRC. De l'avis de la Cour, ce but ne peut pas être atteint si les liens familiaux et sociaux sont rompus par l'expulsion[52]. La CRC est donc un des motifs invoqués pour constater que l'expulsion était une interférence disproportionnée avec les droits du requérant au titre de l'article 8 de la CEDH (respect de la vie familiale).

1.5. Comité européen des droits sociaux

Le CEDS se compose de 15 experts indépendants et impartiaux que se prononcent sur la conformité de la réglementation et des pratiques nationales avec la CSE, soit par la procédure des réclamations collectives soit par la procédure des rapports nationaux[53]. Les organisations nationales et internationales désignées peuvent déposer des réclamations collectives à l'encontre des États parties à la CSE qui

51 CouEDH, *Maslov c. Autriche* [GC], n° 1638/03, 23 juin 2008.

52 *Ibid.*, point 83.

53 Pour plus d'informations, veuillez consulter le site web du CEDS : www.coe.int/t/dghl/monitoring/socialcharter/ecsr/ecsrdefault_FR.asp?.

ont accepté la procédure de réclamation. À ce jour, les réclamations ont concerné la question de savoir si les États ont violé les droits de l'enfant au titre de la CSE sur des questions telles que l'exploitation économique des enfants[54], l'intégrité physique des enfants[55], les droits des enfants migrants en matière de santé[56] et l'accès à l'éducation pour les enfants handicapés[57].

Exemple : Dans l'affaire *Commission internationale de juristes (CIJ) c. Portugal*[58], il était allégué que, bien que la législation portugaise respecte l'âge minimal de 15 ans pour l'admission à l'emploi établi à l'article 7, paragraphe 1, de la Charte sociale européenne, celle-ci n'était pas correctement mise en œuvre. Le CEDS a considéré que l'objet et la finalité de la CSE était de protéger les droits non seulement en théorie mais également dans la pratique, et donc que la législation devait par conséquent être appliquée de manière effective. Constant que de nombreux enfants travaillaient illégalement au Portugal, il a jugé que cette situation constituait une violation de l'article 7, paragraphe 1, de la CSE.

54 CEDS, *Commission internationale de Juristes (CIJ) c. Portugal*, n° 1/1998, 9 septembre 1999.

55 CEDS, *Organisation mondiale contre la Torture (OMCT) c. Grèce*, n° 17/2003, 7 décembre 2004.

56 CEDS, *Défense des Enfants International (DEI) c. Belgique*, n° 69/2011, 23 octobre 2012.

57 CEDS, *Centre de Défense des Droits des Personnes Handicapées Mentales (MDAC) c. Bulgarie*, n° 41/2007, 3 juin 2008, para. 35.

58 CEDS, *Commission internationale de Juristes (CIJ) c. Portugal*, n° 1/1998, 9 septembre 1999.

2 Libertés et droits civils fondamentaux

UE	Questions traitées	CdE
Charte des droits fondamentaux, articles 10 (liberté de religion) et 14 (droit à l'éducation)	**Liberté de pensée, de conscience et de religion**	CEDH, articles 9 (liberté de religion) et 14 (interdiction de discrimination) ; article 2 du Protocole n° 1 (droit des parents d'assurer l'éducation de leurs enfants conformément à leurs convictions) CouEDH, *Dogru c. France*, n° 27058/05, 2008 (port du voile islamique dans un établissement public d'enseignement secondaire) CouEDH, *Kervanci c. France*, n° 31645/04, 2008 (port du voile islamique dans un établissement public d'enseignement secondaire) CouEDH, *Grzelak c. Pologne*, n° 7710/02, 2010 (alternatives à l'éducation religieuse dans des écoles primaires et secondaires) CouEDH, *Lautsi et autres c. Italie* [GC], n° 30814/06, 2011 (présence de crucifix dans des écoles publiques)
Charte des droits fondamentaux, article 11 (liberté d'expression)	**Liberté d'expression et d'information**	CouEDH, article 10 (liberté d'expression) CouEDH, *Handyside c. Royaume-Uni*, n° 5493/72, 1976 (interdiction d'un livre pour enfants) CouEDH, *Gaskin c. Royaume-Uni*, n° 10454/83, 1989 (accès à un dossier personnel conservé pendant l'enfance)

UE	Questions traitées	CdE
Charte des droits fondamentaux, article 24 (droits de l'enfant) CJUE, C-491/10 PPU, *Joseba Andoni Aguirre Zarraga c. Simone Pelz*, 2010 (droit à être entendu, enlèvement d'enfant international)	**Droit à être entendu**	CouEDH, article 6 (droit à un procès équitable) Convention européenne sur l'exercice des droits des enfants, articles 3, 4, 6 et 7 CouEDH, *Sahin c. Allemagne* [GC], n° 30943/96, 2003 (audition d'un enfant par un tribunal dans une procédure d'accès)
Charte des droits fondamentaux, article 12 (liberté de réunion et d'association)	**Droit à la liberté de réunion et d'association**	CouEDH, article 11 (liberté de réunion pacifique et d'association) CouEDH, *Parti populaire démocrate-chrétien c. Moldova*, n° 28793/02, 2006 (participation à des rassemblements dans des lieux publics)

Toute personne jouit des droits civils et des libertés inscrits dans les divers instruments, principalement dans la Charte des droits fondamentaux de l'Union européenne et dans la Convention européenne des droits de l'homme (CEDH), telle qu'elle est interprétée par la Cour européenne des droits de l'homme (CouEDH). Outre la Charte, aucun autre instrument juridique de l'Union européenne ne traite spécifiquement des droits civils abordés dans le présent chapitre dans la mesure où ceux-ci s'appliquent aux enfants. Toutefois, au niveau du Conseil de l'Europe, et plus particulièrement au moyen de la jurisprudence de la CouEDH, la portée et l'interprétation de ces droits civils se sont considérablement développées au fil du temps.

Le présent chapitre présente un aperçu des libertés énumérées au Titre II de la Charte des droits fondamentaux de l'Union européenne pour autant qu'elles aient une incidence sur les droits des enfants. Il analyse le droit de l'enfant à la liberté de pensée, de conscience et de religion (section 2.1), à la liberté d'expression et d'information (section 2.3), le droit de l'enfant à être entendu (section 2.4) et son droit à la liberté de réunion et d'association (section 2.5).

2.1. Liberté de pensée, de conscience et de religion

Points clés

- La liberté de pensée, de conscience et de religion, telle qu'elle est garantie par la Charte des droits fondamentaux et par la CEDH, inclut le droit à changer de religion ou de conviction, ainsi que la liberté de manifester sa religion ou sa conviction par le culte, l'enseignement, les pratiques et l'accomplissement des rites.
- Les parents ont le droit d'assurer l'éducation et l'enseignement de leurs enfants conformément à leurs convictions religieuses, philosophiques et pédagogiques.
- Les parents ont le droit et le devoir de guider l'enfant dans l'exercice de son droit à la liberté de pensée, de conscience et de religion d'une manière qui corresponde au développement des capacités de l'enfant.

2.1.1. Le droit de l'enfant à la liberté de religion

Dans le droit de l'UE, l'article 10 de la Charte des droits fondamentaux de l'Union européenne garantit à toute personne le droit à la liberté de pensée, de conscience et de religion. Ce droit implique la liberté de changer de religion ou de conviction, ainsi que la liberté de manifester sa religion ou sa conviction individuellement ou collectivement, en public ou en privé, par le culte, l'enseignement, les pratiques et l'accomplissement des rites. Le droit à l'objection de conscience est reconnu selon les lois nationales qui en régissent l'exercice (article 10, paragraphe 2).

Dans le droit du CdE, l'article 9 de la CEDH prévoit le droit à la liberté de pensée, de conscience et de religion. Trois dimensions du droit à la liberté de religion ont été distillées dans la jurisprudence de la CouEDH : la dimension interne, la liberté de changer de religion ou de conviction et la liberté de manifester sa religion ou sa conviction. Les deux premières dimensions sont absolues et les États ne peuvent en aucun cas les restreindre[59]. La liberté de manifester sa religion ou ses convictions ne peut faire l'objet de restrictions que si celles-ci, prévues par la loi, constituent des mesures nécessaires dans une société démocratique (article 9, paragraphe 2, de la CEDH).

59 CouEDH, *Darby c. Suède*, n° 11581/85, 23 octobre 1990.

Dans sa jurisprudence, la CouEDH s'est penchée sur la question de la liberté de pensée, de conscience et de religion des enfants, principalement du point de vue du droit à l'éducation et du système scolaire public. La religion dans les écoles est un sujet faisant l'objet d'un débat public très animé dans les pays européens.

Exemple : les affaires *Dogru c. France* et *Kervanci c. France*[60] concernent l'exclusion d'un collège français de deux filles de 11 et 12 ans ayant refusé d'enlever leur foulard durant les cours d'éducation physique. La CouEDH a observé que la limitation du droit des requérantes à manifester leur conviction religieuse avait pour finalité de préserver les impératifs de la laïcité dans l'espace public scolaire. La CouEDH a estimé que la conclusion des autorités nationales, selon laquelle le port d'un voile, tel que le foulard islamique, n'est pas compatible avec la pratique du sport pour des raisons de sécurité et d'hygiène, n'était pas déraisonnable dans la mesure où l'école a mis en balance les convictions religieuses des requérantes et les exigences liées à la protection des droits et libertés des autres et de l'ordre public. Par conséquent, elle a conclu que l'ingérence dans l'exercice du droit des élèves à manifester leur religion était justifiée et proportionnée au but poursuivi. Elle n'a dès lors constaté aucune violation de l'article 9 de la CEDH.

Exemple : l'affaire *Grzelak c. Pologne*[61] concerne le cas d'une école n'ayant dispensé aucun cours d'éthique à un élève exempté d'instruction religieuse et l'ayant ainsi privé des notes liées à ce cours. Pendant toute sa scolarité primaire et secondaire (entre 7 et 18 ans), le requérant n'a reçu aucune instruction religieuse, conformément au souhait de ses parents, qui s'étaient déclarés agnostiques. Les élèves intéressés étant trop peu nombreux, aucun cours d'éthique n'a jamais été organisé et la note relative au cours de « religion/éthique » a ainsi été remplacée par une barre sur les bulletins et certificats scolaires de cet élève. D'après la CouEDH, l'absence d'une note pour le cours de « religion/éthique » sur les bulletins scolaires de l'élève relevait de l'aspect négatif de la liberté de pensée, de conscience et de religion, car les bulletins pouvaient mettre en évidence son absence d'appartenance religieuse. Elle s'apparentait dès lors à une forme de stigmatisation injustifiée. La différence de traitement entre les non-croyants qui

60 CouEDH, *Dogru c. France*, n° 27058/05, 4 décembre 2008 ; CouEDH, *Kervanci c. France*, n° 31645/04, 4 décembre 2008.

61 CouEDH, *Grzelak c. Pologne*, n° 7710/02, 15 juin 2010.

veulent suivre des cours d'éthique et les élèves qui suivent des cours religieux n'était donc pas objectivement et raisonnablement justifiée et il n'existait aucun lien raisonnable de proportionnalité entre les moyens utilisés et le but poursuivi. Dans cette affaire, l'État a outrepassé sa marge d'appréciation puisqu'il a été porté atteinte à l'essence même du droit du requérant à ne pas manifester sa religion ou sa conviction, en violation de l'article 14 de la CEDH, lu en combinaison avec l'article 9 de la CEDH.

2.2. Droits des parents et liberté de religion de leurs enfants

Les droits des parents dans le contexte de la liberté de religion de leurs enfants sont traités différemment dans le droit européen et dans la CRC.

En vertu du droit de l'UE, il convient de respecter le droit des parents d'assurer l'éducation et l'enseignement de leurs enfants conformément à leurs convictions religieuses, philosophiques et pédagogiques, en particulier dans le contexte de la liberté de créer des établissements d'enseignement (article 14, paragraphe 3, de la Charte).

En vertu du droit du CdE, en particulier de l'article 2 du Protocole n° 1 de la CEDH, les États doivent tenir compte des convictions (religieuses) des parents dans l'exercice des fonctions qu'ils assument dans le domaine de l'éducation et de l'enseignement. D'après la CouEDH, ce devoir est large, car il s'applique non seulement au contenu et à l'application des programmes scolaires, mais aussi à l'exercice de toutes les fonctions dévolues à un État.[62] Il couvre l'organisation et le financement de l'enseignement public, la définition et l'aménagement du programme des études, la diffusion d'informations ou de connaissances contenues dans le programme scolaire de manière objective, critique et pluraliste (interdisant donc l'État de poursuivre un but d'endoctrinement qui puisse être considéré comme ne respectant pas les convictions religieuses et philosophiques des parents), ainsi que l'aménagement de l'environnement scolaire, y compris la présence de crucifix dans des classes d'écoles publiques.

62 Voir la jurisprudence pertinente de la CouEDH : CouEDH, *Kjeldsen, Busk Madsen et Pedersen c. Danemark*, n° 5095/71, 5920/72 et 5926/72, 7 décembre 1976 ; CouEDH, *Valsamis c. Grèce*, n° 21787/93, 18 décembre 1996 ; CouEDH, *Folgerø et autres c. Norvège* [GC], n° 15472/02, 29 juin 2007 ; CouEDH, *Hasan et Eylem Zengin c. Turquie*, n° 1448/04, 9 octobre 2007 ; CouEDH, *Lautsi et autres c. Italie* [GC], n° 30814/06, 18 mars 2011.

Exemple : l'affaire *Lautsi et autres c. Italie*[63] concerne la présence de crucifix dans des salles de classe d'écoles publiques. Un parent s'est plaint de la présence de crucifix dans les salles de classes de l'école publique fréquentée par ses enfants, affirmant qu'elle enfreint le principe de laïcité selon lequel elle s'efforce d'éduquer ses enfants. La Grande Chambre de la CouEDH a conclu qu'il incombait à l'État, dans le cadre des fonctions qu'il assume dans le domaine de l'éducation et de l'enseignement, de décider si des crucifix doivent être placés dans les salles de classe des écoles publiques et que cette question relève du champ d'application de la seconde phrase de l'article 2 du Protocole n° 1 de la CEDH. La Cour a affirmé que cette décision relevait en principe de la marge d'appréciation de l'État défendeur et qu'il n'y avait pas de consensus européen sur la question de la présence de symboles religieux dans les écoles publiques. La présence du crucifix dans les salles de classe des écoles publiques – lequel renvoie indubitablement au christianisme – donne à la religion majoritaire du pays une visibilité prépondérante dans l'environnement scolaire. Cela ne suffit toutefois pas en soi pour caractériser une démarche d'endoctrinement de la part de l'État défendeur. Aux yeux de la CouEDH, un crucifix apposé sur un mur est un symbole essentiellement passif, auquel on ne saurait attribuer une influence sur les élèves comparable à celle que peut avoir un discours didactique ou la participation à des activités religieuses. En conséquence, la Grande Chambre a conclu qu'en décidant de maintenir les crucifix dans les salles de classe de l'école publique fréquentées par les enfants de la requérante, les autorités ont agi dans les limites de leur marge d'appréciation et ont donc respecté le droit des parents d'assurer cette éducation et cet enseignement conformément à leurs convictions religieuses et philosophiques.

Au titre du droit international, l'article 14, paragraphe 2, de la CRC exige des États parties qu'ils respectent le droit et le devoir des parents de guider celui-ci dans l'exercice de son droit à la liberté de pensée, de conscience et de religion d'une manière qui corresponde au développement de ses capacités. Dès lors, contrairement à l'article 14, paragraphe 3, de la Charte des droits fondamentaux, la CRC concerne l'exercice du droit à la liberté de l'enfant lui-même. Au titre de la CRC, les parents ont le droit de guider et d'orienter l'enfant non conformément à leurs propres convictions, mais conformément aux convictions des enfants. Le libellé de l'article 14, paragraphe 2, de la CRC va dans le sens de la conception générale

63 CouEDH, *Lautsi et autres c. Italie* [GC], n° 30814/06, 18 mars 2011.

des responsabilités parentales de la CRC, qui établit que les responsabilités parentales doivent être exercées d'une manière qui corresponde au développement des capacités de l'enfant (article 5 de la CRC) et qui est guidée avant tout par l'intérêt supérieur de l'enfant (article 18, paragraphe 1, de la CRC).

2.3. Liberté d'expression et d'information

Points clés

- Tant la Charte des droits fondamentaux de l'UE que la CEDH garantissent la liberté d'expression, qui comprend la liberté d'opinion et la liberté de recevoir ou de communiquer des informations ou des idées sans qu'il puisse y avoir ingérence d'autorités publiques.
- Le droit à la liberté d'information ne comprend pas le droit d'accès aux dossiers concernant la garde d'enfants.
- La fourniture de l'accès aux dossiers relatifs à la garde d'enfants, moyennant l'accord du fournisseur d'informations, peut être compatible avec l'article 8 (droit au respect de la vie privée et familiale) de la CRC, à condition que la décision finale sur l'accès revienne à l'autorité indépendante.

Dans le droit de l'UE, le droit à la liberté d'expression comprend la liberté d'opinion et la liberté de recevoir ou de communiquer des informations ou des idées sans qu'il puisse y avoir ingérence d'autorités publiques et sans considération de frontières (article 11 de la Charte des droits fondamentaux).

Dans le droit du CdE, la liberté d'expression est garantie par l'article 10 de la CEDH et ne peut faire l'objet de restrictions que si celles-ci sont prévues par la loi et constituent des mesures nécessaires, dans une société démocratique, à la réalisation d'un des objectifs légitimes énumérés à l'article 10, paragraphe 2.

Dans sa jurisprudence, la CouEDH a souligné que « [l]a liberté d'expression constitue l'un des fondements essentiels [d'une] société [démocratique], l'une des conditions primordiales de son progrès et de l'épanouissement de chacun. Elle vaut non seulement pour les "informations" ou "idées" accueillies avec faveur

ou considérées comme inoffensives ou indifférentes, mais aussi pour celles qui heurtent, choquent ou inquiètent l'État ou une fraction quelconque de la population ».[64]

Exemple : dans l'affaire *Handyside c. Royaume-Uni*[65], la CouEDH a établi qu'une interdiction imposée par les autorités d'un livre intitulé *The Little Red Schoolbook* était conforme à l'exception prévue à l'article 10, paragraphe 2, de la CEDH relatif à la protection de la morale. L'affaire traite du droit à recevoir des informations adaptées à l'âge et à la maturité de l'enfant, un aspect du droit à la liberté d'expression qui est particulièrement pertinent pour les enfants. Le livre, traduit du danois, a été écrit pour des écoliers et abordait toute une série de normes sociales, dont la sexualité et les drogues. Des jeunes traversant une phase critique de leur développement pouvaient interpréter certains passages du livre comme un encouragement à se livrer à des expériences précoces et nuisibles pour eux, voire à commettre certaines infractions pénales. Par conséquent, selon la CouEDH, les magistrats anglais compétents « étaient en droit de croire à l'époque, dans l'exercice de leur pouvoir d'appréciation, que le Schoolbook aurait des répercussions néfastes sur la moralité de beaucoup des enfants et adolescents qui le liraient »[66].

Parmi les autres affaires concernant des enfants et faisant référence à l'article 10 de la CEDH, on retrouve des affaires qui portent sur le droit à l'accès à des informations relatives à des enfants placés.

Exemple : L'affaire *Gaskin c. Royaume-Uni*[67] concerne une personne qui a été placée pendant la majeure partie de son enfance, période durant laquelle l'autorité locale a conservé des dossiers confidentiels. Parmi ces dossiers figuraient des rapports rédigés par des médecins, des enseignants, des officiers de police et agents de probation, des travailleurs sociaux, des visiteurs de santé, des parents nourriciers et des membres du personnel d'établissements scolaires. Lorsque le requérant a voulu accéder à ces dossiers dans le cadre d'une instance en justice pour dommages corporels à l'encontre de

64 Voir, par exemple, CouEDH, *Handyside c. Royaume-Uni*, n° 5493/72, 7 décembre 1976, para. 49.

65 *Ibid.*

66 *Ibid.*, para. 52.

67 CouEDH, *Gaskin c. Royaume-Uni*, n° 10454/83, 7 juillet 1989.

l'autorité locale, cet accès lui a été refusé. La confidentialité de ces dossiers avait été garantie dans l'intérêt public à un fonctionnement adéquat des services d'aide à l'enfance, qui se trouverait sinon menacé car les informateurs hésiteraient à rédiger leurs rapports en toute franchise. De l'avis de la CouEDH, les personnes ayant été placées durant leur enfance ont un intérêt primordial « à recevoir les renseignements qu'il leur faut pour connaître et comprendre leur enfance et leurs années de formation »[68]. S'il convient de garantir le caractère confidentiel des dossiers officiels, un système qui subordonne l'accès aux dossiers à l'acceptation des informateurs, comme au Royaume-Uni, peut en principe être tenu pour compatible avec l'article 8 de la CEDH si les intérêts de quiconque cherche à consulter des dossiers sont sauvegardés au cas où un informateur ne répond pas ou ne donne pas son consentement. Dans un tel cas, il doit exister un organe indépendant chargé de prendre la décision finale sur l'accès. Aucune procédure de ce type n'était à la disposition du requérant en l'espèce et la Cour a conclu à une atteinte aux droits du requérant au titre de l'article 8 de la CEDH. Toutefois, la Cour n'a observé aucune violation de l'article 10 de la CEDH et a répété que la liberté de recevoir des informations interdit essentiellement à un gouvernement d'empêcher quelqu'un de recevoir des informations que d'autres aspirent ou peuvent consentir à lui fournir, mais n'oblige pas un État à communiquer à l'intéressé les renseignements dont il s'agit.

2.4. Droit à être entendu

Points clés

- En vertu du droit de l'UE, les enfants ont le droit d'exprimer leur opinion librement. Celle-ci est prise en considération pour les sujets qui les concernent, en fonction de leur âge et de leur maturité.
- La CEDH ne prévoit aucun droit absolu des enfants à être entendus par les tribunaux. Cette exigence doit être établie à la lumière des circonstances spécifiques de l'espèce et dépend de l'âge et de la maturité de l'enfant.
- Au titre du droit des Nations Unies, le droit de l'enfant d'exprimer librement son opinion sur toute question l'intéressant a été reconnu comme l'un des principes généraux de la Convention des droits de l'enfant.

68 *Ibid.*, para. 49.

Dans le droit de l'UE, l'article 24, paragraphe 1, de la Charte des droits fondamentaux prévoit que les enfants peuvent exprimer leur opinion librement et que celle-ci est prise en considération pour les sujets qui les concernent, en fonction de leur âge et de leur maturité. Cette disposition est de portée générale et ne se limite pas à des procédures précises. La CJUE a interprété cette disposition en rapport avec le règlement Bruxelles II bis.

> Exemple : l'affaire *Joseba Andoni Aguirre Zarraga c. Simone Pelz*[69] concerne le déplacement d'un enfant mineur de l'Espagne vers l'Allemagne, en violation de la décision relative à la garde de l'enfant. Il a été demandé à la Cour de justice si la juridiction allemande (c'est-à-dire celle du pays où l'enfant a été emmené) pouvait s'opposer à l'exécution d'une décision rendue par un tribunal espagnol (le pays d'origine) sur le base du fait que l'enfant n'a pas été entendu, ce qui enfreint l'article 42, paragraphe 2, point a), du règlement (CE) n° 2201/2003 (règlement Bruxelles II bis) et l'article 24 de la Charte des droits fondamentaux. L'enfant s'était opposée à son retour lorsqu'elle avait exprimé son opinion au cours de la procédure devant le tribunal allemand. La Cour de justice a établi que l'audition d'un enfant ne peut pas constituer une obligation absolue, mais si le tribunal décide qu'elle est nécessaire, il doit offrir à l'enfant une possibilité réelle et effective de s'exprimer. Elle a également considéré que le droit de l'enfant à être entendu, tel qu'il est prévu dans la Charte et dans le règlement Bruxelles II bis, exige que les procédures et conditions légales permettant à celui-ci d'exprimer librement son opinion soient mises à sa disposition et que cette opinion soit recueillie par le juge. Le juge doit prendre toutes les mesures appropriées en vue d'une telle audition, en fonction de l'intérêt supérieur de l'enfant et eu égard aux circonstances de chaque cas d'espèce. Selon l'arrêt de la CJUE, les autorités du pays où l'enfant a été emmené (l'Allemagne) ne peuvent toutefois pas s'opposer au retour de l'enfant sur la base d'une infraction au droit à être entendu commise dans le pays d'origine (l'Espagne).

Au titre du droit du CdE, la CouEDH n'interprète pas le droit au respect de la vie privée et familiale (article 8 de la CEDH) en ce sens qu'elle exige toujours que l'enfant soit entendu en audience. Il revient en principe aux juridictions nationales

69 CJUE, C-491/10 PPU, *Joseba Andoni Aguirre Zarraga c. Simone Pelz*, 22 décembre 2010 ; voir également la section 5.4, qui aborde plus en détails cet arrêt et le fonctionnement du règlement Bruxelles II bis.

d'apprécier les éléments rassemblés par elles, y compris la manière dont les faits pertinents ont été établis. Les tribunaux nationaux ne sont pas toujours tenus d'entendre un enfant en audience lorsqu'est en jeu le droit de visite d'un parent n'exerçant pas la garde. La question doit être appréciée en fonction des circonstances particulières de chaque affaire et compte dûment tenu de l'âge et de la maturité de l'enfant concerné. En outre, la CouEDH garantira souvent, dans le cadre de la branche procédurale de l'article 8, que les autorités prennent les mesures appropriées pour accompagner leurs décisions des garanties nécessaires.

Exemple : dans l'affaire *Sahin c. Allemagne*[70], la mère a interdit tout contact entre le requérant et sa fille de quatre ans. Le tribunal régional allemand a décidé que l'octroi au père de l'accès à sa fille serait préjudiciable à l'enfant en raison des graves tensions entre ses parents. Elle a pris cette décision sans demander à l'enfant si elle voulait continuer à voir son père. Sur la question de l'audition de l'enfant, la CEDH a fait référence à l'explication de l'expert devant le tribunal régional allemand. Après avoir à plusieurs reprises rencontré l'enfant, sa mère et le requérant, l'expert a expliqué que le fait même d'interroger l'enfant comportait pour celle-ci un risque que la prise de dispositions spéciales durant l'audience ne pouvait éviter. La CouEDH a établi que, dans ces circonstances, les exigences procédurales inhérentes à l'article 8 de la CEDH d'entendre un enfant en audience n'impliquaient pas d'imposer l'interrogatoire direct de l'enfant sur sa relation avec son père.

Exemple : dans l'affaire *Sommerfeld c. Allemagne*[71], la fille du requérant âgée de 13 ans avait clairement exprimé, et ce depuis plusieurs années, le souhait de ne pas rencontrer le requérant. Les tribunaux nationaux étaient d'avis que contraindre cette jeune fille à voir le requérant perturberait gravement son équilibre émotionnel et psychologique. La CouEDH a admis que le processus décisionnel avait assuré au requérant la protection requise de ses intérêts[72].

70 CouEDH, *Sahin c. Allemagne* [GC], n° 30943/96, 8 juillet 2003, para. 73. Sur l'aspect spécifique relatif à l'obligation incombant aux tribunaux nationaux d'apprécier les éléments de preuve qu'ils recueillent, ainsi que la pertinence des éléments de preuve que les défendeurs cherchent à apporter, voir l'arrêt de la CouEDH dans l'affaire *Vidal c. Belgique*, n° 12351/86, 22 avril 1992, para. 33.

71 CouEDH, *Sommerfeld c. Allemagne* [GC], n° 31871/96, 8 juillet 2003.

72 *Ibid*., paras. 72 et 88.

La Convention européenne sur l'exercice des droits des enfants évoque le droit des enfants à exprimer librement leur opinion[73]. Cette convention vise à promouvoir les droits des enfants en leur accordant des droits procéduraux dans les procédures familiales devant une autorité judiciaire, en particulier celles relatives à l'exercice des responsabilités parentales, s'agissant notamment de la résidence et du droit de visite à l'égard des enfants. L'article 3 de la Convention accorde aux enfants le droit procédural d'être informé et d'exprimer son opinion dans les procédures. L'article 4 confère à l'enfant le droit de demander la désignation d'un représentant spécial dans les procédures l'intéressant devant une autorité judiciaire. Conformément à l'article 6, les autorités doivent s'assurer que l'enfant a reçu toute information pertinente, consulter l'enfant personnellement, si nécessaire, et permettre à l'enfant d'exprimer son opinion.

Au titre du droit international, l'article 12, paragraphe 1, de la CRC établit qu'un enfant qui est capable de discernement a le droit d'exprimer librement son opinion sur toute question l'intéressant. Les opinions de l'enfant sont dûment prises en considération eu égard à son âge et à son degré de maturité. L'article 12, paragraphe 2, de la CRC dispose en outre qu'il convient de donner à l'enfant la possibilité d'être entendu dans toute procédure judiciaire ou administrative l'intéressant, soit directement, soit par l'intermédiaire d'un représentant ou d'une organisation approprié, de façon compatible avec les règles de procédure du droit national.

Le Comité des droits de l'enfant des Nations Unies a souligné que les États parties devaient soit garantir directement ce droit, soit adopter ou réviser des lois garantissant que l'enfant puisse pleinement bénéficier de ce droit[74]. En outre, ils doivent garantir que l'enfant reçoit toutes les informations et tous les conseils nécessaires pour lui permettre de prendre une décision dans son intérêt supérieur. Le Comité souligne également que l'enfant est autorisé à ne pas exercer ce droit ; l'expression d'une opinion est un choix laissé à l'enfant et non une obligation qui lui incombe.

73 CdE, Convention européenne sur l'exercice des droits des enfants, STCE n° 160, 1996.

74 ONU, Comité des droits de l'enfant, *Observation générale n° 14 (2013) sur le droit de l'enfant à ce que son intérêt supérieur soit une considération primordiale (art. 3, para. 1)*, CRC/C/GC/14.

2.5. Droit à la liberté de réunion et d'association

Points clés

- Tant la Charte des droits fondamentaux de l'UE que la CEDH garantissent la liberté de réunion pacifique et d'association.
- Ce droit autorise les personnes à défendre leur cause avec d'autres et les protège dans cette action.

Dans le droit de l'UE, l'article 12 de la Charte des droits fondamentaux prévoit que toute personne a droit à la liberté de réunion pacifique et à la liberté d'association à tous les niveaux, notamment dans les domaines politique, syndical et civique, ce qui implique le droit de toute personne de fonder avec d'autres des syndicats et de s'y affilier pour la défense de ses intérêts.

Dans le droit du CdE, l'article 11, paragraphe 1, de la CEDH garantit le droit à la liberté de réunion et d'association sous réserve des restrictions énoncées à l'article 11, paragraphe 2.

La CouEDH a explicitement reconnu le droit des enfants à prendre part à des rassemblements dans des lieux publics. Comme elle l'a observé dans l'affaire *Parti populaire démocrate-chrétien c. Moldova*, il semblerait aller à l'encontre de la liberté de réunion des parents et des enfants que d'empêcher ces derniers de participer à des rassemblements qui visent, en particulier, à contester la politique du gouvernement en matière d'enseignement.

Au titre du droit international, les enfants ainsi que les organisations d'enfants peuvent s'appuyer sur la protection prévue par l'article 15 de la CRC, qui contient le droit à la liberté d'association et de réunion pacifique. De nombreuses formes associatives impliquant des enfants ont bénéficié d'une protection internationale à cet égard.

3 Égalité et non-discrimination

UE	Questions traitées	CdE
Charte des droits fondamentaux, Titre III (Égalité), y compris les articles 20 (égalité en droit), 21 (non-discrimination) et 23 (égalité entre hommes et femmes)	**Égalité et non-discrimination**	CEDH, article 14 ; Protocole n° 12 à la CEDH, article 1 (interdiction de la discrimination) Charte sociale européenne (révisée), article E (non-discrimination)
Directive relative à l'égalité raciale (2000/43/CE)	**Non-discrimination fondée sur l'origine ethnique ou raciale**	CouEDH, *D.H. et autres c. République tchèque* [GC], n° 57325/00, 2007 (placement d'enfants roms dans des écoles spéciales) CouEDH, *Oršuš et autres c. Croatie*, n° 15766/03, 2010 (classes réservées aux enfants roms dans des écoles primaires) Convention-cadre pour la protection des minorités nationales (CCPMN), articles 4 et 12
Charte des droits fondamentaux, article 45 (liberté de circulation et de séjour) CJUE, C-200/02, *Kunqian Catherine Zhu et Man Lavette Chen c. Secretary of State for the Home Department*, 2004 (droit de séjour de parents ressortissants d'un État tiers)	**Non-discrimination fondée sur la nationalité et sur la situation au regard de la législation sur l'immigration**	CouEDH, *Ponomaryovi c. Bulgarie*, n° 5335/05, 2011 (frais de scolarité pour les résidents temporaires) CCPMN, articles 4 et 12, paragraphe 3

UE	Questions traitées	CdE
Directive relative à l'égalité en matière d'emploi (2000/78/CE)	Non-discrimination fondée sur l'âge	CEDH, article 14 ; Protocole n° 12 à la CEDH, article 1 (non-discrimination)
CJUE, C-303/06, *S. Coleman c. Attridge Law et Steve Law* [GC], 2008	Non-discrimination fondée sur d'autres motifs protégés	CouEDH, *Fabris c. France* [GC], n° 16574/08, 2013 (droits de succession des enfants nés hors mariage)

L'absence de discrimination est l'un des principes fondamentaux d'une société démocratique. Tant l'Union européenne que le Conseil de l'Europe ont joué un rôle déterminant dans l'interprétation de ce principe. Les institutions de l'UE ont adapté une série de directives qui sont particulièrement pertinentes dans les affaires impliquant des enfants. La CouEDH s'est constituée une importante jurisprudence portant sur le droit de ne pas subir de discrimination au titre de l'article 14 de la CEDH relatif à l'interdiction de discrimination, lu conjointement avec d'autres articles de la Convention.

Le Comité européen des droits sociaux (CEDS) considère que la fonction de l'article E de la Charte sociale européenne (CSE) relatif à la non-discrimination est similaire à celle de l'article 14 de la CEDH : il n'a pas d'existence indépendante et doit être combiné avec une disposition matérielle de la CSE[75].

Le présent chapitre aborde les principes d'égalité et de non-discrimination et se concentre plus spécifiquement sur les motifs ayant servi à constituer la jurisprudence propre aux enfants. Il fournit d'abord des informations générales sur le droit européen en matière de non-discrimination (section 3.1) et présente ensuite la question de l'égalité et de la discrimination fondée sur l'origine ethnique (section 3.2), la nationalité et la situation au regard de la législation sur l'immigration (section 3.3), l'âge (section 3.4) et d'autres motifs faisant l'objet d'une protection, dont le sexe, la langue et l'identité personnelle (section 3.5).

75 CEDS, *Syndicat des Agrégés de l'Enseignement Supérieur (SAGES) c. France*, n° 26/2004, 15 juin 2005, para. 34.

3.1. Législation européenne en matière de non-discrimination

Points clés

- La législation de l'Union européenne et du Conseil de l'Europe interdit toute discrimination fondée sur le sexe, la race, la couleur, l'origine ethnique ou sociale, les caractéristiques génétiques, la langue, la religion ou les convictions, les opinions politiques ou autres, l'appartenance à une minorité nationale, la fortune, la naissance, le handicap, l'âge ou l'orientation sexuelle[76].
- Lorsque la CouEDH établit que des personnes ont été traitées différemment dans une situation significativement similaire, elle examinera s'il existe une justification objective et raisonnable pour cette différence de traitement. Dans le cas contraire, elle conclura que le traitement était discriminatoire et contraire à l'article 14 de la CEDH relatif à la non-discrimination.

Dans le droit de l'UE, l'interdiction de discrimination prévue à l'article 21 de la Charte des droits fondamentaux de l'UE est un principe autonome qui s'applique également à des situations auxquelles aucune autre disposition de la Charte ne s'applique. Les motifs de discrimination interdits et énumérés dans cette disposition sont les discriminations fondées sur le sexe, la race, la couleur, l'origine ethnique ou sociale, les caractéristiques génétiques, la langue, la religion ou les convictions, les opinions politiques ou autres, l'appartenance à une minorité nationale, la fortune, la naissance, le handicap, l'âge ou l'orientation sexuelle ». En revanche, l'article 19 TFUE couvre uniquement les motifs que sont le sexe, la race ou l'origine ethnique, la religion ou les convictions, un handicap, l'âge ou l'orientation sexuelle.

Plusieurs directives de l'UE interdisent toute discrimination dans les domaines de l'emploi, du système d'aide sociale et des biens et services et elles sont toutes potentiellement pertinentes pour ce qui est des enfants. La directive 2000/78/CE du Conseil du 27 novembre 2000 qui porte création d'un cadre général en faveur de l'égalité de traitement en matière d'emploi et de travail (directive relative

76 Pour un aperçu de la législation européenne relative à la non-discrimination, telle qu'elle est constituée par les directives de l'UE sur la non-discrimination et par l'article 14 et le Protocole n° 12 à la CEDH, voir FRA et CouEDH (2011), et sa jurisprudence mise à jour de juillet 2010 à décembre 2011.

à l'égalité en matière d'emploi)[77] interdit la discrimination fondée sur la religion ou les convictions, le handicap, l'âge ou l'orientation sexuelle. La directive 2000/43/CE du Conseil relative à la mise en œuvre du principe de l'égalité de traitement entre les personnes sans distinction de race ou d'origine ethnique (directive sur l'égalité raciale) interdit la discrimination fondée sur l'origine raciale ou ethnique, non seulement dans le contexte de l'emploi et de l'accès aux biens et services, mais aussi dans le domaine de l'aide sociale (y compris la protection sociale, la sécurité sociale et les soins de santé) et de l'éducation[78]. D'autres directives mettent en œuvre le principe de l'égalité de traitement entre les hommes et les femmes dans le domaine de l'emploi et du travail (directive relative à l'égalité entre les femmes et les hommes)[79] et de l'accès aux biens et services et de la fourniture de biens et services (directive sur l'égalité d'accès aux biens et services)[80].

Au titre du droit du CdE, l'interdiction de toute discrimination s'applique à l'exercice des libertés et droits fondamentaux reconnus dans la CEDH (article 14) ainsi qu'à l'exercice de tout droit garanti par le droit national ou prévu dans toute loi d'une autorité publique (article 1 du Protocole n° 12 à la CEDH). Toutefois, l'applicabilité du Protocole n° 12 est limitée dans la mesure où seul un petit nombre de pays l'ont ratifié et où aucune affaire concernant des enfants n'a été jugée sur la base de ce protocole. Les dispositions contenues dans les deux instruments comprennent une liste non exhaustive des motifs de discrimination qui sont interdits : sexe, race, couleur, langue, religion, l'opinion politique ou toute autre opinion, l'origine nationale ou sociale, l'appartenance à une minorité nationale, la fortune, la naissance ou toute autre situation. Si la CouEDH conclut à l'existence d'une différence de traitement entre des personnes se trouvant dans une situation significativement similaire, elle examinera si cette différence se fonde sur une justification objective et raisonnable[81].

77 Directive 2000/78/CE du Conseil, JO 2000 L 303. Tous les instruments juridiques de l'Union sont disponibles sur EUR-Lex, le portail de l'UE donnant accès au droit de l'UE : http://eur-lex.europa.eu.

78 Directive 2000/43/CE du Conseil du 29 juin 2000 relative à la mise en œuvre du principe de l'égalité de traitement entre les personnes sans distinction de race ou d'origine ethnique, JO 2000 L 180.

79 Directive 2006/54/CE (refonte), JO 2006 L 204.

80 Directive 2004/113/CE du Conseil, JO 2004 L 373, p. 37.

81 Pour un aperçu de la jurisprudence de la CouEDH, voir FRA et CouEDH (2011) et sa jurisprudence mise à jour de juillet 2010 à décembre 2011.

L'article E de la CSE inclut également une liste non exhaustive de motifs de discrimination qui sont interdits : la race, la couleur, le sexe, la langue, la religion, les opinions politiques ou toutes autres opinions, l'ascendance nationale ou l'origine sociale, la santé, l'appartenance à une minorité nationale, la naissance. L'annexe à cet article dispose qu'une justification objective et raisonnable d'une différence de traitement peut être la condition d'âge ou de qualification pour l'accès à certaines formes d'éducation[82], auquel cas la différence de traitement n'est pas considérée comme discriminatoire.

Au titre de l'article 4 de la Convention-cadre pour la protection des minorités nationales (CCPMN)[83], les Parties s'engagent à garantir à toute personne appartenant à une minorité nationale le droit à l'égalité devant la loi et à une égale protection de la loi et interdisent toute discrimination fondée sur l'appartenance à une minorité nationale. Elles s'engagent également à adopter, s'il y a lieu, des mesures adéquates en vue de promouvoir, dans tous les domaines de la vie économique, sociale, politique et culturelle, une égalité pleine et effective entre les personnes appartenant à une minorité nationale et celles appartenant à la majorité.

Les sections suivantes analysent les motifs de discrimination spécifiques qui se sont avérés concerner plus particulièrement les enfants.

3.2. Non-discrimination fondée sur l'origine ethnique ou raciale

Points clés

- L'origine ethnique et la race sont des motifs de discrimination interdits.
- Tant l'Union européenne que le Conseil de l'Europe luttent contre la discrimination des Roms dans les domaines de l'éducation, de l'emploi, des soins de santé et du logement.
- La surreprésentation ou la ségrégation d'enfants appartenant à un groupe ethnique spécifique dans des écoles ou classes spéciales ne peut être fondée sur une justification objective que si des garanties appropriées sont mises en place pour le placement des enfants dans ces écoles ou ces classes.

82 CdE, Charte sociale européenne (révisée) (1996), Rapport explicatif, para. 136.

83 CdE, Convention-cadre pour la protection des minorités nationales (CCPMN), STCE n° 157, 1995.

Dans le droit de l'UE, la directive relative à l'égalité raciale interdit la discrimination fondée sur l'origine ethnique ou raciale non seulement dans le domaine de l'emploi et des biens et services, mais aussi dans l'accès au système de protection sociale, à l'éducation et à la sécurité sociale. Les Roms, groupe ethnique particulièrement vulnérable et de taille importante, relèvent très clairement du champ d'application de la directive. Un élément clé de l'offensive contre la discrimination à l'égard des Roms au niveau de l'UE a été l'adoption d'un cadre de l'UE pour les stratégies nationales d'intégration des Roms pour la période allant jusqu'à 2020[84]. La Commission a ensuite procédé à son suivi annuel des stratégies nationales élaborées par les États membres. La directive relative à l'égalité raciale couvre au moins quatre domaines prioritaires qui sont importants pour les enfants roms : l'éducation, l'emploi, les soins de santé et le logement. L'obtention d'une égalité complète dans la pratique peut, dans certains cas, justifier une action positive au bénéfice des Roms, en particulier dans les quatre domaines prioritaires précités[85].

Dans le droit du CdE, la CouEDH a statué dans plusieurs affaires faisant date qui concernent une différence de traitement des enfants roms dans le système éducatif. Ces affaires ont été analysées sur la base de l'article 14, lu conjointement avec l'article 2 du Protocole n° 1 à la CEDH. La Cour a considéré qu'une surreprésentation ou une ségrégation des enfants roms dans des écoles ou classes spécialisées ne pouvait être justifiée objectivement que si des garanties appropriées étaient mises en place pour le placement des enfants dans ces écoles ou classes, telles que des tests spécifiquement conçus pour les enfants roms et tenant compte de leurs besoins ; une évaluation appropriée et un suivi suffisant des progrès accomplis de manière à garantir une intégration dans des classes ordinaires dès la résolution des difficultés d'apprentissage de l'élève ; et des mesures positives visant à remédier aux difficultés d'apprentissage. En l'absence de mesures visant à lutter contre la ségrégation, prolonger la ségrégation éducative des enfants roms dans une école ordinaire offrant un programme ordinaire ne peut dès lors être justifié[86].

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84 Commission européenne (2011), *Cadre de l'UE pour les stratégies nationales d'intégration des Roms pour la période allant jusqu'à 2020 : Communication de la Commission au Parlement européen, au Conseil, au Comité économique et social européen et au Comité des régions*, COM(2011) 173 final, Bruxelles, 5 avril 2011.

85 Commission européenne (2014), *Rapport commun sur l'application de la directive 2000/43/CE du 29 juin 2000 relative à la mise en œuvre du principe de l'égalité de traitement entre les personnes sans distinction de race ou d'origine ethnique (directive sur l'égalité raciale) et de la directive 2000/78/CE du 27 novembre 2000 portant création d'un cadre général en faveur de l'égalité de traitement en matière d'emploi et de travail*, Rapport de la Commission au Parlement européen et au Conseil, COM(2014) 2 final, Bruxelles, 17 janvier 2014.

86 CouEDH, *Lavida et autres c. Grèce*, n° 7973/10, 30 mai 2013.

Exemple : dans l'affaire *D.H. et autres c. République tchèque*[87], la Cour a constaté qu'un nombre disproportionné d'enfants roms étaient placés sans raison dans des écoles spéciales pour enfants ayant des difficultés d'apprentissage. La Cour a exprimé des inquiétudes quant au programme de niveau inférieur suivi par ces écoles et quant à la ségrégation engendrée par ce système. Les enfants roms ont par conséquent reçu une éducation qui a accentué leurs difficultés et compromis leur développement personnel ultérieur, au lieu de les aider à intégrer plus tard les écoles ordinaires et à développer les capacités facilitant leur vie au sein de la population majoritaire. En conséquence, la Cour a conclu à l'existence d'une violation de l'article 14 de la Convention, combiné avec l'article 2 du Protocole n° 1 à la Convention.

Exemple : dans l'affaire *Oršuš et autres c. Croatie*[88], la Cour a examiné l'existence de classes réservées aux Roms au sein d'écoles primaires ordinaires. Par principe, le placement temporaire d'enfants dans une classe séparée au motif qu'ils n'ont pas une maîtrise suffisante de la langue n'est pas en soi discriminatoire. Pareil placement peut être vu comme visant à adapter le système éducatif aux besoins particuliers des enfants ayant des difficultés linguistiques. Toutefois, lorsqu'un tel placement touche les membres d'un groupe ethnique spécifique de manière disproportionnée voire exclusive, il faut que des garanties adaptées soient mises en place. En ce qui concerne le placement initial d'enfants dans des classes séparées, la Cour a observé que le placement ne s'inscrivait pas dans le cadre d'une pratique générale destinée à résoudre les difficultés des enfants n'ayant pas une bonne maîtrise de la langue et que les enfants n'ont pas passé de tests portant spécifiquement sur leur connaissance de la langue. Pour ce qui est du programme offert à ces enfants, certains d'entre eux n'ont suivi aucun programme spécifique (c'est-à-dire des cours de langue spéciaux) de nature à les aider à acquérir les compétences linguistiques nécessaires dans le délai le plus court possible. Aucune procédure de transfert et de suivi n'était en place afin d'assurer le transfert immédiat et automatique des enfants roms dans des classes mixtes dès le niveau linguistique adéquat atteint. Par conséquent, la Cour a conclu à l'existence d'une violation de l'article 14 de la CEDH, combiné à l'article 2 du Protocole n° 1.

87 CouEDH, *D.H. et autres c. République tchèque* [GC], n° 57325/00, 13 novembre 2007, paras. 206 à 210.

88 CouEDH, *Oršuš et autres c. Croatie* [GC], n° 15766/03, 16 mars 2010, para. 157.

Le CEDS considère que, si les politiques éducatives à l'égard des enfants roms peuvent aller de pair avec une souplesse des structures qui réponde à la diversité de cette catégorie de la population et tienne compte de ce que certains groupes mènent une existence itinérante ou semi-itinérante, il ne devrait cependant pas y avoir d'écoles séparées pour les enfants roms[89].

Au titre de l'article 4, paragraphes 2 et 3, de la Convention-cadre pour la protection des minorités nationales, les mesures adéquates adoptées en vue de promouvoir une égalité effective des personnes appartenant à une minorité nationale ne sont pas considérées comme un acte de discrimination. Conformément à l'article 12, paragraphe 3, de la CCPMN, les Parties s'engagent en outre expressément à promouvoir l'égalité des chances dans l'accès à l'éducation à tous les niveaux pour les personnes appartenant à des minorités nationales. Le Comité consultatif de la CCPMN s'est régulièrement penché sur la question de l'accès des enfants roms à l'éducation, conformément à cette disposition.[90]

3.3. Non-discrimination fondée sur la nationalité et la situation au regard de la législation sur l'immigration

Points clés

- La protection contre toute discrimination fondée sur la nationalité est plus limitée dans le champ d'application du droit de l'UE que dans celui du droit du Conseil de l'Europe.
- Au titre du droit de l'UE, la protection contre la discrimination fondée sur la nationalité n'est accordée qu'aux citoyens des États membres de l'UE, comme le prévoit l'article 45 (liberté de circulation et de séjour) de la Charte des droits fondamentaux.
- La CEDH garantit la jouissance des droits à toute personne résidant sur le territoire d'un État membre du Conseil de l'Europe.

89 CEDS, Charte sociale européenne (révisée) – Conclusions 2003 (Bulgarie), art. 17, para. 2, p. 71.

90 Voir Comité consultatif de la Convention-cadre pour la protection des minorités nationales (2006), *Commentaire sur l'éducation au regard de la Convention-cadre pour la protection des minorités nationales*, ACFC/25DOC(2006)002.

En vertu du droit de l'UE, la protection contre la discrimination fondée sur la nationalité est particulièrement importante dans le contexte de la libre circulation des personnes. Les ressortissants de pays tiers (c'est-à-dire les citoyens d'un État qui n'est pas membre de l'UE) bénéficient d'un droit à l'égalité de traitement dans plus ou moins les mêmes domaines que ceux couverts par les directives anti-discrimination lorsqu'ils peuvent être qualifiés de « résidents de longue durée ». Pour le pouvoir, la directive relative au statut des ressortissants de pays tiers résidents de longue durée exige, entre autres conditions, un séjour légal de cinq ans[91]. En outre, la directive 2003/86/CE relative au regroupement familial[92] autorise les ressortissants de pays tiers qui vivent légalement dans un État membre à être rejoints par des membres de leur famille, dans certaines conditions (voir également la section 9.5).

Exemple : l'affaire *Chen*[93] concernait la question de savoir si l'enfant d'un ressortissant d'un pays tiers avait le droit de demeurer dans un État membre de l'UE alors qu'il était né dans un autre État membre et qu'il possédait la citoyenneté de ce dernier. Sa mère, dont il dépendait, était une ressortissante d'un pays tiers. La CJUE a considéré que lorsqu'un État membre impose des exigences aux particuliers cherchant à obtenir la citoyenneté et lorsque ces exigences sont satisfaites, il n'appartient pas à un autre État membre de contester ce droit lorsque la mère et l'enfant demandent à bénéficier d'un droit de séjour. La CJUE a maintenu qu'un État membre ne peut refuser un droit de résidence au parent ayant la garde d'un enfant qui est un citoyen de l'UE, car ce refus priverait de tout effet utile le droit de séjour de l'enfant.

Dans le droit du CdE, la CEDH garantit la jouissance des droits à toutes les personnes vivant dans la juridiction d'un État membre du Conseil de l'Europe, qu'il s'agisse de citoyens ou non, y compris à celles vivant au-delà du territoire national, dans des zones qui relèvent du contrôle effectif d'un État membre. En ce qui concerne l'éducation, la CouEDH considère qu'une différence de traitement d'une personne fondée sur sa nationalité et sa situation au regard de la législation sur l'immigration pourrait constituer une discrimination.

91 Directive 2003/109/CE du Conseil du 25 novembre 2003 relative au statut des ressortissants de pays tiers résidents de longue durée, JO 2004 L 16, p. 44.

92 Directive 2003/86/CE du Conseil du 22 septembre 2003 relative au droit au regroupement familial, JO 2003 L 251, p. 12.

93 CJUE, C-200/02, *Kunqian Catherine Zhu et Man Lavette Chen c. Secretary of State for the Home Department*, 19 octobre 2004.

Exemple : l'affaire *Ponomaryovi c. Bulgarie*[94] concerne des ressortissants étrangers sans permis de séjour permanent et devant payer des frais de scolarité pour fréquenter un établissement d'enseignement secondaire. En règle générale, l'ample latitude qui est d'ordinaire laissée à l'État pour prendre des mesures d'ordre général en matière économique et sociale devait être transposée au domaine de l'enseignement, et ce pour deux raisons :

- l'instruction est un droit directement protégé par la CEDH ;
- l'enseignement est un type très particulier de service public, qui sert de nombreux buts sociétaux.

D'après la CouEDH, la marge d'appréciation de l'État dans ce domaine s'accroît avec le niveau d'enseignement de manière inversement proportionnelle à l'importance de celui-ci pour les individus concernés et pour la société dans son ensemble. Si, pour l'enseignement primaire, l'imposition de frais de scolarité (plus élevés) pour les étrangers est difficile à justifier, elle peut être considérée comme pleinement justifiée au niveau universitaire. Compte tenu de l'importance de l'enseignement secondaire pour l'épanouissement personnel et l'intégration socioprofessionnelle, un examen plus attentif de la proportionnalité de la différence de traitement s'applique à ce type d'enseignement. La Cour a expliqué qu'elle n'avait pas besoin de déterminer si un État avait le droit de priver tous les migrants en situation irrégulière de l'accès à l'instruction qu'il offre à ses ressortissants et à certaines catégories restreintes d'étrangers. Dans le cadre de son appréciation des circonstances spécifiques de l'espèce, elle a établi que cette affaire ne relevait pas de « considérations relatives à la nécessité de bloquer ou de renverser le flux d'immigration illégale ». Les requérants n'ont pas essayé d'abuser du système éducatif bulgare, car ils sont arrivés dans le pays alors qu'ils étaient très jeunes parce que leur mère avait épousé un ressortissant bulgare et n'ont eu d'autre choix que de poursuivre leur scolarité en Bulgarie. Partant, il y a eu violation de l'article 14 de la Convention combiné avec l'article 2 du Protocole n° 1.

94 CouEDH, *Ponomaryovi c. Bulgarie*, n° 5335/05, 21 juin 2011, para. 60.

3.4. Non-discrimination fondée sur l'âge

Point clé

- En vertu du droit de l'UE et de la CEDH, toute discrimination fondée sur l'âge est interdite.

Dans le droit de l'UE, la Charte des droits fondamentaux de l'UE mentionne explicitement l'âge en tant que motif de discrimination interdit à l'article 21. L'article 24 inclut les droits de l'enfant parmi les droits fondamentaux protégés. En vertu de la législation actuelle de l'UE en matière de non-discrimination, la protection contre la discrimination fondée sur l'âge est plus limitée que celle contre la discrimination fondée sur la race et l'origine ethnique ou sur le sexe. Aujourd'hui, l'âge n'est protégé que dans le contexte de l'accès à l'emploi, de la même manière que l'orientation sexuelle, le handicap et la religion ou les convictions.

La directive relative à l'égalité en matière d'emploi s'applique aux enfants qui ont légalement le droit de travailler. Alors que la Convention de l'Organisation internationale du travail concernant l'âge minimum d'admission à l'emploi[95], ratifiée par tous les États membres de l'UE, fixe à 15 ans l'âge minimum pour travailler, des différences entre les États membres de l'UE persistent en la matière[96]. D'après l'article 6 de la directive relative à l'égalité en matière d'emploi, les États membres peuvent justifier des différences de traitement fondées sur l'âge. Ces différences de traitement ne constituent pas une discrimination lorsqu'elles sont objectivement et raisonnablement justifiées par un objectif légitime et que les moyens de réaliser cet objectif sont appropriés et nécessaires. Concernant les enfants et les jeunes, ces différences de traitement peuvent notamment comprendre la mise en place de conditions spéciales d'accès à l'emploi et à la formation professionnelle, d'emploi et de travail en vue de favoriser leur insertion professionnelle ou d'assurer leur protection.

Dans le droit du CdE, l'article 14 de la CEDH et l'article 1 du Protocole n° 12 à la CEDH ne mentionnent pas explicitement l'âge parmi les motifs de discrimination qui sont

95 Organisation internationale du travail (1973), Convention concernant l'âge minimum d'admission à l'emploi, n° 138.

96 Réseau européen d'experts juridiques dans le domaine de la non-discrimination, O'Dempsey, D. et Beale, A. (2011), *Age and employment*, Commission européenne, Direction générale de la Justice, Luxembourg, Office des publications.

interdits. Toutefois, la CouEDH a examiné des cas de discrimination fondée sur l'âge en rapport avec différents droits protégés par la CEDH et ainsi analysé l'âge comme relevant de « toute autre situation ». Dans les affaires *D.G. c. Irlande*[97] et *Bouamar c. Belgique*[98], par exemple, la CouEDH a conclu à l'existence d'une différence de traitement entre les adultes et les enfants dans les systèmes juridiques respectifs des pays en ce qui concerne la détention, une différence qui est pertinente pour l'application de la Convention. Cette différence de traitement découlait de la finalité punitive de la détention pour les adultes et de sa finalité préventive pour les enfants. Dès lors, la Cour a accepté l'âge comme un motif de discrimination possible.

3.5. Non-discrimination fondée sur d'autres motifs

Point clé

- D'autres motifs de discrimination, tels que le handicap ou la naissance, ont été abordés dans la jurisprudence européenne relative aux enfants.

Au titre du droit de l'UE, l'article 21 de la Charte des droits fondamentaux de l'Union européenne interdit également toute discrimination fondée sur d'autres motifs qui concernent particulièrement les enfants, comme le sexe, les caractéristiques génétiques, la langue, le handicap ou l'orientation sexuelle. En ce qui concerne tout au moins le handicap, la CJUE a reconnu que le droit de l'UE protège également contre la « discrimination par association », c'est-à-dire la discrimination à l'encontre d'une personne qui est associée à une autre concernée par la caractéristique protégée (comme la mère d'un enfant souffrant d'un handicap).

Exemple : dans l'affaire *S. Coleman c. Attridge Law et Steve Law*[99], la CJUE a observé que la directive relative à l'égalité en matière d'emploi comporte des dispositions visant à tenir compte spécifiquement des besoins des personnes handicapées. Ce fait ne permet toutefois pas de conclure que le principe de l'égalité de traitement que la directive consacre doit être inter-

97 CouEDH, *D.G. c. Irlande*, n° 39474/98, 16 mai 2002 (voir également la section 11.2.2).

98 CouEDH, *Bouamar c. Belgique*, n° 9106/80, 29 février 1988 (voir également la section 11.2.2).

99 CJUE, C-303/06, *S. Coleman c. Attridge Law et Steve Law* [GC], 17 juillet 2008.

prété de manière restrictive, c'est-à-dire comme interdisant uniquement les discriminations directes fondées sur le handicap et visant exclusivement les personnes handicapées elles-mêmes. D'après la CJUE, la directive s'applique non pas à une catégorie de personnes déterminée, mais à la nature même de la discrimination. Une interprétation limitant l'application de celle-ci aux seules personnes qui sont elles-mêmes handicapées serait susceptible de priver cette directive d'une partie importante de son effet utile et de réduire la protection qu'elle est censée garantir. La CJUE conclut que la directive doit être interprétée en ce sens que l'interdiction de discrimination directe qu'elle prévoit n'est pas limitée aux seules personnes qui sont elles-mêmes handicapées. En conséquence, lorsqu'un employeur traite un employé n'ayant pas lui-même un handicap de manière moins favorable qu'un autre employé dans une situation comparable en raison du handicap de son enfant, auquel il dispense l'essentiel des soins dont celui-ci a besoin, un tel traitement est contraire à l'interdiction de discrimination directe énoncée dans la directive.

Au titre du droit du CdE, la CouEDH s'est penchée sur la question de la discrimination à l'encontre d'enfants dans différentes situations autres que celles déjà mentionnées, comme la discrimination fondée sur la langue[100] ou la filiation[101].

Exemple : dans l'affaire *Fabris c. France*[102], le requérant s'est plaint de ne pas avoir pu bénéficier d'une loi entrée en vigueur en 2001 accordant aux enfants « adultérins » des droits successoraux identiques aux enfants légitimes, une loi adoptée à la suite de l'arrêt rendu en 2000 par la Cour dans l'affaire *Mazurek c. France*[103]. La Cour a considéré que le but légitime visant à protéger les droits successoraux du demi-frère et de la demi-sœur du requérant ne l'emportait pas sur sa prétention à une part de la succession de sa mère. Dans cette affaire, la différence de traitement était discriminatoire dans la mesure où elle ne présentait aucune justification objective et raisonnable. La Cour a considéré qu'il existait une violation de l'article 14 de la CEDH, combiné à l'article 1 du Protocole n° 1 à la CEDH[104].

100 CouEDH, *Affaire « relative à certains aspects du régime linguistique de l'enseignement en Belgique » c. Belgique*, n° 1474/62, 1677/62, 1691/62, 1769/63, 1994/63 et 2126/64, 23 juillet 1968.

101 CEDH, *Fabris c. France* [GC], n° 16574/08, 7 février 2013.

102 *Ibid.*

103 CouEDH, *Mazurek c. France*, n° 34406/97, 1er février 2000.

104 CouEDH, *Fabris c. France* [GC], n° 16574/08, 7 février 2013.

Pour les enfants souffrant de handicaps, le CEDS considère qu'en application de l'article 17, paragraphe 2, de la CSE, il est acceptable d'opérer une distinction entre les enfants handicapés et non handicapés. L'intégration d'enfants souffrant de handicaps dans des écoles ordinaires, dans lesquelles des dispositions sont prises pour tenir compte de leurs besoins spécifiques, doivent toutefois devenir la norme et les écoles spécialisées doivent constituer l'exception[105]. En outre, les enfants fréquentant des établissements d'enseignement spécialisé qui sont conformes à l'article 17, paragraphe 2, de la CSE doivent bénéficier d'une instruction et d'une formation suffisantes de manière à ce qu'un nombre d'enfants fréquentant des écoles spécialisées proportionnel au nombre d'enfants fréquentant des écoles ordinaires terminent leur scolarité[106]. Les droits des enfants en matière d'éducation sont abordés plus en détail dans la section 8.2.

Au titre du droit des Nations Unies, l'article 2 de la CRC interdit la discrimination à l'encontre des enfants pour les motifs énumérés dans une liste non exhaustive, sur laquelle figure spécifiquement la naissance. L'article 2 dispose ce qui suit :

> *1. Les États parties s'engagent à respecter les droits qui sont énoncés dans la présente Convention et à les garantir à tout enfant relevant de leur juridiction, sans distinction aucune, indépendamment de toute considération de race, de couleur, de sexe, de langue, de religion, d'opinion politique ou autre de l'enfant ou de ses parents ou représentants légaux, de leur origine nationale, ethnique ou sociale, de leur situation de fortune, de leur incapacité, de leur naissance ou de toute autre situation.*
>
> *2. Les États parties prennent toutes les mesures appropriées pour que l'enfant soit effectivement protégé contre toutes formes de discrimination ou de sanction motivées par la situation juridique, les activités, les opinions déclarées ou les convictions de ses parents, de ses représentants légaux ou des membres de sa famille.*

105 CEDS, *Association internationale Autisme-Europe contre France*, n° 13/2002, 4 novembre 2003.

106 CEDS, *Centre de défense des droits des personnes handicapées mentales (MDAC) c. Bulgarie*, n° 41/2007, 3 juin 2008.

4 Questions relatives à l'identité personnelle

UE	Questions traitées	CdE
	Enregistrement de la naissance et droit à un nom	CouEDH, *Johansson c. Finlande*, n° 10163/02, 2007 (refus d'enregistrer un nom déjà accordé à d'autres personnes) CCPMN, article 11 (droit d'utiliser le patronyme dans la langue d'origine) Convention européenne en matière d'adoption des enfants (révisée), article 11, paragraphe 3) (conserver le patronyme d'origine d'un enfant adopté)
	Droit à l'identité personnelle	CEDH, articles 6 (procès équitable) et 8 (droit au respect de la vie privée et familiale) CouEDH, *Gaskin c. Royaume-Uni*, n° 10454/83, 1989 (accès refusé au dossier médical de l'enfant) CouEDH, *Mizzi c. Malte*, n° 26111/02, 2006 (incapacité à contester la paternité) CouEDH, *Mennesson c. France*, n° 65192/11, 2014 (gestation pour autrui avec père biologique comme père d'intention) CouEDH, *Godelli c. Italie*, n° 33783/09, 2012 (informations non identifiantes sur la mère biologique) Convention européenne en matière d'adoption des enfants (révisée), article 22

UE	Questions traitées	CdE
	Vol d'identité	CouEDH, *K.U. c. Finlande*, n° 2872/02, 2008 (annonce publiée sur l'internet à l'insu de la victime)
CJUE, C-200/02, *Kunqian Catherine Zhu et Man Lavette Chen c. Secretary of State for the Home Department*, 2004 (droit de séjour de la personne responsable à titre principal d'un enfant citoyen de l'UE) CJUE, C-34/09, *Gerardo Ruiz Zambrano c. Office National de l'Emploi (ONEm)*, 2011 (droit de séjour de ressortissants d'un pays tiers avec enfants citoyens de l'UE mineurs)	Citoyenneté	CouEDH, *Genovese c. Malte*, n° 53124/09, 2011 (refus arbitraire de la citoyenneté à un enfant né hors mariage) Convention européenne sur la nationalité Convention du Conseil de l'Europe sur la prévention des cas d'apatridie en relation avec la succession d'États
	Identité en tant que membre d'une minorité nationale	CCPMN, article 5, paragraphe 1 (préservation des éléments essentiels de l'identité)

Les questions relatives à l'identité personnelle n'ont généralement pas été traitées au niveau européen, compte tenu de la compétence limitée de l'UE dans ce domaine. Toutefois, la CJUE a statué incidemment sur le droit à un nom (en particulier le droit que le nom qui a été reconnu dans l'un des États membres de l'UE le soit dans d'autres) du point de vue du principe de la liberté de circulation. Les aspects liés à la citoyenneté et à la résidence ont aussi été instruits sous l'angle de l'article 20 du TFUE. Le CdE a, quant à lui, en particulier par l'intermédiaire de la jurisprudence de la CouEDH, interprété et développé l'application de plusieurs droits fondamentaux dans le domaine de l'identité personnelle. Les sections suivantes traitent donc uniquement du droit du CdE, à l'exception de quelques domaines pour lesquels les questions d'identité personnelle ont été traitées au niveau de l'UE.

Ce chapitre ne renvoie pas à un droit fondamental spécifique. Il offre un aperçu des questions de droits fondamentaux relatives à l'identité, comme l'enregistrement de la naissance et le droit à un nom (section 4.1), le droit à l'identité personnelle (section 4.2), le vol d'identité (section 4.4), le droit à la citoyenneté (section 4.5) et l'identité des enfants appartenant à une minorité

nationale (section 4.6). D'autres questions afférentes sont traitées dans les autres chapitres, en particulier celles relatives aux abus sexuels (section 7.1.3) ou à la protection des données (chapitre 10). Certains de ces droits, comme le droit à un nom, ont été principalement présentés comme droits parentaux mais cette approche pourrait être facilement transposée aux enfants eux-mêmes, étant donné les implications pour leurs propres droits.

4.1. Enregistrement de la naissance et droit à un nom

Point clé

- Le refus d'enregistrer un prénom qui n'est pas impropre pour un enfant et qui est déjà accepté socialement peut constituer une violation de l'article 8 de la CEDH (droit au respect de la vie privée et familiale).

Contrairement aux traités de l'ONU (par exemple l'article 24, paragraphe 2, du Pacte international relatif aux droits civils et politiques (ICCPR), l'article 7, paragraphe 1, de la CRC et l'article 18 de la Convention relative aux droits des personnes handicapées (CRPD)), les instruments européens sur les droits fondamentaux ne mentionnent pas explicitement le droit à l'enregistrement de la naissance immédiatement après l'accouchement ou le droit à un nom à la naissance.

Dans le droit de l'UE, le droit à un nom a été traité du point de vue de la liberté de circulation. La CJUE considère que la liberté de circulation empêche un État membre de l'UE de refuser de reconnaître le prénom d'un enfant tel qu'il est enregistré dans un autre État membre dont l'enfant a la nationalité, ou où l'enfant est né et a résidé[107].

Dans le droit du CdE, le refus de l'enregistrement de la naissance d'un enfant est abordé sous l'angle de l'article 8 de la CEDH.

D'abord, la CouEDH considère que le nom en tant que « moyen d'identification au sein de la famille et de la société » relève du droit au respect de la vie privée

107 Voir CJUE, C-148/02, *Carlos Garcia Avello c. État belge*, 2 octobre 2003 ; CJUE, C-353/06, *Stefan Grunkin et Dorothee Regina Paul* [GC], 14 octobre 2008.

et familiale tel qu'il est défini dans l'article 8 de la CEDH[108]. Le choix des parents relatif au prénom[109] et au nom de famille[110] de leur enfant concerne leur vie privée. La Cour a statué que le refus des autorités publiques d'enregistrer un prénom choisi en se fondant sur le tort ou préjudice potentiellement causé à l'enfant par ce nom ne constituait pas une violation de l'article 8 de la CEDH[111]. En revanche, le refus d'enregistrer un prénom qui n'est pas inapproprié pour un enfant et qui est déjà accepté socialement peut constituer une violation de l'article 8 de la CEDH.

Exemple : dans l'affaire *Johansson c. Finlande*[112], les autorités ont refusé d'enregistrer le prénom « Axl Mick » car l'orthographe n'était pas conforme à la pratique finlandaise en matière de noms. La CouEDH a admis qu'il fallait prendre en compte l'intérêt supérieur de l'enfant et que la préservation de la pratique nationale relative aux noms était d'intérêt public. Elle a toutefois constaté que ce prénom avait été accepté lors de l'enregistrement d'autres naissances et donc qu'il ne pouvait pas être jugé inapproprié pour un enfant. Étant donné que le nom était déjà accepté socialement en Finlande et que rien n'avait prouvé que ce nom avait eu des conséquences négatives sur l'identité culturelle et linguistique de l'État, la CouEDH a conclu que les considérations d'intérêt public ne l'emportaient pas sur l'intérêt d'enregistrer l'enfant sous le nom choisi. La Cour a donc considéré qu'il y avait eu violation de l'article 8 de la CEDH.

La CouEDH a également jugé que la règle selon laquelle le nom de famille du mari devrait être donné aux enfants légitimes au moment de l'enregistrement de la naissance ne constitue pas en lui-même une violation de la CEDH. Toutefois, l'impossibilité de déroger à cette règle générale a été considérée comme excessivement rigide et discriminatoire pour les femmes et par conséquent en violation de l'article 14 conjointement avec l'article 8 de la CEDH[113].

L'article 11 de la CCPMN reconnaît que toute personne appartenant à une minorité nationale a le droit d'utiliser son nom (patronyme) et ses prénoms dans la

108 CouEDH, *Guillot c. France*, n° 22500/93, 24 octobre 1993, para. 21.

109 CouEDH, *Johansson c. Finlande*, n° 10163/02, 6 septembre 2007, para. 28 ; CouEDH, *Guillot c. France*, n° 22500/93, 24 octobre 1993, para. 22.

110 CouEDH, *Cusan et Fazzo c. Italie*, n° 77/07, 7 janvier 2014, para. 56.

111 CouEDH, *Guillot c. France*, n° 22500/93, 24 octobre 1993, para. 27.

112 CouEDH, *Johansson c. Finlande*, n° 10163/02, 6 septembre 2007.

113 CouEDH, *Cusan et Fazzo c. Italie*, n° 77/07, 7 janvier 2014, para. 67.

langue minoritaire ainsi que le droit à leur reconnaissance officielle, selon les modalités prévues par leur système juridique.

L'article 11, paragraphe 3, de la Convention européenne en matière d'adoption des enfants prévoit la possibilité pour les États parties de conserver le prénom d'origine d'un enfant adopté (Convention sur l'adoption)[114]. C'est une exception au principe général selon lequel le lien juridique entre l'enfant adopté et sa famille d'origine est rompu.

4.2. Droit à l'identité personnelle

Points clés

- Le droit de connaître ses propres origines relève de la vie privée de l'enfant.
- L'établissement de la paternité nécessite de peser minutieusement l'intérêt de l'enfant à connaître son identité par rapport à l'intérêt du père présumé ou allégué, et à l'intérêt général.
- Les accouchements sous X. peuvent être autorisés conformément à l'article 8 de la CEDH (droit au respect de la vie privée et familiale), à condition que l'enfant puisse obtenir au moins des informations non identifiantes sur sa mère et qu'il y ait une possibilité d'obtenir une renonciation à la confidentialité par la mère.
- Un enfant adopté a le droit d'accéder aux informations relatives à ses origines. Les parents biologiques peuvent obtenir un droit légal de ne pas divulguer leur identité mais cela n'équivaut pas à un veto absolu.

Dans le droit du CdE, selon la CouEDH, l'article 8 de la CEDH comprend le droit à l'identité et à l'épanouissement personnel. Les détails de l'identité d'une personne et l'intérêt « à obtenir des informations nécessaires à la découverte de la vérité concernant un aspect important de son identité personnelle, par exemple l'identité de ses géniteurs »[115] ont été jugés importants pour l'épanouissement personnel. La naissance et les circonstances de la naissance relèvent de la vie privée d'un enfant. « Des précisions sur des aspects éminemment personnels de l'enfance, de l'évolution et des antécédents » d'une personne peuvent constituer

114 CdE, Convention européenne en matière d'adoption des enfants (révisée), STCE n° 202, 2008.

115 CouEDH, *Odièvre c. France* [GC], n° 42326/98, 13 février 2003, para. 29.

la « principale source d'information sur [le] passé et [les] années de formation »[116] de cette personne, si bien que l'impossibilité d'accéder à ces informations par l'enfant prête à discussion sous l'angle de l'article 8 de la CEDH.

Selon le droit international, l'article 8 de la CRC prévoit un niveau élevé et assez détaillé de protection du droit de préserver l'identité d'un enfant. Il protège de l'ingérence illicite dans la préservation de l'identité, y compris la nationalité, le nom et les relations familiales, tels que reconnus par la loi. Il garantit aussi « une assistance et une protection appropriées » lorsqu'un enfant est illégalement privé de certains ou de tous les éléments constitutifs de son identité en vue de rétablir son identité le plus rapidement possible.

4.2.1. Établissement de la paternité

Dans le droit du CdE, des enfants ont saisi la CouEDH au sujet de l'impossibilité de déterminer l'identité de leur père naturel. La CouEDH a jugé que la détermination du lien juridique entre un enfant et son père naturel présumé relevait de la vie privée (article 8 de la CEDH). La filiation est un aspect fondamental de l'identité[117]. Toutefois, il convient de ménager un juste équilibre entre l'intérêt d'un enfant à établir la paternité et les intérêts du père présumé ainsi que de l'intérêt général. L'intérêt d'un enfant à avoir une certitude juridique sur sa filiation paternelle ne nuit pas à l'intérêt du père à réfuter la présomption légale de paternité.

> Exemple : dans l'affaire *Mikulić c. Croatie*[118], la requérante née hors mariage a lancé une procédure pour établir la paternité de son père présumé. Le défendeur a refusé à plusieurs reprises de subir un test ADN ordonné par le tribunal, ce qui a conduit à la prolongation inutile des procédures liées à la paternité pendant environ cinq ans. La CouEDH a jugé que, si selon le droit national, les pères présumés ne pouvaient être forcés à subir des tests médicaux, les États devaient offrir d'autres moyens d'identifier rapidement les pères naturels par une autorité indépendante. Elle a donc conclu à une violation de l'article 8 de la CEDH.

116 CouEDH, *Gaskin c. Royaume-Uni*, n° 10454/83, 7 juillet 1989, para. 36.

117 CouEDH, *Mennesson c. France*, n° 65192/11, 26 juin 2014, para. 96.

118 CouEDH, *Mikulić c. Croatie*, n° 53176/99, 7 février 2002, paras. 64-65.

Exemple : dans l'affaire *Mizzi c. Malte*[119], le père présumé n'a pas pu nier la paternité d'un enfant né de sa femme étant donné que le délai légal imparti de six mois s'était écoulé. La CouEDH a examiné l'affaire sous l'angle des articles 6 (droit à un procès équitable) et 8 (respect de la vie privée et familiale) de la CEDH. Elle a constaté qu'imposer un délai durant lequel un père présumé doit intervenir pour renier un enfant vise à assurer une certitude juridique et à protéger l'intérêt de l'enfant à connaître son identité. Ces objectifs ne l'emportent toutefois pas sur le droit du père d'avoir la possibilité de refuser la paternité. L'impossibilité pratique de nier la paternité à la naissance avait dans ce cas placé une charge excessive sur le père présumé, en violation de son droit d'accéder à un tribunal et à un procès équitable tel qu'inscrit dans l'article 6 de la CEDH. Elle constituait aussi une ingérence disproportionnée dans ses droits énoncés dans l'article 8 de la CEDH[120].

L'intérêt de l'enfant à vouloir confirmer la paternité et l'intérêt du père biologique peuvent parfois coïncider. Cela fut le cas dans la situation d'un père qui, en raison de son incapacité juridique, n'a pu lancer de procédure au niveau national pour établir sa filiation avec son enfant. La CouEDH a estimé qu'il n'était pas dans l'intérêt supérieur d'un enfant né hors mariage que son père biologique ne puisse pas lancer de procédure pour établir sa paternité et que l'enfant devait donc s'en remettre entièrement à la discrétion des autorités publiques pour établir sa filiation[121].

Les autorités peuvent avoir l'obligation positive d'intervenir dans les procédures visant à établir la paternité dans l'intérêt supérieur de l'enfant quand le représentant légal (en l'occurrence la mère) de l'enfant n'est pas en mesure de représenter comme il se doit l'enfant, par exemple en cas d'un handicap sévère[122].

Compte tenu du cas spécifique de reconnaissance de filiation entre les parents d'intention et les enfants nés par gestation pour autrui (GPA), la Cour a accepté en principe que les États aient une large marge d'appréciation étant donné qu'il n'y a pas de consensus européen sur l'autorisation ou la reconnaissance de la filiation dans les accords relatifs à la GPA. Toutefois, le fait que la filiation est un aspect fondamental de l'identité d'un enfant réduit cette marge d'appréciation.

119 CouEDH, *Mizzi c. Malte*, n° 26111/02, 12 janvier 2006.

120 *Ibid.*, paras. 112-114.

121 CouEDH, *Krušković c. Croatie*, n° 46185/08, 21 juin 2011, paras. 38-41.

122 CouEDH, *A.M.M. c. Roumanie*, n° 2151/10, 14 février 2012, paras. 58-65.

Exemple : l'affaire *Mennesson c. France*[123] concerne le refus des autorités françaises d'enregistrer deux enfants nées par GPA aux États-Unis dans le registre français des naissances pour des motifs d'ordre public. La CouEDH a jugé qu'il n'y avait pas violation du droit des requérants au respect de la vie familiale car rien ne les empêchait de jouir de leur vie familiale en France et que les obstacles administratifs qu'ils avaient pu rencontrer n'avaient pas été insurmontables. En ce qui concerne le droit au respect de la vie privée des enfants, la Cour a accordé une grande importance à leur intérêt supérieur. Elle a souligné en particulier le fait que l'homme qui devait être enregistré sur l'acte comme le père des enfants était aussi leur père biologique. Refuser la filiation légale d'un enfant quand la filiation biologique est établie et quand le parent concerné reconnaît pleinement l'enfant ne peut être considéré comme conforme à l'intérêt supérieur de l'enfant. La Cour a donc conclu à une violation de l'article 8 de la CEDH à l'égard de la plainte des enfants relative à la « vie privée »[124].

4.2.2. Établissement de la maternité : accouchement sous X

Dans le droit du CdE, l'intérêt d'un enfant à connaître ses origines, en particulier sa mère, doit être pondéré par rapport à d'autres intérêts privés et publics, comme les intérêts de la famille ou des familles concernées, l'intérêt public à éviter les avortements illégaux, les abandons d'enfant, ou la protection de la santé. Les cas où la mère biologique décide de rester anonyme mais où l'enfant peut obtenir au moins des informations non identifiantes sur la mère biologique et a la possibilité d'obtenir une renonciation à la confidentialité de la mère peuvent être conformes à l'article 8 de la CEDH[125].

Exemple : dans l'affaire *Godelli c. Italie*[126], la requérante a été abandonnée à sa naissance par sa mère, qui n'a pas accepté d'être nommée dans l'acte de naissance. La requérante n'a pas pu accéder à des informations non identifiantes sur ses origines et n'a pas pu obtenir la divulgation de l'identité de sa mère. La CouEDH a conclu à une violation de l'article 8 de la CEDH

123 CouEDH, *Mennesson c. France*, n° 65192/11, 26 juin 2014.

124 *Ibid.*, para. 100 ; voir aussi CouEDH, *Labassee c. France*, n° 65941/11, 26 juin 2014, para. 79.

125 CouEDH, *Odièvre c. France* [GC], n° 42326/98, 13 février 2003, paras. 48-49.

126 CouEDH, *Godelli c. Italie*, n° 33783/09, 25 septembre 2012, para. 58.

car l'État n'a pas veillé au juste équilibre entre les intérêts conflictuels de la mère biologique et de l'enfant.

4.3. Établissement de ses origines : adoption

Le droit d'un enfant de connaître ses origines a été particulièrement mis en avant dans le contexte de l'adoption. Les garanties substantielles relatives à l'adoption, en dehors du droit de connaître ses origines, sont traitées dans la section 6.3.

Dans le droit du CdE, l'article 22, paragraphe 3 de la Convention en matière d'adoption des enfants (révisée) constitue une disposition assez ferme sur le droit d'un enfant adopté d'accéder aux informations détenues par les autorités concernant ses origines. Il permet aux États parties d'accorder aux parents d'origine le droit légal de ne pas divulguer leur identité dans la mesure où cela n'équivaut pas à un veto absolu. L'autorité compétente doit être en mesure de déterminer si elle passe outre le droit des parents d'origine et décide de divulguer des informations identifiantes compte tenu des circonstances et des droits respectifs en jeu. Dans le cas d'une adoption plénière, l'enfant adopté doit au moins pouvoir obtenir un document attestant du lieu et de la date de sa naissance[127].

Dans le droit international, la Convention de La Haye sur l'adoption internationale prévoit la possibilité pour un enfant adopté d'accéder aux informations sur l'identité de ses parents « avec les conseils appropriés », mais laisse à chaque État partie le soin de l'y autoriser ou non[128].

4.4. Vol d'identité

Point clé

- Une protection pratique et efficace doit être assurée contre le vol d'identité des enfants.

127 CdE, Convention européenne en matière d'adoption des enfants (révisée), STCE n° 202, 2008, art. 22.

128 Conférence de La Haye de Droit international privé, Convention sur la protection des enfants et la coopération en matière d'adoption internationale, 29 mai 1993, art. 30 (2).

Le vol d'identité se rapporte aux situations où le nom d'un enfant est utilisé à son insu.

Selon le droit du CdE, la CouEDH a traité du vol d'identité en vertu de l'article 8 de la CEDH sur le droit au respect de la vie privée et familiale. Elle a jugé que les États sont obligés d'assurer la protection pratique et efficace des enfants contre le vol d'identité et que les États doivent prendre des mesures efficaces pour identifier et poursuivre les auteurs[129].

> Exemple : dans l'affaire *K.U. c. Finlande*[130], une annonce avait été publiée sur un site internet de rencontres au nom d'un garçon de 12 ans, à son insu. L'annonce mentionnait son âge, son numéro de téléphone et sa description physique et contenait un lien vers un site internet où se trouvait sa photographie. L'annonce était de nature sexuelle et suggérait que ce garçon recherchait une relation intime avec un garçon de son âge ou plus âgé, en faisant donc une cible pour les pédophiles. L'identité de la personne qui avait publié cette annonce ne pouvait être obtenue auprès du fournisseur d'accès à internet en raison de la législation en vigueur. La CouEDH a estimé que l'obligation positive définie à l'article 8 de la CEDH, non seulement pour d'adopter des dispositions en matière pénale qui sanctionnent effectivement les infractions mais aussi pour enquêter sur ces délits et les poursuivre efficacement, revêt une importance d'autant plus grande que le bien-être physique et moral d'un enfant est menacé. Dans cette affaire, la Cour a jugé qu'en étant exposé comme cible pour les pédophiles sur internet, le bien-être physique et moral de l'enfant était menacé. Elle a donc conclu à une violation de l'article 8 de la CEDH.

Les aspects liés au vol d'identité sont étroitement liés à la pédopornographie et à la manipulation d'enfants. Ces aspects sont traités dans la section 7.2.

129 CouEDH, *K.U. c. Finlande*, n° 2872/02, 2 décembre 2008, para. 49.

130 CouEDH, *K.U. c. Finlande*, n° 2872/02, 2 décembre 2008.

4.5. Droit à la citoyenneté

Points clés

- Le droit de séjour des enfants citoyens de l'UE au sein de l'UE ne devrait pas être privé de tout effet utile par le refus du droit de séjour à leur(s) parent(s).
- La CEDH ne garantit pas le droit à la citoyenneté mais un refus arbitraire de la citoyenneté peut relever de l'article 8 de la CEDH (droit au respect de la vie privée et familiale) compte tenu de son impact sur la vie privée d'un individu.

Selon le droit de l'UE, l'article 20, paragraphe 1, du TFUE accorde le statut de citoyen de l'UE à toute personne ayant la nationalité d'un État membre de l'Union. La CJUE a statué sur l'effectivité du droit de séjour des enfants qui ont la citoyenneté d'un des États membres de l'UE mais pas la nationalité de l'État membre de l'UE dans lequel ils résident. Il s'agissait du refus du droit de séjour dans l'Union européenne à un parent en charge d'un enfant citoyen de l'UE. La CJUE a considéré que le refus du droit de séjour à un parent qui est le responsable à titre principal de l'enfant prive le droit de séjour de l'enfant de tout effet utile. En conséquence, le parent qui est le responsable à titre principal de l'enfant a le droit de résider avec l'enfant dans l'État d'accueil[131]. Ces aspects sont détaillés dans la section 9.5.

Selon le droit du CdE, la CEDH ne garantit pas le droit à la citoyenneté[132]. Toutefois, un refus arbitraire de la citoyenneté peut relever de l'article 8 de la CEDH en raison de son impact sur la vie privée d'un individu, qui englobe des aspects de l'identité sociale d'un enfant[133], ce qui renvoie ici à l'identité d'un enfant en société.

Exemple : dans l'affaire *Genovese c. Malte*, la citoyenneté maltaise a été refusée à un enfant né hors mariage en dehors de Malte, d'une mère non maltaise et d'un père reconnu par la justice comme maltais. Le refus de la citoyenneté en tant que tel ne violait pas l'article 8 de la CEDH. En revanche, le refus arbitraire de la citoyenneté en raison de la naissance hors mariage soulevait des questions de discrimination. Un traitement

131 CJUE, C-200/02, *Kunqian Catherine Zhu et Man Lavette Chen c. Secretary of State for the Home Department*, 19 octobre 2004, paras. 45-46.

132 CouEDH, *Slivenko et autres c. Lettonie* [GC], décision sur la recevabilité, n° 48321/99, 23 janvier 2002, para. 77.

133 CouEDH, *Genovese c. Malte*, n° 3124/09, 11 octobre 2011, para. 33.

différencié arbitraire pour ce motif nécessite des raisons solides pour le justifier. En l'absence de telles raisons, une violation de l'article 8 et de l'article 14 de la CEDH a été établie[134].

L'un des principaux objectifs des dispositions des traités sur le droit d'acquérir la citoyenneté est d'éviter l'apatridie. La Convention européenne sur la nationalité contient des dispositions détaillées sur l'acquisition légale de la nationalité pour les enfants et limite les possibilités des enfants de perdre leur citoyenneté[135]. La Convention sur la prévention des cas d'apatridie en relation avec la succession d'États du Conseil de l'Europe contient une obligation d'éviter le statut d'apatride à la naissance (article 10) et stipule le droit à la nationalité de l'État successeur en cas d'apatridie (article 2)[136]. L'article 12 de Convention européenne révisée en matière d'adoption reflète également le souci d'éviter l'apatridie. Selon cet article, les États doivent faciliter l'acquisition de leur nationalité par un enfant adopté par un de leurs ressortissants et la perte de nationalité suite à une adoption est subordonnée à la possession ou l'acquisition d'une autre nationalité.

Dans le droit international, l'article 7 de la CRC garantit le droit d'acquérir une nationalité, de même que l'article 24, paragraphe 3, de l'ICCPR.

4.6. Identité des enfants appartenant à une minorité nationale

Point clé

- Un enfant appartenant à une minorité nationale a le droit d'avoir sa propre culture, de professer et de pratiquer sa propre religion ou d'employer sa propre langue[137].

Dans le droit de l'UE, aucune attention particulière n'a été accordée à l'identité des enfants appartenant à une minorité nationale du point de vue des droits

134 *Ibid.*, para. 43-49.

135 CdE, Convention européenne sur la nationalité, STCE n° 166, 1997, art. 6 et 7.

136 CdE, Convention du Conseil de l'Europe sur la prévention des cas d'apatridie en relation avec la succession d'États, STCE n° 200, 2006.

137 Sur d'autres aspects liés aux droits économiques, sociaux et culturels, voir le chapitre 8.

fondamentaux. En outre, il n'y a pas de jurisprudence majeure au niveau européen qui s'ajoute aux normes du Conseil de l'Europe.

Dans le droit du CdE, l'article 5, paragraphe 1 de la Convention-cadre pour la protection des minorités nationales mentionne explicitement que les États parties s'engagent à préserver les éléments essentiels de l'identité des personnes appartenant à une minorité nationale, à savoir leur religion, leur langue, leurs traditions et leur patrimoine culturel. La CCPMN ne contient aucune disposition spécifique sur les enfants. La question de la langue dans l'enseignement des enfants est traitée dans la section 8.2.

Selon le droit international, l'article 30 de la CRC garantit à un enfant appartenant à une minorité ou à un enfant autochtone le droit « d'avoir sa propre vie culturelle, de professer et de pratiquer sa propre religion ou d'employer sa propre langue en commun avec les autres membres de son groupe ».

5 Vie familiale

UE	Questions traitées	CdE
Charte des droits fondamentaux, article 7 (droit au respect de la vie familiale)	**Droit au respect de la vie familiale**	CEDH, article 8 (droit au respect de la vie familiale)
Charte des droits fondamentaux, article 24 (droits de l'enfant) Règlement en matière d'obligations alimentaires (4/2009)	**Droit d'être élevé par ses parents**	CouEDH, *R.M.S. c. Espagne*, n° 28775/12, 2013 (privation de contact avec la fille)
Charte des droits fondamentaux, article 24 (3) (droit d'entretenir des contacts avec ses deux parents) Règlement Bruxelles II bis (2201/2003) Directive sur la médiation (2008/52/CE)	**Droit d'entretenir des contacts avec ses deux parents**	Convention sur les relations personnelles concernant les enfants

UE	Questions traitées	CdE
Directive sur l'accès à la justice (2002/8/CE) (accès à la justice dans les affaires transfrontalières)	**Séparation parentale**	CouEDH, *Levin c. Suède*, n° 35141/06, 2012 (restriction des droits relatifs aux relations personnelles) CouEDH, *Schneider c. Allemagne*, n° 17080/07, 2011 (contacts entre un enfant et un père non reconnu légalement). CouEDH, *Sommerfeld c. Allemagne* [GC], n° 31871/96, 2003 (contacts entre père et fille) CouEDH, *Mustafa et Armağan Akin c. Turquie*, n° 4694/03, 2010 (contacts entre frère et sœur après octroi de la garde) CouEDH, *Vojnity c. Hongrie*, n° 29617/07, 2013 (restriction des visites fondée sur des convictions religieuses)
Charte des droits fondamentaux, article 24 (droits de l'enfant) Règlement Bruxelles II bis (2201/2003) CJUE, C-211/10 PPU, *Doris Povse c. Mauro Alpago*, 2010 (certificat d'exécution)	**Enlèvement d'enfant**	Convention sur les relations personnelles concernant les enfants CouEDH, *Neulinger et Shuruk c. Suisse* [GC], n° 41615/07, 2010 (enlèvement de l'enfant par la mère) CouEDH, *X c. Lettonie* [GC], n° 27853/09, 2013 (risque grave en cas de retour de l'enfant en vertu de la Convention de La Haye)

Le droit de l'Union européenne et du Conseil de l'Europe garantit le droit au respect de la vie familiale (article 7 de la Charte des droits fondamentaux de l'UE, article 8 de la CEDH). La compétence de l'UE en matière de vie familiale concerne les conflits transnationaux, y compris la reconnaissance et l'exécution de jugements dans les États membres. La CJUE traite de questions relevant de l'intérêt supérieur de l'enfant et le droit à la vie familiale, tels qu'inscrits dans la Charte des droits fondamentaux, en relation avec le règlement Bruxelles II bis. La jurisprudence de la CouEDH relative à la vie familiale reconnaît les droits interdépendants, tels que le droit à la vie familiale et le droit de l'enfant à ce que son intérêt supérieur soit pris en compte, comme une considération primordiale. Elle reconnaît que les droits des enfants sont parfois divergents. Par exemple, le droit de l'enfant au respect de la vie familiale peut être limité pour garantir son intérêt supérieur. En outre, le CdE a adopté divers autres instruments traitant de questions relatives aux relations personnelles, à la garde et à l'exercice des droits des enfants.

Ce chapitre examine le droit de l'enfant au respect de la vie familiale et les droits afférents, notamment leur contenu et leur champ d'application, ainsi que les obligations légales associées et leur interaction avec d'autres droits. Les aspects spécifiques considérés incluent le droit au respect de la vie familiale et ses limites (section 5.1), le droit de l'enfant d'être élevé par ses parents (section 5.2), le droit d'entretenir des contacts avec ses deux parents (section 5.3) et l'enlèvement d'enfant (section 5.4).

5.1. Droit au respect de la vie familiale

Points clés

- Les États ont des obligations positives pour garantir la jouissance effective des enfants de leur droit au respect de la vie familiale.
- Selon le droit de l'UE et du CdE, les autorités judiciaires et administratives doivent tenir compte de l'intérêt supérieur de l'enfant dans toute décision relative au droit de l'enfant au respect de sa vie familiale.

Le droit de l'enfant au respect de la vie familiale inclut plusieurs droits composites, comme le droit de l'enfant d'être élevé par ses parents (section 5.2), le droit d'entretenir des contacts avec ses deux parents (section 5.3), le droit de ne pas être séparé de ses parents sauf si c'est dans l'intérêt supérieur de l'enfant (section 5.4 et chapitre 6) et le droit à la réunification familiale (chapitre 9).

En vertu du droit de l'UE et du droit du CdE, le droit au respect de la vie familiale n'est pas absolu mais sujet à un certain nombre de limitations. Comme le précise la note explicative de la Charte des droits fondamentaux, ces limitations sont identiques à la disposition correspondante de la CEDH, en particulier l'article 8, paragraphe 2[138], à savoir : conformes à la loi et nécessaires dans une société démocratique à la sécurité nationale, à la sûreté publique, au bien-être économique du pays, à la défense de l'ordre et à la prévention des infractions

138 Parlement européen, Conseil de l'Union européenne, Commission européenne (2007), *Explications relatives à la Charte des droits fondamentaux*, 2007/C 303/02, JO 2007 C 303, p. 17-35, voir les explications relatives à l'article 7.

pénales, à la protection de la santé ou de la morale, ou à la protection des droits et libertés d'autrui[139].

La Charte des droits fondamentaux intègre expressément à ce droit l'obligation de tenir compte de l'intérêt supérieur de l'enfant (article 24, paragraphe 2)[140]. Bien que l'obligation de tenir compte de l'intérêt supérieur de l'enfant ne soit pas expressément mentionnée dans la CEDH, la CouEDH intègre cette obligation dans sa jurisprudence[141].

5.2. Droit de l'enfant d'être élevé par ses parents

Points clés

- Le droit de l'UE réglemente les aspects procéduraux du droit de l'enfant d'être élevé par ses parents.
- En vertu de la CEDH, les États ont des devoirs négatifs et positifs pour respecter les droits des enfants et des parents à la vie familiale.

Le droit des enfants de connaître l'identité de leurs parents et le droit d'être élevé par eux sont deux éléments essentiels du droit des enfants au respect de la vie familiale. Ils sont dans une certaine mesure interdépendants : le droit des enfants de connaître leurs parents est garanti par les soins parentaux. Toutefois, ces droits sont parfois distincts, par exemple pour les enfants adoptés ou nés par procréation médicalement assistée. Dans ce cas, le premier droit est associé plus étroitement au droit de l'enfant à l'identité, qui se manifeste par la connaissance de sa filiation biologique, et est donc examiné dans le chapitre 4. Cette section met l'accent sur le second droit : le droit de l'enfant d'être élevé par ses parents.

Le droit de l'UE ne prévoit aucune disposition sur le champ d'application matériel du droit d'être élevé par ses parents. Les instruments de l'UE peuvent viser des

139 CdE, Convention de sauvegarde des Droits de l'Homme et des Libertés fondamentales, STCE n° 5, 1950, art. 8.

140 CJUE, C-400/10 PPU, *J. McB. c. L.E.*, 5 octobre 2010.

141 Voir, par exemple, CouEDH, *Ignaccolo-Zenide c. Roumanie*, n° 31679/96, 25 janvier 2000, para. 94.

aspects transfrontaliers, comme la reconnaissance et l'exécution de jugements à travers les États membres. Le règlement (CE) n° 4/2009 relatif à la compétence, la loi applicable, la reconnaissance et l'exécution des décisions et la coopération en matière d'obligations alimentaires (règlement sur les obligations alimentaires), par exemple, couvre les demandes en matière d'obligations alimentaires transfrontalières découlant des relations de famille[142]. Il établit des règles communes à l'UE visant à assurer le recouvrement des créances alimentaires même lorsque le débiteur ou le créancier est dans un autre État membre de l'UE.

Dans le droit du CdE, la CouEDH a souligné que l'article 8 de la CEDH établit principalement le devoir de l'État de ne pas intervenir dans la vie familiale[143]. Toutefois, les États ont l'obligation positive de prendre les mesures nécessaires pour soutenir les parents et les familles et pour protéger les enfants contre tout abus potentiel[144]. Les enfants ne devraient être séparés de leurs parents que dans ces circonstances exceptionnelles. Si tel est le cas, tout doit être fait pour préserver les relations personnelles et, le cas échéant, pour « réunir » la famille. Les États bénéficient d'une large marge d'appréciation quant à la décision initiale de séparer les enfants de leurs parents[145]. Toutefois, un examen plus approfondi s'impose pour toute autre limitation, telles que les restrictions des droits parentaux aux visites, et pour toute garantie juridique destinée à protéger efficacement le droit des parents et des enfants au respect de leur vie familiale. De telles limitations risquent d'entraver effectivement les relations familiales entre un jeune enfant et l'un des parents ou les deux. De même, les raisons avancées par l'autorité publique pour séparer un nouveau-né de sa mère doivent être extraordinairement impérieuses[146].

Cette marge d'appréciation diminue en fonction de la durée de séparation des enfants de leurs parents et les autorités publiques doivent avancer de fortes raisons pour défendre leur décision de maintenir la séparation[147]. La CouEDH examine si le processus de prise de décision a été équitable et si toutes les parties concernées ont eu la possibilité de plaider leur cause.

142 Conseil de l'UE (2008), Règlement (CE) n° 4/2009 du Conseil du 18 décembre 2008 sur la compétence, la loi applicable, la reconnaissance et l'exécution des décisions et la coopération en matière d'obligations alimentaires, JO 2008 L 7 (règlement sur les obligations alimentaires).

143 CouEDH, *R.M.S. c. Espagne*, n° 28775/12, 18 juin 2013, para. 69.

144 *Ibid.*, para. 69 et suivants.

145 CouEDH, *Y.C. c. Royaume-Uni*, n° 4547/10, 13 mars 2012, para. 137.

146 CouEDH, *K. et T. c. Finlande* [GC], n° 25702/94, 12 juillet 2001, para. 168.

147 CouEDH, *Y.C. c. Royaume-Uni*, n° 4547/10, 13 mars 2012, para. 137.

Exemple : dans l'affaire *R.M.S. c. Espagne*[148], la requérante affirmait avoir été privée de tout contact avec sa fille à partir de ses trois ans et dix mois en raison de son statut socioéconomique. La Cour, qui a conclu à une violation de l'article 8 de la CEDH, a souligné le fait « que les autorités administratives espagnoles auraient dû envisager d'autres mesures moins radicales que la prise en charge de l'enfant ». Elle a aussi rappelé que « le rôle des autorités de protection sociale est précisément d'aider les personnes en difficulté [...], de les guider dans leurs démarches et de les conseiller, entre autres, quant aux différents types d'allocations sociales disponibles, aux possibilités d'obtenir un logement social ou aux autres moyens de surmonter leurs difficultés, comme la requérante avait initialement cherché à le faire. » En conséquence, la CouEDH a jugé « que les autorités espagnoles n'ont pas déployé des efforts adéquats et suffisants pour faire respecter le droit de la requérante à vivre avec son enfant »[149].

Selon le droit international, l'article 5 de la CRC stipule que « les États parties respectent la responsabilité, le droit et le devoir qu'ont les parents [...] de donner à l'enfant, d'une manière qui corresponde au développement de ses capacités, l'orientation et les conseils appropriés à l'exercice des droits que lui reconnaît la présente Convention. » En outre, l'article 9 de la CRC stipule qu'un enfant ne doit pas être séparé de ses parents contre leur gré et que toutes les parties concernées doivent avoir la possibilité de participer aux délibérations liées à cette situation. Les Lignes directrices des Nations Unies relatives à la protection de remplacement pour les enfants étayent plus avant les droits des enfants dans ces circonstances et les devoirs correspondants des États[150].

148 CouEDH, *R.M.S. c. Espagne*, n° 28775/12, 18 juin 2013.

149 *Ibid.*, paras. 86 et 93.

150 ONU, Conseil des droits de l'homme (2009), *Lignes directrices relatives à la protection de remplacement pour les enfants,* A/HRC/11/L.13, 15 juin 2009.

5.3. Droit d'entretenir des contacts avec ses deux parents

Points clés

- Le droit de l'enfant d'entretenir des contacts avec ses deux parents subsiste dans toutes les formes de séparation parentale, qu'elle soit d'origine familiale ou imposée par les autorités publiques.
- Le processus permettant de garantir le droit de l'enfant d'entretenir des contacts avec ses parents et à la réunification familiale nécessite de prendre en compte l'intérêt supérieur de l'enfant comme considération primordiale en tenant dûment compte de l'avis de l'enfant en fonction de son âge et de sa maturité.

Le champ d'application du droit de l'enfant d'entretenir des contacts avec ses parents dépend du contexte. En cas de décision des parents de se séparer, le champ d'application est plus large et normalement limité uniquement par l'intérêt supérieur de l'enfant. Dans le cas d'une séparation imposée par les autorités publiques découlant, par exemple, de l'expulsion ou de l'emprisonnement d'un parent, les autorités publiques agissent pour servir un intérêt protégé et doivent ménager un juste équilibre entre les intérêts des parties et l'obligation de garantir l'intérêt supérieur de l'enfant. Le droit des enfants d'entretenir des contacts avec leurs deux parents est applicable dans les deux cas.

Dans le droit de l'UE, l'article 24, paragraphe 3, de la Charte des droits fondamentaux reconnaît expressément le droit de tout enfant d'entretenir des contacts avec ses *deux* parents. La formulation de cette disposition clarifie le contenu de ce droit, en particulier le sens de « contact » qui doit : être *régulier*, permettre le développement d'une *relation personnelle* et être sous la forme d'un *contact direct*. Il existe toutefois une réserve : le droit de tout enfant d'entretenir des contacts avec ses parents est expressément limité par son intérêt supérieur. Cette disposition, comme le précise la note explicative de la Charte, est expressément avisée par l'article 9 de la CRC.

Conformément aux compétences de l'UE (voir le chapitre 1), une attention particulière a été accordée à la coopération judiciaire (avec pour objectif de créer une zone de liberté, de sécurité et de justice dans laquelle la libre circulation des personnes est garantie). Deux instruments de l'UE sont particulièrement importants

à cet égard : le règlement (CE) n° 2201/2003 du Conseil[151] (Bruxelles II bis) et la directive du 2008/52/CE Parlement européen et du Conseil (directive sur la médiation)[152]. Le règlement Bruxelles II bis est important du point de vue des droits. Premièrement, il s'applique à *toutes* les décisions relatives à la responsabilité parentale, indépendamment du statut marital. Deuxièmement, les règles relatives à la juridiction (déterminées pour la plupart par la résidence habituelle de l'enfant) sont expressément avisées par l'intérêt supérieur de l'enfant. Troisièmement, une attention particulière est accordée au respect de l'opinion de l'enfant[153].

La jurisprudence de la CJUE dans les cas de déplacement illicite d'un enfant suite à une décision prise unilatéralement par l'un des parents vise essentiellement à préserver le droit fondamental de l'enfant d'entretenir des relations personnelles et des contacts directs réguliers avec ses deux parents (article 24, paragraphe 3, de la Charte), étant donné que la Cour soutient que ce droit rejoint indéniablement l'intérêt supérieur de l'enfant. Pour la CJUE, une mesure qui empêche un enfant d'entretenir des relations personnelles et des contacts directs réguliers avec ses deux parents ne peut se justifier que par un autre intérêt de l'enfant d'une intensité telle que ce dernier prime celui sous-tendant ledit droit fondamental[154]. Cela comprend des mesures provisoires, y compris de protection, conformément à l'article 20 du règlement Bruxelles II bis. La Cour a jugé qu'une appréciation équilibrée et raisonnable de tous les intérêts en jeu, qui doit reposer sur des considérations objectives relatives à la personne même de l'enfant et à son environnement social, doit, en principe, être effectuée dans le cadre d'une procédure en vertu des dispositions du règlement Bruxelles II bis[155].

> Exemple : l'affaire *E. c. B.*[156] concerne une procédure entre M. E. (le père) et M^elle^ B. (la mère), en relation avec la compétence des tribunaux du Royaume-Uni pour connaître et statuer sur le lieu de résidence habituelle

151 Conseil de l'UE (2003), Règlement du Conseil (CE) n° 2201/2003 du 27 novembre 2003 relatif à la compétence, la reconnaissance et l'exécution des décisions en matière matrimoniale et en matière de responsabilité parentale des enfants communs, abrogeant le règlement (CE) n° 1347/2000, JO 2003 L 338 (règlement Bruxelles II bis).

152 Parlement européen, Conseil de l'UE (2008), Directive 2008/52/CE du Parlement européen et du Conseil du 21 mai 2008 sur certains aspects de la médiation en matière civile et commerciale, JO 2008 L 136/3 (directive sur la médiation).

153 Voir, par exemple, Règlement du Conseil (CE) n° 2201/2003, préambule (par. 5, 12, 13 et 19) et art. 8, art. 41, para. 2, point c) et art. 42, para. 2, point a).

154 CJUE, C-403/09 PPU, *Jasna Detiček c. Maurizio Sgueglia*, 23 décembre 2009, para. 59.

155 *Ibid.*, para. 60.

156 CJUE, C-436/13, *E. c. B.*, 1 octobre 2014 (synthèse à partir de http://cases.iclr.co.uk)

de leur enfant, S., et le droit de visite du père. Les parents avaient signé un accord devant un tribunal espagnol qui attribuait la garde de l'enfant à la mère et reconnaissait le droit de visite au père. Ultérieurement, la mère a demandé une réduction des droits de visite qui avaient été octroyés au père par cet accord. Le père a déposé une requête auprès de la High Court en vue de l'exécution de l'accord espagnol. La mère a affirmé qu'elle avait prorogé la compétence du tribunal espagnol et a demandé le transfert aux juridictions d'Angleterre et du pays de Galles de la compétence prorogée. Comme suite à l'appel du père, la Cour d'appel a posé plusieurs questions à la CJUE concernant l'interprétation de l'article 12, paragraphe 3, du règlement Bruxelles II bis. La CJUE a jugé que lorsqu'une juridiction est saisie d'une procédure conformément à l'article 12, paragraphe 3, du règlement Bruxelles II bis, l'intérêt supérieur de l'enfant ne peut être préservé que par un examen, dans chaque cas particulier, de la question de savoir si la prorogation de compétence recherchée est conforme à cet intérêt supérieur. Une prorogation de compétence ne vaut que pour la procédure spécifique pour laquelle la juridiction dont la compétence est prorogée est saisie. Après la conclusion finale de la procédure dont découle la prorogation de compétence, cette compétence disparaît, au profit de la juridiction bénéficiant d'une compétence générale en application de l'article 8, paragraphe 1, du règlement Bruxelles II bis.

En matière de responsabilité parentale, le règlement Bruxelles II bis coexiste avec la Convention de La Haye concernant la compétence, la loi applicable, la reconnaissance, l'exécution et la coopération en matière de responsabilité parentale et de mesures de protection des enfants[157]. En application de l'article 61, le règlement Bruxelles II bis prévaudra sur la Convention de La Haye : lorsque l'enfant concerné a sa résidence habituelle sur le territoire d'un État membre, ou en ce qui concerne la reconnaissance et l'exécution d'une décision rendue par la juridiction compétente d'un État membre sur le territoire d'un autre État membre, même si l'enfant concerné a sa résidence habituelle sur le territoire d'un État non membre qui est partie contractante à ladite convention. L'un des enjeux clés selon le règlement Bruxelles II bis est donc la détermination de la résidence habituelle de l'enfant.

157 Organisation mondiale pour la coopération transfrontalière en matière civile et commerciale (1996), Conférence de La Haye de droit international privé, Convention concernant la compétence, la loi applicable, la reconnaissance, l'exécution et la coopération en matière de responsabilité parentale et de mesures de protection des enfants, 19 octobre 1996.

Exemple : dans l'affaire *Mercredi c. Chaffe*[158], la Cour d'appel d'Angleterre et du Pays de Galles a renvoyé une affaire à la CJUE concernant le déplacement d'un enfant de deux mois du Royaume-Uni vers l'île de La Réunion. La CJUE a statué que le concept de résidence habituelle, pour les besoins des articles 8 et 10 du règlement Bruxelles II bis, correspond au lieu qui reflète un certain degré d'intégration de l'enfant à un environnement social et familial. Lorsque la situation concerne un nourrisson qui séjourne avec sa mère depuis quelques jours seulement dans un État membre autre que celui de sa résidence habituelle, vers lequel il a été déplacé, plusieurs éléments sont à prendre en considération : d'une part, la durée, la régularité, les conditions et les raisons du séjour sur le territoire de cet État membre et du déménagement de la mère dans ledit État, et, d'autre part, en raison notamment de l'âge de l'enfant, les origines géographiques et familiales de la mère ainsi que les rapports familiaux et sociaux entretenus par celle-ci et l'enfant dans le même État membre.

Pour garantir la jouissance du droit d'entretenir des contacts avec les deux parents dans les affaires transfrontalières, les instruments visant à réglementer l'accès à la justice qui précisent comment traiter des litiges complexes sont aussi particulièrement importants. Tel est le cas de la directive 2002/8/CE du Conseil (directive sur l'accès à la justice), qui exige d'« améliorer l'accès à la justice dans les affaires transfrontalières par l'établissement de règles minimales communes relatives à l'aide judiciaire accordée dans le cadre de telles affaires »[159]. L'objectif de cette directive est : d'améliorer l'accès à la justice dans les affaires civiles transfrontalières par l'établissement de règles minimales communes relatives à l'aide judiciaire ; de garantir l'octroi d'une aide judiciaire appropriée, sous certaines conditions, aux personnes qui ne peuvent pas assumer les frais de procédure en raison de leur situation financière ; et de faciliter la compatibilité des droits nationaux en la matière et de fournir des mécanismes de coopération entre les autorités des États membres.

Dans le droit du CdE, le droit de tout enfant d'entretenir des contacts avec ses deux parents est implicite dans l'article 8 de la CEDH. La CouEDH affirme que « pour un parent et son enfant, être ensemble représente un élément fondamental de la

158 CJUE, C-497/10 PPU, *Barbara Mercredi c. Richard Chaffe*, 22 décembre 2010.

159 Conseil de l'UE (2003), Directive 2002/8/CE du Conseil du 27 janvier 2003 visant à améliorer l'accès à la justice dans les affaires transfrontalières par l'établissement de règles minimales communes relatives à l'aide judiciaire accordée dans le cadre de telles affaires, JO 2003 L 026 (directive sur l'accès à la justice).

vie familiale »[160]. Mais elle souligne aussi que ce droit peut être limité par l'intérêt supérieur de l'enfant (voir section 5.4 et chapitre 6). Ce droit est au cœur de la prise de décision judiciaire relative à la garde de l'enfant et au contact avec lui.

Dans une série d'affaires, la CouEDH n'a renvoyé à l'intérêt supérieur de l'enfant ni expressément, ni implicitement dans le contexte de la garde et du contact.

Exemple : dans l'affaire *Schneider c. Allemagne*[161], le requérant avait une relation avec une femme mariée et affirmait être le père biologique de son fils, dont le père légalement reconnu était le mari de la mère. Le requérant a fait valoir que la décision des tribunaux nationaux de rejeter sa demande de contact avec l'enfant et d'informations sur l'épanouissement de l'enfant au motif qu'il n'était ni le père légal de l'enfant et qu'il n'avait pas de lien avec l'enfant constituait une violation de ses droits sous l'angle de l'article 8 de la CEDH. En concluant à une violation, la CouEDH a mis en avant le fait que les tribunaux nationaux n'ont pas du tout tenu compte de la question de savoir si, compte tenu des circonstances particulières de l'affaire, le contact entre l'enfant et le requérant aurait été dans l'intérêt supérieur de l'enfant[162]. Concernant la demande du requérant d'informations sur l'épanouissement personnel de l'enfant, la Cour a jugé que les tribunaux nationaux n'avaient pas avancé de raisons suffisantes pour justifier leur ingérence pour les besoins de l'article 8, paragraphe 2[163], et que donc l'ingérence n'avait pas été nécessaire dans une société démocratique.

Exemple : dans l'affaire *Levin c. Suède*[164], la requérante, une mère de trois enfants bénéficiant d'une protection de remplacement dans un cadre non familial, a fait valoir que les restrictions de son droit d'entretenir des contacts avec ses enfants violaient son droit au respect de la vie familiale. La CouEDH a mis en avant l'objectif des restrictions des contacts, à savoir la protection de l'intérêt supérieur des enfants. Dans ce cas particulier, les enfants avaient été négligés quand ils étaient à la charge de la requérante et le contact avec cette dernière a donné lieu à de fortes réactions

160 CouEDH, *K. et T. c. Finlande* [GC], n° 25702/94, 12 juillet 2001, para. 151.

161 CouEDH, *Schneider c. Allemagne*, n° 17080/07, 15 septembre 2011.

162 Voir aussi CouEDH, *Anayo c. Allemagne*, n° 20578/07, 21 décembre 2010, paras. 67 et 71.

163 CouEDH, *Schneider c. Allemagne*, n° 17080/07, 15 septembre 2011, para. 104.

164 CouEDH, *Levin c. Suède*, n° 35141/06, 15 mars 2012, paras. 57 et 69 ; CouEDH, *K. et T. c. Finlande* [GC], n° 25702/94, 12 juillet 2001, para. 151.

négatives de la part des enfants. En concluant qu'il n'y avait pas eu violation de l'article 8 de la CEDH, la Cour a jugé que l'ingérence dans les droits de la requérante avait été proportionnelle à l'objectif légitime poursuivi (l'intérêt supérieur de l'enfant) et s'inscrivait dans la marge des autorités nationales.

Exemple : dans l'affaire *Sommerfeld c. Allemagne*[165], le requérant dénonçait les restrictions de son droit à entretenir des contacts avec sa fille, qui avait exprimé à plusieurs reprises le souhait de ne pas rester en contact avec lui. Le requérant a notamment fait valoir que l'incapacité des tribunaux nationaux à obtenir l'avis d'un expert psychiatrique constituait une faille dans la procédure nationale. La CouEDH, qui a conclu à une non-violation de l'article 8 de la CEDH, a jugé que le tribunal national était suffisamment bien placé pour évaluer les déclarations de la fille et pour établir si celle-ci était en mesure ou non de se former sa propre opinion.

Exemple : dans l'affaire *Mustafa et Armağan Akin c. Turquie*[166], les requérants, un père et son fils, ont fait valoir que les conditions de la garde ordonnée par le tribunal national avaient violé leurs droits sous l'angle de l'article 8 de la CEDH. Ces conditions empêchaient le fils d'être en contact avec sa sœur, qui était sous la garde de sa mère. En outre, le père ne pouvait pas avoir de contact avec ses deux enfants en même temps car les contacts entre son fils et la mère coïncidaient avec les contacts qu'il avait avec sa fille. La CouEDH a jugé que la décision du tribunal national de séparer le frère et la sœur constituait une violation du droit des requérants au respect de la vie familiale, car non seulement elle empêchait le frère et la sœur de se voir, mais aussi leur père d'avoir la compagnie de ses deux enfants simultanément.

Dans le contexte de la garde et du processus décisionnel, la CouEDH interdit toute discrimination incompatible avec l'article 14 de la CEDH.

Exemple : dans l'affaire *Vojnity c. Hongrie*[167], le requérant a fait valoir que l'accès à son fils lui avait été refusé en raison de ses convictions

165 CEDH, *Sommerfeld c. Allemagne*, n° 31871/96, 8 juillet 2003, para. 72.

166 CouEDH, *Mustafa et Armağan Akin c. Turquie*, n° 4694/03, 6 avril 2010.

167 CouEDH, *Vojnity c. Hongrie*, n° 29617/07, 12 février 2013 ; voir aussi CouEDH, *P.V. c. Espagne*, n° 35159/09, 30 novembre 2010.

religieuses[168]. La CouEDH, qui a conclu à une non-violation de l'article 14 conjointement avec l'article 8 de la CEDH, a constaté qu'il n'existait pas de preuves selon lesquelles les convictions religieuses du requérant impliquait des pratiques dangereuses ou exposaient son fils à un préjudice physique ou psychologique[169]. Les décisions des tribunaux nationaux sur le retrait du droit de visite du requérant a rendu toute forme de contact et la continuation de toute sorte de vie familiale impossible, malgré le fait que la rupture totale de contact ne pouvait être justifiée que dans des circonstances exceptionnelles[170]. La CouEDH a donc jugé qu'il n'y avait pas eu de lien de proportionnalité raisonnable entre une interdiction totale du droit de visite du requérant et l'objectif poursuivi, à savoir la protection de l'intérêt supérieur de l'enfant[171].

Exemple : l'affaire *Salgueiro da Silva Mouta c. Portugal*[172] a été portée par un père qui revendiquait la responsabilité parentale de son enfant. Il soutenait que, dans la procédure nationale, les autorités portugaises avaient rejeté sa demande et attribué la responsabilité parentale à la mère en raison de son orientation sexuelle. La CouEDH a jugé que les autorités nationales ont effectivement refusé la garde au motif qu'il était homosexuel – décision qui ne repose sur aucune justification objective et raisonnable. La Cour a conclu à une violation de l'article 8 conjointement avec l'article 14 de la CEDH.

En outre, le droit de l'enfant à entretenir des relations personnelles avec ses deux parents est expressément cité dans la Convention sur les relations personnelles concernant les enfants du CdE[173]. L'article 4, paragraphe 1, de cette convention dispose qu'un « enfant et ses parents ont le droit d'obtenir et d'entretenir des relations personnelles régulières ». Les principes généraux qu'il convient d'appliquer dans la jurisprudence sur le contact soulignent le droit d'un enfant d'être informé et consulté et d'exprimer son opinion, qui doit être dûment prise en compte.

168 CouEDH, *Vojnity c. Hongrie*, n° 29617/07, 12 février 2013, para. 22.

169 *Ibid.*, para. 38.

170 *Ibid.*, para. 41.

171 *Ibid.*, para. 43.

172 CouEDH, *Salgueiro da Silva Mouta c. Portugal*, n° 33290/96, 21 décembre 1999.

173 CdE, Convention sur les relations personnelles concernant les enfants, STCE n° 192, 2003. Voir aussi Organisation mondiale pour la coopération transfrontalière en matière civile et commerciale (1996), Conférence de La Haye de droit international privé, Convention concernant la compétence, la loi applicable, la reconnaissance, l'exécution et la coopération en matière de responsabilité parentale et de mesures de protection des enfants.

L'article 6 de la Convention européenne sur l'exercice des droits des enfants du CdE définit plus avant les étapes nécessaires du processus décisionnel, notamment les obligations légales[174] : d'examiner si l'autorité judiciaire dispose d'informations suffisantes afin de prendre une décision dans l'intérêt supérieur de l'enfant ; de garantir le droit de l'enfant à recevoir des informations sur le processus et les résultats ; et de ménager un espace sûr pour les enfants concernés afin qu'ils puissent exprimer librement leur opinion d'une façon appropriée à leur âge et maturité.

Il est possible que les enfants soient séparés de l'un de leurs parents d'une autre façon, par exemple en raison de l'emprisonnement de ce parent. La CouEDH a été confrontée à cette situation dans l'affaire *Horych c. Pologne*[175], qui concernait la question des conditions dans lesquelles le requérant, un détenu qualifié de dangereux, avait reçu des visites de ses filles mineures. Elle a noté que les visites d'enfants en prison nécessitent des dispositions particulières et peuvent être soumises à des conditions spéciales en fonction de leur âge, des effets potentiels sur leur état émotionnel ou leur bien-être et des circonstances personnelles de la personne à qui ils rendent visite[176]. La Cour a ajouté que les obligations positives de l'État en vertu de l'article 8 incluent le devoir de garantir les conditions adéquates, engendrant le moins de stress possible pour les visiteurs, pour les visites d'enfants, compte tenu des conséquences pratiques de l'emprisonnement[177].

Enfin, le droit des enfants privés de la liberté d'entretenir le contact avec leurs parents est renforcé par certaines dispositions des Lignes directrices du Conseil de l'Europe sur une justice adaptée aux enfants[178]. Ces lignes directrices affirment expressément le droit des enfants privés de leur liberté « de maintenir des contacts réguliers et significatifs avec leurs parents [et] famille » (Article 21, point a)) (voir aussi chapitre 11).

Dans le droit international, le droit d'entretenir des contacts avec ses deux parents est prévu à l'article 9, paragraphe 3, de la CRC : « Les États parties respectent le droit de l'enfant séparé de ses deux parents ou de l'un d'eux d'entretenir régulièrement des relations personnelles et des contacts directs avec ses deux parents, sauf si cela est contraire à l'intérêt supérieur de l'enfant. »

174 CdE, Convention européenne sur l'exercice des droits des enfants, STCE n° 160, 1996.

175 CouEDH, *Horych c. Pologne*, n° 13621/08, 17 avril 2012.

176 *Ibid.*, para. 131.

177 *Ibid.*, para. 131.

178 CdE, Comité des Ministres (2010), *Lignes directrices sur une justice adaptée aux enfants*.

5.4. Déplacement sans droit d'enfant au-delà d'une frontière – enlèvement d'enfant

Points clés

- La CouEDH exige une approche fondée sur les droits de l'enfant pour les déplacements sans droit en violation des accords sur la garde : l'article 8 de la CEDH (respect de la vie privée et familiale) doit être interprété en liaison avec la Convention de La Haye et la CRC.
- Plus spécifiquement, conformément au droit de l'UE, l'enfant doit être entendu durant les délibérations liées à son retour après son déplacement ou non-retour illicite.

L'enlèvement d'enfant désigne une situation dans laquelle un enfant est déplacé ou retenu illicitement dans un autre pays en violation du droit de garde (article 3 de la Convention de La Haye sur les aspects civils de l'enlèvement international d'enfants[179] (Convention de La Haye)). En vertu de la Convention de La Haye, les enfants déplacés ou retenus illicitement doivent être restitués d'urgence à leur pays de résidence habituelle (article 11, paragraphe 1). Les tribunaux du pays de résidence habituelle jugent du bien-fondé du litige relatif à la garde. Les tribunaux du pays d'où a été déplacé l'enfant doivent ordonner son retour dans un délai de six semaines à compter de leur saisine (article 11). La Convention de La Haye repose sur le principe de l'intérêt supérieur de l'enfant. Cette convention part du principe que le déplacement illicite d'un enfant est nuisible en lui-même et que le *statu quo ante* doit être rétabli le plus rapidement possible pour éviter la consolidation légale de situations illicites. Les questions liées à la garde et aux visites doivent être tranchées par les tribunaux compétents dans le pays de résidence habituelle de l'enfant plutôt que par ceux du pays vers lequel l'enfant a été déplacé illicitement. Plusieurs exceptions limitées au mécanisme de retour sont définies dans les articles 12, 13, et 20 de la Convention de La Haye. L'article 13 contient les dispositions qui ont donné lieu à la majorité des litiges, au niveau national et international. Il dispose que le pays vers lequel l'enfant a été déplacé peut refuser d'ordonner le retour de l'enfant s'il existe un risque

179 Organisation mondiale pour la coopération transfrontalière en matière civile et commerciale (1980), Conférence de La Haye de droit international privé, Convention de La Haye du 25 octobre 1980 sur les aspects civils de l'enlèvement international d'enfants, 25 octobre 1980.

grave que le retour de l'enfant ne l'expose à un danger physique ou psychique, ou de toute autre manière ne le place dans une situation intolérable (article 13, point b)). Le retour de l'enfant peut également être refusé si celui-ci s'oppose à son retour et qu'il a atteint une maturité suffisante pour exprimer son opinion (article 13, paragraphe 2).

Dans le droit de l'UE, le principal instrument réglementant l'enlèvement d'enfant entre les États membres de l'UE est le règlement Bruxelles II bis[180], largement fondé sur les dispositions de la Convention de La Haye. Ce règlement complète et prime sur la Convention de La Haye dans les affaires d'enlèvement au sein de l'UE (considérant 17 du Préambule et article 60, point e)). Bien que la Convention de La Haye reste le principal instrument en matière d'enlèvement d'enfant, Bruxelles II bis a dans une certaine mesure « durci » les règles juridictionnelles en faveur des tribunaux du pays d'origine/de résidence habituelle. De même que pour la Convention de La Haye, les tribunaux de l'État où l'enfant étant habituellement résident juste avant son déplacement/non-retour illicite restent compétents pour les affaires d'enlèvement d'enfant. Cette réglementation maintient les mêmes exceptions au retour que celles prévues par la Convention sur l'enlèvement d'enfants.

Toutefois, selon le règlement Bruxelles II bis, contrairement à la Convention de La Haye, l'État de résidence habituelle demeure compétent pour juger du bien-fondé du conflit lié à la garde même après un ordre de non-retour émis en application de l'article 13, point b), de la Convention de La Haye (article 11, paragraphes 6 à 8, du règlement Bruxelles II bis). Le passage de compétence à l'État vers lequel l'enfant a été déplacé peut avoir lieu uniquement dans deux situations, prévues par l'article 10 du règlement Bruxelles II bis. La première situation prévoit que les tribunaux de l'État de refuge auront compétence si l'enfant a acquis une résidence habituelle dans cet État et que toute personne ayant le droit de garde a acquiescé au déplacement ou au non-retour[181]. La deuxième situation se présente lorsque : l'enfant a acquis une résidence habituelle dans l'État vers lequel il a été déplacé ; une période d'au moins un an s'est écoulée après que le parent qui avait le droit de garde a eu ou aurait dû avoir connaissance du lieu où se trouvait l'enfant ; l'enfant s'est intégré dans son nouvel environnement ; et au moins

180 Conseil de l'UE (2003), Règlement du Conseil (CE) n° 2201/2003 du 27 novembre 2003 relatif à la compétence, la reconnaissance et l'exécution des décisions en matière matrimoniale et en matière de responsabilité parentale des enfants communs, abrogeant le règlement (CE) n° 1347/2000, JO 2003 L 338.

181 Règlement Bruxelles II bis, art. 10, point a).

une des quatre conditions énumérées dans l'article 10, point b, du règlement Bruxelles II bis est remplie[182].

Comme les autres instruments juridiques de l'UE, il convient d'interpréter le règlement Bruxelles II bis conformément aux dispositions de la Charte des droits fondamentaux, en particulier l'article 24. La CJUE a eu l'occasion de clarifier l'interprétation de l'article 24 de la Charte eu égard aux enlèvements d'enfant. Comme indiqué dans la section 2.4, la CJUE a jugé dans l'affaire *Aguirre Zarraga* que le droit de l'enfant d'être entendu, inscrit dans l'article 24 de la Charte, nécessite que les procédures et les conditions juridiques qui permettent aux enfants d'exprimer librement leur opinion doivent être rendues accessibles et que cette opinion soit obtenue par le tribunal[183]. Toutefois, selon la CJUE, seuls les tribunaux du pays de résidence habituelle de l'enfant sont habilités à juger de la légalité de leurs propres jugements sous l'angle de la Charte des droits fondamentaux et du règlement Bruxelles II bis. En vertu du principe de confiance mutuelle, les systèmes juridiques des États membres doivent fournir une protection efficace et équivalente des droits fondamentaux. Toute contestation fondée sur les droits de l'homme doivent donc être portées par les parties concernées devant les tribunaux compétents pour juger du bien-fondé du litige lié à la garde en application du règlement. La CJUE a statué que le tribunal d'un État membre vers lequel l'enfant avait été illicitement déplacé ne pouvait s'opposer à l'exécution d'un jugement certifié ordonnant le retour de l'enfant étant donné que seul l'État d'où avait été déplacé l'enfant était compétent pour juger s'il y avait violation de ces dispositions.

Exemple : l'affaire *Povse c. Alpago*[184] concerne le déplacement illicite d'une fillette vers l'Autriche par sa mère. Les tribunaux autrichiens ont rejeté la demande de retour de la fillette en Italie déposée par le père au motif

182 L'article 10, point b), du règlement Bruxelles II bis prévoit les quatre conditions suivantes : i) dans un délai d'un an après que le titulaire d'un droit de garde a eu ou aurait dû avoir connaissance du lieu où se trouvait l'enfant, aucune demande de retour n'a été faite auprès des autorités compétentes de l'État membre où l'enfant a été déplacé ou est retenu ; ii) une demande de retour présentée par le titulaire d'un droit de garde a été retirée et aucune nouvelle demande n'a été présentée dans le délai fixé au point i) ; iii) une affaire portée devant une juridiction de l'État membre dans lequel l'enfant avait sa résidence habituelle immédiatement avant son déplacement ou son non-retour illicites a été close en application de l'article 11, para. 7 ; point iv) une décision de garde n'impliquant pas le retour de l'enfant a été rendue par les juridictions de l'État membre dans lequel l'enfant avait sa résidence habituelle immédiatement avant son déplacement ou son non-retour illicites.

183 CJUE, C-491/10 PPU, *Joseba Adoni Aguirre Zarraga c. Simone Pelz*, 22 décembre 2010. Pour les aspects concernant la participation de l'enfant à cette affaire, voir l'analyse de la section 2.4.

184 CJUE, C-211/10, *Doris Povse c. Mauro Alpago*, 1er juillet 2010.

qu'il y avait un risque grave de préjudice pour l'enfant. Sur la requête du père, le tribunal italien a, quant à lui, estimé qu'il demeurait compétent pour juger du bien-fondé du litige lié à la garde et a ordonné le retour de l'enfant en Italie et émis un certificat d'exécution en vertu de l'article 42 du règlement Bruxelles II bis. L'affaire a été renvoyée à la CJUE par un tribunal autrichien suite à l'appel de la mère contre la demande d'exécution du certificat visant au retour de l'enfant en Italie. La CJUE a jugé qu'une fois qu'un certificat d'exécution est émis, il n'est plus possible de s'opposer au retour de l'enfant dans le pays requérant (ici, l'Autriche), car le certificat est automatiquement exécutable. En outre, la CJUE a jugé que, dans cette affaire, seuls les tribunaux italiens étaient compétents pour juger du risque grave lié au retour de l'enfant par rapport à son intérêt supérieur. Dans l'hypothèse où ces tribunaux considéreraient ce risque comme justifié, ils étaient les seuls compétents pour suspendre leur propre titre exécutoire[185].

Dans le droit du CdE, la Convention européenne sur la reconnaissance et l'exécution des décisions en matière de garde des enfants et le rétablissement de la garde des enfants du CdE[186]et la Convention sur les relations personnelles concernant les enfants[187] prévoient des garanties pour empêcher le déplacement illicite d'enfants et assurer le retour des enfants[188].

La CouEDH traite souvent d'affaires d'enlèvement d'enfant pour lesquelles elle est généralement guidée par les dispositions de la Convention de La Haye quand elle doit interpréter l'article 8 de la CEDH. Mais la CouEDH effectue systématiquement une analyse de l'intérêt supérieur de l'enfant dans ces affaires. Deux arrêts majeurs de la Grande Chambre reflètent la position de la Cour en la matière.

Exemple : l'affaire *Neulinger et Shuruk c. Suisse*[189] a été portée par une mère qui avait déplacé son fils d'Israël en Suisse en violation de l'accord conclu sur le droit de garde. Comme suite à la requête du père en vertu de

185 Une requête basée sur les mêmes faits a été plus tard déposée par la CouEDH et déclarée irrecevable. Voir CouEDH, *Povse c. Autriche*, décision d'irrecevabilité, n° 3890/11, 18 juin 2013.

186 CdE, Convention européenne sur la reconnaissance et l'exécution des décisions en matière de garde des enfants et le rétablissement de la garde des enfants, STCE n° 105, 1980.

187 CdE, Convention sur les relations personnelles concernant les enfants, STCE n° 192, 2003.

188 *Ibid.*, arts. 10, point b), et 16, respectivement ; CdE, Convention européenne sur la reconnaissance et l'exécution des décisions en matière de garde des enfants et le rétablissement de la garde des enfants, STCE n° 105, 1980, art. 8.

189 CouEDH, *Neulinger et Shuruk c. Suisse* [GC], n° 41615/07, 6 juillet 2010.

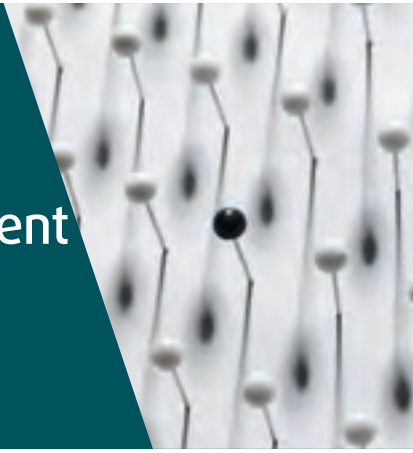
la Convention de La Haye, les autorités suisses ont ordonné le retour de l'enfant en Israël. Selon les tribunaux et les experts nationaux, le retour de l'enfant en Israël ne pouvait être envisagé que si l'enfant était accompagné de sa mère. La mesure en question demeurait dans la marge d'appréciation accordée aux autorités nationales en la matière. Néanmoins, pour évaluer le respect de l'article 8 de la CEDH, il était aussi nécessaire de tenir compte de tout développement depuis le jugement de la Cour fédérale qui ordonnait le retour de l'enfant. Dans le cas présent, l'enfant était de nationalité suisse et s'était bien intégré dans le pays où il vivait de façon continue depuis quatre ans environ. Même s'il avait un âge où il avait encore une grande capacité d'adaptation, le fait d'être de nouveau déplacé aurait probablement des conséquences graves sur lui et devait être pondéré par rapport aux bénéfices qu'il était susceptible d'en retirer. Il convenait aussi de noter que les restrictions de droit de visite du père avaient été imposées avant le déplacement de l'enfant. En outre, le père s'était remarié deux fois depuis et était de nouveau père mais ne versait pas de pension alimentaire pour sa fille. La CouEDH a douté que ces circonstances puissent contribuer au bien-être et à l'épanouissement de l'enfant. Quant à la mère, son retour en Israël pouvait l'exposer à un risque de sanctions pénales, comme une peine de prison. Il était clair qu'une telle situation ne serait pas dans l'intérêt supérieur de l'enfant, sa mère représentant sans doute la seule personne de référence. Le refus de la mère de retourner en Israël n'était donc pas totalement injustifié. En outre, le père n'avait jamais habité seul avec l'enfant et ne l'avait pas revu depuis son départ à l'âge de deux ans. La CouEDH n'était donc pas convaincue qu'il serait dans l'intérêt supérieur de l'enfant de retourner en Israël. Pour la mère, un retour en Israël constituerait une ingérence disproportionnée dans son droit au respect de la vie familiale. En conséquence, il y aurait violation de l'article 8 de la CEDH pour les deux requérants si la décision ordonnant le retour du second requérant en Israël était exécutée.

Exemple : dans *X c. Lettonie*[190], la mère a fait valoir que le retour de sa fille en Australie, d'où elle avait été déplacée illicitement, l'exposerait à un grave préjudice. Lors des délibérations visant à déterminer si les décisions des tribunaux nationaux avaient ménagé un juste équilibre entre les intérêts divergents en jeu, dans les limites de la marge d'appréciation accordée aux États en la matière, l'intérêt supérieur de l'enfant devait constituer une

190 CouEDH, *X c. Lettonie* [GC], n° 27853/09, 26 novembre 2013, paras. 101, 106, 107 et 115-119.

considération primordiale. Pour aboutir à une interprétation cohérente de la CEDH et de la Convention de La Haye, les facteurs pouvant constituer une exception au retour immédiat de l'enfant en vertu des articles 12, 13 et 20 de la Convention de La Haye devaient être dûment pris en compte par l'État requis, qui devait rendre une décision suffisamment raisonnée sur ce point, puis évaluée sous l'angle de l'article 8 de la CEDH. Cet article imposait une obligation procédurale aux autorités nationales lors de l'évaluation d'une demande de retour d'un enfant, les tribunaux devant tenir compte des allégations contestables d'un « risque grave » pour l'enfant en cas de retour et statuer en donnant les raisons spécifiques. Concernant la nature exacte du « risque grave », l'exception prévue par l'article 13, point b), de la Convention de La Haye concernait uniquement les situations qui dépassent ce qu'un enfant peut raisonnablement supporter. Dans le cas présent, la requérante avait soumis à la Cour d'appel lettonne le certificat d'un psychologue concluant qu'il existait un risque de traumatisme pour l'enfant en cas de séparation immédiate d'avec sa mère. Alors qu'il revenait aux tribunaux nationaux de vérifier l'existence d'un « risque grave » pour l'enfant et que le rapport du psychologue était directement lié à l'intérêt supérieur de l'enfant, la juridiction régionale a refusé d'examiner les conclusions de ce rapport sous l'angle des dispositions de l'article 13, point b), de la Convention de La Haye. Dans le même temps, les tribunaux nationaux n'ont pas tranché la question de savoir si la mère était en mesure de suivre sa fille en Australie et de maintenir le contact avec elle. Étant donné que les tribunaux nationaux n'ont pas pu procéder à un examen efficace des allégations de la requérante, le processus décisionnel en vertu du droit national n'a pas satisfait aux exigences procédurales inhérentes à l'article 8 de la CEDH et la requérante a donc souffert d'une ingérence disproportionnée dans son droit au respect de la vie familiale.

6 Protection de remplacement et adoption



UE	Questions traitées	CdE
Charte des droits fondamentaux de l'UE, article 7 (vie familiale) et article 24 (droits de l'enfant) Règlement Bruxelles II bis (2201/2003)	**Protection de remplacement pour les enfants privés de soins parentaux**	CEDH, article 8 (droit au respect de la vie privée et familiale) CSE (révisée), article 17 (droit des enfants et des adolescents à une protection sociale, juridique et économique) CouEDH, *Wallová et Walla c. République tchèque*, n° 23848/04, 2006 (placement en raison de conditions de logement inadéquates) CouEDH, *Saviny c. Ukraine*, n° 39948/06, 2008 (placement en raison de conditions de vie inadéquates) CouEDH, *B. c. Roumanie (n° 2)*, n° 1285/03, 2013 (participation des parents au processus décisionnel) CouEDH, *B.B. et F.B. c. Allemagne*, n° 18734/09 et 9424/11, 2013 (vices de procédure dans le processus décisionnel) CouEDH, *Olsson c. Suède (n° 1)*, n° 10465/83, 1988 (application de l'ordre de prise en charge) CouEDH, *T. c. République tchèque*, n° 19315/11, 2014 (importance du contact)

UE	Questions traitées	CdE
Charte des droits fondamentaux, article 24 (droits de l'enfant)	**Adoption**	Convention européenne en matière d'adoption des enfants (révisée) CouEDH, *Pini et autres c. Roumanie*, n° 78028/01 et 78030/01, 2004 (privilégier les intérêts de l'enfant dans l'adoption) CouEDH, *Kearns c. France*, n° 35991/04, 2008 (consentement des parents à l'adoption). CouEDH, *E.B. c. France* [GC], n° 43546/02, 2008 (capacité d'une personne célibataire homosexuelle à adopter) CouEDH, *Gas et Dubois c. France*, n° 25951/07, 2012 (capacité d'un couple de personnes de même sexe à adopter) CouEDH, *X et autres c. Autriche* [GC], n° 19010/07, 2013 (adoption par le second parent pour couple de personnes de même sexe) CouEDH, *Harroudj c. France*, n° 43631/09, 2012 (kafala et adoption)

Tout enfant a droit au respect de sa vie privée et familiale, un droit reconnu par l'article 7 de la Charte des droits fondamentaux de l'UE et l'article 8 de la Convention européenne des droits de l'homme (CEDH) (voir chapitre 5). Le droit de l'UE et le droit du Conseil de l'Europe rendent compte de l'importance des relations familiales pour l'enfant, et notamment le droit de l'enfant à ne pas être privé du contact avec ses parents, sauf quand cela est contraire aux intérêts de l'enfant[191]. Il est difficile de trouver un équilibre entre s'assurer que l'enfant reste avec sa famille, conformément au respect de la vie familiale, et garantir la protection de l'enfant contre tout préjudice. Lorsqu'un enfant est séparé de sa famille, il peut être placé dans un foyer d'accueil ou dans un hébergement institutionnel. La vie familiale ne s'achève pas avec la séparation et nécessite un maintien du contact afin d'encourager le regroupement familial si cela est dans l'intérêt supérieur de l'enfant. Dans certains cas la séparation est permanente, notamment par le biais d'une adoption. La finalité même de l'adoption implique de respecter des exigences strictes.

Ce chapitre vise à examiner le droit européen en matière de protection de remplacement. Au niveau de l'UE, la question des aspects procéduraux transfrontaliers liés au placement d'enfants dans des structures alternatives est principalement couverte par le règlement Bruxelles II bis. Ce règlement doit être interprété

191 UE (2012), Charte des droits fondamentaux de l'Union européenne, JO 2012 C 326, art. 24 (3).

conformément à la Charte des droits fondamentaux de l'UE, en particulier l'article 24. La CouEDH a également développé une importante jurisprudence traitant des aspects procéduraux et de fond liés au placement d'enfants dans des structures alternatives.

La section 6.1 donne une introduction à certains principes généraux régissant la situation des enfants privés de soins parentaux, la section 6.2 présente la législation concernant le retrait des enfants de la famille pour un placement dans des structures de remplacement et la section 6.3 examine les normes européennes en matière d'adoption.

6.1. Protection de remplacement : principes généraux

Points clés

- Le placement en structure de remplacement représente une mesure de protection temporaire.
- Le droit international confirme que la prise en charge dans un cadre familial doit être privilégiée à un hébergement institutionnel.
- Les enfants ont le droit de recevoir et de communiquer des informations ainsi que d'exprimer leur opinion concernant le placement en structure alternative.

En vertu du droit de l'UE, du droit du Conseil de l'Europe et du droit international, six grands principes apparaissent en matière de protection de remplacement.

En premier lieu, la protection de remplacement est une mesure visant à assurer la protection temporaire des enfants et à faciliter le retour des enfants au sein de leur famille quand cela est possible.[192] Dans l'idéal, il s'agit donc d'une mesure temporaire. Il peut s'agir d'une mesure de protection dans l'attente d'un regroupement familial, par exemple pour les enfants migrants non accompagnés ou

192 ONU, Assemblée générale (2010), *Lignes directrices relatives à la protection de remplacement pour les enfants*, A/RES/64/142, 24 février 2010, points 48 à 51 ; ONU, Comité des droits de l'enfant (2013), *Observation générale n° 14 (2013) sur le droit de l'enfant à ce que son intérêt supérieur soit une considération primordiale (art. 3, para. 1)*, CRC/C/GC/14, points 58 à 70.

séparés de leur famille.[193] Il peut également s'agir d'une mesure de protection dans l'attente d'une évolution de la vie familiale, par exemple une amélioration de la santé d'un parent ou l'apport d'un soutien aux parents.

Deuxièmement, le droit international confirme que la prise en charge dans un cadre familial (tel qu'un placement dans une famille d'accueil) est la forme la plus adaptée de protection de remplacement garantissant la protection et le développement de l'enfant. Ceci est réaffirmé par les *Lignes directrices relatives à la protection de remplacement pour les enfants* de l'ONU et la Convention de l'ONU relative aux droits des personnes handicapées (CRPD) dont l'UE est signataire.[194] La CRPD déclare expressément que « les États Parties s'engagent, lorsque la famille immédiate n'est pas en mesure de s'occuper d'un enfant handicapé, à ne négliger aucun effort pour assurer la prise en charge de l'enfant par la famille élargie et, si cela n'est pas possible, dans un cadre familial au sein de la communauté »[195]. Le placement hors du foyer parental (par exemple un placement en institution) « devrait être limité aux cas où cette solution est particulièrement appropriée, nécessaire et constructive pour l'enfant concerné et répond à son intérêt supérieur »[196].

Troisièmement, le droit de l'enfant à avoir un tuteur ou un représentant légal comme élément principal permettant d'accéder à des droits plus larges[197]. Bien que le droit de l'UE ne prévoie explicitement aucune obligation générale de désigner un tuteur pour les enfants n'étant pas pris en charge par leur famille, au moins sept directives européennes exigent des États membres qu'ils désignent un tuteur pour les enfants dans différentes situations, dont certaines directement

193 ONU, Assemblée générale, Convention relative aux droits de l'enfant, 20 novembre 1989, art. 22 ; ONU, Comité des droits de l'enfant (2005), *Observation générale n° 6 (2005), Traitement des enfants non accompagnés et des enfants séparés en dehors de leur pays d'origine*, CRC/GC/2005/6, 1er septembre 2005, points 81 à 83.

194 ONU, Assemblée générale (2010), *Lignes directrices relatives à la protection de remplacement pour les enfants*, A/RES/64/142, 24 février 2010, points 20 à 22 ; ONU, Comité des droits de l'enfant (2006), *Observation générale n° 7 (2005), Mise en œuvre des droits de l'enfant dans la petite enfance*, CRC/C/GC/7/Rev.136 (b), 20 septembre 2006, point 18. ONU, Convention relative aux droits des personnes handicapées (CRPD), 13 décembre 2006, art. 23 (5) (voir également art. 7).

195 ONU, Convention relative aux droits des personnes handicapées (CRPD), 13 décembre 2006, art. 23 (5).

196 ONU, Assemblée générale (2010), *Lignes directrices relatives à la protection de remplacement pour les enfants*, A/RES/64/142, 24 février 2010, point 21.

197 FRA (2014a), p. 31.

liées à des enfants n'étant pas pris en charge par leur famille[198]. Par ailleurs, ce corpus législatif est étayé par les Lignes directrices des Nations Unies relatives à la protection de remplacement pour les enfants (généralement concernant les enfants sans protection parentale), la CRC (plus précisément concernant les enfants non accompagnés), et la Convention du Conseil de l'Europe sur la lutte contre la traite des êtres humains.[199] Bien souvent, le mandat du tuteur légal vise à protéger l'intérêt supérieur de l'enfant, s'assurer de son bien-être, et compenser sa capacité juridique limitée (ainsi que parfois exercer sa représentation légale)[200].

Le quatrième principe est implicitement compris dans l'article 24 de la Charte des droits fondamentaux de l'UE, et concerne l'obligation légale de prendre des mesures positives afin que le processus décisionnel lié au placement de l'enfant soit guidé par son intérêt supérieur[201] et que son opinion soit prise en compte[202]. Les observations générales n° 5 et 14 du Comité des droits de l'enfant[203] ainsi que les Lignes directrices des Nations Unies relatives à la protection de remplacement pour les enfants insistent sur la nécessité d'assurer le droit de l'enfant à recevoir des informations, y compris à propos de ses droits et de ses options, ainsi que le droit de l'enfant à « être consulté et de voir ses opinions dûment prises en considération, compte tenu de ses capacités »[204].

Cinquièmement, les droits plus larges des enfants définies dans la Charte des droits fondamentaux de l'UE, la CEDH et la CRC restent applicables en cas de placement en structure de remplacement (famille d'accueil ou institution). Ils

198 *Ibid.*, p. 14.

199 ONU, Assemblée générale (2010), *Lignes directrices relatives à la protection de remplacement pour les enfants*, A/RES/64/142, 24 février 2010, points 100 à 103 ; ONU, Comité des droits de l'enfant, *Observation générale n° 6 (2005), Traitement des enfants non accompagnés et des enfants séparés en dehors de leur pays d'origine*, CRC/GC/2005/6, points 33 à 38 ; CdE, Convention sur la lutte contre la traite des êtres humains, STCE n° 197, 2005, art. 10 (4).

200 FRA (2014a), p. 15.

201 ONU, Comité des droits de l'enfant (2013), *Observation générale n° 14 (2013) sur le droit de l'enfant à ce que son intérêt supérieur soit une considération primordiale (art. 3, para. 1)*, CRC/C/GC/14.

202 ONU, Comité des droits de l'enfant (2009), *Observation générale n° 12 (2009), Le droit de l'enfant d'être entendu*, CRC/C/GC/12, point 97.

203 ONU, Comité des droits de l'enfant (2013), *Observation générale n° 14 (2013) sur le droit de l'enfant à ce que son intérêt supérieur soit une considération primordiale (art. 3, par. 1)*, CRC/C/GC/14, point 15 (g) ; *Observation générale n° 5 (2003), Mesures d'application générales de la Convention relative aux droits de l'enfant (art. 4, 42 et 44, par. 6)*, CRC/GC/2003/5, 27 novembre 2003, point 24.

204 ONU, Assemblée générale (2010), *Lignes directrices relatives à la protection de remplacement pour les enfants*, 24 février 2010, A/RES/64/142, point 6.

incluent des droits civiques et politiques (par ex. les droits à la vie privée, la liberté d'expression, la liberté de religion et la protection contre toutes les formes de violence), ainsi que des droits socioéconomiques (y compris les droits à l'éducation, la santé et la participation à la vie culturelle).[205]

Enfin, l'article 4 de la CRC impose aux États de prendre « toutes les mesures législatives, administratives et autres » afin de mettre en œuvre la convention. Ceci s'applique également dans le contexte de la protection de remplacement. L'article 17, paragraphe 1, point c), de la Charte sociale européenne (CSE) révisée exige également des États de prendre toutes les mesures nécessaires et appropriées tendant à assurer une protection et une aide spéciale vis-à-vis de l'enfant ou de l'adolescent temporairement ou définitivement privé de son soutien familial.

Dans le droit de l'UE, la CJUE a jugé que le règlement Bruxelles II bis s'applique aux décisions de placement d'un enfant hors du foyer familial. Comme indiqué au chapitre 5, Bruxelles II bis inclut dans son approche les principes relatifs aux droits des enfants, soulignant que l'égalité de tous les enfants, l'intérêt supérieur de l'enfant et le droit d'être entendu, notamment, doivent être pris en considération[206]. Les « motifs de non-reconnaissance des décisions en matière de responsabilité parentale » tels que mentionnés dans l'article 23 du règlement Bruxelles II bis sont intéressants à ce titre. L'article 23 dispose que les décisions rendues ne sont pas reconnues :

> *(a) si la reconnaissance est manifestement contraire à l'ordre public de l'État membre requis eu égard aux intérêts supérieurs de l'enfant ;*
> *(b) si, sauf en cas d'urgence, elle a été rendue sans que l'enfant, en violation des règles fondamentales de procédure de l'État membre requis, ait eu la possibilité d'être entendu [...].*

En vertu de ce règlement, la juridiction est déterminée en fonction de la résidence habituelle de l'enfant, sous réserve de quelques exceptions limitées, notamment l'intérêt supérieur de l'enfant (articles 8, 12 et 15 de Bruxelles II bis).

205 Charte des droits fondamentaux de l'UE, art. 3 à 4, 7, 10 à 11, 14 et 24 ; CEDH, notamment art. 8 ; et CRC, art. 13 à 14, 16, 19, 28, 29, 24, 31 et 37 ; ONU, Assemblée générale (2010), *Lignes directrices relatives à la protection de remplacement pour les enfants*, 24 février 2010, A/RES/64/142, section 2.

206 Règlement Bruxelles II bis, Préambule. Voir également chapitre 5.

Dans le droit du CdE, la CouEDH a affirmé que la famille est l'environnement naturel permettant à l'enfant de grandir et de s'épanouir. Cependant, lorsque la famille ne peut offrir à l'enfant les soins et la protection requis, un placement dans une structure de remplacement peut être nécessaire. Un retrait de la cellule familiale interfère avec le respect de la vie familiale. La CouEDH a expliqué que, dans la plupart des cas, le placement d'un enfant dans une structure de remplacement doit être considéré comme une mesure temporaire, et que l'enfant doit à terme regagner sa famille en conformité avec le droit au respect de la vie privée et familiale garanti par l'article 8 de la CEDH.[207]

Bien que la CEDH n'impose pas aux États de devoir spécifiquement fournir des soins et une protection aux enfants, l'article 17 de la CSE exige que les États « s'engagent à prendre toutes les mesures nécessaires et appropriées tendant à assurer une protection et une aide spéciale de l'État vis-à-vis de l'enfant ou de l'adolescent temporairement ou définitivement privé de son soutien familial »[208].

6.2. Placement d'enfants en structure de remplacement

Points clés

- Selon le droit du Conseil de l'Europe, le placement d'un enfant en structure de remplacement devrait être prévu par la loi, poursuivre un but légitime, et être nécessaire dans une société démocratique. Il revient à l'autorité compétente de fournir des motifs pertinents et suffisants.
- Selon le droit du Conseil de l'Europe, le processus décisionnel doit respecter certaines garanties procédurales.

Dans le droit du CdE,[209] le placement d'un enfant en structure de remplacement n'est compatible avec l'article 8 de la CEDH que s'il est conforme au droit, pour-

207 CouEDH, *K.A. c. Finlande*, n° 27751/95, 14 janvier 2003. Le Comité des Ministres du Conseil de l'Europe a approuvé cette approche dans sa Recommandation relative aux droits des enfants vivant en institution, Rec(2005)5, adoptée le 16 mars 2005.

208 CdE, Charte sociale européenne (révisée), STCE n° 163, 1996, art. 17 (1) c.

209 Le placement d'enfants en structure alternative est également un sujet de discussion politique depuis de nombreuses années au sein du Conseil de l'Europe. Voir par exemple la résolution du Comité des Ministres (77) 33 sur le placement des enfants, adoptée le 3 novembre 1977.

suit un but légitime (comme la protection de l'intérêt supérieur de l'enfant), et est considéré comme nécessaire dans une société démocratique. Ce dernier élément implique que les juridictions fournissent des raisons à la fois pertinentes et suffisantes afin d'appuyer les moyens utilisés visant à poursuivre le but recherché.

Exemple : dans l'affaire *Olsson c. Suède (n° 1)*[210], les requérants se sont plaints de la décision de placer leurs trois enfants. Considérant que la décision de placement relevait de la marge d'appréciation de l'État, la CouEDH a plus particulièrement examiné la façon dont l'ordre de placement a été mis en œuvre. Selon la Cour, la décision de placement aurait dû être considérée comme une mesure provisoire, devant être interrompue dès que les circonstances le permettaient, étant donné qu'aucune adoption n'était envisagée. Les mesures prises auraient donc dû coïncider avec l'objectif ultime de réunir la famille naturelle. Dans cette perspective, la CouEDH note que les autorités nationales ont placé les enfants dans différentes familles d'accueil relativement éloignées les unes des autres et de leurs parents. Bien que les autorités aient agi de bonne foi en mettant en œuvre l'ordre de placement, la Cour note qu'il n'est pas acceptable de déterminer où les enfants seraient placés en fonction de raisons administratives, comme le manque de places en famille d'accueil ou en hébergement. Dans un domaine si fondamental comme le respect de la vie familiale, de telles considérations ne doivent jouer qu'un rôle plus que secondaire. Ainsi, concluant à une violation de l'article 8 de la CEDH, la CouEDH a déclaré que les mesures prises par les autorités dans le cadre de l'exécution de l'ordre de placement n'étaient pas étayées par des raisons suffisantes pour les considérer comme proportionnellement justifiées par rapport au but légitime poursuivi en vertu de l'article 8.

Plus récemment, la CouEDH a examiné le bien-fondé des décisions de placement d'enfants en structure alternative relativement à l'article 8 de la CEDH.

Exemple : dans l'affaire *Wallová et Walla c. République tchèque*[211] les requérants se sont plaints du placement de leur cinq enfants dans deux familles d'accueil différentes du fait de leurs mauvaises conditions de logement. La garde des enfants avait été confiée à des familles d'accueil

210 CouEDH, *Olsson c. Suède (n° 1)*, n°10465/83, 24 mars 1988.

211 CouEDH, *Wallová et Walla c. République tchèque*, n° 23848/04, 26 octobre 2006.

en 2002 du fait de l'instabilité économique des parents, et les décisions de placement ont ensuite été levées lorsque leur situation économique et leurs conditions de logement se sont améliorées. Dans l'appréciation de cette affaire, la CouEDH a considéré que le motif soutenant la décision de placer les enfants était l'absence d'un logement convenable, et qu'il aurait donc été possible de prendre une mesure moins drastique pour régler leur situation. Selon le droit tchèque, il était possible d'organiser une surveillance des conditions de vie et d'hygiène de la famille, et de les conseiller sur la meilleure façon d'améliorer leur situation, mais cette possibilité n'a pas été exploitée. Même si les raisons justifiant le placement des enfants étaient pertinentes, elles n'étaient pas suffisantes et les autorités n'ont pas fourni assez d'efforts pour aider les requérants à surmonter leurs difficultés à l'aide de mesures alternatives. En concluant à une violation de l'article 8 de la CEDH, la Cour a également pris en compte les conclusions du Comité des droits de l'enfant de l'ONU, qui a observé que le principe de la considération primordiale des intérêts de l'enfant n'était pas suffisamment défini et pris en compte en République tchèque dans le droit, les décisions de justice et les politiques publiques concernant les enfants.

Exemple : dans l'affaire *Saviny c. Ukraine*[212], les enfants des requérants avaient été placés en raison d'un manque de moyens financiers, les autorités nationales ayant conclu que leurs qualités personnelles mettaient en péril la vie, la santé et l'éducation morale de leurs enfants. Lors de l'examen de cette affaire, la CouEDH a mis en doute le bien-fondé des éléments sur lesquels les autorités locales se sont appuyées et a conclu que les informations disponibles pour mesurer l'ampleur réelle de l'aide prodiguée par les services sociaux étaient insuffisantes. Ces informations auraient été pertinentes pour vérifier si les autorités s'étaient acquittées de leur obligation de protéger l'unité familiale et si elles avaient examiné avec suffisamment d'attention l'efficacité de mesures moins restrictives avant de chercher à séparer les enfants de leurs parents. Par ailleurs, à aucun stade de la procédure les enfants n'ont été entendus par les juges. En somme, bien que pertinents, les motifs avancés par les autorités nationales pour retirer leurs enfants aux requérants ne suffisaient pas à justifier une atteinte aussi grave au droit à la vie familiale de ceux-ci. La Cour a donc conclu à la violation de l'article 8 de la CEDH.

212 CouEDH, *Saviny c. Ukraine*, n° 39948/06, 18 décembre 2008.

Au titre de l'article 8 de la CEDH, la CouEDH exige que le processus décisionnel concernant le respect de la vie familiale respecte certaines garanties procédurales. Elle affirme que le processus décisionnel (procédures administratives et judiciaires) conduisant à des mesures d'ingérence dans la vie familiale doit être équitable et respecter les intérêts protégés par l'article 8. Ce qui est visé à l'article 8 est le fait de savoir si « les parents ont été impliqués dans le processus décisionnel [...] à un degré protégeant suffisamment leur intérêts »[213]. Cela inclut notamment de les tenir informés des développements de façon à s'assurer qu'ils peuvent participer aux décisions les concernant[214] et, dans certaines circonstances, d'écouter les enfants concernés[215].

Exemple : dans l'affaire *B. c. Roumanie (n° 2)*[216], la requérante a été diagnostiquée comme atteinte de schizophrénie paranoïde et conduite à plusieurs reprises par la police dans des services psychiatriques pour y être soignée. Ses enfants ne vivaient plus avec elle et avaient été placés dans un centre d'accueil du fait de la maladie de leur mère. La CouEDH devait examiner si, eu égard au caractère sérieux des décisions prises concernant le placement des enfants, le processus décisionnel dans son ensemble avait suffisamment protégé les intérêts des parents. À cet égard, la Cour a noté que la requérante, qui souffrait d'une sévère pathologie psychique, ne s'est pas vu désigner un avocat ou un tuteur à l'instance pour la représenter lors des procédures, de sorte qu'il lui a été impossible de participer au processus décisionnel concernant ses enfants mineurs. De plus, la situation de la requérante et la situation de ses enfants n'avaient été examinées qu'à seulement deux occasions par une cour sur une période de 12 ans avant que les deux enfants n'atteignent la majorité, et qu'il n'existait aucune preuve de contacts réguliers entre les travailleurs sociaux responsables et la requérante, lesquels auraient pu constituer un bon moyen de signaler aux autorités l'opinion de cette dernière. Pour ces raisons, la Cour a estimé que le processus décisionnel concernant le placement des enfants n'a pas suffisamment protégé ses intérêts, et qu'il y avait donc eu violation de l'article 8 de la CEDH.

213 CouEDH, *W. c. Royaume-Uni*, n° 9749/82, 8 juillet 1987, point 64.

214 CouEDH, *McMichael c. Royaume-Uni*, n° 16424/90, 24 février 1995.

215 CouEDH, *B. c. Roumanie (n°2)*, n° 1285/03, 19 février 2013 ; CouEDH, *B.B. et F.B. c. Allemagne*, n° 18734/09 et 9424/11, 14 mars 2013.

216 CouEDH, *B. c. Roumanie (n° 2)*, n° 1285/03, 19 février 2013.

Exemple : dans l'affaire *B.B. et F.B. c. Allemagne*[217], comme suite aux allégations de la fille des requérants âgée de 12 ans et de son frère âgé de 8 ans selon lesquelles ils avaient été sévèrement battus à maintes reprises, les droits parentaux concernant les deux enfants ont été transférés au Tribunal pour enfants et les enfants placés dans un foyer d'accueil. Le tribunal cantonal a donné l'ordre complet de transférer l'autorité parentale à l'office de la jeunesse en basant sa décision sur les déclarations des enfants. Un an plus tard environ, lors de la première rencontre importante avec ses parents, la fille a reconnu avoir menti et n'avoir jamais été battue, et les enfants ont alors été, par la suite, restitués à leur famille. Lors de l'examen de la plainte des requérants selon laquelle les autorités n'avaient pas examiné les faits pertinents de manière suffisamment attentive, la CouEDH a souligné que le fait que des professionnels prennent des décisions erronées ne signifie pas nécessairement que les mesures prises soient en contradiction avec l'article 8 de la CEDH. La décision de placement ne pouvait être évaluée qu'à la lumière de la situation telle que présentée aux autorités locales à cette époque. Dans la décision de la CouEDH, le fait que le tribunal cantonal ne se soit appuyé que sur les déclarations des enfants, alors que les requérants avaient fourni des déclarations de professionnels de santé n'ayant signalé aucun signe de mauvais traitement, associé au fait que le tribunal d'appel n'ait pas réexaminé les enfants, représentaient des éléments pertinents. Les enfants étant placés dans un endroit sûr à l'époque de l'audience de plein droit, il n'y avait aucune raison de se hâter, et les tribunaux auraient pu mener une enquête relative aux faits à leur vitesse, ce qu'ils n'ont pas fait. Au demeurant, les tribunaux allemands ont échoué à fournir des raisons suffisantes au retrait de l'autorité parentale des requérants, en violation de l'article 8 de la CEDH.

Même placés dans des structures alternatives, les enfants conservent le droit de maintenir le contact avec leurs parents. Ce droit a été reconnu en vertu de la CEDH[218], la CouEDH soutenant que le contact mutuel entre les parents et les enfants est un élément fondamental de la vie familiale conformément à l'article 8. Étant donné que le placement en structure de remplacement devrait normalement constituer une mesure temporaire, maintenir les relations familiales est essentiel

217 CouEDH, *B.B. et F.B. c. Allemagne*, n° 18734/09 et 9424/11, 14 mars 2013.

218 CouEDH, *Olsson c. Suède (n° 1)*, n° 10465/83, 24 mars 1988.

pour réussir le retour de l'enfant dans sa famille.[219]. Selon la CEDH, des obligations positives découlent de ces principes, comme l'illustrent les affaires suivantes.

Exemple : dans l'affaire *T. c. République tchèque*[220], la CouEDH a examiné si les droits du père et de la fille (requérants) avaient été violés par le placement de l'enfant et l'échec des autorités à maintenir le contact entre les deux. L'enfant avait été placé dans un établissement spécialisé après le décès de sa mère et après le rejet de la demande de garde du père en raison de craintes quant à sa personnalité. Ses autres demandes à plusieurs reprises de passer les vacances avec sa fille furent rejetées et le centre thérapeutique conclut que les visites n'étaient pas favorables à l'enfant car elle avait peur de lui, et tout contact a alors cessé. Ultérieurement, les tribunaux ont décidé que le contact entre les deux requérants devait être seulement épistolaire, conformément aux vœux de l'enfant. La CouEDH a insisté, en particulier, sur l'intérêt de l'enfant à maintenir les liens avec sa famille, sauf dans des cas extrêmes ne relevant pas de l'intérêt supérieur de l'enfant. Lors de l'examen de la décision de placer l'enfant, la CouEDH a noté avec satisfaction que les autorités locales avaient examiné attentivement la décision, laquelle avait été prise après avoir entendu l'avis d'experts psychologiques et psychiatriques ainsi qu'en tenant compte des souhaits de l'enfant. Il n'y a donc pas eu violation de l'article 8 de la CEDH comme suite à la décision de placer l'enfant. Toutefois, la Cour a considéré que l'article 8 avait été violé comme suite aux restrictions imposées au contact entre les requérants, notamment du fait d'un manque de contrôle exercé sur les décisions de l'établissement de résidence de l'enfant à refuser le contact, étant donné que ces décisions ont réduit de façon décisive les possibilités de regroupement familial.

Exemple : dans *K.A. c. Finlande*[221], les enfants du requérant ont été placés comme suite à des allégations de violences sexuelles. Pendant la durée du placement des enfants, les contacts entre eux et leurs parents étaient restreints et peu d'efforts ont été mis en œuvre pour organiser la réunification de la famille. Lors de l'examen de l'affaire, la CouEDH a noté que l'État avait l'obligation absolue de faciliter la réunification de la famille

219 CouEDH, *Eriksson c. Suède,* n° 11373/85, 22 juin 1989.

220 CouEDH, *T. c. République tchèque*, n° 19315/11, 17 juillet 2014.

221 CouEDH, *K.A. c. Finlande*, n° 27751/95, 14 janvier 2003.

dans un délai raisonnable, en prenant en compte le devoir de protéger l'intérêt supérieur de l'enfant. Selon la Cour, les sévères restrictions apportées au droit de visite du requérant à l'égard de ses enfants témoignent de l'intention des services sociaux de renforcer les liens entre les enfants et leur famille d'accueil et non de les réunir avec leur famille biologique. Cela a eu lieu malgré une amélioration visible de la situation du père. En conséquence, il y a bien eu violation de l'article 8 de la CEDH.

6.3. Adoption

Points clés

- L'adoption représente une solution de placement alternative lorsque les enfants ne peuvent rester avec leur famille biologique.
- Dans l'adoption, l'intérêt supérieur de l'enfant doit toujours primer sur toute autre considération.
- Selon le droit du Conseil de l'Europe ou de l'UE, il n'existe pas de droit d'adopter, mais le processus d'adoption doit répondre à certains critères afin de garantir le respect de l'intérêt supérieur de l'enfant.[220]

Selon le droit international, l'intérêt supérieur de l'enfant doit être la considération primordiale dans les affaires d'adoption. Outre les principes de l'intérêt supérieur, d'autres principes généraux édictés par la CRC orientent et appuient leur mise en œuvre dans le contexte de l'adoption : non-discrimination, droit à la vie, à la survie et au développement, ainsi que le droit d'être entendu.[223] L'observation générale n° 14 du Comité des droits de l'enfant de l'ONU est à cet égard notamment pertinente car elle évoque le « droit de l'enfant à ce que son intérêt supérieur soit une considération primordiale ».[224]

222 Sur l'intérêt de l'enfant à connaître ses origines dans le contexte de l'adoption, voir le chapitre 4.

223 CRC, art. 2, 3, 6 et 12. Voir également, ONU, Comité sur les droits de l'enfant (2010), *Lignes directrices spécifiques aux traités concernant la forme et le contenu des rapports périodiques devant être soumis par les États parties en vertu de l'article 44, paragraphe 1 (b), de la Convention relative aux droits de l'enfant*, CRC/C/58/Rev.2, 23 novembre 2010, paras. 23 à 27.

224 ONU, Comité des droits de l'enfant (2013), *Observation générale n° 14 (2013) sur le droit de l'enfant à ce que son intérêt supérieur soit une considération primordiale (art. 3, para. 1)*, CRC/C/GC/14, art. 3, para. 1.

De même, l'un des objectifs de la Convention de la Haye sur la protection des enfants et la coopération en matière d'adoption internationale est « d'établir des garanties pour que les adoptions internationales aient lieu dans l'intérêt supérieur de l'enfant et dans le respect des droits fondamentaux qui lui sont reconnus en droit international ».[225]

Dans le droit de l'UE, les droits et les devoirs liés à l'article 24 de la Charte des droits fondamentaux de l'UE sont applicables à l'adoption dans la mesure où ils sont abordés par l'UE.

Dans le droit du CdE, le droit au respect de la vie familiale, conformément à l'article 8 de la CEDH, est applicable et fondé dans les affaires d'adoption. Il existe également deux conventions spécifiques du Conseil de l'Europe sur ce sujet : la Convention européenne en matière d'adoption des enfants[226] et la Convention européenne en matière d'adoption des enfants (révisée)[227]. Ces instruments exigent que l'adoption soit considérée selon une approche fondée sur les droits de l'enfant. La Convention européenne en matière d'adoption des enfants (révisée), par exemple, déclare que « l'autorité compétente ne prononce l'adoption que si elle a acquis la conviction que l'adoption est conforme à l'intérêt supérieur de l'enfant. »[228] De même, la CouEDH souligne que l'intérêt supérieur de l'enfant peut primer sur l'intérêt des parents dans certaines situations, y compris dans l'adoption.[229] La Convention européenne en matière d'adoption des enfants (révisée) exige également que l'adoption ne soit pas prononcée par les autorités compétentes sans « le consentement de l'enfant considéré par la législation comme ayant un discernement suffisant ».[230] Par ailleurs, l'enfant n'étant pas considéré comme apte à comprendre devrait « être consulté dans la mesure du possible et son avis et ses souhaits [...] pris en considération eu égard à son degré de maturité »[231].

225 Conférence de La Haye de droit international privé, Convention de la Haye sur la Protection des enfants et la coopération en matière d'adoption internationale, 29 mai 1993, art. 1 (a).

226 CdE, Convention européenne en matière d'adoption des enfants (révisée), STCE n° 202, 2008.

227 *Ibid.* Cette convention a été ouverte à la signature en 2008 et est entrée en vigueur en 2011.

228 *Ibid.*, art. 4.1.

229 CouEDH, *Pini et autres c. Roumanie*, n° 78028/01 et 78030/01, 22 juin 2004.

230 CdE, Convention européenne en matière d'adoption des enfants (révisée), STCE n° 202, 2008, art. 5 (1) b.

231 *Ibid.*, art. 6.

Exemple : dans l'affaire *Pini et autres c. Roumanie*[232], deux couples italiens se sont plaints de la non-exécution par les autorités roumaines de la décision d'un tribunal roumain relative à l'adoption de deux enfants roumains. En violation avec les décisions du tribunal, l'établissement privé dans lequel les enfants résidaient en Roumanie avait refusé de les confier aux requérants. La CouEDH a considéré que les relations entre les requérants et leurs enfants adoptés relevaient bien de la vie familiale selon l'article 8 de la CEDH, même s'ils n'avaient jamais vécu ensemble ou établi de liens affectifs Lors de l'examen de l'affaire, la CouEDH a interprété l'article 8 à la lumière de la CRC et de la Convention de La Haye et a conclu que l'obligation incombant aux autorités de permettre aux requérants d'établir des liens familiaux avec leurs enfants adoptés a été circonscrite du fait de l'intérêt supérieur de l'enfant[233]. À cet égard, elle a considéré que l'intérêt de l'enfant pouvait, selon sa nature et sa gravité, l'emporter sur celui du parent. Par ailleurs, en concluant qu'il n'y avait pas violation de l'article 8, la Cour a estimé que l'importance à privilégier les intérêts de l'enfant par rapport à ceux des parents est accrue dans le cas d'une relation fondée sur l'adoption, car l'adoption consiste à « donner une famille à un enfant et non un enfant à une famille »[234].

Exemple : dans l'affaire *Kearns c. France*[235], la CouEDH a considéré comme conforme à la CEDH le fait qu'une femme irlandaise ayant placé son enfant en vue de son adoption en France, ne puisse retirer son consentement formel à l'issue d'un délai de deux mois. La CouEDH a tout d'abord souligné que le refus opposé par les autorités à la demande de restitution visait un but légitime, à savoir la protection des droits et libertés d'autrui, en l'espèce de l'enfant[236]. Concernant le fait d'imposer un délai de rétraction, le droit français a cherché à trouver un équilibre et une proportionnalité entre les intérêts en conflit de la mère biologique, de l'enfant et de la famille adoptive. Dans la recherche de l'équilibre entre ces différents intérêts, l'intérêt supérieur de l'enfant doit primer[237]. D'après les preuves présentées à la Cour, il était dans l'intérêt supérieur de l'enfant qu'il puisse bénéficier

232 CouEDH, *Pini et autres c. Roumanie*, n° 78028/01 et 78030/01, 22 juin 2004.

233 *Ibid.*, para. 155.

234 *Ibid.*, para. 156.

235 CouEDH, *Kearns c. France*, n° 35991/04, 10 janvier 2008.

236 *Ibid.*, point 73.

237 *Ibid.*, point 79.

rapidement de relations affectives stables, et toutes les mesures permettant de s'assurer que la requérante ait compris les implications de son acte avaient été prises. Au vu de ces considérations, la Cour a conclu que la France avait respecté ses obligations légales envers la requérante au titre de l'article 8 de la CEDH.

La CouEDH a également déclaré que le processus décisionnel relatif à l'adoption devait se faire dans le respect de l'interdiction de la discrimination établie par l'article 14 de la CEDH. La CouEDH a notamment examiné si le refus de donner l'agrément d'adoption à un requérant sur la base de l'orientation sexuelle ou de l'âge était conforme à l'article 14 combiné à l'article 8. Ce faisant, elle a réaffirmé que l'obligation de prendre des mesures proportionnées en vue de protéger l'intérêt supérieur de l'enfant était d'une importance capitale.

Exemple : dans l'affaire *Schwizgebel c. Suisse*[238], la requérante, une femme célibataire âgée de 47 ans, n'a pas pu adopter un second enfant du fait de l'écart d'âge entre elle et l'enfant qu'elle souhaitait adopter. La requérante s'est plainte d'être victime de discrimination fondée sur l'âge. La CouEDH a considéré que, dans l'affaire de la requérante, le rejet de la demande d'autorisation en vue de l'adoption poursuivait un but légitime, à savoir protéger le bien-être de l'enfant[239]. Si l'on tient compte de l'absence de consensus européen sur le droit d'adopter en tant que parent célibataire, les limites d'âge supérieure et inférieure et la différence d'âge entre l'adoptant et l'enfant, ainsi que de la marge d'appréciation considérable qu'il convient de laisser aux États dans ce domaine et de la nécessité de protéger l'intérêt supérieur des enfants, le refus d'autoriser le placement d'un deuxième enfant n'a pas transgressé le principe de proportionnalité[240]. Dès lors, la Cour a conclu que la justification avancée par le gouvernement paraît objective et raisonnable et que la différence de traitement litigieuse n'est pas discriminatoire au sens de l'article 14 de la CEDH.

Exemple : l'affaire *E.B. c. France*[241] concerne le rejet par les autorités nationales d'accorder l'agrément en vue d'adopter à la requérante, une femme lesbienne vivant avec sa partenaire et souhaitant adopter en tant

238 CouEDH, *Schwizgebel c. Suisse*, n° 25762/07, 10 juin 2010.

239 *Ibid.*, point 86.

240 *Ibid.*, point 97.

241 CouEDH, *E.B. c. France* [GC], n° 43546/02, 22 janvier 2008.

que célibataire[242]. La Cour a rappelé que l'article 8 ne garantit pas un droit à fonder une famille ni un droit d'adopter. Toutefois, la plainte pour discrimination peut relever du concept plus large d'un droit spécifique, même si le problème en question ne se réfère pas à un droit spécifique accordé par la CEDH[243]. Étant donné que le droit français autorise l'adoption d'un enfant par une personne célibataire, un tel droit ne peut être refusé sur la base de motifs personnels ou discriminatoires. Comme établi par les tribunaux nationaux, la requérante présentait des qualités humaines certaines et des capacités éducatives, ce qui servait assurément l'intérêt supérieur de l'enfant, notion clé des instruments internationaux pertinents[244]. La Cour a considéré que l'orientation sexuelle de la requérante avait joué un rôle déterminant dans le rejet de la demande d'agrément en vue d'adopter par les autorités, qui ont donc agi de manière discriminatoire par rapport à d'autres personnes célibataires ayant reçu l'agrément d'adoption conformément au droit national[245].

Exemple : l'affaire *Gas et Dubois c. France*[246] porte sur la question de savoir si des couples de même sexe doivent bénéficier du même droit que les couples hétérosexuels en matière d'adoption par le second parent. Les requérantes sont un couple de personnes de même sexe liées par un pacte civil de solidarité. Elles ont élevé ensemble une petite fille conçue par insémination artificielle et mise au monde par l'une des deux en 2000. La demande d'adoption simple de l'autre partenaire a été rejetée en se basant sur le fait que l'adoption priverait la mère biologique de l'enfant de son autorité parentale, ce qui aurait eu des conséquences contraires à l'intention des requérantes et à l'intérêt de l'enfant. Dans le droit français, le seul cas où une adoption simple n'entraîne pas la perte de l'autorité parentale par les parents biologiques en faveur des parents adoptifs est lorsqu'une personne adopte l'enfant de son époux ou épouse. Les requérants ont allégué d'une discrimination par rapport aux couples hétérosexuels mariés et non mariés. Après avoir examiné si elles avaient été discriminées par rapport à un couple marié, la CouEDH a conclu que le mariage conférait un statut particulier, ayant des conséquences sociales, personnelles et juridiques.

242 *Ibid.*, point 49.

243 *Ibid.*, points 41 à 48.

244 *Ibid.*, point 95.

245 *Ibid.*, point 96.

246 CouEDH, *Gas et Dubois c. France*, n° 25951/07, 15 mars 2012.

Pour cette raison, il a été estimé que l'on ne saurait considérer que les requérantes se trouvaient dans une situation juridique comparable à celle des couples mariés. Concernant la comparaison aux couples hétérosexuels non mariés, la Cour a relevé que des couples hétérosexuels ayant conclu un pacte civil de solidarité se verraient également refuser l'adoption simple d'après le droit français. La CouEDH a donc conclu qu'il n'y avait pas eu de différence de traitement fondée sur l'orientation sexuelle, et donc aucune violation des droits des requérantes selon la Convention.

Exemple : l'affaire *X et autres c. Autriche*[247] concerne une plainte d'un couple de personnes de même sexe ayant été discriminé par rapport à des couples hétérosexuels concernant l'adoption par le second parent. Les première et troisième requérantes entretiennent une relation stable et la première requérante souhaitait adopter le deuxième requérant, fils de la troisième requérante. Tout comme dans *Gas et Dubois*, la CouEDH a refusé l'idée selon laquelle les requérantes étaient dans une situation similaire à un couple marié dans lequel l'un des époux souhaite adopter l'enfant de l'autre époux. Cependant, la CouEDH a reconnu que les requérantes étaient dans une situation comparable à un couple hétérosexuel non marié. Alors que l'adoption par le second parent est autorisée par le droit autrichien pour les couples hétérosexuels non mariés, le code civil autrichien indique que quiconque adopte un enfant se substitue au parent biologique du même sexe, ce qui implique que l'adoption par le second parent est légalement impossible pour les couples de personnes de même sexe. La Cour a conclu que dans de telles circonstances, il y a bien eu une différence de traitement pour les requérantes fondée sur leur orientation sexuelle et qu'il n'existait pas de raisons particulièrement solides et convaincantes avancées par le gouvernement, en violation de l'article 14 combiné à l'article 8 de la CEDH.

Enfin, la CouEDH examine également plus particulièrement le bien-fondé de respecter l'esprit et l'objectif du droit international en ce qui concerne le processus décisionnel relatif à l'adoption.

247 CouEDH, *X et autres c. Autriche* [GC], n° 19010/07, 19 février 2013.

Exemple : dans l'affaire *Harroudj c. France*[248], les autorités françaises ont rejeté la demande de la requérante d'adoption plénière d'une petite fille algérienne ayant été abandonnée à la naissance et recueillie par la requérante au titre de la *kafala*, soit une forme de tutelle en droit islamique. Les raisons ayant motivé ce rejet sont le fait que le code civil français précise que l'adoption d'un enfant ne peut être prononcée si la loi de son pays l'interdit (ce qui est le cas dans le droit algérien), et que la kafala avait déjà conféré l'autorité parentale à la requérante, l'autorisant donc à prendre les décisions dans l'intérêt de l'enfant. Par la suite, l'appel de la requérante a été rejeté au motif que le droit national était conforme à la Convention de la Haye sur la protection des enfants et la coopération en matière d'adoption internationale, et que l'article 20 de la CRC avait reconnu la kafala comme préservant, au même titre que l'adoption, l'intérêt supérieur de celui-ci. Lors de l'examen de la plainte de la requérante, la CouEDH a rappelé le principe selon lequel, une fois que des liens familiaux sont établis, l'État a l'obligation d'agir de manière à permettre le développement normal de ces rapports et d'établir des garanties légales permettant l'intégration de l'enfant dans la famille, ainsi que la nécessité d'interpréter la CEDH en conformité avec les principes généraux du droit international. Dans son appréciation, la CouEDH a souligné le souci du tribunal français de respecter l'esprit et l'objectif des conventions internationales, notamment la Convention de l'ONU sur les droits de l'enfant. La kafala étant reconnue en droit français, la requérante était autorisée à exercer l'autorité parentale et à prendre des décisions dans l'intérêt de l'enfant. Il lui était possible, par exemple, d'établir un testament en faveur de l'enfant afin de remédier aux restrictions qu'engendre l'impossibilité d'adopter l'enfant. En conclusion, en contournant progressivement l'interdiction de l'adoption de cette façon, l'État défendeur, qui entend favoriser l'intégration de ces enfants sans les couper immédiatement des règles de leur pays d'origine, a fait preuve de respect envers le pluralisme culturel et trouvé un juste équilibre entre l'intérêt public et celui de la requérante. La Cour a donc conclu que les droits de la requérante n'avaient pas été violés.

248 CouEDH, *Harroudj c. France*, n° 43631/09, 4 octobre 2012.

7 Protection des enfants contre la violence et l'exploitation

UE	Questions traitées	CdE
Directive relative à la lutte contre les abus sexuels et l'exploitation sexuelle des enfants, ainsi que la pédopornographie (2011/93/UE)	**Violence à l'école, à la maison et dans d'autres institutions**	CEDH, articles 2 (droit à la vie), 3 (traitements inhumains ou dégradants.), et 8 (intégrité physique) ; protocole n° 1 de la CEDH, article 2 (droit à l'instruction) CouEDH, *Kayak c. Turquie*, n° 60444/08, 2012 (enfant poignardé à proximité de l'école) CouEDH, *O'Keeffe c. Irlande* [GC], n° 35810/09, 2014 (abus sexuels à l'école) CouEDH, *Campbell et Cosans c. Royaume-Uni*, n° 7511/76 et 7743/76, 1982 (châtiments corporels) CSE (révisée), articles 7 (droit à une protection spéciale contre les dangers physiques et moraux) et 17 (droit à la protection) CEDS, *Organisation Mondiale Contre la Torture (OMCT) c. Belgique*, plainte n° 21/2003, 2004 (interdiction des châtiments corporels en Belgique) Convention du Conseil de l'Europe sur la protection des enfants contre l'exploitation et les abus sexuels (Convention de Lanzarote) Convention du Conseil de l'Europe sur la prévention et la lutte contre la violence à l'égard des femmes et la violence domestique (Convention d'Istanbul)

UE	Questions traitées	CdE
Charte des droits fondamentaux, article 5 (2) (esclavage et travail forcé) Directive relative à la protection des jeunes au travail (94/33/CE) Directive relative à la lutte contre la traite d'êtres humains (2011/36/UE)	**Travail forcé**	CEDH, article 4 (interdiction de la servitude, de l'esclavage et du travail forcé) CouEDH, *C.N. et V. c. France*, n° 67724/09, 2012 (servitude ; obligations de l'État) CSE (révisée), article 7 (10) (protection des enfants contre les dangers physiques et moraux) Convention du Conseil de l'Europe sur la protection des enfants contre l'exploitation et les abus sexuels (Convention de Lanzarote)
Charte des droits fondamentaux de l'UE, article 5 (3) (interdiction de la traite des êtres humains) Directive relative à la lutte contre la traite d'êtres humains (2011/36/UE)	**Traite des enfants**	CEDH, article 4 (interdiction de la servitude) CouEDH, *Rantsev c. Chypre et Russie*, n° 25965/04, 2010 (manquement de l'État à enquêter sur des accusations de traite) Convention du Conseil de l'Europe sur la lutte contre la traite des êtres humains
Directive relative à la lutte contre la traite d'êtres humains (2011/36/UE)	**Pédopornographie**	CEDH, article 8 (droit au respect de la vie privée) CouEDH, *Söderman c. Suède* [GC], n° 5786/08, 2013 (enregistrement vidéo secret d'un enfant) CSE (révisée), article 7 (10) (protection des enfants contre les dangers physiques et moraux) Convention du Conseil de l'Europe sur la protection des enfants contre l'exploitation et les abus sexuels (Convention de Lanzarote) Convention sur la cybercriminalité
	Enfants appartenant à une minorité	CouEDH, *Centre de ressources juridiques au nom de Valentin Câmpeanu c. Roumanie* [GC], n° 47848/08, 2014 (décès d'un jeune homme atteint d'un grave handicap dans un établissement public)
Décision du Conseil 2010/48/CE	**Enfants handicapés**	CouEDH, *Nencheva et autres c. Bulgarie*, n° 48609/06, 2013 (décès d'un enfant dans une institution publique)
Décision 2007/116/CE de la Commission	**Enfants disparus**	CouEDH, *Zorica Jovanović c. Serbie*, n° 21794/08, 2013 (droit à recevoir des informations)

Au sens large, la protection des enfants concerne toutes les mesures destinées à garantir aux enfants l'exercice de leurs droits. Prise au sens strict, elle concerne le droit des enfants à être protégé contre toute forme de violence. Selon le droit international, les États doivent prendre les mesures nécessaires pour s'assurer que les enfants bénéficient d'une protection adéquate et que les droits à l'intégrité physique et à la dignité soient réellement respectés. Le devoir de protection de l'État peut prendre plusieurs formes selon le risque de violence spécifique auquel l'enfant est exposé et selon son auteur. Ainsi, les devoir de l'État sont plus évidents lorsque les enfants sont sous l'autorité et le contrôle de l'État, par exemple lorsqu'ils sont placés dans des établissements publics, ce qui est le cas lorsque le risque de violence est élevé. Le devoir de l'État de protéger peut s'avérer plus compliqué dans les situations où les enfants sont exposés à la violence exercée par des particuliers, comme des membres de leur famille.

La principale compétence de l'UE dans ce domaine est liée aux crimes transfrontaliers (article 83 du TFUE). Des mesures législatives particulières ont été adoptées concernant la pédopornographie et la traite d'êtres humains. L'UE a également adopté une disposition législative obligeant les États membres à d'ériger en infraction pénale diverses formes d'abus sexuels. Au niveau du Conseil de l'Europe, la CEDH (principalement les articles 2, 3 et 8) a précisé les devoirs des États relativement à un grand nombre d'actes constituant une violence contre les enfants. Le CEDS a également été actif dans ce domaine, via sa procédure de communication d'informations et son mécanisme de plainte collective. Par ailleurs, des conventions spécifiques du Conseil de l'Europe, la plus importante étant la Convention du Conseil de l'Europe sur la protection des enfants contre l'exploitation et les abus sexuels (Convention de Lanzarote)[249], sont désormais en vigueur et contrôlent les organismes responsables de surveiller leur mise en œuvre.

Ce chapitre analyse des aspects spécifiques de la violence faite aux enfants et la réponse de la communauté internationale. La section 7.1 traite de la violence à la maison, à l'école et dans d'autres institutions et examine plus particulièrement des sujets comme les châtiments corporels, la maltraitance, la négligence ainsi que la violence sexuelle. La section 7.2 analyse les cas d'exploitation des enfants présentant une dimension transfrontalière, notamment la traite d'êtres humains (à des fins de travail forcé ou d'exploitation sexuelles), la pédopornographie et le pédopiégeage (la sollicitation en ligne d'enfants à des fins sexuelles, « grooming »). Enfin, la section 7.3 traite les cas d'abus où les enfants sont dans des situations particulièrement fragiles.

249 CdE, Convention du Conseil de l'Europe sur la protection des enfants contre l'exploitation et les abus sexuels, STCE n° 201, 2007.

7.1. Violence à l'école, à la maison et dans d'autres contextes

Points clés

- Les États ont le devoir de garantir que les enfants sont bien protégés contre toute forme de violence dans tout contexte.
- Les États ont le devoir d'établir un cadre juridique adapté pour la protection des enfants.
- Les États doivent mener des enquêtes effectives en cas d'allégations d'abus d'un enfant, de violence envers un enfant ou d'atteinte à l'intégrité d'un enfant.

Dans le droit de l'UE,[250] le principal instrument juridique dans ce domaine, fondé sur les articles 82 et 83 du TFUE, est la directive 2011/93/UE sur la lutte contre les abus sexuels et l'exploitation sexuelle des enfants, ainsi que la pédopornographie[251].

Dans le droit du CdE, la CouEDH et le CEDS ont développé un important corpus de jurisprudence concernant la protection des enfants contre la violence dans tous les contextes. De plus, des conventions spécifiques du Conseil de l'Europe, telles que la Convention de Lanzarote, détaillent les garanties nécessaires pour assurer la protection des enfants contre des formes spécifiques de violence.

7.1.1. Champ et portée de la responsabilité de l'État

Dans le droit du CdE, la CouEDH a analysé les formes de violence les plus graves contre les enfants dans différents articles de la CEDH, notamment les articles 2 et 3. La Cour a défini précisément les devoirs incombant aux états lorsque les enfants sont placés dans des établissements étant sous leur autorité.[252] De même, si une certaine conduite ou situation atteint un degré de gravité pouvant être défini comme un traitement inhumain ou dégradant selon l'article 3, l'État a l'obliga-

250 Directive 2011/93/UE du Parlement européen et du Conseil du 13 décembre 2011 relative à la lutte contre les abus sexuels et l'exploitation sexuelle des enfants, ainsi que la pédopornographie, JO 2011 L 335/1.

251 *Ibid.*

252 CouEDH, *Nencheva et autres c. Bulgarie*, n° 48609/06, 18 juin 2013.

tion de protéger les enfants contre les mauvais traitements, y compris ceux du fait de particuliers. Les situations comme la négligence par les parents sur une longue période[253], des abus sexuels répétés par des enseignants,[254] le viol[255], ou les châtiments corporels[256] ont toutes été considérées comme relevant de l'article 3 de la CEDH.

En cas de décès, l'État peut être tenu pour responsable conformément à l'article 2 de la CEDH, même si le décès a été infligé par un particulier, et non par un agent de l'État. Les obligations de l'État varient selon les cas, mais son principal devoir est d'assurer la protection *effective* des enfants contre la violence. En cas de formes graves de maltraitance, les obligations incluent le devoir d'adopter des dispositions pénales efficaces appuyées par des mécanismes d'application[257]. Les États doivent adopter des mesures spéciales et des garanties pour protéger les enfants[258].

La CEDH a été confrontée à plusieurs reprises à des affaires de violences faites à des enfants par des particuliers dans des établissements scolaires, des maisons ou d'autres types d'établissements gérés par des acteurs non-étatiques et pour lesquelles la question de la responsabilité de l'État pouvait être soulevée. Plus important encore, la CouEDH a statué que l'État ne pouvait se soustraire à son obligation de protéger les enfants en déléguant l'administration de services publics majeurs (comme l'éducation) à des particuliers[259]. Dans les affaires concernant la détermination de la responsabilité de l'État, la CouEDH a généralement établi une distinction entre l'obligation générale des États de protéger lorsque le risque n'est pas clairement identifiable, et une obligation spécifique de protection dans les cas où la victime était clairement identifiable. Dans le premier cas, la CouEDH a examiné si l'absence d'intervention de l'État avait entraîné un risque de violence réel pour l'enfant victime.

253 CouEDH, *Z et autres c. Royaume-Uni* [GC], n° 29392/95, 10 mai 2001.

254 CouEDH, *O'Keeffe c. Irlande* [GC], n° 35810/09, 28 janvier 2014.

255 CouEDH, *M.C. c. Bulgarie*, n° 39272/98, 4 décembre 2003.

256 CouEDH, *Tyrer c. Royaume-Uni*, n° 5856/72, 25 avril 1978.

257 CouEDH, *M.C. c. Bulgarie*, n° 39272/98, 4 décembre 2003, para. 150.

258 CouEDH, *O'Keeffe c. Irlande* [GC], n° 35810/09, 28 janvier 2014, para. 146.

259 *Ibid.*, point 150 ; CouEDH, *Costello-Roberts c. Royaume-Uni*, n° 13134/87, 25 mars 1993, para. 27.

Exemple : l'affaire *Kayak c. Turquie*[260] concerne la mort d'un jeune homme de 15 ans après avoir été poignardé par un autre adolescent à proximité de l'école. La CouEDH a estimé que les établissements scolaires ont obligation d'assurer la protection des élèves inscrits contre toutes les formes de violences. Dans cette affaire spécifique, la CouEDH a statué que la Turquie était responsable au sens de l'article 2 de la CEDH pour avoir échoué à protéger le droit à la vie du fils et frère des requérants du fait de l'absence de système de surveillance efficace à cette époque. Du fait de l'absence d'un tel système, il a été possible pour l'adolescent de prendre un couteau dans la cuisine de l'école, dont il s'était ensuite servi pour poignarder la victime.

Exemple : l'affaire *O'Keeffe c. Irlande*[261] concerne des sévices commis dans les années 1970 dans une école nationale irlandaise. À l'époque, les écoles nationales étaient reconnues et subventionnées par l'État, tandis que la gestion et l'administration étaient organisées par l'Église. La requérante, alors élève dans cette établissement à l'époque, a subi à une vingtaine de reprises des abus sexuels par l'un des enseignants de l'école. Elle n'a porté plainte auprès des autorités publiques concernant ces actes qu'en 1998, après avoir eu connaissance d'autres abus sexuels commis par le même enseignant. La CouEDH devait statuer si l'État pouvait être tenu pour responsable des actes d'abus n'ayant pas été signalés à l'époque par les autorités. La Cour a tout d'abord estimé que les abus sexuels subis par la requérante tombaient sous l'empire de l'article 3 de la CEDH. Puis, en se basant sur de nombreux rapports, la CouEDH a estimé que l'État aurait dû être informé des éventuels risques d'abus sexuels dans les écoles. À l'époque, il n'existait pas de procédure adaptée ayant permis à un enfant ou un parent de porter plainte directement auprès de l'État au sujet de sévices. De plus, il n'existait aucun mécanisme de surveillance de la façon dont l'enseignant traitait les enfants. La CouEDH a donc conclu que l'Irlande a failli à ses obligations conformément à l'article 3 de la CEDH car elle n'avait pas mis en place de mécanisme de protection efficace pour des abus commis sur des mineurs dans des écoles.

Selon la CouEDH, les États doivent également mener des enquêtes effectives au sujet d'allégations de mauvais traitements ou en cas de décès, indépendamment de la qualité de l'auteur, à savoir si les actes ont été commis par des

260 CouEDH, *Kayak c. Turquie*, n° 60444/08, 10 juillet 2012.

261 CouEDH, *O'Keeffe c. Irlande* [GC], n° 35810/09, 28 janvier 2014.

agents de l'État[262] ou des particuliers. Une enquête est considérée comme effective lorsque, comme suite à l'enregistrement des plaintes des victimes ou de leurs successeurs, les États mettent en place une procédure capable de mener à l'identification et à la sanction des responsables de violence contraires aux articles 2 ou 3 de la CEDH.

Selon la CSE, le droit des enfants à la protection contre les abus et la maltraitance relèvent principalement des articles 7 et 17.

Par ailleurs, du fait de la Convention de Lanzarote, les États sont obligés d'ériger en infraction pénale diverses formes d'abus sexuels et d'exploitation sexuelle contre des enfants[263]. Elle exige également des États qu'ils prennent les mesures législatives ou autres qui sont nécessaires pour prévenir les abus sexuels sur les enfants, en organisant des campagnes de sensibilisation, en formant les spécialistes chargés de ces questions, en informant les enfants sur les risques d'abus et en fournissant l'aide d'un spécialiste aux personnes risquant de passer à l'acte. De plus, selon les articles 4 et 5 de la Convention du Conseil de l'Europe sur la prévention et la lutte contre la violence à l'égard des femmes et la violence domestique (Convention d'Istanbul)[264], les États s'engagent à adopter des mesures législatives spéciales et à enquêter sur les actes de violence envers les femmes. Selon l'article 22 de la Convention d'Istanbul, les États sont obligés de fournir des services de soutien spécialisés aux femmes et aux enfants victimes de violence domestique.

Selon le droit international, la CRC est l'instrument juridique principal permettant d'assurer la protection des enfants au niveau de l'État. Conformément à l'article 19, les États Parties prennent toutes les mesures législatives, administratives, sociales et éducatives appropriées pour protéger les enfants contre toute forme de violence. Le Comité des droits de l'enfant de l'ONU a publié un nombre important d'observations générales et de recommandations permettant d'interpréter les obligations des États en vertu de la CRC. Par exemple, l'observation générale n° 13 présente les mesures permettant de protéger les enfants contre

262 CouEDH, *Assenov et autres c. Bulgarie*, n° 24760/94, 28 octobre 1998.

263 CdE, *Convention du Conseil de l'Europe sur la protection des enfants contre l'exploitation et les abus sexuels*, STCE n° 201, 2007.

264 CdE, Convention du Conseil de l'Europe sur la prévention et la lutte contre la violence à l'égard des femmes et la violence domestique, STCE n° 201, 2011.

toute forme de violence[265]. L'observation générale n° 5 se réfère aux mesures permettant de mettre en œuvre et contrôler l'application de la CRC dans les législations et les politiques publiques nationales[266].

7.1.2. Châtiments corporels

Le châtiment corporel est généralement défini comme toute forme de châtiment dans lequel la force physique est employée avec l'intention de causer un certain degré de douleur ou de gêne. Bien qu'il s'agisse principalement de frapper des enfants avec la main ou un objet, cela peut également impliquer des actes qui ne sont pas physiques, par exemple des menaces, qui ont comme même résultat l'humiliation de l'enfant[267].

Dans le droit du CdE, la CouEDH a examiné les plaintes relatives à des châtiments corporels comme forme de mesure disciplinaire principalement à la lumière de l'article 3 de la CEDH. Lorsque ce type de mesure atteint le degré de sévérité mentionné à l'article 3 de la CEDH, la CouEDH a estimé que ce châtiment était en violation avec cette disposition[268]. Lorsque les châtiments corporels n'atteignent pas le seuil de sévérité mentionné à l'article 3, ils peuvent néanmoins relever de l'article 8 en tant que droit à l'intégrité physique et morale. Toutefois, la CouEDH n'a jusqu'à présent jamais conclu à une violation sur la base de l'article 8 dans les affaires de châtiments corporels. L'utilisation de châtiments corporels dans les écoles publiques va également à l'encontre des droits des parents à élever leurs enfants selon leurs convictions philosophiques, comme formulé à l'article 2 du Protocole n° 1 de la CEDH.[269]

> Exemple : les affaires *Campbell et Cosans c. Royaume-Uni*[270] concernent la suspension de deux garçons d'un établissement scolaire pour avoir refusé

265 ONU, Comité des droits de l'enfant (2011), *Observation générale n° 13 (2001), Le droit de l'enfant d'être protégé contre toutes les formes de violence*, CRC/C/GC/13, 18 avril 2011.

266 ONU, Comité des droits de l'enfant (2003), *Observation générale n° 5 (2003), Mesures d'application générales de la Convention relative aux droits de l'enfant (art. 4, 42 et 44, par. 6),* CRC/GC/2003/5.

267 ONU, Comité des droits de l'enfant (2007), *Observation générale n° 8 (2006), Le droit de l'enfant à une protection contre les châtiments corporels et les autres formes cruelles ou dégradantes de châtiments, (art. 19, 28 (par. 2) et 37, entre autres)*, CRC/C/GC/8, 2 mars 2007.

268 CouEDH, *Tyrer c. Royaume-Uni,* n° 5856/72, 25 avril 1978.

269 CouEDH, *Campbell et Cosans c. Royaume-Uni,* n° 7511/76 et 7743/76, 25 février 1982, para. 38.

270 CouEDH, *Campbell et Cosans c. Royaume-Uni,* n° 7511/76 et 7743/76, 25 février 1982.

d'accepter un châtiment corporel. La CouEDH a estimé qu'il n'y avait pas violation de l'article 3 de la CEDH car les enfants n'avaient pas été soumis à un châtiment corporel. Cependant, elle a conclu à la violation de l'article 2 du Protocole n° 1 de la CEDH sur la base du fait que, en autorisant les châtiments corporels, l'État défendeur n'avait pas respecté les convictions philosophiques des parents. La CouEDH a également estimé qu'il y avait violation du droit à l'éducation d'un des garçons conformément à l'article 2 du Protocole n° 1 de la CEDH du fait de sa suspension de l'école.

La CSE ne mentionne pas d'interdiction directe des châtiments corporels. Néanmoins, le CEDS a interprété l'article 17 de la CSE comme une obligation[271]. Le CEDS effectuant des contrôles par l'intermédiaire de procédures de communication d'informations et de mécanismes de plainte collective en conformité avec l'article 17, il a estimé que plusieurs États contractants violaient cette disposition en n'interdisant pas toutes les formes de châtiment corporel. Dans trois affaires similaires portées par l'association APPROACH (Association for the Protection of All Children) Ltd. contre la Belgique[272], la République tchèque[273], et la Slovénie[274], le CEDS a conclu à la violation de l'article 17 de la CSE car la législation de ces États manquait de textes juridiques énonçant « l'interdiction expresse et complète de toutes les formes de châtiments corporels infligés aux enfants susceptibles de porter atteinte à leur intégrité physique, à leur dignité, à leur développement ou à leur épanouissement psychique »[275]. Le CEDS a également établi que les lois interdisant les châtiments corporels sur les enfants s'appliquaient aux solutions alternatives de placement comme les hébergements institutionnels, les familles d'accueil et les crèches. À cet égard, il convient de rappeler que l'Assemblée parlementaire du Conseil de l'Europe (APCE) a publié en 2004 une recommandation exigeant des États d'interdire les châtiments corporels[276].

271 Voir, par exemple, CEDS, *Organisation Mondiale Contre la Torture (OMCT) c. Belgique*, n° 21/2003, 7 décembre 2004 ; CEDS, Conclusions XVI-2, Pologne, art. 17, para. 65.

272 CEDS, *Association pour la protection des enfants (APPROACH) Ltd c. Belgique*, n° 98/2013, 29 mai 2015, para. 49.

273 CEDS, *Association pour la protection des enfants (APPROACH) Ltd c. République tchèque*, n° 96/2013, 29 mai 2015.

274 CEDS, *Association pour la protection des enfants (APPROACH) Ltd c. Slovénie*, n° 95/2013, 27 mai 2015.

275 *Ibid.*, para. 51.

276 APCE (2004), Recommandation 1666(2004) relative à l'interdiction du châtiment corporel des enfants en Europe, 23 juin 2004.

Selon le droit international, le châtiment corporel est indirectement considéré comme une forme de violence envers les enfants selon l'article 19, l'article 28, paragraphe 2, et l'article 37 de la CRC. De plus, le Comité des droits de l'enfant a publié l'observation générale n° 8) appelant les États à prendre les mesures appropriées contre toutes les formes de châtiment corporel[277].

7.1.3. Abus sexuels

Les thèmes de la traite des enfants et de la pédopornographie sont respectivement abordés dans les sections 7.2.2 et 7.2.3.

Les abus sexuels sur mineur peuvent prendre diverses formes, dont le harcèlement, les attouchements, l'inceste ou le viol. Les abus sexuels sur mineurs peuvent avoir lieu dans des contextes variés, notamment la maison, l'école, les établissements de placement, les églises etc. Les enfants sont particulièrement vulnérables aux abus sexuels car ils sont souvent sous l'autorité et le contrôle d'adultes et ont accès moins facilement aux mécanismes de plainte.

Dans le droit de l'UE, la directive 2011/93/UE, qui reprend dans une large mesure la Convention de Lanzarote, vise à harmoniser les sanctions pénales minimales pour plusieurs types de délits sexuels sur mineurs.[278] Selon l'article 3 de cette directive, les États membres prennent les mesures de droit pénal permettant de sanctionner diverses formes d'abus sexuels, notamment le fait de faire assister des enfants à des activités sexuelles ou à des abus sexuels, et de se livrer à des activités sexuelles avec un enfant. La directive prévoit des sanctions renforcées si les infractions ont été commises par des personnes de confiance sur des enfants particulièrement vulnérables et/ou en faisant usage de la contrainte. Par ailleurs, les États membres s'assurent que la poursuite de suspects d'abus sexuels sur mineurs est automatique et que les personnes condamnées pour abus sexuels sont empêchées d'exercer des activités professionnelles impliquant des contacts directs et réguliers avec des enfants. La directive prévoit également des dispositions assurant des procédures pénales adaptées aux enfants et la protection des enfants victimes dans les tribunaux.

277 ONU, Comité des droits de l'enfant (2007), *Observation générale n° 8 (2006), Le droit de l'enfant à une protection contre les châtiments corporels et les autres formes cruelles ou dégradantes de châtiments, (art. 19, 28 (par. 2) et 37, entre autres),* CRC/C/GC/8.

278 Directive 2011/93/UE du Parlement européen et du Conseil du 13 décembre 2011 relative à la lutte contre les abus sexuels et l'exploitation sexuelle des enfants, ainsi que la pédopornographie, JO 2011 L 335/1.

La directive 2011/93/UE est rattachée à la décision-cadre 2009/315/JHA[279] sur l'organisation et le contenu des échanges d'informations entre les États membres de l'UE sur les casiers judiciaires. Bien qu'elle ne concerne pas spécifiquement les enfants, cette décision-cadre comble un vide important dans le système de protection, en s'assurant que les autorités des États membres aient accès aux casiers judiciaires des personnes condamnées. Cela facilite l'identification de personnes condamnées pour abus sexuels cherchant un emploi dans des institutions travaillant avec des enfants dans d'autres États membres.

Dans le droit du CdE, la CouEDH a examiné les affaires d'abus sexuels selon les articles 3 et 8 de la CEDH. Les plaintes concernent généralement le manquement des États à prendre les mesures appropriées pour protéger les enfants contre les abus. À la lumière de l'article 3, la CouEDH a également examiné si les États avaient mené des enquêtes effectives suite à des allégations d'abus sexuels. Les plaintes de maltraitance de mineurs présentées au titre de l'article 8 concernent l'incidence de tels actes sur l'intégrité physique de la victime et le droit au respect de la vie familiale. Parfois, la distinction est assez floue entre les obligations des États mentionnées aux articles 3 et 8, la CouEDH appliquant un raisonnement similaire pour conclure à des violations des deux articles. Il convient cependant de noter que les affaires liées à l'article 8 sont plus fréquentes dans des situations concernant un déplacement illicite ou un placement et l'incidence que des allégations d'abus sur mineur peuvent avoir sur la famille. Ces situations sont analysées au chapitre 5.

Exemple : dans *M.C. c. Bulgarie*[280] la requérante était une jeune fille de 14 ans ayant porté plainte en affirmant avoir été violée par deux personnes après une soirée. Sa plainte auprès des autorités locales a été principalement rejetée du fait de l'absence de trace de violence physique. La CouEDH a noté que les allégations de viol relevaient de l'article 3 de la CEDH et que l'État défendeur devait mener une enquête efficace sur la base de ces allégations. En concluant que les autorités bulgares avaient échoué à mener une telle enquête, la CouEDH a invoqué le fait que les autorités rejettent généralement les affaires dans lesquelles la victime n'a opposé aucune résistance physique au viol. La Cour a considéré que ce

279 Décision-cadre du Conseil 2009/315/JHA du 26 février 2009 sur l'organisation et le contenu des échanges d'informations entre les pays de l'Union européenne sur les casiers judiciaires, JO 2009 L 93, p. 23-32.

280 CouEDH, *M.C. c. Bulgarie*, n° 39272/98, 4 décembre 2003.

type de preuve n'était pas conforme avec la réalité des faits concernant les victimes de viol et pouvait donc rendre l'enquête des autorités ineffective en violation de l'article 3 de la CEDH.

Par ailleurs, la Convention de Lanzarote fixe précisément le droit des enfants à être protégés contre les abus sexuels. Cette convention adoptée dans le cadre du Conseil de l'Europe est ouverte à ratification pour des États en dehors de l'Europe. Cet instrument juridiquement contraignant est renforcé par pléthore d'instruments juridiquement non-contraignants visant à assurer que les États prennent effectivement des mesures contre les abus sexuels sur mineur.[281]

7.1.4. Violence domestique et négligence d'enfants

De nombreuses affaires de violence domestique comprennent des allégations d'abus sexuel. Dans ce contexte, les obligations des États selon le droit international sont similaires à celles mentionnées dans la section 7.1.3.

Dans le droit du CdE, ce sont souvent les mères qui portent plainte auprès de la CouEDH pour un manque de l'État de respecter son obligation de protéger contre la violence, tel qu'établi par la CEDH. Les affaires de violence domestique soulèvent des thèmes abordés aux articles 2, 3 et 8 de cette convention. Les États doivent s'acquitter de leurs obligations à prendre des mesures efficaces contre la violence domestique et à mener une enquête effective comme suite à des allégations crédibles de violence domestique ou de négligence d'enfants.

Exemple : dans l'affaire *Kontrová c. Slovaquie*[282], la requérante a été à plusieurs reprises agressée physiquement par son mari. Elle a porté plainte à la police, mais a retiré sa plainte par la suite. Son mari a ensuite menacé de tuer ses enfants. Un parent de la requérante a signalé cet incident à la police. Néanmoins, plusieurs jours après cet incident, le mari de la requérante a tué leurs deux enfants puis s'est donné la mort. La CouEDH a esti-

281 Les exemples incluent : CdE, Comité des Ministres (2001), Recommandation Rec(2001)16 sur la protection des enfants contre l'exploitation sexuelle, 31 octobre 2001 ; APCE (1996), Résolution 1099 (1996) sur l'exploitation sexuelle des enfants, 25 septembre 1996 ; APCE (2000), Résolution 1212 (2000) sur le viol dans les conflits armés, 3 avril 2000 ; APCE (2002), Résolution 1307 (2002) sur l'exploitation sexuelle des enfants : tolérance zéro, 27 septembre 2002.

282 CouEDH, *Kontrová c. Slovaquie*, n° 7510/04, 31 mai 2007.

mé que les obligations de l'État relèvent de l'article 2 de la CEDH lorsqu'il connaît ou devrait connaître l'existence d'un risque réel et immédiat pour la vie d'une personne identifiée. Dans cette affaire, les autorités slovaques auraient dû reconnaître un tel risque du fait des échanges précédents entre la requérante et la police. La police aurait dû respecter ses obligations d'enregistrer la plainte de la requérante, de lancer une enquête criminelle et d'engager des poursuites pénales, ainsi que de dûment consigner les appels d'urgence et de prendre les mesures en réaction aux allégations selon lesquelles le mari avait une arme à feu. Or la police ne s'est pas acquittée de ses obligations et ces manquements ont eu pour conséquence directe la mort des enfants de la requérante, en violation de l'article 2 de la CEDH.

Exemple : l'affaire *Eremia c. République de Moldova*[283] concerne la plainte d'une mère et de ses deux filles à propos de l'échec des autorités à les protéger du comportement violent et abusif de leur mari et père. La CouEDH a estimé que, bien qu'au fait de la situation, les autorités n'avaient pris aucune mesure effective pour protéger la mère contre la poursuite des violences domestiques dont elle faisait l'objet. Elle a ajouté que, bien que ses filles aient été psychologiquement affectées par la vision des violences commises par leur père contre leur mère au domicile familial, rien ou quasiment rien n'avait été fait pour prévenir la répétition d'un tel comportement La Cour a conclu que les autorités moldaves n'avaient pas respecté leurs obligations découlant de l'article 8 de la CEDH.

Des affaires de négligence de mineur, soit dans des établissements publics, soit au domicile familial, ont également été soulevées en vertu de la CEDH. Les obligations des autorités dans des situations de négligence d'enfant par leurs parents sont similaires à celles des affaires présentées précédemment. D'une part, l'État doit mettre en place des mécanismes effectifs pour la protection des enfants, tandis que d'autre part, les autorités de l'État doivent agir pour protéger les enfants dans des situations signalées de négligence d'enfant, ou lorsque les preuves de négligence d'enfant à leur disposition sont suffisantes, qu'il s'agisse d'un domicile privé ou d'un établissement privé.[284] Les affaires de négligence dans les établissements privés imposent aux autorités des obligations directes de protection des enfants en s'assurant qu'ils reçoivent tous les soins (médicaux)

283 CouEDH, *Eremia c. République de Moldova*, n° 3564/11, 28 mai 2013.

284 CouEDH, *Z et autres c. Royaume-Uni* [GC], n° 29392/95, 10 mai 2001.

nécessaires, que les établissements dans lesquels ils sont placé sont appropriés et/ou que l'équipe est formée pour répondre aux besoins des enfants.[285]

La Convention d'Istanbul s'applique également.[286] Bien qu'elle ne concerne pas spécifiquement les enfants, plusieurs références en font mention. Tout d'abord, selon l'article 3, point f), les filles de moins de 18 ans sont considérées comme des « femmes », et toutes les dispositions de la convention s'appliquent donc à elles. Deuxièmement, d'après l'article 2, paragraphe 2, les Parties sont encouragées à appliquer la convention à toutes les victimes de violence domestique, ce qui peut inclure les enfants. En effet, dans les plupart des cas les enfants sont témoins et sont gravement affectés par la violence domestique dans la maison familiale.[287] Enfin, les dispositions de la convention concernant spécifiquement les enfants comprennent des obligations des États à prendre les mesures répondant aux besoins des enfants victimes, à sensibiliser les enfants et à protéger les enfants témoins.

Dans le même ordre d'idée, selon l'article 17 de la CSE, les États sont obligés d'interdire toute forme de violence contre les enfants et d'adopter les dispositions légales pénales et civiles appropriées.

Les problèmes de violence domestique et de négligence d'enfants ont été abordés dans de nombreux instruments juridiquement non-contraignant du Conseil de l'Europe.[288]

285 CouEDH, *Nencheva et autres c. Bulgarie*, n° 48609/06, 18 juin 2013.

286 CdE, Convention du Conseil de l'Europe sur la prévention et la lutte contre la violence à l'égard des femmes et la violence domestique, STCE n° 201, 2011.

287 FRA (2014c), p. 134 à 135. Voir également UNICEF (2006).

288 Notamment : CdE, Comité des Ministres (1985), Recommandation n° R (85) 4 sur la violence dans la famille, 26 mars 1985 ; Comité des Ministres (1990), Recommandation n° R (90) 2 sur les mesures sociales liées à la violence dans la famille, 15 janvier 1990 ; APCE (1998), Recommandation 1371 (1998) sur les abus et la négligence de mineur, 23 avril 1998.

7.2. Exploitation d'enfants, pornographie et pédopiégeage

Point clé

- Les autorités nationales ont l'obligation de coopérer et de collaborer étroitement, y compris dans le déroulement des enquêtes, pour protéger les enfants contre la violence.

7.2.1. Travail forcé

Dans le droit de l'UE, l'esclavage, la servitude et le travail forcé ou obligatoire sont interdits (article 5, paragraphe 2, de la Charte des droits fondamentaux de l'UE). Il est également interdit de faire travailler des enfants (article 32 de la Charte). La directive 94/33/CE est le principal instrument juridique interdisant le travail des enfants.[289] Seules des circonstances exceptionnelles autorisent les États à définir l'âge minimum légal pour travailler en-dessous de l'âge minimum légal pour quitter l'école (article 4, paragraphe 2). Les États doivent s'assurer que les jeunes autorisés à travailler bénéficient de conditions de travail appropriées (articles 6 et 7). Par ailleurs, les enfants ne peuvent être employés que pour certaines activités, comme des tâches domestiques ou des activités culturelles et sociales (article 2, paragraphe 2 et article 5). Cette directive prévoit également des mesures de protection spéciales liées au travail des enfants (section III).

Dans de nombreux cas, les affaires de travail forcé des enfants impliquent des enfants victimes de traite.[290] La directive 2011/36/UE concernant la prévention et la lutte contre la traite des êtres humains reconnaît le travail forcé comme une forme d'exploitation des enfants (article 2, paragraphe 3).[291] Les enfants victimes de traite à des fins de travail forcé sont protégés par la directive au même

289 Directive du Conseil 94/33/CE du 22 juin 1994 relative à la protection des jeunes au travail, JO 1994 L 216.

290 Directive 2011/36/UE du Parlement européen et du Conseil du 15 avril 2011 concernant la prévention et la lutte contre la traite des êtres humains ainsi que la protection des victimes, JO 2011 L 101/1, considérant 11.

291 Directive 2011/36/UE du Parlement européen et du Conseil du 15 avril 2011 concernant la prévention et la lutte contre la traite des êtres humains ainsi que la protection des victimes, JO 2011 L 101/1.

titre que les victimes de traite à d'autres fins (comme l'exploitation sexuelle, voir section 7.1.3)[292].

Dans le droit du CdE, l'article 4 de la CEDH interdit de manière absolue toute forme d'esclavage, de servitude, de travail forcé ou obligatoire. La CouEDH définit le « travail forcé ou obligatoire » comme « tout travail ou service exigé d'un individu sous la menace d'une peine quelconque et pour lequel ledit individu ne s'est pas offert de son plein gré »[293]. La servitude englobe, de plus, « l'obligation pour le « serf » de vivre sur la propriété d'autrui et l'impossibilité de changer sa condition »[294]. La servitude représente une forme aggravée du travail obligatoire.

Dans les affaires liées à des allégations de travail forcé, la CouEDH doit tout d'abord déterminer si les allégations relèvent de l'article 4 de la CEDH.[295] Elle examine ensuite si les États ont satisfait à leurs obligations de mettre en place un cadre législatif et administratif interdisant, réprimant et permettant d'entamer des poursuites effectives en cas de travail forcé ou obligatoire, de servitude et d'esclavage.[296] Concernant les aspects procéduraux de l'article 4, la CouEDH étudie si les autorités nationales ont mené une enquête effective comme suite à des allégations de travail forcé ou de servitude.[297]

Exemple : l'affaire *C.N. et V. c. France*[298] concerne des plaintes pour travail forcé de deux sœurs d'origine burundaise. Après le décès de leurs parents, elles ont été confiées à leur tante et à sa famille vivant en France. Elles ont été logées pendant quatre ans dans une cave de la maison dont les conditions de salubrité étaient prétendument très mauvaises. L'aînée des sœurs n'était pas scolarisée et était occupée toute la journée à accomplir les tâches ménagères et à garder son cousin handicapé. La sœur cadette était scolarisée et travaillait pour la tante et la famille après l'école et après avoir eu le temps de faire ses devoirs. Les deux sœurs ont porté plainte auprès de la CouEDH alléguant avoir été tenues en servitude et assujetties à un travail forcé. La CouEDH a estimé que la première requérante

292 Voir en outre FRA (2015c), p. 40-41

293 CouEDH, *Siliadin c. France*, n° 73316/01, 26 juillet 2005, para. 116.

294 *Ibid.*, para. 123.

295 CouEDH, *C.N. et V. c. France*, n° 67724/09, 11 octobre 2012, para. 70.

296 *Ibid.*, para. 104 et suivant.

297 CouEDH, *C.N. c. Royaume-Uni*, n° 4239/08, 13 novembre 2012, paras. 70 à 82.

298 CouEDH, *C.N. et V. c. France*, n° 67724/09, 11 octobre 2012.

avait bien été assujettie à un travail forcé dans la mesure où elle devait travailler sept jours par semaine sans rémunération ni congés. De plus, elle a été tenue en servitude car elle avait l'impression que sa situation était permanente et qu'elle ne pourrait pas changer. La CouEDH a également estimé que l'État n'avait pas rempli ses obligations, dans la mesure où le cadre juridique en place n'avait pas permis de protéger suffisamment les victimes contre le travail obligatoire. Concernant l'obligation procédurale de mener une enquête, la CouEDH a estimé que les exigences de l'article 4 de la CEDH avaient été respectées, les autorités ayant effectivement mené une enquête rapide et indépendante ayant permis de conduire à l'identification et à la sanction des personnes responsables. La CouEDH a rejeté les allégations de travail forcé de la seconde requérante du fait qu'elle avait pu aller à l'école et qu'elle avait disposé de temps pour faire ses devoirs.

La CSE garantit le droit des enfants à être protégés contre les dangers physiques et moraux dans et à l'extérieur de l'environnement de travail (article 7, paragraphe 10). Le CEDS a déclaré que l'exploitation des enfants par le travail/les tâches domestiques, y compris la traite à des fins d'exploitation par le travail, devait être interdite au niveau national.[299] Les États Parties de la CSE doivent garantir non seulement qu'ils disposent de la législation requise pour prévenir l'exploitation et protéger les enfants et les jeunes, mais aussi que cette législation est effective en pratique.[300]

La Convention de Lanzarote dispose également que les États doivent ériger en infraction pénale toute forme d'exploitation sexuelle des enfants.

7.2.2. Traite des enfants

Dans le droit de l'UE, l'article 83 du TFUE définit la traite d'êtres humains comme un champ de compétence du Parlement européen et du Conseil de l'UE. L'article 5, paragraphe 3, de la Charte des droits fondamentaux de l'UE interdit expressément la traite des êtres humains. La contribution de l'UE est importante dans ce domaine, du fait qu'il a une dimension transnationale.

La directive 2011/36/UE concernant la prévention de la traite des êtres humains et la lutte contre ce phénomène ainsi que la protection des victimes représente

299 CEDS, Conclusions 2004, Bulgarie, p. 57.

300 CEDS, Conclusions 2006, p. 61 ; CEDS, Conclusions 2006, Bulgarie, p. 113.

le premier instrument juridique adopté par le Parlement européen et le Conseil se basant sur l'article 83 du TFUE.[301] Selon l'article 2, paragraphe 1, de cette directive, la traite est définie comme « le recrutement, le transport, le transfert, l'hébergement ou l'accueil de personnes, y compris l'échange ou le transfert du contrôle exercé sur ces personnes, par la menace de recours ou le recours à la force ou d'autres formes de contrainte, par enlèvement, fraude, tromperie, abus d'autorité ou d'une situation de vulnérabilité, ou par l'offre ou l'acceptation de paiements ou d'avantages pour obtenir le consentement d'une personne ayant autorité sur une autre, à des fins d'exploitation ». Cette directive vise à établir des règles minimales relatives à la définition des infractions et des sanctions dans le domaine de la traite des êtres humains. L'ensemble de la directive est applicable aux enfants, et elle inclut également plusieurs dispositions spécifiques aux enfants concernant l'assistance et l'aide à apporter aux enfants victimes de la traite des êtres humains, ainsi qu'à leur protection dans le cadre des enquêtes et des procédures pénales (articles 13 à 16).[302] Des mesures de soutien spécifiques doivent être prises après une appréciation individuelle de la situation particulière de chaque enfant victime (article 14, paragraphe 1). Les États doivent désigner un tuteur représentant l'intérêt supérieur de l'enfant (article 14, paragraphe 2) et fournir un soutien à la famille de l'enfant (article 14, paragraphe 3). Au cours des procédures pénales, les enfants ont le droit à une représentation, à des conseils juridiques gratuits et ont le droit d'être entendus dans des locaux appropriés et par des professionnels formés à cet effet (article 15, paragraphes 1 à 3). Les autres mesures de protection comprennent la possibilité d'une audience à huis clos et la possibilité pour l'enfant d'être entendu à l'audience sans y être présent par le recours à des technologies de communication (article 15, paragraphe 5).[303]

La directive 2004/81/CE est également pertinente pour les enfants victimes de traite.[304] Selon cet instrument, les victimes de traite peuvent bénéficier d'un titre de séjour délivré par les États membres s'ils coopèrent à l'enquête criminelle.

301 Directive 2011/36/UE du Parlement européen et du Conseil du 15 avril 2011 concernant la prévention de la traite des êtres humains et la lutte contre ce phénomène ainsi que la protection des victimes, JO 2011 L 101/1.

302 Détail des dispositions dans FRA et CouEDH (2014), p. 239.

303 Voir FRA (2015b), p. 79.

304 Directive 2004/81/CE du Conseil du 29 avril 2004 relative au titre de séjour délivré aux ressortissants de pays tiers qui sont victimes de la traite des êtres humains ou ont fait l'objet d'une aide à l'immigration clandestine et qui coopèrent avec les autorités compétentes, JO 2004 L 261, p. 19-23.

Néanmoins, la directive ne s'applique aux enfants que dans les limites fixées par les États membres.[305]

En ce qui concerne l'application, l'organisme de l'UE chargé de l'application de la loi (Europol) et l'unité de coopération judiciaire (Eurojust) jouent un rôle important en assurant la coopération entre les États membres afin de détecter et de sanctionner les réseaux organisés de traite. Les dispositions applicables au niveau de l'UE concernant la protection des enfants victimes sont présentées dans la section 11.3 de ce manuel.

Dans le droit du CdE, la CEDH ne prévoit pas de disposition expresse sur la traite. Néanmoins, la CouEDH interprète l'article 4 de la CEDH comme incluant une interdiction de la traite.[306] La Cour a adopté la même définition de la traite que celle précisée à l'article 3, point a), du Protocole visant à prévenir, réprimer et sanctionner la traite des personnes, en particulier des femmes et des enfants, remplaçant la Convention des Nations Unies contre la criminalité transnationale organisée (Protocole de Palerme) et l'article 4, point a), de la Convention du Conseil de l'Europe sur la lutte contre la traite des êtres humains.[307] La CouEDH détermine tout d'abord si une situation particulière comprend une allégation crédible de traite et si donc elle relève de la portée de l'article 4. Si tel est le cas, l'analyse de la CouEDH suit le modèle présenté dans la section 7.2.1 : la Cour examine si le cadre juridique de l'État défendeur offre une protection effective contre la traite, si l'État s'est acquitté de ses obligations dans les circonstances particulières de l'affaire, et si les autorités ont mené une enquête effective comme suite aux allégations plausibles de traite.

Exemple : dans l'affaire *Rantsev c. Chypre et Russie*[308], la plainte a été déposée par le père d'une jeune fille russe décédée dans des circonstances troubles à Chypre. Celle-ci est arrivée à Chypre avec un visa d'artiste de

305 *Ibid.*, art. 3.

306 CouEDH, *Rantsev c. Chypre et Russie*, n° 25965/04, 7 janvier 2010, para. 282.

307 ONU, Protocole visant à prévenir, réprimer et punir la traite des personnes, en particulier des femmes et des enfants, remplaçant la Convention des Nations Unies contre la criminalité transnationale organisée (UNCTOC), New York, 15 novembre 2000 ; CdE, Convention du Conseil de l'Europe sur la lutte contre la traite des êtres humains, STCE n° 197, 2005.

308 CouEDH, *Rantsev c. Chypre et Russie*, n° 25965/04, 7 janvier 2010. L'affaire ne concerne pas le décès d'un enfant ; toutefois, cette affaire mérite d'être mentionnée du fait de l'absence d'affaires de traite d'enfants et notamment au vu de la menace particulière que représente la traite d'enfants.

cabaret. Après ce qui est apparu être une tentative de fuite, elle est morte à la suite d'une chute du balcon d'un appartement appartenant à des connaissances de son employeur. Son père a déposé plainte contre Chypre et la Russie, se plaignant notamment que les autorités n'avaient pas suffisamment enquêté sur le décès de sa fille. La CouEDH a estimé pour la première fois que la traite d'êtres humains relevait de la portée de l'article 4 de la CEDH. Bien que Chypre possède un cadre juridique approprié pour lutter contre la traite, l'article 4 a été a été violé car la pratique administrative obligeant les employeurs à apporter des garanties financières pour les artistes de cabaret ne représentait pas une protection efficace contre la traite et l'exploitation. De plus, dans les circonstances particulières de cette affaire, les autorités chypriotes auraient dû être conscientes que la fille du requérant risquait d'être victime de traite. La Cour a conclu que la police n'avait pas pris les mesures permettant de protéger Melle Rantseva contre l'exploitation. Enfin, il y a eu violation de l'article 4 par la Russie, dans la mesure où les autorités russes n'ont pas mené d'enquête appropriée sur les allégations de traite.

Le CEDS considère que la traite d'êtres humains constitue une violation grave des droits de l'homme et de la dignité humaine et peut être considérée comme une nouvelle forme d'esclavage.[309] L'article 7, paragraphe 10, oblige les États à adopter une législation qui l'érige en infraction pénale.[310] Cette législation doit être renforcée par des mécanismes de surveillance appropriés, des sanctions, ainsi qu'un plan d'action visant à lutter contre la traite des enfants et l'exploitation sexuelle. [311]

Au niveau du traité, la Convention du Conseil de l'Europe sur la lutte contre la traite des êtres humains est le principal instrument lié à la traite d'êtres humains[312]. Compte tenu de l'ensemble des États membres du Conseil de l'Europe, et du fait que la Convention relative à la lutte contre la traite est ouverte à l'adhésion aux États non membres du Conseil de l'Europe,[313] elle complète la directive 2011/36/

309 CEDS, *Fédération des Associations Familiales Catholiques (FAFCE) c. Irlande*, n° 89/2013, 12 septembre 2014, para. 56.

310 CEDS, Conclusions XVII-2 (2005), Pologne, p. 638.

311 CEDS, *Fédération des Associations Familiales Catholiques (FAFCE) c. Irlande*, n° 89/2013, 12 septembre 2014, para. 57.

312 CdE, Convention du Conseil de l'Europe sur la prévention et la lutte contre la violence à l'égard des femmes et la violence domestique, STCE n° 197, 2005.

313 Par exemple, la Biélorussie a adhéré à la convention le 26 novembre 2013.

UE et représente un instrument permettant de lutter contre la traite dans les États Parties à la convention, qu'ils soient membres de l'UE ou non, sur la base de normes et d'obligations communes. La mise en œuvre de la convention est supervisée par un groupe d'experts indépendants (le Groupe d'experts sur la lutte contre la traite des êtres humains, GRETA) évaluant régulièrement la situation de chaque pays et publiant des rapports. À partir de ces rapports, le Comité des Parties à la Convention, le pilier politique du mécanisme de surveillance au titre de la convention, adopte les recommandations destinées aux États Parties sur les mesures à prendre pour mettre en œuvre les conclusions du GRETA et suit les progrès.

7.2.3. Pédopornographie et pédopiégeage

Dans le droit de l'UE, la directive 2011/93/UE est le principal instrument juridique traitant de la pédopornographie[314]. La pornographie est définie comme : « tout matériel représentant de manière visuelle un enfant se livrant à un comportement sexuellement explicite, réel ou simulé ; ii) toute représentation des organes sexuels d'un enfant à des fins principalement sexuelles ; iii) tout matériel représentant de manière visuelle une personne qui paraît être un enfant se livrant à un comportement sexuellement explicite, réel ou simulé, ou toute représentation des organes sexuels d'une personne qui paraît être un enfant, à des fins principalement sexuelles ; ou iv) des images réalistes d'un enfant se livrant à un comportement sexuellement explicite ou des images réalistes des organes sexuels d'un enfant à des fins principalement sexuelles ».[315] L'article 5 de cette directive introduit une obligation pour les États membres de l'UE de prendre toutes les mesures assurant que la production, l'acquisition, la possession, la distribution, la diffusion, la transmission intentionnelles, ou le fait d'offrir, de fournir ou de mettre à disposition intentionnellement de la pédopornographie ainsi que le fait d'accéder à ce type de contenu est passible de sanctions.

Dans le droit du CdE, la CouEDH a examiné à plusieurs reprises des affaires liées à la pédopornographie en vertu de l'article 8 de la CEDH.

314 Directive 2011/93/UE du Parlement européen et du Conseil du 13 décembre 2011 relative à la lutte contre les abus sexuels et l'exploitation sexuelle des enfants, ainsi que la pédopornographie, JO 2011 L 335/1, p. 1-14.

315 *Ibid.*, art. 2, point c.

Exemple : dans l'affaire *Söderman c. Suède*, une plainte a été déposée par une jeune fille dont le beau-père a tenté de la filmer pendant qu'elle prenait sa douche.[316] Ses allégations portaient sur le fait que le cadre juridique suédois n'avait pas suffisamment protégé sa vie privée. La CouEDH a estimé que l'État avait l'obligation de définir un cadre législatif offrant une protection appropriée aux victimes, telles que la requérante. Dans le mesure où cette affaire ne concerne qu'une tentative de filmer la requérante, la CouEDH a estimé que ce cadre législatif ne devait pas nécessairement inclure des sanctions pénales. Les recours, civil ou pénal, mis à disposition de la victime, doivent être efficaces. Sur les faits mêmes de l'affaire, la CouEDH a estimé que la requérante n'avait pas bénéficié de recours civil et pénal efficaces contre la tentative de son beau-père de la filmer, en violation de l'article 8 de la CEDH.

L'article 9 de la Convention du Conseil de l'Europe sur la cybercriminalité[317] exige des États Parties qu'ils érigent des sanctions pénales relatives au fait d'offrir, de mettre à disposition, de distribuer, de transmettre, de se procurer ou de posséder de la pédopornographie ou de produire ce type de contenu par le biais d'un système informatique. Une clause importante est que cette conduite doit être intentionnelle. Le Rapport explicatif de la Convention déclare que l'expression « matière pornographique » doit être interprétée conformément aux normes de droit interne concernant la classification du matériel comme « obscène, incompatible avec les mœurs publiques ou ayant à un autre titre un effet pervers »[318]. Néanmoins, l'obligation d'ériger en infraction pénale certains comportements doit non seulement s'appliquer au contenu représentant visuellement un mineur, mais aussi s'il contient une ou plusieurs images réalistes représentant un enfant se livrant à un comportement sexuel explicite.[319]

Par ailleurs, conformément aux articles 21 et 23 de la Convention de Lanzarote, les États doivent prendre les mesures législatives pour ériger en infraction pénale toute forme de pédopornographie. Selon l'article 21, le fait de recruter, de contraindre et de participer à des spectacles pédopornographiques doit être sanctionné pénalement. Selon l'article 22, le fait de faire assister un enfant à des abus sexuels ou à des activités sexuelles doit également être sanctionné

316 CouEDH, *Söderman c. Suède* [GC], n° 5786/08, 12 novembre 2013.

317 CdE, Convention sur la cybercriminalité, STCE n° 185, 2001.

318 Rapport explicatif du Conseil de l'Europe, Convention du Conseil de l'Europe sur la cybercriminalité, point 99.

319 CdE, Convention sur la cybercriminalité, STCE n° 185, 2001, art. 9 (2).

pénalement. Enfin, l'article 23 exige qu'une législation pénale soit adoptée en ce qui concerne le fait de solliciter des enfants à des fins sexuelles par le biais des technologies de communication et d'information. Le Comité de Lanzarote a adopté un avis relatif à cette disposition, lequel invite les États Parties à la convention à envisager d'étendre les sanctions pénales liées à la sollicitation à des affaires où l'abus sexuel ne résulte pas de la rencontre avec une personne, mais est commis en ligne.[320]

7.3. Groupes à haut risque

Point clé

- Les enfants victimes de disparition forcée ont le droit de préserver leur identité ou de la rétablir.

7.3.1. Enfants appartenant à une minorité

Dans le droit du CdE, les affaires de la CouEDH traitant spécifiquement de la violence envers les enfants appartenant à une minorité sont relativement rares en dehors du contexte de la traite d'êtres humains et du travail forcé. La plupart concerne la ségrégation dans les écoles et la discrimination, lesquelles sont analysées dans la section 3.2.

Exemple : dans l'affaire *Centre de ressources juridiques au nom de Valentin Câmpeanu c. Roumanie*, une ONG a porté plainte au nom d'un jeune homme rom décédé dans un établissement psychiatrique.[321] Il était séropositif et présentait une déficience intellectuelle grave. Des conditions épouvantables régnaient dans l'établissement dans lequel il était placé : pas de chauffage, pas de draps ni de couvertures ou de vêtements, aucune aide de la part du personnel, etc. Du fait de l'absence de parent proche de la victime, l'ONG a porté plainte en son nom pour violation des droits prévus aux articles 2, 3, 5, 8, 13 et 14 de la CEDH. La Grande Chambre a décidé que,

320 Avis du Comité de Lanzarote sur l'art. 23 de la Convention de Lanzarote et sa note explicative, 17 juin 2015.

321 CouEDH, *Centre de ressources juridiques au nom de Valentin Câmpeanu c. Roumanie* [GC], n° 47848/08, 17 juillet 2014.

au vu des circonstances exceptionnelles de l'affaire (extrême vulnérabilité et aucun parent proche connu du jeune homme), l'ONG était autorisée à représenter le requérant décédé. Sur le fond de l'affaire, la CouEDH a estimé qu'il y avait eu violation du volet matériel de l'article 2. Les autorités nationales ont été considérées comme responsable du décès de M. Câmpeanu dans la mesure où elles l'avaient placé dans un établissement dans lequel il est décédé du fait d'une mauvaise alimentation, de mauvaises conditions de vie et de l'absence de soins médicaux adaptés. La CouEDH a également conclu à la violation de l'article 2 car les autorités roumaines n'avaient pas mené d'enquête effective sur le décès de M. Câmpeanu.

Concernant les enfants vivant en institution, la Recommandation Rec(2005)5 du Conseil de l'Europe souscrit à la décision selon laquelle le placement d'un enfant ne saurait faire l'objet d'aucune discrimination.[322]

7.3.2. Enfants handicapés

Dans le droit de l'UE, l'Union européenne a ratifié la CRPD, qui est le premier traité international relatif aux droits de l'homme auquel l'UE a adhéré.[323] La CRPD prévoit des dispositions spécifiques relatives aux enfants. L'UE et ses États membres se sont engagés à assurer que les enfants handicapés puissent jouir pleinement de tous les droits de l'homme sur la base de l'égalité avec les autres enfants. Selon l'article 16 de la CRPD, ils doivent prendre des mesures spécifiques pour protéger les enfants handicapés contre toutes les formes d'abus et d'exploitation.[324]

Dans le droit du CdE, les affaires de la CouEDH concernant les enfants handicapés ont soulevé plusieurs questions, notamment le consentement, les obligations des États de protéger contre la mort et la maltraitance, et les conditions de vie dans des établissements publics.

Exemple : l'affaire *Nencheva et autres c. Bulgarie*[325] concerne le décès de 15 enfants et jeunes adultes placés dans un foyer pour enfants souffrant de

322 CdE, Comité des Ministres (2005), Recommandation Rec(2005)5 relative aux droits des enfants vivant en institution, 16 mars 2005.

323 Conseil de l'Union Européenne (2009), Décision du Conseil 2010/48/CE du 26 novembre 2009 concernant la conclusion, par la Communauté européenne, de la convention des Nations Unies relative aux droits des personnes handicapées JO 2010 L 23/35.

324 Voir également section 3.5.

325 CouEDH, *Nencheva et autres c. Bulgarie*, n° 48609/06, 18 juin 2013.

troubles mentaux et de handicaps physiques. La CouEDH a estimé que les enfants avaient été placés dans un établissement public spécialisé sous le seul contrôle de l'État. Les conditions de vie des enfants dans l'institution étaient des plus mauvaises:ils manquaient de nourriture, de médicaments, ainsi que de vêtements et de linge de lit en quantité suffisante, et vivaient dans des pièces insuffisamment chauffées en hiver. Les autorités compétentes ont été alertées de la situation à plusieurs reprises, et avaient donc, ou auraient dû avoir une connaissance exacte des risques pour la vie des enfants. La CouEDH a conclu à la violation du volet matériel de l'article 2 de la CEDH car les autorités n'avaient pas pris les mesures nécessaires à la protection de la vie des enfants sous leur contrôle. Par ailleurs, les autorités bulgares n'avaient pas mené d'enquête effective comme suite aux décès des enfants des requérants. Du fait des circonstances particulières de l'affaire, les autorités bulgares auraient dû engager d'office une enquête pénale. L'enquête s'est révélée inefficace pour plusieurs raisons : elle a commencé deux ans après le décès des enfants, elle s'est ensuite étendue sur une période déraisonnablement longue, elle n'a pas traité de tous les décès et elle n'a pas permis de faire la lumière sur toutes les circonstances concrètes de cette affaire.

7.4. Enfants disparus

Dans le droit de l'UE, la Commission européenne a mis en place une ligne d'assistance téléphonique (116000) pour les enfants disparus.[326] Ce service prend les appels signalant une disparition d'enfants et les transmet à la police, offre des conseils aux personnes responsables de l'enfant disparu, les soutient et contribue à l'enquête.

Dans le droit du CdE, la disparition forcée d'enfants est traitée dans l'article 8 de la CEDH.

Exemple : L'affaire *Zorica Jovanović c. Serbie*[327] concerne le décès allégué d'un nouveau-né à l'hôpital peu après sa naissance, mais dont le corps n'a jamais été remis aux parents. La mère a dénoncé le manquement de l'État à lui fournir des informations sur ce qu'il était réellement advenu de son fils,

326 Décision de la Commission (2007), Décision de la Commission 2007/698/CE du 29 octobre 2007 modifiant la décision 2007/116/CE en ce qui concerne l'introduction de numéros réservés, JO 2007 L 284/31.

327 CouEDH, *Zorica Jovanović c. Serbie*, n° 21794/08, 26 mars 2013.

notamment la cause du décès allégué, ou la date et l'heure de son enterrement. La CouEDH a conclu que le « manquement continu de l'État défendeur à lui fournir des informations crédibles sur ce qu'il était advenu de son fils » équivalait à une violation de son droit au respect de la vie familiale.[328]

Selon le droit de l'ONU, l'article 25, paragraphe 1, point b), de la Convention internationale pour la protection de toutes les personnes contre les disparitions forcées [329] dispose que les États doivent prendre les mesures nécessaires pour prévenir et réprimer pénalement « la falsification, la dissimulation ou la destruction de documents attestant la véritable identité » des enfants, qu'il s'agisse d'eux-mêmes ou dont les parents ont été soumis à une disparition forcée. Les États doivent également prendre les mesures nécessaires pour rechercher et identifier ces enfants, et les rendre à leur famille d'origine. Compte-tenu de ce droit des enfants à préserver et à voir rétablie leur identité, y compris leur nationalité, leur nom et leurs liens familiaux reconnus par la loi, les États doivent mettre en place des procédures légales permettant de réviser et annuler la procédure d'adoption ou de placement d'enfants trouvant leur origine dans une disparition forcée (article 25, paragraphe 4). La convention réaffirme deux des principes généraux sous-tendant les droits des enfants : l'intérêt supérieur de l'enfant comme une considération primordiale, et le droit de l'enfant d'exprimer son opinion (article 25, paragraphe 5). Bien que peu d'États européens aient ratifié cette convention, son importance dans le cadre normatif européen ne doit pas être sous-estimée.[330]

328 *Ibid.*, point 74.

329 ONU, Convention internationale pour la protection de toutes les personnes contre les disparitions forcées, 20 décembre 2006.

330 À la date du 19 février 2015, neuf des 28 États membres de l'UE ont ratifié cette convention (Allemagne, Autriche, Belgique, Espagne, France, Lituanie, Pays-Bas, Portugal et Slovaquie). De plus, les États membres du Conseil de l'Europe suivants ont ratifié cette convention : Albanie, Arménie, Bosnie-Herzégovine Monténégro et Serbie.

8 Droits économiques, sociaux et culturels, et niveau de vie adéquat

UE	Questions traitées	CdE
Charte des droits fondamentaux, article 14 (éducation) Directive « qualification » (2011/95/UE) CJUE, C-413/99, *Baumbast et R c. Secretary of State for the Home Department*, 2002 (éducation des enfants migrants)	**Droit à l'éducation**	CEDH, Protocole n° 1, article 2 (droit à l'éducation) CSE (révisée), article 17 (droit à l'éducation) CouEDH, *Catan et autres c. République de Moldova et Russie* [GC], n° 43370/04, 8252/05 et 18454/06, 2012 (langue dans les écoles) CouEDH, *D.H. et autres c. République tchèque* [GC], n° 57325/00, 2007 ; CouEDH, *Oršuš et autres c. Croatie* [GC], n° 15766/03, 2010 (discrimination à l'encontre d'enfants roms à l'école) CouEDH, *Ponomaryovi c. Bulgarie*, n° 5335/05, 2011 (discrimination fondée sur la situation d'une personne au regard de la législation sur l'immigration) CCPMN, articles 12, paragraphe 3, et 14 Convention européenne relative au statut juridique du travailleur migrant
Charte des droits fondamentaux, article 35 (accès aux soins médicaux) Directive « qualification » (2011/95/UE), article 29 (prestations essentielles pour les enfants migrants)	**Droit à la santé**	CSE (révisée), articles 11 (droit à la protection de la santé) et 13 (droit à l'assistance médicale et droit de bénéficier de services sociaux) CEDH, articles 2 (droit à la vie) et 8 (droit à l'intégrité physique) CouEDH, *Oyal c. Turquie*, n° 4864/05, 2010 (infection d'un nouveau-né par le VIH) CouEDH, *Iliya Petrov c. Bulgarie*, n° 19202/03, 2012 (blessures contractées dans le bâtiment d'un transformateur électrique) CouEDH, *Centre de ressources juridiques au nom de Valentin Câmpeanu c. Roumanie,* [GC], n° 47848/08, 2014 (décès dans un hôpital neuropsychiatrique)

UE	Questions traitées	CdE
		CouEDH, *Glass c. Royaume-Uni*, n° 61827/00, 2004 (consentement éclairé) CouEDH, *M.A.K et R.K. c. Royaume-Uni*, n° 45901/05 et 40146/06, 2010 (examen pratiqué sans accord parental) CEDS, *Fédération internationale des ligues des droits de l'homme (FIDH) c. France*, n° 14/2003, 2004, (soins médicaux pour enfants migrants) CEDS, *Défense des Enfants International (DEI) c. Belgique*, n° 69/2011, 2012 (enfants en situation irrégulière) Convention sur les droits de l'homme et la biomédecine (Convention d'Oviedo), articles 6 et 8
Charte des droits fondamentaux, article 34, paragraphe 3 (droit à une aide sociale et à une aide au logement)	**Droit au logement**	CSE (révisée), articles 16 (droit de la famille à une protection sociale, juridique et économique), 17 (droit des enfants et des adolescents à une protection sociale, juridique et économique) et 31 (droit au logement) CouEDH, *Bah c. Royaume-Uni*, n° 56328/07, 2011 CouEDH, *Connors c. Royaume-Uni*, n° 66746/01, 2004
Charte des droits fondamentaux, article 34 (sécurité sociale et aide sociale)	**Droit à un niveau de vie suffisant et droit à la sécurité sociale**	CSE (révisée), articles 12 à 14 (droit à la sécurité sociale, droit à l'assistance sociale et médicale et droit à bénéficier des services sociaux), 16 (droit de la famille à une protection sociale, juridique et économique) et 30 (droit à la protection contre la pauvreté et l'exclusion sociale) CEDS, *Comité européen d'action spécialisée pour l'enfant et la famille dans leur milieu de vie (EUROCEF) c. France*, n° 82/2012, 2013 (suspension des allocations familiales pour cause d'absentéisme scolaire) CouEDH, *Konstantin Markin c. Russie* [GC], n° 30078/06, 2012 (congé parental)

Les droits économiques, sociaux et culturels (droits ESC), plus communément appelés droits socioéconomiques ou droits sociaux dans le contexte européen, incluent les droits relatifs au travail ainsi que le droit à l'éducation, à la santé, au logement, à la sécurité sociale et, plus généralement, à un niveau de vie adéquat. Les droits culturels restent très peu développés et rarement pris en compte dans le contexte des bourses et des actions en justice. Certains de leurs aspects sont abordés à la section 4.6 relative à l'identité des enfants appartenant à une minorité ainsi qu'à la section 8.2 consacrée au droit à l'éducation.

Les normes explicites relatives aux droits ESC dans le contexte européen se trouvent essentiellement dans la Charte sociale européenne et la Charte des droits fondamentaux de l'UE, même si la CEDH et ses protocoles incluent également plusieurs dispositions, notamment l'interdiction du travail forcé et le droit à l'éducation. La CouEDH a par ailleurs déclaré que « nulle cloison étanche ne sépare la sphère des droits économiques et sociaux du domaine de la Convention »[331] et considéré que les droits ESC sont inclus dans les droits civils garantis par la CEDH. Ainsi, par exemple, l'accès aux soins de santé a été abordé dans le cadre de l'interdiction de la torture et des peines ou traitements inhumains ou dégradants (article 3 de la CEDH)[332].

Le présent chapitre examine les droits de la CSE présentant un intérêt particulier pour les enfants : le droit à l'éducation (section 8.2) ; le droit à la santé (section 8.3) ; le droit au logement (section 8.4) et le droit à un niveau de vie suffisant et droit à la sécurité sociale (section 8.5).

8.1. Approches relatives aux droits économiques, sociaux et culturels

Points clés

- Garantir la disponibilité des ressources nécessaires est primordial pour assurer la protection des droits sociaux.
- Les éléments essentiels des droits sociaux sont la disponibilité, l'accessibilité, l'adaptabilité et l'acceptabilité.

Dans le droit de l'UE, les droits inscrit dans la CSE ont été intégrés à la Charte des droits fondamentaux de l'UE et sont au même niveau que les droits civils et politiques. Toutefois, l'article 52 de la Charte opère une distinction entre les droits et les principes, car la possibilité d'invoquer les principes devant le juge est limitée.

331 CouEDH, *Airey c. Irlande*, n° 6289/73, 9 octobre 1979, para. 26.

332 Voir par exemple CouEDH, *Factsheet on Prisoners' health-related rights*, février 2015, et *Factsheet on Health*, avril 2015.

Dans le droit du CdE, le CEDS note que lorsque la réalisation de l'un de ces droits est « exceptionnellement complexe et particulièrement onéreuse », la réalisation progressive est évaluée sur la base de trois critères : l'État doit « s'efforcer d'atteindre les objectifs de la [CSE] à une échéance raisonnable, au prix de progrès mesurables, en utilisant au mieux les ressources qu'il peut mobiliser »[333]. Le CEDS introduit également une hiérarchisation en rappelant aux États « l'impact des choix opérés par eux sur les groupes dont la vulnérabilité est la plus grande, ainsi que sur les autres personnes concernées »[334].

Le CEDS affirme, bien que dans le contexte spécifique du droit à la sécurité sociale, que les démarches rétrogrades « afin d'assurer le maintien et la viabilité du système de sécurité sociale existant » sont autorisées pour autant qu'elles ne portent pas « atteinte au cadre essentiel du régime de sécurité sociale national ou priver les individus de l'opportunité de bénéficier de la protection que ce régime offre contre de sérieux risques sociaux et économiques »[335]. La CouEDH admet elle aussi la possibilité de démarches rétrogrades, mais s'assure que la méthode choisie soit raisonnable et propre à atteindre l'objectif légitime visé[336].

Dans le contexte du droit à l'éducation, le CEDS a adopté, conformément à l'approche du Comité des droits économiques, sociaux et culturels des Nations Unies, le cadre analytique relatif à la disponibilité, l'accessibilité, l'adaptabilité et l'acceptabilité[337]. La distinction entre disponibilité et accessibilité est par ailleurs opérée dans la jurisprudence de la CouEDH. Les critères ou éléments essentiels de la disponibilité, de l'accessibilité, de l'acceptabilité et de l'adaptabilité guideront l'analyse présentée ci-après dans la mesure de l'existence d'une jurisprudence pertinente.

333 CEDS, *Association internationale Autisme Europe (AIAE) c. France*, n° 13/2002, 4 novembre 2003, para. 53 ; appliquée dans CEDS, *Action européenne des Handicapés (AEH) c. France*, n° 81/2012, 11 septembre 2013, paras. 94-99.

334 CEDS, *Association internationale Autisme Europe (AIAE) c. France*, n° 13/2002, 4 novembre 2003, para. 53.

335 CEDS, *Fédération générale des employés des compagnies publiques d'électricité (GENOP-DEI) et Confédération des syndicats des fonctionnaires publics (ADEDY) c. Grèce*, n° 66/2011, 23 mai 2012, para. 47.

336 CouEDH, *Markovics et autres c. Hongrie*, décision d'irrecevabilité, n° 77575/11, 19828/13 et 198 29/13, 24 juin 2014, paras. 37 et 39.

337 CEDS, *Centre de Défense des Droits des Personnes Handicapées Mentales (MDAC) c. Bulgarie*, n° 41/2007, 3 juin 2008, para. 37.

8.2. Droit à l'éducation

Points clés

- Les restrictions de l'accessibilité de l'éducation doivent être prévisibles, poursuivre un but légitime, être justifiées et non discriminatoires.
- L'acceptabilité de l'éducation, qui nécessite le respect des convictions religieuses et philosophiques des parents, n'exclut pas la possibilité d'une éducation religieuse ou sexuelle à l'école.
- L'adaptabilité exige des mesures spéciales pour les enfants handicapés ainsi que la possibilité, pour les enfants appartenant à une minorité, de recevoir un apprentissage et un enseignement dans leur propre langue.
- Les enfants ont le droit à une éducation quel que soit leur nationalité ou leur situation au regard de la législation sur l'immigration.

Dans le droit de l'UE, l'article 14, paragraphe 2, de la Charte des droits fondamentaux de l'UE garantit le droit à l'éducation, y compris « la faculté de suivre gratuitement l'enseignement obligatoire ». L'article 14, paragraphe 3, garantit la liberté de créer des établissements d'enseignement ainsi que le droit des parents d'assurer l'éducation et l'enseignement de leurs enfants conformément à leurs convictions religieuses, philosophiques et pédagogiques.

Dans le droit du CdE, l'article 2 du Protocole n° 1 à la CEDH garantit le droit à l'éducation. La CouEDH précise que cet article n'oblige pas les États à mettre un enseignement à disposition des enfants, mais prévoit « un droit d'accès aux établissements scolaires existant à un moment donné »[338]. En outre, le droit à l'éducation inclut également « la possibilité de tirer un bénéfice de l'enseignement suivi, c'est-à-dire le droit d'obtenir, conformément aux règles en vigueur dans chaque État et sous une forme ou une autre, la reconnaissance officielle des études accomplies »[339]. Toutefois, il ne s'agit pas d'un droit absolu et ses limites doivent être prévisibles pour les personnes concernées et poursuivre un but légitime. Les mesures disciplinaires, y compris la suspension ou l'exclusion d'un établissement d'enseignement, sont autorisées pour autant qu'elles répondent aux conditions

338 CouEDH, *Affaire « relative à certains aspects du régime linguistique de l'enseignement en Belgique » c. Belgique*, n° 1474/62, 1677/62, 1691/62, 1769/63, 1994/63 et 2126/64, 23 juillet 1968, point 4.

339 *Ibid.*

relatives aux restrictions autorisées. Pour déterminer si ces formes d'exclusion de l'éducation résultent d'un refus du droit à l'éducation, des facteurs tels que les garanties procédurales, la durée de l'exclusion, les efforts de réintégration et l'adéquation de l'éducation de remplacement seront pris en compte[340].

> Exemple : dans l'affaire *Catan et autres c. République de Moldova et Russie*[341], la CouEDH a examiné la politique linguistique introduites dans les écoles par les autorités séparatistes de Transnistrie. L'objectif de cette politique était la russification. Suite à la fermeture par la force des écoles de langue moldave (utilisant l'alphabet latin), les parents ont dû choisir entre placer leurs enfants dans des écoles où l'enseignement était donné dans une combinaison artificielle de langue moldave et d'alphabet cyrillique et avec des supports d'enseignement produits à l'ère soviétique et les placer dans des écoles moins bien équipées et plus difficiles d'accès, sur le chemin desquelles ils se faisaient harceler et intimider. La fermeture par la force des écoles et le harcèlement qui en a découlé ont été considérés comme une atteinte au droit des enfants à l'éducation constituant une violation de l'article 2 du Protocole n° 1 à la CEDH[342].

Dans le cadre du droit à l'éducation, les parents ont le droit d'exiger le respect de leurs convictions religieuses et philosophiques. Toutefois, « la définition et l'aménagement du programme des études relèvent en principe de la compétence » de l'État[343]. Ce dernier peut également inclure dans le programme scolaire des informations ou des connaissances de nature religieuse ou philosophique, pour autant que celles-ci soient « diffusées de manière suffisamment objective, critique et pluraliste »[344]. Pour garantir le pluralisme, les différences quantitatives et qualitatives au niveau de l'enseignement d'une religion ou d'une philosophie donnée doivent être compensées par la possibilité offerte aux parents d'exempter, partiellement ou totalement, leurs enfants de cet enseignement, notamment la possibilité de ne pas assister à certains cours ou à la formation religieuse dans

340 CouEDH, *Ali c. Royaume-Uni*, n° 40385/06, 11 janvier 2011, para. 58.

341 CouEDH, *Catan et autres c. République de Moldova et Russie* [GC], n° 43370/04, 8252/05 et 18454/06, 19 octobre 2012.

342 *Ibid.*, paras. 141 à 144.

343 CouEDH, *Folgerø et autres c. Norvège*, n° 15472/02, 29 juin 2007, para. 84.

344 *Ibid.*, para. 84.

son ensemble[345]. Voir la section 2.1 au sujet de l'approche adoptée par la CouEDH afin de traiter de cette question sous un angle non discriminatoire.[346]

Aux termes de l'article 17, paragraphe 2, de la CSE révisée, les États prennent « toutes les mesures nécessaires et appropriées tendant [...] à assurer aux enfants et aux adolescents un enseignement primaire et secondaire gratuit, ainsi qu'à favoriser la régularité de la fréquentation scolaire »[347]. Le CEDS a également jugé qu'au titre de cette disposition, les États contractants devaient veiller à ce que les enfants en situation irrégulière sur leur territoire aient également accès à l'éducation[348].

Par ailleurs, les établissements d'enseignement doivent être accessibles à tous sans discrimination[349]. Le CEDS a considéré que « l'intégration des enfants handicapés dans les écoles ordinaires [...] devrait être la règle et l'enseignement en école spécialisée devrait être l'exception »[350]. Les États ne disposent pas d'une large marge d'appréciation en ce qui concerne le choix du type d'école pour les personnes handicapées ; il doit s'agir d'une école ordinaire[351].

Les situations relatives aux différences de traitement dans l'éducation au motif, notamment, de la nationalité, de la situation au regard de la législation sur l'immigration, ou de l'origine ethnique sont abordées au chapitre 3.

Selon la jurisprudence du CEDS, l'éducation sexuelle et génésique doit faire partie des programmes scolaires ordinaires[352]. Si les États disposent d'une large marge d'appréciation pour juger de l'adéquation culturelle des supports d'éducation utilisés, ils doivent garantir une éducation sexuelle et génésique non discriminatoire, « qui ne perpétue pas ou ne renforce pas l'exclusion sociale et le déni de la dignité humaine ». Les moyens éducatifs ne doivent pas renforcer « des

345 *Ibid.*, paras. 85 à 102, et opinion dissidente.

346 CouEDH, *Grzelak c. Pologne*, n° 7710/02, 15 juin 2010.

347 La CSE de 1961 ne contient aucune disposition sur le droit à l'éducation.

348 CEDS, *Médecins du Monde – International c. France*, n° 67/2011, 11 septembre 2012.

349 Voir également, au sujet des enfants handicapés, les chapitres 3 et 7.

350 CEDS, *Centre de Défense des Droits des Personnes Handicapées Mentales (MDAC) c. Bulgarie*, n° 41/2007, 3 juin 2008, para. 35.

351 CEDS, *Action européenne des Handicapés (AEH) c. France*, n° 81/2012, 11 septembre 2013, para. 78.

352 CEDS, *Centre international pour la protection juridique des droits de l'homme (INTERIGHTS) c. Croatie*, n° 45/2007, 30 mars 2009, para. 47.

stéréotypes avilissants », concernant, par exemple, les personnes n'ayant pas d'orientation hétérosexuelle[353].

Enfin, l'adaptabilité de l'éducation nécessite par exemple « la prise de dispositions pour répondre aux besoins spéciaux » des enfants handicapés intégrés dans des écoles ordinaires[354] (voir également la section 3.5).

En outre, aux termes de l'article 12, paragraphe 3, de la CCPMN, les États parties ont pris l'engagement de promouvoir l'égalité des chances en matière d'accès à l'éducation à tous les niveaux pour les personnes appartenant à une minorité nationale (voir également le chapitre 3).[355] Pour les enfants appartenant à une minorité nationale, l'article 14 de la CCPMN garantit le droit d'apprendre et de suivre un enseignement de sa propre langue[356]. La CouEDH a confirmé que le droit à l'éducation impliquait le droit d'être instruit dans la (l'une des) langue(s) nationale(s)[357].

8.2.1. Droit des enfants migrants à l'éducation

Dans le droit de l'UE, le droit fondamental des enfants à l'éducation, quel que soit leur situation au regard de la législation sur l'immigration, est reconnu dans presque tous les aspects de la réglementation de l'UE en matière de migration[358]. Cela étant, l'UE n'est pas compétente pour déterminer le contenu ou la portée des dispositions nationales en matière d'éducation, mais protège le droit des enfants

353 *Ibid.*, paras. 59 et 61.

354 CEDS, *Centre de Défense des Droits des Personnes Handicapées Mentales (MDAC) c. Bulgarie*, n° 41/2007, 3 juin 2008, para. 35.

355 Voir également CdE, Comité consultatif de la convention-cadre pour la protection des minorités nationales (2006), Commentaire sur l'éducation au regard de la Convention-cadre pour la protection des minorités nationales, ACFC/25DOC(2006)002, Partie 2.1.

356 Pour plus de précisions, voir CdE, Comité consultatif de la convention-cadre pour la protection des minorités nationales (CCPMN), Commentaire sur l'éducation au regard de la Convention-cadre pour la protection des minorités nationales, 2006, ACFC/25DOC(2006)002, partie 2.3, et Commentaire thématique n° 3, Les droits linguistiques des personnes appartenant aux minorités nationales en vertu de la Convention-cadre, 2012, ACFC/44DOC(2012)001 rev, partie VI, Droits linguistiques et éducation.

357 CouEDH, *Catan et autres c. République de Moldova et Russie* [GC], n° 43370/04, 8252/05 et 18454/06, 19 octobre 2012, para. 137.

358 Voir par exemple l'article 27 de la directive 2011/95/UE du Parlement européen et du Conseil du 13 décembre 2011 concernant les normes relatives aux conditions que doivent remplir les ressortissants des pays tiers ou les apatrides pour pouvoir bénéficier d'une protection internationale, à un statut uniforme pour les réfugiés ou les personnes pouvant bénéficier de la protection subsidiaire, et au contenu de cette protection (refonte) (directive « qualification »), JO 2011 L 337, p. 9-268.

migrants d'accéder à l'éducation sur une base identique, ou, selon leur statut, similaire à celle des ressortissants nationaux. La directive 2004/114/CE relative aux étudiants réglemente les conditions d'admission des ressortissants de pays tiers à des fins d'études, d'échange d'élèves, de formation non rémunérée ou de volontariat[359]. Cette admission couvre l'entrée et le séjour du ressortissant de pays tiers pour une durée supérieure à trois mois. Les conditions générales d'admission des enfants incluent la présentation d'un document de voyage valide, une autorisation parentale pour le séjour envisagé, une assurance-maladie et, à la demande de l'État membre, le paiement d'un droit pour le traitement de la demande d'admission[360]. Les élèves, par exemple, sont tenus d'apporter la preuve de leur participation à un programme d'échange d'élèves mis en œuvre par une organisation reconnue à cet effet par l'État membre concerné[361]. Les stagiaires non rémunérés doivent apporter, à la demande de l'État membre, la preuve qu'ils disposeront au cours de leur séjour de ressources suffisantes pour couvrir leurs frais de subsistance, de formation et de retour[362]. L'accès des étudiants de l'enseignement supérieur aux activités économiques, y compris à l'emploi, est soumis à certaines restrictions[363].

Les enfants de migrants de l'UE qui déménagent dans un autre État membre de l'UE au titre de la législation en matière de libre circulation bénéficient dans ce contexte des droits les plus favorables. Ils ont le droit d'être admis aux cours d'enseignement général, d'apprentissage et de formation professionnelle dans les mêmes conditions que les ressortissants de l'État membre[364], qu'il s'agisse d'enseignement public ou privé ou d'enseignement obligatoire ou non obligatoire. La CJUE a toujours interprété ce droit de manière large afin de garantir un accès égal à l'éducation, mais aussi, plus largement, aux prestations sociales liées à l'éducation ainsi qu'à toute autre prestation destinée à faciliter la participation à l'éducation. Par exemple, dans l'affaire *Casagrande*, l'enfant d'un travailleur

359 Directive 2004/114/CE du Conseil relative aux conditions d'admission des ressortissants de pays tiers à des fins d'études, d'échange d'élèves, de formation non rémunérée ou de volontariat (directive relative aux étudiants).

360 *Ibid.*, art. 6.

361 *Ibid.*, art. 7.

362 *Ibid.*, art. 10.

363 *Ibid.*, art. 17.

364 Règlement (UE) n° 492/2011 du Parlement européen et du Conseil du 5 avril 2011 relatif à la libre circulation des travailleurs à l'intérieur de l'Union, JO 2011 L 141/1, p. 1-12, art. 10, et directive 2004/38/CE du Parlement européen et du Conseil du 29 avril 2004 relative au droit des citoyens de l'Union et des membres de leurs familles de circuler et de séjourner librement sur le territoire des États membres, modifiant le règlement (CEE) n° 1612/68 et abrogeant les directives 64/221/CEE, 68/360/CEE, 72/194/CEE, 73/148/CEE, 75/34/CEE, 75/35/CEE, 90/364/CEE, 90/365/CEE et 93/96/CEE (directive relative à la liberté de circulation), JO 2004 L 158, p. 77-123, art. 24, para. 1.

migrant a pu accéder à une aide à la formation en fonction des ressources, au titre de la législation de l'UE en matière de libre circulation[365].

Par ailleurs, la législation introduite dans les années 1970 exige des États membres qu'ils dispensent une formation linguistique supplémentaire aux enfants de travailleurs migrants de l'UE, dans la langue de leur État d'accueil et dans leur langue maternelle, afin de faciliter leur intégration dans leur État d'accueil ainsi que dans leur pays d'origine, dans le cas d'un futur retour[366]. Si cette disposition paraît offrir un soutien supplémentaire extrêmement généreux et précieux aux enfants comme suite à leur admission dans une école de l'État d'accueil, son application dans les différents pays a été manifestement inégale et est de plus en plus difficile en raison du vaste éventail de langues à prendre en compte[367].

Exemple : la question à trancher dans l'affaire *Baumbast et R c. Secretary of State for the Home Department*[368] était de savoir si les deux filles d'un travailleur migrant allemand qui s'était installé au Royaume-Uni avec son épouse colombienne et ses filles pouvaient continuer à fréquenter l'école de ce pays après que leur père avait quitté le Royaume-Uni pour un pays tiers, laissant derrière lui son épouse et ses filles. La CJUE a dû déterminer si l'épouse et les filles pouvaient demeurer dans l'État d'accueil indépendamment, bien que M. Baumbast (grâce à qui la famille détenait un droit de séjour) ait effectivement renoncé à son statut de travailleur migrant de l'UE. Pour la CJUE, le facteur décisif était le fait que les enfants étaient intégrés au système éducatif de l'État d'accueil et qu'il aurait été à la fois nuisible et disproportionné de les déraciner à un stade si crucial de leur éducation. La Cour a confirmé que l'importance d'assurer la continuité de l'éducation d'un enfant est telle qu'elle peut permettre d'« ancrer » la résidence d'une famille (qui n'aurait normalement pas pu rester) dans l'État d'accueil pendant la durée des études d'un enfant migrant.

365 CJUE, C-9/74, *Donato Casagrande c. Landeshauptstadt München*, 3 juillet 1974. Ultérieurement confirmé par des arrêts tels que CJUE, C-3/90, *M.J.E. Bernini c. Minister van Onderwijs en Wetenschappen*, 26 février 1992.

366 Directive 77/486/CEE du Conseil visant à la scolarisation des enfants des travailleurs migrants, JO 1977 L 199, p. 32-33. Il est à noter que les enfants migrants ressortissants de pays tiers sont exclus du champ d'application de cette directive.

367 Rapports de la Commission sur la mise en œuvre de la directive 77/486/CEE, COM(84) 54 final et COM(88) 787 final.

368 CJUE, C-413/99, *Baumbast et R c. Secretary of State for the Home Department*, 17 septembre 2002.

La décision *Baumbast* a été suivie à plusieurs reprises[369] et codifiée dans l'article 12, paragraphe 3 de la directive 2004/38/CE[370].

En général, le seul enseignement auquel les enfants ressortissants de pays tiers peuvent accéder dans les mêmes conditions que les ressortissants nationaux est l'enseignement *public* ; en outre, ces enfants n'ont pas droit aux avantages connexes tels que les bourses de subsistance[371]. Certains instruments de l'UE en matière d'immigration vont toutefois plus loin que la simple égalité d'accès en exigeant des États membres qu'ils mettent en œuvre des mécanismes assurant la reconnaissance et la transférabilité des qualifications étrangères même en l'absence de preuves documentaires (article 28 de la directive « qualification »[372]).

Les droits d'éducation des enfants demandeurs d'asile sont encore plus faibles ; ceux-ci doivent bénéficier d'un accès au système éducatif de l'État d'accueil dans des conditions *similaires*, mais pas nécessairement *identiques* à celles appliquées aux ressortissants nationaux[373]. Leur éducation peut ainsi être dispensée dans des centres d'hébergement et non pas des écoles et les autorités peuvent repousser l'accès complet d'un enfant demandeur d'asile à une école pendant une période de trois mois suivant la date de la demande d'asile. Lorsque l'accès au système éducatif est impossible en raison de la situation particulière de

369 CJUE, C-480/08, *Maria Teixeira c. London Borough of Lambeth et Secretary of State for the Home Department*, 23 février 2010 ; CJUE, C-310/08, *London Borough of Harrow c. Nimco Hassan Ibrahim et Secretary of State for the Home Department* [GC], 23 février 2010.

370 Directive 2004/38/CE du Parlement européen et du Conseil du 29 avril 2004 relative au droit des citoyens de l'Union et des membres de leurs familles de circuler et de séjourner librement sur le territoire des États membres, modifiant le règlement (CEE) n° 1612/68 et abrogeant les directives 64/221/CEE, 68/360/CEE, 72/194/CEE, 73/148/CEE, 75/34/CEE, 75/35/CEE, 90/364/CEE, 90/365/CEE et 93/96/CEE, JO 2004 L 158, art. 2, para. 2, point c).

371 Directive 2011/95/UE relative aux conditions à remplir pour le statut de réfugié (directive « qualification »), art. 11 ; directive relative aux résidents de longue durée (2003/109/CE), art. 14 ; directive 2003/86/CE relative regroupement familial, art. 14 ; directive relative à la protection temporaire (2001/55/CE) ; directive sur les conditions d'accueil (2013/33/UE), art. 14, point c) ; et directive « retour » (2008/115/CE).

372 Directive 2011/95/UE du Parlement européen et du Conseil du 13 décembre 2011 concernant les normes relatives aux conditions que doivent remplir les ressortissants des pays tiers ou les apatrides pour pouvoir bénéficier d'une protection internationale, à un statut uniforme pour les réfugiés ou les personnes pouvant bénéficier de la protection subsidiaire, et au contenu de cette protection (refonte) (directive « qualification »), JO 2011 L 337, p. 9.

373 Directive relative aux conditions d'accueil (2013/33/UE). Il est à noter qu'aux termes de la directive relative aux conditions à remplir pour le statut de réfugié (2011/95/UE, art. 27), les enfants réfugiés (qui ont acquis un droit de séjour à long terme) peuvent accéder à l'éducation dans les mêmes conditions que les ressortissants nationaux.

l'enfant, les États membres ont l'obligation de proposer d'autres arrangements éducatifs (article 14, paragraphe 3, de la directive sur les conditions d'accueil)[374].

Dans le droit du CdE, l'article 2 du Protocole n° 1 a été utilisé en conjonction avec l'article 14 pour garantir l'accès des enfants migrants à l'éducation (voir également la section 3.3).

> Exemple : dans l'affaire *Ponomaryovi c. Bulgarie*[375], la CouEDH a examiné l'obligation imposée à deux écoliers russes sans droit de séjour permanent de payer des frais de scolarité pour l'école secondaire. La Cour a conclu que dans ce cas, l'imposition de frais de scolarité pour l'école secondaire avait été discriminatoire et donc contraire à l'article 14 de la CEDH lue en combinaison avec l'article 2 du Protocole n° 1 à la CEDH[376].

La CSE protège les droits d'éducation des enfants migrants à la fois directement (article 17, paragraphe 2) et indirectement, en imposant des limitations aux droits des enfants en matière d'emploi dans le but de leur permettre de bénéficier pleinement de l'enseignement obligatoire (article 7).

Par ailleurs, la Convention européenne relative au statut juridique du travailleur migrant[377] appuie le droit des enfants migrants à accéder « au même titre et dans les mêmes conditions » que les ressortissants nationaux, à l'enseignement général et à la formation professionnelle de l'État d'accueil (article 14, paragraphe 1).

Dans le droit international, l'égalité d'accès à l'éducation des enfants migrants est garantie par la Convention internationale de l'ONU sur la protection des droits de tous les travailleurs migrants et des membres de leur famille (article 30)[378].

L'article 28 de la CRC dispose que tous les enfants ont le droit de suivre gratuitement l'enseignement obligatoire. En vertu de l'article 1, paragraphe 1, point c),

374 Directive 2013/33/UE du Parlement européen et du Conseil du 26 juin 2013 établissant des normes pour l'accueil des personnes demandant la protection internationale (refonte) (directive sur les conditions d'accueil, JO 2013 L 180, p. 96-116.

375 CouEDH, *Ponomaryovi c. Bulgarie*, n° 5335/05, 21 juin 2011.

376 Voir également la section 3.3.

377 CdE, Convention européenne relative au statut juridique du travailleur migrant, STCE n° 93, 1977.

378 ONU, Convention internationale de l'ONU sur la protection des droits de tous les travailleurs migrants et des membres de leur famille, 18 décembre 1990.

ce droit va largement au-delà de l'égalité de l'accès à l'éducation puisqu'il inclut des dispositions relatives au développement de l'identité culturelle de l'enfant, à sa langue et aux valeurs de son pays d'origine.

8.3. Droit à la santé

Points clés

- Les États ont l'obligation positive de prendre des mesures contre les risques sanitaires potentiellement mortels dont les autorités ont ou devraient avoir connaissance.
- Les autorités nationales doivent enquêter de manière adéquate sur les causes de tout décès d'individu.
- Au titre de la CSE, les enfants en situation irrégulière dans un pays ont le droit de bénéficier de soins de médicaux au-delà de l'assistance médicale d'urgence.
- L'acceptabilité des soins de santé nécessite un consentement éclairé ou une autorisation.
- En vertu de la législation de l'UE et de la CSE, sous réserve de plusieurs contraintes, les enfants migrants ont le droit d'accéder à l'assistance sociale et aux soins de santé.

Dans le droit de l'UE, l'article 35 de la Charte des droits fondamentaux de l'UE garantit un droit d'accès aux soins de santé.

Les enfants de migrants ressortissants de l'UE peuvent accéder aux services sociaux et aux soins de santé de la même manière que les ressortissants nationaux, à l'issue d'un délai de trois mois de résidence dans l'État d'accueil[379]. Des droits similaires sont accordés aux enfants de ressortissants de pays tiers ayant obtenu un droit de séjour permanent dans un État membre, bien qu'ils puissent être limités à ce que l'on appelle les « prestations essentielles »[380]. En ce qui concerne les enfants réfugiés et demandeurs d'asile, les États doivent leur garantir l'accès à une assistance sociale appropriée de la même manière que les ressortissants de l'État d'accueil, mais, ici encore, ce droit peut être limité aux « prestations essentielles » (article 29 de la directive « qualification »). La législation exige des

379 Directive relative à la liberté de circulation, art. 24.

380 Directive 2003/109/CE du Conseil du 25 novembre 2003 relative au statut des ressortissants de pays tiers résidents de longue durée, JO 2004 L 16, art. 11, para. 4.

États membres qu'ils fournissent aux enfants migrants vulnérables un accès à une assistance suffisante en matière de soins de santé. Par exemple, les enfants qui ont été victimes de violences ou de torture doivent recevoir un soutien suffisant pour répondre à leurs besoins physiques et mentaux (directive sur les conditions d'accueil (refonte), chapitre IV, article 21, article 23, paragraphe 4, et article 25). La directive « qualification » contient des dispositions similaires pour les enfants migrants vulnérables.

Dans le droit du CdE, la CEDH ne garantit pas expressément un droit aux soins de santé, ni un droit à la santé. Toutefois, la CouEDH a entendu un certain nombre d'affaires relatives à la santé dans des circonstances diverses. En premier, la Cour examine les problèmes de santé qui mettent en danger la vie des enfants. Elle détermine les obligations positives des États aux termes desquelles ils doivent prendre des mesures préventives contre ces risques sanitaires potentiellement mortels dont ils ont ou devraient avoir connaissance.

Exemple : dans l'affaire *Oyal c. Turquie*, l'État n'a pas pris de mesures de prévention contre la propagation du VIH par transfusion sanguine. Par conséquent, un nouveau-né a été infecté par le virus du VIH lors de transfusions sanguines qu'il a reçues dans un hôpital public. Si une certaine forme de réparation a été offerte, la CouEDH a estimé qu'en l'absence de couverture médicale complète pour le traitement et les médicaments de l'enfant jusqu'à la fin de sa vie, l'État n'a pas offert de réparation satisfaisante et a donc violé le droit à la vie (article 2 de la CEDH)[381]. Elle a également ordonné à l'État turc de fournir à la victime une couverture médicale complète jusqu'à la fin de sa vie.

Exemple : dans l'affaire *Iliya Petrov c. Bulgarie*[382], un garçon de 12 ans a été gravement blessé dans le bâtiment d'un transformateur électrique dont la porte était ouverte et qui se situait dans un parc en plein air, où se retrouvaient souvent les enfants et les jeunes. La CouEDH a considéré que l'exploitation d'un réseau électrique représentait une activité faisant courir un risque élevé aux personnes à proximité des installations. L'État a l'obligation de mettre en place une réglementation adéquate, y compris un système permettant de s'assurer de l'application adéquate des règles de sécurité. La Cour a estimé qu'en ne s'assurant pas que le transformateur

381 CouEDH, *Oyal c. Turquie*, n° 4864/05, 23 mars 2010, paras. 71 et 72.

382 CouEDH, *Iliya Petrov c. Belgique*, n° 19202/03, 24 avril 2012.

électrique était sécurisé, alors qu'il était informé des problèmes de sécurité, l'État a commis une violation du droit à la vie (article 2 de la CEDH)[383].

Par ailleurs, les États ont l'obligation positive de prendre en charge le traitement des enfants en situation vulnérable qui sont placés sous la protection des autorités nationales (voir également le chapitre 6 et la section 7.3).

Exemple : l'affaire *Centre de ressources juridiques au nom de Valentin Câmpeanu c. Roumanie*[384] portait sur un adolescent rom séropositif qui souffrait d'un grave handicap intellectuel ainsi que de la tuberculose, d'une pneumonie et d'une hépatite, et qui est décédé à l'âge de 18 ans. Il avait été à la charge de l'État toute sa vie. La CouEDH a détecté de graves lacunes dans le processus décisionnel relatif à l'administration de médicaments et de soins, ainsi qu'un manquement continu de la part du corps médical à son obligation de lui dispenser les soins et les traitements nécessaires. En conséquence, la Cour a conclu à la violation de l'article 2 de la CEDH[385].

Par ailleurs, en l'absence d'une situation d'urgence, la CouEDH a jugé qu'un traitement médical administré sans l'accord parental constituait une violation de l'article 8 de la CEDH.

Exemple : dans l'affaire *Glass c. Royaume-Uni*[386], de la diamorphine avait été administrée à un enfant souffrant de graves handicaps physiques et mentaux malgré l'expression ferme de sa mère de son opposition à un traitement de ce type. La Cour a considéré qu'eu égard aux circonstances de l'enfant la décision des autorités hospitalières de passer outre, en l'absence d'autorisation par un tribunal, à l'objection de la mère au traitement proposé, a violé l'article 8 de la CEDH[387].

383 *Ibid*.

384 CouEDH, *Centre de ressources juridiques au nom de Valentin Câmpeanu c. Roumanie*, [GC], n° 47848/08, 17 juillet 2014. Voir également la description de cet arrêt de la CouEDH au chapitre 7.

385 Voir également la section 7.

386 CouEDH, *Glass c. Royaume-Uni*, n° 61827/00, 9 mars 2004.

387 *Ibid.*, para. 83.

Exemple : dans l'affaire *M.A.K. et R.K. c. Royaume-Uni*[388], une fillette de neuf ans a subi un examen sanguin et des clichés médicaux sans l'accord de ses parents, malgré les instructions explicites de son père de ne pas effectuer d'examen supplémentaire tant que la fillette était seule à l'hôpital. La Cour a conclu qu'en l'absence de toute urgence médicale, ces actes médicaux sans consentement parental constituent une violation de son droit à l'intégrité physique au titre de l'article 8 de la CEDH[389].

Conformément aux articles 6 et 8 de la Convention sur les droits de l'homme et la biomédecine (Convention d'Oviedo)[390], lorsqu'un enfant n'a pas la capacité juridique de consentir à une intervention médicale, celle-ci ne peut être effectuée sans l'autorisation de son représentant, sauf situation d'urgence. Si cette convention n'exige pas le consentement de l'enfant si celui-ci est juridiquement incapable de le donner, elle estime toutefois que l'avis de l'enfant doit être pris en considération « comme un facteur de plus en plus déterminant, en fonction de son âge et de son degré de maturité » (article 6, paragraphe 2).

Par ailleurs, au titre de l'article 11 de la CSE, les parties ont convenu de prendre des mesures visant à prévoir des services de consultation et d'éducation pour ce qui concerne l'amélioration de la santé et le développement du sens de la responsabilité individuelle en matière de santé[391]. L'assistance et les soins médicaux sont garantis par l'article 13 de la CSE à toute personne qui ne dispose pas de ressources suffisantes et qui n'est pas en mesure de se procurer celles-ci par ses propres moyens ou de les recevoir d'une autre source. Enfin, en 2011, le Comité des Ministres a adopté des *Lignes directrices spécifiques au sujet des soins de santé adaptés aux enfants*[392].

Comme l'indiquent les exemples ci-après, le CEDS considère que les enfants migrants résidant irrégulièrement dans un pays ont le droit de bénéficier de soins médicaux au-delà de l'assistance médicale d'urgence. La CSE contient de

388 CouEDH, *M.A.K et R.K. c. Royaume-Uni*, n° 45901/05 et 40146/06, 23 mars 2010.

389 *Ibid.*, para. 79.

390 CdE, Convention pour la protection des droits de l'homme et de la dignité de l'être humain à l'égard des applications de la biologie et de la médecine : Convention sur les droits de l'homme et la biomédecine, STCE n° 164, 1997.

391 En ce qui concerne l'éducation sexuelle et génésique, voir la section consacrée à l'éducation ci-dessus.

392 CdE, Comité des Ministres (2011), *Lignes directrices sur les soins de santé adaptés aux enfants*, 21 septembre 2011.

nombreuses références au droit de l'enfant de bénéficier de services sociaux et de services de soins de santé (articles 11, 12, 13, 14, 16 et 17), valable indépendamment de la situation de l'enfant au regard de la législation sur l'immigration.

Exemple : la décision du CEDS dans l'affaire *Fédération internationale des Ligues des droits de l'homme (FIDH) c. France*[393] concerne l'adoption, en France, d'une loi mettant fin à la dispense de frais médicaux pour les étrangers en situation irrégulière disposant de revenus très faibles et leur imposant le paiement de frais de soins de santé. La CEDS a considéré que les personnes n'ayant pas atteint l'âge de la majorité, y compris les enfants non accompagnés, devaient bénéficier de soins médicaux gratuits.

Exemple : dans l'affaire *Défense des Enfants International (DEI) c. Belgique*[394], le CEDS a conclu à une violation de l'article 17 de la CSE en raison de restrictions de l'assistance médicale fournie aux enfants étrangers en séjour irrégulier. Le Comité a confirmé que « les mineurs migrants en séjour irrégulier ont droit à bénéficier soit de l'aide médicale urgente, soit de soins de santé allant au-delà de l'aide médicale urgente et incluant des soins de santé primaires et secondaires et l'assistance psychologique »[395]. Il a également indiqué que la saturation du réseau d'accueil des mineurs étrangers en séjour irrégulier rendait difficile l'accès aux soins de santé. Le Comité a par ailleurs considéré que l'élimination des causes d'une santé déficiente n'était possible qu'en assurant des logements et des foyers d'accueil aux enfants. Il a donc conclu à l'existence d'une violation de l'article 11, paragraphes 1 et 3, de la CSE due au manque de logements et de foyers d'accueil[396].

La Convention européenne relative au statut juridique du travailleur migrant[397] dispose également que les travailleurs migrants légalement employés sur le territoire d'un autre État, ainsi que leur famille, doivent bénéficier d'un accès égal à l'assistance sociale et médicale (article 19).

393 CEDS, *Fédération internationale des ligues des droits de l'homme (FIDH) c. France*, n° 14/2003, 8 septembre 2004, paras. 35 à 37.

394 CEDS, *Défense des Enfants International (DEI) c. Belgique*, n° 69/2011, 23 octobre 2012.

395 *Ibid.*, para. 128.

396 *Ibid.*, paras. 116 à 118.

397 CdE, Convention européenne relative au statut juridique du travailleur migrant, STCE n° 78, 1977.

Dans le droit international, on trouve d'autres dispositions globales sur le droit à la santé à l'article 12 du Pacte international relatif aux droits économiques, sociaux et culturels (ICESCR)[398] ainsi qu'à l'article 24 de la CRC. Ces instruments insistent sur la prévention et le traitement. Le Comité des droits de l'enfant des Nations Unies souligne qu'il importe d'accéder au meilleur niveau de soins de santé et de nutrition durant la petite enfance[399] et d'assurer l'accès des adolescents aux informations sur la santé sexuelle et génésique[400]. Il a également précisé que le droit des enfants à la santé supposait « le droit d'exercer un contrôle sur sa santé et son corps, y compris la liberté de faire des choix responsables dans le domaine de la santé sexuelle et procréative »[401]. Il encourage les États à « envisager la possibilité d'autoriser les enfants à consentir à certains traitements ou interventions médicales sans l'autorisation d'un parent, d'un prestataire de soins ou d'un tuteur, comme le test du VIH ou des services de santé sexuelle et procréative, notamment un enseignement et des conseils concernant la santé sexuelle, la contraception et l'avortement médicalisé »[402].

8.4. Droit au logement

Points clés

- Le droit à un logement adéquat est garanti par l'article 31 de la CSE.
- Le CEDS a déclaré qu'un abri adéquat doit être mis à disposition des enfants aux enfants qui se trouvent en situation irrégulière dans un pays et que les conditions de vie dans un abri doit assurer le respect de la dignité humaine.
- Selon la CouEDH, un logement inadéquat ne justifie pas le placement en institution publique.

398 ONU, Assemblée générale, Pacte international relatif aux droits économiques, sociaux et culturels (ICESCR), 16 décembre 1966, Vol. 993, p. 3.

399 ONU, Comité des droits de l'enfant (2006), *Observation générale n° 7 (2005), Mise en œuvre des droits de l'enfant dans la petite enfance*, CRC/C/GC/7/Rev.1, para. 27.

400 ONU, Comité des droits de l'enfant (2003), *Observation générale n° 4 (2003), La santé et le développement de l'adolescent dans le contexte de la Convention relative aux droits de l'enfant*, CRC/GC/2003/4, 1er juillet 2003, para. 28.

401 ONU, Comité des droits de l'enfant (2013), *Observation générale n° 15 (2013) sur le droit de l'enfant de jouir du meilleur état de santé possible (art. 24)*, CRC/C/GC/15, 29 mai 2013, para. 24.

402 *Ibid.*, para. 31.

Dans le droit de l'UE, l'article 34, paragraphe 3, de la Charte des droits fondamentaux de l'UE indique que le droit à une aide au logement s'inscrit dans la lutte contre l'exclusion sociale et la pauvreté. Aux termes de la directive relative à l'égalité raciale, le logement fait partie des produits et services mis à la disposition du public dont l'accès et l'offre doivent être assurés de manière non discriminatoire[403]. L'égalité de traitement en matière d'allocations de logement concerne les résidents de longue durée. Toutefois, le droit de l'UE vise à garantir, par exemple, en ce qui concerne le regroupement familial, que les membres de la famille ne constituent pas une charge pour les régimes d'aide sociale des États membres[404]. Conformément à la directive relative au regroupement familial, les demandes de regroupement familial doivent prouver qu'un regroupant valable (c'est-à-dire un ressortissant de pays tiers titulaire d'un titre de séjour d'une durée de validité supérieure ou égale à un an et ayant une perspective fondée d'obtenir un droit de séjour permanent) possède un logement considéré comme normal pour une famille de taille comparable dans la même région. Ce logement doit répondre aux normes générales de salubrité et de sécurité en vigueur dans l'État membre concerné[405].

Dans le droit du CdE, la CEDH ne prévoit pas de droit à un logement, mais si un État décide de fournir un logement, il doit le faire de manière non discriminatoire.

Exemple : dans l'affaire *Bah c. Royaume-Uni*[406] la requérante, qui résidait légalement au Royaume-Uni, a reçu l'autorisation d'être rejointe par son fils à condition que celui-ci n'ait pas recours à l'aide publique. Peu après l'arrivée de son fils, la requérante a demandé une aide pour trouver un logement. Toutefois, son fils étant soumis à la police des étrangers, elle s'est vu refuser la priorité à laquelle son statut de personne involontairement sans domicile avec enfant mineur lui aurait normalement donné droit. Les autorités l'ont finalement aidée à trouver un nouveau logement et lui ont ensuite fourni un logement social. La requérante s'est plainte du caractère discriminatoire du refus de lui accorder la priorité. La CouEDH a estimé qu'il était légitime de définir des critères pour l'allocation de ressources limitées

403 Directive (2000/43/CE) du Conseil du 29 juin 2000 relative à la mise en œuvre du principe de l'égalité de traitement entre les personnes sans distinction de race ou d'origine ethnique, art. 3.

404 Voir également FRA et CouEDH (2014), p. 217-218.

405 Directive 2003/86/CE du Conseil du 22 septembre 2003 relative au droit de regroupement familial (directive relative au regroupement familial), art. 7, para. 1, point a).

406 CouEDH, *Bah c. Royaume-Uni*, n° 56328/07, 27 septembre 2011.

telles que les logements sociaux, pour autant que ces critères ne soient ni arbitraires, ni discriminatoires. Le refus de priorité dont elle a fait l'objet n'avait rien d'arbitraire, puisqu'elle avait fait venir son fils dans l'État membre en pleine connaissance de la condition à laquelle son entrée était subordonnée. Par ailleurs, la requérante n'a jamais été réellement sans domicile et d'autres obligations légales auraient contraint l'autorité locale de prêter assistance à elle et à son fils si le risque de devenir sans domicile s'était concrétisé. La Cour a donc conclu à l'absence de violation de l'article 14 lu en combinaison avec l'article 8 de la CEDH.

La CouEDH entend également des affaires d'éviction de familles roms de sites de stationnement de caravanes[407]. La CouEDH a indirectement traité de la question de la qualité du logement en indiquant qu'un logement inadéquat ne justifiait pas le placement d'enfants en institution publique[408] (voir également les sections 5.2. et 6.2.).

Le droit à un logement d'un niveau suffisant est garanti par l'article 31 de la CSE. D'après le CEDS, « [u]n logement d'un niveau suffisant signifie un logement salubre en termes d'hygiène et de santé, c'est-à-dire qui dispose de tous les éléments de confort essentiels tels que l'eau, le chauffage, l'évacuation des ordures ménagères, les installations sanitaires, l'électricité et doit être doté aussi des structures de sécurité requises saines, non surpeuplé et assorti d'une garantie légale de maintien dans les lieux »[409]. Les évictions sont autorisées si elles sont justifiées, réalisées dans des conditions respectant la dignité des personnes et si des solutions de relogement sont proposées[410]. Les conditions de vie dans un abri « doivent respecter la dignité des personnes » : elles doivent « répondre aux exigences de sureté, de santé et d'hygiène, disposer des éléments de confort essentiels tels que l'accès à l'eau et un chauffage et un éclairage suffisants. Une autre exigence fondamentale est la sûreté des alentours immédiats »[411].

407 CouEDH, *Connors c. Royaume-Uni*, n° 66746/01, 27 mai 2004.

408 CouEDH, *Wallová et Walla c. République tchèque*, n° 23848/04, 26 octobre 2006, paras. 73-74 ; CouEDH, *Havelka et autres c. République tchèque*, n° 23499/06, 21 juin 2007, paras. 57-59.

409 CEDS, *Défense des Enfants International (DEI) c. Pays-Bas*, n° 47/2008, 20 octobre 2009, para. 43.

410 CEDS, *Centre européen pour les droits des Roms (ERRC) c. Italie*, n° 27/2004, 7 décembre 2005, para. 41 ; CEDS, *Médecins du Monde – International c. France*, n° 67/2011, 11 septembre 2012, paras. 74, 75 et 80.

411 CEDS, *Défense des Enfants International (DEI) c. Pays-Bas*, n° 47/2008, 20 octobre 2009, para. 62.

En ce qui concerne le logement des enfants étrangers en situation irrégulière, le CEDS indique que le fait de n'offrir aucun hébergement, de même que l'accueil inapproprié dans des hôtels, constituent une violation de l'article 17, paragraphe 1, de la CSE[412]. Par ailleurs, au titre de l'article 31, paragraphe 2, de la CSE relatif à la prévention de l'état de sans-abri, les États sont tenus de fournir un abri adéquat aux enfants en situation irrégulière sans recourir au placement en détention[413].

8.5. Droit à un niveau de vie suffisant et droit à la sécurité sociale

Points clés

- L'accès aux allocations familiales et au congé parental doit être non-discriminatoire.
- Dans le droit de l'UE, la protection sociale des jeunes travailleurs en contrat d'apprentissage ne doit pas être faible au point de les exclure de la protection générale.
- Au titre de la CSE, la suspension des allocations familiales en cas d'absentéisme scolaire constitue une restriction disproportionnée du droit de la famille à une protection économique, sociale et juridique.

Dans le droit de l'UE, l'article 34, paragraphe 1, de la Charte des droits fondamentaux de l'UE dispose que « [l]'Union reconnaît et respecte le droit d'accès aux prestations de sécurité sociale et aux services sociaux » dans les cas correspondant aux branches classiques de la sécurité sociale (maternité, maladie, accidents du travail, dépendance ou vieillesse et perte d'emploi). Le droit à la sécurité sociale concerne toute personne résidant et circulant légalement dans l'UE. Le droit à une aide sociale est reconnu afin d'assurer une existence digne à tous ceux qui ne disposent pas de ressources suffisantes et de lutter contre l'exclusion sociale et la pauvreté. Tous ces aspects sont définis par les « règles établies par le droit de l'Union et les législations et pratiques nationales » (article 34, paragraphe 1, de la Charte).

412 CEDS, *Défense des Enfants International (DEI) c. Belgique*, n° 69/2011, 23 octobre 2012, paras. 82 et 83. Voir également FRA (2010), p. 33.

413 CEDS, *Défense des Enfants International (DEI) c. Pays-Bas*, n° 47/2008, 20 octobre 2009, para. 64.

Selon la CJUE, lorsque les propres ressortissants d'un État membre ne doivent uniquement résider dans l'État membre pour accéder à une allocation d'éducation, il ne peut être exigé des ressortissants d'autres États membres qu'ils présentent un permis de séjour officiel pour accéder à la même prestation[414]. Le refus du congé parental à certaines catégories de personnes, telles que les mères commanditaires ayant eu un enfant grâce à une convention de mère porteuse, est discriminatoire.[415] Il en va de même pour les fonctionnaires de sexe masculin qui se voient refuser un congé parental au motif que leur épouse ne travaille pas ou n'exerce aucune profession, à moins que, en raison d'une maladie grave ou d'un handicap, elle soit jugée comme étant dans l'incapacité de faire face aux besoins liés à l'éducation d'un enfant[416]. De même, les États membres doivent mettre en place un régime de congé parental spécifique pour les naissances de jumeaux, afin de faire en sorte que ces parents reçoivent une aide adaptée à leurs besoins. Pour ce faire, ils peuvent baser la durée du congé parental sur le nombre d'enfants nés et prévoir d'autres mesures telles qu'une assistance matérielle ou une aide financière[417].

Dans le droit du CdE, la CouEDH a jugé une affaire de discrimination présumée en ce qui concerne l'octroi d'un congé parental et d'allocations parentales en Russie.

> Exemple : dans l'affaire *Konstantin Markin c. Russie*[418], un militaire de l'armée russe s'est vu refuser un congé parental, alors que les femmes militaires ont droit à ce congé. De l'avis de la Cour, l'exclusion des militaires du droit au congé parental ne pouvait pas être raisonnablement justifiée. Ni le fait qu'il s'agisse de forces armées, ni les arguments relatifs de menace pour l'efficacité opérationnelle de l'armée, ni les arguments relatifs au rôle particulier joué par les femmes dans l'éducation des enfants ou aux traditions prévalant dans le pays n'ont été considérées comme des justifications à cette différence de traitement. La Cour a conclu à l'existence d'une violation de l'article 14 lu en combinaison avec l'article 8 de la CEDH.

414 CJUE, C-85/96, *María Martínez Sala c. Freistaat Bayern*, 12 mai 1998, points 60-65.

415 CJUE, C-363/12, *Z c. A Government Department, The Board of Management of a Community School* [GC], 18 mars 2014.

416 CJUE, C-222/14, *Konstantinos Maïstrellis c. Ypourgos Dikaiosynis, Diafaneias kai Anthropinon Dikaiomaton*, 16 juillet 2015, point 53.

417 CJUE, C-149/10, *Zoi Chatzi c. Ypourgos Oikonomikon*, 16 septembre 2010, points 72-75.

418 CouEDH, *Konstantin Markin c. Russie* [GC], n° 30078/06, 22 mars 2012.

D'autres vastes dispositions relatives au droit à la sécurité sociale, au droit à l'assistance sociale et médicale et au droit au bénéfice des services sociaux figurent aux articles 12 à 14 de la CSE. L'article 16 de la CSE indique explicitement que les allocations sociales et familiales constituent un moyen de promouvoir la protection économique, juridique et sociale de la vie de famille. L'article 30 de la CSE établit le droit à la protection contre la pauvreté et l'exclusion sociale. Certaines créances de sécurité sociale peuvent relever de l'article 1 du Protocole n° 1 à la CEDH, pour autant que la législation nationale génère un intérêt patrimonial en assurant le paiement de plein droit d'une prestation sociale, qu'il soit subordonné ou non au paiement préalable de contributions[419].

L'article 12 de la CSE oblige les États à établir ou à maintenir un régime de sécurité sociale, ainsi qu'à s'efforcer de le porter progressivement à un niveau plus haut.

L'article 16 de la CSE exige des États qu'ils promeuvent la protection économique, juridique et sociale de la vie de famille en prenant les mesures appropriées, essentiellement des prestations sociales et familiales, octroyées dans le cadre du régime de sécurité sociale et disponibles universellement ou sur la base des ressources. Ces prestations doivent représenter un complément de revenu adéquat pour un nombre significatif de familles. Le CEDS évalue l'adéquation des prestations familiales (parentales) en se basant sur le revenu équivalent médian (Eurostat)[420]. D'après lui, l'absence totale de système général de prestations familiales n'est pas conforme à la CSE[421].

Le CEDS admet néanmoins que le paiement des allocations familiales soit subordonné au droit de séjour de l'enfant[422]. D'après lui, l'introduction d'une protection très limitée contre les risques économiques et sociaux pour les enfants (15-18 ans) en contrat spécial d'apprentissage (ne leur donnant droit qu'à des prestations en nature au titre de l'assurance maladie et à une assurance contre les accidents du travail à un taux de 1 %) a pour effet d'exclure une catégorie distincte de travailleurs (les mineurs) de la « protection offerte par le système de sécurité sociale dans son ensemble », ce qui constitue une violation de

419 CouEDH, *Stummer c. Autriche* [GC], n° 37452/02, 7 juillet 2011, para. 82.

420 CEDS, Conclusions 2006, Estonie, p. 215.

421 CEDS, Conclusions 2011, Turquie, art. 16.

422 CEDS (2007), Conclusions XVIII-1 - Introduction générale, p. 11.

l'obligation imposée aux États de porter progressivement le régime de sécurité sociale à un niveau plus haut[423].

La suspension des allocations familiales en cas d'absentéisme scolaire constitue également une restriction disproportionnée du droit de la famille à une protection économique, sociale et juridique.

> Exemple : dans le cadre d'une plainte déposée contre la France, le Comité européen d'action spécialisée pour l'enfant et la famille dans leur milieu de vie (EUROCEF) a fait valoir que la suspension des allocations familiales en tant que mesure de lutte contre l'absentéisme scolaire constituait une violation du droit des familles à une protection sociale, juridique et économique au titre de l'article 16 de la CSE. En jugeant la mesure disproportionnée par rapport à l'objectif poursuivi, le Comité a noté que « la mesure contestée de suspension avec éventuelle suppression des allocations familiales fait peser exclusivement sur les parents toute la responsabilité d'assurer le but de réduire l'absentéisme scolaire, et augmente la vulnérabilité économique et sociale des familles affectées »[424].

La Convention européenne relative au statut juridique du travailleur migrant[425] dispose que les travailleurs migrants légalement employés dans un autre État ainsi que leur famille, doivent bénéficier d'un accès égal à la sécurité sociale (article 18) et aux autres « services sociaux » facilitant leur accueil dans l'État de destination (article 10). De même, la Convention européenne de sécurité sociale protège les droits des réfugiés et des apatrides à bénéficier du système de sécurité sociale de l'État d'accueil (y compris des allocations familiales pour les enfants)[426].

Dans le droit international, le droit à un niveau de vie suffisant est garanti par l'article 11 de l'ICESCR ainsi que par l'article 27 de la Convention relative aux droits de l'enfant.

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423 CEDS, *Fédération générale des employés des compagnies publiques d'électricité (GENOP-DEI) et Confédération des syndicats des fonctionnaires publics (ADEDY) c. Grèce*, n° 66/2011, 23 mai 2012, para. 48.

424 CEDS, *Comité européen d'action spécialisée pour l'enfant et la famille dans leur milieu de vie (EUROCEF) c. France*, n° 82/2012, 19 mars 2013, para. 42.

425 CdE, Convention européenne relative au statut juridique du travailleur migrant, STCE n° 93, 1977.

426 CdE, Convention européenne de sécurité sociale, STCE n° 78, 1972.

9 Migration et asile

UE	Questions traitées	CdE
TFUE, article 21 Charte des droits fondamentaux, article 45 (libre circulation) Directive sur les conditions d'accueil (2013/33/UE) Directive « retour » (2008/115/CE) Directive sur les procédures d'asile (2013/32/UE) Règlement de Dublin (n° 604/2013) Directive « qualification » (2011/95/UE) Directive relative à la liberté de circulation (2004/38/CE) CJUE, C-648/11, *The Queen, à la demande de MA et autres c. Secretary of State for the Home Department*, 2013 (transferts Dublin). Code frontières Schengen (Règlement (CE) 562/2006), annexe VII, 6	**Entrée et séjour**	CEDH, article 8 (vie familiale)
Directive sur les procédures d'asile (2013/32/UE), article 25, paragraphe 5	**Détermination de l'âge**	

UE	Questions traitées	CdE
TFUE, articles 67 et 73 et article 79, paragraphe 2, point a) Directive relative au regroupement familial (2003/86/CE) Directive « qualification » (2011/95/UE), article 31 Directive sur les conditions d'accueil (2013/33/UE) Directive relative à la protection temporaire (2001/55/CE) Règlement de Dublin (n° 604/2013) Directive « retour » (2008/115/CE), article 13	**Regroupement familial et enfants séparés**	CEDH, article 8 (droit au respect de la vie privée et familiale) CouEDH, *Şen c. Pays-Bas*, n° 31465/96, 2001 (conciliation des droits) CouEDH, *Jeunesse c. Pays-Bas* [GC], n° 12738/10, 2014 (vie familiale, intérêt supérieur de l'enfant)
Directive sur les conditions d'accueil (2013/33/UE), article 11 Directive « retour » (2008/115/CE), article 17	**Placement d'enfants en détention**	CouEDH, *Mubilanzila Mayeka et Kaniki Mitunga c. Belgique*, n° 13178/03, 2006 (placement en détention en vue d'une expulsion) CouEDH, *Popov c. France*, n° 39472/07 et 39474/07, 2012 (placement en rétention administrative en vue d'une expulsion) CouEDH, *Kanagaratnam et autres c. Belgique*, n° 15297/09, 2011 (placement en détention en vue d'une expulsion)
Directive relative à la liberté de circulation (2004/38/CE), préambule (point 24), articles 7, 12, 13 et article 28, paragraphe 3, point b)	**Expulsion**	CouEDH, *Gül c. Suisse*, n° 23218/94, 1996 (expulsion d'une famille) CouEDH, *Boultif c. Suisse*, n° 54273/00, 2001 (expulsion d'enfants) CouEDH, *Tarakhel c. Suisse*, n° 29217/12, 2014 (expulsion d'enfants)
Charte des droits fondamentaux, articles 47 et 48 (droit à un recours effectif et à un procès équitable, présomption d'innocence et droit de la défense) Directive sur les procédures d'asile (2013/32/UE), articles 7 et 25 Directive relative aux droits des victimes (2012/29/UE), article 8	**Accès à la justice**	CEDH, article 13 (droit à un recours effectif) CouEDH, *Rahimi c. Grèce*, n° 8687/08, 2011 (recours effectif visant à contester des conditions de placement en détention)

L'UE est compétente pour légiférer dans le domaine de la migration et de l'asile. Les dispositions relatives aux enfants migrants régissent toute une série de situations migratoires, telles que la migration professionnelle à long terme, l'asile et la protection subsidiaire et traitent également du cas des migrants en situation irrégulière. En plus de la protection accordée aux enfants migrants par l'article 24 de la Charte des droits fondamentaux de l'UE, les articles 18 et 19 de la Charte traitent du droit d'asile et du droit à la protection en cas d'éloignement, d'expulsion ou d'extradition. L'UE a également accordé son attention aux besoins particuliers des enfants non accompagnés, notamment en ce qui concerne les aspects juridiques, tels que la tutelle et la représentation légales, la détermination de l'âge, la recherche de la famille et le regroupement familial, les procédures d'asile, le placement en rétention et l'expulsion, de même que les aspects ayant trait aux conditions de vie des enfants, notamment le logement, les soins de santé, l'éducation et la formation, la religion, les normes et valeurs culturelles, les loisirs et divertissements, les interactions sociales et les expériences de racisme[427].

Dans le système du CdE, quatre conventions soutiennent particulièrement les droits des enfants migrants dans des contextes différents : la CEDH, la CSE, la Convention européenne relative au statut juridique du travailleur migrant et la Convention européenne sur la nationalité. Le présent chapitre s'intéresse essentiellement à l'application des dispositions de la CEDH, notamment de son article 3 (protection contre les traitements inhumains ou dégradants), son article 4 (privation de liberté) et son article 8 (droit au respect de la vie privée et familiale), seul ou en combinaison avec l'article 14 (non-discrimination). Ces dispositions servent à défendre les droits des enfants migrants, réfugiés et demandeurs d'asile et des membres de leur famille en matière de regroupement familial, d'accès à la justice et de résidence dans l'État d'accueil.

Sur le plan international, plusieurs dispositions de la CRC soutiennent les droits de l'enfant dans le contexte de la migration et de l'asile et ont orienté l'élaboration de mesures juridiques au niveau européen. En particulier, l'article 7 protège le droit de l'enfant à l'enregistrement de sa naissance, à la nationalité et aux soins parentaux ; l'article 8 protège le droit de l'enfant à l'identité, y compris à la nationalité, au nom et aux relations familiales ; l'article 9 garantit que les enfants séparés gardent contact avec leurs deux parents lorsque cela répond à leur intérêt supérieur ; et enfin, l'article 22 accorde aux enfants réfugiés le droit à une protection et à une aide spéciales. Par ailleurs, la Convention des Nations Unies relative

427 Pour plus d'informations, voir FRA (2010) ; FRA (2011a), p. 27-38 ; FRA (2011b), p. 26-30.

au statut des réfugiés[428], ainsi que son Protocole de 1967, sont universellement considérés comme la clé de voûte de la protection internationale des réfugiés.

Les sections suivantes sont consacrées à l'entrée et au séjour (section 9.1) ; à la détermination de l'âge (section 9.2) ; au regroupement familial pour les enfants séparés (section 9.3) ; au placement en détention (section 9.4) ; à l'expulsion (section 9.5) et à l'accès à la justice (section 9.6).

9.1. Entrée et séjour

Points clés

- Les ressortissants de l'UE disposent du droit à la liberté de circulation dans l'UE.
- Les décisions relatives à l'entrée et au séjour d'un enfant doivent être prises dans le cadre des mécanismes et procédures appropriés et dans l'intérêt supérieur de l'enfant.

Dans le droit de l'UE, la nature et la portée des droits des enfants varient considérablement selon la nationalité de l'enfant et de ses parents et selon que l'enfant migre accompagné de ses parents ou non.

La migration des ressortissants de l'UE est réglementée par plusieurs instruments juridiques. Les droits accordés aux ressortissants de l'UE sont vastes et visent à favoriser une mobilité optimale dans l'UE. Premièrement, l'article 21 du TFUE dispose que les citoyens de l'UE et les membres de leur famille ont le droit de circuler et de résider librement sur le territoire des États membres de l'UE. En outre, à leur arrivée dans l'État d'accueil, ils ont le droit d'être traités à égalité avec les ressortissants nationaux en ce qui concerne leur accès au marché du travail et leurs conditions de travail, les prestations et aides sociales, l'école, les soins de santé, etc.[429] L'article 45 de la Charte des droits fondamentaux de l'UE garantit également la liberté de circulation des citoyens de l'UE.

428 ONU, Assemblée générale, Convention relative au statut des réfugiés, 28 juillet 1951, Recueil des traités des Nations Unies, Vol. 189, p. 137.

429 Certaines restrictions ont été imposées aux migrants en provenance de Croatie, le dernier État à avoir rejoint l'UE, pour une période de transition jusqu'à juin 2015, avec la possibilité pour les États membres d'étendre cette période jusqu'en 2020.

En outre, les droits des enfants qui circulent avec des parents, ou avec une personne qui en a la charge, ressortissants de l'UE sont également régis par la directive relative à la liberté de circulation[430], disposant que les membres de la famille ont le droit d'entrer et de résider sur le territoire de l'État d'accueil en même temps que le migrant de l'UE initial ou à la suite de l'installation de celui-ci (article 5, paragraphe 1). Aux fins de cet instrument, le terme « membres de la famille » inclut tout enfant descendant direct du migrant de l'UE ou du conjoint ou partenaire, pour autant qu'il ait moins de 21 ans ou soit « à charge » (article 2, paragraphe 2). Les membres de la famille peuvent être ressortissants de l'UE ou de pays tiers, pour autant que le migrant initial avec lequel ils ont emménagé soit un citoyen de l'UE. Pendant les trois premiers mois suivant son installation, le droit de séjour de la famille est inconditionnel. Par la suite, les citoyens de l'UE souhaitant que leurs enfants restent avec eux dans l'État doivent prouver qu'ils disposent de ressources financières suffisantes et de l'assurance maladie nécessaire pour subvenir à leurs besoins (article 7). Les enfants et les autres membres de la famille obtiennent automatiquement un droit de séjour permanent après une période de cinq années consécutives de résidence dans l'État d'accueil auprès du citoyen de l'UE (article 16, paragraphe 2, et article 18). Ils ne sont alors plus soumis à des conditions en matière de ressources ou d'assurance-maladie.

La liberté de circulation des ressortissants de pays tiers n'appartenant pas à la famille d'un migrant de l'UE est soumise à davantage de restrictions. Ce domaine est réglementé en partie par le droit de l'UE et en partie par les législations nationales en matière d'immigration.

Dans le cadre des procédures de protection internationale, les enfants sont considérés comme des « personnes vulnérables » dont la situation spécifique doit être prise en compte par les États membres au moment d'appliquer le droit de l'UE[431]. Cela impose aux États de détecter et de prendre toute mesure particulière dont les enfants demandeurs d'asile, en particulier, pourraient avoir besoin lorsqu'ils entrent sur le territoire de l'État d'accueil. L'article 24 de la Charte des droits fondamentaux de l'UE s'applique aux exigences d'entrée et de séjour de l'acquis de l'UE en ma-

430 Il est à noter que les dispositions pertinentes de la directive s'appliquent également dans l'EEE. Voir également l'accord sur l'Espace économique européen, 2 mai 1992, troisième partie, Libre circulation des personnes, des services et des capitaux, ainsi que l'accord entre la Communauté européenne et ses États membres, d'une part, et la Confédération suisse, d'autre part, sur la libre circulation des personnes, signé au Luxembourg le 21 juin 1999, entré en vigueur le 1er juin 2002, JO 2002 L 114, p. 6.

431 Voir en particulier l'article 21 de la directive 2013/33/UE relative aux conditions d'accueil et l'article 3, paragraphe 9, de la directive 2008/115/CE sur le retour.

tière d'asile dans la mesure où celui-ci concerne les enfants. Il exige que dans tous les actes relatifs aux enfants, qu'ils soient accomplis par des autorités publiques ou des institutions privées, les États membres veillent à ce que l'intérêt supérieur de l'enfant soit une considération primordiale. Plus précisément, le principe de l'intérêt supérieur sous-tend la mise en œuvre de la directive 2013/32/UE relative à des procédures communes pour l'octroi et le retrait de la protection internationale (directive sur les procédures d'asile)[432] et l'application du règlement établissant les critères et mécanismes de détermination de l'État membre responsable de l'examen d'une demande de protection internationale présentée dans l'un des États membres par un ressortissant de pays tiers ou un apatride (règlement de Dublin) dans la mesure où des enfants sont concernés[433]. Les deux textes contiennent également des garanties spéciales pour les enfants non accompagnés, relatives notamment à leur représentation légale. Le règlement (CE) n° 562/2006 relatif au code frontières Schengen dispose que les garde-frontières doivent s'assurer que les personnes accompagnant des enfants sont investies de l'autorité parentale à leur égard, notamment lorsque l'enfant n'est accompagné que par un seul adulte et qu'il y a des raisons sérieuses de croire qu'il a été illicitement soustrait à la garde de la ou des personne(s) qui détiennent légalement l'autorité parentale à son égard. Dans ce cas, le garde-frontière doit effectuer une recherche plus approfondie afin de déceler d'éventuelles incohérences ou contradictions dans les informations données. Lorsque des enfants voyagent non accompagnés, les garde-frontières doivent s'assurer, par une vérification approfondie des documents de voyage et des autres documents, que les enfants ne quittent pas le territoire contre la volonté de la ou des personne(s) investie(s) de l'autorité parentale à leur égard[434].

En vertu du droit du CdE, les États ont le droit, en vertu du droit international et sans préjudice des obligations qu'ils ont contractées dans les traités, y compris la CEDH, de contrôler l'entrée, le séjour et l'éloignement des ressortissants étrangers. Le droit au respect de la vie privée et familiale consacré à l'article 8 de la CEDH est souvent invoqué comme une garantie contre l'expulsion lorsqu'il est question

432 Directive 2013/32/UE du Parlement européen et du Conseil du 26 juin 2013 relative à des procédures communes pour l'octroi et le retrait de la protection internationale (refonte), JO 2013 L 180, p. 60, art. 25, para. 6.

433 Règlement (UE) n° 604/2013 du Parlement européen et du Conseil du 26 juin 2013 établissant les critères et mécanismes de détermination de l'État membre responsable de l'examen d'une demande de protection internationale introduite dans l'un des États membres par un ressortissant de pays tiers ou un apatride (refonte), JO 2013 L 180/31-180/59, art. 6.

434 Règlement (CE) n° 562/2006 du Parlement européen et du Conseil du 15 mars 2016 établissant un code communautaire relatif au régime de franchissement des frontières par les personnes (code frontières Schengen), annexe VII, 6.

d'enfants qui, faute de quoi, auraient été jugés comme n'ayant pas besoin de protection internationale, notamment de protection subsidiaire. Des violations de l'article 8 ont été constatées dans des affaires impliquant des enfants, la séparation forcée de membres de la famille proche étant susceptible d'avoir des répercussions profondes sur leur éducation, leur stabilité sociale et affective, et leur identité[435].

9.2. Détermination de l'âge[436]

Points clés

- Les procédures de détermination de l'âge doivent tenir compte des droits de l'enfant.
- La détermination de l'âge désigne les procédures par lesquelles les autorités tentent d'établir l'âge légal d'un migrant afin de déterminer les procédures et règles applicables en matière d'immigration.

Dans le droit de l'UE, l'article 25, paragraphe 5, de la directive sur les procédures d'asile permet aux États membres d'avoir recours à des examens médicaux, mais exige que ceux-ci soient effectués « dans le plein respect de la dignité de la personne, [soient] le moins invasif[s] possible et [soient] réalisé[s] par des professionnels de la santé qualifiés ». Cette disposition exige également que les personnes soient informées dans une langue qu'elles comprennent de la possibilité que cette évaluation soit effectuée et que leur consentement à l'examen médical soit obtenu. Un refus de se soumettre à une détermination de l'âge ne peut entraîner le rejet de la demande de protection internationale.

Les méthodes de détermination de l'âge appliquées dans l'UE varient considérablement, que ce soit sur le plan de leur nature ou de leur portée[437]. Au Royaume-Uni, par exemple, le pouvoir judiciaire a révisé les procédures nationales d'évaluation de l'âge et a défini, dans le cadre de l'affaire *Merton*, les exigences de procédure minimales à respecter lors de la détermination de l'âge d'un individu affirmant

435 CouEDH, *Şen c. Pays-Bas*, n° 31465/96, 21 décembre 2001 ; CouEDH, *Tuquabo-Tekle et autres c. Pays-Bas*, n° 60665/00, 1er décembre 2005.

436 Voir également FRA et CouEDH (2014), section 9.1.2.

437 Pour un aperçu des différentes méthodes appliquées dans chaque pays, voir les orientations du Bureau européen d'appui en matière d'asile sur les pratiques d'évaluation de l'âge en Europe, Luxembourg, 2014. Voir également FRA (2010), p. 53-55.

être un enfant non accompagné[438]. Ces exigences incluent notamment le droit du demandeur d'asile d'être informé des motifs de rejet de sa demande ou des objections de la personne ayant conduit l'entretien[439]. Les tribunaux nationaux ont également affirmé la nécessité d'appliquer le principe du bénéfice du doute dans les affaires de détermination de l'âge, bien que certains tribunaux nationaux ont interprété ce principe comme étant un simple « examen bienveillant des éléments de preuve » et non pas comme un principe formel de « bénéfice du doute »[440].

Le droit du CdE ne contient aucune disposition spécifique ou jurisprudence de la CEDH relative aux droits de l'enfant dans le cadre de procédures de détermination de l'âge. Toutefois, l'utilisation de pratiques particulièrement invasives à cette fin peut déclencher l'application des articles 3 ou 8 de la CEDH. L'article 3 a été interprété de façon à inclure une grande diversité de scénarios pouvant être considérés comme inhumains ou dégradants, y compris des examens physiques invasifs pratiqués sur des enfants[441]. Selon l'article 8 appliqué à un contexte d'immigration, les autorités peuvent légitimement interférer avec le droit d'un enfant au respect de la vie privée et réaliser des évaluations de son âge si la loi le permet et si ces évaluations sont nécessaires pour protéger l'un des buts légitimes énoncés à l'article 8, paragraphe 2, de la CEDH.

Dans le cadre du droit international, l'article 8 de la Convention relative aux droits de l'enfant oblige les États à respecter le droit de l'enfant à définir sa propre identité. Cette obligation implique celle d'aider l'enfant à faire valoir son identité, ce qui peut nécessiter la confirmation de son âge. Toutefois, les procédures de détermination de l'âge ne doivent être utilisées qu'en dernier recours.

En tout état de cause, les procédures nationales relatives à la détermination de l'âge doivent reposer sur le principe de l'intérêt supérieur. Selon le Comité des droits de l'enfant des Nations Unies, la détermination de l'âge doit prendre en considération l'apparence physique de l'enfant, mais aussi son degré de maturité psychologique. La détermination de l'âge doit être menée scientifiquement, dans le souci de la sécurité de l'enfant, de manière adaptée à son statut d'enfant

438 Royaume-Uni, Court of Appeal, *R (on the application of B) c. The Mayor and Burgesses of the London Borough of Merton* [2003] EWHC 1689, 14 juillet 2003.

439 Voir également FRA (2010), p. 61-66.

440 Royaume-Uni, Court of Appeal, *R (on the application of CJ) c. Cardiff County* Council [2011] EWCA Civ 1590, 20 décembre 2011, confirmé dans Royaume-Uni, Upper Tribunal, *R (on the application of MK) c. Wolverhampton City Council* [2013] UKUT 00177 (IAC), 26 mars 2013.

441 CouEDH, *Yazgül Yilmaz c. Turquie*, n° 36369/06, 1er février 2011.

et à son sexe et équitablement, afin de prévenir tout risque de violation de l'intégrité physique de l'enfant. Cette détermination doit en outre se faire avec tout le respect dû à la dignité humaine[442].

9.3. Regroupement familial pour les enfants séparés[443]

Points clés

- Les dispositions adoptées au niveau européen ont pour objectif principal de permettre aux enfants de retrouver leurs parents en toute sécurité, que ce soit dans leur pays d'accueil ou leur pays d'origine.
- Au moment de déterminer quels membres de sa famille l'enfant doit rejoindre, la préférence sera donnée à ses parents et/ou aux personnes qui ont la charge de l'enfant.
- Les affaires de regroupement familial doivent être traitées en fonction du principe de l'intérêt supérieur de l'enfant.

En vertu du droit de l'UE, le principal instrument est la directive relative au regroupement familial, qui exige des États membres qu'ils autorisent l'entrée et le séjour sur leur territoire des ressortissants de pays tiers qui sont les parents d'un enfant non accompagné, lorsqu'il n'est pas dans l'intérêt supérieur de l'enfant de les rejoindre à l'étranger. En l'absence de parents, les États membres peuvent à leur entière discrétion autoriser l'entrée et le séjour du tuteur légal de l'enfant ou de tout autre membre de sa famille[444]. La définition de « famille » et les droits qui sont rattachés à ce terme sont dès lors plus généreux dans le contexte des enfants non accompagnés que pour la plupart des autres catégories d'enfants migrants.

En ce qui concerne les enfants demandeurs d'asile, la directive « qualification » souligne la nécessité de veiller dans la mesure du possible à ce que les enfants non accompagnés soient placés auprès de parents adultes dans l'État d'accueil, à ce que les fratries ne soient pas séparées et à ce que les membres de la famille

442 ONU, Comité des droits de l'enfant (2005), *Observation générale n° 6 (2005), Traitement des enfants non accompagnés et des enfants séparés en dehors de leur pays d'origine*, CRC/GC/2005/6, 1er septembre 2005, (V)(a)(31)(A).

443 Voir également FRA et CouEDH (2014), section 5.3, sur le regroupement familial.

444 Respectivement l'article 10, para. 3, points a) et b).

absents soient localisés le plus tôt possible, d'une manière sensible et en veillant à leur sécurité. La directive relative aux conditions d'accueil contient des dispositions similaires pour les enfants non accompagnés qui n'ont pas encore obtenu le statut de réfugié (article 24).

La directive 2001/55/CE du Conseil relative à des normes minimales pour l'octroi d'une protection temporaire en cas d'afflux massif de personnes déplacées et à des mesures tendant à assurer un équilibre entre les efforts consentis par les États membres pour accueillir ces personnes et supporter les conséquences de cet accueil (directive relative à la protection temporaire) cherche également à obtenir le plus tôt possible le regroupement des membres d'une même famille (y compris les enfants) ayant été séparés à la suite d'une évacuation soudaine de leur pays d'origine (article 15)[445]. Toutefois, cette directive n'a encore jamais été appliquée à ce jour. En effet, pour qu'elle soit « déclenchée », une décision du Conseil est nécessaire, et aucune décision de ce type n'a encore été prise.

L'article 24, paragraphe 3, de la directive sur les conditions d'accueil (refonte) exige également des États membres qu'ils commencent si nécessaire à rechercher les membres de la famille de l'enfant non accompagné, le cas échéant avec l'aide d'organisations internationales ou d'autres organisations compétentes dans les plus brefs délais après l'introduction d'une demande de protection internationale, tout en protégeant l'intérêt supérieur de l'enfant. Dans les cas où la vie ou l'intégrité physique d'un enfant ou de ses parents proches pourraient être menacées, en particulier s'ils sont restés dans le pays d'origine, il convient de faire en sorte que la collecte, le traitement et la diffusion d'informations concernant ces personnes soient effectués à titre confidentiel, pour éviter de compromettre leur sécurité. Par ailleurs, conformément à l'article 31, paragraphe 5, de la directive « qualification » (refonte), l'octroi d'une protection internationale à l'enfant ne doit pas interférer avec le début ou la poursuite du processus de recherche.

Le règlement de Dublin dispose par ailleurs que lorsqu'un enfant non accompagné a un ou plusieurs membres de sa famille qui habitent dans un autre État membre et qui peuvent le prendre en charge, les États membres sont tenus, dans la mesure du possible, de réunir l'enfant avec ses proches, à moins que ce ne soit contraire à son intérêt supérieur. Le règlement prévoit en outre l'obligation de rechercher les

445 Directive 2001/55/CE du Conseil du 20 juillet 2001 relative à des normes minimales pour l'octroi d'une protection temporaire en cas d'afflux massif de personnes déplacées et à des mesures tendant à assurer un équilibre entre les efforts consentis par les États membres pour accueillir ces personnes et supporter les conséquences de cet accueil, JO 2001 L 2012.

membres de la famille de l'enfant sur le territoire des États membres, tout en protégeant l'intérêt supérieur de l'enfant (article 6). Notons également que la directive relative aux conditions d'accueil impose l'obligation de commencer à rechercher les membres de la famille de l'enfant non accompagné, si nécessaire avec l'aide d'organisations internationales ou d'autres organisations compétentes (article 24). Ce dernier type d'aide est également prévu dans le règlement de Dublin (article 6).

Le principe de l'intérêt supérieur doit toujours être appliqué au moment de prendre une décision sur le regroupement familial. Par exemple, les parents doivent être en mesure de prouver qu'ils sont aptes à exercer leurs obligations parentales dans l'intérêt de l'enfant. Les tribunaux nationaux jugent illégal le retour de l'enfant dans son pays d'origine lorsque les autorités n'ont pas pu recueillir de preuves attestant de l'existence de dispositions adéquates prises pour l'accueil et la prise en charge de l'enfant dans ce pays (directive « retour », article 10, paragraphe 2).

Dans le droit du CdE, l'article 8 de la CEDH n'octroie pas aux parents migrants et à leurs enfants le droit absolu de choisir où ils veulent vivre. Les autorités nationales peuvent légitimement expulser ou refuser l'entrée de membres de la famille de l'enfant sur leur territoire lorsqu'il n'existe aucun obstacle insurmontable les empêchant de bâtir une vie familiale ailleurs[446]. Les décisions de ce type doivent toujours être proportionnées aux préoccupations d'ordre public plus larges, y compris la volonté d'expulser ou d'empêcher l'entrée d'un proche ayant été impliqué dans une activité criminelle.

Exemple : dans l'affaire *Şen c. Pays-Bas*, la CouEDH a confirmé qu'au moment de trouver un équilibre entre les droits de l'enfant/de la famille et les intérêts d'ordre public plus larges, trois facteurs clés devaient être pris en considération : l'âge des enfants, leur situation dans le pays d'origine et le degré auquel ils dépendent réellement de leurs parents.

Exemple : l'affaire *Jeunesse c. Pays-Bas*[447] traitait du refus des autorités néerlandaises d'autoriser une femme surinamaise mariée à un ressortissant néerlandais, avec lequel elle avait eu trois enfants, à résider aux Pays-Bas au motif de sa vie familiale dans le pays. La CouEDH a considéré que les autorités n'avaient pas tenu suffisamment compte des consé-

446 CouEDH, *Bajsultanov c. Autriche*, n° 54131/10, 12 juin 2012 ; CouEDH, *Latifa Benamar et autres c. Pays-Bas*, décision d'irrecevabilité, n° 43786/04, 5 avril 2005.

447 CouEDH, *Jeunesse c. Pays-Bas*, n° 12738/10, 3 octobre 2014.

quences de leur refus sur les enfants de la requérante et l'intérêt supérieur de ceux-ci. La Cour a conclu à une violation de l'article 8 de la CEDH au motif qu'un juste équilibre n'avait pas été ménagé entre l'intérêt personnel de la requérante et de sa famille à maintenir leur vie familiale aux Pays-Bas et les intérêts d'ordre public du gouvernement relatifs au contrôle de l'immigration.

Dans le droit international, un enfant a le droit de ne pas être séparé de sa famille à moins que la séparation ne soit jugée être dans son intérêt supérieur (article 9, paragraphe 1, de la CRC). L'article 10 de la CRC dispose qu'un enfant dont les parents vivent dans des pays différents doit avoir le droit de circuler entre ces pays afin de rester en contact avec ses deux parents ou pour les rejoindre, selon le droit national en matière d'immigration. Le principe de l'intérêt supérieur consacré à l'article 3 de la CRC est celui sur lequel reposent toutes les décisions relatives au regroupement familial avec un enfant ou un enfant non accompagné. [448]

9.4. Détention

Points clés

- Aux termes du droit européen, le placement d'enfants en détention dans un contexte d'immigration n'est autorisé qu'à titre de mesure de dernier ressort.
- Les autorités nationales sont tenues de placer les enfants dans des lieux d'hébergement de substitution appropriés.

Dans le droit de l'UE, l'article 11 de la directive sur les conditions d'accueil (refonte) dispose que les enfants ne peuvent être placés en rétention qu'à titre de mesure de dernier ressort et uniquement après qu'il a été établi que d'autres mesures moins coercitives ne peuvent être appliquées efficacement. Ce placement en rétention doit être d'une durée la plus brève possible et tout doit être mis en œuvre pour libérer les enfants placés en rétention et les placer dans des lieux d'hébergement appropriés. Lorsque des enfants sont placés en rétention, ils doivent avoir la

448 Selon l'UNICEF, en cas de demande de réunification de l'enfant avec sa famille dans l'État d'accueil, les tribunaux nationaux doivent également veiller à ce que les parents n'exploitent pas leur enfant dans le but d'obtenir un permis de séjour dans ce pays. Voir UNICEF, Application judiciaire de l'article 3 de la CRC en Europe, p. 104. Voir également HCR (2008), Principes directeurs du HCR relatifs à la détermination de l'intérêt supérieur de l'enfant, mai 2008.

possibilité de pratiquer des activités de loisirs, y compris des jeux et des activités récréatives adaptés à leur âge. Selon le même article, les enfants non accompagnés ne peuvent eux aussi être placés en rétention que dans des circonstances exceptionnelles et tous les efforts nécessaires doivent être déployés pour les libérer dans les plus brefs délais. Ils ne doivent jamais être placés en rétention dans des établissements pénitentiaires, mais hébergés dans des centres disposant de personnel et d'installations qui tiennent compte des besoins des personnes de leur âge. Ils doivent être hébergés séparément des adultes.

L'article 17 de la directive « retour » prévoit le placement en rétention d'enfants et de familles dont la demande d'asile a été rejetée sous réserve de certaines conditions. Toutefois, lorsqu'il s'agit d'enfants non accompagnés, ceux-ci doivent être placés dans des centres disposant de personnel et d'installations qui tiennent compte des besoins des personnes de leur âge. Il n'existe à ce jour aucune jurisprudence de la CJUE traitant spécifiquement du placement en rétention d'enfants.

Dans le droit du CdE, le placement en détention des enfants a été abordé dans le cadre des articles 3 et 5 de la CEDH.

Exemple : l'affaire *Mubilanzila Mayeka et Kaniki Mitunga c. Belgique*[449], porte sur le placement en détention d'un enfant non accompagné. Une enfant de cinq ans avait été placée en détention dans un centre de transit pour adultes pendant deux mois, sans bénéficier d'un soutien approprié. L'enfant avait voyagé depuis la République démocratique du Congo sans les documents de voyage nécessaires dans l'espoir de retrouver sa mère, qui avait obtenu le statut de réfugié au Canada. L'enfant a ensuite été rapatriée en République démocratique du Congo, bien qu'aucun membre de sa famille ne l'y attende pour la prendre en charge. La CouEDH avait considéré qu'en l'absence de tout risque que l'enfant ne cherche à se soustraire à la surveillance des autorités belges, sa détention en centre fermé pour adultes ne répondait à aucune nécessité. La Cour a également noté que d'autres mesures, telles que le placement dans un centre spécialisé ou dans une famille d'accueil, prenant davantage en considération l'intérêt supérieur de l'enfant, tel que consacré à l'article 3 de la CRC, auraient pu être prises. La CouEDH a conclu à l'existence de violations des articles 3, 5 et 8 de la CEDH.

449 CouEDH, *Mubilanzila Mayeka et Kaniki Mitunga c. Belgique*, n° 13178/03, 12 octobre 2006.

D'autres cas ont souligné le caractère illégal du placement en détention, même lorsque l'enfant en question était accompagné d'un de ses parents.

Exemple : dans l'affaire *Muskhadzhiyeva et autres c. Belgique*[450], la CouEDH a considéré que le placement en détention administrative, pendant un mois, d'une mère et de ses quatre enfants âgés entre sept mois et sept ans dans un centre de transit fermé constituait une violation de l'article 3 de la CEDH. Dans ses conclusions, la Cour a attiré l'attention sur l'inadaptabilité du centre à la détention d'enfants, ayant de sérieuses conséquences sur leur état psychologique.

Exemple : l'affaire *Popov c. France*[451] concernait la rétention administrative d'une famille pendant deux semaines dans l'attente de leur expulsion vers le Kazakhstan. La CouEDH a conclu à l'existence d'une violation de l'article 3 de la CEDH dans la mesure où les autorités françaises n'avaient pas mesuré les conséquences inévitablement dommageables, pour les deux enfants (âgés de cinq mois et de trois ans), d'un placement dans un centre de rétention dans des conditions qui n'étaient « pas adaptées à la présence d'enfants »[452]. La Cour a également conclu à une violation des articles 5 et 8 à l'égard de la famille entière et fait référence à l'article 37 de la CRC, qui exige que « [t]out enfant privé de liberté soit traité avec humanité et avec le respect dû à la dignité de la personne humaine, et d'une manière tenant compte des besoins des personnes de son âge »[453].

Exemple : de même, dans l'affaire *Kanagaratnam et autres c. Belgique*[454], le placement en détention d'une mère demandeuse d'asile et de ses trois enfants dans un centre fermé pour étrangers en situation irrégulière pendant quatre mois a été jugé constituer une violation des articles 3 et 5 de la CEDH. Malgré le fait que les enfants aient été accompagnés de leur mère, la Cour a considéré qu'en les plaçant dans un centre fermé, les autorités belges les avaient exposés à des sentiments d'angoisse et d'infériorité et

450 CouEDH, *Muskhadzhiyeva et autres c. Belgique*, n° 41442/07, 19 janvier 2010.

451 CouEDH, *Popov c. France*, n° 39472/07 et 39474/07, 19 janvier 2012.

452 *Ibid.*, para. 95.

453 *Ibid.*, para. 90.

454 CouEDH, *Kanagaratnam et autres c. Belgique*, n° 15297/09, 13 décembre 2011.

avaient pris en toute connaissance de cause, le risque de compromettre leur développement.[455]

Dans le droit international, l'article 9, paragraphe 4, de la CRC dispose que lorsqu'un enfant est placé en détention, les autorités nationales doivent donner aux parents les renseignements essentiels quant au lieu où se trouve l'enfant[456].

9.5. Expulsion[457]

Points clés

- La vulnérabilité des enfants migrants face à l'expulsion est étroitement liée au statut de résident de leurs parents dans l'État d'accueil.
- Le principe de l'intérêt supérieur doit orienter toutes les décisions relatives à l'expulsion d'un enfant immigrant et de sa famille/des personnes qui en ont la charge.
- Le droit de l'UE distingue certaines circonstances dans lesquelles les enfants migrants peuvent demeurer dans un État d'accueil quel que soit le statut juridique de leurs parents, notamment pour achever leur éducation ou lorsqu'il serait difficile pour eux de bâtir une vie familiale ailleurs.

Dans le droit de l'UE, comme dans d'autres domaines du droit de l'UE en matière de migration, les règles régissant l'expulsion des enfants varient en fonction de la nationalité de ces derniers, de la nationalité de leurs parents et du contexte de leur migration. Une fois qu'un enfant obtient l'accès à un État membre au titre du droit de l'UE en matière de libre circulation, il peut généralement y demeurer même si le proche avec lequel il avait initialement emménagé perd son droit de résidence ou décide de quitter le pays.

455 Le Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants a décrit, dans son 19e rapport général, des garanties destinées aux migrants en situation irrégulière privés de liberté, accompagnées de garanties supplémentaires pour les enfants. Pour plus d'informations, voir *20 ans de lutte contre la torture - 19e rapport général du Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT), 1er août 2008 - 31 juillet 2009*, CPT/Inf (2009) 27, Strasbourg, 20 octobre 2009.

456 Voir, au sujet des garanties internationales pour les enfants placés en rétention, le *Rapport du Rapporteur spécial sur la torture et autres peines ou traitements cruels, inhumains ou dégradants*, 5 mars 2015, A/HRC/28/68.

457 Également appelée retour, éloignement, rapatriement, extradition en fonction du contexte juridique. Aux fins du présent chapitre, le terme « expulsion » sera utilisé pour définir l'éloignement légal d'un non-ressortissant ou d'une autre personne d'un État. Voir également FRA et CouEDH (2014), section 5.4, sur le maintien de l'unité familiale et la protection contre l'expulsion.

En particulier, au titre de la directive relative à la liberté de circulation, les enfants et les membres de leur famille ont le droit de rester dans l'État d'accueil après le décès du proche citoyen de l'UE avec lequel ils avaient initialement emménagé (article 12, paragraphe 2), pour autant qu'ils aient vécu dans l'État d'accueil pendant au moins 12 mois avant le décès du proche en question. De même, ils peuvent en principe demeurer dans l'État d'accueil après le départ de leur proche. Toutefois, dans les deux cas, si l'enfant/le membre de la famille est un ressortissant de pays tiers, son droit de résidence est subordonné à sa capacité de démontrer qu'il possède suffisamment d'argent pour subvenir à ses besoins. Il doit également posséder une assurance maladie (article 7).

Les règles sont encore plus permissives pour les enfants inscrits dans un établissement d'enseignement de l'État d'accueil. Ces enfants, ainsi que le parent ayant leur garde ou leur pourvoyeur primaire de soins, ont le droit de demeurer dans l'État d'accueil après le décès ou le départ du citoyen migrant de l'UE qu'ils ont initialement rejoint, quel que soit leur nationalité (article 12, paragraphe 3). Si, initialement, cette concession liée à l'éducation semblait ne s'appliquer qu'aux enfants de familles ayant suffisamment de moyens pour subvenir à leurs propres besoins[458], la jurisprudence a ensuite confirmé qu'elle s'appliquait également aux enfants placés dans le système éducatif susceptibles de dépendre de l'aide sociale[459].

Par ailleurs, les membres d'une famille et, plus particulièrement, les proches ressortissants de pays tiers ont également le droit de demeurer dans l'État d'accueil après le divorce du partenaire citoyen de l'UE s'ils ont la garde principale des enfants du couple ou s'ils ont obtenu un droit de visite des enfants devant être exercé dans l'État d'accueil (article 13, paragraphe 2, points b) et d)).

La CJUE s'est basée sur le statut de citoyen de l'UE d'un enfant au titre de l'article 20 du TFUE pour octroyer à ses parents ressortissants de pays tiers un permis de travail et de séjour dans l'État membre dont l'enfant possède la citoyenneté. Ainsi, l'enfant, qui aurait sinon dû quitter l'UE pour accompagner ses parents, peut jouir des droits liés à son statut de citoyen de l'UE[460]. Toutefois, la jurisprudence

458 CJUE, C-413/99, *Baumbast et R c. Secretary of State for the Home Department*, 17 septembre 2002.

459 CJUE, C-480/08, *Maria Teixeira c. London Borough of Lambeth et Secretary of State for the Home Department*, 23 février 2010 ; CJUE, C-310/08, *London Borough of Harrow c. Nimco Hassan Ibrahim et Secretary of State for the Home Department* [GC], 23 février 2010. L'éducation des enfants migrants sera également abordée à la section 8.2.

460 CJUE, C-34/09, *Gerardo Ruiz Zambrano c. Office national de l'emploi (ONEm)*, 8 mars 2011.

postérieure de la CJUE indique que « le seul fait qu'il pourrait paraître souhaitable à un ressortissant d'un État membre, pour des raisons d'ordre économique ou afin de maintenir l'unité familiale sur le territoire de l'Union, que des membres de sa famille, qui ne disposent pas de la nationalité d'un État membre, puissent séjourner avec lui sur le territoire de l'Union, ne suffit pas en soi pour considérer que le citoyen de l'Union serait contraint de quitter le territoire de l'Union si un tel droit n'est pas accordé »[461].

La directive sur la liberté de circulation dispose explicitement que toute expulsion exceptionnelle d'un enfant doit respecter les dispositions de la CRC (considérant 24). Par ailleurs, l'article 28, paragraphe 3, point b), confirme qu'un enfant ne peut être expulsé à moins que son retour ne soit considéré comme étant dans son intérêt supérieur et ne soit conforme aux dispositions de la Convention.

S'agissant des enfants demandeurs d'asile dont la demande a été rejetée, la directive « retour » précise que l'intérêt supérieur de l'enfant doit orienter les décisions relatives au retour des enfants non accompagnés (article 10). Par ailleurs, avant d'éloigner du territoire d'un État membre un enfant non accompagné, les autorités de cet État membre doivent s'assurer qu'il sera remis à un membre de sa famille, à un tuteur désigné ou à des structures d'accueil adéquates dans l'État de retour (article 10, paragraphe 2).

Lorsqu'un enfant demandeur d'asile est renvoyé dans un autre État membre pour y faire étudier sa demande d'asile, le règlement de Dublin dispose que le principe de l'intérêt supérieur doit orienter l'application de la décision (article 6). Le règlement inclut par ailleurs une liste des facteurs à prendre en considération, afin d'aider les autorités à déterminer l'intérêt supérieur de l'enfant. Parmi ces facteurs figurent la prise en considération des possibilités de regroupement familial, le bien-être et le développement social de l'enfant, les aspects relatifs à la sûreté et à la sécurité, en particulier lorsque l'enfant risque d'être victime de la traite des êtres humains, ainsi que le point de vue de l'enfant, en fonction de son âge et de sa maturité.

461 CJUE, C-256/11, *Murat Dereci et autres c. Bundesministerium für Inneres* [GC], 15 novembre 2011, point 68. Voir également CJUE, C-40/11, *Yoshikazu Iida c. Stadt Ulm*, 8 novembre 2012. Voir également FRA et CouEDH (2014), p. 134-136.

Exemple : dans l'affaire *The Queen, à la demande de MA et autres c. Secretary of State for the Home Department*[462], la CJUE a dû déterminer quel État était responsable dans le cas d'un enfant non accompagné qui avait a introduit des demandes d'asile dans plusieurs États membres de l'UE et ne possède aucune famille ou proches dans d'autres États membres de l'UE. La Cour a précisé qu'en l'absence de membres de la famille se trouvant légalement dans un État membre, l'État dans lequel l'enfant est physiquement présent est responsable de l'examen de la demande. Elle s'est appuyée pour cette conclusion sur l'article 24, paragraphe 2 de la Charte des droits fondamentaux de l'UE, aux termes duquel l'intérêt supérieur de l'enfant doit être privilégié dans toutes les actions qui concerne ce dernier.

Dans le droit du CdE, les États disposent théoriquement du droit d'ingérence dans l'exercice du droit au respect de la vie familiale conformément à l'article 8, paragraphe 2, de la CEDH.

Exemple : l'affaire *Gül c. Suisse*[463] concerne un requérant vivant en Suisse avec son épouse et sa fille, tous trois ayant obtenu un permis de séjour pour des motifs humanitaires. Le requérant souhaitait également faire venir en Suisse son fils mineur, resté en Turquie. Toutefois, les autorités suisses ont rejeté sa demande, essentiellement au motif qu'il n'avait pas les moyens de subvenir aux besoins de sa famille. La CouEDH a considéré qu'en quittant la Turquie, le requérant avait été à l'origine de la séparation avec son fils. Ses récentes visites en Turquie tendaient à montrer que ses raisons initiales de demander l'asile en Suisse n'étaient plus d'actualité. Aucun obstacle n'empêchait la famille de se réinstaller dans son pays d'origine, où le fils mineur avait toujours vécu. Tout en reconnaissant que la situation de la famille était très difficile d'un point de vue humain, la Cour n'a trouvé aucune violation de l'article 8 de la CEDH.

Exemple : Dans l'affaire *Üner c. Pays-Bas*[464], la Cour a confirmé la nécessité de tenir compte de l'incidence d'une expulsion sur les enfants d'une famille pour déterminer si cette expulsion constitue une réponse

462 CJUE, C-648/11, *The Queen, à la demande de MA et autres c. Secretary of State for the Home Department*, 6 juin 2013.

463 CouEDH, *Gül c. Suisse*, n° 23218/94, 19 février 1996.

464 CouEDH, *Üner c. Pays-Bas* [GC], n° 46410/99, 18 octobre 2006, paras. 57-58. Voir également *Boultif c. Suisse*, n° 54273/00, 2 août 2001.

proportionnée. Il importe notamment de prendre en considération « l'intérêt et le bien-être des enfants, en particulier la gravité des difficultés que les enfants [...] sont susceptibles de rencontrer dans le pays vers lequel l'intéressé doit être expulsé ; et la solidité des liens sociaux, culturels et familiaux avec le pays hôte et avec le pays de destination ».

Exemple : l'affaire *Tarakhel c. Suisse*[465] porte sur le refus des autorités suisses d'examiner la demande d'asile d'un couple afghan et de leurs six enfants et leur décision de les renvoyer en Italie. La CouEDH a considéré qu'au vu de la situation actuelle du système d'accueil italien et en l'absence d'informations détaillées et fiables quant à la structure précise de destination, les autorités suisses ne disposaient pas d'éléments suffisants pour être assurées qu'en cas de renvoi vers l'Italie, les requérants seraient pris en charge d'une manière adaptée à l'âge des enfants. La Cour a par conséquent estimé que les autorités suisses commettraient une violation de l'article 3 de la CEDH en renvoyant les requérants vers l'Italie sans avoir tout d'abord obtenu auprès des autorités italiennes l'assurance qu'ils seraient accueillis dans des conditions adaptées à l'âge des enfants et que l'unité de la cellule familiale sera préservée.

Dans le droit international, un État doit fournir, sur demande d'un enfant, des parents ou de l'un d'eux, les informations essentielles sur le lieu où se trouve le membre ou les membres de la famille, placés en rétention, emprisonnés, en exil, déportés ou décédés, à moins que la divulgation de ces renseignements ne soit préjudiciable au bien-être de l'enfant (article 9, paragraphe 4, de la CRC).

9.6. Accès à la justice[466]

Point clé

- Les enfants migrants ont le droit à un recours effectif.

Dans le droit de l'UE, le droit de l'enfant d'accéder à la justice dans un contexte d'immigration est défini par divers instruments. Premièrement, le droit à un

465 CouEDH, *Tarakhel c. Suisse*, n° 29217/12, 4 novembre 2014.

466 Voir également FRA et CouEDH (2014), section 4.5, sur l'assistance judiciaire dans les procédures d'asile ou de retour.

recours effectif et à un procès équitable est consacré à l'article 47 de la Charte des droits fondamentaux de l'UE. Cet article prévoit notamment le droit de toute personne à ce que sa cause soit entendue équitablement, publiquement et dans un délai raisonnable par un tribunal indépendant et impartial, en ayant la possibilité de bénéficier de conseils, d'une défense et d'une représentation juridique adéquate conformément à l'article 48. Pour les enfants migrants, ces droits sont renforcés par une série de dispositions de droit dérivé. En particulier, le règlement de Dublin oblige les États membres à veiller à ce que les enfants non accompagnés soient représentés par un professionnel dûment qualifié ayant accès à toutes les informations pertinentes contenues dans le dossier de l'enfant (article 6). On retrouve des dispositions parallèles dans la directive « qualification » (article 31) ainsi que dans la directive sur les procédures d'asile (article 25). Le droit de l'enfant à une représentation juridique est également appuyé par le droit d'accéder aux services d'aide aux victimes et aux services d'aide spécialisés confidentiels au titre de l'article 7 de la directive 2012/29/UE établissant des normes minimales concernant les droits, le soutien et la protection des victimes de la criminalité (directive relative aux droits des victimes)[467].

Toutefois, les droits associés à l'accès à la justice ne sont pas dénués de restrictions et peuvent être soumis à certaines conditions relatives à l'âge. Par exemple, la directive sur les procédures d'asile permet aux États membres de « s'abstenir de désigner un représentant [légal] lorsque le mineur non accompagné atteindra selon toute vraisemblance l'âge de dix-huit ans avant qu'une décision ne soit prise en première instance » (article 25, paragraphe 2).

Dans le droit du CdE, la CouEDH a exclu l'applicabilité de l'article 5 (droit à un procès équitable) dans les cas relatifs à des décisions d'entrée, de séjour et d'expulsion d'étrangers[468]. Toutefois, l'article 13 de la CEDH (droit à un recours effectif) peut être invoqué dans certaines circonstances.

> Exemple : l'affaire *Rahimi c. Grèce*[469] traite des conditions dans lesquels un enfant migrant issu d'Afghanistan, qui était entré illégalement en Grèce, a été détenu dans un centre de rétention puis libéré en vue de son ex-

467 Directive 2012/29/UE du Parlement européen et du Conseil du 25 octobre 2012 établissant des normes minimales concernant les droits, le soutien et la protection des victimes de la criminalité, JO 2012 L 315, p. 55.

468 CouEDH, *Maaouia c. France* [GC], n° 39652/98, 5 octobre 2000.

469 CouEDH, *Rahimi c. Grèce*, n° 8687/08, 5 avril 2011.

pulsion. En concluant à une violation de l'article 13 de la CEDH, la CouEDH a observé que la brochure d'information fournie au requérant n'indiquait pas la procédure à suivre pour introduire une plainte auprès du chef de la police. Par ailleurs, le requérant n'a pas été informé dans une langue qu'il comprenait des recours qui étaient à sa disposition pour se plaindre des conditions de son placement en rétention. En se basant sur les rapports du Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT), la Cour a noté l'absence, en Grèce, d'une autorité indépendante chargée d'inspecter les locaux de détention des forces de l'ordre. Elle a également souligné l'absence d'autorité impartiale nécessaire à l'efficacité du recours. La Cour a donc conclu à une violation de l'article 3, de l'article 5, paragraphes 1 et 4, et de l'article 13 de la CEDH.

La CSE exige des États qu'ils promeuvent la protection juridique (ainsi que sociale et économique) de la famille (article 16). Par ailleurs, l'article 19, paragraphe 1, dispose que les États doivent maintenir des « services gratuits appropriés » et veiller à ce que les travailleurs migrants et leur famille reçoivent des informations exactes sur l'émigration et l'immigration. Une exigence « d'information » similaire (au sujet de l'accès des migrants à la justice) figure à l'article 6 de la Convention européenne relative au statut juridique du travailleur migrant, mais les dispositions plus vastes régissant le « recours aux autorités judiciaires et administratives de l'État d'accueil » (article 26) ciblent exclusivement les travailleurs migrants et non les membres de leur famille[470].

Il convient de noter par ailleurs que le CdE a élaboré des lignes directrices très complètes au sujet de la justice adaptée aux enfants, spécifiant la manière dont toutes les procédures judiciaires et administratives, y compris celles en matière d'immigration, doivent être adaptées pour répondre aux besoins des enfants[471].

Dans le droit international, l'article 37 de la CRC est particulièrement pertinent pour les enfants migrants privés de liberté, puisqu'il leur garantit le droit à un accès rapide à une assistance juridique et à toute autre assistance appropriée, ainsi que le droit de contester la légalité de leur privation de liberté devant un tribunal ou une autre autorité compétente, indépendante et impartiale, dont la prise de décision doit également être rapide.

470 CdE, Convention européenne relative au statut juridique du travailleur migrant, STCE n° 93, 1977.

471 CdE, Comité des Ministres (2010), *Lignes directrices sur une justice adaptée aux enfants*, 17 novembre 2010.

10 Protection des données et des consommateurs

UE	Questions traitées	CdE
Charte des droits fondamentaux, article 38 TFUE, article 169 Directive relative aux droits des consommateurs (2011/83/UE) Directive relative aux pratiques commerciales déloyales (2005/29/CE) Directive relative à la sécurité générale des produits (2001/95/CE) Directive sur les essais cliniques (2001/20/CE) CJUE, C-244/06, *Dynamic Medien Vertriebs GmbH c. Avides Media AG*, 2008 (vente de DVD sur internet) CJUE, C-36/02, *Omega Spielhallen- und Automatenaufstellungs-GmbH c. Oberbürgermeisterin der Bundesstadt Bonn*, 2004 (autorisation de jouer à un jeu) Règlement n° 536/2014 relatif aux essais cliniques de médicaments à usage humain Directive relative aux denrées alimentaires destinées à une alimentation particulière (2009/39/CE)	**Protection des enfants en tant que consommateurs**	Convention européenne sur la télévision transfrontière

UE	Questions traitées	CdE
Directive sur la sécurité des jouets (2009/48/CE) Directive relative aux produits qui, n'ayant pas l'apparence de ce qu'ils sont, compromettent la santé ou la sécurité des consommateurs (87/357/CEE) Directive « Télévision sans frontières » (89/552/CEE) Directive « Services de mé dias audiovisuels » (2010/13/UE)		
Charte des droits fondamentaux, articles 7 (respect de la vie privée et familiale), 8 (protection des données à caractère personnel) et 52 (portée et interprétation des droits et des principes) TFUE, article 16 Directive relative à la protection des données à caractère personnel (95/46/CE)	**Enfants et protection des données à caractère personnel**	CEDH, article 8 (droit au respect de la vie privée et familiale) CouEDH, *K.U. c. Finlande*, n° 2872/02, 2008 (publicité sur internet) CouEDH, *Avilkina et autres c. Russie*, n° 1585/09, 2013 (divulgation de dossiers médicaux) Convention pour la protection des personnes à l'égard du traitement automatisé des données à caractère personnel

Le présent chapitre traite du droit et de la jurisprudence au niveau européen dans le domaine de la protection des consommateurs et des données à caractère personnel. Il existe une abondance de dispositions législatives et de jurisprudence au niveau de l'UE, le TFUE établissant expressément la compétence de l'UE dans ces matières. La contribution du CdE dans ce domaine est plus limitée. Au niveau des traités, il existe deux grandes conventions relatives aux médias et à la protection des données. La CouEDH a également jugé un certain nombre d'affaires relatives à la protection des données de personnes.

Les sections suivantes traiteront de certains aspects particuliers du droit de la consommation relatifs aux enfants (section 10.1) et à la protection des données (section 10.2). Pour chacun de ces thèmes, le cadre juridique général et son applicabilité pour les enfants sera analysé, de même que les normes spéciales destinées à la protection des enfants, le cas échéant.

10.1. Protection des enfants en tant que consommateurs

Points clés

- Selon la CJUE, l'intérêt supérieur des enfants consommateurs et la protection de leurs droits prévalent sur les exigences d'intérêt général et justifient donc les restrictions à la libre circulation des marchandises, des personnes, des services et des capitaux.
- Les enfants consommateurs devraient recevoir les informations nécessaires pour pouvoir prendre en considération tous les faits pertinents et faire un choix en toute connaissance de cause.
- Les pratiques commerciales déloyales sont celles qui ne respectent pas le principe de diligence professionnelle et sont susceptibles d'influencer les décisions commerciales des enfants et adultes consommateurs.
- Les enfants ne peuvent participer à des essais cliniques que lorsqu'on peut espérer que l'administration du médicament procurerait au patient un bénéfice direct plus grand que les risques.
- Le droit de l'UE et du Conseil de l'Europe limitent la quantité de marketing auquel peuvent être exposés les enfants, sans l'interdire à proprement parler.
- Les enfants ont droit à une protection spécifique, notamment contre toute publicité ainsi que contre les programmes de télé-achat susceptibles de leur nuire moralement ou physiquement.
- Le placement de produits dans les programmes pour enfants est interdit.

10.1.1. Droits des consommateurs

Dans le droit de l'UE, les principaux piliers de la protection des consommateurs sont établis à l'article 169, paragraphe 1, du TFUE, ainsi qu'à l'article 38 de la Charte des droits fondamentaux de l'UE. La CJUE a reconnu que l'intérêt supérieur de l'enfant prévaut sur les exigences d'intérêt général et justifie dès lors les limites aux libertés du marché commun.

Exemple : l'affaire *Dynamic Medien*[472] traite de la vente en ligne de DVD de dessins animés japonais en Allemagne. Les dessins animés avaient été approuvés pour les enfants âgés de plus de 15 ans au Royaume-Uni, mais n'avaient pas été jugés appropriés par l'autorité compétente allemande. La CJUE devait par conséquent déterminer si l'interdiction en Allemagne était contraire au principe de liberté de circulation. Elle a conclu que la finalité de la règlementation allemande était de protéger les enfants des informations qui pourraient nuire à leur bien-être. Selon elle, la limitation de la liberté de circulation des marchandises n'est pas disproportionnée tant qu'elle ne va pas au-delà de ce qui est nécessaire pour atteindre l'objectif de protection des enfants poursuivi par l'État membre concerné.

Exemple : l'affaire *Omega*[473] porte sur l'exploitation d'un « laserdrome » en Allemagne. Le jeu pratiqué dans ce « laserdrome » consistait notamment à tirer sur des cibles sensorielles placées sur la veste des joueurs. L'équipement nécessaire à ce jeu avait été fourni par une société britannique et le jeu comme l'équipement avaient été commercialisés légitimement au Royaume-Uni. Le jeu a été interdit en Allemagne au motif qu'il était contraire à certaines valeurs fondamentales telles que la dignité humaine. La CJUE a jugé que la restriction imposée par les autorités allemandes n'était pas contraire au droit de l'Union, puisqu'elle avait été dûment justifiée par des raisons d'ordre public.

Le dernier processus de révision du droit de la consommation de l'UE a débouché sur l'adoption de la directive 2011/83/UE relative aux droits des consommateurs, qui vise à harmoniser pleinement les législations nationales relatives à la vente à distance et aux contrats hors établissement, ainsi qu'à d'autres types de contrats conclus avec les consommateurs[474]. Le but est de parvenir à un équilibre entre un niveau élevé de protection des consommateurs et la compétitivité des entreprises. Conformément à l'article 3, paragraphe 3, point a), la directive n'est pas applicable aux contrats portant sur les services sociaux, y compris le logement social, l'aide à l'enfance et l'aide aux familles et aux personnes se trouvant de

472 CJUE, C-244/06, *Dynamic Medien Vertriebs GmbH c. Avides Media AG*, 14 février 2008.

473 CJUE, C-36/02, *Omega Spielhallen- und Automatenaufstellungs-GmbH c. Oberbürgermeisterin der Bundesstadt Bonn*, 14 octobre 2004.

474 Directive 2011/83/UE du Parlement européen et du Conseil du 25 octobre 2011 relative aux droits des consommateurs, modifiant la directive 93/13/CEE du Conseil et la directive 1999/44/CE du Parlement européen et du Conseil et abrogeant la directive 85/577/CEE du Conseil et la directive 97/7/CE du Parlement européen et du Conseil, JO L 304/64 (cette directive devrait avoir été mise en œuvre au 13 décembre 2013).

manière permanente ou temporaire dans une situation de besoin, y compris les soins de longue durée. Les services sociaux englobent les services aux enfants et à la jeunesse, les services d'aide aux familles, aux parents isolés et aux personnes âgées et les services aux migrants. La directive accorde une attention particulière aux informations précontractuelles. Elle base ses « exigences en matière d'information » sur l'hypothèse que si les consommateurs, y compris les enfants, reçoivent les informations appropriées, ils pourront prendre en considération tous les faits pertinents et opérer un choix en connaissance de cause.

10.1.2. Pratiques commerciales déloyales concernant des enfants

Dans le droit de l'UE, la directive 2005/29/CE relative aux pratiques commerciales déloyales des entreprises vis-à-vis des consommateurs dans le marché intérieur[475] s'applique à l'ensemble des transactions entre entreprises et consommateurs (« B2C »), effectuées en ligne ou non, et portant indifféremment sur les biens ou les services. La directive inclut les enfants dans la catégorie des « consommateurs vulnérables » (article 5, paragraphe 3). Aucune décision commerciale ne peut être prise comme suite à un harcèlement, une contrainte, une influence injustifiée ou des informations trompeuses, et les enfants consommateurs ont le droit de prendre ces décisions librement. Elle interdit les activités de marketing et de publicité de produits créant une confusion avec un autre produit ou avec la marque d'un concurrent et dispose que le consommateur doit recevoir toutes les informations nécessaires de façon claire et compréhensible, au moment approprié pour lui permettre de prendre une décision commerciale (articles 6 et 7).

10.1.3. Sécurité des produits

Dans le droit de l'UE, il existe un cadre global visant à garantir que seuls des produits sûrs et conformes à d'autres égards soient mis sur le marché. En particulier, la directive 2001/95/CE relative à la sécurité générale des produits accorde une attention particulière à la sécurité des enfants en les incluant dans la catégorie des consommateurs pouvant être particulièrement vulnérables aux risques que présentent les produits considérés (considérant 8 de la directive).

475 Directive 2005/29/CE du Parlement européen et du Conseil du 11 mai 2005 relative aux pratiques commerciales déloyales des entreprises vis-à-vis des consommateurs dans le marché intérieur et modifiant la directive 84/450/CEE du Conseil et les directives 97/7/CE, 98/27/CE et 2002/65/CE du Parlement européen et du Conseil et le règlement (CE) n° 2006/2004 du Parlement européen et du Conseil, JO 2005 L 149/22.

Dès lors, la sécurité des produits doit être évaluée en tenant compte de tous les aspects pertinents, en particulier les catégories de consommateurs auxquelles le produit est destiné.

La directive 87/357/CEE du Conseil est une directive spécifique sur la sécurité des produits concernant le rapprochement des législations des États membres relatives aux produits qui, n'ayant pas l'apparence de ce qu'ils sont, compromettent la santé ou la sécurité des consommateurs[476]. Elle interdit la commercialisation, l'importation et la fabrication des produits qui ressemblent à des denrées alimentaires, mais qui ne sont pas comestibles. Les États membres doivent effectuer des contrôles afin de s'assurer qu'aucun produit de ce type ne soit commercialisé. Si un État membre interdit un produit au titre de cette directive, il doit en informer la Commission et fournir des détails afin d'informer les autres États membres. La question particulière de la sécurité des jouets est abordée plus en détail à la section 10.1.6.

10.1.4. Essais cliniques sur les enfants

Dans le droit de l'UE, la directive 2001/20/CE[477] concernant le rapprochement des dispositions des États membres relatives à l'application de bonnes pratiques cliniques dans la conduite d'essais cliniques de médicaments à usage humain inclut les enfants parmi les personnes vulnérables qui ne sont pas en mesure de donner leur consentement légal pour participer à des essais cliniques (considérant 3). Un enfant ne peut participer à un essai clinique que lorsque l'administration du médicament lui procurera un bénéfice direct plus grand que les risques (considérant 3). Les essais cliniques doivent être réalisés en protégeant les sujets de manière optimale (article 4).

De même, le règlement (UE) n° 536/2014 relatif aux essais cliniques de médicaments à usage humain inclut des dispositions spécifiques pour les enfants relevant de la catégorie de la population vulnérable. Ce règlement entend

476 Directive 87/357/CEE du Conseil du 25 juin 1987 concernant le rapprochement des législations des États membres relatives aux produits qui, n'ayant pas l'apparence de ce qu'ils sont, compromettent la santé ou la sécurité des consommateurs, JO 1987 L 192, p. 49.

477 Directive 2001/20/CE du Parlement européen et du Conseil du 4 avril 2001 concernant le rapprochement des dispositions législatives, réglementaires et administratives des États membres relatives à l'application de bonnes pratiques cliniques dans la conduite d'essais cliniques de médicaments à usage humain, JO 2001 L 121, p. 34.

remplacer progressivement la directive 2001/20/CE[478]. Il exige que les demandes d'autorisation d'essais cliniques impliquant des enfants soient attentivement évaluées. Le représentant légal de l'enfant doit donner son accord pour la réalisation d'un essai clinique, de même que l'enfant, s'il est capable de se former une opinion (article 29, paragraphes 1 et 8). Le règlement établit des conditions spéciales pour la réalisation d'essais cliniques en toute sécurité sur les enfants ainsi que pour s'assurer de leur consentement éclairé (article 32). Ces conditions sont les suivantes : aucun encouragement n'est accordé aux participants hormis une compensation pour les frais et pertes de revenus directement liés à la participation à l'essai clinique ; l'essai clinique est destiné à étudier des traitements pour une condition médicale qui ne touche que les enfants ; enfin, il y a des raisons scientifiques de s'attendre à ce que la participation à l'essai clinique entraîne : un bénéfice direct pour le mineur concerné supérieur aux risques et aux contraintes en jeu ; ou certains bénéfices pour la population représentée par le mineur concerné, et un tel essai clinique comportera un risque minimal pour le mineur concerné et imposera une contrainte minimale à ce dernier par rapport au traitement standard de la condition dont il est atteint. Des essais cliniques ne peuvent être réalisés sur des enfants sans avoir auparavant obtenu leur consentement ou celui de leurs représentants légaux que dans des situations d'urgence (article 35, paragraphe 1).

10.1.5. Aliments destinés aux nourrissons et aux enfants en bas âge

Dans le droit de l'UE, la directive 2009/39/CE relative aux denrées alimentaires destinées à une alimentation particulière[479] s'attache expressément à la composition nutritionnelle et à la sécurité des aliments spécifiquement fabriqués pour les nourrissons et les jeunes enfants âgés de moins de 12 mois. Ses dispositions portent sur les préparations pour nourrissons et préparations de suite, les denrées alimentaires à base de céréales et les aliments pour bébés et additifs destinés aux nourrissons et aux enfants en bas âge. La directive a pour objectif de garantir la sécurité des produits et de fournir aux consommateurs des produits adéquats et des informations appropriées. Elle dispose notamment qu'une

478 Règlement (UE) n° 536/2014 du Parlement européen et du Conseil du 16 avril 2014 relatif aux essais cliniques de médicaments à usage humain et abrogeant la directive 2001/20/CE, JO 2014 L 158, p. 1.

479 Directive 2009/39/CE du Parlement européen et du Conseil du 6 mai 2009 relative aux denrées alimentaires destinées à une alimentation particulière, JO 2009 L 124, p. 21.

alimentation particulière doit répondre aux besoins nutritionnels particuliers de certaines catégories de personnes, y compris ceux des nourrissons ou des enfants en bas âge en bonne santé (article 1, paragraphe 3, point c).

10.1.6. Sécurité des jouets

Dans le droit de l'UE, l'article 2 de la directive 2009/48/CE relative à la sécurité des jouets[480] définit les jouets comme étant des « produits conçus ou destinés, exclusivement ou non, à être utilisés à des fins de jeu par des enfants de moins de 14 ans »[481]. L'annexe I contient une liste non-exhaustive d'articles qui ne sont pas considérés comme des jouets, mais qui peuvent prêter à confusion. L'article 2, paragraphe 2, dresse également une liste de jouets exclus du champ d'action de la directive. La directive renforce également les normes de santé et de sécurité en limitant les quantités de certaines substances chimiques pouvant se retrouver dans les matériaux utilisés pour fabriquer les jouets (article 10)[482].

10.1.7. Les enfants et la publicité

Dans le droit de l'UE, la directive 2010/13/UE sur les services de médias audiovisuels (directive « Services de médias audiovisuels »)[483] a élargi le champ de la réglementation juridique établie par la directive 89/552/CEE visant à la coordination de certaines dispositions législatives, réglementaires et administratives des États membres relatives à l'exercice d'activités de radiodiffusion télévisuelle (directive « Télévision sans frontières »). La directive « Services de médias audiovisuels »traite de la limitation de la quantité, de la qualité et du contenu du marketing auquel peuvent être exposés les enfants, en réglementant la durée de la publicité (articles 20, 24 et 27). Elle interdit le placement de produits dans les programmes pour enfants (article 11) et autorise les États membres à interdire la diffusion de logos de parrainage au cours des programmes pour enfants

480 Directive 2009/48/CE du Parlement européen et du Conseil du 18 juin 2009 relative à la sécurité des jouets, JO 2009 L 170.

481 *Ibid.*, art. 2, para. 1.

482 La Commission européenne a par ailleurs conclu des « accords volontaires » avec les industries/commerçants de jouets européens afin d'améliorer la sécurité des jouets. Pour plus d'informations, voir : http://ec.europa.eu/growth/sectors/toys/safety/index_en.htm.

483 Directive 2010/13/UE du Parlement européen et du Conseil du 10 mars 2010 visant à la coordination de certaines dispositions législatives, réglementaires et administratives des États membres relatives à la fourniture de services de médias audiovisuels (directive « Services de médias audiovisuels »), JO 2010 L 95, p. 1.

(article 10, paragraphe 4)[484]. Elle assure l'équilibre entre la protection des enfants et d'autres valeurs démocratiques importantes, telles que la liberté d'expression, en soutenant l'idée qu'une telle protection est possible grâce à l'implication essentielle de la responsabilité parentale (considérants 48 et 59).

La mise en œuvre effective de la directive « Services de médias audiovisuels » est complétée par les recommandations de 1998[485] et 2006[486] relatives à la protection des enfants et de la dignité humaine.

Dans le droit du CdE, la Convention européenne sur la télévision transfrontière[487] a été le premier traité international à établir un cadre juridique pour la libre circulation des programmes de télévision transfrontière en Europe. Cette convention protège spécifiquement les enfants et les jeunes (article 7, paragraphe 2), par exemple en interdisant la diffusion de matériel pornographique et violent ainsi que de programmes incitant à la haine raciale. Elle définit des normes en matière de publicité et réglemente le temps publicitaire et les coupures de publicité.

484 Pour un aperçu plus global du fonctionnement de la directive « Services de médias audiovisuels », voir : Rapport de la Commission au Parlement européen, au Conseil, au Comité économique et social européen et au Comité des régions relatif à l'application de la directive 2010/13/UE (directive « Services de médias audiovisuels »), COM(2012) 203 final, Bruxelles, 4 mai 2012 ; ainsi que Document de travail des services de la Commission joint au premier rapport de la Commission au Parlement européen, au Conseil, au Comité économique et social européen et au Comité des régions relatif à l'application de la directive 2010/13/UE (directive « Services de médias audiovisuels ») accompagnant le document, SWD(2012)125 final, Bruxelles, 4 mai 2012.

485 Recommandation 98/560/CE du Conseil du 24 septembre 1998 concernant le développement de la compétitivité de l'industrie européenne des services audiovisuels et d'information par la promotion de cadres nationaux visant à assurer un niveau comparable et efficace de protection des mineurs et de la dignité humaine, JO 1998 L 270.

486 Recommandation 2006/952/CE du Parlement européen et du Conseil du 20 décembre 2006 sur la protection des mineurs et de la dignité humaine et sur le droit de réponse en liaison avec la compétitivité de l'industrie européenne des services audiovisuels et d'information en ligne, JO 2006 L 378.

487 CdE, Convention européenne sur la télévision transfrontière, STCE n° 132, 1989. Texte révisé conformément aux dispositions du Protocole, STCE n° 171, 2002.

10.2. Enfants et protection des données

Points clés

- Dans le droit de l'UE et du CdE, la protection des données à caractère personnel est reconnue comme étant un droit fondamental.
- Le droit au respect de la vie privée et familiale, du domicile et de la correspondance (article 8 de la CEDH) inclut le droit à la protection des données à caractère personnel.
- Les enfants ont, parmi d'autres droits relatifs à leurs données à caractère personnel, le droit de s'opposer au traitement des données les concernant, sauf raisons impérieuses et légitimes.

10.2.1. Droit européen en matière de protection des données

Dans le droit de l'UE, l'Union est habilitée à légiférer sur les questions relatives à la protection des données (article 16 du TFUE).[488] L'article 8, paragraphe 2, de la Charte des droits fondamentaux de contient des principes clés en matière de protection des données à caractère personnel (traitement loyal, consentement ou but légitime prescrit par la loi, droit d'accès et de rectification), tandis que l'article 8, paragraphe 3, dispose que le respect des règles en matière de protection des données est soumis au contrôle d'une autorité indépendante. Le droit à la protection des données à caractère personnel consacré à l'article 8 peut être limité par la loi, en vue du respect des principes d'une société démocratique tels que les libertés et droits d'autrui (article 52 de la Charte)[489].

La protection des données à caractère personnel est devenue l'un des grands domaines du droit européen relatif à la protection de la vie privée. Directive 95/46/CE relative à la protection des personnes physiques à l'égard du traitement des données à caractère personnel et à la libre circulation de ces données

488 Pour un aperçu général de la législation européenne en matière de protection des données, voir FRA, CouEDH et Conseil de l'Europe (2014).

489 CJUE, affaires jointes C-468/10 et C-469/10, *Asociación Nacional de Establecimientos Financieros de Crédito (ASNEF) et Federación de Comercio Electrónico y Marketing Directo (FECEMD) c. Administración del Estado*, 24 novembre 2011, point 48 ; CJUE, C-275/06, *Productores de Música de España (Promusicae) c. Telefónica de España SAU* [GC], 29 janvier 2008, point 68.

(directive relative à la protection des données)[490] est le principal instrument existant dans ce domaine.

Étant donné que le traitement des données est effectué dans des espaces clos non ouverts au public, les enfants, ainsi que les autres personnes concernées, ne sont généralement pas au courant du traitement de leurs propres données à caractère personnel. Pour compenser la vulnérabilité des personnes dont les données sont traitées, le droit européen garantit aux enfants (et aux autres personnes concernées) des droits individuels spécifiques, tels que le droit d'être informé de la collecte de leurs données, le droit d'accéder aux données stockées et de connaître les détails du traitement, le droit de s'opposer au traitement lorsque celui-ci est illégal et les droits de rectification, d'effacement et de verrouillage des données.

Les responsables du traitement des données doivent fournir des informations adéquates sur le traitement qu'ils effectuent (articles 10 et 11 de la directive relative à la protection des données). L'interprétation d'une manière qui convient à l'âge des enfants implique d'adapter le langage et la forme des informations au niveau de maturité et de compréhension des enfants. Les informations doivent inclure au minimum l'objet du traitement ainsi que l'identité et les coordonnées du responsable du traitement (article 10, points a) et b) de la directive relative à la protection des données).

La directive relative à la protection des données exige le consentement des personnes concernées, quel que soit le caractère sensible des données traitées (articles 7, 8 et 14). Une procédure de consentement adaptée aux enfants suppose de tenir compte des capacités de développement de l'enfant, en l'impliquant progressivement. La première étape consiste à ce que le représentant légal de l'enfant consulte celui-ci pour qu'il donne son consentement, avant de passer à un consentement parallèle de l'enfant et de son représentant légal, puis au consentement de l'adolescent seul.

Les personnes concernées disposent du droit à l'effacement de leurs données, ce qui suppose la possibilité de demander le retrait ou l'effacement de leurs données à caractère personnel, ainsi que le droit de s'opposer au traitement de leurs

490 Directive 95/46/CE du Parlement européen et du Conseil, du 24 octobre 1995, relative à la protection des personnes physiques à l'égard du traitement des données à caractère personnel et à la libre circulation de ces données (directive relative à la protection des données), JO 1995 L 281.

données à caractère personnel. Ce droit a pris énormément d'importance en ce qui concerne les enfants, en raison de la quantité massive de données à caractère personnel relatives à des enfants qui circulent et sont disponibles sur les réseaux sociaux. Si la CJUE n'a pas encore entendu d'affaires concernant des enfants, elle a jugé dans une récente affaire traitant d'un requérant adulte que le droit d'opposition s'appliquait aux données et aux informations « notamment [...] lorsqu'elles apparaissent inadéquates, qu'elles ne sont pas ou plus pertinentes ou sont excessives au regard de ces finalités et du temps qui s'est écoulé »[491]. La CJUE a également considéré que l'applicabilité du droit d'opposition devait être mise en balance avec les autres droits fondamentaux.

Dans le droit du CdE, la CouEDH a considéré que l'article 8 de la CEDH incluait le droit à la protection des données à caractère personnel. La Cour examine les situations dans lesquelles la question de la protection des données se pose, notamment l'interception des communications[492], diverses formes de surveillance[493] et la protection contre le stockage des données à caractère personnel par les autorités publiques[494]. La Cour a par ailleurs considéré que le droit national devait élaborer des mesures appropriées garantissant un recours juridictionnel en cas de violation des droits relatifs à la protection des données.

Exemple : dans l'affaire *K.U. c. Finlande*[495], le requérant était un enfant qui se plaignait qu'une publicité à caractère sexuel a été publiée en son nom sur un site de rencontres en ligne. Le fournisseur de services refusait de divulguer l'identité de la personne ayant publié les informations, au motif d'obligations de confidentialité établies par le droit finlandais. Le requérant affirmait que le droit national n'apportait pas suffisamment de protection contre les actions d'un particulier publiant des données compromettantes au sujet du requérant sur internet. La CouEDH a indiqué que les États avaient des obligations positives qui impliquaient notamment l'adoption de mesures visant au respect de la vie privée jusque dans les relations des

491 CJUE, C-131/12, *Google Spain SL et Google Inc. c. Agencia Española de Protección de Datos (AEPD) et Mario Costeja González* [GC], 13 mai 2014, point 93.

492 Voir par exemple : CouEDH, *Malone c. Royaume-Uni*, n° 8691/79, 2 août 1984 ; CouEDH, *Copland c. Royaume-Uni*, n° 62617/00, 3 avril 2007.

493 Voir par exemple : CouEDH, *Klass et autres c. Allemagne*, n° 5029/71, 6 septembre 1978 ; CouEDH, *Uzun c. Allemagne*, n° 35623/05, 2 septembre 2010.

494 Voir par exemple : CouEDH, *Leander c. Suède*, n° 9248/81, 26 mars 1987 ; CouEDH, *S. et Marper c. Royaume-Uni* [GC], n° 30562/04 et 30566/04, 4 décembre 2008.

495 CouEDH, *K.U. c. Finlande*, n° 2872/02, 2 décembre 2008. Voir également le chapitre 4.

individus entre eux. Dans le cas du requérant, sa protection pratique et effective nécessitait que des mesures effectives soient prises pour identifier et poursuivre l'auteur. Or, l'État ne proposait pas une telle protection et la CouEDH a conclu à une violation de l'article 8 de la CEDH[496].

Exemple : l'affaire *Avilkina et autres c. Russie*[497] porte sur la communication du dossier médical d'une fillette de deux ans au procureur, celui-ci ayant demandé de lui signaler tous les refus de transfusions sanguines émanant de témoins de Jéhovah. Si la Cour a admis que les intérêts d'une enquête pénale pouvaient parfois l'emporter sur l'intérêt d'un patient et de la collectivité dans son ensemble à voir protéger la confidentialité d'informations médicales, elle a toutefois noté que la requérante n'était ni mise en cause en tant que suspecte, ni accusée dans le cadre d'une procédure pénale. En outre, Par ailleurs, les professionnels de la santé qui ont pris en charge la requérante auraient pu demander une autorisation judiciaire pour effectuer une transfusion sanguine, s'ils avaient craint pour la vie de celle-ci. En l'absence de tout besoin social impérieux de demander la communication de données médicales confidentielles concernant la requérante, la CouEDH a conclu à une violation de l'article 8 de la CEDH.

Exemple : dans l'affaire *S. et Marper c. Royaume-Uni*[498], les empreintes digitales et des échantillons d'ADN d'un enfant de onze ans prélevées dans le cadre d'une suspicion de tentative de vol ont été conservées sans limite de temps, bien que l'enfant ait finalement été acquitté. Compte tenu de la nature et de la quantité d'informations personnelles contenues dans les échantillons cellulaires et les profils ADN, leur conservation constituait en elle-même une atteinte au droit du premier requérant au respect de sa vie privée. Les principes clés des instruments pertinents du Conseil de l'Europe, du droit et de la pratique dans les autres États contractants, exigent que la conservation de données soit proportionnée à l'objet de la collecte et limitée dans le temps, notamment dans le secteur de la police. La protection offerte par l'article 8 de la CEDH serait affaiblie de manière inacceptable si l'utilisation de techniques scientifiques modernes dans le système de justice pénale était autorisée à n'importe quel prix et sans une mise en balance attentive des avantages pouvant résulter d'un large recours à ces

496 FRA, CouEDH et CdE (2014), p. 122.

497 CouEDH, *Avilkina et autres c. Russie*, n° 1585/09, 6 juin 2013.

498 CouEDH, *S. and Marper c. Royaume-Uni*, n° 30562/04 et 30566/04, 4 décembre 2008.

techniques, et des intérêts essentiels s'attachant à la protection de la vie privée. À cet égard, le caractère général et indifférencié du pouvoir de conservation en vigueur en Angleterre et au pays de Galles était particulièrement frappant, puisqu'il permettait de que les données puissent être conservées quels que soient la nature et la gravité de l'infraction et l'âge du suspect. La conservation de telles données peut être particulièrement préjudiciable dans le cas de mineurs, en raison de leur situation spéciale et de l'importance que revêt leur développement et leur intégration dans la société. En conclusion, la conservation des données constituait une atteinte disproportionnée au droit du requérant au respect de la vie privée.

La Convention du Conseil de l'Europe pour la protection des personnes à l'égard du traitement automatisé des données à caractère personnel[499] (Convention 108) s'applique à toutes les opérations de traitement de données effectuées dans le secteur public ou privé et protège les individus, y compris les enfants, contre les abus pouvant accompagner le traitement de données à caractère personnel. La Convention 108 comporte un Protocole additionnel réglementant l'institution d'autorités de contrôle et les flux transfrontières de données à caractère personnel vers des États non parties[500].

Les principes énoncés dans la Convention 108 au sujet du traitement des données à caractère personnel portent sur le caractère licite et loyal de la collecte et du traitement automatisé des données, enregistrées à des fins déterminées et légitimes, et non incompatibles avec ces dernières, ni conservées au-delà du temps nécessaire. Ils traitent également de la qualité des données. En l'absence de garanties juridiques convenables, le traitement de données « à caractère sensible », relatives, par exemple, à l'origine raciale, aux opinions politiques, à la santé, aux convictions religieuses, à la vie sexuelle ou aux condamnations pénales d'une personne, est interdit. La Convention consacre également le droit de tous, y compris les enfants, d'être informés de la conservation d'informations les concernant et, si nécessaire, de les faire rectifier. Les limitations des droits établis dans la Convention ne sont autorisées que lorsque des intérêts supérieurs, tels que la sécurité de l'État ou la sûreté publique, sont en jeu.

499 CdE, Convention pour la protection des personnes à l'égard du traitement automatisé des données à caractère personnel, STCE n° 108, 1981.

500 CdE, Protocole additionnel à la Convention pour la protection des personnes à l'égard du traitement automatisé des données à caractère personnel, concernant les autorités de contrôle et les flux transfrontières de données, STCE n° 181, 2001.

Dans le droit international, le droit à la protection des données fait partie du droit au respect de la vie privée de l'enfant inclus à l'article 16 de la CRC. Cet article dispose qu'aucun enfant ne peut être soumis à des immixtions arbitraires ou illégales dans sa vie privée, sa famille, son domicile ou sa correspondance, ni à des atteintes illégales à son honneur et à sa réputation. Ce droit doit être respecté par tous, y compris par le représentant légal de l'enfant.

11

Droits de l'enfant dans le cadre des procédures judiciaires pénales et des dispositifs alternatifs à ces procédures

UE	Questions traitées	CdE
Charte des droits fondamentaux, articles 47 (droit à un recours effectif et à un procès équitable), 48 (présomption d'innocence et droit de la défense) et 49 (principes de légalité et de proportionnalité des délits et des peines) Directive relative au droit à l'interprétation et à la traduction (2010/64/UE) Directive relative au droit à l'information (2012/13/UE) Directive relative au droit d'accès à un avocat (2013/48/UE)	**Garanties liées au droit à un procès équitable**	CEDH, article 6 (procès équitable) CouEDH, *T. c. Royaume-Uni* [GC], n° 24724/94, 1999 (enfants devant les tribunaux) CouEDH, *Panovits c. Chypre*, n° 4268/04, 2008 (accès à un avocat)
Charte des droits fondamentaux, articles 4 (torture, traitements inhumains et dégradants) et 6 (droit à la liberté)	**Détention**	Charte des droits fondamentaux, articles 3 (torture, traitements inhumains et dégradants) et 5 (droit à la liberté) CouEDH, *Bouamar c. Belgique*, n° 9106/80, 1988 (placement en détention en vue d'un encadrement éducatif) CouEDH, *D.G. c. Irlande*, n° 39474/98, 2002 (placement en détention en vue d'un encadrement éducatif) CouEDH, *Nart c. Turquie*, n° 20817/04, 2008 (détention provisoire) CouEDH, *Güveç c. Turquie*, n° 70337/01, 2009 (conditions de placement en détention)

UE	Questions traitées	CdE
Directive relative aux droits des victimes (2012/29/UE) CJUE, C-105/03, *Procédure pénale contre Maria Pupino* [GC], 2005 (comparution d'enfants témoins au tribunal)	**Enfants témoins et victimes**	Charte des droits fondamentaux, articles 3 (torture, traitements inhumains et dégradants) et 8 (vie privée) CouEDH, *Kovač c. Croatie*, n° 503/05, 2007 (enfant témoin) CouEDH, *S.N. c. Suède*, n° 34209/96, 2002 (enfant témoin) CouEDH, *R.R. et autres Hongrie*, n° 19400/11, 2012 (exclusion d'une famille du programme de protection des témoins)

Les droits de l'enfant dans le cadre de procédures judiciaires visant des mineurs concernent les enfants accusés, poursuivis ou condamnés pour une infraction pénale, ainsi que les enfants impliqués dans des procédures judiciaires ou afférentes en tant que victimes et/ou témoins. La position des enfants dans le contexte de la justice des mineurs est réglementée par des dispositions générales en matière de droits de l'homme applicables tant aux adultes qu'aux enfants.

Ce chapitre propose un aperçu des normes européennes pertinentes pour les enfants impliqués dans des procédures judiciaires ou autres. Il aborde les garanties relatives à un procès équitable, y compris la participation effective et l'accès à un avocat, les droits des jeunes délinquants détenus, y compris la détention provisoire (garanties procédurales et de fond), les conditions de détention et la protection contre les mauvais traitements, et la protection des enfants témoins et victimes. Les aspects relatifs à la protection sont particulièrement importants dans les solutions de remplacement aux procédures judiciaires non contentieuses, qui devraient être encouragées dès lors qu'elles peuvent servir au mieux l'intérêt supérieur de l'enfant[501]. Lorsqu'il est question d'enfants, les objectifs de la justice pénale tels que l'intégration sociale, l'éducation et la prévention de la récidive sont d'importants principes fondamentaux[502].

501 CdE, Comité des Ministres (2010), *Lignes directrices sur une justice adaptée aux enfants*, 17 novembre 2010, para. 24.

502 Voir également CdE, Comité des Ministres (2008), Recommandation CM/Rec(2008)11 du Comité des Ministres aux États membres sur les règles européennes pour les délinquants mineurs faisant l'objet de sanctions ou de mesures, 5 novembre 2008, partie I.A.2.

11.1. Garanties liées au droit à un procès équitable

Points clés

- Les enfants impliqués dans une procédure pénale ont le droit d'être traités avec équité et d'une manière adaptée à leur âge.
- Les procédures judiciaires doivent être adaptées aux besoins des enfants afin d'assurer leur participation effective.
- Les enfants ont le droit d'accéder à un avocat dès les premières étapes de la procédure pénale et dès le premier interrogatoire de police.

Tout en décrivant brièvement les exigences générales d'un procès équitable établies au niveau de l'UE comme au niveau du Conseil de l'Europe, la présente section s'intéresse particulièrement aux garanties en matière de procès équitable accordées spécifiquement aux enfants.

Le droit à un procès équitable constitue l'un des piliers fondamentaux d'une société démocratique. Les enfants soupçonnés ou accusés d'une infraction ont le droit à un procès équitable et bénéficient des mêmes garanties que toute autre personne en conflit avec la loi. Les garanties liées au droit à un procès équitable s'appliquent dès le premier interrogatoire de l'enfant et restent valables pendant le procès. Toutefois, les enfants en conflit avec la loi sont particulièrement vulnérables et peuvent dès lors avoir besoin d'une protection supplémentaire. Les instances européennes se sont dotées d'exigences particulières afin de veiller à ce que les besoins de ces enfants soient dûment pris en compte.

Dans le droit de l'UE, plusieurs dispositions de la Charte des droits fondamentaux de l'UE énoncent les droits fondamentaux d'accès à la justice prévoyant des garanties en matière de procès équitable tant pour les adultes que pour les enfants. L'article 47 traite en particulier du droit à un recours effectif et à un procès équitable, en établissant des dispositions particulièrement pertinentes pour les enfants, telles que le droit de toute personne à ce que sa cause soit entendue équitablement, publiquement et dans un délai raisonnable et le droit d'être défendu, représenté et conseillé et de bénéficier d'une aide juridictionnelle. De même, les principes de légalité et de proportionnalité des délits et des peines définis à l'article 49 présentent un intérêt particulier pour les enfants. En outre,

plusieurs directives de l'UE établissent des garanties spéciales en matière de procès équitable dans les procédures pénales : la directive relative au droit à l'interprétation et à la traduction[503], la directive relative au droit à l'information[504] et la directive relative au droit d'accès à un avocat[505]. Les deux premières directives n'incluent pas de garanties spécifiques aux enfants, bien que la directive relative au droit à l'information contienne des dispositions relatives à la situation des suspects vulnérables ou des personnes accusées de manière plus générale. Les dispositions de la directive relative au droit d'accès à un avocat concernant les enfants sont présentées plus en détail à la section 11.2.2.

Même en l'absence de dispositions spécifiques pour les enfants, les États membres doivent observer la Charte des droits fondamentaux de l'UE au moment de mettre en œuvre les dispositions des directives susmentionnées. Dès lors, les principes tels que l'intérêt supérieur de l'enfant, consacré à l'article 24, doivent être pris dûment en considération dans les affaires où un enfant est soumis à l'une des dispositions des directives. À ce jour, aucune affaire n'a été portée devant la CJUE concernant l'interprétation de l'article 24 de la Charte en combinaison avec l'une des directives mentionnées[506].

Un instrument particulièrement important est la proposition de directive de la Commission européenne relative aux garanties procédurales accordées aux enfants soupçonnés ou poursuivis dans le cadre de procédures pénales,[507] qui a pour but de garantir aux enfants un accès obligatoire à un avocat à tous les stades d'une procédure pénale. Cette proposition dispose également que les enfants devraient être rapidement informés de leurs droits, être assistés de leurs parents (ou d'un autre adulte approprié) et être interrogés à huis clos. En outre, les enfants privés de liberté devraient recevoir une éducation appropriée, une

503 Directive 2010/64/CE du Parlement européen et du Conseil du 20 octobre 2010 relative au droit à l'interprétation et à la traduction dans les procédures pénales, JO 2010 L 280, p. 1.

504 Directive 2012/13/UE du Parlement européen et du Conseil du mardi 22 mai 2012 relative au droit à l'information dans le cadre des procédures pénales, JO 2012 L 142, p. 1.

505 Directive 2013/48/UE du Parlement européen et du Conseil du 22 octobre 2013 relative au droit d'accès à un avocat dans le cadre des procédures pénales et des procédures relatives au mandat d'arrêt européen, au droit d'informer un tiers dès la privation de liberté et au droit des personnes privées de liberté de communiquer avec des tiers et avec les autorités consulaires, JO 2013 L 294, p. 1.

506 La CJUE a traité de l'interprétation de l'article 24 dans des procédures relatives à des affaires internationales d'enlèvement d'enfants (voir la section 5.4).

507 Commission européenne (2013), proposition de directive du Parlement européen et du Conseil relative aux garanties procédurales accordées aux enfants soupçonnés ou poursuivis dans le cadre de procédures pénales, COM(2013) 822 final, Bruxelles, 27 novembre 2013.

orientation et une formation, ainsi qu'une assistance médicale et devraient être séparés des adultes[508].

Dans le droit du CdE, les garanties de la CEDH en matière de procès équitable sont établies à l'article 6, qui génère le plus de jurisprudence de la Cour. L'article 6, paragraphe 1, de la CEDH inclut certaines garanties expresses en matière de procès équitable : le droit à un procès équitable et public et à un prononcé public du jugement (sauf lorsque cela est contraire à l'intérêt, notamment, des mineurs) ; le droit à un procès dans un délai raisonnable ; le droit d'être jugé par un tribunal indépendant et impartial ;[509] le droit d'être jugé par un tribunal établi par la loi. La CouEDH a défini des garanties inhérentes au concept de procès équitable : égalité des armes et procédure contradictoire ; droit de garder le silence ; accès à un avocat ; participation effective ; présence à l'audience ; et décision motivée. En outre, tout accusé est présumé innocent jusqu'à ce que sa culpabilité ait été légalement établie (article 6, paragraphe 2, de la CEDH).

Toute personne accusée d'une infraction dispose des droits minimaux suivants : le droit d'être informé, dans le plus court délai, dans une langue qu'elle comprend, de l'accusation portée contre elle (article 6, paragraphe 3, point a), de la CEDH) ; le droit de disposer du temps et des facilités nécessaires à la préparation de sa défense (article 6, paragraphe 3, point b), de la CEDH) ; le droit d'avoir l'assistance d'un défenseur de son choix (article 6, paragraphe 3, point d), de la CEDH) ; le droit d'interroger ou faire interroger les témoins (article 6, paragraphe 3, point d), de la CEDH) ; et le droit de se faire assister gratuitement d'un interprète (article 6, paragraphe 3, point e), de la CEDH). Ces garanties s'appliquent aux adultes comme aux enfants. Toutefois, les aspects qui revêtent une importance particulière pour les enfants et qui ont donné lieu à une jurisprudence spécifique aux enfants incluent le droit à une participation effective ainsi que le droit d'accès à un avocat. Ces deux garanties spécifiques en matière de procès équitable sont donc analysées plus en détail dans le présent chapitre.

508 Voir également la section 11.2. Un autre document pouvant être pertinent en matière de protection des enfants est celui de la Commission européenne (2013), Proposition de directive du Parlement européen et du Conseil concernant l'aide juridictionnelle provisoire pour les suspects et les personnes poursuivies privés de liberté, ainsi que l'aide juridictionnelle dans le cadre des procédures relatives au mandat d'arrêt européen, COM(2013) 824 final, Bruxelles, 27 novembre 2013.

509 CouEDH, *Nortier c. Pays-Bas*, n° 13924/88, 24 août 1993 ; CouEDH, *Adamkiewicz c. Pologne*, n° 54729/00, 2 mars 2010.

Les Lignes directrices du Conseil de l'Europe sur une justice adaptée aux enfants présentent une importance particulière pour les enfants suspectés ou accusés d'infractions[510]. Même si elles ne sont pas juridiquement contraignantes, elles représentent une étape intermédiaire permettant de faire en sorte que les procédures judiciaires, y compris celles qui relèvent du système de justice pénale, prennent en compte les besoins spéciaux des enfants. Ces lignes directrices s'appuient sur la jurisprudence existante de la CouEDH, ainsi que sur des normes juridiques internationales telles que la Convention des Nations Unies sur les droits de l'enfant. Elles constituent un outil utile pour les professionnels qui travaillent avec des enfants. Selon la section I(1), les lignes directrices s'appliquent aux enfants impliqués dans une procédure judiciaire (pénale ou non) ou dans des dispositifs alternatifs à ces procédures. Pour les enfants impliqués dans procédure pénale, les droits d'une importante particulière sont le droit à ce que les informations relatives aux accusations soient données à la fois à l'enfant et aux parents de sorte qu'ils comprennent l'accusation exacte (section IV.A.1.5) ; le droit de n'être interrogé qu'en présence d'un avocat, d'un des parents ou d'une personne de confiance (section IV.C(30)) ; le droit à une procédure rapide (section IV.D(4)) et le droit à des entretiens et à des auditions tenant compte des spécificités de l'enfant (section IV.D(5)).

En juin 2014, l'Assemblée parlementaire du Conseil de l'Europe (APCE) a adopté une résolution relative à une justice pénale des mineurs adaptée aux enfants, dans laquelle elle souligne la nécessité de traiter les enfants en conflit avec la loi selon une approche fondée sur les droits et adaptée aux enfants[511]. L'APCE invite les États membres à mettre en œuvre les normes internationales en matière de droits de l'homme régissant la justice pour mineurs, y compris les Lignes directrices du Conseil de l'Europe sur une justice adaptée aux enfants, et à mettre les lois et pratiques nationales en conformité avec ces normes. L'APCE suggère de n'avoir recours à la privation de liberté qu'à titre de mesure de dernier ressort et d'une une durée aussi brève que possible, en fixant l'âge minimum de la responsabilité pénale à 14 ans, sans accepter de dérogations en cas d'infractions graves et en instaurant un système spécialisé de justice pour mineurs comprenant des mécanismes de déjudiciarisation, des mesures non privatives de liberté et des professionnels spécialisés.

510 CdE, Comité des Ministres (2010), *Lignes directrices sur une justice adaptée aux enfants*, 17 novembre 2010.

511 APCE (2014), « Une justice pénale des mineurs adaptée aux enfants: de la rhétorique à la réalité », Résolution 2010 (2014) .

Dans le droit international, l'article 40 de la CRC reconnaît à tout enfant soupçonné, accusé ou convaincu d'infraction pénale le droit d'être traité équitablement et d'une manière adaptée à son âge. L'objectif premier de la justice des mineurs, aux termes de l'article 40 de la CRC, est de réintégrer les enfants dans la société, là où ils pourront jouer un rôle constructif. L'article 40, paragraphe 2, de la CRC reconnaît le droit de l'enfant à un procès équitable et souligne que l'enfant doit bénéficier de certains droits supplémentaires tels que le droit d'être en présence de ses parents, le droit de faire appel et le droit à la protection totale de leur vie privée à tous les stades de la procédure.

Par ailleurs, d'autres instruments ont développé les principes de procès équitable et de droit à un traitement adapté aux enfants énoncés dans la CRC, notamment le recours à la privation de liberté uniquement à titre de mesure de dernier ressort et d'une durée aussi brève que possible (voir l'article 37, point b), de la CRC). Les plus importants d'entre eux sont l'Ensemble de règles minima des Nations Unies concernant l'administration de la justice pour mineurs (« Règles de Beijing »)[512], les Principes directeurs des Nations Unies pour la prévention de la délinquance juvénile (« Principes directeurs de Riyad »)[513] et les Règles des Nations Unies pour la protection des mineurs privés de liberté (également appelées « Règles de La Havane »)[514]. Les Règles de Beijing fournissent des orientations détaillées sur l'application des exigences en matière de procès équitable et de traitement adapté aux enfants figurant à l'article 40 de la Convention relative aux droits de l'enfant, y compris les objectifs de la justice pour mineurs, la protection de la vie privée, l'instruction et les poursuites, la détention préventive, le jugement et le règlement des affaires et le traitement en milieu ouvert ou en institution. Les Règles de la Havane portent sur le traitement des mineurs privés de liberté. Elles incluent notamment des règles sur la définition de la privation de liberté, de la garde à vue et de la détention provisoire, les conditions de vie dans les institutions pour mineurs, les procédures disciplinaires, les méthodes de classement et le recours à la force ou à la contrainte, les procédures de réclamation, les mécanismes d'inspection et de contrôle et le retour des mineurs dans leur communauté. Enfin, les Principes directeurs de Riyad fournissent des orientations détaillées sur les politiques visant à prévenir la délinquance juvénile.

512 ONU, Assemblée générale (1985), *Ensemble de règles minima des Nations Unies concernant l'administration de la justice pour mineurs*, GA Res. 40/33, 19 novembre 1985.

513 ONU, Assemblée générale (1990), *Principes directeurs des Nations Unies pour la prévention de la délinquance juvénile*, GA Res. 45/112, 14 décembre 1990.

514 ONU, Assemblée générale (1990), *Règles des Nations Unies pour la protection des mineurs privés de liberté*, GA Res. 45/113, 14 décembre 1990.

Le Comité des droits de l'enfant des Nations Unies a publié une observation générale (n° 10)[515] sur les enfants et la justice des mineurs, proposant des orientations détaillées sur la manière d'interpréter et de mettre en œuvre la CRC en ce qui concerne la justice des mineurs. Cette observation aborde des principes importants de la justice des mineurs, tels que le droit à une participation effective, dans le cadre du droit à un procès équitable (voir également la section 11.1.1), le recours à la privation de liberté uniquement à titre de mesure de dernier ressort et d'une durée aussi brève que possible, le recours à la déjudiciarisation et à la prévention de la délinquance juvénile, la prise en compte du principe de l'intérêt supérieur de l'enfant et du principe de non-discrimination dans le système de justice pour mineurs et les limites d'âge. Le Comité des droits de l'enfant des Nations Unies recommande de fixer l'âge minimum de la responsabilité pénale à 12 ans, ou, de préférence, à un âge plus élevé. Il recommande également d'accorder à tous les enfants le droit d'être jugés dans le cadre de la justice des mineurs et interdit le transfert de jeunes de 16 et 17 ans vers le cadre de la justice pour adultes en cas d'infraction grave. D'autres observations générales, traitant par exemple du droit d'être entendu (en rapport avec le droit de participer activement aux procédures pénales) ou de la protection contre toute forme de violence, présentent également un intérêt au regard de la justice des mineurs[516].

11.1.1. Participation effective

Dans le droit de l'UE, l'article 47 de la Charte des droits fondamentaux établit des garanties similaires à celles de l'article 6 de la CEDH, y compris le droit de toute personne à ce que sa cause soit entendue équitablement, publiquement et dans un délai raisonnable par un tribunal indépendant et impartial, le droit à une représentation légale et le droit à un recours effectif. La proposition de directive relative aux garanties procédurales accordées aux enfants soupçonnés ou poursuivis dans le cadre de procédures pénales inclut le droit à une participation effective, ainsi que le droit à une représentation légale[517].

515 ONU, Comité des droits de l'enfant (2007), *Observation générale n° 10 (2007), Les droits de l'enfant dans le système de justice pour mineurs*, CRC/C/GC/07.

516 ONU, Comité des droits de l'enfant (2009), *Observation générale n° 12 (2009), Le droit de l'enfant d'être entendu*, CRC/C/GC/12 ; ONU, Comité des droits de l'enfant (2011), *Observation générale n° 13 (2011), Le droit de l'enfant d'être protégé contre toutes les formes de violence*, CRC/C/GC/13.

517 Commission européenne (2013), Proposition de directive du Parlement européen et du Conseil relative aux garanties procédurales accordées aux enfants soupçonnés ou poursuivis dans le cadre de procédures pénales, COM(2013) 822 final, Bruxelles, 27 novembre 2013.

Dans le droit du CdE, l'article 6 de la CEDH formule des exigences spécifiques visant à garantir la participation effective des enfants aux procédures pénales. En règle générale, il convient de veiller, lors des procédures, à ce que l'âge de l'enfant, son niveau de maturité et ses capacités affectives soient pris en considération[518]. Des exemples concrets d'exigences de « participation effective » sont notamment la présence de l'enfant pendant les audiences, l'organisation d'audiences à huis clos, la publicité limitée, les mesures visant à faire en sorte que l'enfant puisse comprendre les enjeux du procès et la formalité limitée des audiences. À ce jour, la Cour n'a jamais considéré que l'adoption d'un seuil d'âge trop bas pour la responsabilité pénale constituait en soit une violation de l'article 6 de la CEDH. Lorsqu'elle doit déterminer si un enfant est apte à participer effectivement à une procédure nationale, la Cour examine les circonstances concrètes de l'espèce.

Exemple : l'affaire *T. c. Royaume-Uni*[519] porte sur le meurtre d'un enfant de deux ans par deux enfants de dix ans. Ces derniers ont fait l'objet d'un procès public très médiatisé. La procédure en justice a été en partie modifiée dans la mesure où les audiences étaient plus courtes, où les parents du requérant étaient placés à proximité de lui, où un espace de jeu était disponible pendant les pauses, etc. Le requérant, et l'autre enfant mis en examen, ont toutefois été jugés dans un tribunal pour adultes et la plupart des rigueurs d'un procès pénal ont été maintenues. La CouEDH a considéré que le requérant n'avait pas pu participer effectivement à la procédure en raison de la publicité des audiences, associée au niveau élevé d'attention médiatique et de sa capacité limitée à donner des instructions à ses avocats et à fournir des témoignages adéquats. Ses droits au titre de l'article 6 de la CEDH ont donc été violés.

La reconnaissance du droit à une participation effective est également au cœur des Lignes directives du Conseil de l'Europe sur une justice adaptée aux enfants. La justice destinée aux enfants, y compris la justice des mineurs, doit être « accessible, convenant à l'âge de l'enfant, rapide, diligente, adaptée aux besoins et aux droits de l'enfant, et axée sur ceux-ci, et respectueuse des droits de l'enfant, notamment du droit à des garanties procédurales, du droit de participer à la procédure et de la comprendre, du droit au respect de la vie privée et

518 CouEDH, *T c. Royaume-Uni*, n° 24724/94, 16 décembre 1999, para. 61.

519 CouEDH, *T c. Royaume-Uni*, n° 24724/94, 16 décembre 1999.

familiale, ainsi que du droit à l'intégrité et à la dignité »[520]. Les lignes directrices fournissent des orientations spécifiques sur la manière dont les enfants doivent être traités lors de procédures de justice pour mineurs ou d'autres procédures judiciaires. Les enfants devraient disposer du droit d'accès aux tribunaux et aux procédures judiciaires et leurs droits d'être représenté par un avocat, d'être entendus et d'exprimer leur point de vue devraient être garantis ; les retards injustifiés devraient être évités, les procédures devraient être organisées d'une manière adaptée aux enfants (notamment au niveau de l'environnement et du langage) et des garanties spéciales devraient être prises pour enregistrer et donner suite aux preuves/déclarations fournies par les enfants[521].

11.1.2. Accès à un avocat

Dans le droit de l'UE, la directive 2013/48/UE relative au droit d'accès à un avocat[522], devant être mise en œuvre pour le 27 novembre 2016, inclut des références directes aux enfants aux considérants 52 et 55 de son préambule ainsi qu'à son article 5, paragraphes 2 à 4. En vertu du considérant 55 et de l'article 5, paragraphe 2, lorsqu'un enfant est privé de liberté, le titulaire de la responsabilité parentale doit en être averti et être informé des motifs de cette décision, à moins que ce ne soit contraire à l'intérêt supérieur de l'enfant, auquel cas un autre adulte approprié doit être informé. Aux termes de l'article 2, la directive s'applique dès le moment où les personnes sont informées qu'elles sont soupçonnées d'avoir commis une infraction pénale ou qu'elles sont poursuivies à ce titre et jusqu'au terme de la procédure et au prononcé final de leur culpabilité ou de leur innocence. Par ailleurs, l'article 3, paragraphe 3, dispose que l'accès à un avocat inclut le droit pour les suspects ou les personnes poursuivies de rencontrer en privé l'avocat qui les représente et de communiquer avec lui, y compris avant qu'ils ne soient interrogés pour la première fois, le droit à la présence de l'avocat et à la participation effective de celui-ci à l'interrogatoire et le droit à la présence de l'avocat lors de certaines mesures d'enquête ou mesures de collecte de preuves.

520 CdE, Comité des Ministres (2010), *Lignes directrices sur une justice adaptée aux enfants*, 17 novembre 2010, point II. C.

521 *Ibid.*, section D.

522 Directive 2013/48/UE du Parlement européen et du Conseil du 22 octobre 2013 relative au droit d'accès à un avocat dans le cadre des procédures pénales et des procédures relatives au mandat d'arrêt européen, au droit d'informer un tiers dès la privation de liberté et au droit des personnes privées de liberté de communiquer avec des tiers et avec les autorités consulaires, JO 2013 L 294, p. 1.

Dans le droit du CdE, la CouEDH considère l'accès à un avocat comme étant l'un des éléments fondamentaux du droit à un procès équitable[523]. Les personnes soupçonnées d'infraction pénale ont le droit d'accéder à un avocat dès les premières étapes de l'enquête de police. Ce droit peut être limité dans des circonstances exceptionnelles, pour autant que la restriction ne porte pas indûment préjudice aux droits de la personne soupçonnée. D'après la Cour, ce cas peut se produire lorsque les dépositions effectuées sans accès préalable à un avocat sont utilisées à charge de la personne[524]. La Cour contrôle plus strictement l'accès effectif du requérant à un avocat dans les cas impliquant des enfants[525].

Exemple : l'affaire *Panovits c. Chypre*[526] traite d'un jeune de 17 ans inculpé pour meurtre et cambriolage. Il a été amené au commissariat de police accompagné par son père, puis arrêté et emmené dans une pièce séparée pour y être interrogé, sans son père et sans avocat. Pendant l'interrogatoire du requérant, son père a été informé du droit de son fils à contacter un avocat. Quelques minutes plus tard, le père a appris que son fils avait entretemps avoué être l'auteur du crime. La Cour a estimé qu'étant donné l'âge du requérant, il était impossible de supposer qu'il était informé de son droit à une représentation légale avant d'effectuer une déposition. Il était également improbable qu'il ait pu raisonnablement apprécier les conséquences d'un interrogatoire sans l'assistance d'un avocat dans une procédure pénale relative à un meurtre. Bien que les autorités ne semblent à aucun moment avoir été opposées à la possibilité de permettre au requérant d'être assisté par un avocat s'il en faisait la demande, elles ne l'ont pas averti de son droit à pouvoir être assisté d'un avocat gratuitement si nécessaire. Rien ne prouve que le requérant ou son père auraient renoncé expressément et de manière non équivoque à leur droit à une assistance juridique. La Cour a donc conclu à l'existence d'une violation de l'article 6, paragraphe 3, point c), lu en combinaison avec l'article 6, paragraphe 1, de la CEDH.

523 CouEDH, *Salduz c. Turquie*, n° 36391/02, 27 novembre 2008, para. 51.

524 *Ibid.*, para. 62.

525 *Ibid.*, para. 60.

526 CouEDH, *Panovits c. Chypre*, n° 4268/04, 11 décembre 2008.

11.2. Les droits des délinquants juvéniles en matière de détention

Points clés

- Un enfant ne peut être privé de sa liberté qu'en dernier ressort et pour la période appropriée la plus brève possible.
- En cas de détention, les enfants doivent être traités en tenant compte de leur âge et dans le respect de leur dignité.
- Les enfants ne doivent pas être détenus avec des adultes.

Toute personne a droit à la liberté. La privation de liberté constitue dès lors une exception ; elle inclut toute forme de placement, sur ordre d'une autorité judiciaire ou administrative, dans une institution que le mineur n'est pas autorisé à quitter à sa guise[527]. Compte tenu de l'importance de garantir les droits de l'enfant, y compris son intérêt supérieur, les situations de privation de liberté doivent être considérées sous cet angle particulier dès lors qu'elles concernent des enfants.

Si la détention peut être décidée dans différentes circonstances, la présente section s'intéresse particulièrement aux enfants en contact avec les systèmes de justice pénale.

Les instruments internationaux affirment tous sans exception que la détention doit constituer une mesure de dernier ressort. Par conséquent, à chaque fois que se pose la question de placer ou non un enfant en détention, les autorités nationales doivent en premier lieu étudier les solutions alternatives qui répondraient à l'intérêt supérieur de l'enfant tout en favorisant sa réinsertion (article 40, paragraphe 1, de la Convention relative aux droits de l'enfant). Parmi ces autres solutions figurent par exemple « des dispositions relatives [...] aux soins, à l'orientation et à la supervision, aux conseils, à la probation, au placement familial, aux programmes d'éducation généralisée et professionnelle » (article 40, paragraphe 4), de la Convention relative aux droits de l'enfant). La détention d'un enfant ne doit être envisagée que lorsqu'aucune autre solution

527 CdE, Comité des Ministres, Recommandation CM/Rec(2008)11 sur les règles européennes pour les délinquants mineurs faisant l'objet de sanctions ou de mesures, 5 novembre 2008, Règle 21.5.

n'est envisageable. Par ailleurs, la détention doit être ordonnée pour une durée la plus brève possible et dans le cadre des garanties de fond et de procédure adéquates. Compte tenu de leur âge et de leur vulnérabilité, les enfants placés en détention jouissent de droits et de garanties spéciaux.

11.2.1. Formes de détention (garanties de fond et de procédure)

Dans le droit de l'UE, le cadre juridique actuel pour les procédures judiciaires pénales n'inclut pas d'instrument contraignant au sujet de la rétention des enfants.

Dans le droit du CdE, l'article 5 de la CEDH dispose que toute personne a droit à la liberté. La détention constitue une exception qui doit être établie par la législation nationale et ne doit pas être arbitraire. En outre, elle doit être justifiée par l'une des six situations définies de manière exhaustive à l'article 5, paragraphe 1, points a) à f). La détention d'enfants en contact avec le système de justice pénale peut être justifiée par les points a) détention après condamnation par un tribunal compétent, c) détention provisoire ou d) détention aux fins, notamment, d'un encadrement éducatif. Les deux derniers points seront examinés, puisqu'ils ont donné naissance à des obligations spéciales incombant aux autorités nationales.

Détention provisoire

La « détention provisoire » fait référence aux situations dans lesquelles des personnes sont placées en garde à vue parce que soupçonnées d'avoir commis une infraction pénale ou placées en détention provisoire. Cette détention commence le jour où l'accusé est incarcéré et se termine par un jugement quant au fond par un tribunal de première instance[528]. Si les enfants bénéficient des mêmes garanties que les adultes, la CouEDH a établi plusieurs principes supplémentaires visant à renforcer la position des enfants dans les procédures pénales nationales.

La CouEDH interprète généralement l'article 5, paragraphe 1, point c), et paragraphe 3, en ce sens qu'une personne ne peut être placée en détention provisoire qu'en présence de raisons plausibles de le soupçonner d'avoir commis une infraction pénale. En outre, la détention provisoire ne peut excéder un délai raisonnable et doit être réexaminée à des intervalles raisonnables. Plus la période de détention est longue, plus les raisons avancées par les autorités pour

528 CouEDH, *Idalov c. Russie* [GC], n° 5826/03, 22 mai 2012, para. 112.

la justifier doivent être solides. Selon la jurisprudence de la CouEDH, toute personne inculpée d'une infraction doit être libérée jusqu'à son procès, à moins que l'État ne prouve qu'il existe des motifs « pertinents et suffisants » de justifier une détention prolongée[529].

La CouEDH a défini quatre raisons acceptables de refuser la libération sous caution à un détenu en cas de détention provisoire : le risque de fuite, le risque de préjudice à l'administration de la justice, le risque de nouvelle infraction ou le risque de trouble de l'ordre public. En outre, la prolongation d'une détention provisoire doit être limitée au strict nécessaire et l'État doit examiner tous les faits plaidant pour ou contre l'existence d'une véritable exigence d'intérêt public justifiant le maintien de la privation de liberté[530].

Lorsque des enfants sont impliqués, la CouEDH exige des autorités nationales qu'elles accordent une attention particulière à leur âge au moment de pondérer les arguments en faveur ou en défaveur de la détention provisoire ; cette dernière ne doit être utilisée qu'en dernier ressort et sa durée doit être la plus brève possible[531]. Pour ce faire, les autorités doivent examiner les solutions autres que la détention provisoire[532]. Par ailleurs, les autorités nationales doivent faire preuve d'une diligence particulière afin que les procès concernant des enfants aient lieu dans des délais raisonnables[533].

Exemple : dans l'affaire *Nart c. Turquie*[534], le requérant de 17 ans avait été arrêté pour suspicion de cambriolage d'une épicerie. Il avait été placé en détention provisoire, dans une prison pour adultes, pendant 48 jours. En soulignant particulièrement le fait que le requérant était un enfant, la CouEDH a indiqué que la détention provisoire des mineurs doit être utilisée en dernier recours et être aussi brève que possible. Lorsqu'elle est inévitable, les mineurs doivent être détenus séparément des adultes[535]. Dans

529 CouEDH, *Smirnova c. Russie*, n° 46133/99 et 48183/99, 24 juillet 2003, para. 58.

530 *Ibid.*, CouEDH, *Ladent c. Pologne*, n° 11036/03, 18 mars 2008, para. 55.

531 CouEDH, *Korneykova c. Ukraine*, n° 39884/05, 19 janvier 2012, paras. 43-44. Voir également CouEDH, *Selçuk c. Turquie*, n° 21768/02, 10 janvier 2006, paras. 35 et 36 ; CouEDH, *J.M. c. Danemark*, n° 34421/09, 13 novembre 2012, para. 63.

532 CouEDH, *Dinç et Çakır c. Turquie*, n° 66066/09, 9 juillet 2013, para. 63 ; CouEDH, *Güveç c. Turquie*, n° 70337/01, 20 janvier 2009, para. 108.

533 CouEDH, *Kuptsov et Kuptsova c. Russie*, n° 6110/03, 3 mars 2011, para. 91.

534 CouEDH, *Nart c. Turquie*, n° 20817/04, 6 mai 2008.

535 *Ibid.*, para. 31.

ce cas particulier, les autorités avaient tenté de justifier la détention provisoire sur la base des éléments de preuve actuellement disponibles, mais la Cour a considéré que cette raison ne saurait justifier à elle seule la durée de la détention du requérant. La CouEDH a donc conclu à l'existence d'une violation de l'article 5, paragraphe 3, de la CEDH.

Placement en détention en vue d'un encadrement éducatif

Cette forme de détention a été ordonnée dans des situations dans lesquelles l'enfant présentait un besoin particulier d'encadrement éducatif en raison d'une personnalité dérangée et d'un comportement violent. L'article 5, paragraphe 1, point d), de la CEDH cible essentiellement les formes de détention sortant du cadre du système de justice des mineurs.

Exemple : l'affaire *Bouamar c. Belgique*[536] traite du placement d'un enfant en maison d'arrêt à neuf reprises pendant des périodes d'environ 15 jours. Le requérant était un adolescent jugé posséder une personnalité perturbée et un comportement violent. Le gouvernement belge avait expliqué qu'il avait été placé en maison d'arrêt pour suivre une éducation spécialisée. La CouEDH a noté que l'internement d'un mineur en maison d'arrêt n'enfreint pas forcément l'article 5, paragraphe 1, point d), pour autant que les autorités poursuivent l'objectif de placer le mineur sous éducation surveillée. Toutefois, la Cour a considéré que dans le cas d'espèce, les autorités n'avaient pas démontré leur intention ni la possibilité de le placer dans une institution où il pourrait bénéficier d'une éducation spécialisée. La CouEDH a donc conclu à l'existence d'une violation de l'article 5, paragraphe 1, point d), de la CEDH.

Exemple : l'affaire *D.G. c. Irlande*[537] porte sur le placement d'un enfant violent dans un centre de détention. La CouEDH a estimé que les termes d'« éducation surveillée » ne doivent pas être assimilés systématiquement à la notion d'enseignement en salle de classe. L'éducation surveillée suppose que l'autorité locale prenne en charge de nombreux aspects de l'exercice des droits parentaux au bénéfice et pour la protection de l'intéressé. D'après la Cour, les autorités nationales ont le droit de placer des mineurs dans des centres de détention de manière provisoire jusqu'à ce qu'un lo-

536 CouEDH, *Bouamar c. Belgique*, n° 9106/80, 29 février 1988.

537 CouEDH, *D.G. c. Irlande*, n° 39474/98, 16 mai 2002.

gement adéquat soit trouvé, pour autant que la situation soit rapidement réglée. Dans le cas du requérant, cette exigence de rapidité n'a pas été respectée, puisqu'il n'a été placé dans un logement adéquat que plus de six mois après sa sortie de détention. La CouEDH a donc conclu à l'existence d'une violation de l'article 5, paragraphe 1, point d), de la CEDH.

Recours contre une décision de détention, rapidité de l'examen et accès à un avocat

La CouEDH exige des autorités nationales qu'elles fassent preuve d'une diligence particulière dans les cas impliquant des enfants placés en détention. En plus des garanties mentionnées ci-dessus, les autorités nationales doivent veiller à ce que les enfants aient le droit de contester la légalité de leur détention à intervalles raisonnables et à ce qu'ils aient accès à un avocat pendant la procédure statuant sur la légalité de leur détention. Ces recours juridiques doivent par ailleurs être tranchés rapidement par les juridictions nationales. La CouEDH tire ces garanties procédurales du contenu de l'article 5, paragraphe 4, de la CEDH.

Exemple : dans l'affaire *Bouamar c. Belgique*[538], la CouEDH a conclu à une violation de l'article 5, paragraphe 4, pour les raisons suivantes : les audiences relatives à la fixation de la détention du requérant se sont déroulées en l'absence de ses avocats ; la décision n'a pas été prise à bref délai ; il n'y a eu aucune véritable décision au sujet de la légalité de la détention, puisque les tribunaux nationaux ont rejeté les recours du requérant comme sans objet.

11.2.2. Conditions du placement en détention

Dans le droit de l'UE, l'article 4 de la Charte des droits fondamentaux de l'UE interdit la torture et les traitements inhumains ou dégradants. Toutefois, la Charte ne s'appliquant que dans le cadre du droit de l'Union, cette disposition ne peut devenir contraignante pour les États membres qu'en étant rattachée à un autre instrument juridique de l'UE. À ce jour, la CJUE n'a entendu aucune affaire relevant de l'article 4 de la Charte.

538 CouEDH, *Bouamar c. Belgique*, n° 9106/80, 29 février 1988.

Dans le droit du CdE, la CouEDH a jugé que la détention d'enfants avec des adultes pouvait entraîner une violation de l'article 3 [539] ou de l'article 5 de la CEDH[540]. Le manque de soins médicaux appropriés en détention peut également soulever des questions au titre de l'article 3 [541], comme d'autres aspects tels que la dimension des cellules, l'éclairage et les activités récréatives[542]. Au moment d'évaluer la compatibilité des conditions de détention avec les normes de l'article 3 de la CEDH, la Cour s'appuie souvent sur l'ensemble de normes élaborées par le Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT), qui surveille les conditions carcérales sous l'égide de la Convention européenne pour la prévention de la torture et des peines ou traitements inhumains ou dégradants en effectuant des visites sur place dans les États membres du Conseil de l'Europe[543].

Exemple : dans l'affaire *Güveç c. Turquie*[544], un garçon de 15 ans a été arrêté au motif d'être soupçonné d'appartenir au Parti des travailleurs du Kurdistan (PKK). Il a été détenu par le tribunal de la sûreté de l'État dans une prison pour adultes pendant cinq ans. La CouEDH a fait remarquer que sa détention était contraire aux réglementations et obligations de la Turquie au titre des traités internationaux, notamment l'article 37, point c), de la CRC, exigeant que les enfants soient détenus séparément des adultes. La Cour a également noté que le requérant avait commencé à souffrir de problèmes psychologiques en prison, à la suite desquels il a tenté de se suicider à de nombreuses reprises. En outre, les autorités n'ont pas fourni au requérant les soins médicaux dont il avait besoin. Par conséquent, compte tenu de l'âge du requérant, de la durée de sa détention en prison avec des adultes, du fait que les autorités ne lui ont pas fourni l'aide médicale nécessaire pour ses problèmes psychologiques et du fait qu'elles n'ont pris aucune mesure pour empêcher ses nombreuses tentatives de suicide, la Cour n'a aucun doute sur le fait que le requérant a subi un traitement inhumain et dégradant. Il y a donc eu violation de l'article 3 de la CEDH.

539 CouEDH, *Güveç c. Turquie,* n° 70337/01, 20 janvier 2009.

540 CouEDH, *Nart c. Turquie*, n° 20817/04, 6 mai 2008.

541 CouEDH, *Güveç c. Turquie,* n° 70337/01, 20 janvier 2009 ; CouEDH, *Blokhin c. Russie*, n° 47152/06, 14 novembre 2013 (renvoyée vers la Grande Chambre le 24 mars 2014).

542 CouEDH, *Kuptsov et Kuptsova c. Russie*, n° 6110/03, 3 mars 2011, para. 70.

543 Voir par exemple la CouEDH, *Güveç c. Turquie*, n° 70337/01, 20 janvier 2009.

544 *Ibid*.

Le CEDS a toujours interprété l'article 17 de la CSE en ce sens que les enfants détenus ou emprisonnés doivent être séparés des adultes.

Les règles européennes du CdE pour les délinquants mineurs faisant l'objet de sanctions ou de mesures fournissent des orientations détaillées sur les conditions de détention. Elles disposent également que les mineurs ne doivent pas être détenus dans des institutions pour adultes, mais dans des institutions qui ont été spécialement conçues pour eux[545].

Dans le droit international, la Convention relative aux droits de l'enfant contient une disposition distincte relative à la privation de liberté des enfants, indiquant que les enfants doivent être séparés des adultes, à moins que ce ne soit pas dans leur intérêt supérieur (article 37, point c), de la CRC). Cet article dispose également que les enfants ont en principe le droit de maintenir le contact avec leur famille par le biais de visites ou d'échanges de correspondance.

11.2.3. Protection contre les abus et les mauvais traitements

Dans le droit du CdE, la CouEDH a considéré à plusieurs reprises que les autorités nationales étaient responsables de la protection des personnes en détention contre le décès, les abus ou les mauvais traitements infligés par d'autres détenus ou par les autorités elles-mêmes. Les obligations des États à cet égard sont particulièrement strictes, vu que les détenus sont placés sous l'autorité et le contrôle de l'État. [546] En plus de prendre des mesures raisonnables en vue de protéger les détenus, les autorités nationales doivent également enquêter efficacement sur les allégations crédibles de mauvais traitements ou de décès.

Exemple : l'affaire *Çoşelav c. Turquie*[547] portait sur le suicide en prison d'un adolescent qui avait déjà tenté à plusieurs reprises de mettre fin à ses jours. Comme suite à ces tentatives de suicide, les autorités l'avaient transféré d'une aile pour mineurs vers un centre de détention pour adultes.

545 CdE, Comité des Ministres, Recommandation CM/Rec(2008)11 sur les règles européennes pour les délinquants mineurs faisant l'objet de sanctions ou de mesures, 5 novembre 2008, règle 59.1.

546 CouEDH, *Anguelova c. Bulgarie*, n° 38361/97, 13 juin 2002 ; CouEDH, *H.Y. et Hü.Y. c. Turquie*, n° 40262/98, 6 octobre 2005.

547 CouEDH, *Çoşelav c. Turquie*, n° 1413/07, 9 octobre 2012.

Après avoir établi que les autorités étaient conscientes (ou auraient dû l'être) de l'existence d'un risque réel et immédiat pour la vie du fils du requérant, la Cour a ensuite noté que les autorités n'avaient pas pris de mesures raisonnables pour empêcher le drame. La Cour a fortement insisté sur l'âge du défunt et sur le fait qu'il ait été détenu avec des adultes. La CouEDH a donc conclu à une violation du volet matériel de l'article 2 de la CEDH. La Cour a également conclu à une violation de la branche procédurale de l'article 2, tirée de l'absence d'enquête effective sur le décès du fils du requérant par les autorités. Les motifs à l'appui de ces conclusions sont les suivants : les autorités n'ont pas averti rapidement les requérants du décès de leur fils ; le parquet n'a pas examiné l'absence présumée de mesures prises pour éviter le suicide ; et la durée de la procédure administrative ultérieure était excessive.

11.3. Protection des enfants victimes et des témoins

Point clé

- Les enfants victimes et témoins ont le droit à une protection pour éviter toute nouvelle victimisation, à la réadaptation et à la réintégration et à la participation effective aux procédures pénales et autres procédures.

Dans le droit de l'UE comme dans le droit du CdE, la position des enfants victimes et témoins a été reconnue.

Dans le droit de l'UE, la directive 2012/29/UE relative aux droits des victimes[548] reconnaît explicitement la position des enfants victimes. Elle dispose que lorsque la victime est un enfant, son intérêt supérieur doit être une considération primordiale, évaluée au cas-par-cas. En outre, une approche axée sur les spécificités de l'enfant, tenant dûment compte de son âge, de sa maturité, de son opinion, de ses besoins et de ses préoccupations, doit être privilégiée. La directive vise par ailleurs à garantir que l'enfant et le titulaire de l'autorité parentale (ou tout autre

548 Directive 2012/29/UE du Parlement européen et du Conseil du 25 octobre 2012 établissant des normes minimales concernant les droits, le soutien et la protection des victimes de la criminalité, JO 2012 L 315, p. 55.

représentant légal) seront informés de toute mesure ou de tout droit concernant spécifiquement l'enfant (article 1, paragraphe 2). Les enfants victimes ont également le droit d'être entendus pendant les procédures pénales et les États membres doivent veiller à ce qu'ils puissent également apporter des preuves. L'âge et la maturité de l'enfant doivent être dûment pris en considération (article 10, paragraphe 1). Par ailleurs, la directive a pour objectif de protéger la vie privée et l'identité des enfants victimes pendant les procédures pénales afin notamment d'éviter la victimisation secondaire (article 21, paragraphe 1 ; voir également l'article 26). La directive contient également une disposition spéciale relative au droit des enfants victimes à une protection au cours de la procédure pénale (article 24), qui traite de l'enregistrement audiovisuel des auditions des enfants victimes et de leur utilisation en tant qu'éléments de preuve pendant la procédure pénale, de la désignation de représentants spéciaux et du droit à une représentation juridique en son nom propre en cas de conflit d'intérêts entre l'enfant victime et les titulaires de l'autorité parentale. La directive inclut également plusieurs dispositions relatives à la protection des victimes en général, telles que l'accès aux services d'aide aux victimes. Lorsque des enfants ou d'autres groupes vulnérables sont concernés, il convient de mettre à leur disposition des services d'aide spécialisés (voir la section 38 de la résolution accompagnant la directive)[549].

Avant d'être remplacée par la directive relative aux droits des victimes, la décision-cadre 2001/220/JAI relative au statut des victimes dans le cadre des procédures pénales couvrait notamment la participation des victimes, leurs droits et leur traitement équitable. Elle reconnaissait la position spéciale des victimes vulnérables, sans toutefois faire explicitement référence aux enfants. Sur la base de cette décision-cadre, la CJUE a jugé que les enfants pouvaient être qualifiés de vulnérables lorsque l'on tient compte de leur âge et des infractions dont ils estiment avoir été victimes. Ce statut leur donne alors droit à des mesures de protection spéciales, comme l'audition en dehors de l'audience publique et avant la tenue de celle-ci[550]. La CJUE a également jugé que toutes les mesures prises pour protéger les victimes devaient être conçues de manière à ce que l'accusé fasse tout de même l'objet d'un procès équitable. En d'autres termes, la protection des victimes et des témoins ne peut compromettre le droit de la personne accusée à un procès équitable (voir également les exemples de la jurisprudence de la CouEDH)[551].

549 Voir également FRA (2014b), p. 36.

550 CJUE, C-105/03, *Procédure pénale contre Maria Pupino* [GC], 16 juin 2005, point 53.

551 CJUE, C-105/03, *Procédure pénale contre Maria Pupino* [GC], 16 juin 2005. Voir également CJUE, C-507/10, *Procédure pénale contre X.*, 21 décembre 2011.

Exemple : dans l'affaire *Pupino*,[552] une enseignante italienne avait été poursuivie pour mauvais traitements sur un élève. En vertu du code de procédure pénale italien, les témoins doivent, en règle générale, témoigner devant le tribunal pendant le procès. Toutefois, dans certaines circonstances, ce témoignage peut s'effectuer devant un juge avant le procès, dans le cadre d'une procédure spéciale (*incidente probatorio*). Dans le cas d'espèce, le ministère public a demandé à la juridiction nationale d'accepter comme preuves les témoignages qu'ont effectué les jeunes enfants à l'avance, mais celle-ci a refusé. Pour la première fois, la CJUE a donné son interprétation de certaines dispositions relatives à l'apparition des enfants en tant que victimes et témoins devant les tribunaux. Elle a souligné que la décision-cadre 2001/220/JAI exigeait des États membres qu'ils assurent la protection spécifique des victimes vulnérables, ce qui suppose que la juridiction nationale doit pouvoir autoriser les victimes vulnérables à témoigner d'une manière qui garantit leur protection, par exemple en dehors de l'audience publique et avant la tenue de celle-ci. La CJUE a indiqué ce qui suit : « [t]outefois, indépendamment de la question de savoir si la circonstance que la victime d'une infraction pénale est un mineur suffit, en règle générale, pour qualifier une telle victime de particulièrement vulnérable au sens de la décision-cadre, il ne saurait être contesté que lorsque, comme dans l'affaire au principal, des enfants en bas âge prétendent avoir subi des mauvais traitements, de surcroît de la part d'une enseignante, ces enfants sont susceptibles de faire l'objet d'une telle qualification eu égard notamment à leur âge, ainsi qu'à la nature et aux conséquences des infractions dont ils estiment avoir été victimes »[553]. La CJUE a estimé par ailleurs que toutes les mesures relatives à la protection et à la prévention de la victimisation secondaire doivent être élaborées de telle manière que le défendeur bénéficie toujours d'un procès équitable[554].

Dans le droit du CdE, la CouEDH a jugé que l'État avait l'obligation de protéger les intérêts des victimes, également lorsque celles-ci participent en tant que témoins à une procédure pénale. Leurs intérêts au titre des dispositions de la CEDH, telles que les articles 2 et 8, doivent être mis en balance avec ceux de la défense.[555] La CouEDH a rendu un certain nombre d'arrêts relatifs à des affaires

552 CJUE, C-105/03, *Procédure pénale contre Maria Pupino* [GC], 16 juin 2005.

553 *Ibid.*, point 53.

554 *Ibid.*, point 59.

555 CouEDH, *Doorson c. Pays-Bas*, n° 20524/92, 26 mars 1996.

de délits sexuels dans lesquelles des enfants avaient témoigné contre les auteurs présumés. Cette jurisprudence montre que la Cour a admis qu'une procédure pénale portant sur une infraction à caractère sexuel « est souvent vécu[e] comme une épreuve par la victime, en particulier lorsque celle-ci est confrontée contre son gré à l'accusé », a fortiori lorsque la victime est un enfant.[556] La Cour admet donc que dans ce cas de figure, certaines mesures devraient être prises afin de protéger les enfants victimes. Elle a néanmoins aussi noté que ces mesures ne devraient pas compromettre l'exercice adéquat et effectif des droits de la défense et que les autorités judiciaires peuvent être appelées à prendre des mesures qui compensent les obstacles auxquels se heurte la défense.[557]

Exemple : dans l'affaire *Kovač c. Croatie*[558], une fillette de 12 ans a témoigné devant un juge d'instruction en confirmant que le requérant avait commis des actes indécents sur elle. Le requérant n'avait pas assisté à cette déposition et ne s'y était pas fait représenter. Il n'a pas non plus eu la possibilité de contester la déclaration de la victime. La CouEDH a rappelé qu'en règle générale, tous les éléments de preuve doivent être produits en présence de l'accusé lors d'une audience publique en en vue d'un débat contradictoire. L'utilisation en tant que preuves de déclarations faites au stade de l'enquête de police ou de l'instruction n'est pas en soi contraire à l'article 6 de la CEDH pour autant que le défendeur dispose d'une opportunité adéquate et véritable de poser des questions à la victime présumée, ou de remettre en cause sa déposition, au moment des dépositions ou à un stade ultérieur de la procédure. Dans le cas du requérant, les déclarations de la victime étaient les seules preuves directes des faits qui lui étaient reprochés et ces preuves ont joué un rôle décisif dans le verdict de culpabilité rendu par le tribunal. Toutefois, le requérant n'avait pas eu la possibilité de contester ces preuves ou d'obtenir une réponse des tribunaux nationaux concernant sa plainte à cet égard. En outre, la véritable déposition de la victime n'a jamais été lue devant le tribunal : le juge s'est contenté d'indiquer que la victime confirmait la déclaration qu'elle avait fait devant le juge d'instruction. La Cour a donc conclu que le requérant n'avait pas bénéficié d'un procès

556 CouEDH, *S.N. c. Suède*, n° 34209/96, 2 juillet 2002, para. 47.

557 CouEDH, *Bocos-Cuesta c. Pays-Bas*, n° 54789/00, 10 novembre 2005 ; CouEDH, *A.L. c. Finlande*, n° 23220/04, 27 janvier 2009 ; CouEDH, *W. c. Finlande*, n° 14151/02, 24 avril 2007 ; CouEDH, *Kovač c. Croatie*, n° 503/05, 12 juillet 2007.

558 CouEDH, *Kovač c. Croatie*, n° 503/05, 12 juillet 2007.

équitable, en violation de l'article 6, paragraphe 1, lu conjointement avec l'article 6, paragraphe 3, point d), de la CEDH.

Exemple : dans l'affaire *S.N. c. Suède*[559], un garçon de 10 ans a déclaré à la police qu'il avait été abusé sexuellement par le requérant. Le garçon a été interrogé à deux reprises par un inspecteur de police possédant une vaste expérience des cas d'abus d'enfants. Le premier interrogatoire a été filmé et le second a fait l'objet d'un enregistrement audio. L'avocat du requérant n'a pas assisté au deuxième interrogatoire, mais a convenu avec l'inspecteur de police des questions qui devaient être abordées. Pendant le procès, le tribunal de district a diffusé les enregistrements des interrogatoires de l'enfant, mais ne l'a pas interrogé en personne. Le tribunal condamna le requérant en se basant presque exclusivement sur les témoignages de l'enfant. La cour d'appel a confirmé la condamnation. Elle a considéré que les interrogatoires de police fournissaient suffisamment de preuves de la culpabilité du requérant, tout en reconnaissant qu'aucune preuve technique ne permettait d'étayer les allégations de l'enfant, parfois imprécises. La CouEDH a reconnu que dans les affaires concernant des infractions à caractère sexuel, le contre-interrogatoire des témoins n'est pas toujours possible et que leurs témoignages doivent par conséquent être traités avec une extrême prudence. Si les déclarations de l'enfant étaient pratiquement les seules preuves à charge de l'accusé, la procédure a été globalement équitable. L'enregistrement vidéo a été diffusé au cours des audiences de première instance et d'appel et la transcription écrite du second interrogatoire a été lue à haute voix devant le tribunal de district ; la cour d'appel a également écouté l'enregistrement audio. Le requérant a dès lors eu suffisamment d'occasions de mettre en cause les déclarations et la crédibilité de l'enfant au cours de la procédure pénale. La Cour a donc conclu à l'absence de violation de l'article 6, paragraphe 3, point d), de la CEDH.

La jurisprudence de la CouEDH n'exige pas seulement de maintenir un équilibre entre la protection des enfants victimes et le droit du défendeur à un procès équitable, mais aussi que le droit à la vie des témoins et de leur famille, y compris des enfants, consacré par l'article 2 de la CEDH soit protégé, comme le montre l'exemple suivant.

559 CouEDH, *S.N. c. Suède*, n° 34209/96, 2 juillet 2002.

Exemple : l'affaire *R.R. et autres c. Hongrie*[560] porte sur un homme incarcérée qui a témoigné en audience publique au sujet de ses activités de trafic de drogue et qui est entré dans le programme officiel de protection des témoins, avec son épouse et ses deux enfants, afin de les protéger contre les risques de représailles. Lorsque les autorités virent à soupçonner que le prisonnier était toujours en contact avec le milieu criminel, elles l'ont exclu du programme, ainsi que sa famille, pour en avoir enfreint les conditions. Au titre de l'article 2 de la CEDH, les membres de la famille ont fait valoir que leur exclusion du programme de protection des témoins les a exposés à des risques de représailles de la part de la mafia et a ainsi mis leur vie en danger. La Cour a reconnu que l'entrée des requérants dans le programme de protection des témoins et la collaboration du père avec les autorités signifiaient que leur vie était en danger au moment où la mesure a été prise. L'arrêt de leur protection par le programme n'ayant pas été motivé par une réduction de ce risque, mais par une violation des conditions du programme, la Cour n'était pas convaincue que les autorités avaient démontré que les risques avaient cessé d'exister. Par ailleurs, il n'est pas déraisonnable de supposer que, à la suite du retrait des fausses identités des membres de la famille, quiconque aurait souhaité leur nuire pouvait découvrir leurs véritables identités et l'endroit où ils se trouvaient. Ainsi, les autorités ont potentiellement exposé la famille à un danger mortel, en violation de l'article 2 de la CEDH.

L'article 31 de la Convention de Lanzarote indique les mesures générales de protection que les États membres doivent prendre pour protéger les droits et les intérêts des victimes, y compris leurs besoins spécifiques en tant que témoins, à tous les stades des enquêtes et des procédures judiciaires (article 31, paragraphe 1). Ils doivent notamment tenir les victimes informées de leurs droits, des services à leur disposition et du déroulement général de l'enquête ou de la procédure, assurer la protection de leur vie privée et de leur sécurité (y compris en les informant de toute remise en liberté, temporaire ou définitive, de la personne, poursuivie ou condamnée) et en veillant à ce que les victimes et les auteurs d'infractions ne se trouvent en contact direct dans les locaux des services d'enquête et les locaux judiciaires. L'article 31 dispose par ailleurs que les victimes doivent avoir accès à une aide juridique (article 31, paragraphe 3). Les informations fournies aux enfants doivent l'être d'une manière adaptée à leur

560 CouEDH, *R.R. et autres c. Hongrie*, n° 19400/11, 4 décembre 2012.

âge et à leur degré de maturité et dans une langue qu'ils peuvent comprendre (article 31, paragraphe 6).

Les Lignes directrices du CdE sur une justice adaptée aux enfants[561] prêtent également attention à la position de l'enfant victime et témoin, en particulier lorsque celui-ci témoigne dans une procédure judiciaire. Les lignes directrices invitent les États membres à tout mettre en œuvre « pour permettre aux enfants de témoigner dans les environnements les plus favorables et les conditions les meilleures, eu égard à leur âge, leur maturité et leur niveau de compréhension, et en tenant compte de leurs éventuelles difficultés de communication ».[562] Il convient pour cela de faire appel à des professionnels formés. En outre, les déclarations audiovisuelles sont encouragées. Les enfants devraient également, dans les affaires pénales, avoir la possibilité de témoigner en dehors de la présence de l'auteur présumé de l'infraction. Les lignes directrices reconnaissent également que cette approche adaptée aux enfants doit respecter le droit des autres parties à contester le contenu des déclarations de l'enfant. Elles disposent par ailleurs que la vie privée et familiale des enfants témoins doit être protégée (section IV, point a) (9)) et que les procédures doivent se tenir de préférence à huis clos.

Dans le droit international, la position des enfants victimes est expressément reconnue par l'article 39 de la Convention relative aux droits de l'enfant. Aux termes de cette disposition, les États parties doivent prendre toutes les mesures appropriées pour faciliter la réadaptation physique et psychologique et la réinsertion sociale de tout enfant victime d'abus. La réadaptation et la réintégration doivent avoir lieu dans un environnement propice à la santé, au respect de soi-même et à la dignité de l'enfant.

Il est également à noter que les Nations Unies ont adopté des Lignes directrices en matière de justice dans les affaires impliquant les enfants victimes et témoins d'actes criminels.[563] Celles-ci invitent à traiter les enfants victimes et témoins d'une « manière adaptée à l'enfant », une expression qui « dénote une approche équilibrée du droit à la protection et veut dire que l'on prend en compte les be-

561 CdE, Comité des Ministres (2010), *Lignes directrices sur une justice adaptée aux enfants*, 17 novembre 2010. Voir également FRA (2015b).

562 CdE, Comité des Ministres (2010), *Lignes directrices sur une justice adaptée aux enfants*, 17 novembre 2010, para. 64.

563 Conseil économique et social des Nations Unies (ECOSOC), Résolution 2005/20, *Lignes directrices en matière de justice dans les affaires impliquant les enfants victimes et témoins d'actes criminels*, 22 juillet 2005.

soins et points de vue individuels de l'enfant »[564]. Les lignes directrices fournissent des orientations très détaillées sur la manière de mettre en œuvre ces aspects. Le Comité des droits de l'enfant des Nations unies a également souligné, dans son observation générale n° 12, la pertinence de ces lignes directrices des Nations Unies au regard de l'article 12 de la CRC (droit d'être entendu)[565]. Selon le Comité, les enfants victimes et les enfants témoins d'un crime doivent avoir la possibilité d'exercer leur droit d'exprimer librement leurs opinions, ce qui signifie en particulier que « tout doit être fait pour que l'enfant victime et/ou témoin soit consulté sur les questions pertinentes en ce qui concerne son implication dans l'affaire à l'examen, et pour qu'il ait la possibilité d'exprimer librement, à sa manière, ses vues et ses préoccupations en ce qui concerne son implication dans le processus judiciaire » (paragraphe 63 de l'observation générale). Le Comité affirme par ailleurs que « [l]e droit de l'enfant victime ou témoin d'être entendu est [...] lié au droit d'être informé sur des questions comme la possibilité de bénéficier de services de santé, d'assistance psychologique et d'aide sociale, le rôle d'un enfant victime et/ou témoin, le déroulement de «l'interrogatoire», les mécanismes de soutien dont bénéficient les enfants qui soumettent une plainte ou participent à une enquête et à une procédure judiciaire, le lieu et l'heure des audiences, l'existence de mesures de protection, la possibilité de recevoir réparation, et les possibilités d'appel » (paragraphe 64).

564 *Ibid.*, para. 9, point d).

565 ONU, Comité des droits de l'enfant (2009), *Observation générale n° 12 (2009), Le droit de l'enfant d'être entendu*, CRC/C/GC/12, paras. 62 à 64.

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Comment consulter la jurisprudence des cours européennes ?

Cour européenne des droits de l'homme : base de données de jurisprudence HUDOC

La **base de données HUDOC** donne accès gratuitement à la jurisprudence de la CouEDH, via l'adresse suivante : http://HUDOC.echr.coe.int.

Cette base de données est disponible en anglais et en français et met à disposition un moteur de recherche convivial permettant de retrouver facilement la jurisprudence recherchée.

Des tutoriels vidéo et des manuels d'utilisation sont disponibles sur la page d'**aide** d'HUDOC. Pour des détails et exemples sur l'utilisation des filtres et des champs de recherche, l'utilisateur peut placer sa souris sur les icônes ? placées à droite de chaque outil de recherche dans HUDOC.

Les références à la jurisprudence comprises dans ce manuel donnent au lecteur des informations exhaustives lui permettant de retrouver facilement le texte complet des arrêts et décisions cités.

Avant d'entamer une recherche, veuillez noter que l'affichage par défaut reprend les arrêts de Grande chambre et de chambre dans l'ordre chronologique inverse de leur publication. Pour étendre la recherche à d'autres catégories de documents, tels que les décisions, l'utilisateur doit cocher la case correspondante dans le menu « ***catégories de documents*** » en haut, à gauche de l'écran.

La manière la plus simple d'accéder à des affaires est d'entrer le numéro de requête dans le champ « *numéro de requête* » de l'option « ***recherche avancée*** », en haut, à droite de l'écran, puis en cliquant sur « *rechercher* ».

Pour accéder à une jurisprudence plus large relative à d'autres sujets, par exemple les questions liées à l'asile, l'utilisateur peut utiliser le **champ de recherche** arborant une loupe, à droite dans le bandeau supérieur de l'écran. Dans ce champ, l'utilisateur peut lancer une recherche dans les textes à partir :

- d'un mot (enfant, par exemple) ;
- d'une expression (« *enfants migrants* », par exemple) ;
- du titre d'une affaire ;
- de l'État ; ou
- d'une chaîne booléenne (enfants SOUS protection de remplacement, par exemple).

Pour aider l'utilisateur à réaliser une recherche texte, la **recherche booléenne simple** est mise à disposition en cliquant sur la flèche apparaissant dans le **champ de recherche**. Cet outil offre six possibilités de recherche : « *ce mot ou cette expression exact(e)* » ; « *tous les mots suivants* » ; « *l'un des mots suivants* » ; « *aucun des mots suivants* » ; « *proche de ces mots* » et « *recherche booléenne* ».

Une fois sur la page de résultats, l'utilisateur peut restreindre facilement ces derniers à l'aide des filtres proposés dans le menu « ***filtres*** » à gauche de l'écran, en fonction des langues ou de l'État, par exemple. Les filtres peuvent être utilisés seuls ou combinés, pour des résultats encore plus ciblés. Le filtre « *mots-clés* » peut être utile, car il propose souvent des termes issus du texte de la CEDH et est souvent lié directement au raisonnement et aux conclusions de la Cour.

Exemple : pour consulter la jurisprudence de la Cour relative aux expulsions de demandeurs d'asile exposant ces derniers à un risque de torture ou de peine ou traitement inhumain ou dégradant au sens de l'article 3 de la CEDH :

1) l'utilisateur entre l'expression « *demandeurs d'asile* » dans le champ de recherche et clique sur le bouton bleu « *rechercher* » ;

2) sur la page de résultats, il sélectionne ensuite « *3* » dans le filtre « *violation* » du menu « ***filtres*** » pour ne plus afficher que les résultats en lien avec une violation de l'article 3 ; et

3) enfin, il peut sélectionner des mots-clés pertinents sous le filtre « *mots-clés* » pour n'afficher plus que les résultats pertinents concernant l'article 3, en utilisant par exemple la chaîne de mots-clés « *(Art. 3) Interdiction de la torture* ».

Pour les affaires plus importantes, un résumé juridique est disponible dans HUDOC. Ce résumé comprend un chapeau descriptif, ainsi qu'un bref exposé des faits et du droit, s'attardant particulièrement sur les points représentant un intérêt juridique. Si un résumé existe, un lien « Résumés juridiques » apparaîtra dans les résultats, avec le lien vers le texte de l'arrêt ou de la décision. L'utilisateur peut également rechercher exclusivement les résumés juridiques en cochant la case « *résumés juridiques* » dans le menu « ***catégories de documents*** ».

Si des traductions non officielles d'une affaire existent, un lien « Versions linguistiques » apparaîtra dans les résultats, avec le lien vers le texte de l'arrêt ou de la décision. HUDOC propose également des liens vers des sites web extérieurs hébergeant d'autres traductions de la jurisprudence de la CouEDH. Pour plus d'informations, le lecteur est prié de se référer à la page d'aide d'HUDOC, sous l'intitulé « *versions linguistiques* ».

Cour de justice de l'Union européenne : base de données de jurisprudence CURIA

La **base de données de jurisprudence CURIA** donne accès gratuitement à la jurisprudence de la CJCE/CJUE, via l'adresse suivante : http://curia.europa.eu.

Le moteur de recherche est disponible dans toutes les langues officielles de l'UE[566]. La langue peut être sélectionnée en haut et à droite de l'écran. Le moteur de recherche permet de rechercher des informations dans tous les documents liés aux anciennes affaires et aux affaires en instance de la Cour, du Tribunal et du Tribunal de la fonction publique.

566 Langues disponibles depuis le 30 avril 2004 : allemand, anglais, danois, espagnol, finnois, français, grec, italien, néerlandais, portugais et suédois ; depuis le 1er mai 2004 : estonien, hongrois letton, lituanien, polonais, slovaque, slovène et tchèque ; depuis le 1er janvier 2007 : bulgare et roumain ; depuis le 30 avril 2007 : maltais ; et depuis le 31 décembre 2011 : irlandais. Les règlements n° 920/2005 et n° 1257/2010 fixent des dérogations temporaires. Le droit dérivé en vigueur à la date de l'accession de la Croatie est en cours de traduction vers le croate et sera publié progressivement dans l'édition spéciale du Journal officiel de l'Union européenne.

Un document d'**aide** est disponible à l'adresse suivante : http://curia.europa.eu/common/juris/fr/aideGlobale.pdf. Chaque champ de recherche possède également une page d'aide accessible en cliquant sur le point d'interrogation situé devant le champ. Ces pages comprennent des informations utiles pour permettre à l'utilisateur d'utiliser au mieux l'outil.

La manière la plus simple de consulter une affaire donnée est d'entrer le numéro complet de l'affaire dans le champ « ***numéro d'affaire*** », puis de cliquer sur le bouton vert « *rechercher* ». Il est également possible de retrouver une affaire à partir d'une partie seulement de son numéro. En entrant par exemple « *122* » dans le champ « *numéro d'affaire* », l'utilisateur aura accès à toutes les affaires n° 122 de toutes les années devant la Cour, le Tribunal et/ou le Tribunal de la fonction publique.

S'il le désire, l'utilisateur peut également rechercher une affaire à partir de son nom courant en utilisant le champ « ***nom des parties*** ». Les noms des affaires se composent généralement de la forme simplifiée des noms des parties.

Il existe au total 16 champs de recherche multifonctionnels permettant de restreindre les résultats des recherches. Les différents champs de recherche sont faciles d'utilisation et peuvent être combinés de différentes manières. Ils proposent souvent des listes de recherche accessibles en cliquant sur l'icône et en sélectionnant les termes de recherche disponibles.

Pour des recherches plus générales, le champ « ***texte*** » permet de lancer une recherche à partir de mots-clés dans tous les documents publiés dans les recueils (Rec.) de la Cour depuis 1954 et dans les recueils de la jurisprudence « *Fonction publique* » (Rec. FP) depuis 1994.

Pour des recherches plus ciblées en fonction de domaines particuliers, l'utilisateur peut employer le champ « ***matières*** ». Pour cela, il doit cliquer sur l'icône située à droite du champ et sélectionner dans la liste la ou les matière(s) qui l'intéressent. Les résultats de recherche seront alors présentés sous la forme d'une liste alphabétique d'une sélection de documents liés aux questions juridiques abordées dans les décisions de la Cour, du Tribunal et du Tribunal de la fonction publique et dans les conclusions de l'avocat général.

Le site web CURIA propose également les autres outils ci-dessous aux fins de consultation de la jurisprudence.

« ***Accès numérique*** » : cette section permet de retrouver une information pour chacune des affaires introduites devant la Cour, le Tribunal ou le Tribunal de la fonction publique. Les affaires sont présentées en ordre numérique, en fonction de leur dépôt aux greffes respectifs. Elles peuvent être consultées en cliquant sur leurs numéros respectifs. La section « *accès numérique* » est disponible à l'adresse suivante : http://curia.europa.eu/jcms/jcms/Jo2_7045/.

« ***Répertoire de jurisprudence*** » : cette section regroupe, de manière systématique, les sommaires de la jurisprudence reprenant les points de droit essentiels soulevés dans les décisions. Ces résumés se basent le plus fidèlement possible sur le texte même des décisions. La section « *répertoire* » est disponible à l'adresse suivante : http://curia.europa.eu/jcms/jcms/Jo2_7046/.

« ***Notes de doctrine aux arrêts*** » : cette rubrique contient les références aux notes de doctrine relatives aux arrêts de la Cour de justice, du Tribunal et du Tribunal de la fonction publique depuis leur création. Les arrêts sont classés, pour chaque juridiction, par ordre de numéro d'affaire, tandis que les références aux notes sont classées par ordre chronologique de parution. Les références sont données dans leur langue originale. La section « *notes de doctrine aux arrêts* » est disponible à l'adresse suivante : http://curia.europa.eu/jcms/jcms/Jo2_7083/.

« ***Base de données de jurisprudence nationale*** » : cette base de données extérieure est accessible à partir du site web CURIA. Elle donne accès aux jurisprudences nationales pertinentes concernant le droit de l'UE. Elle se base sur une collection de jurisprudence des juridictions des États membres de l'UE sur la base d'un dépouillement sélectif de revues juridiques et de contacts directs avec de nombreuses juridictions nationales. La « *base de données de jurisprudence nationale* » est disponible en anglais et en français, à l'adresse suivante : http://curia.europa.eu/jcms/jcms/Jo2_7062/.

Instruments juridiques cités

Instruments juridiques de l'ONU

Pour de plus amples informations sur les principaux traités des Nations Unies, y compris la CRC et leurs organes de suivi, voir : www.ohchr.org/FR/ProfessionalInterest/Pages/CoreInstruments.aspx.

Pour de plus amples informations sur la Conférence de La Haye sur les conventions de droit international privé relatives à la protection internationale des enfants, relations internationales familiales et patrimoniales, voir : https://www.hcch.net/fr/instruments/conventions/.

Instruments juridiques du CdE

Tous les instruments juridiques du CdE sont disponibles en ligne à l'adresse : http://conventions.coe.int/Treaty.

Pour de plus amples informations sur l'état d'acceptation des instruments juridiques du CdE par les États membres de l'UE, voir la section « Obligations internationales » sur le site web de la FRA à l'adresse : http://fra.europa.eu/fr/publications-and-resources/data-and-maps/obligations-int.

	Titre
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Convention européenne des droits de l'homme	Convention de sauvegarde des Droits de l'Homme et des Libertés fondamentales telle qu'amendée par les Protocoles n° 11 et n° 14, STCE n° 005, Rome, 4.11.1950, p. 1-15.
Protocole additionnel à la Convention européenne des droits de l'homme	Protocole additionnel à la Convention de sauvegarde des Droits de l'Homme et des Libertés fondamentales tel qu'amendé par le Protocole n° 11, STCE n° 009, Paris, 20.3.1952, p. 1-3.
Protocole n° 12 à la Convention européenne des droits de l'homme	Protocole n° 12 à la Convention de sauvegarde des Droits de l'Homme et des Libertés fondamentales, STCE n° 177, Rome, 4.11.2000, p. 1-3.
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Les enfants sont des titulaires de droits à part entière. Ils sont bénéficiaires de tous les droits fondamentaux et de l'homme, et sont sujets de réglementations particulières compte tenu de leurs caractéristiques spécifiques. Ce manuel a pour but de montrer comment le droit et la jurisprudence européens s'adaptent aux intérêts et besoins particuliers des enfants. Il illustre également l'importance des parents et des tuteurs ou d'autres représentants légaux et fait référence, le cas échéant, aux principaux droits et responsabilités conférés aux personnes ayant la charge des enfants. Ce manuel entend sensibiliser le lecteur et approfondir ses connaissances des normes juridiques qui protègent et promeuvent les droits de l'enfant en Europe. Il constitue un ouvrage de référence sur le droit de l'Union européenne (UE) et du Conseil de l'Europe (CdE) relatif à ces domaines. Il explique comment chaque question est réglementée par le droit de l'UE, y compris la Charte des droits fondamentaux de l'Union européenne, ainsi que par la Convention européenne des droits de l'homme (CEDH), la Charte sociale européenne et d'autres instruments du Conseil de l'Europe. Ce manuel est destiné aux juristes non spécialisés, aux juges, aux procureurs, aux autorités chargées de la protection de l'enfance, ainsi qu'à d'autres praticiens et organisations chargés d'assurer la protection juridique des droits de l'enfant. Il explique la jurisprudence essentielle et résume les principaux arrêts de la Cour de justice de l'Union européenne (CJUE) et de la Cour européenne des droits de l'homme (CouEDH).

AGENCE DES DROITS FONDAMENTAUX DE L'UNION EUROPÉENNE
Schwarzenbergplatz 11 – 1040 Vienne – Autriche
Tél. +43 (1) 580 30-60 – Fax +43 (1) 580 30-693
fra.europa.eu – info@fra.europa.eu

CONSEIL DE L'EUROPE
67075 Strasbourg Cedex – France

COUR EUROPÉENNE DES DROITS DE L'HOMME
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- Directive 2011/36/EU sur la traite des êtres humains
- Directive 2012/29/EU sur les droits des victimes de la criminalité
- Directive 2011/93/EU sur la lutte contre les abus sexuels et l'exploitation sexuelle des enfants et contre la pedopornographie

Procédures dans lesquelles l'enfant peut être impliqué

1. Procédures pénales

L'obligation de l'État de prévenir et de punir la violence et la maltraitance des mineurs (première victimisation) *Art. 3-7 CDE; Art. 3 CEDH; Art. 18 Lanzarote; Art. 2-10 Directive 36; Art. 3-17 Directive 93*

Prévention

Introduction d'infractions pénales liées à la violence et aux abus contre les enfants

Sanction

Sanction des auteurs de violences et d'abus envers les mineurs

2. Procédures civiles

Lorsque l'un ou les deux parents sont les auteurs directs de l'abus, ou l'ont autorisé d'une autre manière

Pour garantir un environnement familial sûr et paisible

Art. 9 CDE; Art. 8 CEDH

Restrictions pour les parents

- Video Baldelli
- Video Ceccarelli
- Video Cibinel

Garde de l'enfant confiée à une autre famille

Placement dans un établissement pour enfants traumatisés

Adoption du mineur

- Video Cibinel
- Video Baldelli

Relations entre les procédures pénales et civiles

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Procédures pénales

Objectif → identifier et punir l'auteur d'un comportement contre le mineur, si ce comportement est un crime

Procédures civiles

Objectif → vérifier le caractère approprié de la famille de l'enfant et prévenir tout nouveau dommage.

Ces procédures sont distinctes et indépendantes → un comportement qui n'est pas un crime peut compromettre l'environnement de la famille, justifiant l'intervention du juge

3. Procédures extrajudiciaires

Lorsque la relation entre l'auteur de l'abus et le mineur semble être récupérable

Art. 13 Strasbourg Conv.; Art. 12 Directive 29

L'objectif est d'éviter les procédures intrusives, qui pourraient compromettre définitivement le rétablissement de la relation

- Médiation
- Tentative de Conciliation
- Mesures supplémentaires de rapprochement

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L'intérêt supérieur de l'enfant

Ce principe s'applique à toute procédure et exige que le bien-être psycho-physique de l'enfant soit placé avant tout autre intérêt digne de protection

Art. 3 CDH; Art. 6 Strasbourg Conv.

Le juge doit rassembler toutes les informations nécessaires à une bonne compréhension de l'environnement familial de l'enfant

La décision du juge doit toujours viser la protection des intérêts du mineur

- Video Ceccarelli
- Video Long

Le droit de l'enfant à être consulté

L'opinion de l'enfant doit être connue par le juge et pris en compte dans la décision

Art. 12 CDE; Art. 3 Conv. Strasbourg

Garanties participatives pour l'enfant

BUT

Mesures de protection pour éviter la "victimisation secondaire'

Garanties de participation de l'enfant

carepath

Le droit à être informé`

Art. 31 Lanzarote; Art. 3 Strasbourg Conv.; Art. 3-4 Directive 29

Seul un enfant ayant des connaissances suffisantes peut participer avec profit au processus de décision

A quel propos?

- signification de la procédure
- faits en cause
- droits et protections
- le rôle de l'enfant
- les conséquences possibles de ses opinions

Qui?

- autorité judiciaire
- avocat
- représentant
- expert

Comment?

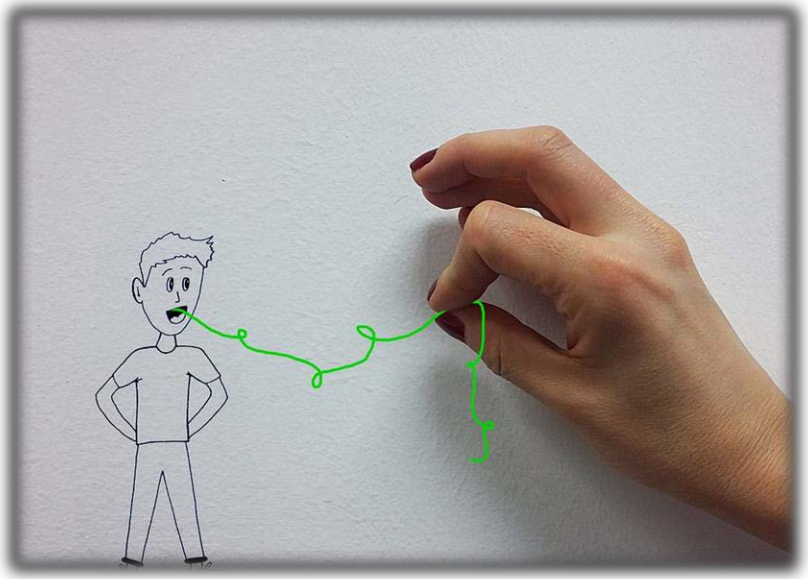
utilisation d'un langage et de concepts adaptés à l'âge et à la compréhension de l'enfant

2. Droit d'être entendu sur les faits en cause

Le mineur peut être invité à témoigner sur les faits pertinents pour la décision

Procédures pénales

L'enfant comme témoin de la violence et des abus subis, afin d'établir la culpabilité de l'accusé



Procédures civiles

L'enfant comme témoin de la violence et des abus subis, afin d'évaluer le caractère adéquat de la famille

Risque élevé de victimisation secondaire

- Video Ceccarelli
- Video Cibinel
- Video Long

3. Droit d'être consulté avant la décision du juge

Avant la décision, l'enfant a le droit d'exprimer son avis sur les questions abordées dans la procédure

Art. 12 CDE; Art. 3 Strasbourg Conv.

Procédures pénales

- début de la procédure
- mesures de précaution
- probation et autres procédures spéciales
- évaluation des preuves

Procédures civiles

- le retrait de la famille
- l'éloignement d'un des parents
- la garde des enfants
- adoption

Souvent, l'opinion est remplacée par la garantie plus forte du consentement

Procédures extrajudiciaires

Consentement à une tentative de médiation ou de conciliation

Le poids de l'opinion dépend du niveau de compréhension de l'enfant

Outils de protection dans le cadre de la procédure

Soutien par une personne
Art. 12 CDE; Art. 31 Lanzarote; Art. 9-10 Strasbourg Conv.; Art. 24 Directive 29

Représentant (si les parents ne sont pas disponibles, ou en cas de conflit d'intérêts)

Il identifie et protège les intérêts de l'enfant

Avocat

Il adopte la stratégie juridique la plus appropriée pour obtenir une décision conforme à l'intérêt de l'enfant

Les professionnels du secteur social ou de la santé
(psychologues, psychiatres, travailleurs sociaux)

- la protection contre la victimisation secondaire
- le soutien au juge, aux parents et aux avocats, pour comprendre les besoins et la fragilité de l'enfant

- Aide pour surmonter le traumatisme dû à la violence vécue

Ces personnes peuvent être désignées par le juge

2. Droit à la vie privée

Art. 16 CDE; Art. 8 CEDH; Art. 21 Directive 29

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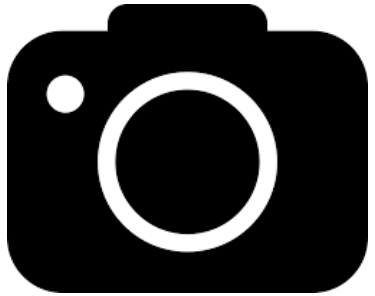
Audience à huis clos, sans présence du public

Limites à la diffusion d'images et d'informations



Limites aux questions sur la vie privée pouvant être adressées à l'enfant pendant l'audition

3. Durée raisonnable des procédures

La victimisation secondaire est également liée à la durée de la procédure *Art. 7 Strasbourg Conv.*

conflit entre différentes valeurs

La décision doit être prise le plus vite possible pour éviter de prolonger le stress

les autres intérêts du mineur et des autres personnes impliquées dans la décision ne peuvent être complètement sacrifiés

Equilibre nécessaire

4. Mesures de Protection au cours de l'audition (partie I)

Lorsque l'enfant témoigne de la maltraitance, de ses relations avec l'auteur du crime, de sa famille *Art. 31 Lanzarote; Art. 18 Directive 29; CEDH, 2.7.2002, S.N. c. Sweden*

⇩

Mesures visant à éviter le risque de victimisation secondaire

Lieu de l'audition

l'audition peut avoir lieu en dehors de la salle d'audience

⇩

Maison du mineur, bureau du juge, cabinet de l'avocat, pièce spéciale

Qui pose les questions?

les questions peuvent ne pas être posées directement par les avocats des parties, mais par le juge, ou par un expert

⇩

Les avocats peuvent être agressifs, ou plus simplement ne pas avoir l'expérience requise pour examiner des mineurs

4. Mesures de protection au cours de l'audition (partie II)

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Il est nécessaire de procéder le plus vite possible à l'audition et d'éviter les répétitions

L'attente de l'audition et les répétitions augmentent le stress

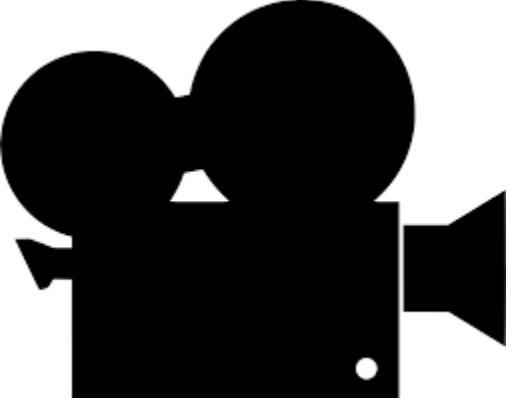
L'audition de l'enfant doit avoir lieu au début de la procédure, puis elle ne doit plus être répétée

Aucun contact avec l'accusé, les parents en conflit d'intérêts et leurs avocats

Le contact visuel peut stresser et intimider l'enfant

- système d'interphone avec verre réfléchissant
- vidéoconférence
- les questions préparées par les avocats mais adressées par le juge ou par un expert dans une salle spéciale

nécessité de trouver un équilibre entre les intérêts de l'enfant et les droits de la défense



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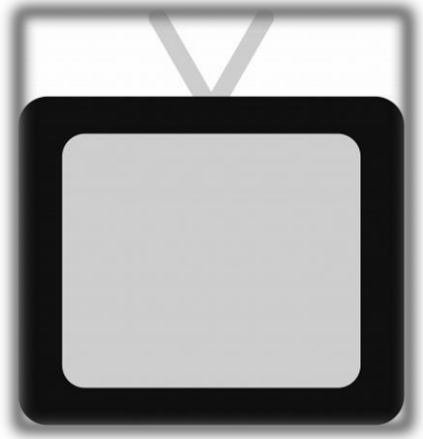
Videos de l'audition d'un enfant



Exemple d'une salle spéciale en Italie

Préparation de l'enfant avant son témoignage

(video 1 et video 2)

le témoignage d'un enfant à propos de l'assassinat de sa soeur

5. Mesures de protection pour permettre l'expression de l'opinion et du consentement de l'enfant

Art. 6 Strasbourg Conv.

La libre expression des opinions ou du consentement peut être affectée par la présence d'autres personnes telles que les parents, les accusés et les avocats

Le juge peut entendre ce que l'enfant veut dire en dehors de la salle d'audience, ou éviter la présence de ces personnes

- Video Ceccarelli
- Video Long

- Video Baldelli
- Video Cibinel

6. Protection du bien-être

Art. 20-21 CDE; Art. 31 Lanzarote; Art. 18 Directive 29

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Avant que la décision finale ne soit prise, des mesures conservatoires provisoires peuvent être adoptées afin de protéger l'enfant

Mesures à l'encontre de l'auteur

- la détention préventive/l'assignation à résidence
- restrictions à l'encontre des parents
- retrait du domicile familial
- interdiction d'approcher l'enfant

Mesures pour le mineur

- la garde provisoire dans une autre famille
- l'éloignement du domicile familial

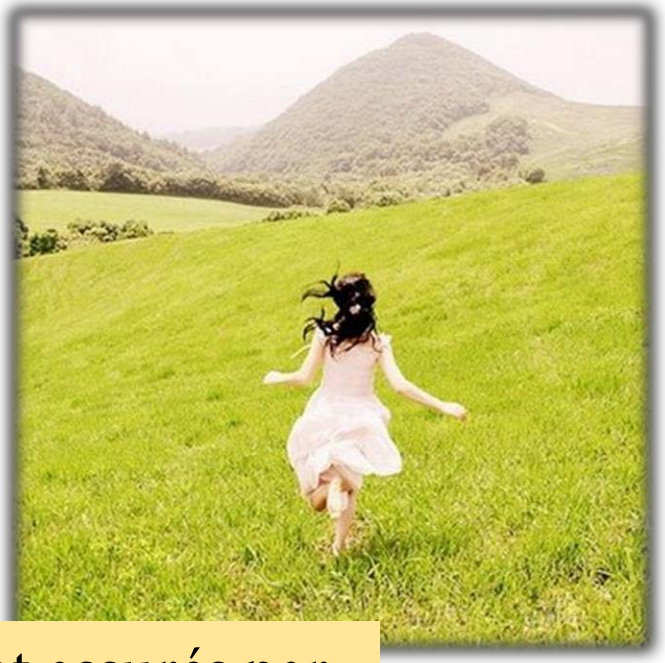
7. Assistance en dehors des procédures

Art. 39 CDE; Art. 31 Lanzarote; Art. 8-9 Directive 29

Video Cibinel

Soutien psychologique et émotionnel en dehors de la procédure

Il faut combattre la victimisation secondaire également avant et après l'audition



La punition des coupables et le rétablissement de la sérénité familiale ne suffisent pas

il est nécessaire d'aider l'enfant à surmonter le traumatisme résultant des abus subis (victimisation primaire)

Ces besoins sont souvent assurés par les services sociaux

Résumé du rôle des professionnels du secteur social ou de la santé

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Au cours des procédures

- Évaluation individuelle des besoins de protection spécifiques
- assistance pendant la participation de l'enfant aux activités procédurales
- évaluation de la fiabilité de l'enfant
- participation aux tentatives de conciliation
- évaluation du niveau de compréhension
- évaluation des conditions familiales

objectif principal → prévenir la victimisation secondaire et fournir au juge des connaissances utiles pour sa décision

en dehors des procédures

- soutien psychologique et émotionnel pour l'enfant
- vérification des conditions de la nouvelle famille

objectif principal → surmonter le traumatisme causé par la violence et les abus subis et restaurer la sérénité familiale

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Autres matériels didactiques utiles

Lignes directrices sur une justice adaptée aux enfants (Conseil de l'Europe)

Handbook for professionals and policymakers on justice in matters involving child victims and witnesses of crime (Nations Unies)

Guidelines on children in contact with the justice system (Association internationale des Magistrats de la jeunesse et de la famille)

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Empowering public authorities and professionals towards trauma-informed leaving care support

L'impact d'une approche fondée sur les droits de l'enfant sur les politiques sociales et les politiques de santé

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

04

Unité

ssage

Comprendre les effets qu'a sur le fonctionnement des politiques sociales et des politiques de la santé une approche centrée sur les droits fondamentaux des enfants et, en particulier, sur leurs droits à la participation.

Cadres juridiques vs politiques

carepath

Les **politiques** sont un élément essentiel dans la lutte contre la violence à l'égard des enfants : la présence d'une législation adéquate interdisant cette violence n'est PAS suffisante !

"Trop souvent, nous constatons que la législation existe, mais que de nombreux enfants restent en marge de la société (...), d'autant plus vulnérables à la violence et aux maltraitances
(Rima Salah, Directrice exécutive adjointe, UNICEF. cit., dans "United Nations Secretary-General's Study on Violence against Children)"

Les politiques sociales, les politiques de la santé et les droits à la participation

carepath

Les enfants contribuent aux politiques :

- ✓ en participant activement au processus de prise de décisions dans **leur cas particulier** (p. ex. au moyen d'entrevues ou de lettres adressées au travailleur social ou au juge en charge de leur cas, par leur participation directe aux réunions lors desquelles des décisions sont prises au sujet de leur cas, par la présence d'un représentant spécial),

- ✓ en participant, en qualité de groupe, à la définition des priorités et des actions de lutte contre la violence à l'égard des enfants (p. ex. Par la création de conseils consultatifs

pour les enfants, la participation des jeunes à la formation des professionnels de l'enfance, la participation des enfants aux études et recherches sur le fonctionnement des services d'accueil des enfants)

Au sein de la famille

« Une famille où les enfants peuvent librement exprimer leurs opinions et être pris au sérieux dès le plus jeune âge.... **joue un rôle préventif contre toutes les formes de violence à la maison et dans la famille** »

Programmes d'éducation des parents portant sur :
- la relation de respect mutuel entre parents et enfants ;
- la participation des enfants à la prise de décisions ;

- les moyens de régler les divergences de vues au sein de la famille

Source: Observation générale No. 12 (2009) *Le droit de l'enfant d'être entendu*

EXEMPLE N° 1

Au niveau mondial et européen, il existe de multiples initiatives de sensibilisation, dont plusieurs visent spécifiquement les parents, pour affirmer l'illégitimité de tout châtiment corporel infligé aux enfants.

Dans la protection de remplacement

« Il convient de mettre en place des mécanismes pour veiller à ce que les enfants bénéficiant d'une protection de remplacement quelle qu'elle soit, notamment en institution, soient en mesure d'exprimer leurs opinions, celles-ci étant dûment prises en considération, en ce qui concerne leur placement, la réglementation relative aux conditions d'accueil dans les familles d'accueil ou les foyers et leur vie quotidienne" (Observation générale No. 12 (2009) *Le droit de l'enfant d'être entendu*)

Par exemple, ils doivent être entendus pour toute décision concernant :

- le choix du moment et de l'endroit de leur placement en protection de remplacement ;
- les membres de la famille avec lesquels maintenir le contact pendant la protection de remplacement, la fréquence et les méthodes de ces contacts ;
- leurs projets d'avenir ;
- des examens périodiques de leur situation ;

(Voir SOS, Children's Villages International/ISS, Les lignes directrices relatives à la protection de remplacement pour les enfants : un cadre pour les NU, Genève, 2009)

Exemples de mécanismes généraux :

- une **institution de contrôle** (comme un *médiateur* des enfants), avec un libre accès aux établissements de séjour, pour pouvoir entendre directement les opinions et les préoccupations de l'enfant ;
- un **conseil représentatif** des enfants en établissement de séjour, chargé de participer à l'élaboration et à la mise en oeuvre de la politique et des règles de l'institution ;
- une **formation spécifique des professionnels**, associant des enfants comme formateurs.

Source: *Observation générale No. 12 (2009) Le droit de l'enfant d'être entendu*

Exemple No. 2

Dans plusieurs pays européens, des **réseaux informels de personnes quittant ou ayant quitté les structures de prise en charge** placées en institutions ou dans des familles d'accueil encouragent la participation et une citoyenneté active :

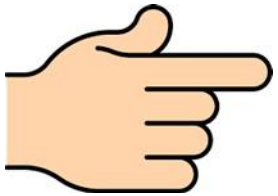
- en suscitant des instants de rencontre, de discussion et d'enrichissement mutuel entre les participants,
- en contribuant à l'amélioration des politiques sociales relatives à la protection de remplacement et au soutien nécessaire des jeunes quittant les structures de prise en charge de l'Etat.

Un réseau "European Care Leavers" est en cours de création.

Source: *http://www.agevolando.org/leavecare-livelife/*

Ce dont les enfants bénéficiant d'une protection de remplacement se soucient le plus est **leur avenir une fois l'âge adulte atteint**, lorsque cesse l'obligation spécifique de l'État de prendre soin d'eux.

Visionnez une action concrète du Réseau italien des enfants quittant les structures de prise en charge pour sensibiliser aux difficultés de l'autonomie une fois la majorité atteinte "18 anni e (non) sentirli"



Visionnez l'action concrète d'un médiateur irlandais "Young person in residential care makes complaint to Ombudsman for Children"

Soins de santé

Les enfants devraient toujours être associés aux discussions et décisions relatives à leur santé

(Unicef- Save The Children, *Every child's right to be heard* , 2009)

Ils ont le « droit d'être **informés** d'une manière adaptée à leur âge et à la capacité de compréhension » (art. 4 EACH –

European Association for Children in Hospital

=

Charter)

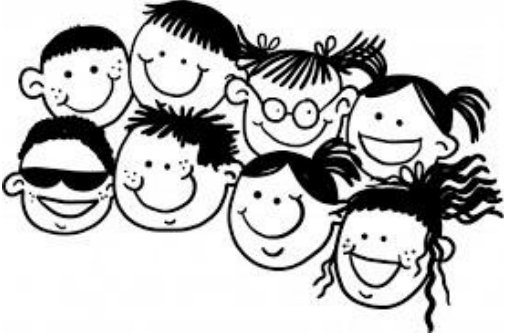
carepath

"Lorsque, selon la loi, un mineur n'a pas la capacité de consentir à une intervention, celle-ci ne peut être effectuée sans l'**autorisation de son représentant**, d'une autorité ou d'une personne ou instance désignée par la loi.
L'**avis du mineur** est pris en considération comme un facteur de plus en plus déterminant, en fonction de son âge et de son degré de maturité."

(art. 6 par. 2 La Convention pour la protection des Droits de l'Homme et de la dignité de l'être humain à l'égard des applications de la biologie et de la médecine)

Lorsqu'ils sont victimes de violence ou d'abus chez eux, les enfants peuvent avoir besoin d'accéder, « sans le consentement de leurs parents, à **des conseils et avis médicaux confidentiels**, sans considération de l'âge de l'enfant ».

Observation générale No. 12 (2009) Le droit de l'enfant d'être entendu



La participation de l'enfant aux décisions concernant sa santé non seulement favorise son bien-être personnel, mais améliore également les politiques de santé et les pratiques en matière de santé et de sécurité.

Parmi les mécanismes possibles :

- systèmes de retour pour tous les usagers des services
- processus de recherche et de consultation avec des enfants comme personnes interrogées et /ou comme chercheurs
- participation des conseils des enfants dans l'élaboration des normes et indicateurs destinés aux services de la santé, respectueux des droits des enfants
- participation des enfants dans les inspections et le suivi

[Unicef- Save The Children, *Every child's right to be heard* , 2009, p.98]

Dans les situations de violence

Les Etats son encouragés à :

- consulter les enfants, y compris les groupes d'enfants marginalisés et défavorisés, dans l'élaboration et la mise en œuvre de mesures législatives, politiques, éducatives et autres visant à combattre toutes les formes de violence. (*Observation générale No. 12 (2009) Le droit de l'enfant d'être entendu*)
  - Faciliter l'accès des personnes ou organisations auxquelles ils peuvent se confier en toute confidentialité et en toute sécurité (*Observation générale No. 12 (2009) Le droit de l'enfant d'être entendu*)
- mettre en place des autorités indépendantes pour garantir les droits de tous les mineurs et, plus particulièrement, des victimes de violence (Observation générale No. 13 (2011) Le droit de l'enfant d'être protégé contre toutes les formes de violence)

EXEMPLE NO. 3

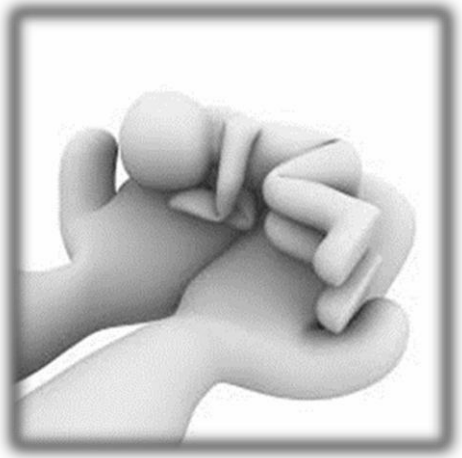
La vidéo du Conseil de l'Europe « Parle à quelqu'un de confiance » traite des abus sexuels en utilisant un langage et des méthodes adaptés aux enfants, **les encourageant à signaler les violences qu'ils ont subies.**

EXEMPLE N° 4

L'Italianaire est une bande dessinée vidéo réalisée avec la participation de cinq jeunes adultes vivant en Italie et originaires d'Égypte, rendue possible grâce à Save the Children, dont l'objectif est d'informer et de sensibiliser les enfants égyptiens vivant dans des zones à fort taux d'émigration enfantine sur les **conditions de vie réelles** en Italie pour les enfants migrants égyptiens.

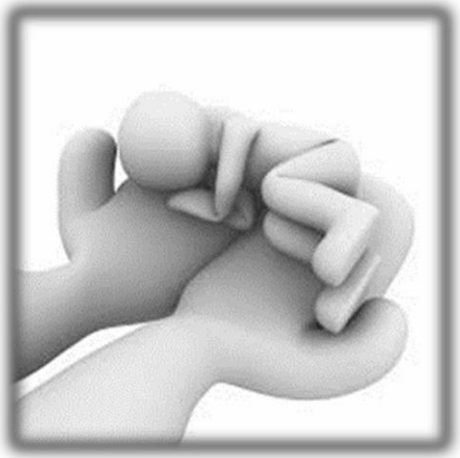
EXEMPLE N° 5

La vidéo du Conseil de l'Europe "Halte au Harcèlement" montre les effets du harcèlement en utilisant des contenus et un langage adaptés aux enfants. Elle encourage les enfants à jouer un rôle moteur dans la lutte contre le harcèlement.



"Le droit des enfants et des jeunes à être entendus peut également jouer un rôle préventif contre toutes les formes de violence à la maison, au sein de la famille, dans les écoles et les institutions."

(European Network of Ombudspersons for Children (ENOC), *Prise de position sur la Violence à l'encontre des enfants*, 2015)



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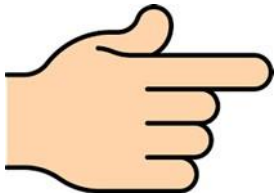
Les adultes devraient garantir la participation des enfants aux processus décisionnels et prendre toutes les précautions voulues pour réduire au minimum le risque pour un enfant d'être, du fait de sa participation, exposé à la violence, à l'exploitation ou à toute autre conséquence négative.

(Observation générale, N°12 (2009) *Le droit de l'enfant d'être entendu*)

Conclusions

Une **approche intégrée** s'impose et devrait prévoir :

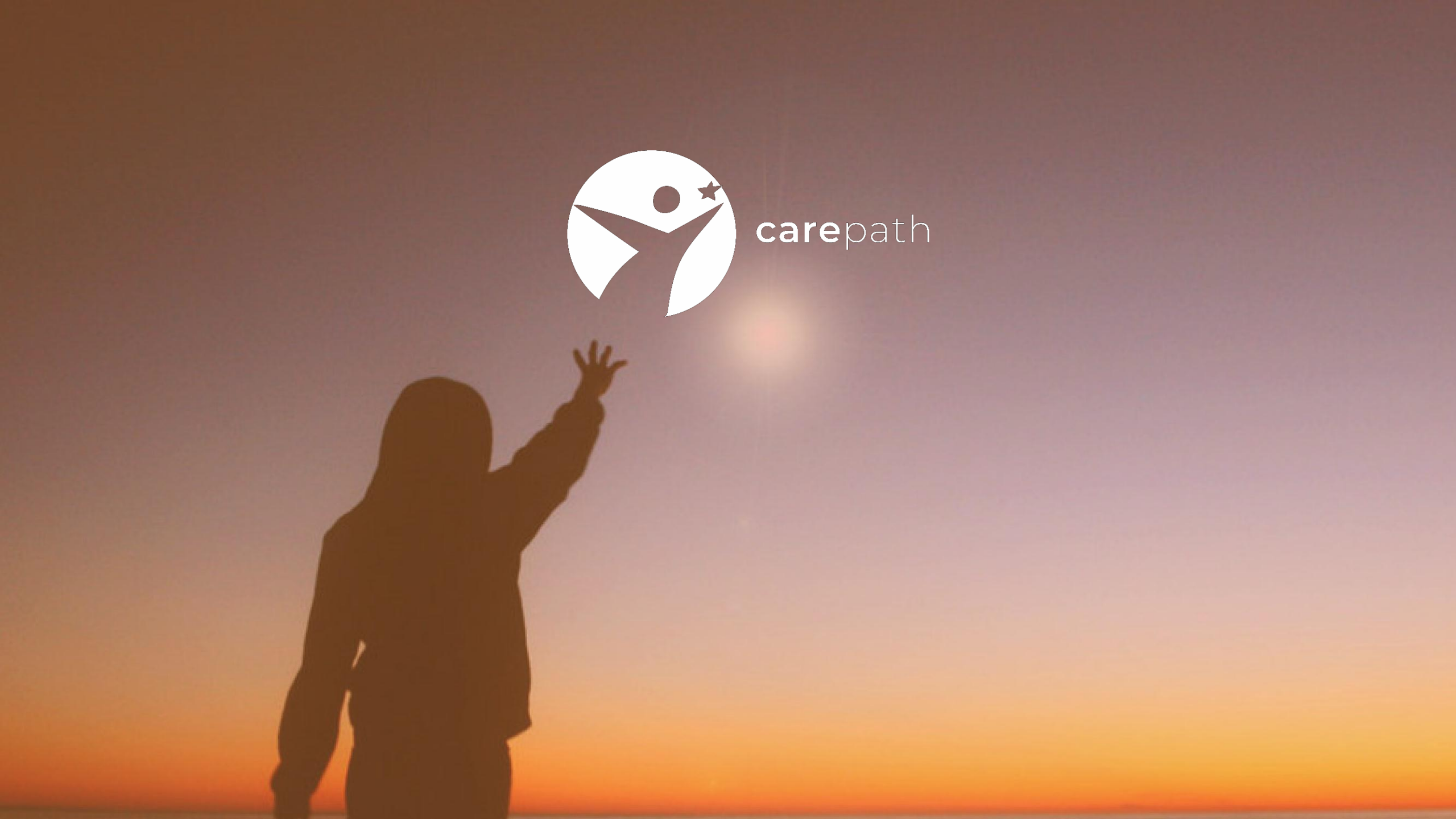
✓ non seulement de combattre, mais également de **prévenir** toute violence à l'encontre des enfants ;
✓ de promouvoir une **culture de respect** des droits de l'enfant ;
✓ d'organiser une **formation spécifique,** destinée aux professionnels travaillant en contact avec les enfants, aux concepts de protection et droits de participation ;
✓ de créer et de gérer des services pour l'enfance adaptés aux besoins des enfants ;
✓ de mettre en place des **services d'aide et d'assistance téléphonique** facilement accessibles aux enfants victimes de violence.



Source: Conseil de l'Europe, *Policy Guidelines on Integrated National Strategies for the Protection of Children from Violence*, 2009. Voir également European Network of Ombudspersons for Children (ENOC), Prise de *position 'Violence against Children"*, 2015.

"Les enfants ont des connaissances uniques sur leurs vies, leurs besoins et leurs préoccupations, ainsi que des idées et des points de vue issus de leur expérience directe....
Des décisions pleinement éclairées par les besoins des enfants seront plus pertinentes, plus efficaces et plus durables"

Source: The Save the Children Found, *Every Child's Right To Be Heard, a resource guide on the UN Committee on the Rights of the Child general comment no.12*, London, 2011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ENOC
European Network of Ombudspersons for Children

European Network of Ombudspersons for Children (ENOC)

Position Statement on 'Violence against Children"

Adopted at the 19th ENOC General Assembly, 24 September 2015, The Hague

"No violence against children is justifiable;
all violence against children is preventable" [1]

We, members of the European Network of Ombudspersons for Children (ENOC), call upon our governments, the European Commission and the Council of Europe to take a stand against violence towards children and to undertake all appropriate action.

ENOC adopts the following definition of violence: "Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power."[2]

Having considered the international binding and non-binding legal instruments, and in particular:

- The UN Convention on the Rights of the Child (1989)
- The Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography (2002)
- General Comment no. 8 of the UN Committee on the Rights of the Child (2006)
- The UN Study on Violence against Children (2006)
- The Council of Europe Guidelines on integrated national strategies for the protection of children from violence (2009)
- The Lanzarote Convention (2010)
- The Council of Europe Guidelines on Child-friendly Justice (2010)
- General Comment no. 13 of the UN Committee on the Rights of the Child (2011)
- The European Union Agenda on the Rights of the Child (2011)

Following and in line with ENOC Statements titled "Violence in a children's rights context" (2005) and "Implementation of the UN Study on Violence against Children recommendations" (2007),

Recognizing the important international momentum around tackling violence against children, especially the imminent adoption by the UN General Assembly of the Sustainable Development Goals and the forthcoming 10th anniversary of the Secretary-General's Study on Violence against Children,

Having consulted with the children and young persons who participated in activities of the European Network of Young Advisors (ENYA) run by ENOC, who expressed the following views:

1. Pinheiro, Paulo Sergio. Rights of the child. Report of the independent expert for the United Nations study on violence against children. 2006.
2. World Health Organization. Child maltreatment ("child abuse"). 2014. Retrieved 18 August 2015 from http://www.who.int/violence_injury_prevention/violence/child/en/

ENOC Secretariat
Council of Europe "Agora" building
Office B5.07.V
67075 Strasbourg Cedex
Tel +33 3 90 21 54 88
e-mail secretariat@ombudsnet.org

> Actions to tackle violence against children should consider the hazards of child poverty often generated by our consumer-based economy. Violence is also produced by state policies or institutions and the result of so-called differences between people: race, religion, disability or gender that they seem to believe our governments fail to address properly. Mass media operate and often contribute to the acceptance and reinforcement of violence against children, by presenting children too often as a threat for our society. Parents and all professionals working with children should be trained how to listen to children, to understand them and take action in order to protect them and avoid further violations of their rights.

ENOC expresses the opinion that, despite all relevant measures adopted by European institutions and states during recent years, violence against children remains one of the greatest direct violation of children's rights in Europe, with an enormous scope and far reaching consequences for its victims. The UN Convention on the Rights of the Child (CRC) states very clearly that every child has the right to grow up without violence and to be protected from it (article 19). Yet a childhood without violence is not the reality for millions of children in Europe[3].

Violence against children can be identified in many aspects of social life. In high income countries, up to 80% of violence against children takes place at home, perpetrated by caregivers[4]. It also may take place in schools, in institutions, in the streets and in the (social) media. Violence is perpetuated both by adults and by peers. Extreme poverty, poor living conditions, social exclusion and racism have been shown to contribute to violence in the home, if families are not properly supported.

ENOC believes all violence against children should be eliminated. No degree of violence against children can be excused; child maltreatment is utterly unacceptable. All our governments have ratified the Convention on the Rights of the Child, and together with all the other binding and non-binding international documents, there is sufficient legal basis for all European countries to take measures to tackle all violence against children. The problem lies in the implementation of the measures we have already agreed upon.

ENOC greatly respects the endeavours of the Council of Europe, United Nations, European Parliament and European Commission. Their efforts have resulted in increased awareness of the issue of violence against children. We are also thankful for all measures introduced by the European Commission to tackle public health issues in a number of policy areas. We are impressed by the results of stringent measures that various European governments have taken to reduce child maltreatment in their countries. Now it is time to ensure that measures that are known to tackle violence against children are rigorously implemented, all over Europe.

Major issues and recommendations

Research has demonstrated that thorough implementation of the following recommended measures to combat five major issues will likely result in a decrease of the number of child victims of no less than 25% within a period of ten years[5]. This is an important milestone on the road towards

3. Sethi, D. et al. (Eds.). European report on preventing child maltreatment. Copenhagen, WHO Regional Office for Europe, 2013.
4. Gilbert, R. et al. Burden and consequences of child maltreatment in high income countries. 2009. Lancet, 373.
5. De Kinderombudsman & Augeo Foundation. Report on violence against children in Europe. The Hague, 2015.

ENOC Secretariat
Council of Europe "Agora" building
Office B5.07.V
67075 Strasbourg Cedex
Tel +33 3 90 21 54 88
e-mail secretariat@ombudsnet.org

absolute eradication. We therefore strongly urge all governments from European countries, as well as the European Commission and European Parliament, to readily implement these measures.

1. Full ban on corporal punishment

The UN Committee on the Rights of the Child stressed in General Comment no. 8 that no form of corporal punishment can be anything other than degrading. However, in Europe many children still grow up in settings where violent upbringing is the norm and where violence is an accepted way of disciplining of and communicating with children. Almost one third of all EU countries do not have a full ban on corporal punishment. A further third of the countries have a ban, but it is not fully implemented, rendering it ineffective. Research evidence demonstrates that it is possible to reduce the share of parents using corporal punishment to less than 5% within a decade when a full ban is implemented and accompanied by thorough public campaigns.

Recommendation No. 1

Implement a full ban on corporal punishment without delay. The ban needs to cover all types of violent punishment, not only at home, but also in other settings, such as day care centres, schools, sports clubs, support services and institutions.

2. Identification and reporting

All states are (already) obliged to take measures to protect children from violence (article 19 CRC). According to the Committee, these measures should include an identification and reporting mechanism (General Comment no. 8). Nonetheless, most child maltreatment still goes undetected and unreported by professionals that are in contact with children or their parents. In many European countries, reliable data on the extent of violence against children is lacking. Furthermore, many countries lack child-friendly procedures and special places for children to disclose violence. Upon disclosing their experiences, children are often not believed. Children with disabilities, those belonging to minority groups and children on the move are often faced with additional obstacles to report their maltreatment. This is a violation of children's right to be heard that often leads to their re-victimization. Data shows that the introduction of high quality identification and reporting procedures can lead to a threefold increase of the screening and reporting rates by education and medical professionals within five years[6].

Recommendation No. 2

Regularly conduct research and collect data on the occurrence of all forms of violence against children, including corporal punishment, in all European countries.

Recommendation No. 3

Provide all professionals whom children and their caregivers regularly come into contact with, such as their teachers and medical professionals, with high quality identification and reporting procedures.

3. Mandatory training and education

Training professionals in the identification and reporting of child maltreatment is crucial to both increasing screening and reporting rates and to enable them to communicate with victims in a trauma sensitive approach. Most of the literature on child maltreatment refers to the need for better training of professionals. Educating children about violence, promoting the principle of equality and encouraging children to think critically about different types of violence in a safe environment have also proven to reduce the occurrence of child maltreatment.

6. De Kinderombudsman & Augeo Foundation. Tackling violence against children in Europe. Ten recommendations and eight targets for the EU member states and the European Commission. The Hague, 2015.

ENOC Secretariat
Council of Europe "Agora" building
Office B5.07.V
67075 Strasbourg Cedex
Tel +33 3 90 21 54 88
e-mail secretariat@ombudsnet.org

Recommendation No. 4
Implement national legislation that mandates all professionals who come in contact with children to be trained and empowered to listen to them using a trauma sensitive approach, to identify abusive situations and act according to a country's reporting procedures.

Recommendation No. 5
Implement legislation that mandates schools, social services and child protection services to have age-appropriate education programmes in place that teach children about children's rights, violence and the prevention of violence and provide these institutions with the means to run such programmes.

4. Insufficient protection for known victims
For too many children, violence is a chronic condition as it is not stopped, even when reported and substantiated. Furthermore, in most European countries there is a lack of data on the protection of victims and the outcome of implemented protection measures on the safety and wellbeing of maltreated children. This is unacceptable.

Recommendation No. 6
Structurally collect data on the impact of the protection measures and services that are provided for the safety and wellbeing of the victims, to promote the prevention of recurrence of violence in the lives of maltreated children.

5. Re-victimization
For many children, even if they have the courage to break the silence, it is not the end of their traumatisation. Lack of coordination between professionals, insufficient levels of support services provided (for example by social workers and psychologists) as well as the prosecution process (among other things, multiple interviews by police, prosecutors and judges not specifically trained to interview children, delays in court proceedings, non-child friendly environments) cause continuous re-victimization of the child and prevent the healing process.

Recommendation no. 7
Put in place stable, well-co-ordinated networks of adequately trained professionals who can promptly begin the intervention process (support and treatment of victims and families) as well as the investigation process (prosecution/court proceeding) in a child-friendly manner.

6. Integrated child protection services
States have to fulfil their responsibilities outlined in article 39 of the CRC, stating that all children who are victims of violence have the right to receive adequate support in order to recover. Still, too many unassisted victims suffer from the psychological, social and emotional consequences resulting from the violence they experienced. Studies have also consistently shown that maltreated children have lower educational achievement than their peers. These impairments could have been prevented and can be dealt with, by integrated child protection services, where there is joint responsible for both the assessment and provision of care aimed at the victims.

Recommendation No. 8
Strengthen the child protection welfare system and guarantee systematic support of child victims of violence to recover in the most suitable environment, responding to their best interests, needs and fundamental rights. Extra attention is needed for vulnerable children, including minority, disabled children, LGBT children, children in armed conflict and children on the move (article 2, 20, 22, 23, 30, 37 and 40 CRC).

ENOC Secretariat
Council of Europe "Agora" building
Office B5.07.V
67075 Strasbourg Cedex
Tel +33 3 90 21 54 88
e-mail secretariat@ombudsnet.org

7. Right to be heard

Children's views must be sought and given due weight as a mandatory step at every point in a child protection system (article 12 CRC, GC no. 12 and 13). We feel this has particular relevance in situations of violence. Children and young people's right to be heard can also play a preventive role against all forms of violence in the home, family, schools and institutions. The ENYA young people stressed that they are not being heard and that there are barriers to participation, particularly for marginalized and/or discriminated groups, for example disabled children, minorities and children on the move.

Recommendation No. 9

Ensure that children's views are sought and given due weight as a mandatory step at every point in a child protection system. Professionals have to be trained in communicating with children.

8. Comprehensive national strategy

In order to fully benefit from the suggested measures, it is crucial to implement them as part of a comprehensive national strategy or agenda. Installing such a strategy is crucial to ensuring a coherent approach to preventing, monitoring and addressing violence against children.

Recommendation No. 10

Implement all recommended measures to combat violence against children, as part of a national commitment and strategy to combat violence against children.

ENOC calls upon national governments, the European Commission and the European Parliament to embrace these recommendations and do everything in their power to ensure thorough implementation. While national governments are the designated bodies to safeguard the wellbeing of children within their territories, the European Commission and European Parliament have an important role in supporting, facilitating and accelerating developments in EU countries. ENOC urges the European Parliament and the European Commission, in particular, to assume responsibility for more extensive data collection, research and training of professionals to narrow the knowledge gap. When these measures have been comprehensively executed, Europe will have made significant advances towards the undisputed mission to safeguard all children in Europe from violence.

ENOC Secretariat
Council of Europe "Agora" building
Office B5.07.V
67075 Strasbourg Cedex
Tel +33 3 90 21 54 88
e-mail secretariat@ombudsnet.org

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Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material
ANNEX 2
–
French Version

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

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The British
Psychological Society
Promoting excellence in psychology

Practice Guidelines

Third edition

August 2017

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Preface

This Third Edition of the Practice Guidelines replaces the second edition published in 2009. Legislation, practice and technology have moved on since then and these changes are captured in the new guidance.

This edition of the guidelines was produced through the British Psychological Society's Professional Practice Board by a working group drawn from the range of Member Networks across The Society whose members are engaged in professional practice, as well as representatives from relevant expert reference groups of The Society, in particular areas of practice. Further information is available in ***Appendix 3: How this document has been developed.***

These Practice Guidelines aim to define good practice for all psychologists whether registered, chartered or in training and offer guidance for decision making. The Guidelines have been designed for broad application across the full range of applied psychology.

The first part of the guidance (sections 1–3) set out considerations for psychologists on different contexts of practice. The second part of the guidance (sections 4–8) sets out guidance for psychologists on how to manage work with clients.

It is recognised that in addition psychologists may require more detailed guidance for some particular roles and responsibilities or for particular situations in which they work. Further information is available in the ***Appendices***.

The Society expects that the guidelines will be used to form a basis for consideration, with the principles being taken into account in the process of decision-making, together with the needs of others and the specific circumstances. No guidance can replace the need for psychologists to use their own professional judgement. Effective practice means exercising this professional judgement in a defensible way that does not put clients or the public at risk, or undermine, or call into question the reputation of the profession as a whole.

The Guidelines will be reviewed in accordance with Society policy within a maximum period of five years in order to reflect current legislation, evidence and practice contexts. Psychologists using the Practice Guidelines should do so in conjunction with the ***BPS Code of Ethics and Conduct*** and the ***BPS Code of Human Research Ethics***, as necessary.

Glossary of terms

Client

The Society's *Code of Ethics and Conduct* uses the term person or people throughout, this is in recognition of the fact that the document is generic and may be used by all psychologists; academics, researchers, students and practitioners alike.

Throughout this Practice Guidelines document the term 'client' is used and refers to any person or persons with whom a psychologist interacts on a professional basis.

For example, the 'client' may be a couple, a family group, an educational institution, a community organisation or group or a private or public organisation including a court, an individual (sometimes referred to as, for example, athlete, child/young person, patient, prisoner, coachee, service user, stakeholder, leader, or student), who are in receipt of the services of the psychologist.

Psychologist

Throughout this Practice Guidelines document the term 'psychologist' is used and refers to all psychologists whether registered, chartered or in training who provide psychological services across the full range of applied psychology, in any context of practice.

1. How psychologists work

1.1 Legal and professional obligations of psychologists

Psychologists' professional practice is impacted upon and governed by a range of legislation and regulation. Particular psychological disciplines may also need to consider additional legislation, regulation and guidelines. It is the psychologist's responsibility to ensure they are aware of the legislation and guidelines that govern their particular area of practice as well as the terms of their employment or terms contracted with a commissioner of their services.

Psychologists are also advised to consider membership of a union or similar body to ensure they have access to appropriate representation, support and legal advice should they be subject to a complaint or disciplinary action, or require support for example with an employment grievance, which may be related to concerns over quality and standards of psychological service provision.

Further information is available in the ***Appendices***. Important examples to note are:

Health and Care Professions Council (HCPC) Registration

It is a statutory requirement for all psychologists wishing to practice using one of the titles protected by the HCPC to register with the HCPC. Unregistered psychologists offering services to the public in any of the domains regulated by the HCPC may commit an offence by doing so, even if they refrain from using protected titles, provided intent to deceive can be proved. The Society's position is that it is in the interests of both the public and the profession for all psychologists providing services in a regulated domain to be registered with the HCPC.

Professional competence

Psychologists should value the continuing development and maintenance of high standards of competence in their practice and the importance of working within the recognised limits of their knowledge, skill, training, education, and experience. Psychologists should consider advances in the evidence base, the need to maintain technical and practical skills and knowledge and the limits of their competence. This is stipulated in both the ***BPS Code of Ethics and Conduct*** and the ***HCPC Standards of Proficiency***.

Professional indemnity insurance

The UK Government has introduced legislation (The Health Care and Associated Professions (Indemnity Arrangements) Order 2014) which now makes it mandatory for health professionals to have a professional indemnity arrangement in place. The HCPC has made having such an arrangement in place a condition of registration.

This may be achieved either through the employer or through a privately arranged policy. An employer's insurance may provide cover only for a negligence claim but not for the costs of a disciplinary hearing. It is the psychologist's responsibility to check carefully that

they have cover in place that meets their personal/professional needs. Further information is available in the ***Society document: Career Support and Development***

Disclosure and Barring Service (DBS) Checks

Psychologists working in certain fields, for example with children or in healthcare, will need to demonstrate they have had a satisfactory criminal records check at the appropriate level for the nature of the work undertaken.

Applicants will be provided with a certificate to demonstrate this. Applicants cannot request a check personally, this can be requested by a psychologist's employer. For psychologists practising independently the Society offers this as a service to members. Further information is available on the ***Society Website: https://beta.bps.org.uk/Practice-Guidelines***

Equality Act 2010

This Act protects people against unfair treatment, promotes equality and prevents discrimination against any of nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. Respect is a core ethical value for psychologists and a commitment to equality of opportunity is embedded in all aspects of psychological practice. Psychologists, where they operate in an organisational context, must also seek to encourage and influence others in ensuring that equality of opportunity is embedded in all thinking and all practice relating to access to services for client groups and recruitment and employment practices.

Providers of service to the public must also make reasonable adjustments for people who have a disability under the Act. This requirement is anticipatory so requires consideration, and adjustment where reasonable, of any barriers which may prevent a person with a disability from using a service.

Data Protection Act 1998

The Data Protection Act defines personal and sensitive personal data, and data must be processed in accordance with eight principles. It gives individuals the right to know what information is held about them and provides a framework to ensure that personal information is handled properly.

Good information governance is at the heart of safe practice. It encompasses physical data security, access controls and acceptable use, data quality, and records management, among other things. Psychologists must have appropriate security to prevent any personal data held from being accidentally or deliberately compromised. In most circumstances, independent practitioners will also need to register as a data controller with the Information Commissioner's Office.

Further information is available in ***Section 7.1: Information governance, Appendix 1: Relevant legislation*** and ***Society Document: Data Protection Act 1998 – Guidelines for Psychologists.***

Freedom of Information Act 2000

The Freedom of Information Act 2000 provides public access to information held by public authorities. Public authorities include government departments, local authorities, the NHS, State schools and police forces.

It does this in two ways:

- public authorities are obliged to publish certain information about their activities; and
- members of the public are entitled to request information from public authorities.

The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland, and by UK-wide public authorities based in Scotland. Information held by Scottish public authorities is covered by Scotland's own Freedom of Information (Scotland) Act 2002.

This legislation permits information to be withheld from disclosure in certain prescribed circumstances, for example information provided in confidence, related to law enforcement or where it relates to personal matters.

Health and Safety at Work Act 1974

This Act places a duty on all employers 'to ensure, so far as is reasonably practicable, the health, safety and welfare at work' (Part 1, Section 2.1) of all their employees. Employees themselves also have obligations under the legislation.

Working together to safeguard children guidance

The Government website provides statutory guidance on inter-agency working to safeguard and promote the welfare of children. Statutory guidance is issued by law; it must be followed unless there is a good reason not to. All organisations, including charities, are expected to comply with this government inter-agency statutory guidance. Psychologists have a duty of care to both their clients and the public. Any allegations of abuse, either ongoing or historic, must be taken seriously and consideration must be given about breaking confidentiality especially in cases where other vulnerable people may be at risk. Further information is available in ***Section 4: Safeguarding***.

Mental Capacity Act 2005

The Mental Capacity Act (2005) provides a clear and comprehensive framework with regard to capacity and consent for all individuals aged 16 years and above in England and Wales.

There are five key principles set out in the Act which underpin practice (quoted from legislative source):

(i) A person must be assumed to have capacity unless it is established that he lacks capacity.

(ii) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(iii) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(iv) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
(v) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

In Scotland the Adults with Incapacity (Scotland) Act 2000 applies and in Northern Ireland the Mental Capacity Act (Northern Ireland) 2016 is used.

Mental Health Act 1983 as amended 2007

The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

The Act sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients. The Code of Practice[1] provides statutory guidance for mental health professionals on how they should carry out their responsibilities in practice under the MHA. Although the Act allows for people to be compulsorily detained and treated without their consent if required, empowerment and involvement of patients as far as is possible is required by the Code of Practice.

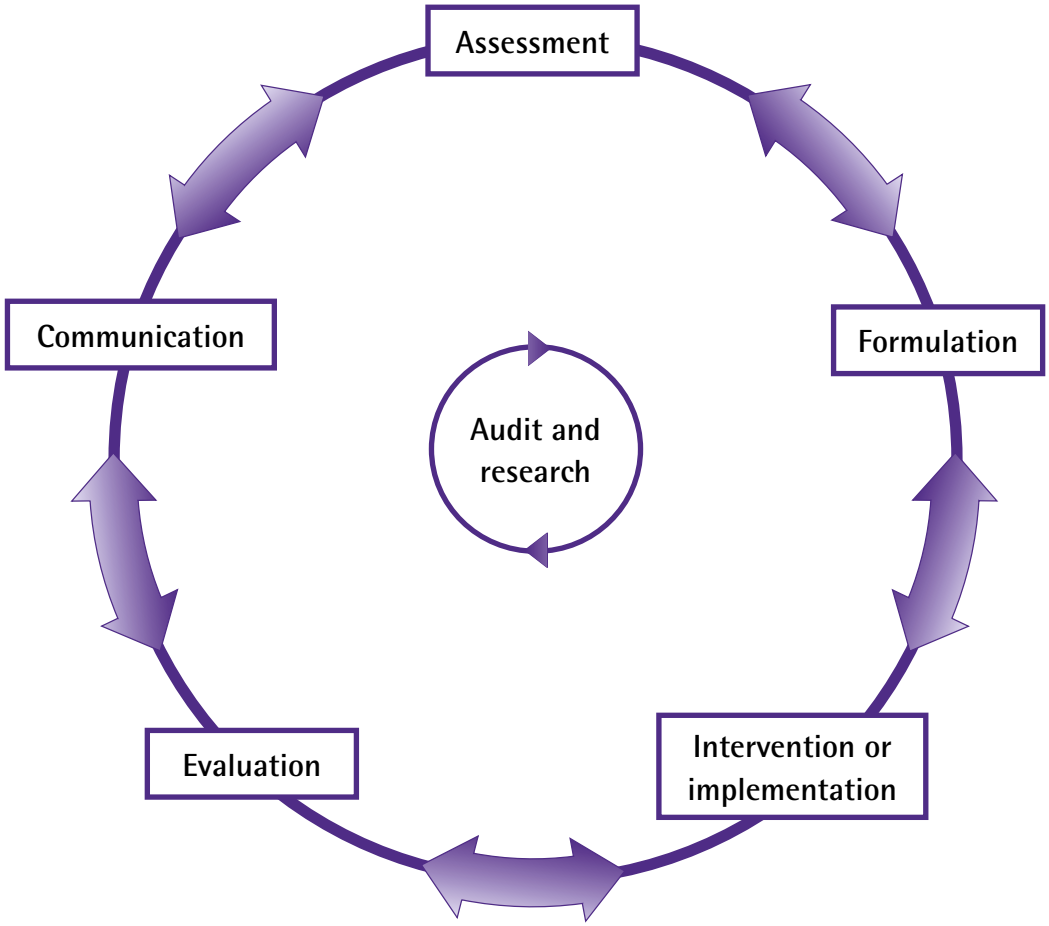
Those involved in working with people subject to provisions of the MHA, including psychologists, must understand and give consideration to the five key principles set out in the Code:
(i) least restrictive option and maximising independence;
(ii) empowerment and involvement;
(iii) respect and dignity;
(iv) purpose and effectiveness; and
(v) efficiency and equity.

1.2 Cycle of professional practice

The professional practice of psychologists is underpinned by four key ethical values – Respect, Competence, Responsibility and Integrity – and five core skills:

- **assessment** and establishment of agreements with the client;
- **formulation** of client needs and problems;
- **intervention or implementation** of solutions;
- **evaluation** of outcomes; and
- **communication** through reporting and reflecting on outcomes.

These core competencies flow and inform each other as illustrated below.



Assessment and establishment of agreements with the client

Assessment of psychological processes and behaviour is derived from the theory and practice of both academic and applied psychology. It includes both assessing change and stability, and comparison with others. Assessment procedures used will depend heavily on the practice context and may include:

- the development and use of psychometric tests following best practice;
- the application of systematic observation and measurement of behaviour in a range of contexts and settings;
- devising structured assessment strategies for individual clients, teams and organisations; and
- the use of a range of interview processes with clients, carers, other stakeholders and other professionals.

Results of these assessments are integrated within the context of the historical, dynamic and developmental processes that will have shaped the client as well as future aspirations or needs. Psychologists have the ability to assess the suitability of different measurement procedures, depending on the purpose for which the assessment is needed, as well as being competent to devise and use context-specific procedures.

Formulation of client needs and problems

Formulation is the summation and integration of the knowledge that is acquired by the assessment process. This will draw on psychological theory and research to provide a framework for describing a client's needs. Because of their particular training in the relationship of theory to practice, psychologists will be able to draw on a number of models to meet needs or support decision-making. This process provides the foundation from which actions derive. What makes this activity unique to psychologists is the knowledge base, experience and information on which they draw. The ability to access, review, critically evaluate, analyse and synthesise data and knowledge from a psychological perspective is one that is distinct to psychologists, both academic and applied.

Intervention or implementation of solutions

This will be the stage where the client's needs, as described by formulation, begin to be met. This may involve the use of psychological models or approaches to, for example, facilitate change, solve a problem or improve the quality of a relationship. All these interventions, or implementation of solutions, are tests of the provisional hypotheses contained in the formulation, and are subject to repeated modification in the light of experience and new data.

Evaluation of and reflecting on outcomes

Evaluation is used to measure the effectiveness of activities and interventions both during and after their implementation. The results of any evaluation and reflection will impact the next steps taken by a psychologist.

Although employers and others may demand certainty about outcomes, psychologists should always be careful to make it clear that they are able to provide only interpretations of behaviour, and advice and guidance, rather than necessarily predicting future behaviours.

Communication through reporting

Communication skills are integral to all aspects of a psychologist's role. Effective communication skills are essential in relation to all aspects of work with others. Communication skills include communication with clients, all forms of electronic and verbal communication, professional letters and reports, and the dissemination of research findings.

Audit and research

Audit and research underpin the cycle, as they help to inform all stages of professional practice.

Audit aims to evaluate how close assessment, formulation, intervention and implementation are against a set of previously given standards of practice. Audit also evaluates how protocols and procedures, for example related to consent or recording of activity, have been followed.

Research provides the evidence base for the practice of psychology. Research methods in psychology vary from qualitative observation to quantitative scientific method, so it is important to distinguish the nature and quality of the evidence underpinning any knowledge or techniques being applied. In general, basic research develops theories, models and data to describe and explain psychological processes and structures, while primary research develops and evaluates ways of using psychological knowledge to intervene with people, organisations, processes or technologies to achieve desired effects. Secondary research consolidates other research to identify higher order trends and directions.

1.3 Reflective practice

One of the key processes that should be encouraged for psychologists is having a complex understanding of self in the context of others. The HCPC requires reflection in the record of continued professional development in order to retain continued registration.

Psychologists will need to make decisions about clients which may have a profound impact on their lives. Decision-making is often subject to various competing biases. Psychologists should be aware of the possibility that they may be influenced by considerations which are not driven by professional knowledge, skills or experience. Maintaining awareness of these biases is important when trying to think through dilemmas.

Sources of influence and bias may include:

- **Cognitive Biases –** Over 150 have been described[2,3,4] including salience (how readily something comes to mind), confirmation bias (the human tendency to look for evidence that confirms their belief and to ignore other evidence), loss aversion (risky behaviour to avoid loss), beliefs about disclosure (tendency to be more honest when they believe their actions will be known by others), and dissonance reduction (justifying actions if consequences are considered worth it).
- **Personal Experience –** the experience of the psychologist may affect how they view or treat a client or situation. This may include current or historical trauma, or the kind of organisation and culture with which they are most familiar. Interventions which may be appropriate in one context may be ineffective and cause distress in another.
- **Motivation –** the original reasons for undertaking the profession may change or be challenged due to fatigue or experience within the profession which may affect the psychologist's viewpoint.
- **Health –** psychologists should be mindful of the potential effect of health conditions or medications which they may be taking, on their practice.
- **Control over the psychologist's own practice –** this refers to clarity and openness in the management of the psychologist's business and maintaining the professional's autonomy in their interactions with clients.
- **Pro bono public work –** psychologists are encouraged, and personally motivated to

engage with such work, while being mindful of impact on the value that is placed on the profession as a whole.

- **An unethical environment –** maintaining self-recognition of what the appropriate ethical standard should be, irrespective of the prevailing situation.
- **Environment –** political realities may lead the psychologist to make compromises; while there is nothing wrong with compromises, their constant use may mean a decline in overall standards.

The literature is generally pessimistic about the ability of practitioners to overcome some of these biases, considering them to be inherent in human thinking patterns. By being aware of and acknowledging them, it can be possible to manage their influence. For example, biases can be levelled out by presenting information in different ways, by engaging the perspectives of people with different experiences and expectations, or by priming thinking with different examples.

A key factor in developing and maintaining these skills is the use of consultation or supervision and having a space where it is possible to open up thinking to the mind of another with a view to extending knowledge about the self.

It is important that psychologists from all disciplines look after their own wellbeing. This is not only important for them as individuals, but also for the quality of the care they give their clients. In their practice and, for example, within their CPD plans and supervision psychologists should consider self-care and how they can maintain their own wellbeing.

It is also important for psychologists to evaluate effectiveness of practice, by welcoming feedback from clients. This can be difficult due to fears of criticism but reflective practitioners are eager to improve and welcome any feedback that will support this process.

1.4 Continuing professional development

Continuing professional development (CPD) is the professional and work-related aspect of lifelong learning. It is an integral part of the process of adapting to change, and essential for maintaining and enhancing professionalism and competence. The Society provides an online facility to record CPD, further information is available on the ***Society website: http://beta.bps.org.uk/Practice-Guidelines***.

- CPD is both a professional expectation and an individual responsibility to taking a structured and self-managed approach to further learning through:
  - actively engaging in a range of CPD
  - maintaining a record of CPD
  - applying learning from CPD to professional practice.
- There is a range of formal and informal learning activities that may be used for CPD and it is recommended that psychologists engage in a mix of CPD activities.
- Professional development is not purely about inputs (i.e. undertaking CPD activities); it also requires a reflective, outcomes-based approach which focuses on the learning gained from CPD and its application to current or future practice, together with the associated benefits for clients and the services provided.

- All members who are registered with the HCPC are required to comply with their CPD requirements as a condition of continued professional registration. Further information is available in ***Appendix 2: Websites and further information***

Mentoring

Psychologists may seek a mentoring relationship with colleagues in order to focus their attention on skills to add to their competencies. Psychologists taking on the role of mentor often support the psychologist with their career path. Early career psychologists may find it beneficial to be mentored by a more experienced psychologist.

1.5 Consultation/supervision

Consultation or supervision is considered an essential part of good practice as a psychologist. There is no legal requirement for supervision, although it is considered an ethical and professional expectation to engage in appropriate consultation in order to support effective practice. Provision of this is therefore an important underpinning to good quality service delivery. The Society's position is, for safe and effective practice in clinical and mental health settings, or with other vulnerable groups, supervision is a requirement of practice.

The objectives of consultation/supervision are:

- to provide practitioners with consultation on their work with clients;
- to enhance the quality and competence of practice offered to all clients;
- to offer psychologists intellectual challenge enabling reflection, transformational learning and psychological support to maximise their responsibility for appropriate self-care; and
- to contribute to the CPD of both psychologist and supervisor by developing competence in the use and practise of supervision.

All aspects of practice are appropriate for discussion in supervision, including research activity, administrative and managerial work, service developments, team working, teaching and the process of supervising others. Supervision is not personal therapy and nor is it a form of, or substitute for, line management or appropriate training.

For psychologists working in a wide range of settings such as therapeutic and organisational settings, supervision is a core component of the psychologist's CPD. For some areas of practice, the nature of supervision changes over time. This may be unique to each psychologist and the context of their application. Expectations should be agreed from the outset and reviewed at appropriate intervals.

Forms of consultation/supervision

Supervision may take the form of clinical supervision, mentoring, coaching, supervision on placement/work setting, tutorials and peer support. Psychologists may engage in one to one supervision; group supervision (facilitated or non-facilitated) or peer supervision and any of these may be face to face or virtual. Whilst it should not be a substitute for line management, a psychologist's supervisor may also be their line manager.

Those working in independent practice, or in the absence of service-based supervision, should seek supervision from appropriately qualified and experienced personnel as appropriate. Peer supervision (individual or group) may be an appropriate way to find collegial support.

Psychologists may select different supervisors, depending on their preferred supervisory style, nature, orientation and their needs at the time. Particularly for experienced psychologists, this may be from an experienced colleague from outside their profession, professional specialty or organisation. Psychologists could also invite supervision from experts by experience for whom they provide services, where appropriate to the context of practice.

The Society maintains the Register of Applied Psychology Practice Supervisors (RAPPS), which recognises psychologists with special expertise in supervision and supervisory practice. Further information is available on the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines***.

Amount of supervision

While there is a specified number of supervision sessions for trainees (e.g. for their Chartered status) which varies across different sub-disciplines of psychology, no definitive amount of supervision is specified as part of CPD. To determine both the quantity and nature of the supervision, the psychologist may consider their need for supervision from various perspectives: their own assessment of need, the competencies required for their practice; the context of their work; organisational requirements; and the support available. For psychologists in employment the arrangements for consultation/supervision should be agreed after considering these factors in consultation with the employer.

Roles and responsibilities of the supervisor

Psychologists undertaking supervision should ensure that they are sufficiently experienced, competent and appropriately trained to provide supervision. Psychologists are often called upon to supervise non-psychologists, in which case these guidelines would also apply.

In supervision, the psychologist as supervisor needs be aware of their own competence in relation to the work of the psychologist and, where necessary, recommend additional supervisors who may have the appropriate level of expertise. Psychologists may offer consultancy supervision to professional colleagues, organisations and stakeholders in line with their competencies.

Psychologists should avoid personal relationships between the supervisor and psychologist which could adversely affect integrity and objectivity.

Psychologists providing consultation/supervision should do so in line with the guidance in other relevant sections of these Practice Guidelines.

Issues of power and control

The nature of supervision itself creates a power imbalance, even between peers. Both the person providing supervision and the person receiving it need to be aware of this.

The supervisory leadership relationship should be both informative and reflective. Psychologists in leadership roles as supervisors should provide regular, informative feedback to the psychologist as well as motivating them to reflect on their own practice, continue to self-assess and improve self-awareness.

1.6 Leadership

Psychologists at any stage of their career are likely to find themselves in a position where they are required to demonstrate or model leadership. This may be an integral part of their practitioner work or may arise through being a leader of a team, including leading in Society work. Leadership is widely quoted and described in the context of leading change as, *'accepting responsibility to create conditions that enable others to achieve shared purpose in the face of uncertainty'*[5]. Furthermore, leaders 'can create conditions interpersonally, structurally, and/or procedurally'[6]. These descriptors highlight the often complex process of psychological change through clinical intervention and also through leading others.

Contemporary leadership styles are generally more aligned to working *within* a team or a system rather than being directive. Leading as a psychologist is likely to include dealing with highly complex information and systems whatever the context. Leading in this way demands high levels of skill in developing, managing and maintaining professional relationships. This may include communicating complex and sensitive information, and reflexivity to enable individuals and teams to co-formulate around difficulty and challenge.

2. Where psychologists work

2.1 Working environment

When undertaking work with clients, psychologists need to give consideration to providing an environment which is welcoming, accessible, safe, and offers privacy. Although choice of workspace is not always available, it is important wherever work takes place with clients that psychologists consider:

- whether lighting, acoustics, heating and seating are comfortable;
- whether confidential conversations may be audible to others;
- whether there are arrangements to ensure client and practitioner safety, for example through easy access to another member of staff if a difficulty arises;
- whether access and exits are safe, well-lit and in areas which are likely to be overseen;
- that reasonable adjustments can be made to support effects of special needs and/or disability;
- whether the setting is culturally acceptable to clients; and
- whether there are facilities and equipment suitable for the clients, for example lavatories, play materials for children.

Where context of practice allows, psychologists could seek the assistance of relevant workplace representatives, for example their trade union representative or human resources staff, in situations where appropriate workplace conditions are not being provided. However, it is acknowledged that sometimes the ideal workspace may not be available or that psychologists may not have access to these workplace representatives due to their context of practice and psychologists should, within the limits of safe practice, be able to adapt to situations within local constraints in order to provide the best service for clients.

Sometimes, it is important to work with clients in representative environments in order to understand behavioural drivers. This will apply if the psychologist's task is to understand behaviours in such environments and provide support, for example through the use of technology, design of procedures, training or team design. Psychologists should consider carefully how to create representative conditions without causing harm. Equally it may sometimes be necessary for psychologists to work in a client's own context as that is where any intervention may be formulated or put in place. Psychologists should ensure they follow the relevant health and safety guidelines in place at their working location even if that location is not their usual place of work.

There may be a temptation to make assumptions about what sort of environment is most suitable, comfortable and culturally appropriate for clients, however it is helpful to ask them and endeavour to make appropriate adjustments to meet their needs.

Lone working

Many psychologists practise in a lone worker workplace and on occasion visit clients in their own homes. When working at home, it is necessary to ensure the proper insurance

and protocols for this type of work, as well as manage boundaries between personal and private space. When working alone, the Suzy Lamplugh Trust recommends always ensuring that someone else has access to schedules and contact details for clients. Psychologists may also want to put in place a 'code word call', where should they fail to answer or speak the correct code word, the police are alerted. This is just an example of an additional safety practice, and there may be different ideas for ensuring personal safety when lone working. However, the important point is to think about keeping safe, have a plan and stick to it. Further information is available in ***Appendix 2: Websites and further information.***

Harassment and bullying

Bullying is behaviour that may take the form of actions or comments that are offensive, which are intended to humiliate, undermine, demean or injure the recipient. It may target an individual or group of individuals and is a form or abuse that may be explicit and therefore obvious, or it may be insidious, an experience recognised only by the recipient and harder to notice by others. Bullying may be vertical (i.e. between managers/supervisors and staff) or horizontal (i.e. between colleagues). Clients may also experience bullying by professionals. While bullying may involve a misuse of power and be committed in the workplace by a manager, supervisor or senior colleagues (sometimes known as downwards bullying), it should be borne in mind that it is not uncommon for senior staff to be bullied by those whose work they oversee.[7] What can be legitimately classified as bullying may take into account the particular personal sensitivities and characteristics of the person suffering the alleged bullying.

Harassment can be defined as actions or comments that are unwanted and which may be related to age, disability, gender reassignment, race, sex, sexual orientation, religion or belief or any other personal characteristic of the recipient. Harassment occurs when someone engages in unwanted conduct in relation to the aforementioned characteristics and that conduct has the purpose or effect of violating the other person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for the other person.

The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Psychologists with concerns over the above behaviour should seek the support of their supervisor, line manager or other appropriate senior staff member, accredited trade union workplace representative or human resources department. Further information is available in ***Appendix 2: Websites and further information.***

Whistleblowing

Whistleblowing is the disclosure of wrong doing (beyond normal managerial channels) and is important as it is a critical way not only of seeking justice for the individual or individuals affected, but also of developing inside information within organisations about incorrect or unfair practices,[8] thereby increasing the evidence required for corrective action to take place.

A whistle-blower is protected by law (the Public Interest (Disclosure) Act 1998) if:

1. They are a worker (this includes trainees and can include self-employed personnel servicing an organisation in certain circumstances).
2. They are acting in the public interest.
3. The disclosure relates to past, present or likely future wrongdoing which involves one or more of the following:
    - criminal offences (which may include fraudulent actions);
    - a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
    - a miscarriage of justice has occurred, is occurring or is likely to occur;
    - the health or safety of any individual has been, is being or is likely to be endangered;
    - the environment has been, is being or is likely to be damaged; or
    - information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

If the individual has been victimised or if they have lost their job due to whistleblowing, the legislation provides them with the right to take a case to an employment tribunal. Whistleblowing is a complex legal area and it is important that anyone considering it considers appropriate advice, for example from an accredited trade union workplace representative or helpline. The relevant human resources department which will have a policy relating to this, or it may be appropriate to seek formal legal advice. Some organisations such as NHS Trusts have a nominated Director responsible for dealing with disclosure issues who may be contacted directly. The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Further information is available in ***Appendix 2: Websites and further information.***

Psychologists can inform on all aspects of the establishment of workplace cultural norms that promote positive managerial and leadership behaviour and can help facilitate the development of cultures that support the disclosure of inappropriate practices. Psychologists are also appropriately qualified to support workers who have been subject to bullying or harassment or who are contemplating or indeed have already 'blown the whistle'. Whistleblowing, and even the prospect of such, can create traumatic responses in workers[9] and can lead to retaliation as a consequence. Empirical evidence highlights the link between whistleblowing and the devastating effects on health that may follow, such as depression, anxiety and symptoms relating to post-traumatic stress[10]. Psychologists are able to work with affected employees and in a consultative capacity with organisations to manage work-related stress disorders caused by these incidents of bullying, harassment and whistleblowing to lessen the risk of absenteeism and to facilitate a return to work following a period of absence. Further information is available in ***Section 8: How to respond when things go wrong.***

2.2 Working in the digital age

Digital media continues to advance in terms of choice and functionality. It is becoming increasingly common for psychologists in particular when working with clients to make use of the internet and/audio-visual technology. These technologies require the psychologist to ensure that the network used is as secure as reasonably possible and, as far as is feasible, assures privacy to their clients.

There can be no guarantee of security when using the internet, and voice over internet protocol (VOIP) services such as 'Skype' or 'FaceTime' are no different, as they use the same data infrastructure as the rest of the internet.

Most, if not all, VOIP systems encrypt the voice into waveforms during digital transit across the internet, and it would be impossible to eavesdrop on these data packets in real time. However, the information is potentially vulnerable to eavesdropping/compromise before encryption by the speaker's system, and after decryption by the listener's system. This will depend upon the security measures in place for the end user's (speaker and listener) own networking infrastructures, be that a company, institution or home user. If an end user's computer has been compromised by any form of malware, then there will be a risk of eavesdropping, data theft and/or denial of service.

The risk for eavesdropping on VOIP systems is no more or less than that of traditional analogue phone systems, and both would require specialist knowledge, equipment and software to be achieved. However, it is recommended that only fit-for-purpose VOIP systems are used, and that public networks, such as Social Media sites, are avoided for VOIP communications. Further information is available on the ***Society website: http://beta.bps.org.uk/Practice-Guidelines***.

Some employers may have their own rules about which media are acceptable to use. The USA has the Health Insurance Portability and Accountability Act (HIPAA) which sets standards for security for electronic data. There is no such provision in the UK to date, and so psychologists must satisfy themselves that any media used to communicate personal data is secure. This is a rapidly changing area and so technology-specific guidance has not been provided in this document. Further information is available in ***Section 7.1: Information governance*** and ***Appendix 2: Websites and further information.***

The use of online 'Apps', computer assisted decision-making and artificial intelligence in psychological practice and research is evolving rapidly. When recommending or using computerised systems psychologists should pay due regard to peoples' health, wellbeing and safety being mindful of Clinical Safety Evaluations, Medical Device Evaluations and other relevant guidance such as NICE.

Use of social media

Many psychologists are using social media, networking sites or blogs to communicate with friends, family, professionals, colleagues and clients. This specific guidance therefore addresses the use of social media by psychologists, and provides practical advice for using them responsibly. Further information is available in ***Appendix 2: Websites and further information.***

Psychologists should:

- Remember that social networking sites are generally public and permanent. Once something is posted online, it remains traceable even if it is later deleted.
- Keep their professional and personal life as separate as possible. This may be best achieved by having separate accounts for work-related communications to those for friends/family.
- Consider whether, in their context of practice, it is appropriate to accept 'friend' requests from current or past clients, if necessary, decline the request via more formal means of communication. It is highly unlikely to be appropriate to accept in a clinical or forensic context.
- Be minded to act responsibly at all times and uphold the reputation of the profession, whether identified as a psychologist or not on the social media platform.
- Be aware that social networking sites may update their services and that privacy settings can be reset to a default that deletes personalised settings.
- Remember that images posted online by family or friends may be accessible, as they may not have set privacy settings as tightly.
- Be minded that social networking sites can make it easier to engage (intentionally or unintentionally) in professional misconduct.
- Report the misconduct of other psychologists on such social networking sites to any relevant parties (such as the employer or the HCPC).
- Be aware of their employer's social media policy.

Psychologists should not:

- Establish inappropriate relationships with clients online.
- Discuss work-related or confidential issues online in any non-secure medium.
- Publish pictures of clients online, where they are classified as clinical records.
- Use social networking sites for whistle-blowing or raising concerns.
- Post defamatory comments about individuals or institutions. Defamation law can apply to any comments posted on the web, irrespective of whether they are made in a personal or professional capacity.

2.3 Working for the court

Psychologists may be asked to act as professional or expert witnesses in court. The main difference between an expert witness and an ordinary witness (i.e. a witness to fact), is that the former are able to give an opinion, whereas ordinary witnesses can give only factual evidence. A professional witnesses' remit can cross the boundary of both fact and opinion.

Psychologists are responsible for ensuring they are sufficiently competent and expert in offering an opinion. It is not appropriate for trainee or assistant psychologists to act as expert witnesses. Indications of competence in respect of the knowledge required by the court, and expertise within a specialised field, may include:

- qualifications and/or degree(s) in the areas(s) in question;
- a number of years of post-doctoral/post-qualification experience;
- academic, professional and scientific publications in relevant areas;
- demonstrations of professional practice, competence, specialist knowledge and expertise with a bearing upon the issues in the case; and

- current experience in applying psychology in the area of claimed expertise.

It follows that a psychologist with trainee or assistant status is unlikely to have the necessary experience and qualifications to be retained as an expert witness by a legal firm. However, trainees or assistants who have written reports on individuals in the course of their employment may be required to give evidence (for example, at a tribunal). If so, they should bear in mind that only qualified psychologists should give evidence of opinion, and that their supervisor is responsible for the professional quality of their work in this situation as in all others.

Psychologists instructed as experts need to ensure that they can provide an independent and impartial opinion, and that their independence is clear to all. Any potential conflicts of interest should be made explicit and should be reported as soon as they arise. This can extend to being asked to provide an expert report on someone the psychologist is providing with therapy as an 'Applicant', 'Claimant' or 'Complainer'. This dual relationship is an unacceptable conflict.

When lawyers seek to introduce expert psychological evidence, it is the judge in the case who decides whether an individual has the requisite expertise to give evidence with the potential to be relevant to the case. The judge also decides whether what the expert asserts is relevant and, therefore, admissible in law.

Expert evidence in civil court proceedings is governed by Part 35 of the Civil Procedure Rules 1998, and its associated practice direction. This rule makes clear that an expert's overriding duty is to help the court on matters within their expertise and that this duty overrides the expert's duty to the person from whom they are receiving instructions. Any report must be written in accordance with the criteria in Practice Direction 35.

Further information is available in ***Society documents: Psychologists as Expert Witnesses: Guidelines and Procedure*** and ***Psychologists as Expert Witnesses in the Family courts in England and Wales.***

2.4 Working for defence and security organisations

Psychologists may work with defence and security interests in many different capacities. This may include supporting military or security personnel to perform their roles through the development of skills and behaviours, supporting the mental health and wellbeing of people affected by threats, activities and events in this context, and offering advice and consultancy. It is also UK Defence practice to enlist uniformed psychologists for roles associated with psychology. However, in general, psychologists in defence will be in a civilian role and therefore not under military command.

While there is a strong sense of common culture within the defence and security sectors, there are also important variations. For example, each of the armed forces has its own organisational culture resulting in different attitudes and behaviours. There are also differences within different sectors of each organisation. All these differences are very important to the individuals concerned, forming a large part of their sense of identity.

Psychologists working with these populations should ensure they investigate and acknowledge cultural differences, particularly when working with other national cultures. They should also take careful account of the environments in which people are living and working. Psychologists can be working with civilians and/or members of the armed forces who are operating in life threatening environments and are required to make decisions under extraordinary pressure. It is usually invalid to extrapolate from behaviour in benign conditions to behaviour under threat, hardship and stress.

3. Who psychologists work with

3.1 Working with Experts by Experience

In relevant services it is best practice for psychologists to work collaboratively with clients and Experts by Experience in developing and delivering all aspects of psychological services. In mental health, the Government is committed to shared decision-making and the principle 'no decision about me without me'[11]. This applies from work with an individual client through to changes in government policy relevant to the services provided by psychologists. Psychologists should develop services, policies and guidelines in collaboration with the people who use their services.

In professional practice it is important and helpful to work collaboratively with clients and, where relevant, others in order to ensure that the application of psychological research and theory is understood by and adapted appropriately to the client group and context, which may differ from the populations on which the research was based.

3.2 Working with assistants/interns

Many graduate psychologists take up assistant psychologist positions on either a paid or an unpaid basis.

The following (non-exhaustive) list provides examples of activities which can be carried out by assistant psychologists/interns. This list can guide those who are working as assistant psychologists/interns to request or refuse a task or assignment, as well as assist those who are practising and supervising to observe boundaries and limitations:

- research, audit and service evaluation;
- literature searches, developing and maintaining training packs, information leaflets, libraries of equipment, and other tasks necessary to the efficient running of the service;
- assessment of individuals and groups, for example, direct observations, formal psychometric testing, semi-structured interviews, and writing appropriate reports;
- delivery of interventions with individuals, groups and organisations;
- undertaking supportive work with carers, family members, employers, human resources professionals, team members, health staff and other professionals;
- delivering training for other professionals (if and when competent to do so); or
- promoting applied psychology services by providing relevant information to referrers, commissioners and others.

An assistant psychologist/intern should not be employed to:

- substitute for qualified applied psychologists; or
- undertake solely administrative or clerical duties for which a clerical assistant should be employed.

In occupational settings, the issue of appropriate supervision and guidance is of particular importance when the needs of individuals and organisational demands need to be balanced. Appropriate mechanisms need to be in place to ensure that no assistant psychologist/intern is, for instance, put in a position where they have to design or decide on any materials or processes which could have a potential harmful impact on individuals or groups or to an organisation (such as potential loss of profit or revenue).

In clinical and forensic settings, there are some additional limitations, related to the clear delineation between qualified and assistant psychologist/intern, as follows:

- An assistant psychologist should carry out only prescribed interventions with individuals or in groups, and should write reports only when under close supervision of the primary, qualified psychologist. Any report should be signed as having been written 'under the supervision of' followed by the name, registration status and job title of the qualified psychologist.
- When an assistant psychologist is called to give evidence in a legal setting, such as a tribunal, the qualified psychologist remains responsible for the professional quality of the assistant's work. This means the qualified psychologist should attend the hearing also, as there may be questions which an assistant cannot answer. Both should bear in mind that an assistant is not qualified to give evidence of opinion.
- An assistant psychologist should not undertake tasks in areas where there is not a competent supervisor.
- An assistant psychologist should not carry out the duties of a care assistant.

The managing or supervising psychologist has a responsibility to ensure that assistant psychologists are not given work to do that is over and above their level of competence. Further information is available in ***Society Document: Applied practitioner psychologist internship programmes and unpaid voluntary assistant psychologist posts.***

3.3 Working with trainee psychologists

The Society's standards related to working with trainees across the domains of applied psychology are set out in the Standards for accreditation of training programmes. These set out: the required core competencies that trainees need to develop, the curriculum and assessment requirements that programme providers need to deliver against, and the requirements of supervised practice; expectations around trainees' understanding of and ability to work ethically and legally; selection and recruitment of trainees; personal and professional development of trainees whilst in training; academic staffing and leadership for accredited programmes; and expectations in relation to quality management. Psychologists working with trainees as practice educators should familiarise themselves with these standards and adhere to them in their work with trainees. Further information is available on the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines.***

3.4 Working with multiple clients

Psychologists will sometimes be in situations where their client will not be one clear individual or group, for example, a psychologist may be employed by an organisation to

provide assessment or psychological support for employees. Psychologists need to consider and be mindful of the demands that this might place on their ethical practice and how this might lead to conflicts of interest.

Identification of the following client hierarchy may be considered[12],[13]:

- Primary client – the person or persons with whom the psychologist is interacting directly: the recipient of a psychological service.
- Commissioning stakeholders – the organisation or overall commissioning body that has sought the psychologist.
- Others affected by the primary client's actions – the customers of the organisation or service, or the personal acquaintances, friends and family of the primary client. In some circumstances, this will be the general public or larger groups interested in the outcomes of the intervention.

The psychologist's role will be mainly to the primary client and then the commissioning stakeholder. It is paramount that issues around boundaries and sharing of information are made explicit and addressed appropriately through a clear contracting agreement. Further information is available in ***Section 3.5: Working with other professionals***, ***Section 5: Making and maintaining agreements*** and ***Section 7: Managing data and confidentiality.***

Within each of the levels of the hierarchy, varying allegiances to associates (friends, family, acquaintances, colleagues) will need to be attended to, as will consideration of the impact of professional activity on the reputation of the profession and all those concerned.

3.5 Working with other professionals (including in multi-agency settings)

In order to meet the complex needs of clients fully, psychologists will often be required to work collaboratively with other professionals from their own or other agencies.

Such collaborative working will be for the benefit of clients and/or the promotion of the safety and protection of the public or the benefit of the organisation, and is required by national policy and legislation in a number of areas in which psychologists work. Engaging in partnerships drawing on a wide range of services and agencies enables psychologists to address identified community issues with the optimum use of resources.

Where appropriate to their context of practice, and consistent with the requirements of psychological practice, psychologists should:

- Work together with colleagues to develop a shared view of the aims and objectives of work at all levels. They should respect the professional standing and views of other colleagues and commit themselves to joint working.
- Make it clear to other professional colleagues what can be expected of them in collaborative work, the work that will be done, and the point at which the work will be terminated.
- Ensure that there are explicit agreements about information-sharing and confidentiality and its limits, and that these are adhered to.

- Practise and encourage in others full and open communication with colleagues/ agencies to support effective collaboration within the boundaries of the agreed limits on information-sharing and confidentiality,
- Demonstrate their commitment to involving clients in multi-agency work, finding ways to engage them and retaining the central principle of better outcomes for clients as the rationale for multi-professional and multi-agency work, as long as this is consistent with public safety.
- Be sensitive to the effects of clients receiving contradictory advice from different professionals or agencies and should work towards a co-ordinated view wherever possible.

3.6 Boundaries in professional relationships

Psychologists seek to establish good relationships and trust with their clients, other professionals, organisations and the community. They are aware of the complexity of professional relationships and the need to observe their boundaries. Multiple relationships occur when a psychologist is in a professional role with a client or colleague and at the same time is in another role with the same person or group e.g. as a supervisor, sports club member or co-author in a publication or where a psychologist is asked to work at a school where their child is a pupil.

Psychologists should:

- Ensure that the relationship reflects the appropriate context within which the practice is taking place.
- Be aware of the issues of multiple relationships and professional boundaries which may lead to (real or perceived) conflicts of interest or ethical considerations.
- Clarify for clients and other relevant stakeholders when these issues might arise.

When acting as leaders in practitioner or managerial roles, psychologists should maintain an awareness of the importance of respect for boundary and power issues within leadership relationships. In particular, an awareness of the possible abuse of these relationships should be maintained at all times. It is important that psychologists explicitly define the boundary of the relationship and negotiate and respect the responsibility that each holds in relation to it. Where psychologists are in a position of power/leadership with individuals, it is particularly important that they exercise caution and consider the possible issues which may arise from developing a personal relationship with these individuals. It may be necessary to seek further supervision where appropriate, with additional peers as necessary.

Psychologists have a duty of care towards their clients, who may be vulnerable, and should maintain a professional emotional distance from clients, services users or relatives and should not enter into an intimate or sexual relationship with any clients, service users or relatives they come into contact with as part of practice. Psychologists should also be aware that their duty of care can continue after a client practitioner relationship has ended.

As far as is reasonably practical, psychologists should not enter into a professional relationship with someone with whom they already have, or have had, a close personal

relationship. This includes family members and friends. Where there is no reasonable alternative, such as a lack of availability of other professionals, and it is acceptable in the particular context of practice, the psychologist should make every effort to remain professional and objective while working with the individual they know or have known. In such circumstances, at the earliest possible opportunity, this should be disclosed and discussed with a manager, where there is one, and supervisor and a note should be made in client records.

A range of psychologists work with people who initially have accessed the services in a dependent position, and have then transitioned to becoming partners and colleagues in service and policy development and design. The nature of the work becomes more collegiate and the psychologist holds multiple roles including facilitating participation, adapting communication and advocacy.

3.7 Working with children and young people

When seeking to work with children and young people, psychologists should consider how they can develop ways of communicating with the child or young person that will be most effective in ensuring they can express their views and feelings.

In most instances psychologists will use their specialist professional training and experience working with children, young people and families in order to understand the developmental needs of the child or young person in question; where a psychologist does not have specialist training that has included children and young people then there would be an expectation that advice or supervision should be sought before working with a child, young person, or their family. Similarly, work with children, young people and their families should take account of wider systemic factors outside of the child or young person; this will usually involve the child's family and may also include their school, and other settings.

As with adult clients, there can be misunderstandings and confusions about the role of a psychologist, the nature of the work being undertaken, and the possible outcomes of the work. It is essential to ask the children and young people about their understanding of what is happening on a regular basis (this may be appropriate at each session) and address any confusion that has arisen.

When working with children and young people, psychologists are advised to ensure that they have ascertained who has parental responsibility and that those with parental responsibility are aware of their planned involvement, if this is appropriate. Psychologists working with children, young people and families need to be aware that young people who are deemed to be competent to make their own decisions: 'Gillick competent'[14] can give their own consent to involvement with a psychologist, and that if a young person gives consent under these circumstances, then parental consent is not required. Similarly, a young person who is 'Gillick competent' can give consent even if parents have declined to give consent; such young people can also ask that parents are not informed of any involvement, and this should be respected by the psychologist; an example here would be in a school setting where a young person may give their own consent to see a psychologist

and may ask for parents not to be informed. Psychologists also need to be aware that where separated or divorced parents share parental responsibility, one parent can give consent.

3.8 Working with people with intellectual disabilities and impaired cognitive abilities

Psychologists are likely to work at some point with a range of people whose cognitive abilities are either temporarily or permanently altered, either by organic or developmental changes. Appropriate assessment of the abilities and skills is required, so that adaptions can be made to further interventions, treatments or management. The implications of the cognitive abilities on the person, their family and the reason for psychology involvement, will need to be considered.

Psychologists working with people with intellectual (learning) disabilities will need to consider adaptations to their approach to ensure the service they are offering is clearly understood, and is adapted to the individual's preferences, strengths and needs. This can include considering adaptations to oral or written communication, psychological assessment, intervention, and outcome evaluation.

Psychologists will need to be flexible and to make reasonable adjustments to their usual practice to ensure an appropriate service is offered. Psychologists should ensure their work is person-centred and respectful of the individual's needs, whether that work involves working with the individual with intellectual disabilities directly, or whether it also includes, or even may predominantly involve, working indirectly with family, carer or professional systems around the individual.

Psychologists will need to be mindful of the range of complex factors that often affect people with intellectual disabilities (e.g. communication needs, poorer mental and physical health outcomes and healthcare service experiences, unemployment, disempowerment, social isolation and exclusion, including experiences of bullying, abuse and hate crime, being overrepresented in the prison population, among others) and, therefore, the specific policy and practice guidance that applies. Further information is available in ***Section 4.2: Safeguarding adults at risk of harm*** and ***Section 6.3: Informed consent with people who may lack capacity.***

3.9 Working with detained people

Where clients are detained involuntarily there will always be a legal framework within which professionals must practise, and they should be aware of how their work fits into that framework. Involuntary detention is not only covered by professional rules and national legislation, but also by international agreements.

Psychologists should be aware that having the approval of one's employer is not necessarily a guarantee that practice is either ethical or legal, as described for example in the Hoffman report[15]. Where practitioners have doubts about the legal or ethical acceptability of employer demands, they should seek advice from an accredited workplace trade union representative, a human resources department, or appropriate helpline. They should

follow their organisation's guidelines on raising concerns at work. Seeking advice outside the immediate setting is helpful as colleagues within the workplace may be subject to the same pressures as they are.

Under the headings below, the role of the practitioner can be seen to be key to the way that detained persons are understood, and this can have a great impact on the way that their cases are handled by the detaining authority. The practitioner therefore has considerable power, whereas the client has very little. This power imbalance should always be borne in mind by practitioners dealing with detained persons. They should also bear in mind that the imbalance can be implicit as well as explicit.

Prisoners

Putting psychological pressure on detained persons to obtain a confession to an offence is illegal under the UN Convention on Torture[16]. In this context, 'psychological pressure' could well include such things as telling indeterminate-sentence prisoners who maintain innocence that they are unlikely to be released unless they engage with an intervention that relies on acknowledgement of guilt. Decisions about release are not the role of the practitioner, unless they are directly involved with, or are a member of the release authority, with a delegated role in the formal decision-making process. An approach to engagement such as this would not be considered beneficial to the client. However, those instructed by any party to the formal Parole Board decision-making process may properly be asked to give an opinion on suitability for release.

Practitioners dealing with detained offenders who have committed violent or sexual offences should guard against being morally judgemental. It is routine for practitioners in this field to encounter offenders who have committed very unpleasant acts with whose victims they can readily identify. Psychologists should be mindful that their own views about a client do not impact on their work.

Care should be taken when working with detained persons whose literacy is poor or whose first language is not English, and who cannot read a report which has been written about them. Even clients who are literate in English will probably not be familiar with psychological terminology, and may need considerable time to read and fully digest a report. People who are detained can also have cognitive challenges or intellectual disabilities which might make this process more difficult.

Persons detained under immigration legislation

Detained people may be afraid of raising a particular topic in case it is misunderstood, or too embarrassed because of cultural standards. For example, in some cultures it is difficult or unacceptable to discuss sexual matters, but sexual violence has been suffered by many asylum seekers in conflict zones, and some discussion of it may be essential in assessing their case. Even within the same culture there can be considerable generational differences.

Psychologists should guard against unwarranted interpretations of psychological evidence by commissioners or authority figures. For example, reporting that someone's story shows inconsistencies may give the impression that they are lying. This may be the case, but inconsistencies alone are insufficient proof of this. It is commonplace for evidence to be

inconsistently reported when people have been through traumatising experiences in areas of conflict, as is often the case with persons detained under immigration legislation.

Practitioners should take particular care in dealing with detained persons whose first language is not English. The opportunities for misunderstanding in both directions should be obvious, and in many cases the correct procedure will be to interview with the help of an interpreter. Failing to use interpreters when it was clearly appropriate to do so could inappropriately compromise the quality of the psychologist's work.

Mental Health Detentions

Mental Health Act 1983 as amended 2007 (England and Wales)
Under the Mental Health Act (MHA) a person can only be detained for treatment if that person is suffering from a mental disorder of a nature of degree that makes it appropriate for them to receive medical treatment in hospital. In the Act 'mental disorder' is defined as 'any disorder or disability of mind'. This definition is very broad but the *Code of Practice* provides guidance on clinically recognised conditions that fall within its meaning. Major categories of mental illness (e.g. affective disorders, schizophrenia and organic mental disorders) are included along with personality disorders, autistic spectrum disorders and learning disabilities (the latter only if accompanied by abnormally aggressive or seriously irresponsible behaviour). Dependence on alcohol or drugs is not considered a mental disorder under the MHA.

In the Act, all 'medical treatment' including psychological interventions is for the purpose of alleviating, or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations. The medical treatment must be required for the health and safety of the client or for the protection of others. This means that the primary purpose of psychological interventions offered and provided to detained persons has to be to reduce the risks that their mental disorder presents to the detained person or others; as once those risks are reduced or minimised the client will no longer require detention and can progress to a less restrictive environment. This requirement points to the importance of an individualised formulation of a client's treatment needs that includes a careful assessment of the risks to self and others (see section on Risk Assessment, p.32).

Under the MHA appropriate medical treatment must be available. This is described as the 'appropriate medical treatment test' in the *Code of Practice*. Such treatment must have the *purpose* of alleviating or preventing a worsening of the disorder or its symptoms or manifestations, even if it cannot be shown in advance that the treatment is likely to have an effect for a particular patient. Thus, appropriate medical treatment need not be likely to achieve those purposes. That is, purpose is not the same as likelihood. The nature and degree of the patient's mental disorder and all the patient's particular circumstances are all relevant to whether the treatment is appropriate.

The appropriate medical treatment test is designed to ensure that patients are not detained for treatment unless they are actually to be offered appropriate treatment for their mental disorder. Thus, the MHA requires only that appropriate treatment is available to a detained patient. The patient's refusal to accept treatment is not an obstacle to detention, so long as appropriate treatment is available.

This has particular relevance for psychological therapies. The Code at chapter 23.20 states:

> *In particular, psychological therapies and other forms of medical treatments which, to be effective, require the patient's cooperation are not automatically inappropriate simply because a patient does not currently wish to engage with them. Such treatments can potentially remain appropriate and available as long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to engage.*

Whilst the availability test of appropriate medical treatment applies to psychological interventions in the same way as for other forms of treatment, it is important for psychologists to avoid placing pressure on clients to participate in such treatment. In order for there to be an effective therapeutic alliance there needs to be trust and this only develops in the absence of coercion. Psychological therapy works when the client decides they are ready for therapy and freely consents to it. There is an inevitable power differential in favour of the clinician. Thus, every attempt should be made to emphasise patient involvement and choice and to avoid coercion in a manner consistent with the *Code of Practice* empowerment and involvement and respect and dignity principles. Further information is available in ***Section 6: Obtaining informed consent.***

The Mental Health Act 2007, which amended the MHA 1983, introduced approved clinicians (AC) who may be drawn from a defined group of professions, including practitioner psychologists listed in the register maintained by the Health and Care Professions Council. ACs are approved by the appropriate national authority to act as an approved clinician for the purposes of the MHA 1983. Responsible clinicians (RC) are ACs who have overall responsibility for an allocated patient's case. The Code of Practice at chapter 36.3 says that a patient's RC should be the available AC with the most appropriate expertise to meet the patient's main assessment and treatment needs. At chapter 36.5 the Code says that where psychological therapies are central to a patient's treatment then it may be appropriate for a professional with particular expertise in this area to act as the RC.

Chapter 39 of the *Code of Practice* provides guidance on the circumstances in which potential conflicts of interest may prevent designated professionals from making an application for or recommendations supporting a patient's detention or guardianship. The potential conflicts of interest dealt with in the Code involve financial, business, professional and personal issues.

The Mental Health (Scotland) Act 2015.

This act, together with the Mental Health (Care and Treatment) (Scotland) Act 2003 sets out the law for detaining patients and restricting patients. For patients to be detained, this has to be considered by the Mental Health Tribunal for Scotland. This applies, for example, to those detained in the NHS who are not subject to a court (forensic) decision.

Restricted patients are 'detained in hospital under a compulsion order with a restriction order'. They have usually committed an offence punishable by imprisonment but as a result of mental disorder are not imprisoned but ordered to be detained in hospital for treatment, without limit of time. They are dealt with through a programme of treatment and rehabilitation – the aim being to prevent recurrence of offending by dealing with the mental disorder'.

Risk assessment

When dealing with detained people seeking release, such as parole applicants or patients seeking release from a mental health tribunal, risk assessment (usually for violence risk) will be a prime consideration. Psychologists should bear in mind that risk assessment is not prediction. Risk assessment instruments are rarely more than about 70 per cent accurate when predicting reconviction and many items on commonly used risk-assessment schedules are of poor predictive value.[17] Psychologists should also bear in mind that risk-assessment instruments are better at identifying low-risk than high-risk individuals[18],[19]. A statement of risk is not a prediction about an individual, but a statement based on the behaviour of a criterion group with which that individual is being compared. Risk is statistical by its very nature, and the value of such comparisons depends upon the individual's similarity to the criterion group upon which the risk assessment instrument was developed. Accuracy may be greatly reduced if the similarity is low[20]. It may be better to think of risk assessment as a process of identifying those risk factors which need to be monitored and controlled if supervision of the individual is to be reduced or withdrawn.

3.10 Working with people who are, or would like to be employed

Psychologists are sometimes commissioned to deliver psychological assessment or training with employees and potential employees. Psychologists should take particular care over the advice provided in follow-up reports, as employers are not trained professionals and may misinterpret advice or psychometric testing results. For example, citing a reading ability level using age is misleading, and could be interpreted as incompetent for the role, when in reality the role does not require a high reading level or a reasonable adjustment could be provided.

Similarly, psychologists should ensure that the tools they are using to assess competence or suitability are appropriate for the role, and have good reliability and validity. Any tools devised by the psychologist are likely to be interpreted by the employer as professional and authoritative, where there is ambiguity or multiple interpretations, this must be made clear, so that decisions about peoples' employment are not made in error.

There are people who work or who would like to work, who may experience cognitive difficulties caused by a range of factors, for example intellectual disabilities, dementia, acquired brain injury. Sometimes this information is known and needs to be considered when assessing and advising. At other times, this possibility of a cognitive or intellectual impairment needs to be considered. The impact of this can be far reaching, in terms of ongoing or future employment, access to benefits and of course associated psychological adjustments for the person and the people around them. Further information is available in ***Section 7: Managing data and confidentiality*** and ***Society Document: Psychological Assessment of Adults with Specific Performance Difficulties at Work.***

3.11 Working with cultural difference

It is expected that all psychologists will have the necessary skills and abilities to work with all sections of the community.

Psychologists need to be aware of stereotypical beliefs and assumptions which manifest in thinking about culture and ethnic groups. Psychologists should bear in mind the history of racism and the early development of Western psychology[21] and culturally biased testing in favour of white, middle-class children. Psychologists need to recognise that multi-ethnic groups are not homogenous groups and there are wide regional and local differences among these groups which can be split by language, dialect and regional variations. Each ethnic community has a distinct identity and religious focus may also vary within and across communities.

Race is not a biologically meaningful concept to apply to people, and even the artificial divisions between the so-called racial groups are nebulous and unstable, biologically, socially and physically.[22]

Psychologists need to understand the discrimination suffered by people from diverse and/or minority ethnic and religious backgrounds as a result of:

- the interchangeable use of the terms race, culture and ethnicity leading either to the perception of black and minority culture, race and ethnicity as unitary or an assumption that knowing about these cultures solves the problem of equality, fairness and availability of services;
- the maintenance of the colour-blind approach in service where 'one size fits all', resulting in a lack of formal recognition of the varied diverse needs as well as these needs being ignored, unacknowledged or assumed to be the same;
- the lack of appropriate culturally relevant psychological therapy available to certain Black and Minority Ethnic (BME) communities;
- being discriminated against on grounds of 'special' needs, effectively considered as 'cultural pathology'; and
- experiencing instances of indirect, subtle, or unintentional discrimination often called 'micro-aggressions'.

It would be expected that all practising psychologists should develop a productive working relationship with culturally and linguistically diverse groups of people by:

- avoiding different types of biases and find new ways (verbally and non-verbally) to build rapport and respect;
- using and working with trained interpreters in assessment, formulation and intervention work as well as research work;
- being aware of the impact of culture, ethnicity and religion in assessment, formulation and intervention processes and the use of norm-referenced tests which do not include minority ethnic groups as part of their standardisation;
- pre-assessing and pre-incorporating ethnic identity (including its fine gradations, region, class and generation) which can have impacts on processes and outcomes of psychological work;
- acknowledging their own ethnocentricity and possible underlying socially conditioned prejudice to people who are 'different'; psychologists need to acknowledge that people can change, irrespective of their differences and psychological distress;
- relooking at current models of mental health which traditionally reflect Western

constructions, and incorporating other world views of psychological wellbeing; and
- understanding and respecting the different concepts of health and illness that exist within different ethnicities, including newly arrived people from Europe and refugees from Syria, Turkey, Somalia etc.

Psychologists need to: address the different life situations and life circumstances experienced by users who wish to use mental health services; hear their voices based on their personal experiences; and act and respond accordingly in a human way.

3.12 Working with people of faith, religion and spirituality

In working with clients who hold a variety of values and religious and spiritual beliefs which may be different from their own, psychologists should consider the following:

- Psychologists should respect clients' values and spiritual beliefs and need to be mindful that their personal beliefs should not be an impediment to engaging with the client.
- Spiritual beliefs are very often beneficial to the client's wellbeing and may be helpful to be incorporated into any intervention to achieve a positive impact where appropriate.
- In some circumstances the client's faith belief may be harmful or detrimental to themselves or others.

3.13 Working with sexual and gender minorities

Psychologists are committed to the fair treatment and inclusion of people who are intersex, people who do not identify as heterosexual and/or people who do not identify with their natally-assigned sex. This section provides guidance to address specific issues in support of these heterogeneous populations. In these guidelines we use the term 'sexual minority(ies)' to refer to individuals whose romantic attraction or sexual attraction is other than heterosexual (different from the majority in the surrounding society), and the term 'gender minorities' to refer to transgender, genderqueer and intersex individuals.

When working with gender and sexual minorities, psychologists are encouraged to:

- remember that sexual and gender minority identities are not indicative of mental health disorders;
- understand that attitudes towards sex, sexuality and gender are located in a changing social, cultural, and political context, and to reflect on their own understanding of these concepts and how it may impact their practice;
- reflect on the limits of their practice when working with certain sexual and gender minority clients, and to consider appropriate referral and training when necessary;
- understand how social stigmatisation (e.g. prejudice, discrimination and violence) poses risks to gender and sexual minority clients;
- consider engaging with the wider socio-political context regarding sexual and gender minorities in order to reduce social stigma;
- be knowledgeable about the diversity of sexual and gender minority identities and practices;

- use the preferred language of the sexual and gender minority individuals;
- understand the unique and particular circumstances and challenges facing clients with diverse gender and sexual identities and practices;
- understand the diversity of forms of relationships and families in gender and sexual minority clients;
- be aware of the potential challenges facing sexual and gender minority clients in their relationships and families;
- be mindful of the intersections between sexual and gender minority and socio-cultural/economic status;
- recognise the particular challenges experienced by gender and sexual minorities with physical and/or mental health difficulties;
- recognise the diversity of developmental pathways for sexual and gender minority children and adults;
- recognise the needs and issues of young people from gender and sexual minorities, and their particular vulnerabilities;
- support the self-determination of their clients in the development of their identities and practices; and
- avoid attempting to change gender or sexual minorities on the basis that they can be 'cured' or because of stigmatising theory, personal, religious and/or socio-cultural beliefs.

Working with racially and ethnically diverse Lesbian, Bisexual, Gay, Trans*, Queer (LGBTQ) populations

Black and minority ethnic (BME) LGBTQ people have to negotiate between the values and beliefs of the mainstream and minority ethnic cultures. Cultural differences in norms, beliefs, and values can be a source of psychological stress[23],[24],[25]. There may be no particular sexual and ethnic minority group to which a BME LGBTQ person can anchor their identity and obtain acceptance and support. This may be a particular issue for BME LGBTQ youth who are exploring their sexuality and sexual identity.

When offering psychological services to racially and ethnically diverse LGBTQ populations, it is not sufficient for a psychologist simply to identify the racial and ethnic identity and background of the client. Ethnic minority status can complicate and exacerbate the issues, challenges and difficulties the client experiences. The client can be affected by the way their ethno-culture community view and understand sex, sexuality and gender. The issue of racism within the LGBTQ community is also an important issue to consider[26],[27],[28],[29]. Sensitivity to the complex dynamics associated with factors such as cultural values about gender roles, religious and procreative beliefs, degree of individual and family acculturation, and the personal and cultural history of discrimination or oppression is also important. All of these factors may have a significant impact on identity integration and psychological and social functioning[30],[31],[32],[33],[34].

Further information is available in ***Society Document: Guidelines and Literature Review for Psychologists Working Therapeutically with Sexual and Gender Minority Clients.***

3.14 Working with people who may be socially excluded

Social exclusion refers to the extent to which individuals are denied access to the prevailing social system and the right to participate in key areas of social, economic and cultural life. This exclusion occurs due to constraints and restrictions rather than as a matter of choice. Exclusion is typically a result of poverty and/or belonging to a social minority group. The impact of social exclusion has been well documented and leads to the perpetuation of cycles of inequality for individuals and groups. These cycles of inequality are perpetuated in terms of income, health, opportunity, relationships and life-span. Further information is available in ***Society Document: Socially inclusive practice.***

Social inclusion is the process where the needs of all members of communities and the groups which constitute them are recognised, prioritised and met, resulting in these individuals feeling valued and respected. Promoting social inclusion is a broader task than promoting equality and tackling discrimination and stigma. It requires psychology professionals to address wider structural issues in society which maintain excluding processes and power differentials.

The range of individuals and groups who may experience disadvantage and exclusion is not limited to the protected characteristics outlined in the Equality Act. For example, people may also experience exclusion because of their age, they are a carer or are in care, they have a low income or low educational achievement, or their cognitive ability is compromised.

When working towards social inclusion psychologists are encouraged to:

- acknowledge, understand and respect the diversity of the communities in which they practise;
- make adjustments where possible and needed, to enable people to fully participate, e.g. to communication, access to services, adaptation to materials and psychological assessment and interventions;
- recognise that they have a professional duty actively to promote equality and opportunity;
- recognise the shame and distress caused by discrimination, and the impact of discrimination on wellbeing;
- acknowledge and respond to the trauma and distress caused by exclusion;
- move beyond the level of the individual and recognise that social exclusion is a structural issue, and that inclusion will be achieved only by structural changes in society and broad policy initiatives;
- acknowledge that there is a responsibility to highlight the links between structural societal factors and mental health problems;
- make employers, policy-makers, clients and the general public aware of situations where policies, practice and the distribution of resources are oppressive, unfair, harmful or illegal;
- challenge social conditions, both as individuals and collectively, that contribute to social exclusion and stigmatisation;
- make services accessible in terms of time, space, familiarity and comfort; make reasonable adjustments to services to meet individuals' needs; people need to be able

to get to places, get into places, feel welcomed to places and feel that they belong in places;

- recognise that inclusive services reflect the communities they serve in terms of the identities and diversity of the staff team;
- recognise the range of interventions that can improve clinical and social outcomes and use influence to ensure these services are commissioned;
- emphasise social outcomes and participation alongside clinical outcomes;
- maintain an emphasis on empowering clients to achieve their social goals; and
- identify natural sources of support and reciprocal relationships for individuals within their communities, and seek out opportunities to help individuals transition out of formal mental health services.

4. Safeguarding

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect[35]. This guidance addresses safeguarding of both children and adults.

Abuse takes many forms and cuts through various domains of life. The categories below are often referred to in investigation/legislation context and are not mutually exclusive with e.g. emotional abuse featuring in the other domains of abuse. Abuse can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

- Physical abuse – is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This could include hitting, poisoning, deprivation of food, water or liberty, rough handling or exposure to heat or cold, amongst other things.
- Sexual violence and abuse – sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding. Sexual violence and abuse can take many forms and may include non-contact sexual activities such as: indecent exposure, stalking, grooming or being made to look at, or be involved in the production of sexually abusive material, or being made to watch sexual activities.
- Psychological/emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, blaming, controlling, intimidation or coercion amongst other things.
- Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not, or could not, consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property of inheritance.
- Institutional abuse is the mistreatment or neglect by a regime or individuals, in settings which people who may be at risk reside in or use. Institutional abuse may occur when routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. It may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services and includes a failure to ensure the necessary preventative and/or protective measures are in place.
- Neglect is the persistent failure to meet basic physical and/or psychological needs. It may involve a parent or carer failing to provide adequate food, clothing and shelter, failing to provide or unresponsiveness to, basic emotional needs or failing to protect from physical harm.

Psychologists are in a particularly relevant position to identify interactions or circumstances that affect health and development. This applies not only to psychologists who undertake direct work with children and vulnerable adults in a variety of settings; but also to those who work with clients, seen for instance in clinics, hospitals or prisons, who may make historical disclosures of abuse or raise concerns about child protection or the welfare of people within their families or communities. Safeguarding is thus the responsibility of all psychologists whatever their role.

4.1 Safeguarding children

The Society endorses *Working Together to Safeguard Children* – A guide to inter-agency working to safeguard and promote the welfare of children[36]. Safeguarding children is the responsibility of everyone.

The guidance defines safeguarding children as protecting children from maltreatment and preventing impairment of children's physical or mental health or development (physical, intellectual, emotional, social and behavioural). Promotion of welfare is defined as ensuring that children grow up in circumstances consistent with the provision of safe and effective care, and taking action to enable all children to have the best life chances.

Child protection within safeguarding refers to the activity that is undertaken to protect specific children who are suffering or likely to suffer significant harm. For the purposes of child protection legislation children are those who have not yet reached their 18th birthday. The child's needs are paramount, and the needs and wishes of each child be they a baby or infant or an older child, should be put first, so every child receives the support they need before a problem escalates.

The policy of Working Together is underpinned by two key principles: (a) safeguarding is everyone's responsibility and for services to be effective each professional and organisation should play their full part; and (b) safeguarding requires a child-centred approach based on a clear understanding of the needs and views of children.

Where there are concerns that a child is at risk of harm, such concerns should normally be communicated following the psychologist's work-place safeguarding protocol. Where this is not applicable, concerns about a child's welfare can be made directly to the local authority children's social care team.

Psychologists should:

- be alert to the heightened vulnerability/possible need for early intervention support for a child who: has a disability, has additional needs (including special educational needs), is a young carer, is showing signs of engaging in anti-social or criminal behaviour, has returned home from care and/or is showing early signs of abuse and/or neglect.
- be alert to heightened vulnerability where a child is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence.
- consider the potential impacts of parental/carer ill-health on the family and whether this creates any significant negative impacts or risks for children within that family;

- be aware that if an adult has responsibilities for children outside the home setting, such as working with children, their mental ill-health and/or their health more generally upon the adult's capacity to work safely;
- be aware that children within the same family can be treated differently (one child may be singled out for abuse);
- be aware/seek to understand how children can come to abuse other children;
- recognise that some professionals use their position to abuse children and vulnerable people; and
- challenge institutional abuse in its many forms.

Psychologists should be aware of situations of risk which require additional consideration, notably:

- sexual exploitation, which involves exploitative situations, contexts and relationships without the child recognising the harm on account of their age/understanding, social/economic and/or emotional vulnerability;
- internet abuse, which can involve cyber bullying, exposure to pornography or violence and exploitation of young people;
- domestic violence which may expose a child to violence directly or indirectly;
- shame-based abuse where children or young people may be physically assaulted or murdered because of bringing perceived 'shame' to their families or breaking cultural expectations of 'honour'; and
- Trafficking, any child transported for exploitative reasons is considered to be a trafficking victim, whether or not they have been forced or deceived. This is partly because it is not considered possible for children to give informed consent. Even when a child understands what has happened they may still appear to submit willingly to what they believe to be the will of their parents or accompanying adults.

Psychologists should have a knowledge and understanding of services for children in need and how to access them. Psychologists confronted with child abuse in any form should contribute to whatever actions are needed to safeguard children and promote their welfare. The needs/interests of adults should not be allowed to take precedence ahead of the needs of the child. Psychologists should work co-operatively with parents/carers unless this is inconsistent with ensuring the child's safety and ensure that the child's view is sought, heard and communicated. Psychologists should share appropriate information in a timely way, discuss any concerns and help analyse information so that an assessment can be made of the child's needs and circumstances. Psychologists should contact the children's services or social services department at the appropriate local authority (in some cases this role has been delegated to a multi-agency safeguarding hub) if they are concerned about a child or a vulnerable adult.

Managing cases of alleged historical abuse

There is a growing recognition that a disclosure of non-recent abuse may reveal current risks to others from an alleged perpetrator. Psychologists have a duty of care to their clients, and in the safeguarding of others. This may place psychologists in complex positions when trying to negotiate and balance their duties and responsibilities.

Psychologists who work with adult clients who disclose non-recent sexual abuse, should recognise that there may be current and ongoing risks posed by the alleged perpetrator to others. Not sharing concerns beyond the consulting room could mean that other children and young people could be at risk.

A client's allegations should be taken seriously, regardless of their presenting problems or mental health diagnosis.

Lack of access to children identified through familial relationships, work or volunteering roles should not eliminate concerns about risk, given opportunities for abuse to occur within communities.

It is crucial that psychologists seek advice from colleagues, particularly colleagues in safeguarding services, within the organisation and also from other agencies tasked with leading on safeguarding (i.e. social services). Psychologists working with clients without a referral and where no stakeholder agency is involved should seek advice from senior experienced colleagues on how to proceed. Psychologists need to be alert to the possibility that abuse may be organised, severe and complex.

There may be times when, in the interests of supporting a client's psychological readiness for disclosure, consultation may continue without requiring identifying details to be provided to the psychologist. It is important that a clients' lack of readiness to disclose does not become an obstacle to receiving psychological help. Further information is available in ***Society Document: Guidance document on the management of disclosures of non-recent (historic) child sexual abuse.***

Where the disclosure is made by the perpetrator of the abuse, risk assessment should be made regarding the context of the setting of the disclosure but there may be a professional obligation to disclose the criminal offence in order to safeguard other potential victims as above.

4.2 Safeguarding adults at risk of harm

The Care Act 2014 brought in new legislation regarding the safeguarding of all vulnerable adults. In some regions there is a move away from the term 'vulnerable adult' towards the concept of an adult at risk of harm.

An adult at risk of harm is a person aged 18 or over with need for care or support, who is experiencing, or is at risk of, abuse or neglect, and as a result of their needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The needs referred to here may cover a variety of personal or life circumstances including (but not limited to) cognitive impairment, age, disability, illness, injury or mental health condition.

The legal context

There is no set piece of legislation for adult safeguarding. It is a mix of criminal law, case law and welfare law. The Care Act 2014, updated in 2016, brought in the first legal framework for safeguarding adults in a single act. It contains a range of regulations and statutory guidance, which form the base upon how social care will develop in the future.

It enshrines the new statutory principle of wellbeing and it makes it the responsibility of local authorities to promote wellbeing when carrying out any of their care and support functions. The act specifies the rights of those who need care and support, their carers, and the funding system for care and support. It recognises that this cannot be achieved by any single agency. Every organisation and person who comes into contact with a child or adult has a responsibility and a role to play to help to keep children and adults safe. Further information is available in ***Appendix 1: Relevant legislation.***

Modern slavery

An important area of concern is modern slavery. The Government website provides details about the government's work to end modern slavery, including details about how to refer victims into the national referral mechanism (NRM). Modern slavery is a serious crime. It encompasses slavery, servitude, and forced or compulsory labour and human trafficking. Modern slavery victims can often face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation.

A person is trafficked if they are brought to (or moved around) a country by others who threaten, frighten, hurt and force them to do work or other things they don't want to do.

A victim of slavery is entitled to help and protection from the UK Government (this is called the National Referral Mechanism), all support is provided on a confidential basis, and support to talk to the police. The National Referral Mechanism has been put in place to identify victims of trafficking and refer them to organisations that will offer help and support. Further information is available in ***Appendix 2: Websites and further information.***

Responding to concerns

Safeguarding adults means:

- Protecting the rights of adults to live in safety, free from abuse and neglect.
- People and organisations working together to prevent and stop both the risks and experience of abuse or neglect.
- People and organisations making sure that the adult's wellbeing is promoted including, where appropriate, taking fully into account their views, feelings and beliefs in deciding on any action.
- Recognising that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances and therefore potential risks to their safety and wellbeing.

Providers' safeguarding arrangements should always promote the adult's wellbeing. Being safe is only one of many things that adults want for themselves and there can be challenges in balancing safety and freedom in a way which protects and fulfils human rights. Providers, and other professionals where relevant, should work with the adult to establish what being safe means to them and how that can be best achieved.

Care and support means different things in every case. The fundamental standard on safeguarding is that children and adults using services must be protected from abuse and improper treatment. Providers should establish and operate systems and processes

effectively to ensure this protection and to investigate allegations of abuse as soon as they are aware of them.

The standard states that care or treatment must not:

- Discriminate on the grounds of any of the protected characteristics of the Equality Act 2010;
- Include acts intended to control or restrain an adult or a child that are not necessary to prevent, or not a proportionate response to, a risk of harm to them or another person if the adult or child was not subject to control or restraint;
- Be degrading to the adult or the child;
- Significantly disregard the needs of the adult or the child for care or treatment.

The standard goes on to state that no adult or child must be deprived of their liberty for the purposes of receiving care or treatment without lawful authority.

Safeguarding Adults Boards were established to help and safeguard adults with care and support needs The Safeguarding Adult Board must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies, according to the values of 'Making Safeguarding Personal' Guide 2014[37]. Making safeguarding personal is not just for people with capacity, it is just as important for people who lack capacity. The Guide specifies outcomes that people might want including to be and to feel safe, to maintain or get friends, to know that this won't happen to anyone else or to be able to protect self in the future.

The following are not outcomes:

- Harm or abuse is substantiated/unsubstantiated.
- The person is receiving increased monitoring or care.

The role of the Care Quality Commission[38] is to monitor, inspect and regulate services to make sure that they meet the fundamental standards of quality and care. The Commission works alongside Safeguarding Adults Boards and Safeguarding Children Boards to share information and intelligence where appropriate to help them identify risks. This includes providing appropriate advice and support to people at risk of radicalisation in sectors such as healthcare and education.

4.3 Terrorism and extremism

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ('specified authorities' listed in Schedule 6 to the Act), in the exercise of their functions, to have 'due regard to the need to prevent people from being drawn into terrorism'. Depending on where the psychologist works, these duties may have relevance in the course of their employment. The term 'due regard' as used in the Act means that the authorities should place an appropriate amount of weight on the need to prevent people being drawn into terrorism when they consider all the other factors relevant to how they carry out their usual functions.

The current UK definition of 'terrorism' is given in the Terrorism Act 2000. In summary, this defines terrorism as an action that endangers or causes serious violence to a person/ people; causes serious damage to property; or seriously interferes or disrupts an electronic system. The use or threat must be designed to influence the government or to intimidate the public and is made for the purpose of advancing a political, religious or ideological cause. People suspected of being involved in such activity must be referred to the police.

'Extremism' is defined in the Prevent Strategy[39] as vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty, and mutual respect and tolerance of different faiths and beliefs. Definitions of extremism can also include calls for the death of members of our armed forces, whether in this country or overseas.

While it is recognised there is no single profile associated with extremism, identity is considered to be central, and risk screening is based on assessment in relation to two general pathways into extremism – criminal and non-criminal. Disengagement follows a similar process. This is a contentious area of practice. Psychologists should ensure they focus on their core role, working in a non-stigmatising way, and avoiding profiling based on characteristics such as race, religion, ethnicity or any other aspect. The psychologist should carefully weigh relevant professional obligations and seek and follow appropriate local and employer guidance. Further information is available in ***Appendix 2: Websites and further information.***

5. Making and maintaining agreements

Both client and psychologist benefit by having arrangements for the work clearly set out from the start. Psychologists should be aware that all professional engagements are ultimately governed by the law of contract. A legally enforceable contract can arise as a result of the parties' entering into a written agreement, but can also arise as a result of a verbal agreement between the contracting parties.

A contract arises if the following are present:

- one of the parties (the offeror) had made an offer to the other party (the offeree);
- the offeree accepts the offeror's offer;
- there is consideration (i.e. something of value) passing from each party to the other, e.g. the offeror provide services to the offeree; the offeree pays the offeror;
- the parties intended to create a legal binding arrangement; and
- the terms of the contract are sufficiently certain.

While this does not mean that all client engagements are made subject to an agreed contract document, it does mean that in the worst-case scenario of a complaint against a psychologist being made, it will be very helpful for the psychologist to be able to demonstrate that they have met their professional obligations to their client. This will be best done by demonstrating that an agreement was made by both parties who knew what they were agreeing to, that the parties had the legal capacity to make such an agreement and that what they were agreeing to is permitted under the law. Where the client does not have the capacity, best interest decisions need to be made in accordance with the Mental Capacity Act. Further information is available in ***Section 6: Obtaining informed consent***.

Psychologists may wish to include the following when making agreements:

- the role and function of the psychologist;
- the psychologist's relevant qualifications, areas of expertise and ways of working;
- relevant limitations of the psychologist's practice, e.g. assessments not accepted or types of activity not undertaken;
- where the psychologist is appointed to work with a third party, the psychologist should make clear their obligations to each of the clients concerned and each client's obligations under the agreement and ensure that there are no conflicts or ambiguities;
- the extent of the psychologist's power and responsibilities when acting on behalf of other agencies;
- obligations in relation to duty of care and safeguarding, and related limitations to confidentiality;
- how confidentiality of client information and data is assured and any limitations to that confidentiality;
- how conflicts of interest will be managed if applicable;
- the client's, or other party's, rights of access to stored information;
- the use of any one-way viewing screens or video or audio recording and the security of any recorded material;

- the nature of psychological activities involved, the reasons for undertaking them and information about the likely outcomes;
- the availability of the psychologist to the client;
- details of fees, together with application of VAT if non-clinical services, or expenses to be billed in connection with the work undertaken;
- what is expected from the client as their contribution to the engagement with the psychologist, expectations for payment and consequences of non-payment;
- ownership of intellectual property rights;
- what might cause a breach of the agreement;
- the rights of each party to withdraw from the agreement and the consequences to any financial agreement;
- recourse to dispute resolution or law;
- the equality and justice aspects of social policies and their possible impact;
- external ethical scrutiny and approval of the engagement, where appropriate; and
- arrangements to terminate the retainer.

In advance of any psychological assessment, the client should be made aware of the availability of services, and the existence of any waiting lists for intervention.

For some approaches, intervention follows an evolving path, unique to each client and his or her life circumstances, which cannot be precisely predicted in advance. Clients should be made aware of this uncertainty, and predictions should be made on the best judgments. It is recognised that it is sometimes unrealistic and undesirable to provide detailed information on all aspects of psychological intervention, and consent should be obtained to a general strategy rather than specific procedures. Further information is available in this document or the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines.***

5.1 The practitioner's right to withdraw their service

There are circumstances in which a psychologist may decide to terminate the agreement for provision of psychological services. The circumstances may be personal or professional.

The personal circumstances may include but will not be restricted to leaving employment in a psychological service, incidences of illness or family commitments.

The professional issues may relate to service structural changes, safety, or provision of most appropriate service.

In these circumstances, psychologists will, as far as possible, work to ease the transition of service provision and give as much notice as is practical in the particular situation.

5.2 Referrals

Where a psychologist finds themselves unable to come to an agreement with a client, the psychologist may refer the client to a suitably qualified colleague. Psychologists will both make and receive referrals when working in services with other professionals.

In making referrals, psychologists should consider the needs of the client and to the best of their knowledge refer to another professional with the appropriate skills and experience.

In receiving referrals, the psychologist should consider whether the referral is appropriate for psychology, establish the client's understanding of the purpose of the referral, and consider as far as possible prior to meeting the client whether the referral falls appropriately within their own areas of practice.

5.3 Representation of the qualifications and status of the psychologist

HCPC registration and BPS Chartered Status

Psychologists are encouraged to state their registration with the HCPC and protected title(s). This will provide assurance that the psychologist meets national standards of training and professional skills.

Use of the 'consultant' title

The term 'consultant' generally does not have a formal definition. Within the medical field it is used by doctors who have considerable experience and proven expertise demonstrated through examination within their respective Royal Colleges.

While there is no clear comparable grading structure for psychologists outside the NHS (within the NHS, the consultant title is used by psychologists who are employed in Band 8C, 8D and 9 positions), the use of this title would be seen to reflect both seniority and specialist expertise.

There is a difference between a 'consultant' psychologist and a psychologist who provides consultations in their context of practice. The Society expects that psychologists should be honest and accurate in representing their professional affiliations and qualifications, including such matters as knowledge, skill, training, education and experience.

The Society's position is that this would be applicable in any situation where expert knowledge or skills is being marketed or promoted, whether or not this is for financial gain. Further information is available in ***Society Document: Guidance on the use of the title 'Consultant Psychologist'.***

6. Obtaining informed consent

Psychologists should always ensure that they have sought and received the consent of those they work with, given of their own free will, without undue influence.

The concept of informed consent relates to the client's right to choose whether to receive psychological services, and to make this choice on the basis of the best information available presented in the most appropriate way. The principles apply, whether the psychologist works in the public, private or voluntary sector or in independent practice.

Psychologists should obtain the informed consent of the client in an appropriate manner prior to undertaking any assessment, intervention or research activities. In all circumstances, common sense and ethical practice should apply when considering the approach to gaining informed consent from those with whom the psychologist is working.

This section refers, in the main, to consent with adults with capacity. Further information on informed consent with discrete communities where further consideration may be needed is available in ***Sections 6.1 to 6.4***.

Obtaining informed consent involves a process which is dynamic and is relevant to the specific assessment, intervention or decision being made at that time. When there are substantive changes in the intervention or when the psychologist has reason to consider the client may no longer consent, consent should be reviewed. Psychologists should ensure that their clients are enabled to play an active role in this process. Clients should be encouraged to ask questions whenever they are in doubt.

Psychologists should be aware that a client's desire for help, and the immediate impact of the psychologist's supportive listening, may affect the client's ability to make informed choices about the help they wish to receive. They should also be aware that their own desires to help a client may bias their presentation of information, such as the probability of successful outcomes.

Psychologists should be aware of the complexities of obtaining informed consent to treatment due to the perceived power, status and authority of the professional psychologist. It may not be clear if the consent given is freely given by the client or, for example, is part of a pattern of compliance towards authority figures. Equally, a client may say that they understand the explanation given by the psychologist, and accept a plan for intervention, in order to avoid the discomfort of being seen not to understand the psychologist's complex language and ideas.

Obtaining informed consent is particularly difficult when the client is obliged to undertake the psychological intervention as part of an employment process or performance measure where they may have obligations under their employment contract; or when detained.

There should ideally be an ongoing dialogue between client and psychologist, as part of the process of joint decision-making. At any point, the client should feel free to ask questions about the impact of the treatment and withdraw consent to continue.

Psychologists should attempt to intervene against the express wish of a client only after careful consideration and in line with relevant legislation, policies and professional practice.

Provision of information for informed consent

In order to ensure that the client has all the information necessary to make an informed decision about whether to take part or not in a psychological activity, they must be provided with relevant information, such as that listed below, in a format that is designed to meet their specific needs.

The psychologist should consider providing information about the following:

- what the psychological activity involves, as far as this is consistent with the model of interaction, e.g. there will be limits in the use of some non-directive therapies and psychometric assessments;
- the benefits of the activity, either directly to the client in the case of assessment or intervention, or indirectly in the case of systemic intervention, or to potential theoretical advances or service improvement;
- any alternative assessment or treatment options and their known availability;
- foreseeable risks and how minor or serious they may be, for example the potential to feel worse at stages during therapeutic interventions;
- what might be the benefits and potential costs and risks to them of engaging or not engaging in the proposed psychological activity; and
- the client's right to withdraw their consent from assessment, treatment or intervention at any stage, along with information about any likely consequences of such withdrawal.

Consent to involvement of others

Psychologists have an obligation to ensure that prospective clients are informed of the extent and limitations of confidentiality with respect to anticipated services, the purposes of any assessment, the nature of the procedures to be employed or the intended uses of any product such as notes or recordings, before the assessment or intervention starts. Further information is available in ***Section 7: Managing data and confidentiality.***

The psychologist should ask the prospective client: whom they would wish to be informed of their assessment or treatment, if anyone; and the information they are willing to share where communication is essential, for example to the referring agent or organisation, management or court. Wherever appropriate, including in the law, the client should have copies of reports or letters or be given feedback so that they are kept fully informed.

If it is deemed necessary to move from individual contact to include others this should where possible be done with the client's prior consent.

Psychologists may be asked to provide consultancy or advice to colleagues about an identified client, without that person's knowledge or when the client has indicated that they do not want to have direct contact with the psychologist. In these circumstances, the psychologist will need to consider their potential involvement and the need for consent.

A psychologist who draws upon the work of other professionals in preparing a report, should seek their consent, where possible and if not already in disclosed records, to include that material and should acknowledge its source in the report.

If a report is requested which draws upon previous or concurrent investigations of a client in other contexts, for example NHS records in the preparation of a report for the court, the client's consent or relevant authority's consent for that information to be used should be sought.

If psychologists wish to use reports on clients which have been compiled by other professionals, they should do so only with the consent of those professionals and use the reports only in the context for which the report was specifically provided.

Information on and consent to record-keeping

Express consent must be sought in advance for the use of video, audio recording or one-way screens, with a clear explanation of the purpose of these. Further information is available in ***Section 7.1: Information governance***

6.1 Informed consent for court

When a psychologist is instructed to give evidence in court, it is the court that should be informed and whose authority should be sought for the work undertaken. When serving as a witness in the legal arena, the psychologist is responsible to the court, rather than to either party.

6.2 Informed consent with children and young people

All children and young people, whatever their age or status, have a right to express their views freely and be involved in any decision-making that affects their lives, which includes judicial and administrative proceedings[40]. Therefore, psychologists who seek to work with children or young people must gain their informed consent. This applies whether the child or young person or another agent with legitimate responsibility for the child or young person has made the request for involvement. Any direction or guidance provided by parents or other caregivers must be 'in accordance with the child's evolving capabilities' and support the 'exercise by the child of his or her rights'[41]. The onus is then on the adults to provide appropriate support to enable the child or young person to express their views and contribute to decision-making.

Every psychologist should consider how they can:

- provide an accessible explanation to the child or young person about their work as a psychologist;
- offer a clear reason for their possible involvement;
- provide an opportunity for the child or young person to talk about what working with the psychologist might involve.
- discuss and agree how information is recorded and possibly shared with others with an awareness that young people who are 'Gillick competent' can consent to information not being shared with parents;

- discuss how the child or young person will be kept safe;
- ensure that the child or young person has understood the psychologist's role and has given their informed consent;
- ensure the child or young person understands they can withdraw their consent at any point;
- ensure their practice acknowledges and respects the culture, community and context of the child or young person.

Occasionally, a disagreement over consent may arise between parent/carer and child or young person and/or between parents/carers. The psychologist would make every effort to resolve the difference of views, perhaps seeking, with agreement, involvement of an appropriate family member and/or a colleague, although as discussed above, a young person who is 'Gillick competent' can legitimately request that family members (including parents) are not involved or informed of any involvement. If the disagreement is not resolved, the psychologist should draw on their professional experience to act in the best interest of the child or young person seeking consultation and support through appropriate channels, including safeguarding and legal departments, and consultation with appropriate colleagues including other professionals.

6.3 Informed consent with people who may lack capacity

It is likely that psychologists at some stage within their careers will be working with people who lack capacity to consent to assessment or treatment. This could be because of a wide range of difficulties such as intellectual disability, brain injury, dementia, severe mental health difficulties, and neurological conditions. As a result, it will often be necessary to make a judgment about a client's ability to give informed consent. This should include whether the person is able to:

- understand the information relevant to the decision (e.g. psychological treatment);
- retain that information;
- use or weigh that information as part of the process of making the decision; and
- communicate their decision (whether by talking, using sign language or any other means.)

The Mental Capacity Act 2005 contains 5 key principles which it is important to understand:

1. A presumption of capacity;
2. Individuals being supported to make their own decisions;
3. Individuals have the right to make 'unwise' decisions;
4. Anything done on behalf of a person with a mental capacity issue should be in their best interests; and
5. An intervention should be on the basis of the 'less restrictive option' weighed up in the particular circumstances of the case.

The Mental Capacity Act Code of Practice[42] expands upon these points (and indeed all aspects of the Act), highlighting the need to assist a client in making a decision for

themselves (with the use, for example, of memory aids, simplified resources, etc.). It should also be noted that the fact that a person is able to retain the information relevant to a decision for a short period does not prevent them from being regarded as able to make the decision.

The Mental Capacity Act (2005) provides a clear framework for what to do if a person lacks capacity to make a range of decisions, including consenting to treatment. The principle of 'best interest' must be followed, and the Act states clearly who needs to be consulted in relation to making such a decision and ensuring that the individual's wishes are considered.

It is good practice to give full information (possibly using adapted resources) to clients even when they are not deemed able to give informed consent. The psychologist must, so far as reasonably practicable, permit and encourage the client to participate, or to improve their clients' ability to participate, as fully as possible in any act done for the client and in any decision affecting them.

In some circumstances, it is possible that there may be others who have been given legal authority for decision-making on behalf of others, such as Power of Attorney for Health and Welfare or Deputyships for Health and Welfare. It is important to note that patients might also have created Property and Affairs Lasting Powers of Attorney. Those acting under a Property and Affairs power alone will not have authority to make decisions in relation to a patient's treatment. If someone is a Health and Welfare Attorney or Deputy, those persons will be able to make those decisions on behalf of others. It is also necessary to ensure that the client has not made an Advance Decision to refuse treatment prior to the loss of capacity, although this is unusual in relation to psychological treatment.

In some clinical contexts, particularly relating to brain injury, intellectual disabilities and dementia, issues related to capacity and best interest are particularly prevalent. Psychologists practising in these areas need to ensure sufficient knowledge and expertise. Further information is available in ***Society Document: Guidance on determining the best interests of adults who lack the capacity to make a decision for themselves.***

6.4 Informed consent with people as employees

Tripartite arrangements where an employer commissions and pays for an assessment or intervention, such as diagnostic assessments for neurodiversity and cognitive functioning return to work assessments, or coaching, potentially give the employer access to data that they will struggle to interpret, or may misinterpret, for example test scores and details of personal life. It is important that the psychologist protects the employee by giving the employer only what they need to know and can reasonably require for the purpose of employment.

The Psychologist should consider whether they will be gathering information that is not usually held by an employer, or is not held routinely for all employees, for example IQ scores and childhood experiences. If so, the psychologist should consider abridging documentation so that the employer receives only the information they 'need to know',

and the employee can if necessary hold a full copy for future reference. This prevents discrimination against employees who are subject to in depth assessment for reasons related to illness, neurodiversity or disability from being unfairly compared to their peers. It also prevents complex psychological information from being held by those who are not qualified to interpret it.

Agreements should be made explicitly about the information which can be shared with the commissioning organisation. In order to aid transparency, information should normally be sent to the client prior to being shared with the organisation.

6.5 Informed consent with detained persons

Prisoners

Informed consent may be harder to obtain when a client is detained. Psychologists working with detained persons should be aware that, as well as UK law, the UK is signatory to a number of conventions on the treatment of detained persons. These conventions not only outlaw physical ill-treatment, but also certain kinds of psychological pressure. For example, it is contrary to the UN Convention on Torture to apply psychological pressure to elicit a confession, or compliance with a regime. In this context, 'psychological pressure' could include making progression contingent on compliance with a particular aspect of the regime. Practitioners should be particularly mindful of the power imbalance in forensic contexts, which is far more acute than is generally found in non-justice system based settings. Only offenders detained in secure hospitals can be required to comply with assessments or treatments under involuntary detention sections of the Mental Health Act.

Mental Health Detentions

For psychologists there can be potential conflicts of interest or what could be better termed 'competing duties of care' between the roles of Responsible Clinician (RC) (for further information on this role see Section 3.5) (including the duty to detain or otherwise compel participation in treatment) and that of psychologist (including, principally, the duty to establish freely-given consent wherever possible to enhance the efficacy of the therapeutic intervention). The MHA Code at chapter 24.34 (medical treatment) states that permission given by a patient to a particular treatment 'under any unfair or undue pressure' is not consent (p.257).

Good outcomes for psychological therapies are associated with positive therapeutic alliances and good working relationships between therapists and patients. The potential for even perceived abuse of power and the inherent power differential between an RC and a detained patient subject to the MHA runs a risk of rupturing this relationship or it becoming coercive. Psychologist RCs must therefore remain aware of and give full consideration to any potential competing duties of care between the RC and psychological therapist roles when providing psychological treatments to patients over whom they have compulsory powers.

The main issues to be considered by psychologist RCs when addressing potential competing duties of care in this context include the following:

1. Psychological treatments (with the possible exception of indirect interventions delivered by proxies such as paid staff and carers) are more likely to be effective when informed consent is obtained. As such, RCs acting as psychological therapists should utilise all reasonable and ethical attempts to obtain consent from patients before proceeding with psychological treatment. The *Code* at chapter 24.34–24.39 (p.257) provides guidance on obtaining consent.
2. The Act permits psychological treatment to be given without consent and the Code provides guidance on how to proceed with treatment in these circumstances (chapter 24.40–24.44, pp.257–258). There may be circumstances, especially when significant risks to others or self have been identified, when it is considered to be necessary for a psychologist RC to proceed with providing psychological treatment without consent. In such circumstances then there should be, where practicable, prior discussion with the MDT involved in the patient's treatment and care about the risks involved. Careful consideration should be given to the availability and merits of another suitably qualified member of the team providing the psychological treatment required with the RC remaining in overall charge of the client's care.
3. There may be situations where it is judged that informed consent cannot be clearly obtained, or where it would appear another available practitioner would be more likely to achieve a more effective outcome (perhaps due to the power differential between patient and RC). In such situations the psychologist RC is advised to refer on to other members of the treatment team who are able to provide the psychological treatment needed, while the RC remains in charge of overall care.

7. Managing data and confidentiality

7.1 Information governance

Psychologists should follow local and national guidance and statutory responsibilities regarding management of data. Psychologists should make, keep and disclose information in records only in accordance with national policy and legislation, and the policies and procedures of the organisation(s) they are employed by/working in collaboration with. Further information is available in ***Section 1.1: Legal and professional obligations of psychologists, Appendix 1: Relevant legislation*** and ***Appendix 2: Websites and further information.***

Psychologists must bear in mind the potential impact of the information in their records on all who may have access to such records, for example, the client, other professionals, managers, authorised carers, etc. Where possible, distinction should be made between fact, observation and opinion, and judgemental comments should be avoided. Psychologists are responsible for holding their records securely to ensure the confidentiality of the information contained within them and to control access to them. Further information is available in ***Society Guidance: Guidelines on the use of Electronic Health Records.***

This guidance applies to all record-keeping on clients, their relatives, carers and/or associates, and their organisations, regardless of the media in which information is held, e.g. written notes and reports, audio- and video-recordings, paper and electronic records, etc.

Records made, kept or accessed by psychologists should be:

- systematic and appropriately detailed;
- in clear language/format;
- accurate;
- up to date; and
- relevant to professional work and to the purpose for which they were collected.

Clients have a legal right to access records concerning them, and this right is enshrined in legislation. Additionally, it is good practice for clients to be given feedback on their content. Sharing records with clients supports the collaborative approach of psychologists and enables clients to have full and effective involvement. Client access to records will be restricted to information about themselves and not third parties. Restrictions will also apply when disclosure would place the clients or others at risk of serious harm.

In tripartite arrangements involving an employer access to information should be governed by agreements made explicitly about the information which can be shared with the commissioning organisation.

Shared records

In some organisations in which psychologists work single, multi-professional, client-based records are held. Such records are designed as shared documents (paper or electronic),

the function of which is primarily to facilitate inter-professional communication to ensure the safe and effective delivery of high quality services. Such records may be shared among organisations/agencies to facilitate care and/or exceptionally, to safeguard the client or others, including the general public. In some contexts, clients have the right to object to their data being disclosed to a third party even someone who might provide essential healthcare. Psychologists should be aware of local codes and policies. Further information is available in ***Section 3.5: Working with other professionals***, ***Section 7: Managing data and confidentiality*** and ***Appendix 2: Websites and further information.***

Psychologists should include in the shared record all information about their work with clients and related others which is required to ensure appropriate multi-professional care and to safeguard the client and relevant others, including the general public.

Third-party and sensitive material should be clearly marked. There should be clarity/clear communication within the multi-professional team about what is and is not shared with the client if there are safeguarding concerns. A system needs to be established about how suspicions and causes of concern are recorded and/or shared.

Where shared records are held, other professionals involved with the clients will have access to such records. This should be explained to the clients at the onset of engagement with them.

The use of sealed envelopes is no longer considered good practice following the findings from serious untoward incident investigations where the existence of sealed envelopes compromised care.

Assessment materials

Psychologists should be mindful at all times of the confidential nature of assessment materials. Many assessment measures are invalidated by prior knowledge of their specific content and objectives. Psychologists who use these materials are required to respect their confidentiality and to avoid their release into the public domain (unless this is explicitly allowed in the nature of the instrument and by the test publisher). Psychologists should, therefore, take reasonable steps to prevent misuse of test data and materials by others. Further information is available from ***Appendix 2: Websites and further information.***

In many organisations, there is only one shared records system. In these cases, it is necessary for psychologists to be able to use the shared records system to hold raw data from psychometric assessment. The results of psychometric assessment will be incorporated into reports which explain their context and appropriate interpretation, and which are included in the shared institutional record. In relation to the visibility of the psychometric instrument and the raw data to other members of the multidisciplinary team who are not psychologists, the onus is on the other professionals not to interpret information where they are unqualified to do so, just as the psychologist would not interpret, for example, physical healthcare test results they are unqualified to interpret. Psychologists may consider whether it is appropriate to mark assessment materials so their nature is clear.

Additional data

Psychologists may wish to keep separate notes to aid their work but which are not intended for sharing with others or to be part of the permanent client record. These notes, often called process notes, which are written for the purposes of reflection on practice, should be anonymised with no other identifying links e.g. initials, appointment time, so that these notes therefore are clearly not part of the client record. Process notes may, for example, be used for reflection and supervision. If process notes are made to assist in compilation of a report, the material should be incorporated, as relevant, into the final report and the process notes then destroyed.

Long-term illness, incapacity or death of a psychologist

Most organisations will have procedures in place in the event of illness, incapacity or death of a psychologist. Psychologists in independent practice are advised to make a professional will and to appoint a professional executor, probably an experienced colleague, whose role it would be to take charge of client records, to inform the clients involved and, where appropriate and practicable, to make provision for continuity of the service provided.

Retention and destruction of records

Psychologists' records should be held securely for as long as they are required for the purpose of psychological work. Psychologists must follow legal requirements, national and local policy frameworks and procedures regarding the retention or disposal of records after the psychologist's work is concluded. Psychologists should ensure that they keep up to date with requirements.

For independent practitioners general guidance is that many independent psychologists keep records relating to contact with adults for 7 years, and follow NHS guidance in relation to children. Where the records derive from work undertaken within an organisation, the maintenance of these records is determined by the organisation's policies and legal requirements.

Retention and destruction of health records, both paper and electronic, is covered in the NHS code of practice for records management. Generally speaking, retention is until age 26 for people seen as children; 20 years after the last contact for adults, and 8 years after death if the death occurred while the person was in the care of the NHS. There are specific requirements for mental health services depending on the nature of the contact.

In education settings, Local authorities generally retain Education Health and Care Plans for 35 years after the case has been closed. Other records are retained until the child is 25.

All records must be destroyed under confidential conditions following organisational procedures or for independent practitioners using a destruction service or process which meets industry standards for document management and can provide the appropriate certification.

7.2 Confidentiality

Clients are entitled to expect that the information they give to psychologists about themselves and others will remain confidential. Psychologists have a duty not to disclose

such information except as discussed below and to bring their confidentiality practice to the attention of their clients, employers, managers and any other professionals involved.

Psychologists have a duty to inform involved parties of their confidentiality standards and practice at the point of first contact. Clients should be informed of the limits of confidentiality where information about them may be shared and confidentiality breached, for example for reasons of safeguarding, requirements of the law, and public protection.

Psychologists have a duty to be aware of the content of any other relevant guidelines and of any other policy guidelines which set out local expectations.

Use of client data for audit must follow the Caldicott principles, which, designed for the NHS, provide helpful guidance for any setting in terms of when it is appropriate to use with client-identifiable data and when anonymised data should be used[43]. Generally under data protection legislation, it is necessary to obtain specific informed consent for the use of client data for particular purposes, and to inform clients of the purposes for which their data is being collected and how it will be used. Further information is available in ***Appendix 2: Websites and further information.***

Disclosure of information

If disclosure of information is deemed necessary, psychologists should obtain specific informed consent from their clients, making the consequences of disclosure as clear and unbiased as possible. There are a number of circumstances where this might not be possible or may not apply: for example where the health, safety, security or welfare of the client or someone else may otherwise be put at risk; and if there are legal or safeguarding responsibilities, such as the need to avoid 'tipping off'. If confidentiality is broken without consent, the client should be told what has been said and to whom, unless such disclosure may expose the client or others to serious harm or is contrary to legal or safeguarding obligations.

Psychologists who are faced with the difficult decision as to whether to disclose information without a client's consent must weigh carefully the arguments for and against disclosure. The responsibility for this decision lies with the individual psychologist although they may seek advice and guidance from appropriate sources such as their employing organisation's Information Governance or Data Protection Lead, Clinical Governance Lead, Caldicott Guardian, Safeguarding named and designated professionals, or legal departments. These other professionals can be the most helpful sources of advice in difficult disclosure situations. Independent practitioners may wish to consult the legal helpline of their professional indemnity insurer.

Circumstances may emerge where clients may present a risk to others or to themselves, or be at risk from others whom they wish to protect. It is then necessary to discuss the importance of disclosure and to encourage it, for example to partners of HIV positive clients, and to employers if a client's mental health status presents a risk to others via driving, handling machinery or interaction in a working situation, for example, flight deck crew. Disclosure without consent, or against the client's expressed wish may be necessary in situations in which failure to disclose appropriate information would expose the client, or

someone else, to a risk of serious harm (including physical or sexual abuse) or death.

The psychologist must weigh up the needs and interests of their own client against the wider welfare, protection and safeguarding of the public.

Disclosure to clients' employers, insurance companies and others

Psychologists have a duty to ensure, at first contact, that clients understand the purpose of any assessment undertaken at the request of employers, the DVLA or insurance companies, and of the psychologist's obligation to disclose the results of that assessment. In the case of assessment for fitness to work or to drive, they should obtain the client's written consent.

Psychologists should consider what each party involved needs to know, gaining understanding and agreement on which aspects will be fed back, in advance. For example, the full detailed and raw scores obtained by a psychologist in recruitment assessment processes may be unsuitable for an employer to receive in full. The commissioning body should be made aware of the decision-making data that they originally requested, in the case of an employer this could include strengths and weaknesses, and recommendations for employer actions, for example.

Primary clients should be advised about and able to preview, with opportunity to ask questions first, any data that will be sent to an employer about them. Bear in mind that the informed consent difficulties still stand and that an employee or potential employee can withdraw consent for the employer to be informed of any part of their results.

This can be very difficult to manage in practice, and requires psychologists to make these agreements with their commissioners before they start the work, so that all are informed of the risks in the service delivery. Further information is available in ***Section 3.4: Working with multiple clients.***

Disclosure after a client's death

After a client's death, relatives or other authorities may seek access to the psychologist's records. In the first instance, the psychologist is advised to follow organisational procedures where they exist which usually deal with the administrative proofs required such as proof of death, proof of kinship and right to access the material requested.

A psychologist's duty of confidentiality continues after a client has died. The psychologist will need to weigh up the circumstances around the request for disclosure and what personal information is being sought. If there has been a specific request by the client for their information to remain confidential, their wishes should usually be respected. If the psychologist is unaware of any instructions from the client, when considering requests for information the following should be taken into account:

- the purpose of the disclosure;
- whether the disclosure of information is likely to cause distress to, or be of benefit to, the client's partner or families;
- the permission of a surviving relative or next of kin is not required, and does not authorise disclosure of confidential information, although the views of those who were close to the client may help the psychologist decide if disclosure is appropriate;

- whether the disclosure will also disclose information about the client's family or anyone else; and
- whether the information is already public knowledge or can be anonymised or coded.

There may be circumstances where the disclosure of information is required, for example:
- to support an inquest or fatal accident inquiry;
- where the disclosure is required by law, is authorised under section 251 of the NHS Act 2006, or is justified in the public interest, such as for education or research;
- in the case of national confidential inquiries or for local clinical audit; and
- when a person has a right of access to records under the Access to Health Records Act 1990 or Access to Health Records (Northern Ireland) Order 1993.

7.3 Confidentiality when safeguarding

In exceptional circumstances it may be necessary to breach the client's confidentiality with or without their immediate knowledge or consent. This would be the case where there are significant risks to the client's psychological wellbeing; where the alleged perpetrator may be a current risk to others or where there is risk of jeopardising a potential investigation. Any decision to breach confidentiality cannot be taken lightly, but can be justified and accounted for if made in good faith because of safeguarding concerns. This is supported by professional guidance. The focus of any intervention including any breach of confidentiality must be on promoting a proportionate, measured approach to balancing the risk of harm with respecting the client's capacity to consent, their choices and preferred outcome for their own life circumstances.

Specified authorities may need to share personal information to ensure, for example, that a person at risk of radicalisation is given appropriate support. When considering sharing personal information, the specified authority should take account of the following:
- necessity and proportionality: personal information should be shared only where it is strictly necessary to the intended outcome and proportionate to it. Key to determining the necessity and proportionality of sharing information will be the professional judgement of the risks to an individual or the public;
- consent: wherever possible the consent of the person concerned should be obtained before sharing any information about them;
- power to share: the sharing of data by public sector bodies requires the existence of the power to do so, in addition to satisfying the requirements of the Data Protection Act 1998 and the Human Rights Act 1998; and
- Data Protection Act and the Common Law Duty of Confidentiality: in engaging with non-public bodies, the specified authority should ensure that they are aware of their own responsibilities under the Data Protection Act and any confidentiality obligations that exist.

In relation to health sector staff, government guidance states it is important that staff understand how to balance client confidentiality with the duty to report. They should also be made aware of the information-sharing agreements in place for sharing information with other sectors, and get advice and support on confidentiality issues when responding

to potential evidence that someone is being drawn into terrorism, either during informal contact or consultation and treatment.

7.4 Confidentiality for the court

Psychologists acting as expert or professional witnesses have a duty to disclose all of the evidence used to reach their opinion where directed by the court to do so.

This could include:

- the details of any tests and assessments administered with professional colleagues;
- notes made during report writing; and
- referenced academic articles or studies.

No information relating to an assessment or report should be disclosed outside the relevant proceedings without agreement. Psychologists should normally seek permission from the instructing party to disclose any information to another health care professional.

Where instructed directly by the court, the Crown Prosecution Service, Procurator Fiscal or a solicitor, the psychologist is required to report or comment on any or all aspects of the case that appear to the psychologist, as an expert in the field, to be relevant or pertinent. In such circumstances, the psychologist is not in a position to offer confidentiality to any person, and should make this position clear to any party with whom they have contact during psychological investigations or assessment.

In these circumstances, it will be important that the psychologist makes sure they are up to date with the legislation and policy guidance regarding public and media access to information available to whichever court or tribunal their instruction arises from. The psychologist will need this awareness so that they can explain to the adult or child concerned what the limits of privacy are in these legal circumstances. They will need to make clear to the client which information needs to be made accessible, by whom and under what circumstances. Only when the client understands this, can they give informed consent.

There are different levels of access to sensitive information in different legal contexts; this will include testimony, documents and professional and expert reports. Many proceedings typically take place in open court, to which the public has access. In these cases, there is a presumption in favour of providing information and documents to third parties which were relied upon by the court in reaching its decision, though not the entire court file.

Where court papers and other materials are received in electronic format, psychologists should ensure that these are stored in a secure, password-protected format. This may require the addition of additional security for documents that arrive in an unsecured form. Where psychologists submit reports in an electronic format they should ensure that these are in a secure, password-protected format.

Psychologists working with clients who are the subject of court proceedings may need to be careful to ensure that they keep all records which may be of relevance to the court process until it is clear that the court has reached a final conclusion, including any appeal that may have been heard.

With few exceptions, applications in the family court are heard in private, with only those immediately involved being allowed to attend and access information. It is possible, however, for duly accredited members of the media to attend hearings in the family court, subject to the power to exclude them on specified grounds.

In most family court proceedings, media representatives have no entitlement to receive or peruse court documents referred to in the course of evidence, submissions or judgment. If media representatives wish to see documents referred to in the family court they may apply to the judge for disclosure but they are subject to strict guidance in terms of what information they can divulge into the public domain.

7.5 Confidentiality with children and young people

When beginning direct work with a child or young person, the psychologist should discuss and agree who will have access to the information arising from the work, with direct reference to principles of 'Gillick competence'. In undertaking this discussion it is helpful to acknowledge that there may be those adults (e.g. parents/carers, other relevant professionals such as teachers, social workers, counsellors) who may have a supportive interest in the work and may wish to have appropriate access to information but the wishes of a 'Gillick competent' young person should take precedence unless there are safeguarding concerns.

Parents or those with legal responsibility may be made aware of this agreement if appropriate, although a young person deemed to be Gillick competent is able to agree to work with a psychologist independently. Those with parental responsibility do not have an automatic right of access to the psychologist's records by making a subject access request under data protection legislation.

The nature and purposes of any work will vary and this will determine how and to whom information will be shared, however the child or young person should always be made aware of who will have access to what and for what purpose and due consideration given to the wishes of a 'Gillick competent' young person about who can have access to information about any involvement with a psychologist. The child or young person should be fully aware of the content of any shared information, including as appropriate, copies of the documents. Whatever is agreed about information sharing including work where information is confidential, the psychologist must ensure the child or young person knows and understands that if there is a risk of harm the psychologist must follow safeguarding procedures.

7.6 Confidentiality with detained persons

When detained persons give informed consent to the collection of information, they do so for a specific purpose and for use by specific people. The use of such information for a different purpose or for use by different people would require separate consent. Thus, although a psychologist may interview and write a report on a detained person, consent for that purpose cannot be taken as allowing a third party access to the psychologist's records on that person, such as notes on (or recordings of) the interview. If psychologists are

put under pressure to reveal such information, they should seek the advice of colleagues including for example those responsible for governance or data protection. They should bear in mind that they have a legal duty to be aware of and comply with data protection legislation and professional confidentiality rules.

7.7 Confidentiality obligations during training

During training, no academic/training documents should identify clients to whom they relate (even by means for example of initials, service name or date of appointment) as any such potential identifiers could be used to trace the client and therefore make the document a part of the clinical record and subject to the relevant provisions of data protection legislation. This includes published reports, case studies prepared for trainee assessments and any articles or publications. Tutors and supervisors should communicate this to their trainees. Trainees should be clearly instructed to both make and keep separately those records which are part of the provision of psychological service and which belong to the service organisation and are subject to its policies and procedures; and papers which are anonymised and are part of the trainee's academic learning, and belong to the trainee and are subject to the training provider's policies and procedures.

Express consent should be obtained by trainees before audio- or video-recording their interactions with clients. If the client is unable to give informed consent, it is unlikely to be appropriate for the recording to be made. Careful consideration should be given before any material is recorded if the client is party to any legal proceedings or family or employment disputes. If material is to be used for purposes other than client care (including teaching and research), the client should be informed of the purposes of the recording. It should be made clear to clients how the material will be used and to whom it will be disclosed, for example, trainee students, other researchers, and supervisors.

The trainee and the client should come to an agreement about how long recorded material should be kept. The general principle is that recordings will be kept for as long as needed to fulfil the purpose for which the client has given consent and no longer. The security of the material must be maintained, and it must be destroyed at the agreed time limit if no longer required.

Informed consent is required before client material in an identifiable format may be published in case studies, presentations or other research reports. It is becoming common practice for clinical material in professional doctorate portfolios to be stripped out before the thesis is placed in online institutional repositories.

8. How to respond when things go wrong

8.1 Managing conflict with a client

Conflict with a client suggests that someone's expectations are not being met. The first objective should be to restore agreement or agree to make changes. The well prepared psychologist will have a client agreement in place and will be able to review the experience against the agreement with the client to address this question. Further information is available in ***Section 5: Making and maintaining agreements***. Even in the absence of an agreement, the psychologist would be advised to enquire with the client where their expectations are unmet or raise their own unmet expectations with the client. This can be an opportunity to put a belated agreement in place.

It may be that the parties agree to set aside the agreement and bring it to an early close. Agreeing to disagree may be a better outcome for psychologist and client who cannot restore agreement. Take account of any need for onward referral either within the service or elsewhere or back to the original referrer, and depending on the nature of the work setting, any financial obligations in closing the work.

The psychologist may find it helpful to consult with appropriate colleagues in preparation for the conversations with the client, such as line or service managers, those with other relevant organisational responsibilities, and supervisors. There may be more general lessons to be drawn as part of reflective practice in relation to the quality of the client agreement for future use.

8.2 Transparency and duty of candour

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 duty of candour (regulation 20) requires all health and adult social care providers registered with the Care Quality Commission to be open with people when things go wrong. Psychologists need to be aware of the terminology relating to this regulation including:

- openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered;
- transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators; and
- candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Psychologists also have a responsibility to ensure that they engage in open and transparent communications with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. Guidance from the Care Quality Commission on duty of candour outlines the specific requirements that providers must follow when things go wrong with care and treatment, including informing people about

the incident, providing reasonable support, providing truthful information, and making an apology. Psychologists are instrumental in supporting organisations to promote a culture that encourages candour, openness and honesty at all levels. Further information is available in ***Appendix 2: Websites and further information.***

8.3 Managing conflict in team settings

Dealing with breakdowns in working relationships, professional disagreements and fitness to practise concerns

As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues (including relating to consultation/supervision or line management) by clear communication, relevant evidence and collaboratively working through the issues in reasoned argument within the context of respectful relationships.

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

Where there is serious or continual disagreement, both parties need to take whatever action is appropriate in their professional context, consulting other experienced professionals as necessary.

Supervisors and line managers have professional obligations concerning professional standards, ethical practice and 'fitness to practise' issues. If line managers or supervisors have any concerns regarding performance in these areas, they have a duty to discuss these with the psychologist and, if necessary, address the matters by in the first instance following appropriate employment policies and procedures, or in the case of an independent practitioner, making a report to the HCPC.

Working in multi-professional or multi-agency contexts

Psychologists may find themselves in conflict with the approaches to work taken by other individual colleagues or by the multi-professional team or agency.

Psychologists should bring to the awareness of the multi-professional team or agency any difficulty in the group working together which may impact on the psychologist's ability to function effectively and ethically in their role. Such issues are best addressed when guided by national and local policy and current legislation before proceeding with multi-professional/multi-agency collaboration. Further information is available in ***Appendix 1: Relevant legislation.***

The psychologist may also have cause for concern about the ability of the team to provide for the needs of the client owing to interpersonal difficulties between members of the multi-agency or multidisciplinary team that might have an indirect impact on the client. As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues by clear communication, relevant evidence and collaboratively

working through the issues in reasoned argument within the context of respectful relationships.

If the situation remains unresolved for any reason, for example because it is judged not to be an issue for active management, the psychologist must make a judgement about whether their involvement in the team is helpful to the client or the working of the team. If not, the psychologist should consult with an appropriate colleague about whether they should disengage from that team.

A psychologist may also experience concerns about the competence or ethical practice of individual colleagues involved in joint working. These concerns may relate to the competence of the colleague to carry out a particular intervention, the appropriateness of an intervention for a particular client or problem, the nature of the relationship between a colleague and his or her client (e.g. potential abuses of power).

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

If they conclude that misconduct has occurred, psychologists should bring the matter to the attention of those charged with the responsibility to investigate such concerns, generally in the first instance an employer or in the case of an independent practitioner, the HCPC. Further information is available in ***Section 2.1: Working environment.***

8.4 Supporting a colleague when a complaint has been made

The receipt of a complaint or allegation can be distressing for all concerned, not least for the person who is the subject of the complaint or allegation. It is important that they receive advice and support from appropriate persons. Any potential conflicts of interest should be considered. It may be that a psychologist is not best placed to offer support and guidance as they may be called as a witness in the complaints process. Encourage colleagues to seek advice from an experienced colleague or supervisor where appropriate.

The psychologist should also be encouraged to seek the support of an accredited workplace trade-union representative who is skilled at supporting people in these situations and can access legal advice if necessary. Legal advice can also be obtained from the professional indemnity insurance broker, and sometimes from household insurance policies where the householder has taken out the legal advice additional option.

Complaints are an increasingly normal occurrence and must be handled in a professional manner. The complaint investigator or professional body will need the psychologist's version of events and any evidence before any conclusions are reached. Psychologists should support colleagues to respond promptly, objectively, factually and honestly to the complaint. The content of the complaint should always be held in confidence.

8.5 If the client remains unhappy

If any conflict or issue as referred to in this section cannot be resolved, it may be appropriate to advise a client or other individual that that they have a right to raise any concerns about a psychologist with the Health and Care Professions Council, further details of which can be found at www.hcpc-uk.org

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Role	Name
Chair of the Practice Guidelines Working Group	Nicola Gale
Academics, Researchers and Teachers in Psychology	Simon Goodson
Children, Young People and their Families	Katie Hunt
Clinical Psychology	Tejinder Kondel and Ste Weatherhead
Coaching Psychology	Paul Philipps
Community Psychology	Ho Law
Counselling Psychology	Helen Nicholas
Crisis, Disaster & Trauma	John Durkin
Defence and Security	Fiona Butcher and Karen Carr
Education and Child Psychology	Charmian Hobbs
Ethics	Martin Fisher
Expert Witness Advisory Group	David Crighton
Forensic Psychology	Robert Forde
Health Psychology	Andrew Haig-Ferguson
Independent Practice	Sonya Wallbank and Jill Wilkinson
Informatics	Graham Fawcett
Intellectual Disabilities	Kate Theodore
Mental Capacity Advisory Group	Gemma Gray

Role	Name
Mental Health Act Advisory Group	John Taylor
Neuropsychology	Katherine Carpenter
Northern Ireland	Alison Clarke
Occupational Psychology	Nancy Doyle, Julie Freeborn, Almuth McDowell and Rainer Kurtz
Older People	Carolien Lamers
Prevent	Clare Fuller
Psychology of Sexualities	Jimmy Couzens
Psychotherapy	Ho Law
Race and Culture	Zenobia Nadirshaw
Safeguarding Advisory Group	Gill Evans, Liz McMonagle and Anne Peake
Scotland	Louise Richards
Social Inclusion	Anna Daiches
Sport and Exercise Psychology	Lee Ann Sharp
Wales	Nicola Massie
Experts by Experience	Joanne Hemmingfield and Simon Mudie
Legal Support	Stephen Pearson, Freeths LLP
Administrator	Emma Smith
Editorial Support	Sally Anderson
Policy Advisor (Professional Practice)	Hannah Farndon

Appendix 1 – Relevant legislation

Unless otherwise stated, Acts can be found on the government website http://www.legislation.gov.uk/

United Kingdom and England

Care Act 2014

An Act to make provision to reform the law relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding adults from abuse or neglect; to make provision about care standards; to establish and make provision about Health Education England; to establish and make provision about the Health Research Authority; to make provision about integrating care and support with health services; and for connected purposes.

Care Standards Act 2000

An Act to establish a National Care Standards Commission; to make provision for the registration and regulation of children's homes, independent hospitals, independent clinics, care homes, residential family centres, independent medical agencies, domiciliary care agencies, fostering agencies, nurses agencies and voluntary adoption agencies; to make provision for the regulation and inspection of local authority fostering and adoption services; to make provision for the registration, regulation and training of those providing child minding or day care' to make provision for the protection of children and vulnerable adults; to amend the law about children looked after in schools and colleges.

Children Act 1989

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Children and Families Act 2014

An Act to make provision about children, families, and people with special educational needs or disabilities; to make provision about the right to request flexible working; and for connected purposes.

Data Protection Act 1998

An Act to make new provision for the regulation of the processing of information relating to individuals, including the obtaining, holding, use or disclosure of such information. The Act states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- fairly and lawfully processed;

- processed for limited purposes;
- adequate, relevant and not excessive;
- accurate and up to date;
- not kept for longer than is necessary;
- processed in line with your rights;
- secure; and
- not transferred to other countries without adequate protection.

Equality Act 2010

An Act to make provision to require Ministers of the Crown and others when making strategic decisions about the exercise of their functions to have regard to the desirability of reducing socio-economic inequalities; to reform and harmonise equality law and restate the greater part of the enactments relating to discrimination and harassment related to certain personal characteristics; to enable certain employers to be required to publish information about the differences in pay between male and female employees; to prohibit victimisation in certain circumstances; to require the exercise of certain functions to be with regard to the need to eliminate discrimination and other prohibited conduct; to enable duties to be imposed in relation to the exercise of public procurement functions; to increase equality of opportunity; to amend the law relating to rights and responsibilities in family relationships; and for connected purposes.

Health and Social Care Act 2012

An Act to establish and make provision about a National Health Service Commissioning Board and clinical commissioning groups and to make other provision about the National Health Service in England; to make provision about public health in the United Kingdom; to make provision about regulating health and adult social care services; to make provision about regulating health and social care workers; to make provision about public involvement in health and social care matters, scrutiny of health matters by local authorities and co-operation of health care services; to make other provision about information relating to health or social care to make other provision about health care; and for connected purposes.

Mental Capacity Act 2005

An Act to make new provision relating to persons who lack capacity; to establish a superior court of record called the Court of Protection in place of the office of the Supreme Court called by that name; to make provision in connection with the Convention on the International Protection of Adults signed at the Hague on 13th January 2000; and for connected purposes.

Mental Health Act 1983 as amended 2007

An Act to consolidate the law relating to mentally disordered persons. The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

Offender Rehabilitation Act 2014

An Act to make provision about the release, and supervision after release, of offenders; to make provision about the extension period for extended sentence prisoners; to make provision about community orders and suspended sentence orders; and for connected purposes.

Official Secrets Act 1989

An Act to replace section 2 of the Official Secrets Act 1911 by provisions protecting more limited classes of official information.

Regulation of Investigatory Powers Act (RIPA) 2000/Investigatory Powers Act 2016

An Act to make provision for and about the interception of communications, the acquisitions and disclosure of data relating to communications, the carrying out of surveillance, the use of human intelligence sources and acquisitions of the means by which electronic data protected by encryption or passwords may be decrypted or accessed; equipment interference, bulk personal datasets and other information; to make provision about the treatment of material held as a result of such interception, equipment interference or acquisition or retention; to establish the Investigatory Powers Commissioner and other Judicial Commissioners and make provision about them and other oversight arrangements; to make further provision about investigatory powers and national security; to amend sections 3 and 5 of the Intelligence Services Act 1994.

Safeguarding Vulnerable Groups Act 2006

An Act to make provision in connection with the protection of children and vulnerable adults. Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.

Northern Ireland

Children Act 1989 – NI has a Criminal Justice Children's Order 1998

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Criminal Justice (Northern Ireland) Act 2013

An Act to amend the law relating to sex offender notification, sexual offences prevention orders and human trafficking; to provide for the destruction, retention, use and other regulation of certain fingerprints and DNA samples and profiles; to provide for the release on license of persons detained under Article 45(2) of the Criminal Justice (Children) (Northern Ireland) Order 1998.

Criminal Justice (Northern Ireland) Order 2008 and Public Protection Arrangements in Northern Ireland (PPANI)

The Criminal Justice (NI) Order 2008 introduced a new sentencing framework, including extended and indeterminate sentences for public protection to reduce the risk of dangerous sexual and violent offenders being released into the community until the risk they pose is considered by the parole commissioners to be at a manageable level. The Public Protection Arrangements in Northern Ireland (PPANI) contained within the Criminal Justice (NI) Order 2008, place a duty on a number of agencies, within the criminal justice sector and elsewhere, to cooperate in the interest of better assessment and management of risk posed by serious sexual and violent offenders.

Justice Act (Northern Ireland) 2015

An Act to provide for a single jurisdiction for county courts and magistrates' courts; to amend the law on committal for trial; to provide for prosecutorial fines; to make provision in relation to victims and witnesses in criminal proceedings and investigations; to amend the law on criminal records and live links; to provide for violent offences prevention orders; to make other amendments relating to the administration of civil and criminal justice; and for connected purposes.

Mental Capacity Act (Northern Ireland) 2016

This Act fused mental health and mental capacity law into a single piece of legislation. The Act provides a framework for broader decision-making which includes: a statutory presumption of capacity, a requirement to support decision-making, mechanisms to allow individuals to plan for times that they do not have capacity, and safeguards to protect the rights of individuals when compulsory interventions or substitute decisions are required. It will remove the ability for someone to be treated for a mental health condition against his or her wishes if he or she retains the capacity to refuse such treatment, thus putting it on a par with the rights that individuals currently enjoy to make decisions regarding physical health treatment.

The Parole Commissioners' Rules (Northern Ireland) 2009

The Parole Commissioners for Northern Ireland are an independent body responsible for making decisions on the release and recall of prisoners sentenced to life, indeterminate custodial sentences, and extended custodial sentences, as well as the recall of prisoners serving determinate sentences.

The Sexual Offences (Northern Ireland) Order 2008

The Sexual Offences (Northern Ireland) Order 2008 lowered the age of sexual consent from 17 to 16 and incorporated significant changes to the law in relation to sexual offences in Northern Ireland; better protection for young people and people with a mental disorder from sexual abuse and exploitation; and sought to clarify issues surrounding consent in sexual assault cases and rape.

Scotland

Adoption and Children (Scotland) Act 2007

An Act of the Scottish Parliament to restate and amend the law relating to adoption; to make other provision in relation to the care of children; to enable provision to be made in relation to allowances in respect of certain children; and for connected purposes.

Adults with Incapacity (Scotland) Act 2000

An Act of the Scottish Parliament to make provision as to the property, financial affairs and personal welfare of adults who are incapable by reason of mental disorder or inability to communicate; and for connected purposes.

Adult Support and Protection (Scotland) Act 2007

An Act of the Scottish Parliament to make provision for the purposes of protecting adults from harm; to require the establishment of committees with functions relating to the safeguarding of adults who are at risk of harm; to amend the law relating to incapable adults; to allow the Public Guardian to intervene in court proceedings; to amend the law relating to mentally disordered persons; and for connected purposes

Children (Scotland) Act 1995

An Act to reform the law of Scotland relating to children, to the adoption of children and to young persons who as children have been looked after by a local authority; to make new provision as respects the relationship between parent and child and guardian and child in the law of Scotland; to make provision as respects residential establishments for children and certain other residential establishments; and for connected purposes.

Children and Young People (Scotland) Act 2014

An Act of the Scottish Parliament to make provision about the rights of children and young people; to make provision about investigations by the Commissioner for Children and Young People in Scotland; to make provision for and about the provision of services and support for or in relation to children and young people; to make provision for an adoption register; to make provision about children's hearings, detention in secure accommodation and consultation on certain proposals in relation to schools; and for connected purposes.

Mental Health (Scotland) Act 2015

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

Mental Health (Care and Treatment) (Scotland) Act 2003

An Act of the Scottish Parliament to restate and amend the law relating to mentally disordered persons; and for connected purposes.

Protection from Abuse (Scotland) Act 2001

An Act of the Scottish Parliament to enable a power of arrest to be attached to interdicts

granted to protect individuals from abuse; to regulate the consequences of such attachment; and for connected purposes.

Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005

An Act of the Scottish Parliament to make it an offence to meet a child following certain preliminary contact and to make other provision for the purposes of protecting children from harm of a sexual nature, including provision for implementing in part Council Framework Decision 2004/68/JHA; and to make further provision about the prevention of sexual offences.

Protection of Vulnerable Groups (Scotland) Act 2007

An Act of the Scottish Parliament to bar certain individuals from working with children or certain adults; to require the Scottish Ministers to keep lists of those individuals; to make further provision in relation to those lists; to establish a scheme under which information about individuals working or seeking to work with children or certain adults is collated and disclosed; to amend Part 5 of the Police Act 1997; to amend the meaning of school care accommodation service in the Regulation of Care (Scotland) Act 2001; and for connected purposes

Public Bodies (Joint Working) (Scotland) Act 2014

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

Regulation of Care (Scotland) Act 2001

An Act of the Scottish Parliament to establish the Scottish Commission for the Regulation of Care and the Scottish Social Services Council; to make provision for the registration and regulation of care services and for the registration, regulation and training of social service workers; to enable local authorities to provide and maintain residential accommodation in which nursing is provided; to make further provision as respects persons who have been looked after by local authorities; to amend the definition of 'place of safety' in the Children (Scotland) Act 1995.

Smoking, Health and Social Care (Scotland) Act 2005

To amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council, the provision of information to the Council and the minimum frequency of inspection of care services by the Commission to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to amend the Public Health (Scotland) Act 1897 to introduce a right of appeal in certain cases under that Act; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland

Social Care (Self-directed Support) (Scotland) Act 2013

An Act of the Scottish Parliament to enable local authorities to provide support to certain carers; to make provision about the way in which certain social care services are provided by local authorities; and for connected purposes.

Vulnerable Witnesses (Scotland) Act 2004

An Act of the Scottish Parliament to make provision for the use of special measures for the purpose of taking the evidence of children and other vulnerable witnesses in criminal or civil proceedings; to make provision about the admissibility of expert psychological or psychiatric evidence as to subsequent behaviour of the complainer in criminal proceedings in respect of certain offences to make provision about the admissibility of certain evidence bearing on the character, conduct or condition of witnesses in proceedings before a sheriff relating to the establishment of grounds of referral to children's hearings; to abolish the competence test for witnesses in criminal and civil proceedings; and for connected purposes.

Wales

The Mental Health (Wales) Measure 2010

This measure places new legal duties on local health boards and local authorities in Wales in relation to the assessment and treatment of mental health problems. The Measure became law in December 2010 and there are 4 parts to it which are as follows:

- Part 1 ensures that there are more mental health services are available within primary care.
- Part 2 makes sure all patients in secondary services have a Care and Treatment plan.
- Part 3 enables all adults discharged from secondary services to refer themselves back to those services.
- Part 4 supports every in-patient to have help from an independent mental health advocate if wanted.

Social Services and Well-being (Wales) Act 2014

An Act of the National Assembly for Wales to reform social services law; to make provision about improving the wellbeing outcomes for people who need care and support and carers who need support; to make provision about co-operation and partnership by public authorities with a view to improving the wellbeing of people; to make provision about complaints relating to social care and palliative care; and for connected purposes.

Violence against women, Domestic Abuse and Sexual Violence (Wales) Act 2015

An Act of the National Assembly for Wales to improve arrangements for the prevention of gender-based violence, domestic abuse and sexual violence; to improve arrangements for the protection of victims of such abuse and violence; to improve support for people affected by such abuse and violence; and to require the appointment of a National Adviser on gender-based violence, domestic abuse and sexual violence.

Well-being of Future Generations (Wales) Act 2015

An Act of the National Assembly for Wales to make provision requiring public bodies to do things in pursuit of the economic, social, environmental and cultural wellbeing of Wales in

a way that accords with the sustainable development principle; to require public bodies to report on such action; to establish a Commissioner for Future Generations to advise and assist public bodies in doing things in accordance with this Act; to establish public services boards in local authority areas; to make provision requiring those boards to plan and take action in pursuit of economic, social, environmental and cultural wellbeing in their area; and for connected purposes.

Appendix 2 – Websites and further information

British Psychological Society – www.bps.org.uk

The Society website has guidance, advice and further information on many topics not covered in these guidelines as well as those mentioned.

Psychologists working in clinical fields will also need to take account of Clinical Guidelines produced by NICE in England and Wales https://www.nice.org.uk/ or SIGN in Scotland http://www.sign.ac.uk/

1.1 Legal and professional obligations of psychologists

HCPC – http://hcpc-uk.org
The Health and Care Professions Council website has lots of information about professional registration including the standards of proficiency for the seven protected titles and information about indemnity insurance

Information Commissioner's Office – https://ico.org.uk/
The ICO website contains lots of useful information for organisations, private practitioners and the public regarding the rights and responsibilities under the data protection and Freedom of Information Acts.

DBS Checks – https://www.gov.uk/disclosure-barring-service-check
The government website provides helpful information for employers regarding these checks.

1.2 Continuing professional development

The HCPC has provided guidance regarding CPD for registrants. http://www.hcpc-uk.org/cpd

2.1 Working environment

Lone Working

Suzy Lamplugh Trust – http://www.suzylamplugh.org/

The Suzy Lamplugh Trust campaigns for personal safety and has lots of advice for people working alone to help to keep safe. They have some good advices and resources available.

Harassment and Bullying

ACAS – http://www.acas.org.uk/
The Advisory, Conciliation and Arbitration Service (ACAS) is a statutory organisation providing help and advice for employers and employees. They have produced guidance on several topics including harassment and bullying aimed separately at employers and employees.

Whistleblowing

Whistleblowing for employees – https://www.gov.uk/whistleblowing

The government has produced some guidance for employees surrounding whistleblowing including what to do and what to expect.

2.2 Working in the digital age

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – http://www.hhs.gov/hipaa/

This American act makes provisions for health information privacy. The government website provides information for professionals regarding this act.

N.B This Act is ONLY law for practice in America.

Social Media

The HCPC has provided guidance regarding the use of social media by professional psychologists.

http://www.hcpc-uk.org/Assets/documents/100035B7Social_media_guidance.pdf

3. Safeguarding

Statutory guidance Working together to safeguard children – https://www.gov.uk/government/publications/working-together-to-safeguard-children–2
Statutory guidance on inter-agency working to safeguard and promote the welfare of children.

Getting it Right for Every Child (GIRFEC) and the Early Years Framework – http://www.maternal-and-early-years.org.uk/getting-it-right-for-every-child-principles-and-values
This is an NHS Scotland approach which establishes the principle of giving all children and young people the best possible start in life as a priority for all services.

UK Government Guidance – https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care
No Secrets sets out a code of practice for the protection of vulnerable adults.

It explains how commissioners and providers of health and social care services should work together to produce and implement local policies and procedures. They should collaborate with the public, voluntary and private sectors and they should also consult clients, their carers and representative groups. Local authority social services departments should co-ordinate the development of policies and procedures.

Protection of vulnerable adults scheme (POVA) – http://www.scie.org.uk/publications/guides/guide03/law/adults.asp
Individuals should be referred to, and included on, the POVA list if they have abused, neglected or otherwise harmed vulnerable adults in their care or placed vulnerable adults

in their care at risk of harm. By making statutory checks against the list, providers of care must ensure they do not offer such individuals employment in care positions. POVA checks are requested as part of disclosures from the Criminal Records Bureau.

Prevention and Protection in Partnership 2015 – https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf

This policy from Northern Ireland is for all organisations working with, or providing services to, adults across the statutory, voluntary, community, independent and faith sectors. It sets clear and proportionate safeguarding expectations across the range of organisations.

Modern Slavery and the national referral mechanism (NRM) – https://www.gov.uk/government/collections/modern-slavery
These pages provide details about the government's work to end modern slavery, including details about how to refer victims into the NRM.

Let's talk about it – http://www.ltai.info/about/
Let's Talk About It is an initiative designed to provide practical help and guidance to the public in order to stop people becoming terrorists or supporting terrorism.

4. Managing data and confidentiality

Information Commissioners Office – https://ico.org.uk/
The Information Commissioners Office produces guidance with regards to data sharing and the Data protection and Freedom of information Acts.

HCPC guidance on confidentiality – http://www.hcpc-uk.co.uk/assets/documents/100023F1GuidanceonconfidentialityFINAL.pdf
The HCPC has provided guidance on confidentiality for registrants.

NHS – https://digital.nhs.uk/article/402/Information-Governance
The NHS has produced guidance regarding Information Governance and security for NHS and partner organisations. The NHS has codes of practice for Records management and Confidentiality.

Caldicott Report – https://www.gov.uk/government/publications/the-information-governance-review
A review was commissioned in 1997 by the Chief Medical Officer of England owing to increasing concern about the ways in which patient information is being used in the NHS in England and Wales and the need to ensure that confidentiality is not undermined. Such concern was largely due to the development of information technology in the service, and its capacity to disseminate information about patients rapidly and extensively. A committee was established under the chairmanship of Dame Fiona Caldicott. The Caldicott Report highlighted six key principles, and made 16 specific recommendations. In 2012 Dame Caldicott produced a follow up report which made 26 further recommendations including the addition of a seventh principle.

Psychological Testing Centre – http://ptc.bps.org.uk/ptc/guidelines-and-information

The PTC website contains lots of guidance about psychometric testing and the management of data generated from those tests.

5. Transparency and duty of candour

Care Quality Commission – http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
The CQC has produced Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare with regards to duty of candour.

Appendix 3 – How this document has been developed

In developing these guidelines, the overall aim and scope of the guidelines was considered at length, and the decision arrived at that they should be applicable to all psychologists irrespective of registration status or practice context. The guidelines have therefore been written in a way which it is hoped is inclusive of the various contexts of practice. Drawing on a broad stakeholder group for the development work, the guidelines aim to cover all the important considerations for practice. It is however recognised they cannot cover every circumstance and also that new issues arise which will require careful consideration by the individual psychologist.

The Practice Guidelines development Working Group was constituted to include all of the member networks of the Society whose members engage in practice, including the HCPC registered practitioners. It included representatives of the Society's national branches in Scotland, Wales and Northern Ireland, in order to ensure applicability to the different national contexts. It also included representation from the expert working groups of the Society's Professional Practice Board and others on specialist topics of practice.

The content of the guidelines has been developed from a combination of revision of the previous edition in the light of professional consensus on current expectations of a good standard of practice of psychology; inclusion of key points from other Society guidance on specific topics with reference to further guidance; and in some cases development of new material drawing on the professional experience of our members or outside professionals in the field. The working group has not used systematic methods to search for or assess the evidence for the material included. Recommendations have been included based on working group consensus. Where there are known areas of professional difference of opinion this has been stated.

A draft of the guidelines was circulated for Society wide consultation and one month allowed for comment. This included circulation to Experts by Experience (psychology service user representatives) with whom the Society works in various contexts. The Guidelines were also sent for comment to the Health and Care Professions Council as the statutory regulator for practitioner psychologists. Comments received were considered carefully by the Working Group and changes made to the text of the guidelines where considered necessary. The annotated audit sheet of the comments received and disposal was provided to a meeting of the Society's Professional Practice Board to assist its consideration of the draft guidelines, by way of final peer scrutiny. The guidelines were reviewed by the Society's legal advisers prior to publication. Final approval of the guidelines was given by the Society's Board of Trustees.

The guidelines will be reviewed and updated in accordance with Society policy after five years or sooner if circumstances indicate this is needed.

To ensure clarity and presentation in a user friendly format, the Guidelines have been edited by professional staff within the Society and the format designed by the Society's Preparation for Print specialists. Where considered helpful, links have been made to

additional web based resources, both to assist practitioner development and to provide up to date information in areas where there is frequent change. Organisational providers of psychological services are encouraged to review how these guidelines are used in practice and feed back to the Society any barriers to application.

In ensuring an appropriate level of independence in the production of these Guidelines, the Society has ensured its conflict of interest policy has been complied with and that no member of the working group's input has been compromised by a conflict of interest. No member has received any form of remuneration other than reimbursement of travel and subsistence expenses in accordance with Society policy. The large size of the working group and peer scrutiny and challenge, as well as the robust consultation process, guards against the potential for any one member or small group of members inappropriately to bias the Guidelines.

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel: 0116 254 9568 Fax 0116 247 0787 E-mail: mail@bps.org.uk Website: www.bps.org.uk

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Principles of recovery oriented mental health practice

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.

> *It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment and connection—and external conditions that facilitate recovery—implementation of human rights, a positive culture of healing, and recovery-oriented services. (Jacobson and Greenley, 2001 p. 482)*

The purpose of principles of recovery oriented mental health practice is to ensure that mental health services are being delivered in a way that supports the recovery of mental health consumers.

1. UNIQUENESS OF THE INDIVIDUAL

Recovery oriented mental health practice:

- recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community
- accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life
- empowers individuals so they recognise that they are at the centre of the care they receive.

2. REAL CHOICES

Recovery oriented mental health practice:

- supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored
- supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time
- ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.

3. ATTITUDES AND RIGHTS

Recovery oriented mental health practice:

- involves listening to, learning from and acting upon communications from the individual and their carers about what is important to each individual
- promotes and protects individual's legal, citizenship and human rights
- supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual
- instils hope in an individual's future and ability to live a meaningful life.

4. DIGNITY AND RESPECT

Recovery oriented mental health practice:

- consists of being courteous, respectful and honest in all interactions
- involves sensitivity and respect for each individual, particularly for their values, beliefs and culture
- challenges discrimination and stigma wherever it exists within our own services or the broader community.

5. PARTNERSHIP AND COMMUNICATION

Recovery oriented mental health practice:

- acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them
- values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement
- involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

6. EVALUATING RECOVERY

Recovery oriented mental health practice:

- ensures and enables continuous evaluation of recovery based practice at several levels
- individuals and their carers can track their own progress
- services demonstrate that they use the individual's experiences of care to inform quality improvement activities
- the mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships as well as health and well being measures.

These Recovery Principles have been adapted from the Hertfordshire Partnership NHS Foundation Trust Recovery Principles in the UK.

SPECIAL ARTICLE

How important are the common factors in psychotherapy? An update

Bruce E. Wampold

Department of Counseling Psychology, University of Wisconsin, Madison, WI, USA; Modum Bad Psychiatric Center, Vikersund, Norway

The common factors have a long history in the field of psychotherapy theory, research and practice. To understand the evidence supporting them as important therapeutic elements, the contextual model of psychotherapy is outlined. Then the evidence, primarily from meta-analyses, is presented for particular common factors, including alliance, empathy, expectations, cultural adaptation, and therapist differences. Then the evidence for four factors related to specificity, including treatment differences, specific ingredients, adherence, and competence, is presented. The evidence supports the conclusion that the common factors are important for producing the benefits of psychotherapy.

Key words: Common factors, contextual model, psychotherapy, alliance, empathy, expectations, cultural adaptation, therapist differences, specific ingredients

(World Psychiatry 2015;14:270–277)

The so-called common factors have a long history in psychiatry, originating with a seminal article by S. Rosenzweig in 1936 (1) and popularized by J. Frank in the various editions of his book *Persuasion and Healing* (2-4). During this period, the common factors have been both embraced and dismissed, creating some tension (5-9). The purpose of this paper is not to review or discuss the debate, but to provide an update, summarizing the evidence related to these factors.

To understand the evidence for the common factors, it is important to keep in mind that these factors are more than a set of therapeutic elements that are common to all or most psychotherapies. They collectively shape a theoretical model about the mechanisms of change in psychotherapy.

A particular common factor model, called the contextual model, has been recently proposed (8,10). Although there are other common factor models (e.g., 4,11), based on different theoretical propositions, the predictions made about the importance of various common factors are similar and the choice of the model does not affect conclusions about the impact of these factors. The contextual model is presented below, followed by a review of the evidence for the common factors imbedded in the model.

THE CONTEXTUAL MODEL

The contextual model posits that there are three pathways through which psychotherapy produces benefits. That is, psychotherapy does not have a unitary influence on patients, but rather works through various mechanisms. The mechanisms underlying the three pathways entail evolved characteristics of humans as the ultimate social species; as such, psychotherapy is a special case of a social healing practice.

Thus, the contextual model provides an alternative explanation for the benefits of psychotherapy to ones that emphasize specific ingredients that are purportedly beneficial for particular disorders due to remediation of an identifiable deficit (8).

The three pathways of the contextual model involve: a) the real relationship, b) the creation of expectations through explanation of disorder and the treatment involved, and c) the enactment of health promoting actions. Before these pathways can be activated, an initial therapeutic relationship must be established.

Initial therapeutic relationship

Before the work of therapy can begin, an initial bond between therapist and patient needs to be created. E. Bordin stated in 1979 that "some basic level of trust surely marks all varieties of therapeutic relationships, but when attention is directed toward the more protected recesses of inner experience, deeper bonds of trust and attachment are required and developed" (12, p. 254). The initial meeting of patient and therapist is essentially the meeting of two strangers, with the patient making a determination of whether the therapist is trustworthy, has the necessary expertise, and will take the time and effort to understand both the problem and the context in which the patient and the problem are situated.

The formation of the initial bond is a combination of bottom-up and top-down processing. Humans make very rapid determination (within 100 ms), based on viewing the face of another human, of whether the other person is trustworthy or not (13), suggesting that patients make very rapid judgments about whether they can trust their therapist. More than likely, patients make rapid judgments about the dress of the therapist, the arrangement and decorations of the room (e.g., diplomas on the wall), and other features of the therapeutic setting (14). However, patients come to therapy with expectations about the nature of psychotherapy as

well, due to prior experiences, recommendations of intimate or influential others, cultural beliefs, and so forth. The initial interaction between patient and therapist is critical, it seems, because more patients prematurely terminate from therapy after the first session than at any other point (15).

Pathway 1: The real relationship

The real relationship, defined psychodynamically, is "the personal relationship between therapist and patient marked by the extent to which each is genuine with the other and perceives/experiences the other in ways that befit the other" (16, p. 119). Although the psychotherapeutic relationship is influenced by general social processes, it is an unusual social relationship in that: a) the interaction is confidential, with some statutory limits (e.g., child abuse reporting), and b) disclosure of difficult material (e.g., of infidelity to a spouse, of shameful affect, and so forth) does not disrupt the social bond. Indeed, in psychotherapy, the patient is able to talk about difficult material without the threat that the therapist will terminate the relationship.

The importance of human connection has been discussed for decades, whether is it called attachment (17), belongingness (18), social support (19), or the lack of loneliness (20,21). In fact, perceived loneliness is a significant risk factor for mortality, equal to or exceeding smoking, obesity, not exercising (for those with chronic cardiac disease or for healthy individuals), environmental pollution, or excessive drinking (22-24). Psychotherapy provides the patient a human connection with an empathic and caring individual, which should be health promoting, especially for patients who have impoverished or chaotic social relations.

Pathway 2: Expectations

Research in a number of areas documents that expectations have a strong influence on experience (25). Indeed, the purported price of a bottle of wine influences rating of pleasantness as well as neural representations (26). The burgeoning research on the effects of placebos documents the importance of expectations, as placebos have robustly shown to alter reported experience as well as demonstrating physiological and neural mechanisms (27,28).

Expectations in psychotherapy work in several possible ways. Frank (4) discussed how patients present to psychotherapy demoralized not only because of their distress, but also because they have attempted many times and in many ways to overcome their problems, always unsuccessfully. Participating in psychotherapy appears to be a form of remoralization.

However, therapy has more specific effects on expectations than simple remoralization. According to the contextual model, patients come to therapy with an explanation for their distress, formed from their own psychological beliefs, which is sometimes called "folk psychology" (29-31). These beliefs, which are influenced by cultural conceptualizations of mental disorder but also are idiosyncratic, are typically not adaptive, in the sense that they do not allow for solutions. Psychotherapy provides an explanation for the patient's difficulties that is adaptive, in the sense that it provides a means to overcome or cope with the difficulties. The patient comes to believe that participating in and successfully completing the tasks of therapy, whatever they may be, will be helpful in coping with his or her problems, which then furthers for the patient the expectation that he or she has ability to enact what is needed. The belief that one can do what is necessary to solve his or her problem has been discussed in various ways, including discussions of mastery (4,32), self-efficacy (33), or response expectancies (25).

Critical to the expectation pathway is that patients believe that the explanation provided and the concomitant treatment actions will be remedial for their problems. Consequently, the patient and therapist will need to be in agreement about the goals of therapy as well as the tasks, which are two critical components of the therapeutic alliance (34,35). Hatcher and Barends described the alliance as "the degree to which the therapy dyad is engaged in collaborative, purposive work" (36, p. 293). Creating expectations in psychotherapy depends on a cogent theoretical explanation, which is provided to the patient and which is accepted by the patient, as well as on therapeutic activities that are consistent with the explanation, and that the patient believes will lead to control over his or her problems. A strong alliance indicates that the patient accepts the treatment and is working together with the therapist, creating confidence in the patient that the treatment will be successful.

Pathway 3: Specific ingredients

The contextual model stipulates that there exists a treatment, particularly one that the patient finds acceptable and that he or she thinks will be remedial for his or her problems, creating the necessary expectations that the patient will experience less distress. Every treatment that meets the conditions of the contextual model will have specific ingredients, that is, each cogent treatment contains certain well-specified therapeutic actions.

The question is how the specific ingredients work to produce the benefits of psychotherapy. Advocates of specific treatments argue that these ingredients are needed to remediate a particular psychological deficit. The contextual model posits that the specific ingredients not only create expectations (pathway 2), but universally produce some salubrious actions. That is, the therapist induces the patient to enact some healthy actions, whether that may be thinking about the world in less maladaptive ways and relying less on dysfunctional schemas (cognitive-behavioral treatments), improving interpersonal relations (interpersonal psychotherapy and some dynamic therapies), being more accepting

of one's self (self-compassion therapies, acceptance and commitment therapy), expressing difficult emotions (emotion-focused and dynamic therapies), taking the perspective of others (mentalization therapies), and so forth. The effect of lifestyle variables on mental health has been understated (37). A strong alliance is necessary for the third pathway as well as the second, as without a strong collaborative work, particularly agreement about the tasks of therapy, the patient will not likely enact the healthy actions.

According to the contextual model, if the treatment elicits healthy patient actions, it will be effective, whereas proponents of specific ingredients as remedial for psychological deficits predict that some treatments – those with the most potent specific ingredients – will be more effective than others (8).

EVIDENCE FOR VARIOUS COMMON FACTORS

Now that the contextual model has been briefly presented, attention is turned toward an update of the evidence for the common factors. Each factor reviewed is imbedded in the contextual model, although each of them is more generically considered atheoretically as an important one. As will be apparent, many of the common factors are not theoretically or empirically distinct.

To present the evidence succinctly and with as little bias and error as possible, we rely on meta-analyses of primary studies. Studies that examine the association of levels of a common factor and outcome are typically reported by some type of correlation statistic (such as Pearson's product-moment correlation), whereas studies that experimentally manipulate and compare conditions typically report some standardized mean difference (such as Cohen's d). For comparison purposes, correlational statistics are converted to Cohen's d. All meta-analyses reported aggregate statistics, corrected for bias, based on the effects of individual studies appropriated weighted. To understand the importance of effects, Cohen (38) classified a d of 0.2 as small, 0.5 as medium, and 0.8 as large. The evidence is summarized in Figure 1, where the effects of various common factors are compared to those of various specific factors.

Alliance

The alliance is composed of three components: the bond, the agreement about the goals of therapy, and the agreement about the tasks of therapy (12). As discussed above, alliance is a critical common factor, instrumental in both pathway 2 and pathway 3.

Alliance is the most researched common factor. Typically the alliance is measured early in therapy (at session 3 or 4) and correlated with final outcome. The most recent meta-analysis of the alliance included nearly 200 studies involving over 14,000 patients and found that the aggregate correlation between alliance and outcome was about .27, which is equivalent to a Cohen's d of 0.57 (39), surpassing the threshold for a medium sized effect.

There have been a number of criticisms of the conclusion that alliance is an important factor in psychotherapy (40), most of which have focused on the correlational nature of alliance research. However, each of the criticisms has been considered and has been found not to attenuate the importance of the alliance (see 8).

First, it could well be that early symptom relief causes a strong alliance at the third or fourth session – that is, early responders report better alliances and have better outcomes. To address this threat, early therapy progress must be statistically controlled or longitudinal research is needed to examine the association of alliance and symptoms over the course of therapy. The studies that have examined this question have found evidence to support either interpretation, but the better designed and more sophisticated studies are converging on the conclusion that the alliance predicts future change in symptoms after controlling for already occurring change.

Second, it could be that the correlation between alliance and outcome is due to the patients' contributions to the alliance. According to this line of thinking, some patients may come to therapy well prepared to form a strong alliance and it is these patients who also have a better prognosis, so the alliance-outcome association is due to the characteristics of the patients rather than to something that therapists provide to the patients. Disentangling the patient and therapist contributions involves the use of multilevel modeling. Recently, Baldwin et al (41) performed such an analysis and found that it was the therapist contribution which was important: more effective therapists were able to form a strong alliance across a range of patients. Patients' contribution did not predict outcome: patients who are able to form better alliances, perhaps because they have secure attachment histories, do not have better prognoses. Indeed, patients with poor attachment histories and chaotic interpersonal relationships may well benefit from a therapist who is able to form alliances with difficult patients. These results have been corroborated by meta-analyses (42).

Third, there may be a halo effect if the patient rates both the alliance and the outcome. However, meta-analyses have shown that the alliance-outcome association is robust even when alliance and outcome are rated by different people. It also appears that the alliance is equally strong for cognitive-behavioral therapies as it is for experiential or dynamic treatments, whether a manual is used to guide treatment or not, and whether the outcomes are targeted symptoms or more global measures.

There are other threats to validity of the alliance as a potent therapeutic factor, but the evidence for each of them is nonexistent or weak (8). The research evidence, by and large, supports the importance of the alliance as an important aspect of psychotherapy, as predicted by the contextual model.

As mentioned above, distinctions between certain common factors are difficult to make. A distinction has been

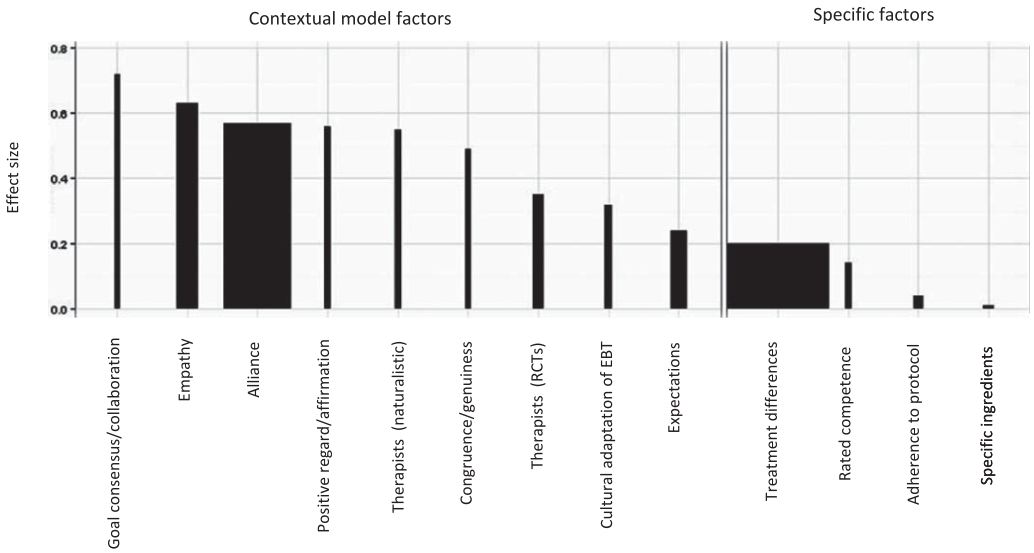

Figure 1 Effect sizes for common factors of the contextual model and specific factors. Width of bars is proportional to number of studies on which effect is based. RCTs – randomized controlled trials, EBT – evidence-based treatments

made between the bond, as defined as a component of the alliance, which is related to purposeful work, and the real relationship, which is focused on the transference-free genuine relationship (8,16). There is some evidence that the real relationship is related to outcome, after controlling for the alliance (16), and, although the evidence is not strong, it does support the first pathway of the contextual model.

A second construct related for the alliance is labeled goal consensus/collaboration. Although related to agreement about the goals and tasks for therapy, goal consensus/collaboration is measured with different instruments. As shown in Figure 1, the effect for goal consensus and collaboration is strong (d=0.72), based on a meta-analysis of 15 studies (43).

Empathy and related constructs

Empathy, a complex process by which an individual can be affected by and share the emotional state of another, assess the reasons for another's state, and identify with the other by adopting his or her perspective, is thought to be necessary for the cooperation, goal sharing, and regulation of social interaction. Such capacities are critical to infant and child rearing, as children, who are unable to care for themselves, signal to the caregiver that care is needed, a process that is then put to use to manage social relations among communities of adult individuals. Therapist expressed empathy is a primary common factor, critical to pathway 1 of the contextual model, but which also augments the effect of expectations.

The power of the empathy in healing was beautifully revealed in a study of placebo acupuncture for patients with irritable bowel syndrome (44). Patients with this syndrome were randomly assigned to a limited interaction condition, an augmented relationship condition, or treatment as usual (waiting list for acupuncture). In the limited interaction condition, the acupuncturist met with the patient briefly, but was not allowed to converse with him or her, and administered the sham acupuncture (a device that gives the sensation of having needles pierce the skin, but they do not). In the augmented relationship condition, the practitioner conversed with the patient about the symptoms, the relevance of lifestyle and relationships to irritable bowel syndrome, as well as the patient's understanding of the cause and meaning of her disorder. All this was done in a warm and friendly manner, using active listening, appropriate silences for reflection, and a communication of confidence and positive expectation. For the four dependent variables (global improvement, adequate relief, symptom severity, and quality of life), the two sham acupuncture conditions were superior to treatment as usual. However, the augmented relationship condition was superior to the limited interaction condition, particularly for quality of life.

The above study is noteworthy because it was an experimental demonstration of the importance of a warm, caring, empathic interaction within a healing setting. Unfortunately, experimental manipulation of empathy in psychotherapy studies is not possible, for design and ethical reasons. Nonetheless, there have been numerous studies (n=59) that have correlated ratings of therapist empathy with outcome, which have been meta-analytically summarized (45), resulting in a relatively large effect (d=0.63; see Figure 1). Constructs related to empathy have also been meta-analyzed and found to be related to outcome, including positive regard/affirmation (d=0.56, n=18; see Figure 1) (46) and congruence/genuineness (d=0.49, n=18; see Figure 1) (47).

It should be recognized that several of the threats to validity for the alliance are also present with regard to empathy. For example, it is clearly easier for a therapist to be warm and

caring toward a motivated, disclosing and cooperative patient than to one who is interpersonally aggressive, and the former types of patients will most likely have better outcomes than the latter, making the empathy/outcome correlation an artifact of patient characteristics rather than therapist action. Unfortunately, studies such as the ones conducted to rule out these threats to validity for the alliance have not been conducted for empathy and related constructs.

Expectations

Examining the role of expectations in psychotherapy is difficult. In medicine, expectations can be induced verbally and then physicochemical agents or procedures can be administered or not, making the two components (creation of expectations and the treatment) independent. In psychotherapy, creating the expectations, through explanation of the patient's disorder, presenting the rationale for the treatment, and participating in the therapeutic actions, is part of therapy. It is difficult to design experimental studies of expectations in psychotherapy (not impossible, but not yet accomplished in any important manner).

The typical way to assess the effect of expectations in psychotherapy is to correlate patient ratings of their expectations with outcomes, but we have seen that such correlational studies produce threats to validity. Furthermore, in many studies, expectations are measured *prior* to when the rationale for the treatment is provided to the patient, when it is the explanation given to the patient that is supposed to create the expectations. Assessing expectations after the explanation has been given (i.e., during the course of treatment) is also problematic, as those patients who have made significant progress in therapy will naturally respond that they think therapy will be helpful.

Despite the difficulties with investigating expectations in psychotherapy, this is a topic of much interest (48-50). Recently, a meta-analysis of expectations showed that there was a relatively small, but statistically significant, relationship between rated expectations and outcome ($d=0.24$, $n=46$; see Figure 1) (49). The best evidence for expectations in the context of healing is derived from studies of the placebo effect, where exquisite care has been taken to experimentally manipulate variables of interest and to control for threats to validity, by using physiological and neurological variables as well as subjective reports. A summary of this literature is beyond the scope of this article, but many excellent reviews are available (8,27,28).

Cultural adaptation of evidence-based treatments

The contextual model emphasizes that the explanation given for the patient's distress and the therapy actions must be acceptable to the patient. Acceptance is partly a function of consistency of the treatment with the patient's beliefs, particularly beliefs about the nature of mental illness and how to cope with the effects of the illness. This suggests that evidence-based treatments that are culturally adapted will be more effective for members of the cultural group for which the adapted treatment is designed. There are many ways to adapt treatments, including those involving language, cultural congruence of therapist and patient, cultural rituals, and explanations adapted to the "myth" of the group.

A recent meta-analysis demonstrated that adapting evidence-based treatments by using an explanation congruent with the cultural group's beliefs (i.e., using the cultural "myth" as the explanation) was more effective than unadapted evidence-based treatments, although the effect was modest ($d=0.32$, $n=21$; see Figure 1) (51).

Therapist effects

Therapist effects are said to exist if some therapists consistently achieve better outcomes with their patients than other therapists, regardless of the nature of the patients or the treatment delivered. Therapist effects have been studied in clinical trials and in naturalistic settings. In both designs, the measure of therapist effects is an intraclass correlation coefficient. Technically, this coefficient indexes the degree to which two patients from the same therapist have similar outcomes relative to two patients from two different therapists. To compare therapist effects to other common factors, the intraclass correlation coefficient is converted to Cohen's d.

The contextual model predicts that there will be differences among therapists *within* a treatment. That is, even though the therapists are delivering the same specific ingredients, some therapists will do so more skillfully and therefore achieve better outcomes than other therapists delivering the same treatment. Evidence for this conjecture is found in clinical trials. A meta-analysis of therapist effects in clinical trials found modest therapist effects ($d=0.35$, $n=29$; see Figure 1) (52). Keep in mind that the therapists in clinical trials generally are included because of their competence and then they are given extra training, supervised, and monitored. Moreover, the patients in such trials are homogeneous, as they have a designated diagnosis and are selected based on various inclusionary/exclusionary criteria. In such designs, patients are randomly assigned to therapists. Consequently, consistent differences among therapists in such trials, although modest, are instructive.

Not surprisingly, therapist effects in naturalistic settings are greater than in clinical trials. In the former settings, therapists are more heterogeneous, patients may not be randomly assigned to therapists, patients are heterogeneous, and so forth. A meta-analysis of therapist effects in such settings found a relatively large effect ($d=0.55$, $n=17$; see Figure 1) (52).

The finding of robust therapist effects raises the question about what are the characteristics or actions of more effective therapists. Recent research has begun to address this

question. Studies have shown that effective therapists (vis-à-vis less effective therapists) are able to form stronger alliances across a range of patients, have a greater level of facilitative interpersonal skills, express more professional self-doubt, and engage in more time outside of the actual therapy practicing various therapy skills (8).

SPECIFIC EFFECTS

Evidence for the common factors is also collected by examining the evidence for specific aspects of psychotherapy. The contextual model makes several predictions about specific effects, which will be discussed as each specific effect is considered.

Treatment differences

When pathway 3 of the contextual model was discussed earlier, it was emphasized that the model contends that all therapies with structure, given by empathic and caring therapists, and which facilitate the patient's engagement in behaviors that are salubrious, will have approximately equal effects. That is, the specific ingredients, discussed in pathway 3, are not critical because they remediate some psychological deficit.

The question of whether some treatments are superior to others has long been debated, with origins at the very beginning of the practice of psychotherapy (think about the disagreements amongst Freud, Adler and Jung, for example). Today, there are claims that some treatments, in general or for specific disorders, are more effective than others. Others, however, claim that there are no differences among psychotherapies, in terms of their outcomes.

The literature addressing this issue is immense and summarizing the results of relative efficacy is not possible. Nevertheless, the various meta-analyses for psychotherapies in general or for specific disorders, if they do find differences among various types of treatment, typically find at most differences of approximately d=0.20, the value shown in Figure 1.

Specific effects from dismantling studies

To many, the dismantling design is the most valid way to identify the effects of specific ingredients. In this design, a specific ingredient is removed from a treatment to determine how much more effective the treatment is in total compared to the treatment without the ingredient that is purportedly remedial for the psychological deficit.

Two meta-analyses have examined dismantling designs and both found minimal differences between the total treatment and the treatment without one or more critical ingredients (d=0.01, n=30, see Figure 1) (53,54). The most recent of these meta-analyses did find that adding an ingredient to an existing treatment increased the effect for targeted variables by a small amount (d=0.28) (53).

Adherence and competence

In clinical trials, it is required that adherence to the protocol and the competence at delivering the treatment are rated. This makes sense: if the goal is to make inferences about a particular treatment, then it is necessary to ensure that the treatment was delivered with the necessary components and not with extraneous components (i.e., with *adherence* to the protocol) and that the treatment components were delivered skillfully (i.e., given *competently*).

It would seem logical theoretically that adherence to the protocol and competence would be related to outcome. That is, for cases where the therapist followed the protocol and did so skillfully, there should be better outcomes. However, this is not the case. In a meta-analysis of adherence and competence (55), effects were small (d=0.04, n=28 for adherence; d=0.14, n=18 for competence; see Figure 1).

The results for adherence and competence demand further explanation. If the specific ingredients of a treatment are critical, then adherence should make a difference – actually delivering those ingredients should be related to outcome. There is evidence that rigid adherence to a protocol can attenuate the alliance and increase resistance to the treatment (i.e., failing to accept the treatment, a contextual model tenet) (8), and that flexibility in adherence is related to better outcomes (56), results consistent with prediction of the contextual model.

The findings for competence are a bit more difficult to understand. Competence in these trials typically is rated by experts in the treatment being given, based on watching therapy sessions. Why can't experts differentiate between "good" therapy and "bad" therapy? If this were indicative of experts' abilities to judge competence, then the notion of psychotherapy supervision would be turned upside down, because what is observed and evaluated would have no relation to outcomes – how could the supervisor then make a case for providing input to the supervisee? But the clue to the resolution of this mystery is found in the definition of competence. Most psychotherapy trials rate the competence *for a specific treatment*. That is, what is rated is the skill in providing the elements of the treatment protocol, rather than common factors, such as empathy, alliance, affirmation, and so forth – aspects of therapy that do predict outcome and seem to differentiate more effective therapists from less effective therapists.

CONCLUSIONS

Although the common factors have been discussed for almost a century, the focus of psychotherapy is typically on the development and dissemination of treatment models. If

not discounted, then the common factors are thought of as perhaps necessary, but clearly not sufficient. The evidence, however, strongly suggests that the common factors must be considered therapeutic and attention must be given to them, in terms of theory, research and practice.

One of the criticisms of the common factors is that they are an atheoretical collection of commonalities. In this paper, the contextual model was presented to convey a theoretical basis for these factors.

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Trauma and Public Mental Health: A Focused Review

Rolf J. Kleber[1,2]*

[1] Utrecht University, Utrecht, Netherlands, [2] Arq Psychotrauma Expert Group, Diemen, Netherlands

Psychological trauma has developed into a very common concept in the scientific community, in mental health care, as well as in popular language and mass media. The purpose of this article is to show the relevance of the discipline of traumatic stress studies to the field of public mental health by examining central concepts and findings concerning trauma and its aftermath and examining implications for public mental health. Attention is paid to the diagnosis of posttraumatic stress disorder (PTSD) and the construct of resilience as well as to specific areas of public mental health activities. A public mental health perspective will help to develop preventive approaches to trauma and extend the impact of various forms of interventions. It will also make clear that trauma care will have to consider the community and the society at large.

Keywords: trauma, posttraumatic stress disorder, resilience, public mental health, war, disasters, violence

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***Correspondence:**
Rolf J. Kleber
r.kleber@uu.nl

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INTRODUCTION

Psychological trauma has developed into a very popular concept in the scientific community, in the world of mental health care, as well as in common language and mass media. The consequences of various shocking events—violence, disasters, acts of terrorism, accidents, and war—receive frequent and enduring attention. The number of scientific and clinical publications has increased enormously and in many media programs ample attention is paid to victims and others affected by these events. The purpose of this article is to show the relevance of the discipline of traumatic stress studies to the field of public mental health by examining central concepts and findings concerning trauma and its aftermath and examining implications for public mental health.

WHAT IS A TRAUMATIC EVENT?

Traumatic events involve the confrontation with war, violence, disasters, sudden loss, serious illness, and other overwhelming and disturbing events. According to the psychiatric classifications [of the *International Classification of Diseases* of the World Health Organization (ICD-11) and the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5)], a traumatic event is defined as the exposure to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (1, 2).

Phenomenologically such an event can be characterized by an extreme sense of powerlessness as well as a disruption of beliefs and expectations. The individual has lost control over the situation and is to a large extent a victim of the circumstances and/or other people (i.e. the perpetrator). In "Jenseits des Lustprinzips" (1920), Freud already posed: "the essence of a traumatic situation is an experience of helplessness that is brought about either externally or internally." At the same time, he or she is confronted with a shattering of basic assumptions. The self-evidence of one's life is gone. The sense of invulnerability,

the idea of the benevolence of the world, and the idea that other people can be trusted are devastated. The obvious certainties of life have disappeared. The images one holds of oneself and the environment no longer adequately fit the new situation. In the words of Janoff-Bulman (3), basic assumptions have been shattered.

Exposure to traumatic events is not rare, as has been consistently found in epidemiological studies. The World Mental Health Surveys of adults were carried out among nearly 70,000 participants from 24 countries ranging in economic status from low to high (4). These data showed that at some time in their life 70.4% of the respondents had experienced at least one type of a traumatic event. The specific rates were: 14% had experienced intimate partner or sexual violence, 34.3% accidents or injuries, 22.9% physical violence, 13.1% war-related events, 34.1% the unexpected or traumatic death of a loved one, and 35.7% experienced traumas that happened to loved ones (e.g., serious illness of a child). As Kessler et al. (4) stated, these findings make clear that it is rather normal to be exposed to a very upsetting event in one's lifetime.

RISE AND BLOOM OF THE CONCEPT OF POST-TRAUMATIC STRESS DISORDER

The concept of *posttraumatic stress disorder* (PTSD) is nowadays so much used that it dominates most thinking about the consequences of violence, disaster, and being a refugee. That development is quite unique as the attention for trauma was very meager just 40, 50 years ago. In the 1970s, the United States became increasingly confronted with the psychological and social difficulties of the nearly three million veterans who had fought in Vietnam. They suffered from nightmares, depression, relationship problems, et cetera. However, because of the ambivalent perspective on the Vietnam War, authorities and professionals were rather reluctant to acknowledge these difficulties, but the increasing concern led to the introduction of the term post-traumatic stress disorder in the anxiety disorders section of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) (5).

The diagnosis of PTSD is directly linked to experiencing or witnessing a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape, or other violent assault (criterion A). According to DSM-5 (1), PTSD consists of four categories of symptoms. Re-experiencing the traumatic event (criterion B) is manifested in symptoms such as intrusive memories, distressing dreams, flashbacks, or distress or physiological reactions upon exposure to cues of the trauma. The other categories are symptoms of avoidance of the reminders of the trauma (criterion C), alterations in memories or mood associated with the trauma (criterion D), and finally clear alterations in physiological arousal and reactivity [criterion E; see further Ref. (1)].

Recently a relatively different definition of PTSD has been introduced in the new version of the International Classification of Diseases of the World Health Organization (2018). It consists of three categories (reexperiencing, avoidance, hyperarousal) with only two core symptoms in each category. The definition may be more flexible to use (allowing for cultural variation and clinical judgment) but is less detailed and comprehensive. Empirical studies have found that prevalence rates may vary between the two classifications and there is often a lack of overlap (i.e., not the same individuals are classified as PTSD patients by the two classifications). This is a major concern for the field of traumatic stress studies. It is a challenge for future research to unravel the differences and to create order (6), as most research is conducted with the DSM definition while most countries in the world use instead ICD.

Prevalence figures for PTSD vary enormously, according to the nature of the events, various risk factors, the time of measurement, and the instruments used. In general, PTSD occurs more when an aggressor is involved (in the case interpersonal violence), for persistent and extended events (e.g., internment, sexual abuse) and for socially charged events (e.g., rape). Among Dutch veterans who were confronted with war violence during deployment in Iraq, the figures of current prevalence varied between 3 and 4% (7). Nine percent of American Vietnam veterans had current PTSD 20 years after the war (8). Figures on PTSD in studies of disasters (man-made, technological, as well as natural) varied mostly around 5% to 15% (9). The prevalence findings also fluctuated strongly in studies of sexual violence, although the rates are generally higher than after other events: between 3.7% and 65%. The already mentioned World Mental Health Surveys (4, 10) determined that intimate partner or sexual violence (such as rape) was a very frequent cause of PTSD. Nevertheless, the unexpected death of loved ones represented the most frequent cause of event-related psychopathology within the general population because of the high frequency with which people experience such a loss. About this last mentioned finding, it is relevant to remark that there is a close relationship between trauma and loss and consequently between PTSD and complicated grief, but they are not similar (11). The concepts of Persistent Complex Bereavement Disorder (1) and Prolonged Grief Disorder (2) as result of the death of a family member or a close friend are included in DSM-5 and ICD-11, respectively.

In a comprehensive and systematic analysis (12) prevalence rates of PTSD and depression were identified from 181 surveys comprising 81,866 refugees and other conflict-affected persons from 40 countries exposed to humanitarian emergencies. Again, rates of reported PTSD and depression showed large inter-survey variability. The prevalence estimates derived from the methodologically most robust surveys provided rates between 13% and 25% for PTSD, as assessed by Steel et al. (12). The risk of PTSD among refugees was increased by experiencing torture and sexual violence, having a higher age, being a woman, and through a long stay in different asylum seekers centers.

Despite the increased knowledge about PTSD and despite the positive results of therapeutic treatments for PTSD, there are various dilemmas and challenges. First, there is a large comorbidity, as most patients also suffer from depression, substance abuse, or other disorders (6). Furthermore, defining the borderline between normal and abnormal behavior after trauma is difficult. Moreover, although this is matter of heavy debate among researchers and clinicians, PTSD is sometimes an overstretched concept in the sense that normal responses to stressful life events are labelled as disorder. Difficulties of diverse groups—from refugees to veterans—are attributed too much or too easily to traumatic events and their resilience is underestimated (13).

IMPACT ON THE INDIVIDUAL

Regarding a public mental health perspective, it is highly relevant to understand that the majority of people exposed to serious live events does not develop disorders. However, this does not mean that they will not suffer from symptoms and difficulties. Most people will experience responses such as intrusions, nightmares, startle reactions, and numbness (14). Findings from large epidemiological studies of disaster victims have made this clear. In 2000 the Netherlands were confronted with a disastrous explosion of a fireworks container area in the middle of a neighborhood. A comprehensive and longitudinal study was conducted among the inhabitants. In the investigation of post-disaster reactions (15) it was found that most inhabitants suffered from various serious symptoms (especially depression, fears, re-experiences, physical symptoms) in the first 2 to 3 weeks after the explosion. At least 87% of the affected residents were highly affected in those first weeks after the disaster.

These responses can be considered functional and normal, as has been made clear in emotion theories (16). People are afraid that it will happen again. They do not feel safe anymore and are constantly alert for danger. They are angry because of the neglect of the responsible authorities or they feel rage in the direction of the perpetrator. They react easily irritated at remarks of other people. They blame themselves for being there at the moment of the disaster or having not done anything to prevent the situation. They feel despaired because of the death of loved ones and the loss of material goods. They have the impression that other people do not understand their distress and sorrow and feel estranged from others. Nevertheless, the intensity and frequency of these distressing and painful responses do not reach the level of disorder.

Although DSM-5 recognizes the possibility of the occurrence of Acute Stress Disorder (ASS) in the first days after an event, a diagnosis that overlaps with PTSD, this diagnosis is rarely used in clinical practice as well as research. Patients with ASS usually report numbness, problems with memory, sleep and concentration, irritability, fears, or anxiety and have frequent re-experiences of the event. The usefulness of acute stress disorder as a classification is controversial in the literature (17). The difference with normal reactions to a major life event and with PTSS, apart from the time criterion (ASS can only be used for disturbances in the first 4 weeks after the experience), is not yet confirmed adequately.

As mentioned above, the world does not make sense any more after such a traumatic experience. Already in the 1940s the psychiatrist and concentration camp survivor Victor Frankl stated that the search for meaning played a crucial role in adaptation to threatening events (18). Cognitive approaches to trauma (e.g., 19) state that successful processing of the traumatic experience takes place when new information (e.g., the implication of the traumatic experience) is assimilated into existing structures or models. Unsuccessful processing occurs when the trauma-related information is not integrated into existing beliefs concerning self-image and world views (20). In low control situations not amenable to direct repair or problem-solving, such as trauma, loss, and serious illness, meaning-making is often the most adaptive strategy. As Schok et al. (20) have argued, meaning can be created by answering the question why an event occurred and why it happened to the person. It can also be operationalized as considering the ways in which one's life changed because of the event and assessing the extent to which one has "made sense of" the experience. Research findings have indicated that these two processes of finding a cause for the extreme event and finding personal benefits in the traumatic experience play independent roles in adjustment after trauma (21, 22). Therefore, the attempt to find meaning discloses itself twofold: in searching for an answer to the question why it happened as well as in rethinking one's attitudes and priorities to restructure one's life along more satisfying lines (23).

IMPACT ON THE COMMUNITY

Violence, disasters, accidents, and war are also stressful events for the community. Consequently, the impact of traumatic events goes beyond those who are directly exposed to the event and affects close relationships, the social environment, and the society at large. A human being does not live in a vacuum. He or she is surrounded by others. And those others will be confronted with the traumatic event and its aftermath too. This holds true for an event that struck an individual, such as a rape. Others hear about the event, perceive the suffering of the victims, and must cope with the implications. Naturally, it holds also true for events that struck a large group of people. For instance, a disaster undermines the social fabric of a community. It can lead to dissolution of social networks and to forced or voluntary migration. Regarding the health care system, it can lead to a disruption of the provision of social services and an erosion of the health care infrastructure (24, 25).

On the other hand, the social environment can stimulate recovery after trauma. The perception of social support has been found to be an influential factor for the effects of traumatic events on the individual as well as the community. For instance, studies undertaken after disasters have shown that social support had a significant stress-buffering effect for post-traumatic problems. Furthermore, a comprehensive meta-analysis (26) has shown that lack of social support systems and lack of sharing of emotions are significant risk factors for mental health disturbances.

THE OTHER SIDE OF TRAUMA: RESILIENCE

The finding that most people confronted with extreme life events did not develop disturbances like PTSD created interest in the phenomenon of *resilience*. This concept has been widely used in recent years in the scientific and clinical world. Resilience refers to a dynamic process involving positive adaptation to one's circumstances in the face of significant adversity, as defined by Luthar and Cicchetti (27). However, there are various understandings of resilience [see Ref. (28)]. Resilience may be treated as a quality, a personal trait, a process, and an outcome. While, for example, some researchers conceive of resilience

as a multiply determined developmental process that is not fixed, others use measures of trait resilience, which favors the assumption that resilience is a personality attribute [see for the different views Ref. (29)].

Investigation of resilience can lead to useful avenues for intervention. The concept offers a different perspective on risk and protection. Focusing on what makes individuals strong rather that what makes them weak may aid to understand what helps them to maintain their mental health. Sleijpen and colleagues examined strategies of young refugees in dealing with negative experiences (28). Their findings revealed that young refugees living in the Netherlands were affected by memories of traumatic events experienced in their country of origin or during the flight, but that current stressors, especially for young people without a residence permit, played a more significant role in determining their psychological well-being. The participants in this study used the following four strategies to deal with traumatic experiences and current stressors: (1) acting autonomously, (2) performing at school, (3) perceiving support from peers and parents, and (4) participating in the new society. These strategies helped the young refugees to strengthen their sense of power and control, they gave them some distraction, and they supported or sustained their spirit within the family unit and the new society [see Ref. (28)].

PROLONGED AFTERMATH

For public mental health initiatives, it is important to realize on the one hand the significance of the resilience of people affected, but at the other hand also the fact that disturbances can last for a very long period. Difficulties do not always disappear in time. Sometimes they may last for a very long time. 10 years after the Enschede Fireworks disaster still 6.7% of a representative sample of the inhabitants of the neighborhood had an indication of chronic disaster-related PTSD (30). 40 years after the Vietnam War (31), prevalence rates of PTSD were 4.5% (male USA veterans) and 6.1% (female veterans). In the World Mental Health Surveys (4), it was also found that PTSD symptoms typically were quite persistent.

The long-term aftermath of trauma can be illustrated with the following research finding. A large community-based sample of child survivors from World War II was compared with a reference group from the Dutch population as well as with clinical groups (32). These children survived internment in the Japanese camps in the former colony of the Dutch East Indies (now Indonesia) during the period 1942–1945 (and afterwards). Most of them were forced to migrate to the Netherlands in the 1940s and 1950s. Long-term sequelae of the persecution were studied by standardized questionnaires on posttraumatic responses, general health, and dissociation. Compared with control individuals of the same age that lived through the German occupation in the Netherlands during World War II, the child survivors from the former Dutch Indies reported significantly more traumatic experiences and mental health disturbances approximately 50 years after the war. 23 percent of these now adult child survivors in the community sample had an indication of PTSD related to the events in World War II [see Ref. (32)].

These results underline the long-term aftermath of traumatic experiences. This conclusion is also relevant for the many war refugees who migrated to Europe in recent years. In the field of psychotraumatology, there has been a continuing debate about the extent to which diagnostic criteria for PTSD adequately cover the posttraumatic symptomatology experienced by individuals exposed to prolonged, repeated, and interpersonal traumatic events, such as occurring in situations of domestic violence, war, and torture (33). This symptomatology is more complex, more severe, and more invasive than that captured by the classic PTSD diagnosis. This manifestation of psychopathology is referred to as *complex PTSD* (CPTSD). In the 11th version of the ICD (2), this concept is added as a formal diagnosis comorbid to PTSD. It consists of impairments in three domains: difficulties in emotion regulation, negative beliefs about oneself, and difficulties in sustaining relationships. The concept is attractive as it focuses on personal changes due to the confrontation with enduring violence and oppression, but it is as such also rather (too) close to personality disorders while it is not clear whether the addition of this new diagnostic concept is really required beyond PTSD. Research is also still indecisive about these matters. Because of these reasons, a concept such as complex PTSD was not included in DSM-5.

PUBLIC HEALTH STRATEGIES

Public health strategies are aimed at preventing or diminishing mental health problems and addressing the causes of these conditions (see also 10). These strategies are active on multiple levels: individual, family, community, and society. Unfortunately, public health care of trauma is a rather underdeveloped area (see Magruder et al., 2107), especially in contrast to the field of treatment of trauma-related disorders, in particular PTSD. Psychotherapies of PTSD have been found successful, as has been shown by many RCT's (randomized controlled trials) and meta-analyses, in comparison with control groups and placebo treatments [e.g., Ref. (34)]. Most evidence has been found for trauma-focused cognitive behavioral therapy and Eye Movement Desensitization and Reprocessing (EMDR), and to a somewhat lesser extent Narrative Exposure Therapy and Brief Eclectic Psychotherapy for PTSD [e.g., Ref. (35)]. However, here we focus only on public health strategies relevant to trauma care. They are all explicitly aimed at preventing the emergence of health problems or preventing the aggravation of these difficulties.

Preventing adversity. First, although it is a truism, one should bear in mind that stopping or avoiding exposure to events that can be experienced as traumatic is a sensible public health strategy. If disasters, accidents, or wars can be prevented by concrete measures, the chance on traumatic experiences and on their negative consequences is, by definition, taken away.

Creating awareness and recognition. Secondly, creating awareness and acknowledgment concerning the impact of trauma on the population is a strategy by which difficulties can be prevented. Psycho-education with the help of brochures is an obvious example of this. Similarly, so-called silent journeys by a community after a violent crime in their neighborhood

and creating monuments ("lieux de memoire") are just as exemplary regarding recognition and appreciation for the people affected by trauma.

The increase of awareness through public health campaigns has been suggested for combatting child sexual abuse (36). Public health campaigns serve to help the identification of affected children and to facilitate the recognition of their difficulties by adults. Such services imply the awareness of the impact of traumatic experiences in diverse domains (individual, societal), the recognition of signs and symptoms, the integration of knowledge about trauma in public health programs, and the prevention of re-traumatization for their users. In this respect, technology-based interventions (e.g., online platforms, social media, mobile applications) can be advantageous. Such campaigns of awareness and recognition should be accompanied by mental health services with adequate interventions for abused persons looking for care. Nevertheless, despite their positive aims and effects, at the same time, all these campaigns may have a downside: they can lead to complications, such as the risks of promoting an unnecessary victim status and medicalizing complaints of the affected persons, resulting in a reduction of the potential for spontaneous recovery (36, 37).

Strengthening resilience. The third group of strategies is focused on bolstering resilience and stimulating self-efficacy. For example, training programs have been developed in the armies of the USA and several European countries to allow military soldiers to deal with the stress of war and to be more resistant to the intense and overwhelming events they will be confronted with.

Counseling. Fourth, counseling people confronted with traumatic events is a well-known intervention in the field of trauma care. Various forms of secondary preventive interventions providing practical care, support, and information have been designed for employees of organizations confronted with extreme events in the work setting, such as the police and banks, but also for victims of large-scale acts of terrorism. These interventions consist of a couple of protocolled sessions in the first 2 or 3 months after a calamity [see for an overview Ref. (38)]. They are considered as quite helpful, although controlled research is mostly lacking. This intervention should not be confused with so-called psychological debriefing, a typically single session of group counseling directly after a disaster or an act of violence. If this form of support is focused too much on the ventilation of emotions, debriefing has been found to have a negative impact: posttraumatic reactions and depressive feelings are worsened and very early exposure to the trauma material may interfere with natural recovery processes (9, 38).

Reconciliation. A related form of post-trauma care are large-scale programs to reconcile people after large-scale conflicts. For instance, a civil war divides families, communities, and nations, often pitting one neighbor against another. Distrust, resentment, and anger dominate post-war society, just as much as passivity and emotional numbness. That is why programs are designed to reconcile people (perpetrators and victims) and to restore trust, connectedness, and social cohesion.

Such truth and reconciliation efforts were conducted in Sierra Leone (39). Community-level forums in 200 villages were set up in which victims detailed war atrocities and perpetrators confessed to war crimes. Research using a randomized control trial among more than 2,000 individuals showed that reconciliation led to greater forgiveness of perpetrators and strengthened social capital: social networks were larger, and people contributed more to public goods in treated villages. However, there were also negative psychological costs next to the positive societal benefits. The reconciliation intervention also worsened psychological health, increasing depression, anxiety, and PTSD in the same villages. For a subset of villages, outcomes were measured 9 months and 31 months after the intervention. Results showed that both positive and negative effects persisted into the longer time horizon. These findings suggest that policy-makers should be careful with reconciliation processes and must find ways to restrict the emphasis on emotions.

Policy making. Finally, there is the overarching field of policy making, a rather underdeveloped topic in trauma care. As Magruder et al. (40) stated, public policies should be formulated to prevent traumatic events, to understand risk and protective factors, to provide early intervention services for individuals and communities at risk of post-trauma maladjustment, and to shape societal norms to eliminate stigma. Extra priorities for improving mental health include a focus on adequately training researchers and professionals, supporting international collaborations, and encouraging scientists to share their expertise with policymakers. Furthermore, integration of physical and mental health care is especially important, as trauma-exposed individuals often seek help in primary care rather than mental health settings. Consequently, posttraumatic disturbances may go undiagnosed.

FINALLY

A public mental health perspective will help to develop preventive approaches to trauma and extend the impact of various forms of interventions. It will also make clear that trauma care will have to consider the community and the society at large. The concept of trauma is an attractive concept. It refers to both spectacular and shocking events that receive huge attention, such as acts of terrorism and large-scale calamities. Something dramatic happens that could happen to anyone: the cause appears to be clear and the responsibility appears to lay elsewhere. One could argue that traumatic experiences show us the limits of our abilities to master our lives and that they defy our efforts to control the circumstances. However, the concept of trauma is also a dangerous concept. It is often used too easy and too quick. Not every stressful event is a traumatic experience and not every person confronted with war, disaster, or terror is traumatized. Overstretching the concept may create the risk of medicalization of regular difficulties of the afflicted people and ignoring the self-reliance and the adaptive skills of them.

AUTHOR CONTRIBUTIONS

I am the sole author. I designed and wrote the manuscript.

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TRAUMA TYPES

ABOUT CHILD TRAUMA

TRAUMA TYPES

- Bullying
- Community Violence
- Complex Trauma
- Disasters
- Early Childhood Trauma
- Intimate Partner Violence
- Medical Trauma
- Physical Abuse
- Refugee Trauma
- Sexual Abuse
- Terrorism and Violence
- Traumatic Grief

POPULATIONS AT RISK

When a child feels intensely threatened by an event he or she is involved in or witnesses, we call that event a trauma. There is a range of traumatic events or trauma types to which children and adolescents can be exposed.

Bullying

Bullying is a deliberate and unsolicited action that occurs with the intent of inflicting social, emotional, physical, and/or psychological harm to someone who often is perceived as being less powerful.

view

Community Violence

Community violence is exposure to intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim.

view

Complex Trauma

Complex trauma describes both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure.

view

Disasters

Natural disasters include hurricanes, earthquakes, tornadoes, wildfires, tsunamis, and floods, as well as extreme weather events such as blizzards, droughts, extreme heat, and wind storms.

view

Early Childhood Trauma

Early childhood trauma generally refers to the traumatic experiences that occur to children aged 0-6.

view

Intimate Partner Violence

Intimate Partner Violence (IPV), also referred to as domestic violence, occurs when an individual purposely causes harm or threatens the risk of harm to any past or current partner or spouse.

view

Medical Trauma

Pediatric medical traumatic stress refers to a set of psychological and physiological responses of children and their families to single or multiple medical events.

view

Physical Abuse

Physical abuse occurs when a parent or caregiver commits an act that results in physical injury to a child or adolescent.

view

Refugee Trauma

Many refugees, especially children, have experienced trauma related to war or persecution that may affect their mental and physical health long after the events have occurred.

view

Sexual Abuse

Child sexual abuse is any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer.

view

Terrorism and Violence

Families and children may be profoundly affected by mass violence, acts of terrorism, or community trauma in the form of shootings, bombings, or other types of attacks.

view

Traumatic Grief

While many children adjust well after a death, other children have ongoing difficulties that interfere with everyday life and make it difficult to recall positive memories of their loved ones.

view

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Traumatic stress: effects on the brain

J. Douglas Bremner, MD

Brain areas implicated in the stress response include the amygdala, hippocampus, and prefrontal cortex. Traumatic stress can be associated with lasting changes in these brain areas. Traumatic stress is associated with increased cortisol and norepinephrine responses to subsequent stressors. Antidepressants have effects on the hippocampus that counteract the effects of stress. Findings from animal studies have been extended to patients with post-traumatic stress disorder (PTSD) showing smaller hippocampal and anterior cingulate volumes, increased amygdala function, and decreased medial prefrontal/anterior cingulate function. In addition, patients with PTSD show increased cortisol and norepinephrine responses to stress. Treatments that are efficacious for PTSD show a promotion of neurogenesis in animal studies, as well as promotion of memory and increased hippocampal volume in PTSD.

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Author affiliations: Departments of Psychiatry and Behavioral Sciences and Radiology, and the Emory Center for Positron Emission Tomography, Emory University School of Medicine, Atlanta, Ga, and the Atlanta VAMC, Decatur, Ga, USA

Address for correspondence: J Douglas Bremner, MD, Emory University, 1256 Briarcliff Rd, Room 308e, Atlanta, GA 30306, USA
(e-mail: jdbremn@emory.edu)

Effects of traumatic stress

Traumatic stressors such as early trauma can lead to post-traumatic stress disorder (PTSD), which affects about 8% of Americans at some time in their lives,[1] as well as depression,[2,3] substance abuse,[1,4] dissociation,[5] personality disorders,[6,7] and health problems.[8] For many trauma victims, PTSD can be a lifelong problem.[9] The President's New Freedom Commission Report highlights the importance of providing services for mental disorders related to early trauma.[10-12] However, the development of effective treatments is limited by gaps in knowledge about the underlying neurobiological mechanisms that mediate symptoms of trauma-related disorders like PTSD. This paper reviews preclinical and clinical studies on the effects of traumatic stress on the brain.

Normal development of the brain across the lifespan

To understand how traumatic stress occurring at different stages of the life cycle interacts with the developing brain, it is useful to review normal brain development. The normal human brain undergoes changes in structure and function across the lifespan from early childhood to late life. Understanding these normal developmental changes is critical for determining the difference between normal development and pathology, and how normal development and pathology interact.

Although the bulk of brain development occurs in utero, the brain continues to develop after birth. In the first 5 years of life there is an overall expansion of brain volume related to development of both gray matter and white

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Selected abbreviations and acronyms

ACTH	*adrenocorticotropic hormone*
BDNF	*brain-derived neurotropic factor*
BPD	*bipolar disorder*
CRF	*corticotropin-releasing factor*
CS	*conditioned stimulus*
FDG	*fluorodeoxyglucose*
HPA	*hypothalamic-pituitary-adrenal*
MRI	*magnetic resonance imaging*
mRNA	*messenger ribonucleic acid*
NAA	N-*acetyl aspartate*
PET	*positron emission tomography*
PTSD	*post-traumatic stress disorder*
US	*unconditioned stimulus*

matter structures; however, from 7 to 17 years of age there is a progressive increase in white matter (felt to be related to ongoing myelination) and decrease in gray matter (felt to be related to neuronal pruning) while overall brain size stays the same.[13-16] Gray matter areas that undergo the greatest increases throughout this latter developmental epoch include frontal cortex and parietal cortex.[17,18] Basal ganglia decrease in size, while corpus callosum,[19,20] hippocampus, and amygdala[21-23] appear to increase in size during childhood, although there may be developmental sex-laterality effects for some of these structures.[24] Overall brain size is 10% larger in boys than girls during childhood.[24]

During the middle part of life (from age 20 to 70) there is a gradual decrease in caudate,[25] diencephalon,[25] and gray matter,[25,26] which is most pronounced in the temporal[27] and frontal cortex,[26] with enlargement of the ventricles[26,27] and no change in white matter.[25,26] Studies have not been able to document changes in hippocampal volume in normal populations during this period.[27] After menopause in women at about the age of 50, however, there are changes in reproductive hormones, such as decreased levels of estrogen. Since estrogen promotes neuronal branching in brain areas such as the hippocampus,[28] a loss of estrogen may lead to changes in neuronal structure. Although the effects of menopause on the brain have not been well studied, it is known that sex hormones also affect brain function and circuitry[29]; therefore, the changes in sex hormones with menopause will presumably affect brain function, as well as possibly structure. There is some evidence in super-elderly individuals (age >70) for modest reductions in hippocampal volume with late stages of aging.[27,30] More robust findings have included increased ventricular volume and reduction in gray matter, temporal lobe, and cerebellum volumes with normal aging, that begins before the age of 70.[25,27,31-33]

Therefore, trauma at different stages in life will presumably have different effects on brain development. The few studies that have looked at this issue do suggest that there are differences in the effects of trauma on neurobiology, depending on the stage of development at which the trauma occurs. Studies in this area, however, have been limited.

Neurobiology of PTSD

PTSD is characterized by specific symptoms, including intrusive thoughts, hyperarousal, flashbacks, nightmares, and sleep disturbances, changes in memory and concentration, and startle responses. Symptoms of PTSD are hypothesized to represent the behavioral manifestation of stress-induced changes in brain structure and function. Stress results in acute and chronic changes in neurochemical systems and specific brain regions, which result in long-term changes in brain "circuits," involved in the stress response.[34-37] Brain regions that are felt to play an important role in PTSD include hippocampus, amygdala, and medial prefrontal cortex. Cortisol and norepinephrine are two neurochemical systems that are critical in the stress response *(Figure 1)*.

The corticotropin-releasing factor (CRF)/hypothalamic-pituitary-adrenal (HPA) axis system plays an important role in the stress response. CRF is released from the hypothalamus, with stimulation of adrenocorticotropic hormone (ACTH) release from the pituitary, resulting in glucocorticoid (cortisol in man) release from the adrenal, which in turn has a negative feedback effect on the axis at the level of the pituitary, as well as central brain sites including hypothalamus and hippocampus. Cortisol has a number of effects which facilitate survival. In addition to its role in triggering the HPA axis, CRF acts centrally to mediate fear-related behaviors,[38] and triggers other neurochemical responses to stress, such as the noradrenergic system via the brain stem locus coeruleus.[39] Noradrenergic neurons release transmitter throughout the brain; this is associated with an increase in alerting and vigilance behaviors, critical for coping with acute threat.[40-42]

Studies in animals showed that early stress has lasting effects on the HPA axis and norepinephrine. A variety of early stressors resulted in increased glucocorticoid

response to subsequent stressors.[43-45] Maternally deprived rats had decreased numbers of glucocorticoid receptors in the hippocampus, hypothalamus, and frontal cortex.[46] Stressed animals demonstrated an inability to terminate the glucocorticoid response to stress,[47,48] as well as deficits in fast-feedback of glucocorticoids on the HPA axis, which could be related to decreased glucocorticoid receptor binding in the hippocampus.[49] Early postnatal adverse experiences increase hypothalamic CRF messenger ribonucleic acid (mRNA), median eminence CRF content, and stress-induced glucocorticoid[50] and ACTH release.[46] These effects could be mediated by an increase in synthesis of CRH mRNA following stress.[51] In nonhuman primates, adverse early experiences resulted in long-term effects on behaviors, as well as elevated levels of CRF in the cerebrospinal fluid.[52] Exposure to chronic stress results in potentiation of noradrenergic responsiveness to subsequent stressors and increased release of norepinephrine in the hippocampus and other brain regions.[42]

Preclinical and clinical studies have shown alterations in memory function following traumatic stress,[53] as well as changes in a circuit of brain areas, including hippocampus, amygdala, and medial prefrontal cortex, that mediate alterations in memory.[54] The hippocampus, a brain area involved in verbal declarative memory, is very sensitive to the effects of stress. Stress in animals is associated with damage to neurons in the CA3 region of the hippocampus (which may be mediated by hypercortisolemia, decreased brain-derived neurotrophic factor (BDNF), and/or elevated glutamate levels) and inhibition of neurogenesis.[55-60] High levels of glucocorticoids seen with stress were also associated with deficits in new learning.[61,62]

Antidepressant treatments have been shown to block the effects of stress and/or promote neurogenesis.[58,63-66] Animal studies have demonstrated several agents with

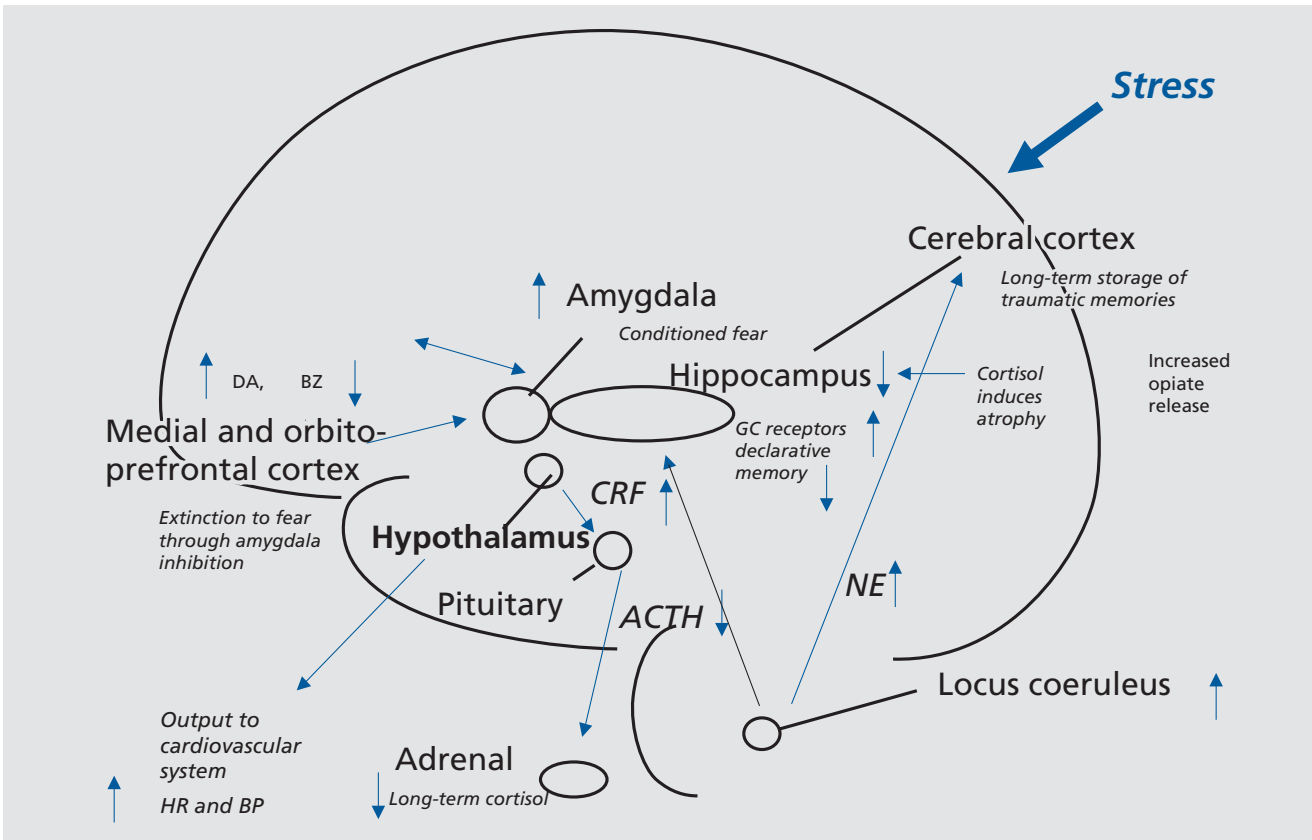

Figure 1. Lasting effects of trauma on the brain, showing long-term dysregulation of norepinephrine and cortisol systems, and vulnerable areas of hippocampus, amygdala, and medial prefrontal cortex that are affected by trauma. GC, glucocorticoid; CRF, corticotropin-releasing factor; ACTH, adrenocorticotropin hormone; NE, norepinephrine; HR, heart rate; BP, blood pressure; DA, dopamine; BZ, benzodiazapine; GC, glucocorticoid

potentially beneficial effects on stress-induced hippocampal damage. It has been found that phenytoin blocks the effects of stress on the hippocampus, probably through modulation of excitatory amino acid-induced neurotoxicity.[67] Other agents, including tianeptine, dihydroepiandosterone (DHEA), and fluoxetine have similar effects.[63,64,66,68-73] These medications may share a common mechanism of action through upregulation of cyclic adenosine monophosphate (cAMP) response element binding protein (CREB) that may lead to regulation of expression of specific target genes involved in structural modeling of the hippocampus. Such treatment effects on BDNF and trkB messenger ribonucleic acid (mRNA), can have long-term effects on brain structure and function. There is new evidence that neurogenesis is necessary for the behavioral effects of antidepressants,[74,75] although this continues to be a source of debate.[72,76]

The hippocampus demonstrates an unusual capacity for neuronal plasticity and regeneration. In addition to findings noted above related to the negative effects of stress on neurogenesis, it has recently been demonstrated that changes in the environment, eg, social enrichment or learning, can modulate neurogenesis in the dentate gyrus of the hippocampus, and slow the normal age-related decline in neurogenesis.[77,78] Rat pups that are handled frequently within the first few weeks of life (picking them up and then returning them to their mother) had increased type II glucocorticoid receptor binding which persisted throughout life, with increased feedback sensitivity to glucocorticoids, and reduced glucocorticoid-mediated hippocampal damage in later life.[79] These effects appear to be due to a type of "stress inoculation" from the mothers' repeated licking of the handled pups.[80] Considered together, these findings suggest that early in the postnatal period there is a naturally occurring brain plasticity in key neural systems that may "program" an organism's biological response to stressful stimuli. These findings may have implications for victims of childhood abuse.

Long-term dysregulation of the HPA axis is associated with PTSD, with low levels of cortisol found in chronic PTSD in many studies[81-86] and elevations in CRF.[82,87] Not all studies, however, have found lower cortisol levels in PTSD.[88-91] Exposure to a traumatic reminder appears to be associated with a potentiated release of cortisol in PTSD.[92]

The few studies of the effects of early stress on neurobiology conducted in clinical populations of traumatized children have generally been consistent with findings from animal studies. Research in traumatized children has been complicated by issues related to psychiatric diagnosis and assessment of trauma.[93] Some studies have not specifically examined psychiatric diagnosis, while others have focused on children with trauma and depression, and others on children with trauma and PTSD. Sexually abused girls (in which effects of specific psychiatric diagnosis were not examined) had normal baseline cortisol and blunted ACTH response to CRF,[94] while women with childhood abuse-related PTSD had hypercortisolemia.[95] Another study of traumatized children in which the diagnosis of PTSD was established showed increased levels of cortisol measured in 24-hour urines.[96] Emotionally neglected children from a Romanian orphanage had elevated cortisol levels over a diurnal period compared with controls.[97] Maltreated school-aged children with clinical-level internalizing problems had elevated cortisol compared with controls.[98] Depressed preschool children showed increased cortisol response to separation stress.[99] Adult women with a history of childhood abuse showed increased suppression of cortisol with low-dose (0.5 mg) dexamethasone.[100] Women with PTSD related to early childhood sexual abuse showed decreased baseline cortisol based on 24-hour diurnal assessments of plasma, and exaggerated cortisol response to stressors (traumatic stressors[101] more than neutral cognitive stressors).[102] We also found that patients with PTSD had less of an inhibition of memory function with synthetic cortisol (dexamethasone) than normal subjects.[103] Adult women with depression and a history of early childhood abuse had an increased cortisol response to a stressful cognitive challenge relative to controls,[104] and a blunted ACTH response to CRF challenge.[105] These findings show long-term changes in stress responsive systems. Early in development, stress is associated with increased cortisol and norepinephrine responsiveness, whereas with adulthood, resting cortisol may be normal or low, but there continues to be increased cortisol and norepinephrine responsiveness to stressors. In addition, early stress is associated with alterations in hippocampal morphology which may not manifest until adulthood, as well as increased amygdala function and decreased medial prefrontal function.

Cognitive function and brain structure in PTSD

Studies in PTSD are consistent with changes in cognition and brain structure. Multiple studies have demonstrated verbal declarative memory deficits in PTSD.[53,106-108]

Patients with PTSD secondary to combat[109-113] and childhood abuse[114,115] were found to have deficits in verbal declarative memory function based on neuropsychological testing. Studies, using a variety of measures (including the Wechsler Memory Scale, the visual and verbal components of the Selective Reminding Test, the Auditory Verbal Learning Test, Paired Associate Recall, the California Verbal New Learning Test, and the Rivermead Behavioral Memory Test), found specific deficits in verbal declarative memory function, with a relative sparing of visual memory and IQ.[109-113,115-124] These studies have been conducted in both patients with PTSD related to Vietnam combat,[109-113,116,119-121,123] rape,[117] the Holocaust,[124-126] adults with early childhood abuse,[115] and traumatized children.[118] One study in adult rape survivors showed that verbal declarative memory deficits are specifically associated with PTSD, and are not a nonspecific effect of trauma exposure.[117] Another study of women with early childhood sexual abuse in which some, but not all, of the patients had PTSD, showed no difference between abused and nonabused women,[127] while another study was not able to show a difference between Vietnam veterans with and without PTSD.[128] Other types of memory disturbances studied in PTSD include gaps in memory for everyday events (dissociative amnesia),[129] deficits in autobiographical memory,[130] an attentional bias for trauma-related material,[131-140] and frontal lobe-related impairments.[141] These studies suggest that traumas such as early abuse with associated PTSD result in deficits in verbal declarative memory. It is not clear if cognitive deficits in early abuse survivors are specific to PTSD and are not related to the nonspecific effects of abuse.

These effects were specific to verbal (not visual) memory, and were significant after controlling for IQ. Some of these studies used neuropsychological tests of declarative memory, such as the Wechsler Memory Scale (WMS) and Selective Reminding Test (SRT), that have been validated as sensitive to loss of neurons in the CA3 region of the hippocampus in epileptics who underwent hippocampal resection.[142,143] Vietnam veterans with PTSD were originally shown by us to have 8% smaller right hippocampal volume based on magnetic resonance imaging (MRI) relative to controls matched for a variety of factors such as alcohol abuse and education ($P<0.05$); smaller volume was correlated with deficits in verbal declarative memory function as measured with the Wechsler Memory Scale.[144] A second study from our group showed a 12% reduction in left hippocampal volume in 17 patients with childhood abuse-related PTSD compared with 17 case-matched controls, that was significant after controlling for confounding factors.[145] Smaller hippocampal volume was shown to be specific to PTSD within the anxiety disorders, and was not seen in panic disorder.[146] Gurvits et al[147] showed bilateral hippocampal volume reductions in combat-related PTSD compared with combat veterans without PTSD and normal controls. Combat severity was correlated with volume reduction. Stein et al[148] found a 5% reduction in left hippocampal volume. Other studies in PTSD have found smaller hippocampal volume and/or reductions in *N*-acetyl aspartate (NAA), a marker of neuronal integrity.[149-153] Studies in childhood[154-156] and new-onset[157,158] PTSD did not find hippocampal volume reduction, although reduced NAA (indicating loss of neuronal integrity) was found in medial prefrontal cortex in childhood PTSD.[159] In a recent meta-analysis we pooled data from all of the published studies and found smaller hippocampal volume for both the left and the right sides, equally in adult men and women with chronic PTSD, and no change in children.[160] More recent studies of holocaust survivors with PTSD did not find a reduction in hippocampal volume, although PTSD patients who developed PTSD in response to an initial trauma had smaller hippocampal volume compared with those who developed PTSD after repeated trauma, suggesting a possible vulnerability of smaller hippocampal volume.[161] Two independent studies have shown that PTSD patients have deficits in hippocampal activation while performing a verbal declarative memory task,[149,162] although it is unclear if this is a deficit in activation or higher hippocampal blood flow at baseline. Both hippocampal atrophy and hippocampal-based memory deficits reversed with treatment with the selective serotonin reuptake inhibitor (SSRI) paroxetine, which has been shown to promote neurogenesis (the growth of neurons) in the hippocampus in preclinical studies.[163] In addition, treatment with the anticonvulsant phenytoin led to an improvement in PTSD symptoms[164] and an increase in right hippocampal and right cerebral volume.[165] We hypothesize that stress-induced hippocampal dysfunction may mediate many of the symptoms of PTSD which are related to memory dysregulation, including both explicit memory deficits as well as fragmentation of memory in abuse survivors. It is unclear at the current time whether these changes are specific to PTSD, whether certain common environmental events (eg, stress) in different disorders lead to similar brain changes, or whether common genetic traits lead to similar outcomes.

The meaning of findings related to deficits in memory and the hippocampus in PTSD, and questions related to the relative contribution of genetic and environmental factors, has become an important topic in the field of PTSD and stress research. There are three possible models, taking into account genetic or environmental factors, which have been proposed to explain smaller hippocampal volume in PTSD: Model A (Environment), Model B (Environment and Genetic), and Model C (Genetic).[166-169] In Model C (Genetic), smaller hippocampal volume represents a premorbid risk factor for PTSD. In support of this model Pitman and colleagues[170] have demonstrated that lower premilitary IQ is associated with combat-related PTSD, as well as finding a correlation between PTSD symptoms and hippocampal volume in twin brothers.[151] Model A (Environment) states that stress leads to damage or inhibition of neurogenesis via hypercortisolemia, decreased BDNF, or increased glutamate. Model B (Environment/Genetic) states that a combination of environmental and genetic factors leads to deficits in hippocampal function and structure. Showing that an intervention like medication changes hippocampal volume and cognition would provide support for at least a partial contribution of the environment to the outcomes of interest.

In addition to the hippocampus, other brain structures have been implicated in a neural circuitry of stress, including the amygdala and prefrontal cortex. The amygdala is involved in memory for the emotional valence of events, and plays a critical role in the acquisition of fear responses. The medial prefrontal cortex includes the anterior cingulate gyrus (Brodmann's area [BA] 32) and subcallosal gyrus (area 25) as well as orbitofrontal cortex. Lesion studies demonstrated that the medial prefrontal cortex modulates emotional responsiveness through inhibition of amygdala function. Conditioned fear responses are extinguished following repeated exposure to the conditioned stimulus in the absence of the unconditioned (aversive, eg, electric shock) stimulus. This inhibition appears to be mediated by medial prefrontal cortical inhibition of amygdala responsiveness.

Animal studies also show that early stress is associated with a decrease in branching of neurons in the medial prefrontal cortex.[171] Rauch and colleagues found smaller volume of the anterior cingulate based on MRI measurements in PTSD[172]; we have replicated these findings in women with abuse and PTSD.[160] An important question is whether these effects are reversible with treatment.

Neural circuits in PTSD

Brain imaging studies have shown alterations in a circuit including medial prefrontal cortex (including anterior cingulate), hippocampus, and amygdala in PTSD. Many of these studies have used different methods to trigger PTSD symptoms (eg, using traumatic cues) and then look at brain function. Stimulation of the noradrenergic system with yohimbine resulted in a failure of activation in dorsolateral prefrontal, temporal, parietal, and orbitofrontal cortex, and decreased function in the hippocampus.[173] Exposure to traumatic reminders in the form of traumatic slides and/or sounds or traumatic scripts was associated with an increase in PTSD symptoms, decreased blood flow, and/or failure of activation in the medial prefrontal cortex/anterior cingulate, including Brodmann's area 25, or subcallosal gyrus, area 32 and 24, as measured with positron emission tomography (PET) or functional MRI (fMRI).[174-183] Other findings in studies of traumatic reminder exposure include decreased function in hippocampus,[176] visual association cortex,[176,180] parietal cortex,[176,179,180,184] and inferior frontal gyrus,[176,179,180,184] and increased function in amygdala,[181,184] posterior cingulate,[174,176,177,180] and parahippocampal gyrus.[174,176,178] Shin and colleagues found a correlation between increased amygdala function and decreased medial prefrontal function with traumatic reminders,[181] indicating a failure of inhibition of the amygdala by the medial prefrontal cortex that could account for increased PTSD symptoms with traumatic reminders. Other studies found increased amygdala and parahippocampal function and decreased medial prefrontal function during performance of an attention task,[182] increased posterior cingulate and parahippocampal gyrus and decreased medial prefrontal and dorsolateral prefrontal function during an emotional Stroop paradigm,[185] and increased amygdala function with exposure to masked fearful faces.[186] Retrieval of emotionally valenced words[187] (eg "rape-mutilate") in women with PTSD from early abuse resulted in decreases in blood flow in an extensive area which included orbitofrontal cortex, anterior cingulate, and medial prefrontal cortex (BA 25, 32, and 9), left hippocampus, and fusiform gyrus/inferior temporal gyrus, with increased activation in posterior cingulate, left inferior parietal cortex, left middle frontal gyrus, and visual association and motor cortex.[188] Another study found a failure of medial prefrontal cortical/anterior cingulate activation, and decreased visual association and parietal

cortex function, in women with abuse and PTSD relative to women with abuse without PTSD, during performance of the emotional Stroop task (ie, naming the color of a word such as "rape").[189] We recently found increased amygdala activation with classical fear conditioning (pairing a shock and a visual stimulus), and decreased medial prefrontal cortex function with extinction, in abuse-related PTSD.[190] The findings described above point to a network of related regions mediating symptoms of PTSD, including medial prefrontal cortex, anterior cingulate, hippocampus, amygdala, posterior cingulate, parietal, visual association, and dorsolateral prefrontal cortex.[191]

Fewer brain imaging studies have been performed in children with PTSD. Several studies have shown alterations in electroencephalogram (EEG) measures of brain activity in children with a variety of traumas who were not selected for diagnosis compared with healthy children. About half of the children in these studies had a psychiatric diagnosis. Abnormalities were located in the anterior frontal cortex and temporal lobe and were localized to the left hemisphere.[192,193] Two studies have found reductions in brain volume in children with trauma and PTSD symptoms.[154,155] One group did not find reductions in hippocampal volume, either at baseline or over a longitudinal period,[154,156] while another group found an 8.5% reduction in hippocampal volume that was not significant after controlling for smaller brain volumes in the PTSD group.[155] One study used single-voxel proton magnetic resonance spectroscopy (proton MRS) to measure relative concentration of NAA and creatinine (a marker of neuronal viability) in the anterior cingulate of 11 children with maltreatment-related PTSD and 11 controls. The authors found a reduction in the ratio of NAA to creatinine in PTSD relative to controls.[159] Studies have also found smaller size of the corpus callosum in children with abuse and PTSD relative to controls.[154] as well as larger volume of the superior temporal gyrus.[194] In a study of abused children in whom diagnosis was not specified, there was an increase in T2 relaxation time in the cerebellar vermis, suggesting dysfunction in this brain region.[195] The reason for differences in findings between adults and children are not clear; however, factors such as chronicity of illness or interaction between trauma and development may explain findings to date.

In summary, dysfunction of a circuit involving the medial prefrontal cortex, dorsolateral prefrontal cortex, and possibly hippocampus and amygdala during exposure to traumatic reminders may underlie symptoms of PTSD. These studies have primarily assessed neural correlates of traumatic remembrance, while little has been done in the way of utilizing cognitive tasks as probes of specific regions, such as memory tasks as probes of hippocampal function.

MRI assessment of brain abnormalities in PTSD and trauma spectrum disorders

Findings of smaller hippocampal volume appear to be associated with a range of trauma related psychiatric disorders, as long as there is the presence of psychological trauma. We have used MRI to show smaller hippocampal volume in PTSD,[144,145,149,196] depression,[197] depression with early abuse,[198] borderline personality disorder (BPD) with early abuse,[199] and Dissociative Identity Disorder (DID) with early abuse.[200] The greatest magnitude of difference was seen in the DID patients, who had unusually severe early childhood sexual abuse histories. We did not find changes in hippocampal volume in patients with panic disorder without a history of abuse (suggesting that findings are not generalized to other anxiety disorders).[201] We found smaller amygdala volume in BPD with early abuse[199] and increased amygdala volume in depression.[197,202] Patients with depression had smaller orbitofrontal cortex volume with no changes in anterior cingulate (BA 32) or medial prefrontal cortex (BA 25).[203] More recently, we found smaller anterior cingulate volume in women with abuse and PTSD relative to controls.[204]

Neural circuits in women with abuse and PTSD

We have used PET to study neural circuits of trauma-related disorders in women with early abuse and a variety of trauma spectrum mental disorders. Initially we studied women with abuse and PTSD.[54,205-208] We initially measured brain activation with a paragraph-encoding task in conjunction with PET O-15 water measurement of brain blood flow. Women with abuse and PTSD showed a failure of hippocampal activation during the memory task relative to controls.[149] Women with abuse and PTSD in this study also had smaller hippocampal volume measured with MRI relative to both women with abuse without PTSD and nonabused non-PTSD women. The failure of hippocampal activation was significant

after controlling differences in hippocampal volume as well as accuracy of encoding. In another study we measured neural correlates of exposure to a personalized script of childhood sexual abuse. Women with abuse and PTSD showed a failure of medial prefrontal and hippocampal activation relative to abused women without PTSD.[176] Women with abuse and PTSD also showed a failure of medial prefrontal and hippocampal function during recall of paired word associates with traumatic-emotional content (eg, "rape-mutilate"),[188] and decreased medial prefrontal function during an emotional Stroop task with trauma-content words.[209] Other studies showed a failure of medial prefrontal activation in women with BPD and early abuse during an abandonment script.[210] Women with BPD and abuse had increased psychophysiological responses to abandonment scripts relative to trauma scripts, while women with PTSD and abuse had the opposite pattern,[211] indicating differential responding in those two disorders in spite of the common exposure to early abuse.

In another project we studied 19 physically healthy women including women with a history of severe childhood sexual abuse and the diagnosis of current PTSD (N=8) and women without childhood abuse or PTSD (N=11).[212] All subjects underwent PET measurement of cerebral blood flow and psychophysiology measurement of heart rate and skin conductance during habituation, acquisition, and extinction conditions, on a single day, with scanning during a control condition on another day separated by 1 week from the active condition. Subjects were randomly assigned to undergo either the active condition or the control condition first (ie, active-control or control-active). Subjects were told at the beginning of the study that they would be exposed to electric shocks and viewing images on a screen during collection of PET and psychophysiology data. During habituation subjects were exposed to a blue square on a screen (conditioned stimulus [CS]), 4 seconds in duration, followed by 6 seconds of a blank screen. CS exposure was repeated eight times at regular intervals over 80 seconds in two separate blocks separated by 8 minutes. One PET image of brain blood flow was obtained starting from the beginning of each of the blocks. During active fear acquisition exposure to the blue square (CS) was paired with an electric shock to the forearm (unconditioned stimulus [UCS]). Subjects had 8 paired CS-UCS presentations at 10-second intervals for each of two blocks. With extinction subjects were again exposed to the blue squares (CS) without shock ("active" extinction). On a second day subjects went through the same procedure with electric shocks delivered randomly when the blue square was not present (unpaired CS-UCS) (an equal number as on day 1) during scans 3 and 4, which served as a control for active fear acquisition.

PTSD subjects had increased symptoms of anxiety, fear, dissociation, distress, substance use disorders (SUDs), and PTSD at all time points during both study days relative to non-PTSD. Acquisition of fear was associated with increased skin conductance (SC) responses to CS exposure during the active versus the control conditions in all subjects. There was increased SC for PTSD during the first CS-UCS presentation. Extinction of fear was associated with increased skin conductance (SC) responses to CS exposure during the active versus the control conditions in all subjects. When PTSD and non-PTSD subjects were examined separately, SC levels were significantly elevated in non-PTSD subjects undergoing extinction following the active compared with the control condition during session one.

PTSD subjects showed activation of the bilateral amygdala during fear acquisition compared with the control condition. Non-PTSD subjects showed an area of activation in the region of the left amygdala. When PTSD subjects and control subjects were directly compared, PTSD subjects showed greater activation of the left amygdala during the fear conditioning condition (pairing of US and CS) relative to the random shock control than healthy women. Other areas that showed increased activation with fear acquisition in PTSD included bilateral superior temporal gyrus (BA 22), cerebellum, bilateral inferior frontal gyrus (BA 44, 45), and posterior cingulate (BA 24). Fear acquisition was associated with decreased function in medial prefrontal cortex, visual association cortex, and medial temporal cortex, inferior parietal lobule function, and other areas. Extinction of fear responses was associated with decreased function in the orbitofrontal and medial prefrontal cortex (including subcallosal gyrus, BA 25, and anterior cingulate BA 32), visual association cortex, and other areas, in the PTSD subjects, but not in the controls. Amygdala blood flow with fear acquisition was negatively correlated with medial prefrontal blood flow with fear extinction (increased blood flow in amygdala correlated with decreased blood flow in medial prefrontal cortex) in all subjects (r=-0.48; P<0.05). Increased amygdala blood flow with fear acquisition was positively correlated with PTSD (r=0.45), anxiety (r=0.44) and disso-

ciative (r=0.80) symptom levels in PTSD (but not non-PTSD) subjects. There was a negative correlation between medial prefrontal blood flow during extinction and anxiety as measured with the Panic Attack Symptom Scale (PASS) during extinction in the PTSD group only, which was significant after correction for multiple comparisons (r=-0.90; P=0.006).[190] This study was consistent with increased amygdala function with fear acquisition, and decreased medial prefrontal (anterior cingulate) function during extinction in PTSD. This is consistent with the model of an overactive amygdala and a failure of medial prefrontal cortex to extinguish, or shut off, the amygdala, when the acute threat is no longer present.

Treatment of PTSD

Intervening soon after the trauma is critical for long-term outcomes, since with time traumatic memories become indelible and resistant to treatment.[213] Early treatments are not necessarily effective. For instance, studies have shown that Critical Incident Stress Debriefing (CISD) can be associated with a worsening of outcome relative to no treatment at all.[214] Pharmacological treatment of chronic PTSD has shown efficacy originally for imipramine,[215] amitriptyline,[216] and phenalzine,[215] and later for brofaramine,[217] paroxetine,[218,219] and sertraline.[220] Selective serotonin reuptake inhibitors (SSRIs) and tianeptine are now recommended as first-line treatment for PTSD.[221-226]

The utility of early treatment is also demonstrated by animal studies showing that pretreatment before stress with antidepressants reduces chronic behavioral deficits related to stress.[227,228] Antidepressants, including both norepinephrine and serotonin reuptake inhibitors, as well as gabapentine and phenytoin, promote nerve growth (neurogenesis) in the hippocampus, while stress inhibits neurogenesis.[63,64,66,69,71,75,229] This is important because hippocampal neurogenesis has been shown to be required for antidepressant response.[74]

Few studies have examined the effects of pharmacological treatment on brain structure and function in patients with trauma-related mental disorders. We studied a group of patients with depression and found no effect of fluoxetine on hippocampal volume, although there were increases in memory function[230] and hippocampal activation measured with PET during a memory encoding task. Depressed patients with a history of childhood trauma were excluded, and we subsequently have found hippocampal volume reductions at baseline in women with early abuse and depression but not in women with depression without early abuse;[198] this suggests that the study design of excluding patients with early trauma may account for the negative result. Other studies in depression showed that smaller hippocampal volume was a predictor of resistance to antidepressant treatment.[231] Smaller orbitofrontal cortex volume is associated with depression; one study in geriatric depression found smaller orbitofrontal cortex volume, while length of antidepressant exposure was correlated with larger orbitofrontal volume.[232]

Several studies have looked at functional brain imaging response to antidepressants in depression. Single photon-emission computed tomography (SPECT) blood flow studies in depression showed that antidepressants increased anterior cingulate, right putamen, and right thalamus function.[233] SPECT Xenon-133 studies showed reduced prefrontal function at baseline in depression, with treatment responders showing reduced perfusion in prefrontal cortex compared with nonresponders after treatment.[234] In a fluorodeoxyglucose (FDG) PET study of brain function patients with depression treated with fluoxetine who had a positive response to treatment had limbic and striatal decreases (subgenual cingulate, hippocampus, insula, and pallidum) and brain stem and dorsal cortical increases (prefrontal, parietal, anterior, and posterior cingulate) in function. Failed response was associated with a persistent 1-week pattern and absence of either subgenual cingulate or prefrontal changes.[235] Sertraline resulted in an increase in middle frontal gyrus activity in depression measured with PET FDG, as well as increased function in right parietal lobe and visual association cortex.[236] Successful paroxetine therapy of depression was associated with increased glucose metabolism measured with PET in dorsolateral, ventrolateral, and medial aspects of the prefrontal cortex, parietal cortex, and dorsal anterior cingulate. Areas of decreased metabolism were noted in both anterior and posterior insular regions (left) as well as right hippocampal and parahippocampal regions.[237] In another PET FDG study, at baseline, subjects with depression had higher normalized metabolism than controls in the prefrontal cortex (and caudate and thalamus), and lower metabolism in the temporal lobe. With treatment with paroxetine, subjects with depression had metabolic changes in the direction of normalization in these regions.[238] A PET FDG study of patients with depression and controls showed that at baseline, the mean metabolism was increased in the left and right lateral orbital cortex/ventrolateral prefrontal cortex (PFC), left amygdala,

and posterior cingulate cortex, and decreased in the subgenual anterior cingulate cortex (ACC) and dorsal medial/dorsal anterolateral PFC in depressives relative to controls. Following treatment with antidepressants, metabolism significantly decreased in the left amygdala and left subgenual ACC. The metabolic reduction in the amygdala and right subgenual ACC appeared largely limited to those subjects who both responded to treatment and remained well at 6 months' follow-up.[239] Another study showed that antidepressant treatment of depression resulted in a decrease in amygdala activation with emotional faces as measured with fMRI.[240] In summary, studies show changes in limbic and prefrontal cortical regions with successful antidepressant treatment of depression.

Fewer studies have looked at the effects of pharmacological treatment on the brain in anxiety disorders. One PET FDG study showed that caudate function decreased with treatment of obsessive compulsive disorder with antidepressants.[241] Paroxetine resulted in a decrease in glutamate/glutamine measured with magnetic resonance spectroscopy (MRS) in children with obsessive-compulsive disorder (OCD).[242] Patients with PTSD were shown to have an increase in hippocampal volume and memory function with paroxetine,[163] and increased right hippocampal and right cerebral volume with phenytoin.[165] No published studies have looked at the effects of pharmacological treatment on brain function in PTSD, or on sensitive markers of brain chemistry like NAA.

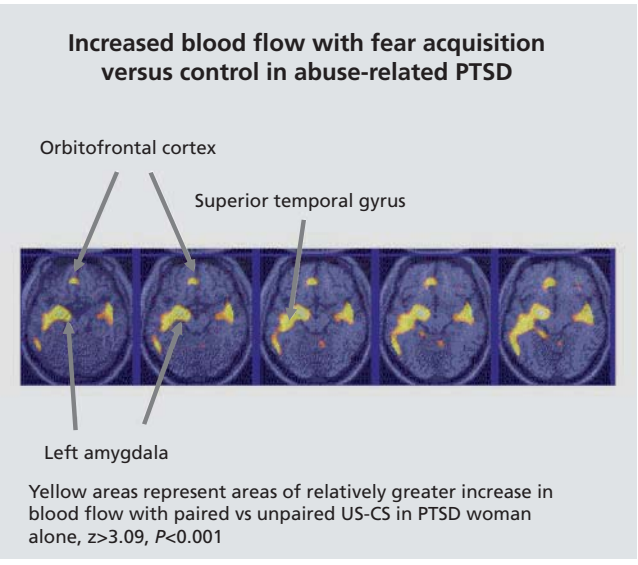

Figure 2. Neural correlates of fear conditioning in women with abuse and PTSD. There was increased amygdala activation with fear acquisition using a classical conditioning paradigm relative to non-PTSD abused women. PTSD, post-traumatic stress disorder

Brain biomarkers like NAA represent an objective marker of neural plasticity. To date psychiatry has relied on subjective reports as the gold standard. However, this is limited by self-reporting and the subjective interpretations of symptoms and response to treatment. Brain markers of antidepressant response may provide a complementary approach to assessing response to treatment, as well as providing insight into the mechanisms of treatment response. Our group is trying to look at mechanisms in the brain underlying treatment response in PTSD.

Effects of pharmacotherapy on brain function and structure in PTSD

We have begun to assess the effects of pharmacotherapy on brain structure and function in PTSD.[243] We recently assessed the effects of phenytoin on brain structure and function. Studies in animals show that phenytoin, which is used in the treatment of epilepsy and is known to modulate glutamatergic function, blocks the effects of stress on the hippocampus.[67] We studied nine patients with PTSD in an open-label function before and after treatment with phenytoin. Phenytoin resulted in a significant improvement in PTSD symptoms.[164] Phenytoin also resulted in increases in both right hippocampal volume and right hemisphere volume.[165] These findings indicate that phenytoin has an effects on PTSD symptoms as well as brain structure in PTSD patients.

We have assessed the effects of open-label paroxetine on memory and the hippocampus in PTSD. Male and female patients with symptoms of PTSD were medication-free for at least 4 weeks before participation in the study. Twenty-eight patients were found to be eligible and started the medication phase. Of the total patient sample five patients did not finish due to noncompliance; 23 patients completed the study.

Before patients started the medication phase, neuropsychological tests were administered, including the *Wechsler Adult Intelligence Scale – Revised*, WAIS-R (arithmetic, vocabulary, picture arrangement, and block design test), two subtests of the *Wechsler Memory Scale-Revised*, WMS-R, including logical memory (free recall of two story narratives, which represents verbal memory) and figural memory (which represents visual memory and involved reproduction of designs after a 6-second presentation); and the verbal and visual components of

the *Selective Reminding Test*, SRT.

Paroxetine was prescribed in the first visit after the pre-treatment assessments. All patients started open-label with a dose of 10 mg daily and were titrated up to 20 mg in 4 days.

Paroxetine treatment resulted in a mean 54% reduction in PTSD symptoms as measured with mean changes from baseline on the CAPS total score ($P<0.005$) among study completers. Improvement was equally strong on all symptom cluster scores (Re-experiencing, Avoidance/Numbing, Hyperarousal). Treatment also resulted in significant improvements in verbal declarative memory as measured with the WMS-R paragraph recall for delayed recall ($P<0.005$) and percent retention (80.2 to 91.1; $P=0.003$), but not immediate recall. Improvements were significant on all subscales of the Verbal Component of the SRT; including long-term recall and delayed recall.

Repeated measures ANOVA with side as the repeated measure showed a main effect for treatment related to a 4.6% increase in mean hippocampal volume (1857.3 mm^3 [SD 225.6] to 1906.2 mm^3, [SD 243.2]) with treatment (F=8.775 df=1. 36; $P=0.005$). Increased hippocampal volume was seen for both left (5.6%) (1807.6 mm^3 [SD 255.5] to 1909.3 mm^3 [SD 236.9]) and right (3.7%) (1906.9 mm^3 [SD 195.8] to 1976.7 mm^3 (SD 249.6]) hippocampus. There was no change in whole brain volume with treatment. Increase in hippocampal volume was significant after adding whole brain volume before and after treatment to the model.

Discussion

Traumatic stress has a broad range of effects on brain function and structure, as well as on neuropsychological components of memory. Brain areas implicated in the stress response include the amygdala, hippocampus, and prefrontal cortex. Neurochemical systems, including cortisol and norepinephrine, play a critical role in the stress response. These brain areas play an important role in the stress response. They also play a critical role in memory, highlighting the important interplay between memory and the traumatic stress response. Preclinical studies show that stress affects these brain areas. Furthermore, antidepressants have effects on the hippocampus that counteract the effects of stress. In fact, promotion of nerve growth (neurogenesis) in the hippocampus may be central to the efficacy of the antidepressants. Studies in patients with PTSD show alterations in brain areas implicated in animal studies, including the amygdala, hippocampus, and prefrontal cortex, as well as in neurochemical stress response systems, including cortisol and norepinephrine. Treatments that are efficacious for PTSD show a promotion of neurogenesis in animal studies, as well as promotion of memory and increased hippocampal volume in PTSD. Future studies are needed to assess neural mechanisms in treatment response in PTSD. ❑

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Estrés traumático: efectos en la cerebro

El estrés traumático surte efectos muy diversos sobre la función y la estructura cerebrales. Las regiones cerebrales implicadas en la respuesta al estrés son la amígdala (núcleo amigdalino), el hipocampo y la corteza prefrontal. Los sistemas neuroquímicos, como el cortisol y la noradrenalina, desempeñan una misión crítica en la respuesta al estrés. Estas regiones cerebrales influyen sobre la respuesta al estrés y sobre la memoria, lo que subraya la interrelación entre la memoria y la respuesta al estrés traumático. Los antidepresivos actúan sobre el hipocampo y contrarrestan el efecto del estrés. Los estudios sobre pacientes con trastorno por estrés postraumático (TEPT) revelan alteraciones en las regiones cerebrales implicadas en los estudios con animales como la amígdala, el hipocampo y la corteza prefrontal, así como en los sistemas neuroquímicos de respuesta al estrés, entre ellos el cortisol y la noradrenalina. Los tratamientos con eficacia frente al TEPT promueven la neurogénesis en los estudios con animales y también aumentan la memoria, y el volumen hipocámpico en el TEPT. Se requieren nuevos estudios para evaluar los mecanismos neurales de la respuesta terapéutica en el TEPT.

Effets du stress traumatique sur le cerveau

Le stress traumatique exerce une grande variété d'effets sur la fonction et la structure cérébrales. Les aires cérébrales impliquées dans la réponse au stress comprennent l'amygdale, l'hippocampe et le cortex préfrontal. Les systèmes neurochimiques, incluant le cortisol et la norépinéphrine, jouent un rôle critique dans la réponse au stress. Ces aires cérébrales influent sur la mémoire et sur la réponse au stress traumatique, soulignant ainsi les interactions existant entre les deux. Les effets des antidépresseurs sur l'hippocampe compensent les effets du stress. Les études chez les patients atteints de trouble stress post-traumatique (ESPT) montrent des modifications des aires cérébrales impliquées au cours des études animales, telles l'amygdale, l'hippocampe et le cortex préfrontal, ainsi que des modifications des systèmes neurochimiques de réponse au stress comme le cortisol et la noradrénaline. Les traitements efficaces dans l'ESPT entraînent une activation de la neurogenèse chez l'animal de même qu'une amélioration de la mémoire et une augmentation du volume de l'hippocampe dans l'ESPT. Il faudra d'autres études pour évaluer les mécanismes neuronaux dans la réponse thérapeutique au cours de l'ESPT.

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Child abuse and neglect

CHILD ABUSE AND NEGLECT

In Western Australia, under the *Children and Community Services Act 2004,* a child is a person under the age of 18 years.

There are generally five types of child abuse and neglect, which may co-exist:

- physical abuse
- sexual abuse
- emotional abuse
- psychological abuse
- child neglect.

Publication: How do I recognise when a child is at risk of abuse or neglect?

Child development and trauma guide

The *Child development and trauma guide* has been developed to assist practitioners to understand typical developmental pathways of children and recognise indicators of trauma at different ages and stages.

Importantly, the resource offers practical, age appropriate advice as to the needs of children, parents and carers when trauma has occurred, and ways in which children and families can be assisted in healing and recovery.

The *Child development and trauma guide* covers the following age groups:

- 0 to 12 months
- 12 months to 3 years
- 3 to 5 years
- 7 to 9 years
- 9 to 12 years
- 12 to 18 years.

Resources

What to do... when you are concerned that a child is being abused or neglected
A3 poster

How do I recognise when a child is at risk of abuse or neglect?
Outlines the five main types of child abuse and neglect.

What does it mean?
A guide for families and carers about how the Department for Child Protection helps keep children safe.

Protecting children
Information for parents, families and friends.

Keeping our kids safe
For aboriginal families and communities.

A TREATMENT IMPROVEMENT PROTOCOL

Trauma-Informed Care in Behavioral Health Services

TIP 57

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

A TREATMENT IMPROVEMENT PROTOCOL

Trauma-Informed Care in Behavioral Health Services

TIP 57

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

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Disclaimer

The views, opinions, and content expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of SAMHSA or HHS. No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described are intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

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Consensus Panel

Note: Each panelist's information reflects his or her affiliation at the time of the Consensus Panel meeting and may not reflect that person's most current affiliation.

Chair

Lisa M. Najavits, Ph.D.
Research Psychologist
Veterans Affairs Boston Healthcare System
Professor of Psychiatry
Boston University School of Medicine
Boston, MA

Co-Chair

Linda B. Cottler, Ph.D., M.P.H.
Professor of Epidemiology in Psychiatry
Department of Psychiatry
Washington University–St. Louis
St. Louis, MO

Workgroup Leaders

Stephanie S. Covington, Ph.D., LCSW, MFCC
Co-Director
Center for Gender and Justice
Institute for Relational Development
La Jolla, CA

Margaret Cramer, Ph.D.
Clinical Psychologist/Clinical Instructor
Harvard Medical School
Boston, MA

Anne M. Herron, M.S.
Director
Treatment Programming
New York State Office of Alcoholism and Substance Abuse Services
Albany, NY

Denise Hien, Ph.D.
Research Scholar
Social Intervention Group
School of Social Work
Columbia University
New York, NY

Dee S. Owens, M.P.A.
Director
Alcohol-Drug Information
Indiana University
Bloomington, IN

Panelists

Charlotte Chapman, M.S., LPC, CAC
Training Director
Division of Addiction Psychiatry
Mid-Atlantic Addiction Technology Transfer Center
Virginia Commonwealth University
Richmond, VA

Scott F. Coffey, Ph.D.
Associate Professor
Department of Psychiatry and Human Behavior
University of Mississippi Medical Center
Jackson, MS

Renee M. Cunningham-Williams, M.S.W., M.P.E., Ph.D.
Research Assistant/Professor of Social Work
Department of Psychiatry
Washington University
St. Louis, MO

Chad D. Emrick, Ph.D.
Administrative Director
Substance Abuse Treatment Program
Denver VA Medical Center (116A1)
Denver, CO

Charles R. Figley, Ph.D.
Professor
Director of the Traumatology Institute
Florida State University
Tallahassee, FL

Larry M. Gentilello, M.D., FACS
Professor and Chairman
Division of Burn, Trauma, and Critical Care
University of Texas Southwestern Medical School
Dallas, TX

Robert Grant, Ph.D.
Trauma Consultant
Oakland, CA

Anthony (Tony) Taiwai Ng, M.D.
Disaster Psychiatrist
Washington, DC

Pallavi Nishith, Ph.D.
Associate Research Professor
Center for Trauma
Department of Psychology
University of Missouri–St. Louis
St. Louis, MO

Joseph B. Stone, Ph.D., CACIII, ICADC
Program Manager and Clinical Supervisor
Confederated Tribes of Grand Ronde Behavioral Health Program
Grand Ronde, OR

Michael Villanueva, Ph.D.
Research Professor
Center on Alcoholism, Substance Abuse, and Addiction
Albuquerque, NM

KAP Expert Panel and Federal Government Participants

Barry S. Brown, Ph.D.
Adjunct Professor
University of North Carolina–Wilmington
Carolina Beach, NC

Jacqueline Butler, M.S.W., LISW, LPCC, CCDC III, CJS
Professor of Clinical Psychiatry
College of Medicine
University of Cincinnati
Cincinnati, OH

Deion Cash
Executive Director
Community Treatment and Correction Center, Inc.
Canton, OH

Debra A. Claymore, M.Ed.Adm.
Owner/Chief Executive Officer
WC Consulting, LLC
Loveland, CO

Carlo C. DiClemente, Ph.D.
Chair
Department of Psychology
University of Maryland–Baltimore County
Baltimore, MD

Catherine E. Dube, Ed.D.
Independent Consultant
Brown University
Providence, RI

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief, Services
Division of Clinical and Services Research
National Institute on Drug Abuse
Bethesda, MD

Michael Galer, D.B.A.
Independent Consultant
Westminster, MA

Renata J. Henry, M.Ed.
Director
Division of Alcoholism, Drug Abuse and Mental Health
Delaware Department of Health and Social Services
New Castle, DE

Joel Hochberg, M.A.
President
Asher & Partners
Los Angeles, CA

Jack Hollis, Ph.D.
Associate Director, Center for Health Research
Kaiser Permanente
Portland, OR

Mary Beth Johnson, M.S.W.
Director
Addiction Technology Transfer Center
University of Missouri–Kansas City
Kansas City, MO

Eduardo Lopez
Executive Producer
EVS Communications
Washington, DC

Holly A. Massett, Ph.D.
Academy for Educational Development
Washington, DC

Diane Miller
Chief
Scientific Communications Branch
National Institute on Alcohol Abuse and Alcoholism
Bethesda, MD

Harry B. Montoya, M.A.
President/Chief Executive Officer
Hands Across Cultures
Española, NM

Richard K. Ries, M.D.
Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, WA

Gloria M. Rodriguez, D.S.W.
Research Scientist
Division of Addiction Services
New Jersey Department of Health and Senior Services
Trenton, NJ

Everett Rogers, Ph.D.
Center for Communications Programs
Johns Hopkins University
Baltimore, MD

Jean R. Slutsky, P.A., M.S.P.H.
Senior Health Policy Analyst
Agency for Healthcare Research & Quality
Rockville, MD

Nedra Klein Weinreich, M.S.
President
Weinreich Communications
Canoga Park, CA

Clarissa Wittenberg
Director
Office of Communications and Public Liaison
National Institute of Mental Health
Bethesda, MD

Consulting Members of the KAP Expert Panel

Paul Purnell, M.A
Social Solutions, LLC
Potomac, MD

Scott Ratzan, M.D., M.P.A., M.A.
Academy for Educational Development
Washington, DC

Thomas W. Valente, Ph.D.
Director
Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Los Angeles, CA

Patricia A. Wright, Ed.D.
Independent Consultant
Baltimore, MD

What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://store.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

Pamela S. Hyde, J.D.
Administrator
Substance Abuse and Mental Health Services Administration

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Frances M. Harding
Director
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

How This TIP Is Organized

This Treatment Improvement Protocol (TIP) is divided into three parts:

- Part 1: *A Practical Guide for the Provision of Behavioral Health Services*
- Part 2: *An Implementation Guide for Behavioral Health Program Administrators*
- Part 3: *A Review of the Literature*

Part 1 is for behavioral health service providers and consists of six chapters. Recurring themes include the variety of ways that substance abuse, mental health, and trauma interact; the importance of context and culture in a person's response to trauma; trauma-informed screening and assessment tools, techniques, strategies, and approaches that help behavioral health professionals assist clients in recovery from mental and substance use disorders who have also been affected by acute or chronic traumas; and the significance of adhering to a strengths-based perspective that acknowledges the resilience within individual clients, providers, and communities.

Chapter 1 lays the groundwork and rationale for the implementation and provision of trauma-informed services. It provides an overview of specific trauma-informed intervention and treatment principles that guide clinicians, other behavioral health workers, and administrators in becoming trauma informed and in creating a trauma-informed organization and workforce. Chapter 2 provides an overview of traumatic experiences. It covers types of trauma; distinguishes among traumas that affect individuals, groups, and communities; describes trauma characteristics; and addresses the socioecological and cultural factors that influence the impact of trauma. Chapter 3 broadly focuses on understanding the impact of trauma, trauma-related stress reactions and associated symptoms, and common mental health and substance use disorders associated with trauma. Chapter 4 provides an introduction to screening and assessment as they relate to trauma and is devoted to screening and assessment processes and tools that are useful in evaluating trauma exposure, its effects, and client intervention and treatment needs. Chapter 5 covers clinical issues that counselors and other behavioral health professionals may need to know and address when treating clients who have histories of trauma. Chapter 6 presents information on specific treatment models for trauma, distinguishing integrated models (which address substance use disorders, mental disorders, and trauma simultaneously) from those that treat trauma alone.

Advice to Counselors and/or Administrators boxes in Part 1 provide practical information for providers. Case illustrations, exhibits, and text boxes further illustrate information in the text by offering practical examples.

Part 2 provides an overview of programmatic and administrative practices that will help behavioral health program administrators increase the capacity of their organizations to deliver

trauma-informed services. Chapter 1 examines the essential ingredients, challenges, and processes in creating and implementing trauma-informed services within an organization. Chapter 2 focuses on key development activities that support staff members, including trauma-informed training and supervision, ethics, and boundaries pertinent to responding to traumatic stress, secondary trauma, and counselor self-care.

Advice to Administrators and/or Supervisors boxes in Part 2 highlight more detailed information that supports the organizational implementation of trauma-informed care (TIC). In addition, case illustrations, organizational activities, and text boxes reinforce the material presented within this section.

Part 3 is a literature review on TIC and behavioral health services and is intended for use by clinical supervisors, interested providers, and administrators. Part 3 has three sections: an analysis of the literature, links to select abstracts of the references most central to the topic, and a general bibliography of the available literature. To facilitate ongoing updates (performed periodically for up to 3 years from first publication), the literature review is only available online at the Substance Abuse and Mental Health Services Administration (SAMHSA) Publications Ordering Web page (http://store.samhsa.gov).

Terminology

Behavioral health: Throughout the TIP, the term "behavioral health" is used. Behavioral health refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illness and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used in this TIP to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use and related problems, treatments and services for mental and substance use disorders, and recovery support. Because behavioral health conditions, taken together, are the leading causes of disability burden in North America, efforts to improve their prevention and treatment will benefit society as a whole. Efforts to reduce the impact of mental and substance use disorders on America's communities, such as those described in this TIP, will help achieve nationwide improvements in health.

Client/consumer: In this TIP, the term "client" means anyone who seeks or receives mental health or substance abuse services. The term "consumer" stands in place of "client" in content areas that address consumer participation and determination. It is not the intent of this document to ignore the relevance and historical origin of the term "consumer" among individuals who have received, been subject to, or are seeking mental health services. Instead, we choose the word "client," given that this terminology is also commonly used in substance abuse treatment services. Note: This TIP also uses the term "participant(s)" instead of "client(s)" for individuals, families, or communities seeking or receiving prevention services.

Complex trauma: This manual adopts the National Child Traumatic Stress Network (NCTSN) definition of complex trauma. The term refers to the pervasive impact, including developmental

consequences, of exposure to multiple or prolonged traumatic events. According to the NCTSN Web site (http://www.nctsn.org/trauma-types), complex trauma typically involves exposure to sequential or simultaneous occurrences of maltreatment, "including psychological maltreatment, neglect, physical and sexual abuse, and domestic violence…. Exposure to these initial traumatic experiences—and the resulting emotional dysregulation and the loss of safety, direction, and the ability to detect or respond to danger cues—often sets off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood" (NCTSN, 2013).

Co-occurring disorders: When an individual has one or more mental disorders as well as one or more substance use disorders (including substance abuse), the term "co-occurring" applies. Although people may have a number of health conditions that co-occur, including physical problems, the term "co-occurring disorders," in this TIP, refers to substance use and mental disorders.

Cultural responsiveness and cultural competence: This TIP uses these terms interchangeably, with "responsiveness" applied to services and systems and "competence" applied to people, to refer to "a set of behaviors, attitudes, and policies that…enable a system, agency, or group of professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 13). Culturally responsive behavioral health services and culturally competent providers "honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services…. [C]ultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time" (U.S. Department of Health and Human Services, 2003, p. 12).

Evidence-based practices: There are many different uses of the term "evidence-based practices." One of the most widely accepted is that of Chambless and Hollon (1998), who say that for a treatment to be considered evidence based, it must show evidence of positive outcomes based on peer-reviewed randomized controlled trials or other equivalent strong methodology. A treatment is labeled "strong" if criteria are met for what Chambless and Hollon term "well-established" treatments. To attain this level, rigorous treatment outcome studies conducted by independent investigators (not just the treatment developer) are necessary. Research support is labeled "modest" when treatments attain criteria for what Chambless and Hollon call "probably efficacious treatments." To meet this standard, one well-designed study or two or more adequately designed studies must support a treatment's efficacy. In addition, it is possible to meet the "strong" and "modest" thresholds through a series of carefully controlled single-case studies. An evidence-based practice derived from sound, science-based theories incorporates detailed and empirically supported procedures and implementation guidelines, including parameters of applications (such as for populations), inclusionary and exclusionary criteria for participation, and target interventions.

Promising practices: Even though current clinical wisdom, theories, and professional and expert consensus may support certain practices, these practices may lack support from studies that are scientifically rigorous in research design and statistical analysis; available studies may be limited in number or sample size, or they may not be applicable to the current setting or population. This TIP refers to such practices as "promising."

Recovery: This term denotes a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Major dimensions that support a life in recovery, as defined by SAMHSA, include:

- ***Health:*** overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.
- ***Home:*** a stable and safe place to live.
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- ***Community:*** relationships and social networks that provide support, friendship, love, and hope.

Resilience: This term refers to the ability to bounce back or rise above adversity as an individual, family, community, or provider. Well beyond individual characteristics of hardiness, resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events. This TIP applies the term "resilience" and its processes to individuals across the life span.

Retraumatization: In its more literal translation, "retraumatization" means the occurrence of traumatic stress reactions and symptoms after exposure to multiple events (Duckworth & Follette, 2011). This is a significant issue for trauma survivors, both because they are at increased risk for higher rates of retraumatization, and because people who are traumatized multiple times often have more serious and chronic trauma-related symptoms than those with single traumas. In this manual, the term not only refers to the effect of being exposed to multiple events, but also implies the process of reexperiencing traumatic stress as a result of a current situation that mirrors or replicates in some way the prior traumatic experiences (e.g., specific smells or other sensory input; interactions with others; responses to one's surroundings or interpersonal context, such as feeling emotionally or physically trapped).

Secondary trauma: Literature often uses the terms "secondary trauma," "compassion fatigue," and "vicarious traumatization" interchangeably. Although compassion fatigue and secondary trauma refer to similar physical, psychological, and cognitive changes and symptoms that behavioral health workers may encounter when they work specifically with clients who have histories of trauma, vicarious trauma usually refers more explicitly to specific cognitive changes, such as in worldview and sense of self (Newell & MacNeil, 2010). This publication uses "secondary trauma" to describe trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event. Secondary trauma can occur among behavioral health service providers across all behavioral health settings and among all professionals who provide services to those who have experienced trauma (e.g., healthcare providers, peer counselors, first responders, clergy, intake workers).

Substance abuse: Throughout the TIP, the term "substance abuse" has been used to refer to both substance abuse and substance dependence. This term was chosen partly because behavioral health professionals commonly use the term substance abuse to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs to determine what possible range of meanings it covers; in most cases, it will refer to all varieties of substance-related

disorders as found in *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (American Psychiatric Association, 2013a).

Trauma: In this text, the term "trauma" refers to experiences that cause intense physical and psychological stress reactions. It can refer to "a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Although many individuals report a single specific traumatic event, others, especially those seeking mental health or substance abuse services, have been exposed to multiple or chronic traumatic events. See the "What Is Trauma" section in Part 1, Chapter 1, for a more indepth definition and discussion of trauma.

Trauma-informed: A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. In May 2012, SAMHSA convened a group of national experts who identified three key elements of a trauma-informed approach: "(1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice" (SAMHSA, 2012, p 4).

Trauma-informed care: TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.

Trauma-specific treatment services: These services are evidence-based and promising practices that facilitate recovery from trauma. The term "trauma-specific services" refers to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.

Trauma survivor: This phrase can refer to anyone who has experienced trauma or has had a traumatic stress reaction. Knowing that the use of language and words can set the tone for recovery or contribute to further retraumatization, it is the intent of this manual to put forth a message of hope by avoiding the term "victim" and instead using the term "survivor" when appropriate.

Part 1: A Practical Guide for the Provision of Behavioral Health Services

1 Trauma-Informed Care: A Sociocultural Perspective

IN THIS CHAPTER

- Scope of the TIP
- Intended Audience
- Before You Begin
- Structure of the TIP
- What Is Trauma?
- Trauma Matters in Behavioral Health Services
- Trauma Informed Intervention and Treatment Principles
- As You Proceed

Many individuals who seek treatment in behavioral health settings have histories of trauma, but they often don't recognize the significant effects of trauma in their lives; either they don't draw connections between their trauma histories and their presenting problems, or they avoid the topic altogether. Likewise, treatment providers may not ask questions that elicit a client's history of trauma, may feel unprepared to address trauma-related issues proactively, or may struggle to address traumatic stress effectively within the constraints of their treatment program, the program's clinical orientation, or their agency's directives.

By recognizing that traumatic experiences and their sequelae tie closely into behavioral health problems, front-line professionals and community-based programs can begin to build a trauma-informed environment across the continuum of care. Key steps include meeting client needs in a safe, collaborative, and compassionate manner; preventing treatment practices that retraumatize people with histories of trauma who are seeking help or receiving services; building on the strengths and resilience of clients in the context of their environments and communities; and endorsing trauma-informed principles in agencies through support, consultation, and supervision of staff.

This Treatment Improvement Protocol (TIP) begins by introducing the scope, purpose, and organization of the topic and describing its intended audience. Along with defining trauma and trauma-informed care (TIC), the first chapter discusses the rationale for addressing trauma in behavioral health services and reviews trauma-informed intervention and treatment principles. These principles serve as the TIP's conceptual framework.

Scope of the TIP

Many individuals experience trauma during their lifetimes. Although many people exposed to trauma demonstrate few or no lingering symptoms, those individuals who have experienced repeated, chronic, or multiple traumas are more likely to exhibit pronounced symptoms and consequences, including substance abuse, mental illness, and health problems. Subsequently, trauma can significantly affect how an individual engages in major life areas as well as treatment.

This TIP provides evidence-based and best practice information for behavioral health service providers and administrators who want to work more effectively with people who have been exposed to acute and chronic traumas and/or are at risk of developing traumatic stress reactions. Using key trauma-informed principles, this TIP addresses trauma-related prevention, intervention, and treatment issues and strategies in behavioral health services. The content is adaptable across behavioral health settings that service individuals, families, and communities—placing emphasis on the importance of coordinating as well as integrating services.

Intended Audience

This TIP is for behavioral health service providers, prevention specialists, and program administrators—the professionals directly responsible for providing care to trauma survivors across behavioral health settings, including substance abuse and mental health services. This TIP also targets primary care professionals, including physicians; teams working with clients and communities who have experienced trauma; service providers in the criminal justice system; and researchers with an interest in this topic.

Before You Begin

This TIP endorses a trauma-informed model of care; this model emphasizes the need for behavioral health practitioners and organizations to recognize the prevalence and pervasive impact of trauma on the lives of the people they serve and develop trauma-sensitive or trauma-responsive services. This TIP provides key information to help behavioral health practitioners and program administrators become trauma aware and informed, improve screening and assessment processes, and implement science-informed intervention strategies across settings and modalities in behavioral health services. Whether provided by an agency or an individual provider, trauma-informed services may or may not include trauma-specific services or trauma specialists (individuals who have advanced training and education to provide specific treatment interventions to address traumatic stress reactions). Nonetheless, TIC anticipates the role that trauma can play across the continuum of care—establishing integrated and/or collaborative processes to address the needs of traumatized individuals and communities proactively.

Individuals who have experienced trauma are at an elevated risk for substance use disorders, including abuse and dependence; mental health problems (e.g., depression and anxiety symptoms or disorders, impairment in relational/social and other major life areas, other distressing symptoms); and physical disorders and conditions, such as sleep disorders. This TIP focuses on specific types of prevention (Institute of Medicine et al., 2009): selective prevention, which targets people who are at risk for developing social, psychological, or other conditions as a result of trauma or who are at greater risk for experiencing trauma due to behavioral health disorders or conditions; and indicated prevention, which targets people who display early signs of trauma-related

symptoms. This TIP identifies interventions, including trauma-informed and trauma-specific strategies, and perceives treatment as a means of prevention—building on resilience, developing safety and skills to negotiate the impact of trauma, and addressing mental and substance use disorders to enhance recovery.

This TIP's target population is adults. Beyond the context of family, this publication does not examine or address youth and adolescent responses to trauma, youth-tailored trauma-informed strategies, or trauma-specific interventions for youth or adolescents, because the developmental and contextual issues of these populations require specialized interventions. Providers who work with young clients who have experienced trauma should refer to the resource list in Appendix B. This TIP covers TIC, trauma characteristics, the impact of traumatic experiences, assessment, and interventions for persons who have had traumatic experiences. Considering the vast knowledge base and specificity of individual, repeated, and chronic forms of trauma, this TIP does not provide a comprehensive overview of the unique characteristics of each type of trauma (e.g., sexual abuse, torture, war-related trauma, murder). Instead, this TIP provides an overview supported by examples. For more information on several specific types of trauma, please refer to TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (Center for Substance Abuse Treatment [CSAT], 2000b), TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b), TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d), and the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (Substance Abuse and Mental Health Services Administration [SAMHSA], planned f).

This TIP, *Trauma-Informed Care in Behavioral Health Services*, is guided by SAMHSA's Strategic Initiatives described in *Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014* (SAMHSA, 2011b). Specific to Strategic Initiative #2, Trauma and Justice, this TIP addresses several goals, objectives, and actions outlined in this initiative by providing behavioral health practitioners, supervisors, and administrators with an introduction to culturally responsive TIC.

Specifically, the TIP presents fundamental concepts that behavioral health service providers can use to:

- Become trauma aware and knowledgeable about the impact and consequences of traumatic experiences for individuals, families, and communities.
- Evaluate and initiate use of appropriate trauma-related screening and assessment tools.
- Implement interventions from a collaborative, strengths-based approach, appreciating the resilience of trauma survivors.
- Learn the core principles and practices that reflect TIC.
- Anticipate the need for specific trauma-informed treatment planning strategies that support the individual's recovery.
- Decrease the inadvertent retraumatization that can occur from implementing standard organizational policies, procedures, and interventions with individuals, including clients and staff, who have experienced trauma or are exposed to secondary trauma.
- Evaluate and build a trauma-informed organization and workforce.

The consensus panelists, as well as other contributors to this TIP, have all had experience as substance abuse and mental health counselors, prevention and peer specialists, supervisors, clinical directors, researchers, or administrators working with individuals, families, and

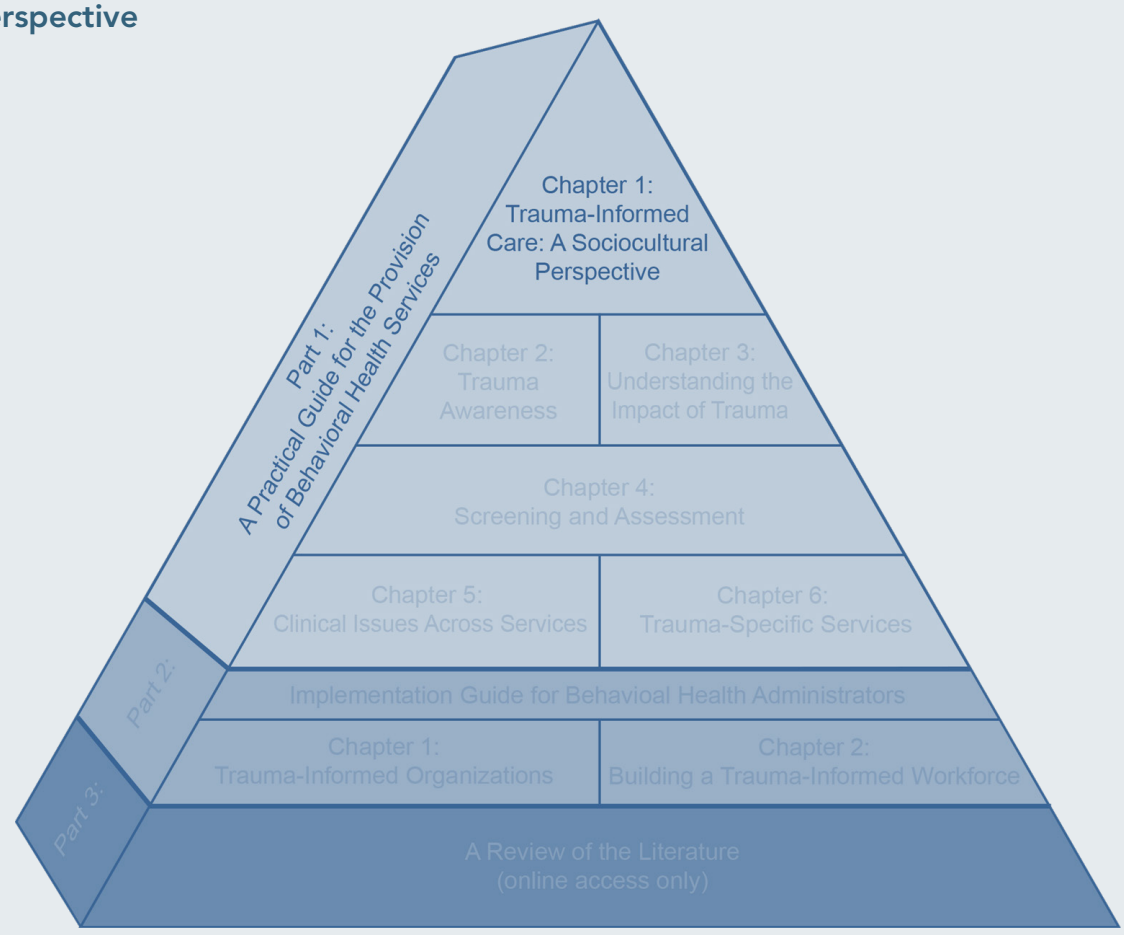
communities who have experienced trauma. The material presented in this TIP uses the wealth of their experience in addition to the available published resources and research relevant to this topic. Throughout the consensus process, the panel members were mindful of the strengths and resilience inherent in individuals, families, and communities affected by trauma and the challenges providers face in addressing trauma and implementing TIC.

Structure of the TIP

Using a TIC framework (Exhibit 1.1-1), this TIP provides information on key aspects of trauma, including what it is; its consequences; screening and assessment; effective prevention, intervention, and treatment approaches; trauma recovery; the impact of trauma on service providers; programmatic and administrative practices; and trauma resources.

Note: To produce a user-friendly but informed document, the first two parts of the TIP include minimal citations. If you are interested in the citations associated with topics covered in Parts 1 and 2, please consult the review of the literature provided in Part 3 (available online at http://store.samhsa.gov). Parts 1 and 2 are easily read and digested on their own, but it is highly recommended that you read the literature review as well.

Exhibit 1.1-1: TIC Framework in Behavioral Health Services—Sociocultural Perspective



What Is Trauma?

According to SAMHSA's Trauma and Justice Strategic Initiative, "trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Trauma can affect people of every race, ethnicity, age, sexual orientation, gender, psychosocial background, and geographic region. A traumatic experience can be a single event, a series of events, and/or a chronic condition (e.g., childhood neglect, domestic violence). Traumas can affect individuals, families, groups, communities, specific cultures, and generations. It generally overwhelms an individual's or community's resources to cope, and it often ignites the "fight, flight, or freeze" reaction at the time of the event(s). It frequently produces a sense of fear, vulnerability, and helplessness.

See Appendix C to read about the history of trauma and trauma interventions.

Often, traumatic events are unexpected. Individuals may experience the traumatic event directly, witness an event, feel threatened, or hear about an event that affects someone they know. Events may be human-made, such as a mechanical error that causes a disaster, war, terrorism, sexual abuse, or violence, or they can be the products of nature (e.g., flooding, hurricanes, tornadoes). Trauma can occur at any age or developmental stage, and often, events that occur outside expected life stages are perceived as traumatic (e.g., a child dying before a parent, cancer as a teen, personal illness, job loss before retirement).

It is not just the event itself that determines whether something is traumatic, but also the individual's experience of the event. Two people may be exposed to the same event or series of events but experience and interpret these events in vastly different ways. Various biopsychosocial and cultural factors influence an individual's immediate response and long-term reactions to trauma. For most, regardless of the severity of the trauma, the immediate or enduring effects of trauma are met with resilience—the ability to rise above the circumstances or to meet the challenges with fortitude.

For some people, reactions to a traumatic event are temporary, whereas others have prolonged reactions that move from acute symptoms to more severe, prolonged, or enduring mental health consequences (e.g., posttraumatic stress and other anxiety disorders, substance use and mood disorders) and medical problems (e.g., arthritis, headaches, chronic pain). Others do not meet established criteria for posttraumatic stress or other mental disorders but encounter significant trauma-related symptoms or culturally expressed symptoms of trauma (e.g., somatization, in which psychological stress is expressed through physical concerns). For that reason, even if an individual does not meet diagnostic criteria for trauma-related disorders, it is important to recognize that trauma may still affect his or her life in significant ways. For more information on traumatic events, trauma characteristics, traumatic stress reactions, and factors that heighten or decrease the impact of trauma, see Part 1, Chapter 2, "Trauma Awareness," and Part 1, Chapter 3, "Understanding the Impact of Trauma."

Trauma Matters in Behavioral Health Services

The past decade has seen an increased focus on the ways in which trauma, psychological distress, quality of life, health, mental illness,

and substance abuse are linked. With the attacks of September 11, 2001, and other acts of terror, the wars in Iraq and Afghanistan, disastrous hurricanes on the Gulf Coast, and sexual abuse scandals, trauma has moved to the forefront of national consciousness.

Trauma was once considered an abnormal experience. However, the first National Comorbidity Study established how prevalent traumas were in the lives of the general population of the United States. In the study, 61 percent of men and 51 percent of women reported experiencing at least one trauma in their lifetime, with witnessing a trauma, being involved in a natural disaster, and/or experiencing a life-threatening accident ranking as the most common events (Kessler et al., 1999). In Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions, 71.6 percent of the sample reported witnessing trauma, 30.7 percent experienced a trauma that resulted in injury, and 17.3 percent experienced psychological trauma (El-Gabalawy, 2012). For a thorough review of the impact of trauma on quality of life and health and among individuals with mental and substance use disorders, refer to Part 3 of this TIP, the online literature review.

Rationale for TIC

Integrating TIC into behavioral health services provides many benefits not only for clients, but also for their families and communities, for behavioral health service organizations, and for staff. Trauma-informed services bring to the forefront the belief that trauma can pervasively affect an individual's well-being, including physical and mental health. For behavioral health service providers, trauma-informed practice offers many opportunities. It reinforces the importance of acquiring trauma-specific knowledge and skills to meet the specific needs of clients; of recognizing that individuals may be affected by trauma regardless of its acknowledgment; of understanding that trauma likely affects many clients who are seeking behavioral health services; and of acknowledging that organizations and providers can retraumatize clients through standard or unexamined policies and practices. TIC stresses the importance of addressing the client individually rather than applying general treatment approaches.

TIC provides clients more opportunities to engage in services that reflect a compassionate perspective of their presenting problems. TIC can potentially provide a greater sense of safety for clients who have histories of trauma and a platform for preventing more serious consequences of traumatic stress (Fallot & Harris, 2001). Although many individuals may not identify the need to connect with their histories, trauma-informed services offer clients a chance to explore the impact of trauma, their strengths and creative adaptations in managing traumatic histories, their resilience, and the relationships among trauma, substance use, and psychological symptoms.

Two Influential Studies That Set the Stage for the Development of TIC

The Adverse Childhood Experiences Study (Centers for Disease Control and Prevention, 2013) was a large epidemiological study involving more than 17,000 individuals from United States; it analyzed the long-term effects of childhood and adolescent traumatic experiences on adult health risks, mental health, healthcare costs, and life expectancy.

The Women, Co-Occurring Disorders and Violence Study (SAMHSA, 2007) was a large multisite study focused on the role of interpersonal and other traumatic stressors among women; the interrelatedness of trauma, violence, and co-occurring substance use and mental disorders; and the incorporation of trauma-informed and trauma-specific principles, models, and services.

Implementing trauma-informed services can improve screening and assessment processes, treatment planning, and placement while also decreasing the risk for retraumatization. The implementation may enhance communication between the client and treatment provider, thus decreasing risks associated with misunderstanding the client's reactions and presenting problems or underestimating the need for appropriate referrals for evaluation or trauma-specific treatment. Organizational investment in developing or improving trauma-informed services may also translate to cost effectiveness, in that services are more appropriately matched to clients from the outset. TIC is an essential ingredient in organizational risk management; it ensures the implementation of decisions that will optimize therapeutic outcomes and minimize adverse effects on the client and, ultimately, the organization. A key principle is the engagement of community, clients, and staff. Clients and staff are more apt to be empowered, invested, and satisfied if they are involved in the ongoing development and delivery of trauma-informed services.

An organization also benefits from work development practices through planning for, attracting, and retaining a diverse workforce of individuals who are knowledgeable about trauma and its impact. Developing a trauma-informed organization involves hiring and promotional practices that attract and retain individuals who are educated and trained in trauma-informed practices on all levels of the organization, including board as well as peer support appointments. Trauma-informed organizations are invested in their staff and adopt similar trauma-informed principles, including establishing and providing ongoing support to promote TIC in practice and in addressing secondary trauma and implementing processes that reinforce the safety of the staff. Even though investing in a trauma-informed workforce does not necessarily guarantee trauma-informed practices, it is more likely that services will evolve more proficiently to meet client, staff, and community needs.

Advice to Counselors: The Importance of TIC

The history of trauma raises various clinical issues. Many counselors do not have extensive training in treating trauma or offering trauma-informed services and may be uncertain of how to respond to clients' trauma-related reactions or symptoms. Some counselors have experienced traumas themselves that may be triggered by clients' reports of trauma. Others are interested in helping clients with trauma but may unwittingly cause harm by moving too deeply or quickly into trauma material or by discounting or disregarding a client's report of trauma. Counselors must be aware of trauma-related symptoms and disorders and how they affect clients in behavioral health treatment.

Counselors with primary treatment responsibilities should also have an understanding of how to recognize trauma-related reactions, how to incorporate treatment interventions for trauma-related symptoms into clients' treatment plans, how to help clients build a safety net to prevent further trauma, how to conduct psychoeducational interventions, and when to make treatment referrals for further evaluations or trauma-specific treatment services. All treatment staff should recognize that traumatic stress symptoms or trauma-related disorders should not preclude an individual from mental health or substance abuse treatment and that all co-occurring disorders need to be addressed on some level in the treatment plan and setting. For example, helping a client in substance abuse treatment gain control over trauma-related symptoms can greatly improve the client's chances of substance abuse recovery and lower the possibility of relapse (Farley, Golding, Young, Mulligan, & Minkoff, 2004; Ouimette, Ahrens, Moos, & Finney, 1998). In addition, assisting a client in achieving abstinence builds a platform upon which recovery from traumatic stress can proceed.

Trauma and Substance Use Disorders

Many people who have substance use disorders have experienced trauma as children or adults (Koenen, Stellman, Sommer, & Stellman, 2008; Ompad et al., 2005). Substance abuse is known to predispose people to higher rates of traumas, such as dangerous situations and accidents, while under the influence (Stewart & Conrod, 2003; Zinzow, Resnick, Amstadter, McCauley, Ruggiero, & Kilpatrick, 2010) and as a result of the lifestyle associated with substance abuse (Reynolds et al., 2005). In addition, people who abuse substances and have experienced trauma have worse treatment outcomes than those without histories of trauma (Driessen et al., 2008; Najavits et al., 2007). Thus, the process of recovery is more difficult, and the counselor's role is more challenging, when clients have histories of trauma. A person presenting with both trauma and substance abuse issues can have a variety of other difficult life problems that commonly accompany these disorders, such as other psychological symptoms or mental disorders, poverty, homelessness, increased risk of HIV and other infections, and lack of social support (Mills, Teesson, Ross, & Peters, 2006; Najavits, Weiss, & Shaw, 1997). Many individuals who seek treatment for substance use disorders have histories of one or more traumas. More than half of women seeking substance abuse treatment report one or more lifetime traumas (Farley, Golding, Young, Mulligan, & Minkoff, 2004; Najavits et al., 1997), and a significant number of clients in inpatient treatment also have subclinical traumatic stress symptoms or posttraumatic stress disorder (PTSD; Falck, Wang, Siegal, & Carlson, 2004; Grant et al., 2004; Reynolds et al., 2005).

Trauma and Mental Disorders

People who are receiving treatment for severe mental disorders are more likely to have histories of trauma, including childhood physical and sexual abuse, serious accidents, homelessness, involuntary psychiatric hospitalizations, drug overdoses, interpersonal violence, and other forms of violence. Many clients with severe mental disorders meet criteria for PTSD; others with serious mental illness who have histories of trauma present with psychological symptoms or mental disorders that are commonly associated with a history of trauma, including anxiety symptoms and disorders, mood disorders (e.g., major depression, dysthymia, bipolar disorder; Mueser et al., 2004), impulse control disorders, and substance use disorders (Kessler, Chiu, Demler, & Walters, 2005).

Traumatic stress increases the risk for mental illness, and findings suggest that traumatic stress increases the symptom severity of mental illness (Spitzer, Vogel, Barnow, Freyberger & Grabe, 2007). These findings propose that traumatic stress plays a significant role in perpetuating and exacerbating mental illness and suggest that trauma often precedes the development of mental disorders. As with trauma and substance use disorders, there is a bidirectional relationship; mental illness increases the risk of experiencing trauma, and trauma increases the risk of developing psychological symptoms and mental disorders. For a more comprehensive review of the interactions among traumatic stress, mental illness, and substance use disorders, refer to Part 3 of this TIP, the online literature review.

Trauma-Informed Intervention and Treatment Principles

TIC is an intervention and organizational approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health services from prevention through treatment. There are many definitions of TIC and various models for incorporating it across organizations, but a "trauma-informed approach incorporates three key elements: (1) *realizing* the prevalence of trauma; (2) *recognizing* how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) *responding* by putting this knowledge into practice" (SAMHSA, 2012, p. 4).

TIC begins with the first contact a person has with an agency; it requires all staff members (e.g., receptionists, intake personnel, direct care staff, supervisors, administrators, peer supports, board members) to recognize that the individual's experience of trauma can greatly influence his or her receptivity to and engagement with services, interactions with staff and clients, and responsiveness to program guidelines, practices, and interventions. TIC includes program policies, procedures, and practices to protect the vulnerabilities of those who have experienced trauma and those who provide trauma-related services. TIC is created through a supportive environment and by redesigning organizational practices, with consumer participation, to prevent practices that could be retraumatizing (Harris & Fallot, 2001c; Hopper et al., 2010). The ethical principle, "first, do no harm," resonates strongly in the application of TIC.

> "A program, organization, or system that is trauma informed realizes the widespread impact of trauma and under stands poten tial paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings."
>
> (SAMHSA, 2012, p. 4)

TIC involves a commitment to building competence among staff and establishing programmatic standards and clinical guidelines that support the delivery of trauma-sensitive services. It encompasses recruiting, hiring, and retaining competent staff; involving consumers, trauma survivors, and peer support specialists in the planning, implementation, and evaluation of trauma-informed services; developing collaborations across service systems to streamline referral processes, thereby securing trauma-specific services when appropriate; and building a continuity of TIC as consumers move from one system or service to the next. TIC involves reevaluating each service delivery component through a trauma-aware lens.

The principles described in the following subsections serve as the TIP's conceptual

Advice to Counselors: Implementing Trauma-Informed Services

Recognizing that trauma affects a majority of clients served within public health systems, the National Center for Trauma-Informed Care (NCTIC) has sought to establish a comprehensive framework to guide systems of care in the development of trauma-informed services. If a system or program is to support the needs of trauma survivors, it must take a systematic approach that offers trauma-specific diagnostic and treatment services, as well as a trauma-informed environment that is able to sustain such services, while fostering positive outcomes for the clients it serves. NCTIC also offers technical assistance in the implementation of trauma-informed services. For specific administrative information on TIC implementation, refer to Part 2, Chapters 1 and 2, of this TIP.

framework. These principles comprise a compilation of resources, including research, theoretical papers, commentaries, and lessons learned from treatment facilities. Key elements are outlined for each principle in providing services to clients affected by trauma and to populations most likely to incur trauma. Although these principles are useful across all prevention and intervention services, settings, and populations, they are of the utmost importance in working with people who have had traumatic experiences.

Promote Trauma Awareness and Understanding

Foremost, a behavioral health service provider must recognize the prevalence of trauma and its possible role in an individual's emotional, behavioral, cognitive, spiritual, and/or physical development, presentation, and well-being. Being vigilant about the prevalence and potential consequences of traumatic events among clients allows counselors to tailor their presentation styles, theoretical approaches, and intervention strategies from the outset to plan for and be responsive to clients' specific needs. Although not every client has a history of trauma, those who have substance use and mental disorders are more likely to have experienced trauma. Being trauma aware does not mean that you must assume everyone has a history of trauma, but rather that you anticipate the possibility from your initial contact and interactions, intake processes, and screening and assessment procedures.

Even the most standard behavioral health practices can retraumatize an individual exposed to prior traumatic experiences if the provider implements them without recognizing or considering that they may do harm. For example, a counselor might develop a treatment plan recommending that a female client—who has been court mandated to substance abuse treatment and was raped as an adult—attend group therapy, but without considering the implications, for her, of the fact that the only available group at the facility is all male and has had a low historical rate of female participation. Trauma awareness is an essential strategy for preventing this type of retraumatization; it reinforces the need for providers to reevaluate their usual practices.

> "Trauma informed care embraces a perspective that highlights adaptation over symptoms and resilience over pathology."
>
> (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005, p. 467)

Becoming trauma aware does not stop with the recognition that trauma can affect clients; instead, it encompasses a broader awareness that traumatic experiences as well as the impact of an individual's trauma can extend to significant others, family members, first responders and other medical professionals, behavioral health workers, broader social networks, and even entire communities. Family members frequently experience the traumatic stress reactions of the individual family member who was traumatized (e.g., angry outbursts, nightmares, avoidant behavior, other symptoms of anxiety, overreactions or underreactions to stressful events). These repetitive experiences can increase the risk of secondary trauma and symptoms of mental illness among the family, heighten the risk for externalizing and internalizing behavior among children (e.g., bullying others, problems in social relationships, health-damaging behaviors), increase children's risk for developing posttraumatic stress later in life, and lead to a greater propensity for traumatic stress reactions across generations of the family. Hence, prevention and intervention services can provide education and age-appropriate programming tailored to develop coping skills and support systems.

So too, behavioral health service providers can be influenced by exposure to trauma-related affect and content when working with clients. A trauma-aware workplace supports supervision and program practices that educate all direct service staff members on secondary trauma, encourages the processing of trauma-related content through participation in peer-supported activities and clinical supervision, and provides them with professional development opportunities to learn about and engage in effective coping strategies that help prevent secondary trauma or trauma-related symptoms. It is important to generate trauma awareness in agencies through education across services and among all staff members who have any direct or indirect contact with clients (including receptionists or intake and admission personnel who engage clients for the first time within the agency). Agencies can maintain a trauma-aware environment through ongoing staff training, continued supervisory and administrative support, collaborative (i.e., involving consumer participation) trauma-responsive program design and implementation, and organizational policies and practices that reflect accommodation and flexibility in attending to the needs of clients affected by trauma.

Recognize That Trauma-Related Symptoms and Behaviors Originate From Adapting to Traumatic Experiences

A trauma-informed perspective views trauma-related symptoms and behaviors as an individual's best and most resilient attempt to manage, cope with, and rise above his or her experience of trauma. Some individuals' means of adapting and coping have produced little difficulty; the coping and adaptive strategies of others have worked in the past but are not working as well now. Some people have difficulties in one area of life but have effectively negotiated and functioned in other areas.

Individuals who have survived trauma vary widely in how they experience and express traumatic stress reactions. Traumatic stress reactions vary in severity; they are often measured by the level of impairment or distress that clients report and are determined by the multiple factors that characterize the trauma itself, individual history and characteristics, developmental factors, sociocultural attributes, and available resources. The characteristics of the trauma and the subsequent traumatic stress reactions can dramatically influence how individuals respond to the environment, relationships, interventions, and treatment services, and those same characteristics can also shape the assumptions that clients/consumers make about their world (e.g., their view of others, sense of safety), their future (e.g., hopefulness, fear of a foreshortened future), and themselves (e.g., feeling resilient, feeling incompetent in regulating emotions). The breadth of these effects may be observable or subtle.

Once you become aware of the significance of traumatic experiences in clients' lives and begin to view their presentation as adaptive, your identification and classification of their presenting symptoms and behaviors can shift from a "pathology" mindset (i.e., defining clients strictly from a diagnostic label, implying that something is wrong with them) to one of resilience—a mindset that views clients' presenting difficulties, behaviors, and emotions as responses to surviving trauma. In essence, you will come to view traumatic stress reactions as *normal* reactions to *abnormal* situations. In embracing the belief that trauma-related reactions are adaptive, you can begin relationships with clients from a hopeful, strengths-based stance that builds upon the belief that their responses to traumatic experiences reflect creativity, self-preservation, and determination.

This will help build mutual and collaborative therapeutic relationships, help clients identify what has worked and has not worked in their attempts to deal with the aftermath of trauma from a nonjudgmental stance, and develop intervention and coping strategies that are more likely to fit their strengths and resources. This view of trauma prevents further retraumatization by not defining traumatic stress reactions as pathological or as symptoms of pathology.

View Trauma in the Context of Individuals' Environments

Many factors contribute to a person's response to trauma, whether it is an individual, group, or community-based trauma. Individual attributes, developmental factors (including protective and risk factors), life history, type of trauma, specific characteristics of the trauma, amount and length of trauma exposure, cultural meaning of traumatic events, number of losses associated with the trauma, available resources (internal and external, such as coping skills and family support), and community reactions are a few of the determinants that influence a person's responses to trauma across time. Refer to the "View Trauma Through a Sociocultural Lens" section later in this chapter for more specific information highlighting the importance of culture in understanding and treating the effects of trauma.

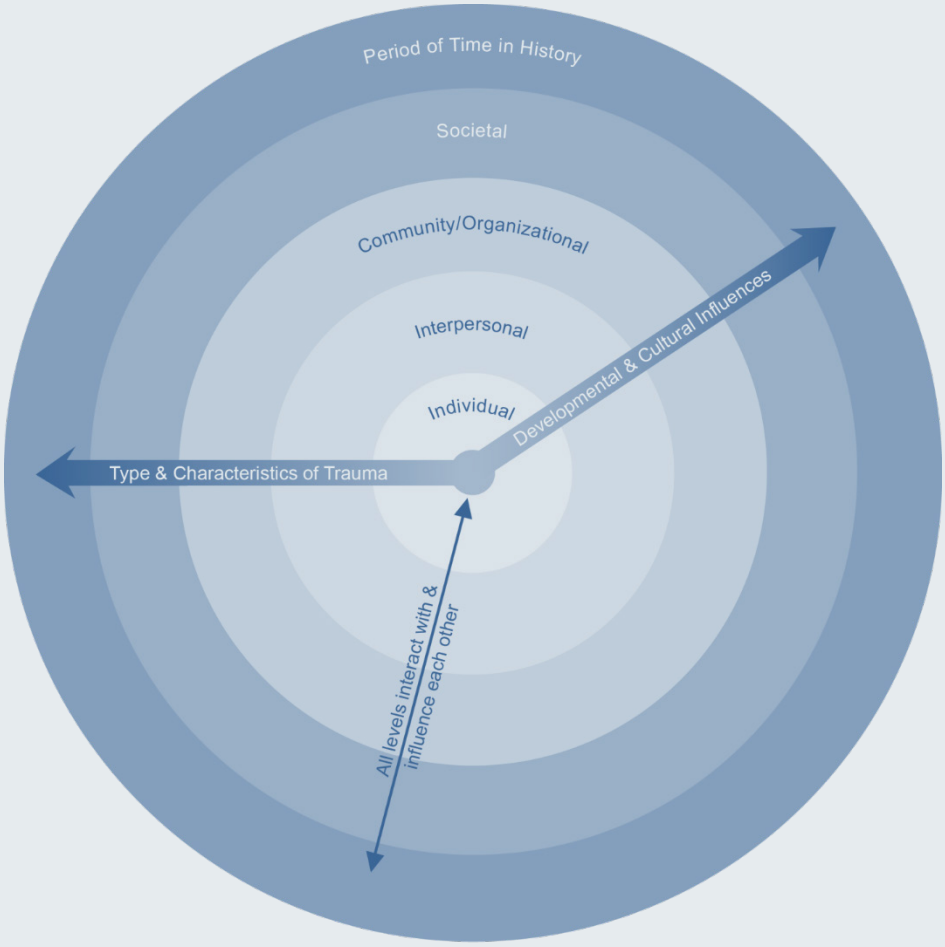
Trauma cannot be viewed narrowly; instead, it needs to be seen through a broader lens—a contextual lens integrating biopsychosocial, interpersonal, community, and societal (the degree of individualistic or collective cultural values) characteristics that are evident preceding and during the trauma, in the immediate and sustained response to the event(s), and in the short- and long-term effects of the traumatic event(s), which may include housing availability, community response, adherence to or maintenance of family routines and structure, and level of family support.

To more adequately understand trauma, you must also consider the contexts in which it occurred. Understanding trauma from this angle helps expand the focus beyond individual characteristics and effects to a broader systemic perspective that acknowledges the influences of social interactions, communities, governments, cultures, and so forth, while also examining the possible interactions among those various influences. Bronfenbrenner's (1979) and Bronfenbrenner and Ceci's (1994) work on ecological models sparked the development of other contextual models. In recent years, the social-ecological framework has been adopted in understanding trauma, in implementing health promotion and other prevention strategies, and in developing treatment interventions (Centers for Disease Control and Prevention, 2009). Here are the three main beliefs of a social-ecological approach (Stokols, 1996):

- Environmental factors greatly influence emotional, physical, and social well-being.
- A fundamental determinant of health versus illness is the degree of fit between individuals' biological, behavioral, and sociocultural needs and the resources available to them.
- Prevention, intervention, and treatment approaches integrate a combination of strategies targeting individual, interpersonal, and community systems.

This TIP uses a social-ecological model to explore trauma and its effects (Exhibit 1.1-2). The focus of this model is not only on negative attributes (risk factors) across each level, but also on positive ingredients (protective factors) that protect against or lessen the impact of trauma. This model also guides the inclusion of certain targeted interventions in this text, including selective and indicated

Exhibit 1.1-2: A Social-Ecological Model for Understanding Trauma and Its Effects



prevention activities. In addition, culture, developmental processes (including the developmental stage or characteristics of the individual and/or community), and the specific era when the trauma(s) occurred can significantly influence how a trauma is perceived and processed, how an individual or community engages in help-seeking, and the degree of accessibility, acceptability, and availability of individual and community resources.

Depending on the developmental stage and/or processes in play, children, adolescents, and adults will perceive, interpret, and cope with traumatic experiences differently. For example, a child may view a news story depicting a traumatic event on television and believe that the trauma is recurring every time they see the scene replayed. Similarly, the era in which one lives and the timing of the trauma can greatly influence an individual or community response. Take, for example, a pregnant woman who is abusing drugs and is wary of receiving medical treatment after being beaten in a domestic dispute. She may fear losing her children or being arrested for child neglect. Even though a number of States have adopted policies focused on the importance of treatment for pregnant women who are abusing drugs and of the accessibility of prenatal care, other States have approached this issue from a criminality standpoint (e.g., with child welfare and criminal laws) in the past few decades. Thus, the traumatic event's timing is a significant

component in understanding the context of trauma and trauma-related responses.

The social-ecological model depicted in Exhibit 1.1-2 provides a systemic framework for looking at individuals, families, and communities affected by trauma in general; it highlights the bidirectional influence that multiple contexts can have on the provision of behavioral health services to people who have experienced trauma (see thin arrow). Each ring represents a different system (refer to Exhibit 1.1-3 for examples of specific factors within each system). The innermost ring represents the individual and his or her biopsychosocial characteristics. The "Interpersonal" circle embodies all immediate relationships including family, friends, peers, and others. The "Community/Organizational" band represents social support networks, workplaces, neighborhoods, and institutions that directly influence the individual and his/her relationships. The "Societal" circle signifies the largest system—State and Federal policies and laws, such as economic and healthcare policies, social norms, governmental systems, and political ideologies. The outermost ring, "Period of Time in History," reflects the significance of the period of time during which the event occurred; it influences each other level represented in the circle. For example, making a comparison of society's attitudes and responses to veterans' homecomings across different wars and conflicts through time shows that homecoming environments can have either a protective or a negative effect on healing from the psychological and physical wounds of war, depending on the era in question. The thicker arrows in the figure represent the key influences of culture, developmental characteristics, and the type and characteristics of the trauma. All told, the context of traumatic events can significantly influence both initial and sustained responses to trauma; treatment needs; selection of prevention, intervention, and other treatment

Exhibit 1.1-3: Understanding the Levels Within the Social-Ecological Model of Trauma and Its Effects

Individual Factors	Interpersonal Factors	Community and Organizational Factors	Societal Factors	Cultural and Developmental Factors	Period of Time in History
Age, biophysical state, mental health status, temperament and other personality traits, education, gender, coping styles, socioeconomic status	Family, peer, and significant other interaction patterns, parent/family mental health, parents' history of trauma, social network	Neighborhood quality, school system and/or work environment, behavioral health system quality and accessibility, faith-based settings, transportation availability, community socioeconomic status, community employment rates	Laws, State and Federal economic and social policies, media, societal norms, judicial system	Collective or individualistic cultural norms, ethnicity, cultural subsystem norms, cognitive and maturational development	Societal attitudes related to military service members' homecomings, changes in diagnostic understanding between DSM-III-R* and DSM-5**

**Diagnostic and Statistical Manual of Mental Disorders,* Third Edition, Revised (American Psychiatric Association [APA], 1987)

***Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (APA, 2013a)

Case Illustration: Marisol

Marisol is a 28-year-old Latina woman working as a barista at a local coffee shop. One evening, she was driving home in the rain when a drunk driver crossed into her lane and hit her head on. Marisol remained conscious as she waited to be freed from the car and was then transported to the hospital. She sustained fractures to both legs. Her recovery involved two surgeries and nearly 6 months of rehabilitation, including initial hospitalization and outpatient physical therapy.

She described her friends and family as very supportive, saying that they often foresaw what she needed before she had to ask. She added that she had an incredible sense of gratitude for her employer and coworkers, who had taken turns visiting and driving her to appointments. Although she was able to return to work after 9 months, Marisol continued experiencing considerable distress about her inability to sleep well, which started just after the accident. Marisol describes repetitive dreams and memories of waiting to be transported to the hospital after the crash. The other driver was charged with driving under the influence (DUI), and it was reported that he had been convicted two other times for a DUI misdemeanor.

Answering the following questions will help you see how the different levels of influence affect the impact and outcome of the traumatic event Marisol experienced, as well as her responses to that event:

1. Based on the limited information provided in this illustration, how might Marisol's personality affect the responses of her family and friends, her coworkers, and the larger community?
2. In what ways could Marisol's ethnic and cultural background influence her recovery?
3. What societal factors could play a role in the car crash itself and the outcomes for Marisol and the other driver?

Explore the influence of the period of time in history during which the scenario occurs—compare the possible outcomes for both Marisol and the other driver if the crash occurred 40 years ago versus in the present day.

strategies; and ways of providing hope and promoting recovery.

Minimize the Risk of Retraumatization or Replicating Prior Trauma Dynamics

Trauma-informed treatment providers acknowledge that clients who have histories of trauma may be more likely to experience particular treatment procedures and practices as negative, reminiscent of specific characteristics of past trauma or abuse, or retraumatizing—feeling as if the past trauma is reoccurring or as if the treatment experience is as dangerous and unsafe as past traumas. For instance, clients may express feelings of powerlessness or being trapped if they are not actively involved in treatment decisions; if treatment processes or providers mirror specific behavior from the clients' past experiences with trauma, they may voice distress or respond in the same way as they did to the original trauma. Among the potentially retraumatizing elements of treatment are seclusion or "time-out" practices that isolate individuals, mislabeling client symptoms as personality or other mental disorders rather than as traumatic stress reactions, interactions that command authority, treatment assignments that could humiliate clients (such as asking a client to wear a sign in group that reflects one of their treatment issues, even if the assignment centers on positive attributes of the client), confronting clients as resistant, or presenting treatment as conditional upon conformity to the provider's beliefs and definitions of issues.

Clients' experiences are unique to the specific traumas they have faced and the surrounding

circumstances before, during, and after that trauma, so remember that even seemingly safe and standard treatment policies and procedures, including physical plant operations (e.g., maintenance, grounds, fire and safety procedures), may feel quite the contrary for a client if one or more of those elements is reminiscent of his or her experience of trauma in some way. Examples include having limited privacy or personal space, being interviewed in a room that feels too isolating or confining, undergoing physical examination by a medical professional of the same sex as the client's previous perpetrator of abuse, attending a group session in which another client expresses anger appropriately in a role play, or being directed not to talk about distressing experiences as a means of deescalating traumatic stress reactions.

Although some treatment policies or procedures are more obviously likely to solicit distress than others, *all* standard practices should be evaluated for their potential to retraumatize a client; this cannot be done without knowing the specific features of the individual's history of trauma. Consider, for instance, a treatment program that serves meals including entrees that combine more than one food group. Your client enters this program and refuses to eat most of the time; he expresses anger toward dietary staff and claims that food choices are limited. You may initially perceive your client's refusal to eat or to avoid certain foods as an eating disorder or a behavioral problem. However, a trauma-aware perspective might change your assumptions; consider that this client experienced neglect and abuse surrounding food throughout childhood (his mother forced him to eat meals prepared by combining anything in the refrigerator and cooking them together).

Advice to Counselors and Administrators: Sending the Right Message About Trauma

How often have you heard "We aren't equipped to handle trauma" or "We don't have time to deal with reactions that surface if traumatic experiences are discussed in treatment" from counselors and administrators in behavioral health services? For agencies, staff members, and clients, these statements present many difficulties and unwanted outcomes. For a client, such comments may replicate his or her earlier encounters with others (including family, friends, and previous behavioral health professionals) who had difficulty acknowledging or talking about traumatic experiences with him or her. A hands-off approach to trauma can also reinforce the client's own desire to avoid such discussions. Even when agencies and staff are motivated in these sentiments by a good intention—to contain clients' feelings of being overwhelmed—such a perspective sends strong messages to clients that their experiences are not important, that they are not capable of handling their trauma-associated feelings, and that dealing with traumatic experiences is simply too dangerous. Statements like these imply that recovery is not possible and provide no structured outlet to address memories of trauma or traumatic stress reactions.

Nevertheless, determining how and when to address traumatic stress in behavioral health services can be a real dilemma, especially if there are no trauma-specific philosophical, programmatic, or procedural processes in place. For example, it is difficult to provide an appropriate forum for a client to address past traumas if no forethought has been given to developing interagency and intra-agency collaborations for trauma-specific services. By anticipating the need for trauma-informed services and planning ahead to provide appropriate services to people who are affected by trauma, behavioral health service providers and program administrators can begin to develop informed intervention strategies that send a powerful, positive message:

- Both clients and providers can competently manage traumatic experiences and reactions.
- Providers are interested in hearing clients' stories and attending to their experiences.
- Recovery is possible.

As a treatment provider, you cannot consistently predict what may or may not be upsetting or retraumatizing to clients. Therefore, it is important to maintain vigilance and an attitude of curiosity with clients, inquiring about the concerns that they express and/or present in treatment. Remember that certain behaviors or emotional expressions can reflect what has happened to them in the past.

Foremost, a trauma-informed approach begins with taking practical steps to reexamine treatment strategies, program procedures, and organizational polices that could solicit distress or mirror common characteristics of traumatic experiences (loss of control, being trapped, or feeling disempowered). To better anticipate the interplay between various treatment elements and the more idiosyncratic aspects of a particular client's trauma history, you can:

- Work with the client to learn the cues he or she associates with past trauma.
- Obtain a good history.
- Maintain a supportive, empathetic, and collaborative relationship.
- Encourage ongoing dialog.
- Provide a clear message of availability and accessibility throughout treatment.

In sum, trauma-informed providers anticipate and respond to potential practices that may be perceived or experienced as retraumatizing to clients; they are able to forge new ways to respond to specific situations that trigger a trauma-related response, and they can provide clients with alternative ways of engaging in a particularly problematic element of treatment.

Create a Safe Environment

The need to create a safe environment is not new to providers; it involves an agency-wide effort supported by effective policies and procedures. However, creating safety within a trauma-informed framework far exceeds the standard expectations of physical plant safety (e.g., facility, environmental, and space-related concerns), security (of staff members, clients, and personal property), policies and procedures (including those specific to seclusion and restraint), emergency management and disaster planning, and adherence to client rights. Providers must be responsive and adapt the environment to establish and support clients' sense of physical and emotional safety.

Beyond anticipating that various environmental stimuli within a program may generate strong emotions and reactions in a trauma survivor (e.g., triggers such as lighting, access to exits, seating arrangements, emotionality within a group, or visual or auditory stimuli) and implementing strategies to help clients cope with triggers that evoke their experiences with trauma, other key elements in establishing a safe environment include consistency in client interactions and treatment processes, following through with what has been reviewed or agreed upon in sessions or meetings, and dependability. Mike's case illustration depicts ways in which the absence of these key elements could erode a client's sense of safety during the treatment process.

Neither providers nor service processes are always perfect. Sometimes, providers

Case Illustration: Mike

From the first time you provide outpatient counseling to Mike, you explain that he can call an agency number that will put him in direct contact with someone who can provide further assistance or support if he has emotional difficulty after the session or after agency hours. However, when he attempts to call one night, no one is available despite what you've described. Instead, Mike is directed by an operator to either use his local emergency room if he perceives his situation to be a crisis or to wait for someone on call to contact him. The inconsistency between what you told him in the session and what actually happens when he calls makes Mike feel unsafe and vulnerable.

unintentionally relay information inaccurately or inconsistently to clients or other staff members; other times, clients mishear something, or extenuating circumstances prevent providers from responding as promised. Creating safety is not about getting it right all the time; it's about how consistently and forthrightly you handle situations with a client when circumstances provoke feelings of being vulnerable or unsafe. Honest and compassionate communication that conveys a sense of handling the situation together generates safety. It is equally important that safety extends beyond the client. Counselors and other behavioral health staff members, including peer support specialists, need to be able to count on the agency to be responsive to and maintain their safety within the environment as well. By incorporating an organizational ethos that recognizes the importance of practices that promote physical safety and emotional well-being, behavioral health staff members may be more likely to seek support and supervision when needed and to comply with clinical and programmatic practices that minimize risks for themselves and their clients.

Beyond an attitudinal promotion of safety, organizational leaders need to consider and create avenues of professional development and assistance that will give their staff the means to seek support and process distressing circumstances or events that occur within the agency or among their clientele, such as case consultation and supervision, formal or informal processes to debrief service providers about difficult clinical issues, and referral processes for client psychological evaluations and employee assistance for staff. Organizational practices are only effective if supported by unswerving trauma awareness, training, and education among staff. Jane's case illustration shows the impact of a minor but necessary postponement in staff orientation for a new hire—not an unusual circumstance in behavioral health programs that have heavy caseloads and high staff turnover.

Identify Recovery From Trauma as a Primary Goal

Often, people who initiate or are receiving mental health or substance abuse services don't identify their experiences with trauma as a significant factor in their current challenges or problems. In part, this is because people who have been exposed to trauma, whether once or repeatedly, are generally reluctant to revisit it. They may already feel stuck in repetitive memories or experiences, which may add to their existing belief that any intervention will make matters worse or, at least, no better. For some clients, any introduction to their trauma-related memories or minor cues reminiscent of the trauma will cause them to experience strong, quick-to-surface emotions, supporting their belief that addressing trauma is dangerous and that they won't be able to handle the

Case Illustration: Jane

Jane, a newly hired female counselor, had a nephew who took his own life. The program that hired her was short of workers at the time; therefore, Jane did not have an opportunity to engage sufficiently in orientation outside of reviewing the policies and procedure manual. In an attempt to present well to her new employer and supervisor, she readily accepted client assignments without considering her recent loss. By not immersing herself in the program's perspective and policies on staff well-being, ethical and clinical considerations in client assignments, and how and when to seek supervision, Jane failed to engage in the practices, heavily supported by the agency, that promoted safety for herself and her clients. Subsequently, she felt emotionally overwhelmed at work and would often abruptly request psychiatric evaluation for clients who expressed any feelings of hopelessness out of sheer panic that they would attempt suicide.

emotions or thoughts that result from attempting to do so. Others readily view their experiences of trauma as being in the past; as a result, they engage in distraction, dissociation, and/or avoidance (as well as adaptation) due to a belief that trauma has little impact on their current lives and presenting problems. Even individuals who are quite aware of the impact that trauma has had on their lives may still struggle to translate or connect how these events continue to shape their choices, behaviors, and emotions. Many survivors draw no connection between trauma and their mental health or substance abuse problems, which makes it more difficult for them to see the value of trauma-informed or trauma-specific interventions, such as creating safety, engaging in psychoeducation, enhancing coping skills, and so forth.

As a trauma-informed provider, it is important that you help clients bridge the gap between their mental health and substance-related issues and the traumatic experiences they may have had. All too often, trauma occurs before substance use and mental disorders develop; then, such disorders and their associated symptoms and consequences create opportunities for additional traumatic events to occur. If individuals engage in mental health and substance abuse treatment without addressing the role that trauma has played in their lives, they are less likely to experience recovery in the long run. For example, a person with a history of trauma is more likely to have anxiety and depressive symptoms, use substances to self-medicate, and/or relapse after exposure to trauma-related cues. Thus, collaboration within and between behavioral health agencies is necessary to make integrated, timely, trauma-specific interventions available from the beginning to clients/consumers who engage in substance abuse and mental health services.

Support Control, Choice, and Autonomy

Not every client who has experienced trauma and is engaged in behavioral health services wants, or sees the need for, trauma-informed or trauma-specific treatment. Clients may think that they've already dealt with their trauma adequately, or they may believe that the effects of past trauma cause minimal distress for them. Other clients may voice the same sentiments, but without conviction—instead using avoidant behavior to deter distressing symptoms or reactions. Still others may struggle to see the role of trauma in their presenting challenges, not connecting their past traumatic experiences with other, more current difficulties (e.g., using substances to self-medicate strong emotions). Simply the idea of acknowledging trauma-related experiences and/or stress reactions may be too frightening or overwhelming for some clients, and others may fear that their reactions will be dismissed. On the other hand, some individuals want so much to dispense with their traumatic experiences and reactions that they hurriedly and repeatedly disclose their experiences before establishing a sufficiently safe environment or learning effective coping strategies to offset distress and other effects of retraumatization.

As these examples show, not everyone affected by trauma will approach trauma-informed services or recognize the impact of trauma in their lives in the same manner. This can be challenging to behavioral health service providers who are knowledgeable about the impact of trauma and who perceive the importance of addressing trauma and its effects with clients. As with knowing that different clients may be at different levels of awareness or stages of change in substance abuse treatment services, you should acknowledge that people affected by trauma

present an array of reactions, various levels of trauma awareness, and different degrees of urgency in their need to address trauma.

Appreciating clients' perception of their presenting problems and viewing their responses to the impact of trauma as adaptive—even when you believe their methods of dealing with trauma to be detrimental—are equally important elements of TIC. By taking the time to engage with clients and understand the ways they have perceived, adjusted to, and responded to traumatic experiences, providers are more likely to project the message that clients possess valuable personal expertise and knowledge about their own presenting problems. This shifts the viewpoint from "Providers know best" to the more collaborative "Together, we can find solutions."

How often have you heard from clients that they don't believe they can handle symptoms that emerge from reexperiencing traumatic cues or memories? Have you ever heard clients state that they can't trust themselves or their reactions, or that they never know when they are going to be triggered or how they are going to react? How confident would you feel about yourself if, at any time, a loud noise could initiate an immediate attempt to hide, duck, or dive behind something? Traumatic experiences have traditionally been described as exposure to events that cause intense fear, helplessness, horror, or feelings of loss of control. Participation in behavioral health services should not mirror these aspects of traumatic experience. Working collaboratively to facilitate clients' sense of control and to maximize clients' autonomy and choices throughout the treatment process, including treatment planning, is crucial in trauma-informed services.

For some individuals, gaining a sense of control and empowerment, along with understanding traumatic stress reactions, may be pivotal ingredients for recovery. By creating opportunities for empowerment, counselors and other behavioral health service providers help reinforce, clients' sense of competence, which is often eroded by trauma and prolonged traumatic stress reactions. Keep in mind that treatment strategies and procedures that prioritize client choice and control need not focus solely on major life decisions or treatment planning; you can apply such approaches to common tasks and everyday interactions between staff and consumers. Try asking your clients some of the following questions (which are only a sample of the types of questions that could be useful):

- What information would be helpful for us to know about what happened to you?
- Where/when would you like us to call you?
- How would you like to be addressed?
- Of the services I've described, which seem to match your present concerns and needs?
- From your experience, what responses from others appear to work best when you feel overwhelmed by your emotions?

Likewise, organizations need to reinforce the importance of staff autonomy, choice, and sense of control. What resources can staff members access, and what choices are available to them, in processing emotionally charged content or events in treatment? How often do administrators and supervisors seek out feedback on how to handle problematic situations (e.g., staff rotations for vacations, case consultations, changes in scheduling)? Think about the parallel between administration and staff members versus staff members and clients; often, the same philosophy, attitudes, and behaviors conveyed to staff members by administrative practices are mirrored in staff–client interactions. Simply stated, if staff members do not feel empowered, it will be a challenge for them to value the need for client empowerment. (For more information on administrative and workforce development issues, refer to Part 2, Chapters 1 and 2.)

Case Illustration: Mina

Mina initially sought counseling after her husband was admitted to an intensive outpatient drug and alcohol program. She was self-referred for low-grade depression, resentment toward her spouse, and codependency. When asked to define "codependency" and how the term applied to her, she responded that she always felt guilty and responsible for everyone in her family and for events that occurred even when she had little or no control over them.

After the intake and screening process, she expressed interest in attending group sessions that focused primarily on family issues and substance abuse, wherein her presenting concerns could be explored. In addition to describing dynamics and issues relating to substance abuse and its impact on her marriage, she referred to her low mood as frozen grief. During treatment, she reluctantly began to talk about an event that she described as life changing: the loss of her father. The story began to unfold in group; her father, who had been 62 years old, was driving her to visit a cousin. During the ride, he had a heart attack and drove off the road. As the car came to stop in a field, she remembered calling 911 and beginning cardiopulmonary resuscitation while waiting for the ambulance. She rode with the paramedics to the hospital, watching them work to save her father's life; however, he was pronounced dead soon after arrival.

She always felt that she never really said goodbye to her father. In group, she was asked what she would need to do or say to feel as if she had revisited that opportunity. She responded in quite a unique way, saying, "I can't really answer this question; the lighting isn't right for me to talk about my dad." The counselor encouraged her to adjust the lighting so that it felt "right" to her. Being invited to do so turned out to be pivotal in her ability to address her loss and to say goodbye to her father on her terms. She spent nearly 10 minutes moving the dimmer switch for the lighting as others in the group patiently waited for her to return to her chair. She then began to talk about what happened during the evening of her father's death, their relationship, the events leading up to that evening, what she had wanted to say to him at the hospital, and the things that she had been wanting to share with him since his death.

Weeks later, as the group was coming to a close, each member spoke about the most important experiences, tools, and insights that he or she had taken from participating. Mina disclosed that the group helped her establish boundaries and coping strategies within her marriage, but said that the event that made the most difference for her had been having the ability to adjust the lighting in the room. She explained that this had allowed her to control something over which she had been powerless during her father's death. To her, the lighting had seemed to stand out more than other details at the scene of the accident, during the ambulance ride, and at the hospital. She felt that the personal experience of losing her father and needing to be with him in the emergency room was marred by the obtrusiveness of staff, procedures, machines, and especially, the harsh lighting. She reflected that she now saw the lighting as a representation of this tragic event and the lack of privacy she had experienced when trying to say goodbye to her father. Mina stated that this moment in group had been the greatest gift: "…to be able to say my goodbyes the way I wanted… I was given an opportunity to have some control over a tragic event where I couldn't control the outcome no matter how hard I tried."

Create Collaborative Relationships and Participation Opportunities

This trauma-informed principle encompasses three main tenets. First, **ensure that the provider–client relationship is collaborative**, regardless of setting or service. Agency staff members cannot make decisions pertaining to interventions or involvement in community services autocratically; instead, they should develop trauma-informed, individualized care plans and/or treatment plans collaboratively with the client and, when appropriate, with family and caregivers. The nonauthoritarian approach that characterizes TIC views clients

as the experts in their own lives and current struggles, thereby emphasizing that clients and providers can learn from each other.

The second tenet is to **build collaboration beyond the provider–client relationship**. Building ongoing relationships across the service system, provider networks, and the local community enhances TIC continuity as clients move from one level of service to the next or when they are involved in multiple services at one time. It also allows you to learn about resources available to your clients in the service system or community and to connect with providers who have more advanced training in trauma-specific interventions and services.

The third tenet emphasizes the need to **ensure client/consumer representation and participation in behavioral health program development, planning, and evaluation as well as in the professional development of behavioral health workers**. To achieve trauma-informed competence in an organization or across systems, clients need to play an active role; this starts with providing program feedback. However, consumer involvement should not end there; rather, it should be encouraged throughout the implementation of trauma-informed services. So too, clients, potential clients, their families, and the community should be invited to participate in forming any behavioral health organization's plans to improve trauma-informed competence, provide TIC, and design relevant treatment services and organizational policies and procedures.

Trauma-informed principles and practices generated without the input of people affected by trauma are difficult to apply effectively. Likewise, staff trainings and presentations should include individuals who have felt the impact of trauma. Their participation reaches past the purely cognitive aspects of such education to offer a personal perspective on the strengths and resilience of people who have experienced trauma. The involvement of trauma survivors in behavioral health education lends a human face to subject matter that is all too easily made cerebral by some staff members in an attempt to avoid the emotionality of the topic.

Consumer participation also means giving clients/consumers the chance to obtain State training and certification, as well as employment in behavioral health settings as peer specialists. Programs that incorporate peer support services reinforce a powerful message—that provider–consumer partnership is important, and that consumers are valued. Peer support specialists are self-identified individuals who have progressed in their own recovery from alcohol dependence, drug addiction, and/or a mental disorder and work within behavioral health programs or at peer support centers to assist others with similar disorders and/or life experiences. Tasks and responsibilities may include leading a peer support group; modeling effective coping, help-seeking, and self-care strategies; helping clients practice new skills or monitor progress; promoting positive self-image to combat clients' potentially negative feelings about themselves and the discrimination they may perceive in the program or community; handling case management tasks; advocating for program changes; and representing a voice of hope that views recovery as possible.

Familiarize the Client With Trauma-Informed Services

Without thinking too much about it, you probably know the purpose of an intake process, the correct way to complete a screening device, the meaning of a lot of the jargon specific to behavioral health, and your program's expectations for client participation; in fact, maybe you're already involved in facilitating these processes in behavioral health services every day, and they've become almost

automatic for you. This can make it easy to forget that nearly everything clients and their families encounter in seeking behavioral health assistance is new to them. Thus, introducing clients to program services, activities, and interventions in a manner that *expects* them to be unfamiliar with these processes is essential, regardless of their clinical and treatment history. Beyond addressing the unfamiliarity of services, educating clients about each process—from first contact all the way through recovery services—gives them a chance to participate actively and make informed decisions across the continuum of care.

Familiarizing clients with trauma-informed services extends beyond explaining program services or treatment processes; it involves explaining the value and type of trauma-related questions that may be asked during an intake process, educating clients about trauma to help normalize traumatic stress reactions, and discussing trauma-specific interventions and other available services (including explanations of treatment methodologies and of the rationale behind specific interventions). Developmentally appropriate psychoeducation about trauma-informed services allows clients to be informed participants.

Incorporate Universal Routine Screenings for Trauma

Screening universally for client histories, experiences, and symptoms of trauma at intake can benefit clients and providers. Most providers know that clients can be affected by trauma, but universal screening provides a steady reminder to be watchful for past traumatic experiences and their potential influence upon a client's interactions and engagement with services across the continuum of care. Screening should guide treatment planning; it alerts the staff to potential issues and serves as a valuable tool to increase clients' awareness of the possible impact of trauma and the importance of addressing related issues during treatment.

Nonetheless, screenings are only as useful as the guidelines and processes established to address positive screens (which occur when clients respond to screening questions in a way that signifies possible trauma-related symptoms or histories). Staff should be trained to use screening tools consistently so that all clients are screened in the same way. Staff members also need to know how to score screenings and when specific variables (e.g., race/ethnicity, native language, gender, culture) may influence screening results. For example, a woman who has been sexually assaulted by a man may be wary of responding to questions if a male staff member or interpreter administers the screening or provides translation services. Likewise, a person in a current abusive or violent relationship may not acknowledge the interpersonal violence in fear of retaliation or as a result of disconnection or denial of his or her experience, and he or she may have difficulty in processing and then living between two worlds—what is acknowledged in treatment versus what is experienced at home.

In addition, staff training on using trauma-related screening tools needs to center on how and when to gather relevant information after the screening is complete. Organizational policies and procedures should guide staff members on how to respond to a positive screening, such as by making a referral for an indepth assessment of traumatic stress, providing the client with an introductory psychoeducational session on the typical biopsychosocial effects of trauma, and/or coordinating care so that the client gains access to trauma-specific services that meet his or her needs. Screening tool selection is an important ingredient in incorporating routine, universal screening practices into behavioral health services. Many screening tools are available, yet they differ in format

and in how they present questions. Select tools based not just on sound test properties, but also according to whether they encompass a broad range of experiences typically considered traumatic and are flexible enough to allow for an individual's own interpretation of traumatic events. For more information on screening and assessment of trauma and trauma-related symptoms and effects, see Chapter 4, "Screening and Assessment," in this TIP.

View Trauma Through a Sociocultural Lens

To understand how trauma affects an individual, family, or community, you must first understand life experiences and cultural background as key contextual elements for that trauma. As demonstrated in Exhibit 1.1-2, many factors shape traumatic experiences and individual and community responses to it; one of the most significant factors is culture. It influences the interpretation and meaning of traumatic events, individual beliefs regarding personal responsibility for the trauma and subsequent responses, and the meaning and acceptability of symptoms, support, and help-seeking behaviors. As this TIP proceeds to describe the differences among cultures pertaining to trauma, remember that there are numerous cross-cutting factors that can directly or indirectly influence the attitudes, beliefs, behaviors, resources, and opportunities within a given culture, subculture, or racial and/or ethnic group (Exhibit 1.1-4). For an indepth

Exhibit 1.1-4: Cross-Cutting Factors of Culture

Culture and Trauma

- Some populations and cultures are more likely than others to experience a traumatic event or a specific type of trauma.
- Rates of traumatic stress are high across all diverse populations and cultures that face military action and political violence.
- Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma.
- Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life.
- Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behavior, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased.
- Traumatic stress symptoms vary according to the type of trauma within the culture.
- Culture affects what qualifies as a legitimate health concern and which symptoms warrant help.
- In addition to shaping beliefs about acceptable forms of help-seeking behavior and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.

exploration of these cross-cutting cultural factors, refer to the planned TIP, *Improving Cultural Competence* (SAMHSA, planned c).

When establishing TIC, it is vital that behavioral health systems, service providers, licensing agencies, and accrediting bodies build culturally responsive practices into their curricula, standards, policies and procedures, and credentialing processes. The implementation of culturally responsive practices will further guide the treatment planning process so that trauma-informed services are more appropriate and likely to succeed.

Use a Strengths-Focused Perspective: Promote Resilience

Fostering individual strengths is a key step in prevention when working with people who have been exposed to trauma. It is also an essential intervention strategy—one that builds on the individual's existing resources and views him or her as a resourceful, resilient survivor. Individuals who have experienced trauma develop many strategies and/or behaviors to adapt to its emotional, cognitive, spiritual, and physical consequences. Some behaviors may be effective across time, whereas others may eventually produce difficulties and disrupt the healing process. Traditionally, behavioral health services have tended to focus on presenting problems, risk factors, and symptoms in an attempt to prevent negative outcomes, provide relief, increase clients' level of functioning, and facilitate healing. However, focusing too much on these areas can undermine clients' sense of competence and hope. Targeting only presenting problems and symptoms does not provide individuals with an opportunity to see their own resourcefulness in managing very stressful and difficult experiences. It is important for providers to engage in interventions using a balanced approach that targets the strengths clients have

> "Trauma informed care recognizes symptoms as originating from adaptations to the traumatic event(s) or context. Validating resilience is important even when past coping behaviors are now causing problems. Understanding a symptom as an adaptation reduces a survivor's guilt and shame, increases their self esteem and provides a guideline for developing new skills and resources to allow new and better adaptation to the current situation."
>
> (Elliot et al., 2005, p. 467)

Advice to Counselors and Administrators: Using Strengths-Oriented Questions

Knowing a client's strengths can help you understand, redefine, and reframe the client's presenting problems and challenges. By focusing and building on an individual's strengths, counselors and other behavioral health professionals can shift the focus from "What is wrong with you?" to "What has worked for you?" It moves attention away from trauma-related problems and toward a perspective that honors and uses adaptive behaviors and strengths to move clients along in recovery.

Potential strengths-oriented questions include:

- The history that you provided suggests that you've accomplished a great deal since the trauma. What are some of the accomplishments that give you the most pride?
- What would you say are your strengths?
- How do you manage your stress today?
- What behaviors have helped you survive your traumatic experiences (during and afterward)?
- What are some of the creative ways that you deal with painful feelings?
- You have survived trauma. What characteristics have helped you manage these experiences and the challenges that they have created in your life?
- If we were to ask someone in your life, who knew your history and experience with trauma, to name two positive characteristics that help you survive, what would they be?
- What coping tools have you learned from your _____ (fill in: cultural history, spiritual practices, athletic pursuits, etc.)?
- Imagine for a moment that a group of people are standing behind you showing you support in some way. Who would be standing there? It doesn't matter how briefly or when they showed up in your life, or whether or not they are currently in your life or alive.
- How do you gain support today? (Possible answers include family, friends, activities, coaches, counselors, other supports, etc.)
- What does recovery look like for you?

developed to survive their experiences and to thrive in recovery. A strengths-based, resilience-minded approach lets trauma survivors begin to acknowledge and appreciate their fortitude and the behaviors that help them survive.

Foster Trauma-Resistant Skills

Trauma-informed services build a foundation on which individuals can begin to explore the role of trauma in their lives; such services can also help determine how best to address and tailor interventions to meet their needs. Prevention, mental health, and substance abuse treatment services should include teaching clients about how trauma can affect their lives; these services should also focus on developing self-care skills, coping strategies, supportive networks, and a sense of competence. Building trauma-resistant skills begins with normalizing the symptoms of traumatic stress and helping clients who have experienced trauma connect the dots between current problems and past trauma when appropriate.

Nevertheless, TIC and trauma-specific interventions that focus on skill-building should not do so at the expense of acknowledging individual strengths, creativity in adapting to trauma, and inherent attributes and tools clients possesses to combat the effects of trauma. Some theoretical models that use skill-building strategies base the value of this approach on a deficit perspective; they assume that some individuals lack the necessary tools to manage specific situations and, because of this deficiency, they encounter problems that others with effective skills would not experience. This type of perspective further assumes that, to recover, these individuals must learn new coping skills and behavior. TIC, on the other hand, makes the assumption that clients

Advice to Administrators: Self-Assessment for Trauma-Informed Systems

NCTIC has developed a self-assessment package for trauma-informed systems to help administrators structurally incorporate trauma into programs and services. The self-assessment can be used by systems of care to guide quality improvement with the goal of establishing fully trauma-informed treatment and recovery efforts (NCTIC, Center for Mental Health Services, 2007). Behavioral health treatment program administrators can use these materials and NCTIC as resources for improvement in delivering TIC.

are the experts in their own lives and have learned to adapt and acquire skills to survive. The TIC approach honors each individual's adaptations and acquired skills, and it helps clients explore how these may not be working as well as they had in the past and how their current repertoire of responses may not be as effective as other strategies.

Demonstrate Organizational and Administrative Commitment to TIC

Becoming a trauma-informed organization requires administrative guidance and support across all levels of an agency. Behavioral health staff will not likely sustain TIC practices without the organization's ongoing commitment to support professional development and to allocate resources that promote these practices. An agency that wishes to commit to TIC will benefit from an organizational assessment of how staff members identify and manage trauma and trauma-related reactions in their clients. Are they trauma aware—do they recognize that trauma can significantly affect a client's ability to function in one or more areas of his or her life? Do the staff members understand that traumatic experiences and trauma-related reactions can greatly influence clients' engagement, participation, and response to services?

Agencies need to embrace specific strategies across each level of the organization to create trauma-informed services; this begins with staff education on the impact of trauma among clients. Other agency strategies that reflect a trauma-informed infrastructure include, but are not limited to:

- Universal screening and assessment procedures for trauma.
- Interagency and intra-agency collaboration to secure trauma-specific services.
- Referral agreements and networks to match clients' needs.
- Mission and value statements endorsing the importance of trauma recognition.
- Consumer- and community-supported committees and trauma response teams.
- Workforce development strategies, including hiring practices.
- Professional development plans, including staff training/supervision focused on TIC.
- Program policies and procedures that ensure trauma recognition and secure trauma-informed practices, trauma-specific services, and prevention of retraumatization.

TIC requires organizational commitment, and often, cultural change. For more information on implementing TIC in organizations, see Part 2, Chapter 1 of this TIP.

Develop Strategies To Address Secondary Trauma and Promote Self-Care

Secondary trauma is a normal occupational hazard for mental health and substance abuse professionals, particularly those who serve populations that are likely to include survivors of trauma (Figley, 1995; Klinic Community Health Centre, 2008). Behavioral health staff members who experience secondary trauma present a range of traumatic stress reactions

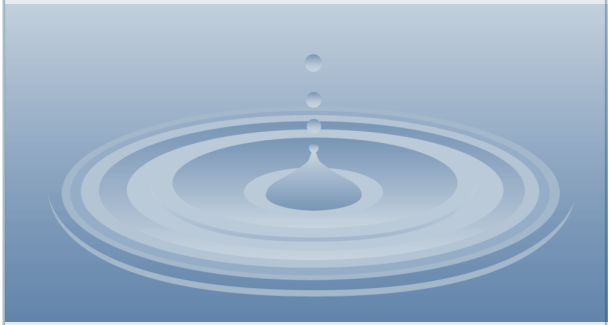
and effects from providing services focused on trauma or listening to clients recount traumatic experiences. So too, when a counselor has a history of personal trauma, working with trauma survivors may evoke memories of the counselor's own trauma history, which may increase the potential for secondary traumatization.

The range of reactions that manifest with secondary trauma can be, but are not necessarily, similar to the reactions presented by clients who have experienced primary trauma. Symptoms of secondary trauma can produce varying levels of difficulty, impairment, or distress in daily functioning; these may or may not meet diagnostic thresholds for acute stress, posttraumatic stress, or adjustment, anxiety, or mood disorders (Bober & Regehr, 2006). Symptoms may include physical or psychological reactions to traumatic memories clients have shared; avoidance behaviors during client interactions or when recalling emotional content in supervision; numbness, limited emotional expression, or diminished affect; somatic complaints; heightened arousal, including insomnia; negative thinking or depressed mood; and detachment from family, friends, and other supports (Maschi & Brown, 2010).

Working daily with individuals who have been traumatized can be a burden for counselors and other behavioral health service providers, but all too often, they blame the symptoms resulting from that burden on other stressors at work or at home. Only in the past 2 decades have literature and trainings begun paying attention to secondary trauma or compassion fatigue; even so, agencies often do not translate this knowledge into routine prevention practices. Counselors and other staff members may find it difficult to engage in activities that could ward off secondary trauma due to time constraints, workload, lack of agency resources, and/or an organizational culture that disapproves of help-seeking or provides inadequate staff support. The demands of providing care to trauma survivors cannot be ignored, lest the provider become increasingly impaired and less effective. Counselors with unacknowledged secondary trauma can cause harm to clients via poorly enforced boundaries, missed appointments, or even abandonment of clients and their needs (Pearlman & Saakvitne, 1995).

Essential components of TIC include organizational and personal strategies to address

The Impact of Trauma



Trauma is similar to a rock hitting the water's surface. The impact first creates the largest wave, which is followed by ever-expanding, but less intense, ripples. Likewise, the influence of a given trauma can be broad, but generally, its effects are less intense for individuals further removed from the trauma; eventually, its impact dissipates all around. For trauma survivors, the impact of trauma can be far-reaching and can affect life areas and relationships long after the trauma occurred. This analogy can also broadly describe the recovery process for individuals who have experienced trauma and for those who have the privilege of hearing their stories. As survivors reveal their trauma-related experiences and struggles to a counselor or another caregiver, the trauma becomes a shared experience, although it is not likely to be as intense for the caregiver as it was for the individual who experienced the trauma. The caregiver may hold onto the trauma's known and unknown effects or may consciously decide to engage in behaviors that provide support to further dissipate the impact of this trauma and the risk of secondary trauma.

Advice to Counselors: Decreasing the Risk of Secondary Trauma and Promoting Self-Care

- **Peer support.** Maintaining adequate social support will help prevent isolation and depression.
- **Supervision and consultation.** Seeking professional support will enable you to understand your own responses to clients and to work with them more effectively.
- **Training.** Ongoing professional training can improve your belief in your abilities to assist clients in their recoveries.
- **Personal therapy.** Obtaining treatment can help you manage specific problems and become better able to provide good treatment to your clients.
- **Maintaining balance.** A healthy, balanced lifestyle can make you more resilient in managing any difficult circumstances you may face.
- **Setting clear limits and boundaries with clients.** Clearly separating your personal and work life allows time to rejuvenate from stresses inherent in being a professional caregiver.

secondary trauma and its physical, cognitive, emotional, and spiritual consequences. In agencies and among individual providers, it is key for the culture to promote acceptability, accessibility, and accountability in seeking help, accessing support and supervision, and engaging in self-care behaviors in and outside of the agency or office. Agencies should involve staff members who work with trauma in developing informal and formal agency practices and procedures to prevent or address secondary trauma. Even though a number of community-based agencies face fiscal constraints, prevention strategies for secondary trauma can be intertwined with the current infrastructure (e.g., staff meetings, education, case consultations and group case discussions, group support, debriefing sessions as appropriate, supervision). For more information on strategies to address and prevent secondary trauma, see Part 2, Chapter 2 of this TIP.

Provide Hope—Recovery Is Possible

What defines recovery from trauma-related symptoms and traumatic stress disorders? Is it the total absence of symptoms or consequences? Does it mean that clients stop having nightmares or being reminded, by cues, of past trauma? When clients who have experienced trauma enter into a helping relationship to address trauma specifically, they are often looking for a cure, a remission of symptoms, or relief from the pain as quickly as possible. However, they often possess a history of unpredictable symptoms and symptom intensity that reinforces an underlying belief that recovery is not possible. On one hand, clients are looking for a message that they can be cured, while on the other hand, they have serious doubts about the likely success of any intervention.

Clients often express ambivalence about dealing with trauma even if they are fully aware of trauma's effects on their lives. The idea of living with more discomfort as they address the past or as they experiment with alternative ways of dealing with trauma-related symptoms or consequences is not an appealing prospect, and it typically elicits fear. Clients may interpret the uncomfortable feelings as dangerous or unsafe even in an environment and relationship that is safe and supportive.

How do you promote hope and relay a message that recovery is possible? First, maintain consistency in delivering services, promoting and providing safety for clients, and showing respect and compassion within the client–provider relationship. Along with clients' commitment to learning how to create safety for themselves, counselors and agencies need

to be aware of, and circumvent, practices that could retraumatize clients. Projecting hope and reinforcing the belief that recovery is possible extends well beyond the practice of establishing safety; it also encompasses discussing what recovery means and how it looks to clients, as well as identifying how they will know that they've entered into recovery in earnest.

Providing hope involves projecting an attitude that recovery is possible. This attitude also involves viewing clients as competent to make changes that will allow them to deal with trauma-related challenges, providing opportunities for them to practice dealing with difficult situations, and normalizing discomfort or difficult emotions and framing these as manageable rather than dangerous. If you convey this attitude consistently to your clients, they will begin to understand that discomfort is not a signal to avoid, but a sign to engage—and that behavioral, cognitive, and emotional responses to cues associated with previous traumas are a normal part of the recovery process. It's not the absence of responses to such triggers that mark recovery, but rather, how clients experience and manage those responses. Clients can also benefit from interacting with others who are further along in their recovery from trauma. Time spent with peer support staff or sharing stories with other trauma survivors who are well on their way to recovery is invaluable—it sends a powerful message that recovery is achievable, that there is no shame in being a trauma survivor, and that there is a future beyond the trauma.

As You Proceed

This chapter has established the foundation and rationale of this TIP, reviewed trauma-informed concepts and terminology, and provided an overview of TIC principles and a guiding framework for this text. As you proceed, be aware of the wide-ranging responses to trauma that occur not only across racially and ethnically diverse groups but also within specific communities, families, and individuals. Counselors, prevention specialists, other behavioral health workers, supervisors, and organizations all need to develop skills to create an environment that is responsive to the unique attributes and experiences of each client. As you read this TIP, remember that many cross-cutting factors influence the experiences, help-seeking behaviors, intervention responses, and outcomes of individuals, families, and populations who have survived trauma. Single, multiple, or chronic exposures to traumatic events, as well as the emotional, cognitive, behavioral, and spiritual responses to trauma, need to be understood within a social-ecological framework that recognizes the many ingredients prior to, during, and after traumatic experiences that set the stage for recovery.

2 Trauma Awareness

IN THIS CHAPTER

- Types of Trauma
- Characteristics of Trauma
- Individual and Sociocultural Features

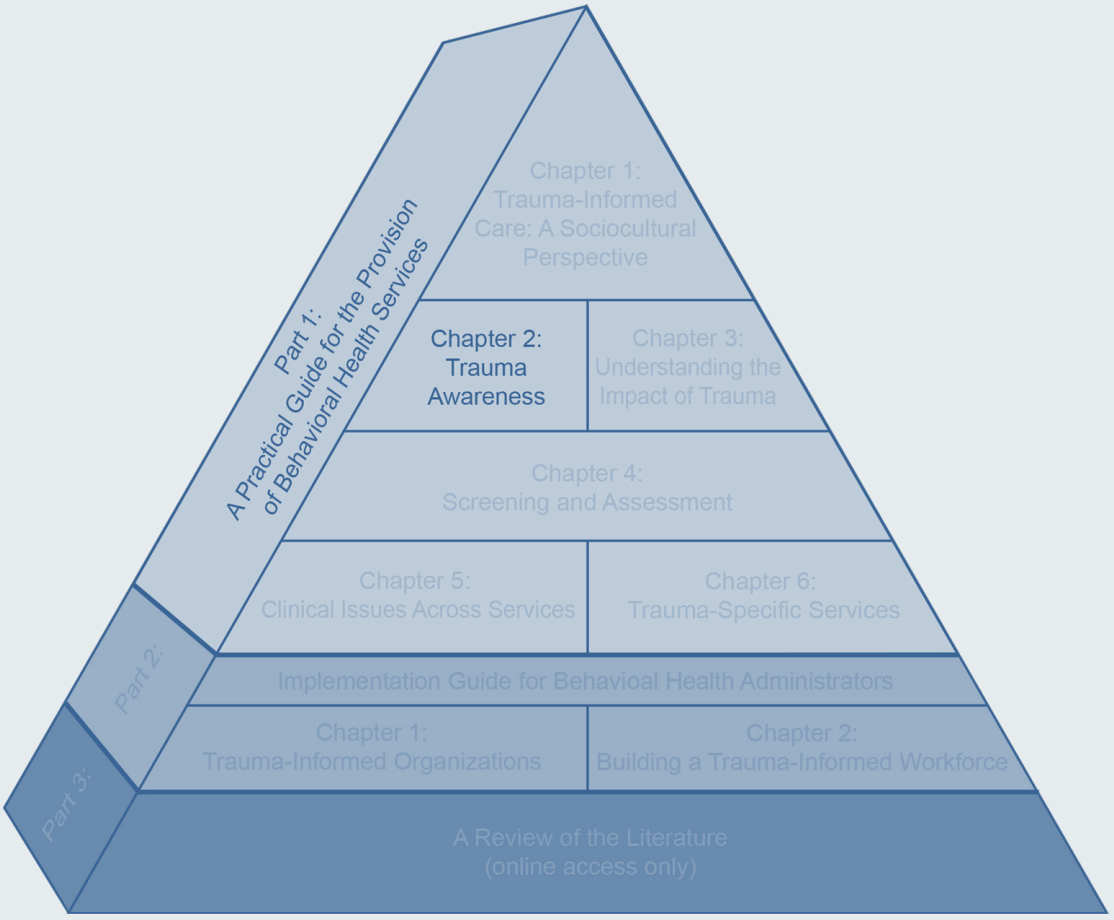
Traumatic experiences typically do not result in long-term impairment for most individuals. It is normal to experience such events across the lifespan; often, individuals, families, and communities respond to them with resilience. This chapter explores several main elements that influence why people respond differently to trauma. Using the social-ecological model outlined in Part 1, Chapter 1, this chapter explores some of the contextual and systemic dynamics that influence individual and community perceptions of trauma and its impact. The three main foci are: types of trauma, objective and subjective characteristics of trauma, and individual and sociocultural features that serve as risk or protective factors.

This chapter's main objective is to highlight the key characteristics of traumatic experiences. Trauma-informed behavioral health service providers understand that many influences shape the effects of trauma among individuals and communities—it is not just the event that determines the outcome, but also the event's context and the resultant interactions across systems.

Types of Trauma

The following section reviews various forms and types of trauma. It does not cover every conceivable trauma that an individual, group, or community may encounter. Specific traumas are reviewed only once, even when they could fit in multiple categories of trauma. Additionally, the order of appearance does not denote a specific trauma's importance or prevalence, and there is no lack of relevance implied if a given trauma is not specifically addressed in this Treatment Improvement Protocol (TIP). The intent is to give a broad perspective of the various categories and types of trauma to behavioral health workers who wish to be trauma informed.

TIC Framework in Behavioral Health Services—Trauma Awareness



Natural or Human-Caused Traumas

The classification of a trauma as natural or caused by humans can have a significant impact on the ways people react to it and on the types of assistance mobilized in its aftermath (see Exhibit 1.2-1 for trauma examples). Natural traumatic experiences can directly affect a small number of people, such as a tree falling on a car during a rainstorm, or many people and communities, as with a hurricane. Natural events, often referred to as "acts of God," are typically unavoidable. Human-caused traumas are caused by human failure (e.g., technological catastrophes, accidents, malevolence) or by human design (e.g., war). Although multiple factors contribute to the severity of a natural or human-caused trauma, traumas perceived as intentionally harmful often make the event more traumatic for people and communities.

For information on resources to prepare States, Territories, and local entities to deliver effective mental health and substance abuse responses during disasters, contact the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Disaster Technical Assistance Center:

4350 East West Hwy, Suite 1100
Bethesda, MD 20814 6233
Phone: 1 800 308 3515
Fax: 1 800 311 7691
Email: DTAC@samhsa.hhs.gov

Exhibit 1.2-1: Trauma Examples

Caused Naturally	Caused by People	
	Accidents, Technological Catastrophes	Intentional Acts
Tornado	Train derailment	Arson
Lightning strike	Roofing fall	Terrorism
Wildfire	Structural collapse	Sexual assault and abuse
Avalanche	Mountaineering accident	Homicides or suicides
Physical ailment or disease	Aircraft crash	Mob violence or rioting
Fallen tree	Car accident due to malfunction	Physical abuse and neglect
Earthquake	Mine collapse or fire	Stabbing or shooting
Dust storm	Radiation leak	Warfare
Volcanic eruption	Crane collapse	Domestic violence
Blizzard	Gas explosion	Poisoned water supply
Hurricane	Electrocution	Human trafficking
Cyclone	Machinery-related accident	School violence
Typhoon	Oil spill	Torture
Meteorite	Maritime accident	Home invasion
Flood	Accidental gun shooting	Bank robbery
Tsunami	Sports-related death	Genocide
Epidemic		Medical or food tampering
Famine		
Landslide or fallen boulder		

How survivors of natural trauma respond to the experience often depends on the degree of devastation, the extent of individual and community losses, and the amount of time it takes to reestablish daily routines, activities, and services (e.g., returning to school or work, being able to do laundry, having products to buy in a local store). The amount, accessibility, and duration of relief services can significantly influence the duration of traumatic stress reactions as well as the recovery process.

Alongside the disruption of daily routines, the presence of community members or outsiders in affected areas may add significant stress or create traumatic experiences in and of themselves. Examples include the threat of others stealing what remains of personal property, restrictions on travel or access to property or living quarters, disruption of privacy within shelters, media attention, and subsequent exposure to repetitive images reflecting the devastation. Therefore, it isn't just the natural disaster or event that can challenge an individual or community; often, the consequences of the event and behavioral responses from others within and outside the community play a role in pushing survivors away from effective coping or toward resilience and recovery.

Human-caused traumas are fundamentally different from natural disasters. They are either intentional, such as a convenience store robbery at gunpoint, or unintentional, such as the technological accident of a bridge collapse (as occurred in Minneapolis, Minnesota, in 2007; U.S. Fire Administration, 2007). The subsequent reactions to these traumas often depend on their intentionality. However, a person or group of people is typically the target of the survivors' anger and blame. Survivors of an unintentionally human-caused traumatic event may feel angry and frustrated because of the lack of protection or care offered by the responsible party or government, particularly if there has been a perceived act of omission. After intentional human-caused acts, survivors often struggle to understand the

Case Illustrations: Quecreek Mine Flood and Greensburg's Tornado

Quecreek Mine Flood

The year following the rescue of nine miners from the Quecreek mine in western Pennsylvania in 2002 was a difficult one for residents of Somerset County. The dazzle of publicity surrounding a handful of workers from a small town, tension between miners and rescuers, and animosity over money for movie and book deals, in addition to the trauma itself, resulted in a rescuer's suicide, a number of miners having trauma-related symptoms, and several rescuers needing to seek treatment for posttraumatic stress disorder (PTSD; Goodell, 2003).

Greensburg's Tornado

Greensburg, a small town in southern Kansas, was hit by a large tornado in 2007 that killed 11 residents and leveled 95 percent of the town while causing severe damage to the remaining 5 percent. Families and community members experienced significant grief and traumatic stress after the disaster. Yet today, Greensburg is rebuilding with a focus on being "green"—that is, environmentally responsible—from design to construction and all the way through demolition. This town has the highest number of Leadership in Energy and Environmental Design–certified buildings in the world. A reality television show about the town's reinvention ran for three seasons, demonstrating the town's residents and business owners working with local government and various corporations to make their home an even better place than it was before the tornado.

motives for performing the act, the calculated or random nature of the act, and the psychological makeup of the perpetrator(s).

Individual, Group, Community, and Mass Traumas

In recognizing the role of trauma and understanding responses to it, consider whether the trauma primarily affected an individual and perhaps his or her family (e.g., automobile accident, sexual or physical assault, severe illness); occurred within the context of a group (e.g., trauma experienced by first responders or those who have seen military combat) or community (e.g., gang-related shootings); transpired within a certain culture; or was a large-scale disaster (e.g., hurricane, terrorist attack). This context can have significant implications for whether (and how) people experience shame as a result of the trauma, the kinds of support and compassion they receive, whether their experiences are normalized or diminished by others, and even the kinds of services they are offered to help them recover and cope.

Individual trauma

An individual trauma refers to an event that only occurs to one person. It can be a single event (e.g., mugging, rape, physical attack, work-related physical injury) or multiple or prolonged events (e.g., a life-threatening illness, multiple sexual assaults). Although the trauma directly affects just one individual, others who know the person and/or are aware of the trauma will likely experience emotional repercussions from the event(s) as well, such as recounting what they said to the person before the event, reacting in disbelief, or thinking that it could just as easily have happened to them, too.

Survivors of individual trauma may not receive the environmental support and concern that members of collectively traumatized groups and communities receive. They are less likely to reveal their traumas or to receive validation of their experiences. Often, shame distorts their perception of responsibility for the trauma. Some survivors of individual traumas, especially those who have kept the trauma secret, may not receive needed comfort and

Advice to Counselors: Working With Clients Who Have Experienced Individual Traumas

In working with clients who have histories of individual trauma, counselors should consider that:

- Empathy, or putting oneself in the shoes of another, is more potent than sympathy (expressing a feeling of sorrow for another person).
- Some clients need to briefly describe the trauma(s) they have experienced, particularly in the early stages of recovery. Strategies that focus on reexperiencing the trauma, retrieving feelings related to the trauma, and bringing past experiences to the forefront should only be implemented if trauma-specific treatment planning and services are available.
- Understanding the trauma, especially in early recovery, should begin with educating the client about and normalizing trauma-related symptoms, creating a sense of safety within the treatment environment, and addressing how trauma symptoms may interfere with the client's life in the present.
- It is helpful to examine how the trauma affects opportunities to receive substance abuse and/or mental health treatment as well as treatment for and recovery from the trauma itself (e.g., by limiting one's willingness to share in or participate in group counseling).
- Identifying and exploring strengths in the client's history can help the client apply those strengths to his or her ability to function in the present.

acceptance from others; they are also are more likely to struggle with issues of causation (e.g., a young woman may feel unduly responsible for a sexual assault), to feel isolated by the trauma, and to experience repeated trauma that makes them feel victimized.

Physical injuries

Physical injuries are among the most prevalent individual traumas. Millions of emergency room (ER) visits each year relate directly to physical injuries. Most trauma patients are relatively young; about 70 percent of injury-related ER cases are people younger than 45 years old (McCaig & Burt, 2005). Dedicated ER hospital units, known as "trauma centers," specialize in physical traumas such as gunshot wounds, stabbings, and other immediate physical injuries. The term "trauma" in relation to ERs does not refer to psychological trauma, which is the focus of this TIP, yet physical injuries can be associated with psychological trauma. Sudden, unexpected, adverse health-related events can lead to extensive psychological trauma for patients and their families.

Excessive alcohol use is the leading risk factor for physical injuries; it's also the most promising target for injury prevention. Studies consistently connect injuries and substance use (Gentilello, Ebel, Wickizer, Salkever, & Rivara, 2005); nearly 50 percent of patients admitted to trauma centers have injuries attributable to alcohol abuse and dependence (Gentilello et al., 1999). One study found that two thirds of ambulatory assault victims presenting to an ER had positive substance use urinalysis results; more than half of all victims had PTSD 3 months later (Roy-Byrne et al.,

Acute stress disorder (ASD) prevalence among patients at medical trauma centers is very high, making trauma related disorders some of the most common complications seen in physically injured patients. Clients who have sustained serious injuries in car crashes, fires, stabbings, shootings, falls, and other events have an increased likelihood of developing trauma related mental disorders. Research suggests that PTSD and/or problem drinking is evident in nearly 50 percent of patients 1 year after discharge from trauma surgical units.

(Zatzick, Jurkovich, Gentilello, Wisner, & Rivara, 2002)

2004). Nearly 28 percent of patients whose drinking was identified as problematic during an ER visit for a physical injury will have a new injury within 1 year (Gentilello et al., 2005). For further information, see TIP 16, *Alcohol and Other Drug Screening of Hospitalized Trauma Patients* (Center for Substance Abuse Treatment [CSAT], 1995a).

Group trauma

The term "group trauma" refers to traumatic experiences that affect a particular group of people. This TIP intentionally distinguishes group trauma from mass trauma to highlight the unique experiences and characteristics of trauma-related reactions among small groups. These groups often share a common identity and history, as well as similar activities and concerns. They include vocational groups who specialize in managing traumas or who routinely place themselves in harm's way—for example, first responders, a group including police and emergency medical personnel. Some examples of group trauma include crews and their families who lose members from a commercial fishing accident, a gang whose members experience multiple deaths and injuries, teams of firefighters who lose members in a roof collapse, responders who attempt to save flood victims, and military service members in a specific theater of operation.

Survivors of group trauma can have different experiences and responses than survivors of individual or mass traumas. Survivors of group trauma, such as military service members and first responders, are likely to experience repeated trauma. They tend to keep the trauma experiences within the group, feeling that others outside the group will not understand; group outsiders are generally viewed as intruders. Members may encourage others in the group to shut down emotionally and repress their traumatic experiences—and there are some occupational roles that necessitate the repression of reactions to complete a mission or to be attentive to the needs at hand. Group members may not want to seek help and may discourage others from doing so out of fear that it may shame the entire group. In this environment, members may see it as a violation of group confidentiality when a member seeks assistance outside the group, such as by going to a counselor.

Group members who have had traumatic experiences in the past may not actively support traumatized colleagues for fear that acknowledging the trauma will increase the risk of repressed trauma-related emotions surfacing. However, groups with adequate resources for helping group members can develop a stronger and more supportive environment for handling subsequent traumas. These main group features influence the course of short- and long-term adjustments, including the development of traumatic stress symptoms associated with mental and substance use disorders.

Certain occupational groups are at greater risk of experiencing trauma—particularly multiple traumas. This TIP briefly reviews two main groups as examples in the following sections: first responders and military service members. For more detailed information on the impact of trauma and deployment, refer to the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (SAMHSA, planned f).

First responders

First responders are usually emergency medical technicians, disaster management personnel, police officers, rescue workers, medical and behavioral health professionals, journalists, and volunteers from various backgrounds. They also include lifeguards, military personnel, and clergy. Stressors associated with the kinds of traumatic events and/or disasters first responders are likely to experience include

exposure to toxic agents, feeling responsible for the lives of others, witnessing catastrophic devastation, potential exposure to gruesome images, observing human and animal suffering and/or death, working beyond physical exhaustion, and the external and internal pressure of working against the clock.

Military service members

Military personnel are likely to experience numerous stressors associated with trauma. Service members who have repeatedly deployed to a war zone are at a greater risk for traumatic stress reactions (also known as combat stress reaction or traumatic stress injury), other military personnel who provide support services are also at risk for traumatic stress and secondary trauma (refer to the glossary portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP). So too, service members who anticipate deployment or redeployment may exhibit psychological symptoms associated with traumatic stress. Some stressors that military service members may encounter include working while physically exhausted, exposure to gunfire, seeing or knowing someone who has been injured or killed, traveling in areas known for roadside bombs and rockets, extended hypervigilance, fear of being struck by an improvised explosive device, and so forth.

Trauma affecting communities and cultures

Trauma that affects communities and cultures covers a broad range of violence and atrocities that erode the sense of safety within a given community, including neighborhoods, schools, towns, and reservations. It may involve violence in the form of physical or sexual assaults, hate crimes, robberies, workplace or gang-related violence, threats, shootings, or stabbings—for example, the school shooting at Virginia Polytechnic Institute and State University in 2007. It also includes actions that attempt to dismantle systemic cultural practices, resources, and identities, such as making boarding school attendance mandatory for Native American children or placing them in non-Native foster homes. Cultural and/or community-based trauma can also occur via indifference or limited responsiveness to specific communities or cultures that are facing a potential catastrophe. Cultural traumas are events that, whether intentionally or not, erode the heritage of a culture—as with prejudice, disenfranchisement, and health inequities (e.g., late prenatal care, inability to afford medications, limited access to culturally appropriate health education, vicinity and quality of affordable medical services), among other examples.

"The excitement of the season had just begun, and then, we heard the news, oil in the water, lots of oil killing lots of water. It is too shocking to understand. Never in the millennium of our tradition have we thought it possible for the water to die, but it is true."

—Chief Walter Meganack, Port Graham, 1989

Of all the groups negatively affected by the Exxon Valdez oil spill, in many ways Alaska Natives were the most devastated. The oil spill destroyed more than economic resources; it shook the core cultural foundation of Native life. Alaska Native subsistence culture is based on an intimate relationship with the environment. Not only does the environment have sacred qualities for Alaska Natives; their survival also depends on the well-being of the ecosystem and the maintenance of cultural norms of subsistence. The spill directly threatened the well-being of the environment, disrupted subsistence behavior, and severely disturbed the sociocultural milieu of Alaska Natives.

Source: Gill & Picou, 1997, pp. 167–168.

Historical trauma

Historical trauma, known also as generational trauma, refers to events that are so widespread as to affect an entire culture; such events also have effects intense enough to influence generations of the culture beyond those who experienced them directly. The enslavement, torture, and lynching of African Americans; the forced assimilation and relocation of American Indians onto reservations; the extermination of millions of Jews and others in Europe during World War II; and the genocidal policies of the Hutus in Rwanda and the Khmer Rouge in Cambodia are examples of historical trauma.

In the past 50 years, research has explored the generational effects of the Holocaust upon survivors and their families. More recent literature has extended the concept of historical or generational trauma to the traumatic experiences of Native Americans. Reduced population, forced relocation, and acculturation are some examples of traumatic experiences that Native people have endured across centuries, beginning with the first European presence in the Americas. These tragic experiences have led to significant loss of cultural identity across generations and have had a significant impact on the well-being of Native communities (Whitbeck, Chen, Hoyt, & Adams, 2004). Data are limited on the association of mental and substance use disorders with historical trauma among Native people, but literature suggests that historical trauma has repercussions across generations, such as depression, grief, traumatic stress, domestic violence, and substance abuse, as well as significant loss of cultural knowledge, language, and identity (Gone, 2009). Historical trauma can increase the vulnerability of multiple generations to the effects of traumas that occur in their own lifetimes.

Mass trauma

Mass traumas or disasters affect large numbers of people either directly or indirectly. It is beyond the scope of this TIP to cover any specific disaster in detail; note, however, that mass traumas include large-scale natural and human-caused disasters (including intentional acts and accidents alike). Mass traumas may involve significant loss of property and lives as well as the widespread disruption of normal routines and services. Responding to such traumas often requires immediate and extensive resources that typically exceed the capacity of the affected communities, States, or countries in which they occur. Recent examples of such large-scale catastrophes include:

- In January 2010, a massive earthquake hit Haiti, killing hundreds of thousands of people and leaving over a million homeless.
- A nuclear reactor meltdown in the Ukraine in 1986 resulted in a technological and environmental disaster that affected tens of millions of people.
- The tsunami in the Indian Ocean in 2005 left hundreds of thousands dead in nine countries.

One factor that influences an individual's response to trauma is his or her ability to process one trauma before another trauma occurs. In mass traumas, the initial event causes considerable destruction, the consequences of which may spawn additional traumas and other stressful events that lead to more difficulties and greater need for adjustments among survivors, first responders, and disaster relief agencies. Often, a chain reaction occurs. Take, for example, Hurricane Katrina and its impact on the people of Louisiana and other coastal States. After the initial flooding, people struggled to obtain basic needs, including food, drinking water, safe shelter, clothing, medicines, personal hygiene items, and so forth, all as concern mounted about the safety of children and

other relatives, friends, and neighbors. In this and similar cases, the destruction from the initial flooding led to mass displacement of families and communities; many people had to relocate far from New Orleans and other badly affected areas, while also needing to gain financial assistance, reinitiate work to generate income, and obtain stable housing. People could not assimilate one stressor before another appeared.

Nevertheless, mass traumas can create an immediate sense of commonality—many people are "in the same boat," thus removing much of the isolation that can occur with other types of trauma. People can acknowledge their difficulties and receive support, even from strangers. It is easier to ask for help because blame is often externalized; large-scale disasters are often referred to as "acts of God" or, in cases of terrorism and other intentional events, as acts of "evil." Even so, survivors of mass trauma often encounter an initial rally of support followed by quickly diminishing services and dwindling care. When the disaster fades from the headlines, public attention and concern are likely to decrease, leaving survivors struggling to reestablish or reinvent their lives without much outside acknowledgment.

The experience of mass trauma can lead to the development of psychological symptoms and substance use at either a subclinical or a diagnostic level (refer to Part 3 of this TIP, available online, for more information highlighting the relationship between trauma and behavioral health problems). Likewise, one of the greatest risks for traumatic stress reactions after a mass tragedy is the presence of preexisting mental and co-occurring disorders, and individuals who are in early recovery from substance use disorders are at greater risk for such reactions as well. Nonetheless, people are amazingly resilient, and most will not develop long-term mental or substance use disorders after an event; in fact, most trauma-related symptoms will resolve in a matter of months (Keane & Piwowarczyk, 2006).

Interpersonal Traumas

Interpersonal traumas are events that occur (and typically continue to reoccur) between people who often know each other, such as spouses or parents and their children. Examples include physical and sexual abuse, sexual assault, domestic violence, and elder abuse.

Intimate partner violence

Intimate partner violence (IPV), often referred to as domestic violence, is a pattern of actual or threatened physical, sexual, and/or emotional abuse. It differs from simple assault in that multiple episodes often occur and the perpetrator is an intimate partner of the victim. Trauma associated with IPV is normally ongoing. Incidents of this form of violence are rarely isolated, and the client may still be in contact with and encountering abuse from the perpetrator while engaged in treatment.

Intimate partners include current and former spouses, boyfriends, and girlfriends. The majority of all nonfatal acts of violence and intimate partner homicides are committed against women; IPV accounts for over 20 percent of nonfatal violence against women but only 3.6 percent of that committed against men (Catalano, 2012). Children are the hidden casualties of IPV. They often witness the assaults or threats directly, within earshot, or by being exposed to the aftermath of the violence (e.g., seeing bruises and destruction of property, hearing the pleas for it to stop or the promises that it will never happen again).

Substance abuse, particularly involving alcohol, is frequently associated with IPV. It is the presence of alcohol-related problems in either partner, rather than the level of alcohol consumption itself, that is the important factor.

Drinking may or may not be the cause of the violence; that said, couples with alcohol-related disorders could have more tension and disagreement within the relationship in general, which leads to aggression and violence. The consumption of alcohol during a dispute is likely to decrease inhibitions and increase impulsivity, thus creating an opportunity for an argument to escalate into a physical altercation. More information on domestic violence and its effects on partners and families, as well as its connection with substance use and trauma-related disorders, is available in TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b), and from the National Online Resource Center on Violence Against Women (http://www.vawnet.org/).

Developmental Traumas

Developmental traumas include specific events or experiences that occur within a given developmental stage and influence later development, adjustment, and physical and mental health. Often, these traumas are related to adverse childhood experiences (ACEs), but they can also result from tragedies that occur outside an expected developmental or life stage (e.g., a child dying before a parent, being diagnosed with a life-threatening illness as a young adult) or from events at any point in the life cycle that create significant loss and have life-altering consequences (e.g., the death of a significant other in the later years that leads to displacement of the surviving partner).

Adverse childhood experiences

Some people experience trauma at a young age through sexual, physical, or emotional abuse and neglect. The Adverse Childhood Experiences Study (Felitti et al., 1998) examined the effects of several categories of ACEs on adult health, including physical and emotional abuse; sexual abuse; a substance-dependent parent; an incarcerated, mentally ill, or suicidal household member; spousal abuse between parents; and divorce or separation that meant one parent was absent during childhood. The National Comorbidity Studies examined the prevalence of trauma and defined childhood adversities as parental death, parental divorce/separation, life-threatening illness, or extreme economic hardship in addition to the childhood experiences included in the Adverse Childhood Experiences Study (Green et al., 2010).

ACEs can negatively affect a person's well-being into adulthood. Whether or not these experiences occur simultaneously, are time-limited, or recur, they set the stage for increased vulnerability to physical, mental, and substance use disorders and enhance the risk

Child Neglect

Child neglect occurs when a parent or caregiver does not give a child the care he or she needs according to his or her age, even though that adult can afford to give that care or is offered help to give that care. Neglect can mean not providing adequate nutrition, clothing, and/or shelter. It can mean that a parent or caregiver is not providing a child with medical or mental health treatment or is not giving prescribed medicines the child needs. Neglect can also mean neglecting the child's education. Keeping a child from school or from special education can be neglect. Neglect also includes exposing a child to dangerous environments (e.g., exposure to domestic violence). It can mean poor supervision for a child, including putting the child in the care of someone incapable of caring for children. It can mean abandoning a child or expelling him or her from home. Lack of psychological care, including emotional support, attention, or love, is also considered neglect—and it is the most common form of abuse reported to child welfare authorities.

Source: dePanfilis, 2006.

for repeated trauma exposure across the life span. Childhood abuse is highly associated with major depression, suicidal thoughts, PTSD, and dissociative symptoms. So too, ACEs are associated with a greater risk of adult alcohol use. When a person experiences several adverse events in childhood, the risk of his or her heavy drinking, self-reported alcohol dependence, and marrying a person who is alcohol dependent is two to four times greater than that of a person with no ACEs (Dube, Anda, Felitti, Edwards, & Croft, 2002).

A detailed examination of the issues involved in providing substance abuse treatment to survivors of child abuse and neglect is the subject of TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT, 2000b).

Political Terror and War

Political terror and war are likely to have lasting consequences for survivors. In essence, anything that threatens the existence, beliefs, well-being, or livelihood of a community is likely to be experienced as traumatic by community members. Whether counselors are working with an immigrant or refugee enclave in the United States or in another country, they should be aware of local events, local history, and the possibility that clients have endured trauma. (For international information about the clinical, historical, and theoretical aspects of trauma and terrorism, see Danieli, Brom, & Sills, 2005.) Terrorism is a unique subtype of human-caused disasters. The overall goal of terrorist attacks is to maximize the uncertainty, anxiety, and fear of a large community, so the responses are often epidemic and affect large numbers of people who have had direct or indirect exposure to an event (Silver et al., 2004; Suvak, Maguen, Litz, Silver, & Holman, 2008). Terrorism has a variety of results not common to other disasters, such as reminders of the unpredictability of terrorist acts; increases in security measures for the general population; intensified suspicion about a particular population, ethnicity, or culture; and heightened awareness and/or arousal.

Refugees

According to the World Refugee Survey, there are an estimated 12 million refugees and asylum seekers, 21 million internally displaced people, and nearly 35 million uprooted people (U.S. Committee for Refugees and Immigrants, 2006). Many of these people have survived horrendous ordeals with profound and lasting effects for individuals and whole populations. In addition to witnessing deaths by execution, starvation, or beatings, many survivors have experienced horrific torture.

Refugees are people who flee their homes because they have experienced or have a reasonable fear of experiencing persecution. They

Torture and Captivity

Torture traumatizes by taking away an individual's personhood. To survive, victims have to give up their sense of self and will. They become the person the torturer designs or a nonperson, simply existing. Inevitably, the shame of the victim is enormous, because the focus of torture is to humiliate and degrade. As a result, victims often seek to hide their trauma and significant parts of their selfhood long after torture has ended and freedom has been obtained. According to Judith Herman, "the methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma. They are organized techniques of disempowerment and disconnection. Methods of psychological control are designed to instill terror and helplessness and to destroy the victim's sense of self in relation to others."

Source: Herman, 1997, p. 77.

differ from immigrants who willingly leave their homes or homeland to seek better opportunities. Although immigrants may experience trauma before migrating to or after reaching their new destination, refugees will often have greater exposure to trauma before migration. Refugees typically come from war-torn countries and may have been persecuted or tortured. Consequently, greater exposure to trauma, such as torture, before migrating often leads to more adjustment-related difficulties and psychological symptoms after relocation (Steel et al., 2009).

Refugees typically face substantial difficulties in assimilating into new countries and cultures. Moreover, the environment can create a new set of challenges that may include additional exposure to trauma and social isolation (Miller et al., 2002). These as well as additional factors influence adjustment, the development of mental illness (including PTSD), and the occurrence of substance use disorders. Additional factors that influence outcomes after relocation include receptivity of the local community, along with opportunities for social support and culturally responsive services.

Among refugee populations in the United States, little research is available on rates of mental illness and co-occurring substance use disorders and traumatic stress among refugee populations. Substance use patterns vary based on cultural factors as well as assimilation, yet research suggests that trauma increases the risk for substance use among refugees after war-related experiences (Kozarić-Kovačić, Ljubin, & Grappe, 2000). Therefore, providers should expect to see trauma-related disorders among refugees who are seeking treatment for a substance use disorder and greater prevalence of substance use disorders among refugees who seek behavioral health services.

Vietnamese Refugees

"Wars always have consequences, both immediate and remote, and the consequences are often tragic. One tragic circumstance often caused by war is the forceful, disorganized, and uncontrollable mass movement of both civilians and soldiers trying to escape the horrors of the wars or of an oppressive regime.…

"Vietnamese communists, by taking power in the North in 1954 and then in the South in 1975, caused two major upheavals in the Land of the Small Dragon, as Vietnam was once called. The first Vietnam War led to the 1954 exodus during which 1 million people fled from the North to the South. The second Vietnam War resulted in the dispersion, from 1975-1992, of approximately 2 million Vietnamese all over the world. These significant, unplanned, and uncoordinated mass movements around the world not only dislocated millions of people, but also caused thousands upon thousands of deaths at sea.…

"The second and third wave of refugees from 1976 onward went through a more difficult time. They had to buy their way out and to hide from soldiers and the police who hunted them down. After catching them, the police either asked for brides or threw the escapees into jails. Those who evaded police still had to face engine failures, sea storms, pirates…They then had to survive overcrowded boats for days or weeks, during which food and water could not be replenished and living conditions were terrible… Many people died from exhaustion, dehydration, and hunger. Others suffered at the hands of terrifying pirates… After the sea ordeal came the overcrowded camps where living conditions were most often substandard and where security was painfully lacking.…

"In the United States, within less than 3 decades, the Vietnamese population grew from a minority of perhaps 1,000 persons to the second largest refugee group behind Cubans."

Source: Vo, 2006, pp. 1–4.

System-Oriented Traumas: Retraumatization

Retraumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma. Unfortunately, treatment settings and clinicians can create retraumatizing experiences, often without being aware of it, and sometimes clients themselves are not consciously aware that a clinical situation has actually triggered a traumatic stress reaction. Agencies that anticipate the risk for retraumatization and actively work on adjusting program policies and procedures to remain sensitive to the histories and needs of individuals who have undergone past trauma are likely to have more success in providing care, retaining clients, and achieving positive outcomes.

Staff and agency issues that can cause retraumatization include:

- Being unaware that the client's traumatic history significantly affects his or her life.
- Failing to screen for trauma history prior to treatment planning.
- Challenging or discounting reports of abuse or other traumatic events.
- Using isolation or physical restraints.
- Using experiential exercises that humiliate the individual.
- Endorsing a confrontational approach in counseling.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling behavior/feelings as pathological.
- Failing to provide adequate security and safety within the program.
- Limiting participation of the client in treatment decisions and planning processes.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate setting.

Advice to Counselors: Addressing Retraumatization

- Anticipate and be sensitive to the needs of clients who have experienced trauma regarding program policies and procedures in the treatment setting that might trigger memories of trauma, such as lack of privacy, feeling pushed to take psychotropic medications, perceiving that they have limited choices within the program or in the selection of the program, and so forth.
- Attend to clients' experiences. Ignoring clients' behavioral and emotional reactions to having their traumatic memories triggered is more likely to increase these responses than decrease them.
- Develop an individual coping plan in anticipation of triggers that the individual is likely to experience in treatment based on his or her history.
- Rehearse routinely the coping strategies highlighted in the coping plan. If the client does not practice strategies prior to being triggered, the likelihood of being able to use them effectively upon triggering is lessened. For example, it is far easier to practice grounding exercises in the absence of severe fear than to wait for that moment when the client is reexperiencing an aspect of a traumatic event. (For more information on grounding exercises, refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*; Najavits, 2002a, pp. 125–131.)
- Recognize that clinical and programmatic efforts to control or contain behavior in treatment can cause traumatic stress reactions, particularly for trauma survivors for whom being trapped was part of the trauma experience.
- Listen for the specific trigger that seems to be driving the client's reaction. It will typically help both the counselor and client understand the behavior and normalize the traumatic stress reactions.
- Make sure that staff and other clients do not shame the trauma survivor for his or her behavior, such as through teasing or joking about the situation.
- Respond with consistency. The client should not get conflicting information or responses from different staff members; this includes information and responses given by administrators.

- Having clients undress in the presence of others.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Imposing agency policies or rules without exceptions or an opportunity for clients to question them.
- Enforcing new restrictions within the program without staff–client communication.
- Limiting access to services for ethnically diverse populations.
- Accepting agency dysfunction, including lack of consistent, competent leadership.

Characteristics of Trauma

The following section highlights several selected characteristics of traumatic experiences that influence the effects of traumatic stress. Objective characteristics are those elements of a traumatic event that are tangible or factual; subjective characteristics include internal processes, such as perceptions of traumatic experiences and meanings assigned to them.

Objective Characteristics

Was it a single, repeated, or sustained trauma?

Trauma can involve a single event, numerous or repeated events, or sustained/chronic experiences. A *single trauma* is limited to a single point in time. A rape, an automobile accident, the sudden death of a loved one—all are examples of a single trauma. Some people who experience a single trauma recover without any specific intervention. But for others—especially those with histories of previous trauma or mental or substance use disorders, or those for whom the trauma experience is particularly horrific or overwhelming—a single trauma can result in traumatic stress symptoms and trauma- and stress-related disorders. Single traumas do not necessarily have a lesser psychological impact than repeated traumas. After the terrorist attacks on September 11, 2001—a significant single trauma—many Manhattan residents experienced intrusive memories and sleep disruption whether they were at the site of the attacks or watched television coverage of it (Ford & Fournier, 2007; Galea et al., 2002).

A series of traumas happening to the same person over time is known as *repeated trauma*. This can include repeated sexual or physical assaults, exposure to frequent injuries of others, or seemingly unrelated traumas. Military personnel, journalists covering stories of mass tragedies or prolonged conflicts, and first responders who handle hundreds of cases each year typify repeated trauma survivors. Repetitive exposure to traumas can have a cumulative effect over one's lifetime. A person who was assaulted during adolescence, diagnosed with a life-threatening illness in his or her thirties, and involved in a serious car accident later in life has experienced repeated trauma.

Some repeated traumas are sustained or chronic. Sustained trauma experiences tend to wear down resilience and the ability to adapt. Some examples include children who endure ongoing sexual abuse, physical neglect, or emotional abuse; people who are in violent relationships; and people who live in chronic poverty. Individuals in chronically stressful, traumatizing environments are particularly susceptible to traumatic stress reactions, substance use, and mental disorders.

Bidirectional relationships exist between trauma and substance use as well as trauma and mental illness. For example, abuse of alcohol and drugs increases the risk of a traumatic experience and creates greater vulnerability to the effects of trauma; substance abuse reduces a person's ability to take corrective and remedial actions that might reduce the impact of the trauma. Likewise, traumatic stress leads to a greater likelihood of

Case Illustration: Yourself

Think of a time that was particularly stressful (but not traumatic) in your life. Revisit this period as an observer watching the events unfold and then ask yourself, "What made this time particularly stressful?" It is likely that a part of your answer will include the difficulty of managing one situation before another circumstance came along demanding your time. Stressful times denote being bombarded with many things at one time, perceived or actual, without sufficient time or ability to address them emotionally, cognitively, spiritually, and/or physically. The same goes for trauma—rapid exposure to numerous traumas one after another lessens one's ability to process the event before the next onslaught. This creates a cumulative effect, making it more difficult to heal from any one trauma.

substance abuse that, in turn, increases the risk for additional exposure to trauma. Paralleling this bidirectional relationship, mental illness increases vulnerability to the effects of trauma and raises the risk for substance use disorders and for encountering additional traumatic events. So too, early exposure to ACEs is associated with traumatic stress reactions and subsequent exposure to trauma in adult years.

People who have encountered multiple and longer doses of trauma are at the greatest risk for developing traumatic stress. For example, military reservists and other military service members who have had multiple long tours of duty are at greater risk for traumatic stress reactions (see the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families;* SAMHSA, planned f). In addition, people are more likely to encounter greater impairment and distress from trauma if that trauma occurs with significant intensity and continues sporadically or unceasingly for extended periods.

Was there enough time to process the experience?

A particularly severe pattern of ongoing trauma, sometimes referred to as "cascading trauma," occurs when multiple traumas happen in a pattern that does not allow an individual to heal from one traumatic event before another occurs. Take, for example, California residents—they repeatedly face consecutive and/or simultaneous natural disasters including fires, landslides, floods, droughts, and earthquakes. In other cases, there is ample time to process an event, but processing is limited because people don't have supportive relationships or environments that model preventive practices. This can lead to greater vulnerability to traumas that occur later in life.

How many losses has the trauma caused?

Trauma itself can create significant distress, but often, the losses associated with a trauma have more far-reaching effects. For instance, a child may be forced to assume adult responsibilities, such as serving as a confidant for a parent who is sexually abusing him or her, and lose the opportunity of a childhood free from adult worries. In another scenario, a couple may initially feel grateful to have escaped a house fire, but they may nevertheless face significant community and financial losses months afterward. In evaluating the impact of trauma, it is helpful to access and discuss the losses associated with the initial trauma. The number of losses greatly influences an individual's ability to bounce back from the tragedy.

In the case illustration on the next page, Rasheed's losses cause him to disconnect from his wife, who loves and supports him. Successful confrontation of losses can be difficult if the losses compound each other, as with Rasheed's loss of his friend, his disability, his employment struggles, and the threats to his marriage and liberty. People can cite a specific

Case Illustration: Rasheed

Rasheed was referred to an employee assistance program by his employer. He considered quitting his job, but his wife insisted he talk to a counselor. He is a 41-year-old auto mechanic who, 4 years ago, caused a head-on collision while attempting to pass another vehicle. A close friend, riding in the passenger's seat, was killed, and two young people in the other vehicle were seriously injured and permanently disabled. Rasheed survived with a significant back injury and has only been able to work sporadically. He was convicted of negligent homicide and placed on probation because of his physical disability. He is on probation for another 4 years, and if he is convicted of another felony during that time, he will have to serve prison time for his prior offense.

While still in the hospital, Rasheed complained of feeling unreal, numb, and disinterested in the care he received. He did not remember the crash but remembers waking up in the hospital 2 days later. He had difficulty sleeping in the hospital and was aware of feelings of impending doom, although he was unaware of the legal charges he would later face. He was diagnosed with ASD.

He was discharged from the hospital with a variety of medications, including pain pills and a sleep aid. He rapidly became dependent on these medications, feeling he could not face the day without the pain medication and being unable to sleep without sleep medicine in larger doses than had been prescribed. Within 3 months of the accident, he was "doctor shopping" for pain pills and even had a friend obtain a prescription for the sleeping medication from that friend's doctor. In the 4 intervening years, Rasheed's drug use escalated, and his blunted emotions and detachment from friends became more profound. He became adept at obtaining pain pills from a variety of sources, most of them illegal. He fears that if he seeks treatment for the drug problem, he will have to admit to felony offenses and will probably be imprisoned. He also does not believe he can manage his life without the pain pills.

In the past 2 years, he has had recurring dreams of driving a car on the wrong side of the road and into the headlights of an oncoming vehicle. In the dream, he cannot control the car and wakes up just before the vehicles crash. At unusual times—for instance, when he is just awakening in the morning, taking a shower, or walking alone—he will feel profound guilt over the death of his friend in the accident. He becomes very anxious when driving in traffic or when he feels he is driving faster than he should. His marriage of 18 years has been marked by increasing emotional distance, and his wife has talked about separating if he does not do something about his problem. He has been unable to work consistently because of back pain and depression. He was laid off from one job because he could not concentrate and was making too many mistakes.

The counselor in the employee assistance program elicited information on Rasheed's drug use, although she suspected Rasheed was minimizing its extent and effects. Knowledgeable about psychological trauma, the counselor helped Rasheed feel safe enough to talk about the accident and how it had affected his life. She was struck by how little Rasheed connected his present difficulties to the accident and its aftermath. The counselor later commented that Rasheed talked about the accident as if it had happened to someone else. Rasheed agreed to continue seeing the counselor for five additional visits, during which time a plan would be made for Rasheed to begin treatment for drug dependence and PTSD.

event as precipitating their trauma, or, in other cases, the specific trauma can symbolize a series of disabling events in which the person felt his or her life was threatened or in which he or she felt emotionally overwhelmed, psychologically disorganized, or significantly disconnected from his or her surroundings. It will be important for Rasheed to understand how his losses played a part in his abuse of prescription medications to cope with symptoms associated with traumatic stress and loss, (e.g., guilt, depression, fear). If not addressed, his trauma could increase his risk for relapse.

Was the trauma expected or unexpected?

When talking about a trauma, people sometimes say they didn't see it coming. Being unprepared, unaware, and vulnerable often increases the risk of psychological injury, but these are common components of most traumas, given that most traumatic events do occur without warning (e.g., car crashes, terrorist attacks, sexual assaults). People with substance use disorders, mental illness, and/or cognitive disabilities may be especially vulnerable in that they may attend less or have competing concerns that diminish attention to what is going on around them, even in high-risk environments. However, most individuals attempt to gain some control over the tragedy by replaying the moments leading up to the event and processing how they could have anticipated it. Some people perseverate on these thoughts for months or years after the event.

Sometimes, a trauma is anticipated but has unexpected or unanticipated consequences, as in the case of Hurricane Katrina. Learning about what is likely to happen can reduce traumatization. For instance, training military personnel in advance of going to combat overseas prepares them to handle traumas and can reduce the impact of trauma.

Were the trauma's effects on the person's life isolated or pervasive?

When a trauma is isolated from the larger context of life, a person's response to it is more likely to be contained and limited. For instance, military personnel in combat situations can be significantly traumatized by what they experience. On return to civilian life or noncombat service, some are able to isolate the traumatic experience so that it does not invade ordinary, day-to-day living. This does not mean that the combat experience was not disturbing or that it will not resurface if the individual encounters an experience that triggers memories of the trauma; it just means that the person can more easily leave the trauma in the past and attend to the present.

Conversely, people who remain in the vicinity of the trauma may encounter greater challenges in recovery. The traumatic event intertwines with various aspects of the person's daily activities and interactions, thus increasing the possibility of being triggered by surrounding cues and experiencing subsequent psychological distress. However, another way to view this potential dilemma for the client is to reframe it as an opportunity—the repetitive exposure to trauma-related cues may provide vital guidance as to when and which treatment and coping techniques to use in the delivery of trauma-informed and trauma-specific behavioral health services.

Who was responsible for the trauma and was the act intentional?

If the severity of a trauma is judged solely by whether the act was intentional or not, events that reflect an intention to harm would be a primary indicator in predicting subsequent difficulties among individuals exposed to this form of trauma. For most survivors, there is an initial disbelief that someone would conceivably intend to harm others, followed by considerable emotional and, at times, behavioral investment in somehow making things right again or in making sense of a senseless, malicious act. For instance, in the wake of the World Trade Center attacks in New York City, people responded via renewed patriotism, impromptu candlelight vigils, attacks on people of Arab and Muslim descent, and unprecedented donations and willingness to wait in long lines to donate blood to the Red Cross. Each example is a response that in some way attempts to right the perceived wrong or attach new meaning to the event and subsequent consequences.

When terrible things happen, it is human nature to assign blame. Trauma survivors can become heavily invested in assigning blame or finding out who was at fault, regardless of the type of trauma. Often, this occurs as an attempt to make sense of, give meaning to, and reestablish a sense of predictability, control, and safety after an irrational or random act. It is far easier to accept that someone, including oneself, is at fault or could have done something different than it is to accept the fact that one was simply in the wrong place at the wrong time.

For some trauma survivors, needing to find out why a trauma occurred or who is at fault can become a significant block to growth when the individual would be better served by asking, "What do I need to do to heal?" Behavioral health professionals can help clients translate what they have learned about responsibility in recovery to other aspects of their lives. For instance, someone in treatment for co-occurring disorders who has internalized that becoming depressed or addicted was not his or her fault, but that recovery *is* a personal responsibility, can then apply the same principle to the experience of childhood abuse and thereby overcome negative judgments of self (e.g., thinking oneself to be a bad person who deserves abuse). The individual can then begin to reassign responsibility by attaching the blame to the perpetrator(s) while at the same time assuming responsibility for recovery.

Was the trauma experienced directly or indirectly?

Trauma that happens to someone directly seems to be more damaging than witnessing trauma that befalls others. For example, it is usually more traumatic to be robbed at gunpoint than to witness someone else being robbed or hearing someone tell a story about being robbed. Yet, sometimes, experiencing another's pain can be equally traumatic. For instance, parents often internalize the pain and suffering of their children when the children are undergoing traumatic circumstances (e.g., treatments for childhood cancer).

There are two ways to experience the trauma of others. An individual may witness the event, such as seeing someone killed or seriously injured in a car accident, or may learn of an event that happened to someone, such as a violent personal assault, suicide, serious accident, injury, or sudden or unexpected death. For many people, the impact of the trauma will depend on a host of variables, including their proximity to the event as eyewitnesses, the witnesses' response in the situation, their relationship to the victims, the degree of helplessness surrounding the experience, their exposure to subsequent consequences, and so on.

Case Illustration: Frank

Frank entered substance abuse treatment with diagnoses of co-occurring PTSD and substance use disorder. While on a whitewater kayak trip with his wife, her kayak became pinned on a rock, and Frank could only watch helplessly as she drowned. His drinking had increased markedly after the accident. He acknowledged a vicious cycle of sleep disturbance with intrusive nightmares followed by vivid memories and feelings of terror and helplessness after he awoke. He drank heavily at night to quiet the nightmares and memories, but heavy alcohol consumption perpetuated his trouble sleeping. He withdrew from contact with many of his old "couple friends" and his wife's family, with whom he had been close. At treatment entry, he described his life as "going to work and coming home." The trauma occurred 3 years before he sought treatment, but Frank continued to feel numb and disconnected from the world. His only emotion was anger, which he tried to keep in check. Integrated treatment for PTSD and substance abuse helped him sleep and taught him coping skills to use when the memories arose; it fostered his engagement and retention in long-term care for both disorders.

The effects of traumas such as genocide and internment in concentration camps can be felt across generations—stories, coping behaviors, and stress reactions can be passed across generational lines far removed from the actual events or firsthand accounts. Known as historical trauma, this type of trauma can affect the functioning of families, communities, and cultures for multiple generations.

What happened since the trauma?

In reviewing traumatic events, it is important to assess the degree of disruption after the initial trauma has passed, such as the loss of employment, assets, community events, behavioral health services, local stores, and recreational areas. There is typically an initial rally of services and support following a trauma, particularly if it is on a mass scale. However, the reality of the trauma's effects and their disruptiveness may have a more lasting impact. The deterioration of normalcy, including the disruption of day-to-day activities and the damage of structures that house these routines, will likely erode the common threads that provide a sense of safety in individual lives and communities. Hence, the degree of disruption in resuming normal daily activities is a significant risk factor for substance use disorders, subclinical psychological symptoms, and mental disorders. For example, adults displaced from their homes because of Hurricanes Katrina or Rita had significantly higher rates of past-month cigarette use, illicit drug use, and binge drinking than those who were not displaced (Office of Applied Studies, 2008).

Subjective Characteristics

Psychological meaning of trauma

An important clinical issue in understanding the impact of trauma is the meaning that the survivor has attached to the traumatic experience. Survivors' unique cognitive interpretations of an event—that is, their beliefs and assumptions—contribute to how they process, react to, cope with, and recover from the trauma. Does the event represent retribution for past deeds committed by the individual or his or her family? How does the individual attach meaning to his or her survival? Does he or she believe that it is a sign of a greater purpose not yet revealed? People who attempt to share their interpretation and meaning of the event can feel misunderstood and sometimes alienated (Paulson & Krippner, 2007; Schein, Spitz, Burlingame, & Muskin, 2006).

> It is important to remember that what happened is not nearly as important as what the trauma means to the individual.

People interpret traumatic events in vastly different ways, and many variables shape how an individual assigns meaning to the experience (framing the meaning through culture, family beliefs, prior life experiences and learning, personality and other psychological features, etc.). Even in an event that happens in a household, each family member may interpret the experience differently. Likewise, the same type of event can occur at two different times in a person's life, but his or her interpretation of the events may differ considerably because of developmental differences acquired between events, current cognitive and emotional processing skills, availability of and access to environmental resources, and so forth.

Disruption of core assumptions and beliefs

Trauma often engenders a crisis of faith (Frankl, 1992) that leads clients to question basic assumptions about life. Were the individual's core or life-organizing assumptions (e.g., about safety, perception of others, fairness, purpose of life, future dreams) challenged or disrupted during or after the traumatic event? (See the seminal work,

Resilience: Connection and Continuity

Research suggests that reestablishing ties to family, community, culture, and spiritual systems is not only vital to the individual, but it also influences the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of survivors of Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents directly affected by the purge experienced fewer negative effects than those who were emotionally or physically severed from their grandparents. Whether the grandparents survived was less important than the connection the grandchildren felt to their pasts.

Shattered Assumptions, by Janoff-Bulman, 1992.) For example, some trauma survivors see themselves as irreparably wounded or beyond the possibility of healing. The following case illustration (Sonja) explores not only the importance of meaning, but also the role that trauma plays in altering an individual's core assumptions—the very assumptions that provide meaning and a means to organize our lives and our interactions with the world and others.

Cultural meaning of trauma

Counselors should strive to appreciate the cultural meaning of a trauma. How do cultural interpretations, cultural support, and cultural responses affect the experience of trauma? It is critical that counselors do not presume to understand the meaning of a traumatic experience without considering the client's cultural context. Culture strongly influences the perceptions of trauma. For instance, a trauma involving shame can be more profound for a person from an Asian culture than for someone from a European culture. Likewise, an Alaska Native individual or community, depending upon their Tribal ancestry, may believe that the traumatic experience serves as a form of retribution. Similarly, the sudden death of a family member or loved one can be less traumatic in a culture that has a strong belief in a positive afterlife. It is important for counselors to recognize that their perceptions of a specific trauma could be very different from their clients' perceptions. Be careful not to judge a client's beliefs in light of your own value system. For more information on culture and how to achieve cultural competence in providing behavioral health services, see SAMHSA's planned TIP, *Improving Cultural Competence* (SAMHSA, planned c).

Individual and Sociocultural Features

A wide variety of social, demographic, environmental, and psychological factors influence a person's experience of trauma, the severity of traumatic stress reactions following the event, and his or her resilience in dealing with the short- and long-term environmental, physical, sociocultural, and emotional consequences. This section addresses a few known factors that influence the risk of trauma along with the development of subclinical and diagnostic traumatic stress symptoms, such as mood and anxiety symptoms and disorders. It is not meant to be an exhaustive exploration of these factors, but rather, a brief presentation to make counselors and other behavioral health professionals aware that various factors influence risk for and protection against traumatic stress and subsequent reactions. (For a broader perspective on such factors, refer to Part 1, Chapter 1.)

Individual Factors

Several factors influence one's ability to deal with trauma effectively and increase one's risk for traumatic stress reactions. Individual factors pertain to the individual's genetic, biological, and psychological makeup and history as they influence the person's experience and

Case Illustration: Sonja

Sonja began to talk about how her life was different after being physically assaulted and robbed in a parking lot at a local strip mall a year ago. She recounts that even though there were people in the parking lot, no one came to her aid until the assailant ran off with her purse. She sustained a cheekbone fracture and developed visual difficulties due to the inflammation from the fracture. She recently sought treatment for depressive symptoms and reported that she had lost interest in activities that typically gave her joy. She reported isolating herself from others and said that her perception of others had changed dramatically since the attack.

Sonja had received a diagnosis of major depression with psychotic features 10 years earlier and received group therapy at a local community mental health center for 3 years until her depression went into remission. She recently became afraid that her depression was becoming more pronounced, and she wanted to prevent another severe depressive episode as well as the use of psychotropic medications, which she felt made her lethargic. Thus, she sought out behavioral health counseling.

As the sessions progressed, and after a psychological evaluation, it was clear that Sonja had some depressive symptoms, but they were subclinical. She denied suicidal thoughts or intent, and her thought process was organized with no evidence of hallucinations or delusions. She described her isolation as a reluctance to shop at area stores. On one hand, Sonja was self-compassionate about her reasons for avoidance, but on the other hand, she was concerned that the traumatic event had altered how she saw life and others. "I don't see people as very caring or kind, like I used to prior to the event. I don't trust them, and I feel people are too self-absorbed. I don't feel safe, and this bothers me. I worry that I'm becoming paranoid again. I guess I know better, but I just want to have the freedom to do what I want and go where I want."

Two months after Sonja initiated counseling, she came to the office exclaiming that things can indeed change. "You won't believe it. I had to go to the grocery store, so I forced myself to go the shopping center that had a grocery store attached to a strip mall. I was walking by a coffee shop, quickly browsing the items in the front window, when a man comes out of the shop talking at me. He says, 'You look like you need a cup of coffee.' What he said didn't register immediately. I looked at him blankly, and he said it again. 'You look like you need a cup of coffee. I'm the owner of the shop, and I noticed you looking in the window, and we have plenty of brewed coffee left before we close the shop. Come on in, it's on the house.' So I did! From that moment on, I began to see people differently. He set it right for me—I feel as if I have myself back again, as if the assault was a sign that I shouldn't trust people, and now I see that there is some goodness in the world. As small as this kindness was, it gave me the hope that I had lost."

For Sonja, the assault changed her assumptions about safety and her view of others. She also attached meaning to the event. She believed that the event was a sign that she shouldn't trust people and that people are uncaring. Yet these beliefs bothered her and contradicted how she saw herself in the world, and she was afraid that her depressive symptoms were returning.

For an inexperienced professional, her presentation may have ignited suspicions that she was beginning to present with psychotic features. However, it is common for trauma survivors to experience changes in core assumptions immediately after the event and to attach meaning to the trauma. Often, a key ingredient in the recovery process is first identifying the meaning of the event and the beliefs that changed following the traumatic experience. So when you hear a client say "I will never see life the same," this expression should trigger further exploration into how life is different, what meaning has been assigned to the trauma, and how the individual has changed his or her perception of self, others, and the future.

(Continued on the next page.)

Case Illustration: Sonja (continued)

Sometimes, reworking the altered beliefs and assumptions occurs with no formal intervention, as with Sonja. In her situation, a random stranger provided a moment that challenged an assumption generated from the trauma. For others, counseling may be helpful in identifying how beliefs and thoughts about self, others, and the world have changed since the event and how to rework them to move beyond the trauma. It is important to understand that the meaning that an individual attaches to the event(s) can either undermine the healing process (e.g., believing that you should not have survived, feeling shame about the trauma, continuing to engage in high-risk activities) or pave the road to recovery (e.g., volunteering to protect victim rights after being sexually assaulted). The following questions can help behavioral health staff members introduce topics surrounding assumptions, beliefs, interpretations, and meanings related to trauma:

- In what ways has your life been different since the trauma?
- How do you understand your survival? (This is an important question for clients who have been exposed to ACEs or cumulative trauma and those who survived a tragedy when others did not.)
- Do you believe that there are reasons that this event happened to you? What are they?
- What meaning does this experience have for you?
- Do you feel that you are the same person as before the trauma? In what ways are you the same? In what ways do you feel different?
- How did this experience change you as a person? Would you like to return to the person you once were? What would you need to do, or what would need to happen, for this to occur?
- Did the traumatic experience change you in a way that you don't like? In what ways?
- How do you view others and your future differently since the trauma?
- What would you like to believe now about the experience?

interpretation of, as well as his or her reactions to, trauma. However, many factors influence individual responses to trauma; it is not just individual characteristics. Failing to recognize that multiple factors aside from individual attributes and history influence experiences during and after trauma can lead to blaming the victim for having traumatic stress.

History of prior psychological trauma

People with histories of prior psychological trauma appear to be the most susceptible to severe traumatic responses (Nishith, Mechanic, & Resick, 2000; Vogt, Bruce, Street, & Stafford, 2007), particularly if they have avoided addressing past traumas. Because minimization, dissociation, and avoidance are common defenses for many trauma survivors, prior traumas are not always consciously available, and when they are, memories can be distorted to avoid painful affects. Some survivors who have repressed their experiences deny a history of trauma or are unable to explain their strong reactions to present situations.

Remember that the effects of trauma are cumulative; therefore, a later trauma that outwardly appears less severe may have more impact upon an individual than a trauma that occurred years earlier. Conversely, individuals who have experienced earlier traumas may have developed effective coping strategies or report positive outcomes as they have learned to adjust to the consequences of the trauma(s). This outcome is often referred to as posttraumatic growth or psychological growth.

Clients in behavioral health treatment who have histories of trauma can respond negatively to or seem disinterested in treatment efforts. They may become uncomfortable in groups that emphasize personal sharing; likewise, an individual who experiences brief bouts of dissociation (a reaction of some trauma survivors) may be misunderstood by others in treatment and seen as uninterested. Providers need to

attend to histories, adjust treatment to avoid retraumatization, and steer clear of labeling clients' behavior as pathological.

History of resilience

Resilience—the ability to thrive despite negative life experiences and heal from traumatic events—is related to the internal strengths and environmental supports of an individual. Most individuals are resilient despite experiencing traumatic stress. The ability to thrive beyond the trauma is associated with individual factors as well as situational and contextual factors. There are not only one or two primary factors that make an individual resilient; many factors contribute to the development of resilience. There is little research to indicate that there are specific traits predictive of resilience; instead, it appears that more general characteristics influence resilience, including neurobiology (Feder, Charney, & Collins, 2011), flexibility in adapting to change, beliefs prior to trauma, sense of self-efficacy, and ability to experience positive emotions (Bonanno & Mancini, 2011).

History of mental disorders

The correlations among traumatic stress, substance use disorders, and co-occurring mental disorders are well known. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (American Psychiatric Association, 2013a), traumatic stress reactions are linked to higher rates of mood, substance-related, anxiety, trauma, stress-related, and other mental disorders, each of which can precede, follow, or emerge concurrently with trauma itself. A co-occurring mental disorder is a significant determinant of whether an individual can successfully address and resolve trauma as it emerges from the past or occurs in the present. Koenen, Stellman, Stellman, and Sommer (2003) found that the risk of developing PTSD following combat trauma was higher for individuals with preexisting conduct disorder, panic disorder, generalized anxiety disorder, and/or major depression than for those without preexisting mental disorders. For additional information on comorbidity of trauma and other mental disorders, see TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c).

Sociodemographic Factors

Demographic variables are not good predictors of who will experience trauma and subsequent traumatic stress reactions. Gender, age, race and ethnicity, sexual orientation, marital status, occupation, income, and education can all have some influence, but not enough to determine who should or should not receive screening for trauma and traumatic stress symptoms. The following sections cover a few selected variables. (For more information, please refer to Part 3 of this TIP, the online literature review.)

Gender

In the United States, men are at greater risk than women for being exposed to stressful events. Despite the higher prevalence among men, lifetime PTSD occurs at about twice the rate among women as it does in men. Less is known about gender differences with subclinical traumatic stress reactions. There are also other gender differences, such as the types of trauma experienced by men and women. Women are more likely to experience physical and sexual assault, whereas men are most likely to experience combat and crime victimization and to witness killings and serious injuries (Breslau, 2002; Kimerling, Ouimette, & Weitlauf, 2007; Tolin & Foa, 2006). Women in military service are subject to the same risks as men and are also at a greater risk for military sexual trauma. Men's traumas often occur in public; women's are more likely to take place in private settings. Perpetrators of traumas against men are often strangers, but women are more likely to know the perpetrator.

Age

In general, the older one becomes, the higher the risk of trauma—but the increase is not dramatic. Age is not particularly important in predicting exposure to trauma, yet at no age is one immune to the risk. However, trauma that occurs in the earlier and midlife years appears to have greater impact on people for different reasons. For younger individuals, the trauma can affect developmental processes, attachment, emotional regulation, life assumptions, cognitive interpretations of later experiences, and so forth (for additional resources, visit the National Child Traumatic Stress Network; http://www.nctsn.org/). For adults in midlife, trauma may have a greater impact due to the enhanced stress or burden of care that often characterizes this stage of life—caring for their children and their parents at the same time. Older adults are as likely as younger adults to recover quickly from trauma, yet they may have greater vulnerabilities, including their ability to survive without injury and their ability to address the current trauma without psychological interference from earlier stressful or traumatic events. Older people are naturally more likely to have had a history of trauma because they have lived longer, thus creating greater vulnerability to the effects of cumulative trauma.

Race, ethnicity, and culture

The potential for trauma exists in all major racial and ethnic groups in American society, yet few studies analyze the relationship of race and ethnicity to trauma exposure and/or traumatic stress reactions. Some studies show that certain racial and ethnic groups are at greater risk for specific traumas. For example, African Americans experienced higher rates of overall violence, aggravated assault, and robbery than Whites but were as likely to be victims of rape or sexual assault (Catalano, 2004). Literature reflects that diverse ethnic, racial, and cultural groups are more likely to experience adverse effects from various traumas and to meet criteria for posttraumatic stress (Bell, 2011).

Sexual orientation and gender identity

Lesbian, gay, bisexual, and transgender individuals are likely to experience various forms of trauma associated with their sexual orientation, including harsh consequences from families and faith traditions, higher risk of assault from casual sexual partners, hate crimes, lack of legal protection, and laws of exclusion (Brown, 2008). Gay and bisexual men as well as transgender people are more likely to experience victimization than lesbians and bisexual women. Dillon (2001) reported a trauma exposure rate of 94 percent among lesbian, gay,

Resilience: Cultural, Racial, and Ethnic Characteristics

The following list highlights characteristics that often nurture resilience among individuals from diverse cultural, racial, and ethnic groups:

- Strong kinship bonds
- Respect for elders and the importance of extended family
- Spirituality and religious practices (e.g., shrine visitations or the use of traditional healers)
- Value in friendships and warm personal relationships
- Expression of humor and creativity
- Instilling a sense of history, heritage, and historical traditions
- Community orientation, activities, and socialization
- Strong work ethic
- Philosophies and beliefs about life, suffering, and perseverance

"Fortune owes its existence to misfortune, and misfortune is hidden in fortune."

–Lao-Tzu teaching, Taoism (Wong & Wong, 2006)

and bisexual individuals; more than 40 percent of respondents experienced harassment due to their sexual orientation. Heterosexual orientation is also a risk for women, as women in relationships with men are at a greater risk of being physically and sexually abused.

People who are homeless

Homelessness is typically defined as the lack of an adequate or regular dwelling, or having a nighttime dwelling that is a publicly or privately supervised institution or a place not intended for use as a dwelling (e.g., a bus station). The U.S. Department of Housing and Urban Development (HUD) estimates that between 660,000 and 730,000 individuals were homeless on any given night in 2005 (HUD, 2007). Two thirds were unaccompanied persons; the other third were people in families. Adults who are homeless and unmarried are more likely to be male than female. About 40 percent of men who are homeless are veterans (National Coalition for the Homeless, 2002); this percentage has grown, including the number of veterans with dependent children (Kuhn & Nakashima, 2011).

Rates of trauma symptoms are high among people who are homeless (76 to 100 percent of women and 67 percent of men; Christensen et al., 2005; Jainchill, Hawke, & Yagelka, 2000), and the diagnosis of PTSD is among the most prevalent non-substance use Axis I disorders (Lester et al., 2007; McNamara, Schumacher, Milby, Wallace, & Usdan, 2001). People who are homeless report high levels of trauma (especially physical and sexual abuse in childhood or as adults) preceding their homeless status; assault, rape, and other traumas frequently happen while they are homeless. Research suggests that many women are homeless because they are fleeing domestic violence (National Coalition for the Homeless, 2002). Other studies suggest that women who are homeless are more likely to have histories of childhood physical and sexual abuse and to have experienced sexual assault as adults. A history of physical and/or sexual abuse is even more common among women who are homeless and have a serious mental illness.

Youth who are homeless, especially those who live without a parent, are likely to have experienced physical and/or sexual abuse. Between 21 and 42 percent of youth runaways report having been sexually abused before leaving their homes; for young women, rates range from 32 to 63 percent (Administration on Children, Youth and Families, 2002). Additionally, data reflect elevated rates of substance abuse for youth who are homeless and have histories of abuse.

More than half of people who are homeless have a lifetime prevalence of mental illness and substance use disorders. Those who are homeless have higher rates of substance abuse (84 percent of men and 58 percent of women), and substance use disorders, including alcohol and drug abuse/dependence, increase with longer lengths of homelessness (North, Eyrich, Pollio, & Spitznagel, 2004).

For more information on providing trauma-informed behavioral health services to clients who are homeless, and for further discussion of the incidence of trauma in this population, see TIP 55-R, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2013b).

3 Understanding the Impact of Trauma

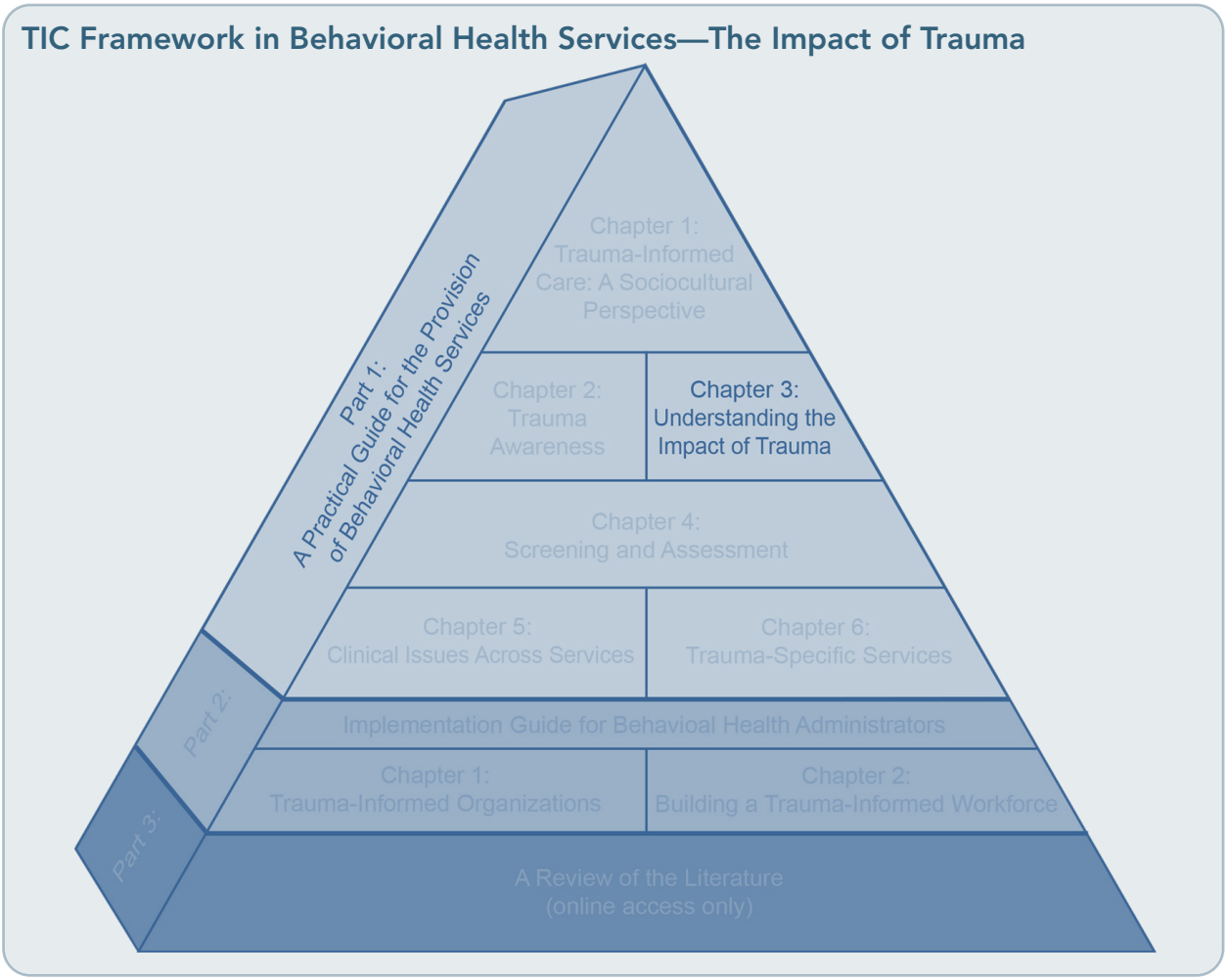
IN THIS CHAPTER

- Sequence of Trauma Reactions
- Common Experiences and Responses to Trauma
- Subthreshold Trauma Related Symptoms
- Specific Trauma Related Psychological Disorders
- Other Trauma Related and Co Occurring Disorders

Trauma-informed care (TIC) involves a broad understanding of traumatic stress reactions and common responses to trauma. Providers need to understand how trauma can affect treatment presentation, engagement, and the outcome of behavioral health services. This chapter examines common experiences survivors may encounter immediately following or long after a traumatic experience.

Trauma, including one-time, multiple, or long-lasting repetitive events, affects everyone differently. Some individuals may clearly display criteria associated with posttraumatic stress disorder (PTSD), but many more individuals will exhibit resilient responses or brief subclinical symptoms or consequences that fall outside of diagnostic criteria. The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors.

This chapter begins with an overview of common responses, emphasizing that traumatic stress reactions are normal reactions to abnormal circumstances. It highlights common short- and long-term responses to traumatic experiences in the context of individuals who may seek behavioral health services. This chapter discusses psychological symptoms not represented in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), and responses associated with trauma that either fall below the threshold of mental disorders or reflect resilience. It also addresses common disorders associated with traumatic stress. This chapter explores the role of culture in defining mental illness, particularly PTSD, and ends by addressing co-occurring mental and substance-related disorders.



Sequence of Trauma Reactions

Survivors' immediate reactions in the aftermath of trauma are quite complicated and are affected by their own experiences, the accessibility of natural supports and healers, their coping and life skills and those of immediate family, and the responses of the larger community in which they live. Although reactions range in severity, even the most acute responses are natural responses to manage trauma—they are not a sign of psychopathology. Coping styles vary from action oriented to reflective and from emotionally expressive to reticent. Clinically, a response style is less important than the degree to which coping efforts successfully allow one to continue necessary activities, regulate emotions, sustain self-esteem, and maintain and enjoy interpersonal contacts. Indeed, a past error in traumatic stress psychology, particularly regarding group or mass traumas, was the assumption that all survivors need to express emotions associated with trauma and talk about the trauma; more recent research indicates that survivors who choose not to process their trauma are just as psychologically healthy as

Foreshortened future: Trauma can affect one's beliefs about the future via loss of hope, limited expectations about life, fear that life will end abruptly or early, or anticipation that normal life events won't occur (e.g., access to education, ability to have a significant and committed relationship, good opportunities for work).

those who do. The most recent psychological debriefing approaches emphasize respecting the individual's style of coping and not valuing one type over another.

Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect. Most responses are normal in that they affect most survivors and are socially acceptable, psychologically effective, and self-limited. Indicators of more severe responses include continuous distress without periods of relative calm or rest, severe dissociation symptoms, and intense intrusive recollections that continue despite a return to safety. Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely. Exhibit 1.3-1 outlines some common reactions.

Common Experiences and Responses to Trauma

A variety of reactions are often reported and/or observed after trauma. Most survivors exhibit immediate reactions, yet these typically resolve without severe long-term consequences. This is because most trauma survivors are highly resilient and develop appropriate coping strategies, including the use of social supports, to deal with the aftermath and effects of trauma. Most recover with time, show minimal distress, and function effectively across major life areas and developmental stages. Even so, clients who show little impairment may still have subclinical symptoms or symptoms that do not fit diagnostic criteria for acute stress disorder (ASD) or PTSD. Only a small percentage of people with a history of trauma show impairment and symptoms that meet criteria for trauma-related stress disorders, including mood and anxiety disorders.

The following sections focus on some common reactions across domains (emotional, physical, cognitive, behavioral, social, and developmental) associated with singular, multiple, and enduring traumatic events. These reactions are often normal responses to trauma but can still be distressing to experience. Such responses are not signs of mental illness, nor do they indicate a mental disorder. Traumatic stress-related disorders comprise a specific constellation of symptoms and criteria.

Emotional

Emotional reactions to trauma can vary greatly and are significantly influenced by the individual's sociocultural history. Beyond the initial emotional reactions during the event, those most likely to surface include anger, fear, sadness, and shame. However, individuals may encounter difficulty in identifying any of these feelings for various reasons. They might lack experience with or prior exposure to emotional expression in their family or community. They may associate strong feelings with the past trauma, thus believing that emotional expression is too dangerous or will lead to feeling out of control (e.g., a sense of "losing it" or going crazy). Still others might deny that they have any feelings associated with their traumatic experiences and define their reactions as numbness or lack of emotions.

Emotional dysregulation

Some trauma survivors have difficulty regulating emotions such as anger, anxiety, sadness, and shame—this is more so when the trauma occurred at a young age (van der Kolk, Roth, Pelcovitz, & Mandel, 1993). In individuals who are older and functioning well

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma

Immediate Emotional Reactions	Delayed Emotional Reactions
Numbness and detachment Anxiety or severe fear Guilt (including survivor guilt) Exhilaration as a result of surviving Anger Sadness Helplessness Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself) Disorientation Feeling out of control Denial Constriction of feelings Feeling overwhelmed	Irritability and/or hostility Depression Mood swings, instability Anxiety (e.g., phobia, generalized anxiety) Fear of trauma recurrence Grief reactions Shame Feelings of fragility and/or vulnerability Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
Immediate Physical Reactions	**Delayed Physical Reactions**
Nausea and/or gastrointestinal distress Sweating or shivering Faintness Muscle tremors or uncontrollable shaking Elevated heartbeat, respiration, and blood pressure Extreme fatigue or exhaustion Greater startle responses Depersonalization	Sleep disturbances, nightmares Somatization (e.g., increased focus on and worry about body aches and pains) Appetite and digestive changes Lowered resistance to colds and infection Persistent fatigue Elevated cortisol levels Hyperarousal Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
Immediate Cognitive Reactions	**Delayed Cognitive Reactions**
Difficulty concentrating Rumination or racing thoughts (e.g., replaying the traumatic event over and over again) Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes) Memory problems (e.g., not being able to recall important aspects of the trauma) Strong identification with victims	Intrusive memories or flashbacks Reactivation of previous traumatic events Self-blame Preoccupation with event Difficulty making decisions Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma Belief that feelings or memories are dangerous Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day) Suicidal thinking
Immediate Behavioral Reactions	**Delayed Behavioral Reactions**
Startled reaction Restlessness Sleep and appetite disturbances Difficulty expressing oneself Argumentative behavior Increased use of alcohol, drugs, and tobacco Withdrawal and apathy Avoidant behaviors	Avoidance of event reminders Social relationship disturbances Decreased activity level Engagement in high-risk behaviors Increased use of alcohol and drugs Withdrawal

(Continued on the next page.)

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma (continued)

Immediate Existential Reactions	Delayed Existential Reactions
Intense use of prayer	Questioning (e.g., "Why me?")
Restoration of faith in the goodness of others (e.g., receiving help from others)	Increased cynicism, disillusionment
Loss of self-efficacy	Increased self-confidence (e.g., "If I can survive this, I can survive anything")
Despair about humanity, particularly if the event was intentional	Loss of purpose
Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)	Renewed faith
	Hopelessness
	Reestablishing priorities
	Redefining meaning and importance of life
	Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)

Sources: Briere & Scott, 2006b; Foa, Stein, & McFarlane, 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011.

prior to the trauma, such emotional dysregulation is usually short lived and represents an immediate reaction to the trauma, rather than an ongoing pattern. Self-medication—namely, substance abuse—is one of the methods that traumatized people use in an attempt to regain emotional control, although ultimately it causes even further emotional dysregulation (e.g., substance-induced changes in affect during and after use). Other efforts toward emotional regulation can include engagement in high-risk or self-injurious behaviors, disordered eating, compulsive behaviors such as gambling or overworking, and repression or denial of emotions; however, not all behaviors associated with self-regulation are considered negative. In fact, some individuals find creative, healthy, and industrious ways to manage strong affect generated by trauma, such as through renewed commitment to physical activity or by creating an organization to support survivors of a particular trauma.

Traumatic stress tends to evoke two emotional extremes: feeling either too much (overwhelmed) or too little (numb) emotion. Treatment can help the client find the optimal level of emotion and assist him or her with appropriately experiencing and regulating difficult emotions. In treatment, the goal is to help clients learn to regulate their emotions without the use of substances or other unsafe behavior. This will likely require learning new coping skills and how to tolerate distressing emotions; some clients may benefit from mindfulness practices, cognitive restructuring, and trauma-specific desensitization approaches, such as exposure therapy and eye movement desensitization and reprocessing (EMDR; refer to Part 1, Chapter 6, for more information on trauma-specific therapies).

Numbing

Numbing is a biological process whereby emotions are detached from thoughts, behaviors, and memories. In the following case illustration, Sadhanna's numbing is evidenced by her limited range of emotions associated with interpersonal interactions and her inability to associate any emotion with her history of abuse. She also possesses a belief in a foreshortened future. A prospective longitudinal study (Malta, Levitt, Martin, Davis, & Cloitre, 2009) that followed the development of PTSD in disaster workers highlighted the importance of understanding and appreciating numbing as a traumatic stress reaction. Because numbing

Case Illustration: Sadhanna

Sadhanna is a 22-year-old woman mandated to outpatient mental health and substance abuse treatment as the alternative to incarceration. She was arrested and charged with assault after arguing and fighting with another woman on the street. At intake, Sadhanna reported a 7-year history of alcohol abuse and one depressive episode at age 18. She was surprised that she got into a fight but admitted that she was drinking at the time of the incident. She also reported severe physical abuse at the hands of her mother's boyfriend between ages 4 and 15. Of particular note to the intake worker was Sadhanna's matter-of-fact way of presenting the abuse history. During the interview, she clearly indicated that she did not want to attend group therapy and hear other people talk about their feelings, saying, "I learned long ago not to wear emotions on my sleeve."

Sadhanna reported dropping out of 10th grade, saying she never liked school. She didn't expect much from life. In Sadhanna's first weeks in treatment, she reported feeling disconnected from other group members and questioned the purpose of the group. When asked about her own history, she denied that she had any difficulties and did not understand why she was mandated to treatment. She further denied having feelings about her abuse and did not believe that it affected her life now. Group members often commented that she did not show much empathy and maintained a flat affect, even when group discussions were emotionally charged.

symptoms hide what is going on inside emotionally, there can be a tendency for family members, counselors, and other behavioral health staff to assess levels of traumatic stress symptoms and the impact of trauma as less severe than they actually are.

Physical

Diagnostic criteria for PTSD place considerable emphasis on psychological symptoms, but some people who have experienced traumatic stress may present initially with physical symptoms. Thus, primary care may be the first and only door through which these individuals seek assistance for trauma-related symptoms. Moreover, there is a significant connection between trauma, including adverse childhood experiences (ACEs), and chronic health conditions. Common physical disorders and symptoms include somatic complaints; sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders.

Somatization

Somatization indicates a focus on bodily symptoms or dysfunctions to express emotional distress. Somatic symptoms are more likely to occur with individuals who have traumatic stress reactions, including PTSD. People from certain ethnic and cultural backgrounds may initially or solely present emotional distress via physical ailments or concerns. Many individuals who present with somatization are likely unaware of the connection between their emotions and the physical symptoms that they're experiencing. At times, clients may remain resistant to exploring emotional content and remain focused on bodily complaints as a means of avoidance. Some clients may insist that their primary problems are physical even when medical evaluations and tests fail to confirm ailments. In these situations, somatization may be a sign of a mental illness. However, various cultures approach emotional distress through the physical realm or view emotional and physical symptoms and well-being as one. It is important not to assume that clients with physical complaints are using somatization as a means to express emotional pain; they may have specific conditions or disorders that require medical attention. Foremost, counselors need to refer for medical evaluation.

Advice to Counselors: Using Information About Biology and Trauma

- Educate your clients:
  - Frame reexperiencing the event(s), hyperarousal, sleep disturbances, and other physical symptoms as physiological reactions to extreme stress.
  - Communicate that treatment and other wellness activities can improve both psychological and physiological symptoms (e.g., therapy, meditation, exercise, yoga). You may need to refer certain clients to a psychiatrist who can evaluate them and, if warranted, prescribe psychotropic medication to address severe symptoms.
  - Discuss traumatic stress symptoms and their physiological components.
  - Explain links between traumatic stress symptoms and substance use disorders, if appropriate.
  - Normalize trauma symptoms. For example, explain to clients that their symptoms are not a sign of weakness, a character flaw, being damaged, or going crazy.
- Support your clients and provide a message of hope—that they are not alone, they are not at fault, and recovery is possible and anticipated.

Biology of trauma

Trauma biology is an area of burgeoning research, with the promise of more complex and explanatory findings yet to come. Although a thorough presentation on the biological aspects of trauma is beyond the scope of this publication, what is currently known is that exposure to trauma leads to a cascade of biological changes and stress responses. These biological alterations are highly associated with PTSD, other mental illnesses, and substance use disorders. These include:

- Changes in limbic system functioning.
- Hypothalamic–pituitary–adrenal axis activity changes with variable cortisol levels.
- Neurotransmitter-related dysregulation of arousal and endogenous opioid systems.

As a clear example, early ACEs such as abuse, neglect, and other traumas affect brain development and increase a person's vulnerability to encountering interpersonal violence as an adult and to developing chronic diseases and other physical illnesses, mental illnesses, substance-related disorders, and impairment in other life areas (Centers for Disease Control and Prevention, 2012).

Hyperarousal and sleep disturbances

A common symptom that arises from traumatic experiences is hyperarousal (also called hypervigilance). Hyperarousal is the body's way of remaining prepared. It is characterized by sleep disturbances, muscle tension, and a lower threshold for startle responses and can persist years after trauma occurs. It is also one of the primary diagnostic criteria for PTSD.

Hyperarousal is a consequence of biological changes initiated by trauma. Although it

Case Illustration: Kimi

Kimi is a 35-year-old Native American woman who was group raped at the age of 16 on her walk home from a suburban high school. She recounts how her whole life changed on that day. "I never felt safe being alone after the rape. I used to enjoy walking everywhere. Afterward, I couldn't tolerate the fear that would arise when I walked in the neighborhood. It didn't matter whether I was alone or with friends—every sound that I heard would throw me into a state of fear. I felt like the same thing was going to happen again. It's gotten better with time, but I often feel as if I'm sitting on a tree limb waiting for it to break. I have a hard time relaxing. I can easily get startled if a leaf blows across my path or if my children scream while playing in the yard. The best way I can describe how I experience life is by comparing it to watching a scary, suspenseful movie—anxiously waiting for something to happen, palms sweating, heart pounding, on the edge of your chair."

serves as a means of self-protection after trauma, it can be detrimental. Hyperarousal can interfere with an individual's ability to take the necessary time to assess and appropriately respond to specific input, such as loud noises or sudden movements. Sometimes, hyperarousal can produce overreactions to situations perceived as dangerous when, in fact, the circumstances are safe.

Along with hyperarousal, sleep disturbances are very common in individuals who have experienced trauma. They can come in the form of early awakening, restless sleep, difficulty falling asleep, and nightmares. Sleep disturbances are most persistent among individuals who have trauma-related stress; the disturbances sometimes remain resistant to intervention long after other traumatic stress symptoms have been successfully treated. Numerous strategies are available beyond medication, including good sleep hygiene practices, cognitive rehearsals of nightmares, relaxation strategies, and nutrition.

Cognitive

Traumatic experiences can affect and alter cognitions. From the outset, trauma challenges the just-world or core life assumptions that

Cognitions and Trauma

The following examples reflect some of the types of cognitive or thought-process changes that can occur in response to traumatic stress.

Cognitive errors: Misinterpreting a current situation as dangerous because it resembles, even remotely, a previous trauma (e.g., a client overreacting to an overturned canoe in 8 inches of water, as if she and her paddle companion would drown, due to her previous experience of nearly drowning in a rip current 5 years earlier).

Excessive or inappropriate guilt: Attempting to make sense cognitively and gain control over a traumatic experience by assuming responsibility or possessing survivor's guilt, because others who experienced the same trauma did not survive.

Idealization: Demonstrating inaccurate rationalizations, idealizations, or justifications of the perpetrator's behavior, particularly if the perpetrator is or was a caregiver. Other similar reactions mirror idealization; traumatic bonding is an emotional attachment that develops (in part to secure survival) between perpetrators who engage in interpersonal trauma and their victims, and Stockholm syndrome involves compassion and loyalty toward hostage takers (de Fabrique, Van Hasselt, Vecchi, & Romano, 2007).

Trauma-induced hallucinations or delusions: Experiencing hallucinations and delusions that, although they are biological in origin, contain cognitions that are congruent with trauma content (e.g., a woman believes that a person stepping onto her bus is her father, who had sexually abused her repeatedly as child, because he wore shoes similar to those her father once wore).

Intrusive thoughts and memories: Experiencing, without warning or desire, thoughts and memories associated with the trauma. These intrusive thoughts and memories can easily trigger strong emotional and behavioral reactions, as if the trauma was recurring in the present. The intrusive thoughts and memories can come rapidly, referred to as flooding, and can be disruptive at the time of their occurrence. If an individual experiences a trigger, he or she may have an increase in intrusive thoughts and memories for a while. For instance, individuals who inadvertently are retraumatized due to program or clinical practices may have a surge of intrusive thoughts of past trauma, thus making it difficult for them to discern what is happening now versus what happened then. Whenever counseling focuses on trauma, it is likely that the client will experience some intrusive thoughts and memories. It is important to develop coping strategies before, as much as possible, and during the delivery of trauma-informed and trauma-specific treatment.

help individuals navigate daily life (Janoff-Bulman, 1992). For example, it would be difficult to leave the house in the morning if you believed that the world was not safe, that all people are dangerous, or that life holds no promise. Belief that one's efforts and intentions can protect oneself from bad things makes it less likely for an individual to perceive personal vulnerability. However, traumatic events—particularly if they are unexpected—can challenge such beliefs.

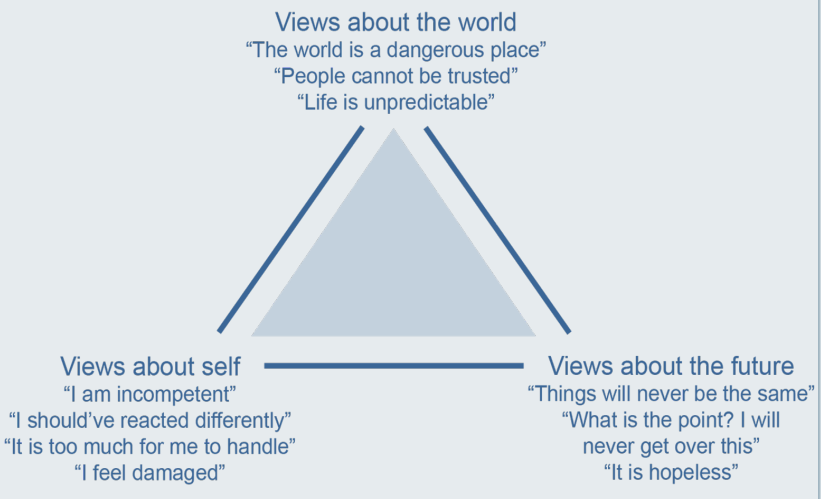
Let's say you always considered your driving time as "your time"—and your car as a safe place to spend that time. Then someone hits you from behind at a highway entrance. Almost immediately, the accident affects how you perceive the world, and from that moment onward, for months following the crash, you feel unsafe in any car. You become hypervigilant about other drivers and perceive that other cars are drifting into your lane or failing to stop at a safe distance behind you. For a time, your perception of safety is eroded, often leading to compensating behaviors (e.g., excessive glancing into the rearview mirror to see whether the vehicles behind you are stopping) until the belief is restored or reworked. Some individuals never return to their previous belief systems after a trauma, nor do they find a way to rework them—thus leading to a worldview that life is unsafe. Still, many other individuals are able to return to organizing core beliefs that support their perception of safety.

Many factors contribute to cognitive patterns prior to, during, and after a trauma. Adopting Beck and colleagues' cognitive triad model (1979), trauma can alter three main cognitive patterns: thoughts about self, the world (others/environment), and the future. To clarify, trauma can lead individuals to see themselves as incompetent or damaged, to see others and the world as unsafe and unpredictable, and to see the future as hopeless—believing that personal suffering will continue, or negative outcomes will preside for the foreseeable future (see Exhibit 1.3-2). Subsequently, this set of cognitions can greatly influence clients' belief in their ability to use internal resources and external support effectively. From a cognitive–behavioral perspective, these cognitions have a bidirectional relationship in sustaining or contributing to the development of depressive and anxiety symptoms after trauma. However, it is possible for cognitive patterns to help protect against debilitating psychological symptoms as well. Many factors contribute to cognitive patterns prior to, during, and after a trauma.

Feeling different

An integral part of experiencing trauma is feeling different from others, whether or not the trauma was an individual or group experience. Traumatic experiences typically feel surreal and challenge the necessity and value of mundane activities of daily life. Survivors

Exhibit 1.3-2: Cognitive Triad of Traumatic Stress



often believe that others will not fully understand their experiences, and they may think that sharing their feelings, thoughts, and reactions related to the trauma will fall short of expectations. However horrid the trauma may be, the *experience* of the trauma is typically profound.

The type of trauma can dictate how an individual feels different or believes that they are different from others. Traumas that generate shame will often lead survivors to feel more alienated from others—believing that they are "damaged goods." When individuals believe that their experiences are unique and incomprehensible, they are more likely to seek support, if they seek support at all, only with others who have experienced a similar trauma.

Triggers and flashbacks

Triggers

A trigger is a stimulus that sets off a memory of a trauma or a specific portion of a traumatic experience. Imagine you were trapped briefly in a car after an accident. Then, several years later, you were unable to unlatch a lock after using a restroom stall; you might have begun to feel a surge of panic reminiscent of the accident, even though there were other avenues of escape from the stall. Some triggers can be identified and anticipated easily, but many are subtle and inconspicuous, often surprising the individual or catching him or her off guard. In treatment, it is important to help clients identify potential triggers, draw a connection between strong emotional reactions and triggers, and develop coping strategies to manage those moments when a trigger occurs. A trigger is any sensory reminder of the traumatic event: a noise, smell, temperature, other physical sensation, or visual scene. Triggers can generalize to any characteristic, no matter how remote, that resembles or represents a previous trauma, such as revisiting the location where the trauma occurred, being alone, having your children reach the same age that you were when you experienced the trauma, seeing the same breed of dog that bit you, or hearing loud voices. Triggers are often associated with the time of day, season, holiday, or anniversary of the event.

Flashbacks

A flashback is reexperiencing a previous traumatic experience as if it were actually happening in that moment. It includes reactions that often resemble the client's reactions during the trauma. Flashback experiences are very brief and typically last only a few seconds, but the emotional aftereffects linger for hours or longer. Flashbacks are commonly initiated by a trigger, but not necessarily. Sometimes, they occur out of the blue. Other times, specific physical states increase a person's vulnerability to reexperiencing a trauma, (e.g., fatigue, high

Advice to Counselors: Helping Clients Manage Flashbacks and Triggers

If a client is triggered in a session or during some aspect of treatment, help the client focus on what is happening in the here and now; that is, use grounding techniques. Behavioral health service providers should be prepared to help the client get regrounded so that they can distinguish between what is happening now versus what had happened in the past (see Covington, 2008, and Najavits, 2002b, 2007b, for more grounding techniques). Offer education about the experience of triggers and flashbacks, and then normalize these events as common traumatic stress reactions. Afterward, some clients need to discuss the experience and understand why the flashback or trigger occurred. It often helps for the client to draw a connection between the trigger and the traumatic event(s). This can be a preventive strategy whereby the client can anticipate that a given situation places him or her at higher risk for retraumatization and requires use of coping strategies, including seeking support.

Source: Green Cross Academy of Traumatology, 2010.

stress levels). Flashbacks can feel like a brief movie scene that intrudes on the client. For example, hearing a car backfire on a hot, sunny day may be enough to cause a veteran to respond as if he or she were back on military patrol. Other ways people reexperience trauma, besides flashbacks, are via nightmares and intrusive thoughts of the trauma.

Dissociation, depersonalization, and derealization

Dissociation is a mental process that severs connections among a person's thoughts, memories, feelings, actions, and/or sense of identity. Most of us have experienced dissociation—losing the ability to recall or track a particular action (e.g., arriving at work but not remembering the last minutes of the drive). Dissociation happens because the person is engaged in an automatic activity and is not paying attention to his or her immediate environment. Dissociation can also occur during severe stress or trauma as a protective element whereby the individual incurs distortion of time, space, or identity. This is a common symptom in traumatic stress reactions.

Dissociation helps distance the experience from the individual. People who have experienced severe or developmental trauma may have learned to separate themselves from distress to survive. At times, dissociation can be very pervasive and symptomatic of a mental disorder, such as dissociative identity disorder (DID; formerly known as multiple personality disorder). According to the DSM-5, "dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (APA, 2013a, p. 291). Dissociative disorder diagnoses are closely associated with histories of severe childhood trauma or pervasive, human-caused, intentional trauma, such as that experienced by concentration camp survivors or victims of ongoing political imprisonment, torture, or long-term isolation. A mental health professional, preferably with significant training in working with dissociative disorders and with trauma, should be consulted when a dissociative disorder diagnosis is suspected.

Potential Signs of Dissociation

- Fixed or "glazed" eyes
- Sudden flattening of affect
- Long periods of silence
- Monotonous voice
- Stereotyped movements
- Responses not congruent with the present context or situation
- Excessive intellectualization

(Briere, 1996a)

The characteristics of DID can be commonly accepted experiences in other cultures, rather than being viewed as symptomatic of a traumatic experience. For example, in non-Western cultures, a sense of alternate beings within oneself may be interpreted as being inhabited by spirits or ancestors (Kirmayer, 1996). Other experiences associated with dissociation include depersonalization—psychologically "leaving one's body," as if watching oneself from a distance as an observer or through derealization, leading to a sense that what is taking place is unfamiliar or is not real.

If clients exhibit signs of dissociation, behavioral health service providers can use grounding techniques to help them reduce this defense strategy. One major long-term consequence of dissociation is the difficulty it causes in connecting strong emotional or physical reactions with an event. Often, individuals may believe that they are going crazy because they are not in touch with the nature of their reactions. By educating clients on the resilient qualities of dissociation while also emphasizing that it prevents them from addressing or

validating the trauma, individuals can begin to understand the role of dissociation. All in all, it is important when working with trauma survivors that the intensity level is not so great that it triggers a dissociative reaction and prevents the person from engaging in the process.

Behavioral

Traumatic stress reactions vary widely; often, people engage in behaviors to manage the aftereffects, the intensity of emotions, or the distressing aspects of the traumatic experience. Some people reduce tension or stress through avoidant, self-medicating (e.g., alcohol abuse), compulsive (e.g., overeating), impulsive (e.g., high-risk behaviors), and/or self-injurious behaviors. Others may try to gain control over their experiences by being aggressive or subconsciously reenacting aspects of the trauma.

Behavioral reactions are also the consequences of, or learned from, traumatic experiences. For example, some people act like they can't control their current environment, thus failing to take action or make decisions long after the trauma (learned helplessness). Other associate elements of the trauma with current activities, such as by reacting to an intimate moment in a significant relationship as dangerous or unsafe years after a date rape. The following sections discuss behavioral consequences of trauma and traumatic stress reactions.

Reenactments

A hallmark symptom of trauma is reexperiencing the trauma in various ways. Reexperiencing can occur through reenactments (literally, to "redo"), by which trauma survivors repetitively relive and recreate a past trauma in their present lives. This is very apparent in children, who play by mimicking what occurred during the trauma, such as by pretending to crash a toy airplane into a toy building after seeing televised images of the terrorist attacks on the World Trade Center on September 11, 2001. Attempts to understand reenactments are very complicated, as reenactments occur for a variety of reasons. Sometimes, individuals reenact past traumas to master them. Examples of reenactments include a variety of behaviors: self-injurious behaviors, hypersexuality, walking alone in unsafe areas or other high-risk behaviors, driving recklessly, or involvement in repetitive destructive relationships (e.g., repeatedly getting into romantic relationships with people who are abusive or violent), to name a few.

Self-harm and self-destructive behaviors

Self-harm is any type of intentionally self-inflicted harm, regardless of the severity of injury or whether suicide is intended. Often, self-harm is an attempt to cope with emotional or physical distress that seems overwhelming or to cope with a profound sense of dissociation or being trapped, helpless, and "damaged" (Herman, 1997; Santa Mina & Gallop, 1998). Self-harm is associated with past childhood sexual abuse and other forms of trauma as well as substance abuse. Thus,

Resilient Responses to Trauma

Many people find healthy ways to cope with, respond to, and heal from trauma. Often, people automatically reevaluate their values and redefine what is important after a trauma. Such resilient responses include:

- Increased bonding with family and community.
- Redefined or increased sense of purpose and meaning.
- Increased commitment to a personal mission.
- Revised priorities.
- Increased charitable giving and volunteerism.

Case Illustration: Marco

Marco, a 30-year-old man, sought treatment at a local mental health center after a 2-year bout of anxiety symptoms. He was an active member of his church for 12 years, but although he sought help from his pastor about a year ago, he reports that he has had no contact with his pastor or his church since that time. Approximately 3 years ago, his wife took her own life. He describes her as his soulmate and has had a difficult time understanding her actions or how he could have prevented them.

In the initial intake, he mentioned that he was the first person to find his wife after the suicide and reported feelings of betrayal, hurt, anger, and devastation since her death. He claimed that everyone leaves him or dies. He also talked about his difficulty sleeping, having repetitive dreams of his wife, and avoiding relationships. In his first session with the counselor, he initially rejected the counselor before the counselor had an opportunity to begin reviewing and talking about the events and discomfort that led him to treatment.

In this scenario, Marco is likely reenacting his feelings of abandonment by attempting to reject others before he experiences another rejection or abandonment. In this situation, the counselor will need to recognize the reenactment, explore the behavior, and examine how reenactments appear in other situations in Marco's life.

addressing self-harm requires attention to the client's reasons for self-harm. More than likely, the client needs help recognizing and coping with emotional or physical distress in manageable amounts and ways.

Among the self-harm behaviors reported in the literature are cutting, burning skin by heat (e.g., cigarettes) or caustic liquids, punching hard enough to self-bruise, head banging, hair pulling, self-poisoning, inserting foreign objects into bodily orifices, excessive nail biting, excessive scratching, bone breaking, gnawing at flesh, interfering with wound healing, tying off body parts to stop breathing or blood flow, swallowing sharp objects, and suicide. Cutting and burning are among the most common forms of self-harm.

Self-harm tends to occur most in people who have experienced repeated and/or early trauma (e.g., childhood sexual abuse) rather than in those who have undergone a single adult trauma (e.g., a community-wide disaster or a serious car accident). There are strong associations between eating disorders, self-harm, and substance abuse (Claes &Vandereycken, 2007; for discussion, see Harned, Najavits, & Weiss, 2006). Self-mutilation is also associated with (and part of the diagnostic criteria for) a number of personality disorders, including borderline and histrionic, as well as DID, depression, and some forms of schizophrenia; these disorders can co-occur with traumatic stress reactions and disorders.

It is important to distinguish self-harm that is suicidal from self-harm that is not suicidal and to assess and manage both of these very serious dangers carefully. Most people who engage in self-harm are not doing so with the intent to kill themselves (Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003)—although self-harm can be life threatening and can escalate into suicidality if not managed therapeutically. Self-harm can be a way of getting attention or manipulating others, but most often it is not. Self-destructive behaviors such as substance abuse, restrictive or binge eating, reckless automobile driving, or high-risk impulsive behavior are different from self-harming behaviors but are also seen in clients with a history of trauma. Self-destructive behaviors differ from self-harming behaviors in that there may be no immediate negative impact of the behavior on the individual; they differ from suicidal behavior in that there is no intent to cause death in the short term.

Advice to Counselors: Working With Clients Who Are Self-Injurious

Counselors who are unqualified or uncomfortable working with clients who demonstrate self-harming, self-destructive, or suicidal or homicidal ideation, intent, or behavior should work with their agencies and supervisors to refer such clients to other counselors. They should consider seeking specialized supervision on how to manage such clients effectively and safely and how to manage their feelings about these issues. The following suggestions assume that the counselor has had sufficient training and experience to work with clients who are self-injurious. To respond appropriately to a client who engages in self-harm, counselors should:

- Screen the client for self-harm and suicide risk at the initial evaluation and throughout treatment.
- Learn the client's perspective on self-harm and how it "helps."
- Understand that self-harm is often a coping strategy to manage the intensity of emotional and/or physical distress.
- Teach the client coping skills that improve his or her management of emotions without self-harm.
- Help the client obtain the level of care needed to manage genuine risk of suicide or severe self-injury. This might include hospitalization, more intensive programming (e.g., intensive outpatient, partial hospitalization, residential treatment), or more frequent treatment sessions. The goal is to stabilize the client as quickly as possible, and then, if possible, begin to focus treatment on developing coping strategies to manage self-injurious and other harmful impulses.
- Consult with other team members, supervisors, and, if necessary, legal experts to determine whether one's efforts with and conceptualization of the self-harming client fit best practice guidelines. See, for example, Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT], 2005c). Document such consultations and the decisions made as a result of them thoroughly and frequently.
- Help the client identify how substance use affects self-harm. In some cases, it can increase the behavior (e.g., alcohol disinhibits the client, who is then more likely to self-harm). In other cases, it can decrease the behavior (e.g., heroin evokes relaxation and, thus, can lessen the urge to self-harm). In either case, continue to help the client understand how abstinence from substances is necessary so that he or she can learn more adaptive coping.
- Work collaboratively with the client to develop a plan to create a sense of safety. Individuals are affected by trauma in different ways; therefore, safety or a safe environment may mean something entirely different from one person to the next. Allow the client to define what safety means to him or her.

Counselors can also help the client prepare a safety card that the client can carry at all times. The card might include the counselor's contact information, a 24-hour crisis number to call in emergencies, contact information for supportive individuals who can be contacted when needed, and, if appropriate, telephone numbers for emergency medical services. The counselor can discuss with the client the types of signs or crises that might warrant using the numbers on the card. Additionally, the counselor might check with the client from time to time to confirm that the information on the card is current.

TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a), has examples of safety agreements specifically for suicidal clients and discusses their uses in more detail. There is no credible evidence that a safety agreement is effective in preventing a suicide attempt or death. Safety agreements for clients with suicidal thoughts and behaviors should only be used as an adjunct support accompanying professional screening, assessment, and treatment for people with suicidal thoughts and behaviors. Keep in mind that safety plans or agreements may be perceived by the trauma survivor as a means of controlling behavior, subsequently replicating or triggering previous traumatic experiences.

All professionals—and in some States, anyone—could have ethical and legal responsibilities to those clients who pose an imminent danger to themselves or others. Clinicians should be aware of the pertinent State laws where they practice and the relevant Federal and professional regulations.

However, as with self-harming behavior, self-destructive behavior needs to be recognized and addressed and may persist—or worsen—without intervention.

Consumption of substances

Substance use often is initiated or increased after trauma. Clients in early recovery—especially those who develop PTSD or have it reactivated—have a higher relapse risk if they experience a trauma. In the first 2 months after September 11, 2001, more than a quarter of New Yorker residents who smoked cigarettes, drank alcohol, or used marijuana (about 265,000 people) increased their consumption. The increases continued 6 months after the attacks (Vlahov, Galea, Ahern, Resnick, & Kilpatrick, 2004). A study by the Substance Abuse and Mental Health Services Administration (SAMHSA, Office of Applied Studies, 2002) used National Survey on Drug Use and Health data to compare the first three quarters of 2001 with the last quarter and reported an increase in the prevalence rate for alcohol use among people 18 or older in the New York metropolitan area during the fourth quarter.

Interviews with New York City residents who were current or former cocaine or heroin users indicated that many who had been clean for 6 months or less relapsed after September 11, 2001. Others, who lost their income and could no longer support their habit, enrolled in methadone programs (Weiss et al., 2002). After the Oklahoma City bombing in 1995, Oklahomans reported double the normal rate of alcohol use, smoking more cigarettes, and a higher incidence of initiating smoking months and even years after the bombing (Smith, Christiansen, Vincent, & Hann, 1999).

Self-medication

Khantzian's self-medication theory (1985) suggests that drugs of abuse are selected for their specific effects. However, no definitive pattern has yet emerged of the use of particular substances in relation to PTSD or trauma symptoms. Use of substances can vary based on a variety of factors, including which trauma symptoms are most prominent for an individual and the individual's access to particular substances. Unresolved traumas sometimes lurk behind the emotions that clients cannot allow themselves to experience. Substance use and abuse in trauma survivors can be a way to self-medicate and thereby avoid or displace difficult emotions associated with traumatic experiences. When the substances are withdrawn, the survivor may use other behaviors to self-soothe, self-medicate, or avoid emotions. As likely, emotions can appear after abstinence in the form of anxiety and depression.

Avoidance

Avoidance often coincides with anxiety and the promotion of anxiety symptoms. Individuals begin to avoid people, places, or situations to alleviate unpleasant emotions, memories, or circumstances. Initially, the avoidance works, but over time, anxiety increases and the perception that the situation is unbearable or dangerous increases as well, leading to a greater need to avoid. Avoidance can be adaptive, but it is also a behavioral pattern that reinforces perceived danger without testing its validity, and it typically leads to greater problems across major life areas (e.g., avoiding emotionally oriented conversations in an intimate relationship). For many individuals who have traumatic stress reactions, avoidance is commonplace. A person may drive 5 miles longer to avoid the road where he or she had an accident. Another individual may avoid crowded places in fear of an assault or to circumvent strong emotional memories about an earlier assault that took place in a crowded area. Avoidance can come in many forms. When people can't tolerate strong affects associated with traumatic memories, they avoid, project,

deny, or distort their trauma-related emotional and cognitive experiences. A key ingredient in trauma recovery is learning to manage triggers, memories, and emotions without avoidance—in essence, becoming desensitized to traumatic memories and associated symptoms.

Social/Interpersonal

A key ingredient in the early stage of TIC is to establish, confirm, or reestablish a support system, including culturally appropriate activities, as soon as possible. Social supports and relationships can be protective factors against traumatic stress. However, trauma typically affects relationships significantly, regardless of whether the trauma is interpersonal or is of some other type. Relationships require emotional exchanges, which means that others who have close relationships or friendships with the individual who survived the trauma(s) are often affected as well—either through secondary traumatization or by directly experiencing the survivor's traumatic stress reactions. In natural disasters, social and community supports can be abruptly eroded and difficult to rebuild after the initial disaster relief efforts have waned.

Survivors may readily rely on family members, friends, or other social supports—or they may avoid support, either because they believe that no one will be understanding or trustworthy or because they perceive their own needs as a burden to others. Survivors who have strong emotional or physical reactions, including outbursts during nightmares, may pull away further in fear of being unable to predict their own reactions or to protect their own safety and that of others. Often, trauma survivors feel ashamed of their stress reactions, which further hampers their ability to use their support systems and resources adequately.

Many survivors of childhood abuse and interpersonal violence have experienced a significant sense of betrayal. They have often encountered trauma at the hands of trusted caregivers and family members or through significant relationships. This history of betrayal can disrupt forming or relying on supportive relationships in recovery, such as peer supports and counseling. Although this fear of trusting others is protective, it can lead to difficulty in connecting with others and greater vigilance in observing the behaviors of others, including behavioral health service providers. It is exceptionally difficult to override the feeling that someone is going to hurt you, take advantage of you, or, minimally, disappoint you. Early betrayal can affect one's ability to develop attachments, yet the formation of supportive relationships is an important antidote in the recovery from traumatic stress.

Developmental

Each age group is vulnerable in unique ways to the stresses of a disaster, with children and the elderly at greatest risk. Young children may display generalized fear, nightmares, heightened arousal and confusion, and physical symptoms, (e.g., stomachaches, headaches). School-age children may exhibit symptoms such as aggressive behavior and anger, regression to behavior seen at younger ages, repetitious traumatic play, loss of ability to concentrate, and worse school performance. Adolescents may display depression and social withdrawal, rebellion, increased risky activities such as sexual acting out, wish for revenge and action-oriented responses to trauma, and sleep and eating disturbances (Hamblen, 2001). Adults may display sleep problems, increased agitation, hypervigilance, isolation or withdrawal, and increased use of alcohol or drugs. Older adults may exhibit increased withdrawal and isolation, reluctance to leave home, worsening of chronic illnesses, confusion, depression, and fear (DeWolfe & Nordboe, 2000b).

Neurobiological Development: Consequences of Early Childhood Trauma

Findings in developmental psychobiology suggest that the consequences of early maltreatment produce enduring negative effects on brain development (DeBellis, 2002; Liu, Diorio, Day, Francis, & Meaney, 2000; Teicher, 2002). Research suggests that the first stage in a cascade of events produced by early trauma and/or maltreatment involves the disruption of chemicals that function as neurotransmitters (e.g., cortisol, norepinephrine, dopamine), causing escalation of the stress response (Heim, Mletzko, Purselle, Musselman, & Nemeroff, 2008; Heim, Newport, Mletzko, Miller, & Nemeroff, 2008; Teicher, 2002). These chemical responses can then negatively affect critical neural growth during specific sensitive periods of childhood development and can even lead to cell death.

Adverse brain development can also result from elevated levels of cortisol and catecholamines by contributing to maturational failures in other brain regions, such as the prefrontal cortex (Meaney, Brake, & Gratton, 2002). Heim, Mletzko et al. (2008) found that the neuropeptide oxytocin—important for social affiliation and support, attachment, trust, and management of stress and anxiety—was markedly decreased in the cerebrospinal fluid of women who had been exposed to childhood maltreatment, particularly those who had experienced emotional abuse. The more childhood traumas a person had experienced, and the longer their duration, the lower that person's current level of oxytocin was likely to be and the higher her rating of current anxiety was likely to be.

Using data from the Adverse Childhood Experiences Study, an analysis by Anda, Felitti, Brown et al. (2006) confirmed that the risk of negative outcomes in affective, somatic, substance abuse, memory, sexual, and aggression-related domains increased as scores on a measure of eight ACEs increased. The researchers concluded that the association of study scores with these outcomes can serve as a theoretical parallel for the effects of cumulative exposure to stress on the developing brain and for the resulting impairment seen in multiple brain structures and functions.

The National Child Traumatic Stress Network (http://www.nctsn.org) offers information about childhood abuse, stress, and physiological responses of children who are traumatized. Materials are available for counselors, educators, parents, and caregivers. There are special sections on the needs of children in military families and on the impact of natural disasters on children's mental health.

Subthreshold Trauma-Related Symptoms

Many trauma survivors experience symptoms that, although they do not meet the diagnostic criteria for ASD or PTSD, nonetheless limit their ability to function normally (e.g., regulate emotional states, maintain steady and rewarding social and family relationships, function competently at a job, maintain a steady pattern of abstinence in recovery). These symptoms can be transient, only arising in a specific context; intermittent, appearing for several weeks or months and then receding; or a part of the individual's regular pattern of functioning (but not to the level of DSM-5 diagnostic criteria). Often, these patterns are termed "subthreshold" trauma symptoms. Like PTSD, the symptoms can be misdiagnosed as depression, anxiety, or another mental illness. Likewise, clients who have experienced trauma may link some of their symptoms to their trauma and diagnose themselves as having PTSD, even though they do not meet all criteria for that disorder.

Combat Stress Reaction

A phenomenon unique to war, and one that counselors need to understand well, is combat stress reaction (CSR). CSR is an acute anxiety reaction occurring during or shortly after participating in military conflicts and wars as well as other operations within the war zone, known as the theater. CSR is not a formal diagnosis, nor is it included in the DSM-5 (APA, 2013a). It is similar to acute stress

Case Illustration: Frank

Frank is a 36-year-old man who was severely beaten in a fight outside a bar. He had multiple injuries, including broken bones, a concussion, and a stab wound in his lower abdomen. He was hospitalized for 3.5 weeks and was unable to return to work, thus losing his job as a warehouse forklift operator. For several years, when faced with situations in which he perceived himself as helpless and overwhelmed, Frank reacted with violent anger that, to others, appeared grossly out of proportion to the situation. He has not had a drink in almost 3 years, but the bouts of anger persist and occur three to five times a year. They leave Frank feeling even more isolated from others and alienated from those who love him. He reports that he cannot watch certain television shows that depict violent anger; he has to stop watching when such scenes occur. He sometimes daydreams about getting revenge on the people who assaulted him.

Psychiatric and neurological evaluations do not reveal a cause for Frank's anger attacks. Other than these symptoms, Frank has progressed well in his abstinence from alcohol. He attends a support group regularly, has acquired friends who are also abstinent, and has reconciled with his family of origin. His marriage is more stable, although the episodes of rage limit his wife's willingness to commit fully to the relationship. In recounting the traumatic event in counseling, Frank acknowledges that he thought he was going to die as a result of the fight, especially when he realized he had been stabbed. As he described his experience, he began to become very anxious, and the counselor observed the rage beginning to appear.

After his initial evaluation, Frank was referred to an outpatient program that provided trauma-specific interventions to address his subthreshold trauma symptoms. With a combination of cognitive–behavioral counseling, EMDR, and anger management techniques, he saw a gradual decrease in symptoms when he recalled the assault. He started having more control of his anger when memories of the trauma emerged. Today, when feeling trapped, helpless, or overwhelmed, Frank has resources for coping and does not allow his anger to interfere with his marriage or other relationships.

reaction, except that the precipitating event or events affect military personnel (and civilians exposed to the events) in an armed conflict situation. The terms "combat stress reaction" and "posttraumatic stress injury" are relatively new, and the intent of using these new terms is to call attention to the unique experiences of combat-related stress as well as to decrease the shame that can be associated with seeking behavioral health services for PTSD (for more information on veterans and combat stress reactions, see the planned TIP, *Reintegration-Related Behavioral Health Issues for Veterans and Military Families*; SAMHSA, planned f).

Although stress mobilizes an individual's physical and psychological resources to perform more effectively in combat, reactions to the stress may persist long after the actual danger has ended. As with other traumas, the nature of the event(s), the reactions of others, and the survivor's psychological history and resources affect the likelihood and severity of CSR. With combat veterans, this translates to the number, intensity, and duration of threat factors; the social support of peers in the veterans' unit; the emotional and cognitive resilience of the service members; and the quality of military leadership. CSR can vary from manageable and mild to debilitating and severe. Common, less severe symptoms of CSR include tension, hypervigilance, sleep problems, anger, and difficulty concentrating. If left untreated, CSR can lead to PTSD.

Common causes of CSR are events such as a direct attack from insurgent small arms fire or a military convoy being hit by an improvised explosive device, but combat stressors encompass a diverse array of traumatizing events, such as seeing grave injuries, watching others

Advice to Counselors: Understanding the Nature of Combat Stress

Several sources of information are available to help counselors deepen their understanding of combat stress and postdeployment adjustment. Friedman (2006) explains how a prolonged combat-ready stance, which is adaptive in a war zone, becomes hypervigilance and overprotectiveness at home. He makes the point that the "mutual interdependence, trust, and affection" (p. 587) that are so necessarily a part of a combat unit are different from relationships with family members and colleagues in a civilian workplace. This complicates the transition to civilian life. *Wheels Down: Adjusting to Life After Deployment* (Moore & Kennedy, 2011) provides practical advice for military service members, including inactive or active duty personnel and veterans, in transitioning from the theater to home.

The following are just a few of the many resources and reports focused on combat-related psychological and stress issues:

- *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Tanielian & Jaycox, 2008)
- *On Killing* (Grossman, 1995), an indepth analysis of the psychological dynamics of combat
- *Haunted by Combat* (Paulson & Krippner, 2007), which contains specific chapters on Reserve and National Guard troops and female veterans
- *Treating Young Veterans: Promoting Resilience Through Practice and Advocacy* (Kelly, Howe-Barksdale, & Gitelson, 2011)

die, and making on-the-spot decisions in ambiguous conditions (e.g., having to determine whether a vehicle speeding toward a military checkpoint contains insurgents with explosives or a family traveling to another area). Such circumstances can lead to combat stress. Military personnel also serve in noncombat positions (e.g., healthcare and administrative roles), and personnel filling these supportive roles can be exposed to combat situations by proximity or by witnessing their results.

Specific Trauma-Related Psychological Disorders

Part of the definition of trauma is that the individual responds with intense fear, helplessness, or horror. Beyond that, in both the short term and the long term, trauma comprises a range of reactions from normal (e.g., being unable to concentrate, feeling sad, having trouble sleeping) to warranting a diagnosis of a trauma-related mental disorder. Most people who experience trauma have no long-lasting disabling effects; their coping skills and the support of those around them are sufficient to help them overcome their difficulties, and their ability to function on a daily basis over time is unimpaired. For others, though, the symptoms of trauma are more severe and last longer. The most common diagnoses associated with trauma are PTSD and ASD, but trauma is also associated with the onset of other mental disorders—particularly substance use disorders, mood disorders, various anxiety disorders, and personality disorders. Trauma also typically exacerbates symptoms of preexisting disorders, and, for people who are predisposed to a mental disorder, trauma can precipitate its onset. Mental disorders can occur almost simultaneously with trauma exposure or manifest sometime thereafter.

Acute Stress Disorder

ASD represents a normal response to stress. Symptoms develop within 4 weeks of the trauma and can cause significant levels of distress. Most individuals who have acute stress reactions never develop further impairment or PTSD. Acute stress disorder is highly associated with the experience of one specific trauma rather than the experience of long-term exposure to chronic traumatic stress. Diagnostic criteria are presented in Exhibit 1.3-3.

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). **Note:** This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks), during which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood:
   5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms:
   6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
   7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors, such as head injury, alcohol, or drugs).

Avoidance Symptoms:
   8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   9. Efforts to avoid external reminders (e.g., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms:
   10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
   11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   12. Hypervigilance.
   13. Problems with concentration.
   14. Exaggerated startle response.

(Continued on the next page.)

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD (continued)

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure. **Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

Source: APA, 2013a, pp. 280–281.

The primary presentation of an individual with an acute stress reaction is often that of someone who appears overwhelmed by the traumatic experience. The need to talk about the experience can lead the client to seem self-centered and unconcerned about the needs of others. He or she may need to describe, in repetitive detail, what happened, or may seem obsessed with trying to understand what happened in an effort to make sense of the experience. The client is often hypervigilant and avoids circumstances that are reminders of the trauma. For instance, someone who was in a serious car crash in heavy traffic can become anxious and avoid riding in a car or driving in traffic for a finite time afterward. Partial amnesia for the trauma often accompanies ASD, and the individual may repetitively question others to fill in details. People with ASD symptoms sometimes seek assurance from others that the event happened in the way they remember, that they are not "going crazy" or "losing it," and that they could not have prevented the event. The next case illustration demonstrates the time-limited nature of ASD.

Differences between ASD and PTSD

It is important to consider the differences between ASD and PTSD when forming a diagnostic impression. The primary difference is the amount of time the symptoms have been present. ASD resolves 2 days to 4 weeks after an event, whereas PTSD continues beyond the 4-week period. The diagnosis of ASD can change to a diagnosis of PTSD if the condition is noted within the first 4 weeks after the event, but the symptoms persist past 4 weeks.

ASD also differs from PTSD in that the ASD diagnosis requires 9 out of 14 symptoms from five categories, including intrusion, negative mood, dissociation, avoidance, and arousal. These symptoms can occur at the time of the trauma or in the following month. Studies indicate that dissociation at the time of trauma is a good predictor of subsequent PTSD, so the inclusion of dissociative symptoms makes it more likely that those who develop ASD will later be diagnosed with PTSD (Bryant & Harvey, 2000). Additionally, ASD is a transient disorder, meaning that it is present in a person's life for a relatively short time and then passes. In contrast, PTSD typically becomes a primary feature of an individual's life. Over a lengthy period, PTSD can have profound effects on clients' perceptions of safety, their sense of hope for the future, their relationships with others, their physical health, the appearance of psychiatric symptoms, and their patterns of substance use and abuse.

There are common symptoms between PTSD and ASD, and untreated ASD is a possible predisposing factor to PTSD, but it is unknown whether most people with ASD are likely to develop PTSD. There is some suggestion that, as with PTSD, ASD is more

Case Illustration: Sheila

Two months ago, Sheila, a 55-year-old married woman, experienced a tornado in her home town. In the previous year, she had addressed a long-time marijuana use problem with the help of a treatment program and had been abstinent for about 6 months. Sheila was proud of her abstinence; it was something she wanted to continue. She regarded it as a mark of personal maturity; it improved her relationship with her husband, and their business had flourished as a result of her abstinence.

During the tornado, an employee reported that Sheila had become very agitated and had grabbed her assistant to drag him under a large table for cover. Sheila repeatedly yelled to her assistant that they were going to die. Following the storm, Sheila could not remember certain details of her behavior during the event. Furthermore, Sheila said that after the storm, she felt numb, as if she was floating out of her body and could watch herself from the outside. She stated that nothing felt real and it was all like a dream.

Following the tornado, Sheila experienced emotional numbness and detachment, even from people close to her, for about 2 weeks. The symptoms slowly decreased in intensity but still disrupted her life. Sheila reported experiencing disjointed or unconnected images and dreams of the storm that made no real sense to her. She was unwilling to return to the building where she had been during the storm, despite having maintained a business at this location for 15 years. In addition, she began smoking marijuana again because it helped her sleep. She had been very irritable and had uncharacteristic angry outbursts toward her husband, children, and other family members.

As a result of her earlier contact with a treatment program, Sheila returned to that program and engaged in psychoeducational, supportive counseling focused on her acute stress reaction. She regained abstinence from marijuana and returned shortly to a normal level of functioning. Her symptoms slowly diminished over a period of 3 weeks. With the help of her counselor, she came to understand the link between the trauma and her relapse, regained support from her spouse, and again felt in control of her life.

prevalent in women than in men (Bryant & Harvey, 2003). However, many people with PTSD do not have a diagnosis or recall a history of acute stress symptoms before seeking treatment for or receiving a diagnosis of PTSD.

Effective interventions for ASD can significantly reduce the possibility of the subsequent development of PTSD. Effective treatment of ASD can also reduce the incidence of other co-occurring problems, such as depression, anxiety, dissociative disorders, and compulsive behaviors (Bryant & Harvey, 2000). Intervention for ASD also helps the individual develop coping skills that can effectively prevent the recurrence of ASD after later traumas.

Although predictive science for ASD and PTSD will continue to evolve, both disorders are associated with increased substance use and mental disorders and increased risk of relapse; therefore, effective screening for ASD and PTSD is important for all clients with these disorders. Individuals in early recovery—lacking well-practiced coping skills, lacking environmental supports, and already operating at high levels of anxiety—are particularly susceptible to ASD. Events that would not normally be disabling can produce symptoms of intense helplessness and fear, numbing and depersonalization, disabling anxiety, and an inability to handle normal life events. Counselors should be able to recognize ASD and treat it rather than attributing the symptoms to a client's lack of motivation to change, being "dry drunk" (for those in substance abuse recovery), or being manipulative.

Posttraumatic Stress Disorder

The trauma-related disorder that receives the greatest attention is PTSD; it is the most

Case Illustration: Michael

Michael is a 62-year-old Vietnam veteran. He is a divorced father of two children and has four grandchildren. Both of his parents were dependent on alcohol. He describes his childhood as isolated. His father physically and psychologically abused him (e.g., he was beaten with a switch until he had welts on his legs, back, and buttocks). By age 10, his parents regarded him as incorrigible and sent him to a reformatory school for 6 months. By age 15, he was using marijuana, hallucinogens, and alcohol and was frequently truant from school.

At age 19, Michael was drafted and sent to Vietnam, where he witnessed the deaths of six American military personnel. In one incident, the soldier he was next to in a bunker was shot. Michael felt helpless as he talked to this soldier, who was still conscious. In Vietnam, Michael increased his use of both alcohol and marijuana. On his return to the United States, Michael continued to drink and use marijuana. He reenlisted in the military for another tour of duty.

His life stabilized in his early 30s, as he had a steady job, supportive friends, and a relatively stable family life. However, he divorced in his late 30s. Shortly thereafter, he married a second time, but that marriage ended in divorce as well. He was chronically anxious and depressed and had insomnia and frequent nightmares. He periodically binged on alcohol. He complained of feeling empty, had suicidal ideation, and frequently stated that he lacked purpose in his life.

In the 1980s, Michael received several years of mental health treatment for dysthymia. He was hospitalized twice and received 1 year of outpatient psychotherapy. In the mid-1990s, he returned to outpatient treatment for similar symptoms and was diagnosed with PTSD and dysthymia. He no longer used marijuana and rarely drank. He reported that he didn't like how alcohol or other substances made him feel anymore—he felt out of control with his emotions when he used them. Michael reported symptoms of hyperarousal, intrusion (intrusive memories, nightmares, and preoccupying thoughts about Vietnam), and avoidance (isolating himself from others and feeling "numb"). He reported that these symptoms seemed to relate to his childhood abuse and his experiences in Vietnam. In treatment, he expressed relief that he now understood the connection between his symptoms and his history.

commonly diagnosed trauma-related disorder, and its symptoms can be quite debilitating over time. Nonetheless, it is important to remember that PTSD symptoms are represented in a number of other mental illnesses, including major depressive disorder (MDD), anxiety disorders, and psychotic disorders (Foa et al., 2006). The DSM-5 (APA, 2013a) identifies four symptom clusters for PTSD: presence of intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. Individuals must have been exposed to actual or threatened death, serious injury, or sexual violence, and the symptoms must produce significant distress and impairment for more than 4 weeks (Exhibit 1.3-4).

Certain characteristics make people more susceptible to PTSD, including one's unique personal vulnerabilities at the time of the traumatic exposure, the support (or lack of support) received from others at the time of the trauma and at the onset of trauma-related symptoms, and the way others in the person's environment gauge the nature of the traumatic event (Brewin, Andrews, & Valentine, 2000).

People with PTSD often present varying clinical profiles and histories. They can experience symptoms that are activated by environmental triggers and then recede for a period of time. Some people with PTSD who show mostly psychiatric symptoms (particularly depression and anxiety) are misdiagnosed and go untreated for their primary condition. For many people, the trauma experience and diagnosis

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled "Posttraumatic Stress Disorder for Children 6 Years and Younger" (APA, 2013a).

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
   5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
   2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
   3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
   4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
   5. Markedly diminished interest or participation in significant activities.
   6. Feelings of detachment or estrangement from others.
   7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

(Continued on the next page.)

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD (continued)

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   2. Reckless or self-destructive behavior.
   3. Hypervigilance.
   4. Exaggerated startle response.
   5. Problems with concentration.
   6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify whether:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Source: APA, 2013a, pp. 271–272.

are obscured by co-occurring substance use disorder symptoms. The important feature of PTSD is that the disorder becomes an orienting feature of the individual's life. How well the person can work, with whom he or she associates, the nature of close and intimate relationships, the ability to have fun and rejuvenate, and the way in which an individual goes about confronting and solving problems in life are all affected by the client's trauma experiences and his or her struggle to recover.

Posttraumatic stress disorder: Timing of symptoms

Although symptoms of PTSD usually begin within 3 months of a trauma in adulthood, there can be a delay of months or even years before symptoms appear for some people. Some people may have minimal symptoms after a trauma but then experience a crisis later in life. Trauma symptoms can appear suddenly, even without conscious memory of the original trauma or without any overt provocation. Survivors of abuse in childhood can have a delayed response triggered by something that happens to them as adults. For example, seeing a movie about child abuse can trigger symptoms related

Advice to Counselors: Helping Clients With Delayed Trauma Responses

Clients who are experiencing a delayed trauma response can benefit if you help them to:

- Create an environment that allows acknowledgment of the traumatic event(s).
- Discuss their initial recall or first suspicion that they were having a traumatic response.
- Become educated on delayed trauma responses.
- Draw a connection between the trauma and presenting trauma-related symptoms.
- Create a safe environment.
- Explore their support systems and fortify them as needed.
- Understand that triggers can precede traumatic stress reactions, including delayed responses to trauma.
- Identify their triggers.
- Develop coping strategies to navigate and manage symptoms.

to the trauma. Other triggers include returning to the scene of the trauma, being reminded of it in some other way, or noting the anniversary of an event. Likewise, combat veterans and survivors of community-wide disasters may seem to be coping well shortly after a trauma, only to have symptoms emerge later when their life situations seem to have stabilized. Some clients in substance abuse recovery only begin to experience trauma symptoms when they maintain abstinence for some time. As individuals decrease tension-reducing or self-medicating behaviors, trauma memories and symptoms can emerge.

Culture and posttraumatic stress

Although research is limited across cultures, PTSD has been observed in Southeast Asian, South American, Middle Eastern, and Native American survivors (Osterman & de Jong, 2007; Wilson & Tang, 2007). As Stamm and Friedman (2000) point out, however, simply observing PTSD does not mean that it is the "best conceptual tool for characterizing posttraumatic distress among non-Western individuals" (p. 73). In fact, many trauma-related symptoms from other cultures do not fit the DSM-5 criteria. These include somatic and psychological symptoms and beliefs about the origins and nature of traumatic events. Moreover, religious and spiritual beliefs can affect how a survivor experiences a traumatic event and whether he or she reports the distress. For example, in societies where attitudes toward karma and the glorification of war veterans are predominant, it is harder for war veterans to come forward and disclose that they are emotionally overwhelmed or struggling. It would be perceived as inappropriate and possibly demoralizing to focus on the emotional distress that he or she still bears. (For a review of cultural competence in treating trauma, refer to Brown, 2008.)

Methods for measuring PTSD are also culturally specific. As part of a project begun in 1972, the World Health Organization (WHO) and the National Institutes of Health (NIH) embarked on a joint study to test the cross-cultural applicability of classification systems for various diagnoses. WHO and NIH identified apparently universal factors of psychological disorders and developed specific instruments to measure them. These instruments, the Composite International Diagnostic Interview and the Schedules for Clinical Assessment in Neuropsychiatry, include certain criteria from the DSM (Fourth Edition, Text Revision; APA, 2000a) as well as criteria from the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10; Exhibit 1.3-5).

Exhibit 1.3-5: ICD-10 Diagnostic Criteria for PTSD

A. The patient must have been exposed to a stressful event or situation (either brief or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.

B. There must be persistent remembering or "reliving" of the stressor in intrusive "flashbacks," vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.

D. Either of the following must be present:
   1. Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor.
   2. Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
      a. Difficulty in falling or staying asleep.
      b. Irritability or outbursts of anger.
      c. Difficulty in concentrating.
      d. Exaggerated startle response.

E. Criteria B, C, and D must all be met within 6 months of the stressful event or at the end of a period of stress. (For some purposes, onset delayed more than 6 months can be included, but this should be clearly specified.)

Source: WHO, 1992.

Complex trauma and complex traumatic stress

When individuals experience multiple traumas, prolonged and repeated trauma during childhood, or repetitive trauma in the context of significant interpersonal relationships, their reactions to trauma have unique characteristics (Herman, 1992). This unique constellation of reactions, called complex traumatic stress, is not recognized diagnostically in the DSM-5, but theoretical discussions and research have begun to highlight the similarities and differences in symptoms of posttraumatic stress versus complex traumatic stress (Courtois & Ford, 2009). Often, the symptoms generated from complex trauma do not fully match PTSD criteria and exceed the severity of PTSD. Overall, literature reflects that PTSD criteria or subthreshold symptoms do not fully account for the persistent and more impairing clinical presentation of complex trauma. Even though current research in the study of traumatology is prolific, it is still in the early stages of development. The idea that there may be more diagnostic variations or subtypes is forthcoming, and this will likely pave the way for more client-matching interventions to better serve those individuals who have been repeatedly exposed to multiple, early childhood, and/or interpersonal traumas.

Other Trauma-Related and Co-Occurring Disorders

The symptoms of PTSD and other mental disorders overlap considerably; these disorders often coexist and include mood, anxiety,

The term "**co occurring disorders**" refers to cases when a person has one or more mental disorders as well as one or more substance use disorders (including sub stance abuse). Co occurring disorders are common among individuals who have a history of trauma and are seeking help.

Advice to Counselors: Universal Screening and Assessment

Only people specifically trained and licensed in mental health assessment should make diagnoses; trauma can result in complicated cases, and many symptoms can be present, whether or not they meet full diagnostic criteria for a specific disorder. Only a trained assessor can distinguish accurately among various symptoms and in the presence of co-occurring disorders. However, behavioral health professionals without specific assessment training can still serve an important role in screening for possible mental disorders using established screening tools (CSAT, 2005c; see also Chapter 4 of this TIP). In agencies and clinics, it is critical to provide such screenings systematically—for each client—as PTSD and other co-occurring disorders are typically underdiagnosed or misdiagnosed.

substance use, and personality disorders. Thus, it's common for trauma survivors to be underdiagnosed or misdiagnosed. If they have not been identified as trauma survivors, their psychological distress is often not associated with previous trauma, and/or they are diagnosed with a disorder that marginally matches their presenting symptoms and psychological sequelae of trauma. The following sections present a brief overview of some mental disorders that can result from (or be worsened by) traumatic stress. PTSD is not the only diagnosis related to trauma nor its only psychological consequence; trauma can broadly influence mental and physical health in clients who already have behavioral health disorders.

People With Mental Disorders

MDD is the most common co-occurring disorder in people who have experienced trauma and are diagnosed with PTSD. A well-established causal relationship exists between stressful events and depression, and a prior history of MDD is predictive of PTSD after exposure to major trauma (Foa et al., 2006).

Many survivors with severe mental disorders function fairly well following trauma, including disasters, as long as essential services aren't interrupted. For others, additional mental health supports may be necessary. For more information, see *Responding to the Needs of People With Serious and Persistent Mental Illness in Times of Major Disaster* (Center for Mental Health Services, 1996).

Co-occurrence is also linked with greater impairment and more severe symptoms of both disorders, and the person is less likely to experience remission of symptoms within 6 months.

Generalized anxiety, obsessive–compulsive, and other anxiety disorders are also associated with PTSD. PTSD may exacerbate anxiety disorder symptoms, but it is also likely that preexisting anxiety symptoms and anxiety disorders increase vulnerability to PTSD. Preexisting anxiety primes survivors for greater hyperarousal and distress. Other disorders, such as personality and somatization disorders, are also associated with trauma, but the history of trauma is often overlooked as a significant factor or necessary target in treatment.

The relationship between PTSD and other disorders is complex. More research is now examining the multiple potential pathways among PTSD and other disorders and how various sequences affect clinical presentation. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c), is valuable in understanding the relationship of substance use to other mental disorders.

People With Substance Use Disorders

There is clearly a correlation between trauma (including individual, group, or mass trauma) and substance use as well as the presence of posttraumatic stress (and other trauma-related disorders) and substance use disorders. Alcohol and drug use can be, for some, an effort to

Co-Occurring PTSD and Other Mental Disorders

- Individuals with PTSD often have at least one additional diagnosis of a mental disorder.
- The presence of other disorders typically worsens and prolongs the course of PTSD and complicates clinical assessment, diagnosis, and treatment.
- The most common co-occurring disorders, in addition to substance use disorders, include mood disorders, various anxiety disorders, eating disorders, and personality disorders.
- Exposure to early, severe, and chronic trauma is linked to more complex symptoms, including impulse control deficits, greater difficulty in emotional regulation and establishing stable relationships, and disruptions in consciousness, memory, identity, and/or perception of the environment (Dom, De, Hulstijn, & Sabbe, 2007; Waldrop, Back, Verduin, & Brady, 2007).
- Certain diagnostic groups and at-risk populations (e.g., people with developmental disabilities, people who are homeless or incarcerated) are more susceptible to trauma exposure and to developing PTSD if exposed but less likely to receive appropriate diagnosis and treatment.
- Given the prevalence of traumatic events in clients who present for substance abuse treatment, counselors should assess all clients for possible trauma-related disorders.

manage traumatic stress and specific PTSD symptoms. Likewise, people with substance use disorders are at higher risk of developing PTSD than people who do not abuse substances. Counselors working with trauma survivors or clients who have substance use disorders have to be particularly aware of the possibility of the other disorder arising.

Timeframe: PTSD and the onset of substance use disorders

Knowing whether substance abuse or PTSD came first informs whether a causal relationship exists, but learning this requires thorough assessment of clients and access to complete data on PTSD; substance use, abuse, and dependence; and the onset of each. Much current research focuses solely on the age of onset of substance use (not abuse), so determining causal relationships can be difficult.

The relationship between PTSD and substance use disorders is thought to be bidirectional and cyclical: substance use increases trauma risk, and exposure to trauma escalates substance use to manage trauma-related symptoms. Three other causal pathways described by Chilcoat and Breslau's seminal work (1998) further explain the relationship between PTSD and substance use disorders:

1. The "self-medication" hypothesis suggests that clients with PTSD use substances to manage PTSD symptoms (e.g., intrusive memories, physical arousal). Substances such as alcohol, cocaine, barbiturates, opioids, and amphetamines are frequently abused in attempts to relieve or numb emotional pain or to forget the event.
2. The "high-risk" hypothesis states that drug and alcohol use places people who use substances in high-risk situations that increase their chances of being exposed to events that lead to PTSD.
3. The "susceptibility" hypothesis suggests that people who use substances are more susceptible to developing PTSD after exposure to trauma than people who do not. Increased vulnerability may result from failure to develop effective stress management strategies, changes in brain chemistry, or damage to neurophysiological systems due to extensive substance use.

PTSD and substance abuse treatment

PTSD can limit progress in substance abuse recovery, increase the potential for relapse, and complicate a client's ability to achieve success in various life areas. Each disorder can mask or hide the symptoms of the other, and both need

Case Illustration: Maria

Maria is a 31-year-old woman diagnosed with PTSD and alcohol dependence. From ages 8 to 12, she was sexually abused by an uncle. Maria never told anyone about the abuse for fear that she would not be believed. Her uncle remains close to the family, and Maria still sees him on certain holidays. When she came in for treatment, she described her emotions and thoughts as out of control. Maria often experiences intrusive memories of the abuse, which at times can be vivid and unrelenting. She cannot predict when the thoughts will come; efforts to distract herself from them do not always work. She often drinks in response to these thoughts or his presence, as she has found that alcohol can dull her level of distress. Maria also has difficulty falling asleep and is often awakened by nightmares. She does not usually remember the dreams, but she wakes up feeling frightened and alert and cannot go back to sleep.

Maria tries to avoid family gatherings but often feels pressured to go. Whenever she sees her uncle, she feels intense panic and anger but says she can usually "hold it together" if she avoids him. Afterward, however, she describes being overtaken by these feelings and unable to calm down. She also describes feeling physically ill and shaky. At these times, she often isolates herself, stays in her apartment, and drinks steadily for several days. Maria also reports distress pertaining to her relationship with her boyfriend. In the beginning of their relationship, she found him comforting and enjoyed his affection, but more recently, she has begun to feel anxious and unsettled around him. Maria tries to avoid sex with him, but she sometimes gives in for fear of losing the relationship. She finds it easier to have sex with him when she is drunk, but she often experiences strong feelings of dread and disgust reminiscent of her abuse. Maria feels guilty and confused about these feelings.

to be assessed and treated if the individual is to have a full recovery. There is a risk of misinterpreting trauma-related symptoms in substance abuse treatment settings. For example, avoidance symptoms in an individual with PTSD can be misinterpreted as lack of motivation or unwillingness to engage in substance abuse treatment; a counselor's efforts to address substance abuse–related behaviors in early recovery can likewise provoke an exaggerated response from a trauma survivor who has profound traumatic experiences of being trapped and controlled. Exhibit 1.3-6 lists important facts about PTSD and substance use disorders for counselors.

Sleep, PTSD, and substance use

Many people have trouble getting to sleep and/or staying asleep after a traumatic event; consequently, some have a drink or two to help them fall asleep. Unfortunately, any initially helpful effects are likely not only to wane quickly, but also to incur a negative rebound effect. When someone uses a substance before going to bed, "sleep becomes lighter and more easily disrupted," and rapid eye movement sleep (REM) "increases, with an associated increase in dreams and nightmares," as the effects wear off (Auerbach, 2003, p. 1185).

People with alcohol dependence report multiple types of sleep disturbances over time, and it is not unusual for clients to report that they cannot fall asleep without first having a drink. Both REM and slow wave sleep are reduced in clients with alcohol dependence, which is also associated with an increase in the amount of time it takes before sleep occurs, decreased overall sleep time, more nightmares, and reduced sleep efficiency. Sleep during withdrawal is "frequently marked by severe insomnia and sleep fragmentation…a loss of restful sleep and feelings of daytime fatigue. Nightmares and vivid dreams are not uncommon" (Auerbach, 2003, pp. 1185–1186).

Confounding changes in the biology of sleep that occur in clients with PTSD and substance use disorders often add to the problems of

Exhibit 1.3-6: PTSD and Substance Use Disorders: Important Treatment Facts

Profile Severity

- PTSD is one of the most common co-occurring mental disorders found in clients in substance abuse treatment (CSAT, 2005c).
- People in treatment for PTSD tend to abuse a wide range of substances, including opioids, cocaine, marijuana, alcohol, and prescription medications.
- People in treatment for PTSD and substance abuse have a more severe clinical profile than those with just one of these disorders.
- PTSD, with or without major depression, significantly increases risk for suicidality (CSAT, 2009a).

Gender Differences

- Rates of trauma-related disorders are high in men and women in substance abuse treatment.
- Women with PTSD and a substance use disorder most frequently experienced rape or witnessed a killing or injury; men with both disorders typically witnessed a killing or injury or were the victim of sudden injury or accident (Cottler, Nishith, & Compton, 2001).

Risk of Continued Cycle of Violence

- While under the influence of substances, a person is more vulnerable to traumatic events (e.g., automobile crashes, assaults).
- Perpetrators of violent assault often are under the influence of substances or test positive for substances at the time of arrest.

Treatment Complications

- It is important to recognize and help clients understand that becoming abstinent from substances does not resolve PTSD; in fact, some PTSD symptoms become worse with abstinence for some people. Both disorders must be addressed in treatment.
- Treatment outcomes for clients with PTSD and a substance use disorder are worse than for clients with other co-occurring disorders or who only abuse substances (Brown, Read, & Kahler, 2003).

recovery. Sleep can fail to return to normal for months or even years after abstinence, and the persistence of sleep disruptions appears related to the likelihood of relapse. Of particular clinical importance is the vicious cycle that can also begin during "slips"; relapse initially improves sleep, but continued drinking leads to sleep disruption. This cycle of initial reduction of an unpleasant symptom, which only ends up exacerbating the process as a whole, can take place for clients with PTSD as well as for clients with substance use disorders. There are effective cognitive–behavioral therapies and nonaddictive pharmacological interventions for sleep difficulties.

4 Screening and Assessment

IN THIS CHAPTER

- Screening and Assessment
- Barriers and Challenges to Trauma Informed Screening and Assessment
- Cross Cultural Screening and Assessment
- Choosing Instruments
- Trauma Informed Screening and Assessment
- Concluding Note

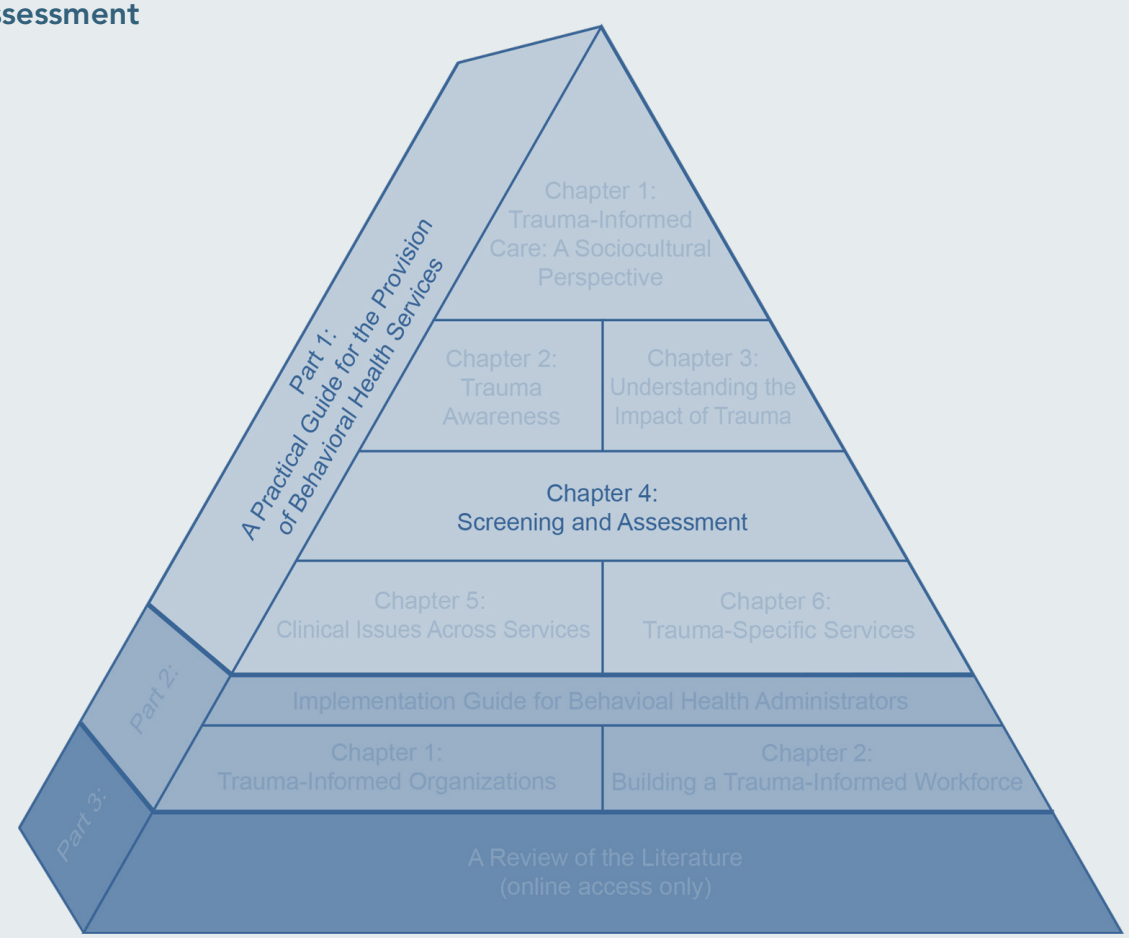
Why screen universally for trauma in behavioral health services? Exposure to trauma is common; in many surveys, more than half of respondents report a history of trauma, and the rates are even higher among clients with mental or substance use disorders. Furthermore, behavioral health problems, including substance use and mental disorders, are more difficult to treat if trauma-related symptoms and disorders aren't detected early and treated effectively (Part 3, Section 1, of this Treatment Improvement Protocol [TIP], available online, summarizes research on the prevalence of trauma and its relationship with other behavioral health problems).

Not addressing traumatic stress symptoms, trauma-specific disorders, and other symptoms/disorders related to trauma can impede successful mental health and substance abuse treatment. Unrecognized, unaddressed trauma symptoms can lead to poor engagement in treatment, premature termination, greater risk for relapse of psychological symptoms or substance use, and worse outcomes. Screening can also prevent misdiagnosis and inappropriate treatment planning. People with histories of trauma often display symptoms that meet criteria for other disorders.

Without screening, clients' trauma histories and related symptoms often go undetected, leading providers to direct services toward symptoms and disorders that may only partially explain client presentations and distress. Universal screening for trauma history and trauma-related symptoms can help behavioral health practitioners identify individuals at risk of developing more pervasive and severe symptoms of traumatic stress. Screening, early identification, and intervention serves as a prevention strategy.

Screening to identify clients who have histories of trauma and experience trauma related symptoms is a prevention strategy.

Trauma-Informed Care Framework in Behavioral Health Services—Screening and Assessment



The chapter begins with a discussion of screening and assessment concepts, with a particular focus on trauma-informed screening. It then highlights specific factors that influence screening and assessment, including timing and environment. Barriers and challenges in providing trauma-informed screening are discussed, along with culturally specific screening and assessment considerations and guidelines. Instrument selection, trauma-informed screening and assessment tools, and trauma-informed screening and assessment processes are reviewed as well. For a more research-oriented perspective on screening and assessment for traumatic stress disorders, please refer to the literature review provided in Part 3 of this TIP, which is available online.

Screening and Assessment

Screening

The first two steps in screening are to determine whether the person has a history of trauma and whether he or she has trauma-related symptoms. Screening mainly obtains answers to "yes" or "no" questions: "Has this client experienced a trauma in the past?" and "Does this client at this time warrant further assessment regarding trauma-related symptoms?" If someone acknowledges a trauma history, then further screening is necessary to determine whether trauma-related symptoms are present. However, the presence of such symptoms does not necessarily say anything about their severity, nor does a positive screen indicate that a disorder actually exists. Positive

Screening is often the first contact between the client and the treatment provider, and the client forms his or her first impression of treatment during this intake process. Thus, how screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client.

screens only indicate that assessment or further evaluation is warranted, and negative screens do not necessarily mean that an individual doesn't have symptoms that warrant intervention.

Screening procedures should always define the steps to take after a positive or negative screening. That is, the screening process establishes precisely how to score responses to screening tools or questions and clearly defines what constitutes a positive score (called a "cut-off score") for a particular potential problem. The screening procedures detail the actions to take after a client scores in the positive range. Clinical supervision is helpful—and sometimes necessary—in judging how to proceed.

Trauma-informed screening is an essential part of the intake evaluation and the treatment planning process, but it is not an end in itself. Screening processes can be developed that allow staff without advanced degrees or graduate-level training to conduct them, whereas assessments for trauma-related disorders require a mental health professional trained in assessment and evaluation processes. The most important domains to screen among individuals with trauma histories include:

- Trauma-related symptoms.
- Depressive or dissociative symptoms, sleep disturbances, and intrusive experiences.
- Past and present mental disorders, including typically trauma-related disorders (e.g., mood disorders).
- Severity or characteristics of a specific trauma type (e.g., forms of interpersonal violence, adverse childhood events, combat experiences).
- Substance abuse.
- Social support and coping styles.
- Availability of resources.
- Risks for self-harm, suicide, and violence.
- Health screenings.

Assessment

When a client screens positive for substance abuse, trauma-related symptoms, or mental disorders, the agency or counselor should follow up with an assessment. A positive screening calls for more action—an assessment that determines and defines presenting struggles to develop an appropriate treatment plan and to make an informed and collaborative decision about treatment placement. Assessment determines the nature and extent of the client's problems; it might require the client to respond to written questions, or it could involve a clinical interview by a mental health or substance abuse professional qualified to assess the client and arrive at a diagnosis. A clinical assessment delves into a client's past and current experiences, psychosocial and cultural history, and assets and resources.

Assessment protocols can require more than a single session to complete and should also use multiple avenues to obtain the necessary clinical information, including self-assessment tools, past and present clinical and medical records, structured clinical interviews, assessment measures, and collateral information from significant others, other behavioral health professionals, and agencies. Qualifications for conducting assessments and clinical interviews are more rigorous than for screening. Advanced degrees, licensing or certification, and special training in administration, scoring, and interpretation of specific assessment instruments and interviews are often

Advice to Counselors: Screening and Assessing Clients

- Ask all clients about any possible history of trauma; use a checklist to increase proper identification of such a history (see the online Adverse Childhood Experiences Study Score Calculator [http://acestudy.org/ace_score] for specific questions about adverse childhood experiences).
- Use only validated instruments for screening and assessment.
- Early in treatment, screen all clients who have histories of exposure to traumatic events for psychological symptoms and mental disorders related to trauma.
- When clients screen positive, also screen for suicidal thoughts and behaviors (see TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*; Center for Substance Abuse Treatment [CSAT], 2009a).
- Do not delay screening; do not wait for a period of abstinence or stabilization of symptoms.
- Be aware that some clients will not make the connection between trauma in their histories and their current patterns of behavior (e.g., alcohol and drug use and/or avoidant behavior).
- Do not require clients to describe emotionally overwhelming traumatic events in detail.
- Focus assessment on how trauma symptoms affect clients' current functioning.
- Consider using paper-and-pencil instruments for screening and assessment as well as self-report measures when appropriate; they are less threatening for some clients than a clinical interview.
- Talk about how you will use the findings to plan the client's treatment, and discuss any immediate action necessary, such as arranging for interpersonal support, referrals to community agencies, or moving directly into the active phase of treatment. It is helpful to explore the strategies clients have used in the past that have worked to relieve strong emotions (Fallot & Harris, 2001).
- At the end of the session, make sure the client is grounded and safe before leaving the interview room (Litz, Miller, Ruef, & McTeague, 2002). Readiness to leave can be assessed by checking on the degree to which the client is conscious of the current environment, what the client's plan is for maintaining personal safety, and what the client's plans are for the rest of the day.

required. Counselors must be familiar with (and obtain) the level of training required for any instruments they consider using.

For people with histories of traumatic life events who screen positive for possible trauma-related symptoms and disorders, thorough assessment gathers all relevant information necessary to understand the role of the trauma in their lives; appropriate treatment objectives, goals, planning, and placement; and any ongoing diagnostic and treatment considerations, including reevaluation or follow-up.

Overall, assessment may indicate symptoms that meet diagnostic criteria for a substance use or mental disorder or a milder form of symptomatology that doesn't reach a diagnostic level—or it may reveal that the positive screen was false and that there is no significant cause for concern. Information from an assessment is used to plan the client's treatment. The plan can include such domains as level of care, acute safety needs, diagnosis, disability, strengths and skills, support network, and cultural context. Assessments should reoccur throughout treatment. Ongoing assessment during treatment can provide valuable information by revealing further details of trauma history as clients' trust in staff members grows and by gauging clients' progress.

Timing of Screening and Assessment

As a trauma-informed counselor, you need to offer psychoeducation and support from the outset of service provision; this begins with explaining screening and assessment and with proper pacing of the initial intake and evaluation process. The client should understand the screening process, why the specific questions are important, and that he or she may choose to delay a response or to not answer a question

at all. Discussing the occurrence or consequences of traumatic events can feel as unsafe and dangerous to the client as if the event were reoccurring. It is important not to encourage avoidance of the topic or reinforce the belief that discussing trauma-related material is dangerous, but be sensitive when gathering information in the initial screening. Initial questions about trauma should be general and gradual. Taking the time to prepare and explain the screening and assessment process to the client gives him or her a greater sense of control and safety over the assessment process.

Clients with substance use disorders

No screening or assessment of trauma should occur when the client is under the influence of alcohol or drugs. Clients under the influence are more likely to give inaccurate information. Although it's likely that clients in an active phase of use (albeit not at the assessment itself) or undergoing substance withdrawal can provide consistent information to obtain a valid screening and assessment, there is insufficient data to know for sure. Some theorists state that no final assessment of trauma or posttraumatic stress disorder (PTSD) should occur during these early phases (Read, Bollinger, & Sharkansky, 2003), asserting that symptoms of withdrawal can mimic PTSD and thus result in overdiagnosis of PTSD and other trauma-related disorders. Alcohol or drugs can also cause memory impairment that clouds the client's history of trauma symptoms. However, Najavits (2004) and others note that underdiagnosis, not overdiagnosis, of trauma and PTSD has been a significant issue in the substance abuse field and thus claim that it is essential to obtain an initial assessment early, which can later be modified if needed (e.g., if the client's symptom pattern changes). Indeed, clinical observations suggest that assessments for both trauma and PTSD—even during active use or withdrawal—appear robust (Coffey, Schumacher, Brady, & Dansky, 2003). Although some PTSD symptoms and trauma memories can be dampened or increased to a degree, their overall presence or absence, as assessed early in treatment, appears accurate (Najavits, 2004).

Conduct Assessments Throughout Treatment

Ongoing assessments let counselors:

- Track changes in the presence, frequency, and intensity of symptoms.
- Learn the relationships among the client's trauma, presenting psychological symptoms, and substance abuse.
- Adjust diagnoses and treatment plans as needed.
- Select prevention strategies to avoid more pervasive traumatic stress symptoms.

The Setting for Trauma Screening and Assessment

Advances in the development of simple, brief, and public-domain screening tools mean that at least a basic screening for trauma can be done in almost any setting. Not only can clients be screened and assessed in behavioral health treatment settings; they can also be evaluated in the criminal justice system, educational settings, occupational settings, physicians' offices, hospital medical and trauma units, and emergency rooms. Wherever they occur, trauma-related screenings and subsequent assessments can reduce or eliminate wasted resources, relapses, and, ultimately, treatment failures among clients who have histories of trauma, mental illness, and/or substance use disorders.

Creating an effective screening and assessment environment

You can greatly enhance the success of treatment by paying careful attention to how you approach the screening and assessment process. Take into account the following points:

- ***Clarify for the client what to expect in the screening and assessment process.*** For example, tell the client that the screening and assessment phase focuses on identifying issues that might benefit from treatment. Inform him or her that during the trauma screening and assessment process, uncomfortable thoughts and feelings can arise. Provide reassurance that, if they do, you'll assist in dealing with this distress—but also let them know that, even with your assistance, some psychological and physical reactions to the interview may last for a few hours or perhaps as long as a few days after the interview, and be sure to highlight the fact that such reactions are normal (Read et al., 2003).
- ***Approach the client in a matter-of-fact, yet supportive, manner.*** Such an approach helps create an atmosphere of trust, respect, acceptance, and thoughtfulness (Melnick & Bassuk, 2000). Doing so helps to normalize symptoms and experiences generated by the trauma; consider informing clients that such events are common but can cause continued emotional distress if they are not treated. Clients may also find it helpful for you to explain the purpose of certain difficult questions. For example, you could say, "Many people have experienced troubling events as children, so some of my questions are about whether you experienced any such events while growing up." Demonstrate kindness and directness in equal measure when screening/assessing clients (Najavits, 2004).
- ***Respect the client's personal space.*** Cultural and ethnic factors vary greatly regarding the appropriate physical distance to maintain during the interview. You should respect the client's personal space, sitting neither too far from nor too close to the client; let your observations of the client's comfort level during the screening and assessment process guide the amount of distance. Clients with trauma may have particular sensitivity about their bodies, personal space, and boundaries.
- ***Adjust tone and volume of speech to suit the client's level of engagement and degree of comfort in the interview process.*** Strive to maintain a soothing, quiet demeanor. Be sensitive to how the client might hear what you have to say in response to personal disclosures. Clients who have been traumatized may be more reactive even to benign or well-intended questions.
- ***Provide culturally appropriate symbols of safety in the physical environment.*** These include paintings, posters, pottery, and other room decorations that symbolize the safety of the surroundings to the client population. Avoid culturally inappropriate or insensitive items in the physical environment.
- ***Be aware of one's own emotional responses to hearing clients' trauma histories.*** Hearing about clients' traumas may be very painful and can elicit strong emotions. The client may interpret your reaction to his or her revelations as disinterest, disgust for the client's behavior, or some other inaccurate interpretation. It is important for you to monitor your interactions and to check in with the client as necessary. You may also feel emotionally drained to the point that it interferes with your ability to accurately listen to or assess clients. This effect of exposure to traumatic stories, known as secondary traumatization, can result in symptoms similar to those experienced by the client (e.g., nightmares, emotional numbing); if necessary, refer to a colleague for assessment (Valent, 2002). Secondary traumatization is addressed in greater detail in Part 2, Chapter 2, of this TIP.
- ***Overcome linguistic barriers via an interpreter.*** Deciding when to add an interpreter requires careful judgment. The interpreter should be knowledgeable of behavioral

health terminology, be familiar with the concepts and purposes of the interview and treatment programming, be unknown to the client, and be part of the treatment team. Avoid asking family members or friends of the client to serve as interpreters.

- ***Elicit only the information necessary for determining a history of trauma and the possible existence and extent of traumatic stress symptoms and related disorders.*** There is no need to probe deeply into the details of a client's traumatic experiences at this stage in the treatment process. Given the lack of a therapeutic relationship in which to process the information safely, pursuing details of trauma can cause retraumatization or produce a level of response that neither you nor your client is prepared to handle. Even if a client wants to tell his or her trauma story, it's your job to serve as "gatekeeper" and preserve the client's safety. Your tone of voice when suggesting postponement of a discussion of trauma is very important. Avoid conveying the message, "I really don't want to hear about it." Examples of appropriate statements are:
  - "Your life experiences are very important, but at this early point in our work together, we should start with what's going on in your life currently rather than discussing past experiences in detail. If you feel that certain past experiences are having a big effect on your life now, it would be helpful for us to discuss them as long as we focus on your safety and recovery right now."
  - "Talking about your past at this point could arouse intense feelings—even more than you might be aware of right now. Later, if you choose to, you can talk with your counselor about how to work on exploring your past."
  - "Often, people who have a history of trauma want to move quickly into the details of the trauma to gain relief. I understand this desire, but my concern for you at this moment is to help you establish a sense of safety and support before moving into the traumatic experiences. We want to avoid retraumatization—meaning, we want to establish resources that weren't available to you at the time of the trauma before delving into more content."
- ***Give the client as much personal control as possible during the assessment by:***
  - Presenting a rationale for the interview and its stress-inducing potential, making clear that the client has the right to refuse to answer any and all questions.
  - Giving the client (where staffing permits) the option of being interviewed by someone of the gender with which he or she is most comfortable.
  - Postponing the interview if necessary (Fallot & Harris, 2001).
- ***Use self-administered, written checklists rather than interviews when possible to assess trauma.*** Traumas can evoke shame, guilt, anger, or other intense feelings that can make it difficult for the client to report them aloud to an interviewer. Clients are more likely to report trauma when they use self-administered screening tools; however, these types of screening instruments only guide the next step. Interviews should coincide with self-administered tools to create a sense of safety for the client (someone is present as he or she completes the screening) and to follow up with more indepth data gathering after a self-administered screening is complete. The Trauma History Questionnaire (THQ) is a self-administered tool (Green, 1996). It has been used successfully with clinical and nonclinical populations, including medical patients, women who have experienced domestic violence, and people with serious mental illness (Hooper, Stockton,

Krupnick, & Green, 2011). Screening instruments (including the THQ) are included in Appendix D of this TIP.

- ***Interview the client if he or she has trouble reading or writing or is otherwise unable to complete a checklist.*** Clients who are likely to minimize their trauma when using a checklist (e.g., those who exhibit significant symptoms of dissociation or repression) benefit from a clinical interview. A trained interviewer can elicit information that a self-administered checklist does not capture. Overall, using both a self-administered questionnaire and an interview can help achieve greater clarity and context.
- ***Allow time for the client to become calm and oriented to the present if he or she has very intense emotional responses when recalling or acknowledging a trauma.*** At such times, avoid responding with such exclamations as "I don't know how you survived that!" (Bernstein, 2000). If the client has difficulty self-soothing, guide him or her through grounding techniques (Exhibit 1.4-1), which are particularly useful—perhaps even critical—to achieving a successful

Exhibit 1.4-1: Grounding Techniques

Grounding techniques are important skills for assessors and all other behavioral health service providers who interact with traumatized clients (e.g., nurses, security, administrators, clinicians). Even if you do not directly conduct therapy, knowledge of grounding can help you defuse an escalating situation or calm a client who is triggered by the assessment process. Grounding strategies help a person who is overwhelmed by memories or strong emotions or is dissociating; they help the person become aware of the here and now. A useful metaphor is the experience of walking out of a movie theater. When the person dissociates or has a flashback, it's like watching a mental movie; grounding techniques help him or her step out of the movie theater into the daylight and the present environment. The client's task is not only to hold on to moments from the past, but also to acknowledge that what he or she was experiencing is from the past. Try the following techniques:

1. **Ask the client to state what he or she observes.**
   Guide the client through this exercise by using statements like, "You seem to feel very scared/angry right now. You're probably feeling things related to what happened in the past. Now, you're in a safe situation. Let's try to stay in the present. Take a slow deep breath, relax your shoulders, put your feet on the floor; let's talk about what day and time it is, notice what's on the wall, etc. What else can you do to feel okay in your body right now?"
2. **Help the client decrease the intensity of affect.**
   - "Emotion dial": A client imagines turning down the volume on his or her emotions.
   - Clenching fists can move the energy of an emotion into fists, which the client can then release.
   - Guided imagery can be used to visualize a safe place.
   - Distraction (see #3 below).
   - Use strengths-based questions (e.g., "How did you survive?" or "What strengths did you possess to survive the trauma?").
3. **Distract the client from unbearable emotional states.**
   - Have the client focus on the external environment (e.g., name red objects in the room).
   - Ask the client to focus on recent and future events (e.g., "to do" list for the day).
   - Help the client use self-talk to remind himself or herself of current safety.
   - Use distractions, such as counting, to return the focus to current reality.
   - Somatosensory techniques (toe-wiggling, touching a chair) can remind clients of current reality.
4. **Ask the client to use breathing techniques.**
   - Ask the client to inhale through the nose and exhale through the mouth.
   - Have the client place his or her hands on his or her abdomen and then watch the hands go up and down while the belly expands and contracts.

Source: Melnick & Bassuk, 2000.

interview when a client has dissociated or is experiencing intense feelings in response to screening and/or interview questions.

- ***Avoid phrases that imply judgment about the trauma.*** For example, don't say to a client who survived Hurricane Katrina and lost family members, "It was God's will," or "It was her time to pass," or "It was meant to be." Do not make assumptions about what a person has experienced. Rather, listen supportively without imposing personal views on the client's experience.
- ***Provide feedback about the results of the screening.*** Keep in mind the client's vulnerability, ability to access resources, strengths, and coping strategies. Present results in a synthesized manner, avoiding complicated, overly scientific jargon or explanations. Allow time to process client reactions during the feedback session. Answer client questions and concerns in a direct, honest, and compassionate manner. Failure to deliver feedback in this way can negatively affect clients' psychological status and severely weaken the potential for developing a therapeutic alliance with the client.
- ***Be aware of the possible legal implications of assessment.*** Information you gather during the screening and assessment process can necessitate mandatory reporting to authorities, even when the client does not want such information disclosed (Najavits, 2004). For example, you can be required to report a client's experience of child abuse even if it happened many years ago or the client doesn't want the information reported. Other legal issues can be quite complex, such as confidentiality of records, pursuing a case against a trauma perpetrator and divulging information to third parties while still protecting the legal status of information used in prosecution, and child custody issues (Najavits, 2004). It's essential that you know the laws in your State, have an expert legal consultant available, and access clinical supervision.

Barriers and Challenges to Trauma-Informed Screening and Assessment

Barriers

It is not necessarily easy or obvious to identify an individual who has survived trauma without screening. Moreover, some clients may deny that they have encountered trauma and its effects even after being screened or asked direct questions aimed at identifying the occurrence of traumatic events. The two main barriers to the evaluation of trauma and its related disorders in behavioral health settings are clients not reporting trauma and providers overlooking trauma and its effects.

Concerning the first main barrier, some events will be experienced as traumatic by one person but considered nontraumatic by another. A history of trauma encompasses not only the experience of a potentially traumatic event, but also the person's responses to it and the meanings he or she attaches to the event. Certain situations make it more likely that the client will not be forthcoming about traumatic events or his or her responses to those events. Some clients might not have ever thought of a particular event or their response to it as traumatic and thus might not report or even recall the event. Some clients might feel a reluctance to discuss something that they sense might bring up uncomfortable feelings (especially with a counselor whom they've only recently met). Clients may avoid openly discussing traumatic events or have difficulty recognizing or articulating their experience of trauma for other reasons, such as feelings of shame, guilt, or fear of retribution by others associated with the event (e.g., in cases of interpersonal or

Common Reasons Why Some Providers Avoid Screening Clients for Trauma

Treatment providers may avoid screening for traumatic events and trauma-related symptoms due to:

- A reluctance to inquire about traumatic events and symptoms because these questions are not a part of the counselor's or program's standard intake procedures.
- Underestimation of the impact of trauma on clients' physical and mental health.
- A belief that treatment of substance abuse issues needs to occur first and exclusively, before treating other behavioral health disorders.
- A belief that treatment should focus solely on presenting symptoms rather than exploring the potential origins or aggravators of symptoms.
- A lack of training and/or feelings of incompetence in effectively treating trauma-related problems (Salyers, Evans, Bond, & Meyer, 2004).
- Not knowing how to respond therapeutically to a client's report of trauma.
- Fear that a probing trauma inquiry will be too disturbing to clients.
- Not using common language with clients that will elicit a report of trauma (e.g., asking clients if they were abused as a child without describing what is meant by abuse).
- Concern that if disorders are identified, clients will require treatment that the counselor or program does not feel capable of providing (Fallot & Harris, 2001).
- Insufficient time for assessment to explore trauma histories or symptoms.
- Untreated trauma-related symptoms of the counselor, other staff members, and administrators.

domestic violence). Still others may deny their history because they are tired of being interviewed or asked to fill out forms and may believe it doesn't matter anyway.

A client may not report past trauma for many reasons, including:

- Concern for safety (e.g., fearing more abuse by a perpetrator for revealing the trauma).
- Fear of being judged by service providers.
- Shame about victimization.
- Reticence about talking with others in response to trauma.
- Not recalling past trauma through dissociation, denial, or repression (although genuine blockage of all trauma memory is rare among trauma survivors; McNally, 2003).
- Lack of trust in others, including behavioral health service providers.
- Not seeing a significant event as traumatic.

Regarding the second major barrier, counselors and other behavioral health service providers may lack awareness that trauma can significantly affect clients' presentations in treatment and functioning across major life areas, such as relationships and work. In addition, some counselors may believe that their role is to treat only the presenting psychological and/or substance abuse symptoms, and thus they may not be as sensitive to histories and effects of trauma. Other providers may believe that a client should abstain from alcohol and drugs for an extended period before exploring trauma symptoms. Perhaps you fear that addressing a clients' trauma history will only exacerbate symptoms and complicate treatment. Behavioral health service providers who hold biases may assume that a client doesn't have a history of trauma and thus fail to ask the "right" questions, or they may be uncomfortable with emotions that arise from listening to client experiences and, as a result, redirect the screening or counseling focus.

Challenges

Awareness of acculturation and language

Acculturation levels can affect screening and assessment results. Therefore, indepth discussions may be a more appropriate way to gain an understanding of trauma from the client's point of view. During the intake, prior to trauma screening, determine the client's history of

Common Assessment Myths

Several common myths contribute to underassessment of trauma-related disorders (Najavits, 2004):

- ***Myth #1: Substance abuse itself is a trauma.*** However devastating substance abuse is, it does not meet the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), criteria for trauma per se. Nevertheless, high-risk behaviors that are more likely to occur during addiction, such as interpersonal violence and self-harm, significantly increase the potential for traumatic injury.
- ***Myth #2: Assessment of trauma is enough.*** Thorough assessment is the best way to identify the existence and extent of trauma-related problems. However, simply identifying trauma-related symptoms and disorders is just the first step. Also needed are individualized treatment protocols and action to implement these protocols.
- ***Myth #3: It is best to wait until the client has ended substance use and withdrawal to assess for PTSD.*** Research does not provide a clear answer to the controversial question of when to assess for PTSD; however, Najavits (2004) and others note that underdiagnosis of trauma and PTSD has been more significant in the substance abuse field than overdiagnosis. Clinical experience shows that the PTSD diagnosis is rather stable during substance use or withdrawal, but symptoms can become more or less intense; memory impairment from alcohol or drugs can also cloud the symptom picture. Thus, it is advisable to establish a tentative diagnosis and then reassess after a period of abstinence, if possible.

migration, if applicable, and primary language. Questions about the client's country of birth, length of time in this country, events or reasons for migration, and ethnic self-identification are also appropriate at intake. Also be aware that even individuals who speak English well might have trouble understanding the subtleties of questions on standard screening and assessment tools. It is not adequate to translate items simply from English into another language; words, idioms, and examples often don't translate directly into other languages and therefore need to be adapted. Screening and assessment should be conducted in the client's preferred language by trained staff members who speak the language or by professional translators familiar with treatment jargon.

Awareness of co-occurring diagnoses

A trauma-informed assessor looks for psychological symptoms that are associated with trauma or simply occur alongside it. Symptom screening involves questions about past or present mental disorder symptoms that may indicate the need for a full mental health assessment. A variety of screening tools are available, including symptom checklists. However, you should only use symptom checklists when you need information about how your client is currently feeling; don't use them to screen for specific disorders. Responses will likely change from one administration of the checklist to the next.

Basic mental health screening tools are available. For example, the Mental Health Screening Form-III screens for present or past symptoms of most mental disorders (Carroll & McGinley, 2001); it is available at no charge from Project Return Foundation, Inc. and is also reproduced in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c). Other screening tools, such as the Beck Depression Inventory II and the Beck Anxiety Inventory (Beck, Wright, Newman, & Liese, 1993), also screen broadly for mental and substance use disorders, as well as for specific disorders often associated with trauma. For further screening information and resources on depression and suicide, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008), and TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a).

For screening substance use disorders, see TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT, 1994); TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT, 1997a); TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT, 1999c); TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c); and TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d).

A common dilemma in the assessment of trauma-related disorders is that certain trauma symptoms are also symptoms of other disorders. Clients with histories of trauma typically present a variety of symptoms; thus, it is important to determine the full scope of symptoms and/or disorders present to help improve treatment planning. Clients with trauma-related and substance use symptoms and disorders are at increased risk for additional Axis I and/or Axis II mental disorders (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Cottler, Nishith, & Compton, 2001). These symptoms need to be distinguished so that other presenting subclinical features or disorders do not go unidentified and untreated. To accomplish this, a comprehensive assessment of the client's mental health is recommended.

Misdiagnosis and underdiagnosis

Many trauma survivors are either misdiagnosed (i.e., given diagnoses that are not accurate) or underdiagnosed (i.e., have one or more diagnoses that have not been identified at all). Such diagnostic errors could result, in part, from the fact that many general instruments to evaluate mental disorders are not sufficiently sensitive to identify posttraumatic symptoms and can misclassify them as other disorders, including personality disorders or psychoses. Intrusive posttraumatic symptoms, for example, can show up on general measures as indicative of hallucinations or obsessions. Dissociative symptoms can be interpreted as indicative of schizophrenia. Trauma-based cognitive symptoms can be scored as evidence for paranoia or other delusional processes (Briere, 1997). Some of the most common misdiagnoses in clients with PTSD and substance abuse are:

- ***Mood and anxiety disorders.*** Overlapping symptoms with such disorders as major depression, generalized anxiety disorder, and bipolar disorder can lead to misdiagnosis.
- ***Borderline personality disorder.*** Historically, this has been more frequently diagnosed than PTSD. Many of the symptoms, including a pattern of intense interpersonal relationships, impulsivity, rapid and unpredictable mood swings, power struggles in the treatment environment, underlying anxiety and depressive symptoms, and transient, stress-related paranoid ideation or severe dissociative symptoms overlap. The effect of this misdiagnosis on treatment can be particularly negative; counselors often view clients with a borderline personality diagnosis as difficult to treat and unresponsive to treatment.
- ***Antisocial personality disorder.*** For men and women who have been traumatized in childhood, "acting out" behaviors, a lack of empathy and conscience, impulsivity, and self-centeredness can be functions of trauma and survival skills rather than true antisocial characteristics.
- ***Attention deficit hyperactivity disorder (ADHD).*** For children and adolescents, impulsive behaviors and concentration problems can be diagnosed as ADHD rather than PTSD.

It is possible, however, for clients to legitimately have any of these disorders in addition to trauma-related disorders. Given the overlap of posttraumatic symptoms with those of other disorders, a wide variety of diagnoses often needs to be considered to avoid misidentifying

other disorders as PTSD and vice versa. A trained and experienced mental health professional will be required to weigh differential diagnoses. TIP 42 (CSAT, 2005c) explores issues related to differential diagnosis.

Cross-Cultural Screening and Assessment

Many trauma-related symptoms and disorders are culture specific, and a client's cultural background must be considered in screening and assessment (for review of assessment and cultural considerations when working with trauma, see Wilson & Tang, 2007). Behavioral health service providers must approach screening and assessment processes with the influences of culture, ethnicity, and race firmly in mind. Cultural factors, such as norms for expressing psychological distress, defining trauma, and seeking help in dealing with trauma, can affect:

- How traumas are experienced.
- The meaning assigned to the event(s).
- How trauma-related symptoms are expressed (e.g., as somatic expressions of distress, level of emotionality, types of avoidant behavior).
- Willingness to express distress or identify trauma with a behavioral health service provider and sense of safety in doing so.
- Whether a specific pattern of behavior, emotional expression, or cognitive process is considered abnormal.
- Willingness to seek treatment inside and outside of one's own culture.
- Response to treatment.
- Treatment outcome.

When selecting assessment instruments, counselors and administrators need to choose,

Culture-Specific Stress Responses

Culture-bound concepts of distress exist that don't necessarily match diagnostic criteria. Culture-specific symptoms and syndromes can involve physical complaints, broad emotional reactions, or specific cognitive features. Many such syndromes are unique to a specific culture but can broaden to cultures that have similar beliefs or characteristics. Culture-bound syndromes are typically treated by traditional medicine and are known throughout the culture. Cultural concepts of distress include:

- ***Ataques de nervios.*** Recognized in Latin America and among individuals of Latino descent, the primary features of this syndrome include intense emotional upset (e.g., shouting, crying, trembling, dissociative or seizure-like episodes). It frequently occurs in response to a traumatic or stressful event in the family.
- ***Nervios.*** This is considered a common idiom of distress among Latinos; it includes a wide range of emotional distress symptoms including headaches, nervousness, tearfulness, stomach discomfort, difficulty sleeping, and dizziness. Symptoms can vary widely in intensity, as can impairment from them. This often occurs in response to stressful or difficult life events.
- ***Susto.*** This term, meaning "fright," refers to a concept found in Latin American cultures, but it is not recognized among Latinos from the Caribbean. *Susto* is attributed to a traumatic or frightening event that causes the soul to leave the body, thus resulting in illness and unhappiness; extreme cases may result in death. Symptoms include appetite or sleep disturbances, sadness, lack of motivation, low self-esteem, and somatic symptoms.
- ***Taijin kyofusho.*** Recognized in Japan and among some American Japanese, this "interpersonal fear" syndrome is characterized by anxiety about and avoidance of interpersonal circumstances. The individual presents worry or a conviction that his or her appearance or social interactions are inadequate or offensive. Other cultures have similar cultural descriptions or syndromes associated with social anxiety.

Sources: APA, 2013, pp. 833–837; Briere & Scott, 2006b.

whenever possible, instruments that are culturally appropriate for the client. Instruments that have been normed for, adapted to, and tested on specific cultural and linguistic groups should be used. Instruments that are not normed for the population are likely to contain cultural biases and produce misleading results. Subsequently, this can lead to misdiagnosis, overdiagnosis, inappropriate treatment plans, and ineffective interventions. Thus, it is important to interpret all test results cautiously and to discuss the limitations of instruments with clients from diverse ethnic populations and cultures. For a review of cross-cultural screening and assessment considerations, refer to the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration, planned c).

Choosing Instruments

Numerous instruments screen for trauma history, indicate symptoms, assess trauma-related and other mental disorders, and identify related clinical phenomena, such as dissociation. One instrument is unlikely to meet all screening or assessment needs or to determine the existence and full extent of trauma symptoms and traumatic experiences. The following sections present general considerations in selecting standardized instruments.

Purpose

Define your assessment needs. Do you need a standardized screening or assessment instrument for clinical purposes? Do you need information on a specific aspect of trauma, such as history, PTSD, or dissociation? Do you wish to make a formal diagnosis, such as PTSD? Do you need to determine quickly whether a client has experienced a trauma? Do you want an assessment that requires a clinician to administer it, or can the client complete the instrument himself or herself? Does the instrument match the current and specific diagnostic criteria established in the DSM-5?

Population

Consider the population to be assessed (e.g., women, children, adolescents, refugees, disaster survivors, survivors of physical or sexual violence, survivors of combat-related trauma, people whose native language is not English); some tools are appropriate only for certain populations. Is the assessment process developmentally and culturally appropriate for your client? Exhibit 1.4-2 lists considerations in choosing a screening or assessment instrument for trauma and/or PTSD.

Instrument Quality

An instrument should be psychometrically adequate in terms of sensitivity and specificity or reliability and validity as measured in several ways under varying conditions. Published research offers information on an instrument's psychometric properties as well as its utility in both research and clinical settings. For further information on a number of widely used trauma evaluation tools, see Appendix D and Antony, Orsillo, and Roemer's paper (2001).

The DSM-5 and Updates to Screening and Assessment Instruments

The recent publication of the DSM-5 (APA, 2013a) reflects changes to certain diagnostic criteria, which will affect screening tools and criteria for trauma-related disorders. Criterion A2 (specific to traumatic stress disorders, acute stress, and posttraumatic stress disorders), included in the fourth edition (text revision) of the DSM (DSM-IV-TR; APA, 2000a), has been eliminated; this criterion stated that the individual's response to the trauma needs to involve intense fear, helplessness, or horror. There are now four cluster symptoms, not three: reexperiencing, avoidance, arousal, and persistent negative alterations in cognitions and mood. Changes to the DSM-5 were made to symptoms within each cluster. Thus, screening will need modification to adjust to this change (APA, 2012b).

Exhibit 1.4-2: Key Areas of Trauma Screening and Assessment

Trauma
Key question: Did the client experience a trauma?

Examples of measures: Life Stressor Checklist-Revised (Wolfe & Kimerling, 1997); Trauma History Questionnaire (Green, 1996); Traumatic Life Events Questionnaire (Kubany et al., 2000).

Note: A good trauma measure identifies events a person experienced (e.g., rape, assault, accident) and also evaluates other trauma-related symptoms (e.g., presence of fear, helplessness, or horror).

Acute Stress Disorder (ASD) and PTSD
Key question: Does the client meet criteria for ASD or PTSD?

Examples of measures: Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990); Modified PTSD Symptom Scale (Falsetti, Resnick, Resnick, & Kilpatrick, 1993); PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993); Stanford Acute Stress Reaction Questionnaire (Cardena, Koopman, Classen, Waelde, & Spiegel, 2000).

Note: A PTSD diagnosis requires the person to meet criteria for having experienced a trauma; some measures include this, but others do not and require use of a separate trauma measure. The CAPS is an interview; the others listed are self-report questionnaires and take less time.

Other Trauma-Related Symptoms
Key question: Does the client have other symptoms related to trauma? These include depressive symptoms, self-harm, dissociation, sexuality problems, and relationship issues, such as distrust.

Examples of measures: Beck Depression Inventory II (Beck, 1993; Beck et al., 1993); Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993); Impact of Event Scale (measures intrusion and avoidance due to exposure to traumatic events; Horowitz, Wilner, & Alvarez, 1979; Weiss & Marmar, 1997); Trauma Symptom Inventory (Briere, 1995); Trauma Symptom Checklist for Children (Briere, 1996b); Modified PTSD Symptom Scale (Falsetti et al., 1993).

Note: These measures can be helpful for clinical purposes and for outcome assessment because they gauge *levels* of symptoms. Trauma-related symptoms are broader than diagnostic criteria and thus useful to measure, even if the patient doesn't meet criteria for any specific diagnoses.

Other Trauma-Related Diagnoses
Key question: Does the client have other disorders related to trauma? These include mood disorders, anxiety disorders besides traumatic stress disorders, and dissociative disorders.

Examples of measures: Mental Health Screening Form III (Carroll & McGinley, 2001); The Mini-International Neuropsychiatric Interview (M.I.N.I.) Structured Clinical Interview for DSM-IV-TR, Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011); Structured Clinical Interview for DSM-IV-TR, Non-Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011a).

Note: For complex symptoms and diagnoses such as dissociation and dissociative disorders, interviews are recommended. Look for measures that incorporate DSM-5 criteria.

Sources: Antony et al., 2001; Najavits, 2004.

Practical Issues

Is the instrument freely and readily available, or is there a fee? Is costly and extensive training required to administer it? Is the instrument too lengthy to be used in the clinical setting? Is it easily administered and scored with accompanying manuals and/or other training materials? How will results be presented to or used with the client? Is technical support available for difficulties in administration, scoring, or interpretation of results? Is special equipment required such as a microphone, a video camera, or a touch-screen computer with audio?

Trauma-Informed Screening and Assessment

The following sections focus on initial screening. For more information on screening and assessment tools, including structured interviews, see Exhibit 1.4-2. Screening is only as good as the actions taken afterward to address a positive screen (when clients acknowledge that they experience symptoms or have encountered events highlighted within the screening). Once a screening is complete and a positive screen is acquired, the client then needs referral for a more indepth assessment to ensure development of an appropriate treatment plan that matches his or her presenting problems.

Establish a History of Trauma

A person cannot have ASD, PTSD, or any trauma-related symptoms without experiencing trauma; therefore, it is necessary to inquire about painful, difficult, or overwhelming past experiences. Initial information should be gathered in a way that is minimally intrusive yet clear. Brief questionnaires can be less threatening to a client than face-to-face interviews, but interviews should be an integral part of any screening and assessment process. If the client initially denies a history of trauma (or minimizes it), administer the questionnaire later or delay additional trauma-related questions until the client has perhaps developed more trust in the treatment setting and feels safer with the thoughts and emotions that might arise in discussing his or her trauma experiences.

The Stressful Life Experiences (SLE) screen (Exhibit 1.4-3) is a checklist of traumas that also considers the client's view of the impact of those events on life functioning. Using the SLE can foster the client–counselor relationship. By going over the answers with the client, you can gain a deep understanding of your client, and the client receives a demonstration of your sensitivity and concern for what the client has experienced. The National Center for PTSD Web site offers similar instruments (http://www.ptsd.va.gov/professional/pages/assessments/assessment.asp).

In addition to broad screening tools that capture various traumatic experiences and symptoms, other screening tools, such as the Combat Exposure Scale (Keane et al., 1989) and the Intimate Partner Violence Screening Tool (Exhibit 1.4-4), focus on acknowledging a specific type of traumatic event.

Screen for Trauma-Related Symptoms and Disorders in Clients With Histories of Trauma

This step evaluates whether the client's trauma resulted in subclinical or diagnosable disorders. The counselor can ask such questions as, "Have you received any counseling or therapy? Have you ever been diagnosed or treated for a psychological disorder in the past? Have you ever been prescribed medications for your emotions in the past?" Screening is typically conducted by a wide variety of behavioral health service providers with different levels of training and education; however, all

Exhibit 1.4-3: SLE Screening

Please fill in the number that best represents how much the following statements describe your experiences. You will need to use two scales, one for how well the statement describes your experiences and one for how stressful you found this experience. The two scales are below.

Describes your Experience:

0	1	2	3	4	5	6	7	8	9	10
Did not experience this	a little like my experiences				somewhat like my experiences					exactly like my experiences

Stressfulness of Experience:

0	1	2	3	4	5	6	7	8	9	10
Not at all stressful	not very stressful				somewhat stressful					extremely stressful

Describes your Experience	Life Experience	Stressfulness Then		Stressfulness Now
	I have witnessed or experienced a natural disaster; like a hurricane or earthquake.			
	I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.			
	I have witnessed or experienced a serious accident or injury.			
	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.			
	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.			
	I have witnessed or experienced the death of my spouse or child.			
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).			
	I or a close friend or family member has been kidnapped or taken hostage.			
	I or a close friend or family member has been the victim of a terrorist attack or torture.			
	I have been involved in combat or a war or lived in a war affected area.			
	I have seen or handled dead bodies other than at a funeral.			
	I have felt responsible for the serious injury or death of another person.			
	I have witnessed or been attacked with a weapon other than in combat or family setting			
	As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury			
	As an adult, I was hit, choked or pushed hard enough to cause injury.			
	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.			
	As a child/teen I was forced to have unwanted sexual contact.			
	As an adult I was forced to have unwanted sexual contact.			
	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact			
	I have witnessed or experienced an extremely stressful event not already mentioned. Please Explain:_____ _____			

Sources: Hudnall Stamm, 1996, 1997. Used with permission.

Exhibit 1.4-4: STaT Intimate Partner Violence Screening Tool

1. Have you ever been in a relationship where your partner has pushed or **Slapped** you?
2. Have you ever been in a relationship where your partner **Threatened** you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken, or punched **Things**?

Source: Paranjape & Liebschutz, 2003. Used with permission

individuals who administer screenings, regardless of education level and experience, should be aware of trauma-related symptoms, grounding techniques, ways of creating safety for the client, proper methods for introducing screening tools, and the protocol to follow when a positive screen is obtained. (See Appendix D for information on specific instruments.) Exhibit 1.4-5 is an example of a screening instrument for trauma symptoms, the Primary Care PTSD (PC-PTSD) Screen. Current research (Prins et al., 2004) suggests that the optimal cutoff score for the PC-PTSD is 3. If sensitivity is of greater concern than efficiency, a cutoff score of 2 is recommended.

Exhibit 1.4-5: PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…

1. Have had nightmares about it or thought about it when you did not want to?
   YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES NO
3. Were constantly on guard, watchful, or easily startled?
   YES NO
4. Felt numb or detached from others, activities, or your surroundings?
   YES NO

Source: Prins et al., 2004. Material used is in the public domain.

Another instrument that can screen for traumatic stress symptoms is the four-item self-report SPAN, summarized in Exhibit 1.4-6, which is derived from the 17-item Davidson Trauma Scale (DTS). SPAN is an acronym for the four items the screening addresses: startle, physiological arousal, anger, and numbness. It was developed using a small, diverse sample of adult patients (N=243; 72 percent women; 17.4 percent African American; average age = 37 years) participating in several clinical studies, including a family study of rape trauma, combat veterans, and Hurricane Andrew survivors, among others.

The SPAN has a high diagnostic accuracy of 0.80 to 0.88, with sensitivity (percentage of true positive instances) of 0.84 and specificity (percentage of true negative instances) of 0.91 (Meltzer-Brody, Churchill, & Davidson, 1999). SPAN scores correlated highly with the full DTS (r = 0.96) and other measures, such as the Impact of Events Scale (r = 0.85) and the Sheehan Disability Scale (r = 0.87).

The PTSD Checklist (Exhibit 1.4-7), developed by the National Center for PTSD, is in the public domain. Originally developed for combat veterans of the Vietnam and Persian

Exhibit 1.4-6: The SPAN

The SPAN instrument is a brief screening tool that asks clients to identify the trauma in their past that is most disturbing to them currently. It then poses four questions that ask clients to rate the frequency and severity with which they have experienced, in the past week, different types of trauma-related symptoms (startle, physiological arousal, anger, and numbness).

To order this screening instrument, use the following contact information:
Multi-Health Systems, Inc.
P.O. Box 950
North Tonawanda, NY
14120-0950
Phone: 800-456-3003

Source: Meltzer-Brody et al., 1999.

Exhibit 1.4-7: The PTSD Checklist

Instructions to Client: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully and circle the number that indicates how much you have been bothered by that problem *in the past month*.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
2. Repeated, disturbing dreams of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
4. Feeling very upset when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
7. Avoiding activities or situations because they reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
8. Trouble remembering important parts of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
9. Loss of interest in activities that you used to enjoy?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
10. Feeling distant or cut off from other people?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
12. Feeling as if your future will somehow be cut short?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
13. Trouble falling or staying asleep?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
14. Feeling irritable or having angry outbursts?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
15. Having difficulty concentrating?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
16. Being "super-alert" or watchful or on guard?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
17. Feeling jumpy or easily startled?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Source: Weathers et al., 1993. Material used is in the public domain.

Gulf Wars, it has since been validated on a variety of noncombat traumas (Keane, Brief, Pratt, & Miller, 2007). When using the checklist, identify a specific trauma first and then have the client answer questions in relation to that one specific trauma.

Other Screening and Resilience Measures

Along with identifying the presence of trauma-related symptoms that warrant assessment to determine the severity of symptoms as well as whether or not the individual possesses subclinical symptoms or has met criteria for a trauma-related disorder, clients should receive other screenings for symptoms associated with trauma (e.g., depression, suicidality). It is important that screenings address both external and internal resources (e.g., support systems, strengths, coping styles). Knowing the client's strengths can significantly shape the treatment planning process by allowing you to use strategies that have already worked for the client and incorporating strategies to build resilience (Exhibit 1.4-8).

Exhibit 1.4-8: Resilience Scales

A number of scales with good psychometric properties measure resilience:

- Resilience Scale (Wagnild & Young, 1993)
- Resilience Scale for Adults (Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003)
- Connor Davidson Resilience Scale, 25-,10-, and 2-Item (Connor & Davidson, 2003; Campbell-Sills & Stein, 2007; Vaishnavi, Connor, & Davidson, 2007, respectively)
- Dispositional Resilience Scale, 45-,30-, 15-item forms (Bartone, Roland, Picano, &Williams, 2008)

Preliminary research shows improvement of individual resilience through treatment interventions in other populations (Lavretsky, Siddarth, & Irwin, 2010).

Screen for suicidality

All clients—particularly those who have experienced trauma—should be screened for suicidality by asking, "In the past, have you ever had suicidal thoughts, had intention to commit suicide, or made a suicide attempt? Do you have any of those feelings now? Have you had any such feelings recently?" Behavioral health service providers should receive training to screen for suicide. Additionally, clients with substance use disorders and a history of psychological trauma are at heightened risk for suicidal thoughts and behaviors; thus, screening for suicidality is indicated. See TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a). For additional descriptions of screening processes for suicidality, see TIP 42 (CSAT, 2005c).

Concluding Note

Screenings are only beneficial if there are follow-up procedures and resources for handling positive screens, such as the ability to review results with and provide feedback to the individual after the screening, sufficient resources to complete a thorough assessment or to make an appropriate referral for an assessment, treatment planning processes that can easily incorporate additional trauma-informed care objectives and goals, and availability and access to trauma-specific services that match the client's needs. Screening is only the first step!

5 Clinical Issues Across Services

IN THIS CHAPTER

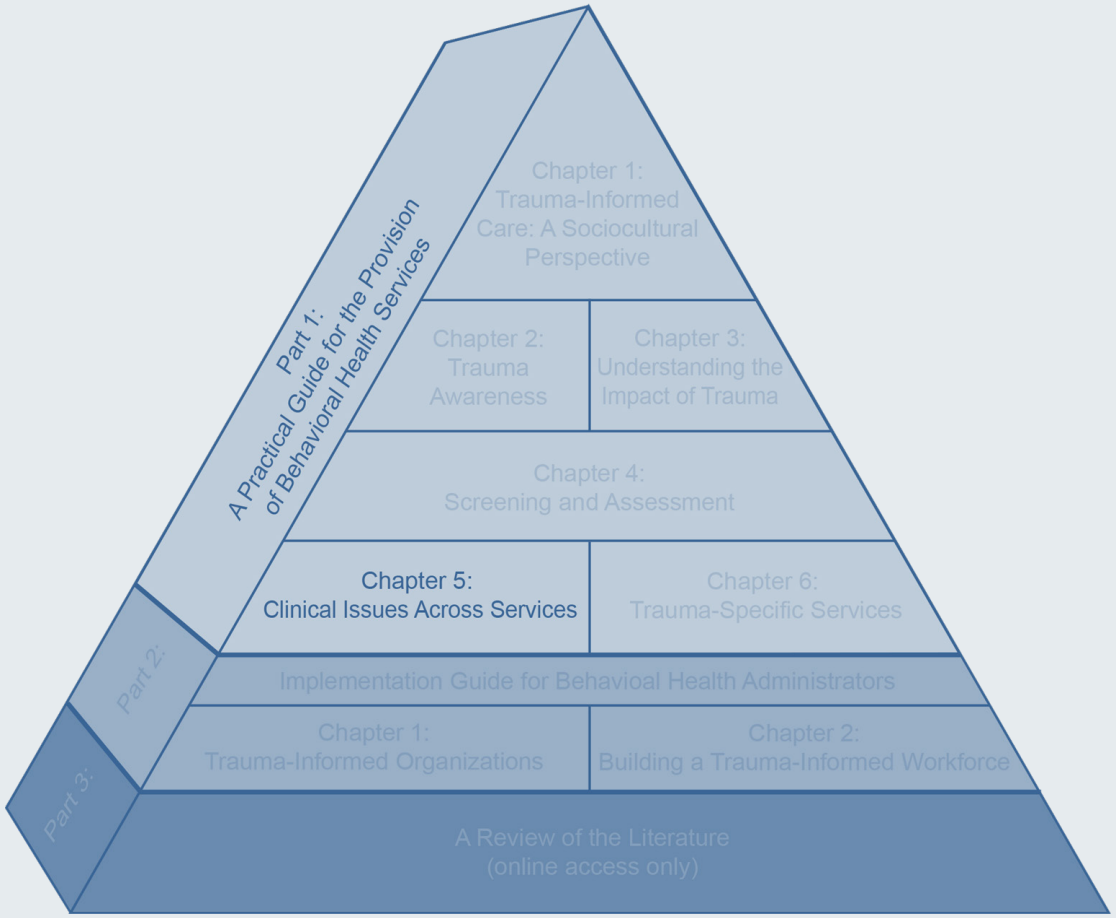
- Trauma Informed Prevention and Treatment Objectives
- Treatment Issues
- Making Referrals to Trauma Specific Services

Many clients in behavioral health treatment may have histories of trauma, so counselors should be prepared to help them address issues that arise from those histories. This chapter begins with a thorough discussion of trauma-informed prevention and treatment objectives along with practical counselor strategies. Specific treatment issues related to working with trauma survivors in a clinical setting are discussed as well, including client engagement, pacing and timing, traumatic memories, and culturally appropriate and gender-responsive services. The chapter ends with guidelines for making referrals to trauma-specific services.

Trauma-Informed Prevention and Treatment Objectives

Trauma-informed care (TIC) not only focuses on identifying individuals who have histories of trauma and traumatic stress symptoms; it also places considerable effort in creating an environment that helps them recognize the impact of trauma and determine the next course of action in a safe place. For some individuals, psychoeducation and development or reinforcement of coping strategies will be the most suitable and effective strategy, whereas others may request or warrant a referral for more trauma-specific interventions (see Part 1, Chapter 6, of this Treatment Improvement Protocol [TIP]). Although research is limited in the area of building resilience to prevent exacerbation of trauma symptoms and traumatic stress disorders, TIC also focuses on prevention strategies to avoid retraumatization in treatment, to promote resilience, and to prevent the development of trauma-related disorders. The following sections highlight key trauma-informed prevention and treatment objectives.

TIC Framework in Behavioral Health Services—Clinical Issues Across Services



Establish Safety

Beyond identifying trauma and trauma-related symptoms, the initial objective of TIC is establishing safety. Borrowing from Herman's (1992) conceptualization of trauma recovery, safety is the first goal of treatment. Establishing safety is especially crucial at the outset of trauma-informed treatment and often becomes a recurrent need when events or therapeutic changes raise safety issues, such as a change in treatment staffing due to vacations.

In the context of TIC, safety has a variety of meanings. Perhaps most importantly, the client has to have some degree of ***safety from trauma symptoms***. Recurring intrusive nightmares; painful memories that burst forth seemingly without provocation; feelings of sadness, anger, shame, or being overwhelmed; or not having control over sudden disconnections from others make moment-to-moment living feel unsafe. Clients might express feeling unsafe through statements such as, "I can't control my feelings," or, "I just space out and disconnect from the world for no reason," or, "I'm afraid to go to sleep because of the nightmares." The intense feelings that accompany trauma can also make clients feel unsafe. They may wake up in the morning feeling fine but become immobilized by depression as the day progresses. Clients with histories of trauma may experience panicky feelings of being trapped or abandoned. An early effort in trauma treatment is thus helping the client

Advice to Counselors: Strategies To Promote Safety

Strategy #1: Teach clients how and when to use grounding exercises when they feel unsafe or overwhelmed.

Strategy #2: Establish some specific routines in individual, group, or family therapy (e.g., have an opening ritual or routine when starting and ending a group session). A structured setting can provide a sense of safety and familiarity for clients with histories of trauma.

Strategy #3: Facilitate a discussion on safe and unsafe behaviors. Have clients identify, on paper, behaviors that promote safety and behaviors that feel unsafe for them today.

Strategy #4: Refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (Najavits, 2002a). This menu-based manual covers an array of treatment topics, including the core concept of safety. Each topic consists of several segments, including preparing for the session, session format, session content, handouts, and guidelines.

Strategy #5: Encourage the development of a safety plan. Depending on the type of trauma, personal safety can be an issue; work with the client to develop a plan that will help him or her feel in control and prepared for the unexpected. If the trauma was a natural or human-caused disaster, encourage thinking about how family and friends will respond and connect in the event of another crisis. If sexual abuse or rape was the event, encourage thinking about future steps that could help make the client safer. There is a delicate balance between preparation and the realization that one cannot prepare for all possible traumatic events. Nonetheless, an action plan can help the client regain a sense of environmental balance.

gain more control over trauma symptoms (and be able to label them as such) by learning more about the client and helping him or her develop new coping skills to handle symptoms when they arise and stay more grounded when flooded with feelings or memories.

A second aspect is ***safety in the environment***. Trauma reactions can be triggered by sudden loud sounds (e.g., television at high volume, raised voices), tension between people, certain smells, or casual touches that are perceived as invasions of physical boundaries. The vulnerability of exposing one's history in the treatment setting can manifest in the client as feeling physically vulnerable and unsafe in the treatment environment. Sudden or inadequately explained treatment transitions, such as moving from one level of treatment to another or changing counselors, can also evoke feelings of danger, abandonment, or instability. Early in treatment, trauma survivors generally value routine and predictability. The counselor should recognize these needs and respond appropriately by offering information in advance, providing nonshaming responses to a client's reactions to stimuli in his or her environment, and helping the client build a daily structure that feels safe.

A third aspect of safety is ***preventing a recurrence of trauma***. People with histories of trauma and substance abuse are more likely to engage in high-risk behaviors and to experience subsequent traumas. Early treatment should focus on helping clients stop using unsafe coping mechanisms, such as substance abuse, self-harm, and other self-destructive behaviors, and replacing them with safe and healthy coping strategies. Helping clients learn to protect themselves in reasonable ways is a positive goal of treatment.

Prevent Retraumatization

A key objective in TIC is to prevent retraumatization generated by intervention and treatment practices and policies. Unfortunately, treatment settings and clinicians can

Advice to Counselors: Strategies To Prevent Retraumatization

Strategy #1: Be sensitive to the needs of clients who have experienced trauma regarding behaviors in the treatment setting that might trigger memories of the trauma.

Strategy #2: Do not ignore clients' symptoms and demands when clients with trauma histories act out in response to triggered trauma memories; doing so may replicate the original traumatic experience.

Strategy #3: Be mindful that efforts to control and contain a client's behaviors in treatment can produce an abnormal reaction, particularly for trauma survivors for whom being trapped was part of the trauma experience.

Strategy #4: Listen for specific triggers that seem to be driving the client's reaction. An important step in recovery is helping the client identify these cues and thereby reach a better understanding of reactions and behaviors.

unintentionally create retraumatizing experiences (for a review of traumas that can occur when treating serious mental illness, see Frueh et al., 2005). For instance, compassionate inquiry into a client's history can seem similar to the interest shown by a perpetrator many years before. Direct confrontation by counselors about behaviors related to substance abuse can be seen, by someone who has been repeatedly physically assaulted, as provocation building up to assault. Counselor and program efforts to help clients constrain destructive behaviors can be interpreted as efforts to control and dominate the individual. Intrusive shaming or insensitive behavior demonstrated by another client in the program can threaten a trauma survivor whose boundaries have been disregarded in the past—thus making the experience of treatment feel dangerous rather than safe. Some staff and agency issues that can result in retraumatization include:

- Disrespectfully challenging reports of abuse or other traumatic events.
- Discounting a client's report of a traumatic event.
- Using isolation.
- Using physical restraints.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling intense rage and other feelings as pathological.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate and/or disrespectful manner.
- Having clients undress in the presence of others.
- Being insensitive to a client's physical or emotional boundaries.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Applying rigid agency policies or rules without an opportunity for clients to question them.
- Accepting agency dysfunction, including a lack of consistent, competent leadership.

Provide Psychoeducation

Trauma-informed education informs clients about traumatic stress and trauma-related symptoms and disorders as well as the related consequences of trauma exposure. It focuses on giving information to clients to help normalize presenting symptoms, to highlight potential short-term and long-term consequences of trauma and various paths to recovery, and to underscore the message that recovery is possible. Education frequently takes place prior to or immediately following an initial screening as a way to prepare clients

Advice to Counselors: Strategies To Implement Psychoeducation

Strategy #1: Remember that this may be the client's first experience with treatment. It's easy to use program or clinical jargon when you're around it every day, but most individuals who seek help are unfamiliar with clinical language, how the program works, and treatment objectives. Psychoeducation begins with understanding the client's expectations and reasons for seeking help, followed by educating the client and other family members about the program. Remember that this is all new for them.

Strategy #2: After obtaining acknowledgment of a trauma history, provide an overview of common symptoms and consequences of traumatic stress, regardless of whether the client affirms having trauma-related symptoms. It is equally important to educate the client on resilience factors associated with recovery from trauma (Wessely et al., 2008). A trauma-informed perspective provides a message that trauma reactions are normal responses to an abnormal situation.

Strategy #3: Develop a resource box that provides an array of printed or multimedia educational materials that address the program, specific symptoms and tools to combat trauma-related symptoms, treatment options and therapy approaches, advantages of peer support, and steps in developing specific coping strategies.

Strategy #4: Develop a rotating educational group that matches services and client schedules to complement treatment. Remember that education can play a pivotal role in enhancing motivation, in normalizing experiences, and in creating a sense of safety as individuals move further into treatment. For some survivors, education can be a powerful intervention or prevention strategy.

for hearing results or to place the screening and subsequent assessment findings in proper context. Education in and of itself, however, does not necessarily constitute a stand-alone treatment; rather, it can be conceptualized as a first step and/or component of more comprehensive treatment. Nonetheless, education may be a prevention and intervention strategy for individuals who have histories of trauma without current consequences or symptoms and/or those who have reported a resolution of past trauma(s). For example, some clients may have significantly delayed onset of traumatic stress symptoms. In this scenario, earlier education can enhance recognition of symptoms and ease the path of seeking treatment.

Some clients do not recognize the link between their current difficulties and their trauma histories; education can help them understand the possible origin of their difficulties. Psychoeducation presents trauma-related symptoms that follow a trauma as normal reactions. By identifying the source of clients' current difficulties and framing them as normal thoughts, emotions, and behaviors in response to trauma, many trauma survivors report a reduction in the intensity of the difficulties or symptoms. Often, a client will express relief that his or her reactions are normal. You may find the U.S. Department of Veterans Affairs (VA) National Center on PTSD's educational handouts on traumatic stress reactions useful.

Psychoeducation goes beyond the identification of traumatic stress symptoms and/or learning about the psychological, cognitive, and physical impacts of trauma. Numerous curricula are available that use psychoeducation as a first-line or complementary approach to trauma-specific therapies to enhance coping strategies in key areas, including safety, emotional regulation, help-seeking, avoidant behavior, and so forth. An example is S.E.L.F., a trauma-informed psychoeducational group curriculum with educational components related to trauma recovery in the following

Case Illustration: Linda

Linda served as an Army nurse in an evacuation hospital in Vietnam. She reported her postdeployment adjustment as difficult and isolating but denied any significant symptoms of traumatic stress throughout her life. Four years ago, Linda sought treatment for alcohol dependence; during the intake, she recalls denying trauma-related symptoms. "I distinctly remember the session," she recounts. "The counselor first took my history but then gave information on typical symptoms and reactions to trauma. I thought, 'Why do I need to hear this? I've survived the worst trauma in my life.' I didn't see the value of this information. Then 3 weeks ago, I began to have recurrent nightmares, the same graphic type I occasionally had when I was in Vietnam. Since then, I've been very anxious, reliving horrible scenes that I'd experienced as a nurse and postponing going to bed in fear of having the dreams again. I didn't understand it. I am 70 years old, and the war happened a long time ago. Then I began putting it together. Recently, the emergency helicopter flight pattern and approach to the area's hospital changed. I began hearing the helicopter periodically in my living room, and it reminded me of Vietnam. I knew then that I needed help; I couldn't stop shaking. I felt as if I was losing control of my emotions. I remembered how the intake counselor took the time to explain common symptoms of trauma. That's why I'm here today."

"This might not sound like a big deal, but for many people relationships have become all about getting: telling your problem story and then getting help with it. There is little, if any, emphasis placed on giving back. That's a big deal!!! Service relationships are like a one way street and both people's roles are clearly defined. But in 'regular' relationships in your community, people give and take all the time. No one is permanently on the taking side or the giving side. This exchange contributes to people feeling ok about being vulnerable (needing help) as well as confident about what they're offering. For many of us, being the role of 'getter' all the time has shaken our confidence, making us feel like we have nothing worthwhile to contribute. Peer support breaks that all down. It gets complicated somewhat when one of us is paid, but modeling this kind of relationship in which both of us learn, offers us the real practice we need to feel like a 'regular' community member as opposed to an 'integrated mental patient'."

(Mead, 2008, p.7)

areas: creating **S**afety, regulating **E**motions, addressing **L**oss, and redefining the **F**uture (Bloom, Foderaro, & Ryan, 2006).

Offer Trauma-Informed Peer Support

Living with a history of trauma can be isolating and consuming. The experience of trauma can reinforce beliefs about being different, alone, and marred by the experience. At times, behavioral health treatment for trauma-related effects can inadvertently reinforce these beliefs. Simply engaging in treatment or receiving specialized services (although warranted) can further strengthen clients' beliefs that there is something wrong with them. Formalized peer support can enhance the treatment experience. Treatment plus peer support can break the cycle of beliefs that reinforce traumatic stress (e.g., believing that one is permanently damaged; that nobody could understand; that no one should or could tolerate one's story). Peer support provides opportunities to form mutual relationships; to learn how one's history shapes perspectives of self, others, and the future; to move beyond trauma; and to mirror and learn alternate coping strategies. Peer support defines recovery as an

Advice to Counselors: Strategies To Enhance Peer Support

Strategy #1: Provide education on what peer support is and is not. Roles and expectations of peer support can be confusing, so providing clarification in the beginning can be quite useful. It is important to provide initial education about peer support and the value of using this resource.

Strategy #2: Use an established peer support curriculum to guide the peer support process. For example, *Intentional Peer Support: An Alternative Approach* (Mead, 2008) is a workbook that highlights four main tasks for peer support: building connections, understanding one's worldview, developing mutuality, and helping each other move toward set desires and goals. This curriculum provides extensive materials for peer support staff members as well as for the individuals seeking peer support.

interactive process, not as a definitive moment wherein someone fixes the "problem."

Normalize Symptoms

Symptoms of trauma can become serious barriers to recovery from substance use and mental disorders, including trauma-related ones. Counselors should be aware of how trauma symptoms can present and how to respond to them when they do appear. A significant step in addressing symptoms is normalizing them. People with traumatic stress symptoms need to know that their symptoms are not unique and that their reactions are common to their experience(s). Often, normalizing symptoms gives considerable relief to clients who may have thought that their symptoms signified some pervasive, untreatable mental disorder.

Advice to Counselors: Strategies To Normalize Symptoms

Strategy #1: Provide psychoeducation on the common symptoms of traumatic stress.

Strategy #2: Research the client's most prevalent symptoms specific to trauma, and then provide education to the client. For example, an individual who was conscious and trapped during or as a result of a traumatic event will more likely be hypervigilant about exits, plan escape routes even in safe environments, and have strong reactions to interpersonal and environmental situations that are perceived as having no options for avoidance or resolution (e.g., feeling stuck in a work environment where the boss is emotionally abusive).

Strategy #3: First, have the client list his or her symptoms. After each symptom, ask the client to list the negative and positive consequences of the symptom. Remember that symptoms serve a purpose, even if they may not appear to work well or work as well as they had in the past. Focus on how the symptoms have served the client in a positive way (see Case Illustration: Hector). This exercise can be difficult, because clients as well as counselors often don't focus on the value of symptoms.

Case Illustration: Hector

Hector was referred to a halfway house specializing in co-occurring disorders after inpatient treatment for methamphetamine dependence and posttraumatic stress disorder (PTSD). In the halfway house, he continued to feel overwhelmed with the frequency and intensity of flashbacks. He often became frustrated, expressing anger and a sense of hopelessness, followed by emotional withdrawal from others in the house. Normalization strategy #3 was introduced in the session. During this exercise, he began to identify many negative aspects of flashbacks. He felt that he couldn't control the occurrence of flashbacks even though he wanted to, and he realized that he often felt shame afterward. In the same exercise, he was also urged to identify positive aspects of flashbacks. Although this was difficult, he realized that flashbacks were clues about content that he needed to address in trauma-specific treatment. "I realized that a flashback, for me, was a billboard advertising what I needed to focus on in therapy."

Identify and Manage Trauma-Related Triggers

Many clients who have traumatic stress are caught off guard with intrusive thoughts, feelings, sensations, or environmental cues of the trauma. This experience can be quite disconcerting, but often, the individual does not draw an immediate connection between the internal or external trigger and his or her reactions. At other times, the trigger is so potent that the individual is unable to discern the present trigger from the past trauma and begins to respond as if the trauma is reoccurring.

Key steps in identifying triggers are to reflect back on the situation, surroundings, or sensations prior to the strong reaction. By doing so, you and your client may be able to determine the connections among these cues, the past trauma(s), and the client's reaction. Once the cue is identified, discuss the ways in which it is connected to past trauma. For some cues, there will be an obvious and immediate connection (e.g., having someone say "I love you" in a significant relationship as an adult and connecting this to an abuser who said the same thing prior to a sexual assault). Other

Advice to Counselors: Strategies To Identify and Manage Trauma-Related Triggers

Strategy #1: Use the Sorting the Past From the Present technique for cognitive realignment (Blackburn, 1995) to help separate the current situation from the past trauma. Identify one trigger at a time, and then discuss the following questions with the client:

- When and where did you begin to notice a reaction?
- How does this situation remind you of your past history or past trauma?
- How are your reactions to the current situation similar to your past reactions to the trauma(s)?
- How was this current situation different from the past trauma?
- How did you react differently to the current situation than to the previous trauma?
- How are you different today (e.g., factors such as age, abilities, strength, level of support)?
- What choices can you make that are different from the past and that can help you address the current situation (trigger)?

After reviewing this exercise several times in counseling, put the questions on a card for the client to carry and use outside of treatment. Clients with substance use disorders can benefit from using the same questions (slightly reworded) to address relapse triggers.

Strategy #2: After the individual identifies the trigger and draws connections between the trigger and past trauma, work with him or her to establish responses and coping strategies to deal with triggers as they occur. Initially, the planned responses will not immediately occur after a trigger, but with practice, the planned responses will move closer to the time of the trigger. Some strategies include an acronym that reflects coping strategies (Exhibit 1.5-1), positive self-talk generated by cognitive–behavioral covert modeling exercises (rehearsal of coping statements), breathing retraining, and use of support systems (e.g., calling someone).

Strategy #3: Self-monitoring is any strategy that asks a client to observe and record the number of times something happens, to note the intensity of specific experiences, or to describe a specific behavioral, emotional, or cognitive phenomenon each time it occurs. For individuals with histories of trauma, triggers and flashbacks can be quite frightening, intense, and powerful. Even if the client has had just one or two triggers or flashbacks, he or she may perceive flashbacks as happening constantly. Often, it takes time to recover from these experiences. Using self-monitoring and asking the client to record each time a trigger occurs, along with describing the trigger and its intensity level (using a scale from 1–10), clients and counselors will gain an understanding of the type of triggers present and the level of distress that each one produces. Moreover, the client may begin to see that the triggers don't actually happen all the time, even though they may seem to occur frequently.

Exhibit 1.5-1: The OBSERVATIONS Coping Strategy

- Take a moment to just ***Observe*** what is happening. Pay attention to your body, your senses, and your environment.
- Focus on your ***Breathing***. Allow your feelings and sensations to wash over you. Breathe.
- Name the ***Situation*** that initiated your response. In what way is this situation familiar to your past? How is it different?
- Remember that ***Emotions*** come and go. They may be intense now, but later they will be less so. Name your feelings.
- ***Recognize*** that this situation does not define you or your future. It does not dictate how things will be, nor is it a sign of things to come. Even if it is familiar, it is only one event.
- ***Validate*** your experience. State, at least internally, what you are feeling, thinking, and experiencing.
- ***Ask*** for help. You don't have to do this alone. Seek support. Other people care for you. Let them!
- ***This*** too shall pass. Remember: There are times that are good and times that are not so good. This hard time will pass.
- ***I*** can handle this. Name your strengths. Your strengths have helped you survive.
- Keep an ***Open*** mind. Look for and try out new solutions.
- ***Name*** strategies that have worked before. Choose one and apply it to this situation.
- Remember you have survived. You are a ***Survivor***!

cues will not be as obvious. With practice, the client can begin to track back through what occurred immediately before an emotional, physical, or behavioral reaction and then examine how that experience reminds him or her of the past.

Draw Connections

Mental health and substance abuse treatment providers have historically underestimated the effects of trauma on their clients for many reasons. Some held a belief that substance

Advice to Counselors: Strategies To Help Clients Draw Connections

Strategy #1: Writing about trauma can help clients gain awareness of their thoughts, feelings, and current experiences and can even improve physical health outcomes (Pennebaker, Kiecolt-Glaser, & Glaser, 1988; Smyth, Hockemeyer, & Tulloch, 2008). Although this tool may help some people draw connections between current experiences and past traumas, it should be used with caution; others may find that it brings up too much intense trauma material (especially among vulnerable trauma survivors with co-occuring substance abuse, psychosis, and current domestic violence). Journal writing is safest when you ask clients to write about present-day specific targets, such as logging their use of coping strategies or identifying strengths with examples. Writing about trauma can also be done via key questions or a workbook that provides questions centered upon trauma experiences and recovery.

Strategy #2: Encourage clients to explore the links among traumatic experiences and mental and substance use disorders. Recognition that a mental disorder or symptom developed after the trauma occurred can provide relief and hope that the symptoms may abate if the trauma is addressed. Ways to help clients connect substance use with trauma histories include (Najavits, 2002b; Najavits, Weiss, & Shaw, 1997):

- Identifying how substances have helped "solve" trauma or PTSD symptoms in the short term (e.g., drinking to get to sleep).
- Teaching clients how trauma, mental, and substance use disorders commonly co-occur so that they will not feel so alone and ashamed about these issues.
- Discussing how substance abuse has impeded healing from trauma (e.g., by blocking feelings and memories).
- Helping clients recognize trauma symptoms as triggers for relapse to substance use and mental distress.
- Working on new coping skills to recover from trauma and substance abuse at the same time.
- Recognizing how both trauma and substance abuse often occur in families through multiple generations.

abuse should be addressed before attending to any co-occurring conditions. Others did not have the knowledge and training to evaluate trauma issues or were uncomfortable or reluctant to discuss these sensitive issues with clients (Ouimette & Brown, 2003). Similarly, in other behavioral health settings, clinicians sometimes address trauma-related symptoms but do not have experience or training in the treatment of substance abuse.

So too, people who have histories of trauma will often be unaware of the connection between the traumas they've experienced and their traumatic stress reactions. They may notice depression, anger, or anxiety, or they may describe themselves as "going crazy" without being able to pinpoint a specific experience that produced the trauma symptoms. Even if clients recognize the events that precipitated their trauma symptoms, they may not understand how others with similar experiences can have different reactions. Thus, a treatment goal for trauma survivors is helping them gain awareness of the connections between their histories of trauma and subsequent consequences. Seeing the connections can improve clients' ability to work on recovery in an integrated fashion.

Teach Balance

You and your clients need to walk a thin line when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session whereby the client dissociates, shuts down, or becomes emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma. Several trauma-specific theories offer guidelines on acceptable levels of distress associated with the traumatic content that the therapy addresses. For example, some traditional desensitization processes start at a very low level of subjective distress, gradually working up through a hierarchy of trauma memories and experiences until those experiences produce minimal reactions when paired with some coping strategy, such as relaxation training. Other desensitization processes start at a higher level of intensity to provide more rapid extinction of traumatic associations and to decrease the risk of avoidance—a behavior that reinforces traumatic stress.

> The Subjective Units of Distress Scale (SUDS) uses a 0 10 rating scale, with 0 representing content that causes no or minimal distress and 10 representing content that is exceptionally distressing and overwhelming.
>
> (Wolpe & Abrams, 1991)

Working with trauma is a delicate balancing act between the development and/or use of coping strategies and the need to process the traumatic experiences. Individuals will choose different paths to recovery; it's a myth that every traumatic experience needs to be expressed and every story told. For some individuals, the use of coping skills, support, and spirituality are enough to recover. Regardless of theoretical beliefs, counselors must teach

Advice to Counselors: Strategy To Teach Balance

Strategy #1: Teach and use the SUDS in counseling. This scale can be useful from the outset as a barometer for the client and counselor to measure the level of distress during and outside of sessions. It provides a common language for the client and counselor, and it can also be used to guide the intensity of sessions. SUDS can tangibly show a client's progress in managing experiences. Without a scale, it is more difficult to grasp that a distressing symptom or circumstance is becoming less and less severe without some repeated measure.

coping strategies as soon as possible. Retraumatization is a risk whenever clients are exposed to their traumatic histories without sufficient tools, supports, and safety to manage emotional, behavioral, and physical reactions.

Build Resilience

Survivors are resilient! Often, counselors and clients who are trauma survivors focus on the negative consequences of trauma while failing to recognize the perseverance and attributes that have helped them survive. It is natural to focus on what's not working rather than what has worked. To promote growth after trauma and establish a strengths-based approach, focus on building on clients' resilience. Current resilience theories claim that building or reinforcing resilience prevents further development of trauma-related symptoms and disorders. The following *Advice to Counselors* box is adapted from the American Psychological Association's 2003 statement on resilience.

Advice to Counselors: Strategies To Build Resilience

Strategy #1: Help clients reestablish personal and social connections. Access community and cultural resources; reconnect the person to healing resources such as mutual-help groups and spiritual supports in the community.

Strategy #2: Encourage the client to take action. Recovery requires activity. Actively taking care of one's own needs early in treatment can evolve into assisting others later on, such as by volunteering at a community organization or helping military families.

Strategy #3: Encourage stability and predictability in the daily routine. Traumatic stress reactions can be debilitating. Keeping a daily routine of sleep, eating, work, errands, household chores, and hobbies can help the client see that life continues. Like exercise, daily living skills take time to take hold as the client learns to live through symptoms.

Strategy #4: Nurture a positive view of personal, social, and cultural resources. Help clients recall ways in which they successfully handled hardships in the past, such as the loss of a loved one, a divorce, or a major illness. Revisit how those crises were addressed.

Strategy #5: Help clients gain perspective. All things pass, even when facing very painful events. Foster a long-term outlook; help clients consider stress and suffering in a spiritual context.

Strategy #6: Help maintain a hopeful outlook. An optimistic outlook enables visions of good things in life and can keep people going even in the hardest times. There are positive aspects to everyone's life. Taking time to identify and appreciate these enhances the client's outlook and helps him or her persevere.

Strategy #7: Encourage participation in peer support, 12-Step, and other mutual-help programs.

Source: American Psychological Association, 2003.

Address Sleep Disturbances

Sleep disturbances are one of the most enduring symptoms of traumatic stress and are a particularly common outcome of severe and prolonged trauma. Sleep disturbances increase one's risk of developing traumatic stress; they significantly alter physical and psychological processes, thus causing problems in daytime functioning (e.g., fatigue, cognitive difficulty, excessive daytime sleepiness). People with sleep disturbances have worse general health and quality of life. The cardiovascular and immune systems, among others, may be affected as well. Sleep disturbances can worsen traumatic stress symptoms and interfere with healing by impeding the brain's ability to process and consolidate traumatic memories (Caldwell & Redeker, 2005).

Sleep disturbances vary among trauma survivors and can include decreased ability to stay asleep, frequent awakenings, early morning unintentional awakening, trouble falling asleep, poor quality of sleep, and disordered

Advice to Counselors: Strategies To Conduct a Sleep Intervention

Strategy #1: Conduct a sleep history assessment focused first on the client's perception of his or her sleep patterns. Assess whether there is difficulty initiating or staying asleep, a history of frequent or early morning awakenings, physically restless sleep, sleepwalking, bedtime aversion, and/or disruptive physical and emotional states upon awakening (e.g., confusion, agitation, feeling unrested). Also determine total sleep time, pattern of nightmares, and use of medications, alcohol, and/or caffeine (see Moul, Hall, Pikonis, & Buysse, 2004, for a review of self-report measures).

Strategy #2: Use a sleep hygiene measure to determine the presence of habits that typically interfere with sleep (e.g., falling asleep while watching television). The National Sleep Foundation Web site (http://www.sleepfoundation.org) provides simple steps for promoting good sleep hygiene.

Strategy #3: Provide education on sleep hygiene practices. Introduce clients to the idea that practicing good sleep hygiene is one step toward gaining control over their sleep disturbances.

Strategy #4: Reassess sleep patterns and history during the course of treatment. Sleep patterns often reflect current client status. For example, clients who are struggling are more likely to have disturbed sleep patterns; sleep disturbances significantly influence clients' mental health status.

Strategy #5: Use interventions such as nightmare rehearsals to target recurrent nightmares. There are numerous examples of imagery-based nightmare rehearsals. Clients may be instructed to rehearse repetitively the recurrent nightmare a few hours before bedtime. In this instruction, the client either rehearses the entire nightmare with someone or visualizes the nightmare several times to gain control over the material and become desensitized to the content. Other strategies involve imagining a change in the outcome of the nightmare (e.g., asking the client to picture getting assistance from others, even though his or her original nightmare reflects dealing with the experience alone).

breathing during sleep (Caldwell & Redeker, 2005). Most traumatic stress literature focuses on nightmares, insomnia, and frequent awakenings. These disturbances are connected to two main symptoms of traumatic stress: hyperarousal (which causes difficulty in falling and remaining asleep) and reexperiencing the trauma (e.g., through recurrent nightmares). Other sleep disturbances trauma survivors report include sleep avoidance or resistance to sleep (see Case Illustration: Selena), panic awakenings, and restless or unwanted body movements (e.g., hitting your spouse unintentionally in bed while asleep; Habukawa, Maeda, & Uchimura, 2010).

Case Illustration: Selena

Selena initially sought treatment for ongoing depression (dysthymia). During treatment, she identified being sexually assaulted while attending a party at college. At times, she blames herself for the incident because she didn't insist that she and her girlfriends stay together during the party and on the way back to their dorm afterward. Selena reported that she only had two drinks that night: "I could never manage more than two drinks before I wanted to just sleep, so I never drank much socially." She was assaulted by someone she barely knew but considered a "big brother" in the brother fraternity of her sorority. "I needed a ride home. During that ride, it happened," she said. For years thereafter, Selena reported mild bouts of depression that began lasting longer and increasing in number. She also reported nightmares and chronic difficulty in falling asleep. In therapy, she noted avoiding her bed until she's exhausted, saying, "I don't like going to sleep; I know what's going to happen." She describes fear of sleeping due to nightmares. "It's become a habit at night. I get very involved in playing computer games to lose track of time. I also leave the television on through the night because then I don't sleep as soundly and have fewer nightmares. But I'm always exhausted."

Build Trust

Some traumatic experiences result from trusting others (e.g., interpersonal trauma). In other cases, trust was violated during or after the traumatic experience, as in cases when help was late to arrive on the scene of a natural disaster. This lack of trust can leave individuals alienated, socially isolated, and terrified of developing relationships. Some feel that the trauma makes them different from others who haven't had similar experiences. Sometimes, a client's trust issues arise from a lack of trust in self—for instance, a lack of trust in one's perceptions, judgment, or memories. People who have also experienced severe mental or substance use disorders may have difficulty trusting others because, during the course of their illness, they felt alienated or discriminated against for behaviors and emotions generated by or associated with the disorders.

Some client groups (e.g., gay, lesbian, and bisexual clients; people from diverse cultures; those with serious mental illness) evidence significant mistrust because their trust has been repeatedly violated in the past. Traumatic experiences then compound this mistrust. Mistrust can come from various sources, is usually unstated, and, if left unaddressed, can impede treatment. For example, some clients leave treatment early or do not engage in potentially beneficial treatments. Others avoid issues of trust and commitment by leaving treatment when those issues begin to arise.

Establishing a safe, trusting relationship is paramount to healing—yet this takes time in the counseling process. Counselors and other behavioral health professionals need to be consistent throughout the course of treatment; this includes maintaining consistency in the parameters set for availability, attendance, and level of empathy. Trust is built on behavior shown inside and outside of treatment; you should immediately address any behavior that may even slightly injure the relationship (e.g., being 5 minutes late for an appointment, not responding to a phone message in a timely manner, being distracted in a session).

Advice to Counselors: Strategies To Build Trust

Strategy #1: Clients can benefit from a support or counseling group composed of other trauma survivors. By comparing themselves with others in the group, they can be inspired by those who are further along in the recovery process and helpful to those who are not faring as well as they are. These groups also motivate clients to trust others by experiencing acceptance and empathy.

Strategy #2: Use conflicts that arise in the program as opportunities. Successful negotiation of a conflict between the client and the counselor is a major milestone (van der Kolk, McFarlane, & Van der Hart, 1996). Helping clients understand that conflicts are healthy and inevitable in relationships (and that they can be resolved while retaining the dignity and respect of all involved) is a key lesson for those whose relationship conflicts have been beset by violence, bitterness, and humiliation.

Strategy #3: Prepare clients for staff changes, vacations, or other separations. Some clients may feel rejected or abandoned if a counselor goes on vacation or is absent due to illness, especially during a period of vulnerability or intense work. A phone call to the client during an unexpected absence can reinforce the importance of the relationship and the client's trust. You can use these opportunities in treatment to help the client understand that separation is part of relationships; work with the client to view separation in a new light.

Strategy #4: Honor the client–counselor relationship, and treat it as significant and mutual. You can support the development of trust by establishing clear boundaries, being dependable, working with the client to define explicit treatment goals and methods, and demonstrating respect for the client's difficulty in trusting you and the therapeutic setting.

Support Empowerment

Strong feelings of powerlessness can arise in trauma survivors seeking to regain some control of their lives. Whether a person has survived a single trauma or chronic trauma, the survivor can feel crushed by the weight of powerlessness. Mental illness and substance abuse, too, can be disempowering; clients may feel that they've lost control over their daily lives, over a behavior such as drug use, or over powerful emotions such as fear, sadness, or anger. Empowerment means helping clients feel greater power and control over their lives, as long as such control is within safe and healthy bounds. A key facet of empowerment is to help clients build on their strengths. Empowerment is more than helping clients discover what they "should" do; it is also helping them take the steps they feel ready to take.

Case Illustration: Abby

Abby, a 30-year-old, nervous-looking woman, is brought by her parents to a community mental health clinic near their home in rural Indiana. During the intake process, the counselor learns that Abby is an Army Reservist who returned from 12 months of combat duty 3 years ago. The war experience changed her in many ways. Her deployment pulled her away from veterinary school as well as the strong emotional support of family, friends, and fellow classmates. She got along with her unit in Iraq and had no disciplinary problems. While there, she served as a truck driver in the Sunni Triangle. Her convoy was attacked often by small arms fire and was once struck by an improvised explosive device. Although Abby sustained only minor injuries, two of her close friends were killed. With each successive convoy, her level of fear and foreboding grew, but she continued performing as a driver.

Since returning to the United States, she has mostly stayed at home and has not returned to school, although she is helping out on the farm with various chores. Abby has isolated herself from both family members and lifelong friends, saying she doesn't think others can understand what she went through and that she prefers being alone. She reports to her parents and the counselor that she is vaguely afraid to be in cars and feels most comfortable in her room or working alone, doing routine tasks, at home. Abby also says that she now understands how fragile life can be.

She has admitted to her parents that she drinks alcohol on a regular basis, something she did not do before her deployment, and that on occasion, she has experienced blackouts. Abby feels she needs a drink before talking with strangers or joining in groups of friends or family. She confided to her father that she isolates herself so that she can drink without having to explain her drinking to others.

The counselor recognizes Abby's general sense of lacking internal control and feeling powerless over what will happen to her in the future. He adopts a motivational interviewing style to establish rapport and a working alliance with Abby. During sessions, the counselor asks Abby to elaborate on her strengths; he reinforces strengths that involve taking action in life, positive self-statements, and comments that deal with future plans. He also introduces Abby to an Iraq War veteran who came home quite discouraged about putting his life together but has done well getting reintegrated. The counselor urges Abby go to the local VA center so that she can meet and bond with other recently returned veterans. He also encourages Abby to attend Alcoholics Anonymous meetings, emphasizing that she won't be pressured to talk or interact with others more than she chooses to.

The counselor continues to see Abby every week and begins using cognitive–behavioral techniques to help her examine some of her irrational fears about not being able to direct her life. He asks Abby to keep a daily diary of activities related to achieving her goals of getting back to school and reestablishing a social network. In each session, Abby reviews her progress using the diary as a memory aid, and the counselor reinforces these positive efforts. After 4 months of treatment, Abby reenrolls in college and is feeling optimistic about her ability to achieve her career plans.

Advice to Counselors: Strategies To Support Empowerment

Strategy #1: Offer clients information about treatment; help them make informed choices. Placing appropriate control for treatment choices in the hands of clients improves their chances of success.

Strategy #2: Give clients the chance to collaborate in the development of their initial treatment plan, in the evaluation of treatment progress, and in treatment plan updates. Incorporate client input into treatment case consultations and subsequent feedback.

Strategy #3: Encourage clients to assume an active role in how the delivery of treatment services occurs. An essential avenue is regularly scheduled and structured client feedback on program and clinical services (e.g., feedback surveys). Some of the most effective initiatives to reinforce client empowerment are the development of peer support services and the involvement of former clients in parts of the organizational structure, such as the advisory board or other board roles.

Strategy #4: Establish a sense of self-efficacy in clients; their belief in their own ability to carry out a specific task successfully—is key. You can help clients come to believe in the possibility of change and in the hope of alternative approaches to achieving change. Supporting clients in accepting increasing responsibility for choosing and carrying out personal change can facilitate their return to empowerment (Miller & Rollnick, 2002).

Acknowledge Grief and Bereavement

The experience of loss is common after traumas, whether the loss is psychological (e.g., no longer feeling safe) or physical (e.g., death of a loved one, destruction of community, physical impairment). Loss can cause public displays of grief, but it is more often a private experience. Grieving processes can be emotionally overwhelming and can lead to increased substance use and other impulsive behaviors as a way to manage grief and other feelings associated with the loss. Even for people who experienced trauma years prior to treatment, grief is still a common psychological issue. Delayed or absent reactions of acute grief can cause exhaustion, lack of strength, gastrointestinal symptoms, and avoidance of emotions.

Risk factors of chronic bereavement (grief lasting more than 6 months) can include:

- Perceived lack of social support.
- Concurrent crises or stressors (including reactivation of PTSD symptoms).
- High levels of ambivalence about the loss.
- An extremely dependent relationship prior to the loss.
- Loved one's death resulting from disaster: unexpected, untimely, sudden, and shocking (New South Wales Institute of Psychiatry & Centre for Mental Health, 2000).

Advice to Counselors: Strategies To Acknowledge and Address Grief

Strategy #1: Help the client grieve by being present, by normalizing the grief, and by assessing social supports and resources.

Strategy #2: When the client begins to discuss or express grief, focus on having him or her voice the losses he or she experienced due to trauma. Remember to clarify that losses include internal experiences, not just physical losses.

Strategy #3: For a client who has difficulty connecting feelings to experiences, assign a feelings journal in which he or she can log and name each feeling he or she experiences, rate the feeling's intensity numerically, and describe the situation during which the feeling occurred. The client may choose to share the journal in an individual or group session.

Strategy #4: Note that some clients benefit from developing a ritual or ceremony to honor their losses, whereas others prefer offering time or resources to an association that represents the loss.

Monitor and Facilitate Stability

Stability refers to an ongoing psychological and physical state whereby one is not overwhelmed by disruptive internal or external stimuli (Briere & Scott, 2006b). It's common for individuals to have an increase in symptoms, distress, or impairment when dealing with the impact of their trauma or talking about specific aspects of their trauma. There is a thin line that the client and counselor need to negotiate and then walk when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session that causes the client to dissociate, shut down, or become emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma.

Advice to Counselors: Strategies To Monitor and Facilitate Stability

Strategy #1: If destabilization occurs during the intake process or treatment, stop exploring the material that triggered the reaction, offer emotional support, and demonstrate ways for the client to self-soothe.

Strategy #2: Seek consultation from supervisors and/or colleagues (e.g., to explore whether a new case conceptualization is needed at this point).

Strategy #3: Refer the client for a further assessment to determine whether a referral is necessary for trauma-specific therapy or a higher level of care, or use of multiple levels of care (e.g., intensive outpatient care, partial hospitalization, residential treatment).

Strategy #4: Focus on coping skills and encourage participation in a peer support program.

Strategy #5: When a client becomes agitated and distressed, carefully explore with the client what is causing this state. When such feelings arise because of current threats in the client's life or environment, it is dangerous to halt or soothe away responses that act as warning signals (Pope & Brown, 1996). When a client is in a situation involving domestic violence, lives in a dangerous neighborhood, or has run out of money for food, he or she requires direct and concrete assistance rather than simple emotional support.

Source: Briere & Scott, 2006b.

Managing Destabilization

When a client becomes destabilized during a session, you can respond in the following manner: "Let's slow down and focus on helping you be and feel safe. What can we do to allow you to take care of yourself at this moment? Then, when you feel ready, we can decide what to focus on next."

Clients should have some psychological stability to engage in trauma-related work. An important distinction can be made between a normative increase in symptoms (e.g., the typical up-and-down course of traumatic stress reactions or substance abuse) and destabilization (dangerous, significant decrease in functioning). Signs of destabilization include (Green Cross Academy of Traumatology, 2007; Najavits, 2002b):

- Increased substance use or other unsafe behavior (e.g., self-harm).
- Increased psychiatric symptoms (e.g., depression, agitation, anxiety, withdrawal, anger).
- Increased symptoms of trauma (e.g., severe dissociation).
- Helplessness or hopelessness expressed verbally or behaviorally.
- Difficulty following through on commitments (e.g., commitment to attend treatment sessions).
- Isolation.
- Notable decline in daily activities (e.g., self-care, hygiene, care of children or pets, going to work).

Treatment Issues

The treatment environment itself can significantly affect how clients experience traumatic stress and how the client responds to treatment. Some specific issues related to working with trauma survivors in a clinical setting are discussed in the following sections.

Client Engagement

A lack of engagement in treatment is the client's inability to make progress toward treatment goals, deal with important topics in treatment, or complete treatment. Clients who have histories of trauma will express ambivalence about treatment similarly to others, except that clients who have traumatic stress can feel more "stuck" and perceive themselves as having fewer options. In addition, clients may be avoiding engagement in treatment because it is one step closer to addressing their trauma. You should attend to the client's motivation to change, implement strategies that address ambivalence toward treatment, and use approaches that help clients overcome avoidant behavior.

Advice to Counselors: Strategies To Foster Engagement

Strategy #1: According to Mahalik (2001), the standard method of handling clients' lack of engagement is exploring it with them, clarifying the situation through discussion with them, reinterpreting (e.g., from "can't" to "won't" to "willing"), and working through the situation toward progress.

Strategy #2: To improve engagement into treatment, try motivational interviewing and enhancement techniques. For additional information on such techniques, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT], 1999b).

Pacing and Timing

Although your training or role as a counselor may prohibit you from providing trauma-specific services, you must still be prepared for the fact that clients are not as focused on when or where it is most appropriate to address trauma—they want relief, and most lay and professional people have been taught that the only path to recovery is disclosure. Some clients are reluctant to talk about anything associated with their histories of trauma. Other clients immediately want to delve into the memories of their trauma without developing a safe environment. The need to gain any relief for the traumatic stress pushes some individuals to disclose too quickly, without having the necessary support and coping skills to manage the intensity of their memories. Clients who enter treatment and immediately disclose past trauma often don't return because the initial encounter was so intense or because they experienced considerable emotional distress for several days afterward and/or in anticipation of the next session.

Proper pacing of sessions, disclosure, and intensity is paramount. Clients who immediately disclose without proper safety nets are actually retraumatizing themselves by reliving the experience without adequate support—often placing themselves in the same circumstances that occurred during the actual traumas they experienced. Although you should not adamantly direct clients not to talk about what happened, it is important to discuss with the clients, even if you have to interrupt them empathically and respectfully, the potential consequences of disclosing too soon and too fast. Ask whether they have done this before, and then inquire about the outcome. Reinforce with clients that trauma heals when there are support, trust, and skills in place to manage the memories of the traumatic experiences. Ideally, disclosure begins after these elements are secured, but realistically, it is a

Advice to Counselors: Strategies To Establish Appropriate Pacing and Timing

Strategy #1: Frequently discuss and request feedback from clients about pacing and timing. Moving too quickly into discussion of the trauma can increase the risk of dissociation, overactivation of memories, and feeling overwhelmed.

Strategy #2: Use the SUDS as a barometer of intensity to determine the level of work.

Strategy #3: Slowly increase the speed of interventions and continually adjust the intensity of interventions; move in and out of very intense work, or use strategies that decrease the intensity when necessary. One approach that typically decreases the intensity of traumatic memories is to ask the individual to imagine that he or she is seeing the scene through a window or on a television screen. This helps decrease intensity and the risk of dissociation. It provides an opportunity for the client to view the trauma from a different perspective and a strategy to use outside of treatment to shift from reliving the trauma to observing it from a neutral position.

Strategy #4: Monitor clients to ensure that treatment does not overwhelm their internal capacities, retraumatize them, or result in excessive avoidance; make sure therapy occurs in the "therapeutic window" (Briere & Scott, 2006b).

Strategy #5: Be alert to signs that discussions of trauma, including screening, assessment, and intake processes, are going too fast. Mild to moderate signs are:
- Missing counseling appointments after discussions of important material.
- Periods of silence.
- Dissociation.
- Misunderstanding what are usually understandable concepts.
- Redirecting the focus of the discussion when certain issues arise.

Strategy #6: Observe the client's emotional state. Slow down; seek consultation if the client exhibits:
- Persistent resistance to addressing trauma symptoms.
- Repetitive flashbacks.
- Increase in dissociation.
- Regression.
- Difficulty in daily functioning (e.g., trouble maintaining everyday self-care tasks).
- Substance use relapses.
- Self-harm or suicidal thoughts/behaviors (e.g., talking about suicide).

Strategy #7: Use caution and avoid (Briere, 1996b, p. 115):
- Encouraging clients to describe traumatic material in detail before they can deal with the consequences of disclosure.
- Using overly stressful interventions (e.g., intensive role-plays, group confrontation, guided imagery).
- Confrontations or interpretations that are too challenging given the client's current functioning.
- Demanding that the client work harder and stop resisting.

Source: Strategies 1–6: Green Cross Academy of Traumatology, 2001. Adapted with permission.

balancing act for both the counselor and client as to when and how much should be addressed in any given session. Remember not to inadvertently give a message that it is too dangerous to talk about trauma; instead, reinforce the importance of addressing trauma without further retraumatization.

Length of Treatment

Many factors influence decisions regarding the length of treatment for a given client. Severity of addiction, type of substance abused, type of trauma, age at which the trauma occurred, level of social support, and the existence of

mental disorders all influence length of treatment. External factors, such as transportation and childcare, caps on insurance coverage, and limitations in professional resources, can also affect length of treatment. In general, longer treatment experiences should be expected for clients who have histories of multiple or early traumas, meet diagnostic criteria for multiple Axis I or Axis II diagnoses, and/or require intensive case management. Most of the empirically studied and/or manual-based models described in the next chapter are short-term models (e.g., lasting several months); however, ongoing care is indicated for clients with more complex co-occurring trauma disorders.

Traumatic Memories

One of the most controversial issues in the trauma field is the phenomenon of "recovered memories" or "traumatic amnesia" (Brewin, 2007). Practitioners working with traumatized individuals are particularly concerned about the possibility of new memories of the traumatic event emerging during the course of therapy and the possibility of these memories being induced by the clinician. Scientific reviews indicate that people can experience amnesia and delayed recall for some memories of a wide variety of traumas, including military combat and prisoner of war experiences, natural disasters and accidents, childhood sexual abuse, and political torture (Bowman & Mertz, 1996; Brewin, 2007; Karon & Widener, 1997; McNally, 2005). In some cases, the survivor will not remember some of what happened, and the counselor may need to help the client face the prospect of never knowing all there is to know about the past and accept moving on with what is known.

Legal Issues

Legal issues can emerge during treatment. A client, for instance, could seek to prosecute a perpetrator of trauma (e.g., for domestic violence) or to sue for damages sustained in an accident or natural disaster. The counselor's role is not to provide legal advice, but rather, to offer support during the process and, if needed, refer the client to appropriate legal help (see Advice to Counselors box on p. 131). A legal matter can dominate the treatment atmosphere for its duration. Some clients have difficulty making progress in treatment until most or all legal matters are resolved and no longer act as ongoing stressors.

Memories of Trauma

Points for counselors to remember are:

- Some people are not able to completely remember past events, particularly events that occurred during high-stress and destabilizing moments.
- In addition to exploring the memories themselves, it can be beneficial to explore how a memory of an event helps the client understand his or her feeling, thinking, and behaving in the present.
- Persistently trying to recall all the details of a traumatic event can impair focus on the present.

Forgiveness

Clients may have all sorts of reactions to what has happened to them. They may feel grateful for the help they received, joy at having survived, and dedication to their recovery. At the other extreme, they may have fantasies of revenge, a loss of belief that the world is a good place, and feelings of rage at what has happened. They may hold a wide variety of beliefs associated with these feelings.

One issue that comes up frequently among counselors is whether to encourage clients to forgive. The issue of forgiveness is a very delicate one. It is key to allow survivors their feelings, even if they conflict with the counselor's own responses. Some may choose to forgive the perpetrator, whereas others may remain angry or seek justice through the courts and other legal means. Early in recovery from

Advice to Counselors: Strategies To Manage Traumatic Memories

Strategy #1: Most people who were sexually abused as children remember all or part of what happened to them, although they do not necessarily fully understand or disclose it. Do not assume that the role of the clinician is to investigate, corroborate, or substantiate allegations or memories of abuse (American Psychiatric Association [APA], 2000b).

Strategy #2: Be aware that forgotten memories of childhood abuse can be remembered years later. Clinicians should maintain an empathic, nonjudgmental, neutral stance toward reported memories of sexual abuse or other trauma. Avoid prejudging the cause of the client's difficulties or the veracity of the client's reports. A counselor's prior belief that physical or sexual abuse, or other factors, are or are not the cause of the client's problems can interfere with appropriate assessment and treatment (APA, 2000b).

Strategy #3: Focus on assisting clients in coming to their own conclusions about the accuracy of their memories or in adapting to uncertainty regarding what actually occurred. The therapeutic goal is to help clients understand the impact of the memories or abuse experiences on their lives and to reduce their detrimental consequences in the present and future (APA, 2000b).

Strategy #4: Some clients have concerns about whether or not a certain traumatic event did or did not happen. In such circumstances, educate clients about traumatic memories, including the fact that memories aren't always exact representations of past events; subsequent events and emotions can have the effect of altering the original memory. Inform clients that it is not always possible to determine whether an event occurred but that treatment can still be effective in alleviating distress.

Strategy #5: There is evidence that suggestibility can be enhanced and pseudomemories can develop in some individuals when hypnosis is used as a memory enhancement or retrieval strategy. Hypnosis and guided imagery techniques can enhance relaxation and teach self-soothing strategies with some clients; however, use of these techniques is not recommended in the active exploration of memories of abuse (Academy of Traumatology, 2007).

Strategy #6: When clients are highly distressed by intrusive flashbacks of delayed memories, help them move through the distress. Teach coping strategies and techniques on how to tolerate strong affect and distress (e.g., mindfulness practices).

trauma, it is best to direct clients toward focusing on stabilization and a return to normal functioning; suggest that, if possible, they delay major decisions about forgiveness until they have a clearer mind for making decisions (Herman, 1997). Even in later stages of recovery, it's not essential for the client to forgive in order to recover. Forgiveness is a personal choice independent of recovery. Respect clients' personal beliefs and meanings; don't push clients to forgive or impose your own beliefs about forgiveness onto clients.

In the long-term healing process, typically months or years after the trauma(s), forgiveness may become part of the discussion for some people and some communities. For example, in South Africa, years after the bitter and bloody apartheid conflicts, a Truth and Reconciliation Commission was established by the Government. Public hearings created dialog and aired what had been experienced as a means, ultimately, to promote forgiveness and community healing. By addressing very difficult topics in public, all could potentially benefit from the discourse. Similarly, a parental survivor of the Oklahoma City bombing was, at first, bitter about his daughter's early, unfair, and untimely death. Today, he gives talks around the world about the abolition of the death penalty. He sat with convicted

Advice to Counselors: Strategies To Manage Legal Proceedings

Strategy #1: If you're aware of legal proceedings, you can play a key role in helping your client prepare emotionally for their impact, such as what it might be like to describe the trauma to a judge or jury, or how to cope with seeing the perpetrator in court. When helping a client prepare, however, be careful not to provide legal advice.

Strategy #2: Help clients separate a successful legal outcome from a successful treatment outcome. If clients connect these two outcomes, difficulties can arise. For example, a client may discontinue treatment after his or her assailant is sentenced to serve prison time, believing that the symptoms will abate without intervention.

Strategy #3: If clients express interest in initiating a civil or criminal suit, encourage them to consider the ways in which they are and are not prepared for this, including their own mental states, capacity for resilience, and inevitable loss of confidentiality (Pope & Brown, 1996). Inform clients coping with legal issues that involvement in the legal process can be retraumatizing.

Strategy #4: Emphasize, for trauma survivors who are involved in legal proceedings against an assailant, that "not guilty" is a legal finding—it is based on the degree of available evidence and is not a claim that certain events in question did not occur. They should also receive, from an attorney or other qualified individual, information on:

- The nature of the legal process as it pertains to the clients' specific cases.
- The estimated duration and cost of legal services, if applicable.
- What to expect during police investigations.
- Court procedures.
- Full information on all possible outcomes.
- What to expect during cross-examination.

Strategy #5: Counselors can be called on to assist with a legal case involving trauma. The court may require you to provide treatment records, to write a letter summarizing your client's progress, or to testify at a trial. Always seek supervisory and legal advice in such situations and discuss with the client the possible repercussions that this might have for the therapeutic relationship. As a general rule, it is best practice to avoid dual roles or relationships.

bomber Timothy McVeigh's father while the man's son was executed in Indiana at a Federal prison several years after the bombing. For this man, forgiveness and acceptance helped him attain personal peace. Other trauma survivors may choose never to forgive what happened, and this, too, is a legitimate response.

Culturally and Gender Responsive Services

Culture is the lens through which reality is interpreted. Without an understanding of culture, it is difficult to gauge how individuals organize, interpret, and resolve their traumas. The challenge is to define how culture affects individuals who have been traumatized.

Increased knowledge of PTSD (Wilson & Tang, 2007), mental illness, and substance use disorders and recovery (Westermeyer, 2004) requires behavioral health practitioners to consider the complicated interactions between culture, personality, mental illness, and substance abuse in adapting treatment protocols. This section offers some general guidelines for working with members of cultures other than one's own. Treatment for traumatic stress, mental illness, substance use disorders, and co-occurring trauma-related symptoms is more effective if it is culturally responsive.

The U.S. Department of Health and Human Services (2003) has defined the term "cultural competence" as follows:

> Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time (p. 12).

Cultural competence is a process that begins with an awareness of one's own culture and beliefs and includes an understanding of how those beliefs affect one's attitudes toward people of other cultures. It is rooted in respect, validation, and openness toward someone whose social and cultural background is different from one's own. For a thorough review of cultural competence, see the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration [SAMHSA], planned c).

Cultural Competence

Cultural competence includes a counselor's knowledge of:

- Whether the client is a survivor of cultural trauma (e.g., genocide, war, government oppression, torture, terrorism).
- How to use cultural brokers (i.e., authorities within the culture who can help interpret cultural patterns and serve as liaisons to those outside the culture).
- How trauma is viewed by an individual's sociocultural support network.
- How to differentiate PTSD, trauma-related symptoms, and other mental disorders in the culture.

For more specific information on cultural competence in trauma therapy, see Brown (2008).

In some cultures, an individual's needs take precedence over group needs (Hui & Triandis, 1986), and problems are seen as deriving from the self. In other cultures, however, complex family, kin, and community systems take precedence over individual needs. Considerable heterogeneity exists within and across most ethnic subcultures and across lines of gender, class, age, and political groups (CSAT, 1999b). Subcultures abound in every culture, such as gangs; populations that are homeless or use substances; orphaned or disenfranchised people; religious, ethnic, and sexual minorities; indigenous people; and refugee and immigrant populations. Some subcultures have more in common with similar subcultures in other countries than with their own cultures (e.g., nonheterosexual populations).

Trauma and substance abuse can themselves be a basis for affiliation with a subculture. De Girolamo (1993) reports that "disaster subcultures" exist within many cultures. These cultures of victimization, like all subcultures, have unique worldviews, codes of conduct, and perceptions of the larger society. In a disaster subculture, people are, to some extent, inured to disaster and heedless of warnings of impending disaster. For example, riverbank erosion in Bangladesh displaces thousands of people each year, yet few believe that it is a serious problem or that the displacement will be permanent (Hutton, 2000). Israelis who have lived with unpredictable violence for many years behave differently in public areas and have adapted to different norms than people who don't commonly experience violence (Young, 2001).

Many people identify with more than one subculture. Some identify with a particular culture or subculture, but not with all of its values. Individual identities are typically a mosaic of factors, including developmental achievements, life experiences, behavioral health histories, traumatic experiences, and

alcohol and illicit drug use; levels of acculturation and/or assimilation vary from one individual to the next as well.

Importance of the trauma aftermath

Counselors working in the immediate aftermath of trauma—whether individual, group, or community in nature—face many challenges. For example, survivors may be forced to adjust without access to other health services, employment, support, or insurance. In these instances, counselors must often work with individuals and communities coping with the trauma while struggling daily to meet basic needs. Research suggests that reestablishing ties to family, community, culture, and spiritual systems can not only be vital to the individual, but can also influence the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of people victimized by Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents affected by the purge experienced fewer negative effects than did those who were emotionally or physically severed from their grandparents. The researchers also found that whether the grandparents survived was less important than the connection the grandchildren managed to keep to their past. Ties to family and community can also have an adverse effect, especially if the family or community downplays the trauma or blames the victim. Counselors need to have a full understanding of available support before advocating a particular approach.

Treatment strategies

Many traditional healing ways have been damaged, forgotten, or lost—yet much wisdom remains. Drawing on the best traditional and contemporary approaches to human distress and defining culturally competent curricula regarding identity and healing (Huriwai, 2002; Wilson & Tang, 2007) both require respect and appreciation for the many ways in which various people characterize and resolve trauma and how they use addictive substances to bear the burdens of human distress.

Community-Based Treatment for Native American Historical Trauma

Key beliefs in community healing:

- Clients carry childhood pain that has led to adult dysfunction.
- Childhood pain must be confronted, confessed, and addressed, if relief is to be obtained.
- Cathartic expression is the initial step in the healing journey toward a lifelong pursuit of introspection and self-improvement.
- The healing journey entails reclamation of indigenous heritage, identity, spirituality, and practices to remedy the pathogenic effects of colonization and other sources of historical trauma.

Source: Gone, 2009.

It is not yet known how well existing PTSD treatments work for individuals who identify primarily with cultures other than mainstream American culture. It is possible that such treatments do work for clients of other cultures, though some cultural adaptation and translation may be required. For example, some PTSD treatments that have been used with subculture groups without adaptation other than language translation and that appear to be effective across cultures include eye movement desensitization and reprocessing (Bleich, Gelkopf, & Solomon, 2003) and Seeking Safety (Daouest et al., 2012).

Gender

Gender differences exist in traumatic stress, mental disorders, and substance use disorders. For example, women have higher rates of PTSD, whereas men have higher rates of substance abuse (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Stewart, Ouimette, & Brown, 2002; Tolin & Foa, 2006).

Working With Clients From Diverse Cultures: Trauma and Substance Abuse

- In socially appropriate ways, educate clients, their loved ones, and possibly members of their extended community about the relationship between substance abuse and PTSD, how substance abuse is often used to cope with trauma, and what treatment entails.
- Make serious efforts to connect clients to supportive and understanding people (preferably within culturally identified groups).
- Help clients understand that many who have not experienced trauma or do not have substance use disorders will not understand the psychological, spiritual, and interpersonal insights that they have gained during their recovery processes.

The types of interpersonal trauma experienced by men and by women are often different. A number of studies (Kimerling, Ouimette, & Weitlauf, 2007) indicate that men experience more combat and crime victimization and women experience more physical and/or sexual assault—implying that men's traumas often occur in public, whereas the traumatization of women is more likely to take place in a private setting, such as a home. Men's abusers are more often strangers. Those who abuse women, on the other hand, are more often in a relationship with them. Women (and girls) often are told, "I love you," during the same time period when the abuse occurs. However, women now serve in the military and thus are increasingly subject to some of the same traumas as men and also to military sexual trauma, which is much more common for women to experience. Similarly, men can be subject to domestic violence or sexual abuse.

In treatment, gender considerations are relevant in a variety of ways, including, but not limited to, the role and impact of societal gender stereotypes upon assessment processes, treatment initiation, and engagement of services (e.g., peer support systems); the selection and implementation of gender-specific and gender-responsive approaches for both men and women at each level of intervention; and the best selection of trauma-related interventions that account for gender-specific differences related to traumatic stress. For an extensive review and discussion of gender-specific and gender-responsive care for traumatic stress and substance use, see the TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d), and TIP 56, *Addressing the Specific Behavioral Health Needs of Men* (SAMHSA, 2013a).

Beyond the complexities of gender considerations, one must also consider whether clients should be given the choice of working with a male or a female counselor. Some clients who have been traumatized have no preference, particularly if their trauma wasn't associated with gender (e.g., a natural disaster, act of terrorism, fire, serious accident). If gender did play a role in trauma (e.g., childhood sexual abuse), clients can have strong fears of working with a counselor who is the same gender as the perpetrator. Many women who experienced sexual abuse (whose perpetrators are typically men) feel uncomfortable being treated by men because of the intense emotions that can be evoked (e.g., anger, fear). Men who experienced sexual abuse (whose perpetrators are also typically men) can feel uncomfortable for the same reasons, or they may feel shame when talking to men due to feelings evoked about masculinity, homosexuality, and so forth. However, not all clients with trauma histories prefer female therapists.

Discuss with clients the possible risks (e.g., initial emotional discomfort) and benefits of being treated by a woman or man (e.g., developing a therapeutic relationship with a man might challenge a client's belief that all men are dangerous), and, if possible, let them then choose the gender of their counselor. Tell

them that if they experience initial emotional discomfort, and the discomfort does not decrease, they can switch to a counselor of the opposite gender. For group therapy that focuses on trauma, similar considerations apply. Generally, gender-specific groups are recommended when possible, but mixed-gender groups also work. Gender also comes into play in substance abuse treatment. Research and clinical observation indicate that significant gender differences occur in many facets of substance abuse and its treatment. For example, men and women experience different physical repercussions of substance use (e.g., women have more health problems), different trajectories (e.g., women become addicted more quickly), and different treatment considerations (e.g., traditional substance abuse treatment was designed for men).

Sexual orientation

Lesbian, gay, bisexual, and transgender (LGBT) clients face specific issues in behavioral health treatment settings, including histories of abuse and discrimination relating to sexual orientation, homophobia in treatment on the part of counselors or other clients, potential difficulty addressing traumatic experiences related to their sexuality or sexual orientation, and often, a significant lack of trust toward others. LGBT people sometimes think that others can't understand them and their specific needs and thus are reluctant to engage in treatment programs in which the clientele is predominantly heterosexual. Some clients react with judgment, anger, or embarrassment when an LGBT client attempts to describe sexual trauma relating to homosexual behavior, making it even harder for LGBT clients to describe their experiences.

Often, individual counseling can address issues the LGBT client isn't comfortable discussing in group treatment. "Providing one-on-one services may decrease the difficulty of mixing heterosexual and LGBT clients in treatment groups and decrease the likelihood that heterosexism or homophobia will become an issue" (CSAT, 2001, p. 56). For more on treating LGBT individuals, see *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT, 2001).

Making Referrals to Trauma-Specific Services

Many people who experience trauma do not exhibit persistent traumatic stress symptoms. In fact, people do recover on their own. So how do you determine who is at higher risk for developing more persistent symptoms of traumatic stress, trauma-related disorders, and traumatic stress disorders? One main factor is the severity of symptoms at the time of screening and assessment. Other factors, beyond trauma characteristics and pretrauma individual characteristics, to consider in making referrals include (Ehlers & Clark, 2003):

- Cognitive appraisals that are excessively negative regarding trauma sequelae, including consequences, changes after the event(s), responses of other people to the trauma, and symptoms.
- Acknowledgment of intrusive memories.
- Engagement in behaviors that reinforce or prevent resolution of trauma, including avoidance, dissociation, and substance use.
- History of physical consequences of trauma (e.g., chronic pain, disfigurement, health problems).
- Experiences of more traumas or stressful life events after the prior trauma.
- Identification of co-occurring mood disorders or serious mental illness.

The next chapter provides an overview of trauma-specific services to complement this chapter and to provide trauma-informed counselors with a general knowledge of trauma-specific treatment approaches.

6 Trauma-Specific Services

IN THIS CHAPTER

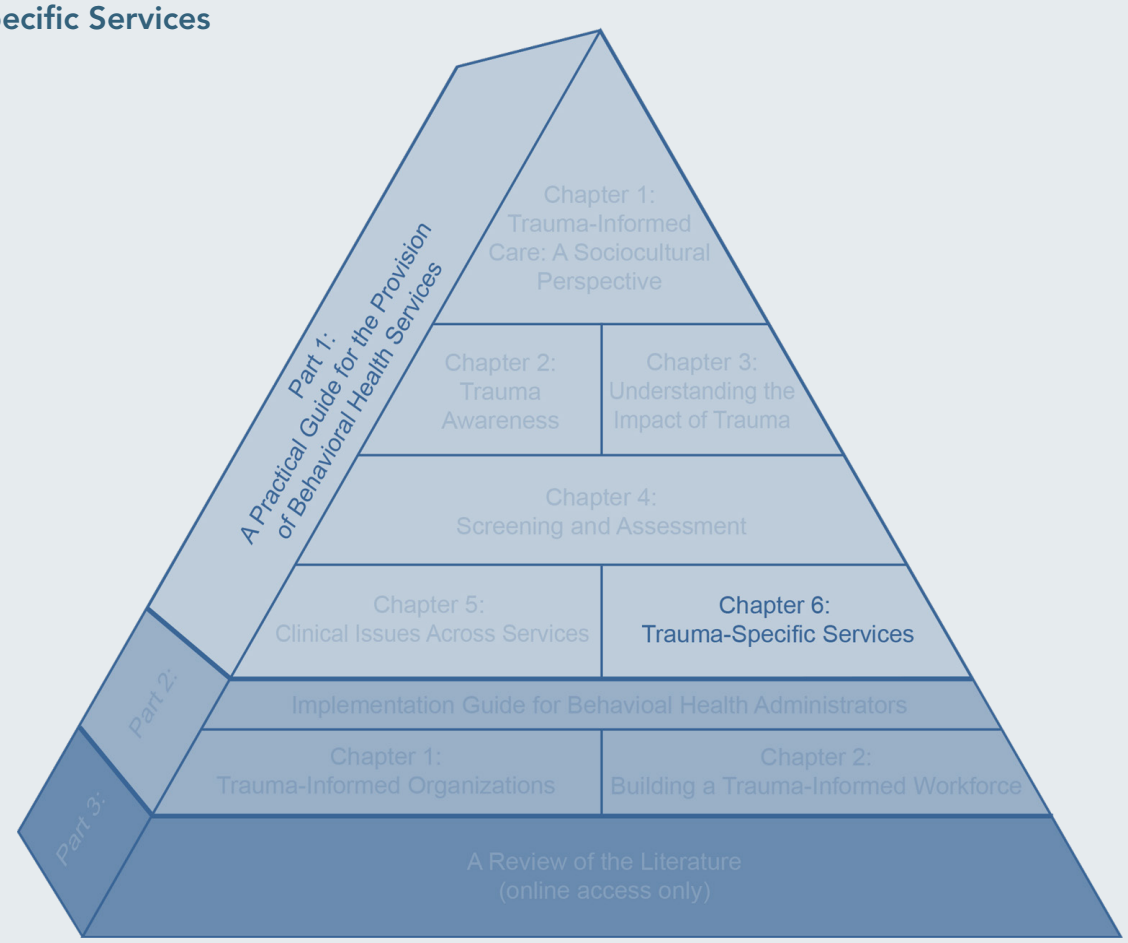
- Introduction
- Trauma Specific Treatment Models
- Integrated Models for Trauma
- Emerging Interventions
- Concluding Note

This chapter covers various treatment approaches designed specifically to treat trauma-related symptoms, trauma-related disorders, and specific disorders of traumatic stress. The models presented do not comprise an exhaustive list, but rather, serve as examples. These models require training and supervised experience to be conducted safely and effectively. The chapter begins with a section on trauma-specific treatment models, providing a brief overview of interventions that can be delivered immediately after a trauma, as well as trauma-specific interventions for use beyond the immediate crisis. The second segment focuses on integrated care that targets trauma-specific treatment for mental, substance use, and co-occurring disorders. Even though entry-level, trauma-informed behavioral health service providers are unlikely to be in a position to use these interventions, having some knowledge of them is nevertheless important. Currently, more research is needed to tease out the most important ingredients of early interventions and their role in the prevention of more pervasive traumatic stress symptoms. More science-based evidence is available for trauma-specific treatments that occur and extend well beyond the immediate reactions to trauma. The last part of the chapter provides a brief review of selected emerging interventions that have not been covered elsewhere in this Treatment Improvement Protocol (TIP).

Introduction

Trauma-specific therapies vary in their approaches and objectives. Some are present focused, some are past focused, and some are combinations (Najavits, 2007a). Present-focused approaches primarily address current coping skills, psychoeducation, and managing symptoms for better functioning. Past-focused approaches primarily focus on telling the trauma story to understand the impact of the trauma on how the person functions today, experiencing emotions that were too overwhelming to experience in the past, and helping clients more effectively cope in the present with their

Trauma-Informed Care Framework in Behavioral Health Services—Trauma-Specific Services



traumatic experiences. Clients participating in present-focused approaches may reveal some of their stories; past-focused approaches emphasize how understanding the past influences current behavior, emotion, and thinking, thereby helping clients cope more effectively with traumatic experiences in the present.

The distinction between these approaches lies in the primary emphasis of the approach. Depending on the nature of the trauma and the specific needs of the client, one approach may be more suitable than the other. For instance, in short-term treatment for clients in early recovery from mental illness and/or substance abuse, present-focused, cognitive–behavioral, or psychoeducational approaches are generally more appropriate. For clients who are stable in their recovery and have histories of developmental trauma where much of the trauma has been repressed, a past-focused orientation may be helpful. Some clients may benefit from both types, either concurrently or sequentially.

This chapter discusses a number of treatment models, general approaches, and techniques. A treatment model is a set of practices designed to alleviate symptoms, promote psychological well-being, or restore mental health. Treatment techniques are specific procedures that can be used as part of a variety of models. Some models and techniques described in this chapter can be used with groups, some with individuals, and some with both. This chapter is selective rather than comprehensive; additional models are described in the literature. See, for example, the PILOTS database on the Web site of the National Center for PTSD

(NCPTSD; http://www.ptsd.va.gov) for treatment literature related to trauma and posttraumatic stress disorder (PTSD). For an overview of models for use with both adult and child populations, refer to *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services* (Center for Mental Health Services, 2008).

Some treatments discussed in this chapter are described as evidence based. Because research on integrated treatment models is so new, many have only been examined in a few studies. Given these circumstances and the fact that an outcome study provides only limited evidence of efficacy, the term "evidence based" should be interpreted cautiously. Additional scientific study is needed to determine whether some treatments discussed herein are, in fact, evidence based. A good resource for evaluating evidence-based, trauma-specific treatment models is *Effective Treatments for PTSD* (Foa, Keane, Friedman, & Cohen, 2009). Although evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with symptoms of trauma that co-occur with mental and substance use disorders (see Allen, 2001, for an indepth discussion of trauma and serious mental illness), other factors must also be weighed, including the specific treatment needs of the client; his or her history of trauma, psychosocial and cultural background, and experiences in prior trauma treatment; the overall treatment plan for the client; and the competencies of the program's clinical staff. Although behavioral health counselors can prepare to help their clients address some of the issues discussed in Chapter 5, specialized training is necessary to provide treatment for co-occurring substance use and mental disorders related to trauma.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has created the National Registry of Evidence-Based Programs and Practices (NREPP) as a resource for reviewing and identifying effective treatment programs. Programs can be nominated for consideration as co-occurring disorders programs or substance abuse prevention or treatment programs, and their quality of evidence, readiness for dissemination, and training considerations are then reviewed. For more detailed information, including details about several evidence-based co-occurring trauma treatment programs, visit the NREPP Web site (http://www.nrepp.samhsa.gov). Program models for specialized groups, such as adolescents, can also be found on the NREPP Web site. For specific research-oriented information on trauma-specific treatments, refer to Part 3 of this TIP, which provides a literature review and links to select abstracts (available online).

Federal Agencies

Both the American Red Cross and the Federal Emergency Management Agency (FEMA) respond to disasters. Behavioral health service providers should understand the basics about these major emergency response agencies. For example, the Red Cross can respond rapidly with funding for food, shelter, and immediate needs, whereas FEMA assistance requires a period of gearing up but provides for longer-term needs. SAMHSA, along with other Federal agencies, assists FEMA in a number of areas of emergency response planning activities. See also SAMHSA's Disaster Technical Assistance Center Web site (http://www.samhsa.gov/dtac) and Technical Assistance Publication 34, *Disaster Planning Handbook for Behavioral Health Treatment Programs* (SAMHSA, 2013).

Trauma-Specific Treatment Models

Immediate Interventions

Intervention in the first 48 hours

The acute intervention period comprises the first 48 hours after a traumatic event. In a

"One day I was called out of bed at 5:00 a.m. to go to a town approximately 30 miles away because a levee had broken…. By 6:00 a.m., my colleagues and I were there with many of the townspeople, with helicopters flying overhead, with trucks going in and out by the main road trying to empty the factories. When we got there, as far as you could see was farmland. By 11 a.m., you could see a 'lake' in the distance. By 2 p.m., the water was on the edge of the town. Being there, at that town, before, during, and after the water came was probably the most valuable function we performed. We were able to share in the grief of the hundreds of people as we stayed with them while their fields, houses, and workplaces were flooded. We witnessed the death of a town, and the people reacted with disbelief, anger, sadness, and numbness. Each person had a different story, but all grieved, and we provided many an opportunity to express it. People cried as the water started rising into their houses. Some had to watch. Some had to leave. At times it was utterly silent as we all waited. There was a woman whose parents sent her away during the floods of '43 and she had been angry for 50 years about it. She was determined that her children and grandchildren would see everything. I spent 12 hours that day just giving support, listening, giving information, and sometimes shedding a tear or two myself."

—Rosemary Schwartzbard, Ph.D., responder to floods along the Mississippi River in 1993

Source: Schwartzbard, 1997.

disaster, rescue operations usually begin with local agencies prior to other organizations arriving on the scene. Law enforcement is likely to take a primary role on site. Whether it is a disaster, group trauma, or individual trauma (including a trauma that affects an entire family, such as a house fire), a hierarchy of needs should be established: survival, safety, security, food, shelter, health (physical and mental), orientation of survivors to immediate local services, and communication with family, friends, and community (National Institute of Mental Health, 2002). In this crucial time, appropriate interventions include educating survivors about resources; educating other providers, such as faith-based organizations and social service groups, to screen for increased psychological effects including use of substances; and use of a trauma response team that assists clients with their immediate needs. No formal interventions should be attempted at this time, but a professionally trained, empathic listener can offer solace and support (Litz & Gray, 2002).

Basic needs

Basic necessities, such as shelter, food, and water, are key to survival and a sense of safety. It is important to focus on meeting these basic needs and on providing a supportive environment. Clients' access to prescribed medications may be interrupted after a trauma, particularly a disaster, so providers should identify clients' medication needs for preexisting physical and mental disorders, including methadone or other pharmacological treatment for substance use. For example, after September 11, 2001, substance abuse treatment program administrators in New York had to seek alternative methadone administration options (Frank, Dewart, Schmeidler, & Demirjian, 2006).

Psychological first aid

The psychological first aid provided in the first 48 hours after a disaster is designed to ensure safety, provide an emotionally supportive environment and activities, identify those with high-risk reactions, and facilitate communication, including strong, reassuring leadership immediately after the event. The primary helping response of psychological first aid is to provide a calm, caring, and supportive environment to set the scene for psychological recovery. It is also essential that all those first responding to a trauma—rescue workers, medical professionals, behavioral health workers (including substance abuse counselors), journalists, and volunteers—be familiar with relevant aspects of traumatic stress. Approaching

Advice to Counselors: Core Actions in Preparing To Deliver Psychological First Aid

- Contact and engagement
- Safety and comfort
- Stabilization
- Information gathering: Current needs and concerns
- Practical assistance
- Connection with social supports
- Information on coping
- Linkage with collaborative services

Source: National Child Traumatic Stress Network & NCPTSD, 2012.

survivors with genuine respect, concern, and knowledge increases the likelihood that the caregiver can (NCPTSD, 2002):

- Answer questions about what survivors may be experiencing.
- Normalize their distress by affirming that what they are experiencing is normal.
- Help them learn to use effective coping strategies.
- Help them be aware of possible symptoms that may require additional assistance.
- Provide a positive experience that will increase their chances of seeking help if they need it in the future.

Clinical experience suggests that care be taken to respect a survivor's individual method of coping; some may want information, for example, whereas others do not. Similarly, some may want to talk about the event, but others won't. An excellent guide to providing psychological first aid is available online from the Terrorism and Disaster Branch of the National Child Traumatic Stress Network (http://www.nctsn.org/content/psychological-first-aid).

Critical incident stress debriefing

Initially developed for work with first responders and emergency personnel, critical incident stress debriefing (CISD; Mitchell & Everly, 2001) is now widely used and encompasses various group protocols used in a variety of settings. This facilitator-led group intervention is for use soon after a traumatic event with exposed people. The goal is to provide psychological closure by encouraging participants to talk about their experiences and then giving a didactic presentation on common stress reactions and management.

The widespread use of CISD has occurred despite the publication of conflicting results regarding its efficacy. Claims that single-session psychological debriefing can prevent development of chronic negative psychological sequelae are not empirically supported (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Some controlled studies suggest that it may impede natural recovery from trauma (McNally, Bryant, & Ehlers, 2003). Other research suggests emphasizing screening to determine the need for early interventions. Mitchell and Everly (2001) point out that many of the studies showing negative

Advice to Counselors: Evidence Related to Immediate Interventions

Evidence related to immediate interventions suggests that:

- Early, brief, focused psychotherapeutic intervention provided in an individual or group format can reduce distress in bereaved spouses, parents, and children.
- Selected cognitive–behavioral approaches may help reduce the incidence, duration, and severity of acute stress disorder (ASD), PTSD, and depression in trauma survivors.
- A one-session individual recital of events and expression of emotions evoked by a traumatic event does not consistently reduce risk of later developing PTSD. In fact, it may increase the risk for adverse outcomes. Perhaps CISD hinders the natural recovery mechanisms that restore pretrauma functioning (Bonanno, 2004).
- The focus initially should be upon screening with follow-up as indicated.

results were not conducted with first responders; that is, CISD may be appropriate for some, but not all, groups. A recent study of 952 U.S. peacekeepers and CISD by the U.S. Army Research Unit–Europe (Adler et al., 2008) found mixed results.

Interventions Beyond the Initial Response to Trauma

In the interest of increasing your overall familiarity with relevant approaches, the following sections review several traumatic stress treatment approaches that counselors will most likely encounter when collaborating with clinicians or agencies that specialize in trauma-specific services and treating traumatic stress.

Cognitive–behavioral therapies

Most PTSD models involve cognitive–behavioral therapy (CBT) that integrates cognitive and behavioral theories by incorporating two ideas: first, that cognitions (or thoughts) mediate between situational demands and one's attempts to respond to them effectively, and second, that behavioral change influences acceptance of altered cognitions about oneself or a situation and establishment of newly learned cognitive–behavioral interaction patterns. In practice, CBT uses a wide range of coping strategies.

There are many different varieties of CBT. CBT originated in the 1970s (Beck, Rush, Shaw & Emery, 1979; Ellis & Harper, 1975) and has expanded since then to address various populations, including people who use substances, people who experience anxiety, people with PTSD or personality disorders, children and adolescents, individuals involved in the criminal justice system, and many others. CBT has also been expanded to include various techniques, coping skills, and approaches, such as dialectical behavior therapy (DBT; Linehan, 1993), Seeking Safety (Najavits, 2002a), and mindfulness (Segal, Williams, & Teasdale, 2002). Traditional CBT emphasizes symptom reduction or resolution, but recent CBT approaches have also emphasized the therapeutic relationship, a particularly important dynamic in trauma treatment (Jackson, Nissenson, & Cloitre, 2009).

A widely accepted framework in treating trauma, substance use disorders, and mental illness categorizes therapies as single (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treatment of multiple disorders delivered by separate clinicians or in separate programs that do not necessarily address the interactions between symptoms and disorders).

CBT has been applied to the treatment of trauma and has also been widely and effectively used in the treatment of substance use. A review of efficacy research on CBT for PTSD is provided by Rothbaum, Meadows, Resick, and Foy (2000). Najavits and colleagues (2009) and O'Donnell and Cook (2006) offer an overview of CBT therapies for treating PTSD and substance abuse. In addition, a free online training resource incorporating CBT for traumatized children within the community, Trauma-Focused CBT, is available from the Medical University of South Carolina (http://tfcbt.musc.edu/).

Cognitive processing therapy

Cognitive processing therapy (CPT) is a manualized 12-session treatment approach that can be administered in a group or individual setting (Resick & Schnicke, 1992, 1993). CPT was developed for rape survivors and combines elements of existing treatments for PTSD, specifically exposure therapy (see the "Exposure Therapy" section later in this chapter) and cognitive therapy. The exposure therapy component of treatment consists of

Advice to Counselors: Relaxation Training, Biofeedback, and Breathing Retraining Strategies

Relaxation training, biofeedback, and breathing retraining strategies may help some clients cope with anxiety, a core symptom of traumatic stress. However, no evidence supports the use of relaxation and biofeedback as effective standalone PTSD treatment techniques (Cahill, Rothbaum, Resick, & Follete, 2009). Both are sometimes used as complementary strategies to manage anxiety symptoms elicited by trauma-related stimuli. Breathing retraining uses focused or controlled breathing to reduce arousal. Breathing retraining and relaxation, along with other interventions when necessary, can help clients with ASD. An important caution in the use of breath work with trauma clients is that it can sometimes act as a trigger—for example, given its focus on the body and its potential to remind them of heavy breathing that occurred during assault. Biofeedback, which requires specialized equipment, combines stress reduction strategies (e.g., progressive muscle relaxation, guided imagery) with feedback from biological system measures (e.g., heart rate, hand temperature) that gauge levels of stress or anxiety reduction. Relaxation training, which requires no specialized equipment, encourages clients to reduce anxiety responses (including physiological responses) to trauma-related stimuli; it is often part of more comprehensive PTSD treatments (e.g., prolonged exposure and stress inoculation training [SIT]).

clients writing a detailed account of their trauma, including thoughts, sensations, and emotions that were experienced during the event. The client then reads the narrative aloud during a session and at home. The cognitive therapy aspect of CPT uses six key PTSD themes identified by McCann and Pearlman (1990): safety, trust, power, control, esteem, and intimacy. The client is guided to identify cognitive distortions in these areas, such as maladaptive beliefs.

Results from randomized, placebo-controlled trials for the treatment of PTSD related to interpersonal violence (Resick, 2001; Resick, Nishith, Weaver, Astin, & Feuer, 2002) support the use of CPT. CPT and prolonged exposure therapy models are equally and highly positive in treating PTSD and depression in rape survivors; CPT is superior in reducing guilt (Nishith, Resick, & Griffin, 2002; Resick et al., 2002; Resick, Nishith, & Griffin, 2003). CPT has shown positive outcomes with refugees when administered in the refugees' native language (Schulz, Marovic-Johnson, & Huber, 2006) and with veterans (Monson et al., 2006). However, CPT has not been studied with high-complexity populations such as individuals with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. CPT requires a 3-day training plus consultation (Karlin et al., 2010). Resick and Schicke (1996) published a CPT treatment manual, *Cognitive Processing Therapy for Rape Victims: A Treatment Manual*.

Exposure therapy

Exposure therapy for PTSD asks clients to directly describe and explore trauma-related memories, objects, emotions, or places. Intense emotions are evoked (e.g., sadness, anxiety) but eventually decrease, desensitizing clients through repeated encounters with traumatic material. Careful monitoring of the pace and appropriateness of exposure-based interventions is necessary to prevent retraumatization (clients can become conditioned to fear the trauma-related material even more). Clients must have ample time to process their memories and integrate cognition and affect, so some sessions can last for 1.5 hours or more. For simple cases, exposure can work in as few as 9 sessions; more complex cases may require 20 or more sessions (Foa, Hembree, & Rothbaum, 2007). Various techniques can

Advice to Counselors: Steps for Introducing a Breathing Exercise

Use the following statements to lead clients through a breathing exercise:

- Place your hands on your stomach. As you inhale, breathe deeply but slowly so that your hands rise with your stomach. As you exhale slowly, practice breathing so that your hands drop with your stomach.
- Inhale slowly through your nose with your mouth closed; don't rush or force in the air.
- Exhale slowly through your mouth with your lips in the whistling position.
- Breathe out for twice as long as you breathe in.

expose the client to traumatic material. Two of the more common methods are exposure through imagery and in vivo ("real life") exposure.

The effectiveness of exposure therapy has been firmly established (Rothbaum et al., 2000); however, adverse reactions to exposure therapy have also been noted. Some individuals who have experienced trauma exhibit an exacerbation of symptoms during or following exposure treatments. Even so, the exacerbation may depend on counselor variables during administration. Practitioners of exposure therapy need comprehensive training to master its techniques (Karlin et al., 2010); a counselor unskilled in the methods of this treatment model can not only fail to help his or her clients, but also cause symptoms to worsen.

Exposure therapy is recommended as a first-line treatment option when the prominent trauma symptoms are intrusive thoughts, flashbacks, or trauma-related fears, panic, and avoidance. However, counselors should exercise caution when using exposure with clients who have not maintained stability in managing mental illness symptoms or abstinence from substance use disorders. Studies and routine use of exposure have consistently excluded high-complexity clients such as those with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. The only trial of exposure therapy with a substance dependence sample found that it did not outperform standard substance abuse treatment on most variables (Mills et al., 2012).

Prolonged exposure therapy for PTSD is listed in SAMHSA's NREPP. For reviews of exposure therapy, also see Najavits (2007a) and Institute of Medicine (2008). In addition to prolonged exposure therapy, other therapies incorporate exposure and desensitization techniques, including eye movement desensitization and reprocessing (EMDR; Shapiro, 2001), cognitive processing, and systematic desensitization therapies (Wolpe, 1958).

Eye movement desensitization and reprocessing

EMDR (Shapiro, 2001) is one of the most widely used therapies for trauma and PTSD. The treatment protocols of EMDR have evolved into sophisticated paradigms requiring training and, preferably, clinical supervision. EMDR draws on a variety of theoretical

A Brief Description of EMDR Therapy

Treatment involves three main concentrations (past memories, present disturbances, future actions) and eight phases. Counselors may work with several phases in one session. Each phase is meant to be revisited either in every session or when appropriate (e.g., the closure process is meant to be conducted at the end of every session, in preparation for the next).

- Phase 1: History and Treatment Planning (1-2 sessions)
- Phase 2: Preparation
- Phase 3: Assessment and Reprocessing
- Phase 4: Desensitization
- Phase 5: Installation
- Phase 6: Body Scan
- Phase 7: Closure
- Phase 8: Reevaluation

Source: EMDR Network, 2012.

frameworks, including psychoneurology, CBT, information processing, and nonverbal representation of traumatic memories. The goal of this therapy is to process the experiences that are causing problems and distress. It is an effective treatment for PTSD (Seidler & Wagner, 2006) and is accepted as an evidence-based practice by the U.S. Department of Veterans Affairs (VA), the Royal College of Psychiatrists, and the International Society for Traumatic Stress Studies (Najavits, 2007a); numerous reviews support its effectiveness (e.g., Mills et al., 2012). EMDR values the development of "resource installation" (calming procedures) and engages in exposure work to desensitize clients to traumatic material, using external tracking techniques across the visual field to assist in processing distressing material. Training in EMDR, available through the EMDR Institute, is required before counselors use this treatment. It is listed in SAMHSA's NREPP (EMDR Network, 2012). Thus far, there is no study examining the use of EMDR with clients in substance abuse treatment. See Part 3 of this TIP, available online, to review empirical work on EMDR.

Narrative therapy

Narrative therapy is an emerging approach to understanding human growth and change; it is founded on the premise that individuals are the experts on their own lives and can access their existing intrapsychic and interpersonal resources to reduce the impact of problems in their lives. Developed for the treatment of PTSD resulting from political or community violence, narrative therapy is based on CBT principles, particularly exposure therapy (Neuner, Schauer, Elbert, & Roth, 2002; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). This approach views psychotherapy not as a scientific practice, but as a natural extension of healing practices that have been present throughout human history. For a trauma survivor, the narrative, as it is told and retold, expresses the traumatic experience, puts the trauma in the context of the survivor's life, and defines the options he or she has for change. Narrative structure helps clients connect events in their lives, reveals strings of events, explores alternative expressions of trauma, evokes explanations for clients' behaviors, and identifies their knowledge and skills. The use of stories in therapy, with the client as the storyteller, generally helps lessen suffering (McLeod, 1997; White, 2004).

In the substance abuse treatment field, many clients will see a connection between narrative therapy and the process of telling their stories in 12 Step programs, in which reframing life stories of feeling trapped, despairing, and hopeless leads to stories of strength, joy, and hope. Key storytelling points at a 12 Step speaker meeting include describing what an experience was like, what happened, and what it is like now.

Skills training in affective and interpersonal regulation

Skills training in affective and interpersonal regulation (STAIR) is a two-phase cognitive–behavioral model that adapts therapies developed by others into a new package (Cloitre, Koenen, Cohen, & Han, 2002). Phase 1 consists of eight weekly sessions of skills training in affect and interpersonal regulation derived from general CBT and DBT (Linehan, 1993) and adapted to address trauma involving childhood abuse. Session topics are labeling and identifying feelings, emotion management, distress tolerance, acceptance of feelings, identifying trauma-based interpersonal schemas, identifying conflict between trauma-generated feelings and current interpersonal goals, role-plays on issues of power and control, and role-plays on developing flexibility in interpersonal situations. Phase 2 features eight

STAIR Steps

Phase 1, tailored to individual clients, is called Skills Training in Affect Regulation and consists of the following components:

- Psychoeducation: Describe the symptoms of PTSD and explain the treatment rationale.
- Training in experiencing and identifying feelings, triggers, and thoughts, as well as training in mood regulation strategies.
- Learning history: Ask the client the following questions—How did the client deal with traumas past and present? How did the client's family deal with feelings? How did the client's family life affect his or her present difficulty experiencing and identifying feeling?
- Emotion regulation skills: Identify the cognitive, behavioral, and social support modalities for coping. Use data gathered with self-monitoring forms to identify strengths and weaknesses in each coping modality. Teach skills such as breathing retraining, self-statements to reduce fear, and social skill training to improve social support.
- Acceptance and tolerance of negative affect: Motivate clients to face distressing situations related to the trauma that are important to them. Review negative repercussions of avoidance. Discuss tolerating negative affect as a step toward achieving specific goals.
- Schema therapy for improved relationships: Identify relevant schemas learned in childhood. Suggest alternative ways of viewing self and others in current relationships. Use role-playing to teach assertiveness, emphasizing response flexibility based on relative power in each relationship.

Once Phase 1 of STAIR is well learned, clients move to Phase 2, which involves exposure therapy.

Source: Mollick & Spett, 2002.

sessions of modified prolonged exposure using a narrative approach.

Cloitre and colleagues (2002) assigned women with PTSD related to childhood abuse randomly to STAIR or a minimal attention waitlist, excluding clients with current substance dependence as well as other complexities. STAIR participants showed significantly greater gains in affect regulation, interpersonal skills, and PTSD symptoms than the control participants. These gains were maintained through follow-up at 3 and 9 months. However, it is not clear from this study whether DBT and exposure were both needed. Phase 1 therapeutic alliance and negative mood regulation skills predicted Phase 2 exposure success in reducing PTSD, suggesting the importance of establishing a strong therapeutic relationship and emotion regulation skills before conducting exposure work with people who have chronic PTSD.

Stress inoculation training

SIT was originally developed to manage anxiety (Meichenbaum, 1994; Meichenbaum & Deffenbacher, 1988). Kilpatrick, Veronen, and Resick (1982) modified SIT to treat rape survivors based on the idea that the anxiety and fear that rape survivors experience during their trauma generalizes to other objectively safe situations. SIT treatment components include education, skills training (muscle relaxation training, breathing retraining, role-playing, guided self-talk, assertiveness training, and thought stopping [i.e., actively and forcefully ending negative thoughts by thinking

SIT has been used to help individuals cope with the aftermath of exposure to stressful events and on a preventative basis to "inoculate" individuals to future and ongoing stressors (Meichenbaum, 1996). This practice as a preventive strategy is similar to promoting disease resistance through immunizations.

Advice to Counselors: SIT Phases

SIT is a prevention and treatment approach that has three overlapping phases. It is often seen as a complementary approach to other interventions for traumatic stress.

Phase 1: Conceptualization and education. This phase has two main objectives. The initial goal is to develop a collaborative relationship that supports and encourages the client to confront stressors and learn new coping strategies. The next objective is to increase the client's understanding of the nature and impact of his or her stress and awareness of alternative coping skills. Many cognitive strategies are used to meet these objectives, including self-monitoring activities, Socratic questioning, identifying strengths and evidence of resilience, and modeling of coping strategies.

Phase 2: Skill acquisition and rehearsal. This phase focuses on developing coping skills and using coping skills that the individual already possesses. This process includes practice across settings, so that the individual begins to generalize the use of his or her skills across situations through rehearsal, rehearsal, and more rehearsal.

Phase 3: Implementation and following through. The main objective is to create more challenging circumstances that elicit higher stress levels for the client. By gradually increasing the challenge, the client can practice coping strategies that mimic more realistic circumstances. Through successful negotiation, the client builds a greater sense of self-efficacy. Common strategies in this phase include imagery and behavioral rehearsal, modeling, role-playing, and graded in vivo exposure.

Source: Meichenbaum, 2007.

"STOP" and then redirecting thoughts in a more positive direction]), and skills application. The goal is to help clients learn to manage their anxiety and to decrease avoidant behavior by using effective coping strategies. Randomized controlled clinical trials have indicated that SIT reduces the severity of PTSD compared with waitlist controls and shows comparable efficacy to exposure therapy. At follow-up (up to 12 months after treatment), gains were maintained (Foa et al., 1999; Foa, Rothbaum, Riggs, & Murdock, 1991).

Other therapies

Numerous interventions introduced in the past 20 years focus on traumatic stress. For some interventions, the evidence is limited, and for other others, it is evolving. One example is the traumatic incident reduction (TIR) approach. This brief memory-oriented intervention is designed for children, adolescents, and adults who have experienced traumatic stress (Valentine & Smith, 2001). Listed in SAMHSA's NREPP, the intervention is designed to process specific traumatic incidents or problematic themes related to the trauma, including specific feelings, emotions, sensations, attitudes, or pain. It involves having clients talk through the traumatic incident repeatedly with the anticipation that changes in affect will occur throughout the repetitions. TIR is a client-centered approach.

Integrated Models for Trauma

This section covers models specifically designed to treat trauma-related symptoms along with either mental or substance use disorders at the same time. Integrated treatments help clients work on several presenting problems simultaneously throughout the treatment, a promising and recommended strategy (Dass-Brailsford & Myrick, 2010; Najavits, 2002b; Nixon & Nearmy, 2011). Thus far, research is limited, but what is available suggests that integrated treatment models effectively reduce

substance abuse, PTSD symptoms, and other mental disorder symptoms. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment, 2005c), offers a detailed description of integrated treatment. In contrast with integrated models, other model types include single (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treatment of multiple disorders delivered by separate clinicians or in separate programs that do not necessarily address the interactions between symptoms and disorders).

Similar to single models, integrated treatment models are designed for use in a variety of settings (e.g., outpatient, day treatment, and/or residential substance abuse and mental health clinics/programs). Most models listed are manual-based treatments that address trauma-related symptoms, mental disorders, and substance use disorders at the same time. Additional approaches and further details on the selected approaches can be found at NREPP (http://www.nrepp.samhsa.gov).

Addiction and Trauma Recovery Integration Model

The Addiction and Trauma Recovery Integrated Model (ATRIUM; Miller & Guidry, 2001) integrates CBT and relational treatment through an emphasis on mental, physical, and spiritual health. This 12-week model for individuals and groups blends psychoeducational, process, and expressive activities, as well as information on the body's responses to addiction and traumatic stress and the impact of trauma and addiction on the mind and spirit. It helps clients explore anxiety, sexuality, self-harm, depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection. It was designed primarily for women and focuses on developmental (childhood) trauma and interpersonal violence, but it recognizes that other types of traumatic events occur.

The ATRIUM model consists of three phases of treatment. The first stage, or "outer circle," consists of the counselor collecting data from the client about his or her trauma history, offering psychoeducation on the nature of trauma, and helping the client assess personal strengths. ATRIUM actively discourages the evocation of memories of abuse or other trauma events in this phase. The second stage, or "middle circle," allows clients and counselors to address trauma symptoms more directly and specifically encourages clients to reach out to and engage with support resources in the community. The middle circle also emphasizes learning new information about trauma and developing additional coping skills. The third stage of the program, the "inner circle," focuses on challenging old beliefs that arose as a result of the trauma. For instance, the concept of "nonprotecting bystander" is used to represent the lack of support that the traumatized person experienced at the time of the trauma. This representation is replaced with the "protective presence" of supportive others today.

ATRIUM was used in one of the nine study sites of SAMHSA's Women, Co-Occurring Disorders and Violence Study. Across all sites, trauma-specific models achieved more favorable outcomes than control sites that did not use trauma-specific models (Morrissey et al., 2005). There has not yet been a study of ATRIUM per se, however. A manual describing the theory behind this model in greater depth, as well as how to implement it, is published under the title *Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit* (Miller & Guidry, 2001).

Beyond Trauma: A Healing Journey for Women

Beyond Trauma (Covington, 2003) is a curriculum for women's services based on theory, research, and clinical experience. It was developed for use in residential, outpatient, and correctional settings; domestic violence programs; and mental health clinics. It uses behavioral techniques and expressive arts and is based on relational therapy. Although the materials are designed for trauma treatment, the connection between trauma and substance abuse in women's lives is a theme throughout. Beyond Trauma has a psychoeducational component that defines trauma by way of its process as well as its impact on the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). Coping skills are emphasized; specific exercises develop emotional wellness.

Concurrent Treatment of PTSD and Cocaine Dependence

Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD) is a 16-session, twice-weekly individual outpatient psychotherapy model designed to treat women and men with co-occurring PTSD and cocaine dependence (Coffey, Schumacher, Brimo, & Brady, 2005). CTPCD combines imagery and in vivo exposure therapy (in which the client becomes desensitized to anxiety-producing stimuli through repeated exposure to them) for the treatment of PTSD with elements of CBT for substance dependence. To balance the dual needs of abstinence skill building and prompt trauma treatment, the first five sessions focus on coping skills for cocaine dependence. Session six transitions into exposure therapy, which begins in earnest in session seven and is combined with CBT for the treatment of substance abuse.

CTPCD helps reduce substance use and PTSD symptoms. The use of any illicit drug, as measured by urine screens, was quite low during the 16-week treatment trial and didn't escalate during the second half of treatment—when most exposure sessions occurred. PTSD symptoms dropped significantly over the course of treatment, as did self-reported depressive symptoms; however, the dropout rate was high (Coffey, Dansky, & Brady, 2003). CTPCD was reformulated into Concurrent Prolonged Exposure (COPE; Mills et al., 2012), which was compared with treatment as usual in a high-complexity clinical sample of individuals who had PTSD and substance dependence. Both treatment conditions resulted in improvements in PTSD with no difference at 3 months (though COPE showed significantly greater improvement at 9 months); moreover, the two conditions did not differ in impact on substance use outcomes, depression, or anxiety.

Integrated CBT

Integrated CBT is a 14-session individual therapy model designed for PTSD and substance use. It incorporates elements such as psychoeducation, cognitive restructuring, and breathing retraining (McGovern, Lamber-Harris, Alterman, Xie, & Meier, 2011). A randomized controlled trial showed that both integrated CBT and individual addiction treatment achieved improvements in substance use and other measures of psychiatric symptom severity with no difference between the treatments.

Seeking Safety

Seeking Safety is an empirically validated, present-focused treatment model that helps clients attain safety from trauma and substance abuse (Najavits, 2002a). The Seeking Safety manual (Najavits, 2002b) offers clinician guidelines and client handouts and is available in

several languages. Training videos and other implementation materials are available online (http://www.seekingsafety.org). Seeking Safety is flexible; it can be used for groups and individuals, with women and men, in all settings and levels of care, by all clinicians, for all types of trauma and substance abuse.

Seeking Safety covers 25 topics that address cognitive, behavioral, interpersonal, and case management domains. The topics can be conducted in any order, using as few or as many as are possible within a client's course of treatment. Each topic represents a coping skill relevant to both trauma and substance abuse, such as compassion, taking good care of yourself, healing from anger, coping with triggers, and asking for help. This treatment model builds hope through an emphasis on ideals and simple, emotionally evocative language and quotations. It attends to clinician processes and offers concrete strategies that are thought to be essential for clients dealing with concurrent substance use disorders and histories of trauma.

More than 20 published studies (which include pilot studies, randomized controlled trials, and multisite trials representing various investigators and populations) provide the evidence base for this treatment model. For more information, see SAMHSA's NREPP Web site (http://www.nrepp.samhsa.gov) as well as the "Outcomes" section of the Seeking Safety Web site (http://www.seekingsafety.org/3-03-06/studies.html). Study samples included people with chronic, severe trauma symptoms and substance dependence who were diverse in ethnicity and were treated in a range of settings (e.g., criminal justice, VA centers, adolescent treatment, homelessness services, public sector). Seeking Safety has shown positive outcomes on trauma symptoms, substance abuse, and other domains (e.g., suicidality, HIV risk, social functioning, problem-solving, sense of meaning); consistently outperformed treatment as usual; and achieved high satisfaction ratings from both clients and clinicians. It has been translated into seven languages, and a version for blind and/or dyslexic individuals is available.

The five key elements of Seeking Safety are:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
2. Integrated treatment (working on trauma and substance abuse at the same time).
3. A focus on ideals to counteract the loss of ideals in both trauma and substance abuse.
4. Four content areas: cognitive, behavioral, interpersonal, and case management.
5. Attention to clinician processes (addressing countertransference, self-care, and other issues).

Substance Dependence PTSD Therapy

Substance Dependence PTSD Therapy (Triffleman, 2000) was designed to help clients of both sexes cope with a broad range of traumas. It combines existing treatments for PTSD and substance abuse into a structured, 40-session (5-month, twice-weekly) individual therapy that occurs in two phases. Phase I is "Trauma-Informed, Addictions-Focused Treatment" and focuses on coping skills and cognitive interventions as well as creating a safe environment. Phase I draws on CBT models, anger management, relaxation training, HIV risk reduction, and motivational enhancement techniques. Phase II, "Trauma-Focused, Addictions-Informed Treatment," begins with psychoeducation about PTSD followed by "Anti-Avoidance I," in which a modified version of stress inoculation training is taught in two to four sessions. Following this is "Anti-Avoidance II," lasting 6 to 10 sessions, in which in vivo exposure is used.

Trauma Affect Regulation: Guide for Education and Therapy

Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford & Russo, 2006; Frisman, Ford, Lin, Mallon, & Chang, 2008) uses emotion and information processing in a present-focused, strengths-based approach to education and skills training for trauma survivors with severe mental, substance use, and co-occurring disorders across diverse populations. TARGET helps trauma survivors understand how trauma changes the brain's

TARGET: The Seven-Step FREEDOM Approach

Focus: Being focused helps a person pay attention and think about what's happening right now instead of just reacting based on alarm signals tied to past trauma. This step teaches participants to use the SOS skill (Slow down, Orient, Self-check) to pay attention to body signals and the immediate environment and to use a simple scale to measure stress and control levels.

Recognize triggers: Recognizing trauma triggers enables a person to anticipate and reset alarm signals as he or she learns to distinguish between a real threat and a reminder. This step helps participants identify personal triggers, take control, and short-circuit their alarm reactions.

Emotion self-check: The goal of this skill is to identify two types of emotions. The first are "alarm" or reactive emotions such as terror, rage, shame, hopelessness, and guilt. Because these emotions are the most noticeable after trauma, they are the alarm system's way of keeping a person primed and ready to fend off further danger. The second type of emotion, "main" emotions, include positive feelings (e.g., happiness, love, comfort, compassion) and feelings that represent positive strivings (e.g., hope, interest, confidence). By balancing both kinds of emotions, a person can reflect and draw on his or her own values and hopes even when the alarm is activated.

Evaluate thoughts: When the brain is in alarm mode, thinking tends to be rigid, global, and catastrophic. Evaluating thoughts, as with identifying emotions, is about achieving a healthier balance of positive as well as negative thinking. Through a two-part process, participants learn to evaluate the situation and their options with a focus on how they choose to act—moving from reactive thoughts to "main" thoughts. This is a fundamental change from the PTSD pattern, which causes problems by taking a person straight from alarm signals to automatic survival reactions.

Define goals: Reactive goals tend to be limited to just making it through the immediate situation or away from the source of danger. These reactive goals are necessary in true emergencies but don't reflect a person's "main" goals of doing worthwhile things and ultimately achieving a good and meaningful life. This step teaches one how to create "main" goals that reflect his or her deeper hopes and values.

Options: The only options that are available when the brain's alarm is turned on and won't turn off are automatic "flight/fight" or "freeze/submit" reactive behaviors that are necessary in emergencies but often unhelpful in ordinary living. This step helps identify positive intentions often hidden by the more extreme reactive options generated by the alarm system. This opens the possibility for a greater range of options that take into consideration one's own needs and goals as well as those of others.

Make a contribution: When the brain's alarm is turned on and reacting to ordinary stressors as if they were emergencies, it is very difficult for a person to come away from experiences with a feeling that they have made a positive difference. This can lead to feelings of alienation, worthlessness, or spiritual distress. The ultimate goal of TARGET is to empower adults and young people to think clearly enough to feel in control of their alarm reactions and, as a result, to be able to recognize the contribution they are making not only to their own lives, but to others' lives as well.

Source: Advanced Trauma Solutions, 2012.

normal stress response into an extreme survival-based alarm response that can lead to PTSD, and it teaches them a seven-step approach to making the PTSD alarm response less distressing and more adaptive (summarized by the acronym FREEDOM: Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution).

TARGET can be presented in individual therapy or gender-specific psychoeducational groups, and it has been adapted for individuals who are deaf; it has also been translated into Spanish and Dutch. TARGET is a resilience-building and recovery program not limited to individual or group psychotherapy; it is also designed to provide an educational curriculum and milieu intervention that affects all areas of practice in school, therapeutic, or correctional programs. TARGET is listed in SAMHSA's NREPP (http://www.nrepp.samhsa.gov).

Trauma Recovery and Empowerment Model

The trauma recovery and empowerment model (TREM) of therapy (Fallot & Harris, 2002; Harris & Community Connections Trauma Work Group, 1998) is a manualized group intervention designed for female trauma survivors with severe mental disorders. TREM addresses the complexity of long-term adaptation to trauma and attends to a range of difficulties common among survivors of sexual and physical abuse. TREM focuses mainly on developing specific recovery skills and current functioning and uses techniques that are effective in trauma recovery services. The model's content and structure, which cover 33 topics, are informed by the role of gender in women's experience of and coping with trauma.

TREM can be adapted for shorter-term residential settings and outpatient substance abuse treatment settings, among others. Adaptations of the model for men and adolescents are available. The model was used in SAMHSA's Women, Co-Occurring Disorders and Violence Study for three of the nine study sites and in SAMHSA's Homeless Families program, and it is listed in SAMHSA's NREPP. This model has been used with clients in substance abuse treatment; research by Toussaint, VanDeMark, Bornemann, and Graeber (2007) shows that women in a residential substance abuse treatment program showed significantly better trauma treatment outcomes using TREM than they did in treatment as usual, but no difference in substance use.

TREM Program Format

Each session includes an experiential exercise to promote group cohesiveness. The 33 sessions are divided into the following general topic areas:

- **Part I–empowerment** introduces gender identity concepts, interpersonal boundaries, and self-esteem.
- **Part II–trauma recovery** concentrates on sexual, physical, and emotional abuse and their relationship to psychiatric symptoms, substance abuse, and relational patterns and issues.
- **Part III–advanced trauma recovery issues** addresses additional trauma issues, such as blame and the role of forgiveness.
- **Part IV–closing rituals** allows participants to assess their progress and encourages them to plan for their continued healing, either on their own or as part of a community of other survivors.
- **Part V–modifications or supplements for special populations** provides modifications for subgroups such as women with serious mental illness, incarcerated women, women who are parents, women who abuse substances, and male survivors.

Source: Mental Health America Centers for Technical Assistance, 2012.

Triad Women's Project

The Triad Project was developed as a part of SAMHSA's Women, Co-Occurring Disorders and Violence Study. It is a comprehensive, trauma-informed, consumer-responsive integrated model designed for female trauma survivors with co-occurring substance use and mental disorders who live in semirural areas. Triad integrates motivational enhancement for substance use disorders, DBT, and intensive case management techniques for co-occurring mental disorders. This program is a 16-week group intervention for women that uses integrated case management services, a curriculum-based treatment group, and a peer support group (Clark & Fearday, 2003).

Emerging Interventions

New interventions are emerging to address traumatic stress symptoms and disorders. The following sections summarize a few interventions not highlighted in prior chapters; this is not an exhaustive list. In addition to specific interventions, technology is beginning to shape the delivery of care and to increase accessibility to tools that complement trauma-specific treatments. Numerous applications are available and evolving. For more information on the role of technology in the delivery of care, see the planned TIP, *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (SAMHSA, planned g).

Couple and Family Therapy

Trauma and traumatic stress affects significant relationships, including the survivor's family. Although minimal research has targeted the effectiveness of family therapy with trauma survivors, it is important to consider the needs of the individual in the context of their relationships. Family and couples therapy may be key to recovery. Family members may experience secondary traumatization silently, lack understanding of traumatic stress symptoms or treatment, and/or have their own histories of trauma that influence their willingness to support the client in the family or to talk about anything related to trauma and its effects. Family members can engage in similar patterns of avoidance and have their own triggers related to the trauma being addressed at the time. A range of couple and family therapies have addressed traumatic stress and PTSD, but few studies exist that support or refute their value. Current couple or family therapies that have some science-based evidence include behavioral family therapy, behavioral marital therapy, cognitive–behavioral couples treatment, and lifestyle management courses (Riggs, Monson, Glynn, & Canterino, 2009).

Mindfulness Interventions

Mindfulness is a process of learning to be present in the moment and observing internal experience (e.g., thoughts, bodily sensations) and external experience (e.g., interactions with others) in a nonjudgmental way. Mindfulness challenges limiting beliefs that arise from trauma, quells anxiety about future events, and simply helps one stay grounded in the present. It plays a significant role in helping individuals who have been traumatized observe their experiences, increase awareness, and tolerate uncomfortable emotions and cognitions.

To date, mindfulness-based interventions appear to be valuable as an adjunct to trauma-specific interventions and in decreasing arousal (Baer, 2003). It may also help individuals tolerate discomfort during exposure-oriented and trauma processing interventions. Overall, mindfulness practices can help clients in managing traumatic stress, coping, and resilience. In a study of firefighters, mindfulness was associated with fewer PTSD symptoms, depressive symptoms, physical symptoms, and alcohol problems when controlling for other variables (Smith et al., 2011).

Becoming an Observer and Learning To Tolerate Discomfort: The Leaf and Stream Metaphor

The following exercise, "leaves floating on a stream," is a classic. Many clinicians and authors provide renditions of this mindfulness practice. The main objectives are to stand back and observe thoughts rather than get caught up in them. Simply stated, thoughts are just thoughts. Thoughts come and go like water flowing down a stream. We don't need to react to the thoughts; instead, we can just notice them.

Conduct the mindfulness exercise for about 10 minutes, then process afterward. Take time to allow participants to visualize each sense as they imagine themselves sitting next to the stream. For example, what does it look like? What do they hear as they sit next to the stream? Don't rush the exercise. As you slowly make the statements detailed in the following two paragraphs, take time in between each statement for participants to be in the exercise without interruption; simply offer gentle guidance.

Begin to sit quietly, bringing your attention to your breath. If you feel comfortable, close your eyes. As you focus on breathing in and out, imagine that you are sitting next to a stream. In your imagination, you may clearly see and hear the stream, or you may have difficulty visualizing the stream. Follow along with the guided exercise; either way, it will work just as well.

Now begin to notice the thoughts that come into your mind. Some thoughts rush by, while others linger. Just allow yourself to notice your thoughts. As you begin to notice each thought, imagine putting those words onto a leaf as it floats by on the stream. Just let the thoughts come, watching them drift by on the leaves. If your thoughts briefly stop, continue to watch the water flow down the stream. Eventually, your thoughts will come again. Just let them come, and as they do, place them onto a leaf. Your attention may wander. Painful feelings may arise. You may feel uncomfortable or start to think that the exercise is "stupid." You may hook onto a thought—rehashing it repeatedly. That's okay; it's what our minds do. As soon as you notice your mind wandering or getting stuck, just gently bring your focus back to your thoughts, and place them onto the leaves. Now, bring your attention back to your breath for a moment, then open your eyes and become more aware of your environment.

Facilitated Questions:

- What was it like for you to observe your thoughts?
- Did you get distracted? Stuck?
- Were you able to bring yourself back to the exercise after getting distracted?
- In what ways was the exercise uncomfortable?
- In what ways was the exercise comforting?

For clients and practitioners who want to develop a greater capacity for mindfulness, see Kabat-Zinn's books *Wherever You Go, There You Are: Mindfulness Meditation In Everyday Life* (1994) and *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* (1990). For clinical applications of mindfulness, see *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse* (Segal et al., 2002) and *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors* (Marlatt & Donovan, 2005).

Pharmacological Therapy

Pharmacotherapy for people with mental, substance use, and traumatic stress disorders needs to be carefully managed by physicians who are well versed in the treatment of each condition. Medications can help manage and control symptoms; however, they are only a part of a comprehensive treatment plan. There

are no specific "antitrauma" drugs; rather, certain drugs target specific trauma symptoms. Clients receiving pharmacotherapy need careful assessment. Some clients with preexisting mental disorders may need further adjustment in medications due to the physiological effects of traumatic stress. In addition, sudden withdrawal from a pattern of self-administered substances can not only lead to dangerous levels of physical distress, but also exacerbate the emergence of more severe PTSD symptoms. Distress after trauma often lessens over time, which can sometimes make the use of medications unnecessary for some individuals. Some trauma survivors do not develop long-term psychological problems from their experiences that require medication; others may simply refuse the initiation of pharmacotherapy or the use of additional medications.

Concluding Note

Behavioral health counselors can best serve clients who have experienced trauma by providing integrated treatment that combines therapeutic models to target presenting symptoms and disorders. Doing so acknowledges that the disorders interact with each other. Some models have integrated curricula; others that address trauma alone can be combined with behavioral health techniques with which the counselor is already familiar.

In part, the choice of a treatment model or general approach will depend on the level of evidence for the model, the counselor's training, identified problems, the potential for prevention, and the client's goals and readiness for treatment. Are improved relationships with family members a goal? Will the client be satisfied if sleep problems decrease, or is the goal resolution of broader issues? Are there substance use or substance-related disorders? Is the goal abstinence? Collaborating with clients to decide on goals, eliciting what they would like from treatment, and determining what they expect to happen can provide some clues as to what treatment models or techniques might be successful in keeping clients engaged in recovery.

Part 2: An Implementation Guide for Behavioral Health Program Administrators

1 Trauma-Informed Organizations

IN THIS CHAPTER

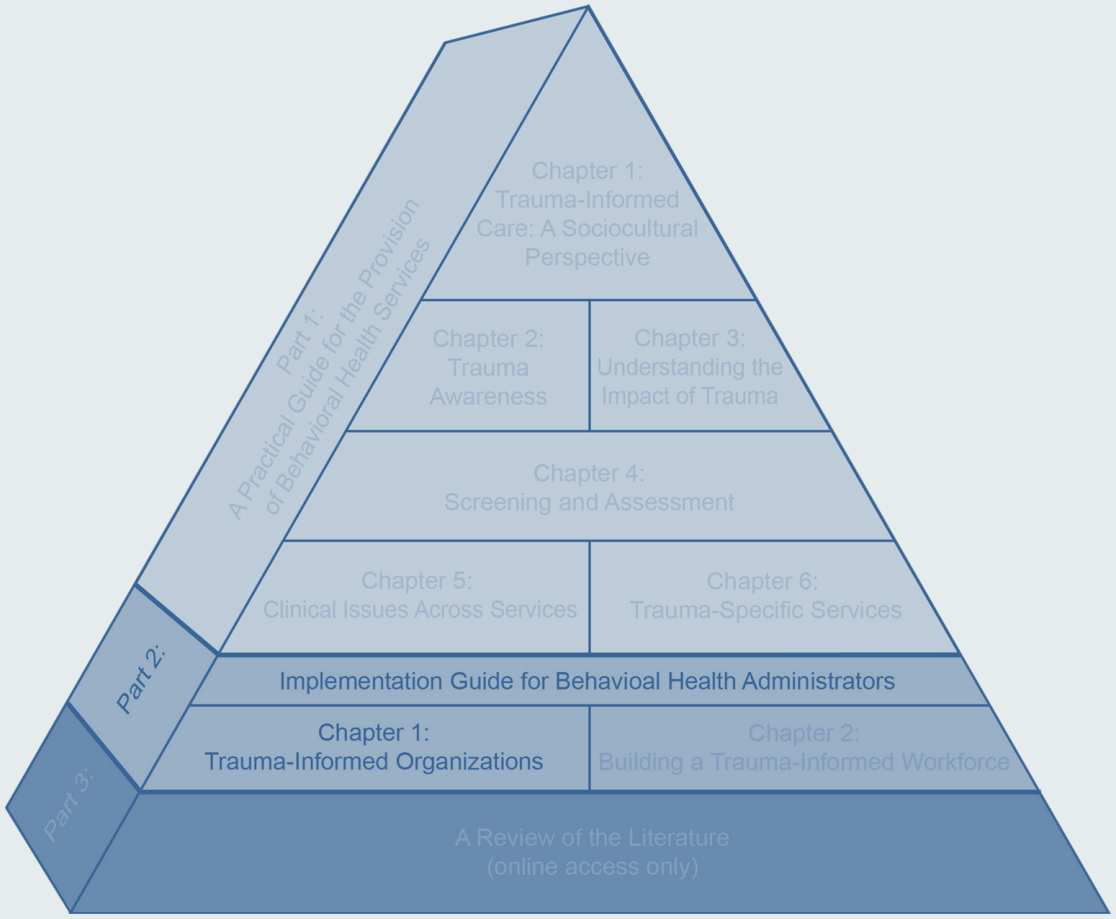
- Show Organizational and Administrative Commitment to TIC
- Use Trauma Informed Principles in Strategic Planning
- Review and Update Vision, Mission, and Value Statements
- Assign a Key Staff Member To Facilitate Change
- Create a Trauma Informed Oversight Committee
- Conduct an Organizational Self Assessment of Trauma Informed Services
- Develop an Implementation Plan
- Develop Policies and Procedures To Ensure Trauma Informed Practices and To Prevent Retraumatization
- Develop a Disaster Plan
- Incorporate Universal Routine Screenings
- Apply Culturally Responsive Principles
- Use Science Based Knowledge
- Create a Peer Support Environment
- Obtain Ongoing Feedback and Evaluations
- Change the Environment To Increase Safety
- Develop Trauma Informed Collaborations

Part 2 provides a broad overview of how to create and implement an institutional framework for trauma-informed services in program delivery and staff development, policies and procedures, administrative practices, and organizational infrastructure in behavioral health services. Chapter 1, "Trauma-Informed Organizations," focuses on specific organizational strategies that will help develop a trauma-informed culture in behavioral health settings. Numerous strategies are presented, including organizational commitment to trauma-informed care (TIC), trauma-informed organizational assessment, implementation of universal screening for trauma, and creation of a peer support environment.

Chapter 2, "Building a Trauma-Informed Workforce," focuses on organizational activities that foster the development of a trauma-informed workforce, including recruiting, hiring, and retaining trauma-informed staff; providing training on evidence-based and emerging trauma-informed best practices; developing competencies specific to TIC; addressing ethical considerations; providing trauma-informed supervision; and preventing and treating secondary trauma in behavioral health service providers.

The strategies described in the following sections can help supervisors and other administrative staff members create a trauma-informed behavioral health environment. As a starting point, the administration should identify key personnel and consumers to guide the organizational change process and the organizational assessment. Administrators and supervisors need to plan for and demonstrate an ongoing commitment to these strategies, or staff may perceive development activities as comprising yet another idea or demand from the agency that is short-lived beyond the initial thrust of training.

TIC Framework in Behavioral Health Services—Trauma-Informed Organizations



Creating a trauma-informed organization is a fluid, ongoing process; it has no completion date. Consumer demographics change across time, exposure to specific types of trauma may become more prevalent, and knowledge of best and evidence-based practices (EBPs) will continue to advance. A trauma-informed organization continues to demonstrate a commitment to compassionate and effective practices and organizational reassessments, and it changes to meet the needs of consumers with histories of trauma. It is encouraging that recent Substance Abuse and Mental Health Services Administration (SAMHSA) data indicates that the majority of over 10,000 programs they surveyed state that they provide trauma-related care (Capezza & Najavits, 2012). However, there remains a major need to make TIC consistently high-quality, routine, and pervasive across treatment systems.

The following stages form the basis of creating a trauma-informed organization:

1. Commit to creating a trauma-informed agency.
2. Create an initial infrastructure to initiate, support, and guide changes.
3. Involve key stakeholders, including consumers who have histories of trauma.
4. Assess whether and to what extent the organization's current policies, procedures, and operations either support TIC or interfere with the development of a trauma-informed approach.
5. Develop an organizational plan to implement and support the delivery of TIC within the agency.

Trauma-Informed Services and Service Systems

"A trauma-informed service system and/or organization is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence and trauma play in the lives of people seeking mental health and addiction services. A 'trauma-informed' organizational environment is capable of supporting and sustaining 'trauma-specific' services as they develop. A trauma-informed system recognizes that trauma results in multiple vulnerabilities and affects many aspects of a survivor's life over the lifespan, and therefore coordinates and integrates trauma-related activities and training with other systems of care serving trauma survivors. A basic understanding of trauma and trauma dynamics…should be held by all staff and should be used to design systems of services in a manner that accommodates the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid retraumatization and facilitate consumer participation in treatment. A trauma-informed service system is knowledgeable and competent to recognize and respond effectively to adults and children traumatically impacted by any of a range of overwhelming adverse experiences, both interpersonal in nature and caused by natural events and disasters. There should be written plans and procedures to develop a trauma-informed service system and/or trauma-informed organizations and facilities with methods to identify and monitor progress. Training programs for this purpose should be implemented."

Source: Jennings, 2009, pp. 111–112.

6. Create collaborations between providers and consumers and among service providers and various community agencies.
7. Put the organizational plan into action.
8. Reassess the implementation of the plan and its ability to meet the needs of consumers and to provide consistent TIC on an ongoing basis.
9. Implement quality improvement measures as needs and problem areas are identified.
10. Institute practices that support sustainability, such as ongoing training, clinical supervision, consumer participation and feedback, and resource allocation.

Strategy #1: Show Organizational and Administrative Commitment to TIC

Foremost, administrators need to understand the impact that trauma can have on people's lives. The consistent delivery of TIC is only as effective as the organization's commitment, which must extend to administrative practices with staff members, program policies and procedures, program design, staffing patterns, use of peer support, staff and peer training and supervision, organizational assessment and consumer feedback, and resources to uphold trauma-informed principles and practices. Even short-term change is not sustainable without the agency's continual commitment.

Typically, desirable organizational change doesn't occur by accident. It comes from steadfast leadership, a convincing message that change is necessary and beneficial for staff and consumers, and resources that support change. Many people naturally resist change; thus, an organization's commitment includes a willingness to discuss with staff members the impact and role of trauma in their service setting, patience in planning and implementation, and

Seminal Resource for Administrators

As you investigate how best to implement or improve trauma informed services within your organization or across systems, review the influential work, *Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services.*

(Harris & Fallot, 2001c)

Advice to Administrators: Managing Staff Reactions to Implementation of New Processes or Ideas

A common hurdle for administrators after introducing a new process or idea is the staff assumption that it will require more work. Frontline staff members are often inundated with many responsibilities beyond face-to-face time with clients. In addition, a common misperception is that if you begin to address trauma, you will have difficulty containing it.

In addition to administrative buy-in, administrators must promote rather than simply announce the implementation of trauma-informed services. Promotion includes educating staff about the rationale for trauma-informed services, offering opportunities for discussion and input from staff and consumers, providing training focused on trauma-informed skills, and so forth. For example, the San Diego Trauma-Informed Guide Team (2012) created a promotional brochure on how TIC can make staff jobs easier:

- Focuses on root problem
- Is preventative
- Increases support system
- Facilitates collaboration
- Shares workload
- Empowers client
- Provides consistency in agencies/systems
- Uses evidence-based best practices

TIC may be cost-effective, lead to less intensive services and less use of services, prevent undue stress for staff members and clients, and prevent client crises caused by old policies that could retraumatize trauma survivors.

the ability to tolerate the uncertainty that naturally accompanies transitions.

Strategy #2: Use Trauma-Informed Principles in Strategic Planning

Strategic planning provides an opportunity to explore and develop short- and long-term goals. The planning process often begins with reevaluating the organizations' values, mission, and vision, yet agencies cannot adequately develop a trauma-informed strategic plan without obtaining specific information about internal (staff, resources, processes) and external environmental (referral constellation, changes in health care, funding sources, State and Federal standards, community needs, consumer demographics, etc.) factors and influences. Data gathered through staff, consumer, organizational, and community assessments shapes the direction of the plan, including projected demands, challenges, obstacles, strengths, weaknesses, and resources. At the conclusion of this planning process, the organization will have specific goals, objectives, and tasks to meet the needs of their stakeholders and to address any anticipated challenges. Ideally, strategic planning should define key steps in developing or refining trauma-informed services within the organization.

Strategy #3: Review and Update Vision, Mission, and Value Statements

Vision, mission, and value statements provide a conceptual framework for TIC development and delivery. They should not be created in isolation; they should reflect voices from the community, populations, and other stakeholders that the organization serves. These statements develop through input, discussion, and assessment. They are not static; they evolve as needs, populations, or environments change.

Statement Example

As behavioral health service providers, we strive to be trauma aware—to understand the dynamics and impact of trauma on the lives of individuals, families, and communities. We strive to create a trauma-sensitive culture by demonstrating, through consumer empowerment, program design, and direct care, an understanding of the relationships among trauma, substance abuse, and mental illness.

Advice to Administrators: How To Create Vision, Value, and Mission Statements

Define the organization's vision, values, and mission to be compatible with TIC. Emphasize the organizational culture needed to provide TIC. An outgrowth of that cultural shift may include an enhanced working environment for employees and consumers that is noncoercive and reduces conflicts, restraint, and seclusion. Even if the current mission statement is appropriate, change it anyway to symbolize intended change within the organization. To define or redefine the vision, values, and mission:

- Involve consumers, all levels of staff, and leadership, including the director/CEO.
- Review:
  - Organizational priorities to identify and manage conflicting priorities.
  - Resources to assess whether reallocation is necessary for change (e.g., to hire peer support specialists, to furnish comfort rooms).
- Operationalize the vision, values, and mission at the level of individual departments
- Evaluate progress at regular staff meetings to ensure that changing the culture of care stays on the agenda.

Source: New Logic Organizational Learning, 2011.

Strategy #4: Assign a Key Staff Member To Facilitate Change

Prior to the development of an oversight committee, a senior staff member with the authority to initiate and implement changes should be assigned to oversee the developmental process. By assigning a trauma-aware senior staff member who is committed to trauma-informed services, it is more likely that the organization's and committee's goals, objectives, and plans will remain in focus. This senior staff member is responsible for ongoing development and facilitation of the oversight committee; management of the initial organizational assessment, reassessments, and other evaluative and feedback processes; and facilitation and oversight of the implementation plan and subsequent changes, including policies and procedures to ensure delivery of TIC.

Strategy #5: Create a Trauma-Informed Oversight Committee

The role of the oversight committee includes providing ongoing input and direction in the initial organizational assessment, strategic plan, plan implementation, reevaluation and development of trauma-informed policies and procedures, and future reassessments. The committee monitors progress and uses real-time data to forge a clear pathway to new processes that support TIC. The committee should involve stakeholders from the community, consumers, specialists, staff members, and administrators. Leadership involvement is necessary. Stakeholders may be alumni, family members, community-based organizations, and other institutions that interact with the agency or would benefit from trauma-informed services.

Initially, the agency must educate the committee on the organization's mission, values, and vision as well as the task at hand—developing trauma-informed services. To ease potential conflicts or confusion about the organization's structure, the guidelines, expectations, and roles of the committee need to be communicated directly to committee members as well as the organization as a whole, including board members, support and professional staff, supervisors, and so forth. The committee also needs to know the extent of their power and the necessary lines of communication before, during, and after evaluating and implementing changes in the organization.

Including consumers and/or those who have lived through trauma is vital. They have unique knowledge, experiences, and perspectives on the impact of treatment design, delivery, policies, and procedures. They offer firsthand information on practices that can potentially retraumatize clients in behavioral health settings and can suggest preventive, alternative practices and solutions. Consumer committee members keep staff and administrators aware of the goal of achieving TIC.

Strategy #6: Conduct an Organizational Self-Assessment of Trauma-Informed Services

An organizational self-assessment evaluates the presence and/or the effectiveness of current trauma-informed practices across each service and level of the organization. This assessment allows an organization to see how it functions within the context of trauma-informed principles and provides feedback to inform the development or revision of the implementation plan for TIC. In essence, this assessment process can serve as a blueprint for change and as a benchmark of compliance with and progress in implementing trauma-informed practices across time. Overall, it is a process of identifying organizational strengths, weaknesses, opportunities, and threats related to the implementation and maintenance of TIC. Refer to Appendix F for sample organizational assessment tools for the organization and the consumer.

The self-assessment should obtain feedback from key stakeholders, particularly consumers, family members, referral sources, community organizations, and all levels of the organization's staff, including nonclinical and clinical staff, supervisors, and administrative personnel. Similar to the universal screening process, an organizational self-assessment is only as effective as the steps taken after data are gathered and analyzed. From this assessment, an implementation plan should be established that highlights the goals, objectives, steps, timeframe, and personnel responsible in overseeing the specific objective. Assessment shouldn't be a once-and-done project. Timely and regularly scheduled organizational assessments should follow to assist in quality improvement. For an explanation of more detailed steps to take in conducting an organizational self-assessment, see Chapter 4 of the planned Treatment Improvement Protocol (TIP), *Improving Cultural Competence* (SAMHSA, planned c).

Advice to Administrators: Ten Steps to Quality Improvement

1. Identify new goals or problems.
2. Gather input from each level of the organization, including consumers and other key stakeholders.
3. Analyze the feedback.
4. Explore improvement options and the potential barriers associated with each.
5. Select the overall approach and specific strategies to address barriers (anticipate barriers, and try to address them before they occur).
6. Develop an implementation plan, and then present the plan to staff members and other key stakeholders not directly involved in the quality improvement process.
7. Implement the plan.
8. Reassess the new plan.
9. Evaluate the results and determine if new goals or additional problems or issues need to be addressed.
10. Repeat the first nine steps.

Strategy #7: Develop an Implementation Plan

Implementation plans should evolve from consumer participation, demographic profiles

Advice to Administrators: Implementation Plan Content

1. **Introduction and overview:** This includes the organization's history, the demographics that characterize its client base, the rationale for the implementation plan, and the incorporation of TIC. Focus on identification of strengths, weaknesses, opportunities, and threats. Provide an overview of goals and objectives.
2. **Specific goals and objectives:** Goals and objectives should address:
   - Workforce development strategies for recruiting, hiring, retaining, training, supervising, and promoting wellness of clinical and nonclinical staff members to support TIC.
   - Consumer participation and peer support development and implementation strategies.
   - Policies, procedures, and practices to support TIC and culturally responsive services, to promote safety, and to prevent retraumatization.
   - Specific evidence-based or best practice adoptions to support TIC.
   - Strategies to amend facility design or environment (plant) operations to reinforce safety.
   - Fiscal planning to ensure sustainability of the steps initiated in the organization.
3. **Guidelines for implementation:** Guidelines should highlight the specific steps, roles, responsibilities, and timeframes for each activity to meet TIC objectives.

of populations served, data from organizational self-assessment, and research on promising and evidence-based trauma-informed practices. Using the framework proposed in this TIP, the oversight committee is responsible for designing a plan that outlines the purpose, goals, objectives, timeframes, and personnel responsible for each objective (Exhibit 2.1-1).

Exhibit 2.1-1: TIC Planning Guidelines

The following publications provide samples of organizational guidelines for implementing TIC.

- Fallot, R. D. & Harris, M. (2009). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.* Washington, DC: Community Connections, 2009.
- Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-informed organizational toolkit.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W. K. Kellogg Foundation.
- Huckshorn, K. (2009). Transforming cultures of care toward recovery oriented services: Guidelines toward creating a trauma informed system of care. In *Trauma informed care (TIC) planning guidelines for use in developing an organizational action plan.* Alexandria, VA: National Association of State Mental Health Program Directors.
- Jennings, A. (2009). *Criteria for building a trauma-informed mental health service system.* Retrieved on May 21, 2013, from http://www.theannainstitute.org/CBTIMHSS.pdf
- Ohio Legal Rights Service (2007). *Trauma-informed treatment in behavioral health settings.* Columbus, OH: Ohio Legal Rights Service.
- Prescott, L., Soares, P., Konnath, K., & Bassuk, E. (2008). *A long journey home: A guide for creating trauma-informed services for mothers and children experiencing homelessness* [draft]. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W.K. Kellogg Foundation.

The following resource is a systemwide set of guidelines for implementing TIC.

- U.S. Department of Health and Human Services, Health Resources and Services Administration (2006). *Model trauma system: Planning and evaluation.* Rockville, MD: Health Resources and Services Administration.

Strategy #8: Develop Policies and Procedures To Ensure Trauma-Informed Practices and To Prevent Retraumatization

In the early stage of evaluating current services and planning for TIC, the committee needs to assess practices, procedures, and policies that may have been or could be retraumatizing to any individual, at any level of the organization, from consumers to administrators. Programs that are not trauma informed are as likely to be unaware of the impact of trauma on staff as they are to be unaware of its influence on consumers. In the initial review, careful scrutiny should be used to eliminate any practice that is potentially harmful, including seclusion and restraint practices, therapeutic activities that are shaming, treatment planning without collaboration, any medical inquiry without privacy, and so forth.

Policies and procedures are the building blocks of each agency. They guide the service process and, if followed, they provide an opportunity for the agency to deliver consistent responses and care. Policies and procedures must incorporate trauma-informed practices across all domains and standards, such as admissions, plant/environmental standards, screening and assessment processes, referrals (to other services, including hospitalization, or for further evaluations), treatment planning, confidentiality, discharge, and more. They also need to be updated periodically to incorporate new science and to meet the changing needs of consumers. By regularly reviewing and adapting administrative and clinical policies and procedures in response to ever-changing needs and evidence, the agency can provide staff members with good guidelines for providing trauma-informed services that are consistent yet flexible.

Program Curriculum: Roadmap to Seclusion-Free and Restraint-Free Mental Health Services

This curriculum, written from consumer perspectives, provides behavioral health staff with education, strategies, and hands-on tools to prevent and ultimately eliminate the use of seclusion and restraint. It includes many handouts for participants and consumers. This training package, available online (http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055), is divided into seven modules plus a resources section:

- Module 1: The Personal Experience of Seclusion and Restraint
- Module 2: Understanding the Impact of Trauma
- Module 3: Creating Cultural Change
- Module 4: Understanding Resilience and Recovery from the Consumer Perspective
- Module 5: Strategies to Prevent Seclusion and Restraint
- Module 6: Sustaining Change Through Consumer and Staff Involvement
- Module 7: Review and Action Plan
- Resource Section

Source: Center for Mental Health Services (CMHS), SAMHSA, 2005.

Strategy #9: Develop a Disaster Plan

Facilities are often required to develop disaster plans, but specific requirements vary from State to State. From the outset, developing a disaster plan in behavioral health services is essential. Many clients in behavioral health services have lived with trauma, so proactive steps that reduce the impact of a new trauma may prevent worsening of symptoms and decrease the risk for more pervasive effects. (See also Technical Assistance Publication 34, *Disaster Planning Handbook for Behavioral Health Treatment Programs* [SAMHSA, 2013].)

Most disaster events cannot be accurately anticipated. Even so, behavioral health organizations can take steps to reduce the impact of a disaster event on program functioning and on the lives of clients. Each service or program should develop a disaster response committee that meets regularly to develop, maintain, and adapt policies and procedures to respond to disasters affecting the program. Committee planning efforts may include:

1. Creating a disaster response team of program staff members tasked with coordinating program administration and services in a disaster event.
2. Establishing a communication process for informing staff and clients of the status of program functioning and for coordinating staff assignments during and shortly after the disaster event.
3. Outlining a process to inform clients and their families of available services, their location, and contact information for accessing services to meet clients' critical needs.
4. Developing plans for service provision during a disaster event and service implementation after the event.
5. Creating special plans for high-risk or special needs clients who need services during and shortly after the disaster. Examples of this are clients who are homeless, in detoxification services or methadone programs, on prescribed psychopharmaceuticals, or at risk for suicide.
6. Making plans for maintaining the security of client records, program records, and facilities during and shortly after the event.
7. Coordinating ahead with other community resources and services to ensure that clients at high risk or with special needs get the services they require as soon as possible.
8. Prioritizing how services will start back up after a disaster event.
9. Providing special services after the event to clients at high risk for trauma reactions and symptoms.
10. Establishing a postdisaster debriefing process to review disaster responses, services, and outcomes.

Some specific disaster events, such as hurricanes, may sometimes offer opportunities for planning and preparation in advance of the disaster event. This preparation time is usually just a few days, but it allows programs to make advance preparations and take advance action to establish lines of communication, stockpile resources, prepare for evacuation of clients, and protect client and program records.

Strategy #10: Incorporate Universal Routine Screenings

A key element of trauma-informed services is the institution of universal routine screening across all services, regardless of the individual's path in accessing services (e.g., primary care, hospitalization, outpatient). Considering the prevalence of trauma among individuals who seek services for mental and substance use disorders, the implementation of screening is paramount. Without screening, clients are not identified as trauma survivors. Subsequently, they miss recovery opportunities and treatment services that would be more likely to meet their needs, while also running a higher risk of being retraumatized by unexamined organizational policies, procedures, and practices. For more information on the rationale, processes, and instruments of universal screening for trauma, refer to Part 1, Chapter 4.

Strategy #11: Apply Culturally Responsive Principles

Providers must be culturally competent when incorporating evidence-based and best practices as well as trauma-informed treatment

models within the organization. Clients' views of behavioral health differ according to race, ethnicity, and culture (refer to the planned Treatment Improvement Protocol [TIP], *Improving Cultural Competence* [SAMHSA, planned c]). Likewise, cultures attach different meanings to trauma, and responses to trauma will vary considerable across cultures (see Part 3, the online literature review, for more information). For example, trauma survivors who come from a collective society or culture, in which the goals of the group take precedence over the goals of the individual, may be more focused on the well-being of their family or the family's response to the trauma survivors' experience. Often, this view runs in opposition to the individualistic perspective of many behavioral health services. Subsequently, treatment providers who are not culturally competent may interpret collective values as a sign of resistance or avoidance in dealing with traumatic stress. CMHS (2003) outlines principles of cultural competence in disaster work applicable across all forms of trauma:

1. ***Recognize the importance of culture and respect diversity.*** Those who value culture and diversity understand their own cultures, attitudes, values, and beliefs, and they work to understand the cultures of others. This includes being able to communicate effectively with those from other cultures, respecting others' feelings about personal space, knowing about others' social organization, understanding how time is viewed, and being aware of others' beliefs about the effects of their behaviors.
2. ***Maintain a current profile of the cultural composition of the community.*** This includes describing the community's population in terms of race and ethnicity, age, gender, religion, refugee and immigrant status, housing status, income levels, rural/urban balance, unemployment, languages spoken, literacy, schools, and businesses.
3. ***Recruit workers who are representative of the community or service area.*** If the workers who are available do not match the community, they should have the personal attributes, knowledge, and skills to develop cultural competence.
4. ***Provide ongoing cultural competence training to staff.*** Topics should include cultural values and traditions, family values, linguistics and literacy, immigration experiences and status, help-seeking behaviors, techniques and strategies for cross-cultural outreach, and the avoidance of stereotypes and labels (DeWolfe & Nordboe, 2000b).
5. ***Ensure that services are accessible, appropriate, and equitable.*** In planning disaster work or TIC, community associations and organizations are invaluable. Gaining their acceptance requires time and energy.
6. ***Recognize the role of help-seeking behaviors, traditions, and natural support networks.*** Culture includes traditions that dictate whom, or which groups, to seek in times of need; how to handle suffering and loss; and how healing takes place. These customs and traditions are respected by a culturally responsive disaster relief program.
7. ***Involve community leaders and organizations representing diverse cultural groups as "cultural brokers."*** Collaborating with community leaders is an effective means of learning about the community, establishing program credibility, and ensuring that services are culturally responsive.
8. ***Ensure that services and information are culturally and linguistically responsive.*** Communication with individuals who do not speak English, who are illiterate in all languages or have limited literacy, and who are deaf or hard of hearing is essential to service provision. Local radio stations, television outlets, and newspapers that are multicultural are an excellent venue for educational information after a disaster.

Using survivors' friends or relatives as interpreters is not recommended, as survivors may be uncomfortable discussing personal matters with family members or friends. Asking children to interpret can place too heavy a responsibility on them and reverses parents' and children's roles.

9. ***Assess and evaluate the program's level of cultural responsiveness.*** Self-assessment and process evaluation can help keep a program on track. A variety of strategies can be used for collecting data and communicating findings to stakeholders.

Strategy #12: Use Science-Based Knowledge

Along with culturally responsive services, trauma-informed organizations must use science-based knowledge to guide program development and the implementation of services, policies, procedures, and practices. This includes the adoption of EBPs (see Part 1, Chapter 6, and Part 3, Section 1, to review definition, treatments, and resources for EBPs). TIC research is quite new; interpret these limited studies and information cautiously. Chambless and Hollon's (1998) criteria, which are still the benchmark for EBPs, are valuable resources for administrators. Look closely at who was included—and excluded—from treatment studies. Often, the types of severe, chronic, and unstable cases seen in community settings are excluded from treatment studies. Evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with mental illness, substance use disorders, and co-occurring psychological trauma. Nonetheless, other variables must also be contemplated before adopting EBPs in an organization, including the cultural appropriateness of the practice; the strength of its clinical focus on strengths-based strategies; training and competence of clinical staff; the cost of training, materials, and implementation; and the ease of maintaining EBP fidelity amidst staff turnover.

For more detailed information on EBPs, visit the National Registry of Evidence Based Programs and Practices (NREPP) Web site (http://nrepp.samhsa.gov). For more specific research oriented information on trauma and trauma specific treatments, refer to the literature review in Part 3 of this TIP, available online.

Strategy #13: Create a Peer-Support Environment

The main purpose of peer support services is to provide consumer mentoring, support, and care coordination for clients with histories of mental illness or substance abuse. The goals are to help others deal with personal and environmental barriers that impede recovery and achieve wellness. Peer support accomplishes this through many activities, including advocacy, support during crises and recovery activities, modeling, education, and assistance in accessing available resources. Peer support programs send a powerful message to staff members, consumers, and the community—that recovery is possible through support, collaboration, and empowerment. These programs reinforce the trauma-informed premise that organizations need to reflect the populations that they serve and involve consumers in planning, implementing, monitoring, and delivering recovery services.

For an introduction to peer support services, see *What Are Peer Recovery Support Services?* (Center for Substance Abuse Treatment, 2009e).

Notably, peer support services have the potential to be considerably flexible to meet client needs at each stage of recovery. Specifically, peer support services can be incorporated

across the continuum of care, starting with outreach services and extending into long-term recovery services. Peer support specialists can enhance consumer motivation to change, to initiate services, and/or to engage in recovery activities. They can play powerful liaison roles by supporting clients entering treatment and explaining what to expect from services. They can ease the transition into treatment, from one service to the next, from one modality to another (e.g., inpatient group to outpatient group), and beyond formal treatment. Moreover, peer support services create an atmosphere focused on mutuality rather than pathology. They provide living models of resilience and promote hope—that recovery is possible and attainable.

Administrators should familiarize themselves with how other organizations have implemented peer support programs, current curricula, certifications and training processes, competencies and ethics, and peer support service State standards or recommendations, if applicable. The Carter Center's Summit in 2009, The Pillars of Peer Support Services, supported in part by SAMHSA and CMHS, highlighted the numerous elements necessary to develop a strong, vital peer workforce (Daniels et al., 2010). These elements include:

- Clear job and service descriptions.
- Job-related competencies and competence-based testing processes.
- Peer support certifications.
- Ongoing continuing education.
- Media and technology access for peer specialists.
- Sustainable funding.
- Research and evaluation components.
- Code of ethics and conduct.
- Competence-based training for supervisors.
- Multilevel support and program support teams.

> "Peer recovery support services are evidence based and have been demonstrated to promote positive health outcomes and control the cost of healthcare. These services are offered by a trained individual with lived experience and recovery from a mental illness, substance use and/or chronic health conditions. Peer recovery support services minimally include chronic illness self management, whole health and wellness promotion and engagement, relapse prevention, life skill coaching, and insurance and health systems navigation."
>
> (Daniels et al., 2012, p. 22)

Advice to Administrators: Sample Peer Support Staff Tasks

- Use active listening skills help peers identify areas of dissatisfaction and benefits of changing beliefs, thoughts, and behavior.
- Use problem-solving skills to help peers identify barriers to recovery and develop plans to meet peer-determined goals.
- Facilitate recovery support groups.
- Link clients with community resources.
- Work with the treatment team to advocate for clients and to remove recovery barriers.
- Participate in consumer panels to educate staff about the consumer perspective and about peer support.
- Participate in hospital-wide committees and workgroups

Source: New Logic Organizational Learning, 2011.

Strategy #14: Obtain Ongoing Feedback and Evaluations

Obtain feedback on and evaluations of organizational performance on a regular basis. Give consumers a clear avenue for offering feedback at any time, and make evaluations assessing the organization's progress toward providing trauma-informed services standard practice. Without feedback and further evaluation, organizations cannot assess whether they are

meeting trauma-informed objectives. A routine monitoring process for TIC implementation gives the organization additional information necessary to combat new obstacles and threats and to understand what works. Regular monitoring equips organizations with the ability to formulate different strategies to meet objectives as well as to respond to the changing needs of the population. Ongoing evaluation and consumer feedback are essential in improving the quality of services.

Strategy #15: Change the Environment To Increase Safety

Practices that generate emotional and physical safety are necessary. Another aspect of creating safety is reevaluating the physical facilities and environment to enhance safety and to circumvent preventable retraumatization. Think how traumatizing it would be if you were a female rape survivor and a night counselor was conducting a room check at 2:00 a.m., or a male security guard was walking the women's residential wing. What would it be like if you were sitting with your back to the door in a small office during an intake interview, if your history included a physical assault and robbery? For most, it would at least increase anxiety; for others it would be retraumatizing. Trauma-informed providers must carefully assess environmental safety. Although you are likely to identify some facility issues that could erode safety for trauma survivors, a safe environment will only be established if regular feedback is obtained from consumers about their experiences with the program.

Strategy #16: Develop Trauma-Informed Collaborations

TIC is about collaboration with consumers, staff members, key stakeholders, and other agencies. Collaborative relationships provide opportunities for consumers to access the most appropriate services as needs arise. Rather than waiting for a crisis or a dire need for a service to investigate available resources, it is far more efficient and compassionate to establish relationships within the agency and with other community resources before these needs arise. No agency can meet the needs of every client; referral agreements and/or collaborative arrangements that integrate the delivery of TIC, including support services (e.g., housing, legal, medical), are important.

Creating Sanctuary

The sanctuary model is a trauma-based therapeutic approach that has been used in inpatient, residential, therapeutic community, and outpatient settings with children, adolescents, and adults. It provides a template for changing social service delivery systems so that they are better equipped to respond to the complex needs of trauma survivors. Sanctuary is informed by four knowledge areas: "the psychobiology of trauma, the active creation of nonviolent environments, principles of social learning, and an understanding of the ways in which complex adaptive systems grow, change, and alter their course" (Bloom et al., 2003, p. 174).

The sanctuary model describes a stage-based approach to healing that is referred to as SAGE: safety, affect modulation, grieving, and emancipation. This model is nonlinear; an individual does not necessarily move from one stage to another in a straight path, but progress in one area does affect progress in other areas (Bloom, 1997; Bloom et al., 2003). SAGE is a cognitive–behavioral translation of the sanctuary model (Bills, 2003). Early in treatment, the focuses are typically on safety and affect management. Safety encompasses four domains: physical, psychological, social, and moral (Bloom, 1997; see http://www.sanctuaryweb.com for further details and a curriculum).

2 Building a Trauma-Informed Workforce

IN THIS CHAPTER

- Introduction
- Workforce Recruitment, Hiring, and Retention
- Training in TIC
- Trauma Informed Counselor Competencies
- Counselor Responsibilities and Ethics
- Clinical Supervision and Consultation
- Secondary Traumatization
- Counselor Self Care

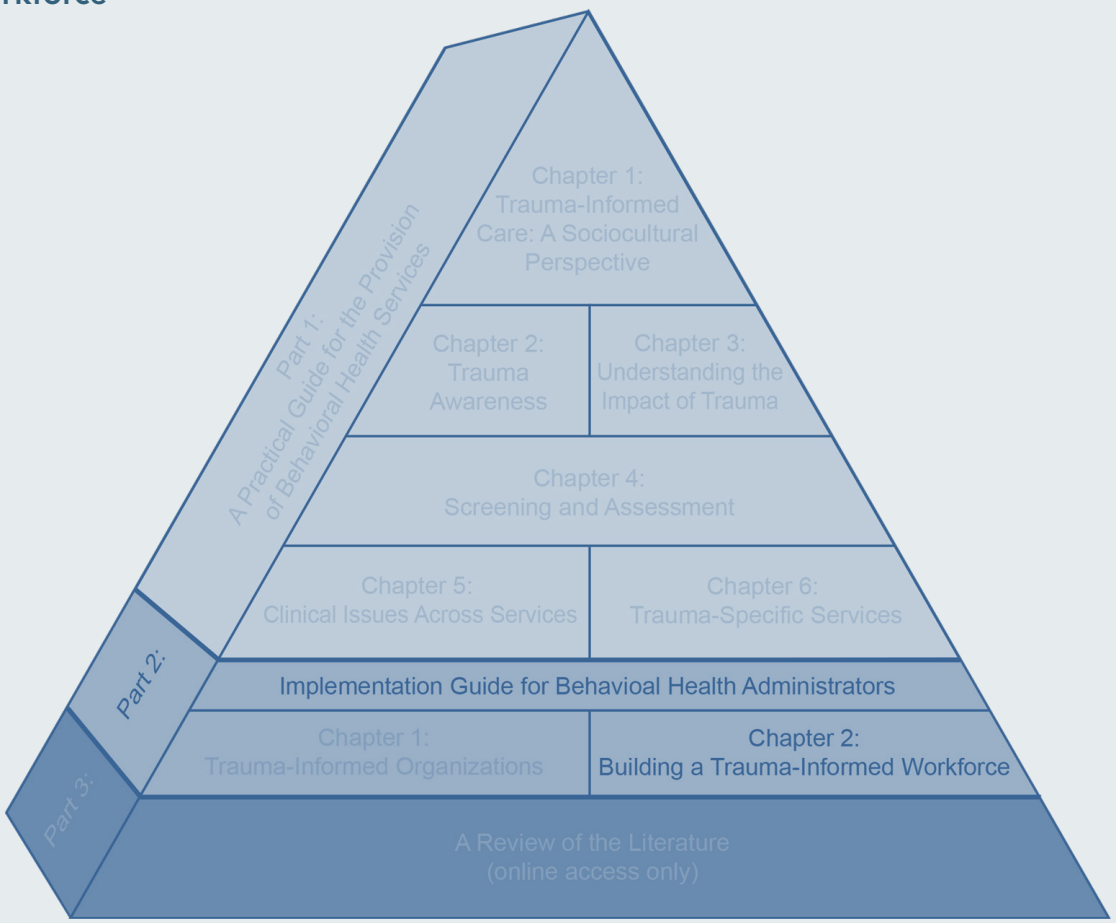
Introduction

For an organization to embrace a trauma-informed care (TIC) model fully, it must adopt a trauma-informed organizational mission and commit resources to support it. This entails implementing an agency-wide strategy for workforce development that is in alignment with the values and principles of TIC and the organization's mission statement. Without a fully trained staff, an organization will not be able to implement the TIC model. However, simply training behavioral health professionals in TIC is not enough. Counselors will not be able to sustain the kind of focus required to adopt and implement a trauma-informed philosophy and services without the ongoing support of administrators and clinical supervisors.

An organizational environment of care for the health, well-being, and safety of, as well as respect for, its staff will enhance the ability of counselors to provide the best possible trauma-informed behavioral health services to clients. This culture of care must permeate the organization from top to bottom. Behavioral health program administrators should aim to strengthen their workforce; doing so "requires creating environments that support the health and well-being, not only of persons with mental and substance use conditions, but of the workforce as well" (Hoge, 2007, p. 58). An organizational culture of care, safety, and respect demands activities that foster the development of trauma-informed counselors. This chapter focuses on key workforce development activities, such as:

- Recruiting, hiring, and retaining trauma-informed staff.
- Training behavioral health service providers on the principles of, and evidence-based and emerging best practices relevant to, TIC.
- Developing and promoting a set of counselor competencies specific to TIC.

TIC Framework in Behavioral Health Services—Building a Trauma-Informed Workforce



- Delineating the responsibilities of counselors and addressing ethical considerations specifically relevant to promoting TIC.
- Providing trauma-informed clinical supervision.
- Committing to prevention and treatment of secondary trauma of behavioral health professionals within the organization.

Addressing each of these areas is essential to building a trauma-informed workforce and an organizational culture that supports TIC.

Workforce Recruitment, Hiring, and Retention

An Action Plan for Behavioral Health Workforce Development (Hoge et al., 2007) emphasizes the importance of organization-wide support and active involvement in workforce recruitment, hiring, and retention in behavioral health systems. One of the key findings of this report is that the work environment itself in many behavioral health settings can be toxic to the workforce and may hinder the delivery of individualized, respectful, collaborative, and client-centered care to service recipients. Factors such as the downward pressure on organizations for higher productivity of counselors increase caseloads and decrease wages of behavioral health staff members and may create a high-stress environment that contributes to low morale and worker dissatisfaction. Other factors that often contribute to low retention of qualified counselors in behavioral health settings include the lack of professional career

ladders, fragile job security, the lack of clinical supervision, and an inability to influence the organization in which they are working (Hoge et al., 2007).

Added to this mix is the intensity of working with people with the co-occurring conditions of trauma-related mental and substance use disorders and the risk of secondary traumatization of counselors. In creating and sustaining a trauma-informed workforce, organizations need to foster a work environment that parallels the treatment philosophy of a trauma-informed system of care. Doing so allows counselors to count on a work environment that values safety, endorses collaboration in the making of decisions at all levels, and promotes counselor well-being.

Recruitment and Hiring in a Trauma-Informed System of Care

In a 2007 technical report (Jennings, 2007b), the National Center for Trauma-Informed Care identified several priorities for organizations with regard to recruitment and hiring trauma-informed staff, including:

- Active recruitment of and outreach to prospective employees who are trauma-informed or have formal education in providing trauma-informed or trauma-specific services in settings such as universities, professional organizations, professional training and conference sites, peer support groups, and consumer advocacy groups.
- Hiring counselors and peer support staff members with educational backgrounds and training in trauma-informed and/or trauma-specific services and/or lived experience of trauma and recovery.
- Providing incentives, bonuses, and promotions for staff members during recruitment and hiring that take into consideration prospective employees' trauma-related education, training, and job responsibilities.

In addition to hiring behavioral health professionals with formal professional education and training, organizations should also "routinely survey the demographics and other characteristics of the population served and recruit a workforce of similar composition" (Hoge et al., 2007, p. 297). Essentially, this means actively engaging in outreach to consumer advocacy groups, recovery-oriented programs, community and faith-based organizations, and former clients/consumers with the intention of recruiting potential employees whose knowledge and expertise comes from their lived experience of trauma, resilience, and recovery. Support staff members, peer support workers, counselors in training, and apprentices can be recruited from this population and offered incentives, such as tuition reimbursement, training stipends, and professional mentoring with the goal of developing a trauma-informed workforce from within the demographic served. Jennings (2007b) calls these staff members "trauma champions" who can provide needed expertise in a trauma-informed organization to promote trauma-informed policies, staff development, and trauma-based services consistent with the mission of the organization (p. 135).

Who Is a Trauma Champion?

"A champion understands the impact of violence and victimization on the lives of people seeking mental health or addiction services and is a front-line worker who thinks 'trauma first.' When trying to understand a person's behavior, the champion will ask, 'is this related to abuse and violence?' A champion will also think about whether his or her own behavior is hurtful or insensitive to the needs of a trauma survivor. The champion is there to do an identified job—he is a case manager or a counselor or a residential specialist—but in addition to his or her job, a champion is there to shine the spotlight on trauma issues."

Source: Harris & Fallot, 2001a, p. 8.

As with hiring behavioral health professionals who are in recovery from substance use disorders, the organization should be transparent and explicit in its recruitment and hiring practices of trauma survivors in recovery. The organization can be transparent by advertising the mission statement of the organization as part of the recruitment process and inviting applicants who are in recovery from trauma to apply. The needs of behavioral health staff members who are in recovery from both substance use and trauma-related conditions and working in a trauma-informed system of care should be addressed in the organization's ongoing training, clinical supervision, and staff development policies and practices.

Workforce Retention

Staff turnover is rampant in behavioral health settings. It is costly to the organization, and as a result, it is costly to clients. A strong therapeutic relationship with a counselor is one of the largest factors in an individual's ability to recover from the overwhelming effects of trauma. When behavioral health professionals leave an organization prematurely or in crisis as a result of chronic levels of high stress or secondary traumatization, clients must deal with disruptions in their relationships with counselors. Some of the organizational factors that contribute to chronic levels of high stress and often lead to high staff turnover include expecting counselors to maintain high caseloads of clients who have experienced trauma; not providing trauma-informed clinical supervision and training to counselors; and failing to provide adequate vacation, health insurance, and other reasonable benefits that support counselors' well-being. Other factors that may have a more profound impact on staff retention include failing to acknowledge the reality of secondary traumatization, promoting the view that counselors' stress reactions are a personal failure instead of a normal response to engaging with clients' traumatic material, and not supporting personal psychotherapy for counselors (Saakvitne, Pearlman, & Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy, 1996).

Research on promoting counselor retention in behavioral health settings demonstrates that

Advice to Administrators: Preventing Turnover and Increasing Workforce Retention

To prevent behavioral health staff turnover and increase retention of qualified, satisfied, and highly committed trauma-informed counselors, consider:

- Offering competitive wages, benefits, and performance incentives that take into account education, training, and levels of responsibility in providing trauma-informed or trauma-specific services.
- Creating a safe working environment that includes both the physical plant and policies and procedures to prevent harassment, stalking, and/or violence in the workplace and to promote respectful interactions amongst staff at all levels of the organization.
- Establishing an organizational policy that normalizes secondary trauma as an accepted part of working in behavioral health settings and views the problem as systemic—not the result of individual pathology or a deficit on the part of the counselor.
- Instituting reasonable, manageable caseloads that mix clients with and without trauma-related concerns.
- Letting staff offer input into clinical and administrative policies that directly affect their work experience.
- Providing vacation, health insurance (which includes coverage for psychotherapy/personal counseling), and other benefits that promote the well-being of the staff.
- Implementing regular, consistent clinical supervision for all clinical staff members.
- Providing ongoing training in trauma-informed services offered by the organization.

behavioral health staff members are interested in the same kind of work environment and benefits as employees in many other fields. They include a "living wage with healthcare benefits; opportunities to grow and advance; clarity in a job role; some autonomy and input into decisions; manageable workloads; administrative support without crushing administrative burden; basic orientation and training for assigned responsibilities; a decent and safe physical work environment; a competent and cohesive team of coworkers; the support of a supervisor; and rewards for exceptional performance" (Hoge et al., 2007, p. 18).

When an organization's administration values its staff by providing competitive salaries and benefits, a safe working environment, a reasonable and manageable workload, input into the making of clinical and administrative policy decisions, and performance incentives, it helps behavioral health workers feel connected to the mission of the organization and become dedicated to its sustainability and growth. This type of work environment demonstrates both a level of respect for counselors (similar to the level of respect a trauma-informed organization displays toward clients) and an appreciation for the complexity of their job responsibilities and the stress they face when working with people who have experienced trauma in their lives. To retain behavioral health professionals working in a trauma-informed setting, wages and performance incentives should be tied not only to education, training, and work experience, but also to levels of responsibility in working with clients who have experienced trauma.

Training in TIC

Training for all staff members is essential in creating a trauma-informed organization. It may seem that training should simply focus on new counselors or on enhancing the skill level of those who have no prior experience in working with trauma, but training should, in fact, be more systematic across the organization to develop fully sustainable trauma-informed services. All employees, including administrative staff members, should receive an orientation and basic education about the prevalence of trauma and its impact on the organization's clients. To ensure safety and reduction of harm, training should cover dynamics of retraumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. Training for all employees must also educate them "about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socioeconomic status on individuals' experiences of trauma" (Jennings, 2007a, p. 5).

All clinical and direct service staff members, regardless of level of experience, should receive more indepth training in screening and assessment of substance use and trauma-related disorders; the relationships among trauma, substance use disorders, and mental disorders; how to understand difficult client behaviors through a trauma-informed lens; how to avoid retraumatizing clients in a clinical setting; the development of personal and professional boundaries unique to clinical work with traumatized clients; how to identify the signs of secondary traumatization in themselves; and how to develop a comprehensive personal and professional self-care plan to prevent and/or ameliorate the effects of secondary traumatization in the workplace. All clinical staff members who work with traumatized clients should receive additional training in evidence-based and promising practices for the treatment of trauma (for information on locating training, see Appendix B.) This might include training done within the agency by experts in the field or training received by attending advanced trauma trainings. Administrators

should provide the time and financial resources to clinical staff members for this professional development activity. Jennings (2007a) suggests that, whenever possible, "trainings should be multi-system, inclusive of staff in mental health and substance abuse, health care, educational, criminal justice, social services systems and agencies, and promoting systems integration and coordination" (p. 5).

Moreover, criminal justice settings, schools, military/veteran programs, and other places in which behavioral health services are provided may benefit from approaches that are sensitive to the special circumstances and cultures of these environments. For example, in exploring trauma-informed correctional care, Miller and Najavits (2012, p. 1) observe:

> Prisons are challenging settings for trauma-informed care. Prisons are designed to house perpetrators, not victims. Inmates arrive shackled and are crammed into overcrowded housing units; lights are on all night, loud speakers blare without warning and privacy is severely limited. Security staff is focused on maintaining order and must assume each inmate is potentially violent. The correctional environment is full of unavoidable triggers, such as pat downs and strip searches, frequent discipline from authority figures, and restricted movement….This is likely to increase trauma-related behaviors and symptoms that can be difficult for prison staff to manage….Yet, if trauma-informed principles are introduced, all staff can play a major role in minimizing triggers, stabilizing offenders, reducing critical incidents, deescalating situations, and avoiding restraint, seclusion or other measures that may repeat aspects of past abuse.

The Need for Training

Behavioral health service providers working with clients who have mental, substance use, and trauma-related disorders need to have the best knowledge, skills, and abilities. Substance abuse counselors, in particular, require additional training and skill development to be able to extend trauma-informed services (within the

Case Illustration: Larry

Larry is a 28-year-old clinical social worker who just finished his master's program in social work and is working in a trauma-informed outpatient program for people with substance use disorders. He is recovering from alcohol use disorder and previously worked in a residential rehabilitation program as a recovery support counselor. There, his primary responsibilities were to take residents to Alcoholics Anonymous (AA) meetings, monitor their participation, and confront them about their substance use issues and noncompliance with the program's requirement of attendance at 12-Step meetings.

In Larry's new position as a counselor, he confronts a client in his group regarding her discomfort with attending AA meetings. The client reports that she feels uncomfortable with the idea that she has to admit that she is powerless over alcohol to be accepted by the group of mostly men. She was sexually abused by her stepfather when she was a child and began drinking heavily and smoking pot when she was 11 years old. The client reacts angrily to Larry's intervention.

In supervision, Larry discusses his concerns regarding the client's resistance to AA and the feedback that he provided to her in group. Beyond focusing supervision on Larry's new role as a counselor in a trauma-informed program, the clinical supervisor recommends that Larry take an interactive, multisession, computer-assisted training on the 12-Step facilitation (TSF) model. The TSF model introduces clients to and assists them with engaging in 12-Step recovery support groups. The agency has the computer-based training available in the office, and Larry agrees to use follow-up coaching sessions with his supervisor to work on implementation of the approach. The supervisor recognizes that Larry is falling back on his own recovery experience and the strategies he relied on in his previous counseling role. He will benefit from further training and coaching in an evidence-based practice that provides a nonaggressive, focused, and structured way to facilitate participation in recovery support groups with clients who have trauma histories.

limits of their professional licensure and scope of practice) to clients who have co-occurring substance use, trauma-related, or mental disorders. Many clinical practice issues in traditional substance abuse treatment are inconsistent with trauma-informed practice, which needs to be addressed with further training. Similarly, mental health clinicians often need training in substance abuse treatment, as they typically do not have backgrounds or experience in that domain. Moreover, several surveys indicate that clinicians consistently perceive the combination of trauma and substance abuse as harder to treat than either one alone (Najavits, Norman, Kivlahan, & Kosten, 2010). It is thus key to emphasize cross-training as part of TIC. Exhibit 2.2-1 addresses these issues and offers suggestions for additional training.

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings

- Some substance abuse counseling strategies commonly used to work through clients' denial and minimization of their substance use issues may be inappropriate when working with trauma survivors (e.g., highly confrontational models can remind trauma survivors of emotional abuse).

  Training: The Stages of Change model of addiction treatment can help counselors shift from the traditional confrontation of denial to conceptualizing clients' ambivalence about changing substance use patterns as a normal part of the precontemplation stage of change. This method is a respectful cognitive–behavioral approach that helps counselors match counseling strategies to their assessment of where each client is in each stage of change, with the ultimate goal of helping clients make changes to health risk behaviors. (Connors, Donovan, & DiClemente, 2001).

- The 12-Step concept of powerlessness (Step 1) may seem unhelpful to trauma survivors for whom the emotional reaction to powerlessness is a major part of their trauma (particularly for victims of repetitive trauma, such as child abuse or intimate partner violence). It can be confusing and counterproductive to dwell on this concept of powerlessness regarding trauma when the therapeutic objective for trauma-informed counseling methods should be to help clients empower themselves. For people in recovery, powerlessness is a paradox, sometimes misunderstood by both counselors and clients, in that the acknowledgment of powerlessness often creates a sense of empowerment. Most clients, with support and respectful guidance from a counselor, will come to understand that powerlessness (as used in 12-Step programs) is not an inability to stand up for oneself or express a need, and it does not mean for one to be powerless in the face of abuse. With this understanding, clients may become more open to participating in 12-Step groups as a resource for their recovery from substance use disorders. When clients continue to struggle with this concept and decline to participate in 12-Step recovery efforts, they may benefit from referral to other forms of mutual-help programs or recovery support groups in which the concept of powerlessness over the substance of abuse is not such a significant issue.

  Training: The TSF model can help counselors develop a more supportive and understanding approach to facilitating clients' involvement in 12-Step recovery groups (if this is a client-generated recovery goal). "Although based on standard counseling models, TSF differs from them in several ways. These differences include TSF's strong emphasis on therapist support, discouragement of aggressive 'confrontation of denial' and therapist self-disclosure, and highly focused and structured format" (Sholomskas & Carroll, 2006, p. 939).

  Another well-intentioned, but often misguided, approach by counselors who have not had formal or extensive training is "digging" for trauma memories without a clear therapeutic rationale or understanding of client readiness. In doing so, the counselor may unintentionally retraumatize the client or produce other harmful effects. In early intervention, it is sufficient simply to acknowledge and validate the pain and suffering of the client without uncovering or exploring specific trauma memories. The counselor who is insufficiently trained in trauma-informed clinical

(Continued on the next page.)

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings (continued)

practice may also press agendas that are ultimately unhelpful, such as insisting that the client forgive an abuser, pursue a legal case against a perpetrator, or engage in trauma treatment, even when the client may not be ready for such steps. These efforts are particularly inappropriate for clients in early recovery from substance use disorders. The first goal in treatment is stabilization

Training: The Seeking Safety model of treating substance abuse and posttraumatic stress disorder (PTSD) can help counselors focus on the primary goal of stabilization and safety in TIC. This model emphasizes safety as the target goal, humanistic themes such as honesty and compassion, and making cognitive–behavioral therapy accessible and interesting to clients who may otherwise be difficult to engage (Najavits, 2002a).

- Treatment should be client-centered; it should acknowledge the client's right to refuse counseling for trauma-related issues. It is important to discuss the advantages and disadvantages of exploring trauma-related concerns, and then, following an open discussion, to allow clients the right to choose their path. This discussion should be part of the informed consent process at the start of treatment. Clients also have the right to change their minds.

  Training: Motivational interviewing, a client-centered, nonpathologizing counseling method, can aid clients in resolving ambivalence about and committing to changing health risk behaviors including substance use, eating disorders, self-injury, avoidant and aggressive behaviors associated with PTSD, suicidality, and medication compliance (Arkowitz, Miller, Westra, & Rollnick, 2008; Kress & Hoffman, 2008). Training in MI can help counselors remain focused on the client's agenda for change, discuss the pros and cons of treatment options, and emphasize the personal choice and autonomy of clients.

In addition to the training needs of substance abuse counselors, all direct care workers in mental health settings, community-based programs, crisis intervention settings, and criminal justice environments should receive training in TIC. Guidelines for training in assisting trauma-exposed populations are presented in Exhibit 2.2-2.

Continuing Education

Research on the effectiveness of single-session didactic and/or skill-building workshops

Exhibit 2.2-2: Guidelines for Training in Mental Health Interventions for Trauma-Exposed Populations

After a year of collaboration in 2002, the Task Force on International Trauma Training of the International Society for Traumatic Stress Studies published a consensus-based set of recommendations for training. Core curricular elements of the recommended training include:

- Competence in listening.
- Recognition of psychosocial and mental problems to promote appropriate assessment.
- Familiarity with established interventions in the client population.
- Full understanding of the local context, including help-seeking expectations, duration of treatment, attitudes toward intervention, cost-effectiveness of intervention, and family attitudes and involvement.
- Strategies for solving problems on the individual, family, and community levels.
- Treatment approaches for medically unexplained somatic pain.
- Collaboration with existing local resources and change agents (e.g., clergy, traditional healers, informal leaders).
- Self-care components.

Source: Weine et al., 2002.

Advice to Administrators: Trauma-Informed Staff Training

- Establish training standards for the evidence-based and promising trauma-informed practice models (such as Seeking Safety) adopted by your organization.
- Bring expert trainers with well-developed curricula in TIC and trauma-specific practices into your organization.
- Select a core group of clinical supervisors and senior counselors to attend multisession training or certification programs. These clinicians can then train the rest of the staff.
- Use sequenced, longitudinal training experiences instead of single-session seminars or workshops.
- Emphasize interactive and experiential learning activities over purely didactic training.
- Provide ongoing mentoring/coaching to behavioral health professionals in addition to regular clinical supervision to enhance compliance with the principles and practices of TIC and to foster counselor mastery of trauma-specific practice models.
- Build organization-wide support for the ongoing integration of new attitudes and counselor skills to sustain constructive, TIC-consistent changes in practice patterns.
- Provide adequate and ongoing training for clinical supervisors in the theory and practice of clinical supervision and the principles and practices of TIC.
- Include information and interactive exercises on how counselors can identify, prevent, and ameliorate secondary traumatic stress (STS) reactions in staff trainings.
- Offer cross-training opportunities to enhance knowledge of trauma-informed processes throughout the system.

demonstrates that immediate gains in counselor knowledge and skills diminish quickly after the training event (Martino, Canning-Ball, Carroll, & Rounsaville, 2011). Consequently, organizations may be spending their scarce financial resources on sending counselors to this kind of training but may not be reaping adequate returns with regard to long-lasting changes in counselor skills and the development of trauma-informed and trauma-specific counselor competencies. Hoge et al. (2007) suggest the implementation of training strategies for behavioral health professionals that have proven to be effective in improving counselor skills, attitudes, and practice approaches. These strategies include: "interactive approaches; sequenced, longitudinal learning experiences; outreach visits, known as academic detailing; auditing of practice with feedback to the learner; reminders; the use of opinion leaders to influence practice; and patient-mediated interventions, such as providing information on treatment options to persons in recovery, which in turn influences the practice patterns of their providers" (p. 124).

Trauma-Informed Counselor Competencies

Hoge et al. (2007) identified a number of counselor competencies in behavioral health practices that are consistent with the skills needed to be effective in a trauma-informed system of care. They include person-centered planning, culturally competent care, development of therapeutic alliances, shared responsibility for decisions, collaboratively developed recovery plans, evidence-based practices, recovery- and resilience-oriented care, interdisciplinary- and team-based practice, and consumer/client advocacy. In addition, counselor competencies critical to the effective delivery of services to clients with trauma-related disorders include:

- Screening for and assessment of trauma history and trauma-related disorders, such as mood and anxiety disorders.
- Awareness of differences between trauma-informed and trauma-specific services.

- Understanding the bidirectional relationships among substance use and mental disorders and trauma.
- Engagement in person-centered counseling.
- Competence in delivering trauma-informed and trauma-specific evidence-based interventions that lessen the symptoms associated with trauma and improve quality of life for clients.
- Awareness of and commitment to counselor self-care practices that prevent or lessen the impact of secondary traumatization on behavioral health workers.

Exhibit 2.2-3 provides a checklist of competencies for counselors working in trauma-informed behavioral health settings. Administrators and clinical supervisors can use this checklist to assess behavioral health professionals' understanding of trauma awareness and counseling skills and determine the need for additional training and clinical supervision.

Counselor Responsibilities and Ethics

Treating all clients in an ethical manner is an expectation of all healthcare providers. It is of special importance when working with clients who have trauma-related disorders, as their trust in others may have been severely shaken. Counselors who work with traumatized individuals on a regular basis have special responsibilities to their clients because of the nature of this work. Administrators and clinical supervisors in trauma-informed organizations should develop policies that clearly define the counselors' job and should provide education about the role of counselors in the organization and their responsibilities to clients.

General Principles Regarding Counselor Responsibilities

The following are some general principles governing the responsibilities of counselors who provide behavioral health services for clients with histories of trauma:

- Counselors are responsible for routinely screening clients for traumatic experiences and trauma-related symptoms (Ouimette & Brown, 2003; see also Treatment Improvement Protocol [TIP] 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Center for Substance Abuse Treatment [CSAT], 2005c).
- Counselors should offer clients with substance use and trauma-related disorders continuing mental health services if it is within their professional license and scope of practice to do so.
- Counselors are responsible for referring clients with substance use disorders and co-occurring trauma-related disorders to treatment that addresses both disorders when the treatment falls outside of the counselor's professional license and scope of practice (Ouimette & Brown, 2003).
- Counselors should refer clients with substance use disorders and co-occurring trauma-related disorders to concurrent participation in mutual-help groups if appropriate (Ouimette & Brown, 2003).
- Counselors have a responsibility to practice the principles of confidentiality in all interactions with clients and to respect clients' wishes not to give up their right to privileged communication.
- Counselors are responsible for educating clients about the limits of confidentiality and what happens to protected health information, along with the client's privilege, when the client signs a release of information or agrees to assign insurance benefits to the provider.
- Counselors must inform clients that treatment for trauma-related disorders is always voluntary.
- Counselors are responsible for being aware of their own secondary trauma and

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist

Trauma Awareness

___ Understands the difference between trauma-informed and trauma-specific services

___ Understands the differences among various kinds of abuse and trauma, including: physical, emotional, and sexual abuse; domestic violence; experiences of war for both combat veterans and survivors of war; natural disasters; and community violence

___ Understands the different effects that various kinds of trauma have on human development and the development of psychological and substance use issues

___ Understands how protective factors, such as strong emotional connections to safe and nonjudgmental people and individual resilience, can prevent and ameliorate the negative impact trauma has on both human development and the development of psychological and substance use issues

___ Understands the importance of ensuring the physical and emotional safety of clients

___ Understands the importance of not engaging in behaviors, such as confrontation of substance use or other seemingly unhealthy client behaviors, that might activate trauma symptoms or acute stress reactions

___ Demonstrates knowledge of how trauma affects diverse people throughout their lifespans and with different mental health problems, cognitive and physical disabilities, and substance use issues

___ Demonstrates knowledge of the impact of trauma on diverse cultures with regard to the meanings various cultures attach to trauma and the attitudes they have regarding behavioral health treatment

___ Demonstrates knowledge of the variety of ways clients express stress reactions both behaviorally (e.g., avoidance, aggression, passivity) and psychologically/emotionally (e.g., hyperarousal, avoidance, intrusive memories)

Counseling Skills

___ Expedites client-directed choice and demonstrates a willingness to work within a mutually empowering (as opposed to a hierarchical) power structure in the therapeutic relationship

___ Maintains clarity of roles and boundaries in the therapeutic relationship

___ Demonstrates competence in screening and assessment of trauma history (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Shows competence in screening and assessment of substance use disorders (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Demonstrates an ability to identify clients' strengths, coping resources, and resilience

___ Facilitates collaborative treatment and recovery planning with an emphasis on personal choice and a focus on clients' goals and knowledge of what has previously worked for them

___ Respects clients' ways of managing stress reactions while supporting and facilitating taking risks to acquire different coping skills that are consistent with clients' values and preferred identity and way of being in the world

___ Demonstrates knowledge and skill in general trauma-informed counseling strategies, including, but not limited to, grounding techniques that manage dissociative experiences, cognitive–behavioral tools that focus on both anxiety reduction and distress tolerance, and stress management and relaxation tools that reduce hyperarousal

(Continued on the next page.)

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist (continued)

___ Identifies signs of STS reactions and takes steps to engage in appropriate self-care activities that lessen the impact of these reactions on clinical work with clients

___ Recognizes when the needs of clients are beyond his or her scope of practice and/or when clients' trauma material activates persistent secondary trauma or countertransference reactions that cannot be resolved in clinical supervision; makes appropriate referrals to other behavioral health professionals

Source: Abrahams et al., 2010.

countertransference reactions and seeking appropriate help in responding to these reactions so that they do not interfere with the best possible treatment for clients.

TIC organizations have responsibilities to clients in their care, including:

- Protecting client confidentiality, particularly in relation to clients' trauma histories. Organizations should comply with the State and Federal laws that protect the confidentiality of clients being treated for mental and substance use disorders.
- Providing clients with an easy-to-read statement of their rights as consumers of mental health and substance abuse services, including the right to confidentiality (Exhibit 2.2-4).
- Providing quality clinical supervision to all counselors and direct-service workers, with an emphasis on TIC. Organizations should, at minimum, comply with State licensing requirements for the provision of clinical supervision to behavioral health workers.
- Establishing and maintaining appropriate guidelines and boundaries for client and counselor behavior in the program setting.
- Creating and maintaining a trauma-informed treatment environment that respects the clients' right to self-determination and need to be treated with dignity and respect.
- Maintaining a work environment that reinforces and supports counselor self-care.

All behavioral health professionals are responsible for abiding by professional standards of care that protect the client. Breaches of confidentiality, inappropriate conduct, and other violations of trust can do further harm to clients who already have histories of trauma. Many treatment facilities have a Client Bill of Rights (or a similar document) that describes the rights and responsibilities of both the counselors and the participants; it often is part of the orientation and informed consent process when a client enters treatment. However, simply reading and acknowledging the receipt of a piece of paper is not a substitute for the dialog that needs to happen in a collaborative therapeutic partnership. Administrators are responsible for providing clients with easy-to-read information describing counselor responsibilities and client rights. Clinical supervisors are responsible for helping counselors engage in a respectful dialog with clients about those rights and responsibilities as part of a comprehensive informed consent process.

Exhibit 2.2-4 is an excerpt from a Client Bill of Rights that outlines clients' right to confidentiality in plain language that is readable and easily understood.

Exhibit 2.2-4: Sample Statement of the Client's Right to Confidentiality From a Client Bill of Rights

Tri-County Mental Health Services is a trauma-informed mental health and substance abuse treatment agency in Maine. Below is a statement regarding clients' right to confidentiality and staff responsibility to protect that privilege; this statement is provided in a brochure outlining consumer rights that is easily accessible to service recipients at the agency and online.

Confidentiality

We will not give out information about you to anyone without your knowledge and permission. This includes written information from your record and verbal information from your providers. Additionally, we will not request any information about you without your knowledge and permission. A Release of Information Form allows you to say what information can be shared and with whom. You determine the length of time this is valid, up to one year.

Tri-County policies prevent any employee of the agency who does not have a direct need to know from having access to any information about you. The penalty for violation can include immediate dismissal.

Exceptions to this rule of confidentiality include times when a client is at immediate risk of harm to self or others, or when ordered by the court. We will make every effort to notify you in these instances.

Source: Tri-County Mental Health Services, 2008, pp. 6-7.

Ethics in Treating Traumatized Clients

All behavioral health professionals must conform to the ethical guidelines established by their profession's State licensing boards and/or certifying organizations. State licensing boards for substance abuse counseling, psychiatry, social work, psychology, professional counseling, and other behavioral health professions provide regulatory standards for ethical practice in these professions. These boards also have specific procedures for responding to complaints regarding the actions of professional caregivers. Additionally, national professional societies have standards for ethical practices. Members of these organizations are expected to practice within the boundaries and scope of these standards. Some of these standards are quite explicit, whereas others are more general; most approach professional ethics not as a rigid set of rules, but rather, as a process of making ethical decisions.

Clinical supervisors are responsible for informing counselors of their ethical responsibilities with regard to their own organization's policies and procedures, monitoring supervisees' reading and understanding the codes of ethics of professional organizations and State licensing boards, and promoting counselor understanding of ethics and how to make decisions ethically as a regular part of clinical supervision, team meetings, and counselor training. Administrators can support high ethical standards by creating an organization-wide ethics task group consisting of counselors, supervisors, and administrators who meet regularly to review and revise clinical policies in line with State and Federal law and professional codes of ethics. Administrators may also act as a support mechanism for counselors who need additional consultation regarding potential ethical dilemmas with clients. The Green Cross Academy of Traumatology provides ethical guidelines for the treatment of clients who have experienced trauma; these guidelines are adapted in Exhibit 2.2-5.

Exhibit 2.2-5: Green Cross Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized

Respect for the dignity of clients

- Recognize and value the personal, social, spiritual, and cultural diversity present in society, without judgment. As a primary ethical commitment, make every effort to provide interventions with respect for the dignity of those served.

Responsible caring

- Take the utmost care to ensure that interventions do no harm.
- Have a commitment to the care of those served until the need for care ends or the responsibility for care is accepted by another qualified service provider.
- Support colleagues in their work and respond promptly to their requests for help.
- Recognize that service to survivors of trauma can exact a toll in stress on providers. Maintain vigilance for signs in self and colleagues of such stress effects, and accept that dedication to the service of others imposes an obligation to sufficient self-care to prevent impaired functioning.
- Engage in continuing education in the appropriate areas of trauma response. Remain current in the field and ensure that interventions meet current standards of care.

Integrity in relationships

- Clearly and accurately represent your training, competence, and credentials. Limit your practice to methods and problems for which you are appropriately trained and qualified. Readily refer to or consult with colleagues who have appropriate expertise; support requests for such referrals or consultations from clients.
- Maintain a commitment to confidentiality, ensuring that the rights of confidentiality and privacy are maintained for all clients.
- Do not provide professional services to people with whom you already have either emotional ties or extraneous relationships of responsibility. The one exception is in the event of an emergency in which no other qualified person is available.
- Refrain from entering other relationships with present or former clients, especially sexual relationships or relationships that normally entail accountability.
- Within agencies, ensure that confidentiality is consistent with organizational policies; explicitly inform individuals of the legal limits of confidentiality.

Responsibility to society

- Be committed to responding to the needs generated by traumatic events, not only at the individual level, but also at the level of community and community organizations in ways that are consistent with your qualifications, training, and competence.
- Recognize that professions exist by virtue of societal charters in expectation of their functioning as socially valuable resources. Seek to educate government agencies and consumer groups about your expertise, services, and standards; support efforts by these agencies and groups to ensure social benefit and consumer protection.
- If you become aware of activities of colleagues that may indicate ethical violations or impairment of functioning, seek first to resolve the matter through direct expression of concern and offers of help to those colleagues. Failing a satisfactory resolution in this manner, bring the matter to the attention of the officers of professional societies and of governments with jurisdiction over professional misconduct.

Clients' universal rights

All clients have the right to:

- Not be judged for any behaviors they used to cope, either at the time of the trauma or after the trauma.
- Be treated at all times with respect, dignity, and concern for their well-being.
- Refuse treatment, unless failure to receive treatment places them at risk of harm to self or others.

(Continued on the next page.)

Exhibit 2.2-5: Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized (continued)

- Be regarded as collaborators in their own treatment plans.
- Provide their informed consent before receiving any treatment.
- Not be discriminated against based on race, culture, sex, religion, sexual orientation, socioeconomic status, disability, or age.
- Have promises kept, particularly regarding issues related to the treatment contract, role of counselor, and program rules and expectations.

Procedures for introducing clients to treatment

Obtain informed consent, providing clients with information on what they can expect while receiving professional services. In addition to general information provided to all new clients, clients presenting for treatment who have histories of trauma should also receive information on:

- The possible short-term and long-term effects of trauma treatment on the client and the client's relationships with others.
- The amount of distress typically experienced with any particular trauma treatment.
- Possible negative effects of a particular trauma treatment.
- The possibility of lapses and relapses when doing trauma work, and the fact that these are a normal and expected part of healing.

Reaching counseling goals through consensus

Collaborate with clients in the design of a clearly defined contract that articulates a specific goal in a specific time period or a contract that allows for a more open-ended process with periodic evaluations of progress and goals.

Informing clients about the healing process

- Clearly explain to clients the nature of the healing process, making sure clients understand.
- Encourage clients to ask questions about any and all aspects of treatment and the therapeutic relationship. Provide clients with answers in a manner they can understand.
- Encourage clients to inform you if the material discussed becomes overwhelming or intolerable.
- Inform clients of the necessity of contacting you or emergency services if they feel suicidal or homicidal, are at risk of self-injury, or have a sense of being out of touch with reality.
- Give clients written contact information about available crisis or emergency services.
- Inform clients about what constitutes growth and recovery and about the fact that some trauma symptoms may not be fully treatable.
- Address unrealistic expectations clients may have about counseling and/or the recovery process.

Level of functioning

- Inform clients that they may not be able to function at the highest level of their ability—or even at their usual level—when working with traumatic material.
- Prepare clients to experience trauma-related symptoms, such as intrusive memories, dissociative reactions, reexperiencing, avoidance behaviors, hypervigilance, or unusual emotional reactivity.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

Boundaries in therapeutic relationships

Maintaining appropriate therapeutic boundaries is a primary ethical concern for behavioral health professionals. Counselors working with clients who have substance use, trauma-related, and other mental disorders may feel challenged at times to maintain boundaries that create a safe therapeutic container. Some clients, especially those with longstanding disorders, bring a history of client–counselor relationships to counseling. Clients who have been traumatized may need help understanding the roles and responsibilities of both the counselor and the client. Clients with trauma-related conditions may also have special needs

Advice to Clinical Supervisors: Recognizing Boundary Confusion

Clinical supervisors should be aware of the following counselor behaviors that can indicate boundary confusion with clients:

- The counselor feels reluctant or embarrassed to discuss specific interactions with a client or details of the client's treatment in supervision or team meetings.
- The counselor feels possessive of the client, advocates with unusual and excessive vehemence for the client, or expresses an unreasonable sense of overresponsibility for the client.
- The counselor becomes defensive and closed to hearing ideas from the supervisor or the treatment team members about approaches to working with a client and/or exploring his or her own emotional reactions to a client.
- The clinician begins or increases personal self-disclosure to the client and is not able to identify legitimate clinical reasons for the self-disclosure.

in establishing appropriate boundaries in the counseling setting; they may be particularly vulnerable and not understand or appreciate the need for professional boundaries, including not engaging in dual relationships. For example, some clients might experience a counselor's boundary around not giving the client his or her personal phone number for emergency calls as a rejection or abandonment. Cultural considerations also influence therapeutic boundaries.

Administrators, in collaboration with clinical supervisors, are responsible for creating policies regarding counselor and client boundaries for various issues (e.g., giving and receiving gifts, counselor personal disclosure, and counselor roles and responsibilities when attending the same 12-Step meetings as clients); policies should be specific to their organization and conform to State and Federal law and behavioral health professional codes of ethics. Clinical supervisors are responsible for training counselors in the informed consent process and effective ways to discuss boundaries with clients when they enter treatment.

Guidelines for establishing and maintaining boundaries in therapeutic relationships, adapted from the Green Cross Academy of Traumatology, are given in Exhibit 2.2-6.

Clients with trauma histories may be especially vulnerable to counselor behaviors that are inconsistent or that are experienced by the client as boundary violations. Examples of such behavior include: being late for appointments, ending counseling sessions early, repeatedly and excessively extending the session time, canceling or "forgetting" appointments multiple times, spending time in the session talking about their own needs and life experiences, exploring opportunities for contact outside the therapeutic relationship (including making arrangements to meet at AA or other 12-Step recovery group meetings), and enforcing rules differently for one client than for another.

Due to the complex dynamics that can arise in the treatment of clients with trauma histories, regularly scheduled clinical supervision, where issues of ethics and boundaries can be discussed, is recommended for counselors. For more information on how clinical supervision can be effectively used, see TIP 52, *Clinical Supervision and the Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Boundary crossing and boundary violation

Although guidelines and codes of ethics are useful tools in helping clinical supervisors and counselors understand the boundaries between counselors and clients, they are open to interpretation and are context-bound. Given these limitations, it is crucial to educate counselors

Exhibit 2.2-6: Boundaries in Therapeutic Relationships

Procedures for Establishing Safety

Roles and boundaries
Counselor roles and boundaries should be established at the start of the counseling relationship and reinforced periodically, particularly at times when the client is experiencing high stress.

Ongoing Relationships and the Issue of Boundaries

Dual relationships
Dual relationships and inappropriate interactions with clients are to be avoided. It is important to tell clients at the beginning of counseling that contact between the counselor and the client can only occur within the boundaries of the professional relationship. This information is part of the informed consent process. Relationships outside these boundaries include sexual or romantic relationships, a counselor also serving as a client's sponsor in 12-Step programs, and any kind of relationship in which the counselor exploits the client for financial gain.

Sexual contact
- Never engage in any form of sexual contact with clients.
- Do not reward sexualized behaviors with attention or reactivity.
- Directly clarify the boundaries of the therapeutic relationship, and address the underlying motivations of persisting sexualized behavior.
- Set limits on a client's inappropriate behaviors while maintaining an ethos of care. Maintain respect for the dignity and worth of the client at all times.
- Understand that a client's attempt to sexualize a therapeutic relationship may reflect an early history of abuse, difficulty understanding social norms, or a variety of psychological problems.
- Readdress the absolute inappropriateness of sexual and/or romantic behavior in a nonlecturing, nonpunitive manner.
- If sexual behavior between clients occurs in a treatment program, counselors should consult with a clinical supervisor. Document the nature of the contact and how the issue is addressed.
- If a counselor has sexual contact with a client, he or she should take responsibility by ceasing counseling practice, referring clients to other treatment providers, and notifying legal and professional authorities. If a counselor is at risk for engaging with a client sexually but has not acted on it, the counselor should immediately consult with a supervisor, colleague, or psychotherapist.

Boundaries
Counselors should use care with self-disclosure or any behaviors that may be experienced as intrusive by the client, including:
- Personal disclosures made for the counselor's own gratification.
- Sexualized behavior with the client.
- Excessively intrusive questions or statements.
- Interrupting the client frequently.
- Violating the client's personal space.
- Interpersonal touch, which might activate intrusive memories or dissociative reactions or be experienced as a boundary violation by the client.
- Being consistently late for appointments or allowing outside influences (such as telephone calls) to interrupt the client's time in a counseling session.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

in TIC settings regarding the boundary issues that may arise for clients who have been traumatized and to give counselors a conceptual framework for understanding the contextual nature of boundaries. For example, it would be useful for clinical supervisors to discuss with

counselors the distinction between boundary crossings and boundary violations in clinical practice. Gutheil and Brodsky (2008) define boundary crossing as a departure from the customary norms of counseling practice in relation to psychological, physical, or social space "that are harmless, are nonexploitative, and may even support or advance the therapy" (p. 20). Examples of boundary crossings include taking phone calls from a client between sessions if the client is in crisis or telling a client a story about the counselor's recovery from trauma (without offering specific personal information or graphic/detailed description of the trauma) with the intention of offering hope that it is possible to recover.

Gutheil and Brodsky (2008) define boundary violations as boundary crossings that are unwanted and dangerous and which exploit the client, stating that "some boundary crossings are inadvisable because of their intent (i.e., they are not done in the service of the patient's well-being and growth, involve extra therapeutic gratification for the therapist) and/or their effect (i.e., they are not likely to benefit the patient and entail a significant risk of harming the patient)" (pp. 20–21). An example of a boundary violation would be when a counselor invites a client to attend the same AA meetings the counselor attends or shares drinking and drugging "war stories" for the counselor's own gratification. Two key elements in understanding when a boundary crossing becomes a boundary violation are the intent of the counselor and the damaging effect on the client. Maintaining a standard of practice of nonexploitation of the client is the primary focus for clinical supervisors and counselors in determining when boundary crossings become boundary violations.

Context is also an important consideration in determining the acceptability of boundary crossings. For example, it may be acceptable for a counselor in a partial hospitalization program for serious mental illness to have a cup of coffee at the kitchen table with a resident, whereas for a counselor in an outpatient mental health program, having a cup of coffee with a client at the local coffee shop would be a much more questionable boundary crossing.

Case Illustration: Denise

Denise is a 40-year-old licensed professional counselor working in an inpatient eating disorder program. She has had extensive training in trauma and eating disorder counseling approaches and has been working as a clinician in mental health settings for 15 years. Denise is usually open to suggestions from her supervisor and other treatment team members about specific strategies to use with clients who have trauma histories and eating disorders. However, in the past week, her supervisor has noticed that she has become defensive in team meetings and individual supervision when discussing a recently admitted young adult who was beaten and raped by her boyfriend; subsequently, the client was diagnosed with PTSD and anorexia. When the clinical supervisor makes note of the change in Denise's attitude and behavior in team meetings since this young woman was admitted, initially Denise becomes defensive, saying that the team just doesn't understand this young woman and that the client has repeatedly told Denise, "You're the only counselor I trust."

The clinical supervisor recognizes that Denise may be experiencing secondary traumatization and boundary confusion due to working with this young woman and to the recent increase in the number of clients with co-occurring trauma-related disorders on her caseload. After further exploration, Denise reveals that her own daughter was raped at the same age as the young woman and that hearing her story has activated an STS reaction in Denise. Her way of coping has been to become overly responsible for and overprotective of the young woman. With the nonjudgmental support of her supervisor, Denise is able to gain perspective, recognize that this young woman is not her daughter, and reestablish boundaries with her that are appropriate to the inpatient treatment setting.

Clinical Supervision and Consultation

Organizational change toward a TIC model doesn't happen in isolation. Ongoing support, supervision, and consultation are key ingredients that reinforce behavioral health professionals' training in trauma-informed and trauma-specific counseling methods and ensure compliance with practice standards and consistency over time. Often, considerable energy and resources are spent on the transition to new clinical and programmatic approaches, but without long-range planning to support those changes over time. The new treatment approach fades quickly, making it hard to recognize and lessening its reliability.

Advice to Clinical Supervisors and Administrators: Adopting an Evidence-Based Model of Clinical Supervision and Training

Just as adopting evidence-based clinical practices in a trauma-informed organization is important in providing cost-effective and outcome-relevant services to clients, adopting an evidence-based model of clinical supervision and training clinical supervisors in that model can enhance the quality and effectiveness of clinical supervision for counselors. This will ultimately enhance client care.

One of the most commonly used and researched integrative models of supervision is the discrimination model, originally published by Janine Bernard in 1979 and since updated (Bernard & Goodyear, 2009). This model is considered a competence-based and social role model of supervision; it includes three areas of focus on counselor competencies (intervention, conceptualization, and personalization) and three possible supervisor roles (teacher, counselor, and consultant).

Counselor competencies:

- Intervention: The supervisor focuses on the supervisee's intervention skills and counseling strategies used with a particular client in a given session.
- Conceptualization: The supervisor focuses on how the supervisee understands what is happening in a session with the client.
- Personalization: The supervisor focuses on the personal style of the counselor and countertransference responses (i.e., personal reactions) of the counselor to the client.

Supervisor roles:

- Teacher: The supervisor teaches the supervisee specific counseling theory and skills and guides the supervisee in the use of specific counseling strategies in sessions with clients. The supervisor as teacher is generally task-oriented. The supervisor is more likely to act as a teacher with beginning counselors.
- Counselor: The supervisor does not act as the counselor's therapist, but helps the counselor reflect on his or her counseling style and personal reactions to specific clients. The supervisor as counselor is interpersonally sensitive and focuses on the process and relational aspects of counseling.
- Consultant: The supervisor is more of a guide, offering the supervisee advice on specific clinical situations. The supervisor as consultant invites the counselor to identify topics and set the agenda for the supervision. The supervisor is more likely to act as a consultant with more advanced counselors.

This model of supervision may be particularly useful in working with counselors in TIC settings, because the supervisor's response to the supervisee is flexible and specific to the supervisee's needs. In essence, it is a counselor-centered model of supervision in which the supervisor can meet the most relevant needs of the supervisee in any given moment.

For a review of other theories and methods of clinical supervision, refer to TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Ongoing supervision and consultation supports the organizational message that TIC is the standard of practice. It normalizes secondary traumatization as a systemic issue (not the individual pathology of the counselor) and reinforces the need for counselor self-care to prevent and lessen the impact of secondary traumatization. Quality clinical supervision for direct care staff demonstrates the organization's commitment to implementing a fully integrated, trauma-informed system of care.

Supervision and Consultation

Historically, there was an administrative belief that counselors who had extensive clinical experience and training would naturally be the best clinical supervisors. However, research does not support this idea (Falender & Shafranske, 2004). Although a competent clinical supervisor needs to have an extensive clinical background in the treatment of substance use, trauma-related, and other mental disorders, it is also essential for any counselor moving into a supervisory role to have extensive training in the theory and practice of clinical supervision before taking on this role. In particular, clinical supervisors in trauma-informed behavioral health settings should be educated in how to perform clinical supervision (not just administrative supervision) of direct service staff and in the importance of providing continuous clinical supervision and support for staff members working with individuals affected by trauma. Clinical

Case Illustration: Arlene

Arlene is a 50-year-old licensed substance abuse counselor who has a personal history of trauma, and she is actively engaged in her own recovery from trauma. She is an experienced counselor who has several years of training in trauma-informed and trauma-specific counseling practices. Her clinical supervisor, acting in the role of consultant, begins the supervision session by inviting her to set the agenda. Arlene brings up a clinical situation in which she feels stuck with a client who is acting out in her Seeking Safety group (for more information on Seeking Safety, see Najavits, 2002a).

Arlene reports that her client gets up suddenly and storms out of the group room two or three times during the session. The supervisor, acting in the role of the counselor and focusing on personalization, asks Arlene to reflect on the client's behavior and what feelings are activated in her in response to the client's anger. Arlene is able to identify her own experience of hyperarousal and then paralysis as a stress reaction related to her prior experience of domestic violence in her first marriage. The supervisor, acting in the role of teacher and focusing on conceptualization, reminds Arlene that her client is experiencing a "fight-or-flight" response to some experience in the group that reminds her of her own trauma experience. The supervisor then suggests to Arlene that her own reactions are normal responses to her previous history of trauma, and that when her client is angry, Arlene is not reexperiencing her own trauma but is being activated by the client's traumatic stress reaction to being in group. In this way, the supervisor highlights the parallel process of the client–counselor's stress reactions to a perceived threat based on prior trauma experiences.

The supervisor, acting again as a consultant and focusing on personalization this time, invites Arlene to reflect on the internal and external resources she might be able to bring to this situation that will help remind her to ground herself so she can lessen the impact of her stress reactions on her counseling strategy with this client. Arlene states that she can create a list of safe people in her life and place this list in her pocket before group. She can use this list as a touchstone to remind her that she is safe and has learned many recovery skills that can help her stay grounded, maintain her boundaries, and deal with her client's behavior. The clinical supervisor, acting as a consultant and now focusing on intervention, asks Arlene if she has some specific ideas about how she can address the client's behavior in group. Arlene and the clinical supervisor spend the remainder of the session discussing different options for addressing the client's behavior and helping her feel safer in group.

supervision in a TIC organization should focus on the following priorities:

- General case consultation
- Specialized consultation in specific and unusual cases
- Opportunities to process clients' traumatic material
- Boundaries in the therapeutic and supervisory relationship
- Assessment of secondary traumatization
- Counselor self-care and stress management
- Personal growth and professional development of the counselor

Supervision of counselors working with traumatized clients should be regularly scheduled, with identified goals and with a supervisor who is trained and experienced in working with trauma survivors. The styles and types of supervision and consultation may vary according to the kind of trauma work and its context. For instance, trauma counseling in a major natural disaster would require a different approach to supervision and consultation than would counseling adults who experienced childhood developmental trauma or counseling clients in an intensive early recovery treatment program using a manualized trauma-specific counseling protocol.

Competence-based clinical supervision is recommended for trauma-informed organizations. Competence-based clinical supervision models identify the knowledge and clinical skills each counselor needs to master, and they use targeted learning strategies and evaluation procedures, such as direct observation of counselor sessions with clients, individualized coaching, and performance-based feedback. Studies on competence-based supervision approaches have demonstrated that these models improve counselor treatment skills and proficiency (Martino et al., 2011).

Whichever model of clinical supervision an organization adopts, the key to successful trauma-informed clinical supervision is the recognition that interactions between the supervisor and the counselor may parallel those between the counselor and the client. Clinical supervisors need to recognize counselors' trauma reactions (whether they are primary or secondary to the work with survivors of trauma) and understand that a confrontational or punitive approach will be ineffective and likely retraumatize counselors.

Clinical supervisors should adopt a respectful and collaborative working relationship with counselors in which role expectations are clearly defined in an informed consent process similar to that used in the beginning of the counselor–client relationship and in which exploring the nature of boundaries in both client–counselor and counselor–supervisor relationships is standard practice. Clear role boundaries, performance expectations, open dialog, and supervisor transparency can go a long way toward creating a safe and respectful relationship container for the supervisor and supervisee and set the stage for a mutually enhancing, collaborative relationship. This respectful, collaborative supervisory relationship is the main source of training and professional growth for the counselor and for the provision of quality care to people with behavioral health disorders.

Secondary Traumatization

The demands of caregiving exact a price from behavioral health professionals that cannot be ignored; otherwise, they may become ineffective in their jobs or, worse, emotionally or psychologically impaired. In a study of Master's level licensed social workers, 15.2 percent of respondents to a survey reported STS as a result of indirect exposure to trauma material at a level that meets the diagnostic criteria for PTSD. This rate is almost twice the rate of PTSD in the general population. The author

STS is a trauma related stress reaction and set of symptoms resulting from exposure to another individual's traumatic experiences rather than from exposure directly to a traumatic event.

concluded that behavioral health professionals' experience of STS is a contributing factor in staff turnover and one reason why many behavioral health service professionals leave the field (Bride, 2007). Secondary traumatization of behavioral health workers is a significant organizational issue for clinical supervisors and administrators in substance abuse and mental health treatment programs to address.

To prevent or lessen the impact of secondary traumatization on behavioral health professionals, clinical supervisors and administrators need to understand secondary trauma from the ecological perspective described in Part 1, Chapter 1 of this TIP. The organization itself creates a social context with risk factors that can increase the likelihood of counselors experiencing STS reactions, but it also contains protective factors that can lessen the risk and impact of STS reactions on staff members. Organizations can lessen the impact of the risk factors associated with working in trauma-informed organizations by mixing caseloads to contain clients both with and without trauma-related issues, supporting ongoing counselor training, providing regular clinical supervision, recognizing counselors' efforts, and offering an empowering work environment in which counselors share in the responsibility of making decisions and can offer input into clinical and program policies that affect their work lives.

When organizations support their counselors in their work with clients who are traumatized, counselors can be more effective, more productive, and feel greater personal and professional satisfaction. In addition, counselors develop a sense of allegiance toward the organization, thus decreasing staff turnover. If organizations do not provide this support, counselors can become demoralized and have fewer emotional and psychological resources to manage the impact of clients' traumatic material and outward behavioral expressions of trauma on their own well-being. Providing counselors with the resources to help them build resilience and prevent feeling overwhelmed should be a high priority for administrators and clinical supervisors in TIC organizations.

Risk and Protective Factors Associated With Secondary Traumatization

Clinical and research literature on trauma describes a number of factors related to the development of secondary trauma reactions and psychological distress in behavioral health professionals across a wide range of practice settings, as well as individual and organizational factors that can prevent or lessen the impact of STS on staff. The risk and protective factors model of understanding secondary trauma is based on the ecological perspective

Advice to Clinical Supervisors: Recognizing Secondary Traumatization

Some counselor behaviors that demonstrate inconsistency to clients may be outward manifestations of secondary traumatization, and they should be discussed with counselors through a trauma-informed lens. It is imperative that clinical supervisors provide a nonjudgmental, safe context in which counselors can discuss these behaviors without fear of reprisal or reprimand. Clinical supervisors should work collaboratively with supervisees to help them understand their behavior and engage in self-care activities that lessen the stress that may be contributing to these behaviors.

outlined in Part 1, Chapter 1 of this TIP. The terms "compassion fatigue," "vicarious traumatization," "secondary traumatization," and "burnout" are used in the literature, sometimes interchangeably and sometimes as distinct constructs. As stated in the terminology portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP, the term "secondary traumatization" refers to traumatic stress reactions and psychological distress from exposure to another individual's traumatic experiences; this term will be used throughout this section, although the studies cited may use other terms.

Risk factors

Individual risk factors that may contribute to the development of STS in behavioral health professionals include preexisting anxiety or mood disorders; a prior history of personal trauma; high caseloads of clients with trauma-related disorders; being younger in age and new to the field with little clinical experience or training in treating trauma-related conditions; unhealthy coping styles, including distancing and detachment from clients and co-workers; and a lack of tolerance for strong emotions (Newall & MacNeil, 2010). Other negative coping strategies include substance abuse, other addictive behaviors, a lack of recreational activities not related to work, and a lack of engagement with social support. A recent study of trauma nurses found that low use of support systems, use of substances, and a lack of hobbies were among the coping strategies that differed between nurses with and without STS (Von Rueden et al., 2010). Other researchers found that clinicians who engaged in negative coping strategies, such as alcohol and illicit drug use, were more likely to experience intrusive trauma symptoms (Way, Van Deusen, Martin, Applegate, & Janle, 2004).

Numerous organizational factors can contribute to the development of STS in counselors who work with clients with trauma-related disorders. These risk factors include organizational constraints, such as lack of resources for clients, lack of clinical supervision for counselors, lack of support from colleagues, and lack of acknowledgment by the organizational culture that secondary traumatization exists and is a normal reaction of counselors to client trauma (Newall & MacNeil, 2010). In a study of 259 individuals providing mental health counseling services, counselors who spent more time in session with clients with trauma-related disorders reported higher levels of traumatic stress symptoms (Bober & Regehr, 2006). Counselors may be more at risk for developing secondary traumatization if the organization does not allow for balancing the distribution of trauma and nontrauma cases amongst staff members.

Protective factors

Much of the clinical and research literature focuses on individual factors that may lessen the impact of STS on behavioral health professionals, including male gender, being older, having more years of professional experience,

Advice to Clinical Supervisors: Recognizing STS in Counselors Who Are In Recovery

For counselors who are in recovery from a substance use or mental disorder, the development of STS may be a potential relapse concern. As Burke, Carruth, and Prichard (2006) point out, "a return to drinking or illicit drug use as a strategy for dealing with secondary trauma reactions would have a profoundly detrimental effect on the recovering counselor" (p. 292). So too, secondary trauma may ignite the reappearance of depressive or anxiety symptoms associated with a previous mental disorder. Clinical supervisors can address these risk factors with counselors and support them in engaging with their own recovery support network (which might include a peer support group or an individual counselor) to develop a relapse prevention plan.

having specialized training in trauma-informed and trauma-specific counseling practices, lacking a personal trauma history, exhibiting personal autonomy in the workplace, using positive personal coping styles, and possessing resilience or the ability to find meaning in stressful life events and to rebound from adversity (Sprang, Clark, & Whitt-Woosley, 2007). Some of these factors, like positive personal coping styles and the ability to find meaning in adversity, can be developed and enhanced through personal growth work, psychotherapy, engagement with spiritual practices and involvement in the spiritual community, and stress reduction strategies like mindfulness meditation. A recent multimethod study of an 8-week workplace mindfulness training group for social workers and other social service workers found that mindfulness meditation increased coping strategies, reduced stress, and enhanced self-care of the participants; findings suggested that workers were more likely to practice stress management techniques like mindfulness at their place of work than at home (McGarrigle & Walsh, 2011). Organizations can support counselors' individual efforts to enhance positive personal coping styles, find meaning in adversity, and reduce stress by providing time for workers during the workday for personal self-care activities, like mindfulness meditation and other stress reduction practices.

One of the organizational protective factors identified in the literature that may lessen the negative impact of secondary traumatization on behavioral health professionals is providing adequate training in trauma-specific counseling strategies, which increases providers' sense of efficacy in helping clients with trauma-related disorders and reduces the sense of hopelessness that is often a part of the work (Bober & Regehr 2006). One study found that specialized trauma training enhanced job satisfaction and reduced levels of compassion fatigue, suggesting that "knowledge and training might provide some protection against the deleterious effects of trauma exposure" (Sprang et al., 2007, p. 272). Another protective factor that may lessen the chances of developing secondary traumatization is having a diverse caseload of clients. Organizations "must determine ways of distributing workload in order to limit the traumatic exposure of any one worker. This may not only serve to reduce the impact of immediate symptoms but may also address the potential longitudinal effects" (Bober & Regehr, 2006, p. 8).

Emotional support from professional colleagues can be a protective factor. A study of substance abuse counselors working with clients who were HIV positive found that workplace support from colleagues and supervisors most effectively prevented burnout (Shoptaw, Stein, & Rawson, 2000). This support was associated with less emotional fatigue and depersonalization, along with a sense of greater personal accomplishment. In a study of domestic violence advocates, workers who received more support from professional peers were less likely to experience secondary traumatization (Slattery & Goodman, 2009).

In addition, counselor engagement in relationally based clinical supervision with a trauma-informed supervisor acts as a protective agent. Slattery and Goodman (2009) note that "for the trauma worker, good supervision can normalize the feelings and experiences, provide support and information about the nature and course of the traumatic reaction, help in the identification of transference and countertransference issues, and reveal feelings or symptoms associated with the trauma" (p. 1362). Workers who reported "engaging, authentic, and empowering relationships with their supervisors" were less likely to experience STS (p. 1369). Thus, it is not simply the frequency and regularity of clinical supervision,

but also the quality of the supervision and the quality of the supervisor–counselor relationship that can lessen the impact of STS on behavioral health professionals.

Engagement with a personal practice of spirituality that provides a sense of connection to a larger perspective and meaning in life is another protective factor that can lessen the impact of STS on counselors (Trippany, Kress, & Wilcoxon, 2004). Although recovering counselors may look to support groups for connection to a spiritual community, other behavioral health professionals might find support for enhancing spiritual meaning and connection in church, a meditation group, creative endeavors, or even volunteer work. The key is for counselors to develop their own unique resources and practices to enhance a sense of meaningful spirituality in their lives. Clinical supervisors should be aware of spiritual engagement as a protective factor in preventing and lessening the impact of STS and should support clinicians in including it in their self-care plans, but they should take care not to promote or reject any particular religious belief system or spiritual practice.

Another protective factor that may lessen the impact of workers' STS is a culture of empowerment in the organization that offers counselors a sense of autonomy, a greater ability to participate in making decisions about clinical and organizational policies, and obtaining support and resources that further their professional development. Slattery & Goodman (2009) surveyed 148 domestic violence advocates working in a range of settings. The authors found that those workers "who reported a high level of shared power were less likely to report posttraumatic stress symptoms, despite their own personal abuse history or degree of exposure to trauma" (p. 1370). To the degree that organizations can provide a cultural context within which behavioral health professionals have autonomy and feel empowered, they will be able to lessen the impact of STS on their professional and personal lives. Self-efficacy and empowerment are antidotes to the experience of powerlessness that often accompanies trauma.

Strategies for Preventing Secondary Traumatization

The key to prevention of secondary traumatization for behavioral health professionals in a trauma-informed organization is to reduce risk and enhance protective factors. Organizational strategies to prevent secondary traumatization include:

- Normalize STS throughout all levels of the organization as a way to help counselors feel safe and respected, enhancing the likelihood that they will talk openly about their experiences in team meetings, peer supervision, and clinical supervision.
- Implement clinical workload policies and practices that maintain reasonable standards for direct-care hours and emphasize balancing trauma-related and nontrauma-related counselor caseloads.
- Increase the availability of opportunities for supportive professional relationships by promoting activities such as team meetings, peer supervision groups, staff retreats, and counselor training that focuses on understanding secondary traumatization and self-care. Administrators and clinical supervisors should provide time at work for counselors to engage in these activities.
- Provide regular trauma-informed clinical supervision that is relationally based. Supervisors should be experienced and trained in trauma-informed and trauma-specific practices and provide a competence-based model of clinical supervision that promotes counselors' professional and personal development. Supervision limited to case consultation or case management is insufficient to

reduce the risk for secondary traumatization and promote counselor resilience.

- Provide opportunities for behavioral health professionals to enhance their sense of autonomy and feel empowered within the organization. Some of these activities include soliciting input from counselors on clinical and administrative policies that affect their work lives, including how to best balance caseloads of clients with and without histories of trauma; inviting representatives of the counseling staff to attend selected agency board of directors and/or management team meetings to offer input on workforce development; and inviting counselors to participate in organizational task forces that develop trauma-informed services, plan staff retreats, or create mechanisms to discuss self-care in team meetings. Administrators and clinical supervisors should assess the organization's unique culture and develop avenues for counselor participation in activities that will enhance their sense of empowerment and efficacy within the organization.

Exhibit 2.2-7 highlights some specific strategies that individual counselors can engage in to prevent secondary traumatization.

Assessment of Secondary Traumatization

Counselors with unacknowledged STS can harm clients, self, and family and friends by becoming unable to focus on and attend to their needs or those of others. They may feel helpless or cynical and withdraw from support systems. Exhibit 2.2-8 describes some emotional, cognitive, and behavioral signs that may indicate that a counselor is experiencing secondary traumatization. Clinical supervisors should be familiar with the manifestations of STS in their counselors and should address signs of STS immediately.

Stamm (2009–2012) has developed and revised a self-assessment tool, the Professional Quality of Life Scale (ProQOL), that measures indicators of counselor compassion fatigue and compassion satisfaction. Compassion fatigue "is best defined as a syndrome consisting of a combination of the symptoms

Exhibit 2.2-7: Counselor Strategies To Prevent Secondary Traumatization

Strategies that counselors can use (with the support and encouragement of supervisors and administrators) to prevent secondary traumatization include:

- ***Peer support*:** Maintaining adequate social support, both personally and professionally, helps prevent isolation and helps counselors share the emotional distress of working with traumatized individuals.
- ***Supervision and consultation*:** Professional consultation will help counselors understand secondary traumatization, their own personal risks, the protective factors that can help them prevent or lessen its impact, and their countertransference reactions to specific clients.
- ***Training*:** Ongoing professional training can improve counselors' understanding of trauma and enhance a sense of mastery and self-efficacy in their work.
- ***Personal psychotherapy or counseling*:** Being in counseling can help counselors become more self-aware and assist them in managing the psychological and emotional distress that often accompanies working with clients who have trauma histories in a number of behavioral health settings.
- ***Maintaining balance in one's life*:** Balancing work and personal life, developing positive coping styles, and maintaining a healthy lifestyle can enhance resilience and the ability to manage stress.
- ***Engaging in spiritual activities that provide meaning and perspective*:** Connection to a spiritual community and spiritual practices (such as meditation) can help counselors gain a larger perspective on trauma and enhance resilience.

Exhibit 2.2-8: Secondary Traumatization Signs

The following are some indicators that counselors may be experiencing secondary traumatization.

Psychological distress
- Distressing emotions: grief, depression, anxiety, dread, fear, rage, shame
- Intrusive imagery of client's traumatic material: nightmares, flooding, flashbacks of client disclosures
- Numbing or avoidance: avoidance of working with client's traumatic material
- Somatic issues: sleep disturbances, headaches, gastrointestinal distress, heart palpitations, chronic physiological arousal
- Addictive/compulsive behaviors: substance abuse, compulsive eating, compulsive working
- Impaired functioning: missed or canceled appointments, decreased use of supervision, decreased ability to engage in self-care, isolation and alienation

Cognitive shifts
- Chronic suspicion about others
- Heightened sense of vulnerability
- Extreme sense of helplessness or exaggerated sense of control over others or situations
- Loss of personal control or freedom
- Bitterness or cynicism
- Blaming the victim or seeing everyone as a victim
- Witness or clinician guilt if client reexperiences trauma or reenacts trauma in counseling
- Feeling victimized by client

Relational disturbances
- Decreased intimacy and trust in personal/professional relationships
- Distancing or detachment from client, which may include labeling clients, pathologizing them, judging them, canceling appointments, or avoiding exploring traumatic material
- Overidentification with the client, which may include a sense of being paralyzed by one's own responses to the client's traumatic material or becoming overly responsible for the client's life

Frame of reference
- Disconnection from one's sense of identity
- Dramatic change in fundamental beliefs about the world
- Loss or distortion of values or principles
- A previous sense of spirituality as comfort or resource decreases or becomes nonexistent
- Loss of faith in something greater
- Existential despair and loneliness

Sources: Figley, 1995; Newall & MacNeil, 2010; Saakvitne et al., 1996.

of secondary traumatic stress and professional burnout" (Newall & MacNeil, 2010, p. 61). Although secondary traumatization as a reaction to exposure to clients' trauma material is similar to PTSD, burnout is a more general type of psychological distress related to the pressures of working in high-stress environments over time. Burnout may be a result of secondary traumatization and/or a contributing factor in the development of secondary traumatization. The ProQOL includes STS and burnout scales that have been validated in research studies (Adams, Figley, & Boscarino, 2008; Newall & MacNeil, 2010).

This tool can be used in individual and group clinical supervision, trainings on self-care, and team meetings as a way for counselors to check in with themselves on their levels of stress and potential signs of secondary traumatization.

Case Illustration: Gui

Gui is a 48-year-old licensed substance abuse counselor who has worked in a methadone maintenance clinic for 12 years. He originally decided to get his degree and become a counselor because he wanted to help people and make a difference in the world. Over the past 6 months, he has felt fatigued a great deal, gets annoyed easily with both clients and coworkers, and has developed a cynical attitude about the world and the people who come to the clinic for help. During this time, the clinic has been forced to lay off a number of counselors due to funding cutbacks. As a result, Gui and the remaining counselors have had a 20 percent increase in the number of weekly client contact hours required as part of their job duties. In addition, the level and severity of clients' trauma-related and other co-occurring disorders, poverty, joblessness, and homelessness has increased.

Gui is a valued employee, and when Gui discusses his thoughts that he might want to leave the clinic with his clinical supervisor, the supervisor listens to Gui's concerns and explores the possibility of having him fill out the ProQOL to get a pulse on his stress level. Gui agrees and is willing to discuss the results with his supervisor. He is not surprised to see that he scores above average on the burnout scale of the instrument but is very surprised to see that he scores below average on the secondary traumatic stress scale and above average on the compassion satisfaction scale. He begins to feel more hopeful that he still finds satisfaction in his job and sees that he is resilient in many ways that he did not acknowledge before.

Gui and the clinical supervisor discuss ways that the supervisor and the organization can lessen the impact of the stress of the work environment on Gui and support the development of a self-care plan that emphasizes his own ability to rebound from adversity and take charge of his self-care.

The compassion satisfaction scale allows counselors to reflect on their resilience and reminds them of why they choose to work with people with substance use and trauma-related disorders, despite the fact that this work can lead to secondary traumatization. The compassion satisfaction subscale reminds counselors that they are compassionate, that one of the reasons they are in a helping profession is that they value service to others, and that helping brings meaning and fulfillment to their lives. Exhibits 2.2-9 through 2.2-11 present the most recent version of the ProQOL.

Addressing Secondary Traumatization

If a counselor is experiencing STS, the organization should address it immediately. Clinical supervisors can collaborate with counselors to devise an individualized plan that is accessible, acceptable, and appropriate for each counselor and that addresses the secondary stress reactions the counselor is experiencing, providing specific self-care strategies to counteract the stress. Decisions about strategies for addressing secondary traumatization should be based on the personal preferences of the counselor, the opportunity for an immediate intervention following a critical incident, and the counselor's level of awareness regarding his or her experience of STS. Counselors may need to talk about what they are experiencing, feeling, and thinking. These experiences can be processed in teams, in consultations with colleagues, and in debriefing meetings to integrate them effectively (Myers & Wee, 2002).

If a critical incident evokes secondary traumatization among staff—such as a client suicide, a violent assault in the treatment program, or another serious event—crisis intervention should be available for workers who would like to participate. Any intervention should be voluntary and tailored to each worker's individual needs (e.g., peer, group, or individual sessions); if possible, these services should be offered continuously instead of just one time.

Exhibit 2.2-9: PRoQOL Scale

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PRoQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *past 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I *[help]*.
___ 3. I get satisfaction from being able to *[help]* people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I *[help]*.
___ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
___ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
___ 10. I feel trapped by my job as a *[helper]*.
___ 11. Because of my *[helping]*, I have felt "on edge" about various things.
___ 12. I like my work as a *[helper]*.
___ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
___ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a *[helper]*.
___ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
___ 21. I feel overwhelmed because my case [work] load seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
___ 24. I am proud of what I can do to *[help]*.
___ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a *[helper]*.
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.

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Exhibit 2.2-10: Your Scores on the ProQOL: Professional Quality of Life Screening

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental healthcare professional.

Compassion Satisfaction _____
Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____
Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____
The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a healthcare professional.

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Source: Stamm, 2012. Used with permission.

Exhibit 2.2-11: What Is My Score and What Does It Mean?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

*You Wrote	Change to
1	5
2	4
3	3
4	2
5	1

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____
Total : _____

The sum of my Compassion Satisfaction questions is	So my score equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score.

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____
Total : _____

The sum of my Burnout questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add the[m] up. When you have added them up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____
Total : _____

The sum of my Secondary Trauma questions is	So my score equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

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The objective of debriefing a critical incident that evokes STS reactions in counselors is to help them dissipate the hyperarousal associated with traumatic stress and prevent long-term aftereffects that might eventually lead to counselor impairment. Because clinical supervisors may also be experiencing secondary traumatization, it is advisable for administrators to invite an outside trauma consultant into the organization to provide a safe space for all staff members (including clinical supervisors) to address and process the critical stress incident. For noncrisis situations, secondary traumatization should be addressed in clinical supervision. Clinical supervisors and counselors should work collaboratively to incorporate regular screening and self-assessment of STS into supervision sessions.

Advice to Clinical Supervisors: Advantages and Disadvantages of Using Psychometric Measures

Using a psychometric measure such as the ProQOL has advantages and disadvantages. It is important to understand that all tests measure averages and ranges but do not account for individual circumstances.

If you use the ProQOL in clinical supervision, present it as a self-assessment tool. Let counselors opt out of sharing their specific results with you and/or your team if it is administered in a group. If counselors choose to share scores on specific items or scales with you, work collaboratively and respectfully with them to explore their own understanding of and meanings attached to their scores. If this tool is not presented to supervisees in a nonjudgmental, mindful way, counselors may feel as if they have failed if their scores on the secondary traumatization scale are above average or if their scores on the compassion satisfaction scale are below average. High scores on the compassion fatigue and burnout scales do not mean that counselors don't care about their clients or that they aren't competent clinicians. The scores are simply one way for you and your supervisees to get a sense of whether they might be at risk for secondary traumatization, what they can do to prevent it, how to address it, and how you can support them.

The potential benefits of using a self-assessment tool like the ProQOL in clinical supervision are that it can help counselors:

- Reflect on their emotional reactions and behaviors and identify possible triggers for secondary traumatization.
- Assess their risk levels.
- Examine alternative coping strategies that may prevent secondary traumatization.
- Understand their own perceptions of themselves and their job satisfaction, affirming what they already know about their risk of secondary traumatization and their compassion satisfaction.
- Reflect on different factors that might contribute to unexpected low or high scores, such as the day of the week, the intensity of the workload, whether they have just come back from the weekend or a vacation, and so forth.
- Increase self-awareness and self-knowledge, because scores on specific items or scales bring to consciousness what is often outside of awareness.
- Realize how resilient they are emotionally, mentally, physically, and spiritually.
- Become aware of and open up conversations about self-care and self-care activities and resources, such as supportive coworkers, team members, and social networks outside of work.

If used regularly, self-assessment tools can help counselors and clinical supervisors monitor STS levels, indicate significant positive and negative changes, and suggest action toward self-care in specific areas. Clinical supervisors should fill out the ProQOL and review results with their own supervisors, a peer supervisor, or a colleague before administering it to supervisees. Doing so enables supervisors to gauge their own reactions to the self-assessment and anticipate potential reactions from supervisees.

Advice to Clinical Supervisors: Is it Supervision or Psychotherapy?

Although there are some aspects of clinical supervision that can be therapeutic and parallel the therapeutic and emotional support that occurs between the counselor and the client, clinical supervision is not therapy. As a result, it is important for clinical supervisors to maintain appropriate boundaries with supervisees when addressing their STS reactions at work.

When does the process in supervision cross over into the realm of practicing therapy with a supervisee? One clear indicator is if the supervisor begins to explore the personal history of the counselor and reflects directly on that history instead of bringing it back to how the counselor's history influences his or her work with a particular client or with clients with trauma histories in general. Clinical supervisors should focus only on counselor issues that may be directly affecting their clinical functioning with clients. If personal issues arise in clinical supervision, counselors should be encouraged to address them in their own counseling or psychotherapy.

Exhibit 2.2-12: Clinical Supervisor Guidelines for Addressing Secondary Traumatization

1. Engage counselors in regular screening/self-assessment of counselors' experience of STS.
2. Address signs of STS with counselors in clinical supervision.
3. Work collaboratively with counselors to develop a comprehensive self-care plan and evaluate its effectiveness on a regular basis.
4. Provide counselors a safe and nonjudgmental environment within which to process STS in individual and group supervision or team meetings.
5. Provide counselors with a safe and nonjudgmental place within which to debrief critical stress incidents at work; bring in an outside consultant if needed.
6. Support and encourage counselors to engage in individual counseling or psychotherapy, when needed, to explore personal issues that may be contributing to secondary traumatization at work.

When STS issues arise, the clinical supervisor should work with counselors to review and revise their self-care plans to determine what strategies are working and whether additional support, like individual psychotherapy or counseling, may be warranted.

Exhibit 2.2-12 outlines some guidelines for clinical supervisors in addressing secondary trauma in behavioral health professionals working with clients who have substance use, mental, and trauma-related disorders.

Counselor Self-Care

In light of the intensity of therapeutic work with clients with co-occurring substance use, mental, and trauma-related disorders and the vulnerability of counselors to secondary traumatization, a comprehensive, individualized self-care plan is highly recommended. Balance is the key to the development of a self-care plan—a balance between home and work, a balance between focusing on self and others, and a balance between rest and activity (Saakvitne, Perlman, & Traumatic Stress Institute/ Center for Adult & Adolescent Psychotherapy 1996). Counselor self-care is also about balancing vulnerability, which allows counselors to be present and available when clients address intensely painful content, with reasonable efforts to preserve their sense of integrity in situations that may threaten the counselors' faith or worldview (Burke et al., 2006). A comprehensive self-care plan should include activities that nourish the physical, psychological/mental, emotional/relational, and spiritual aspects of counselors' lives.

The literature on counselor self-care advocates for individual, team, and organizational strategies that support behavioral health professionals working with clients who have

Case Illustration: Carla

Carla is a 38-year-old case manager working in an integrated mental health and substance abuse agency. She provides in-home case management services to home-bound clients with chronic health and/or severe mental health and substance abuse problems. Many of her clients have PTSD and chronic, debilitating pain.

Both her parents had alcohol use disorders, and as a result, Carla became the caretaker in her family. She loves her job; however, she often works 50 to 60 hours per week and has difficulty leaving her work at work. She often dreams about her clients and wakes up early, feeling anxious. She sometimes has traumatic nightmares, even though she was never physically or sexually abused, and she has never experienced the trauma of violence or a natural disaster. She drinks five cups of coffee and three to four diet sodas every day and grabs burgers and sweets for snacks while she drives from one client to the next. She has gained 20 pounds in the past year and has few friends outside of her coworkers. She has not taken a vacation in more than 2 years. She belongs to the Catholic church down the street, but she has stopped going because she says she is too busy and exhausted by the time Sunday rolls around.

The agency brings in a trainer who meets with the case management department and guides the staff through a self-assessment of their current self-care practices and the development of a comprehensive self-care plan. During the training, Carla acknowledges that she has let her work take over the rest of her life and needs to make some changes to bring her back into balance. She writes out her self-care plan, which includes cutting back on the caffeine, calling a friend she knows from church to go to a movie, going to Mass on Sunday, dusting off her treadmill, and planning a short vacation to the beach. She also decides that she will discuss her plan with her supervisor and begin to ask around for a counselor for herself to talk about her anxiety and her nightmares. In the next supervision session, Carla's supervisor reviews her self-care plan with her and helps Carla evaluate the effectiveness of her self-care strategies. Her supervisor also begins to make plans for how to cover Carla's cases when she takes her vacation.

substance use and trauma-related disorders. Counselors are responsible for developing comprehensive self-care plans and committing to their plans, but clinical supervisors and administrators are responsible for promoting counselor self-care, supporting implementation of counselor self-care plans, and modeling self-care. Counselor self-care is an ethical imperative; just as the entire trauma-informed organization must commit to other ethical issues with regard to the delivery of services to clients with substance use, mental, and trauma-related disorders, it must also commit to the self-care of staff members who are at risk for secondary traumatization as an ethical concern. Saakvitne and colleagues (1996) suggest that when administrators support counselor-self-care, it is not only cost-effective in that it reduces the negative effects of secondary traumatization on counselors (and their clients), but also promotes "hope-sustaining behaviors" in counselors, making them more motivated and open to learning, and thereby improving job performance and client care.

A Comprehensive Self-Care Plan

A self-care plan should include a self-assessment of current coping skills and strategies and the development of a holistic, comprehensive self-care plan that addresses the following four domains:

1. Physical self-care
2. Psychological self-care (includes cognitive/mental aspects)
3. Emotional self-care (includes relational aspects)
4. Spiritual self-care

Activities that may help behavioral health workers find balance and cope with the stress

Advice to Clinical Supervisors: Spirituality

The word "spiritual" in this context is used broadly to denote finding a sense of meaning and purpose in life and/or a connection to something greater than the self. Spiritual meanings and faith experiences are highly individual and can be found within and outside of specific religious contexts.

Engaging in spiritual practices, creative endeavors, and group/community activities can foster a sense of meaning and connection that can counteract the harmful effects of loss of meaning, loss of faith in life, and cognitive shifts in worldview that can be part of secondary traumatization. Counselors whose clients have trauma-related disorders experience fewer disturbances in cognitive schemas regarding worldview and less hopelessness when they engage in spiritually oriented activities, such as meditation, mindfulness practices, being in nature, journaling, volunteer work, attending church, and finding a spiritual community (Burke et al., 2006). Clinical supervisors can encourage counselors to explore their own spirituality and spiritual resources by staying open and attuned to the multidimensional nature of spiritual meaning of supervisees and refraining from imposing any particular set of religious or spiritual beliefs on them. A strong sense of spiritual connection can enhance counselors' resilience and ability to cope with the sometimes overwhelming effects of clients' trauma material and trauma-related behavior (including suicidality) on counselors' faith in life and sense of meaning and purpose.

Modeling Self-Care

"Implementing interventions was not always easy, and one of the more difficult coping strategies to apply had to do with staff working long hours. Many of the staff working at the support center also had full-time jobs working for the Army. In addition, many staff chose to volunteer at the Family Assistance Center and worked 16- to 18-hour days. When we spoke with them about the importance of their own self-care, many barriers emerged: guilt over not working, worries about others being disappointed in them, fear of failure with respect to being unable to provide what the families might need, and a 'strong need to be there.' Talking with people about taking a break or time off proved problematic in that many of them insisted that time off was not needed, despite signs of fatigue, difficulty concentrating, and decreased productivity. Additionally, time off was not modeled. Management, not wanting to fail the families, continued to work long hours, despite our requests to do otherwise. Generally, individuals could see and understand the reasoning behind such endeavors. Actually making the commitment to do so, however, appeared to be an entirely different matter. In fact, our own team, although we kept reasonable hours (8 to 10 per day), did not take a day off in 27 days. Requiring time off as part of membership of a Disaster Response Team might be one way to solve this problem."

—Member of a Disaster Response Team at the Pentagon after September 11

Source: Walser, 2004, pp. 4–5.

of working with clients with trauma-related disorders include talking with colleagues about difficult clinical situations, attending workshops, participating in social activities with family and friends, exercising, limiting client sessions, balancing caseloads to include clients with and without trauma histories, making sure to take vacations, taking breaks during the workday, listening to music, walking in nature, and seeking emotional support in both their personal and professional lives (Saakvitne et al., 1996). In addition, regular clinical supervision and personal psychotherapy or counseling can be positive coping strategies for lessening the impact of STS on counselors. Still, each counselor is unique, and a self-care approach that is helpful to one counselor may not be helpful to another. Exhibits 2.2-13 and 2.2-14 offer tools for self-reflection to help counselors discover which specific self-care activities might best suit them. The worksheet can be used privately by counselors or by clinical supervisors as an exercise in individual supervision, group supervision, team meetings, or trainings on counselor self-care.

Exhibit 2.2-13: Comprehensive Self-Care Plan Worksheet

Name: Date:	Personal	Professional/Workspace
Physical		
Psychological/Mental		
Emotional/Relational		
Spiritual		

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Review the questions in Exhibit 2.2-14, and then write down specific self-care strategies in the form (given in Exhibit 2.2-13) that you're confident you will practice in both personal and professional realms.

The *Comprehensive Self-Care Worksheet* is a tool to help counselors (and clinical supervisors) develop awareness of their current coping strategies and where in the four domains they need to increase their engagement in self-care activities. Once completed, clinical supervisors should periodically review the plan with their supervisees for effectiveness in preventing and/or ameliorating secondary traumatization and then make adjustments as needed.

Essential Components of Self-Care

Saakvitne and colleagues (1996) describe three essential components, the "ABCs," of self-care that effectively address the negative impact of secondary traumatization on counselors:

1. **Awareness** of one's needs, limits, feelings, and internal/external resources. Awareness involves mindful/nonjudgmental attention to one's physical, psychological, emotional, and spiritual needs. Such attention requires quiet time and space that supports self-reflection.
2. **Balance** of activities at work, between work and play, between activity and rest, and between focusing on self and focusing on others. Balance provides stability and helps counselors be more grounded when stress levels are high.
3. **Connection** to oneself, to others, and to something greater than the self. Connection decreases isolation, increases hope, diffuses stress, and helps counselors share the burden of responsibility for client care. It provides an anchor that enhances counselors' ability to witness tremendous suffering without getting caught up in it.

Exhibit 2.2-14: Comprehensive Self-Care Plan Worksheet Instructions

Use the following questions to help you engage in a self-reflective process and develop your comprehensive self-care plan. Be specific and include strategies that are accessible, acceptable, and appropriate to your unique circumstances. Remember to evaluate and revise your plan regularly.

Physical
What are non-chemical things that help my body relax?
What supports my body to be healthy?

Psychological/Mental
What helps my mind relax?
What helps me see a bigger perspective?
What helps me break down big tasks into smaller steps?
What helps me counteract negative self-talk?
What helps me challenge negative beliefs?
What helps me build my theoretical understanding of trauma and addictions?
What helps me enhance my counseling/helping skills in working with traumatized clients?
What helps me become more self-reflective?

Emotional/Relational
What helps me feel grounded and able to tolerate strong feelings?
What helps me express my feelings in a healthy way?
Who helps me cope in positive ways and how do they help?
What helps me feel connected to others?
Who are at least three people I feel safe talking with about my reactions/feelings about clients?
How can I connect with those people on a regular basis?

Spiritual
What helps me find meaning in life?
What helps me feel hopeful?
What sustains me during difficult times?
What connects me to something greater?

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Clinical supervisors can help counselors review their self-care plans through the ABCs by reflecting on these questions:

1. Has the counselor accurately identified his or her needs, limits, feelings, and internal and external resources in the four domains (physical, psychological/mental, emotional/relational, spiritual)?
2. Has the counselor described self-care activities that provide a balance between work and leisure, activity and rest, and a focus on self and others?
3. Has the counselor identified self-care activities that enhance connection to self, others, and something greater than self (or a larger perspective on life)?

Supervisors should make their own self-care plans and review them periodically with their clinical supervisors, a peer supervisor, or a colleague.

Commitment to Self-Care

One of the major obstacles to self-care is giving in to the endless demands of others, both at work and at home. It is therefore essential for counselors with the support of clinical supervisors to become "guardians of [their] boundaries and limits" (Saakvitne et al., 1996, p 136). Creating a daily schedule that includes breaks for rest, exercise, connection with coworkers, and other self-care activities can support counselors in recognizing that they are valuable individuals who are worthy of taking the time to nourish and nurture themselves, thus increasing commitment to self-care. Another way to support counselors in committing to self-care is for supervisors and administrators to model self-care in their own professional and personal lives.

Understanding that counselor self-care is not simply a luxury or a selfish activity, but rather, an ethical imperative (Exhibit 2.2-15) can foster counselors' sense of connection to their own values and accountability to the people they serve as competent and compassionate caregivers. Clinical supervisors and administrators can reinforce this sense of accountability while supporting counselors by providing a caring, trauma-informed work environment

Exhibit 2.2-15: The Ethics of Self-Care

The Green Cross Academy of Traumatology was originally established to serve a need in Oklahoma City following the April 19, 1995, bombing of the Alfred P. Murrah Federal Building. Below are adapted examples of the Academy's code of ethics with regard to worker self-care.

Ethical Principles of Self-Care in Practice
These principles declare that it is unethical not to attend to your self-care as a practitioner, because sufficient self-care prevents harming those we serve.

Standards of self-care guidelines:
- Respect for the dignity and worth of self: A violation lowers your integrity and trust.
- Responsibility of self-care: Ultimately it is your responsibility to take care of yourself—and no situation or person can justify neglecting this duty.
- Self-care and duty to perform: There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care.

Standards of humane practice of self-care:
- Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self-care.
- Physical rest and nourishment: Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
- Emotional rest and nourishment: Every helper deserves emotional and spiritual renewal both in and outside the work context.
- Sustenance modulation: Every helper must utilize self-restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since improper consumption can compromise their competence as a helper.

Commitment to self-care:
- Make a formal, tangible commitment: Written, public, specific, measurable promises of self-care.
- Set deadlines and goals: The self-care plan should set deadlines and goals connected to specific activities of self-care.
- Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care.

Source: Green Cross Academy of Traumatology, 2010. Adapted with permission.

that acknowledges and normalizes secondary traumatization and by offering reasonable resources that make it possible for counselors to do their work and take care of themselves at the same time. Preventing secondary traumatization and lessening its impact on counselors once it occurs is not only cost-effective with regard to decreasing staff turnover and potential discontinuity of services to clients; it is also the ethical responsibility of a trauma-informed organization.

Appendices

Appendix A—Bibliography

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Appendix B—Trauma Resource List

Introduction

As it would be difficult to include every organization focused on trauma, the list of resources in this appendix is not exhaustive; consequently, this list does not include books or other materials concerning the vast nature of this topic, but rather, it concentrates solely on online resources accessible to the public for free or as part of an organization membership. The inclusion of selected resources does not necessarily signify endorsement by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Following these resources for adults is a list of resources focused on children and adolescents and a list of training opportunities.

Technology and Trauma: Using the Web To Treat PTSD

The role of the Internet in helping those who are experiencing posttraumatic stress disorder (PTSD) has expanded rapidly; there are numerous Web sites with toolkits and research publications for clinicians who treat clients with PTSD, as well as Web sites aimed at providing information and support for these individuals. The U.S. military has contributed to the field in developing these avenues—specifically, with interactive Web applications for use on home computers and smartphones.

- PTSD Coach is a smartphone application from the U.S. Department of Veterans Affairs (VA) to help people experiencing PTSD learn about and manage their symptoms (http://www.ptsd.va.gov/public/pages/ptsdcoach.asp).
- Afterdeployment.org is a Web site developed by the Defense Centers of Excellence project led by the National Center for Telehealth & Technology, with interactive workshops about PTSD, traumatic brain injury (TBI), anxiety, and depression, aimed at returning veterans (http://www.afterdeployment.org).
- T2 Virtual PTSD Experience, also developed by the National Center for Telehealth & Technology, is an application to be used within the popular online game Second Life as an interactive way of simulating how PTSD can be acquired within a combat environment, how PTSD may present itself to the person experiencing it, and how to seek effective treatment (http://www.t2health.org/vwproj).

Resources for Adults

Academy of Cognitive Therapy

http://www.academyofct.org
260 South Broad Street
18th Floor
Philadelphia, PA 19102
Phone: 267-350-7683
Email: info@academyofct.org

The Academy of Cognitive Therapy, a nonprofit organization, supports continuing education and research in cognitive therapy, provides a valuable resource in cognitive therapy for professionals and the public at large,

and actively works toward the identification and certification of clinicians skilled in cognitive therapy. Certification is awarded to those individuals who, based on an objective evaluation, have demonstrated an advanced level of expertise in cognitive therapy. The Academy includes physicians, psychologists, social workers, and other mental health professionals from around the world. The Academy formed a Trauma Task Force after September 11, 2001, to disseminate information (available on their Web site) to help people around the world receive the best help possible following trauma.

Addiction Technology Transfer Center Network

http://www.attcnetwork.org/index.asp
5100 Rockhill Road
Kansas City, MO 64110
Phone: 816-235-6888
Email: networkoffice@attcnetwork.org

The Addiction Technology Transfer Center (ATTC) Network serves as a resource for students and professionals to identify international distance education opportunities for the substance abuse treatment field and as a free marketing venue for ATTC-approved sponsors of distance education courses. The ATTC Web site provides trauma-related resources that include case studies, information on working with returning veterans who have been exposed to trauma, and links to various publications on PTSD and secondary traumatic stress.

Agency for Healthcare Research and Quality

http://www.innovations.ahrq.gov/index.aspx
540 Gaither Road
Suite 2000
Rockville, MD 20850
Phone: 301-427-1104

The Agency for Healthcare Research and Quality (AHRQ) is the research arm of HHS, specializing in patient safety and quality improvement, outcomes and effectiveness of care, clinical practice and technology assessment, and healthcare organization and delivery systems. AHRQ also provides funding and technical assistance to health research and research training programs at many universities and institutions. AHRQ's Web site provides links to research publications on PTSD and to other government publications and toolkits dealing with trauma-informed care.

The American Academy of Experts in Traumatic Stress

http://www.aaets.org
203 Deer Road
Ronkonkoma, NY 11779
Phone: 631-543-2217
Email: info@aaets.org

The American Academy of Experts in Traumatic Stress is a multidisciplinary network of professionals who are committed to the advancement of intervention for survivors of trauma. The Academy aims to identify expertise among professionals and across disciplines and to provide meaningful standards for those who work regularly with survivors. The Academy is committed to fostering a greater appreciation of the effects of common traumatic experiences (e.g., chronic illness, accidents, domestic violence, loss) in addition to large-scale disasters and catastrophes. The group's aim is to help all victims to become survivors and, ultimately, to thrive.

American Red Cross Disaster Services

http://www.redcross.org/what-we-do/disaster-relief
American Red Cross National Headquarters
2025 E Street, NW

Washington, DC 20006
Phone: 202-303-4498

Red Cross disaster relief focuses on meeting people's immediate emergency disaster-caused needs. When a disaster threatens or strikes, the Red Cross provides shelter, food, and health and mental health services to address basic human needs. In addition to these services, the core of Red Cross disaster relief is the assistance given to individuals and families affected by disaster to enable them to resume their normal daily activities independently. Training opportunities are also provided.

Anxiety and Depression Association of America

http://www.adaa.org
8701 Georgia Avenue #412
Silver Spring, MD 20910
Phone: 240-485-1001

The Anxiety and Depression Association of America (ADAA) is the only national, nonprofit membership organization dedicated to informing the public, healthcare professionals, and legislators that anxiety disorders are real, serious, and treatable. ADAA promotes the early diagnosis, treatment, and cure of anxiety disorders and is committed to improving the lives of the people who have them. The ADAA Web site provides information about the symptoms of PTSD and how it can be treated, in addition to offering a PTSD self-screening tool.

Association for Behavioral and Cognitive Therapies

http://www.abct.org
305 7th Avenue
16th Floor
New York, NY 10001
Phone: 212-647-1890
Fax: 212-647-1865

The Association for Behavioral and Cognitive Therapies is a professional, interdisciplinary organization concerned with the application of behavioral and cognitive science to understanding human behavior, developing interventions to enhance the human condition, and promoting the appropriate use of these interventions. The association's Web site includes resources for the public and for professionals on trauma and disaster-related problems, a clinical referral directory, and other resources and training opportunities in behavioral therapy.

Association of Traumatic Stress Specialists

http://www.atss.info
88 Pompton Avenue
Verona, NJ 07044
Phone: 973-559-9200
Email: Admin@atss.info

The Association of Traumatic Stress Specialists is an international membership organization that offers three distinct board certifications to qualified individuals who provide services, intervention, response, and/or treatment in the field of traumatic stress. The Association is dedicated to improving the quality of life of all individuals throughout the world who have been affected by traumatic events. Membership represents those who serve survivors of natural disasters, terrorist attacks, injuries and deaths related to serving in the line of duty or to school and workplace violence; veterans; refugees; victims of crime; Holocaust survivors; those affected and exploited by political persecution; and others who have experienced traumatic stress injuries.

Center for Anxiety and Related Disorders

http://www.bu.edu/card
648 Beacon Street
6th Floor

Boston, MA 02215
Phone: 617-353-9610

The Center for Anxiety and Related Disorders (CARD) at Boston University is a clinical and research center dedicated to advancing knowledge and providing care for anxiety, mood, eating, sleep, and related disorders. CARD's Web site offers information regarding PTSD and research publications on trauma and anxiety, in addition to linking to toolkits from the National Child Traumatic Stress Network's Adolescent Traumatic Stress and Substance Abuse Program.

Center for the Study of Traumatic Stress

http://www.cstsonline.org
Uniformed Services University of the Health Sciences
Department of Psychiatry
4301 Jones Bridge Road
Bethesda, MD 20814-4799
Phone: 301-295-2470
Fax: 301-319-6965

The Center for the Study of Traumatic Stress (CSTS) is a federally funded organization established by the Military Health System in 1987 to address Department of Defense concerns regarding health risks and concerns resulting from the traumatic impact of the use of weapons of mass destruction in combat, acts of terrorism and hostage events, combat and peacekeeping operations, natural disasters, and assaults or accidents occurring in both uniformed and civilian communities. CSTS primarily serves members of the armed forces, along with their children and families.

Center for Culture, Trauma and Mental Health Disparities

http://www.semel.ucla.edu/cctmhd
UCLA Semel Institute of Neuroscience & Biobehavioral Sciences
760 Westwood Plaza
Los Angeles, CA 90024
Phone: 310-794-9929

The Collaborative Center for Trauma and Mental Health Disparities at the University of California Los Angeles is a multiethnic and multidisciplinary group that focuses on conducting research and providing training that pertains to trauma in minority populations.

Council of State Governments Justice Center—Mental Health

http://csgjusticecenter.org/jc/category/mental-health
100 Wall Street
20th Floor
New York, NY 10005
Phone: 212-482-2320
Fax: 212-482-2344
Email: consensusproject@csg.org

The Consensus Project is part of the Council of State Governments Justice Center and partners with other organizations, such as SAMHSA's GAINS Center, working to improve outcomes for people, including juveniles, with mental illnesses involved with the criminal justice system. The Consensus Project offers a webinar on trauma services in the criminal justice system and on child trauma and juvenile justice, as well as a local programs database.

Dart Center for Journalism and Trauma

http://www.dartcenter.org
Columbia University
Graduate School of Journalism
2950 Broadway
New York, NY 10027
Phone: 212-854-8056

The Dart Center is dedicated to improving media coverage of trauma, conflict, and

tragedy. The Center also addresses the consequences of such coverage for those working in journalism and provides training and education via seminars, newsroom briefings and consultation on trauma issues, in addition to training for journalism educators and other trainers. The Dart Center Web site offers fact sheets, publications, and DVDs on request for use by journalists, educators, and clinicians.

David Baldwin's Trauma Information Pages

http://www.trauma-pages.com
Phone: 541-686-2598
Email: dvb@trauma-pages.com

This Web site focuses primarily on emotional trauma and traumatic stress, including PTSD and dissociation, whether following individual traumatic experience(s) or a large-scale disaster. The site's purpose is to provide information for clinicians and researchers in the traumatic stress field. Specifically, the focus is on both clinical and research aspects of trauma responses and their resolution.

Disaster Technical Assistance Center

http://www.samhsa.gov/dtac
9300 Lee Highway
Fairfax, VA 22031
Phone: 800-308-3515
Fax: 703-225-2338

SAMHSA has created the Disaster Technical Assistance Center (DTAC) to help States prepare for and respond to a wide range of potential catastrophes—both natural and human-caused disasters. DTAC primarily serves individuals and communities who are recovering from natural and human-caused disasters. It works in conjunction with the Federal Emergency Management Agency (FEMA) and SAMHSA's Emergency Mental Health and Traumatic Stress Services Branch, using strengths-based, outreach-oriented principles conducted in nontraditional settings, as a supplement to programs already in place on a local level.

EMDR Institute, Inc.

http://www.emdr.com
P.O. Box 750
Watsonville, CA 9507
Phone: 831-761-1040
Fax: 831-761-1204
Email: inst@emdr.com

Eye Movement Desensitization and Reprocessing (EMDR) is an information-processing therapy that uses an eight-phase approach. (See the description in Part 1, Chapter 6.) The Web site presents background and descriptive information about this approach to treatment and lists training opportunities, references, and networking groups.

The Federal Emergency Management Agency

http://www.fema.gov
500 C Street SW
Washington, DC 20472
Phone: 202-646-2500

The Federal Emergency Management Agency, a formerly independent agency that became part of the Department of Homeland Security in March 2003, is tasked with responding to, planning for, recovering from, and mitigating against disasters. FEMA can trace its beginnings to the Congressional Act of 1803. This Act, generally considered the first piece of disaster legislation, provided assistance to a New Hampshire town following an extensive fire. In the century that followed, ad hoc legislation was passed more than 100 times in response to hurricanes, earthquakes, floods, and other natural disasters.

The International Critical Incident Stress Foundation, Inc.

http://www.icisf.org
3290 Pine Orchard Lane
Suite 106
Ellicott City, MD 21042
Phone: 410-750-9600
Fax: 410-750-9601
Email: info@icisf.org

The International Critical Incident Stress Foundation, Inc., is a nonprofit, open-membership foundation dedicated to the prevention and mitigation of disabling stress through the provision of education, training, and support services for all emergency services professions; continuing education and training in emergency mental health services for psychologists, psychiatrists, social workers, and licensed professional counselors; and consultation in the establishment of crisis and disaster response programs for varied organizations and communities worldwide.

International Society for the Study of Trauma and Dissociation

http://www.issd.org
8400 Westpark Drive
Second Floor
McLean, VA 22102
Phone: 703-610-9037
Fax: 703-610-0234
Email: info@isst-d.org

The Society is a nonprofit professional association organized for the purposes of information sharing and international networking of clinicians and researchers; providing professional and public education; promoting research and theory about dissociation; and promoting research and training in the identification, treatment, and prevention of dissociative disorders. The Society offers courses in its Dissociative Disorders Psychotherapy Training Program.

The International Society for Traumatic Stress Studies

http://www.istss.org
111 Deer Lake Road
Suite 100
Deerfield, IL 60015
Phone: 847-480-9028
Fax: 847-480-9282

The International Society for Traumatic Stress Studies (ISTSS) was founded in 1985 for professionals to share information about the effects of trauma. ISTSS is dedicated to the discovery and dissemination of knowledge about policy, program, and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences. ISTSS provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma in the United States and around the world.

National Alliance on Mental Illness

http://www.nami.org
3803 N. Fairfax Dr.
Suite 100
Arlington, VA 22203
Phone: 703-524-7600
Fax: 703-524-9094

The National Alliance on Mental Illness (NAMI) is a nonprofit advocacy group founded in 1979 to raise awareness and provide essential and free education, advocacy, and support group programs for people living with mental illness and their loved ones. NAMI operates at the local, State, and national levels, with each level of the organizations providing education, information, support, and advocacy for those with mental illness and their support system. NAMI has developed a Trauma Toolkit and includes a series of lectures for mental health professionals about trauma.

National Association of State Alcohol and Drug Abuse Directors, Inc.

http://www.nasadad.org
1025 Connecticut Ave NW
Suite 605
Washington, DC 20036
Phone: 202-293-0090
Fax: 202-293-1250
Email: dcoffice@nasadad.org

The National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) is a private, not-for-profit educational, scientific, and informational organization. NASADAD's basic purpose is to foster and support the development of effective alcohol and drug abuse prevention and treatment programs throughout every State. NASADAD offers a policy brief with regards to trauma and substance use/abuse in the wake of natural or human-made disasters.

National Association of State Mental Health Program Directors

http://www.nasmhpd.org
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 703-739-9333
Fax: 703-548-9517

The National Association of State Mental Health Program Directors (NASMHPD; pronounced "NASH-pid") is a nonprofit organization dedicated to serving the needs of the Nation's public mental health system through policy development, information dissemination, and technical assistance. NASMHPD represents the $23 billion public mental health service delivery system. As a private, not-for-profit 501(c)(3) membership organization, NASMHPD helps set the agenda and determine the direction of State mental health agency interests across the country, historically including State mental health planning, service delivery, and evaluation. The principal programs operated, funded, and/or regulated by NASMHPD members serve people who have serious mental illnesses, developmental disabilities, and/or substance use disorders. NASMPHD has launched a Technical Assistance Coordinating Center in response to the Alternatives to Restraint and Seclusion State Infrastructure Grant Project, an initiative of SAMHSA's Center for Mental Health Services, designed to promote the implementation and evaluation of best practice approaches to preventing and reducing the use of seclusion and restraint in mental health settings.

National Center for Injury Prevention and Control

http://www.cdc.gov/injury
1600 Clifton Road
Atlanta, GA 30333
Phone: 800-232-4636
Email: cdcinfo@cdc.gov

The National Center for Injury Prevention and Control (NCIPC) was established by the Centers for Disease Control and Prevention in 1992. Through research, surveillance, implementation of evidence-based strategies, capacity building, and communication activities, NCIPC works to reduce morbidity, disability, mortality, and costs associated with injuries and violence. NCIPC is the lead U.S. Federal agency for nonoccupational injury prevention.

National Center for PTSD

http://www.ptsd.va.gov
810 Vermont Avenue NW
Washington, DC 20420
Phone: 802-296-6300
Email: ncptsd@va.gov

The National Center for PTSD (NCPTSD) was created within the Department of

Veterans Affairs in 1989 in response to a Congressional mandate to address the needs of veterans with military-related PTSD. Its mission is to advance the clinical care and social welfare of America's veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders. Its Web site is provided as an educational resource concerning PTSD and other enduring consequences of traumatic stress. The NCPTSD Web site has information about instruments to measure trauma exposure, risk and resilience factors for PTSD, self-report instruments, and interview schedules. Training opportunities are listed at http://www.ptsd.va.gov/about/training/training-programs.asp.

National Center for Telehealth and Technology

http://www.t2health.org
9933C West Hayes Street
Joint Base Lewis-McChord, WA 98431
Phone: 253-968-1914
Fax: 253-968-4192
Email: AskUs@t2health.org

The National Center for Telehealth and Technology is a Federal agency founded by the Department of Defense as part of the Military Health System. It primarily serves veterans and active-duty military personnel who are experiencing adverse health effects due to TBI and PTSD, as well as military children who are coping with their parents' deployment, through the use of technology (e.g., mobile phone applications, deployable telehealth centers).

National Center for Trauma-Informed Care

http://www.samhsa.gov/nctic
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 866-254-4819
Fax: 703-548-9517
Email: NCTIC@NASMHPD.org

The National Center for Trauma-Informed Care (NCTIC) is a Federal center established by SAMHSA in 2005 to offer consultation, technical assistance, education, outreach, and resources to support trauma-informed care in publicly-funded systems and programs. NCTIC primarily serves those who are already receiving services from the behavioral health system and is focused on helping behavioral health services and programs to become more aware of the impact of trauma among consumers, to adapt services to incorporate trauma-informed practices, and to help raise awareness of practices or processes that are more likely to retraumatize consumers.

National Center for Victims of Crime

http://www.victimsofcrime.org
2000 M Street NW
Suite 480
Washington, DC 20036
Phone: 202-467-8700
Fax: 202-467-8701
Email: webmaster@ncvc.org

The National Center for Victims of Crime (NCVC) is a nonprofit organization funded partially by Federal grants from the Department of Justice. It was founded in 1985 and originally known as the Sunny Von Bulow National Victim Advocacy Center. NCVC is a resource center for those affected by violent crimes and also provides training and education for behavioral health service providers.

National Center on Domestic Violence, Trauma & Mental Health

http://www.nationalcenterdvtraumamh.org/
Phone: 312-726-7020
Fax: 312-726-7022

The National Center on Domestic Violence, Trauma & Mental Health was established in 2005 through a grant from the Family Violence Prevention and Services Program, HHS. The Center's mission is to promote accessible, culturally relevant, and trauma-informed responses to domestic violence and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being; this is achieved by providing training and online resources to mental health and substance abuse treatment providers and developing policies to improve system responses to domestic violence survivors and their children.

National Center on Elder Abuse

http://www.ncea.aoa.gov
University of California–Irvine
Program in Geriatric Medicine
101 The City Drive South, 200 Building
Orange, CA 92868
Phone: 855-500-3537
Email: ncea-info@aoa.hhs.gov

The National Center on Elder Abuse (NCEA), part of the U.S. Administration on Aging, serves as a national resource center dedicated to the prevention of elder mistreatment. NCEA provides information to both mental health professionals and the general public and also provides technical assistance and training to States and community-based organizations.

National Center on Family Homelessness

http://www.familyhomelessness.org
200 Reservoir Street
Suite 200
Needham, MA 02494
Phone: 617-964-3834
Fax: 617-244-1758
Email: info@familyhomelessness.org

The National Center on Family Homelessness (NCFH) was founded in 1988 and is a nonprofit organization that conducts research and creates public awareness about the special needs of families experiencing homelessness. NCFH primarily serves veterans who are homeless and their families and young mothers who are homeless with their children. NCFH has developed a Trauma-Informed Organizational Toolkit for Homeless Services.

National Coalition Against Domestic Violence

http://www.ncadv.org
1 Broadway
Suite B210
Denver, CO 80203
Phone: 303-839-1852
Fax: 303-831-9251
Email: mainoffice@ncadv.org

The National Coalition Against Domestic Violence (NCADV) is an advocacy group founded in 1978 and acts as a national information and referral center for the general public, media, survivors of domestic violence and their children, and allied and member agencies and organizations. NCADV also works to influence legislation that would provide protection for survivors of domestic violence and their families and provide funding to shelters, healthcare centers, and other organizations.

National Council for Behavioral Health

http://www.thenationalcouncil.org
1701 K Street NW
Suite 400
Washington, DC 20006
Phone: 202-684-7457
Email: communications@thenationalcouncil.org

The National Council for Behavioral Health is a national community behavioral health

advocacy organization, formed in 1970, to conduct Federal advocacy activities, representing the industry on Capitol Hill and before Federal agencies. It also offers a national consulting service program, various publications, and an annual training conference. The National Council Magazine, 2011, Issue 2, focuses on trauma-informed behavioral health services. The National Council has offered a Learning Community for Adoption of Trauma-Informed Practices, funded by SAMHSA.

National Institute on Drug Abuse

http://drugabuse.gov
National Institute on Drug Abuse
National Institutes of Health
6001 Executive Boulevard
Room 5213, MSC 9561
Bethesda, MD 20892-9561
Phone: 301-443-1124
Email: information@nida.nih.gov

The National Institute on Drug Abuse's (NIDA) mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. NIDA's goal is to ensure that science, not ideology or anecdote, forms the foundation for all of the Nation's drug abuse reduction efforts. NIDA was established in 1974, and in October 1992 it became part of the National Institutes of Health (NIH), HHS. The Institute is organized into divisions and offices, each of which plays an important role in programs of drug abuse research. NIDA has an ongoing research program on women's health and sex/gender differences, including the gathering of information on trauma and substance abuse.

National Institute of Mental Health

http://www.nimh.nih.gov
National Institute of Mental Health
Science Writing, Press, and Dissemination Branch
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: 301-443-4513
Fax: 301-443-4279
Email: nimhinfo@mail.nih.gov

The National Institute of Mental Health (NIMH) is one of the 27 component institutes of NIH, the Federal Government's principal biomedical and behavioral research agency that is part of HHS. NIMH's mission is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior. This public health mandate demands that NIMH use science to achieve better understanding, treatment, and eventually, prevention of these disabling conditions that affect millions of Americans. NIMH offers publications and podcasts related to traumatic events and PTSD.

National Registry for Evidence-Based Programs and Practices

http://www.nrepp.samhsa.gov
Phone: 866-436-7377
Email: nrepp@samhsa.hhs.gov

SAMHSA's National Registry for Evidence-Based Programs and Practices (NREPP) is a searchable online registry of more than 300 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. NREPP offers several interventions that address trauma and PTSD.

National Sexual Violence Resource Center

http://www.nsvrc.org
123 North Enola Drive
Enola, PA 17025
Phone: 717-909-0710
Fax: 717-909-0714

The National Sexual Violence Resource Center (NSVRC) was founded by the Pennsylvania Coalition Against Rape in 2000 and is partially federally funded by grants from the Centers for Disease Control and Prevention. NSVRC advocates for changes in Federal and State legislation to further the goal of ending sexual violence in all communities, in addition to collecting and disseminating a wide range of resources on sexual violence, including statistics, research, position statements, statutes, training curricula, prevention initiatives and program information. NSVRC does not provide direct services to survivors of sexual violence but acts as a resource to support these services.

National Trauma Consortium

http://www.nationaltraumaconsortium.org
520 Ralph Street
Sarasota, FL 34242
Phone: 941-312-9795

The National Trauma Consortium (NTC) is a clearinghouse for information about trauma and emerging best practices in trauma treatment and services and, in addition, offers training and consultation services. NTC also provides resources in the form of downloadable publications and links to other organizations related to mental health and trauma.

National Voluntary Organizations Active in Disasters

http://www.nvoad.org
1501 Lee Highway
Suite 170
Arlington, VA 22209-1109
Phone: 703-778-5088
Fax: 703-778-5091
Email: info@nvoad.org

National Voluntary Organizations Active in Disasters (NVOAD) coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective service and less duplication by getting together before disasters strike. Once disasters occur, NVOAD or an affiliated State VOAD encourages members and other voluntary agencies to convene on site. This cooperative effort has proven to be the most effective way for a wide variety of volunteers and organizations to work together in a crisis. NVOAD's principles are cooperation, coordination, communication, education, mitigation, convening mechanisms, and outreach.

Office for Victims of Crime Training and Technical Assistance Center

https://www.ovcttac.gov/
9300 Lee Highway
Fairfax, VA 22031-6050
Phone: 866-682-8822
TTY: 866-682-8880
Fax: 703-279-4673
Email: TTAC@ovcttac.org

The Office for Victims of Crime Training and Technical Assistance Center provides comprehensive, quality technical assistance and training resources to victims' service providers and allied professionals. Its mission is to support the development of the field by increasing the Nation's capacity to provide crime victims with skilled, capable, and sensitive assistance. Its core functions are needs assessment, capacity building, evaluation, and reporting.

Rape, Abuse & Incest National Network

http://www.rainn.org
1220 L Street NW
Suite 505
Washington, DC 20005
Phone: 202-544-1034
Email: info@rainn.org

The Rape, Abuse & Incest National Network (RAINN) is a nonprofit organization, founded in 1994, that is partially funded by a grant from the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. RAINN provides support for survivors of sexual assault via a telephone hotline and an online hotline and works with the Department of Defense (DoD) to provide a hotline for members of the DoD community who have experienced sexual assault.

SAMHSA's Tribal Training and Technical Assistance Center

http://beta.samhsa.gov/tribal-ttac
201 Corporate Drive
Suite 800
Landover, MD 20785
Phone: 240-650-0257
Email: TA-Request@tribaltechllc.com

SAMHSA's Tribal Training and Technical Assistance Center (Tribal TTAC) is committed to providing comprehensive broad, focused, and/or intensive training and technical assistance to federally recognized Tribes and other American Indian and Alaska Native communities seeking to address and prevent mental and substance use disorders and suicide while promoting mental health. The goal of the Tribal TTAC is to use a culturally relevant, evidence-based, holistic approach to support Native communities in their self-determination efforts through infrastructure development, capacity building, and program planning and implementation.

Sanctuary Model

http://www.sanctuaryweb.com
Phone: 888-538-3124

The goals of the Sanctuary Model include increasing the perceived sense of community/cohesiveness; the degree of social immunity to the spread of violence; the capacity for social learning; the making of decisions democratically and the sharing of responsibility in solving problems and resolving conflicts; the ability to deal with complexity; opportunities for all clients and staff members to experience a truly safe and connected community; opportunities for troubled clients to have corrective emotional, relational, and environmental experiences; and recovery, healing, and growth.

Seeking Safety

http://www.seekingsafety.org
Treatment Innovations
28 Westbourne Road
Newton Centre, MA 02459
Phone: 617-299-1610
Fax: 617-701-1295
Email: info@seekingsafety.org

This Web site provides information about Seeking Safety, a psychotherapeutic intervention for treating trauma, PTSD, and substance abuse. Seeking Safety is a present-focused therapy to help people attain safety from both PTSD and substance abuse. The treatment is also available as a book, which provides both client handouts and guidance for clinicians. The site includes topics included in the treatment program, sample materials, relevant empirical studies, and supplementary articles.

Sidran Institute

http://www.sidran.org
P.O. Box 436
Brooklandville, MD 21022-0436
Phone: 410-825-8888
Fax: 410-560-0134
Email: info@sidran.org

The Sidran Institute is a nationally focused nonprofit organization devoted to helping people who have experienced traumatic life events through education and advocacy. The Institute's education and advocacy focuses on:

- The early recognition and treatment of trauma-related stress in children.
- The understanding of trauma and its long-term effect on adults.
- The strategies in engaging in mutual-help recovery for trauma survivors.
- The clinical methods and practices leading in aiding trauma victims.
- The development of public policy initiatives responsive to the needs of adult and child survivors of traumatic events.

Substance Abuse and Mental Health Services Administration

http://www.samhsa.gov
1 Choke Cherry Lane
Rockville, MD 20857
Phone: 877-726-4727
Fax: 240-221-4292
Email: SAMHSAInfo@samhsa.hhs.gov

SAMHSA is the Federal agency within HHS charged with improving the quality and availability of prevention, treatment, and rehabilitative services to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness. The Emergency Mental Health and Traumatic Stress Services Branch, a branch of SAMHSA's Center for Mental Health Services, works with FEMA to provide crisis counseling training and technical assistance to State and local mental health professionals. SAMHSA offers several publications regarding trauma and PTSD, as well as a publication focusing on creating a seclusion-free and restraint-free environment.

Traumatic Stress Institute

http://www.traumaticstressinstitute.org
Klingberg Family Centers
370 Linwood Street
New Britain, CT 06052
Phone: 860-224-9113

The Traumatic Stress Institute (TSI) works to increase understanding of the psychological impact of trauma and to help victims of violence restore meaning and wholeness to their lives. In meeting these goals, TSI is involved in clinical service, professional training, community education, and research. TSI offers forensic assessment and expert testimony, professional education, training opportunities, and publications. TSI developed the "Risking Connections" trauma treatment program and provides training in the use of this model.

Tulane University Traumatology Institute

http://sites.google.com/site/charlesfigley/Home/traumatologyinstitute
Tulane School of Social Work
6823 St. Charles Ave., Building 9
New Orleans, LA 70118
Phone: 800-631-8234
Email: figley@tulane.edu

The Traumatology Institute, founded in 1996, brings together health and mental health professionals from a wide array of disciplines from throughout the United States and around the world to develop cutting-edge research, treatment approaches, and training programs in the field of traumatology. The Institute facilitates the development of knowledge about the traumatization experience of victims, survivors, and the professionals who serve them. The Traumatology Institute conducts research, education, and service activities toward reducing the deleterious effects of trauma on individuals, families, communities, and entire societies.

Veterans Affairs PTSD Support Services

http://www.ptsdsupport.net/va.html
P.O. Box 5574
Woodland Park, CO 80866
Email: russ@ptsdsupport.net

The Department of Veterans Affairs Medical Centers provide a network of more than 100 specialized programs for veterans with PTSD, working closely in conjunction with the Veterans Web Site (http://www.vetcenter.va.gov) operated by VA's Readjustment Counseling Service. Each specialized PTSD program offers veterans education, evaluation, and treatment conducted by mental health professionals from a variety of disciplines (such as psychiatry, psychology, social work, counseling, and nursing). See also: National Center for PTSD.

White Bison Wellbriety Training Institute

http://www.whitebison.org
701 N. 20th Street
Colorado Springs, CO 80904
Phone: 877-871-1495
Email: info@whitebison.org

White Bison is an American Indian nonprofit charitable organization that focuses on offering sobriety, recovery, addictions prevention, and wellness/Wellbriety learning resources to the Native American community nationwide. White Bison's Wellbriety Training Institute provides training, tools, and resources for historical and intergenerational trauma to trainers and mental health professionals.

Resources for Children and Adolescents

The following section provides resources that address the needs of children and adolescents who are affected by traumatic stress.

American Academy of Child & Adolescent Psychiatry

http://www.aacap.org
3615 Wisconsin Avenue NW
Washington, DC 20016-3007
Phone: 202-966-7300
Fax: 202-966-2891

The American Academy of Child & Adolescent Psychiatry (AACAP) is a national professional medical association dedicated to treating and improving the quality of life for children, adolescents, and families affected by mental, behavioral, and developmental disorders. AACAP distributes information to promote an understanding of mental illnesses and remove the shame associated with them, to advance efforts in prevention of mental illnesses, and to ensure proper treatment and access to services for children and adolescents.

American Professional Society on the Abuse of Children

http://www.apsac.org
350 Poplar Avenue
Elmhurst, IL 60126
Phone: 630-941-1235
Fax: 630-359-4274
E-mail: apsac@apsac.org

The mission of the American Professional Society on the Abuse of Children (APSAC) is to enhance the ability of professionals to respond to children and families affected by abuse and violence. Among other initiatives, APSAC provides education and other sources of information to professionals who work in the child maltreatment and related fields.

Anna Institute

http://www.theannainstitute.org
21 Ocean Street
Rockland, ME 04841
Email: afj@gwi.net

The Anna Institute was founded in memory of artist Anna Caroline Jennings; it focuses on educating both the public and mental health professionals about the effects of sexual abuse and trauma on children. The Anna Institute's Web site provides articles on incorporating

trauma-informed care into existing behavioral health models, presentations on childhood trauma and retraumatization, and handouts for teachers at primary and secondary schools.

Caring for Every Child's Mental Health Campaign

http://www.samhsa.gov/children
P.O. Box 2345
Rockville, MD 20847-2345
Email: nmhic-info@samhsa.hhs.gov

SAMHSA's Caring for Every Child's Mental Health communications campaign is a national public information and education operation. Its goals are to increase public awareness about the importance of protecting the mental health of young people; foster the recognition that many children have mental health problems; and encourage caregivers to seek early, appropriate treatment and services. It also strives to reduce discrimination associated with mental health problems. The campaign is a technical assistance program that is part of the Comprehensive Community Mental Health Services Program for Children and Their Families.

Child Study Center

http://www.aboutourkids.org
One Park Avenue
7th Floor
New York, NY 10016
Phone: 212-263-6622
Email: webmaster@aboutourkids.org

The New York University Child Study Center Web site offers information to parents of children and adolescents with learning, behavioral, and emotional disorders, including PTSD and substance use disorders. An online newsletter is available. Its research initiatives advance understanding of the causes and treatments of child mental disorders, and these findings are integrated into clinical care to provide state-of-the-art service.

Child Trauma Academy

http://www.childtrauma.org
5161 San Felipe
Suite 320
Houston, TX 77056
Phone: 866-943-9779
Email: cta@childtrauma.org

The mission of the Child Trauma Academy is to help improve the lives of traumatized and maltreated children. Through education, service delivery, and program consultation, the academy seeks to advance systems that educate, nurture, protect, and enrich these children.

Child Trauma Institute

http://www.childtrauma.com
P.O. Box 544
Greenfield, MA 01302-0544
Phone: 413-774-2340
Email: cti@childtrauma.com

The Child Trauma Institute provides training, consultation, information, and resources for those who work with trauma-exposed children, adolescents, and adults. The Web site has information for parents, publications for parents and professionals, and links to other child trauma Web sites.

Child Welfare Information Gateway

http://www.childwelfare.gov
Children's Bureau/ACYF
1250 Maryland Avenue SW
Eighth Floor
Washington, DC 20024
Phone: 800-394-3366
Email: info@childwelfare.gov

The Child Welfare Information Gateway (CWIG) is a service of the Children's Bureau in the Administration for Children and Families, part of HHS, which provides information

to child welfare and mental health professionals about programs, research, laws and policies, training approaches, and statistics regarding child welfare, child abuse and neglect, and adoption. CWIG offers educators' toolkits for preventing and responding to child abuse and neglect, a function to search State statutes about child abuse and neglect, and logic model builder toolkits for program administrators.

Child Welfare League of America

http://www.cwla.org
1726 M Street NW
Suite 500
Washington DC, 20036
Phone: 202-688-4200
Fax: 202-833-1689

Through its member child welfare agencies, the Child Welfare League of America develops and disseminates practice standards as benchmarks for high-quality services that protect children and youth; promotes high-quality services through training, consultation, conferences, and publications; formulates and promotes public policies that contribute to the well-being of children and youth; ensures that all child welfare services are provided in a manner that demonstrates respect for cultural and ethnic diversity; and promotes open exchange of data, resources, and ideas within and across systems that serve children, youth, and families.

Eunice Kennedy Shriver National Institute of Child Health and Human Development

http://www.nichd.nih.gov/Pages/index.aspx
31 Center Drive
Building 31, Room 2A32
Bethesda, MD 20892-2425
Phone: 800-370-2943

Established in 1962, NIH's National Institute of Child Health and Human Development (NICHD) focuses on human development processes from conception to later years. The Institute implements, conducts, and supports laboratory research, clinical trials, epidemiological research, and other studies that explore health processes and the impact of disabilities, diseases, and variations on the lives of individuals. NICHD sponsors training for scientists and healthcare providers to promote the goals of the Institute.

National Center for Children Exposed to Violence

http://www.nccev.org
Yale Child Study Center
230 South Frontage Road
P.O. Box 207900
New Haven, CT 06520-7900
Phone: 877-496-2238
Email: colleen.vadala@yale.edu

The National Center for Children Exposed to Violence (NCCEV) seeks to increase the capacity of individuals and communities to reduce the incidence and impact of violence on children and families; to train and support the professionals who provide intervention and treatment; and to increase professional and public awareness of the effects of violence on children, families, communities, and society. The Center's Web site is a rich source of information. NCCEV is supported by grants from the Office of Juvenile Justice and Delinquency Prevention, the Department of Justice, SAMHSA, and the Department of Education.

National Center on Substance Abuse and Child Welfare

http://www.ncsacw.samhsa.gov
P.O. Box 2345
Rockville, MD 20847-2345
Phone: 866-493-2758
Email: ncsacw@cffutures.org

The National Center on Substance Abuse and Child Welfare (NCSACW) is an initiative of HHS and is jointly funded by SAMHSA's Center for Substance Abuse Treatment and the Administration on Children, Youth and Families, Children's Bureau's Office on Child Abuse and Neglect. NCSACW seeks to develop and implement a comprehensive program of information gathering and dissemination, to provide technical assistance, and to develop knowledge that promotes effective practical, organizational, and systemic changes at the local, State, and national levels. Its Web site includes PowerPoint presentations, online tutorials and training, technical assistance presentations, and additional print resources.

National Child Traumatic Stress Network

http://www.nctsnet.org
NCTSN—University of California, Los Angeles
11150 W. Olympic Boulevard
Suite 650
Los Angeles, CA 90064
Phone: 310-235-2633
Fax: 310-235-2612

The National Child Traumatic Stress Network (NCTSN), currently comprising 54 treatment centers nationwide, is funded by SAMHSA's Center for Mental Health Services through the Donald J. Cohen National Child Traumatic Stress Initiative and coordinated by Duke University and the University of California, Los Angeles. The purpose of this congressionally mandated initiative is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. NCTSN works with SAMHSA to raise public awareness of the effects of traumatic stress on children and families, and with other systems of care (including the health, mental health, education, law enforcement, child welfare, juvenile justice, and military family service systems) to ensure that there is a comprehensive trauma-informed continuum of accessible care. Additionally, NCTSN offers a list of evidence-based and promising practices.

National Institute for Trauma and Loss in Children

http://www.starrtraining.org/trauma-and-children
42855 Garfield Road
Suite 111
Clinton Township, MI 48038
Phone: 877-306-5256
Fax: 586-263-4915
Email: TLC@starrtraining.org

The National Institute for Trauma and Loss in Children provides school professionals, crisis intervention teams, medical and mental health professionals, child care professionals, and clinicians with trauma education, training, consultation, referral services, and trauma-specific intervention programs and resource materials needed to help those traumatized by violent or nonviolent trauma-inducing incidents.

National Native Children's Trauma Center

http://iers.umt.edu/National_Native_Childrens_Trauma_Center
Institute for Educational Research and Service
McGill Hall 026
The University of Montana
Missoula, MT 59812-6376
Phone: 406-243-5344
Fax: 406-243-2197
Email: iers@mso.umt.edu

The National Native Children's Trauma Center (NNCTC) is a federally funded organization created by SAMHSA and affiliated with the National Child Traumatic Stress Network. It

is run by the University of Montana. NNCTC offers trauma interventions and trainings to address trauma in American Indian/Alaska Native children, primarily through clinicians, Tribal programs, school systems, and community agencies.

Training Opportunities

The following resources highlight various training and credentialing opportunities for behavioral health professionals interested in gaining more education in treating and providing services to those affected by trauma. It is not an exhaustive list, but provides a starting place for service providers looking for further training.

The Web site of the ISTSS has posted a directory of trauma-related academic and training opportunities (http://www.istss.org/LearningAboutTrauma.htm). It includes links to the institutions providing the programs. The Association for Traumatic Stress Specialists (http://www.atss.info) offers three levels of recognition for education and experience:

- Certified Trauma Specialist (CTS)—designed for counselors, clinicians, and treatment specialists who provide intervention services or individual, group, and/or family counseling. This certification requires 240 hours of education and training in trauma treatment, plus 2,000 hours of trauma counseling and intervention experience.
- Certified Trauma Responder (CTR)—designed for those who provide immediate trauma interventions. It requires a minimum of 40 hours of experience on a crisis or critical incident response team, an associate degree or a high school diploma with successful completion of disaster or critical incident stress debriefing training, and 72 hours of crisis response training.
- Certified Trauma Services Specialist (CTSS)—designed for those who provide immediate trauma intervention, crisis support, advocacy, or victim assistance. It requires 1 year of experience in a trauma-related field, plus specific training.

Some colleges and universities, such as the International Trauma Studies Program at New York University and the Center for Anxiety and Related Disorders at Boston University, provide specialty trauma training for mental health practitioners. The University of Missouri at St. Louis offers specialized training in trauma therapy or research at its Center for Trauma Recovery to students in its Clinical Psychology graduate program. The Center for the Treatment and Study of Anxiety at the University of Pennsylvania provides training for health professionals. The Department of Counseling at the University of Nevada, Las Vegas offers a graduate and undergraduate course on Trauma and Addiction; graduate students can receive training in trauma and addictions as part of the Advanced Graduate Certificate in Addiction Studies. The Medical University of South Carolina offers Web-based courses in trauma-focused cognitive–behavioral therapy (TF-CBT) and in using TF-CBT for childhood traumatic grief. Many universities have faculty members with expertise in trauma and trauma-related subjects, so that training can be accessed through many graduate programs.

The Addiction Technology Transfer Center (ATTC) Network, a resource established in 1993 by the SAMHSA's Center for Substance Abuse Treatment, is a network of 14 independent regional centers with a national office. One of its programs provides long-distance education for clinicians on various topics. Among hundreds of self-paced, self-directed, and supervised courses available online (http://www.attcnetwork.org/learn/education/

dasp.asp) are Substance Abuse Treatment for Trauma Survivors, Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues, Chemical Dependency and Posttraumatic Stress Disorder, Clinical Self-Care for Addiction Counselors and Clinical Supervisors, Eye Movement Desensitization and Reprocessing, Battered Women and Addictions, and Posttraumatic Stress Disorder. ATTC training and educational opportunities are based on empirical research and are intended to bring science to service. Undoubtedly, more distance-learning courses in this specialized area of interest will be developed as professional attention to co-occurring disorders increases.

SAMHSA's Center for Mental Health Services provides training for FEMA-approved crisis counseling programs using Stafford Act funding. These funding resources are available to select agencies designated to provide crisis counseling in the wake of a Presidential Disaster Declaration. Other funding for trauma training may be found through special programs of funding for target groups, such as those who provide mental health services and case management for victims of crime (e.g., Office for Victims of Crime in the U.S. Department of Justice; see p. 257).

The American Red Cross provides limited disaster mental health training. The focus of this training is to orient licensed mental health professionals to the Red Cross Disaster services system and their roles as volunteers.

The National Center for Post-Traumatic Stress Disorder was originally created in 1989 within the U.S. Department of Veterans Affairs (VA) to address the needs of veterans with military-connected PTSD. Its focus has since broadened to include trauma in general. The Center provides a variety of training opportunities for both VA and non-VA mental health personnel, including a PTSD 101 course developed specifically for clinicians who provide services to clients who have experienced trauma (see http://www.ptsd.va.gov/professional/index.asp).

Seeking Safety offers training in trauma, PTSD, and co-occurring disorders to mental health professionals on all levels, from counselors to nurses to administrators. The EMDR International Association (EMDRIA) provides training to clinicians for certification in EMDR via a curriculum including instruction, supervised practicum, and consultation; EMDRIA additionally provides basic training in the field, separate from the certification process. EMDR training is also provided by the EMDR Humanitarian Assistance Program, a nonprofit organization with a training-focused model to assist clinicians in treating trauma.

ISTSS was founded in 1985 to bring attention to the study, assessment, and treatment of traumatized people (http://www.istss.org). ISTSS is a professional society and provides face-to-face training during its annual meeting, especially through the preconference institutes. The ISTSS Web site offers numerous video and audio trainings for continuing education credits. ISTSS and the Figley Institute (http://www.figleyinstitute.com) have established best practice standards. The American Academy of Experts in Traumatic Stress provides training and certification in several different areas (http://www.aaets.org). Similarly, the International Society for the Study of Dissociation (http://www.issd.org) specializes in promoting therapies for dissociative disorders. In 2002, the Green Cross Academy of Traumatology (http://www.greencross.org) established a Commission on Accreditation of Traumatology Education Programs to increase and maintain the high standards in the education and training of traumatologists.

Appendix C—Historical Account of Trauma

Historically, symptoms of traumatic stress have been recorded in both military and civilian populations (Lasiuk & Hegadoren, 2006). Early accounts described the effect of battle conditions on soldiers; "soldier's heart" and "nostalgia" were the terms for traumatic stress reactions used during the American Civil War. As warfare techniques and strategies changed, so did the depiction of soldiers' traumatic stress reactions. The advent of heavy explosives in World War I led to the attribution of symptoms to "shell shock," giving a more physiological description of the effects from explosions (Benedek & Ursano, 2009). On the civilian side, the industrial revolution gave rise to larger and more dramatic catastrophes, including industrial and railway accidents. These, as well as other disasters, are noted in occupational health histories, newspapers, and contemporary literature.

Even with a more physical explanation of traumatic stress (i.e., shell shock), a prevailing attitude remained that the traumatic stress response was due to a character flaw. For instance, a soldier's pain at that time was often seen as a symptom of homesickness. In spite of the efforts of Charcot, Janet, and Freud, who described the psychogenic origin of symptoms as a response to psychological trauma (Lasiuk & Hegadoren, 2006), World War II military recruits were screened in attempt to identify those "who were afflicted with moral weakness," which would prevent them from entering military service.

At the same time, there were new treatment innovations for war-related trauma during World War II. One approach treated soldiers in the field for what was then called "battle fatigue" by allowing some time for rest before returning to battle. During the Korean and Vietnam wars, approaches began to focus more on the use of talk therapy. It was not until the post-Vietnam era that interest in developing treatment alternatives started to take hold. During this time, the U.S. Department of Veterans Affairs (then called the Veterans Administration) developed group therapy for posttraumatic stress disorder (PTSD). Beyond being cost-effective, the technique was well suited to the symptoms of the veterans and fostered socialization and reintegration (Greene et al., 2004).

The publication of the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition (DSM-III), in 1980 marked the introduction of PTSD as a diagnosis, inspired by symptoms presented by veterans of the Vietnam War (Benedek & Ursano, 2009). The diagnosis in this iteration required the identification of a specific stressor—a catastrophic stressor that was outside the range of usual human experience (APA, 1980)—and classified PTSD as

Historical Approaches to Trauma Healing and Recovery

First Generation of Approaches to Trauma Healing and Recovery
The first generation approaches to trauma healing and recovery focused on individual and clinical interventions to address the symptoms of PTSD and moved toward integration of trauma effects into ongoing life activities. The rapidly developing recognition of additional groups with violence and trauma histories—beyond those with war and captivity experiences (e.g., survivors of natural disasters and terrorism, refugees and immigrants fleeing homeland violence and persecution)—presented issues and needs that incited a second generation of approaches to trauma healing and recovery.

Second Generation of Approaches to Trauma Healing and Recovery
The second generation approaches focused on psychosocial education and empowerment models designed to tap into self-healing forces to energize personal and social movement. These approaches often are based on group and peer support models, and provide both support and education on the management of trauma and its affects. These approaches are not designed to replace clinical or alternative therapies; rather, they provide a social context for care.

Concurrent to the development of psychosocial educational empowerment approaches, we also learned that if the approaches are not implemented in organizations or programs that are trauma-informed, they will not take root and may lose effectiveness.

Trauma-Informed Care: A New Paradigm for Public Health Services
Trauma-informed care is a new paradigm for organizing public mental health and human services. Trauma-informed care changes the opening question for those seeking services from "What is wrong with you?" (patient or consumer) to "What has happened to you?" (survivor). Trauma-informed care is initiated by assumption that every person seeking services is a trauma survivor who designs his or her own path to healing, facilitated by support and mentoring from the service provider.

In a trauma-informed environment, survivors are empowered to proactively set goals and to manage progress toward those goals. For most existing organizations or programs, that requires movement from a traditional "top down" hierarchical clinical model to a psychosocial empowerment partnership that embraces all possible tools and paths to healing. In a pluralistic public health system with many levels and types of services and treatment, this is coming to be accepted as a "sine qua non," or "without which not," for humane, dignified, cost-effective, genuinely person-centered support and assistance in moving forward.

Source: Salasin, 2011, p. 18.

an anxiety disorder (Lasiuk & Hegadoren, 2006). Beginning with this definition, the body of research grew, and the scope of application began to broaden, but not without considerable debate on what constituted a trauma.

The social revolution that began in the 1960s, combined with the women's movement and the call for more attention to diverse and disenfranchised groups, set the stage for an increase in the acknowledgement and treatment of victims of interpersonal violence and crime-related trauma (Figley, 2002). The introduction of rape trauma syndrome as a condition highlighted the psychological consequences of sexual assault and the subsequent lack of support from society and the social services system (Kramer & Green, 1997). Subsequently, research began to focus more on interpersonal violence, thus leading to the identification of risk factors and treatment approaches unique to this form of violence and trauma (Olff, Langeland, Drajer, & Gersons, 2007).

With input from international and national mental health organizations and research, the DSM-IV further modified the definition of trauma to include a broader interpretation of the identified stressor (Andreasen, 2010). DSM-5 has maintained the modified definition of trauma, but the criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly (APA, 2013b).

Paralleling the change in DSM criteria, cognitive–behavioral therapy for traumatic stress was developed along with other skills-based approaches (Greene et al., 2004).

Researchers, such as Foa, Resick, D'Zurilla, and Michenbaum, added to the body of knowledge and gave clinicians a variety of tools; these approaches continue to develop and show efficacy even today. There was also renewed interest in the long- and short-term effects of childhood sexual abuse and domestic violence. Interest in documenting the effects of trauma expanded further, including traumatic brain injury, significant orthopedic injuries, and multiple traumas (Starr et al., 2004). So too, the consumer movement in health care began. Consumers insisted on patient rights, humane treatment, and involvement in the treatment process; as a result, the paternalistic approach to health care began to change. As consumers set the initial stage and Federal agencies (e.g., the Substance Abuse and Mental Health Services Administration and its centers) and national organizations promoted the need for trauma-informed policies and care, national studies began to demonstrate the prevalence of traumatic experiences. Research including the Adverse Childhood Experiences and the Women, Co-Occurring, and Violence studies clearly demonstrated the pervasive long-term impact of trauma, reinforcing the call for trauma-informed policies and care. (For more information on the development of trauma-informed care, see Harris and Fallot, 2001b, as well as Jennings, 2004.)

Appendix D—Screening and Assessment Instruments

This appendix provides a selected sample of available tools for screening and assessment of traumatic events and trauma-related symptoms. This is not an exhaustive list, nor does this list focus on screening instruments that capture a broader range of symptoms related to trauma (such as sleep hygiene and dissociation) or other features important in providing trauma-informed care (e.g., resilience level, coping skill style, resource availability). For more information on a broad range of available instruments, refer back to Part 1, Chapter 4. Many of the instruments listed below use criteria found in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000), but with the release of the DSM-5 (APA, 2013a), instruments will evolve, and new versions will be available under the same contact information.

Screening and Assessment Measures

- Clinician Administered PTSD Scale (CAPS)
- Davidson Trauma Scale (DTS)
- Distressing Event Questionnaire (DEQ)
- Evaluation of Lifetime Stressors (ELS)
- Impacts of Event Scale Revised (IES-R)
- Mississippi Scale for Combat-Related PTSD (M-PTSD)
- Penn Inventory for Posttraumatic Stress Disorder
- Posttraumatic Diagnostic Scale (PDS)
- PTSD Symptom Scale-Interview (PSS-I)
- PTSD Symptom Scale: Self-Report Version (MPSS-SR)
- Screen for Posttraumatic Stress Symptoms (SPTSS)
- Structured Interview for PTSD (SI-PTSD)
- Trauma Assessment for Adults (TAA)
- Trauma Assessment for Adults (TAA)–Self Report
- Trauma History Questionnaire (THQ)
- Trauma Symptom Inventory (TSI)
- Traumatic Stress Schedule

Screening and Assessment Measures

Clinician Administered PTSD Scale (CAPS)

Domains:	Posttraumatic stress disorder (PTSD), acute stress disorder (ASD)
Timeframe:	CAPS-Sx: Lifetime and current (past week) CAPS-Dx: Current (past month)
Response format:	Other
Format of administration:	Structured
Number of items:	30
Completion time:	30–60 minutes
Qualifications to administer:	Administered by clinicians and clinical researchers who have a working knowledge of PTSD and by appropriately trained paraprofessionals
How to obtain scale:	Contact Danny G. Kaloupek, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: veterans, car accident survivors Reliability: alpha = .94, test-retest = .90–.98 Validity: sensitivity = .85, specificity = .95 (compared with Structured Clinical Interview for DSM Disorders [SCID]), r = .91 (with MS Scale for Combat-related PTSD) kappa = .77 against the SCID diagnosis; item-total correlations = .49–.82; internal consistency = .94
Author(s):	Dudley David Blake, Frank W. Weathers, Linda M. Nagy, Danny G. Kaloupe, Dennis S. Charney, and Terence M. Keane
Contact:	Danny G. Kaloupek, Ph.D. National Center for PTSD Boston VA Medical Center, 11B 150 South Huntington Avenue Boston, MA 02130
Relevant citations:	Blake, D. D. (1994). Rationale and development of the clinician-administered PTSD scales. *PTSD Research Quarterly, 5,* 1–2. Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8*, 75–90.

Gray, M., Litz, B., Hsu, J., & Lombardo, T. (2004). Psychometric properties of the Life Events Checklist. *Assessment, 11*, 330–341.

Weathers, F. W., Keane, T. M., & Davidson, J. R. (2001). Clinician-Administered PTSD Scale: A review of the first ten years of research. *Depression and Anxiety, 13*, 132–156.

Davidson Trauma Scale (DTS)

Domains:	PTSD symptoms
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument. Education/training requirements may be waived for those granted the right to administer tests at this level (B) in their jurisdiction.
How to obtain scale:	Contact Mental Health Systems, Inc.
Cost or public domain:	Cost: $15.00
Psychometrics:	Populations sampled: rape victims, veterans, hurricane victims, miscellaneous traumas Reliability: alpha = .99, test-retest = .86
Author(s):	Jonathan R.T. Davidson
Contact:	Mental Health Systems, Inc. 908 Niagara Falls Boulevard North Tonawanda, NY, 14120-2060 800-456-3003
Relevant citations:	Davidson, J. R. T., Book, S. W., Colket, J. T., Tupler, L. A., Roth, S., David, D., Hertzberg, M., Mellman, T., Beckham, J.C., Smith, R., Davison, R. M., Katz, R., & Feldman, M. (1997). Assessment of a new self-rating scale for posttraumatic stress disorder. *Psychological Medicine, 27,* 153–160. Davidson, J. R., Tharwani, H. M., & Connor, K. M. (2002). Davidson Trauma Scale (DTS): Normative scores in the general population and effect sizes in placebo-controlled SSRI trials. *Depression and Anxiety, 15*, 75–78.

Distressing Event Questionnaire (DEQ)

Domains:	Posttraumatic Stress Disorder (PTSD) for multiple events
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact Edward Kubany, Ph.D.
How to obtain scale:	Contact Edward Kubany, Ph.D.
Cost or public domain:	Contact Edward Kubany, Ph.D.
Psychometrics:	Population sampled: veterans, battered women Reliability: inter-item r = .93, test-retest = .95; validity: Pearson's r reliability coefficient = .83 (with Penn Inventory, Pearson's r reliability coefficient = .76 (with Beck Depression Inventory)
Author(s):	Edward Kubany, Mary Beth Leisen, Aaron S. Kaplan, Martin P. Kelly
Contact:	Edward Kubany, Ph.D. National Center for PTSD Pacific Islands Division Department of VA Suite 307 Honolulu, HI 96813 Kubany.Edward@honolulu.va.gov
Relevant citations:	Kubany, E. S., Leisen, M. B., Kaplan, A. S., & Kelly, M. P. (2000). Validation of a brief measure of posttraumatic stress disorder: The distressing event questionnaire (DEQ). *Psychological Assessment, 12*, 197–209.

Evaluation of Lifetime Stressors (ELS)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	56
Completion time:	10–20 minutes for screening, 1–3 hours for complete interview
Qualifications to administer:	Should be administered by trained clinicians only

How to obtain scale:	Contact Karen Krinsley, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: male veterans, female sexual abuse survivors Reliability: r = .4–1.0
Author(s):	Karen Krinsley, Frank W. Weathers, Elana Newman, Edward A. Walker, Danny G. Kaloupek, Rachel Kimerling
Relevant citations:	Corcoran, C. B., Green, B. L., Goodman, L. A., & Krinsley, K. E. (2000). Conceptual and methodological issues in trauma history assessment. In A. Y. Shalev, R. Yehuda, & A. C. McFarlane (Eds.), *International handbook of human response to trauma* (pp. 22–232). Dordrecht, Netherlands: Kluwer Academic Publishers. Krinsley, K. (1996). Psychometric review of the Evaluation of Lifetime Stressors (ELS) Questionnaire and Interview. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation (*pp. 160–162). Lutherville, MD: Sidran Press.

Impact of Event Scale Revised (IES-R)

Domains:	PTSD for a single event
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	22
Completion time:	5–10 minutes for screening
Qualifications to administer:	None
How to obtain scale:	http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: earthquake survivors, emergency disaster workers, Vietnam veterans, violence and sexual assault victims Reliability: alpha = .79–.92, test-retest = .89–.94, Pearson's r reliability coefficient = .74–.87
Author(s):	Daniel Weiss and Charles R. Marmar
Relevant citations:	Sundin, E. C. & Horowitz, M. J. (2002). Impact of Event Scale: Psychometric properties. *British Journal of Psychiatry, 180,* 205–209. Weiss, D. S. & Marmar, C. R. (1996).The Impact of Event Scale-Revised. In J. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399–411). New York: Guilford Press. (Includes measure in its entirety.)

Mississippi Scale for Combat-Related PTSD (M-PTSD)

Domains:	PTSD for multiple events
Timeframe:	Contact National Center for PTSD at ncptsd@ncptsd.org
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact National Center for PTSD at ncptsd@va.gov
How to obtain scale:	To order the scale contact the National Center for PTSD
Cost or public domain:	Free (ncptsd@va.gov)
Psychometrics:	Population sampled: veterans Reliability: inter-item r = .94, test-retest = .97 Validity: sensitivity = .93, specificity = .89
Author(s):	Terence M. Keane
Contact:	National Center for PTSD (116D) VA Medical Center 215 N. Main St. White River Junction, VT 05009 http://www.ptsd.va.gov/
Relevant citations:	Engdahl, B. & Eberly, R. (1994). Assessing PTSD among veterans exposed to war trauma 40–50 years ago. *NCP Clinical Quarterly, 4,* 13–14. Keane, T. M., Caddell, J. M., & Taylor, K. L. (1988). Mississippi Scale for Combat-Related Posttraumatic Stress Disorder: Three studies in reliability and validity. *Journal of Consulting and Clinical Psychology, 56,* 85–90.

Penn Inventory for Posttraumatic Stress Disorder

Domains:	PTSD for multiple events
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	26
Completion time:	5–15 minutes

Qualifications to administer:	Contact Melvyn Hammarberg, Ph.D.
How to obtain scale:	Contact Melvyn Hammarberg, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans, oil-rig disaster survivors Reliability: alpha = .94, test-retest = .96
Author(s):	Melvyn Hammarberg
Contact:	Melvyn Hammarberg, Ph.D. Department of Anthropology University of Pennsylvania 325 University Museum 33rd and Spruce Street Philadelphia, PA 19104-6398
Relevant citations:	Hammarberg, M. (1996). Psychometric review of the Penn Interview for Post Traumatic Stress Disorder. In B. H, Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 231–235). Lutherville, MD: Sidran Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Posttraumatic Diagnostic Scale (PDS)

Domains:	DSM-IV PTSD symptom clusters
Timeframe:	Current (past month)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	49
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact National Computer Systems (NCS)
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: accident/fire, disaster, assault, sexual assault, sexual abuse, major illness Reliability: alpha = .92, test-retest = .83 Validity: sensitivity = .89, specificity = .75

Author(s):	Edna B. Foa, Ph.D.
Contact:	National Computer Systems (NCS) 5605 Green Circle Drive Minnetonka, MN 55343
Relevant citations:	Foa, E. (1996). *Post-traumatic Diagnostic Scale manual*. Minneapolis, MN: National Computer Systems. Foa, E., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of PTSD: The Post-traumatic Diagnostic Scale (PDS). *Psychological Assessment, 9*, 445–451. Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

PTSD Symptom Scale-Interview (PSS-I)

Domains:	PTSD single event
Timeframe:	Current (past 2 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17
Completion time:	20 minutes
Qualifications to administer:	Can be administered by a master's level interviewer after a few hours of training.
How to obtain scale:	Contact Edna B. Foa, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: female sexual assault victims, female assault victims Reliability: alpha = .85, test-retest = .80; validity: sensitivity = .88, specificity = .96 (compared with SCID); Pearson's r reliability coefficient = .48–.80 (with Impact of Events intrusion and avoidance, State portion of State-Trait Anxiety Inventory, and MPSS-SR)
Author(s):	Edna B. Foa and Gregory A. Leskin
Contact:	Edna B. Foa, Ph.D. Medical College of Pennsylvania Department of Psychiatry 3200 Henry Avenue Philadelphia, PA 19129-1137

Relevant citations:	Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6*, 459–474. Foa, E. & Tolin, D. F. (2005). Comparison of the PTSD Symptom Scale-Interview Version and the clinician administered PTSD Scale. *Journal of Traumatic Stress, 13*, 181–191. Leskin, G. A. (1999). Screening for trauma and PTSD in a primary care clinic. *NC-PTSD Clinical Quarterly, 8*, 68–69.

PTSD Symptom Scale: Self-Report Version (MPSS-SR)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Contact Sherry Falsetti, Ph.D.
How to obtain scale:	Contact Sherry Falsetti, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: alpha = .96–.97 Validity: sensitivity = .89, specificity = .65
Author(s):	Sherry Falsetti, Patricia A. Resick, Heidi S. Resnick, Dean G. Kilpatrick
Contact:	Sherry Falsetti, Ph.D. University of Illinois College of Medicine Department of Family and Community Medicine 1601 Parkview Avenue Rockford, IL 61107-1897
Relevant citations:	Bonin, M. F., Norton, G. R., Asmundson, G. J., Dicurzio, S., & Pidlubney, S. (2000). Drinking away the hurt: The nature and prevalence of PTSD in substance abuse patients attending a community-based treatment program. *Journal of Behavior Therapy and Experimental Psychiatry, 31*, 55–66. Coffey, S. F., Dansky, B. S., Falsetti, S. A., Saladin, M. E., & Brady, K. T. (1998). Screening for PTSD in a substance abuse sample:

Psychometric properties of a modified version of the PTSD Symptom Scale Self-Report. *Journal of Traumatic Stress, 11,* 393–399.

Falsetti, S. A., Resnick, H. S., Resick, P. A., & Kilpatrick, D. (1993). The Modified PTSD Symptom Scale: A brief self-report measure of post-traumatic stress disorder. *The Behavioral Therapist, 16*, 161–162.

Screen for Posttraumatic Stress Symptoms (SPTSS)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	5 minutes
Qualifications to administer:	Contact Eve Carlson, Ph.D.
How to obtain scale:	Contact Eve Carlson, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: psychiatric inpatients Reliability: split half reliability = .91, test-retest = .82
Author(s):	Eve Carlson, Ph.D.
Contact:	Eve Carlson, Ph.D. National Center for PTSD (352-117-MP) Palo Alto Health Care System 795 Willow Road Menlo Park, CA 94025
Relevant citations:	Carlson, E. (2001). Psychometric study of a brief screen for PTSD: Assessing the impact of multiple traumatic events. *Assessment*, *8*, 431–441.

Structured Interview for PTSD (SI-PTSD)

Domains:	PTSD single event
Timeframe:	Current (past 4 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17

Completion time:	20–30 minutes
Qualifications to administer:	Can be administered by mental health professionals or by paraprofessionals after some training.
How to obtain scale:	Contact Jonathan Davidson, M.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans Reliability: alpha = .94, test-retest = .71, intraclass r = .97 Validity: sensitivity = .96, specificity = .80 (compared with SCID), Pearson's r reliability coefficient = .61 (with IES), Pearson's r reliability coefficient = .51 (with Hamilton Anxiety Scale)
Author(s):	Jonathan Davidson
Contact:	Jonathan Davidson, M.D. Department of Psychiatry Box 3812 Duke University Medical Center Durham, NC 27710-3812
Relevant citations:	Davidson, J. R. T., Kudler, H. S., & Smith, R. D. (1990). Assessment and pharmacotherapy of posttraumatic stress disorder. In J. E. L. Giller (Ed.), *Biological assessment and treatment of post-traumatic stress disorder* (pp. 205–221). Washington, DC: American Psychiatric Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Trauma Assessment for Adults (TAA)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	13
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain

Psychometrics:	Populations sampled: adult mental health center clients; face validity established; feasible; validity established via archival records
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Cusack, K. J., Frueh, B. C., & Brady, K. T. (2004). Trauma history screening in a community mental health center. *Psychiatric Services, 55,* 157–162. Resnick, H. S. (1996). Psychometric review of Trauma Assessment for Adults (TAA). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 362–365). Lutherville, MD: Sidran Press.

Trauma Assessment for Adults (TAA)–Self Report

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	None to date
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Resnick, H. S., Falsetti, S. A., Kilpatrick, D. G., & Freedy, J. R. (1996). Assessment of rape and other civilian trauma-related posttraumatic stress disorder: Emphasis on assessment of potentially traumatic events. In T. W. Miller (Ed.), *Stressful life events* (pp. 231–266). Madison, WI: International Universities Press.

Trauma History Questionnaire (THQ)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured

Number of items:	24
Completion time:	5–15 minutes
Qualifications to administer:	Contact Bonnie L. Green, Ph.D.
How to obtain scale:	Contact Bonnie L. Green, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: psychiatric outpatients, college students, women with breast cancer Reliability: r = 0.7–0.9, intraclass = .76
Author(s):	Bonnie L. Green
Relevant citations:	Hooper, L., Stockton, P., Krupnick, J., & Green, B., (2011). Development, use, and psychometric properties of the Trauma History Questionnaire. *Journal of Loss and Trauma, 16*, 258–283. Muesser, K. T., Salyers, M. P., Rosenberg, S. D., Ford, J. D., Fox, L., & Carty, P. (2001). Psychometric evaluation of trauma and posttraumatic stress disorder assessments in persons with severe mental illness. *Psychological Assessment, 13*, 110–117. Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Trauma Symptom Inventory (TSI)

Domains:	Trauma-related symptoms
Timeframe:	Current (last 6 months)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	100
Completion time:	20 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and courses in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact Psychological Assessment Resources
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: general population Reliability: alpha = .84–.87

Author(s):	John Briere
Contact:	Psychological Assessment Resources Box 998 Odessa, FL 33556
Relevant citations:	Briere, J. (1996). Psychometric review of Trauma Symptom Inventory (TSI). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 381–383). Lutherville, MD: Sidran Press. Briere, J. (1995). *Trauma Symptom Inventory professional manual.* Odessa, FL: Psychological Assessment Resources. Orsillo, S. M. (2001). Measures for acute stress disorder and post-traumatic stress disorder. In M. M. Antony & S. M. Orsillo (Eds.), *Practitioner's guide to empirically based measures of anxiety* (pp. 255–307). New York: KluwerAcademic/Plenum.

Traumatic Stress Schedule

Domains:	Trauma history
Timeframe:	Current (but author suggests any period)
Response format:	Other
Format of administration:	Semi-structured
Number of items:	10 (with 12 probes)
Completion time:	5–30 minutes
Qualifications to administer:	Can be administered by lay interviewer with training
How to obtain scale:	Contact Fran Norris, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: test-retest = .88, frequency of events equal to National Women's Study PTSD Module
Author(s):	Fran Norris
Relevant citations:	Norris, F. H. (1990). Screening for traumatic stress: A scale of use in the general population. *Journal of Applied Social Psychology*, *20*, 1704–1718. (Includes measure in its entirety.) Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Appendix E—Consumer Materials

The following are samples of available consumer materials relating to trauma-informed care and traumatic stress. There is a plethora of consumer information available to meet the immediate and long-term needs of consumers of behavioral health services affected by trauma. In order to not waste effort creating new materials for your client's concerns, it is advisable to explore current science-informed resources. In most cases, consumer materials are already available and easily accessible for free.

AfterDeployment.org (2010). *Just the Facts: Resilience*. Available: http://afterdeployment.org/sites/default/files/pdfs/client-handouts/resilience-understanding.pdf

This Web site provides resources to address symptoms related to traumatic stress in addition to other postdeployment adjustment issues. This site provides information and handouts on resilience, triggers, and other trauma-related topics. It is appropriate for service members as well as civilians.

Blanch, A., Filson, B., & Penny, D. (2012). *Engaging Women in Trauma-Informed Peer Support: A Guidebook*. Available: http://www.nasmhpd.org/publications/engagingwomen.aspx

This draft technical assistance guide was created by the National Center for Trauma-Informed Care (NCTIC) and developed under contract with the National Association of State Mental Health Program Directors. This publication is designed to help make trauma-informed peer support available to women who are trauma survivors and who receive or have received behavioral health services. It is a resource for peers providing support in these or other settings who want to learn how to use trauma-informed principles in supporting women or in the peer support groups. It has been a resource used in the delivery of technical assistance through NCTIC.

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., et al. (2006). Appendix E: Handouts. *Psychological First Aid: Field Operations Guide.* Available: http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_Appx_E_handouts.pdf

Developed jointly with the National Child Traumatic Stress Network and the National Center for PTSD, this curriculum provides a science-informed approach to psychological first aid for response workers. The goals of this module are to assist survivors in the immediate aftermath of disaster and/or terrorism, reduce initial distress, and foster short- and long-term adaptive functioning. This link provides specific survivor-oriented material, such as strategies in seeking and giving support, education on common immediate reactions, and parental tips for children across developmental stages.

Center for Mental Health Services (2002). *Dealing with the Effects of Trauma-A Self-Help Guide.* Available: http://store.samhsa.gov/shin/content//SMA-3717/SMA-3717.pdf

This self-help guide gives practical information and tools to address and manage symptoms and other consequences of traumatic stress. It provides education on a variety of topics, including trauma-related symptoms, advice on the key ingredients of quality care, barriers to recovery, and practical strategies to enhance recovery and manage difficult emotions.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2005). *Roadmap to Seclusion and Restraint Free Mental Health Services*. Available: http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055

This curriculum concerns the elimination of seclusion and restraint. It provides numerous handouts for consumers as well as staff. Several consumer handouts include common reactions to trauma, a trauma screening tool, and strategies to de-escalate agitation and distress.

Mead, S. (2008). *Intentional Peer Support: An Alternative Approach*. Sherry Mead Consulting. Available: http://www.intentionalpeersupport.org/apps/webstore/products/show/3408520

This interactive workbook is designed for individuals who are in peer support roles and those who use peer support services. It provides goals, tasks, competencies, and skills associated with peer support relationships and guidelines for first interviews.

Najavits, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

This evidence-based practice for individuals who have a history of trauma and a substance use disorder provides not only guidelines for clinicians but handouts for individuals. The consumer materials include information on PTSD and substance abuse and their interrelationship, key principles of the Seeking Safety program, coping skills to support safety, and grounding exercises. For additional information and resources, go to http://www.seekingsafety.org.

National Center for PTSD, U.S. Department of Veterans Affairs (2010). *Understanding PTSD*. Available: http://www.ptsd.va.gov/public/understanding_ptsd/booklet.pdf

This booklet provides consumer information on posttraumatic stress, common traumatic stress symptoms, effective treatments, and resources. The National Center for PTSD also provides additional professional and public resources specific to trauma for veterans and civilians.

Sidran Institute (2012). *Healing Self-Injury*. Available: http://healingselfinjury.org/about.html

This Web site provides numerous resources for consumers and professionals to understand self-inflicted violence. It offers publication links, archived newsletters, and a current blog focused on self-harm.

Appendix F—Organizational Assessment for Trauma-Informed Care

The following two resources are organizational assessments, which represent a key strategy in developing or re-evaluating trauma-informed services. The first assessment, presented by the University of South Florida, College of Behavioral and Community Sciences (2012), is designed for staff or key stakeholders. The second assessment comes from the *Trauma-Informed Organizational Toolkit for Homeless Services* (Guarino, Soares, Konnath, Clervil & Bassuk, 2009) and is a consumer version. There are several other assessment tools available, including Fallot and Harris's *Creating Cultures of Trauma-Informed Care (CCTIC): A Self Assessment and Planning Protocol* (2009).

Staff or Key Stakeholder Organizational Assessment Tool
University of South Florida, College of Behavioral and Community Sciences (2012). *Creating Trauma-Informed Care Environments: An Organizational Self-Assessment*. Available: http://www.cfbhn.org/assets/TIC/youthresidentialself%20assess%20Fillable%20FORM%20%282%29.pdf

Consumer Version: Organizational Assessment Tool
Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-Informed Organizational Toolkit for Homeless Services*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. See: pp. 82–93. Available: http://www.familyhomelessness.org/media/90.pdf

Appendix G—SAMHSA Resource Panel

John Bailey
Special Expert
Office of Policy, Planning, and Budget
Office of the Administrator
Substance Abuse and Mental Health Services Administration
Rockville, MD

Shirley Beckett, NCAC II
Certification Administrator
National Association of Alcohol and Drug Abuse Counselors
Washington, DC

Danny Brom, Ph.D.
Director
The Israel Center for the Treatment of Psychotrauma
Latner Institute for the Study of Social Psychiatry and Psychotherapy
Israel

Ling Chin, M.D.
Chief, Clinical Science
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Carol Coley, M.S., USPHS
Senior Program Management Officer
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Christina Currier
Public Health Analyst
Office of Evaluation, Scientific Analysis and Synthesis
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Marlene EchoHawk, Ph.D.
Health Science Administrator
Division of Health
Indian Health Service
U.S. Department of Health and Human Services
Rockville, MD

Jill Shepard Erickson, M.S.W., ACSW
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Angela M. Gonzalez, Ph.D., CDR, USPHS
Special Programs Development Branch-Refugee Mental Health Program
Division of Prevention, Traumatic Stress, and Special Programs
Substance Abuse and Mental Health Services Administration
Rockville, MD

Jacqueline Hendrickson, M.S.W., LCSW-C
Public Health Advisor
Division of Pharmacologic Therapies
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Michael Hilton, Ph.D.
Health Science Administrator
Division of Clinical and Prevention Research
National Institute of Alcohol Abuse and Alcoholism
National Institutes of Health
Bethesda, MD

Kenneth J. Hoffman, M.D., M.P.H.
Medical Director
TRICARE Management Activity
Military Health System-Population Health Programs
Department of Defense, Health Affairs
Falls Church, VA

Kirk E. James, M.D.
Special Expert
Systems Improvement Branch
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Hendree E. Jones, Ph.D.
Assistant Professor
Department of Psychiatry and Behavioral Sciences
Johns Hopkins University Center
Baltimore, MD

Cindy Kleppinger, M.D.
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

David Liu, M.D.
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Richard E. Lopez, J.D., Ph.D.
Social Science Analyst
Co-Occurring and Homeless Branch
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Sue Martone, M.P.A.
Public Health Advisor
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
Washington, DC

Dee S. Owens, M.P.A.
Director
Alcohol-Drug Information Center
Indiana University
Bloomington, IN

Harold I. Perl, Ph.D.
Chief, Health Services Research Branch
Division of Clinical and Prevention Research
National Institute of Alcohol Abuse and Alcoholism
National Institutes of Health
Bethesda, MD

Melissa V. Rael, USPHS
Senior Program Management Officer
Division of State and Community Assistance
Co-Occurring and Homeless Branch
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Lawrence D. Rickards, Ph.D.
Co-Occurring Disorders Program Manager
Homeless Programs Branch
Division of Knowledge Development and Systems Change
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Cecilia Rivera-Casale, Ph.D.
Senior Project Officer
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Terrence Schomburg, Ph.D.
Team Leader
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Richard T. Suchinsky, M.D.
Associate Chief for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC

Beth A. Weinman, M.A.
Coordinator
National Drug Abuse Programs
Correctional Programs Division-Services Branch
U.S. Department of Justice
Washington, DC

Penelope P. Ziegler, M.D.
Head, Treatment Section
American Academy of Addiction Psychiatry
Williamsburg, VA

Appendix H—Field Reviewers

Carol Ackley
Owner/Director
River Ridge Treatment Center
Burnsville, MN

Rosie Anderson-Harper, M.A.
Mental Health Manager
Division of Alcohol and Drug Abuse
Missouri Department of Mental Health
Jefferson City, MO

Reba Architzel
Director
Federal Relations and Policy Analysis
New York State Office of Alcoholism and Substance Abuse Services
Albany, NY

Larry L. Ashley, Ed.S., M.A.
Addictions Specialist
Department of Counseling
University of Nevada, Las Vegas
Las Vegas, NV

G.T. (Gigi) Belanger
Public Health Advisor
Homeless Programs Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Charles H. Bombardier, Ph.D.
Associate Professor
Department of Rehabilitation Medicine
Harborview Medical Center
University of Washington School of Medicine
Seattle, WA

Patricia T. Bowman
Probation Counselor
Fairfax Alcohol Safety Action Program
Fairfax, VA

Patricia Allen Bradford, LISW, LMFT, CTS
Program Manager
Health Care for Homeless Veterans
Columbia, SC

Kathy Brock
Director
Polytechnic University Counseling Center
Brooklyn, NY

Vivian B. Brown, Ph.D.
Chief Executive Officer
Mental Health and Social Services Centers for Innovation in Health
PROTOTYPES
Culver City, CA

Wilma J. Calvert, R.N., Ph.D.
Post-Doctoral Fellow
Department of Psychiatry
Washington University School of Medicine
St. Louis, MO

Jerome F.X. Carroll, Ph.D.
Consultant in private practice
Chair, Columbia University's Drugs & Society Seminar
Brooklyn, NY

Steven J. Chen, Ph.D.
Associate Director
Division of Substance Abuse and Mental Health
Utah Department of Human Services
Salt Lake City, UT

Colleen Clark, M.A., Ph.D.
Research Assistant Professor
Licensed Clinical Psychologist
Triad Women's Project
University of South Florida
Tampa, FL

R.T. Codd, III., Ed.S.
Certified Member of the Academy of Cognitive Therapy
Director/Owner
Cognitive–Behavioral Therapy Center of Western North Carolina
Asheville, NC

Carol Coley, M.S.
Senior Program Management Advisor
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Carol J. Colleran, CAP, ICADC
Director of Primary Programs
Center of Recovery for Older Adults
Hanley-Hazelden Center
West Palm Beach, FL

Stephanie S. Covington, M.S.W., Ph.D.
Co-Director
Center for Gender and Justice
Institute for Relational Development
La Jolla, CA

David A. Deitch, Ph.D.
Professor of Clinical Psychiatry
Director, CCARTA
Department of Clinical Psychiatry
University of California, San Diego
La Jolla, CA

Gail D. Dixon, M.A., CAPP
NIDA Project Manager
Southern Coast Addiction Technology Transfer Center
Tallahassee, FL

Jill Shepard Erickson, M.S.W., ACSW
Public Health Advisor
Child and Family Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Phil Erickson
Substance Abuse Program Manager
Loudoun County Community Services Board
Leesburg, VA

Kathleen J. Farkas, Ph.D., LISW
Mandel School of Applied Social Sciences
Case Western Reserve University
Cleveland, OH

Norma B. Finkelstein, M.S.W., Ph.D.
Executive Director
W.E.L.L. Project
Institute for Health and Recovery
Cambridge, MA

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief
Services Research Branch
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Judith Ford, M.A., MFT
Director of Women's Services
Community Services and Hospitals
Connecticut Department of Mental Health and Addiction Services
Hartford, CT

Julian D. Ford, Ph.D.
Associate Professor
Department of Psychiatry
University of Connecticut Health Center
Farmington, CT

Matthew Friedman, M.D., Ph.D.
Professor of Psychiatry and Pharmacology
Executive Director, National Center for PTSD
Dartmouth Medical School
VA Medical Center
White River Junction, VT

John Galea, M.A.
Deputy Director, New York City Relations
New York State Office of Alcoholism and Substance Abuse Services
New York, NY

Angela M. Gonzalez, Ph.D., CAPT., USPHS
Scientist Officer
Special Programs Development Branch-Refugee Mental Health Program
Division of Prevention, Traumatic Stress, and Special Programs
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Maya D. Hennessey
Women's Specialist
Supervisor, Quality Assurance, Technical Assistance & Training
Office of Special Programs
Division of Substance Abuse
Illinois Department of Human Services and Substance Abuse
Chicago, IL

Michael W. Herring, LCSW
Licensed Clinical Social Worker
Wayne Psychiatric Associates, P.A.
Goldsboro, NC

Nancy J. Hirzel
Clinic Director
Adult Services Division
Jefferson Addictive Disorders Clinic
Jefferson Parish Human Services Authority
Metairie, LA

Robert Holden, M.A.
Program Director
Partners in Drug Abuse Rehabilitation Counseling (PIDARC)
Washington, DC

Kay M. Johnson
Crime Victims Treatment Center - HIV Project
St. Luke's Roosevelt Hospital Center
New York, NY

Kimberly A. Johnson, M.A., NCAC II
Director
Augusta Mental Health Complex
Maine Office of Substance Abuse
Augusta, ME

Sharon D. Johnson, M.S.W., M.P.E., Ph.D.
Assistant Professor
Department of Social Work
University of Missouri-St. Louis
St. Louis, MO

Lorene Lake, M.A., Ed.D.
Executive Director
Chrysalis House, Inc.
Crownsville, MD

Michael S. Levy, Ph.D.
Director of Clinical Treatment Services
CAB Health and Recovery Services
Danvers, MA

T.K. Logan, Ph.D.
Associate Professor
Center on Drug & Alcohol Research
Department of Behavioral Science
University of Kentucky
Lexington, KY

James J. Manlandro, D.O., FAOAAM, FACOFP
Medical Director
Family Addiction Treatment Services, Inc.
Somers Point, NJ

Rozanne Marel, Ph.D.
Head of Epidemiology & Needs Assessment
New York State Office of Alcoholism and Substance Abuse Services
New York, NY

Pamela Martin, Ph.D.
Director
Behavioral Health Services Division
New Mexico Department of Health
Santa Fe, NM

Ruby J. Martinez, Ph.D., R.N., CS
Assistant Professor
School of Nursing
University of Colorado Health Sciences Center
Denver, CO

Sue Martone, M.P.A.
Public Health Advisor
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
Washington, DC

Beth Marty, M.S., LPC
Clinical Program Manager
WYSTAR
Sheridan, WY

Lisa A. Melchior, Ph.D.
Vice President
The Measurement Group, LLC
Culver City, CA

Candace Merritt
Social Worker
Veterans Administration Medical Center
Denver, CO

Pamela A. Mumby, C.N.S., F.N.P., M.S.N.
Adult Psychiatric Nurse Practitioner
Substance Abuse Treatment Program
Veterans Administration Medical Center
Denver, CO

Briana S. Nelson-Goff, Ph.D.
Associate Professor
Family Studies and Human Service
Kansas State University
Manhattan, KS

Sarah Niemeyer
Clinical Director
Amethyst, Inc.
Columbus, OH

Thomas A. Peltz, M.Ed.
Therapist/Licensed Mental Health Counselor
Certified Addiction Specialist
Private Practice
Beverly Farms, MA

Karen Pressman, M.S.W., CADAC, LACDI
Director, Planning and Development
Bureau of Substance Abuse Services
Massachusetts Department of Public Health
Boston, MA

Melissa V. Rael, USPHS
Senior Program Management Officer
Co-Occurring and Homeless Branch
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Lawrence D. Rickards, Ph.D.
Public Health Advisor
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Alice F. Roeling
OAD Inpatient Facility Manager
The Springs of Recovery Adolescent Program
Greenwall Springs, LA

James Rowan, M.A.
Program Manager
Case Management and Offender Services
Arapahoe House, Inc.
Thornton, CO

JoAnn Y. Sacks, Ph.D.
Deputy Director, CIRP
National Development and Research Institutes, Inc.
New York, NY

Darren C. Skinner, M.S.W., Ph.D., LSW
Division Director
Co-Occurring Program
Gaudenzia, Inc.
Philadelphia, PA

Mickey J.W. Smith, M.S.W.
Senior Policy Associate, Behavioral Health
Program, Policy & Practice Unit
Division of Professional Development & Advocacy
National Association of Social Workers
Washington, DC

Richard T. Suchinsky, M.D.
Associate Chief for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC

Wilbur Woodis, M.A.
Management Analyst
Office of Clinical and Preventive Services
Division of Behavioral Health
Indian Health Service
Office of Public Health
U.S. Department of Health and Human Services
Rockville, MD

Appendix I: Cultural Competency and Diversity Network Participants

Charles H. Bombardier, Ph.D.
Associate Professor
Department of Rehabilitation Medicine
Harborview Medical Center
University of Washington School of Medicine
Seattle, WA
Disability Workgroup

Carol S. D'Agostino, CSW, CASAC
Director
Geriatric Addictions Program
LIFESPAN of Greater Rochester, Inc.
Rochester, NY
Aging Workgroup

Thomas L. Geraty, M.S.W., Ph.D., LICSW
Private Practice
Jamaica Plain, MA
LGBT Workgroup

Wayne Lee Mitchell, M.D.
Indian Health Service
Phoenix, AZ
Aging Workgroup

Ann S. Yabusaki, M.Ed., M.A., Ph.D.
Substance Abuse Director
Psychologist
Substance Abuse Programs and Training
Coalition for a Drug-Free Hawaii
Kaneohe, HI
Asian and Pacific Islanders Workgroup and Aging Workgroup

Appendix J: Acknowledgments

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Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under the Substance Abuse and Mental Health Services Administration's Knowledge Application Program (KAP) to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

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A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

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TIP 46 Substance Abuse: Administrative Issues in Outpatient Treatment
Quick Guide for Administrators

TIP 47 Substance Abuse: Clinical Issues in Outpatient Treatment
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TIP 48 Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery

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TIP 50 Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment
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Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

Violence Prevention
A Public Health Issue
Child Abuse & Neglect
Fast Facts
Risk and Protective Factors
Prevention Strategies
Adverse Childhood Experiences
Fast Facts
CDC-Kaiser ACE Study
BRFSS ACE Data
Prevention Strategies
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Youth Violence
Data Sources
Communication Resources

About the CDC-Kaiser ACE Study

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being.

The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors.

More detailed information about the study can be found in the links below or in the article, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults ,".

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Implementing a Trauma-Informed Approach for Youth across Service Sectors

This brief is based on a webinar, ***Implementing a Trauma-Informed Approach for Youth Across Service Sectors***, held Tuesday, May 21, 2013, 2:00 p.m. to 3:30 p.m. EDT. The webinar was sponsored by the Interagency Working Group on Youth Programs (IWGYP), a collaboration of 18 Federal departments and agencies that support programs and services focusing on youth and promote the goal of positive, healthy outcomes for youth. The webinar was planned jointly by the IWGYP and the Substance Abuse and Mental Health Services Administration (SAMHSA). The webinar slides are housed on the IWGYP website, FindYouthInfo.gov, under the Mental Health Youth Topic. The webinar featured three content experts nationally known in their field: Eugene Griffin, J.D., Ph.D., Northwestern University, Feinberg School of Medicine; Julian Ford, Ph.D., University of Connecticut, School of Medicine; and Charles Wilson, MSSW, Chadwick Center for Children and Families Rady Children's Hospital - San Diego, California; all of whom have been supported by SAMHSA trauma-focused grants. Additionally, the webinar included two youth presenters, NC and LS, who spoke about their own lived experience and the importance of trauma-informed care. Both youth are referred to only by initials to protect their privacy. NC is a peer specialist and LS is a law student.

Introduction

Trauma affects youth in all communities, and responses to those experiences by child-serving systems are critical. It is important for providers serving youth to understand how best to respond and support healing.

Service providers and policymakers in the youth-serving field are continually learning more from research[i] about trauma, traumatic experiences, and the various responses to traumatic events. It is important for youth serving systems to develop a greater understanding of the association between trauma and mental health and substance use disorders, and how it can derail the healthy development of youth. The field recognizes the importance of addressing trauma and using a trauma-informed approach in prevention, treatment, and recovery efforts.

This brief discusses the concept and prevalence of trauma; techniques for coping with, and recovering from trauma at an individual and systems level; the core principles for building a framework for understanding trauma; and implementation of elements essential for a trauma-informed system as presented by the featured experts.

Recognizing the effects of trauma and understanding how to address trauma are fundamental to the Trauma and Justice Strategic Initiative at the Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services (HHS). The focus of SAMHSA's Trauma and Justice Strategic Initiative is on integrating a trauma-informed approach throughout health, behavioral health, and related systems to reduce the harmful effects of trauma and violence on individuals, families, and communities and using innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.

As part of this Initiative, with the help of experts, SAMHSA will be releasing a concept paper outlining a framework for trauma and guidance for developing and implementing a trauma-informed approach.

What Do We Mean by Trauma?

After an introduction by Dr. Larke Huang from the Substance Abuse and Mental Health Services Administration (SAMHSA), Dr. Eugene Griffin provided a framework for understanding trauma.

Trauma is a complex experience that affects youth and the systems that serve them in a variety of ways. The experience of trauma can be described through some common elements: event, experience, and effects, also known as "Three E's."[ii] These elements address the uniqueness of an individual's response to an event and how an event affects one's future behavior and well-being.

An **Event** is objective and measurable. Traumatic events include abuse (physical, emotional, sexual); domestic or community violence; an accident or natural disaster; and war or terrorism.

1. An **Experience** is subjective and difficult to measure because it relates to how someone reacts to an event. It is often thought to be life threatening or physically or emotionally overwhelming, and intensity can vary among people and over time. The way one person experiences an event might differ from the way another person does; culture, gender, and age all influence one's experience of the event. Additionally, people experience events in different ways. Resilience, risk and protective factors, and supports may contribute to this experience.
2. **Effects** are the reactions a person has to an event and the ways an experience changes or alters that person's ongoing and future behavior. Classic symptoms include experiencing hyperarousal, such as overreacting or being hypervigilant; re-experiencing an event as nightmares or flashbacks; and avoiding a situation by having a fight, flight, or freeze reaction. The effects of a traumatic event can have a long-term impact on neurobiological development and contribute to negative physical, hormonal, and chemical changes due to stress responses.

Building on this "Three E's" concept of trauma, SAMHSA frames its concept of trauma as: an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[iii] Researchers[iv] report that traumatic stress occurs when an extreme experience overwhelms and alters an individual's stress-related physiological systems and compromises the functioning of stress-response systems (e.g., neuroimmune, neuroendocrine, autonomic, and central nervous system networks).

"What I found worked best is when I was surrounded by people who really got it, who really understood trauma." — LS

Prevalence of Trauma

Many youth are exposed to traumatic events, including those in the juvenile justice and child welfare systems, as well as those who experience homelessness. Building on the three E's concept, we know that the experience of trauma is complex and particular to each individual's life circumstances, which can make quantifying the extent difficult. Some people experience multiple traumas; for example, a youth who has been separated from his or her family and then experiences assault or abuse in a foster home. As many as half of all children that have been involved with the mental health, child welfare, and juvenile justice systems have experienced multiple traumas.[v] LS and NC, two young people formerly involved with the foster care system, comment in the box above on their experiences with multiple traumas.

"When I was seven years old…my brothers and I were placed in foster care…We were immediately separated, and so I felt like that was probably the first traumatic event that I experienced." — LS

"While I was at my foster home, I had gotten into altercations with my foster brother and before he hit me, I felt scared…" — NC

Coping with and Reactions to Trauma

Dr. Julian Ford provided an overview of strategies for youth, families, and communities to recover from trauma. Recovery from the adverse effects of trauma begins with the recognition that the experience of survival threat caused by traumatic events has caused some major changes in the way a person now copes with stress. These ways of coping are necessary and effective in emergencies such as traumatic events, but they interfere with ordinary day-to-day life. Youth who have experienced trauma may develop coping strategies to help them survive.

Chronic Survival Coping

Trauma affects a youth's relationships, sense of survival, and sense of trust and security with people. The reaction to terrible shock, stressors, challenges, and loss is chronic survival coping. An individual trying to cope or recover from serious challenges and stressors will learn techniques to survive, such as staying on edge; being vigilant, watchful, or even distrustful (hypervigilance); or using indifference to mask hopelessness.

Posttraumatic Survival Coping

Physically, posttraumatic survival coping reflects a change in the body, not just a mental and psychological change. It changes how a person's brain works. The brain helps a person learn, explore, try activities, and experience different ways of living. However, a person cannot experience life freely when trying to survive trauma. Instead, that person must put everything else aside and concentrate only on basic survival needs. Some common survival modes or hypervigilance practices are scanning the environment and being on guard for danger; attempting to block out or not think about upsetting things; being ready to fight or flee; experiencing elevated heart rate and adrenalin rush; and being unable to regulate aggression or use anger management techniques.

"I wish that the people who I was working with in my school were more trauma informed and that they were focused - instead of on the disruptive behavior - on what was causing the disruptive behavior." — LS

Hypervigilance can make it difficult to set and accomplish goals even for the most persistent and high achieving person; all goals are trumped by the larger objective of staying safe. This type of coping can lead to difficulties trusting, including parents, caregivers, friends, teachers, and other adults.

Neurobiological Brain Research

Neuroscience indicates that a person's response to stress and use of coping techniques have three components. Dr. Ford provided a metaphor for understanding these complex brain processes:

- The ***"alarm"*** in the brain tells a person to wake up and pay attention. It also tells the body when there is a crisis and to be ready to react and survive.
- The ***"librarian"*** and ***"search engine"*** file and retrieve memories. When the alarm goes off, the memory filing center pulls information from all parts of the brain to figure out what is going on.
- The ***"computer hard drive"*** is the thinking center where all the information is put together and decisions are made.

If the three above components are working well, the thinking center is activated and a person can handle the stressful situation, not worry about survival, and come up with good ideas and plans for handling the situation, thus the alarm is turned off. However, if the alarm is so strong because of extreme stress (e.g., a threat to survival), it can crash the memory filing center and the hard drive in the brain. At that point, survival coping tactics take over. These activities take place in the part of the brain that helps a person survive and be safe. Operating in survival mode is not the ideal way to live because it leads to difficulty relaxing, trusting, focusing, and handling things appropriately.

Recovery from Trauma

A trauma-informed approach is a framework for providing services that should be integrated into everything that a program and system does. Dr. Ford noted that the goal of recovery from trauma is to tap into an existing strength to reset the brain's alarm to not be in persistent survival mode. Resetting the alarm requires strategies to resume thinking clearly. Evidence-based trauma-informed and trauma-specific therapy programs provide youth and their caregivers with strategies to focus their minds and deal with not feeling safe. Learning the strategies for regulating emotions and controlling anxiety is vital to everyday functioning in society. A trauma-informed approach includes youth and caretakers

in future planning. Trauma takes away control of a person's body or life. Reintroducing some control can tap into resiliency, and planning for the future provides hope.[vi]

Strategies for recovery from trauma include recognizing one's own and others' alarm reactions, sweeping one's mind clear before judging and acting, focusing on what is most important and positive, and being aware of stress and personal control levels. These strategies activate the thinking center and reset the alarm.

Many Paths to Recovery: Evidence-Based Models

- Cognitive-behavioral therapies
- Emotion regulation therapies
- Relational-interpersonal therapies
- Psychotherapies for dissociation
- Parent-child and family system therapies
- Social/helping network therapies
- Peer-to-peer support programs

The webinar presenters acknowledged that there are many paths to recovery and recommended common therapeutic approaches implemented by mental health professionals that can assist individuals who have experienced trauma. It is important to understand that trauma-informed care principles can be implemented by people who are not mental health professionals and work in various systems that provide services for individuals who have experienced trauma.

Trauma at the Systems Level

Mr. Charles Wilson provided a discussion of the child welfare system, and its role in addressing youth and families who have experienced trauma. The experience of trauma is complex and personal, and youth and families who have experienced trauma receive services within a variety of community systems. Providers and systems have the ability to help or potentially re-traumatize. A trauma-informed system aligns interactions among youth-serving agencies, such as the child protection systems, lawyers, juvenile judges, law enforcement, schools, and mental health providers so that they better understand how youth, families, and adults respond to trauma.

A trauma-informed system is not just about raising awareness, but changing behavior, actions, and responses. The approach requires doing things differently so as not to re-traumatize or introduce additional trauma. Systems need to support the natural resiliency of children and youth and assist them in identifying their unique strengths.

In a trauma-informed system, caregivers play a central role in recovery, help promote youth's natural resiliency, and give youth tools for managing stress. A strengths-based approach considers and includes the assistance given to caregivers within the system. This approach considers how the system helps caregivers deal with both current and past traumatic stress. The trauma-informed system assists caregivers understand the significant trauma histories of the children and youth that are in their care. Child welfare workers, mental health therapists, foster parents, juvenile judges, and all those working with children who have experienced significant traumatic events are influenced and touched by the trauma and can experience secondary or vicarious traumatic reactions. Therefore, the trauma-informed system responds to the varying impacts of traumatic stress on children, caregivers, and all those who are in contact with the system. Practitioners take this thinking and awareness about trauma and use it in everyday practice.

"The aftercare team also took a lot of time to do safety planning and future planning with me, and that is important because a lot of young people who experience trauma, they express feelings of hopelessness and they are in a constant state of anxiety, and so their ability to project into the future and plan for the future can be seriously impaired." — LS

Core Principles of a Trauma-Informed Approach

Given the presence of trauma in the lives of many youth and the need for systems and providers to support healing, a trauma-informed approach to providing services is critical. According to SAMHSA's concept of trauma[vii], a program, an organization, or a system that is trauma informed is based on four key assumptions:

- ***Realizes*** the widespread impact of trauma and understands potential paths for recovery.
- ***Recognizes*** the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
- ***Responds*** by fully integrating knowledge about trauma into policies, procedures, practices, and settings.
- ***Resists re-traumatization*** of clients as well as staff***.***

The Chadwick Trauma-Informed Systems Project (CTISP)[viii] National Advisory Committee says that in a trauma-informed child welfare system, all parties recognize and respond to the varying impact of traumatic stress on children, caregivers, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and skill into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery.

"I was 13 years old in my first foster home, and I must admit I did not want to be there at first because I was at home with people who I was unfamiliar with…" — NC

SAMHSA's six principles[ix] support a framework for understanding trauma and developing a trauma-informed approach:

- ***Safety:*** Throughout the organization, the staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.
- ***Trustworthiness and transparency:*** Organizational operations and decisions are conducted with transparency and with the goal of building and maintaining trust among clients, family members, staff, and others involved with the organization.
- ***Collaboration and mutuality:*** There is true partnering and leveling of power differences between staff and clients and among organizational staff, from direct care staff to administrators; they recognize that healing happens in relationships and in the meaningful sharing of power and decision making.
- ***Empowerment:*** Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills are developed as needed.
- ***Voice and choice:*** The organization aims to strengthen the experience of choice for clients, family members, and staff and recognizes that every person's experience is unique and requires an individualized approach.
- ***Culture, historical and gender issues:*** The organization incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; are gender-responsive; and incorporate a focus on historical trauma.

These principles underlie the values, beliefs, and attitudes of individuals and organizations offering a trauma-informed approach. Using this approach, organizations foster a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. Trauma-informed organizations build on strengths and assets of clients, staff, and communities instead of responding only to their perceived deficits. They recognize that everyone has a role to play. They address cultural, historical, and gender issues; actively move past cultural stereotypes and biases; offer gender-responsive services; promote the value of cultural connections; and recognize and address historical trauma. In the words of Dr. Ford, "A person does not have to be a therapist to be therapeutic."

Implementation

In his presentation, Mr. Charles Wilson shared the following central elements of providing trauma-informed care within programs, policies, services, and systems as outlined by the child welfare committee of the National Child Traumatic Stress Network. Sources with additional information are provided in the resources section of this brief.

Element 1: Maximize Physical and Psychological Safety for Children and Families

- Safety is a priority. Children and families who have experienced trauma may still feel unsafe even when they are no longer in danger. In addition to ensuring physical safety, it is important to help children and families feel psychologically safe.
- Sometimes even a noise or smell can trigger the feeling of being unsafe and elicit a reaction that a caretaker might not expect or understand. Being aware of and understanding these triggers and changing something seemingly small or insignificant in a daily routine can change behavior from negative to positive.

Element 2: Identify the Trauma-Related Needs of Children

- One of the first steps in helping trauma-exposed children and families is to understand how they have been impacted by trauma.
- Trauma-related needs can be identified through trauma screening and assessment.
- It is important to consider the type(s) of trauma children have experienced when making service referrals and developing service plans. All children need individualized services that are based on their unique circumstances, strengths, and challenges.

"I had reported a child abuse and neglect incident with social services and they did not come and take us out of our home. It was a form of betrayal of trust because you are expecting someone to help you and when that help does not come, then your relationship with the institutions that you need to rely on in order to get out of a bad situation, the relationship is broken." — LS

Element 3: Enhance Child Well-Being and Resilience

- Many children are naturally resilient.
- Systems must recognize and build on children's existing strengths.
- Both individual caseworkers and overall agency policies should support the continuity of children's relationships.
- Staff and agencies should also ensure that children who have been traumatized have access to evidence-based treatments and services.

Element 4: Enhance Family Well-Being and Resilience

- Families are a critical part of both protecting children from harm and enhancing their natural resilience.
- Providing trauma-informed education and services to parents and other caregivers enhances protective capacities.
- Agencies should recognize and assist caregivers to understand the significant trauma histories of the children and youth that are in their care.
- Agencies should assist caregivers to understand their own trauma histories.

"We need to do some self-esteem building and work with young people to acknowledge their strengths. I think when you have experienced trauma, you have a lot of thoughts, beliefs, or feelings of being unworthy or ashamed and you feel a lot of guilt and sometimes that leads to hopelessness. You are not going to work hard to achieve goals if you do not believe you can achieve them, if you do not believe you are worthy of achieving them…" — LS

Element 5: Enhance the Well-Being and Resilience of Those Working in the System

- Staff play important roles in supporting children, but working with people who have experienced abuse, neglect, violence, and other trauma can cause staff to develop secondary traumatic stress reactions.
- Agencies should collect information about trauma and secondary trauma experienced by staff, implement strategies and practices that build resilience and help staff manage stress, and address the impact of secondary traumatic stress on both individuals and on the system as a whole.

> **"The aftercare team was most useful because they worked across the systems…I did not have to do the work that a lot of young people are burdened with, which is finding a way to get our systems to work with one another." — LS**

Element 6: Partner with Youth and Families

- Youth and families should have choices and an active voice in decision making on individual, agency, and systemic levels.
- Youth and family members who have been in the system have a unique perspective and can provide valuable feedback.
- Partnerships with youth and families should occur at all levels.

Element 7: Partner with Agencies and Systems That Interact with Children and Families

- Agencies need to establish strong partnerships with other child- and family-serving systems.
- Service providers should develop common protocols and frameworks.
- Cross-system collaboration enables all helping professionals to see the child as a whole person, thus preventing potentially competing priorities and messages.
- Collaboration between systems promotes cohesive care and better outcomes.

Conclusion

This brief provides an overview of the webinar content as presented by experts in the field regarding the concepts and prevalence of trauma, principles for understanding trauma, and practices for addressing trauma and working with youth who have experienced trauma.

LS and NC, two young people formerly involved with the foster care system, provided much insight on their experiences with multiple traumas. Their shared comments provide important information and practice-based evidence and strategies that child and youth serving systems could incorporate into their work with children and youth who have experienced trauma. Some of the practical applications they described as beneficial to them include:

- Staff working in schools need to be aware of, educated and informed on the effects of trauma for children and youth, and trained in the causes of disruptive behaviors and ways to address these behaviors that do not re-traumatize children and youth;
- Aftercare teams need to provide consistent and ongoing planning with youth to address the after effects of trauma, (e.g., anxiety, sadness, depressions, feelings of hopelessness, anger, shame, guilt) and to build upon their strengths to instill good self-esteem and a belief that they are worthy of and can achieve goals in their life;

- Aftercare teams need to provide ongoing assistance for children and youth to learn skills for daily life, safety planning to address potential re-traumatization, and development of goals for the "here and now" and in their future;
- Aftercare teams need to provide quick response for children and youth who have been traumatized when reports or incidents of child abuse and/or neglect occur. Teams need to remember that these children and youth have been placed in unfamiliar surroundings and they do not feel safe or trust the people or environment immediately. They must rely on the aftercare teams to provide a trusting relationship with staff that will provide safety, protection and security in their lives;
- Aftercare teams need to work across systems to advocate for children and youth who have experienced trauma, and to assist them with the work needed for their daily care and consistent planning for life transitions.

Many strategies for coping with trauma have been noted in this brief, as well as the experiences of LS and NC which can inform child and youth serving systems on the successful practices and strategies that could improve the experience of children and youth who are coping with and healing from trauma. The resources noted below offer a starting point for deeper understanding of trauma and trauma-informed approaches.

Resources

Helping Children and Adolescents Cope with Violence and Disasters: What Community Members Can Do, National Institute of Mental Health, 2013 website information
http://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-violence-and-disasters-community-members/index.shtml

National Child Traumatic Stress Network, Learning Center for Child and Adolescent Trauma, Resources and Training
http://learn.nctsn.org/index.php

National Council for Behavioral Health; Trauma Informed Care
http://www.thenationalcouncil.org/topics/trauma-informed-care/

National Council for Behavioral Health; How to Manage Trauma
http://www.thenationalcouncil.org/wp-content/uploads/2013/05/Trauma-infographic.pdf

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SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

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Introduction

Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. ***In order to maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.***

The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.[1,2,3,4,5] Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences.[6,7,8,9] However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical diseases.[1,10,11]

With appropriate supports and intervention, people can overcome traumatic experiences.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.[12,13] Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems.[5,14] Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.[15,16,17]

In addition, the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

Thus, the pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing "business as usual." In public institutions and service systems, there is increasing recognition that many of the individuals have extensive histories of trauma that, left unaddressed, can get in the way of achieving good health and well-being. For example, a child who suffers from maltreatment or neglect in the home may not be able to concentrate on school work and be successful in school; a women victimized by domestic violence may have trouble performing in the work setting; a jail inmate repeatedly exposed to violence on the street may have difficulty refraining from retaliatory violence and re-offending; a sexually abused homeless youth may engage in self-injury and high risk behaviors to cope with the effects of sexual abuse; and, a veteran may use substances to mask the traumatic memories of combat. The experiences of these individuals are compelling and, unfortunately, all too common. Yet, until recently, gaining a better understanding of how to address the trauma experienced by these individuals and how to mitigate the re-traumatizing effect of many of our public institutions and service settings was not an integral part of the work of these systems. Now, however, there is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their "business" under the framework of a trauma-informed approach.

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Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach

PURPOSE

The purpose of this paper is to develop a working concept of trauma and a trauma-informed approach and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups. SAMHSA puts forth a framework for the behavioral health specialty sectors, that can be adapted to other sectors such as child welfare, education, criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual's capacity to cope with traumatic experiences. In fact, many people with behavioral health problems receive treatment and services in these non-specialty behavioral health systems. SAMHSA intends this framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families and communities. The desired goal is to build a framework that helps systems "talk" to each other, to understand better the connections between trauma and behavioral health issues, and to guide systems to become trauma-informed.

APPROACH

SAMHSA approached this task by integrating three significant threads of work: trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors

of traumatic experiences who have had involvement in multiple service sectors. It was expected that this blending of the research, practice and survivor knowledge would generate a framework for improving the capacity of our service systems and public institutions to better address the trauma-related issues of their constituents.

To begin this work, SAMHSA conducted an environmental scan of trauma definitions and models of trauma informed care. SAMHSA convened a group of national experts who had done extensive work in this area. This included trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of trauma-specific interventions; and policymakers in the field of behavioral health.

From this meeting, SAMHSA developed a working document summarizing the discussions among these experts. The document was then vetted among federal agencies that conduct work in the field of trauma. Simultaneously, it was placed on a SAMHSA website for public comment. Federal agency experts provided rich comments and suggestions; the public comment site drew just over 2,000 respondents and 20,000 comments or endorsements of others' comments. SAMHSA reviewed all of these comments, made revisions to the document and developed the framework and guidance presented in this paper.

The key questions addressed in this paper are:

- **What do we mean by trauma?**
- **What do we mean by a trauma-informed approach?**
- **What are the key principles of a trauma-informed approach?**
- **What is the suggested guidance for implementing a trauma-informed approach?**
- **How do we understand trauma in the context of community?**

SAMHSA's approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA's trauma-focused grants and initiatives, such as SAMHSA's National Child Traumatic Stress Initiative, SAMHSA's National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA's: Jail Diversion Trauma Recovery grant program; Children's Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Reentry and Adult Treatment Drug Court Programs.

Background: Trauma — Where We Are and How We Got Here

The concept of traumatic stress emerged in the field of mental health at least four decades ago. Over the last 20 years, SAMHSA has been a leader in recognizing the need to address trauma as a fundamental obligation for public mental health and substance abuse service delivery and has supported the development and promulgation of trauma-informed systems of care. In 1994, SAMHSA convened the Dare to Vision Conference, an event designed to bring trauma to the foreground and the first national conference in which women trauma survivors talked about their experiences and ways in which standard practices in hospitals re-traumatized and often, triggered memories of previous abuse. In 1998, SAMHSA funded the Women, Co-Occurring Disorders and Violence Study to generate knowledge on the development and evaluation of integrated services approaches for women with co-occurring mental and substance use disorders who also had histories of physical and or sexual abuse. In 2001, SAMHSA funded the National Child Traumatic Stress Initiative to increase understanding of child trauma and develop effective interventions for children exposed to different types of traumatic events.

The American Psychiatric Association (APA) played an important role in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the recently released DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970's.[18,19,20,21] National trauma research and practice centers have conducted significant work in the past few decades, further refining the concept of trauma, and developing effective trauma assessments and treatments.[22,23,24,25] With the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.[3,25]

Simultaneously, an emerging trauma survivors movement has provided another perspective on the understanding of traumatic experiences. Trauma survivors, that is, people with lived experience of trauma, have powerfully and systematically documented their paths to recovery.[26] Traumatic experiences complicate a child's or an adult's capacity to make sense of their lives and to create meaningful consistent relationships in their families and communities.

Trauma survivors have powerfully and systematically documented their paths to recovery.

The convergence of the trauma survivor's perspective with research and clinical work has underscored the central role of traumatic experiences in the lives of people with mental and substance use conditions. The connection between trauma and these conditions offers a potential explanatory model for what has happened to individuals, both children and adults, who come to the attention of the behavioral health and other service systems.[25,27]

People with traumatic experiences, however, do not show up only in behavioral health systems. Responses to these experiences often manifest in behaviors or conditions that result in involvement with the child welfare and the criminal and juvenile justice system or in difficulties in the education, employment or primary care system. Recently, there has also been a focus on individuals in the military and increasing rates of posttraumatic stress disorders.[28,29,30,31]

With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed. Federal research agencies, academic institutions and practice-research partnerships have generated empirically-supported interventions. In SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) alone there are over 15 interventions focusing on the treatment or screening for trauma.

These interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough. Building on lessons learned from SAMHSA's Women, Co-Occurring Disorders and Violence Study; SAMHSA's National Child Traumatic Stress Network; and SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions in which services are provided played a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served. SAMHSA's National Center for Trauma-Informed Care has continued to advance this effort, starting first in the behavioral health sector, but increasingly responding to technical assistance requests for organizational change in the criminal justice, education, and primary care sectors.

FEDERAL, STATE AND LOCAL LEVEL TRAUMA-FOCUSED ACTIVITIES

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

States are elevating a focus on trauma. For example, Oregon Health Authority is looking at different types of trauma across the age span and different population groups. Maine's "Thrive Initiative" incorporates a trauma-informed care focus in their children's systems of care. New York is introducing a trauma-informed initiative in the juvenile justice system. Missouri is exploring a trauma-informed approach for their adult mental health system. In Massachusetts, the Child Trauma Project is focused on taking trauma-informed care statewide in child welfare practice. In Connecticut the Child Health and Development Institute with the state Department of Children and Families is building a trauma-informed system of care throughout the state through policy and workforce development. SAMHSA has supported the further development of trauma-informed approaches through its Mental Health Transformation Grant program directed to State and local governments.

Increasing examples of local level efforts are being documented. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the wellbeing of the community. The Family Policy Council in Washington State convened groups to focus on the impact of adverse childhood experiences on the health and well-being of its local communities and tribal communities. Philadelphia held a summit to further its understanding of the impact of trauma and violence on the psychological and physical health of its communities.

SAMHSA continues its support of grant programs that specifically address trauma.

At the federal level, SAMHSA continues its support of grant programs that specifically address trauma and technical assistance centers that focus on prevention, treatment and recovery from trauma.

Other federal agencies have increased their focus on trauma. The Administration on Children Youth and Families (ACYF) has focused on the complex trauma of children in the child welfare system and how screening and assessing for severity of trauma and linkage with trauma treatments can contribute to improved well-being for these youth. In a joint effort among ACYF, SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the three agencies developed and issued through the CMS State Directors' mechanism, a letter to all State Child Welfare Administrators, Mental Health Commissioners, Single State Agency Directors for Substance Abuse and State Medicaid Directors discussing trauma, its impact on children, screening, assessment and treatment interventions and strategies for paying for such care. The Office of Juvenile Justice and Delinquency Prevention has specific recommendations to address trauma in their Children Exposed to Violence Initiative. The Office of Women's Health has developed a curriculum to train providers in primary care on how to address trauma issues in health care for women. The Department of Labor is examining trauma and the workplace through a federal interagency workgroup. The Department of Defense is honing in on prevention of sexual violence and trauma in the military.

As multiple federal agencies representing varied sectors have recognized the impact of traumatic experiences on the children, adults, and families they serve, they have requested collaboration with SAMHSA in addressing these issues. The widespread recognition of the impact of trauma and the burgeoning interest in developing capacity to respond through trauma-informed approaches compelled SAMHSA to revisit its conceptual framework and approach to trauma, as well as its applicability not only to behavioral health but also to other related fields.

SAMHSA's Concept of Trauma

Decades of work in the field of trauma have generated multiple definitions of trauma. Combing through this work, SAMHSA developed an inventory of trauma definitions and recognized that there were subtle nuances and differences in these definitions.

Desiring a concept that could be shared among its constituencies — practitioners, researchers, and trauma survivors, SAMHSA turned to its expert panel to help craft a concept that would be relevant to public health agencies and service systems. SAMHSA aims to provide a viable framework that can be used to support people receiving services, communities, and stakeholders in the work they do. A review of the existing definitions and discussions of the expert panel generated the following concept:

> ***Individual trauma results from an* event*, series of events, or set of circumstances that is* experienced *by an individual as physically or emotionally harmful or life threatening and that has lasting adverse* effects *on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.***

THE THREE "E'S" OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as "trauma and stressor-related disorders" to include exposure to a traumatic or stressful event as a diagnostic criterion.

The individual's **experience** of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one's country differently from another refugee; one military veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of "why me?" The individual's experience of these events or circumstances is shaped in the context of this powerlessness and questioning. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When a person experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal, shattering a person's trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

How the event is experienced may be linked to a range of factors including the individual's cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure), or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty).[1]

The long-lasting adverse **effects** of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one's neurobiological make-up and ongoing health and well-being. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.[1,3] Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

SAMHSA's Trauma-Informed Approach: Key Assumptions and Principles

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to influence how service systems conduct their business.

The context in which trauma is addressed or treatments deployed contributes to the outcomes for the trauma survivors, the people receiving services, and the individuals staffing the systems. Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.[22,32,33] SAMHSA's concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles.

A program, organization, or system that is trauma-informed* realizes *the widespread impact of trauma and understands potential paths for recovery;* recognizes *the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and* responds *by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively* resist re-traumatization*.

A trauma informed approach is distinct from trauma-specific services or trauma systems. A trauma informed approach is inclusive of trauma-specific interventions, whether assessment, treatment or recovery supports, yet it also incorporates key trauma principles into the organizational culture.

Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.

THE FOUR "R'S: KEY ASSUMPTIONS IN A TRAUMA-INFORMED APPROACH

In a trauma-informed approach, all people at all levels of the organization or system have a basic **realization** about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People's experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional).There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in prevention, treatment, and recovery settings. Similarly, there is a realization that trauma is not confined to the behavioral health specialty service sector, but is integral to other systems (e.g., child welfare, criminal justice, primary health care, peer–run and community organizations) and is often a barrier to effective outcomes in those systems as well.

People in the organization or system are also able to **recognize** the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

The program, organization, or system **responds** by applying the principles of a trauma-informed approach to all areas of functioning. The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma practices. Policies of the organization, such as mission statements, staff handbooks and manuals promote a culture based on beliefs about resilience, recovery, and healing from trauma. For instance, the agency's mission may include an intentional statement on the organization's commitment to promote trauma recovery; agency policies demonstrate a commitment to incorporating perspectives of people served through the establishment of client advisory boards or inclusion of people who have received services on the agency's board of directors; or agency training includes resources for mentoring supervisors on helping staff address secondary traumatic stress. The organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes trust, fairness and transparency. The program's, organization's, or system's response involves a universal precautions approach in which one expects the presence of trauma in lives of individuals being served, ensuring not to replicate it.

A trauma-informed approach seeks to **resist re-traumatization** of clients as well as staff. Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission.[27] Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories. For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

1. **Safety**
2. **Trustworthiness and Transparency**
3. **Peer Support**
4. **Collaboration and Mutuality**
5. **Empowerment, Voice and Choice**
6. **Cultural, Historical, and Gender Issues**

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

The six key principles fundamental to a trauma-informed approach include:[24,36]

1. **Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. **Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.

3. **Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term "Peers" refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as "trauma survivors."

4. **Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: "one does not have to be a therapist to be therapeutic."[12]

5. **Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.[34] Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.

6. **Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Guidance for Implementing a Trauma-Informed Approach

Developing a trauma-informed approach requires change at multiples levels of an organization and systematic alignment with the six key principles described above. The guidance provided here builds upon the work of Harris and Fallot and in conjunction with the key principles, provides a starting point for developing an organizational trauma-informed approach.[20] While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives. Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a "checklist" or a prescriptive step-by-step process. These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care.[35,36,37,38] What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content.

TEN IMPLEMENTATION DOMAINS

1. **Governance and Leadership**
2. **Policy**
3. **Physical Environment**
4. **Engagement and Involvement**
5. **Cross Sector Collaboration**
6. **Screening, Assessment, Treatment Services**
7. **Training and Workforce Development**
8. **Progress Monitoring and Quality Assurance**
9. **Financing**
10. **Evaluation**

GOVERNANCE AND LEADERSHIP: The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within the organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

POLICY: There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be "hard-wired" into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

PHYSICAL ENVIRONMENT OF THE ORGANIZATION: The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of a trauma informed approach through openness, transparency, and shared spaces.

ENGAGEMENT AND INVOLVEMENT OF PEOPLE IN RECOVERY, TRAUMA SURVIVORS, PEOPLE RECEIVING SERVICES, AND FAMILY MEMBERS RECEIVING SERVICES: These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach that differentiates it from the usual approaches to services and care.

CROSS SECTOR COLLABORATION: Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization's mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

SCREENING, ASSESSMENT, AND TREATMENT SERVICES: Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach. Trauma screening and assessment are an essential part of the work. Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

TRAINING AND WORKFORCE DEVELOPMENT: On-going training on trauma and peer-support are essential. The organization's human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals with complex trauma.

PROGRESS MONITORING AND QUALITY ASSURANCE: There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments and treatment.

FINANCING: Financing structures are designed to support a trauma-informed approach which includes resources for: staff training on trauma, key principles of a trauma-informed approach; development of appropriate and safe facilities; establishment of peer-support; provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and development of trauma-informed cross-agency collaborations.

EVALUATION: Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

To further guide implementation, the chart on the next page provides sample questions in each of the ten domains to stimulate change-focused discussion. The questions address examples of the work to be done in any particular domain yet also reflect the six key principles of a trauma-informed approach. Many of these questions and concepts were adapted from the work of Fallot and Harris, Henry, Black-Pond, Richardson, & Vandervort, Hummer and Dollard, and Penney and Cave.[39, 40, 41,42]

While the language in the chart may seem more familiar to behavioral health settings, organizations across systems are encouraged to adapt the sample questions to best fit the needs of the agency, staff, and individuals being served. For example, a juvenile justice agency may want to ask how it would incorporate the principle of safety when examining its physical environment. A primary care setting may explore how it can use empowerment, voice, and choice when developing policies and procedures to provide trauma-informed services (e.g. explaining step by step a potentially invasive procedure to a patient at an OBGYN office).

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

KEY PRINCIPLES					
Safety	**Trustworthiness and Transparency**	**Peer Support**	**Collaboration and Mutuality**	**Empowerment, Voice, and Choice**	**Cultural, Historical, and Gender Issues**
10 IMPLEMENTATION DOMAINS					
Governance and Leadership	• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? • How do the agency's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? • How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?				
Policy	• How do the agency's written policies and procedures include a focus on trauma and issues of safety and confidentiality? • How do the agency's written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery? • How do the agency's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training? • How do human resources policies attend to the impact of working with people who have experienced trauma? • What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?				

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Physical Environment	• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? • In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this? • How has the agency provided space that both staff and people receiving services can use to practice self-care? • How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).
Engagement and Involvement	• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services? • How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information? • How is transparency and trust among staff and clients promoted? • What strategies are used to reduce the sense of power differentials among staff and clients? • How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
Cross Sector Collaboration	• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions? • Are collaborative partners trauma-informed? • How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services? • What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?
Screening, Assessment, Treatment Services	• Is an individual's own definition of emotional safety included in treatment plans? • Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? • Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? • How are peer supports integrated into the service delivery approach? • How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women? • Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding? • How are these trauma-specific practices incorporated into the organization's ongoing operations?

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Training and Workforce Development	• How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences? • How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? • How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? • How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety? • How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors. • What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? • What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?
Progress Monitoring and Quality Assurance	• Is there a system in place that monitors the agency's progress in being trauma-informed? • Does the agency solicit feedback from both staff and individuals receiving services? • What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency? • How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes? • What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?
Financing	• How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? • What funding exists for cross-sector training on trauma and trauma-informed approaches? • What funding exists for peer specialists? • How does the budget support provision of a safe physical environment?
Evaluation	• How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach? • How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? • What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality? • What measures or indicators are used to assess the organizational progress in becoming trauma-informed?

Next Steps: Trauma in the Context of Community

Delving into the work on community trauma is beyond the scope of this document and will be done in the next phase of this work. However, recognizing that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process.

Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.

Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not. The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

Conclusion

As the concept of a trauma-informed approach has become a central focus in multiple service sectors, SAMHSA desires to promote a shared understanding of this concept. The working definitions, key principles, and guidance presented in this document represent a beginning step toward clarifying the meaning of this concept. This document builds upon the extensive work of researchers, practitioners, policymakers, and people with lived experience in the field. A standard, unified working concept will serve to advance the understanding of trauma and a trauma-informed approach for public institutions and service sectors.

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Trauma-informed care in child/family welfare services

Liz Wall, Daryl Higgins and Cathryn Hunter

CHILD FAMILY COMMUNITY AUSTRALIA | INFORMATION EXCHANGE

This paper aims to define and clarify what trauma-informed service delivery means in the context of delivering child/family welfare services in Australia. Exposure to traumatic life events such as child abuse, neglect and domestic violence is a driver of service need. Policies and service providers must respond appropriately to people who are dealing with trauma and its effects in order to ensure best outcomes for individuals and families using these services. In addition to evidence-based programs or clinical interventions that are specific to addressing trauma symptoms, such as trauma-focused cognitive behaviour therapy, there is a need for broader organisational- or service-level systems of care that respond to the needs of clients with a lived experience of trauma that go beyond a clinical response. Some of the challenges identified in implementing and embedding trauma-informed care across services and systems are discussed.

KEY MESSAGES

- Traumatic experiences are common, with people often having multiple adverse experiences across their life. There are many serious and deleterious outcomes associated with exposure to them.
- Clients often present to child/family welfare services with a complex range of symptoms and behaviours related to prior and/or past trauma, which neither they nor those working with them have linked to this previous trauma exposure. As a result they may face an uninformed and fragmented response that is potentially re-traumatising.
- There are a small number of trauma-specific interventions that have been evaluated using a rigorous scientific standard and been shown to be effective—however, the research is often based on populations who have experienced a single traumatic event rather than complex trauma.
- Trauma-informed care is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.
- With the lack of an overarching framework in Australia, there is a danger of inconsistent or piecemeal development of trauma-informed models and practices that do not share a consistent language or framework for implementing trauma-informed systems of care in child/family services.
- As trauma affects a large proportion of the population, survivors are clients in a broad range of human services, and organisations across all settings should consider how a trauma-informed approach could benefit stakeholders, regardless of whether or not the organisation also provides evidence-based trauma-specific interventions.
- Challenges to implementing a trauma-informed approach to care include: a lack of clearly articulated definitions (e.g. of trauma-specific interventions vs the concept and principles of trauma-informed care); translating trauma-informed care to specific practice and service settings; consistency across service settings and systems; care-coordination; a lack of guidance for facilitating complex system change; and a lack of evaluation of models of trauma-informed care.
- Research is needed to explore whether different trauma-informed approaches are required for different population groups, including children, adolescents and adults, or for males and females.

Understanding the experiences of adversity in childhood such as sexual or other abuse as trauma is now recognised to be an important concept for human service delivery sectors. The USA has led efforts to incorporate trauma theory into mental health and other service delivery, largely driven by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA funds two major trauma-related resources, the National Center for Trauma-Informed Care (NCTIC) and the National Child Traumatic Stress Initiative (NCTSI), to provide a focus for developing a shared language and evidence base around trauma and trauma-informed approaches to service. Emerging

efforts in Australia are now contributing to our knowledge of effective practice for children, young people and adults who have experienced trauma from events such as child maltreatment, sexual assault, military service, forced adoption and past family separation practices.

This paper aims to define and clarify what trauma-informed service delivery means in an Australian context. Australia is not as far down the track as the USA in terms of implementing a trauma-informed approach to human service provision in systems such as mental health and child and family services. There is, however, a recognition that exposure to traumatic life events is a driver of service need and that policies and service providers must address and respond to trauma appropriately to ensure best outcomes for individuals and families using these services.

Trauma terminology

There has been extensive debate around the classification and terminology for describing the effects of trauma, as well as the relationship to specific diagnostic terms such as post-traumatic stress disorder (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005; Wall & Quadara, 2014). The latest iteration of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), an international classification system for mental health disorders, has taken a broad approach to the terminology with a category of "Trauma and Stressor Related Disorders" rather than specifically including complex trauma as a diagnostic term.

Any discussion of trauma-informed service delivery requires consideration of the vast array of definitions and terminology that arises around trauma. This section explains some of the different terms, phrases and concepts that are used in the literature to describe trauma and trauma-related service provision.

Recently, there have been attempts to provide consistency in definitions and a shared language around trauma and a trauma-informed approach to care. SAMHSA's (2014) *Concept of Trauma and Guidance for a Trauma-Informed Approach* puts forward definitions and a working concept of trauma and a trauma-informed approach in order to develop a shared understanding of these concepts for service systems and stakeholders. SAMHSA is a key resource for trauma-informed approaches to care and these definitions are likely to be widely adopted.

What is trauma?

Traumatic events have been described as those that "overwhelm the ordinary human adaptations to life [and] … generally involve threats to life or bodily integrity, or a close personal encounter with violence and death" (Herman, 1992, p. 33). SAMHSA's concept of trauma provides a comprehensive definition that encompasses trauma related to one-off events as well as ongoing adversity:

> Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing. (SAMHSA, 2014, p. 7)

Although not diagnostic terms, *complex trauma* and *complex post-traumatic stress disorder* are often used to describe trauma that is the result of stressors that are interpersonal—usually severe, sustained and perpetrated by one human being on another—and where clients may not meet all of the specific diagnostic criteria for post-traumatic stress disorder (PTSD) or where the primary clinical presentation is the associated features due to the global effects of trauma on the person's functioning (Connor & Higgins, 2008a, 2008b). Trauma is particularly damaging when it occurs in childhood. Complex, interpersonally generated trauma is severely disruptive of a person's capacity to manage internal states (Kezelman & Stavropoulos, 2012). Complex trauma symptoms include problems with mood regulation, impulse control, self-perception, attention, memory and somatic disorders (Briere & Jordan, 2004; Burstow, 2003; van der Kolk et al., 2005).

Trauma-informed interventions occur at two levels: trauma-specific interventions and trauma-informed models of care. Organisational responses to trauma tend to occur on a continuum from basic trauma awareness, to trauma sensitivity, trauma responsivity and through to trauma-informed and/or trauma-specific interventions. We argue here that it is helpful for organisations providing services in the child/family welfare domain, and human services more broadly, to think about their organisational responses to trauma based on their particular service and client needs.

Trauma-specific interventions

Trauma-specific interventions refer to clinical services or programs designed to treat and ameliorate the actual symptoms and presentations of trauma. While it is possible for individual practitioners to deliver trauma-specific interventions (such as trauma-focused cognitive behaviour therapy [CBT]) within the context of a service delivery model or agency that is not trauma-informed at a system level, this is far from ideal. Elements of a service may not be consistent with a trauma-informed approach—such as the waiting room design and operation, interactions with administrative staff or the absence of adjunct services to address other presenting issues for which the trauma-specific intervention might not be effective. Trauma-specific services are best delivered as part of a trauma-informed system of care operating within a trauma-aware organisational context (Elliot, Bjelajac, Fallor, Markoff, & Reed, 2005; Kezelman & Stavropoulos, 2012).

Funded by the Department of Veterans' Affairs, Phoenix Australia (previously known at the Australian Centre for Posttraumatic Mental Health) has developed a database that summarises the evidence for effective trauma-specific interventions related to military and veteran families and communities (see *What Emerging Interventions are Effective for the Treatment of Adults with PTSD?* <www.evidencecompass.dva.gov.au/home/question/10>). Regarding adults suffering from PTSD, they found a paucity of evidence in relation to the efficacy of emerging therapies.[1] Phoenix Australia have also published a variety of resources for practitioners working with people affected by trauma, including fact sheets, clinical guidelines, booklets for clients and a smartphone app for clients with post-traumatic stress symptoms <phoenixaustralia.org/for-practitioners/practitioner-resources>.

Trauma-focused cognitive behaviour therapy (TF-CBT) is an evidence-based treatment approach for children who have experienced sexual abuse, exposure to domestic violence or similar traumas.[2] TF-CBT features on a range of databases of evidence-based practices, including the California Evidence-Based Clearinghouse for Child Welfare (CEBC) Program Registry: <www.cebc4cw.org>. Training in TF-CBT is available online from the Medical University of South Carolina website: <tfcbt.musc.edu>. However, a full discussion of evidence-based trauma-specific interventions is beyond the scope of this paper.[3]

Similarly, in relation to adults affected by childhood trauma, Connor and Higgins (2008a, 2008b) outlined a model of trauma-specific intervention for clients who experience complex trauma (who may not meet the criteria for PTSD). Evaluating the model, they found qualitative and quantitative evidence from a small-scale pilot study of the effectiveness of their combined individual and group therapy approach focused on the following elements (using the mnemonic "HEALTH"):

- having a supportive therapist;
- ensuring personal safety;
- assisting with daily functioning;
- learning to manage core PTSD symptoms (self-regulation);
- treating complex PTSD symptoms; and
- having patience and persistence to enable "ego strengthening".

1 The emerging interventions included in their review were: mindfulness, acceptance and commitment therapy, meditation, transcendental meditation, acupuncture, power therapies, and experiential psychotherapies including adventure therapy, art therapy, music therapy, and canine- and equine-assisted psychotherapy. See: <evidencecompass.dva.gov.au/home/question/10>.

2 See: *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma* (Child Welfare Information Gateway, 2012) <www.childwelfare.gov/pubpdfs/trauma.pdf>.

3 See *Approaches Targeting Outcomes for Children Exposed to Trauma Arising From Abuse and Neglect: Evidence, Practice and Implications* (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2014) for a discussion of the evidence of the effectiveness of trauma-specific and trauma-informed practices pertaining specifically to children who have experienced abuse and neglect.

However, there have been criticisms made of trauma-specific interventions. For example:

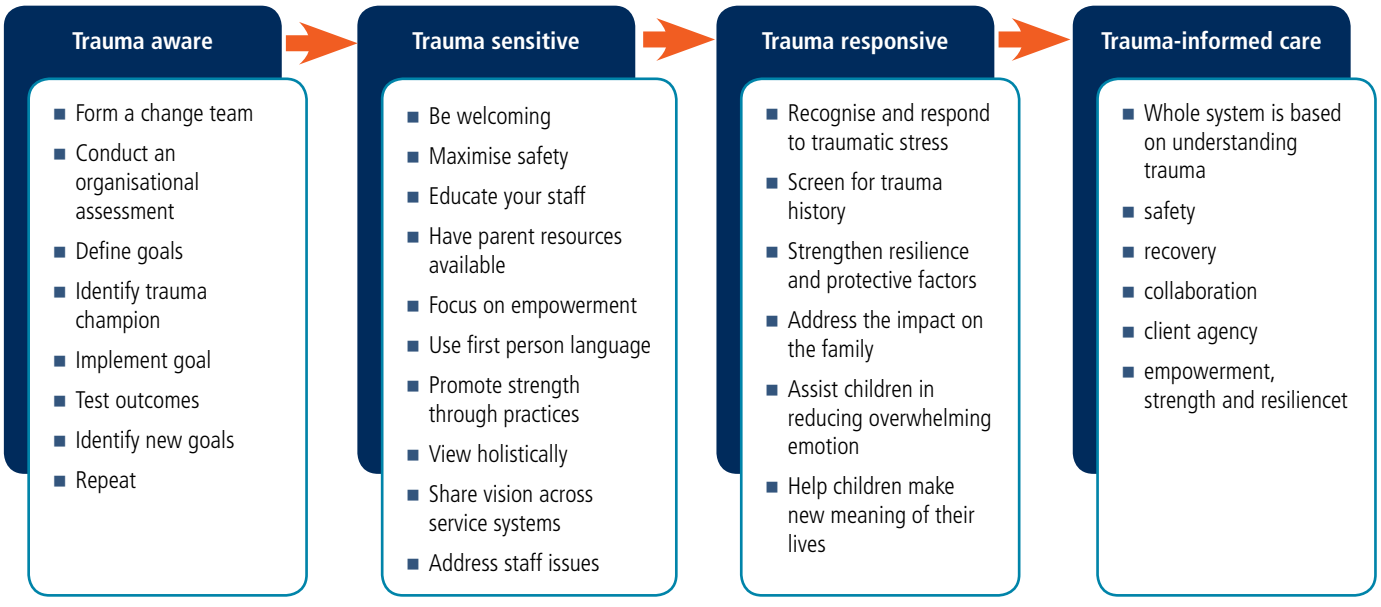
- complex trauma is often inter-relational in nature, so the degree to which research on the treatment of combat-related PSTD applies in these circumstances has been questioned (e.g. for those exposed to prolonged child sexual abuse, particularly if it has resulted in personality or dissociative disorders and is associated with disturbances to affect regulation, self-concept and interpersonal relationships);
- treatment sessions may need to be more frequent and over a longer duration than typical structured programs;
- evaluations of cognitive-based interventions often focus on statistically significant effect sizes rather than clinically meaningful symptom reduction; and
- the value of non-cognitively based interventions, which have been poorly evaluated or not evaluated, are easily overlooked (see: van der Kolk, 2014).

The primary purpose of the paper is not to review the effectiveness—or limitations—of trauma-specific interventions, or even to look specifically at complex trauma and complex PTSD (see: Wall & Quadara, 2014); but rather to explore the broader issue of the value and role of trauma-informed care in child and family welfare service provision.

Trauma-informed model of care

The available literature suggests that there is a continuum from being *trauma aware* (seeking information out about trauma and its implications for organisations) to being *trauma-informed* (a cultural shift at the systemic level). One useful resource sets out the progression in four stages (see Figure 1):

- *trauma aware*: seek information out about trauma;[4]
- *trauma sensitive*: operationalise concepts of trauma within the organisation's work practice;
- *trauma responsive*: respond differently, making changes in behaviour;
- *trauma informed*: entire culture has shifted to reflect a trauma approach in all work practices and settings.



Source: Adapted by Antonia Quadara from Mieseler & Myers (2013)

Figure 1: Practical steps to get from trauma aware to trauma informed

4 At its most basic level, organisations that are trauma aware incorporate trauma awareness into their work. Staff have an understanding of trauma and how symptoms and behavioural presentations in individuals may be responses to traumatic experiences so that behaviours that appear self-destructive or self-defeating can be acknowledged as being adaptive behaviours to trauma that have become maladaptive over time (Hopper, Bassuk, & Olivet, 2010; Markoff, Fallot, Reed, & Elliot, 2005). This applies particularly to broader human service delivery agencies (beyond child/family welfare), particularly if they are not primarily focused on delivering trauma-specific interventions and/or trauma-informed models of care.

SAMHSA's definition of a trauma-informed approach to service is:

> A program, organisation or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff and others involved with the system and responds by fully integrating knowledge about trauma into policies, procedures and practices and seeks to actively resist retraumatisation (SAMHSA, 2014, p. 9)

The main aim of this paper is to explore trauma-informed approaches to care and service delivery specifically in the child and family welfare sectors. While the focus is on how child/family welfare services can be trauma informed, the need extends to other service delivery areas. The trauma literature indicates that trauma survivors are clients in a very broad range of human services such as:

- homelessness (Hopper et al., 2010; Morrison 2009);
- mental health (Kezelman & Stavropoulos, 2012; Muskett, 2014);
- substance abuse treatment; and
- correctional systems (Stathopoulos, 2012).

These types of services have a clear connection to the impacts of trauma, particularly trauma arising from interpersonal victimisation, which has been identified as a driver of human service use (Huntington, Moses, & Veysey, 2005). The term "complex needs" is sometimes used to describe the span of need for an array of services required over a lifetime (Wall & Quadara, 2014). These agencies and services would benefit from being—at a minimum—"trauma aware".

What is the evidence that a trauma-informed approach is needed?

Research suggests that exposure to adverse, potentially traumatic events in childhood is not uncommon (Anda et al., 2006). For example, the Adverse Childhood Experiences (ACE) study in the USA showed that of 17,337 respondents, 64% had experienced at least one adverse experience[5] and approximately 12% had experienced four or more in the first 18 years of life (Anda et al., 2006). Further to this, a recent report suggested that childhood trauma affects an estimated five million Australian adults (Kezelman, Hossack, Stavropoulos, & Burley, 2015). There is also a great deal of evidence associating traumatic experiences with a broad range of deleterious outcomes in childhood, adolescence and adulthood (e.g. Anda et al., 2006; CFCA, 2014a, 2014b; Dube et al., 2001; Hahn Fox, Perez, Cass, Baglivio, & Epps, 2015; Johnson-Reid, Kohl, & Drake, 2012; Nurius, Green, Logan-Greene, & Borja, 2015).

Individual responses to traumatic experiences vary widely, with not all exposure leading to negative outcomes. It is the individual response to the experience that determines whether it is considered traumatic or not (SAMHSA, 2014). If effects occur they can be short- or long-term and may occur immediately following exposure to adversity or have a delayed onset (SAMHSA, 2014).

Multiple studies have reported negative effects associated with experiencing trauma across all facets of life. Mental ill-health, physical illness, social and relational difficulties, and poor academic and employment outcomes have all been linked to previous traumatic experiences. Anda and colleagues (2006) found a strong relationship between increased numbers of adverse childhood experiences and increased prevalence and risk of:

- affective disturbances (e.g. panic attacks, anxiety, hallucinations);
- somatic disturbances (e.g. sleep disturbance, severe obesity);
- smoking, illicit drug use, injected drug use, alcoholism (for people with four or more adverse childhood experiences);
- early intercourse, promiscuity and sexual dissatisfaction;
- impaired memory of childhood; and

5 The adverse childhood experiences measured were three types of childhood abuse: emotional abuse, physical abuse, and contact sexual abuse; and five measures of household dysfunction during childhood: exposure to alcohol or other substance abuse, mental illness, violent treatment of mother or step-mother, criminal behaviour in the household, and parental separation or divorce (Anda et al., 2006, p. 176).

- high perceived stress, difficulty controlling anger and risk of perpetrating intimate partner violence (for people with four or more adverse childhood experiences).

Further to this, the study found that as the number of adverse childhood experiences increased so too did the average number of co-occurring negative outcomes (Anda et al., 2006). There is strong evidence to indicate that certain types of trauma rarely occur in isolation. Research suggests, for example, that the different child maltreatment types are interrelated: sexual abuse, physical abuse, psychological maltreatment, neglect and exposure to domestic and family violence typically occur in combination with each other. A large proportion of children and young people who experience childhood abuse or neglect are exposed to more than one type of abuse (known as "multi-type maltreatment"; Price-Robertson, Higgins, & Vasallo, 2013). Further to this, other forms of victimisation such as bullying or assault by a peer have often been found to co-occur with child maltreatment (known as "poly-victimisation"; see Finkelhor, Ormrod, & Turner, 2007).

Multiple victimisation experiences across different domains are consistently associated with poorer outcomes than a single adverse or maltreatment experience. Those who experience multi-type maltreatment or poly-victimisation are more likely to experience high levels of trauma symptoms and worse outcomes than those who are exposed to no maltreatment or only one type (Finkelhor et al., 2007; Higgins & McCabe, 2001). Supporting these findings, a recent large scale US study of children in the Illinois child welfare system found that children who experienced both violent interpersonal *and* attachment-based ("non-violent") traumas within the caregiver system experienced greater difficulties across several areas of impairment (including attention/behavioural dysregulation and self/relational dysregulation) and were significantly more likely to exhibit PTSD-like symptoms compared to children who had experienced neither type of trauma, violent trauma only or non-violent trauma only (Kisiel et al., 2014).

Co-occurring mental health issues and disorders such as conduct disorder and oppositional defiant disorder (in children), PTSD, depression and other affective disorders, borderline personality disorder, somatoform disorders, psychotic and dissociative disorders have commonly been associated with traumatic experiences (Bateman, Henderson, & Kezelman, 2013; Breslaue, 2009; CFCA, 2014a, 2014b; Nurius et al., 2015; van der Kolk et al., 2005). Self-harm and suicide attempts have also been linked with previous traumatic experiences (Bateman et al., 2013; Cozolino, 2010; Dube et al., 2001; Herman, 1992; Johnson-Reid et al., 2012). In one study, Dube and colleagues (2001) reported that any adverse childhood experience increased the risk of attempted suicide by 2–5 fold with the relationship being partially mediated by illicit drug use, depressed affect and self-reported alcoholism.

Those who have had previous traumatic experiences also commonly report physical health issues. For example, in summarising research on the potential effects of trauma exposure, Bateman and colleagues (2013) found that "survivors of child maltreatment were at increased risk of hepatitis, diabetes, heart disease, cancer, a stroke, are more likely to have surgery and are at increased risk of having one or more chronic pain symptoms" (p. 19). The same authors also noted a range of conditions that child sexual abuse survivors were at increased risk of, including irritable bowel syndrome, asthma, arthritis and digestive problems.

In addition, childhood trauma exposure has been linked to involvement with the criminal justice system. A large study exploring adverse childhood experiences of serious, chronic and violent juvenile offenders and juveniles referred to the justice system for single non-violent offences found that every additional adverse childhood event experienced increased the risk of becoming a serious, chronic and violent juvenile offender by more than 35%, even when other known risk factors for violent behaviour were accounted for (Hahn Fox et al., 2015).

Lastly, difficulties in interpersonal relationships are often reported as a result of experiencing trauma (Bateman et al., 2013; Briere & Spinazzola, 2005; Evans & Coccoma, 2014; van der Kolk, 2005).

Although individual responses to traumatic experiences may vary widely, research has found a strong relationship between the degree of risk of experiencing multiple and complex negative outcomes following traumatic experiences and factors such as the age at which the experience/s occurred, the nature of the experience/s (with negative effects being particularly associated with

trauma of an interpersonal nature such as child abuse and neglect), and the severity and chronicity of the experiences (Cozolino, 2010; Herman, 1992; Kisiel et al., 2014; National Scientific Council on the Developing Child, 2014 [NSCDC]; Resick et al., 2012; van der Kolk et al., 2005). As noted by Cozolino (2010):

> The impact of trauma depends on a complex interaction of the physical and psychological stages of development during which it occurs, the length and degree of the trauma, and the presence of vulnerabilities or past traumas. The impact of chronic trauma becomes woven into the structure of personality and is hidden behind other symptoms, making it difficult to identify, diagnose and treat. (p. 266)

Traumatic events experienced early in life can be extremely damaging to the developing brain. Neural development relies on the interplay of genes and environmental inputs (particularly interaction with primary carers) and early adversity or disrupted attachment relationships that lead to chronic high levels of stress can interfere with key neurobiological development (NSCDC, 2014). Pamela Alexander (2013) suggested that "affective synchronization between mother and child" (p. 45) in carer–infant interactions is crucial for brain development, social development and stress regulation. Early onset, sustained trauma that interferes with this can lead to deficits in multiple domains: dysfunction in fear extinction; affect or emotional regulation; behaviour regulation; learning, cognition and attention; and self and relational dysregulation (Cook et al., 2005; Courtois & Ford, 2009; Evans & Coccoma, 2014; Kisiel et al., 2014; NSCDC, 2014; van der Kolk et al., 2005).

Research has also highlighted that experiencing traumatic events tends to increase the chances of experiencing further traumatic events across the life course. Cozolino (2010) argued that:

> Enduring personality traits and coping strategies that emerge in these situations [experiencing early onset, sustained trauma] tend to decrease positive adaptation and increase an individual's vulnerability to future trauma. This can manifest through engagement in abusive relationships, poor judgement, or a lack of self-protection. (pp. 268–9)

Finally, in examining the need for a trauma-informed approach to care it is pertinent to note that in many cases, due to the co-occurrence of problems resulting from experiencing trauma, individuals may find themselves in multiple systems, cycling in and out of specific services over many years to access, for example, treatment for drug and alcohol addictions, support for employment opportunities and therapeutic services for mental illness.

Historically, the underlying factor often linking a constellation of needs together—the history of abuse and its impacts—has not been adequately acknowledged or integrated into these service systems' service responses to individuals (Harris & Fallot, 2001). Further, populations with complex needs are at high risk of falling through the gaps of service delivery systems due to a lack of service co-ordination and the related barriers to service integration (Whiteford & McKeon, 2012). This can mean that clients: are deemed ineligible for services (e.g. cannot engage in mental health treatment until they have "dealt with" their substance abuse issue or vice versa); are expected to separate out their trauma experiences from their service or treatment needs ("we don't deal with trauma in this parenting class"); and experience services systems' responses as re-traumatising.

The SAMHSA-funded *Women With Co-Occurring Disorders and Violence Study* was a comprehensive 5-year project (1998–2003) across multiple sites, which provided evidence that integrating different services, such as mental health and substance abuse services where there was client need for both, was effective. This study showed that trauma-informed approaches could enhance the effectiveness of mental health and substance abuse services for women with co-occurring mental health and substance abuse disorders (Huntington et al., 2005; Morrisey et al., 2005). A trauma committee for this study also developed an understanding of trauma-informed principles and ways in which mental health and substance abuse service providers could use the approach (Elliot et al., 2005). In the years since the study, further development, debate and discussion has resulted in an expanded evidence base about the effects of trauma and appropriate approaches for services.

What is trauma-informed care?

Trauma-informed care could be described as a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs (Harris & Fallot, 2001). This requires consideration of a person's environment beyond the immediate service being provided and of how their symptoms and presentations may be seen as adaptations to trauma rather than as pathologies (Herman, 1992). At the broadest level, trauma-informed care means that services have an awareness and sensitivity to the way in which clients' presentation and service needs can be understood in the context of their trauma history (Knight, 2015). Kezelman and Stavropoulos (2012) noted that trauma-informed health and welfare settings and systems contrast dramatically with traditional settings and systems as they require different ways of operating, and without this understanding, risk re-traumatising service users. Trauma-informed approaches to care could be described as a strengths-based framework that is responsive to the effects of trauma (Bateman et al., 2013).

Principles of trauma-informed care

Principles of trauma-informed care have been articulated in a range of academic literature and guidance publications (Elliot et al., 2005; Hopper et al., 2010; Jennings, 2004; Kezelman & Stavropoulos, 2012; SAMHSA, 2014). These principles vary in length and number depending on the publication but essentially have the same underlying philosophies, that trauma-informed care means services are trauma aware, safe, strengths-based and integrated.

At the very minimum, trauma-informed services aim to do no further harm through re-traumatising individuals by acknowledging that usual operations may be an inadvertent trigger for exacerbating trauma symptoms. SAMHSA's (2014) approach to trauma-informed care makes four key assumptions that must be present as a basis of implementation for trauma-informed care, with a further six key principles to then be applied.

The key assumptions that SAMHSA has identified as needing to be inherent in any trauma-informed approach are based on four "R"s:

- *Realisation* at all levels of an organisation or system about trauma and its impacts on individuals, families and communities;
- *Recognition* of the signs of trauma;
- *Response*—program, organisation or system responds by applying the principles of a trauma-informed approach; and
- *Resist* re-traumatisation—of clients as well as staff.

In addition to these assumptions, SAMHSA (2014) then described six key principles of a trauma-informed approach:

- *Safety*—Staff and the people they serve feel physically and psychologically safe.
- *Trustworthiness and transparency*—Organisational operations and decisions are transparent and trust is built.
- *Peer support*—Peers is the terminology SAMHSA use for individuals with lived experience of trauma or their caregivers. Peers are also known as "trauma survivors".
- *Collaboration and mutuality*—This principle is about levelling power differentials between staff and clients and amongst organisational staff to ensure a collaborative approach to healing.
- *Empowerment, voice and choice*—This principle emphasises the strengths-based nature of trauma-informed care. The organisation—and ideally the whole service delivery system—fosters recovery and healing.
- *Cultural, historical and gender issues*—A trauma-informed approach incorporates processes that move past cultural stereotypes and biases, and incorporates policies, protocols and processes that are responsive to the cultural needs of clients.

For an example of an Australian model of trauma-informed care, see Tucci and Mitchell's (2015) outline of the basic understanding of trauma that informs appropriate care underpinning the services and training provided by the Australian Childhood Foundation: *9 Plain English Principles of Trauma Informed Care* <www.childhood.org.au/blog/home/2015/april/trauma-informed-care>.

The Berry Street Childhood Institute also provides a number of resources and training on trauma-informed care for children: <www.childhoodinstitute.org.au/Resources>.

Achieving trauma-informed services: Reflection questions for service managers

- What is the likelihood of clients who have experienced trauma accessing our service?
- Do we provide access to trauma-specific evidence-based treatments for current psychological difficulties that result from that trauma (e.g. Trauma-focused cognitive-behaviour therapy)?
  - See *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma* <www.childwelfare.gov/pubpdfs/trauma.pdf>
- Do we provide access to effective treatments for complex trauma and complex PTSD (for which trauma-specific treatments may not be as effective)?
  - (See: Connor & Higgins, 2008a, 2008b; Kezelman & Stavropoulos, 2012).
- Are these trauma-specific interventions provided inhouse, in collaboration with other agencies, or via referral to an external agency (and if so, do we provide active/warm referral)? See:
  - *Interagency collaboration: Part A. What is it, what does it look like, when is it needed and what supports it?* <aifs.gov.au/cfca/publications/interagency-collaboration-part-what-it-what-does-it>
  - *Interagency collaboration: Part B. Does collaboration benefit children and families? Exploring the evidence.* <aifs.gov.au/cfca/publications/interagency-collaboration-part-b-does-collaboration-benefi>
  - *Effective practices for service delivery coordination in Indigenous communities*. <www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2011/ctgc-rs-08.pdf>
- How do we incorporate restorative justice principles?
  - According to Higgins et al. (2014), restorative justice activities might include:
    - addressing trauma and other mental health consequences through evidence-based therapeutic interventions;
    - repairing the injuries caused to relationships, especially between sons/daughters and parents;
    - providing opportunities for truth-telling, storytelling and acknowledgement; and
    - overcoming shame and recognising past actions through public activities and community awareness campaigns.
  - See: Higgins et al., 2014, pp. 41–46: *Forced Adoption Support Services Scoping Study* <www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/forced-adoption-support-services-scoping-study>
- Who in the organisation is likely to come into contact with individuals who have experienced trauma, or be providing information to, or receiving communications from clients experiencing trauma? Thinking from a "client journey" perspective, this might include:
  - phone/intake staff;
  - web/staff with online monitoring;
  - reception;
  - office manager;
  - media and communications staff;
  - other staff or contractors on the premises (e.g. catering, cleaning, security); and
  - project/service delivery professionals and support staff.

- Who is less likely to be interacting with trauma survivors but who need to understand, and who need to support "front-line" workers and other support staff who do?
  - executive staff (who create the authorising environment);
  - managers and team leaders; and
  - mentors and supervisors.

This suggests the value of whole-of-organisation approaches to trauma-informed service delivery, directed at every level to ensure a focus on what helps clients feel safe.

- What should training encompass? Training should include:
  - skills in de-escalation or "holding" clients who are experiencing an acute episode of trauma or re-traumatisation;
  - debriefing and staff protocols for responding to difficult situations and clients presenting with complex circumstances and trauma histories;
  - information on staff care and preventing/responding to secondary or vicarious trauma—the psychological term for changes that can occur to people when they are repeatedly exposed to traumatic material (see <aifs.gov.au/publications/feeling-heavy>);
  - organisational supports to prevent or address vicarious trauma for staff including: clinician self-care skills and reflective practice, caseload management, supervision, debriefing, staff and peer support, workplace safety, comfort and supportive work culture that acknowledges the reality of vicarious trauma (Morrison, 2007);
  - types of events/circumstances in clients' lives that may be traumatising;
  - typical modes of reacting—events/triggers for re-traumatisation; and
  - understanding the impacts of trauma (such as behavioural symptoms typical of PTSD, as well as the developmental impacts of victimisation and trauma on an individual's beliefs—about the self, the world, and the future—e.g. see: Janoff-Bulman & Frieze, 1983).

Further to this, SAMHSA also provide a range of sample questions to consider when implementing a trauma-informed approach <store.samhsa.gov/shin/content//SMA14–4884/SMA14–4884.pdf> (p.14–16).

Which services should be delivering trauma-informed care?

Most of the US literature about trauma-informed care is directed at change in behavioural health services. In Australia there appears to be an emphasis on driving change in the mental health sector. This has the potential to cause confusion about the pathway to providing trauma-informed care in the child, family and community sectors and about what being trauma-informed actually means. One aspect of clarifying these questions is to understand which services should be adopting a trauma-informed approach to human service delivery.

In addition, there are communities and populations for whom violence and intergenerational trauma are a constant reality. Some Indigenous communities, for example, experience the phenomenon of trans-generational trauma whereby trauma is transmitted across a number of generations (Atkinson, 2002). The historical impacts of colonisation on Aboriginal people in Australia have played out in a history of disadvantage and discrimination as traditional Aboriginal life was gradually disrupted and dismantled (Atkinson, 2002; Keel, 2004). The effectiveness of the full range of health and human services in such communities could be enhanced by a trauma-informed approach (Atkinson, 2013).

As outlined in the earlier discussion on principles of trauma-informed care, it is important for services to be culturally attuned and relevant (Atkinson, 2013). This is described by SAMHSA as the principle that the trauma-informed organisation actively moves past cultural and gendered stereotypes and incorporates policies and processes that are responsive to the cultural needs of individuals served, including addressing historical trauma (SAMHSA, 2014) or collective trauma (Atkinson, 2013).

Building on the work of Harris and Fallot, SAMHSA's (2014) *Concept of Trauma and Guidance for a Trauma-Informed Approach* outlined ten implementation domains:

- governance and leadership;
- policy;
- physical environment;
- engagement and involvement;
- cross-sector collaboration;
- screening, assessment, treatment services;
- training and workforce development;
- progress monitoring and quality assurance;
- financing; and
- evaluation (p. 12).

This guidance information is designed to provide a starting point for an organisational approach to implementing trauma-informed care. It also indicates that organisations across *all* settings should consider how trauma-informed approaches could benefit stakeholders regardless of whether they deal with trauma in their day-to-day business. The reality of the prevalence of traumatic experiences in the general population indicates that trauma is not confined to prevention, treatment and recovery settings but is integral in other systems as well (SAMHSA, 2014).

It is important to note that many practices that service providers currently use are likely to already be consistent with a trauma-informed approach, such as conveying empathy and validating the client's experiences (Knight, 2015). What is different about identifying as a trauma-informed service is that there is a paradigm shift in service delivery culture to acknowledge and clearly articulate the importance of trauma in understanding and responding to client presentation.

With the lack of an overarching framework in Australia, there is a danger of developing trauma-informed models and practices that are not sharing a consistent language about what being trauma-informed entails. This issue is discussed in more depth in the section about challenges to implementation later in this paper.

The need for a systems approach to trauma-informed care

Following the lead of the USA, Australian health agencies are moving towards a trauma-informed paradigm for considering health and human service delivery systems (Kezelman & Stavropoulos, 2012) in preference to a medical model of individual illness (DeCanandia, Guarino, & Clervil, 2014).

The effects of traumatic experience often manifest in behaviours that result in people being involved in human service systems that go beyond mental health, such as the criminal justice system (SAMHSA, 2014). A systems approach to trauma-informed care means that implementation goes beyond individual practitioner and service organisation change to extend to whole systems that people who have experienced trauma are likely to interact with. A system, for example, could include the justice, homelessness or child welfare systems. These systems may not include treatment settings but can still affect the people who experience them. In the USA, a range of systems are in the process of adopting a cross-sectoral approach to implementing trauma-informed care and trauma-specific services to support service users (DeCanandia et al., 2014). For example, the behavioural health and health care, veterans' administration, homelessness and education sectors are just a few of the systems that are shifting to a trauma-informed approach (DeCanandia et al., 2014).

The differences between trauma-informed services and trauma-specific services are described in the definitions outlined earlier. It is important to distinguish between them but acknowledge the intersection of the two types. Trauma-specific services are designed to treat the symptoms or manifestations of the effect of a trauma on an individual but these interventions must be delivered in a trauma-informed context. This emphasises an overall philosophy of trauma as a central concept in understanding the presentation of clients within a range of health and welfare settings (Kezelman & Stavropoulos, 2012).

Challenges in implementing a trauma-informed approach to care

As noted previously, implementing trauma-informed care requires a paradigm shift in service delivery (Hopper et al., 2010; Jennings, 2004). The literature around trauma-informed care indicates that there are still some challenges to implementing this approach for systems and services, as well as the need for research to evaluate the approach's effect on client wellbeing and other service delivery outcomes (Ashmore, 2013; Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Hopper et al., 2010; Muskett, 2014). These challenges are discussed in the following sections.

Inconsistent understandings of what it means to be trauma-informed

The most identifiable challenges across the literature are in the need to create shared understandings, and current inconsistencies in education regarding trauma-informed care (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Hopper et al., 2010). It is difficult to align organisational change to a specific practice without a shared understanding or vision of what trauma-informed care actually is. In a comparative study of trauma-informed care in acute mental health inpatient units, Ashmore (2013) identified this as an issue in the implementation of trauma-informed care in an acute patient environment. A lack of definition and of a shared framework, as well as a lack of information specific to an acute mental health inpatient setting, were associated with challenges and inconsistency in implementation.

In their review of the literature, the Parenting Research Centre and the Australian Centre for Post-traumatic Health (2013, now Phoenix Australia) found that although participants within the child and family services sector who worked with children exposed to trauma were familiar with terminology such as "trauma-informed care", they argued that:

- the field still lacked clear definitions or understandings of concepts;
- there were assumptions that children's social and behavioural difficulties were necessarily trauma-related without clear assessment; and
- there was a lack of guidelines for assessment and treatment of trauma.

SAMHSA's (2014) recent guidance document is clearly aimed at addressing this lack of consistency in definitions and the 2012 document by Adults Surviving Child Abuse provides some practice guidelines (Kezelman & Stavropoulos, 2012). However, an aspect of trauma-informed care is that it must be culturally relevant to the populations it serves (Elliot et al., 2005; Jennings, 2004) and any broad level articulation of policy approaches or frameworks must be applicable in a range of systems and settings and for a variety of cohorts.

Translating trauma-informed care to specific practice and service settings

In addition to the array of terminology and concepts that are sometimes used interchangeably and inconsistently, there is a lack of evidence-based guidance for specific settings and systems to assist with coordinating how trauma-informed practice should be provided for particular service settings and specific populations of service users. This issue was identified by Muskett (2013) and Ashmore (2013) in relation to mental health nursing, where the need to remove the use of seclusion and restraint is emphasised but, beyond this, little has been articulated to support the use of specific practices for service settings to adopt to improve service delivery consistent with principles of trauma-informed care. Dealing with survivors of trauma, particularly in a mental health or child protection setting, may require individuals to use their prior experience to respond to specific situations. In such stressful and potentially dangerous settings, crisis management could lead to a de-prioritisation of trauma-informed responses (Conners-Burrow et al., 2013). Training and guidance for staff on how to respond to acute situations appropriately and feel confident that they are acting in accordance with the principles of trauma-informed care is recommended (Knight, 2015; Muskett, 2014).

Facilitating complex system change

As noted by the American Institute for Research, in order to build a trauma-informed system, commitment at all system levels is required. This includes a commitment to ongoing training and service transformation (DeCanandia et al., 2014). Australia is behind the USA and Canada in developing models and systemwide responses to children and other service users impacted by trauma (Bateman et al., 2013). For example, the USA has the National Child Traumatic Stress Network, funded by SAMHSA, which brings a singular and comprehensive focus to responding to childhood trauma. Australia is arguably still at the stage of requiring policy change to articulate a clear direction for moving towards systems of trauma-informed care in a range of different service delivery areas relating to child/family wellbeing (Bateman et al., 2013).

Systemic change is important because it enables people to receive services that are sensitive to the impact of trauma regardless of whether they enter through any particular service setting or intervention.

Large-scale systems change is also logistically difficult and time-consuming and requires commitment and resources (Hopper et al., 2010). Philosophical differences between sectors that need to work together to integrate care can also impede systemic change (Hopper et al., 2010). Ashmore (2013) identified particular features of systems change for systems such as mental health that are challenging. These challenges include that hierarchical systems such as health may encounter resistance and that there is an inherent power inequality between service users and professionals in such environments.

Creating change at a systemic level is more than providing practitioners and organisations with tools. It requires changes to funding models to support outcomes rather than outputs, and changes to education for mental health practitioners, social workers and other specialists. Essentially, this is about a move towards a more holistic understanding of the inter-related biological, psychological and social dimensions of trauma.

Evaluating a trauma-informed approach to care

Studies from the USA, particularly following the Women With Co-Occurring Disorders Study, have found that trauma-informed, integrated services are judged to be cost-effective when compared with treatment as usual in the comparison sites of that particular study (Domino, Morrisey, Chung, Huntington, & Larson, 2005). Although this study is regularly cited in the literature as evidence of the cost-effectiveness of trauma-informed care (DeCanandia et al., 2014, Hopper et al., 2010; Kezelman & Stavropoulos, 2012); in reality, there is a lack of evaluation about cost-effectiveness and other aspects of trauma-informed care approaches, including its effectiveness in improving outcomes for service users (Quadara, 2015). There is also a lack of evaluation tools to measure the extent to which an organisation is trauma-informed, and the lack of consistent definitions further translates into difficulties in identifying a clear method to indicate the degree to which a service or program is trauma-informed (Hopper et al., 2010).

Other challenges identified in evaluating trauma-informed care, highlighted by Hopper et al. (2010), include the difficulty in measuring cultural change and sustainability of change and whether changes in outcome are attributable to trauma-informed environments or trauma-specific interventions. In addition, the need for cross-system collaboration and assessing human service interactions to establish the extent of trauma-informed care practice implementation further complicates evaluation in this area (Kramer et al., 2015).

Applying trauma-informed care principles

To illustrate how trauma-informed care principles can be applied to respond to different trauma issues, we briefly look at service delivery in the context of people affected by the policies that created the Stolen Generation, past adoption practices and humanitarian migration.

The Stolen Generation

In their program logic, the Aboriginal and Torres Strait Islander Healing Foundation (2014, p. 25) explain how a collective healing process for members of the Stolen Generation and their descendants can occur, and the mechanisms that underlie this process. Central to this model is an understanding of an Aboriginal world view and the pervasive trauma of colonisation, and the need for specific strategies to address ongoing, collective trauma. A common element of collective healing projects is that they are based on a trauma-informed or recovery framework. According to the Healing Foundation (2014):

> Trauma-informed practice is a strengths-based approach to healing that: is based on an understanding of, and responsiveness to, the impact of trauma; emphasises physical, psychological, and emotional safety for people seeking help and for the helpers; and creates opportunities for people affected by trauma to rebuild a sense of control and empowerment. It recognises the prevalence of trauma and is sensitive to and informed by the impacts of trauma on the wellbeing of individuals and communities. (p. 47)

Forced adoption and past family removal practices

An example of an issue that has only recently received public acknowledgement of its role in traumatising a large number of Australians is the former practice of forced adoption, or separation from family due to past family removal practices. In their exploration of good practice principles for services addressing the needs of people affected by forced adoption and past family removal practices, Kenny, Higgins, and Morley (2015) noted:

> There is increasing recognition of the potential for trauma for individuals who have been subjected to forced adoption policies and practices, and the value of a "trauma-informed" or "trauma-aware" approach to service delivery. Good practice suggests that service providers should approach all clients with a forced adoption experience as if they might be trauma survivors (p. 8).

In their overview of good practice principles, Kenny et al. (2015, p. 8) outlined the key elements of trauma-informed service delivery. Being a trauma-informed service ensures the provision of:

- a safe and supportive environment that protects against physical harm and re-traumatisation;
- an understanding of clients and their symptoms in relation to their overall life background, experiences and culture;
- continued collaboration between service provider and client throughout all stages of service delivery and treatment;
- an emphasis on skill building rather than managing symptoms;
- an understanding of the symptoms and survival responses required to cope;
- a view of trauma as a fundamental experience that influences an individual's identity rather than a single discrete event; and
- a focus on what has happened to a person rather than what is wrong with a person.[6]

Humanitarian migrants surviving torture and trauma

The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) outline the program logic for their service model as systemic and based on an ecological model of factors that influence and support healing for survivors (see *How We Work* <www.startts.org.au/about-us/how-we-work>).

They aim to provide a range of services that reflect the bio-psycho-social model, such as:

- complementary therapies or neurofeedback to address biological impacts;
- counselling to address psychological impacts; and
- community development projects to support social changes.

6 See Forced Adoptions Community of Practice <aifs.gov.au/projects/forced-adoptions-community-practice>.

"There is nothing more practical than a good theory": The theoretical basis of trauma-informed models of care

(a) Attachment—developing a secure base

Attachment theory (Bowlby, 1988) has been used by developmental psychologists to explain positive, secure relationships between infants and caregivers, and how this forms the template for secure adult interpersonal relationships. Disruption to the relationship or insecure attachment is seen as a fundamental mechanism by which childhood trauma affects adult self-concept, wellbeing and interpersonal relationships. Trauma-informed care systems provide a safe environment to expose disruption to the attachment relationship, and build new internal models and "scripts" of the self and relationships.

(b) Self-regulation and control

Social cognitive theories of self-regulation help explain how individuals respond to threatening events. Key components of many trauma-specific treatments are to help individuals to improve self-regulation, safety, security, sense of control and mastery of their environment, and modulate their emotional reactions to traumatic stimuli. Trauma-informed systems of care are aware of the ways in which programs and organisations can trigger traumatic reactions—or even inadvertently replicate the dynamics of the traumatic events/relationships—and seek to minimise them, and promote environments that facilitate positive affect regulation or "modulation".

(c) Fundamental attribution error—overestimating the personal characteristics, underestimating situational factors

Theories of social psychology have identified that humans often make what is termed the "fundamental attribution error", whereby we over-emphasise a person's personality, or internal characteristics, in explaining their behaviour, and underestimate the environmental, or situational factors, that are external influences on their behaviours (e.g. see: Jones & Harris, 1967). For clients who have experienced trauma—particularly complex trauma involving multiple injuries in the interpersonal domain—it is likely that those around them, including their families, their work colleagues and even their health/mental health professionals, are likely to attribute their interpersonal difficulties and deficits in functioning and wellbeing to an inherent personality flaw, rather than having been shaped by their environment (i.e. the external traumatic events they have endured). Creating new environments of support, and opportunities for "reprograming" life scripts are important. But practitioners need to be open to seeing the external influences and specifically target intervention strategies to remediate the long-standing negative consequences.

Source: The title is a quote from Lewin (1952, p. 169)

Moving forward

Much of the literature identified that the paradigm shift towards implementation of a trauma-informed approach to care needed to include commitment from political leadership at all levels (Ashmore, 2013; Bateman et al., 2013; Kramer et al., 2015).

In Australia, the Mental Health Coordinating Council (Bateman et al., 2013) has articulated the requirement for a policy statement from national and state leaders endorsing the concept of trauma as a priority mental health issue and supporting the transition to a trauma-informed service system. This would ensure that there is an identifiable commitment from governments to support the need for trauma-informed service systems.

The broad dissemination of information about trauma-informed, evidence-based best practice has been identified as an important feature of developing the evidence base around trauma (Kramer et al., 2015). Development of a nationally based resource, such as SAMHSA's National Center for Trauma-Informed Care and the National Child Traumatic Stress Network, would provide an Australian-based network of information to support policy development and service delivery and to enable the use of what is currently known about trauma-informed services in different health and human service sectors. Having central resources such as these, is instrumental in shifting human service systems towards a trauma-informed approach to service delivery.[7] Australia does not yet have a body with such a specific focus but extensive work has been undertaken by organisations such as the Mental Health Coordinating Council and Adults Surviving Child Abuse, among others, to help shape behavioural health policy towards incorporating an understanding of the damaging effects of trauma into policy and service delivery approaches.

Although there are some resources and tools now available to support guidance towards trauma-informed systems of care in Australia (Bateman et. al., 2013), there does not appear to be an overarching trauma framework to support a shift in a consistent way. As noted earlier, organisations in Australia have recognised the need for trauma-informed services and

7 See National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint <www.samhsa.gov/nctic>

interventions but the current array of methods, models and interventions on offer and in use do not support a coordinated and common approach that would ensure trauma-informed has a consistent meaning and interpretation in service delivery.

Conclusion

There is growing awareness of the need, and a strong rationale for the value, of implementing a trauma-informed approach to human service delivery. Such an approach has been adopted and implemented extensively in the USA. In Australia, there is a strong push towards trauma-informed approaches to care, and recognition of the impacts of child abuse and other traumas as a driver of service need. However, there is confusion with the array of terminology used and a lack of reference to specific trauma-informed frameworks to guide the introduction of trauma-informed care in a systemic way. Despite the need, and the conceptual/theoretical rationale, it is important to acknowledge that there is limited empirical evidence to show that working systemically to be trauma aware and providing trauma-informed systems of care leads to reductions in trauma symptoms or other positive outcomes for clients.

Currently, there is no overarching policy to mandate trauma-informed care and no framework to guide evidence-based practice to transition in a systematic way to trauma-informed care in Australia. In addition, improvements to collection of research data and adoption of standardised outcome measures for evaluation would support a more systemic approach to evaluating the implementation of trauma-informed care.

There is value in capturing practice-based evidence; however, this is beyond the scope of the current paper, and would be best carried out via a systematic and rigorous approach to gathering and synthesising information from practitioners working with traumatised clients in a variety of fields—as well as the views of those in service delivery systems that are not yet trauma-informed to examine the barriers and enablers of system change. Similarly, there is a need to articulate findings from the emerging field of trauma-informed practice into concrete policy statements or frameworks that can be applied to different client groups within and across a range of service systems and settings.

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At the time of writing **Liz Wall** was a Senior Research Officer at the Australian Institute of Family Studies. **Daryl Higgins** is Deputy Director (Research) and **Cathryn Hunter** is a Senior Research Officer with the Child Family Community Australia information exchange at the Australian Institute of Family Studies.

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Australian Institute of Family Studies
Level 20, 485 La Trobe Street, Melbourne VIC 3000 Australia
Phone: (03) 9214 7888 Fax: (03) 9214 7839 Internet: <www.aifs.gov.au>

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SCHOOLS

TRAUMA-INFORMED SYSTEMS

Child Welfare

Schools

Essential Elements

NCTSN Resources

Justice

Healthcare

CULTURE AND TRAUMA

FAMILIES AND TRAUMA

FAMILY-YOUTH-PROVIDER-PARTNERSHIPS

SECONDARY TRAUMATIC STRESS

Children's reactions to trauma can interfere considerably with learning and behavior at school. Schools serve as a critical system of support for children who have experienced trauma. Administrators, teachers, and staff can help reduce the effects of trauma on children by recognizing trauma responses, accommodating and responding to traumatized students within the classroom, and referring children to outside professionals when necessary. The National Child Traumatic Stress Network has developed tools and materials to help educators, school staff, and administrators understand and respond to the specific needs of traumatized children.

Essential Elements

The primary mission of schools is to support students in educational achievement. To reach this goal, children must feel safe, supported, and ready to learn.

view

NCTSN Resources

The following resources on Schools were developed by the NCTSN.

view

The NCTSN is funded by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services and jointly coordinated by UCLA and Duke University.

GLBTQDVP

GLBTQ Domestic Violence Project

TRAUMA-INFORMED APPROACHES FOR LGBQT* SURVIVORS OF INTIMATE PARTNER VIOLENCE

A Review of Literature and a Set of Practice Observations

June 2016

Authors:

Erin C. Miller, M.P.S., M.D.V.
Domestic Violence/ Sexual Assault Programs; Newton-Wellesley Hospital

Lisa A. Goodman, Ph.D.
Boston College

Kristie A. Thomas, Ph.D.
Simmons College

Alex Peterson
University of British Columbia

Jillian R. Scheer, M.A.
Boston College

Julie M. Woulfe, M.A.
Boston College

Carole Warshaw, M.D.
National Center on Domestic Violence, Mental Health, and Trauma

Principal Investigator:

Curt Rogers, M.P.A.
GLBTQ Domestic Violence Project

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Produced by
The GLBTQ Domestic Violence Project

For more information on supporting LGBQT* survivors of intimate partner violence, contact one of the organizations below:

The LGBTQ DV Capacity Building Learning Center
c/o The Northwest Network
A program focused on improving research, practice and policy regarding domestic violence in LGBTQ communities.
1-206-568-777 | info@nwnetwork.org | www.nwnetwork.org

FORGE
A transgender anti-violence organization, specializing in technical assistance for victim service agencies, with a focus on domestic violence, sexual assault, dating violence, stalking, and hate crimes.
1-414-559-2123 | AskFORGE@forge-forward.org | www.forge-forward.org

If you would like more information about accessible, culturally relevant trauma-informed approaches for survivors, contact:

The National Center on Domestic Violence, Trauma & Mental Health
A program providing training, support, and consultation to advocates, clinicians, attorneys and policymakers as they work to improve agency and systems-level responses to survivors and their children.
1-312-726-7020 | info@nationalcenterdvtraumamh.org | www.nationalcenterdvtraumamh.org

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Executive Summary

In 2013, the Administration for Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services, awarded a grant to the GLBTQ Domestic Violence Project in Boston, Massachusetts to help improve trauma-informed work with lesbian, gay, bisexual, queer and transgender (LGBQT*) survivors of intimate partner violence (IPV). The following document is a literature review that sets the context for thinking about trauma-informed practice (TIP) for these communities. We developed this review over the course of 2015, supported along the way by an Advisory Board comprised of the NorthEast Two-Spirit Society, Queer Muslims of Boston, Fenway Community Health, the Hispanic Black Gay Coalition, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, and Massachusetts Asian & Pacific Islanders for Health.

This document helps inform a set of practice-based observations that are included in the Appendix (page 40) and are also available as a separate document. At present, there are few, if any, documented LGBQT*-specific models of trauma-informed practice. This literature review and the accompanying practice observations make a clear case for the need for such models, and for the implementation of culturally competent LGBQT* trauma-informed services.

Key takeaways from the literature review include:

- IPV occurs in LGBQT* relationships at rates equal to or higher than rates in heterosexual relationships. Different subgroups within the community may experience different rates or types of IPV, with bisexual and transgender individuals at particularly high risk.

- Although LGBQT* IPV shares many underlying dynamics with IPV in heterosexual couples, it also has unique characteristics, including the types of abusive tactics used and the context of discrimination and social stigma faced by LGBQT* individuals. Within LGBQT* subgroups, there may be additional complexities.

- LGBQT* survivors who are also part of other oppressed groups often face homophobia within their own cultural communities as well as racism, ableism, xenophobia, and colonialism in mainstream communities. Moreover, LGBQT* IPV often occurs in a landscape that includes other forms of abuse and trauma, including family violence, sexual violence, hate crimes, and police brutality. Such overlapping forms of trauma are often interrelated, rendering some members of the LGBQT* communities subject to abuse by more than one person at a time and at more than one point in their lifespans. In the face of these overlapping forms of oppression, LGBQT* survivors are forced to make particularly constrained choices about safety, often trading one kind of safety for another.

- Mental health difficulties are major concerns among LGBQT* people in general. LGBQT* individuals experience higher rates of traumatic events, and may be at greater risk for developing symptoms of PTSD, depression, and anxiety as well as experiencing suicidality and isolation. These concerns are amplified for LGBQT* survivors of IPV, especially transgender individuals and survivors of color. Nonetheless, LGBQT* survivors find strength and resilience through identity affirmation and social support.

- LGBQT* survivors exhibit unique help-seeking behaviors. Overall, they are less likely to seek services from law enforcement and mainstream providers and more likely to rely on informal social support and LGBQT*-focused programs. There also are differences in help-seeking *within* LGBQT* subgroups. For instance, trans individuals may have an especially difficult time accessing culturally competent and non-traumatizing services. For LGBQT* people of color, stigma, economic constraints, and the absence of community outreach are barriers to services.

- Service provision that is not rooted in an expansive understanding of the intersecting oppressions that LGBQT* survivors face may do more harm than good. The kind of harm done by those in a social service system designed to help has been referred to as *sanctuary harm*, which is antithetical to trauma-informed practice.

- Despite growing awareness of the impact of sanctuary harm on clients who experience multiple forms of oppression and of the unique needs of LGBQT* survivors, trauma-informed approaches tailored to LGBQT* communities have been slow to develop. To our knowledge, there are none in the academic literature. It was our Advisory Board that pointed to an alternative model of trauma-informed practice – transformative justice.[1] While the roots of trauma-informed practice grew out of mental health and substance abuse services, transformative justice emerged from activist communities and seeks to uproot the conditions that created traumatic experiences, ending oppression even (if not especially) within helping systems.

We hope that this document will facilitate thinking about how the core principles of trauma-informed practice can be applied to working with LGBQT* survivors and to ameliorating vicarious traumatization among service providers who do their best in difficult circumstances.
Although this document is intended primarily for staff in domestic and sexual violence organizations, it has broad applicability. The information provided can be used to enhance the work of practitioners, advocates, and administrators in other anti-abuse disciplines, homelessness services, mental health and healthcare circles, criminal legal systems, youth services, and an array of other human services disciplines and social change initiatives that seek to serve and ensure the inclusion of LGBQT* communities. The practice-based observations in the Appendix provide further framing for this important endeavor.

[1] The authors wish to thank Hales Burton, at the Fenway Violence Recovery Program, for first suggesting this conceptual shift.

Introduction

IPV refers to the physical and/or emotional abuse of an individual by a current or former intimate partner. It includes the full range of tactics used to create and maintain power and control over another person, including financial abuse, verbal abuse and intimidation, and cultural abuse. In this document, the phrases *intimate partner violence* and *domestic violence* are used interchangeably to denote partner violence. However, it is important to note that domestic violence (DV) is sometimes defined more broadly to include violence and abuse perpetrated by relatives. Although many LGBQT* individuals experience abuse and/or rejection from family and relatives, the dynamics of partner violence versus family violence may differ dramatically. When we discuss the latter, we use the term *family violence* to distinguish it from violence by an intimate partner.

Following a note on language, the literature review is organized into five sections. Section One focuses on the prevalence and dynamics of IPV in LGBQT* communities. Section Two focuses on trauma, mental health, and resilience among LGBQT* individuals to contextualize the critical need for trauma-informed practices for these survivors. Section Three focuses on the range of systemic, institutional, and individual-level barriers that thwart LGBQT* peoples' access to informal and formal support services. Finally, the last section reviews the core principles of a trauma-informed approach to practice, with attention to the needs of service providers who work with LGBQT* survivors, and provides examples of community-specific approaches to trauma.

A Note on Language

The authors wish to acknowledge at the outset the deep complexities of language. LGBQT* stands for lesbian, gay, bisexual, queer, and transgender. It is often used interchangeably with GLBTQ, LGBQT-TS, and similar acronyms to broadly refer to sexual and gender minorities. This document honors the current practice of including an asterisk after the "T" to signify the broad diversity of trans communities, including trans women – transgender individuals who identify as women, though assigned male at birth; trans men – transgender individuals who identify as men, though assigned female at birth; those transitioning from female to male (FTM); those transitioning from male to female (MTF); cross dressers; gender non-conforming individuals; and others who might self-identify as being members of trans communities. In this paper, transgender and trans are used interchangeably.

These definitions belie the complexity of the terms, however. The words *lesbian*, *gay*, *bisexual*, *transgender*, and *queer* all carry particular historical, political and cultural meanings. To a great extent, these words have been shaped in white, Western contexts. Words such as lesbian, gay, and bisexual, for example, are uniquely English. There are seldom translations into other languages that carry the same understanding of LGBQT* identity as being an identity rather than a set of behaviors. Literal translations, into Spanish or Haitian Creole as but two examples, carry few if any of the presumptions that are inherent in English. In many parts of the Latin and Spanish-speaking world, men who engage in sex with

same sex partners are only considered "gay" in the English sense of the word if they are the receptive partner. It is not engaging in the acts that is the determinant of identity, so much as the role that an individual plays (traditionally read as *masculine* or *feminine*) in the conduct of that act. Similarly, men who marry women, but engage in same sex acts with other men, are frequently identified as heterosexual. In short, they are defined by their social role, rather than by their private, intimate acts. Hence the conception of *gay*, as defined in U.S. contexts, frequently fails to apply.

Precisely because identifiers such as LGBQT* were defined in white middle class and academic contexts, the limitations of LGBQT* labels and identifiers may be particularly acute in communities of color, Indigenous communities, and immigrant communities, among others. During the course of crafting this literature review, members of our Advisory Board taught us a tremendous amount. The Hispanic Black Gay Coalition (HBGC) suggested use of the term *same gender loving*, a community-specific phrase coined by Cleo Manago to distinguish African Americans, and in particular African American men, who do not self-identify as being part of the predominantly white gay movement in the U.S., but who nonetheless wish to affirm their same sex intimate relationships. Corey Yarbrough, one of the founding Executive Directors of HBGC, suggested that, for some same gender loving people, this language may be a form of racialized resistance to the racism of the mainstream LGBQT* movement in the U.S. In the alternative, Corey stated, some members of African American communities may be on the *down low*, engaging in same sex sexual activity, but rejecting LGBQT* identifiers as a result of internalized homo- and bi-phobia.

The NorthEast Two-Spirit Society (NETSS) in part echoed Corey's thoughts about the racism of the mainstream LGBQT* movement. In addition, Harlan Pruden, one of co-founders of NETSS, spoke about an "internal muddiness" that some Native peoples may experience when seeking to find language for their experience. Speaking of his own Cree inheritance as a registered member of the Saddle Indian Reservation, Harlan said that when he asked something of an elder, he knew to offer them tobacco, but never understood the spiritual dimension of the ceremony. Having been separated from too much of their own history by colonialism, genocide, and forced assimilation, Harlan stated, many Native people may use the words *Two-Spirit* when what they really mean is gay Indian.[2]

Harlan also spoke at length about the contextual nature of Native Two-Spirit identities. As Harlan put it, "When I am out on a Friday night in a gay club, I am a gay man. Yet when I am in rural Oklahoma at a Two-Spirit gathering, I am a proud Two-Spirit man." Alluding to the unique role and cultural responsibilities that Two-Spirit people often held (and may still hold) in the life of Native communities, Harlan pointed out the obvious differences in the spiritual role of Two-Spirit peoples, and

[2] Two-spirit is a contemporary term, adopted from the Northern Algonquin, and meant to signify the embodiment of both masculine and feminine within one person. Now embraced by many Native peoples as a pan-Indigenous umbrella term connoting both diverse gender expressions and sexual orientations, two-spirit (TS) generally speaks to the respect that Native peoples held for diversity, and the unique sacred and ceremonial roles that TS people held (and may still hold) within their own communities. Herein the phrase TS speaks not simply to a third gender, or to same gender attraction, but more broadly to the history of compulsory Christianization that sought to erase two-spirit peoples within their own nations. Notably, there is no single consensus definition of two-spirit, and the term means different things to different Native peoples.

the political and social function of people claiming LGBQT* identities in mainstream communities. Several members of the project's advisory board echoed this point,
speaking about the complex layering of cultural and spiritual value systems that accompanied their choice to self-identify in, with, and outside of their own communities.

These same Advisory Board members also acknowledged the landscape in which such decisions are made, and stated that individuals in their communities may shift how they self identify as a means of preserving their safety. As the rest of this literature review discusses, LGB, transgender, same gender loving, Two-Spirit, and queer-identified peoples make choices about how, when, and if to "out" themselves in a complex social and political landscape that is too often unsafe, if not violent. Hence, how any individual self-identifies may shift depending on who is asking, why, and in what context. As one Advisory Board member stated, "identities have to be fluid in order to be protective."

Finally, the leadership of HarborCOV, an LGBQT*-affirming DV organization in Boston that specializes in serving communities facing cultural or linguistic barriers, has noted that some cultures may not have the variety or depth of language that words such as LGB, transgender, same gender loving, and Two-Spirit convey. Indeed, Kourou Pich, Co-Executive Director of HarborCOV has observed that people from some cultures and communities may have difficulty finding language for themselves in their own communities, and that that invisibility is intentional – a function both of denial of the existence of sexual minorities in those communities, but also perhaps protectiveness of gender queer and same gender attracted people.

Language is power. We authors, therefore, have put a great deal of thought into the words we use to name peoples' experiences. At the same time, we know that we can never be as inclusive or sensitive as we want to be. We have done our best to honor the range of experiences we are writing about in this document.

Intimate Partner Violence in LGBQT* Communities

Prevalence of IPV in LGBQT Communities*

Historically, DV has been seen primarily as a problem of cisgender[3], heterosexual men abusing cisgender, heterosexual women. Because of this limited framework, research on the prevalence of DV and IPV among LGBQT* and non-female-identified individuals has been scarce and often limited by the use of non-probability sampling, cross-sectional data that precludes causal inference, and inconsistent definitions of IPV and sexual orientation (Brown & Herman, 2015; Finneran & Stephenson, 2012). Recently, however, there has been an increase in studies that provide more rigorous estimates of IPV in LGBQT* communities. The majority of these studies suggest that IPV occurs in LGBQT* relationships at rates equal to or higher than heterosexual, cisgender relationships (Balsam, Rothblum, & Beauchaine, 2005; Duke & Davidson, 2009; Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016; Messinger, 2011; Walters, Chen, & Breiding, 2013). Herein, we briefly present prevalence estimates of LGB IPV before turning to the limited research on prevalence among trans individuals. For a more detailed review of IPV prevalence in LGBQT* communities, see Brown and Herman (2015).

Currently, the best prevalence estimates on partner abuse in LGB communities come from the nationally representative 2010 National Intimate Partner and Sexual Violence Survey (NISVS) conducted by the U.S. Center for Disease Control & Prevention (Walters et al., 2013). Findings suggest higher rates of lifetime IPV experiences (defined as physical violence, sexual violence, or stalking) among lesbians (43.8%), bisexual women (61.1%), and bisexual men (37.3%) – but not gay men (26%) – compared to heterosexual women (35.0%) and heterosexual men (29%). In addition, findings from the California Health Interview warrant mention. Based on a probability sample of California residents ages 18 to 70, this study found that lifetime and 1-year IPV prevalence was higher in sexual minorities compared with heterosexuals, but this was significant only for bisexual women and gay men.

Determining IPV prevalence based on gender identity is difficult due to a lack of studies with representative or even large samples. The National Transgender Discrimination Survey is one of the largest studies of transgender individuals' experience of discrimination with 6,456 participants (Grant, Mottet, & Tanis, 2011). This study did not focus on IPV in particular, but did measure related phenomena. The researchers found that 19% of respondents reported experiences of violence at the hands of a family member specifically due to their gender identity. This statistic is likely an underestimate because it excluded DV perpetrated by non-family intimate partners as well as DV unrelated to gender identity. A much higher percentage of participants reported experiencing actions that may or may not be part of abusive behavior: 29% reported an ex-partner limiting their contact with their children, 45% reported having a relationship end when they came out as trans to their partner, and 57% experienced family rejection (Grant et al., 2011). However, these are unreliable proxies for IPV.

[3] Cisgender is a term that refers to individuals for whom the gender they were assigned at birth matches their gender identity. It can be thought of as meaning "not transgender."

Only one study to date has compared IPV among transgender to IPV among cisgender individuals. Analysis of data from One Colorado's anonymous 2011 LGBT Health Survey (n= 1,193) found that 31.1% of trans respondents reported experiencing IPV, compared to 20.4% of cisgender respondents (Langenderfer-Magruder et al., 2016) – findings that suggest transgender individuals experience higher rates of IPV than their cisgender, LGB counterparts. Furthermore, preliminary evidence suggests that different subgroups within transgender communities experience different rates or types of IPV (Chestnut, Jindasurat, & Varathan, 2012; Clements, Katz, & Marx, 1999). Future studies should examine these differences, particularly with regard to differences between trans men and trans women and with attention to intersecting identities for all participants (e.g., race, sexual orientation, disability, socioeconomic status).

Similarities of LGBQT and Heterosexual IPV*

In general, IPV experienced by LGBQT* individuals follows patterns similar to heterosexual and cisgender individuals (Ristock, 2005). Specifically, abuse can take the form of physical or sexual violence as well as emotional, financial, or verbal abuse. Messinger's (2011) analysis of the National Violence Against Women Survey revealed that the prevalence of various types of abuse in GLB communities mirrored prevalence rates among heterosexuals: Both groups reported prevalence rates that went in descending order from verbal abuse to controlling behavior to physical violence to sexual abuse. However, as described next, there are also unique aspects of IPV in LGBQT* communities, and potentially important differences among LGBQT* subgroups.

Unique Characteristics of IPV in LGB communities

IPV occurs in a larger societal and systemic context of homo-, bi-, and transphobia, heterosexism, misogyny, and patriarchy. These factors can influence abuse tactics and relationship dynamics for LGBQT* survivors, making their experiences different from those of heterosexual survivors. For example, sexual minority victims of IPV may be subject to abusive tactics that leverage systemic and cultural discrimination (i.e., identity abuse; Ard & Makadon, 2011; Balsam, 2001; Balsam & Szymanski, 2005; FORGE, 2014; Gay Men's Domestic Violence Project, 2014; National Center on Domestic & Sexual Violence, 2014; West, 2012). Examples of identity abuse include denying or belittling an individual's LGBQT* identity (e.g., refusing to use preferred gender pronouns), restricting access to a supportive LGBQT* community (NCDSV, 2014), or threatening to disclose a survivor's sexual orientation, gender identity, or HIV/AIDS status (Ristock, 2005). People who use violence against their LGBQT* partners may also use threats to authenticity as a method of control, making survivors feel that they are not "queer enough" or do not understand how LGBQT* relationships are supposed to be (Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thornton, 2006). Controlling behavior, in general, may be a particularly important aspect of DV among LGBQT* couples, and may result in even higher levels of psychological harm than physical abuse alone (Frankland & Brown, 2014).

IPV in LGBQT* survivors can also be minimized in a variety of ways: For example, common portrayals of DV in the media – usually depicting heterosexual relationships, specifically men abusing women – can render invisible even to themselves experiences of underrepresented survivors (Holt, 2011). Pervasive beliefs that LGBQT* relationships are more egalitarian or that gay and lesbian individuals are better able to defend themselves against partners who use violence also serve to render IPV invisible in these communities (Bornstein et al., 2006; Holt, 2011; Walters, 2011).

Finally, although isolation is a commonly used tactic in heterosexual as well as in LGBQT* relationships, it may be more difficult to overcome in tight-knit LGBQT* communities in which relationships and resources are often shared with the abusive partner (Bornstein et al., 2006). The level of isolation is even more pronounced for LGBQT* survivors from rural and immigrant communities (Ristock, 2005).

Unique Characteristics of IPV among Transgender People

There is limited research on the characteristics of IPV in transgender communities. The National Coalition of Anti-Violence Programs 2014 annual survey of its member programs reported that, compared to people who did not identify as transgender, transgender survivors were two times more likely to face threats/intimidation, nearly two times more likely to experience harassment, and over four times more likely to face police violence in response to reporting IPV (National Coalition of Anti-Violence Program, 2015b). Transgender women were at highest risk of experiencing threats/intimidation, harassment, and injury (NCAVP, 2015a), and transgender people of color were the most likely to report experiencing threats of intimidation in their intimate partnerships.

Generally high rates of violence, trauma, and discrimination in the lives of transgender individuals may have a compounding effect, influencing transgender IPV survivors' willingness to identify abuse or seek help. FORGE's safety planning guide remarks that transgender individuals may feel unwanted, or "believe that they are lucky to ever find love, even if that love turns violent" (Guadalupe-Diaz, 2013, p. 3). In a study of transgender relationship violence, some participants could not even conceptualize their trans partner's behavior as abusive because they viewed these partners as being so oppressed themselves (Ristock, 2011).

Multiple Experiences of Violence in LGBQT Communities*

Because of the fragmented nature of research on violence and abuse in the lives of LGBQT* individuals, the prevalence of "polyvictimization"[4] – that is, multiple kinds of violence and abuse committed by different people – in this community is still unknown. However, evidence suggests that LGBQT* individuals are more likely to experience multiple types of violence (e.g. sexual abuse, physical abuse, and exposure to domestic violence during childhood; sexual assault, physical assault, and stalking during adulthood) at the hands of many different types of individuals (family, partners, community members, legal actors, strangers) and at multiple points in their lifetime (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Grant et al., 2011; Stotzer, 2009).

Specific subgroups of LGBQT* survivors are at especially high risk for multiple forms of victimization. One notable example is LGBQT* homeless youth, highly overrepresented among homeless populations (Durso & Gates, 2012; Grant et al., 2011; Hunter, 2008). Evidence indicates that family and partner violence are major drivers of such homelessness (Cochran et al., 2002; Durso & Gates, 2012; Grant et al., 2011; Risser & Shelton, 2002). Homelessness in turn may render LGBQT* peoples increasingly vulnerable to other forms of violence including harassment, hate crimes, police brutality, and sexual exploitation (Amnesty International, 2005; Durso & Gates, 2012; Keuroghlian et al., 2014; Mogul, Ritchie, & Whitlock, 2012; NCAVP, 2015a; NCAVP, 2015b; Reck, 2009). Layered onto these experiences are other types of oppression such as housing, employment, and healthcare, which are themselves traumatogenic and which also act as barriers to help seeking (D'Augelli, 1998; Durso & Gates, 2012; Grant et al., 2011; Tyler, 2008).

Unique Experiences of IPV among Specific Subgroups of LGBQT Survivors*

The experience of IPV for specific subgroups may be quite different than that of White, middle-class LGBQT* survivors (Chavis & Hill, 2009). The intersections of various identities result in unique social contexts shaped by multiple systems of power and oppression (Chavis & Hill, 2009; Feltey, 2001). These systems may shape the way that IPV is enacted and experienced, and the way it is addressed by service providers. Although attention to all intersections would be beyond the scope of this document, here we focus on three subgroups that have received especially scant attention: sexual minorities in Native communities, immigrant and refugee communities, and faith-based communities. Although there is virtually no research on IPV within these subgroups, it is nevertheless instructive to understand this context when considering the experience of IPV for people within these communities. Later sections touch on specific aspects of the help-seeking experience of African-American and Latin@ LGBQT* survivors.

[4] "Polyvictimization" refers to experiences of multiple kinds of violence and abuse, at the hands of multiple people at multiple points in the lifespan. The authors have chosen to put this word in quotes because some have understood it to imply that the victim is somehow responsible for for these experiences. This would obviously be inaccurate and inappropriate. Indeed, there is now a rich literature on the ways that people who use abusive behaviors target individuals with prior trauma histories.

Two-Spirit and LGBT Native Peoples. In general, there is scant research on the experiences of Two-Spirit and LGBT Native individuals. However, the fact that rates of violence and abuse against cisgender, heterosexual Native women are so high suggests that Two-Spirit Native women might be at especially high risk compared to their non-Native sexual minority counterparts (Lehavot, Walters, Simoni, 2009). Consistent with this view, one study showed that 78% of Two-Spirit women reported experiencing physical assault and 85% reported experiencing sexual assault (Lehavot et al. 2009).

These statistics are all the more alarming given that Native women, regardless of Two-Spirit or LBT status, are more likely to experience physical brutality, and therefore injury, during rapes and sexual assaults (Amnesty International, 2007). Further, some Native researchers have noted the disproportionate impact of homo/transphobia that occurs within the Native community given that Two-Spirit survivors may need cultural support from their own people in the face of violence and trauma (Frazer, Somjen, & Pruden, 2010). Not surprisingly then, violence against Two-Spirit and Native LGBQT* individuals also contributes to the development of a range of health and mental health conditions, such as liver disease, substance abuse, PTSD, as well as to behaviors that increase the risk for HIV (Balsam, Huang, Fieland, Simoni, & Walters, 2004; Centers for Disease Control and Prevention, 2001; Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Simoni, Seghal, Walters, 2004). Clearly, more research is needed on IPV in the lives of Two-Spirit and LGBQT* Native peoples.

Immigrants and Refugees. The experiences of LGBQT* immigrant and refugee survivors of IPV are largely invisible in the academic literature. The broader research on DV in heterosexual, cisgender immigrant communities is complex, indicating that they experience lower rates of IPV, but higher rates of IPV homicide compared to non-immigrants (Bohn, 2003; Tjaden & Thoennes, 1998).

Although there is a need for more prevalence research, it is well documented that sexual minority immigrants face challenges resulting from historically homophobic immigration policies (Chung & Lee, 1999). Under the Immigration and Nationality Act of 1917, LGBQT* immigrants were strictly prohibited from entering the United States on the grounds that they were "mentally or physically defective." The Immigration & Naturalization Act of 1952 similarly prevented LGBQT* immigrants from entering the U.S. based on the idea that they were "afflicted with psychopathic personality" (Foss, 1994). Even up to 1990, Public Health Service physicians barred entrance to those immigrants suspected to be LGBQT*, labeling them as "sexual psychopaths." In addition to contending with these oppressive policies, LGBQT* immigrants were also isolated within their own communities and shunned by white, non-immigrant LGBQT* communities because of their immigration status (Cantú, Hurtado, & Anzaldúa, 2012; Moraga & Anzaldúa, 1981). Even today these interpersonal and institutional challenges echo in the lives of sexual minority immigrants and likely create unique challenges for LGBQT* immigrant and refugee survivors of IPV.

Religious or Spiritual LGBQT Survivors*. LGBQT* people have both positive and negative experiences of faith, possibly even simultaneously. Researchers and practitioners highlight the healing value of religious communities and practices for this community (e.g., Queer Muslims of Boston,

FaithTrust Institute; Ryan, Huebner, Diaz, & Sanchez, 2009). Yet, institutionalized religious policies and principles continue to be a major source of social oppression for many LGBQT* people (Clarke, Brown, & Hochstein, 1989; Davidson, 2000; Hilton, 1992; McNeill, 1993; Morrow & Gill, 2003; Spong, 1991; Spong, 1998). For example, many religious practices condemn non-heterosexual behavior (Bouhdiba, 1998; Jaspal & Cinnirella, 2010) and view LGBQT* people as immoral and spiritually corrupt (Morrow & Gill, 2003). For many religious LGBQT* people, family and societal rejection is therefore compounded by the loss of religious communities (Mahaffy, 1996).

Sources of conflict for religious LGBQT* people include anti-gay religious teachings and scriptural interpretations, homo/bi/transphobic church atmospheres, fear of being "outed" in non-affirming religious settings, and microaggressions (i.e., subtle forms of oppression) from people within their religious communities (Brown & Pantalone, 2011; Shuck & Liddle, 2001). Not surprisingly, receiving homophobic messages through a religious medium has been found to be associated with internalized shame among LGBQT* individuals (Herek, 1987; Ream, 2001).

The challenges of participating in a faith community that is not LGBQT*-affirming may be particularly acute for LGBQT* individuals of color and immigrants since the support role of faith-institutions is particularly crucial in these communities due to the lack of other available social supports. For example, Christian religious institutions have served a range of healing functions within African American communities, where faith has been an important source of strength in the face of ongoing racialized violence and oppression (Billingsley, 2003; Cone, 1997; Cone, 2010; Higginbotham, 1994; Lincoln & Mamiya, 1990). Yet, for African American young men, churches are the primary source of anti-gay messages in their communities (Stokes & Peterson, 1998). The loss of access to one's faith community under such circumstances may be particularly wounding. These challenges are real and ongoing, but their effects on LGBQT* survivors of IPV remain unexplored. Most research on the experience of IPV survivors in relation to their faith communities focuses on the spiritual lives of heterosexual, cisgender women. Clearly, more research is needed in this area.

In sum, violence – be it by intimate partners, family and community members, or society at large – is a common occurrence in the lives of many LGBQT* individuals. Because such polyvictimization is rooted in and exacerbated by the larger context of homophobia and transphobia, the experiences of LGBQT* survivors differ in many ways from those of heterosexual, cisgender survivors. Given that experiences differ, so too does the impact of experiencing IPV. We turn next to the research on the mental health consequences of IPV among LGBQT* survivors as well as protective factors that promote resilience.

Trauma and Mental Health in LGBQT* Communities

The emerging literature on how IPV affects the mental health of LGBQT* survivors is mixed, with some studies indicating that the impact is similar for LGBQT* and non-LGBQT* survivors, and others indicating that adverse effects are more common among LGBQT* survivors (Edwards, Sylaska, & Neal, 2015). This section reviews that literature, focusing especially on depression and PTSD – two common mental effects of abuse. As this section will show, emerging research indicates that bisexual and transgender survivors may be at particularly high risk for experiencing adverse mental health effects.

Depression. LGBQT* survivors of IPV, similar to their heterosexual and cisgender counterparts, are particularly at risk of depression. One longitudinal study examining data from a nationally representative survey of adolescents between the ages of 18 and 27 (227 gay and lesbian, 345 bisexual, and 13,490 heterosexual) found that across all three groups, exposure to IPV was significantly related to increased depression – even after controlling for exposure to childhood physical or sexual abuse and homelessness or expulsion from one's home by caregivers (McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012). This is consistent with a more recent meta-analysis examining 19 studies, which found that men who are victims of IPV at the hands of other men are more likely to use substances, suffer from depressive symptoms, have an HIV positive diagnosis, and engage in unprotected sex (Buller, Devries, Howard, & Bacchus, 2014). As a whole, this body of literature suggests that LGBQT* IPV survivors are at greater risk for experiencing depression than LGBQT* individuals without IPV experience.

Looking more closely within the LGBQT* community, there is some evidence indicating that bisexual individuals may have disproportionately high rates of depression as compared to gay and lesbian individuals (Bostwick, Boyd, Hughes, & McCabe, 2010). Interestingly, theoretical work has posited that the relatively high mental health difficulties within the bisexual community may be attributable to the additional stressors of experiencing bi-negative attitudes from both heterosexual and LGTQ communities. The National Epidemiologic Survey on Alcohol and Related Conditions, which compared rates of major depression among lesbian, gay, bisexual and heterosexual adults (*n*=34,653), found that both male and female individuals who reported bisexual behavior had higher lifetime rates of all mood disorders, including depression (Bostwick et al., 2010). By extension, one might expect bisexual survivors of IPV to be at particular risk for depression.

Likewise, there is scant research on depression and other mental health effects of IPV for transgender survivors. There is, however, literature on the relationship between interpersonal violence more generally and symptoms of depression in this community. For example, in one cross-sectional study of over 591 MTF participants from the New York City area, 63% had depression scores in the clinical range. Further, in this same sample, violence that was related to one's gender identity, or gender abuse, was predictive of depression (Nuttbrock et al., 2014). These findings are consistent with another study of 6,436 transgender-identified individuals, in which 19% of respondents had experienced violence at the hands of a family member because of their chosen gender identity. This exposure was associated with over twice the rate of suicidality, with 65% of those who experienced family violence also reporting

having attempted suicide, compared to 32% of those who did not experience family violence (Grant et al., 2011). Overall, though the literature remains inconclusive, it raises questions about whether transgender survivors of IPV could be at increased risk for depression.

PTSD. IPV exposure also increases the risk of PTSD symptoms in the LGBQT* community. According to the CDC's 2010 IPV report described previously (i.e., NISVS) 19.5% of lesbian women, 46.2% of bisexual women and 22.1% of heterosexual women report experiencing at least one symptom of PTSD – defined as having nightmares and intrusive thoughts of the traumatic experience; feeling constantly on guard, watchful or easily startled; and feeling numb or detached in response to an experience of IPV (Walters et al., 2013). Data from bisexual, gay, and heterosexual men were excluded from the analysis due to small sample sizes. Evidence from other research, however, suggests that that the relationship between IPV and PTSD may extend to gay and bisexual male survivors (Pantalone, Hessler, & Simoni, 2010).

Consistent with the findings on IPV and depression, there is initial evidence that bisexual survivors of IPV have higher rates of PTSD than gay and lesbian survivors. According the CDC's NISVS, more than half of bisexual women (57.4%) who experienced physical or sexual violence or stalking reported at least some form of negative impact (e.g., experiencing PTSD symptoms, missing a day of school or work, feeling fearful or concerned for their safety) as compared to a third of lesbian women (33.5%), and a fourth of heterosexual women (28.2%) (Walters et al., 2013). Significantly more bisexual women (46.2%) reported experiencing at least one symptom of PTSD as compared to lesbian (19.5%) and heterosexual women (22.1%) (Walters et al., 2013). These results suggest that bisexual women may be at disproportionately high risk for developing PTSD after experiencing IPV.

Again, literature on the relationship between IPV and PTSD in transgender communities is limited. As noted earlier, transgender individuals are especially likely to experience violence and discrimination in the domains of education, health, family life, and work which may shape their responses to partner violence (Grant et al., 2011). These risks are not equally distributed among trans individuals. Trans women experience higher rates of violence than trans men, probably because they are less able to "pass" (i.e., be perceived as the gender they identify as) (Dean et al., 2000; Mizock & Lewis, 2008). The risks may also be explained by the concept of trans-misogyny: the idea that there is a particular brand of discrimination that combines transphobia with sexism and applies specifically to trans women (Serano, 2007).

In addition, trans people of color are at particularly high risk (Richmond, Burnes, & Carroll, 2012). In a study of MTF youth of color in Chicago, major life stressors included lack of transportation, difficulty finding a job, sex in exchange for resources, being frequently bothered by police, forced sexual activity, difficulty finding a safe place to sleep, difficulty accessing healthcare, and history of incarceration and homelessness (Stieglitz, 2010). Given that multiple experiences of trauma are more likely to result in the development of clinical PTSD (Scott, 2007), it is not surprising that in one study of MTF transgender individuals, 17.8% reported clinically significant symptoms of PTSD (Shipherd, Maguen, Skidmore, &

Abramovitz, 2011). As a whole, the literature on bisexual and transgender communities makes clear the need for researchers to continue to investigate the distinct experiences of subgroups of the LGBQT* community.

The mental health consequences of IPV among LGBQT* survivors must also be understood within the broader context of historical trauma. Historical trauma is a term used to describe repeated communal traumatic events that exist across time, are embedded throughout culture, and can result in an intergenerational cycle of traumatic stress (Sotero, 2007). Oppressed communities subjected to historical trauma are at heightened risk for mental and physical health consequences compared to communities not exposed to such trauma (Danieli, 1998; McMichael, 1999; Sotero, 2007). Not only have LGBQT* people endured such historical trauma as a group, but many such individuals have also experienced intergenerational trauma originating from other identities such as those based on race or religion (DeGruy, 2005; Franklin, Boyd-Franklin, & Kelly, 2006; Jaimes & Halsey, 1992). Studies have shown that cumulative historical traumatic events actually increase survivors' risk for lifetime trauma and interpersonal violence (Chae & Walters, 2009). These forces are critical to understand when considering the mental health impact of violence against various subgroups of the LGBQT* communities.

Resilience in LGBQT Communities*

Research has identified several important factors that contribute to strength and resilience among LGBQT* survivors. In particular, a positive LGBQT* identity, or *identity affirmation,* and social support from friends can profoundly influence survivors' mental health.

Regarding the first of these two factors, LGBQT* identity affirmation has been well documented as critical to positive mental health outcomes. For example, one study investigating 165 lesbian, gay, and bisexual youth found that family support and self-acceptance mediated the relationship between victimization and mental health (Hershberger & D'Augelli. 1995). Another study surveyed 613 lesbian, gay, and bisexual individuals and found that LGB individuals who have positive appraisals of their LGB identity and do not anticipate rejection from others had lower psychological distress (Balsam & Mohr, 2007). In a subsequent study, the same authors found that higher identity acceptance negatively correlated with measures of depression, guilt, fear, hostility, and sadness, and positively correlated with measures of general life satisfaction, self-assurance, and social self-esteem (Mohr & Kendra, 2011). Finally, in a study of trans people of color who were survivors of traumatic events, participants named pride in one's gender and ethnic identity as critical to resilience (Singh & McKleroy, 2011). In short, LGBQT* individuals who feel more positive about being LGBQT* or their ethnicity are able to cope more successfully with the challenges they face.

Social support from friends and family also serves a critical protective role. Moody and Smith (2013), for example, found that perceived support from friends was associated with reduced suicidality among trans individuals. For transgender youth of color, identifying other youth and adults with similar identities helped to validate their experiences of racism within the LGBQT* community (Singh, 2013).

And in one study of MTF youth of color, friends were the most frequently cited source of support, and physicians or case managers were perceived as at least somewhat helpful (Stieglitz, 2010).

Social media has become a critical conduit for accessing social support within the LGBQT* community (Singh, 2013). Online communities have become sites of community organizing, cultural empowerment, and education for LGBQT* people, enhancing both a sense of identity and a sense of social support and community (Mehra, Merkel, & Bishop, 2004). Religion and spirituality may also contribute to resilience, particularly as these become sources of social support (Potter, 2007).

In sum, there is a clear need for supportive mental health and trauma-informed approaches for LGBQT* individuals. Furthermore, these services must recognize the societal factors that contribute to individual mental health concerns. LGB individuals, and transgender individuals in particular, experience high rates of traumatic experiences that stem from social isolation, prejudice, and discrimination. These experiences can have many negative mental health outcomes, and are exacerbated by multiple forms of oppression. Nonetheless, LGBQT* individuals show remarkable resilience by developing strong social support networks, creating and engaging with online and activist LGBQT* communities, and developing a positive LGBQT* identity. Trauma-informed approaches must allow providers to understand the context in which survivors have experienced abuse, identify sources of individual and communal strength and resilience, and support healing. Unfortunately, the current reality for sexual minorities who seek help from informal and formal supports is far different.

Help-Seeking Among LGBQT* Survivors

A range of systemic, institutional, and individual-level barriers uniquely thwart LGBQT* peoples' access to informal and formal support services (Edwards, Sylaska, & Neal, 2015; Helfrich & Simpson, 2006). At the broadest level, pervasive heterosexism renders violence between same sex partners invisible. The myth that IPV occurs only between men and women contributes to the profound difficulty that service professionals have even identifying IPV among LGBQT* couples (Blasko, Winek, & Bieschke, 2007; Brown & Groscup, 2008; Helfrich & Simpson, 2006; Seelau & Seelau, 2005). Brown and Groscup (2008) studied 120 crisis center workers' perceptions of same-sex DV by presenting scenarios in which only the gender of the abuser and survivor were changed, and found that participants ranked same-sex DV as less severe and less likely to get worse than the same scenario among heterosexual pairs. Although service providers may recognize that LGBQT* survivors deserve protection from IPV just as heterosexual survivors do (Sorenson & Thomas, 2009), these kinds of biases may affect their ability even to identify IPV in this community (Basow & Thompson, 2012).

Beyond the invisibility of LGBQT* IPV, a range of factors cause well-meaning social services systems to harm members of marginalized communities, including sexual minorities. Forms of oppression such as racism, colonialism, ableism, heterosexism, sexism, and transphobia that are often implicit in our helping systems can render these systems traumatogenic, especially when these oppressive dynamics are not acknowledged (Buzawa & Buzawa, 2003; Dirks, 2004; Herman, 2003; Walters, Simoni, & Evans-Campbell, 2002). The kind of harm done by institutions designed to provide support has been termed "sanctuary harm" (Bloom 2011; Bloom 2013).

A primary example of a system that causes this kind of sanctuary harm is the healthcare system. Historically, medicine and the health sciences were central to the effort to pathologize same sex relationships and transgenderism. Being gay or lesbian was classified as a mental disorder by the American Psychological Association until 1973, and conceptions of gender dysphoria as a mental health condition did not undergo a similar revolution until 2013 (Bayer, 1987; Drescher & Merlino, 2007).

The continuing impact of this history is evident in the experiences of LGBQT* patients in healthcare settings. Lambda Legal (2010) found that more than half of all sexual minority survey participants had experienced at least one of the following types of discrimination in a healthcare setting: being refused needed care; being blamed for their health status; seeing healthcare professionals refuse to touch them or use excessive precautions; hearing healthcare professionals use harsh or abusive language; or experiencing healthcare professionals being physically rough or abusive. Similarly, Shires and Jaffee (2015) found that over 40 percent of transgender men reported verbal harassment, physical assault, or denial of equal treatment in a doctor's office or hospital. Grant et al. (2011) reported that over one-quarter of respondents in a survey for the National Center for Transgender Equality experienced verbal harassment in medical settings, and that the likelihood of discrimination, abuse, or assault of transgender patients by their provider actually increased with the provider's awareness of their patient's transgender status. Such experiences of discrimination are far more likely to affect

LGBQT* patients of color, financially-oppressed patients, and undocumented patients (Grant et al., 2011; Lambda Legal, 2010).

Other examples of sanctuary harm abound across systems. For example, between 2010 and 2011, LGBQT* survivors reported an increase of incidences in which the police arrested both the abuser and victim when called (28.4% up from 21.9%), an increase in the percentage of LGBQT* survivors seeking shelter who were denied (61.6% up from 44.6%), and a decrease in the percentage of LGBQT* survivors who received requested orders of protection (78.1% down from 83.7%; NCAVP, 2015b). The same study found that transgender IPV survivors were over six times more likely to experience physical violence while interacting with the police than other survivors, and more likely to experience hate violence in shelters than other survivors (notably, trans men were 3.5 times more likely; whereas, trans women 1.3 times more likely) (NCAVP, 2015b). In short, transgender survivors may experience even more re-traumatization and less access to formal support systems than LGB survivors.

Mainstream programs may use heterosexist language in program materials, or have ambiguous or poorly defined policies regarding service provision for LGBQT* survivors (Helfrich & Simpson, 2006). LGBQT* survivors may well anticipate discrimination both from staff members and the heterosexual survivors using these services and may worry that their sexual orientation (and one could assume, gender identity) will be revealed should they actually seek help (Bornstein et al., 2006; McClennen, 2005; Helfrich & Simpson, 2006).

Low-income LGBQT* survivors of color experience another set of barriers: A community needs assessment of Black and Latin@ LGBQT* communities in the greater Boston area (Tod@s, The Hispanic Black Gay Coalition, The Violence Recovery Program at Fenway Health, The Network/La Red, & Renewal House, 2013) found that a lack of outreach to these communities limited their knowledge of IPV resources. In addition, geographic isolation, lack of transportation options, and the cost of making phone calls were major challenges to finding formal help. Similar to Black and Latin@ communities, Two-Spirit individuals identified lack of financial resources, transportation, and geographic inaccessibility as barriers to seeking support (Walters, Horwath, & Simoni, 2001). In addition, the lack of programming specifically aimed at Two-Spirit people and fear of what other Native community members might think were consistently ranked as barriers.

In the context of these institutional barriers, sexual minority survivors describe a range of personal reasons for not seeking support. Many feel that the need to educate a provider about one's identity and experiences would be overwhelming, particularly during a time of crisis (Turrell & Herrmann, 2008). Others worry about further victimization by providers who lack training on LGBQT* issues, and by other clients accessing the same services (Bornstein et al., 2006). Talking about abuse in one's intimate relationship almost always means coming out about one's sexual orientation or possibly one's gender identity. Further, gossip in insular or tight-knit communities raises concerns of confidentiality and retaliation – not just by the abuser but also by the community at large. Gay male survivors may keep silent about abuse and be more reluctant to seek help because they do not see doing so as consistent

with notions of masculinity (Seidler, 2006). According to Spiegel (2003), the abuse thrusts male survivors into "confrontation between two disparate psychosocial processes: the realities of abuse and the mythology of masculinity" (p. 133). Notably, although LGBQT* individuals may be hesitant to contact mainstream domestic violence programs, one survey reported that 86.2% of LGBQT* respondents *would* contact a domestic violence program if it was LGBQT*-specific (Holt, 2011).

Although the majority of LGBQT* survivors do not immediately seek help from the formal service system, they do rely on their informal social support systems; that is, their friends and families (Edwards et al., 2015). And yet, here too, LGBQT* survivors face a range of barriers to support. For example, LGBQT* survivors may be reluctant to seek help from friends and family given their own or their community's gendered beliefs about violence (e.g., women cannot be violent and men cannot be victimized) (Seelau & Seelau, 2005; Walters, 2011). They may be particularly hesitant to seek help from heterosexual friends or family members if they have had previous experiences of heterosexism and cissexism from their peers (Ard & Makadon, 2011). Survivors may have received messages that LGBQT* relationships themselves are "wrong" or "sick." Consequently, they may feel that admitting violence will only confirm these messages, conferring a sense of stigma on the victim, the relationship, and the LGBQT* community in general. Alternately, survivors who feel as though they are representing the LGBQT* community may feel that admitting IPV will harm the LGBQT* community at large (Balsam, 2001). Also, friends and resources may be shared between the survivor and perpetrator to an even greater degree than in heterosexual relationships, further making it difficult to access support (Bornstein et al., 2006).

In sum, a range of factors hinder LGBQT* survivors from seeking formal and informal assistance. Some survivors choose not to seek help from anyone; however, many survivors will make at least an initial attempt, and how they are treated can affect likelihood of seeking help in the future. Formal systems such as DV programs, hospitals, and law enforcement have a responsibility to ensure that they are facilitating help-seeking, not preventing it. To that end, the next section reviews the literature on a trauma-informed approach to practice, with attention to the needs of service providers who work with LGBQT* survivors, and provides examples of community-specific approaches to trauma.

Trauma-Informed Practices

A growing body of literature suggests that incorporating trauma-informed approaches into work with survivors is beneficial for the participant, staff, and overall organization. In this section we review the definition and core principles of a trauma-informed approach. Next, we discuss the need for LGBQT*-specific trauma-informed models and the role of transformative justice in developing such models.[5]

The term trauma-informed services was first used by Maxine Harris and Roger Fallot (2001a) in the context of mental health and addictions treatment programs. They noticed that many individuals seeking these services had experienced high rates of physical and sexual abuse, yet few providers were knowledgeable about trauma and the effects of such violence. As a result, services were not designed with trauma survivors in mind, increasing the possibility of retraumatization by the very services that were supposed to help them.

In response, Harris and Fallot (2001b) proposed creating trauma-informed service systems. This meant recognizing that the majority of people seeking services are likely to have experienced trauma; and that the effects of trauma impact many life domains, including people's experience of services. Thus, they argued, services had to be redesigned to incorporate an understanding of the pervasiveness of trauma and its impact on every aspect of their work. That is, programs and practices needed to be welcoming and appropriate for individuals with a history of trauma; and they needed to minimize retraumatization and promote healing and recovery. This, in turn, required an organizational commitment to trauma-informed practice, and ensuring that the necessary training for staff was in place.

In their initial work, Harris and Fallot (2001a) identified five requirements for creating trauma-informed services: (1) administrative commitment to change; (2) universal screening for trauma history among participants/clients;[6] (3) training and education on trauma for all staff; (4) hiring staff with a deep knowledge of trauma, referred to as "trauma champions;" and (5) reviewing policies and procedures to ensure they do not replicate abusive dynamics.

Although Harris and Fallot's approach was developed in the context of mental health and addictions services, its underlying principles have been adapted and applied to several different service contexts. These contexts include correctional facilities (Hodas, 2006), psychiatric and hospital settings (Jennings, 2004), homelessness services (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009), addiction

[5] While the terms trauma-informed care and a trauma-informed approach are sometimes used interchangeably, the use of these terms has evolved over time. Trauma-informed care while perhaps still applicable in settings that provide health or mental health care, is actually inconsistent with the spirit/principles of a trauma-informed approach which involves service relationships that are fully collaborative rather than one person providing and the other receiving care.

[6] The requirement for universal trauma screening emerged in the context of mental health and addictions treatment services and are not necessarily applicable to other service settings such as DV programs.

services (Covington, 2008), services for children who have experienced abuse (Hodas, 2006; Ko et al., 2008), and DV organizations (Warshaw, Sullivan, & Rivera, 2013; Warshaw 2014; Wilson, Fauci, & Goodman, 2015).

These adaptations have not fundamentally altered the original principles, but have offered more expanded and nuanced interpretations of how they work in practice. In their excellent review, Hopper, Bassuk, and Olivet (2010) identified core principles that cut across different service contexts. These include: trauma awareness (e.g., staff training, consultation, supervision and self-care); safety (e.g., physical and emotional safety for all, awareness of potential triggers, clear roles and boundaries, and cultural diversity); opportunities to rebuild control (e.g., predictable environments, rebuilding efficacy, and personal control over lives); and a strengths-based approach (e.g., focus on future and skills-building).

Furthermore, Elliot, Bjelajac, Fallot, Markoff and Reed (2005) placed trauma-informed principles in the context of the entire service system and environment. For example, in a trauma-informed system, survivors engage with staff as collaborative partners rather than as passive recipients of services, and organizations actively solicit survivor input. In trauma-informed organizations, providers also strive to understand each survivor within the context of their background and life experiences and in terms of what is meaningful to them. Such contextualizing is essential. Because survivors experience trauma and seek support in a social, historical, and political context, healing must also include recognition of this context.

In order to do this difficult work, staff must themselves be supported. A fundamental aspect of a trauma-informed approach, therefore, involves creating an organizational environment that facilitates providers' capacity to do their work well. Clients interact with individual providers, who themselves interact with supervisors and the organization. When providers are subject to stressful organizational dynamics, those stresses interfere with their ability to be effective (Bloom, 2010). One consequence of problematic organizational dynamics is vicarious traumatization (synonymous with secondary traumatic stress or compassion fatigue) among service providers. Vicarious traumatization has been defined by Charles Figley (1995) as "the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7), and symptoms may mimic those of PTSD. Vicarious traumatization has been linked to burnout in several studies (Bemiller & Williams, 2011; Brown & O'Brien, 1998; Ortlepp & Friedman, 2002; Ullman & Townsend, 2007).

Vicarious traumatization is widespread. Findings from a study of 148 advocates working in a range of types of DV organizations indicate that 47.3% of participants met criteria for clinical levels of PTSD symptoms (Slattery & Goodman, 2009). Organizational factors that may contribute to vicarious traumatization include a lack of involvement or influence on decision making, feeling like one's abilities are not being used, being exposed to danger at work, and too much focus on fixed regulations, procedures, and paperwork (Brown & O'Brien, 1998). Indeed, Slattery and Goodman (2009) found that lack of access to power (i.e., equality, voice, representation, shared leadership, and respect) in the

workplace significantly predicted vicarious traumatization above and beyond individual factors (e.g., personal history of trauma and exposure to traumatized clients). They recommended creating a workplace that emphasizes support, cooperation, effective communication, and conflict resolution skills and asserted that efforts to "flatten the hierarchy" and address power differences at the organization may also help minimize vicarious traumatization.

Creating a trauma-informed service system, then, occurs on three levels. The first is focused on the needs of survivors. The second is focused on changing an organization's culture to support staff and fully integrate trauma-informed practices into its service delivery; and the third level acknowledges the larger societal context in which survivors seek services and organizations operate. This level emphasizes not only engagement with the individual as part of a community, but also with community change itself in order to transform the conditions that produce abuse, violence, and trauma in the first place (Warshaw, 2014; Wilson et al., 2015).

These overarching principles have been applied across trauma-informed service systems. However, the particular language used to describe specific practices that arise from them may vary substantially depending on the service setting. The appendix provides a table of six trauma-informed models that have been identified as having some relevance for this project either because of the communities being served (LGBQT* or IPV survivors), the popularity of the model, or the credibility of the organization. See also Wilson and colleagues' (2015) recent qualitative content analysis of key documents – publications, manuals, and training guides – that describe an emerging consensus on trauma-informed practices in the domestic violence context, as well as points of difference and tension.

It is important to note that trauma-*informed* services are different from, but related to, trauma-*specific* services. Whereas trauma-informed services are designed to be implemented at all levels of an organization and focus on limiting the potential for retraumatization among participants, trauma-specific services are aimed at treating actual trauma symptoms (Harris & Fallot, 2001a). Examples of trauma-specific services include grounding techniques, psychoeducation, mind-body approaches and body-based therapies, cognitive behavioral therapy, and complex trauma treatment (Courtois & Ford, 2009; Courtois & Ford, 2015; Jennings, 2004; Resick, 2003; Warshaw & Brashler, 2009). A number of trauma-specific interventions have been tested in experimental or quasi-experimental research designs. Several studies have also attempted to document the effectiveness of trauma-specific services for female survivors of domestic violence. For a systematic review of evidence-based, trauma-specific services for survivors of domestic violence, see Warshaw et al. (2013). It is important to note, however, that none of these studies focused on LGBQT* survivors.

Trauma-informed service models are inherently more difficult to study because they focus less on specific practices and more on general principles, and they rely on change at the organizational level. Nonetheless, the Women, Co-Occurring Disorders, and Violence Study (WCDVS) attempted to evaluate the impact of this approach. As the only longitudinal study of a trauma-informed approach, the WCVDS indicated that women who received trauma-informed services showed small but significant

improvements on mental health outcomes and trauma symptoms relative to treatment as usual, but no effect for substance abuse (e.g., Morrissey et al., 2005). Since then, researchers have developed several tools to measure the presence of trauma-informed principles and practices as experienced by survivors (see, Accessing Safety and Recovery Initiative & the National Center on Domestic Violence, Trauma, & Mental Health, 2012; Goodman et al., in press;), and are testing new measures of the effects of trauma-informed practices on survivor wellbeing (National Center on Domestic Violence, Trauma, & Mental Health, in development), yielding new possibilities for exploring this important approach.

Trauma-Informed Practices with LGBQT Survivors of IPV*

Despite the high rates of IPV and trauma in LGBQT* communities, trauma-informed approaches tailored to LGBQT* communities have been slow to develop. Some non-IPV trauma-specific interventions have been designed with input from LGBQT* individuals and with concern for LGBQT* cultural competence (e.g., de Arrellano, Ko, Danielson, & Sprague, 2008; Real Life Heroes and Target-A). In addition, the Technical Assistance Partnership for Child and Family Mental Health created a webinar that discusses trauma-informed care for LGBQT* homeless youth. However, there are few well developed trauma-informed approaches for LGBQT* clients in service settings generally, and none in the field of IPV services.

Because of the barriers and difficulties faced by LGBQT* survivors, providers who work with these particular communities may face unique challenges, including lack of resources both within and outside of the service organization, exposure to homo-, bi-, and transphobia through hotline prank callers, experiences of discrimination while attempting to connect survivors with resources, and the possibility of increased vicarious trauma through shared LGBQT* identities.

At the same time, advocates may find strength and resiliency through a shared LGBQT* identity, a strong sense of LGBQT* community, and increased work satisfaction in serving marginalized community members. Advocates who identify as LGBQT* also may be able to draw upon their own experiences of discrimination as a source of resilience in the face of hardship. However, these hypotheses, which are informed by the authors' extensive practice experiences, have not been explored in the literature; considerable research is needed to determine the strengths and job stressors for providers who work with LGBQT* survivors.

Examples of Community-Specific Approaches to Trauma

Although there are no well-developed LGBQT*-specific practices, several community-specific approaches that have been developed by members of culturally-specific communities that have experienced multiple and overlapping forms of oppression may serve as guides.

One example, "Indigenist coping," which was first posited by Walters and colleagues (2002), is a Native-specific model that asks providers to abandon a focus on individual pathology, and instead center the historical trauma, ongoing discrimination, and experiences as a colonized people within a first world nation that are the norm for Native peoples in the U.S. (Walters et al., 2002). The multiple traumas experienced by Native peoples both individually and collectively are the foundation of service provision.

Walters and colleagues interpret the disproportionate rates of substance use, mental health challenges, and HIV risk behaviors among Native people, as conditions that might best be addressed and healed within the context of reconnection to the history and spiritual and healing practices of the Native community. Perhaps the most interesting aspect of the Indigenist coping model is its focus on uprooting internalized colonization and integrating identity along political, ethnic, racial, cultural, and spiritual dimensions. Although this model is not specific to Two-Spirit peoples, it is Two-Spirit-inclusive, and provides a conceptual framework that is responsive to the layered traumas experienced by too many Two-Spirit individuals (Walters, et al., 2002).

Similarly, the National Latin@ Network for Healthy Families and Communities has long used human rights and social justice frameworks to interpret trauma. Specifically, they view trauma through an understanding of multiple kinds of historical & collective trauma, the traumatogenic impact of "non-traditional" traumas such as racism, nativism, poverty, and discrimination and unjust denial of services from helping systems currently and historically experienced by Latin peoples. The National Latin@ Network correspondingly looks to identity cultural traditions and collective knowledge and wisdom, as sources of resilience and post-traumatic growth, both for individuals and for entire communities. Much like the Indigenist coping model (Walters et al., 2002), the approach of the National Latin@ Network looks to the community for both healing and leadership (Serrata, 2012).

Transformative Justice as a Trauma-Informed Practice

Transformative justice analyses recognize systemic oppression as contributing to and exacerbating the impact of interpersonal and community violence and seeks justice at every level (Hairston & Oliver, 2006; Generation Five, 2007). Whereas trauma-informed practice was conceptualized in clinical and academic contexts, transformative justice grew out of a community-based intervention model. It moves away from criminalizing and pathologizing those who use violence and toward transforming organizations, conditions, and systems that perpetuate violence. It is critical that trauma-informed practices include transformative justice as an additional lens in service delivery and system reform.

Generation Five (2007), an advocacy-based project working to end childhood sexual abuse, has helped shape a practice-oriented understanding of transformative justice by offering several goals and principles needed to build greater capacity of communities to challenge traumatogenic systems. According to Generation Five, there are four specific goals of transformative justice: safety, healing, and agency for survivors; accountability and transformation for people who use violence; community action,

healing, and accountability among those in positions of power; and, transformation of the social conditions that perpetuate violence. Notably, these goals build on a set of core principles: 1) liberation, 2) shifting power, 3) safety, 4) accountability, 5) collective action, 6) honoring diversity and 7) sustainability. Here, we explain these principles by providing possible ways in which they could be applied to work with LGBQT* survivors.

Liberation refers to ending long-standing intergenerational cycles of systemic and family violence, which can be partly achieved by shifting power away from those whose power has been achieved through domination, oppression, and violence. In the case of LGBQT* survivors, shifting power includes listening and responding to survivors' articulation of their stories and needs in order to promote self-determination. Liberation and shifting power also applies to LGBQT* individuals who use violence: To end intergenerational cycles of violence, it is important to understand their violent behaviors within the context of institutions and norms that perpetuate violence against them. For example, DV organizations can adopt more fluid and nuanced definitions of "victim" and "perpetrator"; that is, definitions that allow for someone to be (or have been) both a victim of violence and someone who used violence. Doing so invites people's full trauma history into the conversation for consideration and healing.

Safety is conceptualized on three intersecting levels. First, on an individual level, LGBQT* survivors must be protected from immediate and future acts of violence via intervention and prevention efforts. Second, within individual communities, action must be taken to foster norms and practices that condemn violence and support conditions for healing. Finally, at the macro level, communities must be accountable to one other in order to challenge institutional power. Part of that accountability includes acknowledging the prevalence and impact of interpersonal and historical trauma on individuals and communities as well as committing to survivor empowerment and healing. For example, mainstream DV programs can develop relationships with LGBQT* community members and programs to work toward long-term accountability of culturally sensitive service provision. They also can engage in ongoing program evaluation, including open discussion of policies, procedures, and staff profiles, in an effort to transform trauma-inducing organizational norms. Futures Without Violence (n.d.) has developed a series of "Program Personnel Policy Questions" for DV organizations to assess their readiness to work with children and teens; many of these questions can be amended to assess readiness to work with LGBQT* survivors. The National Center on Domestic Violence, Trauma & Mental Health's Accessible, Culturally Relevant, DV & Trauma-Informed (ACDVTI) Agency Self-Assessment Tool also provides guidance on organizational readiness and LGBTQ* inclusiveness.

Collective action highlights the need to address cycles of isolation and shame resulting from traumatic experiences by building alliances with communities to transform structures that perpetuate abuse. Additionally, honoring diversity includes creating and implementing interventions that respond to the unique needs of each community. Finally, sustainability refers to building internal capacity of intimate and community networks to support and maintain survivor-centered safety and healing. These last three principles highlight how social service organizations must incorporate advocacy efforts into

their work and cannot operate in isolation. Instead, they must learn from and collaborate with other organizations, specifically culturally specific organizations. Such collaboration includes not only LGBQT* organizations but also organizations that reflect the range of identities that LGBQT* survivors possess. Incorporating a diversity of expertise and perspective into programs and policies is critical for providing a more trauma-informed approach.

Conclusion

This literature review documents the need for LGBQT*-specific trauma-informed practices with survivors of IPV. IPV is at least as common among LGBQT* individuals as heterosexuals, and may be highest in bisexual and transgender communities. Furthermore, although LGBQT* IPV shares many underlying dynamics with IPV in heterosexual couples, it also has unique characteristics, including the types of abusive tactics used and the context of discrimination and social stigma faced by LGBQT* individuals. Moreover, there are additional complexities within LGBQT* subgroups.

LGBQT* survivors also face unique barriers to help-seeking. Overall, LGBQT* individuals are less likely to seek services from law enforcement and mainstream providers and more likely to rely on informal social support and LGBQT*-focused programs. There are also differences in help-seeking *within* LGBQT* subgroups. For instance, trans individuals may have an especially difficult time accessing culturally competent and non-traumatizing services. For LGBQT* people of color, stigma, economic constraints, and the absence of community outreach are barriers to accessing services.

Trauma and mental health are major concerns in LGBQT* communities in general, and for LGBQT* survivors specifically. LGBQT* individuals experience higher rates of traumatic events, and may be more susceptible to developing symptoms of PTSD, depression, isolation, suicidality, and anxiety. These concerns, which must be viewed in the context of historical trauma, are amplified for LGBQT* people of color and transgender individuals. Nonetheless, LGBQT* individuals find strength and resilience through identity affirmation and social support. More research focused on the strengths and sources of resilience of LGBQT* people is needed to complement and inform existing research on pathology and barriers.

Despite the high rates of IPV and trauma that LGBQT* communities experience, trauma-informed approaches tailored to LGBQT* survivors have been slow to develop. We hope that this document will facilitate thinking about how the core principles of trauma-informed practice can be applied to working with this community and to ameliorating vicarious traumatization among service-providers who do their best in difficult circumstances. The practice-based observations in the Appendix provide further framing for this important endeavor.

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Appendix A: Existing Trauma-Informed Approaches

Trauma-informed Approach	Trauma-informed Care with LGBQT* Homeless Youth
Community	LGBQT* Homeless Youth

Principles	Examples of Practices
• Recovery is possible • Healing happens in relationships • Sharing power and governance • Understanding trauma and its impact • Promoting safety • Supporting client control, choice, autonomy • Focus on strengths • Integrating cultural awareness	• Organizational commitment to nondiscrimination and cultural competence • Involve LGBQT* youth in decisions about services • Provide positive LGBQT* role models • Coordinate with LGBQT* service and advocacy organizations • Collaborate with other organizations • Outreach to change public awareness • Include LGBQT* youth in outreach • Assess staff for knowledge, attitudes, skills

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Trauma-informed Approach	Trauma-Informed or Trauma-Denied
Community	Female Survivors of Trauma

Principles	Examples of Practices
• Recognize the impact of violence and victimization on development and coping • Identify recovery from trauma as primary goal • Employ an empowerment model • Strive to maximize women's choice and control over recovery • Services are based in relational collaboration • Create an atmosphere respectful of survivors' need for safety, respect and acceptance • Emphasize women's strengths, adaptations and resiliency • Minimize retraumatization • Services are culturally competent and understand each woman in context • Solicit participant input and involve participants in designing and evaluating services	• Outreach and Engagement: prioritize safety, ask permission, follow client's lead • Screening and Assessment: screen all clients for trauma history, understand survivor's unwillingness to answer certain questions, only ask for necessary information, balance usefulness of information against client needs, clearly communicate reason for asking questions • Resource Coordination and Advocacy: focus on empowering clients, identify strengths, emphasize skill-building • Crisis Intervention: plan for crises in advance, avoid using restraints or forced hospitalizations, make sure clients know their options • Trauma-Specific Services: offered in trauma-informed environment by individuals trained in trauma and its treatment • Parenting Services: build on parents' strengths • Mental Health and Substance Abuse: treat trauma and substance abuse in integrated way, emphasize physical and emotional safety, collaborate on treatment • Healthcare: prepare clients for medical appointments that might be triggering, debrief and review information provided during exam

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Trauma-informed Approach	The Sanctuary Model
Community	Originally for adults who experienced abuse as children, adapted to domestic violence settings

Principles	Examples of Practices
• Core Concepts: nonviolence, viewing organization as whole entity, parallel processes • 7 Commitments: • Nonviolence: physical and psychological nonviolence at all organizational levels • Emotional Intelligence: staff must cultivate awareness of emotional responses and be able to manage and talk about them • Social Learning: organization must be dynamic and constantly identify and respond to changing needs of communities being served • Open Communication: organization should espouse transparency, nonviolent language, and effectively manage conflicts • Democracy: everyone at the agency, clients and staff, should have a voice that is heard • Social Responsibility: create a just and safe organization • Growth and Change: focus should be on the future, with goal of changing and growing over time	

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Trauma-informed Approach	National Center for Domestic Violence, Trauma & Mental Health's Accessible, Culturally Relevant, Domestic Violence-and Trauma-Informed (ACDVTI) Agency Self-Assessment Tool
Community	Domestic violence survivors and programs

Principles	Examples of Practices
• ACDVTI Approach • Be sensitive to the pervasiveness of trauma and its impact on survivors, staff and organizations including historical trauma and ongoing experiences of discrimination and oppression • Recognize the role of coercive control and DV-related safety and confidentiality concerns • Ensure services are welcoming, inclusive, accessible and culturally responsive • Work to minimize retraumatization • Support resilience, healing and well-being • Employ a collaborative strength-based approach • Attend to the quality of interactions for people using services and staff • Involve people using services and communities being served in shaping and evaluating services • Maintain a commitment to changing the conditions that contribute to abuse, violence, discrimination & oppression • Key tenets include recognizing the importance of • Physical and emotional safety • Relationship & connection • Respect, empowerment, transparency, collaboration & choice • Hope & resilience • A survivor-defined approach	The ACDVTI tool provides guidance on engaging in a reflective organization-wide self-assessment process. It is structured to walk agencies through a process of considering what an ACDVTI approach would look like in each of the following 7 domains. • Organizational Commitment and Infrastructure • Staff Support • Physical, Sensory and Relational Environment • Intake Process • Programs and Services • Community Partnership • Evaluation and Feedback It also includes a section on organizational readiness.

National Center on Domestic Violence, Trauma & Mental Health. *Becoming Accessible, Culturally Relevant, Domestic Violence- and Trauma-Informed Organizations: An Organizational Reflection Tool*. National Center on Domestic Violence, Trauma & Mental Health. Chicago, IL. 2015 in press. National Coalition of Anti-Violence Programs.(2012). Hate Violence Against Lesbian, Gay, Bisexual, Transgender, Queer, and HIV- affected Communities In the United States in 2011: A Report from the National Coalition of Anti-Violence Programs. New York City: NCAVP. Retrieved 8/22/2015 from: http://www.cuav.org/wp-content/uploads/2012/08/4379_NCAVPHVReport2011Final_Updated.pdf.

Trauma-informed Approach	SAMHSA TIC in Behavioral Health Services Guide	
Community	Behavioral health service organizations	
Principles		**Examples of Practices**
6 Initial Chapters: • Trauma-informed care: A sociocultural perspective • Trauma awareness • Understanding the impact of trauma • Screening and assessment • Clinical issues across services • Trauma-specific services		• Show organizational and administrative commitment to TIC • Use trauma-informed principles in strategic planning • Review and update vision, mission and value statements • Assign a key staff member to facilitate change • Create a TIC oversight committee • Conduct and organizational self-assessment • Develop an implementation plan • Develop policies and procedures to ensure trauma-informed practices and prevent retraumatization • Develop a disaster plan • Incorporate universal routine screenings • Apply culturally responsive principles • Use science-based knowledge • Create a peer-support environment • Obtain ongoing feedback and evaluations • Change the environment to increase safety • Develop trauma-informed collaborations
Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioral health services*. Rockville, MD: Substance Abuse and Mental Health Services Administration.		

Trauma-informed Approach	Developing Trauma-Informed Organizations Toolkit	
Community	Women with co-occurring disorders and histories of violence	
Principles		**Examples of Practices**
• A comprehensive, continuous, integrated service system • Person-centered services • Trauma • Safety • Family-focused • Diversity		• Establish open dialogue among providers, recipients, and systems • Increase capacity through cross-training, modification and addition of services as necessary • Increase access to peer support • Use respectful, gender-neutral, non-violent language • Recognize and understand cultural differences and how they impact the healing process • Provide co-ed and gender specific services • Staff should be knowledgeable about trauma • Provide access to trauma-specific services • Work with participants to develop calming skills • Validate participant experiences • Allow participant to define their family and support them in their role as parent • Cultural differences should be viewed as community resources and incorporated into service planning
Institute for Health and Recovery. (2012). *Developing Trauma-Informed Organizations: A Tool Kit* (Second ed.). Cambridge, MA: Institute for Health and Recovery.		

Appendix B: A Set of Practice-Based Observations for Trauma-Informed Practice with LGBQT* Survivors of Intimate Partner Violence

GLBTQDVP

GLBTQ Domestic Violence Project

TRAUMA-INFORMED APPROACHES FOR LGBQT* SURVIVORS OF INTIMATE PARTNER VIOLENCE

A Set of Practice Observations
June 2016

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Authors:

Erin C. Miller, M.P.S., M.D.V.
Domestic Violence/ Sexual Assault Programs;
Newton-Wellesley Hospital

Lisa A. Goodman, Ph.D.
Boston College

Kristie A. Thomas, Ph.D.
Simmons College

Carole Warshaw, M.D.
National Center on Domestic Violence, Mental Health, and Trauma

Principal Investigator:

Curt Rogers, M.P.A.
GLBTQ Domestic Violence Project

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Produced by
The GLBTQ Domestic Violence Project

GLBTQDVP

For more information on supporting LGBQT* survivors of intimate partner violence, contact one of the organizations below:

The LGBTQ DV Capacity Building Learning Center
c/o The Northwest Network
A program focused on improving research, practice and policy regarding domestic violence in LGBTQ communities.
1-206-568-777 | info@nwnetwork.org | www.nwnetwork.org

FORGE
A transgender anti-violence organization, specializing in technical assistance for victim service agencies, with a focus on domestic violence, sexual assault, dating violence, stalking, and hate crimes.
1-414-559-2123 | AskFORGE@forge-forward.org | www.forge-forward.org

If you would like more information about accessible, culturally relevant trauma-informed approaches for survivors, contact:

The National Center on Domestic Violence, Trauma & Mental Health
A program providing training, support, and consultation to advocates, clinicians, attorneys and policymakers as they work to improve agency and systems-level responses to survivors and their children.
1-312-726-7020 | info@nationalcenterdvtraumamh.org | www.nationalcenterdvtraumamh.org

Introduction and Project Overview

This document contains a set of preliminary practice observations from the field, which are intended to inform the development of a trauma-informed transformative justice approach specific to lesbian, gay, bisexual, queer, and transgender (LGBQT*) survivors of intimate partner violence (IPV). These observations are the result of a research project that was led by the GLBTQ Domestic Violence Project (GLBTQ-DVP) and funded by the Administration for Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services.

The goal of the project was to help develop a culturally-specific, trauma-informed approach to working with LGBQT* survivors with support and input from a range of stakeholders. To meet this goal, the following activities[1] were conducted over the course of two years (2013-2015):

- A substantive literature review on intimate partner violence in the LGBQT* communities (page 1), which is intended to be read in tandem with the observations
- Input from an advisory committee that included Queer Muslims of Boston, the Hispanic Black Gay Coalition, the Northeast Two Spirit Society, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, Massachusetts Asian & Pacific Islanders for Health, and Fenway Health
- Two focus groups with survivors participating in one GLBTQ DVP program, the goal of which was to explore their experiences seeking help
- Three separate focus groups and multiple individual conversations with staff of one GLBTQ DVP program to assess their perceptions, experiences, and ideas about trauma-informed organizations and providing trauma-informed services
- Surveys of the program's staff as well as LGBQT* practitioners nationally to assess knowledge and experience of trauma-informed practices
- Informal conversations with staff and leadership of LGBQT* culturally-specific organizations across the country
- The authors' own collective experience working with LGBQT* organizations and communities over the past 30 years
- Considerable guidance from the National Center on Domestic Violence, Trauma, & Mental Health

From these multiple sources of data, a set of six observations emerged, which then were simplified and distilled in the hopes that they will be broadly applicable. They are listed here and explained in detail in the subsequent pages.

- Observation 1: The majority of LGBQT* survivors have experienced multiple forms of violence and abuse in their lives. Experiences of historical trauma and ongoing discrimination can compound these multiple experiences of victimization.

[1] The Simmons College Institutional Review Board approved the research activities involving human subjects (i.e., interviews and focus groups with practitioners and program participants).

- Observation 2: Organizations that work with LGBQT* survivors must operate from a place of understanding that perceived "challenges" may actually be creative strengths.

- Observation 3: Organizations that work with LGBQT* survivors must operate from the premise that if LGBQT* communities, staff, board members, organizations, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their family of choice, not merely as a service provider or colleague.

- Observation 4: If practitioners are to truly be of service, a social justice and anti-oppression framework must become the cornerstone of their individual work, their organization's work, and their organization's interactions with the community.

- Observation 5: Staff self-care (and organizational support for self-care) is critical.

- Observation 6: There is a profound need for transformative justice[2] approaches to working with LGBQT* and other multiply oppressed communities.

It is important to note that the authors view these observations as dynamic and evolving, and we are hopeful that LGBQT*organizations, practitioners, activists, and researchers will expand upon them as part of their own trauma-informed, anti-oppression, transformative justice work. Some sections of this addendum tie directly to the literature review (e.g., observations 1 and 5), and others do not. Also, although these observations grew in tandem with the literature review – and should be read together – some of the ideas are not yet supported by a body of literature. Rather, they reflect the practice wisdom and lived experience of LGBQT* practitioners and LGBQT* survivors who contributed to this project.

The practice observations and companion literature review are intended primarily for staff in domestic and sexual violence organizations; however, they are applicable to practitioners in other anti-abuse disciplines, homelessness services, mental health and healthcare circles, criminal legal systems, youth services, and an array of other human services disciplines and social change endeavors that seek to serve and ensure the inclusion of LGBQT* communities.

[2] The authors wish to thank Hales Burton at the Fenway Violence Recovery Program for first suggesting this conceptual shift.

A Note on Language[3]

Before describing the observations, the authors wish to acknowledge the deep complexities of language. In this document, IPV refers to the physical and/or emotional abuse of an individual by a current or former intimate partner. It includes the full range of tactics used to create and maintain power and control over another person, including financial abuse, verbal abuse and intimidation, and cultural abuse. In this document, the phrases *intimate partner violence* and *domestic violence* are used interchangeably to denote partner violence. However, it is important to note that domestic violence (DV) is sometimes defined more broadly to include violence and abuse perpetrated by relatives. Although many LGBQT* individuals experience abuse and/or rejection from family and relatives, the dynamics of partner violence versus family violence may differ dramatically. When we discuss the latter, we use the phrase *family violence* to distinguish it from violence by an intimate partner.

LGBQT* stands for lesbian, gay, bisexual, queer, and transgender. It is often used interchangeably with GLBTQ, LGBQT-TS, and similar acronyms to broadly refer to sexual and gender minorities. This document honors the current practice of including an asterisk after the "T" to signify the broad diversity of trans communities, including trans women – transgender individuals who identify as women, though assigned male at birth; trans men – transgender individuals who identify as men, though assigned female at birth; those transitioning from female to male (FTM); those transitioning from male to female (MTF); cross dressers; gender non-conforming individuals; and others who might self-identify as being members of trans communities. In this paper, transgender and trans are used interchangeably.

These definitions belie the complexity of the terms, however. The words *lesbian*, *gay*, *bisexual*, *transgender*, and *queer* all carry particular historical, political and cultural meanings. To a great extent, these words have been shaped in white, Western contexts. Words such as lesbian, gay, and bisexual, for example, are uniquely English. There are seldom translations into other languages that carry the same understanding of LGBQT* identity as being an identity rather than a set of behaviors. Literal translations, into Spanish or Haitian Creole as but two examples, carry few if any of the presumptions that are inherent in English. In many parts of the Latin and Spanish-speaking world, men who engage in sex with same sex partners are only considered "gay" in the English sense of the word if they are the receptive partner. It is not engaging in the acts that is the determinant of identity, so much as the role that an individual plays (traditionally read as *masculine* or *feminine*) in the conduct of that act. Similarly, men who marry women, but engage in same sex acts with other men, are frequently identified as heterosexual. In short, they are defined by their social role, rather than by their private, intimate acts. Hence the conception of *gay*, as defined in U.S. contexts, frequently fails to apply.

Precisely because identifiers such as LGBQT* were defined in white middle class and academic contexts, the limitations of LGBQT* labels and identifiers may be particularly acute in communities of

[3] For those of you who are reading the literature and practice observations in tandem, please note that this "note on language" section is identical to the "note on language" section in the literature review.

color, Indigenous communities, and immigrant communities, among others. During the course of crafting this literature review, members of our Advisory Board taught us a tremendous amount. The Hispanic Black Gay Coalition (HBGC) suggested use of the term *same gender loving*, a community-specific phrase coined by Cleo Manago to distinguish African Americans, and in particular African American men, who do not self-identify as being part of the predominantly white gay movement in the U.S., but who nonetheless wish to affirm their same sex intimate relationships. Corey Yarbrough, one of the founding Executive Directors of HBGC, suggested that for some same gender loving people this language may be a form of racialized resistance to the racism of the mainstream LGBQT* movement in the U.S. In the alternative, Corey stated, some members of African American communities may be on the *down low*, engaging in same sex sexual activity, but rejecting LGBQT* identifiers as a result of internalized homo and biphobia.

The NorthEast Two-Spirit Society (NETSS) in part echoed Corey's thoughts about the racism of the mainstream LGBQT* movement. In addition, Harlan Pruden, one of co-founders of NETSS, spoke about an "internal muddiness" that some Native peoples may experience when seeking to find language for their experience. Speaking of his own Cree inheritance as a registered member of the Saddle Indian Reservation, Harlan said that when he asked something of an elder, he knew to offer them tobacco, but never understood the spiritual dimension of the ceremony. Having been separated from too much of their own history by colonialism, genocide and forced assimilation, Harlan stated, many Native people may use the words *Two-Spirit* when what they really mean is gay Indian.[4]

Harlan also spoke at length about the contextual nature of Native Two-Spirit identities. As Harlan put it, "When I am out on a Friday night in a gay club, I am a gay man. Yet when I am in rural Oklahoma at a Two-Spirit gathering, I am a proud Two-Spirit man." Alluding to the unique role and cultural responsibilities that Two-Spirit people often held (and may still hold) in the life of Native communities, Harlan pointed out the obvious differences in the spiritual role of Two-Spirit peoples, and the political and social function of people claiming LGBQT* identities in mainstream communities. Several members of the project's advisory board echoed this point,
speaking about the complex layering of cultural and spiritual value systems that accompanied their choice to self-identify in, with, and outside of their own communities.

These same Advisory Board members also acknowledged the landscape in which such decisions are made, and stated that individuals in their communities may shift how they self identify as a means of preserving their safety. As the rest of this literature review discusses, LGB, transgender, same gender loving, Two-Spirit, and queer-identified peoples make choices about how, when, and if to "out" themselves in a complex social and political landscape that is too often unsafe, if not violent. Hence how

[4] Two-Spirit is a contemporary term, adopted from the Northern Algonquin, and meant to signify the embodiment of both masculine and feminine within one person. Now embraced by many Native peoples as a pan-Indigenous umbrella term connoting both diverse gender expressions and sexual orientations, Two-Spirit generally speaks to the respect that Native peoples held for diversity, and the unique sacred and ceremonial roles that Two-Spirit people held (and may still hold) within their own communities. Herein the phrase Two Spirit speaks not simply to a third gender, or to same gender attraction, but more broadly to the history of compulsory Christianization that sought to erase Two-Spirit peoples within their own nations. Notably, there is no single consensus definition of Two-Spirit, and the term means different things to different Native peoples.

any individual self-identifies may shift depending on who is asking, why, and in what context. As one Advisory Board member stated, "identities have to be fluid in order to be protective."

Finally, the leadership of HarborCOV, an LGBQT*-affirming DV organization in Boston that specializes in serving communities facing cultural or linguistic barriers, has noted that some cultures may not have the variety or depth of language that words such as LGB, transgender, same gender loving, and Two-Spirit convey. Indeed, Kourou Pich, Co-Executive Director of HarborCOV has observed that people from some cultures and communities may have difficulty finding language for themselves in their own communities, and that that invisibility is intentional – a function both of denial of the existence of sexual minorities in those communities, but also perhaps protectiveness of gender queer and same gender attracted people.

Language is power. We authors, therefore, have put a great deal of thought into the words we use to name peoples' experiences. At the same time, we know that we can never be as inclusive or sensitive as we want to be. We have done our best to honor the range of experiences we are writing about in this document.

Notes from the Field: A Set of Practice-Base Observations

Observation 1: The majority of LGBQT survivors have experienced multiple forms of violence and abuse in their lives. Experiences of historical trauma and ongoing discrimination can compound these multiple experiences of victimization.*

A trauma-informed approach, at its core, asks that practitioners assume that everyone they serve has experienced some form of violence, abuse, or other trauma in their lives and to see these experiences as the norm, rather than the exception (Felitti et al., 1998; Harris & Fallot, 2001).

Given the prevalence and overlapping nature of violence and abuse in the lives of LGBQT* peoples, it might be more prudent to suggest that practitioners build practices and systems that presume *multiple* forms of victimization among the people they serve. It is not unusual for LGBQT* peoples to be targets of many different forms of violence and abuse at the hands of multiple individuals, at numerous points throughout the lifespan (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Grant, Mottet, & Tanis, 2011; Stotzer, 2009).[5] Indeed, traumatic experiences such as intimate partner

[5] To date, the fragmented nature of the research into violence and abuse in the lives of LGBQT* individuals means that, although there is a broad practice consensus about the prevalence of "polyvictimization" in the lives of LGBQT* peoples, there is little peer-reviewed research examining the phenomenon. However, there is abundant evidence that LGBQT* people, and in particular LGBQT* people of color, are more likely to be targeted for multiple forms of violence and abuse, in multiple contexts (family, partnerships, community) over the course of their lifetime. For example, LGBQT* peoples are disproportionately subject to childhood sexual abuse, bullying by peers, sexual violence in adolescence and adulthood, intimate partner violence, hate crimes, and police brutality (Roberts et al., 2010; Grant et al., 2011; Stotzer, 2009). Again, the authors wish to encourage individuals to read these observations in tandem with the literature review to learn more about these siloed areas of research.

violence, family violence, and other types of trauma that occur over the course of the lifespan, including childhood sexual assault, bullying, hate crimes, or police brutality, may intersect and compound each other in the lives of LGBQT* survivors in ways that create unique challenges for survivors themselves, and unique opportunities for control by future perpetrators.

These interpersonal traumas are often further compounded by experiences of oppression and historical trauma in LGBQT* communities. LGBQT* peoples have historically experienced discrimination at the hands of helping professionals in a range of systems (e.g., healthcare, mental health, criminal-legal, child protection, public assistance, and sexual and domestic violence organizations) – if LGBQT* peoples have been visible in those systems at all.[6] In addition, many of these systems (in particular mental health and criminal-legal systems) have not only pathologized, labeled, isolated, and detained LGBQT* individuals, but also intentionally fractured LGBQT* partnerships, families, and communities. Such treatment is especially the case for multiply marginalized LGBQT* communities, such as communities of color, immigrants and refugees, Two Spirit communities, and people with disabilities.

It is important to understand, however, that these forms of oppression are not merely historical artifact in the lives of LGBQT* survivors, but ongoing and continuing realities, especially for those who are multiply marginalized. This ongoing oppression then exacerbates experiences of current and historical trauma.

A trauma-informed approach encourages practitioners, and indeed entire systems, to minimize the possibilities for retraumatization by creating an atmosphere that prioritizes survivor's need for safety, respect, and acceptance (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Jennings, 2004; Substance Abuse and Mental Health Services Administration, 2014; Warshaw, 2014; Wilson, Fauci & Goodman, 2015). In short, a trauma-informed approach asks first and foremost that practitioners – as well as the systems in which they work – do no harm.

However, for LGBQT* survivors in particular, the mandate to do no harm requires that practitioners understand the concept of *sanctuary harm* – the idea that institutions and institutional gatekeepers can inflict enormous damage on the very people whose healing, empowerment, and safety they are supposed to nurture and protect (Bloom & Farragher, 2011; Smith & Freyd, 2014). Survivors who participated in the focus groups for this project spoke of blatant discrimination, noting, for example, institutions and practitioners who had at times openly refused services to male and LGBQT* survivors. And, in the staff focus groups, participants spoke about the challenges of advocating with organizations that had a funder mandate to be LGBQT* inclusive, but who were still actively resistant to accepting some members of this diverse community.

[6] The authors are mindful that historical trauma means different things in different communities. Many members of First Nation communities frame historical trauma in terms of colonization, genocide, and boarding-school trauma. Members of Jewish communities may frame historical trauma in terms of the intergenerational impact of the Holocaust. And members of the African Diaspora may think of the Middle Passage and the enslavement of African peoples when referencing historical traumas. The specific nature of the historical influences the way it continues to affect the lives of individuals and entire communities.

Conversations with LGBQT* practitioners across the country, especially those from mainstream organizations, surfaced deep ethical tensions over their own roles as institutional actors in organizations and agencies that they believed too often inflicted sanctuary harm. Consciousness of the harm they were doing – and the good they were prevented from doing – was a significant source of mental, emotional, and ethical distress for many practitioners, especially when contrasted with their larger awareness of the needs of the communities and people they were serving.

Observation 2: Organizations that work with LGBQT survivors must operate from a place of understanding that perceived "challenges" may actually be creative strengths.*

Recognizing the potentially significant impact of violence and abuse on development and coping strategies, a trauma-informed approach aims to contextualize coping strategies such as substance use, cutting, eating disorders, "promiscuous" sex, and dissociation as adaptive responses to otherwise intolerable situations (Elliot et al, 2005; Guarino et al., 2009; Jennings, 2004; SAMHSA, 2014, Warshaw 2014). Because it is rooted in clinical frameworks, trauma-informed practice approaches often frame such strategies as necessary within the context of abuse, but no longer adaptive once relative safety had been achieved. Following the examples of Kate Bornstein and Sylvia Rivera, the LGBQT*-specific practitioners who participated in the survey and informal conversations spoke about celebrating survivors' coping strategies as not merely adaptive, but indeed creative, even when such strategies are not on the surface immediately conducive to health or perceived well-being. Given the multiple forms of victimization, ongoing discrimination, and historical trauma that shape the LGBQT* experience, it may be that there is no safety anywhere. In that context, any strategy that allows people to survive – internally or externally – is to be celebrated. As one practitioner put it, "It isn't about coping, it is about surviving. We celebrate survival, because it is so uncertain." Such a response should not preclude practitioners from expressing concern or helping survivors to develop alternative survival strategies in parallel; however, it does require that practitioners fully embrace survivors and honor and respect their own strategies.

Observation 3: Organizations that work with LGBQT survivors must operate from the premise that if LGBQT* communities, staff, board members, organizations, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their family of choice, not merely as a service provider or colleague.*

A trauma-informed approach asks that practitioners base everything they do in relational collaboration. In fact, one of the core principles of a trauma-informed approach is to ensure that goals and strategies are collaboratively defined, and that the partnership between survivor and practitioner is itself a place of healing (Elliot, et al, 2005; SAMHSA, 2014; Warshaw, 2014; Davies & Lyon, 2014; Wilson et al., 2015).

Just as with other historically oppressed communities, the complexities of the LGBQT* experience may be such that a traditional relationship between service provider and client is not sufficient to fully support the person's healing. Instead, a different and more porous set of boundaries may be required – or at least expected. As several LGBQT* practitioners put it, when LGBQT* communities, staff, co-workers, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their "family of choice," not merely as a service provider. Program participants supported this sentiment, describing how one of the most important and helpful aspects of the services they received was the staff's willingness to go "above and beyond their job descriptions." Providing the sort of attention that a friend might provide (e.g., calling to check in or going along to doctor's appointments) was important because, as one survivor expressed, "I had never been treated that way in my life, not even by my family." Although this can raise complex ethical issues for both survivors and practitioners in navigating this important but complicated terrain, recognizing it is critical in working with LGBQT* survivors and working within LGBQT* communities.

Observation 4: If practitioners are to truly be of service, a social justice and anti-oppression framework must become the cornerstone of their individual work, their organization's work, and their organization's interactions with the community.

Another principle of trauma-informed practice is to respond to all people in ways that are sensitive to their individual social locations and contexts (Wilson et al., 2015; see also Elliot, et al, 2005; Jennings, 2004; Guarino et al., 2009; SAMHSA, 2014; National Center on Domestic Violence, Trauma & Mental Health, in press). At a minimum, this principle sets forth an expectation of cultural sensitivity across multiple aspects of identity. Given the chronic and cascading traumas, ongoing oppression and historical trauma referenced above, cultural sensitivity is essential but not sufficient for responding to the experiences of LGBQT* survivors. Instead, attention to individual social locations and contexts must be situated within a broader anti-oppression framework.

LGBQT* practitioners from across the country observed that the broader movements against sexual and domestic violence sometimes minimized the ways in which violence and abuse intersect with other forms of oppression. They took note not simply of the ways in which this lack of proactive attention shaped direct services, but also how it shaped their organization's hiring practices, the tokenization of staff members from historically marginalized communities, the narrow makeup of their organization's governing board, the focus on quantity over holistic quality of services, and the lack of input particularly from transgender community members and community members of color in strategic planning and other organizational activities.

By contrast, they called on practitioners to build organizations that are integrated into and learn from the historically marginalized communities they serve (or should be serving) and that center the knowledge and experiences of those communities. Historically oppressed communities, including LGBQT* communities, are at the leading edge of anti-violence work, not a set of "minority communities" requiring special logistics or uniquely special care. What organizations learn from historically oppressed communities should serve as the foundation of their organizational philosophy, practices, and policies.

Observation 5: Staff self-care (and organizational support for self-care) is critical.

Empathic engagement and bearing witness to other people's pain can affect us deeply. To be effective, it is important for service providers and activists serving people in pain and crisis to be mindful of how they have been affected by their own experiences of trauma *and* how they are affected when they open themselves up to other people's experiences (Saakvitne, Gamble, Pearlman, & Lev, 2000; Hopper, Bassuk, & Olivet, 2010; Bloom & Farragher, 2013; SAMHSA, 2014). Hence, an understanding of vicarious trauma and encouragement to develop strong habits of self-care have become foundational principles in trauma-informed practice (Bloom & Farragher, 2011; Bloom & Farragher, 2013). Thus, to be truly trauma-informed, organizations need to institute programmatic supports for self-care at all levels of the organization (Bloom & Farragher, 2011; Bloom & Farragher, 2013, Warshaw 2014).

Conversations with LGBQT* practitioners across the country led to an additional observation: There is a particular weight that accompanies serving LGBQT* people experiencing violence, abuse, and discrimination while simultaneously identifying with those same communities. Trauma, vicarious trauma, organizational trauma, and historical trauma compounded one another in the lives of the LGBQT* practitioners who contributed to this project, just as they do for the survivors who participate in their programs. Moreover, the impact of compounding trauma was one each group articulated virtually unanimously. Their experiences underscore the need for self-care at the individual level. They also point to need for organizational policies that enable self-care, provide LGBQT*-affirming workspaces, and facilitate connection with the larger community of providers and activists that support and depend upon the work and health of that organization. Essentially, caring for each other individually and as a collective is a critical element of any trauma-informed approach.

Observation 6: There is a profound need for transformative justice[7] approaches to working with LGBQT and other multiply oppressed communities.*

Because the companion literature review focused largely on peer-reviewed, published literature, it did not consider the enormous array of activist literature and art that historically oppressed communities have often used to express their communal strategies for survival and resistance. The work of Incite!, Creative Interventions, Black & Pink, and Break Out, along with broader bodies of art, music, dance, autobiography, fiction, and oral history attest to this creative communal drive.

One innovation that has emerged from this kind of activist energy is the concept of *transformative justice* (Generation Five, 2007; Creative Interventions, 2012). Transformative justice recognizes the profound harm and trauma that mainstream approaches have inflicted on LGBQT* peoples, particularly those who face multiple forms of oppression. Its practitioners argue for an approach that understands these historical harms and seeks to create new and innovative responses that avoid replicating them. Rather than work within the framework of social services, it aims for the liberation of oppressed people as communities not just as individuals, under the fundamental

[7] The authors wish to thank Hales Burton at the Fenway Violence Recovery Program for first suggesting this conceptual shift.

assumption that “individual justice and collective liberation are equally important, mutually supportive, and fundamentally intertwined” (Generation Five, 2007, p.1). In other words, transformative justice seeks to transform the political and cultural conditions that allow violence, abuse and oppression to exist in the first place. It is critical that trauma-informed practices include transformative justice as an additional lens in service delivery and system reform.

Conclusion

In summary, these six observations underscore the ways in which individual, interpersonal, and structural factors coalesce in the lives of LGBQT* survivors of domestic violence, creating a unique context, that affects their experiences and needs. Future trauma-informed approaches for LGBQT* survivors of domestic violence should consider the multi-layered context that surrounds LGBQT* survivors and use that knowledge to inform not only client-level practices, but also organizational-level policies.

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FEATURE

Growth after trauma

Why are some people more resilient than others—and can it be taught?

By Lorna Collier
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As Kay Wilson struggled to make her way through a Jerusalem forest after being repeatedly stabbed by a Palestinian terrorist, she distracted herself from her agony by playing the song "Somewhere Over the Rainbow" in her mind, composing a new piano arrangement while she fought for breath and forced herself to put one bare foot in front of the other.

Wilson, then 46, had been working as a tour guide when, on Dec. 18, 2010, she and a friend were ambushed by terrorists. Wilson witnessed her friend's murder and was herself viciously stabbed with a machete, ultimately playing dead as her attacker plunged his knife into her chest a final time.

She eventually recovered from her severe physical wounds and is healing from her psychological trauma. She now speaks to global audiences about her survival, hoping to "dispel hatred, whether toward Arabs or Jews."

The work "helps me make meaning out of something so senseless," says Wilson, who is also writing a book about her experiences.

After the attack, Wilson had flashbacks and deep survivor's guilt. But like many people who have survived trauma, she has found positive change as well—a new appreciation for life, a newfound sense of personal strength and a new focus on helping others.

Post-traumatic growth (PTG) is a theory that explains this kind of transformation following trauma. It was developed by psychologists Richard Tedeschi, PhD, and Lawrence Calhoun, PhD, in the mid-1990s, and holds that people who endure psychological struggle following adversity can often see positive growth afterward.

"People develop new understandings of themselves, the world they live in, how to relate to other people, the kind of future they might have and a better understanding of how to live life," says Tedeschi.

How can clinicians use PTG theory to help patients? How has new research helped refine understanding of it? Here's a look at developments in the field.

Signs of post-traumatic growth

PTG can be confused with resilience, but the two are different constructs (see "The post-traumatic growth inventory" below).

"PTG is sometimes considered synonymous with resilience because becoming more resilient as a result of struggle with trauma can be an example of PTG—but PTG is different from resilience, says Kanako Taku, PhD, associate professor of psychology at Oakland University, who has both researched PTG and experienced it as a survivor of the 1995 Kobe earthquake in Japan.

"Resiliency is the personal attribute or ability to bounce back," says Taku. PTG, on the other hand, refers to what can happen when someone who has difficulty bouncing back experiences a traumatic event that challenges his or her core beliefs, endures psychological struggle (even a mental illness such as post-traumatic stress disorder), and then ultimately finds a sense of personal growth. It's a process that "takes a lot of time, energy and struggle," Taku says.

Someone who is already resilient when trauma occurs won't experience PTG because a resilient person isn't rocked to the core by an event and doesn't have to seek a new belief system, explains Tedeschi. Less resilient people, on the other hand, may go through distress and confusion as they try to understand why this terrible thing happened to them and what it means for their world view.

To evaluate whether and to what extent someone has achieved growth after a trauma, psychologists use a variety of self-report scales. One that was developed by Tedeschi and Calhoun is the Post-Traumatic Growth Inventory (PTGI) (*Journal of Traumatic Stress*, 1996). It looks for positive responses in five areas:

- Appreciation of life.
- Relationships with others.
- New possibilities in life.
- Personal strength.
- Spiritual change.

The scale is being revised to add new items that will expand the "spiritual change" domain, says Tedeschi. This is being done "to incorporate more existential themes that should resonate with those who are more secular" as well as reflect cross-cultural differences in perceptions of spirituality.

A predisposition for growth?

How many people experience PTG? Tedeschi prefers not to put a hard number on it.

"It all depends on the trauma, the circumstances, the timing of the measurement ... [and] on how you define growth using the PTGI, looking at total score, means, factors or individual items," he says. However, he estimates that about one-half to two-thirds of people show PTG.

Some PTG researchers have tried to corroborate self-reported growth by questioning friends and family members about whether growth "sticks."

"We are getting more studies that show that PTG is generally stable over time, with a few people showing increases and a few showing decreases," Tedeschi says. "It is now up to us to learn what is going on with those who change over time, but the evidence is for stability in general, and also corroboration by others."

There appear to be two traits that make some more likely to experience PTG, says Tedeschi: openness to experience and extraversion. That's because people who are more open are more likely to reconsider their belief systems, says Tedeschi, and extroverts are more likely to be more active in response to trauma and seek out connections with others.

Women also tend to report more growth than men, says Tedeschi, but the difference is relatively small.

Age also can be a factor, with children under 8 less likely to have the cognitive capacity to experience PTG, while those in late adolescence and early adulthood—who may already be trying to determine their world view—are more open to the type of change that such growth reflects, says Tedeschi.

There also may be genetic underpinnings for PTG, but researchers are just beginning to tease this out. In a 2014 study in the *Journal of Affective Disorders*, for example, Harvard social and psychiatric epidemiologist Erin Dunn, ScD, and a team of researchers examined data previously collected from over 200 Hurricane Katrina survivors and found that variants in the gene RGS2 significantly interacted with levels of exposure to the hurricane to predict PTG. RGS2 is linked to fear-related disorders, such as post-traumatic stress disorder, panic disorder and anxiety.

Dunn calls the results "very interesting" but notes that "we have to be somewhat cautious in interpreting it because we were unable to find a similar sample to replicate that finding."

Sarah Lowe, PhD, of Montclair State University, who worked with Dunn on the research, says one difficulty with gene studies for PTG is the concept's complexity. "If you look at what predicts PTG, it is often psychological stress and dysfunction—but also more positive personality traits like optimism and future orientation, which you'd expect would have a very different genetic basis," she says.

Theory into practice

Is it possible to prepare people for PTG, to pave the way should tragedy or trauma strike? Yes, says Tedeschi, noting that psychologists can "allow people to understand that this may be a possibility for themselves" and is a "fairly normal process" if and when trauma occurs.

More often, though, therapists will become involved not before adversity has occurred, but afterward. In this context, they can introduce PTG concepts but need to take care doing so.

H'Sien Hayward, PhD, cautions that therapists should not "jump right into the possibility of growth," which she says can "often be construed as minimizing someone's pain and suffering and minimizing the impact of the loss."

Hayward, who works with veterans at VA Long Beach Medical Center in Long Beach, California, knows about such growth firsthand: She was paralyzed in a car accident when she was 16, ending a competitive athletic career. She overcame that trauma through the help of supportive family and friends, went on to study social psychology at Harvard and has traveled to more than 42 countries, often on humanitarian missions providing counseling and other support to trauma victims. Today, she credits the accident for increasing her strength of character "exponentially" by forcing her to overcome challenges. She also appreciates life and relationships with others—including the near-daily support in the small tasks of daily living that she gets from friends and strangers alike: "those interactions warm my heart."

Yet Hayward is careful not to preach the potential for upside to her patients before they are ready. Instead, she waits for them to express "some positive reaction to the event."

She also helps patients discover what's meaningful in their lives and then helps them schedule activities involving these interests, such as spending more time with family members or doing volunteer work.

Tedeschi says sometimes traditional therapy for trauma patients gives people short-fix solutions to help them resume daily functions, such as sleep or work, but may not provide them with a way of living "beyond just getting by .... We've got to attend to their experience of life and how meaningful, satisfied and fulfilling it is."

One veterans' care facility that takes a nontraditional, PTG approach to trauma treatment is Boulder Crest Retreat in Bluemont, Virginia. The private, donor-supported institute provides free, weeklong nonclinical exercises and activities for vets seeking recovery from combat stress. The treatment is led primarily by veterans who have themselves gone through trauma and achieved growth. Vets are encouraged to deal with past traumas while also discovering their underlying strengths, as well as forging connections with others and ultimately finding ways to give back.

After the intensive program, vets are followed for 18 months with regular Skype check-ins.

Kevin Sakaki, a former Marine and intelligence/special operations veteran, entered Boulder Crest's Warrior program last September and found it transformative. He's noticed such changes in himself as better communication with his family, less anger ("Things don't get to me as much"), a deeper appreciation of "the little things," more generosity and a stronger connection to other people.

Tedeschi is among the psychologists studying the Boulder Crest program's efficacy as part of a research grant funded by the Marcus Foundation.

He hopes that as vets go through the process at Boulder Crest, they "develop new principles for living that involve altruistic behavior, having a mission in life and purpose that goes beyond oneself, so that trauma is transformed into something that's useful not only for oneself but for others."

For further references go to our digital edition to connect directly to the research cited in this article: www.apa.org/monitor/digital.

The post-traumatic growth inventory

To evaluate whether and to what extent someone has achieved growth after a trauma, psychologists look for positive responses in five areas.

1: Appreciation of life

2: Relationships with others

3: New possibilities in life

4: Personal strength

5: Spiritual change

Source: Richard Tedeschi, PhD, and Lawrence Calhoun, PhD, *Journal of Traumatic Stress*, 1996

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REVIEW ARTICLE

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Trauma and trauma care in Europe

Ingo Schäfer[a], Manoëlle Hopchet[b], Naomi Vandamme[c], Dean Ajdukovic[d], Wissam El-Hage[e], Laurine Egreteau[f], Jana Darejan Javakhishvili[g], Nino Makhashvili[h], Astrid Lampe[i], Vittoria Ardino[j], Evaldas Kazlauskas[k], Joanne Mouthaan[l], Marit Sijbrandij[*m], Małgorzata Dragan[n], Maja Lis-Turlejska[o], Margarida Figueiredo-Braga[p,q], Luísa Sales[r], Filip Arnberg[s], Tetiana Nazarenko[t], Natalia Nalyvaiko[u], Cherie Armour[v] and Dominic Murphy[w]

[a]Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany; [b]Belgian Institute for Psychotraumatology, Brussels, Belgium; [c]Belgian Institute for Psychotraumatology, Trauma Center Limburg, Hasselt, Belgium; [d]Department of Psychology, Faculty of Humanities and Social Sciences, University of Zagreb, Zagreb, Croatia; [e]UMR 1253, iBrain, Université de Tours, CHRU de Tours, Inserm, Tours, France; [f]Laurine Egreteau, CHRU de Tours, Clinique Psychiatrique Universitaire, Tours, France; [g]Institute of Addiction Studies, Faculty of Arts and Science, ILia State University, Tbilisi, Georgia; [h]Business School, ILia State University, Tblisi, Georgia; [i]Department of Medical Psychology and Psychotherapy, University Medical Hospital Innsbruck, Innsbruck, Austria; [j]Dipartimento di Scienze dell'Uomo, Urbino University, Urbino, Italy; [k]Center for Psychotraumatology, Institute of Psychology, Vilnius University, Vilnius, Lithuania; [l]Department Clinical Psychology, Institute of Psychology, Leiden University, Leiden, The Netherlands; [m]Faculty of Behavioural and Movement Sciences, VU University Amsterdam, Amsterdam, The Netherlands; [n]Faculty of Psychology, University of Warsaw, Warsaw, Poland; [o]Faculty of Psychology, SWPS University of Social Sciences and Humanities, Warsaw, Poland; [p]Faculty of Medicine, University of Porto, Porto, Portugal; [q]Centre for Social Studies (CES) of the University of Coimbra, Coimbra, Portugal; [r]Department of Psychiatry of the Military Hospital of Coimbra, Centre of Trauma (CES) of the University of Coimbra, Coimbra, Portugal; [s]National Centre for Disaster Psychiatry, Department of Neuroscience, Psychiatry, Uppsala University, Uppsala, Sweden; [t]Non-Governmental organization 'Ukrainian Society of Overcoming the Consequences of Traumatic Events' (USOCTE), Kyiv, Ukraine; [u]International Institute of Depth Psychology, Non-Governmental organization 'Ukrainian Society of Overcoming the Consequences of Traumatic Events' (USOCTE), Kyiv, Ukraine; [v]School of Psychology, Institute of Mental Health Sciences, Faculty of Life & Health Sciences, Ulster University, Coleraine, Northern Ireland, UK; [w]Research Department, Combat Stress, Leatherhead, UK & King's Centre for Military Health Research, Department of Psychological Medicine, King's College London, London, UK

ABSTRACT

The European countries have a long history of exposure to large-scale trauma. In the early 1990s the increasing awareness of the consequences of trauma within the mental health community led to the foundation of local societies for psychotraumatology across Europe and the European Society of Traumatic Stress Studies (ESTSS), which celebrated its 25th anniversary in 2018. The focus of this article is to describe the current state of care for survivors of trauma in the 15 European countries where ESTSS member societies have been established. Brief descriptions on the historical burden of trauma in each country are followed by an overview of the care system for trauma survivors in the countries, the state-of-the-art of interventions, current challenges in caring for survivors and the topics that need to be most urgently addressed in the future. The reports from the different countries demonstrate how important steps towards a better provision of care for survivors of trauma have been made in Europe. Given the cultural and economic diversity of the continent, there are also differences between the European countries, for instance with regard to the use of evidence-based treatments. Strategies to overcome these differences, like the new ESTSS training curricula for care-providers across Europe, are briefly discussed.

Trauma y Atenciones de Trauma en Europa

Los países Europeos tienen una larga historia de exposición a traumas de larga escala. A principios de la década de 1990, la creciente conciencia de las consecuencias del trauma dentro de la comunidad de salud mental condujo a la fundación de las sociedades locales para la psicotraumatología en Europa y la Sociedad Europea de Estudios de Estrés Traumático (ESTSS), la cual celebra en el 2018 su 25° aniversario. El enfoque de este artículo es describir el estado actual de la atención de los sobrevivientes de traumas en los 15 países Europeos, donde las sociedades miembros de la ESTSS se han establecido. Las descripciones breves sobre la carga histórica de trauma en cada país son seguidas por una descripción general del sistema de atención para sobrevivientes de trauma en el país, el estado de la técnica de las intervenciones, los desafíos actuales en el cuidado de sobrevivientes y los temas que necesitan ser abordados con mayor urgencia en el futuro. Los reportes de los diferentes países demuestran los pasos importantes que se han dado en Europa en la entrega de atención para los sobrevivientes de trauma. Dada la diversidad cultural y económica del continente, hay también diferencias entre los países Europeos, por ejemplo en relación al uso de tratamientos basados en la evidencia. Las estrategias para

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心理创伤学; 历史; ESTSS; 欧洲; 创伤; 治疗; 护理; 心理治疗

HIGHLIGHTS

- Important steps towards a better provision of care for victims of trauma were made in the European countries.
- In 2018, ESTSS celebrates its 25th anniversary.
- Strategies to promote a better practice include new ESTSS curricula for professionals across Europe.

CONTACT Ingo Schäfer i.schaefer@uke.de Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany

[*]In close collaboration with fellow NtVP Board members Miriam Lommen, Marie-Louise Meewisse, Trudy Mooren and Maartje Schoorl.

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resolver estas diferencias, como el nuevo curriculum de entrenamiento de la ESTSS para los proveedores de atención a lo largo de Europa son discutidas brevemente.

欧洲的创伤和创伤护理

欧洲国家有遭受大规模创伤的久远历史。在20世纪90年代早期，精神卫生界内越来越意识到创伤的后果，导致了在欧洲各个地区性创伤心理学会和欧洲创伤应激研究学会（European Society of Traumatic Stress Studies；ESTSS）的成立，该学会将于2018年庆祝其成立25周年。本文旨在描述在已建立ESTSS子协会的15个欧洲国家中创伤幸存者护理的当前状况。首先是对每个国家创伤的历史负担的简要描述，之后概述了各国创伤幸存者的护理系统的概述，干预措施的最新技术，护理幸存者面临的的当前挑战以及将来最迫切需要解决的问题。来自不同国家的报告展示了，在欧洲是如何实现为创伤幸存者提供更好的护理。鉴于大陆的文化和经济多样性，欧洲国家之间也存在差异，例如在循证治疗的使用上。我们简要讨论了克服这些差异的策略，例如为跨欧洲的护理服务提供者的新ESTSS培训课程。

1. Introduction

Exposure to trauma is common (Kessler et al., 2017) and its consequences on the individuals and communities affected can hardly be overestimated. In Europe, as in other regions of the world, a high burden of trauma is related to human-made events. In the twentieth century, military conflict took place during every single year in the European region and many of them affected numerous countries (see Table 1). Mass traumatization was also related to military conflicts associated with European colonialism, or conflicts in other continents where European military forces were involved in conflicts (see Table 2). Another massive burden of trauma across Europe resulted from the Holocaust and, throughout most of the twentieth century, from the political oppression by the Soviet communism. Trauma has occurred and still occurs in many societal contexts. For example, these include the familial and institutional abuse of children, different forms of gender-based violence in the European societies, various forms of institutional violence (i.e. in detention facilities of some countries) and also large-scale disasters and terror attacks that struck individual countries. Finally, over the last decades, an increasing number of migrants have reached the European countries, due to war and violence in their homeland (Hall & Olff, 2016; Kartal & Kiropoulos, 2016; Knaevelsrud, Stammel, & Olff, 2017; Munz & Melcop, 2018).

In the last two decades of the twentieth century, the increasing awareness of the consequences of trauma in the mental health community led to the foundation of local working groups and societies for psychotraumatology in several European countries. The European Society of Traumatic Stress Studies (ESTSS), which celebrated its 25th anniversary this year, was founded in 1993. Over two decades, ESTSS was an organization that included both member societies and individual members, which in the first years mainly came from western European countries. Recently, ESTSS has developed into an umbrella organization of the European societies for traumatic stress. This change is the result of a strategic plan that has been pursued over a longer period of time (Gersons, 2013). The ESTSS board consists of representatives from all member societies, which facilitates the work towards common strategic aims, such as promoting a standard curriculum for training in psychotrauma across Europe. In 2018, ESTSS com-

Table 1. Examples of military conflicts in Europe.

Year	Military conflict	Countries affected
1914–1918	First World War	Paneuropean
1917–1922	Soviet revolution	Former Soviet countries
1936–1939	Spanish civil war	Spain
1939–1945	Second World War	Paneuropean
1944–1953	Lithuanian partisan war against Soviet occupation	Lithuania
1968–1998	The Northern Ireland Troubles	UK, Republic of Ireland
1991–2000	Wars following the dissolution of former Yugoslavia	Slovenia, Croatia, Bosnia and Herzegovina Serbia, Montenegro, Kosovo
Since 1990	Military conflicts/wars in the South and North Caucasus	Georgia, Armenia, Azerbaijan and Russia (including North Caucasian region of Russia)
2008	Russian-Georgian war	Georgia, Russia
Since 2014	Conflict in East Ukraine	Ukraine, Russia

The list of military conflicts and countries involved is not all inclusive.

Table 2. Examples of military conflicts outside of Europe.

Year	Military conflict	European countries affected
1945–1949	War in the former Dutch East Indies	The Netherlands
1946–1954	Vietnam war	France
1954–1962	Algeria war	France
1950–1953	Korean war	Belgium, France, Greece, Luxembourg, Netherlands, UK
1961–1974	Portuguese Colonial War in Africa	Portugal
1979–1987	Afghanistan war	Former Soviet countries, UK
1990–1991	Gulf war	Belgium, Denmark, France, Germany, Greece, Hungary, Italy, Netherlands, Norway, Poland, Portugal, Romania, Spain, Sweden, UK
2001–2014	Afghanistan war	Albania, Belgium, Croatia, Czech Republic, Denmark, France, Georgia, Germany, Italy, Lithuania, Norway, Poland, Portugal, Romania, Russia, Spain, Sweden, UK, etc.

The list of military conflicts and countries involved is not all inclusive.

prised of 13 member societies that included 15 European countries and regions. These included Austria, Belgium, Croatia, Georgia, Germany, Lithuania, Italy, The Netherlands, Poland, Portugal, Sweden, the German-speaking and the French-speaking part of Switzerland, Ukraine and the UK (www.estss.org). Moreover, ESTSS had 12 additional affiliated societies and institutions in 2018. The society is constantly working towards the inclusion of further European societies and actively supports the formation of new societies in countries where they do not exist yet, as currently happened in Finland where the Finish Society for Psychotraumatology was launched in 2018.

While a series of articles at the occasion of ESTSS' twentieth anniversary focused on the inspiring and often also entertaining recollections of former presidents on the development of ESTSS (Lueger-Schuster, 2013b), the focus of this article is on the current member societies of ESTSS and on the development of trauma care in the respective countries. After some reflections on the historical burden of trauma in each country, representatives from all the national societies describe the structure of care organizations for trauma survivors, the state-of-the-art of interventions, current challenges in caring for survivors and the topics that need to be most urgently addressed in their countries in the future.

2. Psychotraumatology in Belgium

Five to eight million deaths, perhaps even 10: this was the devastating toll of the conquest and colonial exploitation of the Belgian Congo with King Leopold II, between the 1880s and the First World War (Hochshild, 1998). All traces of this Genocide remained secret until the early 1980s. Concerning the historical burden of the two World Wars (Manfred, 2015), it is the First World War more than the Second World War which, in the collective memory, constitutes a great trauma because of the looting of the country and the massacre of more than six thousand civilians. Recent events that stay more broadly in the mind of the Belgian people include the Heysel Drama in 1985 and the Dutroux affair with the sexual abuse, sequestration and death of young children and adolescents in 1996. In March 2016, the terrorist attacks at the national airport and in the metro of Brussels caused the death of 35 persons (Deschepper et al., 2018). Psychosocial structures vary across the country and have little or no coordination between them. One of the reasons is a difference between the functioning of French- and Flemish-speaking communities. Some structures can be found in both the French- and the Flemish-speaking communities. For instance, Public Welfare Centres and police victim services can be found in both of them. The integration of a psychosocial dimension into emergency and intervention plans was formalized in 2006. For the last 20 years, psychotherapists and other clinicians working in private practices started to specialize in trauma care for survivors. More and more specifically trained psychologists are working in hospitals and mental health centres. Recently, the development of outpatient trauma treatment centres linked to hospitals is evident. Some centres for the provision of trauma care for refugees were established in Brussels and cover the Dutch- as well as the French-speaking part of the country. In 2017, the High Council on Health received a Ministerial request for an opinion on the psychological care and support of persons following terrorist incidents or related disasters.

Until recently, there were no trauma-focused intervention methods in use in Belgium. The main therapeutic currents, for instance cognitive behavioural therapy (CBT) and psychodynamic therapies, were putting their own accents on working with trauma. In 2006, the BIP (Belgian Institute for Psychotraumatology) started the first psychotraumatology course. More trauma centres were created in the following years in principle cities, mainly Antwerp and Brussels. The course is organized in collaboration with two Universities. BIP organizes conferences in collaboration with other institutes or centres in Belgium. An independent Belgian trauma society needs to be created in the near future.

Current challenges in caring for trauma survivors concern the coordination of different support services. The political system in Belgium involves varying responsibilities at several levels, which makes decision-making complex. More visibility through studies on the positive impact and benefits of qualified trauma-focused care will be important. Finally, a well-structured national accreditation system should be put in place in order to continue provision of quality care for trauma survivors.

Among the topics to be most urgently addressed in the future is accessibility of services which is limited due to long waiting lists before survivors get access to psychological care in the Belgium mental health care system. Moreover, new ways of thinking about specialized trauma-care structures are needed.

3. Psychotraumatology in Croatia

The still living burden of the Second World War psychotrauma in Croatia has merged with the trauma of the Homeland War (1991–1995). Throughout the whole post-World War period there was no awareness of the consequences of trauma exposure, the issue was present neither in the health nor in public discourse. Consequently, no specific care was developed and provided. In contrast, the war in the 1990s brought about a high level of awareness of trauma and posttraumatic stress disorder (PTSD). Decades later the war-affected population reports 18% prevalence of PTSD (Priebe et al., 2010). This may be

partly due to lack of effective early trauma interventions and a number of hindering social factors, such as the prolonged economic crisis that affected more the vulnerable populations. The spin-off effect of massive trauma at the social level is a new understanding of the impact of traumatic events on physical and psychological health, as well as on communities (Corkalo Biruski, Ajdukovic, & Löw Stanic, 2014; Lončar & Henigsberg, 2007), which in turn facilitates access to specialized services by people exposed to trauma in everyday life.

Trauma survivors have access to psychiatric services in major hospitals, while veterans receive help within the three specialized regional centres and the National Centre for Psychotrauma. The cost of services are covered by universal national health insurance. Several non-governmental organizations with qualified staff provide supportive therapy to survivors of sexual assault, traffic accidents and other life threatening incidents, as well as domestic violence. The Polyclinic for the Protection of Children based in Zagreb specializes in working with traumatized children. Other facilities focus on prevention and support in the immediate aftermath of traumatic incidents, such as the Crisis Response Network maintained by the Society for Psychological Assistance (SPA).

The psychiatrists' first treatment choice is psychopharmacology. The prevalent therapeutic approach in psychiatric services for veterans is group therapy. Some veterans have been attending such groups for over 25 years. Low use of evidence-based trauma-focused therapies reflects (Schnyder et al., 2015) the prevailing traditional approach in Croatian psychiatry. Hence, traumatized populations still have poor access to effective, evidence-based trauma treatments. Training in trauma-focused CBT and EMDR is offered to practitioners, but this is not fully integrated into the helping system. With the existing high level of competencies in dynamic psychotherapy and psychopharmacology (Britvić et al., 2012), the challenge remains to develop a more stepwise approach to trauma-informed services, increase public awareness of risk and resilience factors, and to expand treatment choices to include evidence-based trauma-focused therapies and make them more available to the general populations in need. The Croatian Society for Traumatic Stress (CSTS) has been working on this challenge since it was founded in 2011 by organizing training workshops. It is currently promoting the ESTSS certified training in psychotrauma for mental health providers. One of the ambitions is to further integrate such training into university curricula so that future generations of mental health professionals are able to provide state-of-the-art care to traumatized people. Similarly, basic and intermediate levels of trauma-related knowledge and skills will be made more available to first responders and other health professionals.

4. Psychotraumatology in France

According to the World Mental Health survey, 72.7% of the French population has been exposed to traumatic events in their lifetime (Husky, Lépine, Gasquet, & Kovess-Masfety, 2015). Intimate partner violence, serious illness of a child and rape were the events associated with highest risk of PTSD. While rape is underreported in France, each year nearly 100,000 individuals claim to be survivors of rape or attempted rape and 500,000 claim to be survivors of intimate partner violence. A fifth of the French population was exposed to war-related events (mainly the Second World War). The twenty-first century was scarred by numerous Islamism extremist attacks, of which the November 2015 Paris attacks have been the bloodiest to date, resulting in more than 264 dead and 914 injured individuals. Traffic fatalities decreased in the past decades, reaching 5.1 per 100,000 inhabitants per year.

Since 1995, medico-psychological emergency units (CUMP for 'Cellules d'Urgence Médico-Psychologiques') are deployed in the case of mass casualty situations and provide immediate psychological support and care. These units were very effective after terror attacks in Paris and Nice, supporting thousands of survivors over many weeks (Hirsch et al., 2015). Psychological assistance aims at providing survivors with an entry point to psychological health care and giving them a first sense of relief, even though they do not provide psychological follow-up care (Vandentorren et al., 2018). In order to ensure long-term high-quality trauma care to all survivors in need across the country, President Emmanuel Macron in November 2017 announced the creation of about 10 ambulatory services specialized in trauma care. These services are aimed at providing medical and psychological care to survivors (minors or adults) that have experienced violence or any traumatic event during their lifetime.

The traditional psychodynamic approach is gradually but slowly replaced by structured trauma-focused psychotherapies, such as CBT or EMDR, and also new technologies (e-PTSD) are being introduced (Bourla, Mouchabac, El Hage, & Ferreri, 2018). However, the provision and access to treatment remain limited by the fact that there is a limited number of experienced trained trauma therapists and that care centres are not always clearly identified or equitably distributed across the country.

The challenges in caring for survivors are to achieve universal access to prevention, improve access to trauma-focused psychotherapies and ensure coordination of specialized care and support. One major challenge is to expand public funding of structured psychotherapies by trained psychologists. It is advisable to ease access to structured trauma-focused

therapies as part of mental health care programmes in compliance with international guidelines. In the end, patients should benefit from personalized treatment strategies for their trauma-related disorders, based on objective information.

The future ambulatory care services specialized in trauma will have to structure the organization of care, to establish a single French umbrella society (involving the national trauma centre and psychotrauma societies such as AFORCUMP-SFP, ALFEST and ABC des Psychotraumas), to be involved in qualifying training curricula, and to set up a French certification committee connected to the ESTSS accreditation committee, in order to meet modern European and international standards.

5. Psychotraumatology in Georgia

Georgia is a post-Soviet country, with a population of approximately 3.3 million. Since becoming independent in the early 1990s, it went through a prolonged series of civil war and ethnic-political conflicts followed by a war with Russia in 2008 and loss of control over more than 20% of the country's territory. Ongoing social, political and economic crises create pressure on the population, 20.6% of whom live under the poverty level and 7.3% of whom are internally displaced. Among the conflict-affected population, 23.3% suffer from PTSD symptoms, 14.0% from depression, 10.4% from anxiety and 12.4% have more than one mental health condition (Makhashvili et al., 2014). In addition, the population still suffers from the inter-generational effects of trauma related to the Soviet invasion and totalitarian past (Javakhishvili, 2014, 2018).

The large proportion of conflict-affected population led to the build-up of trauma care capacities and corresponding institutional developments, i.e. trauma-focused torture victim rehabilitation centres (GCRT), functional since 2000, with the head office in the capital city Tbilisi and branches in eastern and western Georgia. The multidisciplinary teams provide free of charge care for their clients that include forced migrants, ex-prisoners and others. There are a number of non-governmental organizations providing trauma-informed psychosocial services to socially disadvantaged groups, including forced migrants, domestic violence survivors and other target groups.

The Georgian Society of Psychotrauma (GSP) was founded in 2007 with the support of ESTSS. GSP builds capacity within the local professional community and has introduced such evidence-based treatment methods as Trauma-Focused CBT, Brief Eclectic Psychotherapy for PTSD (BEPP) and EMDR, as well as other relevant psychosocial interventions. Since 2008, GSP regularly conducts an annual international multidisciplinary conference 'Trauma and Society'. To assure capacity building and good quality care, an innovative Master Program in Mental Health was founded in 2012 at Ilia State University in Tbilisi, under the lead and with a main perspective on psychotraumatology.

The mental health treatment gap is about 90% in the country. There is a predominant focus on hospital care; community-based services are under-developed. Common mental disorders are under-recognized and under-treated by the state services. There is a need to develop a trauma-informed primary health care system, enlarge the trauma care infrastructure and establish corresponding referral pathways. Another challenge is low awareness of one's own mental health condition. According to a recent study, of those who suffered from mental health symptoms, only 24.8% sought care, 19.6% acknowledge mental health problems but did not seek care, and 54% did not acknowledge mental health problems (Chikovani et al., 2015).

Since most trauma survivors belong to socially disadvantaged groups who are often exposed to multiple traumatization as well as a series of everyday life stressors, we rarely find among these patients simple PTSD. The most widespread trauma-related condition are complex posttraumatic disorders. Therefore, the most urgent need is to evaluate effective methods of addressing complex trauma conditions. From 2016 to 2018, within the framework of an Erasmus Plus cooperation, the Trauma-Focused Cognitive-Behavioural Therapy Train of Trainers (ToT) module was developed, piloted and adapted to the Georgian cultural context in cooperation with Cardiff University. It has proved its effectiveness in the treatment of not only simple but also complex trauma-related disorders. There is a need to collect strong evidence to further prove the effectiveness of these approaches.

6. Psychotraumatology in the German-speaking countries

As in many European countries, the largest historical burden of trauma in Austria, Germany and Switzerland comes from the two twentieth century World Wars and the Holocaust. Over the decades, the different roles of the three countries in these catastrophic events had an influence on the perception of their traumatic impact. In contrast to Switzerland, discourses in Germany and Austria had been more focused on their role as perpetrators and their responsibility for these events. In general, Switzerland has been much less concerned by the two twentieth century World Wars than Germany and Austria. It took a longer time before the trans-generational consequences of war and displacement on parts of the German and Austrian population were also discussed (e.g. Glück, Tran, & Lueger-Schuster, 2012,

Kuwert, Brähler, Glaesmer, Freyberger, & Decker, 2009). Another population that requires expertise on psychotraumatology in the three countries is that of the refugees (e.g. Knaevelsrud et al., 2017; Spiller et al., 2017).

Services for trauma survivors are organized in a similar way in the three German-speaking countries. Non-governmental organizations play an important role in the psychosocial response to disaster and other mass incidents. Some of them also provide care for survivors of individual trauma in the form of local 'crisis intervention units' that closely collaborate with other emergency services. Specialized counselling agencies, usually funded by the local municipal authorities, offer low-threshold services for survivors of childhood abuse, sexual assault and domestic violence. In all three countries, there are also growing networks of clinical outpatient services for survivors of interpersonal violence that are frequently located at psychiatric hospitals. Psychotherapists in private practice play an important role for the treatment of posttraumatic disorders in both children and adults. Moreover, in each of the three German-speaking countries, a larger number of hospitals offer specialized inpatient care for patients with posttraumatic disorders.

The German-speaking Society for Psychotraumatology (DeGPT), the common trauma society of the three German-speaking countries (Germany, Austria and Switzerland), has developed curricula for the training of professionals in different settings (e.g. staff in counselling services, psychotherapists for children and adults) in trauma-related practices. The curricula for psychotherapists have been recognized by important national bodies, like the national chambers of physicians and psychotherapists in Germany. At present, about 50 training institutes in Germany, Austria and Switzerland offer the curricula. The society also coordinates the national German guideline for the treatment of PTSD. Such activities have contributed to the dissemination of evidence-based practices in different settings. However, as in other European countries (Kazlauskas et al., 2016), many psychotherapists still do not feel competent to deal with traumatized populations. As a result, patients can face substantial problems to find adequate help, for instance in the form of trauma-focussed interventions for individuals with PTSD.

The prevention of trauma in different settings remains a challenge. Recently, initiatives in all three German-speaking countries addressed the problem of institutional violence, e.g. in foster care settings, but more efforts are needed to sustainably implement preventive efforts and bodies like the independent commissioner into childhood sexual abuse in Germany (Bergmann, 2011). The dissemination of trauma-informed practices in all parts of the health care system and the social sector is another urgent issue. Finally, the provision of adequate care for the considerable number of migrants from contexts of war and persecution in the German-speaking countries is a challenge for the years to come.

7. Psychotraumatology in Italy

Trauma permeates the history of Italy: war, terrorism, major mass disasters, abuse and maltreatment deeply affected the Italian society across time and generations. During the Second World War, many Italians experienced the effects of torture and deportation leaving a scattered society (Favaro, Rodella, Colombo, & Santonastaso, 1999). In the 1970s, the Italian society faced the 'dark period' of *Brigate Rosse*, a terroristic group who caused many deaths and created a deep sense of fear in the population. Domestic violence is the most common crime against children; indeed, child abuse and maltreatment is a major public health problem. A recent report (Autorità Garante per l'Infanzia, CISMAI and Terre des Hommes, 2016) revealed that each year 950 children are exposed to sexual abuse. In the past year, the percentage of maltreatment and abuse increased by 6%. Italy has also experienced a significant number of natural disasters, like floods and earthquakes, that potentially increased the prevalence of post-traumatic syndromes in the communities. There are no robust data about the actual burden of such traumatic experiences and their effects on the society today.

Italian health and social care systems have not yet fully embraced a trauma-informed approach. This led to fragmented responses to the needs of survivors, especially in terms of preventive initiatives. There is some resistance to implement routine screening and assessment tools for the early detection and prevention of post-traumatic syndromes. For this reason, the system responds late and mainly to traumatization that became complex as a result of missed accurate diagnoses. It is a challenge to acquire a systemic vision of care for traumatized populations, with shared policies and protocols.

Exposure-based therapies are rarely used; EMDR is the only widely implemented intervention in the social care system at all levels. Other trauma-focused therapies (Ehring et al., 2014) – such as trauma-focused CBT or Narrative Exposure Therapy (NET; Schauer, Neuner, & Elbert, 2011) – struggle to be disseminated. Clinicians are asked to integrate different treatment approaches with a good understanding of assessment and psychoeducation techniques. Training of health and social care professionals is a key issue. In Italy, trauma is still seen as a 'psychologist/psychotherapist business', undermining the importance of multidisciplinarity. Furthermore, a synergy between clinical work and research should be

promoted to investigate the outcomes of treatment and to adapt service models accordingly.

There are a few important strategic points the Italian Society of Traumatic Stress Studies (SISST) should consider for the future. Highly traumatized migrants and refugees are one of the priorities requiring a long-term preventive plan to fight longer-term consequences for the society. The second point is the promotion of a more articulated reasoning about the implementation of evidence-based therapies. Furthermore, epidemiological studies are warranted to determine the actual prevalence and incidence of traumatic events in Italian society. Finally, another crucial issue is a comprehensive training in psychotraumatology. The new ESTSS certification represents a good opportunity for trauma-informed capacity building initiatives in the near future.

8. Psychotraumatology in Lithuania

The burden of trauma in Lithuania was largely influenced by the political situation in Europe in the twentieth century. Large-scale traumas associated with the two World Wars, the Holocaust and the prolonged Soviet occupation had a significant impact on the Lithuanian population, marked with suffering and oppression for several generations. Interest in trauma and trauma research in Lithuania was started soon after the collapse of the Soviet Union in the 1990s and several studies explored posttraumatic effects of political violence in the country (Kazlauskas & Zelviene, 2016).

Survivors of traumatic events can seek treatment for mental disorders in the public mental health care system, which includes about 100 primary mental health centres spread across the country, and in more severe cases in psychiatric hospitals. Several non-governmental organizations and crisis centres in the biggest cities in Lithuania are providing help for survivors of interpersonal violence, including psychosocial support and psychotherapy. Additionally, psychotherapists in private practice are also available for trauma survivors. Despite these positive developments, care organizations for trauma survivors are not developed in Lithuania and evidence-based trauma-focused treatments for trauma survivors are not available in the public mental health care system.

Mental health professionals are increasingly aware of the negative effects of trauma on individuals and are interested in learning new ways to help trauma survivors. There is significant progress regarding the implementation of evidence-based trauma-focused treatments, such as EMDR and BEPP, in Lithuania recently. The numbers of therapists trained in trauma-focused treatments are growing, but these treatments are not offered in the public health care system and are available predominantly in private practice which is expensive and not covered by national health care insurance.

Despite the high prevalence of traumatic experiences in Lithuania (Kazlauskas & Zelviene, 2016), it was reported that PTSD is not identified in the Lithuanian national health care system (Kazlauskas, Zelviene, & Eimontas, 2017). The lack of acknowledgment of trauma and PTSD in Lithuania is a major barrier for the development of treatments for trauma survivors in the country.

Future directions of the trauma field in Lithuania include ensuring access to evidence-based treatments for trauma survivors. There is a need of trainings for practitioners to update their knowledge about the impact of trauma, with a particular focus on how to diagnose stress-related disorders and how to provide trauma-focused treatments. Finally, health care and social policy changes on the national level are needed to acknowledge trauma survivors and include evidence-based treatments in the health care of survivors exposed to various traumas, particularly children and adolescents. The Lithuanian trauma society is taking an active role in raising awareness about the effects of trauma to facilitate the further development of care for trauma survivors.

9. Psychotraumatology in the Netherlands

The Second World War marks the largest historical burden and the starting point for psychotrauma care in the Netherlands. Occupation by German and Japanese (in the former Dutch East Indies) armed forces and subsequent post-colonial wars led to over 250,000 military and civilian lives lost. Public awareness for the psychological effects of wartime and other traumatic experiences started around 1975, with the awareness of the Holocaust. In response, Foundation Center ’45 was funded, first focusing on Second World War concentration camp survivors, but soon extending their services to other traumatized populations. The focus on post-war reconstruction, tensions between interest groups and an emphasis on heroics and the resistance, together with a poorly developed mental health care, contributed to this late societal response (Vermetten & Olff, 2013). Subsequent national and international disasters, such as the 1992 Bijlmermeer airplane disaster and the 2000 Enschede fire explosion, further increased professional and public awareness of psychotrauma, and fuelled the establishment of the Dutch Society of Psychotraumatology in 2006.

Mental health care for trauma-related disorders is covered by health insurance at little or no additional personal costs. Facilities for trauma care have been integrated at many levels of health care. Routinely, the first step for individuals with trauma-related symptoms is to consult their general practitioner for referral to secondary health care organizations.

A national standard of care for trauma- and stressor-related disorders is currently underway (Kwaliteitsontwikkeling GGZ, 2018).

Trauma-focused treatment is increasingly offered next to interventions directed at emotion regulation, day-night structure and social support (Vermetten & Olff, 2013). Examples are EMDR, CBT, NET, BEPP and Imagery Rescripting. There is a growing role for E-health interventions (e.g. Olff, 2015). Some institutions use treatment intensification (EMDR or CBT), with preliminary positive effects (Van Woudenberg et al., 2018; Zepeda Méndez, Nijdam, Ter Heide, van der Aa, & Olff, 2018). Although not yet implemented, other treatment innovations include hormonal enhancers (D-cycloserin, cortisol, oxytocin; e.g. Thomaes et al., 2016).

Effective treatment for PTSD due to events in adulthood in fairly well functioning patients seems available, as well as special services and care for the military and the police. One of the greatest practical challenges are the long waiting lists in secondary mental health care, limiting accessibility to care for vulnerable patient groups, such as individuals with multiple (childhood) traumatization, patients with severe physical, neurocognitive and/or psychiatric comorbidities or severe psychosocial problems, and (asylum seeking) refugees. The latter in particular experience difficulties accessing evidence-based care due to stigma, requirement of referral by general practitioners, and language and cultural barriers. Moreover, research on the (cost-)effectiveness of treatments for these target groups is relatively lacking (e.g. Sijbrandij et al., 2017), as well as on improving symptom recovery and treatment adherence of current PTSD treatments.

Topics which should be urgently addressed in the future include improving treatment outcome for specific target groups, i.e. patients with childhood trauma; implementing treatment for target groups that are currently excluded from regular PTSD treatments; family- or system-oriented interventions to prevent inter-generational consequences of trauma and enhance opportunities for social support; evaluation of e-mental health interventions for PTSD and comorbid disorders, including blended treatment options administered within routine clinical practice; increased use of transdiagnostic treatment options for trauma-exposed patients targeting a variety of psychopathology limiting psychosocial functioning; and the use of low-intensity interventions, carried out by non-professional helpers to increase coverage of mental health interventions.

10. Psychotraumatology in Poland

The recognition of the socio-psychological consequences of the Second World War in Poland is an extremely important issue. Poland belongs to the part of Europe which Snyder (2010) called the 'Bloodlands'. The number of ethnic Poles and Polish Jews who died or were murdered in connection to the Second World War amounted to about six million. Poland lost about 17% of its pre-war population (Materski & Szarota, 2009). Moreover, the Soviet invasion and the subsequent imposition of a communist regime led to large groups of people being persecuted. Many survivors of the war (e.g. resistance movement members, people deported to Siberia) were not even recognized as survivors, and speaking about many aspects of war experiences could lead to prosecution. Very little attention has been paid to Second World War issues in medicine and psychology, in comparison to the volume of analogous research in western countries (Lis-Turlejska, Szumiał, & Drapała, 2018). Psychological help for survivors of the war was practically absent, and the need is still not recognized today. Since the collapse of communism, neither war nor other traumas have been recognized on a broader scale. Research has been conducted on the consequences of the great flood of 1997 (Strelau & Zawadzki, 2005), however, other traumatic events, including the death of the president and other governmental officials in the Smolensk plane crash in 2010, have not yet been the subject of psychological research.

There is no coherent care system in Poland for survivors of various traumatic events. A number of crisis intervention centres provide help for 'families in crisis' – mainly for survivors of domestic violence (www.spoleczenstwoobywatelskie.gov.pl). There are non-governmental organizations working with survivors of trauma (e.g. battered women, abused children, survivors of crime). However, they are all underfunded and their capacity is limited. Access to psychotherapy under national health insurance is also limited. Despite the fact that there are many psychotherapists working privately, mainly in larger cities, there are still very few professionals who are specialized in psychotraumatology.

Crisis intervention is probably the most widely offered help to trauma survivors. Practitioners have the opportunity to be trained in different approaches in psychotherapy, including CBT, prolonged exposure therapy and EMDR. However, there is no clear emphasis on evidence-based treatments and they are not widely used in practice. There is also a lack of research on the effectiveness of trauma therapy. The issue of prevention is neglected in general, except training for professional groups (e.g. flight crews, emergency services).

Currently, the most important challenge is to increase access to professional care, specifically increasing access to therapists who offer evidence-based interventions. However, education of the general population about the importance of help seeking and potential benefits out of it is also crucial. It is necessary to further develop research on the

psychosocial consequences of both the Second World War and other large-scale traumatic events. It is also important to encourage the teaching of contemporary curricula on abnormal psychology, including content specific to trauma. This seems to be the most urgent task, alongside further development of the trauma care system and promotion of good practices in psychological care and psychotherapies for trauma survivors.

11. Psychotraumatology in Portugal

A colonial war of 13 years has left to Portugal an individual and collective traumatic heritage (Maia, McIntyre, Pereira, & Ribeiro, 2011). The consequences remain to this day through the intergenerational transmission of trauma (Dias, Sales, Cardoso, & Kleber, 2014). Throughout the years, clinicians, academics and other professionals discussed the psychosocial consequences and reactions to this trauma. Later, the coordinated response to two major accidents promoted a national approach to survivors of crisis and disaster. In 2009, the Centre for Social Studies of the University of Coimbra created the Centre of Trauma (CT), a society that brings together the country's leading organizations who directly deal with potentially traumatic events. Since 2010, CT is a full member of ESTSS.

In Portugal, the National Authority for Civil Protection provides central technical guidance to the organizations who deliver services to survivors of disasters or catastrophes. It is a governmental entity which coordinates the interventions developed and implemented by the different professional groups and organizations (fire fighters, medical emergency services, etc.). Clinical care to trauma survivals is provided by the National Health Service in the first place, but in cooperation with organizations (both non-governmental and governmental) who are specialized in trauma therapies and relevant psychosocial interventions. There is a core team of trained and certificated psychotherapists within CT whose service is accessible to people in need.

The most widespread therapy methods in Portugal are CBT, EMDR, Psychodrama and brief supportive psychotherapeutic strategies. Psychopharmacotherapy is also frequently used alone or in combination with psychological interventions. Treatment takes place in public and private health institutions. A number of governmental and non-governmental organizations currently invests in building the capacity of their staff in trauma care and designing and implementation of preventive interventions. CT is responsible for regular organization of conferences, seminars and the delivery of a biannual psychotrauma course. The course equips professionals from different fields with relevant knowledge and skills.

Professional and organizational preparation and knowledge to treat trauma consequences at the individual, family and social level needs to be optimized and updated. Minorities and refugees at risk may benefit from more integrated assistance. The ability to effectively respond to disasters and catastrophes through the provision of acute trauma care and coordination among the different organizations that are involved in disaster management has to be improved. There is room for improvement regarding the identification of populations at risk, screening for trauma related disorders and responding to the needs of the health care system. Family doctors and nurses, firemen and other professional groups have to be trained to assure their trauma-informed professional performance.

The topics to be addressed in the near future include creating a national plan for PTSD prevention and psychosocial interventions in case of crisis and disaster, as well as founding a network for specific treatment responses to trauma-related disorders, namely PTSD. Good practices have to be disseminated and young researchers and clinicians need to be motivated to work in the field of psychotraumatology. Finally, more effective and organized strategies to address potentially traumatic contexts such as unemployment, marital violence, cyber bulling and road accidents need to be developed, and the cooperative and coordinated work with national and European entities needs to be further increased.

12. Psychotraumatology in Sweden

The Swedish population has enjoyed peace for over 200 years. For a long time, the country did not experience the same increase in attention to psychotraumatology as other European countries with afflicted veteran soldiers from the nineteenth century wars. The impetus for trauma-informed services has instead come from disasters, large accidents and the increased attention to interpersonal abuse. A harrowing bus crash involving 12-year-olds on a school trip in 1988 (Arnberg et al., 2011) became the initiating event for the public organization of crisis support after large-scale events. Events such as the 1994 Estonia ferry disaster in the Baltic sea (e.g. Arnberg, Hultman, Michel, & Lundin, 2013) and the 2004 Southeast Asia tsunami (e.g. Michélsen, Therup-Svedenlöf, Backheden, & Schulman, 2017), both leading to hundreds of Swedish casualties, as well as the recent deployment of Swedish peacekeeping forces around the world, have highlighted the psychosocial consequences of trauma. More recently, the refugee crisis has set off many activities related to culturally informed trauma services.

In Sweden, every municipality has a psychosocial crisis team and there are psychosocial disaster contingency teams at the larger hospitals. A major step forward was the legislation passed in 2000 that

mandates employers to ensure that they have adequate knowledge of and plans for crisis support for their employees. Beyond the acute crisis support, however, access to qualified treatment of chronic traumatization varies across the country. In some regions there are dedicated trauma clinics; in others, there are trauma teams within the psychiatric services. Some regions lack both dedicated trauma clinics and teams.

The acute crisis interventions that are available in Sweden include Psychological First Aid, various forms of unstructured crisis support and a variety of debriefing methods including psychological debriefing (Witteveen et al., 2012). As for the treatment of PTSD, the Swedish National Board of Health and Welfare issues guidelines for public health care. In their latest guidelines from 2017 (The Swedish National Board of Health and Welfare, 2017), trauma-focused psychological treatments were given the highest priority; selective serotonin reuptake inhibitors (SSRIs) were prioritized as a potential but not necessary option for adults with PTSD, although they probably are the most widely used treatment in the country.

Several challenges lie ahead. The use of ineffective preventative interventions remains and the provision of psychosocial support beyond the acute phase is very limited, partly due to compartmentalized organizations. Further development of acute interventions in health care would benefit from robust evidence for early interventions. Trauma-related problems in patients too often go undetected in health care assessments (Al-Saffar, Borgå, & Hällström, 2002). In addition, access to prioritized treatments is underdeveloped in many parts of Sweden: the concentration of relevant competence in metropolitan areas is a salient issue in this country due to its large rural areas.

Another challenge related to the treatment of PTSD is that a large proportion of therapists are due for retirement in the next five years. It will become important for the field to continue to attract younger professionals. It is hoped that a stronger professional community, aided by the Swedish Society for Psychotrauma, can prevent fragmentation of the many regional initiatives, particularly in light of the many refugees across the country, and serve as a force for increasing the quality of and access to trauma treatments.

13. Psychotraumatology in Ukraine

The historical burden of trauma in Ukraine mainly consists of man-made catastrophes. They include the famines in the years 1933 and 1947, the Second World War, the explosion of the Chernobyl nuclear power station, and the current military conflict with Russia, which is officially called 'Anti Terrorist Operation (ATO)'. All events that happened during the Soviet times were hushed up and psychological support has never been provided to the people in need. It was not until the Maidan revolution and the beginning of the current war that psychological services in Ukraine were organized for victims of mass violence.

In Ukraine, care organizations for trauma survivors are currently under development. It presupposes an effective coordination of governmental and non-governmental organizations and professional institutions. The non-governmental organization Ukrainian Society for Overcoming the Consequences of Traumatic Events (USOCTE) was created to reach that aim. This professional organization aims at the development of crisis intervention services as well as capacity for provision of trauma-focused psychological therapies in Ukraine, in accordance with the international standards. Currently, USOCTE provides psychological help to wounded ATO soldiers and veterans, as well as other people who suffer from consequences of the ATO: those living in the ATO zone, internally displaced persons, families of killed soldiers and participants of the Maidan revolution. USOCTE is also engaged in developing training programmes for psychologists and psychoeducational materials for the general population. The methods used in trauma care are EMDR, CBT and the SEE FAR CBT treatment protocol of the Israeli coalition of trauma.

These treatments are offered in a strictly structured way. All clients sign an agreement, which determines the focus of the therapy. According to that agreement, a client has a right to attend 12 free-of-charge sessions. The first sessions are devoted to a detailed diagnostic interview, psycho-education on the signs and nature of posttraumatic disorders and providing information on therapeutic approaches. The following stabilization phase is intended to create a sense of safety by means of different techniques. It is followed by the trauma-focused interventions mentioned above. The final phase of treatment has the aim to integrate the experiences into daily life, assess the results and adapt to the achieved changes.

Challenges in this work are the very high level of psychological disturbance among the people living close to the conflict zone, and their reluctance to acknowledge this and to ask for psychological support (Roberts et al., 2017). It should also be mentioned that women are especially vulnerable on the front-line territory, and suffer multiple problems including high levels of psychological violence. These problems are often not recognized and the population has a tendency to believe that the end of military activities will solve all problems.

To overcome the consequences of the current military conflict in Ukraine, USOCTE is confronted with a number of tasks. They include building up a multilevel system of psychological assistance with the support of governmental and non-governmental organizations as well as monitoring and evaluating the activities of specialists in the psychological field on a regular basis. Moreover, the local communities need to be involved in supporting the aggrieved. Finally, there is a need for a more intensive cooperation and sharing of experiences with international organizations.

14. Psychotraumatology in the UK and Northern Ireland

The 2014 Adult Psychiatric Morbidity Study (APMS) provides the most comprehensive estimates of PTSD within the UK, although the sample is of English residents only (Fear, Bridges, Hatch, Hawkins, & Wessely, 2014). APMS found a PTSD prevalence of 4.4%, with similar rates observed between men and women. PTSD rates in women declined with increasing age; 12.5% of 16–24-year-old women had PTSD. In contrast, in men PTSD remained roughly consistent until declining from age 65. Northern Ireland (NI) has historically experienced a sustained period of political conflict known as the Troubles. The NI Study of Health and Stress identified that NI has one of the highest global rates of PTSD with lifetime and 12 month prevalence rates of 8.8 and 5.1%, respectively (Bunting et al. 2013). Lifetime prevalence in NI females (11%) was substantially higher than the rates in NI men (6.4%). Although there is no specific information on prevalence rates in Scotland and Wales, it is anticipated they are similar to English rates.

The UK's mental health services are provided by the National Health Service (NHS). Although regional variations exist, the first point of access is via family doctors. Community services, often available via self-referral, typically treat survivors of single incident traumas where a diagnosis of PTSD is present without co-morbid problems (e.g. substance misuse). Treatment of more complex cases (e.g. survivors of child abuse, refugees, etc.) is via specialist mental health teams. NHS treatment complies with best practice guidelines compiled by the National Institute for Health Care and Excellence. A range of other non-governmental organizations exist that are staffed by qualified health professionals and offer support to sub-populations of trauma survivors (e.g. survivors of domestic abuse, veterans, etc.). In NI, a Regional Trauma Service is under development to address the mental health legacy of the Troubles.

Interventions to treat PTSD in the UK are typically trauma-focused psychological therapies such as, but not limited to, trauma-focused CBT, EMDR and prolonged exposure (NICE, 2005). In addition, psychopharmacology support is given to manage co-morbid mental health presentations. Increasingly, e-technologies are being developed to help provide cost-effect support that also promote accessibility. For example, an online guided self-help tool for PTSD has been developed and internet-based video technologies have been successfully used to deliver PTSD treatments with much reduced therapist time required. Some providers also utilize compressed therapy where 16–-20 hours of TF-CBT are delivered over a week.

Currently, whilst there is often some delay in accessing specialist mental health assessment services, the biggest bottleneck is in the provision of specialist services for more complex cases of PTSD. Also, whilst APMS has shown that help-seeking for PTSD is improving, the majority of people with PTSD in the UK still do not seek any help.

Whilst, the UK has made considerable efforts to improve the public understanding of mental health, more needs to be done. Additionally, organizations which routinely expose staff to trauma (such as the emergency services, military and child social workers) need to address the issue of PTSD as a result of chronic trauma exposure as there has been limited work done on this topic.

15. Conclusion

The perspectives above show that important steps towards a better provision of care for survivors of trauma have been taken in the European countries. Given the cultural and economic diversity of the continent, there are still some differences between the countries, for instance with regard to the use of evidence-based treatments. Effective treatments have many elements in common (Schnyder et al., 2015) and the treatment of choice is often based on culture and history. The dissemination of evidence-based knowledge and skills has always been a priority of ESTSS (Ajdukovic, 2013, Bisson, 2013, Olff, 2013) and further strategic steps towards this aim have been made recently. In 2018, the first of a series of new ESTSS curricula, the 'Advanced Training in Treating Posttraumatic Disorders in Adults', was approved by the board. The curriculum comprises 120 hours of training and 20 hours of case supervision. It has a strong focus on evidence-based approaches and provides knowledge and skills for the treatment of acute stress disorder, non-complex PTSD and complex posttraumatic disorders (for more detail see www.estss.org). The curriculum has already been adopted by several member societies who are building up local structures to offer the trainings or adopt their national curricula to meet the requirements of the ESTSS curriculum. Other

curricula, for instance for the treatment of trauma-related disorders in children and adolescents, and more basic curricula to promote the idea of trauma-informed care among different groups of professionals, are currently being developed.

The country reports presented in this paper show that many countries share similar challenges and have topics in common that need to be addressed. These topics include, among others, the prevention of trauma, the promotion of trauma-informed practices in the whole health care system and standards of care for groups with special needs, including refugees and internally displaced people. Of increasing importance in the field of mental health is the involvement of trauma survivors in mental health care teams (Van der Schrieck-De Loos, 2013). It was beyond the scope of this paper to describe the large amount of research in the field of psychotraumatology in the European countries, which represents a significant proportion of the global research activities in this field (Olff, 2018). However, similar to the differences with regard to the use of evidence-based treatments, these activities are not evenly distributed between the different European countries. It is part of ESTSS's mission to stimulate and promote research Europe wide.

The current structure of ESTSS allows for a more direct exchange between the member societies and thereby provides the opportunity to effectively address such common issues. It has always been the aim of the society to provide a platform for all professionals in Europe in the field of psychotraumatology to connect, to develop together training and research, guidelines and actions where needed. ESTSS is constantly working towards this aim, for instance by identifying successful models in individual countries or regions and disseminating these experiences among all others. A recent example of this exchange is a series of movies providing information on the consequences of trauma and effective treatments tailored to the needs of the public, professionals from the health care system and trauma survivors that can be downloaded from the ESTSS website. They were developed by a national society (DeGPT) and translated into 10 European languages with the help of other member societies.

ESTSS can look back on 25 years of advocacy for the field of psychotraumatology in Europe. The first European Conference on Traumatic Stress, which can be considered one of the roots of ESTSS, was held three decades ago (Ørner, 2013). During these years, ESTSS has developed a unique profile as a truly international professional society that integrates the diversity of the European countries and greatly benefits from their cultural richness (Lueger-Schuster, 2013a; Olff, 2013). An important part of the society's success story are the ESTSS conferences that attract delegates from all parts of the world. Other important activities included projects like the European Network of Traumatic Stress (TENTS; Bisson, 2013) and the *European Journal of Psychotraumatology* (EJPT). EJPT has become an important platform for the dissemination of knowledge related to psychological trauma and, thanks to the relentless efforts of its founding editor Miranda Olff, has become one of the journals with the highest impact in the field (Olff, 2018).

Over the years, ESTSS had fruitful collaborations with large societies from other regions of the world. There is also a strong involvement of ESTSS in the global collaboration of trauma societies, an initiative that had initially been proposed by the International Society for Traumatic Stress Studies (ISTSS; Schnyder et al., 2017) and developed to a collaboration of all large trauma societies on an equal basis. It already has the function of a global umbrella for defined projects and holds promise to become a more formal global structure.

Only about half of the more than 40 countries on the European continent have established local trauma societies so far, most of which are members of ESTSS. In the coming decades, it will remain one of the most important aims of ESTSS to support the formation of new societies in countries where they do not exist yet, and to provide a common platform and a professional home for trauma specialists from the whole European region.

In their articles at the occasion of the twentieth anniversary of ESTSS, several former presidents described what some of them called the 'infancy and adolescence' of the society (Schnyder, 2013, Turner, 2013). At the age of 25 years, ESTSS has become a young adult. The society has 'grown up' and, with the latest change of its structure, has completed a developmental process that made it stronger and prepared it for the tasks ahead. This would not have been possible without the enthusiasm of a large number of dedicated colleagues from all over Europe. They invested their time and energy over the last 25 years to make the society what it is today. We congratulate ESTSS on its 25th birthday and strongly believe that it will successfully continue its 'adult life' for the good of psychotraumatology in Europe.

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ORCID

Evaldas Kazlauskas http://orcid.org/0000-0002-6654-6220
Marit Sijbrandij http://orcid.org/0000-0001-5430-9810
Małgorzata Dragan http://orcid.org/0000-0001-8221-2012
Margarida Figueiredo-Braga http://orcid.org/0000-0003-2374-4371
Filip Arnberg http://orcid.org/0000-0002-1317-2093
Cherie Armour http://orcid.org/0000-0001-7649-3874
Dominic Murphy http://orcid.org/0000-0002-9596-6603

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- Trauma informed - Αρχή VI
- "Trauma informed" Σχολεία

Εστιάζοντας στους ανθρώπους: Φιλοξενία και ενδυνάμωση

- Εστιάζοντας στην δεξιότητα του παρόχου να προσφέρει ένα ασφαλές καταφύγιο και να ασχοληθεί με το τραύμα
- Παρέχοντας υπηρεσίες σε LGBT άτομα
- Η προσωπική ανάπτυξη είναι απαραίτητη: ανάπτυξη μετά από το τραύμα

Εργαλεία και υφιστάμενη κατάσταση στην Ευρώπη

- Η προσέγγιση της Virginia Axline
- Εργαλεία για την αξιολόγηση του τραύματος
- Ανασκόπηση της φροντίδας τραύματος στις χώρες της Ευρώπης.

Συμπεράσματα

Συμπεράσματα

Συμπεράσματα

Βιβλιογραφία

Quiz

Quiz

Quiz 1

3. Τραύμα: ψυχικό τραύμα, έρευνα, αξιολόγηση και αποτελέσματα

Επισκόπηση
Prerequisite: Quiz

Η έρευνα
Prerequisite: Quiz
Quiz

Έρευνα βάσει αποδείξεων σχετικά με τη φροντίδα με ενημέρωση για το ψυχικό τραύμα
Prerequisite: Η έρευνα
Quiz

Η διαδικασία αξιολόγησης της παρέμβασης
Prerequisite: Έρευνα βάσει αποδείξεων σχετικά με τη φροντίδα με ενημέρωση για το ψυχικό τραύμα
Quiz

4. Ψυχικό τραύμα: Ορθή πρακτική και πολιτικές

Μεθοδολογικές πτυχές της έρευνας σχετικά με την TIC
Prerequisite: Η διαδικασία αξιολόγησης της παρέμβασης
Quiz

Ορθή πρακτική αναφορικά με την TIC: Δυνατότητα μεταφοράς ορθών πρακτικών βάσει αποδείξεων
Prerequisite: Μεθοδολογικές πτυχές της έρευνας σχετικά με την TIC
Quiz

Παρατήρηση: Δείκτες κακομεταχείρισης και κακοποίησης
Prerequisite: Ορθή πρακτική αναφορικά με την TIC: Δυνατότητα μεταφοράς ορθών πρακτικών βάσει αποδείξεων
Quiz

5. Ενότητα 5

Εισαγωγή
Prerequisite: Παρατήρηση: Δείκτες κακομεταχείρισης και κακοποίησης

Μάθημα 5.1
Prerequisite: Παρατήρηση: Δείκτες κακομεταχείρισης και κακοποίησης
Quiz

Μάθημα 5.2
Prerequisite: Μάθημα 5.1
Quiz

6. Ενότητα 6

Μάθημα 6.1
Prerequisite: Μάθημα 5.2
Quiz

Μάθημα 6.2
Prerequisite: Μάθημα 6.1
Quiz

Σύνοψη και συμπεράσματα
Prerequisite: Μάθημα 6.1

7. Final Exams

Εισαγωγή
Prerequisite: Μάθημα 6.2

Αξιολόγηση μαθήματος

Ερωτηματολόγιο αξιολόγησης του πιλοτικού μαθήματος

Ερωτηματολόγιο

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*Campo obbligatorio

Φύλο *

- ◯ Άνδρας
- ◯ Γυναίκα

Email (MOOC email) *

La tua risposta

Χώρα *

La tua risposta

Μορφωτικό επίπεδο *

- ◯ Λύκειο
- ◯ Πτυχίο (Πανεπιστήμιο)
- ◯ Μεταπτυχιακό
- ◯ Altro:

Υφιστάμενη επαγγελματική ιδιότητα *

- ◯ Εκπαιδευτικός
- ◯ Κοινωνικός Λειτουργός
- ◯ Ψυχολόγος
- ◯ Επαγγελματίας φροντίδας υγείας
- ◯ Φοιτητής
- ◯ Altro:

Πλαίσιο εργασίας *

- ◯ Τοπικός Οργανισμός Δημόσιας Υγείας
- ◯ Κοινωνική Υπηρεσία
- ◯ Φιλανθρωπική Δράση
- ◯ Μη Κυβερνητικός Οργανισμός
- ◯ Υπηρεσία για μετανάστες και πρόσφυγες
- ◯ Μη Κερδοσκοπική Οργάνωση
- ◯ Κερδοσκοπική Οργάνωση
- ◯ Οργανισμός Επικεντρωμένος στους Μετανάστες ή/και Πρόσφυγες
- ◯ Altro: _____

Έχετε ποτέ άλλοτε λάβει κάποια εξειδικευμένη εκπαίδευση σχετικά με το ψυχικό τραύμα; *

- ◯ Ναι
- ◯ Όχι

Πόσα χρόνια εργάζεστε με ανηλίκους οι οποίοι έχουν υποστεί κάποια τραυματική εμπειρία; *

- ◯ 1-2
- ◯ 3-5
- ◯ 6-9
- ◯ Περισσότερα από 10
- ◯ Δεν έχω εργαστεί σε αυτό το πεδίο

Invia

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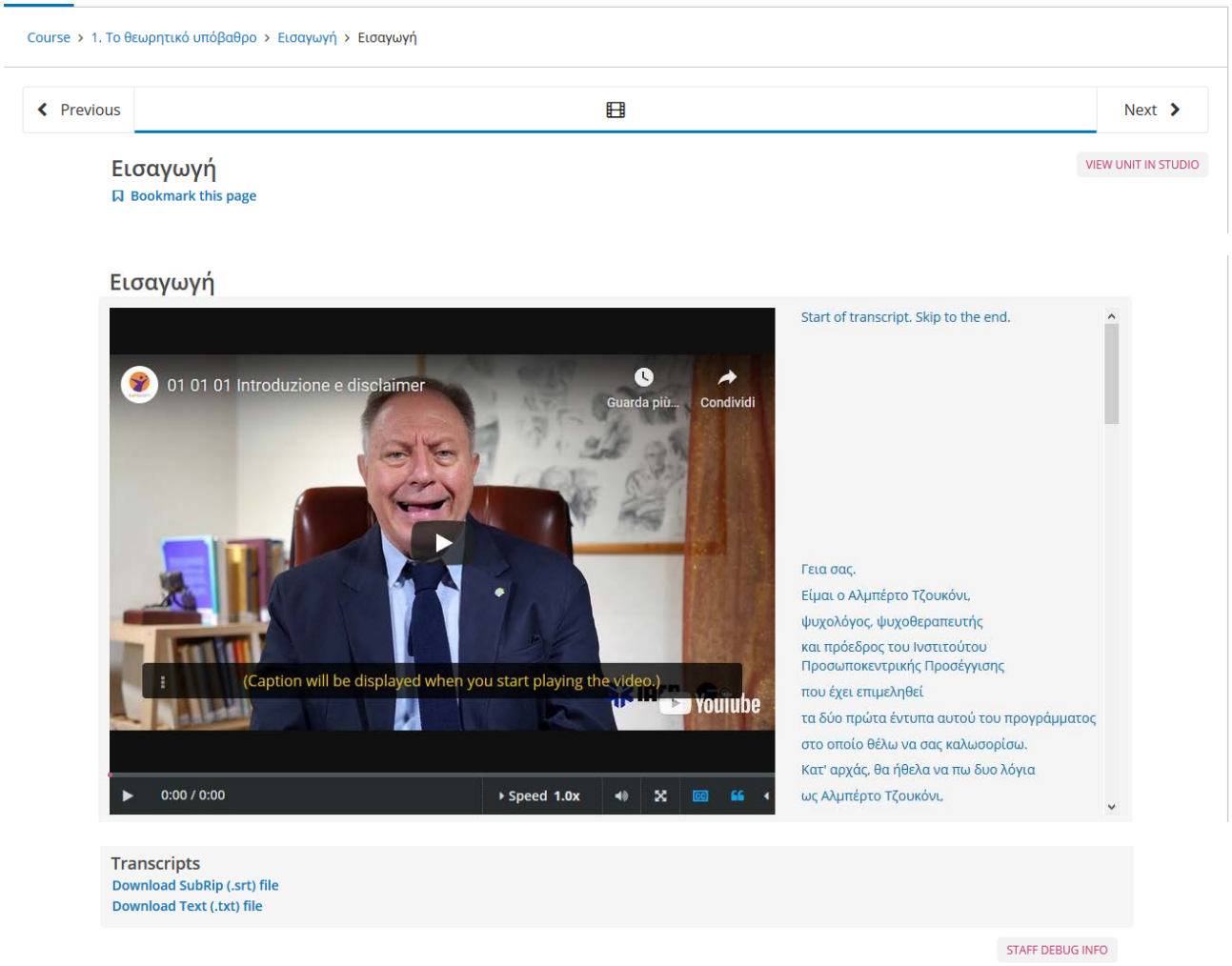
< Previous Next >



Transcript

Γεια σας.

Είμαι ο Αλμπέρτο Τζουκόνι,

ψυχολόγος, ψυχοθεραπευτής

και πρόεδρος του Ινστιτούτου Προσωποκεντρικής Προσέγγισης

που έχει επιμεληθεί

τα δύο πρώτα έντυπα αυτού του προγράμματος

στο οποίο θέλω να σας καλωσορίσω.

Κατ' αρχάς, θα ήθελα να πω δυο λόγια

ως Αλμπέρτο Τζουκόνι,

ως απλός πολίτης,

κι αυτά είναι λόγια ευγνωμοσύνης.

Ειλικρινά ευχαριστώ όσους εργάζεστε για την υποστήριξη και προστασία

των παιδιών

με ψυχολογικά τραύματα.

Η δουλειά που κάνετε έχει εξαιρετική σημασία,

ευαισθησία, λεπτότητα αλλά ενίοτε

και μεγάλο βάρος.

Γνωρίζουμε καλά

ότι

όταν δουλεύουμε με ανθρώπους που υποφέρουν

συχνά αυτό έχει ως αποτέλεσμα

να υποφέρουμε κι εμείς σε σημείο ολοκληρωτικής εξάντλησης.

Γι' αυτό

σας ευχαριστώ ειλικρινά γιατί

με τη δουλειά σας προστατεύετε

μια

πραγματικότητα πολύτιμη για έθνη και κοινότητες: το ανθρώπινο κεφάλαιο.

Όσοι φέρουν ψυχικά τραύματα έχουν απόλυτη ανάγκη από κάθε δυνατή φροντίδα

ώστε να βοηθηθούν στην πλήρη επανένταξή τους

ως μέλη της κοινότητας ενεργά

αλλά και

εποικοδομητικά για τους ίδιους και για τους συνανθρώπους τους.

Θα ήθελα να προσθέσω και κάτι ακόμα, ίσως προφανές, αλλά αξιοσημείωτο:

αυτό το εκπαιδευτικό πρόγραμμα

απευθύνεται σε όλους εσάς, που έχετε διαφορετική καταγωγή, επαγγελματική κατάρτιση και ικανότητες

και, ως γνωστόν, δεσμεύεστε από τους ισχύοντες νόμους, τους κώδικες δεοντολογίας

των διαφόρων επαγγελμάτων

και τους εσωτερικούς κανονισμούς των οργανώσεων στις οποίες συμμετέχετε

να ενεργείτε σύμφωνα με τις γνώσεις και αρμοδιότητές σας χωρίς να υπερβαίνετε

τα όρια και τους περιορισμούς καθώς αυτό θα αποβεί εις βάρος όσων βοηθάτε.

Θα προσθέσω και κάτι άλλο εξίσου προφανές.

Τα πράγματα περιπλέκονται καθώς οι νόμοι δεν είναι ίδιοι

σε όλες τις ευρωπαϊκές χώρες και το συγκεκριμένο πρόγραμμα

απευθύνεται σε διάφορα έθνη και γλώσσες.

Επομένως,

η προσδοκία μας είναι, προφανώς, να εκπαιδεύσουμε ανθρώπους που έχουν επίγνωση

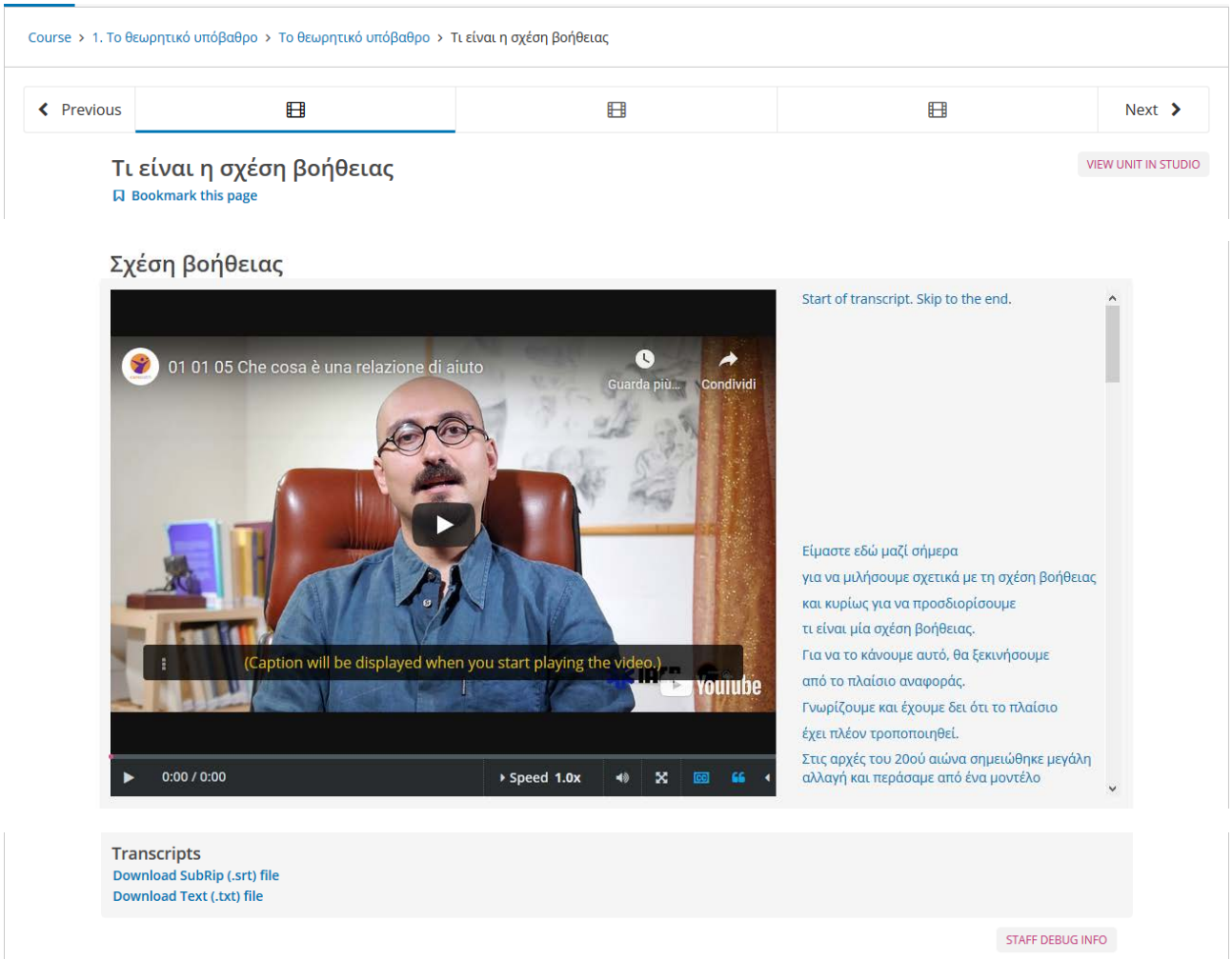
του γεγονότος ότι

ακόμα και ο σεβασμός των ορίων σημαίνει ότι δουλεύουμε αποτελεσματικά

και αποδοτικά.

Ευχαριστώ και πάλι που ξεκινήσατε αυτή την περιπέτεια και εργάζεστε

με τόσο πάθος καθημερινά.



Transcript

Είμαστε εδώ μαζί σήμερα

για να μιλήσουμε σχετικά με τη σχέση βοήθειας

και κυρίως για να προσδιορίσουμε

τι είναι μία σχέση βοήθειας.

Για να το κάνουμε αυτό, θα ξεκινήσουμε

από το πλαίσιο αναφοράς.

Γνωρίζουμε και έχουμε δει ότι το πλαίσιο

έχει πλέον τροποποιηθεί.

Στις αρχές του 20ού αιώνα σημειώθηκε μεγάλη αλλαγή και περάσαμε από ένα μοντέλο μηχανιστικό και απλουστευτικό σε ένα μοντέλο ολιστικό και συστημικό.

Άλλαξε ακόμα και η έννοια της σχέσης βοήθειας. Πράγματι, στο μηχανιστικό απλουστευτικό μοντέλο

η σχέση βοήθειας χαρακτηριζόταν από ασυμμετρία: ο θεραπευτής ήταν ο σημαντικός παράγοντας που επέβαλλε στον θεραπευόμενο την εικόνα της πραγματικότητας και αυτή η δική του εικόνα

κατά κάποιο τρόπο ασκούσε επίδραση στον θεραπευόμενο.

Άρα ο θεραπευόμενος είχε παθητική στάση έναντι του θεραπευτή.

Με την υιοθέτηση του νέου μοντέλου άλλαξαν πολλά πράγματα

γιατί γνωρίζουμε

ότι το κέντρο έγινε η ίδια η σχέση: σημασία δεν έχουν τα μέρη αλλά η σχέση

μεταξύ αυτών των δύο μερών

που τελικά χαρακτηρίζονται

μέσα στην ίδια τη σχέση.

Άραγε ποια μπορεί να είναι η σχέση βοήθειας

σύμφωνα με αυτό το μοντέλο;

Θα μας βοηθήσουν να την ορίσουμε όσα έγραψε, ήδη το 1951, ο Καρλ Ρότζερς, συγγραφέας

που κατέχει εξέχουσα θέση στην κατανόηση της σχέσης βοήθειας υπό αυτή την οπτική.

Ο Καρλ Ρότζερς μας λέει: "η σχέση βοήθειας είναι μία σχέση όπου τουλάχιστον ο ένας από τους δύο

πρωταγωνιστές έχει ως σκοπό να προάγει στον άλλο την εξέλιξη, την ανάπτυξη,

την ωριμότητα και την κατάκτηση

ενός πιο ολοκληρωμένου και κατάλληλου τρόπου συμπεριφοράς.

Υπό αυτή την έννοια, ως "άλλος"

νοείται ένα άτομο ή μία ομάδα.

Με άλλα λόγια, η σχέση βοήθειας θα μπορούσε να οριστεί ως μία κατάσταση

όπου ο ένας συμμετέχων ενθαρρύνει, σε ένα ή και στα δύο μέρη, μία μεγαλύτερη συνειδητοποίηση

των προσωπικών μέσων του υποκειμένου και μία μεγαλύτερη δυνατότητα έκφρασης".

Όπως προκύπτει, ξεχωρίζουν εδώ οι έννοιες ανάπτυξη, προώθηση, μέσα

και άρα ξεχωρίζει

μία νέα οπτική κατά την οποία η σχέση βοήθειας

είναι μία προσέγγιση που θέτει

τους δύο πρωταγωνιστές

της σχέσης σε μία ισοτιμία.

Έτσι, ο θεραπευτής δεν θα είναι

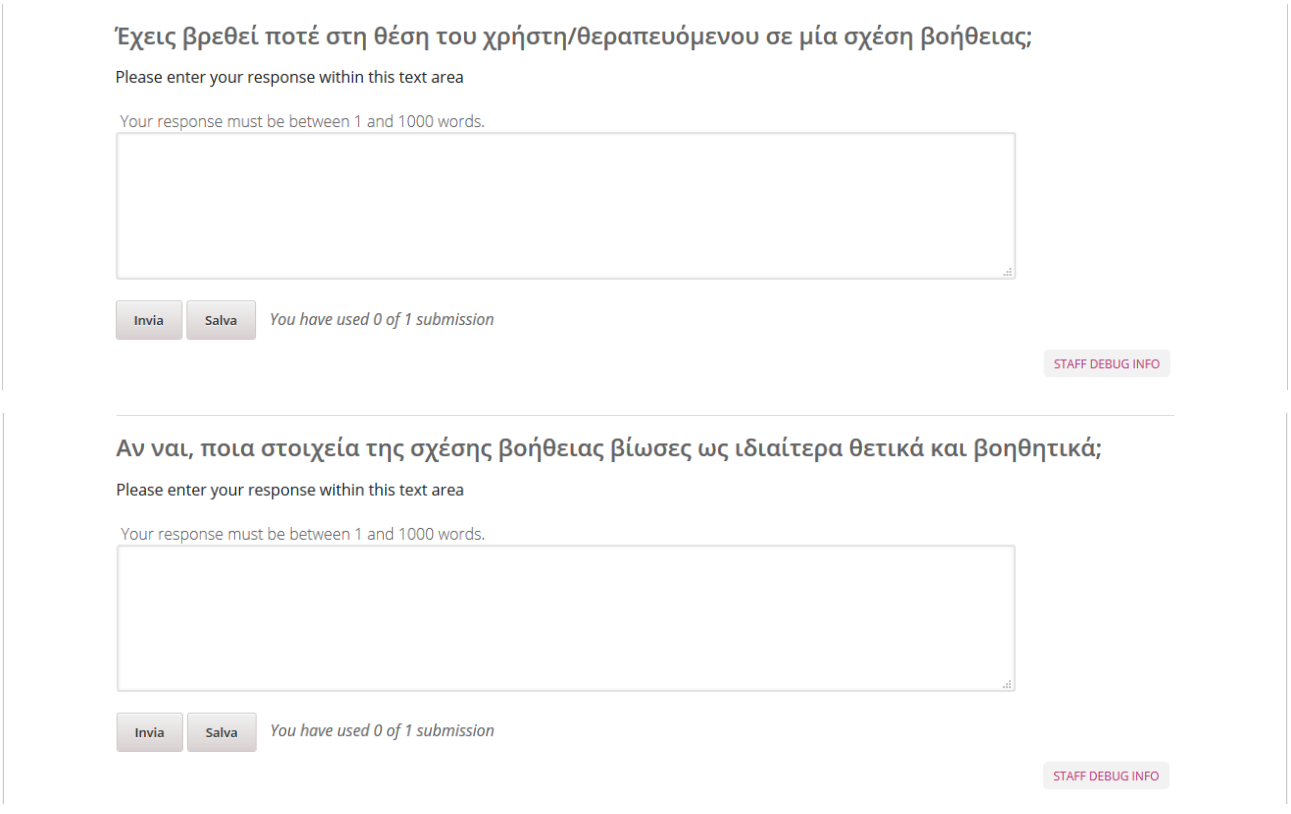
ο ειδήμων και ο σημαντικός παράγοντας

αλλά εκείνος που θα προάγει όλα τα διαθέσιμα μέσα

που είναι εγγενή στο άλλο πρόσωπο.

Με αυτό τον τρόπο θα μπορέσει να ενεργοποιήσει μία διαδικασία συνδημιουργίας μιας πραγματικότητας

πιο λειτουργικής για τον θεραπευόμενο
συνοδεύοντάς τον σε μία διαδικασία, αλλά παραμένοντας στο ίδιο σημείο με εκείνον.
Και ποια χαρακτηριστικά πρέπει να έχει ο θεραπευτής των σχέσεων βοήθειας σήμερα;
Θα πρέπει οπωσδήποτε να παραμένει δυνατός μέσω της γνώσης και άρα να στηρίζεται
σε ένα σύνολο θεωρητικών εννοιών.
Πρέπει
επίσης να γνωρίζει πώς να τις εφαρμόσει και άρα πώς αυτές οι θεωρίες
συγκεκριμενοποιούνται, γίνονται εφαρμόσιμες και τελικά εφαρμόζονται στη σχέση.
Πέρα από την τεχνογνωσία, εφόσον η εστίαση της σχέσης αφορά την ίδια την ποιότητά της,
είναι αναγκαίο να τηρεί την αρμόζουσα στάση, δηλαδή να επιστρατεύει όλες τις προϋποθέσεις
και τα χαρακτηριστικά που διευκολύνουν μία σχέση βοήθειας και την καθιστούν πιο αποτελεσματική.
Μεταξύ αυτών η πρώτη είναι η αυθεντικότητα, η δεύτερη είναι η ικανότητα να βλέπουμε
τον κόσμο με τα μάτια του άλλου και η τρίτη να μην κρίνουμε
τον θεραπευόμενο αλλά να καταφέρουμε να τον κάνουμε αποδεκτό.
Αν αυτό είναι δυνατό, αν αυτές οι τρεις προϋποθέσεις υλοποιηθούν από τον θεραπευτή,
όλα θα οδηγήσουν σε μία διαδικασία αλλαγής
και βελτίωσης.



Και ποια στοιχεία βίωσες ως μη βοηθητικά;

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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Αν δεν έχεις ποτέ βρεθεί στη θέση του χρήστη/θεραπευόμενου σε μία σχέση βοήθειας, ποια στοιχεία, κατά τη γνώμη σου, είναι θετικά και βοηθητικά και ποια στοιχεία δεν είναι βοηθητικά;

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Your response must be between 1 and 1000 words.

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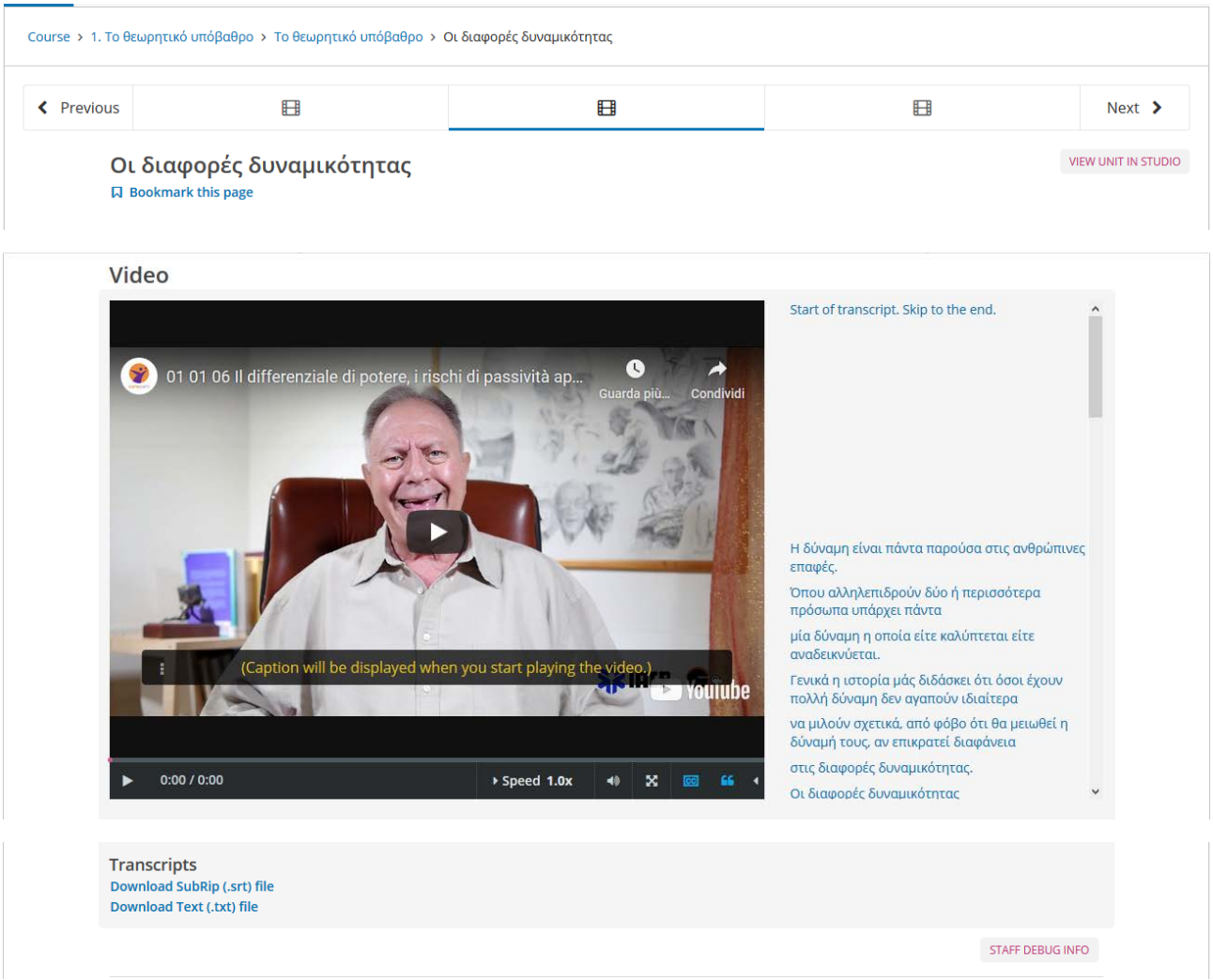


Transcript

Η δύναμη είναι πάντα παρούσα στις ανθρώπινες επαφές.

Όπου αλληλεπιδρούν δύο ή περισσότερα πρόσωπα υπάρχει πάντα

μία δύναμη η οποία είτε καλύπτεται είτε αναδεικνύεται.

Γενικά η ιστορία μάς διδάσκει ότι όσοι έχουν πολλή δύναμη δεν αγαπούν ιδιαίτερα

να μιλούν σχετικά, από φόβο ότι θα μειωθεί η δύναμή τους, αν επικρατεί διαφάνεια

στις διαφορές δυναμικότητας.

Οι διαφορές δυναμικότητας

προφανώς και υπάρχουν πάντα και στις σχέσεις βοήθειας.

Ο θεραπευτής, ο ειδικός,

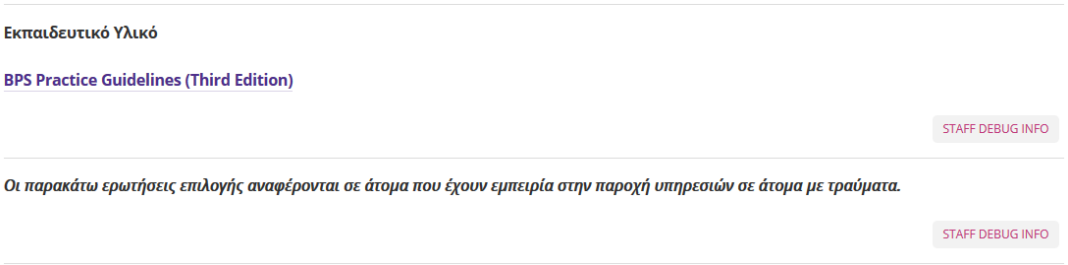
όποιος παρέχει μία υπηρεσία έχει περισσότερη δύναμη

από τον χρήστη, θεραπευόμενο, ασθενή ή όπως αλλιώς τον ορίσουμε. Γιατί;

Γιατί γνωρίζει κάτι του οποίου τα στοιχεία δεν γνωρίζει επακριβώς ο θεραπευόμενος

κι επίσης μπορεί να προσφέρει στον θεραπευόμενο κάτι που χρειάζεται.

Επιπλέον, ο ίδιος ορίζει τους κανόνες
του περιβάλλοντος (δηλαδή της χρήσης της υπηρεσίας) και, μάλιστα, μπορεί να αναστείλει
τη χορήγηση της υπηρεσίας.
Εν ολίγοις,
υπάρχει πάντα μία διαφορά δυναμικότητας μεταξύ του παρόχου και του παραλήπτη μιας υπηρεσίας.
Στο παρελθόν, με το μηχανιστικό-απλουστευτικό μοντέλο των σχέσεων βοήθειας
η διαφορά δυναμικότητας ήταν πολύ αυξημένη.
Είδαμε, σύμφωνα με το νέο μοντέλο της Χάρτας της Οτάβα και το βιοψυχοκοινωνικό μοντέλο,
ότι αυτό δεν ήταν επιθυμητό γιατί η υπερβολική διαφορά δυναμικότητας
μπορεί να οδηγήσει τον χρήστη της υπηρεσίας σε μια παθητική στάση που δεν βοηθά
στην επίτευξη των στόχων της υπηρεσίας.
Άρα σήμερα τείνουμε να εστιάζουμε στους χρήστες, τους θεραπευόμενους και να προάγουμε
την αλλαγή μέσα από πράξεις ενδυνάμωσης που ενθαρρύνουν τον θεραπευόμενο να αναπτύξει
τις ικανότητές του, τη δημιουργικότητά του, την αντοχή του.
Οι έρευνες καταδεικνύουν ότι αυτό είναι όντως χρήσιμο γιατί σε όλους τους τομείς
των σχέσεων βοήθειας επιτυγχάνονται καλύτερα αποτελέσματα σε μικρότερο χρονικό διάστημα
ενώ μειώνονται παρενέργειες και υποτροπές, όπως π.χ. στους τομείς της υγείας και της ευεξίας.
Άρα ο κόσμος προσανατολίζεται όλο και πιο πολύ στο προφανές: ότι όλοι βγαίνουν κερδισμένοι
αν η δύναμη μοιράζεται και αν όλοι συνεισφέρουν στην επίτευξη των στόχων.
Το ίδιο ισχύει και σε κοινωνικό επίπεδο. Άρα μία ενεργή και συνειδητή στάση των πολιτών
συνεισφέρει πολύ περισσότερο σε μία κοινωνική οικολογία και στη συνδιαμόρφωση μιας πολιτικής.
Βιώσιμες σχέσεις για μία βιώσιμη πολιτική.
Το ίδιο ισχύει στις υπηρεσίες που παρέχονται σε παιδιά. Πρόκειται για μικρούς ανθρώπους, όχι για μωρά
που δεν καταλαβαίνουν ή δεν είναι υπεύθυνα. Αυτό το κοινωνικό οικοδόμημα που θεωρεί
τα παιδιά ως "μικρά πράγματα" είναι εντελώς απαρχαιωμένο.



Ποια είναι η γνώμη σου για τη διαφορά δυναμικότητας μεταξύ του θεραπευτή και των θεραπευομένων του στις σχέσεις βοήθειας;

Please enter your response within this text area

Your response must be between 1 and 9999 words.

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Η υπερβολική διαφορά δυναμικότητας μπορεί να έχει ανεπιθύμητες επιπτώσεις; Αν ναι, ποιες είναι αυτές;

Please enter your response within this text area

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Invia Salva *You have used 0 of 1 submission*

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Εσύ στην καθημερινή πρακτική της εργασίας σου προσπαθείς με τρόπο ενεργό να είσαι προσεκτικός σε επίπεδο διαφοράς δυναμικότητας ανάμεσα σε σένα και στους θεραπευομένους σου;

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Your response must be between 1 and 9999 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Αν είσαι προσεκτικός σε επίπεδο διαφοροποίησης δυναμικότητας, γιατί δίνεις προσοχή σε αυτή την πτυχή της σχέσης βοήθειας;

Please enter your response within this text area

Your response must be between 1 and 9999 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

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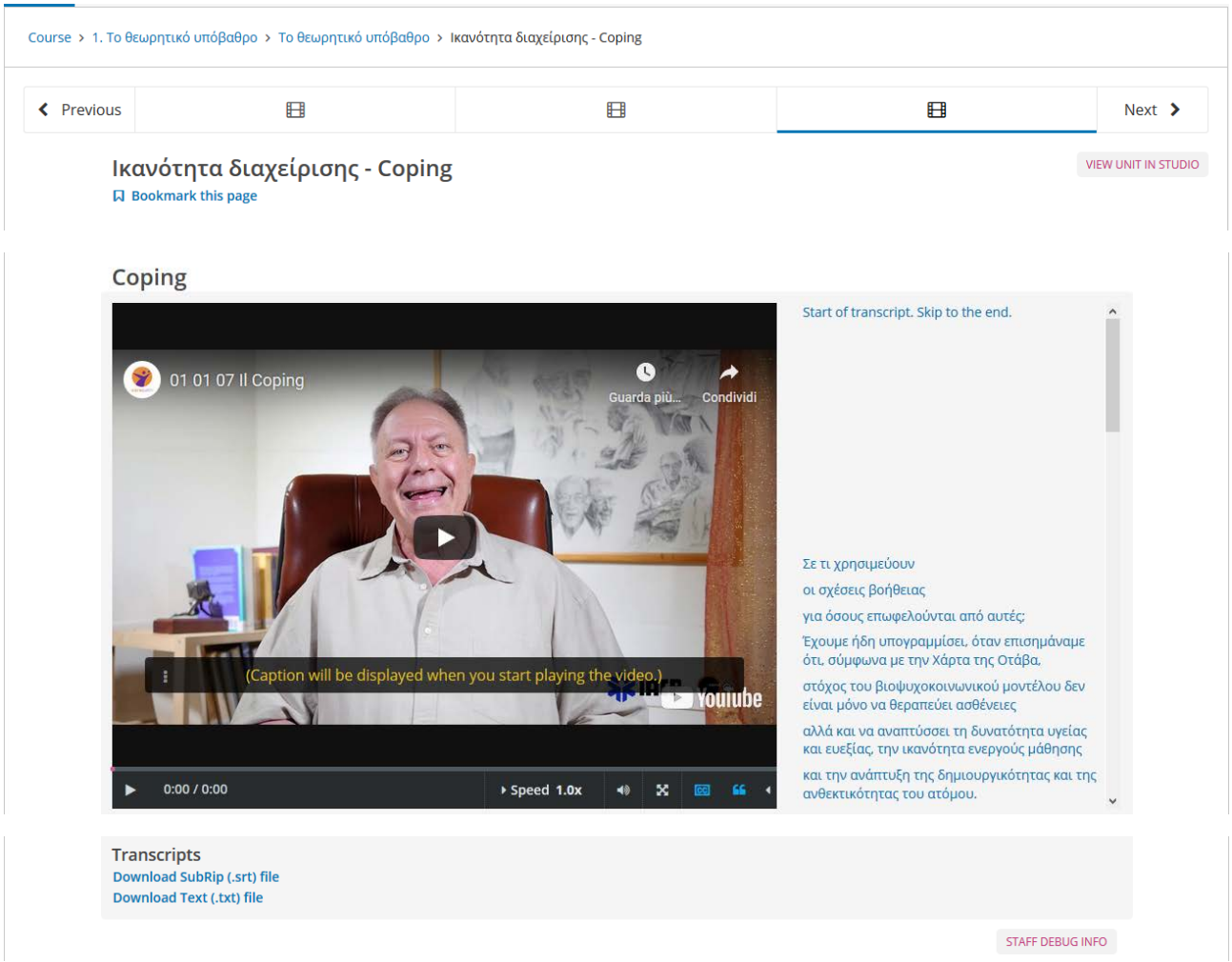


Transcript

Σε τι χρησιμεύουν

οι σχέσεις βοήθειας

για όσους επωφελούνται από αυτές;

Έχουμε ήδη υπογραμμίσει, όταν επισημάναμε ότι, σύμφωνα με την Χάρτα της Οτάβα,

στόχος του βιοψυχοκοινωνικού μοντέλου δεν είναι μόνο να θεραπεύει ασθένειες

αλλά και να αναπτύσσει τη δυνατότητα υγείας και ευεξίας, την ικανότητα ενεργούς μάθησης

και την ανάπτυξη της δημιουργικότητας και της ανθεκτικότητας του ατόμου.

Ένας άλλος τρόπος ανάκλησης αυτής της ικανότητας, που είναι έμφυτη στον ανθρώπινο οργανισμό,

είναι το "coping", αγγλικός όρος που σημαίνει την ικανότητα διαχείρισης των ενδεχομένων της ζωής μας.

Δηλαδή, να διαχειρίζομαι όσο καλύτερα μπορώ τις ικανότητες να σχετίζομαι με τον εαυτό μου,

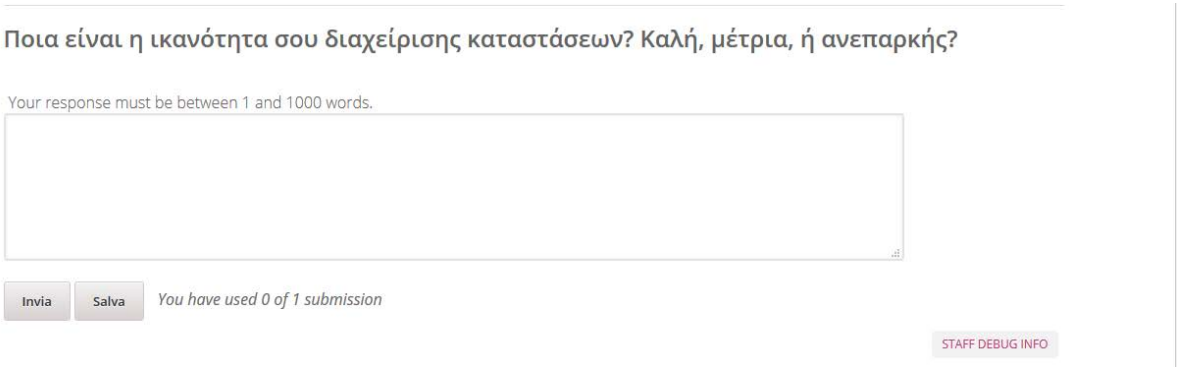
με τους άλλους και με τον κόσμο που με περιβάλλει.

Γνωρίζουμε ότι στις σχέσεις βοήθειας,

σε ό,τι αφορά τα χαρακτηριστικά του αποτελεσματικού θεραπευτή,

ανεξάρτητα από την προσέγγιση που υιοθετεί, για να είναι αποτελεσματικός πρέπει να μπορεί

στη σχέση με τον θεραπευόμενο να επιδεικνύει βαθύ και μη βλαπτικό σεβασμό,
να έχει ενσυναίσθηση και να κατανοεί όσα λέει και νοιώθει ο θεραπευόμενος,
το τι εννοεί, και να σχετίζεται μαζί του με ειλικρίνεια, αυθεντικότητα και διαφάνεια.
Ωστόσο, για να λειτουργήσει αυτό, πρέπει και ο θεραπευόμενος, ο ασθενής, να έχει
ορισμένα χαρακτηριστικά καθώς πρόκειται για ομαδική προσπάθεια.
Στις σχέσεις βοήθειας ως "αποτελεσματικοί" θεωρούνται οι χρήστες που είναι ειλικρινείς
και έχουν κίνητρο να αλλάξουν, ίσως γιατί δεν είναι καλά και θέλουν
με κάποιο τρόπο να μην υποφέρουν πια. Επίσης, έχουν την ικανότητα να έρχονται
σε ψυχολογική επαφή με τον θεραπευτή με τον οποίο συνεργάζονται και να κατανοούν
τα χαρακτηριστικά της σχέσης που θέτει ο θεραπευτής.
Μέσω αυτών των χαρακτηριστικών, μαζί με την επιμονή και την προθυμία
να μάθουμε από τα λάθη μας και το απαιτούμενο θάρρος να παραδεχτούμε
ότι σφάλλαμε, το λάθος μας μετατρέπεται σε σοφό δάσκαλο.
Έτσι, γίνεται σαφές ότι το "coping" είναι μία βέλτιστη κατάσταση λειτουργίας
και αποτέλεσμα μιας ομαδικής προσπάθειας θεραπευτή και θεραπευομένου που στοχεύει
σε μια καλύτερη ποιότητα ζωής και στην καλύτερη συνειδητοποίηση των εγγενών
δυνατοτήτων μας
που είναι καταγεγραμμένες στον γενετικό μας κώδικα και αναπτύσσονται περαιτέρω,
ανάλογα με τις συνθήκες του περιβάλλοντός μας αλλά και με την ιδιαίτερη κλίση μας
και με τον τρόπο που αντιμετωπίζουμε τη ζωή.



Σε επαγγελματικό επίπεδο, ποιά είναι η ικανότητα σου διαχείρισης καταστάσεων ? Καλή, μέτρια, ή ανεπαρκής?'

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Τι θα μπορούσες ή θα ήθελες να κάνεις για να βελτιωθείς στην διαχείριση καταστάσεων σε προσωπικό ή επαγγελματικό επίπεδο?

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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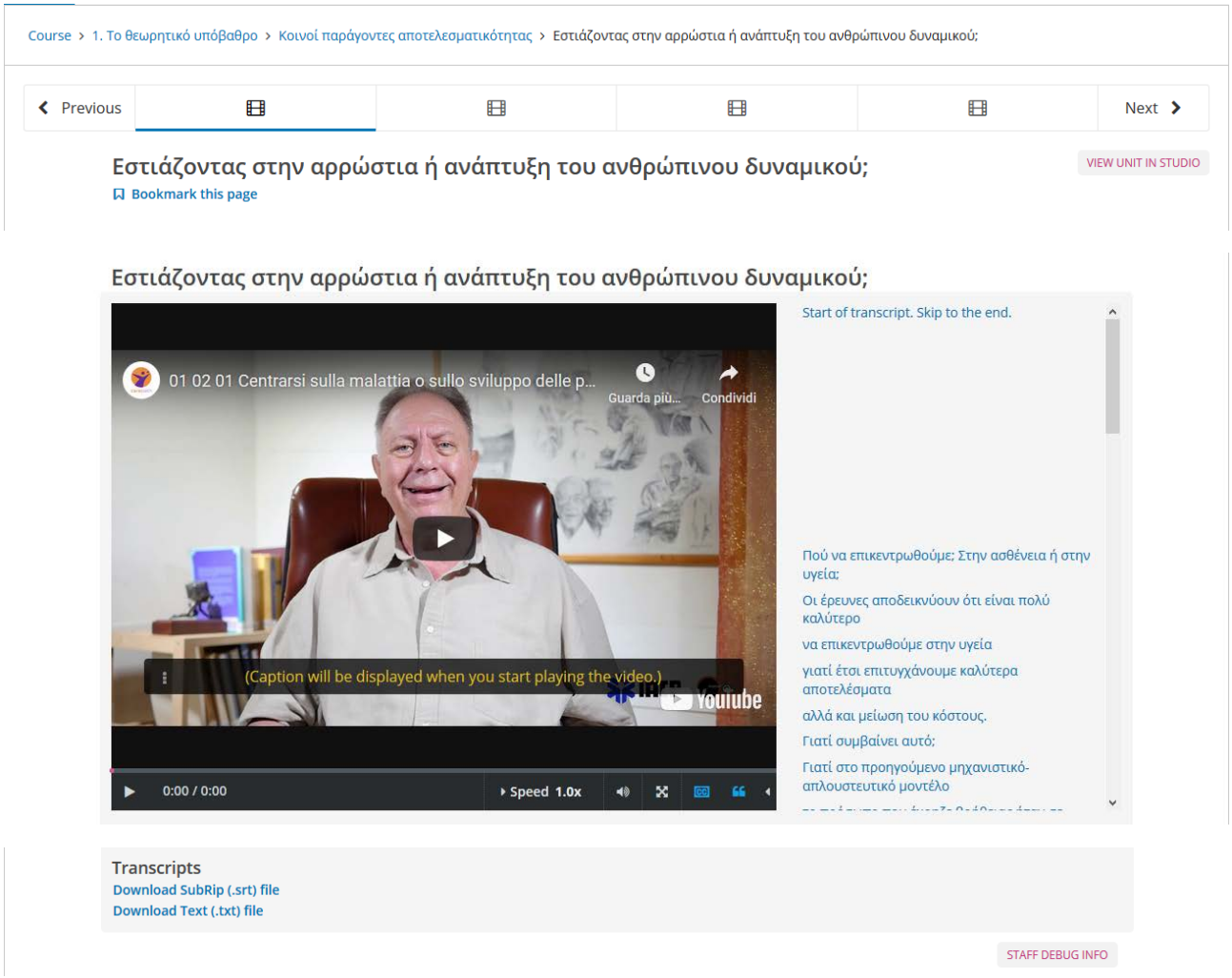

Transcript

Πού να επικεντρωθούμε; Στην ασθένεια ή στην υγεία;

Οι έρευνες αποδεικνύουν ότι είναι πολύ καλύτερο

να επικεντρωθούμε στην υγεία

γιατί έτσι επιτυγχάνουμε καλύτερα αποτελέσματα

αλλά και μείωση του κόστους.

Γιατί συμβαίνει αυτό;

Γιατί στο προηγούμενο μηχανιστικό-απλουστευτικό μοντέλο

το πρόσωπο που έχρηζε βοήθειας ήταν σε κατάσταση παθητικότητας. Όντως, ο λεγόμενος

ασθενής

μπορεί κατά μία έννοια να γίνει πολύ υπομονετικός και παθητικός,

επιδεικνύοντας μια επίκτητη αδράνεια. Αυτός ο κίνδυνος μειώνεται κατά πολύ

στο νέο μοντέλο όπου το πρόσωπο ενθαρρύνεται να χρησιμοποιήσει τη δύναμή του

ώστε να εισέλθει σε μία συνεργασία όπου ακόμα και η εξουσία λήψης των αποφάσεων μοιράζεται

μεταξύ θεραπευτή και θεραπευομένου.

Επιπλέον, οι έρευνες αποδεικνύουν ότι με την προσέγγιση της προαγωγής

της υγείας και της ευεξίας

επιτυγχάνονται,

στις ίδιες κατηγορίες θεραπευομένων, καλύτερα αποτελέσματα.

Για παράδειγμα,

Υιοθετώντας μία πολιτική πρόληψης

των ασθενών σε συνδυασμό με μια καλή σχέση με το νοσηλευτικό προσωπικό,

σε περίπτωση υποβολής σε χειρουργική επέμβαση, με το νέο μοντέλο

μειώνεται η περίοδος νοσηλείας και όσο λιγότερες είναι

οι αρνητικές επιπτώσεις σε μεταχειρουργικό στάδιο,

τόσο μεγαλύτερη είναι η ανάπτυξη των ανοσοποιητικών μηχανισμών άμυνας

καθώς και η συμμόρφωση του ασθενούς,

δηλαδή, η συνεργασία με τον γιατρό και τους νοσηλευτές στην τήρηση των οδηγιών

σχετικά με το τι πρέπει ή δεν πρέπει να κάνει και στην τακτική πρόσληψη των φαρμάκων.

Το νέο μοντέλο αποδεικνύει επίσης ότι είναι πολύ λιγότερες οι αντιρρήσεις από τους ασθενείς

απέναντι στις υγειονομικές δομές και λιγότερο συχνή η αλλαγή θεράποντος ιατρού.

Ενισχύεται, λοιπόν, η ικανότητα συνεργασίας από πλευράς του ασθενούς

και αυτό το νέο μοντέλο έχει ευνοϊκά αποτελέσματα όχι μόνο για τον χρήστη και τους οικείους του,

αλλά και για ολόκληρη την κοινωνία: όταν αναπτύσσουμε πιο πολύ τις δυνατότητές μας

νοσούμε λιγότερο και ζούμε περισσότερο και με καλύτερη υγεία. Και η κοινωνία μας

ευημερεί. Άρα, η προαγωγή της υγείας και της ευεξίας είναι αμοιβαία επωφελής

γιατί όλοι βγαίνουν κερδισμένοι και τα αποτελέσματα μιλούν από μόνα τους.

Μπορείτε να παραλείψετε τις παρακάτω ερωτήσεις εάν δεν εργάζεστε σε κανένα ρόλο στον τομέα της βοήθειας στις σχέσεις.

STAFF DEBUG INFO

Σύμφωνα με όσα πιστεύετε, η εστίαση στο άτομο, σας δίνει πραγματικά καλύτερα αποτελέσματα, όπως τεκμηριώνεται και από την έρευνα ή είναι απλά ωραία λόγια ιδεαλιστών και όχι πολύ δομημένων ανθρώπων;

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Το είδος της εργασίας σας και η καθημερινή πρακτική σας καθιστούν φυσικό να επικεντρωθείτε στον πελάτη σας ή για να το επιτύχετε θα πρέπει να κάνετε μεγάλη προσπάθεια;

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Όταν εργάζεστε ατομοκεντρικά, σας προσφέρει ικανοποίηση;

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Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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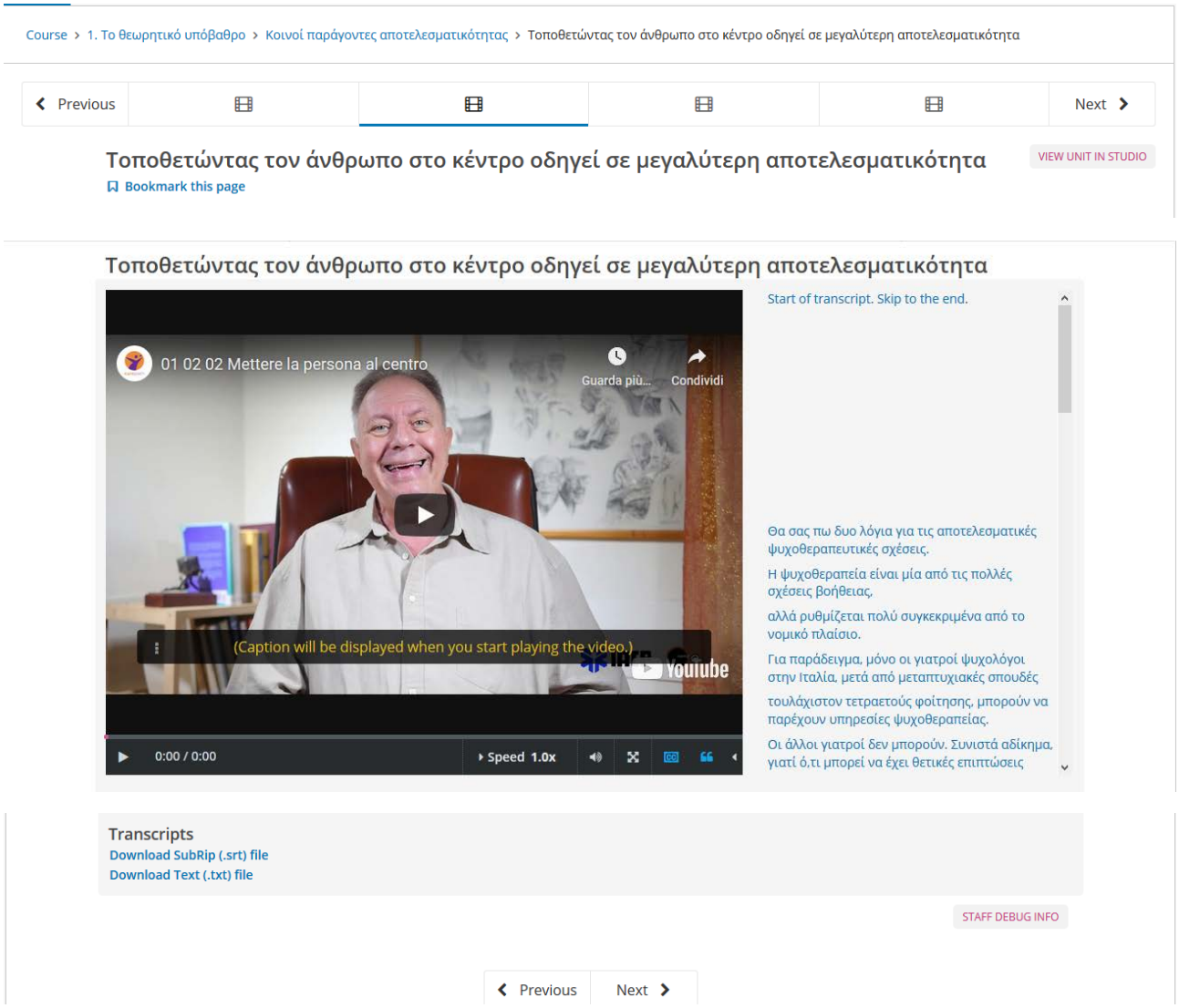


Transcript

Θα σας πω δυο λόγια για τις αποτελεσματικές ψυχοθεραπευτικές σχέσεις.

Η ψυχοθεραπεία είναι μία από τις πολλές σχέσεις βοήθειας,

αλλά ρυθμίζεται πολύ συγκεκριμένα από το νομικό πλαίσιο.

Για παράδειγμα, μόνο οι γιατροί ψυχολόγοι στην Ιταλία, μετά από μεταπτυχιακές σπουδές

τουλάχιστον τετραετούς φοίτησης, μπορούν να παρέχουν υπηρεσίες ψυχοθεραπείας.

Οι άλλοι γιατροί δεν μπορούν. Συνιστά αδίκημα, γιατί ό,τι μπορεί να έχει θετικές επιπτώσεις

σε έναν οργανισμό, αν δεν το προάγουμε με σωστό τρόπο, μπορεί να αποβεί επιζήμιο.

Παρόλα αυτά,

οι έρευνες αποδεικνύουν ότι η αποτελεσματικότητα στον χώρο της ψυχοθεραπείας δεν είναι αποτέλεσμα

συγκεκριμένης θεωρητικής προσέγγισης αλλά μάλλον της ποιότητας των σχέσεων των ψυχοθεραπευτών

που ανήκουν σε διάφορες ψυχοθεραπευτικές σχολές και, όπως και στις σχέσεις βοήθειας,

ισχύουν οι ίδιες μεταβλητές και παράμετροι και στις ψυχοθεραπευτικές σχέσεις.

Ένας ψυχοθεραπευτής είναι αποτελεσματικός όχι γιατί εφαρμόζει ένα ορισμένο θεωρητικό μοντέλο αλλά γιατί μπορεί να σχετίζεται με τον θεραπευόμενο επιδεικνύοντας αποδοχή,

χωρίς κριτική, με βαθύ σεβασμό,

και γιατί έχει

την ικανότητα

όχι να ακούει όχι μόνο ό,τι του λέει ο χρήστης/ασθενής/θεραπευόμενος,

αλλά και το τι σημαίνει ό,τι ειπώνεται για το πρόσωπο του θεραπευόμενου.

Επίσης, μπορεί να σχετίζεται με τον θεραπευόμενο με τρόπο γνήσιο, αυθόρμητο και διάφανο αλλά αυτό δεν αρκεί γιατί η ψυχοθεραπευτική σχέση, όπως και κάθε σχέση βοήθειας, είναι ομαδική προσπάθεια και συνδημιουργία. Πρέπει να δώσει και ο θεραπευόμενος,

διαφορετικά δεν λειτουργεί η σχέση.

Και τι δίνει;

Το κίνητρο για αλλαγή της κατάστασης, που συχνά προκύπτει από μια αίσθηση δυσφορίας

και την ικανότητα ψυχολογικής επαφής με τον συγκεκριμένο ψυχοθεραπευτή.

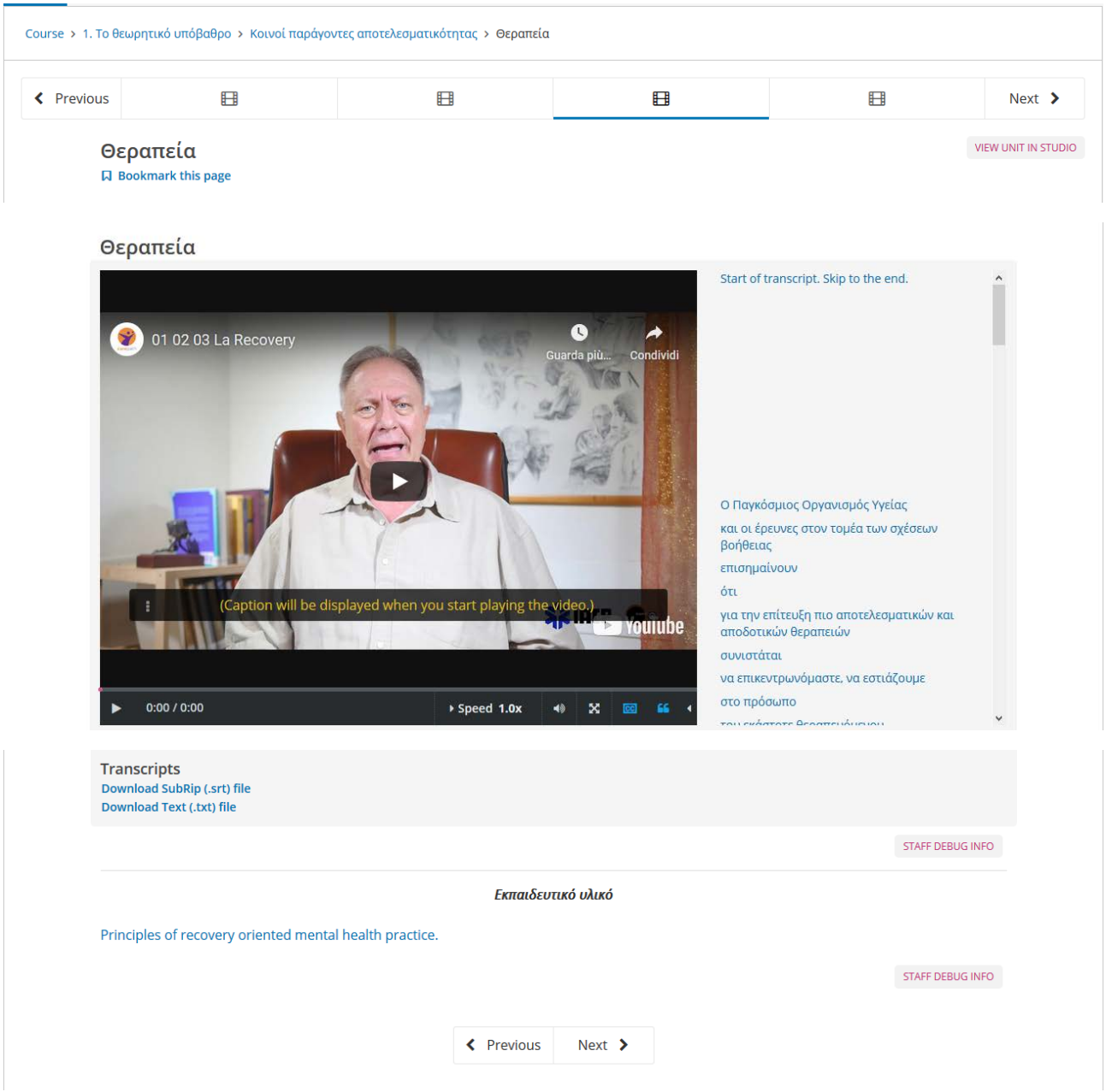
Επιπλέον, υπάρχει

μια τρίτη προϋπόθεση: να μπορεί να κατανοήσει τα χαρακτηριστικά που είναι θεμελιώδη

για τις σχέσεις: δηλαδή, τον βαθύ σεβασμό, την ακρόαση με ενσυναίσθηση και την αυθεντικότητα του ψυχοθεραπευτή του.

Έτσι, οι δυο τους μπορούν να λειτουργήσουν με πολύ θετικά και πιο ικανοποιητικά αποτελέσματα από ό,τι αν ο ασθενής για την ίδια δυσκολία λάμβανε μόνο φαρμακευτική αγωγή ή, προφανώς, καμία αγωγή.

Συνεπώς, και στην ψυχοθεραπεία είναι καλό "φάρμακο" η αποτελεσματική σχέση.



Transcript

Ο Παγκόσμιος Οργανισμός Υγείας

και οι έρευνες στον τομέα των σχέσεων βοήθειας

επισημαίνουν

ότι

για την επίτευξη πιο αποτελεσματικών και αποδοτικών θεραπειών

συνιστάται

να επικεντρωνόμαστε, να εστιάζουμε

στο πρόσωπο

του εκάστοτε θεραπευόμενου

που έχουμε αναλάβει.

Άρα έχει σημασία να προσωποποιούμε τις θεραπείες, να μην τις θεωρούμε ως λευκή μπογιά

με την οποία θα τα βάψουμε όλα λευκά, ανεξάρτητα από το ποιος είναι ο θεραπευόμενος.

Όπως και η ψυχοθεραπεία, προσωποποιούνται και οι σχέσεις βοήθειας

γιατί έτσι βοηθάμε περισσότερο τον Τζίνο, τη Μάιρα, τον Τζόζεφ, τη Μαίρη κτλ.

Γιατί

πρέπει

να εγκαθιδρύσουμε στο μέγιστο δυνατό μια ομαδική εργασία και να δεσμευτούμε σοβαρά σε μια πορεία

όπου ο άλλος θεωρείται πρωταγωνιστής σε αυτή την περιπέτεια αλλαγής.

Η "Task Force 29" του Αμερικανικού Συνδέσμου Ψυχολογίας, που έχουμε ήδη αναφέρει,

αποδεικνύει τη σημασία των προσωποκεντρικών θεραπειών

και

επισημαίνει, επιπλέον, μία εξίσου σημαντική πτυχή:

ότι οι θεραπείες, η φιλοσοφία τους, πρέπει να καθορίζονται

με βάση τις έννοιες της αποκατάστασης (recovery)

και όχι,

όπως γινόταν στο παρελθόν, με βάση έναν αβασάνιστο

και απαισιόδοξο

χαρακτηρισμό μιας κατάστασης ως χρόνιας.

Τι είναι η αποκατάσταση (recovery);

Η αποκατάσταση τις τελευταίες δεκαετίες κατάφερε, με τις ίδιες προβληματικές,

να είναι πιο βοηθητική

και γκρέμισε μια σειρά από μύθους,

όπως

το ότι

η σχιζοφρένεια

είναι μία χρόνια ασθένεια και παθολογία.

Στο παρελθόν υπήρχε αυτή η πεποίθηση,

αλλά ο συγκεκριμένος τρόπος σκέψης αποτελούσε παράλληλα

και μία

αυτοεκπληρούμενη προφητεία

και αυτό, αν το καλοσκεφτούμε, είναι κάτι μάλλον προφανές.

Μάλιστα,

πάντα στο παράδειγμα της σχιζοφρένειας, γνωρίζουμε ότι αυτή υπάρχει

σε κάθε χώρα, αλλά κάθε κουλτούρα την αντιμετωπίζει διαφορετικά.

Σε μερικές κοινωνίες και κουλτούρες ο σχιζοφρενής, ο ψυχωτικός, θεωρείται ως ένας άνθρωπος

που τον έχουν αγγίξει οι θεοί

και για αυτό η κοινότητα τον αντιμετωπίζει με σεβασμό και καλοσύνη και του προσφέρει

τροφή και στέγη όταν τις έχει ανάγκη.

Σε άλλες κοινωνίες, αντίθετα,

είναι ένας απόβλητος που τον εξορίζουν

από την κοινότητα και τον δένουν σε ένα δέντρο στο δάσος.

Στη δική μας κουλτούρα,

σε άλλες εποχές, αντιμετωπίζαμε

αυτά τα άτομα

με τρόπο πολύ διαφορετικό,

ενίοτε απάνθρωπο,

αλλά προφανώς το κάναμε για το καλό τους, όπως όταν πιστεύαμε

ότι το φαινόμενο οφειλόταν σε δαιμονοληψία και βασανίζαμε τους άμοιρους σχιζοφρενείς

με πυρωμένα σίδερα ελπίζοντας, αν το σώμα, σε κατάσταση ιδεοληψίας, γινόταν αφιλόξενο,

να βγει από αυτό ο Διάβολος.

Ή, πάλι,

αντιμετωπίζαμε αυτούς τους ανθρώπους με πολλά άλλα μέσα,

αλλά πάντα με την προφητεία της χρόνιας κατάστασης

και, με απόλυτη ακρίβεια, αυτές οι προφητείες

θα εκπληρωθούν.

Με τη θεώρηση της αποκατάστασης, που λέει, "Όχι, όποια κι αν είναι"

"η κατάστασή σου, αν και απελπιστική"

"όπως στη σχιζοφρένεια, μπορείς να αποκαταστήσεις τη λειτουργικότητα", εκπληρώνεται μια θετική προφητεία,

που, όπως όλες οι προφητείες, ως έναν βαθμό θα εκπληρωθεί.

Γι' αυτό σήμερα βλέπουμε ότι όποιος αντιμετωπίζεται πιο αισιόδοξα εκπληρώνει αυτές τις προφητείες.

Έχουμε, λοιπόν, άτομα που ακόμα βλέπουν πράγματα που δεν βλέπου οι άλλοι, ακούν φωνές

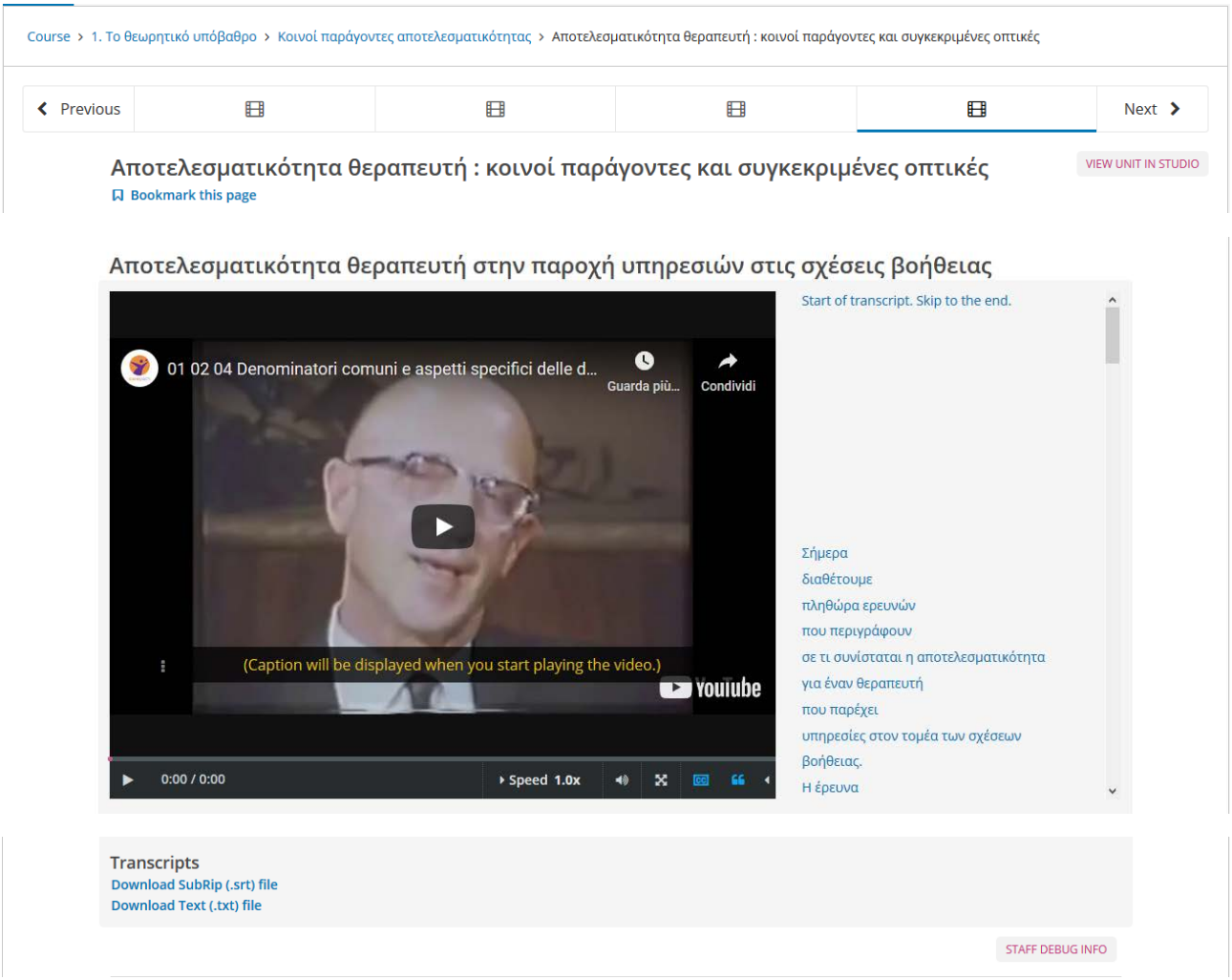
που δεν ακούν οι άλλοι, αλλά είναι έμμισθοι σύμβουλοι σε ιατρεία για το πώς να φερόμαστε

σε ομοιοπαθή άτομα με τρόπο πιο ανθρώπινο και αισιόδοξο, εκπληρώνοντας προφητείες

όχι αρνητικές αλλά θετικές, που είναι εξίσου

αυτοεκπληρούμενες.

Πράγματι, πρέπει να προσέχουμε πού μας οδηγεί η προφητεία.



Transcript

Σήμερα

διαθέτουμε

πληθώρα ερευνών

που περιγράφουν

σε τι συνίσταται η αποτελεσματικότητα

για έναν θεραπευτή

που παρέχει

υπηρεσίες στον τομέα των σχέσεων

βοήθειας.

Η έρευνα

έχει ως αφετηρία

τις υποθέσεις που τόσο ευφυώς διατύπωσε ο Καρλ Ρότζερς,

ο οποίος έμελλε να είναι

ο ιδρυτής της προσωποκεντρικής προσέγγισης

και ένας από τους πατέρες της ανθρωπιστικής φιλοσοφίας.

Το μακρινό 1942 ο Ρότζερς διατύπωσε με επιστημονικό τρόπο

μια σειρά από υποθέσεις

και πέρασε στην εμπειρική του επαλήθευση

σχετικά με το ποιες είναι οι απαραίτητες και επαρκείς προϋποθέσεις ώστε ένας θεραπευτής

να προάγει την αλλαγή.

Αυτές,

από τότε μέχρι σήμερα, επιβεβαιώθηκαν από τις έρευνες: η ικανότητα εγκαθίδρυσης

μιας σχέσης με τον ασθενή, τον θεραπευόμενο, που να χαρακτηρίζεται

από μία στάση χωρίς κριτική,

με βαθιά αποδοχή

και σεβασμό στο πρόσωπο του θεραπευόμενου,

από την ικανότητα

ακρόασης με ευαισθησία, ακρίβεια και ενσυναίσθηση, δηλαδή να καταλαβαίνει όχι μόνο τι λέει ο ασθενής,

αλλά και τι σημαίνει για εκείνον ό,τι ειπώνεται

αλλά και από μία στάση αυθεντικότητας, ευθύτητας

και ειλικρίνειας στη σχέση.

Αυτές οι υποθέσεις επιβεβαιώθηκαν άμεσα

αλλά και στη συνέχεια έχουν επιβεβαιωθεί και λειτουργήσει

σε όλες τις σχέσεις βοήθειας,

ουδεμίας εξαιρουμένης.

Άρα σε αυτό το θέμα

η συνεισφορά του Ρότζερς ήταν μεγάλη

στην εξέλιξη σχέσεων βοήθειας που να μη βασίζονται σε συμβάσεις

αλλά σε εμπειρικά και άρα επιστημονικά θεμέλια.

Νομίζω ότι είναι ακόμα πιο αποκαλυπτικό να ακούσουμε τον ίδιο τον Καρλ Ρότζερς

που περιγράφει τις τρεις απαραίτητες και επαρκείς προϋποθέσεις σε μια περίφημη ταινία του:

Από την πολύχρονη θεραπευτική μου εμπειρία έχω την αίσθηση

ότι αν μπορώ να δημιουργήσω το κατάλληλο κλίμα

την κατάλληλη σχέση, τις κατάλληλες προϋποθέσεις,

η θεραπευτική διαδικασία θα μπορούσε αναπόφευκτα να αρχίσει για τον θεραπευόμενό μου.

Θα αναρωτιέστε ποιο είναι αυτό το κλίμα.

Ποιες είναι αυτές οι προϋποθέσεις;

Θα υπάρχουν άραγε στη συζήτηση με τις γυναίκες ή τα πρόσωπα

που δεν έχω ξαναδεί ποτέ;

Θα προσπαθήσω να περιγράψω συνοπτικά ποιες είναι, κατ' εμέ, αυτές οι τρεις προϋποθέσεις.

Κατ' αρχάς, ένα ερώτημα είναι

αν μπορώ να είμαι αληθινός στη σχέση.

Αυτό αποκτούσε όλο και μεγαλύτερη σημασία για μένα

με την πάροδο των χρόνων.

Νοιώθω ότι

η γνησιότητα είναι άλλος ένας τρόπος να περιγράψουμε το επιθυμητό χαρακτηριστικό.

Μου αρέσειη λέξη "συνέπεια" με την οποία εννοώ πως ό,τι βιώνω μέσα μου είναι παρόν

στην επίγνωσή μου και εξωτερικεύεται μέσω της επικοινωνίας μου.

Κατά μία έννοια,

όταν έχω αυτό το χαρακτηριστικό,

είμαι ολόκληρος μέσα στη σχέση.

Υπάρχει μία άλλη λέξη που θεωρώ ότι το περιγράφει,

νοιώθω ότι μέσα στη σχέση

θα επιθυμούσα μία διαφάνεια, θα ήθελα ο θεραπευόμενος να μπορεί να δει μέσα μου,

να δει ότι δεν του κρύβω τίποτα.

Όταν είμαι αληθινός με τον τρόπο που προσπαθώ να περιγράψω,

ξέρω ότι τα δικά μου συναισθήματα

συχνά θα αναδυθούν στην επιφάνεια και θα εκφραστούν αλλά με κατάλληλο τρόπο

ώστε να μην επιβληθούν στον θεραπευόμενό μου.

Έπειτα,

το δεύτερο ερώτημα είναι αν τελικά θα επαινώ αυτό το πρόσωπο,

αν θα νοιάζομαι για αυτό το πρόσωπο.

Φυσικά, δεν θέλω να υποκρίνομαι ότι νοιάζομαι κάποιον χωρίς να το νοιώθω.

Μάλιστα, αν αντιπαθώ τον θεραπευόμενό μου, νομίζω ότι είναι καλύτερο αυτό να το εκφράσω.

Αλλά ξέρω

ότι η θεραπευτική διαδικασία είναι πιθανότερο να συντελεστεί,

και η εποικοδομητική

αλλαγή είναι πολύ πιο πιθανή,

αν νοιώθω ειλικρινή εκτίμηση για το άτομο με το οποίο δουλεύω.

Μια εκτίμηση για το συγκεκριμένο πρόσωπο ως ξεχωριστό άτομο.

Πείτε το αποδοχή, πείτε το έγνοια,

πείτε το μη κτητική αγάπη, αν θέλετε.

Νομίζω πως όλοι αυτοί οι όροι τείνουν να το περιγράψουν.

Ξέρω ότι η σχέση θα γίνει πιο εποικοδομητική αν υπάρχει κάτι τέτοιο.

Το τρίτο ερώτημα είναι αν θα μπορώ να καταλάβω τον εσωτερικό κόσμο του προσώπου,

εκ των έσω,

αν θα μπορώ να δω μέσα από τα δικά του μάτια,

αν θα είμαι

αρκετά ευαίσθητος

για να περιπλανηθώ

στον εσωτερικό κόσμο των συναισθημάτων του,

για να ξέρω πώς είναι να είμαι εκείνος.

Για να μπορώ να εντοπίσω

όχι μόνο τα επιφανειακά νοήματα αλλά και νοήματα που βρίσκονται

κατά κάποιο τρόπο κάτω από την επιφάνεια.

Ξέρω πως αν καταφέρω,

με ευαισθησία και ακρίβεια, να μπω στον κόσμο των εμπειριών του

τότε η αλλαγή και η θεραπευτική αλλαγή είναι πολύ πιο πιθανές.

Εκπαιδευτικό υλικό

Wampold BE. How important are the common factors in psychotherapy? An update. World Psychiatry. 2015;14(3):270–7.

STAFF DEBUG INFO

Μπορείτε να παραλείψετε τις παρακάτω ερωτήσεις εάν δεν εργάζεστε σε κανένα ρόλο στον τομέα της βοήθειας στις σχέσεις.

STAFF DEBUG INFO

Από τους κοινούς παράγοντες όλων των βοηθητικών σχέσεων που έχετε ακούσει και δει, ποιες αντίστοιχες δεξιότητες σας χαρακτηρίζουν στη δουλειά σας με τους πελάτες;

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Τι θα θέλατε να αναπτύξετε περαιτέρω;

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

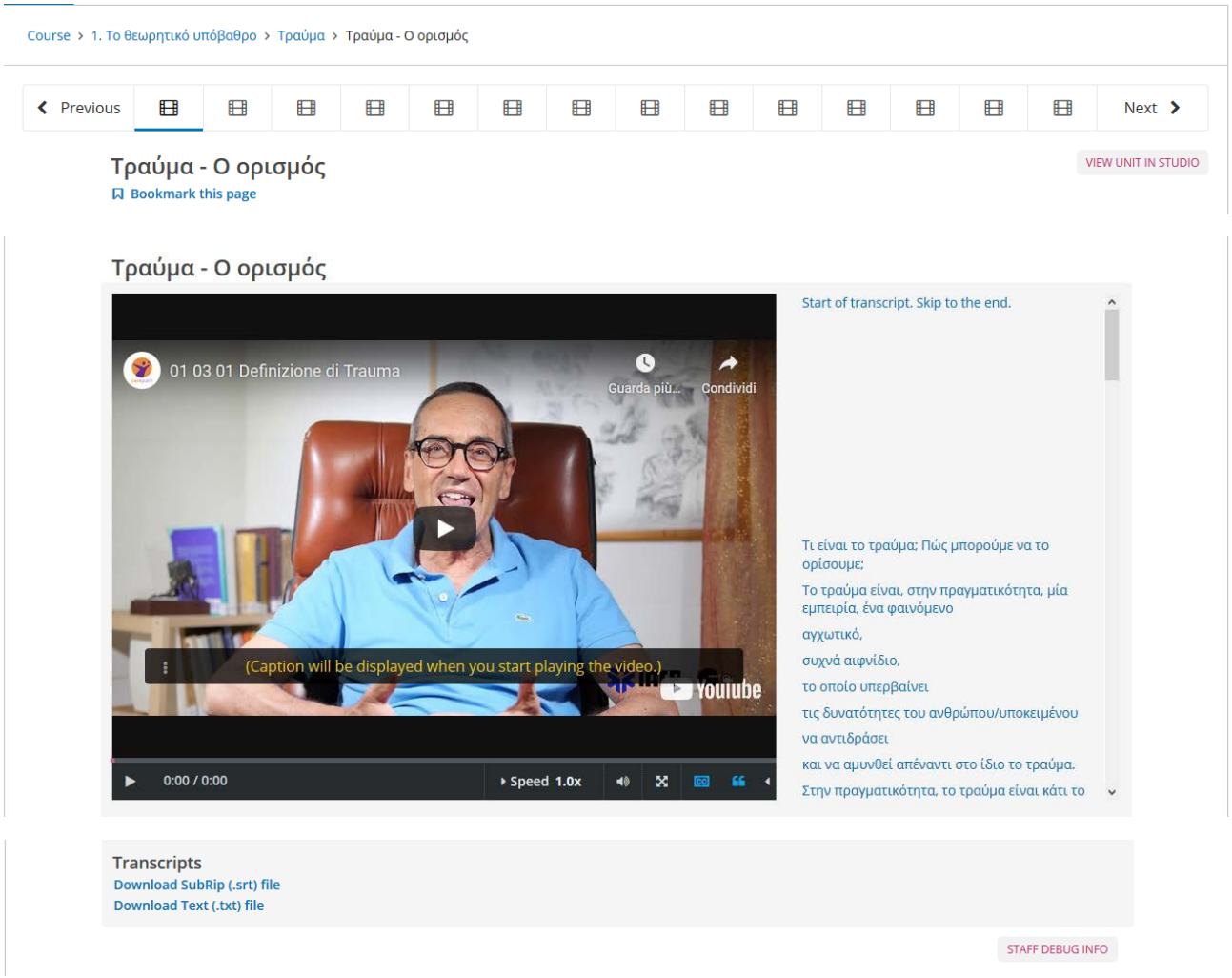
Ο χώρος εργασίας σας σας προσφέρει την ευκαιρία να γίνετε καλύτερος επαγγελματίας; Και αν ναι, πώς;

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO



Transcript

Τι είναι το τραύμα; Πώς μπορούμε να το ορίσουμε;

Το τραύμα είναι, στην πραγματικότητα, μία εμπειρία, ένα φαινόμενο

αγχωτικό,

συχνά αιφνίδιο,

το οποίο υπερβαίνει

τις δυνατότητες του ανθρώπου/υποκειμένου

να αντιδράσει

και να αμυνθεί απέναντι στο ίδιο το τραύμα.

Στην πραγματικότητα, το τραύμα είναι κάτι το οποίο υπερβαίνει τις δυνάμεις

αντίστασης του προσώπου που εκτίθεται σε αυτό.

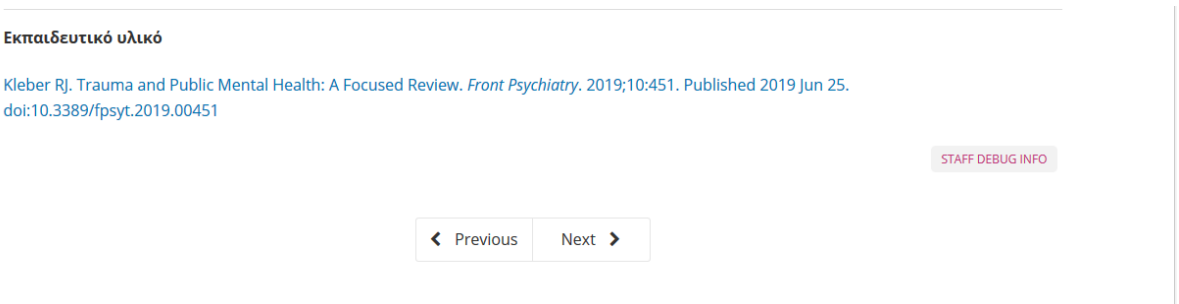
Το τραύμα έχει μελετηθεί

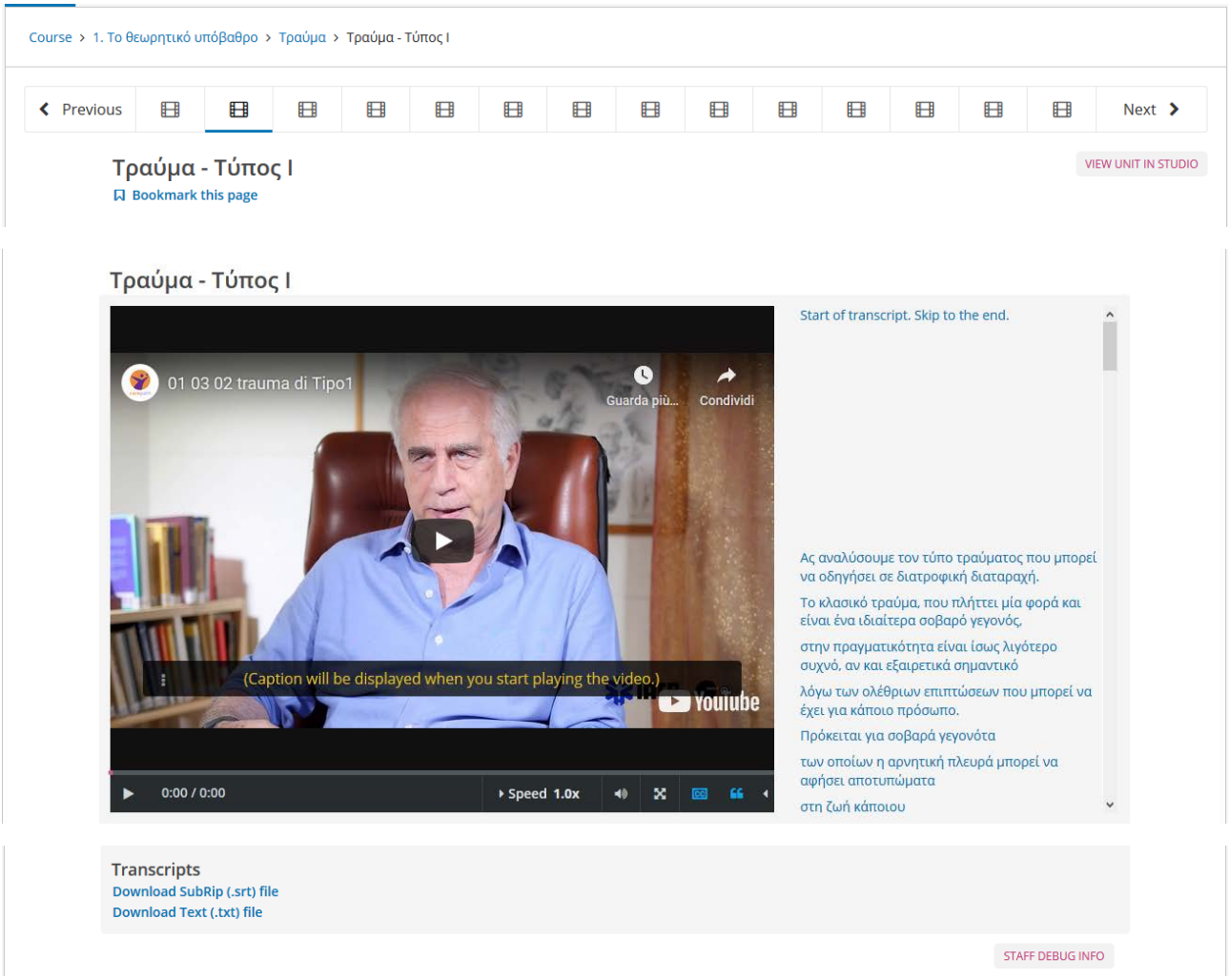
με διάφορους τρόπους.

Για παράδειγμα, υπάρχει το οξύ τραύμα, που οφείλεται

σε φυσικές ή τεχνολογικές καταστροφές, και η τραυματική κατάσταση που είναι
χρόνια/επαναλαμβανόμενη, όπως εκείνη στην οποία εκτίθενται τα μικρά παιδιά.
Ωστόσο,
μπορούμε να πούμε
ότι η ιστορία του τραύματος, από κλινική άποψη, αρχίζει με τη μελέτη των μετατραυματικών νευρώσεων,
που ερευνήθηκαν από τον Φρόιντ, και άρα σε ψυχαναλυτικό πλαίσιο,
και στη συνέχεια μελετήθηκαν εκ νέου από άλλους συγγραφείς.
Και γιατί μετατραυματική νεύρωση; Γιατί μετά από μεγάλους πολέμους, ειδικά
μετά από τον Α' Παγκόσμιο και άλλους πολέμους παρατηρήθηκαν πολλές διαταραχές από την έκθεση
σε πολεμικά τραύματα, που είχαν ψυχολογικές συνέπειες και στη συνέχεια
περιγράφηκαν από τα συστήματα ψυχιατρικής ταξινόμησης, δηλαδή τα συστήματα της ψυχοπαθολογίας,
ως διαταραχή μετατραυματικού στρες. Αυτού του είδους η διαταραχή
είναι η μόνη διαταραχή στην ψυχιατρική που οφείλεται με βεβαιότητα σε έναν εξωτερικό παράγοντα.
Αυτός ο παράγοντας είναι το ίδιο το τραύμα.
Άρα δεν είναι απαραίτητο
όποιος εκτίθεται, για παράδειγμα, σε έναν σεισμό ή σε μία πλημμύρα, να είναι
ο ίδιος αδύναμος, εύθραυστος ή ευάλωτος, γιατί το τραύμα είναι τόσο σημαντικό
και ισχυρότερο των δυνάμεων του ατόμου που από μόνο του μπορεί να έχει επιπτώσεις
σε ψυχολογικό και σωματικό επίπεδο. Σε σωματικό επίπεδο
από τα πιο σημαντικά συμπτώματα της διαταραχής μετατραυματικού στρες
είναι, ακριβώς, τα συμπτώματα νευροφυτικού τύπου.
Συμπτώματα επαγρύπνησης, υπερδιέγερσης,
δηλαδή υπερβολικής επιφυλακής και αντίδρασης στα εξωτερικά ερεθίσματα.
Αυτό, λοιπόν, σημαίνει ότι κάποιος φέρει μέσα του και μερικές αντικειμενικές ενδείξεις
των επιπτώσεων του τραύματος και όχι μόνο υποκειμενικά συμπτώματα.
Το τραύμα έχει μελετηθεί και από πλευράς των ψυχολογικών μηχανισμών,
οι οποίοι είναι πολύ σημαντικοί:
εκείνο που μελέτησε
η ψυχανάλυση, ήδη εξ αρχής,
είναι το γεγονός ότι το τραύμα,
ειδικά αν είναι πρώιμο, για παράδειγμα, στη νηπιακή ηλικία,
υφίσταται μία διαδικασία απώθησης.

Η απώθηση αυτή δεν σημαίνει ότι το τραύμα το ξεχνάμε,
το αρνούμαστε ή το θάβουμε. Το τραύμα μπορεί να εμφανιστεί, να ενεργοποιοηθεί εκ νέου αργότερα,
για παράδειγμα, στην ενήλικη ζωή,
πιθανώς
ως επίπτωση ενός άλλου τραύματος που κατά κάποιο τρόπο ανακαλεί
το προηγούμενο τραύμα. Αυτός είναι ένας μηχανισμός σε δύο στάδια που είχε μελετήσει ο Φρόιντ
διεξοδικά, κατά το οποίο έχουμε το πρώτο τραύμα, που κατά μία έννοια ευαισθητοποιεί το άτομο,
κι ένα δεύτερο τραύμα
που του επαναφέρει την κατάσταση της θυματοποίησης, της αδυναμίας
και της ευθραυστότητας στην οποία είχε βρεθεί,
επαναφέροντας εκ των πραγμάτων την κατάσταση
και οδηγώντας
σε νέα συμπτώματα
και σε μία κλινική κατάσταση που το υποκείμενο βιώνει σαν να ήταν η πρώτη φορά.
Επομένως, το τραύμα της διαταραχής μετατραυματικού στρες
διαπιστώνεται με ακριβή τρόπο
ο οποίος θέτει σε κίνδυνο τη ζωή του υποκειμένου.
Μπορεί να προκληθεί από πολέμους ή βασανιστήρια,
για λόγους τεχνολογικούς ή περιβαλλοντικούς,
αλλά αυτό το τραύμα είναι ακριβέστατο και εύκολα αναγνωρίσιμο
στη ζωή του υποκειμένου.





Transcript

Ας αναλύσουμε τον τύπο τραύματος που μπορεί να οδηγήσει σε διατροφική διαταραχή.

Το κλασικό τραύμα, που πλήττει μία φορά και είναι ένα ιδιαίτερα σοβαρό γεγονός,

στην πραγματικότητα είναι ίσως λιγότερο συχνό, αν και εξαιρετικά σημαντικό

λόγω των ολέθριων επιπτώσεων που μπορεί να έχει για κάποιο πρόσωπο.

Πρόκειται για σοβαρά γεγονότα

των οποίων η αρνητική πλευρά μπορεί να αφήσει αποτυπώματα

στη ζωή κάποιου

προκαλώντας ψυχική ή σωματική βλάβη, ή και τα δύο,

που μπορεί να διαρκέσει

πολλά χρόνια στη ζωή του.

Συνήθως αυτό το τραύμα το εντοπίζουμε στη διαταραχή μετατραυματικού στρες,

αλλά είναι πολύ συχνό και στη διατροφική διαταραχή

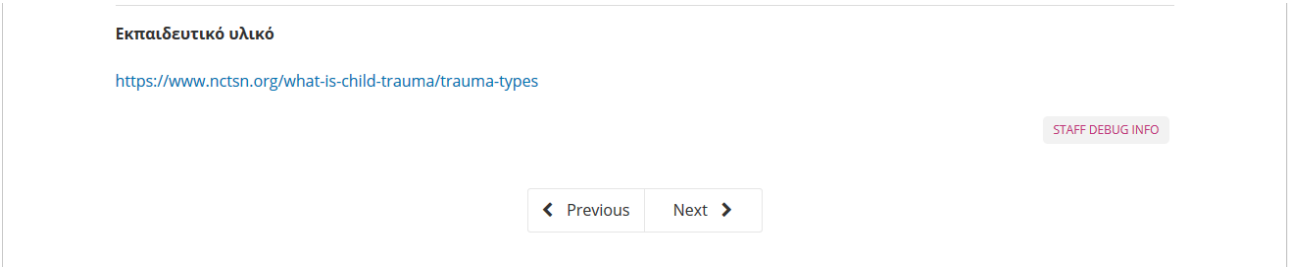
και ιδιαίτερα σε κάποιες μορφές της.

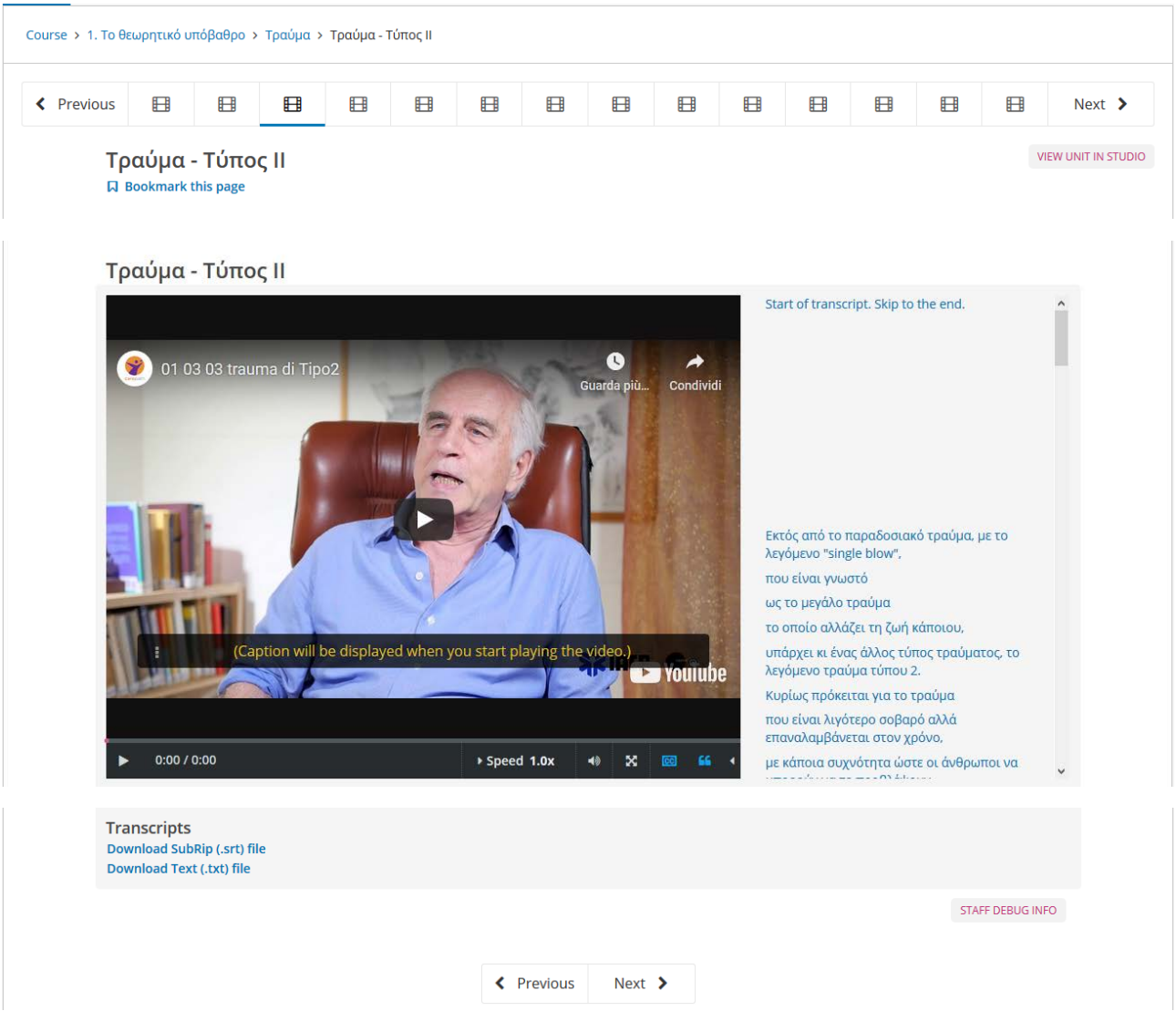
Το τραύμα διακρίνεται σε δύο τμήματα: στο σωματικό τραύμα που μπορεί κυρίως να συμβεί
στη ζωή σε στιγμές ιδιαίτερα δραματικές όπως είναι ο βιασμός,
η ληστεία, η σωματική βία, οι εχθροπραξίες στο πεδίο της μάχης,
μία φυσική καταστροφή, όπως τσουνάμι ή σεισμός,
ένα πολύ σοβαρό αυτοκινητιστικό δυστύχημα,
ένα σιδηροδρομικό ατύχημα,
και στο τραύμα ψυχικού τύπου: όταν η ζωή κάποιου τίθεται
σε σοβαρό κίνδυνο υπό την απειλή ενός προσώπου, μιας ιδιαίτερης κατάστασης
στην οποία μπορεί να περιέλθει,
όπου δεν προκύπτουν γεγονότα
με σωματικό τραυματισμό αλλά απλώς
συνιστούν μια τόσο ακραία και ισχυρή απειλή που δύσκολα μπορεί το πρόσωπο να τη διαγράψει
από τον νου του στο εγγύς μέλλον.
Για όσους υπόκεινται στο τραύμα 1ου τύπου, που αποκαλείται και "εστιακό τραύμα",
το τραύμα χαρακτηρίζεται ως "single blow",
δηλαδή χτυπάει μόνο μία φορά,
αλλά
αφήνει ίχνη ανεξίτηλα
και, μάλιστα, στα συμπτώματα
διατροφικού τύπου έχει επιπτώσεις
πολύ παρόμοιες με εκείνες της διαταραχής μετατραυματικού στρες.
Το τραύμα αυτό μπορεί να έχει μια σειρά από συνέπειες, όπως η διατροφική διαταραχή
που είναι η πιο συνήθης,
αλλά και μια σειρά από συμπτώματα
αρκετά εκτεταμένα
που μπορούν
να οδηγήσουν
σε ένα σύνολο χαρακτηριστικών
τα οποία, όλως περιέργως και ιδίως, είναι όλα παρόντα
στη διατροφική διαταραχή.
Με άλλα λόγια, η διατροφική διαταραχή δεν είναι αμιγώς διατροφική
και υπάρχουν ορισμένα συμπτώματα,

συχνά
και σε κάθε σχετική περίπτωση,
που μπορεί να συνοδεύουν όλες τις διατροφικές διαταραχές και είναι τα εξής:
χαμηλή αυτοεκτίμηση, εντονότατη τάση για κατάθλιψη,
εξαιρετικά διαστρεβλωμένη εικόνα για το σώμα
και τη σεξουαλικότητα,
υψηλός κίνδυνος αυτοκτονίας, αγχώδεις διαταραχές, χρήση αλκοολούχων ουσιών,
διαταραχές ύπνου και διασχιστικές, απώλεια μνήμης, επιθετικότητα και διαταραχές προσωπικότητας.
Είναι μια σειρά από συμπτώματα που δεν μας εκπλήσσουν όταν τα εντοπίζουμε
στις διατροφικές διαταραχές και δεν είναι μεμονωμένα αλλά πάντα συνοδεύονται
από τέτοιου είδους συμπτώματα ή από παθολογίες
που συμπληρώνουν την εικόνα της διατροφικής διαταραχής
και
σπάνια απουσιάζουν.
Πιο συγκεκριμένα, έχουμε
το τραύμα που αφήνει ένα ίχνος,
όπως αυτό το τραύμα τύπου 1,
το οποίο εκδηλώνεται κυρίως προκαλώντας αλεξιθυμία, μία συναισθηματική διαταραχή
που δεν επιτρέπει σε κάποιον να εκφράσει ανοιχτά τα συναισθήματά του
μέσω του λόγου.
Η τάση σε αυτή την περίπτωση, μετά από τραύμα τύπου 1, είναι η έκφραση συναισθημάτων
κυρίως σε επίπεδο μη λεκτικό,
μέσω του σώματος,
και αυτά τα αισθήματα
μπορεί να είναι
πολύ σοβαρά
και να οδηγήσουν
σε συναισθηματική απορρύθμιση, ενίοτε σημαντική, σε σημείο ώστε το άτομο
να επιδεικνύει μία παρόρμηση
ως έναν βαθμό,
και
γνωρίζουμε,

γιατί το συναντάμε
συχνότατα αυτό,
ότι υπάρχουν μορφές νευρικής βουλιμίας στις οποίες το τραύμα
αυτού του τύπου (όπως η κακοποίηση)
είναι
τέτοιας σοβαρότητας και μορφής ώστε να δημιουργεί
συμπτώματα
που μπορούν να οδηγήσουν σε σημαντική απώλεια ελέγχου η οποία επεκτείνεται
σε διάφορα επίπεδα.
Πιο συγκεκριμένα, κυρίως όσα συμβαίνουν σε ένα πρώιμο στάδιο ανάπτυξης,
όταν το τραύμα είναι δραματικό,
όταν οι συνθήκες της οικογένειας
είναι δύσκολα υποφερτές και υποστηρίξιμες,
σε αυτές τις περιπτώσεις
ελλωχεύει ο κίνδυνος της ψυχαναγκαστικής βουλιμίας:
πρόκειται για μία μορφή βουλιμίας
πολύ σοβαρής και επικίνδυνης
όπου μαζί με τις βουλιμικές συμπεριφορές
εκδηλώνονται μεταβολές στην προσωπικότητα
και στη διατροφική συμπεριφορά και κυρίως παρορμητικότητα
που μπορεί να αφορά
τη σεξουαλικότητα
και την τάση
κατανάλωσης τροφής
με τρόπο ανεξέλεγκτο και χωρίς αίσθηση της γεύσης.
Για παράδειγμα, μια τυπική συμπεριφορά
αυτών των ατόμων είναι
η διάπραξη κλοπών στα σούπερ μάρκετ και η κατανάλωση τροφής στο κατάστημα
πριν επιστρέψουν στο σπίτι για να φάνε, αν και έχουν τα χρήματα να αγοράσουν τροφή.
Μία έξαρση
των παρορμήσεων που είδαμε παραπάνω μπορεί να αφορά και τη σεξουαλικότητα,
αλλά κυρίως, πιο σημαντική και επικίνδυνη, είναι η αυτοκαταστροφική παρορμητικότητα

που αφορά αυτοκαταστροφικές συμπεριφορές, όπως το χαράκωμα ή την απόπειρα αυτοκτονίας.
Ο ψυχαναγκαστικός τύπος βουλιμίας είναι ο πιο επικίνδυνος γνωστός τύπος
κυρίως λόγω του υψηλού ποσοστού αυτοκτονιών.
Εν κατακλείδι, ένα τραύμα τύπου 1, ειδικά αν το περιβάλλον δεν είναι υποστηρικτικό,
οδηγεί σε αυτό τον τύπο βουλιμίας, που είναι αναμφίβολα και ο πιο επικίνδυνος,
ιδίως λόγω του υψηλότατου κινδύνου αυτοκτονίας.





Transcript

Εκτός από το παραδοσιακό τραύμα, με το λεγόμενο "single blow",

που είναι γνωστό

ως το μεγάλο τραύμα

το οποίο αλλάζει τη ζωή κάποιου,

υπάρχει κι ένας άλλος τύπος τραύματος, το λεγόμενο τραύμα τύπου 2.

Κυρίως πρόκειται για το τραύμα

που είναι λιγότερο σοβαρό αλλά επαναλαμβάνεται στον χρόνο,

με κάποια συχνότητα ώστε οι άνθρωποι να μπορούν να το προβλέψουν

αλλά να μην μπορούν να προβλέψουν επακριβώς

πότε θα συμβεί και αυτή η αναμονή, η προσδοκία είναι ψυχοφθόρα: προκαλεί

στο υποκείμενο μια ιδιαίτερα έντονη αδυναμία

που του δίνει την εντύπωση

ότι δεν είναι κύριος του εαυτού του.

Σε αυτό τον τύπο τραύματος εντοπίζονται συχνά διατροφικές διαταραχές.

Μπορεί να αφορά ένα ιστορικό

πολύ βίαιων συγκρούσεων στο άμεσο οικογενειακό περιβάλλον

στις οποίες

το παιδί, ο έφηβος,

ή και το νήπιο, έχει παραστεί για μεγάλο μέρος της ζωής του χωρίς σταματημό.

Αυτή η βίαιη σύγκρουση ίσως να οδηγεί σε μία αμιγώς βίαιη συμπεριφορά

που μπορεί να προκαλέσει

ακόμα και μεγάλη βλάβη, ίσως και απώλειες.

Αυτός ο τύπος επαναλαμβανόμενου τραύματος

δημιουργεί μία κατάσταση αναμονής

πολύ δραματική για το υποκείμενο που αναμένει

ότι μπορεί να επέλθει η αντίθεση,

αν και δεν είναι δεδομένο ότι θα συμβεί,

αλλά το ψυχικό τραύμα οφείλεται στην εξαιρετικά έντονη αναμονή

και επαναλαμβάνεται με τέτοια συχνότητα

ώστε η υπόλοιπη ζωή του υποκειμένου

ενδέχεται να φτάσει στο ίδιο είδος φόβου

ακόμα κι όταν έχουν εκλείψει αυτές οι τραυματικές εμπειρίες.

Σε ορισμένες περιπτώσεις υπάρχει η τάση να αναπαράγεται ο ίδιος τύπος τραύματος.

Για παράδειγμα,

μία νέα γυναίκα

που ήταν παρούσα όλη της τη ζωή σε καβγάδες των γονιών της

λόγω του ότι ο ένας απατούσε τον άλλο,

σε κάθε πραγματικότητα της υπόλοιπης ζωής της

επέλεγε μόνο συντρόφους

που εκδήλωναν συμπεριφορά απιστίας και οι προδοσκίες της αύξαναν

την ανάγκη της να ανακαλύψει αν όντως είχε συντελεστεί η απιστία.

Αυτού του είδους η συμπεριφορά

κατά κάποιο τρόπο γίνεται μια επαναλαμβανόμενη πρόβλεψη του βλαπτικού γεγονότος

με τον φόβο ότι μπορεί να συμβεί ανά πάσα στιγμή, λες και η εποχή

της παιδικής ηλικίας δεν πέρασε ποτέ.

Το τραύμα τύπου 2 παράγει, μεταξύ άλλων,

μία τάση μαζικής άρνησης, έναν συναισθηματικό λήθαργο,

σαν το υποκείμενο να τείνει να διαγράφει τα συναισθήματά του.

Άρα πρόκειται για υποκείμενα που φέρονται με τρόπο ψυχρό,

σαν να μην έχουν άλλα συναισθήματα

κάποιες συγκεκριμένες στιγμές της ζωής τους.

Αυτό ονομάζεται νέκρωση (numbing) συναισθημάτων και εκδηλώνεται ως συναισθηματικός λήθαργος.

Είναι ένα από τα βασικά στοιχεία

της λεγόμενης διασχιστικής διαταραχής όπου το υποκείμενο χάνει την ικανότητα

να νοιώθει

τα συνήθη συναισθήματα,

σαν να χάνει

τις βασικές αισθητηριακές ικανότητες,

σαν να είναι απών ή να μην συμμετέχει

στην καθημερινή πραγματικότητα της ζωής του

και της ύπαρξής του.

Επιπροσθέτως,

κυρίως στις διατροφικές διαταραχές

και ακόμα περισσότερο

στις διατροφικές διαταραχές

όπου εκδηλώνεται απώλεια ελέγχου και άρα μη περιοριστική ανορεξία ή ανορεξία

με βουλιμικές συμπεριφορές ή κανονικές βουλιμίες,

σε αυτές τις συμπεριφορές

κρύβεται πάντα μία βαθιά οργή:

το υποκείμενο είναι παθητικό,

μοιάζει να μην αντιδρά

αλλά όταν επιδίδεται σε μία πράξη

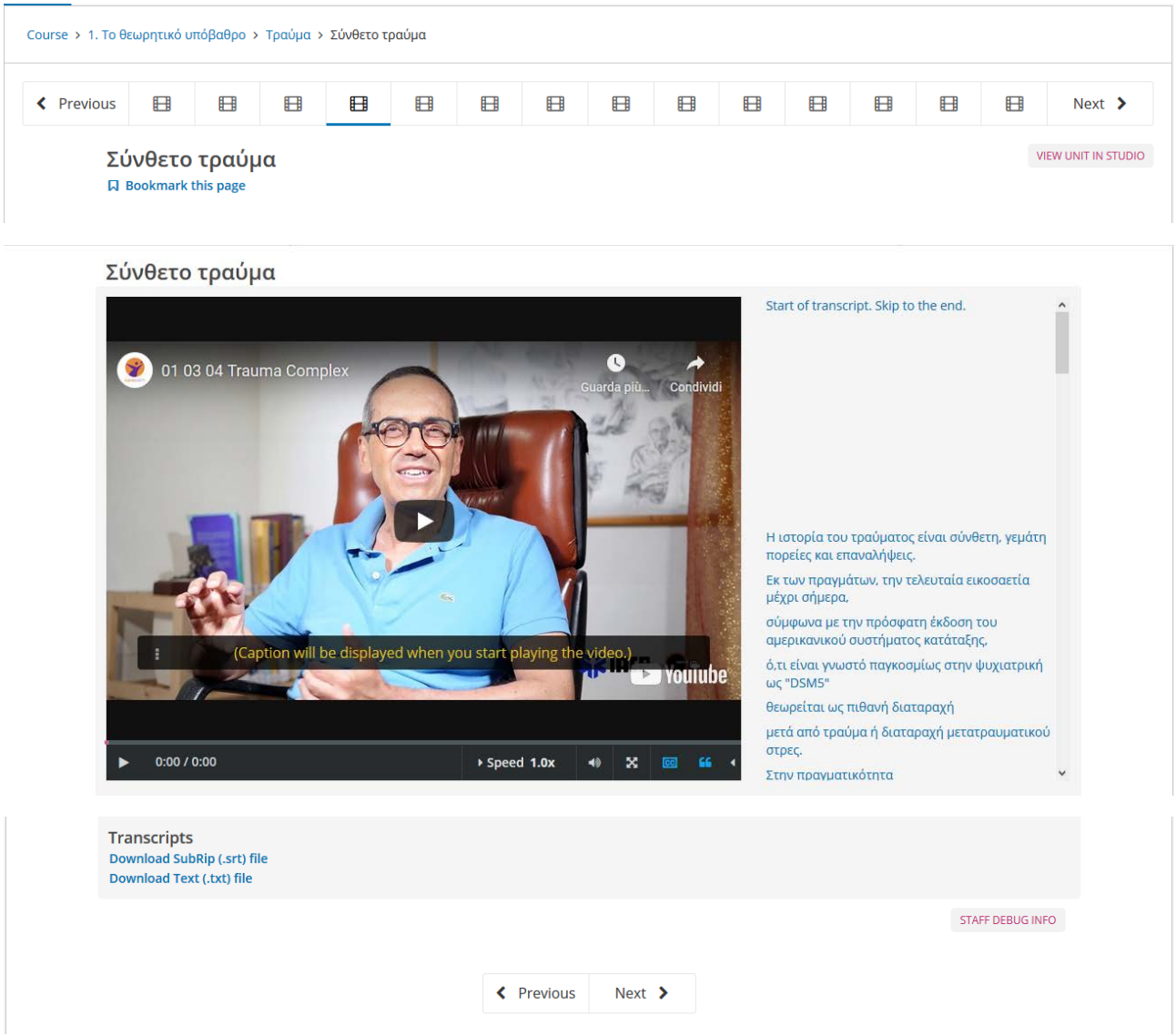
γίνεται αντιληπτή σε αυτόν

μία έντονη οργή,

όπως εκδηλώσεις επιθετικότητας προς τα έξω

αν και πολύ συγκρατημένες,

αλλά όταν το υποκείμενο έχει έντονα συναισθήματα μπορεί να εκφράσει
την βαθιά οργή του με τη μορφή ταραχής που έχει ως συνέπεια
ακόμα και βίαιες συμπεριφορές απέναντι στον εαυτό του ή στους άλλους.
Το υποκείμενο εκδηλώνει μια θλίψη συνεχή, όχι περιοδική αλλά σταθερή
μέσα του
σαν να υπάρχει
ένα παιδικό τραύμα που προκαλεί μία συνεχή παύση
η οποία με τη σειρά της προκαλεί μια αίσθηση απελπισίας
που οδηγεί σε θλίψη η οποία διαρκεί
μια ολόκληρη ζωή.
Πρόκειται, όπως είπαμε, για μικρά τραύματα
που συσσωρεύονται αλλά ονομάζονται
και σύνθετα τραύματα ή σχεσιακά τραύματα καθώς εξαρτώνται
από μια σειρά συνεχιζόμενων σχέσεων απέναντι στους άλλους.
Άρα στη ζωή κάποιου είναι πιθανό
όποιος έχει υποστεί αυτά τα τραύματα να έχει βιώσει στο οικιακό περιβάλλον,
και κυρίως στο οικογενειακό,
πολύ έντονες τραυματικές εμπειρίες.
Είναι διαρκή τραύματα που επαναλαμβάνονται και προκαλούν τα γνωστά μας διασχιστικά συμπτώματα
ή συναισθηματικές προσαρμογές.



Transcript

Η ιστορία του τραύματος είναι σύνθετη, γεμάτη πορείες και επαναλήψεις.

Εκ των πραγμάτων, την τελευταία εικοσαετία μέχρι σήμερα,

σύμφωνα με την πρόσφατη έκδοση του αμερικανικού συστήματος κατάταξης,

ό,τι είναι γνωστό παγκοσμίως στην ψυχιατρική ως "DSM5"

θεωρείται ως πιθανή διαταραχή

μετά από τραύμα ή διαταραχή μετατραυματικού στρες.

Στην πραγματικότητα

η προσοχή των ερευνητών,

πρωτίστως του Βαν ντερ Κολκ που εγκαινίασε

το σύνθετο ζήτημα του τραύματος,

η προσοχή των ερευνητών στράφηκε στα παιδικά τραύματα

που πραγματοποιούνται σε μία ηλικία κατά την οποία
το υποκείμενο
βρίσκεται σε θέση αδυναμίας
και κατωτερότητας, όπως ακριβώς η θέση των μικρών παιδιών.
Αυτός ο τύπος
τραυματικής κατάστασης, τα γεγονότα στα οποία εκτίθεται το μικρό παιδί,
από ψυχοπαθολογική αλλά και νευροβιολογική άποψη,
θεωρείται ως πιθανή προδιαθεσιακή αιτία της ανάπτυξης ψυχιατρικών διαταραχών
πέρα από τα όρια της διαταραχής μετατραυματικού στρες.
Αυτά
τα φαινόμενα
βρεφικών
τραυμάτων
είναι ποικίλου τύπου: μπορεί να είναι οξέα,
παρατεταμένα και επαναλαμβανόμενα στη βρεφική ηλικία
και χαρακτηρίζονται,
ακριβώς, ως κακοποιήσεις
όταν είναι τραυματικά φαινόμενα που αφορούν είτε μια πράξη,
όταν δηλαδή κάνουμε κάτι στο παιδί, όπως οι βρεφικές κακοποιήσεις,
η άσκηση σεξουαλικής ή σωματικής βίας ή η ψυχολογική άσκηση βίας,
είτε μπορεί να αφορούν
μια παράλειψη,
δηλαδή να οφείλονται σε ένα είδος παραμέλησης (neglect)στην παροχή ψυχολογικής
αλλά και σωματικής φροντίδας
στο παιδί οδηγώντας
σε γεγονότα
και καταστάσεις κακομεταχείρισης.
Άρα η κακομεταχείριση και η κακοποίηση είναι φαινόμενα με τα οποία θα ασχοληθούμε
μιλώντας για το σύνθετο τραύμα.
Το σύνθετο τραύμα ή, κατά άλλους, το πρωταρχικό αναπτυξιακό τραύμα,
που συχνά οφείλεται στην αποτυχία
των μορφών

πρωταρχικής φροντίδας,

δηλαδή, των γονέων,

για παράδειγμα.

Επίσης, ονομάζεται και σωρευτικό τραύμα, και ο ψυχαναλυτής Μασούντ Καν ασχολήθηκε

με αυτή την πτυχή του τραύματος: πολλά μικρά γεγονότα ή καταστάσεις τραυματικές

από πράξεις ή παραλείψεις επαναλαμβάνονται κατά τη βρεφική ηλικία οδηγώντας,

σωρευτικά, σε ένα κλίμα ή μια διάσταση τραυματική

την οποία το υποκείμενο θα νοιώσει εκ νέου

στην ενήλικη ζωή του όταν συναντήσει μία δυσκολία,

ένα πρόβλημα ή ένα άλλο τραύμα που θα θυμίζει το προγενέστερο τραύμα.

Ωστόσο, αυτό το προγενέστερο τραύμα είναι σύνθετο, ή μάλλον πολυσύνθετο, και μπορεί

να εκτείνεται χρονικά σε μία περίοδο

πολύ σημαντική και πολύχρονη, ακόμα και σε ολόκληρη την παιδική ηλικία.

Αρκεί να σκεφτούμε καταστάσεις όπου οι οικογένειες

στις οποίες βιώνεται ένα παρατεταμένο κλίμα

φόβου ή βίας εξαιτίας διαταραχών ή προβλημάτων των γονέων,

είτε του ενός είτε του άλλου,

οι οποόι δεν εγγυώνται την ανεμελιά, την αίσθηση ασφάλειας και προστασίας

που όμως είναι πολύ σημαντικές ώστε το παιδί να αναπτύξει

τη λεγόμενη

βασική εμπιστοσύνη που θα του χρησιμεύσει στη μετέπειτα ζωή του ώστε να σχετίζεται

με τους άλλους με τρόπο ήρεμο, ανοιχτό και γεμάτο εμπιστοσύνη.

Το υποκείμενο μπορεί να μην το συνειδητοποιεί αυτό γιατί όλες τις καταστάσεις

μπορεί, λίγο ως πολύ, να τις απωθήσει ή να τις ξεχάσει

και άρα

μπορεί

απλώς

αυτές να ενεργούν εκ των έσω, υπογείως,

ώσπου τελικά θα κληθεί το υποκείμενο να "πληρώσει τον λογαριασμό"

γιατί ανέρχεται στην επιφάνεια αυτή η κατάσταση

με τρόπο ενίοτε εκρηκτικό

και κάτι στην ενήλικη ζωή του υποκειμένου συμβάλλει

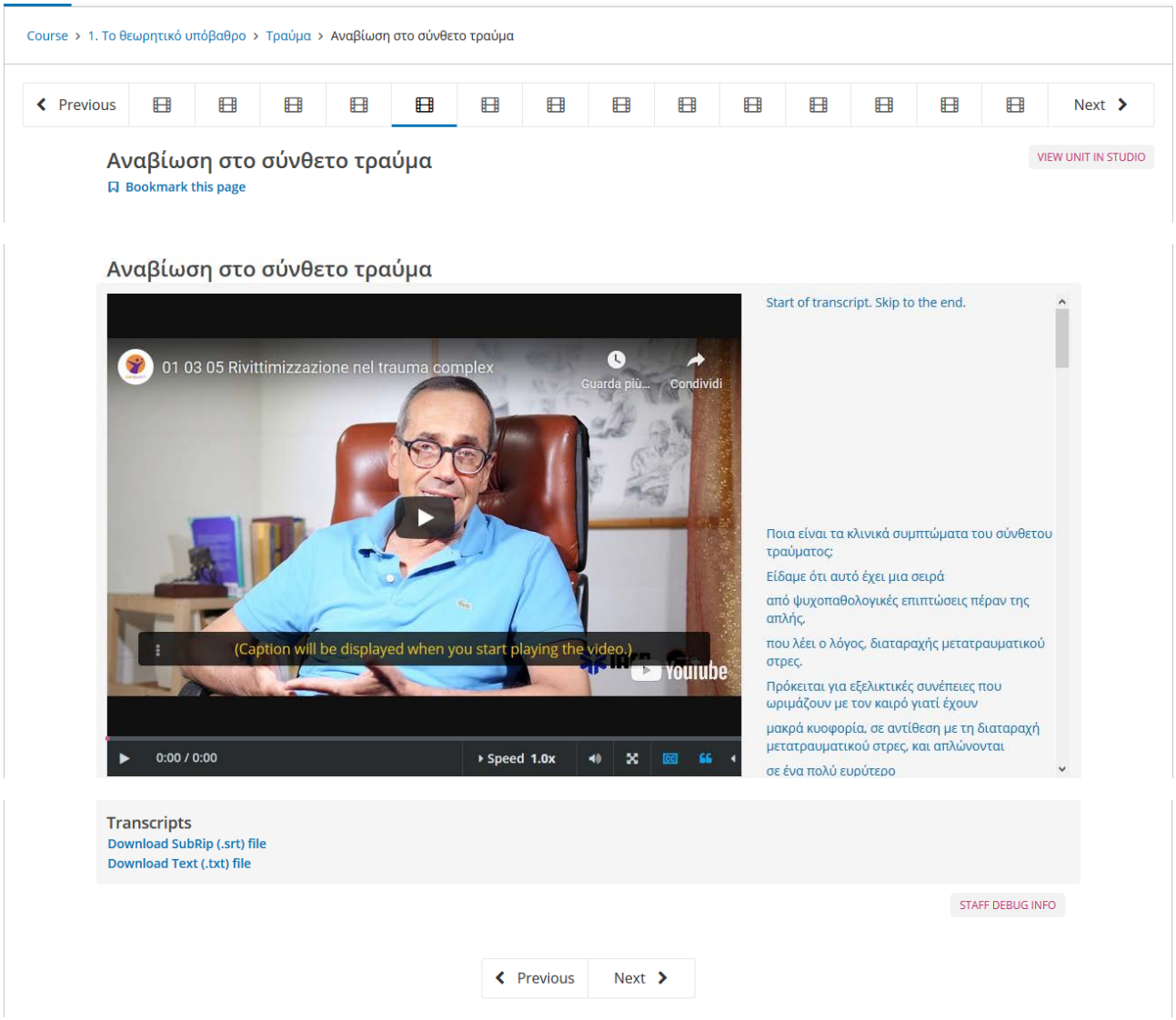
στην αποδόμηση του συναισθηματικού κλίματος

και στη δυσφορία του υποκειμένου, επαναφέροντας έτσι

το σενάριο του τραύματος του παρελθόντος.

Κι αυτό γιατί, όπως είπα, το νέο τραύμα μπορεί να προσελκύσει και να ανακαλέσει

το τραύμα του παρελθόντος, σε μια ολέθρια έλξη.



Transcript

Ποια είναι τα κλινικά συμπτώματα του σύνθετου τραύματος;

Είδαμε ότι αυτό έχει μια σειρά

από ψυχοπαθολογικές επιπτώσεις πέραν της απλής,

που λέει ο λόγος, διαταραχής μετατραυματικού στρες.

Πρόκειται για εξελικτικές συνέπειες που ωριμάζουν με τον καιρό γιατί έχουν

μακρά κυοφορία, σε αντίθεση με τη διαταραχή μετατραυματικού στρες, και απλώνονται

σε ένα πολύ ευρύτερο

φάσμα παθολογικών δυνατοτήτων,

όπως είναι οι διαταραχές

της συναισθηματικής ρύθμισης,

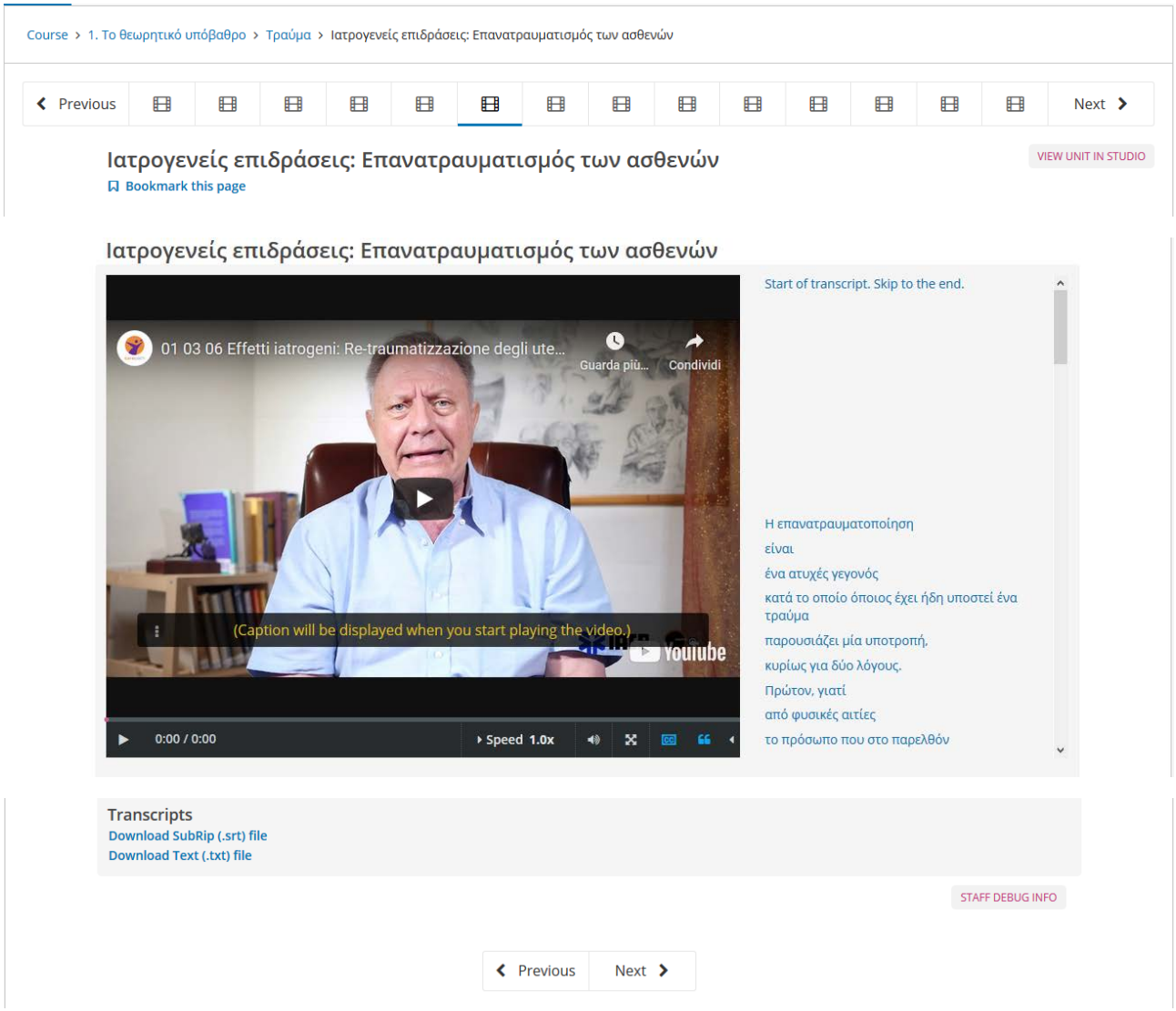
της συναισθηματικότητας

και της συμπεριφοράς.

Αυτό σημαίνει ότι συχνά αυτά τα άτομα,
που έχουν υποστεί κάποιο σύνθετο τραύμα,
αναπτύσσουν μία παρορμητικότητα που δεν οφείλεται στον χαρακτήρα τους
αλλά σε μία διαταραχή που ελέγχει τις παρορμήσεις. Αυτή μπορεί να εντοπιστεί
και να ενεργοποιηθεί
σε βίαιες συμπεριφορές προς τους άλλους ή προς τον εαυτό μας,
σε συμπεριφορές χρήσης ουσιών
με παρορμητικό τρόπο και άρα αφορά σε τοξικομανείς
και στον αλκοολισμό.
Ένας άλλος πολύ σημαντικός τομέας
αφορά τη συναισθηματική ρύθμιση υπό την έννοια
της αυτοεκτίμησης, της δυνατότητας κάποιου να εγκαθιδρύσει
μία βασική εμπιστοσύνη
στον εαυτό του
αλλά και πιθανές ενοχές, σε λανθάνουσα μορφή,
που φέρει μέσα του ήδη από τη βρεφική ηλικία. Σημειεώνουμε ότι ένα παιδί
που υφίσταται κακοποίηση, σεξουαλική, για παράδειγμα, συχνά νιώθει ένοχο
ότι διέπραξε κάτι πρόστυχο και δεν θα μπορέσει να αποδώσει σωστά την ευθύνη
για όσα συνέβησαν στον ενήλικα, ο οποίος εξακολουθεί την κακοποίηση.
Αυτές οι ενοχές μπορούν να αναπτυχθούν, να οδηγήσουν
σε μια καταθλιπτική ευάλωτη κατάσταση.
Η μεγαλύτερη κατάθλιψη μπορεί να επέλθει στην ενήλικη ζωή ως επακόλουθο
ενός σύνθετου τραύματος.
Άλλα πολύ σημαντικά επακόλουθα είναι οι ψυχοσωματικές διαταραχές.
Όντως, ένα τραύμα μπορεί να έχει συνέπειες σε σωματκό επίπεδο,
όπως είναι η σωματική αντιδραστικότητα, ακόμα και σε υπερβολικό βαθμό,
σε καρδιαγγειακό επίπεδο, όπως καρδιοπάθειες και υπέρταση,
η ρύθμιση του πόνου και των ορίων του,
όπως οι διάχυτοι πόνοι σε όλο το σώμα,
η υπερευαισθησία στα ερεθίσματα πόνου
και οι διάφορες σεξουαλικές διαταραχές
οι οποίες, από ψυχοσωματική άποψη,

συνδέονται με διαταραχές στον έλεγχο των παρορμήσεων
που οδηγούν σε ουσιαστικές διαστροφές
και άρα σε προβλήματα μη ελέγχου των σεξουαλικών παρορμήσεων.
Τέλος, σημειώνουμε τις διασχιστικές διαταραχές,
όπως η αποπροσωποποίηση και η αποπραγματοποίηση, φαινόμενα που σήμερα ταυτίζονται
με κάποια δυσκολία αλλά εκδηλώνονται με μια αίσθηση αποξένωσης
που βιώνει το υποκείμενο απέναντι στην πραγματικότητα
και απέναντι στον εαυτό του.
Αυτοί είναι μηχανισμοί άμυνας
απέναντι σε μία πραγματικότητα που για το υποκείμενο είναι ανυπόφορη
και δεν μπορεί να νιώθει ότι τη βιώνει.
Άρα διάσχιση σημαίνει τήρηση αποστάσεων από την πραγματικότητα.
Ο Φρόιντ είχε επισημάνει
αυτόν τον μηχανισμό,
θεμελιώδη για την "καταναγκαστική επανάληψη" όπου το υποκείμενο αποζητά το ίδιο τραύμα,
όχι τόσο
για να υποστεί και πάλι
τις αρνητικές επιπτώσεις του αλλά για να προσπαθήσει να το ξεπεράσει.
Αυτή η προσπάθεια να ξεπεράσει το τραύμα σημαίνει ότι μερικές συμπεριφορές
του υποκειμένου
μπορούν να οδηγήσουν στην αναβίωση καταστάσεων: κλασική η περίπτωση του παιδιού,
του θύματος ενός θύτη, που μπορεί να επανέλθει στην ενήλικη ζωή
σε ρόλους
ταυτόσημους ή και αντίστροφους.
Ο ενήλικας μπορεί να προσπαθήσει
να θυματοποιηθεί εκ νέου, δηλαδή, να δημιουργήσει καταστάσεις
που θα βιώσει και πάλι ως θύμα
των επιπτώσεων
των πράξεων
άλλων προσώπων ή να επιδοθεί σε συμπεριφορές για τις οποίες ο ίδιος
λειτουργεί ως θύτης απέναντι σε ένα θύμα.
Αυτό μπορεί να συμβεί, για παράδειγμα,

όταν ένα παιδί έχει υποστεί σεξουαλική βία και μάλιστα σε πιο προχωρημένη ηλικία,
στην εφηβεία ή στην ενήλικη ζωή.
Είναι μία κατάσταση που αναβιώνει,
για παράδειγμα, σε έναν βιασμό,
στην άσκηση σεξουαλικής βίας
σε μία γυναίκα
που μπορεί να έχει βιώσει
σε πρώτο πρόσωπο ως θύτης ή να επανέλθει ως θύμα,
δημιουργώντας μία κατάσταση
όπου, ακόμα και σε αντιτιθέμενους ρόλους, το τραύμα βιώνεται εκ νέου σε μια προσπάθεια
υπέρβασής του στη λεγόμενη "καταναγκαστική επανάληψη" του Φρόιντ.



Transcript

Η επανατραυματοποίηση

είναι

ένα ατυχές γεγονός

κατά το οποίο όποιος έχει ήδη υποστεί ένα τραύμα

παρουσιάζει μία υποτροπή,

κυρίως για δύο λόγους.

Πρώτον, γιατί

από φυσικές αιτίες

το πρόσωπο που στο παρελθόν

υπέστη ψυχικό τραύμα

εκτίθεται

σε εικόνες ή γεγονότα

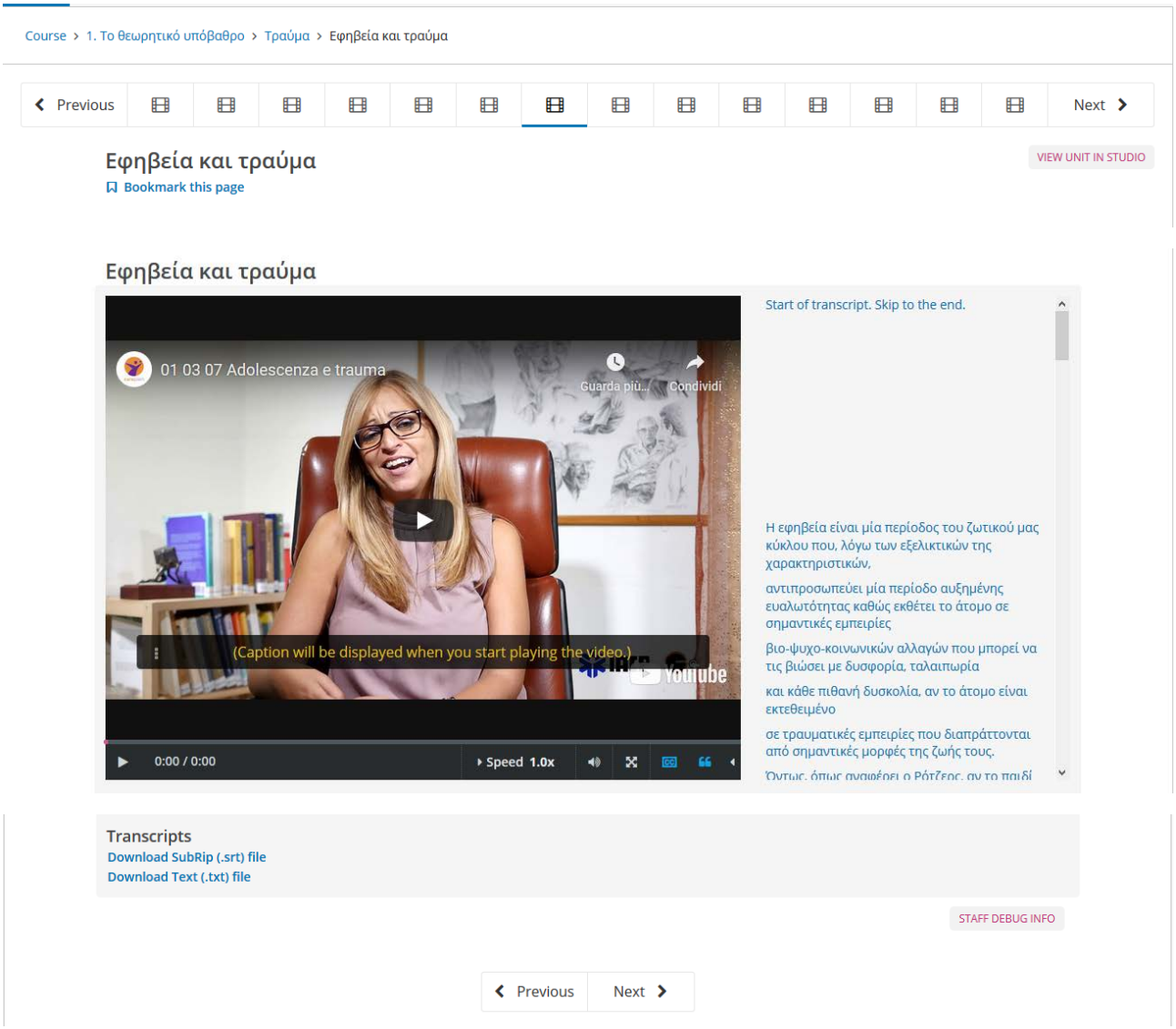
όπου άλλοι είναι θύματα τραύματος και έτσι
το υποκείμενο αναβιώνει
το τραύμα που έχει υποστεί στο παρελθόν.
Ο δεύτερος λόγος,
αντίθετα,
είναι
ένας τύπος επανατραυματοποίησης
που
έχει
ιατρογενή προέλευση,
δηλαδή,
οι θεραπείες
παρέχονται με τρόπο
μη λειτουργικό,
ίσως
όχι από κακή πρόθεση των θεραπευτών
αλλά από απλή άγνοια
του γεγονότος ότι το πρόσωπο που έχει υποστεί τραύμα,
αντί να βοηθηθεί
από την φροντίδα και τις παρεχόμενες θεραπείες,
τελικά
υφίσταται
ακόμα μεγαλύτερο τραύμα.
Με δυο λόγια,
συμβαίνει
όπως όταν
ένα πρόσωπο
προσέρχεται
στα Επείγοντα Περιστατικά
με ένα σπασμένο πόδι
και οι γιατροί δεν κάνουν σωστή διαχείριση
με αποτέλεσμα ο ασθενής να πέσει

από το φορείο και να σπάσει και τα δύο πόδια, διπλασιάζοντας το πρόβλημα,
αληθινή τραγωδία, δηλαδή.
Η ιστορία και η κοινωνιολογία
των θεραπειών
του τραύματος
αποκαλύπτουν ότι, δυστυχώς,
ήταν πολύ σύνηθες στο παρελθόν,
προφανώς από κακή πρόθεση αλλά και άγνοια,
να προκαλούνται
τέτοιου είδους βλάβες,
με ιατρογενή αποτελέσματα.
Οι θεραπείες σε όλο το φάσμα τους,
επειδή αφορούν το σύνθετο και ευαίσθητο σύστημα ενός ανθρώπου,
υπάρχει κίνδυνος να έχουν αποτελέσματα όχι μόνο θετικά αλλά και, ακούσια,
να επιφέρουν περαιτέρω βλάβη. Αυτό ισχύει στα φάρμακα, στις χειρουργικές επεμβάσεις
και σε κάθε τύπο σχέσης βοήθειας,
οι οποίες, αν δεν παρασχεθούν με αποτελεσματικό τρόπο,
γίνονται
αντιπαραγωγικές.
Σε ό,τι αφορά το τραύμα, αυτό είναι πολύ σοβαρό γιατί όποιος έχει δεχθεί τραύμα
είναι ιδιαίτερα
ευαίσθητος
και μπορεί να υποστεί σημαντική βλάβη με μία δεύτερη τραυματοποίηση.
Για αυτό κι εμείς σήμερα
έχουμε μάθει από τα λάθη μας, οι έρευνες έχουν αυξηθεί κατά πολύ
και διαθέτουμε
μία ευρεία γνώση
η οποία φυσικά θα επαυξάνεται στο μέλλον
ώστε να μη διακινδυνεύουμε την επανατραυματοποίηση
όσων έχουν ήδη υποστεί τραύμα.
Αυτές οι προφυλάξεις είναι συγκεκριμένες διαδικασίες
το λεγόμενο "trauma inform",

που επικεντρώνονται στο πρόσωπο του υποκειμένου

που έχει υποστεί τραύμα

και φροντίζουν να μην προκαλέσουν άλλες βλάβες.



Transcript

Η εφηβεία είναι μία περίοδος του ζωτικού μας κύκλου που, λόγω των εξελικτικών της χαρακτηριστικών,
αντιπροσωπεύει μία περίοδο αυξημένης ευαλωτότητας καθώς εκθέτει το άτομο σε σημαντικές εμπειρίες
βιο-ψυχο-κοινωνικών αλλαγών που μπορεί να τις βιώσει με δυσφορία, ταλαιπωρία
και κάθε πιθανή δυσκολία, αν το άτομο είναι εκτεθειμένο
σε τραυματικές εμπειρίες που διαπράττονται από σημαντικές μορφές της ζωής τους.
Όντως, όπως αναφέρει ο Ρότζερς, αν το παιδί μεγαλώσει σε ευνοϊκό περιβάλλον,
θα μπορέσει να μην αναπαράξει, να μην καταπνίξει όσα νοιώθει
και να μην παγώσει τις δραματικές εμπειρίες αλλά να κινηθεί στην πραγματικότητα ικανοποιώντας
τις ανάγκες του και αξιολογώντας τις εμπειρίες ως ευχάριστες ή δυσάρεστες
αναλόγως αν είναι ευνοϊκές ή όχι για την ανάπτυξή του, με εγγενή τη λεγόμενη, κατά Ρότζερς,
τάση επικαιροποίησης, που είναι η ικανότητα αυτοκατανόησης, αυτορρύθμισης και αυτοπραγμάτωσης.
Αντίθετα, αν το παιδί ζει σε ένα περιβάλλον όπου νιώθει ότι η εκτίμηση του αδύναμου

εξαρτάται αποκλειστικά από το πόσο μπορεί να ανταποκριθεί στις απαιτήσεις,
αυτό ίσως το οδηγήσει να "ακρωτηριάσει" αναγκαστικά ένα μέρος του εαυτού του
και να αντιμετωπίσει
την πραγματικότητα οικοδομώντας άκαμπτα κατασκευάσματα,
τα οποία γίνονται ακόμα πιο άκαμπτα
αν οικοδομηθούν με μια συνεχή αίσθηση ασάφειας, απειλών και φόβου, αν το παιδί
μεγαλώνει σε περιβάλλον με εντάσεις.
Σε αυτόν τον βαθύ πυρήνα αποξένωσης μεταξύ της αντίληψης, της βίωσης, του συμβολισμού
και της δράσης δημιουργείται και ενισχύεται η αίσθηση αποξένωσης από τον εαυτό του
στην οποία βασίζεται η αιτιοπαθογένεια.
Άρα βλέπουμε ότι ο έφηβός μας, που μεγάλωσε και ανατράφηκε στο δικό του πλαίσιο σχέσεων,
εκτίθεται στις εξελικτικές αλλαγές στις οποίες αναφερθήκαμε παραπάνω
και όλες αυτές οι καθοριστικές αλλαγές απαιτούν έναν εσωτερικό επανεκσυγχρονισμό,
έναν επανασυγχρονισμό που αφορά το ίδιο το άτομο και τις πιο σημαντικές σχέσεις του
και προϋποθέτει το υποκείμενο να ανακτήσει μία ισορροπία εξίσου ευέλικτη και δυναμική
απέναντι στις εμπειρίες που βιώνει, αλλά και συνεπή στην αίσθηση ταυτότητας που έχει διαμορφώσει
ως εκείνη τη στιγμή. Όλ αυτά απαιτούν έναν επαναπροσδιορισμό της έννοιας
του εαυτού του.
Ας δούμε ποιες είναι αυτές οι αλλαγές που αντιμετωπίζει ο έφηβος.
Η πρώτη από όλες αφορά σαφώς το σώμα: το σώμα του εφήβου είναι
ένα σώμα σε εξέλιξη, με αύξηση βάρους, εμφάνιση δευτερευόντων σεξουαλικών οργάνων
και οργάνων αναπαραγωγής και άρα είναι ένα σώμα που απαιτεί ένα νέο είδος σχέσης με αυτό,
ένα σώμα που ο έφηβος χρησιμοποιεί ως πρωτογενές και ενδιάμεσο όχημα
για να δηλώσει προς τα έξω τα βιώματά του.
Ένα σώμα, λοιπόν, που επιλέγει να το φροντίσει, να το εξωραΐσει,
αλλά και να το γρατζουνίσει, να το χαράξει,
να το ξεχάσει, που επιλέγει να μιλήσει για τον εαυτό του μέσα από αυτό.
Ταυτόχρονα είναι ένα σώμα ορατό στους γύρω του, που αιχμαλωτίζει το βλέμμα των άλλων,
με επιθυμία ή χλευασμό, και εκθέτει τον έφηβο σε νέες εμπειρίες,
νέες ευκαιρίες αλλά και νέους κινδύνους.
Υπάρχουν, επίσης, αλλαγές σε διαπροσωπικό επίπεδο.
Στην οικογένεια τού ζητείται να περάσει από την εξάρτηση, τη φάση φροντίδας και προσκόλλησης,

στην αυτονομία και την αναζήτηση ισορροπίας μεταξύ αυτών των δύο φαινομενικά αντίθετων εξελικτικών ωθήσεων που έχουν αντίκτυπο σε κοινωνικό επίπεδο. Στο εξωτερικό περιβάλλον αλλάζει ο ρόλος του νεαρού στην ομάδα των ομοίων του με άλλες σημαντικές μορφές. Επιπλέον, σημειώνονται αλλαγές σε εγκεφαλικό επίπεδο, όπως έχουν αποδείξει όλες οι πρόσφατες έρευνες.

Ο εγκέφαλος μεταβάλλεται σε επίπεδο δομικό και λειτουργικό κυρίως στις περιοχές του φλοιού που αφορούν τις διαδικασίες λήψης αποφάσεων. Όλα αυτά προκαλούν μία έντονα ευάλωτη κατάσταση που, όπως είπαμε, γίνεται ακόμα εντονότερη, αν το υποκείμενο βιώνει τραυματικές εμπειρίες που υπονομεύουν ή βλάπτουν την εσωτερική αίσθηση ασφάλειας, τη σίγουρη βάση, κατά Μπόουλμπι, όπου κατοικεί η συναισθηματική μας ασφάλεια και νιώθουμε, ορίζουμε, ικανοποιούμε τις ανάγκες μας. Εκεί δεν μπορούμε πάντα να επιστρέφουμε αλλά μπορούμε να βιώσουμε την πολύτιμη εμπειρία της αυξανόμενης αυτονομίας χωρίς να χάσουμε την αγάπη. Αντίθετα, γινόμαστε πλουσιότεροι γνωρίζοντας τους άλλους ανθρώπους.

Από την άλλη, όποιος έχει υποστεί τραύμα, έχει μειωμένη ικανότητα νοητικοποίησης και αυτορρύθμισης των συναισθηματικών καταστάσεων και δεν μπορεί, όπως λέει ο Μπρόμπεργκ, παρά να απομονώσει την τραυματική εμπειρία, όλα τα σχετικά με αυτή βιώματα και περιεχόμενα μέσω της διάσχισης. Η παθολογική διάσχιση, όπως αναφέρει ο Καρέτι, οδηγεί σε μαρασμό του υποκειμένου και των μέσων του γιατί δεν του επιτρέπει να ανασκευάσει τις τραυματικές εμπειρίες σε μια αφήγηση συνεκτική με την ιστορία της δικής του ζωής.

Για αυτό ακριβώς,
αν δουλεύουμε πάνω στην επαφή με τους εφήβους με συναισθηματικό στρες,
μπορούμε να εργαστούμε μαζί τους σε σημαντικό σχεσιακό βάθος,
προσφέροντάς τους σχέσεις με βάθος, βασισμένες στην ακρόαση,
στην ακρόαση με ενσυναίσθηση, στον βαθύ σεβασμό για αυτό που είναι οι έφηβοι, προσεγγίζοντας τις εμπειρίες με τη ματιά τους και προσπαθώντας να συλλάβουμε τις έννοιες που έχουν δώσει οι ίδιοι σε όσα βιώνουν και να τους προσφέρουμε πλαίσια σχέσεων όπου ο νεαρός θα μπορεί, σταδιακά, να επανασυνδεθεί με εκείνα τα κομμάτια του, με τις ανάγκες που αρνούνταν ως τώρα ώστε να τις ξανανιώσει και να επανασυντονιστεί με κάποια κομμάτια του,
με τις εξωτερικές εμπειρίες που βιώνει ως τώρα ως υπερβολικά παράφωνες.

Κάτι τέτοιο είναι δυνατό, αν τους προσφέρουμε πλαίσια σχέσεων στα οποία τους βλέπουμε

με βλέμμα διαφορετικό που δεν τους κολλά την ετικέτα

του νέου σε διαρκή επανάσταση και πάλη με τον εξωτερικό κόσμο ή της απαθούς μορφής

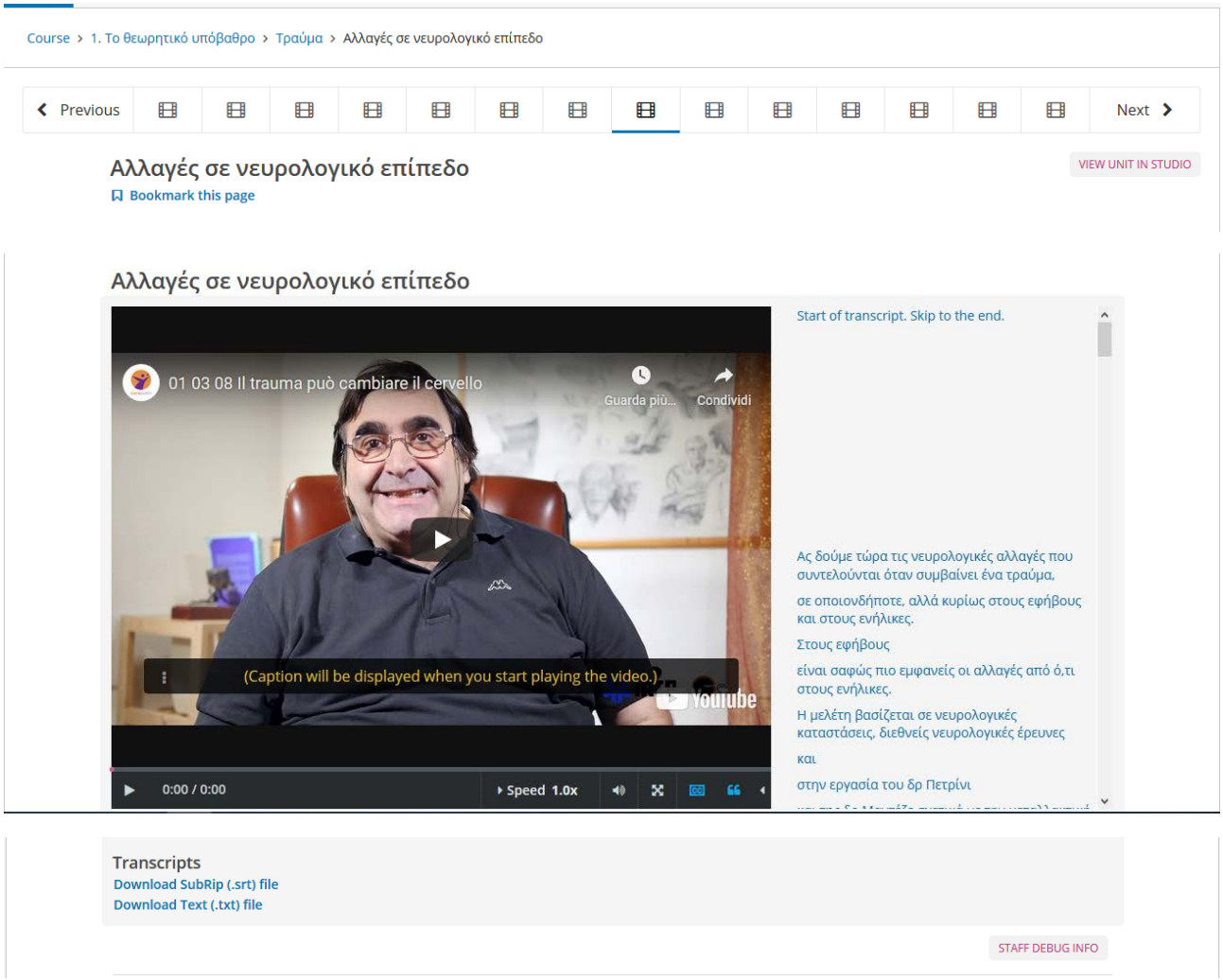
που αφυπνίζεται μόνο από τα κοινωνικά δίκτυα, αλλά τους βλέπουμε ως νέους με χαρακτηριστικά

και εργαλεία ανάλογα των εξελικτικών τους φάσεων, οι οποίοι κινούνται στον κόσμο με περιέργεια,

θέτουν ερωτήματα, παίρνουν απαντήσεις, εξερευνούν, προσπαθούν να υποκειμενοποιήσουν τις εμπειρίες τους,

ώστε στη συνέχεια να σταθούμε κι εμείς ως ενήλικες σε όλη την υπόλοιπη ζωή μας

και να τους προσεγγίζουμε πάντα με ένα βλέμμα που να τους υποστηρίζει.



Transcript

Ας δούμε τώρα τις νευρολογικές αλλαγές που συντελούνται όταν συμβαίνει ένα τραύμα,

σε οποιονδήποτε, αλλά κυρίως στους εφήβους και στους ενήλικες.

Στους εφήβους

είναι σαφώς πιο εμφανείς οι αλλαγές από ό,τι στους ενήλικες.

Η μελέτη βασίζεται σε νευρολογικές καταστάσεις, διεθνείς νευρολογικές έρευνες

και

στην εργασία του δρ Πετρίνι

και της δρ Μαντέζε σχετικά με την μεταλλακτική ψυχαναλυτική τεχνική-διαδικασία:

μία τεχνική

εν μέρει ψυχαναλυτική και εν μέρει νευρολογική

σε απόλυτη συμφωνία

με τις διεθνείς

νευρολογικές έρευνες και τη σχέση μεταξύ νευρολογίας και ψυχανάλυσης.

Είναι γνωστό ότι κάθε άτομο σε μία κατάσταση ευημερίας

αναπτύσσει καθημερινά 1.400 νέους νευρώνες

από τα βλαστοκύτταρα

σε επίπεδο ιππόκαμπου

αλλά και σε οσφρητικό επίπεδο.

Αυτό είναι πολύ σημαντικό γιατί ο ιππόκαμπος είναι το κεντρικό τμήμα της μνήμης

στον οργανισμό μας

που ανακαλείται σε παρόμοιες καταστάσεις, δηλαδή, σε καταστάσεις τραύματος,

ενώ σε οσφρητικό επίπεδο

παρατηρούμε

ότι οι λοβοί του εγκεφάλου μας

δεν είναι

παρά μία αναστροφή του οσφρητικού μας λοβού.

Τα ζώα λειτουργούν με την όσφρηση

κι εμείς λειτουργούμε με τη σκέψη.

Άρα η σκέψη, στον άνθρωπο,

δεν είναι άλλο από την όσφρηση

που έχει διευρυνθεί και αναπτυχθεί

σε αυτά τα εγκεφαλικά κύτταρα.

Σκεφτείτε ότι ο άνθρωπος έχει περίπου 30.000 γονίδια, ελάχιστα για να ορίσουν όλες τις καταστάσεις,

άρα υπεισέρχονται και καταστάσεις οικογενειακές, συναισθηματικές, σχεσιακές, πολιτιστικές και θρησκευτικές.

Πιθανότατα μόλις το 70% των γονιδίων είναι γενετικά προκαθορισμένο

και μόλις το 30% είναι διαχειρίσιμο από τους εξωτερικούς παράγοντες.

Η διαφορά των γονιδίων

μεταξύ ενός στενόμυαλου ανθρώπου κι ενός αρσενικού μπονόμπο είναι ένα 5%.

Ωστόσο,

αν και αυτό το ποσοστό είναι αποκαλυπτικό, η εξίσωση ανθρώπου και μπονόμπο

δεν συγκρίνεται, από κάθε άποψη, σε επίπεδο συναισθημάτων και εργασίας.

Ο πολιτισμός, η θρησκεία, όλες οι εξωτερικές καταστάσεις, η οικογένεια, η κοινότητα

όπου ζούμε είναι πολύ σημαντικά για τη διαμόρφωση του ατόμου.

Τι συμβαίνει

όταν παρουσιάζεται το άγχος;

Μία κατάσταση άγχους ή παραμέλησης (η παραμέληση είναι εξίσου αγχωτική)

σταματά τη δραστηριότητα των βλαστοκυττάρων στο επίπεδο του ιππόκαμπου

και είναι αδύνατη η αντικατάσταση νευρώνων οι οποίοι, υπό κανονικές συνθήκες, χάνονται.

Συνεπώς,

υπάρχει μία απώλεια νευρώνων

στο πιο σημαντικό και βαθύ σημείο του εγκεφάλου που είναι ο ιππόκαμπος.

Η συναισθηματική και διανοητική ρύθμιση που συνοδεύει και υποστηρίζει

αυτές τις εγκεφαλικές αλλαγές

χαρακτηρίζεται

από άγχη και καταθλίψεις

που συνδέονται

με την αμυγδαλή:

ένα μικροσκοπικό σωματίδιο στο εσωτερικό του εγκεφάλου

που υποστηρίζει όλες τις συναισθηματικές και συγκινησιακές καταστάσεις μας,

από την αγάπη ως τη σεξουαλικότητα, την κατανάλωση τροφής

και όλα όσα είναι σημαντικά από συναισθηματική άποψη.

Συντελείται μία μεταβολή των προμετωπιαίων φλοιών, που κατευθύνουν τους στόχους μας.

Αν αποφασίσω να πάω στο θέατρο για να δω έναν ηθοποιό, ο προμετωπιαίος φλοιός

με ωθεί προς αυτή την πράξη και ο μετωπιαίος την πραγματοποιεί αλλά ο προμετωπιαίος φλοιός

αφορά και τις παρορμήσεις. Όταν έχω την παρόρμηση να φύγω ή να παραμείνω

σε έναν τόπο, αυτό το οφείλω στον προμετωπιαίο φλοιό, ενώ ο μετωπιαίος αντιδρά και επικοινωνεί

την ανάγκη μου να παραμείνω, για παράδειγμα, λόγω μιας υποχρέωσης.

Το τρίτο σημείο που βλάπτεται είναι, φυσικά,

ο ιππόκαμπος στη μνήμη. Όπως είπαμε,

η έδρα της μνήμης είναι ο ιππόκαμπος.

Διαμήκεις μελέτες

έχουν αποδείξει ότι τα τραύματα δεν εκφράζονται μέσω μιας διαταραχής τύπου DSM 5 ή ICD 10

που ονομάζεται διαταραχή μετατραυματικού στρες,

αλλά ενίοτε,

μέσω των συμπτωμάτων του άγχους και της κατάθλιψης,

μεταδίδονται καταστάσεις παραίσθησης και αυτό εκδηλώνεται μέσω μεταβολών

στην έννοια του εαυτού μας στο πλαίσιο των διαπροσωπικών σχέσεων.

Ένας άνθρωπος που έχει υποστεί τραύμα

έχει περιορισμούς στη συμπεριφορά αλλά και ψυχικούς περιορισμούς,

δηλαδή, το πρόσωπο μοιάζει μη ικανό

να εκφραστεί

στο εργασιακό περιβάλλον,

στις σχέσεις στοργής,

στις σχέσεις γενικά, στις δραστηριότητες.

Σαν να έχει υποβιβαστεί σε ένα χαμηλότερο

επίπεδο λειτουργίας.

Αυτό οφείλεται στο σύστημα του ιππόκαμπου, της υπόφυσης και του φλοιού των επινεφριδίων (σύστημα HPA).

Στον εγκέφαλο υπάρχει ένας αδένας που ονομάζεται

υπόφυση

από όπου ξεκινούν

όλες οι ορμόνες του οργανισμού μας.

Η σύνδεση του ενδοκρινολογικού-ορμονικού μέρους

με το νευρικό μέρος

υπαγορεύεται

από τον άξονα υποθαλάμου-υπόφυση.

Όλα όσα

φθάνουν στον υποθάλαμο, μία περιοχή θεμελιώδους σημασίας, σχεδόν ένας εγκέφαλος

μικρότερος σε σύγκριση με τον εγκεφαλικό φλοιό,

μεταδίδονται στην υπόφυση και οδηγούν

σε ορισμένες αισθήσεις, δηλαδή, το νευρικό σήμα μεταδίδεται μέσω ορμονικών ουσιών.

Αυτές οι ορμονικές ουσίες

διακλαδώνονται σε όλο τον οργανισμό,

από την υπόφυση,

και ελέγχουν

τον θυρεοειδή,

τη σεξουαλικότητα μέσω των γεννητικών αδένων, την ανδρική και γυναικεία σεξουαλικότητα

με την ανδρική ορμόνη, που καθορίζει και τη γυναικεία σεξουαλικότητα,

κι έπειτα, ιδίως,

την έκλυση της κορτικοτροπίνης: της ορμόνης, ή μάλλον της προορεμόνης του άγχους,

καθώς η κατεξοχήν ορμόνη του άγχους είναι η ACTH, η κορτιζόλη,

για αυτό η χορήγηση κορτιζόνης βοηθά τον οργανισμό να αντιδράσει σε περίπτωση σωματικών δυσλειτουργιών.

Όντως, η κορτιζόλη έχει τα ίδια στοιχεία με την κορτίνη.

Επίσης, σε περίπτωση μάχης ή πολέμου, ο ανθρώπινος οργανισμός είναι προετοιμασμένος.

Η κορτιζόλη (ACTH, για την ακρίβεια) αποτρέπει την αίσθηση του πόνου,

οδηγεί σε μηχανισμούς επιθετικότητας, όπως συμβαίνει και στα ζώα,

και αυτή η κατάσταση είναι σαφώς μια κατάσταση επιθετικότητας.

Όταν αυτός ο μηχανισμός δραστηριότητας

επαναλαμβάνεται,

γίνεται χρόνιος και προκύπτουν καταστάσεις άγχους και οδύνης,

παρατεταμένες,

οι οποίες εξαρτώνται από την αμυγδαλή που αναφέραμε παραπάνω.

Η αμυγδαλή

είναι το "κομό"

της συναισθηματικής μας μνήμης, υπό την έννοια ότι εκεί φυλλάσσονται

όλες οι συναισθηματικές αναμνήσεις, μια φωτογραφική μηχανή της συναισθηματικής πραγματικότητας.

Άρα, για παράδειγμα, το πρώτο φιλί, η πρώτη δουλειά, η πρώτη αίσθηση ευεξίας,

η πρώτη νίκη σε ένα άθλημα, είναι όλα φωτογραφημένα στην αμυγδαλή και ανασύρονται από εκεί

όταν προκύπτουν ανάλογες καταστάσεις. Τη στιγμή που ο ιππόκαμπος

αρχίζει

να απελευθερώνει κορτιζόλη,

αυτή συνδέεται με τους υποδοχείς του ιππόκαμπου, της αμυγδαλής και της προμετωπιαίας περιοχής

και, όταν φτάσει σε ικανοποιητικό επίπεδο, αν η κατάσταση δεν είναι χρόνια,

μειώνει το επίπεδο ACTH και κορτικοτροπίνης (CRF).

Με αυτό τον τρόπο ο ιππόκαμπος ρυθμίζει την ανταπόκρισή μας

στο άγχος.

Όταν, αντίθετα,

είμαστε καλά, επικρατεί η σεροτονίνη. Η σεροτονίνη είναι η ορμόνη της ευτυχίας.

Όντως ισχύει πως, όταν ένα υποκείμενο τελεί υπό κατάθλιψη,

συνταγογραφούνται σεροτονινεργικά φάρμακα.

Η σεροτονίνη

αναστέλλει τις επιθετικές συμπεριφορές και προάγει την κοινωνικοποίηση.

Παράγεται από τη θρυπτοφάνη και εισάγεται στη διατροφή.

Η σεροτονίνη, μαζί με την ωκυτοκίνη, που είναι η ορμόνη του δεσμού, είναι για τον οργανισμό

η πιο θετική και η πιο χρήσιμη ορμόνη,υπό την έννοια ότι, ενώ η σεροτονίνη διεγείρει την κοινωνικότητα

και τις σχέσεις με τους άλλους,

η ωκυτοκίνη, που εκλύεται μετά από 5 δευτερόλεπτα αγκαλιάς με κάποιον άλλο,

είναι η ορμόνη

που διεγείρει τον δεσμό.

Οι έρευνες αποκαλύπτουν ότι οι αγαπημένες δραστηριότητες,

οι σημαντικές σκέψεις και συναισθήματα έχουν

βαθιά θεραπευτική επίδραση στο σώμα μας.

Συνεπώς,

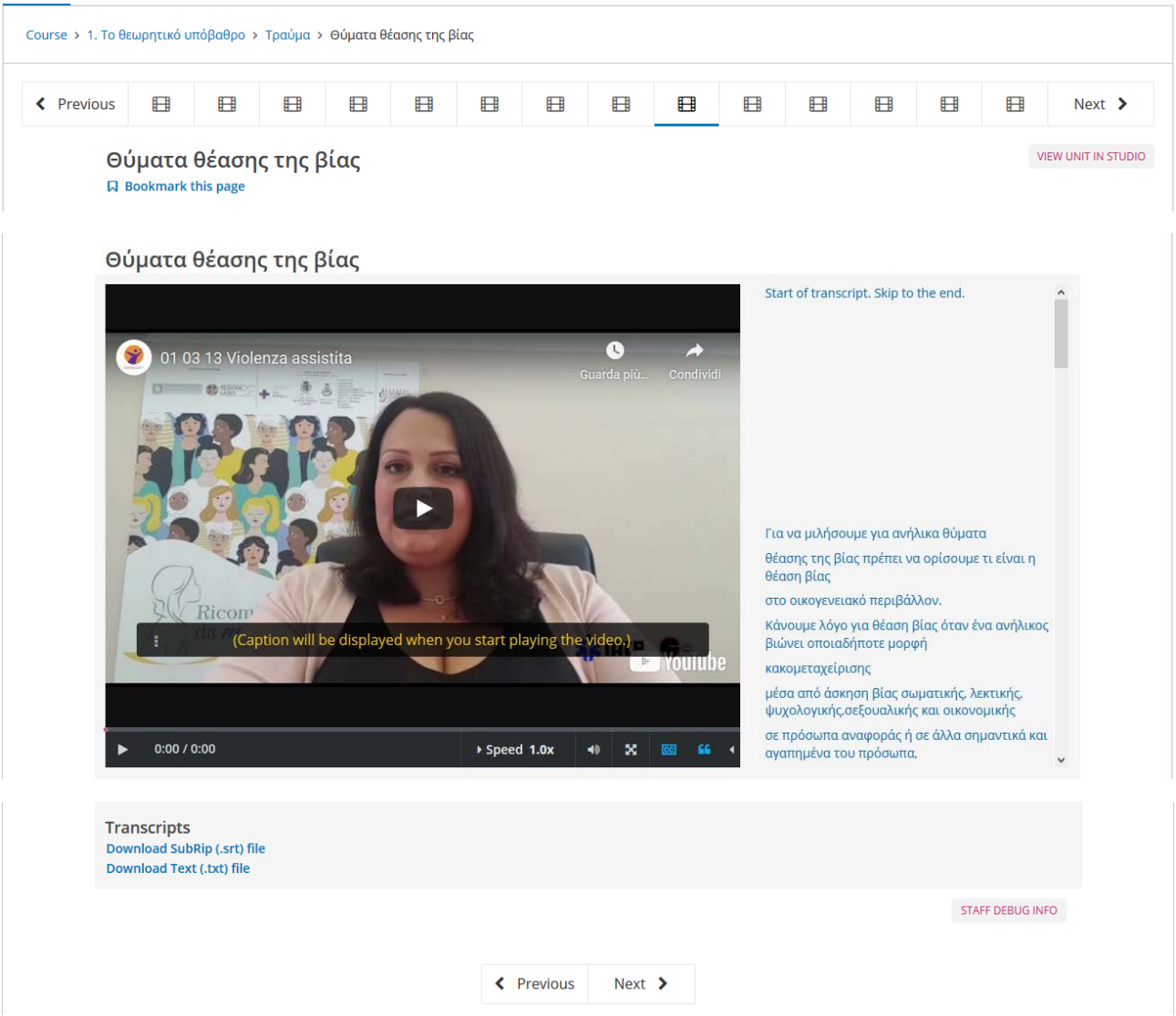
αναμφίβολα υπάρχει,

στον τρόπο ύπαρξής μας,

μια σειρά αντιδράσεων που μεταβάλλουν τον εγκέφαλο και μας ωθούν

στη μεταβολή του σώματος. Σε κάθε περίπτωση υπάρχουν ορμόνες συνδεδεμένες με τις νευροορμόνες

και τα νευρικά ερεθίσματα.



Transcript

Για να μιλήσουμε για ανήλικα θύματα

θέασης της βίας πρέπει να ορίσουμε τι είναι η θέαση βίας

στο οικογενειακό περιβάλλον.

Κάνουμε λόγο για θέαση βίας όταν ένα ανήλικος βιώνει οποιαδήποτε μορφή

κακομεταχείρισης

μέσα από άσκηση βίας σωματικής, λεκτικής, ψυχολογικής,σεξουαλικής και οικονομικής

σε πρόσωπα αναφοράς ή σε άλλα σημαντικά και αγαπημένα του πρόσωπα,

ενήλικες ή ανηλίκους.

Σε αυτό τον τύπο βίας περιλαμβάνονται και όσες ασκούνται από ανήλικο σε άλλους ανηλίκους,

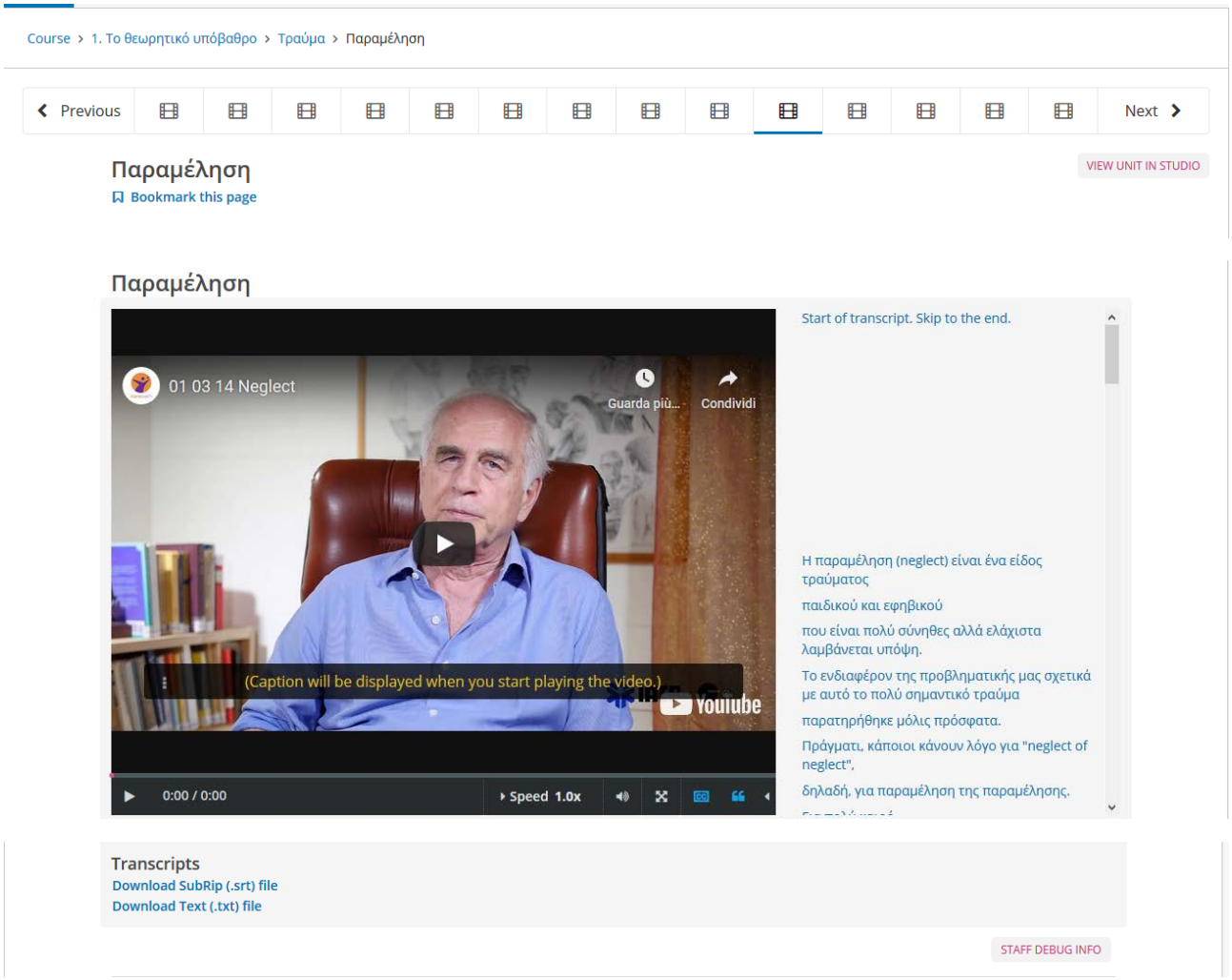
αλλά και σε άλλα μέλη της οικογένειας, όπως άσκηση βίας σε κατοικίδια ζώα.

Πρόκειται για πολύ τραυματικές εμπειρίες για τους ανηλίκους.

Τα χαρακτηριστικά αυτών των εμπειριών ποικίλουν.

Η βία μπορεί να είναι έμμεση: γίνεται αντιληπτή στο εσωτερικό του αντιληπτικού μας πεδίου
και άρα δεν βλέπουμε μόνο τη βία αλλά και την ακούμε.
Πρέπει να το υπογραμμίσουμε αυτό γιατί πολλά θύματα βίας αναφέρουν ότι τα παιδιά,
στη χειροδικία, βρίσκονταν σε άλλο δωμάτιο. Ουσιαστικά και σε αυτές τις περιπτώσεις
πρόκειται για μία μορφή άμεσης βίας σε περίπτωση που το παιδί έχει ακουστική επαφή.
Η εμπειρία μπορεί να είναι έμμεση
όταν ο ανήλικος γνωρίζει ότι η βία συντελείται
ή ότι πρόκειται να συντελεστεί. Είναι σαν να έχουν τα παιδιά κεραίες.
Καταλαβαίνουν πότε υπάρχει μία ένταση στο σπίτι
η οποία προηγείται του επεισοδίου βίας.
Η εμπειρία μπορεί ενίοτε να μην γίνεται αντιληπτή άμεσα ή έμμεσα,
αλλά ο ανήλικος μπορεί να αντιληφθεί τις συνέπειές της.
Για παράδειγμα, βλέπει τη μητέρα με μώλωπες
ή νιώθει τη βία να πλανιέται στο σπίτι. Αυτές είναι περιπτώσεις θέασης βίας.
Υπάρχουν κάποιοι μύθοι σχετικά με τη θέαση βίας.
Το παιδί δεν είναι αδιαπέραστο
από τη βία που ασκείται στο οικογενειακό του περιβάλλον.
Ακόμα κι αν η βία δεν ασκείται ενώπιόν του, μπορεί να το νιώσει ότι διαπράττεται
γιατί το μικρό παιδί δεν είναι ποτέ παθητικός και μη συνειδητός θεατής.
Η θέαση βίας αυξάνει τον κίνδυνο άμεσης άσκησης βίας σε ανηλίκους.
Ο ανήλικος που προσπαθεί να προστατέψει τη μητέρα και παρεμβάλλεται ανάμεσα στους γονείς,
μπορεί να χτυπηθεί από τον πατέρα. Σε αυτή την περίπτωση
η δρ Ανίμπαλι κάνει επίσης λόγο για θέαση βίας
καθώς στις περισσότερες περιπτώσεις η βία ασκείται
από τον άντρα προς τη γυναίκα.
Δεν αποκλείεται η βία να ασκηθεί
από τη μητέρα εναντίον του πατέρα ή γενικά από γυναίκα προς άντρα,
αλλά στατιστικά είναι πολύ λιγότερες αυτές οι περιπτώσεις.
Τα μικρά παιδιά που εκτίθενται στη βία διατρέχουν 5 φορές μεγαλύτερο κίνδυνο
από ό,τι τα παιδιά που δεν είναι μάρτυρες βίας, να γίνουν βίαιοι ως ενήλικες.
Οι επιπτώσεις της θέασης βίας είναι οι εξής.
Ένα αίσθημα φόβου, άγχους, φθοράς, θλίψης,

ουσιαστική κατάθλιψη, αίσθηση οργής, ενοχής, ανεπάρκειας και ντροπής.
Τα μικρά παιδιά χάνουν την εμπιστοσύνη στον εαυτό τους και στους άλλους,
μπορεί να εκδηλώσουν διαταραχές ψυχοσωματικές,
διαταραχές ελέγχου των παρορμήσεων, δυσκολίες στο σχολείο, διαταραχές στη μάθηση,
στο λεξιλόγιο,
στον έλεγχο των σφιγκτήρων, δυσκολίες στις σχέσεις και μπορεί να αναπτύξουν
πλήρη διαταραχή μετατραυματικού στρες γιατί αυτή η τραυματική εμπειρία αναπτύχθηκε
στο πλαίσιο μιας σχέσης εμπιστοσύνης, όπως είναι αυτή της οικογένειας.
Σε βιοψυχοκοινωνικό επίπεδο
οι επιτώσεις της θέασης βίας αντανακλώνται στη συμπεριφορά,
στα συναισθήματα, στη γνωστική λειτουργία, σε σωματικό επίπεδο αλλά και στις σχέσεις του παιδιού.
Το παιδί ζει σε έναν κόσμο σε πλήρη αναβρασμό,
η βία γίνεται κανονικότητα
και κατά συνέπεια το "φυσιολογικό" είναι η βία.
Κι αυτό είναι μέρος της κανονικότητας του παιδιού,
να αναγνωρίζει ως κανονική και φυσιολογική μια βίαιη συμπεριφορά
υποβαθμίζοντας έτσι τη δραματική του εμπειρία και, πιθανώς, αναπαράγοντας
αυτές τις συμπεριφορές.
Πρέπει να εστιάζουμε όλο και περισσότερο στη θέαση της βίας και στις επιπτώσεις της
στους ανηλίκους και στους ενήλικες που πρόκειται αυτοί να γίνουν.



Transcript

Η παραμέληση (neglect) είναι ένα είδος τραύματος

παιδικού και εφηβικού

που είναι πολύ σύνηθες αλλά ελάχιστα λαμβάνεται υπόψη.

Το ενδιαφέρον της προβληματικής μας σχετικά με αυτό το πολύ σημαντικό τραύμα

παρατηρήθηκε μόλις πρόσφατα.

Πράγματι, κάποιοι κάνουν λόγο για "neglect of neglect",

δηλαδή, για παραμέληση της παραμέλησης.

Για πολύ καιρό

αυτή η κατηγορία δεν θεωρούνταν ως καθαυτό τραύμα,

αλλά στην καλύτερη των περιπτώσεων ως μικρό μέρος των γνωστών τραυμάτων.

Στην πραγματικότητα, σήμερα θεωρούμε ότι είναι το πιο διαδεδομένο, το πιο σύνηθες τραύμα

με τις χειρότερες συνέπειες σε ό,τι αφορά τη διάρκεια μες στον χρόνο.

Από αυτή την άποψη, η παραμέληση δηλώνει την υιοθέτηση συμπεριφορών παράλειψης

από όσους θα έπρεπε να παρέχουν φροντίδα
και ναι μεν σε αυτές τις παραλείψεις δεν υπάρχει
κίνδυνος σοβαρής βλάβης αλλά υπάρχει μια σειρά παραλείψεων
που παρατείνονται για μία μακρά χρονική περίοδο.
Πρόκειται για παραλείψεις που μπορούν να συνοδεύουν ένα τραύμα τύπου 1.
Μία κακοποίηση
θα μπορούσε να γίνει διαχειρίσιμη,
τουλάχιστον με έναν κατάλληλο τρόπο,
αλλά
αυτό δεν συμβαίνει, αν το παιδί δεν έχει στο πλάι του έναν γονέα ικανό
να καταλάβει
και να βοηθήσει, να υποστηρίξει, να προστατέψει
το παιδί που υπέστη αυτόν τον τύπο τραύματος.
Η παραμέληση μπορεί να είναι συμπληρωματική του τραύματος τύπου 1,
αλλά και από μόνη της είναι βλαπτική.
Έχουμε διάφορους τύπους παραμέλησης που μπορεί να αφορούν
την υγειονομική περίθαλψη,
την εκπαίδευση, την επίβλεψη του παιδιού,
την προστασία απέναντι στους κινδύνους του περιβάλλοντός του,
τις σωματικές του ανάγκες, τη συναισθηματική υποστήριξη
που παρέχεται κυρίως από την οικογένεια ή πάντως
από όποιον έχει αναλάβει τη φροντίδα του παιδιού.
Αυτός ο τύπος παραμέλησης
μπορεί να φαίνεται ήσσονος σημασίας,
αλλά στην πραγματικότητα δίνει στο πρόσωπο
την αίσθηση ότι δεν έχει καμία προστασία από τους άλλους
και ότι ζει σε ένα εχθρικό περιβάλλον που δεν του εγγυάται κανενός είδους ασφάλεια.
Προφανώς,
αν μιλάμε για διάφορους τύπους παραμέλησης,
είτε σε συναισθηματικό είτε σε σωματικό επίπεδο,
έχουμε δύο τελείως διαφορετικές πλευρές.
Σε μερικές καταστάσεις παραμελείται η συναισθηματικότητα όταν έχουμε

φροντιστές παιδιών ψυχρούς,
αδιάφορους και ελάχιστα συμμετέχοντες.
Η σωματική παραμέληση μπορεί να αφορά, αντίθετα,
αποκλειστικά και μόνο την υλική πλευρά,
τις βασικές ανάγκες
ή να επεκτείνεται και στις εκπαιδευτικές ανάγκες
του παιδιού όταν δεν μπορεί να λάβει από τους γονείς του
τις απαραίτητες πληροφορίες
για να ζήσει σε ένα πλαίσιο σχέσεων.
Επιπλέον, έχουμε την ιατρική παραμέληση,
όταν υπάρχει ανάγκη θεραπείας από παθολογίες
αλλά ο υπεύθυνος φροντίδας του εφήβου ή του παιδιού
δεν πράττει τα δέοντα με συνέπεια
οι παθολογίες να αυξάνονται πιθανώς
και να γίνονται ιδιαίτερα επικίνδυνες ή βλαπτικές.
Η ηθική παραμέληση είναι η έλλειψη συμβουλών για θέματα ηθικής
στη συμπεριφορά ενός ανθρώπου.
Οι συνέπειες αυτών των τύπων παραμέλησης είναι βλαπτικές για τη δημόσια υγεία,
αν και για πολλά χρόνια είχαν υποτιμηθεί.
Σήμερα γνωρίζουμε
ότι η έκθεση
για μεγάλο χρονικό διάστημα
σε παραμέληση μπορεί να οδηγήσει
όχι μόνο στις παθολογίες που προαναφέραμε, όπως η διατροφική διαταραχή,
αλλά και σε μία έλλειψη φαιάς ουσίας στον εγκεφαλικό φλοιό
και άρα σε πολύ μειωμένη γνωστική ικανότητα
σε σχέση με τα υπόλοιπα φυσιολογικά άτομα.
Με αυτά τα δεδομένα συνειδητοποιούμε πόσο σημαντικό είναι να ασχοληθούμε με την παραμέληση
και να προσπαθήσουμε
να επανεγκαθιδρύσουμε σε οικογενειακό και ατομικό πλαίσιο
το είδος της φροντίδας και της προσοχής
που παρέχουν ασφάλεια στο άτομο

και δίνουν την αίσθηση ότι το προστατεύουν και το καταλαβαίνουν.

Συμπερασματικά, σχετικά με τις διάφορες παθολογίες, από τις διατροφικές διαταραχές ως την παραμέληση,

σημειώνουμε ότι η παραμέληση είναι ιδιαίτερα διαδεδομένη σε όσους αναπτύσσουν διατροφή ελλειμματικού ελέγχου,

ακόμα και στην ακραία μορφή της πλήρους απώλειας ελέγχου.

Είναι αναγκαίο να σκεφτούμε μια θεραπευτική σχέση που να δίνει ιδιαίτερη προσοχή

στο πρόσωπο αποδεικνύοντας το ενδιαφέρον μας για τον θεραπευόμενο,

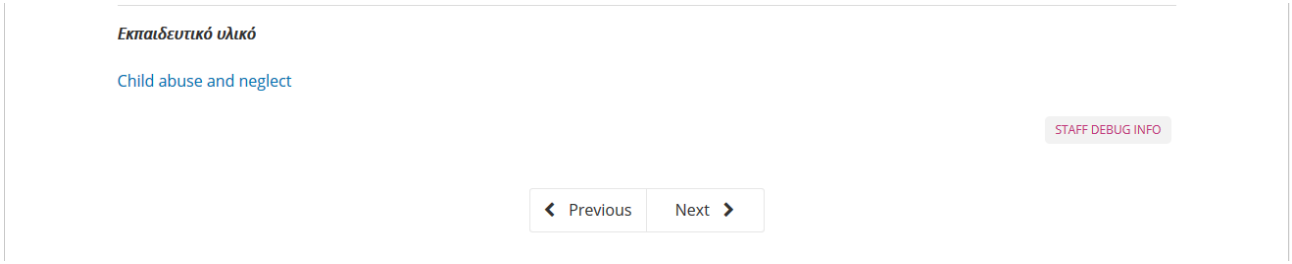
δηλαδή, μία στάση ενσυναίσθησης

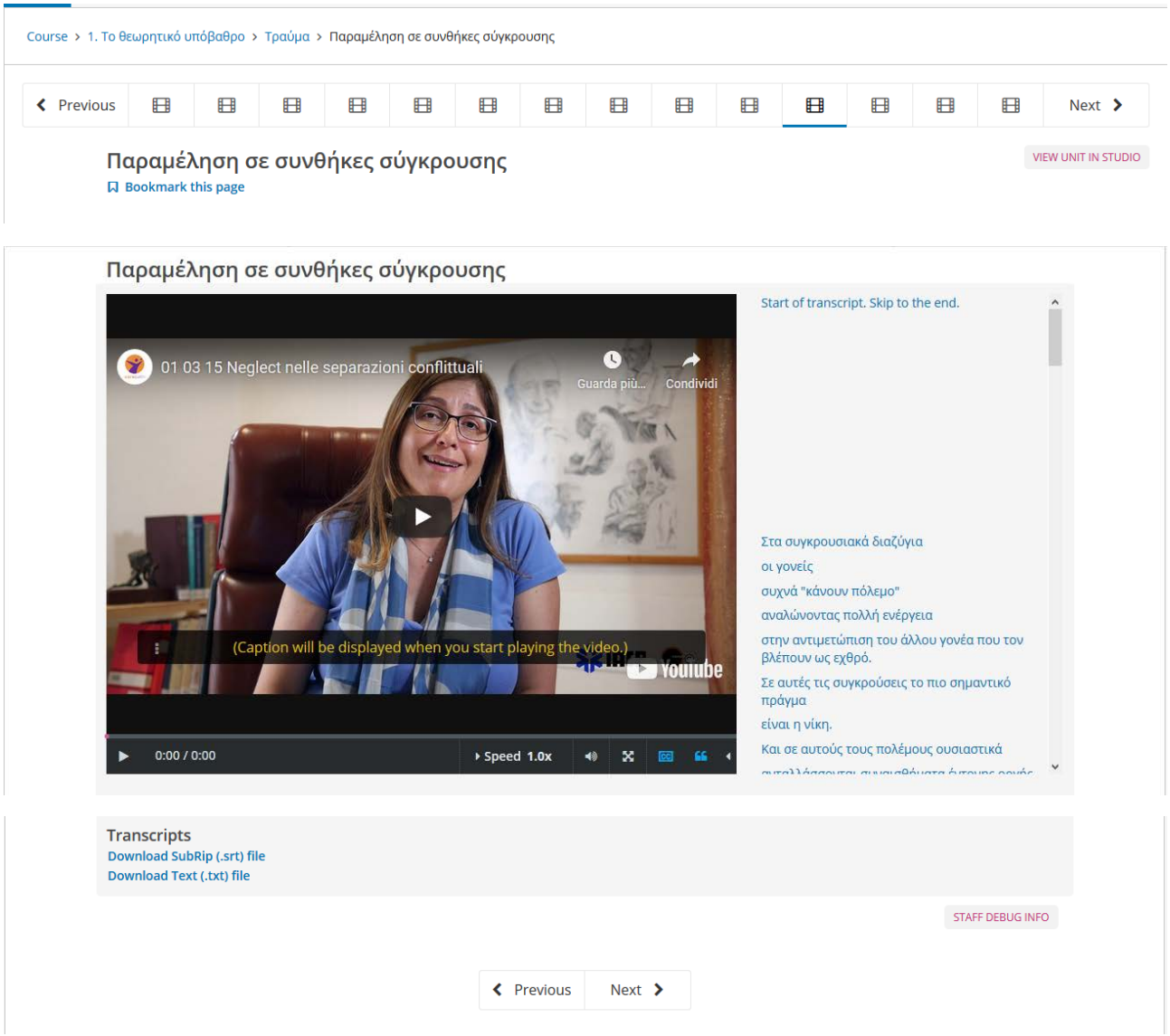
και κατανόησης.

Κι αυτό είναι από τα πιο σημαντικά στοιχεία για την αντιμετώπιση του συγκεκριμένου τραύματος,

που είναι ελάχιστα γνωστό αλλά ιδιαίτερα ύπουλο και εξίσου σημαντικό

με άλλα μεγαλύτερα τραύματα.





Transcript

Στα συγκρουσιακά διαζύγια

οι γονείς

συχνά "κάνουν πόλεμο"

αναλώνοντας πολλή ενέργεια

στην αντιμετώπιση του άλλου γονέα που τον βλέπουν ως εχθρό.

Σε αυτές τις συγκρούσεις το πιο σημαντικό πράγμα

είναι η νίκη.

Και σε αυτούς τους πολέμους ουσιαστικά

ανταλλάσσονται συναισθήματα έντονης οργής

που δηλώνουν, στην πραγματικότητα, πόσο δύσκολο είναι για αυτούς τους ανθρώπους

να έρθουν σε επαφή

με τα συναισθήματα που βιώνουν και που συνδέονται με τη διαδικασία του χωρισμού.
Συναίσθημα απογοήτευσης,
πόνος για την εγκατάλειψη, αίσθηση απουσίας, αίσθηση κενού, μοναξιά
και αίσθηση αποτυχίας.
Αυτά τα πρόσωπα ουσιαστικά εκφράζουν τη δυσκολία τους να επεξεργαστούν
το λεγόμενο ψυχικό διαζύγιο.
Σε αυτό το πλαίσιο
προβάλλει η μορφή του παιδιού
που, ως ανήλικο θα πρέπει να προστατευτεί.
Δυστυχώς, αυτό δεν συμβαίνει γιατί στην πραγματικότητα
ο ανήλικος γίνεται το υπομόχλιο της σύγκρουσης,
γίνεται το κεντρικό της στοιχείο
και, συνεπώς,
οι γονείς αρχίζουν να επικοινωνούν μέσω του ανηλίκου,
το παιδί γίνεται
η γέφυρα ανάμεσα στους δύο γονείς,
το θέμα της συζήτησης για το οποίο καυγαδίζουν οι γονείς
προσπαθώντας
να δηλώσουν
ποιο είναι το καλό
για το παιδί τους.
Σε αυτή την περίπτωση η ευημερία του παιδιού γίνεται μία δικαιολογία
πίσω από την οποία κρύβονται μομφές,
ζήλειες
και προσωπικές ενοχλήσεις.
Το μόνο που δεν υπάρχει
είναι η προστασία του παιδιού, το οποίο πρέπει να είναι πάντα παρόν,
αλλά
η προστασία είναι απαραίτητη
σε πλαίσια ρήξεων
όπως αυτό που προαναφέραμε. Οι γονείς θα μπορούσαν και θα έπρεπε
να συνεργάζονται σε όλα τα θέματα που αφορούν τη γονεϊκή λειτουργία

με στόχο
να ανακουφίσουν το παιδί από ένα βάρος γιατί τα παιδιά, στην πραγματικότητα,
φέρουν βάρος καθώς νιώθουν ένοχα για τον χωρισμό των γονιών τους
και υπεύθυνα για την ευτυχία τους
καθώς είναι η αιτία των καυγάδων τους.
Σε αυτόν τον ύφαλο το παιδί καταλήγει
να μη το βλέπει κανείς
και έτσι γεννιέται ένα παιδικό τραύμα.
Τη στιγμή που είναι ευάλωτο όσο ποτέ
το παιδί δεν το βλέπει κανείς,
οι ανάγκες και τα συναισθήματά του δεν αναγνωρίζονται και δεν καλύπτονται.
Το διαζύγιο είναι πάντα ένα τραυματικό γεγονός
καθώς είναι βλαπτικό
και προκαλεί ένα ρήγμα: ένα γονεϊκό ζεύγος, που στο παιδικό μυαλό
είναι ένας ενιαίος πυρήνας, για κάποιο λόγο
πρέπει να σπάσει στα δύο
και αυτό το εξωτερικό σχίσμα
μεταξύ του πατέρα και της μητέρας
θα προκαλέσει ένα εσωτερικό σχίσμα.
Ωστόσο, στο μυαλό του παιδιού
το γονεϊκό ζεύγος
δεν παύει να υπάρχει και παραμένει,
μόνο που χάνει τη δύναμή του,
την ταυτότητά του,
την αξιοπρέπειά του,
την ιδιότητά του να το καθοδηγεί.
Σε αυτή την περίπτωση υπεισέρχονται και άλλοι παράγοντες
που έχουν
πολύ έντονη φόρτιση
με την αρνητική έννοια.
Υπάρχουν πτυχές που μας δηλώνουν την ταυτότητα του τραύματος,
όπως η ιδιοσυγκρασία του παιδιού,

η ικανότητά του

να ανέχεται την απογοήτευση,

η ποιότητα της σχέσης και ο τύπος αφοσίωσης που οι γονείς

στάθηκαν ικανοί να δημιουργήσουν

πριν το γεγονός του χωρισμού.

Ο παράγοντας που πιο πολύ από όλους

μας μιλά για το τραύμα και το είδος του είναι η ηλικία του παιδιού.

Όσο πιο μικρό είναι το παιδί

τόσο μεγαλύτερο θα είναι το τραύμα

και οι γονείς,

αν και υποσυνείδητα,

ενεργοποιούν μια σειρά από δυσλειτουργικές δυναμικές

που παγιδεύουν το παιδί σε έναν άκαμπτο ρόλο

από τον οποίο δεν καταφέρνει να απαλλαγεί

γιατί,

λόγω του νεαρού

της ηλικίας του,

δεν έχει ακόμα το απαιτούμενο επίπεδο συνειδητοποίησης

ούτε και μια προσωπικότητα σταθερή

και ικανή να απελευθερωθεί, από μόνη της, από αυτή τη φυλακή.

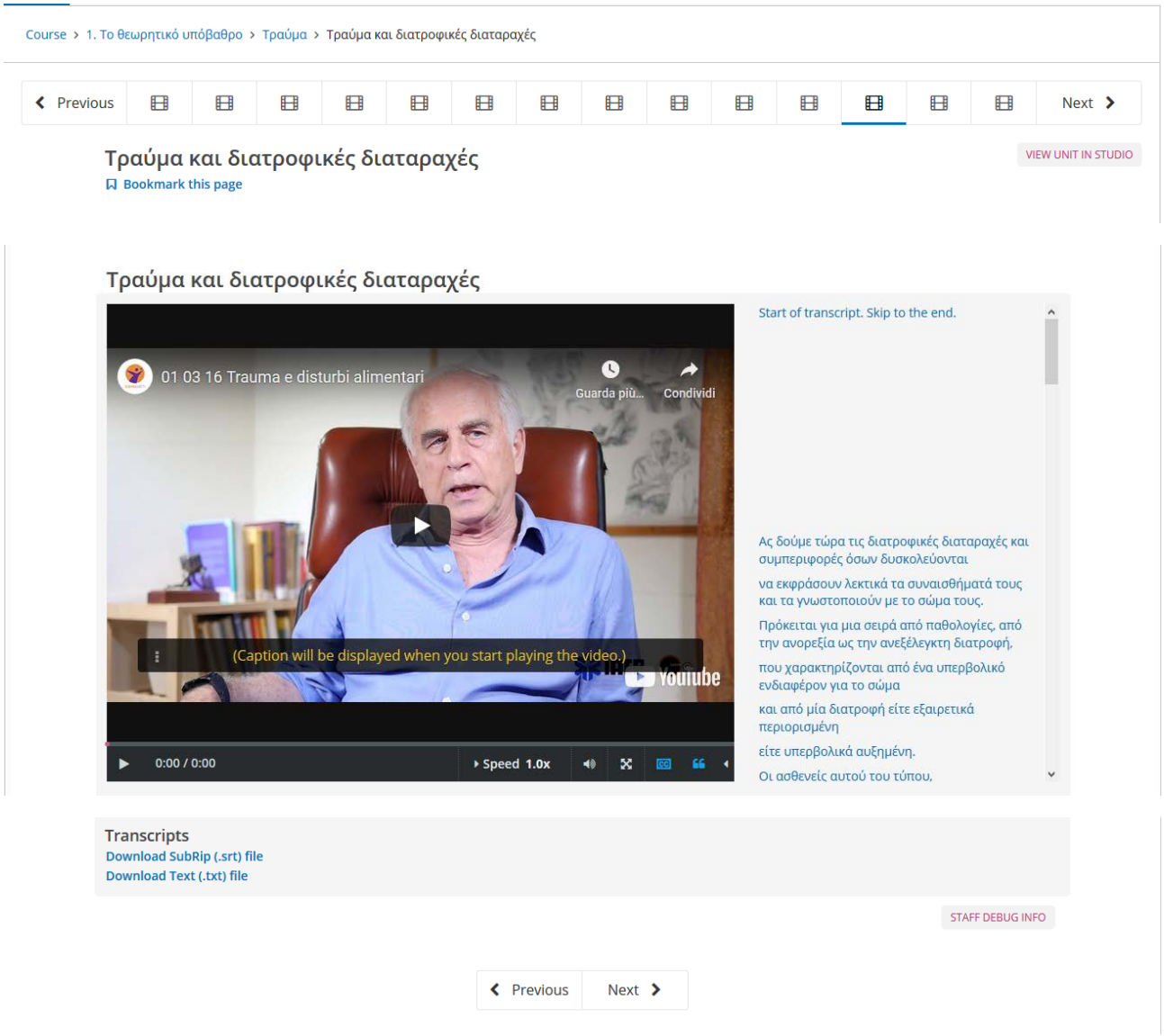
Για αυτό επεμβαίνει σε αυτές τις περιπτώσεις ένας σύμβουλος,

καθώς είναι ικανός να διακρίνει

τον τύπο της δυναμικής που υπάρχει σε μία οικογένεια

και να καταλάβει ποιες παρεμβάσεις πρέπει να κάνει στο γονεϊκό ζεύγος

ώστε να απελευθερώσει το παιδί.



Transcript

Ας δούμε τώρα τις διατροφικές διαταραχές και συμπεριφορές όσων δυσκολεύονται

να εκφράσουν λεκτικά τα συναισθήματά τους και τα γνωστοποιούν με το σώμα τους.

Πρόκειται για μια σειρά από παθολογίες, από την ανορεξία ως την ανεξέλεγκτη διατροφή,

που χαρακτηρίζονται από ένα υπερβολικό ενδιαφέρον για το σώμα

και από μία διατροφή είτε εξαιρετικά περιορισμένη

είτε υπερβολικά αυξημένη.

Οι ασθενείς αυτού του τύπου,

ιδιαίτερα στην περίπτωση της ανορεξίας, είναι κυρίως

θηλυκού γένους.

Η νευρική ανορεξία χαρακτηρίζεται από μεγάλη απώλεια βάρους

σε βαθμό που να είναι εξαιρετικά επικίνδυνο για τη ζωή τους.

Αυτή η απώλεια βάρους είναι επιθυμία και επιδίωξη του ασθενούς, που θεωρεί ότι το σώμα του έχει αναλογίες πολύ μεγαλύτερες από τις πραγματικές.

Στην ανορεξία μπορεί είτε να υπάρχει ένας αυστηρός περιορισμός,
η ποσότητα φαγητού που καταναλώνεται είναι πολύ περιορισμένη,
είτε το βάρος να διατηρείται σε χαμηλά επίπεδα με την πρόσληψη τροφής και στη συνέχεια
με ακραίες ενέργειες εκκαθάρισης
με τις οποίες η αποβολή τροφής είναι μεγαλύτερη από την πρόσληψή της
με συνέπεια την απώλεια βάρους.

Αμέσως μετά ακολουθεί
η νευρική βουλιμία.

Μία παθολογία κατά την οποία
η πρόσληψη τροφής είναι ως επί το πλείστον
μεγάλης κλίμακας,
έχουμε επεισόδια αδηφαγίας,
στιγμές κατά τις οποίες
ο ασθενής προσλαμβάνει τροφή
σε μεγάλη ποσότητα,
αλλά ταυτόχρονα ο ίδιος ασθενής έχει την ικανότητα να μειώνει
το σωματικό του βάρος μέσω της αποβολής
τροφής
και κυρίως
καταφεύγοντας σε ακατάλληλα εργαλεία ή μέσα όπως ο εμετός,
η χρήση καθαρτικών ή διουρητικών,
η χρήση ουσιών που μειώνουν την όρεξη
ή η σωματική δραστηριότητα.

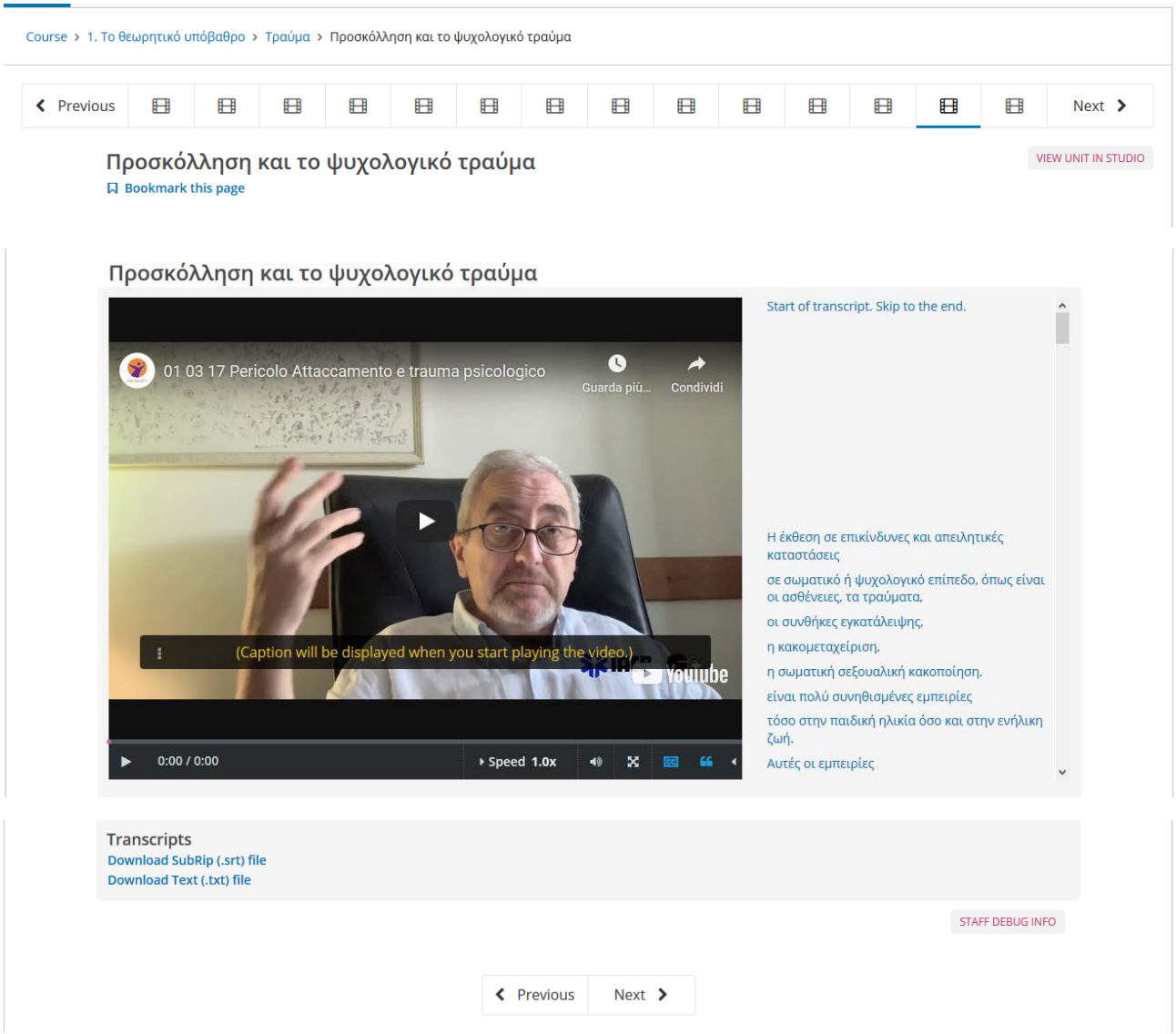
Σε αυτά τα πρόσωπα η ισορροπία του βάρους διατηρείται σε καλά επίπεδα
και σωματικά είναι σε φόρμα.

Το άκρως αντίθετο συμβαίνει
στην ανεξέλεγκτη διατροφή.

Η ανεξέλεγκτη διατροφή
συνίσταται σε έναν τρόπο πρόσληψης τροφής
που βασίζεται σε συνεχή αδηφαγία.

Η διαρκής στροφή στο φαγητό για πολλές ώρες της ημέρας,
μία διατροφή χωρίς φρένο, δηλαδή,
στερούν από το άτομο την ικανότητα
να μειώσει
τη διατροφή
και το βάρος του που ανέρχεται σε υψηλότατα επίπεδα, από 150 ως 200 κιλά,
με συνεπαγόμενους κινδύνους για το σώμα
καθώς το υπερβολικό βάρος μπορεί να προκαλέσει σωματικές παθολογίες
εξαιρετικά σοβαρές.
Αυτές οι τρεις παθολογίες διαδέχονται η μία την άλλη
κι έχουν
ως χαρακτηριστικό
η μία να αντικαθίσταται από την επόμενη όσο μειώνεται η ικανότητα ελέγχου.
Στη νευρική ανορεξία
ο έλεγχος είναι πολύ καλός
και τα άτομα μπορούν να μειώσουν τη διατροφή τους
ως τη διατήρηση ενός εξαιρετικά χαμηλού σωματικού βάρους.
Όταν ο έλεγχος μειώνεται
περνάμε στη νευρική βουλιμία
κατά την οποία,
οι νέοι ή οι νέοι που βιώνουν
αυτό το πρόβλημα,
τρέφονται μεν, και, μάλιστα, σε μεγάλες ποσότητες,
αλλά διατηρούν μια καλή ισορροπία
και έχουν μία ικανότητα ελέγχου που εμφανίζεται αμέσως μετά
την πρόσληψη τροφής, όχι πριν από αυτή,
και, παρόλα αυτά, τους επιτρέπει να διατηρούν
το βάρος τους σε αποδεκτά επίπεδα.
Στον τρίτο τύπο, στην ανεξέλεγκτη διατροφή,
αφιερώνουν όλη τη μέρα τους
αποκλειστικά στο φαγητό,
συχνά μπροστά στην τηλεόραση, χωρίς την επίγνωση της επαναλαμβανόμενης και διαρκούς

πρόσληψης τροφής. Σε κάθε περίπτωση, αυτές οι τρεις παθολογίες
έχουν κάποια κοινά χαρακτηριστικά
που αφορούν όλο το φάσμα των συναισθημάτων
αλλά και το γεγονός της έκθεσης σε ποικίλα τραύματα
τα οποία μπορούν να λαμβάνουν χώρα στις διατροφικές διαταραχές.



Transcript

Η έκθεση σε επικίνδυνες και απειλητικές καταστάσεις

σε σωματικό ή ψυχολογικό επίπεδο, όπως είναι οι ασθένειες, τα τραύματα,

οι συνθήκες εγκατάλειψης,

η κακομεταχείριση,

η σωματική σεξουαλική κακοποίηση,

είναι πολύ συνηθισμένες εμπειρίες

τόσο στην παιδική ηλικία όσο και στην ενήλικη ζωή.

Αυτές οι εμπειρίες

δεν συνεπάγονται αναγκαστικά

την ανάπτυξη ψυχολογικού τραύματος,

καθώς το είδος μας

έχει εξαιρετικά ανεπτυγμένες

ικανότητες

προσαρμογής,

οι οποίες του επιτρέπουν να αντιμετωπίζει ακόμα και ακραίες καταστάσεις

χωρίς να είναι απαραίτητο

να αναπτυχθεί μία κατάσταση ψυχολογικού τραύματος.

Αυτές οι επικίνδυνες καταστάσεις,

αν αντιμετωπιστούν αποτελεσματικά,

κατά κάποιο τρόπο, χάνουν

την ιδιότητά τους εκείνη

που οδηγεί σε έλλειψη προσαρμογής

κι έτσι το άτομο μπορεί να παραμείνει σε μία κατάσταση

ψυχικής

και ψυχολογικής υγείας.

Πιο συγκεκριμένα, το είδος μας έχει αναπτύξει,

με την πάροδο του χρόνου,

ορισμένες ικανότητες,

πολύ εξελιγμένες,

στις σχέσεις και στις συμπεριφορές,

οι οποίες έχουν ως βασική λειτουργία να μας προστατεύουν

όταν ερχόμαστε αντιμέτωποι με κινδύνους.

Αυτό το σύνολο

συμπεριφορών

και στάσεων προσδιορίζεται

με τον όρο "σύστημα προσκόλλησης".

Η λέξη "προσκόλληση"

προέρχεται από τη θεωρία της προσκόλλησης

που είχε αρχικά διατυπώσει κατά τη δεκαετία του 1950

ο Βρετανός ψυχαναλυτής Τζον Μπόουλμπι.

Η θεωρία της προσκόλλησης υποστηρίζει ότι ο άνθρωπος

έχει μία εγγενή προδιάθεση

να αναπτύσσει ιδιαίτερες σχέσεις προσκόλλησης

με πρωταρχικές μορφές, συχνά με τους γονείς,
που επιτελούν
τη βασική λειτουργία
της προστασίας από τους κινδύνους.
Αυτή η θεωρία δεν έχει προκύψει από ψυχολογικές και ψυχαναλυτικές παρατηρήσεις
αλλά από τις πρώτες γνώσεις
που αναπτύσσονταν εκείνη την εποχή
στον τομέα της ηθολογίας,
δηλαδή, της μελέτης της συμπεριφοράς των ζώων,
στη θεωρία της εξέλιξης
και σε νέες θεωρίες γνωστικιστικές,
συστημικές και της επιστήμης των συστημάτων.
Η θεωρία της προσκόλλησης προκύπτει από ένα χωνευτήρι σύγχρονων θεωριών
που άρχιζαν να διαδίδονται κατά τη δεκαετία του 1950.
Σε αυτή τη θεωρία γίνεται λόγος για προσκόλληση, που έχει τη βασική λειτουργία
να προστατεύει από επικίνδυνες καταστάσεις, αλλά όχι μόνο.
Το πρόσωπο που νιώθει ότι βρίσκεται
σε μία επαρκώς ασφαλή κατάσταση
έχει την υποστήριξη
ώστε να εξερευνήσει
το εξωτερικό του περιβάλλον,
γνωρίζοντας
τα προσωπικά του μέσα
και μαθαίνοντας πώς να προλαμβάνει τους κινδύνους που μπορεί να κρύβει το ίδιο το περιβάλλον.
Αυτές οι λειτουργίες
της προσκόλλησης μελετήθηκαν τόσο σε παιδιά κάθε ηλικίας,
ιδίως σε παιδιά 1 και 2 ετών στη σχέση τους με τη μητέρα,
όσο και σε πρωτεύοντα θηλαστικά,
όπως κάποιες έρευνες της δεκαετίας του 1950 σχετικά με μικρούς πιθήκους ρέζους,
οι οποίες
αποδεικνύουν
πόσο σημαντική είναι

και για τα πρωτεύοντα
η λειτουργία προστασίας
εκ μέρους της μητέρας,
περισσότερο και από τη διατροφική λειτουργία.
Η προσκόλληση συχνά διακρίνεται σε ασφαλή και ανασφαλή προσκόλληση.
Η ασφαλής προσκόλληση
χαρακτηρίζεται από μία αίσθηση
ασφάλειας, εμπιστοσύνης απέναντι στο περιβάλλον,
εμπιστοσύνης στα προσωπικά μας μέσα
και στη δυνατότητα λήψης βοήθειας και προστασίας σε περίπτωση κινδύνου.
Η ανασφαλής προσκόλληση
διακρίνεται, με τη σειρά της,
σε ανασφαλή
αμφιθυμική προσκόλληση,
στα παιδιά ορίζεται ως τύπος Γ,
και χαρακτηρίζεται
από μία υπερδιέγερση του οργανισμού
με έμφαση στα συναισθήματα,
με εκδηλώσεις θυμού,
με φοβίες,
με παράπονα
σχετικά με την ανάγκη προστασίας,
με δυσκολία στον αποχωρισμό από τη μητέρα.
Ο άλλος τύπος είναι η ανασφαλής αποφευκτική προσκόλληση,
γνωστή και ως τύπος Α.
Στον αντίποδα της προηγούμενης,
χαρακτηρίζεται από υποδραστηριότητα, ιδίως από μία τήρηση απόστασης
από τις συναισθηματικές αντιδράσεις
που μπορούν να ενθαρρύνονται
από μία κατάσταση κινδύνου,
δηλαδή, από τον φόβο, τον θυμό,
την αίσθηση της ευάλωτης θέσης,

τα οποία συναισθήματα είτε αναστέλλονται
όταν εκφράζονται,
για παράδειγμα, με μία στάση φαινομενικής αδιαφορίας,
είτε αλλοιώνονται και μετατρέπονται
σε εκφράσεις των αντίθετων συναισθημάτων, όπως όταν χαμογελούμε απέναντι σε κάτι τρομακτικό.
Όταν αυτοί οι τρόποι προσκόλλησης
είναι αποτελεσματικοί
προστατεύουν
από τον κίνδυνο
που προέρχεται τόσο από το περιβάλλον
όσο και από τις σχέσεις στις οποίες συμμετέχουμε.
Αν αυτές οι στρατηγικές
είναι αποτελεσματικές
και παρέχουν ικανοποιητική προστασία,
δεν υφίστανται καταστάσεις ψυχολογικού τραύματος
και το άτομο διατηρείται σε μία κατάσταση σχετικής ασφάλειας.
Η κατάσταση ψυχολογικού τραύματος εκδηλώνεται
όταν αυτοί οι τρόποι
είναι αναποτελεσματικοί,
για παράδειγμα, όταν η στάση αναστολής έκφρασης του φόβου, του θυμού
ή των αναγκών του ατόμου
δεν είναι αρκετή για να τον προστατέψει
από τις απειλές του περιβάλλοντός του.
Το ψυχολογικό τραύμα είναι μία κατάσταση στην οποία κάθε δραστηριότητα ψυχικής επεξεργασίας
είναι αρνητικά επηρεασμένη
από μία εμπειρία κινδύνου, είτε παρελθοντική είτε παροντική.
Αυτή μπορεί να προέρχεται από ένα γεγονός ιδιαίτερα έντονο και αιφνίδιο,
όπως ένα σωματικό τραύμα
ή μία κακοποίηση,
αλλά μπορεί να προέρχεται και από μια σειρά εμπειριών που επαναλαμβάνονται
και στο σύνολό τους λειτουργούν
ως τραυματικές:

σε αυτή την περίπτωση μιλάμε για ένα εξελικτικό τραύμα.

Είναι η κατάσταση κατά την οποία ένα παιδί,

για παράδειγμα, μεγαλώνει μέσα σε μία οικογένεια

ακατάλληλη

και με παραμέληση

και στο σύνολό τους αυτές οι παρατεταμένες εμπειρίες δημιουργούν ένα ακατάλληλο κλίμα

ανάπτυξης

που μπορεί να οδηγήσει σε μία κατάσταση ψυχολογικού τραύματος.

Η ικανότητα προσαρμογής και επανεπεξεργασίας μιας δυνητικά τραυματικής κατάστασης κινδύνου

εξαρτάται από ορισμένα χαρακτηριστικά.

Από το άτομο, την ηλικία του, την ωριμότητά του,

την προσωπικότητά του,

τα χαρακτηριστικά της προσκόλλησής του, αν είναι αποτελεσματικά για να το προστατέψουν ή όχι,

τη σωματική του δύναμη και την κατάσταση της υγείας του,

καθώς όποιος νοσεί είναι πιο εύθραυστος

σε ό,τι αφορά την επεξεργασία μιας κατάστασης κινδύνου.

Είναι πολύ σημαντική, επίσης,

η προστατευτική διαθεσιμότητα των μορφών προσκόλλησης, δηλαδή, το άτομο να μη νιώθει μόνο

απέναντι στον κίνδυνο αλλά να το συνοδεύουν σχέσεις προστασίας με ανθρώπους

πρόθυμους να το κάνουν

να νιώσει προστατευμένο

και όχι μόνο του κατά την επεξεργασία

μίας εμπειρίας επικίνδυνης φύσεως.

Σημαντικό ρόλο διαδραματίζει το κοινωνικό πλαίσιο. Είναι θεμελιώδες το άτομο να βρίσκεται

σε ένα φιλόξενο περιβάλλον, με πρόσωπα που το αποδέχονται και το υποστηρίζουν

με την κουλτούρα τους

με τελετουργικά τυπικά

ή με την προσωπική παρουσία, όπως είναι οι φίλοι.

Η διαδικασία προσαρμογής μίας κατάστασης τραύματος δεν είναι άμεση και απαιτεί χρόνο.

Για παράδειγμα,

ένα σοβαρό πένθος,

όπως του συντρόφου ή του γονέα,

απαιτεί συνήθως

ένα ή δύο χρόνια για να μπορέσει κανείς να το επεξεργαστεί με κατάλληλο τρόπο,

χωρίς να μετατραπεί σε μία κατάσταση

τραυματικού πένθους.

Όταν δεν επεξεργαζόμαστε

μία δυνητικά τραυματική εμπειρία,

συνήθως, αυτή συνοδεύεται

από συναισθηματική υπερδιέγερση,

με όνειρα,

εφιάλτες,

φόβους,

αίσθηση απειλής,

ανεξέλεγκτες αντιδράσεις,

όπως στην περίπτωση της διαταραχής μετατραυματικού στρες,

ή από μία κατάσταση υπερβολικής υποδραστηριότητας, δηλαδή μία υπερβολική τήρηση απόστασης

από όλα όσα αφορούν

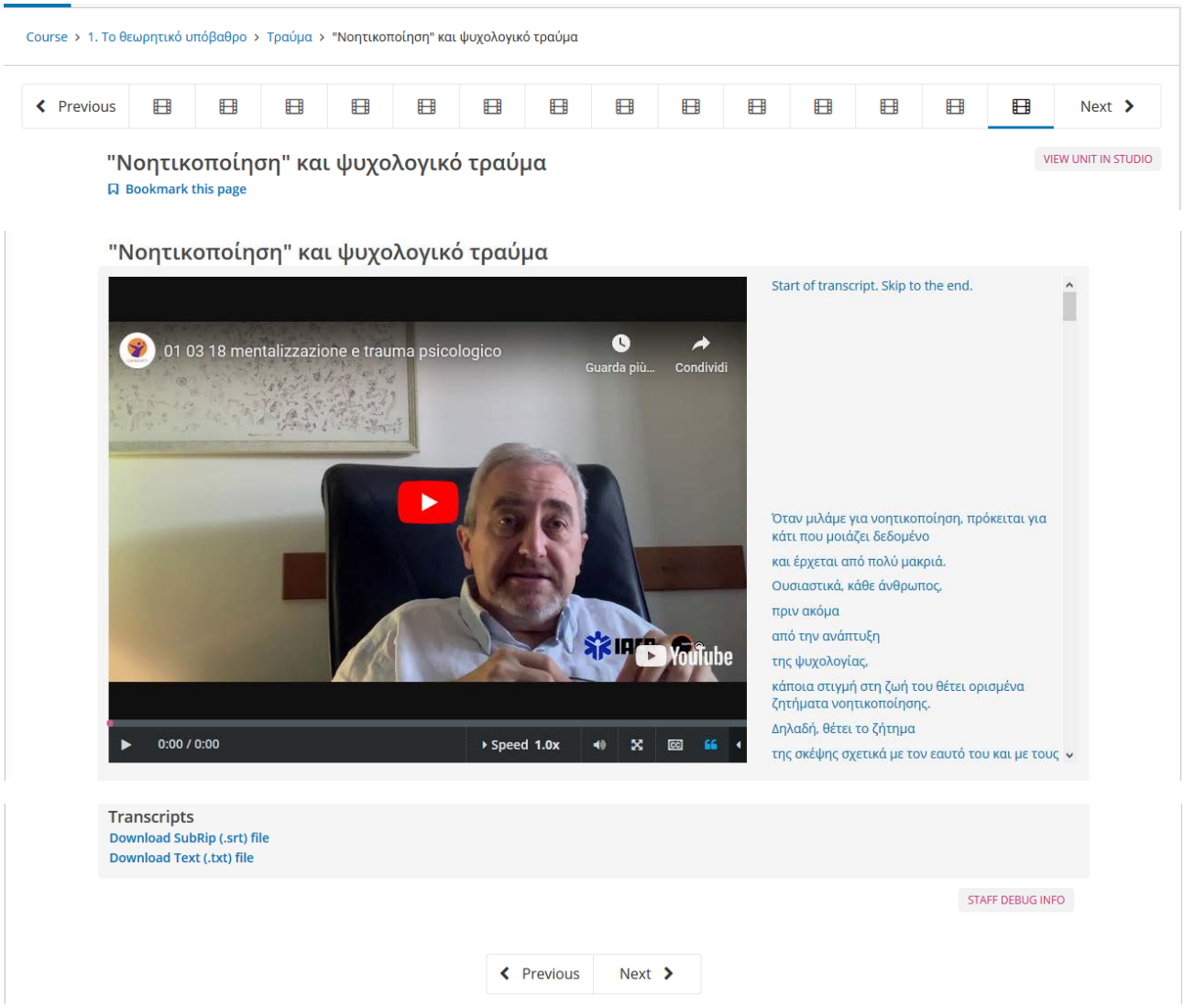
την επικίνδυνη εμπειρία,

καθώς και απουσία αναμνήσεων,

συναισθηματική αναστολή,

και αποφυγή της ομιλίας ή των τοποθεσιών που συνδέονται με την τραυματική εμπειρία.

Όταν έχουμε αυτές τις δύο καταστάσεις, μπορούμε να μιλάμε για ψυχολογικό τραύμα.



Transcript

Όταν μιλάμε για νοητικοποίηση, πρόκειται για κάτι που μοιάζει δεδομένο

και έρχεται από πολύ μακριά.

Ουσιαστικά, κάθε άνθρωπος,

πριν ακόμα

από την ανάπτυξη

της ψυχολογίας,

κάποια στιγμή στη ζωή του θέτει ορισμένα ζητήματα νοητικοποίησης.

Δηλαδή, θέτει το ζήτημα

της σκέψης σχετικά με τον εαυτό του και με τους άλλους,

θεωρώντας ότι εμείς και οι άλλοι

έχουμε νου,

σκέψεις,

συναισθήματα, ανάγκες,
προσδοκίες και πεποιθήσεις
που μας επηρεάζουν.
Ένας απλός τρόπος για να καταλάβουμε την έννοια
της νοητικοποίησης
είναι εκείνος
που αφορά τη θεώρηση
του εαυτού μας και των άλλων
από την άποψη των νοητικών καταστάσεων.
Αυτές οι ικανότητες του είδους μας
αρχίζουν να διαμορφώνονται
γύρω στην ηλικία των 4 ετών,
όταν το παιδί συνειδητοποιεί
πως ό,τι σκέφτεται
και νιώθει
δεν γίνεται απαραίτητα κατανοητό και δεκτό από άλλα πρόσωπα,
όπως όταν η μητέρα δεν γνωρίζει τι περνάει από το μυαλό του μωρού.
Τα μικρά παιδιά, όταν μαθαίνουν
αυτό το σημαντικό νέο, μαθαίνουν παράλληλα
να χρησιμοποιούν
έναν στρατηγικό
τρόπο
προσαρμογής στα προβλήματα
που είναι πολύ χρήσιμος
και σημαντικός. Μαθαίνουν, δηλαδή, τη σπουδαιότητα του ψέματος.
Ένα ψέμα μπορούμε να το πούμε αν νομίζουμε ότι ο νους των άλλων έχει μια θεώρηση
του κόσμου διαφορετική από τη δική μας
και ότι οι άλλοι δεν μπορούν να γνωρίζουν τις σκέψεις ενός ατόμου.
Η νοητικοποίηση
και οι διαδικασίες της βασίζονται σε μια σειρά
από στάδια.
Το πρώτο αφορά το γεγονός ότι είμαστε

σχετικά

ευαίσθητοι στην αντίληψη

των νοητικών καταστάσεων,

δηλαδή, στην αναπαράσταση των νοητικών καταστάσεων

των δικών μας και των άλλων, όπως το να καταλαβαίνουμε

ότι είμαστε χαρούμενοι ή λυπημένοι,

ότι έχουμε προσδοκίες

και προκαταλήψεις.

Επίσης,

η ικανότητα να ερμηνεύουμε τη συμπεριφορά τη δική μας και των άλλων

με βάση

αυτές τις νοητικές καταστάσεις

είναι θεμελιώδης για να μπορούμε να προσαρμοζόμαστε.

Για παράδειγμα, όταν κάποιος στέκεται αμίλητος μπροστά μας,

δεν σκεφτόμαστε ότι δεν έχει

τίποτα να πει.

Σκεφτόμαστε ότι από τον νου του

περνούν εικόνες και σκέψεις

και ότι με τη σιωπή δεν εκφράζει το κενό αλλά μια σειρά από νοητικές καταστάσεις

οι οποίες

αποτελούν τη βάση αυτής της στάσης σιωπής.

Μία δεύτερη σημαντική πτυχή της νοητικοποίησης

είναι ότι η νοητικοποίηση του εαυτού μας

ευνοεί τη ρύθμιση του οργανισμού μας.

Αν, για παράδειγμα, συνειδητοποιούμε

ότι είμαστε

θυμωμένοι

και αρχίσουμε να σκεφτόμαστε

κάτι που ειπώθηκε

και σχετίζεται με τον θυμό,

το γεγονός

ότι συνειδητοποιούμε,

θυμόμαστε,
έχουμε προσδοκίες
και προβλέψεις σχετικά με τις συνέπειες
μιας πράξης
ανοίγει έναν ψυχολογικό δρόμο για τη ρύθμιση του θυμού που έχει ενεργοποιηθεί μέσα μας.
Η καρδιά, η αναπνοή, η παραγωγή ορμονών
που συνδέονται με την ενεργοποίηση του θυμού
αρχίζουν να ρυθμίζονται
από μηχανισμούς ψυχολογικής φύσεως.
Για παράδειγμα, θα μπορούσα να νιώσω
ενοχές επειδή αισθάνομαι θυμό για κάποιον που αγαπώ.
Αυτό αναστέλλει την έκφραση του θυμού
και ρυθμίζει τον ίδιο μας τον οργανισμό.
Πρόκειται για μία θεμελιώδη λειτουργία.
Επίσης, τα πρόσωπα με ελάχιστη ικανότητα
νοητικοποίησης είναι περισσότερο εκτεθειμένα
στην απορρύθμιση του οργανισμού.
Η καρδιά
χτυπάει
πιο γρήγορα και ακανόνιστα,
οι συναισθηματικές αντιδράσεις είναι λιγότερο ελεγχόμενες
και αυτό μακροπρόθεσμα μπορεί να οδηγήσει
σε ασθένειες
που οφείλονται
στη συνεχή απορρύθμιση του οργανισμού.
Μία από τις πιο σημαντικές λειτουργίες του γονέα απέναντι στα παιδιά του
είναι να είναι ο ίδιος
νοητικοποίηση.
Δηλαδή,
να σκέφτεται τα παιδιά
σε σχέση με τις πιθανές
ανάγκες, τα συναισθήματα

και τους φόβους τους,
χαμηλώνοντας, κατά μία έννοια, στο επίπεδο της θέσης των παιδιών
και βλέποντας τα πράγματα και από τη δική τους άποψη.
Για παράδειγμα, ένα παιδί τριών ετών
θα έχει συγκεκριμένα επιχειρήματα
και θα ερμηνεύει λέξεις και συζητήσεις
σύμφωνα με τις ικανότητές του
ως παιδί
και είναι σημαντικό ο ενήλικας, από την πλευρά του,
να έρθει στη θέση του.
Αυτή η κατάσταση, που ορίζεται ως "mindedness"
είναι μία από τις καταστάσεις
που σχετίζονται περισσότερο
με την ασφαλή ανάπτυξη των παιδιών. Είναι μία θεμελιώδης κατάσταση
του καλού γονέα
να καταφέρνει
να έρχεται στη θέση των παιδιών και να αντιλαμβάνεται τις ανάγκες τους.
Την κατάσταση αυτή παρατηρούμε στη μητέρα ενός πολύ μικρού παιδιού
η οποία, για παράδειγμα,
έρχεται στη θέση
του παιδιού,
που κλαίει και είναι ταραγμένο, και σκέφτεται ότι μπορεί να κρυώνει ή να πεινάει,
εκφράζοντας μία κατάσταση του μωρού,
σαν να είχε το παιδί, κατά κάποιο τρόπο, οργανωμένες σκέψεις
και να μπορούσε να τις εκφράσει.
Η ικανότητα αναπαράστασης των νοητικών καταστάσεων των παιδιών
είναι μία βασική κατάσταση την οποία πρέπει να κατακτήσει ο γονέας.
Επίσης, η νοητικοποίηση αποτελεί τη βάση
της ικανότητας αντιμετώπισης του άγχους και των δυνητικά επικίνδυνων καταστάσεων
μέσω της προσαρμογής
χωρίς να αναπτύσσονται καταστάσεις ψυχολογικών τραυμάτων.
Για παράδειγμα,

όταν ένα μικρό παιδί αντιμετωπίζει
μία ασυνάρτητη συμπεριφορά του γονέα,
ο οποίος ίσως προβαίνει σε μια χειρονομία θυμού
ή σωματικής βίας
ή λέει αρνητικά πράγματα στο παιδί,
η ικανότητα αυτού του παιδιού να φανταστεί τη νοητική κατάσταση του γονέα
λειτουργεί ως αποσβεστήρας κραδασμών και του επιτρέπει να σκεφτεί
αυτά που κάνει και λέει ο γονέας
εντός ενός ορισμένου πλαισίου. Μπορεί να σκεφτεί,
"ο μπαμπάς
είναι κουρασμένος και ό,τι λέει δεν ανταποκρίνεται στην πραγματικότητα,
ο μπαμπάς συνήθως
είναι στοργικός και με αγαπάει,
αυτό που συμβαίνει τώρα ισχύει
τη συγκεκριμένη στιγμή και αφορά συγκεκριμένες διαθέσεις, δεν είναι απόλυτο".
Η στάση που μόλις περιγράψαμε προστατεύει από τις νοητικές καταστάσεις
των άλλων
και καθιστά την κατάσταση δυνητικά λιγότερο τραυματική.
Κάτι που παρατηρούμε σαφώς σε ενήλικες με χαμηλά επίπεδα
νοητικοποίησης,
όπως στην περίπτωση
ανθρώπων με οριακή διαταραχή προσωπικότητας,
που είναι πολύ πιο εκτεθειμένοι σε συνεχή ψυχολογικά τραύματα,
είναι πως ό,τι τους συμβαίνει δεν εντάσσεται σε κάποιο πλαίσιο,
δεν υποβάλλεται σε μια διαδικασία επαρκούς σκέψης,
κι έτσι όλα γίνονται
καθολικά, απόλυτα
και
δυνητικά τραυματικά.
Ορισμένες στιγμές
η ανικανότητα
των γονέων να έρχονται στη θέση των παιδιών τους

μπορεί να είναι ιδιαίτερα
επικίνδυνη
και να προκαλεί στάσεις που ένα μικρό παιδί ή ένας έφηβος
μπορούν
να εκδηλώσουν μέσα από συμπεριφορές έντονης επιθετικότητας.
Η επιθετικότητα και οι συμπεριφορές που αυτή υπαγορεύει
μπορούν,
εν μέρει,
να ερμηνευτούν
μέσω της έννοιας της νοητικοποίησης.
Αν, για παράδειγμα, κάποιοι γονείς είναι συνεχώς εκνευρισμένοι
από τις συμπεριφορές ενός παιδιού τους,
όπως όταν ένα παιδί
θέτει
ένα ζήτημα
ή έχει ένα νευρικό ξέσπασμα,
και ο γονέας αρχίζει να απευθύνεται στο παιδί
με αρνητικό τρόπο, λέγοντας ίσως ότι είναι χαζό, άρρωστο ή άχρηστο,
από την πλευρά του παιδιού
η εικόνα που αποκτά για τον εαυτό του αφορά ένα πρόσωπο άρρωστο,
διαταραγμένο,
ή ανίκανο.
Αυτή τη στάση το παιδί την τηρεί ανεξάρτητα
από τις επιθετικές του συμπεριφορές και άρα κάθε φορά που ένας ενήλικας πλησιάζει
ένα παιδί υπό αυτές τις συνθήκες με την πρόθεση να το γνωρίσει
και να του εμπνεύσει εμπιστοσύνη ώστε να ανοιχτεί, η πιθανή απάντηση θα είναι μία στάση
έντονης επιθετικής αντίδρασης,
που στοχεύει στην απομάκρυνση του ενήλικα
καθώς είναι δυνητικά τραυματικός.
Η ίδια περίπτωση αφορά τους νέους που στο σχολείο θεωρούνται ανίκανοι
και τιμωρούνται συχνότερα.
Οι καθηγητές τούς θεωρούν

ως αρνητικά

υποκείμενα

και στο σπίτι αυτά τα παιδιά έχουν γονείς που ενισχύουν

την αρνητική ιδέα για τον εαυτό τους. Αυτά τα παιδιά

απέναντι στους ίδιους ενήλικες που προσπαθούν

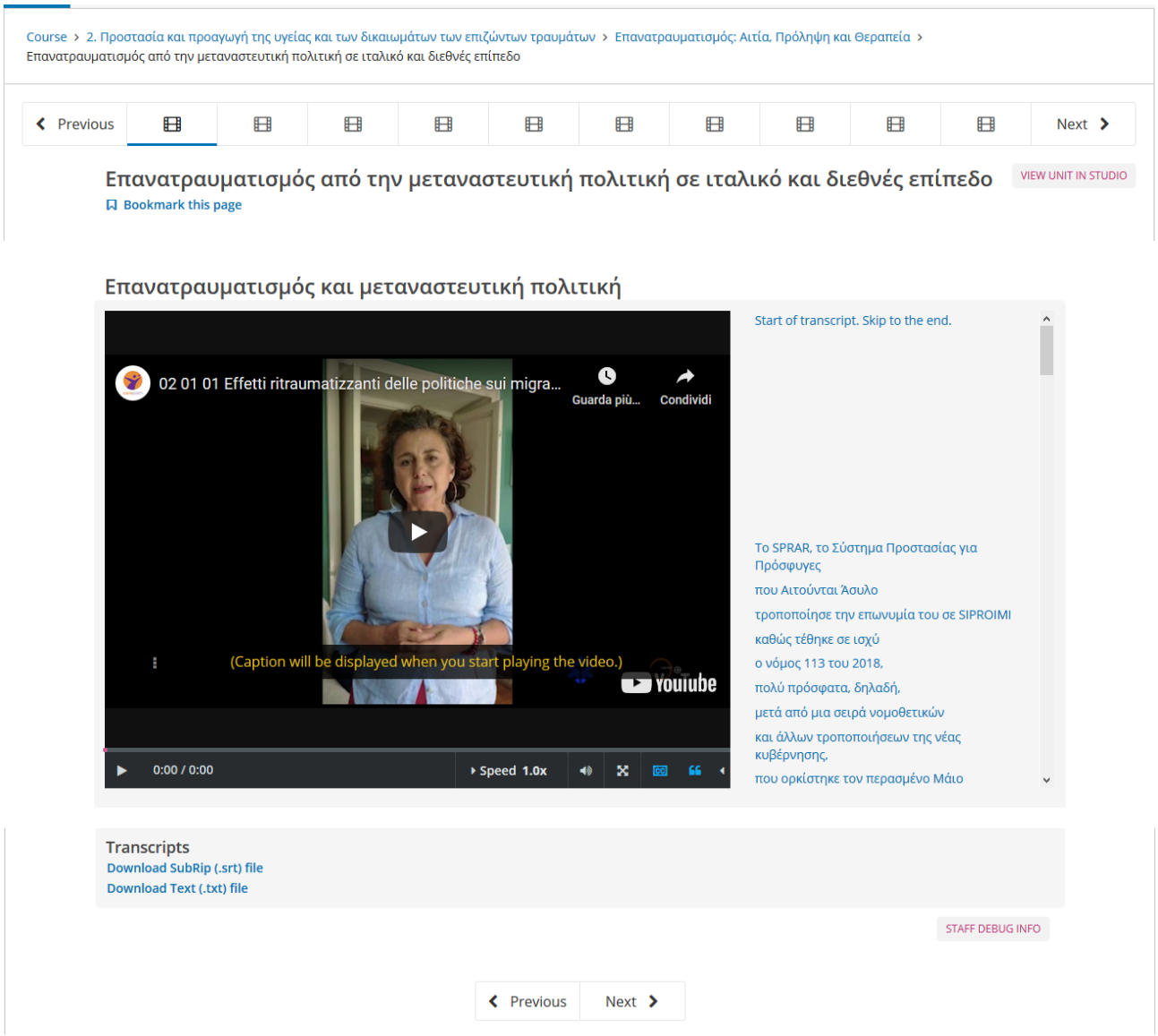
να τους βοηθήσουν (εκπαιδευτές, καθηγητές), έχουν την ίδια στάση έντονης αντιδραστικότητας

και θυμού με στόχο την απομάκρυνση

του άλλου

ώστε να μην επαναληφθεί η εμπειρία

να ακούσουν τα παιδιά να τα περιγράφουν ως πρόσωπα αρνητικά που κάνουν λάθη.



Transcript

Το SPRAR, το Σύστημα Προστασίας για Πρόσφυγες

που Αιτούνται Άσυλο

τροποποίησε την επωνυμία του σε SIPROIMI

καθώς τέθηκε σε ισχύ

ο νόμος 113 του 2018,

πολύ πρόσφατα, δηλαδή,

μετά από μια σειρά νομοθετικών

και άλλων τροποποιήσεων της νέας κυβέρνησης,

που ορκίστηκε τον περασμένο Μάιο

στην Ιταλία, επιφέροντας βελτιώσεις

στο θέμα της μετανάστευσης,

της αίτησης ασύλου και της υποδοχής.
Το SPRAR ιδρύθηκε το 2002 και αποτελείται
από ένα δίκτυο δήμων και τοπικών παραγόντων
οι οποίοι, σε συνεργασία με τις ενώσεις
του τριτογενούς τομέα και τις ΜΚΟ, διαχειρίζονται
σε εθελοντική βάση και με δική τους επιλογή
προγράμματα υποδοχής και ένταξης
για τους αιτούντες άσυλο
και τους πρόσφυγες.
Αυτό το δίκτυο με την πάροδο των χρόνων
είχε μία προοδευτική
και θετική εξέλιξη.
Από τις αρχικές 1.500 θέσεις υποδοχής
στις 35.000 θέσεις σήμερα,
η ιστορία του SPRAR
πέρασε από πολλά στάδια
που επέφεραν ορισμένες αλλαγές.
Η πρώτη αλλαγή αφορούσε
τη θεσμοποίησή του
μέσω ενός νόμου που το κατέστησε
σταθερό και τακτικό
ως κεντρικό σύστημα υποδοχής στην Ιταλία
εκεί όπου τα προηγούμενα χρόνια δεν υπήρχαν
άλλα δομημένα συστήματα υποδοχής
παρά μόνο παρεμβάσεις
επείγοντος χαρακτήρα.
Μία άλλη σημαντική στιγμή ήταν
όταν το 2003 η λεγόμενη "έκτακτη ανάγκη της Βόρειας Αφρικής"
ανέδειξε με ακόμα πιο προφανή τρόπο,
ακόμα και σε ευρωπαϊκό επίπεδο,
την αποτελεσματικότητα και αποδοτικότητα
του μοντέλου του SPRAR στην επίτευξη

των στόχων της κοινωνικής ένταξης
και ενσωμάτωσης.
Το τελευταίο βήμα είναι και το πιο πρόσφατο
και αφορά την τροποποίηση
της ταυτότητας του SPAR, που δεν μπορεί πλέον
να υποδέχεται,
με την έναρξη ισχύος
του νόμου που προανέφερα,
τους αιτούντες άσυλο στα ανθρωπιστικά προγράμματα
γιατί, μεταξύ άλλων, καταργείται η ανθρωπιστική προστασία
και το SPRAR μπορεί να υποδέχεται
αποκλειστικά ανήλικους ασυνόδευτους αλλοδαπούς,
δικαιούχους διεθνούς προστασίας,
που όμως αντιστοιχούν
σε ένα ελάχιστο ποσοστό του συνόλου
των αιτούντων άσυλο,
καθώς και κάποιους νέους τύπους άδειας παραμονής,
τις λεγόμενες ειδικές περιπτώσεις.
Άρα το SPRAR που τώρα μετονομάστηκε
σε SIPROIMI μπορεί πλέον να υποδέχεται
τις ειδικές περιπτώσεις που χρήζουν ιατρικής περίθαλψης,
τα θύματα εμπορίας ανθρώπων,
τα θύματα εργασιακής εκμετάλλευσης,
τα θύματα ενδοοικογενειακής βίας
και φυσικών καταστροφών και όσους διακρίθηκαν
για ιδιαίτερες πράξεις ηρωισμού,
κι όλα αυτά αφορούν αλλοδαπούς
και, φυσικά, όχι Ιταλούς πολίτες,
που έχουν άλλες δομές κοινωνικής προστασίας.
Μπορούμε, λοιπόν, να πούμε ότι το SPRAR
πλέον έχει τον χαρακτήρα
παροχής πρόνοιας προς τους αλλοδαπούς

και δεν είναι πια ένα σύστημα υποδοχής και προστασίας
των ανθρώπων οι οποίοι με κάποιο τρόπο
σχετίζονται με το δικαίωμα ασύλου.
Συνεπώς, αλλάζει ο χαρακτήρας του
κι αυτό θα μπορούσε να είναι θεωρητικά
μια μερικώς θετική εξέλιξη,
αν σκεφτούμε ότι αφορά την προστασία
ανθρώπων που βρίσκονται σε εύθραυστη κατάσταση.
Η δυσκολία αυτή τη στιγμή
έγκειται στο γεγονός
ότι η άδεια παραμονής γίνεται καθοριστική
αλλά αυτό δεν σημαίνει ότι το θύμα εμπορίας ανθρώπων
μπορεί αυτομάτως να αποκτήσει
την άδεια παραμονής ως ειδική περίπτωση
θύματος εμπορίας ανθρώπων.
Το ίδιο ισχύει και για τα θύματα
εργασιακής εκμετάλλευσης και πάει λέγοντας.
Δεν έχουμε σαφή κριτήρια
για το πώς πρέπει να είναι αυτές οι διαδικασίες
και για το πώς θα κατατάξουμε όλους αυτούς τους ανθρώπους
που βρίσκονται σε παρόμοια ευάλωτη κατάσταση
υπό τον ορισμό, νομικό και όχι μόνο,
της ειδικής περίπτωσης.
Μόνο με την τυποποίηση μιας άδειας παραμονής
για ειδική περίπτωση, μπορεί ο ενδιαφερόμενος
να έχει πρόσβαση στο SPRAR
και να επωφεληθεί όλων των υπηρεσιών προστασίας,
κάλυψης και συνοδείας
προς την ένταξη και την ενσωμάτωση
που προβλέπει το SPRAR.
Επιπλέον, δεν έχουν ακόμα προσδιοριστεί
τα κριτήρια και τα προαπαιτούμενα με βάση τα οποία

κάποιος μπορεί να λάβει την άδεια

για ιατροφαρμακευτική περίθαλψη.

Για ποιο τύπο ψυχικού ή σωματικού προβλήματος;

Για ποιο μέγεθος σοβαρότητας;

Για ποιο χρονικό ορίζοντα προβλέπεται αυτή η κάλυψη;

Βρισκόμαστε, λοιπόν,

σε μια πολύ κρίσιμη μεταβατική περίοδο

γιατί πάρα πολλοί άνθρωποι,

οι οποίοι μέχρι πριν από λίγους μήνες

δικαιούνταν πρόσβαση στα προγράμματα του SPRAR,

πλέον δεν τη δικαιούνται.

Αντίστροφα, όλοι όσοι θεωρητικά

φαίνεται ότι μπορούν να έχουν

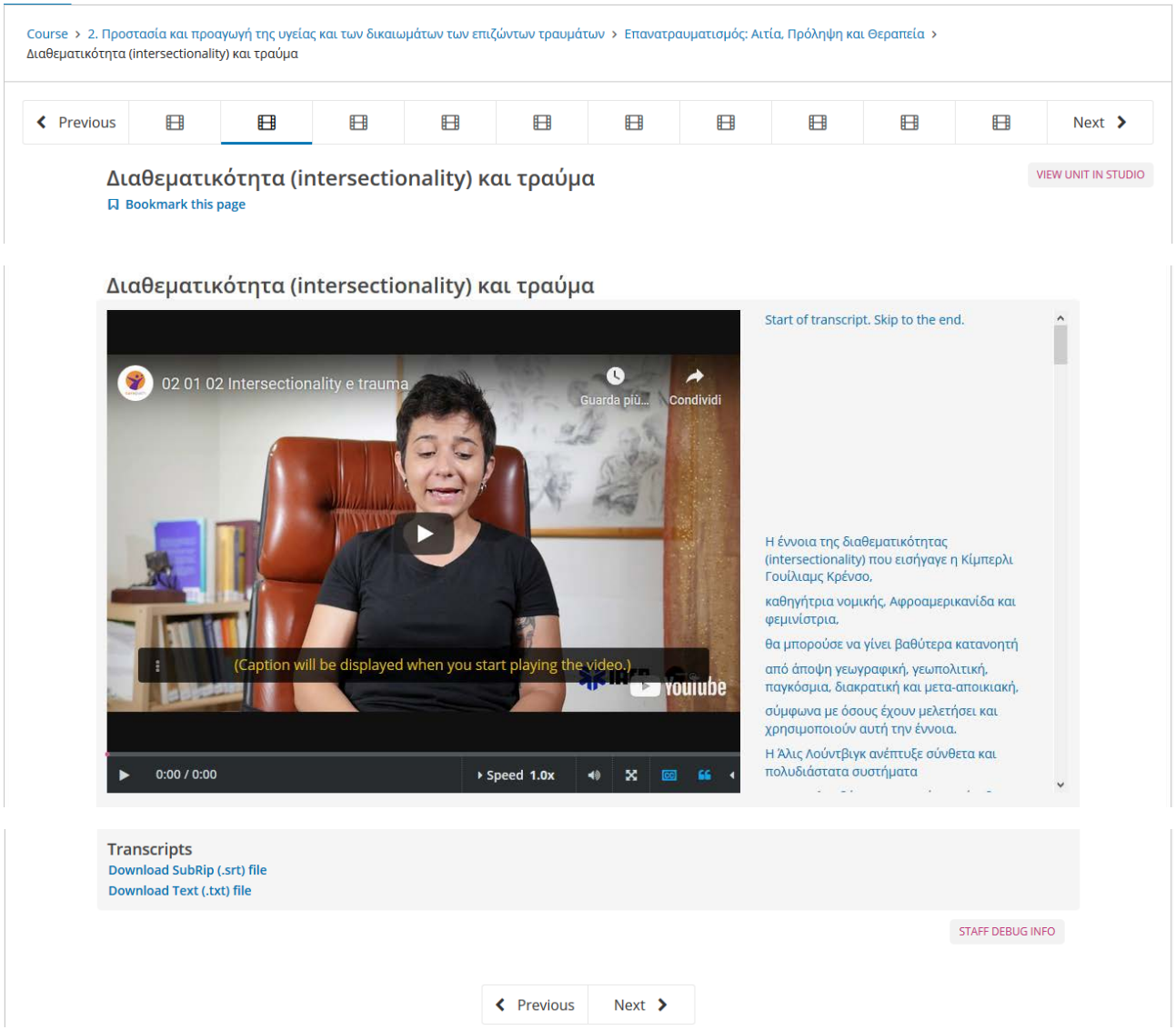
αυτή την πρόσβαση, στην ουσία δεν γνωρίζουν

και ούτε εμείς γνωρίζουμε πώς μπορούμε να τους δώσουμε

τη λεγόμενη "βεβαίωση" με την οποία

ουσιαστικά θα επωφεληθούν

αυτού του δικαιώματος.



Transcript

Η έννοια της διαθεματικότητας (intersectionality) που εισήγαγε η Κίμπερλι Γουίλιαμς Κρένσο,

καθηγήτρια νομικής, Αφροαμερικανίδα και φεμινίστρια,

θα μπορούσε να γίνει βαθύτερα κατανοητή

από άποψη γεωγραφική, γεωπολιτική, παγκόσμια, διακρατική και μετα-αποικιακή,

σύμφωνα με όσους έχουν μελετήσει και χρησιμοποιούν αυτή την έννοια.

Η Άλις Λούντβιγκ ανέπτυξε σύνθετα και πολυδιάστατα συστήματα

που περιλαμβάνουν περαιτέρω επίπεδα διαφοροποίησης,

όπως ίσως το φύλο, η σεξουαλικότητα, η φυλή, το χρώμα του δέρματος, το κράτος, η κοινωνική τάξη, η κουλτούρα

και πάει λέγοντας κι αυτό μας δίνει την έκταση των αναρίθμητων επιπέδων

που πρέπει να λάβουμε υπόψη και να προσέχουμε όταν βρισκόμαστε σε μια σχέση βοήθειας

με πρόσωπα που ανήκουν σε ό,τι κοινώς θεωρούμε ως μειονοτικούς πληθυσμούς.

Για να παραθέσω την Οντρ Λορντ,

θα λέγαμε ότι κανένας αγώνας δεν αφορά μόνο ένα πρόβλημα

γιατί δεν ζούμε ζωές μονοδιάστατες.

Η διεθνικότητα είναι όλο και πιο συχνά ένα στοιχείο ανάπτυξης πολιτικών ισότητας,

είναι μια δυνατότητα,

χάρη στην εργασία των Ηνωμένων Εθνών και της Ευρωπαϊκής Ένωσης, μεταξύ άλλων.

Ας μην ξεχνάμε τις οδηγίες για την καταπολέμηση των διακρίσεων

και όλες τις πρωτοβουλίες σε επίπεδο εθνικό, επαρχιακό και τοπικό

καθώς και τις πολιτικές και τη διαχείριση των διακρίσεων

που υιοθετούνται πλέον σε όλα τα έθνη

της Δύσης,

σε πάρα πολλές εταιρείες.

Προφανώς, αυτό δεν εξαλείφει τις αμφιθυμίες, τα δεινά και τις σιωπές

όσων βιώνουν πολλαπλές καταστάσεις μειονότητας,

έχοντας ίσως ήδη βιώσει τραυματικές καταστάσεις λόγω της μειονοτικής τους ιδιότητας.

Στο έντυπο "Fatto Quotidiano" της 17ης Μαΐου 2018

αναφέρεται μία φράση ενός παιδιού από το Καμερούν.

"Μια μέρα που βλέπαμε στην κουζίνα μια τηλεοπτική εκπομπή για τους ΛΟΑΤΚΙ μετανάστες,

οι Αφρικανοί συμπατριώτες μου άρχισαν να λένε

ότι η Ιταλία είναι μια άθλια χώρα γεμάτη ομοφυλόφιλους

και για άλλη μια φορά ένιωσα ότι δεν ήμουνα ελεύθερος".

Ο Άλεν είναι 22 ετών και δραπέτευσε από κάποιον που τον χτυπούσε και τον αποκαλούσε "δαίμονα",

αφήνοντας πίσω του το Καμερούν,

οπως αναφέρει η εφημερίδα,

όπου η ομοφυλοφιλία συνιστά αδίκημα,

για να ζητήσει στην Ιταλία διεθνή προστασία,

αλλά ο φόβος παρέμεινε για πολύ καιρό αμείωτος

γιατί η ομοφοβία τον ακολούθησε ως το κέντρο υποδοχής της Οδού Ματέα στη Μπολόνια

όπου φιλοξενήθηκε μαζί με τους ομοεθνείς του.

Οι μετανάστες ΛΟΑΤΚΙ, πολύ συχνά, είναι πολύ νεαρής ηλικίας,

δεν μπορούν να βασίζονται

στην υποστήριξη της κοινότητας καταγωγής τους,

με την οποία τυχαίνει να μεταναστεύουν
αλλά συχνά τη χαρακτηρίζει η ίδια ομοφοβία και τρανσφοβία από την οποία δραπέτευσαν.
Δεν μπορούν καν να είναι βέβαιοι ότι θα συναντήσουν μια πολυπολιτισμική πραγματικότητα
όπου θα βιώσουν με ηρεμία τον σεξουαλικό προσανατολισμό ή την ταυτότητά τους.
Όπως υπογραμμίζεται σε πολλές περιπτώσεις συνεντεύξεων στον Βιντσέντσο Μπραμάτο,
πρόεδρο του συλλόγου "Arcigay" της Μπολόνια,
σε μερικές ευρωπαϊκές χώρες, όπως η Γερμανία,
υπάρχουν προστατευμένες δομές υποδοχής διωκόμενων λόγω του σεξουαλικού τους προσανατολισμού,
όπου το προσωπικό έχει λάβει συγκεκριμένη κατάρτιση
με στόχο να μην αναπαράγει επικριτικές ή υποτιμητικές συμπεριφορές που θα αναβίωναν
το στίγμα και το τραύμα αυτών των προσώπων.
Στην Ιταλία, προς το παρόν, ο τρόπος υποδοχής δεν προβλέπει τέτοιες εξειδικεύσεις,
αλλά υπάρχουν θετικές πρωτοβουλίες, όπως το πιλοτικό πρόγραμμα,
που ξεκίνησε το 2017 στη Μόντενα, με ένα μικρό εξαθέσιο διαμέρισμα
μόνο για τους ΛΟΑΤΚΙ αιτούντες άσυλο,
καθώς και ένα γκισέ εξυπηρέτησης μόνο για ΛΟΑΤΚΙ μετανάστες στη Βερόνα.
Για αυτούς τους νεαρούς
μετανάστες
σε μία εξελικτική ηλικία
που ανήκουν στην κοινότητα ΛΟΑΤΚΙ
το ότι ανήκουν σε μία εθνική μειονότητα κάποιας χώρας που τους φιλοξενεί
είναι μόνο ένα μέρος του προβλήματος.
Πράγματι, πολύ συχνά πρόκειται για μία σιωπηλή και τρομαγμένη μειονότητα,
ακόμα και στο πλαίσιο της δικής τους κοινότητας αναφοράς.
Ένα τραύμα αορατότητας, όπως λέει ο Ρότζερς,
διπλασιασμένο,
ένα άγχος μειονότητας, "minority stress" κατά τον Βιτόριο Λιντζιάρντι,
που αφορά μια ασυμβατότητα, κατά τον Ρότζερς, επίσης διπλασιασμένη.
Άρα διπλασιάζεται και ο κίνδυνος για την ψυχοσωματική υγεία αυτών των ανθρώπων
και συνεπώς έχουμε μια ανεκτίμητη απώλεια ανθρώπινου κεφαλαίου.
Κατάρτιση στην υποδοχή σημαίνει κατάρτιση σχετικά με τα ανθρώπινα δικαιώματα
και τις ιδιαιτερότητες

που κομίζει ο μετανάστης ΛΟΑΤΚΙ

στη σχέση βοήθειας.

Η κατάρτιση πρέπει, λοιπόν, να επικεντρώνεται στο πρόσωπο,

να γνωρίζει και να αποδέχεται αυτές τις ιδιαιτερότητες, αν θέλουμε να μιλάμε για πραγματική ένταξη.

Επιπλέον, όταν οι υπηρεσίες προς τους μετανάστες

σχεδιάζονται και παρέχονται χωρίς να λαμβάνεται υπόψη

ο παράγοντας του σεξουαλικού προσανατολισμού και της ταυτότητας φύλου,

ενίοτε είναι μειωμένης αποτελεσματικότητας

τόσο σε ό,τι αφορά τη σχέση με τον θεραπευόμενο,

δηλαδή, οι νέοι αυτοί δεν μπορούν

να λάβουν την αποδοχή που θα μπορούσαν να έχουν,

όσο και σε ό,τι αφορά τη χρησιμότητα των διαδικασιών κατάρτισης ή πρόληψης.

Αναφέρουμε ενδεικτικά τα σεξουαλικά μεταδιδόμενα νοσήματα

και πόσο πολυδιάστατη πρέπει να είναι

η κατάρτιση και σε αυτό το σκέλος

όταν έχουμε έναν έφηβο μετανάστη που ανήκει στη ΛΟΑΤΚΙ κοινότητα.

Από την άλλη, οι υπηρεσίες που παρέχονται από την κοινότητα ΛΟΑΤΚΙ

συνδέονται στενά με ένα δυτικό μοντέλο του γκέι άνδρα και της λεσβίας γυναίκας

και πολύ συχνά αυτά τα μοντέλα δεν λαμβάνουν υπόψη

ένα μοντέλο με το οποίο τα παιδιά αυτά, προερχόμενα από άλλες κουλτούρες,

μπορούν όντως να ταυτιστούν.

Η εμπειρία των προαναφερθέντων πραγματικοτήτων

έχει αποδείξει ότι οι υπηρεσίες

υποστήριξης και συμβουλευτικής που παρέχουν τα ιδρύματα αλλά και οι οργανισμοί

ενδέχεται να μην είναι αποτελεσματικές για αυτά τα παιδιά.

Ως εκ τούτου,

η εργασία με αυτές τις πολλαπλώς μειονοτικές ομάδες

θα απαιτήσει μία διεπιστημονική προσέγγιση

σχετικά με τις πρακτικές των σχέσεων βοήθειας. Στη σχέση με αυτά τα άτομα είναι απαραίτητη

η εμβάθυνση στις διαστάσεις της ομοφυλοφιλίας, της αμφιφυλοφιλίας και της τρανσεξουαλικότητας

στην ιστορία της ψυχιατρικής και της ψυχολογίας,

στην έννοια του στιγματισμού,

της ομοφοβίας, της εσωτερικευμένης ομοφοβίας

και όλα αυτά σε συνδυασμό με διαρκή ενημέρωση των θεραπευτών

σχετικά με τη νομοθεσία

επί αυτών των θεμάτων,

τόσο στις χώρες υποδοχής όσο και στις χώρες προέλευσης όσων χρήζουν υποδοχής.

Επιπλέον, είναι απαραίτητη

η διαρκής εμβάθυνση και γνώση, λόγω της συνεχούς εξέλιξης και τροποίησης,

όλων όσα αφορούν τη νομοθεσία

που συνδέεται με το άσυλο.

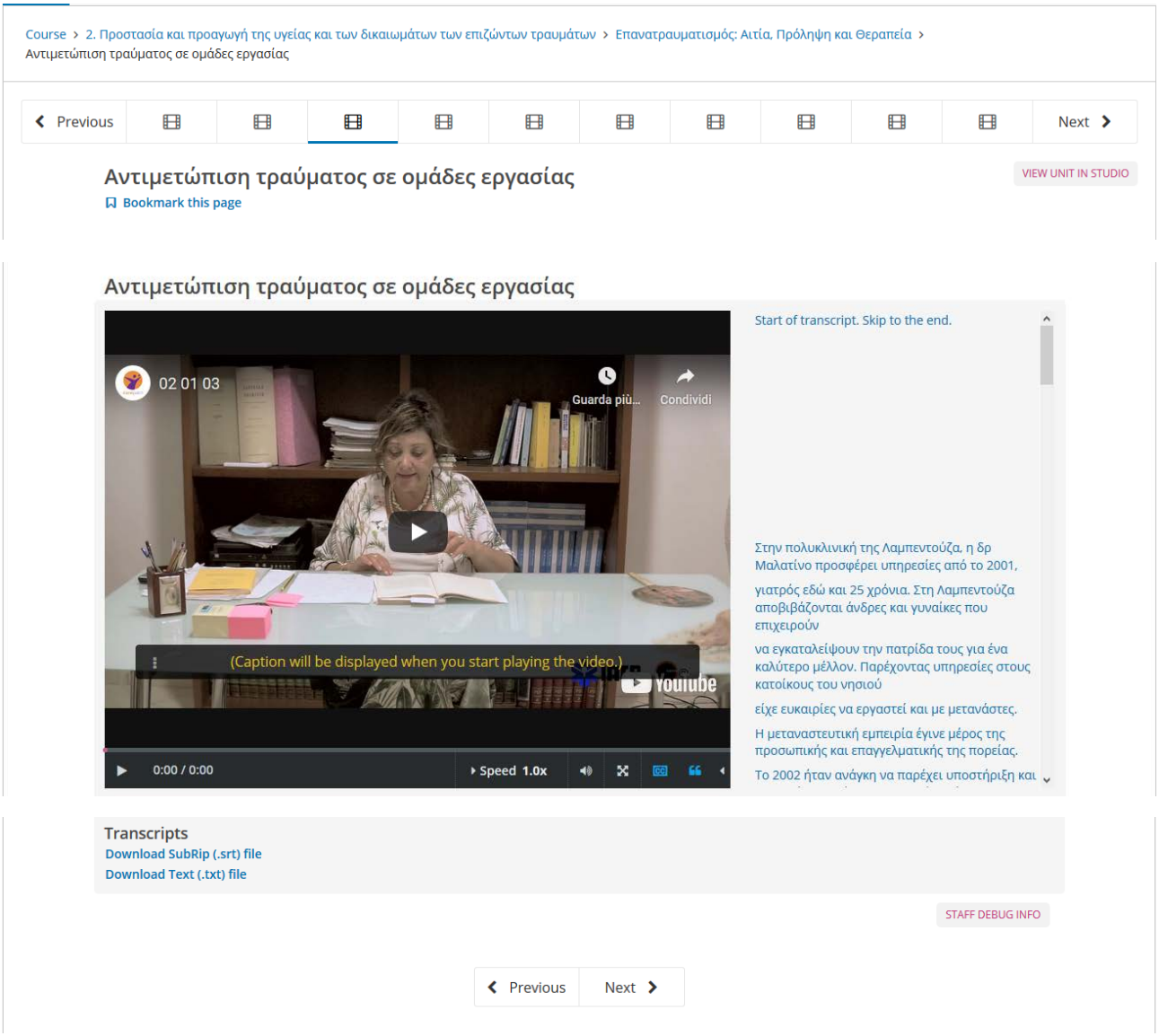
Σε συνεργασία με τεχνικούς εμπειρογνώμονες,

είναι ανάγκη να αναπτύξουμε και να παγιώσουμε, από μια άποψη πιο προσωπική,

μία προσέγγιση με ευαισθησία στο εκάστοτε φύλο

και να διατηρήσουμε ζωντανό μέσα μας και στην ομάδα εργασίας που υποδέχεταιτους εν λόγω νέους

τον στοχασμό για τα ανθρώπινα δικαιώματα ως μια σύμβαση της δυτικής κουλτούρας.



Transcript

Στην πολυκλινική της Λαμπεντούζα, η δρ Μαλατίνο προσφέρει υπηρεσίες από το 2001,

γιατρός εδώ και 25 χρόνια. Στη Λαμπεντούζα αποβιβάζονται άνδρες και γυναίκες που επιχειρούν

να εγκαταλείψουν την πατρίδα τους για ένα καλύτερο μέλλον. Παρέχοντας υπηρεσίες στους κατοίκους του νησιού

είχε ευκαιρίες να εργαστεί και με μετανάστες.

Η μεταναστευτική εμπειρία έγινε μέρος της προσωπικής και επαγγελματικής της πορείας.

Το 2002 ήταν ανάγκη να παρέχει υποστήριξη και θεραπεία στο κέντρο υποδοχής ατόμων

τα οποία, καταλήγοντας στο νησί μετά από ταξίδια πολύ δύσκολα, μακρόχρονα και επικίνδυνα

έως θανάτου, χρειάζονταν φάρμακα και η υπεύθυνη της δομής ζήτησε

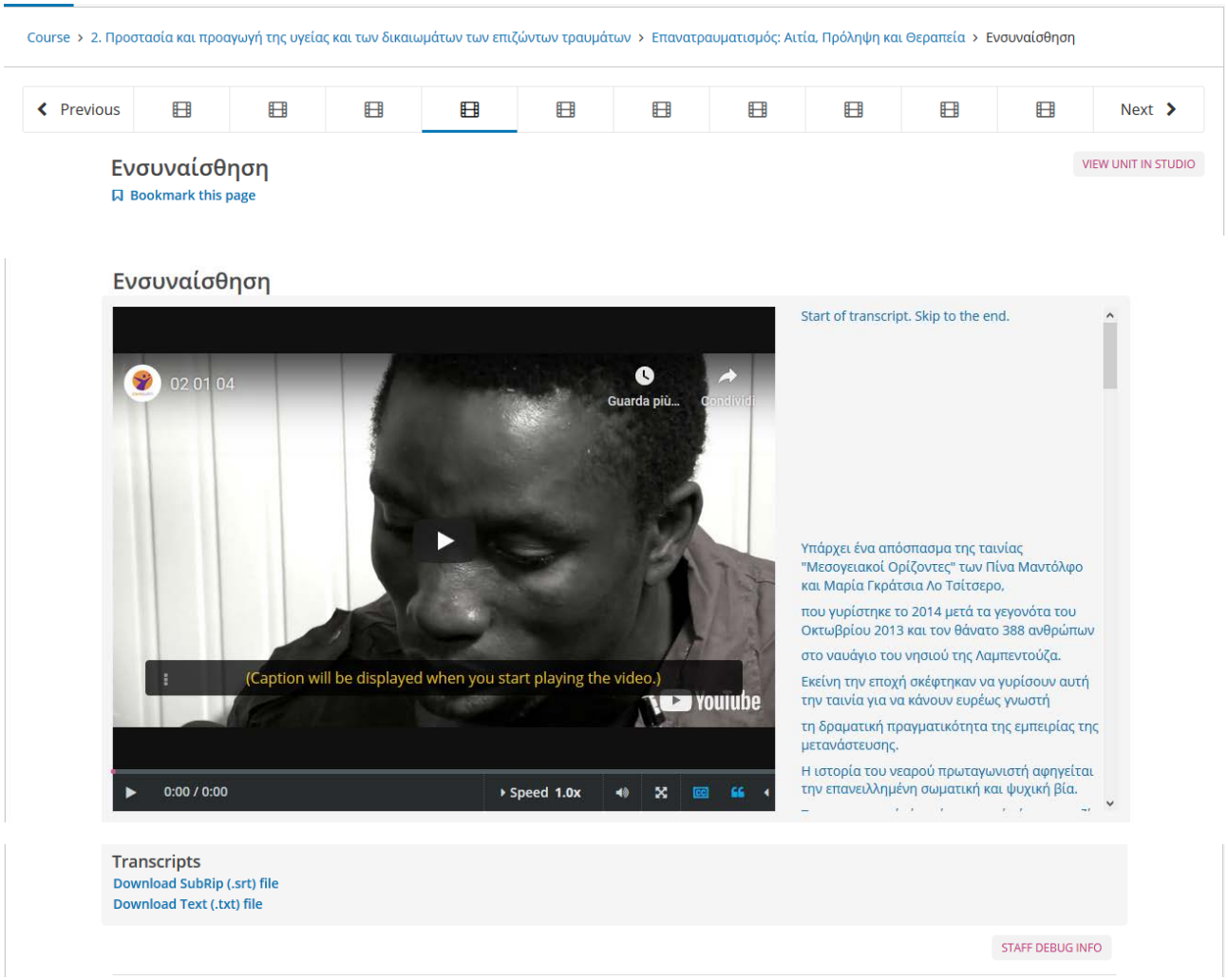
μία ψυχιατρική εκτίμηση των ατόμων που αποβιβάζονταν στο νησί.

Αποδείχτηκε σχεδόν αδύνατο να εκτιμηθεί η ψυχιατρική υγεία ατόμων που έχουν εκτεθεί

και υποβληθεί σε τόσο σοβαρά τραυματικά γεγονότα κι επειδή είχαν διαφορετική κουλτούρα

δεν ζητούσαν βοήθεια ή φαρμακολογική υποστήριξη, καθώς προέρχονταν από περιβάλλοντα
όπου δεν θεωρείται συμβατική η δυτική ιατρική. Εκείνο που στήριζε και βοηθούσε περισσότερο
αυτά τα άτομα σε ορισμένες περιπτώσεις ήταν η προσφυγή σε τελετουργίες μαγικές
ή πολύ σχετικές με την προληπτική μαγική νοοτροπία που κόμιζαν πολλοί από αυτούς.
Η υποδοχή ατόμων τόσο ταλαιπωρημένων ήταν ιδιαίτερη πολύπλοκη όπως και η παροχή
βοήθειας και υποστήριξης. Έτσι, προτάθηκε η οργάνωση ομάδων ακρόασης.
Ήταν μια εξαιρετική εμπειρία για μία ψυχοθεραπεύτρια και ψυχίατρο της μεθόδου του Ρότζερς
που ως εκείνη τη στιγμή συντόνιζε ομάδες ακρόασης σύμφωνα με το μοντέλο του Καρλ Ρότζερς.
Σε αυτές τις ομάδες οι συμμετέχοντες κάθονται σχηματίζοντας κύκλο
και ακούν αμοιβαία, ενώ το βασικό στοιχείο είναι η πλήρης απουσία κριτικής
και ο απόλυτος σεβασμός οποιουδήποτε θέματος θελήσει να πραγματευτεί η ομάδα.
Έτσι, δημιουργείται ένα κλίμα εκμυστηρεύσεων που διευκολύνει πολύ την εμπιστοσύνη και βοηθά
τους συμμετέχοντες, ακόμα και σε ιδιαίτερα προβληματικές συναισθηματικές καταστάσεις, ώστε να επανεπεξεργαστούν
την εμπειρία τους και παράλληλα να βρουν μια μορφή αλληλεγγύης, διαπιστώνοντας πως ό,τι βίωσαν προσωπικά
δεν είναι αναγκαστικά κάτι ατομικό αλλά το βιώνουν και το κατανοούν και άλλα άτομα.
Αυτό και μόνο ευνοεί την ανάλυση, ενίοτε, της δυστυχίας, της σύγκρουσης
ή του επώδυνου γεγονότος. Αυτό ακριβώς συνέβη σε αυτές τις ομάδες.
Ένα στοιχείο σημαντικό και θεμελιώδες ήταν η επίτευξη ισορροπίας με τον πολιτιστικό διαμεσολαβητή,
τον διερμηνέα, γιατί ο θεραπευτής δεν μιλούσε τη γλώσσα των υποκειμένων και οι βασικές συνθήκες
στις οποίες μπορούσαν να δουλέψουν ήταν απολύτως απαγορευτικές λόγω έλλειψης υλικών,
δεν υπήρχαν καρέκλες, ή λόγω απρόβλεπτων καταστάσεων, κάποιες ομάδες είχαν μόλις διασωθεί από ναυάγιο
και μερικοί φορούσαν μόνο κουβέρτες διάσωσης.
Παρά την αλλόκοτη αυτή κατάσταση, όλως περιέργως, διαπιστώθηκε ότι η βαθύτερη αξία
δεν αφορά μόνο τη μορφή αλλά την ουσία. Απέναντι σε ανθρώπους που κόμιζαν
τη δική τους ιστορία
μετά από τρομερά και ατελείωτα ταξίδια, στην έρημο, στη Λιβύη ή με κίνδυνο πνιγμού, οι εμπειρίες
που αφηγήθηκαν ήταν εξαιρετικά τραυματικές ακόμα και για τον θεραπευτή που άκουγε τις ιστορίες,
ο οποίος δυσκολευόταν να βγει από αυτή την κατάσταση δυστυχίας και πόνου
που είχε γίνει εμπειρία και του θεραπευτή. Ανακαλούσε στον θεραπευτή
ένα γεγονός, που είχε ξεχάσει, από την παιδική του ηλικία,

όταν είχε φύγει μία θεία προκαλώντας τόσο πόνο ώστε να φτάσει να απωθήσει αυτή την ανάμνηση.
Υπό το πρίσμα όλων αυτών, όταν υποδεχόμαστε κάποιον
που έχει ζήσει ένα παρόμοιο δράμα, είναι θεμελιώδες να προσπαθούμε πάντα να δίνουμε
το στοιχείο της ακρόασης, που είναι βασικό για να μπορέσει κανείς να ανοιχτεί και να εκφράσει
τα βιώματά του. Επίσης, είναι αναγκαία η ύπαρξη βαθιάς αποδοχής για το πρόσωπο
και η απουσία κριτικής γιατί έτσι ευνοείται η εμπιστοσύνη. Επίσης, είναι σημαντική
η ενσυναίσθηση, που είναι βάλσαμο ψυχής, η αίσθηση ότι ο άλλος έρχεται στη θέση σου
και ακούει σε βάθος σαν να ένιωθε κι εκείνος όλο σου τον πόνο.
Αυτές είναι οι τρεις βασικές προϋποθέσεις κατά Καρλ Ρότζερς για να εργαστούμε με ομάδες
αλλά και στις σχέσεις βοήθειας της ψυχοθεραπείας. Κλείνοντας αυτή την ανάλυση σχετικά με την αξία
των ομάδων τύπου Ρότζερς για την επανεπεξεργασία του τραύματος με μετανάστες, θα επιμείνω
σε ένα ενδιαφέρον στοιχείο: κανένας δεν χρειάστηκε να λάβει φαρμακευτική αγωγή
μετά τη συμμετοχή του στις ομάδες ακρόασης. Ιδιαίτερα βοηθητική είναι η φυσική διάσταση
της ομάδας σε κυκλική διάταξη. Η κυκλικότητα ίσως να αναπαρήγαγε
μέρος των εμπειριών που βιώνουν οι θεραπευόμενοι στις χώρες τους,
όπως στην Ερυθραία, όπου είθισται οι ηλικιωμένοι και οι άνδρες του χωριού να συγκεντρώνονται
κυκλικά γύρω από ένα μεγάλο δέντρο, το λεγόμενο "δέντρο των λέξεων".
Σε αυτή τη συνάντηση, μέσα από τις λέξεις, αποκαταστάθηκε ο ιστός
σε ένα υφάδι που είχε σχιστεί.



Transcript

Υπάρχει ένα απόσπασμα της ταινίας "Μεσογειακοί Ορίζοντες" των Πίνα Μαντόλφο και Μαρία Γκράτσια Λο Τσίτσερο,

που γυρίστηκε το 2014 μετά τα γεγονότα του Οκτωβρίου 2013 και τον θάνατο 388 ανθρώπων

στο ναυάγιο του νησιού της Λαμπεντούζα.

Εκείνη την εποχή σκέφτηκαν να γυρίσουν αυτή την ταινία για να κάνουν ευρέως γνωστή

τη δραματική πραγματικότητα της εμπειρίας της μετανάστευσης.

Η ιστορία του νεαρού πρωταγωνιστή αφηγείται την επανειλλημένη σωματική και ψυχική βία.

Το εντυπωσιακό είναι ότι ο νεαρός έφτασε μαζί με την αδελφή του,

που επίσης υπέστη βία και βιασμό αλλά δεν είχε μιλήσει ποτέ στον αδελφό της

για αυτή την εμπειρία, όπως κι εκείνος είχε βιαστεί και δεν είχε ποτέ μιλήσει για αυτό

στην αδελφή του.

Παρατηρήσαμε ότι ο ίδιος ντρεπόταν πολύ να μιλήσει για αυτή την εμπειρία

για αυτό και ζήτησε να μην είναι παρούσα η αδελφή του, γιατί δεν ήθελε να γνωρίζει εκείνη,

αλλά, όπως ομολόγησε αργότερα, και επειδή ντρεπόταν που ήταν άντρας

και είχε υποστεί τέτοιου είδους βία.

Επισημαίνουμε ότι αυτός ο νεαρός ήταν μόλις 16 ετών.

Στη μαρτυρία του νεαρού ακούμε τι συνέβη κατά τη διάρκεια του ταξιδιού του.

Ο μοναδικός τρόπος για να μη διακοπεί η συναισθηματική του ροή

ήταν να τον ακούμε χωρίς να διακόπτουμε ποτέ την αφήγηση.

Σε ελάχιστες περιπτώσεις, με τρόπο εικονικό, ένα νεύμα του κεφαλιού ή ένα βλέμμα συμφωνίας

πιο βαθύ τον βοηθούσε να μπορέσει να συνεχίσει να μιλάει

για την προσωπική του ιστορία.

Παρατηρούμε, λοιπόν, ότι η ενσυναίσθηση δηλώνεται

όχι τόσο λεκτικά αλλά με εικόνα, δηλαδή, με οπτική επαφή, νεύματα, κλίση του σώματος

προς το μέρος του.

Αυτό ήταν αναγκαίο για να τον βοηθήσουμε να μιλήσει

χωρίς να τον αγγίζουμε ποτέ γιατί το άγγιγμα το θεωρούσε πηγή ντροπής, σαν ένα μωρό ανίκανο

να διερευνήσει μία δύσκολη ιστορία και να την υποστηρίξει. Ήταν μικρότερος

από την αδελφή του αλλά θεωρούσε ότι έπρεπε να υποστηρίξει και να ενθαρρύνει την αδελφή του.

Κι εδώ παρατηρούμε πώς η λεπτότητα, η διακριτικότητα, η ενσυναίσθηση και η ακρόαση ευνοούν

σε βάθος το άνοιγμα στις σχέσεις επείγοντος χαρακτήρα.

Το βίντεο αφορά την εμπειρία

ακρόασης δύο ιστοριών: μιας κοπέλας

ή ενός νεαρού, που είναι αδέλφια.

Αυτά τα δύο αδέλφια ξεκίνησαν από την Ερυθραία,

αποβιβάστηκαν στη Λαμπεντούζα το 2014 και μεταφέρθηκαν στο κέντρο υποδοχής του Μίνεο

όπου και παρέμειναν για να λάβουν την άδεια παραμονής,

αλλά όταν επιχειρήθηκε η συνέντευξή τους για να δώσουν τη μαρτυρία τους

σχετικά με τις εμπειρίες και τις ιστορίες τους, έγινε αντιληπτό, με βάση αυτό το είδος αφήγησης,

ότι έπρεπε η ακρόαση να είναι πολύ προσεκτική και με λεπτότητα γιατί αυτά τα δύο παιδιά

είχαν υποστεί βασανιστήρια και περιστατικά βίας πολύ έντονα και δραματικά.

Ο καθένας τους είχε ζητήσει να μιλήσει χωρίς την παρουσία του άλλου.

Η ιστορία της κοπέλας αφορά την εμπειρία του ταξιδιού που έκανε για να δώσει τη δυνατότητα

στον αδελφό της να αποφύγει την υποχρεωτική στρατιωτική θητεία στα 16 του χρόνια.

Στην αφήγησή της γίνεται κατανοητό ότι λέει κάτι θεμελιώδες: "δεν μπορώ να ξεχάσω,

δεν βρίσκω τη δύναμη να μιλήσω". Πρόκειται για λέξεις - κλειδιά και τότε η ακρόαση

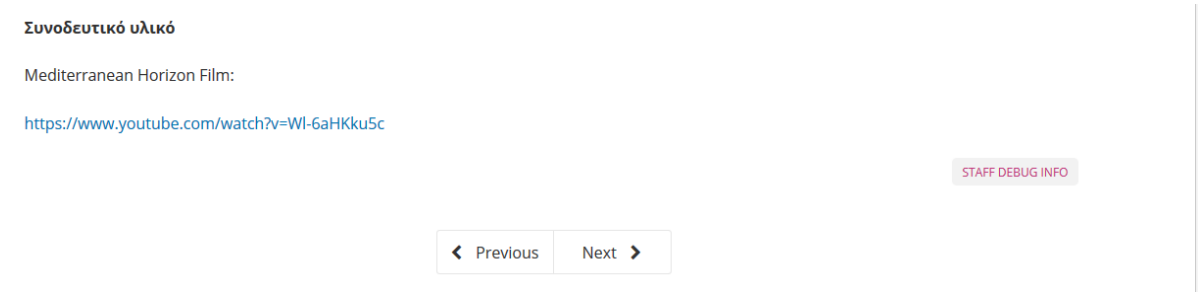
συνοδεύτηκε από την επαφή των χεριών του θεραπευτή και της κοπέλας.

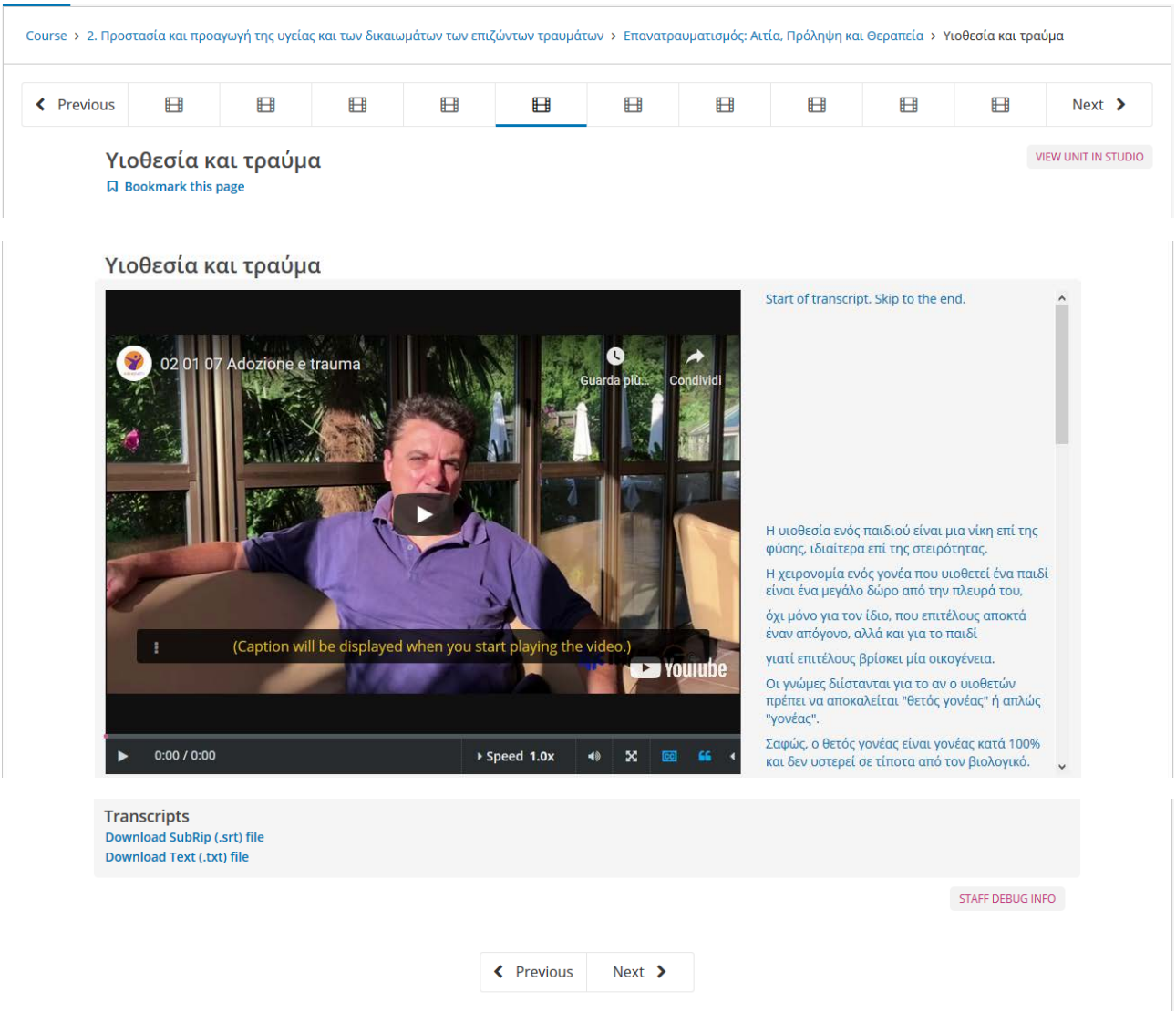
Η δουλειά με σωματική επαφή σε τέτοιες εμπειρίες είναι δύσκολη. Μάλλον είναι προτιμότερο να μην αγγίζουμε τα πρόσωπα που έχουν υποστεί τραύμα και σωματική βία. Στη συγκεκριμένη περίπτωση συνειδητοποιήσαμε ότι η κοπέλα είχε ανάγκη από υποστήριξη σε βάθος για να μπορέσει να αφηγηθεί αυτή την ιστορία κι έτσι ο θεραπευτής ρώτησε αν μπορούσε να της κρατήσει τα χέρια. Το γεγονός ότι τη ρώτησε και δεν το έπραξε παρά τη θέλησή της έκανε πιο πιθανή την περίπτωση να δώσει τη συγκατάθεσή της.

Με αυτή την επαφή δημιουργήθηκε ένα κανάλι ισχυρής και δυνατής ενέργειας όποτε η κοπέλα έπρεπε να μιλήσει για πολύ τραυματικές και επώδυνες πτυχές και είχε την τάση να σταματάει. Έτσι, ο θεραπευτής της έσφιγγε τα χέρια προκαλώντας τη συνέχιση της ενεργειακής ροής, απαραίτητης για να συνεχίσει την ιστορία της.

Κλείνοντας την περιγραφή αυτής της εμπειρίας μπορώ να διαβεβαιώσω ότι η αφήγηση κάποιου, που έχει υποστεί τραύματα, δεν μπορεί ποτέ να αντιμετωπίζεται με απαξίωση ή αγανάκτηση ή τάση υπερβολής. Το θεμελιώδες είναι η ακρόαση της ιστορίας, όπως ακριβώς την αφηγείται, ακούγοντας με μεγάλη ευαισθησία και κυρίως με ενσυναίσθηση και αναγνώριση του πόνου του άλλου.

Αυτό ήταν το θεμελιώδες στοιχείο που επέτρεψε την πρόσβαση σε μια συναισθηματική έκφραση ακόμα πιο έντονη και βαθιά από την ίδια την αφηγούμενη ιστορία.





Transcript

Η υιοθεσία ενός παιδιού είναι μια νίκη επί της φύσης, ιδιαίτερα επί της στειρότητας.

Η χειρονομία ενός γονέα που υιοθετεί ένα παιδί είναι ένα μεγάλο δώρο από την πλευρά του,

όχι μόνο για τον ίδιο, που επιτέλους αποκτά έναν απόγονο, αλλά και για το παιδί

γιατί επιτέλους βρίσκει μία οικογένεια.

Οι γνώμες διίστανται για το αν ο υιοθετών πρέπει να αποκαλείται "θετός γονέας" ή απλώς "γονέας".

Σαφώς, ο θετός γονέας είναι γονέας κατά 100% και δεν υστερεί σε τίποτα από τον βιολογικό.

Αυτό αποδεικνύεται από τις έρευνες αλλά και από τη σχέση που δημιουργείται

μεταξύ παιδιού και γονέα.

Η υιοθεσία ενός παιδιού περιλαμβάνει περισσότερα από ό,τι η σχέση με ένα βιολογικό παιδί.

Για έναν θετό γονέα κάθε φορά που τον αποκαλούν "μπαμπά" είναι μια έκπληξη,

ενώ για τον βιολογικό πατέρα ίσως αυτό να είναι κάτι δεδομένο.

Αυτό σημαίνει ότι ίσως η θετή γονεϊκότητα να είναι πιο έντονη

από ό,τι μπορεί να είναι η βιολογική.

Ωστόσο, αυτό σημαίνει επίσης ότι πρέπει ο γονέας να είναι προσεκτικός: το υιοθετημένο παιδί

έχει το δικαίωμα να είναι ευτυχισμένο. Για να συμβεί αυτό πρέπει να ληφθεί υπόψη

ποια είναι η ιστορία του, που δεν μπορούμε πάντα να γνωρίζουμε γιατί κανείς δεν μας τη διηγείται

και το ίδιο το παιδί δεν τη θυμάται.

Ωστόσο, πρέπει να λαμβάνουμε υπόψη, με ευαισθησία, τα προβλήματα που ενδέχεται

να "κουβαλάει" μαζί του το παιδί.

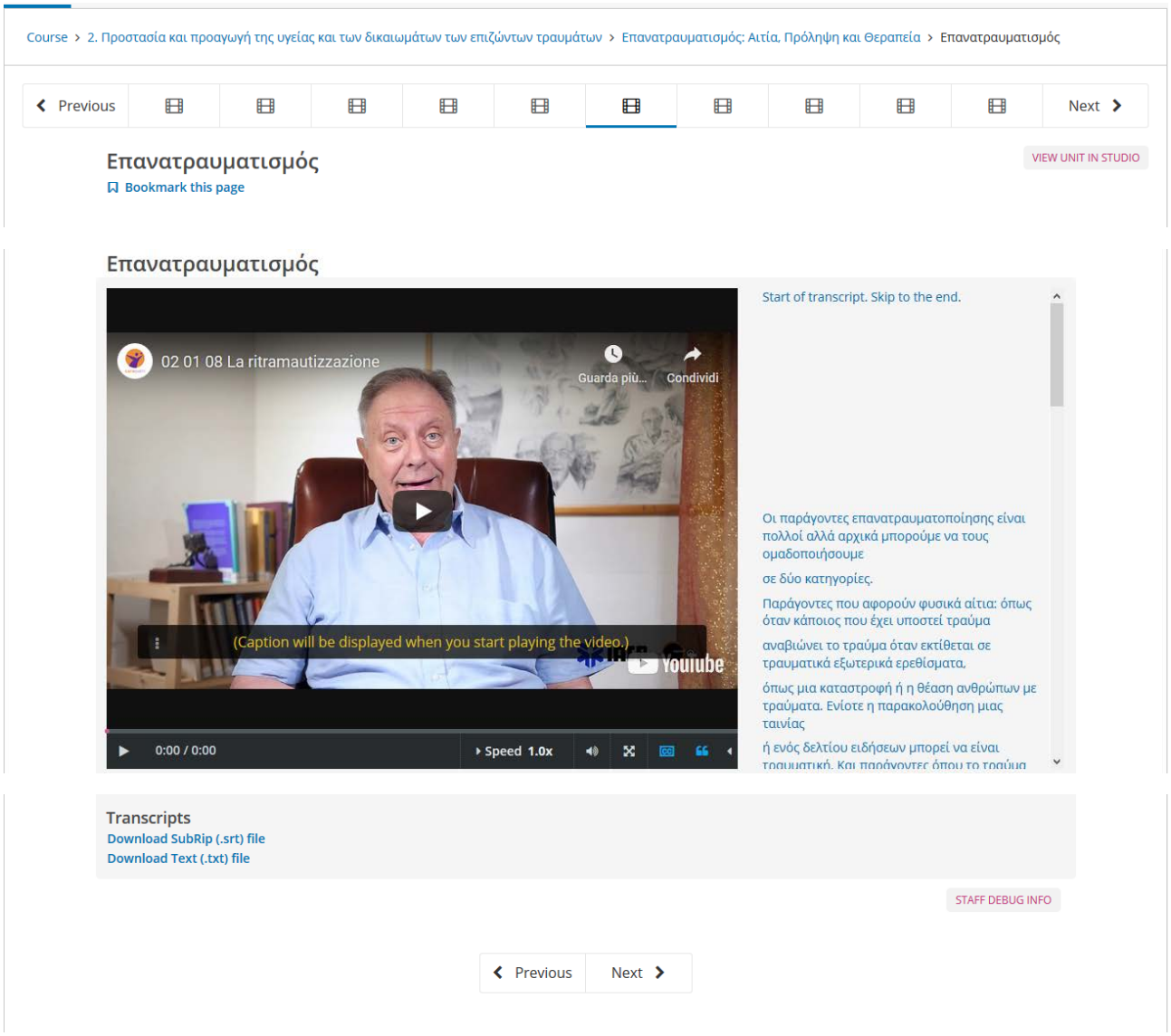
Ο υιοθετημένος, αρχικά ως παιδί κι έπειτα ως ενήλικας, συχνά αντιμετωπίζει υπαρξιακά θέματα.

"Ποια είναι η καταγωγή μου;"

"Γιατί με εγκατέλειψαν;"

Εξηγήσεις δεν μπορούν να δοθούν για τα παραπάνω αλλά αυτό δεν αποκλείει το γεγονός ότι η ζωή είναι ωραία

και ότι όλοι πρέπει να προσπαθούμε να ζούμε όσο το δυνατό καλύτερα.



Transcript

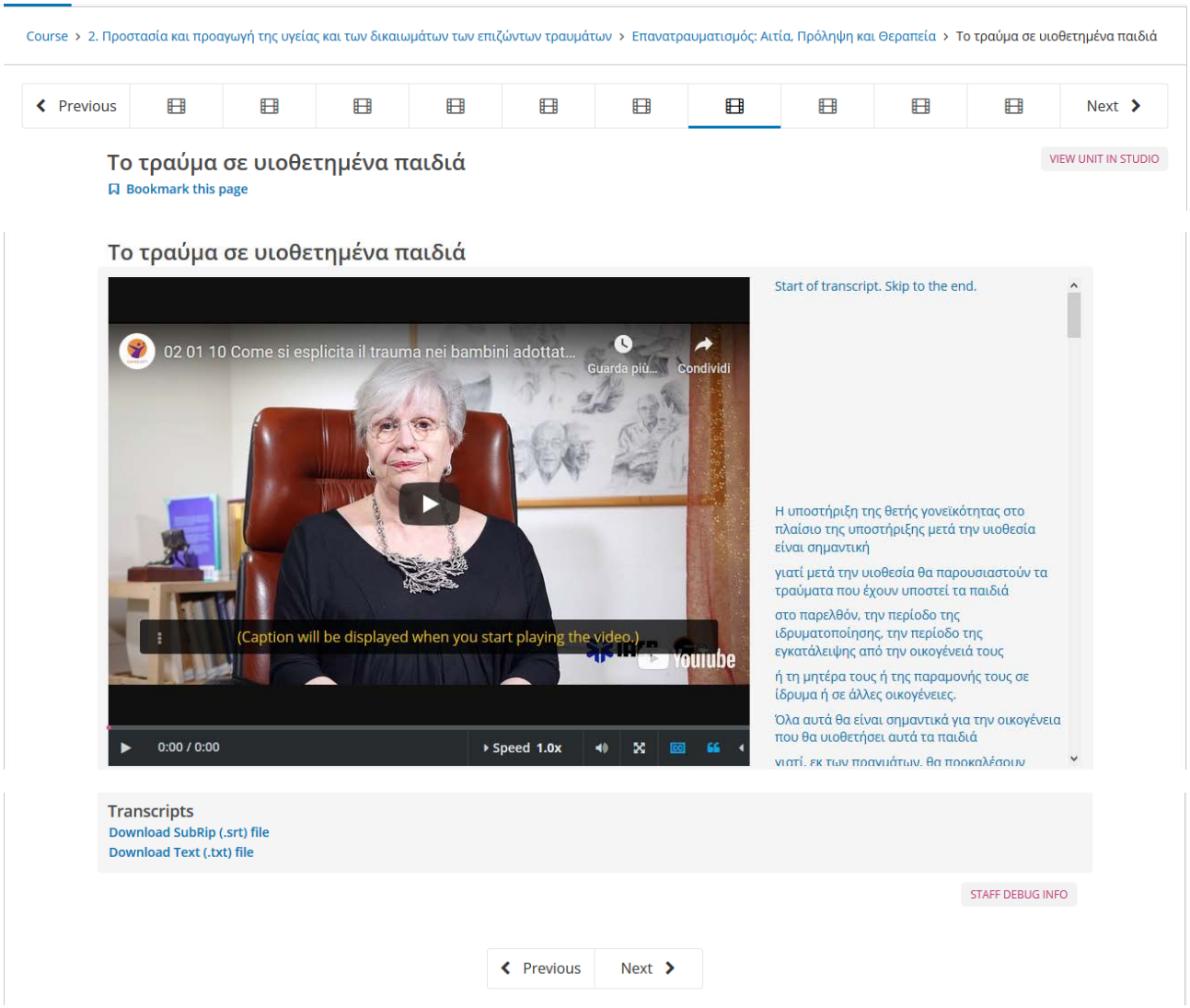
Οι παράγοντες επανατραυματοποίησης είναι πολλοί αλλά αρχικά μπορούμε να τους ομαδοποιήσουμε σε δύο κατηγορίες.

Παράγοντες που αφορούν φυσικά αίτια: όπως όταν κάποιος που έχει υποστεί τραύμα αναβιώνει το τραύμα όταν εκτίθεται σε τραυματικά εξωτερικά ερεθίσματα,

όπως μια καταστροφή ή η θέαση ανθρώπων με τραύματα. Ενίοτε η παρακολούθηση μιας ταινίας ή ενός δελτίου ειδήσεων μπορεί να είναι τραυματική. Και παράγοντες όπου το τραύμα βιώνεται από κάποιον που έχει ήδη υποστεί τραύμα γιατί του παρέχονται υπηρεσίες και θεραπείες από ανειδίκευτα άτομα ή οργανισμούς μη σχετικούς με το τραύμα που, χωρίς να το θέλουν, προκαλούν βλάβες επανατραυματοποιώντας το άτομο.

Όντως, με τον όρο "trauma inform" εννοούνται όλες οι προφυλάξεις και διαδικασίες που υιοθετεί ένας θεραπευτής ή ένας οργανισμός για να αποτρέψει την επανατραυματοποίηση των θεραπευομένων.

Στο παρελθόν, δυστυχώς, έχουμε προκαλέσει τραύματα σε όσους έχουν ήδη υποστεί τραύμα
όχι από κακή πρόθεση αλλά από άγνοια.
Χάρη στις έρευνες και τα κλινικά στοιχεία έχει παρατηρηθεί ότι αυτά τα άτομα,
αν πιέζονταν να κάνουν πράγματα που δεν ήθελαν, αν δεν γίνονταν σεβαστοί οι χρόνοι τους,
αν εξαναγκάζονταν να θυμηθούν τις τραυματικές εμπειρίες τους, προφανώς με καλό σκοπό,
τελείως ασυναίσθητα, υφίσταντο ιατρογενείς βλάβες.
Για αυτό, με τον όρο "trauma inform" εννοούμε σήμερα όλα τα προληπτικά μέτρα,
το δίκτυο ασφαλείας που αναπτύσσεται μέσω των ερευνών, που μας απέδειξαν ότι είναι πολύ σημαντικό,
για να προστατέψουμε όσους έχουν υποστεί τραύμα από τον κίνδυνο επανατραυματοποίησης,
να σεβόμαστε τους χρόνους τους, να επικεντρωνόμαστε στην παροχή υπηρεσιών προς το πρόσωπό τους,
ανάλογα με τις ανάγκες και την ευαισθησία τους, και ποτέ να μην πιέζουμε τους θεραπευόμενους
να κάνουν κάτι για το οποίο δεν είναι ακόμα έτοιμοι.
Ο λόγος είναι πολύ απλός: έχουμε διαπιστώσει ότι τα άτομα που έχουν υποστεί τραύμα
χρειάζονται αποδοχή, καλοσύνη και ασφαλή λιμάνια όπου θα ανακτήσουν τις δυνάμεις τους
και τους ρυθμούς τους στη διερεύνηση, η οποία, λόγω του τραύματος είναι αναγκαστικά επιφυλακτική
λόγω της προηγούμενης εμπειρίας τους.
Άρα η εμπιστοσύνη στις ικανότητες αυτορρύθμισης των θεραπευομένων που έχουν υποστεί τραύμα
αποτελεί θεμελιώδη καλή θεραπεία.
Ο σεβασμός των ατόμων, το σημειώνουμε αυτό, μοιάζει κάτι τόσο απλό αλλά είναι συχνά δύσκολο
στον τομέα των θεραπειών.



Transcript

Η υποστήριξη της θετής γονεϊκότητας στο πλαίσιο της υποστήριξης μετά την υιοθεσία είναι σημαντική γιατί μετά την υιοθεσία θα παρουσιαστούν τα τραύματα που έχουν υποστεί τα παιδιά στο παρελθόν, την περίοδο της ιδρυματοποίησης, την περίοδο της εγκατάλειψης από την οικογένειά τους ή τη μητέρα τους ή της παραμονής τους σε ίδρυμα ή σε άλλες οικογένειες.

Όλα αυτά θα είναι σημαντικά για την οικογένεια που θα υιοθετήσει αυτά τα παιδιά γιατί, εκ των πραγμάτων, θα προκαλέσουν δυσκολίες στη σχέση με τη νέα οικογένεια.

Από την έρευνα γνωρίζουμε ότι τα τραύματα είναι ικανά να διακόπτουν σχέσεις και να τις καθιστούν προβληματικές και δύσκολες. Τα παιδιά δεν αποτελούν εξαίρεση σε αυτό.

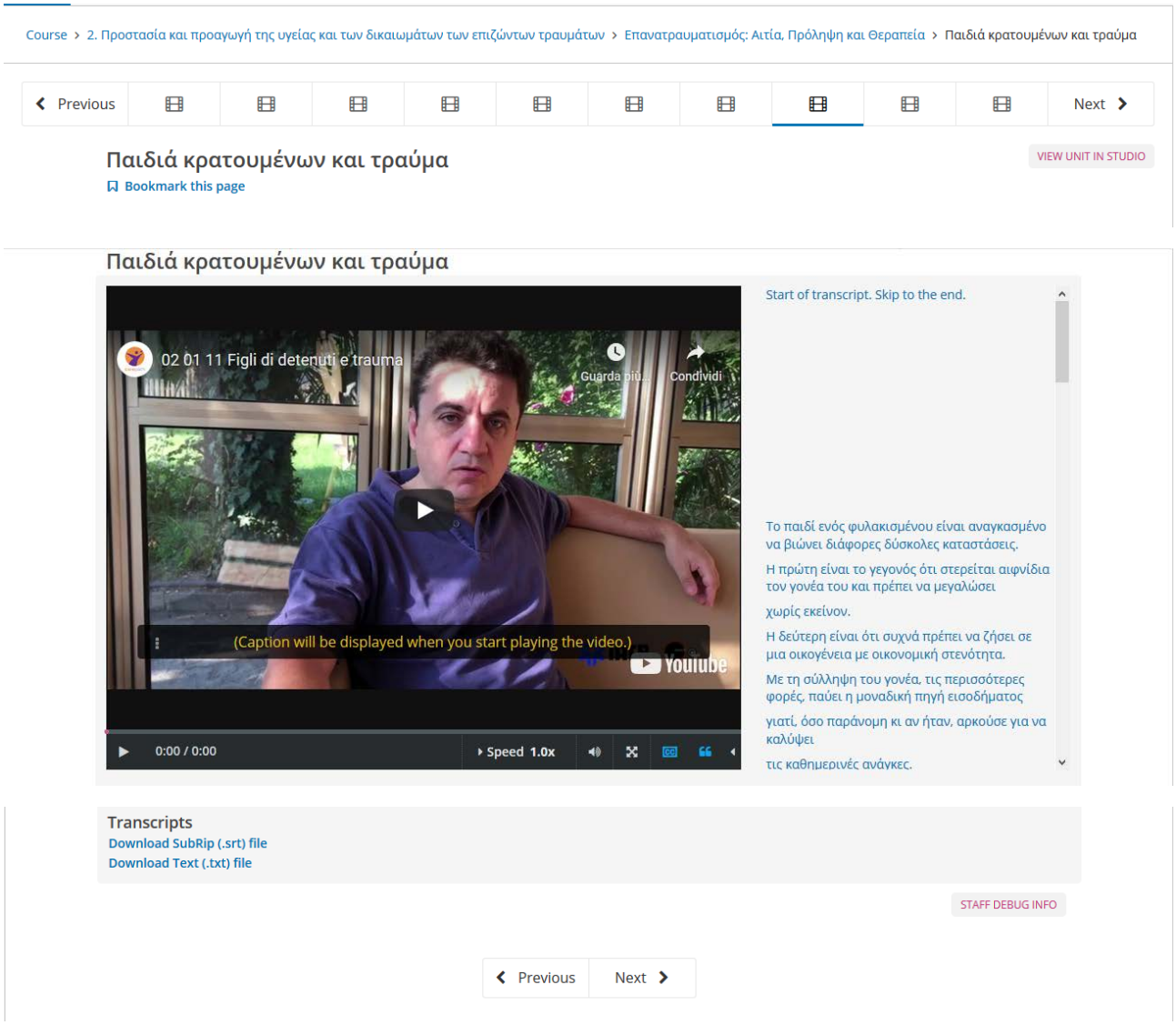
Η συνειδητοποίηση της δυσκολίας που συναντά ένα παιδί στη νέα οικογένεια υιοθεσίας μπορεί να διευκολύνει ή τουλάχιστον να καταστήσει πιο συνειδητό τον γονέα στη διαδρομή που καλείται να ακολουθήσει.

Στις ανταλλαγές που συνιστούν τη σχέση, στις διαδραστικές ανταλλαγές, τα παιδιά

θα είναι δύσκολα διαχειρήσιμα. Μπορεί να δώσουν συγκεχυμένα και ασαφή μηνύματα,
να μοιάζουν αδιάφορα και απόντα.
Όλα αυτά είναι πτυχές που θα αναλυθούν μία προς μία και θα αποτελέσουν μέρος
της ιστορίας κάθε υιοθετημένου ατόμου.
Υπό αυτή την έννοια γνωρίζουμε, από την έρευνα πάντα, ότι κάθε διαδραστική ανταλλαγή διαμορφώνεται
από μικρογεγονότα που, αν αναλυθούν,επηρεάζουν την ανταπόκριση ενήλικα-παιδιού και αντίστροφα.
Η σχέση μεταξύ γονέα και παιδιού στην υιοθεσία δεν αποτελεί εξαίρεση
Για αυτό θα είναι πολύ σημαντική η χρήση του βίντεο, γιατί ειδικά σε αυτή την κατάσταση,
όπου το τραύμα έχει δημιουργήσει δυσκολίες στην ερμηνεία των μικροαναλυτικών στοιχείων διάδρασης,
θα είναι σημαντική η καταγραφή τους σε βίντεο και η παρακολούθησή τους για να δούμε πού και πώς
κινείται το παιδί στη διαδραστική ανταλλαγή και πώς μπορεί να απαντήσει ο γονέας.
Άρα πρέπει να επισημάνουμε και να συστήσουμε τη χρήση του βίντεο
γιατί έτσι θα τεθούν οι βάσεις και θα μπορούμε να κοιτάζουμε με λεπτομέρεια, ανά πάσα στιγμή,
όλα όσα συντελούνται στη σχέση ανταλλαγής μεταξύ παιδιού και γονέα.
Είναι σημαντικό να διευκρινίσουμε ότι αυτή η χρήση του βίντεο πρέπει, και αυτό ισχύει πάντα,
να πραγματοποιείται και να προβάλλεται μόνο από ειδικευμένους θεραπευτές και για αυτή τη χρήση.
Δεν θα μπορεί να χρησιμοποιηθεί από όποιον δεν έχει την απαραίτητη ειδίκευση,
λόγω της ιδιαίτερης λεπτότητας του υπό εξέταση θέματος.
Σημειώνουμε ότι, όπως προαναφέρθηκε, τα υιοθετημένα παιδιά εκπέμπουν μηνύματα
λιγότερο εμφανή, πιο σύντομα και συγκεχυμένα, από ό,τι τα μη υιοθετημένα παιδιά.
Υπό αυτή την έννοια, η χρήση του βίντεο θα είναι πολύ σημαντική γιατί θα επιτρέψει στον γονέα,
παρακολουθώντας, στιγμή προς στιγμή, τη διάδραση, να δει πού και πώς το παιδί είναι σε θέση
να συνδεθεί σχεσιακά μαζί του.
Αυτό θα αποτελέσει ορόσημο στη διαδραστική ανταλλαγή και θα είναι η αρχή
μιας πιθανής νέας δομής κι ενός δεσμού προσκόλλησης.
Μια άλλη πολύ σημαντική πτυχή της έκφρασης του παιδιού είναι η υπερεγρήγορση.
Είναι πολύ σημαντική γιατί μας αφηγείται την ιστορία του, τους φόβους του, την εγκατάλειψη
και παραμέληση που έχει βιώσει, αλλά κυρίως αφηγείται αν αυτό το παιδί έχει υποστεί σωματική βία,
ίσως και κακοποίηση, ή αν ήταν μάρτυρας βίας στην καλύτερη των περιπτώσεων.
Η υπερεγρήγορση είναι μια πτυχή στην οποία το παιδί είναι υπερβολικά εστιασμένο στην έκφραση
του ενήλικα, τον παρακολουθεί συνεχώς για να ερμηνεύσει μέσω της έκφρασης του ενήλικα
αν θα συμβεί κάτι που μπορεί να είναι επικίνδυνο για το παιδί ή αν αυτό που κάνει

μπορεί να αποβεί κατά κάποιο τρόπο επικίνδυνο ή πηγή απειλής.
Είναι, λοιπόν, μια σαφής ένδειξη έλλειψης εμπιστοσύνης του παιδιού απέναντι στον ενήλικα.
Αυτό σταδιακά θα τείνει να εκλείψει πλήρως όσο δουλεύεται η σχέση ενήλικα-παιδιού,
αλλά όχι πάντα με τρόπο οριστικό.
Μία άλλη πτυχή που θα παρουσιάσει το παιδί θα αφορά τη συναισθηματική αδεξιότητα,
ένα στοιχείο πολύ βασανιστικό για τον θετό γονέα γιατί θα νιώσει ότι αυτό το παιδί δεν είναι
ποτέ απολύτως ελεύθερο να εκφράσει την αγάπη και τη συναισθηματική εγγύτητα προς τον ενήλικα.
Δεν είναι ευθύνη του παιδιού αυτό. Είναι κι αυτό ένα μικρό κομμάτι, που εκφράζεται στη σχέση,
μιας ιστορίας του παρελθόντος ιδιαίτερα επώδυνης.
Τα παιδιά είναι συνηθισμένα να μην πλησιάζουν τον ενήλικα, να φροντίζουν ώστε ο ενήλικας
να γίνεται λιγότερο επικίνδυνος στη σχέση, για αυτό δεν είναι συνηθισμένα να τον αγγίζουν
ή να τον αγκαλιάζουν, κάτι που στη νέα σχέση θα μπορούσε να συμβεί.
Επίσης, υπάρχουν παιδιά που είναι ιδιαίτερα κοντά, ίσως και υπερβολικά, ενίοτε κολλημένα,
αλλά αυτό συμβαίνει επειδή δεν ξέρουν πώς να ρυθμίσουν τον τρόπο προσέγγισης του ενήλικα,
δεν γνωρίζουν το υπερβολικά πολύ ή λίγο και είναι αποπροσανατολισμένα και σε αμηχανία.
Άλλες φορές το παιδί πλησιάζει εξαιρετικά αδέξια, με τρόπο σχεδόν ψεύτικο και ελάχιστα αυθόρμητο
κι αυτό το αντιλαμβάνεται αμέσως ο γονέας και τείνει να του προσδώσει έναν χαρακτηρισμό.
Αυτό που συστήνουμε είναι να το βλέπουμε πάντα ως έκφραση μιας στιγμής της ιστορίας του παιδιού.
Δεν ήταν ποτέ ελεύθερο να πλησιάσει, όπως θα ήθελε και όπως θα ένιωθε,
έναν ενήλικα κι αυτό συνεχίζει να γίνεται με τρόπο ελάχιστα αυθόρμητο και πολύ αδέξιο.
Μια άλλη πτυχή που θα αντιμετωπίσει ο γονέας θα είναι η κούραση και η δυσκολία στον ύπνο
αλλά και ο πολύ ταραγμένος ύπνος που δεν ξεκουράζει και η δυσκολία να αποκοιμηθεί.
Ένα επιπλέον στοιχείο αφορά τη δυσκολία στη συγκέντρωση,
που συχνά ερμηνεύεται ως μαθησιακή δυσκολία γενικού τύπου.
Το παιδί δεν έχει μαθησιακή δυσκολία
αλλά η υπερεγρήγορση του προκαλεί συναισθηματικά στοιχεία τόσο δύσκολα, αρνητικά
και κουραστικά που του αποσπούν την προσοχή από το καθήκον που του έχει ανατεθεί.
Για άλλη μια φορά θα δούμε ότι το παιδί είναι συγχρονισμένο στο πρόσωπο του ενήλικα,
στην έκφρασή του, σε ό,τι εκφράζει ο ενήλικας, στην επικινδυνότητα που μπορεί να εκδηλώσει.
Όλα αυτά θα δυσκολέψουν το παιδί στην προσπάθειά του να συγκεντρωθεί.
Όλα αυτά τα στοιχεία είναι εξαιρετικά σημαντικά, αυτές οι συμπεριφορές είναι η αφήγηση
μιας ιστορίας του παρελθόντος. Θα πουν στον θετό γονέα όλα όσα αφορούν την ιστορία του παιδιού

τα οποία ίσως αυτό το παιδί να μην μπορεί να εκφράσει παρά μόνο
μέσα από αυτές τις συμπεριφορές.
Ίσως, για αυτό να είναι σημαντικό να θυμόμαστε ότι πρόκειται για πολύτιμες πληροφορίες
που μπορούν να μας επιτρέψουν να γνωρίσουμε ένα κομμάτι του παρελθόντος απόλυτα άγνωστο
που όμως έχει διαμορφώσει το παιδί ως έχει, στη συγκεκριμένη σχέση ως έχει
με τον νέο θετό γονέα.
Είναι συμπεριφορές που δεν πρέπει να διορθώνουμε αλλά να αποδεχόμαστε στον μέγιστο βαθμό
για να μπορέσουμε να ερμηνεύσουμε κατά το δυνατό τι έχουν να μας πουν για μια παρελθοντική ιστορία
που μπορεί να γίνει, μαζί με αυτό το μικρό παιδί, η κοινή μας ιστορία.
Έτσι, η αφήγηση του παρελθόντος θα λειτουργήσει ως γέφυρα με το αφήγημα του παρόντος.



Transcript

Το παιδί ενός φυλακισμένου είναι αναγκασμένο να βιώνει διάφορες δύσκολες καταστάσεις.

Η πρώτη είναι το γεγονός ότι στερείται αιφνίδια τον γονέα του και πρέπει να μεγαλώσει

χωρίς εκείνον.

Η δεύτερη είναι ότι συχνά πρέπει να ζήσει σε μια οικογένεια με οικονομική στενότητα.

Με τη σύλληψη του γονέα, τις περισσότερες φορές, παύει η μοναδική πηγή εισοδήματος

γιατί, όσο παράνομη κι αν ήταν, αρκούσε για να καλύψει

τις καθημερινές ανάγκες.

Μια άλλη τραγωδία, δευτερεύουσα αλλά εξίσου σημαντική, οφείλεται στο γεγονός ότι το παιδί

κατακλύζεται από κριτική.

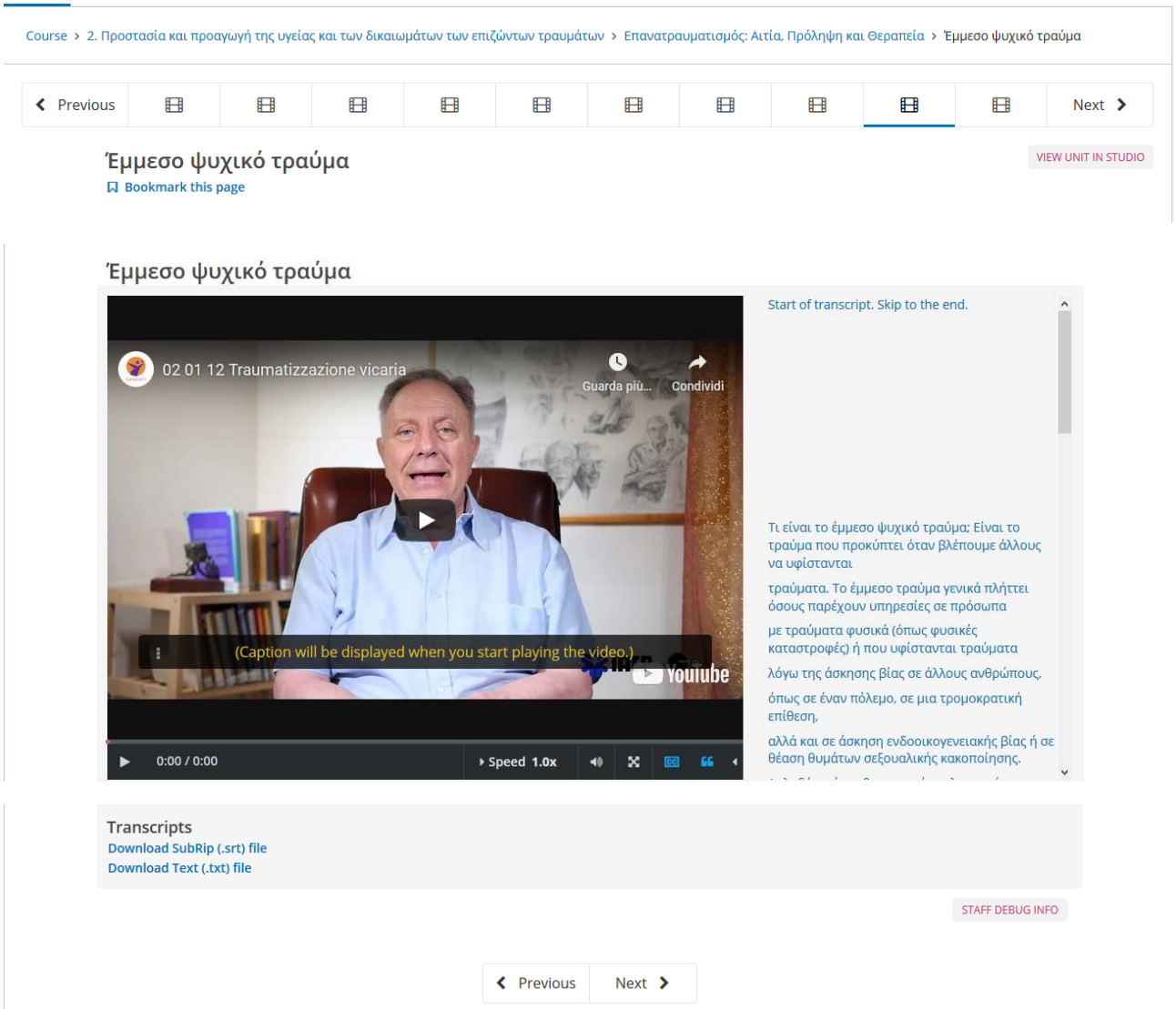
Όταν είσαι παιδί φυλακισμένων γονέων

είσαι και παιδί της ενοχής.

Το παιδί σταδιακά συνδέεται με αυτή την κοινωνική διαδικασία

και οικειοποιείται την κριτική ώσπου πείθεται ότι είναι κι εκείνο άξιο τιμωρίας.
Επίσης, συχνά τα παιδιά φυλακισμένων γονέων είναι αναστατωμένα. Η ταραχή του παιδιού οφείλεται και στο γεγονός ότι δεν έχει έναν γονέα, συχνά τον πατέρα, να το εκπαιδεύσει και να θέσει όρια στις υπερβολικές του απαιτήσεις.
Είναι ένα παιδί αναγκασμένο να ζει μόνο, η μητέρα δεν μπορεί να λύσει όλα τα προβλήματα που συσσωρεύονται πάνω της χωρίς να μπορεί να βασίζεται στη συνεισφορά του συζύγου της.
Είναι μια πρόκληση που πρέπει να αντιμετωπίσει γιατί, δυστυχώς, και οι κοινωνικοί λειτουργοί πέφτουν στην παγίδα του στιγματισμού του παιδιού αντί να δείξουν ακόμα περισσότερη κατανόηση, γιατί το ότι ζει μόνο με τη μητέρα του, σε δυσκολία, οπωσδήποτε δεν είναι κάτι καθόλου εύκολο.
Οι γνώμες διίστανται σχετικά με τον τρόπο πληροφόρησης του παιδιού ότι ο γονέας του έχει συλληφθεί.
Πολλοί γονείς, από ντροπή ή λόγω δυσκολίας, διηγούνται στο παιδί το σενάριο ότι έπρεπε να φύγει ξαφνικά για να εργαστεί.
Ως γνωστόν, "το ψέμα έχει κοντά ποδάρια" και το παιδί δεν πείθεται, γιατί ως τότε ο πατέρας επέστρεφε καθημερινά στο σπίτι από τη δουλειά και είναι περίεργο να άλλαξε ξαφνικά εργασιακή κατάσταση και να έφυγε για μέρες, μήνες, χρόνια, στα Χριστούγεννα, στα γενέθλια κτλ. Έτσι, το παιδί καταλαβαίνει ότι πρόκειται για ψέμα.
Σε αυτές τις περιπτώσεις το καλύτερο είναι να λέμε στα παιδιά την αλήθεια: "ο μπαμπάς έσφαλε, διέπραξε κάποια σφάλματα και δυστυχώς πρέπει να πάει σε έναν τόπο για να απαντήσει για τη συμπεριφορά του αλλά είναι καλά, του παρέχονται όλα τα απαραίτητα, μην ανησυχείς, σύντομα θα μπορείς να τον δεις".
Αυτό είναι ένα άλλο θέμα που αφορά τα παιδιά φυλακισμένων γονέων: αν πρέπει ή όχι να δουν τον γονέα στη φυλακή.
Μερικοί κοινωνικοί λειτουργοί υποστηρίζουν ότι δεν ενδείκνυται αυτό γιατί το περιβάλλον της φυλακής δεν αρμόζει στις ανάγκες του παιδιού.
Είναι αλήθεια πως μπαίνοντας στη φυλακή, βλέπει αστυνομικούς και χώρους όχι πάντα αξιοπρεπείς, αλλά είναι επίσης αλήθεια ότι δεν υπάρχει κάτι πιο σημαντικό για ένα παιδί από το να μπορεί να βλέπει τον γονέα του.
Ουσιαστικά, λοιπόν, θα πρέπει να διευκολύνουμε τις συναντήσεις των φυλακισμένων με τα παιδιά τους.
Μέχρι πριν από λίγα χρόνια ορθώνονταν τοίχοι ανάμεσα στους κρατουμένους και τους επισκέπτες.
Σήμερα πολλά έχουν αλλάξει: σε πολλές φυλακές υπάρχει αίθουσα αναψυχής ή χώροι πιο πολύχρωμοι,

με παιχνίδια, ενώ οι σωφρονιστικοί υπάλληλοι είναι πολύ πιο προετοιμασμένοι
να υποδέχονται παιδιά.
Ωστόσο, δεν είναι αυτό το θέμα μας. Το ζήτημα δεν είναι αν το παιδί πάει ή όχι
σε έναν κατάλληλο χώρο αλλά να διευκολυνθεί η συνάντηση γονέα και παιδιού.
Φυσικά, όλα αυτά δεν ισχύουν αν ο γονέας κρατείται για αδίκημα κατά του ανήλικου παιδιού.



Transcript

Τι είναι το έμμεσο ψυχικό τραύμα; Είναι το τραύμα που προκύπτει όταν βλέπουμε άλλους να υφίστανται τραύματα. Το έμμεσο τραύμα γενικά πλήττει όσους παρέχουν υπηρεσίες σε πρόσωπα
με τραύματα φυσικά (όπως φυσικές καταστροφές) ή που υφίστανται τραύματα
λόγω της άσκησης βίας σε άλλους ανθρώπους,
όπως σε έναν πόλεμο, σε μια τρομοκρατική επίθεση,
αλλά και σε άσκηση ενδοοικογενειακής βίας ή σε θέαση θυμάτων σεξουαλικής κακοποίησης.
Δηλαδή, εγώ ως θεραπευτής καλοπροαίρετα ανοίγομαι και παρέχω βοήθεια, ανθρώπινη υποστήριξη και ψυχολογική επαφή σε ένα θύμα τραύματος αλλά, σε καθημερινή βάση, παρά τη βαθιά σημασία της γενναιοδωρίας του ανοίγματος ακόμα και σε υπαρξιακό επίπεδο, αυτό μπορεί
να επηρεάσει την ψυχική μου υγεία, τις αντοχές μου, τον μεταβολισμό μου και να γίνει η πηγή ενός καθεαυτού τραύματος, με όλες τις γνωστές συνέπειες των τραυμάτων.
Για αυτό είναι σημαντικό να αποτρέπουμε την πρόκληση έμμεσου τραύματος οι θεραπευτές

και όλοι όσοι λόγω εργασίας εκτίθενται σε θύματα τραυμάτων ή βίας,

όπως οι αστυνομικοί, για παράδειγμα, ή οι δημοσιογράφοι και όσοι για διάφορους λόγους έρχονται σε επαφή

με πρόσωπα που έχουν υποστεί τραύμα.

Ένας χρήσιμος κανόνας, λοιπόν, είναι να μπορούμε να αποτρέπουμε το έμμεσο τραύμα,

όπως και ό,τι γενικά αποκαλούμε "burn out" που επίσης πλήττει όσους συμμετέχουν

σε σχέσεις βοήθειας και, μάλιστα, με σφοδρότητα, ιδιαίτερα όταν δεν μπορούμε να επαναφορτίσουμε

τις μπαταρίες μας, να κάνουμε ένα διάλειμμα από τη βαριά, επαχθή αλλά όμορφη εργασία μας

και να έχουμε ισορροπία ανάμεσα στη λεγόμενη ανθρωπιστική εργασία και στην ιδιωτική μας ζωή, την οικογένεια,

τους φίλους και την ψυχαγωγία. Με δυο λόγια, αποτελεί είναι πρόκληση για όσους

παρέχουν επάξια τις υπηρεσίες τους με πάθος, γενναιοδωρία και ενσυναίσθηση να τηρήσουν

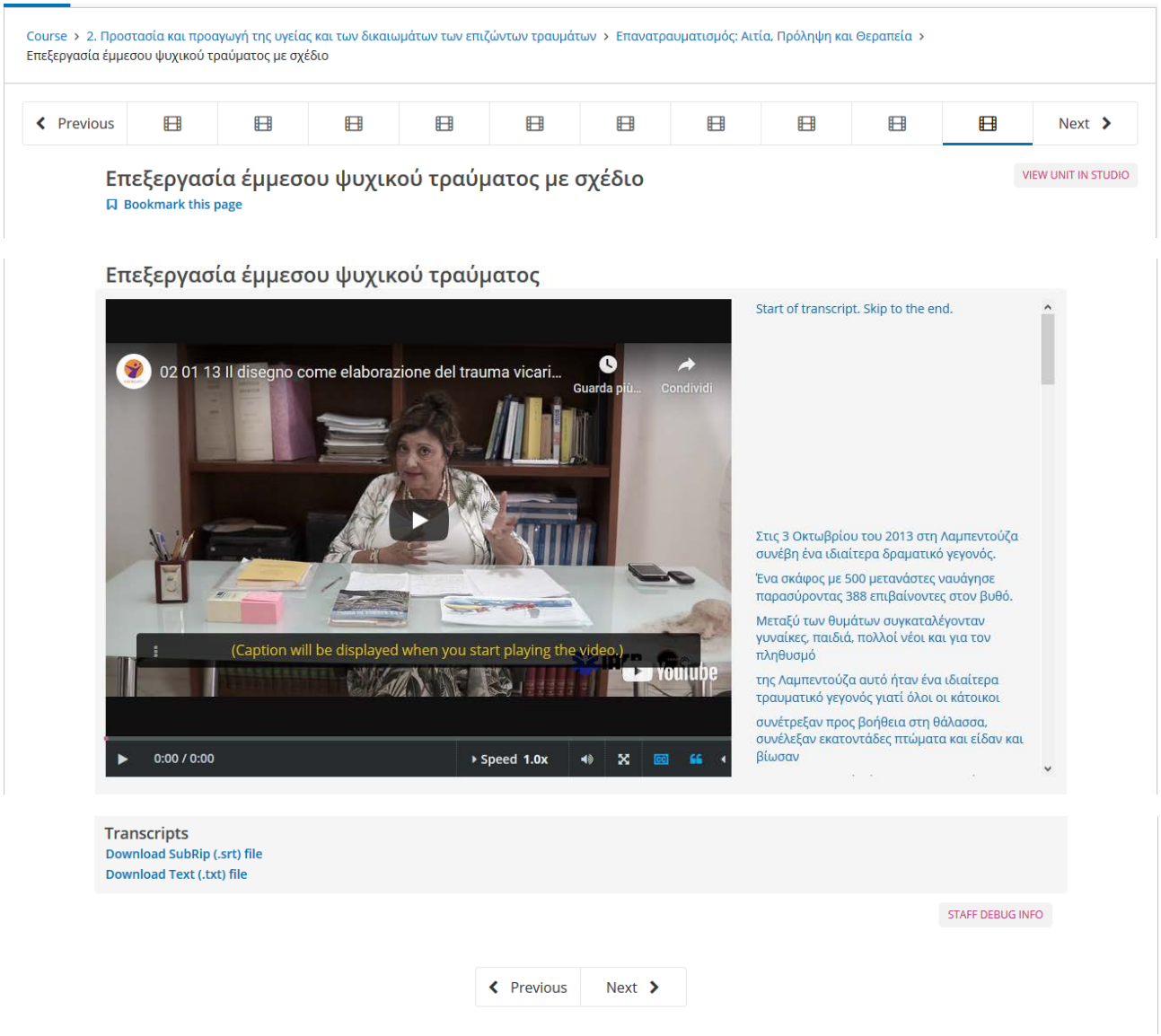
τον ίδιο σεβασμό και για τον εαυτό τους,

γιατί, δυστυχώς, δεν μπορούμε να δώσουμε στους άλλους κάτι που δεν έχουμε.

Άρα έχουμε ηθική υποχρέωση να προάγουμε την αντοχή, την υγεία και την ευεξία μας

γιατί, αν θέλουμε να δώσουμε πολλά, πρέπει να συμπεριλάβουμε και το πρόσωπο

που δεν θα μας εγκαταλείψει ποτέ κάθε στιγμή της ζωής μας: τον εαυτό μας.



Transcript

Στις 3 Οκτωβρίου του 2013 στη Λαμπεντούζα συνέβη ένα ιδιαίτερα δραματικό γεγονός.
Ένα σκάφος με 500 μετανάστες ναυάγησε παρασύροντας 388 επιβαίνοντες στον βυθό.
Μεταξύ των θυμάτων συγκαταλέγονταν γυναίκες, παιδιά, πολλοί νέοι και για τον πληθυσμό
της Λαμπεντούζα αυτό ήταν ένα ιδιαίτερα τραυματικό γεγονός γιατί όλοι οι κάτοικοι
συνέτρεξαν προς βοήθεια στη θάλασσα, συνέλεξαν εκατοντάδες πτώματα και είδαν και βίωσαν
το συγκλονιστικό μέγεθος της τραγικότητας του θανάτου. Μάλιστα, υπήρχε μία μητέρα
που γεννούσε τη στιγμή του ναυαγίου και εντοπίστηκε με το μωρό της
ακόμα συνδεδεμένο με τον ομφάλιο λώρο.
Ένα τέτοιου είδους γεγονός αναπόφευκτα
προκάλεσε ένα έμμεσο ψυχικό τραύμα στον πληθυσμό και έγινε προσπάθεια,
κατά κάποιο τρόπο, στην πολυκλινική, να δοθεί η δυνατότητα ακρόασης,

επισκέψεων και υποστήριξης σε όσους βίωσαν τραυματικές εμπειρίες
και να τους παρασχεθεί βοήθεια,
αλλά μία από τις πιο δύσκολα διαχειρίσιμες περιπτώσεις αφορούσε
την τραυματική εμπειρία των παιδιών, ιδιαίτερα της πρωτοβάθμιας εκπαίδευσης.
Η μετανάστευση στη Λαμπεντούζα είναι μια πολυετής εμπειρία και όλοι, ακόμα και οι νέοι,
γνωρίζουν ότι συχνά τα ταξίδια της ελπίδας καταλήγουν στην απώλεια ζωής,
αλλά τα παιδιά 6 και 7 ετών είναι ιδιαίτερα ευαίσθητα σε τέτοιου είδους εμπειρίες
και πολλά από αυτά άρχισαν να έχουν φόβους, άγχος και φοβίες, χαρακτηριστικές αντιδράσεις
όσων εκτίθενται σε τραυματικές εμπειρίες
στις οποίες η ζωή τίθεται σε κίνδυνο καταλήγοντας στην απώλειά της.
Για αυτά τα παιδιά το συγκεκριμένο γεγονός συνέβη στη δική τους θάλασσα, την οποία βιώνουν
ως πηγή χαράς, παιχνιδιού και διασκέδασης. Η θάλασσα που για τα παιδιά ήταν
ένα στοιχείο χαράς και ανεμελιάς, ξαφνικά μεταμορφώθηκε σε θάλασσα θανάτου.
Μία από τις μεθόδους που εφαρμόστηκαν
για τη διαχείριση αυτού του έμμεσου τραύματος των παιδιών ήταν η πρόταση
να φιλοτεχνήσουν ζωγραφιές και οι ζωγραφιές αυτές τώρα καταδεικνύουν πώς τα παιδιά
απαντούν και αντιδρούν σε αυτό το τραύμα.
Εδώ πρέπει να κάνω μια μικρή εισαγωγή.
Η τέχνη είναι ένα ισχυρό εργαλείο για να κάνει απτά τα επώδυνα και τρομακτικά γεγονότα.
Η τέχνη είναι απελευθερωτική και βοηθά στη διαχείριση των τραυματικών γεγονότων.
Πρέπει να αναρωτηθούμε
τι είναι ένα τραυματικό γεγονός μέσα από τα μάτια των παιδιών.
Σε αυτή την περίπτωση
εξαρτάται από το είδος του γεγονότος. Το τραυματικό γεγονός έχει ποικίλες μορφές.
Μπορεί να είναι ανθρωπογενές (πόλεμοι, τρομοκρατία) ή να προκαλείται από τη φύση (κυκλώνες, σεισμοί).
Όλα τα παραπάνω αφήνουν συγκεκριμένα αποτυπώματα και φόβους στον νου και την ψυχή
των παιδιών.
Από αυτή την άποψη, ήταν αναγκαίο στην περίπτωση του ναυαγίου στη Λαμπεντούζα
να επουλώσουμε το συναισθηματικό εσωτερικό ρήγμα που υπέστησαν τα παιδιά και συνδεόταν
με το ότι το γεγονός θα μπορούσε να ξανασυμβεί εμπλέκοντας, μάλιστα, και τις οικογένειές τους.
Κι αυτό γιατί ένα παιδί 6 και 7 ετών δύσκολα κατανοεί το νόημα του θανάτου και ξέρουμε

ότι τα παιδιά τα ανάγουν όλα στον εαυτό τους.

Αυτά τα γεγονότα και οι ιστορίες θανάτου είχαν ως αποτέλεσμα

πολλά παιδιά να φοβούνται να φάνε ψάρι, γιατί τα ψάρια θα είχαν φάει τα νεκρά παιδιά

και τις μητέρες τους, ή να φοβούνται να πάνε στη θάλασσα όπου ίσως να υπήρχαν πτώματα.

Ήταν αναγκαίο να ανασυνθέσουμε αυτό το παζλ της δικής τους διάστασης ανεμελιάς

στον αντίποδα του φαντασιακού παζλ που κατασκευαζόταν στο νησί της Λαμπεντούζα.

Αυτό κατέστη δυνατό με τη ζωγραφική, όπως είπα παραπάνω.

Με τη ζωγραφική μπορούμε να ανασυνθέσουμε μια αφήγηση του πώς κάθε παιδί ατομικά

αντιλήφθηκε αυτό το γεγονός, γιατί το γεγονός ήταν συλλογικό αλλά η αντίληψή του

ήταν συγκεκριμένη για κάθε παιδί.

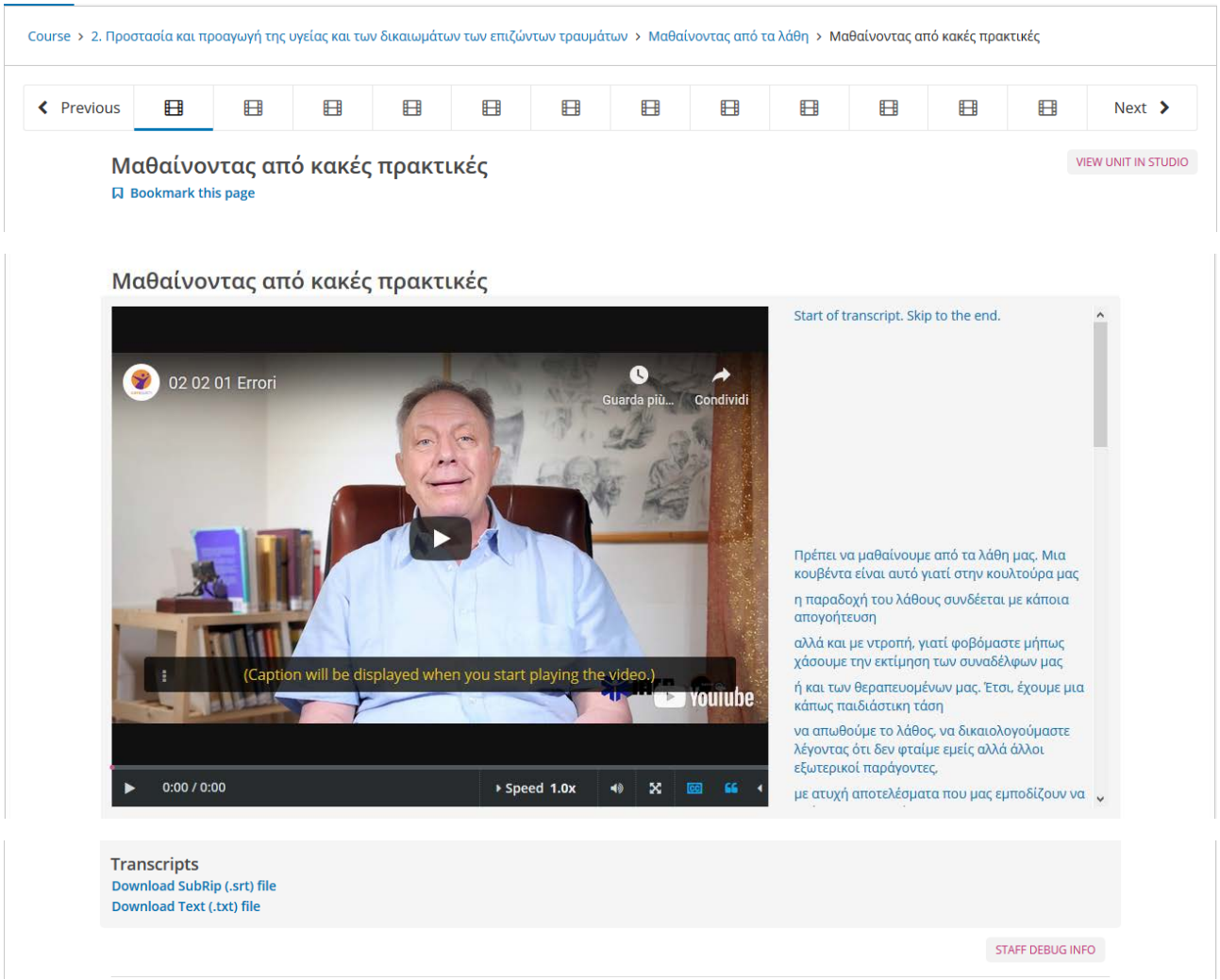
Ήταν σημαντικό να μην προσφέρουμε στοιχεία άμεσης ανακούφισης και επίλυσης

αλλά να αφήσουμε κάθε παιδί, μέσα από γραφιστική και λεκτική επεξεργασία,

μέσα από την ακρόαση και τη ζωγραφική, να βρει τις δικές του προσωπικές λύσεις

σε ένα έντονα βασανιστικό στοιχείο όπως η διάσταση του θανάτου και της απώλειας

που στην ηλικία των 6 - 7 ετών είναι ό,τι πιο οδυνηρό για ένα παιδί.



Transcript

Πρέπει να μαθαίνουμε από τα λάθη μας. Μια κουβέντα είναι αυτό γιατί στην κουλτούρα μας

η παραδοχή του λάθους συνδέεται με κάποια απογοήτευση

αλλά και με ντροπή, γιατί φοβόμαστε μήπως χάσουμε την εκτίμηση των συναδέλφων μας

ή και των θεραπευομένων μας. Έτσι, έχουμε μια κάπως παιδιάστικη τάση

να απωθούμε το λάθος, να δικαιολογούμαστε λέγοντας ότι δεν φταίμε εμείς αλλά άλλοι εξωτερικοί παράγοντες,

με ατυχή αποτελέσματα που μας εμποδίζουν να δούμε το προφανές.

Ότι πίσω από κάθε λάθος κρύβεται ένας θησαυρός σοφίας.

Με τη σωστή μας στάση, δηλαδή τη μη αμυντική, μπορούμε να ανοιχτούμε και να μάθουμε από τα λάθη.

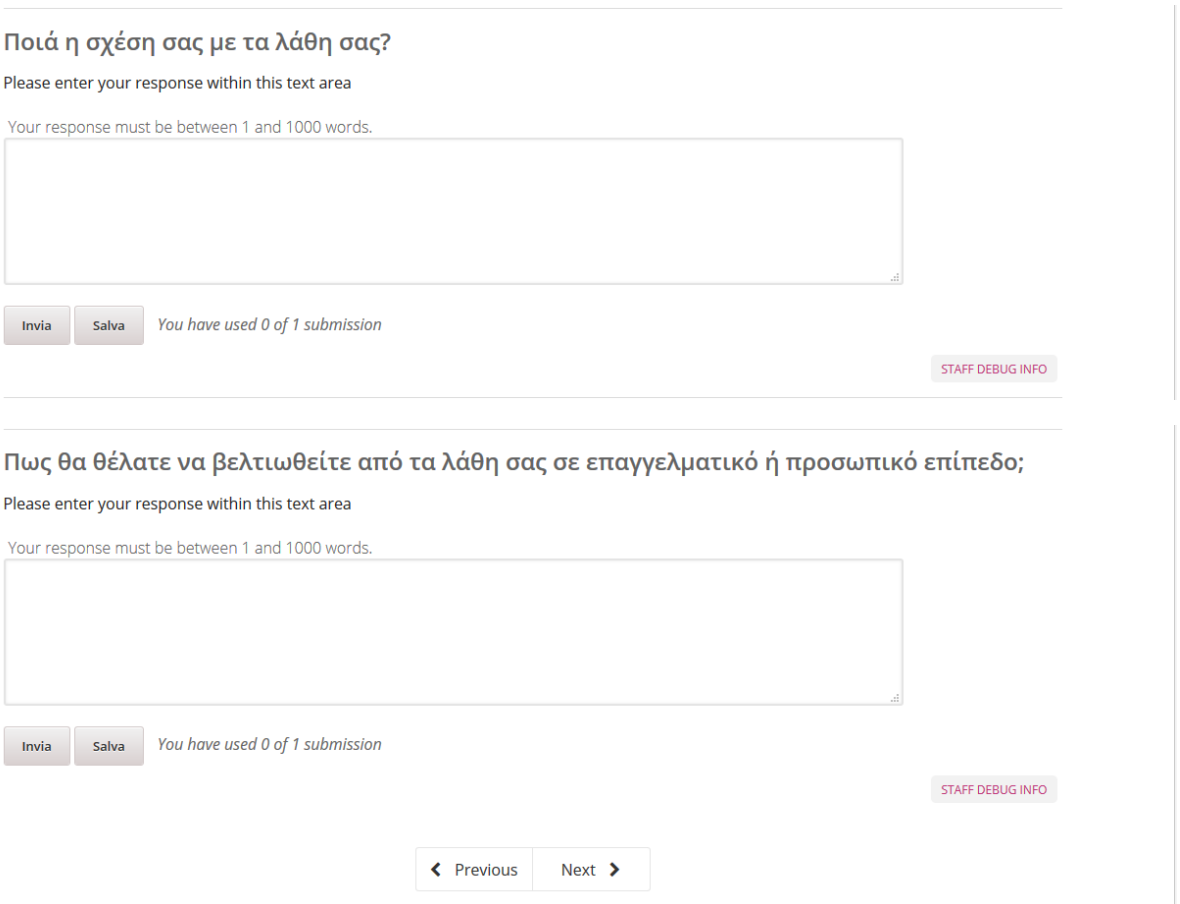
Τα λάθη είναι δάσκαλοι που μας βοηθούν να γίνουμε θεραπευτές

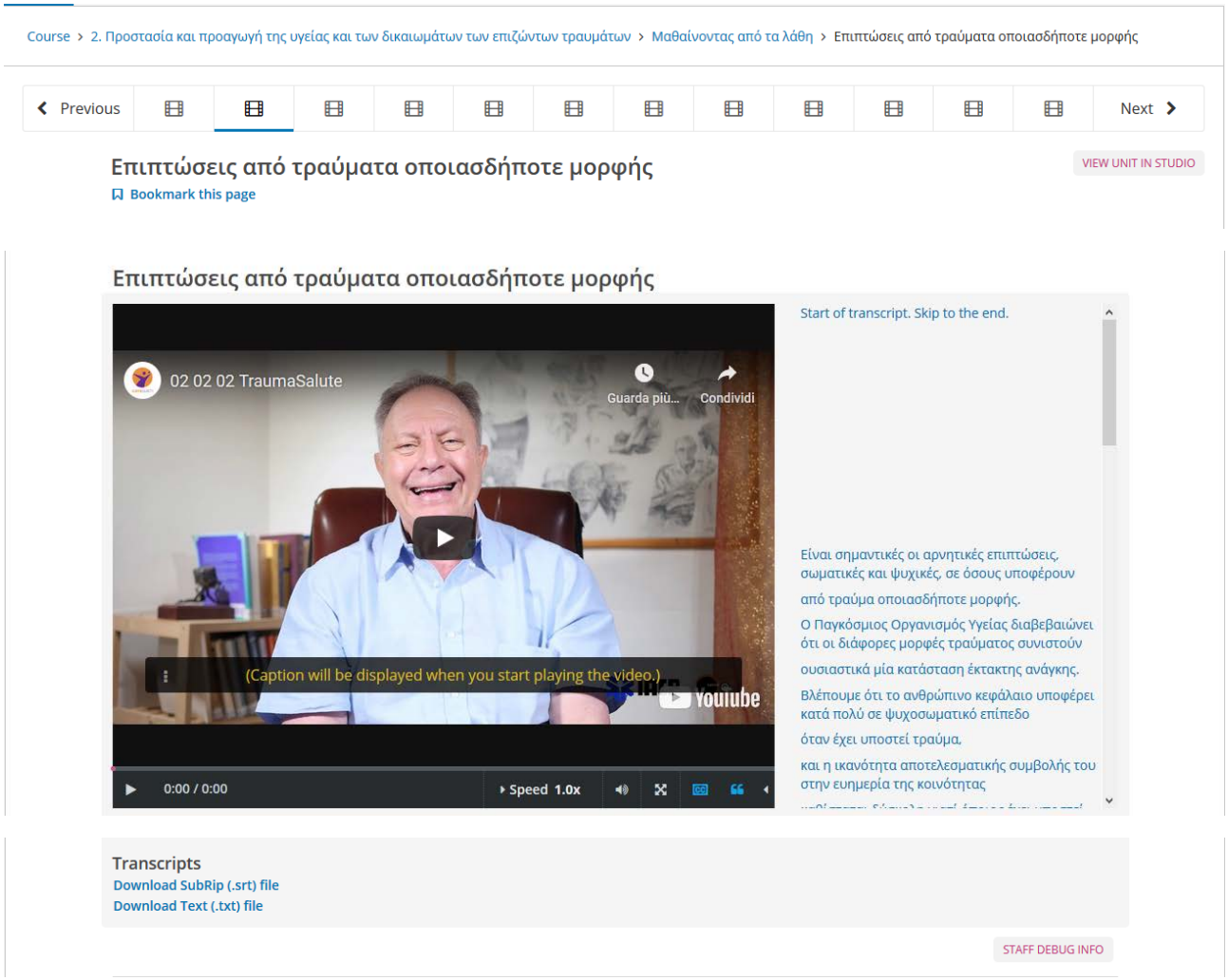
και να κάνουμε ό,τι μας προτρέπουν να πράξουμε

οι θεραπευόμενοι και οι ασθενείς μας, δηλαδή, να κάνουμε την εμπειρία μάθηση.

Η κατάσταση είναι κωμικοτραγική: εμείς οι θεραπευτές της σχέσης βοήθειας ενθαρρύνουμε ολόψυχα

τους θεραπευόμενους να μάθουν από τις εμπειρίες και τα λάθη τους
αλλά αυτό ισχύει για εκείνους και λιγότερο για εμάς. Είμαστε απρόθυμοι να αποδεχτούμε
τη μη άμυνα και να παραδεχτούμε ότι το λάθος είναι δικό μας
και άρα να είμαστε ανοιχτοί στο δίδαγμά του.
Ο δυσλειτουργικός τρόπος αξιοποίησης της εμπειρίας από το λάθος οδηγεί στην απώλεια αυτοεκτίμησης,
ενώ θα έπρεπε να αυξάνεται, σαν να συνέβαινε το εξής παράλογο: όποιος φοβάται
νομίζει ότι είναι δειλός αγνοώντας ότι ο θαρραλέος φοβάται εξίσου αλλά δεν επιτρέπει
στον φόβο να τον αδρανοποιήσει, άρα ο έξυπνος και σοφός αποδέχεται το λάθος και μαθαίνει από αυτό.
Έχουμε πολλά να μάθουμε από τους θεραπευόμενους που συχνά είναι πιο έτοιμοι από εμάς να δεχτούν
ταπεινά να μάθουν από την εμπειρία τους, προσπαθώντας να μην κάνουν πάντα τα ίδια λάθη.
Εμείς, αντίθετα, είμαστε καταδικασμένοι στην επανάληψή τους αρνούμενοι να παραδεχτούμε
ότι με τα λάθη μειώνεται η αυτοπεποίθησή μας γιατί όταν αυτοπροσδιοριζόμαστε ως θύματα
ορίζουμε αυτόματα για τον εαυτό μας μια κατάσταση αδυναμίας.
Για αυτό, λοιπόν, καλωσορίζουμε τα λάθη ως δασκάλους σοφίας.

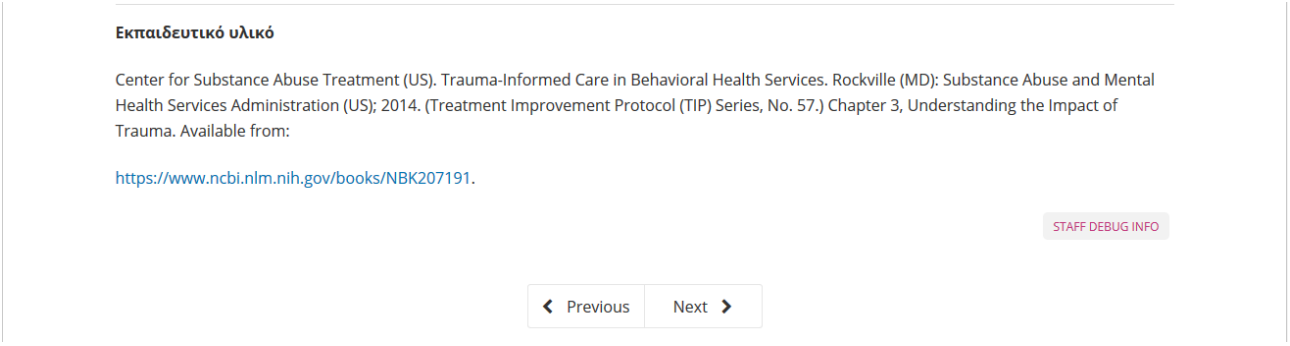


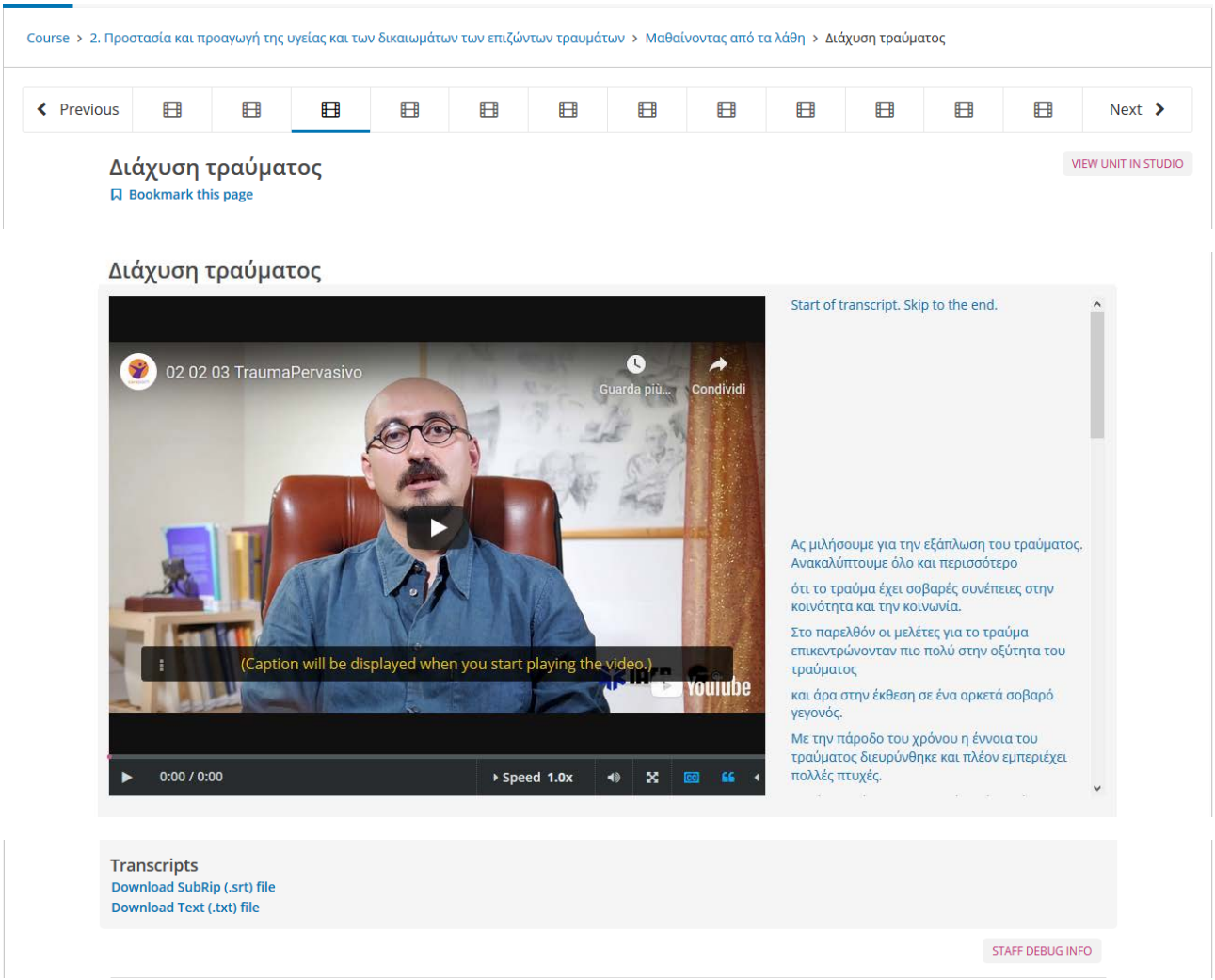


Transcript

Είναι σημαντικές οι αρνητικές επιπτώσεις, σωματικές και ψυχικές, σε όσους υποφέρουν
από τραύμα οποιασδήποτε μορφής.
Ο Παγκόσμιος Οργανισμός Υγείας διαβεβαιώνει ότι οι διάφορες μορφές τραύματος συνιστούν
ουσιαστικά μία κατάσταση έκτακτης ανάγκης.
Βλέπουμε ότι το ανθρώπινο κεφάλαιο υποφέρει κατά πολύ σε ψυχοσωματικό επίπεδο
όταν έχει υποστεί τραύμα,
και η ικανότητα αποτελεσματικής συμβολής του στην ευημερία της κοινότητας
καθίσταται δύσκολη γιατί όποιος έχει υποστεί τραύμα χρήζει θεραπείας
και αυτή, με τη σειρά της, απαιτεί οικονομικούς πόρους και χρηματοδότηση,
ενώ παράλληλα ο ίδιος αδυνατεί να παράξει ευημερία για τον εαυτό του,
την οικογένειά του, την κοινότητα και τη χώρα του.
Επίσης, επισημαίνουμε και άλλη μία πτυχή, πολύ ανησυχητική για τα θύματα τραύματος.
Ότι το θύμα όχι μόνο γίνεται

ένα άτομο με βλάβες στη σωματική και ψυχική του υγεία, αλλά συχνά,
κυρίως για κάποια είδη τραύματος, όπως στα θύματα βίας, σεξουαλικής ή άλλης,
είναι πολλά τα περιστατικά στα οποία γίνονται οι ίδιοι δράστες και τραυματίζουν αθώα άτομα
και από θύματα γίνονται θύτες. Αυτό είναι τρομερό, λες και το τραύμα είναι ένας ιός που εξαπλώνεται
αν δεν εξαλειφθεί, δεν προβλεφθεί, δεν θεραπευτεί αποτελεσματικά στην κοινότητα: γίνεται πανδημία.
Θα μπορούσαμε όντως να μιλήσουμε για πανδημίες, για κάτι που εξαπλώνεται από άνθρωπο σε άνθρωπο
αστραπιαία σε όλο τον πληθυσμό, με αποτέλεσμα η απώλεια ανθρώπινου κεφαλαίου να γίνεται
ολοένα και πιο σοβαρή.
Επίσης, είναι προφανές ότι σε μία βιοψυχοκοινωνική προσέγγιση δεν μπορούμε να αναθέσουμε μόνο
στον τομέα της υγείας την πρόληψη και θεραπεία του τραύματος, αλλά αυτό είναι καθήκον
της πολιτικής όλων των θεσμών: στο σχολείο, στον χώρο εργασίας, στους οργανισμούς και στον κόσμο
της δικαιοσύνης ανηλίκων, οι οποίοι πρέπει να ευαισθητοποιηθούν απέναντι σε αυτά τα ζητήματα
και να συμμετάσχουν σε ένα αποτελεσματικό δίκτυο πρόληψης και αντιμετώπισης του τραύματος.
Κάτι τέτοιο θα αποβεί ευεργετικό για όλους.

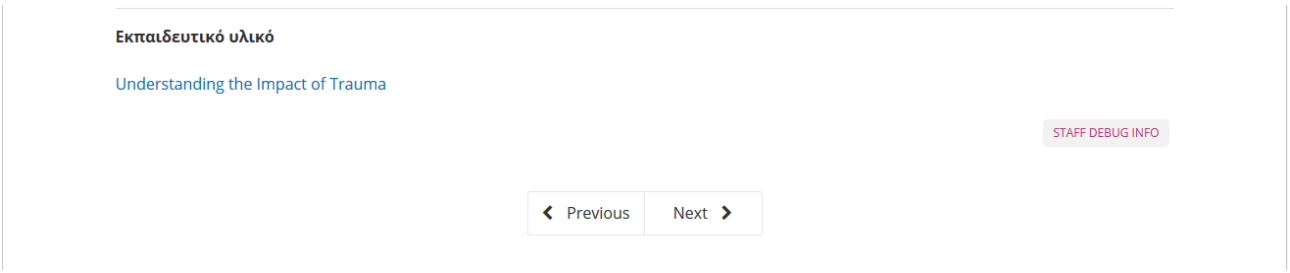


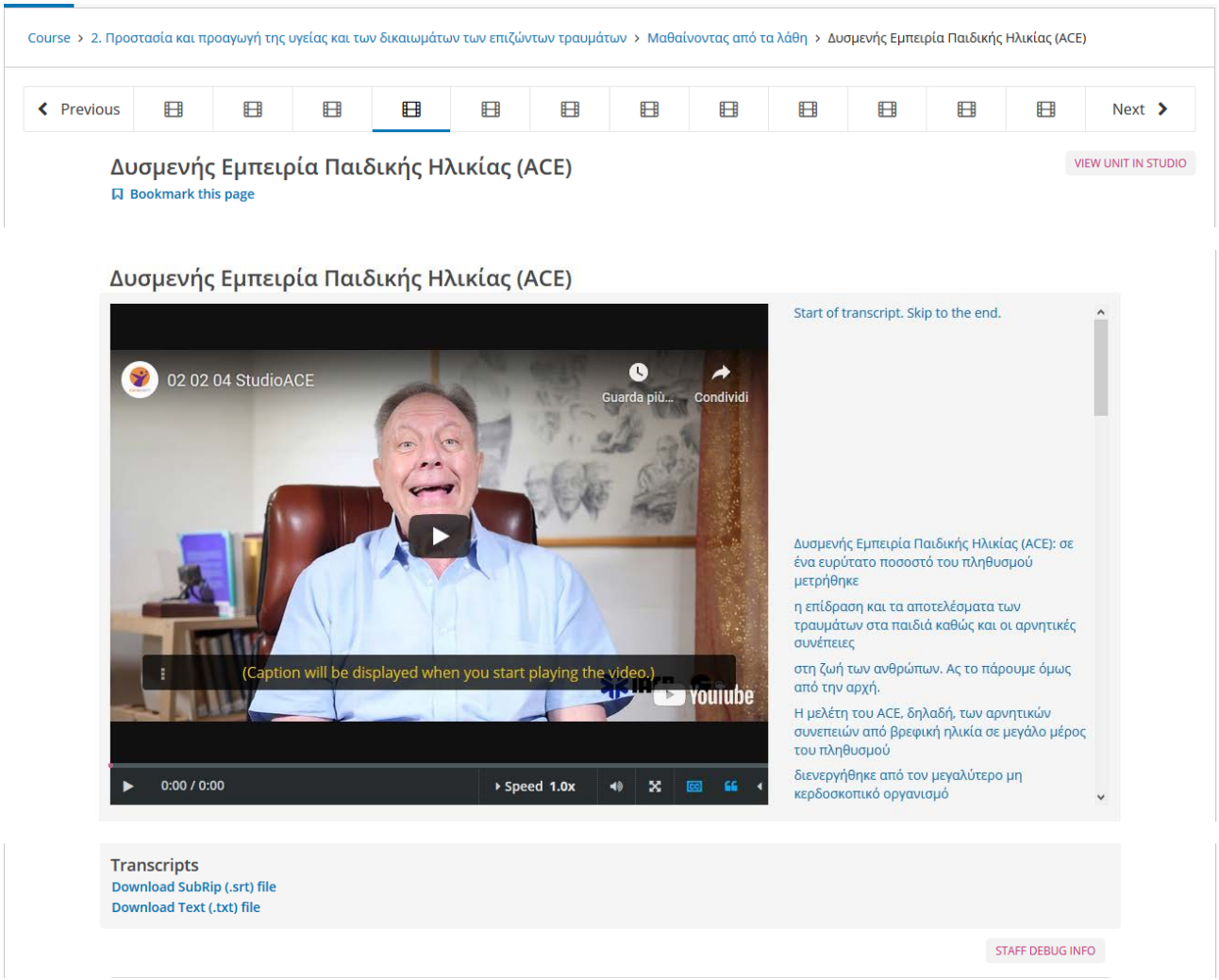


Transcript

Ας μιλήσουμε για την εξάπλωση του τραύματος. Ανακαλύπτουμε όλο και περισσότερο
ότι το τραύμα έχει σοβαρές συνέπειες στην κοινότητα και την κοινωνία.
Στο παρελθόν οι μελέτες για το τραύμα επικεντρώνονταν πιο πολύ στην οξύτητα του τραύματος
και άρα στην έκθεση σε ένα αρκετά σοβαρό γεγονός.
Με την πάροδο του χρόνου η έννοια του τραύματος διευρύνθηκε και πλέον εμπεριέχει πολλές πτυχές.
Σε κάθε περίπτωση, το τραύμα είναι κάτι που έχει την ιδιότητα να εξαπλώνεται
στις κοινωνίες μας. Γνωρίζουμε ότι ένας ενήλικας έχει εκτεθεί, και θα εκτεθεί και στο μέλλον,
τουλάχιστον μία φορά σε κάποιο τραυματικό γεγονός.
Από μελέτες, γνωστές στη βιβλιογραφία ως μελέτες του Μπένγκετ, γνωρίζουμε
ότι το ποσοστό του τραύματος είναι πολύ υψηλό σε διάφορες χώρες, με διαφοροποιήσεις,
αλλά παραμένει, παγκοσμίως, σε υψηλά επίπεδα.
Άρα είναι σημαντικό σήμερα να εμβαθύνουμε σχετικά με τα στοιχεία που λειτουργούν προστατευτικά
αλλά και με όσα αυξάνουν τον κίνδυνο έκθεσης σε τραύμα.

Γνωρίζουμε από άλλες σχετικές μελέτες ότι το τραύμα αποτελεί επίσης τη βάση
πολλών χρόνιων διαταραχών που σήμερα έχουν σοβαρές επιπτώσεις σε οικονομικό επίπεδο
και στη δημόσια υγεία αλλά κυρίως υπονομεύουν τις ικανότητες του ατόμου
να εκφράσει τις δυνατότητές του και να γίνει ένας πολίτης απόλυτα συνειδητός
και χρήσιμος στην κοινότητα και την κοινωνία όπου ζει.
Ακόμα πιο σοβαρό είναι το τραύμα, αν θεωρήσουμε ότι όλα αυτά τα τραύματα λαμβάνουν χώρα
στην αναπτυξιακή περίοδο του ατόμου.
Εκεί ακριβώς, την περίοδο που το άτομο χτίζει
τις ικανότητές του σε επίπεδο συναισθηματικό και κοινωνικό/σχεσιακό, ένα ενδεχόμενο τραύμα
μπορεί να αναστείλει κατά πολύ την ανάπτυξη αυτών των ικανοτήτων,
υπονομεύοντας σημαντικά
τη μελλοντική ανάπτυξη του ατόμου.
Θα είναι, λοιπόν, θεμελιώδες, και είναι ήδη, να εμβαθύνουμε στις γνώσεις μας σχετικά με το τραύμα,
δηλαδή να είμαστε ενημερωμένοι, όπως ακριβώς κάνουμε τώρα από αυτό το βήμα.





Transcript

Δυσμενής Εμπειρία Παιδικής Ηλικίας (ACE): σε ένα ευρύτατο ποσοστό του πληθυσμού μετρήθηκε

η επίδραση και τα αποτελέσματα των τραυμάτων στα παιδιά καθώς και οι αρνητικές συνέπειες

στη ζωή των ανθρώπων. Ας το πάρουμε όμως από την αρχή.

Η μελέτη του ACE, δηλαδή, των αρνητικών συνεπειών από βρεφική ηλικία σε μεγάλο μέρος του πληθυσμού

διενεργήθηκε από τον μεγαλύτερο μη κερδοσκοπικό οργανισμό

ασφαλίσεων υγείας: η "Kaiser Permanente", ιδιωτική μη κερδοσκοπική ασφαλιστική εταιρεία

στην Καλιφόρνια, επένδυσε πολλά εκατομμύρια δολάρια για να εκπονήσει αυτή τη μελέτη

που απέβη επωφελής για όλη την επιστημονική κοινότητα γιατί τώρα γνωρίζουμε, και πλέον παρόμοιες μελέτες

έχουν επιβεβαιώσει τα πρωταρχικά στοιχεία, ότι κατά μέσο όρο τουλάχιστον το 1/3

του πληθυσμού, δηλαδή των πολιτών, πλήττεται σε παιδική ηλικία τουλάχιστον

από ένα δυσμενές επεισόδιο και άρα από ένα τραύμα.

Μικρότερη μερίδα των πολιτών πλήττεται

από δύο τύπους τραυμάτων

και ακόμα λιγότεροι έχουν υποστεί μεγαλύτερο αριθμό τραυμάτων.

Όσο περισσότερα πολλαπλά τραύματα έχει υποστεί κάποιος τόσο περισσότερο υποφέρει από τις αρνητικές επιπτώσεις,

όπως όταν μια μαχαιριά είναι πολύ επώδυνη αλλά ακόμα χειρότερες είναι οι πολλαπλές μαχαιριές.

Τα τραύματα είναι χειρότερα από τις μαχαιριές, γιατί έχουν αρνητικές επιπτώσεις στο σώμα,

όπως οι μαχαιριές, αλλά και στην ψυχή του θύματος της συγκεκριμένης βίας

και επιπλέον είναι, κατά κάποιο τρόπο, σαν ένας ιός που οδηγεί τους πληγέντες

από τραύματα,

κυρίως από τραύματα στα οποία υπήρξαν θύματα βίας, σεξουαλικής κακοποίησης κτλ.,

να γίνουν οι ίδιοι θύτες ως ενήλικοι.

Επιπλέον, τα προβλήματα είναι τόσο ψυχικού όσο και σωματικού τύπου,

αν και συχνά αυτά τα δύο αλληλοσυνδέονται. Δηλαδή, τα άτομα που έχουν υποστεί τραύμα

προσπαθούν ενστικτωδώς να επιδιορθώσουν το τραύμα, να κάνουν το λεγόμενο "coping",

να διαχειριστούν το γεγονός και κάποιες πτυχές αυτής της διαχείρισης του γεγονότος ίσως να είναι

αποτελεσματικές αρχικά αλλά έχουν μεγάλο μακροπρόθεσμο κόστος. Για παράδειγμα,

για να διαχειριστούν τις επιπτώσεις του τραύματος, κάποιοι προσπαθούν να ανακουφιστούν καταναλώνοντας

αλκοόλ ή ναρκωτικές ουσίες, οι οποίες όμως αμέσως δημιουργούν

άλλο πρόβλημα και επιδεινώνουν την κατάσταση,

γιατί τα άτομα γίνονται όλο και πιο εξαρτημένα από το αλκοόλ και τις ουσίες. Σε επίπεδο συμπεριφοράς,

είναι γνωστό ότι αποφεύγουν τους άλλους, αλλά όσο απομονώνονται χάνουν την ευκαιρία

να "γεμίσουν τις μπαταρίες τους" ή επιδίδονταισε σεξουαλικές ασυδοσίες.

Άρα οι δυσμενείς εμπειρίες της παιδικής ηλικίας είναι κοινωνική μάστιγα και, μάλιστα, δαπανηρή

γιατί το κόστος των θεραπειών είναι επαχθέστατο. Προς όφελος όλων, όλοι πρέπει να προσπαθήσουν

για μια αποτελεσματική πρόληψη και θεραπεία των τραυμάτων που υφιστάμεθα ως παιδιά.

Γιατί αυτό θα αποβεί ωφέλιμο

όχι μόνο για τα θύματα αλλά και για όλη την κοινωνία.

Εκπαιδευτικό υλικό

About the CDC-Kaiser ACE Study

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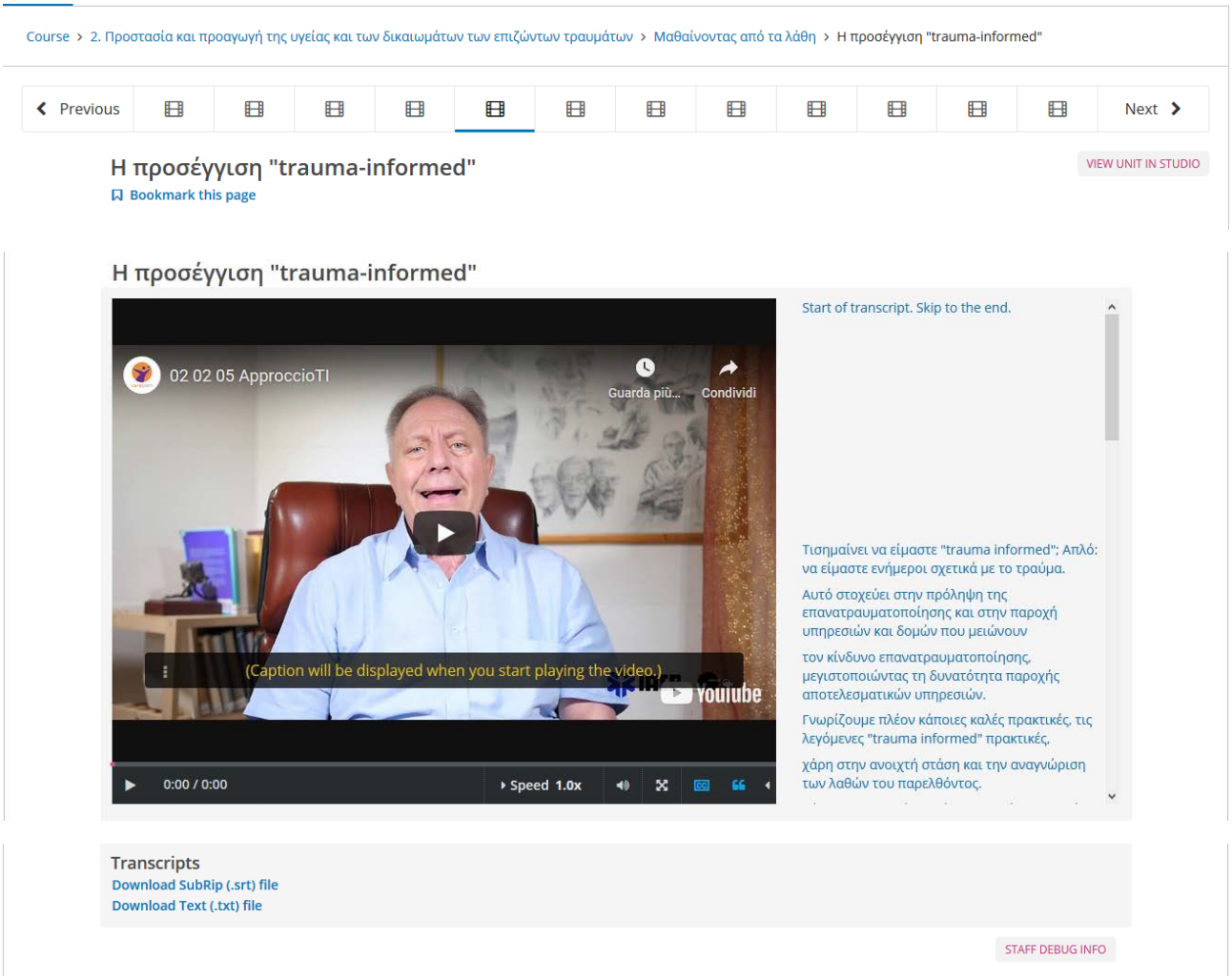


Transcript

Τισημαίνει να είμαστε "trauma informed"; Απλό: να είμαστε ενήμεροι σχετικά με το τραύμα.

Αυτό στοχεύει στην πρόληψη της επανατραυματοποίησης και στην παροχή υπηρεσιών και δομών που μειώνουν

τον κίνδυνο επανατραυματοποίησης, μεγιστοποιώντας τη δυνατότητα παροχής αποτελεσματικών υπηρεσιών.

Γνωρίζουμε πλέον κάποιες καλές πρακτικές, τις λεγόμενες "trauma informed" πρακτικές,

χάρη στην ανοιχτή στάση και την αναγνώριση των λαθών του παρελθόντος.

Λάθη που διαπράξαμε όχι εσκεμμένα, φυσικά, αλλά από άγνοια,

επειδή ακριβώς δεν γνωρίζαμε

ότι κάποιες πτυχές των θεραπειών του παρελθόντος ήταν μέρος του προβλήματος και όχι της λύσης.

Για παράδειγμα, όταν οι θεραπευόμενοι πιέζονταν, παρά τη θέλησή τους, να θυμηθούν παλαιότερα τραύματα

βίωναν εκ νέου τις τραυματικές στιγμές και πάει λέγοντας.

Σήμερα, χάρη σε όσα μάθαμε από τα λάθη του παρελθόντος,

έχουμε μια σειρά από κατευθυντήριες οδηγίες,

από παραμέτρους που βοηθούν στην πρόληψη των βλαβών και στη μεγιστοποίηση των ωφελειών

από τις παρεχόμενες υπηρεσίες.

Κι αυτό, όχι μόνο στον τομέα της υγείας, της ψυχικής υγείας,

αλλά σε κάθε τομέα,

όπως στα σχολεία, στους οργανισμούς, στη νομοθεσία της δικαιοσύνης ανηλίκων

ή και στη γενικότερη νομοθεσία. Η "Trauma Informed School" είναι μια σχολή με ευαισθησία

στην προβληματική του τραύματος κι έτσι οι διδάσκοντες θα ξέρουν πως ένας άτακτος μαθητής

δεν είναι πάντα μόνο άτακτος αλλά εκφράζει μια δυσκολία που οφείλεται σε ένα τραύμα

και με αυτή τη γνώση θα έχουν ένα διορθωτικό εργαλείο, παραπέμποντας τον μαθητή στον ψυχολόγο

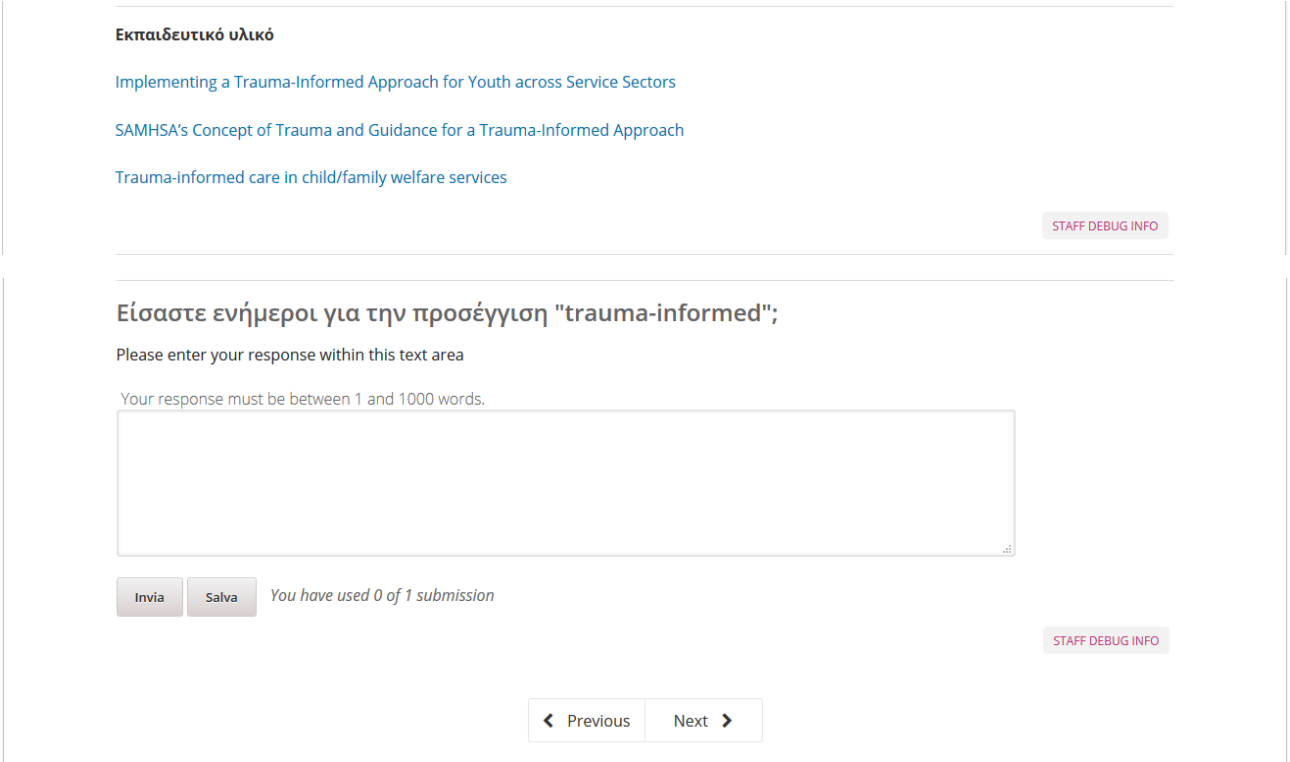
για να λάβει βοήθεια και για να μη γίνει το πρόβλημα ακόμα σοβαρότερο από ό,τι ήδη είναι.

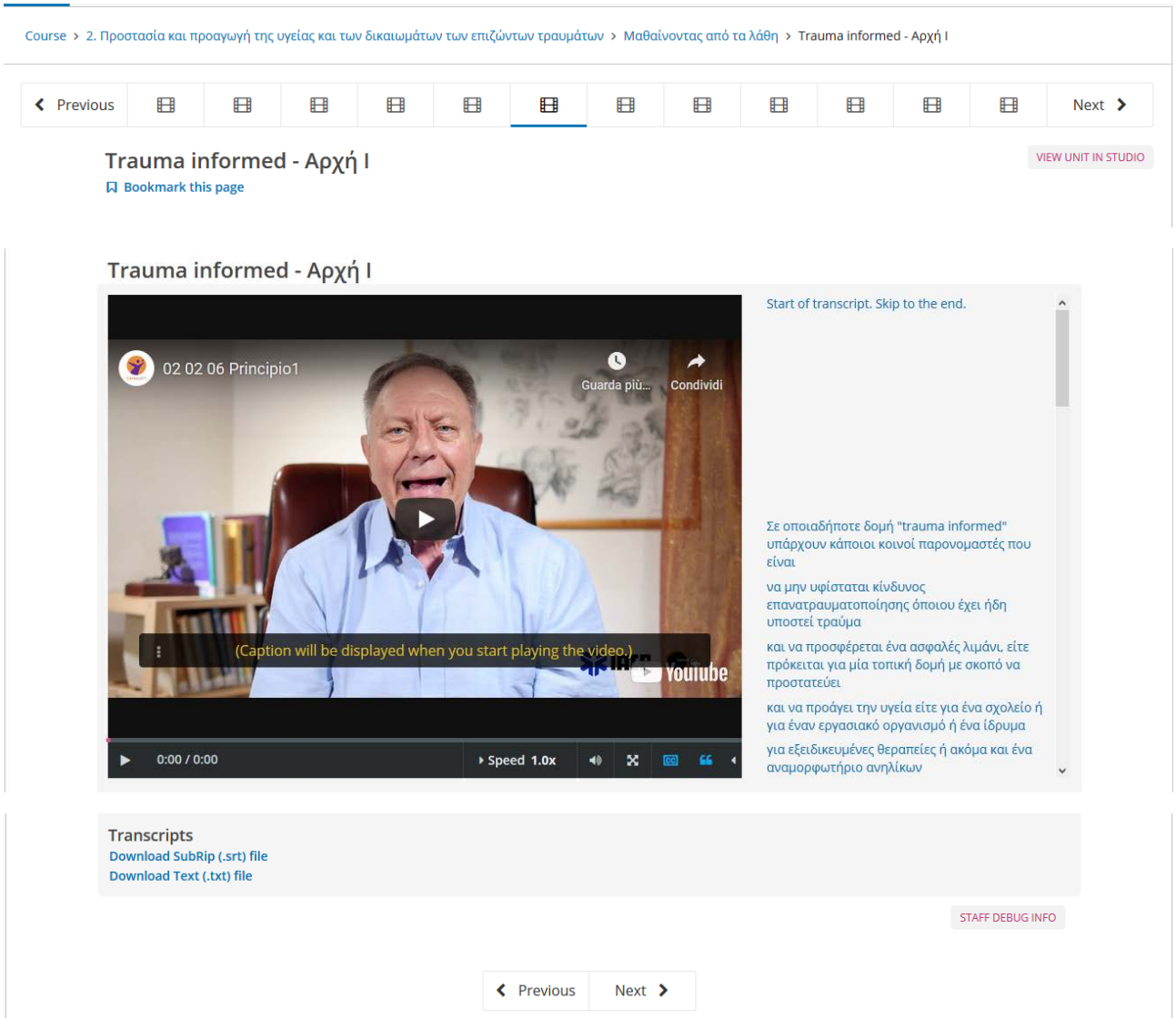
Κατά βάθος, η "trauma informed" προσέγγιση δεν είναι μόνο υποχρέωσή μας, από άποψη ηθική,

κλινική και ψυχικής υγείας, αλλά και αποδοτική στη σχέση κόστους-ωφελειών,

γιατί η παροχή θεραπειών που μειώνουν τις βλάβες αποβαίνει προς όφελος όχι μόνο των θυμάτων

που έχουν υποστεί τραύματα αλλά και ολόκληρης της κοινωνίας.





Transcript

Σε οποιαδήποτε δομή "trauma informed" υπάρχουν κάποιοι κοινοί παρονομαστές που είναι

να μην υφίσταται κίνδυνος επανατραυματοποίησης όποιου έχει ήδη υποστεί τραύμα

και να προσφέρεται ένα ασφαλές λιμάνι, είτε πρόκειται για μία τοπική δομή με σκοπό να προστατεύει

και να προάγει την υγεία είτε για ένα σχολείο ή για έναν εργασιακό οργανισμό ή ένα ίδρυμα

για εξειδικευμένες θεραπείες ή ακόμα και ένα αναμορφωτήριο ανηλίκων

και μέρος του δικαστικού συστήματος.

Ακόμα και μία κοινότητα, για να είναι "trauma informed", πρέπει να έχει αυτούς τους κοινούς παρονομαστές

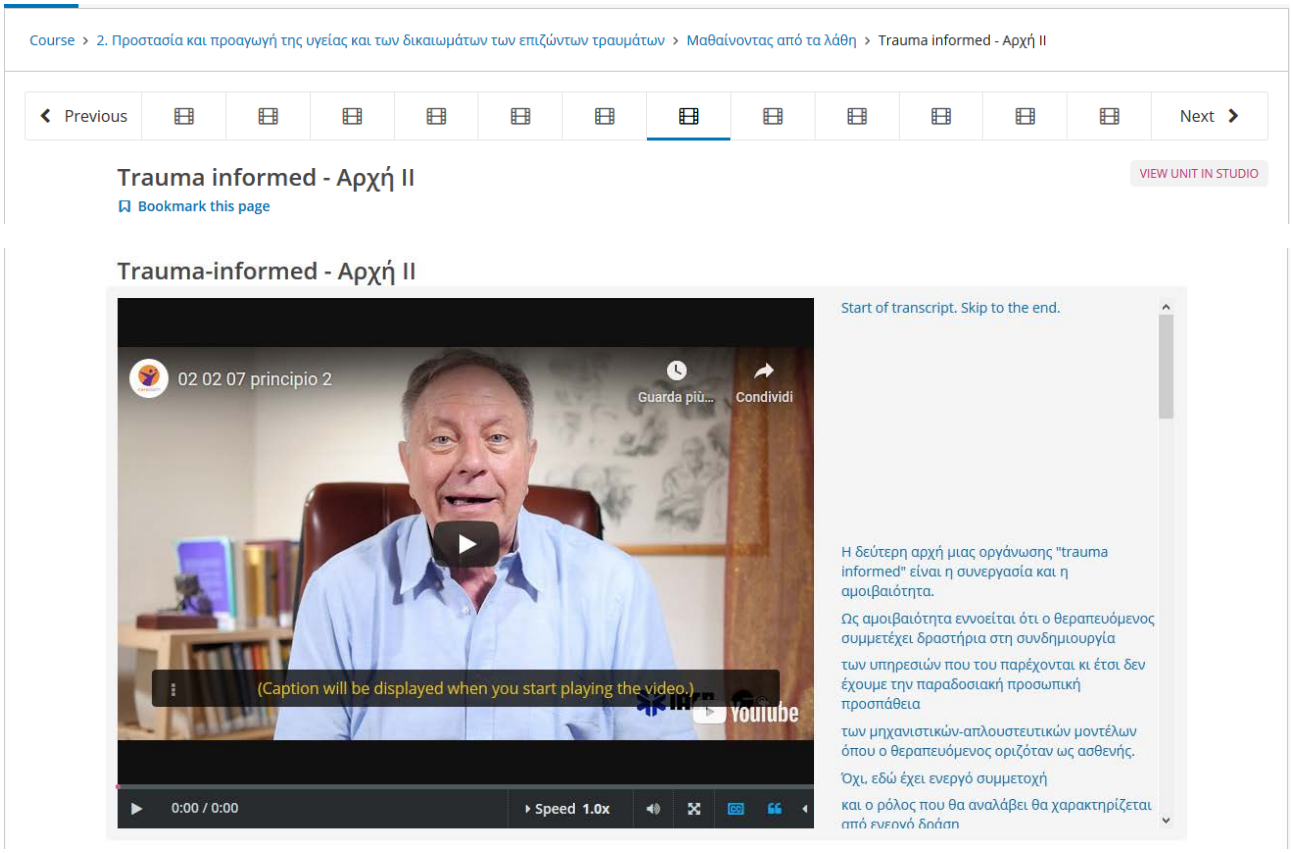
που χαρακτηρίζονται από την εξής κόκκινη γραμμή.

Όλοι οι κοινοί παρονομαστές ενοποιούνται στην επιθυμία να ενημερώσουμε σχετικά

και να εξασφαλίσουμε στον θεραπευόμενο που έχει υποστεί τραύμα

μια πλήρη αίσθηση ασφάλειας,

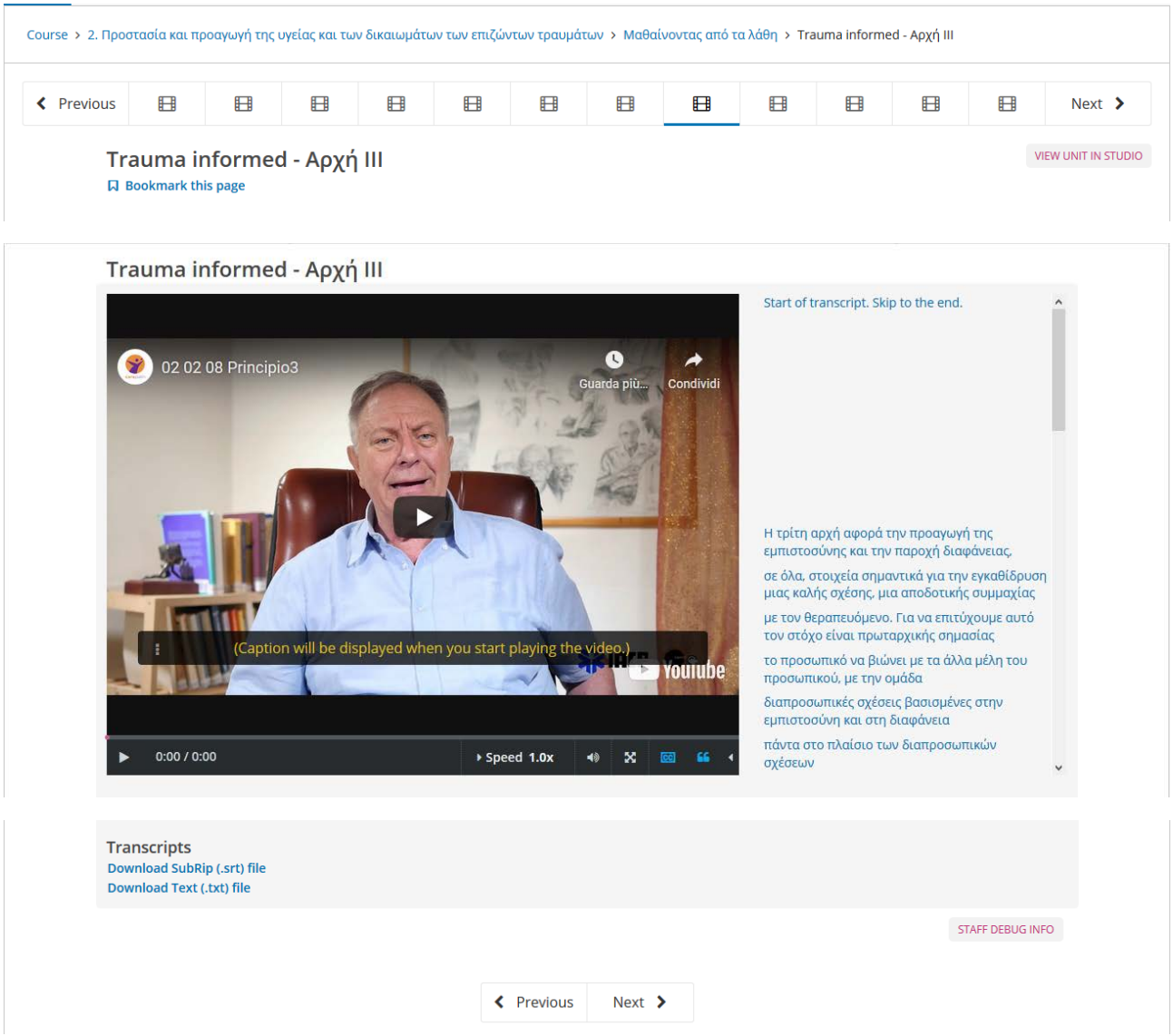
σωματικής και ψυχολογικής, να είμαστε ένα ασφαλές λιμάνι.
Η πρώτη "trauma informed" αρχή είναι ότι η δομή πρέπει να παρέχει ασφάλεια, σωματική
και συναισθηματική, και το πρόσωπο να έχει, αφού ενημερωθεί σχετικά, τη βεβαιότητα
αλλά και την εμπειρία ότι όλα είναι καλά, δεν υπάρχει καμία πιθανότητα επίθεσης εις βάρος του,
βρίσκεται σε έναν ασφαλή τόπο όπου δεν χρειάζεται να είναι σε επιφυλακή
ή να ζει μέσα στην αγωνία.
Η "trauma informed" δομή είναι επίσης πολύ φιλόξενη, σε κάθε πτυχή επικοινωνίας
και μετεπικοινωνίας και άρα ο θεραπευόμενος είναι ευπρόσδεκτος, του λέμε "καλώς ήρθες"
ή "καλώς ήρθες πάλι", και όλοι είναι πεπεισμένοι ότι ο θεραπευόμενος είναι ένα πρόσωπο
που όντως καλωσορίζεται στον χώρο.
Μία δομή, για να κερδίσει την εμπιστοσύνη και να προσφέρει ασφάλεια στους θεραπευόμενους,
πρέπει να είναι συνεπής: όλα της τα μηνύματα πρέπει να αντιστοιχούν πλήρως στις πράξεις της
και να έχουν διάρκεια στον χρόνο.
Μόνο έτσι ο θεραπευόμενος θα μπορέσει να θρέψει και να αναπτύξει αληθινή εμπιστοσύνη
και να νιώσει ότι η δομή όντως είναι φιλόξενη, ένα ασφαλές λιμάνι που μπορεί να εμπιστευτεί.
Σε μία "trauma informed" δομή δεν υπάρχει χώρος ή θέση για τη βία, τη ντροπή και την ενοχή,
όλα τους στοιχεία πολύ προβληματικά που μπορούν να επιβαρύνουν ή να επανατραυματοποιήσουν
όποιον έχει ήδη υποστεί τραύμα.
Επίσης, μια δομή "trauma informed" διασφαλίζει την εχεμύθεια και το επαγγελματικό απόρρητο
και την ιδιωτικότητα του θεραπευόμενου, που δεν θα εκτεθεί σε τέτοιου είδους
κινδύνους και βία.
Επιπλέον, η γλώσσα
σε μία δομή "trauma informed" επικεντρώνεται στο πρόσωπο,
δηλαδή, πρόκειται για μια γλώσσα με σαφήνεια και συνοχή,
την οποία θα μπορεί να καταλάβει ο θεραπευόμενος
και όχι αινιγματικά επαγγελματικά ιδιώματα
που χρειάζεται κανείς τρία πτυχία για να μπορέσει να τα κατανοήσει.



Transcript

Η δεύτερη αρχή μιας οργάνωσης "trauma informed" είναι η συνεργασία και η αμοιβαιότητα.
Ως αμοιβαιότητα εννοείται ότι ο θεραπευόμενος συμμετέχει δραστήρια στη συνδημιουργία
των υπηρεσιών που του παρέχονται κι έτσι δεν έχουμε την παραδοσιακή προσωπική προσπάθεια
των μηχανιστικών-απλουστευτικών μοντέλων όπου ο θεραπευόμενος οριζόταν ως ασθενής.
Όχι, εδώ έχει ενεργό συμμετοχή
και ο ρόλος που θα αναλάβει θα χαρακτηρίζεται από ενεργό δράση
στην πορεία ανάκτησης των ικανοτήτων και των δυνατοτήτων του.
Μία δομή "trauma informed" θα προάγει
την ανάκτηση του αυτοσεβασμού,
που αποτελεί κρίσιμη πτυχή σε όσους έχουν υποστεί τραύμα,
αλλά και την ελπίδα, την ανάρρωση,
την ανάκτηση των δυνατοτήτων τους.
Μία δομή σαν αυτή θα κάνει πάντα σαφές, κυρίως στον εαυτό της,
ότι η ανάκτηση της υγείας, της λειτουργικότητας ενός ατόμου που υποφέρει
από διαταραχή μετατραυματικού στρες,
από τραύματα, μπορεί να επιτευχθεί μόνο μέσα από τις αποτελεσματικές σχέσεις
που το προσωπικό της δομής καταφέρνει να εγκαθιδρύσει με τον θεραπευόμενο.
Πρόκειται, δηλαδή, για ένα ομαδικό παιχνίδι, για μια συμμαχία εργασίας.
Η από κοινού λήψη αποφάσεων είναι κεντρική για τη διασφάλιση της καλής λειτουργίας
της παρεχόμενης υπηρεσίας.
Κατ' αρχάς ξέρουμε καλά, το έχουν αποδείξει οι έρευνες του Κάρασεκ σχετικά με το άγχος,
ότι αν έχω κάποια αγχογόνα ερεθίσματα αλλά αυξημένη δύναμη ελέγχου,
το άγχος μειώνεται,

ενώ αν έχω περιορισμένο έλεγχο της κατάστασης το άγχος αυξάνει.
Αυτή την αρχή εφαρμόζουμε.
Άρα η παραχώρηση στον θεραπευόμενο εξουσίας λήψης αποφάσεων και ελέγχου είναι μέρος της θεραπείας.
Με άλλα λόγια, όταν ο θεραπευόμενος έχει μεγαλύτερο έλεγχο,
είναι ικανός να ξεπεράσει καλύτερα την κατάστασή του.
Μία δομή επικεντρωμένη στην παροχή υπηρεσιών τύπου "trauma informed" δεν ενθαρρύνει υπερβολικές ανισότητες εξουσίας ή επίπεδα διαφοράς δυναμικότητας μεταξύ της δομής,
των θεραπευτών της και του θεραπευόμενου, αλλά ενισχύει ενεργά το άτομο και αναγνωρίζει στον θεραπευόμενο το δικαίωμα να ασκήσει προσωπικό έλεγχο και εξουσία κατά τη συνδημιουργία
της πραγματικότητας που συμβιώνεται.
Η δομή "trauma informed" είναι συστημική και ολιστική υπό την έννοια
ότι έχει απόλυτη επίγνωση
πως πρέπει να λειτουργήσει βασιζόμενη στην κοινωνική οικοδόμηση μιας πραγματικότητας τύπου "trauma informed". Κάθε πτυχή συμβάλλει προς αυτό τον σκοπό.
Συνεπώς, θα υπάρξει σχετική φροντίδα, από το άλφα ως το ωμέγα,
από την έναρξη της εισόδου και την υποδοχή
ως και τα πρόσωπα που έχουν υποβληθεί σε θεραπεία,
καθώς ο θεραπευόμενος θα συνοδεύεται και θα έχει βοήθεια ώστε να ζήσει αποτελεσματικά το μεταθεραπευτικό στάδιο, το λεγόμενο "after care".



Transcript

Η τρίτη αρχή αφορά την προαγωγή της εμπιστοσύνης και την παροχή διαφάνειας,
σε όλα, στοιχεία σημαντικά για την εγκαθίδρυση μιας καλής σχέσης, μια αποδοτικής συμμαχίας
με τον θεραπευόμενο. Για να επιτύχουμε αυτό τον στόχο είναι πρωταρχικής σημασίας
το προσωπικό να βιώνει με τα άλλα μέλη του προσωπικού, με την ομάδα
διαπροσωπικές σχέσεις βασισμένες στην εμπιστοσύνη και στη διαφάνεια
πάντα στο πλαίσιο των διαπροσωπικών σχέσεων
μεταξύ των εργαζομένων, των θεραπευομένων και των οικογενειών τους.
Ένα άλλο σημαντικό στοιχείο είναι ο σεβασμός και η τήρηση των ορίων, γιατί όταν έχουμε
σαφή όρια, δημιουργούμε και σαφή πεδία. Αν δεν σεβόμαστε τα όρια
σημαίνει ότι μολύνουμε τα "περιβάλλοντα" εργασίας και τα καθιστούμε δυσλειτουργικά.
Η διαφάνεια είναι θεμελιώδης και οι πολιτικές πρέπει να είναι σαφείς,

όπου όλα θα διατυπώνονται με γλώσσα όχι γραφειοκρατική αλλά σαφή και διάφανη.

Η σαφήνεια είναι απαραίτητη και για άλλο λόγο.

Όλοι, και κυρίως οι θεραπευόμενοι, πρέπει να γνωρίζουν σε τι χώρο βρίσκονται,

ποια είναι τα δικαιώματα και οι υποχρεώσεις, ποια είναι η δομή και το προσωπικό

με το οποίο δουλεύουν.

Για αυτό είναι αναγκαία η απόλυτη σαφήνεια ρόλων αλλά και η γνώση ότι οι διάφοροι επαγγελματίες

που εργάζονται σε μία δομή έχουν ποικίλα καθήκοντα

και παρέχουν διάφορες υπηρεσίες, κανένας δεν είναι παντογνώστης.

Όπως και σε μία δομημένη κοινωνία ο φούρναρης φτιάχνει το ψωμί,

ο γαλατάς διανέμει το γάλα, ο μηχανικός κάνει το καθήκον του και πάει λέγοντας.

Θεμελιώδης για μία δομή "trauma informed" είναι ο σεβασμός των δικαιωμάτων και η προαγωγή

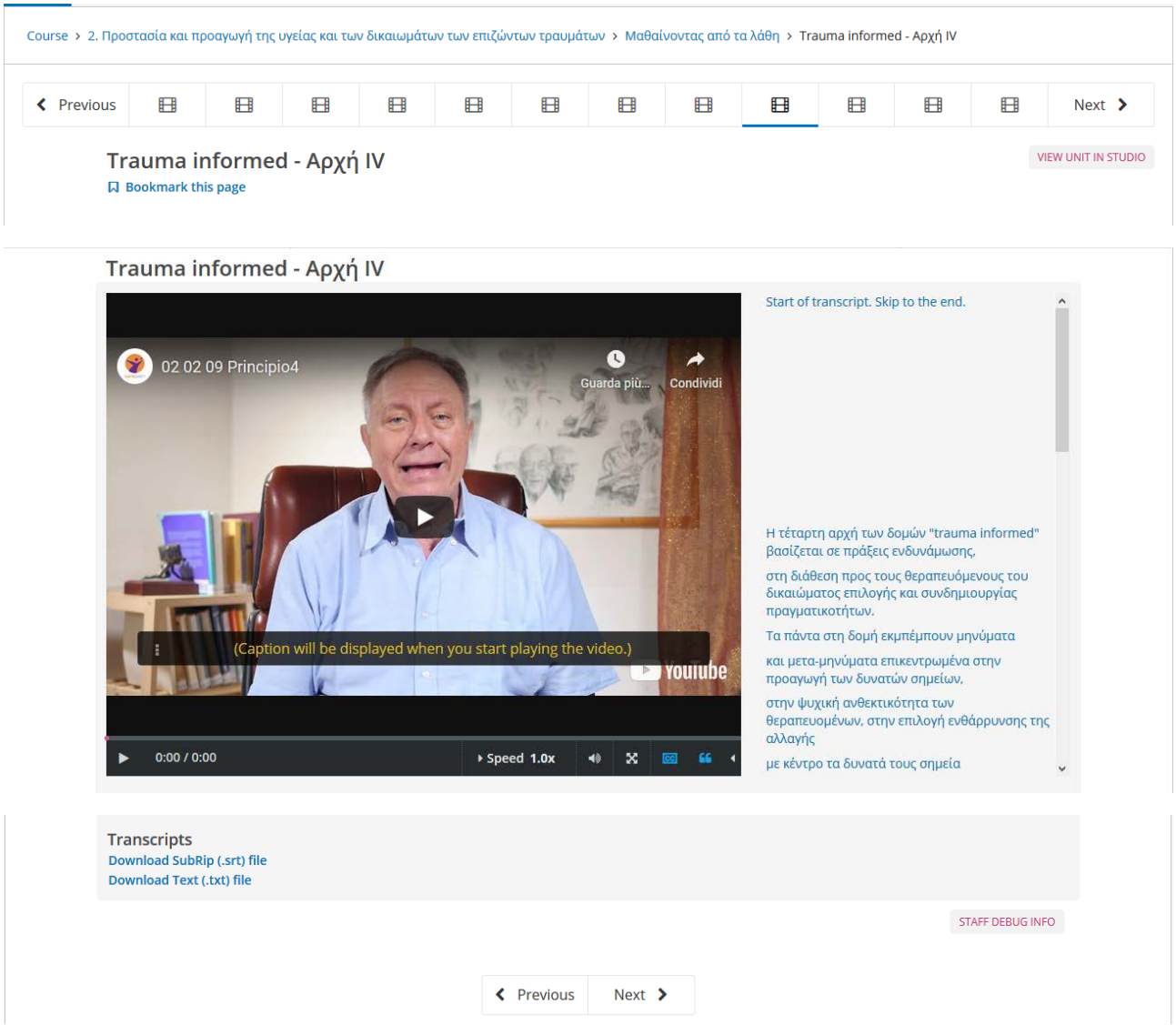
ιδίως των δικαιωμάτων των θεραπευομένων. Είναι, λοιπόν, θεμελιώδης

η λήψη μίας ειλικρινούς, κατόπιν πληροφόρησης, συναίνεσης

εξηγώντας στον θεραπευόμενο πώς αντιμετωπίζονται οι διαδικασίες και η παροχή υπηρεσιών

και κάνοντας ό,τι είναι δυνατό για να διασφαλίσουμε ότι η κατανόηση και η συναίνεση

είναι όντως πραγματικές και όχι απλώς τυπικές διαδικασίες.



Transcript

Η τέταρτη αρχή των δομών "trauma informed" βασίζεται σε πράξεις ενδυνάμωσης,

στη διάθεση προς τους θεραπευόμενους του δικαιώματος επιλογής και συνδημιουργίας πραγματικοτήτων.

Τα πάντα στη δομή εκμπέμπουν μηνύματα

και μετα-μηνύματα επικεντρωμένα στην προαγωγή των δυνατών σημείων,

στην ψυχική ανθεκτικότητα των θεραπευομένων, στην επιλογή ενθάρρυνσης της αλλαγής

με κέντρο τα δυνατά τους σημεία

και όχι τις αδυναμίες ή τις δυσλειτουργίες του θεραπευόμενου.

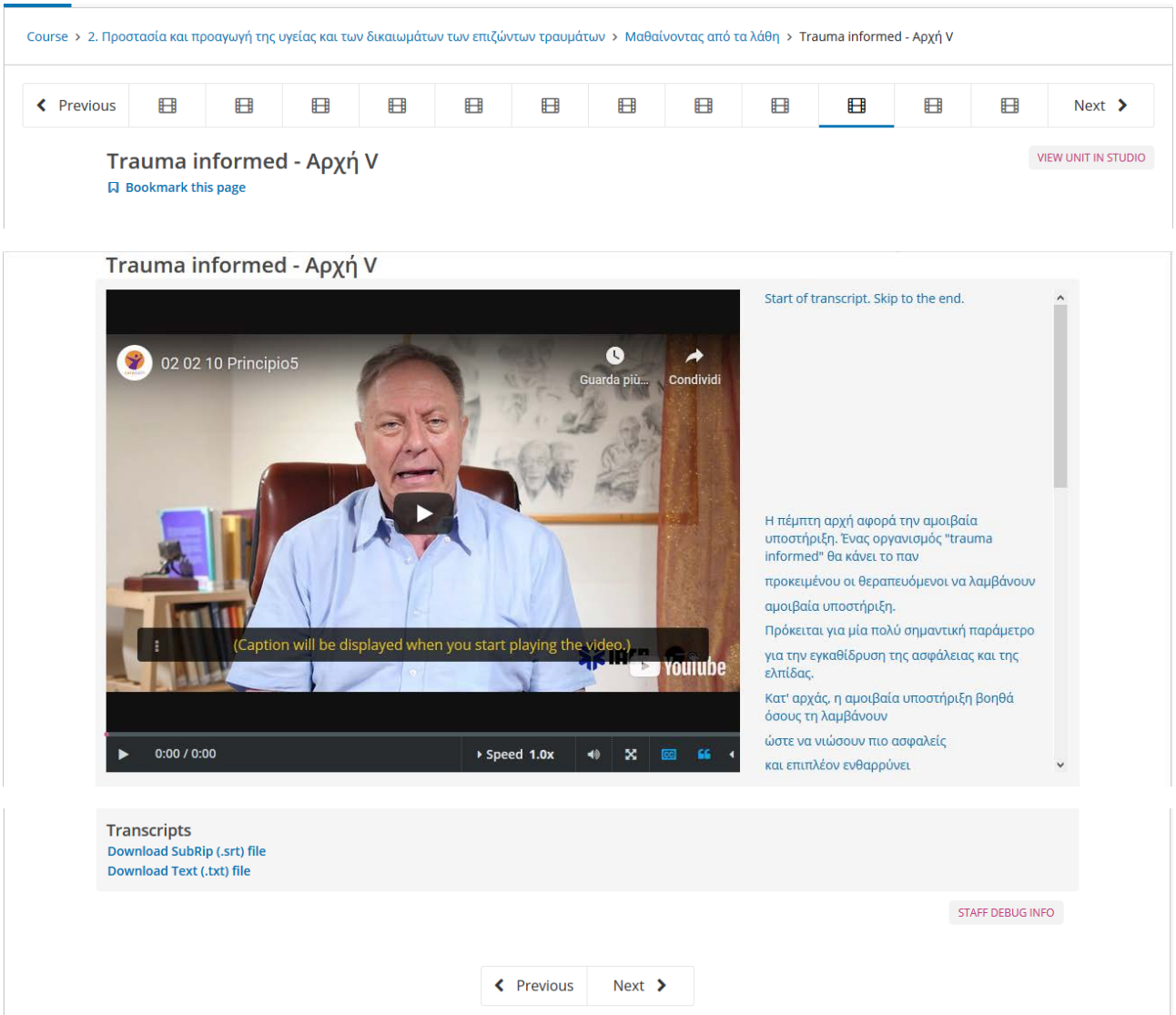
Η έμφαση δίνεται στην προαγωγή της συνειδητοποίησης από τον θεραπευόμενο

του τρόπου με τον οποίο έχει αντιμετωπίσει στο παρελθόν,

ενίοτε αποτελεσματικά, τις διάφορες καταστάσεις, δηλαδή, στη διαχείριση.

Πρόκειται, λοιπόν, για την εφαρμογή μιας φιλοσοφίας με έμφαση στη χρησιμότητα

των δυνατών σημείων ως βάσης. Με άλλα λόγια, στο παρελθόν επικεντρωνόμασταν στις παθολογίες και στον περιορισμό τους,
ενώ τώρα βασιζόμαστε στην υγεία και στη δύναμη προάγοντας την επέκταση και τη διεύρυνσή τους.
Επιπλέον, δίνεται αξία στους κοινωνικούς ρόλους γιατί είμαστε κοινωνικά θηλαστικά
κι αυτό είναι πολύ σημαντικό για την ταυτότητα και την ανάπυξη των δυνατοτήτων μας.
Ο στόχος, όπως δηλώνεται και επιδιώκεται,
είναι να προάγουμε τις ικανότητες αυτορρύθμισης,
αυτονομίας και αυτοδιαχείρισης των θεραπευομένων και έτσι θα τονίσουμε την πιθανότητα ανάπτυξης ακόμα και μέσα από τις τραυματικές εμπειρίες.
Δεν δίνεται έμφαση στο ότι κάποιος είναι ένα άμοιρο θύμα,
αλλά στην ικανότητά του να είναι ψυχικά ανθεκτικός.



Transcript

Η πέμπτη αρχή αφορά την αμοιβαία υποστήριξη. Ένας οργανισμός "trauma informed" θα κάνει το παν
προκειμένου οι θεραπευόμενοι να λαμβάνουν
αμοιβαία υποστήριξη.
Πρόκειται για μία πολύ σημαντική παράμετρο
για την εγκαθίδρυση της ασφάλειας και της ελπίδας.
Κατ' αρχάς, η αμοιβαία υποστήριξη βοηθά όσους τη λαμβάνουν
ώστε να νιώσουν πιο ασφαλείς
και επιπλέον ενθαρρύνει
την ελπίδα τους ότι υπάρχει η πιθανότητα βελτίωσης της κατάστασής τους.
Η αμοιβαία υποστήριξη, λοιπόν, είναι σημαντική για να αυξήσουμε την αυτοπεποίθηση,
την πίστη στις δυνατότητές μας και την αυτοεκτίμηση.
Η αμοιβαία υποστήριξη προάγει επίσης τη δυνατότητα συνεργασίας

και άρα ό,τι είναι θετικό για την προαγωγή του κοινωνικού ρόλου και της δραστηριοποίησης.

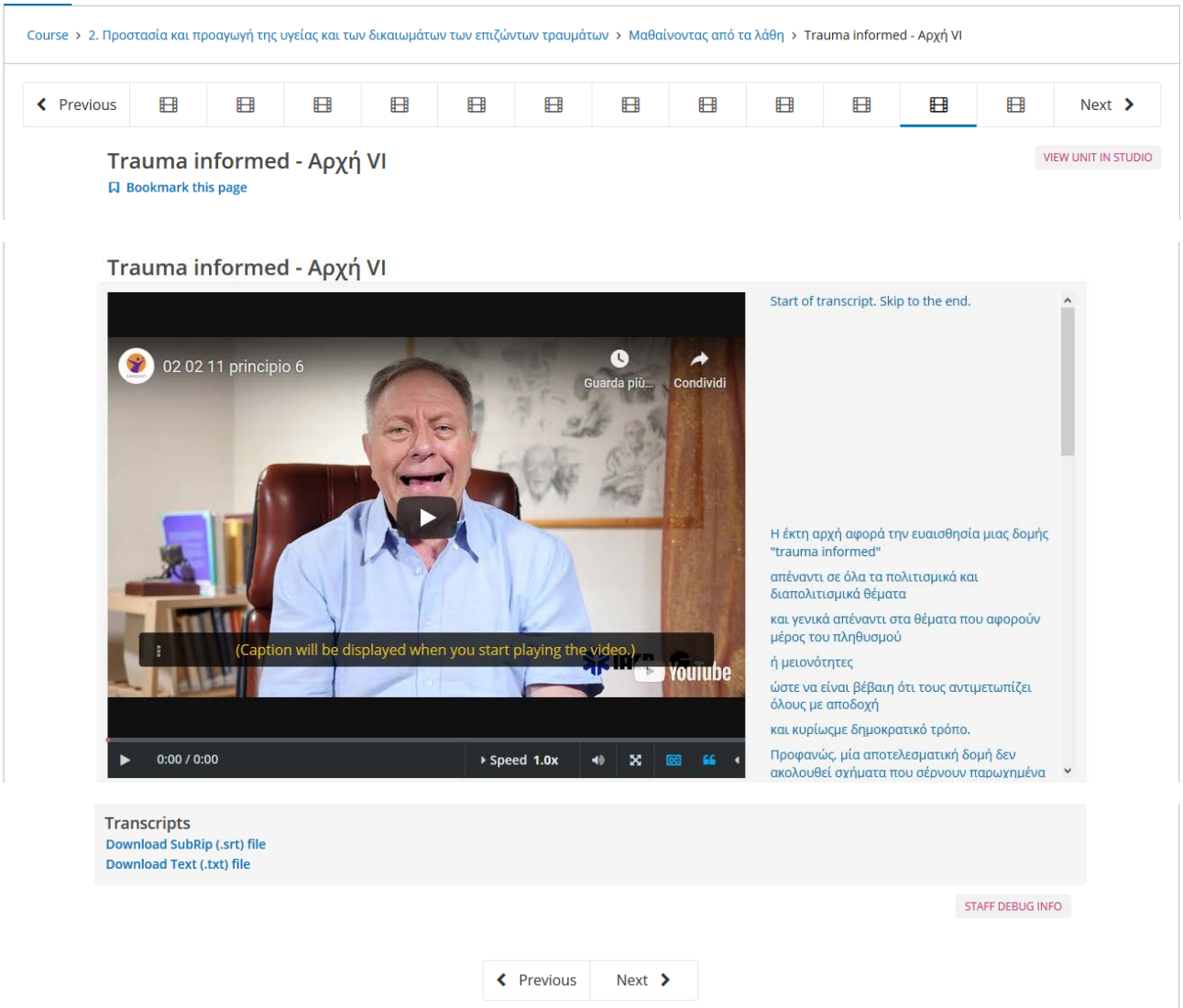
Αναμφίβολα, η αμοιβαία υποστήριξη οδηγεί σε μια διαπροσωπική επικοινωνία

που μπορεί να αξιοποιήσει τη δημιουργία αφηγημάτων,

ως μέρος ενός πολύ πλουσιότερου παζλ

και να αναπτύξει αφηγήματα

ελπίδας και ίασης.



Transcript

Η έκτη αρχή αφορά την ευαισθησία μιας δομής "trauma informed"

απέναντι σε όλα τα πολιτισμικά και διαπολιτισμικά θέματα

και γενικά απέναντι στα θέματα που αφορούν μέρος του πληθυσμού

ή μειονότητες

ώστε να είναι βέβαιη ότι τους αντιμετωπίζει όλους με αποδοχή

και κυρίωςμε δημοκρατικό τρόπο.

Προφανώς, μία αποτελεσματική δομή δεν ακολουθεί σχήματα που σέρνουν παρωχημένα στερεότυπα,

απολύτως άδικα και καταστροφικά απέναντι στις μειονότητες.

Η παρεχόμενη υπηρεσία θα είναι, για παράδειγμα,

πολύ ευαίσθητη απέναντι στη διαφορετικότητα των φύλων

και στον δίκαιο σεβασμό τους

καθώς η αξιοποίηση της διαφορετικότητας θα διευκολύνει και την αξιοποίηση

του πολιτισμικού υποβάθρου, των παραδόσεων,

της κουλτούρας και των εθνών καταγωγής των θεραπευομένων.

Θα δημιουργήσει μία πραγματικότητα πιστή στη φιλοσοφία τους κι έτσι η οργάνωση

και οι διαδικασίες θα είναι στο σύνολό τους

αμερόληπτες και ευαίσθητες απέναντι στις διαφορετικότητες.

Επιπλέον, θα μπορεί να αναγνωρίσει και να αντιμετωπίσει αποτελεσματικά το ιστορικό τραύμα.

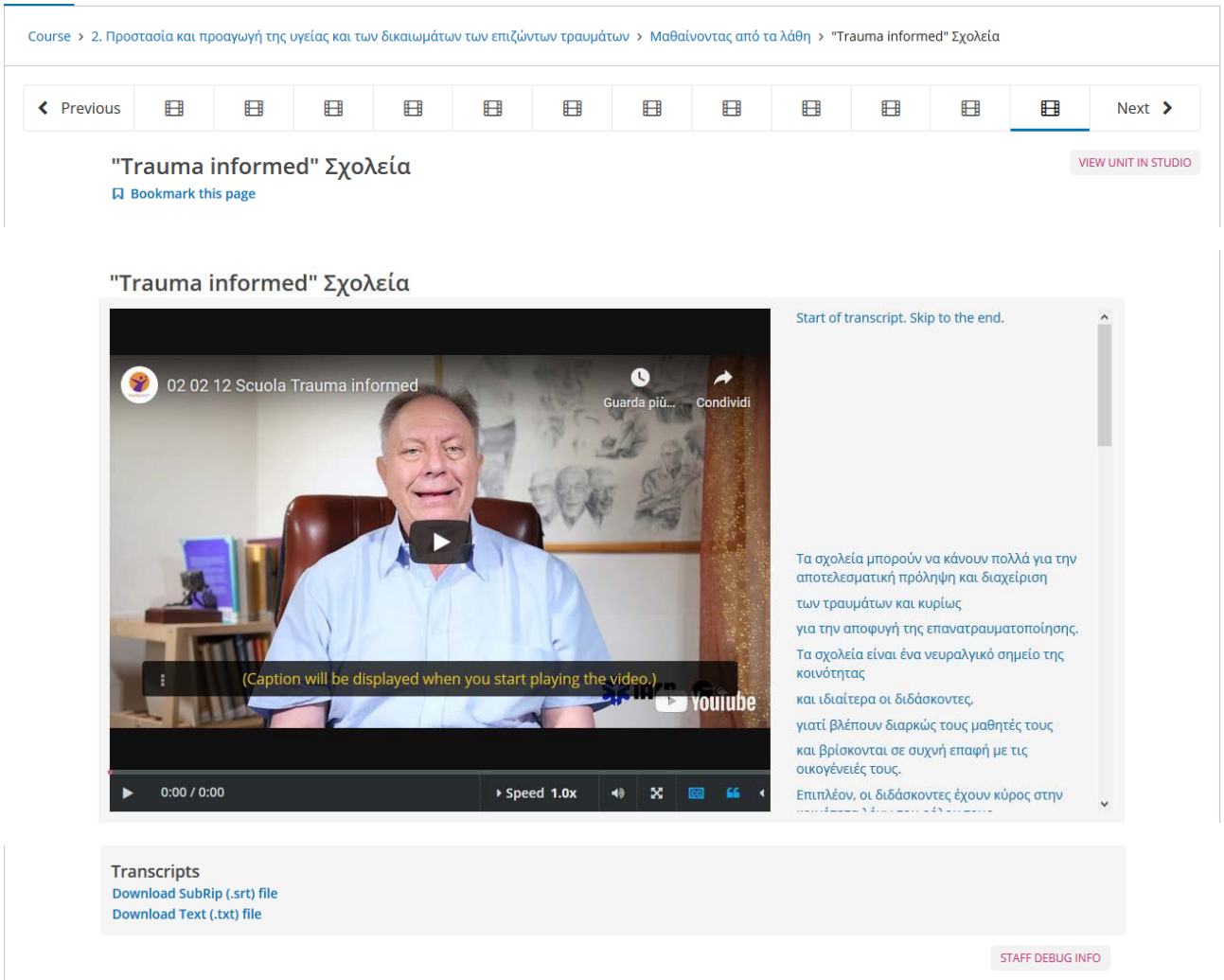
Τα ιστορικά τραύματα συνίστανται σε γεγονότα

μαζικά τραυματικά που έχουν επιπτώσεις ακόμα και σε όσους δεν τα βιώνουν άμεσα. Δραματικό παράδειγμα αποτελεί το ολοκαύτωμα.

Όχι μόνο υπήρξαν εκατομμύρια θύματα του ναζιστικού παραληρήματος

αλλά ακόμα και τα παιδιά και τα εγγόνια τους

υφίστανται τον αντίκτυπο αυτής της κτηνωδίας.



Transcript

Τα σχολεία μπορούν να κάνουν πολλά για την αποτελεσματική πρόληψη και διαχείριση

των τραυμάτων και κυρίως

για την αποφυγή της επανατραυματοποίησης.

Τα σχολεία είναι ένα νευραλγικό σημείο της κοινότητας

και ιδιαίτερα οι διδάσκοντες,

γιατί βλέπουν διαρκώς τους μαθητές τους

και βρίσκονται σε συχνή επαφή με τις οικογένειές τους.

Επιπλέον, οι διδάσκοντες έχουν κύρος στην κοινότητα λόγω του ρόλου τους.

Για αυτό, αν οι διδάσκοντες και όλο το προσωπικό του σχολείου

είναι ευαισθητοποιημένοι

σχετικά με τις παραμέτρους ενός σχολείου "trauma informed"

και ίσως έχουν συμβουλευτεί

έναν ειδικό που θα τους βοηθήσει να κάνουν τις απαραίτητες βελτιώσεις

οι οποίες θα μετατρέψουν το σχολείο από σχολείο με άγνοια της προβληματικής
σε σχολείο ενημερωμένο σχετικά με την προβληματική του τραύματος,
αυτό το σχολείο δεν θα είναι μέρος του προβλήματος αλλά της λύσης.
Κι αυτό, όχι μόνο επειδή οι διδάσκοντες,
ευαισθητοποιημένοι στις προβληματικές του τραύματος, θα μπορούν να είναι πανέτοιμοι
ώστε να αντιληφθούν τις ενδείξεις
τις οποίες, χωρίς τη σχετική εκπαίδευση, θα μπορούσαν να ερμηνεύσουν
απλώς ως προβλήματα πειθαρχίας, αλλά ως διδάσκοντες "trauma informed" θα μπορέσουν
να είναι ευαίσθητοι και να παραπέμψουν σχετικά
τους μαθητές τους, ζητώντας να επαληθευτεί
αν ένας μαθητής χρειάζεται επαγγελματική στήριξη, αν έχει υπάρξει θύμα τραύματος
ή όχι.
Μια άλλη σημαντική επίδραση μπορούν οι διδάσκοντες να ασκήσουν στους γονείς,
οι οποίοι σταδιακά γίνονται "trauma informed" γονείς
και θα μπορέσουν να συνεισφέρουν σημαντικά
σε αυτή την προβληματική.
Με δυο λόγια, ένα σχολείο "trauma informed"
αποτελεί εκπλήρωση του ρόλου του σχολείου, η οποία είναι να έχει
και να διαδίδει αποτελεσματικά τις γνώσεις
ώστε τα παιδιά να λειτουργούν ως προληπτικοί πολίτες της πόλης.
Συνεπώς, ένα σχολείο "trauma informed"
είναι απόλυτα έτοιμο να εκπληρώσει την αποστολή του
ως σχολείου με την καλύτερη έννοια της λέξης.

Εκπαιδευτικό υλικό

Creating Trauma Informed Systems - Schools

STAFF DEBUG INFO

Στην τοπική σου κοινότητα υπάρχουν σχολεία ενήμερα σχετικά με το τραύμα («trauma informed»); Στη χώρα σου;

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

Προκειμένου να μας βοηθήσεις να βελτιώσουμε τη χρησιμότητα αυτού του σεμιναρίου για τους θεραπευτές στο πεδίο, θα μπορούσες να μας υποδείξεις πού μπορούμε να βρούμε πληροφορίες σχετικά με τα ενήμερα περί τραύματος («trauma informed») σχολεία στη χώρα σου, σε ευρωπαϊκό και σε παγκόσμιο επίπεδο;

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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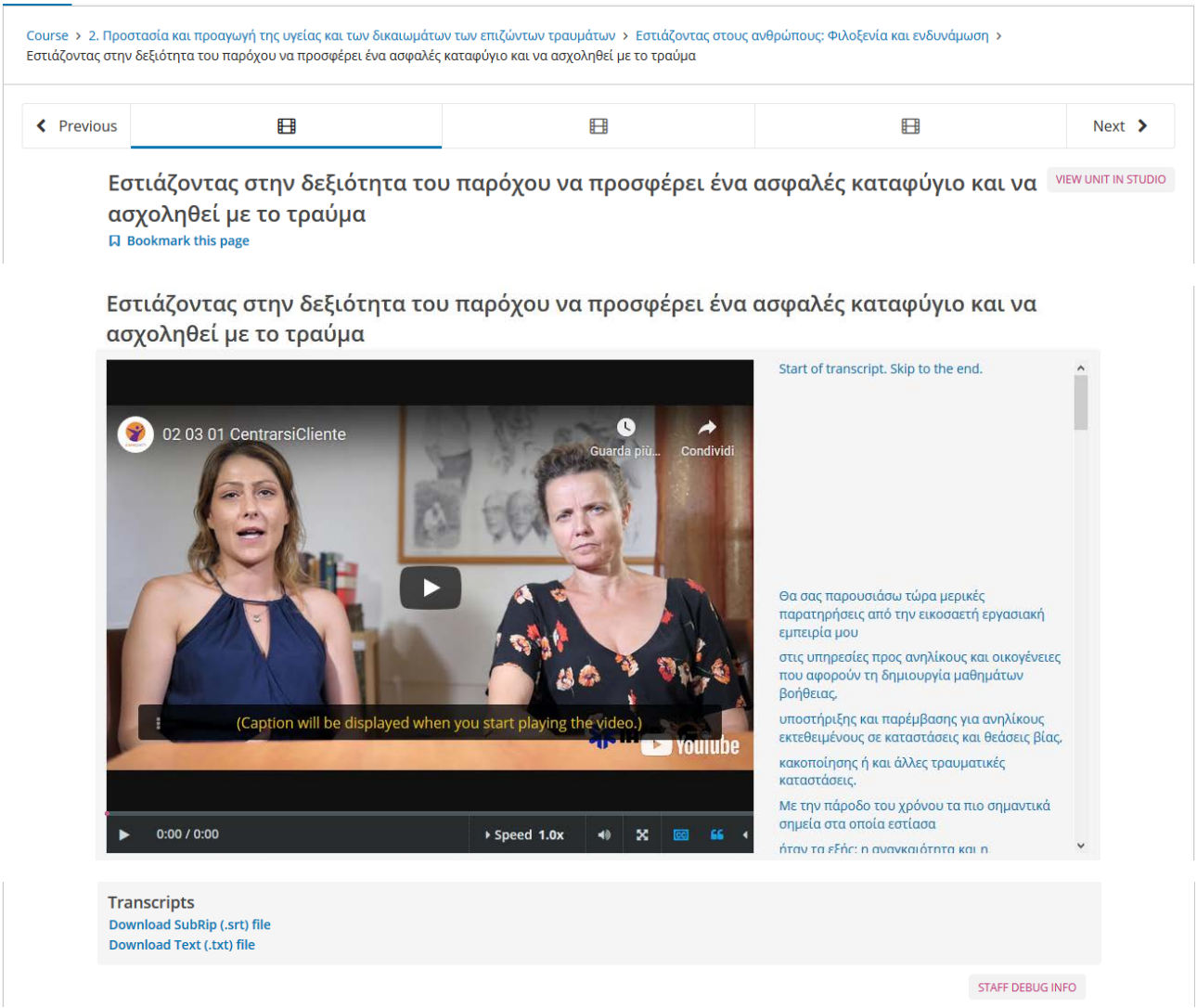
Previous Next



Transcript

Θα σας παρουσιάσω τώρα μερικές παρατηρήσεις από την εικοσαετή εργασιακή εμπειρία μου

στις υπηρεσίες προς ανηλίκους και οικογένειες που αφορούν τη δημιουργία μαθημάτων βοήθειας,

υποστήριξης και παρέμβασης για ανηλίκους εκτεθειμένους σε καταστάσεις και θεάσεις βίας,

κακοποίησης ή και άλλες τραυματικές καταστάσεις.

Με την πάροδο του χρόνου τα πιο σημαντικά σημεία στα οποία εστίασα

ήταν τα εξής: η αναγκαιότητα και η σπουδαιότητα της δημιουργίας, εκτός από την επιστημονική

και τεχνική γνώση, μιας σχέσης που δημιουργεί ένα ασφαλές πλαίσιο για το παιδί.

Ο όρος "ασφαλές" αφορά τη διάσταση της ακρόασης

των αναγκών και απαιτήσεων και τον σεβασμό,

που είναι θεμελιώδης ιδίως σε περιπτώσεις στις οποίες το παιδί προέρχεται από εμπειρίες

που έχουν παραβιάσει την αίσθηση της ασφάλειας, του σεβασμού και της συνέχειας της ζωής.

Ειναι θεμελιώδες να εγγυηθούμε μία διάσταση σεβασμού ώστε να ξαναρχίσει η εξελικτική πορεία του παιδιού.

Τι σημαίνει όμως "διάσταση σεβασμού"; Σημαίνει μία ουσιαστική διάσταση ακρόασης,
ακρόασης με ενσυναίσθηση, όχι εστιασμένης
σε πρωτόκολλα και ανάγκες των θεραπευτών αλλά εστιασμένης
σε ό,τι είναι ολόκληρος ο κόσμος
του παιδιού: οι ανάγκες του, οι χρόνοι του,
που τους σεβόμαστε εφόσον έχουμε απέναντί μας ανηλίκους οι οποίοι έχουν αναπτύξει
μια στάση άμυνας και προστασίας του εαυτού τους.
Είναι, λοιπόν, σημαντικό ο θεραπευτής
να παρεμβαίνει χωρίς να απειλεί να καταρρίψει άμυνες, απορώντας, μεταφέροντας και ρωτώντας,
αλλά με σεβασμό στον χρόνο έκθεσης του παιδιού, έχοντας συνείδηση ότι η άμυνα δεν είναι
παρά ο καλύτερος τρόπος του ανηλίκου να αντιμετωπίσει μία δύναμη συντριπτική.
Στη συνέχεια, σταδιακά, καθώς οι άμυνες θα καθίστανται ανώφελες και λιγότερο αναγκαίες,
θα μπορούμε να συναντήσουμε τον πυρήνα της καρδιάς αυτού του παιδιού.
Η εμπειρία αποδεικνύει ότι είναι σημαντικό να είμαστε επικεντρωμένοι στις ανάγκες του παιδιού.
Θα περιγράψω τώρα τις εμπειρίες που αποκόμισα από τη δραστηριότητά μου ως κοινωνικός λειτουργός
υπηρετώντας επί 8 έτη στον Δήμο της Ρώμης, στον τομέα της πρόληψης, της προστασίας
και της υποστήριξης των ανηλίκων και των οικογενειών τους.
Σε συμφωνία με όσα ανέφερα ήδη σχετικά με την αναγκαιότητα εστίασης στις ανάγκες
του παιδιού, μπορούμε να μιλήσουμε για αναγκαιότητα εστίασης στα χαρακτηριστικά
και στη μοναδικότητα κάθε περίπτωσης, αλλά και όλων των εμπλεκόμενων ατόμων,
όχι μόνο του παιδιού αλλά και των γονέων του. Στην καθημερινή εργασία ως κοινωνικοί λειτουργοί
κυρίως δουλεύουμε με τους γονείς γιατί τα παιδιά που υφίστανται
ή έχουν υποστεί ένα ή περισσότερα τραύματα
συνήθως τα αναλαμβάνουν και τα παρακολουθούν ειδικοί
κατάλληλα καταρτισμένοι για να τα στηρίξουν σε αυτή τη διαδικασία.
Η δραστηριότητα του κοινωνικού λειτουργού είναι να συνοδεύσει τις οικογένειες
στη διαδικασία συνειδητοποίησης
των δυσκολιών, της κρισιμότητας και της ευθραυστότητάς τους,
αλλά και των ταραχών που επέφεραν βλάβες και δυσφορία στα παιδιά τους για να δημιουργήσουμε
δίκτυα υποστήριξης μέσα από τα οποία θα τους στηρίξουμε κατά την απόκτηση
και την αξιοποίηση των απαραίτητων γονεϊκών ευθυνών που εγγυώνται
στον ανήλικο το δικαίωμά του να μεγαλώσει

με ηρεμία στην οικογένειά του,
σε ένα περιβάλλον προστασίας και φροντίδας.
Σύμφωνα με την εμπειρία, ποια είναι τα κύρια αναγκαία στοιχεία ώστε ο θεραπευτής
να δουλέψει σε αυτό το περιβάλλον με αυτά τα άτομα; Σίγουρα είναι οι επιστημονικές γνώσεις
ως επαγγελματίας αλλά και γνώσεις και ικανότητες που αφορούν
πιο πολύ το προσωπικό επίπεδο. Αφορά, λοιπόν, όλα όσα περικλείει
η έννοια του εσωτερικού κόσμου ενός θεραπευτή: τα συναισθήματα, οι προκαταλήψεις,
οι ιδιοσυχνότητες, οι προβολές που τείνουμε να κάνουμε στις σχέσεις μας με τους άλλους.
Εκτός από επαγγελματίες στη σχέση βοήθειας είμαστε και πρόσωπα που συναντούμε
άλλα πρόσωπα.
Τι συμβαίνει όταν πρέπει να δουλέψουμε
με κακοποιητικούς ή βάναυσους γονείς; Δεν σας κρύβω ότι ενίοτε, συχνά θα έλεγα,
βιώνουμε συναισθήματα θυμού, οργής, αγανάκτησης, ακόμα και φόβου.
Σίγουρα αυτό που θέλω να σας πω
είναι ότι δεν πρέπει να υποκρίνεστε ότι δεν υπάρχουν αυτά τα συναισθήματα.
Είναι κομμάτι του εαυτού μας και σε κάθε περίπτωση θα υπεισέλθουν στη σχέση βοήθειας.
Σημασία έχει να τα αναγνωρίζουμε και να τα διαχειριζόμαστε ώστε να μην επηρεάσουν
την πραγματικότητα που έχουμε μπροστά μας και ώστε η προσωπική μας υποκειμενικότητα
να μην είναι η γλώσσα ερμηνείας όσων έχουμε απέναντί μας, συγχέοντας
πραγματικότητες ή ρόλους. Ενίοτε ο θεραπευτής, παρασυρμένος από τα συναισθήματα, τείνει
να δίνει κατευθυντήριες οδηγίες και ο γονέας γίνεται θύμα των αποφάσεων του θεραπευτή.
Αυτό σίγουρα μας απομακρύνει από την εγγύηση της φροντίδας και της προστασίας των ανηλίκων
γιατί, αν δεν είμαστε απόλυτα συγκεντρωμένοι στην πραγματικότητα της κατάστασης, δεν μπορούμε
να καταλάβουμε ή να αντιληφθούμε τις ανάγκες των παιδιών και να κατευθύνουμε τη διαδικασία.
Αντίθετα, όσον αφορά την άμεση σχέση με το παιδί, η παρέμβαση του κοινωνικού λειτουργού
στη συγκεκριμένη περίπτωση είναι πιο περιορισμένη,
αλλά και σε αυτή την περίπτωση υπάρχουν παράμετροι έντονων συναισθημάτων.
Είναι πιθανό να θέλουμε να ενδώσουμε στην προσωπική ανάγκη μας να δώσουμε στα παιδιά τη στοργικότητα
και τη φροντίδα που στερήθηκαν και άλλοτε προσπαθούμε να αντικαταστήσουμε τους θεραπευτές
που τα παρακολουθούν και τα βοηθούν να επεξεργαστούν τα τραύματά τους.

Μπορείτε να παραλείψετε τις ερωτήσεις εάν δεν εργάζεστε στον τομέα της βοήθειας στις σχέσεις.

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Η στάση που τηρείς σε βοηθά να θέσεις το πρόσωπο του θεραπευομένου στο κέντρο της επαγγελματικής σχέσης;

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

Αν δεν εργάζεσαι με επίκεντρο το πρόσωπο του θεραπευομένου, ξέρεις να μας πεις γιατί το κάνεις αυτό;

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

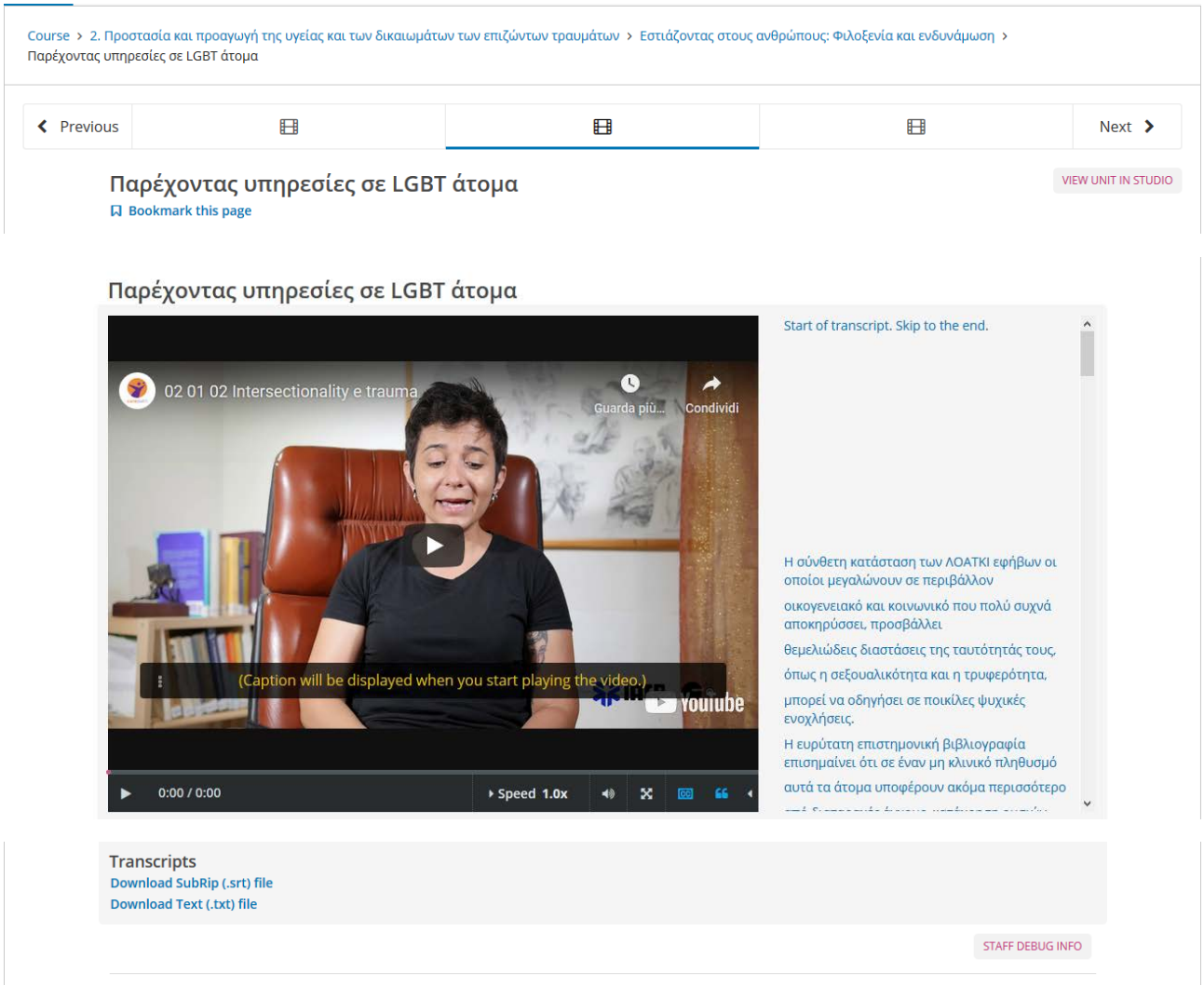
Θεωρείς ότι θα ήταν χρήσιμο να λάβεις κατάρτιση για να μπορέσεις, όποτε το αποφασίσεις, να εργαστείς με επίκεντρο τα πρόσωπα των θεραπευομένων σου;

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO



Transcript

Η σύνθετη κατάσταση των ΛΟΑΤΚΙ εφήβων οι οποίοι μεγαλώνουν σε περιβάλλον
οικογενειακό και κοινωνικό που πολύ συχνά αποκηρύσσει, προσβάλλει
θεμελιώδεις διαστάσεις της ταυτότητάς τους,
όπως η σεξουαλικότητα και η τρυφερότητα,
μπορεί να οδηγήσει σε ποικίλες ψυχικές ενοχλήσεις.
Η ευρύτατη επιστημονική βιβλιογραφία επισημαίνει ότι σε έναν μη κλινικό πληθυσμό
αυτά τα άτομα υποφέρουν ακόμα περισσότερο
από διαταραχές άγχους, κατάχρηση ουσιών, διαταραχή μετατραυματικού στρες
και παρουσιάζουν αυξημένο κίνδυνο αυτοχειρίας.
Οι ερευνητές συσχετίζουν αυτή την αυξημένη παρουσία ψυχικών διαταραχών
με τις διαστάσεις του άγχους μειονότητας και της ομοφοβίας της κοινωνίας.
Άρα το αόρατο και το ανείπωτο προβάλλουν ταυτόχρονα ως αίτια και αποτελέσματα
τραυματικών γεγονότων. Στο πλαίσιο της εμπειρίας αυτών των ατόμων

πραγματώνονται με δραματικό τρόπο οι έννοιες του συσσωρευμένου τραύματος,
του σχεσιακού τραύματος και οι σχετικοί χαρακτηρισμοί των σύνθετων εξελικτικών
διαταραχών τραύματος.
Υπάρχει, λοιπόν, μία κυκλική σχέση
μεταξύ της κοινωνικής προκατάλειψης, της αίσθησης διαχωρισμού, του αόρατου στοιχείου
αλλά και της ανθεκτικότητας σε μια μερίδα πληθυσμού στην οποία δεν αναγνωρίζεται, εκτός από όλα αυτά,
ούτε καν η ιδιότητα του πολίτη, του ανήκειν και της ενσωμάτωσης.
Είναι αναγκαίο, λοιπόν, ο υπέυθυνος για την αποδοχή και την υποστήριξη αυτών των παιδιών
να αναρωτηθεί σχετικά με το πώς θα τα διευκολύνει και πώς θα τα βοηθήσει
να κατακτήσουν το δικαίωμα στην ύπαρξη, στην αξιοπρέπεια, και το δικαίωμα στην αγάπη.
Οι αλλεπάλληλες έρευνες των τελευταίων 50 ετών, που συνεχίζονται, τα έγγραφα, τα εγχειρίδια,
οι οδηγίες που προέκυψαν από αυτές τις έρευνες
κάνουν αναφορά
στα ακόλουθα στοιχεία.
Οι ομοφυλοφιλίες είναι φυσιολογικές και θετικές παραλλαγές της ανθρώπινης σεξουαλικότητας
και δεν συνιστούν, αυτές καθαυτές, δείκτες ψυχικών διαταραχών
ή αναπτυξιακών διαταραχών. Η ομοφυλοφιλία και η αμφιφυλοφιλία
είναι αντικείμενο κοινωνικού στιγματισμού με πιθανές ποικίλες αρνητικές συνέπειες
κατά τη διάρκεια των εξελικτικών διαδικασιών.
Οι επιπτώσεις και οι ομοφυλοφιλικές συμπεριφορές
ενδέχεται να είναι παρούσες σε ποικίλους σεξουαλικούς προσανατολισμούς.
Τα άτομα ΛΟΑΤΚΙ μπορούν να βιώνουν ζωές ικανοποιητικές και ευτυχείς,
να συνάπτουν πολύχρονες σχέσεις ζεύγους και να δημιουργούν οικογένειες εξίσου σταθερές
με τις ετεροφυλοφιλικές. Καμία επιστημονική έρευνα δεν αποδίδει
την ομοφυλοφιλία στο τραύμα ή στη δυσλειτουργία των οικογενειών καταγωγής.
Δεν έχει αποδειχτεί ότι είναι αποτελεσματικές ή ακίνδυνες όλες οι θεραπευτικές προσπάθειες
με στόχο την αλλαγή του σεξουαλικού προσανατολισμού.
Οι οδηγίες του Αμερικανικού Συνδέσμου Ψυχολογίας (APA) του 2012 σχετικά με την ψυχολογική πρακτική
με άτομα ΛΟΑΤΚΙ υπογραμμίζουν πόσο σημαντικό είναι να λαμβάνουμε υπόψη
τη στάση του θεραπευτή και παρόχου βοήθειας απέναντι στην ομοφυλοφιλία
και στην αμφιφυλοφιλία, σε ό,τι αφορά όχι μόνο τη γνώση των επιπτώσεων του στιγματισμού

σε αυτά τα άτομα αλλά και την επίγνωση του κατά πόσον η δική του στάση,

σιωπηρή και ρητή, απέναντι στην ομοφυλοφιλία και την αμφιφυλοφιλία

και άρα η ικανότητά σε αυτά τα θέματα αλλά και το προσωπικό του βλέμμα

σε αυτά τα θέματα, μπορούν να τον επηρεάσουν

στην εκτίμηση και την παρέμβασή του.

Τα κοινά σημεία που μπορούμε να συνάγουμε

από όλα τα ως τώρα γραφόμενα μπορούν να συνοψιστούν στα ακόλουθα.

Προσφέρουμε αποδοχή και υποστήριξη

ενεργοποιώντας μία ακρόαση με σεβασμό και χωρίς κριτική, με ενσυναίσθηση,

η οποία βοηθά στη μείωση της δυσφορίας που οφείλεται στο στρες μειονότητας.

Υιοθετούμε κατάλληλα μέτρα στο στάδιο της γνώσης αυτών των ατόμων.

Η αξιολόγηση πρέπει να στοχεύει στη γνώση του νεαρού ή της νεαρής

σε όλη του την περιπλοκότητα, λαμβάνοντας υπόψη τις αλληλεπιδράσεις

και τις διασυνδέσεις μεταξύ του άγχους μειονότητας, της ψυχικής υγείας και της εσωτερικής

και πνευματικής διάστασης, καθώς και τη θέση που καταλαμβάνει ο σεξουαλικός προσανατολισμός

στη γενική λειτουργία του ατόμου.

Προάγουμε και υποστηρίζουμε ενεργούς τρόπους διαχείρισης.

Γνωρίζουμε ότι για τους εφήβους γενικά είναι πολύ σημαντικό να νιώθουν

δραστικοί παράγοντες στην ύπαρξή τους, ιδίως όταν έρχονται αντιμέτωποι

με αγχογόνα περιστατικά. Ο πάροχος βοήθειας πρέπει να προσπαθήσει να βοηθήσει

τον θεραπευόμενο και να προαγάγει στρατηγικές με στόχο τη γνωσιακή και συναισθηματική του επεξεργασία.

Κατανοούμε εκ νέου τη θεμελιώδη διάσταση

της εφηβείας,

τον ρόλο που διαδραματίζουν οι φιλίες και η ΛΟΑΤΚΙ κοινότητα.

Δεδομένου ότι το άγχος μειονότητας μπορεί να οδηγήσει

στην περιθωριοποίηση και την απομόνωση,

ένας θεμελιώδης στόχος είναι να αυξήσουμε την ικανότητα

αξιοποίησης της κοινωνικής υποστήριξης.

Εξερευνούμε και αναπτύσσουμε την ταυτότητα.

Οι δυναμικές απόδοσης ταυτότητας συνιστούν σημαντική και θεμελιώδη πτυχή

της εφηβείας γενικά αλλά και της εφηβείας των ατόμων ΛΟΑΤΚΙ.

Είναι σημαντικό αυτά τα άτομα να μπορούν να εξερευνήσουν και να ενσωματώσουν,
χωρίς να εξαναγκάζονται στην επιλογή, μία ταυτότητα, ανεξάρτητα από όποια άλλη,
όπως στην περίπτωση του διλήμματος μεταξύ αρσενικού και θηλυκού.
Κατανοούμε τις συγκρούσεις και προάγουμε την ένταξη των ατόμων.
Η σχέση βοήθειας θα πρέπει να ευνοεί
τον διάλογο και τη συγχώνευση των αλληλοσυγκρουόμενων πτυχών του ατόμου,
όπως στην περίπτωση του σεξουαλικού προσανατολισμού έναντι των θρησκευτικών πεποιθήσεων.
Κατανοούμε τα νοήματα που κρύβονται πίσω από τις αιτήσεις αλλαγής σεξουαλικού προσανατολισμού
ή της εφαρμογής μιας θεραπείας αποκατάστασης.
Σε αυτές τις περιπτώσεις είναι απαραίτητος ένας ειδικευμένος ψυχοθεραπευτής
που θα αναλύσει δεόντως την αίτηση του ατόμου αντιλαμβανόμενος το νόημά της,
εξερευνώντας τη συγκεκριμένη επιθυμία, με αναγωγή σε σύνθετες ψυχολογικές δυναμικές,
οικογενειακές και κοινωνικές, που ίσως να έχουν οδηγήσει τον νεαρό ή τη νεαρή
στο να θεωρεί απαράδεκτο ένα συστατικό στοιχείο
της ταυτότητάς του.
Κατανοοούμε και εξερευνούμε τη λεγόμενη διαδικασία "coming out".
Αποδεχόμαστε τα επίπεδα άγχους μειονότητας σε σχέση με τις συνθήκες διπλής μειονότητας
στις οποίες ένα άτομο υφίσταται διακρίσεις όχι μόνο εξαιτίας της ομοφυλοφιλίας
ή της αμφιφυλοφιλίας του αλλά και εξαιτίας άλλων συνθηκών
κοινωνικού στιγματισμού.
Λαμβάνουμε υπόψη το βάρος που έχει το άγχος μειονότητας
στις δυναμικές ζεύγους. Είναι σημαντικό να θυμόμαστε ότι τα γκέι και λεσβιακά ζευγάρια
δεν αναγνωρίζονται από τις κύριες θρησκείες
ή από τα έννομα συστήματα πολλών χωρών. Σε συνδυασμό με αυτό, λαμβάνουμε υπόψη
όλα όσα σχετίζονται με την ομογονεϊκότητα και την απουσία ή την ύπαρξη ελάχιστης
νομικής ρύθμισης για τον σχηματισμό οικογένειας αυτού του τύπου.

Εκπαιδευτικό υλικό

Trauma-Informed Approaches for LGBQT* Survivors of Intimate Partner Violence: A Review of Literature and a Set of Practice Observations

STAFF DEBUG INFO

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Transcript

Με τον όρο "growth after trauma" εννοούμε ένα φαινόμενο

προσωπικής ανάπτυξης κάποιων ατόμων που έχουν υποστεί τραύμα

ως συνέπεια του ίδιου του τραύματος.

Με άλλα λόγια, το τραύμα προκαλεί μεν σημαντικές βλάβες, σοβαρές για τον οργανισμό

και για την ψυχή των εν λόγω ατόμων,

αλλά, εκτός από όλες τις βλάβες, υπάρχει και αυτό το φαινόμενο

το οποίο βιώνουν αρκετά, αν και όχι τα περισσότερα,

θύματα τραυμάτων.

Επισημαίνουμε ότι αυτό δηλώνει για άλλη μια φορά την απίστευτη ανθεκτικότητα

του ανθρώπινου είδους ή ίσως να δηλώνει την ανθεκτικότητα

όλων των μορφών ζωής που έχουν αναπτυχθεί

στην εξέλιξη της ζωής στον πλανήτη μας.

Όποια κι αν είναι η τραγωδία του τραύματος, συγκλονίζει το άτομο, το "σφυροκοπάει",

το πλήττει και το πληγώνει.

Άρα πρόκειται για έναν αληθινό σεισμό, που οι δονήσεις του έχουν επιπτώσεις για το άτομο

τόσο σε σωματικό όσο και σε ψυχικό επίπεδο.

Ωστόσο, μέσα σε τόση αναστάτωση, όπως συμβαίνει συνήθως,

ισχύει το "ουδέν κακόν αμιγές καλού"

γιατί όταν ένα άτομο έχει συγκλονιστεί από κάποιο τραύμα

πρέπει να επαναρρυθμιστεί

στη νέα πραγματικότητα και κάποια άτομα επαναρρυθμίζονται,

αποκαθίστανται εκ νέου, ωριμάζοντας από την εμπειρία.

Άρα, σε υπαρξιακό επίπεδο, βιώνουν

μία εμπειρία ωρίμανσης, με άλλα λόγια,

είναι πιο ανοιχτοί, πιο βέβαιοι στις ηθικές και πνευματικές αξίες τις οποίες βιώνουν πιο ουσιαστικά

και σχετίζονται με τη ζωή,

με τον εαυτό τους, με τους άλλους και με τον κόσμο μέσα από έννοιες

καινούργιες και βαθύτερες.

Ένα προσωπικό παράδειγμα: θυμάμαι τη συγκίνησή μου όταν διάβασα το βιβλίο ενός συναδέλφου,

του Βίκτορ Φρανκλ, που είχε βιώσει την τραγωδία και όλα τα σχετικά τραύματα

ως θύμα του ναζισμού, καθότι Εβραίος,

έγκλειστος σε ναζιστικό στρατόπεδο εξόντωσης.

Λοιπόν, στα στρατόπεδα εξόντωσης, πριν δολοφονήσουν τους ανθρώπους, τους καταπίεζαν

προσπαθώντας να δολοφονήσουν την αξιοπρέπειά τους. Ωστόσο, ένας αριθμός, αν και απειροελάχιστος, ατόμων

όχι μόνο επιβίωνε σε σωματικό επίπεδο, παρόλα τα τραύματα και σε ψυχικό επίπεδο,

αλλά γίνονταν καλύτεροι άνθρωποι και, όπως αφηγείται ο Φρανκλ στο βιβλίο του,

"Ένας ψυχολόγος στα στρατόπεδα συγκέντρωσης", ο ίδιος και άλλοι συγκρατούμενοι ανά τετράδες

εξοικονομούσαν λίγη τροφή για να δώσουν

αγάπη και βοήθεια σε άτομα ακόμα πιο άτυχα από τους ίδιους

(αρρώστους ή αδύναμους), με κίνδυνο να σταλούν στους περίφημους θαλάμους αερίων

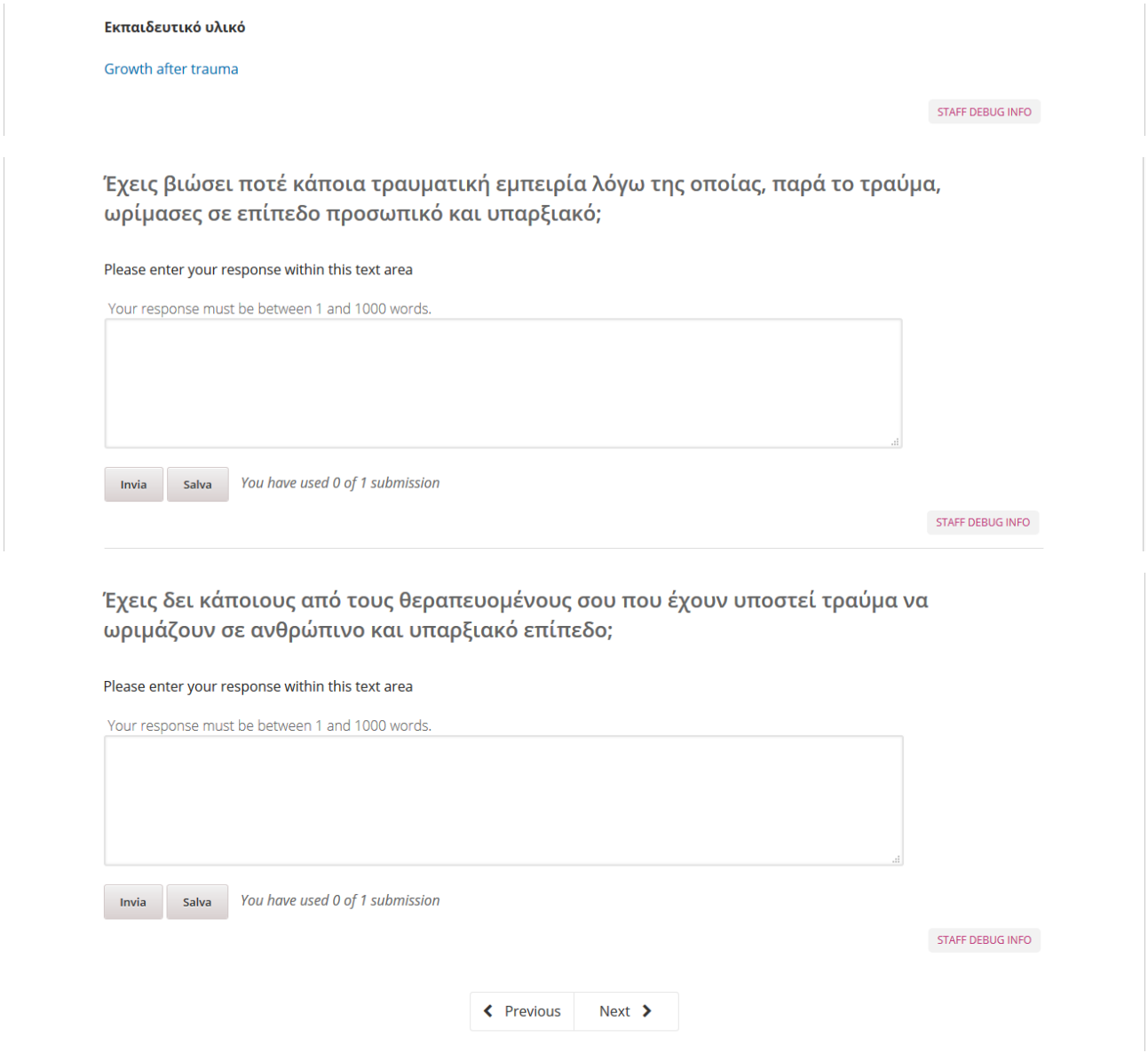
και άρα να θανατωθούν.

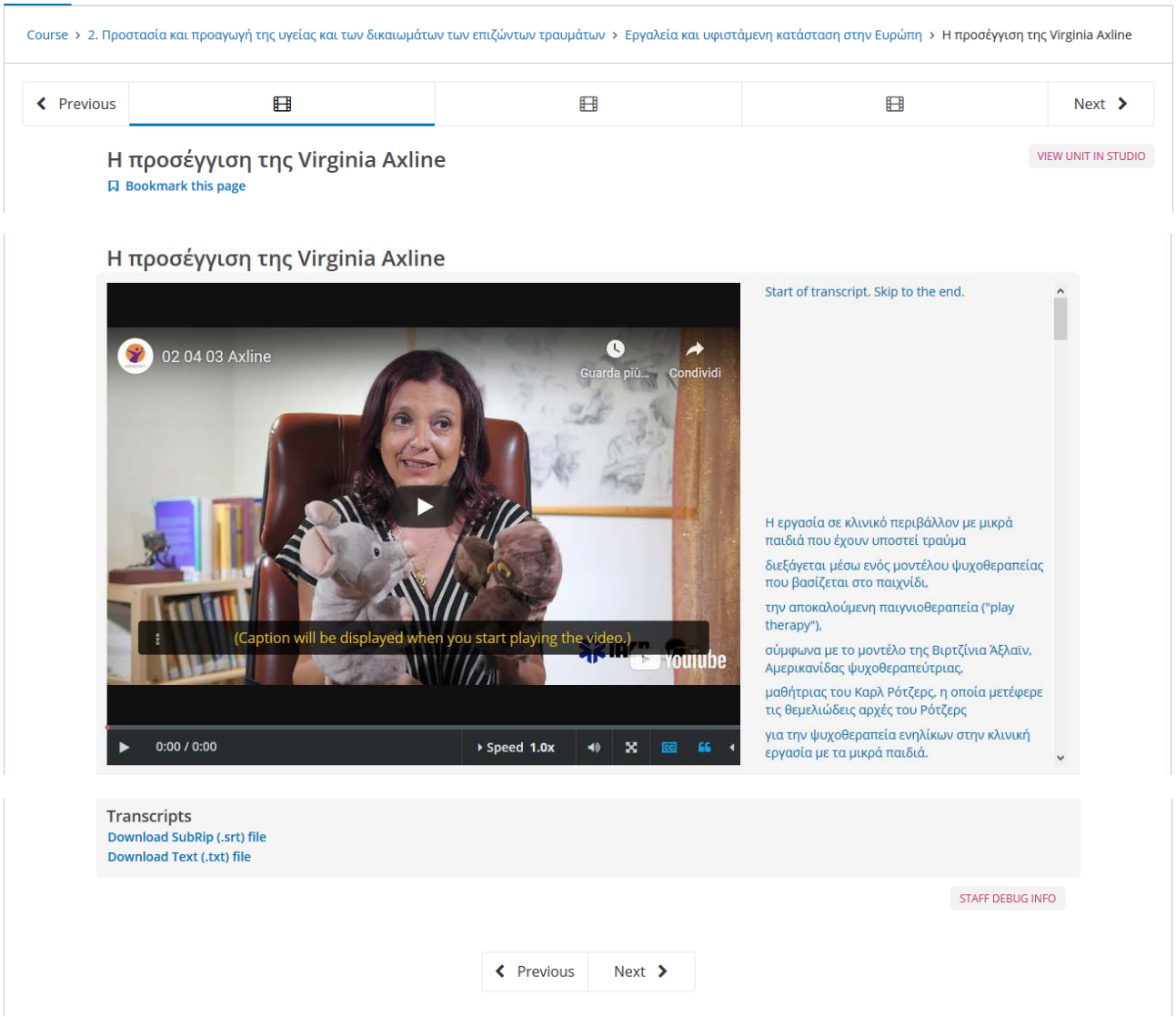
Όσοι από αυτή την ομάδα επέζησαν και απελευθερώθηκαν στο τέλος του ναζιστικού παραλογισμού,

παρά τη σωματική αδυναμία και τα πολλαπλά ψυχικά τραύματα, έγιναν καλύτεροι άνθρωποι

και με πιο ουσιαστική σχέση σε επίπεδο υπαρξιακό με τον εαυτό τους, τους άλλους, τον κόσμο.

Ένα στοιχείο άξιο στοχασμού που ίσως να ενισχύει τις ελπίδες μας.





Transcript

Η εργασία σε κλινικό περιβάλλον με μικρά παιδιά που έχουν υποστεί τραύμα

διεξάγεται μέσω ενός μοντέλου ψυχοθεραπείας που βασίζεται στο παιχνίδι,

την αποκαλούμενη παιγνιοθεραπεία ("play therapy"),

σύμφωνα με το μοντέλο της Βιρτζίνια Άξλαϊν, Αμερικανίδας ψυχοθεραπεύτριας,

μαθήτριας του Καρλ Ρότζερς, η οποία μετέφερε τις θεμελιώδεις αρχές του Ρότζερς

για την ψυχοθεραπεία ενηλίκων στην κλινική εργασία με τα μικρά παιδιά.

Η εργασία αυτή δημοσιεύτηκε στο βιβλίο "Play Therapy" το 1947.

Οι αρχές που επεσήμανε και υπογράμμισε ο Ρότζερς,

θεμελιώδεις για την κατανόηση του εσωτερικού κόσμου του παιδιού,

στις οποίες αναφέρεται η Άξλαϊν, κάνουν λόγο για ένα παιδί με εγγενή την τάση

αναπροσαρμογής των δυνατοτήτων του οργανισμού του

και όλες οι συμπεριφορές του

τείνουν προς αυτόν τον σκοπό.

Μία δεύτερη θέση κάνει λόγο για ένα παιδί ικανό
να αυτορρυθμίζεται γιατί κανείς δεν ξέρει καλύτερα τι είναι το πιο καλό για το ίδιο το παιδί.

Μία τρίτη θέση κάνει λόγο για ένα παιδί
που αναζητά ενεργά όλες εκείνες τις εμπειρίες
που μπορούν να είναι ευνοϊκές για την ανάπτυξή του, για την έκφραση των δυνατοτήτων του
και του οργανισμού του, ενώ θα τείνει να αρνείται όλες τις εμπειρίες που θεωρεί επιζήμιες.

Υπό αυτή την οπτική, η παιγνιοθεραπεία επιτρέπει στο παιδί
να εκφραστεί στις καλύτερες
δυνατές συνθήκες.

Χάρη ακριβώς σε ένα κλίμα ήρεμο, υποστηρικτικό και διευκολυντικό,
το παιδί έχει τη δυνατότητα να εκφράσει καλύτερα το δυναμικό του.

Το διευκολυντικό κλίμα που πραγματοποιείται
στο πλαίσιο της παιγνιοθεραπείας επιτρέπει στο παιδί να ενδυναμωθεί,
να έχει καλύτερη γνώση του εαυτού του και να συμβολίσει σωστά την εμπειρία του,
που σημαίνει, με άλλα λόγια,
να δώσει έκφραση στα αισθήματα και συναισθήματά του.

Η πρόσβαση στον εσωτερικό κόσμο του παιδιού
είναι δυνατή μέσα από τα λεγόμενα "προνομιακά κανάλια" που είναι το παιχνίδι, η ζωγραφική
και το παραμύθι. Μέσα από αυτά τα κανάλια το παιδί μπορεί να εκφραστεί με τρόπο
πιο αυθόρμητο και ελεύθερο, γιατί είναι κανάλια που κατέχει κι έτσι μπορεί
να εκφράσει τις ανάγκες, τις εμπειρίες και τα συναισθήματά του.

Στο πλαίσιο της διαδικασίας της παιγνιοθεραπείας ο θεραπευτής θα φροντίσει να αντανακλά
και να αντικατοπτρίζει στο παιδί όλα όσα προκύπτουν μέσα από το παιχνίδι και να συντονίζεται
με τα συναισθήματά του.

Αυτό επιτρέπει στο παιδί να διευρύνει τη συνειδητότητά του
σε ό,τι αφορά τη συμπεριφορά του.

Η δημιουργία του περιβάλλοντος χώρου στην παιγνιοθεραπεία είναι θεμελιώδης
γιατί είναι ο τρόπος με τον οποίο θα γίνει η ακρόαση του παιδιού. Υπό αυτή την έννοια,
για παράδειγμα, όταν διαθέτουμε μεγάλο υλικό παιχνιδιού, το παιδί μπορεί να εκφραστεί
ελεύθερα, να κινηθεί ελεύθερα στον χώρο
κι αυτό γίνεται για το παιδί μία εμπειρία

ιδιαίτερα σημαντική.
Τη στιγμή που το παιδί νιώθει ελεύθερο διευκολύνεται σε μέγιστο βαθμό
στην εξερεύνηση του εαυτού του
και, μέσω αυτής, συντελείται η αλλαγή
η οποία οδηγεί στην προσωπική ενδυνάμωση ("empowerment").
Επιστρέφοντας στη δημιουργία του περιβάλλοντος,
για παράδειγμα, η παρουσία πολλών υλικών, όπως φύλλα χαρτιού, διάφορα χρώματα, πλαστελίνη,
δοχεία με άμμο όπου μπορεί να σχεδιάσει εικόνες ή και παρουσία βιβλίων,
παραμυθιών που θα μπορείτε να αφηγηθείτε ή να διαβάσετε μαζί,
καθώς και μαριονέτες που επιτρέπουν
στο παιδί να εκφραστεί καλύτερα, όπως η χρήση δύο μαριονετών που το παιδί
και ο θεραπευτής μπορούν να ενδυθούν, σαν κούκλες,
κι όταν την ενδύεται το παιδί αυτή γίνεται μέρος του εαυτού του
κι έτσι μπορεί να διαδράσει με τον θεραπευτή, δίνοντας λόγο στην κούκλα ως κανάλι επικοινωνίας,
κι αυτό είναι σημαντικό γιατί έτσι το παιδί μπορεί να ανοιχτεί με τρόπο
πιο βαθύ και αποτελεσματικό.
Σε αυτή την περίπτωση οι μαριονέτες μπορούν να διαδράσουν
σαν αυτόνομες οντότητες. Είναι σημαντικό ο θεραπευτής να κοιτάζει απευθείας τις μαριονέτες
και όχι το παιδί, γιατί θα το διευκολύνει
να θεωρήσει την κούκλα ως κανάλι έκφρασης
που δεν είναι ο εαυτός του. Η αναπαράσταση ζώων είναι ένα διευκολυντικό στοιχείο
γιατί το παιδί είναι πιο εύκολο να ταυτιστεί με το ζώο από ό,τι με την ανθρώπινη μορφή.
Ο θεραπευτής στη συγκεκριμένη διαδικασία με αυτά τα υλικά παιχνιδιού
το μόνο που θα κάνει θα είναι να συνοδεύει
το παιδί σε αυτή την πορεία και, όπως λέει η Άξλαϊν,
κατά την ψυχοθεραπευτική πορεία το παιδί είναι εκείνο που θα υποδείξει τον δρόμο
και δεν θα το κατευθύνει ο θεραπευτής. Πράγματι, τη στιγμή που το παιδί είναι ελεύθερο
να εκφραστεί είναι δυνατή και η αυτορρύθμιση,
μία από τις θέσεις του Ρότζερς που αναφέραμε παραπάνω.
Υπό αυτή την οπτική, η παιγνιοθεραπεία είναι αποτελεσματική με παιδιά που έχουν βιώσει
τραυματικές εμπειρίες, γιατί η δημιουργία ενός περιβάλλοντος ασφάλειας, οριοθέτησης και ελευθερίας
επιτρέπει στο τραυματισμένο υποκείμενο να εκφράσει καλύτερα

τον εαυτό του και να ξεκινήσει μία διαδικασία

επεξεργασίας της εμπειρίας του.

Η σημασία του παιχνιδιού ενισχύθηκε κατά πολύ

με τις έρευνες στον τομέα της νευροεπιστήμης. Ιδιαίτερα σημαντική είναι

η συμβολή του Πάνκσεπ, που στο βιβλίο του "Η Οικολογία του νου" αναγνωρίζει

επτά θεμελιώδη συστήματα συναισθημάτων στα θηλαστικά.

Μεταξύ αυτών των συστημάτων, μας ενδιαφέρει εδώ περισσότερο

ο προσδιορισμός του κυκλώματος του παιχνιδιού, ενός κυκλώματος γενετικά προσδιορισμένου

που μεσολαβεί για τις θετικές συνέπειες στον εγκέφαλο των θηλαστικών.

Ο Πάνκσεπ διαπίστωσε

ότι σε γενετικό επίπεδο το κύκλωμα του παιχνιδιού υπάρχει σε όλα τα θηλαστικά και άρα τα συνδέει.

Αυτές οι έρευνες υπογραμμίζουν τη σπουδαιότητα του παιχνιδιού για τη γνωσιακή, τη συναισθηματική,

τη σχεσιακή ανάπτυξη του παιδιού

και έχει αποδειχτεί ότι το παιχνίδι διευκολύνει τις ικανότητες διαχείρισης,

όπως, για παράδειγμα, την κοινωνική συνεργασία.

Το γεγονός ότι το παιχνίδι έχει επιβεβαιωθεί

ως αυθόρμητη δραστηριότητα, γενετικά εκπορευόμενη, μας επιτρέπει να προβληματιστούμε στην περίπτωση

ενός παιδιού που δεν παίζει. Ένα παιδί που δεν παίζει είναι¨

κατά κάποιο τρόπο ένδειξη ότι το παιδί

εκείνη τη στιγμή εκφράζει μία δυσφορία.

Η παιγνιοθεραπεία θεωρείται μία ψυχοθεραπευτική παρέμβαση ιδιαίτερα αποτελεσματική

με παιδιά που υποφέρουν, που κομίζουν δυσφορίες, αλλά ακόμα περισσότερο

με παιδιά που κομίζουν

τραυματικές εμπειρίες.

Πιο συγκεκριμένα, στην παιγνιοθεραπεία η κεντρική οπτική γωνία

είναι εκείνη του παιδιού,

το οποίο θεωρείται ως ένα πρόσωπο που μπορεί

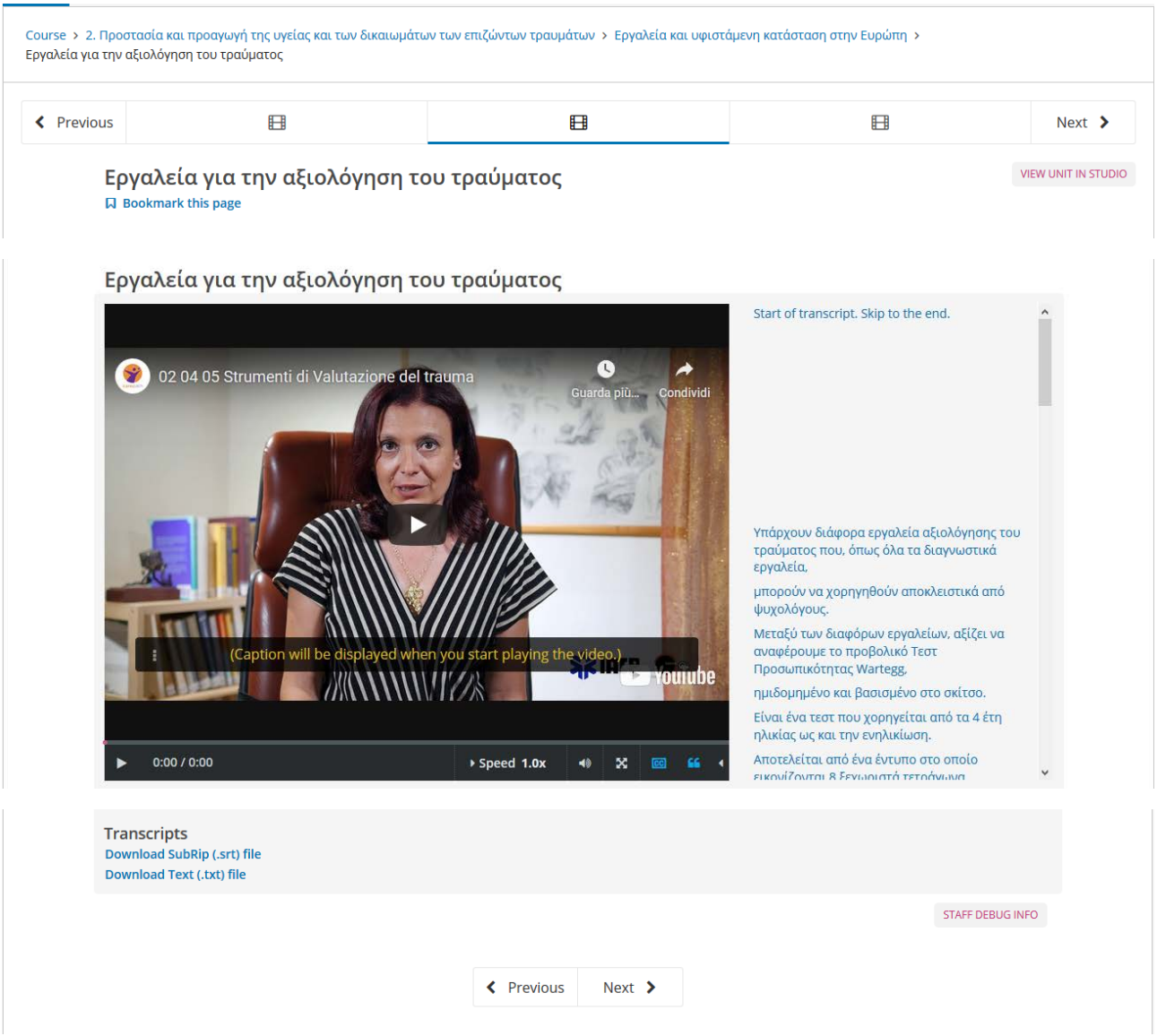
να αφηγηθεί, να μοιραστεί και να εκφράσει όλα του τα αισθήματα, ένα συναίσθημα, αγωνίες

και φόβους, αλλά σε ένα περιβάλλον προστατευτικό, ασφαλές που σέβεται τόσο το ίδιο το παιδί

όσο και τις ιδιαιτερότητές του.

Όλα αυτά μπορούν να βοηθήσουν το παιδί να ξεπεράσει την τραυματική εμπειρία

επιτρέποντάς του να αναπτυχθεί με υγιή τρόπο.



Transcript

Υπάρχουν διάφορα εργαλεία αξιολόγησης του τραύματος που, όπως όλα τα διαγνωστικά εργαλεία, μπορούν να χορηγηθούν αποκλειστικά από ψυχολόγους.

Μεταξύ των διαφόρων εργαλείων, αξίζει να αναφέρουμε το προβολικό Τεστ Προσωπικότητας Wartegg, ημιδομημένο και βασισμένο στο σκίτσο.

Είναι ένα τεστ που χορηγείται από τα 4 έτη ηλικίας ως και την ενηλικίωση.

Αποτελείται από ένα έντυπο στο οποίο εικονίζονται 8 ξεχωριστά τετράγωνα,

οριοθετημένα με μαύρο πλαίσιο, στο καθένα από τα οποία υπάρχει ένα μικρό σύμβολο - ερέθισμα.

Το άτομο που πραγματοποιεί το τεστ πρέπει να συμπληρώσει ένα σχέδιο με αφετηρία ό,τι ήδη εικονίζεται στο πλαίσιο, σε όλα τα πλαίσια, δηλαδή οκτώ σχέδια συνολικά.

Είναι ένα απλούστατο ψυχοδιαγνωστικό εργαλείο που προτιμάται, ακόμα και από άποψη ταχύτητας, και βασίζεται στο σκίτσο, επειδή αυτό προτιμάται ως διευκολυντικό κανάλι για το μικρό παιδί,

όπως αναφέρθηκε προηγουμένως στην παιγνιοθεραπεία (play therapy).

Ως προνομιακό κανάλι έκφρασης του παιδιού διευκολύνει την πραγματοποίησή του.

Το Τεστ Wartegg βασίζεται σε ένα ακριβέστατο σύστημα αποκωδικοποίησης και ερμηνείας.

Παρά την απλότητα της χορήγησης, το σύστημα αποκωδικοποίησης είναι πολύ σύνθετο και ακριβές

και αναφέρεται στο Σύστημα Crisi-Wartegg: μία διαδικασία που ανέπτυξε ο καθηγητής Crisi,

η οποία γενικά επιτρέπει την απόκτηση μιας περιγραφής της λειτουργίας της προσωπικότητας του ατόμου

στο οποίο έχει χορηγηθεί το τεστ.

Σχετικά με τον ειδικό χαρακτήρα του τραύματος το τεστ επιτρέπει, μέσω ερμηνείας καθοριστικών δεικτών,

τον προσδιορισμό της ύπαρξης ενός τραύματος, σε ό,τι αφορά τις επιπτώσεις στο άτομο,

και όλων όσα μπορεί να προκαλέσει η βίωση μιας τραυματικής εμπειρίας,

σε επίπεδο γνωστικό, σχεσιακό και συναισθηματικό.

Το Τεστ Wartegg δεν δημιουργήθηκε ως εξειδικευμένο τεστ εκτίμησης του τραύματος,

αλλά μπορεί να συμβάλλει σημαντικά προς αυτή την κατεύθυνση.

Η αναφορά προκύπτει μετά την αποκωδικοποίηση, η οποία πραγματοποιείται μέσω ενός αρχικού σταδίου

όπου τα σκίτσα μεταφράζονται σε σήματα και αυτά σε δείκτες, που ερμηνεύονται σε διάταξη

δεικτών και περιγράφουν πτυχές της λειτουργίας της προσωπικότητας.

Η δύναμη αυτού του τεστ έγκειται στην απλότητα και την αμεσότητά του και μπορεί να δώσει

μια περιγραφή των επιπτώσεων του τραύματος στην ψυχολογική λειτουργία

του ατόμου.

Εκτός από το Τεστ Wartegg, προβολικού τύπου, υπάρχουν και ερωτηματολόγια αξιολόγησης τραύματος.

Αναφέρουμε ενδεικτικά μερικά από αυτά. Ο Κατάλογος Συμπτωμάτων Hopkins 2,

ερωτηματολόγιο που ανέπτυξε το Πανεπιστήμιο του Χάρβαρντ και δημιουργήθηκε με σκοπό

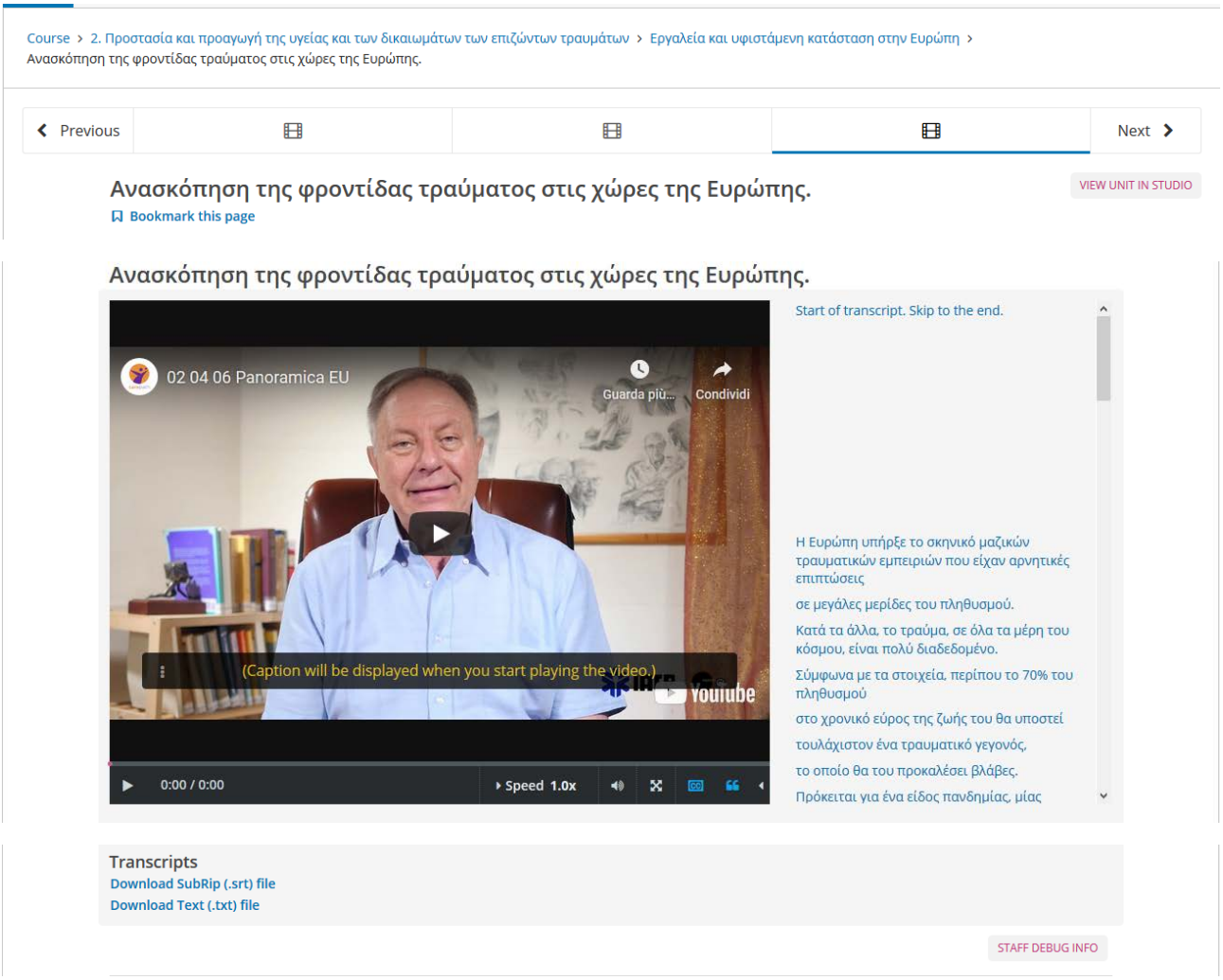
την αξιολόγηση της παρουσίας συμπτωμάτων στα νεαρά προσφυγόπουλα (που έχουν βιώσει αυτή την εμπειρία).

Ένα άλλο ερωτηματολόγιο είναι ο Κατάλογος Συμπτωμάτων Τραύματος για Μικρά Παιδιά,

ένα ερωτηματολόγιο που συμπληρώνεται όχι άμεσα από τον θεραπευόμενο αλλά από τον θεραπευτή.

Και, τέλος, ο Κατάλογος Διαχειριστικής Ανταπόκρισης (CRI),

που χορηγείται σε άτομα 12 ετών και άνω και είναι ένα ερωτηματολόγιο αυτοαξιολόγησης.



Transcript

Η Ευρώπη υπήρξε το σκηνικό μαζικών τραυματικών εμπειριών που είχαν αρνητικές επιπτώσεις

σε μεγάλες μερίδες του πληθυσμού.

Κατά τα άλλα, το τραύμα, σε όλα τα μέρη του κόσμου, είναι πολύ διαδεδομένο.

Σύμφωνα με τα στοιχεία, περίπου το 70% του πληθυσμού

στο χρονικό εύρος της ζωής του θα υποστεί

τουλάχιστον ένα τραυματικό γεγονός,

το οποίο θα του προκαλέσει βλάβες.

Πρόκειται για ένα είδος πανδημίας, μίας ευρύτατα διαδεδομένης επιδημίας,

και, ως τέτοιας, είναι τόσο σοβαρές οι βλάβες που προκαλούν οι συνέπειες των τραυμάτων

σε ψυχικό, σωματικό,

συμπεριφορικό, κοινωνικό και οικονομικό επίπεδο

ώστε θα υποθέταμε

ότι θα να ανησυχούσαν τόσο πολύ οι ευρωπαϊκές χώρες,

από τις πιο προηγμένες παγκοσμίως, ώστε να επενδύσουν σε έρευνες,

τεχνογνωσία, χρηματοδότηση και να αναπτύξουν τις ικανότητες αποτελεσματικής διαχείρισης

αυτής της πανδημίας, όπως και σε πολλά ανάλογα φαινόμενα.

Ωστόσο, δυστυχώς, δεν ισχύει αυτό. Απίστευτο και όμως αληθινό: ελάχιστα έχουν γίνει.

Εξαιρέσεις σε αυτό τον κανόνα είναι κάποια "ενάρετα" κράτη, όπως οι Σκανδιναβικές χώρες.

Στη Σουηδία έχουν προετοιμαστεί όχι μόνο σε επίπεδο θεραπείας των τραυματισμένων ατόμων

αλλά και σε κοινωνικό επίπεδο, αντιμετωπίζοντας με προνοητικότητα

το πρόβλημα, για αυτό σε κάθε πόλη υπάρχει

μια ομάδα κρούσης αφοσιωμένη στο τραύμα.

Ή οι θεραπευτές, όπως οι κοινωνικοί λειτουργοί,

είναι καλά εκπαιδευμένοι, στο πλαίσιο της ακαδημαϊκής διαδικασίας, για τον τρόπο διαχείρισης και πρόληψης

αυτών των ζητημάτων.

Πολλές άλλες ευρωπαϊκές χώρες, ωστόσο, δεν είναι εξίσου αποτελεσματικές.

Αρκεί να σκεφτούμε το Βέλγιο, με άψογο κατά κεφαλήν εισόδημα, άψογη ικανότητα ανάπτυξης,

βιομηχανία και υπηρεσίες, το οποίο μέχρι πριν από λίγα χρόνια δεν κατείχε τα εργαλεία

αντιμετώπισης ή υποστήριξης των θεραπευτών ώστε να αναπτύξουν σε ακαδημαϊκό επίπεδο

ικανότητες διαμόρφωσης του κοινωνικού ρόλου τους.

Η κατάσταση, λοιπόν, σήμερα δεν είναι καθόλου ικανοποιητική, με ποικίλες μεταβλητές,

όπως η Αγγλία και οι χώρες αγγλοσαξωνικού τύπου,

οι οποίες έχουν αναπτύξει με προνοητικότητα

τις δυνατότητες εκπαίδευσης και επένδυσης πόρων για τη δημιουργία θεσμών που μπορούν

να προσφέρουν βοήθεια και θεραπεία σε τραυματισμένα άτομα,

αλλά και πρόληψη του φαινομένου.

Ωστόσο, σε πολλές χώρες, όπως στην Ιταλία, υπάρχει ακόμα πολύς δρόμος να διανύσουμε

πριν γίνει αποδεκτό

να έχουμε μία αξιοπρεπή κατάσταση και μάλιστα υπό έλεγχο.

Μία θετική εργασία πραγματοποιήθηκε, προφανώς, από τους οργανισμούς τραυματολογίας

που αναπτύχθηκαν τις τελευταίες δεκαετίες. Αυτές κατά κάποιο τρόπο υποκατέστησαν

τα εκπαιδευτικά πανεπιστημιακά προγράμματα

σε ό,τι αφορά τα διάφορα επαγγέλματα υγείας δημιουργώντας και παρέχοντας

κατάρτιση, επιμορφώσεις,

ακόμα και δυνατότητες έκδοσης διπλωμάτων

με εξειδίκευση στη θεραπεία του τραύματος.

Πολλά πρέπει να γίνουν ακόμα και την ανάγκη αυτή επιτάσσει η ηθική

αλλά και η κοινωνική υγεία και τα δικαιώματα των ατόμων στην υγεία.

Στην Ιταλία, το άρθρο 33 του Συντάγματος, όπως και σε πολλά άλλα ευρωπαϊκά Συντάγματα,

λέει ότι η υγεία είναι δικαίωμα του κάθε πολίτη, άρα πρέπει να προστατεύουμε και να προάγουμε

την υγεία όλων: αυτό είναι επιτακτική ανάγκη.

Εκπαιδευτικό υλικό

Schäfer I, Hopchet M, Vandamme N, et al. Trauma and trauma care in Europe. *Eur J Psychotraumatol*. 2018;9(1):1556553. Published 2018 Dec 20. doi:10.1080/20008198.2018.1556553

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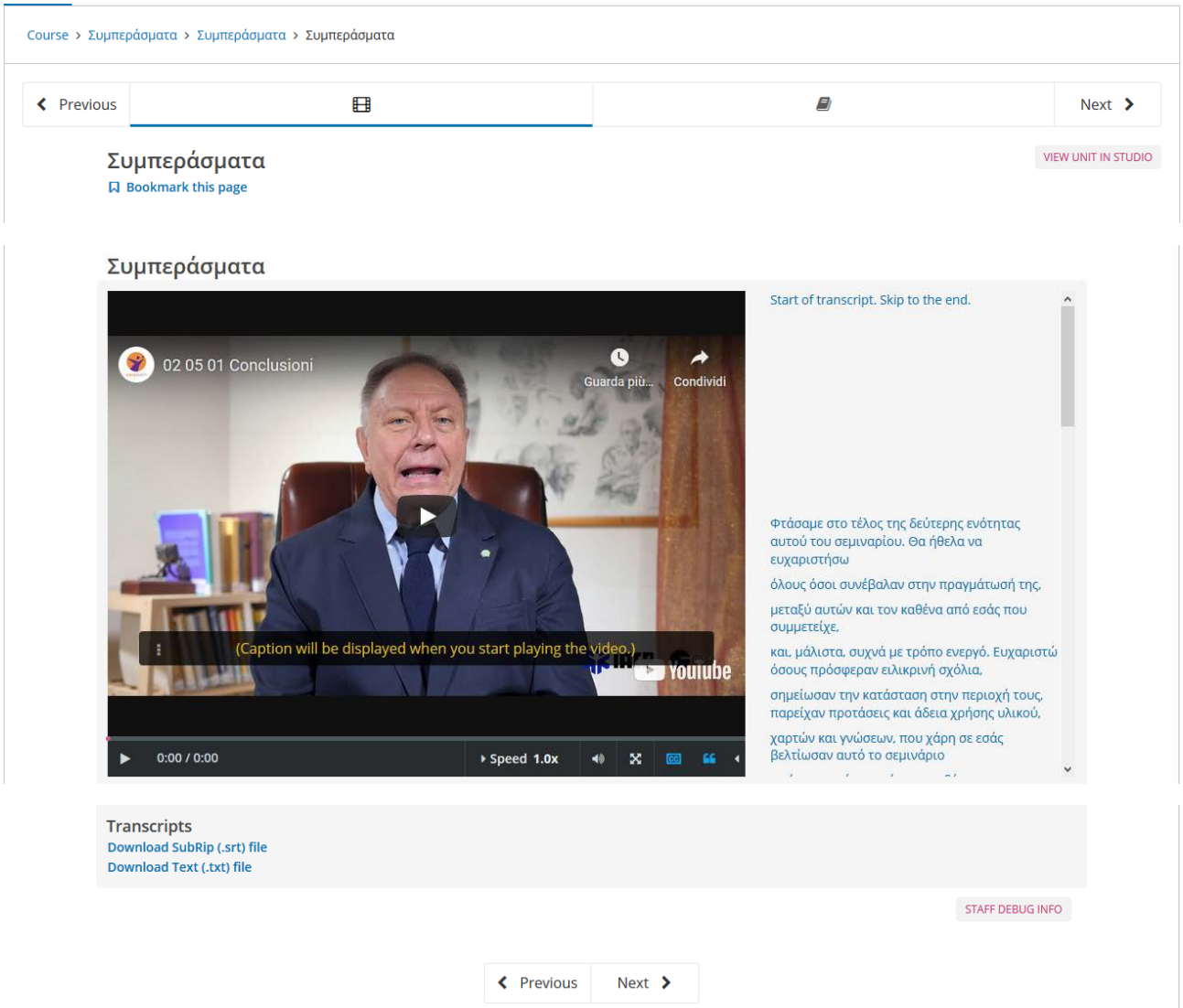

Transcript

Φτάσαμε στο τέλος της δεύτερης ενότητας αυτού του σεμιναρίου. Θα ήθελα να ευχαριστήσω
όλους όσοι συνέβαλαν στην πραγμάτωσή της,
μεταξύ αυτών και τον καθένα από εσάς που συμμετείχε,
και, μάλιστα, συχνά με τρόπο ενεργό. Ευχαριστώ όσους πρόσφεραν ειλικρινή σχόλια,
σημείωσαν την κατάσταση στην περιοχή τους, παρείχαν προτάσεις και άδεια χρήσης υλικού,
χαρτών και γνώσεων, που χάρη σε εσάς βελτίωσαν αυτό το σεμινάριο
σε ό,τι αφορά τις επόμενες εκδόσεις του.
Ένα μεγάλο ευχαριστώ στην ομάδα που εργάστηκε
με υπέρμετρη γενναιοδωρία και δέσμευση για την πραγμάτωση αυτού του έργου που πιστέψαμε
σε ό,τι αφορά τους σκοπούς και τους στόχους του.
Ευχαριστώ όλους τους συναδέλφους εκτός ινστιτούτου
που δέχτηκαν να εργαστούν αφιλοκερδώς

και να δώσουν τη δική τους εικόνα, τη δική τους συμβολή

αλλά και το δικό τους υλικό για να διατεθεί και να διαδοθεί δωρεάν

μέσω της πύλης αυτού του σεμιναρίου.

Ευχαριστώ όλο το προσωπικό του Ινστιτούτου Προσωποκεντρικής Προσέγγισης που τόσο γενναιόδωρα

συνέβαλε εξίσου με όλη του την καρδιά και τον νου για να μοιραστεί τις εμπειρίες του

σε αυτόν τον δύσκολο τομέα της θεραπείας των ανηλίκων που έχουν υποστεί τραύματα.

Επίσης, ευχαριστώ όλους τους οργανισμούς που συνεργάστηκαν μαζί μας

και όλους τους συνεργάτες του προγράμματος "Care Path" που μας βοήθησαν με κάθε τρόπο

αλλά και για τη συμπάθεια και τη φιλικότητα που έδειξαν.

Το τελευταίο ευχαριστώ, το κερασάκι στην τούρτα, απευθύνεται

στον υπεύθυνο του προγράμματος Λούκα Ρολέ και σε όλους τους συναδέλφους του Πανεπιστημίου του Τορίνο.

Είναι, πράγματι, από τους καλύτερους υπεύθυνους ευρωπαϊκών προγραμμάτων τα οποία γνωρίζουμε

και στα οποία συμμετείχαμε.

Ευχαριστούμε και τους συναδέλφους του στη Σχολή Ψυχολογίας του Πανεπιστημίου του Τορίνο.

Είναι εξαιρετικοί και έκαναν τα πάντα,

και ακόμα περισσότερα, για να διευκολύνουν την εργασία μας.

Ευχαριστώ, λοιπόν. Σας ευχαριστώ όλους και καλή συνέχεια με τις υπόλοιπες ενότητες.

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Quiz 1

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Q1

15 points possible (graded)

1. Τι ονομάζουμε σχέση βοήθειας?

- ○ Είναι μια συναισθηματική σχέση όπου ο ένας βασίζεται στη βοήθεια του άλλου
- ○ Είναι μια σχέση που καθιερώνεται μεταξύ ενός επαγγελματία και αυτού που χρησιμοποιεί μια υπηρεσία
- ○ Μια σχέση που ανταποκρίνεται στις ανάγκες του επαγγελματία και του χρήστη υπηρεσιών
- ○ Μια σχέση μεταξύ γιατρού-ασθενή

2. Η γενική θεωρία των συστημάτων διατυπώθηκε από:

- ○ Wertheimer
- ○ Maslow
- ○ Rogers
- ○ Von Bertalanffy

3. Τι είναι το WHO;

- ○ World Science Organization (Παγκόσμιος Οργανισμός Επιστημών)
- ○ Social Medical Organization (Κοινωνικός Ιατρικός Οργανισμός)
- ○ World Health Organisation (Παγκόσμιος Οργανισμός Υγείας)

4. Η Ατομοκεντρική προσέγγιση ξεκίνησε από τον:

- ○ C. Rogers
- ○ O. Rank
- ○ J. Bowlby
- ○ A. Maslow

5. Ποιες από τις προϋποθέσεις οι οποίες είναι απαραίτητες για την καθιέρωση μιας σχέσης βοήθειας δεν θεωρήθηκε από τον C. Rogers;

- ○ Ενσυναίσθηση
- ○ Άνευ όρων αποδοχή
- ○ Ανθεκτικότητα
- ○ Αναλογικότητα

6. Συμμαχία στην εργασία

- ○ Αφορά τις ρυθμίσεις βάσει συμβολαίου μεταξύ του εργαζομένου και του εργοδότη.
- ○ Δεν αφορά το άτομο αλλά μόνο την ομάδα
- ○ Αποτελεί μια επιθυμητή μορφή συνεργασίας σε κάθε σχέση βοήθειας
- ○ Πρόκειται για το σύνολο κανόνων που ορίζει ο επαγγελματίας και το οποίο πρέπει να τηρεί ο χρήστης υπηρεσιών.

7. Η έλλειψη ενσυναίσθησης σε μια σχέση βοήθειας:

- ○ αποτελεί επαγγελματική δεξιότητα
- ○ χρησιμεύει στην καλύτερη κατανόηση της αφήγησης του χρήστη
- ○ αποτελεί μια συνιστώμενη ενέργεια για την πρόληψη της επαγγελματικής εξουθένωσης
- ○ εμποδίζει την αποτελεσματικότητα μιας σχέσης βοήθειας

8. Τι ονομάζουμε σύνθετη μετατραυματική διαταραχή στρες?

- ○ είναι ένας εναλλακτικός όρος για διαταραχή μετατραυματικού στρες
- ○ είναι μια διαταραχή που προέρχεται από χρόνιες τραυματικές εμπειρίες
- ○ είναι ένας όρος που χρησιμοποιείται όταν τα συμπτώματα της μετατραυματικής διαταραχής στρες παραμένουν για περισσότερο από 6 μήνες
- ○ είναι μια διαταραχή που προκαλείται από ένα ομαδικό τραύμα

9. Ποια από τα παρακάτω χαρακτηριστικά δεν είναι επιθυμητά σε ένα σύστημα φροντίδας που χρησιμοποιεί την προσέγγιση "Trauma Informed Care";

- ○ Η αξιολόγηση του ασθενούς σε όλες τις φάσεις φροντίδας
- ○ Η υιοθέτηση μιας ουδέτερης και υποστηρικτικής γλώσσας
- ○ Το να γίνει μια σωστή εκτίμηση του ποια εμπειρία μπορεί να οριστεί ως τραυματική.
- ○ Η εκπαίδευση του προσωπικού πάνω στο τραύμα και στα αποτελέσματα του.

10.Ποιος είναι ο πιο κοινός αιτιοπαθογόνος παράγοντας στην ανάπτυξη ψυχολογικού τραύματος;

- ○ Επαναλαμβανόμενη εμπειρία σωματικής και ψυχολογικής παραμέλησης από τους φροντιστές
- ○ Εμπειρία από πρώτο χέρι φυσικών καταστροφών
- ○ Πρώτη εμπειρία ξαφνικού θανάτου
- ○ Η εμπειρία της σεξουαλικής κακοποίησης ως παιδί

11. Informed trauma care σημαίνει:

- ○ Ένα σύνολο τεχνικών που διευκολύνουν όσους χρησιμοποιούν την τεχνική του EMDR
- ○ Ένα είδος ψυχοθεραπείας
- ○ Μια συστημική προσέγγιση σχετικά με την διαχείριση και την φροντίδα των ανθρώπων που έχουν υποστεί τραυματικές εμπειρίες
- ○ Ένας ειδικός χώρος για ασθενείς που έχουν υποστεί τραυματικές εμπειρίες unanswered

12. Η υποβοηθούμενη βία ορίζεται ως:

- ○ Τραύμα από την παρακολούθηση καταστροφικών γεγονότων
- ○ Κατάσταση στην οποία ένας ανήλικος βοηθά, άμεσα ή έμμεσα, ή αντιλαμβάνεται την επίδραση βιαιοπραγιών που διαπράττονται σε φιγούρες που είναι σημαντικές γι 'αυτόν.
- ○ Είδος βίας που προκαλείται από έναν γονέα στον άλλο γονέα με την ψυχολογική και / ή υλική υποστήριξη (που λαμβάνεται μέσω ψυχολογικής χειραγώγησης) του παιδιού
- ○ Το τραύμα το οποίο προέρχεται από την εμφάνιση φαινομένων γενικής βίας

13. Ποιες είναι οι συνιστώμενες ενέργειες παρέμβασης σε περίπτωση που κάποιος είναι μάρτυρας περιστατικού βίας?

- ○ Ανίχνευση, Προστασία, Αξιολόγηση, Θεραπεία
- ○ Παρατήρηση, αξιολόγηση, θεραπεία, οικογενειακή διαμεσολάβηση
- ○ Ανίχνευση, οικογενειακή διαμονή, θεραπεία, οικογενειακή διαμεσολάβηση, μετεγκατάσταση οικογένειας
- ○ Απομάκρυνση από τον πυρήνα της οικογένειας, Οικογενειακή μεσολάβηση, μετεγκατάσταση οικογένειας

14. Σύμφωνα με την έκθεση του ΠΟΥ (Παγκόσμιος Οργανισμός Υγείας- WHO) που δημοσιεύτηκε το 2013 σχετικά με την πρόληψη της κακοποίησης παιδιών στην Ευρώπη, πόσοι από τα παιδιά κάτω των 15 ετών πεθαίνουν από κακοποίηση παιδιών?

- ○ Μεταξύ 800 και 900
- ○ Μεταξύ 500 και 600
- ○ Μεταξύ 900 και 1000
- ○ Μεταξύ 400 και 500

15. Το σύμπλεγμα PTSD διαφέρει από το PTSD στο ότι αυτό:

- ○ το σύμπλεγμα PTSD είναι σύνηθες στην παιδική ηλικία
- ○ το σύμπλεγμα PTSD εμφανίζεται όταν υπάρχουν περιστατικά βίας σε σχέση εμπιστοσύνης
- ○ το σύμπλεγμα PTSD εμφανίζεται σε περιπτώσεις όπου μαζί με ψυχολογικά συμπτώματα συνυπάρχουν κινητικά συμπτώματα
- ○ το σύμπλεγμα PTSD εμφανίζεται αποκλειστικά σε γυναίκες και ανηλίκους

Invia | You have used 0 of 2 attempts | Salva | Show Answer

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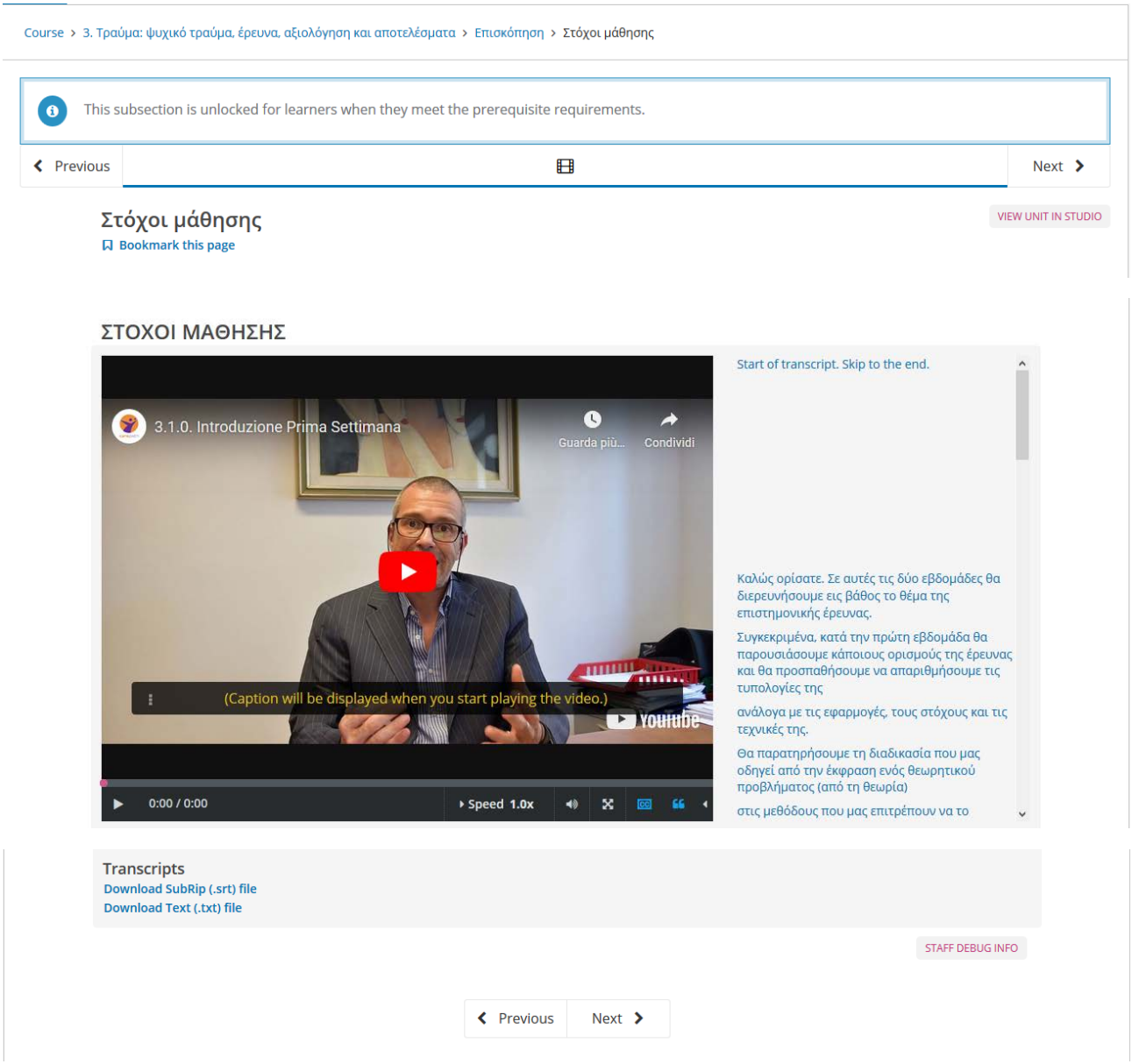

Transcript

Καλώς ορίσατε. Σε αυτές τις δύο εβδομάδες θα διερευνήσουμε εις βάθος το θέμα της επιστημονικής έρευνας.

Συγκεκριμένα, κατά την πρώτη εβδομάδα θα παρουσιάσουμε κάποιους ορισμούς της έρευνας και θα προσπαθήσουμε να απαριθμήσουμε τις τυπολογίες της

ανάλογα με τις εφαρμογές, τους στόχους και τις τεχνικές της.

Θα παρατηρήσουμε τη διαδικασία που μας οδηγεί από την έκφραση ενός θεωρητικού προβλήματος (από τη θεωρία)

στις μεθόδους που μας επιτρέπουν να το διερευνήσουμε,

παράγοντας δεδομένα που μπορούν να ερμηνευτούν και να χρησιμοποιηθούν. Στη συνέχεια, θα ενσωματώσουμε και θα εξετάσουμε εις βάθος

βάθος τις θεμελιώδεις αρχές, τα όρια και τα οφέλη της Έρευνας-δράσης, ως αφετηρία,

ενώ οι συνάδελφοί μου θα εξηγήσουν την έννοια της Έρευνας δράσης,

για να μπορέσουν έπειτα να εξηγήσουν την Έρευνα βάσει αποδείξεων.

Μετά από αυτό, θα εμβαθύνουμε στα πλεονεκτήματα και τις προκλήσεις της ενσωμάτωσης της

Έρευνας βάσει αποδείξεων

Φροντίδα με ενημέρωση για το ψυχικό τραύμα. Ειδικότερα, η διεθνής συνάφεια του θέματος μας δίνει μια εγκάρσια προοπτική

αναφορικά με τα κρίσιμα και τα δυνατά σημεία της

μετατροπής της έρευνας σε κλινική πρακτική. Εδώ θα αναλύσουμε

τα κύρια και συναφή στοιχεία ορθών πρακτικών στην επιστημονική βιβλιογραφία,

μερικά από τα οποία είναι ενημερωτικά. Θα αναρωτηθούμε

και θα προσπαθήσουμε να κατανοήσουμε το νόημα των αναγκών κατάρτισης,

καθώς και πώς αυτές μπορούν να υποστηριχθούν με κάποιο τρόπο και να ληφθούν υπόψη από τον οργανισμό.

Δεν πρέπει να ξεχνάμε ότι μια προσέγγιση σχετικά με τη Φροντίδα με ενημέρωση για το ψυχικό τραύμα έχει σίγουρα μια πτυχή,

έναν αντίκτυπο που είναι θεμελιώδης τόσο για τον οργανισμό όσο και

για τα μεμονωμένα μέλη αυτού. Από εδώ, θα επωφεληθούμε από αυτό το βήμα για να συζητήσουμε

για την επιστημονική διάδοση στην ανάπτυξη και την υλοποίηση συγκεκριμένων παρεμβάσεων

στη Φροντίδα με ενημέρωση για το ψυχικό τραύμα. Φτάνοντας προς το τέλος του ταξιδιού μας αυτήν την εβδομάδα,

θα δούμε τις αξιολογικές πτυχές των οργανισμών

που αναπτύσσουν ή προσπαθούν να αναπτύξουν διαδικασίες ή διεργασίες που αφορούν στην ενημέρωση για το ψυχικό τραύμα.

Εντούτοις, μπορούν να προσφέρουν στους υπαλλήλους,

τους συνεργάτες , τους εθελοντές τους την κατάρτιση και την πληροφόρηση σχετικά με τη Φροντίδα με ενημέρωση για το ψυχικό τραύμα,

καθώς επίσης να προσφέρουν ενδεχομένως αποτελεσματικές παρεμβάσεις που σχετίζονται με

ερευνητικές αποδείξεις στην ψυχοθεραπεία ή μάλλον στη Θεραπεία βάσει αποδείξεων.

Από αυτό το σημείο θα συνοδεύσουμε ο ένας τον άλλον και θα προχωρήσουμε στη δεύτερη εβδομάδα

που θα μας επιτρέψει να εξετάσουμε περαιτέρω ζητήματα, τα οποία σχετίζονται με την έρευνα.

Εγώ και οι συνάδελφοί μου ευχόμαστε σε όλους σας μια

ευχάριστη εβδομάδα σεμιναρίων και καλό μάθημα.

This section is a prerequisite. You must complete this section in order to unlock additional content.

Ορισμός της έρευνας

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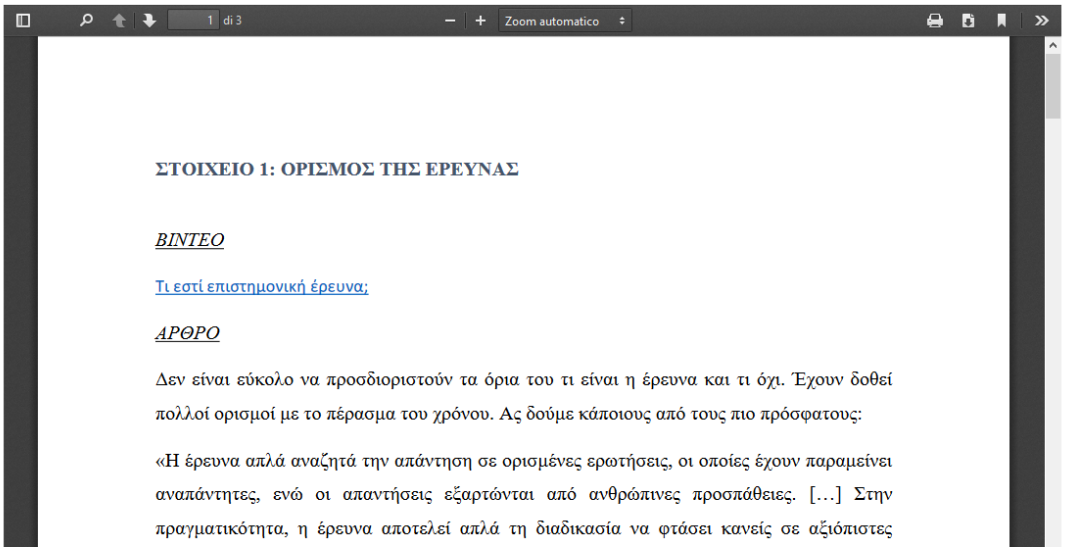

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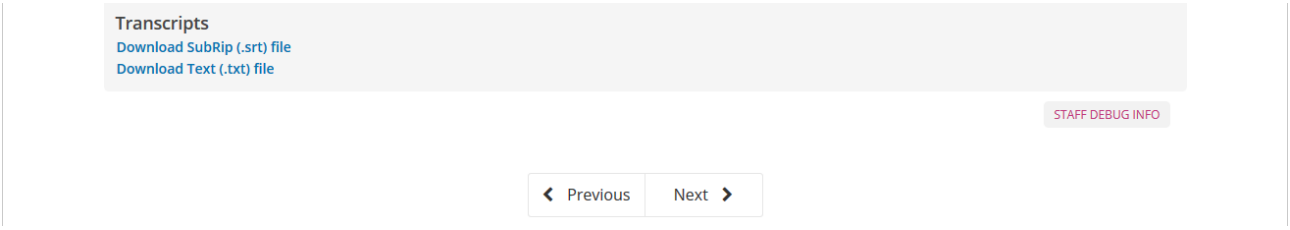
Cos'è la ricerca scientifica?

Start of transcript. Skip to the end.

Ανακάλυψη, αποδοχή και πάθος. Μοίρασμα, μέλλον.
Πολιτισμός και γνώση.
Πρόοδος.
Ανακάλυψη για ένα καλύτερο μέλλον.
Πρόβλεψη.
Ανάπτυξη και γενναιότητα.
Ευχάριστη και ενθαρρυντική.
Δύσκολη και συναρπαστική.
Πάθος, δημιουργικότητα και αφοσίωση.
Πρόκληση



Transcript

Ανακάλυψη, αποδοχή και πάθος. Μοίρασμα, μέλλον.

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Πάθος, δημιουργικότητα και αφοσίωση.

Πρόκληση.

Ανάπτυξη.

Μέλλον. Καινοτομία, επιμονή.

Θυσία αλλά μεγάλη ικανοποίηση.

Ευκαιρία.

Πρόοδος.

Κατανόηση.

Σκληρή δουλειά, ελευθερία και μελέτη.

Φιλοδοξία.

Εξέλιξη.

Προσπάθεια.

Αλλά και διασκέδαση.

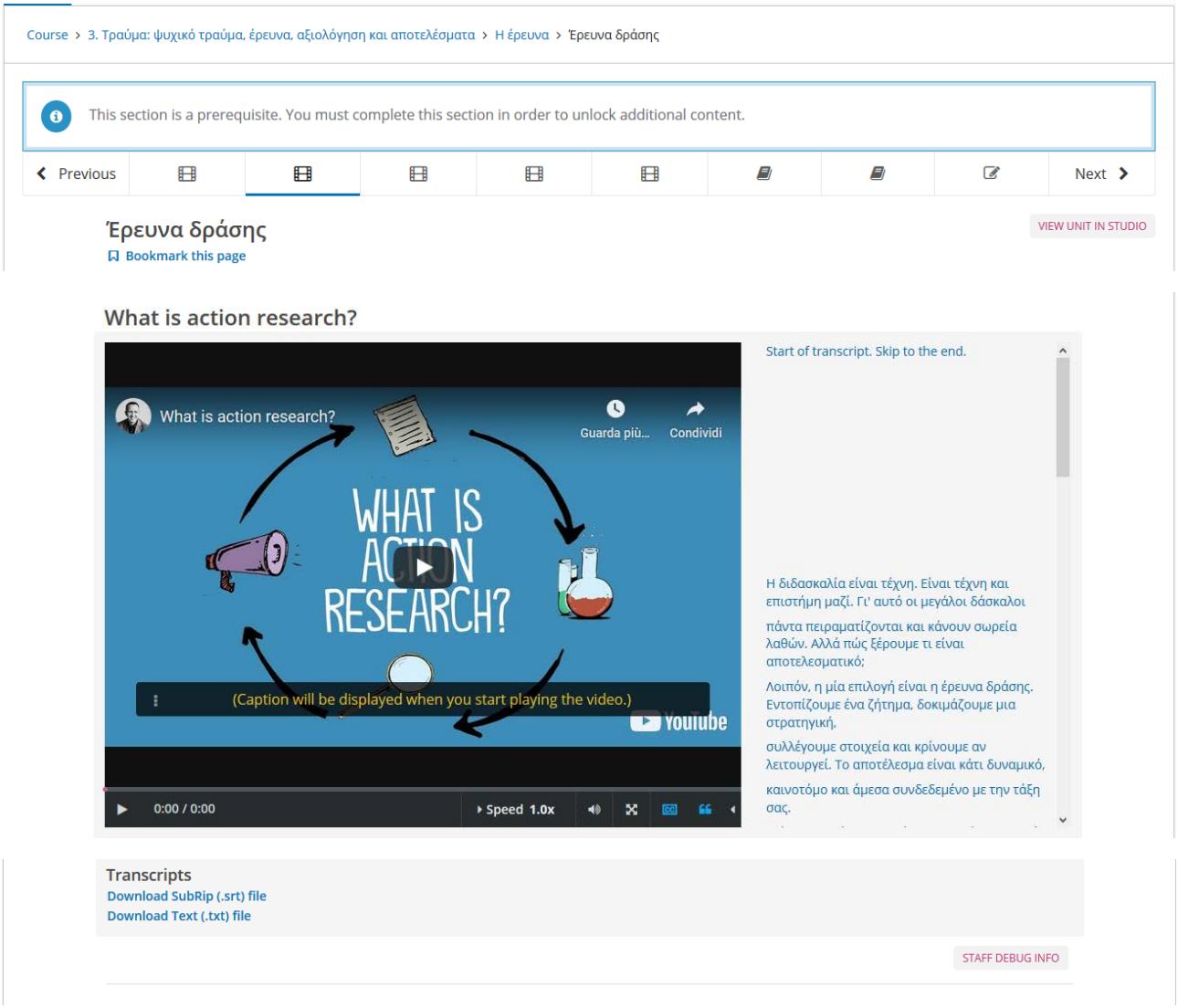
Περιέργεια, καινοτομία, ευημερία.

Η έρευνα είναι στην ανθρώπινη φύση. Ένας άνθρωπος που δεν ερευνά

είναι ένας άνθρωπος που δεν λύνει προβλήματα, που δεν υπάρχει.

Η έρευνα είναι περιέργεια, επιθυμία να μάθουμε την αλήθεια και, κυρίως,

για όσους την έχουν πραγματοποιήσει, είναι η ανεκτίμητη χαρά της ανακάλυψης.



Transcript

Η διδασκαλία είναι τέχνη. Είναι τέχνη και επιστήμη μαζί. Γι' αυτό οι μεγάλοι δάσκαλοι

πάντα πειραματίζονται και κάνουν σωρεία λαθών. Αλλά πώς ξέρουμε τι είναι αποτελεσματικό;

Λοιπόν, η μία επιλογή είναι η έρευνα δράσης. Εντοπίζουμε ένα ζήτημα, δοκιμάζουμε μια στρατηγική,

συλλέγουμε στοιχεία και κρίνουμε αν λειτουργεί. Το αποτέλεσμα είναι κάτι δυναμικό,

καινοτόμο και άμεσα συνδεδεμένο με την τάξη σας.

Η έρευνα δράσης εξαλείφει τα εμπόδια μεταξύ συμμετεχόντων και ερευνητών.

Με άλλα λόγια, ο δάσκαλος συμμετέχει ενεργά στην κατάσταση και παράλληλα διεξάγει την έρευνα.

Υπάρχουν πολλά πλαίσια έρευνας δράσης

αλλά γενικά όλα ακολουθούν παρόμοια διαδικασία. Αρχίζετε με το Στάδιο 1, τον προγραμματισμό της έρευνας.

Εδώ αρχίζετε με το ερωτηματολόγιο, όπου ορίζετε ένα συγκεκριμένο ερώτημα έρευνας.

Πρέπει να είναι κάτι το οποίο να μπορεί να τεθεί σε δοκιμασία.

Έπειτα, κάνετε μία ανασκόπηση της βιβλιογραφίας για να κατανοήσετε καλύτερα το θέμα.

Τέλος, περνάτε στη διαδικασία σχεδιασμού όπου ορίζετε τις μεθόδους δεδομένων, λαμβάνετε υπόψη ζητήματα ηθικής, εξασφαλίζετε τις απαιτούμενες άδειες, ορίζετε προθεσμίες και διαμορφώνετε τα συστήματα.

Έπειτα, περνάτε στο στάδιο της δράσης. Σε αυτό επιδίδεστε σε πολλαπλούς κύκλους πειραματισμού και συλλογής δεδομένων. Η συλλογή δεδομένων μπορεί να περιλαμβάνει ποιοτικά δεδομένα όπως παρατηρήσεις, τέχνεργα και συνεντεύξεις και ποσοτικά δεδομένα όπως αποτελέσματα ερευνών ή δεδομένα επίτευξης στόχων.

Έπειτα, περνάτε στην ανάλυση. Συχνά θα αρχίζετε οργανώνοντας τα δεδομένα με πίνακες ή γραφήματα αναζητώντας συγκεκριμένες τάσεις.

Μπορείτε επίσης να συζητήσετε με συναδέλφους, να γράψετε σε ένα περιοδικό ή να δημιουργήσετε έναν χάρτη συνεργατικών σχηματισμών πριν καταγράψετε τα αποτελέσματα. Τέλος, καταλήγετε στο συμπέρασμά σας.

Στο σημείο αυτό μοιράζεστε την έρευνά σας με τον κόσμο και στοχάζεστε σχετικά με την πρακτική σας. Αυτό, εν τέλει, θα σας οδηγήσει σε νέα ερωτήματα και ο κύκλος θα συνεχίζεται καθώς θα βελτιώνετε την τέχνη σας ως ένας καλύτερος και πιο δημιουργικός δάσκαλος.

ΕΡΕΥΝΑ ΔΡΑΣΗΣ

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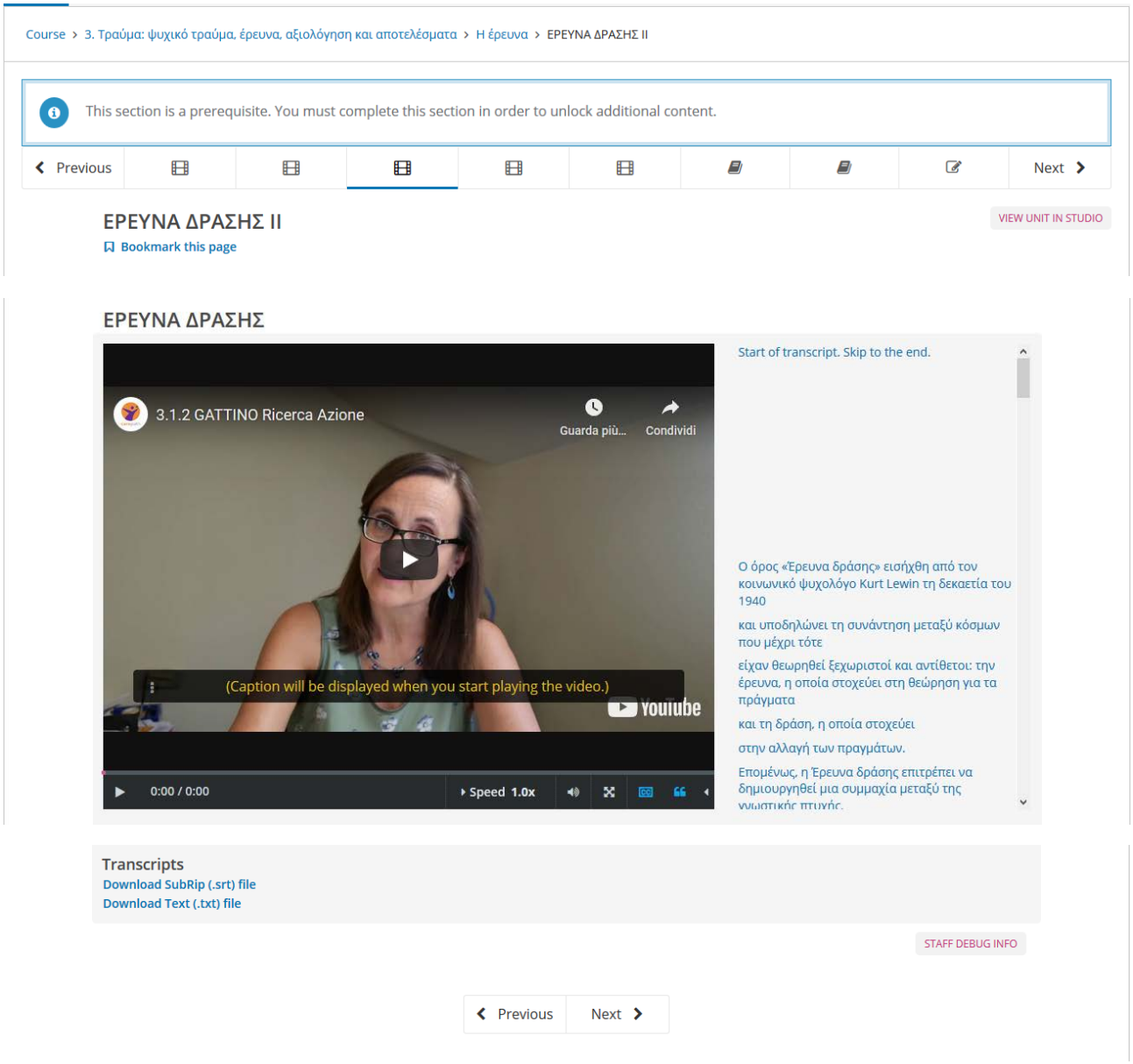

Transcript

Ο όρος «Έρευνα δράσης» εισήχθη από τον κοινωνικό ψυχολόγο Kurt Lewin τη δεκαετία του 1940

και υποδηλώνει τη συνάντηση μεταξύ κόσμων που μέχρι τότε

είχαν θεωρηθεί ξεχωριστοί και αντίθετοι: την έρευνα, η οποία στοχεύει στη θεώρηση για τα πράγματα

και τη δράση, η οποία στοχεύει

στην αλλαγή των πραγμάτων.

Επομένως, η Έρευνα δράσης επιτρέπει να δημιουργηθεί μια συμμαχία μεταξύ της γνωστικής πτυχής,

της Έρευνας, και της εφαρμοστικής πτυχής, της Δράσης, ενώ εκφράζει μια μεταμόρφωση

στον τρόπο σύλληψης, σχεδιασμού και διεξαγωγής έρευνας στις Ανθρωπιστικές Επιστήμες, όπου η πολυπλοκότητα

των υπό μελέτη φαινομένων δεν απλοποιείται, αλλά γίνεται αποδεκτή και λαμβάνεται υπόψη.

Η Έρευνα δράσης διεξάγεται πάντα από τον Lewin σε μια ομαδική ρύθμιση,

καθώς η ομάδα είναι ο ψυχο-κοινωνικός χώρος

μέσα στον οποίο οι άνθρωποι χτίζουν τις ενέργειές τους, ενώ αποτελεί και ένα εργαλείο που μπορεί να διευκολύνει

τις διαδικασίες αλλαγής.

Η Έρευνα δράσης μπορεί να περιγραφεί ως μια οικογένεια ερευνητικών μεθοδολογιών, στόχος των οποίων,

όπως είπαμε, είναι να ενεργοποιήσουν ταυτόχρονα μια πορεία δράσης

(με άλλα λόγια, αλλαγής) και έρευνας (με άλλα λόγια, κατανόησης των φαινομένων).

Αυτή η πορεία λαμβάνει χώρα μέσω μιας ευέλικτης διαδικασίας που αποτελείται από μια αλληλουχία κύκλων,

ο καθένας από τους οποίους είναι δομημένος σε τρία διαδοχικά στάδια: σχεδιασμός, εκτέλεση

και αναγνώριση/έρευνα. Το τελευταίο στάδιο αποσκοπεί στην εκτίμηση των αποτελεσμάτων κάθε φάσης,

στην προετοιμασία μιας ορθολογικής βάσης για την επόμενη φάση και στην αλλαγή, εάν χρειάζεται,

του αρχικού σχεδίου δράσης.

Τι συμβαίνει μετά τον πρώτο κύκλο της Έρευνας-δράσης;

Μόλις αναλυθούν τα αποτελέσματα (και αναλυθεί επίσης η πιθανή αλλαγή που έχει προκύψει

σε σχέση με την αρχική κατάσταση), ξεκινά ένας νέος κύκλος της διαδικασίας,

στον οποίο εισάγονται τα νέα στοιχεία που προέκυψαν από τη δραστηριότητα

που πραγματοποιήθηκε κατά τον προηγούμενο. Αυτοί οι κύκλοι επαναλαμβάνονται μέχρις ότου εξαντληθεί η προβληματική κατάσταση.

Ο σχεδιασμός, η εκτέλεση και η έρευνα υποστηρίζονται από μια κριτική αξιολόγηση

κατά την οποία οι συμμετέχοντες αναρωτιούνται τι λειτούργησε, τι δεν λειτούργησε, τι έμαθαν

και τι μπορεί να γίνει διαφορετικά.

Η κριτική αξιολόγηση κάθε κύκλου επιτρέπει στους ερευνητές δράσης να διορθώνουν τυχόν σφάλματα

και να αναπροσαρμόζουν τις δράσεις στις πραγματικές ανάγκες που προέκυψαν κατά τη διάρκεια της ίδιας της έρευνας.

Ποιος είναι ο στόχος της Έρευνας δράσης;

Στόχος της Έρευνας δράσης είναι η δημιουργία αλλαγής:

αλλαγή στη συμπεριφορά, τις συνήθειες,

τα πλαίσια και άλλα.

Η βασική υπόθεση είναι ότι το status quo δεν επιτρέπει την ευημερία

των ατόμων και ότι μόνο μέσω της αλλαγής μπορεί να βελτιωθεί η κατάσταση.

Επομένως, η αλλαγή πρέπει να προκληθεί, στη συνέχεια να αναλυθεί και να κατανοηθεί,

ενώ πρέπει να είναι και διαρκής.

Σύμφωνα με τον Lewin, για να είναι διαρκής η αλλαγή, πρέπει να περάσει από τρεις φάσεις:

τη «φάση ξεπαγώματος» (unfreezing), η οποία επιτυγχάνεται με βάση τους παράγοντες αντίστασης στην αλλαγή

που συχνά συνδέονται με την τήρηση των κοινωνικών κανόνων,

τη «φάση κίνησης» (moving), όπως για παράδειγμα η αλλαγή και η ανάπτυξη νέων πεποιθήσεων,

αξιών και συμπεριφορών με βάση νέες πληροφορίες και η μετάβαση

από μια παλιά κατάσταση σε μια νέα.

Στο σημείο αυτό, εμφανίζεται η «φάση ξαναπαγώματος» (refreezing) ή «ανασυγκρότησης», κατά την οποία η νέα κατάσταση που έχει δημιουργηθεί

σταθεροποιείται γύρω από μια νέα ισορροπία, δηλαδή, τις νέες αξίες, στάσεις

και συμπεριφορές, οι οποίες καθιερώνονται και ενσωματώνονται στο υπόλοιπο σύστημα.

Μια σημαντική πτυχή της Έρευνας δράσης είναι η ενεργή συμμετοχή

του αποδέκτη, ο οποίος στην πραγματικότητα είναι και ο αποδέκτης και ο παράγοντας

της παρέμβασης και πρέπει να είναι σε θέση να μοιραστεί τους στόχους της ίδιας της έρευνας.

Η βασική υπόθεση της Έρευνας δράσης είναι ότι οι άνθρωποι με τους οποίους εργαζόμαστε είναι ενεργά άτομα,

με δεξιότητες και ικανότητες που πρέπει να συμμετέχουν στην ερευνητική διαδικασία.

Όταν υιοθετεί την προσέγγιση της Έρευνας δράσης, δεν μπορεί κάποιος να αγνοήσει την ενεργή συμμετοχή των ανθρώπων

στους οποίους απευθύνεται η παρέμβαση, ενώ πρέπει να δημιουργήσει μια κατάσταση συνεργασίας

και αντιπαράθεσης με τους αποδέκτες-παράγοντες της παρέμβασης.

Ένα άλλο χαρακτηριστικό στοιχείο αυτής της οικογένειας ερευνητικών μεθοδολογιών,

όπως η Έρευνα δράσης, είναι η απουσία προκαθορισμένης μεθόδου παρέμβασης που πρέπει να εφαρμοστεί.

Στην πραγματικότητα, αυτή η μέθοδος δομείται μαζί με την ομάδα ξεκινώντας από κάποιες θεμελιώδεις αρχές

και με βάση τις αποκρίσεις που παρατηρούνται κατά τη διάρκεια της εργασίας.

Συμβαίνει συχνά το αρχικό μοντέλο να τροποποιείται, καθώς η επιλογή της μεθοδολογίας

και των δράσεων που πρέπει να υλοποιηθούν δομείται κατά τη διάρκεια της διαδικασίας.

Μέχρι στιγμής, έχουμε απεικονίσει τις πτυχές που καθορίζουν την Έρευνα δράσης.

Ας εξετάσουμε τώρα τα στοιχεία που τη διαφοροποιούν από την πειραματική μέθοδο.

Έχουμε αναφέρει ξανά ότι στην Έρευνα δράσης δεν υφίσταται σταθερή παρέμβαση.

Επομένως, όσοι υιοθετούν αυτήν την προσέγγιση επιτρέπουν την εμφάνιση της υπόθεσης κατά τη διάρκεια της διαδικασίας

και την αλλαγή της πορείας της μέσω συνεχούς παρακολούθησης.

Ένα άλλο στοιχείο διαφοράς είναι ότι, στην Έρευνα δράσης, δεν προσπαθούμε να προσδιορίσουμε αιτιώδεις σχέσεις,

να επαληθεύσουμε υποθέσεις από τη βιβλιογραφία ή να καθορίσουμε τα αποτελέσματα των θεραπειών σε αντιπροσωπευτικά δείγματα

με σκοπό να επιβεβαιώσουμε ή να παραποιήσουμε

γενικές θεωρίες.

Στην Έρευνα δράσης, σε κάθε κύκλο, το φαινόμενο στο οποίο παρεμβαίνουμε βρίσκεται περισσότερο

στο επίκεντρο.

Δεν μας ενδιαφέρει η δυνατότητα μέτρησης των μεταβλητών, ενώ στόχος είναι να λυθούν τα προβλήματα

εξετάζοντας διαφορετικές πορείες που δεν μπορούν να προβλεφθούν εκ των προτέρων, αλλά που συνιστούν το αποτέλεσμα και επίσης

το εργαλείο της ομάδας.

Τέλος, ένα άλλο στοιχείο διαφοροποίησης είναι ο τρόπος με τον οποίο παρουσιάζονται τα τελικά αποτελέσματα.

Στην περίπτωση της Έρευνας δράσης, απεικονίζονται σε ολόκληρη την ομάδα

ή σε ολόκληρη την κοινότητα με συμμετοχικούς τρόπους, χρησιμοποιώντας απλοποιημένη,

προσιτή γλώσσα και όχι τεχνικο-επιστημονική γλώσσα, η οποία χαρακτηρίζει τις πειραματικές ερευνητικές εκθέσεις.

Ο στόχος που πρέπει να επιτευχθεί με την παρουσίαση των δεδομένων είναι η δημιουργία νέων αξιολογήσεων,

οι οποίες επιτρέπουν τον προσδιορισμό πιθανών ευκαιριών βελτίωσης.

Σε τελική ανάλυση, βάσει των όσων έχουν ειπωθεί μέχρι στιγμής, μπορούμε να συνοψίσουμε τις βασικές υποθέσεις στις οποίες στηρίζεται η Έρευνα δράσης:

Το γεγονός ότι είναι πρακτική και εννοιολογική.

Η Έρευνα δράσης αναλαμβάνει ως στόχο της τα προβλήματα μιας ομάδας ή μιας κοινότητας.

Ως εκ τούτου, είναι εννοιολογική ως προς τη φύση της, ή με άλλα λόγια, πρόκειται για τοπική έρευνα που λαμβάνει χώρα μέσα σε ένα πλαίσιο.

στοχεύει στην αλλαγή και επικεντρώνεται στη διάσταση της ομάδας

και όχι στο άτομο, τόσο όσον αφορά στην ανάλυση

διαδικασιών όσο και τον καθορισμό των λύσεων και αποτελεσμάτων που έχουν προκύψει.

Επιπλέον, η Έρευνα δράσης χαρακτηρίζεται από πολλαπλά στάδια

και κυκλικό χαρακτήρα που προέρχεται από τη σχεδίαση της έρευνας, η οποία διαμορφώνεται ως εναλλαγή φάσεων

γνώσης και δράσης. θέτει τη συμμετοχή στο επίκεντρο,

όσον αφορά στη συνεργασία και την αλληλεξάρτηση

μεταξύ των ερευνητών και της ομάδας ή των ερευνητών και της κοινότητας.

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Συμμετοχική έρευνα δράσης

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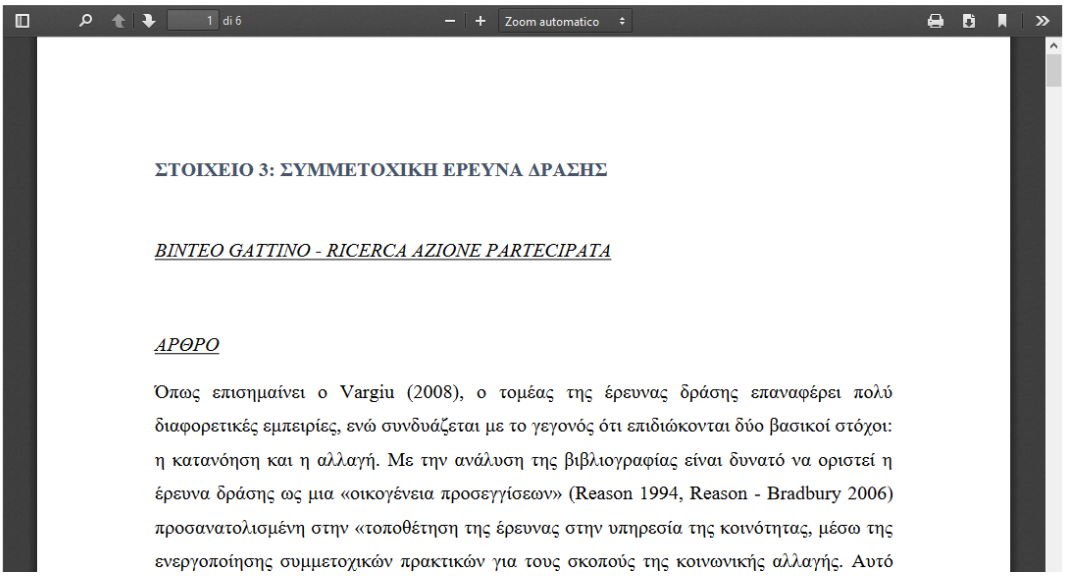
ΣΥΜΜΕΤΟΧΙΚΗ ΕΡΕΥΝΑ ΔΡΑΣΗΣ



1 di 6 Zoom automatico

ΣΤΟΙΧΕΙΟ 3: ΣΥΜΜΕΤΟΧΙΚΗ ΕΡΕΥΝΑ ΔΡΑΣΗΣ

BINTEO GATTINO - RICERCA AZIONE PARTECIPATA

ΑΡΘΡΟ

Όπως επισημαίνει ο Vargiu (2008), ο τομέας της έρευνας δράσης επαναφέρει πολύ διαφορετικές εμπειρίες, ενώ συνδυάζεται με το γεγονός ότι επιδιώκονται δύο βασικοί στόχοι: η κατανόηση και η αλλαγή. Με την ανάλυση της βιβλιογραφίας είναι δυνατό να οριστεί η έρευνα δράσης ως μια «οικογένεια προσεγγίσεων» (Reason 1994, Reason - Bradbury 2006) προσανατολισμένη στην «τοποθέτηση της έρευνας στην υπηρεσία της κοινότητας, μέσω της ενεργοποίησης συμμετοχικών πρακτικών για τους σκοπούς της κοινωνικής αλλαγής. Αυτό

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ΣΥΜΜΕΤΟΧΙΚΗ ΕΡΕΥΝΑ ΔΡΑΣΗΣ

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Έχουμε ήδη εξετάσει τις γενικές υποθέσεις της Έρευνας δράσης, τις οποίες ορίσαμε

ως ένα σύνολο μεθοδολογιών έρευνας.

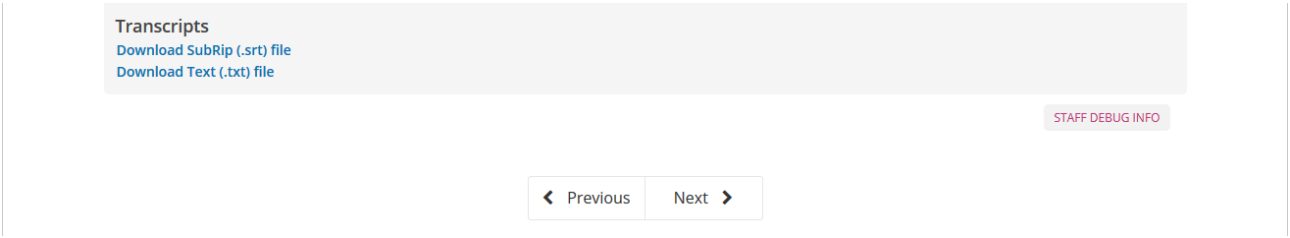
Ας εστιάσουμε και επικεντρωθούμε τώρα σε ένα συγκεκριμένο «μέλος» της οικογένειας της Έρευνας δράσης.

δηλαδή στη Συμμετοχική έρευνα δράσης.

Το κεντρικό στοιχείο της Συμμετοχικής έρευνας δράσης επικεντρώνεται ακριβώς στην ιδέα

μιας κοινής γνώσης μεταξύ του ερευνητή και των αποδεκτών της παρέμβασης,

οι οποίοι είναι συγχρόνως αποδέκτες και



Transcript

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μιας κοινής γνώσης μεταξύ του ερευνητή και των αποδεκτών της παρέμβασης,

οι οποίοι είναι συγχρόνως αποδέκτες και παράγοντες της παρέμβασης. Όπως προαναφέρθηκε, το επίκεντρο της Συμμετοχικής έρευνας δράσης

είναι να θεωρηθεί ότι υπάρχει μια κοινή γνώση με στόχο τη σχεδίαση και την αποκατάσταση

της έννοιας της συλλογικής δράσης.

Η Συμμετοχική έρευνα δράσης θεωρεί σημαντικό η Έρευνα δράσης να σχεδιάζεται και να διεξάγεται

με συλλογικό τρόπο μέσω της συμμετοχής τεχνικών εμπειρογνωμόνων αλλά και ατόμων που ανήκουν στο πλαίσιο στο οποίο παρεμβαίνει

και που μπορούν να επωφεληθούν από την τοπική γνώση και τη γνώση των εμπειρογνωμόνων, αναδεικνύοντας

τις πολλαπλές οπτικές γωνίες και προοπτικές που υπάρχουν

μέσα σε αυτό το συγκεκριμένο πλαίσιο.

Στη βάση των παρεμβάσεων της Συμμετοχικής έρευνας δράσης υπάρχει η αρχή της συμμετοχής,

η οποία προορίζεται ως εργαλείο αλλά και ως στόχος της κοινωνικής αλλαγής της παρέμβασης.

Η Συμμετοχική έρευνα δράσης αναγνωρίζει ότι ένα πρόβλημα προκύπτει από μια ομάδα που αντιμετωπίζει δυσκολίες

σε ένα συγκεκριμένο πλαίσιο και σε μια σαφώς καθορισμένη και με ακρίβεια ιστορική στιγμή.

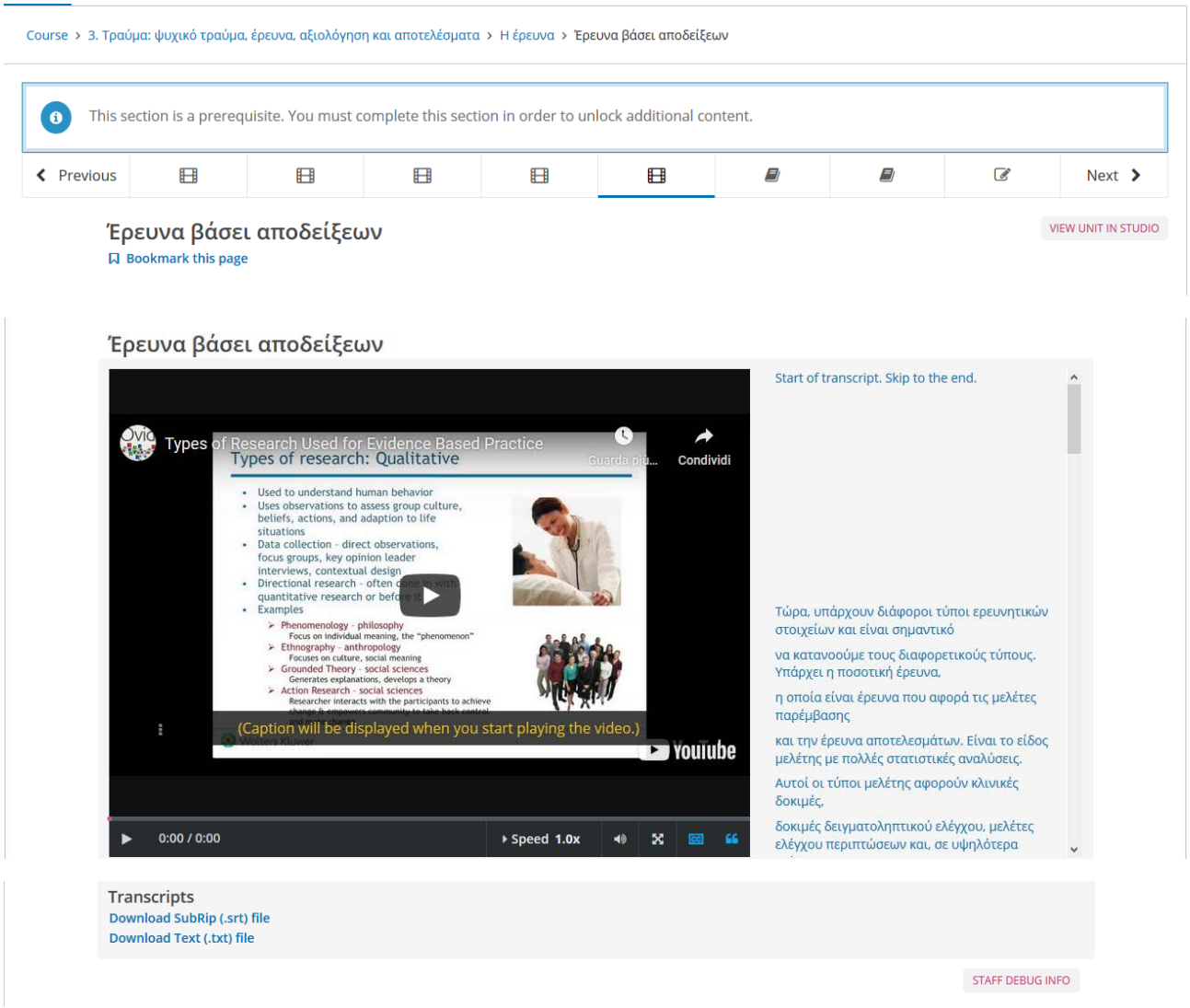
Ο ερευνητής σημειώνει συνεπώς το πρόβλημα, δεν το δημιουργεί, ενώ ο ρόλος του/της είναι να βοηθήσει την ομάδα και την κοινότητα

να προσδιορίσουν τις βασικές πτυχές προκειμένου να μπορέσουν

να συνεχίσουν με τη δράση.

Επομένως, όσοι υιοθετούν την προσέγγιση της Συμμετοχικής έρευνας δράσης πρέπει να δημιουργήσουν μια κατάσταση συνεργασίας και συζήτησης με τους πολίτες

και τους φορείς όσον αφορά στον καθορισμό των προβλημάτων που πρέπει να διερευνηθούν, τη διεξαγωγή της έρευνας και την προετοιμασία της αλλαγής.



Transcript

Τώρα, υπάρχουν διάφοροι τύποι ερευνητικών στοιχείων και είναι σημαντικό
να κατανοούμε τους διαφορετικούς τύπους. Υπάρχει η ποσοτική έρευνα,
η οποία είναι έρευνα που αφορά τις μελέτες παρέμβασης
και την έρευνα αποτελεσμάτων. Είναι το είδος μελέτης με πολλές στατιστικές αναλύσεις.
Αυτοί οι τύποι μελέτης αφορούν κλινικές δοκιμές,
δοκιμές δειγματοληπτικού ελέγχου, μελέτες ελέγχου περιπτώσεων και, σε υψηλότερα επίπεδα,
μετα-αναλύσεις και συστηματικές ανασκοπήσεις. Οι οδηγίες της κλινικής πρακτικής βασίζονται
κυρίως σε ποσοτικά ερευνητικά στοιχεία. Υπάρχει ένας άλλος τύπος έρευνας
που ονομάζεται ποιοτική έρευνα και στην πραγματικότητα διενεργείται
για να κατανοήσουμε την ανθρώπινη συμπεριφορά, το πώς οι άνθρωποι ανταποκρίνονται
στην κατάστασή τους. Έτσι, οι ποιοτικές έρευνες που γνωρίζετε,
πολύ συχνές στη νοσηλευτική και στις Κοινωνικές Επιστήμες,

είναι μελέτες όπως η φαινομενολογία, όπου εξετάζεται το φαινόμενο του νοσείν ή μιας ορισμένης κατάστασης.

Επίσης, σημαίνει εξέταση των εθνογραφικών ομάδων,

με βάση την ανθρωπολογία. Άρα εξετάζουμε ομάδες ανθρώπων σε μια ορισμένη κατάσταση.

Γνωρίζουμε ότι η ποιοτική έρευνα είναι πολύ σημαντική

για την παροχή φροντίδας σήμερα, γιατί πρέπει να είσαστε βέβαιοι

ότι οι ασθενείς σας βιώνουν μια καλή εμπειρία δεχόμενοι τη φροντίδα σας.

Στο επόμενο επίπεδο έρενας ανήκει η δευτερογενής έρευνα και είναι ό,τι αποκαλούμε

συστηματική ανασκόπηση ή μετα-ανάλυση. Η διαφορά μεταξύ της συστηματικής ανασκόπησης

και της μετα-ανάλυσης είναι ότι προσδίδει το ίδιο επίπεδο ακρίβειας

στην ανασκόπηση όλων των ερευνητικών μελετών επί ενός συγκεκριμένου θέματος.

Προσδίδει το ίδιο επίπεδο ακρίβειας στην ανάλυση όλων αυτών των μελετών.

Υπάρχει άλλος ένας περιορισμός: οι συστηματικές ανασκοπήσεις είναι πολύ διαφορετικές

από τις βιβλιογραφικές και οι μετα-αναλύσεις πρέπει να εξετάζονται μεταξύ συναδέλφων,

δηλαδή δύο ή περισσότερα άτομα πρέπει να αξιολογούν

τις μελέτες που περιλαμβάνονται σε μία συστηματική ανασκόπηση ή σε μία μετα-ανάλυση.

Όταν διενεργείτε μία συστηματική ανασκόπηση πρέπει να κοιτάξετε και άλλα πράγματα

για να βεβαιωθείτε σχετικά. Έχει σημασία το πώς παρέχουμε φροντίδα στους ασθενείς μας.

Πρέπει να προσέξετε τα εξής: είναι υλοποιήσιμα τα αποτελέσματα της συστηματικής ανασκόπησης;

Μπορώ στα αλήθεια να την εφαρμόσω σε μια συγκεκριμένη μερίδα του πληθυσμού;

Θα είναι σκόπιμη; Έχει νόημα για τους νοσούντες πληθυσμούς

και για την πρακτική μου ως παρόχου φροντίδας; Θα είναι αποτελεσματική;

Θα κάνει όντως τη διαφορά; Ωστόσο, γνωρίζουμε ότι τα ερευνητικά στοιχεία δεν είναι ισότιμα

και είναι σημαντικό οι πάροχοι φροντίδας, όταν εξετάζουν τα αποτελέσματα

στο πλαίσιο μιας έρευνας, να διαπιστώσουν

το επίπεδο της έρευνας που εξετάζουν. Στη βάση έχουμε όλες τις πρωτότυπες

ερευνητικές μελέτες και αυτές αφορούν τις μελέτες δειγματοληπτικού ελέγχου

και άλλες παρόμοιες. Το αμέσως ανώτερο επίπεδο αφορά τις συστηματικές ανασκοπήσεις

στις μετα-αναλύσεις. Και πάλι, η μετα-ανάλυση συστηματικής ανασκόπησης διεξάγεται

από έναν ερευνητή που εξετάζει όλες τις πρωτότυπες έρευνες σχετικά με ένα ορισμένο θέμα,

κάνοντας μία κριτική αξιολόγηση και σύνθεση κι έπειτα τα συνδυάζει όλα αυτά

υπό τη μορφή της συστηματικής ανασκόπησης. Αυτό θεωρείται υψηλότερο επίπεδο έρευνας

στην ιεραρχία των στοιχείων. Στην κορυφή βρίσκεται η υποστήριξη κλινικών αποφάσεων,

η οποία αφορά εργαλεία που μπορούν να χρησιμοποιούν οι πάροχοι υπηρεσιών υγείας,

να τα διαβάζουν άμεσα αλλά και να τα εφαρμόζουν άμεσα.

Και γιατί είναι τόσο σημαντικό αυτό; Γιατί οι πάροχοι υπηρεσιών υγείας

στο κρεβάτι του πόνου δεν προλαβαίνουν να διαβάσουν 100, 200, 300 σελίδες συστηματικών ανασκοπήσεων

ή μετα-αναλύσεων για να αποφασίσουν στη συνέχεια σχετικά με κάποιον ασθενή.

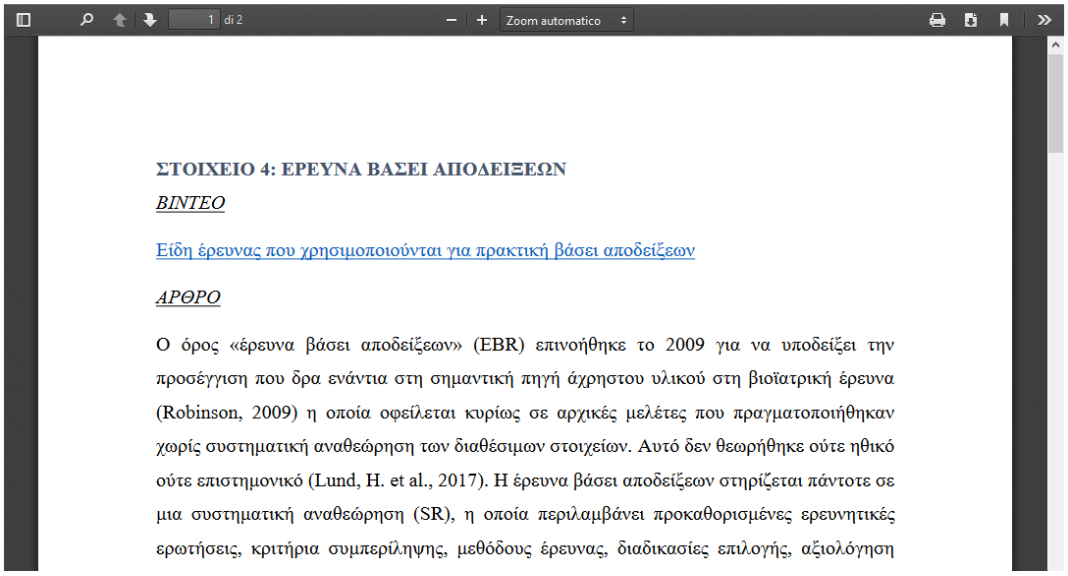
Πρέπει να διαβάσουν τα στοιχεία και να τα θέσουν άμεσα σε εφαρμογή.

Αυτό κάνουν τα εργαλεία υποστήριξης κλινικών αποφάσεων. Όλα αυτά τα εργαλεία

πρέπει να βασίζονται σε συστηματικές ανασκοπήσεις, σε μετα-αναλύσεις,

σε συνοπτικές εκθέσεις στοιχείων ή στα καλύτερα διαθέσιμα αποδεικτικά στοιχεία.

ΕΡΕΥΝΑ ΒΑΣΕΙ ΑΠΟΔΕΙΞΕΩΝ



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Παραδείγματα έρευνας

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Ακολουθεί ένα παράδειγμα μεθόδου έρευνας από τους Bean & Creswell (1980, σελ. 321-322):

«Ο χώρος αυτής της μελέτης ήταν ένα μικρό (με 1000 εγγεγραμμένους φοιτητές), θρησκευτικό, μεικτό, προοδευτικό κολέγιο τέχνης σε μια πόλη από τις κεντροδυτικές πολιτείες με πληθυσμό 175.000 ανθρώπων. Το ποσοστό εγκατάλειψης της σχολής το προηγούμενο έτος ήταν 25%. Τα ποσοστά εγκατάλειψης τείνουν να είναι υψηλότερα μεταξύ των πρωτοετών και των δευτεροετών σπουδαστών, οπότε έγινε μια προσπάθεια να προσεγγίσουμε όσο το δυνατόν περισσότερους πρωτοετείς και δευτεροετείς διανέμοντας το ερωτηματολόγιο μέσα στην τάξη. Η έρευνα σχετικά με την αποχώρηση δείχνει ότι τα αγόρια και τα κορίτσια εγκαταλείπουν το κολέγιο για διαφορετικούς λόγους (Bean, 1978, Spady 1971). Επομένως, στην παρούσα μελέτη έγινε ανάλυση μόνο των γυναικών. Τον Απρίλιο του 1979, 169 γυναίκες απάντησαν στο ερωτηματολόγιο. Ένα ομοιογενές δείγμα 135 γυναικών που ήταν 25 ετών ή νεότερες, άγαμες, Αμερικανίδες και Καυκάσιες είχε επιλεγεί για αυτήν την ανάλυση. Από αυτές, 71 ήταν πρωτοετείς, 55 δευτεροετείς και 9 ήταν τριτοετείς. Το 95% των φοιτητών ήταν μεταξύ 18 και 21 ετών. Αυτό το δείγμα μεροληπτεί υπέρ φοιτητών με υψηλότερες ικανότητες, όπως υποδεικνύεται από τις βαθμολογίες στη δοκιμή ACT. Τα δεδομένα συγκεντρώθηκαν μέσω ερωτηματολογίου που περιείχε 116 στοιχεία. [...] Η πλειονότητα αυτών ήταν στοιχεία τύπου Likert βασισμένα σε μια κλίμακα από «σε πολύ μικρό βαθμό» έως «σε πολύ μεγάλο βαθμό». Άλλα ερωτήματα τέθηκαν για πραγματικές πληροφορίες, όπως οι βαθμολογίες Act, οι βαθμοί λυκείου και το μορφωτικό επίπεδο των γονέων. Όλες οι πληροφορίες που χρησιμοποιήθηκαν σε αυτήν την ανάλυση προέρχονταν από τα στοιχεία του ερωτηματολογίου. Το ερωτηματολόγιο αυτό δημιουργήθηκε και δοκιμάστηκε σε άλλα τρία ιδρύματα πριν από τη χρήση του σε αυτό το κολέγιο. [Οι συγγραφείς συζήτησαν για το όργανο.] [...] Χρησιμοποιήθηκε ανάλυση πολλαπλής παλινδρόμησης και διαδρομής για την ανάλυση των δεδομένων. [...]»

(Creswell, 2014, σελ. 181-182)

Ακολουθεί ένα παράδειγμα ποιοτικής έρευνας (Cardano, Ortalda, σελ. 242-243)

«Σκοπός της έρευνας ήταν να μελετηθεί η έναρξη του καπνίσματος σε προεφήβους (Frohlich, Potvin, Chabot, Corin, 2002). Μετά την αναπαράσταση της συχνότητας καπνίσματος σε προεφήβους σε 32 περιοχές του Κεμπέκ και έχοντας αποκτήσει σχετικές πληροφορίες σχετικά με τους περιορισμούς και τους «διαρθρωτικούς» πόρους που εμποδίζουν τώρα/επιτρέπουν τώρα τη συνήθεια του καπνίσματος σε αυτόν τον πληθυσμό - η παρουσία μαγαζιών που πωλούν τσιγάρα, η παρουσία δημόσιων χώρων όπου δεν επιτρέπεται το κάπνισμα, η παρουσία υποκειμένων που παρακολουθούν τη συμμόρφωση με τους κανόνες, οι οποίοι διέπουν την πώληση τσιγάρων σε εφήβους και το κάπνισμα σε δημόσιους χώρους - , οι συγγραφείς εστιάζουν την προσοχή τους σε οκτώ περιοχές στις οποίες δημιουργούν ομάδες προβληματισμού. Σε κάθε περιοχή, οι συμμετέχοντες προσεγγίζονται μέσω της διαμεσολάβησης των δασκάλων του τοπικού σχολείου, βάζοντάς τους έτσι υπεύθυνους ομάδων αγοριών και κοριτσιών που, κατά πάσα πιθανότητα, γνώριζαν ο ένας τον άλλον και έκαναν παρέα μεταξύ τους πριν από την ομάδα προβληματισμού. Στη μελέτη αυτή, η αμοιβαία γνώση των συμμετεχόντων γίνεται πόρος και όχι όριο, προσφέροντας στους ερευνητές την ευκαιρία να αποκτήσουν πρόσβαση σε ομιλίες που, ίσως λιγότερο «ήπιες», διαμορφώθηκαν στο πλαίσιο της ζωής των συμμετεχόντων. Οι τελευταίοι, εξάλλου, ενισχυμένοι με αμοιβαία υποστήριξη, μπόρεσαν να αντιμετωπίσουν ένα θέμα, τη συνήθεια του καπνίσματος, το οποίο ήταν δύσκολο να συζητηθεί μπροστά σε έναν ενήλικα συνομιλητή με μεγαλύτερη ηρεμία. Η γνώση του εθνογραφικού πλαισίου, των γλωσσικών κωδίκων των κοινωνικών πρακτικών, ευρέως διαδεδομένων στις περιοχές όπου εμφανίστηκαν οι ομάδες προβληματισμού, επέτρεψε στους συγγραφείς να αντιμετωπίσουν τις δυσκολίες που συνήθως σχετίζονται με την υλοποίηση μιας ομάδας προβληματισμού με μια φυσική ομάδα: η πρόσκληση σε κοινές εμπειρίες που δεν εξηγούνται πλήρως στην ομιλία, η χρήση αργκό, η χρήση εκφράσεων ευρετηρίου.»

(Cardano, Ortalda, σελ. 242-243)

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ΑΞΙΟΛΟΓΗΣΗ ΓΝΩΣΕΩΝ

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QUIZ 1

4 points possible (graded)

1. Μια επιστημονική έρευνα...

- ○ Επιτρέπει πάντα μια πιστή καταγραφή της πραγματικότητας
- ○ Ξεκινάει με την συλλογή δεδομένων
- ○ Θα πρέπει πάντα να λαμβάνει υπόψιν την πρότερη αποκτηθείσα γνώση
- ○ Χρησιμοποιεί πάντα μια μόνο μέθοδο (τεχνική)

2. Στην έρευνα -δράσης

- ○ Ενθαρρύνεται η συμμετοχή και η συνεργασία μεταξύ των ερευνητών
- ○ Επιδιώκεται η παρεκβολή των νόμων που έχουν εγγραφεί στη φύση μέσω αντικειμενικής ανάλυσης των φαινομένων
- ○ Δεν θα πρέπει να παραχθούν κοινωνικές μεταβολές στο πλαίσιο της έρευνας
- ○ Ο ερευνητής θα πρέπει να τηρεί μια απολύτως ουδέτερη στάση απέναντι στο αντικείμενο της έρευνας

3. Ποια από αυτά τα βήματα ΔΕΝ αποτελούν μέρος κάθε ερευνητικού έργου που βασίζεται σε τεκμήρια:

- ○ Αξιολόγηση των αποτελεσμάτων
- ○ Επικύρωση του θεωρητικού πλαισίου μέσω της πρακτικής
- ○ Η συστηματική ανασκόπηση της βιβλιογραφίας
- ○ Διαμόρφωση των ερευνητικών υποθέσεων

4. Το κυρίαρχο στοιχείο ανάμεσα στο δίπτυχο Δράση – Έρευνα είναι:

- ○ Η εστίαση στην ιδέα διαμόρφωσης μιας γνώσης που δεν θα μοιράζεται μεταξύ του ερευνητή και του αποδέκτη της παρέμβασης
- ○ Η εκ των προτέρων επιλογή των υπό διερεύνηση προβλημάτων και των εργαλείων που θα χρειαστούν για την μελέτη τους
- ○ Η σαφής και απόλυτη διάκριση ανάμεσα στην Δράση και την Έρευνα
- ○ Η εστίαση στην ιδέα διαμόρφωσης μιας κοινής γνώσης ανάμεσα στον ερευνητή και τον αποδέκτη της παρέμβασης

Invia You have used 0 of 2 attempts

Salva Show Answer

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Έρευνα βάσει αποδείξεων σχετικά με τα TIC/TIP (πρωτόκολλα βελτίωσης της θεραπείας): Διεθνής προοπτική

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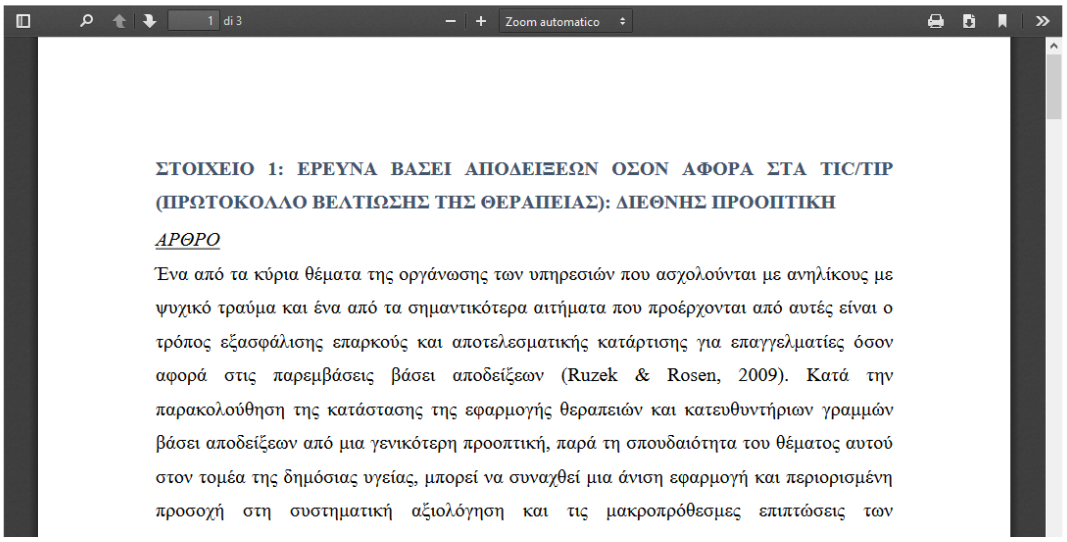
ΕΡΕΥΝΑ ΒΑΣΕΙ ΑΠΟΔΕΙΞΕΩΝ ΟΣΟΝ ΑΦΟΡΑ ΣΤΑ TIC/TIP (ΠΡΩΤΟΚΟΛΛΟ ΒΕΛΤΙΩΣΗΣ ΤΗΣ ΘΕΡΑΠΕΙΑΣ): ΔΙΕΘΝΗΣ ΠΡΟΟΠΤΙΚΗ



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Ανάγκες κατάρτισης σε οργανισμούς που ασχολούνται με την TIC

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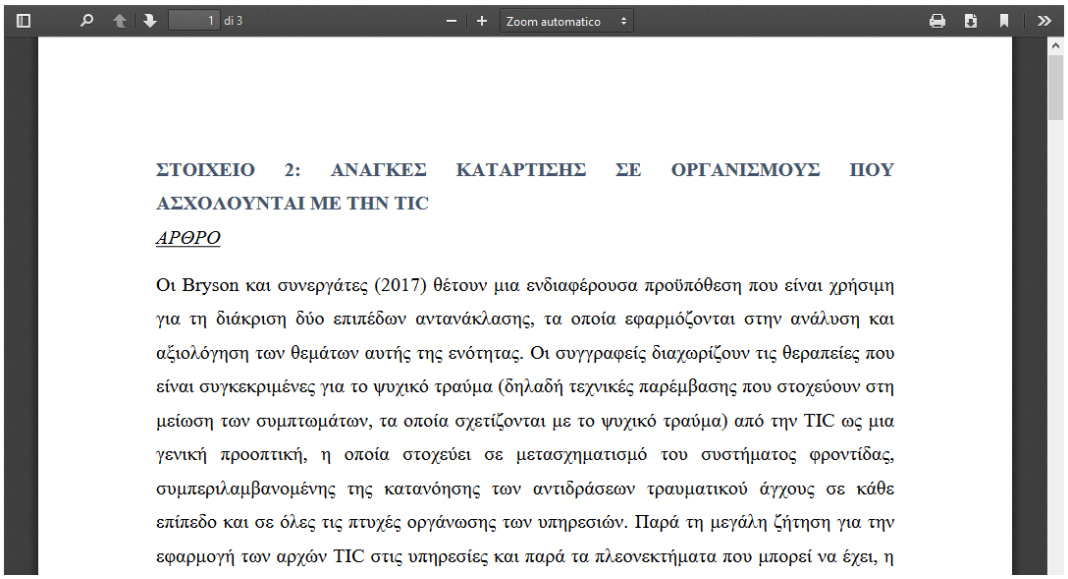
Ανάγκες κατάρτισης σε οργανισμούς που ασχολούνται με την TIC



ΣΤΟΙΧΕΙΟ 2: ΑΝΑΓΚΕΣ ΚΑΤΑΡΤΙΣΗΣ ΣΕ ΟΡΓΑΝΙΣΜΟΥΣ ΠΟΥ ΑΣΧΟΛΟΥΝΤΑΙ ΜΕ ΤΗΝ TIC

ΑΡΘΡΟ

Οι Bryson και συνεργάτες (2017) θέτουν μια ενδιαφέρουσα προϋπόθεση που είναι χρήσιμη για τη διάκριση δύο επιπέδων αντανάκλασης, τα οποία εφαρμόζονται στην ανάλυση και αξιολόγηση των θεμάτων αυτής της ενότητας. Οι συγγραφείς διαχωρίζουν τις θεραπείες που είναι συγκεκριμένες για το ψυχικό τραύμα (δηλαδή τεχνικές παρέμβασης που στοχεύουν στη μείωση των συμπτωμάτων, τα οποία σχετίζονται με το ψυχικό τραύμα) από την TIC ως μια γενική προοπτική, η οποία στοχεύει σε μετασχηματισμό του συστήματος φροντίδας, συμπεριλαμβανομένης της κατανόησης των αντιδράσεων τραυματικού άγχους σε κάθε επίπεδο και σε όλες τις πτυχές οργάνωσης των υπηρεσιών. Παρά τη μεγάλη ζήτηση για την εφαρμογή των αρχών TIC στις υπηρεσίες και παρά τα πλεονεκτήματα που μπορεί να έχει, η

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Διάδοση της έρευνας για το ψυχικό τραύμα σε χώρους οργανισμών

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ΑΡΘΡΟ

Όταν μιλάμε για το θέμα της διάδοσης της έρευνας σε χώρους οργανισμών, οι Ruzek & Rosen (2009) τονίζουν την πολυπλοκότητά του: τα μοντέλα που ασχολούνται με τη διάδοση υπογραμμίζουν πώς αυτό εξαρτάται από πολλαπλούς παράγοντες που αλληλεπιδρούν μεταξύ τους σε διαφορετικά επίπεδα (ατομικά και οργανωτικά). Οι Briggs και συνεργάτες (2012) δείχνουν πώς αναγνωρίζεται ότι η αλλαγή στη γνώση αποτελεί το πρώτο βήμα προς την οργανωτική αλλαγή, αλλά είναι εξίσου θεμελιώδης και η επαλήθευση του πόσο αυτό εμφανίζεται ή μεταφράζεται σε μια πραγματική αλλαγή συμπεριφοράς. Δύο πτυχές φαίνονται σημαντικές: η συστηματική και πολυεπίπεδη πολυπλοκότητα της διάδοσης του επιστημονικού περιεχομένου σε οργανισμούς και η διαδικασία που συνδέει τη γνώση και την πρακτική μέσω ενός πολύπλοκου μηχανισμού ατομικής και οργανωτικής αλλαγής. Αυτή η διαδικασία φέρνει στο προσκήνιο μία από τις συχνότερες αντιδράσεις στην εφαρμογή των νέων βέλτιστων πρακτικών: το γεγονός ότι η επιλογή της εφαρμογής τους στον οργανισμό βιώνεται συχνά ως «εκ των άνω προς τα κάτω» και, ως εκ τούτου, δεν υποστηρίζεται και τόσο από τους κλινικούς ιατρούς (Rohrbach et al., 2006, Ruzek & Rosen, 2009). Πράγματι, στην περίπτωση αυτή, η δέσμευση των φορέων να αλλάξουν την οργανωτική τους πρακτική αποτελεί κομβική διάσταση. Όπως προτείνουν οι συνεισφορές των μελετητών, ένας διακανονισμός κατά τον οποίο η συμφωνία για την αλλαγή διαπραγματεύεται από την ηγεσία με τους υφισταμένους, λαμβάνοντας παράλληλα υπόψη τις τοπικές ανάγκες, συμβάλλει στην επιτυχία της εφαρμογής της (Durlak & DuPre, 2008, Ruzek & Rosen, 2009) . Ένα άλλο κεντρικό θέμα είναι το γεγονός ότι οι οργανισμοί υγειονομικής περίθαλψης συχνά δεν διαθέτουν εξειδικευμένο προσωπικό που να ασχολείται αποκλειστικά με την έρευνα EBP, τη μελέτη των βέλτιστων πρακτικών και στρατηγικών για την εφαρμογή τους και, ειδικότερα, την ανάλυση και συστηματοποίηση της συνεχούς ενσωμάτωσης των αποτελεσμάτων της επιστημονικής έρευνας (Berwick, 2003, Ruzek & Rosen, 2009).

Αναφορικά με αυτό, οι Marvin & Volino Robinson (2018) υπογραμμίζουν την ανάγκη οι οργανισμοί να έχουν ένα όραμα που να εξετάζει την ανάλυση του ιδρύματος ή της ίδιας της υπηρεσίας σχετικά με τη δεξιότητα ή την ετοιμότητα για προσαρμογή και διατήρηση των παρεμβάσεων αλλαγής (στη βιβλιογραφία σημειώνεται ως «οργανωτική ετοιμότητα» και μπορεί να μετρηθεί σε οργανωτικό, ομαδικό ή ατομικό επίπεδο). Η ενασχόληση με αυτήν τη διάσταση στη φάση του σχεδιασμού έχει καθοριστική σημασία για τη διατήρηση της εφαρμογής νέων πρακτικών, την ανάλυση πιθανών εμποδίων στη διαδικασία και τη διατήρηση των πεποιθήσεων και της θετικής στάσης απέναντι στην οργανωτική αλλαγή. Ο ευρύτερος προβληματισμός για το θέμα αυτό περιλαμβάνει το επίκεντρο που θα πρέπει να δοθεί στη σύσταση δημιουργίας στοχοθετημένων στρατηγικών αλλαγής σε συγκεκριμένο οργανισμό (Augustsson et al., 2017, Marvin & Volino Robinson, 2018). Η έρευνα καταδεικνύει τη σημασία της ηγεσίας και του διαχειριστικού οράματος για τη συνδημιουργία του τρόπου αλλαγής σε συγχρονισμό με τους επαγγελματίες και για την κοινή χρήση μιας παιδείας προσανατολισμένης στην εφαρμογή της TIC, η οποία είναι αφιερωμένη, πρωτίστως, στην ανάλυση των αναγκών του προσωπικού.

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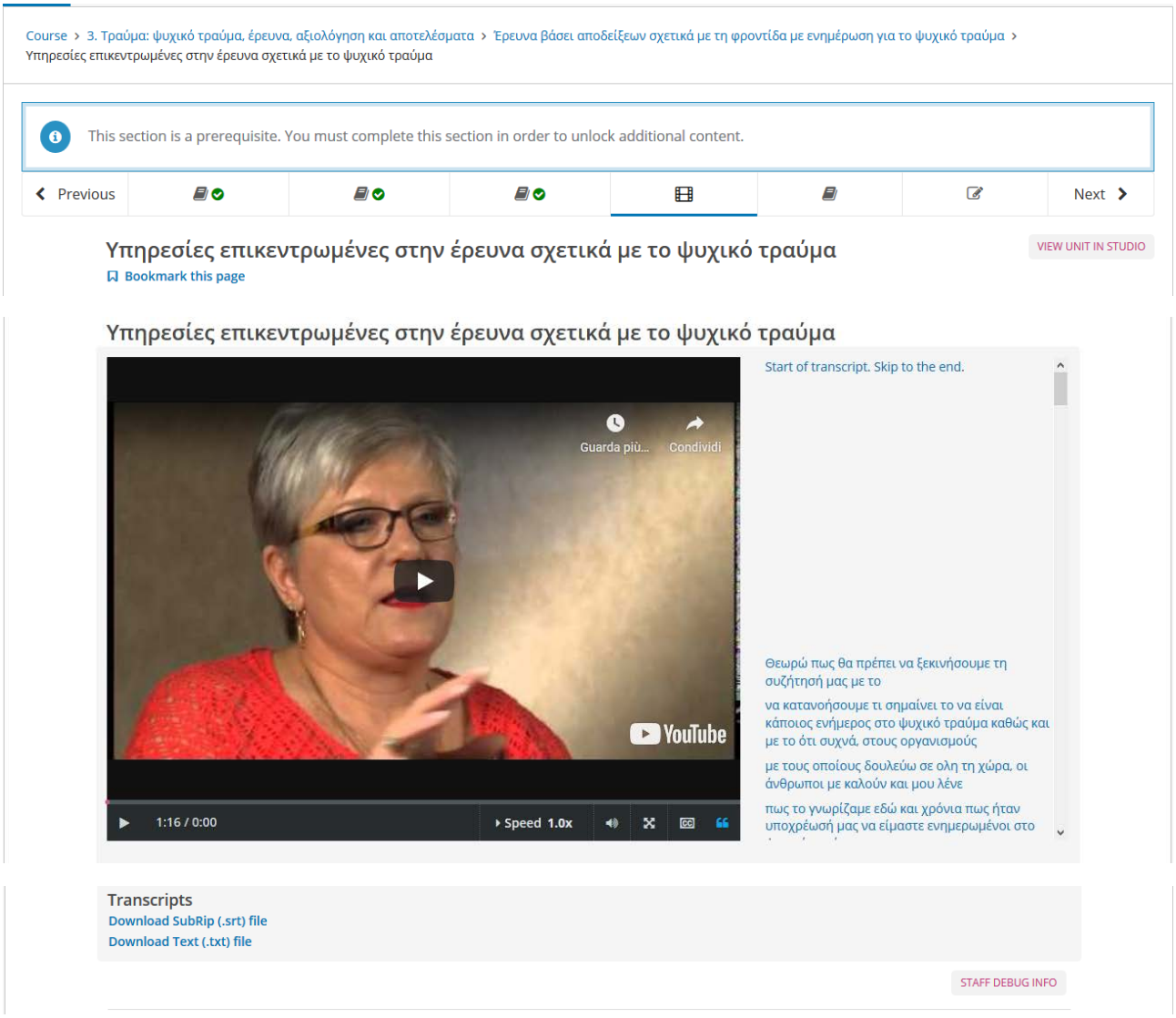


Transcript

Θεωρώ πως θα πρέπει να ξεκινήσουμε τη συζήτησή μας με το

να κατανοήσουμε τι σημαίνει το να είναι κάποιος ενήμερος στο ψυχικό τραύμα καθώς και με το ότι συχνά, στους οργανισμούς

με τους οποίους δουλεύω σε ολη τη χώρα, οι άνθρωποι με καλούν και μου λένε

πως το γνωρίζαμε εδώ και χρόνια πως ήταν υποχρέωσή μας να είμαστε ενημερωμένοι στο ψυχικό τραύμα

κατανοούμε το γιατί αυτό είναι τόσο σημαντικό και ειλικρινά δεν καταλήγουμε πουθενά

Γνωρίζουμε πως υπάρχουν κάποια βήματα τα οποία και πρέπει να κάνουμε

δεν καταφέραμε ποτέ όμως να οργανωθούμε ώστε να μπορούμε

να κάνουμε το επόμενο βήμα. Αυτό που κάναμε στο Εθνικό Συμβούλιο είναι το να αναπτύξουμε

ένα εργαλείο που ονομάζεται "αυτό-αξιολόγηση του οργανισμού" και με αυτό το εργαλείο

συγκεντρώσαμε τις σκέψεις και τις ιδέες των υπευθύνων,

όπως για παράδειγμα αυτές των Roger Fowler, Maxine Harris, Judith Herman και Sandy Blum

και προσπαθήσαμε να συνθέσουμε τη δουλειά τους με τρόπο που να εκφράζει τις πρακτικές

και τις αρχές του τι σημαίνει να είναι κανείς ενημερωμένος στο ψυχικό τραύμα. Για παράδειγμα

η προτεραιότητα στην ασφάλεια ή η διαφάνεια, η αμοιβαιότητα, η επιλογή, η ελευθερία έκφρασης

ο έλεγχος, η συνεργασία, το να δίνει κανείς σε ένα άτομο τον έλεγχο της ζωής του

έτσι αυτό που δημιουργήσαμε είναι ένα εργαλείο με το όνομα " αυτο-αξιολόγηση οργανισμών¨

που κάνει χρήση αυτών ακριβώς των πρακτικών και των κανόνων

προκειμένου να ενεργοποιήσει καθετί σε έναν οργανισμό δείχνει να οδεύει στο να είναι

ενημερωμένο στο ψυχικό τραύμα. Το εργαλείο OSA (κλίμακα αυτο-αξιολόγησης οργανισμών) είναι μία κλίμακα Likert που κυμαίνεται άπο το 0 στο 4

και συμπεριλαμβάνει την απάντηση "μη σχετικό". Δημιουργήσαμε τα 7 πεδία

της ενημερωμένης στο ψυχικό τραύμα φροντίδας και μέσα σε αυτά τα 7 πεδία μπορεί κανείς να αντιληφθεί αυτές

τις αρχές. Στα πλαίσια κάθε πεδίου, υπάρχουν πολλαπλά πρότυπα και αυτά τα πρότυπα

δεν είναι τα μοναδικά. Η ιδέα του OSA είναι να αναγκάσει τους οργανισμούς

να σκεφτούν με διαφορετικό τρόπο αναφορικά με τη δουλειά που κάνουν. Επομένως, για παράδειγμα

στα 7 πεδία, το πρώτο πεδίο είναι "έλεγχος και αξιολόγηση". Επομένως αυτό που θέλουμε

είναι να γνωρίζουμε

το πότε γίνεται ο έλεγχος ενός ανθρώπου από τη στιγμή που εισέρχεται σε μία Δομή. Επίσης όμως θέλουμε

να δώσουμε στους ανθρώπους την ευκαιρία να μιλήσουν για ότι θέλουν,

για κάθε εμπειρία τους σε ένα πλαίσιο ευαισθησίας και βάθους χρόνου. Αν είμαι κάποιος που εισέρχεται

σε έναν οργανισμό και είμαι αρκετά φοβισμένος ή δεν εμπιστεύομαι

αυτόν που συντονίζει την εισαγωγή μου, αυτό που θέλουμε είναι

να είμαστε σε θέση να δημιουργήσουμε ένα περιβάλλον όπου το άτομο μπορεί να νιώσει άνετα

στο να απαντήσει όλες τις απαραίτητες ερωτήσεις. Οι άνθρωποι πρέπει να εκπαιδευτούν

στο πως να κάνουν τις ερωτήσεις και στο πως να δημιουργούν

μία σχέση εμπιστοσύνης από τη πρώτη κιόλας στιγμή που κάποιος εισέλθει στη Δομή.

Το δεύτερο πεδίο αφορά την "φροντίδα και τις υπηρεσίες που βασίζονται στον καταναλωτή" και

είμαι ενθουσιασμένος με το Κοινοτικό Κέντρο Φροντίδας και τον τρόπο που σκέφτονται

και τον τρόπο που εργάζονται καθώς και τον αριθμό των εργαζομένων που εκπαιδεύονται

και ενεργοποιούνται με πολλούς και υπέροχους τρόπους, και δεν είναι

μόνο αυτό. Οι εργαζόμενοι είναι σε θέση να δούνε τις υπηρεσίες μέσα από ένα εντελώς διαφορετικό

τρόπο: γνωρίζουμε πως είναι να μπαίνει κανείς σε μία διαδικασία ελέγχου και αξιολόγησης,

γνωρίζουμε πως είναι να είναι κανείς εγκλωβισμένος σε ένα πλαίσιο που ειλικρινά

δεν δουλεύει, γνωρίζουμε πως είναι να τραυματίζεται κάποιος εκ νέου από το σύστημα και το

να έχει κανείς το δικαίωμα να εισακουσθεί αποτελεί μέρος της δουλειάς, αυτό αποτελεί και ένα παράδειγμα

φροντίδας προσανατολισμένης στον καταναλωτή. Βέβαια το να προσεγγίζει κανείς τα πάντα

μέσα από μία προοπτική προσανατολισμένη στην ανάκαμψη, δείχνει μία πελατοκεντρική προσέγγιση και

ως εκ τούτου αν είμαι το άτομο που λαμβάνει αυτές τις υπηρεσίες, έχω την ευκαιρία

να δηλώσω τι δουλεύει για μένα και τι όχι. Δίνω έτσι δύναμη σε αυτή τη φωνή

και διασφαλίζω πως οι επαγγελματίες του οργανισμού και οι πελάτες

θα έχουν την ευκαιρία πραγματικά να συζητήσουν για το τι δουλεύει σωστά

στον οργανισμό και τι όχι. Επίσης μιλήσαμε για ανάπτυξη του εργατικού δυναμικού

το οποίο θα έχει εκπαιδευτεί πάνω στο ψυχικό τραύμα

συμπεριλαμβάνοντας και την κλινική άσκηση. Οι κλινικοί βέβαια έχουν επαρκή κλινική εκπαίδευση

προκειμένου να κάνουνε τη δουλειά τους. Αν όμως είμαι απλά ο υπάλληλος υποδοχής, τι σημαίνει για μένα το να

εργάζομαι σε έναν οργανισμό που είναι ενημερωμένος στο ψυχικό τραύμα; Κάθε

άνθρωπος κάνει την διαφορά, ακόμη και αν είναι οδηγός λεωφορείου, ακόμη κι αν είναι ο άνθρωπος στην συντήρηση,

μπορεί να κάνει τη διαφορά με το να δημιουργήσει αυτή την κοινωνία όπου οι άνθρωποι αισθάνονται ότι

μπορούν να αρχίσουν να θεραπεύονται. Επίσης αν λάβουμε υπόψη με συμπόνια την κόπωση του προσωπικού,

στην προηγούμενη εργασία μας σήμερα μιλήσαμε για με τις εσωτερικές υπηρεσίες ως προς τους πελάτες, και κατά συνέπεια πως ο

καθένας στον οργανισμό φροντίζει τον άλλο. Δεν μπορείς να έχεις έναν

οργανισμό ενημερωμένο στο ψυχικό τραύμα όταν το προσωπικό δουλεύει υπερβολικά παραπάνω τόσο που

να βιώνει κόπωση συμπόνιας, ώστε να σκέφτεται και τις ανάγκες του

προσωπικού αλλά επίσης και τις επιπτώσεις που υπάρχουν όταν σκέφτομαι πως όταν εγώ δεν φροντίζω τον εαυτό μου

πως μπορώ να είμαι ενεργά εκεί για κάποιον άλλο; Όλο αυτό έχει επίσης σχετίζεται με την καλή κλινική

εποπτεία. Η εποπτεία γίνεται μέσα σε ένα πλαίσιο το οποίο συμφωνεί με την ενημερωμένη με το ψυχικό τραύμα προσέγγιση

ή με μια εποπτεία τιμωρητική; Ο τομέας 4 είναι με βάση τα δεδομένα ο καλύτερος σε αναδυόμενες καλές

πρακτικές, πάντα κοιτάζει για κάτι νέο, δεν λέει "αυτό είναι το μόνο πράγμα που

κάνουμε το οποίο είναι βασισμένο σε αποδεικτικά στοιχεία και ποτέ δεν εξετάζουμε νέα και αναδυόμενα

πράγματα τα οποία μπορεί να συμβαίνουν". Πάντα έχει το βλέμμα στραμμένο στο καλό

υλικό, και πραγματικά, ξέρετε, παρέχοντας κατάρτιση στο προσωπικό, κάνοντας χρήση των

βέλτιστων πρακτικών ανάμεσα σε ομοτίμους, βασισμένων σε αποδεικτικά στοιχεία, όπως το μοντέλο "WHAM" Wellness, Whole Heath Action

Management, όπου οι ομότιμοι βοηθούν τους υπόλοιπους ομοτίμους, ξέρετα, παίρνοντας

τον έλεγχο της δικής τους φυσικής υγείας. Η το μοντέλο "WRAP", Wellness Recovery Action Planning,

το οποίο είναι ένα εξαιρετικό εργαλείο βασισμένο σε στοιχεία καισχετικό με την ενημερωμένη στο ψυχικό τραύμα προσέγγιση, το οποίο

συντελεί στη δημιουργία ασφαλούς περιβάλλοντος. Οι άνθρωποι δεν μπορούν να θεραπευτούν αν δεν αισθάνονται

ασφαλείς. Αν είστε στην ανώτατη εγρήγορση, αν αισθάνεστε ότι περπατάτε μέσα σε ένα

περιβάλλον το οποίο δεν σας καλωσορίζει και δεν αισθάνεστε ασφαλείς,

τίποτα καλό δεν πρόκειται να συμβεί. Κάποιος μου είχε πει, ήμουν σε μια συνάντηση, και

εκεί έβαφαν, απλά έβαφαν ξανά και ανακαίνιζαν την περιοχή της υποδοχής, και ένας

από τους πελάτες ήρθε μέσα και είπε "Μετακομίζουμε;" και ένας άλλος είπε "Όχι, γιατί;"

"Λοιπόν υποθέσαμε, αν το κάνετε αυτό

ωραίο θα πρέπει να φύγουμε" και αυτός είναι ένας

δείκτης ότι οι άνθρωποι δεν αισθάνονται πολύτιμοι, ήταν ένα τεράστιο μάθημα για

αυτούς. Οι άνθρωποι δικαιούνται να απολαμβάνουν φροντίδα σε ένα χώρο και με έναν τρόπο που να δηλώνει "Εγώ

σε σέβομαι, είσαι πολύτιμος", δεν μπορείς να αρχίσεις να θεραπεύεις αν δεν αρχίσεις

να γεμίζεις αυτά τα κενά. και ο τομέας έξι είναι σχετικός με την κατασκευή κοιωνικών συνεργασιών,

όποιοι και αν είμαστε στην κοινότητα μας πρέπει να εργαζόμαστε για να φτιάξουμε κοινότητες,

Η ενημερωμένη στο ψυχικό τραύμα θεραπεία δεν μπορεί να επιτευχθεί στο κενό επομένως αν δεχτώ εξαιρετικές

υπηρεσίες από το πρόγραμμα σου αλλά όταν βγω έξω, ξέρετε, σε ένα οποιοδήποτε άλλο τμήμα και αυτοί

μου συμπεριφερθούν σαν να, ξέρετε, είμαι η λάσπη στο κάτω μέρος του παπουτσιού τους, αυτό αναιρεί όλη την

καλή δουλειά που εγώ έκαν δουλεύοντας με εσένα, οπότε πραγματικά το να φτάσουμε έξω στην

κοινότητα και με το να βοηθήσουμε την κοινότητα να καταλάβει τι σημαίνει να είναι

ενημερωμερωμένη για το ψυχικό τραύμα. Και στο τέλος, ο τομέας επτά είναι σχετικός με τη "Βελτίωση της Απόδοσης"

Πως γνωρίζεις ότι αυτό που παρέχεις κάνει την διαφορά;

Αν εγώ κάνω Χ, αυτό θα δουλεέψει για εμένα; Αυτό θα δουλέψει για τους ανθρώπους τους οποίους εμείς

υπηρετούμε; Κάνω έρευνες ανατροφοδότησης από τους πελάτες; Ρωτάω τους πελάτες σχετικά με το επίπεδο της

ασφάλειας που αισθάνονται; Κάνω έρευνα στο προσωπικό μου; Και όταν κάνω την έρευνα, πράττω

ανάλογα με τα αποτελέσματα; Μόλις έκανα έρευνα οπότε, ξέρετε, ο τρόπος με τον οποίο χρησιμοποιούμε

το μοντέλο OSA είναι, ρωτάμε τους οργανισμούς, όταν ξεκινούν την αξιολόγηση, αυτό αποτελεί

την γραμμή αναφοράς, και μετά τους ρωτάμε και πάλι αφού περάσει ένα χρονικό διάστημα και το ξανακάνουμε, οπότε αυτοί

μπορούν να δουν την πρόδο που έχουν κάνει. κατόπιν χρησιμοποιούμε ένα πλήθος άλλων εργαλείων,

ένα εργαλείο παρακολούθησης της απόδοσης και ένα οδηγό εφαρμογής για να βοηθήσει

τους οργανισμούς να προχωρήσουν, αλλά όλα αυτά είναι ένα στιγμιότυπο του OSA, ένα πολύ γρήγορο

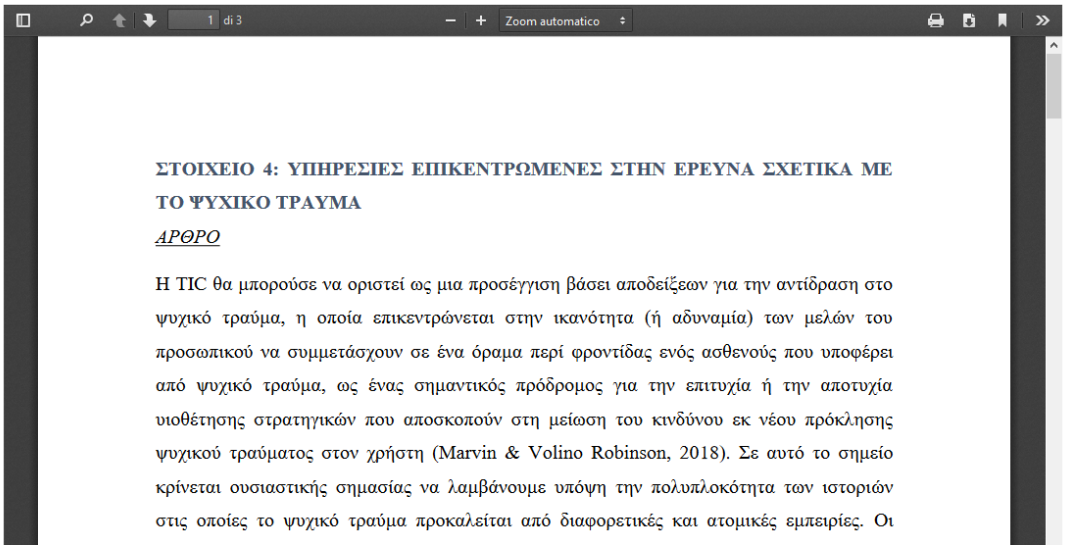
στιγμιότυπο, καθώς το OSA αποτελεί μια χρονοβόρα διεργασία, το OSA δεν είναι

σχεδιασμένο για να πουν οι οργανισμοί "εντάξει, έχουμε τελειώσει τώρα", δεν είναι μια

λίστα ελέγχου, είναι ενας τρόπος να καθοδηγήσετε συνομιλίες, για να αρχίσετε μα κάνετε

αξιοσημείωτες αλλαγές μέσα στον οργανισμό.

ΥΠΗΡΕΣΙΕΣ ΕΠΙΚΕΝΤΡΩΜΕΝΕΣ ΣΤΗΝ ΕΡΕΥΝΑ ΣΧΕΤΙΚΑ ΜΕ ΤΟ ΨΥΧΙΚΟ ΤΡΑΥΜΑ



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QUIZ 2

3 points possible (graded)

1. Μια μελέτη των Ruzek and Rosen (2009) έδειξε ότι στο διεθνές πλαίσιο των παρεμβάσεων που σχετίζονται με την φροντίδα τραύματος:

- ○ Οι ανάγκες συγκεκριμένων υπο-ομάδων αντιμετωπίστηκαν επαρκώς.
- ○ Τα εκπαιδευτικά προγράμματα εφαρμόστηκαν με διαφορετικούς τρόπους, υπογραμμίζοντας την ανάγκη καθορισμού βασικών στοιχείων και εννοιών
- ○ Οι ίδιες θεραπευτικές παρεμβάσεις ήταν εξίσου αποτελεσματικές σε ενήλικες και παιδιά
- ○ Οι θεραπείες εφαρμόστηκαν ομοιόμορφα σε διάφορες χώρες, υπογραμμίζοντας την αποτελεσματικότητα των προσεγγίσεων που εφαρμόστηκαν

2. Η Ενημερωμένη Φροντίδα Τραύματος (TIC)

- ○ Στοχεύει μόνο στην μείωση των συμπτωμάτων που σχετίζονται με το τραύμα, εστιάζοντας σε τεχνικές παρέμβασης
- ○ Έχει ως στόχο να μετατρέψει το σύστημα φροντίδας, εστιάζοντας στην ικανότητα του προσωπικού να υιοθετεί ένα όραμα φροντίδας του τραυματισμένου ασθενούς
- ○ Χρησιμοποιείται αποκλειστικά σε ανηλίκους
- ○ Εφαρμόζει τεχνικές παρέμβασης όπως η συγκράτηση και η απομόνωση

3. Ένα από τα πλεονεκτήματα της επιστημονικής διάδοσης σε οργανισμούς που σχετίζονται με το τραύμα είναι:

- ○ Η δυνατότητα έκφρασης αποκλειστικού ενδιαφέροντος σε θέματα που σχετίζονται με ομάδες εργασίας
- ○ Η μετάβαση σε γενικευμένες θεραπευτικές παρεμβάσεις που θα είναι αποτελεσματικές για όλους τους ασθενείς
- ○ Η εφαρμογή των αποδεικτικών στοιχείων ως μια κάθετη απόφαση από πάνω προς τα κάτω από την ηγεσία των οργανισμών
- ○ Η δυνατότητα της έναρξης μιας διεργασίας εφαρμογής των πιο σύγχρονων και ενημερωμένων και τεκμηριωμένων πρακτικών , με στόχο τη βελτίωση της ευημερίας του προσωπικού και των ασθενών

Invia | You have used 0 of 2 attempts | Salva | Show Answer

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ΟΡΙΣΜΟΙ ΚΑΙ ΧΩΡΟΙ

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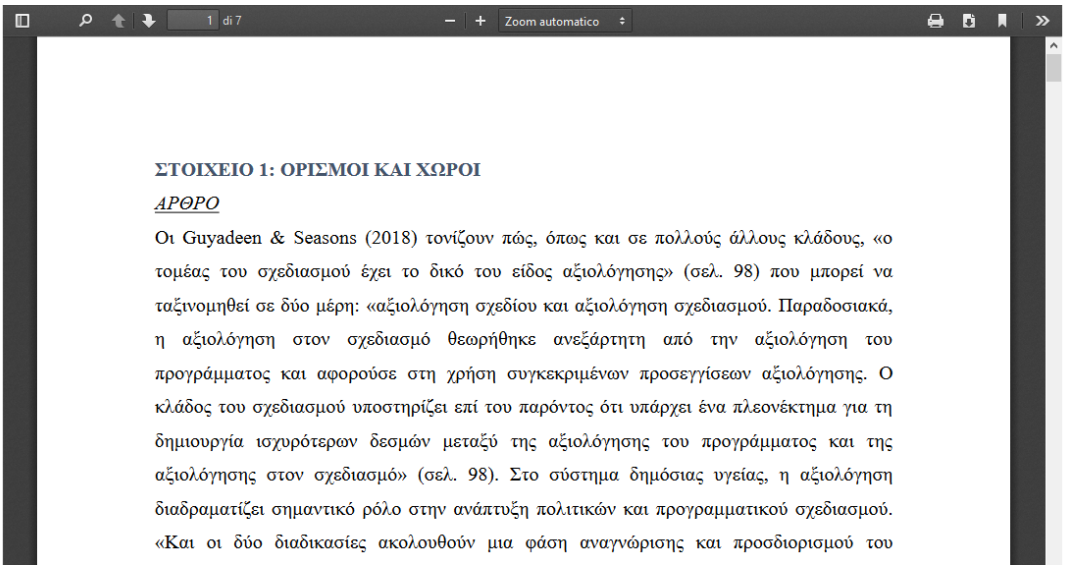

ΣΤΟΙΧΕΙΟ 1: ΟΡΙΣΜΟΙ ΚΑΙ ΧΩΡΟΙ

ΑΡΘΡΟ

Οι Guyadeen & Seasons (2018) τονίζουν πώς, όπως και σε πολλούς άλλους κλάδους, «ο τομέας του σχεδιασμού έχει το δικό του είδος αξιολόγησης» (σελ. 98) που μπορεί να ταξινομηθεί σε δύο μέρη: «αξιολόγηση σχεδίου και αξιολόγηση σχεδιασμού. Παραδοσιακά, η αξιολόγηση στον σχεδιασμό θεωρήθηκε ανεξάρτητη από την αξιολόγηση του προγράμματος και αφορούσε στη χρήση συγκεκριμένων προσεγγίσεων αξιολόγησης. Ο κλάδος του σχεδιασμού υποστηρίζει επί του παρόντος ότι υπάρχει ένα πλεονέκτημα για τη δημιουργία ισχυρότερων δεσμών μεταξύ της αξιολόγησης του προγράμματος και της αξιολόγησης στον σχεδιασμό» (σελ. 98). Στο σύστημα δημόσιας υγείας, η αξιολόγηση διαδραματίζει σημαντικό ρόλο στην ανάπτυξη πολιτικών και προγραμματικού σχεδιασμού. «Και οι δύο διαδικασίες ακολουθούν μια φάση αναγνώρισης και προσδιορισμού του

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Αξιολόγηση αποδοτικότητας και εμπειρίας (αποτελέσματα)

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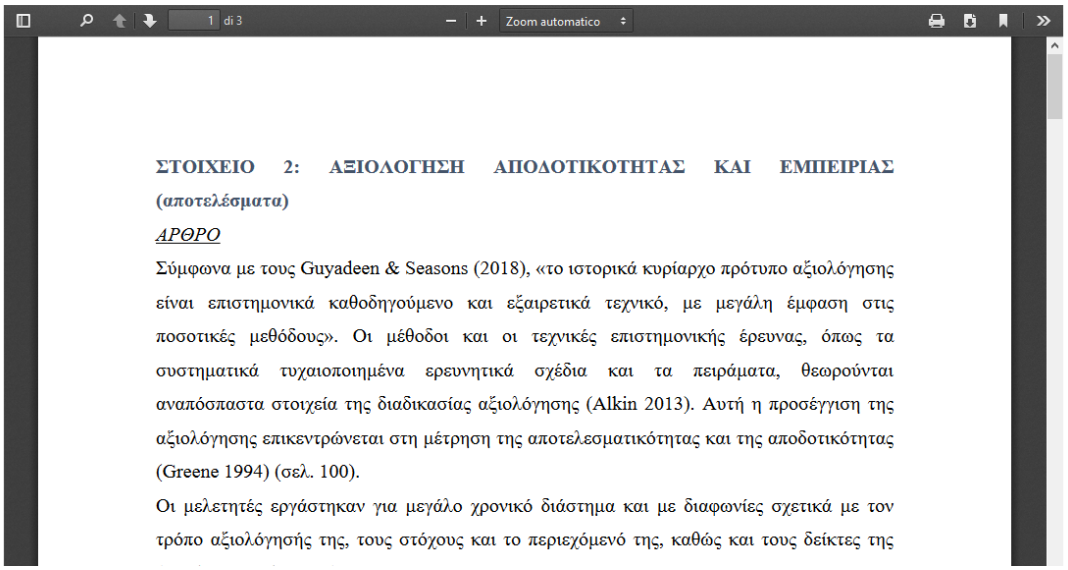
ΑΞΙΟΛΟΓΗΣΗ ΑΠΟΔΟΤΙΚΟΤΗΤΑΣ ΚΑΙ ΕΜΠΕΙΡΙΑΣ (αποτελέσματα)



ΣΤΟΙΧΕΙΟ 2: ΑΞΙΟΛΟΓΗΣΗ ΑΠΟΔΟΤΙΚΟΤΗΤΑΣ ΚΑΙ ΕΜΠΕΙΡΙΑΣ (αποτελέσματα)

ΑΡΘΡΟ

Σύμφωνα με τους Guyadeen & Seasons (2018), «το ιστορικά κυρίαρχο πρότυπο αξιολόγησης είναι επιστημονικά καθοδηγούμενο και εξαιρετικά τεχνικό, με μεγάλη έμφαση στις ποσοτικές μεθόδους». Οι μέθοδοι και οι τεχνικές επιστημονικής έρευνας, όπως τα συστηματικά τυχαιοποιημένα ερευνητικά σχέδια και τα πειράματα, θεωρούνται αναπόσπαστα στοιχεία της διαδικασίας αξιολόγησης (Alkin 2013). Αυτή η προσέγγιση της αξιολόγησης επικεντρώνεται στη μέτρηση της αποτελεσματικότητας και της αποδοτικότητας (Greene 1994) (σελ.. 100).

Οι μελετητές εργάστηκαν για μεγάλο χρονικό διάστημα και με διαφωνίες σχετικά με τον τρόπο αξιολόγησής της, τους στόχους και το περιεχόμενό της, καθώς και τους δείκτες της

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ΑΞΙΟΛΟΓΗΣΗ ΤΗΣ ΑΠΟΤΕΛΕΣΜΑΤΙΚΟΤΗΤΑΣ ΤΩΝ ΠΑΡΕΜΒΑΣΕΩΝ

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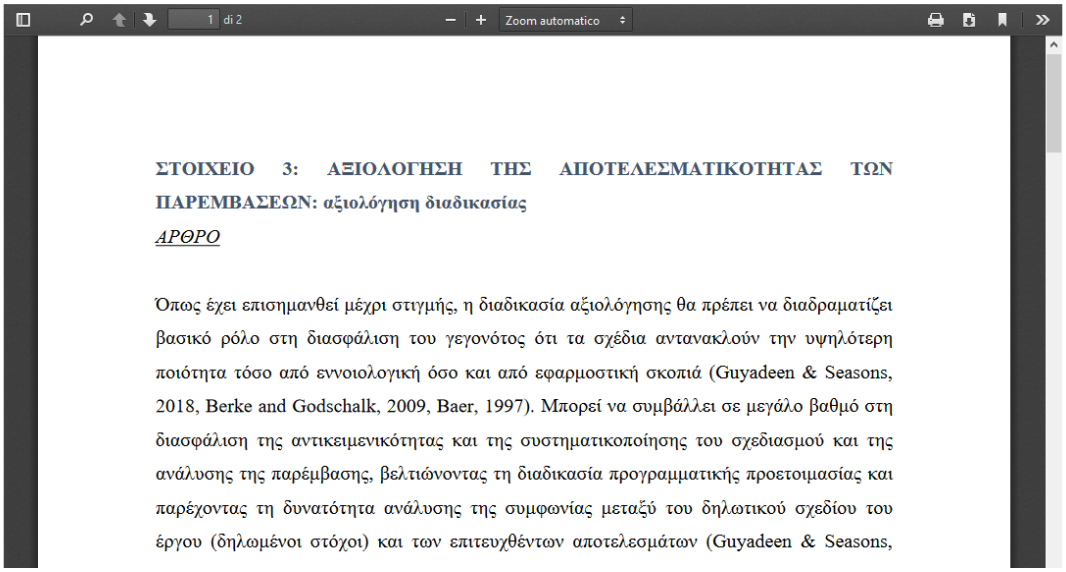
ΑΞΙΟΛΟΓΗΣΗ ΤΗΣ ΑΠΟΤΕΛΕΣΜΑΤΙΚΟΤΗΤΑΣ ΤΩΝ ΠΑΡΕΜΒΑΣΕΩΝ: αξιολόγηση διαδικασίας



ΣΤΟΙΧΕΙΟ 3: ΑΞΙΟΛΟΓΗΣΗ ΤΗΣ ΑΠΟΤΕΛΕΣΜΑΤΙΚΟΤΗΤΑΣ ΤΩΝ ΠΑΡΕΜΒΑΣΕΩΝ: αξιολόγηση διαδικασίας

ΑΡΘΡΟ

Όπως έχει επισημανθεί μέχρι στιγμής, η διαδικασία αξιολόγησης θα πρέπει να διαδραματίζει βασικό ρόλο στη διασφάλιση του γεγονότος ότι τα σχέδια αντανακλούν την υψηλότερη ποιότητα τόσο από εννοιολογική όσο και από εφαρμοστική σκοπιά (Guyadeen & Seasons, 2018, Berke and Godschalk, 2009, Baer, 1997). Μπορεί να συμβάλλει σε μεγάλο βαθμό στη διασφάλιση της αντικειμενικότητας και της συστηματικοποίησης του σχεδιασμού και της ανάλυσης της παρέμβασης, βελτιώνοντας τη διαδικασία προγραμματικής προετοιμασίας και παρέχοντας τη δυνατότητα ανάλυσης της συμφωνίας μεταξύ του δηλωτικού σχεδίου του έργου (δηλωμένοι στόχοι) και των επιτευχθέντων αποτελεσμάτων (Guyadeen & Seasons,

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Βιβλιογραφία

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QUIZ 3

3 points possible (graded)

1. Σύμφωνα με τους Rychetnik, Frommer, Hawe and Shiell (2002), η αξιολόγηση ορίζεται ως:

- ○ Η διαδικασία προσδιορισμού της αξίας μιας παρέμβασης μέσα από την σύγκριση με προκαθορισμένα και ρητά πρότυπα
- ○ Ερευνητική ανάγνωση των δεδομένων που συλλέγονται μέσω μιας επίσημης έρευνας ή μέσω συγκεκριμένων ερευνητικών μοντέλων
- ○ Το κοινωνικό, πολιτικό και/η οργανωτικό πλαίσιο εντός του οποίου προγραμματίζεται η παρέμβαση
- ○ Μια σειρά από αλλαγές και αποτελέσματα τα οποία μπορούν να καθοριστούν εκ των προτέρων

2. Κατά την αξιολόγηση της αποτελεσματικότητας μιας παρέμβασης, ποιο από αυτά ΔΕΝ μοιάζει να αποτελεί σημαντικό παράγοντα? (Rychetnik et al., 2002)

- ○ Η συνάφεια των μετρούμενων επιπτώσεων στο πλαίσιο εφαρμογής
- ○ Το μέγεθος των μετρούμενων αποτελεσμάτων
- ○ Ο αριθμός των παρεμβάσεων που πραγματοποιούνται από τον οργανισμό
- ○ Η ισχύς των αποδεικτικών στοιχείων, που καθορίζεται από ένα συνδυασμό σχεδιασμού μελέτης, μεθοδολογικής ποιότητας και στατιστικής ακρίβειας

3. Η Αξιολόγηση...

- ○ Θα πρέπει να αποφεύγεται η συνεκτίμηση του ενδιαφέροντος των ανθρώπων που συμμετέχουν, στις αποφάσεις που αφορούν τις παρεμβάσεις
- ○ Δεν απαιτεί την συσχετισμό ανάμεσα στις μεθόδους αξιολόγησης και στο σχέδιο που τελεί υπό αξιολόγηση
- ○ Θα πρέπει να γίνεται μόνο στα αποτελέσματα
- ○ Επιτρέπει την εμπειρική τεκμηρίωση των αδύναμων αλλά και των δυνατών σημείων των σχεδίων παρέμβασης

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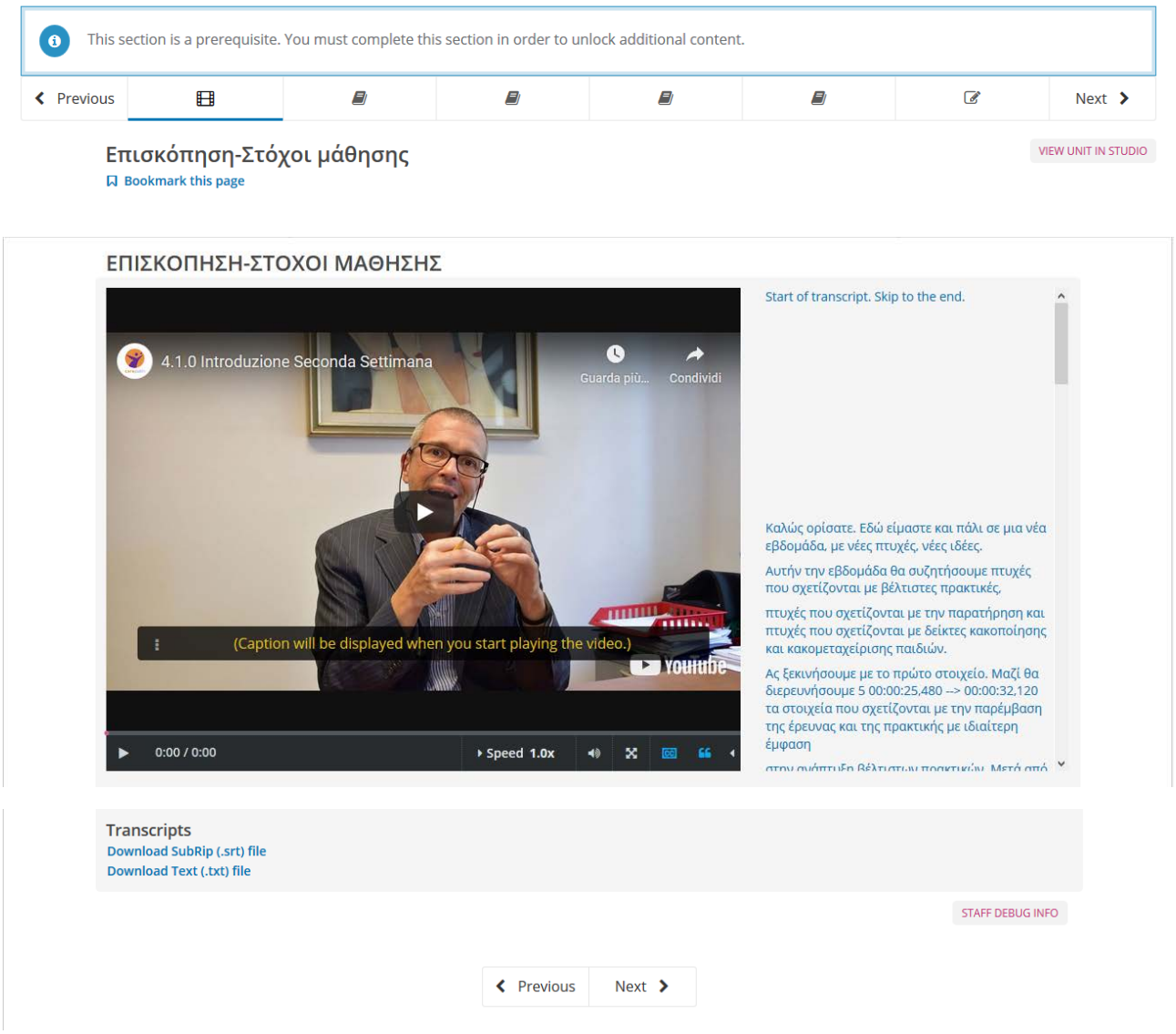

Transcript

Καλώς ορίσατε. Εδώ είμαστε και πάλι σε μια νέα εβδομάδα, με νέες πτυχές, νέες ιδέες.

Αυτήν την εβδομάδα θα συζητήσουμε πτυχές που σχετίζονται με βέλτιστες πρακτικές,

πτυχές που σχετίζονται με την παρατήρηση και πτυχές που σχετίζονται με δείκτες κακοποίησης και κακομεταχείρισης παιδιών.

Ας ξεκινήσουμε με το πρώτο στοιχείο. Μαζί θα διερευνήσουμε 5 00:00:25,480 --> 00:00:32,120 τα στοιχεία που σχετίζονται με την παρέμβαση της έρευνας και της πρακτικής με ιδιαίτερη έμφαση

στην ανάπτυξη βέλτιστων πρακτικών. Μετά από αυτό θα εξετάσουμε τις μεθοδολογικές πτυχές

της έρευνας στη Φροντίδα με ενημέρωση για το ψυχικό τραύμα, την οποία πλέον μάθαμε

να κατανοούμε και να διαβάζουμε, ενώ θα έχουμε την ευκαιρία να κατανοήσουμε περαιτέρω τον τρόπο με τον οποίο αυτές εφαρμόζονται

στον ερευνητικό σχεδιασμό, τον τρόπο χρήσης της Φροντίδας αυτής

στην έρευνα και, στη συνέχεια, να κατανοήσουμε τη σύνδεση από τη θεωρία στην πράξη.

Έπειτα, θα προσπαθήσουμε να προσδιορίσουμε τα στοιχεία που αποτελούν

μια καλή ερευνητική πρόταση εξετάζοντας πτυχές που σχετίζονται με μια ορθή τεχνική, όπως η παρατήρηση.

Η παρατήρηση ως κλινικό εργαλείο, η παρατήρηση ως εργαλείο που μπορεί να επιτρέψει σε έναν φορέα

που συνεργάζεται ή προτίθεται να εργαστεί ή (για χιλιάδες άλλους λόγους)

είναι πρόθυμος να γνωρίσει και να εξετάσει εις βάθος το θέμα της Φροντίδας με ενημέρωση για το ψυχικό τραύμα να χρησιμοποιήσει την παρατήρηση ως μέθοδο,

και για την κατανόηση του ατόμου που εισήλθε σε αυτό το πλαίσιο

(να έχετε κατά νου την έννοια της Φροντίδας με ενημέρωση για το ψυχικό τραύμα).

Και εδώ θα διερευνήσουμε τις απαιτήσεις και τις πιθανές εφαρμογές της κλινικής παρατήρησης και άλλα.

Στη συνέχεια, θα συνεχίσουμε με παραδείγματα

και έννοιες που συζητήθηκαν προηγουμένως, όπως ορθές πρακτικές, παρατήρηση και πώς

μπορούν να εφαρμοστούν στην κακοποίηση και κακομεταχείριση παιδιών, προσπαθώντας ταυτόχρονα να προσδιορίσουμε τους δείκτες,

λαμβάνοντας υπόψη ότι ένας δείκτης είναι μόνο ένας δείκτης, ενώ σίγουρα δεν αποτελεί

ένα θεμελιώδες και συγκεκριμένο στοιχείο κακοποίησης και κακομεταχείρισης, αλλά ένα σύνολο δεικτών

μπορεί να μας ενδιαφέρει ως στοιχείο που πρέπει να έχουμε κατά νου, καθώς μπορεί να υπάρχει κάτι που πρέπει να διερευνηθεί.

Από εδώ θα εξετάσουμε τις διαδικασίες εξέτασης

για την αξιολόγηση του ψυχικού τραύματος και θα προσπαθήσουμε να καταλάβουμε με τους συναδέλφους πόσο σημαντική μπορεί να είναι η εξέτασή

του με σκοπό τη γνώση.

Θα κλείσουμε στην πορεία με πτυχές που σχετίζονται με τη Φροντίδα με ενημέρωση για το ψυχικό τραύμα και τη σύνδεση με την έρευνα

και με το πώς μπορεί να υπάρχει ένα οργανωμένο σύστημα διαδικασιών που να πηγαίνει από τη θεωρία στην πράξη.

Εάν στο πρώτο μέρος, τις δύο πρώτες εβδομάδες, συζητήσαμε και εξετάσαμε με τους συναδέλφους

ίσως την πιο θεωρητική πλευρά του ψυχικού τραύματος, μαζί μας σήμερα,

σε αυτές τις δύο εβδομάδες, συζητήσαμε για την Έρευνα βάσει αποδείξεων ή για την Έρευνα δράσης στη Φροντίδα με ενημέρωση για το ψυχικό τραύμα.

Όμως, από εδώ και στο εξής θα προχωρήσετε σε μια νέα πορεία που θα έχει πάντοτε

ως κεντρικό θέμα το ψυχικό τραύμα και τη Φροντίδα με ενημέρωση για το ψυχικό τραύμα, αλλά από μια ελαφρώς διαφορετική οπτική,

ιδιαίτερα τη νομοθετική πλευρά, ώστε να αντιμετωπιστούν στη συνέχεια ζητήματα που σχετίζονται με τη νομοθεσία, την έρευνα και τις πολιτικές .

Εγώ και οι συνάδελφοί μου σας ευχόμαστε να έχετε,

μια σωστή εξέλιξη στην πορεία αυτή. Έχετε φτάσει πλέον στα μισά του δρόμου,

ίσως και περισσότερο, και σε αυτό το σημείο κατευθύνεστε προς το τέλος του MOOC σας.

Και πάλι σας ευχόμαστε καλή συνέχεια και θα τα ξαναπούμε στο τέλος του MOOC.

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Εισαγωγή στις βασικές μεθοδολογικές πτυχές της έρευνας σχετικά με την TIC (Trauma-Informed-Care)

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Εκπαιδευτικό υλικό

Όπως πρότειναν οι Newman & Ridenour (1998), ο τρόπος με τον οποίο οι ερευνητές πραγματοποιούν μια μελέτη και το ποια συμπεράσματα λαμβάνουν από αυτή είναι δύο πολύ διαφορετικά πράγματα και εξαρτώνται από την προσέγγισή τους ως προς την πραγματικότητα. Επιπλέον, η επιστημολογία αφορά στη μελέτη του πώς γνωρίζουμε τα πράγματα, ενώ η μέθοδος αφορά στην επιλογή της τεχνικής μέσω της οποίας είναι δυνατόν να προχωρήσουμε στη γνώση των φαινομένων (Bernard, 2006).

Όπως επισήμανε ο Lastrucci (1963), η επιστήμη συνιστά «μια αντικειμενική, λογική και συστηματική μέθοδο ανάλυσης φαινομένων που έχει σχεδιαστεί για να επιτρέπει τη συσσώρευση αξιόπιστων γνώσεων» (σελ. 6). Αυτό γίνεται μέσα από τρεις στόχους που καθοδηγούν τις επιλογές του ερευνητή (Bernard, 2006):

- Αντικειμενικότητα: αυτό συνεπάγεται ρητή υπαγωγή στις μετρήσεις, προσοχή στη μεθοδολογία και αναφορά στην αναθεώρηση από συναδέλφους εντός της επιστημονικής κοινότητας.
- Την επιστημονική μέθοδο
- Αξιοπιστία

Η ηθική διάσταση αποτελεί μέρος της επιστημονικής μεθόδου και, όταν μιλάμε για έρευνα στις ανθρωπιστικές επιστήμες, ένα κεντρικό ερώτημα είναι πώς να λειτουργήσουν φαινόμενα που είναι πολύπλοκα από τη φύση τους. Αυτό το είδος διαδικασίας βασίζεται στον ορισμό των μεταβλητών, στην αναζήτηση συσχετίσεων ή σχέσεων μεταξύ τους και στην προσπάθεια κατανόησης του εάν και πώς η παραλλαγή ενός πράγματος προκαλεί παραλλαγή ενός άλλου (Bernard, 2006). Σε σχέση με αυτές τις πτυχές, ένα θεμελιώδες στοιχείο είναι η μέτρηση και η αναγνώριση έγκυρων και αξιόπιστων δεικτών και συνδέεται στενά με τη διάρθρωση των λειτουργικών ορισμών που «αποτελούνται από ένα σύνολο οδηγιών για τον τρόπο μέτρησης μιας μεταβλητής, η οποία έχει καθοριστεί εννοιολογικά» (σελ. 38).

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Η έρευνα σχετικά με την TIC (Trauma-Informed-Care)

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Εκπαιδευτικό υλικό

Στην TIC, μία από τις βασικές έννοιες είναι η χρήση επιστημονικά επικυρωμένων διαδικασιών και εννοιών. Από αυτή την άποψη, είναι απαραίτητο να προωθηθεί μια συνεργατική αλληλεπίδραση μεταξύ κλινικού έργου και έρευνας προκειμένου να διερευνηθούν τα αποτελέσματα της θεραπείας και να αξιολογηθούν τα λειτουργικά μοντέλα των υπηρεσιών αναφορικά με την αποτελεσματικότητα και την αποδοτικότητα, επίσης με την επίσημη διατύπωση αυτών των πτυχών σε συγκεκριμένες κατευθυντήριες γραμμές ή/και την προσοχή στην τήρηση του συγκεκριμένου πρωτοκόλλου στα καθιερωμένα στοιχεία της διεθνούς έρευνας στον τομέα αυτό (Schäfer et al., 2018).

Από την άποψη αυτή, η συμβολή της επιστημονικής έρευνας στην ανάλυση των ορισμών της TIC και των υποκείμενων παραγόντων είναι σημαντική.

Σχετικά με αυτό, οι Becker-Blease (2017), Hanson & Lang (2016) και Johnson (2017) υπογραμμίζουν ορισμένες κρίσιμες πτυχές που σχετίζονται με την TIC και τα προβλήματα εφαρμογής, συμπεριλαμβανομένης, για παράδειγμα, της εστίασης στην επιστημονική βιβλιογραφία σχετικά με τις θεωρητικές πτυχές και τις θεμελιώδεις αρχές εις βάρος της προσοχής στα απτά στοιχεία και την εφαρμογή τους στην πράξη: «υπάρχει ένα κενό στο πώς οι επαγγελματίες μπορούν να μετατρέψουν τη θεωρία και τις αρχές σε καθημερινή πρακτική και επομένως να αξιολογήσουν την αποτελεσματικότητά τους» (Becker-Blease, 2017, σελ. 3). Επομένως, η εστίαση στην έρευνα είναι χρήσιμη για την αξιολόγηση των πρωτοβουλιών, προγραμμάτων και υπηρεσιών αναφορικά με την εφαρμογή με ενημέρωση για το ψυχικό τραύμα, καθώς και για το εάν αυτά σχετίζονται με σημαντικά θετικά αποτελέσματα.

Στην προσπάθεια να πραγματοποιηθεί μια εποικοδομητική και λειτουργική ανταλλαγή μεταξύ εννοιολογικών και θεωρητικών πτυχών και εκείνων που σχετίζονται με την εφαρμογή, θα πρέπει να δοθεί ιδιαίτερη έμφαση στην ανάλυση της δυνατότητας εφαρμογής των τυποποιημένων διαδικασιών και δεικτών, τόσο ως προς τα στοιχεία της διαδικασίας όσο και ως προς τα αποτελέσματα που προέκυψαν. Η επιστημονική βιβλιογραφία για το θέμα αυτό καλεί τους οργανισμούς και τα ιδρύματα να θεωρήσουν ιδιαίτερα σχετική τη διάρθρωση των ερευνητικών έργων, τόσο βασικών όσο και εφαρμοστικών, με στόχο τη διαχείριση των διαδικασιών ελέγχου (έλεγχος βάσει αποδείξεων), την ανάλυση διαδικασιών αξιολόγησης που στοχεύουν στην αναγνώριση τραυματικών γεγονότων και των ιδιαιτεροτήτων τους. Επιπλέον, για τον σκοπό αυτό, είναι σημαντικό οι τυχαιοποιημένες, ελεγχόμενες μελέτες να διεξάγονται σε πειραματική βάση ώστε να ελέγχεται η αποτελεσματικότητα των παρεμβάσεων που προσανατολίζονται στο ψυχικό τραύμα.

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Βασικά στοιχεία παρουσίασης μιας καλής ερευνητικής πρότασης

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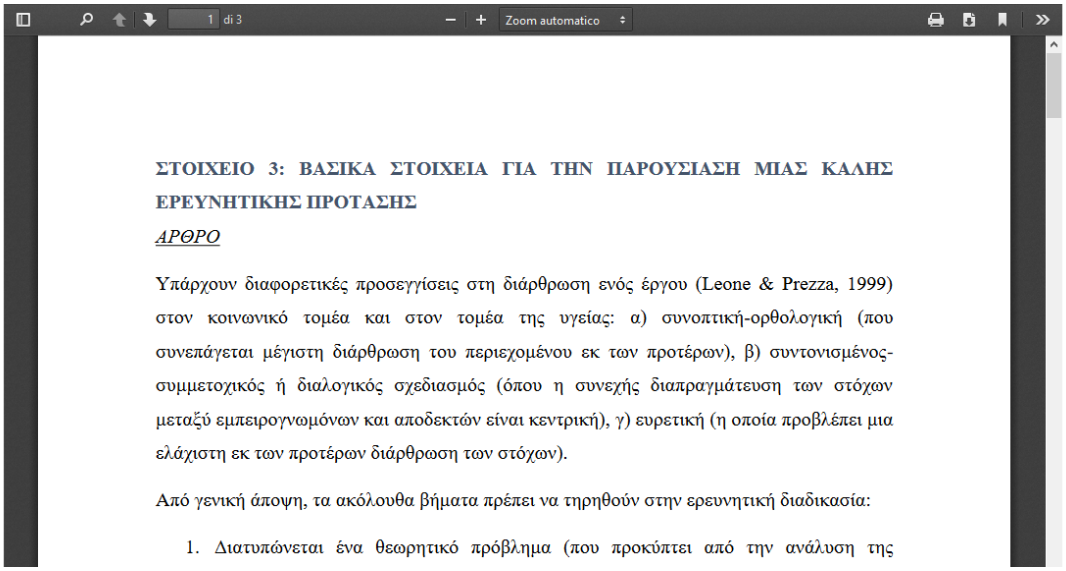
ΒΑΣΙΚΑ ΣΤΟΙΧΕΙΑ ΓΙΑ ΤΗΝ ΠΑΡΟΥΣΙΑΣΗ ΜΙΑΣ ΚΑΛΗΣ ΕΡΕΥΝΗΤΙΚΗΣ ΠΡΟΤΑΣΗΣ



1 di 3 Zoom automatico

ΣΤΟΙΧΕΙΟ 3: ΒΑΣΙΚΑ ΣΤΟΙΧΕΙΑ ΓΙΑ ΤΗΝ ΠΑΡΟΥΣΙΑΣΗ ΜΙΑΣ ΚΑΛΗΣ ΕΡΕΥΝΗΤΙΚΗΣ ΠΡΟΤΑΣΗΣ

ΑΡΘΡΟ

Υπάρχουν διαφορετικές προσεγγίσεις στη διάρθρωση ενός έργου (Leone & Prezza, 1999) στον κοινωνικό τομέα και στον τομέα της υγείας: α) συνοπτική-ορθολογική (που συνεπάγεται μέγιστη διάρθρωση του περιεχομένου εκ των προτέρων), β) συντονισμένος-συμμετοχικός ή διαλογικός σχεδιασμός (όπου η συνεχής διαπραγμάτευση των στόχων μεταξύ εμπειρογνωμόνων και αποδεκτών είναι κεντρική), γ) ευρετική (η οποία προβλέπει μια ελάχιστη εκ των προτέρων διάρθρωση των στόχων).

Από γενική άποψη, τα ακόλουθα βήματα πρέπει να τηρηθούν στην ερευνητική διαδικασία:

1. Διατυπώνεται ένα θεωρητικό πρόβλημα (που προκύπτει από την ανάλυση της

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Βιβλιογραφία

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ΑΞΙΟΛΟΓΗΣΗ ΓΝΩΣΕΩΝ

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Quiz 4

3 points possible (graded)

1. Ο λειτουργικός ορισμός:

- ○ Δεν είναι χρήσιμος για την μέτρηση μιας μεταβλητής
- ○ Είναι υπό επεξεργασία κατά την μέτρηση μιας μεταβλητής
- ○ Ακολουθεί τον εννοιολογικό ορισμό μιας μεταβλητής
- ○ Εκτελείται πριν από τον εννοιολογικό ορισμό μιας μεταβλητής

2. Στο πεδίο της Ενημερωμένης Φροντίδας Τραύματος είναι κρίσιμο να:

- ○ Προωθείται η συνεργατική αλληλεπίδραση μεταξύ της κλινικής εργασίας και της έρευνας
- ○ Αποφευχθεί η συνεκτίμηση της συμβολής της επιστημονικής έρευνας
- ○ Αποφευχθεί η συνεκτίμηση κρίσιμων οπτικών και δυσκολιών κατά την εφαρμογή
- ○ Επιβληθεί μια μεθοδολογία παρέμβασης στους φορείς διαχείρισης

3. Σε κάθε στάδιο της διαδικασίας σχεδιασμού:

- ○ Τα δεδομένα θα πρέπει πάντα α αναλύονται
- ○ Δεν υπάρχει ανάγκη χρονικού προγραμματισμού
- ○ Ο ερευνητής δεν θα πρέπει να θέτει στα ερωτήματα που λαμβάνουν υπόψη τα κρίσιμα στοιχεία από εννοιολογική και πρακτική σκοπιά
- ○ Ο ερευνητής θα πρέπει να θέτει στον εαυτό του αναρωτιέται πάνω σε σημαντικά ερωτήματα που λαμβάνουν υπόψη τα κρίσιμα στοιχεία από εννοιολογική και πρακτική σκοπιά

Invia You have used 0 of 2 attempts

Salva Show Answer

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Ορθή πρακτική αναφορικά με την TIC (Trauma-Informed-Care)

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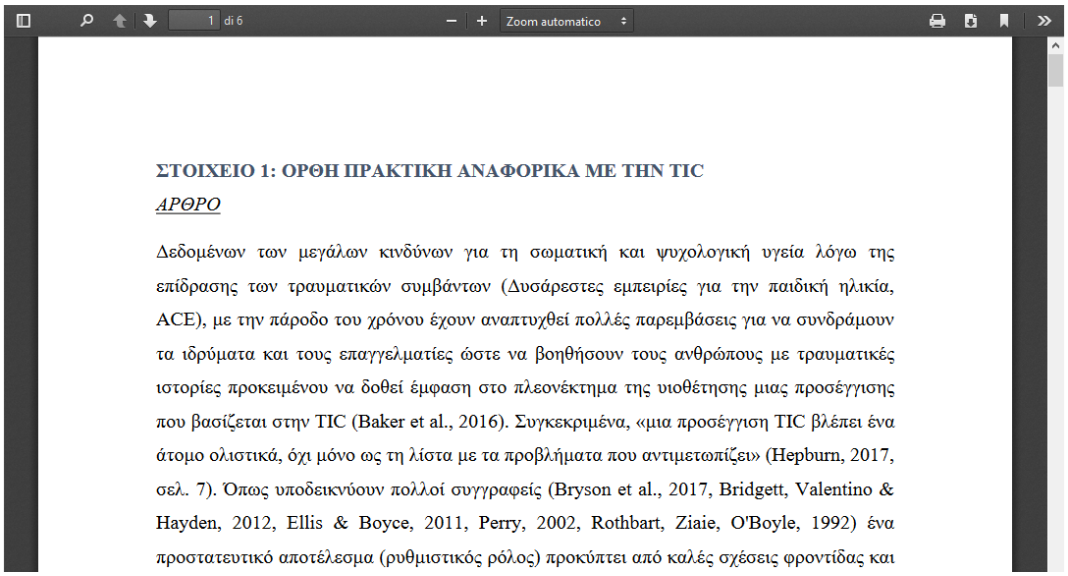
ΟΡΘΗ ΠΡΑΚΤΙΚΗ ΑΝΑΦΟΡΙΚΑ ΜΕ ΤΗΝ TIC



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Θεμελιώδη στοιχεία ορθών πρακτικών

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ΘΕΜΕΛΙΩΔΗ ΣΤΟΙΧΕΙΑ ΟΡΘΩΝ ΠΡΑΚΤΙΚΩΝ

Με την ανάλυση της βιβλιογραφίας και των πρωτοκόλλων για την αξιολόγηση των πρακτικών της TIC, είναι δυνατόν να συμπεράνουμε ότι οι ορθές πρακτικές (που μπορούν να μεταφερθούν σε διαφορετικά πλαίσια) θα πρέπει να περιλαμβάνουν:

1) μόνιμη κατάρτιση όλων των μελών του προσωπικού πάνω στο ψυχικό τραύμα και τους συσχετισμούς του. Αυτή η κατάρτιση δεν θα πρέπει να παρέχεται μόνο σε επαγγελματίες που εργάζονται απευθείας σε κλινικό επίπεδο με τους χρήστες, αλλά σε όλους όσοι εμπλέκονται σε διάφορες θέσεις και με διαφορετικές λειτουργίες στον οργανισμό,

2) συνεχή ενημέρωση του εσωτερικού προσωπικού σχετικά με πρακτικές βάσει αποδείξεων (EBP) για τη θεραπεία του ψυχικού τραύματος και εστίαση στη στάση των επαγγελματιών απέναντι σε αυτές,

3) συνεργασία με εμπειρογνώμονες στον τομέα, προκειμένου να αυξηθεί η διαθεσιμότητα των καταρτισμένων κλινικών παρόχων,

4) συμπερίληψη τυποποιημένων και τεκμηριωμένων διαδικασιών ελέγχου στην κλινική πρακτική και χρήση ειδικών και επικυρωμένων μέτρων/εργαλείων αξιολόγησης για την αναγνώριση τραυματικών συμβάντων (ACE),

5) προσοχή από κοινού στο ιστορικό των χρηστών και τη σύνδεσή του με τα συμπτώματα ή τις δυσκολίες που σχετίζονται με το ψυχικό τραύμα,

6) σύμφωνα με το προηγούμενο σημείο, αναγνώριση της ιδιαιτερότητας του κύκλου ζωής κάθε χρήστη που διασφαλίζεται μέσω ενεργητικής και συμπονετικής ακρόασης εξ ονόματος του συνόλου του προσωπικού,

7) συμπερίληψη και προσεκτική κοινή χρήση του ιστορικού ψυχικού τραύματος στα παιδιά κατά τον σχεδιασμό της παρέμβασης ή κατά τη διατύπωση των περιπτώσεων,

8) εις βάθος αξιολόγηση και συνεχή παρακολούθηση των δεξιοτήτων του προσωπικού (χρήση ειδικά σχεδιασμένων διαδικασιών),

9) εμπεριστατωμένη παρακολούθηση προκειμένου να διατηρηθούν τα πρότυπα που έχουν καθοριστεί για την καλή λειτουργία της TIC και ενδεχομένως να βελτιωθούν τα στοιχεία του ελλείμματος,

10) εφαρμογή διαδικασιών για τη μείωση του άγχους δευτερογενούς ψυχικού τραύματος και αύξηση της ευημερίας του προσωπικού,

11) δημιουργία και διατήρηση ενός καλού δικτύου συνεργασίας όχι μόνο εντός των υπηρεσιών αλλά και με άλλους οργανισμούς στον τομέα αυτό,

12) προσοχή στο επίκεντρο της επικοινωνιακής διάστασης: ο στόχος του υψηλότερου επιπέδου θα πρέπει να είναι να υπάρχουν προσεκτικοί και συνεργατικοί επαγγελματίες για την επιδίωξη στόχων και την εφαρμογή κοινών και συνεργαζόμενων διαδικασιών,

13) προσοχή στις διαδικασίες για μείωση του κινδύνου επανεμφανίσεως του ψυχικού τραύματος στους χρήστες,

14) ενθάρρυνση της συμμετοχής των ασθενών στη σχεδίαση του θεραπευτικού σχεδίου,

15) συμμετοχή των χρηστών στον σχεδιασμό της υπηρεσίας: προσοχή στα σχόλια και τις προτάσεις τους για βελτίωση του οργανισμού και των προσφερόμενων υπηρεσιών,

16) ιδιαίτερη έμφαση στην παροχή υπηρεσιών βασισμένων σε πλεονεκτήματα, με στόχο την προώθηση παραγόντων θετικής εξέλιξης (π.χ. ανθεκτικότητα, ενδυνάμωση),

17) κατάρτιση σε στρατηγικές που αποσκοπούν στην οργάνωση ενός θετικού περιβάλλοντος για τους χρήστες και το προσωπικό,

18) ιδιαίτερη προσοχή στις φυσικές και διαρθρωτικές διαστάσεις της υπηρεσίας,

19) τήρηση και προώθηση των αρχών TIC με συγκεκριμένες και σαφείς πολιτικές,

20) έναν κεντρικό ρόλο που αποδίδεται στη διάσταση της ηγεσίας και στις λειτουργίες της κατά την οργάνωση της υπηρεσίας.

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Καίρια στοιχεία και προκλήσεις

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ΚΑΙΡΙΑ ΣΤΟΙΧΕΙΑ ΚΑΙ ΠΡΟΚΛΗΣΕΙΣ

Παρά το γεγονός ότι το θέμα των συστάσεων για την εφαρμογή των βέλτιστων πρακτικών έχει επισημανθεί ιδιαίτερα, η χρήση πρακτικών βάσει αποδείξεων αποτελεί σήμερα ένα στοιχείο αντίδρασης εκ μέρους ορισμένων επαγγελματιών, οργανισμών και ερευνητών (Gray, Elhai, Schmidt, 2007). Αυτό θα πρέπει να αποτελέσει αντικείμενο ανάλυσης, συζήτησης και προσοχής εκ μέρους οργανισμών που ασχολούνται με την κλινική παρέμβαση στο ψυχικό τραύμα, προκειμένου να δημιουργηθεί και ένας συνεργατικός ορισμός των προτύπων.

Στην πραγματικότητα, παρόλο που η προσέγγιση TIC αναλαμβάνει σημαντικό ρόλο στην οργάνωση των υπηρεσιών και την παροχή φροντίδας για ανθρώπους που υποφέρουν από ψυχικό τραύμα αυτήν τη στιγμή, υπάρχουν ακόμα κάποια εμπόδια στην εφαρμογή της και ακόμη και πριν από αυτό στη διατύπωσή της (Baker, 2016). Συγκεκριμένα, υπάρχουν ελλείψεις ως προς αυτό:

➢ ένας σαφής λειτουργικός ορισμός

➢ η παρουσία ψυχομετρικά έγκυρων εργαλείων για την αξιολόγηση των διαστάσεων της TIC.

Για να καλυφθεί αυτό το κενό, για παράδειγμα, οι Baker και συνεργάτες (2016) δημιούργησαν και επικύρωσαν ένα εργαλείο, την Κλίμακα σχετικά με τις συμπεριφορές που σχετίζονται με τη φροντίδα με ενημέρωση για το ψυχικό τραύμα (ARTIC), για να αξιολογήσουν τις σχετικές με την TIC συμπεριφορές του προσωπικού που εργάζεται σε διαφορετικούς τομείς παρέμβασης ή σε περιβάλλοντα με άτομα με τραυματικές ιστορίες. Προηγουμένως στη δημοσίευσή τους «Καλλιέργεια παιδείας για τη φροντίδα με ενημέρωση για το ψυχικό τραύμα (CCTIC)»: ένα πρωτόκολλο αυτοαξιολόγησης και σχεδιασμού, οι Fallot και Harris (2009) δομήσαν ένα Πρωτόκολλο Αυτοαξιολόγησης και Σχεδιασμού που περιλαμβάνει έξι τομείς, οι οποίοι συνεπάγονται αλλαγές σε επίπεδο υπηρεσίας, διοίκησης ή συστήματος. Η προσοχή στην πολυπλοκότητα της κατάστασης εφαρμογής της TIC καθίσταται όλο και περισσότερο ένας προκλητικός στόχος από την άποψη της προώθησης τόσο για τους μεμονωμένους φορείς όσο και για τις κοινωνικές και υγειονομικές υπηρεσίες στην καθημερινή τους αλληλεπίδραση και τη σχέση τους με την επιστημονική κοινότητα αναφοράς.

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Έρευνα σχετικά με την TIC και σύνδεσή της με πολιτικές

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ΕΡΕΥΝΑ ΣΧΕΤΙΚΑ ΜΕ ΤΗΝ TIC ΚΑΙ ΣΥΝΔΕΣΗ ΤΗΣ ΜΕ ΤΙΣ ΠΟΛΙΤΙΚΕΣ

Ως μοντέλο που στοχεύει στη διάρθρωση της παροχής υπηρεσιών, η TIC υλοποιείται σε ένα μεγάλο και ποικίλο εύρος πλαισίων. Οι Bowen and Murshid (2016) υπογραμμίζουν τον τρόπο με τον οποίο το παράδειγμα αυτό μπορεί να εφαρμοστεί εξίσου, στις θεμελιώδεις αρχές του (ασφάλεια, αξιοπιστία και διαφάνεια, συνεργασία, ενδυνάμωση, επιλογή και διασταύρωση), στις κοινωνικές πολιτικές. Και αυτό, σύμφωνα με την πρόταση των συγγραφέων, δεδομένου ότι η TIC προσφέρει στους επαγγελματίες ψυχικής υγείας (ειδικά στον δημόσιο τομέα) μια πορεία που στοχεύει στην εξάλειψη των ανισοτήτων μέσω της κλινικοοργανωτικής δράσης που, λόγω της ηθικής και δεοντολογικής της διάστασης, μπορεί επίσης να αναχθεί σε μια ευρύτερη πολιτική διάσταση. Ο Reeves (2015) είχε ήδη τονίσει πώς η ευρεία εφαρμογή των μοντέλων φροντίδας με γνώμονα την TIC μπορεί να θέσει στο επίκεντρο της παρέμβασης την ανταπόκριση στις μοναδικές και ιδιόρρυθμες ανάγκες των ατόμων που είναι επιφορτισμένα με τις υπηρεσίες αποκατάστασης, μειώνοντας έτσι τις ανισότητες ευημερίας που βιώνει αυτός ο ευάλωτος πληθυσμός.

Πρόσφατα, οι Levy-Carrick και συνεργάτες (2019) υπογράμμισαν την άνιση μεταχείριση στο πλαίσιο του τραύματος ως κρίσιμο ζήτημα στον εθνικό οργανισμό υπηρεσιών υγείας, την οποία η υιοθέτηση της TIC μπορεί να διορθώσει, αν όχι εντελώς, τουλάχιστον ευρέως. Στην πραγματικότητα, ένα κεντρικό σημείο που υπογραμμίστηκε από τους συγγραφείς είναι ότι η αποτελεσματική εφαρμογή αυτού του παραδείγματος θα εξασφαλίζεται με την πλήρη συμμετοχή των παρόχων φροντίδας στον σχεδιασμό και την υλοποίηση των δραστηριοτήτων σε κάθε βήμα. Στο βιβλίο τους «Caring for the vulnerable: Perspectives in nursing theory, practice, and research», οι De Chesnay and Anderson (2019) έχουν επίσης τονίσει ότι η ψυχική υγεία έχει πολιτικό και συμμετοχικό χαρακτήρα (ιδίως από πλευράς χρηστών). Σύμφωνα με αυτό, ο Παγκόσμιος Οργανισμός Υγείας έχει συχνά προτρέψει πολιτικές για τη δημιουργία ενός χώρου συνεργασίας στον οποίο οι επαγγελματίες και οι ομάδες που υπερασπίζονται τα δικαιώματα των χρηστών των υπηρεσιών ψυχικής υγείας (ομάδες υπεράσπισης) καθώς και ένα ευρύ φάσμα ενδιαφερομένων μπορούν να συμμετάσχουν προς την κατεύθυνση μιας συνέργειας, προσεκτικής για τις αμοιβαίες ανάγκες.

Επιπλέον, όπως συμβαίνει σε ορισμένες περιπτώσεις, είναι σημαντικό να συμβάλλουμε πολιτικά στην απόφαση χρηματοδότησης μελετών για την ανάλυση και την προώθηση πρακτικών βάσει αποδείξεων, τη δημιουργία και τη διάδοση κοινών προτύπων και τον καθορισμό του οργανωτικού δείκτη και των κοινοτικών στόχων των οργανισμών και ιδρυμάτων που εμπλέκονται στην παροχή μοντέλων φροντίδας (Ko et al., 2008, Bateman & Anderson, 2013, Levy-Carrick et al., 2019).

Αυτά που έχουν ειπωθεί μέχρι στιγμής αφορούν στη γενική διάσταση της πολιτικής για την υγεία, αλλά αφορούν επίσης στην τοπική διάσταση ως απάντηση σε συγκεκριμένες ανάγκες της εκάστοτε περιοχής και, ειδικότερα, στις πολιτικές μεμονωμένων οργανισμών ή υπηρεσιών. Η βιβλιογραφία που ασχολείται με την TIC υποδηλώνει ότι «για να εφαρμοστεί ενημερωμένη βοήθεια για το ψυχικό τραύμα, υπάρχει ανάγκη προετοιμασίας, αξιολόγησης και οργανωτικής αλλαγής (Harris & Fallot, 2001, Rivard, Bloom, McCorkle, & Abramovitz, 2005) [...] Η εφαρμογή ενημερωμένων πρακτικών σχετικά με το τραύμα βασίζεται έτσι στη χρήση εξατομικευμένων οργανωτικών δεδομένων για την ενημέρωση του σχεδιασμού και της εφαρμογής» (Hummer et al., 2010, σελ. 82). Η ικανότητα υποστήριξης πολιτικών με δεδομένα από αποτελεσματικές ερευνητικές εγκαταστάσεις αποτελεί αναμφισβήτητα προτεραιότητα και επιθυμητό στρατηγικό στοιχείο (Levy-Carrick et al., 2019). Για παράδειγμα, στο επίπεδο των εργαλείων που είναι χρήσιμα για την ανάλυση του πόσο προσανατολισμένες προς τις αρχές της TIC είναι οι οργανωτικές πολιτικές, το πρωτόκολλο CCTIC που αναπτύχθηκε από τους Fallot and Harris (2009) θα μπορούσε να είναι ιδιαίτερα ενδιαφέρον στον βαθμό που περιπλέκει τομείς και υποτομείς, οι οποίοι εμπλέκονται στην αξιολόγηση οργανωτικών υπηρεσιών και πρωτοβουλιών στον τομέα της φροντίδας ψυχικών τραυμάτων.

Συνεπώς, η υιοθέτηση μιας προοπτικής προσανατολισμένης στην TIC συνεπάγεται ευαισθησία σε αυτό που τόνισαν οι Levy-Carrick και συνεργάτες (2019): «Η βοήθεια προς τους ασθενείς μας και τους εαυτούς μας θα απαιτήσει μια κρίσιμη αλλαγή προοπτικής που πρέπει να παρουσιαστεί στην αρχή της κατάρτισης, να ενισχυθεί σε όλα τα μέρη, να διαμορφωθεί από παλαιότερους επαγγελματίες και να προωθηθεί από τις επόμενες γενιές» (σελ. 107).

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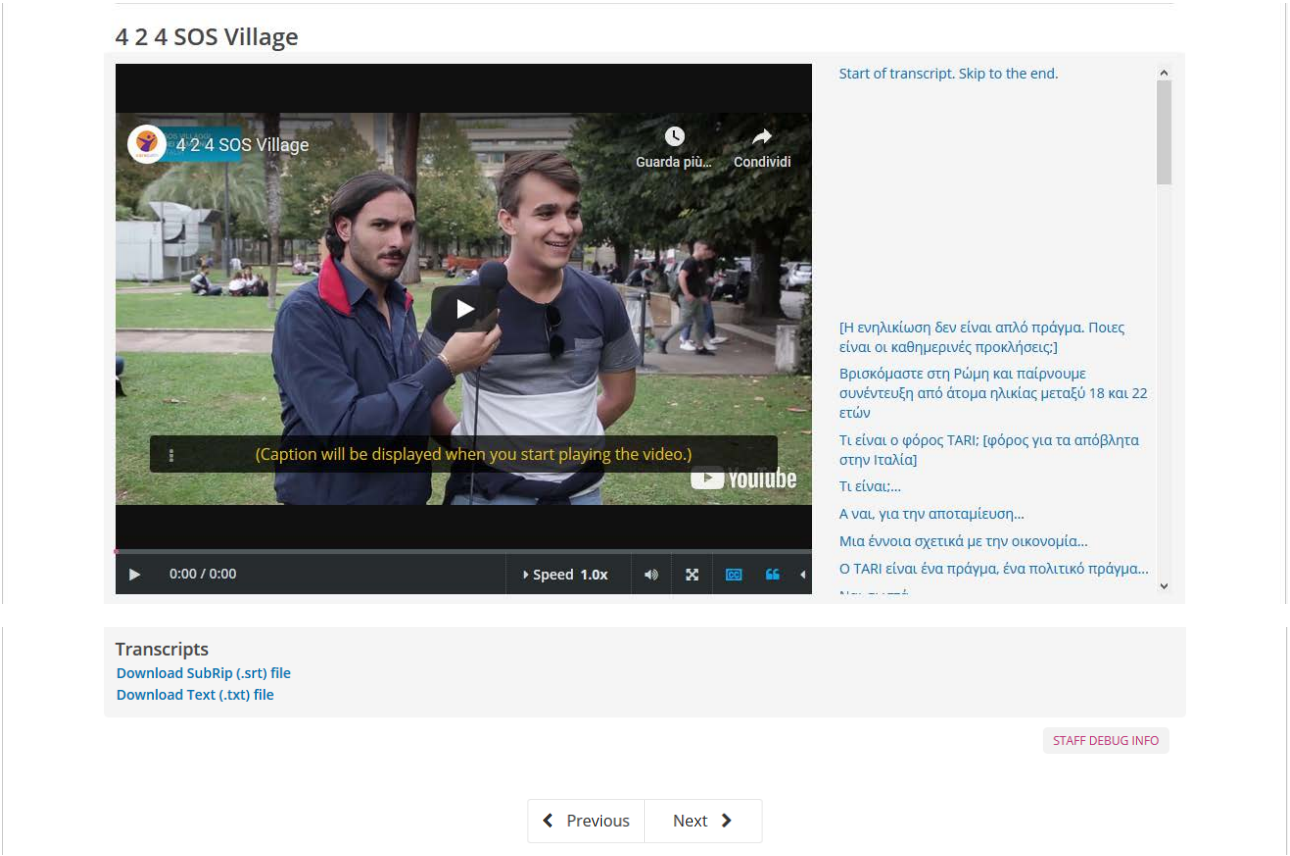

Transcript

[Η ενηλικίωση δεν είναι απλό πράγμα. Ποιες είναι οι καθημερινές προκλήσεις;]

Βρισκόμαστε στη Ρώμη και παίρνουμε συνέντευξη από άτομα ηλικίας μεταξύ 18 και 22 ετών

Τι είναι ο φόρος TARI; [φόρος για τα απόβλητα στην Ιταλία]

Τι είναι;...

Α ναι, για την αποταμίευση...

Μια έννοια σχετικά με την οικονομία...

Ο TARI είναι ένα πράγμα, ένα πολιτικό πράγμα...

Ναι σωστά

Τι είναι ο φόρος TARI;

Ο TARI; Είναι φόρος;

Πρέπει να ψάξεις για σπίτι: πώς θα το κάνεις;

Τι κάνεις; Ποια κίνηση θα κάνεις;

Με τα μέσα μαζικής μεταφοράς...

Η Giulia το βρήκε.

Μέσω ενός μεσιτικού γραφείου.

Μένω στο σπίτι με τη μαμά

που πάντα με περιμένει

Τι είδους συμβόλαιο θα υπογράψεις;

Εννοώ, απλά πληρώνω, δηλαδή πρέπει να πληρώσω

Συμβόλαια, οκ, αορίστου διάρκειας, μακροπρόθεσμα

συμβόλαια...

Εννοώ ότι μόλις μπήκα στη Νομική…

αλλά μόλις ξεκίνησα! Άρα…

Κάνεις το 4…; [4+4, ένα συνηθισμένο συμβόλαιο στέγασης]

4 μήνες;

Συν 5

Τα χρήματα για ενοίκιο είναι πεταμένα λεφτά.

Δηλαδή, το νερό και το ρεύμα περιλαμβάνονται στην τιμή

4;

Ο τραπεζικός λογαριασμός

Μια ανάκριση στα Λατινικά μου φαίνεται πιο εύκολη!

Εεε, δεν ξέρω

Εκεί που κάνεις κατάθεση…

Εάν θέλετε, μπορούμε να μιλήσουμε για τον Σενέκα

Όταν έχεις κάποιο πρόβλημα, ποιον καλείς;

Giulia

Τον μπαμπά

Τον Σενέκα, που έχει πεθάνει…άρα τη μαμά και

τον μπαμπά προς το παρόν.

Μερικές ερωτήσεις έχουν δύσκολες απαντήσεις, αλλά οι νέοι που έγιναν 18 χρονών

και μια μέρα θα πρέπει να τις αντιμετωπίσουν μόνοι τους πια.

Άτομα που αποχωρούν από τη φροντίδα

Δεν ξέρω τι είναι αυτό

Ανάγκες…υγείας;...

Ποιοι είναι αυτοί;

Παίκτες της Λίβερπουλ

Δεν ξέρω τι είναι αυτό, δεν τους έχω ξανακούσει

Δεν καταλαβαίνω την ερώτηση

Κληρικοί

Είναι νέοι που γίνονται 18 χρονών,

ζουν σε ανάδοχη οικογένεια και χρειάζεται να την εγκαταλείψουν και να βρουν μια λύση να είναι ανεξάρτητοι

Τέλεια!

[Το μέλλον χτίζεται μέρα με τη μέρα]

Τι μπορούμε να πούμε σε αυτούς τους νέους ανθρώπους; Ελάτε τώρα;!

Τι… Να τους ευχηθούμε να είναι καλά, τι να τους πούμε;!

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Βιβλιογραφία

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ΑΞΙΟΛΟΓΗΣΗ ΓΝΩΣΕΩΝ

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Quiz 5

3 points possible (graded)

1. Η ενημερωμένη στο τραύμα θεραπευτική προσέγγιση (TIC)

- ○ Αναγνωρίζει αποκλειστικά την ψυχολογική διάσταση του ατόμου
- ○ Προωθεί την φροντίδα του ατόμου μέσα από μια ολιστική οπτική
- ○ Αναγνωρίζει μόνο τη φυσική διάσταση του ατόμου
- ○ Αναγνωρίζει μόνο την κοινωνική διάσταση του ατόμου

2. Σε μια παρέμβαση, για να ληφθούν υπόψη οι βέλτιστες πρακτικές θα πρέπει:

- ○ να αποφεύγεται να δίνεται σημασία στο ιστορικό των ωφελούμενων και στην σύνδεση τους με τα συμπτώματα ή τις δυσκολίες που σχετίζονται με το τραύμα
- ○ να διασφαλίζεται ότι το εσωτερικό προσωπικό συνεχίζει πάντα να εκτελεί τις διαδικασίες στις οποίες είχε αρχικά εκπαιδευτεί
- ○ να αποφεύγονται να λαμβάνονται υπόψη κατά την κλινική πρακτική τυποποιημένες και τεκμηριωμένες διαδικασίες
- ○ να προωθείται η σε βάθος αξιολόγηση και η συνεχής παρακολούθηση των ικανοτήτων του προσωπικού (μέσω της χρήσης ειδικά σχεδιασμένων διαδικασιών)

3. Μια καλή ερευνητική πρόταση...

- ○ διεξάγει ανάλυση σκοπιμότητας και καθορίζει χρονοδιάγραμμα
- ○ διατηρεί τους ερευνητικούς στόχους όσο πιο γενικούς γίνεται
- ○ διατυπώνει πάντα υποθέσεις έρευνας μετά από την συλλογή των δεδομένων
- ○ πάντα παρέχει ένα στρωματοποιημένο δείγμα

3. Μια καλή ερευνητική πρόταση...

- ○ διεξάγει ανάλυση σκοπιμότητας και καθορίζει χρονοδιάγραμμα
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- ○ διατυπώνει πάντα υποθέσεις έρευνας μετά από την συλλογή των δεδομένων
- ○ πάντα παρέχει ένα στρωματοποιημένο δείγμα

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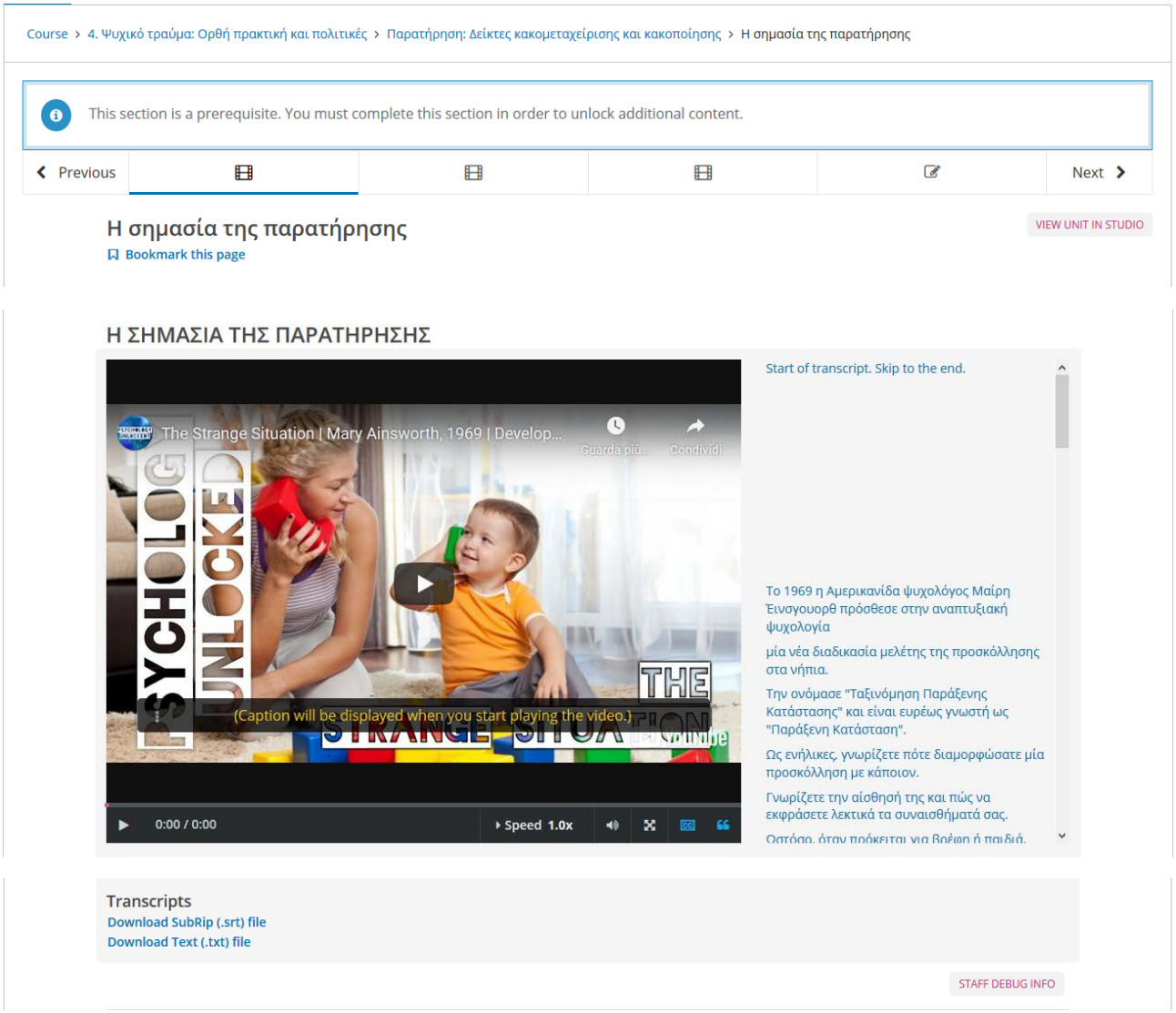


Transcript

Το 1969 η Αμερικανίδα ψυχολόγος Μαίρη Έινσγουορθ πρόσθεσε στην αναπτυξιακή ψυχολογία

μία νέα διαδικασία μελέτης της προσκόλλησης στα νήπια.

Την ονόμασε "Ταξινόμηση Παράξενης Κατάστασης" και είναι ευρέως γνωστή ως "Παράξενη Κατάσταση".

Ως ενήλικες, γνωρίζετε πότε διαμορφώσατε μία προσκόλληση με κάποιον.

Γνωρίζετε την αίσθησή της και πώς να εκφράσετε λεκτικά τα συναισθήματά σας.

Ωστόσο, όταν πρόκειται για βρέφη ή παιδιά,

αυτά δεν έχουν ακόμα αναπτύξει τις συγκεκριμένες δεξιότητες

και άρα οι ερευνητές πρέπει να καταφύγουν σε πιο λεπτές τεχνικές,

όπως είναι η παράξενη κατάσταση, που μετράει την ασφάλεια μιας προσκόλλησης,

σε νήπια 1-2 ετών. μία εικοσάλεπτη συμμετοχική παρατήρηση

στην οποία ο ερευνητής παρατηρεί τις συμπεριφορικές αντιδράσεις του νηπίου σε μια σειρά από σενάρια.

Η Παράξενη Κατάσταση της Έινσγουορθ περιλαμβάνει 8 στάδια, με τρίλεπτη περίπου διάρκεια το καθένα.

Αρχικά η μητέρα, το νήπιο και ο ερευνητής βρίσκονται όλοι μαζί στο δωμάτιο,

έναν μικρό, ουδέτερα χρωματισμένο χώρο με λίγα παιχνίδια για να παίξει το παιδί.

Ο πειραματιστής αποσύρεται μετά από 1 λεπτό περίπου και η μητέρα με το νήπιο μένουν μόνοι

επί 3 περίπου λεπτά. Σε αυτό το στάδιο

οι ερευνητές παρακολουθούν εάν το παιδί νοιώθει την αυτοπεποίθηση να εξερευνήσει το νέο περιβάλλον

έχωντας τη μητέρα σε ασφαλή απόσταση. Ένας άγνωστος μπαίνει στο δωμάτιο με τη μητέρα και το παιδί.

Οι ερευνητές καταγράφουν την αντίδραση του νηπίου σε αυτόν τον άγνωστο που μόλις μπήκε,

ο οποίος μένει μόνος με το νήπιο όταν η μητέρα βγαίνει από το δωμάτιο.

Σε αυτό το στάδιο, οι ερευνητές ανιχνεύουν στη συμπεριφορά του νηπίου 21 00:01:51,450 --> 00:01:55,850 ενδείξεις άγχους αποχωρισμού. Τρία λεπτά αργότερα η μητέρα επιστρέφει

και οι ερευνητές παρατηρούν την αντίδραση του νηπίου στην επανασύνδεση. Ο άγνωστος βγαίνει από το δωμάτιο.

Μετά από λίγα λεπτά η μητέρα βγαίνει από το δωμάτιο αφήνοντας το νήπιο μόνο

για πρώτη φορά στο πείραμα. Ο επόμενος που μπαίνει στο δωμάτιο είναι ο άγνωστος

και, τέλος, μετά από 3 λεπτά επιστρέφει η μητέρα και φεύγει ο άγνωστος.

Γενικά πρόκειται για μία απόλυτα παράξενη κατάσταση για όλους τους εμπλεκόμενους.

Άρα τι μετρούσαν οι ερευνητές; Όταν η μητέρα βρισκόταν στο δωμάτιο με το νήπιο,

μετρούσαν τη συμπεριφορά του νηπίου με βάση τέσσερα κριτήρια.

"Εγγύτητα και αναζήτηση επαφής", "Διατήρηση επαφής",

"Αποφυγή εγγύτητας και επαφής" και "Αντίσταση στην επαφή και την εμψύχωση".

Επίσης, καταγράφονταν οι διερευνητικές συμπεριφορές του νηπίου καθώς εξερευνούσε το περιβάλλον.

Η Έινσγουορθ ανέφερε ότι τα νήπια εκδηλώνουν έναν από τους εξής τρεις τύπους προσκόλλησης.

Τα νήπια με "ασφαλή προσκόλληση" εκδήλωσαν δυσφορία όταν αποχωρίστηκαν τη μητέρα τους, ήταν αποφευκτικά

όταν έμειναν μόνα με τον άγνωστο αλλά φιλικά όταν ήταν παρούσα και η μητέρα

και χαρούμενα όταν η μητέρα έμπαινε και πάλι στο δωμάτιο.

Το 70% των παιδιών ανήκαν σε αυτή την κατηγορία. Το 15% των παιδιών εκδήλωσε "αμφίθυμη προσκόλληση".

Αυτά τα παιδιά παρουσίασαν έντονη δυσφορία

όταν η μητέρα βγήκε από το δωμάτιο και σημαντικό φόβο απέναντι στον άγνωστο.

Όταν η μητέρα επέστρεψε στο δωμάτιο, τα αμφίθυμα παιδιά προσέγγιζαν τη μητέρα

αλλά απέρριπταν την επαφή. Η Έινσγουορθ ανέφερε ότι ένα τελευταίο 15% των παιδιών

είχαν μία "αποφευκτική προσκόλληση". Τα νήπια αυτά δεν εκδηλώνουν ενδιαφέρον όταν η μητέρα

αποχωρεί από το δωμάτιο και παίζουν χαρούμενα με τον άγνωστο.

Όταν η μητέρα επιστρέφει, τα αποφευκτικά παιδιά μετά βίας αντιλαμβάνονται την άφιξή της.

Το 1990 οι Μέιν και Σόλομον πρόσθεσαν ότι ένα πολύ μικρό ποσοστό

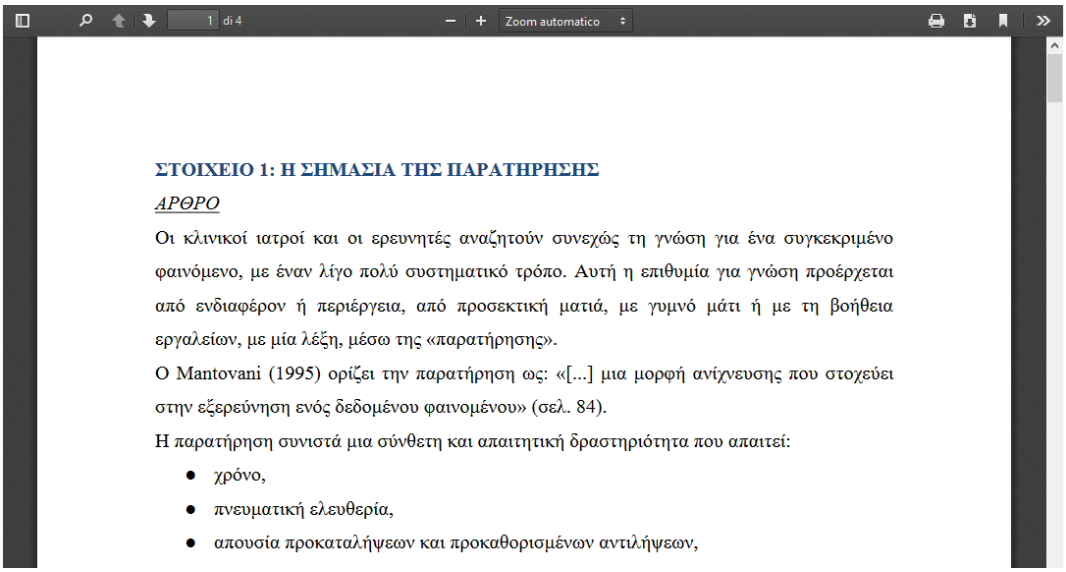
είχε αντιφατική συμπεριφορά και όρισαν αυτή την προσκόλληση ως "αποδιοργανωμένη".

Σύμφωνα με την "Υπόθεση Ευαισθησίας Φροντιστή" της Έινσγουορθ, οι διαφορές στην προσκόλληση νηπίων

εξαρτώνται από τη συμπεριφορά της μητέρας προς το παιδί

κατά τη διάρκεια μίας κρίσιμης περιόδου ανάπτυξής του.

Η ΣΗΜΑΣΙΑ ΤΗΣ ΠΑΡΑΤΗΡΗΣΗΣ



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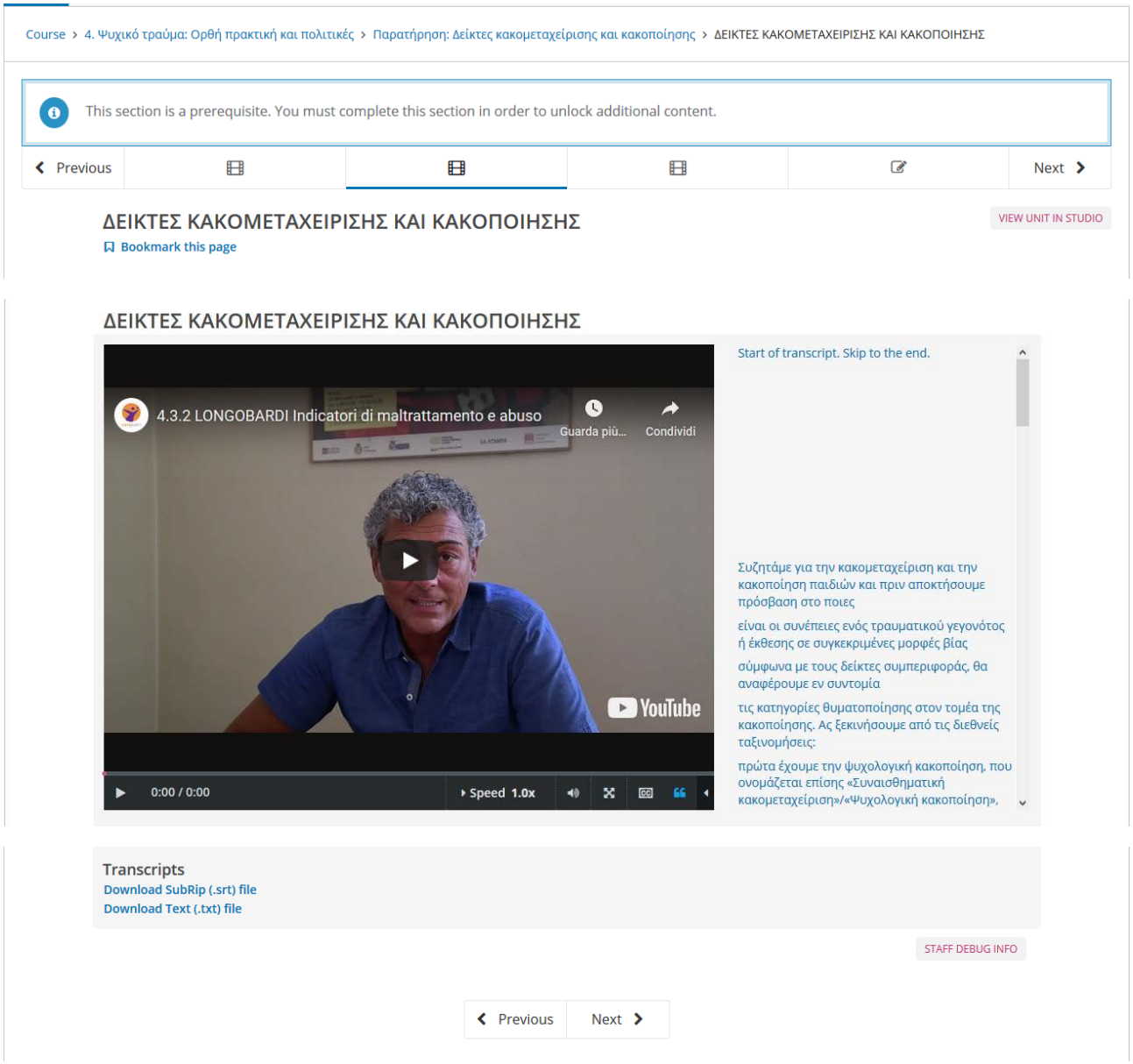

Transcript

Συζητάμε για την κακομεταχείριση και την κακοποίηση παιδιών και πριν αποκτήσουμε πρόσβαση στο ποιες

είναι οι συνέπειες ενός τραυματικού γεγονότος ή έκθεσης σε συγκεκριμένες μορφές βίας

σύμφωνα με τους δείκτες συμπεριφοράς, θα αναφέρουμε εν συντομία

τις κατηγορίες θυματοποίησης στον τομέα της κακοποίησης. Ας ξεκινήσουμε από τις διεθνείς ταξινομήσεις:

πρώτα έχουμε την ψυχολογική κακοποίηση, που ονομάζεται επίσης «Συναισθηματική κακομεταχείριση»/«Ψυχολογική κακοποίηση»,

μετά υπάρχει η σωματική κακοποίηση και τέλος η σεξουαλική κακοποίηση.

Σχετικά με την ψυχολογική κακοποίηση, είναι η έκθεση σε μορφές βίας που χαρακτηρίζονται

από σωματική βλάβη την οποία περνά το παιδί. Αποτελεί συνεπώς

ένα πολύ ισχυρό τραυματικό γεγονός, καθώς έχει συνέπειες για την ανάπτυξη,

τις οποίες θα δούμε παρακάτω. Όταν μιλάμε για ψυχολογική βία,

αναφερόμαστε σε προσβολές, υποτίμηση, κοινωνική απομόνωση

του παιδιού και παραμέληση. Αυτές είναι οι

μορφές βίας που είναι λιγότερο ορατές, αλλά που έχουν ψυχολογικό αντίκτυπο και, ως εκ τούτου, αποτελούν μακροχρόνιο τραυματικό γεγονός.

Τέλος, η σεξουαλική κακοποίηση αναφέρεται σε όλες τις πράξεις που σχετίζονται με θυματοποίηση

και οι οποίες συνδέονται με σωματική έκθεση σε σεξουαλική βία, αιμομιξία,

αγγίγματα ή ακατάλληλα αγγίγματα από όσους έχουν την επιμέλεια του παιδιού σε μια προστατευμένη κατάσταση.

Ας αναλύσουμε τις συνέπειες που σχετίζονται

με την κακοποίηση και τη βία κατά του παιδιού,

λαμβάνοντας υπόψη τόσο τους δείκτες συμπεριφοράς όσο και τους συναισθηματικούς δείκτες. Οι συνέπειες που αντιμετωπίζει το παιδί

κατά τη διάρκεια της ανάπτυξής του είναι, για παράδειγμα,

διαταραχές στην αντίληψη του σώματος και συνεπώς στην εικόνα του σώματός του.

Το παιδί δεν μπορεί να καταλάβει εάν το σώμα του ανήκει σε παιδί ή ενήλικα, επειδή έχει ερωτικοποιηθεί

από νεαρή ηλικία. Άλλες συνέπειες είναι οι χρόνιες δυσκολίες στον ύπνο. Με άλλα λόγια, το τραυματικό γεγονός

έχει αντίκτυπο στη ρύθμιση της ροής ύπνου-αφύπνισης. Έπειτα, υπάρχουν διαταραχές προσοχής και δυσκολίες κατά τη συγκέντρωση

και προσοχή στο σχολείο.

Εάν το παιδί είναι κάτω των 3-5 ετών, μπορεί να προκύψουν και διαταραχές κένωσης.

Κατά την εφηβεία,

άλλες εκδηλώσεις αναστάτωσης που μπορεί να εκφράσει το παιδί ή το νεαρό άτομο είναι οι διατροφικές διαταραχές,

συμπεριλαμβανομένης της ανορεξίας και της βουλιμίας, πράξεις καταφανούς επιθετικότητας έναντι

όλων των υποκειμένων που τείνουν να εκφράζουν συμπεριφορά επίδειξης προσοχής προς το παιδί

(το παιδί μπορεί να υπερασπιστεί τον εαυτό του με καταφανή επιθετικότητα). Τέλος, πράξεις αυτοτραυματισμού,

ακριβώς επειδή υπάρχει εγγενής πόνος, μέσα δηλαδή στο παιδί

που προκαλείται από το τραυματικό γεγονός. Το παιδί αντιδρά τότε προκαλώντας τραυματισμό στον εαυτό του καθώς και σε άλλα υποκείμενα.

Αυτές είναι μερικές από τις συνέπειες της έκθεσης σε τραυματικά γεγονότα κατά τη βρεφική ηλικία,

την παιδική ηλικία και την εφηβεία, αλλά πολλές ακόμη διερευνώνται από τη βιβλιογραφία:

μαθησιακές δυσκολίες, απομόνωση και αντικοινωνική συμπεριφορά,

όπως η χρήση και κατάχρηση οινοπνεύματος και ναρκωτικών, η ασύδοτη σεξουαλική συμπεριφορά, η έκθεση

σε συγκεκριμένες σεξουαλικά μεταδιδόμενες ασθένειες.

Επομένως, αυτό μας κάνει να καταλάβουμε πώς δεν επιτυγχάνεται μια φυσιολογική αναπτυξιακή πορεία,

διότι εκείνοι που φροντίζουν το παιδί και θα πρέπει να λειτουργούν ως τα άτομα που έχουν την επιμέλειά του

κακοποιούν το παιδί σωματικά,

μέσω του ξυλοδαρμού και της εκούσιας πρόκλησης πόνου στο παιδί, σεξουαλικά,

δηλαδή με την ερωτικοποίηση του σώματος του παιδιού ή ψυχολογικά,

δηλαδή με ταπείνωση, απομόνωση και υποτίμηση του παιδιού. Αυτές οι μορφές κακοποίησης έχουν τραυματικό αντίκτυπο στο παιδί

με τις συνέπειες που μόλις εξερευνήσαμε. Αυτές οι συνέπειες αποτελούν επομένως δείκτες

συμπεριφορικού αλλά και συναισθηματικού χαρακτήρα και εκφράζουν μια αναστάτωση που το παιδί

βιώνει σε μια συγκεκριμένη χρονική στιγμή και για την οποία είναι απαραίτητο να υπάρξει έγκαιρη παρέμβαση,

προτού οι συνέπειες γίνουν όλο και πιο τραυματικές και εγγενείς στην ανάπτυξη

της προσωπικότητας του υποκειμένου, σαφώς με συνέπειες ψυχοπαθολογικού χαρακτήρα.

This section is a prerequisite. You must complete this section in order to unlock additional content.

ΔΕΙΚΤΕΣ ΚΑΚΟΜΕΤΑΧΕΙΡΙΣΗΣ ΚΑΙ ΚΑΚΟΠΟΙΗΣΗΣ ΙΙ

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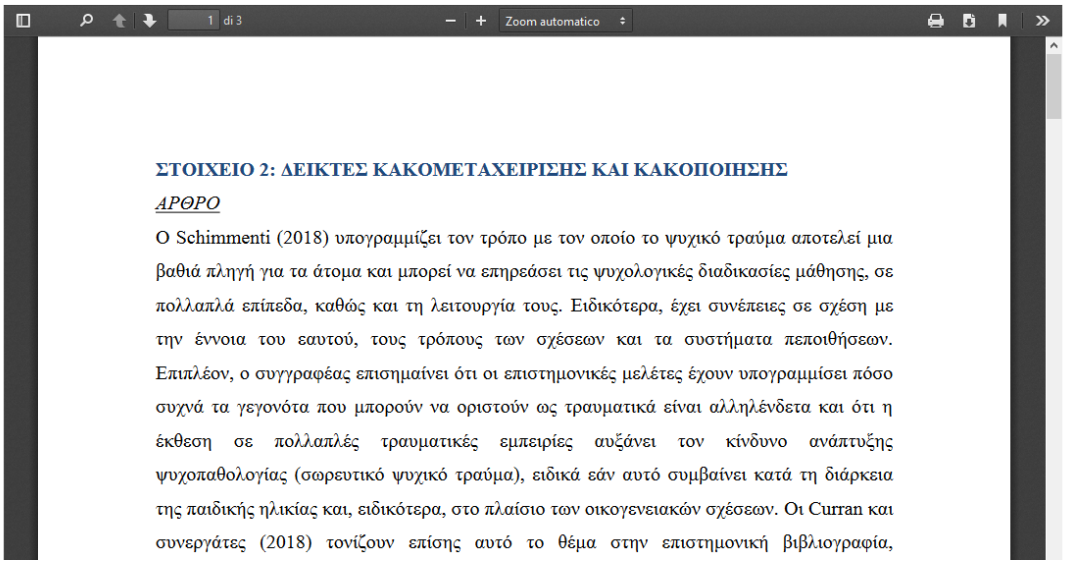

ΣΤΟΙΧΕΙΟ 2: ΔΕΙΚΤΕΣ ΚΑΚΟΜΕΤΑΧΕΙΡΙΣΗΣ ΚΑΙ ΚΑΚΟΠΟΙΗΣΗΣ

ΑΡΘΡΟ

Ο Schimmenti (2018) υπογραμμίζει τον τρόπο με τον οποίο το ψυχικό τραύμα αποτελεί μια βαθιά πληγή για τα άτομα και μπορεί να επηρεάσει τις ψυχολογικές διαδικασίες μάθησης, σε πολλαπλά επίπεδα, καθώς και τη λειτουργία τους. Ειδικότερα, έχει συνέπειες σε σχέση με την έννοια του εαυτού, τους τρόπους των σχέσεων και τα συστήματα πεποιθήσεων. Επιπλέον, ο συγγραφέας επισημαίνει ότι οι επιστημονικές μελέτες έχουν υπογραμμίσει πόσο συχνά τα γεγονότα που μπορούν να οριστούν ως τραυματικά είναι αλληλένδετα και ότι η έκθεση σε πολλαπλές τραυματικές εμπειρίες αυξάνει τον κίνδυνο ανάπτυξης ψυχοπαθολογίας (σωρευτικό ψυχικό τραύμα), ειδικά εάν αυτό συμβαίνει κατά τη διάρκεια της παιδικής ηλικίας και, ειδικότερα, στο πλαίσιο των οικογενειακών σχέσεων. Οι Curran και συνεργάτες (2018) τονίζουν επίσης αυτό το θέμα στην επιστημονική βιβλιογραφία,

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Different types of child abuse

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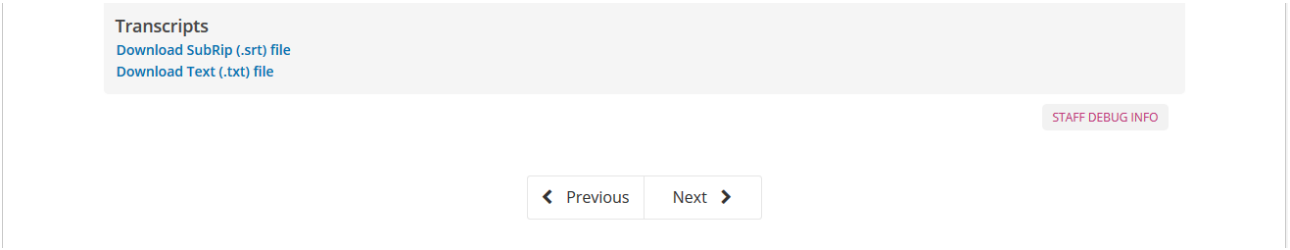
Υπάρχουν πολλοί τύποι παιδικής κακοποίησης. Επιγραμμική κακοποίηση: είναι κάθε τύπος κακοποίησης

που συμβαίνει στο Διαδίκτυο. Μπορεί να έχει τη μορφή μπούλινγκ, αποπλάνησης,

σεξουαλικής κακοποίησης και εκμετάλλευσης στον κυβερνοχώρο από άτομα γνωστά ή άγνωστα.

Η επιγραμμική κακοποίηση μπορεί να περιορίζεται μόνο στο Διαδίκτυο

ή, επιπλέον, να συμβαίνει και στον πραγματικό κόσμο. Καθώς η τεχνολογία είναι πανταχού παρούσα,



Transcript

Υπάρχουν πολλοί τύποι παιδικής κακοποίησης. Επιγραμμική κακοποίηση: είναι κάθε τύπος κακοποίησης που συμβαίνει στο Διαδίκτυο. Μπορεί να έχει τη μορφή μπούλινγκ, αποπλάνησης, σεξουαλικής κακοποίησης και εκμετάλλευσης στον κυβερνοχώρο από άτομα γνωστά ή άγνωστα. Η επιγραμμική κακοποίηση μπορεί να περιορίζεται μόνο στο Διαδίκτυο ή, επιπλέον, να συμβαίνει και στον πραγματικό κόσμο. Καθώς η τεχνολογία είναι πανταχού παρούσα, τα παιδιά και οι νέοι που έχουν υποστεί τέτοια κακοποίηση μπορεί να νοιώθουν παγιδευμένα μην ξέροντας πού να απευθυνθούν γιατί τους ακολουθεί όπου κι αν πάνε, όπως στο υπνοδωμάτιό τους που υποτίθεται ότι είναι ασφαλής τόπος. Αποπλάνηση: συμβαίνει όταν ένας ενήλικας χτίζει μία σχέση με ένα παιδί με στόχο να το κακοποιήσει ή να το εκμεταλλευτεί σεξουαλικά. Αυτό μπορεί να συμβεί στο Διαδίκτυο ή στον πραγματικό κόσμο από γνωστό ή άγνωστο πρόσωπο. Σεξουαλική κακοποίηση: συμβαίνει όταν ένα παιδί εξαναγκάζεται ή πείθεται να συμμετάσχει σε οποιαδήποτε σεξουαλική πράξη, όχι απαραίτητα σωματική. Ενίοτε το παιδί δεν έχει επίγνωση πως ό,τι συμβαίνει συνιστά κακοποίηση ή είναι λανθασμένο. Σωματική κακοποίηση: πρόκειται για τον σκόπιμο τραυματισμό παιδιών που προκαλεί βλάβες όπως σπασμένα πλευρά, εγκαύματα ή κοψίματα. Μπορεί να δέχονται κλωτσιές, γροθιές, ραπίσματα, να τα δηλητηριάζουν, να τα καίνε ή να τους εκσφενδονίζουν αντικείμενα. Τα νήπια μπορεί ενίοτε να τα τραντάζουν με τόση βία που να προκαλεί το θάνατό τους. Εγκατάλειψη: είναι μία διαρκής έλλειψη κάλυψης των πλέον βασικών αναγκών ενός παιδιού. Το να αφήνονται τα παιδιά να πεινούν, άπλυτα ή με ακατάλληλη ένδυση, στέγη και επίβλεψη είναι όλα παραδείγματα παιδιών σε εγκατάλειψη. Επίσης, η εγκατάλειψη μπορεί να υφίσταται όταν ένας γονέας ή φροντιστής δεν προστατεύει ένα παιδί από άλλους τύπους κακοποίησης. Μπούλινγκ: είναι η συμπεριφορά που πληγώνει κάποιον άλλο με χαρακτηρισμούς, χειροδικία, σπρώξιμο, διάδοση φήμης, απειλή ή υπονόμευση κάποιου. Αυτό μπορεί να συμβεί οπουδήποτε, ακόμα και μέσα στο σπίτι του παιδιού και συχνά σε μεγάλο βάθος χρόνου. Συναισθηματική κακοποίηση, γνωστή και ως ψυχολογική κακοποίηση, όταν ένας γονέας ή φροντιστής

διαρκώς κακομεταχειρίζεται ή εγκαταλείπει το παιδί συναισθηματικά,
η οποία μπορεί να αφορά σκόπιμη προσπάθεια να φοβίσει ή να ταπεινώσει ένα παιδί
ή να το απομονώσει ή να το αγνοεί. Επιβλαβής σεξουαλική συμπεριφορά:
τα παιδιά και οι νέοι που αναπτύσσουν επιβλαβή σεξουαλική συμπεριφορά τραυματίζουν τον εαυτό τους
και άλλους χρησιμοποιώντας σεξουαλικά ρητές λέξεις και φράσεις, ανάρμοστα αγγίγματα,
σεξουαλική βία και απειλές ή εμπλοκή σε ολοκληρωμένο σεξ, με διείσδυση,
με άλλα παιδιά ή ενήλικες. Η παιδική σεξουαλική εκμετάλλευση είναι ένα ακόμα είδος κακοποίησης.
Τα παιδιά και οι νέοι που υφίστανται σεξουαλική εκμετάλλευση είναι ευάλωτα άτομα
που έχουν εξαπατηθεί ή χειραγωγηθεί ώστε να πιστέψουν ότι βρίσκονται σε μία σχέση αγάπης.
Ενδέχεται να τους προσφέρουν χρήματα ή άλλες ανταμοιβές με στόχο τη διακίνησή τους
στη σωματεμπορία. Μπορεί να έχουν αποπλανηθεί στο Διαδίκτυο αναπτύσσοντας απόλυτη εξάρτηση
από τον κακοποιητή τους, η οποία καθιστά ακόμα δυσκολότερη τη φυγή τους.
Η εμπορία παιδιών είναι επίσης κακοποίηση. Τα παιδιά μπορεί να διακινούνται για φθηνή εργασία,
σεξουαλική κακοποίηση, οικιακή εργασία, απάτη σχετική με επιδόματα, εξαναγκασμό σε γάμο.

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ΑΞΙΟΛΟΓΗΣΗ ΓΝΩΣΕΩΝ

Quiz 6

4 points possible (graded)

1. Η παρατήρηση ορίζεται ως (Mantovani, 1995):

- ένας αντικειμενικός και αξιόπιστος τρόπος καταγραφής της πραγματικότητας
- Μια ενδιάμεση στιγμή μεταξύ ενός φαινομένου και της ερμηνείας του
- Η περιγραφή ενός είδους σε έναν κατάλογο
- Μια μορφή ανίχνευσης που στοχεύει στην εξερεύνηση ενός συγκεκριμένου φαινομένου

2. Κατά την διάρκεια της παρατήρησης, ένας σημαντικός παράγοντας είναι:

- Να αποφεύγεται η αλληλεπίδραση με το αντικείμενο της παρατήρησης με κάθε κόστος
- Να αποφεύγεται η επιρροή από προλήψεις και προκαταλήψεις
- Η ταχύτητα της κρίσης
- Να χρησιμοποιείτε πάντα δομημένα εργαλεία παρατήρησης

3. Στους ανηλίκους, η παρουσία δεικτών και ενδείξεων που σχετίζονται με κακομεταχείριση και κακοποίηση.....

- μπορούν να ανακύψουν από την παρατήρηση συναισθημάτων και συμπεριφορών
- οδηγούν στην άμεση απώλεια γονικής μέριμνας
- αντιστοιχούν, σε κάθε περίπτωση, σε καταστάσεις κακοποίησης και κακομεταχείρισης
- θα πρέπει να λαμβάνονται υπόψη χωρίς την επίδραση των συμπεριφορών

4. Σύμφωνα με τον Schimmenti (2018), οι τραυματικές εμπειρίες...

- ○ Είναι πάντα εύκολο να ξεπεραστούν μέσα από τη συζήτηση με φίλους και συγγενείς σχετικά με το γεγονός
- ○ Θα πρέπει να καταπιεσθούν με το να προσπαθούμε να μη τις σκεφτόμαστε
- ○ Δεν προκαλούν καμία ζημιά αν αντιμετωπιστούν ως ένα και μοναδικό γεγονός, χάρη στην πλαστικότητα των νευρώνων
- ○ Αυξάνουν την πιθανότητα εμφάνισης ψυχικών ασθενειών, ειδικά όταν το υποκείμενο υπόκειται σε πολλαπλές εκθέσεις (Σωρευτικό τραύμα)

Invia | You have used 0 of 2 attempts

Salva | Show Answer

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Μαθησιακοί στόχοι

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Μαθησιακοί στόχοι

· να γνωρίζουμε συνοπτικά την κοινωνικο-πολιτισμική και νομική διαδικασία που οδήγησε στην παγκόσμια και ευρωπαϊκή αναγνώριση ότι τα παιδιά αποτελούν υποκείμενα δικαιωμάτων και ότι τα κράτη έχουν την υποχρέωση να παρεμβαίνουν άμεσα και αποτελεσματικά για την προστασία τους σε περίπτωση βίας, κακοποίησης ή παραμέλησης

· να γνωρίζουμε τα θεμελιώδη δικαιώματα και τις αρχές που καθορίζονται από το διεθνές και ευρωπαϊκό νομικό πλαίσιο για τα δικαιώματα των παιδιών εντός του οποίου μπορεί να εφαρμοστεί η Φροντίδα με ενημέρωση για το ψυχικό τραύμα (ICT). Ιδιαίτερη προσοχή θα δοθεί στο δικαίωμα των παιδιών να ενημερώνονται και να συμμετέχουν στην απόφαση που τους επηρεάζει, τη φροντίδα τους και το μέλλον τους μετά την αποχώρησή τους από το κέντρο φροντίδας

· να γνωρίζουμε και να κατανοούμε τα νομικά μέσα που εγγυώνται τη συμμετοχή των παιδιών που πάσχουν από ψυχικό τραύμα σε διαδικασίες (διοικητικές και δικαστικές) στις οποίες λαμβάνονται αποφάσεις για την προστασία τους (π.χ. το δικαίωμα του παιδιού που είναι ικανό να διαμορφώσει τη δική του άποψη για ακρόαση και, σε ορισμένες περιπτώσεις, το καθήκον να ζητηθεί η συναίνεσή του)

· να κατανοούμε τα επιχειρησιακά αποτελέσματα της προσέγγισης που βασίζεται στα δικαιώματα των παιδιών (και συγκεκριμένα των δικαιωμάτων συμμετοχής των παιδιών) στις πολιτικές για την κοινωνική μέριμνα και την υγεία

· να γνωρίζουμε και να μαθαίνουμε σε άριστο επίπεδο τη νομική ορολογία.

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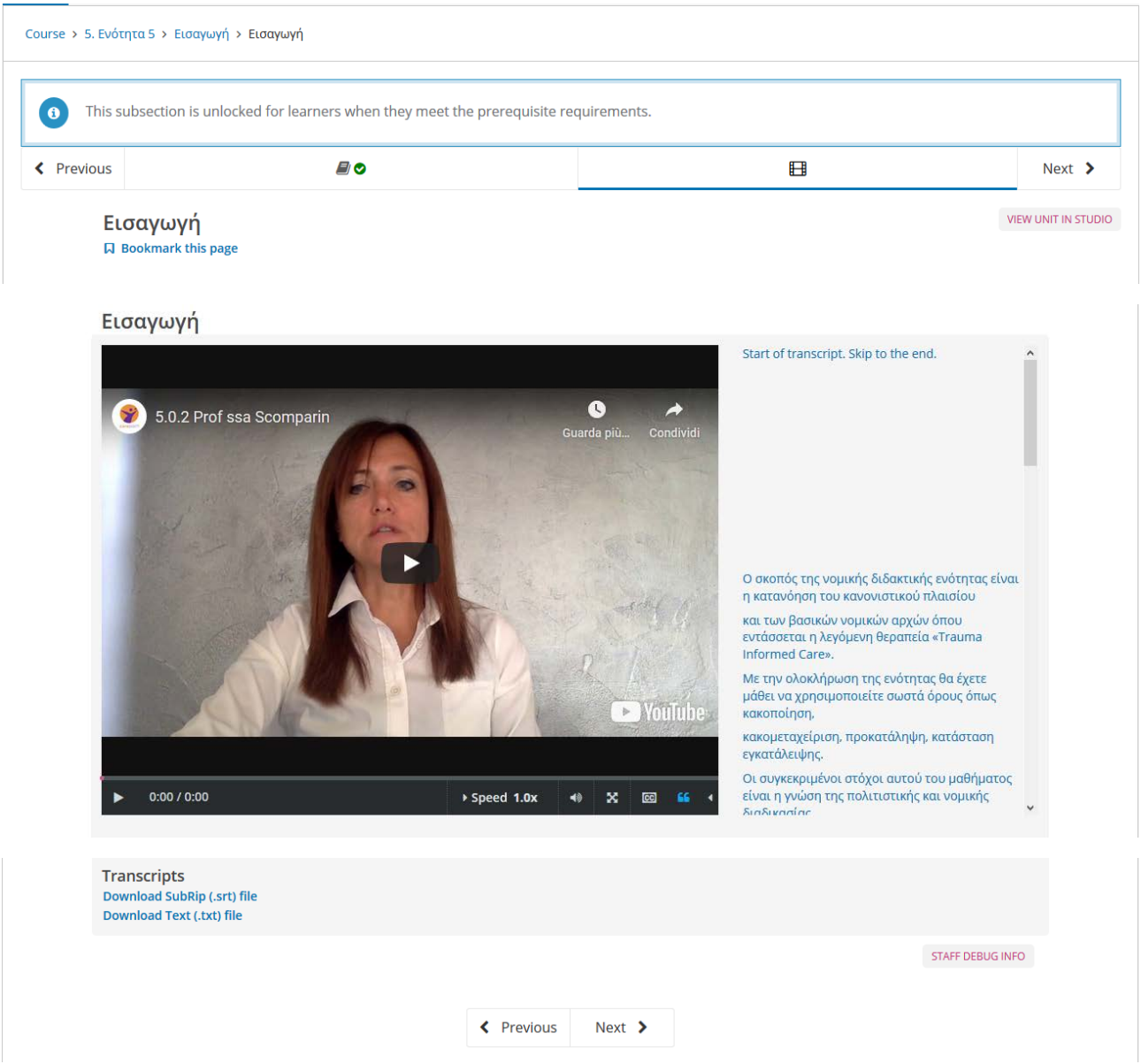

Transcript

Ο σκοπός της νομικής διδακτικής ενότητας είναι η κατανόηση του κανονιστικού πλαισίου
και των βασικών νομικών αρχών όπου εντάσσεται η λεγόμενη θεραπεία «Trauma Informed Care».
Με την ολοκλήρωση της ενότητας θα έχετε μάθει να χρησιμοποιείτε σωστά όρους όπως κακοποίηση,
κακομεταχείριση, προκατάληψη, κατάσταση εγκατάλειψης.
Οι συγκεκριμένοι στόχοι αυτού του μαθήματος είναι η γνώση της πολιτιστικής και νομικής διαδικασίας
που οδήγησε, σε ευρωπαϊκό και παγκόσμιο επίπεδο, στην αναγνώριση ότι τα άτομα μικρής ηλικίας
έχουν δικαιώματα και ότι είναι υποχρέωση της πολιτείας να επεμβαίνει άμεσα
και αποτελεσματικά για την προστασία τους σε περιπτώσεις κακομεταχείρισης.
Στη νομική ενότητα θα μάθετε επίσης να αναγνωρίζετε τα δικαιώματα και τις θεμελιώδεις αρχές που θέτει
το ισχύον διεθνές και ευρωπαϊκό κανονιστικό πλαίσιο σχετικά με τα δικαιώματα των παιδιών

και των εφήβων,

ένα πλαίσιο εντός του οποίου εντάσσεται η θεραπεία «Trauma Informed Care».

Ιδίως σχετικά με τα δικαιώματα των παιδιών και των εφήβων στην ενημέρωση και στην ακρόαση

κατά τις διαδικασίες λήψης αποφάσεων σχετικά με τη βοήθεια, τις θεραπείες και το μέλλον τους

ακόμα και μετά την παύση αρμοδιότητας εκ μέρους της πολιτείας.

Στη νομική ενότητα θα μάθετε επίσης να αναγνωρίζετε και να κατανοείτε πώς λειτουργούν

οι κανονιστικοί μηχανισμοί που εγγυώνται τη συμμετοχή των ανηλίκων, που έχουν υποστεί κακομεταχείριση,

στις διαδικασίες λήψης αποφάσεων, διοικητικές ή νομικές, στις οποίες αποφασίζονται παρεμβάσεις

με σκοπό την προστασία τους.

Άρα, για παράδειγμα, το δικαίωμα του ανηλίκου, με ικανότητα κρίσης, στην ακρόαση

και, σε κάποιες περιπτώσεις, η υποχρέωση της απόκτησης συναίνεσης από τον έφηβο

ώστε να ενεργοποιηθεί το εργαλείο προστασίας.

Τέλος, ένα μέρος της ενότητας θα αφιερωθεί στις λειτουργικές συνέπειες της προσέγγισης

που βασίζεται στα δικαιώματα των παιδιών στις κοινωνικές και υγειονομικές πολιτικές.

Αυτό θα πραγματοποιηθεί μέσω μιας γενικής επισκόπησης αλλά και μερικών περιπτώσεων μελέτης.

Για παράδειγμα, μέσω της ανάλυσης των πολιτικών πάταξης των πρακτικών του γενετήσιου ακρωτηριασμού γυναικών

ή της χρήσης σωματικών τιμωριών στην οικογένεια

ή και μέσω της ανάλυσης των πολιτικών που έχουν υιοθετήσει πολλές χώρες

για τον ορισμό κηδεμόνα ως βοηθού ή συμβούλου των ασυνόδευτων

αλλοδαπών παιδιών.

This section is a prerequisite. You must complete this section in order to unlock additional content.

Νομικό γλωσσάριο για το «ψυχικό τραύμα» της παιδικής ηλικίας

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Νομικό γλωσσάριο για το «ψυχικό τραύμα» της παιδικής ηλικίας

Ο όρος «ψυχικό τραύμα» δεν χρησιμοποιείται συνήθως στη νομική γλώσσα.

Η Διεθνής Σύμβαση για τα Δικαιώματα των Παιδιών και των Εφήβων (CRC), για παράδειγμα, σχεδιάζει να «προστατεύει το παιδί από κάθε μορφή σωματικής ή πνευματικής βίας, τραυματισμού ή κακοποίησης, εγκατάλειψης ή παραμέλησης, κακομεταχείρισης ή εκμετάλλευσης, συμπεριλαμβανομένης της σεξουαλικής κακοποίησης» (Άρθρο 19).

ΚΑΚΟΠΟΙΗΣΗ και ΚΑΚΟΜΕΤΑΧΕΙΡΙΣΗ:

Το Συμβούλιο της Ευρώπης ορίζει ως παιδική κακοποίηση: «τις πράξεις και τις ελλείψεις που διαταράσσουν σοβαρά το παιδί, απειλούν τη σωματική του ακεραιότητα, τη σωματική, πνευματική και ηθική του ανάπτυξη, οι οποίες εκδηλώνονται ως παραμέληση ή/και σωματικά ή/και ψυχικά ή/και σεξουαλικά τραύματα από μέλος της οικογένειας ή από άλλους που φροντίζουν το παιδί» (IV Εγκληματολογικό Σεμινάριο - Στρασβούργο, 1978)

Ο Παγκόσμιος Οργανισμός Υγείας δηλώνει ότι: «για την κακοποίηση και κακομεταχείριση παιδιών (κακοποίηση παιδιών, κακομεταχείριση) όλες οι μορφές σωματικής ή/και συναισθηματικής κακής υγείας, σεξουαλικής κακοποίησης, εγκατάλειψης ή παραμέλησης ή εμπορικής εκμετάλλευσης ή ο,τιδήποτε άλλο που συνεπάγεται πραγματική ή δυνητική προκατάληψη για την υγεία του παιδιού, για την επιβίωσή του, για την ανάπτυξή του ή για την αξιοπρέπειά του στο πλαίσιο μιας σχέσης που χαρακτηρίζεται από ευθύνη, εμπιστοσύνη ή εξουσία» (Παγκόσμιος Οργανισμός Υγείας, Παγκόσμια Έκθεση για τη Βία και την Υγεία, 2002).

Τόσο η κακοποίηση όσο και η κακομεταχείριση μπορούν να έχουν τη μορφή:

- ενεργούς συμπεριφοράς (για παράδειγμα, ξυλοδαρμούς, τραυματισμούς, σεξουαλικές πράξεις, εκμετάλλευση)
- συμπεριφορά παράληψης (για παράδειγμα, επιπολαιότητα, παραμέληση).

Η απουσία φυσικών αποδείξεων ψυχικού τραύματος δεν αποκλείει την υπόθεση κακομεταχείρισης ή κακοποίησης. Για παράδειγμα, η συμπεριφορά του δασκάλου/γονέα που ταπεινώνει, υποτιμά, δυσφημεί ή ασκεί ψυχολογική βία σε ένα παιδί ή το απειλεί μπορεί να αποτελεί κακοποίηση όταν συνίσταται σε ψυχολογική βία που μπορεί να βλάψει την ψυχοσωματική υγεία του παιδιού και να υπονομεύσει την αξιοπρέπειά του.

Οι όροι **ΒΙΑ** και **ΕΚΜΕΤΑΛΛΕΥΣΗ** αναφέρονται συνήθως σε ενεργές συμπεριφορές που λαμβάνουν χώρα εναντίον του παιδιού.

Η **εκμετάλλευση**, συγκεκριμένα, μπορεί να είναι οικονομικής ή σεξουαλικής φύσης

Άρθρο 32 (CRC): «Τα Συμβαλλόμενα Κράτη αναγνωρίζουν το δικαίωμα του παιδιού να προστατεύεται από την οικονομική εκμετάλλευση και από την εκτέλεση οποιασδήποτε εργασίας που ενδέχεται να είναι επικίνδυνη ή να παρεμβαίνει στην εκπαίδευση του παιδιού ή να είναι επιβλαβής για την υγεία του παιδιού ή για τη σωματική, ψυχική, πνευματική, ηθική ή κοινωνική του ανάπτυξη.»

Άρθρο 34, παρ. 1 (CRC): «Τα Συμβαλλόμενα Κράτη δεσμεύονται να προστατεύουν το παιδί από όλες τις μορφές σεξουαλικής εκμετάλλευσης και σεξουαλικής κακοποίησης.»

Η Επιτροπή των Ηνωμένων Εθνών για τα Δικαιώματα του Παιδιού προσδιορίζει ότι με τον όρο «βία» εννοούμε «όλες τις μορφές σωματικής ή ψυχικής βίας, τραυματισμού ή κακοποίησης, εγκατάλειψης ή παραμέλησης, κακοποίησης ή εκμετάλλευσης, συμπεριλαμβανομένης της σεξουαλικής κακοποίησης». Στην κοινή γλώσσα ο όρος βία συχνά χρησιμοποιείται για να ορίσει μόνο τη σωματική βλάβη ή/και την εκ προθέσεως βλάβη. Ωστόσο, η Επιτροπή δίνει ιδιαίτερη έμφαση στο γεγονός ότι η επιλογή του όρου βία σε αυτό το γενικό σχόλιο δεν θα πρέπει να ερμηνεύεται με κανέναν τρόπο ώστε να ελαχιστοποιείται ο αντίκτυπος ή η ανάγκη αντιμετώπισης των μη σωματικών ή/και εκ προθέσεως μορφών βλάβης (όπως, μεταξύ άλλων, εγκατάλειψη και ψυχολογική κακομεταχείριση) (Το δικαίωμα του παιδιού να απαλλαγεί από κάθε μορφή βίας, Γενικό σχόλιο αρ. 13 (2011) CRC / C / GC / 13, 18 Απριλίου 2011).

Τέλος, η φράση **ΚΑΤΑΣΤΑΣΗ ΕΓΚΑΤΑΛΕΙΨΗΣ** αναφέρεται σε κατάσταση σοβαρής και μόνιμης ανεπάρκειας των γονέων να φροντίζουν το παιδί λόγω παραμέλησης, σοβαρής βίας ή εκμετάλλευσης.

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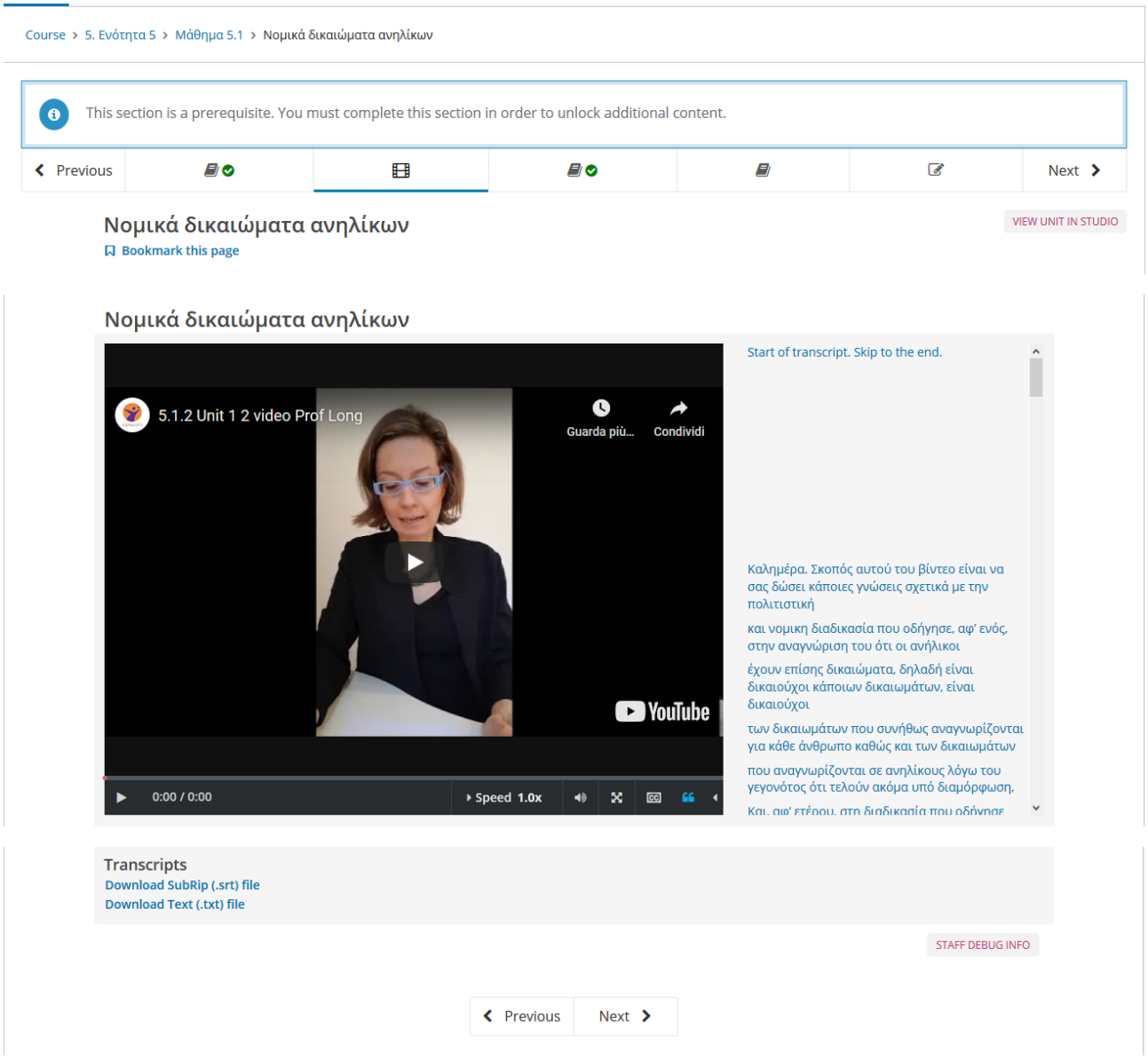

Transcript

Καλημέρα. Σκοπός αυτού του βίντεο είναι να σας δώσει κάποιες γνώσεις σχετικά με την πολιτιστική και νομικη διαδικασία που οδήγησε, αφ' ενός, στην αναγνώριση του ότι οι ανήλικοι έχουν επίσης δικαιώματα, δηλαδή είναι δικαιούχοι κάποιων δικαιωμάτων, είναι δικαιούχοι των δικαιωμάτων που συνήθως αναγνωρίζονται για κάθε άνθρωπο καθώς και των δικαιωμάτων που αναγνωρίζονται σε ανηλίκους λόγω του γεγονότος ότι τελούν ακόμα υπό διαμόρφωση,
Και, αφ' ετέρου, στη διαδικασία που οδήγησε στην αναγνώριση της υποχρέωσης της πολιτείας να παρεμβαίνει με στόχο την προστασία και την προώθηση των δικαιωμάτων των ανηλίκων που είναι θύματα βίας και κακομεταχείρισης. Για να θέσουμε το συγκεκριμένο θέμα θα σας διαβάσω ένα απόσπασμα από ένα βιβλίο του 2006 με τίτλο «Η ζωή και οι κανόνες», των ιταλικών εκδόσεων Φελτρινέλι.

Ο συγγραφέας είναι ο Στέφανο Ροντοτά, νομικός, Ιταλός πολιτικός, μέλος της συγγραφικής ομάδας

του Ευρωπαϊκού Χάρτη Θεμελιωδών Δικαιωμάτων. Γράφει ο Ροντοτά.

«Ο νομικός κανονισμός δεν μπορεί»

«να θεωρείται ως κάτι που εξαλείφει τον πόνο από τον κόσμο, αλλά ως ένα από τα κριτήρια»

«που σηματοδοτούν το όριο του αποδεκτού πόνου, σε προσωπικό και κοινωνικό επίπεδο».

Νομίζω ότι αυτό το κείμενο μας βοηθά να περιγράψουμε το θέμα της αντίδρασης της πολιτείας

στην κακομεταχείριση των παιδιών γιατί επισημαίνει πρωτίστως ότι το δικαίωμα δεν είναι πανίσχυρο.

Κι αυτό σημαίνει ότι, παρόλο που υπάρχουν νομικοί κανόνες οι οποίοι καταστέλλουν τη βία

και την κακομεταχείριση των παιδιών και προσπαθούν να τις προλαμβάνουν,

αυτό δεν σημαίνει, δυστυχώς, ότι παύουν να υφίστανται η βία και η κακομεταχείριση.

Επιπλέον, πρέπει να παραδεχτούμε πως, συγκεκριμένα, όταν υφίσταται αυτή η βία και η κακομεταχείριση,

η πολιτεία δεν καταφέρνει πάντα να ενεργοποιήσει μία άμεση και αποτελεσματική παρέμβαση.

Επίσης, το σύντομο κείμενο του Ροντοτά μας βοηθά να στοχαστούμε σχετικά με το όριο

της κρατικής παρέμβασης, για την προστασία γενικά των προσώπων που βρίσκονται σε κατάσταση δυσχέρειας

και, ιδίως, για την υποστήριξη των ανηλίκων θυμάτων κακομεταχείρισης.

Αυτό το όριο, λοιπόν, μπορεί να ταυτιστεί με την επίθεση, την παραβίαση της ανθρώπινης αξιοπρέπειας.

Άρα η κρατική παρέμβαση πρέπει να πραγματοποιείται όταν το όριο του πόνου

είναι τόσο υψηλό ώστε να βλάπτει την αξιοπρέπεια του ανθρώπου, ενώ το πνεύμα της κρατικής παρέμβασης

σε αυτές τις περιπτώσεις πρέπει να έγκειται στη γενική υποχρέωση

της κοινωνικής αλληλεγγύης που οδηγεί, κι αυτό είναι μία από τις λειτουργίες των δικαιωμάτων,

στην προστασία των ατομικών ελευθεριών και των ατόμων που βρίσκονται σε ευάλωτη κατάσταση.

Ας δούμε τώρα τα ορόσημα αυτής της πορείας που οδήγησε στην αναγνώριση του ανηλίκου

ως προσώπου με δικαιώματα και στην υποχρέωση του κράτους να προστατεύει τους ανηλίκους

που είναι θύματα κακομεταχείρισης.

Ένα πρώτο θεμελιώδες στοιχείο μπορούμε να διακρίνουμε

στο έτος 1874, όταν η πολιτεία της Νέας Υόρκης των ΗΠΑ πραγματοποίησε δίκη

για τις βλάβες που προκάλεσε μία μητέρα στη μικρή της κόρη ονόματι Μέρι Έλεν Γουίλσον.

Η δικαστική υπόθεση της Μέρι Έλεν Γουίλσον Προκάλεσε αίσθηση γιατί αποκάλυψε την ανυπαρξία

ενός δημόσιου συστήματος προστασίας του παιδιού και η συγκεκριμένη υπόθεση οδήγησε στην ίδρυση

του πρώτου οργανισμού για αυτό τον σκοπό, την Εταιρεία Νέας Υόρκης για την πρόληψη

της βάναυσης συμπεριφοράς κατά των παιδιών. Τι είχε συμβεί;

Οι γείτονες είχαν επισημάνει σε μία μεθοδίστρια ιεραπόστολο

ονόματι Έττα Γουίλερ, ότι ένα κοριτσάκι μάλλον 5 ετών, η Μέρι Έλεν, δηλαδή,

που θα αποδεικνυόταν ότι ήταν 10 ετών, ήταν θύμα κακομεταχείρισης από τη μητέρα της.

Η Έττα Γουίλερ μπήκε στο σπίτι δήθεν ζητώντας βοήθεια για μία γειτόνισσα

με χρόνια αναπηρία. Με τη δικαιολογία αναζήτησης βοήθειας για μία γειτόνισσα

η Έττα Γουίλερ μπήκε στο σπίτι των γονέων της Μέρι Έλεν και διαπίστωσε ιδίοις όμμασι

την κατάσταση της μικρής, που όντως ήταν θύμα κακομεταχείρισης, τόσο σωματικής,

καθώς έφερε εγκαύματα, αιματώματα και κοψίματα στο σώμα, αλλά και ενδυμασία ακατάλληλη για την εποχή,

όσο και κακομεταχείρισης ψυχολογικού τύπου, γιατί το κοριτσάκι, για παράδειγμα,

επί πολλές ώρες την ημέρα εξαναγκαζόταν να μένει κλειδωμένο σε μία ντουλάπα,

και δεν μπορούσε να βγει στον δρόμο, παρά μόνο στην αυλή του σπιτιού τη νύχτα.

Η Έττα Γουίλερ επικοινώνησε με την τοπική αρχή ζητώντας από τους αρμόδιους την απομάκρυνση

του κοριτσιού από το σπίτι, αλλά οι τοπικές αρχές αρνήθηκαν γιατί δεν υπήρχε το κατάλληλο νομικό πλαίσιο

που θα επέτρεπε την απομάκρυνσή του. Η Έττα Γουίλερ δεν το έβαλε κάτω: ζήτησε και έλαβε βοήθεια

από έναν δικηγόρο ειδικευμένο στην προστασία των ζώων κατά της βάναυσης μεταχείρισης

και αξιοποιώντας αυτό το κανονιστικό πλαίσιο κατάφερε να απομακρύνει το κορίτσι από το σπίτι.

Κι έτσι, όπως είπα, το 1874 πραγματοποιήθηκε η δίκη που οδήγησε στην καταδίκη

της μητέρας σε ένα έτος φυλάκισης για την κακομεταχείριση που άσκησε στη Μέρι Έλεν.

Ανάμεσα στα κυριότερα ορόσημα, άλλη μία καθοριστική ημερομηνία για την επιβεβαίωση

των δικαιωμάτων των παιδιών είναι το 1924. Αυτή τη φορά είμαστε στην Ευρώπη, στη Γενεύη.

Η Κοινωνία των Εθνών διακηρύσσει τον Χάρτη, τη λεγόμενη «Διακήρυξη της Γενεύης»,

τη Διακήρυξη των δικαιωμάτων του παιδιού. Είναι ένας ακόμη Χάρτης που επικεντρώνεται

στις ανάγκες των ανηλίκων για υλικά αγαθά και στοργή και οι ανήλικοι αντιμετωπίζονται

ως παθητικοί παραλήπτες των δικαιωμάτων. Για παράδειγμα, η Διακήρυξη δηλώνει το εξής.

«Το παιδί που πεινάει πρέπει να τραφεί. Το παιδί που νοσεί πρέπει να θεραπευτεί».

Θα περιμένουμε μερικές ακόμα δεκαετίες για έναν νέο Χάρτη, την Παγκόσμια Διακήρυξη των Δικαιωμάτων

του παιδιού, τη Διακήρυξη της Νέας Υόρκης το 1959, αυτή τη φορά στο πλαίσιο των Ηνωμένων Εθνών,

για να φτάσουμε σε ένα έγγραφο όπου αναγνωρίζονται οι ανήλικοι ως άτομα με δικαιώματα

και άρα εισάγεται η έννοια ότι ακόμα και ο ανήλικος, όπως κάθε άνθρωπος,

μπορεί να είναι άμεσος δικαιούχος δικαιωμάτων. Στην πρώτη αρχή, για παράδειγμα, λέει.

«Το παιδί πρέπει να απολαμβάνει όλα τα δικαιώματα που δηλώνονται»

«στην παρούσα διακήρυξη». Και κατά την τρίτη αρχή, «Το παιδί έχει δικαίωμα»,

«από τη γέννησή του, σε ένα όνομα και μία εθνικότητα». Αυτή η διατύπωση των παιδικών δικαιωμάτων

επανέρχεται στο πιο γνωστό έγγραφο παγκοσμίως σχετικά με τα δικαιώματα της παιδικής ηλικίας

που είναι η Σύμβαση των Ηνωμένων Εθνών του 1989.

Έδωσα έμφαση στον όρο «Σύμβαση»

γιατί αντιπροσωπεύει μία πρώτη σημαντική καινοτομία σε σχέση με τα έγγραφα του 1924 και του 1959.

Η Σύμβαση του 1989 είναι ένα έγγραφο δεσμευτικό για τα κράτη που την έχουν επικυρώσει,

σε αντίθεση με τη Διακήρυξη που είναι μία πράξη με εφαρμογή αμιγώς προγραμματική

και άρα προτρεπτική για τα κράτη στα οποία απευθύνεται.

Η Σύμβαση του 1989 διακρίνεται επίσης για τη θεσμοθέτηση ενός μηχανισμού εποπτείας και ελέγχου

που είναι εστιασμένος στα δικαιώματα των παιδιών, με έδρα στη Γενεύη,

και εξετάζει τις περιοδικές εκθέσεις που υποβάλλονται από τα κράτη μέλη σχετικά με την εφαρμογή

της Σύμβασης στο πλαίσιο του εκάστοτε εθνικού δικαίου. Όσον αφορά τα άρθρα,

αναγνωρίζονται στον ανήλικο όλα τα ανθρώπινα δικαιώματα με βάση τους διεθνείς Χάρτες

συν μερικά ιδιαίτερα δικαιώματα που αφορούν τους ανηλίκους, οι οποίοι τελούν ακόμα υπό διαμόρφωση.

Στο θέμα της κακομεταχείρισης του ανηλίκου σημειώνω, ιδίως, το άρθρο 19

που προστατεύει «το παιδί ενάντια σε κάθε μορφή βίας» εντός του οικογενειακού περιβάλλοντος.

Επίσης, το άρθρο 34, «προστασία κατά της σεξουαλικής εκμετάλλευσης και βίας», το άρθρο 35, «προστασία του ανηλίκου»

«κατά της απαγωγής, πώλησης και εμπορίας», το 37, «προστασία κατά του βασανισμού, ποινών»

«ή απάνθρωπων και βάναυσων συμπεριφορών» και στη συνέχεια το άρθρο 39,

πολύ σημαντικό γιατί ορίζει ότι «τα κράτη μέλη»

«υιοθετούν όλα τα κατάλληλα μέτρα για να διευκολύνουν τη σωματική και ψυχολογική αποκατάσταση»

«και την κοινωνική επανένταξη κάθε παιδιού που είναι θύμα κακομεταχείρισης».

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The Mary Ellen case

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Υποστηρικτικό Υλικό

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Case of Z and other v. The United kingdom

UN Convention on the Rights of the Child - In Child Friendly Language

Convention on the Rights of the Child

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Quiz 5.1

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Q5.1

5 points possible (graded)

1. Στη νομική γλώσσα, ποιο από τα παρακάτω θεωρείται «ψυχικό τραύμα» της παιδικής ηλικίας;:

- ○ κάθε μορφή σωματικής και μη σωματικής βίας, ακόμη κι εάν δεν έχει διαπραχθεί με σκοπό την πρόκλησή του
- ○ μόνο σωματική βία που διαπράττεται με σκοπό την πρόκλησή του
- ○ μόνο σωματική βία, ακόμη κι εάν δεν έχει διαπραχθεί με σκοπό την πρόκλησή του
- ○ κάθε μορφή σωματικής ή μη σωματικής βίας, εφόσον διαπράττεται με σκοπό την πρόκλησή του

2. Στην περίπτωση της Mary Ellen Wilson, το θύμα παιδικής κακοποίησης έλαβε προστασία σύμφωνα με:

- ○ την απαγόρευση βάναυσης μεταχείρισης ζώων
- ○ την απαγόρευση απάνθρωπης και εξευτελιστικής μεταχείρισης
- ○ την απαγόρευση σωματικής τιμωρίας
- ○ την απαγόρευση κακοποίησης παιδιών

3. Ποιο από τα παρακάτω ισχύει;

- ○ Τα παιδιά δεν υπόκεινται σε δικαιώματα
- ○ Τα παιδιά έχουν ειδικά δικαιώματα που τους παρέχονται ως εκπαιδευόμενοι
- ○ Τα παιδιά έχουν μόνο δικαιώματα αναγνωρισμένα σε κάθε άνθρωπο εκ φύσεως
- ○ Τα παιδιά υπόκεινται σε δικαιώματα εφόσον έχουν τη δυνατότητα να διακρίνουν

4. Ποιο από τα παρακάτω αντιπροσωπεύει ένα ειδικό μέσο που αναπτύχθηκε στο πλαίσιο του Συμβουλίου της Ευρώπης για την προστασία του παιδιού;

- ○ ECHR (ΕΣΔΑ)
- ○ Ευρωπαϊκός Κοινωνικός Χάρτης
- ○ Χάρτης της Νίκαιας
- ○ Σύμβαση Λανζαρότε

5. Στην απόφαση της ΕΣΔΑ Z. ΚΑΙ ΑΛΛΟΙ εναντίον του ΗΝΩΜΕΝΟΥ ΒΑΣΙΛΕΙΟΥ, ποιο από τα ακόλουθα αναγνωρίζεται;

- ○ Άρθρο 3 ECHR (Απαγόρευση των βασανιστηρίων)
- ○ Άρθρο 5 ECHR (Δικαίωμα στην ελευθερία και την ασφάλεια)
- ○ Άρθρο 6 ECHR (Δικαίωμα σε δίκαιη δίκη)
- ○ Άρθρο 8 ECHR (Δικαίωμα σεβασμού της ιδιωτικής και οικογενειακής ζωής)

Invia You have used 0 of 2 attempts

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Νομικό γλωσσάριο σχετικά με τους διεθνείς οργανισμούς και τους οργανισμούς και τις συνθήκες της Ευρωπαϊκής Ένωσης

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Νομικό γλωσσάριο σχετικά με τους διεθνείς οργανισμούς και τους οργανισμούς και τις συνθήκες της Ευρωπαϊκής Ένωσης

Οργανισμός Ηνωμένων Εθνών (ΟΗΕ) = διεθνής οργανισμός που ιδρύθηκε το 1945 με σκοπό τη διατήρηση της διεθνούς ειρήνης και ασφάλειας, την ανάπτυξη φιλικών σχέσεων μεταξύ των εθνών, τη συνεργασία για την επίλυση διεθνών προβλημάτων και την προώθηση του σεβασμού των ανθρωπίνων δικαιωμάτων. Αποτελεί κέντρο εναρμόνισης των διαφόρων εθνικών πρωτοβουλιών. Τα μέλη του ΟΗΕ είναι κυρίαρχα κράτη. Τα Ηνωμένα Έθνη δεν αποτελούν παγκόσμια κυβέρνηση και δεν νομοθετούν.

Ωστόσο, ο ΟΗΕ παρέχει τα μέσα για να βοηθήσει στην επίλυση των διεθνών συγκρούσεων και να διαμορφώσει κατάλληλες πολιτικές για ζητήματα κοινού ενδιαφέροντος.

Διεθνής Σύμβαση για τα Δικαιώματα του Παιδιού (CRC) = διεθνής συνθήκη που εγκρίθηκε από τη Γενική Συνέλευση των Ηνωμένων Εθνών το 1989 και εκφράζει συναίνεση για τις υποχρεώσεις των κρατών και της διεθνούς κοινότητας απέναντι στα παιδιά, ενώ αναγνωρίζει για πρώτη φορά ότι τα παιδιά απολαμβάνουν επίσης αστικά, κοινωνικά, πολιτικά, πολιτιστικά και οικονομικά δικαιώματα.

Επιτροπή του ΟΗΕ για τα Δικαιώματα του Παιδιού = θεσπίστηκε από τη Σύμβαση των Ηνωμένων Εθνών για τα Δικαιώματα του Παιδιού προκειμένου να εξεταστεί η πρόοδος που έχουν σημειώσει τα Συμβαλλόμενα Κράτη κατά την εκτέλεση των υποχρεώσεων που απορρέουν από τη Συνθήκη, ενώ απαρτίζεται από 18 εμπειρογνώμονες υψηλού κύρους, οι οποίοι κατέχουν αναγνωρισμένη εμπειρογνωμοσύνη στον καλυπτόμενο από τη Σύμβαση τομέα. Αποστολή της Επιτροπής είναι να αναλύει περιοδικές εκθέσεις σχετικά με την εφαρμογή της Σύμβασης, τις οποίες δεσμεύονται τα Συμβαλλόμενα Κράτη να παρουσιάζουν βάσει των διατάξεων του άρθρου 44 της Σύμβασης.

Ευρωπαϊκή Σύμβαση για τα Δικαιώματα του Ανθρώπου (ΕΣΔΑ) = διεθνής συνθήκη με την οποία τα κράτη μέλη του Συμβουλίου της Ευρώπης εγγυώνται θεμελιώδη αστικά και πολιτικά δικαιώματα όχι μόνο στους δικούς τους πολίτες αλλά και σε οποιονδήποτε υπάγεται στη δικαιοδοσία τους. Η Σύμβαση υπογράφηκε στη Ρώμη στις 4 Νοεμβρίου 1950 και άρχισε να ισχύει το 1953.

Ευρωπαϊκό Δικαστήριο Ανθρωπίνων Δικαιωμάτων (Δικαστήριο του Στρασβούργου) = Διεθνές δικαστήριο που ιδρύθηκε το 1959 με έδρα το Στρασβούργο. Αποφαίνεται επί των ατομικών ή κρατικών προσφυγών που αφορούν υποτιθέμενες παραβιάσεις αστικών και πολιτικών δικαιωμάτων, τα οποία θεσπίστηκαν με την Ευρωπαϊκή Σύμβαση για τα Δικαιώματα του Ανθρώπου. Από το 1998, το Δικαστήριο είναι μόνιμο όργανο, ενώ ιδιώτες μπορούν να απευθύνονται απευθείας σε αυτό.

Συμβούλιο της Ευρώπης = διεθνής οργανισμός σκοπός του οποίου είναι η προώθηση της δημοκρατίας, των ανθρωπίνων δικαιωμάτων, της ευρωπαϊκής πολιτιστικής ταυτότητας και της αναζήτησης λύσεων για κοινωνικά προβλήματα στην Ευρώπη. Ιδρύθηκε στις 5 Μαΐου 1949 με τη Συνθήκη του Λονδίνου, έχει έδρα το Στρασβούργο και αποτελείται από 47 κράτη μέλη, συμπεριλαμβανομένων των 28 μελών της Ευρωπαϊκής Ένωσης.

Προσοχή! Το Συμβούλιο της Ευρώπης είναι εκτός της Ευρωπαϊκής Ένωσης και δεν θα πρέπει να το συγχέουμε με τα όργανά της.

Σύμβαση του Συμβουλίου της Ευρώπης για την προστασία των παιδιών κατά της σεξουαλικής εκμετάλλευσης και της σεξουαλικής κακοποίησης (Σύμβαση Λανζαρότε) = συνθήκη με την οποία τα κράτη μέλη συμφωνούν να ποινικοποιήσουν ορισμένες μορφές σεξουαλικής κακοποίησης παιδιών. Είναι η πρώτη διεθνής συνθήκη που ασχολείται με τη σεξουαλική κακοποίηση παιδιών, η οποία λαμβάνει χώρα μέσα στην οικογένεια.

Σύμβαση του Συμβουλίου της Ευρώπης για την πρόληψη και την καταπολέμηση της βίας κατά των γυναικών και της ενδοοικογενειακής βίας (Σύμβαση Κωνσταντινούπολης) = διεθνής συνθήκη που αποσκοπεί στην πρόληψη της βίας, στην προώθηση της προστασίας των θυμάτων και στην αποτροπή της ατιμωρησίας των δραστών. Αποτελεί το πρώτο νομικά δεσμευτικό διεθνές μέσο για τη δημιουργία ενός ολοκληρωμένου νομικού πλαισίου για την προστασία των γυναικών από οποιαδήποτε μορφή βίας.

Ευρωπαϊκή Ένωση = οικονομικός και πολιτικός οργανισμός μεταξύ 28 χωρών της ευρωπαϊκής ηπείρου που δημιουργήθηκαν μετά τον Δεύτερο Παγκόσμιο Πόλεμο με στόχο την προώθηση μεγαλύτερης οικονομικής συνεργασίας μεταξύ των κρατών μελών. Με την πάροδο του χρόνου, έχει καταστεί οργανισμός που αποσκοπεί στη δημιουργία των βάσεων μιας Ένωσης μεταξύ των ευρωπαϊκών λαών, διασφαλίζοντας τις χώρες και επιδιώκοντας πολιτική ενότητα εξασφαλίζοντας, μέσω κοινής δράσης, οικονομική και κοινωνική πρόοδο, όπως η δημιουργία ενιαίας ευρωπαϊκής αγοράς και η ενίσχυση της κοινωνικής συνοχής.

Χάρτης Θεμελιωδών Δικαιωμάτων της Ευρωπαϊκής Ένωσης (Χάρτης της Νίκαιας)= διακηρύχθηκε κατά τη διάρκεια του Ευρωπαϊκού Συμβουλίου της Νίκαιας στις 20 Δεκεμβρίου 2000, ενώ συγκεντρώνει όλα τα αστικά, πολιτικά, οικονομικά και κοινωνικά δικαιώματα που ισχύουν στην Ευρωπαϊκή Ένωση και καθιερώνει τη θεμελιώδη φύση και το πεδίο των ανθρωπίνων δικαιωμάτων για τους πολίτες της ΕΕ. Παρόλο που κατέστη νομικώς δεσμευτική μόνο μετά την έναρξη ισχύος της Συνθήκης της Λισαβόνας, ενέπνευσε, από τότε που ξεκίνησε, τη δραστηριότητα του Ευρωπαϊκού Κοινοβουλίου. Με τη θέση σε ισχύ της Συνθήκης της Λισαβόνας, ο Χάρτης της Νίκαιας έχει το ίδιο νομικό κύρος με τις συνθήκες και ως εκ τούτου είναι πλήρως δεσμευτικός για τα ευρωπαϊκά θεσμικά όργανα και τα κράτη μέλη.

Δικαστήριο της Ευρωπαϊκής Ένωσης (Δικαστήριο ΔΕΕ - Δικαστήριο του Λουξεμβούργου)= ιδρύθηκε το 1952, εδρεύει στο Λουξεμβούργο και ερμηνεύει το δίκαιο της ΕΕ για να διασφαλίσει ότι εφαρμόζεται με τον ίδιο τρόπο σε όλα τα κράτη μέλη, ενώ επιλύει νομικές διαφορές μεταξύ των εθνικών κυβερνήσεων και των θεσμικών οργάνων της ΕΕ.

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Τα δικαιώματα των παιδιών

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ΤΑ ΔΙΚΑΙΩΜΑΤΑ ΤΩΝ ΠΑΙΔΙΩΝ

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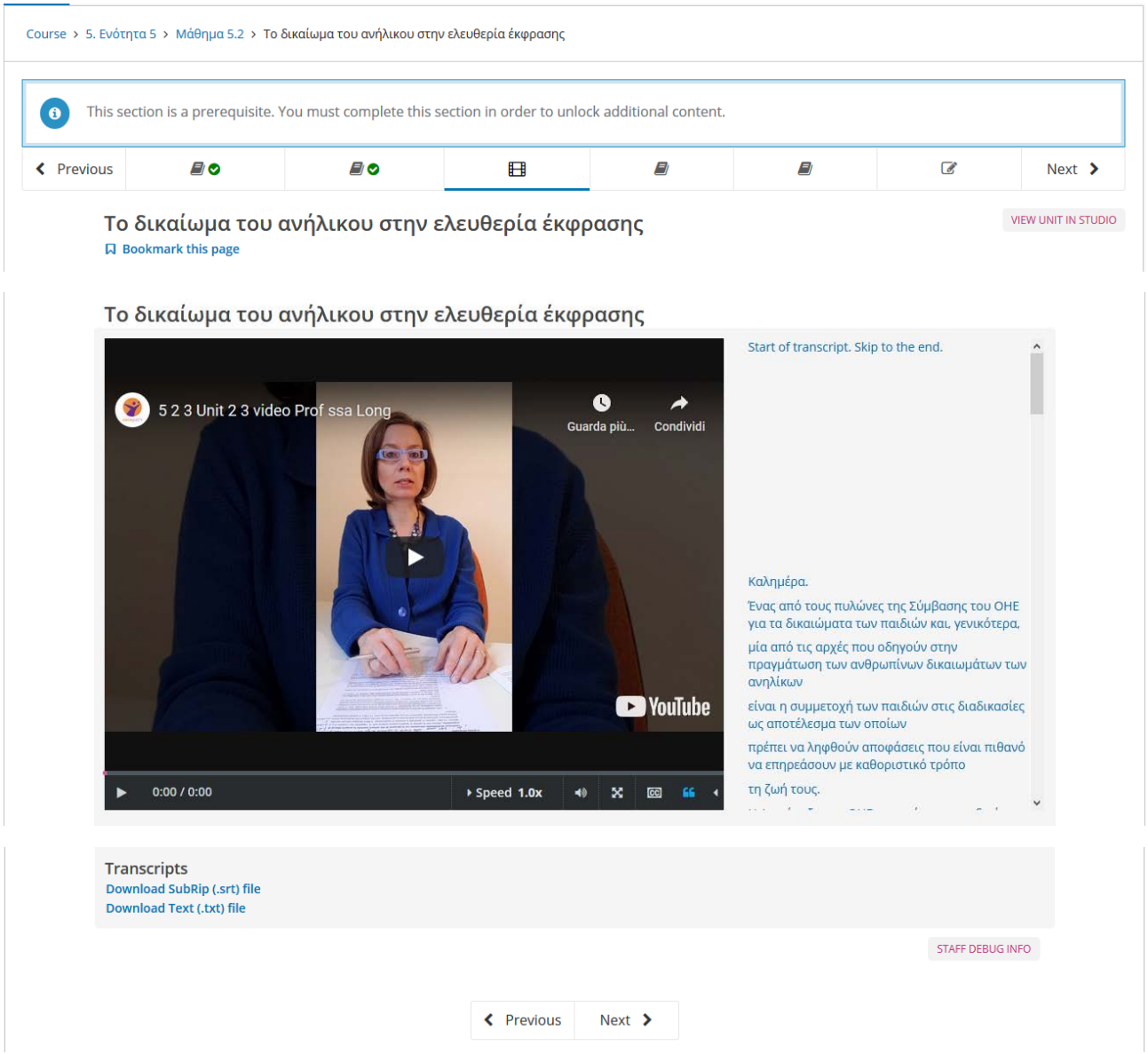

Transcript

Καλημέρα.

Ένας από τους πυλώνες της Σύμβασης του ΟΗΕ για τα δικαιώματα των παιδιών και, γενικότερα,

μία από τις αρχές που οδηγούν στην πραγμάτωση των ανθρωπίνων δικαιωμάτων των ανηλίκων

είναι η συμμετοχή των παιδιών στις διαδικασίες ως αποτέλεσμα των οποίων

πρέπει να ληφθούν αποφάσεις που είναι πιθανό να επηρεάσουν με καθοριστικό τρόπο

τη ζωή τους.

Η Διακήρυξη του ΟΗΕ σχετικά με τα παιδικά δικαιώματα αναγνωρίζει το δικαίωμα του ανηλίκου, ως ανθρώπου,

στην ελευθερία έκφρασης στο άρθρο 12, παράγραφος 1. Και στην επόμενη παράγραφο, την παράγραφο 2,

προσδιορίζει ένα από τα εργαλεία που εγγυώνται τη συμμετοχή του ανηλίκου στις διαδικασίες,

ειδικά το δικαίωμα της ακρόασης, εκ μέρους του δικαστή ή εκ μέρους

των άλλων διοικητικών αρχών που θα λάβουν αποφάσεις προς όφελος του παιδιού.

Αλλά η ακρόαση δεν είναι το μοναδικό εργαλείο που εγγυάται τη συμμετοχή του ανηλίκου

στις αποφάσεις που τον αφορούν.

Η ευρωπαϊκή Διακήρυξη άσκησης των δικαιωμάτων Ανηλίκων, που αφορά συγκεκριμένα

τις νομικές διαδικασίες, στο άρθρο 3 αναγνωρίζει το δικαίωμα του ανηλίκου «να λαμβάνει κάθε σχετική πληροφορία»

και στο άρθρο 4 αναγνωρίζει το δικαίωμα του ανηλίκου να «ζητά [...] τον διορισμό»

«ενός ειδικού αντιπροσώπου» όταν μεταξύ των ασκούντων τη γονική μέριμνα

και του ανηλίκου υπάρχει σύγκρουση συμφερόντων, ενός αντιπροσώπου, δηλαδή, που θα διαχειρίζεται

τις νομικές διαδικασίες.

Αλλά τι σημαίνει ακριβώς ακρόαση του ανηλίκου με κριτήριο την ελευθερία έκφρασής του;

Σημαίνει ότι, αν και ο λαμβάνων την απόφαση κατά την ακρόαση του ανηλίκου θα αποκτήσει

πληροφορίες που θα του είναι χρήσιμες για να καταλήξει στην απόφασή του, ο ενημερωτικός σκοπός

της ακρόασης είναι δευτερεύων απέναντι στη μείζονα σημασία της ακρόασης που είναι

να εγγυηθούμε στον ομιλούντα τη δυνατότητα να εκφραστεί σχετικά με ένα θέμα τόσο σημαντικό

για τη ζωή του.

Εξ ου και μερικές πρακτικές συνέπειες που αφορούν, για παράδειγμα, τον τρόπο ακρόασης.

Αυτό σημαίνει ότι η ακρόαση δεν μπορεί να διεξάγεται σαν ανάκριση ή σαν την ακρόαση

ενός μάρτυρα.

Σημαίνει όμως ότι, για παράδειγμα, ο ανήλικος θα μπορέσει να αρνηθεί την ακρόασή του

από τον δικαστή.

Καθώς η ακρόαση αποτελεί δικαίωμα, ο δικαιούχος μπορεί να επιλέξει να μην ασκήσει το δικαίωμά του.

Ή, επίσης, σε ό,τι αφορά τους λόγους για τους οποίους θα μπορεί να μην προβεί στην ακρόαση,

δεν θα μπορεί η μη ακρόαση ενός ανηλίκου να αιτιολογηθεί λέγοντας

ότι ήταν, στην προκείμενη περίπτωση, περιττή.

Ο μοναδικός λόγος για τον οποίο μπορεί να αποκλειστεί η ακρόαση είναι αν θεωρηθεί ότι η εν λόγω ακρόαση

θα ήταν αντίθετη στο συμφέρον του παιδιού.

Ένας άλλος πυλώνας της Σύμβασης του ΟΗΕ για τα δικαιώματα των παιδιών είναι ακριβώς

η προστασία του ανηλίκου και ο πυλώνας της προστασίας εξισορροπείται με τα δικαιώματα του παιδιού

στη συμμετοχή στις διαδικασίες που το αφορούν.

Και αυτή η ανάγκη εξισορρόπησης προκύπτει επίσης με αναφορά στον ρόλο που διαδραματίζει

η εκδηλωμένη επιθυμία του ανηλίκου κατά την ακρόαση στη λήψη της τελικής απόφασης από την αρμόδια αρχή.

Η αρχή, πράγματι, δεν μπορεί να θεωρείται δεσμευμένη από την εκδηλωμένη επιθυμία του ανηλίκου.

Μπορεί να συμβεί η αρχή να θεωρήσει ότι η εκδηλωμένη επιθυμία του ανηλίκου

στην πραγματικότητα αντιβαίνει στο συμφέρον του.

Ας πούμε, για παράδειγμα, ότι κάποιος ανήλικος, στο πλαίσιο μιας πολιτικής δικονομίας

που αφορά ενδοοικογενειακές κακομεταχειρίσεις, επιμένει να δει τον γονέα του

ή γενικότερα τον ενήλικα που τον κακομεταχειρίστηκε.

Σε αυτή την περίπτωση η αρχή μπορεί να αρνηθεί τις επισκέψεις, να συνεχίσει να τηρεί την αναστολή τους,

ακόμα κι όταν αυτό είναι αντίθετο στην εκδηλωμένη επιθυμία του ανηλίκου.

Υπάρχει διαφορά, λοιπόν, σε σύγκριση με ό,τι ισχύει για τον ενήλικα.

Ο ενήλικας, μάλιστα, έχει το δικαίωμα να αρνηθεί την υγειονομική περίθαλψη

ακόμα κι όταν αυτή η άρνηση συνεπάγεται βέβαιο θάνατο.

Δεν ισχύει το ίδιο για τον ανήλικο γιατί, όπως είπα, το δικαίωμα συμμετοχής

και γενικά το δικαίωμα αυτοδιάθεσης πρέπει να εξισορροπείται με την αρχή

του μείζονος συμφέροντος του παιδιού.

Η ανάγκη εξισορρόπησης επιβάλλει, ωστόσο, στη δικαστική αρχή και γενικά στις αρχές

λήψης αποφάσεων σχετικών με τη ζωή του παιδιού, να ενημερώνουν τον ανήλικα σχετικά με τη ληφθείσα απόφαση

και να εκθέτουν επακριβώς τους λόγους για τους οποίους δεν στάθηκε δυνατό

να σεβαστούν την εκδηλωμένη επιθυμία του παιδιού κατά τη διάρκεια της ακρόασης.

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"Νόμος περί τέκνων"

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Εισαγωγή στην ταινία "Νόμος περί Τέκνων"

Οι κύριοι χαρακτήρες της ταινίας είναι ο Άνταμ, ένα δεκαεπτάχρονο αγόρι, το οποίο αρνείται μια σωτήρια μετάγγιση αίματος για θρησκευτικούς λόγους σε συμφωνία με τους γονείς του, και η Φιόνα Μέι, μια Αγγλίδα δικαστής στον τομέα της οικογένειας και των ανηλίκων, που καλείται να αποφασίσει εάν θα επιτραπεί στους γιατρούς να προχωρήσουν στη μετάγγιση αίματος πάραυτα.

Η ταινία μας επιτρέπει να συλλογιστούμε τα δύο χαρακτηριστικά γνωρίσματα της αρχής των δικαιωμάτων των ανηλίκων για ακρόαση, όπως περιγράφονται στο άρθρο 12 της Σύμβασης των Ηνωμένων Εθνών για τα Δικαιώματα του Παιδιού (CRC).

· **Η ακρόαση είναι ο τρόπος με τον οποίο ο ανήλικος ασκεί τη δική του ελευθερία έκφρασης**. Στην πραγματικότητα, η Φιόνα συναντά τον Άνταμ επειδή θέλει να τον «γνωρίσει» και δεν τον «ακούει» με τη μέθοδο της ανάκρισης ή της ακρόασης μάρτυρα. Δεν περιορίζει τη συνάντησή τους για να εξετάσει σε βάθος τους λόγους για την απόφασή του να αρνηθεί τη μετάγγιση, αλλά συνομιλεί μαζί του αγγίζοντας διάφορα θέματα, όπως η μουσική και η ποίηση.

· **Επιπλέον, η ακρόαση δεν δεσμεύει τον δικαστή με τη βούληση του ανηλίκου. Στην πραγματικότητα, η Φιόνα στην ταινία αποφασίζει να ενεργήσει κατά της βούλησης του Άνταμ**. Σε αντίθεση με τον ενήλικα, ο οποίος έχει το δικαίωμα να αποφασίσει για τη δική του ζωή, ακόμη κι εάν η απόφαση αυτή οδηγεί σε θάνατο (π.χ. τυπικό παράδειγμα της άρνησης μιας σωτήριας μετάγγισης αίματος για θρησκευτικούς λόγους), ο ανήλικος δεν έχει αυτό το δικαίωμα σε όλες τις περιπτώσεις: Το άρθρο 12 της Σύμβασης των Ηνωμένων Εθνών για τα Δικαιώματα του Παιδιού (CRC) ορίζει ότι όποιος αποφασίσει πρέπει να λάβει υπόψη τη γνώμη του ανηλίκου μαζί με την ανάπτυξη με βάση την ηλικία και το επίπεδο ωριμότητάς του, αλλά αυτό δεν είναι δεσμευτικό για τον δικαστή. Πράγματι, εάν ο δικαστής ή το πρόσωπο που καλείται να λάβει απόφαση σχετικά με έναν ανήλικο πιστεύει ότι η βούληση που εκφράζεται κατά την ακρόαση δεν είναι σύμφωνη με το συμφέρον του ανηλίκου, όχι μόνο έχει το δικαίωμα, αλλά πρέπει να αποφασίσει με τον αντίθετο τρόπο.

The Children Act - Official Trailer

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Υποστηρικτικό υλικό

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Handbook on European law rights relating to the rights of the child

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Quiz 5.2

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Q5.2

5 points possible (graded)

1. Τι περιλαμβάνει η σωματική τιμωρία εις βάρος του παιδιού;

- ○ Μόνο σωματική τιμωρία που αποσκοπεί στην πρόκληση πόνου στο παιδί
- ○ Αποκλειστικά σωματική τιμωρία που αποσκοπεί στην πρόκληση πόνου ή αναστάτωσης στο παιδί
- ○ Σωματικές ή μη σωματικές πράξεις, πέραν όσων γίνονται για τη διαπαιδαγώγηση των παιδιών
- ○ Και μη σωματικές πράξεις, όπως απειλές, που αποσκοπούν στην ταπείνωση του παιδιού

2. Ποιο από τα παρακάτω δεν ισχύει;

- ○ Απαγορεύεται η αδικαιολόγητη διαφοροποίηση ανάλογα με την ηλικία
- ○ Οι ανήλικοι έχουν δικαίωμα, εκ φύσεως, σε διαφοροποιημένη θεραπεία βάσει ηλικίας
- ○ Απαγορεύονται όλες οι θεραπείες που διαφοροποιούνται ανάλογα με την ηλικία
- ○ Η θεραπεία των παιδιών πρέπει να εμπνέεται από την αρχή του βέλτιστου συμφέροντος του παιδιού

3. Ποιο από τα ακόλουθα σχετικά με την ακρόαση ενός παιδιού ισχύει;

- ○ Πρέπει να διασφαλίζεται μόνο σε δικαστικές και διοικητικές διαδικασίες που το αφορούν
- ○ Μπορεί να διεξαχθεί όπως η ακρόαση ενός μάρτυρα, αλλά όχι ως ανάκριση
- ○ Μπορεί να αποκλειστεί όταν η γνώμη του παιδιού είναι περιττή
- ○ Πρέπει να διασφαλίζεται μόνο σε δικαστικές και όχι σε διοικητικές διαδικασίες που το αφορούν

4. Σε περίπτωση που γίνεται ακρόαση του παιδιού, είναι η γνώμη του παιδιού δεσμευτική για όσους αποφασίζουν;

- ○ Όχι, αλλά ο υπεύθυνος λήψης της απόφασης πρέπει να τη λάβει υπόψη του
- ○ Ναι
- ○ Όχι, ο υπεύθυνος λήψης της απόφασης μπορεί να την αγνοήσει
- ○ Ναι εφόσον το παιδί εμφανίζει υψηλό βαθμό ωριμότητας

5. Στην απόφαση της ΕΣΔΑ Z. ΚΑΙ ΑΛΛΟΙ εναντίον του ΗΝΩΜΕΝΟΥ ΒΑΣΙΛΕΙΟΥ, ποιο από τα ακόλουθα αναγνωρίζεται;

- ○ Άρθρο 5 ECHR (Δικαίωμα στην ελευθερία και την ασφάλεια)
- ○ Άρθρο 3 ECHR (Απαγόρευση των βασανιστηρίων)
- ○ Άρθρο 6 ECHR (Δικαίωμα σε δίκαιη δίκη)
- ○ Άρθρο 8 ECHR (Δικαίωμα σεβασμού της ιδιωτικής και οικογενειακής ζωής)

Invia | You have used 0 of 2 attempts

Salva | Show Answer

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Νομικό γλωσσάριο σχετικά με τη συμμετοχή των παιδιών

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Πρωτογενής θυματοποίηση = κακοποίηση ή βία, η οποία προκαλεί σοβαρές επιπτώσεις στην σωματική ή και ψυχολογική υγεία του ατόμου.

Δευτερογενής θυματοποίηση = περαιτέρω καταπόνηση που προκαλείται από το άγχος της ίδιας της διαδικασίας, από τη μνήμη της κακοποίησης που υπέστη το άτομο και από την πιθανή επαφή με τον υπαίτιο της συμπεριφοράς, τον δικαστή και τους δικηγόρους.

Ποινική διαδικασία = η δικαστική διαδικασία μέσω της οποίας ο δράστης της συμπεριφοράς κατά του ανηλίκου τιμωρείται, εάν η συμπεριφορά του αποτελεί έγκλημα.

Αστική διαδικασία =η διαδικασία δικαιοδοσίας κατά την οποία ένας δικαστής αξιολογεί την επάρκεια του οικογενειακού περιβάλλοντος του παιδιού και λαμβάνει τα απαραίτητα μέτρα.

Ακρόαση του ανηλίκου = μέρος της αστικής / ποινικής διαδικασίας κατά την οποία ο ανήλικος κάνει δηλώσεις σχετικά με τα γεγονότα που τον αφορούν και σχετίζονται με την απόφαση του δικαστή.

Διαβούλευση με τον ανήλικο = μέρος της διαδικασίας (ειδικά της αστικής) κατά την οποία ο ανήλικος εκφράζει τις απόψεις του, προτού ο δικαστής προβεί σε απόφαση.

Συναίνεση του ανηλίκου = περαιτέρω εγγύηση που συνίσταται στην υποχρέωση του δικαστή να λάβει την ευνοϊκή γνώμη του ανηλίκου προκειμένου να λάβει συγκεκριμένη απόφαση (για παράδειγμα, επιμέλεια ή υιοθεσία).

Εκπρόσωπος = όταν οι γονείς απουσιάζουν, δεν είναι διαθέσιμοι ή βρίσκονται σε σύγκρουση συμφερόντων, ο εκπρόσωπος είναι ένα άτομο που προσδιορίζει τα συμφέροντα του παιδιού και το προστατεύει κατά τη διάρκεια της διαδικασίας.

Δικηγόρος = εξουσιοδοτημένο άτομο που διορίζεται για λάβει μια δικαστική απόφαση στο μέτρο του δυνατού, σύμφωνα με τα συμφέροντα του παιδιού.

Κοινωνικός επαγγελματίας ή επαγγελματίας υγείας = εμπειρογνώμονας ψυχολογίας, ψυχιατρικής ή κοινωνιολογίας, ο οποίος βοηθά το τραυματισμένο παιδί κατά τη διάρκεια των αστικών και ποινικών διαδικασιών και βοηθά τον δικαστή να εκτιμήσει τις ψυχο-φυσικές καταστάσεις και τις ανάγκες του ώστε να το προστατεύσει.

Προληπτικά μέτρα = προσωρινά μέτρα, που εγκρίνονται από τον δικαστή, για την προστασία της ψυχοσωματικής ευημερίας του ανηλίκου κατά τη διάρκεια των διαδικασιών.

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Εκπαιδευτικό υλικό

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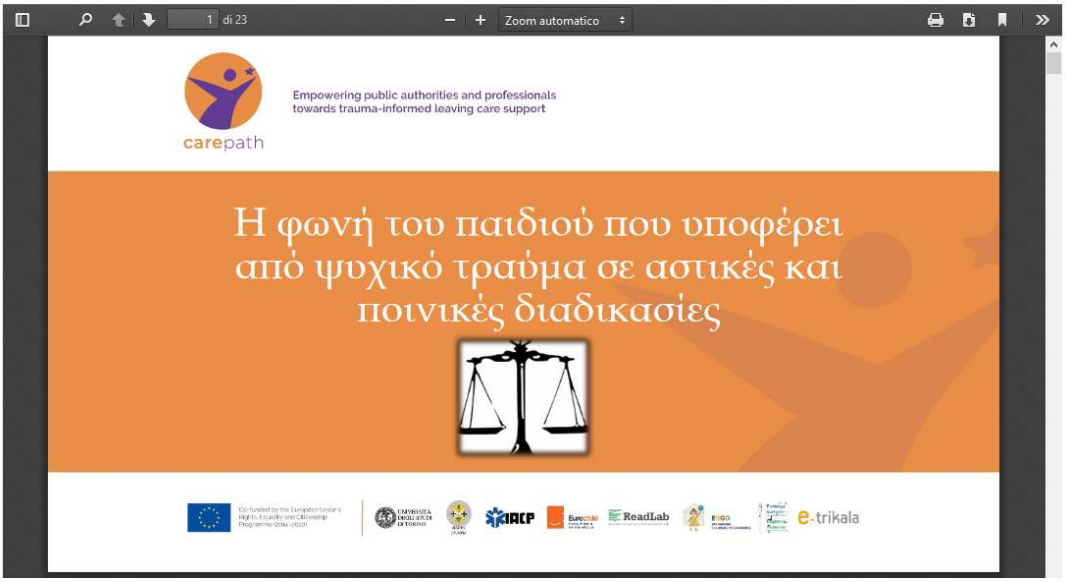
Η φωνή του παιδιού που υποφέρει από ψυχικό τραύμα σε αστικές και ποινικές διαδικασίες



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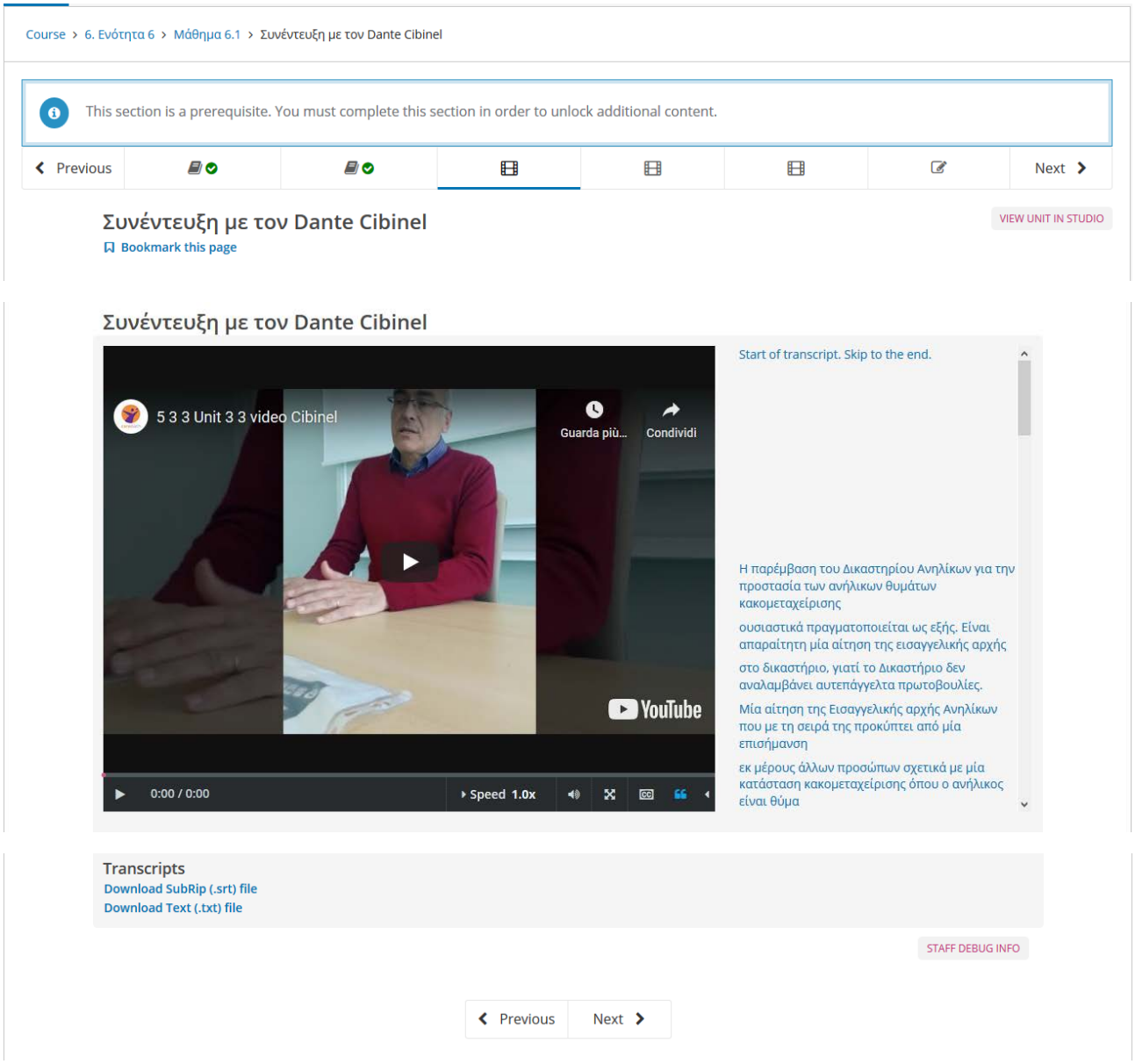


Transcript

Η παρέμβαση του Δικαστηρίου Ανηλίκων για την προστασία των ανήλικων θυμάτων κακομεταχείρισης ουσιαστικά πραγματοποιείται ως εξής. Είναι απαραίτητη μία αίτηση της εισαγγελικής αρχής στο δικαστήριο, γιατί το Δικαστήριο δεν αναλαμβάνει αυτεπάγγελτα πρωτοβουλίες.

Μία αίτηση της Εισαγγελικής αρχής Ανηλίκων που με τη σειρά της προκύπτει από μία επισήμανση εκ μέρους άλλων προσώπων σχετικά με μία κατάσταση κακομεταχείρισης όπου ο ανήλικος είναι θύμα στο οικογενειακό του περιβάλλον.

Αυτά τα άλλα πρόσωπα, που με τη σειρά τους επισημαίνουν στον Εισαγγελέα Ανηλίκων την κατάσταση κακομεταχείρισης, είναι κυρίως οι κοινωνικές υπηρεσίες αλλά μπορούν να είναι και οι σχολικές δομές όπου βρίσκεται το παιδί ή και οι αρχές της Δικαστικής Αστυνομίας που παρεμβαίνουν σε περιπτώσεις που αφορούν αδίκημα.

Προφανώς, υπάρχει και η παρέμβαση της Ποινικής Δικαστικής Αρχής αλλά συχνότατα,
όταν υπάρχουν υποψίες αδικήματος, οι παρεμβάσεις είναι ταυτόχρονες: το Δικαστήριο Ανηλίκων
παρεμβαίνει για τα μέτρα προστασίας, η Ποινική Δικαστική Αρχή παρεμβαίνει
για την διαπίστωση ύπαρξης ή όχι αδικημάτων.
Η παρέμβαση του Δικαστηρίου εξαρτάται από τον τύπο έρευνας που έχει διεξαγάγει ο Εισαγγελέας
στο Δικαστήριο.
Υπάρχουν περιπτώσεις, σοβαρότατες περιπτώσεις, κατά τις οποίες ο Εισαγγελέας,
μπορεί να ζητήσει άμεση και επείγουσα παρέμβαση για την απομάκρυνση του παιδιού
και το Δικαστήριο μπορεί να παρέμβει αναλόγως. Ή περιπτώσεις κατά τις οποίες εξ αρχής
ο Εισαγγελέας ζητά από το Δικαστήριο να προβεί σε ελέγχους για να εξακριβώσει
τη σοβαρότητα της καταγγελθείσας κατάστασης, το κατά πόσο αληθεύει η καταγγελθείσα κατάσταση
και τη σοβαρότητά της και να ορίσει τις κατάλληλες παρεμβάσεις για την προστασία του ανηλίκου.
Κατά τη διάρκεια αυτών των ελέγχων,
ή αμέσως μετά το ενδεχόμενο μέτρο της απομάκρυνσης,
όταν υπάρχει ανάγκη, όταν το Δικαστήριο θεωρεί απολύτως αναγκαία τη λήψη του μέτρου απομάκρυνσης,
στη διάρκεια αυτών των ελέγχων, λοιπόν,
παρεμβαίνουν οι καταγγέλλουσες υπηρεσίες αλλά και άλλες, όπως οι υπηρεσίες που ειδικεύονται στην ψυχολογία,
ή ακόμα παρεμβαίνουν και οι ίδιοι οι γονείς, αν και, προφανώς, η δική τους παρέμβαση
είναι ιδιάζουσα, αλλά στο πλαίσιο της διαδικασίας ο νόμος προβλέπει
να τους ακούσουν πριν το Δικαστήριο λάβει οριστικά μέτρα προστασίας των ανηλίκων
όπως μέτρα περιορισμού της ευθύνης των γονέων,
ή και «αφαιρετικά» μέτρα, όπως αποκαλούνται, δηλαδή μέτρα αποκλεισμού των γονέων από την ευθύνη,
αν φυσικά ο Εισαγγελέας έχει ζητήσει
απόφαση αυτού του τύπου.
Επίσης, γίνεται ακρόαση και του παιδιού σε αυτές τις διαδικασίες, αν έχει συμπληρώσει τα 12 έτη,
όπως ορίζει ο νόμος, ή δεν τα έχει συμπληρώσει αλλά ο Δικαστής το θεωρεί ικανό
να εκφραστεί, να το ακούσουν, λοιπόν, και να εκφράσει μία δική του εκτίμηση
Της κατάστασης.
Προφανώς, είναι μία εκτίμηση που ο Δικαστής θα αξιολογήσει ελεύθερα για να κατανοήσει
κυρίως τις επιθυμίες αλλά και την πραγματική ψυχολογική κατάσταση του ανηλίκου.

Ωστόσο, επαναλαμβάνω: πρόκειται για μία πραγματική ψυχολογική κατάσταση του παιδιού και άρα διαπιστώνεται

και αξιολογείται μέσω της παρέμβασης των εξειδικευμένων υπηρεσιών

που ακούν το παιδί και αναφέρουν στον Δικαστή όσα ήταν σε θέση,

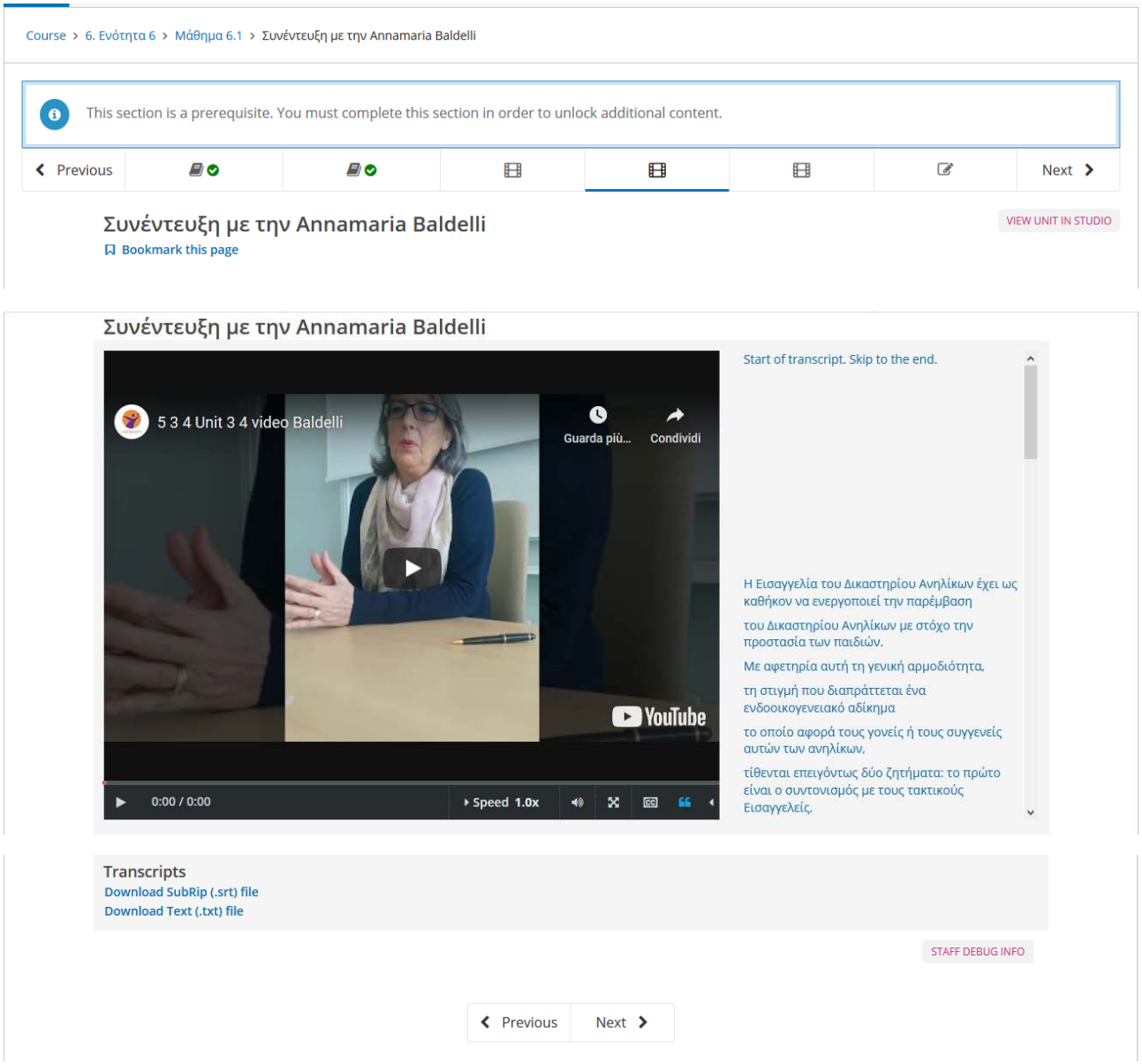
ανάλογα με την ηλικία του,

να πει ο ανήλικος.

Πρόκειται για μία μορφή ακρόασης «με διαμεσολάβηση», θα λέγαμε, που διεξάγεται από άλλα πρόσωπα,

με ειδικές επαγγελματικές δεξιότητες, την οποία χρησιμοποιεί ο Δικαστής

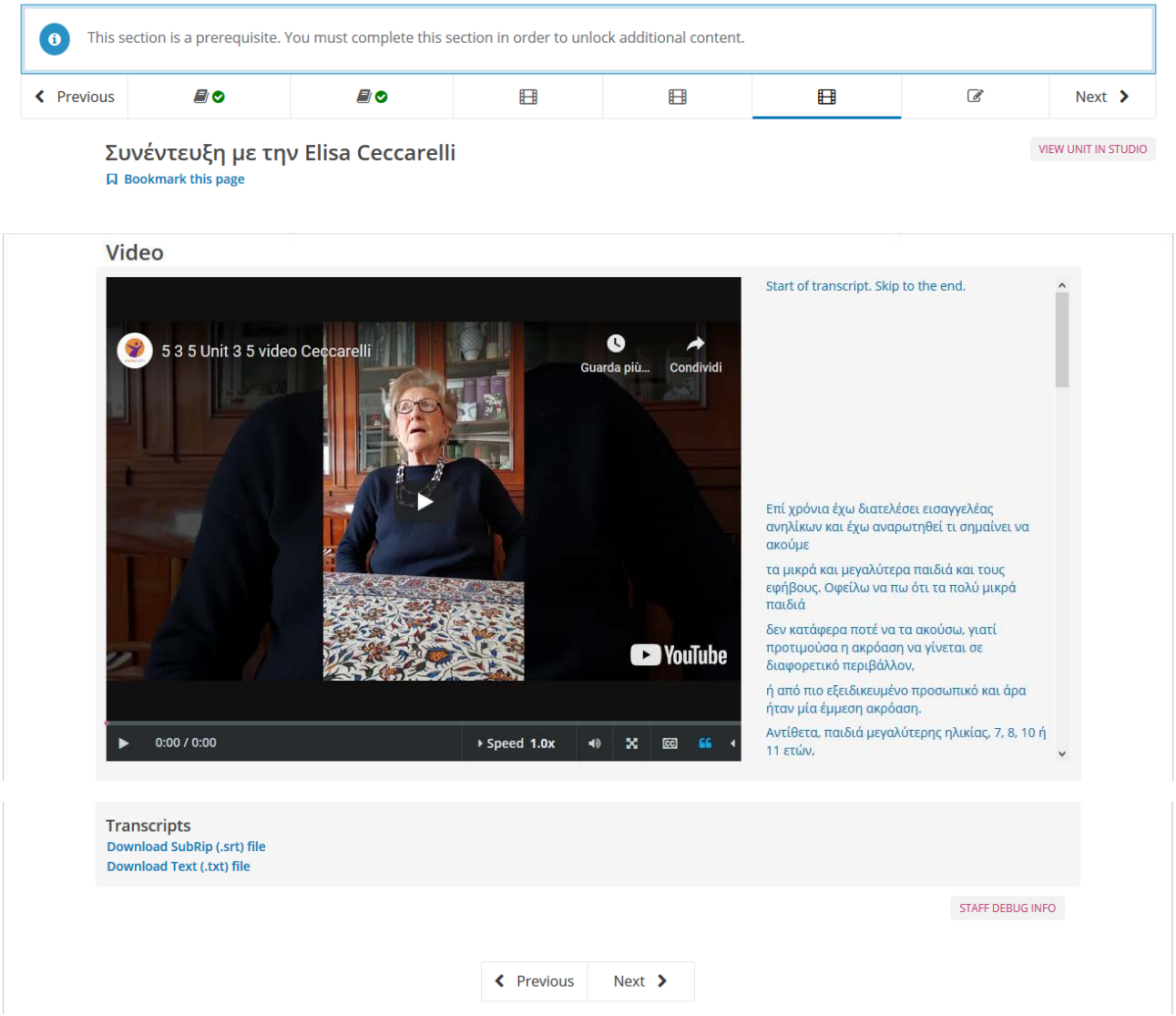
για να λάβει την απόφασή του.



Transcript

Η Εισαγγελία του Δικαστηρίου Ανηλίκων έχει ως καθήκον να ενεργοποιεί την παρέμβαση
του Δικαστηρίου Ανηλίκων με στόχο την προστασία των παιδιών.
Με αφετηρία αυτή τη γενική αρμοδιότητα,
τη στιγμή που διαπράττεται ένα ενδοοικογενειακό αδίκημα
το οποίο αφορά τους γονείς ή τους συγγενείς αυτών των ανηλίκων,
τίθενται επειγόντως δύο ζητήματα: το πρώτο είναι ο συντονισμός με τους τακτικούς Εισαγγελείς,
που έχουν την αρμοδιότητα της ποινικής διαδικασίας, για να αποφευχθούν παρεμβάσεις
που θα μπορούσαν να βλάψουν την ποινική δίωξη,
και το δεύτερο είναι η συλλογή στοιχείων, όχι μόνο για τη γνώση
της κατάστασης σημαντικής ζημίας,

αλλά και στοιχείων για τη γνώση σχετικά με μέσα προσωπικά
και οικογενειακά, ίσως και άλλων συγγενών αλλά και μέσα κοινωνικά, που βρίσκονται
γύρω από αυτό το παιδί, για να στοιχειοθετηθεί μία προσφυγή στο Δικαστήριο Ανηλίκων
με σωστές προοπτικές παρέμβασης.
Η βασική δυσκολία είναι ο περιορισμός των καθυστερήσεων,
γιατί η διαδικασία προστασίας, όπως και η ποινική, έχουν τους χρόνους τους
που δεν είναι πάντα ελεγχόμενοι. Εμείς προσπαθήσαμε να ζητήσουμε
από τις αστυνομικές αρχές να ενημερώνουν συγχρόνως, τόσο την τακτική Εισαγγελία,
αρμόδια για την ποινική διαδικασία απέναντι στον διαπράττοντα το αδίκημα,
όσο και την Εισαγγελία Ανηλίκων, αρμόδια για την προστασία του θύματος του αδικήματος,
ώστε αυτές οι υπηρεσίες να αναγκαστούν να συντονιστούν με τρόπο
έγκαιρο και άμεσο, δηλαδή ήδη από τα πρώτα στάδια της έρευνας.
Αυτός ο τρόπος, υποβοηθούμενος
από συμβάσεις με ποικίλες Εισαγγελίες, μας επέτρεψε να προσδιορίσουμε
ποιος κάνει τι, πότε και πώς, καλύπτοντας, όπως είπα και πριν, τις απαιτήσεις
της σωστής ποινικής διαδικασίας αλλά και τις απαιτήσεις της προστασίας του ανηλίκου.
Ενίοτε μπορεί να συμβεί, κυρίως όταν τα παιδιά νοσηλεύονται στο νοσοκομείο
και δεν υπάρχει διαφωνία των γονέων για τη νοσηλεία, ενίοτε είναι πιθανές
κάποιες καθυστερήσεις στην παρέμβαση της προστασίας και άρα καθυστερήσεις στην παρέμβαση
του Δικαστηρίου Ανηλίκων, γιατί ο ανήλικος χαίρει εκ των πραγμάτων προστασίας
λόγω της νοσηλείας στο νοσοκομείο, επιτρέποντας στον τακτικό Εισαγγελέα, αρμόδιο για την ποινική διαδικασία
απέναντι στον διαπράττοντα το αδίκημα, να προβεί στις απαιτούμενες διαπιστώσεις
με μυστικότητα και άρα αποτελεσματικά.
Όταν πλέον είναι σαφές
ότι δεν μπορεί να αναβληθεί μία πρόβλεψη προστασίας, ο συνάδελφος στην τακτική Εισαγγελία,
αρμόδιος για την ποινική διαδικασία, μπορεί να εκδώσει διοικητική πρόβλεψη προστασίας
μέσω της Δικαστικής Αστυνομίας, σύμφωνα με το άρθρο 403 του αστικού κώδικα,
δηλαδή να θέσει σε προστασία τον ανήλικο, ώσπου στη συνέχεια, με δική μας προσφυγή,
το Δικαστήριο Ανηλίκων να μπορεί να κυρώσει αυτό το προσωρινό μέσο προστασίας.



Transcript

Επί χρόνια έχω διατελέσει εισαγγελέας ανηλίκων και έχω αναρωτηθεί τι σημαίνει να ακούμε

τα μικρά και μεγαλύτερα παιδιά και τους εφήβους. Οφείλω να πω ότι τα πολύ μικρά παιδιά

δεν κατάφερα ποτέ να τα ακούσω, γιατί προτιμούσα η ακρόαση να γίνεται σε διαφορετικό περιβάλλον,

ή από πιο εξειδικευμένο προσωπικό και άρα ήταν μία έμμεση ακρόαση.

Αντίθετα, παιδιά μεγαλύτερης ηλικίας, 7, 8, 10 ή 11 ετών,

έχω ακούσει πολλά.

Κυρίως ήταν παιδιά μέσα σε έντονα συγκρουσιακά οικογενειακά περιβάλλοντα, με γονείς

που δεν αποφάσιζαν να χωρίσουν ή χωρισμένους, αλλά πάντοτε δεμένους μέσω σύγκρουσης και εκδίκησης,

που είχαν βαρύ αντίκτυπο στα παιδιά τους.

Αυτό που προσπαθούσα να πω στα παιδιά,

σε αυτές τις ακροάσεις, ήταν πάνω από όλα ότι υπήρχε κάποιος
που πραγματικά τα άκουγε,
κάποιος που είχε συγκεκριμένο καθήκον να αποφασίσει για το καλύτερο δυνατό για εκείνα,
και η απόφαση αυτή αναγκαστικά
μπορούσε να διαφέρει από ό,τι τα παιδιά
επιθυμούσαν ή εξέφραζαν.
Ωστόσο, αυτό ακριβώς προσπαθούσα να τους πω.
Η απόφαση εξαρτάται από το Δικαστήριο και τον δικαστή. Δουλειά του δικαστή είναι να αποφασίζει
και άρα λαμβάνω υπόψη ό,τι μου διηγείσαι,
θα προσπαθήσω να είμαι όσο γίνεται πιο προσεκτική
να κάνω το καλύτερο για σένα
αλλά η απόφαση δεν θα ταυτίζεται πάντα
με την επιθυμία σου. Αυτό είναι κάτι που συμβαίνει πάντα στη ζωή μας
Και πρέπει να συνηθίσεις να ζεις με αυτό το δεδομένο.
Σε ό,τι αφορά τους γονείς, προσπαθούσα πάντα να διαφυλάξω τη θετική πλευρά της σχέσης των παιδιών
με τους γονείς τους, δηλαδή προσπαθούσα να εξηγήσω Ότι ο μπαμπάς, γενικά οι πατέρες ήταν
πολύ αυταρχικοί στις σχέσεις με τα παιδιά
και άρα τα εξανάγκαζαν να κάνουν πράγματα
που θεωρούσαν χρήσιμα στη συγκρουσιακή τους σχέση με την πρώην σύντροφο,
προσπαθούσα, λοιπόν, να πω το εξής.
«Κοίτα, ο μπαμπάς δεν έχει κάτι εναντίον σου και είναι σωστό να αγαπάς τον μπαμπά».
«Αλλά ξέρουμε ότι έχει κάποια προβλήματα, ότι δεν δέχεται αυτή την κατάσταση».
Πρέπει, λοιπόν, να μπορούμε να διαφυλάξουμε αυτή τη μορφή του μπαμπά.
Εννοώ, δηλαδή, να μην εμμένουμε ποτέ σε συγκρουσιακές συμπεριφορές προς το παιδί.
Γιατίν παράλληλα
προσπαθούμε να διαφυλάξουμε,
τη δυνατότητα του παιδιού να μπορεί να αρνηθεί,
λέγοντας «Όχι, δεν αντέχω άλλο να είμαι με αυτόν τον μπαμπά, δεν αντέχω άλλο»
γιατί το παιδί δεν καταλαβαίνει τελικά.
Θυμάμαι την περίπτωση ενός κοριτσιού περίπου 10 ετών που είχε και τους δύο γονείς.
Ο πατέρας ήταν εξαιρετικά παθολογικός και η προσέγγισή μας ήταν η εξής.
«Εντάξει, περιμένουμε να αλλάξει ο μπαμπάς και αν δεν καταφέρει να αλλάξει,»

«όλο αυτό το βάρος φυσικά δεν θα πρέπει να το σηκώσει το κορίτσι».

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Quiz 6.1

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Q6.1

7 points possible (graded)

1) Η δευτερογενής θυματοποίηση προκαλείται από:

- ○ το άγχος που προκαλείται στους ανηλίκους κατά τη συμμετοχή τους στη διαδικασία
- ○ την παραβίαση που αισθάνονται από την αναγκαία παρέμβαση της δικαστικής αρχής
- ○ το άγχος που προκύπτει από την τοποθέτηση των ανηλίκων σε μια νέα οικογένεια
- ○ την επανάληψη της παραβίασης που είχαν υποστεί

2) Η αρχή του βέλτιστου συμφέροντος του παιδιού:

- ○ εφαρμόζεται μόνο στις ποινικές διαδικασίες
- ○ συνεπάγεται ότι ο δικαστής πρέπει πάντα να λαμβάνει υπόψη, πάνω από όλα, την ψυχολογική και φυσική κατάσταση του παιδιού
- ○ εφαρμόζεται μόνο στις αστικές διαδικασίες
- ○ υποχρεώνει τα κράτη να αποφεύγουν τη συμμετοχή του ανηλίκου σε οποιαδήποτε διαδικασία μετά το παραβιαστικό τραυματικό γεγονός

3) Η ακρόαση του παιδιού ως μάρτυρα:

- ○ πρέπει πάντα να εκτελείται από τον δικαστή
- ○ είναι προτιμότερο να διεξάγεται στο τελευταίο μέρος της διαδικασίας
- ○ είναι καλύτερα να επαναλαμβάνεται τουλάχιστον δύο φορές, για να ελεγχθεί η αξιοπιστία του παιδιού
- ○ είναι προτιμότερο να διεξάγεται κατά την έναρξη της διαδικασίας

4) Η γνώμη που εξέφρασε ο ανήλικος κατά τη διάρκεια της διαδικασίας:

- ○ δεν είναι δεσμευτική, αλλά ο δικαστής πρέπει να την λάβει υπόψη για να αποφασίσει
- ○ είναι πάντοτε δεσμευτική για τον δικαστή
- ○ είναι δεσμευτική για τον δικαστή, αλλά μόνο αν ο ανήλικος είναι τουλάχιστον 14 χρονών
- ○ είναι δεσμευτική για τον δικαστή, αλλά μόνο αν ο ανήλικος έχει επαρκή αντιληπτική ικανότητα

5) Οι ποινικές και αστικές διαδικασίες που ακολουθούν την παραβίαση των παιδιών:

- ○ είναι ξεχωριστές, αλλά η αστική μπορεί να ξεκινήσει μόνο μετά την ποινική
- ○ είναι ξεχωριστές, αλλά η αστική μπορεί να ξεκινήσει μόνο αν, κατά τις ποινικές διαδικασίες, οι γονείς έχουν καταδικαστεί
- ○ αντιμετωπίζουν διαφορετικά θέματα και έχουν διαφορετικούς σκοπούς
- ○ έχουν τον ίδιο σκοπό και το ίδιο αντικείμενο

6) Πότε ο δικαστής διατάσσει ένα προληπτικό μέτρο;

- ○ στο τέλος των διαδικασιών
- ○ προτού ξεκινήσουν οι διαδικασίες
- ○ κατά την διάρκεια των διαδικασιών, για να προστατέψει την φυσική και ψυχική ισορροπία του παιδιού
- ○ κατά τη διάρκεια της διαδικασίας, να εξασφαλίσει την εύλογη διάρκεια της διαδικασίας

7) Εξώδικες διαδικασίες:

- ○ εφαρμόζονται όταν η σχέση μεταξύ του δράστη της παραβίασης και του ανηλίκου φαίνεται να είναι μη θεραπεύσιμη
- ○ εφαρμόζονται μόνο όταν η κακοποίηση είναι σοβαρή
- ○ πρέπει πάντα να εφαρμόζονται
- ○ εφαρμόζονται μόνο όταν η κακομεταχείριση δεν είναι πολύ σοβαρή

Invia | You have used 0 of 2 attempts

Salva | Show Answer

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Νομικό γλωσσάριο για τις πολιτικές των παιδιών

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Κοινωνικές υπηρεσίες = φάσμα υπηρεσιών που παρέχονται από δημόσιους ή ιδιωτικούς φορείς, οι οποίοι ανταποκρίνονται στις συλλογικές και προσωπικές ανάγκες των ανθρώπων. Παρόλο που ο όρος "υπηρεσίες" συνήθως αναφέρεται σε τυποποιημένες διεργασίες, οι οποίες παρέχονται παγκοσμίως στους ανθρώπους ως μέλη μιας κατηγορίας, οι "κοινωνικές υπηρεσίες" ανταποκρίνονται στις "ειδικές ανάγκες" των δικαιούχων.

Κοινωνικές υπηρεσίες για παιδιά και οικογένειες = σειρά μέτρων και δραστηριοτήτων που ανταποκρίνονται στις γενικές ή ατομικές ανάγκες ενός παιδιού ή / και της οικογένειάς του. Αυτού του είδους οι υπηρεσίες στοχεύουν στην ικανοποίηση των διαφορετικών αναγκών των παιδιών και των οικογενειών, όπως ακριβώς κάνουν οι εξειδικευμένες και εντατικές υπηρεσίες.

Κοινωνικές υπηρεσίες φιλικές προς τα παιδιά = κοινωνικές υπηρεσίες που σέβονται, προστατεύουν και αντιλαμβάνονται τα δικαιώματα κάθε παιδιού, συμπεριλαμβανομένου του δικαιώματος πρόσβασης σε παροχές, συμμετοχής και προστασίας και της αρχής του βέλτιστου συμφέροντος του παιδιού. (Σύσταση του Συμβουλίου της Ευρώπης, 16 Νοεμβρίου 2011, αρ. 12, σχετικά με τα δικαιώματα των παιδιών και τις κοινωνικές υπηρεσίες για τα παιδιά και τις οικογένειές τους)

Δικαιοσύνη φιλική προς τα παιδιά = δικαστικά συστήματα που εγγυώνται το σεβασμό και την αποτελεσματική εφαρμογή όλων των δικαιωμάτων των παιδιών στο υψηλότερο δυνατό επίπεδο, λαμβανομένου υπόψη του βαθμού ωριμότητας και κατανόησης του παιδιού. Πρόκειται για προσβάσιμη δικαιοσύνη, προσαρμοσμένη στην ηλικία, ταχεία, επιμελής, προσαρμοσμένη στις ανάγκες του παιδιού και επικεντρωμένη σε αυτά, όσον αφορά τα δικαιώματα τους, συμπεριλαμβανομένου του δικαιώματος για δίκαιη διαδικασία, συμμετοχή και κατανόηση της διαδικασίας, σεβασμό της ιδιωτικής και οικογενειακής ζωής, ακεραιότητα και αξιοπρέπεια. (Βλέπε τις κατευθυντήριες γραμμές της Επιτροπής Υπουργών του Συμβουλίου της Ευρώπης για την φιλική προς τα παιδιά δικαιοσύνη, που εγκρίθηκε από την Επιτροπή Υπουργών του Συμβουλίου της Ευρώπης στις 17 Νοεμβρίου 2010)

Παιδεία και φροντίδα στην παιδική ηλικία (εκπαίδευση και φροντίδα στην παιδική ηλικία ή ECEC) = υπηρεσία που προσφέρεται στα παιδιά από τη γέννηση τους έως την πρωτοβάθμια εκπαίδευση και υπόκειται σε εθνικό κανονιστικό πλαίσιο και σε συμμόρφωση με ένα σύνολο ελάχιστων προτύπων ή / και διαδικασιών διαπίστευσης. Η υπηρεσία περιλαμβάνει ιδιωτικές, δημόσιες και εθελοντικές υπηρεσίες. Οι ευρωπαϊκές χώρες παρουσιάζουν διαφορετικές λύσεις για να εξασφαλίσουν την εκπαίδευση και τη φροντίδα των παιδιών κάτω από την ηλικία της υποχρεωτικής εκπαίδευσης. Εντούτοις, η ECEC καθίσταται όλο και περισσότερο αναπόσπαστο μέρος των εκπαιδευτικών συστημάτων στην Ευρώπη.

(Βλέπε https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2011:0066:FIN:IT:PDF)

Ευρωπαϊκός χώρος τριτοβάθμιας εκπαίδευσης (European Higher Education Area - EHEA) = έργο που στοχεύει στην επίτευξη διαδικασίας σύγκλισης και ενίσχυσης της τριτοβάθμιας εκπαίδευσης ή των πανεπιστημιακών σπουδών στην Ευρώπη. Η διαδικασία αυτή ευθυγραμμίζεται με τις στρατηγικές που έχει η Ευρωπαϊκή Επιτροπή μαζί με τα κράτη μέλη της Ένωσης και ξεκίνησε τα τελευταία χρόνια για την οικοδόμηση μιας πραγματικής Ευρώπης της γνώσης και έχει ως κύριο σκοπό την προώθηση της κινητικότητας και της απασχόλησης των σπουδαστών, να καταστήσουν τα εκπαιδευτικά συστήματα πιο ανταγωνιστικά, να προσελκύσουν μαθητές (και εκπαιδευτικούς) από την Ευρώπη και άλλα μέρη του κόσμου. Τα μέσα για την επίτευξη αυτού του στόχου είναι η στήριξη για μεγαλύτερη συγκρισιμότητα και συμβατότητα μεταξύ των διαφόρων συστημάτων και των διαφόρων ιδρυμάτων της τριτοβάθμιας εκπαίδευσης στην Ευρώπη και για την αύξηση της ποιότητας τους .

(Βλέπε https://ec.europa.eu/education/education-in-the-eu/european-education-area_en)

Η υγειονομική περίθαλψη για τα παιδιά = οι πολιτικές και οι πρακτικές στον τομέα της υγειονομικής περίθαλψης εστιάζονται στα εξελισσόμενα δικαιώματα, στις ανάγκες, στα χαρακτηριστικά, τους πόρους και τις δυνατότητες των παιδιών, λαμβάνοντας υπόψη τη γνώμη τους. (Βλέπε https://rm.coe.int/168046ccef)

Προσέγγιση φιλική προς τα παιδιά για την υγειονομική περίθαλψη = ολοκληρωμένο εννοιολογικό και επιχειρησιακό πλαίσιο που σέβεται πλήρως τα δικαιώματα και τις ανάγκες των παιδιών στον τομέα της υγείας .

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Εκπαιδευτικό υλικό

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Διαμεσολαβητής του παιδιού

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Διαμεσολαβητής παιδιών

Οι αρμοδιότητες που αποδίδουν οι διάφοροι θεσμικοί νόμοι στον διαμεσολαβητή παιδιών οφείλονται σε διάφορες δράσεις: ακρόαση και συμμετοχή, προώθηση και ευαισθητοποίηση, συνεργασία, προετοιμασία προτάσεων, γνωμών και συστάσεων.

Η δραστηριότητα του διαμεσολαβητή παιδιών διαδραματίζει σήμερα ηγετικό ρόλο στις πολιτικές που αποσκοπούν στη διασφάλιση της γνώσης και του σεβασμού των δικαιωμάτων των παιδιών, ενώ επιτρέπει να δίνεται φωνή σε άτομα (παιδιά) που συχνά κινδυνεύουν να είναι αόρατα: https://www.youtube.com/watch?v=jWiE2jHX5yE.

Ο διαμεσολαβητής παιδιών εν περιλήψει:

• παρακολουθεί την εφαρμογή της Σύμβασης για τα δικαιώματα των παιδιών και των εφήβων στη χώρα και συμβάλλει στη διάδοση της γνώσης και της νοοτροπίας των δικαιωμάτων των παιδιών και των εφήβων,

• αναφέρει στις αρμόδιες αρχές τυχόν παραβιάσεις αυτών των δικαιωμάτων,

• ελέγχει ότι τα άτομα μικρής ηλικίας έχουν πλήρη πρόσβαση στα δικαιώματά τους,

• εκφράζει απόψεις για κανονιστικές προτάσεις σχετικά με τους ανηλίκους και για την προστασία των δικαιωμάτων και την ανάπτυξη των υποκειμένων κατά την ηλικία ανάπτυξης.

Πιο συγκεκριμένα, οι λειτουργίες και αρμοδιότητες των αρχών προστασίας (διαμεσολαβητές παιδιών) μπορούν να χωριστούν σε δύο βασικούς τομείς:

• Ο πρώτος τομέας είναι γενικής φύσης και μπορεί να προσδιοριστεί ως παρεμβάσεις για την προώθηση των δικαιωμάτων των παιδιών. Ο διαμεσολαβητής παιδιών, για παράδειγμα, προωθεί τη γνώση και την επιβεβαίωση των ατομικών και των κοινωνικών και πολιτικών δικαιωμάτων των παιδιών και των εφήβων, προωθώντας κάθε πρωτοβουλία που στοχεύει στη συγκεκριμένη πραγματοποίησή τους. Παρακολουθεί την εφαρμογή εντός της χώρας της Σύμβασης για τα Δικαιώματα του Παιδιού. Εκφράζει, κατόπιν αιτήματος των αρμόδιων τοπικών φορέων, γνώμες, προτάσεις και παρατηρήσεις σχετικά με σχέδια νόμων, κανονισμούς και διοικητικές πράξεις όσον αφορά στον ενδεχόμενο αντίκτυπο σε παιδιά και νέους.

• Ο δεύτερος τομέας παρέμβασης είναι συγκεκριμένος και αφορά στις απαντήσεις σε εκθέσεις για την κατάσταση μεμονωμένων παιδιών που αντιμετωπίζουν δυσκολίες. Ο διαμεσολαβητής παιδιών, στην πραγματικότητα, δέχεται ειδοποιήσεις που προέρχονται ακόμη και από ανήλικους (για παράδειγμα, βλ. εδώ), από οικογένειες, από σχολεία, από ενώσεις και θεσμούς, σε περιπτώσεις παραβίασης δικαιωμάτων. Αναφέρει στις αρμόδιες δημόσιες διοικήσεις τυχόν περιπτώσεις παραβίασης δικαιωμάτων, συνεπεία πράξεων ή γεγονότων που καθυστέρησαν, παραλήφθηκαν ή άλλως διεξήχθησαν παράτυπα, για τις οποίες έλαβε γνώση από δημόσιους και ιδιωτικούς φορείς ή από μεμονωμένα άτομα, συμπεριλαμβανομένων των παιδιών.

Όσον αφορά στον τρόπο λειτουργίας του, ο διαμεσολαβητής παιδιών δεν διαθέτει άμεσες και αυστηρές εξουσίες έρευνας, παροχής συμβουλών και κυρώσεων. Η δράση των αρχών προστασίας εκφράζεται ουσιαστικά μέσω της λεγόμενης ηθικής πίεσης, δηλαδή, της πειθούς που ασκείται έναντι των δημοσίων φορέων (υπεύθυνοι λήψης πολιτικών αποφάσεων, τοπικές διοικήσεις, εδαφικές υπηρεσίες κοινωνικής βοήθειας, δικαστικές αρχές) και ιδιωτικών οντοτήτων (γονείς σε σύγκρουση, φορείς τρίτου τομέα) βάσει του καθεστώτος ως αρχή προστασίας. Έτσι, για παράδειγμα, ο διαμεσολαβητής παιδιών μπορεί να συστήσει στις αρμόδιες διοικήσεις την υιοθέτηση παρεμβάσεων βοήθειας και υποστήριξης, καθώς και την υιοθέτηση ειδικών μέτρων, σε περίπτωση συμπεριφοράς παραμέλησης. Προωθεί, στο πλαίσιο των αρμόδιων διοικήσεων, την τροποποίηση ή τη μεταρρύθμιση των μέτρων που θεωρούνται επιζήμια για τα παιδιά και τους νέους. Καλεί τις αρμόδιες διοικήσεις να θεωρούν ως κορυφαίο το καλύτερο συμφέρον του παιδιού.

Ο διαμεσολαβητής παιδιών μπορεί να υφίσταται τόσο σε εθνικό όσο και σε τοπικό επίπεδο.

Στην Ευρώπη συναντάμε το Ευρωπαϊκό Δίκτυο Αρχών Προστασίας Παιδιών και Εφήβων (Ευρωπαϊκό Δίκτυο Συνηγόρων του Παιδιού - ιστοσελίδα: https://enoc.eu/?page_id=174), το οποίο συνεδριάζει τουλάχιστον μία φορά τον χρόνο για να συζητήσει θέματα κοινού ενδιαφέροντος σε ευρωπαϊκό επίπεδο και να προσδιορίσει γραμμές κοινής παρέμβασης.

Οι εθνικές εποπτικές αρχές συνεργάζονται συνεχώς με το διεθνές δίκτυο των αρχών προστασίας των παιδιών, με διεθνείς οργανισμούς και θεσμούς για την προστασία και προαγωγή των δικαιωμάτων των παιδιών και με μη κερδοσκοπικούς οργανισμούς.

Η εναλλαγή διαφόρων θεμάτων επιτρέπει στις αρχές να αναπτύξουν προτάσεις ανάλογα με την εποχή και τις ανάγκες των νέων.

Ένας από τους τομείς παρέμβασης των αρχών προστασίας αφορά στα φαινόμενα βίας και κακομεταχείρισης εις βάρος των ανήλικων (ψυχολογική κακομεταχείριση, σωματική κακοποίηση, βία, σεξουαλική συμπεριφορά, αμέλεια, υποβοηθούμενη βία). Στο σημείο αυτό ανατρέξτε στη δήλωση θέσης του ENOC (Ευρωπαϊκό Δίκτυο Συνηγόρων του Παιδιού) σχετικά με τη «Βία κατά των παιδιών», http://enoc.eu/wp-content/uploads/2014/12/ENOC-position-statement-on-Violence-against-children-2015-FV.pdf

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Ο εθελοντής κηδεμόνας ως «φωνή» του ασυνόδευτου ανηλίκου

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Ο εθελοντής κηδεμόνας ως «φωνή» του ασυνόδευτου ανηλίκου

Πολλοί ανήλικοι αναγκάζονται να εγκαταλείψουν τη χώρα τους και να ζήσουν την παιδική τους ηλικία και την εφηβεία μακριά από το σπίτι τους, χωρισμένοι από τις οικογένειές τους και χωρίς οικογένεια να διασφαλίζει την προστασία των συμφερόντων τους. Η μεγάλη πλειοψηφία τους υπέστη τραυματικές εμπειρίες σχετικές με το μεταναστευτικό ταξίδι, τη ζωή τους πριν από αυτό ή την απομάκρυνση από την οικογένειά τους.

Στο δίκαιο της ΕΕ, η Οδηγία του Ευρωπαϊκού Κοινοβουλίου και του Συμβουλίου, αρ. 2011/95/ΕΕ, ορίζει τον «ασυνόδευτο ανήλικο» ως: «τον ανήλικο που φτάνει στο έδαφος των κρατών μελών χωρίς να συνοδεύεται από ενήλικα που είναι υπεύθυνος γι 'αυτόν, είτε από τον νόμο είτε από την πρακτική του εκάστοτε κράτους μέλους και για όσο διάστημα δεν έχει πράγματι λάβει τη φροντίδα ενός τέτοιου προσώπου. Χαρακτηρίζει έναν ανήλικο που έμεινε ασυνόδευτος μετά την είσοδό του στο έδαφος των κρατών μελών».

Σε πολλά ευρωπαϊκά δικαστικά συστήματα η φιγούρα του εθελοντή κηδεμόνα γίνεται όλο και πιο διαδεδομένη. Πρόκειται για έναν ιδιώτη πολίτη, με υψηλά προσόντα, που καλείται να εκπροσωπεί νομίμως τους ανήλικους, οι οποίοι έφθασαν μόνοι στο έδαφος του κράτους και να διασφαλίζει ότι τα συμφέροντά τους προστατεύονται, οι ανάγκες τους ακούγονται και οι δυνατότητές τους καλλιεργούνται. Ο θεσμός του εθελοντή κηδεμόνα αντιπροσωπεύει, με άλλα λόγια, ένα παράδειγμα ιδιότητας ενεργού πολίτη και επομένως ένα μέσο κοινωνικής πολιτικής για τους ανηλίκους.

Ο Carlo Infuso, ένας δικηγόρος από το Τορίνο, περιγράφει την εμπειρία του ως εθελοντής κηδεμόνας.

«Συνάντησα τον V, τον κηδεμονευόμενό μου, σε μια απολύτως συνηθισμένη περίσταση: μου τον σύστησε η Κοινότητα που τον φιλοξενούσε. Συνάντησα αυτό το αγόρι και πρέπει να πω ότι μετά τη γνωριμία μας δεν ξέραμε για ποιο πράγμα να συζητήσουμε. Τον πήρα λοιπόν με τη μηχανή μου και πήγαμε μια βόλτα, μιλήσαμε λιγάκι και σιγά-σιγά αρχίσαμε να χτίζουμε αυτήν τη σχέση που σήμερα έχει εξελιχθεί σε κάτι ευχάριστο και όμορφο και είναι γεμάτη αμοιβαία εμπιστοσύνη.

Ο V ξεκινάει επιτέλους τη ζωή του εδώ στην Ιταλία. Επωφελείται της διεθνούς προστασίας κι έτσι θα έχει άδεια παραμονής μόλις γίνει 18, αλλά και αργότερα, καθώς θα λάβει άδεια για δύο χρόνια. Θα ζητήσουμε άδεια ώστε να συνεχίσει για να τελειώσει τις σπουδές του.

Αρχίζει επιτέλους να κατανοεί πόσο σημαντικό είναι να μάθει την ιταλική γλώσσα, κάτι που δεν είχε συνειδητοποιήσει πριν, για τον ίδιο, τις σχέσεις τους με τους άλλους και με εμένα, τους φίλους μου, όσους συναντά μέσω εμού, τους οποίους αρχίζει να γνωρίζει καλύτερα. Μαθαίνει επίσης τη σημασία του να μελετήσει ώστε να εργαστεί ως σερβιτόρος. Πίστευε πως το να είναι κανείς σερβιτόρος απλά σήμαινε να σερβίρει φαγητό στο τραπέζι, αλλά αντ' αυτού, μαθαίνει πλέον να φτιάχνει καπουτσίνο, τον καπουτσίνο με σχέδιο πάνω, να σερβίρει με διπλά μαχαιροπίρουνα, από τα αριστερά, από τα δεξιά, να φέρνει ποτήρια νερού, ποτήρια κρασιού, μαθαίνει πώς να τοποθετεί τις πετσέτες και ούτω καθεξής. Ανακαλύπτει λίγο-λίγο την ευχαρίστηση της μάθησης, της μάθησης για δικό του καλό.

Είναι πολύ αστείος. Είναι νέος, ένας έφηβος, και έχει τρέλα με τη μουσική. Φοράει σκουλαρίκι, έχει μοντέρνο κούρεμα...όπως όλα τα αγόρια.

Κάτι που με εξέπληξε στον ρόλο του κηδεμόνα ήταν το γεγονός ότι εκείνος δεν μπλέκεται με όλο αυτό. Όταν για παράδειγμα έπρεπε να αποφασίσουμε για το τι θα σπουδάσει και που, ο V μ είπε: «Δεν έχω γονείς, εσύ είσαι ο Ιταλός πατέρας μου. Αποφασίζεις για εμένα, επειδή ξέρω πως ό,τι κι αν αποφασίσεις θα είναι καλό για εμένα».

Σήμερα, μετά από λίγους μήνες, είμαι χαρούμενος που ο V μπορεί να πει: «Είμαι ευτυχισμένος που επιλέξαμε αυτές τις σπουδές μαζί, καθώς μου αρέσει πολύ αυτή η σχολή».

Το γεγονός ότι κατάφερα, ίσως μέσα από μικρά καθημερινά πράγματα, να ενεργοποιήσω μέσα του έναν μηχανισμό εμπιστοσύνης προς τους άλλους, του επέτρεψε να χτίσει σε ορισμένο βαθμό την αυτοπεποίθησή του και πλέον ο V είναι πιο ικανός να πάρει αποφάσεις που δεν θα μπορούσε πιο πριν, με μεγαλύτερη αντίληψη, λιγότερη επιπολαιότητα και περισσότερη δέσμευση από ποτέ.

Πρόκειται για μια σχέση που χτίζεται (ανάμεσα στον κηδεμόνα και τον κηδεμονευόμενο) και η οποία μπορεί να εξελιχθεί καλά ή άσχημα. Στην περίπτωσή μας, εξελίχθηκε καλά και μας επέτρεψε να δημιουργήσουμε κάτι.

Βρίσκομαι στην ευχάριστη θέση να πω ότι θα φιλοξενήσω τον V αυτό το Σαββατοκύριακο στο σπίτι μου. Απόψε μάλλον θα μαγειρέψει κάτι και είμαστε όλοι πολύ χαρούμενοι».

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Quiz 6.2

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Q6.2

5 points possible (graded)

1. Σε περιπτώσεις ενδοοικογενειακής βίας ή σε περίπτωση σύγκρουσης με γονείς, τα παιδιά και οι έφηβοι:

- ○ πρέπει να έχουν πρόσβαση σε εμπιστευτικές ιατρικές συμβουλές και συμβουλές χωρίς τη συγκατάθεση των γονέων, ανεξάρτητα από την ηλικία τους
- ○ πρέπει να έχουν πρόσβαση σε εμπιστευτικές ιατρικές συμβουλές και συμβουλές χωρίς τη συγκατάθεση των γονέων, εφόσον είναι άνω των 14 ετών
- ○ πρέπει να έχουν πρόσβαση σε εμπιστευτικές ιατρικές συμβουλές και συμβουλές με τη συγκατάθεση των γονέων, ανεξάρτητα από την ηλικία τους
- ○ πρέπει να έχουν πρόσβαση σε εμπιστευτικές ιατρικές συμβουλές και συμβουλές με τη συγκατάθεση των γονέων, εφόσον εμφανίζουν υψηλό βαθμό ωριμότητας

2. Η Διακήρυξη του Βουκουρεστίου για τα Παιδιά της Ευρωπαϊκής Ένωσης είναι ένα μέσο κινητοποίησης των ευρωπαϊκών θεσμικών οργάνων και των κρατών μελών για την καθιέρωση επίσημων δομών και μηχανισμών που προωθούν το δικαίωμα των παιδιών και των νέων:

- ○ να συμμετέχουν στις αποφάσεις της ΕΕ
- ○ να ακούγονται σε κάθε δικαστική ή διοικητική διαδικασία που τους αφορά
- ○ να λαμβάνουν ή να επικοινωνούν πληροφορίες ή ιδέες χωρίς παρεμβάσεις από δημόσιες αρχές και χωρίς συνοριακούς περιορισμούς
- ○ να επωφελούνται της ιδιαίτερης προστασίας και, ως εκ τούτου, το δικαίωμα στη διαφοροποιημένη θεραπεία βάσει της ηλικίας

3. Όταν, σύμφωνα με τον νόμο, ένα παιδί δεν έχει την ικανότητα να δώσει τη συγκατάθεσή του για μια παρέμβαση στην υγεία, αυτή η διαδικασία:

- ○ δεν μπορεί να διεξαχθεί
- ○ μπορεί να διεξαχθεί ακόμη και χωρίς την εξουσιοδότηση του εκπροσώπου, της αρχής, του προσώπου ή του φορέα που ορίζει ο νόμος
- ○ δεν μπορεί να διεξαχθεί χωρίς την εξουσιοδότηση του εκπροσώπου, της αρχής, του προσώπου ή του φορέα που ορίζει ο νόμος
- ○ μπορεί να διεξαχθεί ακόμη και χωρίς την εξουσιοδότηση του εκπροσώπου, της αρχής, του προσώπου ή του φορέα που ορίζει ο νόμος, εφόσον είναι δυνατόν να ανασυσταθεί η βούληση του παιδιού

4. Το βίντεο του Συμβουλίου της Ευρώπης «Πες το σε κάποιον που εμπιστεύεσαι» ασχολείται, με μεθόδους φιλικές προς τα παιδιά, με το θέμα:

- ○ της σεξουαλικής κακοποίησης
- ○ του εκφοβισμού (bullying)
- ○ της μαρτυρίας βίας
- ○ της σωματικής τιμωρίας

5. Ο Διαμεσολαβητής Παιδιών ασκεί:

- ○ αυστηρές εξουσίες έρευνας
- ○ εξουσίες περιορισμού και κυρώσεων
- ○ ρυθμιστικές εξουσίες
- ○ εξουσίες ηθικής πίεσης

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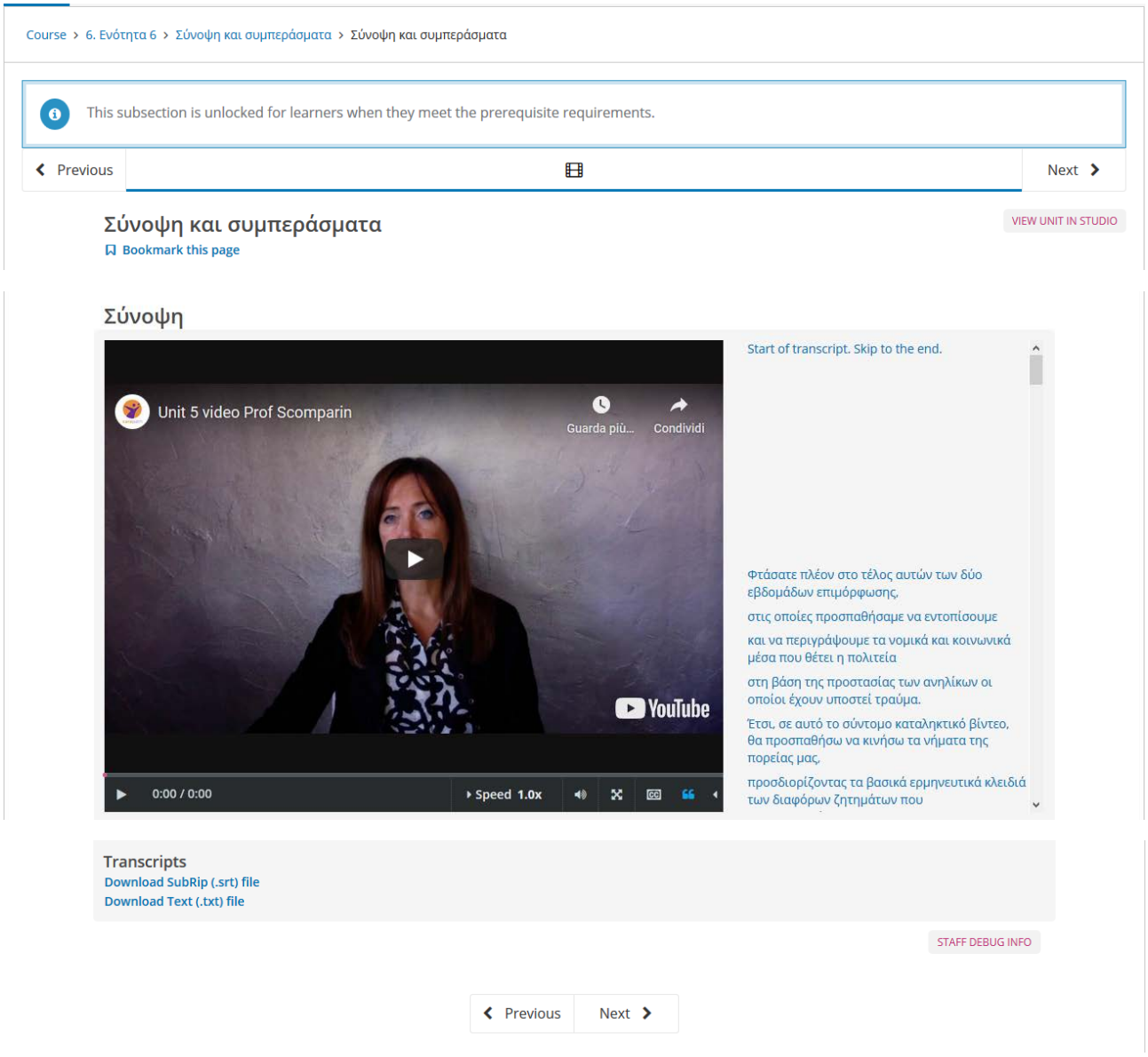


Transcript

Φτάσατε πλέον στο τέλος αυτών των δύο εβδομάδων επιμόρφωσης,

στις οποίες προσπαθήσαμε να εντοπίσουμε

και να περιγράψουμε τα νομικά και κοινωνικά μέσα που θέτει η πολιτεία

στη βάση της προστασίας των ανηλίκων οι οποίοι έχουν υποστεί τραύμα.

Έτσι, σε αυτό το σύντομο καταληκτικό βίντεο, θα προσπαθήσω να κινήσω τα νήματα της πορείας μας,

προσδιορίζοντας τα βασικά ερμηνευτικά κλειδιά των διαφόρων ζητημάτων που πραγματευτήκαμε.

Κατ' αρχάς, είναι σημαντικό να θυμάστε ότι η καθιέρωση των δικαιωμάτων του παιδιού

ήταν μια κατάκτηση επίπονη και καθόλου δεδομένη.

Σαφή μαρτυρία των παραπάνω είναι ασφαλώς η περίπτωση της Μέρι Έλεν Γουίλσον,

που είχε αίσιο τέλος μόνο χάρη στην τόλμη μίας μεθοδίστριας ιεραποστόλου

και στη διαίσθηση ενός δικηγόρου.

Στη συγκεκριμένη περίπτωση, για να απομακρυνθεί μία ανήλικη από ένα οικογενειακό περιβάλλον

τουλάχιστον ακατάλληλο, ήταν αναγκαία η προσφυγή

στους νόμους σχετικά με την κακομεταχείριση των ζώων.

Κι αυτό είναι κάτι που προκαλεί έκπληξη.

Αλλά περισσότερο έκπληκτοι ίσως να μείνατε

με το γεγονός που αφορά την απόφαση "Z. c." στη Μεγάλη Βρετανία, του Ευρωπαϊκού Δικαστηρίου

για τα ανθρώπινα δικαιώματα,

αν μη τι άλλο γιατί πραγματοποιήθηκε εκατό και πλέον χρόνια αργότερα.

Μπορούμε να πούμε, λοιπόν,

ότι, στις αρχές της δεκαετίας του 1990, η ιδέα της υποχρέωσης ενός κράτους

να αποκαθιστά οικογενειακές καταστάσεις προβληματικές για την ευημερία ενός ανηλίκου

καθιερώθηκε με αρκετή δυσκολία.

Οι δικαστές του Ευρωπαϊκού Δικαστηρίου, σε εκείνη την περίπτωση, αναγκάστηκαν να "αποσπάσουν"

αυτή την υποχρέωση από την Ευρωπαϊκή Σύμβαση ανθρωπίνων δικαιωμάτων, αναγνωρίζοντάς την ουσιαστικά

ως απόρροια των απάνθρωπων και ταπεινωτικών συμπεριφορών του άρθρου 3 της Ευρωπαϊκής Σύμβασης.

Υπάρχει κι ένα δεύτερο στοιχείο που πρέπει να θυμόμαστε.

Ότι αποφασιστική ώθηση προς την υπέρβαση

των νομοθετικών κενών, που υπάρχουν

σε κάθε κράτος, αναμφίβολα προέρχεται από το διεθνές δίκαιο

και από το υπερεθνικό δίκαιο.

Ασφαλώς, θα επισημάνουμε τη Σύμβαση της Νέας Υόρκης

και στη συνέχεια, σε ό,τι αφορά την περιοχή μας, πολλές πρωτοβουλίες του Συμβουλίου της Ευρώπης,

καθώς και πρόσφατα, πρωτοβουλίες της Ευρωπαϊκής Ένωσης.

Μόνο μέσα από αυτά τα εργαλεία, θα λέγαμε, η συνείδηση ότι ο ανήλικος είναι

ένα αυτόνομο πρόσωπο με δικαιώματα, που δικαιούται τις δικές του νομικές και ανεξάρτητες θέσεις

έναντι των θέσεων των γονέων, ήταν κάτι που μπόρεσε να καθιερωθεί σταδιακά.

Έτσι, σήμερα

μπορεί όντως να οριστεί ως κοινή κληρονομιά σε κάθε νομοθεσία.

Κατά τον ίδιο τρόπο, είναι προφανές

ότι υπάρχει μία ουσιαστική υποχρέωση των κρατικών αρχών να προλαμβάνουν

και να τιμωρούν σήμερα πιθανές κακομεταχειρίσεις κατά των ανηλίκων, όπως είναι εξίσου προφανές
ότι υπάρχει υποχρέωση αποτελεσματικής συνοδείας όποιου έχει υποστεί κακομεταχείριση
και πλήρους αποκατάστασης της ψυχοσωματικής του ευημερίας.
Υπάρχει κι ένα τρίτο, πολύ σημαντικό ερμηνευτικό κλειδί.
Ο ανήλικος είναι ένα άτομο
με έντονες ιδιαιτερότητες.
Η προσωπικότητά του τελεί ακόμα υπό διαμόρφωση
και, ανάλογα με την ηλικία, χρειάζεται φροντίδες που συνήθως δεν είναι απαραίτητες στον ενήλικα.
Ακόμα περισσότερο, αυτές οι ειδικές φροντίδες
είναι απαραίτητες όταν ο ανήλικος είναι θύμα κακοποιήσεων και βίας,
ίσως, ακόμα περισσότερο, σε οικογενειακό περιβάλλον.
Με άλλα λόγια, θα λέγαμε
πως, σε ό,τι αφορά τους ανηλίκους, για τα δικαιώματα που γενικώς αναγνωρίζονται σε κάθε άτομο
απαιτήθηκε μία αυτόνομη επεξεργασία, που λαμβάνει υπόψη την ιδιαίτερη
και ευαίσθητη συνθήκη των παιδιών.
Για παράδειγμα, όντως ο ανήλικος δικαιούται
να τον ακούν και να εκφράζει την άποψή του σε κάθε θέμα που τον αφορά.
Αλλά, από την άλλη, αν αυτό είναι αναγκαίο προς το βέλτιστο συμφέρον του,
τότε η απόφαση που λαμβάνει τελικά η πολιτεία σε μία δίκη που το αφορά, θα μπορούσε
να είναι διαφορετική από εκείνη που το ίδιο δήλωσε ότι προτιμά. Μπορεί, μάλιστα, να είναι
τελείως διαφορετική από την επιθυμία που εξέφρασε ο ανήλικος.
Έπειτα, πρέπει να θυμόμαστε ένα τέταρτο σημαντικό στοιχείο.
Η πορεία
προς την αποκατάσταση της ευημερίας του ανηλίκου που έχει υποστεί τραύμα
μπορεί να είναι μια πορεία εξίσου επώδυνη
με τη βία και τις κακοποιήσεις που έχει υποστεί.
Υπό αυτή την έννοια, η εγκαθίδρυση μιας ποινικής διαδικασίας,
μιας αστικής διαδικασίας, μετά την κακομεταχείριση, είναι ασφαλώς θεμελιώδης
για την επίτευξη πολλών και σημαντικών στόχων: την τιμωρία εκείνου που διέπραξε
το γεγονός, αν συνιστά αδίκημα,
την αποφυγή επανάληψης των συμπεριφορών κακοποίησης,
την αποκατάσταση της υφιστάμενης βλάβης,

όταν κρίνεται αναγκαίο, την αποκατάσταση ενός κατάλληλου οικογενειακού περιβάλλοντος.
Ας μην ξεχνάμε όμως ότι υπάρχει και η άλλη όψη του νομίσματος,
η οποία αφορά τις θυσίες,
συχνά είναι εξίσου πολλές, που απαιτούνται από τον ανήλικο για να αντιμετωπίσει
όλα τα στάδια μιας δίκης.
Συχνά είναι κρίσιμης σημασίας, για παράδειγμα, η συμμετοχή του
στη δίκη που τον αφορά.
Και αυτή η συμμετοχή, εκτός από δικαίωμα του ανηλίκου,
είναι και σημαντική, ή μάλλον θεμελιώδης, για την διαπίστωση των γεγονότων.
Εκφράζοντας την άποψή του και αφηγούμενο την εμπειρία του, το θύμα μπορεί πάντα να παρέχει
στον δικαστή σημαντικά στοιχεία για την τελική του απόφαση.
Ωστόσο, όπως είδαμε,
υπάρχουν σοβαροί κίνδυνοι δευτερογενούς θυματοποίησης,
γιατί,
κατά την πορεία μιας δίκης,
ο ανήλικος πρέπει πιθανώς να θυμηθεί τα γεγονότα και άρα τα τραύματα που υπέστη.
Πρέπει πιθανότατα
να υποστεί τη δημόσια έκθεση που συνδέεται με το συμβάν του το οποίο εκδικάζεται.
Πρέπει πιθανότατα,
στη διάρκεια της δίκης, να έρθει σε άμεση επαφή με αυτόν που άσκησε την κακοποίηση.
Και όλοι αυτοί είναι πολύ σημαντικοί και σοβαρότατοι κίνδυνοι.
Έπειτα, όταν προκύπτει η αναγκαιότητα υιοθεσίας του ανηλίκου
ή έστω ανάθεσης επιμέλειας, δεν πρέπει να ξεχνάμε πόσο δύσκολη μπορεί να είναι
η ένταξη σε έναν νέο οικογενειακό πυρήνα.
Όλως παραδόξως, θα έλεγα, η υπέρβαση ενός πρώτου τραύματος,
που έχει προκληθεί από την κακοποίηση,
απαιτεί την ανάληψη μιας νέας πορείας, κατάσπαρτης, με τη σειρά της, από τον κίνδυνο
πολλών άλλων μικρών τραυμάτων.
Κι έπειτα ίσως να υπάρχει κι άλλο ένα στοιχείο, πιθανώς το πιο σημαντικό.
Συχνά συμβαίνει τα νέα δικαιώματα και οι νέες προστασίες
να απαιτούν πολύ χρόνο και πολλή ενέργεια για να καθιερωθούν.
Το ίδιο, όπως είδαμε, συνέβη και στην περίπτωση των ανηλίκων.

Σήμερα, λοιπόν,
που υπάρχουν αυτές οι εγγυήσεις, πιθανότατα πρέπει να κάνουμε
ένα ακόμα βήμα.
Είναι ανάγκη να αποκτήσουμε τη συνείδηση ότι το δικαίωμα, από μόνο του, δεν αρκεί.
Ότι οι διεθνείς, υπερεθνικές Συμβάσεις, οι ευρωπαϊκές κατευθυντήριες οδηγίες,
οι νόμοι των μεμονωμένων κρατών, από μόνοι τους, δεν αρκούν.
Είναι το σημείο αφετηρίας,
είναι η βάση πάνω στην οποία
πρέπει να οικοδομήσουμε όλα τα υπόλοιπα.
Εκείνο που έχει πιο πολλή σημασία, σε αυτόν τον τομέα ίσως περισσότερο
από ό,τι σε άλλους, είναι το πώς οι εγγυήσεις που προβλέπονται στα χαρτιά θα εφαρμοστούν,
θα γίνουν πραγματικότητα, μέσα από αποτελεσματικές κοινωνικές πολιτικές.
Γι' αυτό οι κεντρικές και τοπικές διοικήσεις
πρέπει ασφαλώς να αναλάβουν να προωθήσουν, με συγκεκριμένες πρωτοβουλίες, μία κουλτούρα
σεβασμού των δικαιωμάτων των ανηλίκων.
Ταυτόχρονα, πρέπει να δημιουργούν, να ελέγχουν, να επενδύουν
σε υπηρεσίες ειδικά για τα παιδιά και τους εφήβους.
Υπηρεσίες όπως σημεία παροχής βοήθειας, ομάδες υποστήριξης,
εποπτικές και ελεγκτικές αρχές.
Και ας μην ξεχνάμε ότι σημαντικό ρόλο
διαδραματίζουν πάντα ο εθελοντισμός και οι οργανώσεις που προάγουν και προστατεύουν
τα δικαιώματα των ανηλίκων,
γιατί αυτές οι οργανώσεις είναι οπωσδήποτε ένα θεμελιώδες λιθαράκι
στην εφαρμογή αποτελεσματικών και αποδοτικών κοινωνικών υπηρεσιών.
Για την ελαχιστοποίηση του κινδύνου της δευτερογενούς θυματοποίησης, όπως είδαμε,
οι δημόσιες διοικήσεις πρέπει να έχουν την απαραίτητη ευαισθησία και να ενεργούν
με κατάλληλες επενδύσεις.
Για να αναφέρουμε ένα παράδειγμα, πρέπει οπωσδήποτε να διαμορφώσουν
κάποιες αίθουσες του δικαστηρίου ειδικά για την προστατευμένη ακρόαση.
Πρέπει να ευαισθητοποιήσουν κατάλληλα τους δικαστές και τους δικηγόρους.
Πρέπει να εξασφαλίσουν κατάλληλες συνθήκες για τη διεξαγωγή των ακροάσεων του ανηλίκου.
Πρέπει οπωσδήποτε να εγγυηθούν τη συνεχή ψυχολογική υποστήριξη

σε όλη τη διάρκεια της δίκης.

Και, φυσικά, δεν ξεχνάμε τους πρώτους αποδέκτες αυτού του προγράμματος,

δηλαδή τους λειτουργούς, κοινωνικούς και ιατρικούς, που αλληλεπιδρούν με τον ανήλικο,

των οποίων η συμβολή είναι θεμελιώδης.

Γιατί αυτοί οι λειτουργοί είναι,

είσαστε,

οι φύλακες των ανηλίκων έξω από τις δίκες,

για την υπέρβαση του τραύματος από την πρωτογενή θυματοποίηση.

Αλλά είσαστε και οι φύλακες του ανηλίκου μέσα στις δίκες,

γιατί μπορείτε να καταστήσετε

πιο ανεκτό κάτι που δεν θα μπορεί

ποτέ να βιωθεί ως σύνηθες.

Κι έπειτα, είσαστε οι φύλακες των ανηλίκων ακόμα και μετά τις δίκες,

γιατί πρέπει να βρείτε τον τρόπο ώστε η κοπιώδης πορεία

προς την αποκατάσταση της γαλήνης να μην διακοπεί τη στιγμή ακριβώς που θα έπρεπε

να επιταχυνθεί και στη συνέχεια να καρποφορήσει.

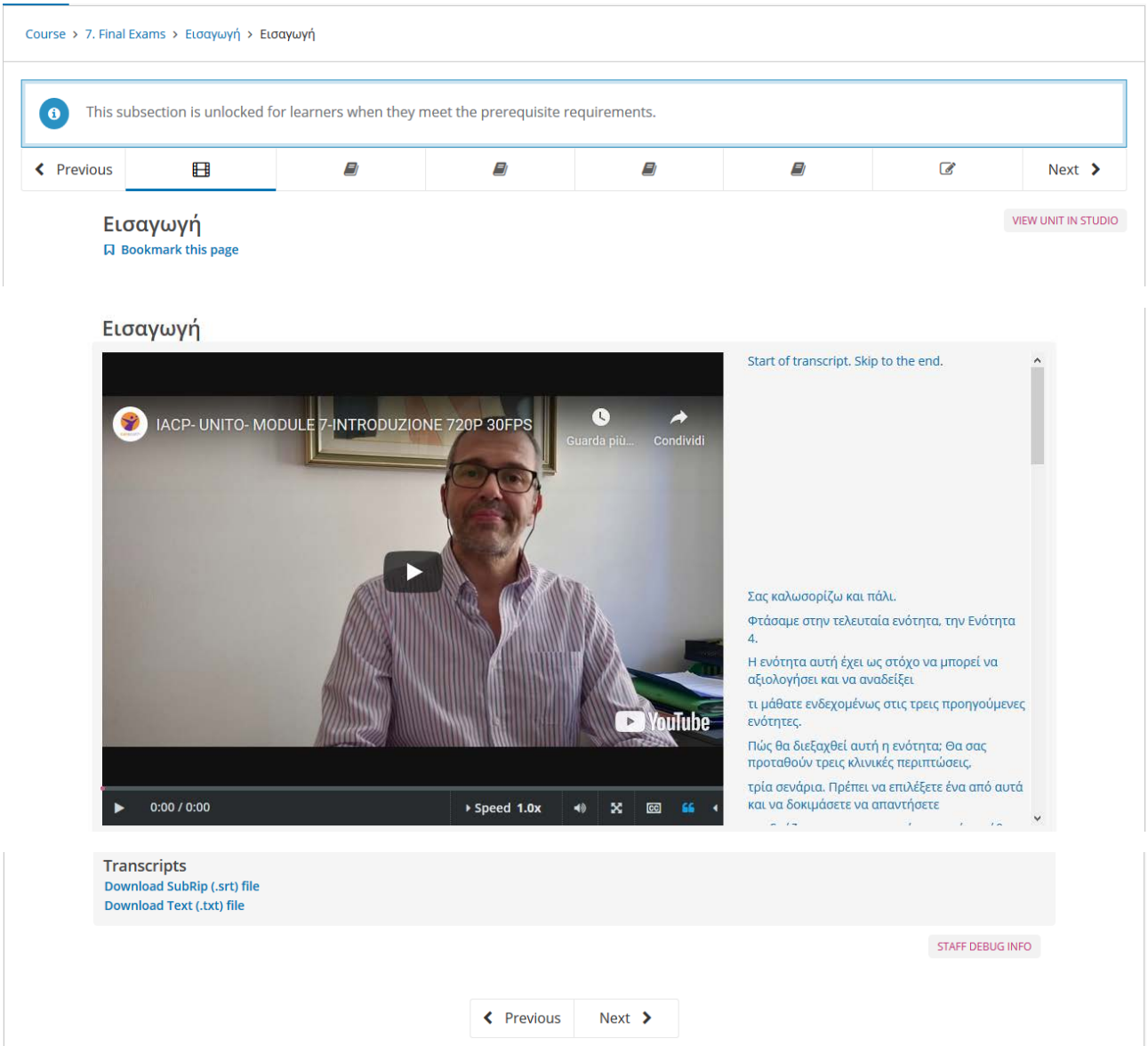
Εν τέλει, είναι πάρα πολλές οι δυσκολίες που περιμένουν το παιδί ή τον έφηβο

που είναι θύμα κακομεταχείρισης.

Αλλά, όπως προσπαθήσαμε να τονίσουμε ως αυτή τη στιγμή, υπάρχουν

και πολλά εργαλεία για να το βοηθήσουμε να αντιμετωπίσει και να νικήσει τις προκλήσεις.

Καλή δουλειά, λοιπόν, σε όλες και όλους.



Transcript

Σας καλωσορίζω και πάλι.

Φτάσαμε στην τελευταία ενότητα, την Ενότητα 4.

Η ενότητα αυτή έχει ως στόχο να μπορεί να αξιολογήσει και να αναδείξει

τι μάθατε ενδεχομένως στις τρεις προηγούμενες ενότητες.

Πώς θα διεξαχθεί αυτή η ενότητα; Θα σας προταθούν τρεις κλινικές περιπτώσεις,

τρία σενάρια. Πρέπει να επιλέξετε ένα από αυτά και να δοκιμάσετε να απαντήσετε

συνδυάζοντας και ενσωματώνοντας ό,τι μάθατε στην Ενότητα 1 "Η Θεωρία",

στην Ενότητα 2 "Η Έρευνα" και στην Ενότητα 3 "Το Νομοθετικό Πλαίσιο", ποια είναι τα κύρια στοιχεία

της Θεραπείας "Trauma Informed" και πώς αυτή μπορεί να εφαρμοστεί

στα τρία σενάρια.

Πώς θα συντάξετε αυτή τη σύντομη αναφορά,

αυτή τη συνοπτική έκθεση; Έχετε διάφορες επιλογές. Μπορείτε να δημιουργήσετε ένα αρχείο σε PowerPoint,

δηλαδή μία παρουσίαση. Μπορείτε να δημιουργήσετε ένα σύντομο βίντεο, δηλαδή να χρησιμοποιήσετε

αυτό τον τύπο αρχείου ή να συντάξετε ένα έγγραφο Word ή ένα αρχείο PDF ή και να χρησιμοποιήσετε

άλλους τρόπους που μπορεί να έχετε κατά νου.

Η ιδιαιτερότητα, η ιδιομορφία αυτής της τελευταίας ενότητας

είναι ότι θα είναι μία ανασκόπηση μεταξύ συναδέλφων. Θα αξιολογήσετε την εργασία ενός άλλου συμμετέχοντα

στο πρόγραμμα και ταυτόχρονα η εργασία σας θα αξιολογηθεί από έναν άλλο συμμετέχοντα.

Θα είναι μία αξιολόγηση μεταξύ ομοτίμων. Την τελευταία αξιολόγηση όμως θα αναλάβει

ένας εκπαιδευτής μεγαλύτερης ηλικίας, ένας από τους υπεύθυνους του προγράμματος.

Αυτό θα λέγαμε ότι είναι στα αλήθεια το τελευταίο απαιτούμενο βήμα για να αποκτήσετε

το πιστοποιητικό συμμετοχής σε αυτό το διαδικτυακό πρόγραμμα κατάρτισης.

Όταν ολοκληρώσετε την τεκμηρίωση και ετοιμάσετε την αναφορά, το βίντεο

ή την παρουσίασή σας σε Power Point, μπορείτε να τα υποβάλλετε. Θα επιλεγεί τυχαία και ανώνυμα

ένας συμμαθητής σας και έπειτα θα κληθείτε κι εσείς να αξιολογήσετε ένα έγγραφο, μία αναφορά ή ένα βίντεο.

Στη συνέχεια θα υποβάλλετε για τελευταία φορά την εργασία σας και τότε ένας καθηγητής

θα δώσει μία τελική αξιολόγηση και θα εγκρίνει, ή όχι, το πέρας του προγράμματος επιμόρφωσής σας.

Ελπίζουμε ότι ήταν ένα ευχάριστο πρόγραμμα,

ότι μπορέσατε να κατανοήσετε κάτι ή έστω ότι επιβεβαιώσατε ή επικυρώσατε επιπλέον γνώσεις

σχετικά με τη Θεραπεία "Trauma Informed". Αν έχετε την ευχαρίστηση, μπορείτε να στείλετε

μερικά σύντομα βίντεο στο τέλος του προγράμματος, με το ονοματεπώνυμό σας, σύντομα έγγραφα

όπου θα επιβεβαιώσουμε ότι συμμετείχατε σε αυτό το πρόγραμμα επιμόρφωσης.

Εγώ προσωπικά, ο Λούκα Ρολέ, και όλη η ομάδα εργασίας του προγράμματος "Care Path",

σας ευχαριστούμε θερμά και πάλι που ήσασταν μαζί μας και ελπίζουμε να σας ξαναδούμε

σε άλλα προγράμματα στο μέλλον.

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Οδηγίες

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1. Κατά τη διάρκεια αυτής της δραστηριότητας σας ζητείται να αναλύσετε την υπόθεση (επιλέγοντας ένα σενάριο) από νομική άποψη, ψυχολογική άποψη και / ή σύμφωνα με την επιστημονική έρευνα. Η απάντησή σας θα πρέπει να περιλαμβάνει τις σκέψεις σας υπό το πρίσμα των θεμελιωδών αρχών της περίθαλψης για τα τραύματα. (μοντέλο TIC). Μπορείτε να υποβάλετε την εργασία σας σε

ο κείμενο (απλά εισάγετε την απάντηση σας στην αντίστοιχη περιοχή) ή

ο Μπορείτε να ανεβάσετε ένα αρχείο που περιέχει την εργασία σας. **Σημαντική σημείωση** - το αρχείο πρέπει να είναι σε μορφή pdf μέχρι 5mb.

Σε περίπτωση που έχετε ετοιμάσει ένα βίντεο, μπορείτε να εισάγετε απλώς τη σύνδεση του δημοσιευμένου σας βίντεο, ώστε να μπορούμε να έχουμε πρόσβαση σε αυτό.

2. Κάθε μαθητής, μετά την υποβολή της δικής του εργασίας, θα πρέπει να αξιολογήσει τουλάχιστον μία εργασία άλλου εκπαιδευόμενου. Αυτό είναι ένα απαραίτητο βήμα για να ολοκληρωθεί η δραστηριότητα και να δοθεί η πιστοποίηση.

Σημαντική σημείωση - Σε περίπτωση που χρειαστεί να αξιολογήσετε μια απάντηση που περιέχεται σε ένα αρχείο, πρέπει να κάνετε λήψη του αρχείου και να το ανοίξετε στην επιφάνεια εργασίας / κινητή συσκευή σας. Βεβαιωθείτε ότι το αρχείο έχει την επέκταση .pdf. Αν όχι, μετονομάστε το αρχείο σας προσθέτοντας το κατάληξη .pdf στο τέλος.

2. Το τελευταίο βήμα περιλαμβάνει την αξιολόγηση του προσωπικού. Μετά την ολοκλήρωση, ο τελικός βαθμός θα είναι διαθέσιμος αμέσως

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Μελέτη περίπτωσης 1

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Η C.F. είναι 15 χρονών και έχει παραπεμφθεί από τα τοπικά νοσοκομεία στην τοπική κοινωνική υπηρεσία.

Παρακολουθεί ακανόνιστα το γυμνάσιο έχοντας μη ικανοποιητική επίδοση και μεταφέρθηκε στον χώρο επειγόντων του νοσοκομείου λόγω κατάποσης υπερβολικής ποσότητας ψυχοτρόπων φαρμάκων.

Μετά την παρέμβαση πρώτων βοηθειών, την έστειλαν πίσω στο σπίτι της, με την υποχρέωση ολόκληρης της οικογένειας να ακολουθήσουν ένα πρόγραμμα υποστήριξης και βοήθειας.

Η ανήλικη επιδεικνύει μια θυμωμένη στάση, δεν θέλει να είναι στη συνέντευξη ή να μιλήσει για την κατάστασή της, και δεν δείχνει να καταλαβαίνει το λόγο αυτής της παραπομπής. Ισχυρίζεται ότι όλο αυτό ήταν ένα ηλίθιο πράγμα που έκανε με τον φίλο της, αλλά που σίγουρα δεν θα το επαναλάβει.

Αφού έλαβε φροντίδα με ενσυναίσθηση σχετικά με τους φόβους που είχε, αναφέρθηκε στο περιστατικό της υπερβολικής δόσης (αναφέρεται στο επεισόδιο ως ότι έκανε "μαλακίες") και δέχθηκε να λάβει πληροφορίες για τους όρους των προσφερόμενων υπηρεσιών. Το κορίτσι φάνηκε να ανοίγει και να μοιράζεται την ιστορία της και την ευαισθησία της. Αναφέρθηκε ότι οι γονείς της έχουν χωρίσει –όχι ακόμη επισήμως- αλλά πριν λίγους μήνες ότι η μητέρα είχε εγκαταλείψει το σπίτι τους.

Η C. αναφέρει ότι η αποχώρηση της μητέρας σηματοδοτεί μια θετική νέα εξέλιξη γι 'αυτήν, δεδομένου ότι έχει μια πολύ δύσκολη σχέση με τη μητέρα της και το γεγονός ότι η μητέρα είναι μακριά από το σπίτι την κάνει να αισθάνεται πιο ήρεμη. Από τη μία πλευρά, αυτό συνεπάγεται ότι δεν υπάρχει πλέον γύρω της το άτομο εκείνο που την βοηθούσε να κάνει πράγματα. Για πολύ καιρό, όταν η C. Πήγαινε στο δημοτικό και στο γυμνάσιο, η μητέρα της ήταν θυμωμένη και την χτυπούσε ή την προσέβαλλε όταν έκανε κάτι λανθασμένο. Η μητέρα της χρησιμοποιούσε ψυχολογική και σωματική βία για να την τιμωρήσει. Οι πιο συνήθεις προσβολές ήταν «Ηλίθια», «είσαι σκύλα». Τελικά, το τελευταίο έτος, η C. άρχισε τελικά να μην υποφέρει παθητικά αυτές τις κακομεταχειρίσεις, άρχισε να ανταποκρίνεται στις επιθέσεις της μητέρας της και μερικές φορές μπήκε σε διαμάχες ακόμη και σε φυσικές μάχες με τη μητέρα της. Βίωσε τη νέα ενεργή συμπεριφορά της με τη μητέρα της ως μια πιο ικανοποιητική για την ίδια συμπεριφορά από την προηγούμενη. Ο πατέρας της είναι μακριά όλη την ημέρα για δουλειά. Η C. λέει ότι είναι καλός άνθρωπος, που παρόλα αυτά επιστρέφει στο σπίτι μόνο το βράδυ και δεν φαίνεται να ενδιαφέρεται για τη δυναμική της οικογένειάς του, πιθανότατα επειδή έρχεται σπίτι πολύ κουρασμένος από την εργασία. Τα πράγματα φαίνονταν ψυχρά ανάμεσα στους γονείς της. Στην οικογένειά της, οι άνθρωποι δεν συγκεντρώνονται για να πραγματοποιήσουν κάποιες κοινές δραστηριότητες. Τις Κυριακές επίσης είναι πάντα εντός σπιτιού ή με τη θεία της (την αδελφή του πατέρα της) .Για την C., η θεία είναι ένας σημαντικός ενήλικας και ένα σημαντικό σημείο αναφοράς.

Όταν η C. ήταν 13 ετών, μαζί με τον φίλο της άρχισαν να καπνίζουν τσιγάρο και μαριχουάνα στο σχολείο. Της άρεσε το αίσθημα της χαλάρωσης και της διασκέδασης που γνώρισε με το κάπνισμα μαριχουάνας και σύντομα άρχισε να βγαίνει μαζί με μια ομάδα ανθρώπων που μοιράζονταν το ίδιο "ενδιαφέρον" καπνίσματος χόρτου.

Μετά από μερικούς μήνες συνεχών δυσκολιών στο σπίτι, η μητέρα της άρχισε να είναι λιγότερο παρούσα, κάθε μέρα το απόγευμα η μητέρα έβγαινε και αυτό επέτρεψε στην C.. να είναι ελεύθερη να προσκαλέσει τους φίλους της στο σπίτι. Αρχικά, ήταν ευχαριστημένη με αυτή τη νέα κατάσταση, θεώρησε ότι ήταν μια βελτίωση της κατάστασης της ζωής της. Μια μέρα όμως ανακαλύπτει, ενώ ταξιδεύει με έναν φίλο, ότι η μητέρα της βλέπει έναν άλλο άνθρωπο. Τους πετυχαίνει να κάθονται σε ένα μπαρ έξω από τη γειτονιά τους σε στάσεις που δηλώνουν με σαφήνεια ότι είναι εραστές.

Σε αυτό το σημείο, η C. αναφέρει ότι τελικά βρέθηκε σε μια θέση να ζητάει και να απαιτεί από τη μητέρα της ό, τι θέλει, γιατί η μητέρα της δεν μπορούσε λόγω του μυστικού να ξεφύγει από τα αιτήματα της κόρης της: Η C. ήθελε να πάρει στο σπίτι το αγόρι της και να είναι εκεί μόνοι τους και ζητάει από την μητέρα της να την αφήσει ήσυχη. Αρχικά, η μητέρα δεν θέλει, αλλά όταν η C. της λέει ότι πρέπει, διαφορετικά θα ενημερώσει τον πατέρα της για την εξωσυζυγική της σχέση, η μητέρα υποκύπτει στο αίτημα της. Τα αιτήματα της C. και οι παραχωρήσεις της μητέρας αυξάνονται. Η C. καλεί όποιον θέλει σπίτι, καπνίζει στο σπίτι, της επιτρέπεται να αγοράσει μπύρα και παίρνει όλα τα χρήματα που ζητάει. Η μητέρα υποχωρεί στα αιτήματά της, αλλά η C. Παράλληλα δέχεται από τη μητέρα τον θυμό τις προσβολές του και όλη την περιφρόνησή της.

Ο πατέρας δεν τα γνωρίζει όλα αυτά. Ενώ μιλάει γι 'αυτό η C δείχνει μια στάση θλιβερού θριάμβου και μεγάλο θυμό.

Αυτή η κατάσταση των πραγμάτων συνεχίζεται για περίπου ένα χρόνο, μέχρι το Σεπτέμβριο, όπου ο πατέρας της, ανακαλύπτει την προδοσία της συζύγου, και της ζητά να φύγει από το σπίτι τους.

Σε αυτό το σημείο η C. είναι ακόμη πιο ελεύθερη μιας και είναι μόνη στο σπίτι μέχρι την επιστροφή του πατέρα του από την εργασία. Αρχίζει να καθυστερεί στο σχολείο ή να μην πηγαίνει καθόλου, μέχρι που μένει στο σπίτι μιας φίλης της και βρίσκει ένα φάρμακο της μητέρας της φίλης της. Αποφασίζουν να προσπαθήσουν να τα πάρουν μαζί. Μετά από αυτό το επεισόδιο, ο πατέρας καλείται από τη μητέρα της φίλης που βρήκε την C και την κόρη της να κοιμούνται βαθιά στο κρεβάτι και σε μια κατάσταση σύγχυσης: «Δυστυχώς» και τα δύο κορίτσια έσπευσαν στα επείγοντα του νοσοκομείου.

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Μελέτη περίπτωσης 2

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Η Β. είναι ένα κορίτσι 15 χρονών και η πρώτη από δύο αδέλφια. Η μητέρα είναι επιχειρηματίας και ο πατέρας είναι άνεργος. Οι τέσσερις τους ζουν σε ένα πολυτελές προάστιο της πόλης.

Η Β. έρχεται στη συμβουλευτική εξαιτίας του σοβαρού φυσικού πόνου που περιλαμβάνει το χαμηλότερο μέρος του σώματος (πόδια και κοιλιά) που δεν εξηγείται από καμία ιατρική κατάσταση (οι γονείς της την είχαν ήδη πάει προς εξέταση σε πολλούς επαγγελματίες).

Αυτός ο πόνος την εμποδίζει να έχει έναν ικανοποιητικό τρόπο ζωής, αντίστοιχο της ηλικίας της: το να συμμετέχει με συνέπεια στο σχολείο είναι κάτι αδύνατον για την ίδια, επομένως κινδυνεύει μείνει στην ίδια τάξη μένοντας από απουσίες. Επιπλέον είναι πολύ δύσκολο να κανονίσει εξόδους με φίλους ή να κάνει κάποιο άθλημα, επειδή κάτι τέτοιο ανά πάσα στιγμή θα μπορούσε να ακυρωθεί εξαιτίας του ξαφνικού αυτού διάτρητου πόνου.

Στην πρώτη μας συνάντηση μοιάζει ατημέλητη, μάλλον εσωστρεφής (χαμηλώνει το βλέμμα της, ψιθυρίζει λίγα λόγια) και γέρνει το σώμα (ξοδεύει όλον τον χρόνο που έχουμε κουλουριασμένη στην καρέκλα της). Αναφέρει ότι αποφάσισε να ζητήσει βοήθεια επειδή αναγνωρίζει την ανάγκη να φροντίσει αυτό το πρόβλημα που όπως αναφέρει: «με κλείνει στο σπίτι μου».

Έχει αρκετά εκτεταμένη γνώση, μεγάλη περιέργεια και έντονη ευφυία, που όλα αυτά φαίνεται να αντιπαραβάλλονται της συμπαγούς και κουλουριασμένης της στάσης.

Λέει ότι δεν έχει ιδέα για το τι μπορεί να έχει ξεκινήσει τα συμπτώματά της, τα οποία εμφανίστηκαν περίπου την εποχή της αρχής της εμμήνου ρύσης.

Αφηγείται ότι έχει υπέροχες σχέσεις με τα μέλη της οικογένειάς της, πολύ λίγους φίλους και να αγωνίζεται πολύ για να είναι σε ομάδες, ανεξάρτητα από το αν αυτές αποτελούνται από συνομήλικους ή από ενήλικες. Απολαμβάνει να διαβάζει και να ακούει μουσική και να μελετά διάφορες γλώσσες ως αυτοδίδαχτη.

Κατά τη διάρκεια του πρώτου έτους της ψυχοθεραπείας, εργάζεται για την εξαφάνιση των συμπτωμάτων της και εστιάζουμε στην ενδυνάμωσή της. Ο πόνος μπορεί να περιγραφεί και αρχίζει να καταπραύνεται. Εμφανίζεται λίγο πριν από την έμμηνο ρύση και την κάνει να χάσει το πολύ μόνο 2 ή 3 μέρες του σχολείου. Ωστόσο, δεν υπάρχει ακόμα συνειδητότητα και αναγνώριση της πηγής προέλευσης των συμπτωμάτων της και, επιπλέον, έχει συχνές κρίσεις πανικού.

Εκτός από τις ατομικές συνεδρίες της Β., συναντώ περιοδικά όλη την οικογένεια η οποία, ακόμα και αν εκφράζει την ανησυχία της για τα βάσανα της Β., αναγνωρίζει τις μεγάλες αλλαγές της και τους πόρους που μπορεί να αξιοποιήσει για να ζήσει και πάλι μια ικανοποιητική ζωή .

Μετά από δύο χρόνια ψυχοθεραπείας, η Β. Μπορεί να διαχειριστεί τις κρίσεις πανικού της, οι οποίες γίνονται ολοένα και πιο σποραδικές και χρησιμοποιεί διάφορες τεχνικές διαχείρισης και αντιμετώπισης του πόνου (αυτοθεραπεέα, γιόγκα, καθοδηγούμενες φαντασιώσεις, τεχνικές αναπνοής).

Ωστόσο, κατά την παρακολούθηση μιας ταινίας στην οποία υπάρχει σκηνή σεξουαλικής επίθεσης, βιώνει μια ξαφνική και έντονη αίσθηση αγωνίας, την οποία θα μου αναφέρει στην επόμενη σύνοδο ως «ένα εσωτερικό black out».

Αρχίζουμε να εξερευνούμε αυτό το συναίσθημα, προσπαθώντας να πλησιάσουμε αυτά τα "θραύσματα του ονείρου" όπως αρχικά αναφέρεται τα οποία αργότερα μετατρέπονται σε θολές εικόνες. Δύσκολο να οριστούν ως αναμνήσεις ή φαντασιώσεις δανεισμένες από βιβλία ή ταινίες.

Η δουλειά με σεβασμό στο χρόνο της και τις συμπεριφορές, έχουν σκοπό να μην αναγκάσουν, τις αμυντικές στρατηγικές της ή τους κατανοητούς φόβους της, αλλά έχοντας ως σκοπό να συνεχίσει να ανακαλύπτει τα εσωτερικά της αποθέματα βοηθούν την Β. να ανακαλέσει σιγά σιγά στην μνήμη της ένα άτομο στο οποίο την είχαν εμπιστευτεί να την προσέχει, οι γονείς όταν ήταν μακριά (στις ηλικίες 3 εως 7) και το οποίο την κακοποίηση σεξουαλικά.

Η ανάκληση της μνήμης αυτής επιτρέπει να ξεκινήσει η διαδικασία όχι μόνο με στόχο να αναφέρει τον κακοποιό και να δημιουργήσει ένα ασφαλές περιβάλλον για τον εαυτό της (ο κακοποιός εξακολουθούσε να βλέπει σποραδικά την οικογένειά αυτή) αλλά και για να νοηματοδοτόσει εκ νέου την ψυχολογική καταπόνηση που μέχρι εκείνη τη στιγμή βίωνε και που δεν μπορούσε να εξηγηθεί ή να νοηματοδοτηθεί.

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Μελέτη περίπτωσης 3

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1. Ο Ρ είναι ενήλικος 13 ετών και έχει παραπεμφθεί από το δικαστήριο σε τοπικό οργανισμό φροντίδας υγείας.

Παρακολούθησε το δημοτικό σχολείο και βρισκόταν σε αναδοχή από την ηλικία των 9 ετών.

Σε αυτή την πρώτη συνάντηση συνοδεύεται από τον παιδαγωγό του οικογενειακού σπιτιού, είναι ανοιχτός και ενδιαφέρεται να γνωρίσει τους ανθρώπους με τους οποίους έχει συνέντευξη για να μπορέσει να λάβει την υπηρεσία μας ως πελάτης. Στην αρχή είναι κοινωνικός, απαντά στις ερωτήσεις, αλληλεπιδρά με τους ανθρώπους, κάνει αστεία και είναι αρκετά συμπαθής. Όταν αρχίζουμε να μιλάμε για τους λόγους αυτής της συνάντησης, αρχίζει να έχει σύγχυση, δεν καταλαβαίνει γιατί είναι εκεί, τι πρέπει να κάνει, τι θέλουμε από αυτόν και αναζητά απαντήσεις σε αυτά τα ερωτήματα, δίνοντας φωνή στην τάση του για αποπροσανατολισμό και στου φόβους του (όπου υποχρεώνεται να είναι ακόμη πιο μακριά από τους γονείς του, τον φόβο ότι τους πληγώνει, τον φόβο ότι κάποιος θα αποφασίσει ότι δεν θα μπορεί πλέον να τους ξαναδει, κλπ.).

Οι γονείς του, μετά από μια περίοδο χωρισμού ζουν τώρα μαζί, ακριβώς όπως την περίοδο όπου ο Ρ. απομακρύνθηκε από την οικογένειά του. Το αγόρι θυμάται πολλές διαμάχες μεταξύ των γονέων του, δεν τα πήγαιναν πολύ καλά και αρκετές φορές η μητέρα, η οποία καταγόταν από διαφορετική χώρα από τη χώρα διαμονής, έκανε απόπειρες να επιστρέψει στην οικογένειά της προέλευσης. Όταν η μητέρα του έφυγε ο Ρ. λυπήθηκε πολύ, αλλά την ίδια στιγμή αισθανόταν και ευτυχής γιατί από τότε οι καυγάδες των γονιών τους σταμάτησαν για λίγο. Αγαπά τους γονείς του και ακόμη και τώρα είναι ευτυχής όταν περνούν χρόνο μαζί.

Μιλάει μαζί τους καθημερινά μέσω τηλεφώνου και τους βλέπει μία φορά την εβδομάδα όταν τον επισκέπτονται στο οικογενειακό σπίτι αναδοχής.

Σε αυτό το σπίτι διαμένει για δύο περίπου χρόνια και είναι εντάξει, αν και θα ήθελε να επιστρέψει στο δικό του σπίτι, αν και δεν ξέρει αν αυτό είναι δυνατόν.

Δεν θυμάται καλά την ημέρα που εισήλθε στην οικογένεια αναδοχής, αλλά ξέρει ότι ο πατέρας του ήταν αυτός που τον είχε συνοδεύσει. Η μητέρα είχε μείνει στο σπίτι να κλαίει και ένιωθε πολύ λύπη γι 'αυτήν. Ο μπαμπάς ήταν πιο δυνατός, επειδή τον είχε συνοδεύσει συνόδευε, και όπως πάντα τον γεμίζε με λόγια, αλλά δεν έκλαιγε.

Ο R. φοβήθηκε πολύ όταν εισήλθε στο σπίτι αναδοχής, αλλά εκεί βρήκε μερικούς συμπαθητικούς και αστείους ανθρώπους που τον έκαναν να αισθάνεται λιγότερο φοβισμένος και ήταν εύκολο να γίνει φίλος και με τους υπόλοιπους.

Ο Ρ. μπήκε στο σπίτι αναδοχής μετά από κάποια περιστατικά σεξουαλικής παρενόχλησης από έναν φίλο των γονέων, ο οποίος κακοποίησε τον μικρό. Ο Ρ. δεν το αναφέρει αυτό σε κανέναν, αλλά σε κάποιο σημείο αυτό αποκαλύπτεται (ο R. ακόμα δεν ξέρει γιατί) και καταλήγουν στο δικαστήριο. Αυτός ήταν ένας φίλος των γονιών του ο οποίος επισκεπτόταν πολύ συχνά το σπίτι των γονιών και ήταν πολύ συμπαθής στον Ρ.. Ένιωθε ότι ήταν και αυτός σημαντικός για αυτόν: Το βράδυ αυτός ο ενήλικας κάποιες φορές του διάβαζε ιστορίες και μερικές φορές ο πατέρας του Ρ θα τον ρωτούσε αν ήθελε να τον πάει στο κρεβάτι.

Όταν αυτά τα άσχημα πράγματα συνέβησαν και ήρθαν στο φως, ο πατέρας του συνόδευσε τον Ρ. στο σπίτι αναδοχής, θέλοντας να τον προστατεύσει από αυτόν τον άνθρωπο.

Ο Ρ. δεν ξέρει πραγματικά πώς αισθάνεται για όλα αυτά, ίσως - λέει - πολύ σύγχυση.

Στο σπίτι της οικογένειας αναδοχής είναι ωραία, αλλά μερικές φορές αισθάνεται λίγο αναγκασμένος να υπακούσει σε κάποιους σκληρούς κανόνες, τότε οργίζεται πολύ και καταλήγει να καταστρέφει αντικείμενα, αλλά ποτέ δεν συμπεριφέρεται άσχημα σε ανθρώπους. Ειδικότερα, ο Ρ. δεν μπορεί να αντέξει το γεγονός ότι για να μιλήσει με τους γονείς του ή για να τους δει πρέπει να ακολουθήσει κανόνες που δεν καταλαβαίνει. Από την άλλη πλευρά, σε αυτό το σπίτι, κάνει ενδιαφέροντα πράγματα (ασχολείται ακόμη και με αθλήματα), αισθάνεται όμορφα στο να σχετίζεται με άλλους ανθρώπους. Του αρέσει να έχει φίλους γύρω του, αν και, μερικές φορές θέλει να μένει μόνος του και να έχει χώρο για τον εαυτό του.

Ο Ρ. έχει δημιουργήσει μια ειδική σχέση με τον παιδαγωγό που τον φροντίζει πολύ και αυτό είναι κάτι που του αρέσει πολύ.

Ο Ρ. έχει πολλούς φόβους για το τι θα συμβεί όταν χρειαστεί να εγκαταλείψει το σπίτι της ανάδοχης οικογένειας, όχι επειδή πρέπει να φύγει τώρα, αλλά ξέρει ότι τελικά σε κάποιο σημείο αυτό θα συμβεί και δεν θέλει οι γονείς του να γνωρίζουν ότι βιώνει αυτούς τους φόβους , επειδή φοβάται ότι θα αισθανθεί λυπημένος και πιστεύει ότι δεν τον αγαπούν.

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Ανοιχτή αξιολόγηση

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ΑΝΟΙΧΤΗ ΑΞΙΟΛΟΓΗΣΗ

This assignment has several steps. In the first step, you'll provide a response to the prompt. The other steps appear below the **Your Response** field.

IN PROGRESS

1 Your Response

NOT AVAILABLE

2 Assess Peers

NOT AVAILABLE

3 Staff Grade

Your Grade: Not Started

MANAGE INDIVIDUAL LEARNERS VIEW ASSIGNMENT STATISTICS GRADE AVAILABLE RESPONSES

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Ερωτηματολόγιο

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ΕΡΩΤΗΜΑΤΟΛΟΓΙΟ

	0 - Καθόλου	1	2	3	4 - Πολύ	5. Δεν γνωρίζω
1. Είναι το περιεχόμενο σύμφωνο με τους εκπαιδευτικούς στόχους?	○	○	○	○	○	○
1. Παρουσιάζονται τα περιεχόμενα του μαθήματος με τρόπο κατανοητό?	○	○	○	○	○	○
1. Είναι ο χρόνος αρκετός για την παρακολούθηση του υλικού στο σύνολό του?	○	○	○	○	○	○
1. Πόσο χρήσιμη είναι η θεματολογία?	○	○	○	○	○	○
1. Είναι εφαρμόσιμα τα θέματα του μαθήματος?	○	○	○	○	○	○
1. Θα προτείνατε το μάθημα σε έναν γνωστό/φίλο/συνάδελφο αυτό το μάθημα?	○	○	○	○	○	○
1. Πως αξιολογείτε την εμπειρία της online κατάρτισης?	○	○	○	○	○	○
1. Πως αξιολογείτε το επίπεδο του μαθήματος CarePath?	○	○	○	○	○	○
1. Τα τεχνικά χαρακτηριστικά (εικόνα, ήχος, συνημμένα) ήταν ικανοποιητικά?	○	○	○	○	○	○
1. Πόσο φιλική προς το χρήστη είναι η συγκεκριμένη πλατφόρμα εκμάθησης?	○	○	○	○	○	○

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carepath

Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material
ANNEX 1
–
Greek Version

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

ΣΤΟΙΧΕΙΟ 1: ΟΡΙΣΜΟΣ ΤΗΣ ΕΡΕΥΝΑΣ

ΒΙΝΤΕΟ

Τι εστί επιστημονική έρευνα;

ΑΡΘΡΟ

Δεν είναι εύκολο να προσδιοριστούν τα όρια του τι είναι η έρευνα και τι όχι. Έχουν δοθεί πολλοί ορισμοί με το πέρασμα του χρόνου. Ας δούμε κάποιους από τους πιο πρόσφατους:

«Η έρευνα απλά αναζητά την απάντηση σε ορισμένες ερωτήσεις, οι οποίες έχουν παραμείνει αναπάντητες, ενώ οι απαντήσεις εξαρτώνται από ανθρώπινες προσπάθειες. […] Στην πραγματικότητα, η έρευνα αποτελεί απλά τη διαδικασία να φτάσει κανείς σε αξιόπιστες λύσεις για ένα πρόβλημα μέσω σχεδιασμένης και συστηματικής συλλογής, ανάλυσης και ερμηνείας δεδομένων.» (Singh, 2006, σελ.1).

«Η έρευνα αποτελεί δημιουργική διαδικασία της ανακάλυψης που αναπτύσσεται σύμφωνα με προκαθορισμένη πορεία και σύμφωνα με προκαθορισμένες διαδικασίες, οι οποίες έχουν παγιωθεί εντός της επιστημονικής κοινότητας» (Corbetta, 2015, σελ.15).

Σε γενικές γραμμές, η έρευνα διεξάγεται «οπουδήποτε η περιέργεια και η διαίσθηση εφαρμόζονται με συστηματική προσέγγιση ώστε να απαντηθούν ερωτήσεις σχετικά με καθημερινά φαινόμενα, εκμεταλλευόμενη τις εμπειρίες και τη γνώση που έχουν ήδη αποκτηθεί (Research Italy, 2013).

Υπάρχουν διαφορετικά είδη έρευνας που διαφέρουν σύμφωνα με την εφαρμογή, τους στόχους και τις μεθόδους έρευνας. Η έρευνα μπορεί στην πραγματικότητα να είναι «εφαρμοσμένη» ή «θεωρητική». Η εφαρμοσμένη έρευνα έχει ως στόχο να βρει μια λύση σε ένα πρόβλημα εφαρμογής που πρέπει να αντιμετωπιστεί, ενώ η θεωρητική έρευνα αφορά κυρίως σε γενικεύσεις και στη διατύπωση μιας θεωρίας (Kothary, 2004, Singh & Masuku, 2013). Ανάλογα με τους στόχους, η έρευνα μπορεί να είναι περιγραφική, εξερευνητική, σχεσιακή ή επεξηγηματική. Η περιγραφική έρευνα αποσκοπεί στο να περιγράψει ένα φαινόμενο, ένα πρόβλημα, μια κατάσταση.

Η σχεσιακή έρευνα αποσκοπεί στο να εξερευνήσει μια σχέση ανάμεσα σε δύο ή περισσότερες μεταβλητές.

Η επεξηγηματική έρευνα αποσκοπεί να επεξηγήσει γιατί συμβαίνουν κάποια πράγματα.

Η εξερευνητική έρευνα αποσκοπεί στο να εξετάσει την εφαρμοσιμότητα μιας μελέτης ή να εξερευνήσει ένα λιγότερο γνωστό θεματικό πεδίο.

Για να ξεκινήσει η έρευνα χρειάζεται ένα σχέδιο δράσης που προσδιορίζεται από διαδικαστικά βήματα, τα οποία πρέπει να διεξαχθούν σε σχέση με την ίδια την έρευνα. Οι φάσεις αυτές είναι γνωστές ως «σχεδίαση έρευνας».

Ανάλογα με τις τεχνικές που χρησιμοποιούνται, η έρευνα μπορεί να χωριστεί σε:

- Ποσοτική έρευνα: χρησιμοποιεί διαρθρωμένη προσέγγιση, αποσκοπεί στην ποσοτικοποίηση της παραλλαγής ή της ποικιλομορφίας ενός φαινομένου, κατάστασης ή συμπεριφοράς μέσω μιας σωστά δομημένης σχεδίασης της έρευνας, η οποία παρέχει ποσοτικά δεδομένα που μπορούν να αναλυθούν για να επαληθεύσουν τις υποθέσεις και να ελέγξουν τις σχέσεις μεταξύ των μεταβλητών.
- Ποιοτική έρευνα: χρησιμοποιεί μια μη διαρθρωμένη προσέγγιση, είναι επεξηγηματική, περιγραφική και επαγωγική, με ιδιαίτερη έμφαση στο πλαίσιο, ενώ έχει ως στόχο να εντοπίσει και να περιγράψει όσο το δυνατόν περισσότερες παραλλαγές σε ένα φαινόμενο, κατάσταση ή συμπεριφορά, κατανοώντας τους λόγους που δικαιολογούν τις παραλλαγές αυτές. Το τελευταίο αυτό συνεπάγεται μια «ερμηνευτική και νατουραλιστική προσέγγιση του κόσμου, πράγμα που σημαίνει ότι οι ποιοτικοί ερευνητές μελετούν τα φαινόμενα στο φυσικό τους πλαίσιο, προσπαθώντας να τους δώσουν νόημα ή να τα ερμηνεύσουν ως προς το νόημα που τους αποδίδουν οι άνθρωποι» (Denzin & Lincoln, 2011, σελ. 3). Ο στόχος της ποιοτικής έρευνας είναι να περιγράψει και να κατανοήσει τα φαινόμενα παρά να τα προβλέψει ή/και να τα ελέγξει (Streubert & Carpenter, 2005).

Η μικτή προσέγγιση, από την άλλη πλευρά, συνδυάζει τόσο ποσοτικές όσο και ποιοτικές ερευνητικές μεθόδους. «Η κοινωνική έρευνα βασίζεται στον ορισμό των μεταβλητών, στην αναζήτηση συσχετισμών μεταξύ τους και στην προσπάθεια να καταλάβουμε εάν και πώς η παραλλαγή ενός πράγματος προκαλεί παραλλαγή σε ένα άλλο. Μερικές συνηθισμένες μεταβλητές που θα συναντήσετε στην κοινωνική έρευνα είναι η ηλικία, το φύλο, η εθνότητα, η φυλή, η εκπαίδευση, το εισόδημα, η οικογενειακή κατάσταση και η απασχόληση» (Bernard, 2006, σελ. 28-29). Επομένως, πρώτη συναντάμε την έννοια της μεταβλητής: κάτι που μπορεί να πάρει περισσότερες από μία τιμές. Σε δεύτερη φάση, έχουμε την έννοια της «μέτρησης»: στην πραγματικότητα, οι μεταβλητές μετρούνται με τους δείκτες τους, οι οποίοι καθορίζονται από τις τιμές της ίδιας της μεταβλητής. Η μέτρηση υποδηλώνει ποια τιμή

πρέπει να καταγραφεί. Κάθε αναζήτηση πρέπει επίσης να σέβεται τις αρχές της εγκυρότητας και της αξιοπιστίας. Η εγκυρότητα σημαίνει ότι η αναζήτηση πρέπει να διαθέτει ακριβή όργανα μέτρησης, δεδομένα και αποτελέσματα, ενώ η αξιοπιστία σημαίνει ότι τα ίδια αποτελέσματα επιτυγχάνονται μετρώντας τα πολλές φορές με το ίδιο όργανο.

Ο Bernard (2006) εξηγεί τα τέσσερα βασικά σημεία που ακολουθεί η ερευνητική διαδικασία:

1. Πρώτα διατυπώνεται ένα θεωρητικό πρόβλημα (επιστημονική θεωρία και βιβλιογραφία).
2. Στη συνέχεια, επιλέγονται κατάλληλες μονάδες ανάλυσης και μέθοδοι.
3. Έπειτα, γίνεται συλλογή και ανάλυση των δεδομένων.
4. Τέλος, η θεωρητική πρόταση με την οποία ξεκίνησε η έρευνα είτε αμφισβητείται είτε υποστηρίζεται.

(Bernard, 2006, σελ.69)

ΣΤΟΙΧΕΙΟ 2: ΕΡΕΥΝΑ ΔΡΑΣΗΣ

ΒΙΝΤΕΟ

Τι εστί έρευνα δράσης;

ΑΡΘΡΟ

Παραδοσιακά, το ερευνητικό έργο έχει να κάνει με την προέκταση των νόμων που εγγράφονται στη φύση του κόσμου με την αντικειμενική ανάλυση των φαινομένων. Ο ερευνητής πρέπει να διαχειριστεί τα φαινόμενα που μελετά από μια απολύτως ουδέτερη σκοπιά. Η έρευνα εξ ορισμού απευθύνεται στη θεωρία. Τείνει στη γενικότητα και στην οικοδόμηση μοντέλων όσο το δυνατόν πιο καθολικών. Η δράση, από την άλλη πλευρά, στην κοινή εμπειρία είναι γεμάτη με κίνητρα, επιθυμίες, συναισθήματα και γνώσεις που συχνά δεν είναι λογικές, είναι αντιφατικές και αποσκοπούν στην πραγματοποίηση, την απόκτηση και τη μετατροπή. Η δράση κατευθύνεται προς την πράξη, συνδέεται με το ιδιαίτερο και το μοναδικό, με το τοπικιστικό και το καταστασιακό, το ιστοριοποιημένο, δεν είναι πάντα προβλέψιμη στην προέλευση και τα αποτελέσματά της (Amerio, 2000). Η Έρευνα δράσης έχει γεννηθεί με την πρόθεση να συνδυάσει αυτές τις δύο διαστάσεις που παραδοσιακά έχουν θεωρηθεί ως ξεχωριστές και ασυμβίβαστες. Οι δύο ακρογωνιαίοι λίθοι της έρευνας δράσης, που την διαφοροποιούν από την παραδοσιακή έρευνα, είναι η συμμετοχή και η συνεργασία. Ο Elliot θα την όριζε ως εξής:

«Η έρευνα δράσης θα μπορούσε να οριστεί ως η μελέτη μιας κοινωνικής κατάστασης με στόχο τη βελτίωση της ποιότητας της δράσης μέσα σε αυτή. Με άλλα λόγια, αποσκοπεί στην εισαγωγή πρακτικής αξιολόγησης σε συγκεκριμένες καταστάσεις. Η εγκυρότητα των «θεωριών» ή των υποθέσεων που δημιουργεί εξαρτάται όχι τόσο από τις «επιστημονικές» επαληθεύσεις της αλήθειας αλλά από τη χρησιμότητά τους να βοηθήσουν τους ανθρώπους να δρουν με πιο έξυπνο και επιδέξιο τρόπο. Στην έρευνα δράσης, οι «θεωρίες» δεν επικυρώνονται ανεξάρτητα και στη συνέχεια εφαρμόζονται στην πράξη. Επικυρώνονται μέσω της πράξης.» (Elliott, 1994, σελ. 97)

Και συνεχίζει:

«Πρέπει να διαγνωσθεί το πρόβλημα - η κατάσταση και να σχεδιαστούν και εφαρμοστούν διορθωτικές ενέργειες, τα αποτελέσματα των οποίων πρέπει να ελέγχονται προκειμένου να γίνουν βελτιώσεις. Αυτή η συνολική διαδικασία ανάλυσης-διάγνωσης-σχεδιασμού-ενεργοποίησης-ελέγχου επιπτώσεων ονομάζεται έρευνα δράσης [...]». (Elliott, 1994, σελ. 96)

Το αρχικό μοντέλο της έρευνας δράσης αναπτύχθηκε από τον Lewin (1946) με στόχο την κατανόηση των προβλημάτων που υπάρχουν σε συγκεκριμένα πλαίσια μέσω της ανταλλαγής γνώσεων μεταξύ ανθρώπων, οι οποίοι είναι και ερευνητές και υποκείμενα πειραμάτων. Η δράση παίρνει ολοένα και περισσότερη αξία επειδή γίνεται μια στιγμή κατά την οποία δημιουργείται η γνώση για το πρόβλημα. Η διαδικασία της αλλαγής πραγματοποιείται σε τρία στάδια:

1. Ξεπάγωμα: παραβιάζεται η αρχική ισορροπία δρώντας με παράγοντες αντίστασης που συνδέονται με την τήρηση κοινωνικών κανόνων.
2. Κίνηση: νέα και υπάρχοντα στοιχεία στον τομέα κινούνται σύμφωνα με τις δυνάμεις που δρουν εντός αυτού.
3. Ξαναπάγωμα: η νέα κατάσταση σταθεροποιείται γύρω από μια νέα ισορροπία.

Επομένως, η έρευνα δράσης αποτελεί μια «συστηματική συλλογή και ανάλυση δεδομένων με σκοπό τη λήψη μέτρων και την πρόκληση αλλαγής», δημιουργώντας κοινές πρακτικές γνώσεις (Gillis & Jackson, 2002, σελ. 264).

Στόχος κάθε έρευνας δράσης είναι η παραγωγή κοινωνικής αλλαγής μέσω της δράσης (ή των δράσεων), που με τη σειρά τους είναι ο τελικός στόχος της έρευνας (Greenwood & Levin, 1998, McNiff & Whitehead, 2006, MacDonald, 2012).

Οι ερευνητές που ξεκινούν μια έρευνα δράσης έχουν κατά νου την υπόθεση ότι η πραγματικότητα δημιουργείται και αναδημιουργείται μέσω μιας συνεχούς κοινωνικής διαδικασίας. Αναγνωρίζουν ότι, σύμφωνα με τους Argyris et al (1982), τα κρίσιμα στοιχεία μιας ερευνητικής προσέγγισης που λειτουργεί μέσα σε μια συγκεκριμένη κοινωνική κατάσταση είναι: συνεργασία μεταξύ ερευνητών και κοινοτήτων αναφοράς, διαδικασία κρίσιμης έρευνας, εστίαση στην κοινωνική πρακτική και μια αντανακλαστική διαδικασία μάθησης. Αυτό συνεπάγεται αναγκαστικά ένα διαφορετικό είδος έρευνας από την επαλήθευση των υποθέσεων, η οποία δίνει περισσότερη προσοχή στα θέματα της έρευνας, που δηλώνονται και συζητούνται απαραίτητα, επιτρέποντας σε όσους ενδιαφέρονται να υποβάλουν την έρευνα προς σοβαρή εξέταση (Checkland & Holwell, 1998).

BINTEO: GATTINO - Ricerca Azione

ΣΤΟΙΧΕΙΟ 3: ΣΥΜΜΕΤΟΧΙΚΗ ΕΡΕΥΝΑ ΔΡΑΣΗΣ

BINTEO GATTINO - RICERCA AZIONE PARTECIPATA

ΑΡΘΡΟ

Όπως επισημαίνει ο Vargiu (2008), ο τομέας της έρευνας δράσης επαναφέρει πολύ διαφορετικές εμπειρίες, ενώ συνδυάζεται με το γεγονός ότι επιδιώκονται δύο βασικοί στόχοι: η κατανόηση και η αλλαγή. Με την ανάλυση της βιβλιογραφίας είναι δυνατό να οριστεί η έρευνα δράσης ως μια «οικογένεια προσεγγίσεων» (Reason 1994, Reason - Bradbury 2006) προσανατολισμένη στην «τοποθέτηση της έρευνας στην υπηρεσία της κοινότητας, μέσω της ενεργοποίησης συμμετοχικών πρακτικών για τους σκοπούς της κοινωνικής αλλαγής. Αυτό συνεπάγεται ουσιαστικές διαφορές σε σχέση με άλλες μορφές έρευνας, όσον αφορά στους στόχους που ο ίδιος ο ερευνητής θέτει, τις επιστημολογικές υποθέσεις και τις πρακτικές του. (σελ. 206). Σύμφωνα με τον συγγραφέα, αυτή η «οικογένεια» συνδέεται με πολλές προσεγγίσεις και πρακτικές, όπως: 1) έρευνα δράσης, 2) συμμετοχική έρευνα, 3) συμμετοχική έρευνα δράσης, 4) συμμετοχική έρευνα δράσης, 5) επιστήμη δράσης, 6) έρευνα δράσης 7) κοινωνιολογία δράσης ή *sociologie de l'action* (Bartoletto, 2006). Ο Vargiu (2008) προσθέτει επίσης τις εμπειρίες που μπορούν να αναχθούν στην Έρευνα βάσει της κοινότητας και στην Έρευνα δράσης (Συμμετοχική) βάσει της κοινότητας, ενώ παρατηρεί ότι «η συμμετοχική έρευνα και η συμμετοχική έρευνα δράσης μπορούν να ενταχθούν στην κατηγορία έρευνας που ο Capecchi (2006) ορίζει ως «con-ricerca»». (σελ. 209). Σύμφωνα με τον συγγραφέα, αυτό που επιτρέπει τη χρήσιμη διαφοροποίηση είναι το επίπεδο συμμετοχής που προβλέπεται στην ερευνητική διαδικασία και πόσος, κατά τον προσδιορισμό των στόχων, των διαδικαστικών στοιχείων και των μέσων, χώρος δίνεται στην υποκειμενική και συλλογική διάσταση.

Η συμμετοχική έρευνα και η έρευνα δράσης αποτελούν όλο και περισσότερο κεντρικά παραδείγματα στις κοινωνικές επιστήμες (Brydon-Miller et al., 2004, Greenwood and Levin, 1998, Kindon, Pain and Kesby, 2007, Jason et al., 2004, Park et al., 1993, Reason and Bradbury, 2006, Selener, 1997, Taggart, 1997). Όπως υποδεικνύεται από τους Kindon, Pain και Kesby (2007) και από τους Mackenzie και συνεργάτες (2012), η Συμμετοχική έρευνα δράσης (PAR) περιλαμβάνει ερευνητές και συμμετέχοντες σε ένα γενικό έργο, με στόχο την εξέταση μιας προβληματικής κατάστασης ή δράσης, αποσκοπώντας έτσι στην τροποποίησή

της προς μια καλύτερη κατεύθυνση (Wadsworth, 1998). Πρόκειται για μια συνεργατική διαδικασία έρευνας, εκπαίδευσης και δράσης (Hall, 1981) προσανατολισμένη προς τον κοινωνικό μετασχηματισμό (McTaggart, 1997), ξεκινώντας από την αναγνώριση της ύπαρξης μιας πληθώρας γνώσεων σε διάφορους θεσμούς και πλαίσια (Kindon, Pain and Kesby, 2007). Η διαδικασία είναι κυκλική (βάσει κύκλων ανάκλασης-δράσης): οι ερευνητές και οι συμμετέχοντες αναγνωρίζουν ένα πρόβλημα ή μια κατάσταση που χρειάζεται να αλλάξει και ξεκινούν έρευνα, η οποία βασίζεται σε δεξιότητες και πόρους για να επιταχυνθεί η σχετική δράση. Τόσο οι ερευνητές όσο και οι συμμετέχοντες αναλογίζονται αυτήν τη δράση, μαθαίνουν από αυτή και προχωρούν σε έναν νέο κύκλο έρευνας/δράσης/προβληματισμού. Όπως διευκρινίζουν οι Kindon, Pain και Kesby (2007), συνεργάζονται επίσης για την ανάπτυξη μεθόδων που αφορούν συγκεκριμένα πλαίσια με σκοπό τη διευκόλυνση αυτών των κύκλων. Συνοπτικά, η PAR επικεντρώνεται στη διαλογική δέσμευση μεταξύ των συνεργατών ερευνητών (Kindon, Pain and Kesby, 2007) κι έτσι, η PAR είναι ένας προσανατολισμός στη διεξαγωγή έρευνας (Reason 2004, Kesby et al, 2005), που απαιτεί μεθοδολογική καινοτομία και λαμβάνει υπόψη την ερευνητική διαδικασία καθώς και τα προϊόντα της: η αποτελεσματικότητά της δεν είναι μόνο εγγενής στην ποιότητα της παραγόμενης πληροφορίας, αλλά καθορίζεται και από τον βαθμό στον οποίο οι δεξιότητες, οι γνώσεις και οι ικανότητες των συμμετεχόντων αναπτύσσονται μέσω της ερευνητικής εμπειρίας (Cornwall and Jewkes 1995, Kesby et al., 2005, 2007, Maguire 1987).

Οι Reason και Bradbury (2006) υποστηρίζουν την ανάγκη υιοθέτησης μιας συμμετοχικής προοπτικής ή μιας παγκόσμιας άποψης, η οποία «μας ζητά να είμαστε σε θέση και να στοχαζόμαστε, να είμαστε σαφείς σχετικά με την προοπτική από την οποία δημιουργείται η γνώση, να βλέπουμε την έρευνα ως διαδικασία γνώσης, να υπηρετούμε τη δημοκρατική και πρακτική δεοντολογία της έρευνας δράσης» (σελ. 7). Σύμφωνα με τον Kindon και τους συνεργάτες (2007), το κλειδί είναι μια οντολογική άποψη που υποδηλώνει ότι οι άνθρωποι είναι δυναμικοί παράγοντες, προικισμένοι με αντανακλαστικές δεξιότητες και προσωπική αλλαγή, καθώς και μια επιστημολογία που αγκαλιάζει αυτές τις δεξιότητες μέσα στην ερευνητική διαδικασία.

Ακολουθώντας μια θεμελιωδώς συμμετοχική προοπτική, στην PAR, οι επιλογές σχετικά με τους τρόπους και τα επίπεδα συμμετοχής δεν γίνονται μόνο *εκ των προτέρων* από τον ερευνητή, αλλά τίθενται υπό διαπραγμάτευση με συναδέλφους και συμμετέχοντες. Οι πιο συνηθισμένες μέθοδοι που χρησιμοποιούνται στην PAR εστιάζουν στον διάλογο, την

αφήγηση και τη συλλογική δράση, ενώ αυτές που χρησιμοποιούνται συχνότερα είναι (Kindon, Pain and Kesby, 2007):

- Έρευνες

- Παρατήρηση συμμετέχοντα

- Δευτερεύουσα ανάλυση δεδομένων

- Μάθηση μέσω της πράξης

- Διάλογος

- Πολιτική δράση

- Ομαδική εργασία και συζητήσεις

- Συνεντεύξεις

- Αφήγηση

- Χαρτογράφηση

- Τέχνη και μέσα της κοινότητας

- Δημιουργία διαγραμμάτων

- Εκπαιδευτικά κέντρα

- Προγράμματα ανταλλαγής

- Κατάταξη και βαθμολόγηση

- Κοινή ανάλυση, καταγραφή και παρουσιάσεις

Όπως έχει ήδη τονιστεί, η ενεργή έρευνα γίνεται συμμετοχική έρευνα δράσης ανάλογα με το ποιος συμμετέχει σε κάθε φάση και σε ποιον βαθμό. Οι συμμετέχοντες ως συνεργάτες μπορούν να ενημερώσουν τη σχεδίαση, να προτείνουν μεθόδους, να διευκολύνουν ορισμένες δραστηριότητες και, πάνω από όλα, να επανεξετάσουν και να αξιολογήσουν τη διαδικασία στο σύνολό της (Mackenzie et al., 2012). Από τη φάση σχεδιασμού, η PAR τείνει να περιλαμβάνει τη χρήση καθιερωμένων ερευνητικών τεχνικών προσαρμοσμένων στην κατάσταση, ενώ θεωρεί απαραίτητο να αναπτυχθεί μια στρατηγική (πριν από τη δράση) για την παρακολούθηση και την αξιολόγηση των αποτελεσμάτων της δράσης. Αυτό θα επιτρέψει την αναγνώριση της έκτασης των αλλαγών αλλά και τη «διατύπωση μιας ισχυρής

επιστημολογίας πάνω στην οποία θα εκτιμηθεί η εγκυρότητα και η σημασία της νέας ή αναδυόμενης γνώσης, όπως σε ένα συστημικό σύστημα σκέψης» (Ison, 2008). Οι αποτελεσματικές διαδικασίες παρακολούθησης και αξιολόγησης παρέχουν την αυστηρότητα της διαδικασίας αξιολόγησης της αποτελεσματικότητας, της καταλληλότητας και της συνάφειας της παρέμβασης στην έρευνα δράσης. Παρέχει επίσης ένα πλαίσιο για τον προσδιορισμό της αιτιότητας κατά τον προσδιορισμό του σε ποιο βαθμό η ερευνητική δραστηριότητα «προκάλεσε» ή «συνέβαλε» στις επιθυμητές αλλαγές στην κατάσταση (McAllister and Vernooy, 1999). (σελ. 12-13). Η αξιολόγηση της διαδικασίας και των αποτελεσμάτων από τους συμμετέχοντες παρέχει μια περαιτέρω οδό για την εδραίωση της δέσμευσης των ενδιαφερομένων μερών, ενώ προσφέρει τη συλλογική ευκαιρία να συνυπάρξουν μια ενεργή και ουσιαστική δέσμευση, στις οποίες οι εναλλακτικές φωνές είναι απαραίτητες και μεταδοτικές. Επομένως, η PAR απαιτεί από τον ερευνητή να εγκαταλείψει τον έλεγχο και να αναλάβει τον ρόλο του διευκολυντή της διαδικασίας (Kindon, Pain and Kesby, 2007, Janssen et al., 2013).

Όπως επισημαίνεται από τον Kangovi και τους συνεργάτες (2014), η PAR στον τομέα της ψυχικής υγείας μπορεί να θεωρηθεί μια καλή στρατηγική για να καταστεί λειτουργική η συμμετοχή του ασθενούς στη σχεδίαση. Ο συνεργατικός και επαναλαμβανόμενος χαρακτήρας της επιτρέπει στους ερευνητές, το προσωπικό στην υγειονομική περίθαλψη και τους ασθενείς να συνεργαστούν κατά τη σχεδίαση των παρεμβάσεων που επικυρώνονται από τους τελικούς χρήστες. Μπορεί επίσης να χρησιμοποιηθεί για να προσαρμόσει μια υπάρχουσα παρέμβαση σε συγκεκριμένες ανάγκες και, όταν διαδοθεί, σε νέους χώρους ή/και ομάδες ασθενών. Σχετικά με το πεδίο εφαρμογής στους νέους πληθυσμούς, όπως υποδεικνύεται από τους Shamrova και Cummings (2017), το παράδειγμα των δικαιωμάτων των παιδιών έχει δώσει μεγαλύτερη ώθηση στους ερευνητές να αναγνωρίσουν τα παιδιά ως ενεργούς συμμετέχοντες στην οικοδόμηση του νοήματος. Σε αυτό, η PAR είναι ένας μηχανισμός μέσω του οποίου η δυνατότητα δράσης διανέμεται στους συμμετέχοντες, υποστηρίζοντας την εφαρμογή των δικαιωμάτων των παιδιών (Checkoway, 2011, Quijada Cerecer, Cahill and Bradley, 2013, Shamrova and Cummings, 2017). Επιπλέον, σε ολόκληρη τη βιβλιογραφία, τα αποτελέσματα σχετικά με την εφαρμογή της αναφέρονται επίσης σε οργανωτικό επίπεδο. Τα πιο συχνά ήταν οι αλλαγές στην οργανωτική παιδεία με στόχο: να αυξηθούν οι δυνατότητες συμμετοχής, να αυξηθεί το επίπεδο συμμετοχής στο παιδί και να διαδοθεί μεγαλύτερη πληροφόρηση ώστε τα προγράμματα να προσαρμοστούν καλύτερα στις ανάγκες των παιδιών και των νέων (Shamrova and Cummings, 2017). Επιπλέον, οι

συγγραφείς (Shamrova and Cummings, 2017) έχουν αναγνωρίσει ορισμένες μεθοδολογικές επιλογές που θα μπορούσαν να βοηθήσουν στη στήριξη της συμμετοχής των παιδιών ως σημαντικής:

- κατάρτιση

- επιλογή και χρήση εργαλείων συλλογής δεδομένων φιλικών προς τα παιδιά

- ενεργή συμμετοχή των παιδιών στην ανάλυση δεδομένων και την ανάγνωση των αποτελεσμάτων

- επιλογή σημαντικών τοποθεσιών για τη διάδοση των ερευνητικών αποτελεσμάτων.

Όσον αφορά στην έρευνα με ευάλωτες ομάδες, όπως επισημαίνουν οι Lushey και Munro (2015), η PAR μπορεί να προωθήσει τα δικαιώματα συμμετοχής των παιδιών και όσων χάνουν τη φροντίδα τους και ταυτόχρονα να ενημερώσει την εμπειρική βάση που προκύπτει από μελέτες σε αυτούς τους πληθυσμούς.

Σε εννοιολογικό επίπεδο, είναι ιδιαίτερα ενδιαφέρουσα η Συμμετοχική έρευνα δράσης των νέων (YPAR) (Anyon et al., 2018, Rodriguez and Brown, 2009), η οποία περιλαμβάνει τις ακόλουθες βασικές αρχές:

1. βασίζεται στην έρευνα
2. οι τομείς που εξερευνώνται είναι οι εμπειρίες ακριβώς όπως τις ζουν οι νέοι
3. είναι συμμετοχική
4. έχει μετασχηματιστικό χαρακτήρα

Οι βασικές της διαδικασίες είναι:

α) η κατανομή εξουσίας μεταξύ των νέων και των ενηλίκων κατά τη διάρκεια ολόκληρης της διαδικασίας

β) η κατάρτιση και εφαρμογή μεθόδων έρευνας και προώθησης

γ) η κρίσιμη χρήση της στρατηγικής σκέψης για τον τρόπο με τον οποίο μπορεί να δημιουργηθεί η κοινωνική αλλαγή

δ) η δημιουργία συμμαχιών με όλα τα ενδιαφερόμενα μέρη.

Τέλος, ένα παράδειγμα έρευνας σύμφωνα με το πρότυπο της PAR είναι αυτό που πραγματοποίησαν οι Törrönen και Vornanen (2014) με άτομα που αποχωρούν από τη φροντίδα. Σύμφωνα με τις παραπάνω αρχές, όπως ανέφεραν οι συγγραφείς, οι εμπλεκόμενοι

επαγγελματίες και ερευνητές ανέλαβαν υποστηρικτικό ρόλο, ενώ οι νέοι διεξήγαγαν συνεντεύξεις, συγκέντρωσαν δεδομένα από τους συνομηλίκους τους και ενθάρρυναν την έκφραση απόψεων σχετικά με τις εμπειρίες (Törrönen & Vauhkonen, 2012). Η κεντρική πτυχή ήταν, στην πραγματικότητα, η προσοχή στο όραμα των ανήλικων που συμμετείχαν ως συν-ερευνητές. Ως εκ τούτου, συμμετείχαν πλήρως στην ερευνητική διαδικασία.

BINTEO: GATTINO - Ricerca Azione Partecipata

ΣΤΟΙΧΕΙΟ 4: ΕΡΕΥΝΑ ΒΑΣΕΙ ΑΠΟΔΕΙΞΕΩΝ

ΒΙΝΤΕΟ

Είδη έρευνας που χρησιμοποιούνται για πρακτική βάσει αποδείξεων

ΑΡΘΡΟ

Ο όρος «έρευνα βάσει αποδείξεων» (EBR) επινοήθηκε το 2009 για να υποδείξει την προσέγγιση που δρα ενάντια στη σημαντική πηγή άχρηστου υλικού στη βιοϊατρική έρευνα (Robinson, 2009) η οποία οφείλεται κυρίως σε αρχικές μελέτες που πραγματοποιήθηκαν χωρίς συστηματική αναθεώρηση των διαθέσιμων στοιχείων. Αυτό δεν θεωρήθηκε ούτε ηθικό ούτε επιστημονικό (Lund, H. et al., 2017). Η έρευνα βάσει αποδείξεων στηρίζεται πάντοτε σε μια συστηματική αναθεώρηση (SR), η οποία περιλαμβάνει προκαθορισμένες ερευνητικές ερωτήσεις, κριτήρια συμπερίληψης, μεθόδους έρευνας, διαδικασίες επιλογής, αξιολόγηση ποιότητας, εξαγωγή δεδομένων και στατιστική ανάλυση (Lund, H. et al., 2017). Οι συστηματικές αναθεωρήσεις χρησιμοποιούνται για να κατανοήσουμε και να δώσουμε προτεραιότητα στην έρευνα, καθώς και εάν αυτή είναι απαραίτητη και χρήσιμη για την κοινότητα ή όχι ή μια πιθανή πηγή άχρηστων πόρων επειδή δεν παράγει νέες επιστημονικές γνώσεις. Οι κατευθυντήριες γραμμές που πρότεινε το Evidence, ένα περιοδικό ανοικτής πρόσβασης του Ιδρύματος GIMBE (ιταλική ομάδα για την τεκμηριωμένη ιατρική), για τη δημιουργία ενός ερευνητικού έργου βάσει αποδείξεων, έχουν ως εξής:

1. Να διατυπωθεί το προκαταρκτικό ερευνητικό ερώτημα και να προσδιοριστούν οι σχετικές συστηματικές αναθεωρήσεις,
2. Να αξιολογηθεί η επάρκεια του σκοπού, της ποιότητας και της ενημέρωσης της έρευνας,
3. Να αξιολογηθούν οι λεπτομέρειες σχετικά με: τον πληθυσμό, την παρέμβαση, τη σύγκριση, τα αποτελέσματα και το εύρος χρόνου (PICOT),
4. Να αξιολογηθεί η μέθοδος που χρησιμοποιήθηκε και τα αποτελέσματα.

Τέλος, οι ερευνητές θα πρέπει να χρησιμοποιούν συστηματικές αναθεωρήσεις για να διατυπώνουν το τελικό ερώτημα της μελέτης που επιθυμούν να προωθήσουν, να δικαιολογούν την ανάγκη για αυτή κατά τη διάρκεια της αίτησης χρηματοδότησης και έγκρισης από την επιτροπή δεοντολογίας, να ερμηνεύουν τα αποτελέσματα της νέας μελέτης στο πλαίσιο των διαθέσιμων στοιχείων και να κάνουν συστάσεις για μελλοντική έρευνα. Με την πάροδο του χρόνου, σημειώθηκε ραγδαία ανάπτυξη στην έρευνα βάσει αποδείξεων, η οποία οδήγησε στη δημοσίευση περίπου δύο εκατομμυρίων άρθρων σε πάνω από είκοσι χιλιάδες περιοδικά. Υπάρχουν πολλοί λόγοι για την ανάπτυξη αυτή, αφενός, ο εκπαιδευτικός

της προσανατολισμός (JAMA, 1992) και η μετατόπιση των παραδειγμάτων (Pagliaro & Colli, 2014) που οδήγησαν στην πρακτική αυτή και, αφετέρου, τα πλεονεκτήματα που η έρευνα βάσει αποδείξεων παρουσιάζει:

- επιτρέπει την παραγωγή γνώσεων και την καθοδήγηση επαγγελματικής πρακτικής σε τομείς όπου υπάρχει μεγαλύτερη αβεβαιότητα σχετικά με τις παρεμβάσεις που πραγματοποιούνται στην κλινική πρακτική,

- μειώνει το άχρηστο υλικό διότι καθορίζει τις προτεραιότητες των ερευνητικών ερωτήσεων λαμβάνοντας υπόψη προηγούμενες συστηματικές αναθεωρήσεις,

- επιτρέπει μια σαφή περιγραφή των ερευνητικών σχεδίων (πληθυσμός στόχος, παρεμβάσεις, συγκρίσεις, αποτελέσματα),

- παρέχει ενημερώσεις και διαδίδει συστηματικές αναθεωρήσεις,

- ενσωματώνει τις αποδείξεις στην κλινική πρακτική,

- επιτρέπει μια συνεχή επανεκτίμηση της γνώσης κάποιου (GIMBE).

ΣΤΟΙΧΕΙΟ 1: ΕΡΕΥΝΑ ΒΑΣΕΙ ΑΠΟΔΕΙΞΕΩΝ ΟΣΟΝ ΑΦΟΡΑ ΣΤΑ TIC/TIP (ΠΡΩΤΟΚΟΛΛΟ ΒΕΛΤΙΩΣΗΣ ΤΗΣ ΘΕΡΑΠΕΙΑΣ): ΔΙΕΘΝΗΣ ΠΡΟΟΠΤΙΚΗ

ΑΡΘΡΟ

Ένα από τα κύρια θέματα της οργάνωσης των υπηρεσιών που ασχολούνται με ανηλίκους με ψυχικό τραύμα και ένα από τα σημαντικότερα αιτήματα που προέρχονται από αυτές είναι ο τρόπος εξασφάλισης επαρκούς και αποτελεσματικής κατάρτισης για επαγγελματίες όσον αφορά στις παρεμβάσεις βάσει αποδείξεων (Ruzek & Rosen, 2009). Κατά την παρακολούθηση της κατάστασης της εφαρμογής θεραπειών και κατευθυντήριων γραμμών βάσει αποδείξεων από μια γενικότερη προοπτική, παρά τη σπουδαιότητα του θέματος αυτού στον τομέα της δημόσιας υγείας, μπορεί να συναχθεί μια άνιση εφαρμογή και περιορισμένη προσοχή στη συστηματική αξιολόγηση και τις μακροπρόθεσμες επιπτώσεις των προγραμμάτων κατάρτισης (Ruzek & Rosen, 2009). Επιπλέον, από συγκριτική άποψη, ο Delaney (2006) υπογράμμισε μια άλλη συναφή πτυχή: σε διεθνές επίπεδο, οι κατευθυντήριες γραμμές και η εφαρμογή τους σε προαιρετικές θεραπείες σε όλη την κλινική πρακτική ποικίλλουν σημαντικά σε εθνικό επίπεδο και σε διαφορετικά κράτη (συμπεριλαμβανομένων των κανονισμών δημόσιας υγείας). Οι Weiner, Schneider & Lyons (2009) μελέτησαν την ανάλυση των μεθόδων βάσει αποδείξεων για τη θεραπεία ψυχικών τραυμάτων σε ανηλίκους. Όπως καθορίζεται από τους συγγραφείς, μερικές από αυτές έχουν δοκιμαστεί μέσω πειραματικών ή σχεδόν πειραματικών μεθόδων, αλλά οι περισσότερες μέθοδοι έχουν δομηθεί για τους ενήλικους πληθυσμούς παρά την εφαρμογή τους και σε ανηλίκους, ενώ έχουν αξιολογηθεί με μικρή ή καθόλου προσοχή στις πολιτισμικές μεταβλητές και τη διαφοροποίηση των υποομάδων βάσει παραγόντων που επηρεάζουν τα αποτελέσματα. Από αυτές τις παρατηρήσεις μπορεί να προκύψει μια ενδιαφέρουσα πρόσκληση για διαπολιτισμική επικύρωση των θεραπειών, η οποία θα επέτρεπε όχι μόνο την επέκταση της αποτελεσματικότητας αλλά και τη διερεύνηση των φραγμών που εμποδίζουν την εφαρμογή τους καθώς και των ευέλικτων απαιτήσεων προσαρμογής σε σχέση με συγκεκριμένες υποομάδες ή συνθήκες εφαρμογής. Οι Courtois & Gold (2009) και Layne & συνεργάτες (2014) υπογράμμισαν την ανάγκη να συμπεριληφθεί μια ειδική εστίαση στο ψυχικό τραύμα και τις συνέπειές του στην κατάρτιση των φορέων, ξεκινώντας από την ενημέρωση του γεγονότος ότι το ψυχικό τραύμα και οι επιπτώσεις του επηρεάζουν όλες τις φάσεις της θεραπείας, συγκεκριμένα, τη δέσμευση του ασθενούς, την αξιολόγηση και την ανταπόκριση στη θεραπεία. Επιπλέον, υπογραμμίζουν, από αυτήν την άποψη, τον σχετικό ρόλο που διαδραματίζει η δημιουργία διεθνών προτύπων και κοινών μεθόδων κατάρτισης για τους

φορείς στην Πρακτική βάσει αποδείξεων (EBP, Lyon et al., 2011). Η EBP επιτρέπει στον φορέα να επιλέξει τις καλύτερες δυνατές επιλογές, επικυρωμένες και κατάλληλες για τη συγκεκριμένη κατάσταση, με βάση τις συγκεκριμένες ανάγκες του πελάτη, τα πλεονεκτήματα και τις περιστάσεις τους (Layne et al., 2014). Προκειμένου να διασφαλιστεί επαρκής κατάρτιση στον τομέα αυτό, είναι επιτακτική η ανάγκη η επιστημονική κοινότητα να δημιουργήσει έναν ορισμό των βασικών ικανοτήτων, δηλαδή μια βάση γνώσης που πρέπει να διαθέτουν όσοι ασχολούνται με ένα ιστορικό ψυχικού τραύματος. Ειδικότερα, αυτή η προσοχή θα πρέπει να επιτρέπει την καλή ποιότητα των παρεχόμενων υπηρεσιών, να αυξάνει την ευθύνη των φορέων και να διαδίδει τις γνώσεις που μοιράζονται και, συχνά, αποτελούν αντικείμενο εγχειριδίων μέσω πρωτοκόλλων μεταξύ διαφόρων κλάδων (ψυχολογία, ψυχοθεραπεία, κοινωνικές επιστήμες, ψυχιατρική κλπ.). Το δίκτυο National Child Traumatic Stress Network (NCTSN) είναι ένα δίκτυο επαγγελματιών, μελών της οικογένειας, ερευνητών και διεθνών συνεργατών που ασχολούνται με τη βελτίωση των προτύπων φροντίδας και την ευκαιρία πρόσβασης σε υπηρεσίες για παιδιά και οικογένειες. Το NCTSN δημιούργησε ένα πρωτόκολλο κατάρτισης με τίτλο CCCT (Core Curriculum on Childhood Trauma) (Layne et al., 2011) που αποσαφηνίζει τα βασικά στοιχεία της παρέμβασης (με την ενσωμάτωσή τους σε έναν ολοκληρωμένο πίνακα βάσει αποδείξεων), τις βασικές έννοιες του ψυχικού τραύματος και των ουσιαστικών θεραπευτικών δεξιοτήτων για τον σχεδιασμό και την εφαρμογή μιας αποτελεσματικής παρέμβασης για παιδιά που υποφέρουν από ψυχικό τραύμα και τις οικογένειές τους. Δύο στοιχεία φαίνονται θεμελιώδη: οι στόχοι της παρέμβασης (στόχοι που αναμένεται να επιτευχθούν μέσω της παρέμβασης) και τα πρακτικά στοιχεία (οι πραγματικές διαδικασίες που πρέπει να εφαρμοστούν για την επίτευξη αποτελεσμάτων). Αυτή η προσοχή στην κατάρτιση των φορέων σχετικά με τις βασικές ικανότητες περνά μέσα από τον προσδιορισμό συγκεκριμένων «χρυσών κανόνων» σε σχέση με την κατάρτιση EBP και τις θεραπείες βάσει αποδείξεων (EBTT, Θεραπείες ψυχικού τραύματος βάσει αποδείξεων). Το CCCT περιλαμβάνει 5 επίπεδα: α) Βάση εμπειρικών αποδείξεων, β) 12 βασικές έννοιες για την κατανόηση των αντιδράσεων τραυματικού άγχους σε παιδιά και οικογένειες, γ) τους στόχους παρέμβασης, δ) πρακτικά στοιχεία (παρατηρήσιμες ενέργειες που τίθενται σε εφαρμογή για την επίτευξη των στόχων), ε) θεραπευτικές δεξιότητες/ικανότητες (δύο υπο-επίπεδα: 1) διαδικαστικές και προσανατολισμένες στη διαδικασία, 2) αξιολογητικές). Το προαναφερθέν μοντέλο υποστηρίζει πρακτικές και ικανότητες βάσει αποδείξεων, όπως συνηθισμένη αξιολόγηση και συλλογή πληροφοριών, θεωρία της πρακτικής, εφαρμογή των αποτελεσμάτων που προέρχονται από την επιστημονική βιβλιογραφία σε μεμονωμένες καταστάσεις ασθενών,

διατύπωση των περιπτώσεων και σχεδιασμός της παρέμβασης. Κατά τη διαδικασία εξέτασης και εφαρμογής του μοντέλου CCCT, μια ομάδα εργασίας έχει σχεδιάσει μια ειδική συνεδρία βελτίωσης των ικανοτήτων στατιστικής ανάλυσης και διάρθρωσης των πρωτοκόλλων μελέτης που είναι χρήσιμα για την επικύρωση της κλινικής πρακτικής. Αυτό που υπογραμμίζεται περισσότερο είναι η πρόσκληση για ανάπτυξη τόσο των θεωρητικών πτυχών όσο και των μεθόδων αξιολόγησης (πολυδιάστατες), καθώς και η εμπειρική βάση που είναι προσβάσιμη στην αξιολόγηση και επικύρωση των παρεμβάσεων (ιδίως για τα αποτελέσματα, τους παρεμβατικούς παράγοντες και την αποτελεσματικότητα των παρεμβάσεων με επίκεντρο την ειδική κατάσταση ενός ατόμου). Οι Briggs & συνεργάτες (2012) προσδιορίζουν περαιτέρω ως προτεραιότητα τη βελτίωση των προτύπων μέσω «[…] της ανάπτυξης, της εφαρμογής και της διάδοσης βάσει αποδείξεων» (σελ. 1). Η διάρθρωση των κατευθυντήριων γραμμών παρέμβασης με στόχο την αναγνώριση των βέλτιστων στόχων και των μεθόδων προσδιορισμού (ποιες συγκεκριμένες περιστάσεις μπορούν να δοθούν στην καλύτερη παρέμβαση) και την αξιολόγηση των αποτελεσμάτων είναι θεμελιώδης και χρήσιμη για τους φορείς και για όσους ασχολούνται με τη διάρθρωση των υπηρεσιών. Τα ερευνητικά σχέδια που μπορεί να είναι χρήσιμα είναι εκείνα που εξετάζουν τη διασύνδεση μεταξύ παραγόντων κινδύνου και διαφορετικών αποτελεσμάτων, προκειμένου να αποσαφηνιστεί σε ποια στοιχεία μπορεί να εστιάσει η παρέμβαση, καθώς και, αναδρομικά, να συμπεριλάβει νέες πτυχές στη θεωρητική κατανόηση του ψυχικού τραύματος και να περιπλέξει το επιστημονικό πλαίσιο. Ιδιαίτερο ενδιαφέρον έχει στην πραγματικότητα η παρατήρηση ότι οι θεραπείες που στοχεύουν στη μείωση των συμπτωμάτων που σχετίζονται με PTSD (διαταραχή μετατραυματικής καταπόνησης) είναι επίσης αποτελεσματικές για τη μείωση των λειτουργικών δυσκολιών που δεν σχετίζονται άμεσα με το αντικείμενο της θεραπείας. Αυτό υπογραμμίζει τον τρόπο με τον οποίο μια θεραπεία εστιασμένη στο ψυχικό τραύμα μπορεί να παράγει θετικές, ευρείας κλίμακας επιδράσεις (Layne et al., 2010).

ΣΤΟΙΧΕΙΟ 2: ΑΝΑΓΚΕΣ ΚΑΤΑΡΤΙΣΗΣ ΣΕ ΟΡΓΑΝΙΣΜΟΥΣ ΠΟΥ ΑΣΧΟΛΟΥΝΤΑΙ ΜΕ ΤΗΝ TIC

ΑΡΘΡΟ

Οι Bryson και συνεργάτες (2017) θέτουν μια ενδιαφέρουσα προϋπόθεση που είναι χρήσιμη για τη διάκριση δύο επιπέδων αντανάκλασης, τα οποία εφαρμόζονται στην ανάλυση και αξιολόγηση των θεμάτων αυτής της ενότητας. Οι συγγραφείς διαχωρίζουν τις θεραπείες που είναι συγκεκριμένες για το ψυχικό τραύμα (δηλαδή τεχνικές παρέμβασης που στοχεύουν στη μείωση των συμπτωμάτων, τα οποία σχετίζονται με το ψυχικό τραύμα) από την TIC ως μια γενική προοπτική, η οποία στοχεύει σε μετασχηματισμό του συστήματος φροντίδας, συμπεριλαμβανομένης της κατανόησης των αντιδράσεων τραυματικού άγχους σε κάθε επίπεδο και σε όλες τις πτυχές οργάνωσης των υπηρεσιών. Παρά τη μεγάλη ζήτηση για την εφαρμογή των αρχών TIC στις υπηρεσίες και παρά τα πλεονεκτήματα που μπορεί να έχει, η επιστημονική συμβολή στην εφαρμογή της TIC για τους ανήλικους πελάτες είναι, δυστυχώς, περιορισμένη (Bryson et al., 2017). Οι Ruzek & Rosen, το 2009, έχουν ήδη παρατηρήσει ότι η διάδοση θεραπειών βάσει αποδείξεων που εστιάζουν σε συμπτώματα, τα οποία σχετίζονται με PTSD, ήταν ένα από τα βασικά στοιχεία για τα οποία δεσμεύτηκαν οργανισμοί που υποστηρίζουν τους ανθρώπους που υποφέρουν από ψυχικό τραύμα και, ως εκ τούτου, γίναμε μάρτυρες μιας αύξησης της επιστημονικής βιβλιογραφίας σχετικά με τους οργανωτικούς παράγοντες, οι οποίοι συνδέονται με την εφαρμογή και τη διάδοση βέλτιστων πρακτικών. Παρά ταύτα, σε μια προηγούμενη ανάλυση που εισήγαγε ο Delaney (2006), επιβεβαιωμένη από τους Ruzek & Rosen (2009) και από τους ίδιους τους Bryson και συνεργάτες (2017), προέκυψε μεγάλη αστάθεια των ποσοστών χρήσης πρακτικών, όπως ο περιορισμός και η απομόνωση. Επιπλέον, όπως τόνισαν οι Valenkamp και συνεργάτες (2014) καθώς και οι Bryson και συνεργάτες (2017), λίγες μελέτες εξέτασαν την αποτελεσματικότητα αυτών των παρεμβάσεων κατά τη σύγκριση με εναλλακτικές μεθόδους εισαγωγής. Η αστάθεια των μεθόδων παρέμβασης, σύμφωνα με τους Ruzek & Rosen (2009), θα φανερώσει την ανάγκη να προχωρήσουμε σε μια συγκριτική ανάλυση των κατευθυντήριων γραμμών και των βέλτιστων διεθνών πρακτικών, προκειμένου να τις καταστήσουμε περισσότερο βασισμένες στον τομέα των προτάσεων οργανωτικής αλλαγής και περισσότερο προσανατολισμένες βάσει αποδείξεων σε επίπεδο πολιτικών. Οι Bryson & συνεργάτες (2017) προσπαθούν, μέσω μιας συστηματικής αναθεώρησης της επιστημονικής βιβλιογραφίας, να υπογραμμίσουν ποιοι παράγοντες κάνουν την εφαρμογή της TIC να λειτουργεί, για ποιον τύπο χρήστη, υπό ποιες συνθήκες, προς ποια κατεύθυνση και για ποιο λόγο. Οι στρατηγικές που θεωρούνται πιο

κοινές σε επιστημονικές συνεισφορές είναι οι εξής: 1) μια ηγεσία προσανατολισμένη στην αλλαγή, 2) η χρήση ερευνητικών δεδομένων για την ενημέρωση της πρακτικής, 3) ανάπτυξη του προσωπικού, 4) η χρήση εργαλείων που αποτρέπουν τον περιορισμό και την απομόνωση, 5) ο ρόλος των χρηστών στο πλαίσιο της παραμονής τους, 6) τεχνικές ενημέρωσης. Ενόψει της ανάγκης να αναλυθεί η λειτουργική πολυπλοκότητα αυτών των στοιχείων, ενώ παράλληλα συνδέονται με τις εδαφικές και οργανωτικές ιδιαιτερότητες, η πρόσκληση των συγγραφέων για υπηρεσίες που ασχολούνται με την εφαρμογή της TIC είναι να προχωρήσουν στην προσπάθεια να αποδείξουν, μέσα από τη διαδικασία της επιστημονικής έρευνας και σε μια διαχρονική προοπτική, την αποτελεσματικότητα τόσο των προσπαθειών όσο και των αλλαγών που εφαρμόζονται για τη βελτίωση της ασφάλειας των ασθενών, καθώς και τα μακροπρόθεσμα αποτελέσματα των θεραπειών. Από κοινού με αυτήν την προοπτική, οι Lang και συνεργάτες (2016) υπογραμμίζουν πόσο σημαντικό είναι να επιτευχθεί συναίνεση σχετικά με το τι συνιστά μια υπηρεσία με ενημέρωση για το ψυχικό τραύμα και πώς να μετρώνται αποτελεσματικά οι παράγοντες που εμπλέκονται. Πρώτα από όλα, τα κεντρικά ζητήματα είναι: πώς να φτάσετε στη βέλτιστη διαδικασία προβολής. πώς να λειτουργήσουν καλύτερα οι θεμελιώδεις αρχές της TIC στην καθημερινή εργασία με υποκείμενα που εκτίθενται σε δυνητικά ή βέβαια τραυματικά γεγονότα και ποιες είναι οι καλύτερες μέθοδοι για την ενίσχυση των υπηρεσιών που ασχολούνται με αυτόν τον πληθυσμό. Επί του παρόντος, υπάρχουν λίγες έρευνες που ασχολούνται με την αποτελεσματικότητα των αλλαγών στην εισαγωγή των ασθενών σε οργανωτικό επίπεδο βάσει TIC και πώς/πόσο αυτές οι αλλαγές είναι χρήσιμες για τα αποτελέσματα της υγείας για τους συμμετέχοντες χρήστες. Μια πρόκληση που αναφέρθηκε από τους ερευνητές θα μπορούσε στην πραγματικότητα να είναι η ενσωμάτωση της έρευνας και των βέλτιστων πρακτικών των EBP, προκειμένου να ενισχυθεί η ποιότητα της υλοποίησης αυτών των υπηρεσιών (λαμβάνοντας παράλληλα υπόψη την ανάλυση του πεδίου των οικονομικών επιπτώσεων αυτών των πρωτοβουλιών), μέσω της ανάπτυξης των ικανοτήτων του προσωπικού, των διαδικασιών επιλογής, των δυνατοτήτων αλλαγής πολιτικής. Κρίσιμο ρόλο προς αυτήν την κατεύθυνση μπορεί να διαδραματίσει η ηγεσία, η οποία πρέπει να στηρίξει μια διαδικασία αλλαγής, μερικές φορές ριζικής, ακόμη και σε επίπεδο οργανωτικής παιδείας (με έμφαση, για παράδειγμα, στη σημασία της TIC). Η κατάρτιση σχετικά με το ψυχικό τραύμα αποτελεί ουσιαστικό στοιχείο, αλλά δεν επαρκεί για έναν οργανισμό ώστε να έχει ενημέρωση για το ψυχικό τραύμα. Μια άλλη σημαντική πτυχή, όπως ορίζεται από τους Kramer και συναδέλφους (2013), είναι η συνεργασία μεταξύ διαφόρων φορέων που ασχολούνται με την παροχή βοήθειας στους ανηλίκους και τις οικογένειές τους, οι οποίοι

ενδεχομένως θα μοιράζονται τις αρχές της TIC. Όσον αφορά σε αυτήν την τελευταία πτυχή, οι συγγραφείς ανέλυσαν την αποτελεσματικότητα της κατάρτισης προσανατολισμένης προς την απόκτηση ειδικών γνώσεων με τη διαχρονική διαχείριση κατάλληλων εργαλείων έρευνας (πριν και μετά την κατάρτιση), καθώς και μιας έρευνας παρακολούθησης για να αναλυθεί το πόσο αυτές οι αποκτηθείσες ικανότητες οδηγούν σε αλλαγές της σχετικής υπηρεσίας. Από την άποψη αυτή, ένα ενδιαφέρον θέμα είναι η ανάλυση των εμποδίων που αντιμετωπίζει ολόκληρο το προσωπικό και η συγκρότηση συγκριτικής έρευνας (με τυχαιοποιημένες ομάδες) που αποσκοπούν στην εξέταση της χρησιμότητας των διαφόρων στρατηγικών, οι οποίες εφαρμόζονται και οι ανάγκες περαιτέρω κατάρτισης, επίσης διαχρονικά.

ΣΤΟΙΧΕΙΟ 4: ΥΠΗΡΕΣΙΕΣ ΕΠΙΚΕΝΤΡΩΜΕΝΕΣ ΣΤΗΝ ΕΡΕΥΝΑ ΣΧΕΤΙΚΑ ΜΕ ΤΟ ΨΥΧΙΚΟ ΤΡΑΥΜΑ

ΑΡΘΡΟ

Η TIC θα μπορούσε να οριστεί ως μια προσέγγιση βάσει αποδείξεων για την αντίδραση στο ψυχικό τραύμα, η οποία επικεντρώνεται στην ικανότητα (ή αδυναμία) των μελών του προσωπικού να συμμετάσχουν σε ένα όραμα περί φροντίδας ενός ασθενούς που υποφέρει από ψυχικό τραύμα, ως ένας σημαντικός πρόδρομος για την επιτυχία ή την αποτυχία υιοθέτησης στρατηγικών που αποσκοπούν στη μείωση του κινδύνου εκ νέου πρόκλησης ψυχικού τραύματος στον χρήστη (Marvin & Volino Robinson, 2018). Σε αυτό το σημείο κρίνεται ουσιαστικής σημασίας να λαμβάνουμε υπόψη την πολυπλοκότητα των ιστοριών στις οποίες το ψυχικό τραύμα προκαλείται από διαφορετικές και ατομικές εμπειρίες. Οι πολιτικές, οι διαδικασίες και η καθημερινή λειτουργία θα μπορούσαν ενδεχομένως να είναι επιπλέον τραυματικές εμπειρίες ή να προκαλέσουν αποκρίσεις που συνδέονται με την ατομική λειτουργία του ψυχικά τραυματισμένου ατόμου, εμποδίζοντάς το να λάβει τη φροντίδα που χρειάζεται. Προκειμένου να αποφευχθούν οι καταστάσεις αυτές και να μην δημιουργηθεί δυσαρέσκεια στα μέλη του προσωπικού, η στροφή προς ειδικά δομημένες και διεθνώς αναγνωρισμένες βέλτιστες πρακτικές μπορεί να είναι χρήσιμη (βλ., για παράδειγμα, τις στρατηγικές που προώθησε η SAMHSA το 2014). Σε συνδυασμό με αυτό, η προοπτική της TIC καλεί τους οργανισμούς να εξετάσουν τον αντίκτυπο της εργασίας με υποκείμενα που φέρουν τραυματικές ιστορίες στα μέλη που εισέρχονται σε κλινικές υπηρεσίες (SAMHSA, 2014, Knight, 2015) και πώς θα μπορούσαν να βοηθηθούν οι φορείς μέσω της κατάρτισης και μιας ηγεσίας ενημερωμένης για το ψυχικό τραύμα, διατηρώντας ένα καλό επίπεδο ευημερίας και αποτελεσματικότητας/αποδοτικότητας στις παρεμβάσεις κατά την εργασία (Manderscheid, 2009). Οι Ruzek & Rosen (2009) εξέτασαν εις βάθος τους παράγοντες που επηρεάζουν τον τρόπο με τον οποίο οι υπηρεσίες λαμβάνουν τα ερευνητικά αποτελέσματα για πρακτικές βάσει αποδείξεων, οι οποίες συνδέονται με τη θεραπεία του ψυχικού τραύματος. Η προσεκτική αξιολόγηση τόσο της διάδοσης της πρακτικής όσο και της έρευνας συνεπάγεται την ενσωμάτωση ενός πεδίου ανάλυσης που αποτελείται από πολλαπλούς παράγοντες, οι οποίοι μπορούν να επηρεάσουν την εξέλιξη της διαδικασίας φροντίδας, τη σχέση των ασθενών ή των δυνητικών χρηστών με τις υπηρεσίες, τη μέθοδο που χρησιμοποιούν οι κλινικοί ιατροί για να μάθουν νέα τις τεχνικές θεραπείας, τις αλλαγές στους οργανισμούς που συνδέονται με τον μετασχηματισμό συμπεριφοράς. Βέβαια, σύμφωνα με το όραμα των συγγραφέων, μια όλο και πιο επείγουσα προτεραιότητα στην

εφαρμογή της εμπειρικής έρευνας στον τομέα αυτό αποτελεί η επικύρωση ή η υποστήριξη μεθόδων θεραπείας που εφαρμόζονται με πιο εύκολο οικονομικά τρόπο. Ειδικότερα, οι ερευνητές ανέλυσαν τον ρόλο των παραγόντων που αφορούν στους φορείς, τους οποίους ανέδειξε η έρευνα όταν έγινε σύνδεση με τα αποτελέσματα. Παρατηρούν ότι οι αξιολογήσεις που πραγματοποιήθηκαν από φορείς εξειδικευμένους στο άγχος που σχετίζεται με ψυχικά τραύματα (συγκεκριμένα αυτοί που ασχολούνται με την PTSD) σχετικά με μια συγκεκριμένη πρακτική, τις ικανότητες και τα χαρακτηριστικά τους (π.χ. το επίπεδο αυτοαποτελεσματικότητας), την προθυμία τους να αλλάξουν σε λειτουργικές πρακτικές (π.χ. υιοθέτηση συγκεκριμένης βέλτιστης πρακτικής, ενσωματώνοντάς την στην καθημερινή τους λειτουργία) είναι επιδρώντες παράγοντες, αλλά σπάνια μελετώνται σε εμπειρικό επίπεδο. Η προσβασιμότητα σε προγράμματα κατάρτισης σχετικά με την EBP και οι ανησυχίες σχετικά με τη δυνατότητα εφαρμογής καινοτομιών στον τομέα της έρευνας που σχετίζονται με τον συγκεκριμένο αντίστοιχο πληθυσμό τους (πρόβλημα γενίκευσης των αποτελεσμάτων) φαίνεται να αποτελούν τις σημαντικότερες μεταβλητές όσον αφορά τη στάση τους απέναντι σε πρακτικές βάσει αποδείξεων, ανεξάρτητα από το θεωρητικό τους πλαίσιο. Η μέθοδος κατάρτισης που φαίνεται ιδιαίτερα αποτελεσματική όσον αφορά στην προώθηση της αλλαγής στη συμπεριφορά φροντίδας φαίνεται να είναι τα εντατικά μαθήματα κατάρτισης, ειδικά όταν απαιτούν την απόδειξη των απαραίτητων ικανοτήτων και όταν απαιτούν αυτές να τεθούν υπό δοκιμή σε όλη τη διαδραστική συμμετοχή στα μαθήματα (με διαθεσιμότητα εποπτείας σε τακτική βάση και, ως εκ τούτου, πέραν της ίδιας της στιγμής της κατάρτισης και των περιπτώσεων κατάρτισης των εκπαιδευτών). Όσον αφορά στους παράγοντες καινοτομίας, οι συγγραφείς υπογραμμίζουν ότι οι αντιλήψεις των ασθενών και των φορέων σχετικά με τις θεραπείες αποτελούν βασικό στοιχείο για την υιοθέτησή τους, ιδιαίτερα αναφορικά με την αποδεδειγμένη αποτελεσματικότητά τους (ακόμη και σε συγκριτικό επίπεδο με άλλες μεθόδους). Όσον αφορά στους συστημικούς παράγοντες, παρατηρούν πόσο ιδιαίτερα σχετική είναι η διαθεσιμότητα χώρων για εποπτεία και διοικητική και οργανωτική υποστήριξη για την επιτυχή εφαρμογή μιας βέλτιστης πρακτικής (Fixsen et al., 2005). Ακόμη πιο σημαντική είναι η ανάγκη να υποστηριχθεί εμπειρικά η δημιουργία συστημάτων φροντίδας με ενημέρωση για το ψυχικό τραύμα (Ko et al., 2008, Ruzek & Rosen, 2009). Επιπλέον, η παρακολούθηση της εφαρμογής της θεραπείας είναι μια άλλη βασική πτυχή της διάδοσης, των επιδράσεων και της πιστότητας στη διαδικασία για την εκπλήρωση των EBP (Rosenheck, 2001b, DuFrene, Noell, Gilbertson & Duhon, 2005, Durlak & DuPre, 2008, Ruzek & Rosen, 2009). Μια ιδιαίτερα ενδιαφέρουσα πτυχή είναι αυτή που αναλύεται από τον Rosenheck (2001a), ο οποίος υπογραμμίζει την αμοιβαία αναδρομική διαδικασία

αλληλεπίδρασης μεταξύ των EBP (στη γενική και τη ρυθμιστική τους διάσταση) και των τοπικών εμπειριών/αναγκών για υλοποίηση. Ο σκοπός της παρακολούθησης, ακόμη και ενόψει του κόστους που συνεπάγεται με οικονομικούς και χρονικούς επενδυτικούς πόρους για υπηρεσίες, θα πρέπει να επιτρέπει στις [υπηρεσίες] να επικεντρωθούν σε κρίσιμα στοιχεία για τα αποτελέσματα της θεραπείας και την αποτελεσματικότητα της θεραπείας (Ruzek & Rosen, 2009). Ένα από τα βασικά ερωτήματα μπορεί να είναι πώς οι τροποποιήσεις του κλινικού ιατρού αναφορικά με συγκεκριμένες ανάγκες ενδέχεται να υπονομεύσουν, να αυξήσουν ή να αφήσουν αμετάβλητες τις επιδράσεις της παρέμβασης (Ruzek & Rosen, 2009).

ΒΙΝΤΕΟ: Φροντίδα με ενημέρωση για το ψυχικό τραύμα

ΣΤΟΙΧΕΙΟ 2: ΑΞΙΟΛΟΓΗΣΗ ΑΠΟΔΟΤΙΚΟΤΗΤΑΣ ΚΑΙ ΕΜΠΕΙΡΙΑΣ (αποτελέσματα)

ΑΡΘΡΟ

Σύμφωνα με τους Guyadeen & Seasons (2018), «το ιστορικά κυρίαρχο πρότυπο αξιολόγησης είναι επιστημονικά καθοδηγούμενο και εξαιρετικά τεχνικό, με μεγάλη έμφαση στις ποσοτικές μεθόδους». Οι μέθοδοι και οι τεχνικές επιστημονικής έρευνας, όπως τα συστηματικά τυχαιοποιημένα ερευνητικά σχέδια και τα πειράματα, θεωρούνται αναπόσπαστα στοιχεία της διαδικασίας αξιολόγησης (Alkin 2013). Αυτή η προσέγγιση της αξιολόγησης επικεντρώνεται στη μέτρηση της αποτελεσματικότητας και της αποδοτικότητας (Greene 1994) (σελ. 100).

Οι μελετητές εργάστηκαν για μεγάλο χρονικό διάστημα και με διαφωνίες σχετικά με τον τρόπο αξιολόγησής της, τους στόχους και το περιεχόμενό της, καθώς και τους δείκτες της (Jacobson et al., 1999). Για παράδειγμα, μια ευρέως διαδεδομένη πρακτική στον τομέα της αξιολόγησης αφορά στην ανάλυση του τρόπου με τον οποίο (κυρίως ποσοτικά) τα προγράμματα προάγουν ή παρεμποδίζουν την επίτευξη των στόχων. Αυτή η προσέγγιση απαιτεί σαφώς καθορισμένους στόχους και αντίστοιχους δείκτες. Η αξιολόγηση της αποτελεσματικότητας είναι μια περίπλοκη διαδικασία και δεν είναι απαλλαγμένη από την ευθύνη λήψης σχετικών αποφάσεων: όπως υπογραμμίζουν οι Craig και συνεργάτες (2008), για την εκτίμηση της αποτελεσματικότητας μιας παρέμβασης, πρέπει να λαμβάνεται πάντοτε υπόψη ως μέθοδος επιλογής η τυχαιοποίηση (π.χ. για την αποφυγή σφαλμάτων επιλογής). Εάν μια συμβατική τυχαιοποιημένη δοκιμή μεταξύ παράλληλων ομάδων δεν είναι κατάλληλη, θα πρέπει να εξεταστούν άλλα τυχαιοποιημένα σχέδια μεθοδολογικής μελέτης ή, εάν δεν είναι εφικτή μια πειραματική προσέγγιση, θα μπορούσαν να ληφθούν υπόψη οιονεί πειραματικά ή παρατηρητικά έργα.

Αναφορικά με την ανάλυση των αποτελεσμάτων της παρέμβασης, εάν το σχέδιο έρευνας διεξάγεται σύμφωνα με την επιστημονική μέθοδο, έχει ως στόχο να επιβεβαιώσει ή να διαψεύσει την ύπαρξη αιτιώδους συνάφειας μεταξύ της παρέμβασης και των αποτελεσμάτων της και να κατανοήσει τους λόγους πίσω από την αποτελεσματικότητα ή έλλειψη αυτής. Η σχεδίαση μελέτης ορίζει επίσης το επίπεδο των αποδείξεων που προκύπτουν από αυτή. Η συστηματική αναθεώρηση των τυχαιοποιημένων ελεγχόμενων δοκιμών (RCT) είναι μία από τις πιο ευρέως χρησιμοποιούμενες και αναγνωρισμένες μεθόδους για την παροχή του καλύτερου επιπέδου αποδεικτικών στοιχείων σχετικά με τις επιδράσεις των παρεμβάσεων πρόληψης ή/και θεραπείας (Rychetnik, Frommer, Hawe & Shiell, 2002). Η μακροπρόθεσμη παρακολούθηση μπορεί να είναι απαραίτητη για να προσδιοριστεί κατά πόσο προκύπτουν τα

αναμενόμενα αποτελέσματα ή εάν οι βραχυπρόθεσμες αλλαγές παραμένουν: «αν και όχι συχνές, τέτοιες μελέτες μπορεί να είναι εξαιρετικά ενημερωτικές» (Craig et al., 2008, σελ. 3). Σχετικά με τα επίπεδα αποδείξεων στην αξιολόγηση των παρεμβάσεων δημόσιας υγείας, αυτά αποτελούν αντικείμενο περαιτέρω μελέτης στην επιστημονική βιβλιογραφία λόγω της εξάρτησής τους από τα κριτήρια που έχουν τεθεί για την εκτίμηση της αξιοπιστίας τους. Από την άποψη αυτή, εξακολουθεί να υπάρχει διαφωνία στον τομέα των RTC που εφαρμόζεται στην ανάλυση των παρεμβάσεων στον τομέα της δημόσιας υγείας. Αφορά κυρίως στη δυσκολία διεξαγωγής αυτών των μελετών εξαιτίας της προγραμματικής πολυπλοκότητας των παρεμβάσεων, της ανάλυσης των αποτελεσμάτων και της υποεκτίμησης της συμβολής των μελετών παρατήρησης. Λόγω της φύσης τους, πολλές δημόσιες παρεμβάσεις απαιτούν πολλαπλές και ευέλικτες στρατηγικές ανάλυσης στις οποίες είναι δύσκολο να προσαρμοστούν μελέτες που βασίζονται σε «κλασικά» μοντέλα RCT, σύμφωνα με τους συγγραφείς (ειδικά επειδή απαιτούν μια πολύ άκαμπτη τυποποίηση της παρέμβασης και την προϋπόθεση τυχαιοποίησης βάσει μεμονωμένων μονάδων). Σημαντικό σημείο της ανάλυσης των ερευνητών είναι ότι τονίζεται πως η εφαρμογή μη τυχαιοποιημένων μεθοδολογιών όπου αυτό είναι δυνατό μπορεί να οδηγήσει σε σημαντική και μη βιώσιμη απώλεια της συνάφειας. Ωστόσο, σύμφωνα με τα όσα είπαν οι Rychetnik και συνεργάτες (2002):

«*η σχεδίαση της μελέτης από μόνη της δεν μπορεί να είναι επαρκής ως το κύριο κριτήριο για την αξιοπιστία των αποδείξεων σχετικά με παρεμβάσεις δημόσιας υγείας*» (σελ. 121).

Ερμηνεία των αποτελεσμάτων

Η διαδικασία αξιολόγησης αποτελεί κεντρική πτυχή της σχεδίασης και της υλοποίησης μιας παρέμβασης, ανεξάρτητα από το εάν τα αποτελέσματα σχετικά με την αποτελεσματικότητα είναι αρνητικά ή θετικά. Στην πραγματικότητα, η απόδειξη της κατάλληλης εφαρμογής των διαδικασιών που προβλέπονται από το πρόγραμμα παρέμβασης και η χρήση αποτελεσματικών δεικτών για την παρακολούθηση της διαδικασίας αναγνωρίζονται ως κεντρικές στην επιστημονική βιβλιογραφία (Rychetnik et al., 2002).

Οι θεωρίες σχετικά με τις παρεμβάσεις, οι προδιαγραφές τους (επεξήγηση και αξιοπιστία) σε σχέση με τις υποκείμενες προϋποθέσεις (υποθέσεις), οι οποίες σχετίζονται με την αποτελεσματικότητα και τη λειτουργικότητα των μέτρων αποτελέσματος και αντίκτυπου, αποτελούν βασικά κριτήρια αξιολόγησης και ερμηνείας της ποιότητάς τους όσον αφορά στη δημόσια υγεία (Rychetnik et al., 2002).

Σύμφωνα με την ανάλυση των Rychetnik και συναδέλφων (2002), διατίθενται πολυδιάστατες προσεγγίσεις στη βιβλιογραφία για την αξιολόγηση της έρευνας σχετικά με τα

αποτελέσματα. Κατά την αξιολόγηση των αποδεικτικών στοιχείων σχετικά με την αποτελεσματικότητα της παρέμβασης είναι σημαντικές τρεις διαστάσεις:

1) «η *ισχύς* των αποδεικτικών στοιχείων που καθορίζεται από έναν συνδυασμό σχεδίασης της μελέτης (επίπεδο), μεθοδολογικής ποιότητας και στατιστικής ακρίβειας» (σελ. 122),
2) «το *μέγεθος* των μετρούμενων αποτελεσμάτων» (σελ. 122),
3) «η *συνάφεια* των μετρούμενων αποτελεσμάτων (όπως παρατηρήθηκε στην αξιολόγηση) με το πλαίσιο υλοποίησης» (σελ. 122).

Οι εμπειρικές αξιολογήσεις ποιότητας είναι σημαντικές, καθώς μπορούν να επηρεάσουν τις αποφάσεις σε πολιτικό ή πρακτικό επίπεδο στον τομέα της δημόσιας υγειονομικής περίθαλψης. Θα πρέπει να διασφαλιστεί προσεκτικά ότι η χρήση ανεπαρκών πρωτοκόλλων αξιολόγησης δεν οδηγεί σε μη ρεαλιστικές ή υπερβολικά δαπανηρές απαιτήσεις. Τα κριτήρια αξιολόγησης θα πρέπει να υποστηρίζουν τη διαδικασία λήψης αποφάσεων, καθώς θα πρέπει να βοηθήσουν να προσδιοριστεί κατά πόσον τα αποτελέσματα που μετρούνται περιλαμβάνουν α) τα συμφέροντα εκείνων που ενδέχεται να συμμετέχουν στην απόφαση ή στην πρόταση της παρέμβασης και το κοινό στόχο, β) εάν τα απρόβλεπτα και αναμενόμενα αποτελέσματα της παρέμβασης έχουν ως αποτέλεσμα οφέλη ή όχι και γ) την αποδοτικότητα της παρέμβασης και την αποτελεσματικότητά της. Σχετικά με την πρώτη διάσταση, η συμβολή όλων των ενδιαφερομένων είναι καθοριστική, δεδομένης της κοινωνικής και πολιτικής φύσης της δημόσιας υγείας. Για τους λόγους αυτούς, σημαντικοί παράγοντες στη διαδικασία αξιολόγησης είναι οι υπεύθυνοι λήψης αποφάσεων και οι ομάδες στόχοι.

Όπως επεσήμαναν οι Guyadeen & Seasons (2018), υπάρχουν μοντέλα αξιολόγησης που δίνουν μεγάλη έμφαση στον πλουραλισμό και στην ανάλυση των διαφόρων ενδιαφερομένων μερών που συμμετέχουν σε μια αξιολόγηση. Επιπλέον, οι ποιοτικές μέθοδοι χρησιμοποιούνται συχνά για να βελτιώσουν το όραμα των προγραμμάτων από τις οπτικές γωνίες των άμεσα ενδιαφερομένων (Greene, 1994). Στην πραγματικότητα, θα μπορούσαν να θεωρηθούν ουσιαστικής σημασίας καθώς έχουν άμεση συμμετοχή (π.χ. χρήματα και προσωπικά συμφέροντα) στην αξιολόγηση.

Η συμμετοχική αξιολόγηση (Cousins, 2004), η αξιολόγηση της ενδυνάμωσης (Fetterman, 2004), η συνεργατική αξιολόγηση (Rodriguez-Campos, 2012) και πιο πρόσφατα η αξιολόγηση της ανάπτυξης (Patton, 2011) θα μπορούσαν να θεωρηθούν ορθά παραδείγματα αποτελεσματικών μεθοδολογιών στον τομέα αυτό (Guyadeen & Seasons, 2018).

ΣΤΟΙΧΕΙΟ 3: ΑΞΙΟΛΟΓΗΣΗ ΤΗΣ ΑΠΟΤΕΛΕΣΜΑΤΙΚΟΤΗΤΑΣ ΤΩΝ ΠΑΡΕΜΒΑΣΕΩΝ: αξιολόγηση διαδικασίας

ΑΡΘΡΟ

Όπως έχει επισημανθεί μέχρι στιγμής, η διαδικασία αξιολόγησης θα πρέπει να διαδραματίζει βασικό ρόλο στη διασφάλιση του γεγονότος ότι τα σχέδια αντανακλούν την υψηλότερη ποιότητα τόσο από εννοιολογική όσο και από εφαρμοστική σκοπιά (Guyadeen & Seasons, 2018, Berke and Godschalk, 2009, Baer, 1997). Μπορεί να συμβάλλει σε μεγάλο βαθμό στη διασφάλιση της αντικειμενικότητας και της συστηματικοποίησης του σχεδιασμού και της ανάλυσης της παρέμβασης, βελτιώνοντας τη διαδικασία προγραμματικής προετοιμασίας και παρέχοντας τη δυνατότητα ανάλυσης της συμφωνίας μεταξύ του δηλωτικού σχεδίου του έργου (δηλωμένοι στόχοι) και των επιτευχθέντων αποτελεσμάτων (Guyadeen & Seasons, 2018). Μέσω της αξιολόγησης είναι επίσης δυνατή η τεκμηρίωση και η εμπειρική αναγνώριση των κενών ή/και των πλεονεκτημάτων (Berke, Smith & Lyles 2012, Guyadeen & Seasons, 2018). Βασική προϋπόθεση είναι ότι για να είναι αποτελεσματικά και να αξιολογούνται τα σχέδια πρέπει να υπάρχει σαφής σχέση μεταξύ των κύριων συνιστωσών ενός σχεδίου (δηλαδή των στόχων και των πολιτικών του) και των μηχανισμών εφαρμογής (Oliveira & Pinho 2010b, Guyadeen & Seasons, 2018). Συνολικά, υπάρχουν δύο γενικές μορφές αξιολόγησης στον σχεδιασμό: α) αξιολόγηση του σχεδίου (π.χ. αξιολόγηση της ποιότητας του σχεδίου, αξιολόγηση της εφαρμογής του σχεδίου και αξιολόγηση των αποτελεσμάτων του σχεδίου) και β) αξιολόγηση του σχεδιασμού (π.χ. αξιολόγηση των διαδικασιών σχεδιασμού και της πρακτικής σχεδιασμού) (Guyadeen & Seasons, 2018). Ενώ η αξιολόγηση του σχεδιασμού περιλαμβάνει τον προσδιορισμό της αποτελεσματικότητας της διαδικασίας σχεδιασμού, η αξιολόγηση του σχεδίου παρέμβασης και τα αποτελέσματά του περιλαμβάνουν την αξιολόγηση της ποιότητας του σχεδίου, την επιτυχία της εφαρμογής του και την επίτευξη των στόχων του (Morckel, 2010, Guyadeen & Seasons , 2018). Αυτές οι μορφές αξιολόγησης είναι παρόμοιες με την αξιολόγηση του προγράμματος επειδή επιδιώκουν τη βελτίωση της διαδικασίας λήψης αποφάσεων, αλλά διαφέρουν λόγω της έμφασης που δίνουν στο σχέδιο, στον τρόπο με τον οποίο δημιουργήθηκε και στα αποτελέσματα που δημιουργούνται από τη δραστηριότητα του σχεδιασμού (Guyadeen & Seasons, 2018). Επιπλέον, υπάρχουν γενικά τρεις τύποι αξιολόγησης του σχεδιασμού: εκ των προτέρων (ή *a priori*), εν εξελίξει και εκ των υστέρων (Guyadeen & Seasons, 2018). Σύμφωνα με τους Oliveira & Pinho (2010), αυτοί οι τύποι αξιολόγησης αντιστοιχούν στα

διάφορα στάδια του σχεδιασμού, τα οποία περιλαμβάνουν την προετοιμασία, την εφαρμογή και την αναθεώρηση του σχεδίου (δηλ., μόλις υλοποιηθεί).

Η υγειονομική περίθαλψη βάσει αποδείξεων έχει ως στόχο να ληφθεί υπόψη η αποδοτικότητα και η αποτελεσματικότητα, αν και μέχρι σήμερα δεν έχει δοθεί έμφαση σε θέματα αποδοτικότητας όσον αφορά στην ιατρική βάσει αποδείξεων. Η αξιολόγηση των αποδεικτικών στοιχείων σχετικά με τις παρεμβάσεις στον τομέα της δημόσιας υγείας πρέπει αναπόφευκτα να προσδιορίζουν κατά πόσο έχει αξιολογηθεί η αποδοτικότητα και, εάν ναι, το επίπεδο αποδοτικότητας που επιτεύχθηκε (Rychetnik, Frommer, Hawe & Shiell, 2002). Επιπλέον, «οι αποφάσεις βάσει αποδείξεων σχετικά με την αξία και τη δυνατότητα εφαρμογής μιας παρέμβασης που συνδέεται με γνώση της αποτελεσματικότητας ταυτόσημων, παρόμοιων ή ανάλογων παρεμβάσεων λαμβάνουν συνήθως χώρα και αξιολογούνται σε διαφορετικό περιβάλλον σε διαφορετική χρονική στιγμή. Για να αξιολογηθεί η δυνατότητα μεταφοράς των αποδείξεων μιας παρέμβασης, απαιτούνται πληροφορίες σχετικά με α) την ίδια την παρέμβαση, β) το πλαίσιο αξιολόγησης και γ) τις αλληλεπιδράσεις μεταξύ παρέμβασης και πλαισίου» (Rychetnik, Frommer, Hawe & Shiell, 2002, σελ. 123). Σε περίπτωση πολύπλοκων παρεμβάσεων, η πίστη δεν είναι εύκολο ζήτημα. Ένα στοιχείο που προσθέτει πολυπλοκότητα είναι το γεγονός ότι η αυστηρή τυποποίηση των διαδικασιών υπονομεύει μερικές φορές την ιδιαιτερότητα της παρέμβασης, όταν αυτή ενεργοποιείται από τοπικές ανάγκες (Craig et al., 2008). Ένα βασικό σημείο που πρέπει να αποσαφηνιστεί είναι το μέγεθος των αλλαγών ή προσαρμογών που επιτρέπονται και η ανάγκη καταγραφής των αλλαγών στην εφαρμογή, έτσι ώστε η πιστότητα να μπορεί να εκτιμηθεί σε σχέση με τον βαθμό τυποποίησης που απαιτείται από το πρωτόκολλο της μελέτης. Η μεταβλητότητα κατά την εφαρμογή, είτε σχεδιασμένη είτε όχι, καθιστά ακόμη πιο σημαντικό το γεγονός ότι οι διαδικασίες αξιολόγησης διαδικασιών και αποτελεσμάτων έχουν αναφερθεί πλήρως και ότι μια σαφής περιγραφή της παρέμβασης παρέχεται ώστε να επιτραπεί η αναπαραγωγή της (Craig et al., 2008).

ΣΤΟΙΧΕΙΟ 3: ΒΑΣΙΚΑ ΣΤΟΙΧΕΙΑ ΓΙΑ ΤΗΝ ΠΑΡΟΥΣΙΑΣΗ ΜΙΑΣ ΚΑΛΗΣ ΕΡΕΥΝΗΤΙΚΗΣ ΠΡΟΤΑΣΗΣ

ΑΡΘΡΟ

Υπάρχουν διαφορετικές προσεγγίσεις στη διάρθρωση ενός έργου (Leone & Prezza, 1999) στον κοινωνικό τομέα και στον τομέα της υγείας: α) συνοπτική-ορθολογική (που συνεπάγεται μέγιστη διάρθρωση του περιεχομένου εκ των προτέρων), β) συντονισμένος-συμμετοχικός ή διαλογικός σχεδιασμός (όπου η συνεχής διαπραγμάτευση των στόχων μεταξύ εμπειρογνωμόνων και αποδεκτών είναι κεντρική), γ) ευρετική (η οποία προβλέπει μια ελάχιστη εκ των προτέρων διάρθρωση των στόχων).

Από γενική άποψη, τα ακόλουθα βήματα πρέπει να τηρηθούν στην ερευνητική διαδικασία:

1. Διατυπώνεται ένα θεωρητικό πρόβλημα (που προκύπτει από την ανάλυση της επιστημονικής θεωρίας και της βιβλιογραφίας).
2. Επιλέγονται κατάλληλες μονάδες ανάλυσης και μέθοδοι.
3. Συλλέγονται και αναλύονται τα δεδομένα.
4. Η θεωρητική πρόταση με την οποία ξεκίνησε η έρευνα είτε αμφισβητείται είτε υποστηρίζεται.

Όπως τονίζει ο Lanzara (1985): «Κάθε παράγοντας που του παρουσιάζεται το πρόβλημα της καινοτομίας ή απλώς της παρέμβασης σε μια κατάσταση για να την τροποποιήσει έχει ένα πρόβλημα σχεδίασης μπροστά του» (σελ. 336). Ο σχεδιασμός είναι μια διαδικασία συστηματοποίησης. Στην πραγματικότητα, η παρουσίαση ενός ερευνητικού έργου είναι μια κρίσιμη και θεμελιώδης φάση που περιλαμβάνει σημαντικές επιλογές, οι οποίες επηρεάζουν τα αποτελέσματά της. Επιπλέον, οι Leone & Prezza (1999) υπογραμμίζουν ότι: «Το να διατυπώσουμε ένα έργο μεταξύ διαφορετικών υποκειμένων, να σκεφτούμε τη συνοχή μεταξύ των διαφόρων μερών (στόχοι, χρόνοι, διαθέσιμοι φορείς...) σημαίνει να προβληματιστούμε για την πρακτική και να ασχοληθούμε με το όριο, με τη μεροληψία και αυτό είναι ακριβώς ό,τι σε μερικά πλαίσια τείνει να καταργηθεί» (σελ. 23) ή θεωρείται υπερβολικά περίπλοκο από άποψη εφαρμογής.

Σύμφωνα με μια εγκάρσια προοπτική, οι συγγραφείς επισημαίνουν τα θεμελιώδη στάδια στη διάρθρωση ενός έργου στον κοινωνικό τομέα:

1. Ιδεασμός: το στάδιο κατά το οποίο υποτίθεται ότι πρόκειται να γίνει ή να προταθεί ένα έργο

2. Ενεργοποίηση: επαλήθευση πόρων, ρόλων, προβλημάτων και στρατηγικών, πιθανή ανάλυση της ζήτησης (πελάτες)
3. Σχεδιασμός: ανάπτυξη του έργου και διάρθρωση των φάσεων που το συνθέτουν, καθιέρωση των περιόδων και καθορισμός των μεθοδολογικών επιλογών
4. Υλοποίηση: έναρξη των δραστηριοτήτων, πρώτος έλεγχος των υποθέσεων, συνεχιζόμενες αλλαγές
5. Επαλήθευση: τελική ανάλυση των αποτελεσμάτων

Επίσης, στον τομέα της επιστημονικής έρευνας, σημαντικά στοιχεία από την άποψη της εφαρμογής είναι:

- Ορισμός και ανάλυση του ερευνητικού αντικειμένου από την άποψη της επιστημονικής βιβλιογραφίας, επεξήγηση του θεωρητικού πλαισίου
- Προσδιορισμός και επεξήγηση των γενικών και των ειδικών στόχων της μελέτης (ερευνητικό ερώτημα: διερευνητικό, αξιολογικό, επεξηγηματικό)
- Διάρθρωση των υποθέσεων
- Προσδιορισμός του πληθυσμού στόχου, εύρεση συμμετεχόντων και διαδικασίες δειγματοληψίας
- Διαδικασίες αξιολόγησης, ορισμός δεικτών, εργαλείων και τεχνικών για την ανάλυση των συλλεγόμενων δεδομένων
- Προγραμματισμός χρόνου (χρονοδιάγραμμα) και ανάλυση εφαρμοσιμότητας (συμπεριλαμβανομένης της κρισιμότητας και των περιορισμών)

Με αυτόν τον τρόπο, μπορούν να χρησιμοποιηθούν μεθοδολογικές τοποθετήσεις ενός ποσοτικού, ποιοτικού ή μικτού πίνακα σύμφωνα με το ερευνητικό ερώτημα.

Κάθε φάση της διαδικασίας σχεδίασης συνεπάγεται ότι ο ερευνητής θέτει σημαντικά ερωτήματα που λαμβάνουν επίσης υπόψη τα κρίσιμα στοιχεία από εννοιολογική και πρακτική άποψη. Το πλαίσιο μέσα στο οποίο διεξάγεται η έρευνα είναι ένα από αυτά, όπως και οι πόροι.

Δεδομένης αυτής της πολυπλοκότητας, είναι θεμελιώδους σημασίας να δοθεί προσοχή στην κατάρτιση του προσωπικού σε αυτήν τη διάσταση, καθώς και στη συνεχή αλληλεπίδραση μεταξύ των επαγγελματιών που ασχολούνται με το κλινικό έργο και των ερευνητών που συμμετέχουν στην έρευνα στην κλινική και για την κλινική.

Επιπλέον, ένας σημαντικός τομέας που δείχνει το επίκεντρό του είναι η διάρθρωση και η επικύρωση εργαλείων που μπορούν να χρησιμοποιηθούν ξεκινώντας από τους στόχους παρέμβασης και έρευνας. Αυτά μπορεί να έχουν διαφορετικές μορφές και να εφαρμόζονται σε συγκεκριμένους στόχους, γι 'αυτό είναι απαραίτητο όλοι οι παράγοντες που συμμετέχουν στη σχεδίαση και την υλοποίηση ενός έργου να συνεργάζονται σε κάθε στάδιο του σχεδίου του έργου, συμπεριλαμβανομένων των μεθοδολογικών επιλογών.

ΣΤΟΙΧΕΙΟ 1: ΟΡΘΗ ΠΡΑΚΤΙΚΗ ΑΝΑΦΟΡΙΚΑ ΜΕ ΤΗΝ TIC

ΑΡΘΡΟ

Δεδομένων των μεγάλων κινδύνων για τη σωματική και ψυχολογική υγεία λόγω της επίδρασης των τραυματικών συμβάντων (Δυσάρεστες εμπειρίες για την παιδική ηλικία, ACE), με την πάροδο του χρόνου έχουν αναπτυχθεί πολλές παρεμβάσεις για να συνδράμουν τα ιδρύματα και τους επαγγελματίες ώστε να βοηθήσουν τους ανθρώπους με τραυματικές ιστορίες προκειμένου να δοθεί έμφαση στο πλεονέκτημα της υιοθέτησης μιας προσέγγισης που βασίζεται στην TIC (Baker et al., 2016). Συγκεκριμένα, «μια προσέγγιση TIC βλέπει ένα άτομο ολιστικά, όχι μόνο ως τη λίστα με τα προβλήματα που αντιμετωπίζει» (Hepburn, 2017, σελ. 7). Όπως υποδεικνύουν πολλοί συγγραφείς (Bryson et al., 2017, Bridgett, Valentino & Hayden, 2012, Ellis & Boyce, 2011, Perry, 2002, Rothbart, Ziaie, O'Boyle, 1992) ένα προστατευτικό αποτέλεσμα (ρυθμιστικός ρόλος) προκύπτει από καλές σχέσεις φροντίδας και υποστηρικτικές σχέσεις, οι οποίες ασκούνται από προσεκτικούς και δραστήριους παρόχους φροντίδας: η ασφάλεια των σχέσεων μειώνει τις βλαβερές συνέπειες του ψυχικού τραύματος στα παιδιά. Το τραυματικό άγχος είναι μια συνήθης κατάσταση στην περίπτωση μιας ACE και συχνά προκαλεί σημαντικές κλινικές εκδηλώσεις (συμπτώματα εσωτερίκευσης ή/και εξωτερίκευσης) που εντοπίζονται συνήθως σε νοσοκομεία ή ξενώνες ειδικούς για ενήλικες και παιδιά (Bryson et al., 2017, Greenwald et al., 2012, Hummer, Dollard & Robst, 2010, Ko et al., 2008). Παραθέτουμε εδώ τους Elliott και συνεργάτες (2005), οι οποίοι δήλωσαν ότι «Οι υπηρεσίες με ενημέρωση για το ψυχικό τραύμα είναι εκείνες στις οποίες η παροχή υπηρεσιών επηρεάζεται από την κατανόηση των επιπτώσεων της διαπροσωπικής βίας και της θυματοποίησης στη ζωή και την ανάπτυξη ενός ατόμου» (σελ. 462) και ότι «Πολλές κοινές διαδικασίες και πρακτικές στους χώρους των υπηρεσιών ενεργοποιούν τις τραυματικές αντιδράσεις και αντιμετωπίζονται ως μη ασφαλή συναισθήματα και πηγή αδυναμίας για τους επιζήσαντες του ψυχικού τραύματος» (σελ. 446). Είναι δυνατό να τονιστεί περαιτέρω ότι οι ορθές πρακτικές θα πρέπει να αξιολογούνται βάσει συγκεκριμένων κριτηρίων, τα οποία προσδιορίζονται και αναλύονται λεπτομερώς στην επιστημονική βιβλιογραφία και περιλαμβάνουν μια προσεκτική αξιολόγηση των σύνθετων παραγόντων που εμπλέκονται στις τραυματικές ιστορίες. Στην πραγματικότητα, σε περιπτώσεις όπου η υπηρεσία ή ο οργανισμός ασχολείται με άτομα που έχουν υποστεί ψυχικό τραύμα, συνιστάται μια προοπτική στην οποία η δημόσια υγεία και η κοινωνική φροντίδα προσανατολίζονται στην πρόληψη και τη μείωση κινδύνων (Bryson et al., 2017). Στον τομέα αυτό, αποτελεί κεντρικό ζήτημα η προώθηση προσεγγίσεων με ενημέρωση για το ψυχικό τραύμα: η φροντίδα με

ενημέρωση για το ψυχικό τραύμα (TIC) και η πρακτική με ενημέρωση για το ψυχικό τραύμα (TIP) είναι τα επιλεγμένα θεραπευτικά παραδείγματα, διότι στοχεύουν στη μεταμόρφωση ολόκληρων συστημάτων φροντίδας, συμπεριλαμβάνοντας μια κατανόηση του άγχους ως απάντηση στο ψυχικό τραύμα σε όλες τις πτυχές της υπηρεσίας και εστιάζοντας στην προτεραιότητα της ασφάλειας και της επιλογής. Επιπρόσθετα, η φιλοσοφία αυτή στοχεύει στη δημιουργία ενός τρόπου θεραπείας επικεντρωμένου στη μη βία, τη μάθηση και τη συνεργασία, όπου δίνεται έμφαση σε όλες τις περιβαλλοντικές και διαπροσωπικές αλληλεπιδράσεις (Bryson et al., 2017). Στη συστηματική αναθεώρηση της βιβλιογραφίας, οι Bryson και συνεργάτες (2017) περιέλαβαν ορισμένα σημαντικά ευρήματα:

- Η «μείωση του φυσικού εξαναγκασμού στην παραδοσιακή και κατ'οίκον ψυχιατρική φροντίδα» (σελ. 11) τονίζεται ως η μείωση/εξάλειψη των στρατηγικών απομόνωσης ή ελέγχου και εξαναγκασμού,

- Βασική πτυχή της TIC είναι «η θεμελιώδης σημασία των ανώτερων υπευθύνων στο να δίνουν προτεραιότητα στην TIC [...] ειδικά όταν το προσωπικό πρέπει να προσαρμοστεί σε νέους τρόπους εργασίας» (σελ. 11),

- οι ερευνητές υπογραμμίζουν την ανάγκη να υποστηριχθεί το προσωπικό μέσω της προηγμένης κατάρτισης, ιδίως όσον αφορά στις διαδικασίες ψυχικών τραυμάτων, της συνεχούς εποπτείας, της καθοδήγησης και της ενημέρωσης,

- σε αυτό το σημείο, είναι σημαντικό να ακούμε τους ασθενείς και τις οικογένειες, δίνοντας ιδιαίτερη προσοχή στις εμπειρίες, τις ανάγκες, τις προτεραιότητές τους σχετικά με τη διαδικασία θεραπείας,

- η σημασία που αποδίδεται στον τομέα της συνεχούς ενημέρωσης των δεδομένων έρευνας και στην ανάλυση των δεικτών αποτελεσμάτων είναι εγκάρσιες διαστάσεις που στοχεύουν στην παροχή κινήτρων και την ενημέρωση σχετικά με τις επιδόσεις των υπηρεσιών και τη βελτίωση της αποτελεσματικότητας,

- η βιβλιογραφία ασχολείται εκτενώς με την «ανάγκη να ευθυγραμμιστεί η τυπική και άτυπη πολιτική και πρακτική με τις γενικές αρχές της πρακτικής με ενημέρωση για το ψυχικό τραύμα» (σελ. 11).

Παρά τη συχνότερη εφαρμογή της, η επιστημονική έρευνα σχετικά με την αποτελεσματικότητα αυτού του τύπου προσέγγισης εξακολουθεί να έχει ελλείψεις (Bryson et al., 2017). Όπως επισημαίνεται από τους Valenkamp, Delaney & Verheij (2014) και

Chandler (2008), υπάρχει έλλειψη τυχαιοποιημένων ελεγχόμενων μελετών που δοκιμάζουν παρεμβάσεις και διερευνούν τους κρίσιμους παράγοντες, οι οποίοι εμπλέκονται στην εφαρμογή θεραπειών προσανατολισμένων στην TIC. Αναφορικά με το τι αποδεικνύεται σήμερα σε διεθνές επίπεδο, οι εμπειρικές μελέτες έχουν δείξει πόσο σημαντική είναι η κατάρτιση για την παροχή στο προσωπικό μιας κοινής γλώσσας που πρέπει να χρησιμοποιείται σχετικά με την εμπειρία του ασθενούς και συγκεκριμένες παρεμβάσεις που πρέπει να χρησιμοποιηθούν σε ασθενείς με ψυχικό τραύμα (Bryson et al., 2017). Το επίκεντρο αυτού του θέματος έχει επίσης επισημανθεί νωρίτερα από τους Le Bel, Huckshorn & Caldwell (2008) και από τους Brown, Baker & Wilcox (2012). Επιπλέον, έχει αποδειχθεί χρήσιμη η ειδική κατάρτιση σχετικά με τις βέλτιστες πρακτικές και τη συμμετοχή των ασθενών στις δραστηριότητες κατάρτισης του προσωπικού (π.χ. με την αναφορά των εμπειριών τους) (Holstead, Lamond, Dalton, Horne & Crick, 2010), καθώς και η συμμετοχή των παιδιών στην ενημέρωση αναφορικά με τις κρίσιμες πτυχές ή στάδια κατά την παροχή φροντίδας (Lebel et al., 2008), την ανταλλαγή δεδομένων και τη συνεχή παρακολούθηση των επιδόσεων/διαδικασιών (σε ατομικό, συλλογικό και επίπεδο μονάδας) (Bryson et al., 2017). Ένας άλλος αναδυόμενος στόχος της επιστημονικής βιβλιογραφίας σχετικά με τις αποτελεσματικές στρατηγικές TIC είναι η ικανότητα των οργανισμών να ευθυγραμμίζουν τις πολιτικές και τις πρακτικές με τις αρχές της φροντίδας με ενημέρωση για το ψυχικό τραύμα (Bryson et al., 2017). Σύμφωνα με αυτό το όραμα, το περιβάλλον και η παιδεία των οργανισμών αποτελούν τα ίδια τα θεραπευτικά εργαλεία και συμβάλλουν στην οικοδόμηση μιας «θεραπευτικής κοινότητας». Ιδιαίτερη σημασία έχουν και τα εξής στοιχεία: 1) εστίαση στη δημιουργία ενός ασφαλούς χώρου θεραπείας τόσο για τους ασθενείς όσο και για το προσωπικό και 2) ενσωμάτωση των αρχών TIC σε δηλώσεις αποστολής και οράματος. Συνοπτικά, οι βασικές στρατηγικές TIC που επισημάνθηκαν από τους Bryson και συνεργάτες (2017) ευθυγραμμίζονται με εκείνες που διέπουν τη NASMHPD (National Association of State Mental Health Program Directors), ενώ και οι δύο παρουσιάζονται στον Πίνακα 1.

Πίνακας 1 Βασικές στρατηγικές της TIC

Bryson και συνεργάτες (2017)
Ένταξη στην κοινότητα
Δέσμευση της ηγεσίας
Επιλογή μοντέλου
Μετασχηματισμός του εργατικού δυναμικού

Προσανατολισμός αποτελεσμάτων
Κοινή διατήρηση
NASMHPD
Ηγεσία προσανατολισμένη στην οργανωτική αλλαγή
Χρήση δεδομένων για ενημέρωση της πρακτικής
Χρήση εργαλείων μείωσης της συγκράτησης και της απομόνωσης
Ανάπτυξη του εργατικού δυναμικού
Βελτίωση του ρόλου του καταναλωτή σε χώρο για εσωτερικούς ασθενείς
Τεχνικές ενδελεχούς ενημέρωσης

Ακόμη, σε μια μελέτη των Azeem και συνεργατών (2011), αυτά τα στρατηγικά στοιχεία ελέγχθηκαν διαχρονικά ώστε να αναλυθεί η μείωση της χρήσης συγκράτησης και απομόνωσης. Πιο συγκεκριμένα, οι συγγραφείς τόνισαν ότι:

- ✓ Η ηγεσία διαδραματίζει κυρίαρχο ρόλο στην πραγματοποίηση αλλαγής της παιδείας, ιδιαίτερα όταν ένα όραμα προσανατολισμένο στην TIC είναι κοινό για όλο το προσωπικό.
- ✓ Η συλλογή και κοινή χρήση των δεδομένων διαδραματίζουν «καθοριστικό ρόλο στα έργα βελτίωσης των επιδόσεων» (σελ. 12) και στις διαδικασίες παρακολούθησης.
- ✓ Η κατάρτιση και συνεχής εκπαίδευση του προσωπικού όσον αφορά στις αρχές της περίθαλψης με προσανατολισμό την ανάρρωση, της προσωποκεντρικής περίθαλψης και της TIC με τις σχετικές αξιολογήσεις επιδόσεων έχει αποδειχθεί ότι έχουν σημαντικές θετικές επιπτώσεις.
- ✓ Θα πρέπει να δοθεί ιδιαίτερη προσοχή στις αρχές της πρωτοβάθμιας πρόληψης, χρησιμοποιώντας ατομικά θεραπευτικά σχέδια που περιλαμβάνουν το ιστορικό του ψυχικού τραύματος και την επικοινωνία με τις στρατηγικές του ασθενούς, της οικογένειας και του προσωπικού.
- ✓ Μια σωστή αρχή για την πρακτική της TIC είναι η συμμετοχή του ασθενούς και της οικογένειας.
- ✓ Εφαρμόστηκαν αποτελεσματικά δραστηριότητες στήριξης της ενημέρωσης, ιδιαίτερα όσον αφορά στις συναισθηματικές πτυχές και τις απαραίτητες αλλαγές στα θεραπευτικά σχέδια, όπως οι παρεμβάσεις για τον μετριασμό της πρόκλησης ψυχικών τραυμάτων και του αντίκτυπου αυτών.

Μελετώντας διαφορετικές προσεγγίσεις της TIC, οι Hanson and Lang (2016) και Johnson (2017) εντόπισαν ορισμένα ζητήματα που θα μπορούσαν να θεωρηθούν σημαντικά για τη διερεύνηση των προσεγγίσεων των υπηρεσιών για τα παιδιά, ενώ κατέληξαν στο συμπέρασμα ότι είναι δυνατός ο προσδιορισμός 15 βασικών συνιστωσών της TIC.

Οι προσδιορισμένες συνιστώσες οργανώθηκαν σε τρία επίπεδα (Hanson & Lang, 2016, σελ. 98):

1. Ανάπτυξη του εργατικού δυναμικού (WD):

- Απαιτείται κατάρτιση για όλο το προσωπικό σχετικά με την ενημέρωση και γνώση της επίδρασης της κακοποίησης ή του ψυχικού τραύματος,

- Μέτρηση της ικανότητας του προσωπικού με καθορισμένα κριτήρια να επιδεικνύουν γνώση/πρακτική σχετικά με το ψυχικό τραύμα,

- Στρατηγικές/διαδικασίες για την αντιμετώπιση/μείωση του άγχους που συνδέεται με δευτερεύον ψυχικό τραύμα μεταξύ του προσωπικού,

- Γνώσεις/δεξιότητες σχετικά με τον τρόπο πρόσβασης και αναφοράς σε βέλτιστες πρακτικές βάσει αποδείξεων επικεντρωμένες στο ψυχικό τραύμα.

2. Υπηρεσίες επικεντρωμένες στο ψυχικό τραύμα (TFS):

- Χρήση τυποποιημένων μέτρων ελέγχου/αξιολόγησης βάσει στοιχείων για τον καθορισμό του ιστορικού και των συμπτωμάτων ή προβλημάτων που σχετίζονται με το ψυχικό τραύμα,

- Συμπερίληψη του ιστορικού του ψυχικού τραύματος του παιδιού στην τεκμηρίωση/στα αρχεία/στην περίπτωση σχεδίου υπηρεσίας,

- Διαθεσιμότητα ειδικευμένων κλινικών ιατρών καταρτισμένων σε πρακτικές βάσει αποδείξεων επικεντρωμένων στο ψυχικό τραύμα,

3. Παράδοση εντός οργανισμού (ORG):

- Συνεργασία, συντονισμός των υπηρεσιών και ανταλλαγή πληροφοριών μεταξύ επαγγελματιών στο πλαίσιο του οργανισμού που σχετίζονται με υπηρεσίες με ενημέρωση για το ψυχικό τραύμα,

- Συνεργασία, συντονισμός των υπηρεσιών και ανταλλαγή πληροφοριών μεταξύ επαγγελματιών στο πλαίσιο άλλων οργανισμών που σχετίζονται με υπηρεσίες με ενημέρωση για το ψυχικό τραύμα,

- Διαδικασίες για μείωση του κινδύνου επανεμφανίσεως του ψυχικού τραύματος του χρήστη,

- Διαδικασίες για τη συμμετοχή του χρήστη και την εισαγωγή στον σχεδιασμό υπηρεσίας και την ανάπτυξη ενός συστήματος με ενημέρωση για το ψυχικό τραύμα,

- Παροχή υπηρεσιών βασισμένων σε πλεονεκτήματα και προώθηση της θετικής ανάπτυξης,

- Παροχή θετικού και ασφαλούς φυσικού περιβάλλοντος,

- Γραπτές πολιτικές που περιλαμβάνουν ρητά και υποστηρίζουν αρχές με ενημέρωση για το ψυχικό τραύμα,

- Ύπαρξη μιας καθορισμένης θέσης ηγεσίας ή μιας θέσης εργασίας που σχετίζεται ειδικά με την TIC.

ΣΤΟΙΧΕΙΟ 1: Η ΣΗΜΑΣΙΑ ΤΗΣ ΠΑΡΑΤΗΡΗΣΗΣ

ΑΡΘΡΟ

Οι κλινικοί ιατροί και οι ερευνητές αναζητούν συνεχώς τη γνώση για ένα συγκεκριμένο φαινόμενο, με έναν λίγο πολύ συστηματικό τρόπο. Αυτή η επιθυμία για γνώση προέρχεται από ενδιαφέρον ή περιέργεια, από προσεκτική ματιά, με γυμνό μάτι ή με τη βοήθεια εργαλείων, με μία λέξη, μέσω της «παρατήρησης».

Ο Mantovani (1995) ορίζει την παρατήρηση ως: «[...] μια μορφή ανίχνευσης που στοχεύει στην εξερεύνηση ενός δεδομένου φαινομένου» (σελ. 84).

Η παρατήρηση συνιστά μια σύνθετη και απαιτητική δραστηριότητα που απαιτεί:

- χρόνο,
- πνευματική ελευθερία,
- απουσία προκαταλήψεων και προκαθορισμένων αντιλήψεων,
- αυτεπίγνωση,
- ικανότητα μη εμπλοκής,
- ικανότητα αναστολής της κρίσης.

Σε κλινικά και ερευνητικά πλαίσια, η παρατήρηση αποκτά μεγάλη σημασία, μεταμορφωμένη από μια απλή και μη επιστημονική μέθοδο σε μια ευέλικτη, δομημένη και αξιόπιστη μέθοδο (Venuti, 2001). Με την πρόοδο των μελετών για παιδιά, για παράδειγμα, έχει εγκαταλειφθεί η χρήση «παιδικών βιογραφιών», για να δοθεί χώρος στη συστηματική παρατήρηση και τον πειραματισμό (Bornstein, 2001). Πράγματι, με την πάροδο του χρόνου οι νατουραλιστικές παρατηρήσεις έχουν αφήσει περιθώρια για τυποποιημένες παρατηρήσεις (Bornstein, 2001). Θα μπορούσε κανείς να ισχυριστεί, σύμφωνα με τα λεγόμενα του Venuti (2001), ότι η παρατήρηση «[...] ενεργεί ως γέφυρα μεταξύ ενός επεξηγηματικού μοντέλου αναφοράς και μιας επακόλουθης διαδικασίας ανάλυσης και ερμηνείας των δεδομένων» (σελ. 58). Επομένως, όταν λέμε παρατηρούμε, δεν αρκεί πλέον μόνο να βλέπουμε μια ομάδα παιδιών να αλληλεπιδρούν ή να καταγράφουμε βίντεο σχετικά με τη συμπεριφορά μεταξύ μητέρας και παιδιού, καθώς η παρατήρηση πρέπει πάντα να αναφέρεται σε ένα θεωρητικό και επεξηγηματικό μοντέλο, το οποίο θα καθοδηγήσει τον ερευνητή να διατυπώσει υποθέσεις και να αναλύσει δεδομένα (Venuti, 2001). Τι να παρατηρήσετε, πώς, πού και πότε θα το κάνετε, θα εξαρτηθεί από τον σκοπό της έρευνας και τη θεωρητική προσέγγιση αναφοράς.

Υπάρχουν διαφορετικά είδη παρατηρήσεων:

- Ψυχαναλυτική παρατήρηση, η οποία έχει την ψυχανάλυση ως θεωρητικό μοντέλο,
- Παρατήρηση κατά Piaget, η οποία έχει την ψυχολογία της ανάπτυξης ως θεωρητικό μοντέλο,
- Ηθολογική παρατήρηση, η οποία έχει την ηθολογία ως θεωρητικό μοντέλο.

Η παρατήρηση κατά Piaget είναι ένα σχεδόν πειραματικό είδος παρατήρησης. Θέτει τα θεμέλιά της στις θεωρητικές προσεγγίσεις του αλληλεπιδρασμού, του δομισμού, του γνωστικισμού και εμβαθύνει τη μελέτη της πορείας της ψυχικής υγείας κατά τη διάρκεια της ανάπτυξής (Vigna, 2002). Δεν περιορίζεται στην καταγραφή όλων όσων κάνει το παιδί, αλλά καθοδηγείται από ορισμένες υποθέσεις που αποτελούν τη βάση της θεωρίας του Piaget. Ο παρατηρητής προσπαθεί να καθιερώσει μια αλληλεπίδραση με τον παρατηρούμενο σε ένα φυσικό πλαίσιο (Petter, 1984, Vigna, 2002). Οι βασικές αρχές αυτής της παρατήρησης είναι δύο:

1. Ο παρατηρητής προσαρμόζεται στο στάδιο ανάπτυξης του παιδιού και, αλληλεπιδρώντας, τροποποιεί τις ίδιες τις συνθήκες της παρατήρησης.
2. Ο παρατηρητής αναπαράγει επανειλημμένα την ίδια κατάσταση παιχνιδιού κατά τη διάρκεια μιας παρατήρησης για να αξιολογήσει εάν η αντίδραση του παιδιού επαναλαμβάνεται με την παρουσία του ίδιου ερεθίσματος και δεν οφείλεται σε τυχαίο γεγονός.

Τα κύρια πλαίσια εφαρμογής αυτού του είδους παρατήρησης είναι ο παιδικός σταθμός και το νηπιαγωγείο.

Η ηθολογική προσέγγιση, από την άλλη πλευρά, εμπνέεται από τη θεωρία της εξέλιξης του Δαρβίνου και το έργο του ηθολόγου Lorenz. Η παρατήρηση ορίζεται ως ηθολογική όταν οι παρατηρητές δεν επηρεάζουν με οποιονδήποτε τρόπο τη συμπεριφορά που ενδιαφέρονται να μελετήσουν και ακυρώνουν όσο το δυνατόν περισσότερο την υποκειμενικότητά τους. Συνήθως αυτή η τεχνική εφαρμόζεται στο φυσικό περιβάλλον στο οποίο μια δεδομένη συμπεριφορά εκδηλώνεται αυθόρμητα. Ωστόσο, είναι δυνατό να χρησιμοποιηθεί το εργαστήριο ως περιβάλλον, υπό την προϋπόθεση ότι είναι εξοπλισμένο με τέτοιο τρόπο ώστε να αναπαραγάγει ένα οικείο περιβάλλον για το παιδί (π.χ. δωμάτιο για παιχνίδι).

Είναι χρήσιμο για τη διερεύνηση των πρώτων χρόνων ζωής, όπου η λεκτική γλώσσα εξακολουθεί να είναι απούσα ή ελλιπής, για δύο λόγους:

1. είναι πιο εύκολο να καθοριστεί το φυσικό περιβάλλον διαβίωσης των μικρών παιδιών,

2. τα μικρά παιδιά δεν συνειδητοποιούν πάντα ότι παρακολουθούνται και, σε κάθε περίπτωση, δεν αντιδρούν μεταβάλλοντας τη συμπεριφορά τους.

Αυτό το είδος παρατήρησης στοχεύει στον αποκλεισμό της υποκειμενικότητας και στην επίτευξη της αντικειμενικότητας που από μόνη της μας επιτρέπει να εξαγάγουμε συμπεράσματα που δεν είναι παραπλανητικά (Lis & Venuti, 1986). Σε αυτόν τον τύπο παρατήρησης, χρησιμοποιούνται διαδικασίες που επιτρέπουν την καταγραφή και την αντικειμενική και συστηματική καταλογογράφηση των συμπεριφορών, ώστε να υπάρχει δυνατότητα να ερμηνευτούν αργότερα υπό το πρίσμα των αρχικών υποθέσεων. Μεταξύ των πλεονεκτημάτων της ηθολογικής παρατήρησης προκύπτουν:

- αύξηση των περιγραφικών μελετών της παιδικής συμπεριφοράς,
- απόδοση σπουδαιότητας στη διαχρονική έρευνα, θεωρούμενη ως η πλέον κατάλληλη για την κατανόηση της διαδικασίας της αλλαγής και της εξελικτικής της σημασίας.

Ωστόσο, η έμφαση στην αντικειμενική περιγραφή μπορεί να μας κάνει να ξεχνάμε ότι όταν παρατηρούμε, είναι αναπόφευκτο να κάνουμε επιλογές. Επιπλέον, η σημασία της ανίχνευσης μικρο-συμπεριφορών, οι οποίες μπορούν να περιγραφούν αντικειμενικά, δεν μπορεί να μας κάνει να ξεχάσουμε την έννοια που μια συγκεκριμένη συμπεριφορά παίρνει σε μια συγκεκριμένη στιγμή και πλαίσιο.

Η ψυχαναλυτική παρατήρηση, από την άλλη πλευρά, είναι ένας τύπος άμεσης παρατήρησης, μια μέθοδος που δεν κάνει χρήση οποιουδήποτε οργάνου εκτός του ίδιου του παρατηρητή. Σύμφωνα με το ψυχαναλυτικό μοντέλο, όταν δεν υπάρχουν φαινόμενα που προβλέπονται βάσει μιας θεωρίας, το «απροσδόκητο» (Bion, 1962) γίνεται σχετικό. Η παρατήρηση σε αυτήν την περίπτωση έχει τη βασική λειτουργία της δημιουργίας ενός χώρου όπου το απροσδόκητη μπορεί να εκφραστεί. Αυτή η εικόνα δεν συνεπάγεται καμία πρόθεση εκ μέρους του παρατηρητή να μας επιτρέψει να κατανοήσουμε τη συνειδητή και ασυνείδητη σκοπιμότητα του παρατηρηθέντος ατόμου. Τα πεδία εφαρμογής είναι:

- ψυχολογική έρευνα,
- κλινικό έργο,
- κατάρτιση ψυχοθεραπευτών και αναλυτών για παιδιά.

Ο παρατηρητής αποτελεί αναπόσπαστο μέρος της κατάστασης και παρατηρεί τόσο τις συμπεριφορές και τις διατυπώσεις όσο και τις διαθέσεις και τα συναισθήματα. Πρέπει επίσης να αξιολογήσει προσεκτικά τη δική του ψυχολογική κατάσταση ως πηγή πληροφοριών για το παρατηρούμενο υποκείμενο, χρησιμοποιώντας τη δική του ομοιότητα για να διαφοροποιηθεί από το τελευταίο και να αποδεχθεί τη δική του παρουσία.

Τέλος, μπορεί κανείς να παρατηρήσει ολόκληρο τον πυρήνα της οικογένειας μέσω δομημένων εργασιών στο κλινικό πλαίσιο ή στο φυσικό περιβάλλον του άλλου. Αυτός ο τύπος παρατήρησης μπορεί να συνδεθεί με μια συνέντευξη με την οικογένεια και έχει την πρόθεση να γίνει κατανοητό το πώς τα μέλη του πυρήνα αλληλεπιδρούν μεταξύ τους και να γίνουν κατανοητές οι επικοινωνίες σε λεκτικό και προφορικό επίπεδο (μορφές έμμεσης διυποκειμενικότητας).

Συμπερασματικά, η παρατήρηση είναι ένας από τους ακρογωνιαίους λίθους του επαγγελματισμού εκείνων που εργάζονται στον τομέα της εκπαίδευσης και της κατάρτισης, συμβάλλοντας στην οικοδόμηση μιας «βασικής συμπεριφοράς» που γίνεται αναπόσπαστο μέρος του τρόπου επαγγελματικής δράσης, ως βασικό στοιχείο της εκπαιδευτικής ικανότητας. Δεν είναι ένα απλό εργαλείο, αλλά ένα σύνολο από συμπεριφορές, μεθοδολογίες και εργαλεία. Αυτά μπορούν να είναι δομημένα (εγγραφή βίντεο, δίκτυα, κατάλογοι ελέγχου κλπ.) ή και όχι (π.χ. ημερολόγιο). Ο παρατηρητής θα πρέπει στη συνέχεια να καταρτιστεί μέσω μιας φάσης κατάρτισης, να αποκτήσει συγκεκριμένες δεξιότητες και γνώσεις για να μπορέσει να χρησιμοποιήσει αυτά τα εργαλεία και να εντοπίσει το φαινόμενο που προτίθεται να μελετήσει (Venuti, 2001). Τα δεδομένα που λαμβάνονται από την παρατήρηση μπορούν να είναι τόσο ποιοτικά όσο και ποσοτικά. Τα ποιοτικά δεδομένα έχουν αφηγηματική δομή (Hilliard, 1993), ενώ τα ποσοτικά δεδομένα μπορούν να χρησιμοποιηθούν για διάφορες μετρήσεις και αναλύσεις (π.χ. μετρήσεις συχνότητας και διάρκειας, διαδοχικές αναλύσεις κλπ.).

ΒΙΝΤΕΟ

The Strange Situation | Mary Ainsworth, 1969 | Αναπτυξιακή Ψυχολογία

ΣΤΟΙΧΕΙΟ 2: ΔΕΙΚΤΕΣ ΚΑΚΟΜΕΤΑΧΕΙΡΙΣΗΣ ΚΑΙ ΚΑΚΟΠΟΙΗΣΗΣ

ΑΡΘΡΟ

Ο Schimmenti (2018) υπογραμμίζει τον τρόπο με τον οποίο το ψυχικό τραύμα αποτελεί μια βαθιά πληγή για τα άτομα και μπορεί να επηρεάσει τις ψυχολογικές διαδικασίες μάθησης, σε πολλαπλά επίπεδα, καθώς και τη λειτουργία τους. Ειδικότερα, έχει συνέπειες σε σχέση με την έννοια του εαυτού, τους τρόπους των σχέσεων και τα συστήματα πεποιθήσεων. Επιπλέον, ο συγγραφέας επισημαίνει ότι οι επιστημονικές μελέτες έχουν υπογραμμίσει πόσο συχνά τα γεγονότα που μπορούν να οριστούν ως τραυματικά είναι αλληλένδετα και ότι η έκθεση σε πολλαπλές τραυματικές εμπειρίες αυξάνει τον κίνδυνο ανάπτυξης ψυχοπαθολογίας (σωρευτικό ψυχικό τραύμα), ειδικά εάν αυτό συμβαίνει κατά τη διάρκεια της παιδικής ηλικίας και, ειδικότερα, στο πλαίσιο των οικογενειακών σχέσεων. Οι Curran και συνεργάτες (2018) τονίζουν επίσης αυτό το θέμα στην επιστημονική βιβλιογραφία, επισημαίνοντας πώς αυτό συνεπάγεται:

1. για παιδιά που έχουν υποστεί πολλαπλές τραυματικές εμπειρίες, αύξηση του κινδύνου κατάθλιψης και αδυναμίας (Arata et al., 2007),
2. σε διαχρονικό επίπεδο κατά την ενηλικίωση για άτομα με ιστορίες σωματικής και ψυχολογικής κακοποίησης, μείωση της αυτοεκτίμησης και των δεξιοτήτων αντιμετώπισης σε σύγκριση με τα συναισθήματα (ιδιαίτερα θυμός και επιθετικότητα), αύξηση της αποκλίνουσας σεξουαλικής συμπεριφοράς και δυσκολία στην ψυχοκοινωνική προσαρμογή (Sesar et al., 2010),
3. για θύματα σεξουαλικής ή σωματικής κακοποίησης, υψηλότερο κίνδυνο ψυχοκοινωνικών δυσκολιών και εμφάνισης κοινωνικής ή αντικοινωνικής συμπεριφοράς, χρόνιων σωματικών συμπτωμάτων, διαταραχών άγχους ή κατάθλιψης, συμπτωμάτων που σχετίζονται με το ψυχικό τραύμα και την απομάκρυνση (Higgins & McCabe, 2000).
4. Επιπλέον, κατά την εφηβεία, η επιστημονική έρευνα παρουσιάζει επίσης αυξημένο κίνδυνο εμφάνισης παραβατικής συμπεριφοράς, κατάχρησης ουσιών και αυτοτραυματισμών, ιδιαίτερα σε άτομα με ιστορικό PTSD ή πολυ-θυματοποίησης.

Σε γενικές γραμμές, η έρευνα προτείνει, από επιδημιολογική άποψη, τη σύνδεση μεταξύ του ψυχικού τραύματος και της σοβαρότητας του προβλήματος. Ακόμη, εάν το ψυχικό τραύμα προκλήθηκε κατά τη διάρκεια της παιδικής ηλικίας, μπορεί να έχει σοβαρές και εξασθενητικές συνέπειες στην ανάπτυξη γνωστικών, συναισθηματικών και κοινωνικών δεξιοτήτων (Curran et al., 2018). Μια πτυχή που φαίνεται να έχει ιδιαίτερα σημαντικό

αντίκτυπο στην ανάπτυξη και τα αποτελέσματα των τραυματικών εμπειριών στην παιδική ηλικία είναι η συναισθηματική παραμέληση των μορφών προσκόλλησης, ιδιαίτερα εκείνων με γονικό ρόλο, για το παιδί (Schimmenti, 2018). Η επαρκής κατανόηση των μηχανισμών που διέπουν την ατομική μεταβλητότητα της ψυχολογικής αντίδρασης στο ψυχικό τραύμα είναι σημαντική τόσο για την αναγνώριση των παιδιών που διατρέχουν κίνδυνο μακροχρόνιας δυσφορίας όσο και για τη δόμηση κατάλληλων και αποτελεσματικών παρεμβάσεων (Ozer et al., 2003, Alisic et al., 2011). Πιο συγκεκριμένα, είναι σημαντικό να δοθεί έμφαση στο γεγονός ότι τα παιδιά αντιδρούν στο ψυχικό τραύμα με διαφορετικό τρόπο από τους ενήλικες, εν μέρει λόγω του επιπέδου ανάπτυξής τους και των δεξιοτήτων τους, συμπεριλαμβανομένης της διαχείρισης του περιεχομένου της μνήμης και των συναισθηματικών αποκρίσεων στα γεγονότα. Οι Lonigan και συνεργάτες (1998) είχαν ήδη τονίσει την ανάγκη να επικεντρωθεί η επιστημονική έρευνα στην ανάλυση των παιδικών αντιδράσεων στο ψυχικό τραύμα και στους παράγοντες που συνδέονται με αυτό. Μία από τις ερωτήσεις που έθεσαν ήταν η ανάγκη διερεύνησης δεικτών, ιδιαίτερα έγκυρων και αξιόπιστων για τον παιδικό πληθυσμό και όχι απλώς δανεισμένων από τις συνθήκες που επικρατούν σε ενήλικα άτομα, σε φυσιολογικές έναντι ψυχοπαθολογικών αντιδράσεων των παιδιών σε ανεπιθύμητα συμβάντα. Ένα ενδιαφέρον πεδίο έρευνας είναι στην πραγματικότητα η διάκριση μεταξύ τυπικών αντιδράσεων στο τραύμα και εκείνων των συνθηκών κατά τις οποίες είναι δυνατό να βρεθεί μια ψυχοπαθολογική απόκριση με ιδιαίτερη έμφαση στο ποια είναι τα συμπτώματα που επιτρέπουν μια διαφορική οπτική μεταξύ των δύο συνθηκών και μια βελτίωση των δυνατοτήτων αποτελεσματικής αξιολόγησης από τους κλινικούς ιατρούς (Lonigan et al., 1998). Η βιβλιογραφία παρέχει πολλές πληροφορίες σχετικά με τους δείκτες κακομεταχείρισης και κακοποίησης, επισημαίνοντας ότι αυτές είναι συχνά μη ειδικά μηνύματα που θα πρέπει να διαβάζονται με φροντίδα και προσοχή, καθώς δεν δείχνουν πάντοτε αποκλειστικά την κακομεταχείριση. Στην πραγματικότητα, είναι απαραίτητο οι φορείς να βελτιώσουν την ικανότητά τους να κατανοούν ότι το παιδί υποφέρει στα πλαίσια μέσα στα οποία βρίσκεται, προσφέροντάς του τις κατάλληλες συνθήκες ώστε να αισθάνεται ευπρόσδεκτο και ότι έχει τη στήριξη να εκφράσει τα συναισθήματα και τις δυσκολίες του. Σε συνδυασμό με τις τεχνικές παρατήρησης, οι φορείς μπορούν να χρησιμοποιήσουν δίκτυα από δείκτες για να διερευνήσουν το πρόβλημα όσο το δυνατόν περισσότερο. Ως παράδειγμα, ανατρέξτε στον σύνδεσμο του εγγράφου που καταρτίστηκε από το CE.S.P.IM (Centro Servizi per il volontariato Provincia di Imperia) με τίτλο «*Il Silenzio dei Passerotti. Project for combating*

and recovering abuse and mistreatment of children», όπου μπορείτε να προβάλετε ορισμένα παραδείγματα δεικτών κακοποίησης και κακομεταχείρισης.

BINTEO

Διάφοροι τύποι κακοποίησης παιδιών

BINTEO LONGOBARDI: INDICATORI DI MALTRATTAMENTO E ABUSO

COUR EUROPÉENNE DES DROITS DE L'HOMME
EUROPEAN COURT OF HUMAN RIGHTS

CASE OF Z AND OTHERS v. THE UNITED KINGDOM

(Application no. 29392/95)

JUDGMENT

STRASBOURG

10 May 2001

In the case of Z and Others v. the United Kingdom,

The European Court of Human Rights, sitting as a Grand Chamber composed of the following judges:

Mr L. WILDHABER, *President*,
Mrs E. PALM,
Mr C.L. ROZAKIS,
Mr J.-P. COSTA,
Mr L. FERRARI BRAVO,
Mr L. CAFLISCH,
Mr P. KŪRIS,
Mr J. CASADEVALL,
Mr B. ZUPANČIČ,
Mrs N. VAJIĆ,
Mr J. HEDIGAN,
Mrs W. THOMASSEN,
Mrs M. TSATSA-NIKOLOVSKA,
Mr E. LEVITS,
Mr K. TRAJA,
Mr A. KOVLER,
Lady Justice ARDEN, ad hoc *judge*,

and also of Mr P.J. MAHONEY, *Deputy Registrar*,

Having deliberated in private on 28 June and 11 October 2000 and on 4 April 2001,

Delivers the following judgment, which was adopted on the last-mentioned date:

PROCEDURE

1. The case was referred to the Court, in accordance with the provisions applicable prior to the entry into force of Protocol No. 11 to the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention"), by the European Commission of Human Rights ("the Commission") on 25 October 1999 (Article 5 § 4 of Protocol No. 11 and former Articles 47 and 48 of the Convention).

2. The case originated in an application (no. 29392/95) against the United Kingdom of Great Britain and Northern Ireland lodged with the Commission under former Article 25 of the Convention by the applicants, Z, A, B, C and D, five British nationals, on 9 October 1995.

3. The applicants alleged that the local authority had failed to take adequate protective measures in respect of the severe neglect and abuse which they were known to be suffering due to their ill-treatment by their

parents and that they had no access to a court or effective remedy in respect of this. They relied on Articles 3, 6, 8 and 13 of the Convention.

4. The Commission declared the application admissible on 26 May 1998. On 6 September 1999, pursuant to the express wishes of D's adoptive parents, the Commission decided that D should no longer be an applicant. In its report of 10 September 1999 (former Article 31 of the Convention) [*Note by the Registry*. The report is obtainable from the Registry], it expressed the unanimous opinion that there had been a violation of Article 3 of the Convention, that no separate issue arose under Article 8, that there had been a violation of Article 6 and that no separate issue arose under Article 13.

5. Before the Court the applicants had been granted legal aid. The President of the Court acceded to their request not to have their names disclosed (Rule 47 § 3 of the Rules of Court).

6. On 6 December 1999 a panel of the Grand Chamber determined that the case should be decided by the Grand Chamber (Rule 100 § 1). The composition of the Grand Chamber was determined according to the provisions of Article 27 §§ 2 and 3 of the Convention and Rule 24. The President of the Court decided that in the interests of the proper administration of justice, the case should be assigned to the Grand Chamber that had been constituted to hear the case of *T.P. and K.M. v. the United Kingdom* ([GC], no. 28945/95, ECHR 2001-V) (Rules 24, 43 § 2, and 71). Sir Nicolas Bratza, the judge elected in respect of the United Kingdom, who had taken part in the Commission's examination of the case, withdrew from sitting in the Grand Chamber (Rule 28). The United Kingdom Government ("the Government") accordingly appointed Lady Justice Arden to sit as an *ad hoc* judge (Article 27 § 2 of the Convention and Rule 29 § 1).

7. The applicants and the Government each filed a memorial. Third-party comments were also received from Professor G. Van Bueren, Director of the Programme on International Rights of the Child, University of London, who had been given leave by the President to intervene in the written procedure (Article 36 § 2 of the Convention and Rule 61 § 3).

8. A hearing took place in public in the Human Rights Building, Strasbourg, on 28 June 2000 (Rule 59 § 2).

There appeared before the Court:

(a) *for the Government*

Ms S. McGRORY, Foreign and Commonwealth Office, *Agent*,
Mr D. ANDERSON QC, Foreign and Commonwealth Office,
Ms J. STRATFORD, Foreign and Commonwealth Office, *Counsel*,
Ms S. RYAN, Foreign and Commonwealth Office,
Ms J. GRAY, Foreign and Commonwealth Office,
Mr M. MURMANE, Foreign and Commonwealth Office, *Advisers*;

(b) *for the applicants*
Mr B. EMMERSON QC, *Counsel*,
Ms P. WOOD, Solicitor,
Mrs M. MAUGHAN, Solicitor,
Ms E. GUMBEL QC,
Ms N. MOLE, of the AIRE Centre, *Advisers*.

The Court heard addresses by Mr Emmerson and Mr Anderson.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

9. The applicants are four full siblings:
– Z, a girl born in 1982;
– A, a boy born in 1984;
– B, a boy born in 1986;
– C, a girl born in 1988.

10. The applicants' parents were married in November 1981.

11. The family was first referred to social services in October 1987 by their health visitor due to concerns about the children and marital problems. Z was reported to be stealing food at night. Following the referral, a professionals' meeting, involving the relevant agencies, was held on 24 November 1987, at which it was decided that a social worker and health visitor should visit. The family were reviewed at a further meeting in March 1988 and as it appeared that concerns had diminished, the file was closed.

12. In September 1988 a neighbour reported that the children were locked outside the house for most of the day.

13. In April 1989 the police reported that the children's bedrooms were filthy. The family's general practitioner also reported that the children's bedrooms were filthy and that their doors were locked. The children's head-teacher, Mrs Armstrong, expressed concern in May 1989 and requested a case conference. In June 1989 the NSPCC (National Society for the Prevention of Cruelty to Children) and the emergency team made a referral after complaints by neighbours that the house was filthy and that the children spent most of the day in their bedrooms, rarely being allowed out to play, and crying frequently. In August 1989 the maternal grandmother complained to the social services about the mother's care and discipline of the children.

14. At a professionals' meeting on 4 October 1989, at which the social services, the applicants' head-teacher, the applicants' general practitioner

and health visitor attended, it was decided that no social worker would be allocated to the family. The school was to monitor the older children's weight and the health visitor was to continue to visit the family regularly. It was agreed that the problem was one of limited and neglectful parenting rather than a risk of physical abuse, and that the parents should be assisted to manage their responsibilities better.

15. In October 1989, whilst the applicants were on holiday, their house was burgled. On entering, the police found it in a filthy state. Used sanitary towels and dirty nappies were discarded in a cupboard and the children's mattresses were sodden with urine. At a professionals' meeting on 13 December 1989, the health visitor requested that the four older children be placed on the Child Protection Register as she felt that their mother could not offer consistent care. This suggestion was rejected. However, a social-work assistant, Ms M., was assigned to the family. It was not considered appropriate to convene a case conference at this stage. Prior to the meeting, Z and A had mentioned to the head-teacher that A had been hit with a poker. It was decided that this statement would be investigated.

16. At a professionals' meeting on 23 March 1990, an improvement was noted in respect of the cleanliness of the house, the children's bedding being clean save on two occasions. However, it was reported that Z and A were taking food from bins at the school. There was still considered to be cause for concern, especially since the birth of another child was expected.

17. At a professionals' meeting on 11 July 1990, the applicants' headmistress reported a deterioration in the children's well-being; Z and A were still taking food from bins and A was soiling himself. Ms M. was visiting weekly at this stage and said that she was checking the children's bedrooms. She had noted that the children ate at 4 or 4.30 p.m. and then did not eat again until the morning. The children were also sent to bed at 6 p.m. It was planned to give the applicant's mother further assistance through a voluntary agency.

18. In or about September 1990, A and B were both reported to have bruising on their faces. The police investigated after neighbours had reported screaming at the applicants' home but apparently found no signs of bruising. They reported to the social services that "the conditions of the house were appalling and not fit for [the] children to live in".

19. At a further professionals' meeting on 3 October 1990, the assistant social worker, Ms M., stated that she was concerned about the applicants' soiling and their mother's lack of interest. Apparently, the children were defecating in their bedroom and smearing excrement on their windows. The head-teacher expressed concern, particularly concerning the boys A and B, and stated that the children had described blocks of wood being placed against their bedroom doors. It was decided to continue monitoring the children.

20. At a professionals' meeting on 5 December 1990, a decision was made to arrange a case conference for January 1991 as a result of concern regarding the applicants' care and the state of their bedroom. Ms M. considered that standards in the boys' bedroom had dramatically dropped. She found the room to be damp and smelly. A's bed was broken and had a metal bar protruding from it. The bedding was damp and grubby with soil marks.

21. In a report dated 24 January 1991, the headmistress stated that A was shabby, ill-kempt and often dirty and that he had been raiding the playground bins for apple cores. Z was pathetic, lacking in vitality and frequently and inexplicably tearful, becoming increasingly isolated from the other girls in her peer group with unfortunate incidents in which detrimental remarks were made about her appearance. B presented as withdrawn, pathetic and bedraggled. He regularly arrived cold, was frequently tearful and craved physical contact from adult helpers. He also appeared to crave for food. She concluded that they were still concerned that the children's needs were not being adequately met and that home conditions and family dynamics were giving reasons for concern.

22. At the case conference held on 28 January 1991, Ms M. stated that the boys' bedroom had no light, carpet or toys and that their bedding was wet, smelly and soil-stained. Their mother did not change the beds. Their head-teacher stated that Z was tearful and withdrawn, A had been raiding school bins and was often dirty, and B was very withdrawn, craved attention and was ravenously hungry. The chairman of the conference concluded that, despite the many concerns about the parenting of the applicants and the conditions in the home, there was little evidence to support going to court. It was felt that the parents were not wilfully neglecting their children and, bearing in mind their own poor upbringing, it was considered that the applicants' parents were doing what they could and that continued support was required to try and improve the situation. It was decided not to place the children on the Child Protection Register.

23. On 5 March 1991 B was found to have “unusual” bruises on his back.

24. At a later social services meeting in April 1991, no change to the children's living conditions was noted. The head-teacher stated that Z and A were still taking food from bins and that A was becoming more withdrawn. Ms M. reported that the mother had stated that the children were taking food from the park bins on the way to school.

25. In July 1991 the applicants' mother informed social services that the children would be better off living in care. On 12 August 1991 the social services received a phone call from a neighbour who stated that the children were frequently locked outside in a filthy back garden, that they constantly screamed and that they were kept for long periods in their bedrooms where they smeared faeces on their windows. The maternal grandparents later told

the guardian *ad litem* that Z, who was treated by her mother as a little servant, was expected to clean the excrement from the windows.

26. From 19 to 28 August 1991, the three older children spent some time with foster carers in respite care. The foster carers reported that A did not know how to wash, bathe or clean his teeth on arrival. He wet his bed every night and stole food from his brother. B was described as being "very frightened. He could not understand how he could play in the garden and the door was left open for him to come back in, he expected to be locked out". He also had to be taught to use the toilet properly and to clean himself.

27. At a professionals' meeting on 18 September 1991, Ms M. stated that the conditions in which the boys were sleeping were deteriorating. The mattresses in the boys' bedroom were ripped and the springs were coming through. The boys were stealing food, and C had also been seen to do this. Their mother stated that she could not control them. It was decided not to arrange a child-protection meeting but to carry out a monthly weight check on the three older children at school, and for the health visitor to check the weight of the two younger children. It was also decided to arrange respite care for Z, A and B in the holidays as well as on one weekend in four.

28. In November-December 1991 C was found to have developed a squint. His mother failed to keep appointments at the eye-clinic over the following months.

29. At a professionals' meeting on 21 November 1991, it was reported that the applicants' mother had said that she could not control the applicants' behaviour which consisted of refusing to go to bed when asked and stealing food. It was considered that the home was in an acceptable condition, though the boys' room still needed attention. The children's weights were recorded. It was noted that Z had put on 2 lb in the previous two months whereas she had only put on 2.5 lb in the preceding two years. A had only put on 3 lb in a year. B had put on 0.5 lb in a year and was on the 50th centile for height. C was on the 25th centile for weight. There was a discussion about the three elder children being accommodated by the local authority to allow the mother "to get back on her feet". The social services considered a six-week period whilst the general practitioner envisaged a period of eighteen to twenty-four months.

30. In December 1991 a social worker was introduced to the applicants' mother with a view to assisting her with shopping, budgeting and cooking.

31. Z, A and B were accommodated by volunteers between January and March 1992, and showed to have gained weight. In March and again in April, their mother asked if the boys, A and B, could be placed for adoption.

32. On 14 January 1992 C started to attend a nursery group at a family centre. She was noted to be unsocialised, lacking in confidence, unable to share, and with poor speech.

33. At a further professionals' meeting on 9 March 1992, it was decided that further respite care would be considered. The children's weights were noted, increases being seen for Z, A and B.

34. The children's parents divorced in April 1992.

35. At another professionals' meeting on 30 April 1992 it was decided that the applicants' mother's request that A and B be placed for adoption be followed up. The headmistress voiced concern over the fundamental pattern of the mother's care of the children, in particular in relation to Z's role in the home and the mothering role which she played. Ms M. reported that conditions were deteriorating for A and B.

36. On 10 June 1992 the applicants' mother demanded that the children be placed in care as she could not cope. She stated that if they were not removed from her care she would batter them. The applicants were placed in emergency foster care. The applicants were entered onto the Child Protection Register under the categories of neglect and emotional abuse after a child-protection meeting on 22 June 1992.

37. The applicants were all fostered separately. Initially, Z was noted to have dirty, ill-fitting clothes. She stated that she did not like living with her siblings as she did not like having to look after them all the time. A wet the bed every night, shunned physical contact and suffered from nightmares. B did not know how to use the toilet or toilet paper. C bonded very quickly with her foster parents.

38. On 8 October 1992 the local authority decided to seek care orders in respect of the children. Interim care orders were made on 7 December 1992.

39. A guardian *ad litem*, who was appointed on 18 January 1993, recommended that all the applicants should be the subject of care orders in order to protect them from further harm. She stated that there was "an abundance of evidence that the children have been subjected to physical and mental ill-treatment". She noted that their health had also been neglected by their parents who frequently missed appointments with opticians and doctors.

40. All the applicants were seen by Dr Dora Black, a consultant child psychiatrist, in January 1993. Dr Black stated that the three older children were all showing signs of psychological disturbance. Z was exhibiting signs of serious depressive illness and had assumed responsibility for her family and for its breakdown. Her mother's behaviour towards her was described as cruel and emotionally abusive. A and B, who suffered from nightmares, were both identified as showing signs of post-traumatic stress disorder and A was also chronically under-attached. Dr Black noted that all children had been deprived of affection and physical care. She described their experiences as "to put it bluntly, horrific", and added that the case was the worst case of neglect and emotional abuse that she had seen in her professional career. In her opinion, social services had "leaned over backwards to avoid putting these children on the Child Protection Register

and had delayed too long, leaving at least three of the children with serious psychological disturbance as a result".

41. Full care orders were made in respect of the applicants on 14 April 1993 by Judge Tyrer sitting at Milton Keynes County Court.

42. In June 1993 the Official Solicitor, acting as the applicants' next friend, commenced proceedings against the local authority claiming damages for negligence and/or breach of statutory duty arguing that the authority had failed to have regard to their welfare as was required by statute and should have acted more quickly and more effectively when apprised of their condition. It was argued that the local authority's failure to act had resulted in psychological damage. The application was struck out as revealing no cause of action, by Mr Justice Turner on 12 November 1993.

43. The applicants appealed to the Court of Appeal, which, on 28 February 1994, upheld the decision of Mr Justice Turner to strike out the application.

44. The applicants appealed to the House of Lords. On 29 June 1995 the House of Lords rejected their appeal, finding that no action lay against the local authority in negligence or breach of statutory duty concerning the discharge of their duties relating to the welfare of children under the Children Act 1989 in respect of child care. The case is reported as *X and Others v. Bedfordshire County Council* [1995] 3 All England Law Reports 353.

45. Lord Browne-Wilkinson gave the leading judgment. In respect of claims for breach of statutory duty, he stated, *inter alia*:

> "... My starting point is that the Acts in question are all concerned to establish an administrative system designed to promote the social welfare of the community. The welfare sector involved is one of peculiar sensitivity, involving very difficult decisions how to strike the balance between protecting the child from immediate feared harm and disrupting the relationship between the child and its parents. In my judgment in such a context it would require exceptionally clear statutory language to show a parliamentary intention that those responsible for carrying out these difficult functions should be liable in damages if, on subsequent investigation with the benefit of hindsight, it was shown that they had reached an erroneous conclusion and therefore failed to discharge their statutory duties. ...
>
> When one turns to the actual words used in the primary legislation to create the duties relied upon in my judgment they are inconsistent with any intention to create a private law cause of action."

46. As regards the claims that the local authority owed a duty of care to the applicants pursuant to the tort of negligence, Lord Browne-Wilkinson stated, *inter alia*:

> "I turn then to consider whether, in accordance with the ordinary principles laid down in *Caparo* [1990] 2 AC 605, the local authority ... owed a direct duty of care to the plaintiffs. The local authority accepts that they could foresee damage to the plaintiffs if they carried out their statutory duties negligently and that the relationship between the authority and the plaintiffs is sufficiently proximate. The third

requirement laid down in *Caparo* is that it must be just and reasonable to impose a common law duty of care in all the circumstances ...

The Master of the Rolls took the view, with which I agree, that the public policy consideration that has first claim on the loyalty of the law is that wrongs should be remedied and that very potent counter considerations are required to override that policy (see [1994] 4 AER 602 at 619). However, in my judgment there are such considerations in this case.

First, in my judgment a common law duty of care would cut across the whole statutory system set up for the protection of children at risk. As a result of the ministerial directions contained in 'Working Together' the protection of such children is not the exclusive territory of the local authority's social services. The system is inter-disciplinary, involving the participation of the police, educational bodies, doctors and others. At all stages the system involves joint discussions, joint recommendations and joint decisions. The key organisation is the Child Protection Conference, a multi-disciplinary body which decides whether to place the child on the Child Protection Register. This procedure by way of joint action takes place, not merely because it is good practice, but because it is required by guidance having statutory force binding on the local authority. The guidance is extremely detailed and extensive: the current edition of 'Working Together' runs to 126 pages. To introduce into such a system a common law duty of care enforceable against only one of the participant bodies would be manifestly unfair. To impose such liability on all the participant bodies would lead to almost impossible problems of disentangling as between the respective bodies the liability, both primary and by way of contribution, of each for reaching a decision found to be negligent.

Second, the task of the local authority and its servants in dealing with children at risk is extraordinarily delicate. Legislation requires the local authority to have regard not only to the physical well-being of the child but also to the advantages of not disrupting the child's family environment. ... In one of the child abuse cases, the local authority is blamed for removing the child precipitately; in the other for failing to remove the children from their mother. As the Report of the Inquiry into Child Abuse in Cleveland 1987 (Cmnd. 412) ('Cleveland Report 1987') said, at p. 244:

> '... It is a delicate and difficult line to tread between taking action too soon and not taking it soon enough. Social services whilst putting the needs of the child first must respect the rights of the parents; they also must work if possible with the parents for the benefit of the children. These parents themselves are often in need of help. Inevitably a degree of conflict develops between those objectives.'

Next, if liability in damages were to be imposed, it might well be that local authorities would adopt a more cautious and defensive approach to their duties. For example, as the Cleveland Report makes clear, on occasions the speedy decision to remove the child is sometimes vital. If the authority is to be made liable in damages for a negligent decision to remove a child (such negligence lying in the failure properly first to investigate the allegations) there would be a substantial temptation to postpone making such a decision until further inquiries have been made in the hope of getting more concrete facts. Not only would the child in fact being abused be prejudiced by such delay, the increased workload inherent in making such investigations would reduce the time available to deal with other cases and other children.

> The relationship between the social worker and the child's parents is frequently one of conflict, the parent wishing to retain care of the child, the social worker having to consider whether to remove it. This is fertile ground in which to breed ill-feeling and litigation, often hopeless, the cost of which both in terms of money and human resources will be diverted from the performance of the social service for which they were provided. The spectre of vexatious and costly litigation is often urged as a reason for not imposing a legal duty. But the circumstances surrounding cases of child abuse make the risk a very high one which cannot be ignored.
>
> If there were no other remedy for maladministration of the statutory system for the protection of children, it would provide substantial argument for imposing a duty of care. But the statutory complaints procedures contained in section 76 of the 1980 Act and the much fuller procedures now available under the 1989 Act provide a means to have grievances investigated though not to recover compensation. Further, it was submitted (and not controverted) that the local authorities Ombudsman would have power to investigate cases such as these.
>
> Finally, your Lordships' decision in *Caparo* [1990] 2 AC 605 lays down that in deciding whether to develop novel categories of negligence the court should proceed incrementally and by analogy with decided categories. We were not referred to any category of case in which a duty of care has been held to exist which is in any way analogous to the present cases. Here, for the first time, the plaintiffs are seeking to erect a common law duty of care in relation to the administration of a statutory social welfare scheme. Such a scheme is designed to protect weaker members of society (children) from harm done to them by others. The scheme involves the administrators in exercising discretion and powers which could not exist in the private sector and which in many cases bring them into conflict with those who, under the general law, are responsible for the child's welfare. To my mind, the nearest analogies are the cases where a common law duty of care has been sought to be imposed upon the police (in seeking to protect vulnerable members of society from wrongs done to them by others) or statutory regulators of financial dealing who are seeking to protect investors from dishonesty. In neither of these cases has it been thought appropriate to superimpose on a statutory regime a common law duty of care giving rise to a claim in damages for failure to protect the weak against the wrongdoer. ... In my judgment, the courts should proceed with great care before holding liable in negligence those who have been charged by Parliament with the task of protecting society from the wrong doings of others."

47. Z and C, the two girls, were meanwhile adopted. The boys, A and B, were initially in foster care. Following the breakdown of B's adoptive placement, he was placed in a therapeutic residential placement in July 1995. After two years, he was again placed with foster parents where he remained, attending school in a special-needs group. In January 1996, A was placed in a therapeutic community, where he stayed for two years. He apparently had a number of foster placements which broke down. Records indicated that he had been in twelve different placements in eight years. He is currently in a children's home.

48. In March 1996, applications were made to the Criminal Injuries Compensation Board (CICB) on behalf of all the children by the adoption society to whom the local authority had delegated certain responsibilities. It was claimed on behalf of Z that she had suffered severe neglect and chronic

deprivation which rendered it likely that specialist care would be necessary during her adolescence, a time where emotional repercussions of the abuse might become apparent; on behalf of A that he had suffered physical deprivation, emotional abuse, physical abuse and possible sexual abuse – he had suffered permanent physical scarring and was still receiving treatment from a child psychiatrist; on behalf of B that he had suffered extreme physical and emotional deprivation and shown signs of sexual abuse – he also had suffered permanent physical scarring and was receiving therapy; and on behalf of C that she had suffered extreme physical and emotional deprivation, and in addition that her need for eye treatment was not being met by her parents.

49. In February 1997, the CICB awarded 1,000 pounds sterling (GBP) to Z, GBP 3,000 to A and GBP 3,000 to B for injuries suffered between 1987 and 1992; it awarded GBP 2,000 to C for injuries suffered between 1988 and 1992. In a letter dated 20 May 1998 from the CICB to the Official Solicitor, it was stated:

> "The Board Member who assessed these cases recognised that the children were exposed to appalling neglect over an extended period but explained to their advisers that the Board could not make an award unless it was satisfied on the whole available evidence that an applicant had suffered an injury – physical or psychological – directly attributable to a crime of violence ... He was nevertheless satisfied, that setting aside 'neglect' the children had some physical and psychological injury inflicted upon them as enabled him to make an award to each child ..."

II. RELEVANT DOMESTIC LAW

A. Local authority's duties in respect of child care

50. Prior to the coming into force of the current legislation, the Children Act 1989, on 14 October 1991, the local authority's duty in respect of child care was governed by the Child Care Act 1980.

Sections 1 and 2 of the Child Care Act 1980 provided that:

> "1. It shall be the duty of every local authority to make available such advice, guidance and assistance as may promote the welfare of children by diminishing the need to receive or keep them in care.
>
> 2. (1) Where it appears to a local authority with respect to a child in their area appearing to them to be under the age of seventeen -
>
> (a) that he has neither parent nor guardian or has been and remains abandoned by his parents or guardian or is lost;
>
> (b) that his parents or guardian are, for the time being or permanently, prevented by reason of mental or bodily disease or infirmity or other incapacity or any other

circumstances from providing for his proper accommodation, maintenance and upbringing; and

(c) in either case, that the intervention of the local authority under this section is necessary in the interests of the welfare of the child, it shall be the duty of the local authority to receive the child into their care under this section."

51. Section 17 of the Children Act 1989 has since provided, *inter alia*:

"17. Provision of services for children in need, their families and others

(1) It shall be the general duty of every local authority (in addition to the other duties imposed on them by this Part) -

(a) to safeguard and promote the welfare of children within their area who are in need; and

(b) so far as is consistent with that duty, to promote the upbringing of such children by their families,

by providing a range and level of services appropriate to those children's needs.

(2) For the purpose principally of facilitating the discharge of their general duty under this section, every local authority shall have the specific duties and powers set out in Part I of Schedule 2.

...

(10) For the purposes of this Part a child shall be taken to be in need if -

(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him of services by a local authority under this Part;

(b) his health or development is likely to be significantly impaired or further impaired, without the provision for him of such services; or

(c) he is disabled ...

(11) ...; and in this Part

'development' means physical, intellectual, emotional, social or behavioural development; and

'health' means physical or mental health."

52. Part III of the Children Act 1989 deals with local authority support for children and families. The policy of the Act is made clear by paragraph 7 of Part I of Schedule 2, which requires local authorities to take reasonable steps designed to reduce the need to bring proceedings relating to children.

53. Section 20 provides that

"20(1) Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of -

(a) there being no person who has parental responsibility for him;

(b) his being lost or having been abandoned; or

(c) the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.

...

(4) A local authority may provide accommodation for any child within their area (even though a person who has parental responsibility for him is able to provide him with accommodation) if they consider that to do so would safeguard or promote the child's welfare."

54. Part V of the Children Act 1989 deals with the protection of children. Section 47 provides as follows:

"47(1) Where a local authority -

...

(b) have reasonable cause to suspect that a child who lives or is found, in their area is suffering, or is likely to suffer, significant harm,

the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

...

(8) Where, as a result of complying with this section, a local authority conclude that they should take action to safeguard or promote the child's welfare they shall take action (so far as it is within their power and reasonably practicable for them to do so)."

B. Complaints procedure

55. The complaints procedure is provided by section 26 of the Children Act 1989:

"Review of cases and inquiries into representations

...

(3) Every local authority shall establish a procedure for considering any representations (including any complaint) made to them by -

(a) any child ... who is not being looked after by them but is in need;

(b) a parent of his;

...

(e) such other person as the authority consider has a sufficient interest in the child's welfare to warrant his representations being considered by them,

about the discharge by the authority of any of their functions under this Part in relation to the child.

(4) The procedure shall ensure that at least one person who is not a member or officer of the authority takes part in -

(a) the consideration; and

(b) any discussions which are held by the local authority about the action (if any) to be taken in relation to the child in the light of this consideration.

...

(7) Where any representation has been considered under the procedure established by the local authority under this section, the authority shall -

(a) have due regard to the findings of those considering the representation; and

(b) take such steps as are reasonably practicable to notify (in writing) -

(i) the person making the representation;

(ii) the child (if the authority consider that he has sufficient understanding); and

(iii) such other persons (if any) as appear to the authority to be likely to be affected,

of the authority's decision in the matter and their reasons for taking that decision and of any action which they have taken, or propose to take.

(8) Every local authority shall give such publicity to their procedure for considering representations under this section as they consider appropriate."

56. The powers of the Secretary of State to investigate the actions of the local authority are set out in sections 81 and 84 of the Children Act 1989.

"81. (1) The Secretary of State may cause an inquiry to be held into any matter connected with -

(a) the function of the social services committee of a local authority, in so far as those functions relate to children;

...

84. Local authority failure to comply with statutory duty: default power of Secretary of State

(1) If the Secretary of State is satisfied that any local authority has failed, without reasonable excuse, to comply with any of the duties imposed on them by or under this Act he may make an order declaring that authority to be in default with respect to that duty.

...

(3) Any order under subsection (1) may contain such directions for the purpose of ensuring that the duty is complied with, within such period as may be specified in the order, as appears to the Secretary of State to be necessary.

(4) Any such directions shall, on the application of the Secretary of State, be enforceable by mandamus."

C. Actions for damages against the local authority

57. In England and Wales there is no single tort which imposes liability to pay compensation for civil wrongs. Instead there is a series of separate torts, for example, trespass, conversion, conspiracy, negligence and defamation.

58. Negligence arises in specific categories of situations. These categories are capable of being extended. There are three elements to the tort of negligence: a duty of care, breach of the duty of care, and damage. The duty of care may be described as the concept which defines the categories of relationships in which the law may impose liability on a defendant in damages if he or she is shown to have acted carelessly. To show a duty of care, the claimant must show that the situation comes within an existing established category of cases where a duty of care has been held to exist. In novel situations, in order to show a duty of care, the claimant must satisfy a threefold test, establishing:

– that damage to the claimant was foreseeable;

– that the claimant was in an appropriate relationship of proximity to the defendant; and,

– that it is fair, just and reasonable to impose liability on the defendant.

These criteria apply to claims against private persons as well as claims against public bodies. The leading case is *Caparo Industries plc v. Dickman* ([1990] 2 Appeal Cases 605).

59. If the courts decide that as a matter of law there is no duty of care owed in a particular situation, that decision will (subject to the doctrine of precedent) apply in future cases where the parties are in the same relationship.

60. The decision in *X and Others v. Bedfordshire County Council* ([1995] 3 All England Law Reports 353) is the leading authority in the United Kingdom in this area. It held that local authorities could not be sued for negligence or for breach of statutory duty in respect of the discharge of

their functions concerning the welfare of children. The leading judgment is reported at length in the facts above (see paragraphs 45-46 above).

61. Since *X and Others v. Bedfordshire County Council*, there have been two further significant judgments regarding the extent of liability of local authorities in child care matters.

62. The Court of Appeal gave judgment in *W. and Others v. Essex County Council* ([1998] 3 All England Law Reports 111). This case concerned the claims by a mother and father (first and second plaintiffs), who had agreed to act as foster parents, that the defendant local authority placed G., a 15-year-old boy, in their home although they knew that he was a suspect or known sexual abuser. During G.'s stay in their home, the plaintiffs' three children (fourth to sixth plaintiffs) were all sexually abused and suffered psychiatric illness. The plaintiffs brought an action against the local authority and the social worker involved, claiming damages for negligence and for negligent misstatement. On the defendants' application to strike out the statement of claim as disclosing no reasonable cause of action, the judges struck out the parents' claims but refused to strike out the claims of the children. The Court of Appeal upheld his decision. The headnote for the judgment summarised the Court of Appeal's findings as follows:

> "(1) Although no claim in damages lay in respect of decisions by a local authority in the exercise of a statutory discretion, if the decision complained of was so unreasonable that it fell outside the ambit of the discretion conferred, there was no *a priori* reason for excluding common law liability. In the instant case, the giving of information to the parents was part and parcel of the defendants' performance of their statutory powers and duties, and it had been conceded that it was arguable that those decisions fell outside the ambit of their discretion. Accordingly, since it had also been conceded that the damage to the children was reasonably foreseeable and that there was sufficient proximity, the question for the court was whether it was just and reasonable to impose a duty of care on the council or the social worker. Having regard to the fact that common law duty of care would cut across the whole statutory set up for the protection of children at risk, that the task of the local authority and its servants in dealing with such children was extraordinarily difficult and delicate, that local authorities might adopt a more defensive approach to their duties if liability in damages were imposed, that the relationship between parents and social workers was frequently one of conflict and that the plaintiff children's injuries were compensatable under the Criminal Injuries Compensation Scheme, it was not just and reasonable to do so. It followed that no duty of care was owed to the plaintiff parents who in any event were secondary victims in respect of their claim for psychiatric illness ...
>
> (2) (Stuart-Smith LJ dissenting) It was arguable that the policy considerations against imposing a common law duty of care on a local authority in relation to the performance of its statutory duties to protect children did not apply when the children whose safety was under consideration were those in respect of whom it was not performing any statutory duty. Accordingly, since in the instant case, the plaintiff children were not children for whom the council had carried out any immediate caring responsibilities under the child welfare system but were living at home with their parents, and express assurances had been given that a sexual abuser would not be placed in their home, their claim should proceed ..."

63. On further appeal by the parents, the House of Lords on 16 March 2000 held that it was impossible to say that the psychiatric injury allegedly suffered by the parents, flowing from a feeling that they had brought the abuser and their children together or from a feeling of responsibility for not having detected the abuse earlier, was outside the range of psychiatric injury recognised by the law, nor was it unarguable that the local authority had owed a duty of care to the parents. The parents' claim could not be said to be so certainly or clearly bad that they should be barred from pursuing it to trial and their appeal was allowed.

64. The House of Lords gave judgment on 17 June 1999 in *Barrett v. London Borough of Enfield* ([1999] 3 Weekly Law Reports 79). That case concerned the claims of the plaintiff, who had been in care from the age of ten months to 17 years, that the local authority had negligently failed to safeguard his welfare causing him deep-seated psychiatric problems. The local authority had applied to strike out the case as disclosing no cause of action. The House of Lords, upholding the plaintiff's appeal, unanimously held that the judgment in *X and Others v. Bedfordshire County Council* did not in the circumstances of this case prevent a claim of negligence being brought against a local authority by a child formerly in its care.

65. Lord Browne-Wilkinson, in his judgment in that case, commented as follows on the operation of the duty of care:

> "(1) Although the word 'immunity' is sometimes incorrectly used, a holding that it is not fair, just and reasonable to hold liable a particular class of defendants whether generally or in relation to a particular type of activity is not to give immunity from a liability to which the rest of the world is subject. It is a prerequisite to there being any liability in negligence at all that as a matter of policy it is fair, just and reasonable in those circumstances to impose liability in negligence. (2) In a wide range of cases public policy has led to the decision that the imposition of liability would not be fair and reasonable in the circumstances, e.g. some activities of financial regulators, building inspectors, ship surveyors, social workers dealing with sex abuse cases. In all these cases and many others the view has been taken that the proper performance of the defendant's primary functions for the benefit of society as a whole will be inhibited if they are required to look over their shoulder to avoid liability in negligence. In English law the decision as to whether it is fair, just and reasonable to impose a liability in negligence on a particular class of would-be defendants depends on weighing in the balance the total detriment to the public interest in all cases from holding such class liable in negligence as against the total loss to all would-be plaintiffs if they are not to have a cause of action in respect of the loss they have individually suffered. (3) In English law, questions of public policy and the question whether it is fair and reasonable to impose liability in negligence are decided as questions of law. Once the decision is taken that, say, company auditors though liable to shareholders for negligent auditing are not liable to those proposing to invest in the company (see *Caparo Industries plc v. Dickman* [1990] 1 All ER 568, [1990] 2 AC 605), that decision will apply to all future cases of the same kind. The decision does not depend on weighing the balance between the extent of the damage to the plaintiff and the damage to the public in each particular case."

D. Striking-out procedure

66. At the relevant time, Order 18, Rule 19 of the Rules of the Supreme Court provided that a claim could be struck out if it disclosed no reasonable cause of action. This jurisdiction has been described as being reserved for "plain and obvious cases", in which a claim was "obviously unsustainable".

67. In applications to strike out, the courts proceeded on the basis that all the allegations set out in the claimant's pleadings were true. The question for the courts was whether, assuming that the claimant could substantiate all factual allegations at trial, the claim disclosed a reasonable cause of action.

68. The striking out procedure, now contained in Part 3.4(2) of the Civil Procedure Rules in force since 1999, is regarded as an important feature of English civil procedure, performing the function of securing speedy and effective justice, *inter alia*, by allowing a court to decide promptly which issues need full investigation and trial, and disposing summarily of the others. By means of this procedure, it can be determined at an early stage, with minimal cost to the parties, whether the facts as pleaded reveal a claim existing in law.

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION

69. The applicants alleged that the local authority had failed to protect them from inhuman and degrading treatment contrary to Article 3 of the Convention, which provides:

> "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

70. In its report the Commission expressed the unanimous opinion that there had been a violation of Article 3 of the Convention. It considered that there was a positive obligation on the Government to protect children from treatment contrary to this provision. The authorities had been aware of the serious ill-treatment and neglect suffered by the four children over a period of years at the hands of their parents and failed, despite the means reasonably available to them, to take any effective steps to bring it to an end.

71. The applicants requested the Court to confirm this finding of a violation.

72. The Government did not contest the Commission's finding that the treatment suffered by the four applicants reached the level of severity prohibited by Article 3 and that the State failed in its positive obligation,

under Article 3 of the Convention, to provide the applicants with adequate protection against inhuman and degrading treatment.

73. The Court reiterates that Article 3 enshrines one of the most fundamental values of democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment. The obligation on High Contracting Parties under Article 1 of the Convention to secure to everyone within their jurisdiction the rights and freedoms defined in the Convention, taken in conjunction with Article 3, requires States to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman or degrading treatment, including such ill-treatment administered by private individuals (see *A. v. the United Kingdom*, judgment of 23 September 1998, *Reports of Judgments and Decisions* 1998-VI, p. 2699, § 22). These measures should provide effective protection, in particular, of children and other vulnerable persons and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge (see, *mutatis mutandis*, *Osman v. the United Kingdom*, judgment of 28 October 1998, *Reports* 1998-VIII, pp. 3159-60, § 116).

74. There is no dispute in the present case that the neglect and abuse suffered by the four applicant children reached the threshold of inhuman and degrading treatment (as recounted in paragraphs 11-36 above). This treatment was brought to the local authority's attention, at the earliest in October 1987. It was under a statutory duty to protect the children and had a range of powers available to them, including the removal of the children from their home. These were, however, only taken into emergency care, at the insistence of the mother, on 30 April 1992. Over the intervening period of four and a half years, they had been subjected in their home to what the consultant child psychiatrist who examined them referred as horrific experiences (see paragraph 40 above). The Criminal Injuries Compensation Board had also found that the children had been subject to appalling neglect over an extended period and suffered physical and psychological injury directly attributable to a crime of violence (see paragraph 49 above). The Court acknowledges the difficult and sensitive decisions facing social services and the important countervailing principle of respecting and preserving family life. The present case, however, leaves no doubt as to the failure of the system to protect these applicant children from serious, long-term neglect and abuse.

75. Accordingly, there has been a violation of Article 3 of the Convention.

II. ALLEGED VIOLATION OF ARTICLE 8 OF THE CONVENTION

76. The applicants alleged, in the alternative to their complaints under Article 3 of the Convention, that the circumstances in which they suffered

ill-treatment, causing them physical and psychological injury, disclosed a breach of Article 8 of the Convention, which under the principle of respect for private life, protected physical and moral integrity.

77. Having regard to its finding of a violation of Article 3, the Court considers that no separate issue arises under Article 8 of the Convention.

III. ALLEGED VIOLATION OF ARTICLE 6 OF THE CONVENTION

78. The applicants complained that they had been denied access to a court to determine their claims against the local authority in negligence. They relied on Article 6 of the Convention.

79. Article 6 § 1 provides in its first sentence:

> "In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law."

80. The Government denied that there was any civil right in issue in the case or any restriction on access, while the Commission found unanimously that there had been a breach of Article 6, in that the House of Lords had applied an exclusionary rule concerning the liability of local authorities in child care matters which constituted in the circumstances a disproportionate restriction on the applicants' access to a court.

A. Submissions of the parties

1. The applicants

81. The applicants submitted that their negligence claim was plainly arguable as a matter of domestic law, relying, *inter alia*, on *Osman*, cited above. The right to sue in negligence, a cause of action framed in general terms, was an established civil right in domestic law. The local authority had conceded that they could have foreseen damage to the applicants if they carried out their duties negligently and that there was a proximate relationship, thereby satisfying the first two limbs of the test for the duty of care. There was a strong argument that public policy considerations required a duty of care to be imposed and there was no prior decision excluding liability. The applicants also pointed to the fact that the judge who made the care orders specifically released the case papers to the Official Solicitor so that he could investigate and, if appropriate, pursue negligence claims; that the Official Solicitor considered that there were arguable claims in negligence; that the Legal Aid Board granted legal aid to pursue the claims to the House of Lords; and that the Court of Appeal which rejected the claims by a majority granted leave to appeal to the House of Lords, the precondition for such leave being that the claim was arguable in domestic

law; that the Master of the Rolls, in the Court of Appeal, found that there was duty of care, stating the contrary to be "an affront to common sense"; and that in previous cases, local authorities had paid settlements in negligence cases, on the basis that they were potentially liable. There was a serious dispute in domestic law, therefore, as to the existence of any exclusionary principle, which has continued since, and Article 6 was applicable.

82. The exclusionary rule applied by the House of Lords permitted the applicants' claims to be struck out without determining the facts and without a trial. This applied regardless of the merits or the seriousness of the harm suffered. Designed to protect local authorities from wasting resources on having to defend an action at all, this amounted in practical effect to an immunity and acted as a restriction on access to a court.

83. The application of a blanket rule which excluded the determination of the applicants' claims irrespective of the seriousness of the harm suffered, the nature and extent of negligence involved, or the fundamental rights which were at stake, constituted a disproportionate restriction on their right of access to a court. They emphasised the severity of the damage suffered by them due to prolonged exposure to abuse and neglect against which the public policy arguments against imposition of liability had little weight, namely, the alleged risk of frivolous litigation, the increased caution of social services in fulfilling their functions or the difficulty or sensitivity of the issues. Indeed, the requirement to investigate effectively cases of treatment contrary to Article 3 pointed strongly to the recognition of a right of access to a court where the State's responsibility had been engaged for inhuman or degrading treatment of vulnerable children. They referred to the Court's finding in *Osman* (cited above, p. 3170, § 151) that the domestic courts should be able to distinguish between degrees of negligence or harm and give consideration to the justice of a particular case. An exclusionary rule on that basis should be capable of yielding to competing human rights considerations on the facts of a particular case.

2. The Government

84. The Government submitted that Article 6 guaranteed a fair trial in the determination only of such civil rights and obligations as are (at least arguably) recognised in national law. It does not bear on the substantive question of whether a right to compensation exists in any given situation. The proceedings brought by the applicants established that no right existed. The decision to strike out their claim touched on the scope of the domestic law. By ruling that a right of action did not exist in a particular set of circumstances, the courts were applying substantive limits to tort liability, as the legislature might do in statute (see, for example, *Powell and Rayner v. the United Kingdom*, judgment of 21 February 1990, Series A no. 172,

pp. 16-17, § 36). There was no established cause of action which was restricted. Accordingly, they claimed that Article 6 § 1 was not applicable.

85. The Government argued in the alternative that there was no immunity applied which could be regarded as a restriction on access to a court. Even assuming that there was an arguable issue, there could in their view be no doubt that the dispute was subject to a fair and public hearing in compliance with the guarantees of Article 6. The striking-out procedure was an important way of securing the speedy and cost-effective determination of cases that were hopeless in law. It achieved those aims without inhibiting claimants' rights to present any arguments in their favour to a court. Thus, as factual matters were assumed to be those pleaded, the claimants were not prejudiced by the lack of hearing of evidence, while they could put forward any arguments in their favour to persuade the court that their claim was sustainable as a matter of law.

86. Assuming that their arguments on the above failed, the Government argued that any restriction on access to a court nonetheless pursued a legitimate aim and was proportionate. It aimed to preserve the efficiency of a vital sector of public service. The exclusion of liability was strictly limited in scope to the category of cases to which it applied, actions for misfeasance, vicarious liability for employees remaining unaffected. The domestic courts had themselves weighed up the public policy issues for and against liability in light of the principles of English tort law and the social and political philosophy underlying those principles. A very substantial margin of appreciation would therefore be appropriate in any international adjudication.

B. The Court's assessment

1. Applicability of Article 6 of the Convention

87. The Court recalls its constant case-law to the effect that "Article 6 § 1 extends only to '*contestations*' (disputes) over (civil) 'rights and obligations' which can be said, at least on arguable grounds, to be recognised under domestic law; it does not itself guarantee any particular content for (civil) 'rights and obligations' in the substantive law of the Contracting States" (see *James and Others v. the United Kingdom*, judgment of 21 February 1986, Series A no. 98, pp. 46-47, § 81; *Lithgow and Others v. the United Kingdom*, judgment of 8 July 1986, Series A no. 102, p. 70, § 192; and *The Holy Monasteries v. Greece*, judgment of 9 December 1994, Series A no. 301-A, pp. 36-37, § 80). It will however apply to disputes of a "genuine and serious nature" concerning the actual existence of the right as well as to the scope or manner in which it is exercised (see *Benthem v. the Netherlands*, judgment of 23 October 1985, Series A no. 97, pp. 14-15, § 32).

88. In the present case, the applicants were claiming damages on the basis of alleged negligence, a tort in English law which is largely developed through the case-law of the domestic courts. It is agreed by the parties that there was no previous court decision which indicated that liability existed in respect of damage caused negligently by a local authority in carrying out its child protection duties. It was in the applicants' case that the domestic courts were called on to rule whether this situation fell within one of the existing categories of negligence liability, or whether any of the categories should be extended to this situation (see paragraphs 57-65 above).

89. The Court is satisfied that at the outset of the proceedings there was a serious and genuine dispute about the existence of the right asserted by the applicants under the domestic law of negligence as shown, *inter alia*, by the grant of legal aid to the applicants and the decision of the Court of Appeal that their claims merited leave to appeal to the House of Lords. The Government's submission that there was no arguable (civil) "right" for the purposes of Article 6 once the House of Lords had ruled that no duty of care arose has relevance rather to any claims which were lodged or pursued subsequently by other plaintiffs. The House of Lords' decision did not remove, retrospectively, the arguability of the applicants' claims (see *Le Calvez v. France*, judgment of 29 July 1998, *Reports* 1998-V, pp. 1899-900, § 56). In such circumstances, the Court finds that the applicants had, on at least arguable grounds, a claim under domestic law.

90. Article 6 was, therefore, applicable to the proceedings brought by these applicants alleging negligence by the local authority. The Court must, therefore, examine whether the requirements of Article 6 were complied with in those proceedings.

2. Compliance with Article 6 of the Convention

91. The Court, in *Golder v. the United Kingdom* (judgment of 21 February 1975, Series A no. 18, pp. 13-18, §§ 28-36), held that the procedural guarantees laid down in Article 6 concerning fairness, publicity and expeditiousness would be meaningless if there were no protection of the pre-condition for the enjoyment of those guarantees, namely, access to a court. It established this as an inherent aspect of the safeguards enshrined in Article 6, referring to the principles of the rule of law and the avoidance of arbitrary power which underlie much of the Convention.

92. Article 6 § 1 "may ... be relied on by anyone who considers that an interference with the exercise of one of his (civil) rights is unlawful and complains that he has not had the possibility of submitting that claim to a tribunal meeting the requirements of Article 6 § 1" (see *Le Compte, Van Leuven and De Meyere v. Belgium*, judgment of 23 June 1981, Series A no. 43, p. 20, § 44). Where there is a serious and genuine dispute as to the lawfulness of such an interference, going either to the very existence or the scope of the asserted civil right, Article 6 § 1 entitles the individual "to have

this question of domestic law determined by a tribunal" (see *Sporrong and Lönnroth v. Sweden*, judgment of 23 September 1982, Series A no. 52, p. 30, § 81; see also *Tre Traktörer AB v. Sweden*, judgment of 7 July 1989, Series A no. 159, p. 18, § 40).

93. The right is not absolute, however. It may be subject to legitimate restrictions such as statutory limitation periods, security for costs orders, regulations concerning minors and persons of unsound mind (see *Stubbings and Others v. the United Kingdom*, judgment of 22 October 1996, *Reports* 1996-IV, pp. 1502-03, §§ 51-52; *Tolstoy Miloslavsky v. the United Kingdom*, judgment of 13 July 1995, Series A no. 316-B, pp. 80-81, §§ 62-67; and *Golder*, cited above, p. 19, § 39). Where the individual's access is limited either by operation of law or in fact, the Court will examine whether the limitation imposed impaired the essence of the right and, in particular, whether it pursued a legitimate aim and there was a reasonable relationship of proportionality between the means employed and the aim sought to be achieved (see *Ashingdane v. the United Kingdom*, judgment of 28 May 1985, Series A no. 93, pp. 24-25, § 57). If the restriction is compatible with these principles, no violation of Article 6 will arise.

94. It is contended by the applicants in this case that the decision of the House of Lords, finding that the local authority owed no duty of care, deprived them of access to a court as it was effectively an exclusionary rule, or an immunity from liability, which prevented their claims from being decided on the facts.

95. The Court observes, firstly, that the applicants were not prevented in any practical manner from bringing their claims before the domestic courts. Indeed, the case was litigated with vigour up to the House of Lords, the applicants being provided with legal aid for that purpose. Nor is it that any procedural rules or limitation periods had been relied on. The domestic courts were concerned with the application brought by the defendants to have the case struck out as disclosing no reasonable cause of action. This involved the pre-trial determination of whether, assuming the facts of the applicants' case as pleaded were true, there was a sustainable claim in law. The arguments before the courts were, therefore, concentrated on the legal issues, primarily whether a duty of care in negligence was owed to the applicants by the local authority.

96. Moreover, the Court is not persuaded that the House of Lords' decision that, as a matter of law, there was no duty of care in the applicants' case may be characterised as either an exclusionary rule or an immunity which deprived them of access to a court. As Lord Browne-Wilkinson explained in his leading speech, the House of Lords was concerned with the issue whether a novel category of negligence, that is a category of cases in which a duty of care had not previously been held to exist, should be developed by the courts in their law-making role under the common law

(see paragraph 46 above). The House of Lords, after weighing in the balance the competing considerations of public policy, decided not to extend liability in negligence into a new area. In so doing, it circumscribed the range of liability under tort law.

97. That decision did end the case, without the factual matters being determined on the evidence. However, if as a matter of law, there was no basis for the claim, the hearing of evidence would have been an expensive and time-consuming process which would not have provided the applicants with any remedy at its conclusion. There is no reason to consider the striking-out procedure which rules on the existence of sustainable causes of action as *per se* offending the principle of access to a court. In such a procedure, the plaintiff is generally able to submit to the court the arguments supporting his or her claims on the law and the court will rule on those issues at the conclusion of an adversarial procedure (see paragraphs 66-68 above).

98. Nor is the Court persuaded by the suggestion that, irrespective of the position in domestic law, the decision disclosed an immunity in fact or practical effect due to its allegedly sweeping or blanket nature. That decision concerned only one aspect of the exercise of local authorities' powers and duties and cannot be regarded as an arbitrary removal of the courts' jurisdiction to determine a whole range of civil claims (see *Fayed v. the United Kingdom*, judgment of 21 September 1994, Series A no. 294-B, pp. 49-50, § 65). As it has recalled above in paragraph 87, it is a principle of Convention case-law that Article 6 does not in itself guarantee any particular content for civil rights and obligations in national law, although other Articles such as those protecting the right to respect for family life (Article 8) and the right to property (Article 1 of Protocol No. 1) may do so. It is not enough to bring Article 6 § 1 into play that the non-existence of a cause of action under domestic law may be described as having the same effect as an immunity, in the sense of not enabling the applicant to sue for a given category of harm.

99. Furthermore, it cannot be said that the House of Lords came to its conclusion without carefully balancing the policy reasons for and against the imposition of liability on the local authority in the circumstances of the applicants' case. Lord Browne-Wilkinson, in his leading judgment in the House of Lords, acknowledged that the public policy principle that wrongs should be remedied required very potent counter-considerations to be overridden (see paragraph 46 above). He weighed that principle against the other public policy concerns in reaching the conclusion that it was not fair, just or reasonable to impose a duty of care on the local authority in the applicants' case. It may be noted that in subsequent cases the domestic courts have further defined this area of law concerning the liability of local authorities in child-care matters, holding that a duty of care may arise in other factual situations, where, for example, a child has suffered harm once

in local authority care, or a foster family has suffered harm as a result of the placement in their home by the local authority of an adolescent with a history of abusing younger children (see *W. and Others v. Essex County Council* and *Barrett*, both cited above, paragraphs 62-65 above).

100. The applicants, and the Commission in its report, relied on *Osman* (cited above) as indicating that the exclusion of liability in negligence, in that case concerning the acts or omissions of the police in the investigation and prevention of crime, acted as a restriction on access to a court. The Court considers that its reasoning in *Osman* was based on an understanding of the law of negligence (see, in particular, *Osman*, cited above, pp. 3166-67, §§ 138-39) which has to be reviewed in the light of the clarifications subsequently made by the domestic courts and notably by the House of Lords. The Court is satisfied that the law of negligence as developed in the domestic courts since the case of *Caparo Industries plc* (cited above) and as recently analysed in the case of *Barrett* (cited above, loc. cit.) includes the fair, just and reasonable criterion as an intrinsic element of the duty of care and that the ruling of law concerning that element in this case does not disclose the operation of an immunity. In the present case, the Court is led to the conclusion that the inability of the applicants to sue the local authority flowed not from an immunity but from the applicable principles governing the substantive right of action in domestic law. There was no restriction on access to a court of the kind contemplated in *Ashingdane* (cited above, loc. cit.).

101. The applicants may not, therefore, claim that they were deprived of any right to a determination on the merits of their negligence claims. Their claims were properly and fairly examined in light of the applicable domestic legal principles concerning the tort of negligence. Once the House of Lords had ruled on the arguable legal issues that brought into play the applicability of Article 6 § 1 of the Convention (see paragraphs 87-89 above), the applicants could no longer claim any entitlement under Article 6 § 1 to obtain any hearing concerning the facts. As pointed out above, such a hearing would have served no purpose, unless a duty of care in negligence had been held to exist in their case. It is not for this Court to find that this should have been the outcome of the striking-out proceedings since this would effectively involve substituting its own views as to the proper interpretation and content of domestic law.

102. It is nonetheless the case that the interpretation of domestic law by the House of Lords resulted in the applicants' case being struck out. The tort of negligence was held not to impose a duty of care on the local authority in the exercise of its statutory powers. Their experiences were described as "horrific" by a psychiatrist (see paragraph 40 above) and the Court has found that they were victims of a violation of Article 3 (see paragraph 74 above). Yet the outcome of the domestic proceedings they brought is that they, and any children with complaints such as theirs, cannot sue the local

authority in negligence for compensation, however foreseeable – and severe – the harm suffered and however unreasonable the conduct of the local authority in failing to take steps to prevent that harm. The applicants are correct in their assertions that the gap they have identified in domestic law is one that gives rise to an issue under the Convention, but in the Court's view it is an issue under Article 13, not Article 6 § 1.

103. The Court emphasises that the object and purpose underlying the Convention, as set out in Article 1, is that the rights and freedoms should be secured by the Contracting State within its jurisdiction. It is fundamental to the machinery of protection established by the Convention that the national systems themselves provide redress for breaches of its provisions, the Court exerting its supervisory role subject to the principle of subsidiarity. In that context, Article 13, which requires an effective remedy in respect of violations of the Convention, takes on a crucial function. The applicants' complaints are essentially that that they have not been afforded a remedy in the courts for the failure to ensure them the level of protection against abuse to which they were entitled under Article 3 of the Convention. The domestic courts referred to "the public-policy consideration that has first claim on the loyalty of the law" as being that "wrongs should be remedied" (see paragraph 46 above). As far as Convention wrongs are concerned, that principle is embodied in Article 13 (see, *inter alia*, *Kudła v. Poland* [GC], no. 30210/96, § 152, ECHR 2000-XI). It is under Article 13 that the applicants' right to a remedy should be examined and, if appropriate, vindicated.

104. Accordingly, the Court finds that there has been no violation of Article 6 of the Convention.

IV. ALLEGED VIOLATION OF ARTICLE 13 OF THE CONVENTION

105. The applicants submitted that they had not been afforded any remedy for the damage which they had suffered as a result of the failure of the local authority to protect them, relying on Article 13 of the Convention, which provides:

> "Everyone whose rights and freedoms as set forth in [the] Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."

106. The applicants argued that the exclusionary rule established by the House of Lords in their case deprived them of any effective remedy within the national legal system for the violation of Article 3 which they suffered. While the remedy required by Article 13 need not always be judicial in character, in their case a judicial determination was required. This was because the tort of negligence was the only remedy in national law capable of determining the substance of their complaint and which (but for the

alleged immunity) would closely match the requirements of the Convention. Also the accountability of public officials, central to both Articles 3 and 13, required a right of access to a court whereby the individual could hold the responsible officials to account in adversarial proceedings and obtain an enforceable order for compensation if the claim was substantiated. The wording of Article 13 also prohibited the creation of immunities for public officials and any such immunity must be regarded as contrary to the object and purpose of the Convention.

107. The Government pointed out that there were a number of remedies available to the applicants which went some way towards providing effective redress. This included the payment of compensation from the Criminal Injuries Compensation Board (CICB), the possibility of complaining to the Local Government Ombudsman, and the complaints procedure under the Children Act 1989. However, the Government accepted that in the particular circumstances of this case, the remedies were insufficient, alone or cumulatively, to satisfy the requirements of Article 13. They conceded that there had been a serious violation of one of the most important Convention rights, that the CICB could only award compensation for criminal acts, not for the consequences of neglect, and that any recommendation by the Ombudsman would not have been legally enforceable. They had been under the obligation, in this case, to ensure that some form of compensation was made available for damage caused by the breach of Article 3, whether by a broader statutory compensation scheme, an enforceable Ombudsman's award, or through the courts. They pointed out that from October 2000, when the Human Rights Act 1998 came into force, a victim would be able to bring proceedings in the courts against a public authority for a breach of a substantive right, and the courts would be empowered to award damages.

108. As the Court has stated on many occasions, Article 13 of the Convention guarantees the availability at the national level of a remedy to enforce the substance of the Convention rights and freedoms in whatever form they might happen to be secured in the domestic legal order. Article 13 thus requires the provision of a domestic remedy to deal with the substance of an "arguable complaint" under the Convention and to grant appropriate relief, although the Contracting States are afforded some discretion as to the manner in which they conform to their Convention obligations under this provision. The scope of the obligation under Article 13 also varies depending on the nature of the applicant's complaint under the Convention. Nevertheless, the remedy required by Article 13 must be "effective" in practice as well as in law (see, among other authorities, *Aydın v. Turkey*, judgment of 25 September 1997, *Reports* 1997-VI, pp. 1895-96, § 103).

109. The Court has previously held that where a right with as fundamental an importance as the right to life or the prohibition against torture, inhuman and degrading treatment is at stake, Article 13 requires, in

addition to the payment of compensation where appropriate, a thorough and effective investigation capable of leading to the identification and punishment of those responsible, including effective access for the complainant to the investigation procedure (see *Kaya v. Turkey*, judgment of 19 February 1998, *Reports* 1998-I, pp. 330-31, § 107). These cases, however, concerned alleged killings or infliction of treatment contrary to Article 3 involving potential criminal responsibility on the part of security force officials. Where alleged failure by the authorities to protect persons from the acts of others is concerned, Article 13 may not always require that the authorities undertake the responsibility for investigating the allegations. There should, however, be available to the victim or the victim's family a mechanism for establishing any liability of State officials or bodies for acts or omissions involving the breach of their rights under the Convention. Furthermore, in the case of a breach of Articles 2 and 3 of the Convention, which rank as the most fundamental provisions of the Convention, compensation for the non-pecuniary damage flowing from the breach should in principle be part of the range of available remedies.

110. The applicants have argued that in their case an effective remedy could only be provided by adversarial court proceedings against the public body responsible for the breach. The Court notes that the Government have conceded that the range of remedies at the disposal of the applicants was insufficiently effective. They have pointed out that in the future, under the Human Rights Act 1998, victims of human rights breaches will be able to bring proceedings in courts empowered to award damages. The Court does not consider it appropriate in this case to make any findings as to whether only court proceedings could have furnished effective redress, though judicial remedies indeed furnish strong guarantees of independence, access for the victim and family, and enforceability of awards in compliance with the requirements of Article 13 (see, *mutatis mutandis*, *Klass and Others v. Germany*, judgment of 6 September 1978, Series A no. 28, p. 30, § 67).

111. The Court finds that in this case the applicants did not have available to them an appropriate means of obtaining a determination of their allegations that the local authority failed to protect them from inhuman and degrading treatment and the possibility of obtaining an enforceable award of compensation for the damage suffered thereby. Consequently, they were not afforded an effective remedy in respect of the breach of Article 3 and there has, accordingly, been a violation of Article 13 of the Convention.

V. APPLICATION OF ARTICLE 41 OF THE CONVENTION

112. Article 41 of the Convention provides:

> "If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party."

A. Pecuniary damage

1. The applicants

113. The applicants submitted that they should be compensated for loss of future earnings and the costs of future medical expenses. Their experiences have, in different ways and to differing extents, blighted their lives. A substantial award should be made to enable them to enter life with a modicum of financial security, the potential to build an independent existence and the means to pay for therapeutic treatment and support.

114. The applicants provided updated medical reports dated 16 May 2000 by Dr Jean Harris-Hendriks concerning their progress and prognosis for the future.

(i) Z was described as having made a recovery from the serious depressive illness suffered at the time of her removal into care. While she was no longer suffering from any psychiatric illness, she had emotional, social and practical difficulties far beyond those normally affecting a girl of her age and was statistically vulnerable to anxiety and perhaps depressive illness in adult life. Her problems were classified as being of moderate severity. It was estimated that she would need psychotherapeutic treatment, outside the National Health Service, estimated at 60 to 100 sessions costing 70 to 90 pounds sterling (GBP) per session, to cope with her vulnerability, particularly at periods of transition. She was likely to remain vulnerable on the labour market, though it was anticipated that she would be able to take on further education, sustain her own mental health and enter the workforce. On her behalf, her representatives claimed GBP 9,000 for the cost of future psychiatric treatment, and GBP 40,000 to offset her handicap on the labour market, a total of GBP 49,000.

(ii) A had failed to appear for an interview with Dr Harris-Hendriks, who also commented on the lack of detailed information concerning periods spent by A in care. She had, however, interviewed him on behalf of the local authority in May 1993 and had some records concerning his past treatment and problems. On that basis, she concluded that he was suffering from long-term psychiatric illness and had a poor prognosis for recovery. His chances of fitting into the normal school system remained very poor. He

was prone to aggressiveness and had difficulty with everyday tasks. He was currently suffering from a reactive attachment disorder, resulting directly from severe parental neglect and abuse. The prognosis for the future was extremely bleak and he was likely to require intermittent hospitalisation. He was seriously handicapped on the labour market and was unlikely ever to be able to hold down a job. Assuming that he might otherwise have been able to obtain low-paid manual employment earning GBP 15,000 per year, and a normal working life to age 65, and taking into account uncertainties and early settlement, he claimed GBP 150,000 in loss of future earnings. As he had a substantial and continuing need for psychiatric treatment outside the National Health Service (NHS), he claimed GBP 50,000 as a minimum estimate for future treatment. This made a total of GBP 200,000.

(iii) B was still suffering from untreated post-traumatic stress disorder and a chronic, generalised anxiety disorder. He had horrific nightmares and, if left untreated, was likely to continue in the same disturbed emotional state. He required open-ended psychiatric treatment into adult life, outside the limited provision of the NHS. This was estimated at a cost of GBP 50,000 minimum. He is vulnerable in terms of both schooling and employment opportunities because of a chronic psychiatric disorder and limited social skills. His prospects of future employment were not as bleak as those of A, but he was likely to have substantial interruptions in his employment. On the assumption of six gaps of one year, on an average labourer's wage of GBP 15,000 per year, he claimed GBP 90,000. This made a total of GBP 140,000.

(iv) C was described as happy in her adoptive home, though carrying a substantial burden about her origins and reminders of them. She was recurrently angry and anxious about her natural mother. She had some remaining behavioural problems which were likely to be containable with good substitute parenting. She was, however, more liable than other children to anxiety and there was a statistical risk of depression in adult life. She did not currently require psychiatric treatment although provision should be made for treatment in adolescence and adulthood. At a recommended 30 to 50 sessions at GBP 70 to 90, a claim was made for GBP 4,500 for future psychiatric treatment. GBP 10,000 was claimed for loss of future earnings, making a total of GBP 14,500.

The reports commented that all the children would have benefited from compensation for their claims in 1994 as this would have allowed additional psychotherapeutic help, improving their prognosis. In A's case, his difficulties had been exacerbated by this lack of help while appropriate psychiatric, educational and environmental help might have substantially improved his prognosis. In B's case, more psychotherapeutic help could have reduced his current vulnerability and given a less gloomy prognosis. The reports also deplored that the psychotherapeutic referrals recommended for A and B in 1993 (for both) and 1998 (for B) had not been pursued by the

local authority on their behalf, and noted that one of the social workers had been told that there was no time or money for this work to be done.

2. The Government

115. The Government submitted that it was wrong to rely on domestic case-law and scales of assessment in just-satisfaction claims under Article 41 as the Court made its own assessment in accordance with principles in its own case-law. They emphasised that it must also be taken into account that the ill-treatment and neglect suffered by the applicants was not inflicted by the local authority but by their parents. It was also relevant that the breach of Article 3 arose only after there had been a failure to take effective steps when the situation in the home failed to show significant improvement – there was no ground for assuming that the children should have been removed from their home immediately. Nor should any award be made in respect of any alleged violation of Article 13 as that damage would be compensated by the award made under Article 3. In assessing what compensation would be equitable, it should also be taken into account that a number of compensatory remedies were available to the applicant, in particular, they received awards from the CICB.

116. As regards the recent medical reports, the Government considered that these were framed in largely identical terms with no attempt to distinguish the children's condition by reference to their age at the time of the violation, their sex and the duration of the treatment. No consideration was given either to what part was played by the temperament of the applicants, and by environmental factors including the care which they had received since 1992. Nor was any regard given to any harm which they might have suffered since being taken into care.

117. Turning to the specific claims made, the Government noted that Z had recovered from her depressive illness and had been doing remarkably well during her schooling, with no significant problems. There was nothing to substantiate the asserted claim for 60 to 100 sessions of psychotherapeutic treatment. Given her positive progress, the claim of statistical vulnerability to future anxiety and depressive illness was not substantiated either.

The report on A was in their view particularly unsatisfactory as it was issued without A having appeared for interview and without full information about his history. While he was not referred to a special clinic as suggested, he did receive therapeutic work in the community where he lived between 1996 and 1998. There was no or little basis for the assumption that his difficulties were exacerbated by the failure of his earlier compensation claim.

The report on B was similarly highly speculative and unsubstantiated, with regard to the alleged adverse impact of the lack of compensation. Its comments on his educational difficulties were inconsistent.

The report on C indicated that she was not psychiatrically ill and was coping well, rendering the conclusion that she had emotional and practical difficulties beyond the average girl of her age difficult to understand. The statements concerning likely future need and alleged impact of the failure of the compensation claim were unsupported by the evidence.

118. The Government submitted that in light of these considerations a reasonable sum of GBP 20,000 for Z, GBP 40,000 for A, GBP 30,000 for B, and GBP 10,000 for C would afford the applicants just satisfaction for both pecuniary and non-pecuniary damage.

3. The Court's assessment

119. As regards the applicants' claims for pecuniary loss, the Court's case-law establishes that there must be a clear causal connection between the damage claimed by the applicant and the violation of the Convention and that this may, in the appropriate case, include compensation in respect of loss of earnings (see, among other authorities, *Barberà, Messegué and Jabardo v. Spain* (Article 50), judgment of 13 June 1994, Series A no. 285-C, pp. 57-58, §§ 16-20, and *Çakıcı v. Turkey* [GC], no. 23657/94, § 127, ECHR 1999-IV).

120. A precise calculation of the sums necessary to make complete reparation (*restitutio in integrum*) in respect of the pecuniary losses suffered by the applicants may be prevented by the inherently uncertain character of the damage flowing from the violation (see *Young, James and Webster v. the United Kingdom* (Article 50), judgment of 18 October 1982, Series A no. 55, pp. 6-7, § 11). An award may still be made notwithstanding the large number of imponderables involved in the assessment of future losses, though the greater the lapse of time involved, the more uncertain the link becomes between the breach and the damage. The question to be decided in such cases is the level of just satisfaction, in respect of both past and future pecuniary losses, which it is necessary to award each applicant, the matter to be determined by the Court at its discretion, having regard to what is equitable (see The Sunday Times *v. the United Kingdom (no. 1)* (Article 50), judgment of 6 November 1980, Series A no. 38, p. 9, § 15, and *Smith and Grady v. the United Kingdom* (just satisfaction), nos. 33985/96 and 33986/96, §§ 18-19, ECHR 2000-IX). In that determination, the awards made in comparable domestic cases is a relevant but not decisive consideration.

121. Turning to the present case, the Court recalls that all four children suffered psychological and physical damage resulting from the abuse and neglect of their parents over a period of more than four years (see paragraphs 11-40 above). The breach of Article 3 concerned the failure of the local authority to take reasonable steps available to them to protect them from that damage. There is a direct causal link, therefore, between the breach and the damage suffered by the children. While it is correct, as

asserted by the Government, that there is no finding that the children should have immediately been taken into care and that they might have suffered damage even if effective steps had been taken at an earlier stage, the Court notes that the severity of the damage suffered by the children is inextricably linked to the long period of time over which the abuse persisted, which factor is also at the heart of the violation of Article 3 in this case.

122. The Court has taken into consideration the points made by the Government concerning the medical reports provided by the applicants, in particular, the lack of any attempt to compare the children's prospects in education and employment prior to their being taken into care. It cannot be excluded, for example, that A and B, who were identified as having educational difficulties, would have experienced some problems in any event. However, such assessments would inevitably be imprecise and based on some degree of speculation, as were the views expressed by Dr Harris-Hendriks concerning the future prognosis and effect on the educational and employment prospects. It may also be noted that the medical reports have not been tested in adversarial proceedings.

123. It is nonetheless possible, on the basis of the information available to the Court, to conclude that the four children will, in all probability, suffer from the effects of their experiences for the rest of their lives. Their capacity to cope with this past trauma will depend on their own personal abilities and the support to which they may have access.

124. It is clear that Z has made an excellent recovery from her depressive illness and, receiving support from her new family, is expected to do well at school and in the future in general. C, who, due to her young age, was less damaged by events, has also successfully integrated into a new family and is attending school without problem. In their case, the Court finds that it is not possible with any degree of certainty to draw conclusions as to future difficulties in the employment sphere. Notwithstanding their current positive prognosis, it may be considered as reasonably possible that in the future they will have some need of professional help in coping with problems which may arise as they grow older and in coming to terms with their childhood experience. An award to cover future psychotherapeutic care will assist in providing them with the support necessary to that process.

125. A was the most severely damaged of the children and suffers an ongoing psychiatric illness. Therapeutic care would help him now and will be necessary in the future. The Court is satisfied that the medical report may be relied on in this respect, Dr Harris-Hendriks having previously examined A and having access to sufficient information to support her opinion. Having integrated neither into a family nor into the education system, the prognosis for A may reasonably be described as bleak. In his case, it may be claimed that the damage suffered from the abuse will in all probability affect his prospects of gaining employment in the future. An award is appropriate to reflect this loss.

126. B is suffering from post-traumatic stress and anxiety disorders, which are likely to continue to affect him for some time to come. He requires both current and future psychiatric treatment. He is attending school, in a special-needs group. It is also probable, though to a lesser extent than A, that he will have problems in obtaining and sustaining employment in later life. An award is appropriate to reflect this.

127. Bearing in mind the uncertainties of the applicants' situations, and making an assessment on an equitable basis, the Court awards Z the sum of GBP 8,000 for future medical costs; A the sum of GBP 50,000 for future medical costs and GBP 50,000 for loss of employment opportunities; B the sum of GBP 50,000 for future medical costs and GBP 30,000 for loss of employment opportunities; and C the sum of GBP 4,000 for future medical costs.

B. Non-pecuniary damage

1. The applicants

128. The applicants claimed non-pecuniary damage in respect of the physical and psychiatric damage sustained. Z had suffered a serious depressive illness and severe malnutrition, and it was predicted that she would need long-term psychiatric care, probably into adulthood. A had suffered from post-traumatic stress disorder and was chronically under-attached. There was evidence to suggest that his father had hit him with a poker and that he had been sexually abused. He had suffered permanent scarring and was expected to require long-term psychiatric care. B had also suffered post-traumatic stress disorder, with some evidence of being beaten by a poker and being sexually abused. He suffered very bad nightmares and would wake up screaming. He was expected to require long-term psychiatric care. C had been less seriously damaged but was also expected to require some psychiatric treatment. Her health had been neglected by her mother and she had a squint as a result.

According to the assessment of Dr Black, Z, A and B had suffered psychiatric damage falling at the upper end of the severe bracket. They exhibited "marked problems" in their ability to cope with life and in their relationships with family, friends and those with whom they came into contact. A and B in particular had a poor prognosis and there was a likelihood of future vulnerability. C had suffered damage in the "moderately severe" bracket. Although she presented significant problems in the areas above, she had a more favourable prognosis.

Having regard to the levels of awards in such cases in the domestic courts, the applicants considered that a reasonable sum would be GBP 35,000 for Z, GBP 45,000 for A, GBP 40,000 for B, and GBP 25,000 for C.

2. The Government

129. As stated above, the Government considered that sums of GBP 20,000 for Z, GBP 40,000 for A, GBP 30,000 for B, and GBP 10,000 for C would afford the applicants just satisfaction for both pecuniary and non-pecuniary damage.

3. The Court's assessment

130. The children in this case suffered very serious abuse and neglect over a period of more than four years. Z, A and B suffered, and in the case of the two boys, still suffer psychiatric illness as a result. A and B also suffered physical injury and C suffered neglect in respect of an eye condition. The description of the conditions which they endured and the traumatic effects which this had on the children leave the Court with no doubt that a substantial award to reflect their pain and suffering is appropriate.

131. In making this assessment, the Court recalls that the rates applied in domestic cases, though relevant, are not decisive. It does not consider it appropriate or desirable to attempt to distinguish between the children in this context. Making an assessment on an equitable basis, the Court awards each child the sum of GBP 32,000.

C. Costs and expenses

132. The applicants claimed GBP 52,781.28 inclusive of value-added tax (VAT) by way of legal costs and expenses, which included fees for attendance at hearings before the Commission and the Court, fees for Dr Harris-Hendriks and submissions on Article 41 of the Convention.

133. The Government did not dispute the hourly rate or number of hours claimed by the applicants' principal legal advisers. They did query the involvement of a leading counsel as an expert on negligence law in addition to the leading counsel with human rights expertise. They also queried the involvement of the AIRE Centre in addition to an experienced counsel and solicitor, and noted that the AIRE Centre's fees for attending the hearing had also been billed in full in the second case, *T.P. and K.M. v. the United Kingdom* [GC], no. 28945/95, ECHR 2001-V, heard before the Court on the same day. They proposed that GBP 43,000 was a reasonable sum, taking these deductions into account. However, if no violation of Articles 6 and 8 of the Convention was found, they disputed the necessity for any of the fees incurred after April 2000 when the Government conceded a breach of Articles 3 and 13 of the Convention. In those circumstances, a reasonable sum would be GBP 36,000.

134. The Court recalls that only legal costs and expenses found to have been actually and necessarily incurred and which are reasonable as to

quantum are recoverable under Article 41 of the Convention (see, among other authorities, *Nikolova v. Bulgaria* [GC], no. 31195/96, § 79, ECHR 1999-II). It observes that the case involved important and complex issues, both concerning the facts which were established by the Commission, and the legal aspects. It does not consider that the costs incurred after April 2000 should be disallowed as such, as there were outstanding issues to be determined, including the claims of pecuniary and non-pecuniary damage arising out of the breaches conceded by the Government. As, however, the complaint made under Article 6, which was a significant part of the application, was unsuccessful, the costs and expenses allowed should be reduced. The Court has had regard to the fact that the Article 6 complaint was to some extent interconnected with the complaint about the inadequacy of remedies under Article 13.

135. In light of these matters, the Court awards the global sum of GBP 39,000 for legal costs and expenses, inclusive of VAT.

D. Default interest

136. According to the information available to the Court, the statutory rate of interest applicable in the United Kingdom at the date of adoption of the present judgment is 7.5% per annum.

FOR THESE REASONS, THE COURT

1. *Holds* unanimously that there has been a violation of Article 3 of the Convention.

2. *Holds* unanimously that no separate issue arises under Article 8 of the Convention.

3. *Holds* by twelve votes to five that there has been no violation of Article 6 of the Convention.

4. *Holds* by fifteen votes to two that there has been a violation of Article 13 of the Convention.

5. *Holds* unanimously
   (a) that the respondent State is to pay the applicants, within three months, the following amounts:
      (i) GBP 8,000 (eight thousand pounds sterling) to Z, GBP 100,000 (one hundred thousand pounds sterling) to A, GBP 80,000 (eighty

thousand pounds sterling) to B, and GBP 4,000 (four thousand pounds sterling) to C in respect of pecuniary damage;

(ii) GBP 32,000 (thirty-two thousand pounds sterling) to each applicant for non-pecuniary damage;

(iii) GBP 39,000 (thirty-nine thousand pounds sterling) in respect of costs and expenses, inclusive of VAT;

(b) that simple interest at an annual rate of 7.5% shall be payable from the expiry of the above-mentioned three months until settlement;

6. *Dismisses* unanimously the remainder of the applicants' claims for just satisfaction.

Done in English and in French, and delivered at a public hearing in the Human Rights Building, Strasbourg, on 10 May 2001.

Luzius WILDHABER
President

Paul MAHONEY
Deputy Registrar

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the following separate opinions are annexed to this judgment:

(a) concurring opinion of Lady Justice Arden as to Article 6;

(b) concurring opinion of Lady Justice Arden as to Article 41, joined by Mr Kovler;

(c) partly dissenting opinion of Mr Rozakis joined by Mrs Palm;

(d) partly dissenting opinion of Mrs Thomassen joined by Mr Casadevall and Mr Kovler.

L.W.
P.J.M.

CONCURRING OPINION OF LADY JUSTICE ARDEN AS TO ARTICLE 6

I agree that Article 6 of the Convention is applicable in this case and that it is not violated for the reasons given by the majority. I attach particular importance to the majority's affirmation of the well-established principle of Convention case-law that Article 6 does not guarantee any particular content for civil rights and obligations (see paragraphs 87, 98, 100 and 101 of the judgment). In the present case the applicants failed to obtain any remedy under the domestic law because the domestic courts held that they had no cause of action in English law (*X v. Bedfordshire County Council* [1995] 2 Appeal Cases 633).

Founding themselves upon the erroneous proposition as a matter of domestic law that they had some general right to sue in negligence where the defendant's act had caused damage and there was sufficient proximity, the applicants sought to argue that the decision of the English courts amounted to a sweeping or blanket immunity. I agree with the conclusion, in paragraph 98 of the judgment, that the facts of this case do not support that argument. In my view, when the courts in England, proceeding incrementally under the common law system of judicial law-making, hold that a hitherto unconsidered category of harm does not, as a matter of law, fall within the scope of the tort of negligence, they cannot properly be described as creating an "immunity", whether blanket or limited (see the speech of Lord Browne-Wilkinson in *Barrett v. the London Borough of Enfield* [1999] 3 Weekly Law Reports 79, paragraph 65 of the judgment in the present case). What the decision of the House of Lords in the present case did was to determine a legal issue fixing the limits on the substantive content of a domestic "civil right". In any event the decision was fully and carefully reasoned. It could not be regarded as the product of arbitrariness and it applied only to closely defined circumstances (see paragraphs 98-99 of the judgment).

Paragraph 98 of the judgment refers to *Fayed v. the United Kingdom* (judgment of 21 September 1994, Series A no. 294-B). In that case the Court contemplated the possibility that there might be a violation of the right of access to a court if, for example, a State could remove from the jurisdiction of the courts a whole range of civil claims, or confer immunities from civil liability on large groups or categories of persons (ibid., pp. 49-50, § 65). At the same time, however, the Court also stated that the Convention enforcement bodies could not create, by way of interpretation of Article 6, a substantive civil right which had no legal basis in the State concerned. Yet that is what the applicants are inviting the Court to do in the present case. Once the conclusion is reached that the right on which the applicants seek to rely has no legal basis in national law, the question of whether there was an

"immunity" such as to rely on the principle referred to in *Fayed* strictly does not arise.

In *Fayed* the Court did not settle the question whether the operation of a defence to a claim in defamation conferred by English law on a public officer was such as to attract the application of the right of access to a court under Article 6 § 1 or, rather, the substantive right to respect for one's private life under Article 8. Instead, it chose to "proceed on the basis that Article 6 § 1 [was] applicable to the facts of the case" (ibid., pp. 50-51, § 67). It explained that it did so as a matter of procedural convenience because the same central issues of legitimate aim and proportionality would have been raised under Article 8, and because the parties' arguments had been directed solely to Article 6 § 1. The result in that case does not, therefore, set any precedent for the applicability of Article 6 § 1 or detract from the principle to which, as stated, I attach particular importance, namely that Article 6 does not guarantee any particular content for civil rights and obligations (see paragraphs 87, 98, 100 and 101 of the present judgment).

CONCURRING OPINION OF LADY JUSTICE ARDEN AS TO ARTICLE 41, JOINED BY JUDGE KOVLER

Article 41 of the Convention enables the Court in appropriate cases to "afford just satisfaction to the injured party". The judgment of the Court awards two sums to each applicant by way of just satisfaction: one sum in respect of pecuniary damage and the other sum in respect of non-pecuniary damage. In the case of pecuniary damage, each applicant is awarded a different sum. However, in respect of non-pecuniary damage, each applicant is awarded an identical amount. Thus, with regard to non-pecuniary damage, the applicants' cases are not assessed individually. The applicants are treated as having suffered equal distress. In addition, no distinction is drawn between the suffering of any one applicant as against that of any other applicant, despite the differences between the cases of the applicants.

I agree that the just satisfaction which the Court awards to the applicants for the violation of Article 13 should include a sum on account of non-pecuniary damage in addition to the sums awarded in respect of pecuniary damage. I have no doubt that such an award is justified. However, in my opinion, the Court should not award the same sum to each applicant but rather should make a separate award to each applicant, reflecting the suffering of that applicant.

As paragraph 128 of the judgment shows, the applicants themselves have sought different amounts: GBP 35,000 for Z, GBP 45,000 for A, GBP 40,000 for B, and GBP 25,000 for C.

All the applicants endured suffering before they were taken into care. After they were taken into care they were assessed by consultant child psychiatrists: in 1993 by Dr Black, and in 2000 by Dr Harris-Hendriks. The diagnosis of A indicates that his case is the most serious. In 1993 he was diagnosed as suffering from post-traumatic stress disorder, and in 2000 he was diagnosed as suffering from a personality disorder for which the prognosis was unfavourable. B was considered to have a post-traumatic stress disorder in both 1993 and 2000, as well as social difficulties, and in addition in 2000 a generalised anxiety disorder, but the prognosis for him was uncertain rather than unfavourable. On the other hand, the initial diagnosis in 1993 of Z as suffering from a severe depressive illness has not been borne out, though it is considered that she may suffer anxiety and perhaps depressive illness in later life. In 2000 C's difficulties were described as moderate; she was regarded as vulnerable to anxiety and likely to need psychotherapeutic help in the future, but she had not suffered any psychiatric disorder.

In the circumstances my preferred course would have been to have performed a separate assessment of the amount to be awarded for non-pecuniary damage to each applicant. Having considered the evidence on the Article 41 issue, I consider that an appropriate amount would have been

GBP 25,000 for Z, GBP 40,000 for A, GBP 35,000 for B, and GBP 15,000 for C.

PARTLY DISSENTING OPINION OF JUDGE ROZAKIS JOINED BY JUDGE PALM

With great regret I am unable to follow the assessment and the conclusions of the majority of the Court that, in the instant case, there has been no violation of Article 6 § 1 of the Convention in so far as access of the applicants to a court of law is concerned. The reasons which have led me to depart from the majority's findings are as follows:

1. The majority is satisfied that the proceedings before the national courts, which culminated in a decision of the House of Lords, met the requirements of Article 6 § 1 as regards the applicants' right to have access to a court for the determination of their civil rights. As the Court observes in paragraph 101 of the judgment, the applicants may not "claim that they were deprived of any right to a determination on their merits of their negligence claims. Their claims were properly and fairly examined in the light of the applicable domestic principle concerning the tort of negligence". And, as it is also stated in paragraph 95, "[t]he arguments before the courts were, therefore, concentrated on the legal issues, primarily whether a duty of care in negligence was owed to the applicants by the local authority". It is difficult for one to accept this approach. The applicants' claims before the national courts did not, of course, refer to this preliminary issue. Their complaint was that the local authorities acted with gross negligence in a case involving a statutory duty of care and that, because of the damage inflicted on them by the failure of the authorities to properly discharge their responsibilities, compensation was due. They submitted this civil right to the courts and nurtured the legitimate expectation that it would be dealt with by the courts through an examination on the merits following an adversarial procedure that would enable them to prove the veracity of their claims. If it may be asserted that, as a general rule the question of access to a court is determined by the subject matter of the claims before the national courts, then the applicants never enjoyed access: at all stages of the domestic examination of their case, the national courts solely examined the jurisdictional problem of whether they could entertain the merits of the case before them, thus confining themselves to the preliminary question of whether an exclusionary rule exists, preventing them from examining the merits. An exclusionary rule which was eventually established by them, not on the basis of statutory requirements or specific precedents that were binding on them, but on the basis of a particular interpretation by them of the requirements of English law in the light of the circumstances of the case before them.

2. It is one matter, of course, to accept that there was no access to a court – which, unfortunately, the majority did not clearly accept – and another to say that, in the circumstances of a particular case, the absence of access is justified because it serves a particular purpose which is proportionate to the

damage done to an individual not enjoying the protection otherwise afforded to him by Article 6 of the Convention.

I am prepared to subscribe to this alternative approach, on which the majority has also embarked – without, however, making a clear distinction between the absence of access and the circumstances justifying a proportional denial of it. However, I am not prepared to accept that the facts of the case may lead us to the conclusion that the applicants were correctly and proportionately deprived of their right because the public-interest considerations prevailed over their legitimate expectation to have their claims examined on the merits.

First of all, it transpires clearly from the facts of the case that the right to sue in negligence was an established civil right in domestic law, that the public-care authorities accepted that they had been negligent in their behaviour, and that there was a proximate relationship in accordance with the criteria determined by national law. Further, the way that the judicial authorities dealt with the matter shows that the case presented serious issues that warranted serious examination: as the applicants pointed out, the judge who made the care orders specifically released the case papers to the Official Solicitor so that he could investigate and, if appropriate, pursue negligence claims; the Official Solicitor considered that there were arguable claims in negligence; the Legal Aid Board granted legal aid to pursue the claims to the House of Lords; and the Court of Appeal, which rejected the claims by a majority, granted leave to appeal to the House of Lords, the precondition for such leave being that the claim was arguable in domestic law; the Master of the Rolls in the Court of Appeal found that there was a duty of care, stating the contrary to be "an affront to common sense"; and, in previous cases, local authorities had settled negligence claims on the basis that they were potentially liable.

So, the only reason which eventually led to this case being struck out was an interpretation by the national courts, and particularly the House of Lords, based on an argument of expediency and as a matter of policy. Indeed, by applying the third test of the English law of torts on negligence – namely, whether it was fair, just and reasonable to impose liability on the public-care authorities in the circumstances of the case, the House of Lords found that it would be detrimental to the exercise of the duties of the public body in question to impose upon them the excessive burden of tortious liability for acts or omissions in the discharge of their duties. The position taken by the House of Lords in this matter was novel and tantamount to a refusal to extend tortious liability for civil wrongs arising out of a duty of care by local authorities for child care.

It is not the Court's task to enter into an examination of the social-policy considerations which led the national courts to interpret the third test in the way they did. Yet, it is its task to look at the circumstances surrounding the particular decisions taken and to assess their significance when applying its

own test of proportionality; and it seems difficult for me to accept that in view of the importance attached to the facts of the case by the various judicial and other bodies, and the novel character of the House of Lords' ruling, the creation of new case-law barring the examination of the case on its merits was proportionate to the need for adequate protection of individuals (and society generally) against negligence by public authorities.

Secondly, and more importantly, this Court has found a violation of Article 3 of the Convention on the basis of a finding that "the neglect and abuse suffered by the four applicant children reached the threshold of inhuman and degrading treatment" (see paragraph 74 of the judgment). Again it is difficult for me to accept that serious matters of public concern – as are all matters involving a violation of Article 3 – may be left outside the protection of independent and impartial tribunals established by law, and providing all the guarantees required by Article 6 of the Convention. The majority, however, holds a different view since it accepts that, even in circumstances where there has been a violation of the substance of Article 3, the Contracting States "are afforded some discretion as to the manner in which they conform to their Convention obligations ..." provided that some effective remedy exists to deal with individual complaints concerning inhuman and degrading treatment. Hence, they conclude that, in the present situation, Article 13, but not Article 6, has been violated.

It seems to me that the present case may be considered as the *locus classicus* of the limits afforded to States by the Convention to determine the modalities of access to domestic courts. Our case-law has repeatedly underlined the fact that the right to a tribunal is not unlimited – and rightly so. Yet, the Court is free to determine in which instances a Contracting State oversteps its freedom of choice and becomes liable under Article 6; and one criterion which can readily assist the Court in drawing the line between instances where a State retains its discretion, and instances where a State is bound to offer judicial guarantees to those falling under its jurisdiction, is the severity of the complaint before the national authorities. If the complaint may involve a violation of core Convention rights – such as Articles 2 and 3 – the Court is bound, to my mind, to find that the States are obliged not simply to offer an effective remedy (as required by Article 13), but a judicial remedy covering all the requirements of Article 6.

3. Most of the ideas put forward in the previous lines have as their source of inspiration *Osman v. the United Kingdom* (judgment of 28 October 1998, *Reports of Judgments and Decisions* 1998-VIII) which the majority has not followed in the present judgment. The main reason which has led the majority to depart from the established case-law is explained in paragraph 100 of the present judgment:

> "... The Court considers that its reasoning in *Osman* was based on an understanding of the law of negligence ... which has to be reviewed in the light of the clarifications subsequently made by the domestic courts and by notably the House of Lords. The

> Court is satisfied that the law of negligence as developed in the domestic courts since the case of *Caparo Industries plc* ... and as recently analysed in the case of *Barrett* ... includes the fair, just and reasonable criterion as an intrinsic element of the duty of care and that the ruling of law concerning that element in this case does not disclose the operation of an immunity. In the present case, the Court is led to the conclusion that the inability of the applicants to sue the local authority flowed not from an immunity but from the applicable principles governing the substantive right of action in domestic law. ..."

I do not think that in *Osman* the Court was very much concerned with this subtle issue raised by this judgment in the above-mentioned paragraph. The Court in *Osman* never said that the jurisdictional bar was an immunity to be distinguished from the applicable principles governing the substantive right of action in domestic law. It simply considered that "the application of the [exclusionary] rule in this manner without further enquiry into the existence of competing public interest considerations only serves *to confer a blanket immunity* on the police for their acts and omissions during the investigation and suppression of crime and amounts to an unjustifiable restriction on an applicant's right to have a determination on the merits of his or her claim against the police in deserving cases" (see *Osman*, cited above, p. 3170, § 151 – emphasis added). It went on to express the opinion that, in cases where the harm sustained by a complainant was of the most serious nature, examination of the merits could not be automatically excluded by the application of a rule which "*amounts to the grant of an immunity to the police*". In conclusion, the Court in *Osman* was mainly concerned with the fact that the applicants in a very serious case of possible substantive human-rights violations did not have the opportunity to air their grievances before a court of law; it was not concerned with whether the reason behind it being impossible to examine the case on the merits was or was not the result of an immunity provided for by national law acting as a procedural bar having such an effect. It simply found that the impossibility amounted to a grant of an immunity. Under these circumstances how can we distinguish between *Osman* and the present case?

For all the above reasons I believe that Article 6 (access to a court) has been violated and, hence, I consider that Article 13 does not raise a separate ground for violation, Article 6 being the *lex specialis* in this case.

PARTLY DISSENTING OPINION OF JUDGE THOMASSEN JOINED BY JUDGES CASADEVALL AND KOVLER

I am unable to agree with the majority that there has been no violation of Article 6 of the Convention in this case.

The Court is unanimous that the authorities failed to protect the applicants, young children, from inhuman and degrading treatment and its majority observes that the applicants were denied "a determination of their allegations that the local authority failed to protect them from inhuman and degrading treatment and the possibility of obtaining an enforceable award of compensation for the damage suffered thereby" (see paragraph 111 of the judgment).

Despite the severe negligence by the authorities, which allowed the ill-treatment of the applicants to continue for so many years and caused the applicants physical and psychiatric injuries amounting to a violation of Article 3, the applicants could not hold the authorities accountable in domestic court proceedings. By reference to policy factors (for example, difficulties of attributing responsibility between different agencies, sensitivity of decisions, risk of inculcating in local authorities a cautious and defensive approach to exercise of their duties, risk of costly and vexatious litigation) the domestic courts decided that the local authority could not be held liable in negligence in the exercise of their statutory powers to protect children. *De facto*, the local authority was thus declared to be immune for claims because they had acted in the exercise of their statutory powers to protect children.

In my view the applicants' rights under Article 6 were thereby violated as they had no access to a court in order to have a decision on their claims, which were arguable under national law. The facts of this case and the way in which domestic law operated are very similar to those in *Osman v. the United Kingdom* (judgment of 28 October 1998, *Reports of Judgments and Decisions* 1998-VIII) where the applicants' claims for negligence against the police were struck out for policy reasons relating to the perceived interests in preventing the efficiency of the police service being undermined by litigation. In *Osman* the Court found that the application of an exclusionary rule barring liability of the police for negligence in the exercise of their functions of investigating and preventing crime constituted a disproportionate restriction on access to a court for the applicants. The majority's reasons for not following the decisions in *Osman* (see paragraph 100 of the judgment) are not, to my mind, convincing. There seem to have been no striking or significant changes in the law of negligence since that case and all relevant matters concerning the content of domestic law had been brought to the attention of the Court by the parties in *Osman*. I am of the opinion that the conclusion under Article 6 in this case must be the same.

It is true that, as the majority observes in paragraph 95 of the judgment, the applicants were not prevented in any practical manner from bringing their claims before the domestic courts. The case was litigated up to the House of Lords, the applicants being provided with legal aid for that purpose. Nor is it the case that any procedural rules of limitation had been relied on. However, the notion of "access to a court" under Article 6 guarantees not only that the applicants have their claims brought before the courts, but implies also the right to have those claims examined on the basis of the facts before the courts and to have them decided on.

I agree with the majority saying in paragraph 98 that Article 6 does not in itself guarantee any particular content for civil rights and obligations in national law. But where there is an arguable claim under domestic tort law as in this case (see paragraph 89 of the judgment), requiring that the applicants obtain a decision by a court on the liability of those responsible for allowing their ill-treatment to continue for many years, cannot, in my opinion, be said to determine the content of domestic law.

I would observe that the Court's supervision of the activities of national courts in defining "access" or "liability" seems to take place on a wider basis. In *Fayed v. the United Kingdom* (judgment of 21 September 1994, Series A no. 294-B, pp. 49-50, § 65), the Court said:

> "Certainly the Convention enforcement bodies may not create by way of interpretation of Article 6 § 1 a substantive civil right which has no legal basis in the State concerned. However, it would not be consistent with the rule of law in a democratic society or with the basic principle underlying Article 6 § 1 – namely that civil claims must be capable of being submitted to a judge for adjudication – if, for example, a State could, without restraint or control by the Convention enforcement bodies, remove from the jurisdiction of the courts a whole range of civil claims or confer immunities from civil liability on large groups or categories of persons ..."

To reach its conclusion that the decision by the House of Lords did not amount to the granting of an immunity, the Court's majority observes, in paragraph 99, that in cases concerning the liability of local authorities in child-care matters brought after the applicants' case, the domestic courts have held that a duty of care may arise. But this does not change the fact that an immunity was conferred on the authorities in the applicants' case. Apparently the immunity applied in the applicants' case was found no longer appropriate in subsequent cases, the national courts taking into account, amongst other factors, the Court's approach in *Osman*, cited above.

While it has been alleged by the Government that a finding of a violation in this case would undermine the striking-out procedure used to avoid pointless litigation of baseless claims, I consider that this argument has not been substantiated by the material placed before the Court. The domestic courts have continued to strike cases out after the Court's judgment in *Osman*. A finding of a violation in this case would mean only that these applicants' claims, which involved serious ill-treatment contrary to a

fundamental human right, should not have been struck out on the basis of general policy arguments. This Court has found no denial of access to a court where judges have struck out cases where there has been no proximity or foreseeability (see, for example, *Powell v. the United Kingdom* (dec.), no. 45305/99, ECHR 2000-V, and *Bromiley v. the United Kingdom* (dec.), no. 33747/96, 23 November 1999, unreported).

The majority of the Court finds that the applicants were not afforded an effective remedy in respect of the breach of Article 3 and they conclude that Article 13, not Article 6, was violated.

My conclusion would be that the "remedy" to which the applicants were entitled should have been access to a court in order to have their damages settled. Restrictions to access to a court in order to protect the interests of the local authority exercising their powers to protect children may be necessary and justified under Article 6. However, I would say that in this case, where it is agreed that the child applicants were victims of the failure of the system to protect them from serious, long-term neglect and abuse, the immunity conferred on the local authority because of policy reasons cannot be seen as proportionate.

Therefore, I believe that Article 6 was violated.

I voted for a violation of Article 13 because I agree with the majority that the applicants, whose rights under Article 3 of the Convention were violated, had no effective remedy before the national authorities.

UN Convention on the Rights of the Child

In Child Friendly Language

"Rights" are things every child should have or be able to do. All children have the same rights. These rights are listed in the UN Convention on the Rights of the Child. Almost every country has agreed to these rights. All the rights are connected to each other, and all are equally important. Sometimes, we have to think about rights in terms of what is the best for children in a situation, and what is critical to life and protection from harm. As you grow, you have more responsibility to make choices and exercise your rights.

Article 1
Everyone under 18 has these rights.

Article 2
All children have these rights, no matter who they are, where they live, what their parents do, what language they speak, what their religion is, whether they are a boy or girl, what their culture is, whether they have a disability, whether they are rich or poor. No child should be treated unfairly on any basis.

Article 3
All adults should do what is best for you. When adults make decisions, they should think about how their decisions will affect children.

Article 4
The government has a responsibility to make sure your rights are protected. They must help your family to protect your rights and create an environment where you can grow and reach your potential.

Article 5
Your family has the responsibility to help you learn to exercise your rights, and to ensure that your rights are protected.

Article 6
You have the right to be alive.

Article 7
You have the right to a name, and this should be officially recognized by the government. You have the right to a nationality (to belong to a country).

Article 8
You have the right to an identity – an official record of who you are. No one should take this away from you.

Article 9
You have the right to live with your parent(s), unless it is bad for you. You have the right to live with a family who cares for you.

Article 10
If you live in a different country than your parents do, you have the right to be together in the same place.

Article 11
You have the right to be protected from kidnapping.

Article 12
You have the right to give your opinion, and for adults to listen and take it seriously.

Article 13
You have the right to find out things and share what you think with others, by talking, drawing, writing or in any other way unless it harms or offends other people.

Article 14
You have the right to choose your own religion and beliefs. Your parents should help you decide what is right and wrong, and what is best for you.

Article 15
You have the right to choose your own friends and join or set up groups, as long as it isn't harmful to others.

Article 16
You have the right to privacy.

Article 17
You have the right to get information that is important to your well-being, from radio, newspaper, books, computers and other sources. Adults should make sure that the information you are getting is not harmful, and help you find and understand the information you need.

Article 18
You have the right to be raised by your parent(s) if possible.

Article 19
You have the right to be protected from being hurt and mistreated, in body or mind.

Article 20
You have the right to special care and help if you cannot live with your parents.

Article 21
You have the right to care and protection if you are adopted or in foster care.

Article 22
You have the right to special protection and help if you are a refugee (if you have been forced to leave your home and live in another country), as well as all the rights in this Convention.

Article 23
You have the right to special education and care if you have a disability, as well as all the rights in this Convention, so that you can live a full life.

Article 24
You have the right to the best health care possible, safe water to drink, nutritious food, a clean and safe environment, and information to help you stay well.

Article 25
If you live in care or in other situations away from home, you have the right to have these living arrangements looked at regularly to see if they are the most appropriate.

Article 26
You have the right to help from the government if you are poor or in need.

Article 27
You have the right to food, clothing, a safe place to live and to have your basic needs met. You should not be disadvantaged so that you can't do many of the things other kids can do.

Article 28
You have the right to a good quality education. You should be encouraged to go to school to the highest level you can.

Article 29
Your education should help you use and develop your talents and abilities. It should also help you learn to live peacefully, protect the environment and respect other people.

Article 30
You have the right to practice your own culture, language and religion - or any you choose. Minority and indigenous groups need special protection of this right.

Article 31
You have the right to play and rest.

Article 32
You have the right to protection from work that harms you, and is bad for your health and education. If you work, you have the right to be safe and paid fairly.

Article 33
You have the right to protection from harmful drugs and from the drug trade.

Article 34
You have the right to be free from sexual abuse.Article 35No one is allowed to kidnap or sell you.

Article 36
You have the right to protection from any kind of exploitation (being taken advantage of).

Article 37
No one is allowed to punish you in a cruel or harmful way.

Article 38
You have the right to protection and freedom from war. Children under 15 cannot be forced to go into the army or take part in war.

Article 39
You have the right to help if you've been hurt, neglected or badly treated.

Article 40
You have the right to legal help and fair treatment in the justice system that respects your rights.

Article 41
If the laws of your country provide better protection of your rights than the articles in this Convention, those laws should apply.

Article 42
You have the right to know your rights! Adults should know about these rights and help you learn about them, too.

Articles 43 to 54
These articles explain how governments and international organizations like UNICEF will work to ensure children are protected with their rights.

unicef

QUEEN ALEXANDRA FOUNDATION FOR CHILDREN

Canadian Heritage Patrimoine canadien

Convention on the Rights of the Child

Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989

entry into force 2 September 1990, in accordance with article 49

Preamble

The States Parties to the present Convention,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Bearing in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance,

Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

Considering that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity,

Bearing in mind that the need to extend particular care to the child has been stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular in articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in article 10) and in the statutes and relevant instruments of specialized agencies and international organizations concerned with the welfare of children,

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth",

Recalling the provisions of the Declaration on Social and Legal Principles relating to the Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally; the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) ; and the Declaration on the Protection of Women and Children in Emergency and Armed Conflict, Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration,

Taking due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child, Recognizing the importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries,

Have agreed as follows:

PART I

Article 1

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2

1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 4

States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

Article 5

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Article 6

1. States Parties recognize that every child has the inherent right to life. 2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 7

1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and. as far as possible, the right to know and be cared for by his or her parents.

2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

Article 8

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.

2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

Article 9

1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.

2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.

3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests.

4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

Article 10

1. In accordance with the obligation of States Parties under article 9, paragraph 1, applications by a child or his or her parents to enter or leave a State Party for the purpose of family reunification shall be dealt with by States Parties in a positive, humane and expeditious manner. States Parties shall further ensure that the submission of such a request shall entail no adverse consequences for the applicants and for the members of their family.

2. A child whose parents reside in different States shall have the right to maintain on a regular basis, save in exceptional circumstances personal relations and direct contacts with both parents. Towards that end and in accordance with the obligation of States Parties under article 9, paragraph 1, States Parties shall respect the right of the child and his or her parents to leave any country, including their

own, and to enter their own country. The right to leave any country shall be subject only to such restrictions as are prescribed by law and which are necessary to protect the national security, public order (ordre public), public health or morals or the rights and freedoms of others and are consistent with the other rights recognized in the present Convention.

Article 11

1. States Parties shall take measures to combat the illicit transfer and non-return of children abroad.

2. To this end, States Parties shall promote the conclusion of bilateral or multilateral agreements or accession to existing agreements.

Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 13

1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.

2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:

(a) For respect of the rights or reputations of others; or

(b) For the protection of national security or of public order (ordre public), or of public health or morals.

Article 14

1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.

2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

Article 15

1. States Parties recognize the rights of the child to freedom of association and to freedom of peaceful assembly.

2. No restrictions may be placed on the exercise of these rights other than those imposed in conformity with the law and which are necessary in a democratic society in the interests of national security or public safety, public order (ordre public), the protection of public health or morals or the protection of the rights and freedoms of others.

Article 16

1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.

2. The child has the right to the protection of the law against such interference or attacks.

Article 17

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health.

To this end, States Parties shall:

(a) Encourage the mass media to disseminate information and material of social and cultural benefit to the child and in accordance with the spirit of article 29;

(b) Encourage international co-operation in the production, exchange and dissemination of such information and material from a diversity of cultural, national and international sources;

(c) Encourage the production and dissemination of children's books;

(d) Encourage the mass media to have particular regard to the linguistic needs of the child who belongs to a minority group or who is indigenous;

(e) Encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being, bearing in mind the provisions of articles 13 and 18.

Article 18

1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.

2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.

3. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Article 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 20

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

2. States Parties shall in accordance with their national laws ensure alternative care for such a child.

3. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Article 21

States Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall:

(a) Ensure that the adoption of a child is authorized only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary;

(b) Recognize that inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin;

(c) Ensure that the child concerned by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;

(d) Take all appropriate measures to ensure that, in inter-country adoption, the placement does not result in improper financial gain for those involved in it;

(e) Promote, where appropriate, the objectives of the present article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework, to ensure that the placement of the child in another country is carried out by competent authorities or organs.

Article 22

1. States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.

2. For this purpose, States Parties shall provide, as they consider appropriate, co-operation in any efforts by the United Nations and other competent intergovernmental organizations or non-governmental organizations co-operating with the United Nations to protect and assist such a child and to trace the parents or other members of the family of any refugee child in order to obtain information necessary for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his or her family environment for any reason , as set forth in the present Convention.

Article 23

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development

4. States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 25

States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 26

1. States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.

2. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

Article 27

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.

3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.

4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

Article 28

1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:

(a) Make primary education compulsory and available free to all;

(b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;

(c) Make higher education accessible to all on the basis of capacity by every appropriate means;

(d) Make educational and vocational information and guidance available and accessible to all children;

(e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.

3. States Parties shall promote and encourage international cooperation in matters relating to education, in particular with a view to contributing to the elimination of ignorance and illiteracy

throughout the world and facilitating access to scientific and technical knowledge and modern teaching methods. In this regard, particular account shall be taken of the needs of developing countries.

Article 29

1. States Parties agree that the education of the child shall be directed to:

(a) The development of the child's personality, talents and mental and physical abilities to their fullest potential;

(b) The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;

(c) The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own;

(d) The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin;

(e) The development of respect for the natural environment.

2. No part of the present article or article 28 shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principle set forth in paragraph 1 of the present article and to the requirements that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

Article 30

In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.

Article 31

1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.

2. States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.

Article 32

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

2. States Parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, States Parties shall in particular:

(a) Provide for a minimum age or minimum ages for admission to employment;

(b) Provide for appropriate regulation of the hours and conditions of employment;

(c) Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

Article 33

States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

(a) The inducement or coercion of a child to engage in any unlawful sexual activity;

(b) The exploitative use of children in prostitution or other unlawful sexual practices;

(c) The exploitative use of children in pornographic performances and materials.

Article 35

States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

Article 36

States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

Article 37

States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;

(d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 38

1. States Parties undertake to respect and to ensure respect for rules of international humanitarian law applicable to them in armed conflicts which are relevant to the child.

2. States Parties shall take all feasible measures to ensure that persons who have not attained the age of fifteen years do not take a direct part in hostilities.

3. States Parties shall refrain from recruiting any person who has not attained the age of fifteen years into their armed forces. In recruiting among those persons who have attained the age of fifteen years but who have not attained the age of eighteen years, States Parties shall endeavour to give priority to those who are oldest.

4. In accordance with their obligations under international humanitarian law to protect the civilian population in armed conflicts, States Parties shall take all feasible measures to ensure protection and care of children who are affected by an armed conflict.

Article 39

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

Article 40

1. States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.

2. To this end, and having regard to the relevant provisions of international instruments, States Parties shall, in particular, ensure that:

(a) No child shall be alleged as, be accused of, or recognized as having infringed the penal law by reason of acts or omissions that were not prohibited by national or international law at the time they were committed;

(b) Every child alleged as or accused of having infringed the penal law has at least the following guarantees:

(i) To be presumed innocent until proven guilty according to law;

(ii) To be informed promptly and directly of the charges against him or her, and, if appropriate, through his or her parents or legal guardians, and to have legal or other appropriate assistance in the preparation and presentation of his or her defence;

(iii) To have the matter determined without delay by a competent, independent and impartial authority or judicial body in a fair hearing according to law, in the presence of legal or other appropriate assistance and, unless it is considered not to be in the best interest of the child, in particular, taking into account his or her age or situation, his or her parents or legal guardians;

(iv) Not to be compelled to give testimony or to confess guilt; to examine or have examined adverse witnesses and to obtain the participation and examination of witnesses on his or her behalf under conditions of equality;

(v) If considered to have infringed the penal law, to have this decision and any measures imposed in consequence thereof reviewed by a higher competent, independent and impartial authority or judicial body according to law;

(vi) To have the free assistance of an interpreter if the child cannot understand or speak the language used;

(vii) To have his or her privacy fully respected at all stages of the proceedings.

3. States Parties shall seek to promote the establishment of laws, procedures, authorities and institutions specifically applicable to children alleged as, accused of, or recognized as having infringed the penal law, and, in particular:

(a) The establishment of a minimum age below which children shall be presumed not to have the capacity to infringe the penal law;

(b) Whenever appropriate and desirable, measures for dealing with such children without resorting to judicial proceedings, providing that human rights and legal safeguards are fully respected. 4. A variety of dispositions, such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate both to their circumstances and the offence.

Article 41

Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of the child and which may be contained in:

(a) The law of a State party; or

(b) International law in force for that State.

PART II

Article 42

States Parties undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike.

Article 43

1. For the purpose of examining the progress made by States Parties in achieving the realization of the obligations undertaken in the present Convention, there shall be established a Committee on the Rights of the Child, which shall carry out the functions hereinafter provided.

2. The Committee shall consist of ten experts of high moral standing and recognized competence in the field covered by this Convention. The members of the Committee shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution, as well as to the principal legal systems.

3. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.

4. The initial election to the Committee shall be held no later than six months after the date of the entry into force of the present Convention and thereafter every second year. At least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to States Parties inviting them to submit their nominations within two months. The Secretary-General shall subsequently prepare a list in alphabetical order of all persons thus nominated, indicating States Parties which have nominated them, and shall submit it to the States Parties to the present Convention.

5. The elections shall be held at meetings of States Parties convened by the Secretary-General at United Nations Headquarters. At those meetings, for which two thirds of States Parties shall constitute

a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

6. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election if renominated. The term of five of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these five members shall be chosen by lot by the Chairman of the meeting.

7. If a member of the Committee dies or resigns or declares that for any other cause he or she can no longer perform the duties of the Committee, the State Party which nominated the member shall appoint another expert from among its nationals to serve for the remainder of the term, subject to the approval of the Committee.

8. The Committee shall establish its own rules of procedure.

9. The Committee shall elect its officers for a period of two years.

10. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee. The Committee shall normally meet annually. The duration of the meetings of the Committee shall be determined, and reviewed, if necessary, by a meeting of the States Parties to the present Convention, subject to the approval of the General Assembly.

11. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.

12. With the approval of the General Assembly, the members of the Committee established under the present Convention shall receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide.

Article 44

1. States Parties undertake to submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have adopted which give effect to the rights recognized herein and on the progress made on the enjoyment of those rights

(a) Within two years of the entry into force of the Convention for the State Party concerned;

(b) Thereafter every five years.

2. Reports made under the present article shall indicate factors and difficulties, if any, affecting the degree of fulfilment of the obligations under the present Convention. Reports shall also contain sufficient information to provide the Committee with a comprehensive understanding of the implementation of the Convention in the country concerned.

3. A State Party which has submitted a comprehensive initial report to the Committee need not, in its subsequent reports submitted in accordance with paragraph 1 (b) of the present article, repeat basic information previously provided.

4. The Committee may request from States Parties further information relevant to the implementation of the Convention.

5. The Committee shall submit to the General Assembly, through the Economic and Social Council, every two years, reports on its activities.

6. States Parties shall make their reports widely available to the public in their own countries.

Article 45

In order to foster the effective implementation of the Convention and to encourage international co-operation in the field covered by the Convention:

(a) The specialized agencies, the United Nations Children's Fund, and other United Nations organs shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies, the United Nations Children's Fund and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite the specialized agencies, the United Nations Children's Fund, and other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities;

(b) The Committee shall transmit, as it may consider appropriate, to the specialized agencies, the United Nations Children's Fund and other competent bodies, any reports from States Parties that contain a request, or indicate a need, for technical advice or assistance, along with the Committee's observations and suggestions, if any, on these requests or indications;

(c) The Committee may recommend to the General Assembly to request the Secretary-General to undertake on its behalf studies on specific issues relating to the rights of the child;

(d) The Committee may make suggestions and general recommendations based on information received pursuant to articles 44 and 45 of the present Convention. Such suggestions and general recommendations shall be transmitted to any State Party concerned and reported to the General Assembly, together with comments, if any, from States Parties.

PART III

Article 46

The present Convention shall be open for signature by all States.

Article 47

The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

Article 48

The present Convention shall remain open for accession by any State. The instruments of accession shall be deposited with the Secretary-General of the United Nations.

Article 49

1. The present Convention shall enter into force on the thirtieth day following the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.

2. For each State ratifying or acceding to the Convention after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the deposit by such State of its instrument of ratification or accession.

Article 50

1. Any State Party may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate the proposed amendment to States Parties, with a request that they indicate whether they favour a conference of States Parties for the purpose of considering and voting upon the proposals. In the event that, within four months from the date of such communication, at least one third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any

amendment adopted by a majority of States Parties present and voting at the conference shall be submitted to the General Assembly for approval.

2. An amendment adopted in accordance with paragraph 1 of the present article shall enter into force when it has been approved by the General Assembly of the United Nations and accepted by a two-thirds majority of States Parties.

3. When an amendment enters into force, it shall be binding on those States Parties which have accepted it, other States Parties still being bound by the provisions of the present Convention and any earlier amendments which they have accepted.

Article 51

1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.

2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.

3. Reservations may be withdrawn at any time by notification to that effect addressed to the Secretary-General of the United Nations, who shall then inform all States. Such notification shall take effect on the date on which it is received by the Secretary-General

Article 52

A State Party may denounce the present Convention by written notification to the Secretary-General of the United Nations. Denunciation becomes effective one year after the date of receipt of the notification by the Secretary-General.

Article 53

The Secretary-General of the United Nations is designated as the depositary of the present Convention.

Article 54

The original of the present Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations. IN WITNESS THEREOF the undersigned plenipotentiaries, being duly authorized thereto by their respective governments, have signed the present Convention.

carepath

Empowering public authorities and professionals
towards trauma-informed leaving care support

ΤΑ ΔΙΚΑΙΩΜΑΤΑ ΤΩΝ ΠΑΙΔΙΩΝ ΣΥΜΦΩΝΑ ΜΕ ΤΟ ΔΙΚΑΙΟ ΤΗΣ ΔΙΕΘΝΟΥΣ ΚΑΙ ΕΥΡΩΠΑΪΚΗΣ ΕΝΩΣΗΣ

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

02 κεφάλαιο

Στόχοι:

- ✓ Η απόκτηση γνώσης σχετικά με τα θεμελιώδη δικαιώματα και τις που θεσπίζονται από το διεθνές και ευρωπαϊκό νομικό πλαίσιο και αφορούν τα δικαιώματα των παιδιών, στα πλαίσια των οποίων μπορεί να εφαρμοστεί το η τεχνική TIC (Trauma informed Therapy)
- ✓ Η πλήρης κατανόηση των δικαιωμάτων συμμετοχής των παιδιών.

Τι ορίζουμε ως παιδί;

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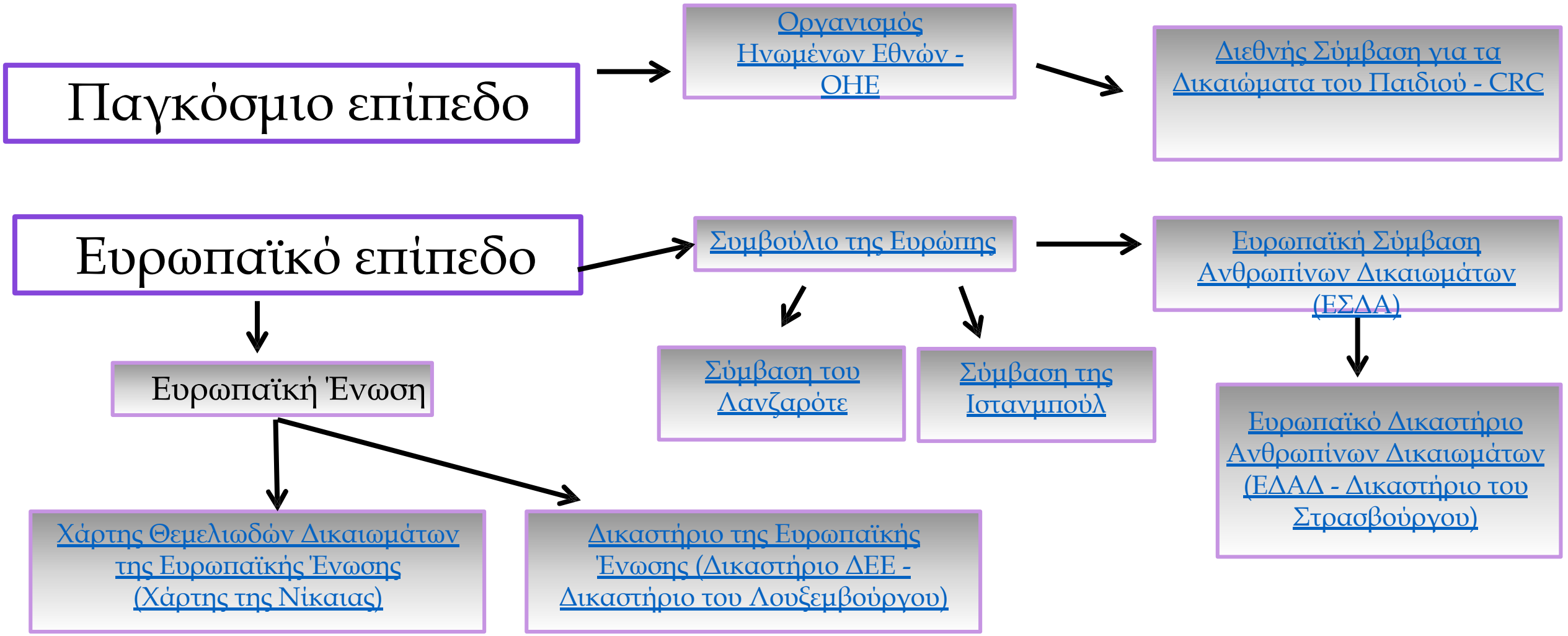
Η Διεθνής Σύμβαση για τα Δικαιώματα του Παιδιού (CRC) ορίζει ότι "παιδί ορίζεται κάθε άνθρωπος ηλικίας κάτω των δεκαοκτώ ετών" (άρθρο 1).

Ομοίως, τα περισσότερα όργανα του Συμβουλίου της Ευρώπης σχετικά με το τι είναι παιδί, υιοθετούν τον ορισμό που έχει ορίσει η CRC.

Εντός της Ευρωπαϊκής Ένωσης δεν υπάρχει περιγραφή της έννοιας του "παιδιού" και ως εκ τούτου ο ορισμός της CRC χρησιμοποιείται ευρέως.

Νομικό Πλαίσιο



ΤΑ ΔΙΚΑΙΩΜΑΤΑ ΚΑΙ ΟΙ ΕΛΕΥΘΕΡΙΕΣ ΤΩΝ ΠΑΙΔΙΩΝ

Όλα τα άτομα, συμπεριλαμβανομένων των παιδιών, απολαμβάνουν ελευθεριών και δικαιωμάτων αναγνωρισμένων από νομικές πράξεις (συμβάσεις, συνθήκες, δηλώσεις) σχετικά με τα ανθρώπινα δικαιώματα, σύμφωνα με τον Χάρτη των Θεμελιωδών Δικαιωμάτων της Ευρωπαϊκής Ένωσης (Χάρτης της Νίκαιας) και την Ευρωπαϊκή Σύμβαση Ανθρωπίνων Δικαιωμάτων (ΕΣΔΑ)

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ΘΕΜΕΛΙΩΔΗ ΔΙΚΑΙΩΜΑΤΑ ΚΑΙ ΕΛΕΥΘΕΡΙΕΣ

ΠΟΛΙΤΙΚΑ ΔΙΚΑΙΩΜΑΤΑ

ΟΙΚΟΝΟΜΙΚΑ, ΚΟΙΝΩΝΙΚΑ ΚΑΙ ΠΟΛΙΤΙΣΤΙΚΑ ΔΙΚΑΙΩΜΑΤΑ

ΕΛΕΥΘΕΡΙΕΣ ΚΑΙ ΘΕΜΕΛΙΩΔΗ ΠΟΛΙΤΙΚΑ ΔΙΚΑΙΩΜΑΤΑ

- Ονομάζονται δικαιώματα "πρώτης γενιάς" και θεωρούνται θεμελιώδη καθώς η παραβίαση τους βλάπτει εις βάθος την ζωή του ανθρώπου.
- Απαιτούν από τα κράτη να μην παρεμβαίνουν στην ιδιωτική σφαίρα του ατόμου και να συμμετέχουν ενεργά σε μια δραστηριότητα ώστε να εξασφαλίζεται η πραγματική απόλαυση ενός θεμελιώδους δικαιώματος

Για παράδειγμα, το δικαίωμα σεβασμού της οικογενειακής ζωής (άρθρο 8 ΕΣΔΑ) ζητά από τα κράτη να μην χωρίζουν τα παιδιά από τους γονείς τους, εκτός εάν αυτό είναι απολύτως απαραίτητο για την προστασία των ίδιων των παιδιών, αλλά και να λαμβάνουν μέτρα για την προώθηση της ανάπτυξης σχέσεων μεταξύ των γονέων και των παιδιών στηρίζοντας έτσι τον γονέα που δεν έχει την επιμέλεια ώστε να έχει πρόσβαση στο παιδί του και να ξεπερνά την αδικαιολόγητη αντίθεση του άλλου γονέα

Δικαίωμα σεβασμού για οικογενειακή ζωή

Ο καθένας έχει το δικαίωμα να απολαμβάνει την

"οικογενειακή ζωή" όπως βιώνεται στην πράξη

(για παράδειγμα, το παιδί έχει το δικαίωμα να μεγαλώσει στην οικογένεια και να διατηρήσει επαφή και με τους δύο γονείς σε περίπτωση χωρισμού).

Άρθρα αναφοράς:

- Άρθρο 7 (δικαίωμα σεβασμού για οικογενειακή ζωή) Χάρτης της Νίκαις
- Άρθρο 8 (δικαίωμα σεβασμού για οικογενειακή ζωή) ECHR
- Άρθρα 8 και 9 CRC

Το δικαίωμα του σεβασμού της ιδιωτικής ζωής

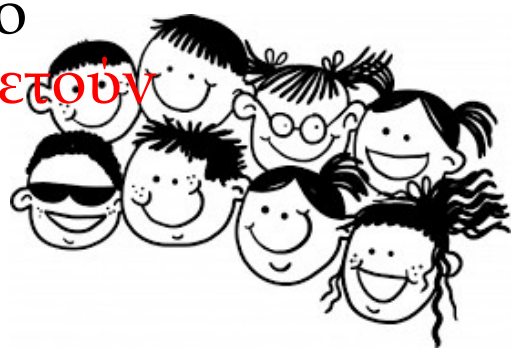
Η έννοια της "ιδιωτικής ζωής" αναπτύχθηκε από την νομολογία του Διαστηρίου του Στρασβούργου , είναι ευρεία και περιλαμβάνει πολλές πτυχές της ατομικής ταυτότητας (για παράδειγμα, τη σωματική και ηθική ακεραιότητα ενός ατόμου, το όνομα, την εικόνα, την ιδιωτικότητα και την προστασία των προσωπικών δεδομένων).

Άρθρα αναφοράς

- Άρθρο 7 (δικαίωμα του σεβασμού της ιδιωτικής ζωής) Charter of Nice
- Άρθρο 8 (δικαίωμα του σεβασμού της ιδιωτικής ζωής) ECHR
- Άρθρο 16 CRC

Κατάργηση των διακρίσεων

Διαφορετικές συμπεριφορές που βασίζονται στο φύλο, τη φυλή, το χρώμα του δέρματος, την εθνική ή κοινωνική προέλευση, τα γενετικά χαρακτηριστικά, τη γλώσσα, τις πεποιθήσεις ή τη θρησκεία, τις πολιτικές ή άλλες απόψεις ανθρώπων που ανήκουν σε άλλη εθνική μειονότητα, που αφορούν την οικονομική κατάσταση, την γέννηση, την αναπηρία, τηνηλικία ή τον γενετήσιο προσανατολισμό απαγορεύονται και θεωρούνται **διάκριση**, εκτός κι εάν εξυπηρετούν νόμιμο σκοπό



Άρθρα αναφοράς:

- Άρθρο 7 (δικαίωμα σεβασμού της ιδιωτικής ζωής), Άρθρο 20 (ισότητα ενώπιον του νόμου) και Άρθρο 21 (κατά των διακρίσεων) Χάρτης της Νίκαιας
- Άρθρο 14 ECHR; Άρθρο 1 του Πρωτοκόλλου No. 12 of the ECHR (κατά των διακρίσεων)
- Άρθρο E (Κατά των διακρίσεων) Ευρωπαϊκός Κοινωνικός Χάρτης (ESC)
- Άρθρο 8 (δικαίωμα σεβασμού της ιδιωτικής ζωής) ECHR
- Άρθρο 2 CRC

Αρχή του βέλτιστου συμφέροντος του παιδιού

Τα παιδιά και οι νέοι έχουν το δικαίωμα, ως ανήλικοι, να επωφελούνται από ειδική προστασία και, επομένως, να επωφελούνται από διαφοροποιημένη θεραπεία βάσει της ηλικίας

Άρθρο αναφοράς:

Άρθρο 3 Επιτροπή για τα δικαιώματα του παιδιού (CRC)

ΠΑΡΑΔΕΙΓΜΑ 1

Ο δικαστής, από τον οποίο ζητήθηκε να αποφασίσει σχετικά με την επιμέλεια των παιδιών μετά τον χωρισμό/το διαζύγιο των γονέων πρέπει να αποφασίσει μόνο με βάση το τι είναι καλύτερο για το παιδί και όχι για τους γονείς

Ελευθερία έκφρασης

Ο καθένας έχει δικαίωμα στην ελευθερία της έκφρασης. Το δικαίωμα αυτό περιλαμβάνει την ελευθερία έκφρασης απόψεων και την αποδοχή και παροχή πληροφοριών και ιδεών χωρίς την παρέμβαση της δημόσιας αρχής και ανεξαρτήτως συνόρων.

(Άρθρο 10, παράγραφος 1 ECHR)

<u>Άρθρα αναφοράς:</u>

- Άρθρο 11 και Άρθρο 24 παράγραφος 1 Χάρτη της Νίκαιας
- Άρθρο 10 ECHR
- Άρθρο 12, παράγραφος 1 CRC

Το δικαίωμα του παιδιού να ακούγεται

«Παρέχεται στο παιδί η δυνατότητα ακρόασης σε οποιαδήποτε δικαστική και διοικητική διαδικασία που το αφορά, είτε άμεσα είτε μέσω αντιπροσώπου ή κατάλληλου φορέα, κατά τρόπο σύμφωνο με τους διαδικαστικούς κανόνες του εθνικού δικαίου». (Άρθρο 12 CRC)

Για περισσότερες πληροφορίες σχετικά με το δικαίωμα του παιδιού να ακουστεί, ανατρέξτε στο Unit_2_3_video_Prof._Long

Άρθρα αναφοράς:

- Άρθρο 12 Επιτροπή για τα δικαιώματα του παιδιού (CRC)
- Άρθρα 3 και 6 Ευρωπαϊκή Σύμβαση για τη άσκηση των δικαιωμάτων των παιδιών

Το δικαίωμα του παιδιού να προστατεύεται από τη βία και την εκμετάλλευση

«Τα κράτη-μέρη θα λάβουν όλα τα κατάλληλα νομοθετικά, διοικητικά, κοινωνικά και εκπαιδευτικά μέτρα για την προστασία του παιδιού από κάθε μορφή σωματικής ή ψυχικής βίας, τραυματισμού ή κακοποίησης, εγκατάλειψης ή παραμέλησης, κακομεταχείρισης ή εκμετάλλευσης, συμπεριλαμβανομένης της σεξουαλικής κακοποίησης» (Άρθρο 19, παρ. 1, Διεθνής Σύμβαση για τα Δικαιώματα του Παιδιού - CRC)

Υπόθεση Ζ και Άλλοι εναντίον του Ηνωμένου Βασιλείου

Άρθρα αναφοράς:

- • Άρθρα 2 (δικαίωμα στη ζωή), 3 (απάνθρωπη ή ταπεινωτική μεταχείριση) και 8 (σωματική ακεραιότητα) ΕΣΔΑ, Πρωτόκολλο αριθ. 1 της ΕΣΔΑ, άρθρο 2 (δικαίωμα στην εκπαίδευση)
- • Άρθρα 7 (δικαίωμα ειδικής προστασίας από φυσικούς και ηθικούς κινδύνους) και 17 (δικαίωμα προστασίας) Ευρωπαϊκός Κοινωνικός Χάρτης (ESC)
- • Σύμβαση για την προστασία των παιδιών από σεξουαλική εκμετάλλευση και κακοποίηση (Σύμβαση Λανζαρότε)
- • Σύμβαση για την πρόληψη και την καταπολέμηση της βίας κατά των γυναικών και της ενδοοικογενειακής βίας (Σύμβαση Κωνσταντινούπολης)
- • Οδηγία για την καταπολέμηση της σεξουαλικής κακοποίησης και της σεξουαλικής εκμετάλλευσης παιδιών και της παιδικής πορνογραφίας (2011/93/ΕΕ)

Παράδειγμα 2: Μάρτυρας βίαιου γενονότος

Η βία δεν προκαλεί μόνο ζημιά όταν εκτελείται, αλλά και όταν τα παιδιά γίνονται μάρτυρες βίαιων επεισοδίων.

Με το να βλέπουν, να ακούν, να βιώνουν αγωνία, να γίνονται μάρτυρες συναισθηματικού βάρους, να επηρεάζονται και να συγκλονίζονται χωρίς να μπορούν να κάνουν τίποτα. Σημαίνει την έκθεση ενός παιδιού σε οποιαδήποτε μορφή κακομεταχείρισης που πραγματοποιείται μέσω πράξεων σωματικής, λεκτικής, ψυχολογικής, σεξουαλικής και οικονομικής βίας, σε πρόσωπα αναφοράς ή σε άλλα σημαντικά πρόσωπα από συναισθηματικής πλευράς στο οικιακό και το οικογενειακό περιβάλλον. Όλα αυτά μαρτυρούν βία.
Είναι ένα φαινόμενο που δεν έχει βγει ακόμη στην επιφάνεια, είναι σχεδόν «αόρατο», το οποίο χαρακτηρίζεται από πολλαπλά σημάδια, τα αποτελέσματα των οποίων μπορεί να είναι καταστροφικά για τη σωματική, γνωστική και συμπεριφορική ανάπτυξη των παιδιών
(Save the Children https://www.savethechildren.it/campagne/abbattiamo-il-muro-del-silenzio)

Τα παιδιά που γίνονται μάρτυρες μιας βίαιης πράξης υποφέρουν από αυτή
https://www.youtube.com/watch?v=aNbVwD86JqU

Άρθρα αναφοράς:
Άρθρο 19 CRC
Άρθρο 17 European Social Charter (ESC)

Η ιστορία ενός παιδιού μάρτυρα
https://www.youtube.com/watch?v=hYX8cRkiklE

ΠΑΡΑΔΕΙΓΜΑ 3: Σωματική τιμωρία

Ως σωματικές τιμωρίες θεωρούνται:

- • κάθε τιμωρία για την οποία χρησιμοποιείται σωματική δύναμη ώστε να προκαλέσει έναν ορισμένο βαθμό πόνου ή συμφοράς, ανεξάρτητα από το πόσο μικρή είναι
- • εξίσου σκληρές και υποτιμητικές μορφές μη σωματικής τιμωρίας, για παράδειγμα, τιμωρίες που αποσκοπούν να δυσφημήσουν το παιδί, να το ταπεινώσουν, να το μειώσουν, να το καταστήσουν μισητό, να το καταστήσουν αποδιοπομπαίο τράγο, να το απειλήσουν, να το τρομοκρατήσουν ή να το κοροϊδέψουν (UN Committee on the Rights of the Child, General Comment n. 8 of 2006)

Εναντιωθείτε στο χαστούκισμα

https://www.youtube.com/watch?v=FB6_Og-x6Cw

Άρθρα αναφοράς:

Άρθρο 3 ΕΣΔΑ

Άρθρα 19, 28, παρ. 2 και 37 CRC

Παράδειγμα 4 : Σεξουαλική κακοποίηση

Θεωρείται «σεξουαλική κακοποίηση» η συμμετοχή σε σεξουαλικές δραστηριότητες με ένα παιδί όπου:

- • γίνεται χρήση εξαναγκασμού, βίας ή απειλών, ή γίνεται κατάχρηση μιας αναγνωρισμένης θέσης εμπιστοσύνης, εξουσίας ή επιρροής πάνω στο παιδί, ακόμη
- και εντός της οικογένειας,
  • γίνεται κατάχρηση μιας ιδιαίτερα ευάλωτης κατάστασης του παιδιού, κυρίως λόγω ψυχικής ή σωματικής αναπηρίας ή κατάστασης εξάρτησης.

(Άρθρο 18, παράγραφος 1, Σύμβαση του Συμβουλίου της Ευρώπης για την προστασία των παιδιών από τη σεξουαλική εκμετάλλευση και τη σεξουαλική κακοποίηση - Σύμβαση Λανζαρότε)

Δεν μπορείς να πατήσεις εδω!
https://www.youtube.com/watch?v=ZNmu7plH5c8

Άρθρα αναφοράς:

- Άρθρα 32 και 34 CRC
- Σύμβαση του Λανζαρότε

ΟΙΚΟΝΟΜΙΚΑ, ΚΟΙΝΩΝΙΚΑ ΚΑΙ ΠΟΛΙΤΙΣΤΙΚΑ ΔΙΚΑΙΩΜΑΤΑ

Αντιπροσωπεύουν τα λεγόμενα δικαιώματα "δεύτερης γενιάς" που κάθε κράτος καλείται να διασφαλίσει προκειμένου να ξεπεράσει τις κοινωνικές ανισότητες, τις οικονομικές ανισορροπίες, τα μειονεκτήματα που προκαλούνται από τη φύση, την ηλικία κλπ

Η συγκεκριμένη ανάπτυξη και διασφάλιση τους γίνεται (δυστυχώς!) σταδιακά και ακολουθώντας τα οικονομικο-διαρθρωτικά προβλήματα που αντιμετωπίζει κάθε κράτος.

Δικαίωμα στην υγεία

"Η υγεία είναι μια κατάσταση πλήρους σωματικής, πνευματικής και κοινωνικής ευημερίας και όχι απλώς η απουσία ασθένειας ή αναπηρίας"

(Παγκόσμια Οργάνωση Υγείας (WHO), 1948)

Άρθρα αναφοράς:

- Άρθρο 35 (πρόσβαση στην υγειονομική περίλθαψη) Charter of Nice
- Άρθρο 25 Οικουμενική Διακύρηξη των Ανθρωπίνων Δικαιωμάτων
- Άρθρο 24, 25 and 26 CRC
- Άρθρο 2 (δικαίωμα στη ζωή) and άρθρο 3 (διακίωμα στη σωματική ακεραιότητα) ECHR
- Άρθρο 11 (Δικαίωμα στην προστασία της υγείας) and 13 (δικαίωμα κοινωνικής και ιατρικής βοήθειας) Ευρωπαϊκός Κοινωνικός Χάρτης (CSE)
- Άρθρο 6 Ευρωπαϊκή Σύμβαση για την Προστασία των Ανθρωπίνων Δικαιωμάτων και την Αξιοπρέπεια του Ανθρώπου όσον αφορά τις Εφαρμογές της Βιολογίας και της Ιατρικής, αποκαλούμενη ως "Σύμβαση του Οβιέδο"

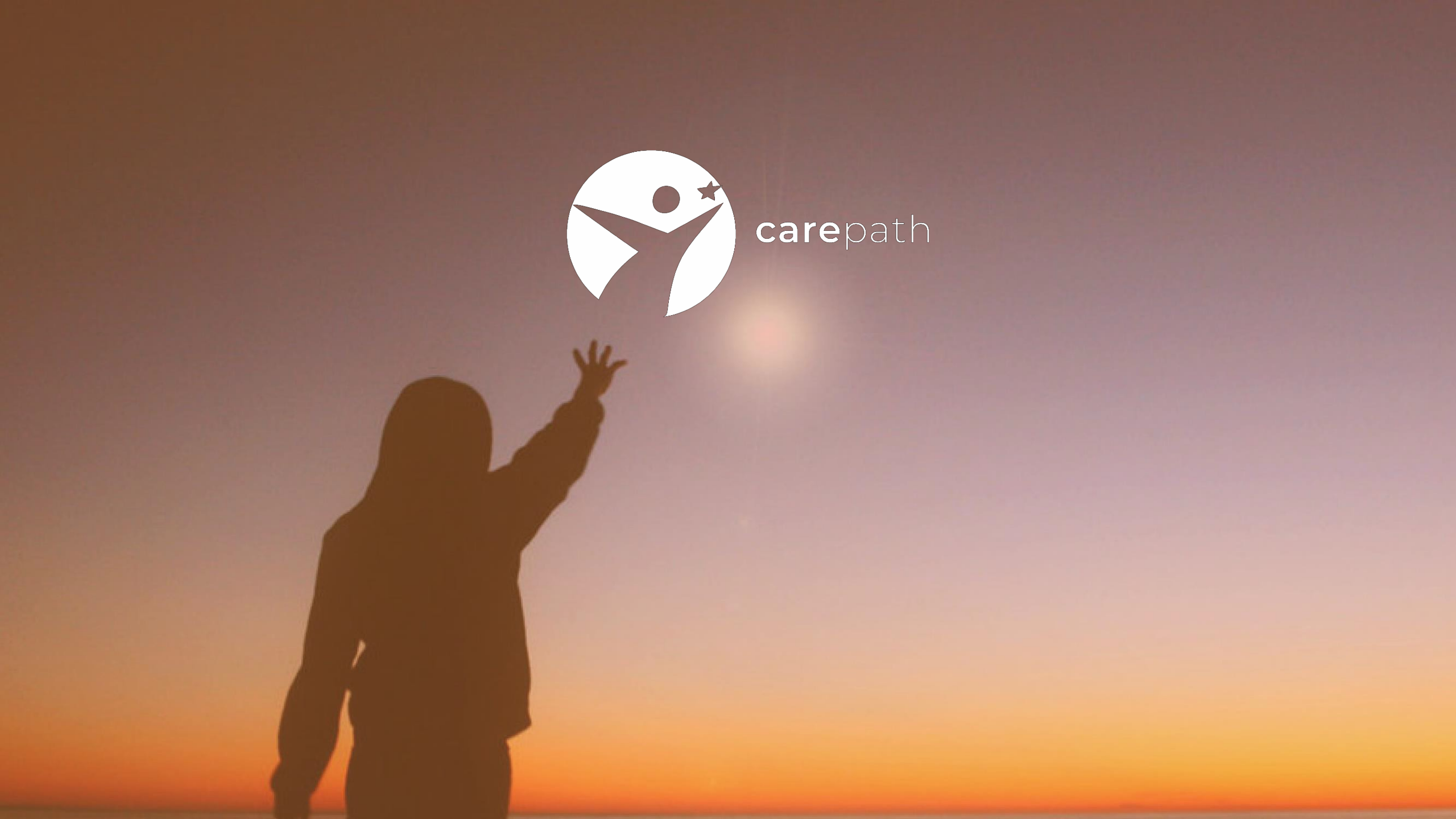
Δικαίωμα στην εκπαίδευση

"Όλοι έχουν δικαίωμα στην εκπαίδευση. Η εκπαίδευση θα πρέπει να είναι ελεύθερη τουλάχιστον στη στοιχειώδη και θεμελιώδη της βαθμίδα. Η στοιχειώδης εκπαίδευση θα πρέπει να είναι υποχρεωτική. Η τεχνική και επαγγελματική εκπαίδευση καθίσταται διαθέσιμη στην ανώτερη εκπαίδευση και θα πρέπει να είναι εξίσου προσβάσιμη σε όλους, υπό ίσους όρους, ανάλογα με τις ικανότητες τους."

(Άρθρο 26 , Οικουμενική Διακύρηξη για τα Ανθρώπινα Δικαιώματα)

Το δικαίωμα στην εκπαίδευση δεν αναφέρεται στην εκμάθηση βασικών σχολικών θεμάτων αλλά θα πρέπει να εκλαμβάνεται με μια ευρύτερη έννοια. Η εκπαίδευση πρέπει να επιδιώκει την ανάπτυξη της προσωπικότητας του παιδιού, καθώς και των ψυχικών και σωματικών του ιδιοτήτων και στάσεων. (Άρθρο 29 CRC)

<u>Άρθρα αναφοράς:</u>
Άρθρο 14 Charter of Nice
Άρθρο 28 and 29 CRC
Άρθρο 17 ECHR
Άρθρο 2 του Πρωτοκόλλου No. 1 ECHR


carepath

HANDBOOK

Handbook on European law relating to the rights of the child

FRA
EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

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CONSEIL DE L'EUROPE

Handbook on European law relating to the rights of the child

Foreword

This handbook on European law relating to the rights of the child is jointly prepared by the European Union Agency for Fundamental Rights (FRA) and the Council of Europe together with the Registry of the European Court of Human Rights. It is the fourth in a series of handbooks on European law jointly prepared by our organisations. Previous handbooks were dedicated to European law relating to non-discrimination law, asylum, borders and immigration, and data protection.

We embarked on this new joint project in the context of the celebrations of the 25th anniversary of the United Nations Convention on the Rights of the Child – which all European states have ratified – to shed light on the role of European legal standards in securing the enjoyment by children of their universal rights.

Children are full-fledged holders of rights. This handbook thus aims to raise awareness and improve the knowledge of the legal standards that protect and promote these rights in Europe. The Treaty on European Union (TEU) sets forth the Union's obligation to promote the protection of the rights of the child. The Charter of Fundamental Rights of the European Union (EU), EU regulations and directives, as well as the jurisprudence of the Court of Justice of the EU (CJEU), have contributed to further determining the protection of the rights of children. In the Council of Europe, a large number of conventions focus on specific aspects of the protection of the rights of the child, ranging from their rights and safety in cyberspace to the adoption of children. These conventions contribute to enriching the protection granted to children under the European Convention on Human Rights and the European Social Charter, including the jurisprudence of the European Court of Human Rights (ECtHR) and the decisions of the European Committee of Social Rights (ECSR).

This handbook is designed for non-specialist legal professionals, judges, public prosecutors, child protection authorities, and other practitioners and organisations responsible for ensuring the legal protection of the rights of the child.

We would like to thank Prof. Ton Liefaard, LL.M. Simona Florescu, JD. Margaret Fine, Prof. Karl Hanson, Prof. Ursula Kilkelly, Dr. Roberta Ruggiero, Prof. Helen Stalford and Prof. Wouter Vandenhole for their contribution in drafting this handbook. We would also like to thank all those who provided input and support throughout its preparation.

Snežana Samardžić-Marković

Director General of Democracy
Council of Europe

Michael O'Flaherty

Director of the European Union
Agency for Fundamental Rights

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Acronyms

CJEU	Court of Justice of the European Union (prior to December 2009, European Court of Justice, ECJ)
CoE	Council of Europe
CPT	European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment
CRC	United Nations Convention on the Rights of the Child
CRD	Consumer Rights Directive
CRPD	United Nations Convention on the Rights of Persons with Disabilities
ECHR	Convention for the Protection of Human Rights and Fundamental Freedoms (commonly known as European Convention on Human Rights, ECHR)
ECOSOC	United Nations Economic and Social Council
ECtHR	European Court of Human Rights
ECPT	European Convention for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment
ECSR	European Committee of Social Rights
EEA	European Economic Area
EEC	European Economic Community
ESC	European Social Charter
EU	European Union
FCNM	Council of Europe Framework Convention for the Protection of National Minorities
FRA	European Union Agency for Fundamental Rights
GC	Grand Chamber (of the European Court of Human Rights)
GPSD	Directive on General Product Safety
GRETA	Group of Experts on Action against Trafficking in Human Beings
ICCPR	United Nations International Covenant on Civil and Political Rights

ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
PACE	Parliamentary Assembly of the Council of Europe
TCN	Third-country nationals
TEU	Treaty on European Union
TFEU	Treaty on the Functioning of the European Union
TSD	Directive on the safety of toys
UCPD	Directive concerning unfair business-to-consumer commercial practices in the internal market
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees

How to use this handbook

This handbook provides an overview of the fundamental rights of children in the European Union (EU) and the Council of Europe (CoE) member states. It is broad in scope. It acknowledges children as beneficiaries of all human/fundamental rights, as well as subjects of special regulation given their specific characteristics. Children's rights is a cross-sectorial field of law. In this handbook the emphasis is on the areas of law which are of specific importance to children.

This handbook is designed to assist legal practitioners who are not specialised in the field of children's rights. It is intended for lawyers, judges, prosecutors, social workers and others working with national authorities, as well as non-governmental organisations (NGOs) and other bodies that may be confronted with legal questions relating to these subjects. It is a point of reference on both EU and CoE law related to these subject areas, explaining how each issue is regulated under EU law as well as under the European Convention on Human Rights (ECHR), the European Social Charter (ESC) and other instruments of the CoE. Each chapter first includes a single table of applicable law under the two separate European legal systems. Then the law under each system is presented consecutively in relation to each topic covered. This allows the reader to see where the two legal systems converge and where they differ. Where relevant, there are also references to the United Nations (UN) Convention on the Rights of the Child (CRC) and other international instruments.

Practitioners in non-EU states that are member states of the CoE and thereby parties to the ECHR can access the information relevant to their own country by going straight to the CoE sections. Practitioners in EU Member States will need to use both sections as those states are bound by both legal orders. For readers who need more information on a particular issue, a list of references to more specialised material can be found in the 'Further reading' section of the handbook.

ECHR law is presented through short references to selected European Court of Human Rights (ECtHR) cases related to the handbook topic covered. These have been chosen from existing ECtHR judgments and decisions on children's rights issues.

EU law is found in legislative measures that have been adopted, in relevant provisions of the Treaties and in particular in the Charter of Fundamental Rights

of the European Union, as interpreted in the case law of the Court of Justice of the European Union (CJEU – known before December 2009 as the European Court of Justice (ECJ)).

The case law described or cited in this handbook provides examples of an important body of both ECtHR and CJEU case law. The handbook includes, as far as possible given its limited scope and introductory nature, legal developments until 1 January 2015, although later developments have also been included when possible.

The handbook includes an introductory chapter, which briefly explains the role of the two legal systems as established by CoE and EU law, and contains 10 substantive chapters covering the following issues:

- civil rights and freedoms;
- equality;
- personal identity issues;
- family life;
- alternative care and adoption;
- child protection against violence and exploitation;
- economic, social and cultural rights;
- migration and asylum;
- consumer and data protection;
- children's rights within criminal justice and alternative proceedings.

Each chapter covers a distinct subject while cross-references to other topics and chapters provide a fuller understanding of the applicable legal framework. Key points are presented at the beginning of each section.

1 Introduction to European children's rights law: context and key principles

EU	Issues covered	CoE
Free Movement Directive (2004/38/EC), Article 2 (2) (c)	'Child' as a holder of rights	Convention on Action against Trafficking in Human Beings, Article 4 (d) Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention), Article 3 (a) ECtHR, *Marckx v. Belgium*, No. 6833/74, 1979 (the applicant child was six years old when the Court delivered judgment)
Young Workers Directive (94/33/EC), Article 3	Protection of young people at work	ESC (revised), Article 7 (right of children and young persons to protection)
Charter of Fundamental Rights, Article 14 (2) (right to education)	Right to receive free compulsory education	
Charter of Fundamental Rights, Article 21 (non-discrimination)	Prohibition of discrimination on grounds of age	
Charter of Fundamental Rights, Article 32 (prohibition of child labour and protection of young people at work) Directive on combating the sexual abuse and sexual exploitation of children and child pornography (2011/93/EU) Anti-Trafficking Directive (2011/36/EU)	Prohibition of exploitative child labour	ESC (revised), Article 7 (right of children and young persons to protection)

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 24 (rights of the child) Treaty on European Union, Article 3 (3)	Protection of children's rights (general)	
Charter of Fundamental Rights, Article 7 (respect for private and family life)	Right to respect for private and family life	ECHR, Article 8 (right to respect for private and family life) Convention on the Legal Status of Children born out of Wedlock Convention on the Adoption of Children (revised) Convention on Contact Concerning Children Convention on the Exercise of Children's Rights ECtHR, *Maslov v. Austria* [GC], No. 1638/03, 2008 (deportation of the applicant, convicted of criminal offences as a child)
CJEU, C-413/99, *Baumbast and R v. Secretary of State for the Home Department*, 2002 CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 2004 CJEU, C-148/02, *Carlos Garcia Avello v. Belgian State*, 2003 CJEU, C-310/08, *London Borough of Harrow v. Nimco Hassan Ibrahim and Secretary of State for the Home Department*, 2010 CJEU, C-480/08, *Maria Teixeira v. London Borough of Lambeth and Secretary of State for the Home Department*, 2010	Freedom of movement	

This introductory chapter explains how children's rights law has developed at the European level, which key principles guide its application, and which key aspects of children's rights European law addresses. It sets the background for the subject-specific analysis of the following chapters.

1.1. Core concepts

Key point

- European children's rights law builds on existing measures at the national and international level.

1.1.1. Scope of European children's rights law

In referring to 'European children's rights law', the focus is on primary sources of law (treaties, conventions, secondary legislation and case law) introduced by the Council of Europe (CoE) and the European Union (EU). Where relevant, reference is made to other European sources that influence the development of European children's rights law, including key policy documents, guidelines or other non-binding/soft-law instruments.

Children are holders of rights, rather than just objects of protection. They are beneficiaries of all human/fundamental rights and subjects of special regulations, given their specific characteristics. Much European case law derives from litigation initiated by parents or other legal representatives of children, given the limited legal capacity of children. While this handbook aims to illustrate how the law accommodates the specific interests and needs of children, it also illustrates the importance of parents/guardians or other legal representatives and makes reference, where appropriate, to where rights and responsibilities are most prominently vested in children's carers. In such instances, the United Nations (UN) Convention on the Rights of the Child (CRC)[1] approach is adopted, namely that parental responsibilities need to be exercised with the best interests of the child as their primary concern and in a manner consistent with the evolving capacities of the child.

1.1.2. 'Child' as a holder of rights

Under international law, the CRC establishes in its Article 1 that "a child means every human being below the age of eighteen years". This is the legal parameter currently used, also in Europe, to define what a child is.

1 UN, General Assembly (1989), Convention on the Rights of the Child, 20 November 1989.

Under EU law, there is no single, formal definition of 'child' set out in any of the treaties, their subordinate legislation or case law. The definition of a child can vary considerably under EU law, depending on the regulatory context. For example, EU law governing the free movement rights of EU citizens and their family members defines 'children' as "direct descendants who are under the age of 21 or are dependent",[2] essentially endorsing a biological and economic notion as opposed to one based on minority.

Some EU laws ascribe different rights to children according to their age. Directive 94/33/EC on the protection of young people at work (Young Workers Directive),[3] for example, which regulates children's access to and conditions of formal employment across the EU Member States, distinguishes between 'young people' (a blanket term for all persons under the age of 18 years), 'adolescents' (any young person of at least 15 years of age, but less than 18 years of age – who is no longer subject to compulsory full-time schooling) and 'children' (defined as those under the age of 15 – who are largely prohibited from undertaking formal employment).

Other areas of EU law, particularly those areas in which EU action complements that of Member States (such as social security, immigration and education), defer to national law to determine who is a child. In these contexts the CRC definition is generally adopted.

Under CoE law, most instruments relating to children adopt the CRC definition of a child. Examples include Article 4 (d) of the Council of Europe Convention on Action against Trafficking in Human Beings[4] or Article 3 (a) of the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention).[5]

2 Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States amending Regulation (EEC) No. 1612/68 and repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC and 93/96/EEC, OJ L 158, 30 April 2004 and OJ L 158, 29 April 2004, Art. 2 (2) (c).

3 Directive 94/33/EC of 20 August 1994 on the protection of young people at work, OJ 1994 L 216, Art. 3.

4 Council of Europe, Convention on Action against Trafficking in Human Beings, CETS No. 197, 15 May 2005.

5 Council of Europe, Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, CETS No. 201, 25 October 2007.

The European Convention on Human Rights (ECHR) does not contain a definition of a child, but its Article 1 obliges states to secure Convention rights to "everyone" within their jurisdiction. Article 14 of the ECHR guarantees the enjoyment of the rights set out in the Convention "without discrimination on any ground", including grounds of age.[6] The European Court of Human Rights (ECtHR) has accepted applications by and on behalf of children irrespective of their age.[7] In its jurisprudence, it has accepted the CRC definition of a child,[8] endorsing the "below the age of 18 years" notion.

The same applies to the European Social Charter (ESC) and its interpretation by the European Committee of Social Rights (ECSR).[9]

1.2. Background to European children's rights law

The majority of European children's rights law to date has been developed by the EU and the CoE. In addition to the UN, other international institutions, such as the Hague Conference on Private International Law, have also adopted important instruments that continue to inform the development of European law. Although these international frameworks have operated separately from one another, links are increasingly being drawn between them.[10] Inter-institutional cooperation is particularly strong between the CoE and the EU.

6 ECtHR, *Schwizgebel v. Switzerland*, No. 25762/07, 10 June 2010. See also FRA and ECtHR (2010), p. 102.

7 See, for example, ECtHR, *Marckx v. Belgium*, No. 6833/74, 13 June 1979, where the applicant child was six years old when the Court delivered the judgment.

8 ECtHR, *Güveç v. Turkey*, No. 70337/01, 20 January 2009; ECtHR, *Çoşelav v. Turkey*, No. 1413/07, 9 October 2012.

9 ECSR, *Defence for Children International (DCI) v. the Netherlands*, No. 47/2008, 20 October 2009, para. 25.

10 See, for instance, Chapter 5, which illustrates how EU family law regulating cross-border child abduction works with the Convention of 25 October 1980 on the Civil Aspects of International Child Abduction (Hague Child Abduction Convention).

1.2.1. European Union: development of children's rights law and the areas of protection covered

In the past, children's rights developed in the EU in a piecemeal fashion. Historically, European child law was largely aimed at addressing specific child-related aspects of broader economic and politically driven initiatives, for example in the field of consumer protection[11] and the free movement of persons.[12] More recently, however, children's rights have been addressed as part of a more coordinated EU agenda, based on three key milestones:

- the introduction of the Charter of Fundamental Rights of the European Union;
- the entry into force of the Treaty of Lisbon in December 2009;
- the adoption of the European Commission Communication on a special place for children in EU external action, and of the Council EU Guidelines for the promotion and protection of the rights of the child.

The first milestone was the introduction of the EU Charter of Fundamental Rights in 2000.[13] With the entry into force of the Treaty of Lisbon, on 1 December 2009, the Charter enjoys the same legal status as the EU treaties (Article 6 of the Treaty on European Union (TEU)). It obliges the EU and its Member States to protect the rights enshrined in it when implementing EU law. The EU Charter of Fundamental Rights contains the first detailed references to children's rights at the EU constitutional level, including through the recognition of children's right to receive free compulsory education (Article 14 (2)), a prohibition of discrimination on grounds of age (Article 21), and a prohibition of exploitative child labour (Article 32). Significantly, the Charter contains a dedicated provision on children's rights (Article 24). This articulates three key children's rights principles: the right to express their views freely in accordance with their age and maturity (Article 24 (1)); the right to have their best interests taken as

11 For example, Directive 2009/48/EC of the European Parliament and of the Council of 18 June 2009 on the safety of toys, OJ 2009 L 170, which enforces safety measures for children's toys.

12 For example, Directive 2004/38/EC.

13 EU (2012), Charter of Fundamental Rights of the European Union, OJ 2012 C 326.

a primary consideration in all actions relating to them (Article 24 (2)); and the right to maintain on a regular basis a personal relationship and direct contact with both parents (Article 24 (3)).

The second key milestone was the Lisbon Treaty, which, as noted above, entered into force on 1 December 2009.[14] This instrument made important institutional, procedural and constitutional changes to the EU by amending the TEU and the former European Community Treaty (now the Treaty on the Functioning of the European Union (TFEU)).[15] These changes enhanced the EU's potential to advance children's rights, not least by identifying the "protection of the rights of the child" as a general stated objective of the EU (Article 3 (3) of the TEU) and as an important aspect of the EU's external relations policy (Article 3 (5) of the TEU). More specific references to children are included within the TFEU as well, enabling the EU to enact legislative measures aimed at combating sexual exploitation and human trafficking (Article 79 (2) (d) and Article 83 (1)).

This has led to the adoption of the directives on combating child sexual abuse, child sexual exploitation and child pornography,[16] and on preventing and combating trafficking in human beings and protecting its victims,[17] which also contain provisions addressing specific needs of child victims. The more recent directive establishing minimum standards on the rights, support and protection of victims of crime similarly devotes many of its provisions to children.[18]

The third important milestone occurred at a more strategic, policy level, initially in the context of the EU's external cooperation agenda and latterly in relation to internal issue**s**. Specifically, the Council of the EU adopted 'EU Guidelines for the promotion and protection of the rights of the child'[19] and the European Commission adopted its Communication on *A special place*

14 EU (2007), Treaty of Lisbon amending the Treaty on European Union and the Treaty establishing the European Community, signed at Lisbon, OJ 2007 C 306, pp. 1–271.

15 See consolidated versions of European Communities (2012), Treaty on European Union (TEU) and Treaty on the Functioning of the European Union (TFEU), OJ 2012 C 326.

16 Directive 2011/93/EU, OJ 2011 L 335, p. 1.

17 Directive 2011/36/EU, OJ 2011 L 101, p. 1.

18 Directive 2012/29/EU, OJ 2012 L 315, p. 57.

19 Council of the European Union (2007), *EU Guidelines for the promotion and protection of the rights of the child*, Brussels, 10 December 2007.

for children in EU external action[20] to mainstream children's rights into all EU activities with non-EU Member States. Similarly, in 2011, the European Commission adopted the EU Agenda for the rights of the child, setting out key priorities for the development of children's rights law and policy across the EU Member States.[21] The agenda also included the targeting of the legislative processes relevant to child protection, such as the aforementioned adoption of the directive on victim's rights.

Most recently, this has been complemented with the Commission's adoption of a comprehensive strategy to support Member States in addressing poverty and social exclusion through a range of early-years interventions (for children of pre-school and primary school age).[22] While this particular initiative, like the agenda, is not legally binding, both are significant insofar as they establish the blueprint for the EU's normative and methodological approach to children's rights law – a blueprint that is firmly associated with the CRC and located within an ethic of child protection, participation and non-discrimination.

The EU may legislate only where it has been given competence under the treaties (Articles 2 to 4 of the TFEU). As children's rights is a cross-sectorial field, EU competence needs to be determined on a case-by-case basis. To date, areas relevant for children's rights where the EU has extensively legislated are:

- data and consumer protection;
- asylum and migration;
- cooperation in civil and criminal matters.

Articles 6 (1) of the TEU and 51 (2) of the EU Charter of Fundamental Rights provide that the Charter does not extend the competences of the EU, nor does it modify or establish a new power or task for the EU. The Charter provisions

20 European Commission (2008), *A special place for children in EU external action: Communication from the Commission to the Council, the European Parliament, the European Economic And Social Committee and the Committee of the Regions*, COM (2008) 55 final, Brussels, 5 February 2008.

21 European Commission (2011), *An EU agenda for the rights of the child: Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions*, COM (2011) 0060 final, Brussels, 15 February 2011.

22 European Commission (2013), *Investing in children: breaking the cycle of disadvantage*, Recommendation 2013/112/EU, Brussels.

are addressed to the EU institutions and to Member States only when they are implementing EU law. While always binding on the EU, the Charter provisions become legally binding for the Member States only where they act within the scope of EU law.

Each of the following chapters includes a brief overview of the EU's competence in areas dealt with under the respective chapter.

1.2.2. Council of Europe: development of children's rights law and the areas of protection covered

In contrast to the EU, ever since its establishment, the CoE has a clear mandate to protect and promote human rights. Its primary human rights treaty, ratified by all CoE member states, is the Convention for the Protection of Human Rights and Fundamental Freedoms, or European Convention on Human Rights (ECHR), which contains specific references to children. The main ones are as follows: Article 5 (1) (d) provides for the lawful detention of a child for the purposes of educational supervision; Article 6 (1) restricts the right to a fair and public hearing where this is in the interest of juveniles; Article 2 of Protocol No. 1 provides for the right to education and requires states to respect parents' religious and philosophical convictions in the education of their children. Moreover, all the other general provisions of the ECHR are applicable to everyone, including children. Some have been shown to have particular relevance to children, namely Article 8, which guarantees the right to respect for private and family life, and Article 3, which prohibits torture, inhuman and degrading treatment and punishment. By using interpretative approaches that focus on the positive obligations inherent in the ECHR provisions, the ECtHR has developed a large body of case law dealing with children's rights, including frequent references to the CRC. That said, the ECtHR analyses applications on a case-by-case basis and therefore does not offer a comprehensive overview of children's rights under the ECHR.

The CoE's other main human rights treaty, the European Social Charter (ESC[23] – revised in 1996[24]), provides for the protection of social rights, with specific

23 Council of Europe, European Social Charter, CETS No. 35, 18 October 1961.

24 Council of Europe, European Social Charter (revised), CETS No. 163, 3 May 1996.

provision for children's rights. It contains two provisions of particular importance for children's rights. Article 7 sets out the obligation to protect children from economic exploitation. Article 17 requires states to take all appropriate and necessary measures designed to ensure that children receive the care, assistance, education and training they need (including free primary and secondary education), to protect children and young persons from negligence, violence or exploitation and to provide protection for children deprived of their family's support. Implementation of the ESC is overseen by the European Committee of Social Rights (ECSR), which is composed of independent experts who rule on the conformity of national law and practice with the ESC either by way of a collective complaints procedure or a national reporting procedure.

In addition, the CoE has adopted a number of treaties that address a range of specific children's rights issues. These include the:

- Convention on the Legal Status of Children born out of Wedlock;[25]
- Convention on the Adoption of Children, revised in 2008;[26]
- Convention on Contact Concerning Children;[27]
- Convention on the Exercise of Children's Rights;[28]
- Council of Europe Convention on Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention).[29]

Finally, at the policy level it is important to note that in 2006, the CoE launched its programme 'Building a Europe for and with Children' – a transversal plan of action for addressing children's rights issues, including the adoption of

25 Council of Europe, European Convention on the Legal Status of Children born out of Wedlock, CETS No. 85, 15 October 1975.

26 Council of Europe, Convention on the Adoption of Children (Revised), CETS No. 202, 27 November 2008.

27 Council of Europe, Convention on Contact concerning Children, CETS No. 192, 15 May 2003.

28 Council of Europe, European Convention on the Exercise of Children's Rights, CETS No. 160, 25 January 1996.

29 Council of Europe, Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, CETS No. 201, 25 October 2007.

standard setting instruments across a range of areas.[30] Current priorities are focused on four key areas:[31]

- promoting child-friendly services and systems;
- eliminating all forms of violence against children;
- guaranteeing the rights of children in vulnerable situations;
- promoting child participation.

The principal aim of the CoE's children's rights programme is to support the implementation of international standards in the field of children's rights by all CoE member states, and in particular to promote the implementation of the CRC, highlighting its main principles: non-discrimination, the right to life and development, the best interests of the child as a primary consideration for decision-makers, and the right of children to be heard.[32]

The programme has overseen the adoption of several children's rights instruments offering practical guidance to complement binding European legal measures, including:

- Guidelines on child-friendly justice;[33]
- Guidelines on child-friendly healthcare;[34]
- Recommendation on integrated national strategies for the protection of children from violence;[35]

30 For more information, see http://www.coe.int/t/dg3/children/.

31 Council of Europe, Committee of Ministers (2011), Council of Europe Strategy for the Rights of the Child (2012–2015), CM (2011)171 final, 15 February 2012.

32 *Ibid.*

33 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010.

34 Council of Europe, Committee of Ministers (2011), *Guidelines on child-friendly health care*, 21 September 2011.

35 Council of Europe, Committee of Ministers (2009), Recommendation CM/Rec(2009)10 of the Committee of Ministers to member states on integrated national strategies for the protection of children from violence, 18 November 2009.

- Recommendation on children's rights and social services friendly to children and families;[36]

- Recommendation on participation of children and young people under the age of 18.[37]

In doing so, the programme has ensured that Europe is at the heart of standard-setting in children's rights and has also led the way, through various means, to ensure that children's voices are central to that process. The programme also aims to support the implementation of the ECHR and of the ESC and to promote other existing CoE legal instruments in relation to childhood (participation, protection and rights), youth and family.[38]

1.3. European children's rights law and the UN Convention on the Rights of the Child

Key point

- European children's rights law is largely based on the UN Convention on the Rights of the Child (CRC).

The fact that all EU and CoE member states are parties to the CRC gives the CRC important standing at the European level. It effectively imposes common legal obligations on European states with a knock-on effect on the way European institutions develop and apply children's rights.

In this way, the CRC has become the touchstone for the development of European children's rights law, with the result that the CoE and the EU increasingly draw on its influence. In particular, the integration of CRC principles and provisions into

36 Council of Europe, Committee of Ministers (2011), Recommendation Rec (2011)12 on children's rights and social services friendly to children and families, 16 November 2011.

37 Council of Europe, Committee of Ministers (2012), Recommendation Rec(2012)2 on the participation of children and young people under the age of 18, 28 March 2012.

38 Council of Europe, Committee of Ministers (2011), *Council of Europe Strategy for the Rights of the Child (2012–2015)*, CM (2011)171 final, 15 February 2012.

binding instruments and case law at the European level gives the CRC greater force, and opens up more effective channels of enforcement for those seeking to invoke children's rights in Europe. Specific examples of this are provided throughout this handbook.

The EU is not and cannot become a party to the CRC, since there is no legal mechanism within the CRC to allow entities other than states to accede to it. However, the EU relies on "general principles of EU law" (written and unwritten principles drawn from the common, constitutional traditions of the Member States) to supplement and guide interpretations of the EU Treaties (Article 6 (3) of the TEU). Court of Justice of the European Union (CJEU) rulings have confirmed that any obligation arising from EU membership should not conflict with Member States' obligations derived from their domestic constitutions and international human rights commitments.[39] As all EU Member States have ratified the CRC, the EU is bound to adhere to the principles and provisions enshrined therein, at least in relation to matters that fall within the scope of the EU's competence (as defined by the EU treaties).

This obligation is reinforced by other EU treaties and in particular by the EU Charter of Fundamental Rights. Article 24 of the Charter is directly inspired by CRC provisions, including some that have acquired the rank of 'CRC principles', notably the best interests of the child principle (Article 3 of the CRC), the child participation principle (Article 12 of the CRC) and the child's right to live with and/or enjoy a relationship with his or her parents (Article 9 of the CRC).

The importance of the CRC in guiding the development of EU children's rights is expressed in the Commission's Agenda for the Rights of the Child, which asserts that "the standards and principles of the UNCRC must continue to guide EU policies and actions that have an impact on the rights of the child".[40] In this spirit, child-related legislative instruments, almost without exception, are accompanied by either explicit reference to the CRC or more implicit reference to children's rights principles, such as 'best interests', the child's right to participate in decisions that affect him or her, or the right to be protected from discrimination.

39 For example CJEU, C-4/73, *J. Nold, Kohlen- und Baustoffgroßhandlung v. Commission of the European Communities*, 14 May 1974.

40 European Commission (2011), *An EU Agenda for the Rights of the Child*, COM (2011) 0060 final, Brussels.

The CoE, similarly to the EU, is not as an organisation legally bound to the CRC, although all CoE member states are individual parties to this convention. Nevertheless, the ECHR cannot be interpreted in a vacuum, but must instead be interpreted in harmony with the general principles of international law. Any relevant rules of international law applicable in the relations between the States Parties to the ECHR should be taken into account, in particular the rules concerning the universal protection of human rights. The obligations that the ECHR lays on its States Parties in the field of children's rights more specifically must be interpreted in light of the CRC.[41] The ECSR has also explicitly referred to the CRC in its decisions.[42] Moreover, the standard-setting and treaty-making activities of the CoE are influenced by CRC principles and provisions. For example, the *Guidelines on child friendly justice*[43] are directly informed by a range of CRC provisions, not to mention the accompanying General Comments of the UN Committee on the Rights of the Child.[44]

1.4. Role of the European courts in interpreting and enforcing European children's rights

1.4.1. The Court of Justice of the European Union

The CJEU issues decisions regarding many types of legal actions. In children's rights cases, the CJEU has so far mainly reviewed preliminary references (Article 267 of the TFEU).[45] These are procedures where a national court or tribunal asks the CJEU for an interpretation of primary EU law (i.e. treaties) or secondary

41 ECtHR, *Harroudj v. France*, No. 43631/09, 4 October 2012, para. 42.

42 ECSR, *World Organisation against Torture (OMCT) v. Ireland*, Complaint No. 18/2003, 7 December 2004, paras. 61–63; ECSR, *Defence for Children International (DCI) v. the Netherlands*, Complaint No. 47/2008, 20 October 2009.

43 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010.

44 See UN, Committee on the Rights of the Child (2007), *General Comment No. 10 (2007): Children's rights in juvenile justice*, CRC/C/GC/10, 25 April 2007; UN, Committee on the Rights of the Child (2009), *General Comment No. 12 (2009): The right of the child to be heard*, CRC/C/GC/12, 1 July 2009; and UN, Committee on the Rights of the Child (2013), *General Comment No. 14 (2013) on the right of the child to have his or her best interest taken as a primary consideration (art.3, para.1)*, CRC/C/GC/14, 29 May 2013.

45 The only exception is an action for annulment: CJEU, C-540/03, *European Parliament v. Council of the European Union* [GC], 27 June 2006.

EU law (i.e. decisions and legislation) that is of relevance to a national case pending before that national court or tribunal.

Until recent years, the CJEU had only adjudicated a few children's rights cases. With the adoption of more explicit children's rights legislative measures and a more prominent children's rights agenda, however, it is likely that children's rights will feature more regularly on the CJEU's listings in the future.

The CJEU has delivered most of its judgments concerning children's rights in the context of free movement and EU citizenship – areas in which the EU has enjoyed long-standing competence. Here the CJEU has expressly acknowledged that children enjoy the benefits associated with EU citizenship in their own right, thereby extending independent residence as well as both social and educational entitlement to children, on grounds of EU nationality.[46]

There is only one instance in which the CJEU directly used the CRC to determine how EU law should be interpreted in relation to children, namely in the *Dynamic Medien GmbH v. Avides Media AG* case. This case concerns the lawfulness of German labelling restrictions on imported DVDs and videos, which were already subject to similar controls in the United Kingdom. The CJEU concluded that the German labelling checks constituted a lawful restriction of the EU's free movement of goods provisions (which otherwise preclude double regulatory processes of this nature), given that they aimed to protect the welfare of children. The CJEU supported its decision by reference to Article 17 of the CRC, which encourages signatory states to develop appropriate guidelines for the protection of children from media-generated information and material injurious to their well-being.[47] Requirements of proportionality apply, however, with regard to the examination procedures established to protect children, which should be readily accessible, and possible to complete within a reasonable period.[48]

46 See CJEU, C-413/99, *Baumbast and R v. Secretary of State for the Home Department*, 17 September 2002; CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 19 October 2004; CJEU, C-148/02, *Carlos Garcia Avello v. Belgian State*, 2 October 2003; CJEU, C-310/08, *London Borough of Harrow v. Nimco Hassan Ibrahim and Secretary of State for the Home Department* [GC], 23 February 2010; CJEU, C-480/08, *Maria Teixeira v. London Borough of Lambeth and Secretary of State for the Home Department*, 23 February 2010. These cases are revisited in Chapters 8 and 9.

47 CJEU, C-244/06, *Dynamic Medien Vertriebs GmbH v. Avides Media AG*, 14 February 2008, paras. 42 and 52.

48 *Ibid.*, paras. 49 and 50.

In other cases, the CJEU has alluded to general children's rights principles also encapsulated in CRC provisions (such as the child's best interests and the right to be heard) to inform its judgments, particularly in the context of cross-border child abduction cases.[49]

That aside, the EU has traditionally been circumspect in attaching decisive force to the CRC, particularly in more politically sensitive areas such as immigration control,[50] although this is changing in recent jurisprudence, as discussed in the chapters that follow. Since the adoption of the EU Charter of Fundamental Rights, CJEU references to its articles on children's rights often resonate with references to the CRC, given the similarity between provisions.

1.4.2. The European Court of Human Rights

The ECtHR mainly decides on individual applications lodged in accordance with Articles 34 and 35 of the ECHR. ECtHR jurisdiction extends to all matters concerning the interpretation and application of the ECHR and its Protocols (Article 32 of the ECHR).

In contrast to the CJEU, the ECtHR has a vast jurisprudence on children's rights. Although many cases under Article 8 of the ECHR on the right to respect for private and family life are considered from a parents' rather than children's rights perspective, cases under other substantive provisions do not necessarily involve parents and have a clearer focus on the rights of the children concerned, such as the right to protection from inhuman and degrading treatment (Article 3 of the ECHR) or the right to a fair trial (Article 6 of the ECHR).

Although the ECtHR often refers to the CRC when addressing claims pursued either by or on behalf of children, it does not systematically attach decisive weight to it. In some cases, the children's rights principles, as articulated by the CRC, have had a profound influence on the ECtHR's reasoning, notably as concerns the Court's interpretation of Article 6 of the ECHR (right to a fair trial) in relation to the treatment of children in conflict with the law (see Chapter 11). In other areas, the approach of the ECtHR may vary slightly from that of the CRC,

49 CJEU, C-491/10 PPU, *Joseba Andoni Aguirre Zarraga v. Simone Pelz*, 22 December 2010. See further Chapter 5.

50 CJEU, C-540/03, *European Parliament v. Council of the European Union* [GC], 27 June 2006.

for example as regards hearing children in court (see Chapter 2). And in some cases, the ECtHR has explicitly relied on the CRC.

> Example: *Maslov v. Austria*[51] concerns the deportation of the applicant, who had been convicted of a number of criminal offences as a minor. The ECtHR held that where expulsion measures against a juvenile offender were concerned, the obligation to take the best interests of the child into account included an obligation to facilitate the child's reintegration, in line with Article 40 of the CRC. In the ECtHR's view, reintegration would not be achieved by severing the child's family or social ties through expulsion.[52] The CRC is thus one of the grounds used to find that the expulsion was a disproportionate interference with the applicant's rights under Article 8 of the ECHR (respect for family life).

1.5. European Committee of Social Rights

The ECSR comprises 15 independent and impartial experts who rule on the conformity of national law and practice with the ESC, either through the collective complaints procedure or the national reporting procedure.[53] Designated national and international organisations can engage in collective complaints against states that are party to the ESC and have accepted the complaints procedure. To date, complaints have involved whether states have violated children's rights under the ESC on issues including the economic exploitation of children,[54] the physical integrity of children,[55] the health rights of migrant children[56] and access to education by children with disabilities.[57]

51 ECtHR, *Maslov v. Austria* [GC], No. 1638/03, 23 June 2008.

52 *Ibid.*, para. 83.

53 For more information, see the ECSR website: www.coe.int/t/dghl/monitoring/socialcharter/ECSR/ECSRdefault_en.asp.

54 ESCR, *International Commission of Jurists (ICJ) v. Portugal*, Complaint No. 1/1998, 9 September 1999.

55 ESCR, *World Organisation Against Torture (OMCT) v. Greece*, Complaint No. 17/2003, 7 December 2004.

56 ESCR, *Defence for Children International (DCI) v. Belgium*, Complaint No. 69/2011, 23 October 2012.

57 ECSR, *Mental Disability Advocacy Center (MDAC) v. Bulgaria*, Complaint No. 41/2007, 3 June 2008, para. 35.

Example: In *International Commission of Jurists (ICJ) v. Portugal*,[58] it was alleged that although Portuguese legislation respected the minimum age of 15 years for admission to employment established by Article 7 (1) of the ESC, it was not adequately enforced. The ECSR held that the aim and purpose of the ESC was to protect rights not only in theory but also in fact, and thus that legislation must be applied effectively. Noting that a large number of children were employed illegally in Portugal, it found this situation to be in violation of Article 7 (1) of the ESC.

58 ESCR, *International Commission of Jurists (ICJ) v. Portugal*, Complaint No. 1/1998, 9 September 1999.

2 Basic civil rights and freedoms

EU	Issues covered	CoE
Charter of Fundamental Rights, Articles 10 (freedom of religion) and 14 (right to education)	**Freedom of thought, conscience and religion**	ECHR, Articles 9 (freedom of religion) and 14 (prohibition of discrimination); Article 2 of Protocol No. 1 (right of parents to ensure teaching of their children in conformity with their convictions) ECtHR, *Dogru v. France*, No. 27058/05, 2008 (wearing of Islamic headscarf at a state secondary school) ECtHR, *Kervanci v. France*, No. 31645/04, 2008 (wearing of Islamic headscarf at a state secondary school) ECtHR, *Grzelak v. Poland*, No. 7710/02, 2010 (alternatives to religious education in primary and secondary schools) ECtHR, *Lautsi and Others v. Italy* [GC], No. 30814/06, 2011 (display of crucifixes in state schools)
Charter of Fundamental Rights, Article 11 (freedom of expression)	**Freedom of expression and information**	ECHR, Article 10 (freedom of expression) ECtHR, *Handyside v. the United Kingdom*, No. 5493/72, 1976 (banning of a book for children) ECtHR, *Gaskin v. the United Kingdom*, No. 10454/83, 1989 (access to case-file kept during childhood)

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 24 (rights of the child) CJEU, C-491/10 PPU, *Joseba Andoni Aguirre Zarraga v. Simone Pelz*, 2010 (right to be heard, international child abduction)	**Right to be heard**	ECHR, Article 6 (fair trial) European Convention on the Exercise of Children's Rights, Articles 3, 4, 6 and 7 ECtHR, *Sahin v. Germany* [GC], No. 30943/96, 2003 (hearing a child in court in access proceedings)
Charter of Fundamental Rights, Article 12 (freedom of assembly and association)	**Right to freedom of assembly and of association**	ECHR, Article 11 (freedom of peaceful assembly and association) ECtHR, *Christian Democratic People's Party v. Moldova*, No. 28793/02, 2006 (attending gatherings in public space)

All persons enjoy the civil rights and freedoms laid down in various instruments, most notably the EU Charter of Fundamental Rights and the European Convention on Human Rights (ECHR) as interpreted by the European Court of Human Rights (ECtHR). Other than the Charter, no EU legal instrument deals specifically with the civil rights discussed in this chapter as they apply to children. At CoE level, however, the scope and interpretation of these civil rights have been developed extensively over the years, in particular through ECtHR case law.

This chapter presents an overview of the freedoms listed in Title II of the EU Charter of Fundamental Rights insofar as they have an impact on children's rights. It analyses the right of the child to freedom of thought, conscience and religion (Section 2.1), to freedom of expression and information (Section 2.3), the child's right to be heard (Section 2.4), and the right to freedom of assembly and of association (Section 2.5).

2.1. Freedom of thought, conscience and religion

Key points

- Freedom of thought, conscience and religion, as guaranteed under the EU Charter of Fundamental Rights and the ECHR, includes the right to change religion or belief and the freedom to manifest religion or belief in worship, teaching, practice and observance.
- Parents have the right to ensure the education and teaching of their children in conformity with their religious, philosophical and pedagogical convictions.
- Parents have the right and duty to provide direction to the child in the exercise of the child's right to freedom of thought, conscience and religion in a manner consistent with the evolving capacities of the child.

2.1.1. The child's right to freedom of religion

Under EU law, Article 10 of the EU Charter of Fundamental Rights guarantees to everyone the freedom of thought, conscience and religion. This right includes the freedom to change one's religion or belief and the freedom, either alone or in community with others and in public or in private, to manifest one's religion or belief in worship, teaching, practice and observance. The right to conscientious objection is recognised in accordance with the national laws (Article 10 (2) of the Charter).

Under CoE law, Article 9 of the ECHR provides the right to freedom of thought, conscience and religion. Three dimensions of the right to freedom of religion have been distilled from the ECtHR's case law: the internal dimension; the freedom to change one's religion or belief; and the freedom to manifest one's religion or belief. The first two dimensions are absolute, and states may not limit them under any circumstance.[59] The freedom to manifest one's religion or belief may be limited if such limitations are prescribed by law, pursue a legitimate aim and are necessary in a democratic society (Article 9 (2) of the ECHR).

In its case law, the ECtHR has dealt with children's freedom of thought, conscience and religion, mainly in relation to the right to education and the state school system. A topic of much public debate in European countries is religion in schools.

59 ECtHR, *Darby v. Sweden*, No. 11581/85, 23 October 1990.

Example: The cases of *Dogru v. France* and *Kervanci v. France*[60] concern the exclusion from the first year of a French state secondary school of two girls, aged 11 and 12 years, as a result of their refusal to remove their headscarves during physical education classes. The ECtHR observed that the purpose of the restriction on the applicants' right to manifest their religious convictions was to adhere to the requirements of secularism in state schools. According to the national authorities, wearing a veil, such as the Islamic headscarf, was incompatible with sports classes for health and safety reasons. The ECtHR deemed this reasonable, as the school balanced the applicants' religious convictions against the requirements of protecting the rights and freedoms of others and the public order. Accordingly, it concluded that the interference with the freedom of the pupils to manifest their religion was justified and proportionate to the aim pursued. It therefore found no violation of Article 9 of the ECHR.

Example: The case *Grzelak v. Poland*[61] concerns the failure to provide a pupil excused from religious instruction with ethics classes and associated marks. During his entire schooling at primary and secondary level (between the ages of seven and 18 years), the applicant did not receive religious instruction, in conformity with the wishes of his parents, who were declared agnostics. As too few pupils were interested, no class in ethics was ever organised, and he received school reports and certificates that contained a straight line instead of a mark for 'religion/ethics'. According to the ECtHR, the absence of a mark for 'religion/ethics' on the boy's school reports fell within the ambit of the negative aspect of freedom of thought, conscience and religion, as the reports could point to his lack of religious affiliation. It therefore amounted to a form of unwarranted stigmatisation. The difference in treatment between non-believers who wished to follow ethics classes and pupils who followed religious classes was thus not objectively and reasonably justified, nor was there a reasonable relationship of proportionality between the means used and the aim pursued. The state's margin of appreciation was exceeded in this matter, as the very essence of the applicant's right not to manifest his religion or convictions was infringed, in violation of Article 14 of the ECHR taken in conjunction with Article 9 of the ECHR.

60 ECtHR, *Dogru v. France*, No. 27058/05, 4 December 2008; ECtHR, *Kervanci v. France*, No. 31645/04, 4 December 2008 (available in French).

61 ECtHR, *Grzelak v. Poland*, No. 7710/02, 15 June 2010.

2.2. Parents' rights and the freedom of religion of their children

The rights of parents in the context of the freedom of religion of their children are addressed differently in European law compared to the CRC.

Under EU law, due respect must be given to the right of parents to ensure the education and teaching of their children in conformity with their religious, philosophical and pedagogical convictions, in particular in the context of the freedom to found educational establishments (Article 14 (3) of the Charter).

Under CoE law, in particular Article 2 of Protocol No. 1 to the ECHR, states must take into account the parent's (religious) convictions in the exercise of every function they undertake in the sphere of education and teaching. According to the ECtHR, this duty is broad, as it applies not only to the content and implementation of school curricula, but also to the performance of all functions a state assumes.[62] It includes the organisation and financing of public education, the setting and planning of the curriculum, the conveying of information or knowledge included in the curriculum in an objective, critical and pluralistic manner (hence forbidding the state to pursue an aim of indoctrination that might be considered as not respecting parents' religious and philosophical convictions), as well as the organisation of the school environment, including the presence of crucifixes in state-school classrooms.

Example: The case *Lautsi and Others v. Italy*[63] concerns the display of crucifixes in state-school classrooms. A parent complained that the presence of crucifixes in the classrooms of the state school attended by her children infringed the principle of secularism according to which she sought to educate her children. The ECtHR Grand Chamber found that it was up to the state, as part of its functions in relation to education and teaching, to decide whether or not crucifixes should be present in state-school classrooms, and that this fell within the scope of the second

62 See the relevant ECtHR case law: ECtHR, *Kjeldsen, Busk Madsen and Pedersen v. Denmark*, Nos. 5095/71, 5920/72 and 5926/72, 7 December 1976; ECtHR, *Valsamis v. Greece*, No. 21787/93, 18 December 1996; ECtHR, *Folgerø and Others v. Norway* [GC], No. 15472/02, 29 June 2007; ECtHR, *Hasan and Eylem Zengin v. Turkey*, No. 1448/04, 9 October 2007; ECtHR, *Lautsi and Others v. Italy* [GC], No. 30814/06, 18 March 2011.

63 ECtHR, *Lautsi and Others v. Italy* [GC], No. 30814/06, 18 March 2011.

sentence of Article 2 of Protocol No. 1 to the ECHR. The Court argued that in principle this decision falls within the margin of appreciation of the respondent state, and that there is no European consensus on the presence of religious symbols in state schools. It is true that the presence of crucifixes in state-school classrooms – a sign which undoubtedly refers to Christianity – gives visible prominence in the school environment to a country's majority religion. However, this is not in itself sufficient to denote a process of indoctrination on the respondent state's part. In the ECtHR's view, a crucifix on a wall is an essentially passive symbol that cannot be deemed to have an influence on pupils comparable to that of speech or participation in religious activities. Accordingly, the Grand Chamber concluded that, in deciding to keep crucifixes in the state-school classrooms the applicant's children attended, the authorities had acted within the limits of their margin of appreciation and thus respected the right of parents to ensure education and teaching in conformity with their own religious and philosophical convictions.

Under international law, Article 14 (2) of the CRC requires States Parties to respect the rights and duties of parents to provide direction to their child in the exercise of his/her right to freedom of thought, conscience and religion in a manner consistent with the evolving capacities of the child. Thus, as opposed to Article 14 (3) of the EU Charter of Fundamental Rights, the CRC focuses on the exercise of the freedom of the child him/herself. Under the CRC, parents have the right to provide guidance and direction not in accordance with their own convictions, but in accordance with the convictions held by the children. The wording of Article 14 (2) of the CRC is in line with the CRC's general conception of parental responsibilities: that parental responsibilities must be exercised consistently with the evolving capacities of the child (Article 5 of the CRC), and based on the best interests of the child (Article 18 (1) of the CRC).

2.3. Freedom of expression and information

Key points

- Both the EU Charter of Fundamental Rights and the ECHR guarantee the right to freedom of expression, which includes the freedom to hold opinions and to receive and impart information and ideas without interference by public authorities.
- The right to freedom of information does not include the right of access to childcare records.
- Making access to childcare records dependent on the consent of the contributor of the information may be compatible with Article 8 (the right to respect for private and family life) of the ECHR, provided that an independent authority has the final say in deciding whether access should be granted.

Under EU law, the right to freedom of expression includes the freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers (Article 11 of the EU Charter of Fundamental Rights).

Under CoE law, freedom of expression is guaranteed by Article 10 of the ECHR and may be limited only if the limitation is prescribed by law, pursues one of the legitimate aims listed in Article 10 (2) and is necessary in a democratic society.

In its case law, the ECtHR stressed that "[f]reedom of expression constitutes one of the essential foundations of [a democratic] society, one of the basic conditions for its progress and for the development of every man [...] it is applicable not only to 'information' or 'ideas' that are favourably received or regarded as inoffensive or as a matter of indifference, but also to those that offend, shock or disturb the State or any sector of the population".[64]

64 See, for example, ECtHR, *Handyside v. the United Kingdom*, No. 5493/72, 7 December 1976, para. 49.

Example: In *Handyside v. the United Kingdom*,[65] the ECtHR found that a ban imposed by the authorities on a book called *Little Red School Book* was in accordance with the exception laid down in Article 10 (2) of the ECHR on the protection of morals. The case deals with the right to receive information appropriate for a child's age and maturity – an aspect of the right to freedom of expression that is particularly relevant for children. The book, which was translated from Danish, was written for school-age children and questioned a series of social norms, including sexuality and drugs. Young people could interpret certain passages of the book at a critical stage of their development as an encouragement to indulge in precocious activities harmful for them or even to commit certain criminal offences. Therefore, according to the ECtHR, the competent English judges "were entitled, in the exercise of their discretion, to think at the relevant time that the book would have pernicious effects on the morals of many of the children and adolescents who would read it".[66]

Other child cases referencing Article 10 of the ECHR concern the right of access to information of children placed in care.

Example: The case *Gaskin v. the United Kingdom*[67] concerns a person who was placed in care for most of his childhood, during which period the local authority kept confidential records. These included various reports by medical practitioners, school teachers, police and probation officers, social workers, health visitors, foster parents and residential school staff. When the applicant sought access to those records for the purpose of proceeding for personal injuries against the local authority, he was refused. The confidentiality of such records had been warranted in the public interest for the proper operation of the childcare service, which would be jeopardised if contributors to the records were reluctant to be frank in their reports in the future. The ECtHR accepted that persons who were in state care as children had a vital interest "in receiving the information necessary to know and to understand their childhood and early development".[68] While the confidentiality of public records needs to be guaranteed, a system like the British one, which made access to records dependent on the consent of

65 *Ibid.*

66 *Ibid.*, para. 52.

67 ECtHR, *Gaskin v. the United Kingdom*, No. 10454/83, 7 July 1989.

68 *Ibid.*, para. 49.

the contributor, could in principle be compatible with Article 8 of the ECHR if the interests of the individual seeking access to records were secured when a contributor to the records was unavailable or improperly refused consent. In such a case, an independent authority should ultimately decide whether access should be granted. No such procedure was available to the applicant in the present case and the Court found a violation of the applicant's rights under Article 8 of the ECHR. The ECtHR, however, found no violation of Article 10 of the ECHR, reiterating that the right to freedom to receive information prohibits a government from restricting a person from receiving information that others wish or may be willing to impart, but does not oblige a state to impart the information in question to the individual.

2.4. Right to be heard

Key points

- Under EU law, children have the right to express their views freely. Their views shall be taken into consideration on matters which concern them in accordance with their age and maturity.
- Under the ECHR, there is no absolute requirement to hear a child in court. Whether or not to do so has to be assessed in light of the specific circumstances of each case and is dependent on the child's age and maturity.
- Under UN law, children's right to express their own views freely in all matters affecting them has been recognised as one of the general principles of the Convention on the Rights of the Child.

Under EU law, Article 24 (1) of the EU Charter of Fundamental Rights provides that children may express their views freely, and that such views shall be taken into consideration on matters which concern them in accordance with their age and maturity. This provision is of general applicability, and is not restricted to particular proceedings. The CJEU interpreted the meaning of this provision in conjunction with the Brussels II bis Regulation.

Example: *Joseba Andoni Aguirre Zarraga v. Simone Pelz*[69] concerns the removal of a minor child from Spain to Germany in breach of custody rulings. The CJEU was asked whether the German court (i.e. the court of the country the child was removed to) could oppose the enforcement order by the Spanish court (the country of origin) on the basis that the child had not been heard, thereby infringing Article 42 (2) (a) of Regulation No. 2201/2003 (Brussels II bis) and Article 24 of the EU Charter of Fundamental Rights. The child had opposed the return when she expressed her views within proceedings before the German court. The CJEU reasoned that hearing a child is not an absolute right, but that if a court decides it is necessary, it must offer the child a genuine and effective opportunity to express his or her views. It also held that the right of the child to be heard, as provided in the Charter and Brussels II bis Regulation, requires legal procedures and conditions which enable children to express their views freely to be available to them, and the court to obtain those views. The court also needs to take all appropriate measures to arrange such hearings, with regard to the children's best interests and the circumstances of each individual case. According to the CJEU's ruling, however, the authorities of the country the child had been removed to (Germany) could not oppose a return of the child on the basis of a breach of the right to be heard in the country of origin (Spain).

Under CoE law, the ECtHR does not interpret the right to respect for private and family life (Article 8 of the ECHR) as always requiring the child to be heard in court. As a general rule, it is for the national courts to assess the evidence before them, including the means used to ascertain the relevant facts. Domestic courts are not always required to hear a child in court on the issue of access to a parent who does not have custody rights. This issue has to be assessed in light of the specific circumstances of each case, having due regard to the age and maturity of the child concerned. Moreover, the ECtHR will often ensure, under the procedural limb of Article 8, that the authorities have taken appropriate steps to accompany their decisions with the necessary safeguards.

69 CJEU, C-491/10 PPU, *Joseba Andoni Aguirre Zarraga v. Simone Pelz*, 22 December 2010; see also Section 5.4, which discusses further details of this ruling and the operation of the Brussels II bis regulation.

Example: In the case of *Sahin v. Germany*,[70] the mother prohibited all contact between the applicant and his four-year old daughter. The German regional court decided that granting the father access to his daughter would be harmful to the child because of the serious tensions between the parents. It did so without hearing the child whether she wanted to continue seeing her father. On the question of hearing the child in court, the ECtHR referred to the expert's explanation before the regional court in Germany. After several meetings with the child, her mother and the applicant, the expert considered that the process of questioning the child could have entailed a risk for her, which could not have been avoided by special arrangements in court. The ECtHR found that, in these circumstances, the procedural requirements implicit in Article 8 of the ECHR – to hear a child in court – did not amount to obliging the direct questioning of the child on her relationship with her father.

Example: In *Sommerfeld v. Germany*,[71] the applicant's 13-year-old daughter had expressed a clear wish not to see the applicant and had done so for several years. The domestic courts were of the view that forcing her to see the applicant would seriously disturb her emotional and psychological balance. The ECtHR accepted that the decision-making process provided the applicant with the required protection of his interests.[72]

The European Convention on the Exercise of Children's Rights deals with the right of children to express their views freely.[73] This convention aims to promote children's rights by granting them specific procedural rights in family proceedings before a judicial authority, in particular for proceedings involving the exercise of parental responsibilities, such as residence and access to children. Article 3 of the convention grants children the right to be informed and to express their views in proceedings as a procedural right. In Article 4, the child is granted the right to apply for the appointment of a special representative in proceedings before a judicial authority affecting her or him. In line with Article 6, authorities must ensure that the child has received all relevant in-

70 ECtHR, *Sahin v. Germany* [GC], No. 30943/96, 8 July 2003, para. 73. On the specific aspect of national courts having to assess the evidence they have obtained, as well as the relevance of the evidence that defendants seek to adduce, see also ECtHR, *Vidal v. Belgium*, No. 12351/86, 22 April 1992, para. 33.

71 ECtHR, *Sommerfeld v. Germany* [GC], No. 31871/96, 8 July 2003.

72 *Ibid.*, paras. 72 and 88.

73 Council of Europe, European Convention on the Exercise of Children's Rights, CETS No. 160, 1996.

formation, consult her or him in person, if appropriate, and allow the child to express her or his views.

Under international law, Article 12 (1) of the CRC affirms that a child who is capable of forming her or his own views has the right to express these views freely in all matters affecting her or him. The child's views should be given due weight in accordance with her or his age and maturity. Article 12 (2) of the CRC furthermore prescribes that the child must be provided the opportunity to be heard in any judicial and administrative proceedings affecting her or him, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

The UN Committee on the Rights of the Child stressed that States Parties should either directly guarantee this right, or adopt or revise laws so that this right can be fully enjoyed by the child.[74] Furthermore, they must ensure that the child receives all necessary information and advice to make a decision in favour of her or his best interests. The committee also notes that a child has the right not to exercise this right; expressing views is a choice, not an obligation.

2.5. Right to freedom of assembly and association

Key points

- Both the EU Charter of Fundamental Rights and the ECHR guarantee the freedom of peaceful assembly and association.
- This right enables and protects individuals to further their causes together with others.

Under EU law, Article 12 of the EU Charter of Fundamental Rights provides that everyone has the right to freedom of peaceful assembly and association at all levels, in particular in political, trade union and civic matters. This implies the

74 UN, Committee on the Rights of the Child, *General Comment No. 14 (2013) on the right of the child to have his or her best interest taken as a primary consideration (art.3, para.1)*, CRC/C/GC/14, 29 May 2013.

right of everyone to form and to join trade unions for the protection of his or her interests.

Under CoE law, Article 11 (1) of the ECHR guarantees the right to freedom of assembly and association subject to the restrictions of Article 11 (2).

The ECtHR has explicitly asserted the right of children to attend gatherings in a public space. As the Court noted in *Christian Democratic People's Party v. Moldova*, it would be contrary to the parent's and children's freedom of assembly to prevent them from attending events, in particular to protest against government policy on schooling.

Under international law, individual children as well as children's organisations can rely on the protection offered by Article 15 of the CRC, which contains the right to freedom of association and of peaceful assembly. A large variety of associational forms in which children are engaged have been granted international protection based on this provision.

3 Equality and non-discrimination

EU	Issues covered	CoE
Charter of Fundamental Rights, Title III (Equality), including Articles 20 (equality before the law), 21 (non-discrimination) and 23 (equality between men and women)	Equality and non-discrimination	ECHR, Article 14; Protocol No. 12 to the ECHR, Article 1 (non-discrimination) ESC (revised), Article E (non-discrimination)
Racial Equality Directive (2000/43/EC)	Non-discrimination based on race and ethnic origin	ECtHR, *D.H. and Others v. the Czech Republic* [GC], No. 57325/00, 2007 (placement of Roma children in special schools) ECtHR, *Oršuš and Others v. Croatia*, No. 15766/03, 2010 (Roma-only classes in primary schools) Framework Convention for the Protection of National Minorities (FCNM), Articles 4 and 12
Charter of Fundamental Rights, Article 45 (freedom of movement and of residence) CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 2004 (residence rights of third-country national parents)	Non-discrimination based on nationality and immigration status	ECtHR, *Ponomaryovi v. Bulgaria*, No. 5335/05, 2011 (school fees for temporary residents) FCNM, Articles 4 and 12, para. 3
Employment Equality Directive (2000/78/EC)	Non-discrimination based on age	ECHR, Article 14; Protocol No. 12 to the ECHR, Article 1 (non-discrimination)
CJEU, C-303/06, *S. Coleman v. Attridge Law and Steve Law* [GC], 2008	Non-discrimination based on other protected grounds	ECtHR, *Fabris v. France* [GC], No. 16574/08, 2013 (inheritance rights for children born out of wedlock)

Freedom from discrimination is one of the basic principles of a democratic society. Both the EU and the CoE have been instrumental in interpreting this principle. EU institutions have adopted a series of directives which are highly relevant for children's issues. The European Court of Human Rights (ECtHR) has developed a substantial body of case law on the freedom from discrimination under Article 14 of the ECHR on the prohibition of discrimination, in conjunction with other Convention articles.

The European Committee of Social Rights (ECSR) considers the function of Article E of the European Social Charter (ESC) on non-discrimination to be similar to that of Article 14 of the European Convention on Human Rights (ECHR): it has no independent existence and must be combined with one of the ESC's substantive provisions.[75]

This chapter addresses the principles of equality and non-discrimination, with a focus on those grounds where child-specific case law has been developed. It first provides general information on European non-discrimination law (Section 3.1), and then presents the issue of equality and discrimination of children based on ethnic origin (Section 3.2), nationality and immigration status (Section 3.3), age (Section 3.4), and other protected grounds, including gender, language and personal identity (Section 3.5).

3.1. European non-discrimination law

Key points

- EU and CoE law prohibit discrimination on the grounds of sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age and sexual orientation.[76]
- When the ECtHR establishes that persons have been treated differently in a relevantly similar situation, it will investigate whether there is an objective and reasonable justification. If not, it will conclude that the treatment was discriminatory, in breach of Article 14 of the ECHR on the prohibition of discrimination.

75 ECSR, *Syndicat des Agrégés de l'Enseignement Supérieur (SAGES) v. France*, Complaint No. 26/2004, 15 June 2005, para. 34.

76 For an overview of European non-discrimination law, as constituted by the EU non-discrimination directives and Art. 14 of and Protocol 12 to the ECHR, see: FRA and ECtHR (2011), and its case law update July 2010–December 2011.

Under EU law, the prohibition of discrimination in Article 21 of the EU Charter of Fundamental Rights is a free-standing principle that also applies to situations not covered by any other Charter provision. The grounds on which discrimination is explicitly prohibited in this provision include sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age and sexual orientation. By contrast, Article 19 of the TFEU only covers the grounds of sex, racial or ethnic origin, religion or belief, disability, age and sexual orientation.

Several EU directives prohibit discrimination in the areas of employment, the welfare system and goods and services, all of which are potentially relevant to children. Council Directive 2000/78/EC, which establishes a general framework for equal treatment in employment and occupation (Employment Equality Directive),[77] prohibits discrimination on the grounds of religion or belief, disability, age and sexual orientation. Council Directive 2000/43/EC, implementing the principle of equal treatment between persons irrespective of racial or ethnic origin (Racial Equality Directive), prohibits discrimination on the basis of race or ethnicity not only in the context of employment and access to goods and services, but also in relation to the welfare system (including social protection, social security and healthcare) and to education.[78] Further directives implement the principle of equal treatment between men and women in matters of employment and occupation (Gender Equality Directive)[79] and in the access to and supply of goods and services (Gender Goods and Services Directive).[80]

Under CoE law, the prohibition of discrimination applies to the exercise of any of the substantive rights and freedoms set forth in the ECHR (Article 14), as well as to the exercise of any right guaranteed under domestic law or in any act by a public authority (Article 1 of Protocol No. 12 to the ECHR). Protocol 12, however, is of limited applicability, since it has only been ratified by a small number of countries and no child-related cases have yet been decided on its basis. The provisions set forth in both instruments include a non-exhaustive list of grounds on which discrimination is prohibited: sex, race, colour, language,

77 Council Directive 2000/78/EC, OJ 2000 L 303. All EU legal instruments are available on the EU's online portal providing access to EU law eur-lex: http://eur-lex.europa.eu/homepage.html.

78 Council Directive 2000/43/EC of 29 June 2000 implementing the principal of equal treatment between persons irrespective of racial or ethnic origin, OJ 2000 L 180, 29 June 2000.

79 Directive 2006/54/EC (recast), OJ 2006 L 204.

80 Council Directive 2004/113/EC, OJ 2004 L 373, p. 37.

religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status. Where the ECtHR finds that persons in relevantly similar positions have been treated differently, it will investigate whether this can be objectively and reasonably justified.[81]

Article E of the ESC also includes a non-exhaustive list of grounds on which discrimination is prohibited: race, colour, sex, language, religion, political or other opinion, national extraction or social origin, health, association with a national minority, or birth. The appendix to this article clarifies that differential treatment based on an objective and reasonable justification includes requiring a certain age or capacity for access to some forms of education[82] – and that this is therefore not discriminatory.

Under Article 4 of the Framework Convention for the Protection of National Minorities[83] (FCNM), States Parties guarantee to persons belonging to national minorities the right of equality before the law and equal protection by the law, and prohibit discrimination based on belonging to a national minority. They also undertake to adopt, where necessary, adequate measures to promote, in all areas of economic, social, political and cultural life, full and effective equality between persons belonging to a national minority and those belonging to the majority.

The following sections analyse specific grounds of discrimination which have proven of particular relevance for children.

81 For an overview of the ECtHR case law, see FRA and ECtHR (2011) and its case law update July 2010–December 2011.

82 Council of Europe, European Social Charter (revised) (1996), Explanatory report, para. 136.

83 Council of Europe, Framework Convention for the Protection of National Minorities (FCNM), CETS No. 157, 1995.

3.2. Non-discrimination based on race or ethnic origin

Key points

- Race and ethnic origin are prohibited grounds of discrimination.
- Both the EU and the CoE tackle discrimination of the Roma in the areas of education, employment, healthcare and housing.
- The over-representation or segregation of children belonging to a specific ethnic group in special schools or classes can only be objectively justified if appropriate safeguards for referring children to these schools or classes are put in place.

Under EU law, the Racial Equality Directive prohibits discrimination on the basis of race or ethnicity not only in the context of employment and goods and services, but also in accessing the welfare system, education and social security. The Roma, as a particularly sizeable and vulnerable ethnic group, fall squarely within the scope of the directive. A key element of the drive to tackle discrimination of the Roma at EU level was the adoption of an EU Framework for National Roma Integration Strategies up to 2020.[84] This has been followed by the European Commission's annual monitoring of the national strategies developed by EU Member States. The Racial Equality Directive covers at least four key areas that are important for Roma children: education, employment, healthcare and housing. Achieving full equality in practice may in certain circumstances warrant Roma-specific positive action, in particular in these four key areas.[85]

Under CoE law, the ECtHR has ruled in several landmark cases on the differential treatment of Roma children in the educational system. These cases were analysed under Article 14 taken together with Article 2 of Protocol No. 1 to the

84 European Commission (EC) (2011), *An EU framework for national Roma integration strategies up to 2020: Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions*, COM(2011) 173 final, Brussels, 5 April 2011.

85 European Commission (2014), *Joint Report on the application of Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin and of Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation*, Report from the Commission to the European Parliament and the Council, COM(2014) 2 final, Brussels, 17 January 2014.

ECHR. The ECtHR held that the over-representation or segregation of Roma children in special schools or classes could only be objectively justified by putting in place appropriate safeguards for referring children to these schools or classes, such as tests specifically designed for and sensitive to the needs of Roma children; appropriate evaluation and monitoring of progress so that integration in ordinary classes takes place as soon as learning difficulties have been remedied; and positive measures to address learning difficulties. In the absence of effective anti-segregationist measures, prolonging the educational segregation of Roma children in a mainstream school with a regular program could thus not be justified.[86]

Example: In *D.H. and Others v. the Czech Republic,*[87] the ECtHR found that a disproportionate number of Roma children were placed in special schools for children with learning difficulties without justification. The Court was concerned about the more basic curriculum offered in these schools and the segregation that the system caused. Roma children thus received an education that compounded their difficulties and compromised their subsequent personal development instead of helping them to integrate into the mainstream education system and develop the skills that would facilitate life among the majority population. Consequently, the ECtHR found a violation of Article 14 of the ECHR in conjunction with Article 2 of Protocol No. 1 to the ECHR.

Example: In *Oršuš and Others v. Croatia*,[88] the ECtHR examined the existence of Roma-only classes within ordinary primary schools. As a matter of principle, temporarily placing children in a separate class due to their inadequate command of the language of instruction is not discriminatory as such. Such a placement can be seen as adapting the educational system to the special needs of children with language difficulties. However, as soon as this placement disproportionally or exclusively affects members of a specific ethnic group, safeguards have to be put in place. For the initial placement in separate classes, the ECtHR noted that the placement was not part of a general practice to address the problems of children with an

86 ECtHR, *Lavida and Others v. Greece*, No. 7973/10, 30 May 2013 (available in French).

87 ECtHR, *D.H. and Others v. the Czech Republic* [GC], No. 57325/00, 13 November 2007, paras. 206–210.

88 ECtHR, *Oršuš and Others v. Croatia* [GC], No. 15766/03, 16 March 2010, para. 157.

inadequate command of the language, and that no specific testing of the children's command of the language had taken place. As to the curriculum offered to them, some children were not offered any specific programme (i.e., special language classes) to acquire the necessary language skills in the shortest time possible. There was neither a transferral nor a monitoring procedure in place to ensure the immediate and automatic transfer to the mixed classes as soon as the Roma children attained adequate language proficiency. Consequently, the Court found that this was in violation of Article 14 of the ECHR in conjunction with Article 2 of Protocol No. 1.

The ECSR holds that, even though educational policies of Roma children may be accompanied by flexible structures to meet the diversity of the group and may take into account the fact that some groups lead an itinerant or semi-itinerant lifestyle, there should be no separate schools for Roma children.[89]

Under Article 4 (2) and (3) FCNM, special measures adopted to promote the effective equality of persons belonging to national minorities shall not be regarded as discriminatory. In accordance with Article 12 (3) FCNM, States Parties moreover expressly undertake to promote equal opportunities for access to education at all levels for persons belonging to national minorities. The Advisory Committee on the FCNM has regularly examined the equal access to education of Roma children in line with this provision.[90]

89 ECSR, European Social Charter (revised) – Conclusions 2003 (Bulgaria), Art. 17, para. 2, p. 53.

90 See Council of Europe, Advisory Committee on the FCNM, *Commentary on Education under the Framework Convention for the Protection of National Minorities* (2006), ACFC/25DOC(2006)002.

3.3. Non-discrimination based on nationality and immigration status

Key points

- Protection against discrimination based on nationality is more limited in scope under EU law than under CoE law.
- Under EU law, protection against discrimination based on nationality is only granted to citizens of EU Member States, as enshrined in Article 45 (freedom of movement and of residence) of the EU Charter of Fundamental Rights.
- The ECHR guarantees the enjoyment of rights to all persons within the jurisdiction of a member state.

Under EU law, protection against discrimination based on nationality is particularly prominent in the context of the free movement of persons. Third-country nationals (i.e. persons who are citizens of a state that is not a member of the EU) enjoy a right to equal treatment in broadly the same areas as those covered by the non-discrimination directives when they qualify as 'long-term residents'. For qualifying as such, the Third-Country Nationals Directive requires, among other conditions, a period of five years of lawful residence.[91] In addition, Directive 2003/86/EC on the right to family reunification (Family Reunification Directive) [92] allows for third-country nationals lawfully residing in a Member State to be joined by family members, under certain conditions (see also Section 9.5).

Example: The *Chen* case[93] concerns the question of whether a child of a third-country national had the right to reside in one EU Member State when she was born in a different Member State and held the citizenship of the latter. Her mother, on whom she depended, was a third-country national. The CJEU determinedthat, when a Member State imposes require-

91 Directive 2003/109/EC of 23 January 2004 concerning the status of third-country nationals who are long-term residents, OJ 2004 L 16, p. 44.

92 Directive 2003/86/EC of 3 October 2003 on the right to family reunification, OJ 2003 L 251, p. 12.

93 CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 19 October 2004.

ments on individuals seeking citizenship, and these are met, it is not open to a different Member State to then challenge that entitlement when the mother and the child apply for residence. The CJEU confirmed that a Member State cannot refuse a right of residence to a parent who is the carer of a child who is an EU citizen, as this would deprive the child's right of residence of any useful effect.

Under CoE law, the ECHR guarantees the enjoyment of rights to all those living within the jurisdiction of a member state, whether they are citizens or not, including those living beyond the national territory, in areas under the effective control of a member state. Regarding education, the ECtHR therefore holds that differential treatment on grounds of nationality and immigration status could amount to discrimination.

Example: *Ponomaryovi v. Bulgaria*[94] concerns the issue of foreign nationals lacking permanent residence permits having to pay school fees for their secondary education. As a matter of principle, the normally wide margin of appreciation in cases of general measures of economic or social strategy needed to be qualified in the field of education, for two reasons:

- the right to education enjoys direct protection under the ECHR;
- education is a very particular type of public service, which serves broad societal functions.

According to the ECtHR, the margin of appreciation increases with the level of education, in inverse proportion to the importance of that education for those concerned and for society at large. So, while for primary schooling (higher) fees for foreigners are hard to justify, they may be fully justified at the university level. Given the importance of secondary education for personal development, and social and professional integration, a stricter scrutiny of the proportionality of the differential treatment applies for that level of education. The Court clarified that it did not take any position on whether or not a state is entitled to deprive all irregular migrants from the educational benefits it provides to nationals and certain limited categories of foreigners. In assessing the particular circumstances of the case, it found that no "considerations relating to the need to stem or reverse the flow of illegal immigration" applied. The applicants had not tried to abuse

94 ECtHR, *Ponomaryovi v. Bulgaria*, No. 5335/05, 21 June 2011, para. 60.

the Bulgarian educational system, as they had come to live in Bulgaria at a very young age following their mother's marriage with a Bulgarian, so they had no choice but to go to school in Bulgaria. There had accordingly been a violation of Article 14 of the ECHR in conjunction with Article 2 of Protocol No. 1 to the ECHR.

3.4. Non-discrimination based on age

Key point

- Under both EU law and the ECHR, discrimination on the grounds of age is prohibited.

Under EU law, the EU Charter of Fundamental Rights in Article 21 explicitly mentions 'age' as a ground on which discrimination is prohibited. Article 24 includes the rights of the child among the protected fundamental rights. Under current EU legislation on non-discrimination, protection from discrimination on the basis of age is more limited than protection on the basis of race and ethnicity or on the basis of sex. Age is currently only protected in the context of access to employment, similarly to sexual orientation, disability and religion or belief.

The Employment Equality Directive is applicable to children who are legally entitled to work. While the International Labour Organization Convention concerning Minimum Age for Admission to Employment,[95] ratified by all EU Member States, establishes a minimum age of 15 years, differences regarding this minimum age persist among the EU Member States.[96] According to Article 6 of the Employment Equality Directive, Member States may provide justifications for differences of treatment on grounds of age. These differences do not constitute discrimination if they are objectively and reasonably justified by a legitimate aim, and if the means of achieving that aim are appropriate and necessary. Concerning children and young people, such differences of treat-

95 International Labour Organization (ILO) (1973), Convention concerning Minimum Age for Admission to Employment, No. 138.

96 European Network of Legal Experts in the non-discrimination field, O'Dempsey, D. and Beale, A. (2011), *Age and employment*, European Commission, Directorate-General for Justice, Luxembourg, Publications Office.

ment may, for instance, include the setting of special conditions on access to employment and vocational training, employment and occupation, to promote their vocational integration or ensure their protection.

Under CoE law, Article 14 of the ECHR and Article 1 of Protocol 12 to the ECHR do not explicitly mention 'age' in the list of grounds on which discrimination is prohibited. The ECtHR, however, has examined issues of age discrimination in relation to various rights protected by the ECHR, and thereby implicitly analysed age as being included among 'other status'. In *D.G. v. Ireland*[97] and *Bouamar v. Belgium*,[98] for instance, the ECtHR found that there was a difference in treatment between adults and children in the countries' respective justice systems regarding detention, relevant to the application of the Convention. This difference in treatment stemmed from the punitive purpose of detention as regards adults and its preventive purpose in respect of children. Hence, the Court accepted 'age' as a possible ground for discrimination.

3.5. Non-discrimination based on other protected grounds

Key point

- Further grounds of discrimination, such as disability or birth, have been addressed in European jurisprudence pertaining to children.

Under EU law, Article 21 of the EU Charter of Fundamental Rights also prohibits discrimination based on other grounds particularly relevant to children, such as sex, genetic features, language, disability or sexual orientation. At least for disability, the CJEU has accepted that EU law also protects against so-called 'discrimination by association', i.e. discrimination against a person who is associated with another who has the protected characteristic (such as the mother of a child with disabilities).

97 ECtHR, *D.G. v. Ireland*, No. 39474/98, 16 May 2002 (see also Section 11.2.2).

98 ECtHR, *Bouamar v. Belgium*, No. 9106/80, 29 February 1988 (see also Section 11.2.2).

Example: In *S. Coleman v. Attridge Law and Steve Law*,[99] the CJEU noted that the Employment Equality Directive includes certain provisions designed to specifically accommodate the needs of persons with disabilities. This, however, does not lead to the conclusion that the principle of equal treatment enshrined in the directive must be interpreted strictly, as prohibiting only direct discrimination on the grounds of disability and relating exclusively to persons with disabilities. According to the CJEU, the directive applies not to a particular category of persons but to the very nature of the discrimination. An interpretation limiting its application to persons with disabilities wouldd**e**prive the directive of an important element of its effectiveness and reduce the protection that it is intended to guarantee. The CJEU concluded that the directive must be interpreted as meaning that the prohibition of direct discrimination laid down therein is not limited to persons with disabilities. Consequently, where an employer treated an employee who did not have a disability less favourably than another employee in a comparable situation, based on the disability of the former employee's child, whose care was provided primarily by that employee, such treatment was contrary to the prohibition of direct discrimination laid down by the directive.

Under CoE law, the ECtHR has dealt with discrimination against children in a variety of situations other than those already mentioned, such as discrimination based on language[100] or affiliation.[101]

Example: In *Fabris v. France*, [102] the applicant complained that he had been unable to benefit from a law introduced in 2001 granting children 'born of adultery' identical inheritance rights to those of legitimate children, a law passed following the ECtHR's judgment in *Mazurek v. France*[103] in 2000. The Court held that the legitimate aim of protecting the inheritance rights of the applicant's half-brother and half-sister did not outweigh his claim to a share of his mother's estate. In this case, the difference in treatment had

99 CJEU, C-303/06, *S. Coleman v. Attridge Law and Steve Law* [GC], 17 July 2008.

100 ECtHR, *Case "Relating to certain aspects of the laws on the use of languages in education in Belgium" v. Belgium*, Nos. 1474/62, 1677/62, 1691/62, 1769/63, 1994/63 and 2126/64, 23 July 1968.

101 ECtHR, *Fabris v. France* [GC], No. 16574/08, 7 February 2013.

102 *Ibid.*

103 ECtHR, *Mazurek v. France*, No. 34406/97, 1 February 2000.

been discriminatory, since it had no objective and reasonable justification. The Court found that it was in breach of Article 14 of the ECHR taken in conjunction with Article 1 of Protocol No. 1 to the ECHR.[104]

For children with disabilities, the ECSR holds that in the application of Article 17 (2) of the ESC it is acceptable to make a distinction between children with and without disabilities. It should, nevertheless, be the norm to integrate children with disabilities into mainstream schools, in which arrangements are made to cater for their special needs, and specialised schools should be the exception.[105] In addition, children attending special education schools that conform with Article 17 (2) of the ESC must be given sufficient instruction and training, so that proportionally an equivalent number of children in specialised schools and in mainstream schools complete their schooling.[106] The rights of children in relation to education are further addressed in Section 8.2.

Under UN law, Article 2 of the CRC prohibits discrimination against children on a non-exhaustive list of grounds, specifically listing 'birth' as one of them. Article 2 provides that:

> *1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.*
>
> *2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.*

104 ECtHR, *Fabris v. France* [GC], No. 16574/08, 7 February 2013.

105 ECSR, *International Association Autism Europe (IAAE) v. France*, Complaint No. 13/2002, 4 November 2003.

106 ECSR, *Mental Disability Advocacy Center (MDAC) v. Bulgaria*, Complaint No. 41/2007, 3 June 2008.

4 Personal identity issues

EU	Issues covered	CoE
	Birth registration and right to a name	ECtHR, *Johansson v. Finland*, No. 10163/02, 2007 (refusal to register a name previously granted to other persons) FCNM, Article 11 (right to use the surname in original language) European Convention on the Adoption of Children (Revised), Article 11 (3) (retaining the original name of an adopted child)
	Right to personal identity	ECHR, Articles 6 (fair trial) and 8 (right to respect for private and family life) ECtHR, *Gaskin v. the United Kingdom*, No. 10454/83, 1989 (refusal of access to child care records) ECtHR, *Mizzi v. Malta*, No. 26111/02, 2006 (inability to challenge paternity) ECtHR, *Mennesson v. France*, No. 65192/11, 2014 (surrogacy with biological father as intended father) ECtHR, *Godelli v. Italy*, No. 33783/09, 2012 (non-identifying information about birth mother) European Convention on the Adoption of Children (Revised), Article 22
	Identity theft	ECtHR, *K.U. v. Finland*, No. 2872/02, 2008 (advertisement placed on the internet without the knowledge of the victim)

EU	Issues covered	CoE
CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 2004 (residence right of the primary care giver of a child, citizen of the EU) CJEU, C-34/09, *Gerardo Ruiz Zambrano v. Office National de l'Emploi (ONEm)*, 2011 (residence rights of TCN with minor EU citizen children)	**Citizenship**	ECtHR, *Genovese v. Malta*, No. 53124/09, 2011 (arbitrary denial of citizenship to child born out of wedlock) European Convention on Nationality CoE Convention on the Avoidance of Statelessness in Relation to State Succession
	Identity as member of national minority	FCNM, Article 5 (1) (preservation of the essential elements of the identity)

Issues of personal identity have generally not been addressed at EU level, in view of the EU's limited competence in that area. However, the CJEU has incidentally ruled on the right to a name (particularly the right to have the name which has been recognised in one EU Member State also recognised in others) from the perspective of the freedom of movement principle. Citizenship and residency aspects have also been adjudicated in light of Article 20 of the TFEU. The CoE, on the other hand, in particular through the case law of the ECtHR, has interpreted and developed the application of several fundamental rights in the area of personal identity. Therefore, with the exception of several areas in which issues of personal identity have been addressed at EU level, the following sections deal only with CoE law.

This chapter does not refer to a specific fundamental right. Rather, it provides a cross-section of fundamental rights issues that are related to identity, such as birth registration and the right to a name (Section 4.1); the right to personal identity (Section 4.2); identity theft (Section 4.4); the right to citizenship (Section 4.5); and the identity of children belonging to national minorities (Section 4.6). Several related issues are dealt with in other chapters, in particular concerning sexual abuse (Section 7.1.3) or data protection (Chapter 10). Some of these rights, such as the right to a name, have mainly been claimed as parental rights, but the approach could easily be transposed to children themselves, given the implications for their own rights.

4.1. Birth registration and the right to a name

Key point

- Refusal to register a first name not unsuitable for a child which has already gained acceptance may be in breach of Article 8 of the ECHR (right to respect for private and family life).

Unlike UN treaties (e.g. Article 24 (2) of the International Covenant on Civil and Political Rights (ICCPR), Article 7 (1) of the CRC and Article 18 of the Convention on the Rights of Persons with Disabilities (CRPD)), the European instruments on fundamental rights do not explicitly provide for the right to birth registration immediately after birth or the right to a name from birth.

Under EU law, the right to a name has been addressed from the perspective of the freedom of movement. The CJEU holds that freedom of movement precludes an EU Member State from refusing to recognise a child's surname as registered in another Member State of which the child is a national or where the child was born and had resided.[107]

Under CoE law, refusal of birth registration of children may raise an issue under Article 8 of the ECHR.

First, the ECtHR found that the name as "a means of identifying persons within their families and the community" falls within the scope of the right to respect for private and family life as enshrined in Article 8 of the ECHR.[108] The parents' choice of their child's first name[109] and family name[110] is part of their private life. The Court has held that the refusal of state authorities to register a chosen forename based on the likely harm or prejudice that the name might cause the

107 See CJEU, C-148/02, *Carlos Garcia Avello v. Belgian State*, 2 October 2003; CJEU, C-353/06, *Stefan Grunkin and Dorothee Regina Paul* [GC], 14 October 2008.

108 ECtHR, *Guillot v. France*, No. 22500/93, 24 October 1993, para. 21.

109 ECtHR, *Johansson v. Finland*, No. 10163/02, 6 September 2007, para. 28; ECtHR, *Guillot v. France*, No. 22500/93, 24 October 1993, para. 22.

110 ECtHR, *Cusan and Fazzo v. Italy*, No. 77/07, 7 January 2014, para. 56.

child did not violate Article 8 of the ECHR.[111] Refusal to register a first name, however, that is not unsuitable for a child and that has already gained acceptance may be in breach of Article 8 of the ECHR.

> Example: In *Johansson v. Finland*,[112] the authorities refused to register the forename "Axl Mick", because the spelling did not comply with the Finnish naming practice. The ECtHR accepted that due regard had to be given to the child's best interests, and that the preservation of the national naming practice was in the public interest. It found, however, that the name had been accepted for official registration in other cases and could therefore not be considered unsuitable for a child. Since the name had already gained acceptance in Finland and it had not been contended that this name had negatively affected the cultural and linguistic identity of the state, the ECtHR concluded that the public-interest considerations did not outweigh the interest of having the child registered under the name chosen. The Court thus found that there had been a violation of Article 8 of the ECHR.

The ECtHR has also found that a rule stating that the husband's family name should be given to legitimate children at the moment of birth registration does not in itself violate the ECHR. However, the impossibility to derogate from this general rule was found to be excessively rigid and discriminatory for women, and therefore in violation of Article 14, taken in conjunction with Article 8 of the ECHR.[113]

Article 11 of the FCNM provides that every person belonging to a national minority has the right to use his or her surname (patronym) and first names in his or her minority language, as well as the right to have it officially recognised, albeit subject to modalities provided for in the legal system.

Article 11 (3) of the Revised European Convention on the Adoption of Children provides for the possibility for States Parties to keep the original surname of an adopted child (Adoption Convention).[114] This is an exception to the general principle that the legal relationship between the adopted child and his or her original family is severed.

111 ECtHR, *Guillot v. France*, No. 22500/93, 24 October 1993, para. 27.

112 ECtHR, *Johansson v. Finland*, No. 10163/02, 6 September 2007.

113 ECtHR, *Cusan and Fazzo v. Italy*, No. 77/07, 7 January 2014, para. 67.

114 Council of Europe, European Convention on the Adoption of Children (Revised), CETS No. 202, 2008.

4.2. Right to personal identity

Key points

- The right to know one's origins falls within the scope of a child's private life.
- The establishment of paternity requires carefully balancing the child's interest in knowing his or her identity with the interest of the presumed or alleged father, and with the general interest.
- Anonymous births may be permissible under Article 8 of the ECHR (right to respect for private and family life) provided that the child can at least obtain non-identifying information about the mother and that there is a possibility of seeking a confidentiality waiver by the mother.
- An adopted child has the right to access information concerning his or her origins. Biological parents may be granted a legal right not to disclose their identity, but this does not amount to an absolute veto.

Under CoE law, according to the ECtHR, Article 8 of the ECHR includes the right to identity and personal development. Details of a person's identity and the interest "in obtaining information necessary to discover the truth concerning important aspects of one's personal identity, such as the identity of one's parents"[115] have been considered relevant to personal development. Birth and the circumstances of birth form part of a child's private life. "[I]nformation concerning highly personal aspects of [one's] childhood, development and history" can constitute a "principal source of information about [one's] past and formative years",[116] so that lack of access to that information by the child raises an issue under Article 8 of the ECHR.

Under international law, Article 8 of the CRC provides for a high and rather detailed level of protection of the right to preserve a child's identity. It protects against unlawful interference with the preservation of identity, including nationality, name and family relations, as recognised by law. It also guarantees "appropriate assistance and protection" where a child is illegally deprived of some or all elements of his or her identity, with a view to speedily re-establish that identity.

115 ECtHR, *Odièvre v. France* [GC], No. 42326/98, 13 February 2003, para. 29.

116 ECtHR, *Gaskin v. the United Kingdom*, No. 10454/83, 7 July 1989, para. 36.

4.2.1. Establishing paternity

Under CoE law, children have complained to the ECtHR about the impossibility of determining the identity of their natural fathers. The ECtHR held that the determination of the legal relationship between a child and the alleged natural father was part of the scope of private life (Article 8 of the ECHR). Affiliation is a fundamental aspect of one's identity.[117] A child's interest in establishing paternity, however, must be balanced against the interests of the presumed father as well as the general interest. Indeed, a child's interest in having legal certainty about his or her paternal affiliation does not trump a father's interest in rebutting the legal presumption of paternity.

Example: In *Mikulić v. Croatia*,[118] the applicant was born out of wedlock and instituted proceedings for establishment of paternity against her presumed father. The respondent refused to appear on several occasions for court-ordered DNA testing, which led to unnecessary protraction of the paternity proceedings for about five years. The ECtHR held that if under domestic law alleged fathers could not be compelled to undergo medical testing, states had to provide for alternative means allowing for the swift identification of natural fathers by an independent authority. It found a violation of Article 8 of the ECHR in the applicant's case.

Example: In *Mizzi v. Malta*,[119] the presumed father was unable to deny paternity of a child born by his wife since the legally prescribed six-month time limit had elapsed. The ECtHR examined the case under both Articles 6 (right to a fair trial) and 8 (respect of private and family life) of the ECHR. It noted that introducing a time-limit within which a presumed father must take action to disavow a child aims to ensure legal certainty and protect the interest of the child to know his or her identity. These aims, however, do not outweigh the right of the father to have the opportunity to deny paternity. The practical impossibility of denying paternity since birth had in this case put an excessive burden on the presumed father, in violation of his right of access to a court and a fair trial as enshrined in Article 6 of

117 ECtHR, *Mennesson v. France*, No. 65192/11, 26 June 2014, para. 96.

118 ECtHR, *Mikulić v. Croatia*, No. 53176/99, 7 February 2002, paras. 64–65.

119 ECtHR, *Mizzi v. Malta*, No. 26111/02, 12 January 2006.

the ECHR. It had also disproportionately interfered with his rights under Article 8 of the ECHR.[120]

The interests of a child seeking to ascertain paternity and the interests of the biological father may sometimes coincide. This occurred in a situation where a father, due to his lack of legal capacity, was unable to institute proceedings at the domestic level to establish affiliation with his child. The ECtHR found that it was not in the best interests of a child born out of wedlock that his biological father was unable to institute proceedings to have his paternity established, and that the child was therefore entirely dependent on the discretion of state authorities to have its affiliation established.[121]

Authorities may have a positive obligation to intervene in proceedings to establish paternity in the best interests of the child when the legal representative (in this case the mother) of the child is unable to properly represent the child, for instance because of a serious disability.[122]

With regard to the specific case of recognition of affiliation between intended parents and children born out of surrogacy, the Court accepted in principle that states have a wide margin of appreciation, since there is no European consensus on allowing or recognising affiliation in surrogacy arrangements. The fact, however, that affiliation is a fundamental aspect of a child's identity reduces that margin of appreciation.

Example: *Mennesson v. France*[123] concerns the refusal of French authorities to register children born out of surrogacy in the United States in the French birth register on public policy grounds. The ECtHR found no violation of the applicants' right to respect for family life, concluding that they were in no way prevented from enjoying family life in France and that administrative obstacles they might have faced had not been insurmountable. With regard to the right to respect for the private life of the children, the Court attached great importance to their best interests. It particularly emphasised that the man who was intended to be registered as the children's father on the certificate was also their biological father. To deny a child

120 *Ibid.*, paras. 112–114.

121 ECtHR, *Kruškovic v. Croatia*, No. 46185/08, 21 June 2011, paras. 38–41.

122 ECtHR, *A.M.M. v. Romania*, No. 2151/10, 14 February 2012, paras. 58–65 (available in French).

123 ECtHR, *Mennesson v. France*, No. 65192/11, 26 June 2014.

legal affiliation when a biological affiliation is established and when the parent concerned claims full recognition cannot be held to be in conformity with the best interests of the children. The Court therefore found a violation of Article 8 of the ECHR in respect of the "private life" complaint of the children.[124]

4.2.2. Establishing maternity: anonymous birth

Under CoE law, a child's interest in knowing his or her origins, and in particular his or her mother, must be balanced with other private and public interests, such as the interests of the family or families involved, the public interest of preventing illegal abortions, child abandonment or the protection of health. Cases where the birth mother decides to remain anonymous, but the child can at least obtain non-identifying information about the birth mother and the child has the possibility to seek a confidentiality waiver from the mother, might be in conformity with Article 8 of the ECHR.[125]

Example: In *Godelli v. Italy*,[126] the applicant was abandoned at birth by her mother, who did not consent to being named on the birth certificate. The applicant could not access non-identifying information concerning her origins nor could she obtain disclosure of her mother's identity. The ECtHR found a violation of Article 8 of the ECHR, because the state did not strike a proper balance between the competing interests of birth mother and child.

4.3. Establishing one's origin: adoption

A child's right to know his or her origins has gained particular prominence in the context of adoption. The substantive guarantees related to adoption, outside the right to know one's origins, are dealt with in Section 6.3.

Under CoE law, Article 22 (3) of the European Convention on the Adoption of Children (revised) is a fairly robust provision on the adopted child's right to access information held by the authorities concerning his or her origins. It allows

124 *Ibid*., para. 100; see also ECtHR, *Labassee v. France*, No. 65941/11, 26 June 2014, para. 79.

125 ECtHR, *Odièvre v. France* [GC], No. 42326/98, 13 February 2003, paras. 48–49.

126 ECtHR, *Godelli v. Italy*, No. 33783/09, 25 September 2012, para. 58.

for States Parties to grant the parents of origin a legal right not to disclose their identity, as long as it does not amount to an absolute veto. The competent authority must be able to determine whether it overrides the parents of origin's right and can disclose identifying information in light of the circumstances and the respective rights at stake. In the case of full adoption, the adopted child must at least be able to obtain a document attesting the date and place of birth.[127]

Under international law, the Hague Convention on Inter-Country Adoption provides for the possibility for an adopted child to access information about the identity of his or her parents "under appropriate guidance", but leaves it to each State Party to allow for it, or not.[128]

4.4. Identity theft

Key point

- Practical and effective protection must be ensured against identity theft of children.

Identity theft concerns situations where a child's name is used without his or her knowledge.

Under CoE law, the ECtHR has dealt with identity theft under Article 8 of the ECHR on the right to respect for private and family life. It held that states are obliged to ensure the practical and effective protection of children against identity theft, and that states must take effective steps to identify and prosecute the perpetrator.[129]

127 Council of Europe, European Convention on the Adoption of Children (Revised), CETS No. 202, 2008, Art. 22.

128 Hague Conference on Private International Law, Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption, 29 May 1993, Art. 30 (2).

129 ECtHR, *K.U. v. Finland*, No. 2872/02, 2 December 2008, para. 49.

Example: In *K.U. v. Finland*,[130] an advertisement was placed on an internet dating website in the name of a 12-year-old boy, without his knowledge. It mentioned his age, telephone number, physical description and contained a link to a webpage containing his picture. The advertisement was of a sexual nature, suggesting that the boy was looking for an intimate relationship with a boy of his age or older, thus making him a target for paedophiles. The identity of the person who placed the advertisement could not be obtained from the internet provider due to the legislation in place. The ECtHR held that the positive obligation under Article 8 of the ECHR not only to criminalise offences but also to effectively investigate and prosecute them, assumes even greater importance when the physical and moral welfare of a child is threatened. In this case, the Court found that by being exposed as a target for paedophiliac approaches on the internet the child's physical and moral welfare was threatened. There was consequently a breach of Article 8 of the ECHR.

Aspects related to identity theft are closely related to child pornography and grooming. These are dealt with in Section 7.2.

4.5. Right to citizenship

Key points

- The right of residence within the EU of children who are EU citizens should not be deprived of any useful effect by refusing residence rights to their parent(s).
- The ECHR does not guarantee the right to citizenship, but an arbitrary refusal of citizenship may fall under Article 8 of the ECHR (right to respect for private and family life) due to its impact on an individual's private life.

Under EU law, Article 20 (1) of the TFEU grants the status of EU citizen to every Member State national of the EU. The CJEU ruled on the effectiveness of the right of residence of children who have EU citizenship but not the nationality of the EU Member State where they reside. At stake was the refusal of residence rights within the EU to a parent who was the carer of a child with EU citizenship. The CJEU held that the refusal of residence rights to a parent who is the

130 ECtHR, *K.U. v. Finland*, No. 2872/02, 2 December 2008.

primary caregiver of a child deprives the child's right of residence of any useful effect. Hence, the parent who is the primary caregiver has the right to reside with the child in the host state.[131] These aspects are addressed in more detail in Section 9.5.

Under CoE law, the ECHR does not guarantee the right to citizenship.[132] An arbitrary refusal of citizenship, however, may come within the scope of Article 8 of the ECHR because of its impact on an individual's private life, which embraces aspects of a child's social identity[133] – which here refers to the identity a child has in society.

> Example: In *Genovese v. Malta*, Maltese citizenship was denied to a child born out of wedlock outside of Malta to a non-Maltese mother and a judicially-recognised Maltese father. The refusal of citizenship as such did not violate Article 8 of the ECHR. The arbitrary denial of citizenship on the ground of birth out of wedlock, however, raised questions of discrimination. Arbitrary differential treatment on this ground requires weighty reasons by way of justification. In the absence of such reasons, a violation of Article 8 together with Article 14 of the ECHR was found.[134]

A key concern in treaty provisions on the right to acquire citizenship is the avoidance of statelessness. The European Convention on Nationality contains detailed provisions on children's legal acquisition of nationality, and restricts the possibilities for children to lose citizenship.[135] The CoE Convention on the Avoidance of Statelessness in Relation to State Succession contains an obligation to avoid statelessness at birth (Article 10) and provides for the right to the nationality of the successor state in case of statelessness (Article 2).[136] Article 12 of the Revised European Convention on Adoption also echoes the concern to avoid statelessness; states have to facilitate the acquisition of their nationality by a child adopted by one of their nationals, and loss of nationality

131 CJEU, C-200/02, *Kunqian Catherine Zhu and Man Lavette Chen v. Secretary of State for the Home Department*, 19 October 2004, paras. 45–46.

132 ECtHR, *Slivenko and Others v. Latvia* [GC], Decision on admissibility, No. 48321/99, 23 January 2002, para. 77.

133 ECtHR, *Genovese v. Malta*, No. 53124/09, 11 October 2011, para. 33.

134 *Ibid.*, paras. 43–49.

135 Council of Europe, European Convention on Nationality, CETS No. 166, 1997, Arts. 6 and 7.

136 Council of Europe, Convention on the Avoidance of Statelessness in relation to State Succession, CETS No. 200, 2006.

as a consequence of adoption is conditional upon possession or acquisition of another nationality.

Under international law, Article 7 of the CRC guarantees the right to acquire a nationality, as does Article 24 (3) of the ICCPR.

4.6. Identity of children belonging to national minorities

Key point

- A child belonging to a national minority has the right to enjoy his or her own culture, profess and practice his or her own religion, and use his or her own language.[136]

Under EU law, no particular attention has been paid to the identity of children belonging to national minorities from a fundamental rights' perspective. Furthermore, there is no leading jurisprudence in the EU that adds to the CoE standards.

Under CoE law, Article 5 (1) of the FCNM explicitly mentions that States Parties undertake to preserve the essential elements of the identity of persons belonging to national minorities, i.e. their religion, language, traditions and cultural heritage. There is no child-specific provision in the FCNM. The question of language in education is dealt with in Section 8.2.

Under international law, Article 30 of the CRC guarantees to a child belonging to a national minority or an indigenous child the right "to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language" in community with other members of his or her group.

137 On other aspects of economic, social and cultural rights, see further Chapter 8.

5 Family life

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 7 (right to respect for family life)	Right to respect for family life	ECHR, Article 8 (right to respect for family life)
Charter of Fundamental Rights, Article 24 (rights of the child) Maintenance Regulation (4/2009)	Right to be cared for by parents	ECtHR, *R.M.S. v. Spain*, No. 28775/12, 2013 (deprivation of contact with daughter)
Charter of Fundamental Rights, Article 24 (3) (right to maintain contact with both parents) Brussels II bis Regulation (2201/2003) Mediation Directive (2008/52/EC)	Right to maintain contact with both parents	Convention on Contact concerning Children
Access to Justice Directive (2002/8/EC) (access to justice in cross border disputes)	Parental separation	ECtHR, *Levin v. Sweden*, No. 35141/06, 2012 (restriction of contact rights) ECtHR, *Schneider v. Germany*, No. 17080/07, 2011 (contact between a child and non-legally recognised father). ECtHR, *Sommerfeld v. Germany* [GC], No. 31871/96, 2003 (contact between father and daughter) ECtHR, *Mustafa and Armağan Akin v. Turkey*, No. 4694/03, 2010 (contact between siblings after custody award) ECtHR, *Vojnity v. Hungary*, No. 29617/07, 2013 (restriction on access on the ground of religious convictions)

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 24 (rights of the child) Brussels II bis Regulation (2201/2003) CJEU, C211/10 PPU, *Doris Povse v. Mauro Alpago*, 2010 (enforcement certificate)	**Child abduction**	Convention on Contact concerning Children ECtHR, *Neulinger and Shuruk v. Switzerland* [GC], No. 41615/07, 2010 (taking of child by mother) ECtHR, *X v. Latvia* [GC], No. 27853/09, 2013 (grave risk in case of child's return under Hague Convention)

European law – both EU and CoE – provides for the right to respect for family life (Article 7 of the EU Charter of Fundamental Rights; Article 8 of the ECHR). The EU's competence in matters of family life relates to cross-border disputes, including recognition and enforcement of judgments across Member States. The CJEU deals with matters such as the child's best interests and the right to family life as laid down in the EU Charter of Fundamental Rights, relative to the Brussels II bis Regulation. ECtHR case law relating to family life recognises interdependent rights, such as the right to family life and the right of the child to have their best interests, as a primary consideration. It acknowledges that children's rights are sometimes conflicting. The right of the child to respect for family life, for instance, may be limited to secure their best interests. Further, the CoE has adopted various other instruments which deal with matters related to contact, custody and exercise of children's rights.

This chapter examines the child's right to respect for family life and associated rights, especially the content and scope of these rights as well as the associated legal obligations and their interaction with other rights. Specific aspects addressed include the right to respect for family life and its limitations (Section 5.1), the right of the child to be cared for by his/her parents (Section 5.2), the right to maintain contact with both parents (Section 5.3) and child abduction (Section 5.4).

5.1. Right to respect for family life

Key points

- States have positive obligations to ensure children's effective enjoyment of their right to respect for family life.
- Under both EU and CoE law, judicial and administrative authorities should take into account the child's best interests in any decision related to the child's right to respect for his/her family life.

The child's right to respect for family life includes a number of composite rights, such as: the child's right to be cared for by his/her parents (Section 5.2); the right to maintain contact with both parents (Section 5.3); the right not to be separated from parents except where it is in the child's best interests (Section 5.4 and Chapter 6); and the right to family reunification (Chapter 9).

Under both EU law and CoE law, the right to respect for family life is not absolute, and subject to a number of limitations. These limitations, as the explanatory note to the EU Charter of Fundamental Rights[138] clarifies, are the same as for the corresponding provision of the ECHR, specifically Article 8 (2), that is: in accordance with the law and necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.[139]

The EU Charter of Fundamental Rights expressly incorporates within this right an obligation to consider the best interests of the child (Article 24 (2)).[140] Even though the obligation to observe the child's best interests is not expressly laid down under the ECHR, the ECtHR incorporates that obligation in its case law.[141]

138 European Parliament, Council of the European Union, European Commission (2007), "*Explanations relating to the Charter of Fundamental Rights*", 2007/C 303/02, OJ 2007 C 303, 14 December 2007, pp. 17–35, see explanation relating to Art. 7.

139 Council of Europe, Convention for the Protection of Human Rights and Fundamental Freedoms, CETS No. 5, 1950, Art. 8.

140 CJEU, C400/10 PPU, *J. McB. v. L.E.*, 5 October 2010.

141 See, for example, ECtHR, *Ignaccolo-Zenide v. Romania*, No. 31679/96, 25 January 2000, para. 94.

5.2. Right of the child to be cared for by his/her parents

Key points

- EU law regulates procedural aspects of the child's right to be cared for by his/her parents.
- Under the ECHR, states have negative and positive duties to respect children's and parents' rights to family life.

The right of children to know the identity of their parents and the right to be cared for by them are two core components of children's right to respect for family life. They are to an extent interdependent: children's right to know their parents is ensured through parental care. Sometimes, however, these rights are distinct - for example, for children who are adopted or born as a result of medically-assisted procreation. Here the right is more closely associated with the child's right to identity, as expressed by knowing his/her biological parentage, and is therefore considered in Chapter 4. The focus of this section is on the second right: the right of the child to be cared for by his/her parents.

Under EU law, there are no provisions dealing with the substantive scope of the right to be cared for by parents. EU instruments may deal with cross-border aspects, such as recognition and enforcement of judgements across Member States. Regulation 4/2009 on jurisdiction, applicable law, recognition and enforcement of decisions and cooperation in matters relating to maintenance (Maintenance Regulation), for instance, covers cross-border maintenance applications arising from family relationships.[142] It establishes common rules for the entire EU, aiming to ensure the recovery of maintenance claims even where the debtor or creditor is in another country.

Under CoE law, the ECtHR has underscored that Article 8 of the ECHR primarily establishes the duty of the state not to intervene in family life.[143] However, states

142 Council of the European Union (2008), Council Regulation (EC) No. 4/2009 of 18 December 2008 on jurisdiction, applicable law, recognition and enforcement of decisions and cooperation in matters relating to maintenance, OJ 2008 L 7 (Maintenance Regulation).

143 ECtHR, *R.M.S. v. Spain*, No. 28775/12, 18 June 2013, para. 69.

also have a positive obligation to take the necessary measures to both support parents and families and to protect children against potential abuse.[144] Children should only be separated from their parents in exceptional circumstances. In these cases, everything must be done to preserve personal relations and, when appropriate, to 'rebuild' the family. States enjoy a wide margin of appreciation when taking the initial decision to separate children from their parents.[145] However, stricter scrutiny is called for regarding any further limitations, such as restrictions placed on parental rights of access, and any legal safeguards designed to secure the effective protection of the right of parents and children to respect for their family life. Such further limitations entail the danger that the family relations between a young child and one or both parents would be effectively curtailed. Equally, when it comes to separating mothers from new-born babies, the reasons put forth by the state must be extraordinarily compelling.[146]

The margin of appreciation decreases with the amount of time children are separated from their parents, and state authorities should put forward strong reasons to support their decision to maintain the separation.[147] The ECtHR analyses whether the decision-making process was fair and whether all parties involved were given the opportunity to present their case.

Example: In *R.M.S. v. Spain*[148], the applicant argued that she had been deprived of all contact with her daughter from the age of three years and 10 months onwards on the basis of her socio-economic status. In finding a violation of Article 8 of the ECHR, the Court stressed that "the Spanish administrative authorities should have considered other less drastic measures than taking the child into care". It also stated that: "The role of the social welfare authorities is precisely to help persons in difficulty [...], to provide them with guidance and to advise them on matters such as the different types of benefits available, the possibility of obtaining social housing and other means of overcoming their difficulties, such as those originally sought by the applicant." Accordingly, the ECtHR held "that the Spanish authorities failed to undertake appropriate and sufficient efforts to secure the applicant's right to live with her child".[149]

144 *Ibid.*, para. 69 and following.

145 ECtHR, *Y.C. v. the United Kingdom*, No. 4547/10, 13 March 2012, para. 137.

146 ECtHR, *K. and T. v. Finland* [GC], No. 25702/94, 12 July 2001, para. 168.

147 ECtHR, *Y.C. v. the United Kingdom*, No. 4547/10, 13 March 2012, para. 137.

148 ECtHR, *R.M.S. v. Spain*, No. 28775/12, 18 June 2013.

149 *Ibid.*, paras. 86 and 93.

Under international law, Article 5 of the CRC provides that "States Parties shall respect the responsibilities, rights and duties of parents, [...] to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention". Furthermore, Article 9 of the CRC states that a child shall not be separated from his/her parents against his/her will, and that all parties must be given the opportunity to participate in any proceedings relating to this situation. The UN Guidelines on Alternative Care further substantiate the rights of children in these circumstances and the corresponding duties of states.[150]

5.3. Right to maintain contact with both parents

Key points

- The right of the child to maintain contact with both parents subsists in all forms of parental separation: family-related and state-sanctioned.
- The process of ensuring the right of the child to maintain contact with his/her parents and family reunification requires regard for the best interests of the child as a primary consideration, giving due weight to the views of the child in accordance with his/her age and maturity.

The scope of the right to maintain contact with parents differs depending on the context. In the event of a decision of the parents to separate from each other, the scope is broader and normally limited only by the best interests of the child. In the context of a state-sanctioned separation resulting from, for instance, expulsion or imprisonment of a parent, state authorities act in furtherance of a protected interest, and must strike a fair balance between the interests of the parties and the obligation to ensure the best interests of the child. The right of children to maintain contact with both parents is applicable in both instances.

Under EU law, Article 24 (3) of the EU Charter of Fundamental Rights expressly recognises every child's right to maintain contact with both parents. The

150 UN, Human Rights Council (2009), *UN Guidelines for the Alternative Care of Children*, UN Doc. A/HRC/11/L.13, 15 June 2009.

provision's wording clarifies the content of the right, particularly the meaning of contact, which must: occur on a *regular basis*; allow the development of a *personal relationship*; and be in the form of *direct contact*. There is, however, a caveat: the right of each child to maintain contact with her or his parents is expressly limited by their best interests. This provision, as the explanatory note to the Charter clarifies, is expressly informed by Article 9 of the CRC.

In line with EU competences (see Chapter 1), there has been a specific focus on judicial cooperation (with the objective of creating an area of freedom, security and justice in which the free movement of persons is ensured). Two EU instruments are of particular relevance: Council Regulation (EC) No. 2201/2003[151] (Brussels II bis), and European Parliament and Council Directive 2008/52/EC (Mediation Directive).[152] From a rights perspective, the Brussels II bis Regulation is significant. First, it applies to *all* decisions on parental responsibility, irrespective of marital status. Second, the rules relating to jurisdiction (determined for the most part by the child's habitual residence) are expressly informed by the best interests of the child; and third, there is particular regard for ensuring the respect of children's views.[153]

CJEU jurisprudence in cases of wrongful removal of a child following a decision taken unilaterally by one of the parents has primarily aimed to uphold the fundamental right of the child to maintain on a regular basis a personal relationship and direct contact with both parents (Article 24 (3) of the Charter), as the Court asserts that this right undeniably merges into the best interests of any child. In the CJEU's view, a measure that prevents the child to maintain on a regular basis a personal relationship and direct contact with both parents can be justified only by another interest of the child of such importance that it takes priority over the interest underlying that fundamental right.[154] This includes provisional, including protective, measures under Article 20 of the Brussels II bis Regulation. The Court ruled that a balanced and reasonable

151 Council of the European Union (2003), Council Regulation (EC) No. 2201/2003 of 27 November 2003 concerning jurisdiction and the recognition and enforcement of judgments in matrimonial matters and the matters of parental responsibility, repealing Regulation (EC) No 1347/2000, OJ 2003 L 338 (Brussels II bis).

152 European Parliament, Council of the European Union (2008), Directive 2008/52/EC of the European Parliament and the Council of 21 May 2008 on certain aspects of mediation in civil and commercial matters, OJ 2008 L 136/3 (*Mediation Directive*).

153 See, for example, Council Regulation (EC) No. 2201/2003, Preamble (paras. 5, 12, 13 and 19) and Articles 8, 41 (2) (c) and 42 (2) (a).

154 CJEU, C-403/09 PPU, *Jasna Detiček v. Maurizio Sgueglia*, 23 December 2009, para. 59.

assessment of all the interests involved, which must be based on objective considerations relating to the actual person of the child and his or her social environment, must in principle be performed in proceedings in accordance with the provisions of Brussels II bis Regulation.[155]

> Example: The case of *E. v. B.*[156] concerns proceedings between Mr. E. (the father) and Ms. B. (the mother), in relation to the jurisdiction of the courts of the United Kingdom to hear and determine the usual place of residence of their child, S., and the rights of access of the father. The parents had signed an agreement before a Spanish court whereby the mother had custody, and access was granted to the father. Subsequently, the mother sought to reduce the rights of access which had been granted to the father by that agreement. The father submitted an application before the High Court seeking the enforcement of the Spanish agreement. The mother submitted that she had prorogued the jurisdiction of the Spanish court and sought to transfer the prorogued jurisdiction to the courts of England and Wales. On the father's appeal, the Court of Appeal referred several questions to the CJEU concerning the interpretation of Article 12 (3) of the Brussels II bis Regulation. The CJEU held that where a court is seized of proceedings in accordance with Article 12 (3) of the Brussels II bis Regulation, the best interests of the child can only be safeguarded by a review, in each specific case, of the question of whether the prorogation of jurisdiction which is sought is consistent with the child's best interests. A prorogation of jurisdiction is valid only in relation to the specific proceedings for which the court whose jurisdiction is prorogued is seized. After the final conclusion of the proceedings from which the prorogation of jurisdiction derives, that jurisdiction comes to an end, in favour of the court benefiting from a general jurisdiction under Article 8 (1) of the Brussels II bis Regulation.

With regard to parental responsibility, Brussels II bis co-exists with the Hague Convention on jurisdiction, applicable law, recognition, enforcement and cooperation in respect of parental responsibility and measures for the protection of children.[157] Pursuant to Article 61, Brussels II bis shall take precedence over

155 *Ibid.*, para. 60.

156 CJEU, C-436/13, *E. v. B.*, 1 October 2014 (summary adjusted from http://cases.iclr.co.uk).

157 The World Organisation for Cross-border Cooperation in Civil and Commercial Matters (1996), Hague Conference on private international law, Convention on Jurisdiction, Applicable Law, Recognition, Enforcement and Co-Operation in respect of Parental Responsibility and Measures for the Protection of Children, 19 October 1996.

the Hague Convention: (a) if the child concerned has her or his habitual residence on the territory of a Member State or (b) as concerns the recognition and enforcement of a judgment rendered in a court of a Member State on the territory of another Member State, even if the child concerned has her or his habitual residence on the territory of a third state which is a contracting Party to the Hague Convention. Therefore, a key issue under the Brussels II bis Regulation is the determination of the habitual residence of the child.

Example: In *Mercredi v. Chaffe,*[158] the Court of Appeal of England and Wales referred a case to the CJEU concerning the removal of a two-month-old child from the United Kingdom to the French island of Réunion. The CJEU ruled that the concept of habitual residence, for the purposes of Articles 8 and 10 of the Brussels II bis Regulation corresponds to the place which reflects some degree of integration by the child in a social and family environment. Where the situation concerns an infant who has been staying with his/her mother only a few days in a Member State – other than that of his/her habitual residence – to which he/she was removed, the factors that must be taken into consideration include: first, the duration, regularity, conditions and reasons for the stay in the territory of that EU Member State and for the mother's move to that state; and second, with particular reference to the child's age, the mother's geographic and family origins, and the family and social connections which the mother and child have with that Member State.

Also of particular relevance for the enjoyment of the right to maintain contact with both parents in cross-border disputes are the instruments related to regulating access to justice that clarify how to handle complex disputes, such as Council Directive 2002/8/EC (Access to Justice Directive), which requires "improv[ing] access to justice in cross-border disputes by establishing minimum common rules relating to legal aid for such disputes".[159] The purpose of this directive is to: improve access to justice in cross-border civil cases by establishing common minimum rules relating to legal aid; ensure that appropriate legal aid is granted, under certain conditions, to persons who cannot meet the cost of proceedings on account of their financial situation; and facilitate compatibil-

158 CJEU, C-497/10 PPU, *Barbara Mercredi v. Richard Chaffe*, 22 December 2010.

159 Council of the European Union (2003), Council Directive 2002/8/EC of 27 January 2003 to improve access to justice in cross-border disputes by establishing minimum common rules relating to legal aid for such disputes, OJ 2003 L 026 (Access to justice directive).

ity of national laws in this matter and to provide for cooperation mechanisms between the authorities of the Member States.

Under CoE law, the right of each child to maintain contact with both parents is implicit in Article 8 of the ECHR. The ECtHR affirms that "the mutual enjoyment by parent and child of each other's company constitutes a fundamental element of family life".[160] It also emphasises, however, that this right may be limited by the best interests of the child (see Section 5.4 and Chapter 6). This right is at the centre of judicial decision-making about custody of and contact with children.

In a series of cases, the ECtHR has either expressly or implicitly referred to the best interests of the child within the context of custody and contact.

> Example: In *Schneider v. Germany*,[161] the applicant had a relationship with a married woman and claimed to be the biological father of her son, whose legally recognised father was the mother's husband. The applicant argued that the decision of the domestic courts to dismiss his application for contact with the child and information about the child's development on the basis that he was neither the child's legal father nor had a relationship with the child violated his rights under Article 8 of the ECHR. In finding a violation, the ECtHR focused on the failure of the domestic courts to give any consideration to the question of whether, in the particular circumstances of the case, contact between the child and the applicant would have been in the child's best interest.[162] As regards the applicant's request for information about the child's personal development, the Court held that the domestic courts failed to give sufficient reasons to justify their interference for the purposes of Article 8 (2)[163] and that, therefore, the interference had not been "necessary in a democratic society".

160 ECtHR, *K. and T. v. Finland* [GC], No. 25702/94, 12 July 2001, para. 151.

161 ECtHR, *Schneider v. Germany*, No. 17080/07, 15 September 2011.

162 See also ECtHR, *Anayo v. Germany*, No. 20578/07, 21 December 2010, paras. 67 and 71.

163 ECtHR, *Schneider v. Germany*, No. 17080/07, 15 September 2011, para. 104.

Example: In *Levin v. Sweden*[164] the applicant, a mother of three children in alternative non-family based care, argued that the restrictions on her right to maintain contact with her children violated her right to respect for family life. The ECtHR focused on the objective of the contact restrictions, i.e. protecting the best interests of the children. In that particular case, the children had been neglected while in the care of the applicant, and contact with her revealed strong negative reactions on the part of the children. In holding that there had been no violation of Article 8 of the ECHR, the Court found that the interference with the applicant's rights had been "proportionate to the legitimate aim pursued [the best interests of the children] and within the margin of the domestic authorities".

Example: In *Sommerfeld v. Germany*[165] the applicant complained about the restrictions on his right to maintain contact with his daughter, who had consistently expressed that she did not wish to remain in contact with him. In particular, the applicant argued that the failure of the domestic courts to obtain a psychological expert opinion constituted a flaw in the domestic proceedings. In finding no violation of Article 8 of the ECHR, the ECtHR concluded that the domestic court had been well placed to evaluate the daughter's statements and to establish whether or not she had been able to make up her own mind.

Example: In *Mustafa and Armağan Akin v. Turkey*,[166] the applicants – a father and a son – argued that the terms of a custody order by the domestic court had violated their rights under Article 8 of the ECHR. These terms prevented the son from having contact with his sister, who was in the custody of their mother. Moreover, the father could not have contact with both of his children together because his son's contact with his mother coincided with his own contact with his daughter. The ECtHR held that the decision of the domestic court separating the two siblings constituted a violation of the applicants' right to respect for their family life, as it not only prevented the two siblings from seeing each other, but also made it impossible for their father to enjoy the company of both his children at the same time.

164 ECtHR, *Levin v. Sweden*, No. 35141/06, 15 March 2012, paras. 57 and 69; ECtHR, *K. and T. v. Finland* [GC], No. 25702/94, 12 July 2001, para. 151.

165 ECtHR, *Sommerfeld v. Germany* [GC], No. 31871/96, 8 July 2003, para. 72.

166 ECtHR, *Mustafa and Armağan Akin v. Turkey*, No. 4694/03, 6 April 2010.

In the context of custody and contact decision-making, the ECtHR also prohibits discrimination incompatible with Article 14 of the ECHR.

Example: In the case of *Vojnity v. Hungary*,[167] the applicant argued that he had been denied access to his son due to his religious convictions.[168] In finding a violation of Article 14 in conjunction with Article 8 of the ECHR, the ECtHR observed that there was no evidence that the applicant's religious convictions involved dangerous practices or exposed his son to physical or psychological harm.[169] The domestic courts' decisions on the removal of the applicant's access rights rendered any form of contact and the establishment of any kind of further family life impossible, despite the fact that total severance of contact could be justified only in exceptional circumstances.[170] The ECtHR, therefore, held that there had been no reasonable relationship of proportionality between a total ban on the applicant's access rights and the aim pursued, namely the protection of the best interest of the child.[171]

Example: The case of *Salgueiro da Silva Mouta v. Portugal*[172] was brought by a father who claimed parental responsibility over his child. He alleged that, in the national proceedings, the Portuguese authorities had dismissed his claim and awarded parental responsibility to the mother on the basis of his sexual orientation. The ECtHR found that the domestic authorities indeed refused custody on the ground that he was homosexual – a decision that does not have an objective and reasonable justification. The Court concluded that Article 8 taken together with Article 14 of the ECHR were violated.

167 ECtHR, *Vojnity v. Hungary*, No. 29617/07, 12 February 2013; see also ECtHR, *P.V. v. Spain*, No. 35159/09, 30 November 2010 (available in French and Spanish).

168 ECtHR, *Vojnity v. Hungary*, No. 29617/07, 12 February 2013, para. 22.

169 *Ibid.*, para. 38.

170 *Ibid.*, para. 41.

171 *Ibid.*, para. 43.

172 ECtHR, *Salgueiro da Silva Mouta v. Portugal*, No. 33290/96, 21 December 1999.

Furthermore, the right of the child to maintain contact with both parents is expressly cited within the CoE Convention on Contact Concerning Children.[173] Article 4 (1) of this convention states that "a child and his or her parents shall have the right to obtain and maintain regular contact with each other". The general principles to be applied in jurisprudence about contact emphasise the right of a child to be informed, consulted and to express his or her views, and for these views to be given due weight. Article 6 of the CoE Convention on the Exercise of Children's Rights[174] further identifies requisites of judicial decision-making, including the legal obligations to: consider whether the judicial authority has sufficient information to determine the best interests of the child; ensure the right of the child to information about the process and outcomes; and open a safe space for affected children to freely express their views in an age/maturity appropriate manner.

Situations may arise in which children are otherwise separated from a parent, for example as a result of the parent's imprisonment. The ECtHR was faced with such a situation in *Horych v. Poland*,[175] where it addressed the issue of the conditions in which the applicant, categorised as a dangerous prisoner, had received visits from his minor daughters. It noted that "visits from children [...] in prison require special arrangements and may be subjected to specific conditions depending on their age, possible effects on their emotional state or well-being and on the personal circumstances of the person visited".[176] The Court went on to say that "positive obligations of the State under Article 8, [...] include a duty to secure the appropriate, as stress-free for visitors as possible, conditions for receiving visits from his children, regard being had to the practical consequences of imprisonment". [177]

Finally, the right of children deprived of the liberty to maintain contact with their parents is reinforced by selected provisions of the CoE Guidelines on

173 Council of Europe, Convention on Contact Concerning Children, CETS No. 192, 2003. See also The World Organisation for Cross-border Cooperation in Civil and Commercial Matters (1996), Hague Conference on private international law, Convention on Jurisdiction, Applicable Law, Recognition, Enforcement and Co-Operation in respect of Parental Responsibility and Measures for the Protection of Children.

174 Council of Europe, European Convention on the Exercise of Children's Rights, CETS No. 160, 1996.

175 ECtHR, *Horych v. Poland*, No. 13621/08, 17 April 2012.

176 *Ibid.*, para. 131.

177 *Ibid.*, para. 131.

child-friendly justice.[178] The guidelines expressly affirm the right of children deprived of their liberty "to maintain regular meaningful contact with parents [and] family" (Article 21 (a)) (see also Chapter 11).

Under international law, the right to maintain contact with both parents is affirmed in Article 9 (3) of the CRC: "State Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests."

5.4. Improper removal of children across borders — child abduction

Key points

- The ECtHR requires a child rights-based approach to improper removals in breach of custody arrangements: Article 8 of the ECHR (right to respect for private and family life) must be interpreted in connection with the Hague Convention and the CRC.
- EU law requires more specifically that the child be heard during the proceedings relating to his/her return following wrongful removal or retention.

Child abduction refers to a situation in which a child is removed or retained across national borders in breach of existing custody arrangements (Article 3 of the Hague Convention on the Civil Aspects of International Child Abduction[179] (Hague Convention)). Under the Hague Convention, wrongfully removed or retained children are to be returned speedily to their country of habitual residence (Article 11 (1)). The courts of the country of habitual residence determine the merits of the custody dispute. The courts of the country from which the child has been removed should order the return within six weeks from the date that the return application is made (Article 11). The Hague Convention is underpinned by the principle of the child's best interests. In the context of this convention, the presumption is that the unlawful removal of a child is in itself

178 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*.

179 The World Organisation for Cross-border Cooperation in Civil and Commercial Matters (1980), Hague conference on private international law, Hague Convention of 25 October 1980 on the civil aspects of international child abduction, 25 October 1980.

harmful and that the *status quo ante* should be restored as soon as possible to avoid the legal consolidation of wrongful situations. Issues of custody and access should be determined by the courts that have jurisdiction in the place of the child's habitual residence rather than those of the country to which the child has been wrongfully removed. There are several limited exceptions to the return mechanism, established in Articles 12, 13, and 20 of the Hague Convention. Article 13 includes the provisions that have generated most of the litigation, both at a domestic and at an international level. It establishes that the country the child has been removed to may refuse to return a child, where the return would expose him/her to a grave risk of harm or otherwise place him/her in an intolerable situation (Article 13 (b)). A return may equally be refused if the child objects to the return if he or she has attained the level of maturity to express his/her views (Article 13 (2)).

Under EU law, the most important instrument regulating child abduction between EU Member States is the Brussels II bis Regulation,[180] largely based on the provisions of the Hague Convention. This regulation complements and takes precedence over the Hague Convention in intra-EU abduction cases (Recital 17 of the Preamble and Article 60 (e)). Although the Hague Convention remains the main child-abduction instrument, in certain respects Brussels II bis has 'tightened' the jurisdictional rules in favour of the courts of origin/habitual residence. Similar to the Hague Convention, the courts of the state where the child was habitually resident immediately prior to improper removal/retention retain the jurisdiction in cases of child abduction. The regulation maintains the same exceptions to the return as those included in the Child Abduction Convention.

However, under Brussels II bis, as opposed to the Hague Convention, the state of habitual residence retains jurisdiction to adjudicate the merits of the custody dispute, even after a non-return order is issued in application of Article 13 (b) of the Hague Convention (Article 11 (6)–(8) of the Brussels II bis Regulation). The change of jurisdiction to the state the child has been removed to may only occur in two situations, provided for under Article 10 of the Brussels II bis Regulation. The first situation stipulates that the courts of the state of refuge shall have jurisdiction if the child has acquired habitual residence in that state

180 Council of the European Union (2003), Council Regulation (EC) No. 2201/2003 of 27 November 2003 concerning jurisdiction and the recognition and enforcement of judgments in matrimonial matters and the matters of parental responsibility, repealing Regulation (EC) No 1347/2000, OJ 2003) L 338.

and each person having right of custody has acquiesced in the removal or retention.[181] The second situation arises where the child: has acquired habitual residence in the state he/she has been removed to; a period of one year has elapsed since the parent left behind had or should have had knowledge of the whereabouts of the child; the child is settled into his new environment; and at least one of the four further conditions listed in Article 10 (b) of the Brussels II bis Regulation are met.[182]

As with all other EU legal instruments, Brussels II bis must be interpreted in accordance with the provisions of the EU Charter of Fundamental Rights, in particular Article 24. The CJEU has had the opportunity to clarify the interpretation of Article 24 in the context of child abductions. As discussed in Section 2.4, in the *Aguirre Zarraga Case*, the CJEU ruled that the right of the child to be heard, enshrined in Article 24 of the Charter, requires that the legal procedures and conditions which enable children to express their views freely be made available to them, and that those views be obtained by the court.[183] According to the CJEU however, it is only for the courts of the child's habitual residence to examine the lawfulness of their own judgments in the light of the EU Charter of Fundamental Rights and the Brussels II bis Regulation. According to the mutual trust principle, Member States' legal systems should provide effective and equivalent protection of fundamental rights. Therefore, the interested parties have to bring any human rights-based challenge before the courts which have jurisdiction over the merits of the custody dispute pursuant to the regulation. The CJEU ruled that the court of the Member State to which the child had been wrongfully removed could not oppose the enforcement of a certified judgement, ordering the return of the child, since the assessment of whether there was an infringement of these provisions fell exclusively within the jurisdiction of the state from which the child had been removed.

181 Art. 10 (a) of the Brussels II bis Regulation.

182 Art. 10 (b) of the Brussels II bis Regulation provides for four alternative conditions as follows: (i) within one year after the holder of rights of custody has had or should have had knowledge of the whereabouts of the child, no request for return has been lodged before the competent authorities of the Member State where the child has been removed to or is being retained; (ii) a request for return lodged by the holder of rights of custody has been withdrawn and no new request has been lodged within the time limit set in paragraph (i); (iii) a case before the court in the Member State where the child was habitually resident immediately before the wrongful removal or retention has been closed pursuant to Art. 11 (7); (iv) a judgment on custody that does not entail the return of the child has been issued by the courts of the Member State where the child was habitually resident immediately before the wrongful removal or retention.

183 CJEU, C-491/10 PPU, *Joseba Adoni Aguirre Zarraga v. Simone Pelz*, 22 December 2010. On aspects concerning child participation in this case, see further the analysis in Section 2.4.

Example: The case of *Povse v. Alpago*[184] concerns the unlawful removal of a girl to Austria by her mother. The Austrian courts dismissed the father's application for return of his daughter to Italy on the ground that there was a grave risk of harm to the child. Meanwhile, upon the request of the father, the Italian court ruled that it retained jurisdiction to adjudicate the merits of the custody dispute and issued an order for the return of the child to Italy and an enforcement certificate on the basis of Article 42 of Brussels II bis. The case was referred to the CJEU by an Austrian court following the mother's appeal against the application for enforcement of the certificate and the ensuing return order of the child to Italy. The CJEU ruled that once a certificate of enforcement has been issued there are no possibilities of opposing the return in the country the child has been removed to (in this case Austria), as the certificate is automatically enforceable. Further, the CJEU decided that, in this case, only the Italian courts were competent to adjudicate on the serious risk to the child's best interests entailed by the return. Assuming that these courts were to consider such a risk justified, they retained sole competence to suspend their own enforcement order[185].

Under CoE law, the CoE European Convention on Recognition and Enforcement of Decisions Concerning Custody of Children and on Restoration of Custody[186]and the Convention on Contact concerning Children[187] include safeguards to prevent the improper removal of children and ensure the return of children.[188]

The ECtHR often deals with child abduction cases, and is in such instances generally guided by provisions of the Hague Convention when interpreting Article 8 of the ECHR. However, the ECtHR inevitably conducts an analysis of the child's best interests in these cases. Two leading Grand Chamber judgments reflect the court's position on this matter.

184 CJEU, C-211/10, *Doris Povse v. Mauro Alpago*, 1 July 2010.

185 An application based on the same facts was later lodged with the ECtHR and declared inadmissible. See ECtHR, *Povse v. Austria*, Decision of inadmissibility, No. 3890/11, 18 June 2013.

186 Council of Europe, European Convention on Recognition and Enforcement of Decisions concerning Custody of Children and on Restoration of Custody of Children, CETS No. 105, 1980.

187 Council of Europe, Convention on Contact Concerning Children, CETS No. 192, 2003.

188 *Ibid.*, Arts. 10 (b) and 16, respectively; Council of Europe, European Convention on Recognition and Enforcement of Decisions concerning Custody of Children and on Restoration of Custody of Children, CETS No. 105, 1980, Art. 8.

Example: The case *Neulinger and Shuruk v. Switzerland*[189] was brought by a mother, who had removed her son from Israel to Switzerland in breach of existing guardianship arrangements. Upon the father's application under the Hague Convention, the Swiss authorities ordered the child's return to Israel. In the opinion of the national courts and experts, the child's return to Israel could be envisaged only if he was accompanied by his mother. The measure in question remained within the margin of appreciation afforded to national authorities in such matters. Nevertheless, to assess compliance with Article 8 of the ECHR, it was also necessary to take into account any developments since the Federal Court's judgment ordering the child's return. In the present case, the child was a Swiss national and had settled well in the country, where he had been living continuously for about four years. Although he was at an age where he still had a significant capacity for adaptation, being uprooted again would probably have serious consequences for him and had to be weighed against any benefit he was likely to gain from it. It was also noteworthy that restrictions had been imposed on the father's right of access before the child's removal. Moreover, the father had remarried twice since then and was now a father again, but failed to pay maintenance for his daughter. The ECtHR doubted that such circumstances would be conducive to the child's well-being and development. As to the mother, her return to Israel could expose her to a risk of criminal sanctions, such as a prison sentence. It was clear that such a situation would not be in the child's best interests, given that his mother was probably the only person to whom he related. The mother's refusal to return to Israel was not, therefore, totally unjustified. Moreover, the father had never lived alone with the child and had not seen him since the child's departure at the age of two. The ECtHR was thus not convinced that it would be in the child's best interests to return to Israel. As to the mother, a return to Israel would mean a disproportionate interference with her right to respect for her family life. Consequently, there would be a violation of Article 8 of the ECHR in respect of both applicants if the decision ordering the second applicant's return to Israel were to be enforced.

189 ECtHR, *Neulinger and Shuruk v. Switzerland* [GC], No. 41615/07, 6 July 2010.

Example: In *X v. Latvia*,[190] the mother argued that the return of her daughter to Australia, from where she had been wrongfully removed, would expose her to serious harm. In determining whether the decisions of the national courts had struck a fair balance between the competing interests at stake – within the margin of appreciation afforded to states in such matters – the best interests of the child had to be a primary consideration. To achieve a harmonious interpretation of the ECHR and the Hague Convention, the factors capable of constituting an exception to the child's immediate return under Articles 12, 13 and 20 of the Hague Convention had to be genuinely taken into account by the requested state, which had to issue a decision that was sufficiently reasoned on this point, and then evaluated in light of Article 8 of the ECHR. This Article imposed a procedural obligation on the domestic authorities, requiring that when assessing an application for a child's return, the courts had to consider arguable allegations of a "grave risk" for the child in the event of return and make a ruling giving specific reasons. As to the exact nature of the "grave risk", the exception provided for in Article 13 (b) of the Hague Convention concerned only situations which go beyond what a child could reasonably bear. In the present case, the applicant had submitted to the Latvian Appeal Court a psychologist's certificate concluding that there existed a risk of trauma for the child in the event of immediate separation from her mother. Although it was for the national courts to verify the existence of a "grave risk" for the child, and the psychological report was directly linked to the best interests of the child, the regional court refused to examine the conclusions of that report in light of the provisions of Article 13 (b) of the Hague Convention. At the same time, the national courts also failed to deal with the issue of whether it was possible for the mother to follow her daughter to Australia and to maintain contact with her. As the national courts had failed to carry out an effective examination of the applicant's allegations, the decision-making process under domestic law did not satisfy the procedural requirements inherent in Article 8 of the ECHR, and the applicant had therefore suffered a disproportionate interference with her right to respect for her family life.

190 ECtHR, *X v. Latvia* [GC], No. 27853/09, 26 November 2013, paras. 101, 106, 107 and 115–119.

6 Alternative care to family care and adoption

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 7 (family life) and Article 24 (rights of the child) Brussels II bis Regulation (2201/2003)	Alternative care to family care	ECHR, Article 8 (right to respect for private and family life) ESC (revised), Article 17 (right of children and young persons to social, legal and economic protection) ECtHR, *Wallová and Walla v. the Czech Republic*, No. 23848/04, 2006 (placement in care due to inadequate housing) ECtHR, *Saviny v. Ukraine*, No. 39948/06, 2008 (placement in care due to socio-economic reasons) ECtHR, *B. v. Romania (No. 2)*, No. 1285/03, 2013 (parents involvement in decision-making) ECtHR, *B.B. and F.B. v. Germany*, Nos. 18734/09 and 9424/11, 2013 (procedural flaws in decision-making process). ECtHR, *Olsson v. Sweden (No. 1),* No. 10465/83, 1988 (implementation of care order) ECtHR, *T. v. the Czech Republic*, No. 19315/11, 2014 (importance of contact).

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 24 (rights of the child)	**Adoption**	European Convention on the Adoption of Children (Revised) ECtHR, *Pini and Others v. Romania*, Nos. 78028/01 and 78030/01, 2004 (priority of child's interests in adoption) ECtHR, *Kearns v. France*, No. 35991/04, 2008 (parental consent to adoption). ECtHR, *E.B. v. France* [GC], No. 43546/02, 2008 (lesbian woman's eligibility to adopt). ECtHR, *Gas and Dubois v. France*, No. 25951/07, 2012 (gay couple's eligibility to adopt). ECtHR, *X and Others v. Austria* [GC], No. 19010/07, 2013 (second parent adoption for same sex couple). ECtHR, *Harroudj v. France*, No. 43631/09, 2012 (kafala and adoption).

Every child has the right to respect for family life, a right recognised under Article 7 of the EU Charter of Fundamental Rights and Article 8 of the European Convention on Human Rights (ECHR) (see Chapter 5). Both EU and Council of Europe law reflect the importance to the child of family relationships, and this includes the child's right not to be deprived of contact with his/her parents, except when this is contrary to the child's best interests.[191] Finding a balance between ensuring the child remains with his/her family – in line with the respect for family life – and ensuring the child is protected from harm is difficult. Where a child is removed from his/her family, he/she may be placed in either foster care or residential care. Family life does not end with this separation and requires that contact continues to support family reunification if it is in the child's best interests. In certain circumstances, permanent removal, through adoption, will take place. The finality of adoption means that stringent requirements must be followed.

The purpose of this chapter is to consider European law on alternative care. EU law, mainly through the Brussels II bis Regulation, deals with cross-border procedural aspects related to placing children in alternative care. This regulation should be interpreted according to the EU Charter of Fundamental Rights, in particular Article 24. The ECtHR has also developed an extensive body of case law dealing with both substantive and procedural matters of placing children into alternative care.

191 EU (2012), Charter of Fundamental Rights of the European Union, OJ 2012 C 326, Art. 24 (3).

Section 6.1 begins by introducing some of the general principles governing the situation of children deprived of family care, Section 6.2 outlines the law concerning the child's removal into alternative care and Section 6.3 considers the European standards on adoption.

6.1. Alternative care: general principles

Key points

- Alternative care is a temporary protective measure.
- International law confirms that family-based care should be preferred over residential care.
- Children have the right to information and to express their view with respect to placement into alternative care.

Under EU, CoE and international law, viewed together, six broad principles relating to alternative care emerge.

First, alternative care is a protective measure that ensures children's interim safety and facilitates children's return to their families where possible.[192] Ideally, it is thus a temporary solution. Sometimes, it is a protective measure pending family reunification, for example of unaccompanied or separated child migrants with their families.[193] Other times it is a protective measure pending developments in family life, for example, improvements in the health of a parent or provision of support to parents.

Second, international law confirms that family-based care (such as foster care) is the optimal form of alternative care for securing children's protection and development. This is affirmed by the UN Guidelines for the Alternative

192 UN, General Assembly (2010), *Guidelines for the alternative care of children*, A/RES/64/142, 24 February 2010, paras. 48–51; Committee on the Rights of the Child (2013), *General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3 para. 1)*, UN Doc. CRC/C/GC/14, 29 May 2013, paras. 58–70.

193 UN, General Assembly, Convention on the Rights of the Child, 20 November 1989, Art. 22; Committee on the Rights of the Child (2005), *General Comment No. 6 (2005): Treatment of unaccompanied and separated children outside their country of origin*, UN Doc. CRC/GC/2005/6, 1 September 2005, paras. 81–83.

Care of Children and the UN Convention on the Rights of Persons with Disabilities (CRPD), to which the EU is a party.[194] The CRPD expressly states that "States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting".[195] Non-family based care (e.g. residential care) "should be limited to cases where such a setting is specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests".[196]

Third, the child's right to a guardian or representative is key to securing his or her broader rights.[197] Although there is no explicit general obligation in EU law to appoint a guardian for children without parental care, at least seven EU directives require Member States to appoint a guardian for children within different contexts, some directly related to children without parental care.[198] Further, this body of law is substantiated by the UN Guidelines for the Alternative Care of Children (generally regarding children without parental care), the CRC (specifically regarding unaccompanied children) and the CoE Convention on Action against Trafficking in Human Beings.[199] Most often the mandate of a legal guardian is to safeguard the child's best interests, ensure his or her overall well-being and complement his/her limited legal capacity (and also sometimes to exercise legal representation).[200]

Fourth, implicit within Article 24 of the EU Charter of Fundamental Rights is the legal obligation to take positive measures to ensure that decision-making

194 UN, General Assembly (2010), *Guidelines for the alternative care of children*, A/RES/64/142, 24 February 2010, paras. 20–22; UN, Committee on the Rights of the Child (2006), *General Comment No. 7 (2005): Implementing child rights in early childhood*, UN Doc. CRC/C/GC/7/Rev.136 (b), 20 September 2006, para. 18. UN, Convention on the rights of persons with disabilities (CRPD), 13 December 2006, Art. 23 (5) (see also Art. 7).

195 UN, Convention on the Rights of Persons with Disabilities (CRPD), 13 December 2006, Art. 23 (5).

196 UN, General Assembly (2010), *Guidelines for the alternative care of children*, 24 February 2010, A/RES/64/142, para. 21.

197 FRA (2014a), p. 31.

198 *Ibid.*, p. 14.

199 UN, General Assembly (2010), *Guidelines for the alternative care of children*, 24 February 2010, A/RES/64/142, paras. 100–103; UN, Committee on the Rights of the Child, *General Comment No. 6, (2005): Treatment of unaccompanied and separated children outside their country of origin*, UN Doc. CRC/GC/2005/6, 1 September 2005, paras. 33–38; Council of Europe, Convention on Action against Trafficking in Human Beings, CETS No. 197, 2005, Art. 10 (4).

200 FRA (2014a), p. 15.

about a child's placement is guided by his/her best interests[201] and views.[202] General Comments No. 5 and 14 of the Committee on the Rights of the Child[203] as well as the UN Guidelines for the Alternative Care of Children emphasise the need to ensure the child's right to information, including on his/her rights and options, as well as the child's right "to be consulted and to have his/her views duly taken into account in accordance with his/her evolving capacities".[204]

Fifth, children's broader rights within the EU Charter of Fundamental Rights, the ECHR and the CRC remain applicable to cases of alternative care (foster or residential care). This includes their civil and political rights (e.g. their rights to privacy, freedom of expression and freedom of religion and protection from all forms of violence) and their socio-economic rights (including their rights to education, healthcare and participation in cultural life).[205]

Finally, Article 4 of the CRC requires states to take "all appropriate legislative, administrative, and other measures" to implement the convention. This applies equally to the context of alternative care. Article 17 (1) (c) of the revised European Social Charter (ESC) similarly requires states to take all appropriate and necessary measures designed to provide protection and special aid for children and young persons temporarily or definitively deprived of their family's support.

Under EU law, the CJEU ruled that the Brussels II bis Regulation applies to decisions to place a child in alternative care. As noted in Chapter 5, Brussels II bis incorporates children's rights principles in its approach, emphasising that the equality of all children, the best interests of the child and the right to be heard, amongst others, should be taken into account.[206] Here the

201 UN, Committee on the Rights of the Child (2013), *General Comment No. 14 (2013) on the right to have his/her best interest taken as a primary consideration (art.3 para.1),* UN Doc. CRC/C/GC/14, 29 May 2013.

202 UN, Committee on the Rights of the Child (2009), *General Comment No. 12 (2009): The right of the child to be heard*, UN Doc. CRC/C/GC/12, 20 July 2009, para. 97.

203 UN, Commitee on the Rights of the Child, *General Comment No. 14*, para. 15 (g), 29 May 2013; *General Comment No. 5*, para. 24, 27 November 2003.

204 UN, General Assembly (2010), *Guidelines for the alternative care of children*, 24 February 2010, A/RES/64/142, para. 6.

205 EU Charter of Fundamental Rights, Arts. 3–4, 7, 10–11, 14 and 24; ECHR, especially Art. 8; and CRC, Arts. 13–14, 16, 19, 28, 29, 24, 31 and 37; UN, General Assembly (2010), *Guidelines for the alternative care of children*, 24 February 2010, A/RES/64/142, Sec. 2.

206 Brussels II bis, Preamble. See also Chapter 5.

"grounds of non-recognition for judgments relating to parental responsibility", as expressed in Article 23 of the Brussels II bis Regulation, are instructive. Article 23 states that judgments shall not be recognised:

> *"(a) if such recognition is manifestly contrary to the public policy of the Member State in which recognition is sought taking into account the best interests of the child;*
> *(b) if it was given, except in case of urgency, without the child having been given an opportunity to be heard, in violation of fundamental principles of procedure of the Member State in which recognition is sought […]."*

Under the regulation, jurisdiction is determined on the basis of the child's habitual residence, with several limited exceptions, including the child's best interests (Articles 8, 12 and 15 of Brussels II bis).

Under CoE law, the ECtHR affirms that the family is the natural environment for the growth and well-being of children. However, where the family cannot provide the child with the requisite care and protection, removal to an alternative care setting may be required. Such removal interferes with the respect for family life. The ECtHR has explained that in most cases the placement of a child in alternative care should be intended as a temporary measure and that the child must ultimately be reunited with his/her family in fulfilment of the right to respect for private and family life under Article 8 of the ECHR.[207]

Although the ECHR does not impose any specific duty on states to provide children with care and protection, Article 17 of the ESC requires that states "take all appropriate and necessary measures designed to provide protection and special aid from the state for children and young persons temporarily or definitively deprived of their family's support".[208]

207 ECtHR, *K.A. v. Finland*, No. 27751/95, 14 January 2003. The Committee of Ministers of the Council of Europe has endorsed this approach in its Recommendation on the rights of children living in residential institutions, adopted on 16 March 2005.

208 Council of Europe, European Social Charter (revised), CETS No. 163, 1996, Art. 17 (1) c.

6.2. Placing children in alternative care

Key points

- Under the CoE law, placing a child in alternative care should be provided for by law, pursue a legitimate aim and be necessary in a democratic society. Relevant and sufficient reasons must be put forward by the competent authority.
- Under CoE law, the decision-making process must follow certain procedural safeguards.

Under CoE law,[209] the child's placement in alternative care is only compatible with Article 8 of the ECHR when it is in accordance with the law, pursues a legitimate aim (such as the protection of the child's best interests) and is considered necessary in a democratic society. This last aspect requires that the courts give reasons that are both relevant and sufficient to support the means used to pursue the desired aim.

Example: In *Olsson v. Sweden (No. 1)*,[210] the applicants complained about the decision to place their three children into care. Finding that the care decision fell within the state's margin of appreciation, the ECtHR focused on the manner in which the care order was implemented. According to the Court, the care decision should have been regarded as a temporary measure, to be discontinued as soon as circumstances permitted, given that adoption was not being considered. Measures taken should thus have been consistent with the ultimate aim of reuniting the natural family. In this light, the ECtHR noted that the national authorities had placed the children in separate foster homes, at a significant distance from each other and their parents. Although the authorities had acted in good faith in implementing the care order, the Court noted that it was unacceptable for administrative difficulties, such as the lack of appropriate foster families or placements, to determine where the children would be placed. In such a fundamental area as respect for family life, such considerations could not be allowed to play more than a secondary role. Thus, in finding a violation

209 The placement of children in alternative care has also been a topic of political debate in the CoE for many years. See for instance the Committee of Ministers Resolution (77) 33 on the placement of children, adopted on 3 November 1977.

210 ECtHR, *Olsson v. Sweden (No. 1)*, No. 10465/83, 24 March 1988.

of Article 8 of the ECHR, the ECtHR stated that the measures taken by the authorities in the implementation of the care order were not supported by sufficient reasons to render them proportionate to the legitimate aim pursued under Article 8.

More recently, the ECtHR considered the merits of decisions to place children in alternative care under Article 8 of the ECHR.

Example: In *Wallová and Walla v. the Czech Republic*[211] the applicants complained about the placement of their five children in two separate children's homes due to their poor housing situation. Custody of the children was given to the children's homes in 2002 on the basis of the parents' economic instability and the care orders were later lifted when their economic and housing situation improved. The ECtHR found that the underlying reason for the decision to place the children in care had been a lack of suitable housing and as such a less drastic measure could have been used to address their situation. Under Czech law, there was a possibility to monitor the family's living and hygiene conditions, and to advise them on how to improve their situation, but this option was not used. While the reasons given for placing the children in care were relevant, they were not sufficient, and the authorities did not make enough efforts to help the applicants overcome their difficulties through alternative measures. In concluding that there had been a violation of Article 8 of the ECHR, the Court also took note of the conclusions of the UN Committee on the Rights of the Child, which observed that the principle of primary consideration of the best interests of the child was still not adequately defined and reflected in all Czech legislation, court decisions and policies affecting children.

Example: In *Saviny v. Ukraine*,[212] the applicants' children were placed in care due to the parents' lack of financial means and the domestic court's conclusion that their personal qualities endangered their children's lives, health and moral upbringing. In assessing the case, the ECtHR questioned the adequacy of the evidence on which the domestic authorities had based their findings and considered that there was insufficient information available on the extent of social assistance made available. This would

211 ECtHR, *Wallová and Walla v. the Czech Republic*, No. 23848/04, 26 October 2006 (available in French).

212 ECtHR, *Saviny v. Ukraine*, No. 39948/06, 18 December 2008.

have been pertinent in evaluating whether the authorities had discharged the duty to keep the family together and whether they had sufficiently explored the effectiveness of less drastic alternatives before seeking to separate the children from their parents. Furthermore, at no stage of the proceedings had the children been heard by the judges. In sum, although the reasons given by the national authorities for removal of the applicants' children were relevant, they were not sufficient to justify such a serious interference with the applicants' family life. Therefore, the Court found that there had been a violation of Article 8 of the ECHR.

The ECtHR requires under Article 8 of the ECHR that decision-making concerning respect for family life must adhere to certain procedural safeguards. It states that the decision-making process (administrative and judicial proceedings) leading to measures of interference with family life must be fair and afford due respect to the interests protected by Article 8. What is considered under Article 8 is whether "the parents have been involved in the decision-making process [...] to a degree sufficient to provide them with [a] requisite protection of their interests".[213] This includes keeping them informed about developments, ensuring that they can participate in decisions made about them[214] and, in certain circumstances, hearing from the children concerned.[215]

Example: In *B. v. Romania (No. 2)*,[216] the applicant had been diagnosed with paranoid schizophrenia and taken by the police on a number of occasions to psychiatric institutions for treatment. Her children no longer lived with her and were placed in a care home because of their mother's illness. The ECtHR had to examine whether, having regard to the serious nature of the decisions to be taken as regards placing children into care, the decision-making process, seen as a whole, provided the parents to a sufficient degree with the requisite protection of their interests. In that connection, the Court observed that the applicant, who was suffering from a severe mental disorder, had not been assigned either a lawyer or a guardian *ad litem* to represent her during the proceedings, so that it had been impossible for her to take part in the decision-making process concerning her

213 ECtHR, *W. v. the United Kingdom*, No. 9749/82, 8 July 1987, para. 64.

214 ECtHR, *McMichael v. the United Kingdom*, No. 16424/90, 24 February 1995.

215 ECtHR, *B. v. Romania (No. 2)*, No. 1285/03, 19 February 2013; ECtHR, *B.B. and F.B. v. Germany*, Nos. 18734/09 and 9424/11, 14 March 2013.

216 ECtHR, *B. v. Romania (No. 2)*, No. 1285/03, 19 February 2013.

minor children. In addition, the applicant's situation and the situation of her children had been examined by a court on only two occasions over a period of 12 years before both children had reached majority, and there was no evidence of regular contact between social workers and the applicant, which may otherwise have provided suitable means of representing her views to the authorities. In light of these facts, the Court concluded that the decision-making process around her children's placement in care had not adequately protected her interests, and that there had thus been a violation of her rights under Article 8 of the ECHR.

Example: In *B.B. and F.B. v. Germany*,[217] following allegations from the applicants' 12-year-old daughter that she and her eight-year-old brother had been repeatedly beaten by their father, the parental rights in respect of the two children were transferred to the Youth Court and the children were placed in a children's home. The District Court made a full order transferring parental authority from the applicants to the Youth Office, reaching its decision on the basis of direct evidence from the children. About a year later, at the first subsequent meeting with their parents, the daughter admitted that she had lied about having been beaten, and the children were eventually returned to their parents. In considering the applicants' complaint that the authorities had failed to adequately examine the relevant facts, the ECtHR emphasised that mistaken assessments by professionals did not necessarily mean that measures taken would be incompatible with Article 8 of the ECHR. The placement decision could only be assessed in light of the situation as presented to the domestic authorities at the time. In the ECtHR's assessment, the fact that the District Court had relied only on the statements of the children, while the applicants had submitted statements from medical professionals who had not noticed any signs of ill-treatment, combined with the fact that the Court of Appeal had not re-examined the children, were significant. As the children were in a safe placement at the time of the full hearing, there had been no need for haste, and the courts could have established an investigation into the facts of their own motion, which they failed to do. In sum, the German courts failed to give sufficient reasons for their decision to withdraw the applicants' parental authority, in breach of Article 8 of the ECHR.

217 ECtHR, *B.B. and F.B. v. Germany*, Nos. 18734/09 and 9424/11, 14 March 2013.

Even when placed in alternative care, children retain the right to maintain contact with their parents. This right has been recognised under the ECHR,[218] as the ECtHR holds that mutual contact between parents and children is a fundamental part of family life under Article 8. Given that placement in alternative care should normally be a temporary measure, maintaining family relationships is essential to ensure the successful return of the child to his/her family.[219] Under the ECHR, positive duties flow from these principles, as illustrated by the following cases.

Example: In *T. v. the Czech Republic*,[220] the ECtHR considered whether the rights of a father and daughter (applicants) had been violated by the placement of the child in care and the failure of the authorities to support contact between them. The child had been placed in a specialist institution after the death of her mother and after the father's applications for custody of his daughter had been denied due to concerns about his personality. Further requests to spend holidays with his daughter were denied and a therapeutic centre concluded that the visits were not beneficial to the child as she was afraid of him, at which time all contact was terminated. Later on, the courts decided that contact between the two applicants should only take place in writing, in accordance with the wishes of the child. The ECtHR emphasised *inter alia* a child's interests in maintaining ties with his/her family, except in particularly extreme cases where this would not be in the child's best interest. In examining the decision to place the child into care, the ECtHR noted with approval that the domestic authorities had given careful consideration to their decision, which was made after hearing expert psychological and psychiatric opinions as well as taking into account the wishes of the child. There had thus been no violation of Article 8 of the ECHR in relation to the decision to place the child in care. However, the Court went on to find that Article 8 had been violated as a result of the restrictions imposed on the contact between the applicants, in particular due to the lack of oversight of decisions by the child's residential institution to deny contact, given that these decisions ultimately reduced the chances of family reunification.

218 ECtHR, *Olsson v. Sweden (No. 1)*, No. 10465/83, 24 March 1988.

219 ECtHR *Eriksson v. Sweden*, No. 11373/85, 22 June 1989.

220 ECtHR, *T. v. the Czech Republic*, No. 19315/11, 17 July 2014 (available in French).

Example: In *K.A. v. Finland*,[221] the applicant's children were placed in alternative care due to allegations that they were being sexually abused. During the children's placement in care, little contact took place between them and their parents and little effort was made to plan for their reunification. Examining the case, the ECtHR noted that the state has a positive duty to facilitate family reunification as soon as reasonably feasible, taking into account the duty to protect the best interests of the child. According to the ECtHR, the severe restrictions on the applicant's right to visit his children reflected the social welfare authority's intention to strengthen the ties between the children and the foster family, rather than to reunite the original family. This was made notwithstanding a noted improvement in the father's circumstances. Accordingly, there was a violation of Article 8 of the ECHR.

6.3. Adoption

Key points

- Adoption ensures alternative care for children who cannot remain with their biological families.
- The best interests of the child must be the paramount consideration in adoption.
- There is no right to adopt under EU or CoE law, but the adoption process must adhere to certain criteria to ensure that it is in the best interests of the child.[220]

Under international law, the best interests of the child must be the paramount consideration in cases of adoption. Aside from the best interests principle, other general principles of the CRC also guide and inform its implementation in the context of adoption: non-discrimination, the right to life, survival and development and respect for children's views.[223] Of particular relevance is

221 ECtHR, *K.A. v. Finland*, No. 27751/95, 14 January 2003.

222 On the interest of the child to know his/her origins in the context of adoption, see Chapter 4.

223 CRC, Arts. 2, 3, 6 and 12. See also, UN, Committee on the Rights of the Child (2010), Treaty-specific guidelines regarding the form and content of periodic reports to be submitted by States Parties under Article 44, paragraph 1 (b), of the Convention on the Rights of the Child, UN Doc. CRC/C/58/Rev.2, 23 November 2010, paras. 23–27.

the UN Committee on the Rights of the Child's General Comment No. 14 on the "right of the child to have his or her best interests taken as a primary consideration".[224]

Similarly, one of the objectives of the Hague Convention on Protection of Children and Co-operation in respect of Intercountry Adoption is to "to establish safeguards to ensure that intercountry adoptions take place in the best interests of the child and with respect for his or her fundamental rights as recognised in international law".[225]

Under EU law, the rights and associated legal obligations in Article 24 of the EU Charter of Fundamental Rights are applicable to adoption in so far as it is addressed by the EU.

Under CoE law, the right to respect for family life as expressed in Article 8 of the ECHR is applicable and relied on in adoption cases. There are also two specific CoE conventions on this subject: the European Convention on the Adoption of Children[226] and the European Convention on the Adoption of Children (revised).[227] These instruments require a child rights-based approach to adoption. The European Convention on the Adoption of Children (revised), for instance, states that "[t]he competent authority shall not grant an adoption unless it is satisfied that the adoption will be in the best interests of the child".[228] Likewise, the ECtHR emphasises that the best interests of the child may override those of the parent in certain circumstances, including in adoption.[229] The European Convention on the Adoption of Children (revised) also requires that adoption should not be granted by the competent authority without "the consent of the child considered by law as having sufficient understanding".[230] Moreover, the child not deemed to understand this shall "as far as possible, be consulted

224 UN Committee on the Rights of the Child (2013), *General comment No. 14 (2013) on the right of the child to have his/her best interests taken as a primary consideration*, CRC /C/GC/14, Art. 3, para. 1.

225 Hague Conference on private international law, The Hague Convention on Protection of Children and Cooperation in respect of Intercountry Adoption, 29 May 1993, Art. 1(a).

226 Council of Europe, European Convention on the Adoption of Children (Revised), CETS No. 202, 2008.

227 *Ibid.* This Convention opened for signature in 2008 and came into force in 2011.

228 *Ibid.*, Art. 4 (1).

229 ECtHR, *Pini and Others v. Romania*, Nos. 78028/01 and 78030/01, 22 June 2004.

230 Council of Europe, European Convention on the Adoption of Children (Revised), CETS No. 202, 2008, Art. 5 (1) b.

and his or her views and wishes shall be taken into account having regard to his or her degree of maturity".[231]

Example: In *Pini and Others v. Romania*,[232] two Italian couples complained about the failure of the Romanian authorities to execute the decision of a Romanian court concerning their adoption of two Romanian children. In breach of court orders, the private institution in which the children resided in Romania had refused to hand them over to the applicants. The ECtHR held that the relationship between the applicants and their adopted children fell within the scope of family life under Article 8 of the ECHR, even though they had never lived together or established emotional ties. Considering the case, the ECtHR interpreted Article 8 in light of the CRC and the Hague Convention in finding that the positive obligation on the authorities to enable the applicants to establish family ties with their adopted children was circumscribed by the best interests of the child.[233] In this regard, it held that the child's interests may, depending on their nature and seriousness, override those of the parent. Furthermore, in finding that there was no violation of Article 8, the Court emphasised that in a relationship based on adoption it is important that the child's interests should prevail over those of the parents, since adoption meant providing a child with a family, not a family with a child.[234]

Example: In *Kearns v. France*,[235] the ECtHR found it compatible with the ECHR that an Irish woman, who had placed her child for adoption in France, could not revoke her formal consent to adoption after the expiry of a two-month period. The ECtHR first underlined that the national authorities' refusal of the request for the child's return pursued the legitimate aim of protecting the rights and freedoms of others, in this case the child.[236] In relation to the imposition of a time-limit for the withdrawal of consent, the French law sought to strike a fair balance and ensure proportionality between the conflicting interests of the biological mother, the child and the adoptive family. In this process, the child's best interests

231 *Ibid.*, Art. 6.

232 ECtHR, *Pini and Others v. Romania*, Nos. 78028/01 and 78030/01, 22 June 2004.

233 *Ibid.*, para. 155.

234 *Ibid.*, para. 156.

235 ECtHR, *Kearns v. France*, No. 35991/04, 10 January 2008.

236 *Ibid.*, para. 73.

had to be paramount.[237] From the evidence presented to the Court, it was in the child's best interests to enjoy stable relations within a new family as quickly as possible and all of the necessary steps had been taken to ensure that the applicant understood the precise implications of her action. In light of these considerations, the Court held that France had not failed in its positive obligations towards the applicant under Article 8 of the ECHR.

The ECtHR also affirms that decision-making about adoption must take place in a manner consistent with the prohibition of discrimination established in Article 14 of the ECHR. In particular, the ECtHR considered whether the applicants' exclusion from eligibility to adopt on the grounds of either sexual orientation or age was compatible with Article 14, in conjunction with Article 8. In doing so, it reaffirms that the duty to take proportionate action with a view to protecting the best interests of the child is of central importance.

Example: In *Schwizgebel v. Switzerland*,[238] the applicant, a single 47-year-old woman, was unable to adopt a second child given the age gap between her and the child she wished to adopt. The applicant claimed to be a victim of discrimination on the grounds of age. The ECtHR considered that the denial of authorisation to receive a child with a view to adoption in the applicant's case pursued the legitimate aim of protecting the well-being and rights of the child.[239] Given the lack of European consensus concerning the right to adopt as a single parent, the lower and upper age-limits for adopters and the age-difference between the adopter and the child, and the state's consequent broad margin of appreciation in this area as well as the need to protect children's best interests, the refusal to authorise the placement of a second child did not contravene the proportionality principle.[240] The Court therefore found that the justification given by the government appeared objective and reasonable and that the difference in treatment complained of had not been discriminatory within the meaning of Article 14 of the ECHR.

237 *Ibid.*, para. 79.

238 ECtHR, *Schwizgebel v. Switzerland*, No. 25762/07, 10 June 2010.

239 *Ibid.*, para. 86.

240 *Ibid.*, para. 97.

Example: The case of *E.B. v. France*[241] concerns the refusal of the national authorities to grant approval for the purposes of adoption to the applicant, a lesbian living with her partner who sought to adopt as a single person.[242] The Court reiterated that Article 8 of the ECHR did not in itself confer a right to found a family or adopt. However, a discrimination complaint could fall within the broader scope of a particular right, even if the issue in question did not relate to a specific entitlement granted by the ECHR.[243] Given that French law allowed single persons to adopt, such a right could not be denied to an individual on discriminatory grounds. As established by domestic courts, the applicant presented undoubted personal qualities and an aptitude for bringing up children, which were assuredly in the child's best interests, a key notion in the relevant international instruments.[244] The Court formed the view that the applicant's sexual orientation played a determinative role in the refusal of the authorities to allow her to adopt, amounting to discriminatory treatment by comparison to other single individuals who were entitled to adopt under national law.[245]

Example: The case of *Gas and Dubois v. France*[246] concerns the question of whether same-sex couples should have an equal right to second-parent adoption as heterosexual couples. The applicants were a same-sex couple who had entered into a civil partnership. Together they had brought up a daughter, who was conceived by artificial insemination and borne by one of them in 2000. The other partner's application for a simple adoption was rejected on the grounds that the adoption would deprive the child's biological mother of her parental rights, which would run counter to both the applicant's intentions and the child's best interests. Under French law, the only situation in which a simple adoption does not result in the removal of the biological parents' rights in favour of the adoptive parent is when an individual adopts his/her spouse's child. The applicants alleged that they had been discriminated against compared with both married and unmarried heterosexual couples. Examining whether they had been discriminated against compared with a married couple, the

241 ECtHR, *E.B. v. France* [GC], No. 43546/02, 22 January 2008.

242 *Ibid.*, para. 49.

243 *Ibid.*, paras. 41–48.

244 *Ibid.*, para. 95.

245 *Ibid.*, para. 96.

246 ECtHR, *Gas and Dubois v. France*, No. 25951/07, 15 March 2012.

ECtHR concluded that marriage conferred a special status, giving rise to social, personal and legal consequences; for that reason, the applicants could not be said to be in a relevantly similar situation to married couples. Concerning the comparison with unmarried couples of opposite sex, the Court concluded that a comparable heterosexual couple in a civil partnership would also have their application for a simple adoption refused under the provisions of French law. The ECtHR consequently concluded that there had been no difference in treatment based on sexual orientation and thus no violation of the applicants' Convention rights.

Example: The case of *X and Others v. Austria*[247] concerns a complaint from a same-sex couple that it had been discriminated against in comparison with different-sex couples as regards second-parent adoption. The first and third applicants were in a stable relationship and the first applicant sought to adopt the second applicant, who was the son of the third applicant. As in *Gas and Dubois*, the ECtHR rejected the notion that the applicants were in an analogous position to a married couple in which one spouse wants to adopt the child of the other spouse. However, the ECtHR accepted that the applicants were in a comparable situation to an unmarried heterosexual couple. While second-parent adoption for unmarried heterosexual couples is permissible under Austrian law, the Austrian Civil Code provides that anyone who adopts a child would replace the biological parent of the same sex, meaning that second-parent adoption for same-sex couples is a legal impossibility. The Court concluded that in such circumstances there had been a difference in treatment of the applicants on the grounds of their sexual orientation and that no sufficiently weighty and convincing reasons had been advanced by the Government, in breach of Article 14 in conjunction with Article 8 of the ECHR.

Finally, the ECtHR also focuses its attention on the merits of abiding by the spirit and purpose of international law with respect to decision-making about adoption.

247 ECtHR, *X and Others v. Austria* [GC], No. 19010/07, 19 February 2013.

Example: In *Harroudj v. France*,[248] the French authorities refused the applicant's request for the full adoption of an Algerian girl who had been abandoned at birth and placed in the applicant's care under *kafala* – guardianship under Islamic law. The reasons for such a refusal were the fact that the French Civil Code does not allow for the adoption of a child whose adoption would be prohibited under the law of his/her country of origin (which is the case for Algerian law), and the fact that *kafala* already gave the applicant parental authority allowing her to take decisions in the child's best interests. A subsequent appeal was rejected on the basis that the domestic law was consistent with the Hague Convention on the Protection of Children and Co-operation in Respect of Intercountry Adoption and that Article 20 of the CRC recognised *kafala* as being on a par with adoption in preserving the child's best interests. In examining the applicant's complaint, the ECtHR recalled the principle that, once a family tie is established, the state has to act in a manner calculated to enable that tie to be developed and establish legal safeguards that render possible the child's integration in the family, as well as the need to interpret the ECHR harmoniously with the general principles of international law. In its assessment, the ECtHR underlined the French courts' concern to abide by the spirit and purpose of international conventions, including the UN Convention on the Rights of the Child. *Kafala* was recognised under French law and the applicant was allowed to exercise parental authority and take decisions in the child's interest. It was open to her, for example, to draw up a will in the child's favour, overcoming difficulties stemming from the restriction on adoption. In conclusion, by gradually obviating the prohibition of adoption in this manner, the respondent state, which sought to encourage the integration of children of foreign origin without cutting them off immediately from the rules of their country of origin, showed respect for cultural pluralism and struck a fair balance between the public interest and that of the applicant. The ECtHR thus found no violation of the applicant's rights.

248 ECtHR, *Harroudj v. France*, No. 43631/09, 4 October 2012.

7 Child protection against violence and exploitation

EU	Issues covered	CoE
Directive on combating the sexual abuse and sexual exploitation of children and child pornography (2011/93/EU)	**Violence in schools, at home and other settings**	ECHR, Articles 2 (right to life), 3 (inhuman and degrading treatment), and 8 (physical integrity); Protocol No. 1 to the ECHR, Article 2 (right to education) ECtHR, *Kayak v. Turkey*, No. 60444/08, 2012 (stabbing in the vicinity of a school) ECtHR, *O'Keeffe v. Ireland* [GC], No. 35810/09, 2014 (sexual abuse in school) ECtHR, *Campbell and Cosans v. the United Kingdom*, Nos. 7511/76 and 7743/76, 1982 (corporal punishment) ESC (revised), Articles 7 (right to special protection against physical and moral hazards) and 17 (right to protection) ECSR, *World Organisation against Torture (OMCT) v. Belgium*, Complaint No. 21/2003, 2004 (prohibition of corporal punishment in Belgium) Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention) Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention)

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 5 (2) (forced or compulsory labour) Young Workers Directive (94/33/EC) Anti-Trafficking Directive (2011/36/EU)	**Forced labour**	ECHR, Article 4 (freedom from servitude, forced and compulsory labour) ECtHR, *C.N. and V. v. France*, No. 67724/09, 2012 (servitude; positive obligations of the state) ESC (revised), Article 7 (10) (protection of children against physical and moral dangers) CoE Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention)
Charter of Fundamental Rights, Article 5 (3) (prohibition of trafficking) Anti-Trafficking Directive (2011/36/EU)	**Child trafficking**	ECHR, Article 4 (freedom from servitude) ECtHR, *Rantsev v. Cyprus and Russia*, No. 25965/04, 2010 (failure of the state to investigate alleged accusations of trafficking) CoE Convention on Action against Trafficking in Human Beings
Anti-Trafficking Directive (2011/36/EU)	**Child pornography**	ECHR, Article 8 (right to respect for private life) ECtHR, *Söderman v. Sweden* [GC], No. 5786/08, 2013 (secret filming of a child) ESC (revised), Article 7 (10) (special protection against physical and moral dangers) Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention) Convention on Cybercrime
	Children belonging to a minority	ECtHR, *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], No. 47848/08, 2014 (death of a severely disabled young man in a state institution)
Council Decision 2010/48/EC	**Children with disabilities**	ECtHR, *Nencheva and Others v. Bulgaria*, No. 48609/06, 2013 (death of children in a state institution)
Commission Decision 2007/698/EC	**Missing children**	ECtHR, *Zorica Jovanović v. Serbia*, No. 21794/08, 2013 (right to information)

Child protection in the broad sense relates to all measures designed to ensure the exercise of children's rights. In the narrow sense, it relates to the rights of children to be free from all forms of violence. Under international law, states must take measures to ensure children benefit from adequate protection and their rights to physical integrity and dignity are effectively observed. The duty of the state to protect may take various forms, depending on the specific risk of violence a child is exposed to and the perpetrator thereof. Thus, states' duties are more evident where children are under the authority and control of the state, for example where they are placed in public institutions. This happens when the risk of violence is high. The state's duty to protect may prove more difficult in cases where children are exposed to violence by private actors, such as their family members.

The European Union's main competence in the area relates to cross-border crimes (Article 83 of the Treaty on the Functioning of the European Union (TFEU)). Particular legislative measures have therefore been enacted with respect to child pornography and human trafficking. The EU has also passed legislation requiring Member States to criminalise several forms of sexual abuse. At the Council of Europe (CoE) level, the European Convention on Human Rights (ECHR) – mainly under Articles 2, 3 and 8 – has elaborated on states' duties in relation to a wide range of acts constituting violence against children. The ECSR has also been active in the field, both through its reporting procedure and its collective complaint mechanism. Further, specific CoE conventions, most notably the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention),[249] are now in place and monitoring bodies in charge of supervising their implementation.

This chapter analyses specific aspects of violence against children and the response of the international community. Section 7.1 looks at violence at home, school and other settings and focuses on issues such as corporal punishment, child abuse and neglect, and sexual violence. Section 7.2 looks at cases of child exploitation which have a marked cross-border dimension, including human trafficking (for the purposes of forced labour or sexual exploitation), child pornography and grooming. Finally, Section 7.3 deals with instances of abuse where children are in particularly vulnerable situations.

249 Council of Europe, Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, CETS No. 201, 2007.

7.1. Violence at home, in schools or other settings

Key points

- States have the duty to ensure that children are effectively protected against violence and harm in all settings.
- States have the duty to provide an adequate legal framework for child protection.
- States must conduct effective investigations into arguable allegations of child abuse, violence against children and harm to children.

Under EU law,[250] the main legal instrument in this field, enacted on the basis of Articles 82 and 83 of the TFEU, is Directive 2011/93/EU on combating sexual abuse and sexual exploitation of children and child pornography.[251]

Under CoE law, the ECtHR and the ECSR have developed a substantial body of case law regarding the protection of children against violence in all settings. In addition, specific CoE conventions (e.g. the Lanzarote Convention) provide detailed guarantees to protect children against specific forms of violence.

7.1.1. Scope of state responsibility

Under CoE law, the ECtHR has analysed the most severe forms of violence against children under various articles of the ECHR, most notably Articles 2 and 3. The Court has identified clear duties incumbent on states whenever children are placed in institutions under their authority.[252] Likewise, if a certain conduct or situation reaches the level of severity after which it qualifies as inhuman or degrading treatment under Article 3, the state has positive obligations to protect children against ill-treatment, including treatment administered by private individuals. Situations such as long-term neglect by parents,[253] repeated sexual

250 Directive 2011/93/EU of the European Parliament and of the Council of 13 December 2011 on combating the sexual abuse and sexual exploitation of children and child pornography, OJ 2011 L 335/1.

251 *Ibid*.

252 ECtHR, *Nencheva and Others v. Bulgaria*, No. 48609/06, 18 June 2013 (available in French).

253 ECtHR, *Z and Others v. the United Kingdom* [GC], No. 29392/95, 10 May 2001.

abuse by school teachers,[254] rape,[255] or corporal punishments[256] have all been found to fall within the scope of Article 3 of the ECHR.

In the case of a death, a state may be held responsible under Article 2 of the ECHR, even if the death was inflicted by a private person, and not by an agent of the state. States' positive obligations vary from case to case, the core duty being to secure the *effective* protection of children against violence. In cases of serious forms of ill-treatment, positive obligations include the duty to enact effective criminal law provisions which are backed by the law-enforcement machinery.[257] States must also adopt special measures and safeguards for protecting children.[258]

The ECHR was faced on several occasions with cases concerning violence against children administered by private individuals in schools, private homes or other establishments which were ran by non-state actors, where it was questionable whether state responsibility could arise. More importantly, the ECtHR ruled that a state may not absolve itself of the duty to protect children by delegating the administration of important public services – such as education – to private individuals.[259] In cases concerning the determination of state responsibility, the ECtHR generally distinguished between the states' general obligation to protect, when the risk was not clearly identifiable, and a specific obligation to protect, in cases where the victim was clearly identifiable. In the former case, the ECtHR analysed whether the absence of state intervention resulted in a real risk of violence for the child victim.

Example: The case of *Kayak v. Turkey*[260] concerns the stabbing to death of a 15-year-old boy by another teenager, in the vicinity of a school. The ECtHR found that schools have an obligation to protect those enrolled from all forms of violence. In this specific case the ECtHR ruled that Turkey was responsible under Article 2 of the ECHR for failing to protect the right to life

254 ECtHR, *O'Keeffe v. Ireland* [GC], No. 35810/09, 28 January 2014.

255 ECtHR, *M.C. v. Bulgaria*, No. 39272/98, 4 December 2003.

256 ECtHR, *Tyrer v. the United Kingdom*, No. 5856/72, 25 April 1978.

257 ECtHR, *M.C. v. Bulgaria*, No. 39272/98, 4 December 2003, para. 150.

258 ECtHR, *O'Keeffe v. Ireland* [GC], No. 35810/09, 28 January 2014, para. 146.

259 *Ibid.*, para. 150; ECtHR, *Costello-Roberts v. the United Kingdom*, No. 13134/87, 25 March 1993, para. 27.

260 ECtHR, *Kayak v. Turkey*, No. 60444/08, 10 July 2012 (available in French).

of the applicants' son and brother, as there was no effective surveillance system in place at the time. In the absence of such a system, it was possible for a teenager to take a knife from the kitchen school, which he used to stab the victim.

Example: The case of *O'Keeffe v. Ireland*[261] concerns acts of abuse committed in the 1970s in an Irish National School. At the time, national schools in Ireland were recognised and paid for by the state, whereas the management and administration was entrusted to the Church. The applicant, a pupil at the time, was subjected to approximately 20 acts of sexual abuse by one of the school teachers. She only complained to the state authorities about these acts in 1998, after finding out about other acts of sexual abuse committed by the same teacher. The ECtHR had to determine whether the state could be held liable for acts of abuse which were not reported at the time to the authorities. The Court first found that the acts of abuse to which the applicant had been subjected fell within the scope of Article 3 of the ECHR. Then, based on various reports, the ECtHR found that the state should have been aware of the potential risks of sexual abuse in schools. At the time, there was no adequate procedure in place which would have allowed a child or a parent to complain directly to the state about acts of abuse. There was also no supervision mechanisms of the teachers' treatment of children. The ECtHR therefore concluded that Ireland had failed to fulfil its positive obligations under Article 3 of the ECHR, since it did not provide an effective protection mechanism for acts of abuse against minors in schools.

Pursuant to the ECtHR, states must also conduct effective investigations into allegations of ill-treatment or loss of life, irrespective of whether the acts were perpetrated by state agents[262] or by private persons. An investigation is effective if, upon the receipt of complaints from victims or their successors, states put in place a procedure capable of leading to the identification and punishment of those responsible for acts of violence contrary to either Articles 2 or 3 of the ECHR.

Under the ESC, children's rights to protection from abuse and ill-treatment fall mainly under Articles 7 and 17.

261 ECtHR, *O'Keeffe v. Ireland* [GC], No. 35810/09, 28 January 2014.

262 ECtHR, *Assenov and Others v. Bulgaria*, No. 24760/94, 28 October 1998.

Further, under the Lanzarote Convention, states are required to criminalise various forms of sexual abuse and sexual exploitation against children.[263] This convention also requires states to take legislative or other measures to prevent sexual abuse of children, by organising awareness-raising campaigns, training specialist staff, informing children on the risks of abuse, and providing specialist help to individuals who risk committing child abuse crimes. Furthermore, under Articles 4 and 5 of the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention),[264] states undertake to enact special legislative measures and to investigate acts of violence against women. Under Article 22 of the Istanbul Convention, states are obliged to ensure specialist support services to women and children who are victims of domestic violence.

Under international law, the CRC is the key legal instrument for ensuring child protection at state level. Pursuant to Article 19, States Parties have the duty to take legislative, administrative, social and educational measures to protect children against all forms of violence. The UN Committee on the Rights of the Child has issued an important number of General Comments and recommendations interpreting states' obligations under the CRC. For instance, General Comment No. 13 describes measures to protect children against all forms of violence.[265] General Comment No. 5 refers to measures to implement and monitor the CRC in national laws and policies.[266]

263 Council of Europe, Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, CETS No. 201, 2007.

264 Council of Europe, Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, CETS No. 210, 2011.

265 UN, Committee on the Rights of the Child (2011), *General comment No. 13*, CRC/C/GC/13, 18 April 2011.

266 UN, Committee on the Rights of the Child (2003), *General comment No. 5*, CRC/GC/2003/5, 27 November 2003.

7.1.2. Corporal punishment

Corporal punishment is generally defined as any form of physical punishment intended to cause someone pain or discomfort. It mostly relates to hitting children with the hand or with an object, but it may also involve non-physical acts, such as threats, which have the same end result – the humiliation of the child.[267]

Under CoE law, the ECtHR has analysed complaints about corporal punishment as a form of disciplinary measure mainly under Article 3 of the ECHR. Where the measure reached the level of severity required under Article 3, the ECtHR found that the treatment violated that provision.[268] Where measures of corporal punishment do not reach the threshold of severity required under Article 3, they may nevertheless fall under Article 8 as part of the right to physical and moral integrity. However, the ECtHR has to date not found a violation on the merits of Article 8 in corporal punishment cases. The use of corporal punishment in state schools may also breach the rights of the parents to raise their children according to their philosophical convictions, as provided for under Article 2 of Protocol No. 1 to the ECHR.[269]

Example: The cases of *Campbell and Cosans v. the United Kingdom*[270] concern the suspension from school of two boys for refusing to accept corporal punishment. The ECtHR found no violation of Article 3 of the ECHR as the children had not actually been subjected to corporal punishment. It found, however, a violation of Article 2 of Protocol No. 1 to the ECHR on the grounds that, by allowing for corporal punishment, the respondent state had failed to respect the parents' philosophical convictions. The ECtHR also found a violation of one of the boys' right to education provided for under Article 2 of Protocol No. 1 to the ECHR, on account of his suspension from school.

267 UN, Committee on the Rights of the Child (2007), *General Comment No. 8 (2006): The right of the child to protection from corporal punishment and other cruel or degrading forms of punishment' (Arts. 19; 28, para. 2; and 37 inter alia)*, CRC/C/GC/8, 2 March 2007.

268 ECtHR, *Tyrer v. the United Kingdom*, No. 5856/72, 25 April 1978.

269 ECtHR, *Campbell and Cosans v. the United Kingdom*, Nos. 7511/76 and 7743/76, 25 February 1982, para. 38.

270 ECtHR, *Campbell and Cosans v. the United Kingdom*, Nos. 7511/76 and 7743/76, 25 February 1982.

The ESC does not include any direct prohibition against corporal punishment. Nevertheless, the ECSR has read such an obligation into Article 17 of the ESC.[271] By virtue of its supervision, both through the reporting procedure and the collective complaints procedure of states' compliance with Article 17, the ECSR has found that several contracting states breach this provision by not prohibiting all forms of corporal punishment. In three similar cases filed by the Association for the Protection of All Children (APPROACH) Ltd. against Belgium,[272] the Czech Republic,[273] and Slovenia[274] respectively, the ECSR found a violation of Article 17 of the ESC, as these states lacked legislation setting out "an express and comprehensive prohibition on all forms of corporal punishment of children that is likely to affect their physical integrity, dignity, development or psychological well-being".[275] The ECSR also established that laws prohibiting the corporal punishment of children must be applicable to such forms of alternative care as institutional care, foster care and kindergartens. It should also be recalled in this regard that the Council of Europe's Parliamentary Assembly issued in 2004 a recommendation requesting all contracting states to ban corporal punishment.[276]

Under international law, corporal punishment is indirectly considered a form of violence against children falling under Articles 19, 28 (2) and 37 of the CRC. Moreover, the Committee on the Rights of the Child has issued General Comment No. 8/2006, calling on states to take appropriate measures against all forms of corporal punishment.[277]

271 See, for example, ECSR, *World Organisation against Torture (OMCT) v. Belgium*, Complaint No. 21/2003, 7 December 2004; ECSR, Conclusions XVI-2, Poland, Art. 17, p. 65.

272 ECSR, *Association for the Protection of All Children (APPROACH) v. Belgium*, Complaint No. 98/2013, 29 May 2015, para. 49.

273 ECSR, *Association for the Protection of All Children (APPROACH) v. Czech Republic*, Complaint No. 96/2013, 29 May 2015.

274 ECSR, *Association for the Protection of All Children (APPROACH) v. Slovenia*, Complaint No. 95/2013, 27 May 2015.

275 ECSR, *Association for the Protection of All Children (APPROACH) v. Slovenia*, Complaint No. 95/2013, 27 May 2015, para. 51.

276 Council of Europe, Parliamentary Assembly (2004), Recommendation 1666 (2004) on a Europe-wide ban on corporal punishment of children, 23 June 2004.

277 UN, Committee on the Rights of the Child (2007), *General Comment No. 8 (2006): The right of the child to protection from corporal punishment and other cruel or degrading forms of punishment (arts. 19; 28, para. 2; and 37, inter alia)*, CRC/C/GC/8, 2 March 2007.

7.1.3. Sexual abuse

Human trafficking and child pornography is dealt with in Sections 7.2.2 and 7.2.3 respectively.

Child sexual abuse may take many forms, including harassment, touching, incest or rape. Child sexual abuse can take place in various settings, including homes, schools, care-institutions, churches, etc. Children are particularly vulnerable to sexual abuse, as they often find themselves under the authority and control of adults and have less access to complaint mechanisms.

Under EU law, Directive 2011/93/EU – largely reflecting the approach of the Lanzarote Convention – seeks to harmonise minimum criminal sanctions for various child sexual abuse offences between Member States.[278] Under Article 3 of this directive, Member States must take criminal law measures to ensure the sanctioning of various forms of sexual abuse, including causing children to witness sexual activities or sexual abuse, and engaging in sexual activities with children. The directive provides for increased penalties if the acts are committed by persons in a position of trust against particularly vulnerable children and/or through the use of coercion. Further, Member States must ensure that the prosecution of suspects of child abuse takes place automatically and that persons convicted of sexual abuse crimes are prevented from exercising any professional activities involving direct or regular contact with children. The directive also includes provisions on child-friendly proceedings and ensures the protection of child victims in courts.

Directive 2011/93/EU is linked to the Framework Decision 2009/315/JHA[279] on the organisation and content of the exchange of information extracted from the criminal record between Member States. Despite not being child-specific, this Framework Decision fills an important gap in the protection system, ensuring that Member States' authorities have access to the criminal records of convicted persons. This facilitates the identification of individuals convicted of sexual abuse looking for a job in institutions working with children in other Member States.

278 Directive 2011/93/EU of the European Parliament and of the Council of 13 December 2011 on combating the sexual abuse and sexual exploitation of children and child pornography, OJ 2011 L 335/1.

279 Council Framework Decision 2009/315/JHA of 26 February 2009 on the organisation and content of the exchange of information extracted from the criminal record between Member States, OJ 2009 L 93, pp. 23–32.

Under CoE law, the ECtHR has examined cases of sexual abuse under Articles 3 and 8 of the ECHR. Complaints generally concern the failure of states to take appropriate measures to protect children from abuse. In the context of Article 3, the ECtHR has also examined whether states conducted effective investigations into allegations of sexual abuse. Child-abuse claims made under Article 8 concern the impact of such acts on the physical integrity of the victim and on the right to respect for family life. At times, the distinction between states' obligations under Articles 3 and 8 is rather blurred, the ECtHR using similar reasoning for finding violations of both Articles. It should be noted, however, that Article 8 cases have been more common in situations concerning undue removal/taking into care and the impact of allegations of child abuse on the family. These situations are analysed in Chapter 5.

Example: In *M.C. v. Bulgaria*[280] the applicant was a 14-year-old girl, who claimed to have been raped by two individuals after she had gone out one evening. Her complaint before the domestic authorities had been dismissed mainly as no form of physical violence had been found. The ECtHR noted that allegations of rape fell under Article 3 of the ECHR and that the respondent state had to conduct an effective investigation into such allegations. In finding that the Bulgarian authorities failed to conduct such an investigation, the ECtHR relied on evidence that the authorities generally dismissed cases where the victim could not show physical opposition to the act of rape. The Court found that such a standard of proof was not in accordance with factual realities concerning victims of rape and was therefore capable of rendering the authorities' investigation ineffective in breach of Article 3 of the ECHR.

Further, the Lanzarote Convention regulates in detail the right of children to be protected from sexual abuse. This convention adopted in the framework of the CoE, is open to ratification by states outside Europe. This binding instrument is backed by a plethora of non-legally binding instruments aimed at further ensuring that states enact effective measures against child sexual abuse.[281]

280 ECtHR, *M.C. v. Bulgaria*, No. 39272/98, 4 December 2003.

281 Examples include: Council of Europe, Committee of Ministers (2001), Recommendation Rec (2001) 16 on the protection of children against sexual exploitation, 31 October 2001; Council of Europe, Parliamentary Assembly (1996), Resolution 1099 (1996) on the sexual exploitation of children, 25 September 1996; Council of Europe, Parliamentary Assembly (2000), Resolution 1212 (2000) on rape in armed conflicts, 3 April 2000; Council of Europe, Parliamentary Assembly (2002), Resolution 1307 (2002) on sexual exploitation of children: zero tolerance, 27 September 2002.

7.1.4. Domestic violence and child neglect

Many cases of domestic violence include allegations of sexual abuse. In this sense, states' obligations under international law are similar to those listed in Section 7.1.3 above.

Under CoE law, it has usually been mothers who have complained to the ECtHR that the state has failed to adequately discharge its obligation – established by the ECHR – to protect against harm. Domestic violence cases raised issues under Articles 2, 3 and 8 of this Convention. States must comply with their positive obligation to take effective measures against domestic violence and conduct an effective investigation into arguable allegations of domestic violence or child neglect.

Example: In the case of *Kontrová v. Slovakia*,[282] the applicant had on several occasions been physically assaulted by her husband. She complained to the police, but later withdrew her complaint. Her husband subsequently threatened to murder their children. A relative reported this incident to the police. Nevertheless, several days after the incident, the applicant's husband shot himself and their two children dead. The ECtHR held that a state's positive obligations arise in the sphere of Article 2 of the ECHR whenever the authorities know or ought to know of the existence of a real and immediate risk to the life of an identified individual. In this case, the Slovak authorities should have known of such a risk by virtue of the pre-existing communications between the applicant and the police. The positive obligations of the police should have entailed registering the applicant's criminal complaint, launching a criminal investigation and initiating criminal proceedings, keeping a proper record of the emergency calls and taking action in respect of the allegations that the applicant's husband had a shotgun. The police, however, failed to meet its obligations and the direct consequence of those failures was the death of the applicant's children, in breach of Article 2 of the ECHR.

282 ECtHR, *Kontrová v. Slovakia*, No. 7510/04, 31 May 2007.

Example: The case of *Eremia v. the Republic of Moldova*[283] concerns the complaint of a mother and her two daughters about the authorities' failure to protect them from the violent and abusive behaviour of their husband and father. The ECtHR held that, despite their knowledge of the abuse, the authorities failed to take effective measures to protect the mother from further domestic violence. It also considered that, despite the detrimental psychological effects on the daughters witnessing their father's violence against their mother in the family home, little or no action had been taken to prevent the recurrence of such behaviour. The Court found that the Moldovan authorities had not properly complied with their obligations under Article 8 of the ECHR.

Cases of child neglect, either in state institutions or at home, have also been raised under the ECHR. The obligations of the authorities in situations of parental child neglect are similar to those in the cases presented previously. On the one hand, the state needs to put in place effective mechanisms for child protection, while on the other, state authorities must take action for protecting children in cases of reported child neglect, or where there is enough evidence of child neglect at their disposal, be it in homes or in privately-run institutions.[284] Cases of neglect in state institutions impose direct obligations on the authorities to protect children by ensuring that they receive adequate (medical) care, that the facilities where they are placed are adequate and/or the staff is trained to deal with the needs of children.[285]

The Istanbul Convention is also relevant.[286] Though not child-specific, it includes several references to children. First, under Article 3 (f), girls below the age of 18 are to be considered 'women', therefore, all the provisions of the convention apply to them. Secondly, under Article 2 (2), States Parties are encouraged to apply the convention to all victims of domestic violence, which can include children. In fact, in most cases children are witnesses to and are severely affected by domestic violence within the home.[287] Finally, child-specific provisions of the convention include obligations for states to take measures to address the needs of child victims, raise awareness among children, and protect child witnesses.

283 ECtHR, *Eremia v. the Republic of Moldova*, No. 3564/11, 28 May 2013.

284 ECtHR, *Z and Others v. the United Kingdom* [GC], No. 29392/95, 10 May 2001.

285 ECtHR, *Nencheva and Others v. Bulgaria,* No. 48609/06, 18 June 2013 (available in French).

286 Council of Europe, Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, CETS No. 210, 2011.

287 FRA (2014c), pp. 134–135. See also UNICEF (2006).

In the same vein, under Article 17 of the ESC, states are obliged to prohibit all forms of violence against children and to adopt adequate criminal and civil law provisions.

The issues of domestic violence and child neglect have been addressed in various non-legally binding instruments of the CoE.[288]

7.2. Child exploitation, pornography and grooming

Key points

- State authorities have a duty to cooperate and effectively work together to protect children against violence, including in the conduct of investigations.

7.2.1. Forced labour

Under EU law, slavery, servitude, forced or compulsory labour are prohibited (Article 5 (2) of the EU Charter of Fundamental Rights). The employment of children is also prohibited (Article 32 of the Charter). Directive 94/33/EC is the main legal instrument prohibiting child labour.[289] Only in exceptional circumstances are states allowed to set the minimum age for employment below the minimum school leaving age (Article 4 (2)). States have to ensure that young people admitted to work benefit from appropriate working conditions (Articles 6 and 7). Furthermore, children can only be employed for certain activities, such as light domestic work or social and cultural activities (Articles 2 (2) and 5). The directive also sets out specific protection measures to be taken in cases of child labour (Section III).

288 Examples include: Council of Europe, Committee of Ministers (1985), Recommendation No. R (85) 4 on violence in the family, 26 March 1985; Council of Europe, Committee of Ministers (1990), Recommendation No. R (90) 2 on social measures concerning violence in the family, 15 January 1990; Council of Europe, Parliamentary Assembly (1998), Recommendation 1371 (1998) on abuse and neglect of children, 23 April 1998.

289 Council Directive 94/33/EC of 22 June 1994 on the Protection of Young People at Work, OJ 1994 L 216.

In many instances, forced child labour cases involve trafficked children.[290] Directive 2011/36/EU on preventing and combating trafficking in human beings recognises forced labour as a form of child exploitation (Article 2 (3)).[291] Children trafficked for the purposes of forced labour are protected under the directive in the same way as victims of trafficking for other purposes (such as sexual exploitation, see Section 7.1.3).[292]

Under CoE law, Article 4 of the ECHR prohibits in absolute terms all forms of slavery, servitude, forced and compulsory labour. The ECtHR defines "forced or compulsory labour" as "work or service which is exacted from any person under the menace of any penalty against the will of the person concerned and for which the said person has not offered himself voluntarily".[293] Servitude includes, in addition, "the obligation for the 'serf' to live on another person's property and the impossibility of altering his condition".[294] Servitude is therefore an aggravated form of compulsory labour.

In cases concerning allegations of forced labour, the ECtHR first determines whether the allegations fall within the scope of Article 4 of the ECHR.[295] It then analyses whether states have complied with their positive obligations to put in place a legislative and administrative framework that prohibits, punishes and effectively prosecutes cases of forced or compulsory labour, servitude and slavery.[296] As regards the procedural aspect of Article 4, the ECtHR examines whether the domestic authorities conducted an effective investigation into arguable allegations of forced labour or servitude.[297]

290 Recital 11, Directive 2011/36/EU of the European Parliament and of the Council of 15 April 2011 on preventing and combating trafficking in human beings and protecting its victims, OJ 2011 L 101/1.

291 Directive 2011/36/EU of the European Parliament and of the Council of 15 April 2011 on preventing and combating trafficking in human beings and protecting its victims, OJ 2011 L 101/1.

292 See further FRA (2015c), pp. 40–41.

293 ECtHR, *Siliadin v. France*, No. 73316/01, 26 July 2005, para. 116.

294 *Ibid.*, para. 123.

295 ECtHR, *C.N. and V. v. France*, No. 67724/09, 11 October 2012, para. 70.

296 *Ibid.*, para. 104 and following.

297 ECtHR, *C.N. v. the United Kingdom*, No. 4239/08, 13 November 2012, paras. 70–82.

Example: The case of *C.N. and V. v. France*[298] concerns the forced-labour claims of two sisters of Burundian origin. After the death of their parents, they were taken to live with their aunt and her family in France. They were accommodated for four years in the basement of the house in allegedly very bad conditions. The older sister did not attend school and spent all her time doing household chores and taking care of her aunt's disabled son. The younger sister attended school and worked for the aunt and her family after school and after having been given time to do her homework. Both sisters lodged a complaint with the ECtHR that they had been held in servitude and subjected to forced labour. The ECtHR found that the first applicant had indeed been subject to forced labour as she had to work seven days a week with no remuneration and no holiday. Moreover, she had been held in servitude because she had the feeling that her situation was permanent, with no likelihood of change. The ECtHR further found that the state did not meet its positive obligations, since the legal framework in place did not offer effective protection to victims of compulsory labour. Concerning the procedural obligation to investigate, the ECtHR held that the requirements of Article 4 of the ECHR had been met, as the authorities had conducted a prompt independent investigation capable of leading to the identification and punishment of those responsible. The ECtHR dismissed the second applicant's allegations of forced labour, reasoning that she had been able to go to school and was given time to do her homework.

The ESC guarantees the right of children to be protected against physical and moral dangers within and outside the working environment (Article 7 (10)). The ECSR observed that domestic/labour exploitation of children, including trafficking for the purposes of labour exploitation, must be prohibited at state level.[299] States Parties to the ESC must ensure not only that they have the necessary legislation to prevent exploitation and protect children and young persons, but also that this legislation is effective in practice.[300]

The Lanzarote Convention also stipulates that states should criminalise all forms of child sexual exploitation.

298 ECtHR, *C.N. and V. v. France*, No. 67724/09, 11 October 2012.

299 ECSR Conclusions 2004, Bulgaria, p. 57.

300 ECSR Conclusions 2006, Albania, p. 61; ECSR Conclusions 2006, Bulgaria, p. 113.

7.2.2. Child trafficking

Under EU law, Article 83 of the TFEU identifies trafficking in human beings as a field where the EU Parliament and Council have legislative powers. Article 5 (3) of the EU Charter of Fundamental Rights contains an express prohibition of trafficking in human beings. The contribution of the EU is valued here, as this is an area with cross-border dimensions.

Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting its victims is the first instrument passed by the European Parliament and the Council based on Article 83 of the TFEU.[301] Under Article 2 (1) of this directive, trafficking is defined as "the recruitment, transportation, transfer, harbouring or reception of persons, including the exchange or transfer of control over those persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation". The purpose of the directive is to set out minimum rules for the definition and sanctioning of human trafficking-related offences (Article 1). The directive as a whole is relevant for children, and it also includes several child-specific provisions relating to assistance and support of child victims of trafficking and protection in criminal investigations (Articles 13–16).[302] Specific support measures are to be taken pursuant to a specialist assessment of each individual victim (Article 14 (1)). States should appoint a guardian to represent the child's best interests (Article 14 (2)) and provide support to the family of the child (Article 14 (3)). During criminal proceedings, children have the right to a representative, free legal counselling, and the right to be heard in adequate premises and by trained professionals (Article 15 (1)–(3)). Further protection measures include the possibility to conduct hearings without the presence of the public and the possibility to hear the child indirectly via communication technologies (Article 15 (5)).[303]

301 Directive 2011/36/EU of the European Parliament and of the Council of 15 April 2011 on preventing and combating trafficking in human beings and protecting its victims, OJ 2011 L 101/1.

302 Provisions detailed in FRA and ECtHR (2014), p. 222.

303 See FRA (2015b), p. 79.

Directive 2004/81/EC is also relevant for trafficked children.[304] Under this instrument, victims of trafficking may be issued residence permits by the host Member States, provided they cooperate in the criminal investigation. Nevertheless, the directive only applies to children to the extent decided by Member States.[305]

When it comes to enforcement, the EU's law enforcement agency (Europol) and the EU's Judicial Cooperation Unit (Eurojust) play important roles in ensuring cooperation between Member States to identify and prosecute organised trafficking networks. The relevant provisions for the protection of child victims at EU level are addressed in Section 11.3 of this handbook.

Under CoE law, the ECHR does not include any express provision on trafficking. Nevertheless, the ECtHR interprets Article 4 of the ECHR as including a prohibition of trafficking.[306] The Court has adopted the same definition of trafficking as laid down in Article 3 (a) of the Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the UN Convention against Transnational Organized Crime (Palermo Protocol) and Article 4 (a) of the CoE Convention on Action against Trafficking in Human Beings.[307] The ECtHR first identifies whether a particular situation involves a credible allegation of trafficking and thus falls under the scope of Article 4. If it does, the ECtHR's analysis will follow the patterns described in Section 7.2.1: the Court looks into whether the legal framework of the respondent state offers effective protection against trafficking, whether the state has discharged its positive obligations in the particular circumstances of the case and whether the authorities have conducted an effective investigation into arguable allegations of trafficking.

304 Council Directive 2004/81/EC of 29 April 2004 on the residence permit issued to third-country nationals who are victims of trafficking in human beings or who have been the subject of an action to facilitate irregular immigration, who cooperate with the competent authorities, OJ 2004 L 261, pp. 19–23.

305 *Ibid.*, Art. 3.

306 ECtHR, *Rantsev v. Cyprus and Russia*, No. 25965/04, 7 January 2010, para. 282.

307 UN, Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (UNCTOC), New York, 15 November 2000; Council of Europe, Council of Europe Convention on Action against Trafficking in Human Beings, CETS No. 197, 2005.

Example: The case of *Rantsev v. Russia and Cyprus*[308] was lodged by the father of a young Russian girl who died under suspicious circumstances in Cyprus. She had entered Cyprus on a cabaret artist visa. After what appeared to be an escape attempt, she died by falling off the balcony of an apartment belonging to acquaintances of her employer. Her father lodged a complaint against both Russia and Cyprus, essentially claiming that the authorities had not appropriately investigated the death of his daughter. The ECtHR held for the first time that trafficking in human beings falls under the scope of Article 4 of the ECHR. Although Cyprus had an adequate legal framework to combat trafficking, Article 4 was violated, as the administrative practice of requiring employers to issue financial guarantees for cabaret dancers did not offer effective protection against trafficking and exploitation. Further, in the particular circumstances of the case, the Cypriot authorities should have known that the applicant's daughter was at risk of being trafficked. The Court ruled that the police failed to take measures to protect Ms Rantseva against exploitation. Finally, it found a violation of Article 4 by Russia, since the Russian authorities did not appropriately investigate the allegations of trafficking.

The ECSR considers trafficking in human beings to constitute a grave violation of human rights and human dignity, and to amount to a new form of slavery.[309] Under Article 7 (10), states must enact legislation to criminalise it.[310] This legislation must be backed by an adequate supervisory mechanism, sanctions, and an action plan to combat child trafficking and sexual exploitation. [311]

At treaty level, the CoE Convention on Action against Trafficking in Human Beings is the key instrument addressing human trafficking.[312] In view of the broader membership of the CoE and the fact that the Anti-Trafficking Convention is open to accession by non-CoE member states,[313] it complements the

308 ECtHR, *Rantsev v. Cyprus and Russia*, No. 25965/04, 7 January 2010. The case does not concern the death of a child; however, this case is worth mentioning in absence of ECtHR child-specific trafficking cases and in view of the particular threat of trafficking to children.

309 ECSR, *Federation of Catholic Family Associations in Europe (FAFCE) v. Ireland*, No. 89/2013, 12 September 2014, para. 56.

310 ECSR, Conclusions XVII-2 (2005), Poland, p. 638.

311 ECSR, *Federation of Catholic Family Associations in Europe (FAFCE) v. Ireland*, No. 89/2013, 12 September 2014, para. 57.

312 Council of Europe, Council of Europe Convention on Action against Trafficking in Human Beings, CETS No. 197, 2005.

313 For example, Belarus acceded to the convention on 26 November 2013.

EU Directive 2011/36/EU and is instrumental in combating trafficking in states party to the convention, whether EU members or not, on the basis of common standards and obligations. The implementation of the convention is monitored by a group of independent experts (the Group of Experts on Action against Trafficking in Human Beings GRETA), who periodically assess the situation in each country and publish reports. On the basis of these reports, the Committee of the Parties to the Convention, the political pillar of the monitoring mechanism under the convention, adopts recommendations to States Parties concerning measures to be taken to implement GRETA's conclusions and follows up on progress.

7.2.3. Child pornography and grooming

Under EU law, Directive 2011/93/EU is the main legal instrument addressing child pornography.[314] Pornography is defined as: "(i) any material that visually depicts a child engaged in real or simulated sexually explicit conduct; (ii) any depiction of the sexual organs of a child for primarily sexual purposes; (iii) any material that visually depicts any person appearing to be a child engaged in real or simulated sexually explicit conduct or any depiction of the sexual organs of any person appearing to be a child, for primarily sexual purposes; or (iv) realistic images of a child engaged in sexually explicit conduct or realistic images of the sexual organs of a child, for primarily sexual purposes."[315] Article 5 of this directive introduces an obligation for EU Member States to take all necessary measures to ensure that the intentional production, acquisition, possession, distribution, dissemination, transmission, offering, supplying or making available of child pornography as well as knowingly obtaining access to this type of content is punishable.

Under CoE law, the ECtHR has on several occasions analysed cases concerning child pornography under Article 8 of the ECHR.

Example: The case of *Söderman v. Sweden* was brought by a girl whose stepfather attempted to film her while she was taking a shower.[316] She alleged that the Swedish legislative framework did not adequately protect

314 Directive 2011/93/EU of the European Parliament and of the Council of 13 December 2011 on combating the sexual abuse and sexual exploitation of children and child pornography, OJ 2011 L 335/1, pp. 1–14.

315 *Ibid.*, Art. 2 (c).

316 ECtHR, *Söderman v. Sweden* [GC], No. 5786/08, 12 November 2013.

her private life. The ECtHR held that the state has positive obligations to set up a legislative framework offering adequate protection to victims such as the applicant. As this case concerns only an attempt to film the applicant, the ECtHR held that such legislative framework does not necessarily have to include criminal sanctions. The remedies offered to a victim – either civil or criminal – have to be effective. On the facts of the case, the ECtHR held that the applicant did not benefit from effective criminal or civil remedies against her stepfather's attempt to film her, in breach of Article 8 of the ECHR.

Article 9 of the CoE Convention on Cybercrime[317] requires States Parties to criminalise the conduct of offering, making available, distributing, transmitting, procuring or possessing child pornography or producing such material through a computer system. An important requirement is that this conduct must be intentional. The Explanatory Report of the Convention states that the term 'pornographic material' is dependent on national standards concerning materials classified as "obscene, inconsistent with public morals or similarly corrupt".[318] Nevertheless, this obligation to criminalise should not only apply to material if it visually depicts a child, but also if it depicts a person appearing to be one or realistic images representing a child who is engaged in sexually explicit conduct.[319]

Further, pursuant to Articles 21 to 23 of the Lanzarote Convention, states are required to take legislative measures to criminalise various forms of child pornography. Under Article 21, recruiting, coercing and participating in child pornography activities should be criminalised. Under Article 22, causing children to witness sexual (abuse) acts must equally be criminalised. Finally, Article 23 requires that criminal legislation be enacted in relation to acts of solicitation of children for sexual purposes through information and communication technologies. The Lanzarote Committee has adopted an opinion on this provision, which invites the States Parties to the convention to consider extending the criminalisation of solicitation to cases when the sexual abuse is not the result of a meeting in person but committed online.[320]

317 Council of Europe, Convention on Cybercrime, CETS No. 185, 2001.

318 Explanatory report to the Council of Europe, Council of Europe Convention on Cybercrime, para. 99.

319 Council of Europe, Convention on Cybercrime, CETS No. 185, 2001, Art. 9 (2).

320 Lanzarote Committee Opinion on Art. 23 of the Lanzarote Convention and its explanatory note, 17 June 2015.

7.3. High risk groups

Key point

- Children victims of forced disappearance (known as 'enforced disappearance' in international law) have the right to preserve or to re-establish their identity.

7.3.1. Children belonging to a minority

Under CoE law, ECtHR cases dealing specifically with violence against minority children – outside the context of human trafficking and forced labour – are rather sparse. They mainly concern segregation in schools and discrimination, which is analysed in Section 3.2.

Example: In the case of *Centre of Legal Resources on behalf of Valentin Câmpeanu v. Romania*, an NGO lodged an application in the name of a young Roma boy who died in a state institution.[321] He was HIV-positive and had a severe intellectual disability. The conditions in the institution where he lived were appalling: there was no heating, no bedding or clothes, no support from staff, etc. In the absence of any close relative of the victim, an NGO alleged on his behalf the infringement of the rights established by Articles 2, 3, 5, 8, 13 and 14 of the ECHR. The Grand Chamber decided that, in the exceptional circumstances of the case (the extreme vulnerability and lack of any known next-of-kin of the young Roma), the NGO had standing to represent the deceased applicant. On the merits, the ECtHR found a violation of the substantive limb of Article 2. The domestic authorities were found liable for the death of Mr. Câmpeanu as they had placed him in an institution where he died due to the lacked adequate food, accommodation and medical care. The ECtHR also found a violation of Article 2 due to the fact that the Romanian authorities did not conduct an effective investigation into the death of Mr. Câmpeanu.

321 ECtHR, *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], No. 47848/08, 17 July 2014.

With respect to children living in institutions, the CoE Recommendation Rec(2005)5 supports the decision that the placement of a child should not be based on discriminatory grounds.[322]

7.3.2. Children with disabilities

Under EU law, the EU has become a party to the CRPD, the first international treaty in the field of human rights to which the EU has acceded.[323] The CRPD includes specific provisions related to children. EU Member States and the EU have undertaken to ensure the enjoyment of human rights by children with disabilities on an equal basis with other children. Under Article 16 of the CRPD, they must take specific measures to protect children with disabilities from abuse and exploitation.[324]

Under CoE law, ECtHR cases concerning children with disabilities have raised several issues, including consent, states' positive obligations to protect from death and ill-treatment, and living conditions in state-run facilities.

Example: The case of *Nencheva and Others v. Bulgaria*[325] concerns the death of 15 children and young adults in a home for people with mental and psychical disabilities. The ECtHR held that the children had been placed in a specialised public institution under the sole control of the state. The living conditions of the children in the institution were appalling: they lacked food, medicine, clothing and heating. The competent authorities had been alerted to this situation on several occasions, and were consequently aware or should have been aware of the risks of death. The ECtHR found a violation of the substantive limb of Article 2 of the ECHR, as the authorities did not take measures to protect the lives of children placed under their control. Further, the Bulgarian authorities did not conduct an effective investigation into the deaths of the applicants' children. In the particular circumstances of the case, the Bulgarian authorities should have launched an *ex officio* criminal investigation. The investigation was

322 Council of Europe, Committee of Ministers (2005), Recommendation Rec (2005)5 on the rights of children living in residential institutions, 16 March 2005.

323 Council of the European Union (2009), Council Decision 2010/48/EC of 26 November 2009 concerning the conclusion, by the European Community, of the United Nations Convention on the Rights of Persons with Disabilities, OJ 2010 L 23/35.

324 See also Section 3.5.

325 ECtHR, *Nencheva and Others v. Bulgaria*, No. 48609/06, 18 June 2013 (available in French).

deemed ineffective for several reasons: it had started two years after the death of the children, it had lasted unreasonably long, it did not cover the death of all the children and it did not clarify all the relevant factors in the matter.

7.4. Missing children

Under EU law, the EU Commission has launched a hotline number (116000) for missing children.[326] This service takes calls reporting missing children and passes them on to the police authorities, offers guidance to and supports the persons responsible for the missing child, and supports the investigation.

Under CoE law, the enforced disappearance of children has been addressed under Article 8 of the ECHR.

Example: In *Zorica Jovanović v. Serbia*,[327] a new-born baby allegedly died in hospital shortly after birth, but his body was never transferred to the parents. The mother complained that the state had failed to provide her with any information about the fate of her son, including the cause of his alleged death or time and place of his burial. The ECtHR held that a state's "continuing failure to provide [the mother] with credible information as to the fate of her son" amounted to a violation of her right to respect for family life.[328]

Under UN law, Article 25 (1) (b) of the International Convention for the Protection of All Persons from Enforced Disappearance[329] stipulates that states must prevent and punish the "falsification, concealment or destruction of documents attesting to the true identity" of children that are themselves or whose parents are subjected to enforced disappearance. States must also take the necessary measures to search for and identify these children, and to return them to their families of origin. In light of these children's right to preserve,

326 Commission Decision (2007), Commission Decision 2007/698/EC of 29 October 2007 amending Decision 2007/116/EC as regards the introduction of additional reserved numbers, OJ 2007, L 284/31.

327 ECtHR, *Zorica Jovanović v. Serbia*, No. 21794/08, 26 March 2013.

328 *Ibid.*, para. 74.

329 UN, International Convention for the Protection of All Persons from Enforced Disappearance, 20 December 2006.

or to have re-established, their identity, including their nationality, name and family relations as recognised by law, states need to have legal procedures in place to review and annul any adoption or placement of children involved in enforced disappearances (Article 25 (4)). The convention reiterates two of the general principles underpinning children's rights: the best interests of the child as a primary consideration and the right of the child to express his/her views (Article 25 (5)). Whereas a relatively low number of European states have ratified this convention, its relevance to the European normative framework should not be dismissed.[330]

330 As at 19 February 2015, nine out of the 28 EU Member States had ratified this convention (Austria, Belgium, Spain, France, Germany, Lithuania, Netherlands, Portugal and Slovakia). In addition, the following CoE member states have ratified the convention: Serbia, Montenegro, Bosnia and Herzegovina, Armenia and Albania.

8 Economic, social and cultural rights and adequate standard of living

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 14 (education) Qualification Directive (2011/95/EU) CJEU, C-413/99, *Baumbast and R v. Secretary of State for the Home Department*, 2002 (education of migrant children)	**Right to education**	ECHR, Protocol No. 1, Article 2 (right to education) ESC (revised), Article 17 (right to education) ECtHR, *Catan and Others v. Moldova and Russia* [GC], Nos. 43370/04, 8252/05 and 18454/06, 2012 (language in schools) ECtHR, *D.H. and Others v. the Czech Republic* [GC], No. 57325/00, 2007; ECtHR, *Oršuš and Others v. Croatia* [GC], No. 15766/03, 2010 (discrimination in school of Roma children) ECtHR, *Ponomaryovi v. Bulgaria*, No. 5335/05, 2011 (discrimination on ground of immigration status) FCNM, Articles 12 (3) and 14 European Convention on the Legal Status of Migrant Workers
Charter of Fundamental Rights, Article 35 (access to health care) Qualification Directive (2011/95/EU), Article 29 (core benefits for migrant children)	**Right to health**	ESC (revised), Articles 11 (right to protection of health) and 13 (right to social and medical assistance) ECHR, Articles 2 (right to life) and 8 (right to physical integrity) ECtHR, *Oyal v. Turkey*, No. 4864/05, 2010 (HIV infection of a newborn) ECtHR, *Iliya Petrov v. Bulgaria*, No. 19202/03, 2012 (injury in an electricity substation) ECtHR, *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], No. 47848/08, 2014 (death in an institution)

EU	Issues covered	CoE
		ECtHR, *Glass v. the United Kingdom*, No. 61827/00, 2004 (informed consent) ECtHR, *M.A.K and R.K. v. the United Kingdom*, Nos. 45901/05 and 40146/06, 2010 (test without parental consent) ECSR, *International Federation of Human Rights Leagues (FIDH) v. France*, Complaint No. 14/2003, 2004, (medical care for migrant children) ECSR, *Defence for Children International (DCI) v. Belgium*, Complaint No. 69/2011, 2012 (children in an irregular situation) Convention on Human Rights and Biomedicine (Oviedo Convention), Articles 6 and 8
Charter of Fundamental Rights, Article 34 (3) (right to social and housing assistance)	**Right to housing**	ESC (revised), Articles 16 (right of the family to social, legal and economic protection), 17 (right of children and young persons to social, legal and economic protection) and 31 (right to housing) ECtHR, *Bah v. the United Kingdom*, No. 56328/07, 2011 ECtHR, *Connors v. the United Kingdom*, No. 66746/01, 2004.
Charter of Fundamental Rights, Article 34 (social security and social assistance)	**Right to an adequate standard of living and right to social security**	ESC (revised), Articles 12–14 (rights to social security, social and medical assistance, and to benefit from social welfare services), 16 (right of the family to social, legal and economic protection) and 30 (right to protection against poverty and exclusion) ECSR, *European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) v. France*, Complaint No. 82/2012, 2013 (suspension of family allowances for truancy) ECtHR, *Konstantin Markin v. Russia* [GC], No. 30078/06, 2012 (parental leave)

Economic, social and cultural rights (ESC rights), more often referred to as socio-economic rights or social rights in a European context, include work-related rights as well as the right to education, health, housing, social security and, more generally, an adequate standard of living. Cultural rights have remained largely underdeveloped and unaddressed in scholarship and litigation. Aspects of them are addressed in Section 4.6 on the identity of children belonging to a minority and in Section 8.2 under the right to education.

Explicit standards on ESC rights in the European context can mainly be found in the European Social Charter and the EU Charter of Fundamental Rights, although the ECHR and its protocols also include several relevant provisions, for instance the prohibition of forced labour and the right to education. Moreover, the ECtHR has argued that there is "no water-tight division separating [the] sphere [of social and economic rights] from the field covered by the Convention"[331] and has read ESC rights into the civil rights guaranteed by the ECHR. In that way, for example, access to health care has been dealt with under the prohibition of torture, inhuman and degrading treatment and punishment (Article 3 of the ECHR).[332]

This chapter analyses ESC rights that are of specific relevance to children: the right to education (Section 8.2); the right to health (Section 8.3); the right to housing (Section 8.4); and the right to an adequate standard of living and social security (Section 8.5).

8.1. Approaches to economic, social and cultural rights

Key points

- Securing the availability of adequate resources is key to ensure the protection of social rights.
- Essential elements of social rights are availability, accessibility, adaptability and acceptability.

Under EU law, ESC rights have been included in the EU Charter of Fundamental Rights on par with civil and political rights. However, Article 52 of the Charter distinguishes between rights and principles, with the latter being limited in the way they are "judicially cognisable".

331 ECtHR, *Airey v. Ireland*, No. 6289/73, 9 October 1979, para. 26.

332 See, for example, ECtHR, Factsheet on Prisoners' health-related rights, February 2015, and Factsheet on Health, April 2015.

Under CoE law, the ECSR notes that when the realisation of a right is "exceptionally complex and particularly expensive to resolve", it assesses progressive realisation against three criteria: measures must be taken "to achieve the objectives of the Charter within a reasonable time, with measurable progress and to an extent consistent with the maximum use of available resources".[333] It also introduces a prioritisation, in that it reminds states of "the impact that their choices will have for groups with heightened vulnerabilities as well as for others persons affected".[334]

The ECSR, albeit in the specific context of the right to social security, argues that retrogressive steps "in order to ensure the maintenance and sustainability of the existing social security system" are permissible provided they do not "undermine the core framework of a national social security system or deny individuals the opportunity to enjoy the protection it offers against serious social and economic risk".[335] The ECtHR also accepts the possibility of retrogressive steps, but examines whether the method chosen is reasonable and suitable to the achievement of the legitimate aim pursued.[336]

In the context of the right to education, the ECSR, in line with the approach of the UN Committee on Economic, Social and Cultural Rights, has adopted the analytical framework of availability, accessibility, acceptability and adaptability.[337] The distinction between availability and accessibility also features in the case law of the ECtHR. The criteria or essential elements of availability, accessibility, acceptability and adaptability guide the analysis that follows, to the extent that relevant case law is available.

333 ECSR, *International Association Autism Europe (IAAE) v. France*, Complaint No. 13/2002, 4 November 2003, para. 53; applied in ECSR, *European Action of the Disabled (AEH) v. France*, Complaint No. 81/2012, 11 September 2013, paras. 94–99.

334 ECSR, *International Association Autism Europe (IAAE) v. France*, Complaint No. 13/2002, 4 November 2003, para. 53.

335 ECSR, *General Federation of Employees of the National Electric Power Corporation (GENOP-DEI) and Confederation of Greek Civil Servants' Trade Unions (ADEDY) v. Greece*, Complaint No. 66/2011, 23 May 2012, para. 47.

336 ECtHR, *Markovics and Others v. Hungary*, Decision of inadmissibility, Nos. 77575/11, 19828/13 and 19829/13, 24 June 2014, paras. 37 and 39.

337 ECSR, *Mental Disability Advocacy Center (MDAC) v. Bulgaria*, Complaint No. 41/2007, 3 June 2008, para. 37.

8.2. Right to education

Key points

- Limitations to the accessibility of education must be foreseeable, pursue a legitimate aim and must be justified and non-discriminatory.
- Acceptability of education, which requires respect for the religious and philosophical convictions of parents, does not exclude the possibility of religious or sexual education in schools.
- Adaptability requires special measures for children with disabilities and the possibility for children belonging to a minority to learn and be taught in their own language.
- Children have the right to education regardless of their nationality or migration status.

Under EU law, Article 14 (2) of the EU Charter of Fundamental Rights guarantees the right to education, including "the possibility to receive free compulsory education". In its third paragraph, Article 14 ensures the freedom to found educational establishments and the right of parents to ensure the education and teaching of their children in conformity with their religious, philosophical and pedagogical convictions.

Under CoE law, Article 2 of Protocol No. 1 to the ECHR guarantees the right to education. The ECtHR clarifies that this article does not oblige states to make education available; it provides "a right of access to educational institutions existing at a given time".[338] In addition, the right to education also includes "the possibility of drawing profit from the education received, that is to say, the right to obtain, in conformity with the rules in force in each state, and in one form or another, official recognition of the studies [...] completed".[339] However, this is not an absolute right; limitations must be foreseeable for those concerned and must pursue a legitimate aim. Disciplinary measures, including suspension or expulsion from an educational institution, are allowed, provided they meet the conditions for permissible limitations. To assess whether these forms of exclusion from education result in a denial of the right to ed-

338 ECtHR, *Case "Relating to certain aspects of the laws on the use of languages in education in Belgium" v. Belgium*, Nos. 1474/62, 1677/62, 1691/62, 1769/63, 1994/63 and 2126/64, 23 July 1968, para. 4.

339 *Ibid.*

ucation, factors such as the procedural safeguards, duration of the exclusion, reintegration efforts and adequacy of alternative education provided will be considered.[340]

> Example: In *Catan and Others v. Moldova and Russia*,[341] the ECtHR looked into the language policy introduced in schools by the separatist authorities in Transdniestria. The objective of this language policy was Russification. Following the forced closure of Moldovan-language schools (using the Latin alphabet), parents had to choose between sending their children to schools where they were taught in an artificial combination of language and Cyrillic alphabet and with teaching materials produced in Soviet times, or to sending their children to schools that were less well equipped and less conveniently situated, on their way to which they were subjected to harassment and intimidation. The forced closure of schools and subsequent harassment was held to be an unjustified interference with the children's right to education that amounted to a violation of Article 2 of Protocol No. 1 to the ECHR.[342]

As part of the right to education, parents have the right to respect for their religious and philosophical convictions. However, "the setting and planning of the curriculum fall in principle within the competence" of the state.[343] They can also integrate information or knowledge of a religious or philosophical kind in the school curriculum, on condition that it is "conveyed in an objective, critical and pluralistic manner".[344] To safeguard pluralism, quantitative and qualitative differences in teaching a particular religion or philosophy must be balanced by offering parents the possibility of either partially or fully exempting their children from such teaching, namely the possibility not to attend certain classes or the religious course as a whole.[345] For the ECtHR's way of dealing with the issue from a non-discrimination angle, see Section 2.1.[346]

340 ECtHR, *Ali v. the United Kingdom*, No. 40385/06, 11 January 2011, para. 58.

341 ECtHR, *Catan and Others v. Moldova and Russia* [GC], Nos. 43370/04, 8252/05 and 18454/06, 19 October 2012.

342 *Ibid.*, paras. 141–144.

343 ECtHR, *Folgerø and Others v. Norway* [GC], No. 15472/02, 29 June 2007, para. 84.

344 *Ibid.*, para. 84.

345 *Ibid.*, paras. 85–102 and Dissenting opinion.

346 ECtHR, *Grzelak v. Poland*, No. 7710/02, 15 June 2010.

Pursuant to Article 17 (2) of the revised ESC, states undertake "to take all appropriate and necessary measures designed [...] to provide to children and young persons a free primary and secondary education as well as to encourage regular attendance at schools".[347] Additionally, the ECSR ruled that under this provision, contracting states should ensure that children unlawfully present in their territory also have access to education.[348]

Furthermore, educational institutions have to be accessible to everyone without discrimination.[349] The ESCR held that the "integration of children with disabilities into mainstream schools [...] should be the norm and teaching in specialised schools must be the exception".[350] States do not enjoy a wide margin of appreciation regarding the choice of the type of school for persons with disabilities; it must be a mainstream school.[351]

Situations concerning differential treatment in education on grounds such as nationality, immigration status or ethnic origin are dealt with in Chapter 3.

Under the ECSR case law, sexual and reproductive health education must be part of the ordinary curriculum.[352] Whereas states enjoy a wide margin of appreciation in determining the cultural appropriateness of the educational material used, they must ensure non-discriminatory sexual and reproductive health education "which does not perpetuate or reinforce social exclusion and the denial of human dignity". Educational materials must not "reinforce demeaning stereotypes", for instance concerning persons of non-heterosexual orientation.[353]

347 The ESC of 1961 does not contain a provision on the right to education.

348 ECSR, *Médecins du Monde – International v. France*, Complaint No. 67/2011, 11 September 2012.

349 On the issue of children with disabilities, see further Chapters 3 and 7.

350 ECSR, *Mental Disability Advocacy Center (MDAC) v. Bulgaria*, Complaint No. 41/2007, 3 June 2008, para. 35.

351 ECSR, *European Action of the Disabled (AEH) v. France*, Complaint No. 81/2012, 11 September 2013, para. 78.

352 ECSR, *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v. Croatia*, Complaint No. 45/2007, 30 March 2009, para. 47.

353 *Ibid.*, paras. 59 and 61.

Finally, adaptability of education requires, for example, that for children with disabilities who are integrated into mainstream schools, "arrangements are made to cater for their special needs"[354] (see also Section 3.5).

In addition, under Article 12 (3) of the FCNM, States Parties undertake to promote equal opportunities for access to education at all levels for persons belonging to national minorities (see also Chapter 3).[355] For children belonging to national minorities, Article 14 of the FCNM contains the right to learn and be taught one's own language.[356] The ECtHR has confirmed that the right to education implies the right to be educated in (one of) the national language(s).[357]

8.2.1. Right to education of migrant children

Under EU law, children's fundamental right to education, regardless of their migration status, is recognised in virtually all aspects of EU migration law.[358] That said, the EU does not have the competence to determine the content or scope of national educational provisions. Rather, the EU protects migrant children's right to access education on the same or, depending on their status, similar basis as nationals. The Students Directive (2004/114/EC) regulates the conditions of admission of third-country nationals for the purposes of studies, pupil exchange, unremunerated training or voluntary service.[359] This admission

354 ECSR, *Mental Disability Advocacy Center (MDAC) v. Bulgaria*, Complaint No. 41/2007, 3 June 2008, para. 35.

355 See further Council of Europe, Advisory Committee on the Framework Convention for the Protection of National Minorities (FCNM), Commentary on Education under the Framework Convention for the Protection of National Minorities, 2006, ACFC/25DOC(2006)002, Part 2.1.

356 For further clarification, see Council of Europe, Advisory Committee on the Framework Convention for the Protection of National Minorities (FCNM), Commentary on Education under the Framework Convention for the Protection of National Minorities, 2006, ACFC/25DOC(2006)002, Part 2.3, and Thematic Commentary No. 3: The language rights of persons belonging to national minorities under the Framework Convention, 2012, ACFC/44DOC(2012)001 rev, Part VI, Language Rights and Education.

357 ECtHR, *Catan and Others v. Moldova and Russia* [GC], Nos. 43370/04, 8252/05 and 18454/06, 19 October 2012, para. 137.

358 E.g. Art. 27 Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (Recast) (Qualification Directive), OJ 2011 L 337/9, pp. 9–268.

359 Council Directive 2004/114/EC on the conditions of admission of third-country nationals for the purposes of studies, pupil exchange, unremunerated training or voluntary service (Students Directive).

covers the entry and residence of the third-country national for a period exceeding three months. The general conditions of admission for children include the presentation of a valid travel document, parental authorisation for the planned stay, sickness insurance and, if the Member State so requests, the payment of a fee for processing the application for admission.[360] School pupils for instance are required to provide evidence of participation in a pupil exchange scheme operated by an organisation recognised by the Member State.[361] Unremunerated trainees are subject to providing the evidence the Member State requires to ensure that during their stay they will have sufficient resources to cover their subsistence, training and return travel costs.[362] Access to economic activities, including employment, by higher education students are subject to restrictions.[363]

The children of EU migrants who move to another EU Member State under free movement law benefit from the most favourable entitlement in this context. They have a right to be admitted to that state's general educational, apprenticeship and vocational training courses under the same conditions as nationals.[364] This includes public and private, and compulsory and non-compulsory education. The CJEU has always interpreted this entitlement broadly to ensure equal access to education, but also to broader, education-related social benefits, as well as to any benefits intended to facilitate educational attendance. For example, in the *Casagrande* case, the child of a migrant worker was able to access a means-tested educational grant under EU free movement law.[365]

360 *Ibid.*, Art, 6.

361 *Ibid.*, Art. 7.

362 *Ibid.*, Art. 10.

363 *Ibid.*, Art. 17.

364 Regulation (EU) 492/2011 of the European Parliament and of the Council of 5 April 2011 on freedom of movement for workers within the Union, OJ 2011 L 141/1, pp. 1–12, Art. 10; and Directive 2004/38 of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States amending Regulation (EEC) No. 1612/68 and repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC and 93/96/EEC (Free Movement Directive), OJ 2004 L 158, pp. 77–123, Art. 24 (1).

365 CJEU, C-9/74, *Donato Casagrande v. Landeshauptstadt München*, 3 July 1974. Subsequently confirmed in cases such as CJEU, C-3/90, *M.J.E. Bernini v. Minister van Onderwijs en Wetenschappen*, 26 February 1992.

Moreover, legislation introduced in the 1970s requires Member States to provide supplementary language tuition for children of EU migrant workers, in both the host state language and in their mother tongue, with a view to facilitate their integration in the host state and in their country of origin should they subsequently return.[366] While this seems to offer quite generous and valuable supplementary support to children following their admission to a school in the host state, its implementation across different countries has been notoriously patchy and increasingly impractical given the range of different languages to accommodate.[367]

Example: The issue in *Baumbast and R v. Secretary of State for the Home Department*[368] was whether the two daughters of a German migrant worker who moved to the United Kingdom with his Colombian wife and daughters, could continue to attend school there after he left the United Kingdom for a non-EU Member State, leaving his wife and daughters behind. The CJEU was faced with the question of whether his wife and daughters could remain in the host state independently, notwithstanding the fact that Mr Baumbast (from whom the family derived their residence rights) had effectively relinquished his status as an EU migrant worker. The decisive factor for the CJEU was that the children were integrated into the education system of the host state and it would have been both harmful and disproportionate to uproot them at such a crucial point in their education. The Court confirmed that such is the importance of achieving continuity in children's education that it can effectively 'anchor' the (otherwise non-qualifying) family's residence in the host state for the duration of a migrant child's studies.

366 Council Directive 77/486/EEC on the education of the children of migrant workers, OJ 1977 L 199, pp. 32–33. Note that third-country national migrant children are excluded from its scope.

367 Commission reports on the implementation of Directive 77/486/EEC, COM(84) 54 final and COM(88) 787 final.

368 CJEU, C-413/99, *Baumbast and R v. Secretary of State for the Home Department*, 17 September 2002.

The *Baumbast* decision was followed in successive cases[369] and has been codified in Article 12 (3) of Directive 2004/38/EC (Free Movement Directive).[370]

Third-country national children can generally only access *publicly-funded* education under the same conditions as nationals, and are excluded from associated benefits such as maintenance grants.[371] Some EU immigration instruments, however, go further than granting mere equality of access, requiring Member States to implement mechanisms to ensure due recognition and transferability of foreign qualifications, even in the absence of documentary evidence (Article 28 of the Qualification Directive).[372]

The educational rights of asylum-seeking children are weaker still; they must be granted access to the host state's education system on *similar,* but not necessarily the *same* terms as those that apply to nationals.[373] As such, education may be provided in accommodation centres rather than schools, and the authorities can postpone asylum-seeking children's full access to a school for up to three months from the date of application for asylum. Where access to the education system is impossible due to the specific situation of the child, Member States are obliged to offer alternative education arrangements (Article 14 (3) of the Reception Conditions Directive).[374]

369 CJEU, C-480/08, *Maria Teixeira v. London Borough of Lambeth and Secretary of State for the Home Department*, 23 February 2010; CJEU, C-310/08, *London Borough of Harrow v. Nimco Hassan Ibrahim and Secretary of State for the Home Department* [GC], 23 February 2010.

370 Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States amending Regulation (EEC) No. 1612/68 and repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC and 93/96/EEC, OJ 2004 L 158, Art. 2 (2) (c) and Art. 12 (3).

371 Refugee Qualification Directive 2011/95/EU, Art. 11; Long-Term Residents Directive (Directive 2003/109/EC), Art. 14; Directive 2003/86/EC on the right to family reunification, Art. 14; Temporary Protection Directive (2001/55/EC); Reception Directive (2013/33/EU), Art 14(c); and Return Directive (2008/115/EC).

372 Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (Recast) (Qualification Directive), OJ 2011 L 337/9.

373 Reception Conditions Directive (2013/33/EU). Note that, under the Refugee Qualification Directive (2011/95/EU, Art. 27), child refugees (who have acquired longer term residence rights) can access education under the same conditions as nationals.

374 Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (Recast) (Reception Directive), OJ 2013 L 180/96, pp. 96–116.

Under CoE law, Article 2, Protocol No. 1 has been used in conjunction with Article 14 to secure migrant children's access to education (see also Section 3.3).

> Example: In *Ponomaryovi v. Bulgaria*,[375] the ECtHR considered the requirement for two Russian school children without permanent residence to pay secondary school fees. The Court concluded that imposing fees for secondary school in their case had been discriminatory and thus contrary to Article 14 of the ECHR taken together with Article 2 of Protocol No. 1 to the ECHR.[376].

The ESC protects migrant children's educational rights both directly (Article 17, paragraph 2) and indirectly, imposing restrictions on children's employment rights with a view to enabling them to obtain the full benefits of compulsory education (Article 7).

Furthermore, the European Convention on the Legal Status of Migrant Workers[377] endorses migrant children's right to access "on the same basis and under the same conditions as nationals", general education and vocational training in the host state (Article 14 (1)).

Under international law, migrant children's equality of access to education is supported by the International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families (Article 30).[378]

Article 28 of the CRC provides that all children have the right to free compulsory education. According to Article 29 (1) (c), this right extends far beyond equality of access to education and includes provisions concerning the development of the child's cultural identity, language and values of the child's country of origin.

375 ECtHR, *Ponomaryovi v. Bulgaria*, No. 5335/05, 21 June 2011.

376 See also Section 3.3.

377 Council of Europe, European Convention on the Legal Status of Migrant Workers, CETS No. 93, 1977.

378 UN, Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 18 December 1990.

8.3. Right to health

Key points

- States have positive obligations to take measures against life-endangering health risks that the authorities are or ought to be aware of.
- State authorities must undertake an effective investigation in case of a person's death.
- Under the ESC, children who are unlawfully in the country are entitled to healthcare beyond urgent medical assistance.
- Acceptability of healthcare requires informed consent or authorisation.
- Under EU law and the ESC, subject to several limitations, migrant children are entitled to access social assistance and healthcare.

Under EU law, Article 35 of the EU Charter of Fundamental Rights guarantees a right of access to healthcare.

Children of EU migrant nationals can access social welfare and health support on the same basis as nationals, following three months of residence in the host state.[379] Similar rights are extended to the children of third-country nationals who have acquired permanent residence in a Member State, although these may be restricted to so-called 'core benefits'.[380] As far as refugee and asylum-seeking children are concerned, Member States have to provide access to appropriate social assistance on an equal basis as nationals of the host state, but, again, this can be limited to 'core benefits' (Article 29 of the Qualification Directive). The legislation requires Member States to provide vulnerable migrant children with access to sufficient healthcare support. For instance, children who have suffered violence or torture must be provided with sufficient support to address their physical and mental needs (Chapter IV Recast Reception Directive, Articles 21, 23 (4) and 25). The Qualification Directive contains similar provisions for vulnerable child migrants.

379 Free Movement Directive, Art. 24.

380 Council Directive 2003/109/EC of 25 November 2003 concerning the status of third-country nationals who are long-term residents, OJ L 16, 23.1.2004, Art. 11 (4)).

Under CoE law, the ECHR does not expressly guarantee a right to healthcare or a right to health. However, the ECtHR has dealt with a number of health-related cases in a variety of circumstances. First, the Court examines life-endangering health issues for children. It identifies positive obligations incumbent on the state to take preventive measures against life-endangering health risks that it knows or should know about.

Example: In *Oyal v. Turkey*, the state failed to take preventive measures against the spread of HIV through blood transfusions. As a consequence, a new-born baby was infected with the HIV virus during blood transfusions at a state hospital. While some redress was offered, the ECtHR found that, in the absence of full medical cover for treatment and medication during the lifetime of the child concerned, the state had failed to offer satisfactory redress and thereby violated the right to life (Article 2 of the ECHR).[381] In addition, it ordered the Turkish State to provide free and full medical cover during the lifetime of the victim.

Example: In *Iliya Petrov v. Bulgaria*,[382] a 12-year old boy got seriously injured in an electricity substation. The substation was located in an outdoor park where children and young people often met, and the door was not locked. The ECtHR held that the exploitation of an electricity grid is an activity that poses a heightened risk to persons who are close to the installations. The state has an obligation to put adequate regulation in place, including a system to control the proper application of security rules. The Court ruled that the failure of the state to ensure that the electricity substation was secured, although it knew about the safety problems, amounted to a violation of the right to life (Article 2 of the ECHR).[383]

Moreover, states have positive obligations to account for the treatment of children in a vulnerable situation who are in the care of state authorities (see also Chapter 6 and Section 7.3).

381 ECtHR, *Oyal v. Turkey*, No. 4864/05, 23 March 2010, paras. 71–72.

382 ECtHR, *Iliya Petrov v. Bulgaria*, No. 19202/03, 24 April 2012 (available in French).

383 *Ibid.*

Example: The case of *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania*[384] concerned an HIV-positive Roma teenager who had a severe intellectual disability and also suffered from tuberculosis, pneumonia and hepatitis, and died at the age of 18. He had been in state care throughout his life. The ECtHR found serious shortcomings in the decision-making concerning the provision of medication and care, and a continuous failure of the medical staff to provide him with appropriate care and treatment. Article 2 of the ECHR had therefore been violated.[385]

Furthermore, in the absence of an emergency, the ECtHR found that medical treatment without parental consent is in breach of Article 8 of the ECHR.

Example: In *Glass v. the United Kingdom*,[386] diamorphine had been administered to a child with severe disability, notwithstanding firm objections by his mother. The ECtHR found that the decision of the hospital authorities to override the mother's objection to the proposed treatment in the absence of authorisation by a Court resulted in a breach of Article 8 of the ECHR.[387]

Example: In *M.A.K. and R.K. v. the United Kingdom*,[388] a nine year old girl underwent a blood test and photographs without parental consent, notwithstanding her father's express instructions not to carry out any further tests while the girl was alone in the hospital. In the absence of any medical urgency, these medical interventions without parental consent were held to be in violation of her right to physical integrity under Article 8 of the ECHR.[389]

In accordance with Articles 6 and 8 of the Convention on Human Rights and Biomedicine,[390] when a child does not have the legal capacity to consent to

384 ECtHR, *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], No. 47848/08, 17 July 2014. See further the description of this ECHR ruling in Chapter 7.

385 See also Section 7.

386 ECtHR, *Glass v. the United Kingdom*, No. 61827/00, 9 March 2004.

387 *Ibid.*, para. 83.

388 ECtHR, *M.A.K. and R.K. v. the United Kingdom*, Nos. 45901/05 and 40146/06, 23 March 2010.

389 *Ibid.*, para. 79.

390 Council of Europe, Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, CETS No. 164, 1997.

a medical intervention, that intervention may only be carried out with the authorisation of his or her representative, save in an emergency situation. Whereas this convention does not require the consent of the child if he or she is legally incapable of consenting, it does hold that the opinion of the child must be taken into consideration "as an increasingly determining factor in proportion to his or her age and degree of maturity" (Article 6 (2)).

Furthermore, under Article 11 of the ESC, States Parties agree to take appropriate measures to provide for advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health.[391] Medical assistance and care is guaranteed under Article 13 of the ESC to those who are without adequate resources and unable to secure those resources by their own efforts or from other sources. Finally, in 2011 the Committee of Ministers adopted child-specific guidelines on child-friendly healthcare.[392]

As indicated in the following examples, the ECSR holds that migrant children staying irregularly in a country are entitled to healthcare beyond urgent medical assistance. The ESC includes many references to children's rights to social welfare and health services (Articles 11, 12, 13, 14, 16 and 17), which apply regardless of their migration status.

Example: The ECSR decision in *International Federation of Human Rights Leagues (FIDH) v. France*[393] concerns France passing a law which ended the exemption of immigrants in an irregular situation with very low incomes from paying for medical treatment, and imposed health care charges. The ECSR ruled that individuals who have not reached the age of majority, including unaccompanied children, must be provided with free medical care.

391 On sexual and reproductive health education, see also under education (Section 8.2).

392 Council of Europe, Committee of Ministers (2011), Guidelines on child-friendly health care, 21 September 2011.

393 ECSR, *International Federation of Human Rights Leagues (FIDH) v. France*, Complaint No. 14/2003, 8 September 2004, paras. 35–37.

Example: In *Defence for Children International (DCI) v. Belgium*,[394] the ECSR found a violation of Article 17 of the ESC because of restrictions on medical assistance to undocumented migrant children. The Committee confirmed "the right of migrant minors unlawfully in a country to receive health care extending beyond urgent medical assistance and including primary and secondary care, as well as psychological assistance".[395] It also stated that the lack of reception facilities for foreign minors unlawfully in the country made access to health care difficult. Moreover, it found that causes of ill-health can only be removed to the extent that children are provided with housing and foster homes. Accordingly, it held that there was a violation of Article 11 (1) and (3) of the ESC due to the lack of housing and foster homes.[396]

The European Convention on the Legal Status of Migrant Workers[397] similarly provides that migrant workers who are lawfully employed in the territory of another state, as well as their families, should receive equal access to social and medical assistance (Article 19).

Under international law, more comprehensive provisions on the right to health can be found in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)[398] and in Article 24 of the CRC. These instruments emphasise prevention and treatment. The UN Committee on the Rights of the Child emphasises the importance of access to the highest attainable standard of healthcare and nutrition during early childhood,[399] and access for adolescents to sexual and reproductive information.[400] It has also clarified that children's right to health entails "the right to control one's health and body,

394 ECSR, *Defence for Children International (DCI) v. Belgium*, Complaint No. 69/2011, 23 October 2012.

395 *Ibid.*, para. 128.

396 *Ibid.*, paras. 116–118.

397 Council of Europe, European Convention on the Legal Status of Migrant Workers, CETS No. 93, 1977.

398 UN, General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, Vol. 993, p. 3.

399 UN, Committee on the Rights of the Child (2006), *General Comment No. 7 (2005): Implementing child rights in early childhood* , UN Doc. CRC/C/GC/7/Rev.1, para. 27.

400 UN, Committee on the Rights of the Child (2003), *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, UN Doc. CRC/GC/2003/4, para. 28.

including sexual and reproductive freedom to make responsible choices".[401] It encourages states to "consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion".[402]

8.4. Right to housing

Key points

- The right to adequate housing is guaranteed in Article 31 of the ESC.
- The ECSR holds that adequate shelter is to be provided to children residing irregularly in a country and that the living conditions in shelters must be in keeping with human dignity.
- According to the ECtHR, inadequate housing does not justify placement into public care.

Under EU law, Article 34 (3) of the EU Charter of Fundamental Rights contains a reference to the right to housing assistance as part of the struggle against social exclusion and poverty. The Racial Equality Directive highlights housing among the goods and services available to the public to which non-discriminatory access and supply should be granted.[403] Non-differential treatment regarding housing benefits applies to long-term residents. However, EU law tries to ensure, regarding family reunification for instance, that family members will not constitute a burden for the Member States' social assistance systems.[404] The Family Reunification Directive requires applications for family reunification to provide evidence that a valid sponsor of family reunification (i.e. a third-country national allowed to reside for a period of one year or more and with a reasonable prospect of obtaining the right of permanent residence)

401 UN, Committee on the Rights of the Child (2013), *General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, UN Doc. CRC/C/GC/15, para. 24.

402 *Ibid.*, para. 31.

403 Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin, Art. 3.

404 See further FRA and ECtHR (2014), p. 201.

has accommodation regarded as normal for a comparable family in the same region. The accommodation should meet the general health and safety standards in force in the Member State concerned.[405]

Under CoE law, there is no right to be provided with housing under the ECHR, but if a state decides to provide housing, it must do so in a non-discriminatory way.

> Example: In *Bah v. the United Kingdom*[406] the applicant, who was lawfully residing in the UK, was allowed to be joined by her son on the condition that he did not have recourse to public funds. Shortly after her son's arrival, the applicant sought assistance in finding accommodation. However, because her son was subject to immigration control, she was refused the priority to which her status as an unintentionally homeless person with a minor child would ordinarily have entitled her. The authorities ultimately helped her find new accommodation and later provided her with social housing. The applicant complained that the refusal to grant her priority had been discriminatory. The ECtHR held that it was legitimate to put in place criteria for the allocation of limited resources such as social housing, provided that such criteria were not arbitrary or discriminatory. There had been nothing arbitrary in the denial of priority to the applicant, who had brought her son into the country in full awareness of the condition attached to his leave to enter. Moreover, the applicant had never in fact been homeless and there were other statutory duties which would have required the local authority to assist her and her son had the threat of homelessness actually manifested itself. Consequently, there had been no violation of Article 14 taken in conjunction with Article 8 of the ECHR.

The ECtHR also examines cases of eviction of Roma families from caravan sites.[407] The ECtHR has indirectly dealt with the issue of the quality of housing, stating that inadequate housing does not justify placing children into public care[408] (see also Sections 5.2. and 6.2.).

405 Council Directive 2003/86/EC on the right to family reunification of 22 September 2003 (Family Reunification Directive) Art. 7 (1) (a).

406 ECtHR, *Bah v. the United Kingdom*, No. 56328/07, 27 September 2011.

407 ECtHR, *Connors v. the United Kingdom*, No. 66746/01, 27 May 2004.

408 ECtHR, *Wallová and Walla v. the Czech Republic*, No. 23848/04, 26 October 2006, paras. 73–74 (available in French); ECtHR, *Havelka and Others v. the Czech Republic*, No. 23499/06, 21 June 2007, paras. 57–59 (available in French).

The right to adequate housing is guaranteed in Article 31 of the ESC. The ECSR holds that "[a]dequate housing under Article 31 (1) means a dwelling which is safe from a sanitary and health point of view, i.e. it must possess all basic amenities, such as water, heating, waste disposal, sanitation facilities and electricity and must also be structurally secure, not overcrowded and with secure tenure supported by the law".[409] Evictions are permissible if justified, carried out in conditions that respect dignity, and if alternative accommodation is made available.[410] Living conditions in a shelter "should be such as to enable living in keeping with human dignity [...] [and] must fulfil the demands for safety, health and hygiene, including basic amenities, i.e. clean water, sufficient lighting and heating. The basic requirements of temporary housing include also security of the immediate surroundings."[411]

With regard to housing for foreign children in an irregular situation, the ECSR holds that both the failure to provide any form of accommodation and the provision of inappropriate accommodation in hotels amount to a violation of Article 17 (1) of the ESC.[412] Moreover, under Article 31 (2) of the ESC on the prevention of homelessness, states are required to provide adequate shelter to children in an irregular situation without resorting to detention.[413]

409 ECSR, *Defence for Children International (DCI) v. the Netherlands*, Complaint No. 47/2008, 20 October 2009, para. 43.

410 ECSR, *European Roma Rights Centre (ERRC) v. Italy*, Complaint No. 27/2004, 7 December 2005, para. 41; ECSR, *Médecins du Monde – International v. France*, Complaint No. 67/2011, 11 September 2012, paras. 74–75 and 80.

411 ECSR, *Defence for Children International (DCI) v. the Netherlands*, Complaint No. 47/2008, 20 October 2009, para. 62.

412 ECSR, *Defence for Children International (DCI) v. Belgium*, Complaint No. 69/2011, 23 October 2012, paras. 82–83. See also FRA (2010), p. 30.

413 ECSR, *Defence for Children International (DCI) v. the Netherlands*, Complaint No. 47/2008, 20 October 2009, para. 64.

8.5. Right to an adequate standard of living and right to social security

Key points

- Access to child allowances and parental leave must be non-discriminatory.
- Under EU law, the social security coverage of young workers in apprenticeship contracts should not be so low that it excludes them from the general range of protection.
- Under the ESC, the suspension of family allowances in case of truancy is a disproportionate limitation to the right of the family to economic, social and legal protection.

Under EU law, Article 34 (1) of the EU Charter of Fundamental Rights stipulates that the "Union recognises and respects the entitlement to social security benefits and social services" in cases that correspond to the traditional branches of social security (maternity, illness, industrial accidents, dependency or old age, and loss of employment). Entitlement extends to everyone residing and moving legally within the EU. The right to social assistance is recognised to ensure a decent existence for those who lack sufficient resources and to combat social exclusion and poverty. All these aspects are qualified by the "rules laid down by Union Law and national laws and practices" (Article 34 (1) of the Charter).

The CJEU holds that, where a Member State's own nationals are only required to reside in the Member State to access a child-raising allowance, nationals of other EU Member States cannot be made to produce a formal residence permit to access the same benefits.[414] The refusal of parental leave to certain categories of persons, such as commissioning mothers who have a baby through a surrogacy arrangement, is discriminatory.[415] The same applies to male civil servants who are refused parental leave if their wives do not work or exercise any profession, unless the wives are unable to meet the needs related to the upbringing of the child due to serious illness or injury.[416] Similarly, Member States have to establish a parental leave regime in the event of the birth of

414 CJEU, C-85/96, *María Martínez Sala v. Freistaat Bayern*, 12 May 1998, paras. 60–65.

415 CJEU, C363/12, *Z v. A Government Department, The Board of Management of a Community School* [GC], 18 March 2014.

416 CJEU, C-222/14, *Konstantinos Maïstrellis v. Ypourgos Dikaiosynis, Diafaneias kai Anthropinon Dikaiomaton*, 16 July 2015, para. 53.

twins that ensures these parents receive treatment particular to their needs. This can be ensured through basing the length of parental leave on the number of children born, and providing for other measures, such as material assistance or financial aid.[417]

Under CoE law, the ECtHR examined alleged discrimination in the granting of parental leave and parental allowances in Russia.

> Example: In *Konstantin Markin v. Russia*,[418] parental leave was refused to a serviceman in the Russian army, while servicewomen were entitled to such leave. In the Court's view, the exclusion of servicemen from the entitlement to parental leave could not be reasonably justified. Neither the special armed forces context and assertions about the risk to operational effectiveness, nor the arguments about the special role of women in raising children or the prevailing traditions in the country were found to justify the differential treatment. The Court found that Article 14 in conjunction with Article 8 of the ECHR had been violated.

More extensive provisions on the right to social security, the right to social and medical assistance, and the right to benefit from social welfare services can be found in Articles 12–14 of the ESC. Article 16 of the ESC explicitly mentions social and family benefits as a way the economic, legal and social protection of the family life can be promoted. Article 30 of the ESC provides for a right to protection against poverty and social exclusion. Certain social security claims may fall within the scope of Article 1, Protocol No. 1 to the ECHR, provided that national legislation generates a proprietary interest by providing for the payment as of right of a welfare benefit, whether conditional or not on the prior payment of contributions.[419]

Article 12 of the ESC requires states to establish or maintain a social security system, and to endeavour to raise it progressively to a higher level.

Article 16 of the ESC requires states to ensure the economic, legal and social protection of the family by appropriate means. The primary means should be family or child benefits, provided as part of social security and available either

417 CJEU, C-149/10, *Zoi Chatzi v. Ypourgos Oikonomikon*, 16 September 2010, paras. 72–75.

418 ECtHR, *Konstantin Markin v. Russia* [GC], No. 30078/06, 22 March 2012.

419 ECtHR, *Stummer v. Austria* [GC], No. 37452/02, 7 July 2011, para. 82.

universally or subject to a means-test. These benefits must constitute an adequate income supplement for a significant number of families. The ECSR assesses the adequacy of family (parental) benefits with respect to the median equivalised income (Eurostat).[420] The ECSR finds that the absence of any general system of family benefits is not in conformity with the ESC.[421]

The ECSR accepts, however, that the payment of child benefits may be made conditional based on the child's residence.[422] It holds that the introduction of only very limited protection against social and economic risks given to children (15–18 years old) in special apprenticeship contracts (they were only entitled to sickness benefits in kind and to occupational accident coverage at a rate of 1 %) effectively excludes a distinct category of (minor) workers from the "general range of protection offered by the social security system at large". It is hence in violation of the state's obligation to progressively raise the system of social security.[423]

The suspension of family allowances in cases of truancy is also a disproportionate limitation on the right of the family to economic, social and legal protection.

Example: In a complaint against France, the European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) argued that suspending family allowances as a measure to address truancy was a violation of the right of families to social, legal and economic protection under Article 16 of the ESC. In finding the measure disproportionate to the aim pursued, the Committee noted that "the contested measure of suspending and possibly suppressing family allowances makes parents exclusively responsible for pursuing the aim of reducing truancy and increases the economic and social vulnerability of the families concerned".[424]

420 ECSR, Conclusions 2006, Estonia, p. 215

421 ECSR, Conclusions 2011, Turkey, Art. 16.

422 ECSR (2007), Conclusions XVIII-1 – General Introduction, p. 11.

423 ECSR, *General Federation of Employees of the National Electric Power Corporation (GENOP-DEI) and Confederation of Greek Civil Servants' Trade Unions (ADEDY) v. Greece*, Complaint No. 66/2011, 23 May 2012, para. 48.

424 ECSR, *European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) v. France*, Complaint No. 82/2012, 19 March 2013, para. 42.

The European Convention on the Legal Status of Migrant Workers[425] provides that migrant workers lawfully employed in another state as well as their families should receive equal access to social security (Article 18), and other "social services" that facilitate their reception in the host state (Article 10). Similarly, the European Convention on Social Security protects refugees and stateless persons' rights to access social security provision in the host state (including family benefits for children).[426]

Under international law, the right to an adequate standard of living is guaranteed in Article 11 of the ICESCR and Article 27 of the CRC.

425 Council of Europe, European Convention on the Legal Status of Migrant Workers, CETS No. 93, 1977.

426 Council of Europe, European Convention on Social Security, CETS No. 78, 1972.

9 Migration and asylum

EU	Issues covered	CoE
TFEU, Article 21 Charter of Fundamental Rights, Article 45 (freedom of movement) Reception Conditions Directive (2013/33/EU) Return Directive (2008/115/EC) Asylum Procedures Directive (2013/32/EU) Dublin Regulation (No. 604/2013) Qualification Directive (2011/95/EU) Freedom of Movement Directive (2004/38/EC) CJEU, C-648/11, *The Queen, on the application of MA and Others v. Secretary of State for the Home Department*, 2013 (Dublin transfers) Schengen Borders Code Regulation (562/2006), Annex VII, 6	Entry and residence	ECHR, Article 8 (family life)
Asylum Procedures Directive (2013/32/EU), Article 25(5)	Age assessment	
TFEU, Articles 67, 73 and 79 (2) (a) Family Reunification Directive (2003/86/EC) Qualification Directive (2011/95/EU), Article 31 Reception Conditions Directive (2013/33/EU) Temporary Protection Directive (2001/55/EC) Dublin Regulation (No. 604/2013) Return Directive (2008/115/EC), Article 13	Family reunification and separated children	ECHR, Article 8 (right to respect for private and family life) ECtHR, *Şen v. the Netherlands*, No. 31465/96, 2001 (balancing rights) ECtHR, *Jeunesse v. the Netherlands* [GC], No. 12738/10, 2014 (family life, child's best interests)

EU	Issues covered	CoE
Reception Conditions Directive, (2013/33/EU), Article 11 Return Directive (2008/115/EC), Article 17	Detention of children	ECtHR, *Mubilanzila Mayeka and Kaniki Mitunga v. Belgium*, No. 13178/03, 2006 (detention in view of expulsion) ECtHR, *Popov v. France*, Nos. 39472/07 and 39474/07, 2012 (detention in view of expulsion) ECtHR, *Kanagaratnam and Others v. Belgium*, No. 15297/09, 2011 (detention in view of expulsion)
Freedom of Movement Directive (2004/38/EC), Preamble (para. 24), Articles 7, 12, 13 and 28 (3) (b)	Expulsion	ECtHR, *Gül v. Switzerland*, No. 23218/94, 1996 (deportation of family) ECtHR, *Boultif v. Switzerland*, No. 54273/00, 2001 (deportation of childen) ECtHR, *Tarakhel v. Switzerland* [GC], No. 29217/12, 2014 (deportation of children)
Charter of Fundamental Rights, Articles 47–48 (right to an effective remedy and to a fair trial, presumption of innocence and right of defence) Asylum Procedures Directive (2013/32/EU), Article 7 and 25 Victims' Directive (2012/29/EU), Article 8	Access to justice	ECHR, Article 13 (right to an effective remedy) ECtHR, *Rahimi v. Greece*, No. 8687/08, 2011 (effective remedies to challenge conditions of detention)

The EU has clear competence to legislate in the area of migration and asylum. Provisions covering migrant children govern a range of migration situations, including long-term work-related migration, asylum, and subsidiary protection, and also addresses the situation of migrants in an irregular situation. In addition to the protection migrant children are entitled to under Article 24 of the EU Charter of Fundamental Rights, Articles 18 and 19 of the Charter deal with the right to asylum and protection in the event of removal, expulsion or

extradition. The EU has also paid attention to the specific needs of unaccompanied children, including regarding legal aspects such as legal guardianship and legal representation, age assessment, family tracing and reunification, asylum procedures, detention, and expulsion, as well as aspects relating to the living conditions of the children, including accommodation, healthcare, education and training, religion, cultural norms and values, recreation and leisure and social interaction and experiences of racism.[427]

Within the CoE system, four conventions in particular support the rights of migrant children in different contexts: the ECHR, the ESC, the European Convention on the Legal Status of Migrant Workers and the European Convention on Nationality. This chapter mainly focuses on the implementation of ECHR provisions, notably Article 3 (protection against inhuman, degrading treatment), Article 5 (deprivation of liberty), and Article 8 (right to respect for private and family life), taken alone or in conjunction with Article 14 (non-discrimination). These provisions are used to support migrant, refugee and asylum seeking children's and their family members' rights to family reunification, access to justice and ongoing residence in the host state.

At the international level, a number of CRC provisions uphold children's rights in the context of migration and asylum and have informed the development of legal measures at the European level. Specifically, Article 7 protects children's right to birth registration, nationality, and parental care; Article 8 protects the child's right to identity, including nationality, name and family relations; Article 9 ensures that separated children should maintain contact with both parents where it is in their best interests; and Article 22 provides refugee children with the right to special protection and help. Further, the UN Convention Relating to the Status of Refugees[428] along with its 1967 Protocol are universally regarded as the centrepiece of international refugee protection.

The following sections focus on entry and residence (Section 9.1); age assessment (Section 9.2); family reunification for separated children (Section 9.3); detention (Section 9.4); expulsion (Section 9.5) and access to justice (Section 9.6).

427 See further, FRA (2010); FRA (2011a), pp. 27–38; FRA (2011b), pp. 26–30.

428 UN, General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, Vol. 189, p. 137.

9.1. Entry and residence

Key points

- EU nationals enjoy the right to freedom of movement within the EU.
- Decisions on child entry and residence should be taken in the framework of appropriate mechanisms and procedures and in the child's best interests.

Under EU law, the nature and scope of children's rights differs largely according to the nationality of the child and the child's parents and according to whether the child is migrating with his/her parents or independently.

The migration of EU nationals is regulated by various legal instruments. The rights granted to EU nationals are far-reaching and aim to stimulate optimum mobility across the EU. First, Article 21 of the TFEU provides that EU citizens and their family members have a right to move and reside freely within the territory of any EU Member State. Moreover, once they arrive in the host state, they have a right to be treated equally to nationals of that state in relation to their access to and conditions of work, social and welfare benefits, school, healthcare, etc.[429] Article 45 of the EU Charter of Fundamental Rights equally guarantees the freedom of movement of EU citizens.

Further, the rights of children who move with EU-national parents/carers are also governed by the Free Movement Directive.[430]This stipulates that family members have a right to enter and reside in the host state either with or following the primary EU migrant's move there (Article 5 (1)). Family members, for the purposes of this instrument, include any biological children of either the EU migrant or their spouse or partner, provided they are under the age of 21 or are "dependent" (Article 2 (2)). They may be both EU and non-EU nationals, provided the primary migrant with whom they have moved is an EU

429 Some restrictions have been imposed on migrants from Croatia, the most recent country to accede to the EU, for a transitional period up until June 2015, with the possibility for Member States of extending the period in which restrictions will be imposed until 2020.

430 Please note that relevant provisions of the directive also apply in the EEA. See further Agreement on the European Economic Area, 2 May 1992, Part III, Free Movement of Persons, Services and Capital and Agreement between the European Community and its Member Sates, on the one part, and the Swiss Confederation, on the other, on the free movement of persons, signed in Luxembourg on 21 June 1999, entered into force on 1 June 2002, OJ 2002 L 114/6.

national. For the first three months following their move, the family's right of residence is unconditional, but thereafter EU citizens who wish their children to remain with them in the host state must demonstrate that they have sufficient financial resources and comprehensive sickness insurance to support them (Article 7). Children and other family members automatically acquire permanent residence after a period of five consecutive years of residence in the host state with the EU citizen (Articles 16 (2) and 18). At that point, they are no longer subject to any resources/sickness insurance conditions.

The freedom of movement of third-country nationals who do not belong to the family of an EU migrant is subject to more restrictions. This area is partially regulated by EU law and partially regulated by national immigration laws.

In the context of international protection procedures, children are regarded as "vulnerable persons" whose specific situation Member States are required to take into account when implementing EU law.[431] This requires states to identify and accommodate any special provision that asylum-seeking children in particular might need when they enter the host state. Article 24 of the EU Charter of Fundamental Rights applies to the entry and residence requirements of the EU asylum *acquis* as it relates to children. It requires that in all actions relating to children, whether taken by public authorities or private institutions, EU Member States ensure that the best interests of the child are a primary consideration. More specifically, the best interests principle underpins the implementation of Directive 2013/32/EU on common procedures for granting and withdrawing international protection (Asylum Procedures Directive)[432] and the Regulation establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person (Dublin Regulation) as they relate to children.[433] Both texts also contain specific guarantees for unaccompanied children, including their legal representation. The Regulation (562/2006) on the Schengen Borders Code

431 See specifically Reception Conditions Directive 2013/33/EU, Art. 21 and Return Directive 2008/115/EC, Art. 3 (9).

432 Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection (recast), 29 June 2013, L 180/60, Art. 25(6).

433 Regulation (EU) No. 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person (recast), OJ 2013 L. 180/31-180/59, Art. 6.

requires border guards to check that the persons accompanying children have parental care over them, especially where children are accompanied by only one adult and there are serious grounds for suspecting that the children may have been unlawfully removed from the custody of their legal guardian(s). In this case, the border guard must investigate further to detect any inconsistencies or contradictions in the information given. If children are travelling unaccompanied, border guards must ensure, by means of thorough checks on travel and supporting documents, that the children are not leaving the territory against the wishes of the person(s) responsible for their parental care.[434]

Under CoE law, states have the right, as a matter of well-established international law and subject to their treaty obligations, including the ECHR, to control the entry, residence and expulsion of aliens. The right to respect for private and family life in Article 8 of the ECHR is often invoked as a safeguard against expulsion in cases concerning children who otherwise would have been assessed as not in need of international protection, including subsidiary protection. Article 8 violations have been found in cases involving children, as forced separation from close family members is likely to have an acute impact on their education, social and emotional stability and identity.[435]

9.2. Age assessment[436]

Key points

- Age assessment procedures must take account of the child's rights.
- Age assessment refers to the procedures through which authorities seek to establish the legal age of a migrant to determine which immigration procedures and rules need to be followed.

Under EU law, Article 25 (5) of the Asylum Procedures Directive allows Member States to resort to medical examinations, but requires that these be performed

434 Regulation (562/2006) of the European Parliament and the Council of 15 March 2016 establishing a Community Code on the rules governing the movement of persons across borders (Schengen Borders Code) Annex VII, 6.

435 ECtHR, *Şen v. the Netherlands*, No. 31465/96, 21 December 2001 (available in French); ECtHR, *Tuquabo-Tekle and Others v. the Netherlands*, No. 60665/00, 1 December 2005.

436 See also FRA and ECtHR (2014), Section 9.1.2.

"with full respect for the individual's dignity, shall be the least invasive examination, and shall be carried out by qualified medical professionals". This provision also requires that individuals are informed in a language they can understand that such an assessment may be carried out and their consent to examination should be obtained. The refusal to undergo age assessment cannot result in a rejection of the application for international protection.

There is significant variation in the nature and scope of age assessment methods applied across the EU.[437] In the UK for instance, the judiciary has reviewed domestic procedures on age assessment, and in the case of *Merton* it determined the minimum procedural requirements for assessing age when an individual claims to be an unaccompanied child.[438] Such requirements include, among others, the right of the asylum seeker to be informed about the reasons for rejection or objections of the interviewer.[439] National courts have also stated the need to apply the benefit of doubt in age assessment cases, although this has been interpreted by some national courts as a mere "sympathetic assessment of evidence" rather than a formal "benefit of doubt" principle.[440]

Under CoE law, there is no specific provision or ECtHR case law relating to children's rights in the context of age assessment procedures. However, particularly invasive practices used to this end might raise an issue under Articles 3 or 8 of the ECHR. Article 3 has been interpreted to include a broad range of scenarios that might be considered inhumane or degrading, including invasive physical examinations of children.[441] Under Article 8, applied to an immigration context, the authorities could legitimately interfere with a child's right to privacy and conduct age assessments if in accordance with the law and necessary to protect one of the legitimate aims listed in Article 8 (2) of the ECHR.

Under international law, Article 8 of the CRC obliges states to respect the child's right to identity. This implies an obligation to assist a child in asserting

437 For an overview of the various methods applied in each country, see the European Asylum Support Office Guidelines on Age Assessment Practice in Europe, Luxembourg, 2014. See further, FRA (2010), pp. 53–55.

438 United Kingdom, Court of Appeal, *R (on the application of B) v. The Mayor and Burgesses of the London Borough of Merton* [2003] EWHC 1689, 14 July 2003.

439 See FRA (2010), pp. 61–66.

440 United Kingdom, Court of Appeal, *R (on the application of CJ) v. Cardiff County* Council [2011] EWCA Civ 1590, 20 December 2011, reaffirmed in United Kingdom, Upper Tribunal, *R (on the application of MK) v. Wolverhampton City Council* [2013] UKUT 00177 (IAC), 26 March 2013.

441 ECtHR, *Yazgül Yilmaz v. Turkey*, No. 36369/06, 1 February 2011 (available in French).

his or her identity, which may involve confirming the child's age. Age assessment procedures, however, should be a last resort.

In any case, the best interests principle should underpin national procedures on age assessment. The UN Committee on the Rights of the Child affirms that age assessment should take into account the physical appearance of the child and his or her psychological maturity. The assessment must be conducted in a scientific, safe, child- and gender-sensitive and fair manner, avoiding any risk of violation of the physical integrity of the child, and giving due respect to human dignity.[442]

9.3. Family reunification for separated children[443]

Key points

- European-level provisions focus mainly on reuniting children safely with their parents, either in the host country or their country of origin.
- Preference will be given to the child's parents and/or primary carers when determining which family members should be reunited with the family.
- The child's best interests must guide family reunification cases.

Under EU law, the most notable instrument is the Family Reunification Directive, which requires Member States to authorise the entry and residence of the unaccompanied child's parents who are third-country nationals – in those situations where it is not in the child's best interest to join his/her parents abroad instead. In the absence of a parent, Member States have the discretion to authorise the entry and residence of the child's legal guardian or any other member of the family.[444] The definition and rights attached to 'family' are therefore more generous in the context of unaccompanied children than for most other categories of child migrants.

442 UN, Committee on the Rights of the Child, *General Comment No. 6 (2005): Treatment of unaccompanied and separated children outside their country of origin*, UN Doc. CRC/GC/2005/6, 1 September 2005, (V)(a)(31)(A).

443 See also FRA and ECtHR (2014), Section 5.3 on family reunification.

444 Arts. 10 (3) (a) and (b), respectively.

As to asylum-seeking children, the Qualification Directive emphasises the need to ensure, where possible, that an unaccompanied child is placed with adult relatives in the host state, that he or she remains with any siblings, and that absent family members are located in a sensitive and safe manner as soon as practicable (Article 31). The Reception Conditions Directive makes similar provisions for unaccompanied children who have not yet acquired refugee status (Article 24).

Council Directive 2001/55/EC on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof (Temporary Protection Directive) also seeks to expedite the reunification of family members (including children) who have been separated from one another following a sudden evacuation from their country of origin (Article 15).[445] However, this directive has to date not been applied; for it to be 'triggered', a Council decision is required – and such a decision has not yet been taken.

Article 24.3 of the Reception Conditions Directive (Recast) also requires that Member States start tracing the members of the unaccompanied child's family, where necessary. This is done with the assistance of international or other relevant organisations as soon as possible after an application for international protection is made, whilst protecting the child's best interests. In cases of a possible threat to the life or integrity of a child or his/her close relatives, particularly if they have remained in the country of origin, care must be taken to ensure that the collection, processing and circulation of information concerning them is undertaken on a confidential basis to avoid jeopardising their safety. Further, in accordance with Article 31 (5) of the Qualifications Directive (Recast), the granting of international protection to the child should not interfere with the start or continuation of the tracing process.

The Dublin Regulation provides, in addition, that if an unaccompanied child has a relative or relatives living in another Member State who can take care of him or her, Member States are obliged, where possible, to unite the child with them, unless this is contrary to the child's best interests (Article 8). In addition,

445 Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof, OJ 2001 L 212.

the Regulation contains an obligation to trace the relatives on the territory of Member States, while protecting the best interests of the child (Article 6). Furthermore, the Reception Conditions Directive contains an obligation to start tracing the members of the child's family, where necessary with the assistance of international or other relevant organisations (Article 24). The latter type of assistance is also envisaged under the Dublin Regulation (Article 6).

The best interests principle must always be applied when considering a decision concerning family reunification. For example, parents must be able to prove that they are capable of exercising their parental duties to the benefit of the child. National courts will find a child's return to his or her country of origin unlawful when authorities have failed to gather evidence that there are adequate arrangements for the child's reception and care in that country (Return Directive, Article 10 (2)).

Under CoE law, Article 8 of the ECHR does not allow migrant parents and their children an absolute right to choose where they want to live. National authorities can legitimately deport or refuse entry to family members provided there are no insurmountable obstacles to establishing family life elsewhere.[446] Such decisions must always be a proportionate response to wider public policy concerns, including the desire to deport or prevent the entry of a parent who has been involved in criminal activity.

Example: In *Şen v. Netherlands* the ECtHR confirmed that in striking a balance between the rights of the child/family and wider public policy interests, three key factors must be taken into account: the age of the children; their situation in the country of origin; and the degree to which they actually depend on their parents.

Example: The case of *Jeunesse v. the Netherlands*[447] concerns the Dutch authorities' refusal to allow a Surinamese woman married to a Dutch national, with whom she had three children, to reside in the Netherlands on the basis of her family life in the country. The ECtHR considered that the authorities had not paid enough attention to the impact of their re-

446 ECtHR, *Bajsultanov v. Austria*, No. 54131/10, 12 June 2012; ECtHR, *Latifa Benamar and Others v. the Netherlands*, Decision of inadmissibility, No. 43786/04, 5 April 2005.

447 ECtHR, *Jeunesse v. the Netherlands* [GC], No. 12738/10, 3 October 2014.

fusal on the applicant's children and their best interests. The ECtHR found a violation of Article 8 of the ECHR on account that a fair balance had not been struck between the personal interests of the applicant and her family in maintaining their family life in the Netherlands and the public order interests of the Government in controlling immigration.

Under international law, a child has the right not to be separated from his or her family unless separation is deemed to be in the child's best interests (Article 9 (1) CRC). Article 10 of the CRC provides that a child whose parents live in different countries should be allowed to move between those countries to stay in contact with them both, or to reunify, subject to national immigration law. The best interests principle, as enshrined in Article 3 of the CRC, underpins all decisions relating to family reunification with a child or unaccompanied child.[448]

9.4. Detention

Key points

- European law authorises the detention of children in an immigration context only as a measure of last resort.
- National authorities are obliged to place children in appropriate alternative accommodation.

Under EU law, Article 11 of the Reception Conditions Directive (Recast) requires that children should only be detained as a last measure and only if less coercive measures cannot be applied effectively. Such detention should be for the shortest period of time possible, and all efforts made to release those detained and to place them in a suitable accommodation. Where children are detained, they should have the possibility to engage in leisure activities, including play and recreational activities appropriate to their age. According to the same article, unaccompanied children too should only be detained in exceptional circumstances, and all efforts should be made to release them as soon as

448 According to UNICEF, in relation to claims to reunite the child with his/her family in the host state, national courts must also ensure that parents are not exploiting their children in order to obtain residence permits for that country. See UNICEF, Judicial implementation of Art. 3 of the CRC in Europe, p. 104. See also UNHCR (2008), *Guidelines on Determining the Best Interests of the Child*, May 2008.

possible. They should never be detained in prison accommodation, but rather be provided with accommodation in institutions equipped with personnel and age-appropriate facilities. Their accommodation should be separate from adults.

Article 17 of the Return Directive envisages the detention of children and families whose asylum application has been rejected subject to certain conditions. With regard to unaccompanied children, however, it requires that they be placed in institutions provided with staff and facilities which respond to the needs of persons of their age. There is as of yet no CJEU case law relating specifically to the detention of children.

Under CoE law, the detention of migrant children has been addressed in the context of Articles 3 and 5 of the ECHR.

> Example: *Mubilanzila Mayeka and Kaniki Mitunga v. Belgium*,[449] concerns an unaccompanied child held in detention. A five year old child was detained in a transit centre for adults for two months without appropriate support. The child had travelled from the Democratic Republic of Congo without the necessary travel papers in the hope of being reunited with her mother, who had obtained refugee status in Canada. The child was subsequently returned to the Democratic Republic of Congo, despite the fact that she had no family members waiting there to care for her. The ECtHR ruled that in the absence of any risk of the child seeking to evade the supervision of the Belgian authorities, detaining her in a closed centre for adults had been unnecessary. The ECtHR also noted that other measures – such as placing her in a specialised centre or with foster parents – could have been taken that would have been more conducive to the best interest of the child as enshrined in Article 3 of the CRC. The ECtHR found violations of Articles 3, 5 and 8 of the ECHR.

Other cases have highlighted the illegality of detention, even where the child in question was accompanied by a parent.

449 ECtHR, *Mubilanzila Mayeka and Kaniki Mitunga v. Belgium*, No. 13178/03, 12 October 2006.

Example: In *Muskhadzhiyeva and Others v. Belgium*,[450] the ECtHR ruled that the month-long detention in a closed transit centre of a mother and her four children, aged between seven months and seven years, constituted a violation of Article 3 of the ECHR. In reaching its conclusions, the Court drew attention to the fact that the centre was "ill-equipped to receive children", with serious consequences for their mental health.

Example: *Popov v. France*[451] concerns the administrative detention of a family for two weeks pending their deportation to Kazakhstan, confirms this ruling. The ECtHR found a violation of Article 3 of the ECHR insofar as the French authorities had not measured the inevitably harmful effects on the two children (who were five months and three years old) of being held in a detention centre in conditions that were "ill-adapted to the presence of children".[452] The Court also found a violation of Article 5 and Article 8 in respect of the whole family and referred to Article 37 of the CRC, which provides that "[e]very child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age".[453]

Example: Similarly, in *Kanagaratnam and Others v. Belgium*,[454] the detention of an asylum-seeking mother and her three children in a closed centre for aliens in an irregular situation for four months amounted to a breach of Articles 3 and 5 of the ECHR. Despite the fact that the children were accompanied by their mother, the Court considered that, by placing them in a closed centre, the Belgian authorities had exposed them to feelings of anxiety and inferiority and had, in full knowledge of the facts, risked compromising their development. [455]

450 ECtHR, *Muskhadzhiyeva and Others v. Belgium*, No. 41442/07, 19 January 2010 (available in French).

451 ECtHR, *Popov v. France*, Nos. 39472/07 and 39474/07, 19 January 2012.

452 *Ibid.*, para. 95.

453 *Ibid.*, para. 90.

454 ECtHR, *Kanagaratnam and Others v. Belgium*, No. 15297/09, 13 December 2011 (available in French).

455 The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), in its 19th General Report has described safeguards for irregular migrants deprived of their liberty, and additional safeguards for children; see further: *20 years of combating torture, 19th General Report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)*, 1 August 2008 to 31 July 2009.

Under international law, Article 9 (4) of the CRC provides that when a child is detained, state authorities must inform the child's parents of his or her whereabouts.[456]

9.5. Expulsion[457]

Key points

- The vulnerability of migrant children to expulsion is intrinsically linked with their parents' residence status in the host state.
- The best interests principle should guide all decisions relating to the expulsion of immigrant children and their family/primary carers.
- Under EU law, there are circumstances in which migrant children can remain in a host state notwithstanding their parents' legal status, particularly with a view to completing their education or where establishing family life elsewhere would be difficult.

Under EU law, as with other areas of EU migration law, rules governing the expulsion of children differ according to their nationality, their parents' nationality and the context of their migration. Once a child obtains access to a Member State under EU free movement law, he/she is likely to be able to remain there, even if the EU migrant parent he/she originally moved with no longer qualifies for ongoing residence or decides to leave.

Specifically, under the Free Movement Directive**,** children and other family members can remain in the host state following the death of the EU citizen parent they initially moved with (Article 12 (2)), provided they lived in the host state for at least 12 months before their parent's death. Similarly, they can, in principle, remain in the host state following their parent's departure. However, in both cases, if the child/family member is a third-country national, their ongoing residence is contingent on their being able to demonstrate they have

456 On international safeguards for children in situation of detention see *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, 5 March 2015, A/HRC/28/68.

457 Otherwise referred to as return, removal, repatriation, extradition, or deportation, depending on the legal context. For the purposes of this chapter, the term expulsion will be used to define the lawful removal of a non-national or other person from a state. See also FRA and ECtHR (2014), Section 5.4 on maintaining the family – protection from expulsion.

enough money to support themselves. They must also have sickness insurance (Article 7).

The rules are even more permissive for children enrolled in education facilities in the host state. In such cases, they and their custodial parent or carer are entitled to remain in the host state following the death or departure of the primary EU migrant citizen, irrespective of the child's nationality (Article 12 (3)). While originally it was thought that this education-related concession only applied to children in families with sufficient money to support themselves,[458] later case law has confirmed that it extends to children in education who may be dependent on social welfare support.[459]

Furthermore, family members and particularly third-country national parents also enjoy a right to remain in the host state following divorce from the partner who was an EU citizen, if they have primary custody of the couple's children or have been awarded rights of access to the children that must be exercised in the host state (Articles 13 (2) (b) and 13 (2) (d)).

The CJEU has referred to a child's status as an EU citizen under Article 20 of the TFEU to grant the child's third-country national parents a permit to work and reside in the EU Member State of the child's citizenship. This enables the child to enjoy the rights attached to his/her status as an EU citizen, in so far as the child would otherwise have to leave the EU to accompany his/her parents.[460] Subsequent CJEU jurisprudence indicates, however, that "the mere fact that it might appear desirable to a national of a Member State, for economic reasons or in order to keep his family together in the territory of the Union, for the members of his family who do not have the nationality of a Member State to be able to reside with him in the territory of the Union, is not sufficient in itself to support the view that the Union citizen will be forced to leave Union territory if such a right is not granted".[461]

458 CJEU C-413/99, *Baumbast and R v. Secretary of State for the Home Department*, 17 September 2002.

459 CJEU C-480/08, *Maria Teixeira v. London Borough of Lambeth and Secretary of State for the Home Department*, 23 February 2010; CJEU C-310/08, *London Borough of Harrow v. Nimco Hassan Ibrahim and Secretary of State for the Home Department* [GC], 23 February 2010. The education of migrant children is considered further in Section 8.2.

460 CJEU, C-34/09, *Gerardo Ruiz Zambrano v. Office National de l'Emploi (ONEm)*, 8 March 2011.

461 CJEU, C-256/11, *Murat Dereci and Others v. Bundesministerium für Inneres* [GC], 15 November 2011, para. 68. See also CJEU, C-40/11, *Yoshikazu Iida v. Stadt Ulm*, 8 November 2012. See further, FRA and ECtHR (2014), pp. 125–127.

The Free Movement Directive explicitly provides that any exceptional expulsion of children should be in line with the provisions of the CRC (Recital 24). Moreover, Article 28 (3) (b) endorses children's immunity from expulsion unless it is deemed to be in their best interests and in accordance with the CRC.

As far as asylum seeking children whose claim has been rejected are concerned, the Return Directive specifies that the best interests of the child should inform decisions relating to the return of unaccompanied children (Article 10). Moreover, before removing an unaccompanied child from a Member State, the authorities of that Member State must be satisfied that the child will be returned to a member of his/her family, a nominated guardian or adequate reception facilities in the state of return (Article 10 (2)).

In circumstances where asylum seeking children are returned to another Member State to have their asylum claim assessed, the Dublin Regulation stipulates that the best interests principle must guide the application of such decisions (Article 6). Furthermore, the regulation provides a checklist of factors to assist the authorities' determination of what is in the child's best interests. This includes due account for the child's family reunification possibilities; the child's well-being and social development; safety and security considerations, in particular where there is a risk of the child being a victim of human trafficking; and the views of the child, in accordance with his or her age and maturity.

Example: In *The Queen, on the application of MA and Others v. Secretary of State for the Home Department*,[462] the CJEU had to determine which state was responsible in the case of an unaccompanied child who had submitted asylum applications in different EU Member States and who had no family or relatives in other EU Member States. The CJEU clarified that in the absence of a family member legally present in a Member State, the state in which the child is physically present is responsible for examining such a claim. In doing so, it relied on Article 24 (2) of the EU Charter of Fundamental Rights, whereby in all actions relating to children, the child's best interests are to be a primary consideration.

Under CoE law, states are, in principle, permitted to interfere with the right to respect for family life in accordance with Article 8 (2) of the ECHR.

462 CJEU, C-648/11, *The Queen, on the application of MA and Others v. Secretary of State for the Home Department*, 6 June 2013.

Example: *Gül v. Switzerland*[463] concerns an applicant who lived in Switzerland with his wife and daughter, who were all granted residence permits on humanitarian grounds. He also wished to bring to Switzerland their minor son, whom they had left behind in Turkey, but the Swiss authorities refused to grant him this request, mainly on the grounds that he had insufficient means to provide for his family. The ECtHR held that by leaving Turkey the applicant had himself caused the separation with his son. His recent visits to Turkey showed that his initial reasons for applying for political asylum in Switzerland were no longer valid. There were no obstacles preventing the family from establishing themselves in their country of origin, where their minor son had always lived. While acknowledging that their family's situation was very difficult from the human point of view, the Court found no breach of Article 8 of the ECHR.

Example: In *Üner v. The Netherlands*[464] it was confirmed that consideration should be given to the impact that expulsion would have on any children in a family when determining whether it was a proportionate response. This involved considering: "the best interests and well-being of the children, in particular the seriousness of the difficulties which any children [...] are likely to encounter in the country to which the applicant is to be expelled; and the solidity of social, cultural and family ties with the host country and with the country of destination".

Example: The case of *Tarakhel v. Switzerland*[465] concerns the refusal of the Swiss authorities to examine the asylum application of an Afghan couple and their six children, and their decision to send them back to Italy. The ECtHR found that, in view of the current situation regarding the reception system in Italy, and in the absence of detailed and reliable information concerning the specific facility of destination, the Swiss authorities did not possess sufficient assurances that, if returned to Italy, the applicants would be taken charge of in a manner adapted to the age of the children. The ECtHR therefore found that there would be a violation of Article 3 of the ECHR if the Swiss authorities were to send the applicants back to Italy under the Dublin II Reg-

463 ECtHR, *Gül v. Switzerland*, No. 23218/94, 19 February 1996.

464 *ECtHR*, *Üner v. The Netherlands* [GC], No. 46410/99, 18 October 2006, paras. 57–58. See also *Boultif v. Switzerland*, No. 54273/00, 2 August 2001.

465 ECtHR, *Tarakhel v. Switzerland* [GC], No. 29217/12, 4 November 2014.

ulation without having first obtained individual assurances from the Italian authorities that the applicants would be taken charge of in a manner adapted to the age of the children and that the family would be kept together.

Under international law, a state shall upon request provide the parent(s) or the child with essential information concerning the whereabouts of the absent family member(s) in instances of detention, imprisonment, exile, deportation or death, unless it would be detrimental to the well-being of the child (Article 9 (4) of the CRC).

9.6. Access to justice[466]

Key point

- Migrant children have the right to an effective remedy.

Under EU law, children's rights to access justice in an immigration context are set out in a range of different instruments. First, the right to an effective legal remedy and to a fair trial is set out in Article 47 of the EU Charter of Fundamental Rights. This includes a right to a fair and public hearing within a reasonable time by an independent and impartial tribunal, including having the possibility of advice, a defence and appropriate legal representation under Article 48. For child migrants, this is reinforced by a range of secondary legislative provisions. In particular, the Dublin Regulation obliges Member States to ensure that an unaccompanied child is represented by an appropriately qualified professional who has access to all of the relevant information in the child's file (Article 6). Parallel provisions are found in the Qualification Directive (Article 31) and in the Asylum Procedures Directive (Article 25). Children's right to legal representation is also supported by their right to access victim services and special confidential support services under Article 8 of Directive 2012/29/EU establishing minimum standards on the rights, support and protection of victims of crime (Victims' Directive).[467]

466 See also FRA and ECtHR (2014), Section 4.5 on legal assistance in asylum and return procedures.

467 Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, OJ 2012 L 315/55.

Rights associated with access to justice are not without their limitations, however, and may be subject to certain age conditions. For example, the Asylum Procedures Directive allows Member States to "refrain from appointing a [legal] representative where the unaccompanied minor will in all likelihood reach the age of 18 before a decision at first instance is taken" (Article 25 (2)).

Under CoE law, the ECtHR ruled out the applicability of Article 6 (right to a fair trial) in cases concerning decisions on entry, stay and deportation of aliens.[468] However, Article 13 of the ECHR (the right to an effective remedy) may be relied on in certain circumstances.

Example: *Rahimi v. Greece*[469] concerns the conditions in which a migrant child from Afghanistan, who had entered Greece irregularly, was held in a detention centre and subsequently released with a view to his expulsion. In finding a violation of Article 13 of the ECHR, the ECtHR noted that the information brochure provided to the applicant did not indicate the procedure to be followed to make a complaint to the chief of police. Moreover, the applicant was not informed in a language which he understood of the available remedies he could use to complain about the conditions of his detention. Relying on the reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), the ECtHR noted the absence in Greece of an independent authority for the inspection of detention facilities of the law-enforcement agencies. It also noted that there was no impartial authority to make the remedy effective. Accordingly, it found violations of Article 3, Article 5 paragraphs 1 and 4, and Article 13 of the ECHR.

The ESC requires states to promote the legal (as well as social and economic) development of the family (Article 16). Moreover, Article 19 (1) requires states to maintain "adequate and free services" and to ensure that migrant workers and their families receive accurate information relating to emigration and immigration. A similar 'information' requirement (central to migrants' access to justice) is contained in Article 6 of the European Convention on the legal status of migrant workers, but the more extensive provisions governing "right

468 ECtHR, *Maaouia v. France* [GC], No. 39652/98, 5 October 2000.

469 ECtHR, *Rahimi v. Greece*, No. 8687/08, 5 April 2011 (available in French).

of access to the courts and administrative authorities" (Article 26) are directed exclusively at migrant workers rather than their family members.[470]

In addition, it is worth noting that the CoE has developed very comprehensive guidelines on child-friendly justice, which set out how all justice and administrative proceedings, including immigration proceedings, should be adapted to meet the needs of children.[471]

Under international law, Article 37 of the CRC is particularly relevant for migrant children deprived of their liberty, as it ensures these children the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of their liberty before a court or other competent, independent and impartial authority, whose decision must furthermore be prompt.

470 Council of Europe, European Convention on the Legal Status of Migrant Workers, CETS No. 93, 1977.

471 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010.

10 Consumer and personal data protection

EU	Issues covered	CoE
Charter of Fundamental Rights, Article 38 TFEU, Article 169 Consumer Rights Directive (2011/83/EU) Unfair Business-to-Consumer Commercial Practices Directive (2005/29/EC) General Product Safety Directive (2001/95/EC) Clinical Trials Directive (2001/20/EC) CJEU, C-244/06, *Dynamic Medien Vertriebs GmbH v. Avides Media AG*, 2008 (sale over the internet of DVDs) CJEU, C-36/02, *Omega Spielhallen- und Automatenaufstellungs-GmbH v. Oberbürgermeisterin der Bundesstadt Bonn*, 2004 (licence for playing a game) Regulation 536/2014 on clinical trials on medicinal products for human use Directive on foodstuffs intended for particular nutritional uses (2009/39/EC) Toy Safety Directive (2009/48/EC) Directive concerning products which, appearing to be other than they are, endanger the health or safety of consumers (87/357/EEC) Television Without Frontiers Directive (89/552/EEC) Audiovisual Media Services Directive (2010/13/EU)	Protection of children as consumers	European Convention on Transfrontier Television

EU	Issues covered	CoE
Charter of Fundamental Rights, Articles 7 (respect for private and family life), 8 (protection of personal data) and 52 (scope and interpretation of rights and principles) TFEU, Article 16 Data Protection Directive (95/46/EC)	Children and data protection	ECHR, Article 8 (right to respect for private and family life) ECtHR, *K.U. v. Finland*, No. 2872/02, 2008 (advertisement on the internet) ECtHR, *Avilkina and Others v. Russia*, No. 1585/09, 2013 (disclosure of medical records) Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data

This chapter addresses European legislation and case law in the field of consumer and data protection. There is an abundance of legislation and case law at the EU level, as the TFEU expressly lays down the EU's competence in these matters. The CoE's contribution in this field is more limited. At treaty level there are two main conventions on media and data protection. The ECtHR has also decided on a number of cases concerning the data protection of individuals.

The following sections shall concentrate on specific aspects of consumer law relating to children (Section 10.1) and data protection (Section 10.2). For each of these issues, the general legal framework and its applicability for children is analysed, as well as the specific norms for the protection of children, where relevant.

10.1. Protection of children as consumers

Key points

- According to the CJEU, child consumers' best interests and the protection of their rights override requirements of public interest justifying limits to the free movement of goods, persons, services and capital.
- Children as consumers should be provided with relevant information so as to be able to consider all relevant facts and make an informed choice.
- Unfair commercial practices are those that do not comply with the principle of professional diligence and may influence adult and child consumers' transactional decisions.
- Children can be included in clinical trials only if the administered medicinal product is expected to be of direct benefit to them, thereby outweighing the risks.
- EU and CoE law limit the amount of marketing children may be exposed to, without banning it as such.
- Children are entitled to specific protection, which implies protection against any advertising as well as tele-shopping programmes which could cause moral or physical harm to them.
- The placement of products advertisements in children's programmes is forbidden.

10.1.1. Consumer rights

Under EU law, the main pillars of consumer protection are laid down in Article 169 (1) of the TFEU and Article 38 of the EU Charter of Fundamental Rights. The CJEU has recognised that the best interests of the child override requirements of public interest, justifying limits to the common market freedoms.

Example: The case of *Dynamic Medien*[472] concerns the sale over the internet in Germany of DVDs of Japanese cartoons. The cartoons had been approved for children over 15 years of age in the United Kingdom. They had not been rated as appropriate by the relevant German authority. The main question before the CJEU was whether the prohibition in Germany was contrary to the freedom of movement principle. The CJEU found that the

472 CJEU, C-244/06, *Dynamic Medien Vertriebs GmbH v. Avides Media AG*, 14 February 2008.

main purpose of the German law was to protect children from information that would be detrimental to their well-being. It ruled that the restriction on the freedom of movement of goods was not disproportionate as long as it did not go beyond what was necessary to attain the objective of protecting children pursued by the Member State concerned.

Example: The case of *Omega*[473] concerns the operation of a 'laserdrome' in Germany. The game played in the 'laserdrome' included hitting sensory targets placed on the jackets worn by players. The equipment for the game was supplied by a British company and both the game and the equipment had been lawfully marketed in the United Kingdom. The game was prohibited in Germany on the ground that it was contrary to fundamental values such as human dignity. The CJEU found that the restriction imposed by the German authorities was not contrary to EU law, as it had been duly justified on public policy grounds.

The most recent review process of the EU consumer law resulted in the adoption of the Consumer Rights Directive 2011/83/EU (CRD), which aims to fully harmonise national laws on distance-selling and off-premises contracts, as well as other types of consumer contracts.[474] The intention is to balance a high level of consumer protection and the competitiveness of enterprises. As per Article 3 (3) (a), the CRD is not applicable to contracts for social services, including social housing, childcare and support of families and persons permanently or temporarily in need, including of long-term care. Social services include services for children and youth, assistance services for families, single parents and older persons, and services for migrants. The CRD dedicates specific attention to pre-contractual information. It bases its 'information requirements' on the assumption that if consumers, including children, are provided with due information, they will be able to consider all relevant facts and make an informed choice.

473 CJEU, C-36/02, *Omega Spielhallen- und Automatenaufstellungs-GmbH v. Oberbürgermeisterin der Bundesstadt Bonn*, 14 October 2004.

474 Directive 2011/83/EU of the European Parliament and the Council of 25 October 2011 on consumer rights, amending Council Directive 93/13/EEC and Directive 1999/44/EC of the European Parliament and of the Council and repealing Council Directive 85/577/EEC and Directive 97/7/EC of the European Parliament and of the Council, OJ 2011 L 304/64 (it should have been implemented by 13 December 2013).

10.1.2. Unfair commercial practices on children

Under EU law, Directive 2005/29/EC, concerning unfair business-to-consumer commercial practices in the internal market (UCPD),[475] covers the totality of business-to-consumer transactions (whether operated offline or online, involving both goods and services). Children are included in the UCPD in the category of 'vulnerable consumers' (Article 5 (3)). Transactional decisions cannot be taken following harassment, coercion or undue influence or misleading information, and child consumers have the right to make these decisions freely. The directive prohibits product marketing and advertising activities which create confusion with another product or with a competitor's trademark, and requires that all the necessary information for consumers be provided to them in a clear and comprehensible manner, and at a suitable time to enable them to make a transactional decision (Articles 6 and 7).

10.1.3. Products' safety

Under EU law, there is a comprehensive framework to ensure that only safe and otherwise compliant products find their way on to the market. In particular, Directive 2001/95/EC on general product safety (GPSD) dedicates specific attention to the safety of children by including them in the category of consumers who can be particularly vulnerable to the risks posed by the products under consideration (Recital 8 of the GPSD). Therefore, the safety of the product needs to be assessed, taking into account all the relevant aspects, in particular the categories of consumers to which the product is destined.

Council Directive 87/357/EEC is a specific product safety directive on the approximation of the laws of the Member States concerning products which, appearing to be other than they are, endanger the health or safety of consumers.[476] It prohibits the marketing, importing and manufacturing of products that look like foodstuffs, but that are not edible. Member States must carry out checks to ensure that no such products are marketed. If a Member State bans

475 Directive 2005/29/EC of European Parliament and of the Council of 11 May 2005 concerning unfair business-to-consumer commercial practices in the internal market and amending Council Directive 84/450/EEC, Directives 97/7/EC, 98/27/EC and 2002/65/EC of the European Parliament and of the Council and Regulation (EC) No. 2006/2004 of the European Parliament and of the Council, OJ 2005 L 149/22.

476 Council Directive 87/357/EEC of 25 June 1987 on the approximation of the laws of the Member States concerning products which, appearing to be other than they are, endanger the health or safety of consumers, OJ 1987 L 192/49.

a product under the terms of this directive, it must inform the Commission and provide details to inform the other Member States. The question of toy safety in particular is discussed in more detail under Section 10.1.6.

10.1.4. Clinical trials on children

Under EU law, Directive 2001/20/EC[477] on the approximation of national provisions relating to the implementation of 'good clinical practice' in the conduct of clinical trials on medicinal products for human use includes children among vulnerable persons who are incapable of giving legal consent to clinical trials (Recital 3). Children may only be included in clinical trials if they directly benefit from receiving the medicinal product and if such benefits outweigh the risks (Recital 3). Clinical trials should afford subjects the best possible protection (Article 4).

Similarly, Regulation (EU) No. 536/2014 on clinical trials on medicinal products for human use includes specific provisions for children in the vulnerable population category (Article 10 (1)). This regulation aims to gradually replace Directive 2001/20/EC.[478] It requires that applications for the authorisation of clinical trials involving children be carefully assessed. A child's legal representative must consent to a clinical trial taking place, as must the child if he/she is capable of forming an opinion (Article 29 (1) and (8)). The regulation lays down specific conditions for conducting safe clinical trials on children and ensuring their informed consent (Article 32). These conditions are that: no incentives are given to the subject except for compensation for expenses and loss of earnings directly related to the participation in the clinical trial; the clinical trial is intended to investigate treatments for a medical condition that only occurs in children; and there are scientific grounds for expecting that participation in the clinical trial will produce: a direct benefit for the minor concerned outweighing the risks and burdens involved; or some benefit for the population represented by the minor concerned and such a clinical trial will pose only minimal risk to, and will impose minimal burden on, the minor concerned in comparison with the standard treatment of the minor's condition. Only in emergency situations may

477 Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use, OJ 2001 L 121/34.

478 Regulation (EU) 536/2014 of the European Parliament and the Council of 16 April 2014 on clinical trials on medicinal products for human use, and repealing Directive 2001/20/EC, OJ 2014 L 158/1.

clinical trials be performed on children without having previously obtained their consent or the consent of their legal representatives (Article 35 (1)).

10.1.5. Food intended for infants and young children

Under EU law, Directive 2009/39/EC on foodstuffs intended for particular nutritional uses[479] focuses on the nutritional composition and safety of foods specifically manufactured for infants and young children under the age of 12 months. Its rules concern infant and follow-on formulae, processed cereal-based foods and baby foods and additives in foods for infants and young children. The directive aims to guarantee product safety and to provide the consumer with suitable products and appropriate information. It specifies, amongst other things, that a particular nutritional use shall fulfil the particular nutritional requirements of certain categories of persons, including those of infants or young children in good health (Article 1 (3) (c)).

10.1.6. Toy safety

Under EU law, Directive 2009/48/EC on the safety of toys (TSD)[480] defines toys in its Article 2 as "products designed or intended, whether or not exclusively, for use in play by children under 14 years of age".[481] Annex I provides a non-exhaustive list of items that are not considered toys, but that could be subject to confusion. Article 2 (2) also lists some toys that are excluded from its range of action. The TSD also reinforces health and safety standards by limiting the amounts of certain chemicals that may be contained in the material used for toys (Article 10).[482]

479 Directive 2009/39/EC of the European Parliament and of the Council of 6 May 2009 on foodstuffs intended for particular nutritional uses, OJ 2009 L 124/21.

480 Directive 2009/48/EC of the European Parliament and of the Council of 18 June 2009 on the safety of toys, OJ 2009 L 170.

481 *Ibid.*, Art. 2 (1).

482 The European Commission has also concluded 'voluntary agreements' with European toys industries/traders in order to improve toy safety. See further: http://ec.europa.eu/growth/sectors/toys/safety/index_en.htm.

10.1.7. Children and advertising

Under EU law, Directive 2010/13/EU on Audiovisual Media Services (AVMS Directive)[483] expanded the scope of legal regulation of the Directive 89/552/EEC on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the pursuit of television broadcasting activities (Television Without Frontiers (TWF) Directive). The AVMS Directive deals with the limitation of the amount, quality and content of marketing children may be exposed to, regulating the duration of advertisement (Articles 20, 24 and 27). It forbids product placement in children's programmes (Article 11) and authorises Member States to prohibit the display of sponsorship logos during programmes for children (Article 10 (4)).[484] The AVMS Directive balances the protection of children with other important democratic values, such as the freedom of expression, supporting the idea that such protection is possible through the essential involvement of parental responsibility (Recitals 48 and 59).

The effective implementation of the AVMS Directive is supplemented by the 1998[485] and 2006[486] recommendations on the protection of children and human dignity.

483 Directive 2010/13/EU of the European Parliament and the Council of 10 March 2010 on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the provision of audiovisual media services (Audiovisual Media Services Directive), OJ 2010 L 95/1.

484 For a more general overview of the functioning of the AMS Directive, please refer to: COM(2012) 203 final, Report from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, on the application of Directive 2010/13/EU ('Audiovisual Media Service Directive'), Brussels, 4 May 2012 and SWD(2012) 125 final, Commission Staff Working Document attached to the First Report from the Commission to the European Parliament, the Council, The European Economic And Social Committee And The Committee of the Regions on the Application of Directive 2010/13/EU 'Audiovisual Media Services' accompanying the document, Brussels, 4 May 2012.

485 Council Recommendation 98/560/EC of 24 September 1998 on the development of the competitiveness of the European audiovisual and information services industry by promoting national frameworks aimed at achieving a comparable and effective level of protection of minors and human dignity, OJ 1998 L 270.

486 Recommendation 2006/952/EC of the European Parliament and of the Council of 20 December 2006 on the protection of minors and human dignity and on the right of reply in relation to the competitiveness of the European audiovisual and on-line information services industry, OJ 2006 L 378.

Under CoE law, the European Convention on Transfrontier Television[487] was the first international treaty to create a legal framework for the free circulation of transfrontier television programmes in Europe. It specifically protects children and youth (Article 7 (2)), for instance forbidding the screening of pornographic and violent material and of programmes inciting to racial hatred. It identifies advertising standards and regulates advertising time and advertising breaks.

10.2. Children and personal data protection

Key points

- Under EU and CoE law, personal data protection has been acknowledged as a fundamental right.
- The right to respect for private and family life, home and correspondence (Article 8 of the ECHR) includes the right to protection of personal data.
- Children have, among other rights relating to their personal data, the right to object to the processing of their data, except on compelling legitimate grounds.

10.2.1. European data protection law

Under EU law, the EU has competence to legislate on data protection matters (Article 16 of the TFEU).[488] Article 8 (2) of the EU Charter of Fundamental Rights contains key data protection principles (fair processing, consent or legitimate aim prescribed by law, right to access and rectification), whereas Article 8 (3) requires that compliance with data protection rules be subject to control by an independent authority. The right to the protection of personal data established in Article 8 may be limited in accordance with the law and for the respect of the principles of a democratic society such as the freedoms and rights of others (Article 52 of the Charter).[489]

487 Council of Europe, European Convention on Transfrontier Television, CETS No. 132, 1989. Amended according to the provisions of the Protocol, CETS No. 171, 2002.

488 For a general overview of European data protection law, see: FRA and CoE (2014).

489 CJEU, Joined cases C-468/10 and C-469/10, *Asociación Nacional de Establecimientos Financieros de Crédito (ASNEF) and Federación de Comercio Electrónico y Marketing Directo (FECEMD) v. Administración del Estado*, 24 November 2011, para. 48; CJEU, C-275/06, *Productores de Música de España (Promusicae) v. Telefónica de España SAU* [GC], 29 January 2008, para. 68.

Personal data protection has emerged as one of the key areas of European law relating to privacy. Directive 95/46/EC on the protection of individuals with regard to the processing of personal data and on the free movement of such data (Data Protection Directive)[490] is the main instrument in this field.

Because data processing is operated in closed spaces not open to the public, children as well as other data subjects are usually unaware of the processing of their own personal data. To counteract the vulnerability of data subjects, European law guarantees children (and other data subjects) specific individual rights, such as the right to be informed that their data are being collected, the right to access the stored data and to learn about the details of the processing operation, the right to object in case of unlawful processing, the rights to rectification, erasure and blocking of data.

Controllers of processing operations must provide adequate information with regard to processing of data (Articles 10 and 11 of the Data Protection Directive). Interpreted in a child-friendly manner, this implies that the language and the form of the information need to be adapted to the level of maturity and understanding of children. As a minimum requirement, the information must include the purpose of processing, as well as the identity and contact details of the controller (Articles 10 (a) and (b) of the Data Protection Directive).

The Data Protection Directive provides for the consent of data subjects, regardless of the sensitivity of the data processed (Articles 7, 8 and 14). A child-friendly consent procedure would entail taking into account the child's evolving capacities, progressively involving him or her. The first step entails a child being consulted by his/her legal representative prior to providing consent, before moving on to a parallel consent of the child and his or her legal representative, to the sole consent of the adolescent child.

Data subjects have the right to erasure of data, which entails the possibility of having their personal data removed or deleted upon their request, and also the right to object to the processing of their personal data. The latter has become increasingly important for children because of the massive amount of children's personal data circulated and available through social networking. Although the CJEU has not yet addressed cases concerning children, in a recent

490 Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data (Data Protection Directive), OJ 1995 L 281.

case concerning an adult applicant, it held that the right to object applies to data and information, "in particular where they appear to be inadequate, irrelevant or no longer relevant, or excessive in relation to those purposes and in the light of the time that has elapsed".[491] The CJEU also held that the applicability of the right to object needs to be balanced against other fundamental rights.

Under CoE law, the ECtHR has read the right to protection of personal data into Article 8 of the ECHR. The Court examines situations where the issue of data protection arises, including the interception of communications,[492] various forms of surveillance[493] and the protection against storage of personal data by public authorities.[494] Furthermore, the ECtHR ruled that national law must set out appropriate measures to ensure judicial remedies against infringements of data protection rights.

Example: In *K.U. v. Finland*,[495] the applicant was a child who complained that an advertisement of a sexual nature had been posted in his name on an internet dating site. The service provider refused to reveal the identity of the person who had posted the information because of confidentiality obligations under Finnish law. The applicant claimed that domestic law did not provide sufficient protection against the actions of a private person placing incriminating data about the applicant on the internet. The ECtHR held that states have positive obligations which involve adopting measures designed to secure respect for private life even in the sphere of relations between individuals. In the applicant's case, his practical and effective protection required that effective steps be taken to identify and prosecute the perpetrator. However, such protection was not afforded by the state, and the Court found a violation of Article 8 of the ECHR.[496]

491 CJEU, C-131/12, *Google Spain SL and Google Inc. v. Agencia Española de Protección de Datos (AEPD) and Mario Costeja González* [GC], 13 May 2014, para. 93.

492 See, for example: ECtHR, *Malone v. the United Kingdom*, No. 8691/79, 2 August 1984; ECtHR, *Copland v. the United Kingdom*, No. 62617/00, 3 April 2007.

493 See, for example: ECtHR, *Klass and Others v. Germany*, No. 5029/71, 6 September 1978; ECtHR, *Uzun v. Germany*, No. 35623/05, 2 September 2010.

494 See, for example: ECtHR, *Leander v. Sweden*, No. 9248/81, 26 March 1987; ECtHR, *S. and Marper v. the United Kingdom* [GC], Nos. 30562/04 and 30566/04, 4 December 2008.

495 ECtHR, *K.U. v. Finland*, No. 2872/02, 2 December 2008. See further Chapter 4.

496 FRA and CoE (2014), p. 122.

Example: *Avilkina and Others v. Russia*[497] concerns the disclosure of a two year old girl's medical files to the prosecutor, following his request to be informed about all refusals by Jehovah's Witnesses concerning blood transfusions. Acknowledging that the interests of a patient and the community as a whole in protecting the confidentiality of medical data might be outweighed by the interests of investigating crime, the Court noted that the applicant was not a suspect or accused in any criminal proceedings. In addition, the medical professionals providing treatment to the applicant could have applied for judicial authorisation for a blood transfusion, had they believed her to be in a life-threatening situation. In the absence of any pressing social need for requesting the disclosure of the confidential medical information concerning the applicant, the ECtHR found a violation of Article 8 of the ECHR.

Example: In *S. and Marper v. the United Kingdom*,[498] an eleven year old's fingerprints and DNA taken in relation with the suspicion of attempted robbery were retained without a time limit, even though he was ultimately acquitted. Given the nature and amount of personal information contained in cellular samples and DNA profiles, their retention in itself amounted to an interference with the first applicant's right to respect for private life. The core principles of the relevant instruments of the Council of Europe and the law and practice of the other contracting states require the retention of data to be proportionate in relation to the purpose of collection and limited in time, particularly in the police sector. The protection afforded by Article 8 of the ECHR would be unacceptably weakened if the use of modern scientific techniques in the criminal justice system were allowed at any cost and without carefully balancing their potential benefits against important private-life interests. In that respect, the blanket and indiscriminate nature of the power of retention in England and Wales was particularly striking, since it allowed data to be retained for an unlimited period of time and irrespective of the nature or gravity of the offence or of the age of the suspect. Retention could be especially harmful in the case of minors, given their special situation and the importance of their development and integration in society. In conclusion, the retention of data constituted a disproportionate interference with the applicant's right to respect for private life.

497 ECtHR, *Avilkina and Others v. Russia*, No. 1585/09, 6 June 2013.

498 ECtHR, *S. and Marper v. the United Kingdom* [GC], Nos. 30562/04 and 30566/04, 4 December 2008.

The Council of Europe Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data[499] (Convention 108) applies to all data processing carried out both in the private and public sectors, and protects the individual, children included, against abuses which may accompany the processing of personal data. Convention 108 has an additional protocol which regulates the establishment of supervisory authorities and cross-border flow of personal data to non-Parties to the convention.[500]

The principles laid down in Convention 108 related to the processing of personal data concern fair and lawful collection and automatic processing of data, stored for specified legitimate purposes and not for use for ends incompatible with those purposes, nor kept for longer than is necessary. They also concern the quality of the data. In the absence of proper legal safeguards, the processing of 'sensitive' data, such as on a person's race, politics, health, religion, sexual life or criminal record, is prohibited. The convention also enshrines the individual's right, children included, to know that information is stored on him or her and, if necessary, to have it corrected. Restrictions on the rights laid down in the convention are possible only when overriding interests, such as state security or defence, are at stake.

Under international law, the right to data protection is part of the child's right to privacy contained in Article 16 of the CRC. This article provides that a child shall not be subject to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation. This right must be respected by everybody, including the child's legal representative.

499 Council of Europe, Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data, CETS No. 108, 1981.

500 Council of Europe, Additional Protocol to the Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data, regarding supervisory authorities and transborder data flows, CETS No. 181, 2001.

11 Children's rights within criminal justice and alternative (non-judicial) proceedings

EU	Issues Covered	CoE
Charter of Fundamental Rights, Articles 47 (right to an effective remedy and to fair trial), 48 (presumption of innocence and right of defence) and 49 (principles of legality and proportionality of criminal offences and penalties) Right to Interpretation and Translation Directive (2010/64/EU) Right to Information Directive (2012/13/EU) Access to a Lawyer Directive (2013/48/EU)	**Fair trial guarantees**	ECHR, Article 6 (fair trial) ECtHR, *T. v. the United Kingdom* [GC], No. 24724/94, 1999 (children in court) ECtHR, *Panovits v. Cyprus*, No. 4268/04, 2008 (access to a lawyer)
Charter of Fundamental Rights, Articles 4 (torture, inhuman and degrading treatment) and 6 (right to liberty)	**Detention**	ECHR, Articles 3 (torture, inhuman and degrading treatment) and 5 (right to liberty) ECtHR, *Bouamar v. Belgium*, No. 9106/80, 1988 (detention for educational supervision) ECtHR, *D.G. v. Ireland*, No. 39474/98, 2002 (detention for educational supervision) ECtHR, *Nart v. Turkey*, No. 20817/04, 2008 (pre-trial detention) ECtHR, *Güveç v. Turkey*, No. 70337/01, 2009 (conditions of detention)

EU	Issues Covered	CoE
Victims' Directive (2012/29/EU) CJEU, C-105/03, *Criminal proceedings against Maria Pupino* [GC], 2005 (standing of child witnesses in court)	**Child witnesses and victims**	ECHR, Articles 3 (torture, inhuman and degrading treatment) and 8 (private life) ECtHR, *Kovač v. Croatia*, No. 503/05, 2007 (child witness) ECtHR, *S.N. v. Sweden*, No. 34209/96, 2002 (child witness) ECtHR, *R.R. and Others v. Hungary*, No. 19400/11, 2012 (exclusion of family from the witness protection programme)

Children's rights in the context of juvenile justice proceedings concern children accused of, prosecuted for or sentenced for having committed criminal offences, as well as children who participate in justice or related proceedings as victims and/or witnesses. The position of children in the context of juvenile justice is regulated by general human rights provisions relevant to both adults and children.

This chapter presents an overview of the European norms relevant to children involved in judicial and alternative proceedings. It addresses fair trial guarantees, including effective participation and access to a lawyer, the rights of detained young offenders, including pre-trial detention (substantive and procedural safeguards), conditions of detention and protection against ill-treatment, and the protection of child witnesses and victims. Protection aspects are especially relevant for non-adversarial, alternative proceedings, which should be used whenever these may best serve the child's best interests.[501] In the case of children, objectives of criminal justice, such as social integration, education and prevention of re-offending, are basic principles that are valued.[502]

501 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010, para. 24.

502 See further, Council of Europe, Committee of Ministers (2008), Recommendation CM/Rec (2008)11 of the Committee of Ministers to member states on the European Rules for juvenile offenders subject to sanctions or measures, 5 November 2008, Part I.A.2.

11.1. Fair trial guarantees

Key points

- Children in criminal proceedings are entitled to be treated fairly and in a child-friendly manner.
- Court proceedings should be adjusted to children's needs to ensure their effective participation.
- Children have the right to access a lawyer from the initial stages of the criminal proceedings and from the first police interrogation.

While briefly outlining the general requirements for a fair trial at both the EU and CoE level, this section places particular emphasis on child-specific fair trial guarantees.

The right to a fair trial is a core pillar of a democratic society. Children suspected or accused of a crime have the right to a fair trial, and they benefit from the same guarantees as any other person in conflict with the law. Fair trial guarantees apply from the child's first interrogation and subsist during the trial. Children in conflict with the law are, however, particularly vulnerable and may therefore need additional protection. European bodies have developed specific requirements to ensure that these children's needs are effectively met.

Under EU law, several provisions of the EU Charter of Fundamental Rights establish basic rights of access to justice which sustain fair trial guarantees for both adults and children. Article 47 deals specifically with the right to an effective remedy and to fair trial, establishing requirements of particular relevance for children, such as the reasonability of time in having a fair and public hearing, and the rights to be defended, represented and advised as well as to legal aid. Similarly, the principles of legality and proportionality of criminal offences and penalties established in Article 49 are particularly relevant for children. In addition, several EU directives lay down specific fair trial guarantees in criminal proceedings: the Right to Interpretation and Translation Directive,[503] the Right

503 Directive 2010/64/EU of the European Parliament and of the Council of 20 October 2010 on the right to interpretation and translation in criminal proceedings, OJ 2010 L 280/1.

to Information Directive,[504] and the Access to a Lawyer Directive.[505] The first two directives do not include child-specific guarantees, although the Right to Information Directive contains provisions addressing the situation of vulnerable suspects or accused persons more generally. The child-related provisions of the Access to a Lawyer Directive are elaborated upon in Section 11.2.2.

Even in the absence of child-specific provisions, Member States must observe the EU Charter of Fundamental Rights when implementing the provisions of the aforementioned directives. Therefore, principles such as the child's best interests, enshrined in Article 24, should be given due weight in cases where children are the subject of any of the provisions of the directives. To date, no cases have been brought to the CJEU concerning the interpretation of Article 24 of the Charter in conjunction with one the mentioned directives.[506]

Of specific importance is the European Commission proposal for a directive on procedural safeguards for criminally suspected or accused children,[507] which aims to provide children mandatory access to a lawyer at all stages of criminal proceedings. It also provides that children should benefit from prompt information about their rights, the assistance of parents (or other appropriate persons) and questioning behind closed doors. In addition, children deprived of liberty should be entitled to receive appropriate education, guidance, training, and medical care, and to be kept separate from adults.[508]

Under CoE law, the ECHR fair trial guarantees are laid down in Article 6, which generates the most extensive case law of the ECtHR. Article 6 (1) of the ECHR includes some express fair trial guarantees: the right to a fair public hearing/

504 Directive 2012/13/EU of the European Parliament and of the Council of 22 May 2012 on the right to information in criminal proceedings, OJ 2012 L 142/1.

505 Directive 2013/48/EU of the European Parliament and of the Council of 22 October 2013 on the right of access to a lawyer in criminal proceedings and in European arrest warrant proceedings, and on the right to have a third party informed upon deprivation of liberty and to communicate with third persons and with consular authorities while deprived of liberty, OJ 2013 L 294/1.

506 The CJEU has dealt with the interpretation of Art. 24 in proceedings relating to international child abduction (see Section 5.4).

507 European Commission (2013), Proposal for a Directive of the European Parliament and of the Council on procedural safeguards for children suspected or accused in criminal proceedings, COM(2013) 822 final, Brussels, 27 November 2013.

508 See further Section 11.2. Of relevance for child protection can also be the European Commission (2013), Proposal for a Directive of the European Parliament and of the Council on provisional legal aid for suspects or accused persons deprived of liberty and legal aid in European arrest warrant proceedings, COM(2013) 824 final, Brussels, 27 November 2013.

pronouncement (unless it is contrary to, among others, the interests of juveniles); the right to a trial within reasonable time; the right to a trial by an independent and impartial tribunal; [509] and the right to a trial by a tribunal established by law. Inherent in the concept of a fair trial, the ECtHR has developed guarantees: equality of arms and adversarial proceedings; the right to remain silent; access to a lawyer; effective participation; presence at the hearing; and reasoned decisions. In addition, everyone must be presumed innocent until proven guilty, according to law (Article 6 (2) of the ECHR).

Everyone charged with a criminal offence shall have the following minimum rights: the right to be informed promptly about the charges in a language she/he understands (Article 6 (3) (a) of the ECHR); the right to have adequate time and facilities for the preparation of her/his defence (Article 6 (3) (b) of the ECHR); the right to have legal assistance of her/his own choosing (Article 6 (3) (c) of the ECHR); the right to examine or have witnesses examined (Article 6 (3) (d) of the ECHR); and the right to have the free assistance of an interpreter (Article 6 (3) (e) of the ECHR). These guarantees apply to adults and children alike. However, aspects of particular importance to children which have generated child-specific case law include the right to effective participation, as well as the right to access a lawyer. These two specific fair trial guarantees are therefore further elaborated upon in this chapter.

Of high importance for child suspects/accused are the CoE's *Guidelines on child friendly justice*.[510] Even if the guidelines are not legally binding, they represent a stepping stone in ensuring that justice proceedings, including those part of the criminal justice system, take into account the specific needs of children. They are built on existing ECtHR case law and other European and international legal standards, such as the UN Convention on the Rights of the Child. They are a useful tool for professionals dealing with children. According to Section I (1), the guidelines apply to children in judicial (criminal or non-criminal) proceedings or in alternatives to such proceedings. Of specific importance for children in criminal proceedings is the right to have the information on criminal charges explained to both the child and the parents in a way that they understand the exact charge (Section IV.A.1.5); the right to be questioned only in the presence of the lawyer/parents or a person of trust (Section C (30)); the right to

509 ECtHR, *Nortier v. the Netherlands*, No. 13924/88, 24 August 1993; ECtHR, *Adamkiewicz v. Poland*, No. 54729/00, 2 March 2010.

510 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010.

speedy proceedings (Section D (4)) and the right to child-sensitive interviews or hearings (Section D (5)).

In June 2014, PACE adopted a resolution on child-friendly juvenile justice, with which it underscores the need for a rights-based and child-specific treatment of children in conflict with the law.[511] PACE calls upon Member States to implement international human right standards regarding juvenile justice, including the CoE's Guidelines on child friendly justice, and to bring national laws and practice in conformity with these standards. PACE suggests using liberty deprivation only as a measure of last resort and for the shortest possible period of time, setting the minimum age of criminal responsibility at 14 years old, without allowing for exceptions in cases of serious offences, and establishing a specialised juvenile justice system, including diversion mechanisms, non-custodial measures and specialised professionals.

Under international law, Article 40 of the CRC acknowledges that every child alleged as, accused of, or recognised as having infringed penal law is entitled to be treated fairly and in a manner that takes into account his/her age. The key objective of juvenile justice according to Article 40 of the CRC is to reintegrate children in society, in which they can play a constructive role. Article 40 (2) of the CRC recognises children's right to a fair trial and that children have some additional entitlements, including the right to be assisted by parents, the right to appeal and the right to have their privacy fully protected at all stages of the proceedings.

Further, other instruments have developed the CRC principles of fair trial and the right to be treated in a child-specific way, including the use of liberty deprivation as a measure of last resort and only for the shortest appropriate period of time (see Article 37 (b) of the CRC). Of particular importance are the UN Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules),[512] the UN Guidelines for the Prevention of Juvenile Delinquency (Riyadh Guidelines)[513] and the UN Rules for the Protection of Juveniles Deprived

511 Parliamentary Assembly of the Council of Europe, Resolution 2010 (2014), "Child-friendly juvenile justice: from rhetoric to reality".

512 UN, General Assembly (1985), *UN Standard Minimum Rules for the Administration of Juvenile Justice*, UN Doc. GA Res. 40/33,19 November 1985.

513 UN, General Assembly (1990), *UN Guidelines for the Prevention of Juvenile Delinquency*, UN Doc. GA Res. 45/112, 14 December 1990.

of their Liberty (also known as the 'Havana Rules').[514] The Beijing Rules provide detailed guidance on the implementation of Article 40 of the CRC's fair trial requirements and child-specific treatment, including the aims of juvenile justice, protection of privacy, investigation and prosecution, pre-trial detention, adjudication and disposition, and institutional and non-institutional treatment. The Havana Rules concern the treatment of juveniles deprived of their liberty and include rules regarding the definition of liberty deprivation, police custody and pre-trial detention, juvenile institution conditions, disciplinary procedures, screening methods and the use of force or restraint, complaint mechanisms, inspection and monitoring mechanisms and the reintegration of juveniles. Finally, the Riyadh Guidelines provide detailed guidelines regarding policies aiming at the prevention of juvenile delinquency.

The UNCRC issued one General Comment (No. 10)[515] on children and juvenile justice, which offers detailed guidance on how to interpret and implement the CRC as far as juvenile justice is concerned. This comment deals with important juvenile justice principles, including the right to effective participation as part of the right to a fair trial (see further in Section 11.1.1), the use of deprivation of liberty as a measure of last resort and for the shortest appropriate period of time, the use of diversion and prevention of juvenile delinquency, the embedment of the best interests of the child principle and the principle of non-discrimination in the juvenile justice system, and age limits. The UNCRC recommends to set the minimum age of criminal responsibility at 12, or preferably higher. It also recommends to grant all children the right to be dealt with in the context of juvenile justice and prohibits transferring 16 and 17 year olds to the adult criminal system in cases of serious offences. Other general comments, e.g. regarding the right to be heard (which is connected to the right to participate effectively in justice proceedings), and the protection against all forms of violence, are also relevant for juvenile justice.[516]

514 UN, General Assembly (1990), UN Rules for the Protection of Juveniles Deprived of their Liberty, UN Doc. GA Res. 45/113, 14 December 1990.

515 UN, Committee on the Rights of the Child (2007), *General Comment No. 10 on Children's rights in juvenile justice*, CRC/C/GC/07, 25 April 2007.

516 UN, Committee on the Rights of the Child (CRC) (2009), *General Comment No. 12 (2009): The right of the child to be heard*, CRC/C/GC/12, 1 July 2009; UN, Committee on the Rights of the Child (2011), *General Comment No. 13 (2011) – The right of the child to freedom from all forms of violence,* CRC/C/GC/13, 18 April 2011.

11.1.1. Effective participation

Under EU law, Article 47 of the EU Charter of Fundamental Rights lays down similar guarantees to those provided under Article 6 of the ECHR, including the right to a fair and public hearing within a reasonable time by an independent and impartial tribunal, the right to legal representation and the right to effective remedies. The proposed directive on procedural safeguards for criminally suspected or accused children includes the right to effective participation, as well as the right to legal representation.[517]

Under CoE law, the ECtHR has elaborated under Article 6 specific requirements for ensuring children's effective participation in criminal trials. As a general rule, proceedings should ensure that account is taken of the child's age, level of maturity and emotional capacities.[518] Concrete examples of 'effective participation' requirements include the child's presence during the hearings, holding of *in camera* hearings, limited publicity, ensuring that the child understands what is at stake and limited formality of court sessions. So far the ECtHR has not held that setting the age of criminal responsibility too low constitutes in itself a violation of Article 6 of the ECHR. When assessing whether a child was able to participate effectively in the national proceedings the ECtHR looks at the concrete circumstances of each case.

Example: The case of *T. v. the United Kingdom*[519] concerns the murder of a two year old by two ten year olds. They were committed to public trial under big media attention. The court procedure was partly modified, in that shorter sessions were held, the applicant's parents were placed close to him, a playing area was available during breaks, etc. Nevertheless, the applicant and his co-accused were tried in an adult court, and most of the rigors of a criminal trial were preserved. The ECtHR held that the applicant had not been able to participate effectively in the proceedings due to the publicity of the sessions combined with the high level of media attention and to his limited capacity to instruct his lawyers and to provide adequate testimonies. His rights under Article 6 of the ECHR were therefore violated.

517 European Commission (2013), Proposal for a Directive of the European Parliament and of the Council on procedural safeguards for children suspected or accused in criminal proceedings, COM(2013) 822 final, Brussels, 27 November 2013.

518 ECtHR, *T. v. the United Kingdom* [GC], No. 24724/94, 16 December 1999, para. 61.

519 ECtHR, *T. v. the United Kingdom* [GC], No. 24724/94, 16 December 1999.

The recognition of the right to effective participation is also at the core of the Council of Europe's Guidelines on child-friendly justice. Justice for children, including juvenile justice, should be "accessible, age appropriate, speedy, diligent, adapted to and focused on the needs and rights of the child, respecting the rights of the child including the right to due process, to participate in and to understand the proceedings, to respect for private and family life and to integrity and dignity".[520] The guidelines provide specific guidance on how children should be treated during juvenile justice or other justice proceedings. Children should have access to court and judicial proceedings, and their rights to legal counsel and representation and to be heard and express their views should be safeguarded; undue delay should be avoided, proceedings should be organised in a child-friendly way (which affects the environment and language) and special safeguards should be in place to take and respond to evidence/statements provided by children.[521]

11.1.2. Access to a lawyer

Under EU law, the Access to a Lawyer Directive 2013/48/EU[522] – to be implemented by 27 November 2016 – includes direct references to children in Recitals 52 and 55 of its preamble, as well as in Article 5 (2)–(4). Pursuant to Recital 55 and Article 5 (2), if a child is deprived of liberty, the holder of parental responsibility shall be notified and be given reasons thereof, unless this would be contrary to the child's best interests. In the latter case, another appropriate adult shall be informed. According to Article 2, the directive applies from the moment suspects or accused are made aware of having committed a criminal offence until the conclusion of the proceedings by a final determination of guilt or innocence. Further, Article 3 (3) lays down that access to a lawyer includes the right of suspects/accused to meet and communicate with the lawyer in private, including before the first interrogation, the presence and effective participation of the lawyer during questioning and the lawyer's presence during several investigative or evidence gathering acts.

520 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010, para. II. C.

521 *Ibid.*, Section D.

522 Directive 2013/48/EU of the European Parliament and of the Council of 22 October 2013 on the right of access to a lawyer in criminal proceedings and in European arrest warrant proceedings, and on the right to have a third party informed upon deprivation of liberty and to communicate with third persons and with consular authorities while deprived of liberty, OJ 2013 L 294/1.

Under CoE law, the ECtHR considers access to a lawyer to be one of the fundamental elements of the right to a fair trial.[523] Individuals charged with a criminal offence have the right to access a lawyer from the early stages of a police investigation. That right may be limited in exceptional circumstances, provided that the limitation does not unduly prejudice the rights of the accused. The ECtHR has found that this could occur when statements given without having had access to a lawyer are used for conviction.[524] The ECtHR's scrutiny of whether an applicant had effective access to a lawyer is stricter in cases involving children.[525]

Example: The case of *Panovits v. Cyprus*[526] concerns a 17 year old who was charged with murder and robbery. He was brought to the police station, accompanied by his father. He was then arrested and taken to a separate room for questioning, in the absence of the father or a lawyer. While the applicant was being questioned, his father was informed of the applicant's right to contact a lawyer. Several minutes later, the father was told that his son had meanwhile confessed to having committed the crime. The ECtHR found that, in view of his age, the applicant could not have been considered to be aware of his right to legal representation before making any statement. It was also unlikely that he could reasonably have appreciated the consequences of him being questioned without the assistance of a lawyer in criminal proceedings concerning a murder. Even though the authorities appeared to have at all times been willing to allow the applicant to be assisted by a lawyer if he so requested, they had failed to make him aware of his right to request the assignment of a lawyer free of charge if necessary. There was no evidence that the applicant or his father expressly and unequivocally waived their right to legal assistance. Consequently, the Court found a violation of Article 6 (3) (c) in conjunction with Article 6 (1) of the ECHR.

523 ECtHR, *Salduz v. Turkey* [GC], No. 36391/02, 27 November 2008, para. 51.

524 *Ibid.*, para. 62.

525 *Ibid.*, para. 60.

526 ECtHR, *Panovits v. Cyprus*, No. 4268/04, 11 December 2008.

11.2. Rights of young offenders in relation to detention

Key points

- Children may only be deprived of their liberty as a last resort and for the shortest appropriate period of time.
- If detained, children are to be treated age-appropriately and with respect for their dignity.
- Children should not be detained together with adults.

Every person has the right to liberty. Deprivation of liberty therefore constitutes an exception and includes any form of placement in an institution by decision of a judicial or administrative authority, from which the juvenile is not permitted to leave at will.[527] Given the importance of safeguarding the rights of the child, including their best interests, situations of liberty-deprivation should be considered from that particular angle when concerning children.

While detention occurs in various circumstances, this section focuses on children in contact with the criminal justice systems.

International instruments universally affirm that detention must be a measure of last resort. This means that state authorities faced with the question of placing a child in detention should first give adequate consideration to alternatives to protect the best interests of the child, as well as to further the reintegration of the child (Article 40 (1) of the CRC). Alternatives can include, for example: "care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes" (Article 40 (4) of the CRC). Only where alternatives are not feasible should detention be considered. Moreover, detention should only be ordered for the shortest period of time and under appropriate substantive and procedural guarantees. In view of their age and vulnerability, children benefit from special rights and guarantees when placed in detention.

527 Rule 21.5 of Council of Europe, Committee of Ministers (2008), Recommendation CM/Rec(2008)11 on the European Rules for juvenile offenders subject to sanctions or measures, 5 November 2008.

11.2.1. Forms of detention (substantive and procedural guarantees)

Under EU law, the current legal framework for criminal justice proceedings does not include a binding instrument regarding the detention of children.

Under CoE law, Article 5 of the ECHR provides that everyone has the right to liberty. Detention is an exception which should be provided for by national law and should not be arbitrary. In addition, detention has to be justified under one of the six exhaustive situations listed under Articles 5 (1) (a) to (f). Detention of children in contact with the criminal justice system can be justified under paragraphs (a) detention after conviction by a competent court; (c) pre-trial detention; or (d) detention for the purpose of educational supervision in particular. The latter two shall be analysed, as they have given rise to specific duties on the part of the state authorities.

Pre-trial detention

'Pre-trial detention' refers to situations where individuals are taken into police custody on suspicion of having committed a criminal offence, or are held in remand. It starts when an individual is taken into custody and ends with the determination on the merits of the case by a court of first instance.[528] While children benefit from the same guarantees as adults, the ECtHR has laid down several additional principles to strengthen the position of children in domestic criminal proceedings.

The ECtHR has generally interpreted Article 5 (1) (c) and Article 5 (3) as requiring that a person be placed in pre-trial detention only if there is a reasonable suspicion of him/her having committed a criminal offence. Further, pre-trial detention should not exceed a reasonable time and should be reviewed at reasonable intervals. The longer the period of detention, the stronger the reasons put forward by the authorities to justify it need to be. According to ECtHR case law, a person charged with an offence must always be released pending trial, unless the state can show that there are "relevant and sufficient" reasons to justify the continued detention.[529]

528 ECtHR, *Idalov v. Russia* [GC], No. 5826/03, 22 May 2012, para. 112.

529 ECtHR, *Smirnova v. Russia*, No. 46133/99 and 48183/99, 24 July 2003, para. 58.

The ECtHR developed four basic acceptable reasons for refusing bail to the detainee in cases of pre-trial detention: the risks of absconding, of prejudicing the administration of justice, of committing further offences or of causing public disorder. In addition, the continuation of pre-trial detention should be strictly necessary, and the state must examine all the facts arguing for or against the existence of a genuine requirement of public interest justifying a continued deprivation of liberty.[530]

In cases involving children, the ECtHR mandates that state authorities should pay particular attention to the child's age when balancing the relevant arguments for and against pre-trial detention; it should be used as a measure of last resort and for the shortest possible period.[531] This implies that the authorities should consider alternatives to pre-trial detention.[532]Furthermore, state authorities should display special diligence in bringing children to trial within a reasonable time.[533]

Example: In *Nart v. Turkey*,[534] the 17 year old applicant was arrested on suspicion of having robbed a grocery shop. He was placed in pre-trial detention, in an adult prison, for 48 days. With particular reference to the fact that the applicant was a child, the ECtHR stated that "pre-trial detention of minors should be used only as a measure of last resort; it should be as short as possible and, where detention is strictly necessary, minors should be kept apart from adults".[535] In this particular case the authorities attempted to justify the pre-trial detention on the basis of the 'state of evidence', but the ECtHR found that this reason alone could not justify the length of the applicant's detention. Consequently, the ECtHR found a violation of Article 5 (3) of the ECHR.

530 *Ibid.*, paras. 58–59; ECtHR, *Ladent v. Poland*, No. 11036/03, 18 March 2008, para. 55.

531 ECtHR, *Korneykova v. Ukraine*, No. 39884/05, 19 January 2012, paras. 43–44. See also ECtHR, *Selçuk v. Turkey*, No. 21768/02, 10 January 2006, paras. 35–36; ECtHR, *J.M. v. Denmark*, No. 34421/09, 13 November 2012, para. 63.

532 ECtHR, *Dinç and Çakır v. Turkey*, No. 66066/09, 9 July 2013, para. 63 (available in French); ECtHR, *Güveç v. Turkey*, No. 70337/01, 20 January 2009, para. 108.

533 ECtHR, *Kuptsov and Kuptsova v. Russia*, No. 6110/03, 3 March 2011, para. 91.

534 ECtHR, *Nart v. Turkey*, No. 20817/04, 6 May 2008.

535 *Ibid.*, para. 31.

Detention for the purpose of educational supervision

This form of detention has been ordered in situations where the child has a particular need for educational supervision because of a disturbed personality and violent behaviour. Article 5 (1) (d) of the ECHR primarily targets forms of detention outside the scope of the juvenile justice system.

Example: The case of *Bouamar v. Belgium*[536] concerns the placement of a child in a remand prison on nine occasions for periods of around 15 days. The applicant was an adolescent considered to have a disturbed personality and violent behaviour. The Belgian Government submitted that he had been placed in the remand prison for the purpose of educational supervision. The ECtHR noted that interim placements in a remand prison are not in themselves contrary to Article 5 (1) (d), as long as the authorities pursue the purpose of placing the juvenile under educational supervision. However, the ECtHR found that in the applicant's case the authorities failed to show that they had the intention or possibility to place him in an institution where he could benefit from educational supervision. Consequently, the ECtHR found a violation of Article 5 (1) (d) of the ECHR.

Example: *D.G. v. Ireland*[537] concerns the placement of a violent child in a detention centre. The ECtHR held that the notion of 'educational supervision' should not be equated strictly with classroom teaching. Educational supervision entails many aspects of the exercise of parental rights by the local authority for the benefit and protection of the person concerned. The ECtHR held that it is permissible for domestic authorities to place juveniles in detention facilities on a temporary basis until suitable accommodation is found, as long as this happens speedily. In the applicant's case the speediness requirement was not met as he was only placed in a suitable accommodation more than six months after his release from detention. The ECtHR therefore found a violation of Article 5 (1) (d) of the ECHR.

536 ECtHR, *Bouamar v. Belgium*, No. 9106/80, 29 February 1988.

537 ECtHR, *D.G. v. Ireland*, No. 39474/98, 16 May 2002.

Appeals to detention, speediness of review and access to a lawyer

The ECtHR requires particular diligence from national authorities in cases involving children in detention. In addition to the guarantees mentioned above, state authorities must ensure that children have the right to challenge the lawfulness of the detention at reasonable intervals, and that they have access to a lawyer during the proceedings determining the lawfulness of their detention. Furthermore, these legal challenges need to be decided speedily by domestic courts. The ECtHR derives these procedural guarantees from the text of Article 5 (4) of the ECHR.

> Example: In *Bouamar v. Belgium*,[538] the ECtHR found a violation of Article 5 (4) because: the hearings for the determination of the applicant's detention took place in the absence of his lawyers; they were not decided speedily; there was no actual decision on the 'lawfulness of the detention', since the domestic courts dismissed the applicant's appeals as devoid of purpose.

11.2.2. Conditions of detention

Under EU law, Article 4 of the EU Charter of Fundamental Rights prohibits torture and inhuman or degrading treatment. However, as the Charter only applies within the scope of EU law, this provision has to be linked to another EU legal instrument dealing with detention in order to bind Member States in this respect. So far, there have not been any cases before the CJEU in relation to Article 4 of the Charter.

Under CoE law, the ECtHR found that detaining children together with adults might lead to a breach of Article 3[539] or Article 5 of the ECHR.[540] Further, lack of adequate medical care in detention could also raise issues under Article 3.[541] Other aspects which may potentially raise issues under Article 3 include available cell space, lighting, and recreational activities.[542] In assessing the compatibility of conditions of detention with the standards of Article 3 of

538 ECtHR, *Bouamar v. Belgium*, No. 9106/80, 29 February 1988.

539 ECtHR, *Güveç v. Turkey*, No. 70337/01, 20 January 2009.

540 ECtHR, *Nart v. Turkey*, No. 20817/04, 6 May 2008.

541 ECtHR, *Güveç v. Turkey*, No. 70337/01, 20 January 2009; ECtHR, *Blokhin v. Russia*, No. 47152/06, 14 November 2013 (referred to the GC on 24 March 2014).

542 ECtHR, *Kuptsov and Kuptsova v. Russia*, No. 6110/03, 3 March 2011, para. 70.

the ECHR, the ECtHR often relies on the set of standards developed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), which monitors prison conditions under the umbrella of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment by conducting site visits to CoE member states.[543]

Example: In *Güveç v. Turkey*,[544] a fifteen year old boy was arrested on suspicion of membership of the Kurdistan Working Party (PKK). He was detained by the State Security Court in a prison for adults for five years. The ECtHR observed that his detention contravened Turkish regulations and obligations under international treaties, including, among others, Article 37 (c) of the CRC, which requires that children are kept separately from adults. The Court also noted that the applicant began to have psychological problems in prison, as a result of which he repeatedly attempted to commit suicide. In addition, the authorities failed to provide the applicant with adequate medical care. Consequently, given the applicant's age, the length of his detention in prison together with adults, the failure of the authorities to provide adequate medical care for his psychological problems, and their failure to take steps to prevent his repeated attempts to commit suicide, the ECtHR had no doubt that the applicant was subjected to inhuman and degrading treatment. There had accordingly been a violation of Article 3 of the ECHR.

The ECSR has consistently interpreted Article 17 of the ESC to the effect that if children are detained or imprisoned, they should be separated from adults.

The CoE European Rules for juvenile offenders subject to sanctions or measures provide detailed guidance on conditions of detention. They also provide that juveniles should not be held in institutions for adults, but in institutions specially designed for them.[545]

543 See, for example, ECtHR, *Güveç v. Turkey*, No. 70337/01, 20 January 2009.

544 *Ibid*.

545 Council of Europe, Committee of Ministers (2008), CM/Rec(2008)11 on the European Rules for juvenile offenders subject to sanctions or measures, 5 November 2008, Rule 59.1.

Under international law, the CRC contains a separate provision on deprivation of liberty of children. which states that children must be separated from adults, unless it is not in their best interest to do so (Article 37 (c) of the CRC). This article also stipulates that children, in principle, have the right to maintain contact with their family through correspondence or visits.

11.2.3. Protection against abuse and ill-treatment

Under CoE law, the ECtHR has repeatedly held that domestic authorities are responsible for protecting persons in detention from death, abuse or ill-treatment caused by other inmates or the authorities themselves. States' obligations in this respect are particularly strong, since detainees are under the authority and control of the state.[546] In addition to taking reasonable measures to protect inmates, state authorities must also conduct effective investigations into arguable allegations of ill-treatment or death.

Example: The case of *Çoşelav v. Turkey* concerns the suicide of an adolescent in prison,[547] who had previously unsuccessfully attempted to commit suicide on several occasions. Following those attempts, the authorities transferred him from a wing for juveniles to a detention facility for adults. Having first established that the authorities knew or ought to have known of the existence of a real and immediate risk to the life of the applicants' son, the Court then noted that the authorities failed to take reasonable measures to prevent the risk of suicide. The ECtHR placed a strong emphasis on the age of the deceased and the fact that he had been detained together with adults. Consequently, the ECtHR found a violation of the substantive aspect of Article 2 of the ECHR. In addition, the Court also found a violation of the procedural limb of Article 2 due to the authorities' failure to conduct an effective investigation into the death of the applicants' son. The reasons supporting these findings include: the failure of the authorities to promptly inform the applicants of their son's death; the failure of the prosecution to examine the alleged failures in preventing the suicide; and the excessive length of the ensuing administrative proceeding.

546 ECtHR, *Anguelova v. Bulgaria*, No. 38361/97, 13 June 2002; ECtHR, *H.Y. and Hü.Y. v. Turkey*, No. 40262/98, 6 October 2005.

547 ECtHR, Çoşelav v. Turkey, No. 1413/07, 9 October 2012.

11.3. Protection of child victims and witnesses

Key point

- Child victims and witnesses are entitled to protection against further victimisation, to recovery and reintegration and to effective participation in criminal and alternative proceedings.

Under both EU and CoE law, the position of child victims and witnesses has been recognised.

Under EU law, the Victim's Rights Directive 2012/29/EU[548] explicitly recognises the position of child victims. It provides that, when the victim is a child, his or her best interests are a primary consideration and must be assessed on an individual basis. In addition, a child-sensitive approach must prevail, which means the child's age, maturity, views, needs and concerns must be taken into account. Moreover, the directive aims to ensure that the child and the holder of parental responsibility (or another legal representative) will be informed of any measures or rights specifically focused on the child (Article 1 (2)). Child victims also have the right to be heard during criminal proceedings, and Member States must ensure that they can also provide evidence. Due account must be taken of the child's age and maturity (Article 10 (1)). Furthermore, the directive aims to protect the privacy and identity of child victims during criminal proceedings, to prevent secondary victimisation, among other reasons (Article 21 (1), see also Article 26). Moreover, the directive establishes a special provision on the right to protection of child victims during criminal proceedings (Article 24), which deals with the audiovisual recording of interviews with child victims and its use as evidence in criminal proceedings, the appointment of special representatives, and the right to legal representation in the child's own name if there is a conflict of interests between the child victim and the holders of parental responsibility. The directive furthermore contains various provisions for the protection of victims in general, such as access to victim support services. In the case of children or other vulnerable groups, specialist support

548 Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, OJ 2012 L 315/55.

services should be made available (see Section 38 of the resolution accompanying the directive).[549]

Before being replaced by the Victims' Directive, Framework Decision 2001/220/JHA on the standing of victims in criminal proceedings covered among other things the participation of victims, their rights and fair treatment. It recognised the special position of vulnerable victims, although it did not explicitly refer to children. Pursuant to this framework decision, the CJEU has ruled that children can be qualified as vulnerable when taking into account their age and the offences of which they consider themselves to have been victims. This consequently entitles them to special measures of protection, such as hearing them outside the trial court and before the trial takes place.[550] The CJEU has also ruled that all measures taken to protect victims must be designed in a way that the accused still receives a fair trial. In other words, the protection of victims and witnesses may not jeopardise the right of the accused person to a fair trial (see also the examples of case law of the ECtHR).[551]

Example: In the *Pupino* case,[552] an Italian school teacher was prosecuted for maltreating a pupil. Under the Italian Code of Criminal Procedure, witnesses must, as a rule, testify in court during the trial. In certain circumstances, however, their evidence may be taken before a judge ahead of trial through a special procedure (*incidente probatorio*). In this case, the public prosecutor asked the national court to allow the testimonies of the young children given in advance as evidence, but the national court refused. For the first time, the CJEU gave its interpretation of some of the provisions relevant to the standing of children as victims and witnesses in criminal proceedings. It underscored that the Framework Decision 2001/220/JHA requires Member States to ensure the specific protection of vulnerable victims, which means that the national court must be able to authorise vulnerable victims to testify in a way that guarantees their protection, for example outside the trial and before it takes place. The CJEU stated: "However, independently of whether a victim's minority is as a general rule sufficient to classify such a victim as particularly vulnerable

549 See FRA (2014b), p. 36.

550 CJEU, C-105/03, *Criminal proceedings against Maria Pupino* [GC], 16 June 2005, para. 53.

551 CJEU, C-105/03, *Criminal proceedings against Maria Pupino* [GC], 16 June 2005. See also CJEU, C-507/10, *Criminal proceedings against X*, 21 December 2011.

552 CJEU, C-105/03, *Criminal proceedings against Maria Pupino* [GC], 16 June 2005.

within the meaning of the Framework Decision, it cannot be denied that where, as in this case, young children claim to have been maltreated, and maltreated, moreover, by a teacher, those children are suitable for such classification, having regard in particular to their age and to the nature and consequences of the offences of which they consider themselves to be a victim".[553] Furthermore, the CJEU ruled that all measures concerning the protection and prevention of secondary victimisation must be designed in such a way that the defendant is still granted a fair trial.[554]

Under CoE law, the ECtHR ruled that there is a duty of the state to protect victims' interests. This is true for victims who participate as witnesses in criminal proceedings. Their interests under ECHR provisions, such as Article 2 and Article 8, must be balanced against the interests of the defence.[555] The ECtHR has a number of rulings concerning sexual offences in which children testified against the alleged perpetrators. This case law shows that the Court recognised that criminal proceedings concerning sexual offences "are often conceived of as an ordeal by the victim, in particular when the latter was unwillingly confronted with the defendant" and that this was even more prominent when children were concerned.[556] Consequently, the Court accepted that in such cases certain measures may be taken for the purpose of protecting the child victims. However, it also noted that such measures may not jeopardise the adequate and effective exercise of the rights of the defence, and the judicial authorities may therefore be required to take measures which counterbalance the handicaps under which the defence operates.[557]

Example: In *Kovač v. Croatia*,[558] a 12 year old girl testified before an investigating judge that the applicant had committed indecent acts on her. The applicant had not been present or represented during the said testimony, nor was he given the opportunity to contest the victim's statement The ECtHR reiterated that, as a rule, all evidence must be provided in

553 *Ibid.*, para. 53.

554 *Ibid.*, para. 59.

555 ECtHR, *Doorson v. the Netherlands*, No. 20524/92, 26 March 1996.

556 ECtHR, *S.N. v. Sweden*, No. 34209/96, 2 July 2002, para. 47.

557 ECtHR, *Bocos-Cuesta v. the Netherlands*, No. 54789/00, 10 November 2005; ECtHR, *A.L. v. Finland*, No. 23220/04, 27 January 2009; ECtHR, *W. v. Finland*, No. 14151/02, 24 April 2007; ECtHR, *Kovač v. Croatia*, No. 503/05, 12 July 2007.

558 ECtHR, *Kovač v. Croatia*, No. 503/05, 12 July 2007.

the presence of the accused at a public hearing with a view to adversarial arguments. If statements at the stage of the police inquiry or the judicial investigation are used as evidence, this is not in itself inconsistent with Article 6 of the ECHR, provided that the defendant is given an adequate and proper opportunity to challenge and question the witness concerned, either at the time of making the statements or at a later stage of the proceedings. In the applicant's case, the victim's statements were the only direct evidence of the facts held against the applicant, and this evidence was decisive in the court's decision to issue a guilty verdict. However, the applicant had been unable to contest or obtain a reply from the domestic courts concerning his complaint in that respect. What is more, the victim's actual statement had never been read out before the trial court. Instead, the judge merely noted that the victim upheld her statement made before the investigating judge. Therefore, the ECtHR concluded that the applicant had not been afforded a fair trial, a breach of Article 6 (1) in conjunction with Article 6 (3) (d) of the ECHR.

Example: In *S.N. v. Sweden*,[559] a ten-year-old boy testified to the police that he was sexually abused by the applicant. The boy was interviewed twice by a police inspector with significant experience in child abuse cases. The first interview was videotaped, the second audiotaped. The lawyer of the applicant did not attend the second interview, but agreed with the police-inspector on the issues that needed to be discussed. During the trial, the District Court played the recordings of the child's interviews, but did not examine him in person. The court ultimately convicted the applicant, relying almost entirely on the child's testimonies. The Court of Appeal upheld the conviction. It found that the police interviews provided sufficient evidence for the applicant's guilt to be established, even though it acknowledged that there was no technical evidence supporting the child's allegations, which were sometimes imprecise. The ECtHR accepted that, in sexual offence cases, cross-examination of a witness is not always possible and that, in such cases, witness testimonies should be treated with extreme care. Although the statements made by the child were virtually the sole evidence against the accused, the proceedings as a whole were fair. The videotape was shown during the trial and appeal hearings and the transcript of the second interview was read out before the District Court; the audiotape was also played before the Court of Appeal. This gave the

559 ECtHR, *S.N. v. Sweden*, No. 34209/96, 2 July 2002.

applicant sufficient opportunity to challenge the child's testimony and his credibility in the course of the criminal proceedings. Consequently, there had been no violation of Article 6 (3) (d) of the ECHR.

The case law of the ECtHR is not only about balancing the protection of child victims and the right of the defendant to a fair trial, but also about the protection of the right to life of witnesses and their families, including children, under Article 2 of the ECHR, as shown by the following example.

Example: *R.R. and Others v. Hungary*[560] concerns a prisoner who testified in open court about his drug-trafficking activities and who was, along with his wife and two children, put in the official witness-protection programme for risk of retribution. When the authorities realised that the prisoner was still in contact with criminal circles, they removed him and his family from the witness protection programme for having breached its terms. Under Article 2 of the ECHR, the family claimed that their exclusion from the witness-protection programme had put their lives at risk of mafia retribution. The Court accepted that the applicants' inclusion in the witness protection programme and the father's collaboration with the authorities meant that the applicants' lives had been at risk when the measure was originally put in place. As the cancellation of their protection by the programme was not motivated by a reduction of that risk, but by a breach of its terms, the Court was not persuaded that the authorities had proven that the risk had ceased to exist. Furthermore, it was not unreasonable to suppose that, following the withdrawal of the family's cover identities, their identities and whereabouts became accessible to anyone wishing to harm them. In that way, the authorities potentially exposed the family to a life-threatening danger, in breach of Article 2 of the ECHR.

Article 31 of the Lanzarote Convention indicates which general measures of protection Member States should take to protect the rights and interests of victims, including their special needs as witnesses, at all stages of investigations and criminal proceedings (Article 31 (1)). These measures include information about their rights as victims, the availability of services and the general progress of the investigation or proceedings, the protection of their privacy and safety (including information on the release of the person prosecuted or convicted) and the avoidance of contact between victims and perpetrators in

560 ECtHR, *R.R. and Others v. Hungary*, No. 19400/11, 4 December 2012.

court and law enforcement agency premises. In addition, Article 31 provides that victims must have access to legal aid (Article 31 (3)). The information provided must be adapted to children's age and maturity and be in a language he or she understands (Article 31 (6)).

The CoE's *Guidelines on child friendly justice*[561] also pay attention to the position of the child victim and witness, particularly when he or she gives evidence in judicial proceedings. The guidelines call upon member states to make "'[e]very effort […] for children to give evidence in the most favourable settings and under the most suitable conditions, having regard to their age, maturity and level of understanding and any communication difficulties they may have".[562] To this end, trained professionals should be involved, and, for example, audiovisual statements encouraged. Children should also have the opportunity to give evidence in criminal cases without the presence of the alleged perpetrator. The guidelines also recognise that this child-friendly approach should respect the right of other parties to contest the content of the child's statements. In addition, the guidelines provide that the privacy and family life of child witnesses should be protected (Section IV (a) (9)) and proceedings should preferably be held *in camera*.

Under international law, the position of child victims has been explicitly recognised in Article 39 of the CRC. This provision stipulates that States Parties must take all appropriate measures to promote physical and psychological recovery and social reintegration of child victims. This recovery and reintegration must take place in an environment which fosters the health, self-respect and dignity of the child.

It is also important to note that the UN has adopted the Guidelines on Justice in Matters involving Child Victims and Witnesses of Crime.[563] These guidelines call for child victims and witnesses to be treated in a "child-sensitive manner", which "denotes an approach that balances the child's right to protection and that takes into account the child's individual needs and views".[564] The guide-

561 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010. See also FRA (2015b).

562 Council of Europe, Committee of Ministers (2010), *Guidelines on child friendly justice*, 17 November 2010, para. 64.

563 UN Economic and Social Council (ECOSOC), Resolution 2005/20, *Guidelines on Justice in Matters involving Child Victims and Witnesses of Crime*, 22 July 2005.

564 *Ibid.*, para. 9 (d).

lines provide very detailed guidance on how to implement these aspects. The UN Committee on the Rights of the Child has also underscored the relevance of these UN Guidelines under Article 12 of the CRC (right to be heard) in its General Comment.[565] According to the committee, child victims and child witnesses of a crime must be given an opportunity to fully exercise their rights to freely express their views, which in particular "means that every effort has to be made to ensure that a child victim and/or witness is consulted on the relevant matters with regard to involvement in the case under scrutiny, and enabled to express freely, and in her or his own manner, views and concerns regarding her or his involvement in the judicial process".[566] The Committee also argues that "the right of the child victim and witness is [...] linked to the right to be informed about issues such as availability of health, psychological and social services, the role of a child victim and/or witness, the ways in which 'questioning' is conducted, existing support mechanisms in place for the child when submitting a complaint and participating in investigations and court proceedings, the specific places and times of hearings, the availability of protective measures, the possibilities of receiving reparation, and the provisions for appeal".[567]

565 UN, Committee on the Rights of the Child (2009), *General Comment no. 12 (2009): The right of the child to be heard*, CRC/C/GC/12, 1 July 2009, paras. 62–64.

566 *Ibid.*, para. 63.

567 *Ibid.*, para. 64.

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How to find case law of the European Courts

European Court of Human Rights: HUDOC case law database

The **HUDOC database** provides free access to ECtHR case law: http://HUDOC.echr.coe.int.

The database is available in English and French and provides a user-friendly search engine that makes it easy to find case law.

Video tutorials and user manuals are available on the HUDOC **Help** page. For details and examples of how to use filters and search fields, the user can place the mouse pointer on the ? at the right of every search tool in the Hudoc interface.

The case law references in this handbook provide the reader with comprehensive information that will enable them to easily find the full text of the judgment or decision cited.

Before starting a search, please note that the default settings show the Grand Chamber and Chamber judgments in the order of the latest judgment published. To search in other collections such as decisions, the user should tick the appropriate box in the **Document Collections** field appearing on the upper left side of the screen.

The simplest way to find cases is by entering the application number into the **Application Number** field under the **Advanced Search** on the upper right side of the screen and then clicking the blue 'Search' button.

To access further case law pertaining to other issues, for example, children-related issues, the user can use the **Search field** indicated with a magnifying glass on the top right part of the screen. In the search field, the user can search in the text using a:

- single word (e.g. child)
- phrase (e.g. "migrant children")
- case title
- State
- Boolean phrase (e.g. child IN alternative care)

To help the user perform a text search, the **Simple Boolean search** is available by clicking on the arrow appearing inside the **Search field**. The Simple Boolean search offers six search possibilities: this exact word or phrase, all of these words, any of these words, none of these words, near these words, free Boolean search.

Once the search results appear, the user can easily narrow the results using the filters appearing in the **Filters** field on the left side of the screen, for example, "Language" or "State". Filters can be used individually or in combination to further narrow the results. The "Keywords" filter can be a useful tool, as it often comprises terms extracted from the text of the ECHR and is directly linked to the Court's reasoning and conclusions.

Example: Finding the Court's case law on the issue of expulsion of asylum seekers putting them at risk of torture or inhuman or degrading treatment or punishment under Article 3 ECHR

1) The user first enters the phrase "asylum seekers" into the **Search field** and clicks the blue **Search button**.

2) After the search results appear, the user then selects the "3" under the **Violation filter** in the **Filters field** to narrow the results to those related to a violation of Article 3.

3) The user can then select the relevant keywords under the **Keywords filter** to narrow the results to those relevant to Article 3, such as the keyword "(Art. 3) Prohibition of torture".

For more significant cases, a legal summary is available in HUDOC. The summary comprises a descriptive head note, a concise presentation of the facts and the law, with emphasis on points of legal interest. If a summary exists, a link **Legal Summaries** will appear in the results together with the link to the judgment text or decision. Alternatively, the user can search exclusively for legal summaries by ticking the "Legal Summaries" box in the **Document Collections** field.

If non-official translations of a given case have been published, a link **Language versions** will appear in the results together with the link to the judgment text or decision. HUDOC also provides links to third-party internet sites that host other translations of ECtHR case law. For more information, see "Language versions" under the HUDOC "Help" section.

Court of Justice of the European Union: CURIA case law database

The **CURIA case law database** provides free access to ECJ/CJEU case law: http://curia.europa.eu.

The search engine is available in all official EU languages.[568] The **language** can be selected on the upper right side of the screen. The search engine can be used to search for information in all documents related to concluded and pending cases by the Court of Justice, the General Court and the Civil Service Tribunal.

There is a **Help** section available at http://curia.europa.eu/common/juris/en/aideGlobale.pdf#. Each search box also has a help page that can be accessed by clicking the icon and contains useful information to help the user make the best possible use of the tool.

The simplest way to find a specific case is to enter the full case number into the search box entitled **Case number** and then clicking the green 'Search' button. It is also possible to search for a case using a part of the case number. For example, entering 122 in the 'Case number' field will find Case No. 122 for

568 Available since 30 April 2004: Spanish, Danish, German, Greek, English, French, Italian, Dutch, Portuguese, Finnish and Swedish; since 1 May 2004: Czech, Estonian, Latvian, Lithuanian, Hungarian, Polish, Slovak and Slovene; since 1 January 2007: Bulgarian and Romanian; since 30 April 2007: Maltese; since 31 December 2011: Irish; temporary derogations have been laid down by Regulation (EC) No. 920/2005 and Regulation (EU) No. 1257/2010. Secondary legislation in force at the date of accession is being translated into Croatian and will gradually be published in the Special edition of the Official Journal of the European Union.

cases from any year and before any of the three courts: Court of Justice, the General Court and/or the Civil Service Tribunal.

Alternatively, one can also use the **Name of parties** field to search with the common name of a case. This is usually the simplified form of the names of the parties to the case.

There are a total of 16 multi-functional search fields available to help narrow the search results. The different search fields are user-friendly and can be used in various combinations. The fields often have search lists that can be accessed by clicking the icon and selecting available search terms.

For more general searches, using the **Text** field produces results based on keyword searches in all documents published in the European Court Reports since 1954, and since 1994 for the European Court Reports – Staff Cases (ECR-SC).

For more subject-specific searches, the **Subject-matter** field can be used. This requires clicking the icon to the right of the field and selecting the relevant subject(s) from the list. The search results will then produce an alphabetised list of selected documents related to the legal questions dealt with in the decisions of the Court of Justice, the General Court, the Civil Service Tribunal and in the Opinions of the Advocates General.

The CURIA website also has additional case law tools:

Numerical access: this section is a collection of case information for any case brought before one of the three courts. The cases are listed by their case number and in the order in which they were lodged at the relevant registry. Cases can be consulted by clicking on their case number. The 'Numerical access' section is available at: http://curia.europa.eu/jcms/jcms/Jo2_7045/.

Digest of the case-law: this section offers a systematic classification of case law summaries on the essential points of law stated in the decision in question. These summaries are based as closely as possible on the actual wording of that decision. The 'Digest' section is available at: http://curia.europa.eu/jcms/jcms/Jo2_7046/.

Annotation of judgments: this section contains references to annotations by legal commentators relating to the judgments delivered by the three courts

since they were first established. The judgments are listed separately by court or tribunal in chronological order according to their case number, while the annotations by legal commentators are listed in chronological order according to their appearance. References appear in their original language. The 'Annotation of judgments' section is available at: http://curia.europa.eu/jcms/jcms/Jo2_7083/.

National case-law database: this external database can be accessed through the CURIA website. It offers access to relevant national case law concerning EU law. The database is based on a collection of case law from EU Member State national courts and/or tribunals. The information has been collected by a selective trawl of legal journals and direct contact with numerous national courts and tribunals. The 'National case-law database' is available in English and in French and is available at: http://curia.europa.eu/jcms/jcms/Jo2_7062/.

Legal instruments referenced

UN legal instruments

On core UN treaties, including the CRC and their monitoring bodies see: www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx.

On the Hague Conference on Private International Law Conventions relating to the International Protection of Children family and property relations see: https://www.hcch.net/en/instruments/conventions.

CoE legal instruments

All CoE legal instruments are available online at http://conventions.coe.int/Treaty/.

For information about the status of acceptance of CoE legal instruments by EU Member States, see 'International obligations' on the FRA website at: http://fra.europa.eu/en/publications-and-resources/data-and-maps/int-obligations.

	Title
Children's rights/civil rights	
European Convention on Human Rights	Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocols No. 11 and No. 14, CETS No.: 005, Rome, 4.11.1950, pp. 1–15.
Protocol to the European Convention on Human Rights	Protocol to the Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocol No. 11, CETS No.: 009, Paris, 20.3.1952, pp. 1–3.
Protocol No. 12 to the European Convention on Human Rights	Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms, CETS No.: 177, Rome, 4.11.2000, pp. 1–3.
European Convention on the Exercise of Children's Rights	European Convention on the Exercise of Children's Rights, CETS No.: 160, Strasbourg, 25.1.1996, pp. 1–10.
European Convention on the Legal Status of Children born out of Wedlock	European Convention on the Legal Status of Children born out of Wedlock, CETS No.: 085, Strasbourg, 15.10.1975, pp. 1–5.
Convention on Human Rights and Biomedicine (Oviedo Convention)	Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, CETS No.: 164, Oviedo, 4.4.1997, pp. 1–12.
Personal identity issues	
Framework Convention for the Protection of National Minorities	Framework Convention for the Protection of National Minorities, CETS No.: 157, Strasbourg, 1.2.1995, pp. 1–10.
European Convention on Nationality	European Convention on Nationality, CETS No.: 166, Strasbourg, 6.11.1997, pp. 1–13.
Convention on the Avoidance of Statelessness in relation to State Succession	Council of Europe Convention on the Avoidance of Statelessness in relation to State Succession, CETS No.: 200, Strasbourg, 19.5.2006, pp. 1–7.
Family life and parental care	
Convention on Contact concerning Children	Convention on Contact concerning Children, CETS No.: 192, Strasbourg, 15.5.2003, pp. 1–13.
European Convention on the Adoption of Children (revised)	European Convention on the Adoption of Children (revised), CETS No.: 202, Strasbourg, 27.11.2008, pp. 1–11.
European Convention on Recognition and Enforcement of Decisions concerning Custody of Children and on Restoration of Custody of Children	European Convention on Recognition and Enforcement of Decisions concerning Custody of Children and on Restoration of Custody of Children, CETS No.: 105, Luxembourg, 20.5.1980, pp. 1–12.

Child protection against violence and exploitation	
Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention)	Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, CETS No.: 201, Lanzarote, 25.10.2007, pp. 1–21.
European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment	European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, CETS No.: 126, Strasbourg, 26.11.1987, pp. 1–9.
Convention on Cybercrime	Convention on Cybercrime, CETS No.: 185, Budapest, 23.11.2001, pp. 1–27.
Council of Europe Convention on Action against Trafficking in Human Beings	Council of Europe Convention on Action against Trafficking in Human Beings, CETS No.: 197, Warsaw, 16.5.2005, pp. 1–21.
Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention)	Council of Europe Convention on preventing and combating violence against women and domestic violence, CETS No.: 210, Istanbul, 11.5.2011, pp. 1–31.
Economic, social and cultural rights	
European Social Charter	European Social Charter, CETS No. 035, Turin, 18.10.1961, pp. 1–18.
European Social Charter (revised)	European Social Charter (revised), CETS No. 163, Strasbourg, 3.5.1996, pp. 1-29.
Issues on migration and asylum	
European Convention on the Repatriation of Minors	European Convention on the Repatriation of Minors, CETS No.: 071, The Hague, 28.5.1970, pp. 1–9.
European Convention on the Legal Status of Migrant Workers	European Convention on the Legal Status of Migrant Workers, CETS No.: 093, Strasbourg, 24.11.1977, pp. 1–14.
European Convention on Social Security	European Convention on Social Security, CETS No.: 078, Paris, 14.12.1972, pp. 1–42.
European Code of Social Security	European Code of Social Security, CETS No.: 048, Strasbourg, 16.4.1964, pp. 1–33.
Consumer and data protection	
Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data	Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data, CETS No.: 108, Strasbourg, 28.1.1981, pp. 1–10.
European Convention on Transfrontier Television	European Convention on Transfrontier Television, CETS No.: 132, Strasbourg, 5.5.1989, pp. 1–20.

EU legal instruments

All EU legal instruments are available online at http://eur-lex.europa.eu.

Short-hand name	Title
Non-discrimination	
Racial Equality Directive (2000/43/EC)	Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin, OJ L 180, 19.7.2000, pp. 22–26.
Employment Equality Directive (2000/78/EC)	Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation, OJ L 303, 2.12.2000, pp. 16–22.
Gender Goods and Services Directive (2004/113/EC)	Council Directive 2004/113/EC of 13 December 2004 implementing the principle of equal treatment between men and women in the access to and supply of goods and services, OJ L 373, 21.12.2004, pp. 37–43.
Family life and parental care	
Brussels II bis Regulation (EC) No. 2201/2003	Council Regulation (EC) No. 2201/2003 of 27 November 2003 concerning jurisdiction and the recognition and enforcement of judgments in matrimonial matters and the matters of parental responsibility, repealing Regulation (EC) No. 1347/2000, OJ L 338, 23.12.2003, pp. 1–29.
Maintenance Regulation (EC) No. 4/2009	Council Regulation (EC) No. 4/2009 of 18 December 2008 on jurisdiction, applicable law, recognition and enforcement of decisions and cooperation in matters relating to maintenance obligations, OJ L 7, 10.1.2009, pp. 1–79.
Mediation Directive (2008/52/EC)	Directive 2008/52/EC of the European Parliament and of the Council of 21 May 2008 on certain aspects of mediation in civil and commercial matters, OJ L 136, 24.5.2008, pp. 3–8.
Access to Justice Directive (2002/8/EC)	Council Directive 2002/8/EC of 27 January 2003 to improve access to justice in cross-border disputes by establishing minimum common rules relating to legal aid for such disputes, OJ L 26, 31.1.2003, pp. 41–47.
Child protection against violence and exploitation	
Young Workers Directive (94/33/EC)	Council Directive 94/33/EC of 22 June 1994 on the protection of young people at work, OJ L 216, 20.8.1994, pp. 12–20.
Anti-Trafficking Directive (2011/36/EU)	Directive 2011/36/EU of the European Parliament and of the Council of 5 April 2011 on preventing and combating trafficking in human beings and protecting its victims, and replacing Council Framework Decision 2002/629/JHA, OJ L 101, 15.4.2011, pp. 1–11.

Directive on combating the sexual abuse and sexual exploitation of children and child pornography (2011/93/EU)	Directive 2011/93/EU of the European Parliament and of the Council of 13 December 2011 on combating the sexual abuse and sexual exploitation of children and child pornography, and replacing Council Framework Decision 2004/68/JHA, OJ L 335, 17.12.2011, pp. 1–14.
Victims' Directive (2012/29/EU)	Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA, OJ L 315, 14.11.2012, pp. 57–73.
Residence Permits for Victims of Anti-Trafficking Directive (2004/81/EC)	Council Directive 2004/81/EC of 29 April 2004 on the residence permit issued to third-country nationals who are victims of trafficking in human beings or who have been the subject of an action to facilitate illegal immigration, who cooperate with the competent authorities, OJ L 261, 6.8.2004, pp. 19–23.
Commission Decision 2007/698/EC	Commission Decision of 29 October 2007 amending Decision 2007/116/EC as regards the introduction of additional reserved numbers beginning with 116 (notified under document number C(2007) 5139) (Text with EEA relevance), OJ L 284, 30.10.2007, pp. 31–32.
Migration and asylum, including social rights of migrant children	
Asylum Procedures Directive (2013/32/EU)	Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection, OJ L 180, 29.6.2013, pp. 60–95.
Dublin Regulation (EU) No. 604/2013	Regulation (EU) No. 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person, OJ L 180, 29.6.2013, pp. 31–59.
Qualification Directive (2011/95/EU)	Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted, OJ L 337, 20.12.2011, pp. 9–26.
Regulation (EU) No. 492/2011	Regulation (EU) No. 492/2011 of the European Parliament and of the Council of 5 April 2011 on freedom of movement for workers within the Union Text with EEA relevance, OJ L 141, 27.5.2011, pp. 1–12.

Free Movement Directive (2004/38/EC)	Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States amending Regulation (EEC) No. 1612/68 and repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC and 93/96/EEC (Text with EEA relevance), OJ L 158, 30.4.2004, pp. 77–123.
Council Directive 77/486/EEC on the education of the children of migrant workers	Council Directive 77/486/EEC of 25 July 1977 on the education of the children of migrant workers, OJ L 199, 6.8.1977, pp. 32–33.
Family Reunification Directive (2003/86/EC)	Council Directive 2003/86/EC of 22 September 2003 on the right to family reunification, OJ L 251, 3.10.2003, pp. 12–18.
Temporary Protection Directive (2001/55/EC)	Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof, OJ L 212, 7.8.2001, pp. 12–23.
Reception Conditions Directive (2013/33/EU)	Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection, OJ L 180, 29.6.2013, pp. 96–116.
Return Directive (2008/115/EC)	Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals, OJ L 348, 24.12.2008, pp. 98–107.
Long-Term Residents Directive (2003/109/EC)	Council Directive 2003/109/EC of 25 November 2003 concerning the status of third-country nationals who are long-term residents, OJ L 16, 23.1.2004, pp. 44–53.
Schengen Borders Code Regulation (EC) No. 562/2006	Regulation (EC) No. 562/2006 of the European Parliament and of the Council o f15 March 2006 establishing a Community Code on the rules governing the movement of persons across borders (Schengen Borders Code), OJ L 105, 13.4.2006, pp. 1–32.
Consumer and personal data protection	
Consumer Rights Directive (2011/83/EU)	Directive 2011/83/EU of the European Parliament and of the Council of 25 October 2011 on consumer rights, amending Council Directive 93/13/EEC and Directive 1999/44/EC of the European Parliament and of the Council and repealing Council Directive 85/577/EEC and Directive 97/7/EC of the European Parliament and of the Council Text with EEA relevance, OJ L 304, 22.11.2011, pp. 64–88.

Directive 87/357/EEC concerning products which, appearing to be other than they are, endanger the health or safety of consumers	Council Directive 87/357/EEC of 25 June 1987 on the approximation of the laws of the Member States concerning products which, appearing to be other than they are, endanger the health or safety of consumers, OJ L 192, 11.7.87, pp. 49–50.
Distance Selling Directive (97/7/EC)	Directive 97/7/EC of the European Parliament and of the Council of 20 May 1997 on the protection of consumers in respect of distance contracts – Statement by the Council and the Parliament re Article 6 (1) – Statement by the Commission re Article 3 (1), first indent, OJ L 144, 4.6.1997, pp. 19–27.
General Product Safety Directive (2001/95/EC)	Directive 2001/95/EC of the European Parliament and of the Council of 3 December 2001 on general product safety (Text with EEA relevance), OJ L 11, 15.1.2002, pp. 4–17.
Directive 2009/39/EC on foodstuffs intended for particular nutritional uses	Directive 2009/39/EC of the European Parliament and of the Council of 6 May 2009 on foodstuffs intended for particular nutritional uses (recast) (Text with EEA relevance), OJ L 124, 20.5.2009, pp. 21–29.
Toy Safety Directive (2009/48/EC)	Directive 2009/48/EC of the European Parliament and of the Council of 18 June 2009 on the safety of toys (Text with EEA relevance), OJ L 170, 30.6.2009, pp. 1–37.
Television Without Frontiers Directive (89/552/EEC)	Council Directive 89/552/EEC of 3 October 1989 on the coordination of certain provisions laid down by Law, Regulation or Administrative Action in Member States concerning the pursuit of television broadcasting activities, OJ L 298, 17.10.1989, pp. 23–30.
Audiovisual Media Services Directive (2010/13/EU)	Directive 2010/13/EU of the European Parliament and of the Council of 10 March 2010 on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the provision of audiovisual media services (Text with EEA relevance), OJ L 95, 15.4.2010, pp. 1–24.
Data Protection Directive (95/46/EC)	Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data, OJ L 281, 23.11.95, pp. 31–50.
Directive 2002/58/EC concerning the processing of personal data and the protection of privacy in the electronic communications sector	Directive 2002/58/EC of the European Parliament and of the Council of 12 July 2002 concerning the processing of personal data and the protection of privacy in the electronic communications sector (Directive on privacy and electronic communications), OJ L 201, 31.7.2002, pp. 37–47.

Unfair Business-to-Consumer Commercial Practices Directive (2005/29/EC)	Directive 2005/29/EC of the European Parliament and of the Council of 11 May 2005 concerning unfair business-to-consumer commercial practices in the internal market and amending Council Directive 84/450/EEC, Directives 97/7/EC, 98/27/EC and 2002/65/EC of the European Parliament and of the Council and Regulation (EC) No. 2006/2004 of the European Parliament and of the Council ('Unfair Commercial Practices Directive') (Text with EEA relevance), OJ L 149, 11.6.2005, pp. 22–39.
Clinical Trials Directive (2001/20/EC)	Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use, OJ L 121, 1.5.2001, pp. 34–44.
Regulation 536/2014 on clinical trials on medicinal products for human use	Regulation (EU) No. 536/2014 of the European Parliament and of the Council of 16 April 2014 on clinical trials on medicinal products for human use, and repealing Directive 2001/20/EC (Text with EEA relevance), OJ L 158, 27.5.2014, pp. 1–76.
Criminal justice and alternative proceedings	
Right to Interpretation and Translation Directive (2010/64/EU)	Directive 2010/64/EU of the European Parliament and of the Council of 20 October 2010 on the right to interpretation and translation in criminal proceedings, OJ L 280, 26.10.2010, pp. 1–7.
Right to Information Directive (2012/13/EU)	Directive 2012/13/EU of the European Parliament and of the Council of 22 May 2012 on the right to information in criminal proceedings, OJ L 142, 1.6.2012, pp. 1–10.
Access to a Lawyer Directive (2013/48/EU)	Directive 2013/48/EU of the European Parliament and of the Council of 22 October 2013 on the right of access to a lawyer in criminal proceedings and in European arrest warrant proceedings, and on the right to have a third party informed upon deprivation of liberty and to communicate with third persons and with consular authorities while deprived of liberty, OJ L 294, 6.11.2013, pp. 1–12.
Charter of Fundamental Rights	Charter of Fundamental Rights of the European Union, OJ C 326, 26.10.2012, pp. 391–407.
Children with disabilities	
Council Decision 2010/48/EC	Council Decision 2010/48/EC concerning the conclusion, by the European Community, of the United Nations Convention on the Rights of Persons with Disabilities, OJ L 23, 27.1.2010, pp. 35–61.

A great deal of information on the European Union Agency for Fundamental Rights is available on the internet. It can be accessed through the FRA website at fra.europa.eu.

Further information on the case law of the European Court of Human Rights is available on the Court's website: echr.coe.int. The HUDOC search portal provides access to judgments and decisions in English and/or French, translations into additional languages, legal summaries, press releases and other information on the work of the Court.

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EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

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Children are full-fledged holders of rights. They are beneficiaries of all human and fundamental rights and subjects of special regulations, given their specific characteristics. This handbook aims to illustrate how European law and case law accommodate the specific interests and needs of children. It also illustrates the importance of parents and guardians or other legal representatives and makes reference, where appropriate, to where rights and responsibilities are most prominently vested in children's carers. This handbook aims to raise awareness and improve the knowledge of the legal standards that protect and promote children's rights in Europe. It is a point of reference on both European Union (EU) and Council of Europe (CoE) law related to these subjects, explaining how each issue is regulated under EU law, including the Charter of Fundamental Rights of the European Union, as well as under the European Convention on Human Rights (ECHR), the European Social Charter (ESC) and other CoE instruments. The handbook is designed for non-specialist legal professionals, judges, public prosecutors, child protection authorities, and other practitioners and organisations responsible for ensuring the legal protection of the rights of the child. It explains key jurisprudence, summarising major rulings of both the Court of Justice of the European Union (CJEU) and the European Court of Human Rights (ECtHR).

EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS
Schwarzenbergplatz 11 – 1040 Vienna – Austria
Tel. +43 (1) 580 30-60 – Fax +43 (1) 580 30-693
fra.europa.eu – info@fra.europa.eu

COUNCIL OF EUROPE
67075 Strasbourg Cedex – France

EUROPEAN COURT OF HUMAN RIGHTS
Tel. +33 (0) 3 88 41 20 18 – Fax +33 (0) 3 88 41 27 30
echr.coe.int – publishing@echr.coe.int

CHILDREN'S RIGHTS DIVISION
Tel. +33 (0) 388 41 25 07 – Fax +33 (0) 90 21 52 85
coe.int/children – children@coe.int

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Ενότητα 03

Στόχοι μάθησης

Να περιγραφούν οι δυνατότητες συμμετοχής του παιδιού που υποφέρει από ψυχικό τραύμα σε αστικές και ποινικές διαδικασίες που τον αφορούν, καθώς και τα μέτρα που αποσκοπούν στη διασφάλιση της ασφάλειας και της ψυχοσωματικής του ευεξίας

Κύριες πηγές σε διεθνές και ευρωπαϊκό επίπεδο

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- Σύμβαση για τα δικαιώματα του παιδιού (CRC)
- Ευρωπαϊκή σύμβαση για την άσκηση των δικαιωμάτων των παιδιών (Σύμβαση Στρασβούργου)
- Σύμβαση Λανζαρότε
- Ευρωπαϊκή σύμβαση ανθρωπίνων δικαιωμάτων (ECHR) (ECHR)

- Χάρτης θεμελιωδών δικαιωμάτων της Ευρωπαϊκής Ένωσης
- Οδηγία 2011/36/ΕΕ για την εμπορία ανθρώπων
- Οδηγία 2012/29/ΕΕ για τα δικαιώματα των θυμάτων εγκληματικότητας
- Οδηγία 2011/93/ΕΕ σχετικά με την καταπολέμηση της σεξουαλικής κακοποίησης και της σεξουαλικής εκμετάλλευσης παιδιών και της παιδικής πορνογραφίας

Διαδικασίες στις οποίες ενδέχεται να εμπλακεί το παιδί

1. οινικές διαδικασίες

Η υποχρέωση του κράτους να προλαμβάνει και να τιμωρεί τη βία και την κακοποίηση εναντίον των ανηλίκων (πρωτογενής θυματοποίηση)

Άρθρα 3-7 CRC, Άρθρο 3 ECHR, Άρθρο 18 Λανζαρότε,
Άρθρα 2-10 Οδηγία 36, Άρθρα 3-17 Οδηγία 93

Πρόληψη

Εισαγωγή ποινικών αδικημάτων σχετικών με τη βία και την κακοποίηση παιδιών

Τιμωρία

Τιμωρία όσων ασκούν βία και κακοποίηση εναντίον ανηλίκων

2. Αστικές διαδικασίες

Όταν ο ένας ή και οι δύο γονείς ασκούν με άμεσο τρόπο κακοποίηση ή άλλως την έχουν επιτρέψει

Για τη διασφάλιση ενός ασφαλούς και ήσυχου οικογενειακού περιβάλλοντος

Άρθρο 9 CRC, Άρθρο 8 ECHR

Περιορισμοί για γονείς

- Video Baldelli
- Video Ceccarelli
- Video Cibinel

Επιμέλεια του παιδιού από άλλη οικογένεια

Εισαγωγή σε εγκαταστάσεις για παιδιά που πάσχουν από ψυχικό τραύμα

Υιοθεσία του ανηλίκου

- Video Cibinel
- Video Baldelli

Σχέσεις ανάμεσα σε ποινικές και αστικές διαδικασίες

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Ποινικές διαδικασίες

Στόχος: η ταυτοποίηση και τιμωρία του δράστη σχετικά με την συμπεριφορά του απέναντι στο ανήλικο παιδί, εφόσον η συμπεριφορά αυτή αποτελεί έγκλημα.

Αστικές διαδικασίες

Στόχος: ο έλεγχος της καταλληλότητας της οικογένειας του παιδιού και η πρόληψη περαιτέρω τραυματισμού.

Οι διαδικασίες αυτές είναι ξεχωριστές και ανεξάρτητες → η συμπεριφορά που δεν αποτελεί έγκλημα μπορεί να θέσει σε κίνδυνο το οικογενειακό περιβάλλον, δικαιολογώντας την επέμβαση του δικαστή

3. Εξωδικαστικές διαδικασίες

Όταν η σχέση ανάμεσα σε αυτόν που ασκεί την κακοποίηση και τον ανήλικο φαίνεται να είναι αναστρέψιμη.

Άρθρο 13 Σύμβαση Στρασβούργου, Άρθρο 12 Οδηγία 29

Στόχος είναι να αποφευχθούν παρεμβατικές διαδικασίες, οι οποίες θα μπορούσαν τελικά να θέσουν σε κίνδυνο την αποκατάσταση προς σχέσης

- Μεσολάβηση
- Προσπάθεια συμβιβασμού
- Πρόσθετα μέτρα επαναπροσέγγισης

carepath

Το βέλτιστο συμφέρον του παιδιού

Αυτή η αρχή ισχύει για κάθε διαδικασία και απαιτεί η ψυχοσωματική ευημερία του παιδιού να μπαίνει πάνω από κάθε άλλο συμφέρον άξιο προστασίας

Άρθρο 3 CRC, Άρθρο 6 Σύμβαση Στρασβούργου

Ο δικαστής πρέπει να συγκεντρώνει τις απαραίτητες πληροφορίες για να γνωρίζει τα επίμαχα γεγονότα και το οικογενειακό περιβάλλον του παιδιού

Η απόφαση του δικαστή πρέπει πάντα να προσανατολίζεται προς την προστασία των συμφερόντων του ανηλίκου

- Video Ceccarelli
- Video Long

Δικαίωμα του παιδιού να το συμβουλεύονται

Ο δικαστής θα πρέπει να γνωρίζει τις απόψεις του παιδιού, οι οποίες πρέπει να λαμβάνονται υπόψη κατά τη λήψη απόφασης

Άρθρο 12 CRC, Άρθρο 3 Σύμβαση Στρασβούργου

Εγγυήσεις συμμετοχής για το παιδί

BUT

Μέτρα προστασίας για την αποφυγή «δευτερογενούς θυματοποίησης»

Εγγυήσεις συμμετοχής για το παιδί

1. Το δικαίωμα πληροφόρησης
    1. Άρθρο 31 Λανζαρότε, Άρθρο 3 Σύμβαση Στρασβούργου, Άρθρα 3-4 Οδηγία 29

Μόνο ένα παιδί με επαρκείς γνώσεις μπορεί να συμμετέχει με επικερδή τρόπο στη διαδικασία λήψης αποφάσεων

Σχετικά με τι;

- έννοια των διαδικασιών
- επίμαχα γεγονότα
- δικαιώματα και προστασία
- ο ρόλος του παιδιού
- πιθανές συνέπειες των απόψεων του

Ποιος;

- δικαστική αρχή
- δικηγόρος
- εκπρόσωπος
- εμπειρογνώμονας

Πώς;

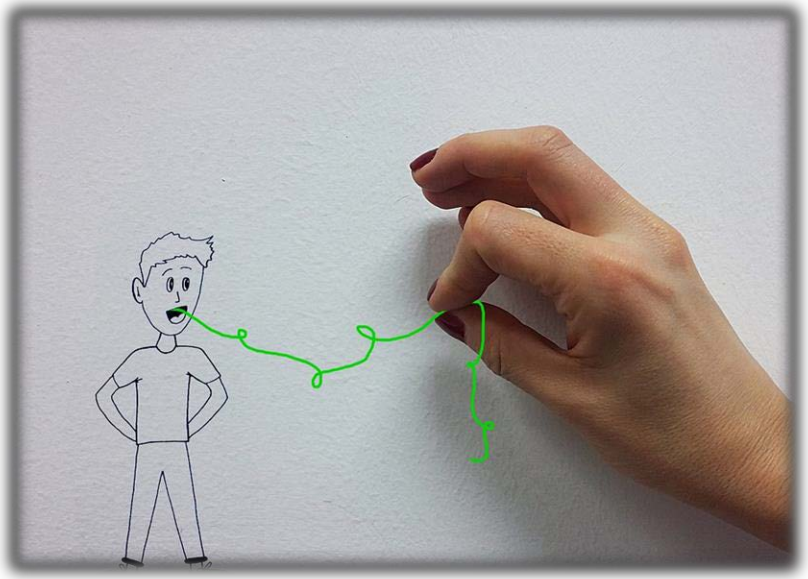
χρήση γλώσσας και εννοιών κατάλληλων για την ηλικία και την αντίληψη του παιδιού

2. Δικαίωμα ακρόασης σχετικά με τα επίμαχα γεγονότα

Μπορεί να ζητηθεί από τον ανήλικο να καταθέσει για γεγονότα που σχετίζονται με την απόφαση

Ποινικές διαδικασίες

Το παιδί ως μάρτυρας βίας και κακοποίησης προκειμένου να εξακριβωθεί η ενοχή του κατηγορουμένου



Αστικές διαδικασίες

Το παιδί ως μάρτυρας βίας και κακοποίησης προκειμένου να αξιολογηθεί η καταλληλόλητα της οικογένειας

Υψηλός κίνδυνος δευτερογενούς θυματοποίησης

- Video Ceccarelli
- Video Cibinel
- Video Long

3. Δικαίωμα ακρόασης πριν την απόφαση του δικαστή

Πριν την απόφαση, το παιδί έχει το δικαίωμα να εκφράσει τις απόψεις του πάνω σε θέματα που εξετάζονται κατά τη διαδικασία

Άρθρο 12 CRC, Άρθρο 3 Σύμβαση Στρασβούργου

Ποινικές διαδικασίες

- έναρξη των διαδικασιών
- προληπτικά μέτρα
- δικαστική επιτήρηση και άλλες ειδικές διαδικασίες
- αξιολόγηση αποδεικτικών στοιχείων

Αστικές διαδικασίες

- απομάκρυνση από την οικογένεια
- απομάκρυνση από έναν γονέα
- επιμέλεια παιδιού
- υιοθεσία

Εξώδικαστικές διαδικασίες

συναίνεση για μεσολάβηση ή προσπάθεια συμβιβασμού

Συχνά η γνώμη αντικαθίσταται από την ισχυρότερη εγγύηση συναίνεσης

Το βάρος της γνώμης εξαρτάται από την αντίληψη του παιδιού

Εργαλεία προστασίας κατά τις διαδικασίες

1. Πρόσωπα υποστήριξης

1. Άρθρο 12 CRC, Άρθρο 31 Λανζαρότε, Άρθρα 9-10 Σύμβαση Στρασβούργου, Άρθρο 24 Οδηγία 29

Εκπρόσωπος (εφόσον οι γονείς δεν είναι διαθέσιμοι ή έχουν σύγκρουση συμφερόντων)

Προσδιορίζει και προστατεύει τα συμφέροντα του παιδιού

Δικηγόρος

Υιοθετεί την πιο κατάλληλη νομική στρατηγική για την επίτευξη απόφασης σύμφωνα με τα συμφέροντα του παιδιού

Επαγγελματίες κοινωνικής μέριμνας και υγείας (ψυχολόγοι, ψυχίατροι, κοινωνικοί λειτουργοί)

- προστασία από δευτερογενή θυματοποίηση
- υποστήριξη του δικαστή, των γονέων και των δικηγόρων για την κατανόηση των αναγκών και της ευαισθησίας του παιδιού
- συμβολή ώστε να ξεπεραστεί το ψυχικό τραύμα που προήλθε από βία

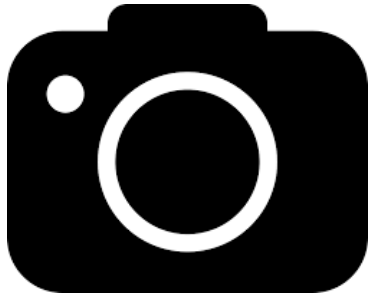
Αυτά τα πρόσωπα μπορούν να ορίζονται μόνο από τον δικαστή

2. Ιδιωτική ζωή

1. Άρθρο 16 CRC, Άρθρο 8 ECHR, Άρθρο 21 Οδηγία 29

Ακρόαση εν συμβουλίω, χωρίς παρουσία κοινού

Περιορισμοί στη διάδοση εικόνων και πληροφοριών



Περιορισμοί στις ερωτήσεις σχετικά με την ιδιωτική ζωή που μπορούν να απευθύνονται στο παιδί κατά τη διάρκεια της ακρόασης

3. Εύλογη διάρκεια των διαδικασιών

Η δευτερογενής θυματοποίηση συνδέεται επίσης με τη διάρκεια των διαδικασιών
Άρθρο 7 Σύμβαση Στρασβούργου

σύγκρουση μεταξύ διαφορετικών αξιών

η απόφαση πρέπει να λαμβάνεται όσο το δυνατόν γρηγορότερα για την αποφυγή παρατεταμένου άγχους

τα άλλα συμφέροντα του ανηλίκου και των άλλων ατόμων που εμπλέκονται στη λήψη της απόφασης δεν μπορούν να θυσιαστούν εντελώς

ανάγκη για ισορροπία

4. Μέτρα προστασίας κατά τη διάρκεια της ακρόασης (μέρος Ι)

Όταν το παιδί καταθέτει για την κακοποίηση, τις σχέσεις του με τον δράστη, την οικογένειά του

Άρθρο 31 Λανζαρότε, Άρθρο 18 Οδηγία 29, ECHR, 2.7.2002, S.N. εναντίον Σουηδίας

Μέτρα για την αποφυγή του κινδύνου δευτερογενούς θυματοποίησης

Χώρος της ακρόασης

η ακρόαση μπορεί να γίνει εκτός της αίθουσας του δικαστηρίου

σπίτι του ανηλίκου, γραφείο δικαστή, γραφείο δικηγόρου, ειδική αίθουσα

Ποιος κάνει τις ερωτήσεις;

οι ερωτήσεις μπορεί να μην απευθύνονται άμεσα από τους δικηγόρους των μερών, αλλά από τον δικαστή ή από εμπειρογνώμονα

οι δικηγόροι μπορεί να είναι επιθετικοί ή απλώς μπορεί να μην έχουν εμπειρία στην ανάκριση ανηλίκων

4. Μέτρα προστασίας κατά τη διάρκεια της ακρόασης (μέρος ΙΙ)

Είναι απαραίτητο να προχωρήσουμε όσο το δυνατόν γρηγορότερα στην ακρόαση και να αποφύγουμε τις επαναλήψεις

Η αναμονή για την ακρόαση και οι επαναλήψεις αυξάνουν το άγχος

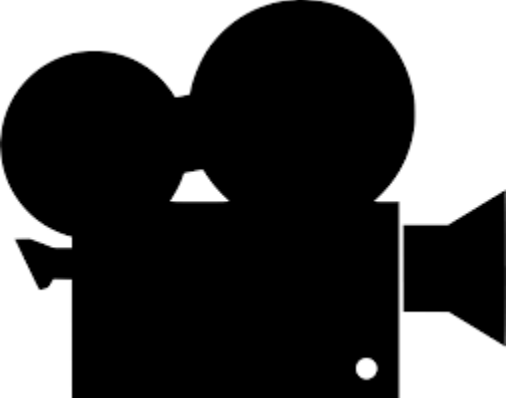
Η ακρόαση του παιδιού πρέπει να λάβει χώρα στα πρώιμα στάδια της διαδικασίας και στη συνέχεια δεν πρέπει να επαναληφθεί άλλη φορά

Καμία επαφή με τον κατηγορούμενο, τους γονείς που έχουν σύγκρουση συμφερόντων και τους δικηγόρους τους

Η επαφή με τα μάτια μπορεί να αγχώσει και να τρομάξει το παιδί

- σύστημα ενδοεπικοινωνίας πίσω από τζάμι
- εικονοτηλεδιάσκεψη
- ερωτήσεις που έχουν ετοιμάσει οι δικηγόροι, αλλά απευθύνονται από τον δικαστή ή από εμπειρογνώμονα σε ειδική αίθουσα

ανάγκη για εξισορρόπηση των συμφερόντων του παιδιού και των δικαιωμάτων της υπεράσπισης



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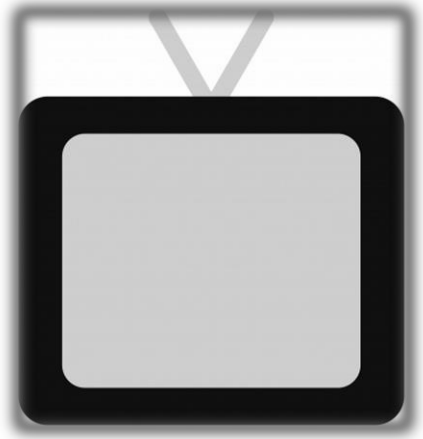
Βίντεο από ακροάσεις παιδιών

Παράδειγμα ειδικής αίθουσας στην Ιταλία



Προετοιμασία του παιδιού πριν την κατάθεση (video 1 και video 2)

Κατάθεση ενός παιδιού για τον φόνο της αδερφής του

5. Μέτρα προστασίας για την έκφραση των απόψεων ή της συναίνεσης του παιδιού

Άρθρο 6 Σύμβαση Στρασβούργου

Η ελευθερία έκφρασης της γνώμης ή της συναίνεσης θα μπορούσε να επηρεαστεί από την παρουσία άλλων ατόμων, όπως γονείς, κατηγορούμενος και δικηγόροι

Ο δικαστής μπορεί να ακούσει όσα θέλει να πει το παιδί εκτός της δικαστικής αίθουσας ή απουσία αυτών των ατόμων

- Video Ceccarelli
- Video Long

- Video Baldelli
- Video Cibinel

6. Προστασία της ευημερίας κατά τη διάρκεια των διαδικασιών Άρθρα 20-21 CRC, Άρθρο 31 Λανζαρότε, Άρθρο 18 Οδηγία 29

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Πριν ληφθεί η τελική απόφαση, προσωρινά προληπτικά μέτρα μπορούν να εφαρμοστούν για την προστασία του παιδιού

Μέτρα εναντίον του δράστη

- προληπτική κράτηση/κατ'οίκον περιορισμός
- περιορισμοί εναντίον των γονιών
- απομάκρυνση από την οικογενειακή εστία
- απαγόρευση προσέγγισης του παιδιού

Μέτρα για τον ανήλικο

- προσωρινή επιμέλεια από άλλη οικογένεια
- απομάκρυνση από την οικογενειακή εστία

7. Βοήθεια εκτός των διαδικασιών

Άρθρο 39 CRC, Άρθρο 31 Λανζαρότε, Άρθρα 8-9 Οδηγία 29

Video Cibinel

Ψυχολογική και συναισθηματική υποστήριξη εκτός των διαδικασιών

Η δευτερογενής θυματοποίηση πρέπει να αντιμετωπίζεται τόσον πριν όσο και μετά την ακρόαση

Η τιμωρία του ενόχου και η αποκατάσταση της οικογενειακής γαλήνης δεν επαρκούν

είναι απαραίτητο να υποστηρίζουμε το παιδί για να ξεπεράσει το ψυχικό τραύμα που προήλθε από κακοποίηση (πρωτογενής θυματοποίηση)

Οι ανάγκες αυτές διασφαλίζονται συχνά μέσα από το έργο των κοινωνικών υπηρεσιών

Περίληψη του ρόλου των επαγγελματιών κοινωνικής μέριμνας και υγείας

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Εντός των διαδικασιών

- ατομική αξιολόγηση συγκεκριμένων αναγκών προστασίας
- βοήθεια κατά τη συμμετοχή του παιδιού σε διαδικαστικές δραστηριότητες
- αξιολόγηση της αξιοπιστίας του παιδιού
- συμμετοχή σε προσπάθειες συμβιβασμού
- αξιολόγηση της αντίληψης
- αξιολόγηση των οικογενειακών συνθηκών

κύριος στόχος → να αποτραπεί η δευτερογενής θυματοποίηση και να παρέχονται στον δικαστή χρήσιμες γνώσεις για την απόφασή του

Εκτός των διαδικασιών

- ψυχολογική και συναισθηματική υποστήριξη για το παιδί
- έλεγχος των συνθηκών της νέας οικογένειας

κύριος στόχος → να ξεπεραστεί το ψυχικό τραύμα που προκλήθηκε από βία και κακοποίηση και να αποκατασταθεί η οικογενειακή γαλήνη

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Άλλο χρήσιμο υλικό μάθησης

Κατευθυντήριες γραμμές σχετικά με τη δικαιοσύνη για τα παιδιά (Συμβούλιο της Ευρώπης)

Εγχειρίδιο για τους επαγγελματίες και τους υπεύθυνους χάραξης πολιτικής σχετικά με τη δικαιοσύνη σε θέματα παιδιών ως θυμάτων και μαρτύρων εγκληματικών πράξεων
(Ηνωμένα Έθνη)

Κατευθυντήριες γραμμές για τα παιδιά που έρχονται σε επαφή με το δικαστικό σύστημα (Διεθνής Ένωση Δικαστών και Εισαγγελέων για Νέους και Οικογένειες)

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Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material
ANNEX 2
–
Greek Version

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

Principles of recovery oriented mental health practice

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.

> *It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment and connection—and external conditions that facilitate recovery—implementation of human rights, a positive culture of healing, and recovery-oriented services. (Jacobson and Greenley, 2001 p. 482)*

The purpose of principles of recovery oriented mental health practice is to ensure that mental health services are being delivered in a way that supports the recovery of mental health consumers.

1. UNIQUENESS OF THE INDIVIDUAL

Recovery oriented mental health practice:

- recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community
- accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life
- empowers individuals so they recognise that they are at the centre of the care they receive.

2. REAL CHOICES

Recovery oriented mental health practice:

- supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored
- supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time
- ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.

3. ATTITUDES AND RIGHTS

Recovery oriented mental health practice:

- involves listening to, learning from and acting upon communications from the individual and their carers about what is important to each individual
- promotes and protects individual's legal, citizenship and human rights
- supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual
- instils hope in an individual's future and ability to live a meaningful life.

4. DIGNITY AND RESPECT

Recovery oriented mental health practice:

- consists of being courteous, respectful and honest in all interactions
- involves sensitivity and respect for each individual, particularly for their values, beliefs and culture
- challenges discrimination and stigma wherever it exists within our own services or the broader community.

5. PARTNERSHIP AND COMMUNICATION

Recovery oriented mental health practice:

- acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them
- values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement
- involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

6. EVALUATING RECOVERY

Recovery oriented mental health practice:

- ensures and enables continuous evaluation of recovery based practice at several levels
- individuals and their carers can track their own progress
- services demonstrate that they use the individual's experiences of care to inform quality improvement activities
- the mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships as well as health and well being measures.

These Recovery Principles have been adapted from the Hertfordshire Partnership NHS Foundation Trust Recovery Principles in the UK.

SPECIAL ARTICLE

How important are the common factors in psychotherapy? An update

Bruce E. Wampold

Department of Counseling Psychology, University of Wisconsin, Madison, WI, USA; Modum Bad Psychiatric Center, Vikersund, Norway

The common factors have a long history in the field of psychotherapy theory, research and practice. To understand the evidence supporting them as important therapeutic elements, the contextual model of psychotherapy is outlined. Then the evidence, primarily from meta-analyses, is presented for particular common factors, including alliance, empathy, expectations, cultural adaptation, and therapist differences. Then the evidence for four factors related to specificity, including treatment differences, specific ingredients, adherence, and competence, is presented. The evidence supports the conclusion that the common factors are important for producing the benefits of psychotherapy.

Key words: Common factors, contextual model, psychotherapy, alliance, empathy, expectations, cultural adaptation, therapist differences, specific ingredients

(World Psychiatry 2015;14:270–277)

The so-called common factors have a long history in psychiatry, originating with a seminal article by S. Rosenzweig in 1936 (1) and popularized by J. Frank in the various editions of his book *Persuasion and Healing* (2-4). During this period, the common factors have been both embraced and dismissed, creating some tension (5-9). The purpose of this paper is not to review or discuss the debate, but to provide an update, summarizing the evidence related to these factors.

To understand the evidence for the common factors, it is important to keep in mind that these factors are more than a set of therapeutic elements that are common to all or most psychotherapies. They collectively shape a theoretical model about the mechanisms of change in psychotherapy.

A particular common factor model, called the contextual model, has been recently proposed (8,10). Although there are other common factor models (e.g., 4,11), based on different theoretical propositions, the predictions made about the importance of various common factors are similar and the choice of the model does not affect conclusions about the impact of these factors. The contextual model is presented below, followed by a review of the evidence for the common factors imbedded in the model.

THE CONTEXTUAL MODEL

The contextual model posits that there are three pathways through which psychotherapy produces benefits. That is, psychotherapy does not have a unitary influence on patients, but rather works through various mechanisms. The mechanisms underlying the three pathways entail evolved characteristics of humans as the ultimate social species; as such, psychotherapy is a special case of a social healing practice.

Thus, the contextual model provides an alternative explanation for the benefits of psychotherapy to ones that emphasize specific ingredients that are purportedly beneficial for particular disorders due to remediation of an identifiable deficit (8).

The three pathways of the contextual model involve: a) the real relationship, b) the creation of expectations through explanation of disorder and the treatment involved, and c) the enactment of health promoting actions. Before these pathways can be activated, an initial therapeutic relationship must be established.

Initial therapeutic relationship

Before the work of therapy can begin, an initial bond between therapist and patient needs to be created. E. Bordin stated in 1979 that "some basic level of trust surely marks all varieties of therapeutic relationships, but when attention is directed toward the more protected recesses of inner experience, deeper bonds of trust and attachment are required and developed" (12, p. 254). The initial meeting of patient and therapist is essentially the meeting of two strangers, with the patient making a determination of whether the therapist is trustworthy, has the necessary expertise, and will take the time and effort to understand both the problem and the context in which the patient and the problem are situated.

The formation of the initial bond is a combination of bottom-up and top-down processing. Humans make very rapid determination (within 100 ms), based on viewing the face of another human, of whether the other person is trustworthy or not (13), suggesting that patients make very rapid judgments about whether they can trust their therapist. More than likely, patients make rapid judgments about the dress of the therapist, the arrangement and decorations of the room (e.g., diplomas on the wall), and other features of the therapeutic setting (14). However, patients come to therapy with expectations about the nature of psychotherapy as

well, due to prior experiences, recommendations of intimate or influential others, cultural beliefs, and so forth. The initial interaction between patient and therapist is critical, it seems, because more patients prematurely terminate from therapy after the first session than at any other point (15).

Pathway 1: The real relationship

The real relationship, defined psychodynamically, is "the personal relationship between therapist and patient marked by the extent to which each is genuine with the other and perceives/experiences the other in ways that befit the other" (16, p. 119). Although the psychotherapeutic relationship is influenced by general social processes, it is an unusual social relationship in that: a) the interaction is confidential, with some statutory limits (e.g., child abuse reporting), and b) disclosure of difficult material (e.g., of infidelity to a spouse, of shameful affect, and so forth) does not disrupt the social bond. Indeed, in psychotherapy, the patient is able to talk about difficult material without the threat that the therapist will terminate the relationship.

The importance of human connection has been discussed for decades, whether is it called attachment (17), belongingness (18), social support (19), or the lack of loneliness (20,21). In fact, perceived loneliness is a significant risk factor for mortality, equal to or exceeding smoking, obesity, not exercising (for those with chronic cardiac disease or for healthy individuals), environmental pollution, or excessive drinking (22-24). Psychotherapy provides the patient a human connection with an empathic and caring individual, which should be health promoting, especially for patients who have impoverished or chaotic social relations.

Pathway 2: Expectations

Research in a number of areas documents that expectations have a strong influence on experience (25). Indeed, the purported price of a bottle of wine influences rating of pleasantness as well as neural representations (26). The burgeoning research on the effects of placebos documents the importance of expectations, as placebos have robustly shown to alter reported experience as well as demonstrating physiological and neural mechanisms (27,28).

Expectations in psychotherapy work in several possible ways. Frank (4) discussed how patients present to psychotherapy demoralized not only because of their distress, but also because they have attempted many times and in many ways to overcome their problems, always unsuccessfully. Participating in psychotherapy appears to be a form of remoralization.

However, therapy has more specific effects on expectations than simple remoralization. According to the contextual model, patients come to therapy with an explanation for their distress, formed from their own psychological beliefs, which is sometimes called "folk psychology" (29-31). These beliefs, which are influenced by cultural conceptualizations of mental disorder but also are idiosyncratic, are typically not adaptive, in the sense that they do not allow for solutions. Psychotherapy provides an explanation for the patient's difficulties that is adaptive, in the sense that it provides a means to overcome or cope with the difficulties. The patient comes to believe that participating in and successfully completing the tasks of therapy, whatever they may be, will be helpful in coping with his or her problems, which then furthers for the patient the expectation that he or she has ability to enact what is needed. The belief that one can do what is necessary to solve his or her problem has been discussed in various ways, including discussions of mastery (4,32), self-efficacy (33), or response expectancies (25).

Critical to the expectation pathway is that patients believe that the explanation provided and the concomitant treatment actions will be remedial for their problems. Consequently, the patient and therapist will need to be in agreement about the goals of therapy as well as the tasks, which are two critical components of the therapeutic alliance (34,35). Hatcher and Barends described the alliance as "the degree to which the therapy dyad is engaged in collaborative, purposive work" (36, p. 293). Creating expectations in psychotherapy depends on a cogent theoretical explanation, which is provided to the patient and which is accepted by the patient, as well as on therapeutic activities that are consistent with the explanation, and that the patient believes will lead to control over his or her problems. A strong alliance indicates that the patient accepts the treatment and is working together with the therapist, creating confidence in the patient that the treatment will be successful.

Pathway 3: Specific ingredients

The contextual model stipulates that there exists a treatment, particularly one that the patient finds acceptable and that he or she thinks will be remedial for his or her problems, creating the necessary expectations that the patient will experience less distress. Every treatment that meets the conditions of the contextual model will have specific ingredients, that is, each cogent treatment contains certain well-specified therapeutic actions.

The question is how the specific ingredients work to produce the benefits of psychotherapy. Advocates of specific treatments argue that these ingredients are needed to remediate a particular psychological deficit. The contextual model posits that the specific ingredients not only create expectations (pathway 2), but universally produce some salubrious actions. That is, the therapist induces the patient to enact some healthy actions, whether that may be thinking about the world in less maladaptive ways and relying less on dysfunctional schemas (cognitive-behavioral treatments), improving interpersonal relations (interpersonal psychotherapy and some dynamic therapies), being more accepting

of one's self (self-compassion therapies, acceptance and commitment therapy), expressing difficult emotions (emotion-focused and dynamic therapies), taking the perspective of others (mentalization therapies), and so forth. The effect of lifestyle variables on mental health has been understated (37). A strong alliance is necessary for the third pathway as well as the second, as without a strong collaborative work, particularly agreement about the tasks of therapy, the patient will not likely enact the healthy actions.

According to the contextual model, if the treatment elicits healthy patient actions, it will be effective, whereas proponents of specific ingredients as remedial for psychological deficits predict that some treatments – those with the most potent specific ingredients – will be more effective than others (8).

EVIDENCE FOR VARIOUS COMMON FACTORS

Now that the contextual model has been briefly presented, attention is turned toward an update of the evidence for the common factors. Each factor reviewed is imbedded in the contextual model, although each of them is more generically considered atheoretically as an important one. As will be apparent, many of the common factors are not theoretically or empirically distinct.

To present the evidence succinctly and with as little bias and error as possible, we rely on meta-analyses of primary studies. Studies that examine the association of levels of a common factor and outcome are typically reported by some type of correlation statistic (such as Pearson's product-moment correlation), whereas studies that experimentally manipulate and compare conditions typically report some standardized mean difference (such as Cohen's d). For comparison purposes, correlational statistics are converted to Cohen's d. All meta-analyses reported aggregate statistics, corrected for bias, based on the effects of individual studies appropriated weighted. To understand the importance of effects, Cohen (38) classified a d of 0.2 as small, 0.5 as medium, and 0.8 as large. The evidence is summarized in Figure 1, where the effects of various common factors are compared to those of various specific factors.

Alliance

The alliance is composed of three components: the bond, the agreement about the goals of therapy, and the agreement about the tasks of therapy (12). As discussed above, alliance is a critical common factor, instrumental in both pathway 2 and pathway 3.

Alliance is the most researched common factor. Typically the alliance is measured early in therapy (at session 3 or 4) and correlated with final outcome. The most recent meta-analysis of the alliance included nearly 200 studies involving over 14,000 patients and found that the aggregate correlation between alliance and outcome was about .27, which is equivalent to a Cohen's d of 0.57 (39), surpassing the threshold for a medium sized effect.

There have been a number of criticisms of the conclusion that alliance is an important factor in psychotherapy (40), most of which have focused on the correlational nature of alliance research. However, each of the criticisms has been considered and has been found not to attenuate the importance of the alliance (see 8).

First, it could well be that early symptom relief causes a strong alliance at the third or fourth session – that is, early responders report better alliances and have better outcomes. To address this threat, early therapy progress must be statistically controlled or longitudinal research is needed to examine the association of alliance and symptoms over the course of therapy. The studies that have examined this question have found evidence to support either interpretation, but the better designed and more sophisticated studies are converging on the conclusion that the alliance predicts future change in symptoms after controlling for already occurring change.

Second, it could be that the correlation between alliance and outcome is due to the patients' contributions to the alliance. According to this line of thinking, some patients may come to therapy well prepared to form a strong alliance and it is these patients who also have a better prognosis, so the alliance-outcome association is due to the characteristics of the patients rather than to something that therapists provide to the patients. Disentangling the patient and therapist contributions involves the use of multilevel modeling. Recently, Baldwin et al (41) performed such an analysis and found that it was the therapist contribution which was important: more effective therapists were able to form a strong alliance across a range of patients. Patients' contribution did not predict outcome: patients who are able to form better alliances, perhaps because they have secure attachment histories, do not have better prognoses. Indeed, patients with poor attachment histories and chaotic interpersonal relationships may well benefit from a therapist who is able to form alliances with difficult patients. These results have been corroborated by meta-analyses (42).

Third, there may be a halo effect if the patient rates both the alliance and the outcome. However, meta-analyses have shown that the alliance-outcome association is robust even when alliance and outcome are rated by different people. It also appears that the alliance is equally strong for cognitive-behavioral therapies as it is for experiential or dynamic treatments, whether a manual is used to guide treatment or not, and whether the outcomes are targeted symptoms or more global measures.

There are other threats to validity of the alliance as a potent therapeutic factor, but the evidence for each of them is nonexistent or weak (8). The research evidence, by and large, supports the importance of the alliance as an important aspect of psychotherapy, as predicted by the contextual model.

As mentioned above, distinctions between certain common factors are difficult to make. A distinction has been

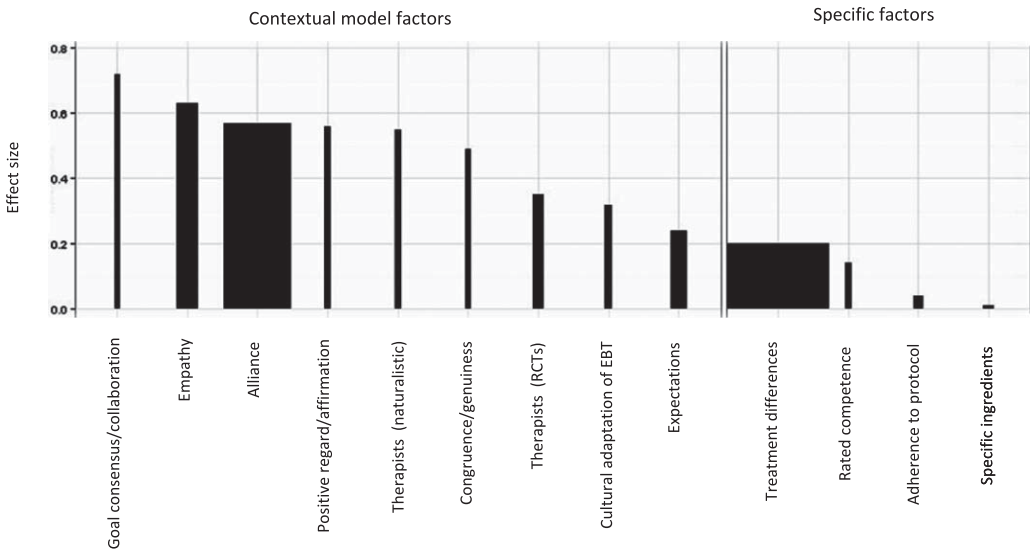

Figure 1 Effect sizes for common factors of the contextual model and specific factors. Width of bars is proportional to number of studies on which effect is based. RCTs – randomized controlled trials, EBT – evidence-based treatments

made between the bond, as defined as a component of the alliance, which is related to purposeful work, and the real relationship, which is focused on the transference-free genuine relationship (8,16). There is some evidence that the real relationship is related to outcome, after controlling for the alliance (16), and, although the evidence is not strong, it does support the first pathway of the contextual model.

A second construct related for the alliance is labeled goal consensus/collaboration. Although related to agreement about the goals and tasks for therapy, goal consensus/collaboration is measured with different instruments. As shown in Figure 1, the effect for goal consensus and collaboration is strong (d=0.72), based on a meta-analysis of 15 studies (43).

Empathy and related constructs

Empathy, a complex process by which an individual can be affected by and share the emotional state of another, assess the reasons for another's state, and identify with the other by adopting his or her perspective, is thought to be necessary for the cooperation, goal sharing, and regulation of social interaction. Such capacities are critical to infant and child rearing, as children, who are unable to care for themselves, signal to the caregiver that care is needed, a process that is then put to use to manage social relations among communities of adult individuals. Therapist expressed empathy is a primary common factor, critical to pathway 1 of the contextual model, but which also augments the effect of expectations.

The power of the empathy in healing was beautifully revealed in a study of placebo acupuncture for patients with irritable bowel syndrome (44). Patients with this syndrome were randomly assigned to a limited interaction condition, an augmented relationship condition, or treatment as usual (waiting list for acupuncture). In the limited interaction condition, the acupuncturist met with the patient briefly, but was not allowed to converse with him or her, and administered the sham acupuncture (a device that gives the sensation of having needles pierce the skin, but they do not). In the augmented relationship condition, the practitioner conversed with the patient about the symptoms, the relevance of lifestyle and relationships to irritable bowel syndrome, as well as the patient's understanding of the cause and meaning of her disorder. All this was done in a warm and friendly manner, using active listening, appropriate silences for reflection, and a communication of confidence and positive expectation. For the four dependent variables (global improvement, adequate relief, symptom severity, and quality of life), the two sham acupuncture conditions were superior to treatment as usual. However, the augmented relationship condition was superior to the limited interaction condition, particularly for quality of life.

The above study is noteworthy because it was an experimental demonstration of the importance of a warm, caring, empathic interaction within a healing setting. Unfortunately, experimental manipulation of empathy in psychotherapy studies is not possible, for design and ethical reasons. Nonetheless, there have been numerous studies (n=59) that have correlated ratings of therapist empathy with outcome, which have been meta-analytically summarized (45), resulting in a relatively large effect (d=0.63; see Figure 1). Constructs related to empathy have also been meta-analyzed and found to be related to outcome, including positive regard/affirmation (d=0.56, n=18; see Figure 1) (46) and congruence/genuineness (d=0.49, n=18; see Figure 1) (47).

It should be recognized that several of the threats to validity for the alliance are also present with regard to empathy. For example, it is clearly easier for a therapist to be warm and

caring toward a motivated, disclosing and cooperative patient than to one who is interpersonally aggressive, and the former types of patients will most likely have better outcomes than the latter, making the empathy/outcome correlation an artifact of patient characteristics rather than therapist action. Unfortunately, studies such as the ones conducted to rule out these threats to validity for the alliance have not been conducted for empathy and related constructs.

Expectations

Examining the role of expectations in psychotherapy is difficult. In medicine, expectations can be induced verbally and then physicochemical agents or procedures can be administered or not, making the two components (creation of expectations and the treatment) independent. In psychotherapy, creating the expectations, through explanation of the patient's disorder, presenting the rationale for the treatment, and participating in the therapeutic actions, is part of therapy. It is difficult to design experimental studies of expectations in psychotherapy (not impossible, but not yet accomplished in any important manner).

The typical way to assess the effect of expectations in psychotherapy is to correlate patient ratings of their expectations with outcomes, but we have seen that such correlational studies produce threats to validity. Furthermore, in many studies, expectations are measured *prior* to when the rationale for the treatment is provided to the patient, when it is the explanation given to the patient that is supposed to create the expectations. Assessing expectations after the explanation has been given (i.e., during the course of treatment) is also problematic, as those patients who have made significant progress in therapy will naturally respond that they think therapy will be helpful.

Despite the difficulties with investigating expectations in psychotherapy, this is a topic of much interest (48-50). Recently, a meta-analysis of expectations showed that there was a relatively small, but statistically significant, relationship between rated expectations and outcome ($d=0.24$, $n=46$; see Figure 1) (49). The best evidence for expectations in the context of healing is derived from studies of the placebo effect, where exquisite care has been taken to experimentally manipulate variables of interest and to control for threats to validity, by using physiological and neurological variables as well as subjective reports. A summary of this literature is beyond the scope of this article, but many excellent reviews are available (8,27,28).

Cultural adaptation of evidence-based treatments

The contextual model emphasizes that the explanation given for the patient's distress and the therapy actions must be acceptable to the patient. Acceptance is partly a function of consistency of the treatment with the patient's beliefs, particularly beliefs about the nature of mental illness and how to cope with the effects of the illness. This suggests that evidence-based treatments that are culturally adapted will be more effective for members of the cultural group for which the adapted treatment is designed. There are many ways to adapt treatments, including those involving language, cultural congruence of therapist and patient, cultural rituals, and explanations adapted to the "myth" of the group.

A recent meta-analysis demonstrated that adapting evidence-based treatments by using an explanation congruent with the cultural group's beliefs (i.e., using the cultural "myth" as the explanation) was more effective than unadapted evidence-based treatments, although the effect was modest ($d=0.32$, $n=21$; see Figure 1) (51).

Therapist effects

Therapist effects are said to exist if some therapists consistently achieve better outcomes with their patients than other therapists, regardless of the nature of the patients or the treatment delivered. Therapist effects have been studied in clinical trials and in naturalistic settings. In both designs, the measure of therapist effects is an intraclass correlation coefficient. Technically, this coefficient indexes the degree to which two patients from the same therapist have similar outcomes relative to two patients from two different therapists. To compare therapist effects to other common factors, the intraclass correlation coefficient is converted to Cohen's d.

The contextual model predicts that there will be differences among therapists *within* a treatment. That is, even though the therapists are delivering the same specific ingredients, some therapists will do so more skillfully and therefore achieve better outcomes than other therapists delivering the same treatment. Evidence for this conjecture is found in clinical trials. A meta-analysis of therapist effects in clinical trials found modest therapist effects ($d=0.35$, $n=29$; see Figure 1) (52). Keep in mind that the therapists in clinical trials generally are included because of their competence and then they are given extra training, supervised, and monitored. Moreover, the patients in such trials are homogeneous, as they have a designated diagnosis and are selected based on various inclusionary/exclusionary criteria. In such designs, patients are randomly assigned to therapists. Consequently, consistent differences among therapists in such trials, although modest, are instructive.

Not surprisingly, therapist effects in naturalistic settings are greater than in clinical trials. In the former settings, therapists are more heterogeneous, patients may not be randomly assigned to therapists, patients are heterogeneous, and so forth. A meta-analysis of therapist effects in such settings found a relatively large effect ($d=0.55$, $n=17$; see Figure 1) (52).

The finding of robust therapist effects raises the question about what are the characteristics or actions of more effective therapists. Recent research has begun to address this

question. Studies have shown that effective therapists (vis-à-vis less effective therapists) are able to form stronger alliances across a range of patients, have a greater level of facilitative interpersonal skills, express more professional self-doubt, and engage in more time outside of the actual therapy practicing various therapy skills (8).

SPECIFIC EFFECTS

Evidence for the common factors is also collected by examining the evidence for specific aspects of psychotherapy. The contextual model makes several predictions about specific effects, which will be discussed as each specific effect is considered.

Treatment differences

When pathway 3 of the contextual model was discussed earlier, it was emphasized that the model contends that all therapies with structure, given by empathic and caring therapists, and which facilitate the patient's engagement in behaviors that are salubrious, will have approximately equal effects. That is, the specific ingredients, discussed in pathway 3, are not critical because they remediate some psychological deficit.

The question of whether some treatments are superior to others has long been debated, with origins at the very beginning of the practice of psychotherapy (think about the disagreements amongst Freud, Adler and Jung, for example). Today, there are claims that some treatments, in general or for specific disorders, are more effective than others. Others, however, claim that there are no differences among psychotherapies, in terms of their outcomes.

The literature addressing this issue is immense and summarizing the results of relative efficacy is not possible. Nevertheless, the various meta-analyses for psychotherapies in general or for specific disorders, if they do find differences among various types of treatment, typically find at most differences of approximately d=0.20, the value shown in Figure 1.

Specific effects from dismantling studies

To many, the dismantling design is the most valid way to identify the effects of specific ingredients. In this design, a specific ingredient is removed from a treatment to determine how much more effective the treatment is in total compared to the treatment without the ingredient that is purportedly remedial for the psychological deficit.

Two meta-analyses have examined dismantling designs and both found minimal differences between the total treatment and the treatment without one or more critical ingredients (d=0.01, n=30, see Figure 1) (53,54). The most recent of these meta-analyses did find that adding an ingredient to an existing treatment increased the effect for targeted variables by a small amount (d=0.28) (53).

Adherence and competence

In clinical trials, it is required that adherence to the protocol and the competence at delivering the treatment are rated. This makes sense: if the goal is to make inferences about a particular treatment, then it is necessary to ensure that the treatment was delivered with the necessary components and not with extraneous components (i.e., with *adherence* to the protocol) and that the treatment components were delivered skillfully (i.e., given *competently*).

It would seem logical theoretically that adherence to the protocol and competence would be related to outcome. That is, for cases where the therapist followed the protocol and did so skillfully, there should be better outcomes. However, this is not the case. In a meta-analysis of adherence and competence (55), effects were small (d=0.04, n=28 for adherence; d=0.14, n=18 for competence; see Figure 1).

The results for adherence and competence demand further explanation. If the specific ingredients of a treatment are critical, then adherence should make a difference – actually delivering those ingredients should be related to outcome. There is evidence that rigid adherence to a protocol can attenuate the alliance and increase resistance to the treatment (i.e., failing to accept the treatment, a contextual model tenet) (8), and that flexibility in adherence is related to better outcomes (56), results consistent with prediction of the contextual model.

The findings for competence are a bit more difficult to understand. Competence in these trials typically is rated by experts in the treatment being given, based on watching therapy sessions. Why can't experts differentiate between "good" therapy and "bad" therapy? If this were indicative of experts' abilities to judge competence, then the notion of psychotherapy supervision would be turned upside down, because what is observed and evaluated would have no relation to outcomes – how could the supervisor then make a case for providing input to the supervisee? But the clue to the resolution of this mystery is found in the definition of competence. Most psychotherapy trials rate the competence *for a specific treatment*. That is, what is rated is the skill in providing the elements of the treatment protocol, rather than common factors, such as empathy, alliance, affirmation, and so forth – aspects of therapy that do predict outcome and seem to differentiate more effective therapists from less effective therapists.

CONCLUSIONS

Although the common factors have been discussed for almost a century, the focus of psychotherapy is typically on the development and dissemination of treatment models. If

not discounted, then the common factors are thought of as perhaps necessary, but clearly not sufficient. The evidence, however, strongly suggests that the common factors must be considered therapeutic and attention must be given to them, in terms of theory, research and practice.

One of the criticisms of the common factors is that they are an atheoretical collection of commonalities. In this paper, the contextual model was presented to convey a theoretical basis for these factors.

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REVIEW
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Trauma and Public Mental Health: A Focused Review

Rolf J. Kleber[1,2]*

[1] Utrecht University, Utrecht, Netherlands, [2] Arq Psychotrauma Expert Group, Diemen, Netherlands

Psychological trauma has developed into a very common concept in the scientific community, in mental health care, as well as in popular language and mass media. The purpose of this article is to show the relevance of the discipline of traumatic stress studies to the field of public mental health by examining central concepts and findings concerning trauma and its aftermath and examining implications for public mental health. Attention is paid to the diagnosis of posttraumatic stress disorder (PTSD) and the construct of resilience as well as to specific areas of public mental health activities. A public mental health perspective will help to develop preventive approaches to trauma and extend the impact of various forms of interventions. It will also make clear that trauma care will have to consider the community and the society at large.

Keywords: trauma, posttraumatic stress disorder, resilience, public mental health, war, disasters, violence

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Jutta Lindert,
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Eva-Maria Pichler,
University of Zurich, Switzerland

***Correspondence:**
Rolf J. Kleber
r.kleber@uu.nl

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INTRODUCTION

Psychological trauma has developed into a very popular concept in the scientific community, in the world of mental health care, as well as in common language and mass media. The consequences of various shocking events—violence, disasters, acts of terrorism, accidents, and war—receive frequent and enduring attention. The number of scientific and clinical publications has increased enormously and in many media programs ample attention is paid to victims and others affected by these events. The purpose of this article is to show the relevance of the discipline of traumatic stress studies to the field of public mental health by examining central concepts and findings concerning trauma and its aftermath and examining implications for public mental health.

WHAT IS A TRAUMATIC EVENT?

Traumatic events involve the confrontation with war, violence, disasters, sudden loss, serious illness, and other overwhelming and disturbing events. According to the psychiatric classifications [of the *International Classification of Diseases* of the World Health Organization (ICD-11) and the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5)], a traumatic event is defined as the exposure to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (1, 2).

Phenomenologically such an event can be characterized by an extreme sense of powerlessness as well as a disruption of beliefs and expectations. The individual has lost control over the situation and is to a large extent a victim of the circumstances and/or other people (i.e. the perpetrator). In "Jenseits des Lustprinzips" (1920), Freud already posed: "the essence of a traumatic situation is an experience of helplessness that is brought about either externally or internally." At the same time, he or she is confronted with a shattering of basic assumptions. The self-evidence of one's life is gone. The sense of invulnerability,

the idea of the benevolence of the world, and the idea that other people can be trusted are devastated. The obvious certainties of life have disappeared. The images one holds of oneself and the environment no longer adequately fit the new situation. In the words of Janoff-Bulman (3), basic assumptions have been shattered.

Exposure to traumatic events is not rare, as has been consistently found in epidemiological studies. The World Mental Health Surveys of adults were carried out among nearly 70,000 participants from 24 countries ranging in economic status from low to high (4). These data showed that at some time in their life 70.4% of the respondents had experienced at least one type of a traumatic event. The specific rates were: 14% had experienced intimate partner or sexual violence, 34.3% accidents or injuries, 22.9% physical violence, 13.1% war-related events, 34.1% the unexpected or traumatic death of a loved one, and 35.7% experienced traumas that happened to loved ones (e.g., serious illness of a child). As Kessler et al. (4) stated, these findings make clear that it is rather normal to be exposed to a very upsetting event in one's lifetime.

RISE AND BLOOM OF THE CONCEPT OF POST-TRAUMATIC STRESS DISORDER

The concept of *posttraumatic stress disorder* (PTSD) is nowadays so much used that it dominates most thinking about the consequences of violence, disaster, and being a refugee. That development is quite unique as the attention for trauma was very meager just 40, 50 years ago. In the 1970s, the United States became increasingly confronted with the psychological and social difficulties of the nearly three million veterans who had fought in Vietnam. They suffered from nightmares, depression, relationship problems, et cetera. However, because of the ambivalent perspective on the Vietnam War, authorities and professionals were rather reluctant to acknowledge these difficulties, but the increasing concern led to the introduction of the term post-traumatic stress disorder in the anxiety disorders section of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) (5).

The diagnosis of PTSD is directly linked to experiencing or witnessing a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape, or other violent assault (criterion A). According to DSM-5 (1), PTSD consists of four categories of symptoms. Re-experiencing the traumatic event (criterion B) is manifested in symptoms such as intrusive memories, distressing dreams, flashbacks, or distress or physiological reactions upon exposure to cues of the trauma. The other categories are symptoms of avoidance of the reminders of the trauma (criterion C), alterations in memories or mood associated with the trauma (criterion D), and finally clear alterations in physiological arousal and reactivity [criterion E; see further Ref. (1)].

Recently a relatively different definition of PTSD has been introduced in the new version of the International Classification of Diseases of the World Health Organization (2018). It consists of three categories (reexperiencing, avoidance, hyperarousal) with only two core symptoms in each category. The definition may be more flexible to use (allowing for cultural variation and clinical judgment) but is less detailed and comprehensive. Empirical studies have found that prevalence rates may vary between the two classifications and there is often a lack of overlap (i.e., not the same individuals are classified as PTSD patients by the two classifications). This is a major concern for the field of traumatic stress studies. It is a challenge for future research to unravel the differences and to create order (6), as most research is conducted with the DSM definition while most countries in the world use instead ICD.

Prevalence figures for PTSD vary enormously, according to the nature of the events, various risk factors, the time of measurement, and the instruments used. In general, PTSD occurs more when an aggressor is involved (in the case interpersonal violence), for persistent and extended events (e.g., internment, sexual abuse) and for socially charged events (e.g., rape). Among Dutch veterans who were confronted with war violence during deployment in Iraq, the figures of current prevalence varied between 3 and 4% (7). Nine percent of American Vietnam veterans had current PTSD 20 years after the war (8). Figures on PTSD in studies of disasters (man-made, technological, as well as natural) varied mostly around 5% to 15% (9). The prevalence findings also fluctuated strongly in studies of sexual violence, although the rates are generally higher than after other events: between 3.7% and 65%. The already mentioned World Mental Health Surveys (4, 10) determined that intimate partner or sexual violence (such as rape) was a very frequent cause of PTSD. Nevertheless, the unexpected death of loved ones represented the most frequent cause of event-related psychopathology within the general population because of the high frequency with which people experience such a loss. About this last mentioned finding, it is relevant to remark that there is a close relationship between trauma and loss and consequently between PTSD and complicated grief, but they are not similar (11). The concepts of Persistent Complex Bereavement Disorder (1) and Prolonged Grief Disorder (2) as result of the death of a family member or a close friend are included in DSM-5 and ICD-11, respectively.

In a comprehensive and systematic analysis (12) prevalence rates of PTSD and depression were identified from 181 surveys comprising 81,866 refugees and other conflict-affected persons from 40 countries exposed to humanitarian emergencies. Again, rates of reported PTSD and depression showed large inter-survey variability. The prevalence estimates derived from the methodologically most robust surveys provided rates between 13% and 25% for PTSD, as assessed by Steel et al. (12). The risk of PTSD among refugees was increased by experiencing torture and sexual violence, having a higher age, being a woman, and through a long stay in different asylum seekers centers.

Despite the increased knowledge about PTSD and despite the positive results of therapeutic treatments for PTSD, there are various dilemmas and challenges. First, there is a large comorbidity, as most patients also suffer from depression, substance abuse, or other disorders (6). Furthermore, defining the borderline between normal and abnormal behavior after trauma is difficult. Moreover, although this is matter of heavy debate among researchers and clinicians, PTSD is sometimes an overstretched concept in the sense that normal responses to stressful life events are labelled as disorder. Difficulties of diverse groups—from refugees to veterans—are attributed too much or too easily to traumatic events and their resilience is underestimated (13).

IMPACT ON THE INDIVIDUAL

Regarding a public mental health perspective, it is highly relevant to understand that the majority of people exposed to serious live events does not develop disorders. However, this does not mean that they will not suffer from symptoms and difficulties. Most people will experience responses such as intrusions, nightmares, startle reactions, and numbness (14). Findings from large epidemiological studies of disaster victims have made this clear. In 2000 the Netherlands were confronted with a disastrous explosion of a fireworks container area in the middle of a neighborhood. A comprehensive and longitudinal study was conducted among the inhabitants. In the investigation of post-disaster reactions (15) it was found that most inhabitants suffered from various serious symptoms (especially depression, fears, re-experiences, physical symptoms) in the first 2 to 3 weeks after the explosion. At least 87% of the affected residents were highly affected in those first weeks after the disaster.

These responses can be considered functional and normal, as has been made clear in emotion theories (16). People are afraid that it will happen again. They do not feel safe anymore and are constantly alert for danger. They are angry because of the neglect of the responsible authorities or they feel rage in the direction of the perpetrator. They react easily irritated at remarks of other people. They blame themselves for being there at the moment of the disaster or having not done anything to prevent the situation. They feel despaired because of the death of loved ones and the loss of material goods. They have the impression that other people do not understand their distress and sorrow and feel estranged from others. Nevertheless, the intensity and frequency of these distressing and painful responses do not reach the level of disorder.

Although DSM-5 recognizes the possibility of the occurrence of Acute Stress Disorder (ASS) in the first days after an event, a diagnosis that overlaps with PTSD, this diagnosis is rarely used in clinical practice as well as research. Patients with ASS usually report numbness, problems with memory, sleep and concentration, irritability, fears, or anxiety and have frequent re-experiences of the event. The usefulness of acute stress disorder as a classification is controversial in the literature (17). The difference with normal reactions to a major life event and with PTSS, apart from the time criterion (ASS can only be used for disturbances in the first 4 weeks after the experience), is not yet confirmed adequately.

As mentioned above, the world does not make sense any more after such a traumatic experience. Already in the 1940s the psychiatrist and concentration camp survivor Victor Frankl stated that the search for meaning played a crucial role in adaptation to threatening events (18). Cognitive approaches to trauma (e.g., 19) state that successful processing of the traumatic experience takes place when new information (e.g., the implication of the traumatic experience) is assimilated into existing structures or models. Unsuccessful processing occurs when the trauma-related information is not integrated into existing beliefs concerning self-image and world views (20). In low control situations not amenable to direct repair or problem-solving, such as trauma, loss, and serious illness, meaning-making is often the most adaptive strategy. As Schok et al. (20) have argued, meaning can be created by answering the question why an event occurred and why it happened to the person. It can also be operationalized as considering the ways in which one's life changed because of the event and assessing the extent to which one has "made sense of" the experience. Research findings have indicated that these two processes of finding a cause for the extreme event and finding personal benefits in the traumatic experience play independent roles in adjustment after trauma (21, 22). Therefore, the attempt to find meaning discloses itself twofold: in searching for an answer to the question why it happened as well as in rethinking one's attitudes and priorities to restructure one's life along more satisfying lines (23).

IMPACT ON THE COMMUNITY

Violence, disasters, accidents, and war are also stressful events for the community. Consequently, the impact of traumatic events goes beyond those who are directly exposed to the event and affects close relationships, the social environment, and the society at large. A human being does not live in a vacuum. He or she is surrounded by others. And those others will be confronted with the traumatic event and its aftermath too. This holds true for an event that struck an individual, such as a rape. Others hear about the event, perceive the suffering of the victims, and must cope with the implications. Naturally, it holds also true for events that struck a large group of people. For instance, a disaster undermines the social fabric of a community. It can lead to dissolution of social networks and to forced or voluntary migration. Regarding the health care system, it can lead to a disruption of the provision of social services and an erosion of the health care infrastructure (24, 25).

On the other hand, the social environment can stimulate recovery after trauma. The perception of social support has been found to be an influential factor for the effects of traumatic events on the individual as well as the community. For instance, studies undertaken after disasters have shown that social support had a significant stress-buffering effect for post-traumatic problems. Furthermore, a comprehensive meta-analysis (26) has shown that lack of social support systems and lack of sharing of emotions are significant risk factors for mental health disturbances.

THE OTHER SIDE OF TRAUMA: RESILIENCE

The finding that most people confronted with extreme life events did not develop disturbances like PTSD created interest in the phenomenon of *resilience*. This concept has been widely used in recent years in the scientific and clinical world. Resilience refers to a dynamic process involving positive adaptation to one's circumstances in the face of significant adversity, as defined by Luthar and Cicchetti (27). However, there are various understandings of resilience [see Ref. (28)]. Resilience may be treated as a quality, a personal trait, a process, and an outcome. While, for example, some researchers conceive of resilience

as a multiply determined developmental process that is not fixed, others use measures of trait resilience, which favors the assumption that resilience is a personality attribute [see for the different views Ref. (29)].

Investigation of resilience can lead to useful avenues for intervention. The concept offers a different perspective on risk and protection. Focusing on what makes individuals strong rather that what makes them weak may aid to understand what helps them to maintain their mental health. Sleijpen and colleagues examined strategies of young refugees in dealing with negative experiences (28). Their findings revealed that young refugees living in the Netherlands were affected by memories of traumatic events experienced in their country of origin or during the flight, but that current stressors, especially for young people without a residence permit, played a more significant role in determining their psychological well-being. The participants in this study used the following four strategies to deal with traumatic experiences and current stressors: (1) acting autonomously, (2) performing at school, (3) perceiving support from peers and parents, and (4) participating in the new society. These strategies helped the young refugees to strengthen their sense of power and control, they gave them some distraction, and they supported or sustained their spirit within the family unit and the new society [see Ref. (28)].

PROLONGED AFTERMATH

For public mental health initiatives, it is important to realize on the one hand the significance of the resilience of people affected, but at the other hand also the fact that disturbances can last for a very long period. Difficulties do not always disappear in time. Sometimes they may last for a very long time. 10 years after the Enschede Fireworks disaster still 6.7% of a representative sample of the inhabitants of the neighborhood had an indication of chronic disaster-related PTSD (30). 40 years after the Vietnam War (31), prevalence rates of PTSD were 4.5% (male USA veterans) and 6.1% (female veterans). In the World Mental Health Surveys (4), it was also found that PTSD symptoms typically were quite persistent.

The long-term aftermath of trauma can be illustrated with the following research finding. A large community-based sample of child survivors from World War II was compared with a reference group from the Dutch population as well as with clinical groups (32). These children survived internment in the Japanese camps in the former colony of the Dutch East Indies (now Indonesia) during the period 1942–1945 (and afterwards). Most of them were forced to migrate to the Netherlands in the 1940s and 1950s. Long-term sequelae of the persecution were studied by standardized questionnaires on posttraumatic responses, general health, and dissociation. Compared with control individuals of the same age that lived through the German occupation in the Netherlands during World War II, the child survivors from the former Dutch Indies reported significantly more traumatic experiences and mental health disturbances approximately 50 years after the war. 23 percent of these now adult child survivors in the community sample had an indication of PTSD related to the events in World War II [see Ref. (32)].

These results underline the long-term aftermath of traumatic experiences. This conclusion is also relevant for the many war refugees who migrated to Europe in recent years. In the field of psychotraumatology, there has been a continuing debate about the extent to which diagnostic criteria for PTSD adequately cover the posttraumatic symptomatology experienced by individuals exposed to prolonged, repeated, and interpersonal traumatic events, such as occurring in situations of domestic violence, war, and torture (33). This symptomatology is more complex, more severe, and more invasive than that captured by the classic PTSD diagnosis. This manifestation of psychopathology is referred to as *complex PTSD* (CPTSD). In the 11th version of the ICD (2), this concept is added as a formal diagnosis comorbid to PTSD. It consists of impairments in three domains: difficulties in emotion regulation, negative beliefs about oneself, and difficulties in sustaining relationships. The concept is attractive as it focuses on personal changes due to the confrontation with enduring violence and oppression, but it is as such also rather (too) close to personality disorders while it is not clear whether the addition of this new diagnostic concept is really required beyond PTSD. Research is also still indecisive about these matters. Because of these reasons, a concept such as complex PTSD was not included in DSM-5.

PUBLIC HEALTH STRATEGIES

Public health strategies are aimed at preventing or diminishing mental health problems and addressing the causes of these conditions (see also 10). These strategies are active on multiple levels: individual, family, community, and society. Unfortunately, public health care of trauma is a rather underdeveloped area (see Magruder et al., 2107), especially in contrast to the field of treatment of trauma-related disorders, in particular PTSD. Psychotherapies of PTSD have been found successful, as has been shown by many RCT's (randomized controlled trials) and meta-analyses, in comparison with control groups and placebo treatments [e.g., Ref. (34)]. Most evidence has been found for trauma-focused cognitive behavioral therapy and Eye Movement Desensitization and Reprocessing (EMDR), and to a somewhat lesser extent Narrative Exposure Therapy and Brief Eclectic Psychotherapy for PTSD [e.g., Ref. (35)]. However, here we focus only on public health strategies relevant to trauma care. They are all explicitly aimed at preventing the emergence of health problems or preventing the aggravation of these difficulties.

Preventing adversity. First, although it is a truism, one should bear in mind that stopping or avoiding exposure to events that can be experienced as traumatic is a sensible public health strategy. If disasters, accidents, or wars can be prevented by concrete measures, the chance on traumatic experiences and on their negative consequences is, by definition, taken away.

Creating awareness and recognition. Secondly, creating awareness and acknowledgment concerning the impact of trauma on the population is a strategy by which difficulties can be prevented. Psycho-education with the help of brochures is an obvious example of this. Similarly, so-called silent journeys by a community after a violent crime in their neighborhood

and creating monuments ("lieux de memoire") are just as exemplary regarding recognition and appreciation for the people affected by trauma.

The increase of awareness through public health campaigns has been suggested for combatting child sexual abuse (36). Public health campaigns serve to help the identification of affected children and to facilitate the recognition of their difficulties by adults. Such services imply the awareness of the impact of traumatic experiences in diverse domains (individual, societal), the recognition of signs and symptoms, the integration of knowledge about trauma in public health programs, and the prevention of re-traumatization for their users. In this respect, technology-based interventions (e.g., online platforms, social media, mobile applications) can be advantageous. Such campaigns of awareness and recognition should be accompanied by mental health services with adequate interventions for abused persons looking for care. Nevertheless, despite their positive aims and effects, at the same time, all these campaigns may have a downside: they can lead to complications, such as the risks of promoting an unnecessary victim status and medicalizing complaints of the affected persons, resulting in a reduction of the potential for spontaneous recovery (36, 37).

Strengthening resilience. The third group of strategies is focused on bolstering resilience and stimulating self-efficacy. For example, training programs have been developed in the armies of the USA and several European countries to allow military soldiers to deal with the stress of war and to be more resistant to the intense and overwhelming events they will be confronted with.

Counseling. Fourth, counseling people confronted with traumatic events is a well-known intervention in the field of trauma care. Various forms of secondary preventive interventions providing practical care, support, and information have been designed for employees of organizations confronted with extreme events in the work setting, such as the police and banks, but also for victims of large-scale acts of terrorism. These interventions consist of a couple of protocolled sessions in the first 2 or 3 months after a calamity [see for an overview Ref. (38)]. They are considered as quite helpful, although controlled research is mostly lacking. This intervention should not be confused with so-called psychological debriefing, a typically single session of group counseling directly after a disaster or an act of violence. If this form of support is focused too much on the ventilation of emotions, debriefing has been found to have a negative impact: posttraumatic reactions and depressive feelings are worsened and very early exposure to the trauma material may interfere with natural recovery processes (9, 38).

Reconciliation. A related form of post-trauma care are large-scale programs to reconcile people after large-scale conflicts. For instance, a civil war divides families, communities, and nations, often pitting one neighbor against another. Distrust, resentment, and anger dominate post-war society, just as much as passivity and emotional numbness. That is why programs are designed to reconcile people (perpetrators and victims) and to restore trust, connectedness, and social cohesion.

Such truth and reconciliation efforts were conducted in Sierra Leone (39). Community-level forums in 200 villages were set up in which victims detailed war atrocities and perpetrators confessed to war crimes. Research using a randomized control trial among more than 2,000 individuals showed that reconciliation led to greater forgiveness of perpetrators and strengthened social capital: social networks were larger, and people contributed more to public goods in treated villages. However, there were also negative psychological costs next to the positive societal benefits. The reconciliation intervention also worsened psychological health, increasing depression, anxiety, and PTSD in the same villages. For a subset of villages, outcomes were measured 9 months and 31 months after the intervention. Results showed that both positive and negative effects persisted into the longer time horizon. These findings suggest that policy-makers should be careful with reconciliation processes and must find ways to restrict the emphasis on emotions.

Policy making. Finally, there is the overarching field of policy making, a rather underdeveloped topic in trauma care. As Magruder et al. (40) stated, public policies should be formulated to prevent traumatic events, to understand risk and protective factors, to provide early intervention services for individuals and communities at risk of post-trauma maladjustment, and to shape societal norms to eliminate stigma. Extra priorities for improving mental health include a focus on adequately training researchers and professionals, supporting international collaborations, and encouraging scientists to share their expertise with policymakers. Furthermore, integration of physical and mental health care is especially important, as trauma-exposed individuals often seek help in primary care rather than mental health settings. Consequently, posttraumatic disturbances may go undiagnosed.

FINALLY

A public mental health perspective will help to develop preventive approaches to trauma and extend the impact of various forms of interventions. It will also make clear that trauma care will have to consider the community and the society at large. The concept of trauma is an attractive concept. It refers to both spectacular and shocking events that receive huge attention, such as acts of terrorism and large-scale calamities. Something dramatic happens that could happen to anyone: the cause appears to be clear and the responsibility appears to lay elsewhere. One could argue that traumatic experiences show us the limits of our abilities to master our lives and that they defy our efforts to control the circumstances. However, the concept of trauma is also a dangerous concept. It is often used too easy and too quick. Not every stressful event is a traumatic experience and not every person confronted with war, disaster, or terror is traumatized. Overstretching the concept may create the risk of medicalization of regular difficulties of the afflicted people and ignoring the self-reliance and the adaptive skills of them.

AUTHOR CONTRIBUTIONS

I am the sole author. I designed and wrote the manuscript.

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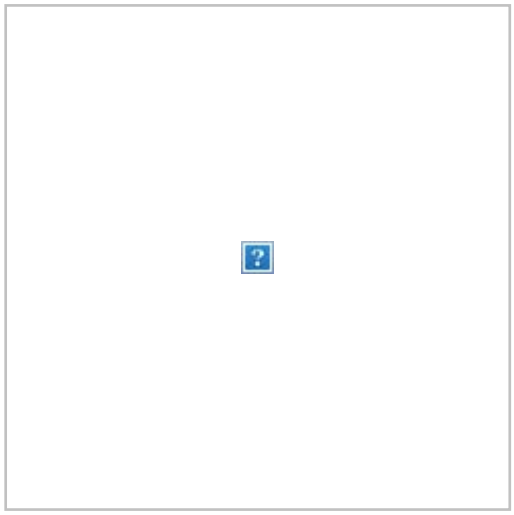
Home

GET HELP NOW

TRAUMA TYPES

When a child feels intensely threatened by an event he or she is involved in or witnesses, we call that event a trauma. There is a range of traumatic events or trauma types to which children and adolescents can be exposed.

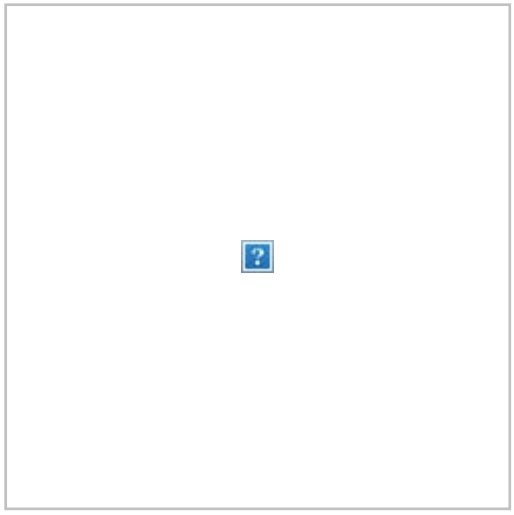
Bullying



Bullying is a deliberate and unsolicited action that occurs with the intent of inflicting social, emotional, physical, and/or psychological harm to someone who often is perceived as being less powerful.

view

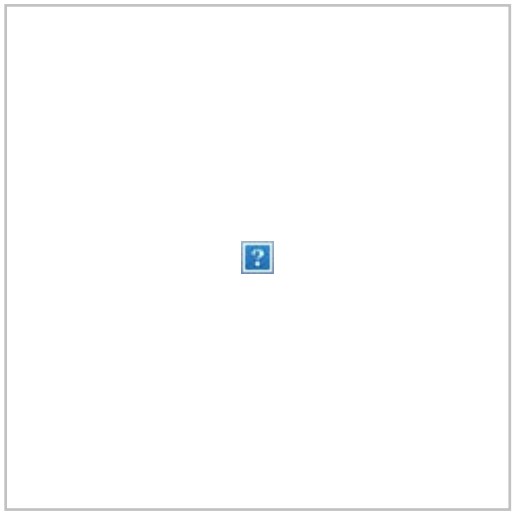
Community Violence



Community violence is exposure to intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim.

view

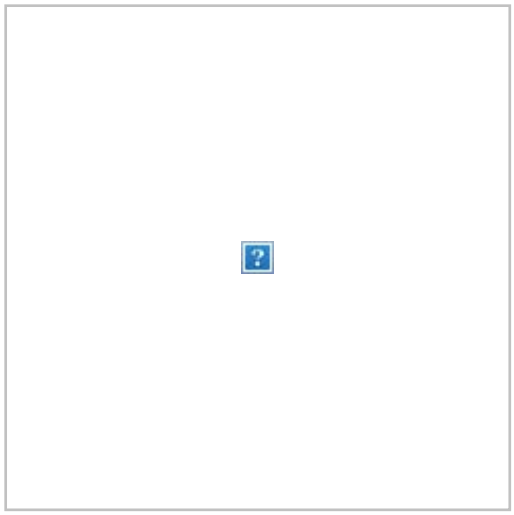
Complex Trauma



Complex trauma describes both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure.

view

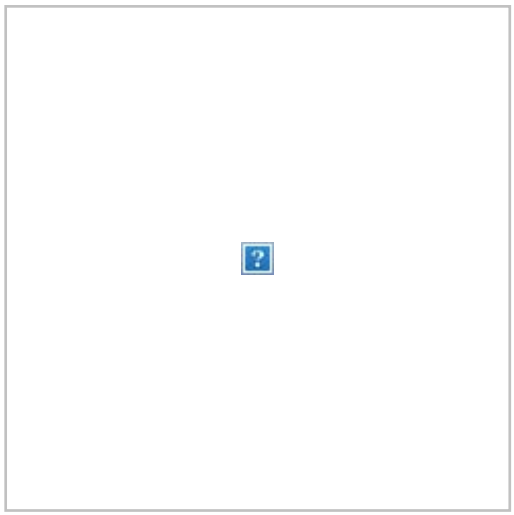
Disasters



Natural disasters include hurricanes, earthquakes, tornadoes, wildfires, tsunamis, and floods, as well as extreme weather events such as blizzards, droughts, extreme heat, and wind storms.

view

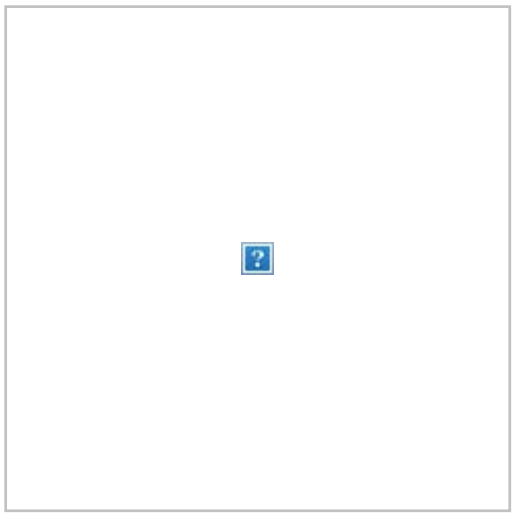
Early Childhood Trauma



Early childhood trauma generally refers to the traumatic experiences that occur to children aged 0-6.

view

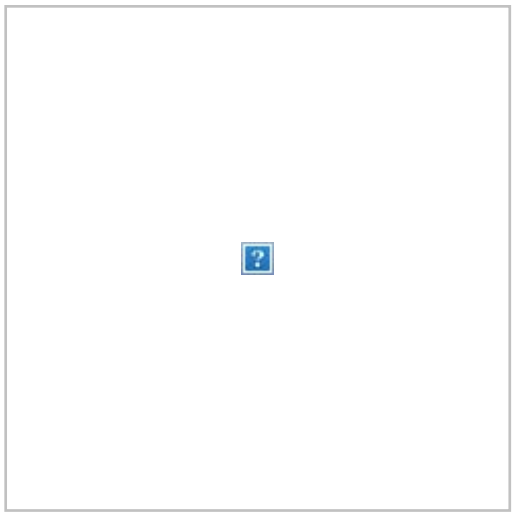
Intimate Partner Violence



Intimate Partner Violence (IPV), also referred to as domestic violence, occurs when an individual purposely causes harm or threatens the risk of harm to any past or current partner or spouse.

view

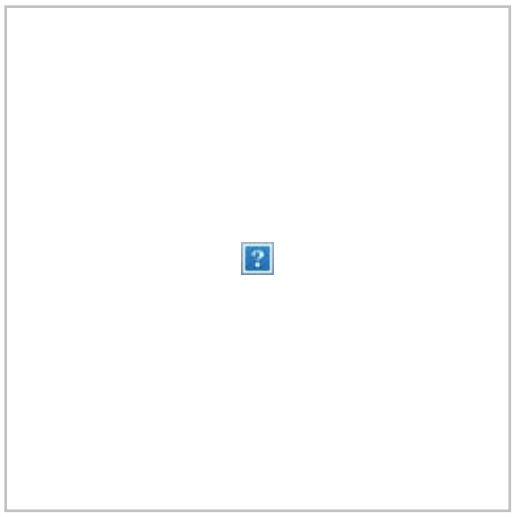
Medical Trauma



Pediatric medical traumatic stress refers to a set of psychological and physiological responses of children and their families to single or multiple medical events.

view

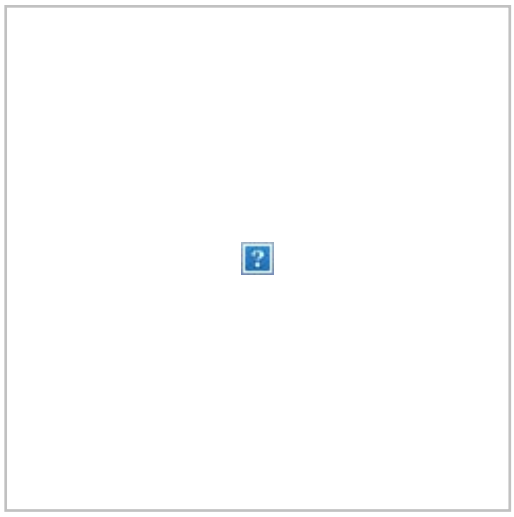
Physical Abuse



Physical abuse occurs when a parent or caregiver commits an act that results in physical injury to a child or adolescent.

view

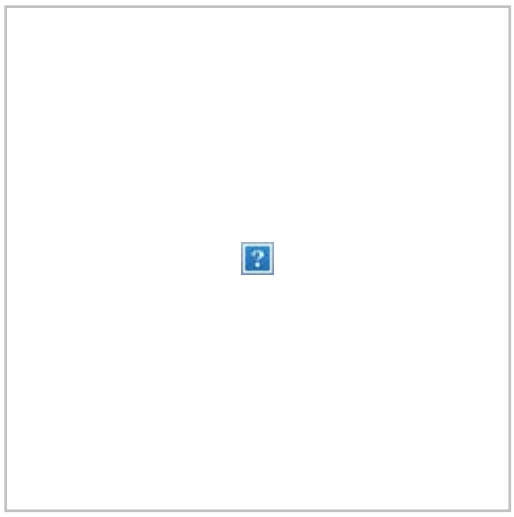
Refugee Trauma



Many refugees, especially children, have experienced trauma related to war or persecution that may affect their mental and physical health long after the events have occurred.

view

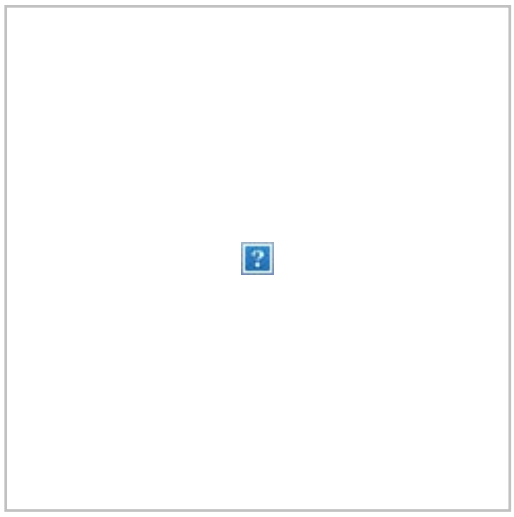
Sexual Abuse



Child sexual abuse is any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer.

view

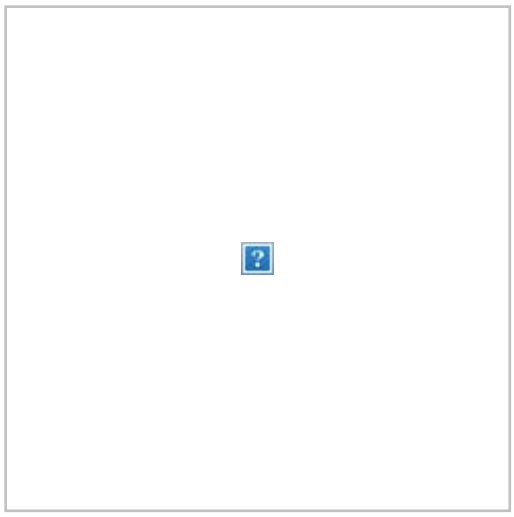
Terrorism and Violence



Families and children may be profoundly affected by mass violence, acts of terrorism, or community trauma in the form of shootings, bombings, or other types of attacks.

view

Traumatic Grief



While many children adjust well after a death, other children have ongoing difficulties that interfere with everyday life and make it difficult to recall positive memories of their loved ones.

view

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Traumatic stress: effects on the brain

J. Douglas Bremner, MD

Brain areas implicated in the stress response include the amygdala, hippocampus, and prefrontal cortex. Traumatic stress can be associated with lasting changes in these brain areas. Traumatic stress is associated with increased cortisol and norepinephrine responses to subsequent stressors. Antidepressants have effects on the hippocampus that counteract the effects of stress. Findings from animal studies have been extended to patients with post-traumatic stress disorder (PTSD) showing smaller hippocampal and anterior cingulate volumes, increased amygdala function, and decreased medial prefrontal/anterior cingulate function. In addition, patients with PTSD show increased cortisol and norepinephrine responses to stress. Treatments that are efficacious for PTSD show a promotion of neurogenesis in animal studies, as well as promotion of memory and increased hippocampal volume in PTSD.

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Keywords: *positron emission tomography; depression; stress; post-traumatic stress disorder*

Author affiliations: Departments of Psychiatry and Behavioral Sciences and Radiology, and the Emory Center for Positron Emission Tomography, Emory University School of Medicine, Atlanta, Ga, and the Atlanta VAMC, Decatur, Ga, USA

Address for correspondence: J Douglas Bremner, MD, Emory University, 1256 Briarcliff Rd, Room 308e, Atlanta, GA 30306, USA
(e-mail: jdbremn@emory.edu)

Effects of traumatic stress

Traumatic stressors such as early trauma can lead to post-traumatic stress disorder (PTSD), which affects about 8% of Americans at some time in their lives,[1] as well as depression,[2,3] substance abuse,[1,4] dissociation,[5] personality disorders,[6,7] and health problems.[8] For many trauma victims, PTSD can be a lifelong problem.[9] The President's New Freedom Commission Report highlights the importance of providing services for mental disorders related to early trauma.[10-12] However, the development of effective treatments is limited by gaps in knowledge about the underlying neurobiological mechanisms that mediate symptoms of trauma-related disorders like PTSD. This paper reviews preclinical and clinical studies on the effects of traumatic stress on the brain.

Normal development of the brain across the lifespan

To understand how traumatic stress occurring at different stages of the life cycle interacts with the developing brain, it is useful to review normal brain development. The normal human brain undergoes changes in structure and function across the lifespan from early childhood to late life. Understanding these normal developmental changes is critical for determining the difference between normal development and pathology, and how normal development and pathology interact.

Although the bulk of brain development occurs in utero, the brain continues to develop after birth. In the first 5 years of life there is an overall expansion of brain volume related to development of both gray matter and white

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Selected abbreviations and acronyms

ACTH	*adrenocorticotropic hormone*
BDNF	*brain-derived neurotropic factor*
BPD	*bipolar disorder*
CRF	*corticotropin-releasing factor*
CS	*conditioned stimulus*
FDG	*fluorodeoxyglucose*
HPA	*hypothalamic-pituitary-adrenal*
MRI	*magnetic resonance imaging*
mRNA	*messenger ribonucleic acid*
NAA	N-*acetyl aspartate*
PET	*positron emission tomography*
PTSD	*post-traumatic stress disorder*
US	*unconditioned stimulus*

matter structures; however, from 7 to 17 years of age there is a progressive increase in white matter (felt to be related to ongoing myelination) and decrease in gray matter (felt to be related to neuronal pruning) while overall brain size stays the same.[13-16] Gray matter areas that undergo the greatest increases throughout this latter developmental epoch include frontal cortex and parietal cortex.[17,18] Basal ganglia decrease in size, while corpus callosum,[19,20] hippocampus, and amygdala[21-23] appear to increase in size during childhood, although there may be developmental sex-laterality effects for some of these structures.[24] Overall brain size is 10% larger in boys than girls during childhood.[24]

During the middle part of life (from age 20 to 70) there is a gradual decrease in caudate,[25] diencephalon,[25] and gray matter,[25,26] which is most pronounced in the temporal[27] and frontal cortex,[26] with enlargement of the ventricles[26,27] and no change in white matter.[25,26] Studies have not been able to document changes in hippocampal volume in normal populations during this period.[27] After menopause in women at about the age of 50, however, there are changes in reproductive hormones, such as decreased levels of estrogen. Since estrogen promotes neuronal branching in brain areas such as the hippocampus,[28] a loss of estrogen may lead to changes in neuronal structure. Although the effects of menopause on the brain have not been well studied, it is known that sex hormones also affect brain function and circuitry[29]; therefore, the changes in sex hormones with menopause will presumably affect brain function, as well as possibly structure. There is some evidence in super-elderly individuals (age >70) for modest reductions in hippocampal volume with late stages of aging.[27,30] More robust findings have included increased ventricular volume and reduction in gray matter, temporal lobe, and cerebellum volumes with normal aging, that begins before the age of 70.[25,27,31-33]

Therefore, trauma at different stages in life will presumably have different effects on brain development. The few studies that have looked at this issue do suggest that there are differences in the effects of trauma on neurobiology, depending on the stage of development at which the trauma occurs. Studies in this area, however, have been limited.

Neurobiology of PTSD

PTSD is characterized by specific symptoms, including intrusive thoughts, hyperarousal, flashbacks, nightmares, and sleep disturbances, changes in memory and concentration, and startle responses. Symptoms of PTSD are hypothesized to represent the behavioral manifestation of stress-induced changes in brain structure and function. Stress results in acute and chronic changes in neurochemical systems and specific brain regions, which result in long-term changes in brain "circuits," involved in the stress response.[34-37] Brain regions that are felt to play an important role in PTSD include hippocampus, amygdala, and medial prefrontal cortex. Cortisol and norepinephrine are two neurochemical systems that are critical in the stress response *(Figure 1)*.

The corticotropin-releasing factor (CRF)/hypothalamic-pituitary-adrenal (HPA) axis system plays an important role in the stress response. CRF is released from the hypothalamus, with stimulation of adrenocorticotropic hormone (ACTH) release from the pituitary, resulting in glucocorticoid (cortisol in man) release from the adrenal, which in turn has a negative feedback effect on the axis at the level of the pituitary, as well as central brain sites including hypothalamus and hippocampus. Cortisol has a number of effects which facilitate survival. In addition to its role in triggering the HPA axis, CRF acts centrally to mediate fear-related behaviors,[38] and triggers other neurochemical responses to stress, such as the noradrenergic system via the brain stem locus coeruleus.[39] Noradrenergic neurons release transmitter throughout the brain; this is associated with an increase in alerting and vigilance behaviors, critical for coping with acute threat.[40-42]

Studies in animals showed that early stress has lasting effects on the HPA axis and norepinephrine. A variety of early stressors resulted in increased glucocorticoid

response to subsequent stressors.[43-45] Maternally deprived rats had decreased numbers of glucocorticoid receptors in the hippocampus, hypothalamus, and frontal cortex.[46] Stressed animals demonstrated an inability to terminate the glucocorticoid response to stress,[47,48] as well as deficits in fast-feedback of glucocorticoids on the HPA axis, which could be related to decreased glucocorticoid receptor binding in the hippocampus.[49] Early postnatal adverse experiences increase hypothalamic CRF messenger ribonucleic acid (mRNA), median eminence CRF content, and stress-induced glucocorticoid[50] and ACTH release.[46] These effects could be mediated by an increase in synthesis of CRH mRNA following stress.[51] In nonhuman primates, adverse early experiences resulted in long-term effects on behaviors, as well as elevated levels of CRF in the cerebrospinal fluid.[52] Exposure to chronic stress results in potentiation of noradrenergic responsiveness to subsequent stressors and increased release of norepinephrine in the hippocampus and other brain regions.[42]

Preclinical and clinical studies have shown alterations in memory function following traumatic stress,[53] as well as changes in a circuit of brain areas, including hippocampus, amygdala, and medial prefrontal cortex, that mediate alterations in memory.[54] The hippocampus, a brain area involved in verbal declarative memory, is very sensitive to the effects of stress. Stress in animals is associated with damage to neurons in the CA3 region of the hippocampus (which may be mediated by hypercortisolemia, decreased brain-derived neurotrophic factor (BDNF), and/or elevated glutamate levels) and inhibition of neurogenesis.[55-60] High levels of glucocorticoids seen with stress were also associated with deficits in new learning.[61,62]

Antidepressant treatments have been shown to block the effects of stress and/or promote neurogenesis.[58,63-66] Animal studies have demonstrated several agents with

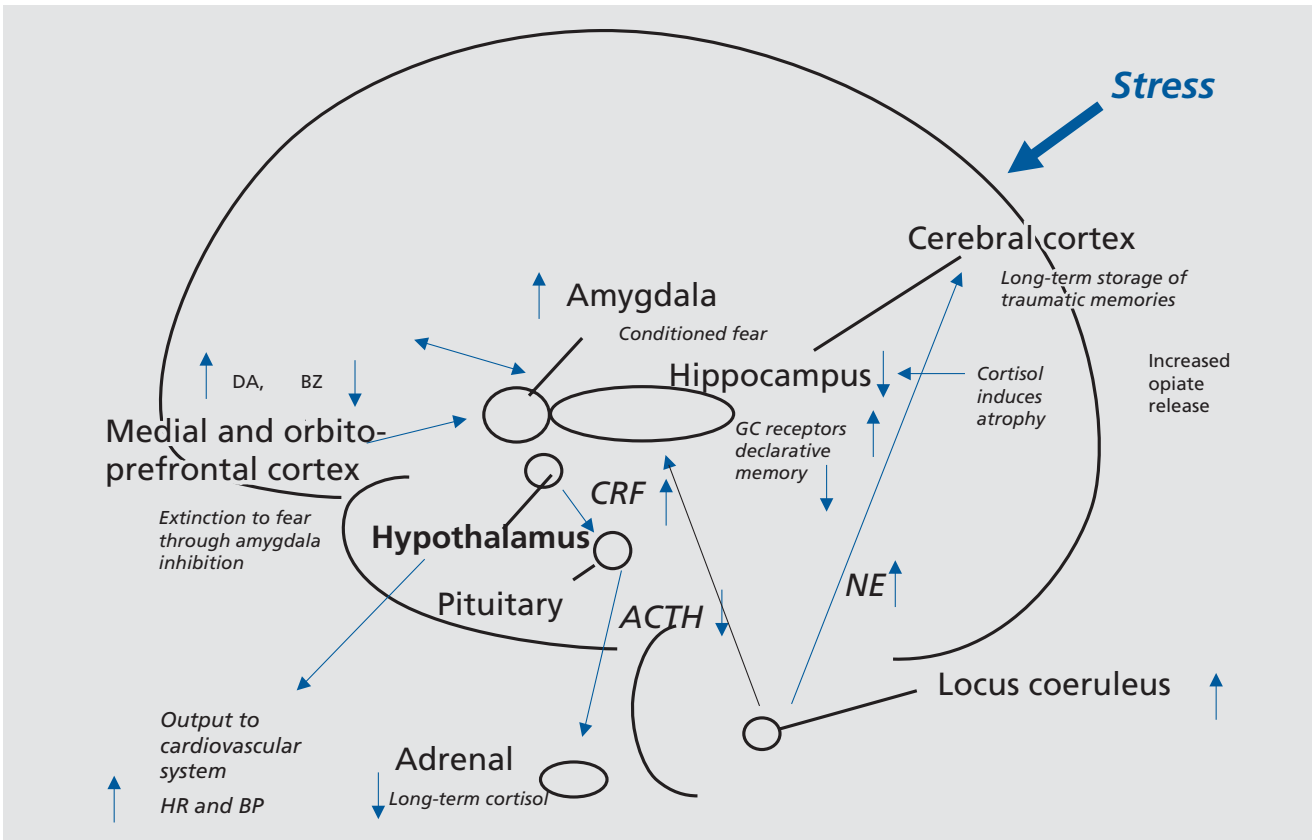

Figure 1. Lasting effects of trauma on the brain, showing long-term dysregulation of norepinephrine and cortisol systems, and vulnerable areas of hippocampus, amygdala, and medial prefrontal cortex that are affected by trauma. GC, glucocorticoid; CRF, corticotropin-releasing factor; ACTH, adrenocorticotropin hormone; NE, norepinephrine; HR, heart rate; BP, blood pressure; DA, dopamine; BZ, benzodiazapine; GC, glucocorticoid

potentially beneficial effects on stress-induced hippocampal damage. It has been found that phenytoin blocks the effects of stress on the hippocampus, probably through modulation of excitatory amino acid-induced neurotoxicity.[67] Other agents, including tianeptine, dihydroepiandosterone (DHEA), and fluoxetine have similar effects.[63,64,66,68-73] These medications may share a common mechanism of action through upregulation of cyclic adenosine monophosphate (cAMP) response element binding protein (CREB) that may lead to regulation of expression of specific target genes involved in structural modeling of the hippocampus. Such treatment effects on BDNF and trkB messenger ribonucleic acid (mRNA), can have long-term effects on brain structure and function. There is new evidence that neurogenesis is necessary for the behavioral effects of antidepressants,[74,75] although this continues to be a source of debate.[72,76]

The hippocampus demonstrates an unusual capacity for neuronal plasticity and regeneration. In addition to findings noted above related to the negative effects of stress on neurogenesis, it has recently been demonstrated that changes in the environment, eg, social enrichment or learning, can modulate neurogenesis in the dentate gyrus of the hippocampus, and slow the normal age-related decline in neurogenesis.[77,78] Rat pups that are handled frequently within the first few weeks of life (picking them up and then returning them to their mother) had increased type II glucocorticoid receptor binding which persisted throughout life, with increased feedback sensitivity to glucocorticoids, and reduced glucocorticoid-mediated hippocampal damage in later life.[79] These effects appear to be due to a type of "stress inoculation" from the mothers' repeated licking of the handled pups.[80] Considered together, these findings suggest that early in the postnatal period there is a naturally occurring brain plasticity in key neural systems that may "program" an organism's biological response to stressful stimuli. These findings may have implications for victims of childhood abuse.

Long-term dysregulation of the HPA axis is associated with PTSD, with low levels of cortisol found in chronic PTSD in many studies[81-86] and elevations in CRF.[82,87] Not all studies, however, have found lower cortisol levels in PTSD.[88-91] Exposure to a traumatic reminder appears to be associated with a potentiated release of cortisol in PTSD.[92]

The few studies of the effects of early stress on neurobiology conducted in clinical populations of traumatized children have generally been consistent with findings from animal studies. Research in traumatized children has been complicated by issues related to psychiatric diagnosis and assessment of trauma.[93] Some studies have not specifically examined psychiatric diagnosis, while others have focused on children with trauma and depression, and others on children with trauma and PTSD. Sexually abused girls (in which effects of specific psychiatric diagnosis were not examined) had normal baseline cortisol and blunted ACTH response to CRF,[94] while women with childhood abuse-related PTSD had hypercortisolemia.[95] Another study of traumatized children in which the diagnosis of PTSD was established showed increased levels of cortisol measured in 24-hour urines.[96] Emotionally neglected children from a Romanian orphanage had elevated cortisol levels over a diurnal period compared with controls.[97] Maltreated school-aged children with clinical-level internalizing problems had elevated cortisol compared with controls.[98] Depressed preschool children showed increased cortisol response to separation stress.[99] Adult women with a history of childhood abuse showed increased suppression of cortisol with low-dose (0.5 mg) dexamethasone.[100] Women with PTSD related to early childhood sexual abuse showed decreased baseline cortisol based on 24-hour diurnal assessments of plasma, and exaggerated cortisol response to stressors (traumatic stressors[101] more than neutral cognitive stressors).[102] We also found that patients with PTSD had less of an inhibition of memory function with synthetic cortisol (dexamethasone) than normal subjects.[103] Adult women with depression and a history of early childhood abuse had an increased cortisol response to a stressful cognitive challenge relative to controls,[104] and a blunted ACTH response to CRF challenge.[105] These findings show long-term changes in stress responsive systems. Early in development, stress is associated with increased cortisol and norepinephrine responsiveness, whereas with adulthood, resting cortisol may be normal or low, but there continues to be increased cortisol and norepinephrine responsiveness to stressors. In addition, early stress is associated with alterations in hippocampal morphology which may not manifest until adulthood, as well as increased amygdala function and decreased medial prefrontal function.

Cognitive function and brain structure in PTSD

Studies in PTSD are consistent with changes in cognition and brain structure. Multiple studies have demonstrated verbal declarative memory deficits in PTSD.[53,106-108]

Patients with PTSD secondary to combat[109-113] and childhood abuse[114,115] were found to have deficits in verbal declarative memory function based on neuropsychological testing. Studies, using a variety of measures (including the Wechsler Memory Scale, the visual and verbal components of the Selective Reminding Test, the Auditory Verbal Learning Test, Paired Associate Recall, the California Verbal New Learning Test, and the Rivermead Behavioral Memory Test), found specific deficits in verbal declarative memory function, with a relative sparing of visual memory and IQ.[109-113,115-124] These studies have been conducted in both patients with PTSD related to Vietnam combat,[109-113,116,119-121,123] rape,[117] the Holocaust,[124-126] adults with early childhood abuse,[115] and traumatized children.[118] One study in adult rape survivors showed that verbal declarative memory deficits are specifically associated with PTSD, and are not a nonspecific effect of trauma exposure.[117] Another study of women with early childhood sexual abuse in which some, but not all, of the patients had PTSD, showed no difference between abused and nonabused women,[127] while another study was not able to show a difference between Vietnam veterans with and without PTSD.[128] Other types of memory disturbances studied in PTSD include gaps in memory for everyday events (dissociative amnesia),[129] deficits in autobiographical memory,[130] an attentional bias for trauma-related material,[131-140] and frontal lobe-related impairments.[141] These studies suggest that traumas such as early abuse with associated PTSD result in deficits in verbal declarative memory. It is not clear if cognitive deficits in early abuse survivors are specific to PTSD and are not related to the nonspecific effects of abuse.

These effects were specific to verbal (not visual) memory, and were significant after controlling for IQ. Some of these studies used neuropsychological tests of declarative memory, such as the Wechsler Memory Scale (WMS) and Selective Reminding Test (SRT), that have been validated as sensitive to loss of neurons in the CA3 region of the hippocampus in epileptics who underwent hippocampal resection.[142,143] Vietnam veterans with PTSD were originally shown by us to have 8% smaller right hippocampal volume based on magnetic resonance imaging (MRI) relative to controls matched for a variety of factors such as alcohol abuse and education ($P<0.05$); smaller volume was correlated with deficits in verbal declarative memory function as measured with the Wechsler Memory Scale.[144] A second study from our group showed a 12% reduction in left hippocampal volume in 17 patients with childhood abuse-related PTSD compared with 17 case-matched controls, that was significant after controlling for confounding factors.[145] Smaller hippocampal volume was shown to be specific to PTSD within the anxiety disorders, and was not seen in panic disorder.[146] Gurvits et al[147] showed bilateral hippocampal volume reductions in combat-related PTSD compared with combat veterans without PTSD and normal controls. Combat severity was correlated with volume reduction. Stein et al[148] found a 5% reduction in left hippocampal volume. Other studies in PTSD have found smaller hippocampal volume and/or reductions in *N*-acetyl aspartate (NAA), a marker of neuronal integrity.[149-153] Studies in childhood[154-156] and new-onset[157,158] PTSD did not find hippocampal volume reduction, although reduced NAA (indicating loss of neuronal integrity) was found in medial prefrontal cortex in childhood PTSD.[159] In a recent meta-analysis we pooled data from all of the published studies and found smaller hippocampal volume for both the left and the right sides, equally in adult men and women with chronic PTSD, and no change in children.[160] More recent studies of holocaust survivors with PTSD did not find a reduction in hippocampal volume, although PTSD patients who developed PTSD in response to an initial trauma had smaller hippocampal volume compared with those who developed PTSD after repeated trauma, suggesting a possible vulnerability of smaller hippocampal volume.[161] Two independent studies have shown that PTSD patients have deficits in hippocampal activation while performing a verbal declarative memory task,[149,162] although it is unclear if this is a deficit in activation or higher hippocampal blood flow at baseline. Both hippocampal atrophy and hippocampal-based memory deficits reversed with treatment with the selective serotonin reuptake inhibitor (SSRI) paroxetine, which has been shown to promote neurogenesis (the growth of neurons) in the hippocampus in preclinical studies.[163] In addition, treatment with the anticonvulsant phenytoin led to an improvement in PTSD symptoms[164] and an increase in right hippocampal and right cerebral volume.[165] We hypothesize that stress-induced hippocampal dysfunction may mediate many of the symptoms of PTSD which are related to memory dysregulation, including both explicit memory deficits as well as fragmentation of memory in abuse survivors. It is unclear at the current time whether these changes are specific to PTSD, whether certain common environmental events (eg, stress) in different disorders lead to similar brain changes, or whether common genetic traits lead to similar outcomes.

The meaning of findings related to deficits in memory and the hippocampus in PTSD, and questions related to the relative contribution of genetic and environmental factors, has become an important topic in the field of PTSD and stress research. There are three possible models, taking into account genetic or environmental factors, which have been proposed to explain smaller hippocampal volume in PTSD: Model A (Environment), Model B (Environment and Genetic), and Model C (Genetic).[166-169] In Model C (Genetic), smaller hippocampal volume represents a premorbid risk factor for PTSD. In support of this model Pitman and colleagues[170] have demonstrated that lower premilitary IQ is associated with combat-related PTSD, as well as finding a correlation between PTSD symptoms and hippocampal volume in twin brothers.[151] Model A (Environment) states that stress leads to damage or inhibition of neurogenesis via hypercortisolemia, decreased BDNF, or increased glutamate. Model B (Environment/Genetic) states that a combination of environmental and genetic factors leads to deficits in hippocampal function and structure. Showing that an intervention like medication changes hippocampal volume and cognition would provide support for at least a partial contribution of the environment to the outcomes of interest.

In addition to the hippocampus, other brain structures have been implicated in a neural circuitry of stress, including the amygdala and prefrontal cortex. The amygdala is involved in memory for the emotional valence of events, and plays a critical role in the acquisition of fear responses. The medial prefrontal cortex includes the anterior cingulate gyrus (Brodmann's area [BA] 32) and subcallosal gyrus (area 25) as well as orbitofrontal cortex. Lesion studies demonstrated that the medial prefrontal cortex modulates emotional responsiveness through inhibition of amygdala function. Conditioned fear responses are extinguished following repeated exposure to the conditioned stimulus in the absence of the unconditioned (aversive, eg, electric shock) stimulus. This inhibition appears to be mediated by medial prefrontal cortical inhibition of amygdala responsiveness.

Animal studies also show that early stress is associated with a decrease in branching of neurons in the medial prefrontal cortex.[171] Rauch and colleagues found smaller volume of the anterior cingulate based on MRI measurements in PTSD[172]; we have replicated these findings in women with abuse and PTSD.[160] An important question is whether these effects are reversible with treatment.

Neural circuits in PTSD

Brain imaging studies have shown alterations in a circuit including medial prefrontal cortex (including anterior cingulate), hippocampus, and amygdala in PTSD. Many of these studies have used different methods to trigger PTSD symptoms (eg, using traumatic cues) and then look at brain function. Stimulation of the noradrenergic system with yohimbine resulted in a failure of activation in dorsolateral prefrontal, temporal, parietal, and orbitofrontal cortex, and decreased function in the hippocampus.[173] Exposure to traumatic reminders in the form of traumatic slides and/or sounds or traumatic scripts was associated with an increase in PTSD symptoms, decreased blood flow, and/or failure of activation in the medial prefrontal cortex/anterior cingulate, including Brodmann's area 25, or subcallosal gyrus, area 32 and 24, as measured with positron emission tomography (PET) or functional MRI (fMRI).[174-183] Other findings in studies of traumatic reminder exposure include decreased function in hippocampus,[176] visual association cortex,[176,180] parietal cortex,[176,179,180,184] and inferior frontal gyrus,[176,179,180,184] and increased function in amygdala,[181,184] posterior cingulate,[174,176,177,180] and parahippocampal gyrus.[174,176,178] Shin and colleagues found a correlation between increased amygdala function and decreased medial prefrontal function with traumatic reminders,[181] indicating a failure of inhibition of the amygdala by the medial prefrontal cortex that could account for increased PTSD symptoms with traumatic reminders. Other studies found increased amygdala and parahippocampal function and decreased medial prefrontal function during performance of an attention task,[182] increased posterior cingulate and parahippocampal gyrus and decreased medial prefrontal and dorsolateral prefrontal function during an emotional Stroop paradigm,[185] and increased amygdala function with exposure to masked fearful faces.[186] Retrieval of emotionally valenced words[187] (eg "rape-mutilate") in women with PTSD from early abuse resulted in decreases in blood flow in an extensive area which included orbitofrontal cortex, anterior cingulate, and medial prefrontal cortex (BA 25, 32, and 9), left hippocampus, and fusiform gyrus/inferior temporal gyrus, with increased activation in posterior cingulate, left inferior parietal cortex, left middle frontal gyrus, and visual association and motor cortex.[188] Another study found a failure of medial prefrontal cortical/anterior cingulate activation, and decreased visual association and parietal

cortex function, in women with abuse and PTSD relative to women with abuse without PTSD, during performance of the emotional Stroop task (ie, naming the color of a word such as "rape").[189] We recently found increased amygdala activation with classical fear conditioning (pairing a shock and a visual stimulus), and decreased medial prefrontal cortex function with extinction, in abuse-related PTSD.[190] The findings described above point to a network of related regions mediating symptoms of PTSD, including medial prefrontal cortex, anterior cingulate, hippocampus, amygdala, posterior cingulate, parietal, visual association, and dorsolateral prefrontal cortex.[191]

Fewer brain imaging studies have been performed in children with PTSD. Several studies have shown alterations in electroencephalogram (EEG) measures of brain activity in children with a variety of traumas who were not selected for diagnosis compared with healthy children. About half of the children in these studies had a psychiatric diagnosis. Abnormalities were located in the anterior frontal cortex and temporal lobe and were localized to the left hemisphere.[192,193] Two studies have found reductions in brain volume in children with trauma and PTSD symptoms.[154,155] One group did not find reductions in hippocampal volume, either at baseline or over a longitudinal period,[154,156] while another group found an 8.5% reduction in hippocampal volume that was not significant after controlling for smaller brain volumes in the PTSD group.[155] One study used single-voxel proton magnetic resonance spectroscopy (proton MRS) to measure relative concentration of NAA and creatinine (a marker of neuronal viability) in the anterior cingulate of 11 children with maltreatment-related PTSD and 11 controls. The authors found a reduction in the ratio of NAA to creatinine in PTSD relative to controls.[159] Studies have also found smaller size of the corpus callosum in children with abuse and PTSD relative to controls.[154] as well as larger volume of the superior temporal gyrus.[194] In a study of abused children in whom diagnosis was not specified, there was an increase in T2 relaxation time in the cerebellar vermis, suggesting dysfunction in this brain region.[195] The reason for differences in findings between adults and children are not clear; however, factors such as chronicity of illness or interaction between trauma and development may explain findings to date.

In summary, dysfunction of a circuit involving the medial prefrontal cortex, dorsolateral prefrontal cortex, and possibly hippocampus and amygdala during exposure to traumatic reminders may underlie symptoms of PTSD. These studies have primarily assessed neural correlates of traumatic remembrance, while little has been done in the way of utilizing cognitive tasks as probes of specific regions, such as memory tasks as probes of hippocampal function.

MRI assessment of brain abnormalities in PTSD and trauma spectrum disorders

Findings of smaller hippocampal volume appear to be associated with a range of trauma related psychiatric disorders, as long as there is the presence of psychological trauma. We have used MRI to show smaller hippocampal volume in PTSD,[144,145,149,196] depression,[197] depression with early abuse,[198] borderline personality disorder (BPD) with early abuse,[199] and Dissociative Identity Disorder (DID) with early abuse.[200] The greatest magnitude of difference was seen in the DID patients, who had unusually severe early childhood sexual abuse histories. We did not find changes in hippocampal volume in patients with panic disorder without a history of abuse (suggesting that findings are not generalized to other anxiety disorders).[201] We found smaller amygdala volume in BPD with early abuse[199] and increased amygdala volume in depression.[197,202] Patients with depression had smaller orbitofrontal cortex volume with no changes in anterior cingulate (BA 32) or medial prefrontal cortex (BA 25).[203] More recently, we found smaller anterior cingulate volume in women with abuse and PTSD relative to controls.[204]

Neural circuits in women with abuse and PTSD

We have used PET to study neural circuits of trauma-related disorders in women with early abuse and a variety of trauma spectrum mental disorders. Initially we studied women with abuse and PTSD.[54,205-208] We initially measured brain activation with a paragraph-encoding task in conjunction with PET O-15 water measurement of brain blood flow. Women with abuse and PTSD showed a failure of hippocampal activation during the memory task relative to controls.[149] Women with abuse and PTSD in this study also had smaller hippocampal volume measured with MRI relative to both women with abuse without PTSD and nonabused non-PTSD women. The failure of hippocampal activation was significant

after controlling differences in hippocampal volume as well as accuracy of encoding. In another study we measured neural correlates of exposure to a personalized script of childhood sexual abuse. Women with abuse and PTSD showed a failure of medial prefrontal and hippocampal activation relative to abused women without PTSD.[176] Women with abuse and PTSD also showed a failure of medial prefrontal and hippocampal function during recall of paired word associates with traumatic-emotional content (eg, "rape-mutilate"),[188] and decreased medial prefrontal function during an emotional Stroop task with trauma-content words.[209] Other studies showed a failure of medial prefrontal activation in women with BPD and early abuse during an abandonment script.[210] Women with BPD and abuse had increased psychophysiological responses to abandonment scripts relative to trauma scripts, while women with PTSD and abuse had the opposite pattern,[211] indicating differential responding in those two disorders in spite of the common exposure to early abuse.

In another project we studied 19 physically healthy women including women with a history of severe childhood sexual abuse and the diagnosis of current PTSD (N=8) and women without childhood abuse or PTSD (N=11).[212] All subjects underwent PET measurement of cerebral blood flow and psychophysiology measurement of heart rate and skin conductance during habituation, acquisition, and extinction conditions, on a single day, with scanning during a control condition on another day separated by 1 week from the active condition. Subjects were randomly assigned to undergo either the active condition or the control condition first (ie, active-control or control-active). Subjects were told at the beginning of the study that they would be exposed to electric shocks and viewing images on a screen during collection of PET and psychophysiology data. During habituation subjects were exposed to a blue square on a screen (conditioned stimulus [CS]), 4 seconds in duration, followed by 6 seconds of a blank screen. CS exposure was repeated eight times at regular intervals over 80 seconds in two separate blocks separated by 8 minutes. One PET image of brain blood flow was obtained starting from the beginning of each of the blocks. During active fear acquisition exposure to the blue square (CS) was paired with an electric shock to the forearm (unconditioned stimulus [UCS]). Subjects had 8 paired CS-UCS presentations at 10-second intervals for each of two blocks. With extinction subjects were again exposed to the blue squares (CS) without shock ("active" extinction). On a second day subjects went through the same procedure with electric shocks delivered randomly when the blue square was not present (unpaired CS-UCS) (an equal number as on day 1) during scans 3 and 4, which served as a control for active fear acquisition.

PTSD subjects had increased symptoms of anxiety, fear, dissociation, distress, substance use disorders (SUDs), and PTSD at all time points during both study days relative to non-PTSD. Acquisition of fear was associated with increased skin conductance (SC) responses to CS exposure during the active versus the control conditions in all subjects. There was increased SC for PTSD during the first CS-UCS presentation. Extinction of fear was associated with increased skin conductance (SC) responses to CS exposure during the active versus the control conditions in all subjects. When PTSD and non-PTSD subjects were examined separately, SC levels were significantly elevated in non-PTSD subjects undergoing extinction following the active compared with the control condition during session one.

PTSD subjects showed activation of the bilateral amygdala during fear acquisition compared with the control condition. Non-PTSD subjects showed an area of activation in the region of the left amygdala. When PTSD subjects and control subjects were directly compared, PTSD subjects showed greater activation of the left amygdala during the fear conditioning condition (pairing of US and CS) relative to the random shock control than healthy women. Other areas that showed increased activation with fear acquisition in PTSD included bilateral superior temporal gyrus (BA 22), cerebellum, bilateral inferior frontal gyrus (BA 44, 45), and posterior cingulate (BA 24). Fear acquisition was associated with decreased function in medial prefrontal cortex, visual association cortex, and medial temporal cortex, inferior parietal lobule function, and other areas. Extinction of fear responses was associated with decreased function in the orbitofrontal and medial prefrontal cortex (including subcallosal gyrus, BA 25, and anterior cingulate BA 32), visual association cortex, and other areas, in the PTSD subjects, but not in the controls. Amygdala blood flow with fear acquisition was negatively correlated with medial prefrontal blood flow with fear extinction (increased blood flow in amygdala correlated with decreased blood flow in medial prefrontal cortex) in all subjects (r=-0.48; P<0.05). Increased amygdala blood flow with fear acquisition was positively correlated with PTSD (r=0.45), anxiety (r=0.44) and disso-

ciative (r=0.80) symptom levels in PTSD (but not non-PTSD) subjects. There was a negative correlation between medial prefrontal blood flow during extinction and anxiety as measured with the Panic Attack Symptom Scale (PASS) during extinction in the PTSD group only, which was significant after correction for multiple comparisons (r=-0.90; P=0.006).[190] This study was consistent with increased amygdala function with fear acquisition, and decreased medial prefrontal (anterior cingulate) function during extinction in PTSD. This is consistent with the model of an overactive amygdala and a failure of medial prefrontal cortex to extinguish, or shut off, the amygdala, when the acute threat is no longer present.

Treatment of PTSD

Intervening soon after the trauma is critical for long-term outcomes, since with time traumatic memories become indelible and resistant to treatment.[213] Early treatments are not necessarily effective. For instance, studies have shown that Critical Incident Stress Debriefing (CISD) can be associated with a worsening of outcome relative to no treatment at all.[214] Pharmacological treatment of chronic PTSD has shown efficacy originally for imipramine,[215] amitriptyline,[216] and phenalzine,[215] and later for brofaramine,[217] paroxetine,[218,219] and sertraline.[220] Selective serotonin reuptake inhibitors (SSRIs) and tianeptine are now recommended as first-line treatment for PTSD.[221-226]

The utility of early treatment is also demonstrated by animal studies showing that pretreatment before stress with antidepressants reduces chronic behavioral deficits related to stress.[227,228] Antidepressants, including both norepinephrine and serotonin reuptake inhibitors, as well as gabapentine and phenytoin, promote nerve growth (neurogenesis) in the hippocampus, while stress inhibits neurogenesis.[63,64,66,69,71,75,229] This is important because hippocampal neurogenesis has been shown to be required for antidepressant response.[74]

Few studies have examined the effects of pharmacological treatment on brain structure and function in patients with trauma-related mental disorders. We studied a group of patients with depression and found no effect of fluoxetine on hippocampal volume, although there were increases in memory function[230] and hippocampal activation measured with PET during a memory encoding task. Depressed patients with a history of childhood trauma were excluded, and we subsequently have found hippocampal volume reductions at baseline in women with early abuse and depression but not in women with depression without early abuse;[198] this suggests that the study design of excluding patients with early trauma may account for the negative result. Other studies in depression showed that smaller hippocampal volume was a predictor of resistance to antidepressant treatment.[231] Smaller orbitofrontal cortex volume is associated with depression; one study in geriatric depression found smaller orbitofrontal cortex volume, while length of antidepressant exposure was correlated with larger orbitofrontal volume.[232]

Several studies have looked at functional brain imaging response to antidepressants in depression. Single photon-emission computed tomography (SPECT) blood flow studies in depression showed that antidepressants increased anterior cingulate, right putamen, and right thalamus function.[233] SPECT Xenon-133 studies showed reduced prefrontal function at baseline in depression, with treatment responders showing reduced perfusion in prefrontal cortex compared with nonresponders after treatment.[234] In a fluorodeoxyglucose (FDG) PET study of brain function patients with depression treated with fluoxetine who had a positive response to treatment had limbic and striatal decreases (subgenual cingulate, hippocampus, insula, and pallidum) and brain stem and dorsal cortical increases (prefrontal, parietal, anterior, and posterior cingulate) in function. Failed response was associated with a persistent 1-week pattern and absence of either subgenual cingulate or prefrontal changes.[235] Sertraline resulted in an increase in middle frontal gyrus activity in depression measured with PET FDG, as well as increased function in right parietal lobe and visual association cortex.[236] Successful paroxetine therapy of depression was associated with increased glucose metabolism measured with PET in dorsolateral, ventrolateral, and medial aspects of the prefrontal cortex, parietal cortex, and dorsal anterior cingulate. Areas of decreased metabolism were noted in both anterior and posterior insular regions (left) as well as right hippocampal and parahippocampal regions.[237] In another PET FDG study, at baseline, subjects with depression had higher normalized metabolism than controls in the prefrontal cortex (and caudate and thalamus), and lower metabolism in the temporal lobe. With treatment with paroxetine, subjects with depression had metabolic changes in the direction of normalization in these regions.[238] A PET FDG study of patients with depression and controls showed that at baseline, the mean metabolism was increased in the left and right lateral orbital cortex/ventrolateral prefrontal cortex (PFC), left amygdala,

and posterior cingulate cortex, and decreased in the subgenual anterior cingulate cortex (ACC) and dorsal medial/dorsal anterolateral PFC in depressives relative to controls. Following treatment with antidepressants, metabolism significantly decreased in the left amygdala and left subgenual ACC. The metabolic reduction in the amygdala and right subgenual ACC appeared largely limited to those subjects who both responded to treatment and remained well at 6 months' follow-up.[239] Another study showed that antidepressant treatment of depression resulted in a decrease in amygdala activation with emotional faces as measured with fMRI.[240] In summary, studies show changes in limbic and prefrontal cortical regions with successful antidepressant treatment of depression.

Fewer studies have looked at the effects of pharmacological treatment on the brain in anxiety disorders. One PET FDG study showed that caudate function decreased with treatment of obsessive compulsive disorder with antidepressants.[241] Paroxetine resulted in a decrease in glutamate/glutamine measured with magnetic resonance spectroscopy (MRS) in children with obsessive-compulsive disorder (OCD).[242] Patients with PTSD were shown to have an increase in hippocampal volume and memory function with paroxetine,[163] and increased right hippocampal and right cerebral volume with phenytoin.[165] No published studies have looked at the effects of pharmacological treatment on brain function in PTSD, or on sensitive markers of brain chemistry like NAA.

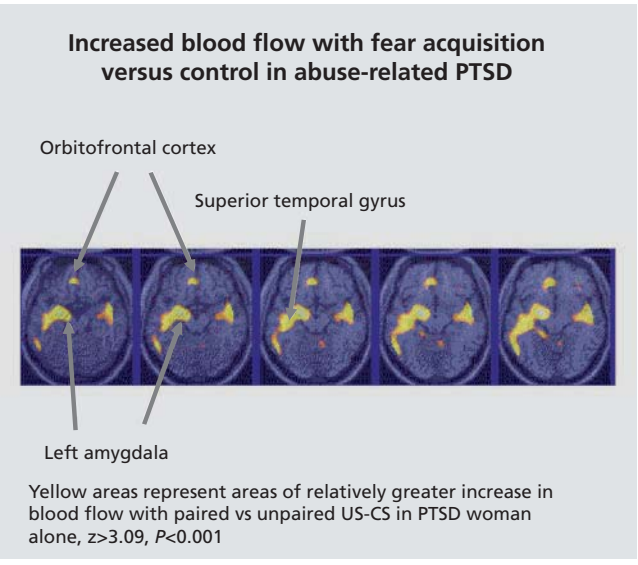

Figure 2. Neural correlates of fear conditioning in women with abuse and PTSD. There was increased amygdala activation with fear acquisition using a classical conditioning paradigm relative to non-PTSD abused women. PTSD, post-traumatic stress disorder

Brain biomarkers like NAA represent an objective marker of neural plasticity. To date psychiatry has relied on subjective reports as the gold standard. However, this is limited by self-reporting and the subjective interpretations of symptoms and response to treatment. Brain markers of antidepressant response may provide a complementary approach to assessing response to treatment, as well as providing insight into the mechanisms of treatment response. Our group is trying to look at mechanisms in the brain underlying treatment response in PTSD.

Effects of pharmacotherapy on brain function and structure in PTSD

We have begun to assess the effects of pharmacotherapy on brain structure and function in PTSD.[243] We recently assessed the effects of phenytoin on brain structure and function. Studies in animals show that phenytoin, which is used in the treatment of epilepsy and is known to modulate glutamatergic function, blocks the effects of stress on the hippocampus.[67] We studied nine patients with PTSD in an open-label function before and after treatment with phenytoin. Phenytoin resulted in a significant improvement in PTSD symptoms.[164] Phenytoin also resulted in increases in both right hippocampal volume and right hemisphere volume.[165] These findings indicate that phenytoin has an effects on PTSD symptoms as well as brain structure in PTSD patients.

We have assessed the effects of open-label paroxetine on memory and the hippocampus in PTSD. Male and female patients with symptoms of PTSD were medication-free for at least 4 weeks before participation in the study. Twenty-eight patients were found to be eligible and started the medication phase. Of the total patient sample five patients did not finish due to noncompliance; 23 patients completed the study.

Before patients started the medication phase, neuropsychological tests were administered, including the *Wechsler Adult Intelligence Scale – Revised*, WAIS-R (arithmetic, vocabulary, picture arrangement, and block design test), two subtests of the *Wechsler Memory Scale-Revised*, WMS-R, including logical memory (free recall of two story narratives, which represents verbal memory) and figural memory (which represents visual memory and involved reproduction of designs after a 6-second presentation); and the verbal and visual components of

the *Selective Reminding Test*, SRT.

Paroxetine was prescribed in the first visit after the pre-treatment assessments. All patients started open-label with a dose of 10 mg daily and were titrated up to 20 mg in 4 days.

Paroxetine treatment resulted in a mean 54% reduction in PTSD symptoms as measured with mean changes from baseline on the CAPS total score ($P<0.005$) among study completers. Improvement was equally strong on all symptom cluster scores (Re-experiencing, Avoidance/Numbing, Hyperarousal). Treatment also resulted in significant improvements in verbal declarative memory as measured with the WMS-R paragraph recall for delayed recall ($P<0.005$) and percent retention (80.2 to 91.1; $P=0.003$), but not immediate recall. Improvements were significant on all subscales of the Verbal Component of the SRT; including long-term recall and delayed recall.

Repeated measures ANOVA with side as the repeated measure showed a main effect for treatment related to a 4.6% increase in mean hippocampal volume (1857.3 mm^3 [SD 225.6] to 1906.2 mm^3, [SD 243.2]) with treatment (F=8.775 df=1. 36; $P=0.005$). Increased hippocampal volume was seen for both left (5.6%) (1807.6 mm^3 [SD 255.5] to 1909.3 mm^3 [SD 236.9]) and right (3.7%) (1906.9 mm^3 [SD 195.8] to 1976.7 mm^3 (SD 249.6]) hippocampus. There was no change in whole brain volume with treatment. Increase in hippocampal volume was significant after adding whole brain volume before and after treatment to the model.

Discussion

Traumatic stress has a broad range of effects on brain function and structure, as well as on neuropsychological components of memory. Brain areas implicated in the stress response include the amygdala, hippocampus, and prefrontal cortex. Neurochemical systems, including cortisol and norepinephrine, play a critical role in the stress response. These brain areas play an important role in the stress response. They also play a critical role in memory, highlighting the important interplay between memory and the traumatic stress response. Preclinical studies show that stress affects these brain areas. Furthermore, antidepressants have effects on the hippocampus that counteract the effects of stress. In fact, promotion of nerve growth (neurogenesis) in the hippocampus may be central to the efficacy of the antidepressants. Studies in patients with PTSD show alterations in brain areas implicated in animal studies, including the amygdala, hippocampus, and prefrontal cortex, as well as in neurochemical stress response systems, including cortisol and norepinephrine. Treatments that are efficacious for PTSD show a promotion of neurogenesis in animal studies, as well as promotion of memory and increased hippocampal volume in PTSD. Future studies are needed to assess neural mechanisms in treatment response in PTSD. ❑

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Estrés traumático: efectos en la cerebro

El estrés traumático surte efectos muy diversos sobre la función y la estructura cerebrales. Las regiones cerebrales implicadas en la respuesta al estrés son la amígdala (núcleo amigdalino), el hipocampo y la corteza prefrontal. Los sistemas neuroquímicos, como el cortisol y la noradrenalina, desempeñan una misión crítica en la respuesta al estrés. Estas regiones cerebrales influyen sobre la respuesta al estrés y sobre la memoria, lo que subraya la interrelación entre la memoria y la respuesta al estrés traumático. Los antidepresivos actúan sobre el hipocampo y contrarrestan el efecto del estrés. Los estudios sobre pacientes con trastorno por estrés postraumático (TEPT) revelan alteraciones en las regiones cerebrales implicadas en los estudios con animales como la amígdala, el hipocampo y la corteza prefrontal, así como en los sistemas neuroquímicos de respuesta al estrés, entre ellos el cortisol y la noradrenalina. Los tratamientos con eficacia frente al TEPT promueven la neurogénesis en los estudios con animales y también aumentan la memoria, y el volumen hipocámpico en el TEPT. Se requieren nuevos estudios para evaluar los mecanismos neurales de la respuesta terapéutica en el TEPT.

Effets du stress traumatique sur le cerveau

Le stress traumatique exerce une grande variété d'effets sur la fonction et la structure cérébrales. Les aires cérébrales impliquées dans la réponse au stress comprennent l'amygdale, l'hippocampe et le cortex préfrontal. Les systèmes neurochimiques, incluant le cortisol et la norépinéphrine, jouent un rôle critique dans la réponse au stress. Ces aires cérébrales influent sur la mémoire et sur la réponse au stress traumatique, soulignant ainsi les interactions existant entre les deux. Les effets des antidépresseurs sur l'hippocampe compensent les effets du stress. Les études chez les patients atteints de trouble stress post-traumatique (ESPT) montrent des modifications des aires cérébrales impliquées au cours des études animales, telles l'amygdale, l'hippocampe et le cortex préfrontal, ainsi que des modifications des systèmes neurochimiques de réponse au stress comme le cortisol et la noradrénaline. Les traitements efficaces dans l'ESPT entraînent une activation de la neurogenèse chez l'animal de même qu'une amélioration de la mémoire et une augmentation du volume de l'hippocampe dans l'ESPT. Il faudra d'autres études pour évaluer les mécanismes neuronaux dans la réponse thérapeutique au cours de l'ESPT.

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A TREATMENT IMPROVEMENT PROTOCOL

Trauma-Informed Care in Behavioral Health Services

TIP 57

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A TREATMENT IMPROVEMENT PROTOCOL

Trauma-Informed Care in Behavioral Health Services

TIP 57

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

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Disclaimer

The views, opinions, and content expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of SAMHSA or HHS. No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described are intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

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Consensus Panel

Note: Each panelist's information reflects his or her affiliation at the time of the Consensus Panel meeting and may not reflect that person's most current affiliation.

Chair

Lisa M. Najavits, Ph.D.
Research Psychologist
Veterans Affairs Boston Healthcare System
Professor of Psychiatry
Boston University School of Medicine
Boston, MA

Co-Chair

Linda B. Cottler, Ph.D., M.P.H.
Professor of Epidemiology in Psychiatry
Department of Psychiatry
Washington University–St. Louis
St. Louis, MO

Workgroup Leaders

Stephanie S. Covington, Ph.D., LCSW, MFCC
Co-Director
Center for Gender and Justice
Institute for Relational Development
La Jolla, CA

Margaret Cramer, Ph.D.
Clinical Psychologist/Clinical Instructor
Harvard Medical School
Boston, MA

Anne M. Herron, M.S.
Director
Treatment Programming
New York State Office of Alcoholism and Substance Abuse Services
Albany, NY

Denise Hien, Ph.D.
Research Scholar
Social Intervention Group
School of Social Work
Columbia University
New York, NY

Dee S. Owens, M.P.A.
Director
Alcohol-Drug Information
Indiana University
Bloomington, IN

Panelists

Charlotte Chapman, M.S., LPC, CAC
Training Director
Division of Addiction Psychiatry
Mid-Atlantic Addiction Technology Transfer Center
Virginia Commonwealth University
Richmond, VA

Scott F. Coffey, Ph.D.
Associate Professor
Department of Psychiatry and Human Behavior
University of Mississippi Medical Center
Jackson, MS

Renee M. Cunningham-Williams, M.S.W., M.P.E., Ph.D.
Research Assistant/Professor of Social Work
Department of Psychiatry
Washington University
St. Louis, MO

Chad D. Emrick, Ph.D.
Administrative Director
Substance Abuse Treatment Program
Denver VA Medical Center (116A1)
Denver, CO

Charles R. Figley, Ph.D.
Professor
Director of the Traumatology Institute
Florida State University
Tallahassee, FL

Larry M. Gentilello, M.D., FACS
Professor and Chairman
Division of Burn, Trauma, and Critical Care
University of Texas Southwestern Medical School
Dallas, TX

Robert Grant, Ph.D.
Trauma Consultant
Oakland, CA

Anthony (Tony) Taiwai Ng, M.D.
Disaster Psychiatrist
Washington, DC

Pallavi Nishith, Ph.D.
Associate Research Professor
Center for Trauma
Department of Psychology
University of Missouri–St. Louis
St. Louis, MO

Joseph B. Stone, Ph.D., CACIII, ICADC
Program Manager and Clinical Supervisor
Confederated Tribes of Grand Ronde Behavioral Health Program
Grand Ronde, OR

Michael Villanueva, Ph.D.
Research Professor
Center on Alcoholism, Substance Abuse, and Addiction
Albuquerque, NM

KAP Expert Panel and Federal Government Participants

Barry S. Brown, Ph.D.
Adjunct Professor
University of North Carolina–Wilmington
Carolina Beach, NC

Jacqueline Butler, M.S.W., LISW, LPCC, CCDC III, CJS
Professor of Clinical Psychiatry
College of Medicine
University of Cincinnati
Cincinnati, OH

Deion Cash
Executive Director
Community Treatment and Correction Center, Inc.
Canton, OH

Debra A. Claymore, M.Ed.Adm.
Owner/Chief Executive Officer
WC Consulting, LLC
Loveland, CO

Carlo C. DiClemente, Ph.D.
Chair
Department of Psychology
University of Maryland–Baltimore County
Baltimore, MD

Catherine E. Dube, Ed.D.
Independent Consultant
Brown University
Providence, RI

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief, Services
Division of Clinical and Services Research
National Institute on Drug Abuse
Bethesda, MD

Michael Galer, D.B.A.
Independent Consultant
Westminster, MA

Renata J. Henry, M.Ed.
Director
Division of Alcoholism, Drug Abuse and Mental Health
Delaware Department of Health and Social Services
New Castle, DE

Joel Hochberg, M.A.
President
Asher & Partners
Los Angeles, CA

Jack Hollis, Ph.D.
Associate Director, Center for Health Research
Kaiser Permanente
Portland, OR

Mary Beth Johnson, M.S.W.
Director
Addiction Technology Transfer Center
University of Missouri–Kansas City
Kansas City, MO

Eduardo Lopez
Executive Producer
EVS Communications
Washington, DC

Holly A. Massett, Ph.D.
Academy for Educational Development
Washington, DC

Diane Miller
Chief
Scientific Communications Branch
National Institute on Alcohol Abuse and Alcoholism
Bethesda, MD

Harry B. Montoya, M.A.
President/Chief Executive Officer
Hands Across Cultures
Española, NM

Richard K. Ries, M.D.
Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, WA

Gloria M. Rodriguez, D.S.W.
Research Scientist
Division of Addiction Services
New Jersey Department of Health and Senior Services
Trenton, NJ

Everett Rogers, Ph.D.
Center for Communications Programs
Johns Hopkins University
Baltimore, MD

Jean R. Slutsky, P.A., M.S.P.H.
Senior Health Policy Analyst
Agency for Healthcare Research & Quality
Rockville, MD

Nedra Klein Weinreich, M.S.
President
Weinreich Communications
Canoga Park, CA

Clarissa Wittenberg
Director
Office of Communications and Public Liaison
National Institute of Mental Health
Bethesda, MD

Consulting Members of the KAP Expert Panel

Paul Purnell, M.A
Social Solutions, LLC
Potomac, MD

Scott Ratzan, M.D., M.P.A., M.A.
Academy for Educational Development
Washington, DC

Thomas W. Valente, Ph.D.
Director
Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Los Angeles, CA

Patricia A. Wright, Ed.D.
Independent Consultant
Baltimore, MD

What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://store.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

Pamela S. Hyde, J.D.
Administrator
Substance Abuse and Mental Health Services Administration

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Frances M. Harding
Director
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

How This TIP Is Organized

This Treatment Improvement Protocol (TIP) is divided into three parts:

- Part 1: *A Practical Guide for the Provision of Behavioral Health Services*
- Part 2: *An Implementation Guide for Behavioral Health Program Administrators*
- Part 3: *A Review of the Literature*

Part 1 is for behavioral health service providers and consists of six chapters. Recurring themes include the variety of ways that substance abuse, mental health, and trauma interact; the importance of context and culture in a person's response to trauma; trauma-informed screening and assessment tools, techniques, strategies, and approaches that help behavioral health professionals assist clients in recovery from mental and substance use disorders who have also been affected by acute or chronic traumas; and the significance of adhering to a strengths-based perspective that acknowledges the resilience within individual clients, providers, and communities.

Chapter 1 lays the groundwork and rationale for the implementation and provision of trauma-informed services. It provides an overview of specific trauma-informed intervention and treatment principles that guide clinicians, other behavioral health workers, and administrators in becoming trauma informed and in creating a trauma-informed organization and workforce. Chapter 2 provides an overview of traumatic experiences. It covers types of trauma; distinguishes among traumas that affect individuals, groups, and communities; describes trauma characteristics; and addresses the socioecological and cultural factors that influence the impact of trauma. Chapter 3 broadly focuses on understanding the impact of trauma, trauma-related stress reactions and associated symptoms, and common mental health and substance use disorders associated with trauma. Chapter 4 provides an introduction to screening and assessment as they relate to trauma and is devoted to screening and assessment processes and tools that are useful in evaluating trauma exposure, its effects, and client intervention and treatment needs. Chapter 5 covers clinical issues that counselors and other behavioral health professionals may need to know and address when treating clients who have histories of trauma. Chapter 6 presents information on specific treatment models for trauma, distinguishing integrated models (which address substance use disorders, mental disorders, and trauma simultaneously) from those that treat trauma alone.

Advice to Counselors and/or Administrators boxes in Part 1 provide practical information for providers. Case illustrations, exhibits, and text boxes further illustrate information in the text by offering practical examples.

Part 2 provides an overview of programmatic and administrative practices that will help behavioral health program administrators increase the capacity of their organizations to deliver

trauma-informed services. Chapter 1 examines the essential ingredients, challenges, and processes in creating and implementing trauma-informed services within an organization. Chapter 2 focuses on key development activities that support staff members, including trauma-informed training and supervision, ethics, and boundaries pertinent to responding to traumatic stress, secondary trauma, and counselor self-care.

Advice to Administrators and/or Supervisors boxes in Part 2 highlight more detailed information that supports the organizational implementation of trauma-informed care (TIC). In addition, case illustrations, organizational activities, and text boxes reinforce the material presented within this section.

Part 3 is a literature review on TIC and behavioral health services and is intended for use by clinical supervisors, interested providers, and administrators. Part 3 has three sections: an analysis of the literature, links to select abstracts of the references most central to the topic, and a general bibliography of the available literature. To facilitate ongoing updates (performed periodically for up to 3 years from first publication), the literature review is only available online at the Substance Abuse and Mental Health Services Administration (SAMHSA) Publications Ordering Web page (http://store.samhsa.gov).

Terminology

Behavioral health: Throughout the TIP, the term "behavioral health" is used. Behavioral health refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illness and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used in this TIP to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use and related problems, treatments and services for mental and substance use disorders, and recovery support. Because behavioral health conditions, taken together, are the leading causes of disability burden in North America, efforts to improve their prevention and treatment will benefit society as a whole. Efforts to reduce the impact of mental and substance use disorders on America's communities, such as those described in this TIP, will help achieve nationwide improvements in health.

Client/consumer: In this TIP, the term "client" means anyone who seeks or receives mental health or substance abuse services. The term "consumer" stands in place of "client" in content areas that address consumer participation and determination. It is not the intent of this document to ignore the relevance and historical origin of the term "consumer" among individuals who have received, been subject to, or are seeking mental health services. Instead, we choose the word "client," given that this terminology is also commonly used in substance abuse treatment services. Note: This TIP also uses the term "participant(s)" instead of "client(s)" for individuals, families, or communities seeking or receiving prevention services.

Complex trauma: This manual adopts the National Child Traumatic Stress Network (NCTSN) definition of complex trauma. The term refers to the pervasive impact, including developmental

consequences, of exposure to multiple or prolonged traumatic events. According to the NCTSN Web site (http://www.nctsn.org/trauma-types), complex trauma typically involves exposure to sequential or simultaneous occurrences of maltreatment, "including psychological maltreatment, neglect, physical and sexual abuse, and domestic violence…. Exposure to these initial traumatic experiences—and the resulting emotional dysregulation and the loss of safety, direction, and the ability to detect or respond to danger cues—often sets off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood" (NCTSN, 2013).

Co-occurring disorders: When an individual has one or more mental disorders as well as one or more substance use disorders (including substance abuse), the term "co-occurring" applies. Although people may have a number of health conditions that co-occur, including physical problems, the term "co-occurring disorders," in this TIP, refers to substance use and mental disorders.

Cultural responsiveness and cultural competence: This TIP uses these terms interchangeably, with "responsiveness" applied to services and systems and "competence" applied to people, to refer to "a set of behaviors, attitudes, and policies that…enable a system, agency, or group of professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 13). Culturally responsive behavioral health services and culturally competent providers "honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services…. [C]ultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time" (U.S. Department of Health and Human Services, 2003, p. 12).

Evidence-based practices: There are many different uses of the term "evidence-based practices." One of the most widely accepted is that of Chambless and Hollon (1998), who say that for a treatment to be considered evidence based, it must show evidence of positive outcomes based on peer-reviewed randomized controlled trials or other equivalent strong methodology. A treatment is labeled "strong" if criteria are met for what Chambless and Hollon term "well-established" treatments. To attain this level, rigorous treatment outcome studies conducted by independent investigators (not just the treatment developer) are necessary. Research support is labeled "modest" when treatments attain criteria for what Chambless and Hollon call "probably efficacious treatments." To meet this standard, one well-designed study or two or more adequately designed studies must support a treatment's efficacy. In addition, it is possible to meet the "strong" and "modest" thresholds through a series of carefully controlled single-case studies. An evidence-based practice derived from sound, science-based theories incorporates detailed and empirically supported procedures and implementation guidelines, including parameters of applications (such as for populations), inclusionary and exclusionary criteria for participation, and target interventions.

Promising practices: Even though current clinical wisdom, theories, and professional and expert consensus may support certain practices, these practices may lack support from studies that are scientifically rigorous in research design and statistical analysis; available studies may be limited in number or sample size, or they may not be applicable to the current setting or population. This TIP refers to such practices as "promising."

Recovery: This term denotes a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Major dimensions that support a life in recovery, as defined by SAMHSA, include:

- ***Health:*** overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.
- ***Home:*** a stable and safe place to live.
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- ***Community:*** relationships and social networks that provide support, friendship, love, and hope.

Resilience: This term refers to the ability to bounce back or rise above adversity as an individual, family, community, or provider. Well beyond individual characteristics of hardiness, resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events. This TIP applies the term "resilience" and its processes to individuals across the life span.

Retraumatization: In its more literal translation, "retraumatization" means the occurrence of traumatic stress reactions and symptoms after exposure to multiple events (Duckworth & Follette, 2011). This is a significant issue for trauma survivors, both because they are at increased risk for higher rates of retraumatization, and because people who are traumatized multiple times often have more serious and chronic trauma-related symptoms than those with single traumas. In this manual, the term not only refers to the effect of being exposed to multiple events, but also implies the process of reexperiencing traumatic stress as a result of a current situation that mirrors or replicates in some way the prior traumatic experiences (e.g., specific smells or other sensory input; interactions with others; responses to one's surroundings or interpersonal context, such as feeling emotionally or physically trapped).

Secondary trauma: Literature often uses the terms "secondary trauma," "compassion fatigue," and "vicarious traumatization" interchangeably. Although compassion fatigue and secondary trauma refer to similar physical, psychological, and cognitive changes and symptoms that behavioral health workers may encounter when they work specifically with clients who have histories of trauma, vicarious trauma usually refers more explicitly to specific cognitive changes, such as in worldview and sense of self (Newell & MacNeil, 2010). This publication uses "secondary trauma" to describe trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event. Secondary trauma can occur among behavioral health service providers across all behavioral health settings and among all professionals who provide services to those who have experienced trauma (e.g., healthcare providers, peer counselors, first responders, clergy, intake workers).

Substance abuse: Throughout the TIP, the term "substance abuse" has been used to refer to both substance abuse and substance dependence. This term was chosen partly because behavioral health professionals commonly use the term substance abuse to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs to determine what possible range of meanings it covers; in most cases, it will refer to all varieties of substance-related

disorders as found in *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (American Psychiatric Association, 2013a).

Trauma: In this text, the term "trauma" refers to experiences that cause intense physical and psychological stress reactions. It can refer to "a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Although many individuals report a single specific traumatic event, others, especially those seeking mental health or substance abuse services, have been exposed to multiple or chronic traumatic events. See the "What Is Trauma" section in Part 1, Chapter 1, for a more indepth definition and discussion of trauma.

Trauma-informed: A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. In May 2012, SAMHSA convened a group of national experts who identified three key elements of a trauma-informed approach: "(1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice" (SAMHSA, 2012, p 4).

Trauma-informed care: TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.

Trauma-specific treatment services: These services are evidence-based and promising practices that facilitate recovery from trauma. The term "trauma-specific services" refers to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.

Trauma survivor: This phrase can refer to anyone who has experienced trauma or has had a traumatic stress reaction. Knowing that the use of language and words can set the tone for recovery or contribute to further retraumatization, it is the intent of this manual to put forth a message of hope by avoiding the term "victim" and instead using the term "survivor" when appropriate.

Part 1: A Practical Guide for the Provision of Behavioral Health Services

1 Trauma-Informed Care: A Sociocultural Perspective

IN THIS CHAPTER

- Scope of the TIP
- Intended Audience
- Before You Begin
- Structure of the TIP
- What Is Trauma?
- Trauma Matters in Behavioral Health Services
- Trauma Informed Intervention and Treatment Principles
- As You Proceed

Many individuals who seek treatment in behavioral health settings have histories of trauma, but they often don't recognize the significant effects of trauma in their lives; either they don't draw connections between their trauma histories and their presenting problems, or they avoid the topic altogether. Likewise, treatment providers may not ask questions that elicit a client's history of trauma, may feel unprepared to address trauma-related issues proactively, or may struggle to address traumatic stress effectively within the constraints of their treatment program, the program's clinical orientation, or their agency's directives.

By recognizing that traumatic experiences and their sequelae tie closely into behavioral health problems, front-line professionals and community-based programs can begin to build a trauma-informed environment across the continuum of care. Key steps include meeting client needs in a safe, collaborative, and compassionate manner; preventing treatment practices that retraumatize people with histories of trauma who are seeking help or receiving services; building on the strengths and resilience of clients in the context of their environments and communities; and endorsing trauma-informed principles in agencies through support, consultation, and supervision of staff.

This Treatment Improvement Protocol (TIP) begins by introducing the scope, purpose, and organization of the topic and describing its intended audience. Along with defining trauma and trauma-informed care (TIC), the first chapter discusses the rationale for addressing trauma in behavioral health services and reviews trauma-informed intervention and treatment principles. These principles serve as the TIP's conceptual framework.

Scope of the TIP

Many individuals experience trauma during their lifetimes. Although many people exposed to trauma demonstrate few or no lingering symptoms, those individuals who have experienced repeated, chronic, or multiple traumas are more likely to exhibit pronounced symptoms and consequences, including substance abuse, mental illness, and health problems. Subsequently, trauma can significantly affect how an individual engages in major life areas as well as treatment.

This TIP provides evidence-based and best practice information for behavioral health service providers and administrators who want to work more effectively with people who have been exposed to acute and chronic traumas and/or are at risk of developing traumatic stress reactions. Using key trauma-informed principles, this TIP addresses trauma-related prevention, intervention, and treatment issues and strategies in behavioral health services. The content is adaptable across behavioral health settings that service individuals, families, and communities—placing emphasis on the importance of coordinating as well as integrating services.

Intended Audience

This TIP is for behavioral health service providers, prevention specialists, and program administrators—the professionals directly responsible for providing care to trauma survivors across behavioral health settings, including substance abuse and mental health services. This TIP also targets primary care professionals, including physicians; teams working with clients and communities who have experienced trauma; service providers in the criminal justice system; and researchers with an interest in this topic.

Before You Begin

This TIP endorses a trauma-informed model of care; this model emphasizes the need for behavioral health practitioners and organizations to recognize the prevalence and pervasive impact of trauma on the lives of the people they serve and develop trauma-sensitive or trauma-responsive services. This TIP provides key information to help behavioral health practitioners and program administrators become trauma aware and informed, improve screening and assessment processes, and implement science-informed intervention strategies across settings and modalities in behavioral health services. Whether provided by an agency or an individual provider, trauma-informed services may or may not include trauma-specific services or trauma specialists (individuals who have advanced training and education to provide specific treatment interventions to address traumatic stress reactions). Nonetheless, TIC anticipates the role that trauma can play across the continuum of care—establishing integrated and/or collaborative processes to address the needs of traumatized individuals and communities proactively.

Individuals who have experienced trauma are at an elevated risk for substance use disorders, including abuse and dependence; mental health problems (e.g., depression and anxiety symptoms or disorders, impairment in relational/social and other major life areas, other distressing symptoms); and physical disorders and conditions, such as sleep disorders. This TIP focuses on specific types of prevention (Institute of Medicine et al., 2009): selective prevention, which targets people who are at risk for developing social, psychological, or other conditions as a result of trauma or who are at greater risk for experiencing trauma due to behavioral health disorders or conditions; and indicated prevention, which targets people who display early signs of trauma-related

symptoms. This TIP identifies interventions, including trauma-informed and trauma-specific strategies, and perceives treatment as a means of prevention—building on resilience, developing safety and skills to negotiate the impact of trauma, and addressing mental and substance use disorders to enhance recovery.

This TIP's target population is adults. Beyond the context of family, this publication does not examine or address youth and adolescent responses to trauma, youth-tailored trauma-informed strategies, or trauma-specific interventions for youth or adolescents, because the developmental and contextual issues of these populations require specialized interventions. Providers who work with young clients who have experienced trauma should refer to the resource list in Appendix B. This TIP covers TIC, trauma characteristics, the impact of traumatic experiences, assessment, and interventions for persons who have had traumatic experiences. Considering the vast knowledge base and specificity of individual, repeated, and chronic forms of trauma, this TIP does not provide a comprehensive overview of the unique characteristics of each type of trauma (e.g., sexual abuse, torture, war-related trauma, murder). Instead, this TIP provides an overview supported by examples. For more information on several specific types of trauma, please refer to TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (Center for Substance Abuse Treatment [CSAT], 2000b), TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b), TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d), and the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (Substance Abuse and Mental Health Services Administration [SAMHSA], planned f).

This TIP, *Trauma-Informed Care in Behavioral Health Services*, is guided by SAMHSA's Strategic Initiatives described in *Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014* (SAMHSA, 2011b). Specific to Strategic Initiative #2, Trauma and Justice, this TIP addresses several goals, objectives, and actions outlined in this initiative by providing behavioral health practitioners, supervisors, and administrators with an introduction to culturally responsive TIC.

Specifically, the TIP presents fundamental concepts that behavioral health service providers can use to:

- Become trauma aware and knowledgeable about the impact and consequences of traumatic experiences for individuals, families, and communities.
- Evaluate and initiate use of appropriate trauma-related screening and assessment tools.
- Implement interventions from a collaborative, strengths-based approach, appreciating the resilience of trauma survivors.
- Learn the core principles and practices that reflect TIC.
- Anticipate the need for specific trauma-informed treatment planning strategies that support the individual's recovery.
- Decrease the inadvertent retraumatization that can occur from implementing standard organizational policies, procedures, and interventions with individuals, including clients and staff, who have experienced trauma or are exposed to secondary trauma.
- Evaluate and build a trauma-informed organization and workforce.

The consensus panelists, as well as other contributors to this TIP, have all had experience as substance abuse and mental health counselors, prevention and peer specialists, supervisors, clinical directors, researchers, or administrators working with individuals, families, and

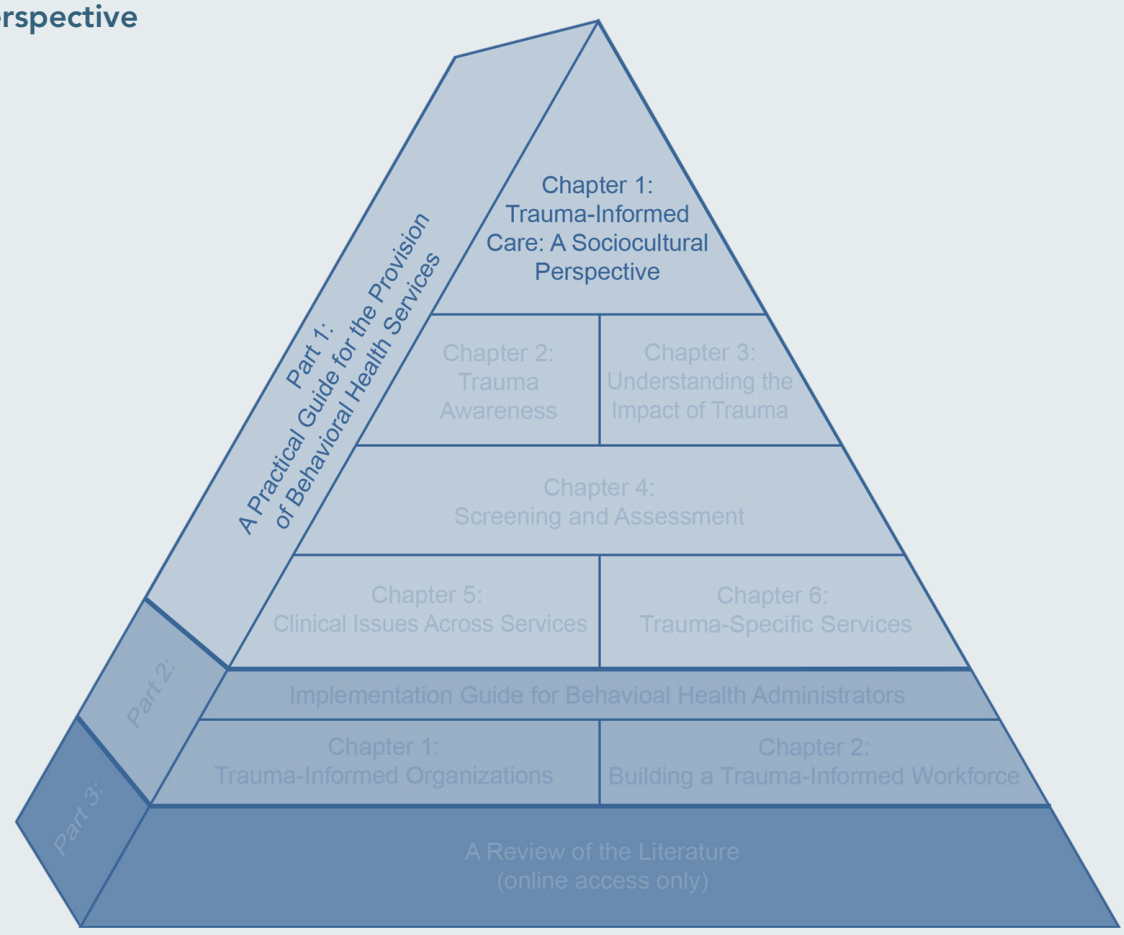
communities who have experienced trauma. The material presented in this TIP uses the wealth of their experience in addition to the available published resources and research relevant to this topic. Throughout the consensus process, the panel members were mindful of the strengths and resilience inherent in individuals, families, and communities affected by trauma and the challenges providers face in addressing trauma and implementing TIC.

Structure of the TIP

Using a TIC framework (Exhibit 1.1-1), this TIP provides information on key aspects of trauma, including what it is; its consequences; screening and assessment; effective prevention, intervention, and treatment approaches; trauma recovery; the impact of trauma on service providers; programmatic and administrative practices; and trauma resources.

Note: To produce a user-friendly but informed document, the first two parts of the TIP include minimal citations. If you are interested in the citations associated with topics covered in Parts 1 and 2, please consult the review of the literature provided in Part 3 (available online at http://store.samhsa.gov). Parts 1 and 2 are easily read and digested on their own, but it is highly recommended that you read the literature review as well.

Exhibit 1.1-1: TIC Framework in Behavioral Health Services—Sociocultural Perspective



What Is Trauma?

According to SAMHSA's Trauma and Justice Strategic Initiative, "trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Trauma can affect people of every race, ethnicity, age, sexual orientation, gender, psychosocial background, and geographic region. A traumatic experience can be a single event, a series of events, and/or a chronic condition (e.g., childhood neglect, domestic violence). Traumas can affect individuals, families, groups, communities, specific cultures, and generations. It generally overwhelms an individual's or community's resources to cope, and it often ignites the "fight, flight, or freeze" reaction at the time of the event(s). It frequently produces a sense of fear, vulnerability, and helplessness.

See Appendix C to read about the history of trauma and trauma interventions.

Often, traumatic events are unexpected. Individuals may experience the traumatic event directly, witness an event, feel threatened, or hear about an event that affects someone they know. Events may be human-made, such as a mechanical error that causes a disaster, war, terrorism, sexual abuse, or violence, or they can be the products of nature (e.g., flooding, hurricanes, tornadoes). Trauma can occur at any age or developmental stage, and often, events that occur outside expected life stages are perceived as traumatic (e.g., a child dying before a parent, cancer as a teen, personal illness, job loss before retirement).

It is not just the event itself that determines whether something is traumatic, but also the individual's experience of the event. Two people may be exposed to the same event or series of events but experience and interpret these events in vastly different ways. Various biopsychosocial and cultural factors influence an individual's immediate response and long-term reactions to trauma. For most, regardless of the severity of the trauma, the immediate or enduring effects of trauma are met with resilience—the ability to rise above the circumstances or to meet the challenges with fortitude.

For some people, reactions to a traumatic event are temporary, whereas others have prolonged reactions that move from acute symptoms to more severe, prolonged, or enduring mental health consequences (e.g., posttraumatic stress and other anxiety disorders, substance use and mood disorders) and medical problems (e.g., arthritis, headaches, chronic pain). Others do not meet established criteria for posttraumatic stress or other mental disorders but encounter significant trauma-related symptoms or culturally expressed symptoms of trauma (e.g., somatization, in which psychological stress is expressed through physical concerns). For that reason, even if an individual does not meet diagnostic criteria for trauma-related disorders, it is important to recognize that trauma may still affect his or her life in significant ways. For more information on traumatic events, trauma characteristics, traumatic stress reactions, and factors that heighten or decrease the impact of trauma, see Part 1, Chapter 2, "Trauma Awareness," and Part 1, Chapter 3, "Understanding the Impact of Trauma."

Trauma Matters in Behavioral Health Services

The past decade has seen an increased focus on the ways in which trauma, psychological distress, quality of life, health, mental illness,

and substance abuse are linked. With the attacks of September 11, 2001, and other acts of terror, the wars in Iraq and Afghanistan, disastrous hurricanes on the Gulf Coast, and sexual abuse scandals, trauma has moved to the forefront of national consciousness.

Trauma was once considered an abnormal experience. However, the first National Comorbidity Study established how prevalent traumas were in the lives of the general population of the United States. In the study, 61 percent of men and 51 percent of women reported experiencing at least one trauma in their lifetime, with witnessing a trauma, being involved in a natural disaster, and/or experiencing a life-threatening accident ranking as the most common events (Kessler et al., 1999). In Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions, 71.6 percent of the sample reported witnessing trauma, 30.7 percent experienced a trauma that resulted in injury, and 17.3 percent experienced psychological trauma (El-Gabalawy, 2012). For a thorough review of the impact of trauma on quality of life and health and among individuals with mental and substance use disorders, refer to Part 3 of this TIP, the online literature review.

Rationale for TIC

Integrating TIC into behavioral health services provides many benefits not only for clients, but also for their families and communities, for behavioral health service organizations, and for staff. Trauma-informed services bring to the forefront the belief that trauma can pervasively affect an individual's well-being, including physical and mental health. For behavioral health service providers, trauma-informed practice offers many opportunities. It reinforces the importance of acquiring trauma-specific knowledge and skills to meet the specific needs of clients; of recognizing that individuals may be affected by trauma regardless of its acknowledgment; of understanding that trauma likely affects many clients who are seeking behavioral health services; and of acknowledging that organizations and providers can retraumatize clients through standard or unexamined policies and practices. TIC stresses the importance of addressing the client individually rather than applying general treatment approaches.

TIC provides clients more opportunities to engage in services that reflect a compassionate perspective of their presenting problems. TIC can potentially provide a greater sense of safety for clients who have histories of trauma and a platform for preventing more serious consequences of traumatic stress (Fallot & Harris, 2001). Although many individuals may not identify the need to connect with their histories, trauma-informed services offer clients a chance to explore the impact of trauma, their strengths and creative adaptations in managing traumatic histories, their resilience, and the relationships among trauma, substance use, and psychological symptoms.

Two Influential Studies That Set the Stage for the Development of TIC

The Adverse Childhood Experiences Study (Centers for Disease Control and Prevention, 2013) was a large epidemiological study involving more than 17,000 individuals from United States; it analyzed the long-term effects of childhood and adolescent traumatic experiences on adult health risks, mental health, healthcare costs, and life expectancy.

The Women, Co-Occurring Disorders and Violence Study (SAMHSA, 2007) was a large multisite study focused on the role of interpersonal and other traumatic stressors among women; the interrelatedness of trauma, violence, and co-occurring substance use and mental disorders; and the incorporation of trauma-informed and trauma-specific principles, models, and services.

Implementing trauma-informed services can improve screening and assessment processes, treatment planning, and placement while also decreasing the risk for retraumatization. The implementation may enhance communication between the client and treatment provider, thus decreasing risks associated with misunderstanding the client's reactions and presenting problems or underestimating the need for appropriate referrals for evaluation or trauma-specific treatment. Organizational investment in developing or improving trauma-informed services may also translate to cost effectiveness, in that services are more appropriately matched to clients from the outset. TIC is an essential ingredient in organizational risk management; it ensures the implementation of decisions that will optimize therapeutic outcomes and minimize adverse effects on the client and, ultimately, the organization. A key principle is the engagement of community, clients, and staff. Clients and staff are more apt to be empowered, invested, and satisfied if they are involved in the ongoing development and delivery of trauma-informed services.

An organization also benefits from work development practices through planning for, attracting, and retaining a diverse workforce of individuals who are knowledgeable about trauma and its impact. Developing a trauma-informed organization involves hiring and promotional practices that attract and retain individuals who are educated and trained in trauma-informed practices on all levels of the organization, including board as well as peer support appointments. Trauma-informed organizations are invested in their staff and adopt similar trauma-informed principles, including establishing and providing ongoing support to promote TIC in practice and in addressing secondary trauma and implementing processes that reinforce the safety of the staff. Even though investing in a trauma-informed workforce does not necessarily guarantee trauma-informed practices, it is more likely that services will evolve more proficiently to meet client, staff, and community needs.

Advice to Counselors: The Importance of TIC

The history of trauma raises various clinical issues. Many counselors do not have extensive training in treating trauma or offering trauma-informed services and may be uncertain of how to respond to clients' trauma-related reactions or symptoms. Some counselors have experienced traumas themselves that may be triggered by clients' reports of trauma. Others are interested in helping clients with trauma but may unwittingly cause harm by moving too deeply or quickly into trauma material or by discounting or disregarding a client's report of trauma. Counselors must be aware of trauma-related symptoms and disorders and how they affect clients in behavioral health treatment.

Counselors with primary treatment responsibilities should also have an understanding of how to recognize trauma-related reactions, how to incorporate treatment interventions for trauma-related symptoms into clients' treatment plans, how to help clients build a safety net to prevent further trauma, how to conduct psychoeducational interventions, and when to make treatment referrals for further evaluations or trauma-specific treatment services. All treatment staff should recognize that traumatic stress symptoms or trauma-related disorders should not preclude an individual from mental health or substance abuse treatment and that all co-occurring disorders need to be addressed on some level in the treatment plan and setting. For example, helping a client in substance abuse treatment gain control over trauma-related symptoms can greatly improve the client's chances of substance abuse recovery and lower the possibility of relapse (Farley, Golding, Young, Mulligan, & Minkoff, 2004; Ouimette, Ahrens, Moos, & Finney, 1998). In addition, assisting a client in achieving abstinence builds a platform upon which recovery from traumatic stress can proceed.

Trauma and Substance Use Disorders

Many people who have substance use disorders have experienced trauma as children or adults (Koenen, Stellman, Sommer, & Stellman, 2008; Ompad et al., 2005). Substance abuse is known to predispose people to higher rates of traumas, such as dangerous situations and accidents, while under the influence (Stewart & Conrod, 2003; Zinzow, Resnick, Amstadter, McCauley, Ruggiero, & Kilpatrick, 2010) and as a result of the lifestyle associated with substance abuse (Reynolds et al., 2005). In addition, people who abuse substances and have experienced trauma have worse treatment outcomes than those without histories of trauma (Driessen et al., 2008; Najavits et al., 2007). Thus, the process of recovery is more difficult, and the counselor's role is more challenging, when clients have histories of trauma. A person presenting with both trauma and substance abuse issues can have a variety of other difficult life problems that commonly accompany these disorders, such as other psychological symptoms or mental disorders, poverty, homelessness, increased risk of HIV and other infections, and lack of social support (Mills, Teesson, Ross, & Peters, 2006; Najavits, Weiss, & Shaw, 1997). Many individuals who seek treatment for substance use disorders have histories of one or more traumas. More than half of women seeking substance abuse treatment report one or more lifetime traumas (Farley, Golding, Young, Mulligan, & Minkoff, 2004; Najavits et al., 1997), and a significant number of clients in inpatient treatment also have subclinical traumatic stress symptoms or posttraumatic stress disorder (PTSD; Falck, Wang, Siegal, & Carlson, 2004; Grant et al., 2004; Reynolds et al., 2005).

Trauma and Mental Disorders

People who are receiving treatment for severe mental disorders are more likely to have histories of trauma, including childhood physical and sexual abuse, serious accidents, homelessness, involuntary psychiatric hospitalizations, drug overdoses, interpersonal violence, and other forms of violence. Many clients with severe mental disorders meet criteria for PTSD; others with serious mental illness who have histories of trauma present with psychological symptoms or mental disorders that are commonly associated with a history of trauma, including anxiety symptoms and disorders, mood disorders (e.g., major depression, dysthymia, bipolar disorder; Mueser et al., 2004), impulse control disorders, and substance use disorders (Kessler, Chiu, Demler, & Walters, 2005).

Traumatic stress increases the risk for mental illness, and findings suggest that traumatic stress increases the symptom severity of mental illness (Spitzer, Vogel, Barnow, Freyberger & Grabe, 2007). These findings propose that traumatic stress plays a significant role in perpetuating and exacerbating mental illness and suggest that trauma often precedes the development of mental disorders. As with trauma and substance use disorders, there is a bidirectional relationship; mental illness increases the risk of experiencing trauma, and trauma increases the risk of developing psychological symptoms and mental disorders. For a more comprehensive review of the interactions among traumatic stress, mental illness, and substance use disorders, refer to Part 3 of this TIP, the online literature review.

Trauma-Informed Intervention and Treatment Principles

TIC is an intervention and organizational approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health services from prevention through treatment. There are many definitions of TIC and various models for incorporating it across organizations, but a "trauma-informed approach incorporates three key elements: (1) *realizing* the prevalence of trauma; (2) *recognizing* how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) *responding* by putting this knowledge into practice" (SAMHSA, 2012, p. 4).

TIC begins with the first contact a person has with an agency; it requires all staff members (e.g., receptionists, intake personnel, direct care staff, supervisors, administrators, peer supports, board members) to recognize that the individual's experience of trauma can greatly influence his or her receptivity to and engagement with services, interactions with staff and clients, and responsiveness to program guidelines, practices, and interventions. TIC includes program policies, procedures, and practices to protect the vulnerabilities of those who have experienced trauma and those who provide trauma-related services. TIC is created through a supportive environment and by redesigning organizational practices, with consumer participation, to prevent practices that could be retraumatizing (Harris & Fallot, 2001c; Hopper et al., 2010). The ethical principle, "first, do no harm," resonates strongly in the application of TIC.

> "A program, organization, or system that is trauma informed realizes the widespread impact of trauma and under stands poten tial paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings."
>
> (SAMHSA, 2012, p. 4)

TIC involves a commitment to building competence among staff and establishing programmatic standards and clinical guidelines that support the delivery of trauma-sensitive services. It encompasses recruiting, hiring, and retaining competent staff; involving consumers, trauma survivors, and peer support specialists in the planning, implementation, and evaluation of trauma-informed services; developing collaborations across service systems to streamline referral processes, thereby securing trauma-specific services when appropriate; and building a continuity of TIC as consumers move from one system or service to the next. TIC involves reevaluating each service delivery component through a trauma-aware lens.

The principles described in the following subsections serve as the TIP's conceptual

Advice to Counselors: Implementing Trauma-Informed Services

Recognizing that trauma affects a majority of clients served within public health systems, the National Center for Trauma-Informed Care (NCTIC) has sought to establish a comprehensive framework to guide systems of care in the development of trauma-informed services. If a system or program is to support the needs of trauma survivors, it must take a systematic approach that offers trauma-specific diagnostic and treatment services, as well as a trauma-informed environment that is able to sustain such services, while fostering positive outcomes for the clients it serves. NCTIC also offers technical assistance in the implementation of trauma-informed services. For specific administrative information on TIC implementation, refer to Part 2, Chapters 1 and 2, of this TIP.

framework. These principles comprise a compilation of resources, including research, theoretical papers, commentaries, and lessons learned from treatment facilities. Key elements are outlined for each principle in providing services to clients affected by trauma and to populations most likely to incur trauma. Although these principles are useful across all prevention and intervention services, settings, and populations, they are of the utmost importance in working with people who have had traumatic experiences.

Promote Trauma Awareness and Understanding

Foremost, a behavioral health service provider must recognize the prevalence of trauma and its possible role in an individual's emotional, behavioral, cognitive, spiritual, and/or physical development, presentation, and well-being. Being vigilant about the prevalence and potential consequences of traumatic events among clients allows counselors to tailor their presentation styles, theoretical approaches, and intervention strategies from the outset to plan for and be responsive to clients' specific needs. Although not every client has a history of trauma, those who have substance use and mental disorders are more likely to have experienced trauma. Being trauma aware does not mean that you must assume everyone has a history of trauma, but rather that you anticipate the possibility from your initial contact and interactions, intake processes, and screening and assessment procedures.

Even the most standard behavioral health practices can retraumatize an individual exposed to prior traumatic experiences if the provider implements them without recognizing or considering that they may do harm. For example, a counselor might develop a treatment plan recommending that a female client—who has been court mandated to substance abuse treatment and was raped as an adult—attend group therapy, but without considering the implications, for her, of the fact that the only available group at the facility is all male and has had a low historical rate of female participation. Trauma awareness is an essential strategy for preventing this type of retraumatization; it reinforces the need for providers to reevaluate their usual practices.

> "Trauma informed care embraces a perspective that highlights adaptation over symptoms and resilience over pathology."
>
> (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005, p. 467)

Becoming trauma aware does not stop with the recognition that trauma can affect clients; instead, it encompasses a broader awareness that traumatic experiences as well as the impact of an individual's trauma can extend to significant others, family members, first responders and other medical professionals, behavioral health workers, broader social networks, and even entire communities. Family members frequently experience the traumatic stress reactions of the individual family member who was traumatized (e.g., angry outbursts, nightmares, avoidant behavior, other symptoms of anxiety, overreactions or underreactions to stressful events). These repetitive experiences can increase the risk of secondary trauma and symptoms of mental illness among the family, heighten the risk for externalizing and internalizing behavior among children (e.g., bullying others, problems in social relationships, health-damaging behaviors), increase children's risk for developing posttraumatic stress later in life, and lead to a greater propensity for traumatic stress reactions across generations of the family. Hence, prevention and intervention services can provide education and age-appropriate programming tailored to develop coping skills and support systems.

So too, behavioral health service providers can be influenced by exposure to trauma-related affect and content when working with clients. A trauma-aware workplace supports supervision and program practices that educate all direct service staff members on secondary trauma, encourages the processing of trauma-related content through participation in peer-supported activities and clinical supervision, and provides them with professional development opportunities to learn about and engage in effective coping strategies that help prevent secondary trauma or trauma-related symptoms. It is important to generate trauma awareness in agencies through education across services and among all staff members who have any direct or indirect contact with clients (including receptionists or intake and admission personnel who engage clients for the first time within the agency). Agencies can maintain a trauma-aware environment through ongoing staff training, continued supervisory and administrative support, collaborative (i.e., involving consumer participation) trauma-responsive program design and implementation, and organizational policies and practices that reflect accommodation and flexibility in attending to the needs of clients affected by trauma.

Recognize That Trauma-Related Symptoms and Behaviors Originate From Adapting to Traumatic Experiences

A trauma-informed perspective views trauma-related symptoms and behaviors as an individual's best and most resilient attempt to manage, cope with, and rise above his or her experience of trauma. Some individuals' means of adapting and coping have produced little difficulty; the coping and adaptive strategies of others have worked in the past but are not working as well now. Some people have difficulties in one area of life but have effectively negotiated and functioned in other areas.

Individuals who have survived trauma vary widely in how they experience and express traumatic stress reactions. Traumatic stress reactions vary in severity; they are often measured by the level of impairment or distress that clients report and are determined by the multiple factors that characterize the trauma itself, individual history and characteristics, developmental factors, sociocultural attributes, and available resources. The characteristics of the trauma and the subsequent traumatic stress reactions can dramatically influence how individuals respond to the environment, relationships, interventions, and treatment services, and those same characteristics can also shape the assumptions that clients/consumers make about their world (e.g., their view of others, sense of safety), their future (e.g., hopefulness, fear of a foreshortened future), and themselves (e.g., feeling resilient, feeling incompetent in regulating emotions). The breadth of these effects may be observable or subtle.

Once you become aware of the significance of traumatic experiences in clients' lives and begin to view their presentation as adaptive, your identification and classification of their presenting symptoms and behaviors can shift from a "pathology" mindset (i.e., defining clients strictly from a diagnostic label, implying that something is wrong with them) to one of resilience—a mindset that views clients' presenting difficulties, behaviors, and emotions as responses to surviving trauma. In essence, you will come to view traumatic stress reactions as *normal* reactions to *abnormal* situations. In embracing the belief that trauma-related reactions are adaptive, you can begin relationships with clients from a hopeful, strengths-based stance that builds upon the belief that their responses to traumatic experiences reflect creativity, self-preservation, and determination.

This will help build mutual and collaborative therapeutic relationships, help clients identify what has worked and has not worked in their attempts to deal with the aftermath of trauma from a nonjudgmental stance, and develop intervention and coping strategies that are more likely to fit their strengths and resources. This view of trauma prevents further retraumatization by not defining traumatic stress reactions as pathological or as symptoms of pathology.

View Trauma in the Context of Individuals' Environments

Many factors contribute to a person's response to trauma, whether it is an individual, group, or community-based trauma. Individual attributes, developmental factors (including protective and risk factors), life history, type of trauma, specific characteristics of the trauma, amount and length of trauma exposure, cultural meaning of traumatic events, number of losses associated with the trauma, available resources (internal and external, such as coping skills and family support), and community reactions are a few of the determinants that influence a person's responses to trauma across time. Refer to the "View Trauma Through a Sociocultural Lens" section later in this chapter for more specific information highlighting the importance of culture in understanding and treating the effects of trauma.

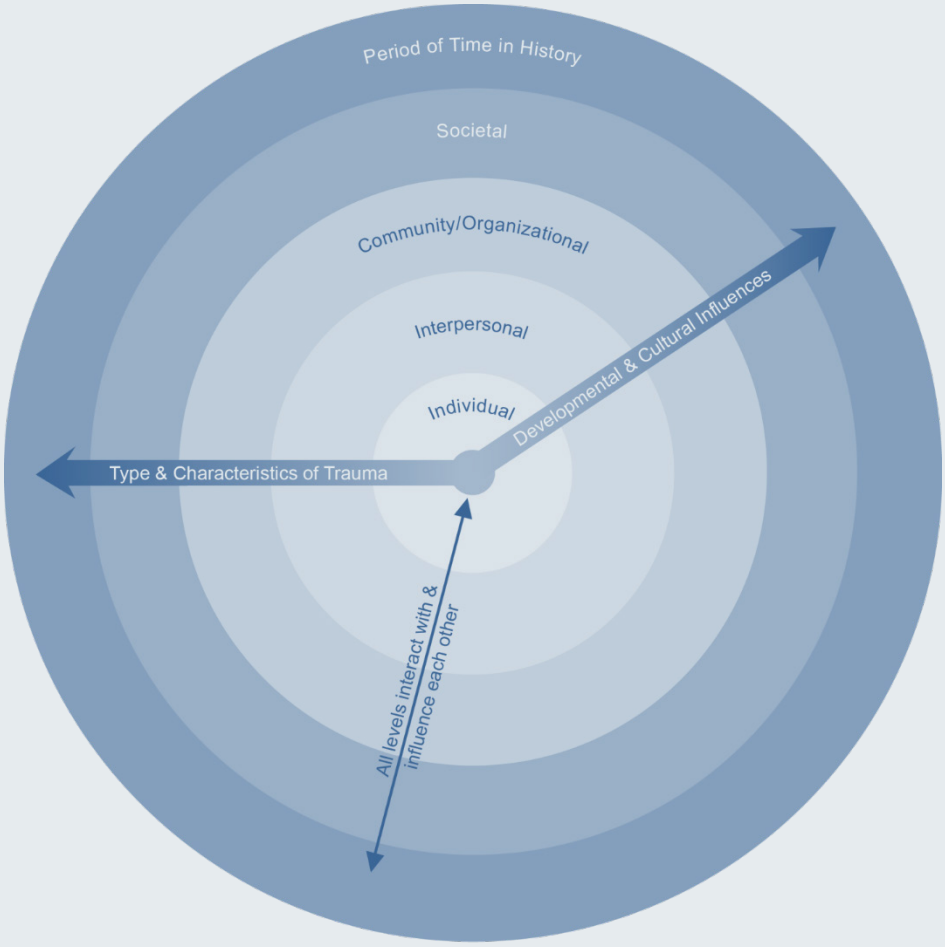
Trauma cannot be viewed narrowly; instead, it needs to be seen through a broader lens—a contextual lens integrating biopsychosocial, interpersonal, community, and societal (the degree of individualistic or collective cultural values) characteristics that are evident preceding and during the trauma, in the immediate and sustained response to the event(s), and in the short- and long-term effects of the traumatic event(s), which may include housing availability, community response, adherence to or maintenance of family routines and structure, and level of family support.

To more adequately understand trauma, you must also consider the contexts in which it occurred. Understanding trauma from this angle helps expand the focus beyond individual characteristics and effects to a broader systemic perspective that acknowledges the influences of social interactions, communities, governments, cultures, and so forth, while also examining the possible interactions among those various influences. Bronfenbrenner's (1979) and Bronfenbrenner and Ceci's (1994) work on ecological models sparked the development of other contextual models. In recent years, the social-ecological framework has been adopted in understanding trauma, in implementing health promotion and other prevention strategies, and in developing treatment interventions (Centers for Disease Control and Prevention, 2009). Here are the three main beliefs of a social-ecological approach (Stokols, 1996):

- Environmental factors greatly influence emotional, physical, and social well-being.
- A fundamental determinant of health versus illness is the degree of fit between individuals' biological, behavioral, and sociocultural needs and the resources available to them.
- Prevention, intervention, and treatment approaches integrate a combination of strategies targeting individual, interpersonal, and community systems.

This TIP uses a social-ecological model to explore trauma and its effects (Exhibit 1.1-2). The focus of this model is not only on negative attributes (risk factors) across each level, but also on positive ingredients (protective factors) that protect against or lessen the impact of trauma. This model also guides the inclusion of certain targeted interventions in this text, including selective and indicated

Exhibit 1.1-2: A Social-Ecological Model for Understanding Trauma and Its Effects



prevention activities. In addition, culture, developmental processes (including the developmental stage or characteristics of the individual and/or community), and the specific era when the trauma(s) occurred can significantly influence how a trauma is perceived and processed, how an individual or community engages in help-seeking, and the degree of accessibility, acceptability, and availability of individual and community resources.

Depending on the developmental stage and/or processes in play, children, adolescents, and adults will perceive, interpret, and cope with traumatic experiences differently. For example, a child may view a news story depicting a traumatic event on television and believe that the trauma is recurring every time they see the scene replayed. Similarly, the era in which one lives and the timing of the trauma can greatly influence an individual or community response. Take, for example, a pregnant woman who is abusing drugs and is wary of receiving medical treatment after being beaten in a domestic dispute. She may fear losing her children or being arrested for child neglect. Even though a number of States have adopted policies focused on the importance of treatment for pregnant women who are abusing drugs and of the accessibility of prenatal care, other States have approached this issue from a criminality standpoint (e.g., with child welfare and criminal laws) in the past few decades. Thus, the traumatic event's timing is a significant

component in understanding the context of trauma and trauma-related responses.

The social-ecological model depicted in Exhibit 1.1-2 provides a systemic framework for looking at individuals, families, and communities affected by trauma in general; it highlights the bidirectional influence that multiple contexts can have on the provision of behavioral health services to people who have experienced trauma (see thin arrow). Each ring represents a different system (refer to Exhibit 1.1-3 for examples of specific factors within each system). The innermost ring represents the individual and his or her biopsychosocial characteristics. The "Interpersonal" circle embodies all immediate relationships including family, friends, peers, and others. The "Community/Organizational" band represents social support networks, workplaces, neighborhoods, and institutions that directly influence the individual and his/her relationships. The "Societal" circle signifies the largest system—State and Federal policies and laws, such as economic and healthcare policies, social norms, governmental systems, and political ideologies. The outermost ring, "Period of Time in History," reflects the significance of the period of time during which the event occurred; it influences each other level represented in the circle. For example, making a comparison of society's attitudes and responses to veterans' homecomings across different wars and conflicts through time shows that homecoming environments can have either a protective or a negative effect on healing from the psychological and physical wounds of war, depending on the era in question. The thicker arrows in the figure represent the key influences of culture, developmental characteristics, and the type and characteristics of the trauma. All told, the context of traumatic events can significantly influence both initial and sustained responses to trauma; treatment needs; selection of prevention, intervention, and other treatment

Exhibit 1.1-3: Understanding the Levels Within the Social-Ecological Model of Trauma and Its Effects

Individual Factors	Interpersonal Factors	Community and Organizational Factors	Societal Factors	Cultural and Developmental Factors	Period of Time in History
Age, biophysical state, mental health status, temperament and other personality traits, education, gender, coping styles, socioeconomic status	Family, peer, and significant other interaction patterns, parent/family mental health, parents' history of trauma, social network	Neighborhood quality, school system and/or work environment, behavioral health system quality and accessibility, faith-based settings, transportation availability, community socioeconomic status, community employment rates	Laws, State and Federal economic and social policies, media, societal norms, judicial system	Collective or individualistic cultural norms, ethnicity, cultural subsystem norms, cognitive and maturational development	Societal attitudes related to military service members' homecomings, changes in diagnostic understanding between DSM-III-R* and DSM-5**

**Diagnostic and Statistical Manual of Mental Disorders,* Third Edition, Revised (American Psychiatric Association [APA], 1987)

***Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (APA, 2013a)

Case Illustration: Marisol

Marisol is a 28-year-old Latina woman working as a barista at a local coffee shop. One evening, she was driving home in the rain when a drunk driver crossed into her lane and hit her head on. Marisol remained conscious as she waited to be freed from the car and was then transported to the hospital. She sustained fractures to both legs. Her recovery involved two surgeries and nearly 6 months of rehabilitation, including initial hospitalization and outpatient physical therapy.

She described her friends and family as very supportive, saying that they often foresaw what she needed before she had to ask. She added that she had an incredible sense of gratitude for her employer and coworkers, who had taken turns visiting and driving her to appointments. Although she was able to return to work after 9 months, Marisol continued experiencing considerable distress about her inability to sleep well, which started just after the accident. Marisol describes repetitive dreams and memories of waiting to be transported to the hospital after the crash. The other driver was charged with driving under the influence (DUI), and it was reported that he had been convicted two other times for a DUI misdemeanor.

Answering the following questions will help you see how the different levels of influence affect the impact and outcome of the traumatic event Marisol experienced, as well as her responses to that event:

1. Based on the limited information provided in this illustration, how might Marisol's personality affect the responses of her family and friends, her coworkers, and the larger community?
2. In what ways could Marisol's ethnic and cultural background influence her recovery?
3. What societal factors could play a role in the car crash itself and the outcomes for Marisol and the other driver?

Explore the influence of the period of time in history during which the scenario occurs—compare the possible outcomes for both Marisol and the other driver if the crash occurred 40 years ago versus in the present day.

strategies; and ways of providing hope and promoting recovery.

Minimize the Risk of Retraumatization or Replicating Prior Trauma Dynamics

Trauma-informed treatment providers acknowledge that clients who have histories of trauma may be more likely to experience particular treatment procedures and practices as negative, reminiscent of specific characteristics of past trauma or abuse, or retraumatizing—feeling as if the past trauma is reoccurring or as if the treatment experience is as dangerous and unsafe as past traumas. For instance, clients may express feelings of powerlessness or being trapped if they are not actively involved in treatment decisions; if treatment processes or providers mirror specific behavior from the clients' past experiences with trauma, they may voice distress or respond in the same way as they did to the original trauma. Among the potentially retraumatizing elements of treatment are seclusion or "time-out" practices that isolate individuals, mislabeling client symptoms as personality or other mental disorders rather than as traumatic stress reactions, interactions that command authority, treatment assignments that could humiliate clients (such as asking a client to wear a sign in group that reflects one of their treatment issues, even if the assignment centers on positive attributes of the client), confronting clients as resistant, or presenting treatment as conditional upon conformity to the provider's beliefs and definitions of issues.

Clients' experiences are unique to the specific traumas they have faced and the surrounding

circumstances before, during, and after that trauma, so remember that even seemingly safe and standard treatment policies and procedures, including physical plant operations (e.g., maintenance, grounds, fire and safety procedures), may feel quite the contrary for a client if one or more of those elements is reminiscent of his or her experience of trauma in some way. Examples include having limited privacy or personal space, being interviewed in a room that feels too isolating or confining, undergoing physical examination by a medical professional of the same sex as the client's previous perpetrator of abuse, attending a group session in which another client expresses anger appropriately in a role play, or being directed not to talk about distressing experiences as a means of deescalating traumatic stress reactions.

Although some treatment policies or procedures are more obviously likely to solicit distress than others, *all* standard practices should be evaluated for their potential to retraumatize a client; this cannot be done without knowing the specific features of the individual's history of trauma. Consider, for instance, a treatment program that serves meals including entrees that combine more than one food group. Your client enters this program and refuses to eat most of the time; he expresses anger toward dietary staff and claims that food choices are limited. You may initially perceive your client's refusal to eat or to avoid certain foods as an eating disorder or a behavioral problem. However, a trauma-aware perspective might change your assumptions; consider that this client experienced neglect and abuse surrounding food throughout childhood (his mother forced him to eat meals prepared by combining anything in the refrigerator and cooking them together).

Advice to Counselors and Administrators: Sending the Right Message About Trauma

How often have you heard "We aren't equipped to handle trauma" or "We don't have time to deal with reactions that surface if traumatic experiences are discussed in treatment" from counselors and administrators in behavioral health services? For agencies, staff members, and clients, these statements present many difficulties and unwanted outcomes. For a client, such comments may replicate his or her earlier encounters with others (including family, friends, and previous behavioral health professionals) who had difficulty acknowledging or talking about traumatic experiences with him or her. A hands-off approach to trauma can also reinforce the client's own desire to avoid such discussions. Even when agencies and staff are motivated in these sentiments by a good intention—to contain clients' feelings of being overwhelmed—such a perspective sends strong messages to clients that their experiences are not important, that they are not capable of handling their trauma-associated feelings, and that dealing with traumatic experiences is simply too dangerous. Statements like these imply that recovery is not possible and provide no structured outlet to address memories of trauma or traumatic stress reactions.

Nevertheless, determining how and when to address traumatic stress in behavioral health services can be a real dilemma, especially if there are no trauma-specific philosophical, programmatic, or procedural processes in place. For example, it is difficult to provide an appropriate forum for a client to address past traumas if no forethought has been given to developing interagency and intra-agency collaborations for trauma-specific services. By anticipating the need for trauma-informed services and planning ahead to provide appropriate services to people who are affected by trauma, behavioral health service providers and program administrators can begin to develop informed intervention strategies that send a powerful, positive message:

- Both clients and providers can competently manage traumatic experiences and reactions.
- Providers are interested in hearing clients' stories and attending to their experiences.
- Recovery is possible.

As a treatment provider, you cannot consistently predict what may or may not be upsetting or retraumatizing to clients. Therefore, it is important to maintain vigilance and an attitude of curiosity with clients, inquiring about the concerns that they express and/or present in treatment. Remember that certain behaviors or emotional expressions can reflect what has happened to them in the past.

Foremost, a trauma-informed approach begins with taking practical steps to reexamine treatment strategies, program procedures, and organizational polices that could solicit distress or mirror common characteristics of traumatic experiences (loss of control, being trapped, or feeling disempowered). To better anticipate the interplay between various treatment elements and the more idiosyncratic aspects of a particular client's trauma history, you can:

- Work with the client to learn the cues he or she associates with past trauma.
- Obtain a good history.
- Maintain a supportive, empathetic, and collaborative relationship.
- Encourage ongoing dialog.
- Provide a clear message of availability and accessibility throughout treatment.

In sum, trauma-informed providers anticipate and respond to potential practices that may be perceived or experienced as retraumatizing to clients; they are able to forge new ways to respond to specific situations that trigger a trauma-related response, and they can provide clients with alternative ways of engaging in a particularly problematic element of treatment.

Create a Safe Environment

The need to create a safe environment is not new to providers; it involves an agency-wide effort supported by effective policies and procedures. However, creating safety within a trauma-informed framework far exceeds the standard expectations of physical plant safety (e.g., facility, environmental, and space-related concerns), security (of staff members, clients, and personal property), policies and procedures (including those specific to seclusion and restraint), emergency management and disaster planning, and adherence to client rights. Providers must be responsive and adapt the environment to establish and support clients' sense of physical and emotional safety.

Beyond anticipating that various environmental stimuli within a program may generate strong emotions and reactions in a trauma survivor (e.g., triggers such as lighting, access to exits, seating arrangements, emotionality within a group, or visual or auditory stimuli) and implementing strategies to help clients cope with triggers that evoke their experiences with trauma, other key elements in establishing a safe environment include consistency in client interactions and treatment processes, following through with what has been reviewed or agreed upon in sessions or meetings, and dependability. Mike's case illustration depicts ways in which the absence of these key elements could erode a client's sense of safety during the treatment process.

Neither providers nor service processes are always perfect. Sometimes, providers

Case Illustration: Mike

From the first time you provide outpatient counseling to Mike, you explain that he can call an agency number that will put him in direct contact with someone who can provide further assistance or support if he has emotional difficulty after the session or after agency hours. However, when he attempts to call one night, no one is available despite what you've described. Instead, Mike is directed by an operator to either use his local emergency room if he perceives his situation to be a crisis or to wait for someone on call to contact him. The inconsistency between what you told him in the session and what actually happens when he calls makes Mike feel unsafe and vulnerable.

unintentionally relay information inaccurately or inconsistently to clients or other staff members; other times, clients mishear something, or extenuating circumstances prevent providers from responding as promised. Creating safety is not about getting it right all the time; it's about how consistently and forthrightly you handle situations with a client when circumstances provoke feelings of being vulnerable or unsafe. Honest and compassionate communication that conveys a sense of handling the situation together generates safety. It is equally important that safety extends beyond the client. Counselors and other behavioral health staff members, including peer support specialists, need to be able to count on the agency to be responsive to and maintain their safety within the environment as well. By incorporating an organizational ethos that recognizes the importance of practices that promote physical safety and emotional well-being, behavioral health staff members may be more likely to seek support and supervision when needed and to comply with clinical and programmatic practices that minimize risks for themselves and their clients.

Beyond an attitudinal promotion of safety, organizational leaders need to consider and create avenues of professional development and assistance that will give their staff the means to seek support and process distressing circumstances or events that occur within the agency or among their clientele, such as case consultation and supervision, formal or informal processes to debrief service providers about difficult clinical issues, and referral processes for client psychological evaluations and employee assistance for staff. Organizational practices are only effective if supported by unswerving trauma awareness, training, and education among staff. Jane's case illustration shows the impact of a minor but necessary postponement in staff orientation for a new hire—not an unusual circumstance in behavioral health programs that have heavy caseloads and high staff turnover.

Identify Recovery From Trauma as a Primary Goal

Often, people who initiate or are receiving mental health or substance abuse services don't identify their experiences with trauma as a significant factor in their current challenges or problems. In part, this is because people who have been exposed to trauma, whether once or repeatedly, are generally reluctant to revisit it. They may already feel stuck in repetitive memories or experiences, which may add to their existing belief that any intervention will make matters worse or, at least, no better. For some clients, any introduction to their trauma-related memories or minor cues reminiscent of the trauma will cause them to experience strong, quick-to-surface emotions, supporting their belief that addressing trauma is dangerous and that they won't be able to handle the

Case Illustration: Jane

Jane, a newly hired female counselor, had a nephew who took his own life. The program that hired her was short of workers at the time; therefore, Jane did not have an opportunity to engage sufficiently in orientation outside of reviewing the policies and procedure manual. In an attempt to present well to her new employer and supervisor, she readily accepted client assignments without considering her recent loss. By not immersing herself in the program's perspective and policies on staff well-being, ethical and clinical considerations in client assignments, and how and when to seek supervision, Jane failed to engage in the practices, heavily supported by the agency, that promoted safety for herself and her clients. Subsequently, she felt emotionally overwhelmed at work and would often abruptly request psychiatric evaluation for clients who expressed any feelings of hopelessness out of sheer panic that they would attempt suicide.

emotions or thoughts that result from attempting to do so. Others readily view their experiences of trauma as being in the past; as a result, they engage in distraction, dissociation, and/or avoidance (as well as adaptation) due to a belief that trauma has little impact on their current lives and presenting problems. Even individuals who are quite aware of the impact that trauma has had on their lives may still struggle to translate or connect how these events continue to shape their choices, behaviors, and emotions. Many survivors draw no connection between trauma and their mental health or substance abuse problems, which makes it more difficult for them to see the value of trauma-informed or trauma-specific interventions, such as creating safety, engaging in psychoeducation, enhancing coping skills, and so forth.

As a trauma-informed provider, it is important that you help clients bridge the gap between their mental health and substance-related issues and the traumatic experiences they may have had. All too often, trauma occurs before substance use and mental disorders develop; then, such disorders and their associated symptoms and consequences create opportunities for additional traumatic events to occur. If individuals engage in mental health and substance abuse treatment without addressing the role that trauma has played in their lives, they are less likely to experience recovery in the long run. For example, a person with a history of trauma is more likely to have anxiety and depressive symptoms, use substances to self-medicate, and/or relapse after exposure to trauma-related cues. Thus, collaboration within and between behavioral health agencies is necessary to make integrated, timely, trauma-specific interventions available from the beginning to clients/consumers who engage in substance abuse and mental health services.

Support Control, Choice, and Autonomy

Not every client who has experienced trauma and is engaged in behavioral health services wants, or sees the need for, trauma-informed or trauma-specific treatment. Clients may think that they've already dealt with their trauma adequately, or they may believe that the effects of past trauma cause minimal distress for them. Other clients may voice the same sentiments, but without conviction—instead using avoidant behavior to deter distressing symptoms or reactions. Still others may struggle to see the role of trauma in their presenting challenges, not connecting their past traumatic experiences with other, more current difficulties (e.g., using substances to self-medicate strong emotions). Simply the idea of acknowledging trauma-related experiences and/or stress reactions may be too frightening or overwhelming for some clients, and others may fear that their reactions will be dismissed. On the other hand, some individuals want so much to dispense with their traumatic experiences and reactions that they hurriedly and repeatedly disclose their experiences before establishing a sufficiently safe environment or learning effective coping strategies to offset distress and other effects of retraumatization.

As these examples show, not everyone affected by trauma will approach trauma-informed services or recognize the impact of trauma in their lives in the same manner. This can be challenging to behavioral health service providers who are knowledgeable about the impact of trauma and who perceive the importance of addressing trauma and its effects with clients. As with knowing that different clients may be at different levels of awareness or stages of change in substance abuse treatment services, you should acknowledge that people affected by trauma

present an array of reactions, various levels of trauma awareness, and different degrees of urgency in their need to address trauma.

Appreciating clients' perception of their presenting problems and viewing their responses to the impact of trauma as adaptive—even when you believe their methods of dealing with trauma to be detrimental—are equally important elements of TIC. By taking the time to engage with clients and understand the ways they have perceived, adjusted to, and responded to traumatic experiences, providers are more likely to project the message that clients possess valuable personal expertise and knowledge about their own presenting problems. This shifts the viewpoint from "Providers know best" to the more collaborative "Together, we can find solutions."

How often have you heard from clients that they don't believe they can handle symptoms that emerge from reexperiencing traumatic cues or memories? Have you ever heard clients state that they can't trust themselves or their reactions, or that they never know when they are going to be triggered or how they are going to react? How confident would you feel about yourself if, at any time, a loud noise could initiate an immediate attempt to hide, duck, or dive behind something? Traumatic experiences have traditionally been described as exposure to events that cause intense fear, helplessness, horror, or feelings of loss of control. Participation in behavioral health services should not mirror these aspects of traumatic experience. Working collaboratively to facilitate clients' sense of control and to maximize clients' autonomy and choices throughout the treatment process, including treatment planning, is crucial in trauma-informed services.

For some individuals, gaining a sense of control and empowerment, along with understanding traumatic stress reactions, may be pivotal ingredients for recovery. By creating opportunities for empowerment, counselors and other behavioral health service providers help reinforce, clients' sense of competence, which is often eroded by trauma and prolonged traumatic stress reactions. Keep in mind that treatment strategies and procedures that prioritize client choice and control need not focus solely on major life decisions or treatment planning; you can apply such approaches to common tasks and everyday interactions between staff and consumers. Try asking your clients some of the following questions (which are only a sample of the types of questions that could be useful):

- What information would be helpful for us to know about what happened to you?
- Where/when would you like us to call you?
- How would you like to be addressed?
- Of the services I've described, which seem to match your present concerns and needs?
- From your experience, what responses from others appear to work best when you feel overwhelmed by your emotions?

Likewise, organizations need to reinforce the importance of staff autonomy, choice, and sense of control. What resources can staff members access, and what choices are available to them, in processing emotionally charged content or events in treatment? How often do administrators and supervisors seek out feedback on how to handle problematic situations (e.g., staff rotations for vacations, case consultations, changes in scheduling)? Think about the parallel between administration and staff members versus staff members and clients; often, the same philosophy, attitudes, and behaviors conveyed to staff members by administrative practices are mirrored in staff–client interactions. Simply stated, if staff members do not feel empowered, it will be a challenge for them to value the need for client empowerment. (For more information on administrative and workforce development issues, refer to Part 2, Chapters 1 and 2.)

Case Illustration: Mina

Mina initially sought counseling after her husband was admitted to an intensive outpatient drug and alcohol program. She was self-referred for low-grade depression, resentment toward her spouse, and codependency. When asked to define "codependency" and how the term applied to her, she responded that she always felt guilty and responsible for everyone in her family and for events that occurred even when she had little or no control over them.

After the intake and screening process, she expressed interest in attending group sessions that focused primarily on family issues and substance abuse, wherein her presenting concerns could be explored. In addition to describing dynamics and issues relating to substance abuse and its impact on her marriage, she referred to her low mood as frozen grief. During treatment, she reluctantly began to talk about an event that she described as life changing: the loss of her father. The story began to unfold in group; her father, who had been 62 years old, was driving her to visit a cousin. During the ride, he had a heart attack and drove off the road. As the car came to stop in a field, she remembered calling 911 and beginning cardiopulmonary resuscitation while waiting for the ambulance. She rode with the paramedics to the hospital, watching them work to save her father's life; however, he was pronounced dead soon after arrival.

She always felt that she never really said goodbye to her father. In group, she was asked what she would need to do or say to feel as if she had revisited that opportunity. She responded in quite a unique way, saying, "I can't really answer this question; the lighting isn't right for me to talk about my dad." The counselor encouraged her to adjust the lighting so that it felt "right" to her. Being invited to do so turned out to be pivotal in her ability to address her loss and to say goodbye to her father on her terms. She spent nearly 10 minutes moving the dimmer switch for the lighting as others in the group patiently waited for her to return to her chair. She then began to talk about what happened during the evening of her father's death, their relationship, the events leading up to that evening, what she had wanted to say to him at the hospital, and the things that she had been wanting to share with him since his death.

Weeks later, as the group was coming to a close, each member spoke about the most important experiences, tools, and insights that he or she had taken from participating. Mina disclosed that the group helped her establish boundaries and coping strategies within her marriage, but said that the event that made the most difference for her had been having the ability to adjust the lighting in the room. She explained that this had allowed her to control something over which she had been powerless during her father's death. To her, the lighting had seemed to stand out more than other details at the scene of the accident, during the ambulance ride, and at the hospital. She felt that the personal experience of losing her father and needing to be with him in the emergency room was marred by the obtrusiveness of staff, procedures, machines, and especially, the harsh lighting. She reflected that she now saw the lighting as a representation of this tragic event and the lack of privacy she had experienced when trying to say goodbye to her father. Mina stated that this moment in group had been the greatest gift: "…to be able to say my goodbyes the way I wanted… I was given an opportunity to have some control over a tragic event where I couldn't control the outcome no matter how hard I tried."

Create Collaborative Relationships and Participation Opportunities

This trauma-informed principle encompasses three main tenets. First, **ensure that the provider–client relationship is collaborative**, regardless of setting or service. Agency staff members cannot make decisions pertaining to interventions or involvement in community services autocratically; instead, they should develop trauma-informed, individualized care plans and/or treatment plans collaboratively with the client and, when appropriate, with family and caregivers. The nonauthoritarian approach that characterizes TIC views clients

as the experts in their own lives and current struggles, thereby emphasizing that clients and providers can learn from each other.

The second tenet is to **build collaboration beyond the provider–client relationship**. Building ongoing relationships across the service system, provider networks, and the local community enhances TIC continuity as clients move from one level of service to the next or when they are involved in multiple services at one time. It also allows you to learn about resources available to your clients in the service system or community and to connect with providers who have more advanced training in trauma-specific interventions and services.

The third tenet emphasizes the need to **ensure client/consumer representation and participation in behavioral health program development, planning, and evaluation as well as in the professional development of behavioral health workers**. To achieve trauma-informed competence in an organization or across systems, clients need to play an active role; this starts with providing program feedback. However, consumer involvement should not end there; rather, it should be encouraged throughout the implementation of trauma-informed services. So too, clients, potential clients, their families, and the community should be invited to participate in forming any behavioral health organization's plans to improve trauma-informed competence, provide TIC, and design relevant treatment services and organizational policies and procedures.

Trauma-informed principles and practices generated without the input of people affected by trauma are difficult to apply effectively. Likewise, staff trainings and presentations should include individuals who have felt the impact of trauma. Their participation reaches past the purely cognitive aspects of such education to offer a personal perspective on the strengths and resilience of people who have experienced trauma. The involvement of trauma survivors in behavioral health education lends a human face to subject matter that is all too easily made cerebral by some staff members in an attempt to avoid the emotionality of the topic.

Consumer participation also means giving clients/consumers the chance to obtain State training and certification, as well as employment in behavioral health settings as peer specialists. Programs that incorporate peer support services reinforce a powerful message—that provider–consumer partnership is important, and that consumers are valued. Peer support specialists are self-identified individuals who have progressed in their own recovery from alcohol dependence, drug addiction, and/or a mental disorder and work within behavioral health programs or at peer support centers to assist others with similar disorders and/or life experiences. Tasks and responsibilities may include leading a peer support group; modeling effective coping, help-seeking, and self-care strategies; helping clients practice new skills or monitor progress; promoting positive self-image to combat clients' potentially negative feelings about themselves and the discrimination they may perceive in the program or community; handling case management tasks; advocating for program changes; and representing a voice of hope that views recovery as possible.

Familiarize the Client With Trauma-Informed Services

Without thinking too much about it, you probably know the purpose of an intake process, the correct way to complete a screening device, the meaning of a lot of the jargon specific to behavioral health, and your program's expectations for client participation; in fact, maybe you're already involved in facilitating these processes in behavioral health services every day, and they've become almost

automatic for you. This can make it easy to forget that nearly everything clients and their families encounter in seeking behavioral health assistance is new to them. Thus, introducing clients to program services, activities, and interventions in a manner that *expects* them to be unfamiliar with these processes is essential, regardless of their clinical and treatment history. Beyond addressing the unfamiliarity of services, educating clients about each process—from first contact all the way through recovery services—gives them a chance to participate actively and make informed decisions across the continuum of care.

Familiarizing clients with trauma-informed services extends beyond explaining program services or treatment processes; it involves explaining the value and type of trauma-related questions that may be asked during an intake process, educating clients about trauma to help normalize traumatic stress reactions, and discussing trauma-specific interventions and other available services (including explanations of treatment methodologies and of the rationale behind specific interventions). Developmentally appropriate psychoeducation about trauma-informed services allows clients to be informed participants.

Incorporate Universal Routine Screenings for Trauma

Screening universally for client histories, experiences, and symptoms of trauma at intake can benefit clients and providers. Most providers know that clients can be affected by trauma, but universal screening provides a steady reminder to be watchful for past traumatic experiences and their potential influence upon a client's interactions and engagement with services across the continuum of care. Screening should guide treatment planning; it alerts the staff to potential issues and serves as a valuable tool to increase clients' awareness of the possible impact of trauma and the importance of addressing related issues during treatment.

Nonetheless, screenings are only as useful as the guidelines and processes established to address positive screens (which occur when clients respond to screening questions in a way that signifies possible trauma-related symptoms or histories). Staff should be trained to use screening tools consistently so that all clients are screened in the same way. Staff members also need to know how to score screenings and when specific variables (e.g., race/ethnicity, native language, gender, culture) may influence screening results. For example, a woman who has been sexually assaulted by a man may be wary of responding to questions if a male staff member or interpreter administers the screening or provides translation services. Likewise, a person in a current abusive or violent relationship may not acknowledge the interpersonal violence in fear of retaliation or as a result of disconnection or denial of his or her experience, and he or she may have difficulty in processing and then living between two worlds—what is acknowledged in treatment versus what is experienced at home.

In addition, staff training on using trauma-related screening tools needs to center on how and when to gather relevant information after the screening is complete. Organizational policies and procedures should guide staff members on how to respond to a positive screening, such as by making a referral for an indepth assessment of traumatic stress, providing the client with an introductory psychoeducational session on the typical biopsychosocial effects of trauma, and/or coordinating care so that the client gains access to trauma-specific services that meet his or her needs. Screening tool selection is an important ingredient in incorporating routine, universal screening practices into behavioral health services. Many screening tools are available, yet they differ in format

and in how they present questions. Select tools based not just on sound test properties, but also according to whether they encompass a broad range of experiences typically considered traumatic and are flexible enough to allow for an individual's own interpretation of traumatic events. For more information on screening and assessment of trauma and trauma-related symptoms and effects, see Chapter 4, "Screening and Assessment," in this TIP.

View Trauma Through a Sociocultural Lens

To understand how trauma affects an individual, family, or community, you must first understand life experiences and cultural background as key contextual elements for that trauma. As demonstrated in Exhibit 1.1-2, many factors shape traumatic experiences and individual and community responses to it; one of the most significant factors is culture. It influences the interpretation and meaning of traumatic events, individual beliefs regarding personal responsibility for the trauma and subsequent responses, and the meaning and acceptability of symptoms, support, and help-seeking behaviors. As this TIP proceeds to describe the differences among cultures pertaining to trauma, remember that there are numerous cross-cutting factors that can directly or indirectly influence the attitudes, beliefs, behaviors, resources, and opportunities within a given culture, subculture, or racial and/or ethnic group (Exhibit 1.1-4). For an indepth

Exhibit 1.1-4: Cross-Cutting Factors of Culture

Culture and Trauma

- Some populations and cultures are more likely than others to experience a traumatic event or a specific type of trauma.
- Rates of traumatic stress are high across all diverse populations and cultures that face military action and political violence.
- Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma.
- Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life.
- Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behavior, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased.
- Traumatic stress symptoms vary according to the type of trauma within the culture.
- Culture affects what qualifies as a legitimate health concern and which symptoms warrant help.
- In addition to shaping beliefs about acceptable forms of help-seeking behavior and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.

exploration of these cross-cutting cultural factors, refer to the planned TIP, *Improving Cultural Competence* (SAMHSA, planned c).

When establishing TIC, it is vital that behavioral health systems, service providers, licensing agencies, and accrediting bodies build culturally responsive practices into their curricula, standards, policies and procedures, and credentialing processes. The implementation of culturally responsive practices will further guide the treatment planning process so that trauma-informed services are more appropriate and likely to succeed.

Use a Strengths-Focused Perspective: Promote Resilience

Fostering individual strengths is a key step in prevention when working with people who have been exposed to trauma. It is also an essential intervention strategy—one that builds on the individual's existing resources and views him or her as a resourceful, resilient survivor. Individuals who have experienced trauma develop many strategies and/or behaviors to adapt to its emotional, cognitive, spiritual, and physical consequences. Some behaviors may be effective across time, whereas others may eventually produce difficulties and disrupt the healing process. Traditionally, behavioral health services have tended to focus on presenting problems, risk factors, and symptoms in an attempt to prevent negative outcomes, provide relief, increase clients' level of functioning, and facilitate healing. However, focusing too much on these areas can undermine clients' sense of competence and hope. Targeting only presenting problems and symptoms does not provide individuals with an opportunity to see their own resourcefulness in managing very stressful and difficult experiences. It is important for providers to engage in interventions using a balanced approach that targets the strengths clients have

> "Trauma informed care recognizes symptoms as originating from adaptations to the traumatic event(s) or context. Validating resilience is important even when past coping behaviors are now causing problems. Understanding a symptom as an adaptation reduces a survivor's guilt and shame, increases their self esteem and provides a guideline for developing new skills and resources to allow new and better adaptation to the current situation."
>
> (Elliot et al., 2005, p. 467)

Advice to Counselors and Administrators: Using Strengths-Oriented Questions

Knowing a client's strengths can help you understand, redefine, and reframe the client's presenting problems and challenges. By focusing and building on an individual's strengths, counselors and other behavioral health professionals can shift the focus from "What is wrong with you?" to "What has worked for you?" It moves attention away from trauma-related problems and toward a perspective that honors and uses adaptive behaviors and strengths to move clients along in recovery.

Potential strengths-oriented questions include:

- The history that you provided suggests that you've accomplished a great deal since the trauma. What are some of the accomplishments that give you the most pride?
- What would you say are your strengths?
- How do you manage your stress today?
- What behaviors have helped you survive your traumatic experiences (during and afterward)?
- What are some of the creative ways that you deal with painful feelings?
- You have survived trauma. What characteristics have helped you manage these experiences and the challenges that they have created in your life?
- If we were to ask someone in your life, who knew your history and experience with trauma, to name two positive characteristics that help you survive, what would they be?
- What coping tools have you learned from your _____ (fill in: cultural history, spiritual practices, athletic pursuits, etc.)?
- Imagine for a moment that a group of people are standing behind you showing you support in some way. Who would be standing there? It doesn't matter how briefly or when they showed up in your life, or whether or not they are currently in your life or alive.
- How do you gain support today? (Possible answers include family, friends, activities, coaches, counselors, other supports, etc.)
- What does recovery look like for you?

developed to survive their experiences and to thrive in recovery. A strengths-based, resilience-minded approach lets trauma survivors begin to acknowledge and appreciate their fortitude and the behaviors that help them survive.

Foster Trauma-Resistant Skills

Trauma-informed services build a foundation on which individuals can begin to explore the role of trauma in their lives; such services can also help determine how best to address and tailor interventions to meet their needs. Prevention, mental health, and substance abuse treatment services should include teaching clients about how trauma can affect their lives; these services should also focus on developing self-care skills, coping strategies, supportive networks, and a sense of competence. Building trauma-resistant skills begins with normalizing the symptoms of traumatic stress and helping clients who have experienced trauma connect the dots between current problems and past trauma when appropriate.

Nevertheless, TIC and trauma-specific interventions that focus on skill-building should not do so at the expense of acknowledging individual strengths, creativity in adapting to trauma, and inherent attributes and tools clients possesses to combat the effects of trauma. Some theoretical models that use skill-building strategies base the value of this approach on a deficit perspective; they assume that some individuals lack the necessary tools to manage specific situations and, because of this deficiency, they encounter problems that others with effective skills would not experience. This type of perspective further assumes that, to recover, these individuals must learn new coping skills and behavior. TIC, on the other hand, makes the assumption that clients

Advice to Administrators: Self-Assessment for Trauma-Informed Systems

NCTIC has developed a self-assessment package for trauma-informed systems to help administrators structurally incorporate trauma into programs and services. The self-assessment can be used by systems of care to guide quality improvement with the goal of establishing fully trauma-informed treatment and recovery efforts (NCTIC, Center for Mental Health Services, 2007). Behavioral health treatment program administrators can use these materials and NCTIC as resources for improvement in delivering TIC.

are the experts in their own lives and have learned to adapt and acquire skills to survive. The TIC approach honors each individual's adaptations and acquired skills, and it helps clients explore how these may not be working as well as they had in the past and how their current repertoire of responses may not be as effective as other strategies.

Demonstrate Organizational and Administrative Commitment to TIC

Becoming a trauma-informed organization requires administrative guidance and support across all levels of an agency. Behavioral health staff will not likely sustain TIC practices without the organization's ongoing commitment to support professional development and to allocate resources that promote these practices. An agency that wishes to commit to TIC will benefit from an organizational assessment of how staff members identify and manage trauma and trauma-related reactions in their clients. Are they trauma aware—do they recognize that trauma can significantly affect a client's ability to function in one or more areas of his or her life? Do the staff members understand that traumatic experiences and trauma-related reactions can greatly influence clients' engagement, participation, and response to services?

Agencies need to embrace specific strategies across each level of the organization to create trauma-informed services; this begins with staff education on the impact of trauma among clients. Other agency strategies that reflect a trauma-informed infrastructure include, but are not limited to:

- Universal screening and assessment procedures for trauma.
- Interagency and intra-agency collaboration to secure trauma-specific services.
- Referral agreements and networks to match clients' needs.
- Mission and value statements endorsing the importance of trauma recognition.
- Consumer- and community-supported committees and trauma response teams.
- Workforce development strategies, including hiring practices.
- Professional development plans, including staff training/supervision focused on TIC.
- Program policies and procedures that ensure trauma recognition and secure trauma-informed practices, trauma-specific services, and prevention of retraumatization.

TIC requires organizational commitment, and often, cultural change. For more information on implementing TIC in organizations, see Part 2, Chapter 1 of this TIP.

Develop Strategies To Address Secondary Trauma and Promote Self-Care

Secondary trauma is a normal occupational hazard for mental health and substance abuse professionals, particularly those who serve populations that are likely to include survivors of trauma (Figley, 1995; Klinic Community Health Centre, 2008). Behavioral health staff members who experience secondary trauma present a range of traumatic stress reactions

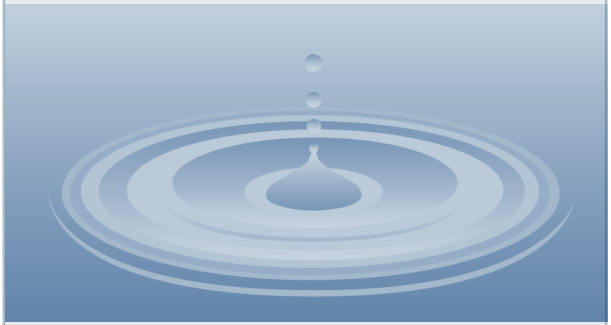
and effects from providing services focused on trauma or listening to clients recount traumatic experiences. So too, when a counselor has a history of personal trauma, working with trauma survivors may evoke memories of the counselor's own trauma history, which may increase the potential for secondary traumatization.

The range of reactions that manifest with secondary trauma can be, but are not necessarily, similar to the reactions presented by clients who have experienced primary trauma. Symptoms of secondary trauma can produce varying levels of difficulty, impairment, or distress in daily functioning; these may or may not meet diagnostic thresholds for acute stress, posttraumatic stress, or adjustment, anxiety, or mood disorders (Bober & Regehr, 2006). Symptoms may include physical or psychological reactions to traumatic memories clients have shared; avoidance behaviors during client interactions or when recalling emotional content in supervision; numbness, limited emotional expression, or diminished affect; somatic complaints; heightened arousal, including insomnia; negative thinking or depressed mood; and detachment from family, friends, and other supports (Maschi & Brown, 2010).

Working daily with individuals who have been traumatized can be a burden for counselors and other behavioral health service providers, but all too often, they blame the symptoms resulting from that burden on other stressors at work or at home. Only in the past 2 decades have literature and trainings begun paying attention to secondary trauma or compassion fatigue; even so, agencies often do not translate this knowledge into routine prevention practices. Counselors and other staff members may find it difficult to engage in activities that could ward off secondary trauma due to time constraints, workload, lack of agency resources, and/or an organizational culture that disapproves of help-seeking or provides inadequate staff support. The demands of providing care to trauma survivors cannot be ignored, lest the provider become increasingly impaired and less effective. Counselors with unacknowledged secondary trauma can cause harm to clients via poorly enforced boundaries, missed appointments, or even abandonment of clients and their needs (Pearlman & Saakvitne, 1995).

Essential components of TIC include organizational and personal strategies to address

The Impact of Trauma



Trauma is similar to a rock hitting the water's surface. The impact first creates the largest wave, which is followed by ever-expanding, but less intense, ripples. Likewise, the influence of a given trauma can be broad, but generally, its effects are less intense for individuals further removed from the trauma; eventually, its impact dissipates all around. For trauma survivors, the impact of trauma can be far-reaching and can affect life areas and relationships long after the trauma occurred. This analogy can also broadly describe the recovery process for individuals who have experienced trauma and for those who have the privilege of hearing their stories. As survivors reveal their trauma-related experiences and struggles to a counselor or another caregiver, the trauma becomes a shared experience, although it is not likely to be as intense for the caregiver as it was for the individual who experienced the trauma. The caregiver may hold onto the trauma's known and unknown effects or may consciously decide to engage in behaviors that provide support to further dissipate the impact of this trauma and the risk of secondary trauma.

Advice to Counselors: Decreasing the Risk of Secondary Trauma and Promoting Self-Care

- **Peer support.** Maintaining adequate social support will help prevent isolation and depression.
- **Supervision and consultation.** Seeking professional support will enable you to understand your own responses to clients and to work with them more effectively.
- **Training.** Ongoing professional training can improve your belief in your abilities to assist clients in their recoveries.
- **Personal therapy.** Obtaining treatment can help you manage specific problems and become better able to provide good treatment to your clients.
- **Maintaining balance.** A healthy, balanced lifestyle can make you more resilient in managing any difficult circumstances you may face.
- **Setting clear limits and boundaries with clients.** Clearly separating your personal and work life allows time to rejuvenate from stresses inherent in being a professional caregiver.

secondary trauma and its physical, cognitive, emotional, and spiritual consequences. In agencies and among individual providers, it is key for the culture to promote acceptability, accessibility, and accountability in seeking help, accessing support and supervision, and engaging in self-care behaviors in and outside of the agency or office. Agencies should involve staff members who work with trauma in developing informal and formal agency practices and procedures to prevent or address secondary trauma. Even though a number of community-based agencies face fiscal constraints, prevention strategies for secondary trauma can be intertwined with the current infrastructure (e.g., staff meetings, education, case consultations and group case discussions, group support, debriefing sessions as appropriate, supervision). For more information on strategies to address and prevent secondary trauma, see Part 2, Chapter 2 of this TIP.

Provide Hope—Recovery Is Possible

What defines recovery from trauma-related symptoms and traumatic stress disorders? Is it the total absence of symptoms or consequences? Does it mean that clients stop having nightmares or being reminded, by cues, of past trauma? When clients who have experienced trauma enter into a helping relationship to address trauma specifically, they are often looking for a cure, a remission of symptoms, or relief from the pain as quickly as possible. However, they often possess a history of unpredictable symptoms and symptom intensity that reinforces an underlying belief that recovery is not possible. On one hand, clients are looking for a message that they can be cured, while on the other hand, they have serious doubts about the likely success of any intervention.

Clients often express ambivalence about dealing with trauma even if they are fully aware of trauma's effects on their lives. The idea of living with more discomfort as they address the past or as they experiment with alternative ways of dealing with trauma-related symptoms or consequences is not an appealing prospect, and it typically elicits fear. Clients may interpret the uncomfortable feelings as dangerous or unsafe even in an environment and relationship that is safe and supportive.

How do you promote hope and relay a message that recovery is possible? First, maintain consistency in delivering services, promoting and providing safety for clients, and showing respect and compassion within the client–provider relationship. Along with clients' commitment to learning how to create safety for themselves, counselors and agencies need

to be aware of, and circumvent, practices that could retraumatize clients. Projecting hope and reinforcing the belief that recovery is possible extends well beyond the practice of establishing safety; it also encompasses discussing what recovery means and how it looks to clients, as well as identifying how they will know that they've entered into recovery in earnest.

Providing hope involves projecting an attitude that recovery is possible. This attitude also involves viewing clients as competent to make changes that will allow them to deal with trauma-related challenges, providing opportunities for them to practice dealing with difficult situations, and normalizing discomfort or difficult emotions and framing these as manageable rather than dangerous. If you convey this attitude consistently to your clients, they will begin to understand that discomfort is not a signal to avoid, but a sign to engage—and that behavioral, cognitive, and emotional responses to cues associated with previous traumas are a normal part of the recovery process. It's not the absence of responses to such triggers that mark recovery, but rather, how clients experience and manage those responses. Clients can also benefit from interacting with others who are further along in their recovery from trauma. Time spent with peer support staff or sharing stories with other trauma survivors who are well on their way to recovery is invaluable—it sends a powerful message that recovery is achievable, that there is no shame in being a trauma survivor, and that there is a future beyond the trauma.

As You Proceed

This chapter has established the foundation and rationale of this TIP, reviewed trauma-informed concepts and terminology, and provided an overview of TIC principles and a guiding framework for this text. As you proceed, be aware of the wide-ranging responses to trauma that occur not only across racially and ethnically diverse groups but also within specific communities, families, and individuals. Counselors, prevention specialists, other behavioral health workers, supervisors, and organizations all need to develop skills to create an environment that is responsive to the unique attributes and experiences of each client. As you read this TIP, remember that many cross-cutting factors influence the experiences, help-seeking behaviors, intervention responses, and outcomes of individuals, families, and populations who have survived trauma. Single, multiple, or chronic exposures to traumatic events, as well as the emotional, cognitive, behavioral, and spiritual responses to trauma, need to be understood within a social-ecological framework that recognizes the many ingredients prior to, during, and after traumatic experiences that set the stage for recovery.

2 Trauma Awareness

IN THIS CHAPTER

- Types of Trauma
- Characteristics of Trauma
- Individual and Sociocultural Features

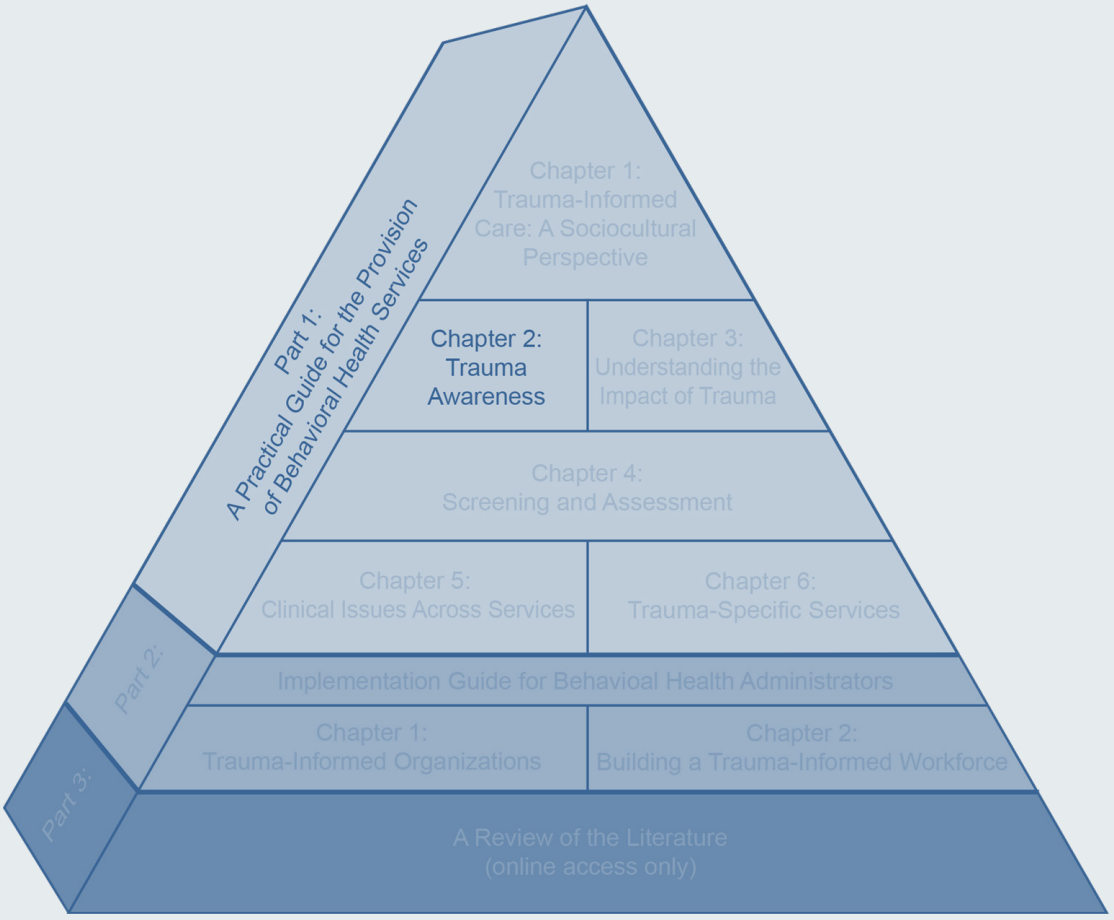
Traumatic experiences typically do not result in long-term impairment for most individuals. It is normal to experience such events across the lifespan; often, individuals, families, and communities respond to them with resilience. This chapter explores several main elements that influence why people respond differently to trauma. Using the social-ecological model outlined in Part 1, Chapter 1, this chapter explores some of the contextual and systemic dynamics that influence individual and community perceptions of trauma and its impact. The three main foci are: types of trauma, objective and subjective characteristics of trauma, and individual and sociocultural features that serve as risk or protective factors.

This chapter's main objective is to highlight the key characteristics of traumatic experiences. Trauma-informed behavioral health service providers understand that many influences shape the effects of trauma among individuals and communities—it is not just the event that determines the outcome, but also the event's context and the resultant interactions across systems.

Types of Trauma

The following section reviews various forms and types of trauma. It does not cover every conceivable trauma that an individual, group, or community may encounter. Specific traumas are reviewed only once, even when they could fit in multiple categories of trauma. Additionally, the order of appearance does not denote a specific trauma's importance or prevalence, and there is no lack of relevance implied if a given trauma is not specifically addressed in this Treatment Improvement Protocol (TIP). The intent is to give a broad perspective of the various categories and types of trauma to behavioral health workers who wish to be trauma informed.

TIC Framework in Behavioral Health Services—Trauma Awareness



Natural or Human-Caused Traumas

The classification of a trauma as natural or caused by humans can have a significant impact on the ways people react to it and on the types of assistance mobilized in its aftermath (see Exhibit 1.2-1 for trauma examples). Natural traumatic experiences can directly affect a small number of people, such as a tree falling on a car during a rainstorm, or many people and communities, as with a hurricane. Natural events, often referred to as "acts of God," are typically unavoidable. Human-caused traumas are caused by human failure (e.g., technological catastrophes, accidents, malevolence) or by human design (e.g., war). Although multiple factors contribute to the severity of a natural or human-caused trauma, traumas perceived as intentionally harmful often make the event more traumatic for people and communities.

For information on resources to prepare States, Territories, and local entities to deliver effective mental health and substance abuse responses during disasters, contact the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Disaster Technical Assistance Center:

4350 East West Hwy, Suite 1100
Bethesda, MD 20814 6233
Phone: 1 800 308 3515
Fax: 1 800 311 7691
Email: DTAC@samhsa.hhs.gov

Exhibit 1.2-1: Trauma Examples

Caused Naturally	Caused by People	
	Accidents, Technological Catastrophes	Intentional Acts
Tornado	Train derailment	Arson
Lightning strike	Roofing fall	Terrorism
Wildfire	Structural collapse	Sexual assault and abuse
Avalanche	Mountaineering accident	Homicides or suicides
Physical ailment or disease	Aircraft crash	Mob violence or rioting
Fallen tree	Car accident due to malfunction	Physical abuse and neglect
Earthquake	Mine collapse or fire	Stabbing or shooting
Dust storm	Radiation leak	Warfare
Volcanic eruption	Crane collapse	Domestic violence
Blizzard	Gas explosion	Poisoned water supply
Hurricane	Electrocution	Human trafficking
Cyclone	Machinery-related accident	School violence
Typhoon	Oil spill	Torture
Meteorite	Maritime accident	Home invasion
Flood	Accidental gun shooting	Bank robbery
Tsunami	Sports-related death	Genocide
Epidemic		Medical or food tampering
Famine		
Landslide or fallen boulder		

How survivors of natural trauma respond to the experience often depends on the degree of devastation, the extent of individual and community losses, and the amount of time it takes to reestablish daily routines, activities, and services (e.g., returning to school or work, being able to do laundry, having products to buy in a local store). The amount, accessibility, and duration of relief services can significantly influence the duration of traumatic stress reactions as well as the recovery process.

Alongside the disruption of daily routines, the presence of community members or outsiders in affected areas may add significant stress or create traumatic experiences in and of themselves. Examples include the threat of others stealing what remains of personal property, restrictions on travel or access to property or living quarters, disruption of privacy within shelters, media attention, and subsequent exposure to repetitive images reflecting the devastation. Therefore, it isn't just the natural disaster or event that can challenge an individual or community; often, the consequences of the event and behavioral responses from others within and outside the community play a role in pushing survivors away from effective coping or toward resilience and recovery.

Human-caused traumas are fundamentally different from natural disasters. They are either intentional, such as a convenience store robbery at gunpoint, or unintentional, such as the technological accident of a bridge collapse (as occurred in Minneapolis, Minnesota, in 2007; U.S. Fire Administration, 2007). The subsequent reactions to these traumas often depend on their intentionality. However, a person or group of people is typically the target of the survivors' anger and blame. Survivors of an unintentionally human-caused traumatic event may feel angry and frustrated because of the lack of protection or care offered by the responsible party or government, particularly if there has been a perceived act of omission. After intentional human-caused acts, survivors often struggle to understand the

Case Illustrations: Quecreek Mine Flood and Greensburg's Tornado

Quecreek Mine Flood

The year following the rescue of nine miners from the Quecreek mine in western Pennsylvania in 2002 was a difficult one for residents of Somerset County. The dazzle of publicity surrounding a handful of workers from a small town, tension between miners and rescuers, and animosity over money for movie and book deals, in addition to the trauma itself, resulted in a rescuer's suicide, a number of miners having trauma-related symptoms, and several rescuers needing to seek treatment for posttraumatic stress disorder (PTSD; Goodell, 2003).

Greensburg's Tornado

Greensburg, a small town in southern Kansas, was hit by a large tornado in 2007 that killed 11 residents and leveled 95 percent of the town while causing severe damage to the remaining 5 percent. Families and community members experienced significant grief and traumatic stress after the disaster. Yet today, Greensburg is rebuilding with a focus on being "green"—that is, environmentally responsible—from design to construction and all the way through demolition. This town has the highest number of Leadership in Energy and Environmental Design–certified buildings in the world. A reality television show about the town's reinvention ran for three seasons, demonstrating the town's residents and business owners working with local government and various corporations to make their home an even better place than it was before the tornado.

motives for performing the act, the calculated or random nature of the act, and the psychological makeup of the perpetrator(s).

Individual, Group, Community, and Mass Traumas

In recognizing the role of trauma and understanding responses to it, consider whether the trauma primarily affected an individual and perhaps his or her family (e.g., automobile accident, sexual or physical assault, severe illness); occurred within the context of a group (e.g., trauma experienced by first responders or those who have seen military combat) or community (e.g., gang-related shootings); transpired within a certain culture; or was a large-scale disaster (e.g., hurricane, terrorist attack). This context can have significant implications for whether (and how) people experience shame as a result of the trauma, the kinds of support and compassion they receive, whether their experiences are normalized or diminished by others, and even the kinds of services they are offered to help them recover and cope.

Individual trauma

An individual trauma refers to an event that only occurs to one person. It can be a single event (e.g., mugging, rape, physical attack, work-related physical injury) or multiple or prolonged events (e.g., a life-threatening illness, multiple sexual assaults). Although the trauma directly affects just one individual, others who know the person and/or are aware of the trauma will likely experience emotional repercussions from the event(s) as well, such as recounting what they said to the person before the event, reacting in disbelief, or thinking that it could just as easily have happened to them, too.

Survivors of individual trauma may not receive the environmental support and concern that members of collectively traumatized groups and communities receive. They are less likely to reveal their traumas or to receive validation of their experiences. Often, shame distorts their perception of responsibility for the trauma. Some survivors of individual traumas, especially those who have kept the trauma secret, may not receive needed comfort and

Advice to Counselors: Working With Clients Who Have Experienced Individual Traumas

In working with clients who have histories of individual trauma, counselors should consider that:

- Empathy, or putting oneself in the shoes of another, is more potent than sympathy (expressing a feeling of sorrow for another person).
- Some clients need to briefly describe the trauma(s) they have experienced, particularly in the early stages of recovery. Strategies that focus on reexperiencing the trauma, retrieving feelings related to the trauma, and bringing past experiences to the forefront should only be implemented if trauma-specific treatment planning and services are available.
- Understanding the trauma, especially in early recovery, should begin with educating the client about and normalizing trauma-related symptoms, creating a sense of safety within the treatment environment, and addressing how trauma symptoms may interfere with the client's life in the present.
- It is helpful to examine how the trauma affects opportunities to receive substance abuse and/or mental health treatment as well as treatment for and recovery from the trauma itself (e.g., by limiting one's willingness to share in or participate in group counseling).
- Identifying and exploring strengths in the client's history can help the client apply those strengths to his or her ability to function in the present.

acceptance from others; they are also are more likely to struggle with issues of causation (e.g., a young woman may feel unduly responsible for a sexual assault), to feel isolated by the trauma, and to experience repeated trauma that makes them feel victimized.

Physical injuries

Physical injuries are among the most prevalent individual traumas. Millions of emergency room (ER) visits each year relate directly to physical injuries. Most trauma patients are relatively young; about 70 percent of injury-related ER cases are people younger than 45 years old (McCaig & Burt, 2005). Dedicated ER hospital units, known as "trauma centers," specialize in physical traumas such as gunshot wounds, stabbings, and other immediate physical injuries. The term "trauma" in relation to ERs does not refer to psychological trauma, which is the focus of this TIP, yet physical injuries can be associated with psychological trauma. Sudden, unexpected, adverse health-related events can lead to extensive psychological trauma for patients and their families.

Excessive alcohol use is the leading risk factor for physical injuries; it's also the most promising target for injury prevention. Studies consistently connect injuries and substance use (Gentilello, Ebel, Wickizer, Salkever, & Rivara, 2005); nearly 50 percent of patients admitted to trauma centers have injuries attributable to alcohol abuse and dependence (Gentilello et al., 1999). One study found that two thirds of ambulatory assault victims presenting to an ER had positive substance use urinalysis results; more than half of all victims had PTSD 3 months later (Roy-Byrne et al.,

Acute stress disorder (ASD) prevalence among patients at medical trauma centers is very high, making trauma related disorders some of the most common complications seen in physically injured patients. Clients who have sustained serious injuries in car crashes, fires, stabbings, shootings, falls, and other events have an increased likelihood of developing trauma related mental disorders. Research suggests that PTSD and/or problem drinking is evident in nearly 50 percent of patients 1 year after discharge from trauma surgical units.

(Zatzick, Jurkovich, Gentilello, Wisner, & Rivara, 2002)

2004). Nearly 28 percent of patients whose drinking was identified as problematic during an ER visit for a physical injury will have a new injury within 1 year (Gentilello et al., 2005). For further information, see TIP 16, *Alcohol and Other Drug Screening of Hospitalized Trauma Patients* (Center for Substance Abuse Treatment [CSAT], 1995a).

Group trauma

The term "group trauma" refers to traumatic experiences that affect a particular group of people. This TIP intentionally distinguishes group trauma from mass trauma to highlight the unique experiences and characteristics of trauma-related reactions among small groups. These groups often share a common identity and history, as well as similar activities and concerns. They include vocational groups who specialize in managing traumas or who routinely place themselves in harm's way—for example, first responders, a group including police and emergency medical personnel. Some examples of group trauma include crews and their families who lose members from a commercial fishing accident, a gang whose members experience multiple deaths and injuries, teams of firefighters who lose members in a roof collapse, responders who attempt to save flood victims, and military service members in a specific theater of operation.

Survivors of group trauma can have different experiences and responses than survivors of individual or mass traumas. Survivors of group trauma, such as military service members and first responders, are likely to experience repeated trauma. They tend to keep the trauma experiences within the group, feeling that others outside the group will not understand; group outsiders are generally viewed as intruders. Members may encourage others in the group to shut down emotionally and repress their traumatic experiences—and there are some occupational roles that necessitate the repression of reactions to complete a mission or to be attentive to the needs at hand. Group members may not want to seek help and may discourage others from doing so out of fear that it may shame the entire group. In this environment, members may see it as a violation of group confidentiality when a member seeks assistance outside the group, such as by going to a counselor.

Group members who have had traumatic experiences in the past may not actively support traumatized colleagues for fear that acknowledging the trauma will increase the risk of repressed trauma-related emotions surfacing. However, groups with adequate resources for helping group members can develop a stronger and more supportive environment for handling subsequent traumas. These main group features influence the course of short- and long-term adjustments, including the development of traumatic stress symptoms associated with mental and substance use disorders.

Certain occupational groups are at greater risk of experiencing trauma—particularly multiple traumas. This TIP briefly reviews two main groups as examples in the following sections: first responders and military service members. For more detailed information on the impact of trauma and deployment, refer to the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (SAMHSA, planned f).

First responders

First responders are usually emergency medical technicians, disaster management personnel, police officers, rescue workers, medical and behavioral health professionals, journalists, and volunteers from various backgrounds. They also include lifeguards, military personnel, and clergy. Stressors associated with the kinds of traumatic events and/or disasters first responders are likely to experience include

exposure to toxic agents, feeling responsible for the lives of others, witnessing catastrophic devastation, potential exposure to gruesome images, observing human and animal suffering and/or death, working beyond physical exhaustion, and the external and internal pressure of working against the clock.

Military service members

Military personnel are likely to experience numerous stressors associated with trauma. Service members who have repeatedly deployed to a war zone are at a greater risk for traumatic stress reactions (also known as combat stress reaction or traumatic stress injury), other military personnel who provide support services are also at risk for traumatic stress and secondary trauma (refer to the glossary portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP). So too, service members who anticipate deployment or redeployment may exhibit psychological symptoms associated with traumatic stress. Some stressors that military service members may encounter include working while physically exhausted, exposure to gunfire, seeing or knowing someone who has been injured or killed, traveling in areas known for roadside bombs and rockets, extended hypervigilance, fear of being struck by an improvised explosive device, and so forth.

Trauma affecting communities and cultures

Trauma that affects communities and cultures covers a broad range of violence and atrocities that erode the sense of safety within a given community, including neighborhoods, schools, towns, and reservations. It may involve violence in the form of physical or sexual assaults, hate crimes, robberies, workplace or gang-related violence, threats, shootings, or stabbings—for example, the school shooting at Virginia Polytechnic Institute and State University in 2007. It also includes actions that attempt to dismantle systemic cultural practices, resources, and identities, such as making boarding school attendance mandatory for Native American children or placing them in non-Native foster homes. Cultural and/or community-based trauma can also occur via indifference or limited responsiveness to specific communities or cultures that are facing a potential catastrophe. Cultural traumas are events that, whether intentionally or not, erode the heritage of a culture—as with prejudice, disenfranchisement, and health inequities (e.g., late prenatal care, inability to afford medications, limited access to culturally appropriate health education, vicinity and quality of affordable medical services), among other examples.

"The excitement of the season had just begun, and then, we heard the news, oil in the water, lots of oil killing lots of water. It is too shocking to understand. Never in the millennium of our tradition have we thought it possible for the water to die, but it is true."

—Chief Walter Meganack, Port Graham, 1989

Of all the groups negatively affected by the Exxon Valdez oil spill, in many ways Alaska Natives were the most devastated. The oil spill destroyed more than economic resources; it shook the core cultural foundation of Native life. Alaska Native subsistence culture is based on an intimate relationship with the environment. Not only does the environment have sacred qualities for Alaska Natives; their survival also depends on the well-being of the ecosystem and the maintenance of cultural norms of subsistence. The spill directly threatened the well-being of the environment, disrupted subsistence behavior, and severely disturbed the sociocultural milieu of Alaska Natives.

Source: Gill & Picou, 1997, pp. 167–168.

Historical trauma

Historical trauma, known also as generational trauma, refers to events that are so widespread as to affect an entire culture; such events also have effects intense enough to influence generations of the culture beyond those who experienced them directly. The enslavement, torture, and lynching of African Americans; the forced assimilation and relocation of American Indians onto reservations; the extermination of millions of Jews and others in Europe during World War II; and the genocidal policies of the Hutus in Rwanda and the Khmer Rouge in Cambodia are examples of historical trauma.

In the past 50 years, research has explored the generational effects of the Holocaust upon survivors and their families. More recent literature has extended the concept of historical or generational trauma to the traumatic experiences of Native Americans. Reduced population, forced relocation, and acculturation are some examples of traumatic experiences that Native people have endured across centuries, beginning with the first European presence in the Americas. These tragic experiences have led to significant loss of cultural identity across generations and have had a significant impact on the well-being of Native communities (Whitbeck, Chen, Hoyt, & Adams, 2004). Data are limited on the association of mental and substance use disorders with historical trauma among Native people, but literature suggests that historical trauma has repercussions across generations, such as depression, grief, traumatic stress, domestic violence, and substance abuse, as well as significant loss of cultural knowledge, language, and identity (Gone, 2009). Historical trauma can increase the vulnerability of multiple generations to the effects of traumas that occur in their own lifetimes.

Mass trauma

Mass traumas or disasters affect large numbers of people either directly or indirectly. It is beyond the scope of this TIP to cover any specific disaster in detail; note, however, that mass traumas include large-scale natural and human-caused disasters (including intentional acts and accidents alike). Mass traumas may involve significant loss of property and lives as well as the widespread disruption of normal routines and services. Responding to such traumas often requires immediate and extensive resources that typically exceed the capacity of the affected communities, States, or countries in which they occur. Recent examples of such large-scale catastrophes include:

- In January 2010, a massive earthquake hit Haiti, killing hundreds of thousands of people and leaving over a million homeless.
- A nuclear reactor meltdown in the Ukraine in 1986 resulted in a technological and environmental disaster that affected tens of millions of people.
- The tsunami in the Indian Ocean in 2005 left hundreds of thousands dead in nine countries.

One factor that influences an individual's response to trauma is his or her ability to process one trauma before another trauma occurs. In mass traumas, the initial event causes considerable destruction, the consequences of which may spawn additional traumas and other stressful events that lead to more difficulties and greater need for adjustments among survivors, first responders, and disaster relief agencies. Often, a chain reaction occurs. Take, for example, Hurricane Katrina and its impact on the people of Louisiana and other coastal States. After the initial flooding, people struggled to obtain basic needs, including food, drinking water, safe shelter, clothing, medicines, personal hygiene items, and so forth, all as concern mounted about the safety of children and

other relatives, friends, and neighbors. In this and similar cases, the destruction from the initial flooding led to mass displacement of families and communities; many people had to relocate far from New Orleans and other badly affected areas, while also needing to gain financial assistance, reinitiate work to generate income, and obtain stable housing. People could not assimilate one stressor before another appeared.

Nevertheless, mass traumas can create an immediate sense of commonality—many people are "in the same boat," thus removing much of the isolation that can occur with other types of trauma. People can acknowledge their difficulties and receive support, even from strangers. It is easier to ask for help because blame is often externalized; large-scale disasters are often referred to as "acts of God" or, in cases of terrorism and other intentional events, as acts of "evil." Even so, survivors of mass trauma often encounter an initial rally of support followed by quickly diminishing services and dwindling care. When the disaster fades from the headlines, public attention and concern are likely to decrease, leaving survivors struggling to reestablish or reinvent their lives without much outside acknowledgment.

The experience of mass trauma can lead to the development of psychological symptoms and substance use at either a subclinical or a diagnostic level (refer to Part 3 of this TIP, available online, for more information highlighting the relationship between trauma and behavioral health problems). Likewise, one of the greatest risks for traumatic stress reactions after a mass tragedy is the presence of preexisting mental and co-occurring disorders, and individuals who are in early recovery from substance use disorders are at greater risk for such reactions as well. Nonetheless, people are amazingly resilient, and most will not develop long-term mental or substance use disorders after an event; in fact, most trauma-related symptoms will resolve in a matter of months (Keane & Piwowarczyk, 2006).

Interpersonal Traumas

Interpersonal traumas are events that occur (and typically continue to reoccur) between people who often know each other, such as spouses or parents and their children. Examples include physical and sexual abuse, sexual assault, domestic violence, and elder abuse.

Intimate partner violence

Intimate partner violence (IPV), often referred to as domestic violence, is a pattern of actual or threatened physical, sexual, and/or emotional abuse. It differs from simple assault in that multiple episodes often occur and the perpetrator is an intimate partner of the victim. Trauma associated with IPV is normally ongoing. Incidents of this form of violence are rarely isolated, and the client may still be in contact with and encountering abuse from the perpetrator while engaged in treatment.

Intimate partners include current and former spouses, boyfriends, and girlfriends. The majority of all nonfatal acts of violence and intimate partner homicides are committed against women; IPV accounts for over 20 percent of nonfatal violence against women but only 3.6 percent of that committed against men (Catalano, 2012). Children are the hidden casualties of IPV. They often witness the assaults or threats directly, within earshot, or by being exposed to the aftermath of the violence (e.g., seeing bruises and destruction of property, hearing the pleas for it to stop or the promises that it will never happen again).

Substance abuse, particularly involving alcohol, is frequently associated with IPV. It is the presence of alcohol-related problems in either partner, rather than the level of alcohol consumption itself, that is the important factor.

Drinking may or may not be the cause of the violence; that said, couples with alcohol-related disorders could have more tension and disagreement within the relationship in general, which leads to aggression and violence. The consumption of alcohol during a dispute is likely to decrease inhibitions and increase impulsivity, thus creating an opportunity for an argument to escalate into a physical altercation. More information on domestic violence and its effects on partners and families, as well as its connection with substance use and trauma-related disorders, is available in TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b), and from the National Online Resource Center on Violence Against Women (http://www.vawnet.org/).

Developmental Traumas

Developmental traumas include specific events or experiences that occur within a given developmental stage and influence later development, adjustment, and physical and mental health. Often, these traumas are related to adverse childhood experiences (ACEs), but they can also result from tragedies that occur outside an expected developmental or life stage (e.g., a child dying before a parent, being diagnosed with a life-threatening illness as a young adult) or from events at any point in the life cycle that create significant loss and have life-altering consequences (e.g., the death of a significant other in the later years that leads to displacement of the surviving partner).

Adverse childhood experiences

Some people experience trauma at a young age through sexual, physical, or emotional abuse and neglect. The Adverse Childhood Experiences Study (Felitti et al., 1998) examined the effects of several categories of ACEs on adult health, including physical and emotional abuse; sexual abuse; a substance-dependent parent; an incarcerated, mentally ill, or suicidal household member; spousal abuse between parents; and divorce or separation that meant one parent was absent during childhood. The National Comorbidity Studies examined the prevalence of trauma and defined childhood adversities as parental death, parental divorce/separation, life-threatening illness, or extreme economic hardship in addition to the childhood experiences included in the Adverse Childhood Experiences Study (Green et al., 2010).

ACEs can negatively affect a person's well-being into adulthood. Whether or not these experiences occur simultaneously, are time-limited, or recur, they set the stage for increased vulnerability to physical, mental, and substance use disorders and enhance the risk

Child Neglect

Child neglect occurs when a parent or caregiver does not give a child the care he or she needs according to his or her age, even though that adult can afford to give that care or is offered help to give that care. Neglect can mean not providing adequate nutrition, clothing, and/or shelter. It can mean that a parent or caregiver is not providing a child with medical or mental health treatment or is not giving prescribed medicines the child needs. Neglect can also mean neglecting the child's education. Keeping a child from school or from special education can be neglect. Neglect also includes exposing a child to dangerous environments (e.g., exposure to domestic violence). It can mean poor supervision for a child, including putting the child in the care of someone incapable of caring for children. It can mean abandoning a child or expelling him or her from home. Lack of psychological care, including emotional support, attention, or love, is also considered neglect—and it is the most common form of abuse reported to child welfare authorities.

Source: dePanfilis, 2006.

for repeated trauma exposure across the life span. Childhood abuse is highly associated with major depression, suicidal thoughts, PTSD, and dissociative symptoms. So too, ACEs are associated with a greater risk of adult alcohol use. When a person experiences several adverse events in childhood, the risk of his or her heavy drinking, self-reported alcohol dependence, and marrying a person who is alcohol dependent is two to four times greater than that of a person with no ACEs (Dube, Anda, Felitti, Edwards, & Croft, 2002).

A detailed examination of the issues involved in providing substance abuse treatment to survivors of child abuse and neglect is the subject of TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT, 2000b).

Political Terror and War

Political terror and war are likely to have lasting consequences for survivors. In essence, anything that threatens the existence, beliefs, well-being, or livelihood of a community is likely to be experienced as traumatic by community members. Whether counselors are working with an immigrant or refugee enclave in the United States or in another country, they should be aware of local events, local history, and the possibility that clients have endured trauma. (For international information about the clinical, historical, and theoretical aspects of trauma and terrorism, see Danieli, Brom, & Sills, 2005.) Terrorism is a unique subtype of human-caused disasters. The overall goal of terrorist attacks is to maximize the uncertainty, anxiety, and fear of a large community, so the responses are often epidemic and affect large numbers of people who have had direct or indirect exposure to an event (Silver et al., 2004; Suvak, Maguen, Litz, Silver, & Holman, 2008). Terrorism has a variety of results not common to other disasters, such as reminders of the unpredictability of terrorist acts; increases in security measures for the general population; intensified suspicion about a particular population, ethnicity, or culture; and heightened awareness and/or arousal.

Refugees

According to the World Refugee Survey, there are an estimated 12 million refugees and asylum seekers, 21 million internally displaced people, and nearly 35 million uprooted people (U.S. Committee for Refugees and Immigrants, 2006). Many of these people have survived horrendous ordeals with profound and lasting effects for individuals and whole populations. In addition to witnessing deaths by execution, starvation, or beatings, many survivors have experienced horrific torture.

Refugees are people who flee their homes because they have experienced or have a reasonable fear of experiencing persecution. They

Torture and Captivity

Torture traumatizes by taking away an individual's personhood. To survive, victims have to give up their sense of self and will. They become the person the torturer designs or a nonperson, simply existing. Inevitably, the shame of the victim is enormous, because the focus of torture is to humiliate and degrade. As a result, victims often seek to hide their trauma and significant parts of their selfhood long after torture has ended and freedom has been obtained. According to Judith Herman, "the methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma. They are organized techniques of disempowerment and disconnection. Methods of psychological control are designed to instill terror and helplessness and to destroy the victim's sense of self in relation to others."

Source: Herman, 1997, p. 77.

differ from immigrants who willingly leave their homes or homeland to seek better opportunities. Although immigrants may experience trauma before migrating to or after reaching their new destination, refugees will often have greater exposure to trauma before migration. Refugees typically come from war-torn countries and may have been persecuted or tortured. Consequently, greater exposure to trauma, such as torture, before migrating often leads to more adjustment-related difficulties and psychological symptoms after relocation (Steel et al., 2009).

Refugees typically face substantial difficulties in assimilating into new countries and cultures. Moreover, the environment can create a new set of challenges that may include additional exposure to trauma and social isolation (Miller et al., 2002). These as well as additional factors influence adjustment, the development of mental illness (including PTSD), and the occurrence of substance use disorders. Additional factors that influence outcomes after relocation include receptivity of the local community, along with opportunities for social support and culturally responsive services.

Among refugee populations in the United States, little research is available on rates of mental illness and co-occurring substance use disorders and traumatic stress among refugee populations. Substance use patterns vary based on cultural factors as well as assimilation, yet research suggests that trauma increases the risk for substance use among refugees after war-related experiences (Kozarić-Kovačić, Ljubin, & Grappe, 2000). Therefore, providers should expect to see trauma-related disorders among refugees who are seeking treatment for a substance use disorder and greater prevalence of substance use disorders among refugees who seek behavioral health services.

Vietnamese Refugees

"Wars always have consequences, both immediate and remote, and the consequences are often tragic. One tragic circumstance often caused by war is the forceful, disorganized, and uncontrollable mass movement of both civilians and soldiers trying to escape the horrors of the wars or of an oppressive regime.…

"Vietnamese communists, by taking power in the North in 1954 and then in the South in 1975, caused two major upheavals in the Land of the Small Dragon, as Vietnam was once called. The first Vietnam War led to the 1954 exodus during which 1 million people fled from the North to the South. The second Vietnam War resulted in the dispersion, from 1975-1992, of approximately 2 million Vietnamese all over the world. These significant, unplanned, and uncoordinated mass movements around the world not only dislocated millions of people, but also caused thousands upon thousands of deaths at sea.…

"The second and third wave of refugees from 1976 onward went through a more difficult time. They had to buy their way out and to hide from soldiers and the police who hunted them down. After catching them, the police either asked for brides or threw the escapees into jails. Those who evaded police still had to face engine failures, sea storms, pirates…They then had to survive overcrowded boats for days or weeks, during which food and water could not be replenished and living conditions were terrible… Many people died from exhaustion, dehydration, and hunger. Others suffered at the hands of terrifying pirates… After the sea ordeal came the overcrowded camps where living conditions were most often substandard and where security was painfully lacking.…

"In the United States, within less than 3 decades, the Vietnamese population grew from a minority of perhaps 1,000 persons to the second largest refugee group behind Cubans."

Source: Vo, 2006, pp. 1–4.

System-Oriented Traumas: Retraumatization

Retraumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma. Unfortunately, treatment settings and clinicians can create retraumatizing experiences, often without being aware of it, and sometimes clients themselves are not consciously aware that a clinical situation has actually triggered a traumatic stress reaction. Agencies that anticipate the risk for retraumatization and actively work on adjusting program policies and procedures to remain sensitive to the histories and needs of individuals who have undergone past trauma are likely to have more success in providing care, retaining clients, and achieving positive outcomes.

Staff and agency issues that can cause retraumatization include:

- Being unaware that the client's traumatic history significantly affects his or her life.
- Failing to screen for trauma history prior to treatment planning.
- Challenging or discounting reports of abuse or other traumatic events.
- Using isolation or physical restraints.
- Using experiential exercises that humiliate the individual.
- Endorsing a confrontational approach in counseling.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling behavior/feelings as pathological.
- Failing to provide adequate security and safety within the program.
- Limiting participation of the client in treatment decisions and planning processes.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate setting.

Advice to Counselors: Addressing Retraumatization

- Anticipate and be sensitive to the needs of clients who have experienced trauma regarding program policies and procedures in the treatment setting that might trigger memories of trauma, such as lack of privacy, feeling pushed to take psychotropic medications, perceiving that they have limited choices within the program or in the selection of the program, and so forth.
- Attend to clients' experiences. Ignoring clients' behavioral and emotional reactions to having their traumatic memories triggered is more likely to increase these responses than decrease them.
- Develop an individual coping plan in anticipation of triggers that the individual is likely to experience in treatment based on his or her history.
- Rehearse routinely the coping strategies highlighted in the coping plan. If the client does not practice strategies prior to being triggered, the likelihood of being able to use them effectively upon triggering is lessened. For example, it is far easier to practice grounding exercises in the absence of severe fear than to wait for that moment when the client is reexperiencing an aspect of a traumatic event. (For more information on grounding exercises, refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*; Najavits, 2002a, pp. 125–131.)
- Recognize that clinical and programmatic efforts to control or contain behavior in treatment can cause traumatic stress reactions, particularly for trauma survivors for whom being trapped was part of the trauma experience.
- Listen for the specific trigger that seems to be driving the client's reaction. It will typically help both the counselor and client understand the behavior and normalize the traumatic stress reactions.
- Make sure that staff and other clients do not shame the trauma survivor for his or her behavior, such as through teasing or joking about the situation.
- Respond with consistency. The client should not get conflicting information or responses from different staff members; this includes information and responses given by administrators.

- Having clients undress in the presence of others.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Imposing agency policies or rules without exceptions or an opportunity for clients to question them.
- Enforcing new restrictions within the program without staff–client communication.
- Limiting access to services for ethnically diverse populations.
- Accepting agency dysfunction, including lack of consistent, competent leadership.

Characteristics of Trauma

The following section highlights several selected characteristics of traumatic experiences that influence the effects of traumatic stress. Objective characteristics are those elements of a traumatic event that are tangible or factual; subjective characteristics include internal processes, such as perceptions of traumatic experiences and meanings assigned to them.

Objective Characteristics

Was it a single, repeated, or sustained trauma?

Trauma can involve a single event, numerous or repeated events, or sustained/chronic experiences. A *single trauma* is limited to a single point in time. A rape, an automobile accident, the sudden death of a loved one—all are examples of a single trauma. Some people who experience a single trauma recover without any specific intervention. But for others—especially those with histories of previous trauma or mental or substance use disorders, or those for whom the trauma experience is particularly horrific or overwhelming—a single trauma can result in traumatic stress symptoms and trauma- and stress-related disorders. Single traumas do not necessarily have a lesser psychological impact than repeated traumas. After the terrorist attacks on September 11, 2001—a significant single trauma—many Manhattan residents experienced intrusive memories and sleep disruption whether they were at the site of the attacks or watched television coverage of it (Ford & Fournier, 2007; Galea et al., 2002).

A series of traumas happening to the same person over time is known as *repeated trauma*. This can include repeated sexual or physical assaults, exposure to frequent injuries of others, or seemingly unrelated traumas. Military personnel, journalists covering stories of mass tragedies or prolonged conflicts, and first responders who handle hundreds of cases each year typify repeated trauma survivors. Repetitive exposure to traumas can have a cumulative effect over one's lifetime. A person who was assaulted during adolescence, diagnosed with a life-threatening illness in his or her thirties, and involved in a serious car accident later in life has experienced repeated trauma.

Some repeated traumas are sustained or chronic. Sustained trauma experiences tend to wear down resilience and the ability to adapt. Some examples include children who endure ongoing sexual abuse, physical neglect, or emotional abuse; people who are in violent relationships; and people who live in chronic poverty. Individuals in chronically stressful, traumatizing environments are particularly susceptible to traumatic stress reactions, substance use, and mental disorders.

Bidirectional relationships exist between trauma and substance use as well as trauma and mental illness. For example, abuse of alcohol and drugs increases the risk of a traumatic experience and creates greater vulnerability to the effects of trauma; substance abuse reduces a person's ability to take corrective and remedial actions that might reduce the impact of the trauma. Likewise, traumatic stress leads to a greater likelihood of

Case Illustration: Yourself

Think of a time that was particularly stressful (but not traumatic) in your life. Revisit this period as an observer watching the events unfold and then ask yourself, "What made this time particularly stressful?" It is likely that a part of your answer will include the difficulty of managing one situation before another circumstance came along demanding your time. Stressful times denote being bombarded with many things at one time, perceived or actual, without sufficient time or ability to address them emotionally, cognitively, spiritually, and/or physically. The same goes for trauma—rapid exposure to numerous traumas one after another lessens one's ability to process the event before the next onslaught. This creates a cumulative effect, making it more difficult to heal from any one trauma.

substance abuse that, in turn, increases the risk for additional exposure to trauma. Paralleling this bidirectional relationship, mental illness increases vulnerability to the effects of trauma and raises the risk for substance use disorders and for encountering additional traumatic events. So too, early exposure to ACEs is associated with traumatic stress reactions and subsequent exposure to trauma in adult years.

People who have encountered multiple and longer doses of trauma are at the greatest risk for developing traumatic stress. For example, military reservists and other military service members who have had multiple long tours of duty are at greater risk for traumatic stress reactions (see the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families;* SAMHSA, planned f). In addition, people are more likely to encounter greater impairment and distress from trauma if that trauma occurs with significant intensity and continues sporadically or unceasingly for extended periods.

Was there enough time to process the experience?

A particularly severe pattern of ongoing trauma, sometimes referred to as "cascading trauma," occurs when multiple traumas happen in a pattern that does not allow an individual to heal from one traumatic event before another occurs. Take, for example, California residents—they repeatedly face consecutive and/or simultaneous natural disasters including fires, landslides, floods, droughts, and earthquakes. In other cases, there is ample time to process an event, but processing is limited because people don't have supportive relationships or environments that model preventive practices. This can lead to greater vulnerability to traumas that occur later in life.

How many losses has the trauma caused?

Trauma itself can create significant distress, but often, the losses associated with a trauma have more far-reaching effects. For instance, a child may be forced to assume adult responsibilities, such as serving as a confidant for a parent who is sexually abusing him or her, and lose the opportunity of a childhood free from adult worries. In another scenario, a couple may initially feel grateful to have escaped a house fire, but they may nevertheless face significant community and financial losses months afterward. In evaluating the impact of trauma, it is helpful to access and discuss the losses associated with the initial trauma. The number of losses greatly influences an individual's ability to bounce back from the tragedy.

In the case illustration on the next page, Rasheed's losses cause him to disconnect from his wife, who loves and supports him. Successful confrontation of losses can be difficult if the losses compound each other, as with Rasheed's loss of his friend, his disability, his employment struggles, and the threats to his marriage and liberty. People can cite a specific

Case Illustration: Rasheed

Rasheed was referred to an employee assistance program by his employer. He considered quitting his job, but his wife insisted he talk to a counselor. He is a 41-year-old auto mechanic who, 4 years ago, caused a head-on collision while attempting to pass another vehicle. A close friend, riding in the passenger's seat, was killed, and two young people in the other vehicle were seriously injured and permanently disabled. Rasheed survived with a significant back injury and has only been able to work sporadically. He was convicted of negligent homicide and placed on probation because of his physical disability. He is on probation for another 4 years, and if he is convicted of another felony during that time, he will have to serve prison time for his prior offense.

While still in the hospital, Rasheed complained of feeling unreal, numb, and disinterested in the care he received. He did not remember the crash but remembers waking up in the hospital 2 days later. He had difficulty sleeping in the hospital and was aware of feelings of impending doom, although he was unaware of the legal charges he would later face. He was diagnosed with ASD.

He was discharged from the hospital with a variety of medications, including pain pills and a sleep aid. He rapidly became dependent on these medications, feeling he could not face the day without the pain medication and being unable to sleep without sleep medicine in larger doses than had been prescribed. Within 3 months of the accident, he was "doctor shopping" for pain pills and even had a friend obtain a prescription for the sleeping medication from that friend's doctor. In the 4 intervening years, Rasheed's drug use escalated, and his blunted emotions and detachment from friends became more profound. He became adept at obtaining pain pills from a variety of sources, most of them illegal. He fears that if he seeks treatment for the drug problem, he will have to admit to felony offenses and will probably be imprisoned. He also does not believe he can manage his life without the pain pills.

In the past 2 years, he has had recurring dreams of driving a car on the wrong side of the road and into the headlights of an oncoming vehicle. In the dream, he cannot control the car and wakes up just before the vehicles crash. At unusual times—for instance, when he is just awakening in the morning, taking a shower, or walking alone—he will feel profound guilt over the death of his friend in the accident. He becomes very anxious when driving in traffic or when he feels he is driving faster than he should. His marriage of 18 years has been marked by increasing emotional distance, and his wife has talked about separating if he does not do something about his problem. He has been unable to work consistently because of back pain and depression. He was laid off from one job because he could not concentrate and was making too many mistakes.

The counselor in the employee assistance program elicited information on Rasheed's drug use, although she suspected Rasheed was minimizing its extent and effects. Knowledgeable about psychological trauma, the counselor helped Rasheed feel safe enough to talk about the accident and how it had affected his life. She was struck by how little Rasheed connected his present difficulties to the accident and its aftermath. The counselor later commented that Rasheed talked about the accident as if it had happened to someone else. Rasheed agreed to continue seeing the counselor for five additional visits, during which time a plan would be made for Rasheed to begin treatment for drug dependence and PTSD.

event as precipitating their trauma, or, in other cases, the specific trauma can symbolize a series of disabling events in which the person felt his or her life was threatened or in which he or she felt emotionally overwhelmed, psychologically disorganized, or significantly disconnected from his or her surroundings. It will be important for Rasheed to understand how his losses played a part in his abuse of prescription medications to cope with symptoms associated with traumatic stress and loss, (e.g., guilt, depression, fear). If not addressed, his trauma could increase his risk for relapse.

Was the trauma expected or unexpected?

When talking about a trauma, people sometimes say they didn't see it coming. Being unprepared, unaware, and vulnerable often increases the risk of psychological injury, but these are common components of most traumas, given that most traumatic events do occur without warning (e.g., car crashes, terrorist attacks, sexual assaults). People with substance use disorders, mental illness, and/or cognitive disabilities may be especially vulnerable in that they may attend less or have competing concerns that diminish attention to what is going on around them, even in high-risk environments. However, most individuals attempt to gain some control over the tragedy by replaying the moments leading up to the event and processing how they could have anticipated it. Some people perseverate on these thoughts for months or years after the event.

Sometimes, a trauma is anticipated but has unexpected or unanticipated consequences, as in the case of Hurricane Katrina. Learning about what is likely to happen can reduce traumatization. For instance, training military personnel in advance of going to combat overseas prepares them to handle traumas and can reduce the impact of trauma.

Were the trauma's effects on the person's life isolated or pervasive?

When a trauma is isolated from the larger context of life, a person's response to it is more likely to be contained and limited. For instance, military personnel in combat situations can be significantly traumatized by what they experience. On return to civilian life or noncombat service, some are able to isolate the traumatic experience so that it does not invade ordinary, day-to-day living. This does not mean that the combat experience was not disturbing or that it will not resurface if the individual encounters an experience that triggers memories of the trauma; it just means that the person can more easily leave the trauma in the past and attend to the present.

Conversely, people who remain in the vicinity of the trauma may encounter greater challenges in recovery. The traumatic event intertwines with various aspects of the person's daily activities and interactions, thus increasing the possibility of being triggered by surrounding cues and experiencing subsequent psychological distress. However, another way to view this potential dilemma for the client is to reframe it as an opportunity—the repetitive exposure to trauma-related cues may provide vital guidance as to when and which treatment and coping techniques to use in the delivery of trauma-informed and trauma-specific behavioral health services.

Who was responsible for the trauma and was the act intentional?

If the severity of a trauma is judged solely by whether the act was intentional or not, events that reflect an intention to harm would be a primary indicator in predicting subsequent difficulties among individuals exposed to this form of trauma. For most survivors, there is an initial disbelief that someone would conceivably intend to harm others, followed by considerable emotional and, at times, behavioral investment in somehow making things right again or in making sense of a senseless, malicious act. For instance, in the wake of the World Trade Center attacks in New York City, people responded via renewed patriotism, impromptu candlelight vigils, attacks on people of Arab and Muslim descent, and unprecedented donations and willingness to wait in long lines to donate blood to the Red Cross. Each example is a response that in some way attempts to right the perceived wrong or attach new meaning to the event and subsequent consequences.

When terrible things happen, it is human nature to assign blame. Trauma survivors can become heavily invested in assigning blame or finding out who was at fault, regardless of the type of trauma. Often, this occurs as an attempt to make sense of, give meaning to, and reestablish a sense of predictability, control, and safety after an irrational or random act. It is far easier to accept that someone, including oneself, is at fault or could have done something different than it is to accept the fact that one was simply in the wrong place at the wrong time.

For some trauma survivors, needing to find out why a trauma occurred or who is at fault can become a significant block to growth when the individual would be better served by asking, "What do I need to do to heal?" Behavioral health professionals can help clients translate what they have learned about responsibility in recovery to other aspects of their lives. For instance, someone in treatment for co-occurring disorders who has internalized that becoming depressed or addicted was not his or her fault, but that recovery *is* a personal responsibility, can then apply the same principle to the experience of childhood abuse and thereby overcome negative judgments of self (e.g., thinking oneself to be a bad person who deserves abuse). The individual can then begin to reassign responsibility by attaching the blame to the perpetrator(s) while at the same time assuming responsibility for recovery.

Was the trauma experienced directly or indirectly?

Trauma that happens to someone directly seems to be more damaging than witnessing trauma that befalls others. For example, it is usually more traumatic to be robbed at gunpoint than to witness someone else being robbed or hearing someone tell a story about being robbed. Yet, sometimes, experiencing another's pain can be equally traumatic. For instance, parents often internalize the pain and suffering of their children when the children are undergoing traumatic circumstances (e.g., treatments for childhood cancer).

There are two ways to experience the trauma of others. An individual may witness the event, such as seeing someone killed or seriously injured in a car accident, or may learn of an event that happened to someone, such as a violent personal assault, suicide, serious accident, injury, or sudden or unexpected death. For many people, the impact of the trauma will depend on a host of variables, including their proximity to the event as eyewitnesses, the witnesses' response in the situation, their relationship to the victims, the degree of helplessness surrounding the experience, their exposure to subsequent consequences, and so on.

Case Illustration: Frank

Frank entered substance abuse treatment with diagnoses of co-occurring PTSD and substance use disorder. While on a whitewater kayak trip with his wife, her kayak became pinned on a rock, and Frank could only watch helplessly as she drowned. His drinking had increased markedly after the accident. He acknowledged a vicious cycle of sleep disturbance with intrusive nightmares followed by vivid memories and feelings of terror and helplessness after he awoke. He drank heavily at night to quiet the nightmares and memories, but heavy alcohol consumption perpetuated his trouble sleeping. He withdrew from contact with many of his old "couple friends" and his wife's family, with whom he had been close. At treatment entry, he described his life as "going to work and coming home." The trauma occurred 3 years before he sought treatment, but Frank continued to feel numb and disconnected from the world. His only emotion was anger, which he tried to keep in check. Integrated treatment for PTSD and substance abuse helped him sleep and taught him coping skills to use when the memories arose; it fostered his engagement and retention in long-term care for both disorders.

The effects of traumas such as genocide and internment in concentration camps can be felt across generations—stories, coping behaviors, and stress reactions can be passed across generational lines far removed from the actual events or firsthand accounts. Known as historical trauma, this type of trauma can affect the functioning of families, communities, and cultures for multiple generations.

What happened since the trauma?

In reviewing traumatic events, it is important to assess the degree of disruption after the initial trauma has passed, such as the loss of employment, assets, community events, behavioral health services, local stores, and recreational areas. There is typically an initial rally of services and support following a trauma, particularly if it is on a mass scale. However, the reality of the trauma's effects and their disruptiveness may have a more lasting impact. The deterioration of normalcy, including the disruption of day-to-day activities and the damage of structures that house these routines, will likely erode the common threads that provide a sense of safety in individual lives and communities. Hence, the degree of disruption in resuming normal daily activities is a significant risk factor for substance use disorders, subclinical psychological symptoms, and mental disorders. For example, adults displaced from their homes because of Hurricanes Katrina or Rita had significantly higher rates of past-month cigarette use, illicit drug use, and binge drinking than those who were not displaced (Office of Applied Studies, 2008).

Subjective Characteristics

Psychological meaning of trauma

An important clinical issue in understanding the impact of trauma is the meaning that the survivor has attached to the traumatic experience. Survivors' unique cognitive interpretations of an event—that is, their beliefs and assumptions—contribute to how they process, react to, cope with, and recover from the trauma. Does the event represent retribution for past deeds committed by the individual or his or her family? How does the individual attach meaning to his or her survival? Does he or she believe that it is a sign of a greater purpose not yet revealed? People who attempt to share their interpretation and meaning of the event can feel misunderstood and sometimes alienated (Paulson & Krippner, 2007; Schein, Spitz, Burlingame, & Muskin, 2006).

> It is important to remember that what happened is not nearly as important as what the trauma means to the individual.

People interpret traumatic events in vastly different ways, and many variables shape how an individual assigns meaning to the experience (framing the meaning through culture, family beliefs, prior life experiences and learning, personality and other psychological features, etc.). Even in an event that happens in a household, each family member may interpret the experience differently. Likewise, the same type of event can occur at two different times in a person's life, but his or her interpretation of the events may differ considerably because of developmental differences acquired between events, current cognitive and emotional processing skills, availability of and access to environmental resources, and so forth.

Disruption of core assumptions and beliefs

Trauma often engenders a crisis of faith (Frankl, 1992) that leads clients to question basic assumptions about life. Were the individual's core or life-organizing assumptions (e.g., about safety, perception of others, fairness, purpose of life, future dreams) challenged or disrupted during or after the traumatic event? (See the seminal work,

Resilience: Connection and Continuity

Research suggests that reestablishing ties to family, community, culture, and spiritual systems is not only vital to the individual, but it also influences the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of survivors of Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents directly affected by the purge experienced fewer negative effects than those who were emotionally or physically severed from their grandparents. Whether the grandparents survived was less important than the connection the grandchildren felt to their pasts.

Shattered Assumptions, by Janoff-Bulman, 1992.) For example, some trauma survivors see themselves as irreparably wounded or beyond the possibility of healing. The following case illustration (Sonja) explores not only the importance of meaning, but also the role that trauma plays in altering an individual's core assumptions—the very assumptions that provide meaning and a means to organize our lives and our interactions with the world and others.

Cultural meaning of trauma

Counselors should strive to appreciate the cultural meaning of a trauma. How do cultural interpretations, cultural support, and cultural responses affect the experience of trauma? It is critical that counselors do not presume to understand the meaning of a traumatic experience without considering the client's cultural context. Culture strongly influences the perceptions of trauma. For instance, a trauma involving shame can be more profound for a person from an Asian culture than for someone from a European culture. Likewise, an Alaska Native individual or community, depending upon their Tribal ancestry, may believe that the traumatic experience serves as a form of retribution. Similarly, the sudden death of a family member or loved one can be less traumatic in a culture that has a strong belief in a positive afterlife. It is important for counselors to recognize that their perceptions of a specific trauma could be very different from their clients' perceptions. Be careful not to judge a client's beliefs in light of your own value system. For more information on culture and how to achieve cultural competence in providing behavioral health services, see SAMHSA's planned TIP, *Improving Cultural Competence* (SAMHSA, planned c).

Individual and Sociocultural Features

A wide variety of social, demographic, environmental, and psychological factors influence a person's experience of trauma, the severity of traumatic stress reactions following the event, and his or her resilience in dealing with the short- and long-term environmental, physical, sociocultural, and emotional consequences. This section addresses a few known factors that influence the risk of trauma along with the development of subclinical and diagnostic traumatic stress symptoms, such as mood and anxiety symptoms and disorders. It is not meant to be an exhaustive exploration of these factors, but rather, a brief presentation to make counselors and other behavioral health professionals aware that various factors influence risk for and protection against traumatic stress and subsequent reactions. (For a broader perspective on such factors, refer to Part 1, Chapter 1.)

Individual Factors

Several factors influence one's ability to deal with trauma effectively and increase one's risk for traumatic stress reactions. Individual factors pertain to the individual's genetic, biological, and psychological makeup and history as they influence the person's experience and

Case Illustration: Sonja

Sonja began to talk about how her life was different after being physically assaulted and robbed in a parking lot at a local strip mall a year ago. She recounts that even though there were people in the parking lot, no one came to her aid until the assailant ran off with her purse. She sustained a cheekbone fracture and developed visual difficulties due to the inflammation from the fracture. She recently sought treatment for depressive symptoms and reported that she had lost interest in activities that typically gave her joy. She reported isolating herself from others and said that her perception of others had changed dramatically since the attack.

Sonja had received a diagnosis of major depression with psychotic features 10 years earlier and received group therapy at a local community mental health center for 3 years until her depression went into remission. She recently became afraid that her depression was becoming more pronounced, and she wanted to prevent another severe depressive episode as well as the use of psychotropic medications, which she felt made her lethargic. Thus, she sought out behavioral health counseling.

As the sessions progressed, and after a psychological evaluation, it was clear that Sonja had some depressive symptoms, but they were subclinical. She denied suicidal thoughts or intent, and her thought process was organized with no evidence of hallucinations or delusions. She described her isolation as a reluctance to shop at area stores. On one hand, Sonja was self-compassionate about her reasons for avoidance, but on the other hand, she was concerned that the traumatic event had altered how she saw life and others. "I don't see people as very caring or kind, like I used to prior to the event. I don't trust them, and I feel people are too self-absorbed. I don't feel safe, and this bothers me. I worry that I'm becoming paranoid again. I guess I know better, but I just want to have the freedom to do what I want and go where I want."

Two months after Sonja initiated counseling, she came to the office exclaiming that things can indeed change. "You won't believe it. I had to go to the grocery store, so I forced myself to go the shopping center that had a grocery store attached to a strip mall. I was walking by a coffee shop, quickly browsing the items in the front window, when a man comes out of the shop talking at me. He says, 'You look like you need a cup of coffee.' What he said didn't register immediately. I looked at him blankly, and he said it again. 'You look like you need a cup of coffee. I'm the owner of the shop, and I noticed you looking in the window, and we have plenty of brewed coffee left before we close the shop. Come on in, it's on the house.' So I did! From that moment on, I began to see people differently. He set it right for me—I feel as if I have myself back again, as if the assault was a sign that I shouldn't trust people, and now I see that there is some goodness in the world. As small as this kindness was, it gave me the hope that I had lost."

For Sonja, the assault changed her assumptions about safety and her view of others. She also attached meaning to the event. She believed that the event was a sign that she shouldn't trust people and that people are uncaring. Yet these beliefs bothered her and contradicted how she saw herself in the world, and she was afraid that her depressive symptoms were returning.

For an inexperienced professional, her presentation may have ignited suspicions that she was beginning to present with psychotic features. However, it is common for trauma survivors to experience changes in core assumptions immediately after the event and to attach meaning to the trauma. Often, a key ingredient in the recovery process is first identifying the meaning of the event and the beliefs that changed following the traumatic experience. So when you hear a client say "I will never see life the same," this expression should trigger further exploration into how life is different, what meaning has been assigned to the trauma, and how the individual has changed his or her perception of self, others, and the future.

(Continued on the next page.)

Case Illustration: Sonja (continued)

Sometimes, reworking the altered beliefs and assumptions occurs with no formal intervention, as with Sonja. In her situation, a random stranger provided a moment that challenged an assumption generated from the trauma. For others, counseling may be helpful in identifying how beliefs and thoughts about self, others, and the world have changed since the event and how to rework them to move beyond the trauma. It is important to understand that the meaning that an individual attaches to the event(s) can either undermine the healing process (e.g., believing that you should not have survived, feeling shame about the trauma, continuing to engage in high-risk activities) or pave the road to recovery (e.g., volunteering to protect victim rights after being sexually assaulted). The following questions can help behavioral health staff members introduce topics surrounding assumptions, beliefs, interpretations, and meanings related to trauma:

- In what ways has your life been different since the trauma?
- How do you understand your survival? (This is an important question for clients who have been exposed to ACEs or cumulative trauma and those who survived a tragedy when others did not.)
- Do you believe that there are reasons that this event happened to you? What are they?
- What meaning does this experience have for you?
- Do you feel that you are the same person as before the trauma? In what ways are you the same? In what ways do you feel different?
- How did this experience change you as a person? Would you like to return to the person you once were? What would you need to do, or what would need to happen, for this to occur?
- Did the traumatic experience change you in a way that you don't like? In what ways?
- How do you view others and your future differently since the trauma?
- What would you like to believe now about the experience?

interpretation of, as well as his or her reactions to, trauma. However, many factors influence individual responses to trauma; it is not just individual characteristics. Failing to recognize that multiple factors aside from individual attributes and history influence experiences during and after trauma can lead to blaming the victim for having traumatic stress.

History of prior psychological trauma

People with histories of prior psychological trauma appear to be the most susceptible to severe traumatic responses (Nishith, Mechanic, & Resick, 2000; Vogt, Bruce, Street, & Stafford, 2007), particularly if they have avoided addressing past traumas. Because minimization, dissociation, and avoidance are common defenses for many trauma survivors, prior traumas are not always consciously available, and when they are, memories can be distorted to avoid painful affects. Some survivors who have repressed their experiences deny a history of trauma or are unable to explain their strong reactions to present situations.

Remember that the effects of trauma are cumulative; therefore, a later trauma that outwardly appears less severe may have more impact upon an individual than a trauma that occurred years earlier. Conversely, individuals who have experienced earlier traumas may have developed effective coping strategies or report positive outcomes as they have learned to adjust to the consequences of the trauma(s). This outcome is often referred to as posttraumatic growth or psychological growth.

Clients in behavioral health treatment who have histories of trauma can respond negatively to or seem disinterested in treatment efforts. They may become uncomfortable in groups that emphasize personal sharing; likewise, an individual who experiences brief bouts of dissociation (a reaction of some trauma survivors) may be misunderstood by others in treatment and seen as uninterested. Providers need to

attend to histories, adjust treatment to avoid retraumatization, and steer clear of labeling clients' behavior as pathological.

History of resilience

Resilience—the ability to thrive despite negative life experiences and heal from traumatic events—is related to the internal strengths and environmental supports of an individual. Most individuals are resilient despite experiencing traumatic stress. The ability to thrive beyond the trauma is associated with individual factors as well as situational and contextual factors. There are not only one or two primary factors that make an individual resilient; many factors contribute to the development of resilience. There is little research to indicate that there are specific traits predictive of resilience; instead, it appears that more general characteristics influence resilience, including neurobiology (Feder, Charney, & Collins, 2011), flexibility in adapting to change, beliefs prior to trauma, sense of self-efficacy, and ability to experience positive emotions (Bonanno & Mancini, 2011).

History of mental disorders

The correlations among traumatic stress, substance use disorders, and co-occurring mental disorders are well known. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (American Psychiatric Association, 2013a), traumatic stress reactions are linked to higher rates of mood, substance-related, anxiety, trauma, stress-related, and other mental disorders, each of which can precede, follow, or emerge concurrently with trauma itself. A co-occurring mental disorder is a significant determinant of whether an individual can successfully address and resolve trauma as it emerges from the past or occurs in the present. Koenen, Stellman, Stellman, and Sommer (2003) found that the risk of developing PTSD following combat trauma was higher for individuals with preexisting conduct disorder, panic disorder, generalized anxiety disorder, and/or major depression than for those without preexisting mental disorders. For additional information on comorbidity of trauma and other mental disorders, see TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c).

Sociodemographic Factors

Demographic variables are not good predictors of who will experience trauma and subsequent traumatic stress reactions. Gender, age, race and ethnicity, sexual orientation, marital status, occupation, income, and education can all have some influence, but not enough to determine who should or should not receive screening for trauma and traumatic stress symptoms. The following sections cover a few selected variables. (For more information, please refer to Part 3 of this TIP, the online literature review.)

Gender

In the United States, men are at greater risk than women for being exposed to stressful events. Despite the higher prevalence among men, lifetime PTSD occurs at about twice the rate among women as it does in men. Less is known about gender differences with subclinical traumatic stress reactions. There are also other gender differences, such as the types of trauma experienced by men and women. Women are more likely to experience physical and sexual assault, whereas men are most likely to experience combat and crime victimization and to witness killings and serious injuries (Breslau, 2002; Kimerling, Ouimette, & Weitlauf, 2007; Tolin & Foa, 2006). Women in military service are subject to the same risks as men and are also at a greater risk for military sexual trauma. Men's traumas often occur in public; women's are more likely to take place in private settings. Perpetrators of traumas against men are often strangers, but women are more likely to know the perpetrator.

Age

In general, the older one becomes, the higher the risk of trauma—but the increase is not dramatic. Age is not particularly important in predicting exposure to trauma, yet at no age is one immune to the risk. However, trauma that occurs in the earlier and midlife years appears to have greater impact on people for different reasons. For younger individuals, the trauma can affect developmental processes, attachment, emotional regulation, life assumptions, cognitive interpretations of later experiences, and so forth (for additional resources, visit the National Child Traumatic Stress Network; http://www.nctsn.org/). For adults in midlife, trauma may have a greater impact due to the enhanced stress or burden of care that often characterizes this stage of life—caring for their children and their parents at the same time. Older adults are as likely as younger adults to recover quickly from trauma, yet they may have greater vulnerabilities, including their ability to survive without injury and their ability to address the current trauma without psychological interference from earlier stressful or traumatic events. Older people are naturally more likely to have had a history of trauma because they have lived longer, thus creating greater vulnerability to the effects of cumulative trauma.

Race, ethnicity, and culture

The potential for trauma exists in all major racial and ethnic groups in American society, yet few studies analyze the relationship of race and ethnicity to trauma exposure and/or traumatic stress reactions. Some studies show that certain racial and ethnic groups are at greater risk for specific traumas. For example, African Americans experienced higher rates of overall violence, aggravated assault, and robbery than Whites but were as likely to be victims of rape or sexual assault (Catalano, 2004). Literature reflects that diverse ethnic, racial, and cultural groups are more likely to experience adverse effects from various traumas and to meet criteria for posttraumatic stress (Bell, 2011).

Sexual orientation and gender identity

Lesbian, gay, bisexual, and transgender individuals are likely to experience various forms of trauma associated with their sexual orientation, including harsh consequences from families and faith traditions, higher risk of assault from casual sexual partners, hate crimes, lack of legal protection, and laws of exclusion (Brown, 2008). Gay and bisexual men as well as transgender people are more likely to experience victimization than lesbians and bisexual women. Dillon (2001) reported a trauma exposure rate of 94 percent among lesbian, gay,

Resilience: Cultural, Racial, and Ethnic Characteristics

The following list highlights characteristics that often nurture resilience among individuals from diverse cultural, racial, and ethnic groups:

- Strong kinship bonds
- Respect for elders and the importance of extended family
- Spirituality and religious practices (e.g., shrine visitations or the use of traditional healers)
- Value in friendships and warm personal relationships
- Expression of humor and creativity
- Instilling a sense of history, heritage, and historical traditions
- Community orientation, activities, and socialization
- Strong work ethic
- Philosophies and beliefs about life, suffering, and perseverance

"Fortune owes its existence to misfortune, and misfortune is hidden in fortune."

–Lao-Tzu teaching, Taoism (Wong & Wong, 2006)

and bisexual individuals; more than 40 percent of respondents experienced harassment due to their sexual orientation. Heterosexual orientation is also a risk for women, as women in relationships with men are at a greater risk of being physically and sexually abused.

People who are homeless

Homelessness is typically defined as the lack of an adequate or regular dwelling, or having a nighttime dwelling that is a publicly or privately supervised institution or a place not intended for use as a dwelling (e.g., a bus station). The U.S. Department of Housing and Urban Development (HUD) estimates that between 660,000 and 730,000 individuals were homeless on any given night in 2005 (HUD, 2007). Two thirds were unaccompanied persons; the other third were people in families. Adults who are homeless and unmarried are more likely to be male than female. About 40 percent of men who are homeless are veterans (National Coalition for the Homeless, 2002); this percentage has grown, including the number of veterans with dependent children (Kuhn & Nakashima, 2011).

Rates of trauma symptoms are high among people who are homeless (76 to 100 percent of women and 67 percent of men; Christensen et al., 2005; Jainchill, Hawke, & Yagelka, 2000), and the diagnosis of PTSD is among the most prevalent non-substance use Axis I disorders (Lester et al., 2007; McNamara, Schumacher, Milby, Wallace, & Usdan, 2001). People who are homeless report high levels of trauma (especially physical and sexual abuse in childhood or as adults) preceding their homeless status; assault, rape, and other traumas frequently happen while they are homeless. Research suggests that many women are homeless because they are fleeing domestic violence (National Coalition for the Homeless, 2002). Other studies suggest that women who are homeless are more likely to have histories of childhood physical and sexual abuse and to have experienced sexual assault as adults. A history of physical and/or sexual abuse is even more common among women who are homeless and have a serious mental illness.

Youth who are homeless, especially those who live without a parent, are likely to have experienced physical and/or sexual abuse. Between 21 and 42 percent of youth runaways report having been sexually abused before leaving their homes; for young women, rates range from 32 to 63 percent (Administration on Children, Youth and Families, 2002). Additionally, data reflect elevated rates of substance abuse for youth who are homeless and have histories of abuse.

More than half of people who are homeless have a lifetime prevalence of mental illness and substance use disorders. Those who are homeless have higher rates of substance abuse (84 percent of men and 58 percent of women), and substance use disorders, including alcohol and drug abuse/dependence, increase with longer lengths of homelessness (North, Eyrich, Pollio, & Spitznagel, 2004).

For more information on providing trauma-informed behavioral health services to clients who are homeless, and for further discussion of the incidence of trauma in this population, see TIP 55-R, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2013b).

3 Understanding the Impact of Trauma

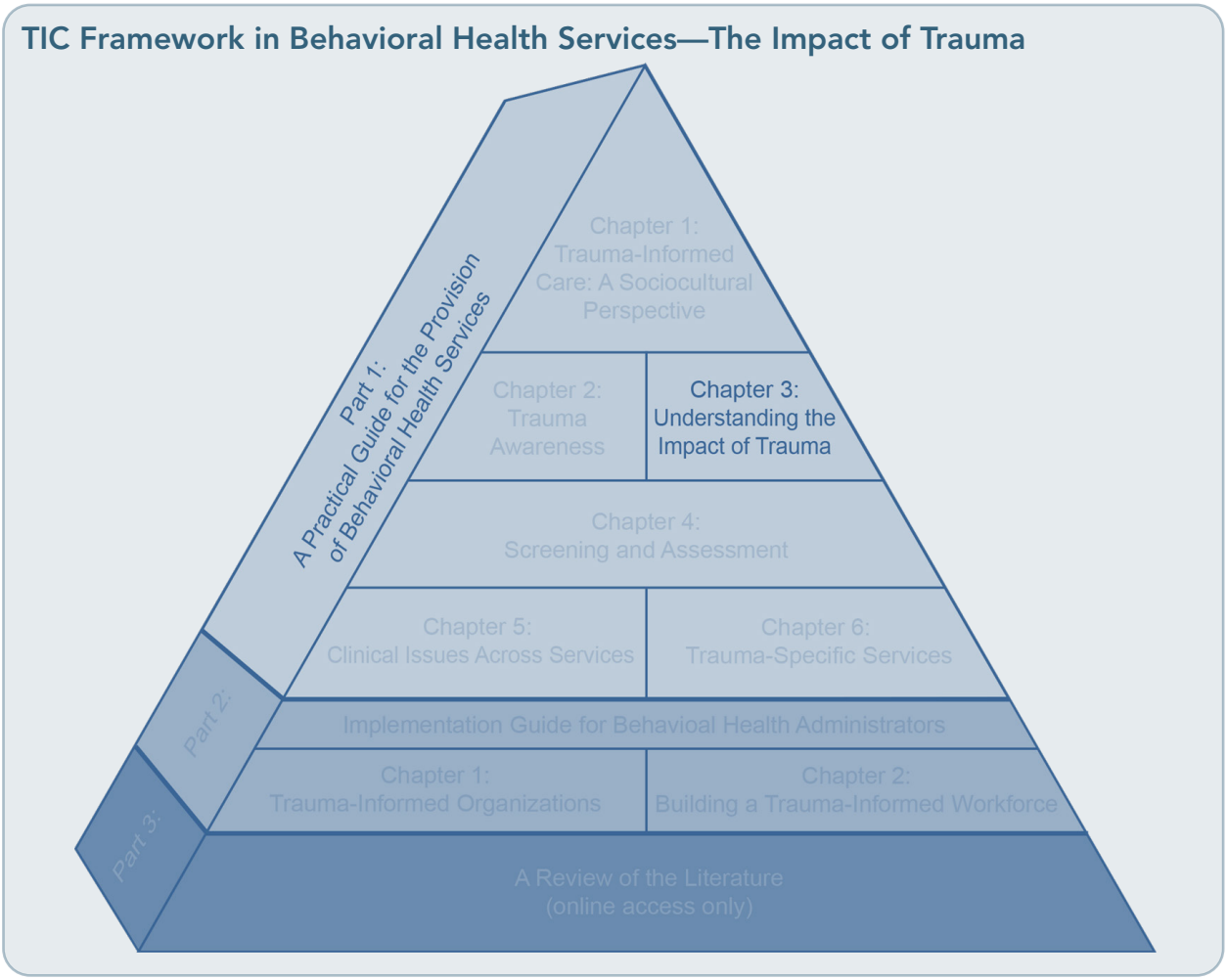
IN THIS CHAPTER

- Sequence of Trauma Reactions
- Common Experiences and Responses to Trauma
- Subthreshold Trauma Related Symptoms
- Specific Trauma Related Psychological Disorders
- Other Trauma Related and Co Occurring Disorders

Trauma-informed care (TIC) involves a broad understanding of traumatic stress reactions and common responses to trauma. Providers need to understand how trauma can affect treatment presentation, engagement, and the outcome of behavioral health services. This chapter examines common experiences survivors may encounter immediately following or long after a traumatic experience.

Trauma, including one-time, multiple, or long-lasting repetitive events, affects everyone differently. Some individuals may clearly display criteria associated with posttraumatic stress disorder (PTSD), but many more individuals will exhibit resilient responses or brief subclinical symptoms or consequences that fall outside of diagnostic criteria. The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors.

This chapter begins with an overview of common responses, emphasizing that traumatic stress reactions are normal reactions to abnormal circumstances. It highlights common short- and long-term responses to traumatic experiences in the context of individuals who may seek behavioral health services. This chapter discusses psychological symptoms not represented in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), and responses associated with trauma that either fall below the threshold of mental disorders or reflect resilience. It also addresses common disorders associated with traumatic stress. This chapter explores the role of culture in defining mental illness, particularly PTSD, and ends by addressing co-occurring mental and substance-related disorders.



Sequence of Trauma Reactions

Survivors' immediate reactions in the aftermath of trauma are quite complicated and are affected by their own experiences, the accessibility of natural supports and healers, their coping and life skills and those of immediate family, and the responses of the larger community in which they live. Although reactions range in severity, even the most acute responses are natural responses to manage trauma—they are not a sign of psychopathology. Coping styles vary from action oriented to reflective and from emotionally expressive to reticent. Clinically, a response style is less important than the degree to which coping efforts successfully allow one to continue necessary activities, regulate emotions, sustain self-esteem, and maintain and enjoy interpersonal contacts. Indeed, a past error in traumatic stress psychology, particularly regarding group or mass traumas, was the assumption that all survivors need to express emotions associated with trauma and talk about the trauma; more recent research indicates that survivors who choose not to process their trauma are just as psychologically healthy as

Foreshortened future: Trauma can affect one's beliefs about the future via loss of hope, limited expectations about life, fear that life will end abruptly or early, or anticipation that normal life events won't occur (e.g., access to education, ability to have a significant and committed relationship, good opportunities for work).

those who do. The most recent psychological debriefing approaches emphasize respecting the individual's style of coping and not valuing one type over another.

Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect. Most responses are normal in that they affect most survivors and are socially acceptable, psychologically effective, and self-limited. Indicators of more severe responses include continuous distress without periods of relative calm or rest, severe dissociation symptoms, and intense intrusive recollections that continue despite a return to safety. Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely. Exhibit 1.3-1 outlines some common reactions.

Common Experiences and Responses to Trauma

A variety of reactions are often reported and/or observed after trauma. Most survivors exhibit immediate reactions, yet these typically resolve without severe long-term consequences. This is because most trauma survivors are highly resilient and develop appropriate coping strategies, including the use of social supports, to deal with the aftermath and effects of trauma. Most recover with time, show minimal distress, and function effectively across major life areas and developmental stages. Even so, clients who show little impairment may still have subclinical symptoms or symptoms that do not fit diagnostic criteria for acute stress disorder (ASD) or PTSD. Only a small percentage of people with a history of trauma show impairment and symptoms that meet criteria for trauma-related stress disorders, including mood and anxiety disorders.

The following sections focus on some common reactions across domains (emotional, physical, cognitive, behavioral, social, and developmental) associated with singular, multiple, and enduring traumatic events. These reactions are often normal responses to trauma but can still be distressing to experience. Such responses are not signs of mental illness, nor do they indicate a mental disorder. Traumatic stress-related disorders comprise a specific constellation of symptoms and criteria.

Emotional

Emotional reactions to trauma can vary greatly and are significantly influenced by the individual's sociocultural history. Beyond the initial emotional reactions during the event, those most likely to surface include anger, fear, sadness, and shame. However, individuals may encounter difficulty in identifying any of these feelings for various reasons. They might lack experience with or prior exposure to emotional expression in their family or community. They may associate strong feelings with the past trauma, thus believing that emotional expression is too dangerous or will lead to feeling out of control (e.g., a sense of "losing it" or going crazy). Still others might deny that they have any feelings associated with their traumatic experiences and define their reactions as numbness or lack of emotions.

Emotional dysregulation

Some trauma survivors have difficulty regulating emotions such as anger, anxiety, sadness, and shame—this is more so when the trauma occurred at a young age (van der Kolk, Roth, Pelcovitz, & Mandel, 1993). In individuals who are older and functioning well

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma

Immediate Emotional Reactions	Delayed Emotional Reactions
Numbness and detachment Anxiety or severe fear Guilt (including survivor guilt) Exhilaration as a result of surviving Anger Sadness Helplessness Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself) Disorientation Feeling out of control Denial Constriction of feelings Feeling overwhelmed	Irritability and/or hostility Depression Mood swings, instability Anxiety (e.g., phobia, generalized anxiety) Fear of trauma recurrence Grief reactions Shame Feelings of fragility and/or vulnerability Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
Immediate Physical Reactions	**Delayed Physical Reactions**
Nausea and/or gastrointestinal distress Sweating or shivering Faintness Muscle tremors or uncontrollable shaking Elevated heartbeat, respiration, and blood pressure Extreme fatigue or exhaustion Greater startle responses Depersonalization	Sleep disturbances, nightmares Somatization (e.g., increased focus on and worry about body aches and pains) Appetite and digestive changes Lowered resistance to colds and infection Persistent fatigue Elevated cortisol levels Hyperarousal Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
Immediate Cognitive Reactions	**Delayed Cognitive Reactions**
Difficulty concentrating Rumination or racing thoughts (e.g., replaying the traumatic event over and over again) Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes) Memory problems (e.g., not being able to recall important aspects of the trauma) Strong identification with victims	Intrusive memories or flashbacks Reactivation of previous traumatic events Self-blame Preoccupation with event Difficulty making decisions Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma Belief that feelings or memories are dangerous Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day) Suicidal thinking
Immediate Behavioral Reactions	**Delayed Behavioral Reactions**
Startled reaction Restlessness Sleep and appetite disturbances Difficulty expressing oneself Argumentative behavior Increased use of alcohol, drugs, and tobacco Withdrawal and apathy Avoidant behaviors	Avoidance of event reminders Social relationship disturbances Decreased activity level Engagement in high-risk behaviors Increased use of alcohol and drugs Withdrawal

(Continued on the next page.)

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma (continued)

Immediate Existential Reactions	Delayed Existential Reactions
Intense use of prayer	Questioning (e.g., "Why me?")
Restoration of faith in the goodness of others (e.g., receiving help from others)	Increased cynicism, disillusionment
Loss of self-efficacy	Increased self-confidence (e.g., "If I can survive this, I can survive anything")
Despair about humanity, particularly if the event was intentional	Loss of purpose
Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)	Renewed faith
	Hopelessness
	Reestablishing priorities
	Redefining meaning and importance of life
	Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)

Sources: Briere & Scott, 2006b; Foa, Stein, & McFarlane, 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011.

prior to the trauma, such emotional dysregulation is usually short lived and represents an immediate reaction to the trauma, rather than an ongoing pattern. Self-medication—namely, substance abuse—is one of the methods that traumatized people use in an attempt to regain emotional control, although ultimately it causes even further emotional dysregulation (e.g., substance-induced changes in affect during and after use). Other efforts toward emotional regulation can include engagement in high-risk or self-injurious behaviors, disordered eating, compulsive behaviors such as gambling or overworking, and repression or denial of emotions; however, not all behaviors associated with self-regulation are considered negative. In fact, some individuals find creative, healthy, and industrious ways to manage strong affect generated by trauma, such as through renewed commitment to physical activity or by creating an organization to support survivors of a particular trauma.

Traumatic stress tends to evoke two emotional extremes: feeling either too much (overwhelmed) or too little (numb) emotion. Treatment can help the client find the optimal level of emotion and assist him or her with appropriately experiencing and regulating difficult emotions. In treatment, the goal is to help clients learn to regulate their emotions without the use of substances or other unsafe behavior. This will likely require learning new coping skills and how to tolerate distressing emotions; some clients may benefit from mindfulness practices, cognitive restructuring, and trauma-specific desensitization approaches, such as exposure therapy and eye movement desensitization and reprocessing (EMDR; refer to Part 1, Chapter 6, for more information on trauma-specific therapies).

Numbing

Numbing is a biological process whereby emotions are detached from thoughts, behaviors, and memories. In the following case illustration, Sadhanna's numbing is evidenced by her limited range of emotions associated with interpersonal interactions and her inability to associate any emotion with her history of abuse. She also possesses a belief in a foreshortened future. A prospective longitudinal study (Malta, Levitt, Martin, Davis, & Cloitre, 2009) that followed the development of PTSD in disaster workers highlighted the importance of understanding and appreciating numbing as a traumatic stress reaction. Because numbing

Case Illustration: Sadhanna

Sadhanna is a 22-year-old woman mandated to outpatient mental health and substance abuse treatment as the alternative to incarceration. She was arrested and charged with assault after arguing and fighting with another woman on the street. At intake, Sadhanna reported a 7-year history of alcohol abuse and one depressive episode at age 18. She was surprised that she got into a fight but admitted that she was drinking at the time of the incident. She also reported severe physical abuse at the hands of her mother's boyfriend between ages 4 and 15. Of particular note to the intake worker was Sadhanna's matter-of-fact way of presenting the abuse history. During the interview, she clearly indicated that she did not want to attend group therapy and hear other people talk about their feelings, saying, "I learned long ago not to wear emotions on my sleeve."

Sadhanna reported dropping out of 10th grade, saying she never liked school. She didn't expect much from life. In Sadhanna's first weeks in treatment, she reported feeling disconnected from other group members and questioned the purpose of the group. When asked about her own history, she denied that she had any difficulties and did not understand why she was mandated to treatment. She further denied having feelings about her abuse and did not believe that it affected her life now. Group members often commented that she did not show much empathy and maintained a flat affect, even when group discussions were emotionally charged.

symptoms hide what is going on inside emotionally, there can be a tendency for family members, counselors, and other behavioral health staff to assess levels of traumatic stress symptoms and the impact of trauma as less severe than they actually are.

Physical

Diagnostic criteria for PTSD place considerable emphasis on psychological symptoms, but some people who have experienced traumatic stress may present initially with physical symptoms. Thus, primary care may be the first and only door through which these individuals seek assistance for trauma-related symptoms. Moreover, there is a significant connection between trauma, including adverse childhood experiences (ACEs), and chronic health conditions. Common physical disorders and symptoms include somatic complaints; sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders.

Somatization

Somatization indicates a focus on bodily symptoms or dysfunctions to express emotional distress. Somatic symptoms are more likely to occur with individuals who have traumatic stress reactions, including PTSD. People from certain ethnic and cultural backgrounds may initially or solely present emotional distress via physical ailments or concerns. Many individuals who present with somatization are likely unaware of the connection between their emotions and the physical symptoms that they're experiencing. At times, clients may remain resistant to exploring emotional content and remain focused on bodily complaints as a means of avoidance. Some clients may insist that their primary problems are physical even when medical evaluations and tests fail to confirm ailments. In these situations, somatization may be a sign of a mental illness. However, various cultures approach emotional distress through the physical realm or view emotional and physical symptoms and well-being as one. It is important not to assume that clients with physical complaints are using somatization as a means to express emotional pain; they may have specific conditions or disorders that require medical attention. Foremost, counselors need to refer for medical evaluation.

Advice to Counselors: Using Information About Biology and Trauma

- Educate your clients:
  - Frame reexperiencing the event(s), hyperarousal, sleep disturbances, and other physical symptoms as physiological reactions to extreme stress.
  - Communicate that treatment and other wellness activities can improve both psychological and physiological symptoms (e.g., therapy, meditation, exercise, yoga). You may need to refer certain clients to a psychiatrist who can evaluate them and, if warranted, prescribe psychotropic medication to address severe symptoms.
  - Discuss traumatic stress symptoms and their physiological components.
  - Explain links between traumatic stress symptoms and substance use disorders, if appropriate.
  - Normalize trauma symptoms. For example, explain to clients that their symptoms are not a sign of weakness, a character flaw, being damaged, or going crazy.
- Support your clients and provide a message of hope—that they are not alone, they are not at fault, and recovery is possible and anticipated.

Biology of trauma

Trauma biology is an area of burgeoning research, with the promise of more complex and explanatory findings yet to come. Although a thorough presentation on the biological aspects of trauma is beyond the scope of this publication, what is currently known is that exposure to trauma leads to a cascade of biological changes and stress responses. These biological alterations are highly associated with PTSD, other mental illnesses, and substance use disorders. These include:

- Changes in limbic system functioning.
- Hypothalamic–pituitary–adrenal axis activity changes with variable cortisol levels.
- Neurotransmitter-related dysregulation of arousal and endogenous opioid systems.

As a clear example, early ACEs such as abuse, neglect, and other traumas affect brain development and increase a person's vulnerability to encountering interpersonal violence as an adult and to developing chronic diseases and other physical illnesses, mental illnesses, substance-related disorders, and impairment in other life areas (Centers for Disease Control and Prevention, 2012).

Hyperarousal and sleep disturbances

A common symptom that arises from traumatic experiences is hyperarousal (also called hypervigilance). Hyperarousal is the body's way of remaining prepared. It is characterized by sleep disturbances, muscle tension, and a lower threshold for startle responses and can persist years after trauma occurs. It is also one of the primary diagnostic criteria for PTSD.

Hyperarousal is a consequence of biological changes initiated by trauma. Although it

Case Illustration: Kimi

Kimi is a 35-year-old Native American woman who was group raped at the age of 16 on her walk home from a suburban high school. She recounts how her whole life changed on that day. "I never felt safe being alone after the rape. I used to enjoy walking everywhere. Afterward, I couldn't tolerate the fear that would arise when I walked in the neighborhood. It didn't matter whether I was alone or with friends—every sound that I heard would throw me into a state of fear. I felt like the same thing was going to happen again. It's gotten better with time, but I often feel as if I'm sitting on a tree limb waiting for it to break. I have a hard time relaxing. I can easily get startled if a leaf blows across my path or if my children scream while playing in the yard. The best way I can describe how I experience life is by comparing it to watching a scary, suspenseful movie—anxiously waiting for something to happen, palms sweating, heart pounding, on the edge of your chair."

serves as a means of self-protection after trauma, it can be detrimental. Hyperarousal can interfere with an individual's ability to take the necessary time to assess and appropriately respond to specific input, such as loud noises or sudden movements. Sometimes, hyperarousal can produce overreactions to situations perceived as dangerous when, in fact, the circumstances are safe.

Along with hyperarousal, sleep disturbances are very common in individuals who have experienced trauma. They can come in the form of early awakening, restless sleep, difficulty falling asleep, and nightmares. Sleep disturbances are most persistent among individuals who have trauma-related stress; the disturbances sometimes remain resistant to intervention long after other traumatic stress symptoms have been successfully treated. Numerous strategies are available beyond medication, including good sleep hygiene practices, cognitive rehearsals of nightmares, relaxation strategies, and nutrition.

Cognitive

Traumatic experiences can affect and alter cognitions. From the outset, trauma challenges the just-world or core life assumptions that

Cognitions and Trauma

The following examples reflect some of the types of cognitive or thought-process changes that can occur in response to traumatic stress.

Cognitive errors: Misinterpreting a current situation as dangerous because it resembles, even remotely, a previous trauma (e.g., a client overreacting to an overturned canoe in 8 inches of water, as if she and her paddle companion would drown, due to her previous experience of nearly drowning in a rip current 5 years earlier).

Excessive or inappropriate guilt: Attempting to make sense cognitively and gain control over a traumatic experience by assuming responsibility or possessing survivor's guilt, because others who experienced the same trauma did not survive.

Idealization: Demonstrating inaccurate rationalizations, idealizations, or justifications of the perpetrator's behavior, particularly if the perpetrator is or was a caregiver. Other similar reactions mirror idealization; traumatic bonding is an emotional attachment that develops (in part to secure survival) between perpetrators who engage in interpersonal trauma and their victims, and Stockholm syndrome involves compassion and loyalty toward hostage takers (de Fabrique, Van Hasselt, Vecchi, & Romano, 2007).

Trauma-induced hallucinations or delusions: Experiencing hallucinations and delusions that, although they are biological in origin, contain cognitions that are congruent with trauma content (e.g., a woman believes that a person stepping onto her bus is her father, who had sexually abused her repeatedly as child, because he wore shoes similar to those her father once wore).

Intrusive thoughts and memories: Experiencing, without warning or desire, thoughts and memories associated with the trauma. These intrusive thoughts and memories can easily trigger strong emotional and behavioral reactions, as if the trauma was recurring in the present. The intrusive thoughts and memories can come rapidly, referred to as flooding, and can be disruptive at the time of their occurrence. If an individual experiences a trigger, he or she may have an increase in intrusive thoughts and memories for a while. For instance, individuals who inadvertently are retraumatized due to program or clinical practices may have a surge of intrusive thoughts of past trauma, thus making it difficult for them to discern what is happening now versus what happened then. Whenever counseling focuses on trauma, it is likely that the client will experience some intrusive thoughts and memories. It is important to develop coping strategies before, as much as possible, and during the delivery of trauma-informed and trauma-specific treatment.

help individuals navigate daily life (Janoff-Bulman, 1992). For example, it would be difficult to leave the house in the morning if you believed that the world was not safe, that all people are dangerous, or that life holds no promise. Belief that one's efforts and intentions can protect oneself from bad things makes it less likely for an individual to perceive personal vulnerability. However, traumatic events—particularly if they are unexpected—can challenge such beliefs.

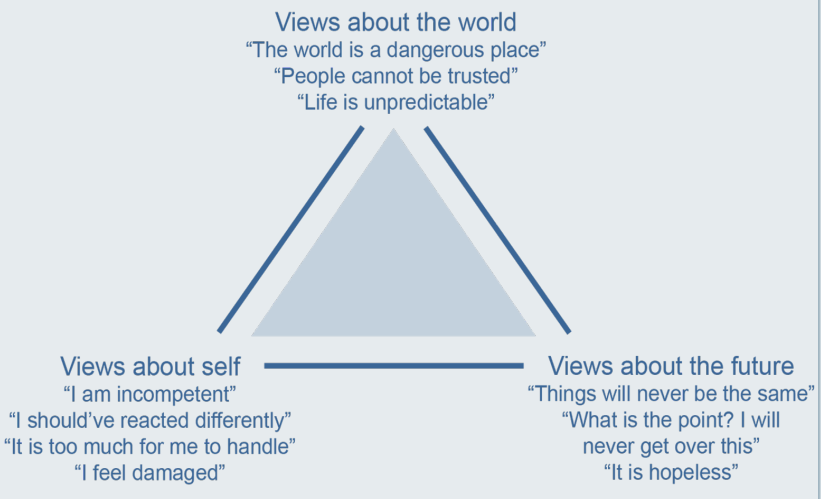
Let's say you always considered your driving time as "your time"—and your car as a safe place to spend that time. Then someone hits you from behind at a highway entrance. Almost immediately, the accident affects how you perceive the world, and from that moment onward, for months following the crash, you feel unsafe in any car. You become hypervigilant about other drivers and perceive that other cars are drifting into your lane or failing to stop at a safe distance behind you. For a time, your perception of safety is eroded, often leading to compensating behaviors (e.g., excessive glancing into the rearview mirror to see whether the vehicles behind you are stopping) until the belief is restored or reworked. Some individuals never return to their previous belief systems after a trauma, nor do they find a way to rework them—thus leading to a worldview that life is unsafe. Still, many other individuals are able to return to organizing core beliefs that support their perception of safety.

Many factors contribute to cognitive patterns prior to, during, and after a trauma. Adopting Beck and colleagues' cognitive triad model (1979), trauma can alter three main cognitive patterns: thoughts about self, the world (others/environment), and the future. To clarify, trauma can lead individuals to see themselves as incompetent or damaged, to see others and the world as unsafe and unpredictable, and to see the future as hopeless—believing that personal suffering will continue, or negative outcomes will preside for the foreseeable future (see Exhibit 1.3-2). Subsequently, this set of cognitions can greatly influence clients' belief in their ability to use internal resources and external support effectively. From a cognitive–behavioral perspective, these cognitions have a bidirectional relationship in sustaining or contributing to the development of depressive and anxiety symptoms after trauma. However, it is possible for cognitive patterns to help protect against debilitating psychological symptoms as well. Many factors contribute to cognitive patterns prior to, during, and after a trauma.

Feeling different

An integral part of experiencing trauma is feeling different from others, whether or not the trauma was an individual or group experience. Traumatic experiences typically feel surreal and challenge the necessity and value of mundane activities of daily life. Survivors

Exhibit 1.3-2: Cognitive Triad of Traumatic Stress



often believe that others will not fully understand their experiences, and they may think that sharing their feelings, thoughts, and reactions related to the trauma will fall short of expectations. However horrid the trauma may be, the *experience* of the trauma is typically profound.

The type of trauma can dictate how an individual feels different or believes that they are different from others. Traumas that generate shame will often lead survivors to feel more alienated from others—believing that they are "damaged goods." When individuals believe that their experiences are unique and incomprehensible, they are more likely to seek support, if they seek support at all, only with others who have experienced a similar trauma.

Triggers and flashbacks

Triggers

A trigger is a stimulus that sets off a memory of a trauma or a specific portion of a traumatic experience. Imagine you were trapped briefly in a car after an accident. Then, several years later, you were unable to unlatch a lock after using a restroom stall; you might have begun to feel a surge of panic reminiscent of the accident, even though there were other avenues of escape from the stall. Some triggers can be identified and anticipated easily, but many are subtle and inconspicuous, often surprising the individual or catching him or her off guard. In treatment, it is important to help clients identify potential triggers, draw a connection between strong emotional reactions and triggers, and develop coping strategies to manage those moments when a trigger occurs. A trigger is any sensory reminder of the traumatic event: a noise, smell, temperature, other physical sensation, or visual scene. Triggers can generalize to any characteristic, no matter how remote, that resembles or represents a previous trauma, such as revisiting the location where the trauma occurred, being alone, having your children reach the same age that you were when you experienced the trauma, seeing the same breed of dog that bit you, or hearing loud voices. Triggers are often associated with the time of day, season, holiday, or anniversary of the event.

Flashbacks

A flashback is reexperiencing a previous traumatic experience as if it were actually happening in that moment. It includes reactions that often resemble the client's reactions during the trauma. Flashback experiences are very brief and typically last only a few seconds, but the emotional aftereffects linger for hours or longer. Flashbacks are commonly initiated by a trigger, but not necessarily. Sometimes, they occur out of the blue. Other times, specific physical states increase a person's vulnerability to reexperiencing a trauma, (e.g., fatigue, high

Advice to Counselors: Helping Clients Manage Flashbacks and Triggers

If a client is triggered in a session or during some aspect of treatment, help the client focus on what is happening in the here and now; that is, use grounding techniques. Behavioral health service providers should be prepared to help the client get regrounded so that they can distinguish between what is happening now versus what had happened in the past (see Covington, 2008, and Najavits, 2002b, 2007b, for more grounding techniques). Offer education about the experience of triggers and flashbacks, and then normalize these events as common traumatic stress reactions. Afterward, some clients need to discuss the experience and understand why the flashback or trigger occurred. It often helps for the client to draw a connection between the trigger and the traumatic event(s). This can be a preventive strategy whereby the client can anticipate that a given situation places him or her at higher risk for retraumatization and requires use of coping strategies, including seeking support.

Source: Green Cross Academy of Traumatology, 2010.

stress levels). Flashbacks can feel like a brief movie scene that intrudes on the client. For example, hearing a car backfire on a hot, sunny day may be enough to cause a veteran to respond as if he or she were back on military patrol. Other ways people reexperience trauma, besides flashbacks, are via nightmares and intrusive thoughts of the trauma.

Dissociation, depersonalization, and derealization

Dissociation is a mental process that severs connections among a person's thoughts, memories, feelings, actions, and/or sense of identity. Most of us have experienced dissociation—losing the ability to recall or track a particular action (e.g., arriving at work but not remembering the last minutes of the drive). Dissociation happens because the person is engaged in an automatic activity and is not paying attention to his or her immediate environment. Dissociation can also occur during severe stress or trauma as a protective element whereby the individual incurs distortion of time, space, or identity. This is a common symptom in traumatic stress reactions.

Dissociation helps distance the experience from the individual. People who have experienced severe or developmental trauma may have learned to separate themselves from distress to survive. At times, dissociation can be very pervasive and symptomatic of a mental disorder, such as dissociative identity disorder (DID; formerly known as multiple personality disorder). According to the DSM-5, "dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (APA, 2013a, p. 291). Dissociative disorder diagnoses are closely associated with histories of severe childhood trauma or pervasive, human-caused, intentional trauma, such as that experienced by concentration camp survivors or victims of ongoing political imprisonment, torture, or long-term isolation. A mental health professional, preferably with significant training in working with dissociative disorders and with trauma, should be consulted when a dissociative disorder diagnosis is suspected.

Potential Signs of Dissociation

- Fixed or "glazed" eyes
- Sudden flattening of affect
- Long periods of silence
- Monotonous voice
- Stereotyped movements
- Responses not congruent with the present context or situation
- Excessive intellectualization

(Briere, 1996a)

The characteristics of DID can be commonly accepted experiences in other cultures, rather than being viewed as symptomatic of a traumatic experience. For example, in non-Western cultures, a sense of alternate beings within oneself may be interpreted as being inhabited by spirits or ancestors (Kirmayer, 1996). Other experiences associated with dissociation include depersonalization—psychologically "leaving one's body," as if watching oneself from a distance as an observer or through derealization, leading to a sense that what is taking place is unfamiliar or is not real.

If clients exhibit signs of dissociation, behavioral health service providers can use grounding techniques to help them reduce this defense strategy. One major long-term consequence of dissociation is the difficulty it causes in connecting strong emotional or physical reactions with an event. Often, individuals may believe that they are going crazy because they are not in touch with the nature of their reactions. By educating clients on the resilient qualities of dissociation while also emphasizing that it prevents them from addressing or

validating the trauma, individuals can begin to understand the role of dissociation. All in all, it is important when working with trauma survivors that the intensity level is not so great that it triggers a dissociative reaction and prevents the person from engaging in the process.

Behavioral

Traumatic stress reactions vary widely; often, people engage in behaviors to manage the aftereffects, the intensity of emotions, or the distressing aspects of the traumatic experience. Some people reduce tension or stress through avoidant, self-medicating (e.g., alcohol abuse), compulsive (e.g., overeating), impulsive (e.g., high-risk behaviors), and/or self-injurious behaviors. Others may try to gain control over their experiences by being aggressive or subconsciously reenacting aspects of the trauma.

Behavioral reactions are also the consequences of, or learned from, traumatic experiences. For example, some people act like they can't control their current environment, thus failing to take action or make decisions long after the trauma (learned helplessness). Other associate elements of the trauma with current activities, such as by reacting to an intimate moment in a significant relationship as dangerous or unsafe years after a date rape. The following sections discuss behavioral consequences of trauma and traumatic stress reactions.

Reenactments

A hallmark symptom of trauma is reexperiencing the trauma in various ways. Reexperiencing can occur through reenactments (literally, to "redo"), by which trauma survivors repetitively relive and recreate a past trauma in their present lives. This is very apparent in children, who play by mimicking what occurred during the trauma, such as by pretending to crash a toy airplane into a toy building after seeing televised images of the terrorist attacks on the World Trade Center on September 11, 2001. Attempts to understand reenactments are very complicated, as reenactments occur for a variety of reasons. Sometimes, individuals reenact past traumas to master them. Examples of reenactments include a variety of behaviors: self-injurious behaviors, hypersexuality, walking alone in unsafe areas or other high-risk behaviors, driving recklessly, or involvement in repetitive destructive relationships (e.g., repeatedly getting into romantic relationships with people who are abusive or violent), to name a few.

Self-harm and self-destructive behaviors

Self-harm is any type of intentionally self-inflicted harm, regardless of the severity of injury or whether suicide is intended. Often, self-harm is an attempt to cope with emotional or physical distress that seems overwhelming or to cope with a profound sense of dissociation or being trapped, helpless, and "damaged" (Herman, 1997; Santa Mina & Gallop, 1998). Self-harm is associated with past childhood sexual abuse and other forms of trauma as well as substance abuse. Thus,

Resilient Responses to Trauma

Many people find healthy ways to cope with, respond to, and heal from trauma. Often, people automatically reevaluate their values and redefine what is important after a trauma. Such resilient responses include:

- Increased bonding with family and community.
- Redefined or increased sense of purpose and meaning.
- Increased commitment to a personal mission.
- Revised priorities.
- Increased charitable giving and volunteerism.

Case Illustration: Marco

Marco, a 30-year-old man, sought treatment at a local mental health center after a 2-year bout of anxiety symptoms. He was an active member of his church for 12 years, but although he sought help from his pastor about a year ago, he reports that he has had no contact with his pastor or his church since that time. Approximately 3 years ago, his wife took her own life. He describes her as his soulmate and has had a difficult time understanding her actions or how he could have prevented them.

In the initial intake, he mentioned that he was the first person to find his wife after the suicide and reported feelings of betrayal, hurt, anger, and devastation since her death. He claimed that everyone leaves him or dies. He also talked about his difficulty sleeping, having repetitive dreams of his wife, and avoiding relationships. In his first session with the counselor, he initially rejected the counselor before the counselor had an opportunity to begin reviewing and talking about the events and discomfort that led him to treatment.

In this scenario, Marco is likely reenacting his feelings of abandonment by attempting to reject others before he experiences another rejection or abandonment. In this situation, the counselor will need to recognize the reenactment, explore the behavior, and examine how reenactments appear in other situations in Marco's life.

addressing self-harm requires attention to the client's reasons for self-harm. More than likely, the client needs help recognizing and coping with emotional or physical distress in manageable amounts and ways.

Among the self-harm behaviors reported in the literature are cutting, burning skin by heat (e.g., cigarettes) or caustic liquids, punching hard enough to self-bruise, head banging, hair pulling, self-poisoning, inserting foreign objects into bodily orifices, excessive nail biting, excessive scratching, bone breaking, gnawing at flesh, interfering with wound healing, tying off body parts to stop breathing or blood flow, swallowing sharp objects, and suicide. Cutting and burning are among the most common forms of self-harm.

Self-harm tends to occur most in people who have experienced repeated and/or early trauma (e.g., childhood sexual abuse) rather than in those who have undergone a single adult trauma (e.g., a community-wide disaster or a serious car accident). There are strong associations between eating disorders, self-harm, and substance abuse (Claes &Vandereycken, 2007; for discussion, see Harned, Najavits, & Weiss, 2006). Self-mutilation is also associated with (and part of the diagnostic criteria for) a number of personality disorders, including borderline and histrionic, as well as DID, depression, and some forms of schizophrenia; these disorders can co-occur with traumatic stress reactions and disorders.

It is important to distinguish self-harm that is suicidal from self-harm that is not suicidal and to assess and manage both of these very serious dangers carefully. Most people who engage in self-harm are not doing so with the intent to kill themselves (Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003)—although self-harm can be life threatening and can escalate into suicidality if not managed therapeutically. Self-harm can be a way of getting attention or manipulating others, but most often it is not. Self-destructive behaviors such as substance abuse, restrictive or binge eating, reckless automobile driving, or high-risk impulsive behavior are different from self-harming behaviors but are also seen in clients with a history of trauma. Self-destructive behaviors differ from self-harming behaviors in that there may be no immediate negative impact of the behavior on the individual; they differ from suicidal behavior in that there is no intent to cause death in the short term.

Advice to Counselors: Working With Clients Who Are Self-Injurious

Counselors who are unqualified or uncomfortable working with clients who demonstrate self-harming, self-destructive, or suicidal or homicidal ideation, intent, or behavior should work with their agencies and supervisors to refer such clients to other counselors. They should consider seeking specialized supervision on how to manage such clients effectively and safely and how to manage their feelings about these issues. The following suggestions assume that the counselor has had sufficient training and experience to work with clients who are self-injurious. To respond appropriately to a client who engages in self-harm, counselors should:

- Screen the client for self-harm and suicide risk at the initial evaluation and throughout treatment.
- Learn the client's perspective on self-harm and how it "helps."
- Understand that self-harm is often a coping strategy to manage the intensity of emotional and/or physical distress.
- Teach the client coping skills that improve his or her management of emotions without self-harm.
- Help the client obtain the level of care needed to manage genuine risk of suicide or severe self-injury. This might include hospitalization, more intensive programming (e.g., intensive outpatient, partial hospitalization, residential treatment), or more frequent treatment sessions. The goal is to stabilize the client as quickly as possible, and then, if possible, begin to focus treatment on developing coping strategies to manage self-injurious and other harmful impulses.
- Consult with other team members, supervisors, and, if necessary, legal experts to determine whether one's efforts with and conceptualization of the self-harming client fit best practice guidelines. See, for example, Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT], 2005c). Document such consultations and the decisions made as a result of them thoroughly and frequently.
- Help the client identify how substance use affects self-harm. In some cases, it can increase the behavior (e.g., alcohol disinhibits the client, who is then more likely to self-harm). In other cases, it can decrease the behavior (e.g., heroin evokes relaxation and, thus, can lessen the urge to self-harm). In either case, continue to help the client understand how abstinence from substances is necessary so that he or she can learn more adaptive coping.
- Work collaboratively with the client to develop a plan to create a sense of safety. Individuals are affected by trauma in different ways; therefore, safety or a safe environment may mean something entirely different from one person to the next. Allow the client to define what safety means to him or her.

Counselors can also help the client prepare a safety card that the client can carry at all times. The card might include the counselor's contact information, a 24-hour crisis number to call in emergencies, contact information for supportive individuals who can be contacted when needed, and, if appropriate, telephone numbers for emergency medical services. The counselor can discuss with the client the types of signs or crises that might warrant using the numbers on the card. Additionally, the counselor might check with the client from time to time to confirm that the information on the card is current.

TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a), has examples of safety agreements specifically for suicidal clients and discusses their uses in more detail. There is no credible evidence that a safety agreement is effective in preventing a suicide attempt or death. Safety agreements for clients with suicidal thoughts and behaviors should only be used as an adjunct support accompanying professional screening, assessment, and treatment for people with suicidal thoughts and behaviors. Keep in mind that safety plans or agreements may be perceived by the trauma survivor as a means of controlling behavior, subsequently replicating or triggering previous traumatic experiences.

All professionals—and in some States, anyone—could have ethical and legal responsibilities to those clients who pose an imminent danger to themselves or others. Clinicians should be aware of the pertinent State laws where they practice and the relevant Federal and professional regulations.

However, as with self-harming behavior, self-destructive behavior needs to be recognized and addressed and may persist—or worsen—without intervention.

Consumption of substances

Substance use often is initiated or increased after trauma. Clients in early recovery—especially those who develop PTSD or have it reactivated—have a higher relapse risk if they experience a trauma. In the first 2 months after September 11, 2001, more than a quarter of New Yorker residents who smoked cigarettes, drank alcohol, or used marijuana (about 265,000 people) increased their consumption. The increases continued 6 months after the attacks (Vlahov, Galea, Ahern, Resnick, & Kilpatrick, 2004). A study by the Substance Abuse and Mental Health Services Administration (SAMHSA, Office of Applied Studies, 2002) used National Survey on Drug Use and Health data to compare the first three quarters of 2001 with the last quarter and reported an increase in the prevalence rate for alcohol use among people 18 or older in the New York metropolitan area during the fourth quarter.

Interviews with New York City residents who were current or former cocaine or heroin users indicated that many who had been clean for 6 months or less relapsed after September 11, 2001. Others, who lost their income and could no longer support their habit, enrolled in methadone programs (Weiss et al., 2002). After the Oklahoma City bombing in 1995, Oklahomans reported double the normal rate of alcohol use, smoking more cigarettes, and a higher incidence of initiating smoking months and even years after the bombing (Smith, Christiansen, Vincent, & Hann, 1999).

Self-medication

Khantzian's self-medication theory (1985) suggests that drugs of abuse are selected for their specific effects. However, no definitive pattern has yet emerged of the use of particular substances in relation to PTSD or trauma symptoms. Use of substances can vary based on a variety of factors, including which trauma symptoms are most prominent for an individual and the individual's access to particular substances. Unresolved traumas sometimes lurk behind the emotions that clients cannot allow themselves to experience. Substance use and abuse in trauma survivors can be a way to self-medicate and thereby avoid or displace difficult emotions associated with traumatic experiences. When the substances are withdrawn, the survivor may use other behaviors to self-soothe, self-medicate, or avoid emotions. As likely, emotions can appear after abstinence in the form of anxiety and depression.

Avoidance

Avoidance often coincides with anxiety and the promotion of anxiety symptoms. Individuals begin to avoid people, places, or situations to alleviate unpleasant emotions, memories, or circumstances. Initially, the avoidance works, but over time, anxiety increases and the perception that the situation is unbearable or dangerous increases as well, leading to a greater need to avoid. Avoidance can be adaptive, but it is also a behavioral pattern that reinforces perceived danger without testing its validity, and it typically leads to greater problems across major life areas (e.g., avoiding emotionally oriented conversations in an intimate relationship). For many individuals who have traumatic stress reactions, avoidance is commonplace. A person may drive 5 miles longer to avoid the road where he or she had an accident. Another individual may avoid crowded places in fear of an assault or to circumvent strong emotional memories about an earlier assault that took place in a crowded area. Avoidance can come in many forms. When people can't tolerate strong affects associated with traumatic memories, they avoid, project,

deny, or distort their trauma-related emotional and cognitive experiences. A key ingredient in trauma recovery is learning to manage triggers, memories, and emotions without avoidance—in essence, becoming desensitized to traumatic memories and associated symptoms.

Social/Interpersonal

A key ingredient in the early stage of TIC is to establish, confirm, or reestablish a support system, including culturally appropriate activities, as soon as possible. Social supports and relationships can be protective factors against traumatic stress. However, trauma typically affects relationships significantly, regardless of whether the trauma is interpersonal or is of some other type. Relationships require emotional exchanges, which means that others who have close relationships or friendships with the individual who survived the trauma(s) are often affected as well—either through secondary traumatization or by directly experiencing the survivor's traumatic stress reactions. In natural disasters, social and community supports can be abruptly eroded and difficult to rebuild after the initial disaster relief efforts have waned.

Survivors may readily rely on family members, friends, or other social supports—or they may avoid support, either because they believe that no one will be understanding or trustworthy or because they perceive their own needs as a burden to others. Survivors who have strong emotional or physical reactions, including outbursts during nightmares, may pull away further in fear of being unable to predict their own reactions or to protect their own safety and that of others. Often, trauma survivors feel ashamed of their stress reactions, which further hampers their ability to use their support systems and resources adequately.

Many survivors of childhood abuse and interpersonal violence have experienced a significant sense of betrayal. They have often encountered trauma at the hands of trusted caregivers and family members or through significant relationships. This history of betrayal can disrupt forming or relying on supportive relationships in recovery, such as peer supports and counseling. Although this fear of trusting others is protective, it can lead to difficulty in connecting with others and greater vigilance in observing the behaviors of others, including behavioral health service providers. It is exceptionally difficult to override the feeling that someone is going to hurt you, take advantage of you, or, minimally, disappoint you. Early betrayal can affect one's ability to develop attachments, yet the formation of supportive relationships is an important antidote in the recovery from traumatic stress.

Developmental

Each age group is vulnerable in unique ways to the stresses of a disaster, with children and the elderly at greatest risk. Young children may display generalized fear, nightmares, heightened arousal and confusion, and physical symptoms, (e.g., stomachaches, headaches). School-age children may exhibit symptoms such as aggressive behavior and anger, regression to behavior seen at younger ages, repetitious traumatic play, loss of ability to concentrate, and worse school performance. Adolescents may display depression and social withdrawal, rebellion, increased risky activities such as sexual acting out, wish for revenge and action-oriented responses to trauma, and sleep and eating disturbances (Hamblen, 2001). Adults may display sleep problems, increased agitation, hypervigilance, isolation or withdrawal, and increased use of alcohol or drugs. Older adults may exhibit increased withdrawal and isolation, reluctance to leave home, worsening of chronic illnesses, confusion, depression, and fear (DeWolfe & Nordboe, 2000b).

Neurobiological Development: Consequences of Early Childhood Trauma

Findings in developmental psychobiology suggest that the consequences of early maltreatment produce enduring negative effects on brain development (DeBellis, 2002; Liu, Diorio, Day, Francis, & Meaney, 2000; Teicher, 2002). Research suggests that the first stage in a cascade of events produced by early trauma and/or maltreatment involves the disruption of chemicals that function as neurotransmitters (e.g., cortisol, norepinephrine, dopamine), causing escalation of the stress response (Heim, Mletzko, Purselle, Musselman, & Nemeroff, 2008; Heim, Newport, Mletzko, Miller, & Nemeroff, 2008; Teicher, 2002). These chemical responses can then negatively affect critical neural growth during specific sensitive periods of childhood development and can even lead to cell death.

Adverse brain development can also result from elevated levels of cortisol and catecholamines by contributing to maturational failures in other brain regions, such as the prefrontal cortex (Meaney, Brake, & Gratton, 2002). Heim, Mletzko et al. (2008) found that the neuropeptide oxytocin—important for social affiliation and support, attachment, trust, and management of stress and anxiety—was markedly decreased in the cerebrospinal fluid of women who had been exposed to childhood maltreatment, particularly those who had experienced emotional abuse. The more childhood traumas a person had experienced, and the longer their duration, the lower that person's current level of oxytocin was likely to be and the higher her rating of current anxiety was likely to be.

Using data from the Adverse Childhood Experiences Study, an analysis by Anda, Felitti, Brown et al. (2006) confirmed that the risk of negative outcomes in affective, somatic, substance abuse, memory, sexual, and aggression-related domains increased as scores on a measure of eight ACEs increased. The researchers concluded that the association of study scores with these outcomes can serve as a theoretical parallel for the effects of cumulative exposure to stress on the developing brain and for the resulting impairment seen in multiple brain structures and functions.

The National Child Traumatic Stress Network (http://www.nctsn.org) offers information about childhood abuse, stress, and physiological responses of children who are traumatized. Materials are available for counselors, educators, parents, and caregivers. There are special sections on the needs of children in military families and on the impact of natural disasters on children's mental health.

Subthreshold Trauma-Related Symptoms

Many trauma survivors experience symptoms that, although they do not meet the diagnostic criteria for ASD or PTSD, nonetheless limit their ability to function normally (e.g., regulate emotional states, maintain steady and rewarding social and family relationships, function competently at a job, maintain a steady pattern of abstinence in recovery). These symptoms can be transient, only arising in a specific context; intermittent, appearing for several weeks or months and then receding; or a part of the individual's regular pattern of functioning (but not to the level of DSM-5 diagnostic criteria). Often, these patterns are termed "subthreshold" trauma symptoms. Like PTSD, the symptoms can be misdiagnosed as depression, anxiety, or another mental illness. Likewise, clients who have experienced trauma may link some of their symptoms to their trauma and diagnose themselves as having PTSD, even though they do not meet all criteria for that disorder.

Combat Stress Reaction

A phenomenon unique to war, and one that counselors need to understand well, is combat stress reaction (CSR). CSR is an acute anxiety reaction occurring during or shortly after participating in military conflicts and wars as well as other operations within the war zone, known as the theater. CSR is not a formal diagnosis, nor is it included in the DSM-5 (APA, 2013a). It is similar to acute stress

Case Illustration: Frank

Frank is a 36-year-old man who was severely beaten in a fight outside a bar. He had multiple injuries, including broken bones, a concussion, and a stab wound in his lower abdomen. He was hospitalized for 3.5 weeks and was unable to return to work, thus losing his job as a warehouse forklift operator. For several years, when faced with situations in which he perceived himself as helpless and overwhelmed, Frank reacted with violent anger that, to others, appeared grossly out of proportion to the situation. He has not had a drink in almost 3 years, but the bouts of anger persist and occur three to five times a year. They leave Frank feeling even more isolated from others and alienated from those who love him. He reports that he cannot watch certain television shows that depict violent anger; he has to stop watching when such scenes occur. He sometimes daydreams about getting revenge on the people who assaulted him.

Psychiatric and neurological evaluations do not reveal a cause for Frank's anger attacks. Other than these symptoms, Frank has progressed well in his abstinence from alcohol. He attends a support group regularly, has acquired friends who are also abstinent, and has reconciled with his family of origin. His marriage is more stable, although the episodes of rage limit his wife's willingness to commit fully to the relationship. In recounting the traumatic event in counseling, Frank acknowledges that he thought he was going to die as a result of the fight, especially when he realized he had been stabbed. As he described his experience, he began to become very anxious, and the counselor observed the rage beginning to appear.

After his initial evaluation, Frank was referred to an outpatient program that provided trauma-specific interventions to address his subthreshold trauma symptoms. With a combination of cognitive–behavioral counseling, EMDR, and anger management techniques, he saw a gradual decrease in symptoms when he recalled the assault. He started having more control of his anger when memories of the trauma emerged. Today, when feeling trapped, helpless, or overwhelmed, Frank has resources for coping and does not allow his anger to interfere with his marriage or other relationships.

reaction, except that the precipitating event or events affect military personnel (and civilians exposed to the events) in an armed conflict situation. The terms "combat stress reaction" and "posttraumatic stress injury" are relatively new, and the intent of using these new terms is to call attention to the unique experiences of combat-related stress as well as to decrease the shame that can be associated with seeking behavioral health services for PTSD (for more information on veterans and combat stress reactions, see the planned TIP, *Reintegration-Related Behavioral Health Issues for Veterans and Military Families*; SAMHSA, planned f).

Although stress mobilizes an individual's physical and psychological resources to perform more effectively in combat, reactions to the stress may persist long after the actual danger has ended. As with other traumas, the nature of the event(s), the reactions of others, and the survivor's psychological history and resources affect the likelihood and severity of CSR. With combat veterans, this translates to the number, intensity, and duration of threat factors; the social support of peers in the veterans' unit; the emotional and cognitive resilience of the service members; and the quality of military leadership. CSR can vary from manageable and mild to debilitating and severe. Common, less severe symptoms of CSR include tension, hypervigilance, sleep problems, anger, and difficulty concentrating. If left untreated, CSR can lead to PTSD.

Common causes of CSR are events such as a direct attack from insurgent small arms fire or a military convoy being hit by an improvised explosive device, but combat stressors encompass a diverse array of traumatizing events, such as seeing grave injuries, watching others

Advice to Counselors: Understanding the Nature of Combat Stress

Several sources of information are available to help counselors deepen their understanding of combat stress and postdeployment adjustment. Friedman (2006) explains how a prolonged combat-ready stance, which is adaptive in a war zone, becomes hypervigilance and overprotectiveness at home. He makes the point that the "mutual interdependence, trust, and affection" (p. 587) that are so necessarily a part of a combat unit are different from relationships with family members and colleagues in a civilian workplace. This complicates the transition to civilian life. *Wheels Down: Adjusting to Life After Deployment* (Moore & Kennedy, 2011) provides practical advice for military service members, including inactive or active duty personnel and veterans, in transitioning from the theater to home.

The following are just a few of the many resources and reports focused on combat-related psychological and stress issues:

- *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Tanielian & Jaycox, 2008)
- *On Killing* (Grossman, 1995), an indepth analysis of the psychological dynamics of combat
- *Haunted by Combat* (Paulson & Krippner, 2007), which contains specific chapters on Reserve and National Guard troops and female veterans
- *Treating Young Veterans: Promoting Resilience Through Practice and Advocacy* (Kelly, Howe-Barksdale, & Gitelson, 2011)

die, and making on-the-spot decisions in ambiguous conditions (e.g., having to determine whether a vehicle speeding toward a military checkpoint contains insurgents with explosives or a family traveling to another area). Such circumstances can lead to combat stress. Military personnel also serve in noncombat positions (e.g., healthcare and administrative roles), and personnel filling these supportive roles can be exposed to combat situations by proximity or by witnessing their results.

Specific Trauma-Related Psychological Disorders

Part of the definition of trauma is that the individual responds with intense fear, helplessness, or horror. Beyond that, in both the short term and the long term, trauma comprises a range of reactions from normal (e.g., being unable to concentrate, feeling sad, having trouble sleeping) to warranting a diagnosis of a trauma-related mental disorder. Most people who experience trauma have no long-lasting disabling effects; their coping skills and the support of those around them are sufficient to help them overcome their difficulties, and their ability to function on a daily basis over time is unimpaired. For others, though, the symptoms of trauma are more severe and last longer. The most common diagnoses associated with trauma are PTSD and ASD, but trauma is also associated with the onset of other mental disorders—particularly substance use disorders, mood disorders, various anxiety disorders, and personality disorders. Trauma also typically exacerbates symptoms of preexisting disorders, and, for people who are predisposed to a mental disorder, trauma can precipitate its onset. Mental disorders can occur almost simultaneously with trauma exposure or manifest sometime thereafter.

Acute Stress Disorder

ASD represents a normal response to stress. Symptoms develop within 4 weeks of the trauma and can cause significant levels of distress. Most individuals who have acute stress reactions never develop further impairment or PTSD. Acute stress disorder is highly associated with the experience of one specific trauma rather than the experience of long-term exposure to chronic traumatic stress. Diagnostic criteria are presented in Exhibit 1.3-3.

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). **Note:** This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks), during which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood:
   5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms:
   6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
   7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors, such as head injury, alcohol, or drugs).

Avoidance Symptoms:
   8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   9. Efforts to avoid external reminders (e.g., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms:
   10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
   11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   12. Hypervigilance.
   13. Problems with concentration.
   14. Exaggerated startle response.

(Continued on the next page.)

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD (continued)

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure. **Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

Source: APA, 2013a, pp. 280–281.

The primary presentation of an individual with an acute stress reaction is often that of someone who appears overwhelmed by the traumatic experience. The need to talk about the experience can lead the client to seem self-centered and unconcerned about the needs of others. He or she may need to describe, in repetitive detail, what happened, or may seem obsessed with trying to understand what happened in an effort to make sense of the experience. The client is often hypervigilant and avoids circumstances that are reminders of the trauma. For instance, someone who was in a serious car crash in heavy traffic can become anxious and avoid riding in a car or driving in traffic for a finite time afterward. Partial amnesia for the trauma often accompanies ASD, and the individual may repetitively question others to fill in details. People with ASD symptoms sometimes seek assurance from others that the event happened in the way they remember, that they are not "going crazy" or "losing it," and that they could not have prevented the event. The next case illustration demonstrates the time-limited nature of ASD.

Differences between ASD and PTSD

It is important to consider the differences between ASD and PTSD when forming a diagnostic impression. The primary difference is the amount of time the symptoms have been present. ASD resolves 2 days to 4 weeks after an event, whereas PTSD continues beyond the 4-week period. The diagnosis of ASD can change to a diagnosis of PTSD if the condition is noted within the first 4 weeks after the event, but the symptoms persist past 4 weeks.

ASD also differs from PTSD in that the ASD diagnosis requires 9 out of 14 symptoms from five categories, including intrusion, negative mood, dissociation, avoidance, and arousal. These symptoms can occur at the time of the trauma or in the following month. Studies indicate that dissociation at the time of trauma is a good predictor of subsequent PTSD, so the inclusion of dissociative symptoms makes it more likely that those who develop ASD will later be diagnosed with PTSD (Bryant & Harvey, 2000). Additionally, ASD is a transient disorder, meaning that it is present in a person's life for a relatively short time and then passes. In contrast, PTSD typically becomes a primary feature of an individual's life. Over a lengthy period, PTSD can have profound effects on clients' perceptions of safety, their sense of hope for the future, their relationships with others, their physical health, the appearance of psychiatric symptoms, and their patterns of substance use and abuse.

There are common symptoms between PTSD and ASD, and untreated ASD is a possible predisposing factor to PTSD, but it is unknown whether most people with ASD are likely to develop PTSD. There is some suggestion that, as with PTSD, ASD is more

Case Illustration: Sheila

Two months ago, Sheila, a 55-year-old married woman, experienced a tornado in her home town. In the previous year, she had addressed a long-time marijuana use problem with the help of a treatment program and had been abstinent for about 6 months. Sheila was proud of her abstinence; it was something she wanted to continue. She regarded it as a mark of personal maturity; it improved her relationship with her husband, and their business had flourished as a result of her abstinence.

During the tornado, an employee reported that Sheila had become very agitated and had grabbed her assistant to drag him under a large table for cover. Sheila repeatedly yelled to her assistant that they were going to die. Following the storm, Sheila could not remember certain details of her behavior during the event. Furthermore, Sheila said that after the storm, she felt numb, as if she was floating out of her body and could watch herself from the outside. She stated that nothing felt real and it was all like a dream.

Following the tornado, Sheila experienced emotional numbness and detachment, even from people close to her, for about 2 weeks. The symptoms slowly decreased in intensity but still disrupted her life. Sheila reported experiencing disjointed or unconnected images and dreams of the storm that made no real sense to her. She was unwilling to return to the building where she had been during the storm, despite having maintained a business at this location for 15 years. In addition, she began smoking marijuana again because it helped her sleep. She had been very irritable and had uncharacteristic angry outbursts toward her husband, children, and other family members.

As a result of her earlier contact with a treatment program, Sheila returned to that program and engaged in psychoeducational, supportive counseling focused on her acute stress reaction. She regained abstinence from marijuana and returned shortly to a normal level of functioning. Her symptoms slowly diminished over a period of 3 weeks. With the help of her counselor, she came to understand the link between the trauma and her relapse, regained support from her spouse, and again felt in control of her life.

prevalent in women than in men (Bryant & Harvey, 2003). However, many people with PTSD do not have a diagnosis or recall a history of acute stress symptoms before seeking treatment for or receiving a diagnosis of PTSD.

Effective interventions for ASD can significantly reduce the possibility of the subsequent development of PTSD. Effective treatment of ASD can also reduce the incidence of other co-occurring problems, such as depression, anxiety, dissociative disorders, and compulsive behaviors (Bryant & Harvey, 2000). Intervention for ASD also helps the individual develop coping skills that can effectively prevent the recurrence of ASD after later traumas.

Although predictive science for ASD and PTSD will continue to evolve, both disorders are associated with increased substance use and mental disorders and increased risk of relapse; therefore, effective screening for ASD and PTSD is important for all clients with these disorders. Individuals in early recovery—lacking well-practiced coping skills, lacking environmental supports, and already operating at high levels of anxiety—are particularly susceptible to ASD. Events that would not normally be disabling can produce symptoms of intense helplessness and fear, numbing and depersonalization, disabling anxiety, and an inability to handle normal life events. Counselors should be able to recognize ASD and treat it rather than attributing the symptoms to a client's lack of motivation to change, being "dry drunk" (for those in substance abuse recovery), or being manipulative.

Posttraumatic Stress Disorder

The trauma-related disorder that receives the greatest attention is PTSD; it is the most

Case Illustration: Michael

Michael is a 62-year-old Vietnam veteran. He is a divorced father of two children and has four grandchildren. Both of his parents were dependent on alcohol. He describes his childhood as isolated. His father physically and psychologically abused him (e.g., he was beaten with a switch until he had welts on his legs, back, and buttocks). By age 10, his parents regarded him as incorrigible and sent him to a reformatory school for 6 months. By age 15, he was using marijuana, hallucinogens, and alcohol and was frequently truant from school.

At age 19, Michael was drafted and sent to Vietnam, where he witnessed the deaths of six American military personnel. In one incident, the soldier he was next to in a bunker was shot. Michael felt helpless as he talked to this soldier, who was still conscious. In Vietnam, Michael increased his use of both alcohol and marijuana. On his return to the United States, Michael continued to drink and use marijuana. He reenlisted in the military for another tour of duty.

His life stabilized in his early 30s, as he had a steady job, supportive friends, and a relatively stable family life. However, he divorced in his late 30s. Shortly thereafter, he married a second time, but that marriage ended in divorce as well. He was chronically anxious and depressed and had insomnia and frequent nightmares. He periodically binged on alcohol. He complained of feeling empty, had suicidal ideation, and frequently stated that he lacked purpose in his life.

In the 1980s, Michael received several years of mental health treatment for dysthymia. He was hospitalized twice and received 1 year of outpatient psychotherapy. In the mid-1990s, he returned to outpatient treatment for similar symptoms and was diagnosed with PTSD and dysthymia. He no longer used marijuana and rarely drank. He reported that he didn't like how alcohol or other substances made him feel anymore—he felt out of control with his emotions when he used them. Michael reported symptoms of hyperarousal, intrusion (intrusive memories, nightmares, and preoccupying thoughts about Vietnam), and avoidance (isolating himself from others and feeling "numb"). He reported that these symptoms seemed to relate to his childhood abuse and his experiences in Vietnam. In treatment, he expressed relief that he now understood the connection between his symptoms and his history.

commonly diagnosed trauma-related disorder, and its symptoms can be quite debilitating over time. Nonetheless, it is important to remember that PTSD symptoms are represented in a number of other mental illnesses, including major depressive disorder (MDD), anxiety disorders, and psychotic disorders (Foa et al., 2006). The DSM-5 (APA, 2013a) identifies four symptom clusters for PTSD: presence of intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. Individuals must have been exposed to actual or threatened death, serious injury, or sexual violence, and the symptoms must produce significant distress and impairment for more than 4 weeks (Exhibit 1.3-4).

Certain characteristics make people more susceptible to PTSD, including one's unique personal vulnerabilities at the time of the traumatic exposure, the support (or lack of support) received from others at the time of the trauma and at the onset of trauma-related symptoms, and the way others in the person's environment gauge the nature of the traumatic event (Brewin, Andrews, & Valentine, 2000).

People with PTSD often present varying clinical profiles and histories. They can experience symptoms that are activated by environmental triggers and then recede for a period of time. Some people with PTSD who show mostly psychiatric symptoms (particularly depression and anxiety) are misdiagnosed and go untreated for their primary condition. For many people, the trauma experience and diagnosis

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled "Posttraumatic Stress Disorder for Children 6 Years and Younger" (APA, 2013a).

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
   5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
   2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
   3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
   4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
   5. Markedly diminished interest or participation in significant activities.
   6. Feelings of detachment or estrangement from others.
   7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

(Continued on the next page.)

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD (continued)

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   2. Reckless or self-destructive behavior.
   3. Hypervigilance.
   4. Exaggerated startle response.
   5. Problems with concentration.
   6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify whether:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Source: APA, 2013a, pp. 271–272.

are obscured by co-occurring substance use disorder symptoms. The important feature of PTSD is that the disorder becomes an orienting feature of the individual's life. How well the person can work, with whom he or she associates, the nature of close and intimate relationships, the ability to have fun and rejuvenate, and the way in which an individual goes about confronting and solving problems in life are all affected by the client's trauma experiences and his or her struggle to recover.

Posttraumatic stress disorder: Timing of symptoms

Although symptoms of PTSD usually begin within 3 months of a trauma in adulthood, there can be a delay of months or even years before symptoms appear for some people. Some people may have minimal symptoms after a trauma but then experience a crisis later in life. Trauma symptoms can appear suddenly, even without conscious memory of the original trauma or without any overt provocation. Survivors of abuse in childhood can have a delayed response triggered by something that happens to them as adults. For example, seeing a movie about child abuse can trigger symptoms related

Advice to Counselors: Helping Clients With Delayed Trauma Responses

Clients who are experiencing a delayed trauma response can benefit if you help them to:

- Create an environment that allows acknowledgment of the traumatic event(s).
- Discuss their initial recall or first suspicion that they were having a traumatic response.
- Become educated on delayed trauma responses.
- Draw a connection between the trauma and presenting trauma-related symptoms.
- Create a safe environment.
- Explore their support systems and fortify them as needed.
- Understand that triggers can precede traumatic stress reactions, including delayed responses to trauma.
- Identify their triggers.
- Develop coping strategies to navigate and manage symptoms.

to the trauma. Other triggers include returning to the scene of the trauma, being reminded of it in some other way, or noting the anniversary of an event. Likewise, combat veterans and survivors of community-wide disasters may seem to be coping well shortly after a trauma, only to have symptoms emerge later when their life situations seem to have stabilized. Some clients in substance abuse recovery only begin to experience trauma symptoms when they maintain abstinence for some time. As individuals decrease tension-reducing or self-medicating behaviors, trauma memories and symptoms can emerge.

Culture and posttraumatic stress

Although research is limited across cultures, PTSD has been observed in Southeast Asian, South American, Middle Eastern, and Native American survivors (Osterman & de Jong, 2007; Wilson & Tang, 2007). As Stamm and Friedman (2000) point out, however, simply observing PTSD does not mean that it is the "best conceptual tool for characterizing posttraumatic distress among non-Western individuals" (p. 73). In fact, many trauma-related symptoms from other cultures do not fit the DSM-5 criteria. These include somatic and psychological symptoms and beliefs about the origins and nature of traumatic events. Moreover, religious and spiritual beliefs can affect how a survivor experiences a traumatic event and whether he or she reports the distress. For example, in societies where attitudes toward karma and the glorification of war veterans are predominant, it is harder for war veterans to come forward and disclose that they are emotionally overwhelmed or struggling. It would be perceived as inappropriate and possibly demoralizing to focus on the emotional distress that he or she still bears. (For a review of cultural competence in treating trauma, refer to Brown, 2008.)

Methods for measuring PTSD are also culturally specific. As part of a project begun in 1972, the World Health Organization (WHO) and the National Institutes of Health (NIH) embarked on a joint study to test the cross-cultural applicability of classification systems for various diagnoses. WHO and NIH identified apparently universal factors of psychological disorders and developed specific instruments to measure them. These instruments, the Composite International Diagnostic Interview and the Schedules for Clinical Assessment in Neuropsychiatry, include certain criteria from the DSM (Fourth Edition, Text Revision; APA, 2000a) as well as criteria from the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10; Exhibit 1.3-5).

Exhibit 1.3-5: ICD-10 Diagnostic Criteria for PTSD

A. The patient must have been exposed to a stressful event or situation (either brief or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.

B. There must be persistent remembering or "reliving" of the stressor in intrusive "flashbacks," vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.

D. Either of the following must be present:
   1. Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor.
   2. Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
      a. Difficulty in falling or staying asleep.
      b. Irritability or outbursts of anger.
      c. Difficulty in concentrating.
      d. Exaggerated startle response.

E. Criteria B, C, and D must all be met within 6 months of the stressful event or at the end of a period of stress. (For some purposes, onset delayed more than 6 months can be included, but this should be clearly specified.)

Source: WHO, 1992.

Complex trauma and complex traumatic stress

When individuals experience multiple traumas, prolonged and repeated trauma during childhood, or repetitive trauma in the context of significant interpersonal relationships, their reactions to trauma have unique characteristics (Herman, 1992). This unique constellation of reactions, called complex traumatic stress, is not recognized diagnostically in the DSM-5, but theoretical discussions and research have begun to highlight the similarities and differences in symptoms of posttraumatic stress versus complex traumatic stress (Courtois & Ford, 2009). Often, the symptoms generated from complex trauma do not fully match PTSD criteria and exceed the severity of PTSD. Overall, literature reflects that PTSD criteria or subthreshold symptoms do not fully account for the persistent and more impairing clinical presentation of complex trauma. Even though current research in the study of traumatology is prolific, it is still in the early stages of development. The idea that there may be more diagnostic variations or subtypes is forthcoming, and this will likely pave the way for more client-matching interventions to better serve those individuals who have been repeatedly exposed to multiple, early childhood, and/or interpersonal traumas.

Other Trauma-Related and Co-Occurring Disorders

The symptoms of PTSD and other mental disorders overlap considerably; these disorders often coexist and include mood, anxiety,

The term "**co occurring disorders**" refers to cases when a person has one or more mental disorders as well as one or more substance use disorders (including sub stance abuse). Co occurring disorders are common among individuals who have a history of trauma and are seeking help.

Advice to Counselors: Universal Screening and Assessment

Only people specifically trained and licensed in mental health assessment should make diagnoses; trauma can result in complicated cases, and many symptoms can be present, whether or not they meet full diagnostic criteria for a specific disorder. Only a trained assessor can distinguish accurately among various symptoms and in the presence of co-occurring disorders. However, behavioral health professionals without specific assessment training can still serve an important role in screening for possible mental disorders using established screening tools (CSAT, 2005c; see also Chapter 4 of this TIP). In agencies and clinics, it is critical to provide such screenings systematically—for each client—as PTSD and other co-occurring disorders are typically underdiagnosed or misdiagnosed.

substance use, and personality disorders. Thus, it's common for trauma survivors to be underdiagnosed or misdiagnosed. If they have not been identified as trauma survivors, their psychological distress is often not associated with previous trauma, and/or they are diagnosed with a disorder that marginally matches their presenting symptoms and psychological sequelae of trauma. The following sections present a brief overview of some mental disorders that can result from (or be worsened by) traumatic stress. PTSD is not the only diagnosis related to trauma nor its only psychological consequence; trauma can broadly influence mental and physical health in clients who already have behavioral health disorders.

People With Mental Disorders

MDD is the most common co-occurring disorder in people who have experienced trauma and are diagnosed with PTSD. A well-established causal relationship exists between stressful events and depression, and a prior history of MDD is predictive of PTSD after exposure to major trauma (Foa et al., 2006).

Many survivors with severe mental disorders function fairly well following trauma, including disasters, as long as essential services aren't interrupted. For others, additional mental health supports may be necessary. For more information, see *Responding to the Needs of People With Serious and Persistent Mental Illness in Times of Major Disaster* (Center for Mental Health Services, 1996).

Co-occurrence is also linked with greater impairment and more severe symptoms of both disorders, and the person is less likely to experience remission of symptoms within 6 months.

Generalized anxiety, obsessive–compulsive, and other anxiety disorders are also associated with PTSD. PTSD may exacerbate anxiety disorder symptoms, but it is also likely that preexisting anxiety symptoms and anxiety disorders increase vulnerability to PTSD. Preexisting anxiety primes survivors for greater hyperarousal and distress. Other disorders, such as personality and somatization disorders, are also associated with trauma, but the history of trauma is often overlooked as a significant factor or necessary target in treatment.

The relationship between PTSD and other disorders is complex. More research is now examining the multiple potential pathways among PTSD and other disorders and how various sequences affect clinical presentation. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c), is valuable in understanding the relationship of substance use to other mental disorders.

People With Substance Use Disorders

There is clearly a correlation between trauma (including individual, group, or mass trauma) and substance use as well as the presence of posttraumatic stress (and other trauma-related disorders) and substance use disorders. Alcohol and drug use can be, for some, an effort to

Co-Occurring PTSD and Other Mental Disorders

- Individuals with PTSD often have at least one additional diagnosis of a mental disorder.
- The presence of other disorders typically worsens and prolongs the course of PTSD and complicates clinical assessment, diagnosis, and treatment.
- The most common co-occurring disorders, in addition to substance use disorders, include mood disorders, various anxiety disorders, eating disorders, and personality disorders.
- Exposure to early, severe, and chronic trauma is linked to more complex symptoms, including impulse control deficits, greater difficulty in emotional regulation and establishing stable relationships, and disruptions in consciousness, memory, identity, and/or perception of the environment (Dom, De, Hulstijn, & Sabbe, 2007; Waldrop, Back, Verduin, & Brady, 2007).
- Certain diagnostic groups and at-risk populations (e.g., people with developmental disabilities, people who are homeless or incarcerated) are more susceptible to trauma exposure and to developing PTSD if exposed but less likely to receive appropriate diagnosis and treatment.
- Given the prevalence of traumatic events in clients who present for substance abuse treatment, counselors should assess all clients for possible trauma-related disorders.

manage traumatic stress and specific PTSD symptoms. Likewise, people with substance use disorders are at higher risk of developing PTSD than people who do not abuse substances. Counselors working with trauma survivors or clients who have substance use disorders have to be particularly aware of the possibility of the other disorder arising.

Timeframe: PTSD and the onset of substance use disorders

Knowing whether substance abuse or PTSD came first informs whether a causal relationship exists, but learning this requires thorough assessment of clients and access to complete data on PTSD; substance use, abuse, and dependence; and the onset of each. Much current research focuses solely on the age of onset of substance use (not abuse), so determining causal relationships can be difficult.

The relationship between PTSD and substance use disorders is thought to be bidirectional and cyclical: substance use increases trauma risk, and exposure to trauma escalates substance use to manage trauma-related symptoms. Three other causal pathways described by Chilcoat and Breslau's seminal work (1998) further explain the relationship between PTSD and substance use disorders:

1. The "self-medication" hypothesis suggests that clients with PTSD use substances to manage PTSD symptoms (e.g., intrusive memories, physical arousal). Substances such as alcohol, cocaine, barbiturates, opioids, and amphetamines are frequently abused in attempts to relieve or numb emotional pain or to forget the event.
2. The "high-risk" hypothesis states that drug and alcohol use places people who use substances in high-risk situations that increase their chances of being exposed to events that lead to PTSD.
3. The "susceptibility" hypothesis suggests that people who use substances are more susceptible to developing PTSD after exposure to trauma than people who do not. Increased vulnerability may result from failure to develop effective stress management strategies, changes in brain chemistry, or damage to neurophysiological systems due to extensive substance use.

PTSD and substance abuse treatment

PTSD can limit progress in substance abuse recovery, increase the potential for relapse, and complicate a client's ability to achieve success in various life areas. Each disorder can mask or hide the symptoms of the other, and both need

Case Illustration: Maria

Maria is a 31-year-old woman diagnosed with PTSD and alcohol dependence. From ages 8 to 12, she was sexually abused by an uncle. Maria never told anyone about the abuse for fear that she would not be believed. Her uncle remains close to the family, and Maria still sees him on certain holidays. When she came in for treatment, she described her emotions and thoughts as out of control. Maria often experiences intrusive memories of the abuse, which at times can be vivid and unrelenting. She cannot predict when the thoughts will come; efforts to distract herself from them do not always work. She often drinks in response to these thoughts or his presence, as she has found that alcohol can dull her level of distress. Maria also has difficulty falling asleep and is often awakened by nightmares. She does not usually remember the dreams, but she wakes up feeling frightened and alert and cannot go back to sleep.

Maria tries to avoid family gatherings but often feels pressured to go. Whenever she sees her uncle, she feels intense panic and anger but says she can usually "hold it together" if she avoids him. Afterward, however, she describes being overtaken by these feelings and unable to calm down. She also describes feeling physically ill and shaky. At these times, she often isolates herself, stays in her apartment, and drinks steadily for several days. Maria also reports distress pertaining to her relationship with her boyfriend. In the beginning of their relationship, she found him comforting and enjoyed his affection, but more recently, she has begun to feel anxious and unsettled around him. Maria tries to avoid sex with him, but she sometimes gives in for fear of losing the relationship. She finds it easier to have sex with him when she is drunk, but she often experiences strong feelings of dread and disgust reminiscent of her abuse. Maria feels guilty and confused about these feelings.

to be assessed and treated if the individual is to have a full recovery. There is a risk of misinterpreting trauma-related symptoms in substance abuse treatment settings. For example, avoidance symptoms in an individual with PTSD can be misinterpreted as lack of motivation or unwillingness to engage in substance abuse treatment; a counselor's efforts to address substance abuse–related behaviors in early recovery can likewise provoke an exaggerated response from a trauma survivor who has profound traumatic experiences of being trapped and controlled. Exhibit 1.3-6 lists important facts about PTSD and substance use disorders for counselors.

Sleep, PTSD, and substance use

Many people have trouble getting to sleep and/or staying asleep after a traumatic event; consequently, some have a drink or two to help them fall asleep. Unfortunately, any initially helpful effects are likely not only to wane quickly, but also to incur a negative rebound effect. When someone uses a substance before going to bed, "sleep becomes lighter and more easily disrupted," and rapid eye movement sleep (REM) "increases, with an associated increase in dreams and nightmares," as the effects wear off (Auerbach, 2003, p. 1185).

People with alcohol dependence report multiple types of sleep disturbances over time, and it is not unusual for clients to report that they cannot fall asleep without first having a drink. Both REM and slow wave sleep are reduced in clients with alcohol dependence, which is also associated with an increase in the amount of time it takes before sleep occurs, decreased overall sleep time, more nightmares, and reduced sleep efficiency. Sleep during withdrawal is "frequently marked by severe insomnia and sleep fragmentation…a loss of restful sleep and feelings of daytime fatigue. Nightmares and vivid dreams are not uncommon" (Auerbach, 2003, pp. 1185–1186).

Confounding changes in the biology of sleep that occur in clients with PTSD and substance use disorders often add to the problems of

Exhibit 1.3-6: PTSD and Substance Use Disorders: Important Treatment Facts

Profile Severity

- PTSD is one of the most common co-occurring mental disorders found in clients in substance abuse treatment (CSAT, 2005c).
- People in treatment for PTSD tend to abuse a wide range of substances, including opioids, cocaine, marijuana, alcohol, and prescription medications.
- People in treatment for PTSD and substance abuse have a more severe clinical profile than those with just one of these disorders.
- PTSD, with or without major depression, significantly increases risk for suicidality (CSAT, 2009a).

Gender Differences

- Rates of trauma-related disorders are high in men and women in substance abuse treatment.
- Women with PTSD and a substance use disorder most frequently experienced rape or witnessed a killing or injury; men with both disorders typically witnessed a killing or injury or were the victim of sudden injury or accident (Cottler, Nishith, & Compton, 2001).

Risk of Continued Cycle of Violence

- While under the influence of substances, a person is more vulnerable to traumatic events (e.g., automobile crashes, assaults).
- Perpetrators of violent assault often are under the influence of substances or test positive for substances at the time of arrest.

Treatment Complications

- It is important to recognize and help clients understand that becoming abstinent from substances does not resolve PTSD; in fact, some PTSD symptoms become worse with abstinence for some people. Both disorders must be addressed in treatment.
- Treatment outcomes for clients with PTSD and a substance use disorder are worse than for clients with other co-occurring disorders or who only abuse substances (Brown, Read, & Kahler, 2003).

recovery. Sleep can fail to return to normal for months or even years after abstinence, and the persistence of sleep disruptions appears related to the likelihood of relapse. Of particular clinical importance is the vicious cycle that can also begin during "slips"; relapse initially improves sleep, but continued drinking leads to sleep disruption. This cycle of initial reduction of an unpleasant symptom, which only ends up exacerbating the process as a whole, can take place for clients with PTSD as well as for clients with substance use disorders. There are effective cognitive–behavioral therapies and nonaddictive pharmacological interventions for sleep difficulties.

4 Screening and Assessment

IN THIS CHAPTER

- Screening and Assessment
- Barriers and Challenges to Trauma Informed Screening and Assessment
- Cross Cultural Screening and Assessment
- Choosing Instruments
- Trauma Informed Screening and Assessment
- Concluding Note

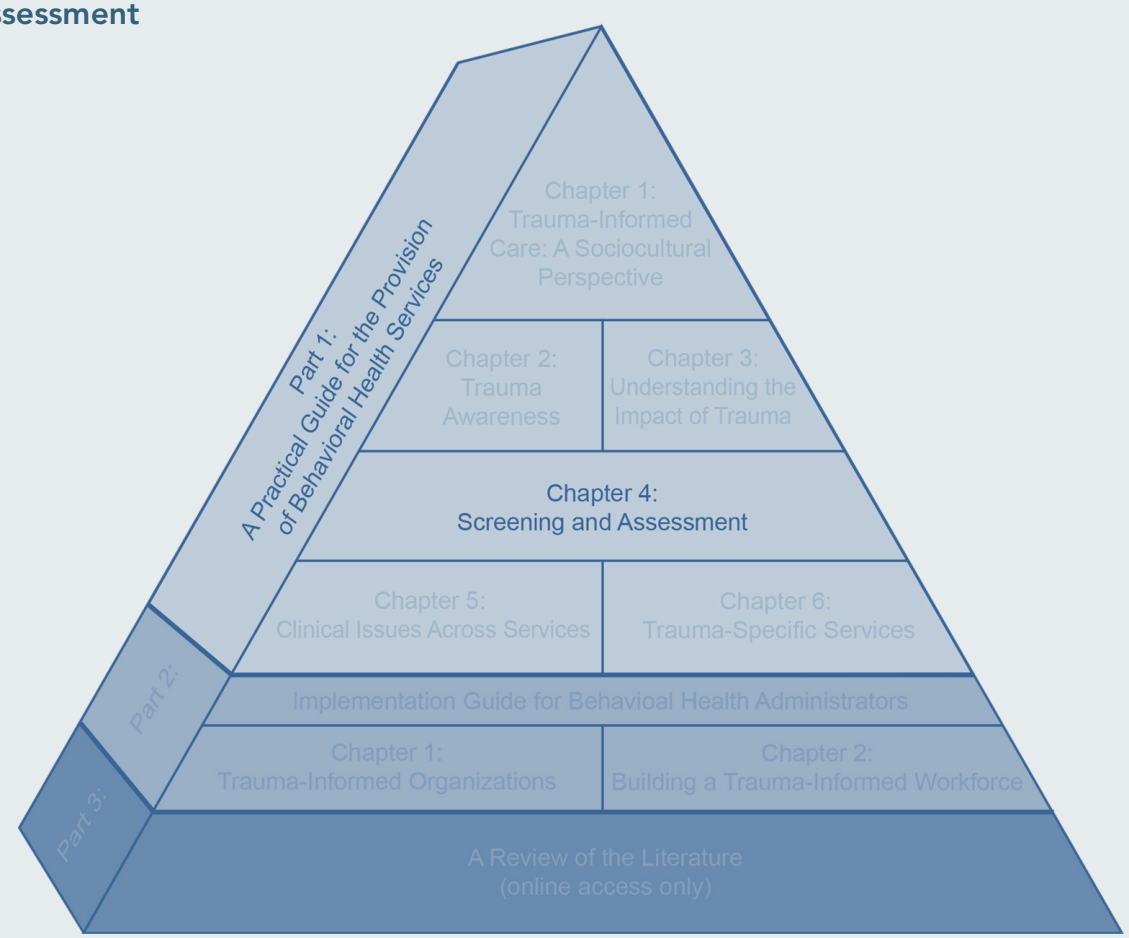
Why screen universally for trauma in behavioral health services? Exposure to trauma is common; in many surveys, more than half of respondents report a history of trauma, and the rates are even higher among clients with mental or substance use disorders. Furthermore, behavioral health problems, including substance use and mental disorders, are more difficult to treat if trauma-related symptoms and disorders aren't detected early and treated effectively (Part 3, Section 1, of this Treatment Improvement Protocol [TIP], available online, summarizes research on the prevalence of trauma and its relationship with other behavioral health problems).

Not addressing traumatic stress symptoms, trauma-specific disorders, and other symptoms/disorders related to trauma can impede successful mental health and substance abuse treatment. Unrecognized, unaddressed trauma symptoms can lead to poor engagement in treatment, premature termination, greater risk for relapse of psychological symptoms or substance use, and worse outcomes. Screening can also prevent misdiagnosis and inappropriate treatment planning. People with histories of trauma often display symptoms that meet criteria for other disorders.

Without screening, clients' trauma histories and related symptoms often go undetected, leading providers to direct services toward symptoms and disorders that may only partially explain client presentations and distress. Universal screening for trauma history and trauma-related symptoms can help behavioral health practitioners identify individuals at risk of developing more pervasive and severe symptoms of traumatic stress. Screening, early identification, and intervention serves as a prevention strategy.

Screening to identify clients who have histories of trauma and experience trauma related symptoms is a prevention strategy.

Trauma-Informed Care Framework in Behavioral Health Services—Screening and Assessment



The chapter begins with a discussion of screening and assessment concepts, with a particular focus on trauma-informed screening. It then highlights specific factors that influence screening and assessment, including timing and environment. Barriers and challenges in providing trauma-informed screening are discussed, along with culturally specific screening and assessment considerations and guidelines. Instrument selection, trauma-informed screening and assessment tools, and trauma-informed screening and assessment processes are reviewed as well. For a more research-oriented perspective on screening and assessment for traumatic stress disorders, please refer to the literature review provided in Part 3 of this TIP, which is available online.

Screening and Assessment

Screening

The first two steps in screening are to determine whether the person has a history of trauma and whether he or she has trauma-related symptoms. Screening mainly obtains answers to "yes" or "no" questions: "Has this client experienced a trauma in the past?" and "Does this client at this time warrant further assessment regarding trauma-related symptoms?" If someone acknowledges a trauma history, then further screening is necessary to determine whether trauma-related symptoms are present. However, the presence of such symptoms does not necessarily say anything about their severity, nor does a positive screen indicate that a disorder actually exists. Positive

Screening is often the first contact between the client and the treatment provider, and the client forms his or her first impression of treatment during this intake process. Thus, how screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client.

screens only indicate that assessment or further evaluation is warranted, and negative screens do not necessarily mean that an individual doesn't have symptoms that warrant intervention.

Screening procedures should always define the steps to take after a positive or negative screening. That is, the screening process establishes precisely how to score responses to screening tools or questions and clearly defines what constitutes a positive score (called a "cut-off score") for a particular potential problem. The screening procedures detail the actions to take after a client scores in the positive range. Clinical supervision is helpful—and sometimes necessary—in judging how to proceed.

Trauma-informed screening is an essential part of the intake evaluation and the treatment planning process, but it is not an end in itself. Screening processes can be developed that allow staff without advanced degrees or graduate-level training to conduct them, whereas assessments for trauma-related disorders require a mental health professional trained in assessment and evaluation processes. The most important domains to screen among individuals with trauma histories include:

- Trauma-related symptoms.
- Depressive or dissociative symptoms, sleep disturbances, and intrusive experiences.
- Past and present mental disorders, including typically trauma-related disorders (e.g., mood disorders).
- Severity or characteristics of a specific trauma type (e.g., forms of interpersonal violence, adverse childhood events, combat experiences).
- Substance abuse.
- Social support and coping styles.
- Availability of resources.
- Risks for self-harm, suicide, and violence.
- Health screenings.

Assessment

When a client screens positive for substance abuse, trauma-related symptoms, or mental disorders, the agency or counselor should follow up with an assessment. A positive screening calls for more action—an assessment that determines and defines presenting struggles to develop an appropriate treatment plan and to make an informed and collaborative decision about treatment placement. Assessment determines the nature and extent of the client's problems; it might require the client to respond to written questions, or it could involve a clinical interview by a mental health or substance abuse professional qualified to assess the client and arrive at a diagnosis. A clinical assessment delves into a client's past and current experiences, psychosocial and cultural history, and assets and resources.

Assessment protocols can require more than a single session to complete and should also use multiple avenues to obtain the necessary clinical information, including self-assessment tools, past and present clinical and medical records, structured clinical interviews, assessment measures, and collateral information from significant others, other behavioral health professionals, and agencies. Qualifications for conducting assessments and clinical interviews are more rigorous than for screening. Advanced degrees, licensing or certification, and special training in administration, scoring, and interpretation of specific assessment instruments and interviews are often

Advice to Counselors: Screening and Assessing Clients

- Ask all clients about any possible history of trauma; use a checklist to increase proper identification of such a history (see the online Adverse Childhood Experiences Study Score Calculator [http://acestudy.org/ace_score] for specific questions about adverse childhood experiences).
- Use only validated instruments for screening and assessment.
- Early in treatment, screen all clients who have histories of exposure to traumatic events for psychological symptoms and mental disorders related to trauma.
- When clients screen positive, also screen for suicidal thoughts and behaviors (see TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*; Center for Substance Abuse Treatment [CSAT], 2009a).
- Do not delay screening; do not wait for a period of abstinence or stabilization of symptoms.
- Be aware that some clients will not make the connection between trauma in their histories and their current patterns of behavior (e.g., alcohol and drug use and/or avoidant behavior).
- Do not require clients to describe emotionally overwhelming traumatic events in detail.
- Focus assessment on how trauma symptoms affect clients' current functioning.
- Consider using paper-and-pencil instruments for screening and assessment as well as self-report measures when appropriate; they are less threatening for some clients than a clinical interview.
- Talk about how you will use the findings to plan the client's treatment, and discuss any immediate action necessary, such as arranging for interpersonal support, referrals to community agencies, or moving directly into the active phase of treatment. It is helpful to explore the strategies clients have used in the past that have worked to relieve strong emotions (Fallot & Harris, 2001).
- At the end of the session, make sure the client is grounded and safe before leaving the interview room (Litz, Miller, Ruef, & McTeague, 2002). Readiness to leave can be assessed by checking on the degree to which the client is conscious of the current environment, what the client's plan is for maintaining personal safety, and what the client's plans are for the rest of the day.

required. Counselors must be familiar with (and obtain) the level of training required for any instruments they consider using.

For people with histories of traumatic life events who screen positive for possible trauma-related symptoms and disorders, thorough assessment gathers all relevant information necessary to understand the role of the trauma in their lives; appropriate treatment objectives, goals, planning, and placement; and any ongoing diagnostic and treatment considerations, including reevaluation or follow-up.

Overall, assessment may indicate symptoms that meet diagnostic criteria for a substance use or mental disorder or a milder form of symptomatology that doesn't reach a diagnostic level—or it may reveal that the positive screen was false and that there is no significant cause for concern. Information from an assessment is used to plan the client's treatment. The plan can include such domains as level of care, acute safety needs, diagnosis, disability, strengths and skills, support network, and cultural context. Assessments should reoccur throughout treatment. Ongoing assessment during treatment can provide valuable information by revealing further details of trauma history as clients' trust in staff members grows and by gauging clients' progress.

Timing of Screening and Assessment

As a trauma-informed counselor, you need to offer psychoeducation and support from the outset of service provision; this begins with explaining screening and assessment and with proper pacing of the initial intake and evaluation process. The client should understand the screening process, why the specific questions are important, and that he or she may choose to delay a response or to not answer a question

at all. Discussing the occurrence or consequences of traumatic events can feel as unsafe and dangerous to the client as if the event were reoccurring. It is important not to encourage avoidance of the topic or reinforce the belief that discussing trauma-related material is dangerous, but be sensitive when gathering information in the initial screening. Initial questions about trauma should be general and gradual. Taking the time to prepare and explain the screening and assessment process to the client gives him or her a greater sense of control and safety over the assessment process.

Clients with substance use disorders

No screening or assessment of trauma should occur when the client is under the influence of alcohol or drugs. Clients under the influence are more likely to give inaccurate information. Although it's likely that clients in an active phase of use (albeit not at the assessment itself) or undergoing substance withdrawal can provide consistent information to obtain a valid screening and assessment, there is insufficient data to know for sure. Some theorists state that no final assessment of trauma or posttraumatic stress disorder (PTSD) should occur during these early phases (Read, Bollinger, & Sharkansky, 2003), asserting that symptoms of withdrawal can mimic PTSD and thus result in overdiagnosis of PTSD and other trauma-related disorders. Alcohol or drugs can also cause memory impairment that clouds the client's history of trauma symptoms. However, Najavits (2004) and others note that underdiagnosis, not overdiagnosis, of trauma and PTSD has been a significant issue in the substance abuse field and thus claim that it is essential to obtain an initial assessment early, which can later be modified if needed (e.g., if the client's symptom pattern changes). Indeed, clinical observations suggest that assessments for both trauma and PTSD—even during active use or withdrawal—appear robust (Coffey, Schumacher, Brady, & Dansky, 2003). Although some PTSD symptoms and trauma memories can be dampened or increased to a degree, their overall presence or absence, as assessed early in treatment, appears accurate (Najavits, 2004).

Conduct Assessments Throughout Treatment

Ongoing assessments let counselors:

- Track changes in the presence, frequency, and intensity of symptoms.
- Learn the relationships among the client's trauma, presenting psychological symptoms, and substance abuse.
- Adjust diagnoses and treatment plans as needed.
- Select prevention strategies to avoid more pervasive traumatic stress symptoms.

The Setting for Trauma Screening and Assessment

Advances in the development of simple, brief, and public-domain screening tools mean that at least a basic screening for trauma can be done in almost any setting. Not only can clients be screened and assessed in behavioral health treatment settings; they can also be evaluated in the criminal justice system, educational settings, occupational settings, physicians' offices, hospital medical and trauma units, and emergency rooms. Wherever they occur, trauma-related screenings and subsequent assessments can reduce or eliminate wasted resources, relapses, and, ultimately, treatment failures among clients who have histories of trauma, mental illness, and/or substance use disorders.

Creating an effective screening and assessment environment

You can greatly enhance the success of treatment by paying careful attention to how you approach the screening and assessment process. Take into account the following points:

- ***Clarify for the client what to expect in the screening and assessment process.*** For example, tell the client that the screening and assessment phase focuses on identifying issues that might benefit from treatment. Inform him or her that during the trauma screening and assessment process, uncomfortable thoughts and feelings can arise. Provide reassurance that, if they do, you'll assist in dealing with this distress—but also let them know that, even with your assistance, some psychological and physical reactions to the interview may last for a few hours or perhaps as long as a few days after the interview, and be sure to highlight the fact that such reactions are normal (Read et al., 2003).
- ***Approach the client in a matter-of-fact, yet supportive, manner.*** Such an approach helps create an atmosphere of trust, respect, acceptance, and thoughtfulness (Melnick & Bassuk, 2000). Doing so helps to normalize symptoms and experiences generated by the trauma; consider informing clients that such events are common but can cause continued emotional distress if they are not treated. Clients may also find it helpful for you to explain the purpose of certain difficult questions. For example, you could say, "Many people have experienced troubling events as children, so some of my questions are about whether you experienced any such events while growing up." Demonstrate kindness and directness in equal measure when screening/assessing clients (Najavits, 2004).
- ***Respect the client's personal space.*** Cultural and ethnic factors vary greatly regarding the appropriate physical distance to maintain during the interview. You should respect the client's personal space, sitting neither too far from nor too close to the client; let your observations of the client's comfort level during the screening and assessment process guide the amount of distance. Clients with trauma may have particular sensitivity about their bodies, personal space, and boundaries.
- ***Adjust tone and volume of speech to suit the client's level of engagement and degree of comfort in the interview process.*** Strive to maintain a soothing, quiet demeanor. Be sensitive to how the client might hear what you have to say in response to personal disclosures. Clients who have been traumatized may be more reactive even to benign or well-intended questions.
- ***Provide culturally appropriate symbols of safety in the physical environment.*** These include paintings, posters, pottery, and other room decorations that symbolize the safety of the surroundings to the client population. Avoid culturally inappropriate or insensitive items in the physical environment.
- ***Be aware of one's own emotional responses to hearing clients' trauma histories.*** Hearing about clients' traumas may be very painful and can elicit strong emotions. The client may interpret your reaction to his or her revelations as disinterest, disgust for the client's behavior, or some other inaccurate interpretation. It is important for you to monitor your interactions and to check in with the client as necessary. You may also feel emotionally drained to the point that it interferes with your ability to accurately listen to or assess clients. This effect of exposure to traumatic stories, known as secondary traumatization, can result in symptoms similar to those experienced by the client (e.g., nightmares, emotional numbing); if necessary, refer to a colleague for assessment (Valent, 2002). Secondary traumatization is addressed in greater detail in Part 2, Chapter 2, of this TIP.
- ***Overcome linguistic barriers via an interpreter.*** Deciding when to add an interpreter requires careful judgment. The interpreter should be knowledgeable of behavioral

health terminology, be familiar with the concepts and purposes of the interview and treatment programming, be unknown to the client, and be part of the treatment team. Avoid asking family members or friends of the client to serve as interpreters.

- ***Elicit only the information necessary for determining a history of trauma and the possible existence and extent of traumatic stress symptoms and related disorders.*** There is no need to probe deeply into the details of a client's traumatic experiences at this stage in the treatment process. Given the lack of a therapeutic relationship in which to process the information safely, pursuing details of trauma can cause retraumatization or produce a level of response that neither you nor your client is prepared to handle. Even if a client wants to tell his or her trauma story, it's your job to serve as "gatekeeper" and preserve the client's safety. Your tone of voice when suggesting postponement of a discussion of trauma is very important. Avoid conveying the message, "I really don't want to hear about it." Examples of appropriate statements are:
  - "Your life experiences are very important, but at this early point in our work together, we should start with what's going on in your life currently rather than discussing past experiences in detail. If you feel that certain past experiences are having a big effect on your life now, it would be helpful for us to discuss them as long as we focus on your safety and recovery right now."
  - "Talking about your past at this point could arouse intense feelings—even more than you might be aware of right now. Later, if you choose to, you can talk with your counselor about how to work on exploring your past."
  - "Often, people who have a history of trauma want to move quickly into the details of the trauma to gain relief. I understand this desire, but my concern for you at this moment is to help you establish a sense of safety and support before moving into the traumatic experiences. We want to avoid retraumatization—meaning, we want to establish resources that weren't available to you at the time of the trauma before delving into more content."
- ***Give the client as much personal control as possible during the assessment by:***
  - Presenting a rationale for the interview and its stress-inducing potential, making clear that the client has the right to refuse to answer any and all questions.
  - Giving the client (where staffing permits) the option of being interviewed by someone of the gender with which he or she is most comfortable.
  - Postponing the interview if necessary (Fallot & Harris, 2001).
- ***Use self-administered, written checklists rather than interviews when possible to assess trauma.*** Traumas can evoke shame, guilt, anger, or other intense feelings that can make it difficult for the client to report them aloud to an interviewer. Clients are more likely to report trauma when they use self-administered screening tools; however, these types of screening instruments only guide the next step. Interviews should coincide with self-administered tools to create a sense of safety for the client (someone is present as he or she completes the screening) and to follow up with more indepth data gathering after a self-administered screening is complete. The Trauma History Questionnaire (THQ) is a self-administered tool (Green, 1996). It has been used successfully with clinical and nonclinical populations, including medical patients, women who have experienced domestic violence, and people with serious mental illness (Hooper, Stockton,

Krupnick, & Green, 2011). Screening instruments (including the THQ) are included in Appendix D of this TIP.

- ***Interview the client if he or she has trouble reading or writing or is otherwise unable to complete a checklist.*** Clients who are likely to minimize their trauma when using a checklist (e.g., those who exhibit significant symptoms of dissociation or repression) benefit from a clinical interview. A trained interviewer can elicit information that a self-administered checklist does not capture. Overall, using both a self-administered questionnaire and an interview can help achieve greater clarity and context.
- ***Allow time for the client to become calm and oriented to the present if he or she has very intense emotional responses when recalling or acknowledging a trauma.*** At such times, avoid responding with such exclamations as "I don't know how you survived that!" (Bernstein, 2000). If the client has difficulty self-soothing, guide him or her through grounding techniques (Exhibit 1.4-1), which are particularly useful—perhaps even critical—to achieving a successful

Exhibit 1.4-1: Grounding Techniques

Grounding techniques are important skills for assessors and all other behavioral health service providers who interact with traumatized clients (e.g., nurses, security, administrators, clinicians). Even if you do not directly conduct therapy, knowledge of grounding can help you defuse an escalating situation or calm a client who is triggered by the assessment process. Grounding strategies help a person who is overwhelmed by memories or strong emotions or is dissociating; they help the person become aware of the here and now. A useful metaphor is the experience of walking out of a movie theater. When the person dissociates or has a flashback, it's like watching a mental movie; grounding techniques help him or her step out of the movie theater into the daylight and the present environment. The client's task is not only to hold on to moments from the past, but also to acknowledge that what he or she was experiencing is from the past. Try the following techniques:

1. **Ask the client to state what he or she observes.**
   Guide the client through this exercise by using statements like, "You seem to feel very scared/angry right now. You're probably feeling things related to what happened in the past. Now, you're in a safe situation. Let's try to stay in the present. Take a slow deep breath, relax your shoulders, put your feet on the floor; let's talk about what day and time it is, notice what's on the wall, etc. What else can you do to feel okay in your body right now?"
2. **Help the client decrease the intensity of affect.**
   - "Emotion dial": A client imagines turning down the volume on his or her emotions.
   - Clenching fists can move the energy of an emotion into fists, which the client can then release.
   - Guided imagery can be used to visualize a safe place.
   - Distraction (see #3 below).
   - Use strengths-based questions (e.g., "How did you survive?" or "What strengths did you possess to survive the trauma?").
3. **Distract the client from unbearable emotional states.**
   - Have the client focus on the external environment (e.g., name red objects in the room).
   - Ask the client to focus on recent and future events (e.g., "to do" list for the day).
   - Help the client use self-talk to remind himself or herself of current safety.
   - Use distractions, such as counting, to return the focus to current reality.
   - Somatosensory techniques (toe-wiggling, touching a chair) can remind clients of current reality.
4. **Ask the client to use breathing techniques.**
   - Ask the client to inhale through the nose and exhale through the mouth.
   - Have the client place his or her hands on his or her abdomen and then watch the hands go up and down while the belly expands and contracts.

Source: Melnick & Bassuk, 2000.

interview when a client has dissociated or is experiencing intense feelings in response to screening and/or interview questions.

- ***Avoid phrases that imply judgment about the trauma.*** For example, don't say to a client who survived Hurricane Katrina and lost family members, "It was God's will," or "It was her time to pass," or "It was meant to be." Do not make assumptions about what a person has experienced. Rather, listen supportively without imposing personal views on the client's experience.
- ***Provide feedback about the results of the screening.*** Keep in mind the client's vulnerability, ability to access resources, strengths, and coping strategies. Present results in a synthesized manner, avoiding complicated, overly scientific jargon or explanations. Allow time to process client reactions during the feedback session. Answer client questions and concerns in a direct, honest, and compassionate manner. Failure to deliver feedback in this way can negatively affect clients' psychological status and severely weaken the potential for developing a therapeutic alliance with the client.
- ***Be aware of the possible legal implications of assessment.*** Information you gather during the screening and assessment process can necessitate mandatory reporting to authorities, even when the client does not want such information disclosed (Najavits, 2004). For example, you can be required to report a client's experience of child abuse even if it happened many years ago or the client doesn't want the information reported. Other legal issues can be quite complex, such as confidentiality of records, pursuing a case against a trauma perpetrator and divulging information to third parties while still protecting the legal status of information used in prosecution, and child custody issues (Najavits, 2004). It's essential that you know the laws in your State, have an expert legal consultant available, and access clinical supervision.

Barriers and Challenges to Trauma-Informed Screening and Assessment

Barriers

It is not necessarily easy or obvious to identify an individual who has survived trauma without screening. Moreover, some clients may deny that they have encountered trauma and its effects even after being screened or asked direct questions aimed at identifying the occurrence of traumatic events. The two main barriers to the evaluation of trauma and its related disorders in behavioral health settings are clients not reporting trauma and providers overlooking trauma and its effects.

Concerning the first main barrier, some events will be experienced as traumatic by one person but considered nontraumatic by another. A history of trauma encompasses not only the experience of a potentially traumatic event, but also the person's responses to it and the meanings he or she attaches to the event. Certain situations make it more likely that the client will not be forthcoming about traumatic events or his or her responses to those events. Some clients might not have ever thought of a particular event or their response to it as traumatic and thus might not report or even recall the event. Some clients might feel a reluctance to discuss something that they sense might bring up uncomfortable feelings (especially with a counselor whom they've only recently met). Clients may avoid openly discussing traumatic events or have difficulty recognizing or articulating their experience of trauma for other reasons, such as feelings of shame, guilt, or fear of retribution by others associated with the event (e.g., in cases of interpersonal or

Common Reasons Why Some Providers Avoid Screening Clients for Trauma

Treatment providers may avoid screening for traumatic events and trauma-related symptoms due to:

- A reluctance to inquire about traumatic events and symptoms because these questions are not a part of the counselor's or program's standard intake procedures.
- Underestimation of the impact of trauma on clients' physical and mental health.
- A belief that treatment of substance abuse issues needs to occur first and exclusively, before treating other behavioral health disorders.
- A belief that treatment should focus solely on presenting symptoms rather than exploring the potential origins or aggravators of symptoms.
- A lack of training and/or feelings of incompetence in effectively treating trauma-related problems (Salyers, Evans, Bond, & Meyer, 2004).
- Not knowing how to respond therapeutically to a client's report of trauma.
- Fear that a probing trauma inquiry will be too disturbing to clients.
- Not using common language with clients that will elicit a report of trauma (e.g., asking clients if they were abused as a child without describing what is meant by abuse).
- Concern that if disorders are identified, clients will require treatment that the counselor or program does not feel capable of providing (Fallot & Harris, 2001).
- Insufficient time for assessment to explore trauma histories or symptoms.
- Untreated trauma-related symptoms of the counselor, other staff members, and administrators.

domestic violence). Still others may deny their history because they are tired of being interviewed or asked to fill out forms and may believe it doesn't matter anyway.

A client may not report past trauma for many reasons, including:

- Concern for safety (e.g., fearing more abuse by a perpetrator for revealing the trauma).
- Fear of being judged by service providers.
- Shame about victimization.
- Reticence about talking with others in response to trauma.
- Not recalling past trauma through dissociation, denial, or repression (although genuine blockage of all trauma memory is rare among trauma survivors; McNally, 2003).
- Lack of trust in others, including behavioral health service providers.
- Not seeing a significant event as traumatic.

Regarding the second major barrier, counselors and other behavioral health service providers may lack awareness that trauma can significantly affect clients' presentations in treatment and functioning across major life areas, such as relationships and work. In addition, some counselors may believe that their role is to treat only the presenting psychological and/or substance abuse symptoms, and thus they may not be as sensitive to histories and effects of trauma. Other providers may believe that a client should abstain from alcohol and drugs for an extended period before exploring trauma symptoms. Perhaps you fear that addressing a clients' trauma history will only exacerbate symptoms and complicate treatment. Behavioral health service providers who hold biases may assume that a client doesn't have a history of trauma and thus fail to ask the "right" questions, or they may be uncomfortable with emotions that arise from listening to client experiences and, as a result, redirect the screening or counseling focus.

Challenges

Awareness of acculturation and language

Acculturation levels can affect screening and assessment results. Therefore, indepth discussions may be a more appropriate way to gain an understanding of trauma from the client's point of view. During the intake, prior to trauma screening, determine the client's history of

Common Assessment Myths

Several common myths contribute to underassessment of trauma-related disorders (Najavits, 2004):

- ***Myth #1: Substance abuse itself is a trauma.*** However devastating substance abuse is, it does not meet the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), criteria for trauma per se. Nevertheless, high-risk behaviors that are more likely to occur during addiction, such as interpersonal violence and self-harm, significantly increase the potential for traumatic injury.
- ***Myth #2: Assessment of trauma is enough.*** Thorough assessment is the best way to identify the existence and extent of trauma-related problems. However, simply identifying trauma-related symptoms and disorders is just the first step. Also needed are individualized treatment protocols and action to implement these protocols.
- ***Myth #3: It is best to wait until the client has ended substance use and withdrawal to assess for PTSD.*** Research does not provide a clear answer to the controversial question of when to assess for PTSD; however, Najavits (2004) and others note that underdiagnosis of trauma and PTSD has been more significant in the substance abuse field than overdiagnosis. Clinical experience shows that the PTSD diagnosis is rather stable during substance use or withdrawal, but symptoms can become more or less intense; memory impairment from alcohol or drugs can also cloud the symptom picture. Thus, it is advisable to establish a tentative diagnosis and then reassess after a period of abstinence, if possible.

migration, if applicable, and primary language. Questions about the client's country of birth, length of time in this country, events or reasons for migration, and ethnic self-identification are also appropriate at intake. Also be aware that even individuals who speak English well might have trouble understanding the subtleties of questions on standard screening and assessment tools. It is not adequate to translate items simply from English into another language; words, idioms, and examples often don't translate directly into other languages and therefore need to be adapted. Screening and assessment should be conducted in the client's preferred language by trained staff members who speak the language or by professional translators familiar with treatment jargon.

Awareness of co-occurring diagnoses

A trauma-informed assessor looks for psychological symptoms that are associated with trauma or simply occur alongside it. Symptom screening involves questions about past or present mental disorder symptoms that may indicate the need for a full mental health assessment. A variety of screening tools are available, including symptom checklists. However, you should only use symptom checklists when you need information about how your client is currently feeling; don't use them to screen for specific disorders. Responses will likely change from one administration of the checklist to the next.

Basic mental health screening tools are available. For example, the Mental Health Screening Form-III screens for present or past symptoms of most mental disorders (Carroll & McGinley, 2001); it is available at no charge from Project Return Foundation, Inc. and is also reproduced in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c). Other screening tools, such as the Beck Depression Inventory II and the Beck Anxiety Inventory (Beck, Wright, Newman, & Liese, 1993), also screen broadly for mental and substance use disorders, as well as for specific disorders often associated with trauma. For further screening information and resources on depression and suicide, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008), and TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a).

For screening substance use disorders, see TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT, 1994); TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT, 1997a); TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT, 1999c); TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c); and TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d).

A common dilemma in the assessment of trauma-related disorders is that certain trauma symptoms are also symptoms of other disorders. Clients with histories of trauma typically present a variety of symptoms; thus, it is important to determine the full scope of symptoms and/or disorders present to help improve treatment planning. Clients with trauma-related and substance use symptoms and disorders are at increased risk for additional Axis I and/or Axis II mental disorders (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Cottler, Nishith, & Compton, 2001). These symptoms need to be distinguished so that other presenting subclinical features or disorders do not go unidentified and untreated. To accomplish this, a comprehensive assessment of the client's mental health is recommended.

Misdiagnosis and underdiagnosis

Many trauma survivors are either misdiagnosed (i.e., given diagnoses that are not accurate) or underdiagnosed (i.e., have one or more diagnoses that have not been identified at all). Such diagnostic errors could result, in part, from the fact that many general instruments to evaluate mental disorders are not sufficiently sensitive to identify posttraumatic symptoms and can misclassify them as other disorders, including personality disorders or psychoses. Intrusive posttraumatic symptoms, for example, can show up on general measures as indicative of hallucinations or obsessions. Dissociative symptoms can be interpreted as indicative of schizophrenia. Trauma-based cognitive symptoms can be scored as evidence for paranoia or other delusional processes (Briere, 1997). Some of the most common misdiagnoses in clients with PTSD and substance abuse are:

- ***Mood and anxiety disorders.*** Overlapping symptoms with such disorders as major depression, generalized anxiety disorder, and bipolar disorder can lead to misdiagnosis.
- ***Borderline personality disorder.*** Historically, this has been more frequently diagnosed than PTSD. Many of the symptoms, including a pattern of intense interpersonal relationships, impulsivity, rapid and unpredictable mood swings, power struggles in the treatment environment, underlying anxiety and depressive symptoms, and transient, stress-related paranoid ideation or severe dissociative symptoms overlap. The effect of this misdiagnosis on treatment can be particularly negative; counselors often view clients with a borderline personality diagnosis as difficult to treat and unresponsive to treatment.
- ***Antisocial personality disorder.*** For men and women who have been traumatized in childhood, "acting out" behaviors, a lack of empathy and conscience, impulsivity, and self-centeredness can be functions of trauma and survival skills rather than true antisocial characteristics.
- ***Attention deficit hyperactivity disorder (ADHD).*** For children and adolescents, impulsive behaviors and concentration problems can be diagnosed as ADHD rather than PTSD.

It is possible, however, for clients to legitimately have any of these disorders in addition to trauma-related disorders. Given the overlap of posttraumatic symptoms with those of other disorders, a wide variety of diagnoses often needs to be considered to avoid misidentifying

other disorders as PTSD and vice versa. A trained and experienced mental health professional will be required to weigh differential diagnoses. TIP 42 (CSAT, 2005c) explores issues related to differential diagnosis.

Cross-Cultural Screening and Assessment

Many trauma-related symptoms and disorders are culture specific, and a client's cultural background must be considered in screening and assessment (for review of assessment and cultural considerations when working with trauma, see Wilson & Tang, 2007). Behavioral health service providers must approach screening and assessment processes with the influences of culture, ethnicity, and race firmly in mind. Cultural factors, such as norms for expressing psychological distress, defining trauma, and seeking help in dealing with trauma, can affect:

- How traumas are experienced.
- The meaning assigned to the event(s).
- How trauma-related symptoms are expressed (e.g., as somatic expressions of distress, level of emotionality, types of avoidant behavior).
- Willingness to express distress or identify trauma with a behavioral health service provider and sense of safety in doing so.
- Whether a specific pattern of behavior, emotional expression, or cognitive process is considered abnormal.
- Willingness to seek treatment inside and outside of one's own culture.
- Response to treatment.
- Treatment outcome.

When selecting assessment instruments, counselors and administrators need to choose,

Culture-Specific Stress Responses

Culture-bound concepts of distress exist that don't necessarily match diagnostic criteria. Culture-specific symptoms and syndromes can involve physical complaints, broad emotional reactions, or specific cognitive features. Many such syndromes are unique to a specific culture but can broaden to cultures that have similar beliefs or characteristics. Culture-bound syndromes are typically treated by traditional medicine and are known throughout the culture. Cultural concepts of distress include:

- ***Ataques de nervios.*** Recognized in Latin America and among individuals of Latino descent, the primary features of this syndrome include intense emotional upset (e.g., shouting, crying, trembling, dissociative or seizure-like episodes). It frequently occurs in response to a traumatic or stressful event in the family.
- ***Nervios.*** This is considered a common idiom of distress among Latinos; it includes a wide range of emotional distress symptoms including headaches, nervousness, tearfulness, stomach discomfort, difficulty sleeping, and dizziness. Symptoms can vary widely in intensity, as can impairment from them. This often occurs in response to stressful or difficult life events.
- ***Susto.*** This term, meaning "fright," refers to a concept found in Latin American cultures, but it is not recognized among Latinos from the Caribbean. *Susto* is attributed to a traumatic or frightening event that causes the soul to leave the body, thus resulting in illness and unhappiness; extreme cases may result in death. Symptoms include appetite or sleep disturbances, sadness, lack of motivation, low self-esteem, and somatic symptoms.
- ***Taijin kyofusho.*** Recognized in Japan and among some American Japanese, this "interpersonal fear" syndrome is characterized by anxiety about and avoidance of interpersonal circumstances. The individual presents worry or a conviction that his or her appearance or social interactions are inadequate or offensive. Other cultures have similar cultural descriptions or syndromes associated with social anxiety.

Sources: APA, 2013, pp. 833–837; Briere & Scott, 2006b.

whenever possible, instruments that are culturally appropriate for the client. Instruments that have been normed for, adapted to, and tested on specific cultural and linguistic groups should be used. Instruments that are not normed for the population are likely to contain cultural biases and produce misleading results. Subsequently, this can lead to misdiagnosis, overdiagnosis, inappropriate treatment plans, and ineffective interventions. Thus, it is important to interpret all test results cautiously and to discuss the limitations of instruments with clients from diverse ethnic populations and cultures. For a review of cross-cultural screening and assessment considerations, refer to the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration, planned c).

Choosing Instruments

Numerous instruments screen for trauma history, indicate symptoms, assess trauma-related and other mental disorders, and identify related clinical phenomena, such as dissociation. One instrument is unlikely to meet all screening or assessment needs or to determine the existence and full extent of trauma symptoms and traumatic experiences. The following sections present general considerations in selecting standardized instruments.

Purpose

Define your assessment needs. Do you need a standardized screening or assessment instrument for clinical purposes? Do you need information on a specific aspect of trauma, such as history, PTSD, or dissociation? Do you wish to make a formal diagnosis, such as PTSD? Do you need to determine quickly whether a client has experienced a trauma? Do you want an assessment that requires a clinician to administer it, or can the client complete the instrument himself or herself? Does the instrument match the current and specific diagnostic criteria established in the DSM-5?

Population

Consider the population to be assessed (e.g., women, children, adolescents, refugees, disaster survivors, survivors of physical or sexual violence, survivors of combat-related trauma, people whose native language is not English); some tools are appropriate only for certain populations. Is the assessment process developmentally and culturally appropriate for your client? Exhibit 1.4-2 lists considerations in choosing a screening or assessment instrument for trauma and/or PTSD.

Instrument Quality

An instrument should be psychometrically adequate in terms of sensitivity and specificity or reliability and validity as measured in several ways under varying conditions. Published research offers information on an instrument's psychometric properties as well as its utility in both research and clinical settings. For further information on a number of widely used trauma evaluation tools, see Appendix D and Antony, Orsillo, and Roemer's paper (2001).

The DSM-5 and Updates to Screening and Assessment Instruments

The recent publication of the DSM-5 (APA, 2013a) reflects changes to certain diagnostic criteria, which will affect screening tools and criteria for trauma-related disorders. Criterion A2 (specific to traumatic stress disorders, acute stress, and posttraumatic stress disorders), included in the fourth edition (text revision) of the DSM (DSM-IV-TR; APA, 2000a), has been eliminated; this criterion stated that the individual's response to the trauma needs to involve intense fear, helplessness, or horror. There are now four cluster symptoms, not three: reexperiencing, avoidance, arousal, and persistent negative alterations in cognitions and mood. Changes to the DSM-5 were made to symptoms within each cluster. Thus, screening will need modification to adjust to this change (APA, 2012b).

Exhibit 1.4-2: Key Areas of Trauma Screening and Assessment

Trauma
Key question: Did the client experience a trauma?

Examples of measures: Life Stressor Checklist-Revised (Wolfe & Kimerling, 1997); Trauma History Questionnaire (Green, 1996); Traumatic Life Events Questionnaire (Kubany et al., 2000).

Note: A good trauma measure identifies events a person experienced (e.g., rape, assault, accident) and also evaluates other trauma-related symptoms (e.g., presence of fear, helplessness, or horror).

Acute Stress Disorder (ASD) and PTSD
Key question: Does the client meet criteria for ASD or PTSD?

Examples of measures: Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990); Modified PTSD Symptom Scale (Falsetti, Resnick, Resnick, & Kilpatrick, 1993); PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993); Stanford Acute Stress Reaction Questionnaire (Cardena, Koopman, Classen, Waelde, & Spiegel, 2000).

Note: A PTSD diagnosis requires the person to meet criteria for having experienced a trauma; some measures include this, but others do not and require use of a separate trauma measure. The CAPS is an interview; the others listed are self-report questionnaires and take less time.

Other Trauma-Related Symptoms
Key question: Does the client have other symptoms related to trauma? These include depressive symptoms, self-harm, dissociation, sexuality problems, and relationship issues, such as distrust.

Examples of measures: Beck Depression Inventory II (Beck, 1993; Beck et al., 1993); Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993); Impact of Event Scale (measures intrusion and avoidance due to exposure to traumatic events; Horowitz, Wilner, & Alvarez, 1979; Weiss & Marmar, 1997); Trauma Symptom Inventory (Briere, 1995); Trauma Symptom Checklist for Children (Briere, 1996b); Modified PTSD Symptom Scale (Falsetti et al., 1993).

Note: These measures can be helpful for clinical purposes and for outcome assessment because they gauge *levels* of symptoms. Trauma-related symptoms are broader than diagnostic criteria and thus useful to measure, even if the patient doesn't meet criteria for any specific diagnoses.

Other Trauma-Related Diagnoses
Key question: Does the client have other disorders related to trauma? These include mood disorders, anxiety disorders besides traumatic stress disorders, and dissociative disorders.

Examples of measures: Mental Health Screening Form III (Carroll & McGinley, 2001); The Mini-International Neuropsychiatric Interview (M.I.N.I.) Structured Clinical Interview for DSM-IV-TR, Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011); Structured Clinical Interview for DSM-IV-TR, Non-Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011a).

Note: For complex symptoms and diagnoses such as dissociation and dissociative disorders, interviews are recommended. Look for measures that incorporate DSM-5 criteria.

Sources: Antony et al., 2001; Najavits, 2004.

Practical Issues

Is the instrument freely and readily available, or is there a fee? Is costly and extensive training required to administer it? Is the instrument too lengthy to be used in the clinical setting? Is it easily administered and scored with accompanying manuals and/or other training materials? How will results be presented to or used with the client? Is technical support available for difficulties in administration, scoring, or interpretation of results? Is special equipment required such as a microphone, a video camera, or a touch-screen computer with audio?

Trauma-Informed Screening and Assessment

The following sections focus on initial screening. For more information on screening and assessment tools, including structured interviews, see Exhibit 1.4-2. Screening is only as good as the actions taken afterward to address a positive screen (when clients acknowledge that they experience symptoms or have encountered events highlighted within the screening). Once a screening is complete and a positive screen is acquired, the client then needs referral for a more indepth assessment to ensure development of an appropriate treatment plan that matches his or her presenting problems.

Establish a History of Trauma

A person cannot have ASD, PTSD, or any trauma-related symptoms without experiencing trauma; therefore, it is necessary to inquire about painful, difficult, or overwhelming past experiences. Initial information should be gathered in a way that is minimally intrusive yet clear. Brief questionnaires can be less threatening to a client than face-to-face interviews, but interviews should be an integral part of any screening and assessment process. If the client initially denies a history of trauma (or minimizes it), administer the questionnaire later or delay additional trauma-related questions until the client has perhaps developed more trust in the treatment setting and feels safer with the thoughts and emotions that might arise in discussing his or her trauma experiences.

The Stressful Life Experiences (SLE) screen (Exhibit 1.4-3) is a checklist of traumas that also considers the client's view of the impact of those events on life functioning. Using the SLE can foster the client–counselor relationship. By going over the answers with the client, you can gain a deep understanding of your client, and the client receives a demonstration of your sensitivity and concern for what the client has experienced. The National Center for PTSD Web site offers similar instruments (http://www.ptsd.va.gov/professional/pages/assessments/assessment.asp).

In addition to broad screening tools that capture various traumatic experiences and symptoms, other screening tools, such as the Combat Exposure Scale (Keane et al., 1989) and the Intimate Partner Violence Screening Tool (Exhibit 1.4-4), focus on acknowledging a specific type of traumatic event.

Screen for Trauma-Related Symptoms and Disorders in Clients With Histories of Trauma

This step evaluates whether the client's trauma resulted in subclinical or diagnosable disorders. The counselor can ask such questions as, "Have you received any counseling or therapy? Have you ever been diagnosed or treated for a psychological disorder in the past? Have you ever been prescribed medications for your emotions in the past?" Screening is typically conducted by a wide variety of behavioral health service providers with different levels of training and education; however, all

Exhibit 1.4-3: SLE Screening

Please fill in the number that best represents how much the following statements describe your experiences. You will need to use two scales, one for how well the statement describes your experiences and one for how stressful you found this experience. The two scales are below.

Describes your Experience:

0	1	2	3	4	5	6	7	8	9	10
Did not experience this	a little like my experiences				somewhat like my experiences					exactly like my experiences

Stressfulness of Experience:

0	1	2	3	4	5	6	7	8	9	10
Not at all stressful	not very stressful				somewhat stressful					extremely stressful

Describes your Experience	Life Experience	Stressfulness Then		Stressfulness Now
	I have witnessed or experienced a natural disaster; like a hurricane or earthquake.			
	I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.			
	I have witnessed or experienced a serious accident or injury.			
	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.			
	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.			
	I have witnessed or experienced the death of my spouse or child.			
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).			
	I or a close friend or family member has been kidnapped or taken hostage.			
	I or a close friend or family member has been the victim of a terrorist attack or torture.			
	I have been involved in combat or a war or lived in a war affected area.			
	I have seen or handled dead bodies other than at a funeral.			
	I have felt responsible for the serious injury or death of another person.			
	I have witnessed or been attacked with a weapon other than in combat or family setting			
	As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury			
	As an adult, I was hit, choked or pushed hard enough to cause injury.			
	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.			
	As a child/teen I was forced to have unwanted sexual contact.			
	As an adult I was forced to have unwanted sexual contact.			
	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact			
	I have witnessed or experienced an extremely stressful event not already mentioned. Please Explain:_____ _____			

Sources: Hudnall Stamm, 1996, 1997. Used with permission.

Exhibit 1.4-4: STaT Intimate Partner Violence Screening Tool

1. Have you ever been in a relationship where your partner has pushed or **Slapped** you?
2. Have you ever been in a relationship where your partner **Threatened** you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken, or punched **Things**?

Source: Paranjape & Liebschutz, 2003. Used with permission

individuals who administer screenings, regardless of education level and experience, should be aware of trauma-related symptoms, grounding techniques, ways of creating safety for the client, proper methods for introducing screening tools, and the protocol to follow when a positive screen is obtained. (See Appendix D for information on specific instruments.) Exhibit 1.4-5 is an example of a screening instrument for trauma symptoms, the Primary Care PTSD (PC-PTSD) Screen. Current research (Prins et al., 2004) suggests that the optimal cutoff score for the PC-PTSD is 3. If sensitivity is of greater concern than efficiency, a cutoff score of 2 is recommended.

Exhibit 1.4-5: PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…

1. Have had nightmares about it or thought about it when you did not want to?
   YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES NO
3. Were constantly on guard, watchful, or easily startled?
   YES NO
4. Felt numb or detached from others, activities, or your surroundings?
   YES NO

Source: Prins et al., 2004. Material used is in the public domain.

Another instrument that can screen for traumatic stress symptoms is the four-item self-report SPAN, summarized in Exhibit 1.4-6, which is derived from the 17-item Davidson Trauma Scale (DTS). SPAN is an acronym for the four items the screening addresses: startle, physiological arousal, anger, and numbness. It was developed using a small, diverse sample of adult patients (N=243; 72 percent women; 17.4 percent African American; average age = 37 years) participating in several clinical studies, including a family study of rape trauma, combat veterans, and Hurricane Andrew survivors, among others.

The SPAN has a high diagnostic accuracy of 0.80 to 0.88, with sensitivity (percentage of true positive instances) of 0.84 and specificity (percentage of true negative instances) of 0.91 (Meltzer-Brody, Churchill, & Davidson, 1999). SPAN scores correlated highly with the full DTS (r = 0.96) and other measures, such as the Impact of Events Scale (r = 0.85) and the Sheehan Disability Scale (r = 0.87).

The PTSD Checklist (Exhibit 1.4-7), developed by the National Center for PTSD, is in the public domain. Originally developed for combat veterans of the Vietnam and Persian

Exhibit 1.4-6: The SPAN

The SPAN instrument is a brief screening tool that asks clients to identify the trauma in their past that is most disturbing to them currently. It then poses four questions that ask clients to rate the frequency and severity with which they have experienced, in the past week, different types of trauma-related symptoms (startle, physiological arousal, anger, and numbness).

To order this screening instrument, use the following contact information:
Multi-Health Systems, Inc.
P.O. Box 950
North Tonawanda, NY
14120-0950
Phone: 800-456-3003

Source: Meltzer-Brody et al., 1999.

Exhibit 1.4-7: The PTSD Checklist

Instructions to Client: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully and circle the number that indicates how much you have been bothered by that problem *in the past month*.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
2. Repeated, disturbing dreams of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
4. Feeling very upset when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
7. Avoiding activities or situations because they reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
8. Trouble remembering important parts of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
9. Loss of interest in activities that you used to enjoy?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
10. Feeling distant or cut off from other people?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
12. Feeling as if your future will somehow be cut short?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
13. Trouble falling or staying asleep?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
14. Feeling irritable or having angry outbursts?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
15. Having difficulty concentrating?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
16. Being "super-alert" or watchful or on guard?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
17. Feeling jumpy or easily startled?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Source: Weathers et al., 1993. Material used is in the public domain.

Gulf Wars, it has since been validated on a variety of noncombat traumas (Keane, Brief, Pratt, & Miller, 2007). When using the checklist, identify a specific trauma first and then have the client answer questions in relation to that one specific trauma.

Other Screening and Resilience Measures

Along with identifying the presence of trauma-related symptoms that warrant assessment to determine the severity of symptoms as well as whether or not the individual possesses subclinical symptoms or has met criteria for a trauma-related disorder, clients should receive other screenings for symptoms associated with trauma (e.g., depression, suicidality). It is important that screenings address both external and internal resources (e.g., support systems, strengths, coping styles). Knowing the client's strengths can significantly shape the treatment planning process by allowing you to use strategies that have already worked for the client and incorporating strategies to build resilience (Exhibit 1.4-8).

Exhibit 1.4-8: Resilience Scales

A number of scales with good psychometric properties measure resilience:

- Resilience Scale (Wagnild & Young, 1993)
- Resilience Scale for Adults (Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003)
- Connor Davidson Resilience Scale, 25-,10-, and 2-Item (Connor & Davidson, 2003; Campbell-Sills & Stein, 2007; Vaishnavi, Connor, & Davidson, 2007, respectively)
- Dispositional Resilience Scale, 45-,30-, 15-item forms (Bartone, Roland, Picano, &Williams, 2008)

Preliminary research shows improvement of individual resilience through treatment interventions in other populations (Lavretsky, Siddarth, & Irwin, 2010).

Screen for suicidality

All clients—particularly those who have experienced trauma—should be screened for suicidality by asking, "In the past, have you ever had suicidal thoughts, had intention to commit suicide, or made a suicide attempt? Do you have any of those feelings now? Have you had any such feelings recently?" Behavioral health service providers should receive training to screen for suicide. Additionally, clients with substance use disorders and a history of psychological trauma are at heightened risk for suicidal thoughts and behaviors; thus, screening for suicidality is indicated. See TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a). For additional descriptions of screening processes for suicidality, see TIP 42 (CSAT, 2005c).

Concluding Note

Screenings are only beneficial if there are follow-up procedures and resources for handling positive screens, such as the ability to review results with and provide feedback to the individual after the screening, sufficient resources to complete a thorough assessment or to make an appropriate referral for an assessment, treatment planning processes that can easily incorporate additional trauma-informed care objectives and goals, and availability and access to trauma-specific services that match the client's needs. Screening is only the first step!

5 Clinical Issues Across Services

IN THIS CHAPTER

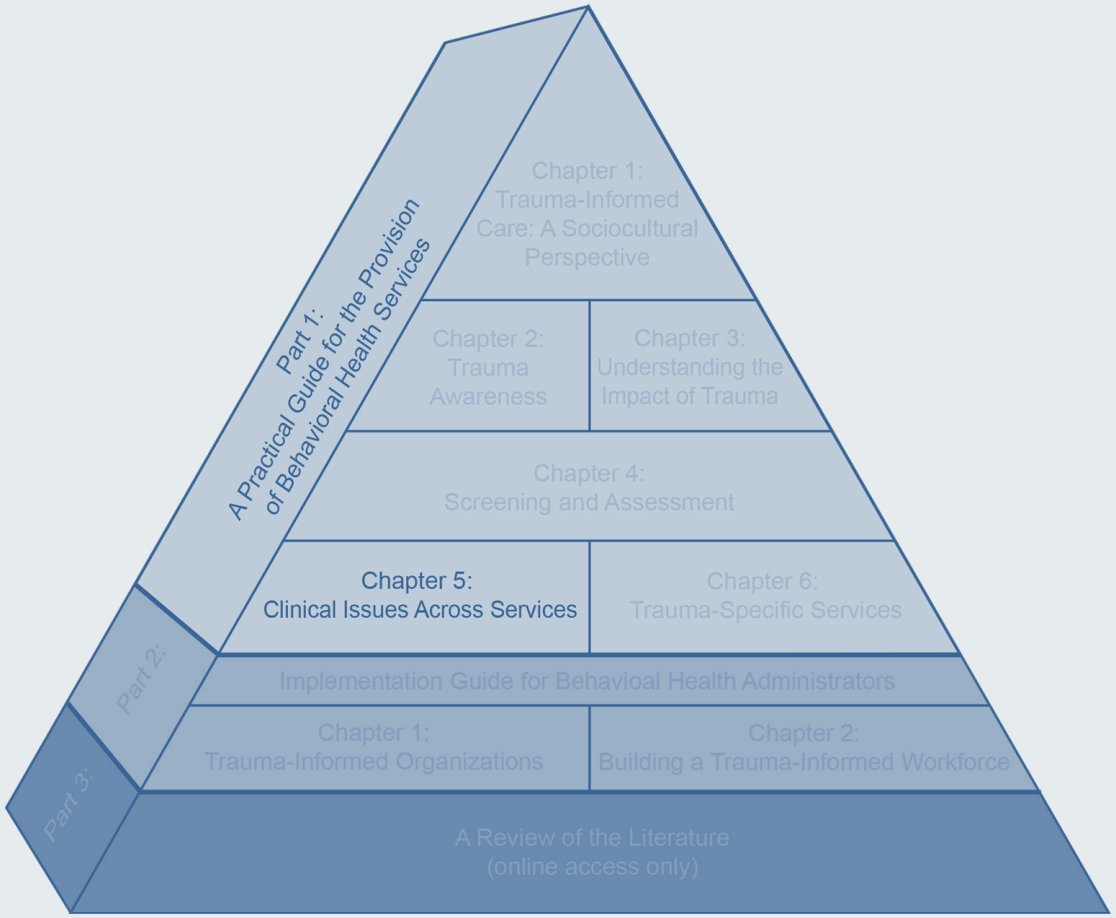
- Trauma Informed Prevention and Treatment Objectives
- Treatment Issues
- Making Referrals to Trauma Specific Services

Many clients in behavioral health treatment may have histories of trauma, so counselors should be prepared to help them address issues that arise from those histories. This chapter begins with a thorough discussion of trauma-informed prevention and treatment objectives along with practical counselor strategies. Specific treatment issues related to working with trauma survivors in a clinical setting are discussed as well, including client engagement, pacing and timing, traumatic memories, and culturally appropriate and gender-responsive services. The chapter ends with guidelines for making referrals to trauma-specific services.

Trauma-Informed Prevention and Treatment Objectives

Trauma-informed care (TIC) not only focuses on identifying individuals who have histories of trauma and traumatic stress symptoms; it also places considerable effort in creating an environment that helps them recognize the impact of trauma and determine the next course of action in a safe place. For some individuals, psychoeducation and development or reinforcement of coping strategies will be the most suitable and effective strategy, whereas others may request or warrant a referral for more trauma-specific interventions (see Part 1, Chapter 6, of this Treatment Improvement Protocol [TIP]). Although research is limited in the area of building resilience to prevent exacerbation of trauma symptoms and traumatic stress disorders, TIC also focuses on prevention strategies to avoid retraumatization in treatment, to promote resilience, and to prevent the development of trauma-related disorders. The following sections highlight key trauma-informed prevention and treatment objectives.

TIC Framework in Behavioral Health Services—Clinical Issues Across Services



Establish Safety

Beyond identifying trauma and trauma-related symptoms, the initial objective of TIC is establishing safety. Borrowing from Herman's (1992) conceptualization of trauma recovery, safety is the first goal of treatment. Establishing safety is especially crucial at the outset of trauma-informed treatment and often becomes a recurrent need when events or therapeutic changes raise safety issues, such as a change in treatment staffing due to vacations.

In the context of TIC, safety has a variety of meanings. Perhaps most importantly, the client has to have some degree of ***safety from trauma symptoms***. Recurring intrusive nightmares; painful memories that burst forth seemingly without provocation; feelings of sadness, anger, shame, or being overwhelmed; or not having control over sudden disconnections from others make moment-to-moment living feel unsafe. Clients might express feeling unsafe through statements such as, "I can't control my feelings," or, "I just space out and disconnect from the world for no reason," or, "I'm afraid to go to sleep because of the nightmares." The intense feelings that accompany trauma can also make clients feel unsafe. They may wake up in the morning feeling fine but become immobilized by depression as the day progresses. Clients with histories of trauma may experience panicky feelings of being trapped or abandoned. An early effort in trauma treatment is thus helping the client

Advice to Counselors: Strategies To Promote Safety

Strategy #1: Teach clients how and when to use grounding exercises when they feel unsafe or overwhelmed.

Strategy #2: Establish some specific routines in individual, group, or family therapy (e.g., have an opening ritual or routine when starting and ending a group session). A structured setting can provide a sense of safety and familiarity for clients with histories of trauma.

Strategy #3: Facilitate a discussion on safe and unsafe behaviors. Have clients identify, on paper, behaviors that promote safety and behaviors that feel unsafe for them today.

Strategy #4: Refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (Najavits, 2002a). This menu-based manual covers an array of treatment topics, including the core concept of safety. Each topic consists of several segments, including preparing for the session, session format, session content, handouts, and guidelines.

Strategy #5: Encourage the development of a safety plan. Depending on the type of trauma, personal safety can be an issue; work with the client to develop a plan that will help him or her feel in control and prepared for the unexpected. If the trauma was a natural or human-caused disaster, encourage thinking about how family and friends will respond and connect in the event of another crisis. If sexual abuse or rape was the event, encourage thinking about future steps that could help make the client safer. There is a delicate balance between preparation and the realization that one cannot prepare for all possible traumatic events. Nonetheless, an action plan can help the client regain a sense of environmental balance.

gain more control over trauma symptoms (and be able to label them as such) by learning more about the client and helping him or her develop new coping skills to handle symptoms when they arise and stay more grounded when flooded with feelings or memories.

A second aspect is ***safety in the environment***. Trauma reactions can be triggered by sudden loud sounds (e.g., television at high volume, raised voices), tension between people, certain smells, or casual touches that are perceived as invasions of physical boundaries. The vulnerability of exposing one's history in the treatment setting can manifest in the client as feeling physically vulnerable and unsafe in the treatment environment. Sudden or inadequately explained treatment transitions, such as moving from one level of treatment to another or changing counselors, can also evoke feelings of danger, abandonment, or instability. Early in treatment, trauma survivors generally value routine and predictability. The counselor should recognize these needs and respond appropriately by offering information in advance, providing nonshaming responses to a client's reactions to stimuli in his or her environment, and helping the client build a daily structure that feels safe.

A third aspect of safety is ***preventing a recurrence of trauma***. People with histories of trauma and substance abuse are more likely to engage in high-risk behaviors and to experience subsequent traumas. Early treatment should focus on helping clients stop using unsafe coping mechanisms, such as substance abuse, self-harm, and other self-destructive behaviors, and replacing them with safe and healthy coping strategies. Helping clients learn to protect themselves in reasonable ways is a positive goal of treatment.

Prevent Retraumatization

A key objective in TIC is to prevent retraumatization generated by intervention and treatment practices and policies. Unfortunately, treatment settings and clinicians can

Advice to Counselors: Strategies To Prevent Retraumatization

Strategy #1: Be sensitive to the needs of clients who have experienced trauma regarding behaviors in the treatment setting that might trigger memories of the trauma.

Strategy #2: Do not ignore clients' symptoms and demands when clients with trauma histories act out in response to triggered trauma memories; doing so may replicate the original traumatic experience.

Strategy #3: Be mindful that efforts to control and contain a client's behaviors in treatment can produce an abnormal reaction, particularly for trauma survivors for whom being trapped was part of the trauma experience.

Strategy #4: Listen for specific triggers that seem to be driving the client's reaction. An important step in recovery is helping the client identify these cues and thereby reach a better understanding of reactions and behaviors.

unintentionally create retraumatizing experiences (for a review of traumas that can occur when treating serious mental illness, see Frueh et al., 2005). For instance, compassionate inquiry into a client's history can seem similar to the interest shown by a perpetrator many years before. Direct confrontation by counselors about behaviors related to substance abuse can be seen, by someone who has been repeatedly physically assaulted, as provocation building up to assault. Counselor and program efforts to help clients constrain destructive behaviors can be interpreted as efforts to control and dominate the individual. Intrusive shaming or insensitive behavior demonstrated by another client in the program can threaten a trauma survivor whose boundaries have been disregarded in the past—thus making the experience of treatment feel dangerous rather than safe. Some staff and agency issues that can result in retraumatization include:

- Disrespectfully challenging reports of abuse or other traumatic events.
- Discounting a client's report of a traumatic event.
- Using isolation.
- Using physical restraints.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling intense rage and other feelings as pathological.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate and/or disrespectful manner.
- Having clients undress in the presence of others.
- Being insensitive to a client's physical or emotional boundaries.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Applying rigid agency policies or rules without an opportunity for clients to question them.
- Accepting agency dysfunction, including a lack of consistent, competent leadership.

Provide Psychoeducation

Trauma-informed education informs clients about traumatic stress and trauma-related symptoms and disorders as well as the related consequences of trauma exposure. It focuses on giving information to clients to help normalize presenting symptoms, to highlight potential short-term and long-term consequences of trauma and various paths to recovery, and to underscore the message that recovery is possible. Education frequently takes place prior to or immediately following an initial screening as a way to prepare clients

Advice to Counselors: Strategies To Implement Psychoeducation

Strategy #1: Remember that this may be the client's first experience with treatment. It's easy to use program or clinical jargon when you're around it every day, but most individuals who seek help are unfamiliar with clinical language, how the program works, and treatment objectives. Psychoeducation begins with understanding the client's expectations and reasons for seeking help, followed by educating the client and other family members about the program. Remember that this is all new for them.

Strategy #2: After obtaining acknowledgment of a trauma history, provide an overview of common symptoms and consequences of traumatic stress, regardless of whether the client affirms having trauma-related symptoms. It is equally important to educate the client on resilience factors associated with recovery from trauma (Wessely et al., 2008). A trauma-informed perspective provides a message that trauma reactions are normal responses to an abnormal situation.

Strategy #3: Develop a resource box that provides an array of printed or multimedia educational materials that address the program, specific symptoms and tools to combat trauma-related symptoms, treatment options and therapy approaches, advantages of peer support, and steps in developing specific coping strategies.

Strategy #4: Develop a rotating educational group that matches services and client schedules to complement treatment. Remember that education can play a pivotal role in enhancing motivation, in normalizing experiences, and in creating a sense of safety as individuals move further into treatment. For some survivors, education can be a powerful intervention or prevention strategy.

for hearing results or to place the screening and subsequent assessment findings in proper context. Education in and of itself, however, does not necessarily constitute a stand-alone treatment; rather, it can be conceptualized as a first step and/or component of more comprehensive treatment. Nonetheless, education may be a prevention and intervention strategy for individuals who have histories of trauma without current consequences or symptoms and/or those who have reported a resolution of past trauma(s). For example, some clients may have significantly delayed onset of traumatic stress symptoms. In this scenario, earlier education can enhance recognition of symptoms and ease the path of seeking treatment.

Some clients do not recognize the link between their current difficulties and their trauma histories; education can help them understand the possible origin of their difficulties. Psychoeducation presents trauma-related symptoms that follow a trauma as normal reactions. By identifying the source of clients' current difficulties and framing them as normal thoughts, emotions, and behaviors in response to trauma, many trauma survivors report a reduction in the intensity of the difficulties or symptoms. Often, a client will express relief that his or her reactions are normal. You may find the U.S. Department of Veterans Affairs (VA) National Center on PTSD's educational handouts on traumatic stress reactions useful.

Psychoeducation goes beyond the identification of traumatic stress symptoms and/or learning about the psychological, cognitive, and physical impacts of trauma. Numerous curricula are available that use psychoeducation as a first-line or complementary approach to trauma-specific therapies to enhance coping strategies in key areas, including safety, emotional regulation, help-seeking, avoidant behavior, and so forth. An example is S.E.L.F., a trauma-informed psychoeducational group curriculum with educational components related to trauma recovery in the following

Case Illustration: Linda

Linda served as an Army nurse in an evacuation hospital in Vietnam. She reported her postdeployment adjustment as difficult and isolating but denied any significant symptoms of traumatic stress throughout her life. Four years ago, Linda sought treatment for alcohol dependence; during the intake, she recalls denying trauma-related symptoms. "I distinctly remember the session," she recounts. "The counselor first took my history but then gave information on typical symptoms and reactions to trauma. I thought, 'Why do I need to hear this? I've survived the worst trauma in my life.' I didn't see the value of this information. Then 3 weeks ago, I began to have recurrent nightmares, the same graphic type I occasionally had when I was in Vietnam. Since then, I've been very anxious, reliving horrible scenes that I'd experienced as a nurse and postponing going to bed in fear of having the dreams again. I didn't understand it. I am 70 years old, and the war happened a long time ago. Then I began putting it together. Recently, the emergency helicopter flight pattern and approach to the area's hospital changed. I began hearing the helicopter periodically in my living room, and it reminded me of Vietnam. I knew then that I needed help; I couldn't stop shaking. I felt as if I was losing control of my emotions. I remembered how the intake counselor took the time to explain common symptoms of trauma. That's why I'm here today."

"This might not sound like a big deal, but for many people relationships have become all about getting: telling your problem story and then getting help with it. There is little, if any, emphasis placed on giving back. That's a big deal!!! Service relationships are like a one way street and both people's roles are clearly defined. But in 'regular' relationships in your community, people give and take all the time. No one is permanently on the taking side or the giving side. This exchange contributes to people feeling ok about being vulnerable (needing help) as well as confident about what they're offering. For many of us, being the role of 'getter' all the time has shaken our confidence, making us feel like we have nothing worthwhile to contribute. Peer support breaks that all down. It gets complicated somewhat when one of us is paid, but modeling this kind of relationship in which both of us learn, offers us the real practice we need to feel like a 'regular' community member as opposed to an 'integrated mental patient'."

(Mead, 2008, p.7)

areas: creating **S**afety, regulating **E**motions, addressing **L**oss, and redefining the **F**uture (Bloom, Foderaro, & Ryan, 2006).

Offer Trauma-Informed Peer Support

Living with a history of trauma can be isolating and consuming. The experience of trauma can reinforce beliefs about being different, alone, and marred by the experience. At times, behavioral health treatment for trauma-related effects can inadvertently reinforce these beliefs. Simply engaging in treatment or receiving specialized services (although warranted) can further strengthen clients' beliefs that there is something wrong with them. Formalized peer support can enhance the treatment experience. Treatment plus peer support can break the cycle of beliefs that reinforce traumatic stress (e.g., believing that one is permanently damaged; that nobody could understand; that no one should or could tolerate one's story). Peer support provides opportunities to form mutual relationships; to learn how one's history shapes perspectives of self, others, and the future; to move beyond trauma; and to mirror and learn alternate coping strategies. Peer support defines recovery as an

Advice to Counselors: Strategies To Enhance Peer Support

Strategy #1: Provide education on what peer support is and is not. Roles and expectations of peer support can be confusing, so providing clarification in the beginning can be quite useful. It is important to provide initial education about peer support and the value of using this resource.

Strategy #2: Use an established peer support curriculum to guide the peer support process. For example, *Intentional Peer Support: An Alternative Approach* (Mead, 2008) is a workbook that highlights four main tasks for peer support: building connections, understanding one's worldview, developing mutuality, and helping each other move toward set desires and goals. This curriculum provides extensive materials for peer support staff members as well as for the individuals seeking peer support.

interactive process, not as a definitive moment wherein someone fixes the "problem."

Normalize Symptoms

Symptoms of trauma can become serious barriers to recovery from substance use and mental disorders, including trauma-related ones. Counselors should be aware of how trauma symptoms can present and how to respond to them when they do appear. A significant step in addressing symptoms is normalizing them. People with traumatic stress symptoms need to know that their symptoms are not unique and that their reactions are common to their experience(s). Often, normalizing symptoms gives considerable relief to clients who may have thought that their symptoms signified some pervasive, untreatable mental disorder.

Advice to Counselors: Strategies To Normalize Symptoms

Strategy #1: Provide psychoeducation on the common symptoms of traumatic stress.

Strategy #2: Research the client's most prevalent symptoms specific to trauma, and then provide education to the client. For example, an individual who was conscious and trapped during or as a result of a traumatic event will more likely be hypervigilant about exits, plan escape routes even in safe environments, and have strong reactions to interpersonal and environmental situations that are perceived as having no options for avoidance or resolution (e.g., feeling stuck in a work environment where the boss is emotionally abusive).

Strategy #3: First, have the client list his or her symptoms. After each symptom, ask the client to list the negative and positive consequences of the symptom. Remember that symptoms serve a purpose, even if they may not appear to work well or work as well as they had in the past. Focus on how the symptoms have served the client in a positive way (see Case Illustration: Hector). This exercise can be difficult, because clients as well as counselors often don't focus on the value of symptoms.

Case Illustration: Hector

Hector was referred to a halfway house specializing in co-occurring disorders after inpatient treatment for methamphetamine dependence and posttraumatic stress disorder (PTSD). In the halfway house, he continued to feel overwhelmed with the frequency and intensity of flashbacks. He often became frustrated, expressing anger and a sense of hopelessness, followed by emotional withdrawal from others in the house. Normalization strategy #3 was introduced in the session. During this exercise, he began to identify many negative aspects of flashbacks. He felt that he couldn't control the occurrence of flashbacks even though he wanted to, and he realized that he often felt shame afterward. In the same exercise, he was also urged to identify positive aspects of flashbacks. Although this was difficult, he realized that flashbacks were clues about content that he needed to address in trauma-specific treatment. "I realized that a flashback, for me, was a billboard advertising what I needed to focus on in therapy."

Identify and Manage Trauma-Related Triggers

Many clients who have traumatic stress are caught off guard with intrusive thoughts, feelings, sensations, or environmental cues of the trauma. This experience can be quite disconcerting, but often, the individual does not draw an immediate connection between the internal or external trigger and his or her reactions. At other times, the trigger is so potent that the individual is unable to discern the present trigger from the past trauma and begins to respond as if the trauma is reoccurring.

Key steps in identifying triggers are to reflect back on the situation, surroundings, or sensations prior to the strong reaction. By doing so, you and your client may be able to determine the connections among these cues, the past trauma(s), and the client's reaction. Once the cue is identified, discuss the ways in which it is connected to past trauma. For some cues, there will be an obvious and immediate connection (e.g., having someone say "I love you" in a significant relationship as an adult and connecting this to an abuser who said the same thing prior to a sexual assault). Other

Advice to Counselors: Strategies To Identify and Manage Trauma-Related Triggers

Strategy #1: Use the Sorting the Past From the Present technique for cognitive realignment (Blackburn, 1995) to help separate the current situation from the past trauma. Identify one trigger at a time, and then discuss the following questions with the client:

- When and where did you begin to notice a reaction?
- How does this situation remind you of your past history or past trauma?
- How are your reactions to the current situation similar to your past reactions to the trauma(s)?
- How was this current situation different from the past trauma?
- How did you react differently to the current situation than to the previous trauma?
- How are you different today (e.g., factors such as age, abilities, strength, level of support)?
- What choices can you make that are different from the past and that can help you address the current situation (trigger)?

After reviewing this exercise several times in counseling, put the questions on a card for the client to carry and use outside of treatment. Clients with substance use disorders can benefit from using the same questions (slightly reworded) to address relapse triggers.

Strategy #2: After the individual identifies the trigger and draws connections between the trigger and past trauma, work with him or her to establish responses and coping strategies to deal with triggers as they occur. Initially, the planned responses will not immediately occur after a trigger, but with practice, the planned responses will move closer to the time of the trigger. Some strategies include an acronym that reflects coping strategies (Exhibit 1.5-1), positive self-talk generated by cognitive–behavioral covert modeling exercises (rehearsal of coping statements), breathing retraining, and use of support systems (e.g., calling someone).

Strategy #3: Self-monitoring is any strategy that asks a client to observe and record the number of times something happens, to note the intensity of specific experiences, or to describe a specific behavioral, emotional, or cognitive phenomenon each time it occurs. For individuals with histories of trauma, triggers and flashbacks can be quite frightening, intense, and powerful. Even if the client has had just one or two triggers or flashbacks, he or she may perceive flashbacks as happening constantly. Often, it takes time to recover from these experiences. Using self-monitoring and asking the client to record each time a trigger occurs, along with describing the trigger and its intensity level (using a scale from 1–10), clients and counselors will gain an understanding of the type of triggers present and the level of distress that each one produces. Moreover, the client may begin to see that the triggers don't actually happen all the time, even though they may seem to occur frequently.

Exhibit 1.5-1: The OBSERVATIONS Coping Strategy

- Take a moment to just ***Observe*** what is happening. Pay attention to your body, your senses, and your environment.
- Focus on your ***Breathing***. Allow your feelings and sensations to wash over you. Breathe.
- Name the ***Situation*** that initiated your response. In what way is this situation familiar to your past? How is it different?
- Remember that ***Emotions*** come and go. They may be intense now, but later they will be less so. Name your feelings.
- ***Recognize*** that this situation does not define you or your future. It does not dictate how things will be, nor is it a sign of things to come. Even if it is familiar, it is only one event.
- ***Validate*** your experience. State, at least internally, what you are feeling, thinking, and experiencing.
- ***Ask*** for help. You don't have to do this alone. Seek support. Other people care for you. Let them!
- ***This*** too shall pass. Remember: There are times that are good and times that are not so good. This hard time will pass.
- ***I*** can handle this. Name your strengths. Your strengths have helped you survive.
- Keep an ***Open*** mind. Look for and try out new solutions.
- ***Name*** strategies that have worked before. Choose one and apply it to this situation.
- Remember you have survived. You are a ***Survivor***!

cues will not be as obvious. With practice, the client can begin to track back through what occurred immediately before an emotional, physical, or behavioral reaction and then examine how that experience reminds him or her of the past.

Draw Connections

Mental health and substance abuse treatment providers have historically underestimated the effects of trauma on their clients for many reasons. Some held a belief that substance

Advice to Counselors: Strategies To Help Clients Draw Connections

Strategy #1: Writing about trauma can help clients gain awareness of their thoughts, feelings, and current experiences and can even improve physical health outcomes (Pennebaker, Kiecolt-Glaser, & Glaser, 1988; Smyth, Hockemeyer, & Tulloch, 2008). Although this tool may help some people draw connections between current experiences and past traumas, it should be used with caution; others may find that it brings up too much intense trauma material (especially among vulnerable trauma survivors with co-occuring substance abuse, psychosis, and current domestic violence). Journal writing is safest when you ask clients to write about present-day specific targets, such as logging their use of coping strategies or identifying strengths with examples. Writing about trauma can also be done via key questions or a workbook that provides questions centered upon trauma experiences and recovery.

Strategy #2: Encourage clients to explore the links among traumatic experiences and mental and substance use disorders. Recognition that a mental disorder or symptom developed after the trauma occurred can provide relief and hope that the symptoms may abate if the trauma is addressed. Ways to help clients connect substance use with trauma histories include (Najavits, 2002b; Najavits, Weiss, & Shaw, 1997):

- Identifying how substances have helped "solve" trauma or PTSD symptoms in the short term (e.g., drinking to get to sleep).
- Teaching clients how trauma, mental, and substance use disorders commonly co-occur so that they will not feel so alone and ashamed about these issues.
- Discussing how substance abuse has impeded healing from trauma (e.g., by blocking feelings and memories).
- Helping clients recognize trauma symptoms as triggers for relapse to substance use and mental distress.
- Working on new coping skills to recover from trauma and substance abuse at the same time.
- Recognizing how both trauma and substance abuse often occur in families through multiple generations.

abuse should be addressed before attending to any co-occurring conditions. Others did not have the knowledge and training to evaluate trauma issues or were uncomfortable or reluctant to discuss these sensitive issues with clients (Ouimette & Brown, 2003). Similarly, in other behavioral health settings, clinicians sometimes address trauma-related symptoms but do not have experience or training in the treatment of substance abuse.

So too, people who have histories of trauma will often be unaware of the connection between the traumas they've experienced and their traumatic stress reactions. They may notice depression, anger, or anxiety, or they may describe themselves as "going crazy" without being able to pinpoint a specific experience that produced the trauma symptoms. Even if clients recognize the events that precipitated their trauma symptoms, they may not understand how others with similar experiences can have different reactions. Thus, a treatment goal for trauma survivors is helping them gain awareness of the connections between their histories of trauma and subsequent consequences. Seeing the connections can improve clients' ability to work on recovery in an integrated fashion.

Teach Balance

You and your clients need to walk a thin line when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session whereby the client dissociates, shuts down, or becomes emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma. Several trauma-specific theories offer guidelines on acceptable levels of distress associated with the traumatic content that the therapy addresses. For example, some traditional desensitization processes start at a very low level of subjective distress, gradually working up through a hierarchy of trauma memories and experiences until those experiences produce minimal reactions when paired with some coping strategy, such as relaxation training. Other desensitization processes start at a higher level of intensity to provide more rapid extinction of traumatic associations and to decrease the risk of avoidance—a behavior that reinforces traumatic stress.

> The Subjective Units of Distress Scale (SUDS) uses a 0 10 rating scale, with 0 representing content that causes no or minimal distress and 10 representing content that is exceptionally distressing and overwhelming.
>
> (Wolpe & Abrams, 1991)

Working with trauma is a delicate balancing act between the development and/or use of coping strategies and the need to process the traumatic experiences. Individuals will choose different paths to recovery; it's a myth that every traumatic experience needs to be expressed and every story told. For some individuals, the use of coping skills, support, and spirituality are enough to recover. Regardless of theoretical beliefs, counselors must teach

Advice to Counselors: Strategy To Teach Balance

Strategy #1: Teach and use the SUDS in counseling. This scale can be useful from the outset as a barometer for the client and counselor to measure the level of distress during and outside of sessions. It provides a common language for the client and counselor, and it can also be used to guide the intensity of sessions. SUDS can tangibly show a client's progress in managing experiences. Without a scale, it is more difficult to grasp that a distressing symptom or circumstance is becoming less and less severe without some repeated measure.

coping strategies as soon as possible. Retraumatization is a risk whenever clients are exposed to their traumatic histories without sufficient tools, supports, and safety to manage emotional, behavioral, and physical reactions.

Build Resilience

Survivors are resilient! Often, counselors and clients who are trauma survivors focus on the negative consequences of trauma while failing to recognize the perseverance and attributes that have helped them survive. It is natural to focus on what's not working rather than what has worked. To promote growth after trauma and establish a strengths-based approach, focus on building on clients' resilience. Current resilience theories claim that building or reinforcing resilience prevents further development of trauma-related symptoms and disorders. The following *Advice to Counselors* box is adapted from the American Psychological Association's 2003 statement on resilience.

Advice to Counselors: Strategies To Build Resilience

Strategy #1: Help clients reestablish personal and social connections. Access community and cultural resources; reconnect the person to healing resources such as mutual-help groups and spiritual supports in the community.

Strategy #2: Encourage the client to take action. Recovery requires activity. Actively taking care of one's own needs early in treatment can evolve into assisting others later on, such as by volunteering at a community organization or helping military families.

Strategy #3: Encourage stability and predictability in the daily routine. Traumatic stress reactions can be debilitating. Keeping a daily routine of sleep, eating, work, errands, household chores, and hobbies can help the client see that life continues. Like exercise, daily living skills take time to take hold as the client learns to live through symptoms.

Strategy #4: Nurture a positive view of personal, social, and cultural resources. Help clients recall ways in which they successfully handled hardships in the past, such as the loss of a loved one, a divorce, or a major illness. Revisit how those crises were addressed.

Strategy #5: Help clients gain perspective. All things pass, even when facing very painful events. Foster a long-term outlook; help clients consider stress and suffering in a spiritual context.

Strategy #6: Help maintain a hopeful outlook. An optimistic outlook enables visions of good things in life and can keep people going even in the hardest times. There are positive aspects to everyone's life. Taking time to identify and appreciate these enhances the client's outlook and helps him or her persevere.

Strategy #7: Encourage participation in peer support, 12-Step, and other mutual-help programs.

Source: American Psychological Association, 2003.

Address Sleep Disturbances

Sleep disturbances are one of the most enduring symptoms of traumatic stress and are a particularly common outcome of severe and prolonged trauma. Sleep disturbances increase one's risk of developing traumatic stress; they significantly alter physical and psychological processes, thus causing problems in daytime functioning (e.g., fatigue, cognitive difficulty, excessive daytime sleepiness). People with sleep disturbances have worse general health and quality of life. The cardiovascular and immune systems, among others, may be affected as well. Sleep disturbances can worsen traumatic stress symptoms and interfere with healing by impeding the brain's ability to process and consolidate traumatic memories (Caldwell & Redeker, 2005).

Sleep disturbances vary among trauma survivors and can include decreased ability to stay asleep, frequent awakenings, early morning unintentional awakening, trouble falling asleep, poor quality of sleep, and disordered

Advice to Counselors: Strategies To Conduct a Sleep Intervention

Strategy #1: Conduct a sleep history assessment focused first on the client's perception of his or her sleep patterns. Assess whether there is difficulty initiating or staying asleep, a history of frequent or early morning awakenings, physically restless sleep, sleepwalking, bedtime aversion, and/or disruptive physical and emotional states upon awakening (e.g., confusion, agitation, feeling unrested). Also determine total sleep time, pattern of nightmares, and use of medications, alcohol, and/or caffeine (see Moul, Hall, Pikonis, & Buysse, 2004, for a review of self-report measures).

Strategy #2: Use a sleep hygiene measure to determine the presence of habits that typically interfere with sleep (e.g., falling asleep while watching television). The National Sleep Foundation Web site (http://www.sleepfoundation.org) provides simple steps for promoting good sleep hygiene.

Strategy #3: Provide education on sleep hygiene practices. Introduce clients to the idea that practicing good sleep hygiene is one step toward gaining control over their sleep disturbances.

Strategy #4: Reassess sleep patterns and history during the course of treatment. Sleep patterns often reflect current client status. For example, clients who are struggling are more likely to have disturbed sleep patterns; sleep disturbances significantly influence clients' mental health status.

Strategy #5: Use interventions such as nightmare rehearsals to target recurrent nightmares. There are numerous examples of imagery-based nightmare rehearsals. Clients may be instructed to rehearse repetitively the recurrent nightmare a few hours before bedtime. In this instruction, the client either rehearses the entire nightmare with someone or visualizes the nightmare several times to gain control over the material and become desensitized to the content. Other strategies involve imagining a change in the outcome of the nightmare (e.g., asking the client to picture getting assistance from others, even though his or her original nightmare reflects dealing with the experience alone).

breathing during sleep (Caldwell & Redeker, 2005). Most traumatic stress literature focuses on nightmares, insomnia, and frequent awakenings. These disturbances are connected to two main symptoms of traumatic stress: hyperarousal (which causes difficulty in falling and remaining asleep) and reexperiencing the trauma (e.g., through recurrent nightmares). Other sleep disturbances trauma survivors report include sleep avoidance or resistance to sleep (see Case Illustration: Selena), panic awakenings, and restless or unwanted body movements (e.g., hitting your spouse unintentionally in bed while asleep; Habukawa, Maeda, & Uchimura, 2010).

Case Illustration: Selena

Selena initially sought treatment for ongoing depression (dysthymia). During treatment, she identified being sexually assaulted while attending a party at college. At times, she blames herself for the incident because she didn't insist that she and her girlfriends stay together during the party and on the way back to their dorm afterward. Selena reported that she only had two drinks that night: "I could never manage more than two drinks before I wanted to just sleep, so I never drank much socially." She was assaulted by someone she barely knew but considered a "big brother" in the brother fraternity of her sorority. "I needed a ride home. During that ride, it happened," she said. For years thereafter, Selena reported mild bouts of depression that began lasting longer and increasing in number. She also reported nightmares and chronic difficulty in falling asleep. In therapy, she noted avoiding her bed until she's exhausted, saying, "I don't like going to sleep; I know what's going to happen." She describes fear of sleeping due to nightmares. "It's become a habit at night. I get very involved in playing computer games to lose track of time. I also leave the television on through the night because then I don't sleep as soundly and have fewer nightmares. But I'm always exhausted."

Build Trust

Some traumatic experiences result from trusting others (e.g., interpersonal trauma). In other cases, trust was violated during or after the traumatic experience, as in cases when help was late to arrive on the scene of a natural disaster. This lack of trust can leave individuals alienated, socially isolated, and terrified of developing relationships. Some feel that the trauma makes them different from others who haven't had similar experiences. Sometimes, a client's trust issues arise from a lack of trust in self—for instance, a lack of trust in one's perceptions, judgment, or memories. People who have also experienced severe mental or substance use disorders may have difficulty trusting others because, during the course of their illness, they felt alienated or discriminated against for behaviors and emotions generated by or associated with the disorders.

Some client groups (e.g., gay, lesbian, and bisexual clients; people from diverse cultures; those with serious mental illness) evidence significant mistrust because their trust has been repeatedly violated in the past. Traumatic experiences then compound this mistrust. Mistrust can come from various sources, is usually unstated, and, if left unaddressed, can impede treatment. For example, some clients leave treatment early or do not engage in potentially beneficial treatments. Others avoid issues of trust and commitment by leaving treatment when those issues begin to arise.

Establishing a safe, trusting relationship is paramount to healing—yet this takes time in the counseling process. Counselors and other behavioral health professionals need to be consistent throughout the course of treatment; this includes maintaining consistency in the parameters set for availability, attendance, and level of empathy. Trust is built on behavior shown inside and outside of treatment; you should immediately address any behavior that may even slightly injure the relationship (e.g., being 5 minutes late for an appointment, not responding to a phone message in a timely manner, being distracted in a session).

Advice to Counselors: Strategies To Build Trust

Strategy #1: Clients can benefit from a support or counseling group composed of other trauma survivors. By comparing themselves with others in the group, they can be inspired by those who are further along in the recovery process and helpful to those who are not faring as well as they are. These groups also motivate clients to trust others by experiencing acceptance and empathy.

Strategy #2: Use conflicts that arise in the program as opportunities. Successful negotiation of a conflict between the client and the counselor is a major milestone (van der Kolk, McFarlane, & Van der Hart, 1996). Helping clients understand that conflicts are healthy and inevitable in relationships (and that they can be resolved while retaining the dignity and respect of all involved) is a key lesson for those whose relationship conflicts have been beset by violence, bitterness, and humiliation.

Strategy #3: Prepare clients for staff changes, vacations, or other separations. Some clients may feel rejected or abandoned if a counselor goes on vacation or is absent due to illness, especially during a period of vulnerability or intense work. A phone call to the client during an unexpected absence can reinforce the importance of the relationship and the client's trust. You can use these opportunities in treatment to help the client understand that separation is part of relationships; work with the client to view separation in a new light.

Strategy #4: Honor the client–counselor relationship, and treat it as significant and mutual. You can support the development of trust by establishing clear boundaries, being dependable, working with the client to define explicit treatment goals and methods, and demonstrating respect for the client's difficulty in trusting you and the therapeutic setting.

Support Empowerment

Strong feelings of powerlessness can arise in trauma survivors seeking to regain some control of their lives. Whether a person has survived a single trauma or chronic trauma, the survivor can feel crushed by the weight of powerlessness. Mental illness and substance abuse, too, can be disempowering; clients may feel that they've lost control over their daily lives, over a behavior such as drug use, or over powerful emotions such as fear, sadness, or anger. Empowerment means helping clients feel greater power and control over their lives, as long as such control is within safe and healthy bounds. A key facet of empowerment is to help clients build on their strengths. Empowerment is more than helping clients discover what they "should" do; it is also helping them take the steps they feel ready to take.

Case Illustration: Abby

Abby, a 30-year-old, nervous-looking woman, is brought by her parents to a community mental health clinic near their home in rural Indiana. During the intake process, the counselor learns that Abby is an Army Reservist who returned from 12 months of combat duty 3 years ago. The war experience changed her in many ways. Her deployment pulled her away from veterinary school as well as the strong emotional support of family, friends, and fellow classmates. She got along with her unit in Iraq and had no disciplinary problems. While there, she served as a truck driver in the Sunni Triangle. Her convoy was attacked often by small arms fire and was once struck by an improvised explosive device. Although Abby sustained only minor injuries, two of her close friends were killed. With each successive convoy, her level of fear and foreboding grew, but she continued performing as a driver.

Since returning to the United States, she has mostly stayed at home and has not returned to school, although she is helping out on the farm with various chores. Abby has isolated herself from both family members and lifelong friends, saying she doesn't think others can understand what she went through and that she prefers being alone. She reports to her parents and the counselor that she is vaguely afraid to be in cars and feels most comfortable in her room or working alone, doing routine tasks, at home. Abby also says that she now understands how fragile life can be.

She has admitted to her parents that she drinks alcohol on a regular basis, something she did not do before her deployment, and that on occasion, she has experienced blackouts. Abby feels she needs a drink before talking with strangers or joining in groups of friends or family. She confided to her father that she isolates herself so that she can drink without having to explain her drinking to others.

The counselor recognizes Abby's general sense of lacking internal control and feeling powerless over what will happen to her in the future. He adopts a motivational interviewing style to establish rapport and a working alliance with Abby. During sessions, the counselor asks Abby to elaborate on her strengths; he reinforces strengths that involve taking action in life, positive self-statements, and comments that deal with future plans. He also introduces Abby to an Iraq War veteran who came home quite discouraged about putting his life together but has done well getting reintegrated. The counselor urges Abby go to the local VA center so that she can meet and bond with other recently returned veterans. He also encourages Abby to attend Alcoholics Anonymous meetings, emphasizing that she won't be pressured to talk or interact with others more than she chooses to.

The counselor continues to see Abby every week and begins using cognitive–behavioral techniques to help her examine some of her irrational fears about not being able to direct her life. He asks Abby to keep a daily diary of activities related to achieving her goals of getting back to school and reestablishing a social network. In each session, Abby reviews her progress using the diary as a memory aid, and the counselor reinforces these positive efforts. After 4 months of treatment, Abby reenrolls in college and is feeling optimistic about her ability to achieve her career plans.

Advice to Counselors: Strategies To Support Empowerment

Strategy #1: Offer clients information about treatment; help them make informed choices. Placing appropriate control for treatment choices in the hands of clients improves their chances of success.

Strategy #2: Give clients the chance to collaborate in the development of their initial treatment plan, in the evaluation of treatment progress, and in treatment plan updates. Incorporate client input into treatment case consultations and subsequent feedback.

Strategy #3: Encourage clients to assume an active role in how the delivery of treatment services occurs. An essential avenue is regularly scheduled and structured client feedback on program and clinical services (e.g., feedback surveys). Some of the most effective initiatives to reinforce client empowerment are the development of peer support services and the involvement of former clients in parts of the organizational structure, such as the advisory board or other board roles.

Strategy #4: Establish a sense of self-efficacy in clients; their belief in their own ability to carry out a specific task successfully—is key. You can help clients come to believe in the possibility of change and in the hope of alternative approaches to achieving change. Supporting clients in accepting increasing responsibility for choosing and carrying out personal change can facilitate their return to empowerment (Miller & Rollnick, 2002).

Acknowledge Grief and Bereavement

The experience of loss is common after traumas, whether the loss is psychological (e.g., no longer feeling safe) or physical (e.g., death of a loved one, destruction of community, physical impairment). Loss can cause public displays of grief, but it is more often a private experience. Grieving processes can be emotionally overwhelming and can lead to increased substance use and other impulsive behaviors as a way to manage grief and other feelings associated with the loss. Even for people who experienced trauma years prior to treatment, grief is still a common psychological issue. Delayed or absent reactions of acute grief can cause exhaustion, lack of strength, gastrointestinal symptoms, and avoidance of emotions.

Risk factors of chronic bereavement (grief lasting more than 6 months) can include:

- Perceived lack of social support.
- Concurrent crises or stressors (including reactivation of PTSD symptoms).
- High levels of ambivalence about the loss.
- An extremely dependent relationship prior to the loss.
- Loved one's death resulting from disaster: unexpected, untimely, sudden, and shocking (New South Wales Institute of Psychiatry & Centre for Mental Health, 2000).

Advice to Counselors: Strategies To Acknowledge and Address Grief

Strategy #1: Help the client grieve by being present, by normalizing the grief, and by assessing social supports and resources.

Strategy #2: When the client begins to discuss or express grief, focus on having him or her voice the losses he or she experienced due to trauma. Remember to clarify that losses include internal experiences, not just physical losses.

Strategy #3: For a client who has difficulty connecting feelings to experiences, assign a feelings journal in which he or she can log and name each feeling he or she experiences, rate the feeling's intensity numerically, and describe the situation during which the feeling occurred. The client may choose to share the journal in an individual or group session.

Strategy #4: Note that some clients benefit from developing a ritual or ceremony to honor their losses, whereas others prefer offering time or resources to an association that represents the loss.

Monitor and Facilitate Stability

Stability refers to an ongoing psychological and physical state whereby one is not overwhelmed by disruptive internal or external stimuli (Briere & Scott, 2006b). It's common for individuals to have an increase in symptoms, distress, or impairment when dealing with the impact of their trauma or talking about specific aspects of their trauma. There is a thin line that the client and counselor need to negotiate and then walk when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session that causes the client to dissociate, shut down, or become emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma.

Advice to Counselors: Strategies To Monitor and Facilitate Stability

Strategy #1: If destabilization occurs during the intake process or treatment, stop exploring the material that triggered the reaction, offer emotional support, and demonstrate ways for the client to self-soothe.

Strategy #2: Seek consultation from supervisors and/or colleagues (e.g., to explore whether a new case conceptualization is needed at this point).

Strategy #3: Refer the client for a further assessment to determine whether a referral is necessary for trauma-specific therapy or a higher level of care, or use of multiple levels of care (e.g., intensive outpatient care, partial hospitalization, residential treatment).

Strategy #4: Focus on coping skills and encourage participation in a peer support program.

Strategy #5: When a client becomes agitated and distressed, carefully explore with the client what is causing this state. When such feelings arise because of current threats in the client's life or environment, it is dangerous to halt or soothe away responses that act as warning signals (Pope & Brown, 1996). When a client is in a situation involving domestic violence, lives in a dangerous neighborhood, or has run out of money for food, he or she requires direct and concrete assistance rather than simple emotional support.

Source: Briere & Scott, 2006b.

Managing Destabilization

When a client becomes destabilized during a session, you can respond in the following manner: "Let's slow down and focus on helping you be and feel safe. What can we do to allow you to take care of yourself at this moment? Then, when you feel ready, we can decide what to focus on next."

Clients should have some psychological stability to engage in trauma-related work. An important distinction can be made between a normative increase in symptoms (e.g., the typical up-and-down course of traumatic stress reactions or substance abuse) and destabilization (dangerous, significant decrease in functioning). Signs of destabilization include (Green Cross Academy of Traumatology, 2007; Najavits, 2002b):

- Increased substance use or other unsafe behavior (e.g., self-harm).
- Increased psychiatric symptoms (e.g., depression, agitation, anxiety, withdrawal, anger).
- Increased symptoms of trauma (e.g., severe dissociation).
- Helplessness or hopelessness expressed verbally or behaviorally.
- Difficulty following through on commitments (e.g., commitment to attend treatment sessions).
- Isolation.
- Notable decline in daily activities (e.g., self-care, hygiene, care of children or pets, going to work).

Treatment Issues

The treatment environment itself can significantly affect how clients experience traumatic stress and how the client responds to treatment. Some specific issues related to working with trauma survivors in a clinical setting are discussed in the following sections.

Client Engagement

A lack of engagement in treatment is the client's inability to make progress toward treatment goals, deal with important topics in treatment, or complete treatment. Clients who have histories of trauma will express ambivalence about treatment similarly to others, except that clients who have traumatic stress can feel more "stuck" and perceive themselves as having fewer options. In addition, clients may be avoiding engagement in treatment because it is one step closer to addressing their trauma. You should attend to the client's motivation to change, implement strategies that address ambivalence toward treatment, and use approaches that help clients overcome avoidant behavior.

Advice to Counselors: Strategies To Foster Engagement

Strategy #1: According to Mahalik (2001), the standard method of handling clients' lack of engagement is exploring it with them, clarifying the situation through discussion with them, reinterpreting (e.g., from "can't" to "won't" to "willing"), and working through the situation toward progress.

Strategy #2: To improve engagement into treatment, try motivational interviewing and enhancement techniques. For additional information on such techniques, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT], 1999b).

Pacing and Timing

Although your training or role as a counselor may prohibit you from providing trauma-specific services, you must still be prepared for the fact that clients are not as focused on when or where it is most appropriate to address trauma—they want relief, and most lay and professional people have been taught that the only path to recovery is disclosure. Some clients are reluctant to talk about anything associated with their histories of trauma. Other clients immediately want to delve into the memories of their trauma without developing a safe environment. The need to gain any relief for the traumatic stress pushes some individuals to disclose too quickly, without having the necessary support and coping skills to manage the intensity of their memories. Clients who enter treatment and immediately disclose past trauma often don't return because the initial encounter was so intense or because they experienced considerable emotional distress for several days afterward and/or in anticipation of the next session.

Proper pacing of sessions, disclosure, and intensity is paramount. Clients who immediately disclose without proper safety nets are actually retraumatizing themselves by reliving the experience without adequate support—often placing themselves in the same circumstances that occurred during the actual traumas they experienced. Although you should not adamantly direct clients not to talk about what happened, it is important to discuss with the clients, even if you have to interrupt them empathically and respectfully, the potential consequences of disclosing too soon and too fast. Ask whether they have done this before, and then inquire about the outcome. Reinforce with clients that trauma heals when there are support, trust, and skills in place to manage the memories of the traumatic experiences. Ideally, disclosure begins after these elements are secured, but realistically, it is a

Advice to Counselors: Strategies To Establish Appropriate Pacing and Timing

Strategy #1: Frequently discuss and request feedback from clients about pacing and timing. Moving too quickly into discussion of the trauma can increase the risk of dissociation, overactivation of memories, and feeling overwhelmed.

Strategy #2: Use the SUDS as a barometer of intensity to determine the level of work.

Strategy #3: Slowly increase the speed of interventions and continually adjust the intensity of interventions; move in and out of very intense work, or use strategies that decrease the intensity when necessary. One approach that typically decreases the intensity of traumatic memories is to ask the individual to imagine that he or she is seeing the scene through a window or on a television screen. This helps decrease intensity and the risk of dissociation. It provides an opportunity for the client to view the trauma from a different perspective and a strategy to use outside of treatment to shift from reliving the trauma to observing it from a neutral position.

Strategy #4: Monitor clients to ensure that treatment does not overwhelm their internal capacities, retraumatize them, or result in excessive avoidance; make sure therapy occurs in the "therapeutic window" (Briere & Scott, 2006b).

Strategy #5: Be alert to signs that discussions of trauma, including screening, assessment, and intake processes, are going too fast. Mild to moderate signs are:
- Missing counseling appointments after discussions of important material.
- Periods of silence.
- Dissociation.
- Misunderstanding what are usually understandable concepts.
- Redirecting the focus of the discussion when certain issues arise.

Strategy #6: Observe the client's emotional state. Slow down; seek consultation if the client exhibits:
- Persistent resistance to addressing trauma symptoms.
- Repetitive flashbacks.
- Increase in dissociation.
- Regression.
- Difficulty in daily functioning (e.g., trouble maintaining everyday self-care tasks).
- Substance use relapses.
- Self-harm or suicidal thoughts/behaviors (e.g., talking about suicide).

Strategy #7: Use caution and avoid (Briere, 1996b, p. 115):
- Encouraging clients to describe traumatic material in detail before they can deal with the consequences of disclosure.
- Using overly stressful interventions (e.g., intensive role-plays, group confrontation, guided imagery).
- Confrontations or interpretations that are too challenging given the client's current functioning.
- Demanding that the client work harder and stop resisting.

Source: Strategies 1–6: Green Cross Academy of Traumatology, 2001. Adapted with permission.

balancing act for both the counselor and client as to when and how much should be addressed in any given session. Remember not to inadvertently give a message that it is too dangerous to talk about trauma; instead, reinforce the importance of addressing trauma without further retraumatization.

Length of Treatment

Many factors influence decisions regarding the length of treatment for a given client. Severity of addiction, type of substance abused, type of trauma, age at which the trauma occurred, level of social support, and the existence of

mental disorders all influence length of treatment. External factors, such as transportation and childcare, caps on insurance coverage, and limitations in professional resources, can also affect length of treatment. In general, longer treatment experiences should be expected for clients who have histories of multiple or early traumas, meet diagnostic criteria for multiple Axis I or Axis II diagnoses, and/or require intensive case management. Most of the empirically studied and/or manual-based models described in the next chapter are short-term models (e.g., lasting several months); however, ongoing care is indicated for clients with more complex co-occurring trauma disorders.

Traumatic Memories

One of the most controversial issues in the trauma field is the phenomenon of "recovered memories" or "traumatic amnesia" (Brewin, 2007). Practitioners working with traumatized individuals are particularly concerned about the possibility of new memories of the traumatic event emerging during the course of therapy and the possibility of these memories being induced by the clinician. Scientific reviews indicate that people can experience amnesia and delayed recall for some memories of a wide variety of traumas, including military combat and prisoner of war experiences, natural disasters and accidents, childhood sexual abuse, and political torture (Bowman & Mertz, 1996; Brewin, 2007; Karon & Widener, 1997; McNally, 2005). In some cases, the survivor will not remember some of what happened, and the counselor may need to help the client face the prospect of never knowing all there is to know about the past and accept moving on with what is known.

Legal Issues

Legal issues can emerge during treatment. A client, for instance, could seek to prosecute a perpetrator of trauma (e.g., for domestic violence) or to sue for damages sustained in an accident or natural disaster. The counselor's role is not to provide legal advice, but rather, to offer support during the process and, if needed, refer the client to appropriate legal help (see Advice to Counselors box on p. 131). A legal matter can dominate the treatment atmosphere for its duration. Some clients have difficulty making progress in treatment until most or all legal matters are resolved and no longer act as ongoing stressors.

Memories of Trauma

Points for counselors to remember are:

- Some people are not able to completely remember past events, particularly events that occurred during high-stress and destabilizing moments.
- In addition to exploring the memories themselves, it can be beneficial to explore how a memory of an event helps the client understand his or her feeling, thinking, and behaving in the present.
- Persistently trying to recall all the details of a traumatic event can impair focus on the present.

Forgiveness

Clients may have all sorts of reactions to what has happened to them. They may feel grateful for the help they received, joy at having survived, and dedication to their recovery. At the other extreme, they may have fantasies of revenge, a loss of belief that the world is a good place, and feelings of rage at what has happened. They may hold a wide variety of beliefs associated with these feelings.

One issue that comes up frequently among counselors is whether to encourage clients to forgive. The issue of forgiveness is a very delicate one. It is key to allow survivors their feelings, even if they conflict with the counselor's own responses. Some may choose to forgive the perpetrator, whereas others may remain angry or seek justice through the courts and other legal means. Early in recovery from

Advice to Counselors: Strategies To Manage Traumatic Memories

Strategy #1: Most people who were sexually abused as children remember all or part of what happened to them, although they do not necessarily fully understand or disclose it. Do not assume that the role of the clinician is to investigate, corroborate, or substantiate allegations or memories of abuse (American Psychiatric Association [APA], 2000b).

Strategy #2: Be aware that forgotten memories of childhood abuse can be remembered years later. Clinicians should maintain an empathic, nonjudgmental, neutral stance toward reported memories of sexual abuse or other trauma. Avoid prejudging the cause of the client's difficulties or the veracity of the client's reports. A counselor's prior belief that physical or sexual abuse, or other factors, are or are not the cause of the client's problems can interfere with appropriate assessment and treatment (APA, 2000b).

Strategy #3: Focus on assisting clients in coming to their own conclusions about the accuracy of their memories or in adapting to uncertainty regarding what actually occurred. The therapeutic goal is to help clients understand the impact of the memories or abuse experiences on their lives and to reduce their detrimental consequences in the present and future (APA, 2000b).

Strategy #4: Some clients have concerns about whether or not a certain traumatic event did or did not happen. In such circumstances, educate clients about traumatic memories, including the fact that memories aren't always exact representations of past events; subsequent events and emotions can have the effect of altering the original memory. Inform clients that it is not always possible to determine whether an event occurred but that treatment can still be effective in alleviating distress.

Strategy #5: There is evidence that suggestibility can be enhanced and pseudomemories can develop in some individuals when hypnosis is used as a memory enhancement or retrieval strategy. Hypnosis and guided imagery techniques can enhance relaxation and teach self-soothing strategies with some clients; however, use of these techniques is not recommended in the active exploration of memories of abuse (Academy of Traumatology, 2007).

Strategy #6: When clients are highly distressed by intrusive flashbacks of delayed memories, help them move through the distress. Teach coping strategies and techniques on how to tolerate strong affect and distress (e.g., mindfulness practices).

trauma, it is best to direct clients toward focusing on stabilization and a return to normal functioning; suggest that, if possible, they delay major decisions about forgiveness until they have a clearer mind for making decisions (Herman, 1997). Even in later stages of recovery, it's not essential for the client to forgive in order to recover. Forgiveness is a personal choice independent of recovery. Respect clients' personal beliefs and meanings; don't push clients to forgive or impose your own beliefs about forgiveness onto clients.

In the long-term healing process, typically months or years after the trauma(s), forgiveness may become part of the discussion for some people and some communities. For example, in South Africa, years after the bitter and bloody apartheid conflicts, a Truth and Reconciliation Commission was established by the Government. Public hearings created dialog and aired what had been experienced as a means, ultimately, to promote forgiveness and community healing. By addressing very difficult topics in public, all could potentially benefit from the discourse. Similarly, a parental survivor of the Oklahoma City bombing was, at first, bitter about his daughter's early, unfair, and untimely death. Today, he gives talks around the world about the abolition of the death penalty. He sat with convicted

Advice to Counselors: Strategies To Manage Legal Proceedings

Strategy #1: If you're aware of legal proceedings, you can play a key role in helping your client prepare emotionally for their impact, such as what it might be like to describe the trauma to a judge or jury, or how to cope with seeing the perpetrator in court. When helping a client prepare, however, be careful not to provide legal advice.

Strategy #2: Help clients separate a successful legal outcome from a successful treatment outcome. If clients connect these two outcomes, difficulties can arise. For example, a client may discontinue treatment after his or her assailant is sentenced to serve prison time, believing that the symptoms will abate without intervention.

Strategy #3: If clients express interest in initiating a civil or criminal suit, encourage them to consider the ways in which they are and are not prepared for this, including their own mental states, capacity for resilience, and inevitable loss of confidentiality (Pope & Brown, 1996). Inform clients coping with legal issues that involvement in the legal process can be retraumatizing.

Strategy #4: Emphasize, for trauma survivors who are involved in legal proceedings against an assailant, that "not guilty" is a legal finding—it is based on the degree of available evidence and is not a claim that certain events in question did not occur. They should also receive, from an attorney or other qualified individual, information on:

- The nature of the legal process as it pertains to the clients' specific cases.
- The estimated duration and cost of legal services, if applicable.
- What to expect during police investigations.
- Court procedures.
- Full information on all possible outcomes.
- What to expect during cross-examination.

Strategy #5: Counselors can be called on to assist with a legal case involving trauma. The court may require you to provide treatment records, to write a letter summarizing your client's progress, or to testify at a trial. Always seek supervisory and legal advice in such situations and discuss with the client the possible repercussions that this might have for the therapeutic relationship. As a general rule, it is best practice to avoid dual roles or relationships.

bomber Timothy McVeigh's father while the man's son was executed in Indiana at a Federal prison several years after the bombing. For this man, forgiveness and acceptance helped him attain personal peace. Other trauma survivors may choose never to forgive what happened, and this, too, is a legitimate response.

Culturally and Gender Responsive Services

Culture is the lens through which reality is interpreted. Without an understanding of culture, it is difficult to gauge how individuals organize, interpret, and resolve their traumas. The challenge is to define how culture affects individuals who have been traumatized.

Increased knowledge of PTSD (Wilson & Tang, 2007), mental illness, and substance use disorders and recovery (Westermeyer, 2004) requires behavioral health practitioners to consider the complicated interactions between culture, personality, mental illness, and substance abuse in adapting treatment protocols. This section offers some general guidelines for working with members of cultures other than one's own. Treatment for traumatic stress, mental illness, substance use disorders, and co-occurring trauma-related symptoms is more effective if it is culturally responsive.

The U.S. Department of Health and Human Services (2003) has defined the term "cultural competence" as follows:

> Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time (p. 12).

Cultural competence is a process that begins with an awareness of one's own culture and beliefs and includes an understanding of how those beliefs affect one's attitudes toward people of other cultures. It is rooted in respect, validation, and openness toward someone whose social and cultural background is different from one's own. For a thorough review of cultural competence, see the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration [SAMHSA], planned c).

Cultural Competence

Cultural competence includes a counselor's knowledge of:

- Whether the client is a survivor of cultural trauma (e.g., genocide, war, government oppression, torture, terrorism).
- How to use cultural brokers (i.e., authorities within the culture who can help interpret cultural patterns and serve as liaisons to those outside the culture).
- How trauma is viewed by an individual's sociocultural support network.
- How to differentiate PTSD, trauma-related symptoms, and other mental disorders in the culture.

For more specific information on cultural competence in trauma therapy, see Brown (2008).

In some cultures, an individual's needs take precedence over group needs (Hui & Triandis, 1986), and problems are seen as deriving from the self. In other cultures, however, complex family, kin, and community systems take precedence over individual needs. Considerable heterogeneity exists within and across most ethnic subcultures and across lines of gender, class, age, and political groups (CSAT, 1999b). Subcultures abound in every culture, such as gangs; populations that are homeless or use substances; orphaned or disenfranchised people; religious, ethnic, and sexual minorities; indigenous people; and refugee and immigrant populations. Some subcultures have more in common with similar subcultures in other countries than with their own cultures (e.g., nonheterosexual populations).

Trauma and substance abuse can themselves be a basis for affiliation with a subculture. De Girolamo (1993) reports that "disaster subcultures" exist within many cultures. These cultures of victimization, like all subcultures, have unique worldviews, codes of conduct, and perceptions of the larger society. In a disaster subculture, people are, to some extent, inured to disaster and heedless of warnings of impending disaster. For example, riverbank erosion in Bangladesh displaces thousands of people each year, yet few believe that it is a serious problem or that the displacement will be permanent (Hutton, 2000). Israelis who have lived with unpredictable violence for many years behave differently in public areas and have adapted to different norms than people who don't commonly experience violence (Young, 2001).

Many people identify with more than one subculture. Some identify with a particular culture or subculture, but not with all of its values. Individual identities are typically a mosaic of factors, including developmental achievements, life experiences, behavioral health histories, traumatic experiences, and

alcohol and illicit drug use; levels of acculturation and/or assimilation vary from one individual to the next as well.

Importance of the trauma aftermath

Counselors working in the immediate aftermath of trauma—whether individual, group, or community in nature—face many challenges. For example, survivors may be forced to adjust without access to other health services, employment, support, or insurance. In these instances, counselors must often work with individuals and communities coping with the trauma while struggling daily to meet basic needs. Research suggests that reestablishing ties to family, community, culture, and spiritual systems can not only be vital to the individual, but can also influence the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of people victimized by Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents affected by the purge experienced fewer negative effects than did those who were emotionally or physically severed from their grandparents. The researchers also found that whether the grandparents survived was less important than the connection the grandchildren managed to keep to their past. Ties to family and community can also have an adverse effect, especially if the family or community downplays the trauma or blames the victim. Counselors need to have a full understanding of available support before advocating a particular approach.

Treatment strategies

Many traditional healing ways have been damaged, forgotten, or lost—yet much wisdom remains. Drawing on the best traditional and contemporary approaches to human distress and defining culturally competent curricula regarding identity and healing (Huriwai, 2002; Wilson & Tang, 2007) both require respect and appreciation for the many ways in which various people characterize and resolve trauma and how they use addictive substances to bear the burdens of human distress.

Community-Based Treatment for Native American Historical Trauma

Key beliefs in community healing:

- Clients carry childhood pain that has led to adult dysfunction.
- Childhood pain must be confronted, confessed, and addressed, if relief is to be obtained.
- Cathartic expression is the initial step in the healing journey toward a lifelong pursuit of introspection and self-improvement.
- The healing journey entails reclamation of indigenous heritage, identity, spirituality, and practices to remedy the pathogenic effects of colonization and other sources of historical trauma.

Source: Gone, 2009.

It is not yet known how well existing PTSD treatments work for individuals who identify primarily with cultures other than mainstream American culture. It is possible that such treatments do work for clients of other cultures, though some cultural adaptation and translation may be required. For example, some PTSD treatments that have been used with subculture groups without adaptation other than language translation and that appear to be effective across cultures include eye movement desensitization and reprocessing (Bleich, Gelkopf, & Solomon, 2003) and Seeking Safety (Daouest et al., 2012).

Gender

Gender differences exist in traumatic stress, mental disorders, and substance use disorders. For example, women have higher rates of PTSD, whereas men have higher rates of substance abuse (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Stewart, Ouimette, & Brown, 2002; Tolin & Foa, 2006).

Working With Clients From Diverse Cultures: Trauma and Substance Abuse

- In socially appropriate ways, educate clients, their loved ones, and possibly members of their extended community about the relationship between substance abuse and PTSD, how substance abuse is often used to cope with trauma, and what treatment entails.
- Make serious efforts to connect clients to supportive and understanding people (preferably within culturally identified groups).
- Help clients understand that many who have not experienced trauma or do not have substance use disorders will not understand the psychological, spiritual, and interpersonal insights that they have gained during their recovery processes.

The types of interpersonal trauma experienced by men and by women are often different. A number of studies (Kimerling, Ouimette, & Weitlauf, 2007) indicate that men experience more combat and crime victimization and women experience more physical and/or sexual assault—implying that men's traumas often occur in public, whereas the traumatization of women is more likely to take place in a private setting, such as a home. Men's abusers are more often strangers. Those who abuse women, on the other hand, are more often in a relationship with them. Women (and girls) often are told, "I love you," during the same time period when the abuse occurs. However, women now serve in the military and thus are increasingly subject to some of the same traumas as men and also to military sexual trauma, which is much more common for women to experience. Similarly, men can be subject to domestic violence or sexual abuse.

In treatment, gender considerations are relevant in a variety of ways, including, but not limited to, the role and impact of societal gender stereotypes upon assessment processes, treatment initiation, and engagement of services (e.g., peer support systems); the selection and implementation of gender-specific and gender-responsive approaches for both men and women at each level of intervention; and the best selection of trauma-related interventions that account for gender-specific differences related to traumatic stress. For an extensive review and discussion of gender-specific and gender-responsive care for traumatic stress and substance use, see the TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d), and TIP 56, *Addressing the Specific Behavioral Health Needs of Men* (SAMHSA, 2013a).

Beyond the complexities of gender considerations, one must also consider whether clients should be given the choice of working with a male or a female counselor. Some clients who have been traumatized have no preference, particularly if their trauma wasn't associated with gender (e.g., a natural disaster, act of terrorism, fire, serious accident). If gender did play a role in trauma (e.g., childhood sexual abuse), clients can have strong fears of working with a counselor who is the same gender as the perpetrator. Many women who experienced sexual abuse (whose perpetrators are typically men) feel uncomfortable being treated by men because of the intense emotions that can be evoked (e.g., anger, fear). Men who experienced sexual abuse (whose perpetrators are also typically men) can feel uncomfortable for the same reasons, or they may feel shame when talking to men due to feelings evoked about masculinity, homosexuality, and so forth. However, not all clients with trauma histories prefer female therapists.

Discuss with clients the possible risks (e.g., initial emotional discomfort) and benefits of being treated by a woman or man (e.g., developing a therapeutic relationship with a man might challenge a client's belief that all men are dangerous), and, if possible, let them then choose the gender of their counselor. Tell

them that if they experience initial emotional discomfort, and the discomfort does not decrease, they can switch to a counselor of the opposite gender. For group therapy that focuses on trauma, similar considerations apply. Generally, gender-specific groups are recommended when possible, but mixed-gender groups also work. Gender also comes into play in substance abuse treatment. Research and clinical observation indicate that significant gender differences occur in many facets of substance abuse and its treatment. For example, men and women experience different physical repercussions of substance use (e.g., women have more health problems), different trajectories (e.g., women become addicted more quickly), and different treatment considerations (e.g., traditional substance abuse treatment was designed for men).

Sexual orientation

Lesbian, gay, bisexual, and transgender (LGBT) clients face specific issues in behavioral health treatment settings, including histories of abuse and discrimination relating to sexual orientation, homophobia in treatment on the part of counselors or other clients, potential difficulty addressing traumatic experiences related to their sexuality or sexual orientation, and often, a significant lack of trust toward others. LGBT people sometimes think that others can't understand them and their specific needs and thus are reluctant to engage in treatment programs in which the clientele is predominantly heterosexual. Some clients react with judgment, anger, or embarrassment when an LGBT client attempts to describe sexual trauma relating to homosexual behavior, making it even harder for LGBT clients to describe their experiences.

Often, individual counseling can address issues the LGBT client isn't comfortable discussing in group treatment. "Providing one-on-one services may decrease the difficulty of mixing heterosexual and LGBT clients in treatment groups and decrease the likelihood that heterosexism or homophobia will become an issue" (CSAT, 2001, p. 56). For more on treating LGBT individuals, see *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT, 2001).

Making Referrals to Trauma-Specific Services

Many people who experience trauma do not exhibit persistent traumatic stress symptoms. In fact, people do recover on their own. So how do you determine who is at higher risk for developing more persistent symptoms of traumatic stress, trauma-related disorders, and traumatic stress disorders? One main factor is the severity of symptoms at the time of screening and assessment. Other factors, beyond trauma characteristics and pretrauma individual characteristics, to consider in making referrals include (Ehlers & Clark, 2003):

- Cognitive appraisals that are excessively negative regarding trauma sequelae, including consequences, changes after the event(s), responses of other people to the trauma, and symptoms.
- Acknowledgment of intrusive memories.
- Engagement in behaviors that reinforce or prevent resolution of trauma, including avoidance, dissociation, and substance use.
- History of physical consequences of trauma (e.g., chronic pain, disfigurement, health problems).
- Experiences of more traumas or stressful life events after the prior trauma.
- Identification of co-occurring mood disorders or serious mental illness.

The next chapter provides an overview of trauma-specific services to complement this chapter and to provide trauma-informed counselors with a general knowledge of trauma-specific treatment approaches.

6 Trauma-Specific Services

IN THIS CHAPTER

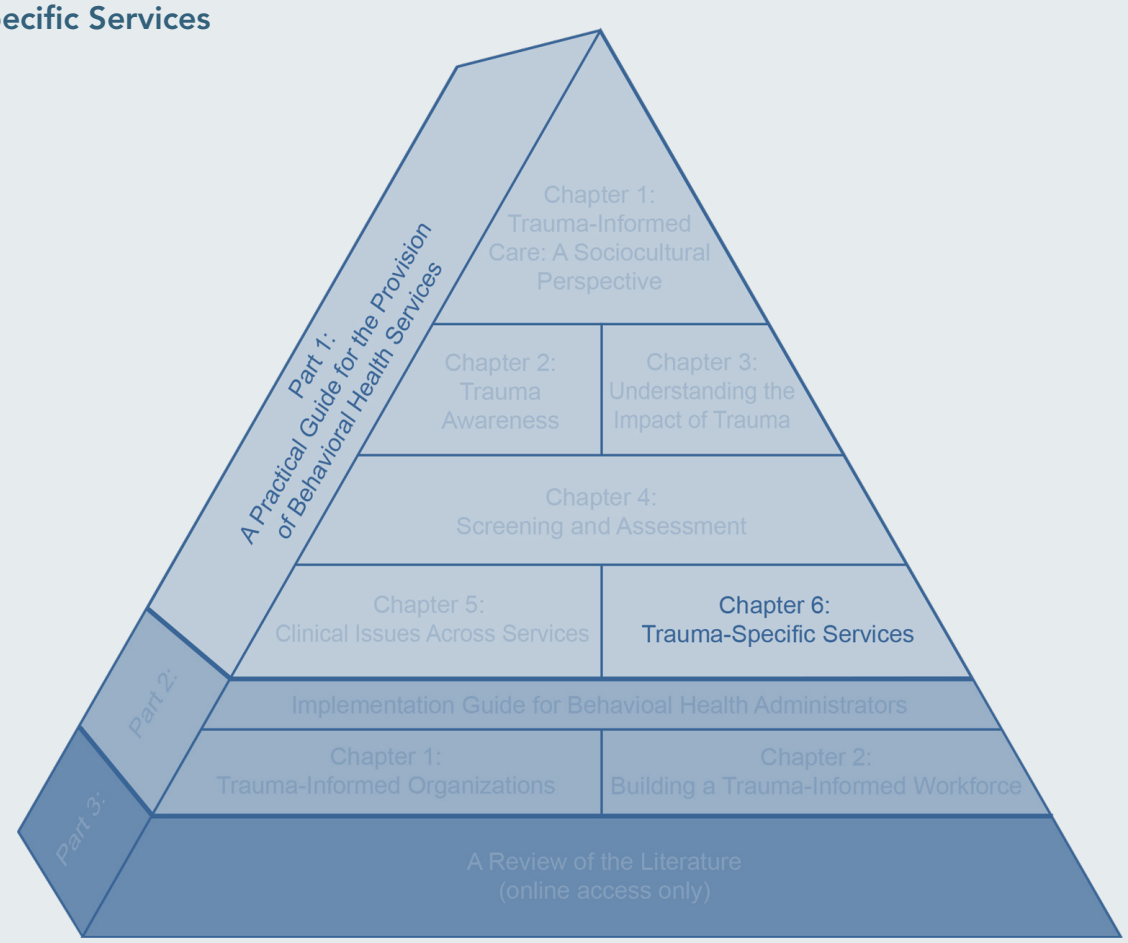
- Introduction
- Trauma Specific Treatment Models
- Integrated Models for Trauma
- Emerging Interventions
- Concluding Note

This chapter covers various treatment approaches designed specifically to treat trauma-related symptoms, trauma-related disorders, and specific disorders of traumatic stress. The models presented do not comprise an exhaustive list, but rather, serve as examples. These models require training and supervised experience to be conducted safely and effectively. The chapter begins with a section on trauma-specific treatment models, providing a brief overview of interventions that can be delivered immediately after a trauma, as well as trauma-specific interventions for use beyond the immediate crisis. The second segment focuses on integrated care that targets trauma-specific treatment for mental, substance use, and co-occurring disorders. Even though entry-level, trauma-informed behavioral health service providers are unlikely to be in a position to use these interventions, having some knowledge of them is nevertheless important. Currently, more research is needed to tease out the most important ingredients of early interventions and their role in the prevention of more pervasive traumatic stress symptoms. More science-based evidence is available for trauma-specific treatments that occur and extend well beyond the immediate reactions to trauma. The last part of the chapter provides a brief review of selected emerging interventions that have not been covered elsewhere in this Treatment Improvement Protocol (TIP).

Introduction

Trauma-specific therapies vary in their approaches and objectives. Some are present focused, some are past focused, and some are combinations (Najavits, 2007a). Present-focused approaches primarily address current coping skills, psychoeducation, and managing symptoms for better functioning. Past-focused approaches primarily focus on telling the trauma story to understand the impact of the trauma on how the person functions today, experiencing emotions that were too overwhelming to experience in the past, and helping clients more effectively cope in the present with their

Trauma-Informed Care Framework in Behavioral Health Services—Trauma-Specific Services



traumatic experiences. Clients participating in present-focused approaches may reveal some of their stories; past-focused approaches emphasize how understanding the past influences current behavior, emotion, and thinking, thereby helping clients cope more effectively with traumatic experiences in the present.

The distinction between these approaches lies in the primary emphasis of the approach. Depending on the nature of the trauma and the specific needs of the client, one approach may be more suitable than the other. For instance, in short-term treatment for clients in early recovery from mental illness and/or substance abuse, present-focused, cognitive–behavioral, or psychoeducational approaches are generally more appropriate. For clients who are stable in their recovery and have histories of developmental trauma where much of the trauma has been repressed, a past-focused orientation may be helpful. Some clients may benefit from both types, either concurrently or sequentially.

This chapter discusses a number of treatment models, general approaches, and techniques. A treatment model is a set of practices designed to alleviate symptoms, promote psychological well-being, or restore mental health. Treatment techniques are specific procedures that can be used as part of a variety of models. Some models and techniques described in this chapter can be used with groups, some with individuals, and some with both. This chapter is selective rather than comprehensive; additional models are described in the literature. See, for example, the PILOTS database on the Web site of the National Center for PTSD

(NCPTSD; http://www.ptsd.va.gov) for treatment literature related to trauma and posttraumatic stress disorder (PTSD). For an overview of models for use with both adult and child populations, refer to *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services* (Center for Mental Health Services, 2008).

Some treatments discussed in this chapter are described as evidence based. Because research on integrated treatment models is so new, many have only been examined in a few studies. Given these circumstances and the fact that an outcome study provides only limited evidence of efficacy, the term "evidence based" should be interpreted cautiously. Additional scientific study is needed to determine whether some treatments discussed herein are, in fact, evidence based. A good resource for evaluating evidence-based, trauma-specific treatment models is *Effective Treatments for PTSD* (Foa, Keane, Friedman, & Cohen, 2009). Although evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with symptoms of trauma that co-occur with mental and substance use disorders (see Allen, 2001, for an indepth discussion of trauma and serious mental illness), other factors must also be weighed, including the specific treatment needs of the client; his or her history of trauma, psychosocial and cultural background, and experiences in prior trauma treatment; the overall treatment plan for the client; and the competencies of the program's clinical staff. Although behavioral health counselors can prepare to help their clients address some of the issues discussed in Chapter 5, specialized training is necessary to provide treatment for co-occurring substance use and mental disorders related to trauma.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has created the National Registry of Evidence-Based Programs and Practices (NREPP) as a resource for reviewing and identifying effective treatment programs. Programs can be nominated for consideration as co-occurring disorders programs or substance abuse prevention or treatment programs, and their quality of evidence, readiness for dissemination, and training considerations are then reviewed. For more detailed information, including details about several evidence-based co-occurring trauma treatment programs, visit the NREPP Web site (http://www.nrepp.samhsa.gov). Program models for specialized groups, such as adolescents, can also be found on the NREPP Web site. For specific research-oriented information on trauma-specific treatments, refer to Part 3 of this TIP, which provides a literature review and links to select abstracts (available online).

Federal Agencies

Both the American Red Cross and the Federal Emergency Management Agency (FEMA) respond to disasters. Behavioral health service providers should understand the basics about these major emergency response agencies. For example, the Red Cross can respond rapidly with funding for food, shelter, and immediate needs, whereas FEMA assistance requires a period of gearing up but provides for longer-term needs. SAMHSA, along with other Federal agencies, assists FEMA in a number of areas of emergency response planning activities. See also SAMHSA's Disaster Technical Assistance Center Web site (http://www.samhsa.gov/dtac) and Technical Assistance Publication 34, *Disaster Planning Handbook for Behavioral Health Treatment Programs* (SAMHSA, 2013).

Trauma-Specific Treatment Models

Immediate Interventions

Intervention in the first 48 hours

The acute intervention period comprises the first 48 hours after a traumatic event. In a

"One day I was called out of bed at 5:00 a.m. to go to a town approximately 30 miles away because a levee had broken…. By 6:00 a.m., my colleagues and I were there with many of the townspeople, with helicopters flying overhead, with trucks going in and out by the main road trying to empty the factories. When we got there, as far as you could see was farmland. By 11 a.m., you could see a 'lake' in the distance. By 2 p.m., the water was on the edge of the town. Being there, at that town, before, during, and after the water came was probably the most valuable function we performed. We were able to share in the grief of the hundreds of people as we stayed with them while their fields, houses, and workplaces were flooded. We witnessed the death of a town, and the people reacted with disbelief, anger, sadness, and numbness. Each person had a different story, but all grieved, and we provided many an opportunity to express it. People cried as the water started rising into their houses. Some had to watch. Some had to leave. At times it was utterly silent as we all waited. There was a woman whose parents sent her away during the floods of '43 and she had been angry for 50 years about it. She was determined that her children and grandchildren would see everything. I spent 12 hours that day just giving support, listening, giving information, and sometimes shedding a tear or two myself."

—Rosemary Schwartzbard, Ph.D., responder to floods along the Mississippi River in 1993

Source: Schwartzbard, 1997.

disaster, rescue operations usually begin with local agencies prior to other organizations arriving on the scene. Law enforcement is likely to take a primary role on site. Whether it is a disaster, group trauma, or individual trauma (including a trauma that affects an entire family, such as a house fire), a hierarchy of needs should be established: survival, safety, security, food, shelter, health (physical and mental), orientation of survivors to immediate local services, and communication with family, friends, and community (National Institute of Mental Health, 2002). In this crucial time, appropriate interventions include educating survivors about resources; educating other providers, such as faith-based organizations and social service groups, to screen for increased psychological effects including use of substances; and use of a trauma response team that assists clients with their immediate needs. No formal interventions should be attempted at this time, but a professionally trained, empathic listener can offer solace and support (Litz & Gray, 2002).

Basic needs

Basic necessities, such as shelter, food, and water, are key to survival and a sense of safety. It is important to focus on meeting these basic needs and on providing a supportive environment. Clients' access to prescribed medications may be interrupted after a trauma, particularly a disaster, so providers should identify clients' medication needs for preexisting physical and mental disorders, including methadone or other pharmacological treatment for substance use. For example, after September 11, 2001, substance abuse treatment program administrators in New York had to seek alternative methadone administration options (Frank, Dewart, Schmeidler, & Demirjian, 2006).

Psychological first aid

The psychological first aid provided in the first 48 hours after a disaster is designed to ensure safety, provide an emotionally supportive environment and activities, identify those with high-risk reactions, and facilitate communication, including strong, reassuring leadership immediately after the event. The primary helping response of psychological first aid is to provide a calm, caring, and supportive environment to set the scene for psychological recovery. It is also essential that all those first responding to a trauma—rescue workers, medical professionals, behavioral health workers (including substance abuse counselors), journalists, and volunteers—be familiar with relevant aspects of traumatic stress. Approaching

Advice to Counselors: Core Actions in Preparing To Deliver Psychological First Aid

- Contact and engagement
- Safety and comfort
- Stabilization
- Information gathering: Current needs and concerns
- Practical assistance
- Connection with social supports
- Information on coping
- Linkage with collaborative services

Source: National Child Traumatic Stress Network & NCPTSD, 2012.

survivors with genuine respect, concern, and knowledge increases the likelihood that the caregiver can (NCPTSD, 2002):

- Answer questions about what survivors may be experiencing.
- Normalize their distress by affirming that what they are experiencing is normal.
- Help them learn to use effective coping strategies.
- Help them be aware of possible symptoms that may require additional assistance.
- Provide a positive experience that will increase their chances of seeking help if they need it in the future.

Clinical experience suggests that care be taken to respect a survivor's individual method of coping; some may want information, for example, whereas others do not. Similarly, some may want to talk about the event, but others won't. An excellent guide to providing psychological first aid is available online from the Terrorism and Disaster Branch of the National Child Traumatic Stress Network (http://www.nctsn.org/content/psychological-first-aid).

Critical incident stress debriefing

Initially developed for work with first responders and emergency personnel, critical incident stress debriefing (CISD; Mitchell & Everly, 2001) is now widely used and encompasses various group protocols used in a variety of settings. This facilitator-led group intervention is for use soon after a traumatic event with exposed people. The goal is to provide psychological closure by encouraging participants to talk about their experiences and then giving a didactic presentation on common stress reactions and management.

The widespread use of CISD has occurred despite the publication of conflicting results regarding its efficacy. Claims that single-session psychological debriefing can prevent development of chronic negative psychological sequelae are not empirically supported (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Some controlled studies suggest that it may impede natural recovery from trauma (McNally, Bryant, & Ehlers, 2003). Other research suggests emphasizing screening to determine the need for early interventions. Mitchell and Everly (2001) point out that many of the studies showing negative

Advice to Counselors: Evidence Related to Immediate Interventions

Evidence related to immediate interventions suggests that:

- Early, brief, focused psychotherapeutic intervention provided in an individual or group format can reduce distress in bereaved spouses, parents, and children.
- Selected cognitive–behavioral approaches may help reduce the incidence, duration, and severity of acute stress disorder (ASD), PTSD, and depression in trauma survivors.
- A one-session individual recital of events and expression of emotions evoked by a traumatic event does not consistently reduce risk of later developing PTSD. In fact, it may increase the risk for adverse outcomes. Perhaps CISD hinders the natural recovery mechanisms that restore pretrauma functioning (Bonanno, 2004).
- The focus initially should be upon screening with follow-up as indicated.

results were not conducted with first responders; that is, CISD may be appropriate for some, but not all, groups. A recent study of 952 U.S. peacekeepers and CISD by the U.S. Army Research Unit–Europe (Adler et al., 2008) found mixed results.

Interventions Beyond the Initial Response to Trauma

In the interest of increasing your overall familiarity with relevant approaches, the following sections review several traumatic stress treatment approaches that counselors will most likely encounter when collaborating with clinicians or agencies that specialize in trauma-specific services and treating traumatic stress.

Cognitive–behavioral therapies

Most PTSD models involve cognitive–behavioral therapy (CBT) that integrates cognitive and behavioral theories by incorporating two ideas: first, that cognitions (or thoughts) mediate between situational demands and one's attempts to respond to them effectively, and second, that behavioral change influences acceptance of altered cognitions about oneself or a situation and establishment of newly learned cognitive–behavioral interaction patterns. In practice, CBT uses a wide range of coping strategies.

There are many different varieties of CBT. CBT originated in the 1970s (Beck, Rush, Shaw & Emery, 1979; Ellis & Harper, 1975) and has expanded since then to address various populations, including people who use substances, people who experience anxiety, people with PTSD or personality disorders, children and adolescents, individuals involved in the criminal justice system, and many others. CBT has also been expanded to include various techniques, coping skills, and approaches, such as dialectical behavior therapy (DBT; Linehan, 1993), Seeking Safety (Najavits, 2002a), and mindfulness (Segal, Williams, & Teasdale, 2002). Traditional CBT emphasizes symptom reduction or resolution, but recent CBT approaches have also emphasized the therapeutic relationship, a particularly important dynamic in trauma treatment (Jackson, Nissenson, & Cloitre, 2009).

A widely accepted framework in treating trauma, substance use disorders, and mental illness categorizes therapies as single (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treatment of multiple disorders delivered by separate clinicians or in separate programs that do not necessarily address the interactions between symptoms and disorders).

CBT has been applied to the treatment of trauma and has also been widely and effectively used in the treatment of substance use. A review of efficacy research on CBT for PTSD is provided by Rothbaum, Meadows, Resick, and Foy (2000). Najavits and colleagues (2009) and O'Donnell and Cook (2006) offer an overview of CBT therapies for treating PTSD and substance abuse. In addition, a free online training resource incorporating CBT for traumatized children within the community, Trauma-Focused CBT, is available from the Medical University of South Carolina (http://tfcbt.musc.edu/).

Cognitive processing therapy

Cognitive processing therapy (CPT) is a manualized 12-session treatment approach that can be administered in a group or individual setting (Resick & Schnicke, 1992, 1993). CPT was developed for rape survivors and combines elements of existing treatments for PTSD, specifically exposure therapy (see the "Exposure Therapy" section later in this chapter) and cognitive therapy. The exposure therapy component of treatment consists of

Advice to Counselors: Relaxation Training, Biofeedback, and Breathing Retraining Strategies

Relaxation training, biofeedback, and breathing retraining strategies may help some clients cope with anxiety, a core symptom of traumatic stress. However, no evidence supports the use of relaxation and biofeedback as effective standalone PTSD treatment techniques (Cahill, Rothbaum, Resick, & Follete, 2009). Both are sometimes used as complementary strategies to manage anxiety symptoms elicited by trauma-related stimuli. Breathing retraining uses focused or controlled breathing to reduce arousal. Breathing retraining and relaxation, along with other interventions when necessary, can help clients with ASD. An important caution in the use of breath work with trauma clients is that it can sometimes act as a trigger—for example, given its focus on the body and its potential to remind them of heavy breathing that occurred during assault. Biofeedback, which requires specialized equipment, combines stress reduction strategies (e.g., progressive muscle relaxation, guided imagery) with feedback from biological system measures (e.g., heart rate, hand temperature) that gauge levels of stress or anxiety reduction. Relaxation training, which requires no specialized equipment, encourages clients to reduce anxiety responses (including physiological responses) to trauma-related stimuli; it is often part of more comprehensive PTSD treatments (e.g., prolonged exposure and stress inoculation training [SIT]).

clients writing a detailed account of their trauma, including thoughts, sensations, and emotions that were experienced during the event. The client then reads the narrative aloud during a session and at home. The cognitive therapy aspect of CPT uses six key PTSD themes identified by McCann and Pearlman (1990): safety, trust, power, control, esteem, and intimacy. The client is guided to identify cognitive distortions in these areas, such as maladaptive beliefs.

Results from randomized, placebo-controlled trials for the treatment of PTSD related to interpersonal violence (Resick, 2001; Resick, Nishith, Weaver, Astin, & Feuer, 2002) support the use of CPT. CPT and prolonged exposure therapy models are equally and highly positive in treating PTSD and depression in rape survivors; CPT is superior in reducing guilt (Nishith, Resick, & Griffin, 2002; Resick et al., 2002; Resick, Nishith, & Griffin, 2003). CPT has shown positive outcomes with refugees when administered in the refugees' native language (Schulz, Marovic-Johnson, & Huber, 2006) and with veterans (Monson et al., 2006). However, CPT has not been studied with high-complexity populations such as individuals with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. CPT requires a 3-day training plus consultation (Karlin et al., 2010). Resick and Schicke (1996) published a CPT treatment manual, *Cognitive Processing Therapy for Rape Victims: A Treatment Manual*.

Exposure therapy

Exposure therapy for PTSD asks clients to directly describe and explore trauma-related memories, objects, emotions, or places. Intense emotions are evoked (e.g., sadness, anxiety) but eventually decrease, desensitizing clients through repeated encounters with traumatic material. Careful monitoring of the pace and appropriateness of exposure-based interventions is necessary to prevent retraumatization (clients can become conditioned to fear the trauma-related material even more). Clients must have ample time to process their memories and integrate cognition and affect, so some sessions can last for 1.5 hours or more. For simple cases, exposure can work in as few as 9 sessions; more complex cases may require 20 or more sessions (Foa, Hembree, & Rothbaum, 2007). Various techniques can

Advice to Counselors: Steps for Introducing a Breathing Exercise

Use the following statements to lead clients through a breathing exercise:

- Place your hands on your stomach. As you inhale, breathe deeply but slowly so that your hands rise with your stomach. As you exhale slowly, practice breathing so that your hands drop with your stomach.
- Inhale slowly through your nose with your mouth closed; don't rush or force in the air.
- Exhale slowly through your mouth with your lips in the whistling position.
- Breathe out for twice as long as you breathe in.

expose the client to traumatic material. Two of the more common methods are exposure through imagery and in vivo ("real life") exposure.

The effectiveness of exposure therapy has been firmly established (Rothbaum et al., 2000); however, adverse reactions to exposure therapy have also been noted. Some individuals who have experienced trauma exhibit an exacerbation of symptoms during or following exposure treatments. Even so, the exacerbation may depend on counselor variables during administration. Practitioners of exposure therapy need comprehensive training to master its techniques (Karlin et al., 2010); a counselor unskilled in the methods of this treatment model can not only fail to help his or her clients, but also cause symptoms to worsen.

Exposure therapy is recommended as a first-line treatment option when the prominent trauma symptoms are intrusive thoughts, flashbacks, or trauma-related fears, panic, and avoidance. However, counselors should exercise caution when using exposure with clients who have not maintained stability in managing mental illness symptoms or abstinence from substance use disorders. Studies and routine use of exposure have consistently excluded high-complexity clients such as those with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. The only trial of exposure therapy with a substance dependence sample found that it did not outperform standard substance abuse treatment on most variables (Mills et al., 2012).

Prolonged exposure therapy for PTSD is listed in SAMHSA's NREPP. For reviews of exposure therapy, also see Najavits (2007a) and Institute of Medicine (2008). In addition to prolonged exposure therapy, other therapies incorporate exposure and desensitization techniques, including eye movement desensitization and reprocessing (EMDR; Shapiro, 2001), cognitive processing, and systematic desensitization therapies (Wolpe, 1958).

Eye movement desensitization and reprocessing

EMDR (Shapiro, 2001) is one of the most widely used therapies for trauma and PTSD. The treatment protocols of EMDR have evolved into sophisticated paradigms requiring training and, preferably, clinical supervision. EMDR draws on a variety of theoretical

A Brief Description of EMDR Therapy

Treatment involves three main concentrations (past memories, present disturbances, future actions) and eight phases. Counselors may work with several phases in one session. Each phase is meant to be revisited either in every session or when appropriate (e.g., the closure process is meant to be conducted at the end of every session, in preparation for the next).

- Phase 1: History and Treatment Planning (1-2 sessions)
- Phase 2: Preparation
- Phase 3: Assessment and Reprocessing
- Phase 4: Desensitization
- Phase 5: Installation
- Phase 6: Body Scan
- Phase 7: Closure
- Phase 8: Reevaluation

Source: EMDR Network, 2012.

frameworks, including psychoneurology, CBT, information processing, and nonverbal representation of traumatic memories. The goal of this therapy is to process the experiences that are causing problems and distress. It is an effective treatment for PTSD (Seidler & Wagner, 2006) and is accepted as an evidence-based practice by the U.S. Department of Veterans Affairs (VA), the Royal College of Psychiatrists, and the International Society for Traumatic Stress Studies (Najavits, 2007a); numerous reviews support its effectiveness (e.g., Mills et al., 2012). EMDR values the development of "resource installation" (calming procedures) and engages in exposure work to desensitize clients to traumatic material, using external tracking techniques across the visual field to assist in processing distressing material. Training in EMDR, available through the EMDR Institute, is required before counselors use this treatment. It is listed in SAMHSA's NREPP (EMDR Network, 2012). Thus far, there is no study examining the use of EMDR with clients in substance abuse treatment. See Part 3 of this TIP, available online, to review empirical work on EMDR.

Narrative therapy

Narrative therapy is an emerging approach to understanding human growth and change; it is founded on the premise that individuals are the experts on their own lives and can access their existing intrapsychic and interpersonal resources to reduce the impact of problems in their lives. Developed for the treatment of PTSD resulting from political or community violence, narrative therapy is based on CBT principles, particularly exposure therapy (Neuner, Schauer, Elbert, & Roth, 2002; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). This approach views psychotherapy not as a scientific practice, but as a natural extension of healing practices that have been present throughout human history. For a trauma survivor, the narrative, as it is told and retold, expresses the traumatic experience, puts the trauma in the context of the survivor's life, and defines the options he or she has for change. Narrative structure helps clients connect events in their lives, reveals strings of events, explores alternative expressions of trauma, evokes explanations for clients' behaviors, and identifies their knowledge and skills. The use of stories in therapy, with the client as the storyteller, generally helps lessen suffering (McLeod, 1997; White, 2004).

In the substance abuse treatment field, many clients will see a connection between narrative therapy and the process of telling their stories in 12 Step programs, in which reframing life stories of feeling trapped, despairing, and hopeless leads to stories of strength, joy, and hope. Key storytelling points at a 12 Step speaker meeting include describing what an experience was like, what happened, and what it is like now.

Skills training in affective and interpersonal regulation

Skills training in affective and interpersonal regulation (STAIR) is a two-phase cognitive–behavioral model that adapts therapies developed by others into a new package (Cloitre, Koenen, Cohen, & Han, 2002). Phase 1 consists of eight weekly sessions of skills training in affect and interpersonal regulation derived from general CBT and DBT (Linehan, 1993) and adapted to address trauma involving childhood abuse. Session topics are labeling and identifying feelings, emotion management, distress tolerance, acceptance of feelings, identifying trauma-based interpersonal schemas, identifying conflict between trauma-generated feelings and current interpersonal goals, role-plays on issues of power and control, and role-plays on developing flexibility in interpersonal situations. Phase 2 features eight

STAIR Steps

Phase 1, tailored to individual clients, is called Skills Training in Affect Regulation and consists of the following components:

- Psychoeducation: Describe the symptoms of PTSD and explain the treatment rationale.
- Training in experiencing and identifying feelings, triggers, and thoughts, as well as training in mood regulation strategies.
- Learning history: Ask the client the following questions—How did the client deal with traumas past and present? How did the client's family deal with feelings? How did the client's family life affect his or her present difficulty experiencing and identifying feeling?
- Emotion regulation skills: Identify the cognitive, behavioral, and social support modalities for coping. Use data gathered with self-monitoring forms to identify strengths and weaknesses in each coping modality. Teach skills such as breathing retraining, self-statements to reduce fear, and social skill training to improve social support.
- Acceptance and tolerance of negative affect: Motivate clients to face distressing situations related to the trauma that are important to them. Review negative repercussions of avoidance. Discuss tolerating negative affect as a step toward achieving specific goals.
- Schema therapy for improved relationships: Identify relevant schemas learned in childhood. Suggest alternative ways of viewing self and others in current relationships. Use role-playing to teach assertiveness, emphasizing response flexibility based on relative power in each relationship.

Once Phase 1 of STAIR is well learned, clients move to Phase 2, which involves exposure therapy.

Source: Mollick & Spett, 2002.

sessions of modified prolonged exposure using a narrative approach.

Cloitre and colleagues (2002) assigned women with PTSD related to childhood abuse randomly to STAIR or a minimal attention waitlist, excluding clients with current substance dependence as well as other complexities. STAIR participants showed significantly greater gains in affect regulation, interpersonal skills, and PTSD symptoms than the control participants. These gains were maintained through follow-up at 3 and 9 months. However, it is not clear from this study whether DBT and exposure were both needed. Phase 1 therapeutic alliance and negative mood regulation skills predicted Phase 2 exposure success in reducing PTSD, suggesting the importance of establishing a strong therapeutic relationship and emotion regulation skills before conducting exposure work with people who have chronic PTSD.

Stress inoculation training

SIT was originally developed to manage anxiety (Meichenbaum, 1994; Meichenbaum & Deffenbacher, 1988). Kilpatrick, Veronen, and Resick (1982) modified SIT to treat rape survivors based on the idea that the anxiety and fear that rape survivors experience during their trauma generalizes to other objectively safe situations. SIT treatment components include education, skills training (muscle relaxation training, breathing retraining, role-playing, guided self-talk, assertiveness training, and thought stopping [i.e., actively and forcefully ending negative thoughts by thinking

SIT has been used to help individuals cope with the aftermath of exposure to stressful events and on a preventative basis to "inoculate" individuals to future and ongoing stressors (Meichenbaum, 1996). This practice as a preventive strategy is similar to promoting disease resistance through immunizations.

Advice to Counselors: SIT Phases

SIT is a prevention and treatment approach that has three overlapping phases. It is often seen as a complementary approach to other interventions for traumatic stress.

Phase 1: Conceptualization and education. This phase has two main objectives. The initial goal is to develop a collaborative relationship that supports and encourages the client to confront stressors and learn new coping strategies. The next objective is to increase the client's understanding of the nature and impact of his or her stress and awareness of alternative coping skills. Many cognitive strategies are used to meet these objectives, including self-monitoring activities, Socratic questioning, identifying strengths and evidence of resilience, and modeling of coping strategies.

Phase 2: Skill acquisition and rehearsal. This phase focuses on developing coping skills and using coping skills that the individual already possesses. This process includes practice across settings, so that the individual begins to generalize the use of his or her skills across situations through rehearsal, rehearsal, and more rehearsal.

Phase 3: Implementation and following through. The main objective is to create more challenging circumstances that elicit higher stress levels for the client. By gradually increasing the challenge, the client can practice coping strategies that mimic more realistic circumstances. Through successful negotiation, the client builds a greater sense of self-efficacy. Common strategies in this phase include imagery and behavioral rehearsal, modeling, role-playing, and graded in vivo exposure.

Source: Meichenbaum, 2007.

"STOP" and then redirecting thoughts in a more positive direction]), and skills application. The goal is to help clients learn to manage their anxiety and to decrease avoidant behavior by using effective coping strategies. Randomized controlled clinical trials have indicated that SIT reduces the severity of PTSD compared with waitlist controls and shows comparable efficacy to exposure therapy. At follow-up (up to 12 months after treatment), gains were maintained (Foa et al., 1999; Foa, Rothbaum, Riggs, & Murdock, 1991).

Other therapies

Numerous interventions introduced in the past 20 years focus on traumatic stress. For some interventions, the evidence is limited, and for other others, it is evolving. One example is the traumatic incident reduction (TIR) approach. This brief memory-oriented intervention is designed for children, adolescents, and adults who have experienced traumatic stress (Valentine & Smith, 2001). Listed in SAMHSA's NREPP, the intervention is designed to process specific traumatic incidents or problematic themes related to the trauma, including specific feelings, emotions, sensations, attitudes, or pain. It involves having clients talk through the traumatic incident repeatedly with the anticipation that changes in affect will occur throughout the repetitions. TIR is a client-centered approach.

Integrated Models for Trauma

This section covers models specifically designed to treat trauma-related symptoms along with either mental or substance use disorders at the same time. Integrated treatments help clients work on several presenting problems simultaneously throughout the treatment, a promising and recommended strategy (Dass-Brailsford & Myrick, 2010; Najavits, 2002b; Nixon & Nearmy, 2011). Thus far, research is limited, but what is available suggests that integrated treatment models effectively reduce

substance abuse, PTSD symptoms, and other mental disorder symptoms. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment, 2005c), offers a detailed description of integrated treatment. In contrast with integrated models, other model types include single (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treatment of multiple disorders delivered by separate clinicians or in separate programs that do not necessarily address the interactions between symptoms and disorders).

Similar to single models, integrated treatment models are designed for use in a variety of settings (e.g., outpatient, day treatment, and/or residential substance abuse and mental health clinics/programs). Most models listed are manual-based treatments that address trauma-related symptoms, mental disorders, and substance use disorders at the same time. Additional approaches and further details on the selected approaches can be found at NREPP (http://www.nrepp.samhsa.gov).

Addiction and Trauma Recovery Integration Model

The Addiction and Trauma Recovery Integrated Model (ATRIUM; Miller & Guidry, 2001) integrates CBT and relational treatment through an emphasis on mental, physical, and spiritual health. This 12-week model for individuals and groups blends psychoeducational, process, and expressive activities, as well as information on the body's responses to addiction and traumatic stress and the impact of trauma and addiction on the mind and spirit. It helps clients explore anxiety, sexuality, self-harm, depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection. It was designed primarily for women and focuses on developmental (childhood) trauma and interpersonal violence, but it recognizes that other types of traumatic events occur.

The ATRIUM model consists of three phases of treatment. The first stage, or "outer circle," consists of the counselor collecting data from the client about his or her trauma history, offering psychoeducation on the nature of trauma, and helping the client assess personal strengths. ATRIUM actively discourages the evocation of memories of abuse or other trauma events in this phase. The second stage, or "middle circle," allows clients and counselors to address trauma symptoms more directly and specifically encourages clients to reach out to and engage with support resources in the community. The middle circle also emphasizes learning new information about trauma and developing additional coping skills. The third stage of the program, the "inner circle," focuses on challenging old beliefs that arose as a result of the trauma. For instance, the concept of "nonprotecting bystander" is used to represent the lack of support that the traumatized person experienced at the time of the trauma. This representation is replaced with the "protective presence" of supportive others today.

ATRIUM was used in one of the nine study sites of SAMHSA's Women, Co-Occurring Disorders and Violence Study. Across all sites, trauma-specific models achieved more favorable outcomes than control sites that did not use trauma-specific models (Morrissey et al., 2005). There has not yet been a study of ATRIUM per se, however. A manual describing the theory behind this model in greater depth, as well as how to implement it, is published under the title *Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit* (Miller & Guidry, 2001).

Beyond Trauma: A Healing Journey for Women

Beyond Trauma (Covington, 2003) is a curriculum for women's services based on theory, research, and clinical experience. It was developed for use in residential, outpatient, and correctional settings; domestic violence programs; and mental health clinics. It uses behavioral techniques and expressive arts and is based on relational therapy. Although the materials are designed for trauma treatment, the connection between trauma and substance abuse in women's lives is a theme throughout. Beyond Trauma has a psychoeducational component that defines trauma by way of its process as well as its impact on the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). Coping skills are emphasized; specific exercises develop emotional wellness.

Concurrent Treatment of PTSD and Cocaine Dependence

Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD) is a 16-session, twice-weekly individual outpatient psychotherapy model designed to treat women and men with co-occurring PTSD and cocaine dependence (Coffey, Schumacher, Brimo, & Brady, 2005). CTPCD combines imagery and in vivo exposure therapy (in which the client becomes desensitized to anxiety-producing stimuli through repeated exposure to them) for the treatment of PTSD with elements of CBT for substance dependence. To balance the dual needs of abstinence skill building and prompt trauma treatment, the first five sessions focus on coping skills for cocaine dependence. Session six transitions into exposure therapy, which begins in earnest in session seven and is combined with CBT for the treatment of substance abuse.

CTPCD helps reduce substance use and PTSD symptoms. The use of any illicit drug, as measured by urine screens, was quite low during the 16-week treatment trial and didn't escalate during the second half of treatment—when most exposure sessions occurred. PTSD symptoms dropped significantly over the course of treatment, as did self-reported depressive symptoms; however, the dropout rate was high (Coffey, Dansky, & Brady, 2003). CTPCD was reformulated into Concurrent Prolonged Exposure (COPE; Mills et al., 2012), which was compared with treatment as usual in a high-complexity clinical sample of individuals who had PTSD and substance dependence. Both treatment conditions resulted in improvements in PTSD with no difference at 3 months (though COPE showed significantly greater improvement at 9 months); moreover, the two conditions did not differ in impact on substance use outcomes, depression, or anxiety.

Integrated CBT

Integrated CBT is a 14-session individual therapy model designed for PTSD and substance use. It incorporates elements such as psychoeducation, cognitive restructuring, and breathing retraining (McGovern, Lamber-Harris, Alterman, Xie, & Meier, 2011). A randomized controlled trial showed that both integrated CBT and individual addiction treatment achieved improvements in substance use and other measures of psychiatric symptom severity with no difference between the treatments.

Seeking Safety

Seeking Safety is an empirically validated, present-focused treatment model that helps clients attain safety from trauma and substance abuse (Najavits, 2002a). The Seeking Safety manual (Najavits, 2002b) offers clinician guidelines and client handouts and is available in

several languages. Training videos and other implementation materials are available online (http://www.seekingsafety.org). Seeking Safety is flexible; it can be used for groups and individuals, with women and men, in all settings and levels of care, by all clinicians, for all types of trauma and substance abuse.

Seeking Safety covers 25 topics that address cognitive, behavioral, interpersonal, and case management domains. The topics can be conducted in any order, using as few or as many as are possible within a client's course of treatment. Each topic represents a coping skill relevant to both trauma and substance abuse, such as compassion, taking good care of yourself, healing from anger, coping with triggers, and asking for help. This treatment model builds hope through an emphasis on ideals and simple, emotionally evocative language and quotations. It attends to clinician processes and offers concrete strategies that are thought to be essential for clients dealing with concurrent substance use disorders and histories of trauma.

More than 20 published studies (which include pilot studies, randomized controlled trials, and multisite trials representing various investigators and populations) provide the evidence base for this treatment model. For more information, see SAMHSA's NREPP Web site (http://www.nrepp.samhsa.gov) as well as the "Outcomes" section of the Seeking Safety Web site (http://www.seekingsafety.org/3-03-06/studies.html). Study samples included people with chronic, severe trauma symptoms and substance dependence who were diverse in ethnicity and were treated in a range of settings (e.g., criminal justice, VA centers, adolescent treatment, homelessness services, public sector). Seeking Safety has shown positive outcomes on trauma symptoms, substance abuse, and other domains (e.g., suicidality, HIV risk, social functioning, problem-solving, sense of meaning); consistently outperformed treatment as usual; and achieved high satisfaction ratings from both clients and clinicians. It has been translated into seven languages, and a version for blind and/or dyslexic individuals is available.

The five key elements of Seeking Safety are:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
2. Integrated treatment (working on trauma and substance abuse at the same time).
3. A focus on ideals to counteract the loss of ideals in both trauma and substance abuse.
4. Four content areas: cognitive, behavioral, interpersonal, and case management.
5. Attention to clinician processes (addressing countertransference, self-care, and other issues).

Substance Dependence PTSD Therapy

Substance Dependence PTSD Therapy (Triffleman, 2000) was designed to help clients of both sexes cope with a broad range of traumas. It combines existing treatments for PTSD and substance abuse into a structured, 40-session (5-month, twice-weekly) individual therapy that occurs in two phases. Phase I is "Trauma-Informed, Addictions-Focused Treatment" and focuses on coping skills and cognitive interventions as well as creating a safe environment. Phase I draws on CBT models, anger management, relaxation training, HIV risk reduction, and motivational enhancement techniques. Phase II, "Trauma-Focused, Addictions-Informed Treatment," begins with psychoeducation about PTSD followed by "Anti-Avoidance I," in which a modified version of stress inoculation training is taught in two to four sessions. Following this is "Anti-Avoidance II," lasting 6 to 10 sessions, in which in vivo exposure is used.

Trauma Affect Regulation: Guide for Education and Therapy

Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford & Russo, 2006; Frisman, Ford, Lin, Mallon, & Chang, 2008) uses emotion and information processing in a present-focused, strengths-based approach to education and skills training for trauma survivors with severe mental, substance use, and co-occurring disorders across diverse populations. TARGET helps trauma survivors understand how trauma changes the brain's

TARGET: The Seven-Step FREEDOM Approach

Focus: Being focused helps a person pay attention and think about what's happening right now instead of just reacting based on alarm signals tied to past trauma. This step teaches participants to use the SOS skill (Slow down, Orient, Self-check) to pay attention to body signals and the immediate environment and to use a simple scale to measure stress and control levels.

Recognize triggers: Recognizing trauma triggers enables a person to anticipate and reset alarm signals as he or she learns to distinguish between a real threat and a reminder. This step helps participants identify personal triggers, take control, and short-circuit their alarm reactions.

Emotion self-check: The goal of this skill is to identify two types of emotions. The first are "alarm" or reactive emotions such as terror, rage, shame, hopelessness, and guilt. Because these emotions are the most noticeable after trauma, they are the alarm system's way of keeping a person primed and ready to fend off further danger. The second type of emotion, "main" emotions, include positive feelings (e.g., happiness, love, comfort, compassion) and feelings that represent positive strivings (e.g., hope, interest, confidence). By balancing both kinds of emotions, a person can reflect and draw on his or her own values and hopes even when the alarm is activated.

Evaluate thoughts: When the brain is in alarm mode, thinking tends to be rigid, global, and catastrophic. Evaluating thoughts, as with identifying emotions, is about achieving a healthier balance of positive as well as negative thinking. Through a two-part process, participants learn to evaluate the situation and their options with a focus on how they choose to act—moving from reactive thoughts to "main" thoughts. This is a fundamental change from the PTSD pattern, which causes problems by taking a person straight from alarm signals to automatic survival reactions.

Define goals: Reactive goals tend to be limited to just making it through the immediate situation or away from the source of danger. These reactive goals are necessary in true emergencies but don't reflect a person's "main" goals of doing worthwhile things and ultimately achieving a good and meaningful life. This step teaches one how to create "main" goals that reflect his or her deeper hopes and values.

Options: The only options that are available when the brain's alarm is turned on and won't turn off are automatic "flight/fight" or "freeze/submit" reactive behaviors that are necessary in emergencies but often unhelpful in ordinary living. This step helps identify positive intentions often hidden by the more extreme reactive options generated by the alarm system. This opens the possibility for a greater range of options that take into consideration one's own needs and goals as well as those of others.

Make a contribution: When the brain's alarm is turned on and reacting to ordinary stressors as if they were emergencies, it is very difficult for a person to come away from experiences with a feeling that they have made a positive difference. This can lead to feelings of alienation, worthlessness, or spiritual distress. The ultimate goal of TARGET is to empower adults and young people to think clearly enough to feel in control of their alarm reactions and, as a result, to be able to recognize the contribution they are making not only to their own lives, but to others' lives as well.

Source: Advanced Trauma Solutions, 2012.

normal stress response into an extreme survival-based alarm response that can lead to PTSD, and it teaches them a seven-step approach to making the PTSD alarm response less distressing and more adaptive (summarized by the acronym FREEDOM: Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution).

TARGET can be presented in individual therapy or gender-specific psychoeducational groups, and it has been adapted for individuals who are deaf; it has also been translated into Spanish and Dutch. TARGET is a resilience-building and recovery program not limited to individual or group psychotherapy; it is also designed to provide an educational curriculum and milieu intervention that affects all areas of practice in school, therapeutic, or correctional programs. TARGET is listed in SAMHSA's NREPP (http://www.nrepp.samhsa.gov).

Trauma Recovery and Empowerment Model

The trauma recovery and empowerment model (TREM) of therapy (Fallot & Harris, 2002; Harris & Community Connections Trauma Work Group, 1998) is a manualized group intervention designed for female trauma survivors with severe mental disorders. TREM addresses the complexity of long-term adaptation to trauma and attends to a range of difficulties common among survivors of sexual and physical abuse. TREM focuses mainly on developing specific recovery skills and current functioning and uses techniques that are effective in trauma recovery services. The model's content and structure, which cover 33 topics, are informed by the role of gender in women's experience of and coping with trauma.

TREM can be adapted for shorter-term residential settings and outpatient substance abuse treatment settings, among others. Adaptations of the model for men and adolescents are available. The model was used in SAMHSA's Women, Co-Occurring Disorders and Violence Study for three of the nine study sites and in SAMHSA's Homeless Families program, and it is listed in SAMHSA's NREPP. This model has been used with clients in substance abuse treatment; research by Toussaint, VanDeMark, Bornemann, and Graeber (2007) shows that women in a residential substance abuse treatment program showed significantly better trauma treatment outcomes using TREM than they did in treatment as usual, but no difference in substance use.

TREM Program Format

Each session includes an experiential exercise to promote group cohesiveness. The 33 sessions are divided into the following general topic areas:

- **Part I–empowerment** introduces gender identity concepts, interpersonal boundaries, and self-esteem.
- **Part II–trauma recovery** concentrates on sexual, physical, and emotional abuse and their relationship to psychiatric symptoms, substance abuse, and relational patterns and issues.
- **Part III–advanced trauma recovery issues** addresses additional trauma issues, such as blame and the role of forgiveness.
- **Part IV–closing rituals** allows participants to assess their progress and encourages them to plan for their continued healing, either on their own or as part of a community of other survivors.
- **Part V–modifications or supplements for special populations** provides modifications for subgroups such as women with serious mental illness, incarcerated women, women who are parents, women who abuse substances, and male survivors.

Source: Mental Health America Centers for Technical Assistance, 2012.

Triad Women's Project

The Triad Project was developed as a part of SAMHSA's Women, Co-Occurring Disorders and Violence Study. It is a comprehensive, trauma-informed, consumer-responsive integrated model designed for female trauma survivors with co-occurring substance use and mental disorders who live in semirural areas. Triad integrates motivational enhancement for substance use disorders, DBT, and intensive case management techniques for co-occurring mental disorders. This program is a 16-week group intervention for women that uses integrated case management services, a curriculum-based treatment group, and a peer support group (Clark & Fearday, 2003).

Emerging Interventions

New interventions are emerging to address traumatic stress symptoms and disorders. The following sections summarize a few interventions not highlighted in prior chapters; this is not an exhaustive list. In addition to specific interventions, technology is beginning to shape the delivery of care and to increase accessibility to tools that complement trauma-specific treatments. Numerous applications are available and evolving. For more information on the role of technology in the delivery of care, see the planned TIP, *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (SAMHSA, planned g).

Couple and Family Therapy

Trauma and traumatic stress affects significant relationships, including the survivor's family. Although minimal research has targeted the effectiveness of family therapy with trauma survivors, it is important to consider the needs of the individual in the context of their relationships. Family and couples therapy may be key to recovery. Family members may experience secondary traumatization silently, lack understanding of traumatic stress symptoms or treatment, and/or have their own histories of trauma that influence their willingness to support the client in the family or to talk about anything related to trauma and its effects. Family members can engage in similar patterns of avoidance and have their own triggers related to the trauma being addressed at the time. A range of couple and family therapies have addressed traumatic stress and PTSD, but few studies exist that support or refute their value. Current couple or family therapies that have some science-based evidence include behavioral family therapy, behavioral marital therapy, cognitive–behavioral couples treatment, and lifestyle management courses (Riggs, Monson, Glynn, & Canterino, 2009).

Mindfulness Interventions

Mindfulness is a process of learning to be present in the moment and observing internal experience (e.g., thoughts, bodily sensations) and external experience (e.g., interactions with others) in a nonjudgmental way. Mindfulness challenges limiting beliefs that arise from trauma, quells anxiety about future events, and simply helps one stay grounded in the present. It plays a significant role in helping individuals who have been traumatized observe their experiences, increase awareness, and tolerate uncomfortable emotions and cognitions.

To date, mindfulness-based interventions appear to be valuable as an adjunct to trauma-specific interventions and in decreasing arousal (Baer, 2003). It may also help individuals tolerate discomfort during exposure-oriented and trauma processing interventions. Overall, mindfulness practices can help clients in managing traumatic stress, coping, and resilience. In a study of firefighters, mindfulness was associated with fewer PTSD symptoms, depressive symptoms, physical symptoms, and alcohol problems when controlling for other variables (Smith et al., 2011).

Becoming an Observer and Learning To Tolerate Discomfort: The Leaf and Stream Metaphor

The following exercise, "leaves floating on a stream," is a classic. Many clinicians and authors provide renditions of this mindfulness practice. The main objectives are to stand back and observe thoughts rather than get caught up in them. Simply stated, thoughts are just thoughts. Thoughts come and go like water flowing down a stream. We don't need to react to the thoughts; instead, we can just notice them.

Conduct the mindfulness exercise for about 10 minutes, then process afterward. Take time to allow participants to visualize each sense as they imagine themselves sitting next to the stream. For example, what does it look like? What do they hear as they sit next to the stream? Don't rush the exercise. As you slowly make the statements detailed in the following two paragraphs, take time in between each statement for participants to be in the exercise without interruption; simply offer gentle guidance.

Begin to sit quietly, bringing your attention to your breath. If you feel comfortable, close your eyes. As you focus on breathing in and out, imagine that you are sitting next to a stream. In your imagination, you may clearly see and hear the stream, or you may have difficulty visualizing the stream. Follow along with the guided exercise; either way, it will work just as well.

Now begin to notice the thoughts that come into your mind. Some thoughts rush by, while others linger. Just allow yourself to notice your thoughts. As you begin to notice each thought, imagine putting those words onto a leaf as it floats by on the stream. Just let the thoughts come, watching them drift by on the leaves. If your thoughts briefly stop, continue to watch the water flow down the stream. Eventually, your thoughts will come again. Just let them come, and as they do, place them onto a leaf. Your attention may wander. Painful feelings may arise. You may feel uncomfortable or start to think that the exercise is "stupid." You may hook onto a thought—rehashing it repeatedly. That's okay; it's what our minds do. As soon as you notice your mind wandering or getting stuck, just gently bring your focus back to your thoughts, and place them onto the leaves. Now, bring your attention back to your breath for a moment, then open your eyes and become more aware of your environment.

Facilitated Questions:

- What was it like for you to observe your thoughts?
- Did you get distracted? Stuck?
- Were you able to bring yourself back to the exercise after getting distracted?
- In what ways was the exercise uncomfortable?
- In what ways was the exercise comforting?

For clients and practitioners who want to develop a greater capacity for mindfulness, see Kabat-Zinn's books *Wherever You Go, There You Are: Mindfulness Meditation In Everyday Life* (1994) and *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* (1990). For clinical applications of mindfulness, see *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse* (Segal et al., 2002) and *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors* (Marlatt & Donovan, 2005).

Pharmacological Therapy

Pharmacotherapy for people with mental, substance use, and traumatic stress disorders needs to be carefully managed by physicians who are well versed in the treatment of each condition. Medications can help manage and control symptoms; however, they are only a part of a comprehensive treatment plan. There

are no specific "antitrauma" drugs; rather, certain drugs target specific trauma symptoms. Clients receiving pharmacotherapy need careful assessment. Some clients with preexisting mental disorders may need further adjustment in medications due to the physiological effects of traumatic stress. In addition, sudden withdrawal from a pattern of self-administered substances can not only lead to dangerous levels of physical distress, but also exacerbate the emergence of more severe PTSD symptoms. Distress after trauma often lessens over time, which can sometimes make the use of medications unnecessary for some individuals. Some trauma survivors do not develop long-term psychological problems from their experiences that require medication; others may simply refuse the initiation of pharmacotherapy or the use of additional medications.

Concluding Note

Behavioral health counselors can best serve clients who have experienced trauma by providing integrated treatment that combines therapeutic models to target presenting symptoms and disorders. Doing so acknowledges that the disorders interact with each other. Some models have integrated curricula; others that address trauma alone can be combined with behavioral health techniques with which the counselor is already familiar.

In part, the choice of a treatment model or general approach will depend on the level of evidence for the model, the counselor's training, identified problems, the potential for prevention, and the client's goals and readiness for treatment. Are improved relationships with family members a goal? Will the client be satisfied if sleep problems decrease, or is the goal resolution of broader issues? Are there substance use or substance-related disorders? Is the goal abstinence? Collaborating with clients to decide on goals, eliciting what they would like from treatment, and determining what they expect to happen can provide some clues as to what treatment models or techniques might be successful in keeping clients engaged in recovery.

Part 2: An Implementation Guide for Behavioral Health Program Administrators

1 Trauma-Informed Organizations

IN THIS CHAPTER

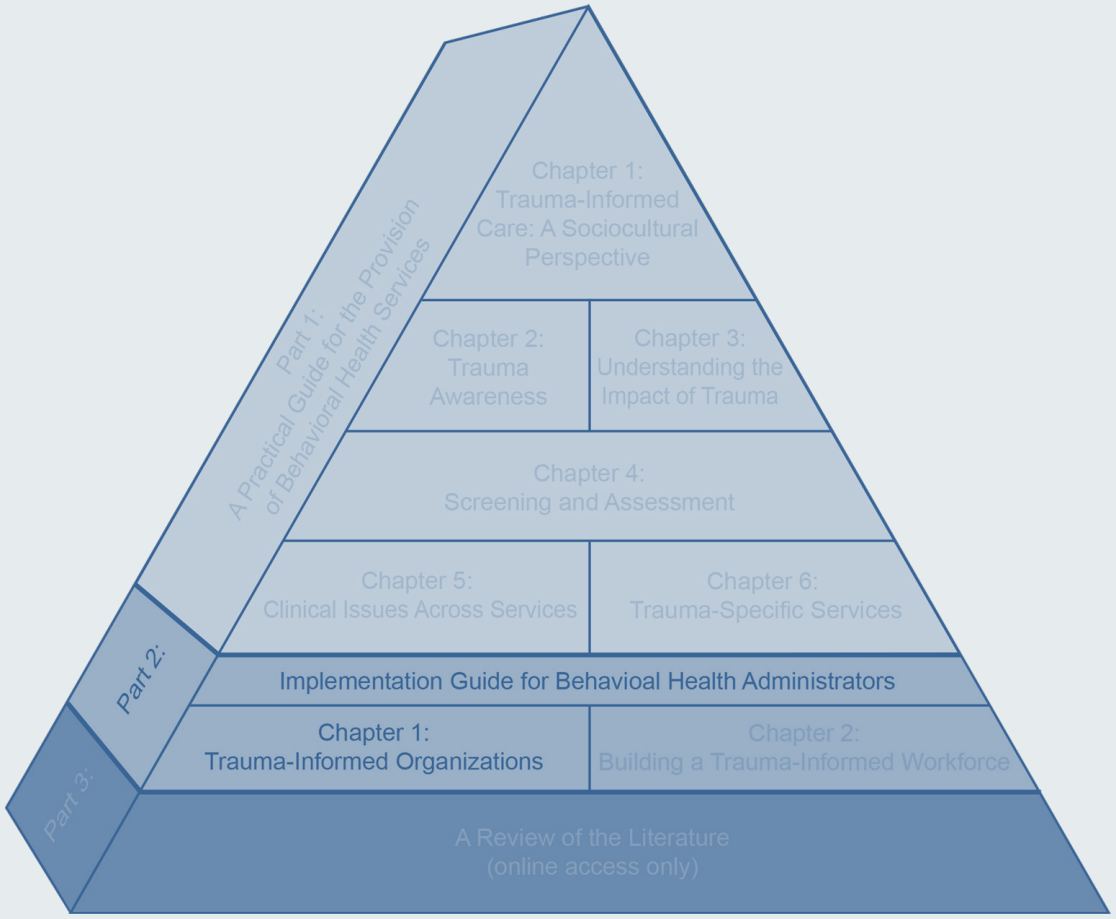
- Show Organizational and Administrative Commitment to TIC
- Use Trauma Informed Principles in Strategic Planning
- Review and Update Vision, Mission, and Value Statements
- Assign a Key Staff Member To Facilitate Change
- Create a Trauma Informed Oversight Committee
- Conduct an Organizational Self Assessment of Trauma Informed Services
- Develop an Implementation Plan
- Develop Policies and Procedures To Ensure Trauma Informed Practices and To Prevent Retraumatization
- Develop a Disaster Plan
- Incorporate Universal Routine Screenings
- Apply Culturally Responsive Principles
- Use Science Based Knowledge
- Create a Peer Support Environment
- Obtain Ongoing Feedback and Evaluations
- Change the Environment To Increase Safety
- Develop Trauma Informed Collaborations

Part 2 provides a broad overview of how to create and implement an institutional framework for trauma-informed services in program delivery and staff development, policies and procedures, administrative practices, and organizational infrastructure in behavioral health services. Chapter 1, "Trauma-Informed Organizations," focuses on specific organizational strategies that will help develop a trauma-informed culture in behavioral health settings. Numerous strategies are presented, including organizational commitment to trauma-informed care (TIC), trauma-informed organizational assessment, implementation of universal screening for trauma, and creation of a peer support environment.

Chapter 2, "Building a Trauma-Informed Workforce," focuses on organizational activities that foster the development of a trauma-informed workforce, including recruiting, hiring, and retaining trauma-informed staff; providing training on evidence-based and emerging trauma-informed best practices; developing competencies specific to TIC; addressing ethical considerations; providing trauma-informed supervision; and preventing and treating secondary trauma in behavioral health service providers.

The strategies described in the following sections can help supervisors and other administrative staff members create a trauma-informed behavioral health environment. As a starting point, the administration should identify key personnel and consumers to guide the organizational change process and the organizational assessment. Administrators and supervisors need to plan for and demonstrate an ongoing commitment to these strategies, or staff may perceive development activities as comprising yet another idea or demand from the agency that is short-lived beyond the initial thrust of training.

TIC Framework in Behavioral Health Services—Trauma-Informed Organizations



Creating a trauma-informed organization is a fluid, ongoing process; it has no completion date. Consumer demographics change across time, exposure to specific types of trauma may become more prevalent, and knowledge of best and evidence-based practices (EBPs) will continue to advance. A trauma-informed organization continues to demonstrate a commitment to compassionate and effective practices and organizational reassessments, and it changes to meet the needs of consumers with histories of trauma. It is encouraging that recent Substance Abuse and Mental Health Services Administration (SAMHSA) data indicates that the majority of over 10,000 programs they surveyed state that they provide trauma-related care (Capezza & Najavits, 2012). However, there remains a major need to make TIC consistently high-quality, routine, and pervasive across treatment systems.

The following stages form the basis of creating a trauma-informed organization:

1. Commit to creating a trauma-informed agency.
2. Create an initial infrastructure to initiate, support, and guide changes.
3. Involve key stakeholders, including consumers who have histories of trauma.
4. Assess whether and to what extent the organization's current policies, procedures, and operations either support TIC or interfere with the development of a trauma-informed approach.
5. Develop an organizational plan to implement and support the delivery of TIC within the agency.

Trauma-Informed Services and Service Systems

"A trauma-informed service system and/or organization is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence and trauma play in the lives of people seeking mental health and addiction services. A 'trauma-informed' organizational environment is capable of supporting and sustaining 'trauma-specific' services as they develop. A trauma-informed system recognizes that trauma results in multiple vulnerabilities and affects many aspects of a survivor's life over the lifespan, and therefore coordinates and integrates trauma-related activities and training with other systems of care serving trauma survivors. A basic understanding of trauma and trauma dynamics…should be held by all staff and should be used to design systems of services in a manner that accommodates the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid retraumatization and facilitate consumer participation in treatment. A trauma-informed service system is knowledgeable and competent to recognize and respond effectively to adults and children traumatically impacted by any of a range of overwhelming adverse experiences, both interpersonal in nature and caused by natural events and disasters. There should be written plans and procedures to develop a trauma-informed service system and/or trauma-informed organizations and facilities with methods to identify and monitor progress. Training programs for this purpose should be implemented."

Source: Jennings, 2009, pp. 111–112.

6. Create collaborations between providers and consumers and among service providers and various community agencies.
7. Put the organizational plan into action.
8. Reassess the implementation of the plan and its ability to meet the needs of consumers and to provide consistent TIC on an ongoing basis.
9. Implement quality improvement measures as needs and problem areas are identified.
10. Institute practices that support sustainability, such as ongoing training, clinical supervision, consumer participation and feedback, and resource allocation.

Strategy #1: Show Organizational and Administrative Commitment to TIC

Foremost, administrators need to understand the impact that trauma can have on people's lives. The consistent delivery of TIC is only as effective as the organization's commitment, which must extend to administrative practices with staff members, program policies and procedures, program design, staffing patterns, use of peer support, staff and peer training and supervision, organizational assessment and consumer feedback, and resources to uphold trauma-informed principles and practices. Even short-term change is not sustainable without the agency's continual commitment.

Typically, desirable organizational change doesn't occur by accident. It comes from steadfast leadership, a convincing message that change is necessary and beneficial for staff and consumers, and resources that support change. Many people naturally resist change; thus, an organization's commitment includes a willingness to discuss with staff members the impact and role of trauma in their service setting, patience in planning and implementation, and

Seminal Resource for Administrators

As you investigate how best to implement or improve trauma informed services within your organization or across systems, review the influential work, *Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services.*

(Harris & Fallot, 2001c)

Advice to Administrators: Managing Staff Reactions to Implementation of New Processes or Ideas

A common hurdle for administrators after introducing a new process or idea is the staff assumption that it will require more work. Frontline staff members are often inundated with many responsibilities beyond face-to-face time with clients. In addition, a common misperception is that if you begin to address trauma, you will have difficulty containing it.

In addition to administrative buy-in, administrators must promote rather than simply announce the implementation of trauma-informed services. Promotion includes educating staff about the rationale for trauma-informed services, offering opportunities for discussion and input from staff and consumers, providing training focused on trauma-informed skills, and so forth. For example, the San Diego Trauma-Informed Guide Team (2012) created a promotional brochure on how TIC can make staff jobs easier:

- Focuses on root problem
- Is preventative
- Increases support system
- Facilitates collaboration
- Shares workload
- Empowers client
- Provides consistency in agencies/systems
- Uses evidence-based best practices

TIC may be cost-effective, lead to less intensive services and less use of services, prevent undue stress for staff members and clients, and prevent client crises caused by old policies that could retraumatize trauma survivors.

the ability to tolerate the uncertainty that naturally accompanies transitions.

Strategy #2: Use Trauma-Informed Principles in Strategic Planning

Strategic planning provides an opportunity to explore and develop short- and long-term goals. The planning process often begins with reevaluating the organizations' values, mission, and vision, yet agencies cannot adequately develop a trauma-informed strategic plan without obtaining specific information about internal (staff, resources, processes) and external environmental (referral constellation, changes in health care, funding sources, State and Federal standards, community needs, consumer demographics, etc.) factors and influences. Data gathered through staff, consumer, organizational, and community assessments shapes the direction of the plan, including projected demands, challenges, obstacles, strengths, weaknesses, and resources. At the conclusion of this planning process, the organization will have specific goals, objectives, and tasks to meet the needs of their stakeholders and to address any anticipated challenges. Ideally, strategic planning should define key steps in developing or refining trauma-informed services within the organization.

Strategy #3: Review and Update Vision, Mission, and Value Statements

Vision, mission, and value statements provide a conceptual framework for TIC development and delivery. They should not be created in isolation; they should reflect voices from the community, populations, and other stakeholders that the organization serves. These statements develop through input, discussion, and assessment. They are not static; they evolve as needs, populations, or environments change.

Statement Example

As behavioral health service providers, we strive to be trauma aware—to understand the dynamics and impact of trauma on the lives of individuals, families, and communities. We strive to create a trauma-sensitive culture by demonstrating, through consumer empowerment, program design, and direct care, an understanding of the relationships among trauma, substance abuse, and mental illness.

Advice to Administrators: How To Create Vision, Value, and Mission Statements

Define the organization's vision, values, and mission to be compatible with TIC. Emphasize the organizational culture needed to provide TIC. An outgrowth of that cultural shift may include an enhanced working environment for employees and consumers that is noncoercive and reduces conflicts, restraint, and seclusion. Even if the current mission statement is appropriate, change it anyway to symbolize intended change within the organization. To define or redefine the vision, values, and mission:

- Involve consumers, all levels of staff, and leadership, including the director/CEO.
- Review:
  - Organizational priorities to identify and manage conflicting priorities.
  - Resources to assess whether reallocation is necessary for change (e.g., to hire peer support specialists, to furnish comfort rooms).
- Operationalize the vision, values, and mission at the level of individual departments
- Evaluate progress at regular staff meetings to ensure that changing the culture of care stays on the agenda.

Source: New Logic Organizational Learning, 2011.

Strategy #4: Assign a Key Staff Member To Facilitate Change

Prior to the development of an oversight committee, a senior staff member with the authority to initiate and implement changes should be assigned to oversee the developmental process. By assigning a trauma-aware senior staff member who is committed to trauma-informed services, it is more likely that the organization's and committee's goals, objectives, and plans will remain in focus. This senior staff member is responsible for ongoing development and facilitation of the oversight committee; management of the initial organizational assessment, reassessments, and other evaluative and feedback processes; and facilitation and oversight of the implementation plan and subsequent changes, including policies and procedures to ensure delivery of TIC.

Strategy #5: Create a Trauma-Informed Oversight Committee

The role of the oversight committee includes providing ongoing input and direction in the initial organizational assessment, strategic plan, plan implementation, reevaluation and development of trauma-informed policies and procedures, and future reassessments. The committee monitors progress and uses real-time data to forge a clear pathway to new processes that support TIC. The committee should involve stakeholders from the community, consumers, specialists, staff members, and administrators. Leadership involvement is necessary. Stakeholders may be alumni, family members, community-based organizations, and other institutions that interact with the agency or would benefit from trauma-informed services.

Initially, the agency must educate the committee on the organization's mission, values, and vision as well as the task at hand—developing trauma-informed services. To ease potential conflicts or confusion about the organization's structure, the guidelines, expectations, and roles of the committee need to be communicated directly to committee members as well as the organization as a whole, including board members, support and professional staff, supervisors, and so forth. The committee also needs to know the extent of their power and the necessary lines of communication before, during, and after evaluating and implementing changes in the organization.

Including consumers and/or those who have lived through trauma is vital. They have unique knowledge, experiences, and perspectives on the impact of treatment design, delivery, policies, and procedures. They offer firsthand information on practices that can potentially retraumatize clients in behavioral health settings and can suggest preventive, alternative practices and solutions. Consumer committee members keep staff and administrators aware of the goal of achieving TIC.

Strategy #6: Conduct an Organizational Self-Assessment of Trauma-Informed Services

An organizational self-assessment evaluates the presence and/or the effectiveness of current trauma-informed practices across each service and level of the organization. This assessment allows an organization to see how it functions within the context of trauma-informed principles and provides feedback to inform the development or revision of the implementation plan for TIC. In essence, this assessment process can serve as a blueprint for change and as a benchmark of compliance with and progress in implementing trauma-informed practices across time. Overall, it is a process of identifying organizational strengths, weaknesses, opportunities, and threats related to the implementation and maintenance of TIC. Refer to Appendix F for sample organizational assessment tools for the organization and the consumer.

The self-assessment should obtain feedback from key stakeholders, particularly consumers, family members, referral sources, community organizations, and all levels of the organization's staff, including nonclinical and clinical staff, supervisors, and administrative personnel. Similar to the universal screening process, an organizational self-assessment is only as effective as the steps taken after data are gathered and analyzed. From this assessment, an implementation plan should be established that highlights the goals, objectives, steps, timeframe, and personnel responsible in overseeing the specific objective. Assessment shouldn't be a once-and-done project. Timely and regularly scheduled organizational assessments should follow to assist in quality improvement. For an explanation of more detailed steps to take in conducting an organizational self-assessment, see Chapter 4 of the planned Treatment Improvement Protocol (TIP), *Improving Cultural Competence* (SAMHSA, planned c).

Advice to Administrators: Ten Steps to Quality Improvement

1. Identify new goals or problems.
2. Gather input from each level of the organization, including consumers and other key stakeholders.
3. Analyze the feedback.
4. Explore improvement options and the potential barriers associated with each.
5. Select the overall approach and specific strategies to address barriers (anticipate barriers, and try to address them before they occur).
6. Develop an implementation plan, and then present the plan to staff members and other key stakeholders not directly involved in the quality improvement process.
7. Implement the plan.
8. Reassess the new plan.
9. Evaluate the results and determine if new goals or additional problems or issues need to be addressed.
10. Repeat the first nine steps.

Strategy #7: Develop an Implementation Plan

Implementation plans should evolve from consumer participation, demographic profiles

Advice to Administrators: Implementation Plan Content

1. **Introduction and overview:** This includes the organization's history, the demographics that characterize its client base, the rationale for the implementation plan, and the incorporation of TIC. Focus on identification of strengths, weaknesses, opportunities, and threats. Provide an overview of goals and objectives.
2. **Specific goals and objectives:** Goals and objectives should address:
   - Workforce development strategies for recruiting, hiring, retaining, training, supervising, and promoting wellness of clinical and nonclinical staff members to support TIC.
   - Consumer participation and peer support development and implementation strategies.
   - Policies, procedures, and practices to support TIC and culturally responsive services, to promote safety, and to prevent retraumatization.
   - Specific evidence-based or best practice adoptions to support TIC.
   - Strategies to amend facility design or environment (plant) operations to reinforce safety.
   - Fiscal planning to ensure sustainability of the steps initiated in the organization.
3. **Guidelines for implementation:** Guidelines should highlight the specific steps, roles, responsibilities, and timeframes for each activity to meet TIC objectives.

of populations served, data from organizational self-assessment, and research on promising and evidence-based trauma-informed practices. Using the framework proposed in this TIP, the oversight committee is responsible for designing a plan that outlines the purpose, goals, objectives, timeframes, and personnel responsible for each objective (Exhibit 2.1-1).

Exhibit 2.1-1: TIC Planning Guidelines

The following publications provide samples of organizational guidelines for implementing TIC.

- Fallot, R. D. & Harris, M. (2009). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.* Washington, DC: Community Connections, 2009.
- Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-informed organizational toolkit.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W. K. Kellogg Foundation.
- Huckshorn, K. (2009). Transforming cultures of care toward recovery oriented services: Guidelines toward creating a trauma informed system of care. In *Trauma informed care (TIC) planning guidelines for use in developing an organizational action plan.* Alexandria, VA: National Association of State Mental Health Program Directors.
- Jennings, A. (2009). *Criteria for building a trauma-informed mental health service system.* Retrieved on May 21, 2013, from http://www.theannainstitute.org/CBTIMHSS.pdf
- Ohio Legal Rights Service (2007). *Trauma-informed treatment in behavioral health settings.* Columbus, OH: Ohio Legal Rights Service.
- Prescott, L., Soares, P., Konnath, K., & Bassuk, E. (2008). *A long journey home: A guide for creating trauma-informed services for mothers and children experiencing homelessness* [draft]. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W.K. Kellogg Foundation.

The following resource is a systemwide set of guidelines for implementing TIC.

- U.S. Department of Health and Human Services, Health Resources and Services Administration (2006). *Model trauma system: Planning and evaluation.* Rockville, MD: Health Resources and Services Administration.

Strategy #8: Develop Policies and Procedures To Ensure Trauma-Informed Practices and To Prevent Retraumatization

In the early stage of evaluating current services and planning for TIC, the committee needs to assess practices, procedures, and policies that may have been or could be retraumatizing to any individual, at any level of the organization, from consumers to administrators. Programs that are not trauma informed are as likely to be unaware of the impact of trauma on staff as they are to be unaware of its influence on consumers. In the initial review, careful scrutiny should be used to eliminate any practice that is potentially harmful, including seclusion and restraint practices, therapeutic activities that are shaming, treatment planning without collaboration, any medical inquiry without privacy, and so forth.

Policies and procedures are the building blocks of each agency. They guide the service process and, if followed, they provide an opportunity for the agency to deliver consistent responses and care. Policies and procedures must incorporate trauma-informed practices across all domains and standards, such as admissions, plant/environmental standards, screening and assessment processes, referrals (to other services, including hospitalization, or for further evaluations), treatment planning, confidentiality, discharge, and more. They also need to be updated periodically to incorporate new science and to meet the changing needs of consumers. By regularly reviewing and adapting administrative and clinical policies and procedures in response to ever-changing needs and evidence, the agency can provide staff members with good guidelines for providing trauma-informed services that are consistent yet flexible.

Program Curriculum: Roadmap to Seclusion-Free and Restraint-Free Mental Health Services

This curriculum, written from consumer perspectives, provides behavioral health staff with education, strategies, and hands-on tools to prevent and ultimately eliminate the use of seclusion and restraint. It includes many handouts for participants and consumers. This training package, available online (http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055), is divided into seven modules plus a resources section:

- Module 1: The Personal Experience of Seclusion and Restraint
- Module 2: Understanding the Impact of Trauma
- Module 3: Creating Cultural Change
- Module 4: Understanding Resilience and Recovery from the Consumer Perspective
- Module 5: Strategies to Prevent Seclusion and Restraint
- Module 6: Sustaining Change Through Consumer and Staff Involvement
- Module 7: Review and Action Plan
- Resource Section

Source: Center for Mental Health Services (CMHS), SAMHSA, 2005.

Strategy #9: Develop a Disaster Plan

Facilities are often required to develop disaster plans, but specific requirements vary from State to State. From the outset, developing a disaster plan in behavioral health services is essential. Many clients in behavioral health services have lived with trauma, so proactive steps that reduce the impact of a new trauma may prevent worsening of symptoms and decrease the risk for more pervasive effects. (See also Technical Assistance Publication 34, *Disaster Planning Handbook for Behavioral Health Treatment Programs* [SAMHSA, 2013].)

Most disaster events cannot be accurately anticipated. Even so, behavioral health organizations can take steps to reduce the impact of a disaster event on program functioning and on the lives of clients. Each service or program should develop a disaster response committee that meets regularly to develop, maintain, and adapt policies and procedures to respond to disasters affecting the program. Committee planning efforts may include:

1. Creating a disaster response team of program staff members tasked with coordinating program administration and services in a disaster event.
2. Establishing a communication process for informing staff and clients of the status of program functioning and for coordinating staff assignments during and shortly after the disaster event.
3. Outlining a process to inform clients and their families of available services, their location, and contact information for accessing services to meet clients' critical needs.
4. Developing plans for service provision during a disaster event and service implementation after the event.
5. Creating special plans for high-risk or special needs clients who need services during and shortly after the disaster. Examples of this are clients who are homeless, in detoxification services or methadone programs, on prescribed psychopharmaceuticals, or at risk for suicide.
6. Making plans for maintaining the security of client records, program records, and facilities during and shortly after the event.
7. Coordinating ahead with other community resources and services to ensure that clients at high risk or with special needs get the services they require as soon as possible.
8. Prioritizing how services will start back up after a disaster event.
9. Providing special services after the event to clients at high risk for trauma reactions and symptoms.
10. Establishing a postdisaster debriefing process to review disaster responses, services, and outcomes.

Some specific disaster events, such as hurricanes, may sometimes offer opportunities for planning and preparation in advance of the disaster event. This preparation time is usually just a few days, but it allows programs to make advance preparations and take advance action to establish lines of communication, stockpile resources, prepare for evacuation of clients, and protect client and program records.

Strategy #10: Incorporate Universal Routine Screenings

A key element of trauma-informed services is the institution of universal routine screening across all services, regardless of the individual's path in accessing services (e.g., primary care, hospitalization, outpatient). Considering the prevalence of trauma among individuals who seek services for mental and substance use disorders, the implementation of screening is paramount. Without screening, clients are not identified as trauma survivors. Subsequently, they miss recovery opportunities and treatment services that would be more likely to meet their needs, while also running a higher risk of being retraumatized by unexamined organizational policies, procedures, and practices. For more information on the rationale, processes, and instruments of universal screening for trauma, refer to Part 1, Chapter 4.

Strategy #11: Apply Culturally Responsive Principles

Providers must be culturally competent when incorporating evidence-based and best practices as well as trauma-informed treatment

models within the organization. Clients' views of behavioral health differ according to race, ethnicity, and culture (refer to the planned Treatment Improvement Protocol [TIP], *Improving Cultural Competence* [SAMHSA, planned c]). Likewise, cultures attach different meanings to trauma, and responses to trauma will vary considerable across cultures (see Part 3, the online literature review, for more information). For example, trauma survivors who come from a collective society or culture, in which the goals of the group take precedence over the goals of the individual, may be more focused on the well-being of their family or the family's response to the trauma survivors' experience. Often, this view runs in opposition to the individualistic perspective of many behavioral health services. Subsequently, treatment providers who are not culturally competent may interpret collective values as a sign of resistance or avoidance in dealing with traumatic stress. CMHS (2003) outlines principles of cultural competence in disaster work applicable across all forms of trauma:

1. ***Recognize the importance of culture and respect diversity.*** Those who value culture and diversity understand their own cultures, attitudes, values, and beliefs, and they work to understand the cultures of others. This includes being able to communicate effectively with those from other cultures, respecting others' feelings about personal space, knowing about others' social organization, understanding how time is viewed, and being aware of others' beliefs about the effects of their behaviors.
2. ***Maintain a current profile of the cultural composition of the community.*** This includes describing the community's population in terms of race and ethnicity, age, gender, religion, refugee and immigrant status, housing status, income levels, rural/urban balance, unemployment, languages spoken, literacy, schools, and businesses.
3. ***Recruit workers who are representative of the community or service area.*** If the workers who are available do not match the community, they should have the personal attributes, knowledge, and skills to develop cultural competence.
4. ***Provide ongoing cultural competence training to staff.*** Topics should include cultural values and traditions, family values, linguistics and literacy, immigration experiences and status, help-seeking behaviors, techniques and strategies for cross-cultural outreach, and the avoidance of stereotypes and labels (DeWolfe & Nordboe, 2000b).
5. ***Ensure that services are accessible, appropriate, and equitable.*** In planning disaster work or TIC, community associations and organizations are invaluable. Gaining their acceptance requires time and energy.
6. ***Recognize the role of help-seeking behaviors, traditions, and natural support networks.*** Culture includes traditions that dictate whom, or which groups, to seek in times of need; how to handle suffering and loss; and how healing takes place. These customs and traditions are respected by a culturally responsive disaster relief program.
7. ***Involve community leaders and organizations representing diverse cultural groups as "cultural brokers."*** Collaborating with community leaders is an effective means of learning about the community, establishing program credibility, and ensuring that services are culturally responsive.
8. ***Ensure that services and information are culturally and linguistically responsive.*** Communication with individuals who do not speak English, who are illiterate in all languages or have limited literacy, and who are deaf or hard of hearing is essential to service provision. Local radio stations, television outlets, and newspapers that are multicultural are an excellent venue for educational information after a disaster.

Using survivors' friends or relatives as interpreters is not recommended, as survivors may be uncomfortable discussing personal matters with family members or friends. Asking children to interpret can place too heavy a responsibility on them and reverses parents' and children's roles.

9. ***Assess and evaluate the program's level of cultural responsiveness.*** Self-assessment and process evaluation can help keep a program on track. A variety of strategies can be used for collecting data and communicating findings to stakeholders.

Strategy #12: Use Science-Based Knowledge

Along with culturally responsive services, trauma-informed organizations must use science-based knowledge to guide program development and the implementation of services, policies, procedures, and practices. This includes the adoption of EBPs (see Part 1, Chapter 6, and Part 3, Section 1, to review definition, treatments, and resources for EBPs). TIC research is quite new; interpret these limited studies and information cautiously. Chambless and Hollon's (1998) criteria, which are still the benchmark for EBPs, are valuable resources for administrators. Look closely at who was included—and excluded—from treatment studies. Often, the types of severe, chronic, and unstable cases seen in community settings are excluded from treatment studies. Evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with mental illness, substance use disorders, and co-occurring psychological trauma. Nonetheless, other variables must also be contemplated before adopting EBPs in an organization, including the cultural appropriateness of the practice; the strength of its clinical focus on strengths-based strategies; training and competence of clinical staff; the cost of training, materials, and implementation; and the ease of maintaining EBP fidelity amidst staff turnover.

For more detailed information on EBPs, visit the National Registry of Evidence Based Programs and Practices (NREPP) Web site (http://nrepp.samhsa.gov). For more specific research oriented information on trauma and trauma specific treatments, refer to the literature review in Part 3 of this TIP, available online.

Strategy #13: Create a Peer-Support Environment

The main purpose of peer support services is to provide consumer mentoring, support, and care coordination for clients with histories of mental illness or substance abuse. The goals are to help others deal with personal and environmental barriers that impede recovery and achieve wellness. Peer support accomplishes this through many activities, including advocacy, support during crises and recovery activities, modeling, education, and assistance in accessing available resources. Peer support programs send a powerful message to staff members, consumers, and the community—that recovery is possible through support, collaboration, and empowerment. These programs reinforce the trauma-informed premise that organizations need to reflect the populations that they serve and involve consumers in planning, implementing, monitoring, and delivering recovery services.

For an introduction to peer support services, see *What Are Peer Recovery Support Services?* (Center for Substance Abuse Treatment, 2009e).

Notably, peer support services have the potential to be considerably flexible to meet client needs at each stage of recovery. Specifically, peer support services can be incorporated

across the continuum of care, starting with outreach services and extending into long-term recovery services. Peer support specialists can enhance consumer motivation to change, to initiate services, and/or to engage in recovery activities. They can play powerful liaison roles by supporting clients entering treatment and explaining what to expect from services. They can ease the transition into treatment, from one service to the next, from one modality to another (e.g., inpatient group to outpatient group), and beyond formal treatment. Moreover, peer support services create an atmosphere focused on mutuality rather than pathology. They provide living models of resilience and promote hope—that recovery is possible and attainable.

Administrators should familiarize themselves with how other organizations have implemented peer support programs, current curricula, certifications and training processes, competencies and ethics, and peer support service State standards or recommendations, if applicable. The Carter Center's Summit in 2009, The Pillars of Peer Support Services, supported in part by SAMHSA and CMHS, highlighted the numerous elements necessary to develop a strong, vital peer workforce (Daniels et al., 2010). These elements include:

- Clear job and service descriptions.
- Job-related competencies and competence-based testing processes.
- Peer support certifications.
- Ongoing continuing education.
- Media and technology access for peer specialists.
- Sustainable funding.
- Research and evaluation components.
- Code of ethics and conduct.
- Competence-based training for supervisors.
- Multilevel support and program support teams.

> "Peer recovery support services are evidence based and have been demonstrated to promote positive health outcomes and control the cost of healthcare. These services are offered by a trained individual with lived experience and recovery from a mental illness, substance use and/or chronic health conditions. Peer recovery support services minimally include chronic illness self management, whole health and wellness promotion and engagement, relapse prevention, life skill coaching, and insurance and health systems navigation."
>
> (Daniels et al., 2012, p. 22)

Advice to Administrators: Sample Peer Support Staff Tasks

- Use active listening skills help peers identify areas of dissatisfaction and benefits of changing beliefs, thoughts, and behavior.
- Use problem-solving skills to help peers identify barriers to recovery and develop plans to meet peer-determined goals.
- Facilitate recovery support groups.
- Link clients with community resources.
- Work with the treatment team to advocate for clients and to remove recovery barriers.
- Participate in consumer panels to educate staff about the consumer perspective and about peer support.
- Participate in hospital-wide committees and workgroups

Source: New Logic Organizational Learning, 2011.

Strategy #14: Obtain Ongoing Feedback and Evaluations

Obtain feedback on and evaluations of organizational performance on a regular basis. Give consumers a clear avenue for offering feedback at any time, and make evaluations assessing the organization's progress toward providing trauma-informed services standard practice. Without feedback and further evaluation, organizations cannot assess whether they are

meeting trauma-informed objectives. A routine monitoring process for TIC implementation gives the organization additional information necessary to combat new obstacles and threats and to understand what works. Regular monitoring equips organizations with the ability to formulate different strategies to meet objectives as well as to respond to the changing needs of the population. Ongoing evaluation and consumer feedback are essential in improving the quality of services.

Strategy #15: Change the Environment To Increase Safety

Practices that generate emotional and physical safety are necessary. Another aspect of creating safety is reevaluating the physical facilities and environment to enhance safety and to circumvent preventable retraumatization. Think how traumatizing it would be if you were a female rape survivor and a night counselor was conducting a room check at 2:00 a.m., or a male security guard was walking the women's residential wing. What would it be like if you were sitting with your back to the door in a small office during an intake interview, if your history included a physical assault and robbery? For most, it would at least increase anxiety; for others it would be retraumatizing. Trauma-informed providers must carefully assess environmental safety. Although you are likely to identify some facility issues that could erode safety for trauma survivors, a safe environment will only be established if regular feedback is obtained from consumers about their experiences with the program.

Strategy #16: Develop Trauma-Informed Collaborations

TIC is about collaboration with consumers, staff members, key stakeholders, and other agencies. Collaborative relationships provide opportunities for consumers to access the most appropriate services as needs arise. Rather than waiting for a crisis or a dire need for a service to investigate available resources, it is far more efficient and compassionate to establish relationships within the agency and with other community resources before these needs arise. No agency can meet the needs of every client; referral agreements and/or collaborative arrangements that integrate the delivery of TIC, including support services (e.g., housing, legal, medical), are important.

Creating Sanctuary

The sanctuary model is a trauma-based therapeutic approach that has been used in inpatient, residential, therapeutic community, and outpatient settings with children, adolescents, and adults. It provides a template for changing social service delivery systems so that they are better equipped to respond to the complex needs of trauma survivors. Sanctuary is informed by four knowledge areas: "the psychobiology of trauma, the active creation of nonviolent environments, principles of social learning, and an understanding of the ways in which complex adaptive systems grow, change, and alter their course" (Bloom et al., 2003, p. 174).

The sanctuary model describes a stage-based approach to healing that is referred to as SAGE: safety, affect modulation, grieving, and emancipation. This model is nonlinear; an individual does not necessarily move from one stage to another in a straight path, but progress in one area does affect progress in other areas (Bloom, 1997; Bloom et al., 2003). SAGE is a cognitive–behavioral translation of the sanctuary model (Bills, 2003). Early in treatment, the focuses are typically on safety and affect management. Safety encompasses four domains: physical, psychological, social, and moral (Bloom, 1997; see http://www.sanctuaryweb.com for further details and a curriculum).

2 Building a Trauma-Informed Workforce

IN THIS CHAPTER

- Introduction
- Workforce Recruitment, Hiring, and Retention
- Training in TIC
- Trauma Informed Counselor Competencies
- Counselor Responsibilities and Ethics
- Clinical Supervision and Consultation
- Secondary Traumatization
- Counselor Self Care

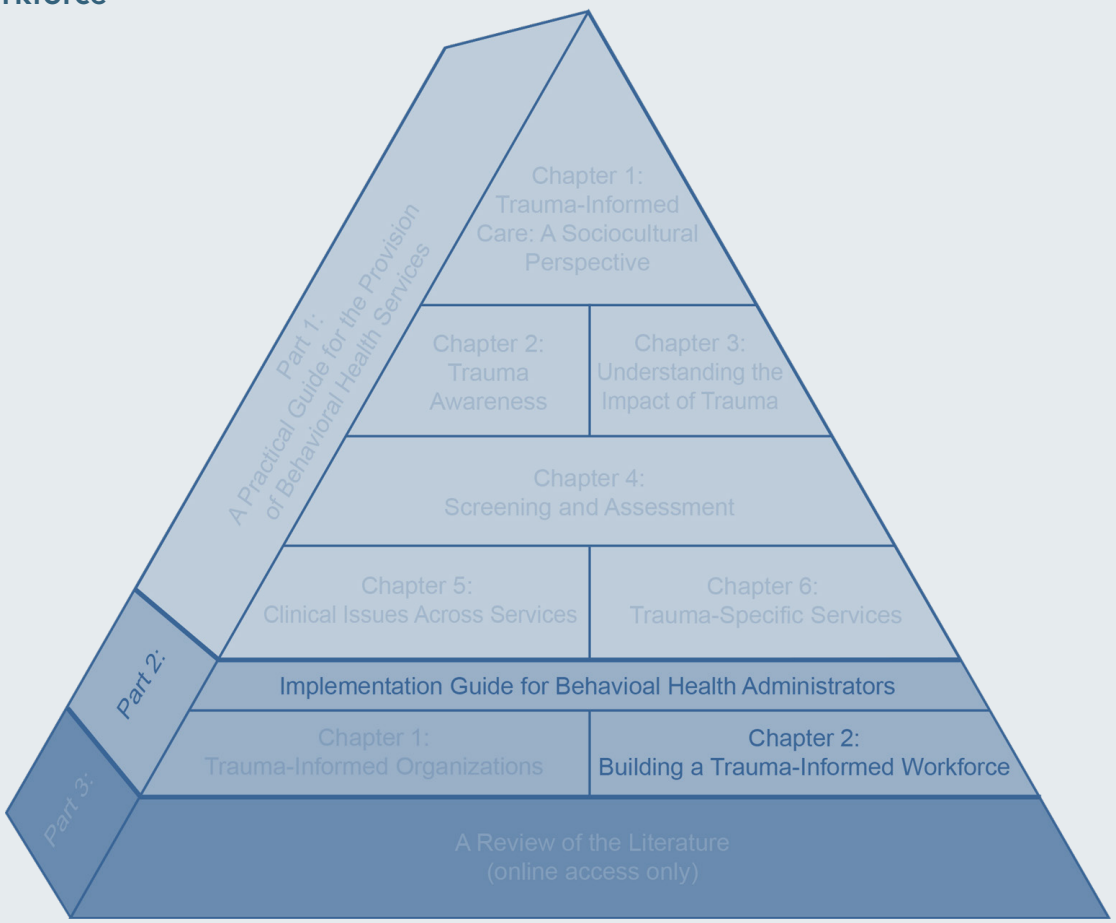
Introduction

For an organization to embrace a trauma-informed care (TIC) model fully, it must adopt a trauma-informed organizational mission and commit resources to support it. This entails implementing an agency-wide strategy for workforce development that is in alignment with the values and principles of TIC and the organization's mission statement. Without a fully trained staff, an organization will not be able to implement the TIC model. However, simply training behavioral health professionals in TIC is not enough. Counselors will not be able to sustain the kind of focus required to adopt and implement a trauma-informed philosophy and services without the ongoing support of administrators and clinical supervisors.

An organizational environment of care for the health, well-being, and safety of, as well as respect for, its staff will enhance the ability of counselors to provide the best possible trauma-informed behavioral health services to clients. This culture of care must permeate the organization from top to bottom. Behavioral health program administrators should aim to strengthen their workforce; doing so "requires creating environments that support the health and well-being, not only of persons with mental and substance use conditions, but of the workforce as well" (Hoge, 2007, p. 58). An organizational culture of care, safety, and respect demands activities that foster the development of trauma-informed counselors. This chapter focuses on key workforce development activities, such as:

- Recruiting, hiring, and retaining trauma-informed staff.
- Training behavioral health service providers on the principles of, and evidence-based and emerging best practices relevant to, TIC.
- Developing and promoting a set of counselor competencies specific to TIC.

TIC Framework in Behavioral Health Services—Building a Trauma-Informed Workforce



- Delineating the responsibilities of counselors and addressing ethical considerations specifically relevant to promoting TIC.
- Providing trauma-informed clinical supervision.
- Committing to prevention and treatment of secondary trauma of behavioral health professionals within the organization.

Addressing each of these areas is essential to building a trauma-informed workforce and an organizational culture that supports TIC.

Workforce Recruitment, Hiring, and Retention

An Action Plan for Behavioral Health Workforce Development (Hoge et al., 2007) emphasizes the importance of organization-wide support and active involvement in workforce recruitment, hiring, and retention in behavioral health systems. One of the key findings of this report is that the work environment itself in many behavioral health settings can be toxic to the workforce and may hinder the delivery of individualized, respectful, collaborative, and client-centered care to service recipients. Factors such as the downward pressure on organizations for higher productivity of counselors increase caseloads and decrease wages of behavioral health staff members and may create a high-stress environment that contributes to low morale and worker dissatisfaction. Other factors that often contribute to low retention of qualified counselors in behavioral health settings include the lack of professional career

ladders, fragile job security, the lack of clinical supervision, and an inability to influence the organization in which they are working (Hoge et al., 2007).

Added to this mix is the intensity of working with people with the co-occurring conditions of trauma-related mental and substance use disorders and the risk of secondary traumatization of counselors. In creating and sustaining a trauma-informed workforce, organizations need to foster a work environment that parallels the treatment philosophy of a trauma-informed system of care. Doing so allows counselors to count on a work environment that values safety, endorses collaboration in the making of decisions at all levels, and promotes counselor well-being.

Recruitment and Hiring in a Trauma-Informed System of Care

In a 2007 technical report (Jennings, 2007b), the National Center for Trauma-Informed Care identified several priorities for organizations with regard to recruitment and hiring trauma-informed staff, including:

- Active recruitment of and outreach to prospective employees who are trauma-informed or have formal education in providing trauma-informed or trauma-specific services in settings such as universities, professional organizations, professional training and conference sites, peer support groups, and consumer advocacy groups.
- Hiring counselors and peer support staff members with educational backgrounds and training in trauma-informed and/or trauma-specific services and/or lived experience of trauma and recovery.
- Providing incentives, bonuses, and promotions for staff members during recruitment and hiring that take into consideration prospective employees' trauma-related education, training, and job responsibilities.

In addition to hiring behavioral health professionals with formal professional education and training, organizations should also "routinely survey the demographics and other characteristics of the population served and recruit a workforce of similar composition" (Hoge et al., 2007, p. 297). Essentially, this means actively engaging in outreach to consumer advocacy groups, recovery-oriented programs, community and faith-based organizations, and former clients/consumers with the intention of recruiting potential employees whose knowledge and expertise comes from their lived experience of trauma, resilience, and recovery. Support staff members, peer support workers, counselors in training, and apprentices can be recruited from this population and offered incentives, such as tuition reimbursement, training stipends, and professional mentoring with the goal of developing a trauma-informed workforce from within the demographic served. Jennings (2007b) calls these staff members "trauma champions" who can provide needed expertise in a trauma-informed organization to promote trauma-informed policies, staff development, and trauma-based services consistent with the mission of the organization (p. 135).

Who Is a Trauma Champion?

"A champion understands the impact of violence and victimization on the lives of people seeking mental health or addiction services and is a front-line worker who thinks 'trauma first.' When trying to understand a person's behavior, the champion will ask, 'is this related to abuse and violence?' A champion will also think about whether his or her own behavior is hurtful or insensitive to the needs of a trauma survivor. The champion is there to do an identified job—he is a case manager or a counselor or a residential specialist—but in addition to his or her job, a champion is there to shine the spotlight on trauma issues."

Source: Harris & Fallot, 2001a, p. 8.

As with hiring behavioral health professionals who are in recovery from substance use disorders, the organization should be transparent and explicit in its recruitment and hiring practices of trauma survivors in recovery. The organization can be transparent by advertising the mission statement of the organization as part of the recruitment process and inviting applicants who are in recovery from trauma to apply. The needs of behavioral health staff members who are in recovery from both substance use and trauma-related conditions and working in a trauma-informed system of care should be addressed in the organization's ongoing training, clinical supervision, and staff development policies and practices.

Workforce Retention

Staff turnover is rampant in behavioral health settings. It is costly to the organization, and as a result, it is costly to clients. A strong therapeutic relationship with a counselor is one of the largest factors in an individual's ability to recover from the overwhelming effects of trauma. When behavioral health professionals leave an organization prematurely or in crisis as a result of chronic levels of high stress or secondary traumatization, clients must deal with disruptions in their relationships with counselors. Some of the organizational factors that contribute to chronic levels of high stress and often lead to high staff turnover include expecting counselors to maintain high caseloads of clients who have experienced trauma; not providing trauma-informed clinical supervision and training to counselors; and failing to provide adequate vacation, health insurance, and other reasonable benefits that support counselors' well-being. Other factors that may have a more profound impact on staff retention include failing to acknowledge the reality of secondary traumatization, promoting the view that counselors' stress reactions are a personal failure instead of a normal response to engaging with clients' traumatic material, and not supporting personal psychotherapy for counselors (Saakvitne, Pearlman, & Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy, 1996).

Research on promoting counselor retention in behavioral health settings demonstrates that

Advice to Administrators: Preventing Turnover and Increasing Workforce Retention

To prevent behavioral health staff turnover and increase retention of qualified, satisfied, and highly committed trauma-informed counselors, consider:

- Offering competitive wages, benefits, and performance incentives that take into account education, training, and levels of responsibility in providing trauma-informed or trauma-specific services.
- Creating a safe working environment that includes both the physical plant and policies and procedures to prevent harassment, stalking, and/or violence in the workplace and to promote respectful interactions amongst staff at all levels of the organization.
- Establishing an organizational policy that normalizes secondary trauma as an accepted part of working in behavioral health settings and views the problem as systemic—not the result of individual pathology or a deficit on the part of the counselor.
- Instituting reasonable, manageable caseloads that mix clients with and without trauma-related concerns.
- Letting staff offer input into clinical and administrative policies that directly affect their work experience.
- Providing vacation, health insurance (which includes coverage for psychotherapy/personal counseling), and other benefits that promote the well-being of the staff.
- Implementing regular, consistent clinical supervision for all clinical staff members.
- Providing ongoing training in trauma-informed services offered by the organization.

behavioral health staff members are interested in the same kind of work environment and benefits as employees in many other fields. They include a "living wage with healthcare benefits; opportunities to grow and advance; clarity in a job role; some autonomy and input into decisions; manageable workloads; administrative support without crushing administrative burden; basic orientation and training for assigned responsibilities; a decent and safe physical work environment; a competent and cohesive team of coworkers; the support of a supervisor; and rewards for exceptional performance" (Hoge et al., 2007, p. 18).

When an organization's administration values its staff by providing competitive salaries and benefits, a safe working environment, a reasonable and manageable workload, input into the making of clinical and administrative policy decisions, and performance incentives, it helps behavioral health workers feel connected to the mission of the organization and become dedicated to its sustainability and growth. This type of work environment demonstrates both a level of respect for counselors (similar to the level of respect a trauma-informed organization displays toward clients) and an appreciation for the complexity of their job responsibilities and the stress they face when working with people who have experienced trauma in their lives. To retain behavioral health professionals working in a trauma-informed setting, wages and performance incentives should be tied not only to education, training, and work experience, but also to levels of responsibility in working with clients who have experienced trauma.

Training in TIC

Training for all staff members is essential in creating a trauma-informed organization. It may seem that training should simply focus on new counselors or on enhancing the skill level of those who have no prior experience in working with trauma, but training should, in fact, be more systematic across the organization to develop fully sustainable trauma-informed services. All employees, including administrative staff members, should receive an orientation and basic education about the prevalence of trauma and its impact on the organization's clients. To ensure safety and reduction of harm, training should cover dynamics of retraumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. Training for all employees must also educate them "about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socioeconomic status on individuals' experiences of trauma" (Jennings, 2007a, p. 5).

All clinical and direct service staff members, regardless of level of experience, should receive more indepth training in screening and assessment of substance use and trauma-related disorders; the relationships among trauma, substance use disorders, and mental disorders; how to understand difficult client behaviors through a trauma-informed lens; how to avoid retraumatizing clients in a clinical setting; the development of personal and professional boundaries unique to clinical work with traumatized clients; how to identify the signs of secondary traumatization in themselves; and how to develop a comprehensive personal and professional self-care plan to prevent and/or ameliorate the effects of secondary traumatization in the workplace. All clinical staff members who work with traumatized clients should receive additional training in evidence-based and promising practices for the treatment of trauma (for information on locating training, see Appendix B.) This might include training done within the agency by experts in the field or training received by attending advanced trauma trainings. Administrators

should provide the time and financial resources to clinical staff members for this professional development activity. Jennings (2007a) suggests that, whenever possible, "trainings should be multi-system, inclusive of staff in mental health and substance abuse, health care, educational, criminal justice, social services systems and agencies, and promoting systems integration and coordination" (p. 5).

Moreover, criminal justice settings, schools, military/veteran programs, and other places in which behavioral health services are provided may benefit from approaches that are sensitive to the special circumstances and cultures of these environments. For example, in exploring trauma-informed correctional care, Miller and Najavits (2012, p. 1) observe:

> Prisons are challenging settings for trauma-informed care. Prisons are designed to house perpetrators, not victims. Inmates arrive shackled and are crammed into overcrowded housing units; lights are on all night, loud speakers blare without warning and privacy is severely limited. Security staff is focused on maintaining order and must assume each inmate is potentially violent. The correctional environment is full of unavoidable triggers, such as pat downs and strip searches, frequent discipline from authority figures, and restricted movement….This is likely to increase trauma-related behaviors and symptoms that can be difficult for prison staff to manage….Yet, if trauma-informed principles are introduced, all staff can play a major role in minimizing triggers, stabilizing offenders, reducing critical incidents, deescalating situations, and avoiding restraint, seclusion or other measures that may repeat aspects of past abuse.

The Need for Training

Behavioral health service providers working with clients who have mental, substance use, and trauma-related disorders need to have the best knowledge, skills, and abilities. Substance abuse counselors, in particular, require additional training and skill development to be able to extend trauma-informed services (within the

Case Illustration: Larry

Larry is a 28-year-old clinical social worker who just finished his master's program in social work and is working in a trauma-informed outpatient program for people with substance use disorders. He is recovering from alcohol use disorder and previously worked in a residential rehabilitation program as a recovery support counselor. There, his primary responsibilities were to take residents to Alcoholics Anonymous (AA) meetings, monitor their participation, and confront them about their substance use issues and noncompliance with the program's requirement of attendance at 12-Step meetings.

In Larry's new position as a counselor, he confronts a client in his group regarding her discomfort with attending AA meetings. The client reports that she feels uncomfortable with the idea that she has to admit that she is powerless over alcohol to be accepted by the group of mostly men. She was sexually abused by her stepfather when she was a child and began drinking heavily and smoking pot when she was 11 years old. The client reacts angrily to Larry's intervention.

In supervision, Larry discusses his concerns regarding the client's resistance to AA and the feedback that he provided to her in group. Beyond focusing supervision on Larry's new role as a counselor in a trauma-informed program, the clinical supervisor recommends that Larry take an interactive, multisession, computer-assisted training on the 12-Step facilitation (TSF) model. The TSF model introduces clients to and assists them with engaging in 12-Step recovery support groups. The agency has the computer-based training available in the office, and Larry agrees to use follow-up coaching sessions with his supervisor to work on implementation of the approach. The supervisor recognizes that Larry is falling back on his own recovery experience and the strategies he relied on in his previous counseling role. He will benefit from further training and coaching in an evidence-based practice that provides a nonaggressive, focused, and structured way to facilitate participation in recovery support groups with clients who have trauma histories.

limits of their professional licensure and scope of practice) to clients who have co-occurring substance use, trauma-related, or mental disorders. Many clinical practice issues in traditional substance abuse treatment are inconsistent with trauma-informed practice, which needs to be addressed with further training. Similarly, mental health clinicians often need training in substance abuse treatment, as they typically do not have backgrounds or experience in that domain. Moreover, several surveys indicate that clinicians consistently perceive the combination of trauma and substance abuse as harder to treat than either one alone (Najavits, Norman, Kivlahan, & Kosten, 2010). It is thus key to emphasize cross-training as part of TIC. Exhibit 2.2-1 addresses these issues and offers suggestions for additional training.

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings

- Some substance abuse counseling strategies commonly used to work through clients' denial and minimization of their substance use issues may be inappropriate when working with trauma survivors (e.g., highly confrontational models can remind trauma survivors of emotional abuse).

  Training: The Stages of Change model of addiction treatment can help counselors shift from the traditional confrontation of denial to conceptualizing clients' ambivalence about changing substance use patterns as a normal part of the precontemplation stage of change. This method is a respectful cognitive–behavioral approach that helps counselors match counseling strategies to their assessment of where each client is in each stage of change, with the ultimate goal of helping clients make changes to health risk behaviors. (Connors, Donovan, & DiClemente, 2001).

- The 12-Step concept of powerlessness (Step 1) may seem unhelpful to trauma survivors for whom the emotional reaction to powerlessness is a major part of their trauma (particularly for victims of repetitive trauma, such as child abuse or intimate partner violence). It can be confusing and counterproductive to dwell on this concept of powerlessness regarding trauma when the therapeutic objective for trauma-informed counseling methods should be to help clients empower themselves. For people in recovery, powerlessness is a paradox, sometimes misunderstood by both counselors and clients, in that the acknowledgment of powerlessness often creates a sense of empowerment. Most clients, with support and respectful guidance from a counselor, will come to understand that powerlessness (as used in 12-Step programs) is not an inability to stand up for oneself or express a need, and it does not mean for one to be powerless in the face of abuse. With this understanding, clients may become more open to participating in 12-Step groups as a resource for their recovery from substance use disorders. When clients continue to struggle with this concept and decline to participate in 12-Step recovery efforts, they may benefit from referral to other forms of mutual-help programs or recovery support groups in which the concept of powerlessness over the substance of abuse is not such a significant issue.

  Training: The TSF model can help counselors develop a more supportive and understanding approach to facilitating clients' involvement in 12-Step recovery groups (if this is a client-generated recovery goal). "Although based on standard counseling models, TSF differs from them in several ways. These differences include TSF's strong emphasis on therapist support, discouragement of aggressive 'confrontation of denial' and therapist self-disclosure, and highly focused and structured format" (Sholomskas & Carroll, 2006, p. 939).

  Another well-intentioned, but often misguided, approach by counselors who have not had formal or extensive training is "digging" for trauma memories without a clear therapeutic rationale or understanding of client readiness. In doing so, the counselor may unintentionally retraumatize the client or produce other harmful effects. In early intervention, it is sufficient simply to acknowledge and validate the pain and suffering of the client without uncovering or exploring specific trauma memories. The counselor who is insufficiently trained in trauma-informed clinical

(Continued on the next page.)

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings (continued)

practice may also press agendas that are ultimately unhelpful, such as insisting that the client forgive an abuser, pursue a legal case against a perpetrator, or engage in trauma treatment, even when the client may not be ready for such steps. These efforts are particularly inappropriate for clients in early recovery from substance use disorders. The first goal in treatment is stabilization

Training: The Seeking Safety model of treating substance abuse and posttraumatic stress disorder (PTSD) can help counselors focus on the primary goal of stabilization and safety in TIC. This model emphasizes safety as the target goal, humanistic themes such as honesty and compassion, and making cognitive–behavioral therapy accessible and interesting to clients who may otherwise be difficult to engage (Najavits, 2002a).

- Treatment should be client-centered; it should acknowledge the client's right to refuse counseling for trauma-related issues. It is important to discuss the advantages and disadvantages of exploring trauma-related concerns, and then, following an open discussion, to allow clients the right to choose their path. This discussion should be part of the informed consent process at the start of treatment. Clients also have the right to change their minds.

  Training: Motivational interviewing, a client-centered, nonpathologizing counseling method, can aid clients in resolving ambivalence about and committing to changing health risk behaviors including substance use, eating disorders, self-injury, avoidant and aggressive behaviors associated with PTSD, suicidality, and medication compliance (Arkowitz, Miller, Westra, & Rollnick, 2008; Kress & Hoffman, 2008). Training in MI can help counselors remain focused on the client's agenda for change, discuss the pros and cons of treatment options, and emphasize the personal choice and autonomy of clients.

In addition to the training needs of substance abuse counselors, all direct care workers in mental health settings, community-based programs, crisis intervention settings, and criminal justice environments should receive training in TIC. Guidelines for training in assisting trauma-exposed populations are presented in Exhibit 2.2-2.

Continuing Education

Research on the effectiveness of single-session didactic and/or skill-building workshops

Exhibit 2.2-2: Guidelines for Training in Mental Health Interventions for Trauma-Exposed Populations

After a year of collaboration in 2002, the Task Force on International Trauma Training of the International Society for Traumatic Stress Studies published a consensus-based set of recommendations for training. Core curricular elements of the recommended training include:

- Competence in listening.
- Recognition of psychosocial and mental problems to promote appropriate assessment.
- Familiarity with established interventions in the client population.
- Full understanding of the local context, including help-seeking expectations, duration of treatment, attitudes toward intervention, cost-effectiveness of intervention, and family attitudes and involvement.
- Strategies for solving problems on the individual, family, and community levels.
- Treatment approaches for medically unexplained somatic pain.
- Collaboration with existing local resources and change agents (e.g., clergy, traditional healers, informal leaders).
- Self-care components.

Source: Weine et al., 2002.

Advice to Administrators: Trauma-Informed Staff Training

- Establish training standards for the evidence-based and promising trauma-informed practice models (such as Seeking Safety) adopted by your organization.
- Bring expert trainers with well-developed curricula in TIC and trauma-specific practices into your organization.
- Select a core group of clinical supervisors and senior counselors to attend multisession training or certification programs. These clinicians can then train the rest of the staff.
- Use sequenced, longitudinal training experiences instead of single-session seminars or workshops.
- Emphasize interactive and experiential learning activities over purely didactic training.
- Provide ongoing mentoring/coaching to behavioral health professionals in addition to regular clinical supervision to enhance compliance with the principles and practices of TIC and to foster counselor mastery of trauma-specific practice models.
- Build organization-wide support for the ongoing integration of new attitudes and counselor skills to sustain constructive, TIC-consistent changes in practice patterns.
- Provide adequate and ongoing training for clinical supervisors in the theory and practice of clinical supervision and the principles and practices of TIC.
- Include information and interactive exercises on how counselors can identify, prevent, and ameliorate secondary traumatic stress (STS) reactions in staff trainings.
- Offer cross-training opportunities to enhance knowledge of trauma-informed processes throughout the system.

demonstrates that immediate gains in counselor knowledge and skills diminish quickly after the training event (Martino, Canning-Ball, Carroll, & Rounsaville, 2011). Consequently, organizations may be spending their scarce financial resources on sending counselors to this kind of training but may not be reaping adequate returns with regard to long-lasting changes in counselor skills and the development of trauma-informed and trauma-specific counselor competencies. Hoge et al. (2007) suggest the implementation of training strategies for behavioral health professionals that have proven to be effective in improving counselor skills, attitudes, and practice approaches. These strategies include: "interactive approaches; sequenced, longitudinal learning experiences; outreach visits, known as academic detailing; auditing of practice with feedback to the learner; reminders; the use of opinion leaders to influence practice; and patient-mediated interventions, such as providing information on treatment options to persons in recovery, which in turn influences the practice patterns of their providers" (p. 124).

Trauma-Informed Counselor Competencies

Hoge et al. (2007) identified a number of counselor competencies in behavioral health practices that are consistent with the skills needed to be effective in a trauma-informed system of care. They include person-centered planning, culturally competent care, development of therapeutic alliances, shared responsibility for decisions, collaboratively developed recovery plans, evidence-based practices, recovery- and resilience-oriented care, interdisciplinary- and team-based practice, and consumer/client advocacy. In addition, counselor competencies critical to the effective delivery of services to clients with trauma-related disorders include:

- Screening for and assessment of trauma history and trauma-related disorders, such as mood and anxiety disorders.
- Awareness of differences between trauma-informed and trauma-specific services.

- Understanding the bidirectional relationships among substance use and mental disorders and trauma.
- Engagement in person-centered counseling.
- Competence in delivering trauma-informed and trauma-specific evidence-based interventions that lessen the symptoms associated with trauma and improve quality of life for clients.
- Awareness of and commitment to counselor self-care practices that prevent or lessen the impact of secondary traumatization on behavioral health workers.

Exhibit 2.2-3 provides a checklist of competencies for counselors working in trauma-informed behavioral health settings. Administrators and clinical supervisors can use this checklist to assess behavioral health professionals' understanding of trauma awareness and counseling skills and determine the need for additional training and clinical supervision.

Counselor Responsibilities and Ethics

Treating all clients in an ethical manner is an expectation of all healthcare providers. It is of special importance when working with clients who have trauma-related disorders, as their trust in others may have been severely shaken. Counselors who work with traumatized individuals on a regular basis have special responsibilities to their clients because of the nature of this work. Administrators and clinical supervisors in trauma-informed organizations should develop policies that clearly define the counselors' job and should provide education about the role of counselors in the organization and their responsibilities to clients.

General Principles Regarding Counselor Responsibilities

The following are some general principles governing the responsibilities of counselors who provide behavioral health services for clients with histories of trauma:

- Counselors are responsible for routinely screening clients for traumatic experiences and trauma-related symptoms (Ouimette & Brown, 2003; see also Treatment Improvement Protocol [TIP] 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Center for Substance Abuse Treatment [CSAT], 2005c).
- Counselors should offer clients with substance use and trauma-related disorders continuing mental health services if it is within their professional license and scope of practice to do so.
- Counselors are responsible for referring clients with substance use disorders and co-occurring trauma-related disorders to treatment that addresses both disorders when the treatment falls outside of the counselor's professional license and scope of practice (Ouimette & Brown, 2003).
- Counselors should refer clients with substance use disorders and co-occurring trauma-related disorders to concurrent participation in mutual-help groups if appropriate (Ouimette & Brown, 2003).
- Counselors have a responsibility to practice the principles of confidentiality in all interactions with clients and to respect clients' wishes not to give up their right to privileged communication.
- Counselors are responsible for educating clients about the limits of confidentiality and what happens to protected health information, along with the client's privilege, when the client signs a release of information or agrees to assign insurance benefits to the provider.
- Counselors must inform clients that treatment for trauma-related disorders is always voluntary.
- Counselors are responsible for being aware of their own secondary trauma and

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist

Trauma Awareness

___ Understands the difference between trauma-informed and trauma-specific services

___ Understands the differences among various kinds of abuse and trauma, including: physical, emotional, and sexual abuse; domestic violence; experiences of war for both combat veterans and survivors of war; natural disasters; and community violence

___ Understands the different effects that various kinds of trauma have on human development and the development of psychological and substance use issues

___ Understands how protective factors, such as strong emotional connections to safe and nonjudgmental people and individual resilience, can prevent and ameliorate the negative impact trauma has on both human development and the development of psychological and substance use issues

___ Understands the importance of ensuring the physical and emotional safety of clients

___ Understands the importance of not engaging in behaviors, such as confrontation of substance use or other seemingly unhealthy client behaviors, that might activate trauma symptoms or acute stress reactions

___ Demonstrates knowledge of how trauma affects diverse people throughout their lifespans and with different mental health problems, cognitive and physical disabilities, and substance use issues

___ Demonstrates knowledge of the impact of trauma on diverse cultures with regard to the meanings various cultures attach to trauma and the attitudes they have regarding behavioral health treatment

___ Demonstrates knowledge of the variety of ways clients express stress reactions both behaviorally (e.g., avoidance, aggression, passivity) and psychologically/emotionally (e.g., hyperarousal, avoidance, intrusive memories)

Counseling Skills

___ Expedites client-directed choice and demonstrates a willingness to work within a mutually empowering (as opposed to a hierarchical) power structure in the therapeutic relationship

___ Maintains clarity of roles and boundaries in the therapeutic relationship

___ Demonstrates competence in screening and assessment of trauma history (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Shows competence in screening and assessment of substance use disorders (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Demonstrates an ability to identify clients' strengths, coping resources, and resilience

___ Facilitates collaborative treatment and recovery planning with an emphasis on personal choice and a focus on clients' goals and knowledge of what has previously worked for them

___ Respects clients' ways of managing stress reactions while supporting and facilitating taking risks to acquire different coping skills that are consistent with clients' values and preferred identity and way of being in the world

___ Demonstrates knowledge and skill in general trauma-informed counseling strategies, including, but not limited to, grounding techniques that manage dissociative experiences, cognitive–behavioral tools that focus on both anxiety reduction and distress tolerance, and stress management and relaxation tools that reduce hyperarousal

(Continued on the next page.)

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist (continued)

___ Identifies signs of STS reactions and takes steps to engage in appropriate self-care activities that lessen the impact of these reactions on clinical work with clients

___ Recognizes when the needs of clients are beyond his or her scope of practice and/or when clients' trauma material activates persistent secondary trauma or countertransference reactions that cannot be resolved in clinical supervision; makes appropriate referrals to other behavioral health professionals

Source: Abrahams et al., 2010.

countertransference reactions and seeking appropriate help in responding to these reactions so that they do not interfere with the best possible treatment for clients.

TIC organizations have responsibilities to clients in their care, including:

- Protecting client confidentiality, particularly in relation to clients' trauma histories. Organizations should comply with the State and Federal laws that protect the confidentiality of clients being treated for mental and substance use disorders.
- Providing clients with an easy-to-read statement of their rights as consumers of mental health and substance abuse services, including the right to confidentiality (Exhibit 2.2-4).
- Providing quality clinical supervision to all counselors and direct-service workers, with an emphasis on TIC. Organizations should, at minimum, comply with State licensing requirements for the provision of clinical supervision to behavioral health workers.
- Establishing and maintaining appropriate guidelines and boundaries for client and counselor behavior in the program setting.
- Creating and maintaining a trauma-informed treatment environment that respects the clients' right to self-determination and need to be treated with dignity and respect.
- Maintaining a work environment that reinforces and supports counselor self-care.

All behavioral health professionals are responsible for abiding by professional standards of care that protect the client. Breaches of confidentiality, inappropriate conduct, and other violations of trust can do further harm to clients who already have histories of trauma. Many treatment facilities have a Client Bill of Rights (or a similar document) that describes the rights and responsibilities of both the counselors and the participants; it often is part of the orientation and informed consent process when a client enters treatment. However, simply reading and acknowledging the receipt of a piece of paper is not a substitute for the dialog that needs to happen in a collaborative therapeutic partnership. Administrators are responsible for providing clients with easy-to-read information describing counselor responsibilities and client rights. Clinical supervisors are responsible for helping counselors engage in a respectful dialog with clients about those rights and responsibilities as part of a comprehensive informed consent process.

Exhibit 2.2-4 is an excerpt from a Client Bill of Rights that outlines clients' right to confidentiality in plain language that is readable and easily understood.

Exhibit 2.2-4: Sample Statement of the Client's Right to Confidentiality From a Client Bill of Rights

Tri-County Mental Health Services is a trauma-informed mental health and substance abuse treatment agency in Maine. Below is a statement regarding clients' right to confidentiality and staff responsibility to protect that privilege; this statement is provided in a brochure outlining consumer rights that is easily accessible to service recipients at the agency and online.

Confidentiality

We will not give out information about you to anyone without your knowledge and permission. This includes written information from your record and verbal information from your providers. Additionally, we will not request any information about you without your knowledge and permission. A Release of Information Form allows you to say what information can be shared and with whom. You determine the length of time this is valid, up to one year.

Tri-County policies prevent any employee of the agency who does not have a direct need to know from having access to any information about you. The penalty for violation can include immediate dismissal.

Exceptions to this rule of confidentiality include times when a client is at immediate risk of harm to self or others, or when ordered by the court. We will make every effort to notify you in these instances.

Source: Tri-County Mental Health Services, 2008, pp. 6-7.

Ethics in Treating Traumatized Clients

All behavioral health professionals must conform to the ethical guidelines established by their profession's State licensing boards and/or certifying organizations. State licensing boards for substance abuse counseling, psychiatry, social work, psychology, professional counseling, and other behavioral health professions provide regulatory standards for ethical practice in these professions. These boards also have specific procedures for responding to complaints regarding the actions of professional caregivers. Additionally, national professional societies have standards for ethical practices. Members of these organizations are expected to practice within the boundaries and scope of these standards. Some of these standards are quite explicit, whereas others are more general; most approach professional ethics not as a rigid set of rules, but rather, as a process of making ethical decisions.

Clinical supervisors are responsible for informing counselors of their ethical responsibilities with regard to their own organization's policies and procedures, monitoring supervisees' reading and understanding the codes of ethics of professional organizations and State licensing boards, and promoting counselor understanding of ethics and how to make decisions ethically as a regular part of clinical supervision, team meetings, and counselor training. Administrators can support high ethical standards by creating an organization-wide ethics task group consisting of counselors, supervisors, and administrators who meet regularly to review and revise clinical policies in line with State and Federal law and professional codes of ethics. Administrators may also act as a support mechanism for counselors who need additional consultation regarding potential ethical dilemmas with clients. The Green Cross Academy of Traumatology provides ethical guidelines for the treatment of clients who have experienced trauma; these guidelines are adapted in Exhibit 2.2-5.

Exhibit 2.2-5: Green Cross Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized

Respect for the dignity of clients

- Recognize and value the personal, social, spiritual, and cultural diversity present in society, without judgment. As a primary ethical commitment, make every effort to provide interventions with respect for the dignity of those served.

Responsible caring

- Take the utmost care to ensure that interventions do no harm.
- Have a commitment to the care of those served until the need for care ends or the responsibility for care is accepted by another qualified service provider.
- Support colleagues in their work and respond promptly to their requests for help.
- Recognize that service to survivors of trauma can exact a toll in stress on providers. Maintain vigilance for signs in self and colleagues of such stress effects, and accept that dedication to the service of others imposes an obligation to sufficient self-care to prevent impaired functioning.
- Engage in continuing education in the appropriate areas of trauma response. Remain current in the field and ensure that interventions meet current standards of care.

Integrity in relationships

- Clearly and accurately represent your training, competence, and credentials. Limit your practice to methods and problems for which you are appropriately trained and qualified. Readily refer to or consult with colleagues who have appropriate expertise; support requests for such referrals or consultations from clients.
- Maintain a commitment to confidentiality, ensuring that the rights of confidentiality and privacy are maintained for all clients.
- Do not provide professional services to people with whom you already have either emotional ties or extraneous relationships of responsibility. The one exception is in the event of an emergency in which no other qualified person is available.
- Refrain from entering other relationships with present or former clients, especially sexual relationships or relationships that normally entail accountability.
- Within agencies, ensure that confidentiality is consistent with organizational policies; explicitly inform individuals of the legal limits of confidentiality.

Responsibility to society

- Be committed to responding to the needs generated by traumatic events, not only at the individual level, but also at the level of community and community organizations in ways that are consistent with your qualifications, training, and competence.
- Recognize that professions exist by virtue of societal charters in expectation of their functioning as socially valuable resources. Seek to educate government agencies and consumer groups about your expertise, services, and standards; support efforts by these agencies and groups to ensure social benefit and consumer protection.
- If you become aware of activities of colleagues that may indicate ethical violations or impairment of functioning, seek first to resolve the matter through direct expression of concern and offers of help to those colleagues. Failing a satisfactory resolution in this manner, bring the matter to the attention of the officers of professional societies and of governments with jurisdiction over professional misconduct.

Clients' universal rights

All clients have the right to:

- Not be judged for any behaviors they used to cope, either at the time of the trauma or after the trauma.
- Be treated at all times with respect, dignity, and concern for their well-being.
- Refuse treatment, unless failure to receive treatment places them at risk of harm to self or others.

(Continued on the next page.)

Exhibit 2.2-5: Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized (continued)

- Be regarded as collaborators in their own treatment plans.
- Provide their informed consent before receiving any treatment.
- Not be discriminated against based on race, culture, sex, religion, sexual orientation, socioeconomic status, disability, or age.
- Have promises kept, particularly regarding issues related to the treatment contract, role of counselor, and program rules and expectations.

Procedures for introducing clients to treatment

Obtain informed consent, providing clients with information on what they can expect while receiving professional services. In addition to general information provided to all new clients, clients presenting for treatment who have histories of trauma should also receive information on:

- The possible short-term and long-term effects of trauma treatment on the client and the client's relationships with others.
- The amount of distress typically experienced with any particular trauma treatment.
- Possible negative effects of a particular trauma treatment.
- The possibility of lapses and relapses when doing trauma work, and the fact that these are a normal and expected part of healing.

Reaching counseling goals through consensus

Collaborate with clients in the design of a clearly defined contract that articulates a specific goal in a specific time period or a contract that allows for a more open-ended process with periodic evaluations of progress and goals.

Informing clients about the healing process

- Clearly explain to clients the nature of the healing process, making sure clients understand.
- Encourage clients to ask questions about any and all aspects of treatment and the therapeutic relationship. Provide clients with answers in a manner they can understand.
- Encourage clients to inform you if the material discussed becomes overwhelming or intolerable.
- Inform clients of the necessity of contacting you or emergency services if they feel suicidal or homicidal, are at risk of self-injury, or have a sense of being out of touch with reality.
- Give clients written contact information about available crisis or emergency services.
- Inform clients about what constitutes growth and recovery and about the fact that some trauma symptoms may not be fully treatable.
- Address unrealistic expectations clients may have about counseling and/or the recovery process.

Level of functioning

- Inform clients that they may not be able to function at the highest level of their ability—or even at their usual level—when working with traumatic material.
- Prepare clients to experience trauma-related symptoms, such as intrusive memories, dissociative reactions, reexperiencing, avoidance behaviors, hypervigilance, or unusual emotional reactivity.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

Boundaries in therapeutic relationships

Maintaining appropriate therapeutic boundaries is a primary ethical concern for behavioral health professionals. Counselors working with clients who have substance use, trauma-related, and other mental disorders may feel challenged at times to maintain boundaries that create a safe therapeutic container. Some clients, especially those with longstanding disorders, bring a history of client–counselor relationships to counseling. Clients who have been traumatized may need help understanding the roles and responsibilities of both the counselor and the client. Clients with trauma-related conditions may also have special needs

Advice to Clinical Supervisors: Recognizing Boundary Confusion

Clinical supervisors should be aware of the following counselor behaviors that can indicate boundary confusion with clients:

- The counselor feels reluctant or embarrassed to discuss specific interactions with a client or details of the client's treatment in supervision or team meetings.
- The counselor feels possessive of the client, advocates with unusual and excessive vehemence for the client, or expresses an unreasonable sense of overresponsibility for the client.
- The counselor becomes defensive and closed to hearing ideas from the supervisor or the treatment team members about approaches to working with a client and/or exploring his or her own emotional reactions to a client.
- The clinician begins or increases personal self-disclosure to the client and is not able to identify legitimate clinical reasons for the self-disclosure.

in establishing appropriate boundaries in the counseling setting; they may be particularly vulnerable and not understand or appreciate the need for professional boundaries, including not engaging in dual relationships. For example, some clients might experience a counselor's boundary around not giving the client his or her personal phone number for emergency calls as a rejection or abandonment. Cultural considerations also influence therapeutic boundaries.

Administrators, in collaboration with clinical supervisors, are responsible for creating policies regarding counselor and client boundaries for various issues (e.g., giving and receiving gifts, counselor personal disclosure, and counselor roles and responsibilities when attending the same 12-Step meetings as clients); policies should be specific to their organization and conform to State and Federal law and behavioral health professional codes of ethics. Clinical supervisors are responsible for training counselors in the informed consent process and effective ways to discuss boundaries with clients when they enter treatment.

Guidelines for establishing and maintaining boundaries in therapeutic relationships, adapted from the Green Cross Academy of Traumatology, are given in Exhibit 2.2-6.

Clients with trauma histories may be especially vulnerable to counselor behaviors that are inconsistent or that are experienced by the client as boundary violations. Examples of such behavior include: being late for appointments, ending counseling sessions early, repeatedly and excessively extending the session time, canceling or "forgetting" appointments multiple times, spending time in the session talking about their own needs and life experiences, exploring opportunities for contact outside the therapeutic relationship (including making arrangements to meet at AA or other 12-Step recovery group meetings), and enforcing rules differently for one client than for another.

Due to the complex dynamics that can arise in the treatment of clients with trauma histories, regularly scheduled clinical supervision, where issues of ethics and boundaries can be discussed, is recommended for counselors. For more information on how clinical supervision can be effectively used, see TIP 52, *Clinical Supervision and the Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Boundary crossing and boundary violation

Although guidelines and codes of ethics are useful tools in helping clinical supervisors and counselors understand the boundaries between counselors and clients, they are open to interpretation and are context-bound. Given these limitations, it is crucial to educate counselors

Exhibit 2.2-6: Boundaries in Therapeutic Relationships

Procedures for Establishing Safety

Roles and boundaries
Counselor roles and boundaries should be established at the start of the counseling relationship and reinforced periodically, particularly at times when the client is experiencing high stress.

Ongoing Relationships and the Issue of Boundaries

Dual relationships
Dual relationships and inappropriate interactions with clients are to be avoided. It is important to tell clients at the beginning of counseling that contact between the counselor and the client can only occur within the boundaries of the professional relationship. This information is part of the informed consent process. Relationships outside these boundaries include sexual or romantic relationships, a counselor also serving as a client's sponsor in 12-Step programs, and any kind of relationship in which the counselor exploits the client for financial gain.

Sexual contact
- Never engage in any form of sexual contact with clients.
- Do not reward sexualized behaviors with attention or reactivity.
- Directly clarify the boundaries of the therapeutic relationship, and address the underlying motivations of persisting sexualized behavior.
- Set limits on a client's inappropriate behaviors while maintaining an ethos of care. Maintain respect for the dignity and worth of the client at all times.
- Understand that a client's attempt to sexualize a therapeutic relationship may reflect an early history of abuse, difficulty understanding social norms, or a variety of psychological problems.
- Readdress the absolute inappropriateness of sexual and/or romantic behavior in a nonlecturing, nonpunitive manner.
- If sexual behavior between clients occurs in a treatment program, counselors should consult with a clinical supervisor. Document the nature of the contact and how the issue is addressed.
- If a counselor has sexual contact with a client, he or she should take responsibility by ceasing counseling practice, referring clients to other treatment providers, and notifying legal and professional authorities. If a counselor is at risk for engaging with a client sexually but has not acted on it, the counselor should immediately consult with a supervisor, colleague, or psychotherapist.

Boundaries
Counselors should use care with self-disclosure or any behaviors that may be experienced as intrusive by the client, including:
- Personal disclosures made for the counselor's own gratification.
- Sexualized behavior with the client.
- Excessively intrusive questions or statements.
- Interrupting the client frequently.
- Violating the client's personal space.
- Interpersonal touch, which might activate intrusive memories or dissociative reactions or be experienced as a boundary violation by the client.
- Being consistently late for appointments or allowing outside influences (such as telephone calls) to interrupt the client's time in a counseling session.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

in TIC settings regarding the boundary issues that may arise for clients who have been traumatized and to give counselors a conceptual framework for understanding the contextual nature of boundaries. For example, it would be useful for clinical supervisors to discuss with

counselors the distinction between boundary crossings and boundary violations in clinical practice. Gutheil and Brodsky (2008) define boundary crossing as a departure from the customary norms of counseling practice in relation to psychological, physical, or social space "that are harmless, are nonexploitative, and may even support or advance the therapy" (p. 20). Examples of boundary crossings include taking phone calls from a client between sessions if the client is in crisis or telling a client a story about the counselor's recovery from trauma (without offering specific personal information or graphic/detailed description of the trauma) with the intention of offering hope that it is possible to recover.

Gutheil and Brodsky (2008) define boundary violations as boundary crossings that are unwanted and dangerous and which exploit the client, stating that "some boundary crossings are inadvisable because of their intent (i.e., they are not done in the service of the patient's well-being and growth, involve extra therapeutic gratification for the therapist) and/or their effect (i.e., they are not likely to benefit the patient and entail a significant risk of harming the patient)" (pp. 20–21). An example of a boundary violation would be when a counselor invites a client to attend the same AA meetings the counselor attends or shares drinking and drugging "war stories" for the counselor's own gratification. Two key elements in understanding when a boundary crossing becomes a boundary violation are the intent of the counselor and the damaging effect on the client. Maintaining a standard of practice of nonexploitation of the client is the primary focus for clinical supervisors and counselors in determining when boundary crossings become boundary violations.

Context is also an important consideration in determining the acceptability of boundary crossings. For example, it may be acceptable for a counselor in a partial hospitalization program for serious mental illness to have a cup of coffee at the kitchen table with a resident, whereas for a counselor in an outpatient mental health program, having a cup of coffee with a client at the local coffee shop would be a much more questionable boundary crossing.

Case Illustration: Denise

Denise is a 40-year-old licensed professional counselor working in an inpatient eating disorder program. She has had extensive training in trauma and eating disorder counseling approaches and has been working as a clinician in mental health settings for 15 years. Denise is usually open to suggestions from her supervisor and other treatment team members about specific strategies to use with clients who have trauma histories and eating disorders. However, in the past week, her supervisor has noticed that she has become defensive in team meetings and individual supervision when discussing a recently admitted young adult who was beaten and raped by her boyfriend; subsequently, the client was diagnosed with PTSD and anorexia. When the clinical supervisor makes note of the change in Denise's attitude and behavior in team meetings since this young woman was admitted, initially Denise becomes defensive, saying that the team just doesn't understand this young woman and that the client has repeatedly told Denise, "You're the only counselor I trust."

The clinical supervisor recognizes that Denise may be experiencing secondary traumatization and boundary confusion due to working with this young woman and to the recent increase in the number of clients with co-occurring trauma-related disorders on her caseload. After further exploration, Denise reveals that her own daughter was raped at the same age as the young woman and that hearing her story has activated an STS reaction in Denise. Her way of coping has been to become overly responsible for and overprotective of the young woman. With the nonjudgmental support of her supervisor, Denise is able to gain perspective, recognize that this young woman is not her daughter, and reestablish boundaries with her that are appropriate to the inpatient treatment setting.

Clinical Supervision and Consultation

Organizational change toward a TIC model doesn't happen in isolation. Ongoing support, supervision, and consultation are key ingredients that reinforce behavioral health professionals' training in trauma-informed and trauma-specific counseling methods and ensure compliance with practice standards and consistency over time. Often, considerable energy and resources are spent on the transition to new clinical and programmatic approaches, but without long-range planning to support those changes over time. The new treatment approach fades quickly, making it hard to recognize and lessening its reliability.

Advice to Clinical Supervisors and Administrators: Adopting an Evidence-Based Model of Clinical Supervision and Training

Just as adopting evidence-based clinical practices in a trauma-informed organization is important in providing cost-effective and outcome-relevant services to clients, adopting an evidence-based model of clinical supervision and training clinical supervisors in that model can enhance the quality and effectiveness of clinical supervision for counselors. This will ultimately enhance client care.

One of the most commonly used and researched integrative models of supervision is the discrimination model, originally published by Janine Bernard in 1979 and since updated (Bernard & Goodyear, 2009). This model is considered a competence-based and social role model of supervision; it includes three areas of focus on counselor competencies (intervention, conceptualization, and personalization) and three possible supervisor roles (teacher, counselor, and consultant).

Counselor competencies:

- Intervention: The supervisor focuses on the supervisee's intervention skills and counseling strategies used with a particular client in a given session.
- Conceptualization: The supervisor focuses on how the supervisee understands what is happening in a session with the client.
- Personalization: The supervisor focuses on the personal style of the counselor and countertransference responses (i.e., personal reactions) of the counselor to the client.

Supervisor roles:

- Teacher: The supervisor teaches the supervisee specific counseling theory and skills and guides the supervisee in the use of specific counseling strategies in sessions with clients. The supervisor as teacher is generally task-oriented. The supervisor is more likely to act as a teacher with beginning counselors.
- Counselor: The supervisor does not act as the counselor's therapist, but helps the counselor reflect on his or her counseling style and personal reactions to specific clients. The supervisor as counselor is interpersonally sensitive and focuses on the process and relational aspects of counseling.
- Consultant: The supervisor is more of a guide, offering the supervisee advice on specific clinical situations. The supervisor as consultant invites the counselor to identify topics and set the agenda for the supervision. The supervisor is more likely to act as a consultant with more advanced counselors.

This model of supervision may be particularly useful in working with counselors in TIC settings, because the supervisor's response to the supervisee is flexible and specific to the supervisee's needs. In essence, it is a counselor-centered model of supervision in which the supervisor can meet the most relevant needs of the supervisee in any given moment.

For a review of other theories and methods of clinical supervision, refer to TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Ongoing supervision and consultation supports the organizational message that TIC is the standard of practice. It normalizes secondary traumatization as a systemic issue (not the individual pathology of the counselor) and reinforces the need for counselor self-care to prevent and lessen the impact of secondary traumatization. Quality clinical supervision for direct care staff demonstrates the organization's commitment to implementing a fully integrated, trauma-informed system of care.

Supervision and Consultation

Historically, there was an administrative belief that counselors who had extensive clinical experience and training would naturally be the best clinical supervisors. However, research does not support this idea (Falender & Shafranske, 2004). Although a competent clinical supervisor needs to have an extensive clinical background in the treatment of substance use, trauma-related, and other mental disorders, it is also essential for any counselor moving into a supervisory role to have extensive training in the theory and practice of clinical supervision before taking on this role. In particular, clinical supervisors in trauma-informed behavioral health settings should be educated in how to perform clinical supervision (not just administrative supervision) of direct service staff and in the importance of providing continuous clinical supervision and support for staff members working with individuals affected by trauma. Clinical

Case Illustration: Arlene

Arlene is a 50-year-old licensed substance abuse counselor who has a personal history of trauma, and she is actively engaged in her own recovery from trauma. She is an experienced counselor who has several years of training in trauma-informed and trauma-specific counseling practices. Her clinical supervisor, acting in the role of consultant, begins the supervision session by inviting her to set the agenda. Arlene brings up a clinical situation in which she feels stuck with a client who is acting out in her Seeking Safety group (for more information on Seeking Safety, see Najavits, 2002a).

Arlene reports that her client gets up suddenly and storms out of the group room two or three times during the session. The supervisor, acting in the role of the counselor and focusing on personalization, asks Arlene to reflect on the client's behavior and what feelings are activated in her in response to the client's anger. Arlene is able to identify her own experience of hyperarousal and then paralysis as a stress reaction related to her prior experience of domestic violence in her first marriage. The supervisor, acting in the role of teacher and focusing on conceptualization, reminds Arlene that her client is experiencing a "fight-or-flight" response to some experience in the group that reminds her of her own trauma experience. The supervisor then suggests to Arlene that her own reactions are normal responses to her previous history of trauma, and that when her client is angry, Arlene is not reexperiencing her own trauma but is being activated by the client's traumatic stress reaction to being in group. In this way, the supervisor highlights the parallel process of the client–counselor's stress reactions to a perceived threat based on prior trauma experiences.

The supervisor, acting again as a consultant and focusing on personalization this time, invites Arlene to reflect on the internal and external resources she might be able to bring to this situation that will help remind her to ground herself so she can lessen the impact of her stress reactions on her counseling strategy with this client. Arlene states that she can create a list of safe people in her life and place this list in her pocket before group. She can use this list as a touchstone to remind her that she is safe and has learned many recovery skills that can help her stay grounded, maintain her boundaries, and deal with her client's behavior. The clinical supervisor, acting as a consultant and now focusing on intervention, asks Arlene if she has some specific ideas about how she can address the client's behavior in group. Arlene and the clinical supervisor spend the remainder of the session discussing different options for addressing the client's behavior and helping her feel safer in group.

supervision in a TIC organization should focus on the following priorities:

- General case consultation
- Specialized consultation in specific and unusual cases
- Opportunities to process clients' traumatic material
- Boundaries in the therapeutic and supervisory relationship
- Assessment of secondary traumatization
- Counselor self-care and stress management
- Personal growth and professional development of the counselor

Supervision of counselors working with traumatized clients should be regularly scheduled, with identified goals and with a supervisor who is trained and experienced in working with trauma survivors. The styles and types of supervision and consultation may vary according to the kind of trauma work and its context. For instance, trauma counseling in a major natural disaster would require a different approach to supervision and consultation than would counseling adults who experienced childhood developmental trauma or counseling clients in an intensive early recovery treatment program using a manualized trauma-specific counseling protocol.

Competence-based clinical supervision is recommended for trauma-informed organizations. Competence-based clinical supervision models identify the knowledge and clinical skills each counselor needs to master, and they use targeted learning strategies and evaluation procedures, such as direct observation of counselor sessions with clients, individualized coaching, and performance-based feedback. Studies on competence-based supervision approaches have demonstrated that these models improve counselor treatment skills and proficiency (Martino et al., 2011).

Whichever model of clinical supervision an organization adopts, the key to successful trauma-informed clinical supervision is the recognition that interactions between the supervisor and the counselor may parallel those between the counselor and the client. Clinical supervisors need to recognize counselors' trauma reactions (whether they are primary or secondary to the work with survivors of trauma) and understand that a confrontational or punitive approach will be ineffective and likely retraumatize counselors.

Clinical supervisors should adopt a respectful and collaborative working relationship with counselors in which role expectations are clearly defined in an informed consent process similar to that used in the beginning of the counselor–client relationship and in which exploring the nature of boundaries in both client–counselor and counselor–supervisor relationships is standard practice. Clear role boundaries, performance expectations, open dialog, and supervisor transparency can go a long way toward creating a safe and respectful relationship container for the supervisor and supervisee and set the stage for a mutually enhancing, collaborative relationship. This respectful, collaborative supervisory relationship is the main source of training and professional growth for the counselor and for the provision of quality care to people with behavioral health disorders.

Secondary Traumatization

The demands of caregiving exact a price from behavioral health professionals that cannot be ignored; otherwise, they may become ineffective in their jobs or, worse, emotionally or psychologically impaired. In a study of Master's level licensed social workers, 15.2 percent of respondents to a survey reported STS as a result of indirect exposure to trauma material at a level that meets the diagnostic criteria for PTSD. This rate is almost twice the rate of PTSD in the general population. The author

STS is a trauma related stress reaction and set of symptoms resulting from exposure to another individual's traumatic experiences rather than from exposure directly to a traumatic event.

concluded that behavioral health professionals' experience of STS is a contributing factor in staff turnover and one reason why many behavioral health service professionals leave the field (Bride, 2007). Secondary traumatization of behavioral health workers is a significant organizational issue for clinical supervisors and administrators in substance abuse and mental health treatment programs to address.

To prevent or lessen the impact of secondary traumatization on behavioral health professionals, clinical supervisors and administrators need to understand secondary trauma from the ecological perspective described in Part 1, Chapter 1 of this TIP. The organization itself creates a social context with risk factors that can increase the likelihood of counselors experiencing STS reactions, but it also contains protective factors that can lessen the risk and impact of STS reactions on staff members. Organizations can lessen the impact of the risk factors associated with working in trauma-informed organizations by mixing caseloads to contain clients both with and without trauma-related issues, supporting ongoing counselor training, providing regular clinical supervision, recognizing counselors' efforts, and offering an empowering work environment in which counselors share in the responsibility of making decisions and can offer input into clinical and program policies that affect their work lives.

When organizations support their counselors in their work with clients who are traumatized, counselors can be more effective, more productive, and feel greater personal and professional satisfaction. In addition, counselors develop a sense of allegiance toward the organization, thus decreasing staff turnover. If organizations do not provide this support, counselors can become demoralized and have fewer emotional and psychological resources to manage the impact of clients' traumatic material and outward behavioral expressions of trauma on their own well-being. Providing counselors with the resources to help them build resilience and prevent feeling overwhelmed should be a high priority for administrators and clinical supervisors in TIC organizations.

Risk and Protective Factors Associated With Secondary Traumatization

Clinical and research literature on trauma describes a number of factors related to the development of secondary trauma reactions and psychological distress in behavioral health professionals across a wide range of practice settings, as well as individual and organizational factors that can prevent or lessen the impact of STS on staff. The risk and protective factors model of understanding secondary trauma is based on the ecological perspective

Advice to Clinical Supervisors: Recognizing Secondary Traumatization

Some counselor behaviors that demonstrate inconsistency to clients may be outward manifestations of secondary traumatization, and they should be discussed with counselors through a trauma-informed lens. It is imperative that clinical supervisors provide a nonjudgmental, safe context in which counselors can discuss these behaviors without fear of reprisal or reprimand. Clinical supervisors should work collaboratively with supervisees to help them understand their behavior and engage in self-care activities that lessen the stress that may be contributing to these behaviors.

outlined in Part 1, Chapter 1 of this TIP. The terms "compassion fatigue," "vicarious traumatization," "secondary traumatization," and "burnout" are used in the literature, sometimes interchangeably and sometimes as distinct constructs. As stated in the terminology portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP, the term "secondary traumatization" refers to traumatic stress reactions and psychological distress from exposure to another individual's traumatic experiences; this term will be used throughout this section, although the studies cited may use other terms.

Risk factors

Individual risk factors that may contribute to the development of STS in behavioral health professionals include preexisting anxiety or mood disorders; a prior history of personal trauma; high caseloads of clients with trauma-related disorders; being younger in age and new to the field with little clinical experience or training in treating trauma-related conditions; unhealthy coping styles, including distancing and detachment from clients and co-workers; and a lack of tolerance for strong emotions (Newall & MacNeil, 2010). Other negative coping strategies include substance abuse, other addictive behaviors, a lack of recreational activities not related to work, and a lack of engagement with social support. A recent study of trauma nurses found that low use of support systems, use of substances, and a lack of hobbies were among the coping strategies that differed between nurses with and without STS (Von Rueden et al., 2010). Other researchers found that clinicians who engaged in negative coping strategies, such as alcohol and illicit drug use, were more likely to experience intrusive trauma symptoms (Way, Van Deusen, Martin, Applegate, & Janle, 2004).

Numerous organizational factors can contribute to the development of STS in counselors who work with clients with trauma-related disorders. These risk factors include organizational constraints, such as lack of resources for clients, lack of clinical supervision for counselors, lack of support from colleagues, and lack of acknowledgment by the organizational culture that secondary traumatization exists and is a normal reaction of counselors to client trauma (Newall & MacNeil, 2010). In a study of 259 individuals providing mental health counseling services, counselors who spent more time in session with clients with trauma-related disorders reported higher levels of traumatic stress symptoms (Bober & Regehr, 2006). Counselors may be more at risk for developing secondary traumatization if the organization does not allow for balancing the distribution of trauma and nontrauma cases amongst staff members.

Protective factors

Much of the clinical and research literature focuses on individual factors that may lessen the impact of STS on behavioral health professionals, including male gender, being older, having more years of professional experience,

Advice to Clinical Supervisors: Recognizing STS in Counselors Who Are In Recovery

For counselors who are in recovery from a substance use or mental disorder, the development of STS may be a potential relapse concern. As Burke, Carruth, and Prichard (2006) point out, "a return to drinking or illicit drug use as a strategy for dealing with secondary trauma reactions would have a profoundly detrimental effect on the recovering counselor" (p. 292). So too, secondary trauma may ignite the reappearance of depressive or anxiety symptoms associated with a previous mental disorder. Clinical supervisors can address these risk factors with counselors and support them in engaging with their own recovery support network (which might include a peer support group or an individual counselor) to develop a relapse prevention plan.

having specialized training in trauma-informed and trauma-specific counseling practices, lacking a personal trauma history, exhibiting personal autonomy in the workplace, using positive personal coping styles, and possessing resilience or the ability to find meaning in stressful life events and to rebound from adversity (Sprang, Clark, & Whitt-Woosley, 2007). Some of these factors, like positive personal coping styles and the ability to find meaning in adversity, can be developed and enhanced through personal growth work, psychotherapy, engagement with spiritual practices and involvement in the spiritual community, and stress reduction strategies like mindfulness meditation. A recent multimethod study of an 8-week workplace mindfulness training group for social workers and other social service workers found that mindfulness meditation increased coping strategies, reduced stress, and enhanced self-care of the participants; findings suggested that workers were more likely to practice stress management techniques like mindfulness at their place of work than at home (McGarrigle & Walsh, 2011). Organizations can support counselors' individual efforts to enhance positive personal coping styles, find meaning in adversity, and reduce stress by providing time for workers during the workday for personal self-care activities, like mindfulness meditation and other stress reduction practices.

One of the organizational protective factors identified in the literature that may lessen the negative impact of secondary traumatization on behavioral health professionals is providing adequate training in trauma-specific counseling strategies, which increases providers' sense of efficacy in helping clients with trauma-related disorders and reduces the sense of hopelessness that is often a part of the work (Bober & Regehr 2006). One study found that specialized trauma training enhanced job satisfaction and reduced levels of compassion fatigue, suggesting that "knowledge and training might provide some protection against the deleterious effects of trauma exposure" (Sprang et al., 2007, p. 272). Another protective factor that may lessen the chances of developing secondary traumatization is having a diverse caseload of clients. Organizations "must determine ways of distributing workload in order to limit the traumatic exposure of any one worker. This may not only serve to reduce the impact of immediate symptoms but may also address the potential longitudinal effects" (Bober & Regehr, 2006, p. 8).

Emotional support from professional colleagues can be a protective factor. A study of substance abuse counselors working with clients who were HIV positive found that workplace support from colleagues and supervisors most effectively prevented burnout (Shoptaw, Stein, & Rawson, 2000). This support was associated with less emotional fatigue and depersonalization, along with a sense of greater personal accomplishment. In a study of domestic violence advocates, workers who received more support from professional peers were less likely to experience secondary traumatization (Slattery & Goodman, 2009).

In addition, counselor engagement in relationally based clinical supervision with a trauma-informed supervisor acts as a protective agent. Slattery and Goodman (2009) note that "for the trauma worker, good supervision can normalize the feelings and experiences, provide support and information about the nature and course of the traumatic reaction, help in the identification of transference and countertransference issues, and reveal feelings or symptoms associated with the trauma" (p. 1362). Workers who reported "engaging, authentic, and empowering relationships with their supervisors" were less likely to experience STS (p. 1369). Thus, it is not simply the frequency and regularity of clinical supervision,

but also the quality of the supervision and the quality of the supervisor–counselor relationship that can lessen the impact of STS on behavioral health professionals.

Engagement with a personal practice of spirituality that provides a sense of connection to a larger perspective and meaning in life is another protective factor that can lessen the impact of STS on counselors (Trippany, Kress, & Wilcoxon, 2004). Although recovering counselors may look to support groups for connection to a spiritual community, other behavioral health professionals might find support for enhancing spiritual meaning and connection in church, a meditation group, creative endeavors, or even volunteer work. The key is for counselors to develop their own unique resources and practices to enhance a sense of meaningful spirituality in their lives. Clinical supervisors should be aware of spiritual engagement as a protective factor in preventing and lessening the impact of STS and should support clinicians in including it in their self-care plans, but they should take care not to promote or reject any particular religious belief system or spiritual practice.

Another protective factor that may lessen the impact of workers' STS is a culture of empowerment in the organization that offers counselors a sense of autonomy, a greater ability to participate in making decisions about clinical and organizational policies, and obtaining support and resources that further their professional development. Slattery & Goodman (2009) surveyed 148 domestic violence advocates working in a range of settings. The authors found that those workers "who reported a high level of shared power were less likely to report posttraumatic stress symptoms, despite their own personal abuse history or degree of exposure to trauma" (p. 1370). To the degree that organizations can provide a cultural context within which behavioral health professionals have autonomy and feel empowered, they will be able to lessen the impact of STS on their professional and personal lives. Self-efficacy and empowerment are antidotes to the experience of powerlessness that often accompanies trauma.

Strategies for Preventing Secondary Traumatization

The key to prevention of secondary traumatization for behavioral health professionals in a trauma-informed organization is to reduce risk and enhance protective factors. Organizational strategies to prevent secondary traumatization include:

- Normalize STS throughout all levels of the organization as a way to help counselors feel safe and respected, enhancing the likelihood that they will talk openly about their experiences in team meetings, peer supervision, and clinical supervision.
- Implement clinical workload policies and practices that maintain reasonable standards for direct-care hours and emphasize balancing trauma-related and nontrauma-related counselor caseloads.
- Increase the availability of opportunities for supportive professional relationships by promoting activities such as team meetings, peer supervision groups, staff retreats, and counselor training that focuses on understanding secondary traumatization and self-care. Administrators and clinical supervisors should provide time at work for counselors to engage in these activities.
- Provide regular trauma-informed clinical supervision that is relationally based. Supervisors should be experienced and trained in trauma-informed and trauma-specific practices and provide a competence-based model of clinical supervision that promotes counselors' professional and personal development. Supervision limited to case consultation or case management is insufficient to

reduce the risk for secondary traumatization and promote counselor resilience.

- Provide opportunities for behavioral health professionals to enhance their sense of autonomy and feel empowered within the organization. Some of these activities include soliciting input from counselors on clinical and administrative policies that affect their work lives, including how to best balance caseloads of clients with and without histories of trauma; inviting representatives of the counseling staff to attend selected agency board of directors and/or management team meetings to offer input on workforce development; and inviting counselors to participate in organizational task forces that develop trauma-informed services, plan staff retreats, or create mechanisms to discuss self-care in team meetings. Administrators and clinical supervisors should assess the organization's unique culture and develop avenues for counselor participation in activities that will enhance their sense of empowerment and efficacy within the organization.

Exhibit 2.2-7 highlights some specific strategies that individual counselors can engage in to prevent secondary traumatization.

Assessment of Secondary Traumatization

Counselors with unacknowledged STS can harm clients, self, and family and friends by becoming unable to focus on and attend to their needs or those of others. They may feel helpless or cynical and withdraw from support systems. Exhibit 2.2-8 describes some emotional, cognitive, and behavioral signs that may indicate that a counselor is experiencing secondary traumatization. Clinical supervisors should be familiar with the manifestations of STS in their counselors and should address signs of STS immediately.

Stamm (2009–2012) has developed and revised a self-assessment tool, the Professional Quality of Life Scale (ProQOL), that measures indicators of counselor compassion fatigue and compassion satisfaction. Compassion fatigue "is best defined as a syndrome consisting of a combination of the symptoms

Exhibit 2.2-7: Counselor Strategies To Prevent Secondary Traumatization

Strategies that counselors can use (with the support and encouragement of supervisors and administrators) to prevent secondary traumatization include:

- ***Peer support*:** Maintaining adequate social support, both personally and professionally, helps prevent isolation and helps counselors share the emotional distress of working with traumatized individuals.
- ***Supervision and consultation*:** Professional consultation will help counselors understand secondary traumatization, their own personal risks, the protective factors that can help them prevent or lessen its impact, and their countertransference reactions to specific clients.
- ***Training*:** Ongoing professional training can improve counselors' understanding of trauma and enhance a sense of mastery and self-efficacy in their work.
- ***Personal psychotherapy or counseling*:** Being in counseling can help counselors become more self-aware and assist them in managing the psychological and emotional distress that often accompanies working with clients who have trauma histories in a number of behavioral health settings.
- ***Maintaining balance in one's life*:** Balancing work and personal life, developing positive coping styles, and maintaining a healthy lifestyle can enhance resilience and the ability to manage stress.
- ***Engaging in spiritual activities that provide meaning and perspective*:** Connection to a spiritual community and spiritual practices (such as meditation) can help counselors gain a larger perspective on trauma and enhance resilience.

Exhibit 2.2-8: Secondary Traumatization Signs

The following are some indicators that counselors may be experiencing secondary traumatization.

Psychological distress
- Distressing emotions: grief, depression, anxiety, dread, fear, rage, shame
- Intrusive imagery of client's traumatic material: nightmares, flooding, flashbacks of client disclosures
- Numbing or avoidance: avoidance of working with client's traumatic material
- Somatic issues: sleep disturbances, headaches, gastrointestinal distress, heart palpitations, chronic physiological arousal
- Addictive/compulsive behaviors: substance abuse, compulsive eating, compulsive working
- Impaired functioning: missed or canceled appointments, decreased use of supervision, decreased ability to engage in self-care, isolation and alienation

Cognitive shifts
- Chronic suspicion about others
- Heightened sense of vulnerability
- Extreme sense of helplessness or exaggerated sense of control over others or situations
- Loss of personal control or freedom
- Bitterness or cynicism
- Blaming the victim or seeing everyone as a victim
- Witness or clinician guilt if client reexperiences trauma or reenacts trauma in counseling
- Feeling victimized by client

Relational disturbances
- Decreased intimacy and trust in personal/professional relationships
- Distancing or detachment from client, which may include labeling clients, pathologizing them, judging them, canceling appointments, or avoiding exploring traumatic material
- Overidentification with the client, which may include a sense of being paralyzed by one's own responses to the client's traumatic material or becoming overly responsible for the client's life

Frame of reference
- Disconnection from one's sense of identity
- Dramatic change in fundamental beliefs about the world
- Loss or distortion of values or principles
- A previous sense of spirituality as comfort or resource decreases or becomes nonexistent
- Loss of faith in something greater
- Existential despair and loneliness

Sources: Figley, 1995; Newall & MacNeil, 2010; Saakvitne et al., 1996.

of secondary traumatic stress and professional burnout" (Newall & MacNeil, 2010, p. 61). Although secondary traumatization as a reaction to exposure to clients' trauma material is similar to PTSD, burnout is a more general type of psychological distress related to the pressures of working in high-stress environments over time. Burnout may be a result of secondary traumatization and/or a contributing factor in the development of secondary traumatization. The ProQOL includes STS and burnout scales that have been validated in research studies (Adams, Figley, & Boscarino, 2008; Newall & MacNeil, 2010).

This tool can be used in individual and group clinical supervision, trainings on self-care, and team meetings as a way for counselors to check in with themselves on their levels of stress and potential signs of secondary traumatization.

Case Illustration: Gui

Gui is a 48-year-old licensed substance abuse counselor who has worked in a methadone maintenance clinic for 12 years. He originally decided to get his degree and become a counselor because he wanted to help people and make a difference in the world. Over the past 6 months, he has felt fatigued a great deal, gets annoyed easily with both clients and coworkers, and has developed a cynical attitude about the world and the people who come to the clinic for help. During this time, the clinic has been forced to lay off a number of counselors due to funding cutbacks. As a result, Gui and the remaining counselors have had a 20 percent increase in the number of weekly client contact hours required as part of their job duties. In addition, the level and severity of clients' trauma-related and other co-occurring disorders, poverty, joblessness, and homelessness has increased.

Gui is a valued employee, and when Gui discusses his thoughts that he might want to leave the clinic with his clinical supervisor, the supervisor listens to Gui's concerns and explores the possibility of having him fill out the ProQOL to get a pulse on his stress level. Gui agrees and is willing to discuss the results with his supervisor. He is not surprised to see that he scores above average on the burnout scale of the instrument but is very surprised to see that he scores below average on the secondary traumatic stress scale and above average on the compassion satisfaction scale. He begins to feel more hopeful that he still finds satisfaction in his job and sees that he is resilient in many ways that he did not acknowledge before.

Gui and the clinical supervisor discuss ways that the supervisor and the organization can lessen the impact of the stress of the work environment on Gui and support the development of a self-care plan that emphasizes his own ability to rebound from adversity and take charge of his self-care.

The compassion satisfaction scale allows counselors to reflect on their resilience and reminds them of why they choose to work with people with substance use and trauma-related disorders, despite the fact that this work can lead to secondary traumatization. The compassion satisfaction subscale reminds counselors that they are compassionate, that one of the reasons they are in a helping profession is that they value service to others, and that helping brings meaning and fulfillment to their lives. Exhibits 2.2-9 through 2.2-11 present the most recent version of the ProQOL.

Addressing Secondary Traumatization

If a counselor is experiencing STS, the organization should address it immediately. Clinical supervisors can collaborate with counselors to devise an individualized plan that is accessible, acceptable, and appropriate for each counselor and that addresses the secondary stress reactions the counselor is experiencing, providing specific self-care strategies to counteract the stress. Decisions about strategies for addressing secondary traumatization should be based on the personal preferences of the counselor, the opportunity for an immediate intervention following a critical incident, and the counselor's level of awareness regarding his or her experience of STS. Counselors may need to talk about what they are experiencing, feeling, and thinking. These experiences can be processed in teams, in consultations with colleagues, and in debriefing meetings to integrate them effectively (Myers & Wee, 2002).

If a critical incident evokes secondary traumatization among staff—such as a client suicide, a violent assault in the treatment program, or another serious event—crisis intervention should be available for workers who would like to participate. Any intervention should be voluntary and tailored to each worker's individual needs (e.g., peer, group, or individual sessions); if possible, these services should be offered continuously instead of just one time.

Exhibit 2.2-9: PRoQOL Scale

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PRoQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *past 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I *[help]*.
___ 3. I get satisfaction from being able to *[help]* people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I *[help]*.
___ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
___ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
___ 10. I feel trapped by my job as a *[helper]*.
___ 11. Because of my *[helping]*, I have felt "on edge" about various things.
___ 12. I like my work as a *[helper]*.
___ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
___ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a *[helper]*.
___ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
___ 21. I feel overwhelmed because my case [work] load seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
___ 24. I am proud of what I can do to *[help]*.
___ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a *[helper]*.
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.

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Exhibit 2.2-10: Your Scores on the ProQOL: Professional Quality of Life Screening

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental healthcare professional.

Compassion Satisfaction _____
Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____
Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____
The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a healthcare professional.

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Source: Stamm, 2012. Used with permission.

Exhibit 2.2-11: What Is My Score and What Does It Mean?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

*You Wrote	Change to
1	5
2	4
3	3
4	2
5	1

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____
Total : _____

The sum of my Compassion Satisfaction questions is	So my score equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score.

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____
Total : _____

The sum of my Burnout questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add the[m] up. When you have added them up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____
Total : _____

The sum of my Secondary Trauma questions is	So my score equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

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The objective of debriefing a critical incident that evokes STS reactions in counselors is to help them dissipate the hyperarousal associated with traumatic stress and prevent long-term aftereffects that might eventually lead to counselor impairment. Because clinical supervisors may also be experiencing secondary traumatization, it is advisable for administrators to invite an outside trauma consultant into the organization to provide a safe space for all staff members (including clinical supervisors) to address and process the critical stress incident. For noncrisis situations, secondary traumatization should be addressed in clinical supervision. Clinical supervisors and counselors should work collaboratively to incorporate regular screening and self-assessment of STS into supervision sessions.

Advice to Clinical Supervisors: Advantages and Disadvantages of Using Psychometric Measures

Using a psychometric measure such as the ProQOL has advantages and disadvantages. It is important to understand that all tests measure averages and ranges but do not account for individual circumstances.

If you use the ProQOL in clinical supervision, present it as a self-assessment tool. Let counselors opt out of sharing their specific results with you and/or your team if it is administered in a group. If counselors choose to share scores on specific items or scales with you, work collaboratively and respectfully with them to explore their own understanding of and meanings attached to their scores. If this tool is not presented to supervisees in a nonjudgmental, mindful way, counselors may feel as if they have failed if their scores on the secondary traumatization scale are above average or if their scores on the compassion satisfaction scale are below average. High scores on the compassion fatigue and burnout scales do not mean that counselors don't care about their clients or that they aren't competent clinicians. The scores are simply one way for you and your supervisees to get a sense of whether they might be at risk for secondary traumatization, what they can do to prevent it, how to address it, and how you can support them.

The potential benefits of using a self-assessment tool like the ProQOL in clinical supervision are that it can help counselors:

- Reflect on their emotional reactions and behaviors and identify possible triggers for secondary traumatization.
- Assess their risk levels.
- Examine alternative coping strategies that may prevent secondary traumatization.
- Understand their own perceptions of themselves and their job satisfaction, affirming what they already know about their risk of secondary traumatization and their compassion satisfaction.
- Reflect on different factors that might contribute to unexpected low or high scores, such as the day of the week, the intensity of the workload, whether they have just come back from the weekend or a vacation, and so forth.
- Increase self-awareness and self-knowledge, because scores on specific items or scales bring to consciousness what is often outside of awareness.
- Realize how resilient they are emotionally, mentally, physically, and spiritually.
- Become aware of and open up conversations about self-care and self-care activities and resources, such as supportive coworkers, team members, and social networks outside of work.

If used regularly, self-assessment tools can help counselors and clinical supervisors monitor STS levels, indicate significant positive and negative changes, and suggest action toward self-care in specific areas. Clinical supervisors should fill out the ProQOL and review results with their own supervisors, a peer supervisor, or a colleague before administering it to supervisees. Doing so enables supervisors to gauge their own reactions to the self-assessment and anticipate potential reactions from supervisees.

Advice to Clinical Supervisors: Is it Supervision or Psychotherapy?

Although there are some aspects of clinical supervision that can be therapeutic and parallel the therapeutic and emotional support that occurs between the counselor and the client, clinical supervision is not therapy. As a result, it is important for clinical supervisors to maintain appropriate boundaries with supervisees when addressing their STS reactions at work.

When does the process in supervision cross over into the realm of practicing therapy with a supervisee? One clear indicator is if the supervisor begins to explore the personal history of the counselor and reflects directly on that history instead of bringing it back to how the counselor's history influences his or her work with a particular client or with clients with trauma histories in general. Clinical supervisors should focus only on counselor issues that may be directly affecting their clinical functioning with clients. If personal issues arise in clinical supervision, counselors should be encouraged to address them in their own counseling or psychotherapy.

Exhibit 2.2-12: Clinical Supervisor Guidelines for Addressing Secondary Traumatization

1. Engage counselors in regular screening/self-assessment of counselors' experience of STS.
2. Address signs of STS with counselors in clinical supervision.
3. Work collaboratively with counselors to develop a comprehensive self-care plan and evaluate its effectiveness on a regular basis.
4. Provide counselors a safe and nonjudgmental environment within which to process STS in individual and group supervision or team meetings.
5. Provide counselors with a safe and nonjudgmental place within which to debrief critical stress incidents at work; bring in an outside consultant if needed.
6. Support and encourage counselors to engage in individual counseling or psychotherapy, when needed, to explore personal issues that may be contributing to secondary traumatization at work.

When STS issues arise, the clinical supervisor should work with counselors to review and revise their self-care plans to determine what strategies are working and whether additional support, like individual psychotherapy or counseling, may be warranted.

Exhibit 2.2-12 outlines some guidelines for clinical supervisors in addressing secondary trauma in behavioral health professionals working with clients who have substance use, mental, and trauma-related disorders.

Counselor Self-Care

In light of the intensity of therapeutic work with clients with co-occurring substance use, mental, and trauma-related disorders and the vulnerability of counselors to secondary traumatization, a comprehensive, individualized self-care plan is highly recommended. Balance is the key to the development of a self-care plan—a balance between home and work, a balance between focusing on self and others, and a balance between rest and activity (Saakvitne, Perlman, & Traumatic Stress Institute/ Center for Adult & Adolescent Psychotherapy 1996). Counselor self-care is also about balancing vulnerability, which allows counselors to be present and available when clients address intensely painful content, with reasonable efforts to preserve their sense of integrity in situations that may threaten the counselors' faith or worldview (Burke et al., 2006). A comprehensive self-care plan should include activities that nourish the physical, psychological/mental, emotional/relational, and spiritual aspects of counselors' lives.

The literature on counselor self-care advocates for individual, team, and organizational strategies that support behavioral health professionals working with clients who have

Case Illustration: Carla

Carla is a 38-year-old case manager working in an integrated mental health and substance abuse agency. She provides in-home case management services to home-bound clients with chronic health and/or severe mental health and substance abuse problems. Many of her clients have PTSD and chronic, debilitating pain.

Both her parents had alcohol use disorders, and as a result, Carla became the caretaker in her family. She loves her job; however, she often works 50 to 60 hours per week and has difficulty leaving her work at work. She often dreams about her clients and wakes up early, feeling anxious. She sometimes has traumatic nightmares, even though she was never physically or sexually abused, and she has never experienced the trauma of violence or a natural disaster. She drinks five cups of coffee and three to four diet sodas every day and grabs burgers and sweets for snacks while she drives from one client to the next. She has gained 20 pounds in the past year and has few friends outside of her coworkers. She has not taken a vacation in more than 2 years. She belongs to the Catholic church down the street, but she has stopped going because she says she is too busy and exhausted by the time Sunday rolls around.

The agency brings in a trainer who meets with the case management department and guides the staff through a self-assessment of their current self-care practices and the development of a comprehensive self-care plan. During the training, Carla acknowledges that she has let her work take over the rest of her life and needs to make some changes to bring her back into balance. She writes out her self-care plan, which includes cutting back on the caffeine, calling a friend she knows from church to go to a movie, going to Mass on Sunday, dusting off her treadmill, and planning a short vacation to the beach. She also decides that she will discuss her plan with her supervisor and begin to ask around for a counselor for herself to talk about her anxiety and her nightmares. In the next supervision session, Carla's supervisor reviews her self-care plan with her and helps Carla evaluate the effectiveness of her self-care strategies. Her supervisor also begins to make plans for how to cover Carla's cases when she takes her vacation.

substance use and trauma-related disorders. Counselors are responsible for developing comprehensive self-care plans and committing to their plans, but clinical supervisors and administrators are responsible for promoting counselor self-care, supporting implementation of counselor self-care plans, and modeling self-care. Counselor self-care is an ethical imperative; just as the entire trauma-informed organization must commit to other ethical issues with regard to the delivery of services to clients with substance use, mental, and trauma-related disorders, it must also commit to the self-care of staff members who are at risk for secondary traumatization as an ethical concern. Saakvitne and colleagues (1996) suggest that when administrators support counselor-self-care, it is not only cost-effective in that it reduces the negative effects of secondary traumatization on counselors (and their clients), but also promotes "hope-sustaining behaviors" in counselors, making them more motivated and open to learning, and thereby improving job performance and client care.

A Comprehensive Self-Care Plan

A self-care plan should include a self-assessment of current coping skills and strategies and the development of a holistic, comprehensive self-care plan that addresses the following four domains:

1. Physical self-care
2. Psychological self-care (includes cognitive/mental aspects)
3. Emotional self-care (includes relational aspects)
4. Spiritual self-care

Activities that may help behavioral health workers find balance and cope with the stress

Advice to Clinical Supervisors: Spirituality

The word "spiritual" in this context is used broadly to denote finding a sense of meaning and purpose in life and/or a connection to something greater than the self. Spiritual meanings and faith experiences are highly individual and can be found within and outside of specific religious contexts.

Engaging in spiritual practices, creative endeavors, and group/community activities can foster a sense of meaning and connection that can counteract the harmful effects of loss of meaning, loss of faith in life, and cognitive shifts in worldview that can be part of secondary traumatization. Counselors whose clients have trauma-related disorders experience fewer disturbances in cognitive schemas regarding worldview and less hopelessness when they engage in spiritually oriented activities, such as meditation, mindfulness practices, being in nature, journaling, volunteer work, attending church, and finding a spiritual community (Burke et al., 2006). Clinical supervisors can encourage counselors to explore their own spirituality and spiritual resources by staying open and attuned to the multidimensional nature of spiritual meaning of supervisees and refraining from imposing any particular set of religious or spiritual beliefs on them. A strong sense of spiritual connection can enhance counselors' resilience and ability to cope with the sometimes overwhelming effects of clients' trauma material and trauma-related behavior (including suicidality) on counselors' faith in life and sense of meaning and purpose.

Modeling Self-Care

"Implementing interventions was not always easy, and one of the more difficult coping strategies to apply had to do with staff working long hours. Many of the staff working at the support center also had full-time jobs working for the Army. In addition, many staff chose to volunteer at the Family Assistance Center and worked 16- to 18-hour days. When we spoke with them about the importance of their own self-care, many barriers emerged: guilt over not working, worries about others being disappointed in them, fear of failure with respect to being unable to provide what the families might need, and a 'strong need to be there.' Talking with people about taking a break or time off proved problematic in that many of them insisted that time off was not needed, despite signs of fatigue, difficulty concentrating, and decreased productivity. Additionally, time off was not modeled. Management, not wanting to fail the families, continued to work long hours, despite our requests to do otherwise. Generally, individuals could see and understand the reasoning behind such endeavors. Actually making the commitment to do so, however, appeared to be an entirely different matter. In fact, our own team, although we kept reasonable hours (8 to 10 per day), did not take a day off in 27 days. Requiring time off as part of membership of a Disaster Response Team might be one way to solve this problem."

—Member of a Disaster Response Team at the Pentagon after September 11

Source: Walser, 2004, pp. 4–5.

of working with clients with trauma-related disorders include talking with colleagues about difficult clinical situations, attending workshops, participating in social activities with family and friends, exercising, limiting client sessions, balancing caseloads to include clients with and without trauma histories, making sure to take vacations, taking breaks during the workday, listening to music, walking in nature, and seeking emotional support in both their personal and professional lives (Saakvitne et al., 1996). In addition, regular clinical supervision and personal psychotherapy or counseling can be positive coping strategies for lessening the impact of STS on counselors. Still, each counselor is unique, and a self-care approach that is helpful to one counselor may not be helpful to another. Exhibits 2.2-13 and 2.2-14 offer tools for self-reflection to help counselors discover which specific self-care activities might best suit them. The worksheet can be used privately by counselors or by clinical supervisors as an exercise in individual supervision, group supervision, team meetings, or trainings on counselor self-care.

Exhibit 2.2-13: Comprehensive Self-Care Plan Worksheet

Name: Date:	Personal	Professional/Workspace
Physical		
Psychological/Mental		
Emotional/Relational		
Spiritual		

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Review the questions in Exhibit 2.2-14, and then write down specific self-care strategies in the form (given in Exhibit 2.2-13) that you're confident you will practice in both personal and professional realms.

The *Comprehensive Self-Care Worksheet* is a tool to help counselors (and clinical supervisors) develop awareness of their current coping strategies and where in the four domains they need to increase their engagement in self-care activities. Once completed, clinical supervisors should periodically review the plan with their supervisees for effectiveness in preventing and/or ameliorating secondary traumatization and then make adjustments as needed.

Essential Components of Self-Care

Saakvitne and colleagues (1996) describe three essential components, the "ABCs," of self-care that effectively address the negative impact of secondary traumatization on counselors:

1. **Awareness** of one's needs, limits, feelings, and internal/external resources. Awareness involves mindful/nonjudgmental attention to one's physical, psychological, emotional, and spiritual needs. Such attention requires quiet time and space that supports self-reflection.
2. **Balance** of activities at work, between work and play, between activity and rest, and between focusing on self and focusing on others. Balance provides stability and helps counselors be more grounded when stress levels are high.
3. **Connection** to oneself, to others, and to something greater than the self. Connection decreases isolation, increases hope, diffuses stress, and helps counselors share the burden of responsibility for client care. It provides an anchor that enhances counselors' ability to witness tremendous suffering without getting caught up in it.

Exhibit 2.2-14: Comprehensive Self-Care Plan Worksheet Instructions

Use the following questions to help you engage in a self-reflective process and develop your comprehensive self-care plan. Be specific and include strategies that are accessible, acceptable, and appropriate to your unique circumstances. Remember to evaluate and revise your plan regularly.

Physical
What are non-chemical things that help my body relax?
What supports my body to be healthy?

Psychological/Mental
What helps my mind relax?
What helps me see a bigger perspective?
What helps me break down big tasks into smaller steps?
What helps me counteract negative self-talk?
What helps me challenge negative beliefs?
What helps me build my theoretical understanding of trauma and addictions?
What helps me enhance my counseling/helping skills in working with traumatized clients?
What helps me become more self-reflective?

Emotional/Relational
What helps me feel grounded and able to tolerate strong feelings?
What helps me express my feelings in a healthy way?
Who helps me cope in positive ways and how do they help?
What helps me feel connected to others?
Who are at least three people I feel safe talking with about my reactions/feelings about clients?
How can I connect with those people on a regular basis?

Spiritual
What helps me find meaning in life?
What helps me feel hopeful?
What sustains me during difficult times?
What connects me to something greater?

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Clinical supervisors can help counselors review their self-care plans through the ABCs by reflecting on these questions:

1. Has the counselor accurately identified his or her needs, limits, feelings, and internal and external resources in the four domains (physical, psychological/mental, emotional/relational, spiritual)?
2. Has the counselor described self-care activities that provide a balance between work and leisure, activity and rest, and a focus on self and others?
3. Has the counselor identified self-care activities that enhance connection to self, others, and something greater than self (or a larger perspective on life)?

Supervisors should make their own self-care plans and review them periodically with their clinical supervisors, a peer supervisor, or a colleague.

Commitment to Self-Care

One of the major obstacles to self-care is giving in to the endless demands of others, both at work and at home. It is therefore essential for counselors with the support of clinical supervisors to become "guardians of [their] boundaries and limits" (Saakvitne et al., 1996, p 136). Creating a daily schedule that includes breaks for rest, exercise, connection with coworkers, and other self-care activities can support counselors in recognizing that they are valuable individuals who are worthy of taking the time to nourish and nurture themselves, thus increasing commitment to self-care. Another way to support counselors in committing to self-care is for supervisors and administrators to model self-care in their own professional and personal lives.

Understanding that counselor self-care is not simply a luxury or a selfish activity, but rather, an ethical imperative (Exhibit 2.2-15) can foster counselors' sense of connection to their own values and accountability to the people they serve as competent and compassionate caregivers. Clinical supervisors and administrators can reinforce this sense of accountability while supporting counselors by providing a caring, trauma-informed work environment

Exhibit 2.2-15: The Ethics of Self-Care

The Green Cross Academy of Traumatology was originally established to serve a need in Oklahoma City following the April 19, 1995, bombing of the Alfred P. Murrah Federal Building. Below are adapted examples of the Academy's code of ethics with regard to worker self-care.

Ethical Principles of Self-Care in Practice
These principles declare that it is unethical not to attend to your self-care as a practitioner, because sufficient self-care prevents harming those we serve.

Standards of self-care guidelines:
- Respect for the dignity and worth of self: A violation lowers your integrity and trust.
- Responsibility of self-care: Ultimately it is your responsibility to take care of yourself—and no situation or person can justify neglecting this duty.
- Self-care and duty to perform: There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care.

Standards of humane practice of self-care:
- Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self-care.
- Physical rest and nourishment: Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
- Emotional rest and nourishment: Every helper deserves emotional and spiritual renewal both in and outside the work context.
- Sustenance modulation: Every helper must utilize self-restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since improper consumption can compromise their competence as a helper.

Commitment to self-care:
- Make a formal, tangible commitment: Written, public, specific, measurable promises of self-care.
- Set deadlines and goals: The self-care plan should set deadlines and goals connected to specific activities of self-care.
- Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care.

Source: Green Cross Academy of Traumatology, 2010. Adapted with permission.

that acknowledges and normalizes secondary traumatization and by offering reasonable resources that make it possible for counselors to do their work and take care of themselves at the same time. Preventing secondary traumatization and lessening its impact on counselors once it occurs is not only cost-effective with regard to decreasing staff turnover and potential discontinuity of services to clients; it is also the ethical responsibility of a trauma-informed organization.

Appendices

Appendix A—Bibliography

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Appendix B—Trauma Resource List

Introduction

As it would be difficult to include every organization focused on trauma, the list of resources in this appendix is not exhaustive; consequently, this list does not include books or other materials concerning the vast nature of this topic, but rather, it concentrates solely on online resources accessible to the public for free or as part of an organization membership. The inclusion of selected resources does not necessarily signify endorsement by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Following these resources for adults is a list of resources focused on children and adolescents and a list of training opportunities.

Technology and Trauma: Using the Web To Treat PTSD

The role of the Internet in helping those who are experiencing posttraumatic stress disorder (PTSD) has expanded rapidly; there are numerous Web sites with toolkits and research publications for clinicians who treat clients with PTSD, as well as Web sites aimed at providing information and support for these individuals. The U.S. military has contributed to the field in developing these avenues—specifically, with interactive Web applications for use on home computers and smartphones.

- PTSD Coach is a smartphone application from the U.S. Department of Veterans Affairs (VA) to help people experiencing PTSD learn about and manage their symptoms (http://www.ptsd.va.gov/public/pages/ptsdcoach.asp).
- Afterdeployment.org is a Web site developed by the Defense Centers of Excellence project led by the National Center for Telehealth & Technology, with interactive workshops about PTSD, traumatic brain injury (TBI), anxiety, and depression, aimed at returning veterans (http://www.afterdeployment.org).
- T2 Virtual PTSD Experience, also developed by the National Center for Telehealth & Technology, is an application to be used within the popular online game Second Life as an interactive way of simulating how PTSD can be acquired within a combat environment, how PTSD may present itself to the person experiencing it, and how to seek effective treatment (http://www.t2health.org/vwproj).

Resources for Adults

Academy of Cognitive Therapy

http://www.academyofct.org
260 South Broad Street
18th Floor
Philadelphia, PA 19102
Phone: 267-350-7683
Email: info@academyofct.org

The Academy of Cognitive Therapy, a nonprofit organization, supports continuing education and research in cognitive therapy, provides a valuable resource in cognitive therapy for professionals and the public at large,

and actively works toward the identification and certification of clinicians skilled in cognitive therapy. Certification is awarded to those individuals who, based on an objective evaluation, have demonstrated an advanced level of expertise in cognitive therapy. The Academy includes physicians, psychologists, social workers, and other mental health professionals from around the world. The Academy formed a Trauma Task Force after September 11, 2001, to disseminate information (available on their Web site) to help people around the world receive the best help possible following trauma.

Addiction Technology Transfer Center Network

http://www.attcnetwork.org/index.asp
5100 Rockhill Road
Kansas City, MO 64110
Phone: 816-235-6888
Email: networkoffice@attcnetwork.org

The Addiction Technology Transfer Center (ATTC) Network serves as a resource for students and professionals to identify international distance education opportunities for the substance abuse treatment field and as a free marketing venue for ATTC-approved sponsors of distance education courses. The ATTC Web site provides trauma-related resources that include case studies, information on working with returning veterans who have been exposed to trauma, and links to various publications on PTSD and secondary traumatic stress.

Agency for Healthcare Research and Quality

http://www.innovations.ahrq.gov/index.aspx
540 Gaither Road
Suite 2000
Rockville, MD 20850
Phone: 301-427-1104

The Agency for Healthcare Research and Quality (AHRQ) is the research arm of HHS, specializing in patient safety and quality improvement, outcomes and effectiveness of care, clinical practice and technology assessment, and healthcare organization and delivery systems. AHRQ also provides funding and technical assistance to health research and research training programs at many universities and institutions. AHRQ's Web site provides links to research publications on PTSD and to other government publications and toolkits dealing with trauma-informed care.

The American Academy of Experts in Traumatic Stress

http://www.aaets.org
203 Deer Road
Ronkonkoma, NY 11779
Phone: 631-543-2217
Email: info@aaets.org

The American Academy of Experts in Traumatic Stress is a multidisciplinary network of professionals who are committed to the advancement of intervention for survivors of trauma. The Academy aims to identify expertise among professionals and across disciplines and to provide meaningful standards for those who work regularly with survivors. The Academy is committed to fostering a greater appreciation of the effects of common traumatic experiences (e.g., chronic illness, accidents, domestic violence, loss) in addition to large-scale disasters and catastrophes. The group's aim is to help all victims to become survivors and, ultimately, to thrive.

American Red Cross Disaster Services

http://www.redcross.org/what-we-do/disaster-relief
American Red Cross National Headquarters
2025 E Street, NW

Washington, DC 20006
Phone: 202-303-4498

Red Cross disaster relief focuses on meeting people's immediate emergency disaster-caused needs. When a disaster threatens or strikes, the Red Cross provides shelter, food, and health and mental health services to address basic human needs. In addition to these services, the core of Red Cross disaster relief is the assistance given to individuals and families affected by disaster to enable them to resume their normal daily activities independently. Training opportunities are also provided.

Anxiety and Depression Association of America

http://www.adaa.org
8701 Georgia Avenue #412
Silver Spring, MD 20910
Phone: 240-485-1001

The Anxiety and Depression Association of America (ADAA) is the only national, nonprofit membership organization dedicated to informing the public, healthcare professionals, and legislators that anxiety disorders are real, serious, and treatable. ADAA promotes the early diagnosis, treatment, and cure of anxiety disorders and is committed to improving the lives of the people who have them. The ADAA Web site provides information about the symptoms of PTSD and how it can be treated, in addition to offering a PTSD self-screening tool.

Association for Behavioral and Cognitive Therapies

http://www.abct.org
305 7th Avenue
16th Floor
New York, NY 10001
Phone: 212-647-1890
Fax: 212-647-1865

The Association for Behavioral and Cognitive Therapies is a professional, interdisciplinary organization concerned with the application of behavioral and cognitive science to understanding human behavior, developing interventions to enhance the human condition, and promoting the appropriate use of these interventions. The association's Web site includes resources for the public and for professionals on trauma and disaster-related problems, a clinical referral directory, and other resources and training opportunities in behavioral therapy.

Association of Traumatic Stress Specialists

http://www.atss.info
88 Pompton Avenue
Verona, NJ 07044
Phone: 973-559-9200
Email: Admin@atss.info

The Association of Traumatic Stress Specialists is an international membership organization that offers three distinct board certifications to qualified individuals who provide services, intervention, response, and/or treatment in the field of traumatic stress. The Association is dedicated to improving the quality of life of all individuals throughout the world who have been affected by traumatic events. Membership represents those who serve survivors of natural disasters, terrorist attacks, injuries and deaths related to serving in the line of duty or to school and workplace violence; veterans; refugees; victims of crime; Holocaust survivors; those affected and exploited by political persecution; and others who have experienced traumatic stress injuries.

Center for Anxiety and Related Disorders

http://www.bu.edu/card
648 Beacon Street
6th Floor

Boston, MA 02215
Phone: 617-353-9610

The Center for Anxiety and Related Disorders (CARD) at Boston University is a clinical and research center dedicated to advancing knowledge and providing care for anxiety, mood, eating, sleep, and related disorders. CARD's Web site offers information regarding PTSD and research publications on trauma and anxiety, in addition to linking to toolkits from the National Child Traumatic Stress Network's Adolescent Traumatic Stress and Substance Abuse Program.

Center for the Study of Traumatic Stress

http://www.cstsonline.org
Uniformed Services University of the Health Sciences
Department of Psychiatry
4301 Jones Bridge Road
Bethesda, MD 20814-4799
Phone: 301-295-2470
Fax: 301-319-6965

The Center for the Study of Traumatic Stress (CSTS) is a federally funded organization established by the Military Health System in 1987 to address Department of Defense concerns regarding health risks and concerns resulting from the traumatic impact of the use of weapons of mass destruction in combat, acts of terrorism and hostage events, combat and peacekeeping operations, natural disasters, and assaults or accidents occurring in both uniformed and civilian communities. CSTS primarily serves members of the armed forces, along with their children and families.

Center for Culture, Trauma and Mental Health Disparities

http://www.semel.ucla.edu/cctmhd
UCLA Semel Institute of Neuroscience & Biobehavioral Sciences
760 Westwood Plaza
Los Angeles, CA 90024
Phone: 310-794-9929

The Collaborative Center for Trauma and Mental Health Disparities at the University of California Los Angeles is a multiethnic and multidisciplinary group that focuses on conducting research and providing training that pertains to trauma in minority populations.

Council of State Governments Justice Center—Mental Health

http://csgjusticecenter.org/jc/category/mental-health
100 Wall Street
20th Floor
New York, NY 10005
Phone: 212-482-2320
Fax: 212-482-2344
Email: consensusproject@csg.org

The Consensus Project is part of the Council of State Governments Justice Center and partners with other organizations, such as SAMHSA's GAINS Center, working to improve outcomes for people, including juveniles, with mental illnesses involved with the criminal justice system. The Consensus Project offers a webinar on trauma services in the criminal justice system and on child trauma and juvenile justice, as well as a local programs database.

Dart Center for Journalism and Trauma

http://www.dartcenter.org
Columbia University
Graduate School of Journalism
2950 Broadway
New York, NY 10027
Phone: 212-854-8056

The Dart Center is dedicated to improving media coverage of trauma, conflict, and

tragedy. The Center also addresses the consequences of such coverage for those working in journalism and provides training and education via seminars, newsroom briefings and consultation on trauma issues, in addition to training for journalism educators and other trainers. The Dart Center Web site offers fact sheets, publications, and DVDs on request for use by journalists, educators, and clinicians.

David Baldwin's Trauma Information Pages

http://www.trauma-pages.com
Phone: 541-686-2598
Email: dvb@trauma-pages.com

This Web site focuses primarily on emotional trauma and traumatic stress, including PTSD and dissociation, whether following individual traumatic experience(s) or a large-scale disaster. The site's purpose is to provide information for clinicians and researchers in the traumatic stress field. Specifically, the focus is on both clinical and research aspects of trauma responses and their resolution.

Disaster Technical Assistance Center

http://www.samhsa.gov/dtac
9300 Lee Highway
Fairfax, VA 22031
Phone: 800-308-3515
Fax: 703-225-2338

SAMHSA has created the Disaster Technical Assistance Center (DTAC) to help States prepare for and respond to a wide range of potential catastrophes—both natural and human-caused disasters. DTAC primarily serves individuals and communities who are recovering from natural and human-caused disasters. It works in conjunction with the Federal Emergency Management Agency (FEMA) and SAMHSA's Emergency Mental Health and Traumatic Stress Services Branch, using strengths-based, outreach-oriented principles conducted in nontraditional settings, as a supplement to programs already in place on a local level.

EMDR Institute, Inc.

http://www.emdr.com
P.O. Box 750
Watsonville, CA 9507
Phone: 831-761-1040
Fax: 831-761-1204
Email: inst@emdr.com

Eye Movement Desensitization and Reprocessing (EMDR) is an information-processing therapy that uses an eight-phase approach. (See the description in Part 1, Chapter 6.) The Web site presents background and descriptive information about this approach to treatment and lists training opportunities, references, and networking groups.

The Federal Emergency Management Agency

http://www.fema.gov
500 C Street SW
Washington, DC 20472
Phone: 202-646-2500

The Federal Emergency Management Agency, a formerly independent agency that became part of the Department of Homeland Security in March 2003, is tasked with responding to, planning for, recovering from, and mitigating against disasters. FEMA can trace its beginnings to the Congressional Act of 1803. This Act, generally considered the first piece of disaster legislation, provided assistance to a New Hampshire town following an extensive fire. In the century that followed, ad hoc legislation was passed more than 100 times in response to hurricanes, earthquakes, floods, and other natural disasters.

The International Critical Incident Stress Foundation, Inc.

http://www.icisf.org
3290 Pine Orchard Lane
Suite 106
Ellicott City, MD 21042
Phone: 410-750-9600
Fax: 410-750-9601
Email: info@icisf.org

The International Critical Incident Stress Foundation, Inc., is a nonprofit, open-membership foundation dedicated to the prevention and mitigation of disabling stress through the provision of education, training, and support services for all emergency services professions; continuing education and training in emergency mental health services for psychologists, psychiatrists, social workers, and licensed professional counselors; and consultation in the establishment of crisis and disaster response programs for varied organizations and communities worldwide.

International Society for the Study of Trauma and Dissociation

http://www.issd.org
8400 Westpark Drive
Second Floor
McLean, VA 22102
Phone: 703-610-9037
Fax: 703-610-0234
Email: info@isst-d.org

The Society is a nonprofit professional association organized for the purposes of information sharing and international networking of clinicians and researchers; providing professional and public education; promoting research and theory about dissociation; and promoting research and training in the identification, treatment, and prevention of dissociative disorders. The Society offers courses in its Dissociative Disorders Psychotherapy Training Program.

The International Society for Traumatic Stress Studies

http://www.istss.org
111 Deer Lake Road
Suite 100
Deerfield, IL 60015
Phone: 847-480-9028
Fax: 847-480-9282

The International Society for Traumatic Stress Studies (ISTSS) was founded in 1985 for professionals to share information about the effects of trauma. ISTSS is dedicated to the discovery and dissemination of knowledge about policy, program, and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences. ISTSS provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma in the United States and around the world.

National Alliance on Mental Illness

http://www.nami.org
3803 N. Fairfax Dr.
Suite 100
Arlington, VA 22203
Phone: 703-524-7600
Fax: 703-524-9094

The National Alliance on Mental Illness (NAMI) is a nonprofit advocacy group founded in 1979 to raise awareness and provide essential and free education, advocacy, and support group programs for people living with mental illness and their loved ones. NAMI operates at the local, State, and national levels, with each level of the organizations providing education, information, support, and advocacy for those with mental illness and their support system. NAMI has developed a Trauma Toolkit and includes a series of lectures for mental health professionals about trauma.

National Association of State Alcohol and Drug Abuse Directors, Inc.

http://www.nasadad.org
1025 Connecticut Ave NW
Suite 605
Washington, DC 20036
Phone: 202-293-0090
Fax: 202-293-1250
Email: dcoffice@nasadad.org

The National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) is a private, not-for-profit educational, scientific, and informational organization. NASADAD's basic purpose is to foster and support the development of effective alcohol and drug abuse prevention and treatment programs throughout every State. NASADAD offers a policy brief with regards to trauma and substance use/abuse in the wake of natural or human-made disasters.

National Association of State Mental Health Program Directors

http://www.nasmhpd.org
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 703-739-9333
Fax: 703-548-9517

The National Association of State Mental Health Program Directors (NASMHPD; pronounced "NASH-pid") is a nonprofit organization dedicated to serving the needs of the Nation's public mental health system through policy development, information dissemination, and technical assistance. NASMHPD represents the $23 billion public mental health service delivery system. As a private, not-for-profit 501(c)(3) membership organization, NASMHPD helps set the agenda and determine the direction of State mental health agency interests across the country, historically including State mental health planning, service delivery, and evaluation. The principal programs operated, funded, and/or regulated by NASMHPD members serve people who have serious mental illnesses, developmental disabilities, and/or substance use disorders. NASMPHD has launched a Technical Assistance Coordinating Center in response to the Alternatives to Restraint and Seclusion State Infrastructure Grant Project, an initiative of SAMHSA's Center for Mental Health Services, designed to promote the implementation and evaluation of best practice approaches to preventing and reducing the use of seclusion and restraint in mental health settings.

National Center for Injury Prevention and Control

http://www.cdc.gov/injury
1600 Clifton Road
Atlanta, GA 30333
Phone: 800-232-4636
Email: cdcinfo@cdc.gov

The National Center for Injury Prevention and Control (NCIPC) was established by the Centers for Disease Control and Prevention in 1992. Through research, surveillance, implementation of evidence-based strategies, capacity building, and communication activities, NCIPC works to reduce morbidity, disability, mortality, and costs associated with injuries and violence. NCIPC is the lead U.S. Federal agency for nonoccupational injury prevention.

National Center for PTSD

http://www.ptsd.va.gov
810 Vermont Avenue NW
Washington, DC 20420
Phone: 802-296-6300
Email: ncptsd@va.gov

The National Center for PTSD (NCPTSD) was created within the Department of

Veterans Affairs in 1989 in response to a Congressional mandate to address the needs of veterans with military-related PTSD. Its mission is to advance the clinical care and social welfare of America's veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders. Its Web site is provided as an educational resource concerning PTSD and other enduring consequences of traumatic stress. The NCPTSD Web site has information about instruments to measure trauma exposure, risk and resilience factors for PTSD, self-report instruments, and interview schedules. Training opportunities are listed at http://www.ptsd.va.gov/about/training/training-programs.asp.

National Center for Telehealth and Technology

http://www.t2health.org
9933C West Hayes Street
Joint Base Lewis-McChord, WA 98431
Phone: 253-968-1914
Fax: 253-968-4192
Email: AskUs@t2health.org

The National Center for Telehealth and Technology is a Federal agency founded by the Department of Defense as part of the Military Health System. It primarily serves veterans and active-duty military personnel who are experiencing adverse health effects due to TBI and PTSD, as well as military children who are coping with their parents' deployment, through the use of technology (e.g., mobile phone applications, deployable telehealth centers).

National Center for Trauma-Informed Care

http://www.samhsa.gov/nctic
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 866-254-4819
Fax: 703-548-9517
Email: NCTIC@NASMHPD.org

The National Center for Trauma-Informed Care (NCTIC) is a Federal center established by SAMHSA in 2005 to offer consultation, technical assistance, education, outreach, and resources to support trauma-informed care in publicly-funded systems and programs. NCTIC primarily serves those who are already receiving services from the behavioral health system and is focused on helping behavioral health services and programs to become more aware of the impact of trauma among consumers, to adapt services to incorporate trauma-informed practices, and to help raise awareness of practices or processes that are more likely to retraumatize consumers.

National Center for Victims of Crime

http://www.victimsofcrime.org
2000 M Street NW
Suite 480
Washington, DC 20036
Phone: 202-467-8700
Fax: 202-467-8701
Email: webmaster@ncvc.org

The National Center for Victims of Crime (NCVC) is a nonprofit organization funded partially by Federal grants from the Department of Justice. It was founded in 1985 and originally known as the Sunny Von Bulow National Victim Advocacy Center. NCVC is a resource center for those affected by violent crimes and also provides training and education for behavioral health service providers.

National Center on Domestic Violence, Trauma & Mental Health

http://www.nationalcenterdvtraumamh.org/
Phone: 312-726-7020
Fax: 312-726-7022

The National Center on Domestic Violence, Trauma & Mental Health was established in 2005 through a grant from the Family Violence Prevention and Services Program, HHS. The Center's mission is to promote accessible, culturally relevant, and trauma-informed responses to domestic violence and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being; this is achieved by providing training and online resources to mental health and substance abuse treatment providers and developing policies to improve system responses to domestic violence survivors and their children.

National Center on Elder Abuse

http://www.ncea.aoa.gov
University of California–Irvine
Program in Geriatric Medicine
101 The City Drive South, 200 Building
Orange, CA 92868
Phone: 855-500-3537
Email: ncea-info@aoa.hhs.gov

The National Center on Elder Abuse (NCEA), part of the U.S. Administration on Aging, serves as a national resource center dedicated to the prevention of elder mistreatment. NCEA provides information to both mental health professionals and the general public and also provides technical assistance and training to States and community-based organizations.

National Center on Family Homelessness

http://www.familyhomelessness.org
200 Reservoir Street
Suite 200
Needham, MA 02494
Phone: 617-964-3834
Fax: 617-244-1758
Email: info@familyhomelessness.org

The National Center on Family Homelessness (NCFH) was founded in 1988 and is a nonprofit organization that conducts research and creates public awareness about the special needs of families experiencing homelessness. NCFH primarily serves veterans who are homeless and their families and young mothers who are homeless with their children. NCFH has developed a Trauma-Informed Organizational Toolkit for Homeless Services.

National Coalition Against Domestic Violence

http://www.ncadv.org
1 Broadway
Suite B210
Denver, CO 80203
Phone: 303-839-1852
Fax: 303-831-9251
Email: mainoffice@ncadv.org

The National Coalition Against Domestic Violence (NCADV) is an advocacy group founded in 1978 and acts as a national information and referral center for the general public, media, survivors of domestic violence and their children, and allied and member agencies and organizations. NCADV also works to influence legislation that would provide protection for survivors of domestic violence and their families and provide funding to shelters, healthcare centers, and other organizations.

National Council for Behavioral Health

http://www.thenationalcouncil.org
1701 K Street NW
Suite 400
Washington, DC 20006
Phone: 202-684-7457
Email: communications@thenationalcouncil.org

The National Council for Behavioral Health is a national community behavioral health

advocacy organization, formed in 1970, to conduct Federal advocacy activities, representing the industry on Capitol Hill and before Federal agencies. It also offers a national consulting service program, various publications, and an annual training conference. The National Council Magazine, 2011, Issue 2, focuses on trauma-informed behavioral health services. The National Council has offered a Learning Community for Adoption of Trauma-Informed Practices, funded by SAMHSA.

National Institute on Drug Abuse

http://drugabuse.gov
National Institute on Drug Abuse
National Institutes of Health
6001 Executive Boulevard
Room 5213, MSC 9561
Bethesda, MD 20892-9561
Phone: 301-443-1124
Email: information@nida.nih.gov

The National Institute on Drug Abuse's (NIDA) mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. NIDA's goal is to ensure that science, not ideology or anecdote, forms the foundation for all of the Nation's drug abuse reduction efforts. NIDA was established in 1974, and in October 1992 it became part of the National Institutes of Health (NIH), HHS. The Institute is organized into divisions and offices, each of which plays an important role in programs of drug abuse research. NIDA has an ongoing research program on women's health and sex/gender differences, including the gathering of information on trauma and substance abuse.

National Institute of Mental Health

http://www.nimh.nih.gov
National Institute of Mental Health
Science Writing, Press, and Dissemination Branch
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: 301-443-4513
Fax: 301-443-4279
Email: nimhinfo@mail.nih.gov

The National Institute of Mental Health (NIMH) is one of the 27 component institutes of NIH, the Federal Government's principal biomedical and behavioral research agency that is part of HHS. NIMH's mission is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior. This public health mandate demands that NIMH use science to achieve better understanding, treatment, and eventually, prevention of these disabling conditions that affect millions of Americans. NIMH offers publications and podcasts related to traumatic events and PTSD.

National Registry for Evidence-Based Programs and Practices

http://www.nrepp.samhsa.gov
Phone: 866-436-7377
Email: nrepp@samhsa.hhs.gov

SAMHSA's National Registry for Evidence-Based Programs and Practices (NREPP) is a searchable online registry of more than 300 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. NREPP offers several interventions that address trauma and PTSD.

National Sexual Violence Resource Center

http://www.nsvrc.org
123 North Enola Drive
Enola, PA 17025
Phone: 717-909-0710
Fax: 717-909-0714

The National Sexual Violence Resource Center (NSVRC) was founded by the Pennsylvania Coalition Against Rape in 2000 and is partially federally funded by grants from the Centers for Disease Control and Prevention. NSVRC advocates for changes in Federal and State legislation to further the goal of ending sexual violence in all communities, in addition to collecting and disseminating a wide range of resources on sexual violence, including statistics, research, position statements, statutes, training curricula, prevention initiatives and program information. NSVRC does not provide direct services to survivors of sexual violence but acts as a resource to support these services.

National Trauma Consortium

http://www.nationaltraumaconsortium.org
520 Ralph Street
Sarasota, FL 34242
Phone: 941-312-9795

The National Trauma Consortium (NTC) is a clearinghouse for information about trauma and emerging best practices in trauma treatment and services and, in addition, offers training and consultation services. NTC also provides resources in the form of downloadable publications and links to other organizations related to mental health and trauma.

National Voluntary Organizations Active in Disasters

http://www.nvoad.org
1501 Lee Highway
Suite 170
Arlington, VA 22209-1109
Phone: 703-778-5088
Fax: 703-778-5091
Email: info@nvoad.org

National Voluntary Organizations Active in Disasters (NVOAD) coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective service and less duplication by getting together before disasters strike. Once disasters occur, NVOAD or an affiliated State VOAD encourages members and other voluntary agencies to convene on site. This cooperative effort has proven to be the most effective way for a wide variety of volunteers and organizations to work together in a crisis. NVOAD's principles are cooperation, coordination, communication, education, mitigation, convening mechanisms, and outreach.

Office for Victims of Crime Training and Technical Assistance Center

https://www.ovcttac.gov/
9300 Lee Highway
Fairfax, VA 22031-6050
Phone: 866-682-8822
TTY: 866-682-8880
Fax: 703-279-4673
Email: TTAC@ovcttac.org

The Office for Victims of Crime Training and Technical Assistance Center provides comprehensive, quality technical assistance and training resources to victims' service providers and allied professionals. Its mission is to support the development of the field by increasing the Nation's capacity to provide crime victims with skilled, capable, and sensitive assistance. Its core functions are needs assessment, capacity building, evaluation, and reporting.

Rape, Abuse & Incest National Network

http://www.rainn.org
1220 L Street NW
Suite 505
Washington, DC 20005
Phone: 202-544-1034
Email: info@rainn.org

The Rape, Abuse & Incest National Network (RAINN) is a nonprofit organization, founded in 1994, that is partially funded by a grant from the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. RAINN provides support for survivors of sexual assault via a telephone hotline and an online hotline and works with the Department of Defense (DoD) to provide a hotline for members of the DoD community who have experienced sexual assault.

SAMHSA's Tribal Training and Technical Assistance Center

http://beta.samhsa.gov/tribal-ttac
201 Corporate Drive
Suite 800
Landover, MD 20785
Phone: 240-650-0257
Email: TA-Request@tribaltechllc.com

SAMHSA's Tribal Training and Technical Assistance Center (Tribal TTAC) is committed to providing comprehensive broad, focused, and/or intensive training and technical assistance to federally recognized Tribes and other American Indian and Alaska Native communities seeking to address and prevent mental and substance use disorders and suicide while promoting mental health. The goal of the Tribal TTAC is to use a culturally relevant, evidence-based, holistic approach to support Native communities in their self-determination efforts through infrastructure development, capacity building, and program planning and implementation.

Sanctuary Model

http://www.sanctuaryweb.com
Phone: 888-538-3124

The goals of the Sanctuary Model include increasing the perceived sense of community/cohesiveness; the degree of social immunity to the spread of violence; the capacity for social learning; the making of decisions democratically and the sharing of responsibility in solving problems and resolving conflicts; the ability to deal with complexity; opportunities for all clients and staff members to experience a truly safe and connected community; opportunities for troubled clients to have corrective emotional, relational, and environmental experiences; and recovery, healing, and growth.

Seeking Safety

http://www.seekingsafety.org
Treatment Innovations
28 Westbourne Road
Newton Centre, MA 02459
Phone: 617-299-1610
Fax: 617-701-1295
Email: info@seekingsafety.org

This Web site provides information about Seeking Safety, a psychotherapeutic intervention for treating trauma, PTSD, and substance abuse. Seeking Safety is a present-focused therapy to help people attain safety from both PTSD and substance abuse. The treatment is also available as a book, which provides both client handouts and guidance for clinicians. The site includes topics included in the treatment program, sample materials, relevant empirical studies, and supplementary articles.

Sidran Institute

http://www.sidran.org
P.O. Box 436
Brooklandville, MD 21022-0436
Phone: 410-825-8888
Fax: 410-560-0134
Email: info@sidran.org

The Sidran Institute is a nationally focused nonprofit organization devoted to helping people who have experienced traumatic life events through education and advocacy. The Institute's education and advocacy focuses on:

- The early recognition and treatment of trauma-related stress in children.
- The understanding of trauma and its long-term effect on adults.
- The strategies in engaging in mutual-help recovery for trauma survivors.
- The clinical methods and practices leading in aiding trauma victims.
- The development of public policy initiatives responsive to the needs of adult and child survivors of traumatic events.

Substance Abuse and Mental Health Services Administration

http://www.samhsa.gov
1 Choke Cherry Lane
Rockville, MD 20857
Phone: 877-726-4727
Fax: 240-221-4292
Email: SAMHSAInfo@samhsa.hhs.gov

SAMHSA is the Federal agency within HHS charged with improving the quality and availability of prevention, treatment, and rehabilitative services to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness. The Emergency Mental Health and Traumatic Stress Services Branch, a branch of SAMHSA's Center for Mental Health Services, works with FEMA to provide crisis counseling training and technical assistance to State and local mental health professionals. SAMHSA offers several publications regarding trauma and PTSD, as well as a publication focusing on creating a seclusion-free and restraint-free environment.

Traumatic Stress Institute

http://www.traumaticstressinstitute.org
Klingberg Family Centers
370 Linwood Street
New Britain, CT 06052
Phone: 860-224-9113

The Traumatic Stress Institute (TSI) works to increase understanding of the psychological impact of trauma and to help victims of violence restore meaning and wholeness to their lives. In meeting these goals, TSI is involved in clinical service, professional training, community education, and research. TSI offers forensic assessment and expert testimony, professional education, training opportunities, and publications. TSI developed the "Risking Connections" trauma treatment program and provides training in the use of this model.

Tulane University Traumatology Institute

http://sites.google.com/site/charlesfigley/Home/traumatologyinstitute
Tulane School of Social Work
6823 St. Charles Ave., Building 9
New Orleans, LA 70118
Phone: 800-631-8234
Email: figley@tulane.edu

The Traumatology Institute, founded in 1996, brings together health and mental health professionals from a wide array of disciplines from throughout the United States and around the world to develop cutting-edge research, treatment approaches, and training programs in the field of traumatology. The Institute facilitates the development of knowledge about the traumatization experience of victims, survivors, and the professionals who serve them. The Traumatology Institute conducts research, education, and service activities toward reducing the deleterious effects of trauma on individuals, families, communities, and entire societies.

Veterans Affairs PTSD Support Services

http://www.ptsdsupport.net/va.html
P.O. Box 5574
Woodland Park, CO 80866
Email: russ@ptsdsupport.net

The Department of Veterans Affairs Medical Centers provide a network of more than 100 specialized programs for veterans with PTSD, working closely in conjunction with the Veterans Web Site (http://www.vetcenter.va.gov) operated by VA's Readjustment Counseling Service. Each specialized PTSD program offers veterans education, evaluation, and treatment conducted by mental health professionals from a variety of disciplines (such as psychiatry, psychology, social work, counseling, and nursing). See also: National Center for PTSD.

White Bison Wellbriety Training Institute

http://www.whitebison.org
701 N. 20th Street
Colorado Springs, CO 80904
Phone: 877-871-1495
Email: info@whitebison.org

White Bison is an American Indian nonprofit charitable organization that focuses on offering sobriety, recovery, addictions prevention, and wellness/Wellbriety learning resources to the Native American community nationwide. White Bison's Wellbriety Training Institute provides training, tools, and resources for historical and intergenerational trauma to trainers and mental health professionals.

Resources for Children and Adolescents

The following section provides resources that address the needs of children and adolescents who are affected by traumatic stress.

American Academy of Child & Adolescent Psychiatry

http://www.aacap.org
3615 Wisconsin Avenue NW
Washington, DC 20016-3007
Phone: 202-966-7300
Fax: 202-966-2891

The American Academy of Child & Adolescent Psychiatry (AACAP) is a national professional medical association dedicated to treating and improving the quality of life for children, adolescents, and families affected by mental, behavioral, and developmental disorders. AACAP distributes information to promote an understanding of mental illnesses and remove the shame associated with them, to advance efforts in prevention of mental illnesses, and to ensure proper treatment and access to services for children and adolescents.

American Professional Society on the Abuse of Children

http://www.apsac.org
350 Poplar Avenue
Elmhurst, IL 60126
Phone: 630-941-1235
Fax: 630-359-4274
E-mail: apsac@apsac.org

The mission of the American Professional Society on the Abuse of Children (APSAC) is to enhance the ability of professionals to respond to children and families affected by abuse and violence. Among other initiatives, APSAC provides education and other sources of information to professionals who work in the child maltreatment and related fields.

Anna Institute

http://www.theannainstitute.org
21 Ocean Street
Rockland, ME 04841
Email: afj@gwi.net

The Anna Institute was founded in memory of artist Anna Caroline Jennings; it focuses on educating both the public and mental health professionals about the effects of sexual abuse and trauma on children. The Anna Institute's Web site provides articles on incorporating

trauma-informed care into existing behavioral health models, presentations on childhood trauma and retraumatization, and handouts for teachers at primary and secondary schools.

Caring for Every Child's Mental Health Campaign

http://www.samhsa.gov/children
P.O. Box 2345
Rockville, MD 20847-2345
Email: nmhic-info@samhsa.hhs.gov

SAMHSA's Caring for Every Child's Mental Health communications campaign is a national public information and education operation. Its goals are to increase public awareness about the importance of protecting the mental health of young people; foster the recognition that many children have mental health problems; and encourage caregivers to seek early, appropriate treatment and services. It also strives to reduce discrimination associated with mental health problems. The campaign is a technical assistance program that is part of the Comprehensive Community Mental Health Services Program for Children and Their Families.

Child Study Center

http://www.aboutourkids.org
One Park Avenue
7th Floor
New York, NY 10016
Phone: 212-263-6622
Email: webmaster@aboutourkids.org

The New York University Child Study Center Web site offers information to parents of children and adolescents with learning, behavioral, and emotional disorders, including PTSD and substance use disorders. An online newsletter is available. Its research initiatives advance understanding of the causes and treatments of child mental disorders, and these findings are integrated into clinical care to provide state-of-the-art service.

Child Trauma Academy

http://www.childtrauma.org
5161 San Felipe
Suite 320
Houston, TX 77056
Phone: 866-943-9779
Email: cta@childtrauma.org

The mission of the Child Trauma Academy is to help improve the lives of traumatized and maltreated children. Through education, service delivery, and program consultation, the academy seeks to advance systems that educate, nurture, protect, and enrich these children.

Child Trauma Institute

http://www.childtrauma.com
P.O. Box 544
Greenfield, MA 01302-0544
Phone: 413-774-2340
Email: cti@childtrauma.com

The Child Trauma Institute provides training, consultation, information, and resources for those who work with trauma-exposed children, adolescents, and adults. The Web site has information for parents, publications for parents and professionals, and links to other child trauma Web sites.

Child Welfare Information Gateway

http://www.childwelfare.gov
Children's Bureau/ACYF
1250 Maryland Avenue SW
Eighth Floor
Washington, DC 20024
Phone: 800-394-3366
Email: info@childwelfare.gov

The Child Welfare Information Gateway (CWIG) is a service of the Children's Bureau in the Administration for Children and Families, part of HHS, which provides information

to child welfare and mental health professionals about programs, research, laws and policies, training approaches, and statistics regarding child welfare, child abuse and neglect, and adoption. CWIG offers educators' toolkits for preventing and responding to child abuse and neglect, a function to search State statutes about child abuse and neglect, and logic model builder toolkits for program administrators.

Child Welfare League of America

http://www.cwla.org
1726 M Street NW
Suite 500
Washington DC, 20036
Phone: 202-688-4200
Fax: 202-833-1689

Through its member child welfare agencies, the Child Welfare League of America develops and disseminates practice standards as benchmarks for high-quality services that protect children and youth; promotes high-quality services through training, consultation, conferences, and publications; formulates and promotes public policies that contribute to the well-being of children and youth; ensures that all child welfare services are provided in a manner that demonstrates respect for cultural and ethnic diversity; and promotes open exchange of data, resources, and ideas within and across systems that serve children, youth, and families.

Eunice Kennedy Shriver National Institute of Child Health and Human Development

http://www.nichd.nih.gov/Pages/index.aspx
31 Center Drive
Building 31, Room 2A32
Bethesda, MD 20892-2425
Phone: 800-370-2943

Established in 1962, NIH's National Institute of Child Health and Human Development (NICHD) focuses on human development processes from conception to later years. The Institute implements, conducts, and supports laboratory research, clinical trials, epidemiological research, and other studies that explore health processes and the impact of disabilities, diseases, and variations on the lives of individuals. NICHD sponsors training for scientists and healthcare providers to promote the goals of the Institute.

National Center for Children Exposed to Violence

http://www.nccev.org
Yale Child Study Center
230 South Frontage Road
P.O. Box 207900
New Haven, CT 06520-7900
Phone: 877-496-2238
Email: colleen.vadala@yale.edu

The National Center for Children Exposed to Violence (NCCEV) seeks to increase the capacity of individuals and communities to reduce the incidence and impact of violence on children and families; to train and support the professionals who provide intervention and treatment; and to increase professional and public awareness of the effects of violence on children, families, communities, and society. The Center's Web site is a rich source of information. NCCEV is supported by grants from the Office of Juvenile Justice and Delinquency Prevention, the Department of Justice, SAMHSA, and the Department of Education.

National Center on Substance Abuse and Child Welfare

http://www.ncsacw.samhsa.gov
P.O. Box 2345
Rockville, MD 20847-2345
Phone: 866-493-2758
Email: ncsacw@cffutures.org

The National Center on Substance Abuse and Child Welfare (NCSACW) is an initiative of HHS and is jointly funded by SAMHSA's Center for Substance Abuse Treatment and the Administration on Children, Youth and Families, Children's Bureau's Office on Child Abuse and Neglect. NCSACW seeks to develop and implement a comprehensive program of information gathering and dissemination, to provide technical assistance, and to develop knowledge that promotes effective practical, organizational, and systemic changes at the local, State, and national levels. Its Web site includes PowerPoint presentations, online tutorials and training, technical assistance presentations, and additional print resources.

National Child Traumatic Stress Network

http://www.nctsnet.org
NCTSN—University of California, Los Angeles
11150 W. Olympic Boulevard
Suite 650
Los Angeles, CA 90064
Phone: 310-235-2633
Fax: 310-235-2612

The National Child Traumatic Stress Network (NCTSN), currently comprising 54 treatment centers nationwide, is funded by SAMHSA's Center for Mental Health Services through the Donald J. Cohen National Child Traumatic Stress Initiative and coordinated by Duke University and the University of California, Los Angeles. The purpose of this congressionally mandated initiative is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. NCTSN works with SAMHSA to raise public awareness of the effects of traumatic stress on children and families, and with other systems of care (including the health, mental health, education, law enforcement, child welfare, juvenile justice, and military family service systems) to ensure that there is a comprehensive trauma-informed continuum of accessible care. Additionally, NCTSN offers a list of evidence-based and promising practices.

National Institute for Trauma and Loss in Children

http://www.starrtraining.org/trauma-and-children
42855 Garfield Road
Suite 111
Clinton Township, MI 48038
Phone: 877-306-5256
Fax: 586-263-4915
Email: TLC@starrtraining.org

The National Institute for Trauma and Loss in Children provides school professionals, crisis intervention teams, medical and mental health professionals, child care professionals, and clinicians with trauma education, training, consultation, referral services, and trauma-specific intervention programs and resource materials needed to help those traumatized by violent or nonviolent trauma-inducing incidents.

National Native Children's Trauma Center

http://iers.umt.edu/National_Native_Childrens_Trauma_Center
Institute for Educational Research and Service
McGill Hall 026
The University of Montana
Missoula, MT 59812-6376
Phone: 406-243-5344
Fax: 406-243-2197
Email: iers@mso.umt.edu

The National Native Children's Trauma Center (NNCTC) is a federally funded organization created by SAMHSA and affiliated with the National Child Traumatic Stress Network. It

is run by the University of Montana. NNCTC offers trauma interventions and trainings to address trauma in American Indian/Alaska Native children, primarily through clinicians, Tribal programs, school systems, and community agencies.

Training Opportunities

The following resources highlight various training and credentialing opportunities for behavioral health professionals interested in gaining more education in treating and providing services to those affected by trauma. It is not an exhaustive list, but provides a starting place for service providers looking for further training.

The Web site of the ISTSS has posted a directory of trauma-related academic and training opportunities (http://www.istss.org/LearningAboutTrauma.htm). It includes links to the institutions providing the programs. The Association for Traumatic Stress Specialists (http://www.atss.info) offers three levels of recognition for education and experience:

- Certified Trauma Specialist (CTS)—designed for counselors, clinicians, and treatment specialists who provide intervention services or individual, group, and/or family counseling. This certification requires 240 hours of education and training in trauma treatment, plus 2,000 hours of trauma counseling and intervention experience.
- Certified Trauma Responder (CTR)—designed for those who provide immediate trauma interventions. It requires a minimum of 40 hours of experience on a crisis or critical incident response team, an associate degree or a high school diploma with successful completion of disaster or critical incident stress debriefing training, and 72 hours of crisis response training.
- Certified Trauma Services Specialist (CTSS)—designed for those who provide immediate trauma intervention, crisis support, advocacy, or victim assistance. It requires 1 year of experience in a trauma-related field, plus specific training.

Some colleges and universities, such as the International Trauma Studies Program at New York University and the Center for Anxiety and Related Disorders at Boston University, provide specialty trauma training for mental health practitioners. The University of Missouri at St. Louis offers specialized training in trauma therapy or research at its Center for Trauma Recovery to students in its Clinical Psychology graduate program. The Center for the Treatment and Study of Anxiety at the University of Pennsylvania provides training for health professionals. The Department of Counseling at the University of Nevada, Las Vegas offers a graduate and undergraduate course on Trauma and Addiction; graduate students can receive training in trauma and addictions as part of the Advanced Graduate Certificate in Addiction Studies. The Medical University of South Carolina offers Web-based courses in trauma-focused cognitive–behavioral therapy (TF-CBT) and in using TF-CBT for childhood traumatic grief. Many universities have faculty members with expertise in trauma and trauma-related subjects, so that training can be accessed through many graduate programs.

The Addiction Technology Transfer Center (ATTC) Network, a resource established in 1993 by the SAMHSA's Center for Substance Abuse Treatment, is a network of 14 independent regional centers with a national office. One of its programs provides long-distance education for clinicians on various topics. Among hundreds of self-paced, self-directed, and supervised courses available online (http://www.attcnetwork.org/learn/education/

dasp.asp) are Substance Abuse Treatment for Trauma Survivors, Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues, Chemical Dependency and Posttraumatic Stress Disorder, Clinical Self-Care for Addiction Counselors and Clinical Supervisors, Eye Movement Desensitization and Reprocessing, Battered Women and Addictions, and Posttraumatic Stress Disorder. ATTC training and educational opportunities are based on empirical research and are intended to bring science to service. Undoubtedly, more distance-learning courses in this specialized area of interest will be developed as professional attention to co-occurring disorders increases.

SAMHSA's Center for Mental Health Services provides training for FEMA-approved crisis counseling programs using Stafford Act funding. These funding resources are available to select agencies designated to provide crisis counseling in the wake of a Presidential Disaster Declaration. Other funding for trauma training may be found through special programs of funding for target groups, such as those who provide mental health services and case management for victims of crime (e.g., Office for Victims of Crime in the U.S. Department of Justice; see p. 257).

The American Red Cross provides limited disaster mental health training. The focus of this training is to orient licensed mental health professionals to the Red Cross Disaster services system and their roles as volunteers.

The National Center for Post-Traumatic Stress Disorder was originally created in 1989 within the U.S. Department of Veterans Affairs (VA) to address the needs of veterans with military-connected PTSD. Its focus has since broadened to include trauma in general. The Center provides a variety of training opportunities for both VA and non-VA mental health personnel, including a PTSD 101 course developed specifically for clinicians who provide services to clients who have experienced trauma (see http://www.ptsd.va.gov/professional/index.asp).

Seeking Safety offers training in trauma, PTSD, and co-occurring disorders to mental health professionals on all levels, from counselors to nurses to administrators. The EMDR International Association (EMDRIA) provides training to clinicians for certification in EMDR via a curriculum including instruction, supervised practicum, and consultation; EMDRIA additionally provides basic training in the field, separate from the certification process. EMDR training is also provided by the EMDR Humanitarian Assistance Program, a nonprofit organization with a training-focused model to assist clinicians in treating trauma.

ISTSS was founded in 1985 to bring attention to the study, assessment, and treatment of traumatized people (http://www.istss.org). ISTSS is a professional society and provides face-to-face training during its annual meeting, especially through the preconference institutes. The ISTSS Web site offers numerous video and audio trainings for continuing education credits. ISTSS and the Figley Institute (http://www.figleyinstitute.com) have established best practice standards. The American Academy of Experts in Traumatic Stress provides training and certification in several different areas (http://www.aaets.org). Similarly, the International Society for the Study of Dissociation (http://www.issd.org) specializes in promoting therapies for dissociative disorders. In 2002, the Green Cross Academy of Traumatology (http://www.greencross.org) established a Commission on Accreditation of Traumatology Education Programs to increase and maintain the high standards in the education and training of traumatologists.

Appendix C—Historical Account of Trauma

Historically, symptoms of traumatic stress have been recorded in both military and civilian populations (Lasiuk & Hegadoren, 2006). Early accounts described the effect of battle conditions on soldiers; "soldier's heart" and "nostalgia" were the terms for traumatic stress reactions used during the American Civil War. As warfare techniques and strategies changed, so did the depiction of soldiers' traumatic stress reactions. The advent of heavy explosives in World War I led to the attribution of symptoms to "shell shock," giving a more physiological description of the effects from explosions (Benedek & Ursano, 2009). On the civilian side, the industrial revolution gave rise to larger and more dramatic catastrophes, including industrial and railway accidents. These, as well as other disasters, are noted in occupational health histories, newspapers, and contemporary literature.

Even with a more physical explanation of traumatic stress (i.e., shell shock), a prevailing attitude remained that the traumatic stress response was due to a character flaw. For instance, a soldier's pain at that time was often seen as a symptom of homesickness. In spite of the efforts of Charcot, Janet, and Freud, who described the psychogenic origin of symptoms as a response to psychological trauma (Lasiuk & Hegadoren, 2006), World War II military recruits were screened in attempt to identify those "who were afflicted with moral weakness," which would prevent them from entering military service.

At the same time, there were new treatment innovations for war-related trauma during World War II. One approach treated soldiers in the field for what was then called "battle fatigue" by allowing some time for rest before returning to battle. During the Korean and Vietnam wars, approaches began to focus more on the use of talk therapy. It was not until the post-Vietnam era that interest in developing treatment alternatives started to take hold. During this time, the U.S. Department of Veterans Affairs (then called the Veterans Administration) developed group therapy for posttraumatic stress disorder (PTSD). Beyond being cost-effective, the technique was well suited to the symptoms of the veterans and fostered socialization and reintegration (Greene et al., 2004).

The publication of the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition (DSM-III), in 1980 marked the introduction of PTSD as a diagnosis, inspired by symptoms presented by veterans of the Vietnam War (Benedek & Ursano, 2009). The diagnosis in this iteration required the identification of a specific stressor—a catastrophic stressor that was outside the range of usual human experience (APA, 1980)—and classified PTSD as

Historical Approaches to Trauma Healing and Recovery

First Generation of Approaches to Trauma Healing and Recovery
The first generation approaches to trauma healing and recovery focused on individual and clinical interventions to address the symptoms of PTSD and moved toward integration of trauma effects into ongoing life activities. The rapidly developing recognition of additional groups with violence and trauma histories—beyond those with war and captivity experiences (e.g., survivors of natural disasters and terrorism, refugees and immigrants fleeing homeland violence and persecution)—presented issues and needs that incited a second generation of approaches to trauma healing and recovery.

Second Generation of Approaches to Trauma Healing and Recovery
The second generation approaches focused on psychosocial education and empowerment models designed to tap into self-healing forces to energize personal and social movement. These approaches often are based on group and peer support models, and provide both support and education on the management of trauma and its affects. These approaches are not designed to replace clinical or alternative therapies; rather, they provide a social context for care.

Concurrent to the development of psychosocial educational empowerment approaches, we also learned that if the approaches are not implemented in organizations or programs that are trauma-informed, they will not take root and may lose effectiveness.

Trauma-Informed Care: A New Paradigm for Public Health Services
Trauma-informed care is a new paradigm for organizing public mental health and human services. Trauma-informed care changes the opening question for those seeking services from "What is wrong with you?" (patient or consumer) to "What has happened to you?" (survivor). Trauma-informed care is initiated by assumption that every person seeking services is a trauma survivor who designs his or her own path to healing, facilitated by support and mentoring from the service provider.

In a trauma-informed environment, survivors are empowered to proactively set goals and to manage progress toward those goals. For most existing organizations or programs, that requires movement from a traditional "top down" hierarchical clinical model to a psychosocial empowerment partnership that embraces all possible tools and paths to healing. In a pluralistic public health system with many levels and types of services and treatment, this is coming to be accepted as a "sine qua non," or "without which not," for humane, dignified, cost-effective, genuinely person-centered support and assistance in moving forward.

Source: Salasin, 2011, p. 18.

an anxiety disorder (Lasiuk & Hegadoren, 2006). Beginning with this definition, the body of research grew, and the scope of application began to broaden, but not without considerable debate on what constituted a trauma.

The social revolution that began in the 1960s, combined with the women's movement and the call for more attention to diverse and disenfranchised groups, set the stage for an increase in the acknowledgement and treatment of victims of interpersonal violence and crime-related trauma (Figley, 2002). The introduction of rape trauma syndrome as a condition highlighted the psychological consequences of sexual assault and the subsequent lack of support from society and the social services system (Kramer & Green, 1997). Subsequently, research began to focus more on interpersonal violence, thus leading to the identification of risk factors and treatment approaches unique to this form of violence and trauma (Olff, Langeland, Drajer, & Gersons, 2007).

With input from international and national mental health organizations and research, the DSM-IV further modified the definition of trauma to include a broader interpretation of the identified stressor (Andreasen, 2010). DSM-5 has maintained the modified definition of trauma, but the criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly (APA, 2013b).

Paralleling the change in DSM criteria, cognitive–behavioral therapy for traumatic stress was developed along with other skills-based approaches (Greene et al., 2004).

Researchers, such as Foa, Resick, D'Zurilla, and Michenbaum, added to the body of knowledge and gave clinicians a variety of tools; these approaches continue to develop and show efficacy even today. There was also renewed interest in the long- and short-term effects of childhood sexual abuse and domestic violence. Interest in documenting the effects of trauma expanded further, including traumatic brain injury, significant orthopedic injuries, and multiple traumas (Starr et al., 2004). So too, the consumer movement in health care began. Consumers insisted on patient rights, humane treatment, and involvement in the treatment process; as a result, the paternalistic approach to health care began to change. As consumers set the initial stage and Federal agencies (e.g., the Substance Abuse and Mental Health Services Administration and its centers) and national organizations promoted the need for trauma-informed policies and care, national studies began to demonstrate the prevalence of traumatic experiences. Research including the Adverse Childhood Experiences and the Women, Co-Occurring, and Violence studies clearly demonstrated the pervasive long-term impact of trauma, reinforcing the call for trauma-informed policies and care. (For more information on the development of trauma-informed care, see Harris and Fallot, 2001b, as well as Jennings, 2004.)

Appendix D—Screening and Assessment Instruments

This appendix provides a selected sample of available tools for screening and assessment of traumatic events and trauma-related symptoms. This is not an exhaustive list, nor does this list focus on screening instruments that capture a broader range of symptoms related to trauma (such as sleep hygiene and dissociation) or other features important in providing trauma-informed care (e.g., resilience level, coping skill style, resource availability). For more information on a broad range of available instruments, refer back to Part 1, Chapter 4. Many of the instruments listed below use criteria found in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000), but with the release of the DSM-5 (APA, 2013a), instruments will evolve, and new versions will be available under the same contact information.

Screening and Assessment Measures

- Clinician Administered PTSD Scale (CAPS)
- Davidson Trauma Scale (DTS)
- Distressing Event Questionnaire (DEQ)
- Evaluation of Lifetime Stressors (ELS)
- Impacts of Event Scale Revised (IES-R)
- Mississippi Scale for Combat-Related PTSD (M-PTSD)
- Penn Inventory for Posttraumatic Stress Disorder
- Posttraumatic Diagnostic Scale (PDS)
- PTSD Symptom Scale-Interview (PSS-I)
- PTSD Symptom Scale: Self-Report Version (MPSS-SR)
- Screen for Posttraumatic Stress Symptoms (SPTSS)
- Structured Interview for PTSD (SI-PTSD)
- Trauma Assessment for Adults (TAA)
- Trauma Assessment for Adults (TAA)–Self Report
- Trauma History Questionnaire (THQ)
- Trauma Symptom Inventory (TSI)
- Traumatic Stress Schedule

Screening and Assessment Measures

Clinician Administered PTSD Scale (CAPS)

Domains:	Posttraumatic stress disorder (PTSD), acute stress disorder (ASD)
Timeframe:	CAPS-Sx: Lifetime and current (past week) CAPS-Dx: Current (past month)
Response format:	Other
Format of administration:	Structured
Number of items:	30
Completion time:	30–60 minutes
Qualifications to administer:	Administered by clinicians and clinical researchers who have a working knowledge of PTSD and by appropriately trained paraprofessionals
How to obtain scale:	Contact Danny G. Kaloupek, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: veterans, car accident survivors Reliability: alpha = .94, test-retest = .90–.98 Validity: sensitivity = .85, specificity = .95 (compared with Structured Clinical Interview for DSM Disorders [SCID]), r = .91 (with MS Scale for Combat-related PTSD) kappa = .77 against the SCID diagnosis; item-total correlations = .49–.82; internal consistency = .94
Author(s):	Dudley David Blake, Frank W. Weathers, Linda M. Nagy, Danny G. Kaloupe, Dennis S. Charney, and Terence M. Keane
Contact:	Danny G. Kaloupek, Ph.D. National Center for PTSD Boston VA Medical Center, 11B 150 South Huntington Avenue Boston, MA 02130
Relevant citations:	Blake, D. D. (1994). Rationale and development of the clinician-administered PTSD scales. *PTSD Research Quarterly, 5,* 1–2. Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8*, 75–90.

Gray, M., Litz, B., Hsu, J., & Lombardo, T. (2004). Psychometric properties of the Life Events Checklist. *Assessment, 11*, 330–341.

Weathers, F. W., Keane, T. M., & Davidson, J. R. (2001). Clinician-Administered PTSD Scale: A review of the first ten years of research. *Depression and Anxiety, 13*, 132–156.

Davidson Trauma Scale (DTS)

Domains:	PTSD symptoms
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument. Education/training requirements may be waived for those granted the right to administer tests at this level (B) in their jurisdiction.
How to obtain scale:	Contact Mental Health Systems, Inc.
Cost or public domain:	Cost: $15.00
Psychometrics:	Populations sampled: rape victims, veterans, hurricane victims, miscellaneous traumas Reliability: alpha = .99, test-retest = .86
Author(s):	Jonathan R.T. Davidson
Contact:	Mental Health Systems, Inc. 908 Niagara Falls Boulevard North Tonawanda, NY, 14120-2060 800-456-3003
Relevant citations:	Davidson, J. R. T., Book, S. W., Colket, J. T., Tupler, L. A., Roth, S., David, D., Hertzberg, M., Mellman, T., Beckham, J.C., Smith, R., Davison, R. M., Katz, R., & Feldman, M. (1997). Assessment of a new self-rating scale for posttraumatic stress disorder. *Psychological Medicine, 27,* 153–160. Davidson, J. R., Tharwani, H. M., & Connor, K. M. (2002). Davidson Trauma Scale (DTS): Normative scores in the general population and effect sizes in placebo-controlled SSRI trials. *Depression and Anxiety, 15*, 75–78.

Distressing Event Questionnaire (DEQ)

Domains:	Posttraumatic Stress Disorder (PTSD) for multiple events
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact Edward Kubany, Ph.D.
How to obtain scale:	Contact Edward Kubany, Ph.D.
Cost or public domain:	Contact Edward Kubany, Ph.D.
Psychometrics:	Population sampled: veterans, battered women Reliability: inter-item r = .93, test-retest = .95; validity: Pearson's r reliability coefficient = .83 (with Penn Inventory, Pearson's r reliability coefficient = .76 (with Beck Depression Inventory)
Author(s):	Edward Kubany, Mary Beth Leisen, Aaron S. Kaplan, Martin P. Kelly
Contact:	Edward Kubany, Ph.D. National Center for PTSD Pacific Islands Division Department of VA Suite 307 Honolulu, HI 96813 Kubany.Edward@honolulu.va.gov
Relevant citations:	Kubany, E. S., Leisen, M. B., Kaplan, A. S., & Kelly, M. P. (2000). Validation of a brief measure of posttraumatic stress disorder: The distressing event questionnaire (DEQ). *Psychological Assessment, 12*, 197–209.

Evaluation of Lifetime Stressors (ELS)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	56
Completion time:	10–20 minutes for screening, 1–3 hours for complete interview
Qualifications to administer:	Should be administered by trained clinicians only

How to obtain scale:	Contact Karen Krinsley, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: male veterans, female sexual abuse survivors Reliability: r = .4–1.0
Author(s):	Karen Krinsley, Frank W. Weathers, Elana Newman, Edward A. Walker, Danny G. Kaloupek, Rachel Kimerling
Relevant citations:	Corcoran, C. B., Green, B. L., Goodman, L. A., & Krinsley, K. E. (2000). Conceptual and methodological issues in trauma history assessment. In A. Y. Shalev, R. Yehuda, & A. C. McFarlane (Eds.), *International handbook of human response to trauma* (pp. 22–232). Dordrecht, Netherlands: Kluwer Academic Publishers. Krinsley, K. (1996). Psychometric review of the Evaluation of Lifetime Stressors (ELS) Questionnaire and Interview. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation (*pp. 160–162). Lutherville, MD: Sidran Press.

Impact of Event Scale Revised (IES-R)

Domains:	PTSD for a single event
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	22
Completion time:	5–10 minutes for screening
Qualifications to administer:	None
How to obtain scale:	http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: earthquake survivors, emergency disaster workers, Vietnam veterans, violence and sexual assault victims Reliability: alpha = .79–.92, test-retest = .89–.94, Pearson's r reliability coefficient = .74–.87
Author(s):	Daniel Weiss and Charles R. Marmar
Relevant citations:	Sundin, E. C. & Horowitz, M. J. (2002). Impact of Event Scale: Psychometric properties. *British Journal of Psychiatry, 180,* 205–209. Weiss, D. S. & Marmar, C. R. (1996).The Impact of Event Scale-Revised. In J. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399–411). New York: Guilford Press. (Includes measure in its entirety.)

Mississippi Scale for Combat-Related PTSD (M-PTSD)

Domains:	PTSD for multiple events
Timeframe:	Contact National Center for PTSD at ncptsd@ncptsd.org
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact National Center for PTSD at ncptsd@va.gov
How to obtain scale:	To order the scale contact the National Center for PTSD
Cost or public domain:	Free (ncptsd@va.gov)
Psychometrics:	Population sampled: veterans Reliability: inter-item r = .94, test-retest = .97 Validity: sensitivity = .93, specificity = .89
Author(s):	Terence M. Keane
Contact:	National Center for PTSD (116D) VA Medical Center 215 N. Main St. White River Junction, VT 05009 http://www.ptsd.va.gov/
Relevant citations:	Engdahl, B. & Eberly, R. (1994). Assessing PTSD among veterans exposed to war trauma 40–50 years ago. *NCP Clinical Quarterly, 4,* 13–14. Keane, T. M., Caddell, J. M., & Taylor, K. L. (1988). Mississippi Scale for Combat-Related Posttraumatic Stress Disorder: Three studies in reliability and validity. *Journal of Consulting and Clinical Psychology, 56,* 85–90.

Penn Inventory for Posttraumatic Stress Disorder

Domains:	PTSD for multiple events
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	26
Completion time:	5–15 minutes

Qualifications to administer:	Contact Melvyn Hammarberg, Ph.D.
How to obtain scale:	Contact Melvyn Hammarberg, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans, oil-rig disaster survivors Reliability: alpha = .94, test-retest = .96
Author(s):	Melvyn Hammarberg
Contact:	Melvyn Hammarberg, Ph.D. Department of Anthropology University of Pennsylvania 325 University Museum 33rd and Spruce Street Philadelphia, PA 19104-6398
Relevant citations:	Hammarberg, M. (1996). Psychometric review of the Penn Interview for Post Traumatic Stress Disorder. In B. H, Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 231–235). Lutherville, MD: Sidran Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Posttraumatic Diagnostic Scale (PDS)

Domains:	DSM-IV PTSD symptom clusters
Timeframe:	Current (past month)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	49
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact National Computer Systems (NCS)
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: accident/fire, disaster, assault, sexual assault, sexual abuse, major illness Reliability: alpha = .92, test-retest = .83 Validity: sensitivity = .89, specificity = .75

Author(s):	Edna B. Foa, Ph.D.
Contact:	National Computer Systems (NCS) 5605 Green Circle Drive Minnetonka, MN 55343
Relevant citations:	Foa, E. (1996). *Post-traumatic Diagnostic Scale manual*. Minneapolis, MN: National Computer Systems. Foa, E., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of PTSD: The Post-traumatic Diagnostic Scale (PDS). *Psychological Assessment, 9*, 445–451. Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

PTSD Symptom Scale-Interview (PSS-I)

Domains:	PTSD single event
Timeframe:	Current (past 2 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17
Completion time:	20 minutes
Qualifications to administer:	Can be administered by a master's level interviewer after a few hours of training.
How to obtain scale:	Contact Edna B. Foa, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: female sexual assault victims, female assault victims Reliability: alpha = .85, test-retest = .80; validity: sensitivity = .88, specificity = .96 (compared with SCID); Pearson's r reliability coefficient = .48–.80 (with Impact of Events intrusion and avoidance, State portion of State-Trait Anxiety Inventory, and MPSS-SR)
Author(s):	Edna B. Foa and Gregory A. Leskin
Contact:	Edna B. Foa, Ph.D. Medical College of Pennsylvania Department of Psychiatry 3200 Henry Avenue Philadelphia, PA 19129-1137

Relevant citations:	Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6*, 459–474. Foa, E. & Tolin, D. F. (2005). Comparison of the PTSD Symptom Scale-Interview Version and the clinician administered PTSD Scale. *Journal of Traumatic Stress, 13*, 181–191. Leskin, G. A. (1999). Screening for trauma and PTSD in a primary care clinic. *NC-PTSD Clinical Quarterly, 8*, 68–69.

PTSD Symptom Scale: Self-Report Version (MPSS-SR)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Contact Sherry Falsetti, Ph.D.
How to obtain scale:	Contact Sherry Falsetti, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: alpha = .96–.97 Validity: sensitivity = .89, specificity = .65
Author(s):	Sherry Falsetti, Patricia A. Resick, Heidi S. Resnick, Dean G. Kilpatrick
Contact:	Sherry Falsetti, Ph.D. University of Illinois College of Medicine Department of Family and Community Medicine 1601 Parkview Avenue Rockford, IL 61107-1897
Relevant citations:	Bonin, M. F., Norton, G. R., Asmundson, G. J., Dicurzio, S., & Pidlubney, S. (2000). Drinking away the hurt: The nature and prevalence of PTSD in substance abuse patients attending a community-based treatment program. *Journal of Behavior Therapy and Experimental Psychiatry, 31*, 55–66. Coffey, S. F., Dansky, B. S., Falsetti, S. A., Saladin, M. E., & Brady, K. T. (1998). Screening for PTSD in a substance abuse sample:

Psychometric properties of a modified version of the PTSD Symptom Scale Self-Report. *Journal of Traumatic Stress, 11,* 393–399.

Falsetti, S. A., Resnick, H. S., Resick, P. A., & Kilpatrick, D. (1993). The Modified PTSD Symptom Scale: A brief self-report measure of post-traumatic stress disorder. *The Behavioral Therapist, 16*, 161–162.

Screen for Posttraumatic Stress Symptoms (SPTSS)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	5 minutes
Qualifications to administer:	Contact Eve Carlson, Ph.D.
How to obtain scale:	Contact Eve Carlson, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: psychiatric inpatients Reliability: split half reliability = .91, test-retest = .82
Author(s):	Eve Carlson, Ph.D.
Contact:	Eve Carlson, Ph.D. National Center for PTSD (352-117-MP) Palo Alto Health Care System 795 Willow Road Menlo Park, CA 94025
Relevant citations:	Carlson, E. (2001). Psychometric study of a brief screen for PTSD: Assessing the impact of multiple traumatic events. *Assessment*, *8*, 431–441.

Structured Interview for PTSD (SI-PTSD)

Domains:	PTSD single event
Timeframe:	Current (past 4 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17

Completion time:	20–30 minutes
Qualifications to administer:	Can be administered by mental health professionals or by paraprofessionals after some training.
How to obtain scale:	Contact Jonathan Davidson, M.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans Reliability: alpha = .94, test-retest = .71, intraclass r = .97 Validity: sensitivity = .96, specificity = .80 (compared with SCID), Pearson's r reliability coefficient = .61 (with IES), Pearson's r reliability coefficient = .51 (with Hamilton Anxiety Scale)
Author(s):	Jonathan Davidson
Contact:	Jonathan Davidson, M.D. Department of Psychiatry Box 3812 Duke University Medical Center Durham, NC 27710-3812
Relevant citations:	Davidson, J. R. T., Kudler, H. S., & Smith, R. D. (1990). Assessment and pharmacotherapy of posttraumatic stress disorder. In J. E. L. Giller (Ed.), *Biological assessment and treatment of post-traumatic stress disorder* (pp. 205–221). Washington, DC: American Psychiatric Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Trauma Assessment for Adults (TAA)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	13
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain

Psychometrics:	Populations sampled: adult mental health center clients; face validity established; feasible; validity established via archival records
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Cusack, K. J., Frueh, B. C., & Brady, K. T. (2004). Trauma history screening in a community mental health center. *Psychiatric Services, 55,* 157–162. Resnick, H. S. (1996). Psychometric review of Trauma Assessment for Adults (TAA). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 362–365). Lutherville, MD: Sidran Press.

Trauma Assessment for Adults (TAA)–Self Report

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	None to date
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Resnick, H. S., Falsetti, S. A., Kilpatrick, D. G., & Freedy, J. R. (1996). Assessment of rape and other civilian trauma-related posttraumatic stress disorder: Emphasis on assessment of potentially traumatic events. In T. W. Miller (Ed.), *Stressful life events* (pp. 231–266). Madison, WI: International Universities Press.

Trauma History Questionnaire (THQ)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured

Number of items:	24
Completion time:	5–15 minutes
Qualifications to administer:	Contact Bonnie L. Green, Ph.D.
How to obtain scale:	Contact Bonnie L. Green, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: psychiatric outpatients, college students, women with breast cancer Reliability: r = 0.7–0.9, intraclass = .76
Author(s):	Bonnie L. Green
Relevant citations:	Hooper, L., Stockton, P., Krupnick, J., & Green, B., (2011). Development, use, and psychometric properties of the Trauma History Questionnaire. *Journal of Loss and Trauma, 16*, 258–283. Muesser, K. T., Salyers, M. P., Rosenberg, S. D., Ford, J. D., Fox, L., & Carty, P. (2001). Psychometric evaluation of trauma and posttraumatic stress disorder assessments in persons with severe mental illness. *Psychological Assessment, 13*, 110–117. Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Trauma Symptom Inventory (TSI)

Domains:	Trauma-related symptoms
Timeframe:	Current (last 6 months)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	100
Completion time:	20 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and courses in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact Psychological Assessment Resources
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: general population Reliability: alpha = .84–.87

Author(s):	John Briere
Contact:	Psychological Assessment Resources Box 998 Odessa, FL 33556
Relevant citations:	Briere, J. (1996). Psychometric review of Trauma Symptom Inventory (TSI). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 381–383). Lutherville, MD: Sidran Press. Briere, J. (1995). *Trauma Symptom Inventory professional manual.* Odessa, FL: Psychological Assessment Resources. Orsillo, S. M. (2001). Measures for acute stress disorder and post-traumatic stress disorder. In M. M. Antony & S. M. Orsillo (Eds.), *Practitioner's guide to empirically based measures of anxiety* (pp. 255–307). New York: KluwerAcademic/Plenum.

Traumatic Stress Schedule

Domains:	Trauma history
Timeframe:	Current (but author suggests any period)
Response format:	Other
Format of administration:	Semi-structured
Number of items:	10 (with 12 probes)
Completion time:	5–30 minutes
Qualifications to administer:	Can be administered by lay interviewer with training
How to obtain scale:	Contact Fran Norris, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: test-retest = .88, frequency of events equal to National Women's Study PTSD Module
Author(s):	Fran Norris
Relevant citations:	Norris, F. H. (1990). Screening for traumatic stress: A scale of use in the general population. *Journal of Applied Social Psychology*, *20*, 1704–1718. (Includes measure in its entirety.) Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Appendix E—Consumer Materials

The following are samples of available consumer materials relating to trauma-informed care and traumatic stress. There is a plethora of consumer information available to meet the immediate and long-term needs of consumers of behavioral health services affected by trauma. In order to not waste effort creating new materials for your client's concerns, it is advisable to explore current science-informed resources. In most cases, consumer materials are already available and easily accessible for free.

AfterDeployment.org (2010). *Just the Facts: Resilience*. Available: http://afterdeployment.org/sites/default/files/pdfs/client-handouts/resilience-understanding.pdf

This Web site provides resources to address symptoms related to traumatic stress in addition to other postdeployment adjustment issues. This site provides information and handouts on resilience, triggers, and other trauma-related topics. It is appropriate for service members as well as civilians.

Blanch, A., Filson, B., & Penny, D. (2012). *Engaging Women in Trauma-Informed Peer Support: A Guidebook*. Available: http://www.nasmhpd.org/publications/engagingwomen.aspx

This draft technical assistance guide was created by the National Center for Trauma-Informed Care (NCTIC) and developed under contract with the National Association of State Mental Health Program Directors. This publication is designed to help make trauma-informed peer support available to women who are trauma survivors and who receive or have received behavioral health services. It is a resource for peers providing support in these or other settings who want to learn how to use trauma-informed principles in supporting women or in the peer support groups. It has been a resource used in the delivery of technical assistance through NCTIC.

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., et al. (2006). Appendix E: Handouts. *Psychological First Aid: Field Operations Guide.* Available: http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_Appx_E_handouts.pdf

Developed jointly with the National Child Traumatic Stress Network and the National Center for PTSD, this curriculum provides a science-informed approach to psychological first aid for response workers. The goals of this module are to assist survivors in the immediate aftermath of disaster and/or terrorism, reduce initial distress, and foster short- and long-term adaptive functioning. This link provides specific survivor-oriented material, such as strategies in seeking and giving support, education on common immediate reactions, and parental tips for children across developmental stages.

Center for Mental Health Services (2002). *Dealing with the Effects of Trauma-A Self-Help Guide.* Available: http://store.samhsa.gov/shin/content//SMA-3717/SMA-3717.pdf

This self-help guide gives practical information and tools to address and manage symptoms and other consequences of traumatic stress. It provides education on a variety of topics, including trauma-related symptoms, advice on the key ingredients of quality care, barriers to recovery, and practical strategies to enhance recovery and manage difficult emotions.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2005). *Roadmap to Seclusion and Restraint Free Mental Health Services*. Available: http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055

This curriculum concerns the elimination of seclusion and restraint. It provides numerous handouts for consumers as well as staff. Several consumer handouts include common reactions to trauma, a trauma screening tool, and strategies to de-escalate agitation and distress.

Mead, S. (2008). *Intentional Peer Support: An Alternative Approach*. Sherry Mead Consulting. Available: http://www.intentionalpeersupport.org/apps/webstore/products/show/3408520

This interactive workbook is designed for individuals who are in peer support roles and those who use peer support services. It provides goals, tasks, competencies, and skills associated with peer support relationships and guidelines for first interviews.

Najavits, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

This evidence-based practice for individuals who have a history of trauma and a substance use disorder provides not only guidelines for clinicians but handouts for individuals. The consumer materials include information on PTSD and substance abuse and their interrelationship, key principles of the Seeking Safety program, coping skills to support safety, and grounding exercises. For additional information and resources, go to http://www.seekingsafety.org.

National Center for PTSD, U.S. Department of Veterans Affairs (2010). *Understanding PTSD*. Available: http://www.ptsd.va.gov/public/understanding_ptsd/booklet.pdf

This booklet provides consumer information on posttraumatic stress, common traumatic stress symptoms, effective treatments, and resources. The National Center for PTSD also provides additional professional and public resources specific to trauma for veterans and civilians.

Sidran Institute (2012). *Healing Self-Injury*. Available: http://healingselfinjury.org/about.html

This Web site provides numerous resources for consumers and professionals to understand self-inflicted violence. It offers publication links, archived newsletters, and a current blog focused on self-harm.

Appendix F—Organizational Assessment for Trauma-Informed Care

The following two resources are organizational assessments, which represent a key strategy in developing or re-evaluating trauma-informed services. The first assessment, presented by the University of South Florida, College of Behavioral and Community Sciences (2012), is designed for staff or key stakeholders. The second assessment comes from the *Trauma-Informed Organizational Toolkit for Homeless Services* (Guarino, Soares, Konnath, Clervil & Bassuk, 2009) and is a consumer version. There are several other assessment tools available, including Fallot and Harris's *Creating Cultures of Trauma-Informed Care (CCTIC): A Self Assessment and Planning Protocol* (2009).

Staff or Key Stakeholder Organizational Assessment Tool
University of South Florida, College of Behavioral and Community Sciences (2012). *Creating Trauma-Informed Care Environments: An Organizational Self-Assessment*. Available: http://www.cfbhn.org/assets/TIC/youthresidentialself%20assess%20Fillable%20FORM%20%282%29.pdf

Consumer Version: Organizational Assessment Tool
Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-Informed Organizational Toolkit for Homeless Services*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. See: pp. 82–93. Available: http://www.familyhomelessness.org/media/90.pdf

Appendix G—SAMHSA Resource Panel

John Bailey
Special Expert
Office of Policy, Planning, and Budget
Office of the Administrator
Substance Abuse and Mental Health Services Administration
Rockville, MD

Shirley Beckett, NCAC II
Certification Administrator
National Association of Alcohol and Drug Abuse Counselors
Washington, DC

Danny Brom, Ph.D.
Director
The Israel Center for the Treatment of Psychotrauma
Latner Institute for the Study of Social Psychiatry and Psychotherapy
Israel

Ling Chin, M.D.
Chief, Clinical Science
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Carol Coley, M.S., USPHS
Senior Program Management Officer
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Christina Currier
Public Health Analyst
Office of Evaluation, Scientific Analysis and Synthesis
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Marlene EchoHawk, Ph.D.
Health Science Administrator
Division of Health
Indian Health Service
U.S. Department of Health and Human Services
Rockville, MD

Jill Shepard Erickson, M.S.W., ACSW
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Angela M. Gonzalez, Ph.D., CDR, USPHS
Special Programs Development Branch-Refugee Mental Health Program
Division of Prevention, Traumatic Stress, and Special Programs
Substance Abuse and Mental Health Services Administration
Rockville, MD

Jacqueline Hendrickson, M.S.W., LCSW-C
Public Health Advisor
Division of Pharmacologic Therapies
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Michael Hilton, Ph.D.
Health Science Administrator
Division of Clinical and Prevention Research
National Institute of Alcohol Abuse and Alcoholism
National Institutes of Health
Bethesda, MD

Kenneth J. Hoffman, M.D., M.P.H.
Medical Director
TRICARE Management Activity
Military Health System-Population Health Programs
Department of Defense, Health Affairs
Falls Church, VA

Kirk E. James, M.D.
Special Expert
Systems Improvement Branch
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Hendree E. Jones, Ph.D.
Assistant Professor
Department of Psychiatry and Behavioral Sciences
Johns Hopkins University Center
Baltimore, MD

Cindy Kleppinger, M.D.
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

David Liu, M.D.
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Richard E. Lopez, J.D., Ph.D.
Social Science Analyst
Co-Occurring and Homeless Branch
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Sue Martone, M.P.A.
Public Health Advisor
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
Washington, DC

Dee S. Owens, M.P.A.
Director
Alcohol-Drug Information Center
Indiana University
Bloomington, IN

Harold I. Perl, Ph.D.
Chief, Health Services Research Branch
Division of Clinical and Prevention Research
National Institute of Alcohol Abuse and Alcoholism
National Institutes of Health
Bethesda, MD

Melissa V. Rael, USPHS
Senior Program Management Officer
Division of State and Community Assistance
Co-Occurring and Homeless Branch
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Lawrence D. Rickards, Ph.D.
Co-Occurring Disorders Program Manager
Homeless Programs Branch
Division of Knowledge Development and Systems Change
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Cecilia Rivera-Casale, Ph.D.
Senior Project Officer
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Terrence Schomburg, Ph.D.
Team Leader
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Richard T. Suchinsky, M.D.
Associate Chief for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC

Beth A. Weinman, M.A.
Coordinator
National Drug Abuse Programs
Correctional Programs Division-Services Branch
U.S. Department of Justice
Washington, DC

Penelope P. Ziegler, M.D.
Head, Treatment Section
American Academy of Addiction Psychiatry
Williamsburg, VA

Appendix H—Field Reviewers

Carol Ackley
Owner/Director
River Ridge Treatment Center
Burnsville, MN

Rosie Anderson-Harper, M.A.
Mental Health Manager
Division of Alcohol and Drug Abuse
Missouri Department of Mental Health
Jefferson City, MO

Reba Architzel
Director
Federal Relations and Policy Analysis
New York State Office of Alcoholism and Substance Abuse Services
Albany, NY

Larry L. Ashley, Ed.S., M.A.
Addictions Specialist
Department of Counseling
University of Nevada, Las Vegas
Las Vegas, NV

G.T. (Gigi) Belanger
Public Health Advisor
Homeless Programs Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Charles H. Bombardier, Ph.D.
Associate Professor
Department of Rehabilitation Medicine
Harborview Medical Center
University of Washington School of Medicine
Seattle, WA

Patricia T. Bowman
Probation Counselor
Fairfax Alcohol Safety Action Program
Fairfax, VA

Patricia Allen Bradford, LISW, LMFT, CTS
Program Manager
Health Care for Homeless Veterans
Columbia, SC

Kathy Brock
Director
Polytechnic University Counseling Center
Brooklyn, NY

Vivian B. Brown, Ph.D.
Chief Executive Officer
Mental Health and Social Services Centers for Innovation in Health
PROTOTYPES
Culver City, CA

Wilma J. Calvert, R.N., Ph.D.
Post-Doctoral Fellow
Department of Psychiatry
Washington University School of Medicine
St. Louis, MO

Jerome F.X. Carroll, Ph.D.
Consultant in private practice
Chair, Columbia University's Drugs & Society Seminar
Brooklyn, NY

Steven J. Chen, Ph.D.
Associate Director
Division of Substance Abuse and Mental Health
Utah Department of Human Services
Salt Lake City, UT

Colleen Clark, M.A., Ph.D.
Research Assistant Professor
Licensed Clinical Psychologist
Triad Women's Project
University of South Florida
Tampa, FL

R.T. Codd, III., Ed.S.
Certified Member of the Academy of Cognitive Therapy
Director/Owner
Cognitive–Behavioral Therapy Center of Western North Carolina
Asheville, NC

Carol Coley, M.S.
Senior Program Management Advisor
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Carol J. Colleran, CAP, ICADC
Director of Primary Programs
Center of Recovery for Older Adults
Hanley-Hazelden Center
West Palm Beach, FL

Stephanie S. Covington, M.S.W., Ph.D.
Co-Director
Center for Gender and Justice
Institute for Relational Development
La Jolla, CA

David A. Deitch, Ph.D.
Professor of Clinical Psychiatry
Director, CCARTA
Department of Clinical Psychiatry
University of California, San Diego
La Jolla, CA

Gail D. Dixon, M.A., CAPP
NIDA Project Manager
Southern Coast Addiction Technology Transfer Center
Tallahassee, FL

Jill Shepard Erickson, M.S.W., ACSW
Public Health Advisor
Child and Family Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Phil Erickson
Substance Abuse Program Manager
Loudoun County Community Services Board
Leesburg, VA

Kathleen J. Farkas, Ph.D., LISW
Mandel School of Applied Social Sciences
Case Western Reserve University
Cleveland, OH

Norma B. Finkelstein, M.S.W., Ph.D.
Executive Director
W.E.L.L. Project
Institute for Health and Recovery
Cambridge, MA

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief
Services Research Branch
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Judith Ford, M.A., MFT
Director of Women's Services
Community Services and Hospitals
Connecticut Department of Mental Health and Addiction Services
Hartford, CT

Julian D. Ford, Ph.D.
Associate Professor
Department of Psychiatry
University of Connecticut Health Center
Farmington, CT

Matthew Friedman, M.D., Ph.D.
Professor of Psychiatry and Pharmacology
Executive Director, National Center for PTSD
Dartmouth Medical School
VA Medical Center
White River Junction, VT

John Galea, M.A.
Deputy Director, New York City Relations
New York State Office of Alcoholism and Substance Abuse Services
New York, NY

Angela M. Gonzalez, Ph.D., CAPT., USPHS
Scientist Officer
Special Programs Development Branch-Refugee Mental Health Program
Division of Prevention, Traumatic Stress, and Special Programs
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Maya D. Hennessey
Women's Specialist
Supervisor, Quality Assurance, Technical Assistance & Training
Office of Special Programs
Division of Substance Abuse
Illinois Department of Human Services and Substance Abuse
Chicago, IL

Michael W. Herring, LCSW
Licensed Clinical Social Worker
Wayne Psychiatric Associates, P.A.
Goldsboro, NC

Nancy J. Hirzel
Clinic Director
Adult Services Division
Jefferson Addictive Disorders Clinic
Jefferson Parish Human Services Authority
Metairie, LA

Robert Holden, M.A.
Program Director
Partners in Drug Abuse Rehabilitation Counseling (PIDARC)
Washington, DC

Kay M. Johnson
Crime Victims Treatment Center - HIV Project
St. Luke's Roosevelt Hospital Center
New York, NY

Kimberly A. Johnson, M.A., NCAC II
Director
Augusta Mental Health Complex
Maine Office of Substance Abuse
Augusta, ME

Sharon D. Johnson, M.S.W., M.P.E., Ph.D.
Assistant Professor
Department of Social Work
University of Missouri-St. Louis
St. Louis, MO

Lorene Lake, M.A., Ed.D.
Executive Director
Chrysalis House, Inc.
Crownsville, MD

Michael S. Levy, Ph.D.
Director of Clinical Treatment Services
CAB Health and Recovery Services
Danvers, MA

T.K. Logan, Ph.D.
Associate Professor
Center on Drug & Alcohol Research
Department of Behavioral Science
University of Kentucky
Lexington, KY

James J. Manlandro, D.O., FAOAAM, FACOFP
Medical Director
Family Addiction Treatment Services, Inc.
Somers Point, NJ

Rozanne Marel, Ph.D.
Head of Epidemiology & Needs Assessment
New York State Office of Alcoholism and Substance Abuse Services
New York, NY

Pamela Martin, Ph.D.
Director
Behavioral Health Services Division
New Mexico Department of Health
Santa Fe, NM

Ruby J. Martinez, Ph.D., R.N., CS
Assistant Professor
School of Nursing
University of Colorado Health Sciences Center
Denver, CO

Sue Martone, M.P.A.
Public Health Advisor
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
Washington, DC

Beth Marty, M.S., LPC
Clinical Program Manager
WYSTAR
Sheridan, WY

Lisa A. Melchior, Ph.D.
Vice President
The Measurement Group, LLC
Culver City, CA

Candace Merritt
Social Worker
Veterans Administration Medical Center
Denver, CO

Pamela A. Mumby, C.N.S., F.N.P., M.S.N.
Adult Psychiatric Nurse Practitioner
Substance Abuse Treatment Program
Veterans Administration Medical Center
Denver, CO

Briana S. Nelson-Goff, Ph.D.
Associate Professor
Family Studies and Human Service
Kansas State University
Manhattan, KS

Sarah Niemeyer
Clinical Director
Amethyst, Inc.
Columbus, OH

Thomas A. Peltz, M.Ed.
Therapist/Licensed Mental Health Counselor
Certified Addiction Specialist
Private Practice
Beverly Farms, MA

Karen Pressman, M.S.W., CADAC, LACDI
Director, Planning and Development
Bureau of Substance Abuse Services
Massachusetts Department of Public Health
Boston, MA

Melissa V. Rael, USPHS
Senior Program Management Officer
Co-Occurring and Homeless Branch
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Lawrence D. Rickards, Ph.D.
Public Health Advisor
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Alice F. Roeling
OAD Inpatient Facility Manager
The Springs of Recovery Adolescent Program
Greenwall Springs, LA

James Rowan, M.A.
Program Manager
Case Management and Offender Services
Arapahoe House, Inc.
Thornton, CO

JoAnn Y. Sacks, Ph.D.
Deputy Director, CIRP
National Development and Research Institutes, Inc.
New York, NY

Darren C. Skinner, M.S.W., Ph.D., LSW
Division Director
Co-Occurring Program
Gaudenzia, Inc.
Philadelphia, PA

Mickey J.W. Smith, M.S.W.
Senior Policy Associate, Behavioral Health
Program, Policy & Practice Unit
Division of Professional Development & Advocacy
National Association of Social Workers
Washington, DC

Richard T. Suchinsky, M.D.
Associate Chief for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC

Wilbur Woodis, M.A.
Management Analyst
Office of Clinical and Preventive Services
Division of Behavioral Health
Indian Health Service
Office of Public Health
U.S. Department of Health and Human Services
Rockville, MD

Appendix I: Cultural Competency and Diversity Network Participants

Charles H. Bombardier, Ph.D.
Associate Professor
Department of Rehabilitation Medicine
Harborview Medical Center
University of Washington School of Medicine
Seattle, WA
Disability Workgroup

Carol S. D'Agostino, CSW, CASAC
Director
Geriatric Addictions Program
LIFESPAN of Greater Rochester, Inc.
Rochester, NY
Aging Workgroup

Thomas L. Geraty, M.S.W., Ph.D., LICSW
Private Practice
Jamaica Plain, MA
LGBT Workgroup

Wayne Lee Mitchell, M.D.
Indian Health Service
Phoenix, AZ
Aging Workgroup

Ann S. Yabusaki, M.Ed., M.A., Ph.D.
Substance Abuse Director
Psychologist
Substance Abuse Programs and Training
Coalition for a Drug-Free Hawaii
Kaneohe, HI
Asian and Pacific Islanders Workgroup and Aging Workgroup

Appendix J: Acknowledgments

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Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under the Substance Abuse and Mental Health Services Administration's Knowledge Application Program (KAP) to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

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A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

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TIP 17 Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System—*Replaced by TIP 44*

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Quick Guide for Clinicians and Administrators

TIP 22 LAAM in the Treatment of Opiate Addiction—*Replaced by TIP 43*

TIP 23 Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing
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TIP 24 A Guide to Substance Abuse Services for Primary Care Clinicians
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TIP 25 Substance Abuse Treatment and Domestic Violence
Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers
Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators
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Substance Abuse Among Older Adults: A Guide for Social Service Providers
Substance Abuse Among Older Adults: Physician's Guide
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Case Management for Substance Abuse Treatment: A Guide for Treatment Providers
Case Management for Substance Abuse Treatment: A Guide for Administrators
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TIP 28 Naltrexone and Alcoholism Treatment—*Replaced by TIP 49*

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TIP 30 Continuity of Offender Treatment for Substance Use Disorders From Institution to Community
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TIP 33 Treatment for Stimulant Use Disorders
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TIP 35 Enhancing Motivation for Change in Substance Abuse Treatment
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TIP 36 Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues
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TIP 37 Substance Abuse Treatment for Persons With HIV/AIDS
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TIP 39 Substance Abuse Treatment and Family Therapy
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Family Therapy Can Help: For People in Recovery From Mental Illness or Addiction

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TIP 42 Substance Abuse Treatment for Persons With Co-Occurring Disorders
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TIP 43 Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs
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TIP 44 Substance Abuse Treatment for Adults in the Criminal Justice System
Quick Guide for Clinicians
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Implementing a Trauma-Informed Approach for Youth across Service Sectors

This brief is based on a webinar, ***Implementing a Trauma-Informed Approach for Youth Across Service Sectors***, held Tuesday, May 21, 2013, 2:00 p.m. to 3:30 p.m. EDT. The webinar was sponsored by the Interagency Working Group on Youth Programs (IWGYP), a collaboration of 18 Federal departments and agencies that support programs and services focusing on youth and promote the goal of positive, healthy outcomes for youth. The webinar was planned jointly by the IWGYP and the Substance Abuse and Mental Health Services Administration (SAMHSA). The webinar slides are housed on the IWGYP website, FindYouthInfo.gov, under the Mental Health Youth Topic. The webinar featured three content experts nationally known in their field: Eugene Griffin, J.D., Ph.D., Northwestern University, Feinberg School of Medicine; Julian Ford, Ph.D., University of Connecticut, School of Medicine; and Charles Wilson, MSSW, Chadwick Center for Children and Families Rady Children's Hospital - San Diego, California; all of whom have been supported by SAMHSA trauma-focused grants. Additionally, the webinar included two youth presenters, NC and LS, who spoke about their own lived experience and the importance of trauma-informed care. Both youth are referred to only by initials to protect their privacy. NC is a peer specialist and LS is a law student.

Introduction

Trauma affects youth in all communities, and responses to those experiences by child-serving systems are critical. It is important for providers serving youth to understand how best to respond and support healing.

Service providers and policymakers in the youth-serving field are continually learning more from research[i] about trauma, traumatic experiences, and the various responses to traumatic events. It is important for youth serving systems to develop a greater understanding of the association between trauma and mental health and substance use disorders, and how it can derail the healthy development of youth. The field recognizes the importance of addressing trauma and using a trauma-informed approach in prevention, treatment, and recovery efforts.

This brief discusses the concept and prevalence of trauma; techniques for coping with, and recovering from trauma at an individual and systems level; the core principles for building a framework for understanding trauma; and implementation of elements essential for a trauma-informed system as presented by the featured experts.

Recognizing the effects of trauma and understanding how to address trauma are fundamental to the Trauma and Justice Strategic Initiative at the Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services (HHS). The focus of SAMHSA's Trauma and Justice Strategic Initiative is on integrating a trauma-informed approach throughout health, behavioral health, and related systems to reduce the harmful effects of trauma and violence on individuals, families, and communities and using innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.

As part of this Initiative, with the help of experts, SAMHSA will be releasing a concept paper outlining a framework for trauma and guidance for developing and implementing a trauma-informed approach.

What Do We Mean by Trauma?

After an introduction by Dr. Larke Huang from the Substance Abuse and Mental Health Services Administration (SAMHSA), Dr. Eugene Griffin provided a framework for understanding trauma.

Trauma is a complex experience that affects youth and the systems that serve them in a variety of ways. The experience of trauma can be described through some common elements: event, experience, and effects, also known as "Three E's."[ii] These elements address the uniqueness of an individual's response to an event and how an event affects one's future behavior and well-being.

An **Event** is objective and measurable. Traumatic events include abuse (physical, emotional, sexual); domestic or community violence; an accident or natural disaster; and war or terrorism.

1. An **Experience** is subjective and difficult to measure because it relates to how someone reacts to an event. It is often thought to be life threatening or physically or emotionally overwhelming, and intensity can vary among people and over time. The way one person experiences an event might differ from the way another person does; culture, gender, and age all influence one's experience of the event. Additionally, people experience events in different ways. Resilience, risk and protective factors, and supports may contribute to this experience.
2. **Effects** are the reactions a person has to an event and the ways an experience changes or alters that person's ongoing and future behavior. Classic symptoms include experiencing hyperarousal, such as overreacting or being hypervigilant; re-experiencing an event as nightmares or flashbacks; and avoiding a situation by having a fight, flight, or freeze reaction. The effects of a traumatic event can have a long-term impact on neurobiological development and contribute to negative physical, hormonal, and chemical changes due to stress responses.

Building on this "Three E's" concept of trauma, SAMHSA frames its concept of trauma as: an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[iii] Researchers[iv] report that traumatic stress occurs when an extreme experience overwhelms and alters an individual's stress-related physiological systems and compromises the functioning of stress-response systems (e.g., neuroimmune, neuroendocrine, autonomic, and central nervous system networks).

"What I found worked best is when I was surrounded by people who really got it, who really understood trauma." — LS

Prevalence of Trauma

Many youth are exposed to traumatic events, including those in the juvenile justice and child welfare systems, as well as those who experience homelessness. Building on the three E's concept, we know that the experience of trauma is complex and particular to each individual's life circumstances, which can make quantifying the extent difficult. Some people experience multiple traumas; for example, a youth who has been separated from his or her family and then experiences assault or abuse in a foster home. As many as half of all children that have been involved with the mental health, child welfare, and juvenile justice systems have experienced multiple traumas.[v] LS and NC, two young people formerly involved with the foster care system, comment in the box above on their experiences with multiple traumas.

"When I was seven years old…my brothers and I were placed in foster care…We were immediately separated, and so I felt like that was probably the first traumatic event that I experienced." — LS

"While I was at my foster home, I had gotten into altercations with my foster brother and before he hit me, I felt scared…" — NC

Coping with and Reactions to Trauma

Dr. Julian Ford provided an overview of strategies for youth, families, and communities to recover from trauma. Recovery from the adverse effects of trauma begins with the recognition that the experience of survival threat caused by traumatic events has caused some major changes in the way a person now copes with stress. These ways of coping are necessary and effective in emergencies such as traumatic events, but they interfere with ordinary day-to-day life. Youth who have experienced trauma may develop coping strategies to help them survive.

Chronic Survival Coping

Trauma affects a youth's relationships, sense of survival, and sense of trust and security with people. The reaction to terrible shock, stressors, challenges, and loss is chronic survival coping. An individual trying to cope or recover from serious challenges and stressors will learn techniques to survive, such as staying on edge; being vigilant, watchful, or even distrustful (hypervigilance); or using indifference to mask hopelessness.

Posttraumatic Survival Coping

Physically, posttraumatic survival coping reflects a change in the body, not just a mental and psychological change. It changes how a person's brain works. The brain helps a person learn, explore, try activities, and experience different ways of living. However, a person cannot experience life freely when trying to survive trauma. Instead, that person must put everything else aside and concentrate only on basic survival needs. Some common survival modes or hypervigilance practices are scanning the environment and being on guard for danger; attempting to block out or not think about upsetting things; being ready to fight or flee; experiencing elevated heart rate and adrenalin rush; and being unable to regulate aggression or use anger management techniques.

"I wish that the people who I was working with in my school were more trauma informed and that they were focused - instead of on the disruptive behavior - on what was causing the disruptive behavior." — LS

Hypervigilance can make it difficult to set and accomplish goals even for the most persistent and high achieving person; all goals are trumped by the larger objective of staying safe. This type of coping can lead to difficulties trusting, including parents, caregivers, friends, teachers, and other adults.

Neurobiological Brain Research

Neuroscience indicates that a person's response to stress and use of coping techniques have three components. Dr. Ford provided a metaphor for understanding these complex brain processes:

- The ***"alarm"*** in the brain tells a person to wake up and pay attention. It also tells the body when there is a crisis and to be ready to react and survive.
- The ***"librarian"*** and ***"search engine"*** file and retrieve memories. When the alarm goes off, the memory filing center pulls information from all parts of the brain to figure out what is going on.
- The ***"computer hard drive"*** is the thinking center where all the information is put together and decisions are made.

If the three above components are working well, the thinking center is activated and a person can handle the stressful situation, not worry about survival, and come up with good ideas and plans for handling the situation, thus the alarm is turned off. However, if the alarm is so strong because of extreme stress (e.g., a threat to survival), it can crash the memory filing center and the hard drive in the brain. At that point, survival coping tactics take over. These activities take place in the part of the brain that helps a person survive and be safe. Operating in survival mode is not the ideal way to live because it leads to difficulty relaxing, trusting, focusing, and handling things appropriately.

Recovery from Trauma

A trauma-informed approach is a framework for providing services that should be integrated into everything that a program and system does. Dr. Ford noted that the goal of recovery from trauma is to tap into an existing strength to reset the brain's alarm to not be in persistent survival mode. Resetting the alarm requires strategies to resume thinking clearly. Evidence-based trauma-informed and trauma-specific therapy programs provide youth and their caregivers with strategies to focus their minds and deal with not feeling safe. Learning the strategies for regulating emotions and controlling anxiety is vital to everyday functioning in society. A trauma-informed approach includes youth and caretakers

in future planning. Trauma takes away control of a person's body or life. Reintroducing some control can tap into resiliency, and planning for the future provides hope.[vi]

Strategies for recovery from trauma include recognizing one's own and others' alarm reactions, sweeping one's mind clear before judging and acting, focusing on what is most important and positive, and being aware of stress and personal control levels. These strategies activate the thinking center and reset the alarm.

Many Paths to Recovery: Evidence-Based Models

- Cognitive-behavioral therapies
- Emotion regulation therapies
- Relational-interpersonal therapies
- Psychotherapies for dissociation
- Parent-child and family system therapies
- Social/helping network therapies
- Peer-to-peer support programs

The webinar presenters acknowledged that there are many paths to recovery and recommended common therapeutic approaches implemented by mental health professionals that can assist individuals who have experienced trauma. It is important to understand that trauma-informed care principles can be implemented by people who are not mental health professionals and work in various systems that provide services for individuals who have experienced trauma.

Trauma at the Systems Level

Mr. Charles Wilson provided a discussion of the child welfare system, and its role in addressing youth and families who have experienced trauma. The experience of trauma is complex and personal, and youth and families who have experienced trauma receive services within a variety of community systems. Providers and systems have the ability to help or potentially re-traumatize. A trauma-informed system aligns interactions among youth-serving agencies, such as the child protection systems, lawyers, juvenile judges, law enforcement, schools, and mental health providers so that they better understand how youth, families, and adults respond to trauma.

A trauma-informed system is not just about raising awareness, but changing behavior, actions, and responses. The approach requires doing things differently so as not to re-traumatize or introduce additional trauma. Systems need to support the natural resiliency of children and youth and assist them in identifying their unique strengths.

In a trauma-informed system, caregivers play a central role in recovery, help promote youth's natural resiliency, and give youth tools for managing stress. A strengths-based approach considers and includes the assistance given to caregivers within the system. This approach considers how the system helps caregivers deal with both current and past traumatic stress. The trauma-informed system assists caregivers understand the significant trauma histories of the children and youth that are in their care. Child welfare workers, mental health therapists, foster parents, juvenile judges, and all those working with children who have experienced significant traumatic events are influenced and touched by the trauma and can experience secondary or vicarious traumatic reactions. Therefore, the trauma-informed system responds to the varying impacts of traumatic stress on children, caregivers, and all those who are in contact with the system. Practitioners take this thinking and awareness about trauma and use it in everyday practice.

"The aftercare team also took a lot of time to do safety planning and future planning with me, and that is important because a lot of young people who experience trauma, they express feelings of hopelessness and they are in a constant state of anxiety, and so their ability to project into the future and plan for the future can be seriously impaired." — LS

Core Principles of a Trauma-Informed Approach

Given the presence of trauma in the lives of many youth and the need for systems and providers to support healing, a trauma-informed approach to providing services is critical. According to SAMHSA's concept of trauma[vii], a program, an organization, or a system that is trauma informed is based on four key assumptions:

- ***Realizes*** the widespread impact of trauma and understands potential paths for recovery.
- ***Recognizes*** the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
- ***Responds*** by fully integrating knowledge about trauma into policies, procedures, practices, and settings.
- ***Resists re-traumatization*** of clients as well as staff***.***

The Chadwick Trauma-Informed Systems Project (CTISP)[viii] National Advisory Committee says that in a trauma-informed child welfare system, all parties recognize and respond to the varying impact of traumatic stress on children, caregivers, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and skill into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery.

"I was 13 years old in my first foster home, and I must admit I did not want to be there at first because I was at home with people who I was unfamiliar with…" — NC

SAMHSA's six principles[ix] support a framework for understanding trauma and developing a trauma-informed approach:

- ***Safety:*** Throughout the organization, the staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.
- ***Trustworthiness and transparency:*** Organizational operations and decisions are conducted with transparency and with the goal of building and maintaining trust among clients, family members, staff, and others involved with the organization.
- ***Collaboration and mutuality:*** There is true partnering and leveling of power differences between staff and clients and among organizational staff, from direct care staff to administrators; they recognize that healing happens in relationships and in the meaningful sharing of power and decision making.
- ***Empowerment:*** Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills are developed as needed.
- ***Voice and choice:*** The organization aims to strengthen the experience of choice for clients, family members, and staff and recognizes that every person's experience is unique and requires an individualized approach.
- ***Culture, historical and gender issues:*** The organization incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; are gender-responsive; and incorporate a focus on historical trauma.

These principles underlie the values, beliefs, and attitudes of individuals and organizations offering a trauma-informed approach. Using this approach, organizations foster a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. Trauma-informed organizations build on strengths and assets of clients, staff, and communities instead of responding only to their perceived deficits. They recognize that everyone has a role to play. They address cultural, historical, and gender issues; actively move past cultural stereotypes and biases; offer gender-responsive services; promote the value of cultural connections; and recognize and address historical trauma. In the words of Dr. Ford, "A person does not have to be a therapist to be therapeutic."

Implementation

In his presentation, Mr. Charles Wilson shared the following central elements of providing trauma-informed care within programs, policies, services, and systems as outlined by the child welfare committee of the National Child Traumatic Stress Network. Sources with additional information are provided in the resources section of this brief.

Element 1: Maximize Physical and Psychological Safety for Children and Families

- Safety is a priority. Children and families who have experienced trauma may still feel unsafe even when they are no longer in danger. In addition to ensuring physical safety, it is important to help children and families feel psychologically safe.
- Sometimes even a noise or smell can trigger the feeling of being unsafe and elicit a reaction that a caretaker might not expect or understand. Being aware of and understanding these triggers and changing something seemingly small or insignificant in a daily routine can change behavior from negative to positive.

Element 2: Identify the Trauma-Related Needs of Children

- One of the first steps in helping trauma-exposed children and families is to understand how they have been impacted by trauma.
- Trauma-related needs can be identified through trauma screening and assessment.
- It is important to consider the type(s) of trauma children have experienced when making service referrals and developing service plans. All children need individualized services that are based on their unique circumstances, strengths, and challenges.

"I had reported a child abuse and neglect incident with social services and they did not come and take us out of our home. It was a form of betrayal of trust because you are expecting someone to help you and when that help does not come, then your relationship with the institutions that you need to rely on in order to get out of a bad situation, the relationship is broken." — LS

Element 3: Enhance Child Well-Being and Resilience

- Many children are naturally resilient.
- Systems must recognize and build on children's existing strengths.
- Both individual caseworkers and overall agency policies should support the continuity of children's relationships.
- Staff and agencies should also ensure that children who have been traumatized have access to evidence-based treatments and services.

Element 4: Enhance Family Well-Being and Resilience

- Families are a critical part of both protecting children from harm and enhancing their natural resilience.
- Providing trauma-informed education and services to parents and other caregivers enhances protective capacities.
- Agencies should recognize and assist caregivers to understand the significant trauma histories of the children and youth that are in their care.
- Agencies should assist caregivers to understand their own trauma histories.

"We need to do some self-esteem building and work with young people to acknowledge their strengths. I think when you have experienced trauma, you have a lot of thoughts, beliefs, or feelings of being unworthy or ashamed and you feel a lot of guilt and sometimes that leads to hopelessness. You are not going to work hard to achieve goals if you do not believe you can achieve them, if you do not believe you are worthy of achieving them…" — LS

Element 5: Enhance the Well-Being and Resilience of Those Working in the System

- Staff play important roles in supporting children, but working with people who have experienced abuse, neglect, violence, and other trauma can cause staff to develop secondary traumatic stress reactions.
- Agencies should collect information about trauma and secondary trauma experienced by staff, implement strategies and practices that build resilience and help staff manage stress, and address the impact of secondary traumatic stress on both individuals and on the system as a whole.

> **"The aftercare team was most useful because they worked across the systems…I did not have to do the work that a lot of young people are burdened with, which is finding a way to get our systems to work with one another." — LS**

Element 6: Partner with Youth and Families

- Youth and families should have choices and an active voice in decision making on individual, agency, and systemic levels.
- Youth and family members who have been in the system have a unique perspective and can provide valuable feedback.
- Partnerships with youth and families should occur at all levels.

Element 7: Partner with Agencies and Systems That Interact with Children and Families

- Agencies need to establish strong partnerships with other child- and family-serving systems.
- Service providers should develop common protocols and frameworks.
- Cross-system collaboration enables all helping professionals to see the child as a whole person, thus preventing potentially competing priorities and messages.
- Collaboration between systems promotes cohesive care and better outcomes.

Conclusion

This brief provides an overview of the webinar content as presented by experts in the field regarding the concepts and prevalence of trauma, principles for understanding trauma, and practices for addressing trauma and working with youth who have experienced trauma.

LS and NC, two young people formerly involved with the foster care system, provided much insight on their experiences with multiple traumas. Their shared comments provide important information and practice-based evidence and strategies that child and youth serving systems could incorporate into their work with children and youth who have experienced trauma. Some of the practical applications they described as beneficial to them include:

- Staff working in schools need to be aware of, educated and informed on the effects of trauma for children and youth, and trained in the causes of disruptive behaviors and ways to address these behaviors that do not re-traumatize children and youth;
- Aftercare teams need to provide consistent and ongoing planning with youth to address the after effects of trauma, (e.g., anxiety, sadness, depressions, feelings of hopelessness, anger, shame, guilt) and to build upon their strengths to instill good self-esteem and a belief that they are worthy of and can achieve goals in their life;

- Aftercare teams need to provide ongoing assistance for children and youth to learn skills for daily life, safety planning to address potential re-traumatization, and development of goals for the "here and now" and in their future;
- Aftercare teams need to provide quick response for children and youth who have been traumatized when reports or incidents of child abuse and/or neglect occur. Teams need to remember that these children and youth have been placed in unfamiliar surroundings and they do not feel safe or trust the people or environment immediately. They must rely on the aftercare teams to provide a trusting relationship with staff that will provide safety, protection and security in their lives;
- Aftercare teams need to work across systems to advocate for children and youth who have experienced trauma, and to assist them with the work needed for their daily care and consistent planning for life transitions.

Many strategies for coping with trauma have been noted in this brief, as well as the experiences of LS and NC which can inform child and youth serving systems on the successful practices and strategies that could improve the experience of children and youth who are coping with and healing from trauma. The resources noted below offer a starting point for deeper understanding of trauma and trauma-informed approaches.

Resources

Helping Children and Adolescents Cope with Violence and Disasters: What Community Members Can Do, National Institute of Mental Health, 2013 website information
http://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-violence-and-disasters-community-members/index.shtml

National Child Traumatic Stress Network, Learning Center for Child and Adolescent Trauma, Resources and Training
http://learn.nctsn.org/index.php

National Council for Behavioral Health; Trauma Informed Care
http://www.thenationalcouncil.org/topics/trauma-informed-care/

National Council for Behavioral Health; How to Manage Trauma
http://www.thenationalcouncil.org/wp-content/uploads/2013/05/Trauma-infographic.pdf

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Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2009). Collaborative treatment of traumatized children and teens: The Trauma Systems Therapy Approach;

Mollica, R. F. (2006). Healing invisible wounds: Paths to hope and recovery in a violent world.

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SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

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Introduction

Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. ***In order to maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.***

The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.[1,2,3,4,5] Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences.[6,7,8,9] However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical diseases.[1,10,11]

With appropriate supports and intervention, people can overcome traumatic experiences.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.[12,13] Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems.[5,14] Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.[15,16,17]

In addition, the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

Thus, the pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing "business as usual." In public institutions and service systems, there is increasing recognition that many of the individuals have extensive histories of trauma that, left unaddressed, can get in the way of achieving good health and well-being. For example, a child who suffers from maltreatment or neglect in the home may not be able to concentrate on school work and be successful in school; a women victimized by domestic violence may have trouble performing in the work setting; a jail inmate repeatedly exposed to violence on the street may have difficulty refraining from retaliatory violence and re-offending; a sexually abused homeless youth may engage in self-injury and high risk behaviors to cope with the effects of sexual abuse; and, a veteran may use substances to mask the traumatic memories of combat. The experiences of these individuals are compelling and, unfortunately, all too common. Yet, until recently, gaining a better understanding of how to address the trauma experienced by these individuals and how to mitigate the re-traumatizing effect of many of our public institutions and service settings was not an integral part of the work of these systems. Now, however, there is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their "business" under the framework of a trauma-informed approach.

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Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach

PURPOSE

The purpose of this paper is to develop a working concept of trauma and a trauma-informed approach and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups. SAMHSA puts forth a framework for the behavioral health specialty sectors, that can be adapted to other sectors such as child welfare, education, criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual's capacity to cope with traumatic experiences. In fact, many people with behavioral health problems receive treatment and services in these non-specialty behavioral health systems. SAMHSA intends this framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families and communities. The desired goal is to build a framework that helps systems "talk" to each other, to understand better the connections between trauma and behavioral health issues, and to guide systems to become trauma-informed.

APPROACH

SAMHSA approached this task by integrating three significant threads of work: trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors

of traumatic experiences who have had involvement in multiple service sectors. It was expected that this blending of the research, practice and survivor knowledge would generate a framework for improving the capacity of our service systems and public institutions to better address the trauma-related issues of their constituents.

To begin this work, SAMHSA conducted an environmental scan of trauma definitions and models of trauma informed care. SAMHSA convened a group of national experts who had done extensive work in this area. This included trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of trauma-specific interventions; and policymakers in the field of behavioral health.

From this meeting, SAMHSA developed a working document summarizing the discussions among these experts. The document was then vetted among federal agencies that conduct work in the field of trauma. Simultaneously, it was placed on a SAMHSA website for public comment. Federal agency experts provided rich comments and suggestions; the public comment site drew just over 2,000 respondents and 20,000 comments or endorsements of others' comments. SAMHSA reviewed all of these comments, made revisions to the document and developed the framework and guidance presented in this paper.

The key questions addressed in this paper are:

- **What do we mean by trauma?**
- **What do we mean by a trauma-informed approach?**
- **What are the key principles of a trauma-informed approach?**
- **What is the suggested guidance for implementing a trauma-informed approach?**
- **How do we understand trauma in the context of community?**

SAMHSA's approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA's trauma-focused grants and initiatives, such as SAMHSA's National Child Traumatic Stress Initiative, SAMHSA's National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA's: Jail Diversion Trauma Recovery grant program; Children's Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Reentry and Adult Treatment Drug Court Programs.

Background: Trauma — Where We Are and How We Got Here

The concept of traumatic stress emerged in the field of mental health at least four decades ago. Over the last 20 years, SAMHSA has been a leader in recognizing the need to address trauma as a fundamental obligation for public mental health and substance abuse service delivery and has supported the development and promulgation of trauma-informed systems of care. In 1994, SAMHSA convened the Dare to Vision Conference, an event designed to bring trauma to the foreground and the first national conference in which women trauma survivors talked about their experiences and ways in which standard practices in hospitals re-traumatized and often, triggered memories of previous abuse. In 1998, SAMHSA funded the Women, Co-Occurring Disorders and Violence Study to generate knowledge on the development and evaluation of integrated services approaches for women with co-occurring mental and substance use disorders who also had histories of physical and or sexual abuse. In 2001, SAMHSA funded the National Child Traumatic Stress Initiative to increase understanding of child trauma and develop effective interventions for children exposed to different types of traumatic events.

The American Psychiatric Association (APA) played an important role in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the recently released DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970's.[18,19,20,21] National trauma research and practice centers have conducted significant work in the past few decades, further refining the concept of trauma, and developing effective trauma assessments and treatments.[22,23,24,25] With the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.[3,25]

Simultaneously, an emerging trauma survivors movement has provided another perspective on the understanding of traumatic experiences. Trauma survivors, that is, people with lived experience of trauma, have powerfully and systematically documented their paths to recovery.[26] Traumatic experiences complicate a child's or an adult's capacity to make sense of their lives and to create meaningful consistent relationships in their families and communities.

Trauma survivors have powerfully and systematically documented their paths to recovery.

The convergence of the trauma survivor's perspective with research and clinical work has underscored the central role of traumatic experiences in the lives of people with mental and substance use conditions. The connection between trauma and these conditions offers a potential explanatory model for what has happened to individuals, both children and adults, who come to the attention of the behavioral health and other service systems.[25,27]

People with traumatic experiences, however, do not show up only in behavioral health systems. Responses to these experiences often manifest in behaviors or conditions that result in involvement with the child welfare and the criminal and juvenile justice system or in difficulties in the education, employment or primary care system. Recently, there has also been a focus on individuals in the military and increasing rates of posttraumatic stress disorders.[28,29,30,31]

With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed. Federal research agencies, academic institutions and practice-research partnerships have generated empirically-supported interventions. In SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) alone there are over 15 interventions focusing on the treatment or screening for trauma.

These interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough. Building on lessons learned from SAMHSA's Women, Co-Occurring Disorders and Violence Study; SAMHSA's National Child Traumatic Stress Network; and SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions in which services are provided played a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served. SAMHSA's National Center for Trauma-Informed Care has continued to advance this effort, starting first in the behavioral health sector, but increasingly responding to technical assistance requests for organizational change in the criminal justice, education, and primary care sectors.

FEDERAL, STATE AND LOCAL LEVEL TRAUMA-FOCUSED ACTIVITIES

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

States are elevating a focus on trauma. For example, Oregon Health Authority is looking at different types of trauma across the age span and different population groups. Maine's "Thrive Initiative" incorporates a trauma-informed care focus in their children's systems of care. New York is introducing a trauma-informed initiative in the juvenile justice system. Missouri is exploring a trauma-informed approach for their adult mental health system. In Massachusetts, the Child Trauma Project is focused on taking trauma-informed care statewide in child welfare practice. In Connecticut the Child Health and Development Institute with the state Department of Children and Families is building a trauma-informed system of care throughout the state through policy and workforce development. SAMHSA has supported the further development of trauma-informed approaches through its Mental Health Transformation Grant program directed to State and local governments.

Increasing examples of local level efforts are being documented. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the wellbeing of the community. The Family Policy Council in Washington State convened groups to focus on the impact of adverse childhood experiences on the health and well-being of its local communities and tribal communities. Philadelphia held a summit to further its understanding of the impact of trauma and violence on the psychological and physical health of its communities.

SAMHSA continues its support of grant programs that specifically address trauma.

At the federal level, SAMHSA continues its support of grant programs that specifically address trauma and technical assistance centers that focus on prevention, treatment and recovery from trauma.

Other federal agencies have increased their focus on trauma. The Administration on Children Youth and Families (ACYF) has focused on the complex trauma of children in the child welfare system and how screening and assessing for severity of trauma and linkage with trauma treatments can contribute to improved well-being for these youth. In a joint effort among ACYF, SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the three agencies developed and issued through the CMS State Directors' mechanism, a letter to all State Child Welfare Administrators, Mental Health Commissioners, Single State Agency Directors for Substance Abuse and State Medicaid Directors discussing trauma, its impact on children, screening, assessment and treatment interventions and strategies for paying for such care. The Office of Juvenile Justice and Delinquency Prevention has specific recommendations to address trauma in their Children Exposed to Violence Initiative. The Office of Women's Health has developed a curriculum to train providers in primary care on how to address trauma issues in health care for women. The Department of Labor is examining trauma and the workplace through a federal interagency workgroup. The Department of Defense is honing in on prevention of sexual violence and trauma in the military.

As multiple federal agencies representing varied sectors have recognized the impact of traumatic experiences on the children, adults, and families they serve, they have requested collaboration with SAMHSA in addressing these issues. The widespread recognition of the impact of trauma and the burgeoning interest in developing capacity to respond through trauma-informed approaches compelled SAMHSA to revisit its conceptual framework and approach to trauma, as well as its applicability not only to behavioral health but also to other related fields.

SAMHSA's Concept of Trauma

Decades of work in the field of trauma have generated multiple definitions of trauma. Combing through this work, SAMHSA developed an inventory of trauma definitions and recognized that there were subtle nuances and differences in these definitions.

Desiring a concept that could be shared among its constituencies — practitioners, researchers, and trauma survivors, SAMHSA turned to its expert panel to help craft a concept that would be relevant to public health agencies and service systems. SAMHSA aims to provide a viable framework that can be used to support people receiving services, communities, and stakeholders in the work they do. A review of the existing definitions and discussions of the expert panel generated the following concept:

> ***Individual trauma results from an* event*, series of events, or set of circumstances that is* experienced *by an individual as physically or emotionally harmful or life threatening and that has lasting adverse* effects *on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.***

THE THREE "E'S" OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as "trauma and stressor-related disorders" to include exposure to a traumatic or stressful event as a diagnostic criterion.

The individual's **experience** of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one's country differently from another refugee; one military veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of "why me?" The individual's experience of these events or circumstances is shaped in the context of this powerlessness and questioning. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When a person experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal, shattering a person's trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

How the event is experienced may be linked to a range of factors including the individual's cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure), or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty).[1]

The long-lasting adverse **effects** of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one's neurobiological make-up and ongoing health and well-being. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.[1,3] Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

SAMHSA's Trauma-Informed Approach: Key Assumptions and Principles

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to influence how service systems conduct their business.

The context in which trauma is addressed or treatments deployed contributes to the outcomes for the trauma survivors, the people receiving services, and the individuals staffing the systems. Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.[22,32,33] SAMHSA's concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles.

A program, organization, or system that is trauma-informed* realizes *the widespread impact of trauma and understands potential paths for recovery;* recognizes *the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and* responds *by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively* resist re-traumatization*.

A trauma informed approach is distinct from trauma-specific services or trauma systems. A trauma informed approach is inclusive of trauma-specific interventions, whether assessment, treatment or recovery supports, yet it also incorporates key trauma principles into the organizational culture.

Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.

THE FOUR "R'S: KEY ASSUMPTIONS IN A TRAUMA-INFORMED APPROACH

In a trauma-informed approach, all people at all levels of the organization or system have a basic **realization** about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People's experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional).There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in prevention, treatment, and recovery settings. Similarly, there is a realization that trauma is not confined to the behavioral health specialty service sector, but is integral to other systems (e.g., child welfare, criminal justice, primary health care, peer–run and community organizations) and is often a barrier to effective outcomes in those systems as well.

People in the organization or system are also able to **recognize** the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

The program, organization, or system **responds** by applying the principles of a trauma-informed approach to all areas of functioning. The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma practices. Policies of the organization, such as mission statements, staff handbooks and manuals promote a culture based on beliefs about resilience, recovery, and healing from trauma. For instance, the agency's mission may include an intentional statement on the organization's commitment to promote trauma recovery; agency policies demonstrate a commitment to incorporating perspectives of people served through the establishment of client advisory boards or inclusion of people who have received services on the agency's board of directors; or agency training includes resources for mentoring supervisors on helping staff address secondary traumatic stress. The organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes trust, fairness and transparency. The program's, organization's, or system's response involves a universal precautions approach in which one expects the presence of trauma in lives of individuals being served, ensuring not to replicate it.

A trauma-informed approach seeks to **resist re-traumatization** of clients as well as staff. Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission.[27] Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories. For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

1. **Safety**
2. **Trustworthiness and Transparency**
3. **Peer Support**
4. **Collaboration and Mutuality**
5. **Empowerment, Voice and Choice**
6. **Cultural, Historical, and Gender Issues**

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

The six key principles fundamental to a trauma-informed approach include:[24,36]

1. **Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. **Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.

3. **Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term "Peers" refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as "trauma survivors."

4. **Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: "one does not have to be a therapist to be therapeutic."[12]

5. **Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.[34] Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.

6. **Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Guidance for Implementing a Trauma-Informed Approach

Developing a trauma-informed approach requires change at multiples levels of an organization and systematic alignment with the six key principles described above. The guidance provided here builds upon the work of Harris and Fallot and in conjunction with the key principles, provides a starting point for developing an organizational trauma-informed approach.[20] While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives. Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a "checklist" or a prescriptive step-by-step process. These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care.[35,36,37,38] What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content.

TEN IMPLEMENTATION DOMAINS

1. **Governance and Leadership**
2. **Policy**
3. **Physical Environment**
4. **Engagement and Involvement**
5. **Cross Sector Collaboration**
6. **Screening, Assessment, Treatment Services**
7. **Training and Workforce Development**
8. **Progress Monitoring and Quality Assurance**
9. **Financing**
10. **Evaluation**

GOVERNANCE AND LEADERSHIP: The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within the organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

POLICY: There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be "hard-wired" into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

PHYSICAL ENVIRONMENT OF THE ORGANIZATION: The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of a trauma informed approach through openness, transparency, and shared spaces.

ENGAGEMENT AND INVOLVEMENT OF PEOPLE IN RECOVERY, TRAUMA SURVIVORS, PEOPLE RECEIVING SERVICES, AND FAMILY MEMBERS RECEIVING SERVICES: These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach that differentiates it from the usual approaches to services and care.

CROSS SECTOR COLLABORATION: Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization's mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

SCREENING, ASSESSMENT, AND TREATMENT SERVICES: Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach. Trauma screening and assessment are an essential part of the work. Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

TRAINING AND WORKFORCE DEVELOPMENT: On-going training on trauma and peer-support are essential. The organization's human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals with complex trauma.

PROGRESS MONITORING AND QUALITY ASSURANCE: There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments and treatment.

FINANCING: Financing structures are designed to support a trauma-informed approach which includes resources for: staff training on trauma, key principles of a trauma-informed approach; development of appropriate and safe facilities; establishment of peer-support; provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and development of trauma-informed cross-agency collaborations.

EVALUATION: Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

To further guide implementation, the chart on the next page provides sample questions in each of the ten domains to stimulate change-focused discussion. The questions address examples of the work to be done in any particular domain yet also reflect the six key principles of a trauma-informed approach. Many of these questions and concepts were adapted from the work of Fallot and Harris, Henry, Black-Pond, Richardson, & Vandervort, Hummer and Dollard, and Penney and Cave.[39, 40, 41,42]

While the language in the chart may seem more familiar to behavioral health settings, organizations across systems are encouraged to adapt the sample questions to best fit the needs of the agency, staff, and individuals being served. For example, a juvenile justice agency may want to ask how it would incorporate the principle of safety when examining its physical environment. A primary care setting may explore how it can use empowerment, voice, and choice when developing policies and procedures to provide trauma-informed services (e.g. explaining step by step a potentially invasive procedure to a patient at an OBGYN office).

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

KEY PRINCIPLES					
Safety	**Trustworthiness and Transparency**	**Peer Support**	**Collaboration and Mutuality**	**Empowerment, Voice, and Choice**	**Cultural, Historical, and Gender Issues**
10 IMPLEMENTATION DOMAINS					
Governance and Leadership	• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? • How do the agency's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? • How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?				
Policy	• How do the agency's written policies and procedures include a focus on trauma and issues of safety and confidentiality? • How do the agency's written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery? • How do the agency's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training? • How do human resources policies attend to the impact of working with people who have experienced trauma? • What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?				

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Physical Environment	• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? • In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this? • How has the agency provided space that both staff and people receiving services can use to practice self-care? • How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).
Engagement and Involvement	• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services? • How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information? • How is transparency and trust among staff and clients promoted? • What strategies are used to reduce the sense of power differentials among staff and clients? • How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
Cross Sector Collaboration	• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions? • Are collaborative partners trauma-informed? • How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services? • What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?
Screening, Assessment, Treatment Services	• Is an individual's own definition of emotional safety included in treatment plans? • Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? • Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? • How are peer supports integrated into the service delivery approach? • How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women? • Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding? • How are these trauma-specific practices incorporated into the organization's ongoing operations?

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Training and Workforce Development	• How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences? • How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? • How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? • How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety? • How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors. • What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? • What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?
Progress Monitoring and Quality Assurance	• Is there a system in place that monitors the agency's progress in being trauma-informed? • Does the agency solicit feedback from both staff and individuals receiving services? • What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency? • How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes? • What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?
Financing	• How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? • What funding exists for cross-sector training on trauma and trauma-informed approaches? • What funding exists for peer specialists? • How does the budget support provision of a safe physical environment?
Evaluation	• How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach? • How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? • What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality? • What measures or indicators are used to assess the organizational progress in becoming trauma-informed?

Next Steps: Trauma in the Context of Community

Delving into the work on community trauma is beyond the scope of this document and will be done in the next phase of this work. However, recognizing that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process.

Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.

Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not. The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

Conclusion

As the concept of a trauma-informed approach has become a central focus in multiple service sectors, SAMHSA desires to promote a shared understanding of this concept. The working definitions, key principles, and guidance presented in this document represent a beginning step toward clarifying the meaning of this concept. This document builds upon the extensive work of researchers, practitioners, policymakers, and people with lived experience in the field. A standard, unified working concept will serve to advance the understanding of trauma and a trauma-informed approach for public institutions and service sectors.

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Trauma-informed care in child/family welfare services

Liz Wall, Daryl Higgins and Cathryn Hunter

CHILD FAMILY COMMUNITY AUSTRALIA | INFORMATION EXCHANGE

This paper aims to define and clarify what trauma-informed service delivery means in the context of delivering child/family welfare services in Australia. Exposure to traumatic life events such as child abuse, neglect and domestic violence is a driver of service need. Policies and service providers must respond appropriately to people who are dealing with trauma and its effects in order to ensure best outcomes for individuals and families using these services. In addition to evidence-based programs or clinical interventions that are specific to addressing trauma symptoms, such as trauma-focused cognitive behaviour therapy, there is a need for broader organisational- or service-level systems of care that respond to the needs of clients with a lived experience of trauma that go beyond a clinical response. Some of the challenges identified in implementing and embedding trauma-informed care across services and systems are discussed.

KEY MESSAGES

- Traumatic experiences are common, with people often having multiple adverse experiences across their life. There are many serious and deleterious outcomes associated with exposure to them.
- Clients often present to child/family welfare services with a complex range of symptoms and behaviours related to prior and/or past trauma, which neither they nor those working with them have linked to this previous trauma exposure. As a result they may face an uninformed and fragmented response that is potentially re-traumatising.
- There are a small number of trauma-specific interventions that have been evaluated using a rigorous scientific standard and been shown to be effective—however, the research is often based on populations who have experienced a single traumatic event rather than complex trauma.
- Trauma-informed care is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.
- With the lack of an overarching framework in Australia, there is a danger of inconsistent or piecemeal development of trauma-informed models and practices that do not share a consistent language or framework for implementing trauma-informed systems of care in child/family services.
- As trauma affects a large proportion of the population, survivors are clients in a broad range of human services, and organisations across all settings should consider how a trauma-informed approach could benefit stakeholders, regardless of whether or not the organisation also provides evidence-based trauma-specific interventions.
- Challenges to implementing a trauma-informed approach to care include: a lack of clearly articulated definitions (e.g. of trauma-specific interventions vs the concept and principles of trauma-informed care); translating trauma-informed care to specific practice and service settings; consistency across service settings and systems; care-coordination; a lack of guidance for facilitating complex system change; and a lack of evaluation of models of trauma-informed care.
- Research is needed to explore whether different trauma-informed approaches are required for different population groups, including children, adolescents and adults, or for males and females.

Understanding the experiences of adversity in childhood such as sexual or other abuse as trauma is now recognised to be an important concept for human service delivery sectors. The USA has led efforts to incorporate trauma theory into mental health and other service delivery, largely driven by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA funds two major trauma-related resources, the National Center for Trauma-Informed Care (NCTIC) and the National Child Traumatic Stress Initiative (NCTSI), to provide a focus for developing a shared language and evidence base around trauma and trauma-informed approaches to service. Emerging

efforts in Australia are now contributing to our knowledge of effective practice for children, young people and adults who have experienced trauma from events such as child maltreatment, sexual assault, military service, forced adoption and past family separation practices.

This paper aims to define and clarify what trauma-informed service delivery means in an Australian context. Australia is not as far down the track as the USA in terms of implementing a trauma-informed approach to human service provision in systems such as mental health and child and family services. There is, however, a recognition that exposure to traumatic life events is a driver of service need and that policies and service providers must address and respond to trauma appropriately to ensure best outcomes for individuals and families using these services.

Trauma terminology

There has been extensive debate around the classification and terminology for describing the effects of trauma, as well as the relationship to specific diagnostic terms such as post-traumatic stress disorder (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005; Wall & Quadara, 2014). The latest iteration of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), an international classification system for mental health disorders, has taken a broad approach to the terminology with a category of "Trauma and Stressor Related Disorders" rather than specifically including complex trauma as a diagnostic term.

Any discussion of trauma-informed service delivery requires consideration of the vast array of definitions and terminology that arises around trauma. This section explains some of the different terms, phrases and concepts that are used in the literature to describe trauma and trauma-related service provision.

Recently, there have been attempts to provide consistency in definitions and a shared language around trauma and a trauma-informed approach to care. SAMHSA's (2014) *Concept of Trauma and Guidance for a Trauma-Informed Approach* puts forward definitions and a working concept of trauma and a trauma-informed approach in order to develop a shared understanding of these concepts for service systems and stakeholders. SAMHSA is a key resource for trauma-informed approaches to care and these definitions are likely to be widely adopted.

What is trauma?

Traumatic events have been described as those that "overwhelm the ordinary human adaptations to life [and] … generally involve threats to life or bodily integrity, or a close personal encounter with violence and death" (Herman, 1992, p. 33). SAMHSA's concept of trauma provides a comprehensive definition that encompasses trauma related to one-off events as well as ongoing adversity:

> Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing. (SAMHSA, 2014, p. 7)

Although not diagnostic terms, *complex trauma* and *complex post-traumatic stress disorder* are often used to describe trauma that is the result of stressors that are interpersonal—usually severe, sustained and perpetrated by one human being on another—and where clients may not meet all of the specific diagnostic criteria for post-traumatic stress disorder (PTSD) or where the primary clinical presentation is the associated features due to the global effects of trauma on the person's functioning (Connor & Higgins, 2008a, 2008b). Trauma is particularly damaging when it occurs in childhood. Complex, interpersonally generated trauma is severely disruptive of a person's capacity to manage internal states (Kezelman & Stavropoulos, 2012). Complex trauma symptoms include problems with mood regulation, impulse control, self-perception, attention, memory and somatic disorders (Briere & Jordan, 2004; Burstow, 2003; van der Kolk et al., 2005).

Trauma-informed interventions occur at two levels: trauma-specific interventions and trauma-informed models of care. Organisational responses to trauma tend to occur on a continuum from basic trauma awareness, to trauma sensitivity, trauma responsivity and through to trauma-informed and/or trauma-specific interventions. We argue here that it is helpful for organisations providing services in the child/family welfare domain, and human services more broadly, to think about their organisational responses to trauma based on their particular service and client needs.

Trauma-specific interventions

Trauma-specific interventions refer to clinical services or programs designed to treat and ameliorate the actual symptoms and presentations of trauma. While it is possible for individual practitioners to deliver trauma-specific interventions (such as trauma-focused cognitive behaviour therapy [CBT]) within the context of a service delivery model or agency that is not trauma-informed at a system level, this is far from ideal. Elements of a service may not be consistent with a trauma-informed approach—such as the waiting room design and operation, interactions with administrative staff or the absence of adjunct services to address other presenting issues for which the trauma-specific intervention might not be effective. Trauma-specific services are best delivered as part of a trauma-informed system of care operating within a trauma-aware organisational context (Elliot, Bjelajac, Fallor, Markoff, & Reed, 2005; Kezelman & Stavropoulos, 2012).

Funded by the Department of Veterans' Affairs, Phoenix Australia (previously known at the Australian Centre for Posttraumatic Mental Health) has developed a database that summarises the evidence for effective trauma-specific interventions related to military and veteran families and communities (see *What Emerging Interventions are Effective for the Treatment of Adults with PTSD?* <www.evidencecompass.dva.gov.au/home/question/10>). Regarding adults suffering from PTSD, they found a paucity of evidence in relation to the efficacy of emerging therapies.[1] Phoenix Australia have also published a variety of resources for practitioners working with people affected by trauma, including fact sheets, clinical guidelines, booklets for clients and a smartphone app for clients with post-traumatic stress symptoms <phoenixaustralia.org/for-practitioners/practitioner-resources>.

Trauma-focused cognitive behaviour therapy (TF-CBT) is an evidence-based treatment approach for children who have experienced sexual abuse, exposure to domestic violence or similar traumas.[2] TF-CBT features on a range of databases of evidence-based practices, including the California Evidence-Based Clearinghouse for Child Welfare (CEBC) Program Registry: <www.cebc4cw.org>. Training in TF-CBT is available online from the Medical University of South Carolina website: <tfcbt.musc.edu>. However, a full discussion of evidence-based trauma-specific interventions is beyond the scope of this paper.[3]

Similarly, in relation to adults affected by childhood trauma, Connor and Higgins (2008a, 2008b) outlined a model of trauma-specific intervention for clients who experience complex trauma (who may not meet the criteria for PTSD). Evaluating the model, they found qualitative and quantitative evidence from a small-scale pilot study of the effectiveness of their combined individual and group therapy approach focused on the following elements (using the mnemonic "HEALTH"):

- having a supportive therapist;
- ensuring personal safety;
- assisting with daily functioning;
- learning to manage core PTSD symptoms (self-regulation);
- treating complex PTSD symptoms; and
- having patience and persistence to enable "ego strengthening".

1 The emerging interventions included in their review were: mindfulness, acceptance and commitment therapy, meditation, transcendental meditation, acupuncture, power therapies, and experiential psychotherapies including adventure therapy, art therapy, music therapy, and canine- and equine-assisted psychotherapy. See: <evidencecompass.dva.gov.au/home/question/10>.

2 See: *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma* (Child Welfare Information Gateway, 2012) <www.childwelfare.gov/pubpdfs/trauma.pdf>.

3 See *Approaches Targeting Outcomes for Children Exposed to Trauma Arising From Abuse and Neglect: Evidence, Practice and Implications* (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2014) for a discussion of the evidence of the effectiveness of trauma-specific and trauma-informed practices pertaining specifically to children who have experienced abuse and neglect.

However, there have been criticisms made of trauma-specific interventions. For example:

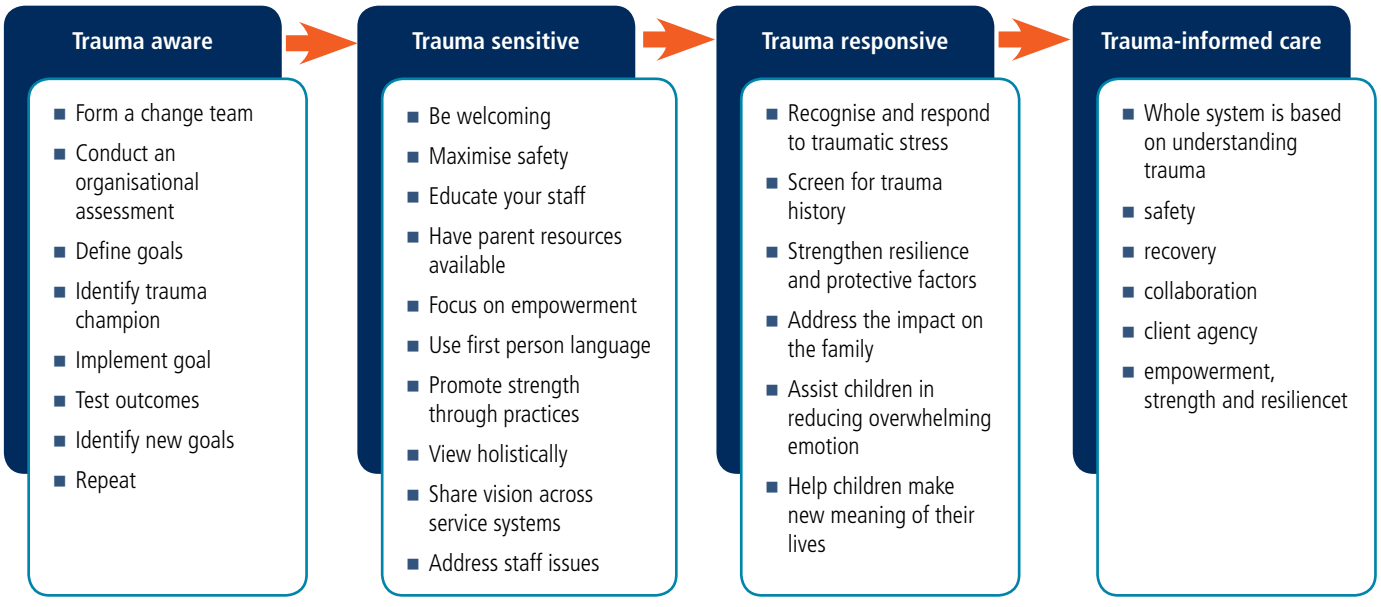
- complex trauma is often inter-relational in nature, so the degree to which research on the treatment of combat-related PSTD applies in these circumstances has been questioned (e.g. for those exposed to prolonged child sexual abuse, particularly if it has resulted in personality or dissociative disorders and is associated with disturbances to affect regulation, self-concept and interpersonal relationships);
- treatment sessions may need to be more frequent and over a longer duration than typical structured programs;
- evaluations of cognitive-based interventions often focus on statistically significant effect sizes rather than clinically meaningful symptom reduction; and
- the value of non-cognitively based interventions, which have been poorly evaluated or not evaluated, are easily overlooked (see: van der Kolk, 2014).

The primary purpose of the paper is not to review the effectiveness—or limitations—of trauma-specific interventions, or even to look specifically at complex trauma and complex PTSD (see: Wall & Quadara, 2014); but rather to explore the broader issue of the value and role of trauma-informed care in child and family welfare service provision.

Trauma-informed model of care

The available literature suggests that there is a continuum from being *trauma aware* (seeking information out about trauma and its implications for organisations) to being *trauma-informed* (a cultural shift at the systemic level). One useful resource sets out the progression in four stages (see Figure 1):

- *trauma aware*: seek information out about trauma;[4]
- *trauma sensitive*: operationalise concepts of trauma within the organisation's work practice;
- *trauma responsive*: respond differently, making changes in behaviour;
- *trauma informed*: entire culture has shifted to reflect a trauma approach in all work practices and settings.



Source: Adapted by Antonia Quadara from Mieseler & Myers (2013)

Figure 1: Practical steps to get from trauma aware to trauma informed

4 At its most basic level, organisations that are trauma aware incorporate trauma awareness into their work. Staff have an understanding of trauma and how symptoms and behavioural presentations in individuals may be responses to traumatic experiences so that behaviours that appear self-destructive or self-defeating can be acknowledged as being adaptive behaviours to trauma that have become maladaptive over time (Hopper, Bassuk, & Olivet, 2010; Markoff, Fallot, Reed, & Elliot, 2005). This applies particularly to broader human service delivery agencies (beyond child/family welfare), particularly if they are not primarily focused on delivering trauma-specific interventions and/or trauma-informed models of care.

SAMHSA's definition of a trauma-informed approach to service is:

> A program, organisation or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff and others involved with the system and responds by fully integrating knowledge about trauma into policies, procedures and practices and seeks to actively resist retraumatisation (SAMHSA, 2014, p. 9)

The main aim of this paper is to explore trauma-informed approaches to care and service delivery specifically in the child and family welfare sectors. While the focus is on how child/family welfare services can be trauma informed, the need extends to other service delivery areas. The trauma literature indicates that trauma survivors are clients in a very broad range of human services such as:

- homelessness (Hopper et al., 2010; Morrison 2009);
- mental health (Kezelman & Stavropoulos, 2012; Muskett, 2014);
- substance abuse treatment; and
- correctional systems (Stathopoulos, 2012).

These types of services have a clear connection to the impacts of trauma, particularly trauma arising from interpersonal victimisation, which has been identified as a driver of human service use (Huntington, Moses, & Veysey, 2005). The term "complex needs" is sometimes used to describe the span of need for an array of services required over a lifetime (Wall & Quadara, 2014). These agencies and services would benefit from being—at a minimum—"trauma aware".

What is the evidence that a trauma-informed approach is needed?

Research suggests that exposure to adverse, potentially traumatic events in childhood is not uncommon (Anda et al., 2006). For example, the Adverse Childhood Experiences (ACE) study in the USA showed that of 17,337 respondents, 64% had experienced at least one adverse experience[5] and approximately 12% had experienced four or more in the first 18 years of life (Anda et al., 2006). Further to this, a recent report suggested that childhood trauma affects an estimated five million Australian adults (Kezelman, Hossack, Stavropoulos, & Burley, 2015). There is also a great deal of evidence associating traumatic experiences with a broad range of deleterious outcomes in childhood, adolescence and adulthood (e.g. Anda et al., 2006; CFCA, 2014a, 2014b; Dube et al., 2001; Hahn Fox, Perez, Cass, Baglivio, & Epps, 2015; Johnson-Reid, Kohl, & Drake, 2012; Nurius, Green, Logan-Greene, & Borja, 2015).

Individual responses to traumatic experiences vary widely, with not all exposure leading to negative outcomes. It is the individual response to the experience that determines whether it is considered traumatic or not (SAMHSA, 2014). If effects occur they can be short- or long-term and may occur immediately following exposure to adversity or have a delayed onset (SAMHSA, 2014).

Multiple studies have reported negative effects associated with experiencing trauma across all facets of life. Mental ill-health, physical illness, social and relational difficulties, and poor academic and employment outcomes have all been linked to previous traumatic experiences. Anda and colleagues (2006) found a strong relationship between increased numbers of adverse childhood experiences and increased prevalence and risk of:

- affective disturbances (e.g. panic attacks, anxiety, hallucinations);
- somatic disturbances (e.g. sleep disturbance, severe obesity);
- smoking, illicit drug use, injected drug use, alcoholism (for people with four or more adverse childhood experiences);
- early intercourse, promiscuity and sexual dissatisfaction;
- impaired memory of childhood; and

5 The adverse childhood experiences measured were three types of childhood abuse: emotional abuse, physical abuse, and contact sexual abuse; and five measures of household dysfunction during childhood: exposure to alcohol or other substance abuse, mental illness, violent treatment of mother or step-mother, criminal behaviour in the household, and parental separation or divorce (Anda et al., 2006, p. 176).

- high perceived stress, difficulty controlling anger and risk of perpetrating intimate partner violence (for people with four or more adverse childhood experiences).

Further to this, the study found that as the number of adverse childhood experiences increased so too did the average number of co-occurring negative outcomes (Anda et al., 2006). There is strong evidence to indicate that certain types of trauma rarely occur in isolation. Research suggests, for example, that the different child maltreatment types are interrelated: sexual abuse, physical abuse, psychological maltreatment, neglect and exposure to domestic and family violence typically occur in combination with each other. A large proportion of children and young people who experience childhood abuse or neglect are exposed to more than one type of abuse (known as "multi-type maltreatment"; Price-Robertson, Higgins, & Vasallo, 2013). Further to this, other forms of victimisation such as bullying or assault by a peer have often been found to co-occur with child maltreatment (known as "poly-victimisation"; see Finkelhor, Ormrod, & Turner, 2007).

Multiple victimisation experiences across different domains are consistently associated with poorer outcomes than a single adverse or maltreatment experience. Those who experience multi-type maltreatment or poly-victimisation are more likely to experience high levels of trauma symptoms and worse outcomes than those who are exposed to no maltreatment or only one type (Finkelhor et al., 2007; Higgins & McCabe, 2001). Supporting these findings, a recent large scale US study of children in the Illinois child welfare system found that children who experienced both violent interpersonal *and* attachment-based ("non-violent") traumas within the caregiver system experienced greater difficulties across several areas of impairment (including attention/behavioural dysregulation and self/relational dysregulation) and were significantly more likely to exhibit PTSD-like symptoms compared to children who had experienced neither type of trauma, violent trauma only or non-violent trauma only (Kisiel et al., 2014).

Co-occurring mental health issues and disorders such as conduct disorder and oppositional defiant disorder (in children), PTSD, depression and other affective disorders, borderline personality disorder, somatoform disorders, psychotic and dissociative disorders have commonly been associated with traumatic experiences (Bateman, Henderson, & Kezelman, 2013; Breslaue, 2009; CFCA, 2014a, 2014b; Nurius et al., 2015; van der Kolk et al., 2005). Self-harm and suicide attempts have also been linked with previous traumatic experiences (Bateman et al., 2013; Cozolino, 2010; Dube et al., 2001; Herman, 1992; Johnson-Reid et al., 2012). In one study, Dube and colleagues (2001) reported that any adverse childhood experience increased the risk of attempted suicide by 2–5 fold with the relationship being partially mediated by illicit drug use, depressed affect and self-reported alcoholism.

Those who have had previous traumatic experiences also commonly report physical health issues. For example, in summarising research on the potential effects of trauma exposure, Bateman and colleagues (2013) found that "survivors of child maltreatment were at increased risk of hepatitis, diabetes, heart disease, cancer, a stroke, are more likely to have surgery and are at increased risk of having one or more chronic pain symptoms" (p. 19). The same authors also noted a range of conditions that child sexual abuse survivors were at increased risk of, including irritable bowel syndrome, asthma, arthritis and digestive problems.

In addition, childhood trauma exposure has been linked to involvement with the criminal justice system. A large study exploring adverse childhood experiences of serious, chronic and violent juvenile offenders and juveniles referred to the justice system for single non-violent offences found that every additional adverse childhood event experienced increased the risk of becoming a serious, chronic and violent juvenile offender by more than 35%, even when other known risk factors for violent behaviour were accounted for (Hahn Fox et al., 2015).

Lastly, difficulties in interpersonal relationships are often reported as a result of experiencing trauma (Bateman et al., 2013; Briere & Spinazzola, 2005; Evans & Coccoma, 2014; van der Kolk, 2005).

Although individual responses to traumatic experiences may vary widely, research has found a strong relationship between the degree of risk of experiencing multiple and complex negative outcomes following traumatic experiences and factors such as the age at which the experience/s occurred, the nature of the experience/s (with negative effects being particularly associated with

trauma of an interpersonal nature such as child abuse and neglect), and the severity and chronicity of the experiences (Cozolino, 2010; Herman, 1992; Kisiel et al., 2014; National Scientific Council on the Developing Child, 2014 [NSCDC]; Resick et al., 2012; van der Kolk et al., 2005). As noted by Cozolino (2010):

> The impact of trauma depends on a complex interaction of the physical and psychological stages of development during which it occurs, the length and degree of the trauma, and the presence of vulnerabilities or past traumas. The impact of chronic trauma becomes woven into the structure of personality and is hidden behind other symptoms, making it difficult to identify, diagnose and treat. (p. 266)

Traumatic events experienced early in life can be extremely damaging to the developing brain. Neural development relies on the interplay of genes and environmental inputs (particularly interaction with primary carers) and early adversity or disrupted attachment relationships that lead to chronic high levels of stress can interfere with key neurobiological development (NSCDC, 2014). Pamela Alexander (2013) suggested that "affective synchronization between mother and child" (p. 45) in carer–infant interactions is crucial for brain development, social development and stress regulation. Early onset, sustained trauma that interferes with this can lead to deficits in multiple domains: dysfunction in fear extinction; affect or emotional regulation; behaviour regulation; learning, cognition and attention; and self and relational dysregulation (Cook et al., 2005; Courtois & Ford, 2009; Evans & Coccoma, 2014; Kisiel et al., 2014; NSCDC, 2014; van der Kolk et al., 2005).

Research has also highlighted that experiencing traumatic events tends to increase the chances of experiencing further traumatic events across the life course. Cozolino (2010) argued that:

> Enduring personality traits and coping strategies that emerge in these situations [experiencing early onset, sustained trauma] tend to decrease positive adaptation and increase an individual's vulnerability to future trauma. This can manifest through engagement in abusive relationships, poor judgement, or a lack of self-protection. (pp. 268–9)

Finally, in examining the need for a trauma-informed approach to care it is pertinent to note that in many cases, due to the co-occurrence of problems resulting from experiencing trauma, individuals may find themselves in multiple systems, cycling in and out of specific services over many years to access, for example, treatment for drug and alcohol addictions, support for employment opportunities and therapeutic services for mental illness.

Historically, the underlying factor often linking a constellation of needs together—the history of abuse and its impacts—has not been adequately acknowledged or integrated into these service systems' service responses to individuals (Harris & Fallot, 2001). Further, populations with complex needs are at high risk of falling through the gaps of service delivery systems due to a lack of service co-ordination and the related barriers to service integration (Whiteford & McKeon, 2012). This can mean that clients: are deemed ineligible for services (e.g. cannot engage in mental health treatment until they have "dealt with" their substance abuse issue or vice versa); are expected to separate out their trauma experiences from their service or treatment needs ("we don't deal with trauma in this parenting class"); and experience services systems' responses as re-traumatising.

The SAMHSA-funded *Women With Co-Occurring Disorders and Violence Study* was a comprehensive 5-year project (1998–2003) across multiple sites, which provided evidence that integrating different services, such as mental health and substance abuse services where there was client need for both, was effective. This study showed that trauma-informed approaches could enhance the effectiveness of mental health and substance abuse services for women with co-occurring mental health and substance abuse disorders (Huntington et al., 2005; Morrisey et al., 2005). A trauma committee for this study also developed an understanding of trauma-informed principles and ways in which mental health and substance abuse service providers could use the approach (Elliot et al., 2005). In the years since the study, further development, debate and discussion has resulted in an expanded evidence base about the effects of trauma and appropriate approaches for services.

What is trauma-informed care?

Trauma-informed care could be described as a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs (Harris & Fallot, 2001). This requires consideration of a person's environment beyond the immediate service being provided and of how their symptoms and presentations may be seen as adaptations to trauma rather than as pathologies (Herman, 1992). At the broadest level, trauma-informed care means that services have an awareness and sensitivity to the way in which clients' presentation and service needs can be understood in the context of their trauma history (Knight, 2015). Kezelman and Stavropoulos (2012) noted that trauma-informed health and welfare settings and systems contrast dramatically with traditional settings and systems as they require different ways of operating, and without this understanding, risk re-traumatising service users. Trauma-informed approaches to care could be described as a strengths-based framework that is responsive to the effects of trauma (Bateman et al., 2013).

Principles of trauma-informed care

Principles of trauma-informed care have been articulated in a range of academic literature and guidance publications (Elliot et al., 2005; Hopper et al., 2010; Jennings, 2004; Kezelman & Stavropoulos, 2012; SAMHSA, 2014). These principles vary in length and number depending on the publication but essentially have the same underlying philosophies, that trauma-informed care means services are trauma aware, safe, strengths-based and integrated.

At the very minimum, trauma-informed services aim to do no further harm through re-traumatising individuals by acknowledging that usual operations may be an inadvertent trigger for exacerbating trauma symptoms. SAMHSA's (2014) approach to trauma-informed care makes four key assumptions that must be present as a basis of implementation for trauma-informed care, with a further six key principles to then be applied.

The key assumptions that SAMHSA has identified as needing to be inherent in any trauma-informed approach are based on four "R"s:

- *Realisation* at all levels of an organisation or system about trauma and its impacts on individuals, families and communities;
- *Recognition* of the signs of trauma;
- *Response*—program, organisation or system responds by applying the principles of a trauma-informed approach; and
- *Resist* re-traumatisation—of clients as well as staff.

In addition to these assumptions, SAMHSA (2014) then described six key principles of a trauma-informed approach:

- *Safety*—Staff and the people they serve feel physically and psychologically safe.
- *Trustworthiness and transparency*—Organisational operations and decisions are transparent and trust is built.
- *Peer support*—Peers is the terminology SAMHSA use for individuals with lived experience of trauma or their caregivers. Peers are also known as "trauma survivors".
- *Collaboration and mutuality*—This principle is about levelling power differentials between staff and clients and amongst organisational staff to ensure a collaborative approach to healing.
- *Empowerment, voice and choice*—This principle emphasises the strengths-based nature of trauma-informed care. The organisation—and ideally the whole service delivery system—fosters recovery and healing.
- *Cultural, historical and gender issues*—A trauma-informed approach incorporates processes that move past cultural stereotypes and biases, and incorporates policies, protocols and processes that are responsive to the cultural needs of clients.

For an example of an Australian model of trauma-informed care, see Tucci and Mitchell's (2015) outline of the basic understanding of trauma that informs appropriate care underpinning the services and training provided by the Australian Childhood Foundation: *9 Plain English Principles of Trauma Informed Care* <www.childhood.org.au/blog/home/2015/april/trauma-informed-care>.

The Berry Street Childhood Institute also provides a number of resources and training on trauma-informed care for children: <www.childhoodinstitute.org.au/Resources>.

Achieving trauma-informed services: Reflection questions for service managers

- What is the likelihood of clients who have experienced trauma accessing our service?
- Do we provide access to trauma-specific evidence-based treatments for current psychological difficulties that result from that trauma (e.g. Trauma-focused cognitive-behaviour therapy)?
  - See *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma* <www.childwelfare.gov/pubpdfs/trauma.pdf>
- Do we provide access to effective treatments for complex trauma and complex PTSD (for which trauma-specific treatments may not be as effective)?
  - (See: Connor & Higgins, 2008a, 2008b; Kezelman & Stavropoulos, 2012).
- Are these trauma-specific interventions provided inhouse, in collaboration with other agencies, or via referral to an external agency (and if so, do we provide active/warm referral)? See:
  - *Interagency collaboration: Part A. What is it, what does it look like, when is it needed and what supports it?* <aifs.gov.au/cfca/publications/interagency-collaboration-part-what-it-what-does-it>
  - *Interagency collaboration: Part B. Does collaboration benefit children and families? Exploring the evidence.* <aifs.gov.au/cfca/publications/interagency-collaboration-part-b-does-collaboration-benefi>
  - *Effective practices for service delivery coordination in Indigenous communities*. <www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2011/ctgc-rs-08.pdf>
- How do we incorporate restorative justice principles?
  - According to Higgins et al. (2014), restorative justice activities might include:
    - addressing trauma and other mental health consequences through evidence-based therapeutic interventions;
    - repairing the injuries caused to relationships, especially between sons/daughters and parents;
    - providing opportunities for truth-telling, storytelling and acknowledgement; and
    - overcoming shame and recognising past actions through public activities and community awareness campaigns.
  - See: Higgins et al., 2014, pp. 41–46: *Forced Adoption Support Services Scoping Study* <www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/forced-adoption-support-services-scoping-study>
- Who in the organisation is likely to come into contact with individuals who have experienced trauma, or be providing information to, or receiving communications from clients experiencing trauma? Thinking from a "client journey" perspective, this might include:
  - phone/intake staff;
  - web/staff with online monitoring;
  - reception;
  - office manager;
  - media and communications staff;
  - other staff or contractors on the premises (e.g. catering, cleaning, security); and
  - project/service delivery professionals and support staff.

- Who is less likely to be interacting with trauma survivors but who need to understand, and who need to support "front-line" workers and other support staff who do?
  - executive staff (who create the authorising environment);
  - managers and team leaders; and
  - mentors and supervisors.

This suggests the value of whole-of-organisation approaches to trauma-informed service delivery, directed at every level to ensure a focus on what helps clients feel safe.

- What should training encompass? Training should include:
  - skills in de-escalation or "holding" clients who are experiencing an acute episode of trauma or re-traumatisation;
  - debriefing and staff protocols for responding to difficult situations and clients presenting with complex circumstances and trauma histories;
  - information on staff care and preventing/responding to secondary or vicarious trauma—the psychological term for changes that can occur to people when they are repeatedly exposed to traumatic material (see <aifs.gov.au/publications/feeling-heavy>);
  - organisational supports to prevent or address vicarious trauma for staff including: clinician self-care skills and reflective practice, caseload management, supervision, debriefing, staff and peer support, workplace safety, comfort and supportive work culture that acknowledges the reality of vicarious trauma (Morrison, 2007);
  - types of events/circumstances in clients' lives that may be traumatising;
  - typical modes of reacting—events/triggers for re-traumatisation; and
  - understanding the impacts of trauma (such as behavioural symptoms typical of PTSD, as well as the developmental impacts of victimisation and trauma on an individual's beliefs—about the self, the world, and the future—e.g. see: Janoff-Bulman & Frieze, 1983).

Further to this, SAMHSA also provide a range of sample questions to consider when implementing a trauma-informed approach <store.samhsa.gov/shin/content//SMA14–4884/SMA14–4884.pdf> (p.14–16).

Which services should be delivering trauma-informed care?

Most of the US literature about trauma-informed care is directed at change in behavioural health services. In Australia there appears to be an emphasis on driving change in the mental health sector. This has the potential to cause confusion about the pathway to providing trauma-informed care in the child, family and community sectors and about what being trauma-informed actually means. One aspect of clarifying these questions is to understand which services should be adopting a trauma-informed approach to human service delivery.

In addition, there are communities and populations for whom violence and intergenerational trauma are a constant reality. Some Indigenous communities, for example, experience the phenomenon of trans-generational trauma whereby trauma is transmitted across a number of generations (Atkinson, 2002). The historical impacts of colonisation on Aboriginal people in Australia have played out in a history of disadvantage and discrimination as traditional Aboriginal life was gradually disrupted and dismantled (Atkinson, 2002; Keel, 2004). The effectiveness of the full range of health and human services in such communities could be enhanced by a trauma-informed approach (Atkinson, 2013).

As outlined in the earlier discussion on principles of trauma-informed care, it is important for services to be culturally attuned and relevant (Atkinson, 2013). This is described by SAMHSA as the principle that the trauma-informed organisation actively moves past cultural and gendered stereotypes and incorporates policies and processes that are responsive to the cultural needs of individuals served, including addressing historical trauma (SAMHSA, 2014) or collective trauma (Atkinson, 2013).

Building on the work of Harris and Fallot, SAMHSA's (2014) *Concept of Trauma and Guidance for a Trauma-Informed Approach* outlined ten implementation domains:

- governance and leadership;
- policy;
- physical environment;
- engagement and involvement;
- cross-sector collaboration;
- screening, assessment, treatment services;
- training and workforce development;
- progress monitoring and quality assurance;
- financing; and
- evaluation (p. 12).

This guidance information is designed to provide a starting point for an organisational approach to implementing trauma-informed care. It also indicates that organisations across *all* settings should consider how trauma-informed approaches could benefit stakeholders regardless of whether they deal with trauma in their day-to-day business. The reality of the prevalence of traumatic experiences in the general population indicates that trauma is not confined to prevention, treatment and recovery settings but is integral in other systems as well (SAMHSA, 2014).

It is important to note that many practices that service providers currently use are likely to already be consistent with a trauma-informed approach, such as conveying empathy and validating the client's experiences (Knight, 2015). What is different about identifying as a trauma-informed service is that there is a paradigm shift in service delivery culture to acknowledge and clearly articulate the importance of trauma in understanding and responding to client presentation.

With the lack of an overarching framework in Australia, there is a danger of developing trauma-informed models and practices that are not sharing a consistent language about what being trauma-informed entails. This issue is discussed in more depth in the section about challenges to implementation later in this paper.

The need for a systems approach to trauma-informed care

Following the lead of the USA, Australian health agencies are moving towards a trauma-informed paradigm for considering health and human service delivery systems (Kezelman & Stavropoulos, 2012) in preference to a medical model of individual illness (DeCanandia, Guarino, & Clervil, 2014).

The effects of traumatic experience often manifest in behaviours that result in people being involved in human service systems that go beyond mental health, such as the criminal justice system (SAMHSA, 2014). A systems approach to trauma-informed care means that implementation goes beyond individual practitioner and service organisation change to extend to whole systems that people who have experienced trauma are likely to interact with. A system, for example, could include the justice, homelessness or child welfare systems. These systems may not include treatment settings but can still affect the people who experience them. In the USA, a range of systems are in the process of adopting a cross-sectoral approach to implementing trauma-informed care and trauma-specific services to support service users (DeCanandia et al., 2014). For example, the behavioural health and health care, veterans' administration, homelessness and education sectors are just a few of the systems that are shifting to a trauma-informed approach (DeCanandia et al., 2014).

The differences between trauma-informed services and trauma-specific services are described in the definitions outlined earlier. It is important to distinguish between them but acknowledge the intersection of the two types. Trauma-specific services are designed to treat the symptoms or manifestations of the effect of a trauma on an individual but these interventions must be delivered in a trauma-informed context. This emphasises an overall philosophy of trauma as a central concept in understanding the presentation of clients within a range of health and welfare settings (Kezelman & Stavropoulos, 2012).

Challenges in implementing a trauma-informed approach to care

As noted previously, implementing trauma-informed care requires a paradigm shift in service delivery (Hopper et al., 2010; Jennings, 2004). The literature around trauma-informed care indicates that there are still some challenges to implementing this approach for systems and services, as well as the need for research to evaluate the approach's effect on client wellbeing and other service delivery outcomes (Ashmore, 2013; Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Hopper et al., 2010; Muskett, 2014). These challenges are discussed in the following sections.

Inconsistent understandings of what it means to be trauma-informed

The most identifiable challenges across the literature are in the need to create shared understandings, and current inconsistencies in education regarding trauma-informed care (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Hopper et al., 2010). It is difficult to align organisational change to a specific practice without a shared understanding or vision of what trauma-informed care actually is. In a comparative study of trauma-informed care in acute mental health inpatient units, Ashmore (2013) identified this as an issue in the implementation of trauma-informed care in an acute patient environment. A lack of definition and of a shared framework, as well as a lack of information specific to an acute mental health inpatient setting, were associated with challenges and inconsistency in implementation.

In their review of the literature, the Parenting Research Centre and the Australian Centre for Post-traumatic Health (2013, now Phoenix Australia) found that although participants within the child and family services sector who worked with children exposed to trauma were familiar with terminology such as "trauma-informed care", they argued that:

- the field still lacked clear definitions or understandings of concepts;
- there were assumptions that children's social and behavioural difficulties were necessarily trauma-related without clear assessment; and
- there was a lack of guidelines for assessment and treatment of trauma.

SAMHSA's (2014) recent guidance document is clearly aimed at addressing this lack of consistency in definitions and the 2012 document by Adults Surviving Child Abuse provides some practice guidelines (Kezelman & Stavropoulos, 2012). However, an aspect of trauma-informed care is that it must be culturally relevant to the populations it serves (Elliot et al., 2005; Jennings, 2004) and any broad level articulation of policy approaches or frameworks must be applicable in a range of systems and settings and for a variety of cohorts.

Translating trauma-informed care to specific practice and service settings

In addition to the array of terminology and concepts that are sometimes used interchangeably and inconsistently, there is a lack of evidence-based guidance for specific settings and systems to assist with coordinating how trauma-informed practice should be provided for particular service settings and specific populations of service users. This issue was identified by Muskett (2013) and Ashmore (2013) in relation to mental health nursing, where the need to remove the use of seclusion and restraint is emphasised but, beyond this, little has been articulated to support the use of specific practices for service settings to adopt to improve service delivery consistent with principles of trauma-informed care. Dealing with survivors of trauma, particularly in a mental health or child protection setting, may require individuals to use their prior experience to respond to specific situations. In such stressful and potentially dangerous settings, crisis management could lead to a de-prioritisation of trauma-informed responses (Conners-Burrow et al., 2013). Training and guidance for staff on how to respond to acute situations appropriately and feel confident that they are acting in accordance with the principles of trauma-informed care is recommended (Knight, 2015; Muskett, 2014).

Facilitating complex system change

As noted by the American Institute for Research, in order to build a trauma-informed system, commitment at all system levels is required. This includes a commitment to ongoing training and service transformation (DeCanandia et al., 2014). Australia is behind the USA and Canada in developing models and systemwide responses to children and other service users impacted by trauma (Bateman et al., 2013). For example, the USA has the National Child Traumatic Stress Network, funded by SAMHSA, which brings a singular and comprehensive focus to responding to childhood trauma. Australia is arguably still at the stage of requiring policy change to articulate a clear direction for moving towards systems of trauma-informed care in a range of different service delivery areas relating to child/family wellbeing (Bateman et al., 2013).

Systemic change is important because it enables people to receive services that are sensitive to the impact of trauma regardless of whether they enter through any particular service setting or intervention.

Large-scale systems change is also logistically difficult and time-consuming and requires commitment and resources (Hopper et al., 2010). Philosophical differences between sectors that need to work together to integrate care can also impede systemic change (Hopper et al., 2010). Ashmore (2013) identified particular features of systems change for systems such as mental health that are challenging. These challenges include that hierarchical systems such as health may encounter resistance and that there is an inherent power inequality between service users and professionals in such environments.

Creating change at a systemic level is more than providing practitioners and organisations with tools. It requires changes to funding models to support outcomes rather than outputs, and changes to education for mental health practitioners, social workers and other specialists. Essentially, this is about a move towards a more holistic understanding of the inter-related biological, psychological and social dimensions of trauma.

Evaluating a trauma-informed approach to care

Studies from the USA, particularly following the Women With Co-Occurring Disorders Study, have found that trauma-informed, integrated services are judged to be cost-effective when compared with treatment as usual in the comparison sites of that particular study (Domino, Morrisey, Chung, Huntington, & Larson, 2005). Although this study is regularly cited in the literature as evidence of the cost-effectiveness of trauma-informed care (DeCanandia et al., 2014, Hopper et al., 2010; Kezelman & Stavropoulos, 2012); in reality, there is a lack of evaluation about cost-effectiveness and other aspects of trauma-informed care approaches, including its effectiveness in improving outcomes for service users (Quadara, 2015). There is also a lack of evaluation tools to measure the extent to which an organisation is trauma-informed, and the lack of consistent definitions further translates into difficulties in identifying a clear method to indicate the degree to which a service or program is trauma-informed (Hopper et al., 2010).

Other challenges identified in evaluating trauma-informed care, highlighted by Hopper et al. (2010), include the difficulty in measuring cultural change and sustainability of change and whether changes in outcome are attributable to trauma-informed environments or trauma-specific interventions. In addition, the need for cross-system collaboration and assessing human service interactions to establish the extent of trauma-informed care practice implementation further complicates evaluation in this area (Kramer et al., 2015).

Applying trauma-informed care principles

To illustrate how trauma-informed care principles can be applied to respond to different trauma issues, we briefly look at service delivery in the context of people affected by the policies that created the Stolen Generation, past adoption practices and humanitarian migration.

The Stolen Generation

In their program logic, the Aboriginal and Torres Strait Islander Healing Foundation (2014, p. 25) explain how a collective healing process for members of the Stolen Generation and their descendants can occur, and the mechanisms that underlie this process. Central to this model is an understanding of an Aboriginal world view and the pervasive trauma of colonisation, and the need for specific strategies to address ongoing, collective trauma. A common element of collective healing projects is that they are based on a trauma-informed or recovery framework. According to the Healing Foundation (2014):

> Trauma-informed practice is a strengths-based approach to healing that: is based on an understanding of, and responsiveness to, the impact of trauma; emphasises physical, psychological, and emotional safety for people seeking help and for the helpers; and creates opportunities for people affected by trauma to rebuild a sense of control and empowerment. It recognises the prevalence of trauma and is sensitive to and informed by the impacts of trauma on the wellbeing of individuals and communities. (p. 47)

Forced adoption and past family removal practices

An example of an issue that has only recently received public acknowledgement of its role in traumatising a large number of Australians is the former practice of forced adoption, or separation from family due to past family removal practices. In their exploration of good practice principles for services addressing the needs of people affected by forced adoption and past family removal practices, Kenny, Higgins, and Morley (2015) noted:

> There is increasing recognition of the potential for trauma for individuals who have been subjected to forced adoption policies and practices, and the value of a "trauma-informed" or "trauma-aware" approach to service delivery. Good practice suggests that service providers should approach all clients with a forced adoption experience as if they might be trauma survivors (p. 8).

In their overview of good practice principles, Kenny et al. (2015, p. 8) outlined the key elements of trauma-informed service delivery. Being a trauma-informed service ensures the provision of:

- a safe and supportive environment that protects against physical harm and re-traumatisation;
- an understanding of clients and their symptoms in relation to their overall life background, experiences and culture;
- continued collaboration between service provider and client throughout all stages of service delivery and treatment;
- an emphasis on skill building rather than managing symptoms;
- an understanding of the symptoms and survival responses required to cope;
- a view of trauma as a fundamental experience that influences an individual's identity rather than a single discrete event; and
- a focus on what has happened to a person rather than what is wrong with a person.[6]

Humanitarian migrants surviving torture and trauma

The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) outline the program logic for their service model as systemic and based on an ecological model of factors that influence and support healing for survivors (see *How We Work* <www.startts.org.au/about-us/how-we-work>).

They aim to provide a range of services that reflect the bio-psycho-social model, such as:

- complementary therapies or neurofeedback to address biological impacts;
- counselling to address psychological impacts; and
- community development projects to support social changes.

6 See Forced Adoptions Community of Practice <aifs.gov.au/projects/forced-adoptions-community-practice>.

"There is nothing more practical than a good theory": The theoretical basis of trauma-informed models of care

(a) Attachment—developing a secure base

Attachment theory (Bowlby, 1988) has been used by developmental psychologists to explain positive, secure relationships between infants and caregivers, and how this forms the template for secure adult interpersonal relationships. Disruption to the relationship or insecure attachment is seen as a fundamental mechanism by which childhood trauma affects adult self-concept, wellbeing and interpersonal relationships. Trauma-informed care systems provide a safe environment to expose disruption to the attachment relationship, and build new internal models and "scripts" of the self and relationships.

(b) Self-regulation and control

Social cognitive theories of self-regulation help explain how individuals respond to threatening events. Key components of many trauma-specific treatments are to help individuals to improve self-regulation, safety, security, sense of control and mastery of their environment, and modulate their emotional reactions to traumatic stimuli. Trauma-informed systems of care are aware of the ways in which programs and organisations can trigger traumatic reactions—or even inadvertently replicate the dynamics of the traumatic events/relationships—and seek to minimise them, and promote environments that facilitate positive affect regulation or "modulation".

(c) Fundamental attribution error—overestimating the personal characteristics, underestimating situational factors

Theories of social psychology have identified that humans often make what is termed the "fundamental attribution error", whereby we over-emphasise a person's personality, or internal characteristics, in explaining their behaviour, and underestimate the environmental, or situational factors, that are external influences on their behaviours (e.g. see: Jones & Harris, 1967). For clients who have experienced trauma—particularly complex trauma involving multiple injuries in the interpersonal domain—it is likely that those around them, including their families, their work colleagues and even their health/mental health professionals, are likely to attribute their interpersonal difficulties and deficits in functioning and wellbeing to an inherent personality flaw, rather than having been shaped by their environment (i.e. the external traumatic events they have endured). Creating new environments of support, and opportunities for "reprograming" life scripts are important. But practitioners need to be open to seeing the external influences and specifically target intervention strategies to remediate the long-standing negative consequences.

Source: The title is a quote from Lewin (1952, p. 169)

Moving forward

Much of the literature identified that the paradigm shift towards implementation of a trauma-informed approach to care needed to include commitment from political leadership at all levels (Ashmore, 2013; Bateman et al., 2013; Kramer et al., 2015).

In Australia, the Mental Health Coordinating Council (Bateman et al., 2013) has articulated the requirement for a policy statement from national and state leaders endorsing the concept of trauma as a priority mental health issue and supporting the transition to a trauma-informed service system. This would ensure that there is an identifiable commitment from governments to support the need for trauma-informed service systems.

The broad dissemination of information about trauma-informed, evidence-based best practice has been identified as an important feature of developing the evidence base around trauma (Kramer et al., 2015). Development of a nationally based resource, such as SAMHSA's National Center for Trauma-Informed Care and the National Child Traumatic Stress Network, would provide an Australian-based network of information to support policy development and service delivery and to enable the use of what is currently known about trauma-informed services in different health and human service sectors. Having central resources such as these, is instrumental in shifting human service systems towards a trauma-informed approach to service delivery.[7] Australia does not yet have a body with such a specific focus but extensive work has been undertaken by organisations such as the Mental Health Coordinating Council and Adults Surviving Child Abuse, among others, to help shape behavioural health policy towards incorporating an understanding of the damaging effects of trauma into policy and service delivery approaches.

Although there are some resources and tools now available to support guidance towards trauma-informed systems of care in Australia (Bateman et. al., 2013), there does not appear to be an overarching trauma framework to support a shift in a consistent way. As noted earlier, organisations in Australia have recognised the need for trauma-informed services and

7 See National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint <www.samhsa.gov/nctic>

interventions but the current array of methods, models and interventions on offer and in use do not support a coordinated and common approach that would ensure trauma-informed has a consistent meaning and interpretation in service delivery.

Conclusion

There is growing awareness of the need, and a strong rationale for the value, of implementing a trauma-informed approach to human service delivery. Such an approach has been adopted and implemented extensively in the USA. In Australia, there is a strong push towards trauma-informed approaches to care, and recognition of the impacts of child abuse and other traumas as a driver of service need. However, there is confusion with the array of terminology used and a lack of reference to specific trauma-informed frameworks to guide the introduction of trauma-informed care in a systemic way. Despite the need, and the conceptual/theoretical rationale, it is important to acknowledge that there is limited empirical evidence to show that working systemically to be trauma aware and providing trauma-informed systems of care leads to reductions in trauma symptoms or other positive outcomes for clients.

Currently, there is no overarching policy to mandate trauma-informed care and no framework to guide evidence-based practice to transition in a systematic way to trauma-informed care in Australia. In addition, improvements to collection of research data and adoption of standardised outcome measures for evaluation would support a more systemic approach to evaluating the implementation of trauma-informed care.

There is value in capturing practice-based evidence; however, this is beyond the scope of the current paper, and would be best carried out via a systematic and rigorous approach to gathering and synthesising information from practitioners working with traumatised clients in a variety of fields—as well as the views of those in service delivery systems that are not yet trauma-informed to examine the barriers and enablers of system change. Similarly, there is a need to articulate findings from the emerging field of trauma-informed practice into concrete policy statements or frameworks that can be applied to different client groups within and across a range of service systems and settings.

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At the time of writing **Liz Wall** was a Senior Research Officer at the Australian Institute of Family Studies. **Daryl Higgins** is Deputy Director (Research) and **Cathryn Hunter** is a Senior Research Officer with the Child Family Community Australia information exchange at the Australian Institute of Family Studies.

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Australian Institute of Family Studies
Level 20, 485 La Trobe Street, Melbourne VIC 3000 Australia
Phone: (03) 9214 7888 Fax: (03) 9214 7839 Internet: <www.aifs.gov.au>

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GLBTQDVP

GLBTQ Domestic Violence Project

TRAUMA-INFORMED APPROACHES FOR LGBQT* SURVIVORS OF INTIMATE PARTNER VIOLENCE

A Review of Literature and a Set of Practice Observations

June 2016

Authors:

Erin C. Miller, M.P.S., M.D.V.
Domestic Violence/ Sexual Assault Programs; Newton-Wellesley Hospital

Lisa A. Goodman, Ph.D.
Boston College

Kristie A. Thomas, Ph.D.
Simmons College

Alex Peterson
University of British Columbia

Jillian R. Scheer, M.A.
Boston College

Julie M. Woulfe, M.A.
Boston College

Carole Warshaw, M.D.
National Center on Domestic Violence, Mental Health, and Trauma

Principal Investigator:

Curt Rogers, M.P.A.
GLBTQ Domestic Violence Project

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Produced by
The GLBTQ Domestic Violence Project

For more information on supporting LGBQT* survivors of intimate partner violence, contact one of the organizations below:

The LGBTQ DV Capacity Building Learning Center
c/o The Northwest Network
A program focused on improving research, practice and policy regarding domestic violence in LGBTQ communities.
1-206-568-777 | info@nwnetwork.org | www.nwnetwork.org

FORGE
A transgender anti-violence organization, specializing in technical assistance for victim service agencies, with a focus on domestic violence, sexual assault, dating violence, stalking, and hate crimes.
1-414-559-2123 | AskFORGE@forge-forward.org | www.forge-forward.org

If you would like more information about accessible, culturally relevant trauma-informed approaches for survivors, contact:

The National Center on Domestic Violence, Trauma & Mental Health
A program providing training, support, and consultation to advocates, clinicians, attorneys and policymakers as they work to improve agency and systems-level responses to survivors and their children.
1-312-726-7020 | info@nationalcenterdvtraumamh.org | www.nationalcenterdvtraumamh.org

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Executive Summary

In 2013, the Administration for Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services, awarded a grant to the GLBTQ Domestic Violence Project in Boston, Massachusetts to help improve trauma-informed work with lesbian, gay, bisexual, queer and transgender (LGBQT*) survivors of intimate partner violence (IPV). The following document is a literature review that sets the context for thinking about trauma-informed practice (TIP) for these communities. We developed this review over the course of 2015, supported along the way by an Advisory Board comprised of the NorthEast Two-Spirit Society, Queer Muslims of Boston, Fenway Community Health, the Hispanic Black Gay Coalition, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, and Massachusetts Asian & Pacific Islanders for Health.

This document helps inform a set of practice-based observations that are included in the Appendix (page 40) and are also available as a separate document. At present, there are few, if any, documented LGBQT*-specific models of trauma-informed practice. This literature review and the accompanying practice observations make a clear case for the need for such models, and for the implementation of culturally competent LGBQT* trauma-informed services.

Key takeaways from the literature review include:

- IPV occurs in LGBQT* relationships at rates equal to or higher than rates in heterosexual relationships. Different subgroups within the community may experience different rates or types of IPV, with bisexual and transgender individuals at particularly high risk.

- Although LGBQT* IPV shares many underlying dynamics with IPV in heterosexual couples, it also has unique characteristics, including the types of abusive tactics used and the context of discrimination and social stigma faced by LGBQT* individuals. Within LGBQT* subgroups, there may be additional complexities.

- LGBQT* survivors who are also part of other oppressed groups often face homophobia within their own cultural communities as well as racism, ableism, xenophobia, and colonialism in mainstream communities. Moreover, LGBQT* IPV often occurs in a landscape that includes other forms of abuse and trauma, including family violence, sexual violence, hate crimes, and police brutality. Such overlapping forms of trauma are often interrelated, rendering some members of the LGBQT* communities subject to abuse by more than one person at a time and at more than one point in their lifespans. In the face of these overlapping forms of oppression, LGBQT* survivors are forced to make particularly constrained choices about safety, often trading one kind of safety for another.

- Mental health difficulties are major concerns among LGBQT* people in general. LGBQT* individuals experience higher rates of traumatic events, and may be at greater risk for developing symptoms of PTSD, depression, and anxiety as well as experiencing suicidality and isolation. These concerns are amplified for LGBQT* survivors of IPV, especially transgender individuals and survivors of color. Nonetheless, LGBQT* survivors find strength and resilience through identity affirmation and social support.

- LGBQT* survivors exhibit unique help-seeking behaviors. Overall, they are less likely to seek services from law enforcement and mainstream providers and more likely to rely on informal social support and LGBQT*-focused programs. There also are differences in help-seeking *within* LGBQT* subgroups. For instance, trans individuals may have an especially difficult time accessing culturally competent and non-traumatizing services. For LGBQT* people of color, stigma, economic constraints, and the absence of community outreach are barriers to services.

- Service provision that is not rooted in an expansive understanding of the intersecting oppressions that LGBQT* survivors face may do more harm than good. The kind of harm done by those in a social service system designed to help has been referred to as *sanctuary harm*, which is antithetical to trauma-informed practice.

- Despite growing awareness of the impact of sanctuary harm on clients who experience multiple forms of oppression and of the unique needs of LGBQT* survivors, trauma-informed approaches tailored to LGBQT* communities have been slow to develop. To our knowledge, there are none in the academic literature. It was our Advisory Board that pointed to an alternative model of trauma-informed practice – transformative justice.[1] While the roots of trauma-informed practice grew out of mental health and substance abuse services, transformative justice emerged from activist communities and seeks to uproot the conditions that created traumatic experiences, ending oppression even (if not especially) within helping systems.

We hope that this document will facilitate thinking about how the core principles of trauma-informed practice can be applied to working with LGBQT* survivors and to ameliorating vicarious traumatization among service providers who do their best in difficult circumstances.
Although this document is intended primarily for staff in domestic and sexual violence organizations, it has broad applicability. The information provided can be used to enhance the work of practitioners, advocates, and administrators in other anti-abuse disciplines, homelessness services, mental health and healthcare circles, criminal legal systems, youth services, and an array of other human services disciplines and social change initiatives that seek to serve and ensure the inclusion of LGBQT* communities. The practice-based observations in the Appendix provide further framing for this important endeavor.

[1] The authors wish to thank Hales Burton, at the Fenway Violence Recovery Program, for first suggesting this conceptual shift.

Introduction

IPV refers to the physical and/or emotional abuse of an individual by a current or former intimate partner. It includes the full range of tactics used to create and maintain power and control over another person, including financial abuse, verbal abuse and intimidation, and cultural abuse. In this document, the phrases *intimate partner violence* and *domestic violence* are used interchangeably to denote partner violence. However, it is important to note that domestic violence (DV) is sometimes defined more broadly to include violence and abuse perpetrated by relatives. Although many LGBQT* individuals experience abuse and/or rejection from family and relatives, the dynamics of partner violence versus family violence may differ dramatically. When we discuss the latter, we use the term *family violence* to distinguish it from violence by an intimate partner.

Following a note on language, the literature review is organized into five sections. Section One focuses on the prevalence and dynamics of IPV in LGBQT* communities. Section Two focuses on trauma, mental health, and resilience among LGBQT* individuals to contextualize the critical need for trauma-informed practices for these survivors. Section Three focuses on the range of systemic, institutional, and individual-level barriers that thwart LGBQT* peoples' access to informal and formal support services. Finally, the last section reviews the core principles of a trauma-informed approach to practice, with attention to the needs of service providers who work with LGBQT* survivors, and provides examples of community-specific approaches to trauma.

A Note on Language

The authors wish to acknowledge at the outset the deep complexities of language. LGBQT* stands for lesbian, gay, bisexual, queer, and transgender. It is often used interchangeably with GLBTQ, LGBQT-TS, and similar acronyms to broadly refer to sexual and gender minorities. This document honors the current practice of including an asterisk after the "T" to signify the broad diversity of trans communities, including trans women – transgender individuals who identify as women, though assigned male at birth; trans men – transgender individuals who identify as men, though assigned female at birth; those transitioning from female to male (FTM); those transitioning from male to female (MTF); cross dressers; gender non-conforming individuals; and others who might self-identify as being members of trans communities. In this paper, transgender and trans are used interchangeably.

These definitions belie the complexity of the terms, however. The words *lesbian*, *gay*, *bisexual*, *transgender*, and *queer* all carry particular historical, political and cultural meanings. To a great extent, these words have been shaped in white, Western contexts. Words such as lesbian, gay, and bisexual, for example, are uniquely English. There are seldom translations into other languages that carry the same understanding of LGBQT* identity as being an identity rather than a set of behaviors. Literal translations, into Spanish or Haitian Creole as but two examples, carry few if any of the presumptions that are inherent in English. In many parts of the Latin and Spanish-speaking world, men who engage in sex with

same sex partners are only considered "gay" in the English sense of the word if they are the receptive partner. It is not engaging in the acts that is the determinant of identity, so much as the role that an individual plays (traditionally read as *masculine* or *feminine*) in the conduct of that act. Similarly, men who marry women, but engage in same sex acts with other men, are frequently identified as heterosexual. In short, they are defined by their social role, rather than by their private, intimate acts. Hence the conception of *gay*, as defined in U.S. contexts, frequently fails to apply.

Precisely because identifiers such as LGBQT* were defined in white middle class and academic contexts, the limitations of LGBQT* labels and identifiers may be particularly acute in communities of color, Indigenous communities, and immigrant communities, among others. During the course of crafting this literature review, members of our Advisory Board taught us a tremendous amount. The Hispanic Black Gay Coalition (HBGC) suggested use of the term *same gender loving*, a community-specific phrase coined by Cleo Manago to distinguish African Americans, and in particular African American men, who do not self-identify as being part of the predominantly white gay movement in the U.S., but who nonetheless wish to affirm their same sex intimate relationships. Corey Yarbrough, one of the founding Executive Directors of HBGC, suggested that, for some same gender loving people, this language may be a form of racialized resistance to the racism of the mainstream LGBQT* movement in the U.S. In the alternative, Corey stated, some members of African American communities may be on the *down low*, engaging in same sex sexual activity, but rejecting LGBQT* identifiers as a result of internalized homo- and bi-phobia.

The NorthEast Two-Spirit Society (NETSS) in part echoed Corey's thoughts about the racism of the mainstream LGBQT* movement. In addition, Harlan Pruden, one of co-founders of NETSS, spoke about an "internal muddiness" that some Native peoples may experience when seeking to find language for their experience. Speaking of his own Cree inheritance as a registered member of the Saddle Indian Reservation, Harlan said that when he asked something of an elder, he knew to offer them tobacco, but never understood the spiritual dimension of the ceremony. Having been separated from too much of their own history by colonialism, genocide, and forced assimilation, Harlan stated, many Native people may use the words *Two-Spirit* when what they really mean is gay Indian.[2]

Harlan also spoke at length about the contextual nature of Native Two-Spirit identities. As Harlan put it, "When I am out on a Friday night in a gay club, I am a gay man. Yet when I am in rural Oklahoma at a Two-Spirit gathering, I am a proud Two-Spirit man." Alluding to the unique role and cultural responsibilities that Two-Spirit people often held (and may still hold) in the life of Native communities, Harlan pointed out the obvious differences in the spiritual role of Two-Spirit peoples, and

[2] Two-spirit is a contemporary term, adopted from the Northern Algonquin, and meant to signify the embodiment of both masculine and feminine within one person. Now embraced by many Native peoples as a pan-Indigenous umbrella term connoting both diverse gender expressions and sexual orientations, two-spirit (TS) generally speaks to the respect that Native peoples held for diversity, and the unique sacred and ceremonial roles that TS people held (and may still hold) within their own communities. Herein the phrase TS speaks not simply to a third gender, or to same gender attraction, but more broadly to the history of compulsory Christianization that sought to erase two-spirit peoples within their own nations. Notably, there is no single consensus definition of two-spirit, and the term means different things to different Native peoples.

the political and social function of people claiming LGBQT* identities in mainstream communities. Several members of the project's advisory board echoed this point,
speaking about the complex layering of cultural and spiritual value systems that accompanied their choice to self-identify in, with, and outside of their own communities.

These same Advisory Board members also acknowledged the landscape in which such decisions are made, and stated that individuals in their communities may shift how they self identify as a means of preserving their safety. As the rest of this literature review discusses, LGB, transgender, same gender loving, Two-Spirit, and queer-identified peoples make choices about how, when, and if to "out" themselves in a complex social and political landscape that is too often unsafe, if not violent. Hence, how any individual self-identifies may shift depending on who is asking, why, and in what context. As one Advisory Board member stated, "identities have to be fluid in order to be protective."

Finally, the leadership of HarborCOV, an LGBQT*-affirming DV organization in Boston that specializes in serving communities facing cultural or linguistic barriers, has noted that some cultures may not have the variety or depth of language that words such as LGB, transgender, same gender loving, and Two-Spirit convey. Indeed, Kourou Pich, Co-Executive Director of HarborCOV has observed that people from some cultures and communities may have difficulty finding language for themselves in their own communities, and that that invisibility is intentional – a function both of denial of the existence of sexual minorities in those communities, but also perhaps protectiveness of gender queer and same gender attracted people.

Language is power. We authors, therefore, have put a great deal of thought into the words we use to name peoples' experiences. At the same time, we know that we can never be as inclusive or sensitive as we want to be. We have done our best to honor the range of experiences we are writing about in this document.

Intimate Partner Violence in LGBQT* Communities

Prevalence of IPV in LGBQT Communities*

Historically, DV has been seen primarily as a problem of cisgender[3], heterosexual men abusing cisgender, heterosexual women. Because of this limited framework, research on the prevalence of DV and IPV among LGBQT* and non-female-identified individuals has been scarce and often limited by the use of non-probability sampling, cross-sectional data that precludes causal inference, and inconsistent definitions of IPV and sexual orientation (Brown & Herman, 2015; Finneran & Stephenson, 2012). Recently, however, there has been an increase in studies that provide more rigorous estimates of IPV in LGBQT* communities. The majority of these studies suggest that IPV occurs in LGBQT* relationships at rates equal to or higher than heterosexual, cisgender relationships (Balsam, Rothblum, & Beauchaine, 2005; Duke & Davidson, 2009; Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016; Messinger, 2011; Walters, Chen, & Breiding, 2013). Herein, we briefly present prevalence estimates of LGB IPV before turning to the limited research on prevalence among trans individuals. For a more detailed review of IPV prevalence in LGBQT* communities, see Brown and Herman (2015).

Currently, the best prevalence estimates on partner abuse in LGB communities come from the nationally representative 2010 National Intimate Partner and Sexual Violence Survey (NISVS) conducted by the U.S. Center for Disease Control & Prevention (Walters et al., 2013). Findings suggest higher rates of lifetime IPV experiences (defined as physical violence, sexual violence, or stalking) among lesbians (43.8%), bisexual women (61.1%), and bisexual men (37.3%) – but not gay men (26%) – compared to heterosexual women (35.0%) and heterosexual men (29%). In addition, findings from the California Health Interview warrant mention. Based on a probability sample of California residents ages 18 to 70, this study found that lifetime and 1-year IPV prevalence was higher in sexual minorities compared with heterosexuals, but this was significant only for bisexual women and gay men.

Determining IPV prevalence based on gender identity is difficult due to a lack of studies with representative or even large samples. The National Transgender Discrimination Survey is one of the largest studies of transgender individuals' experience of discrimination with 6,456 participants (Grant, Mottet, & Tanis, 2011). This study did not focus on IPV in particular, but did measure related phenomena. The researchers found that 19% of respondents reported experiences of violence at the hands of a family member specifically due to their gender identity. This statistic is likely an underestimate because it excluded DV perpetrated by non-family intimate partners as well as DV unrelated to gender identity. A much higher percentage of participants reported experiencing actions that may or may not be part of abusive behavior: 29% reported an ex-partner limiting their contact with their children, 45% reported having a relationship end when they came out as trans to their partner, and 57% experienced family rejection (Grant et al., 2011). However, these are unreliable proxies for IPV.

[3] Cisgender is a term that refers to individuals for whom the gender they were assigned at birth matches their gender identity. It can be thought of as meaning "not transgender."

Only one study to date has compared IPV among transgender to IPV among cisgender individuals. Analysis of data from One Colorado's anonymous 2011 LGBT Health Survey (n= 1,193) found that 31.1% of trans respondents reported experiencing IPV, compared to 20.4% of cisgender respondents (Langenderfer-Magruder et al., 2016) – findings that suggest transgender individuals experience higher rates of IPV than their cisgender, LGB counterparts. Furthermore, preliminary evidence suggests that different subgroups within transgender communities experience different rates or types of IPV (Chestnut, Jindasurat, & Varathan, 2012; Clements, Katz, & Marx, 1999). Future studies should examine these differences, particularly with regard to differences between trans men and trans women and with attention to intersecting identities for all participants (e.g., race, sexual orientation, disability, socioeconomic status).

Similarities of LGBQT and Heterosexual IPV*

In general, IPV experienced by LGBQT* individuals follows patterns similar to heterosexual and cisgender individuals (Ristock, 2005). Specifically, abuse can take the form of physical or sexual violence as well as emotional, financial, or verbal abuse. Messinger's (2011) analysis of the National Violence Against Women Survey revealed that the prevalence of various types of abuse in GLB communities mirrored prevalence rates among heterosexuals: Both groups reported prevalence rates that went in descending order from verbal abuse to controlling behavior to physical violence to sexual abuse. However, as described next, there are also unique aspects of IPV in LGBQT* communities, and potentially important differences among LGBQT* subgroups.

Unique Characteristics of IPV in LGB communities

IPV occurs in a larger societal and systemic context of homo-, bi-, and transphobia, heterosexism, misogyny, and patriarchy. These factors can influence abuse tactics and relationship dynamics for LGBQT* survivors, making their experiences different from those of heterosexual survivors. For example, sexual minority victims of IPV may be subject to abusive tactics that leverage systemic and cultural discrimination (i.e., identity abuse; Ard & Makadon, 2011; Balsam, 2001; Balsam & Szymanski, 2005; FORGE, 2014; Gay Men's Domestic Violence Project, 2014; National Center on Domestic & Sexual Violence, 2014; West, 2012). Examples of identity abuse include denying or belittling an individual's LGBQT* identity (e.g., refusing to use preferred gender pronouns), restricting access to a supportive LGBQT* community (NCDSV, 2014), or threatening to disclose a survivor's sexual orientation, gender identity, or HIV/AIDS status (Ristock, 2005). People who use violence against their LGBQT* partners may also use threats to authenticity as a method of control, making survivors feel that they are not "queer enough" or do not understand how LGBQT* relationships are supposed to be (Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thornton, 2006). Controlling behavior, in general, may be a particularly important aspect of DV among LGBQT* couples, and may result in even higher levels of psychological harm than physical abuse alone (Frankland & Brown, 2014).

IPV in LGBQT* survivors can also be minimized in a variety of ways: For example, common portrayals of DV in the media – usually depicting heterosexual relationships, specifically men abusing women – can render invisible even to themselves experiences of underrepresented survivors (Holt, 2011). Pervasive beliefs that LGBQT* relationships are more egalitarian or that gay and lesbian individuals are better able to defend themselves against partners who use violence also serve to render IPV invisible in these communities (Bornstein et al., 2006; Holt, 2011; Walters, 2011).

Finally, although isolation is a commonly used tactic in heterosexual as well as in LGBQT* relationships, it may be more difficult to overcome in tight-knit LGBQT* communities in which relationships and resources are often shared with the abusive partner (Bornstein et al., 2006). The level of isolation is even more pronounced for LGBQT* survivors from rural and immigrant communities (Ristock, 2005).

Unique Characteristics of IPV among Transgender People

There is limited research on the characteristics of IPV in transgender communities. The National Coalition of Anti-Violence Programs 2014 annual survey of its member programs reported that, compared to people who did not identify as transgender, transgender survivors were two times more likely to face threats/intimidation, nearly two times more likely to experience harassment, and over four times more likely to face police violence in response to reporting IPV (National Coalition of Anti-Violence Program, 2015b). Transgender women were at highest risk of experiencing threats/intimidation, harassment, and injury (NCAVP, 2015a), and transgender people of color were the most likely to report experiencing threats of intimidation in their intimate partnerships.

Generally high rates of violence, trauma, and discrimination in the lives of transgender individuals may have a compounding effect, influencing transgender IPV survivors' willingness to identify abuse or seek help. FORGE's safety planning guide remarks that transgender individuals may feel unwanted, or "believe that they are lucky to ever find love, even if that love turns violent" (Guadalupe-Diaz, 2013, p. 3). In a study of transgender relationship violence, some participants could not even conceptualize their trans partner's behavior as abusive because they viewed these partners as being so oppressed themselves (Ristock, 2011).

Multiple Experiences of Violence in LGBQT Communities*

Because of the fragmented nature of research on violence and abuse in the lives of LGBQT* individuals, the prevalence of "polyvictimization"[4] – that is, multiple kinds of violence and abuse committed by different people – in this community is still unknown. However, evidence suggests that LGBQT* individuals are more likely to experience multiple types of violence (e.g. sexual abuse, physical abuse, and exposure to domestic violence during childhood; sexual assault, physical assault, and stalking during adulthood) at the hands of many different types of individuals (family, partners, community members, legal actors, strangers) and at multiple points in their lifetime (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Grant et al., 2011; Stotzer, 2009).

Specific subgroups of LGBQT* survivors are at especially high risk for multiple forms of victimization. One notable example is LGBQT* homeless youth, highly overrepresented among homeless populations (Durso & Gates, 2012; Grant et al., 2011; Hunter, 2008). Evidence indicates that family and partner violence are major drivers of such homelessness (Cochran et al., 2002; Durso & Gates, 2012; Grant et al., 2011; Risser & Shelton, 2002). Homelessness in turn may render LGBQT* peoples increasingly vulnerable to other forms of violence including harassment, hate crimes, police brutality, and sexual exploitation (Amnesty International, 2005; Durso & Gates, 2012; Keuroghlian et al., 2014; Mogul, Ritchie, & Whitlock, 2012; NCAVP, 2015a; NCAVP, 2015b; Reck, 2009). Layered onto these experiences are other types of oppression such as housing, employment, and healthcare, which are themselves traumatogenic and which also act as barriers to help seeking (D'Augelli, 1998; Durso & Gates, 2012; Grant et al., 2011; Tyler, 2008).

Unique Experiences of IPV among Specific Subgroups of LGBQT Survivors*

The experience of IPV for specific subgroups may be quite different than that of White, middle-class LGBQT* survivors (Chavis & Hill, 2009). The intersections of various identities result in unique social contexts shaped by multiple systems of power and oppression (Chavis & Hill, 2009; Feltey, 2001). These systems may shape the way that IPV is enacted and experienced, and the way it is addressed by service providers. Although attention to all intersections would be beyond the scope of this document, here we focus on three subgroups that have received especially scant attention: sexual minorities in Native communities, immigrant and refugee communities, and faith-based communities. Although there is virtually no research on IPV within these subgroups, it is nevertheless instructive to understand this context when considering the experience of IPV for people within these communities. Later sections touch on specific aspects of the help-seeking experience of African-American and Latin@ LGBQT* survivors.

[4] "Polyvictimization" refers to experiences of multiple kinds of violence and abuse, at the hands of multiple people at multiple points in the lifespan. The authors have chosen to put this word in quotes because some have understood it to imply that the victim is somehow responsible for for these experiences. This would obviously be inaccurate and inappropriate. Indeed, there is now a rich literature on the ways that people who use abusive behaviors target individuals with prior trauma histories.

Two-Spirit and LGBT Native Peoples. In general, there is scant research on the experiences of Two-Spirit and LGBT Native individuals. However, the fact that rates of violence and abuse against cisgender, heterosexual Native women are so high suggests that Two-Spirit Native women might be at especially high risk compared to their non-Native sexual minority counterparts (Lehavot, Walters, Simoni, 2009). Consistent with this view, one study showed that 78% of Two-Spirit women reported experiencing physical assault and 85% reported experiencing sexual assault (Lehavot et al. 2009).

These statistics are all the more alarming given that Native women, regardless of Two-Spirit or LBT status, are more likely to experience physical brutality, and therefore injury, during rapes and sexual assaults (Amnesty International, 2007). Further, some Native researchers have noted the disproportionate impact of homo/transphobia that occurs within the Native community given that Two-Spirit survivors may need cultural support from their own people in the face of violence and trauma (Frazer, Somjen, & Pruden, 2010). Not surprisingly then, violence against Two-Spirit and Native LGBQT* individuals also contributes to the development of a range of health and mental health conditions, such as liver disease, substance abuse, PTSD, as well as to behaviors that increase the risk for HIV (Balsam, Huang, Fieland, Simoni, & Walters, 2004; Centers for Disease Control and Prevention, 2001; Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Simoni, Seghal, Walters, 2004). Clearly, more research is needed on IPV in the lives of Two-Spirit and LGBQT* Native peoples.

Immigrants and Refugees. The experiences of LGBQT* immigrant and refugee survivors of IPV are largely invisible in the academic literature. The broader research on DV in heterosexual, cisgender immigrant communities is complex, indicating that they experience lower rates of IPV, but higher rates of IPV homicide compared to non-immigrants (Bohn, 2003; Tjaden & Thoennes, 1998).

Although there is a need for more prevalence research, it is well documented that sexual minority immigrants face challenges resulting from historically homophobic immigration policies (Chung & Lee, 1999). Under the Immigration and Nationality Act of 1917, LGBQT* immigrants were strictly prohibited from entering the United States on the grounds that they were "mentally or physically defective." The Immigration & Naturalization Act of 1952 similarly prevented LGBQT* immigrants from entering the U.S. based on the idea that they were "afflicted with psychopathic personality" (Foss, 1994). Even up to 1990, Public Health Service physicians barred entrance to those immigrants suspected to be LGBQT*, labeling them as "sexual psychopaths." In addition to contending with these oppressive policies, LGBQT* immigrants were also isolated within their own communities and shunned by white, non-immigrant LGBQT* communities because of their immigration status (Cantú, Hurtado, & Anzaldúa, 2012; Moraga & Anzaldúa, 1981). Even today these interpersonal and institutional challenges echo in the lives of sexual minority immigrants and likely create unique challenges for LGBQT* immigrant and refugee survivors of IPV.

Religious or Spiritual LGBQT Survivors*. LGBQT* people have both positive and negative experiences of faith, possibly even simultaneously. Researchers and practitioners highlight the healing value of religious communities and practices for this community (e.g., Queer Muslims of Boston,

FaithTrust Institute; Ryan, Huebner, Diaz, & Sanchez, 2009). Yet, institutionalized religious policies and principles continue to be a major source of social oppression for many LGBQT* people (Clarke, Brown, & Hochstein, 1989; Davidson, 2000; Hilton, 1992; McNeill, 1993; Morrow & Gill, 2003; Spong, 1991; Spong, 1998). For example, many religious practices condemn non-heterosexual behavior (Bouhdiba, 1998; Jaspal & Cinnirella, 2010) and view LGBQT* people as immoral and spiritually corrupt (Morrow & Gill, 2003). For many religious LGBQT* people, family and societal rejection is therefore compounded by the loss of religious communities (Mahaffy, 1996).

Sources of conflict for religious LGBQT* people include anti-gay religious teachings and scriptural interpretations, homo/bi/transphobic church atmospheres, fear of being "outed" in non-affirming religious settings, and microaggressions (i.e., subtle forms of oppression) from people within their religious communities (Brown & Pantalone, 2011; Shuck & Liddle, 2001). Not surprisingly, receiving homophobic messages through a religious medium has been found to be associated with internalized shame among LGBQT* individuals (Herek, 1987; Ream, 2001).

The challenges of participating in a faith community that is not LGBQT*-affirming may be particularly acute for LGBQT* individuals of color and immigrants since the support role of faith-institutions is particularly crucial in these communities due to the lack of other available social supports. For example, Christian religious institutions have served a range of healing functions within African American communities, where faith has been an important source of strength in the face of ongoing racialized violence and oppression (Billingsley, 2003; Cone, 1997; Cone, 2010; Higginbotham, 1994; Lincoln & Mamiya, 1990). Yet, for African American young men, churches are the primary source of anti-gay messages in their communities (Stokes & Peterson, 1998). The loss of access to one's faith community under such circumstances may be particularly wounding. These challenges are real and ongoing, but their effects on LGBQT* survivors of IPV remain unexplored. Most research on the experience of IPV survivors in relation to their faith communities focuses on the spiritual lives of heterosexual, cisgender women. Clearly, more research is needed in this area.

In sum, violence – be it by intimate partners, family and community members, or society at large – is a common occurrence in the lives of many LGBQT* individuals. Because such polyvictimization is rooted in and exacerbated by the larger context of homophobia and transphobia, the experiences of LGBQT* survivors differ in many ways from those of heterosexual, cisgender survivors. Given that experiences differ, so too does the impact of experiencing IPV. We turn next to the research on the mental health consequences of IPV among LGBQT* survivors as well as protective factors that promote resilience.

Trauma and Mental Health in LGBQT* Communities

The emerging literature on how IPV affects the mental health of LGBQT* survivors is mixed, with some studies indicating that the impact is similar for LGBQT* and non-LGBQT* survivors, and others indicating that adverse effects are more common among LGBQT* survivors (Edwards, Sylaska, & Neal, 2015). This section reviews that literature, focusing especially on depression and PTSD – two common mental effects of abuse. As this section will show, emerging research indicates that bisexual and transgender survivors may be at particularly high risk for experiencing adverse mental health effects.

Depression. LGBQT* survivors of IPV, similar to their heterosexual and cisgender counterparts, are particularly at risk of depression. One longitudinal study examining data from a nationally representative survey of adolescents between the ages of 18 and 27 (227 gay and lesbian, 345 bisexual, and 13,490 heterosexual) found that across all three groups, exposure to IPV was significantly related to increased depression – even after controlling for exposure to childhood physical or sexual abuse and homelessness or expulsion from one's home by caregivers (McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012). This is consistent with a more recent meta-analysis examining 19 studies, which found that men who are victims of IPV at the hands of other men are more likely to use substances, suffer from depressive symptoms, have an HIV positive diagnosis, and engage in unprotected sex (Buller, Devries, Howard, & Bacchus, 2014). As a whole, this body of literature suggests that LGBQT* IPV survivors are at greater risk for experiencing depression than LGBQT* individuals without IPV experience.

Looking more closely within the LGBQT* community, there is some evidence indicating that bisexual individuals may have disproportionately high rates of depression as compared to gay and lesbian individuals (Bostwick, Boyd, Hughes, & McCabe, 2010). Interestingly, theoretical work has posited that the relatively high mental health difficulties within the bisexual community may be attributable to the additional stressors of experiencing bi-negative attitudes from both heterosexual and LGTQ communities. The National Epidemiologic Survey on Alcohol and Related Conditions, which compared rates of major depression among lesbian, gay, bisexual and heterosexual adults (*n*=34,653), found that both male and female individuals who reported bisexual behavior had higher lifetime rates of all mood disorders, including depression (Bostwick et al., 2010). By extension, one might expect bisexual survivors of IPV to be at particular risk for depression.

Likewise, there is scant research on depression and other mental health effects of IPV for transgender survivors. There is, however, literature on the relationship between interpersonal violence more generally and symptoms of depression in this community. For example, in one cross-sectional study of over 591 MTF participants from the New York City area, 63% had depression scores in the clinical range. Further, in this same sample, violence that was related to one's gender identity, or gender abuse, was predictive of depression (Nuttbrock et al., 2014). These findings are consistent with another study of 6,436 transgender-identified individuals, in which 19% of respondents had experienced violence at the hands of a family member because of their chosen gender identity. This exposure was associated with over twice the rate of suicidality, with 65% of those who experienced family violence also reporting

having attempted suicide, compared to 32% of those who did not experience family violence (Grant et al., 2011). Overall, though the literature remains inconclusive, it raises questions about whether transgender survivors of IPV could be at increased risk for depression.

PTSD. IPV exposure also increases the risk of PTSD symptoms in the LGBQT* community. According to the CDC's 2010 IPV report described previously (i.e., NISVS) 19.5% of lesbian women, 46.2% of bisexual women and 22.1% of heterosexual women report experiencing at least one symptom of PTSD – defined as having nightmares and intrusive thoughts of the traumatic experience; feeling constantly on guard, watchful or easily startled; and feeling numb or detached in response to an experience of IPV (Walters et al., 2013). Data from bisexual, gay, and heterosexual men were excluded from the analysis due to small sample sizes. Evidence from other research, however, suggests that that the relationship between IPV and PTSD may extend to gay and bisexual male survivors (Pantalone, Hessler, & Simoni, 2010).

Consistent with the findings on IPV and depression, there is initial evidence that bisexual survivors of IPV have higher rates of PTSD than gay and lesbian survivors. According the CDC's NISVS, more than half of bisexual women (57.4%) who experienced physical or sexual violence or stalking reported at least some form of negative impact (e.g., experiencing PTSD symptoms, missing a day of school or work, feeling fearful or concerned for their safety) as compared to a third of lesbian women (33.5%), and a fourth of heterosexual women (28.2%) (Walters et al., 2013). Significantly more bisexual women (46.2%) reported experiencing at least one symptom of PTSD as compared to lesbian (19.5%) and heterosexual women (22.1%) (Walters et al., 2013). These results suggest that bisexual women may be at disproportionately high risk for developing PTSD after experiencing IPV.

Again, literature on the relationship between IPV and PTSD in transgender communities is limited. As noted earlier, transgender individuals are especially likely to experience violence and discrimination in the domains of education, health, family life, and work which may shape their responses to partner violence (Grant et al., 2011). These risks are not equally distributed among trans individuals. Trans women experience higher rates of violence than trans men, probably because they are less able to "pass" (i.e., be perceived as the gender they identify as) (Dean et al., 2000; Mizock & Lewis, 2008). The risks may also be explained by the concept of trans-misogyny: the idea that there is a particular brand of discrimination that combines transphobia with sexism and applies specifically to trans women (Serano, 2007).

In addition, trans people of color are at particularly high risk (Richmond, Burnes, & Carroll, 2012). In a study of MTF youth of color in Chicago, major life stressors included lack of transportation, difficulty finding a job, sex in exchange for resources, being frequently bothered by police, forced sexual activity, difficulty finding a safe place to sleep, difficulty accessing healthcare, and history of incarceration and homelessness (Stieglitz, 2010). Given that multiple experiences of trauma are more likely to result in the development of clinical PTSD (Scott, 2007), it is not surprising that in one study of MTF transgender individuals, 17.8% reported clinically significant symptoms of PTSD (Shipherd, Maguen, Skidmore, &

Abramovitz, 2011). As a whole, the literature on bisexual and transgender communities makes clear the need for researchers to continue to investigate the distinct experiences of subgroups of the LGBQT* community.

The mental health consequences of IPV among LGBQT* survivors must also be understood within the broader context of historical trauma. Historical trauma is a term used to describe repeated communal traumatic events that exist across time, are embedded throughout culture, and can result in an intergenerational cycle of traumatic stress (Sotero, 2007). Oppressed communities subjected to historical trauma are at heightened risk for mental and physical health consequences compared to communities not exposed to such trauma (Danieli, 1998; McMichael, 1999; Sotero, 2007). Not only have LGBQT* people endured such historical trauma as a group, but many such individuals have also experienced intergenerational trauma originating from other identities such as those based on race or religion (DeGruy, 2005; Franklin, Boyd-Franklin, & Kelly, 2006; Jaimes & Halsey, 1992). Studies have shown that cumulative historical traumatic events actually increase survivors' risk for lifetime trauma and interpersonal violence (Chae & Walters, 2009). These forces are critical to understand when considering the mental health impact of violence against various subgroups of the LGBQT* communities.

Resilience in LGBQT Communities*

Research has identified several important factors that contribute to strength and resilience among LGBQT* survivors. In particular, a positive LGBQT* identity, or *identity affirmation,* and social support from friends can profoundly influence survivors' mental health.

Regarding the first of these two factors, LGBQT* identity affirmation has been well documented as critical to positive mental health outcomes. For example, one study investigating 165 lesbian, gay, and bisexual youth found that family support and self-acceptance mediated the relationship between victimization and mental health (Hershberger & D'Augelli. 1995). Another study surveyed 613 lesbian, gay, and bisexual individuals and found that LGB individuals who have positive appraisals of their LGB identity and do not anticipate rejection from others had lower psychological distress (Balsam & Mohr, 2007). In a subsequent study, the same authors found that higher identity acceptance negatively correlated with measures of depression, guilt, fear, hostility, and sadness, and positively correlated with measures of general life satisfaction, self-assurance, and social self-esteem (Mohr & Kendra, 2011). Finally, in a study of trans people of color who were survivors of traumatic events, participants named pride in one's gender and ethnic identity as critical to resilience (Singh & McKleroy, 2011). In short, LGBQT* individuals who feel more positive about being LGBQT* or their ethnicity are able to cope more successfully with the challenges they face.

Social support from friends and family also serves a critical protective role. Moody and Smith (2013), for example, found that perceived support from friends was associated with reduced suicidality among trans individuals. For transgender youth of color, identifying other youth and adults with similar identities helped to validate their experiences of racism within the LGBQT* community (Singh, 2013).

And in one study of MTF youth of color, friends were the most frequently cited source of support, and physicians or case managers were perceived as at least somewhat helpful (Stieglitz, 2010).

Social media has become a critical conduit for accessing social support within the LGBQT* community (Singh, 2013). Online communities have become sites of community organizing, cultural empowerment, and education for LGBQT* people, enhancing both a sense of identity and a sense of social support and community (Mehra, Merkel, & Bishop, 2004). Religion and spirituality may also contribute to resilience, particularly as these become sources of social support (Potter, 2007).

In sum, there is a clear need for supportive mental health and trauma-informed approaches for LGBQT* individuals. Furthermore, these services must recognize the societal factors that contribute to individual mental health concerns. LGB individuals, and transgender individuals in particular, experience high rates of traumatic experiences that stem from social isolation, prejudice, and discrimination. These experiences can have many negative mental health outcomes, and are exacerbated by multiple forms of oppression. Nonetheless, LGBQT* individuals show remarkable resilience by developing strong social support networks, creating and engaging with online and activist LGBQT* communities, and developing a positive LGBQT* identity. Trauma-informed approaches must allow providers to understand the context in which survivors have experienced abuse, identify sources of individual and communal strength and resilience, and support healing. Unfortunately, the current reality for sexual minorities who seek help from informal and formal supports is far different.

Help-Seeking Among LGBQT* Survivors

A range of systemic, institutional, and individual-level barriers uniquely thwart LGBQT* peoples' access to informal and formal support services (Edwards, Sylaska, & Neal, 2015; Helfrich & Simpson, 2006). At the broadest level, pervasive heterosexism renders violence between same sex partners invisible. The myth that IPV occurs only between men and women contributes to the profound difficulty that service professionals have even identifying IPV among LGBQT* couples (Blasko, Winek, & Bieschke, 2007; Brown & Groscup, 2008; Helfrich & Simpson, 2006; Seelau & Seelau, 2005). Brown and Groscup (2008) studied 120 crisis center workers' perceptions of same-sex DV by presenting scenarios in which only the gender of the abuser and survivor were changed, and found that participants ranked same-sex DV as less severe and less likely to get worse than the same scenario among heterosexual pairs. Although service providers may recognize that LGBQT* survivors deserve protection from IPV just as heterosexual survivors do (Sorenson & Thomas, 2009), these kinds of biases may affect their ability even to identify IPV in this community (Basow & Thompson, 2012).

Beyond the invisibility of LGBQT* IPV, a range of factors cause well-meaning social services systems to harm members of marginalized communities, including sexual minorities. Forms of oppression such as racism, colonialism, ableism, heterosexism, sexism, and transphobia that are often implicit in our helping systems can render these systems traumatogenic, especially when these oppressive dynamics are not acknowledged (Buzawa & Buzawa, 2003; Dirks, 2004; Herman, 2003; Walters, Simoni, & Evans-Campbell, 2002). The kind of harm done by institutions designed to provide support has been termed "sanctuary harm" (Bloom 2011; Bloom 2013).

A primary example of a system that causes this kind of sanctuary harm is the healthcare system. Historically, medicine and the health sciences were central to the effort to pathologize same sex relationships and transgenderism. Being gay or lesbian was classified as a mental disorder by the American Psychological Association until 1973, and conceptions of gender dysphoria as a mental health condition did not undergo a similar revolution until 2013 (Bayer, 1987; Drescher & Merlino, 2007).

The continuing impact of this history is evident in the experiences of LGBQT* patients in healthcare settings. Lambda Legal (2010) found that more than half of all sexual minority survey participants had experienced at least one of the following types of discrimination in a healthcare setting: being refused needed care; being blamed for their health status; seeing healthcare professionals refuse to touch them or use excessive precautions; hearing healthcare professionals use harsh or abusive language; or experiencing healthcare professionals being physically rough or abusive. Similarly, Shires and Jaffee (2015) found that over 40 percent of transgender men reported verbal harassment, physical assault, or denial of equal treatment in a doctor's office or hospital. Grant et al. (2011) reported that over one-quarter of respondents in a survey for the National Center for Transgender Equality experienced verbal harassment in medical settings, and that the likelihood of discrimination, abuse, or assault of transgender patients by their provider actually increased with the provider's awareness of their patient's transgender status. Such experiences of discrimination are far more likely to affect

LGBQT* patients of color, financially-oppressed patients, and undocumented patients (Grant et al., 2011; Lambda Legal, 2010).

Other examples of sanctuary harm abound across systems. For example, between 2010 and 2011, LGBQT* survivors reported an increase of incidences in which the police arrested both the abuser and victim when called (28.4% up from 21.9%), an increase in the percentage of LGBQT* survivors seeking shelter who were denied (61.6% up from 44.6%), and a decrease in the percentage of LGBQT* survivors who received requested orders of protection (78.1% down from 83.7%; NCAVP, 2015b). The same study found that transgender IPV survivors were over six times more likely to experience physical violence while interacting with the police than other survivors, and more likely to experience hate violence in shelters than other survivors (notably, trans men were 3.5 times more likely; whereas, trans women 1.3 times more likely) (NCAVP, 2015b). In short, transgender survivors may experience even more re-traumatization and less access to formal support systems than LGB survivors.

Mainstream programs may use heterosexist language in program materials, or have ambiguous or poorly defined policies regarding service provision for LGBQT* survivors (Helfrich & Simpson, 2006). LGBQT* survivors may well anticipate discrimination both from staff members and the heterosexual survivors using these services and may worry that their sexual orientation (and one could assume, gender identity) will be revealed should they actually seek help (Bornstein et al., 2006; McClennen, 2005; Helfrich & Simpson, 2006).

Low-income LGBQT* survivors of color experience another set of barriers: A community needs assessment of Black and Latin@ LGBQT* communities in the greater Boston area (Tod@s, The Hispanic Black Gay Coalition, The Violence Recovery Program at Fenway Health, The Network/La Red, & Renewal House, 2013) found that a lack of outreach to these communities limited their knowledge of IPV resources. In addition, geographic isolation, lack of transportation options, and the cost of making phone calls were major challenges to finding formal help. Similar to Black and Latin@ communities, Two-Spirit individuals identified lack of financial resources, transportation, and geographic inaccessibility as barriers to seeking support (Walters, Horwath, & Simoni, 2001). In addition, the lack of programming specifically aimed at Two-Spirit people and fear of what other Native community members might think were consistently ranked as barriers.

In the context of these institutional barriers, sexual minority survivors describe a range of personal reasons for not seeking support. Many feel that the need to educate a provider about one's identity and experiences would be overwhelming, particularly during a time of crisis (Turrell & Herrmann, 2008). Others worry about further victimization by providers who lack training on LGBQT* issues, and by other clients accessing the same services (Bornstein et al., 2006). Talking about abuse in one's intimate relationship almost always means coming out about one's sexual orientation or possibly one's gender identity. Further, gossip in insular or tight-knit communities raises concerns of confidentiality and retaliation – not just by the abuser but also by the community at large. Gay male survivors may keep silent about abuse and be more reluctant to seek help because they do not see doing so as consistent

with notions of masculinity (Seidler, 2006). According to Spiegel (2003), the abuse thrusts male survivors into "confrontation between two disparate psychosocial processes: the realities of abuse and the mythology of masculinity" (p. 133). Notably, although LGBQT* individuals may be hesitant to contact mainstream domestic violence programs, one survey reported that 86.2% of LGBQT* respondents *would* contact a domestic violence program if it was LGBQT*-specific (Holt, 2011).

Although the majority of LGBQT* survivors do not immediately seek help from the formal service system, they do rely on their informal social support systems; that is, their friends and families (Edwards et al., 2015). And yet, here too, LGBQT* survivors face a range of barriers to support. For example, LGBQT* survivors may be reluctant to seek help from friends and family given their own or their community's gendered beliefs about violence (e.g., women cannot be violent and men cannot be victimized) (Seelau & Seelau, 2005; Walters, 2011). They may be particularly hesitant to seek help from heterosexual friends or family members if they have had previous experiences of heterosexism and cissexism from their peers (Ard & Makadon, 2011). Survivors may have received messages that LGBQT* relationships themselves are "wrong" or "sick." Consequently, they may feel that admitting violence will only confirm these messages, conferring a sense of stigma on the victim, the relationship, and the LGBQT* community in general. Alternately, survivors who feel as though they are representing the LGBQT* community may feel that admitting IPV will harm the LGBQT* community at large (Balsam, 2001). Also, friends and resources may be shared between the survivor and perpetrator to an even greater degree than in heterosexual relationships, further making it difficult to access support (Bornstein et al., 2006).

In sum, a range of factors hinder LGBQT* survivors from seeking formal and informal assistance. Some survivors choose not to seek help from anyone; however, many survivors will make at least an initial attempt, and how they are treated can affect likelihood of seeking help in the future. Formal systems such as DV programs, hospitals, and law enforcement have a responsibility to ensure that they are facilitating help-seeking, not preventing it. To that end, the next section reviews the literature on a trauma-informed approach to practice, with attention to the needs of service providers who work with LGBQT* survivors, and provides examples of community-specific approaches to trauma.

Trauma-Informed Practices

A growing body of literature suggests that incorporating trauma-informed approaches into work with survivors is beneficial for the participant, staff, and overall organization. In this section we review the definition and core principles of a trauma-informed approach. Next, we discuss the need for LGBQT*-specific trauma-informed models and the role of transformative justice in developing such models.[5]

The term trauma-informed services was first used by Maxine Harris and Roger Fallot (2001a) in the context of mental health and addictions treatment programs. They noticed that many individuals seeking these services had experienced high rates of physical and sexual abuse, yet few providers were knowledgeable about trauma and the effects of such violence. As a result, services were not designed with trauma survivors in mind, increasing the possibility of retraumatization by the very services that were supposed to help them.

In response, Harris and Fallot (2001b) proposed creating trauma-informed service systems. This meant recognizing that the majority of people seeking services are likely to have experienced trauma; and that the effects of trauma impact many life domains, including people's experience of services. Thus, they argued, services had to be redesigned to incorporate an understanding of the pervasiveness of trauma and its impact on every aspect of their work. That is, programs and practices needed to be welcoming and appropriate for individuals with a history of trauma; and they needed to minimize retraumatization and promote healing and recovery. This, in turn, required an organizational commitment to trauma-informed practice, and ensuring that the necessary training for staff was in place.

In their initial work, Harris and Fallot (2001a) identified five requirements for creating trauma-informed services: (1) administrative commitment to change; (2) universal screening for trauma history among participants/clients;[6] (3) training and education on trauma for all staff; (4) hiring staff with a deep knowledge of trauma, referred to as "trauma champions;" and (5) reviewing policies and procedures to ensure they do not replicate abusive dynamics.

Although Harris and Fallot's approach was developed in the context of mental health and addictions services, its underlying principles have been adapted and applied to several different service contexts. These contexts include correctional facilities (Hodas, 2006), psychiatric and hospital settings (Jennings, 2004), homelessness services (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009), addiction

[5] While the terms trauma-informed care and a trauma-informed approach are sometimes used interchangeably, the use of these terms has evolved over time. Trauma-informed care while perhaps still applicable in settings that provide health or mental health care, is actually inconsistent with the spirit/principles of a trauma-informed approach which involves service relationships that are fully collaborative rather than one person providing and the other receiving care.

[6] The requirement for universal trauma screening emerged in the context of mental health and addictions treatment services and are not necessarily applicable to other service settings such as DV programs.

services (Covington, 2008), services for children who have experienced abuse (Hodas, 2006; Ko et al., 2008), and DV organizations (Warshaw, Sullivan, & Rivera, 2013; Warshaw 2014; Wilson, Fauci, & Goodman, 2015).

These adaptations have not fundamentally altered the original principles, but have offered more expanded and nuanced interpretations of how they work in practice. In their excellent review, Hopper, Bassuk, and Olivet (2010) identified core principles that cut across different service contexts. These include: trauma awareness (e.g., staff training, consultation, supervision and self-care); safety (e.g., physical and emotional safety for all, awareness of potential triggers, clear roles and boundaries, and cultural diversity); opportunities to rebuild control (e.g., predictable environments, rebuilding efficacy, and personal control over lives); and a strengths-based approach (e.g., focus on future and skills-building).

Furthermore, Elliot, Bjelajac, Fallot, Markoff and Reed (2005) placed trauma-informed principles in the context of the entire service system and environment. For example, in a trauma-informed system, survivors engage with staff as collaborative partners rather than as passive recipients of services, and organizations actively solicit survivor input. In trauma-informed organizations, providers also strive to understand each survivor within the context of their background and life experiences and in terms of what is meaningful to them. Such contextualizing is essential. Because survivors experience trauma and seek support in a social, historical, and political context, healing must also include recognition of this context.

In order to do this difficult work, staff must themselves be supported. A fundamental aspect of a trauma-informed approach, therefore, involves creating an organizational environment that facilitates providers' capacity to do their work well. Clients interact with individual providers, who themselves interact with supervisors and the organization. When providers are subject to stressful organizational dynamics, those stresses interfere with their ability to be effective (Bloom, 2010). One consequence of problematic organizational dynamics is vicarious traumatization (synonymous with secondary traumatic stress or compassion fatigue) among service providers. Vicarious traumatization has been defined by Charles Figley (1995) as "the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7), and symptoms may mimic those of PTSD. Vicarious traumatization has been linked to burnout in several studies (Bemiller & Williams, 2011; Brown & O'Brien, 1998; Ortlepp & Friedman, 2002; Ullman & Townsend, 2007).

Vicarious traumatization is widespread. Findings from a study of 148 advocates working in a range of types of DV organizations indicate that 47.3% of participants met criteria for clinical levels of PTSD symptoms (Slattery & Goodman, 2009). Organizational factors that may contribute to vicarious traumatization include a lack of involvement or influence on decision making, feeling like one's abilities are not being used, being exposed to danger at work, and too much focus on fixed regulations, procedures, and paperwork (Brown & O'Brien, 1998). Indeed, Slattery and Goodman (2009) found that lack of access to power (i.e., equality, voice, representation, shared leadership, and respect) in the

workplace significantly predicted vicarious traumatization above and beyond individual factors (e.g., personal history of trauma and exposure to traumatized clients). They recommended creating a workplace that emphasizes support, cooperation, effective communication, and conflict resolution skills and asserted that efforts to "flatten the hierarchy" and address power differences at the organization may also help minimize vicarious traumatization.

Creating a trauma-informed service system, then, occurs on three levels. The first is focused on the needs of survivors. The second is focused on changing an organization's culture to support staff and fully integrate trauma-informed practices into its service delivery; and the third level acknowledges the larger societal context in which survivors seek services and organizations operate. This level emphasizes not only engagement with the individual as part of a community, but also with community change itself in order to transform the conditions that produce abuse, violence, and trauma in the first place (Warshaw, 2014; Wilson et al., 2015).

These overarching principles have been applied across trauma-informed service systems. However, the particular language used to describe specific practices that arise from them may vary substantially depending on the service setting. The appendix provides a table of six trauma-informed models that have been identified as having some relevance for this project either because of the communities being served (LGBQT* or IPV survivors), the popularity of the model, or the credibility of the organization. See also Wilson and colleagues' (2015) recent qualitative content analysis of key documents – publications, manuals, and training guides – that describe an emerging consensus on trauma-informed practices in the domestic violence context, as well as points of difference and tension.

It is important to note that trauma-*informed* services are different from, but related to, trauma-*specific* services. Whereas trauma-informed services are designed to be implemented at all levels of an organization and focus on limiting the potential for retraumatization among participants, trauma-specific services are aimed at treating actual trauma symptoms (Harris & Fallot, 2001a). Examples of trauma-specific services include grounding techniques, psychoeducation, mind-body approaches and body-based therapies, cognitive behavioral therapy, and complex trauma treatment (Courtois & Ford, 2009; Courtois & Ford, 2015; Jennings, 2004; Resick, 2003; Warshaw & Brashler, 2009). A number of trauma-specific interventions have been tested in experimental or quasi-experimental research designs. Several studies have also attempted to document the effectiveness of trauma-specific services for female survivors of domestic violence. For a systematic review of evidence-based, trauma-specific services for survivors of domestic violence, see Warshaw et al. (2013). It is important to note, however, that none of these studies focused on LGBQT* survivors.

Trauma-informed service models are inherently more difficult to study because they focus less on specific practices and more on general principles, and they rely on change at the organizational level. Nonetheless, the Women, Co-Occurring Disorders, and Violence Study (WCDVS) attempted to evaluate the impact of this approach. As the only longitudinal study of a trauma-informed approach, the WCVDS indicated that women who received trauma-informed services showed small but significant

improvements on mental health outcomes and trauma symptoms relative to treatment as usual, but no effect for substance abuse (e.g., Morrissey et al., 2005). Since then, researchers have developed several tools to measure the presence of trauma-informed principles and practices as experienced by survivors (see, Accessing Safety and Recovery Initiative & the National Center on Domestic Violence, Trauma, & Mental Health, 2012; Goodman et al., in press;), and are testing new measures of the effects of trauma-informed practices on survivor wellbeing (National Center on Domestic Violence, Trauma, & Mental Health, in development), yielding new possibilities for exploring this important approach.

Trauma-Informed Practices with LGBQT Survivors of IPV*

Despite the high rates of IPV and trauma in LGBQT* communities, trauma-informed approaches tailored to LGBQT* communities have been slow to develop. Some non-IPV trauma-specific interventions have been designed with input from LGBQT* individuals and with concern for LGBQT* cultural competence (e.g., de Arrellano, Ko, Danielson, & Sprague, 2008; Real Life Heroes and Target-A). In addition, the Technical Assistance Partnership for Child and Family Mental Health created a webinar that discusses trauma-informed care for LGBQT* homeless youth. However, there are few well developed trauma-informed approaches for LGBQT* clients in service settings generally, and none in the field of IPV services.

Because of the barriers and difficulties faced by LGBQT* survivors, providers who work with these particular communities may face unique challenges, including lack of resources both within and outside of the service organization, exposure to homo-, bi-, and transphobia through hotline prank callers, experiences of discrimination while attempting to connect survivors with resources, and the possibility of increased vicarious trauma through shared LGBQT* identities.

At the same time, advocates may find strength and resiliency through a shared LGBQT* identity, a strong sense of LGBQT* community, and increased work satisfaction in serving marginalized community members. Advocates who identify as LGBQT* also may be able to draw upon their own experiences of discrimination as a source of resilience in the face of hardship. However, these hypotheses, which are informed by the authors' extensive practice experiences, have not been explored in the literature; considerable research is needed to determine the strengths and job stressors for providers who work with LGBQT* survivors.

Examples of Community-Specific Approaches to Trauma

Although there are no well-developed LGBQT*-specific practices, several community-specific approaches that have been developed by members of culturally-specific communities that have experienced multiple and overlapping forms of oppression may serve as guides.

One example, "Indigenist coping," which was first posited by Walters and colleagues (2002), is a Native-specific model that asks providers to abandon a focus on individual pathology, and instead center the historical trauma, ongoing discrimination, and experiences as a colonized people within a first world nation that are the norm for Native peoples in the U.S. (Walters et al., 2002). The multiple traumas experienced by Native peoples both individually and collectively are the foundation of service provision.

Walters and colleagues interpret the disproportionate rates of substance use, mental health challenges, and HIV risk behaviors among Native people, as conditions that might best be addressed and healed within the context of reconnection to the history and spiritual and healing practices of the Native community. Perhaps the most interesting aspect of the Indigenist coping model is its focus on uprooting internalized colonization and integrating identity along political, ethnic, racial, cultural, and spiritual dimensions. Although this model is not specific to Two-Spirit peoples, it is Two-Spirit-inclusive, and provides a conceptual framework that is responsive to the layered traumas experienced by too many Two-Spirit individuals (Walters, et al., 2002).

Similarly, the National Latin@ Network for Healthy Families and Communities has long used human rights and social justice frameworks to interpret trauma. Specifically, they view trauma through an understanding of multiple kinds of historical & collective trauma, the traumatogenic impact of "non-traditional" traumas such as racism, nativism, poverty, and discrimination and unjust denial of services from helping systems currently and historically experienced by Latin peoples. The National Latin@ Network correspondingly looks to identity cultural traditions and collective knowledge and wisdom, as sources of resilience and post-traumatic growth, both for individuals and for entire communities. Much like the Indigenist coping model (Walters et al., 2002), the approach of the National Latin@ Network looks to the community for both healing and leadership (Serrata, 2012).

Transformative Justice as a Trauma-Informed Practice

Transformative justice analyses recognize systemic oppression as contributing to and exacerbating the impact of interpersonal and community violence and seeks justice at every level (Hairston & Oliver, 2006; Generation Five, 2007). Whereas trauma-informed practice was conceptualized in clinical and academic contexts, transformative justice grew out of a community-based intervention model. It moves away from criminalizing and pathologizing those who use violence and toward transforming organizations, conditions, and systems that perpetuate violence. It is critical that trauma-informed practices include transformative justice as an additional lens in service delivery and system reform.

Generation Five (2007), an advocacy-based project working to end childhood sexual abuse, has helped shape a practice-oriented understanding of transformative justice by offering several goals and principles needed to build greater capacity of communities to challenge traumatogenic systems. According to Generation Five, there are four specific goals of transformative justice: safety, healing, and agency for survivors; accountability and transformation for people who use violence; community action,

healing, and accountability among those in positions of power; and, transformation of the social conditions that perpetuate violence. Notably, these goals build on a set of core principles: 1) liberation, 2) shifting power, 3) safety, 4) accountability, 5) collective action, 6) honoring diversity and 7) sustainability. Here, we explain these principles by providing possible ways in which they could be applied to work with LGBQT* survivors.

Liberation refers to ending long-standing intergenerational cycles of systemic and family violence, which can be partly achieved by shifting power away from those whose power has been achieved through domination, oppression, and violence. In the case of LGBQT* survivors, shifting power includes listening and responding to survivors' articulation of their stories and needs in order to promote self-determination. Liberation and shifting power also applies to LGBQT* individuals who use violence: To end intergenerational cycles of violence, it is important to understand their violent behaviors within the context of institutions and norms that perpetuate violence against them. For example, DV organizations can adopt more fluid and nuanced definitions of "victim" and "perpetrator"; that is, definitions that allow for someone to be (or have been) both a victim of violence and someone who used violence. Doing so invites people's full trauma history into the conversation for consideration and healing.

Safety is conceptualized on three intersecting levels. First, on an individual level, LGBQT* survivors must be protected from immediate and future acts of violence via intervention and prevention efforts. Second, within individual communities, action must be taken to foster norms and practices that condemn violence and support conditions for healing. Finally, at the macro level, communities must be accountable to one other in order to challenge institutional power. Part of that accountability includes acknowledging the prevalence and impact of interpersonal and historical trauma on individuals and communities as well as committing to survivor empowerment and healing. For example, mainstream DV programs can develop relationships with LGBQT* community members and programs to work toward long-term accountability of culturally sensitive service provision. They also can engage in ongoing program evaluation, including open discussion of policies, procedures, and staff profiles, in an effort to transform trauma-inducing organizational norms. Futures Without Violence (n.d.) has developed a series of "Program Personnel Policy Questions" for DV organizations to assess their readiness to work with children and teens; many of these questions can be amended to assess readiness to work with LGBQT* survivors. The National Center on Domestic Violence, Trauma & Mental Health's Accessible, Culturally Relevant, DV & Trauma-Informed (ACDVTI) Agency Self-Assessment Tool also provides guidance on organizational readiness and LGBTQ* inclusiveness.

Collective action highlights the need to address cycles of isolation and shame resulting from traumatic experiences by building alliances with communities to transform structures that perpetuate abuse. Additionally, honoring diversity includes creating and implementing interventions that respond to the unique needs of each community. Finally, sustainability refers to building internal capacity of intimate and community networks to support and maintain survivor-centered safety and healing. These last three principles highlight how social service organizations must incorporate advocacy efforts into

their work and cannot operate in isolation. Instead, they must learn from and collaborate with other organizations, specifically culturally specific organizations. Such collaboration includes not only LGBQT* organizations but also organizations that reflect the range of identities that LGBQT* survivors possess. Incorporating a diversity of expertise and perspective into programs and policies is critical for providing a more trauma-informed approach.

Conclusion

This literature review documents the need for LGBQT*-specific trauma-informed practices with survivors of IPV. IPV is at least as common among LGBQT* individuals as heterosexuals, and may be highest in bisexual and transgender communities. Furthermore, although LGBQT* IPV shares many underlying dynamics with IPV in heterosexual couples, it also has unique characteristics, including the types of abusive tactics used and the context of discrimination and social stigma faced by LGBQT* individuals. Moreover, there are additional complexities within LGBQT* subgroups.

LGBQT* survivors also face unique barriers to help-seeking. Overall, LGBQT* individuals are less likely to seek services from law enforcement and mainstream providers and more likely to rely on informal social support and LGBQT*-focused programs. There are also differences in help-seeking *within* LGBQT* subgroups. For instance, trans individuals may have an especially difficult time accessing culturally competent and non-traumatizing services. For LGBQT* people of color, stigma, economic constraints, and the absence of community outreach are barriers to accessing services.

Trauma and mental health are major concerns in LGBQT* communities in general, and for LGBQT* survivors specifically. LGBQT* individuals experience higher rates of traumatic events, and may be more susceptible to developing symptoms of PTSD, depression, isolation, suicidality, and anxiety. These concerns, which must be viewed in the context of historical trauma, are amplified for LGBQT* people of color and transgender individuals. Nonetheless, LGBQT* individuals find strength and resilience through identity affirmation and social support. More research focused on the strengths and sources of resilience of LGBQT* people is needed to complement and inform existing research on pathology and barriers.

Despite the high rates of IPV and trauma that LGBQT* communities experience, trauma-informed approaches tailored to LGBQT* survivors have been slow to develop. We hope that this document will facilitate thinking about how the core principles of trauma-informed practice can be applied to working with this community and to ameliorating vicarious traumatization among service-providers who do their best in difficult circumstances. The practice-based observations in the Appendix provide further framing for this important endeavor.

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Appendix A: Existing Trauma-Informed Approaches

Trauma-informed Approach	Trauma-informed Care with LGBQT* Homeless Youth
Community	LGBQT* Homeless Youth

Principles	Examples of Practices
• Recovery is possible • Healing happens in relationships • Sharing power and governance • Understanding trauma and its impact • Promoting safety • Supporting client control, choice, autonomy • Focus on strengths • Integrating cultural awareness	• Organizational commitment to nondiscrimination and cultural competence • Involve LGBQT* youth in decisions about services • Provide positive LGBQT* role models • Coordinate with LGBQT* service and advocacy organizations • Collaborate with other organizations • Outreach to change public awareness • Include LGBQT* youth in outreach • Assess staff for knowledge, attitudes, skills

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Trauma-informed Approach	Trauma-Informed or Trauma-Denied
Community	Female Survivors of Trauma

Principles	Examples of Practices
• Recognize the impact of violence and victimization on development and coping • Identify recovery from trauma as primary goal • Employ an empowerment model • Strive to maximize women's choice and control over recovery • Services are based in relational collaboration • Create an atmosphere respectful of survivors' need for safety, respect and acceptance • Emphasize women's strengths, adaptations and resiliency • Minimize retraumatization • Services are culturally competent and understand each woman in context • Solicit participant input and involve participants in designing and evaluating services	• Outreach and Engagement: prioritize safety, ask permission, follow client's lead • Screening and Assessment: screen all clients for trauma history, understand survivor's unwillingness to answer certain questions, only ask for necessary information, balance usefulness of information against client needs, clearly communicate reason for asking questions • Resource Coordination and Advocacy: focus on empowering clients, identify strengths, emphasize skill-building • Crisis Intervention: plan for crises in advance, avoid using restraints or forced hospitalizations, make sure clients know their options • Trauma-Specific Services: offered in trauma-informed environment by individuals trained in trauma and its treatment • Parenting Services: build on parents' strengths • Mental Health and Substance Abuse: treat trauma and substance abuse in integrated way, emphasize physical and emotional safety, collaborate on treatment • Healthcare: prepare clients for medical appointments that might be triggering, debrief and review information provided during exam

Elliot, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477.

Trauma-informed Approach	The Sanctuary Model
Community	Originally for adults who experienced abuse as children, adapted to domestic violence settings

Principles	Examples of Practices
• Core Concepts: nonviolence, viewing organization as whole entity, parallel processes • 7 Commitments: • Nonviolence: physical and psychological nonviolence at all organizational levels • Emotional Intelligence: staff must cultivate awareness of emotional responses and be able to manage and talk about them • Social Learning: organization must be dynamic and constantly identify and respond to changing needs of communities being served • Open Communication: organization should espouse transparency, nonviolent language, and effectively manage conflicts • Democracy: everyone at the agency, clients and staff, should have a voice that is heard • Social Responsibility: create a just and safe organization • Growth and Change: focus should be on the future, with goal of changing and growing over time	

The Sanctuary Model. Accessed 7/2014, from http://www.sanctuaryweb.com/

Trauma-informed Approach	National Center for Domestic Violence, Trauma & Mental Health's Accessible, Culturally Relevant, Domestic Violence-and Trauma-Informed (ACDVTI) Agency Self-Assessment Tool
Community	Domestic violence survivors and programs

Principles	Examples of Practices
• ACDVTI Approach • Be sensitive to the pervasiveness of trauma and its impact on survivors, staff and organizations including historical trauma and ongoing experiences of discrimination and oppression • Recognize the role of coercive control and DV-related safety and confidentiality concerns • Ensure services are welcoming, inclusive, accessible and culturally responsive • Work to minimize retraumatization • Support resilience, healing and well-being • Employ a collaborative strength-based approach • Attend to the quality of interactions for people using services and staff • Involve people using services and communities being served in shaping and evaluating services • Maintain a commitment to changing the conditions that contribute to abuse, violence, discrimination & oppression • Key tenets include recognizing the importance of • Physical and emotional safety • Relationship & connection • Respect, empowerment, transparency, collaboration & choice • Hope & resilience • A survivor-defined approach	The ACDVTI tool provides guidance on engaging in a reflective organization-wide self-assessment process. It is structured to walk agencies through a process of considering what an ACDVTI approach would look like in each of the following 7 domains. • Organizational Commitment and Infrastructure • Staff Support • Physical, Sensory and Relational Environment • Intake Process • Programs and Services • Community Partnership • Evaluation and Feedback It also includes a section on organizational readiness.

National Center on Domestic Violence, Trauma & Mental Health. *Becoming Accessible, Culturally Relevant, Domestic Violence- and Trauma-Informed Organizations: An Organizational Reflection Tool*. National Center on Domestic Violence, Trauma & Mental Health. Chicago, IL. 2015 in press. National Coalition of Anti-Violence Programs.(2012). Hate Violence Against Lesbian, Gay, Bisexual, Transgender, Queer, and HIV- affected Communities In the United States in 2011: A Report from the National Coalition of Anti-Violence Programs. New York City: NCAVP. Retrieved 8/22/2015 from: http://www.cuav.org/wp-content/uploads/2012/08/4379_NCAVPHVReport2011Final_Updated.pdf.

Trauma-informed Approach	SAMHSA TIC in Behavioral Health Services Guide	
Community	Behavioral health service organizations	
Principles		**Examples of Practices**
6 Initial Chapters: • Trauma-informed care: A sociocultural perspective • Trauma awareness • Understanding the impact of trauma • Screening and assessment • Clinical issues across services • Trauma-specific services		• Show organizational and administrative commitment to TIC • Use trauma-informed principles in strategic planning • Review and update vision, mission and value statements • Assign a key staff member to facilitate change • Create a TIC oversight committee • Conduct and organizational self-assessment • Develop an implementation plan • Develop policies and procedures to ensure trauma-informed practices and prevent retraumatization • Develop a disaster plan • Incorporate universal routine screenings • Apply culturally responsive principles • Use science-based knowledge • Create a peer-support environment • Obtain ongoing feedback and evaluations • Change the environment to increase safety • Develop trauma-informed collaborations
Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioral health services*. Rockville, MD: Substance Abuse and Mental Health Services Administration.		

Trauma-informed Approach	Developing Trauma-Informed Organizations Toolkit	
Community	Women with co-occurring disorders and histories of violence	
Principles		**Examples of Practices**
• A comprehensive, continuous, integrated service system • Person-centered services • Trauma • Safety • Family-focused • Diversity		• Establish open dialogue among providers, recipients, and systems • Increase capacity through cross-training, modification and addition of services as necessary • Increase access to peer support • Use respectful, gender-neutral, non-violent language • Recognize and understand cultural differences and how they impact the healing process • Provide co-ed and gender specific services • Staff should be knowledgeable about trauma • Provide access to trauma-specific services • Work with participants to develop calming skills • Validate participant experiences • Allow participant to define their family and support them in their role as parent • Cultural differences should be viewed as community resources and incorporated into service planning
Institute for Health and Recovery. (2012). *Developing Trauma-Informed Organizations: A Tool Kit* (Second ed.). Cambridge, MA: Institute for Health and Recovery.		

Appendix B: A Set of Practice-Based Observations for Trauma-Informed Practice with LGBQT* Survivors of Intimate Partner Violence

GLBTQDVP

GLBTQ Domestic Violence Project

TRAUMA-INFORMED APPROACHES FOR LGBQT* SURVIVORS OF INTIMATE PARTNER VIOLENCE

A Set of Practice Observations
June 2016

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Authors:

Erin C. Miller, M.P.S., M.D.V.
Domestic Violence/ Sexual Assault Programs;
Newton-Wellesley Hospital

Lisa A. Goodman, Ph.D.
Boston College

Kristie A. Thomas, Ph.D.
Simmons College

Carole Warshaw, M.D.
National Center on Domestic Violence, Mental Health, and Trauma

Principal Investigator:

Curt Rogers, M.P.A.
GLBTQ Domestic Violence Project

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Produced by
The GLBTQ Domestic Violence Project

GLBTQDVP

For more information on supporting LGBQT* survivors of intimate partner violence, contact one of the organizations below:

The LGBTQ DV Capacity Building Learning Center
c/o The Northwest Network
A program focused on improving research, practice and policy regarding domestic violence in LGBTQ communities.
1-206-568-777 | info@nwnetwork.org | www.nwnetwork.org

FORGE
A transgender anti-violence organization, specializing in technical assistance for victim service agencies, with a focus on domestic violence, sexual assault, dating violence, stalking, and hate crimes.
1-414-559-2123 | AskFORGE@forge-forward.org | www.forge-forward.org

If you would like more information about accessible, culturally relevant trauma-informed approaches for survivors, contact:

The National Center on Domestic Violence, Trauma & Mental Health
A program providing training, support, and consultation to advocates, clinicians, attorneys and policymakers as they work to improve agency and systems-level responses to survivors and their children.
1-312-726-7020 | info@nationalcenterdvtraumamh.org | www.nationalcenterdvtraumamh.org

Introduction and Project Overview

This document contains a set of preliminary practice observations from the field, which are intended to inform the development of a trauma-informed transformative justice approach specific to lesbian, gay, bisexual, queer, and transgender (LGBQT*) survivors of intimate partner violence (IPV). These observations are the result of a research project that was led by the GLBTQ Domestic Violence Project (GLBTQ-DVP) and funded by the Administration for Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services.

The goal of the project was to help develop a culturally-specific, trauma-informed approach to working with LGBQT* survivors with support and input from a range of stakeholders. To meet this goal, the following activities[1] were conducted over the course of two years (2013-2015):

- A substantive literature review on intimate partner violence in the LGBQT* communities (page 1), which is intended to be read in tandem with the observations
- Input from an advisory committee that included Queer Muslims of Boston, the Hispanic Black Gay Coalition, the Northeast Two Spirit Society, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, Massachusetts Asian & Pacific Islanders for Health, and Fenway Health
- Two focus groups with survivors participating in one GLBTQ DVP program, the goal of which was to explore their experiences seeking help
- Three separate focus groups and multiple individual conversations with staff of one GLBTQ DVP program to assess their perceptions, experiences, and ideas about trauma-informed organizations and providing trauma-informed services
- Surveys of the program's staff as well as LGBQT* practitioners nationally to assess knowledge and experience of trauma-informed practices
- Informal conversations with staff and leadership of LGBQT* culturally-specific organizations across the country
- The authors' own collective experience working with LGBQT* organizations and communities over the past 30 years
- Considerable guidance from the National Center on Domestic Violence, Trauma, & Mental Health

From these multiple sources of data, a set of six observations emerged, which then were simplified and distilled in the hopes that they will be broadly applicable. They are listed here and explained in detail in the subsequent pages.

- Observation 1: The majority of LGBQT* survivors have experienced multiple forms of violence and abuse in their lives. Experiences of historical trauma and ongoing discrimination can compound these multiple experiences of victimization.

[1] The Simmons College Institutional Review Board approved the research activities involving human subjects (i.e., interviews and focus groups with practitioners and program participants).

- Observation 2: Organizations that work with LGBQT* survivors must operate from a place of understanding that perceived "challenges" may actually be creative strengths.

- Observation 3: Organizations that work with LGBQT* survivors must operate from the premise that if LGBQT* communities, staff, board members, organizations, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their family of choice, not merely as a service provider or colleague.

- Observation 4: If practitioners are to truly be of service, a social justice and anti-oppression framework must become the cornerstone of their individual work, their organization's work, and their organization's interactions with the community.

- Observation 5: Staff self-care (and organizational support for self-care) is critical.

- Observation 6: There is a profound need for transformative justice[2] approaches to working with LGBQT* and other multiply oppressed communities.

It is important to note that the authors view these observations as dynamic and evolving, and we are hopeful that LGBQT*organizations, practitioners, activists, and researchers will expand upon them as part of their own trauma-informed, anti-oppression, transformative justice work. Some sections of this addendum tie directly to the literature review (e.g., observations 1 and 5), and others do not. Also, although these observations grew in tandem with the literature review – and should be read together – some of the ideas are not yet supported by a body of literature. Rather, they reflect the practice wisdom and lived experience of LGBQT* practitioners and LGBQT* survivors who contributed to this project.

The practice observations and companion literature review are intended primarily for staff in domestic and sexual violence organizations; however, they are applicable to practitioners in other anti-abuse disciplines, homelessness services, mental health and healthcare circles, criminal legal systems, youth services, and an array of other human services disciplines and social change endeavors that seek to serve and ensure the inclusion of LGBQT* communities.

[2] The authors wish to thank Hales Burton at the Fenway Violence Recovery Program for first suggesting this conceptual shift.

A Note on Language[3]

Before describing the observations, the authors wish to acknowledge the deep complexities of language. In this document, IPV refers to the physical and/or emotional abuse of an individual by a current or former intimate partner. It includes the full range of tactics used to create and maintain power and control over another person, including financial abuse, verbal abuse and intimidation, and cultural abuse. In this document, the phrases *intimate partner violence* and *domestic violence* are used interchangeably to denote partner violence. However, it is important to note that domestic violence (DV) is sometimes defined more broadly to include violence and abuse perpetrated by relatives. Although many LGBQT* individuals experience abuse and/or rejection from family and relatives, the dynamics of partner violence versus family violence may differ dramatically. When we discuss the latter, we use the phrase *family violence* to distinguish it from violence by an intimate partner.

LGBQT* stands for lesbian, gay, bisexual, queer, and transgender. It is often used interchangeably with GLBTQ, LGBQT-TS, and similar acronyms to broadly refer to sexual and gender minorities. This document honors the current practice of including an asterisk after the "T" to signify the broad diversity of trans communities, including trans women – transgender individuals who identify as women, though assigned male at birth; trans men – transgender individuals who identify as men, though assigned female at birth; those transitioning from female to male (FTM); those transitioning from male to female (MTF); cross dressers; gender non-conforming individuals; and others who might self-identify as being members of trans communities. In this paper, transgender and trans are used interchangeably.

These definitions belie the complexity of the terms, however. The words *lesbian*, *gay*, *bisexual*, *transgender*, and *queer* all carry particular historical, political and cultural meanings. To a great extent, these words have been shaped in white, Western contexts. Words such as lesbian, gay, and bisexual, for example, are uniquely English. There are seldom translations into other languages that carry the same understanding of LGBQT* identity as being an identity rather than a set of behaviors. Literal translations, into Spanish or Haitian Creole as but two examples, carry few if any of the presumptions that are inherent in English. In many parts of the Latin and Spanish-speaking world, men who engage in sex with same sex partners are only considered "gay" in the English sense of the word if they are the receptive partner. It is not engaging in the acts that is the determinant of identity, so much as the role that an individual plays (traditionally read as *masculine* or *feminine*) in the conduct of that act. Similarly, men who marry women, but engage in same sex acts with other men, are frequently identified as heterosexual. In short, they are defined by their social role, rather than by their private, intimate acts. Hence the conception of *gay*, as defined in U.S. contexts, frequently fails to apply.

Precisely because identifiers such as LGBQT* were defined in white middle class and academic contexts, the limitations of LGBQT* labels and identifiers may be particularly acute in communities of

[3] For those of you who are reading the literature and practice observations in tandem, please note that this "note on language" section is identical to the "note on language" section in the literature review.

color, Indigenous communities, and immigrant communities, among others. During the course of crafting this literature review, members of our Advisory Board taught us a tremendous amount. The Hispanic Black Gay Coalition (HBGC) suggested use of the term *same gender loving*, a community-specific phrase coined by Cleo Manago to distinguish African Americans, and in particular African American men, who do not self-identify as being part of the predominantly white gay movement in the U.S., but who nonetheless wish to affirm their same sex intimate relationships. Corey Yarbrough, one of the founding Executive Directors of HBGC, suggested that for some same gender loving people this language may be a form of racialized resistance to the racism of the mainstream LGBQT* movement in the U.S. In the alternative, Corey stated, some members of African American communities may be on the *down low*, engaging in same sex sexual activity, but rejecting LGBQT* identifiers as a result of internalized homo and biphobia.

The NorthEast Two-Spirit Society (NETSS) in part echoed Corey's thoughts about the racism of the mainstream LGBQT* movement. In addition, Harlan Pruden, one of co-founders of NETSS, spoke about an "internal muddiness" that some Native peoples may experience when seeking to find language for their experience. Speaking of his own Cree inheritance as a registered member of the Saddle Indian Reservation, Harlan said that when he asked something of an elder, he knew to offer them tobacco, but never understood the spiritual dimension of the ceremony. Having been separated from too much of their own history by colonialism, genocide and forced assimilation, Harlan stated, many Native people may use the words *Two-Spirit* when what they really mean is gay Indian.[4]

Harlan also spoke at length about the contextual nature of Native Two-Spirit identities. As Harlan put it, "When I am out on a Friday night in a gay club, I am a gay man. Yet when I am in rural Oklahoma at a Two-Spirit gathering, I am a proud Two-Spirit man." Alluding to the unique role and cultural responsibilities that Two-Spirit people often held (and may still hold) in the life of Native communities, Harlan pointed out the obvious differences in the spiritual role of Two-Spirit peoples, and the political and social function of people claiming LGBQT* identities in mainstream communities. Several members of the project's advisory board echoed this point,
speaking about the complex layering of cultural and spiritual value systems that accompanied their choice to self-identify in, with, and outside of their own communities.

These same Advisory Board members also acknowledged the landscape in which such decisions are made, and stated that individuals in their communities may shift how they self identify as a means of preserving their safety. As the rest of this literature review discusses, LGB, transgender, same gender loving, Two-Spirit, and queer-identified peoples make choices about how, when, and if to "out" themselves in a complex social and political landscape that is too often unsafe, if not violent. Hence how

[4] Two-Spirit is a contemporary term, adopted from the Northern Algonquin, and meant to signify the embodiment of both masculine and feminine within one person. Now embraced by many Native peoples as a pan-Indigenous umbrella term connoting both diverse gender expressions and sexual orientations, Two-Spirit generally speaks to the respect that Native peoples held for diversity, and the unique sacred and ceremonial roles that Two-Spirit people held (and may still hold) within their own communities. Herein the phrase Two Spirit speaks not simply to a third gender, or to same gender attraction, but more broadly to the history of compulsory Christianization that sought to erase Two-Spirit peoples within their own nations. Notably, there is no single consensus definition of Two-Spirit, and the term means different things to different Native peoples.

any individual self-identifies may shift depending on who is asking, why, and in what context. As one Advisory Board member stated, "identities have to be fluid in order to be protective."

Finally, the leadership of HarborCOV, an LGBQT*-affirming DV organization in Boston that specializes in serving communities facing cultural or linguistic barriers, has noted that some cultures may not have the variety or depth of language that words such as LGB, transgender, same gender loving, and Two-Spirit convey. Indeed, Kourou Pich, Co-Executive Director of HarborCOV has observed that people from some cultures and communities may have difficulty finding language for themselves in their own communities, and that that invisibility is intentional – a function both of denial of the existence of sexual minorities in those communities, but also perhaps protectiveness of gender queer and same gender attracted people.

Language is power. We authors, therefore, have put a great deal of thought into the words we use to name peoples' experiences. At the same time, we know that we can never be as inclusive or sensitive as we want to be. We have done our best to honor the range of experiences we are writing about in this document.

Notes from the Field: A Set of Practice-Base Observations

Observation 1: The majority of LGBQT survivors have experienced multiple forms of violence and abuse in their lives. Experiences of historical trauma and ongoing discrimination can compound these multiple experiences of victimization.*

A trauma-informed approach, at its core, asks that practitioners assume that everyone they serve has experienced some form of violence, abuse, or other trauma in their lives and to see these experiences as the norm, rather than the exception (Felitti et al., 1998; Harris & Fallot, 2001).

Given the prevalence and overlapping nature of violence and abuse in the lives of LGBQT* peoples, it might be more prudent to suggest that practitioners build practices and systems that presume *multiple* forms of victimization among the people they serve. It is not unusual for LGBQT* peoples to be targets of many different forms of violence and abuse at the hands of multiple individuals, at numerous points throughout the lifespan (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Grant, Mottet, & Tanis, 2011; Stotzer, 2009).[5] Indeed, traumatic experiences such as intimate partner

[5] To date, the fragmented nature of the research into violence and abuse in the lives of LGBQT* individuals means that, although there is a broad practice consensus about the prevalence of "polyvictimization" in the lives of LGBQT* peoples, there is little peer-reviewed research examining the phenomenon. However, there is abundant evidence that LGBQT* people, and in particular LGBQT* people of color, are more likely to be targeted for multiple forms of violence and abuse, in multiple contexts (family, partnerships, community) over the course of their lifetime. For example, LGBQT* peoples are disproportionately subject to childhood sexual abuse, bullying by peers, sexual violence in adolescence and adulthood, intimate partner violence, hate crimes, and police brutality (Roberts et al., 2010; Grant et al., 2011; Stotzer, 2009). Again, the authors wish to encourage individuals to read these observations in tandem with the literature review to learn more about these siloed areas of research.

violence, family violence, and other types of trauma that occur over the course of the lifespan, including childhood sexual assault, bullying, hate crimes, or police brutality, may intersect and compound each other in the lives of LGBQT* survivors in ways that create unique challenges for survivors themselves, and unique opportunities for control by future perpetrators.

These interpersonal traumas are often further compounded by experiences of oppression and historical trauma in LGBQT* communities. LGBQT* peoples have historically experienced discrimination at the hands of helping professionals in a range of systems (e.g., healthcare, mental health, criminal-legal, child protection, public assistance, and sexual and domestic violence organizations) – if LGBQT* peoples have been visible in those systems at all.[6] In addition, many of these systems (in particular mental health and criminal-legal systems) have not only pathologized, labeled, isolated, and detained LGBQT* individuals, but also intentionally fractured LGBQT* partnerships, families, and communities. Such treatment is especially the case for multiply marginalized LGBQT* communities, such as communities of color, immigrants and refugees, Two Spirit communities, and people with disabilities.

It is important to understand, however, that these forms of oppression are not merely historical artifact in the lives of LGBQT* survivors, but ongoing and continuing realities, especially for those who are multiply marginalized. This ongoing oppression then exacerbates experiences of current and historical trauma.

A trauma-informed approach encourages practitioners, and indeed entire systems, to minimize the possibilities for retraumatization by creating an atmosphere that prioritizes survivor's need for safety, respect, and acceptance (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Jennings, 2004; Substance Abuse and Mental Health Services Administration, 2014; Warshaw, 2014; Wilson, Fauci & Goodman, 2015). In short, a trauma-informed approach asks first and foremost that practitioners – as well as the systems in which they work – do no harm.

However, for LGBQT* survivors in particular, the mandate to do no harm requires that practitioners understand the concept of *sanctuary harm* – the idea that institutions and institutional gatekeepers can inflict enormous damage on the very people whose healing, empowerment, and safety they are supposed to nurture and protect (Bloom & Farragher, 2011; Smith & Freyd, 2014). Survivors who participated in the focus groups for this project spoke of blatant discrimination, noting, for example, institutions and practitioners who had at times openly refused services to male and LGBQT* survivors. And, in the staff focus groups, participants spoke about the challenges of advocating with organizations that had a funder mandate to be LGBQT* inclusive, but who were still actively resistant to accepting some members of this diverse community.

[6] The authors are mindful that historical trauma means different things in different communities. Many members of First Nation communities frame historical trauma in terms of colonization, genocide, and boarding-school trauma. Members of Jewish communities may frame historical trauma in terms of the intergenerational impact of the Holocaust. And members of the African Diaspora may think of the Middle Passage and the enslavement of African peoples when referencing historical traumas. The specific nature of the historical influences the way it continues to affect the lives of individuals and entire communities.

Conversations with LGBQT* practitioners across the country, especially those from mainstream organizations, surfaced deep ethical tensions over their own roles as institutional actors in organizations and agencies that they believed too often inflicted sanctuary harm. Consciousness of the harm they were doing – and the good they were prevented from doing – was a significant source of mental, emotional, and ethical distress for many practitioners, especially when contrasted with their larger awareness of the needs of the communities and people they were serving.

Observation 2: Organizations that work with LGBQT survivors must operate from a place of understanding that perceived "challenges" may actually be creative strengths.*

Recognizing the potentially significant impact of violence and abuse on development and coping strategies, a trauma-informed approach aims to contextualize coping strategies such as substance use, cutting, eating disorders, "promiscuous" sex, and dissociation as adaptive responses to otherwise intolerable situations (Elliot et al, 2005; Guarino et al., 2009; Jennings, 2004; SAMHSA, 2014, Warshaw 2014). Because it is rooted in clinical frameworks, trauma-informed practice approaches often frame such strategies as necessary within the context of abuse, but no longer adaptive once relative safety had been achieved. Following the examples of Kate Bornstein and Sylvia Rivera, the LGBQT*-specific practitioners who participated in the survey and informal conversations spoke about celebrating survivors' coping strategies as not merely adaptive, but indeed creative, even when such strategies are not on the surface immediately conducive to health or perceived well-being. Given the multiple forms of victimization, ongoing discrimination, and historical trauma that shape the LGBQT* experience, it may be that there is no safety anywhere. In that context, any strategy that allows people to survive – internally or externally – is to be celebrated. As one practitioner put it, "It isn't about coping, it is about surviving. We celebrate survival, because it is so uncertain." Such a response should not preclude practitioners from expressing concern or helping survivors to develop alternative survival strategies in parallel; however, it does require that practitioners fully embrace survivors and honor and respect their own strategies.

Observation 3: Organizations that work with LGBQT survivors must operate from the premise that if LGBQT* communities, staff, board members, organizations, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their family of choice, not merely as a service provider or colleague.*

A trauma-informed approach asks that practitioners base everything they do in relational collaboration. In fact, one of the core principles of a trauma-informed approach is to ensure that goals and strategies are collaboratively defined, and that the partnership between survivor and practitioner is itself a place of healing (Elliot, et al, 2005; SAMHSA, 2014; Warshaw, 2014; Davies & Lyon, 2014; Wilson et al., 2015).

Just as with other historically oppressed communities, the complexities of the LGBQT* experience may be such that a traditional relationship between service provider and client is not sufficient to fully support the person's healing. Instead, a different and more porous set of boundaries may be required – or at least expected. As several LGBQT* practitioners put it, when LGBQT* communities, staff, co-workers, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their "family of choice," not merely as a service provider. Program participants supported this sentiment, describing how one of the most important and helpful aspects of the services they received was the staff's willingness to go "above and beyond their job descriptions." Providing the sort of attention that a friend might provide (e.g., calling to check in or going along to doctor's appointments) was important because, as one survivor expressed, "I had never been treated that way in my life, not even by my family." Although this can raise complex ethical issues for both survivors and practitioners in navigating this important but complicated terrain, recognizing it is critical in working with LGBQT* survivors and working within LGBQT* communities.

Observation 4: If practitioners are to truly be of service, a social justice and anti-oppression framework must become the cornerstone of their individual work, their organization's work, and their organization's interactions with the community.

Another principle of trauma-informed practice is to respond to all people in ways that are sensitive to their individual social locations and contexts (Wilson et al., 2015; see also Elliot, et al, 2005; Jennings, 2004; Guarino et al., 2009; SAMHSA, 2014; National Center on Domestic Violence, Trauma & Mental Health, in press). At a minimum, this principle sets forth an expectation of cultural sensitivity across multiple aspects of identity. Given the chronic and cascading traumas, ongoing oppression and historical trauma referenced above, cultural sensitivity is essential but not sufficient for responding to the experiences of LGBQT* survivors. Instead, attention to individual social locations and contexts must be situated within a broader anti-oppression framework.

LGBQT* practitioners from across the country observed that the broader movements against sexual and domestic violence sometimes minimized the ways in which violence and abuse intersect with other forms of oppression. They took note not simply of the ways in which this lack of proactive attention shaped direct services, but also how it shaped their organization's hiring practices, the tokenization of staff members from historically marginalized communities, the narrow makeup of their organization's governing board, the focus on quantity over holistic quality of services, and the lack of input particularly from transgender community members and community members of color in strategic planning and other organizational activities.

By contrast, they called on practitioners to build organizations that are integrated into and learn from the historically marginalized communities they serve (or should be serving) and that center the knowledge and experiences of those communities. Historically oppressed communities, including LGBQT* communities, are at the leading edge of anti-violence work, not a set of "minority communities" requiring special logistics or uniquely special care. What organizations learn from historically oppressed communities should serve as the foundation of their organizational philosophy, practices, and policies.

Observation 5: Staff self-care (and organizational support for self-care) is critical.

Empathic engagement and bearing witness to other people's pain can affect us deeply. To be effective, it is important for service providers and activists serving people in pain and crisis to be mindful of how they have been affected by their own experiences of trauma *and* how they are affected when they open themselves up to other people's experiences (Saakvitne, Gamble, Pearlman, & Lev, 2000; Hopper, Bassuk, & Olivet, 2010; Bloom & Farragher, 2013; SAMHSA, 2014). Hence, an understanding of vicarious trauma and encouragement to develop strong habits of self-care have become foundational principles in trauma-informed practice (Bloom & Farragher, 2011; Bloom & Farragher, 2013). Thus, to be truly trauma-informed, organizations need to institute programmatic supports for self-care at all levels of the organization (Bloom & Farragher, 2011; Bloom & Farragher, 2013, Warshaw 2014).

Conversations with LGBQT* practitioners across the country led to an additional observation: There is a particular weight that accompanies serving LGBQT* people experiencing violence, abuse, and discrimination while simultaneously identifying with those same communities. Trauma, vicarious trauma, organizational trauma, and historical trauma compounded one another in the lives of the LGBQT* practitioners who contributed to this project, just as they do for the survivors who participate in their programs. Moreover, the impact of compounding trauma was one each group articulated virtually unanimously. Their experiences underscore the need for self-care at the individual level. They also point to need for organizational policies that enable self-care, provide LGBQT*-affirming workspaces, and facilitate connection with the larger community of providers and activists that support and depend upon the work and health of that organization. Essentially, caring for each other individually and as a collective is a critical element of any trauma-informed approach.

Observation 6: There is a profound need for transformative justice[7] approaches to working with LGBQT and other multiply oppressed communities.*

Because the companion literature review focused largely on peer-reviewed, published literature, it did not consider the enormous array of activist literature and art that historically oppressed communities have often used to express their communal strategies for survival and resistance. The work of Incite!, Creative Interventions, Black & Pink, and Break Out, along with broader bodies of art, music, dance, autobiography, fiction, and oral history attest to this creative communal drive.

One innovation that has emerged from this kind of activist energy is the concept of *transformative justice* (Generation Five, 2007; Creative Interventions, 2012). Transformative justice recognizes the profound harm and trauma that mainstream approaches have inflicted on LGBQT* peoples, particularly those who face multiple forms of oppression. Its practitioners argue for an approach that understands these historical harms and seeks to create new and innovative responses that avoid replicating them. Rather than work within the framework of social services, it aims for the liberation of oppressed people as communities not just as individuals, under the fundamental

[7] The authors wish to thank Hales Burton at the Fenway Violence Recovery Program for first suggesting this conceptual shift.

assumption that “individual justice and collective liberation are equally important, mutually supportive, and fundamentally intertwined” (Generation Five, 2007, p.1). In other words, transformative justice seeks to transform the political and cultural conditions that allow violence, abuse and oppression to exist in the first place. It is critical that trauma-informed practices include transformative justice as an additional lens in service delivery and system reform.

Conclusion

In summary, these six observations underscore the ways in which individual, interpersonal, and structural factors coalesce in the lives of LGBQT* survivors of domestic violence, creating a unique context, that affects their experiences and needs. Future trauma-informed approaches for LGBQT* survivors of domestic violence should consider the multi-layered context that surrounds LGBQT* survivors and use that knowledge to inform not only client-level practices, but also organizational-level policies.

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REVIEW ARTICLE

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Trauma and trauma care in Europe

Ingo Schäfer[a], Manoëlle Hopchet[b], Naomi Vandamme[c], Dean Ajdukovic[d], Wissam El-Hage[e], Laurine Egreteau[f], Jana Darejan Javakhishvili[g], Nino Makhashvili[h], Astrid Lampe[i], Vittoria Ardino[j], Evaldas Kazlauskas[k], Joanne Mouthaan[l], Marit Sijbrandij[*m], Małgorzata Dragan[n], Maja Lis-Turlejska[o], Margarida Figueiredo-Braga[p,q], Luísa Sales[r], Filip Arnberg[s], Tetiana Nazarenko[t], Natalia Nalyvaiko[u], Cherie Armour[v] and Dominic Murphy[w]

[a]Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany; [b]Belgian Institute for Psychotraumatology, Brussels, Belgium; [c]Belgian Institute for Psychotraumatology, Trauma Center Limburg, Hasselt, Belgium; [d]Department of Psychology, Faculty of Humanities and Social Sciences, University of Zagreb, Zagreb, Croatia; [e]UMR 1253, iBrain, Université de Tours, CHRU de Tours, Inserm, Tours, France; [f]Laurine Egreteau, CHRU de Tours, Clinique Psychiatrique Universitaire, Tours, France; [g]Institute of Addiction Studies, Faculty of Arts and Science, ILia State University, Tbilisi, Georgia; [h]Business School, ILia State University, Tblisi, Georgia; [i]Department of Medical Psychology and Psychotherapy, University Medical Hospital Innsbruck, Innsbruck, Austria; [j]Dipartimento di Scienze dell'Uomo, Urbino University, Urbino, Italy; [k]Center for Psychotraumatology, Institute of Psychology, Vilnius University, Vilnius, Lithuania; [l]Department Clinical Psychology, Institute of Psychology, Leiden University, Leiden, The Netherlands; [m]Faculty of Behavioural and Movement Sciences, VU University Amsterdam, Amsterdam, The Netherlands; [n]Faculty of Psychology, University of Warsaw, Warsaw, Poland; [o]Faculty of Psychology, SWPS University of Social Sciences and Humanities, Warsaw, Poland; [p]Faculty of Medicine, University of Porto, Porto, Portugal; [q]Centre for Social Studies (CES) of the University of Coimbra, Coimbra, Portugal; [r]Department of Psychiatry of the Military Hospital of Coimbra, Centre of Trauma (CES) of the University of Coimbra, Coimbra, Portugal; [s]National Centre for Disaster Psychiatry, Department of Neuroscience, Psychiatry, Uppsala University, Uppsala, Sweden; [t]Non-Governmental organization 'Ukrainian Society of Overcoming the Consequences of Traumatic Events' (USOCTE), Kyiv, Ukraine; [u]International Institute of Depth Psychology, Non-Governmental organization 'Ukrainian Society of Overcoming the Consequences of Traumatic Events' (USOCTE), Kyiv, Ukraine; [v]School of Psychology, Institute of Mental Health Sciences, Faculty of Life & Health Sciences, Ulster University, Coleraine, Northern Ireland, UK; [w]Research Department, Combat Stress, Leatherhead, UK & King's Centre for Military Health Research, Department of Psychological Medicine, King's College London, London, UK

ABSTRACT

The European countries have a long history of exposure to large-scale trauma. In the early 1990s the increasing awareness of the consequences of trauma within the mental health community led to the foundation of local societies for psychotraumatology across Europe and the European Society of Traumatic Stress Studies (ESTSS), which celebrated its 25th anniversary in 2018. The focus of this article is to describe the current state of care for survivors of trauma in the 15 European countries where ESTSS member societies have been established. Brief descriptions on the historical burden of trauma in each country are followed by an overview of the care system for trauma survivors in the countries, the state-of-the-art of interventions, current challenges in caring for survivors and the topics that need to be most urgently addressed in the future. The reports from the different countries demonstrate how important steps towards a better provision of care for survivors of trauma have been made in Europe. Given the cultural and economic diversity of the continent, there are also differences between the European countries, for instance with regard to the use of evidence-based treatments. Strategies to overcome these differences, like the new ESTSS training curricula for care-providers across Europe, are briefly discussed.

Trauma y Atenciones de Trauma en Europa

Los países Europeos tienen una larga historia de exposición a traumas de larga escala. A principios de la década de 1990, la creciente conciencia de las consecuencias del trauma dentro de la comunidad de salud mental condujo a la fundación de las sociedades locales para la psicotraumatología en Europa y la Sociedad Europea de Estudios de Estrés Traumático (ESTSS), la cual celebra en el 2018 su 25° aniversario. El enfoque de este artículo es describir el estado actual de la atención de los sobrevivientes de traumas en los 15 países Europeos, donde las sociedades miembros de la ESTSS se han establecido. Las descripciones breves sobre la carga histórica de trauma en cada país son seguidas por una descripción general del sistema de atención para sobrevivientes de trauma en el país, el estado de la técnica de las intervenciones, los desafíos actuales en el cuidado de sobrevivientes y los temas que necesitan ser abordados con mayor urgencia en el futuro. Los reportes de los diferentes países demuestran los pasos importantes que se han dado en Europa en la entrega de atención para los sobrevivientes de trauma. Dada la diversidad cultural y económica del continente, hay también diferencias entre los países Europeos, por ejemplo en relación al uso de tratamientos basados en la evidencia. Las estrategias para

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HIGHLIGHTS

- Important steps towards a better provision of care for victims of trauma were made in the European countries.
- In 2018, ESTSS celebrates its 25th anniversary.
- Strategies to promote a better practice include new ESTSS curricula for professionals across Europe.

CONTACT Ingo Schäfer i.schaefer@uke.de Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany

[*]In close collaboration with fellow NtVP Board members Miriam Lommen, Marie-Louise Meewisse, Trudy Mooren and Maartje Schoorl.

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resolver estas diferencias, como el nuevo curriculum de entrenamiento de la ESTSS para los proveedores de atención a lo largo de Europa son discutidas brevemente.

欧洲的创伤和创伤护理

欧洲国家有遭受大规模创伤的久远历史。在20世纪90年代早期，精神卫生界内越来越意识到创伤的后果，导致了在欧洲各个地区性创伤心理学会和欧洲创伤应激研究学会（European Society of Traumatic Stress Studies；ESTSS）的成立，该学会将于2018年庆祝其成立25周年。本文旨在描述在已建立ESTSS子协会的15个欧洲国家中创伤幸存者护理的当前状况。首先是对每个国家创伤的历史负担的简要描述，之后概述了各国创伤幸存者的护理系统的概述，干预措施的最新技术，护理幸存者面临的的当前挑战以及将来最迫切需要解决的问题。来自不同国家的报告展示了，在欧洲是如何实现为创伤幸存者提供更好的护理。鉴于大陆的文化和经济多样性，欧洲国家之间也存在差异，例如在循证治疗的使用上。我们简要讨论了克服这些差异的策略，例如为跨欧洲的护理服务提供者的新ESTSS培训课程。

1. Introduction

Exposure to trauma is common (Kessler et al., 2017) and its consequences on the individuals and communities affected can hardly be overestimated. In Europe, as in other regions of the world, a high burden of trauma is related to human-made events. In the twentieth century, military conflict took place during every single year in the European region and many of them affected numerous countries (see Table 1). Mass traumatization was also related to military conflicts associated with European colonialism, or conflicts in other continents where European military forces were involved in conflicts (see Table 2). Another massive burden of trauma across Europe resulted from the Holocaust and, throughout most of the twentieth century, from the political oppression by the Soviet communism. Trauma has occurred and still occurs in many societal contexts. For example, these include the familial and institutional abuse of children, different forms of gender-based violence in the European societies, various forms of institutional violence (i.e. in detention facilities of some countries) and also large-scale disasters and terror attacks that struck individual countries. Finally, over the last decades, an increasing number of migrants have reached the European countries, due to war and violence in their homeland (Hall & Olff, 2016; Kartal & Kiropoulos, 2016; Knaevelsrud, Stammel, & Olff, 2017; Munz & Melcop, 2018).

In the last two decades of the twentieth century, the increasing awareness of the consequences of trauma in the mental health community led to the foundation of local working groups and societies for psychotraumatology in several European countries. The European Society of Traumatic Stress Studies (ESTSS), which celebrated its 25th anniversary this year, was founded in 1993. Over two decades, ESTSS was an organization that included both member societies and individual members, which in the first years mainly came from western European countries. Recently, ESTSS has developed into an umbrella organization of the European societies for traumatic stress. This change is the result of a strategic plan that has been pursued over a longer period of time (Gersons, 2013). The ESTSS board consists of representatives from all member societies, which facilitates the work towards common strategic aims, such as promoting a standard curriculum for training in psychotrauma across Europe. In 2018, ESTSS com-

Table 1. Examples of military conflicts in Europe.

Year	Military conflict	Countries affected
1914–1918	First World War	Paneuropean
1917–1922	Soviet revolution	Former Soviet countries
1936–1939	Spanish civil war	Spain
1939–1945	Second World War	Paneuropean
1944–1953	Lithuanian partisan war against Soviet occupation	Lithuania
1968–1998	The Northern Ireland Troubles	UK, Republic of Ireland
1991–2000	Wars following the dissolution of former Yugoslavia	Slovenia, Croatia, Bosnia and Herzegovina Serbia, Montenegro, Kosovo
Since 1990	Military conflicts/wars in the South and North Caucasus	Georgia, Armenia, Azerbaijan and Russia (including North Caucasian region of Russia)
2008	Russian-Georgian war	Georgia, Russia
Since 2014	Conflict in East Ukraine	Ukraine, Russia

The list of military conflicts and countries involved is not all inclusive.

Table 2. Examples of military conflicts outside of Europe.

Year	Military conflict	European countries affected
1945–1949	War in the former Dutch East Indies	The Netherlands
1946–1954	Vietnam war	France
1954–1962	Algeria war	France
1950–1953	Korean war	Belgium, France, Greece, Luxembourg, Netherlands, UK
1961–1974	Portuguese Colonial War in Africa	Portugal
1979–1987	Afghanistan war	Former Soviet countries, UK
1990–1991	Gulf war	Belgium, Denmark, France, Germany, Greece, Hungary, Italy, Netherlands, Norway, Poland, Portugal, Romania, Spain, Sweden, UK
2001–2014	Afghanistan war	Albania, Belgium, Croatia, Czech Republic, Denmark, France, Georgia, Germany, Italy, Lithuania, Norway, Poland, Portugal, Romania, Russia, Spain, Sweden, UK, etc.

The list of military conflicts and countries involved is not all inclusive.

prised of 13 member societies that included 15 European countries and regions. These included Austria, Belgium, Croatia, Georgia, Germany, Lithuania, Italy, The Netherlands, Poland, Portugal, Sweden, the German-speaking and the French-speaking part of Switzerland, Ukraine and the UK (www.estss.org). Moreover, ESTSS had 12 additional affiliated societies and institutions in 2018. The society is constantly working towards the inclusion of further European societies and actively supports the formation of new societies in countries where they do not exist yet, as currently happened in Finland where the Finish Society for Psychotraumatology was launched in 2018.

While a series of articles at the occasion of ESTSS' twentieth anniversary focused on the inspiring and often also entertaining recollections of former presidents on the development of ESTSS (Lueger-Schuster, 2013b), the focus of this article is on the current member societies of ESTSS and on the development of trauma care in the respective countries. After some reflections on the historical burden of trauma in each country, representatives from all the national societies describe the structure of care organizations for trauma survivors, the state-of-the-art of interventions, current challenges in caring for survivors and the topics that need to be most urgently addressed in their countries in the future.

2. Psychotraumatology in Belgium

Five to eight million deaths, perhaps even 10: this was the devastating toll of the conquest and colonial exploitation of the Belgian Congo with King Leopold II, between the 1880s and the First World War (Hochshild, 1998). All traces of this Genocide remained secret until the early 1980s. Concerning the historical burden of the two World Wars (Manfred, 2015), it is the First World War more than the Second World War which, in the collective memory, constitutes a great trauma because of the looting of the country and the massacre of more than six thousand civilians. Recent events that stay more broadly in the mind of the Belgian people include the Heysel Drama in 1985 and the Dutroux affair with the sexual abuse, sequestration and death of young children and adolescents in 1996. In March 2016, the terrorist attacks at the national airport and in the metro of Brussels caused the death of 35 persons (Deschepper et al., 2018). Psychosocial structures vary across the country and have little or no coordination between them. One of the reasons is a difference between the functioning of French- and Flemish-speaking communities. Some structures can be found in both the French- and the Flemish-speaking communities. For instance, Public Welfare Centres and police victim services can be found in both of them. The integration of a psychosocial dimension into emergency and intervention plans was formalized in 2006. For the last 20 years, psychotherapists and other clinicians working in private practices started to specialize in trauma care for survivors. More and more specifically trained psychologists are working in hospitals and mental health centres. Recently, the development of outpatient trauma treatment centres linked to hospitals is evident. Some centres for the provision of trauma care for refugees were established in Brussels and cover the Dutch- as well as the French-speaking part of the country. In 2017, the High Council on Health received a Ministerial request for an opinion on the psychological care and support of persons following terrorist incidents or related disasters.

Until recently, there were no trauma-focused intervention methods in use in Belgium. The main therapeutic currents, for instance cognitive behavioural therapy (CBT) and psychodynamic therapies, were putting their own accents on working with trauma. In 2006, the BIP (Belgian Institute for Psychotraumatology) started the first psychotraumatology course. More trauma centres were created in the following years in principle cities, mainly Antwerp and Brussels. The course is organized in collaboration with two Universities. BIP organizes conferences in collaboration with other institutes or centres in Belgium. An independent Belgian trauma society needs to be created in the near future.

Current challenges in caring for trauma survivors concern the coordination of different support services. The political system in Belgium involves varying responsibilities at several levels, which makes decision-making complex. More visibility through studies on the positive impact and benefits of qualified trauma-focused care will be important. Finally, a well-structured national accreditation system should be put in place in order to continue provision of quality care for trauma survivors.

Among the topics to be most urgently addressed in the future is accessibility of services which is limited due to long waiting lists before survivors get access to psychological care in the Belgium mental health care system. Moreover, new ways of thinking about specialized trauma-care structures are needed.

3. Psychotraumatology in Croatia

The still living burden of the Second World War psychotrauma in Croatia has merged with the trauma of the Homeland War (1991–1995). Throughout the whole post-World War period there was no awareness of the consequences of trauma exposure, the issue was present neither in the health nor in public discourse. Consequently, no specific care was developed and provided. In contrast, the war in the 1990s brought about a high level of awareness of trauma and posttraumatic stress disorder (PTSD). Decades later the war-affected population reports 18% prevalence of PTSD (Priebe et al., 2010). This may be

partly due to lack of effective early trauma interventions and a number of hindering social factors, such as the prolonged economic crisis that affected more the vulnerable populations. The spin-off effect of massive trauma at the social level is a new understanding of the impact of traumatic events on physical and psychological health, as well as on communities (Corkalo Biruski, Ajdukovic, & Löw Stanic, 2014; Lončar & Henigsberg, 2007), which in turn facilitates access to specialized services by people exposed to trauma in everyday life.

Trauma survivors have access to psychiatric services in major hospitals, while veterans receive help within the three specialized regional centres and the National Centre for Psychotrauma. The cost of services are covered by universal national health insurance. Several non-governmental organizations with qualified staff provide supportive therapy to survivors of sexual assault, traffic accidents and other life threatening incidents, as well as domestic violence. The Polyclinic for the Protection of Children based in Zagreb specializes in working with traumatized children. Other facilities focus on prevention and support in the immediate aftermath of traumatic incidents, such as the Crisis Response Network maintained by the Society for Psychological Assistance (SPA).

The psychiatrists' first treatment choice is psychopharmacology. The prevalent therapeutic approach in psychiatric services for veterans is group therapy. Some veterans have been attending such groups for over 25 years. Low use of evidence-based trauma-focused therapies reflects (Schnyder et al., 2015) the prevailing traditional approach in Croatian psychiatry. Hence, traumatized populations still have poor access to effective, evidence-based trauma treatments. Training in trauma-focused CBT and EMDR is offered to practitioners, but this is not fully integrated into the helping system. With the existing high level of competencies in dynamic psychotherapy and psychopharmacology (Britvić et al., 2012), the challenge remains to develop a more stepwise approach to trauma-informed services, increase public awareness of risk and resilience factors, and to expand treatment choices to include evidence-based trauma-focused therapies and make them more available to the general populations in need. The Croatian Society for Traumatic Stress (CSTS) has been working on this challenge since it was founded in 2011 by organizing training workshops. It is currently promoting the ESTSS certified training in psychotrauma for mental health providers. One of the ambitions is to further integrate such training into university curricula so that future generations of mental health professionals are able to provide state-of-the-art care to traumatized people. Similarly, basic and intermediate levels of trauma-related knowledge and skills will be made more available to first responders and other health professionals.

4. Psychotraumatology in France

According to the World Mental Health survey, 72.7% of the French population has been exposed to traumatic events in their lifetime (Husky, Lépine, Gasquet, & Kovess-Masfety, 2015). Intimate partner violence, serious illness of a child and rape were the events associated with highest risk of PTSD. While rape is underreported in France, each year nearly 100,000 individuals claim to be survivors of rape or attempted rape and 500,000 claim to be survivors of intimate partner violence. A fifth of the French population was exposed to war-related events (mainly the Second World War). The twenty-first century was scarred by numerous Islamism extremist attacks, of which the November 2015 Paris attacks have been the bloodiest to date, resulting in more than 264 dead and 914 injured individuals. Traffic fatalities decreased in the past decades, reaching 5.1 per 100,000 inhabitants per year.

Since 1995, medico-psychological emergency units (CUMP for 'Cellules d'Urgence Médico-Psychologiques') are deployed in the case of mass casualty situations and provide immediate psychological support and care. These units were very effective after terror attacks in Paris and Nice, supporting thousands of survivors over many weeks (Hirsch et al., 2015). Psychological assistance aims at providing survivors with an entry point to psychological health care and giving them a first sense of relief, even though they do not provide psychological follow-up care (Vandentorren et al., 2018). In order to ensure long-term high-quality trauma care to all survivors in need across the country, President Emmanuel Macron in November 2017 announced the creation of about 10 ambulatory services specialized in trauma care. These services are aimed at providing medical and psychological care to survivors (minors or adults) that have experienced violence or any traumatic event during their lifetime.

The traditional psychodynamic approach is gradually but slowly replaced by structured trauma-focused psychotherapies, such as CBT or EMDR, and also new technologies (e-PTSD) are being introduced (Bourla, Mouchabac, El Hage, & Ferreri, 2018). However, the provision and access to treatment remain limited by the fact that there is a limited number of experienced trained trauma therapists and that care centres are not always clearly identified or equitably distributed across the country.

The challenges in caring for survivors are to achieve universal access to prevention, improve access to trauma-focused psychotherapies and ensure coordination of specialized care and support. One major challenge is to expand public funding of structured psychotherapies by trained psychologists. It is advisable to ease access to structured trauma-focused

therapies as part of mental health care programmes in compliance with international guidelines. In the end, patients should benefit from personalized treatment strategies for their trauma-related disorders, based on objective information.

The future ambulatory care services specialized in trauma will have to structure the organization of care, to establish a single French umbrella society (involving the national trauma centre and psychotrauma societies such as AFORCUMP-SFP, ALFEST and ABC des Psychotraumas), to be involved in qualifying training curricula, and to set up a French certification committee connected to the ESTSS accreditation committee, in order to meet modern European and international standards.

5. Psychotraumatology in Georgia

Georgia is a post-Soviet country, with a population of approximately 3.3 million. Since becoming independent in the early 1990s, it went through a prolonged series of civil war and ethnic-political conflicts followed by a war with Russia in 2008 and loss of control over more than 20% of the country's territory. Ongoing social, political and economic crises create pressure on the population, 20.6% of whom live under the poverty level and 7.3% of whom are internally displaced. Among the conflict-affected population, 23.3% suffer from PTSD symptoms, 14.0% from depression, 10.4% from anxiety and 12.4% have more than one mental health condition (Makhashvili et al., 2014). In addition, the population still suffers from the inter-generational effects of trauma related to the Soviet invasion and totalitarian past (Javakhishvili, 2014, 2018).

The large proportion of conflict-affected population led to the build-up of trauma care capacities and corresponding institutional developments, i.e. trauma-focused torture victim rehabilitation centres (GCRT), functional since 2000, with the head office in the capital city Tbilisi and branches in eastern and western Georgia. The multidisciplinary teams provide free of charge care for their clients that include forced migrants, ex-prisoners and others. There are a number of non-governmental organizations providing trauma-informed psychosocial services to socially disadvantaged groups, including forced migrants, domestic violence survivors and other target groups.

The Georgian Society of Psychotrauma (GSP) was founded in 2007 with the support of ESTSS. GSP builds capacity within the local professional community and has introduced such evidence-based treatment methods as Trauma-Focused CBT, Brief Eclectic Psychotherapy for PTSD (BEPP) and EMDR, as well as other relevant psychosocial interventions. Since 2008, GSP regularly conducts an annual international multidisciplinary conference 'Trauma and Society'. To assure capacity building and good quality care, an innovative Master Program in Mental Health was founded in 2012 at Ilia State University in Tbilisi, under the lead and with a main perspective on psychotraumatology.

The mental health treatment gap is about 90% in the country. There is a predominant focus on hospital care; community-based services are under-developed. Common mental disorders are under-recognized and under-treated by the state services. There is a need to develop a trauma-informed primary health care system, enlarge the trauma care infrastructure and establish corresponding referral pathways. Another challenge is low awareness of one's own mental health condition. According to a recent study, of those who suffered from mental health symptoms, only 24.8% sought care, 19.6% acknowledge mental health problems but did not seek care, and 54% did not acknowledge mental health problems (Chikovani et al., 2015).

Since most trauma survivors belong to socially disadvantaged groups who are often exposed to multiple traumatization as well as a series of everyday life stressors, we rarely find among these patients simple PTSD. The most widespread trauma-related condition are complex posttraumatic disorders. Therefore, the most urgent need is to evaluate effective methods of addressing complex trauma conditions. From 2016 to 2018, within the framework of an Erasmus Plus cooperation, the Trauma-Focused Cognitive-Behavioural Therapy Train of Trainers (ToT) module was developed, piloted and adapted to the Georgian cultural context in cooperation with Cardiff University. It has proved its effectiveness in the treatment of not only simple but also complex trauma-related disorders. There is a need to collect strong evidence to further prove the effectiveness of these approaches.

6. Psychotraumatology in the German-speaking countries

As in many European countries, the largest historical burden of trauma in Austria, Germany and Switzerland comes from the two twentieth century World Wars and the Holocaust. Over the decades, the different roles of the three countries in these catastrophic events had an influence on the perception of their traumatic impact. In contrast to Switzerland, discourses in Germany and Austria had been more focused on their role as perpetrators and their responsibility for these events. In general, Switzerland has been much less concerned by the two twentieth century World Wars than Germany and Austria. It took a longer time before the trans-generational consequences of war and displacement on parts of the German and Austrian population were also discussed (e.g. Glück, Tran, & Lueger-Schuster, 2012,

Kuwert, Brähler, Glaesmer, Freyberger, & Decker, 2009). Another population that requires expertise on psychotraumatology in the three countries is that of the refugees (e.g. Knaevelsrud et al., 2017; Spiller et al., 2017).

Services for trauma survivors are organized in a similar way in the three German-speaking countries. Non-governmental organizations play an important role in the psychosocial response to disaster and other mass incidents. Some of them also provide care for survivors of individual trauma in the form of local 'crisis intervention units' that closely collaborate with other emergency services. Specialized counselling agencies, usually funded by the local municipal authorities, offer low-threshold services for survivors of childhood abuse, sexual assault and domestic violence. In all three countries, there are also growing networks of clinical outpatient services for survivors of interpersonal violence that are frequently located at psychiatric hospitals. Psychotherapists in private practice play an important role for the treatment of posttraumatic disorders in both children and adults. Moreover, in each of the three German-speaking countries, a larger number of hospitals offer specialized inpatient care for patients with posttraumatic disorders.

The German-speaking Society for Psychotraumatology (DeGPT), the common trauma society of the three German-speaking countries (Germany, Austria and Switzerland), has developed curricula for the training of professionals in different settings (e.g. staff in counselling services, psychotherapists for children and adults) in trauma-related practices. The curricula for psychotherapists have been recognized by important national bodies, like the national chambers of physicians and psychotherapists in Germany. At present, about 50 training institutes in Germany, Austria and Switzerland offer the curricula. The society also coordinates the national German guideline for the treatment of PTSD. Such activities have contributed to the dissemination of evidence-based practices in different settings. However, as in other European countries (Kazlauskas et al., 2016), many psychotherapists still do not feel competent to deal with traumatized populations. As a result, patients can face substantial problems to find adequate help, for instance in the form of trauma-focussed interventions for individuals with PTSD.

The prevention of trauma in different settings remains a challenge. Recently, initiatives in all three German-speaking countries addressed the problem of institutional violence, e.g. in foster care settings, but more efforts are needed to sustainably implement preventive efforts and bodies like the independent commissioner into childhood sexual abuse in Germany (Bergmann, 2011). The dissemination of trauma-informed practices in all parts of the health care system and the social sector is another urgent issue. Finally, the provision of adequate care for the considerable number of migrants from contexts of war and persecution in the German-speaking countries is a challenge for the years to come.

7. Psychotraumatology in Italy

Trauma permeates the history of Italy: war, terrorism, major mass disasters, abuse and maltreatment deeply affected the Italian society across time and generations. During the Second World War, many Italians experienced the effects of torture and deportation leaving a scattered society (Favaro, Rodella, Colombo, & Santonastaso, 1999). In the 1970s, the Italian society faced the 'dark period' of *Brigate Rosse*, a terroristic group who caused many deaths and created a deep sense of fear in the population. Domestic violence is the most common crime against children; indeed, child abuse and maltreatment is a major public health problem. A recent report (Autorità Garante per l'Infanzia, CISMAI and Terre des Hommes, 2016) revealed that each year 950 children are exposed to sexual abuse. In the past year, the percentage of maltreatment and abuse increased by 6%. Italy has also experienced a significant number of natural disasters, like floods and earthquakes, that potentially increased the prevalence of post-traumatic syndromes in the communities. There are no robust data about the actual burden of such traumatic experiences and their effects on the society today.

Italian health and social care systems have not yet fully embraced a trauma-informed approach. This led to fragmented responses to the needs of survivors, especially in terms of preventive initiatives. There is some resistance to implement routine screening and assessment tools for the early detection and prevention of post-traumatic syndromes. For this reason, the system responds late and mainly to traumatization that became complex as a result of missed accurate diagnoses. It is a challenge to acquire a systemic vision of care for traumatized populations, with shared policies and protocols.

Exposure-based therapies are rarely used; EMDR is the only widely implemented intervention in the social care system at all levels. Other trauma-focused therapies (Ehring et al., 2014) – such as trauma-focused CBT or Narrative Exposure Therapy (NET; Schauer, Neuner, & Elbert, 2011) – struggle to be disseminated. Clinicians are asked to integrate different treatment approaches with a good understanding of assessment and psychoeducation techniques. Training of health and social care professionals is a key issue. In Italy, trauma is still seen as a 'psychologist/psychotherapist business', undermining the importance of multidisciplinarity. Furthermore, a synergy between clinical work and research should be

promoted to investigate the outcomes of treatment and to adapt service models accordingly.

There are a few important strategic points the Italian Society of Traumatic Stress Studies (SISST) should consider for the future. Highly traumatized migrants and refugees are one of the priorities requiring a long-term preventive plan to fight longer-term consequences for the society. The second point is the promotion of a more articulated reasoning about the implementation of evidence-based therapies. Furthermore, epidemiological studies are warranted to determine the actual prevalence and incidence of traumatic events in Italian society. Finally, another crucial issue is a comprehensive training in psychotraumatology. The new ESTSS certification represents a good opportunity for trauma-informed capacity building initiatives in the near future.

8. Psychotraumatology in Lithuania

The burden of trauma in Lithuania was largely influenced by the political situation in Europe in the twentieth century. Large-scale traumas associated with the two World Wars, the Holocaust and the prolonged Soviet occupation had a significant impact on the Lithuanian population, marked with suffering and oppression for several generations. Interest in trauma and trauma research in Lithuania was started soon after the collapse of the Soviet Union in the 1990s and several studies explored posttraumatic effects of political violence in the country (Kazlauskas & Zelviene, 2016).

Survivors of traumatic events can seek treatment for mental disorders in the public mental health care system, which includes about 100 primary mental health centres spread across the country, and in more severe cases in psychiatric hospitals. Several non-governmental organizations and crisis centres in the biggest cities in Lithuania are providing help for survivors of interpersonal violence, including psychosocial support and psychotherapy. Additionally, psychotherapists in private practice are also available for trauma survivors. Despite these positive developments, care organizations for trauma survivors are not developed in Lithuania and evidence-based trauma-focused treatments for trauma survivors are not available in the public mental health care system.

Mental health professionals are increasingly aware of the negative effects of trauma on individuals and are interested in learning new ways to help trauma survivors. There is significant progress regarding the implementation of evidence-based trauma-focused treatments, such as EMDR and BEPP, in Lithuania recently. The numbers of therapists trained in trauma-focused treatments are growing, but these treatments are not offered in the public health care system and are available predominantly in private practice which is expensive and not covered by national health care insurance.

Despite the high prevalence of traumatic experiences in Lithuania (Kazlauskas & Zelviene, 2016), it was reported that PTSD is not identified in the Lithuanian national health care system (Kazlauskas, Zelviene, & Eimontas, 2017). The lack of acknowledgment of trauma and PTSD in Lithuania is a major barrier for the development of treatments for trauma survivors in the country.

Future directions of the trauma field in Lithuania include ensuring access to evidence-based treatments for trauma survivors. There is a need of trainings for practitioners to update their knowledge about the impact of trauma, with a particular focus on how to diagnose stress-related disorders and how to provide trauma-focused treatments. Finally, health care and social policy changes on the national level are needed to acknowledge trauma survivors and include evidence-based treatments in the health care of survivors exposed to various traumas, particularly children and adolescents. The Lithuanian trauma society is taking an active role in raising awareness about the effects of trauma to facilitate the further development of care for trauma survivors.

9. Psychotraumatology in the Netherlands

The Second World War marks the largest historical burden and the starting point for psychotrauma care in the Netherlands. Occupation by German and Japanese (in the former Dutch East Indies) armed forces and subsequent post-colonial wars led to over 250,000 military and civilian lives lost. Public awareness for the psychological effects of wartime and other traumatic experiences started around 1975, with the awareness of the Holocaust. In response, Foundation Center ’45 was funded, first focusing on Second World War concentration camp survivors, but soon extending their services to other traumatized populations. The focus on post-war reconstruction, tensions between interest groups and an emphasis on heroics and the resistance, together with a poorly developed mental health care, contributed to this late societal response (Vermetten & Olff, 2013). Subsequent national and international disasters, such as the 1992 Bijlmermeer airplane disaster and the 2000 Enschede fire explosion, further increased professional and public awareness of psychotrauma, and fuelled the establishment of the Dutch Society of Psychotraumatology in 2006.

Mental health care for trauma-related disorders is covered by health insurance at little or no additional personal costs. Facilities for trauma care have been integrated at many levels of health care. Routinely, the first step for individuals with trauma-related symptoms is to consult their general practitioner for referral to secondary health care organizations.

A national standard of care for trauma- and stressor-related disorders is currently underway (Kwaliteitsontwikkeling GGZ, 2018).

Trauma-focused treatment is increasingly offered next to interventions directed at emotion regulation, day-night structure and social support (Vermetten & Olff, 2013). Examples are EMDR, CBT, NET, BEPP and Imagery Rescripting. There is a growing role for E-health interventions (e.g. Olff, 2015). Some institutions use treatment intensification (EMDR or CBT), with preliminary positive effects (Van Woudenberg et al., 2018; Zepeda Méndez, Nijdam, Ter Heide, van der Aa, & Olff, 2018). Although not yet implemented, other treatment innovations include hormonal enhancers (D-cycloserin, cortisol, oxytocin; e.g. Thomaes et al., 2016).

Effective treatment for PTSD due to events in adulthood in fairly well functioning patients seems available, as well as special services and care for the military and the police. One of the greatest practical challenges are the long waiting lists in secondary mental health care, limiting accessibility to care for vulnerable patient groups, such as individuals with multiple (childhood) traumatization, patients with severe physical, neurocognitive and/or psychiatric comorbidities or severe psychosocial problems, and (asylum seeking) refugees. The latter in particular experience difficulties accessing evidence-based care due to stigma, requirement of referral by general practitioners, and language and cultural barriers. Moreover, research on the (cost-)effectiveness of treatments for these target groups is relatively lacking (e.g. Sijbrandij et al., 2017), as well as on improving symptom recovery and treatment adherence of current PTSD treatments.

Topics which should be urgently addressed in the future include improving treatment outcome for specific target groups, i.e. patients with childhood trauma; implementing treatment for target groups that are currently excluded from regular PTSD treatments; family- or system-oriented interventions to prevent inter-generational consequences of trauma and enhance opportunities for social support; evaluation of e-mental health interventions for PTSD and comorbid disorders, including blended treatment options administered within routine clinical practice; increased use of transdiagnostic treatment options for trauma-exposed patients targeting a variety of psychopathology limiting psychosocial functioning; and the use of low-intensity interventions, carried out by non-professional helpers to increase coverage of mental health interventions.

10. Psychotraumatology in Poland

The recognition of the socio-psychological consequences of the Second World War in Poland is an extremely important issue. Poland belongs to the part of Europe which Snyder (2010) called the 'Bloodlands'. The number of ethnic Poles and Polish Jews who died or were murdered in connection to the Second World War amounted to about six million. Poland lost about 17% of its pre-war population (Materski & Szarota, 2009). Moreover, the Soviet invasion and the subsequent imposition of a communist regime led to large groups of people being persecuted. Many survivors of the war (e.g. resistance movement members, people deported to Siberia) were not even recognized as survivors, and speaking about many aspects of war experiences could lead to prosecution. Very little attention has been paid to Second World War issues in medicine and psychology, in comparison to the volume of analogous research in western countries (Lis-Turlejska, Szumiał, & Drapała, 2018). Psychological help for survivors of the war was practically absent, and the need is still not recognized today. Since the collapse of communism, neither war nor other traumas have been recognized on a broader scale. Research has been conducted on the consequences of the great flood of 1997 (Strelau & Zawadzki, 2005), however, other traumatic events, including the death of the president and other governmental officials in the Smolensk plane crash in 2010, have not yet been the subject of psychological research.

There is no coherent care system in Poland for survivors of various traumatic events. A number of crisis intervention centres provide help for 'families in crisis' – mainly for survivors of domestic violence (www.spoleczenstwoobywatelskie.gov.pl). There are non-governmental organizations working with survivors of trauma (e.g. battered women, abused children, survivors of crime). However, they are all underfunded and their capacity is limited. Access to psychotherapy under national health insurance is also limited. Despite the fact that there are many psychotherapists working privately, mainly in larger cities, there are still very few professionals who are specialized in psychotraumatology.

Crisis intervention is probably the most widely offered help to trauma survivors. Practitioners have the opportunity to be trained in different approaches in psychotherapy, including CBT, prolonged exposure therapy and EMDR. However, there is no clear emphasis on evidence-based treatments and they are not widely used in practice. There is also a lack of research on the effectiveness of trauma therapy. The issue of prevention is neglected in general, except training for professional groups (e.g. flight crews, emergency services).

Currently, the most important challenge is to increase access to professional care, specifically increasing access to therapists who offer evidence-based interventions. However, education of the general population about the importance of help seeking and potential benefits out of it is also crucial. It is necessary to further develop research on the

psychosocial consequences of both the Second World War and other large-scale traumatic events. It is also important to encourage the teaching of contemporary curricula on abnormal psychology, including content specific to trauma. This seems to be the most urgent task, alongside further development of the trauma care system and promotion of good practices in psychological care and psychotherapies for trauma survivors.

11. Psychotraumatology in Portugal

A colonial war of 13 years has left to Portugal an individual and collective traumatic heritage (Maia, McIntyre, Pereira, & Ribeiro, 2011). The consequences remain to this day through the intergenerational transmission of trauma (Dias, Sales, Cardoso, & Kleber, 2014). Throughout the years, clinicians, academics and other professionals discussed the psychosocial consequences and reactions to this trauma. Later, the coordinated response to two major accidents promoted a national approach to survivors of crisis and disaster. In 2009, the Centre for Social Studies of the University of Coimbra created the Centre of Trauma (CT), a society that brings together the country's leading organizations who directly deal with potentially traumatic events. Since 2010, CT is a full member of ESTSS.

In Portugal, the National Authority for Civil Protection provides central technical guidance to the organizations who deliver services to survivors of disasters or catastrophes. It is a governmental entity which coordinates the interventions developed and implemented by the different professional groups and organizations (fire fighters, medical emergency services, etc.). Clinical care to trauma survivals is provided by the National Health Service in the first place, but in cooperation with organizations (both non-governmental and governmental) who are specialized in trauma therapies and relevant psychosocial interventions. There is a core team of trained and certificated psychotherapists within CT whose service is accessible to people in need.

The most widespread therapy methods in Portugal are CBT, EMDR, Psychodrama and brief supportive psychotherapeutic strategies. Psychopharmacotherapy is also frequently used alone or in combination with psychological interventions. Treatment takes place in public and private health institutions. A number of governmental and non-governmental organizations currently invests in building the capacity of their staff in trauma care and designing and implementation of preventive interventions. CT is responsible for regular organization of conferences, seminars and the delivery of a biannual psychotrauma course. The course equips professionals from different fields with relevant knowledge and skills.

Professional and organizational preparation and knowledge to treat trauma consequences at the individual, family and social level needs to be optimized and updated. Minorities and refugees at risk may benefit from more integrated assistance. The ability to effectively respond to disasters and catastrophes through the provision of acute trauma care and coordination among the different organizations that are involved in disaster management has to be improved. There is room for improvement regarding the identification of populations at risk, screening for trauma related disorders and responding to the needs of the health care system. Family doctors and nurses, firemen and other professional groups have to be trained to assure their trauma-informed professional performance.

The topics to be addressed in the near future include creating a national plan for PTSD prevention and psychosocial interventions in case of crisis and disaster, as well as founding a network for specific treatment responses to trauma-related disorders, namely PTSD. Good practices have to be disseminated and young researchers and clinicians need to be motivated to work in the field of psychotraumatology. Finally, more effective and organized strategies to address potentially traumatic contexts such as unemployment, marital violence, cyber bulling and road accidents need to be developed, and the cooperative and coordinated work with national and European entities needs to be further increased.

12. Psychotraumatology in Sweden

The Swedish population has enjoyed peace for over 200 years. For a long time, the country did not experience the same increase in attention to psychotraumatology as other European countries with afflicted veteran soldiers from the nineteenth century wars. The impetus for trauma-informed services has instead come from disasters, large accidents and the increased attention to interpersonal abuse. A harrowing bus crash involving 12-year-olds on a school trip in 1988 (Arnberg et al., 2011) became the initiating event for the public organization of crisis support after large-scale events. Events such as the 1994 Estonia ferry disaster in the Baltic sea (e.g. Arnberg, Hultman, Michel, & Lundin, 2013) and the 2004 Southeast Asia tsunami (e.g. Michélsen, Therup-Svedenlöf, Backheden, & Schulman, 2017), both leading to hundreds of Swedish casualties, as well as the recent deployment of Swedish peacekeeping forces around the world, have highlighted the psychosocial consequences of trauma. More recently, the refugee crisis has set off many activities related to culturally informed trauma services.

In Sweden, every municipality has a psychosocial crisis team and there are psychosocial disaster contingency teams at the larger hospitals. A major step forward was the legislation passed in 2000 that

mandates employers to ensure that they have adequate knowledge of and plans for crisis support for their employees. Beyond the acute crisis support, however, access to qualified treatment of chronic traumatization varies across the country. In some regions there are dedicated trauma clinics; in others, there are trauma teams within the psychiatric services. Some regions lack both dedicated trauma clinics and teams.

The acute crisis interventions that are available in Sweden include Psychological First Aid, various forms of unstructured crisis support and a variety of debriefing methods including psychological debriefing (Witteveen et al., 2012). As for the treatment of PTSD, the Swedish National Board of Health and Welfare issues guidelines for public health care. In their latest guidelines from 2017 (The Swedish National Board of Health and Welfare, 2017), trauma-focused psychological treatments were given the highest priority; selective serotonin reuptake inhibitors (SSRIs) were prioritized as a potential but not necessary option for adults with PTSD, although they probably are the most widely used treatment in the country.

Several challenges lie ahead. The use of ineffective preventative interventions remains and the provision of psychosocial support beyond the acute phase is very limited, partly due to compartmentalized organizations. Further development of acute interventions in health care would benefit from robust evidence for early interventions. Trauma-related problems in patients too often go undetected in health care assessments (Al-Saffar, Borgå, & Hällström, 2002). In addition, access to prioritized treatments is underdeveloped in many parts of Sweden: the concentration of relevant competence in metropolitan areas is a salient issue in this country due to its large rural areas.

Another challenge related to the treatment of PTSD is that a large proportion of therapists are due for retirement in the next five years. It will become important for the field to continue to attract younger professionals. It is hoped that a stronger professional community, aided by the Swedish Society for Psychotrauma, can prevent fragmentation of the many regional initiatives, particularly in light of the many refugees across the country, and serve as a force for increasing the quality of and access to trauma treatments.

13. Psychotraumatology in Ukraine

The historical burden of trauma in Ukraine mainly consists of man-made catastrophes. They include the famines in the years 1933 and 1947, the Second World War, the explosion of the Chernobyl nuclear power station, and the current military conflict with Russia, which is officially called 'Anti Terrorist Operation (ATO)'. All events that happened during the Soviet times were hushed up and psychological support has never been provided to the people in need. It was not until the Maidan revolution and the beginning of the current war that psychological services in Ukraine were organized for victims of mass violence.

In Ukraine, care organizations for trauma survivors are currently under development. It presupposes an effective coordination of governmental and non-governmental organizations and professional institutions. The non-governmental organization Ukrainian Society for Overcoming the Consequences of Traumatic Events (USOCTE) was created to reach that aim. This professional organization aims at the development of crisis intervention services as well as capacity for provision of trauma-focused psychological therapies in Ukraine, in accordance with the international standards. Currently, USOCTE provides psychological help to wounded ATO soldiers and veterans, as well as other people who suffer from consequences of the ATO: those living in the ATO zone, internally displaced persons, families of killed soldiers and participants of the Maidan revolution. USOCTE is also engaged in developing training programmes for psychologists and psychoeducational materials for the general population. The methods used in trauma care are EMDR, CBT and the SEE FAR CBT treatment protocol of the Israeli coalition of trauma.

These treatments are offered in a strictly structured way. All clients sign an agreement, which determines the focus of the therapy. According to that agreement, a client has a right to attend 12 free-of-charge sessions. The first sessions are devoted to a detailed diagnostic interview, psycho-education on the signs and nature of posttraumatic disorders and providing information on therapeutic approaches. The following stabilization phase is intended to create a sense of safety by means of different techniques. It is followed by the trauma-focused interventions mentioned above. The final phase of treatment has the aim to integrate the experiences into daily life, assess the results and adapt to the achieved changes.

Challenges in this work are the very high level of psychological disturbance among the people living close to the conflict zone, and their reluctance to acknowledge this and to ask for psychological support (Roberts et al., 2017). It should also be mentioned that women are especially vulnerable on the front-line territory, and suffer multiple problems including high levels of psychological violence. These problems are often not recognized and the population has a tendency to believe that the end of military activities will solve all problems.

To overcome the consequences of the current military conflict in Ukraine, USOCTE is confronted with a number of tasks. They include building up a multilevel system of psychological assistance with the support of governmental and non-governmental organizations as well as monitoring and evaluating the activities of specialists in the psychological field on a regular basis. Moreover, the local communities need to be involved in supporting the aggrieved. Finally, there is a need for a more intensive cooperation and sharing of experiences with international organizations.

14. Psychotraumatology in the UK and Northern Ireland

The 2014 Adult Psychiatric Morbidity Study (APMS) provides the most comprehensive estimates of PTSD within the UK, although the sample is of English residents only (Fear, Bridges, Hatch, Hawkins, & Wessely, 2014). APMS found a PTSD prevalence of 4.4%, with similar rates observed between men and women. PTSD rates in women declined with increasing age; 12.5% of 16–24-year-old women had PTSD. In contrast, in men PTSD remained roughly consistent until declining from age 65. Northern Ireland (NI) has historically experienced a sustained period of political conflict known as the Troubles. The NI Study of Health and Stress identified that NI has one of the highest global rates of PTSD with lifetime and 12 month prevalence rates of 8.8 and 5.1%, respectively (Bunting et al. 2013). Lifetime prevalence in NI females (11%) was substantially higher than the rates in NI men (6.4%). Although there is no specific information on prevalence rates in Scotland and Wales, it is anticipated they are similar to English rates.

The UK's mental health services are provided by the National Health Service (NHS). Although regional variations exist, the first point of access is via family doctors. Community services, often available via self-referral, typically treat survivors of single incident traumas where a diagnosis of PTSD is present without co-morbid problems (e.g. substance misuse). Treatment of more complex cases (e.g. survivors of child abuse, refugees, etc.) is via specialist mental health teams. NHS treatment complies with best practice guidelines compiled by the National Institute for Health Care and Excellence. A range of other non-governmental organizations exist that are staffed by qualified health professionals and offer support to sub-populations of trauma survivors (e.g. survivors of domestic abuse, veterans, etc.). In NI, a Regional Trauma Service is under development to address the mental health legacy of the Troubles.

Interventions to treat PTSD in the UK are typically trauma-focused psychological therapies such as, but not limited to, trauma-focused CBT, EMDR and prolonged exposure (NICE, 2005). In addition, psychopharmacology support is given to manage co-morbid mental health presentations. Increasingly, e-technologies are being developed to help provide cost-effect support that also promote accessibility. For example, an online guided self-help tool for PTSD has been developed and internet-based video technologies have been successfully used to deliver PTSD treatments with much reduced therapist time required. Some providers also utilize compressed therapy where 16–-20 hours of TF-CBT are delivered over a week.

Currently, whilst there is often some delay in accessing specialist mental health assessment services, the biggest bottleneck is in the provision of specialist services for more complex cases of PTSD. Also, whilst APMS has shown that help-seeking for PTSD is improving, the majority of people with PTSD in the UK still do not seek any help.

Whilst, the UK has made considerable efforts to improve the public understanding of mental health, more needs to be done. Additionally, organizations which routinely expose staff to trauma (such as the emergency services, military and child social workers) need to address the issue of PTSD as a result of chronic trauma exposure as there has been limited work done on this topic.

15. Conclusion

The perspectives above show that important steps towards a better provision of care for survivors of trauma have been taken in the European countries. Given the cultural and economic diversity of the continent, there are still some differences between the countries, for instance with regard to the use of evidence-based treatments. Effective treatments have many elements in common (Schnyder et al., 2015) and the treatment of choice is often based on culture and history. The dissemination of evidence-based knowledge and skills has always been a priority of ESTSS (Ajdukovic, 2013, Bisson, 2013, Olff, 2013) and further strategic steps towards this aim have been made recently. In 2018, the first of a series of new ESTSS curricula, the 'Advanced Training in Treating Posttraumatic Disorders in Adults', was approved by the board. The curriculum comprises 120 hours of training and 20 hours of case supervision. It has a strong focus on evidence-based approaches and provides knowledge and skills for the treatment of acute stress disorder, non-complex PTSD and complex posttraumatic disorders (for more detail see www.estss.org). The curriculum has already been adopted by several member societies who are building up local structures to offer the trainings or adopt their national curricula to meet the requirements of the ESTSS curriculum. Other

curricula, for instance for the treatment of trauma-related disorders in children and adolescents, and more basic curricula to promote the idea of trauma-informed care among different groups of professionals, are currently being developed.

The country reports presented in this paper show that many countries share similar challenges and have topics in common that need to be addressed. These topics include, among others, the prevention of trauma, the promotion of trauma-informed practices in the whole health care system and standards of care for groups with special needs, including refugees and internally displaced people. Of increasing importance in the field of mental health is the involvement of trauma survivors in mental health care teams (Van der Schrieck-De Loos, 2013). It was beyond the scope of this paper to describe the large amount of research in the field of psychotraumatology in the European countries, which represents a significant proportion of the global research activities in this field (Olff, 2018). However, similar to the differences with regard to the use of evidence-based treatments, these activities are not evenly distributed between the different European countries. It is part of ESTSS's mission to stimulate and promote research Europe wide.

The current structure of ESTSS allows for a more direct exchange between the member societies and thereby provides the opportunity to effectively address such common issues. It has always been the aim of the society to provide a platform for all professionals in Europe in the field of psychotraumatology to connect, to develop together training and research, guidelines and actions where needed. ESTSS is constantly working towards this aim, for instance by identifying successful models in individual countries or regions and disseminating these experiences among all others. A recent example of this exchange is a series of movies providing information on the consequences of trauma and effective treatments tailored to the needs of the public, professionals from the health care system and trauma survivors that can be downloaded from the ESTSS website. They were developed by a national society (DeGPT) and translated into 10 European languages with the help of other member societies.

ESTSS can look back on 25 years of advocacy for the field of psychotraumatology in Europe. The first European Conference on Traumatic Stress, which can be considered one of the roots of ESTSS, was held three decades ago (Ørner, 2013). During these years, ESTSS has developed a unique profile as a truly international professional society that integrates the diversity of the European countries and greatly benefits from their cultural richness (Lueger-Schuster, 2013a; Olff, 2013). An important part of the society's success story are the ESTSS conferences that attract delegates from all parts of the world. Other important activities included projects like the European Network of Traumatic Stress (TENTS; Bisson, 2013) and the *European Journal of Psychotraumatology* (EJPT). EJPT has become an important platform for the dissemination of knowledge related to psychological trauma and, thanks to the relentless efforts of its founding editor Miranda Olff, has become one of the journals with the highest impact in the field (Olff, 2018).

Over the years, ESTSS had fruitful collaborations with large societies from other regions of the world. There is also a strong involvement of ESTSS in the global collaboration of trauma societies, an initiative that had initially been proposed by the International Society for Traumatic Stress Studies (ISTSS; Schnyder et al., 2017) and developed to a collaboration of all large trauma societies on an equal basis. It already has the function of a global umbrella for defined projects and holds promise to become a more formal global structure.

Only about half of the more than 40 countries on the European continent have established local trauma societies so far, most of which are members of ESTSS. In the coming decades, it will remain one of the most important aims of ESTSS to support the formation of new societies in countries where they do not exist yet, and to provide a common platform and a professional home for trauma specialists from the whole European region.

In their articles at the occasion of the twentieth anniversary of ESTSS, several former presidents described what some of them called the 'infancy and adolescence' of the society (Schnyder, 2013, Turner, 2013). At the age of 25 years, ESTSS has become a young adult. The society has 'grown up' and, with the latest change of its structure, has completed a developmental process that made it stronger and prepared it for the tasks ahead. This would not have been possible without the enthusiasm of a large number of dedicated colleagues from all over Europe. They invested their time and energy over the last 25 years to make the society what it is today. We congratulate ESTSS on its 25th birthday and strongly believe that it will successfully continue its 'adult life' for the good of psychotraumatology in Europe.

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ORCID

Evaldas Kazlauskas http://orcid.org/0000-0002-6654-6220
Marit Sijbrandij http://orcid.org/0000-0001-5430-9810
Małgorzata Dragan http://orcid.org/0000-0001-8221-2012
Margarida Figueiredo-Braga http://orcid.org/0000-0003-2374-4371
Filip Arnberg http://orcid.org/0000-0002-1317-2093
Cherie Armour http://orcid.org/0000-0001-7649-3874
Dominic Murphy http://orcid.org/0000-0002-9596-6603

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Violence Prevention
A Public Health Issue
Child Abuse & Neglect
Fast Facts
Risk and Protective Factors
Prevention Strategies
Adverse Childhood Experiences
Fast Facts
CDC-Kaiser ACE Study
BRFSS ACE Data
Resources
Journal Articles
Presentation Graphics
Essentials for Childhood
Violence against Children Surveys
Preventing Abusive Head Trauma
Preventing Child Sexual Abuse
Resources
Elder Abuse
Intimate Partner Violence
Sexual Violence
Suicide
Youth Violence
Data Sources
Communication Resources

About the CDC-Kaiser ACE Study

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being.

The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors.

More detailed information about the study can be found in the links below or in the article, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults ,".

Open All Close All

The ACE Pyramid +

Study Questionnaires +

Data and Statistics +

Major Findings +

Page last reviewed: April 2, 2019
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Related Links

Data & Statistics (WISQARS)

Home & Recreational Safety

Opioid Overdose Prevention

Traumatic Brain Injury

Motor Vehicle Safety

Press Room

SCHOOLS

TRAUMA-INFORMED SYSTEMS

Child Welfare

Schools

Essential Elements

NCTSN Resources

Justice

Healthcare

CULTURE AND TRAUMA

FAMILIES AND TRAUMA

FAMILY-YOUTH-PROVIDER-PARTNERSHIPS

SECONDARY TRAUMATIC STRESS

Children's reactions to trauma can interfere considerably with learning and behavior at school. Schools serve as a critical system of support for children who have experienced trauma. Administrators, teachers, and staff can help reduce the effects of trauma on children by recognizing trauma responses, accommodating and responding to traumatized students within the classroom, and referring children to outside professionals when necessary. The National Child Traumatic Stress Network has developed tools and materials to help educators, school staff, and administrators understand and respond to the specific needs of traumatized children.

Essential Elements

The primary mission of schools is to support students in educational achievement. To reach this goal, children must feel safe, supported, and ready to learn.

view

NCTSN Resources

The following resources on Schools were developed by the NCTSN.

view

The NCTSN is funded by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services and jointly coordinated by UCLA and Duke University.

carepath

Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material MODULES – Italian Version

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

CarePath: Trauma-informed leaving care support empowering public authorities and professionals

CarePath - CP01-ITx
Started - 16 gen 2020

Resume Course

CarePath: CP01-ITx
CarePath: Trauma-informed leaving care support empowering public authorities and professionals

- Introduzione
  - Questionario pre-corso
    - Questionario pre-corso
- Modulo 1
  - Introduzione
    - Introduzione
  - Le basi teoriche
    - Che cosa è una relazione di aiuto
    - Esercizi 1.1
    - Il differenziale di potere
    - Esercizi 1.2
    - Il coping

Esercizi 1.3

I denominatori comuni dell'efficacia

Medicina centrata sulla persona-Promozione del cambiamento centrata sulla persona

Esercizi 2.1

Mettere la persona al centro

La recovery

L'efficacia professionale nelle relazioni di aiuto

Esercizi 2.2

I traumi

Definizione di Trauma

Trauma Tipo 1

Trauma Tipo 2

Trauma complex

Rivittimizzazione nel trauma complex

Effetti iatrogeni: Re-traumatizzazione degli utenti

Adolescenza e trauma

Il trauma può cambiare il cervello

Violenza assistita

Neglect

Neglect nelle separazioni conflittuali

Trauma e disturbi alimentari

Pericolo Attaccamento e trauma psicologico

Mentalizzazzione e trauma psicologico

Materiale di approfondimento

1.I La cornice di riferimento

1.II Elementi di storia e Sociologia della Conoscenza

1.III Brevi cenni sulla sociologia delle cure mediche

2.I Promozione dei risultati

2.II Essere un professionista, operare sempre in scienza e coscienza

2.III La bussola del professionista

2. IV Progettazione e gestione dei setting di relazioni di aiuto efficaci e alleanze di lavoro efficaci

2.V La resilienza

2.VI L'alleanza di lavoro

2.VII Supervisione e supervisione tra pari

3.I Il trauma e il soggetto psicotico

3.II Il trauma negli stati limite

3.III La teoria polivagale

3.IV Oncologia e trauma

Modulo 2

La ritraumatizzazione: le cause, la prevenzione e i trattamenti

Effetti di ritraumatizzazione provocati dalle politiche sui migranti a livello Italiano e Internazionale

Intersectionality e trauma

Elaborazione del trauma con gruppi d'incontro centrati sulla persona

L'Ascolto empatico per facilitare l'elaborazione del trauma

Adozione e trauma

La ritramautizzazione

Come si esplicita il trauma nei bambini adottati e la video intervention therapy

Figli di detenuti e trauma

Traumatizzazione vicaria

Il disegno come elaborazione del trauma vicario dei piccoli abitanti di Lampedusa

Imparare dagli errori

Imparare dagli errori: le lezioni che si debbono trarre dalle "cattive pratiche"

Il trauma ha effetti significativi sulla salute fisica e mentale ed è una delle principali cause di morbilità e mortalità di generazione in generazione

Il trauma è pervasivo

Breve aggiornamento su Trauma: Lo studio ACE

L'approccio trauma informed

Principio trauma informed 1

Principio trauma informed 2

Principio trauma informed 3

Principio trauma informed 4

Principio trauma informed 5

Principio trauma informed 6

Scuola Trauma informed

Centrarsi sulle persone: accoglienza e empowerment

Centrarsi sul cliente

Accoglienza di utenti LGBT

La crescita personale ed esistenziale - growth after trauma

Strumenti e situazione europea

Art therapy - Il lavoro di Virginia Axline

Strumenti di valutazione del trauma

Panoramica europea nazione per nazione del trauma care

Conclusioni

Conclusioni

Bibliografia

Quiz 1&2

Quiz

Quiz 1

Materiale di approfondimento

1.I Danni psicologici e fisici dei traumi nelle donne sopravvissute alla tratta di esseri umani

1.II Il trauma dei bambini in adozione rifiutati

3.I Centrarsi sulle persone non sui traumi!

3.II Approcci scientificamente validati per minori affetti da trauma

3.III Task Force 29

4.I Pet therapy

4.II Il Kids Workshop

3. Trauma: Ricerca, valutazione e outcomes

La Ricerca
Prerequisite: Quiz 1&2
Quiz

EBR in TIC
Prerequisite: La Ricerca
Quiz

Il processo di valutazione dell'intervento
Prerequisite: EBR in TIC
Quiz

4. Trauma: Good practice and policies

4. Trauma: Good practice and policies

Introduzione
Prerequisite: Il processo di valutazione dell'intervento

Aspetti metodologici della ricerca in TIC
Prerequisite: Il processo di valutazione dell'intervento
Quiz

Buone Pratiche in TIC
Prerequisite: Aspetti metodologici della ricerca in TIC
Quiz

L'osservazione e gli indicatori di maltrattamento e abuso
Prerequisite: Buone Pratiche in TIC
Quiz

5. Modulo 5

Introduzione
Prerequisite: L'osservazione e gli indicatori di maltrattamento e abuso

Lezione 5.1
Prerequisite: L'osservazione e gli indicatori di maltrattamento e abuso
Quiz

Lezione 5.2

Prerequisite: Lezione 5.1

Quiz

6. Modulo 6

Lezione 6.1

Prerequisite: Lezione 5.2

Quiz

Lezione 6.2

Prerequisite: Lezione 6.1

Quiz

Riassunto e conclusioni

Prerequisite: Lezione 6.2

7. Final exams

Introduzione

Prerequisite: Lezione 6.2

Final Exams

Course evaluation

Course Evaluation

Domande per valutazione

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

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Questionario pre-corso

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CarePath MOOC

Benvenuto al CarePath Massive Open Online Course! Prima di andare avanti, fatti conoscere meglio!

*Campo obbligatorio

Genere *

- ◯ Maschio
- ◯ Femmina

Email (MOOC email) *

La tua risposta

Nazione *

La tua risposta

Livello di istruzione *

- ◯ Diploma di scuola superiore
- ◯ Laurea triennale
- ◯ Laurea Magistrale
- ◯ Altro:

Professione attuale o descrizione del proprio lavoro: *

- ◯ Educatore
- ◯ Assistente sociale
- ◯ Psicologo
- ◯ Operatore sanitario
- ◯ Studente
- ◯ Psichiatra
- ◯ Altro:

In quale contesto lavori? *

- ◯ Servizio sanitario pubblico
- ◯ Servizio sociale
- ◯ Volontariato
- ◯ Organizzazione non governativa-ONG
- ◯ Servizio per migranti e rifugiati
- ◯ Organizzazione senza scopo di lucro (Non-profit)
- ◯ Organizzazione a scopo di lucro
- ◯ Organizzazione che si occupa di persone immigrate e/o rifugiate
- ◯ Altro: _____

Ha mai avuto una formazione specifica sul trauma? * *

- ◯ Si
- ◯ No

Da quanti anni lavori con i minori che hanno avuto esperienze traumatiche? * *

- ◯ 1-2
- ◯ 3-5
- ◯ 6-9
- ◯ più di 10
- ◯ Non ho mai lavorato in questo campo

Invia

Non inviare mai le password tramite Moduli Google.

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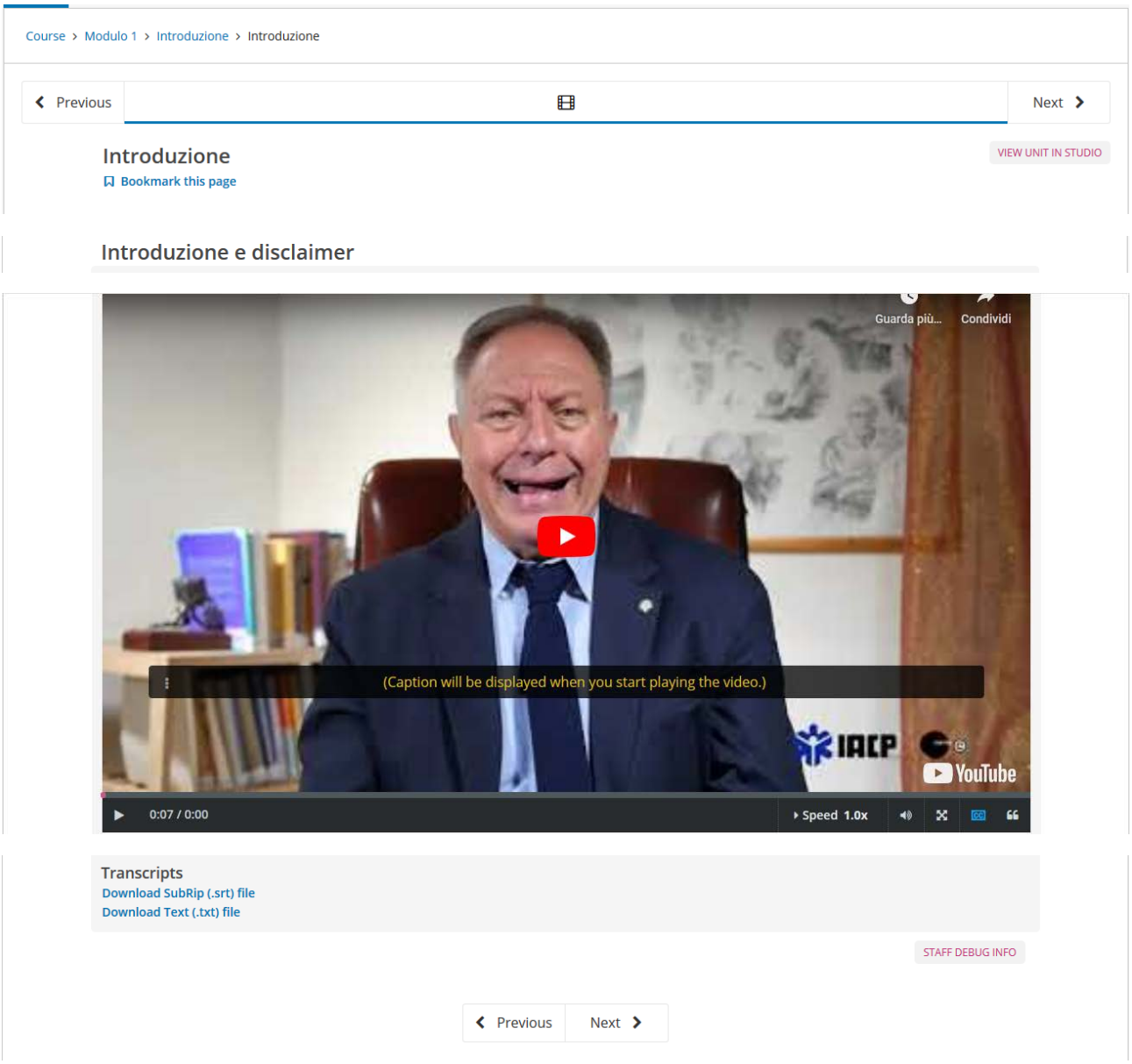


Transcript

Salve,

sono Alberto Zucconi,

psicologo psicoterapeuta

e presidente dell'Istituto Centrato sulla Persona

che ha curato

i primi due moduli di questo corso

al quale volevo darvi il benvenuto.

Prima di tutto vorrei dire due parole

come Alberto Zucconi,

cittadino,

e sono parole di gratitudine.

Un grazie sincero ad ognuno di voi che lavora a supporto e tutela

di minori

traumatizzati.

Il vostro è un lavoro importantissimo,

sensibile, delicato, ma alcune volte anche

molto pesante.

Sappiamo bene

che

lavorare con persone che soffrono

a volte fa anche

soffrire e può anche portarci al burn-out.

Quindi

un grazie sincero perchè il vostro

lavoro è a tutela

di

una realtà preziosa per una nazione e per una comunità: il capitale umano.

Le persone traumatizzate hanno tutto il bisogno di tutte le cure possibili

per essere aiutate a rientrare, a pieno titolo, ad essere

membri attivi della comunità

ed

essere costruttivi per sé stessi e gli altri membri della comunità.

Vorrei aggiungere un'altra cosa, forse ovvia, ma che è meglio sottolineare:

questo corso

è indirizzato a tutti voi che siete diversa provenienza, professionalità e competenze

e che - cosa risaputa -siete tenuti dalle leggi vigenti, dagli ordinamenti deontologici

delle varie professioni

e dalle regole interne delle varie organizzazioni di cui fate parte,

a fare tutto quello che sapete fare ed a cui siete è preposti a fare e di non valicare

i confini e i limiti, perché questo non sarebbe certo a favore dei vostri assistiti.

Aggiungo ancora un’altra cosa ovvia,

per complicare le cose le leggi non sono le stesse

in tutte le nazioni europee e questo è un corso

indirizzato a varie nazioni e in varie lingue,

quindi -

ovviamente - l'aspettativa è quella di erogare un corso a persone consapevoli

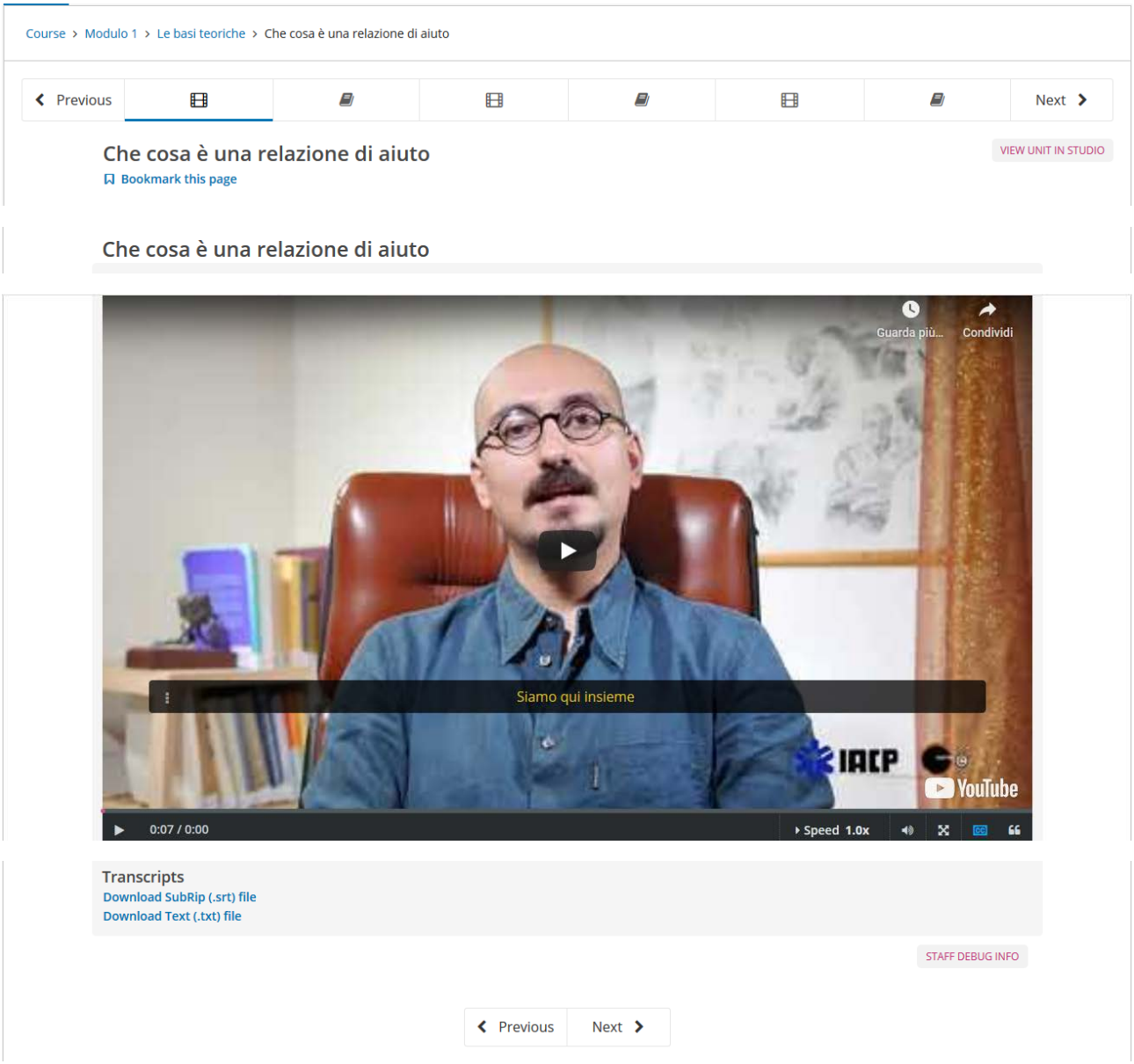
del fatto che anche

rispettare i limiti significa lavorare efficacemente

ed efficientemente.

Ancora grazie per essere saliti a bordo di questa avventura e grazie per il lavoro quotidiano

che svolgete con passione.



Transcript

Siamo qui insieme

oggi proprio per parlare di relazione di aiuto,

soprattutto per andare a definire

che cosa sia una relazione d'aiuto;

per fare questo è necessario partire dal

paradigma di riferimento.

Sappiamo e abbiamo visto che il paradigma

si è modificato.

All'inizio del '900 c'è stato un grosso cambiamento e si è passati da un paradigma

meccanicistico riduzionista ad uno olistico e sistemico.

Anche il modo di intendere una relazione di aiuto è cambiata, infatti nel paradigma meccanicistico riduzionista
la relazione d'aiuto era caratterizzata da un'asimmetria: il professionista era l'agente significante
che imponeva al proprio paziente la visione della realtà, la sua visione della realtà,
in qualche modo agiva creando degli effetti nel proprio paziente
e quindi questiera passivo presso il professionista.
Con l'adozione del nuovo paradigma molte cose si sono modificate
perchè sappiamo che
il centro è divenuto la relazione: l'importanza non è sulle parti, ma sulla relazione
in cui sono queste parti
e che vanno
con essa ad essere qualificate.
La relazione d'aiuto alla luce di questo nuovo paradigma
quale può essere?
Per aiutarci a definirla leggiamo le parole scritte da Carl Rogers già nel 1951, autore
che occupa un posto di primo piano nell'intendere la relazione di aiuto proprio in questa ottica.
Carl Rogers ci dice: "la relazione d'aiuto è una relazione in cui almeno uno dei due
protagonisti ha lo scopo di promuovere nell'altro la crescita, lo sviluppo,
la maturità e il
raggiungimento di un modo di agire più adeguato ed integrato;
'altro in questo senso può
essere un individuo o un gruppo.
In altre parole la relazione di aiuto potrebbe essere definita come una situazione in cui
uno dei partecipanti cerca di favorire, in una o in ambedue le parti, una maggiore realizzazione
delle risorse personali del soggetto e una maggiore possibilità di espressione".
Si evince qui le parole che meglio risaltano sono valorizzazione, promozione, risorse
e quindi
questa nuova ottica in cui vedere la relazione di aiuto
è un'ottica che pone
i due protagonisti
della relazione in una parità,
così il professionista non sarà

l’esperto agente significante,
ma sarà colui che andrà a promuovere tutte quelle
risorse che sono intrinseche all’altra persona.
Così facendo potrà innescare un processo di co-costruzione della realtà
più funzionale per il cliente
andando così ad accompagnarlo in un processo, stando però li dove è lui.
Allora quale caratteristiche deve avere il professionista delle relazioni di aiuto oggi?
Sicuramente deve poter farsi forza attraverso un sapere, deve cioè avere un corpus di nozioni
teoriche a cui appoggiarsi,
deve
oltretutto saperle applicare e quindi queste teorie vanno
anche rese concrete, vanno applicate e sapute applicare nella relazione.
Oltre al saper fare, dato che il focus della relazione è proprio la qualità della relazione
stessa, sarà necessario saper essere, sapere cioè mettere in campo tutte quelle condizioni
e qualità che facilitano e rendono una relazione di aiuto efficace.
Tra queste sappiamo sicuramente che l’autenticità è una, che il saper vedere il mondo con gli
occhi dell’altro è la seconda e che la terza è il non giudicare
il cliente, ma riuscire ad accoglierlo.
Se questo è possibile, se queste tre condizioni saranno attuate dal professionista,
tutto si avvierà verso un processo di cambiamento
e di miglioramento.

Esercizi 1.1

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VIEW UNIT IN STUDIO

Sei mai stato nel ruolo di utente/ cliente in una relazione di aiuto?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Se si quali aspetti della relazione di aiuto ha esperito come particolarmente positivi e facilitanti?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

E quali aspetti hai esperito come non facilitanti?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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Se non sei mai stato nel ruolo di utente/cliente in una relazione di aiuto, quali aspetti a tuoi parere sono positivi e facilitanti e quali aspetti non sono facilitanti?

Please enter your response within this text area

Your response must be between 1 and 10000 words.

Invia Salva

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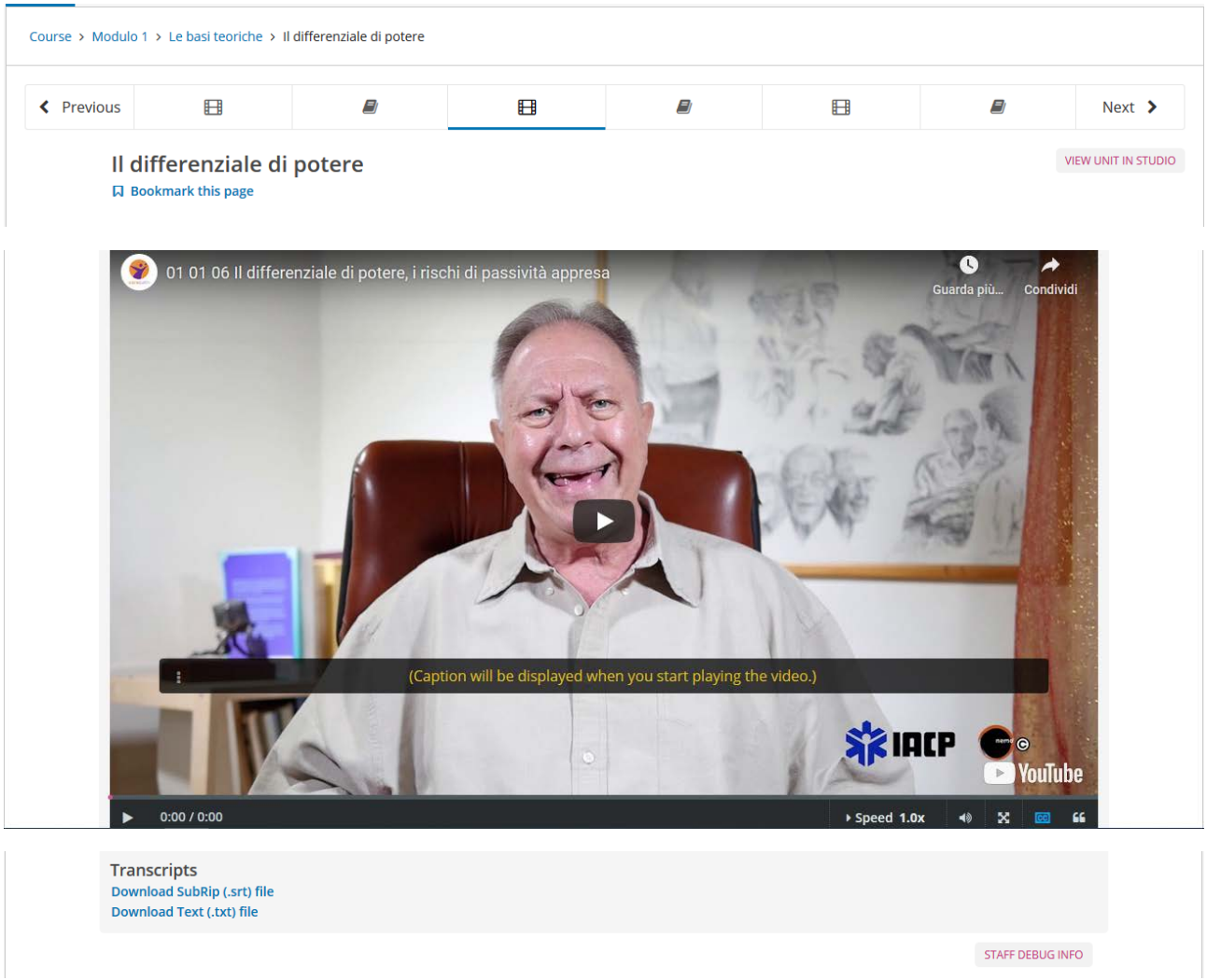


Transcript

Il potere è sempre presente nelle interazioni umane.

Dove due o più persone interagiscono c'è sempre

un potere che può essere oscurato o messo in evidenza.

In genere la storia ci insegna che coloro i quali hanno molto potere non amano molto

discutere su questo argomento perché temono di avere meno potere se c'è trasparenza

sui differenziali di potere.

I differenziali di potere

esistono ovviamente sempre anche nelle relazioni di aiuto.

Il professionista, l'esperto,

colui o colei il quale offre un servizio ha più potere

dell'utente, cliente, paziente che si voglia definire. Perchè?

Perchè sa qualcosa di cui l'utente non conoscere esattamente gli elementi,

in più può offrire al cliente qualcosa di cui il cliente ha bisogno,

inoltre disegna le regole

del setting (cioè della fruizione del servizio) e può addirittura sospendere l'erogazione

del servizio stesso.

Insomma

c'è sempre un differenziale di potere tra chi eroga un servizio e chi lo riceve.

In passato, con il paradigma meccanicistico-riduzionista, nelle relazioni di aiuto il differenziale

di potere era molto elevato.

Si è visto, alla luce anche del nuovo paradigma della Carta di Ottawa e del paradigma biopsicosociale,

che questo non era auspicabile perché un differenziale di potere eccessivamente alto

può portare al fruitore del servizio ad assumere una connotazione passiva che non aiuta a raggiungere

gli obiettivi del servizio stesso.

Oggi quindi si tende a centrarsi sugli utenti, sulle persone dei clienti, ed incoraggiare

il cambiamento attraverso azioni di empowerment che responsabilizzano il cliente a sviluppare

le proprie capacità, la propria creatività e la propria resilienza.

Questo, le ricerche lo evidenziando in molto chiaro, è veramente utile in quanto in tutti

i campi delle relazioni di aiuto si ottengono migliori risultati in minor tempo e si abbassano

- per esempio nel campo della salute e del benessere - effetti secondari e ricadute;

quindi il mondo si sta sempre più orientando all'evidenza che tutti guadagnano se il

potere è condiviso e se tutte le persone contribuiscono a raggiungere gli obiettivi.

Tutto ciò anche a livello della società e quindi una cittadinanza attiva, consapevole

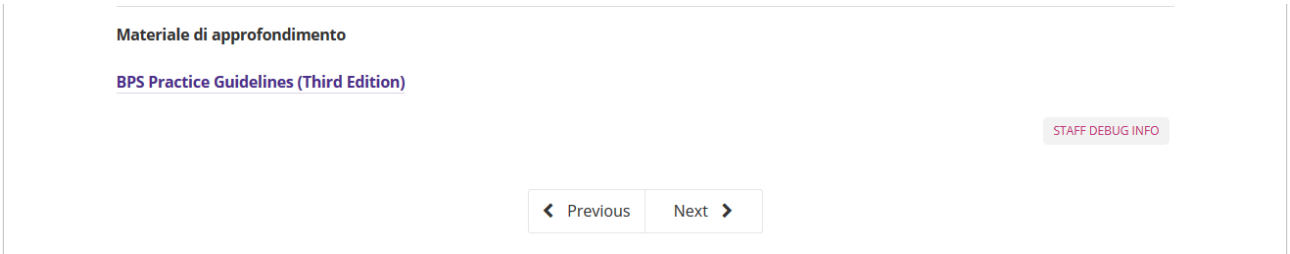
contribuisce molto di più ad una ecologia sociale e alla costruzione comune della policy:

per relazioni sostenibili una policy sostenibile.

Ciò è vero anche quando si erogano servizi ai bambini che sono piccole persone, non sono

bambini che non capiscono e che non sono responsabili, questa costruzione sociale dei bambini come

delle "piccole cose" è senz'altro obsoleta.



Esercizi 1.2

VIEW UNIT IN STUDIO

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Puoi non fare questo esercizio se non lavori nel campo dell'offerta di servizi a minori affetti da trauma

STAFF DEBUG INFO

Tu che pensi veramente su differenziale di potere tra operatore nelle relazioni di aiuto e i suoi utenti?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

You have used 1 of 1 submission

STAFF DEBUG INFO

Troppo differenziale di potere può creare effetti indesiderati? Se si quali?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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Tu nella tua opera quotidiana nel tuo lavoro cerchi attivamente di essere attento al livello di differenziale di potere tra te e i tuoi utenti,?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Se ci stai attento al livello di differenziale di potere, perché metti attenzione a questo aspetto della relazione di aiuto?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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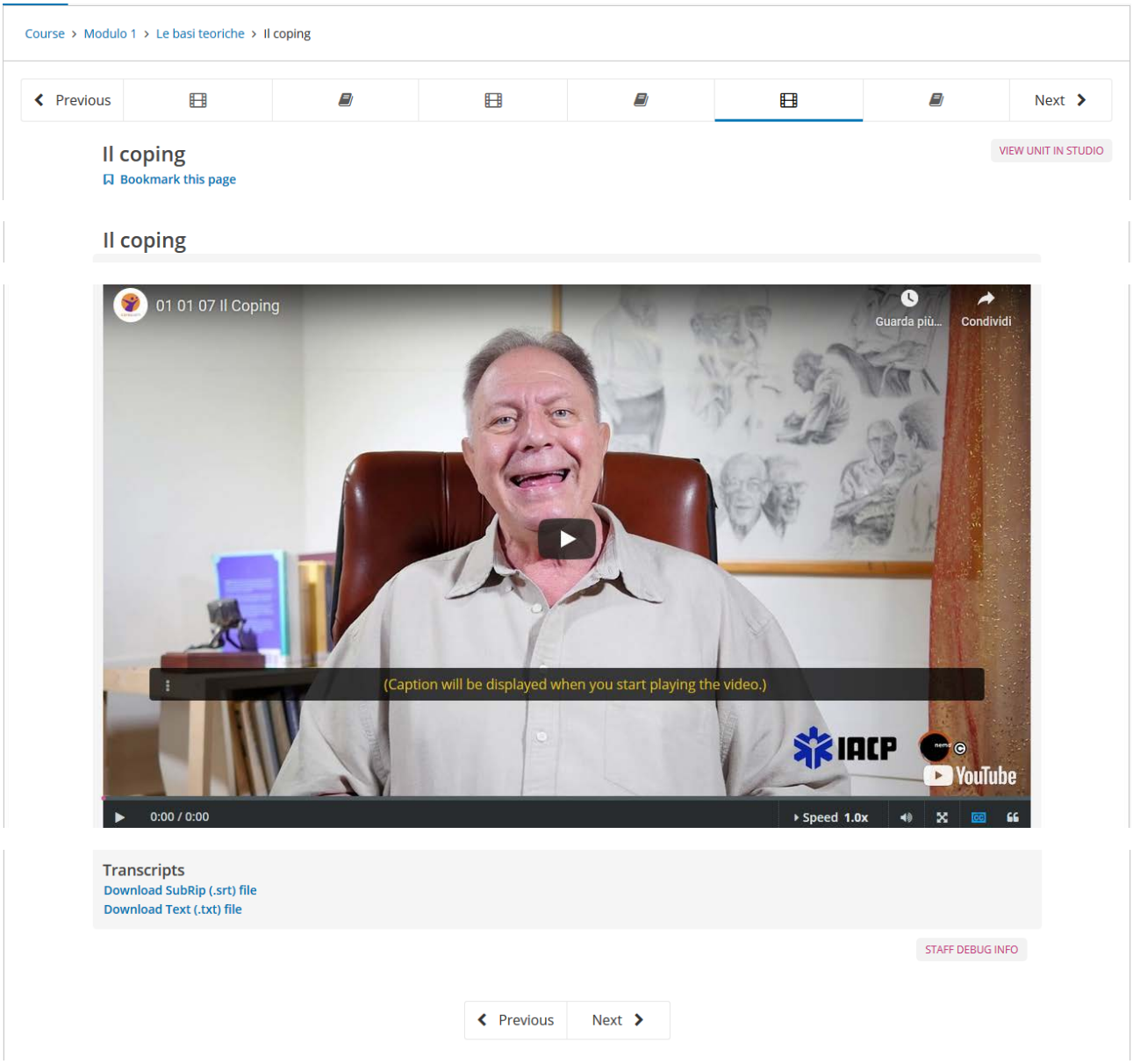

Transcript

A cosa servono

le relazioni di aiuto

per coloro che se ne avvalgono?

Abbiamo sottolineato in precedenza, quando abbiamo evidenziato l'obiettivo della carta di Ottawa del paradigma biopsicosociale, è quello non solo di curare le malattie, ma di sviluppare il potenziale di salute e benessere, la capacità di apprendimento attivo e di sviluppare la propria creatività e resilienza.

Un'altro modo di appellare questa capacità innata negli organismi umani è quella di coping: termine inglese che in italiano significa saper gestire le proprie evenienze di vita; in altre parole di saper gestire al meglio le capacità di relazione con me stesso,

con gli altri e con il mondo che mi circonda.

Sappiamo che nelle relazioni di aiuto,

per quanto riguarda le qualità che il professionista

efficace a prescindere dall'approccio che usa, questi per essere efficace deve sapersi

relazionare con il suo utente con alte qualità di rispetto profondo e non pregiudizio,

di comprensione empatica non solo di quello che dice l'utente, ma quello che sente, i suoi

significati, e rapportarsi a lui con onestà, autenticità, trasparenza.

E necessario però anche da parte dell'utente, cliente, paziente delle capacità perché

questo funzioni, poiché si tratta di un gioco di squadra.

Nelle relazioni di aiuto gli utenti che si potrebbero definire "efficaci", sono utenti

che sono sinceri e si sentono motivati al cambiamento, magari perchè non stanno bene

e vogliono cessare di soffrire in qualche maniera, inoltre hanno la capacità di entrare

in contatto psicologico con il professionista che lavora con loro e di percepire le qualità

relazionali che il professionista mette nella relazione.

Queste capacità fanno sviluppare, insieme anche alla capacità di perseveranza, all'essere

disponibile ad imparare dagli errori, con il coraggio che serve per di ammettere che

si ha sbagliato, per far diventare l'errore un saggio maestro.

Questo sottolinea quanto il coping sia una situazione ottimale di funzionamento e il

risultato di un gioco di squadra del professionista e del suo cliente per il raggiungimento di

obiettivi di maggiore qualità di vita e maggiore realizzazione delle intrinseche

potenzialità

che ognuno di noi è nato proprio e sono descritte nel suo codice genetico e poi sviluppate ulteriormente,

più o meno con le condizioni ambientali che noi troviamo, ma anche con l'attitudine

che abbiamo e come ci poniamo di fronte alla vita.

Esercizi 1.3

VIEW UNIT IN STUDIO

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Qual è a livello personale la tua capacità di gestire le varie situazioni della vita? Buono, medio, non sufficiente ?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

E a livello professionale qual è la tua capacità di gestione delle varie situazioni con utenti, loro familiari, colleghi, i superiori? Buona, media, non sufficiente?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Cosa potresti e vorresti fare eventualmente per migliorare le tue capacità di coping a livello personale e professionale?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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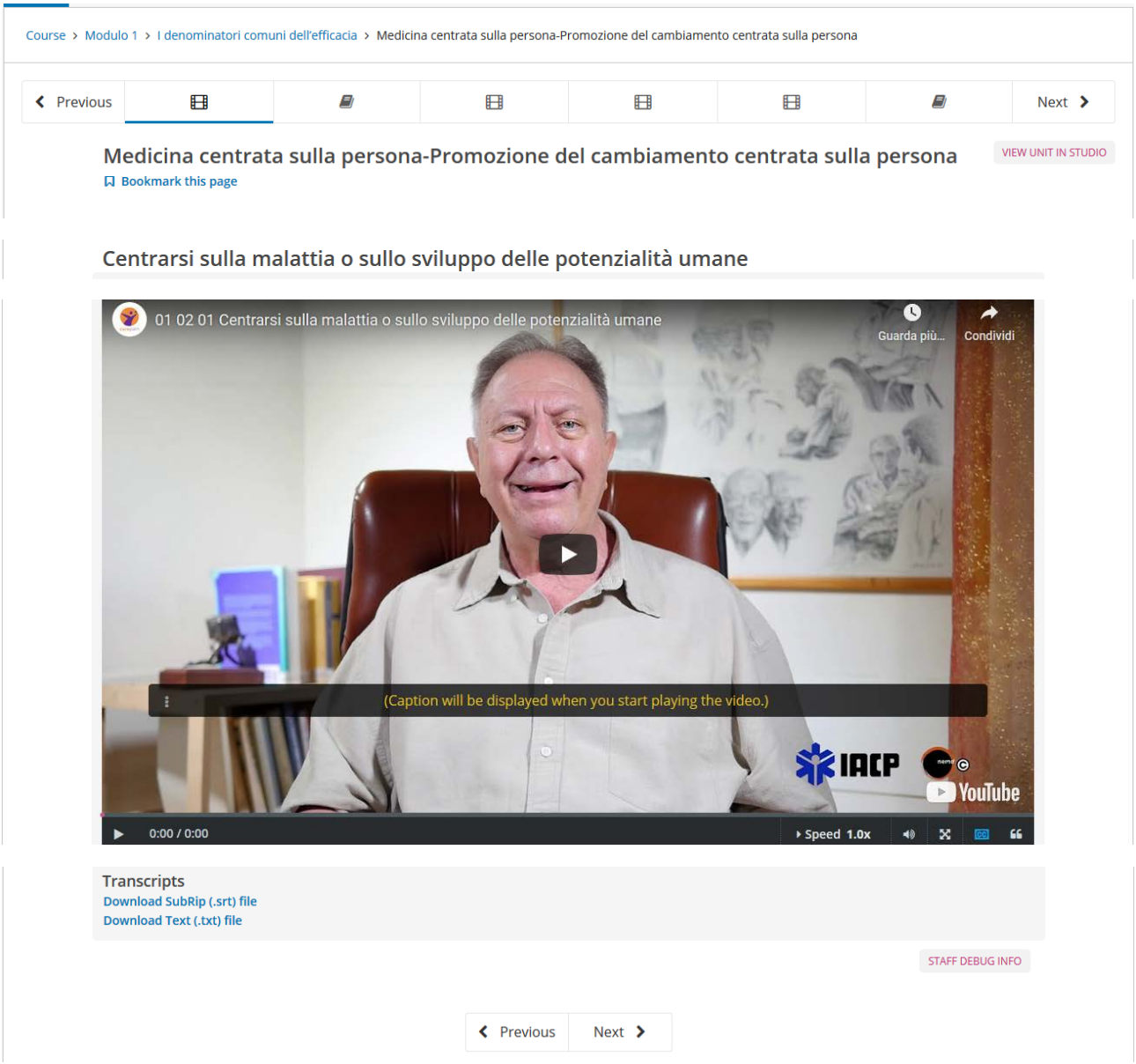

Transcript

Centrarsi sulla malattia o sulla salute?

Le ricerche ci mostrano che è molto meglio

centrarsi sulla salute

perché si ottengono maggiori successi

e si abbassano i costi.

Perché ciò avviene?

Perchè nel precedente paradigma meccanicistico riduzionista

la persona che aveva bisogno di aiuto era in una condizione di passivizzazione, infatti l'appellativo

paziente

può diventare in un certo senso troppo paziente, cioè troppo passivo; indicare

l’assunzione di una passività acquisita. Questo è un rischio molto meno evidente nel nuovo paradigma perché si incoraggia la persona all’uso del proprio potere ad essere ed entrare in una partnership, dove anche al il potere decisionale è condiviso tra professionista e il suo utente.

Inoltre le ricerche ci mostrano che con un approccio di promozione alla salute e del benessere si ottengono, per le stesse categorie di utenti, risultati migliori.

Per esempio un rapporto proattivo dei pazienti con una buona relazione con lo staff ospedaliero, nel caso in cui si tratti di ricevere un intervento chirurgico, attraverso il nuovo modello la durata dei giorni di degenza è inferiore e minori sono le conseguenze negative post operatorie, maggiore è lo sviluppo delle difese immunitarie e maggiore è la compliance, cioè la collaborazione con il medico e gli infermieri per rispettare le istruzioni di manutenzioni che possono essere di non fare o fare delle cose, prendere regolarmente dei farmaci.

Il nuovo modello mostra anche molto minore litigiosità da parte degli utenti nei confronti delle strutture sanitarie e risulta anche molto meno frequente il cambio medico curante.

Quello che era forzato, quindi, era la capacità di collaborazione dell’utente e questo nuovo paradigma non solo favorisce i risultati per l’utente e per i suoi familiari, ma per la società tutta, perché una società dove le persone sviluppano più il loro potenziale si ammalano di meno, hanno vite più longeve e meno contrastate da malattie; è una società più prospera. Insomma promuovere la salute e il benessere è una opzione win-win dove tutti risultano vincenti e i risultati parlano da soli.

Esercizi 2.1

Bookmark this page

VIEW UNIT IN STUDIO

Puoi non fare questo esercizio se non lavori nel campo delle relazioni di aiuto.

STAFF DEBUG INFO

Secondo te centrarsi sulle persone da veramente migliori risultati documentati dalle ricerche oppure sono belle parole ma di persone idealiste ma poco concrete?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Il tuo stile di lavoro e nella pratica quotidiana ti viene naturale centrarti sulle persone oppure devi fare un grande sforzo?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Quando ti centri sulle persone provi soddisfazione di essere capace di farlo?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Come ti auto valuti nella tua capacità di centrarti sulle persone?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

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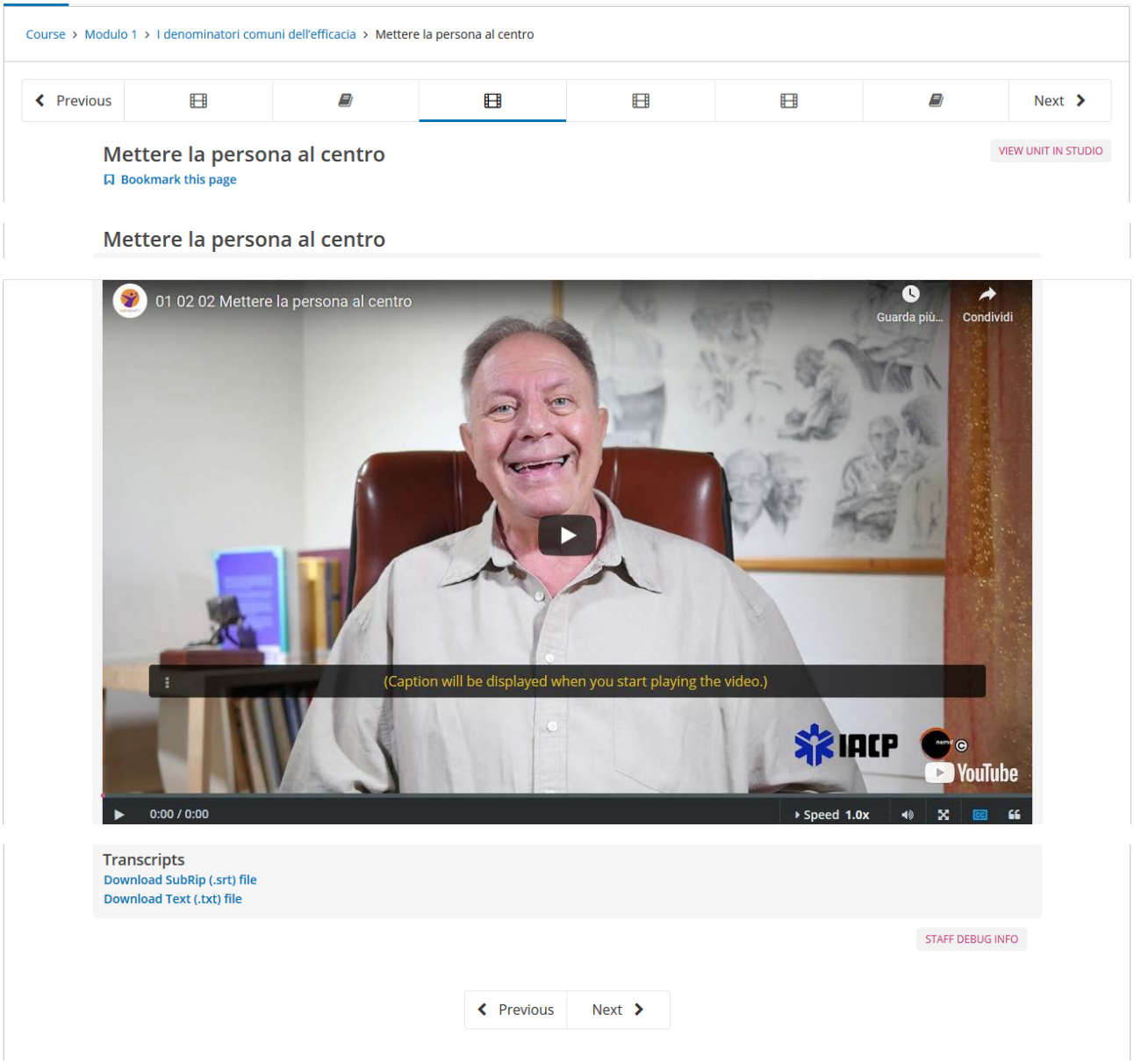


Transcript

Vorrei dire alcune parole su le relazioni psicoterapeutiche efficaci.

La psicoterapia è una delle tante relazioni di aiuto,

ma regolata dalle leggi in maniera

specifica: per esempio qui in Italia soltanto medici psicologi possono - se hanno fatto

una scuola di specializzazione di almeno quattro anni - erogare servizi di psicoterapia;

gli altri non possono, sarebbe un reato perché tutto quello che impatta un organismo

- e quindi fa bene - può, se non saputo promuovere nella maniera giusta, ovviamente fare male.

Ebbene

le riceve mostrano che l'efficacia nel campo della psicoterapia non deriva dallo

specifico approccio teorico, deriva molto di più dalle qualità relazionali degli psicoterapeuti

appartenenti ai vari approcci psicoterapici e, come nelle relazioni di aiuto, anche nelle relazioni psicoterapeutiche le stesse variabili, gli stessi fattori, sono operanti.

Un psicoterapeuta efficace non lo è perché applica un certo modello teorico, lo è perchè ha la capacità di relazionarsi con il suo utente con ampie dosi di capacità di accoglienza, non giudizio, rispetto profondo

e perchè ha

la capacità

non solo di ascoltare quello che il suo utente/paziente/cliente gli dice,

ma che cosa significa per la persona dell'utente.

È poi capace di relazionarsi al cliente in maniera genuina, spontanea, trasparente,

ma non basta perchè la relazione psicoterapica come ogni relazione di aiuto è un gioco di squadra, una co-costruzione e quindi il cliente, l'utente, il paziente ci mette del suo,

altrimenti non funziona.

E cosa?

La motivazione che spesso viene fornita dalla sensazione di disagio - e quindi la motivazione al cambiamento -

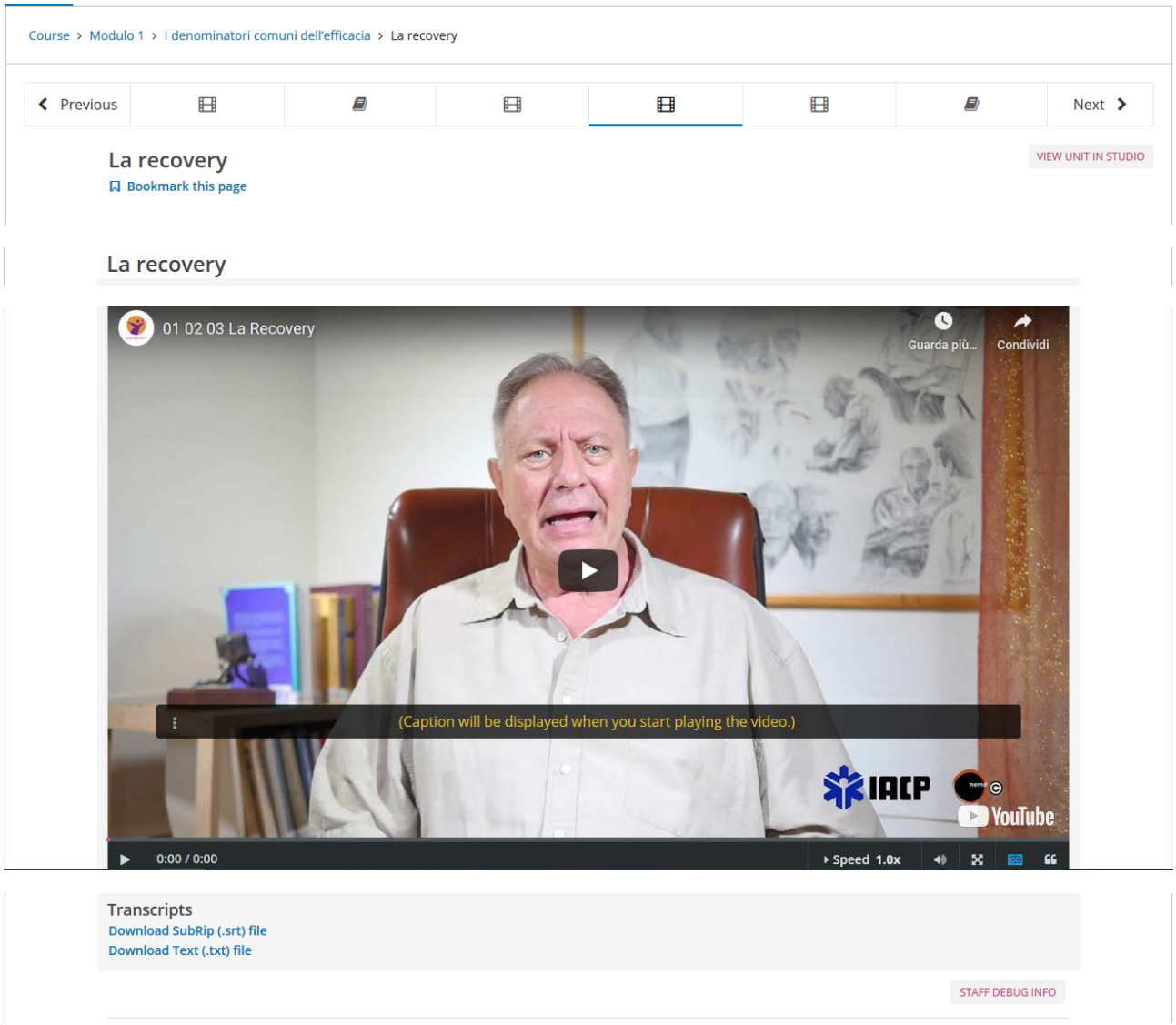
e poi la capacità di contatto psicologico con quello psicoterapeuta

e, inoltre,

la terza condizione: essere capace di percepire la qualità delle relazioni e quelle qualità che sono fondamentali, cioè: il rispetto profondo, l'ascolto empatico e l'autenticità del suo psicoterapeuta.

In questo modo la diade potrà funzionare con risultati molto positivi e più efficaci se la persona per lo stesso disagio ricevesse solo un trattamento farmacologico, o ovviamente nessun trattamento.

Insomma anche nel settore psicoterapico la relazione efficace è buona medicina.



Transcript

L'organizzazione Mondiale della Sanità

ed anche le ricerche nel campo delle relazioni di aiuto,

suggeriscono

che

per avere maggiore efficacia e efficienza dei trattamenti

è raccomandabile

centrarsi, focalizzarsi,

sulla persona dell'individuo

di quel cliente che

abbiamo preso in carico.

Insomma, è importante personalizzare i trattamenti, non come fossero giusto un barattolo di vernice bianco e allora dipingiamo di bianco a prescindere da chi sono gli utenti.

Come la psicoterapia va personalizzata, anche le relazioni di aiuto vanno personalizzate,
perché così si aiuta meglio Gino, Maira, Joseph, Mary, etc.
Perchè
dobbiamo
stabilire al massimo un lavoro di squadra e impegnarci seriamente in un percorso
che vede l'altro come protagonista di questa avventura di cambiamento.
La Task Force 29, che abbiamo già menzionato, dell'American Psychological Association,
mostra l'importanza di centrare sulle persone i trattamenti
e
raccomanda, inoltre, anche un'altro aspetto importante:
che i trattamenti, la loro filosofia, deve essere impostata a
concetti di recovery
invece
che come si faceva precedentemente, ad una facile
e pessimistica
visione di cronicità.
Che cos'è la recovery?
La ricovery negli ultimi decenni ha sviluppato una capacità, con le stesse problematiche
di essere maggiormente d'aiuto,
e ha sfatato alcuni miti,
come quello
che
la schizofrenica
è un'affezione, una patologia, cronica.
Prima si pensava così,
ma il il fatto di pensare in questo modo costitutiva anche
una
profezia autoavverante
e questo, se ci pensiamo bene, è un po' una ovvietà.
Tanto è vero
che, sempre usando l'esempio della schizofrenia, noi sappiamo che esiste
in ogni paese, tuttavia nessuna cultura la tratta ugualmente.

In alcune società e culture lo schizofrenico, lo psicotico, viene considerato come una persona
toccata dagli dei
e perciò la comunità lo vive con rispetto, benevolenza e gli offre
cibo, riparo quando ne ha bisogno;
in altre società
invece è un reietto che viene bandito
dalla comunità e incatenato ad un albero nella foresta.
Nella nostra cultura,
in epoche diverse, abbiamo trattato
queste persone
in maniera molto diversa,
a volte anche crudelmente,
ma ovviamente lo facevamo per il loro bene, come quando credevamo
che fosse un fenomeno derivante da una possessione diabolica e allora torturavamo questi poveretti
con ferri roventi così, se il corpo posseduto da un diavoletto diventava per questo scomodo
si sperava che il diavolo ne uscisse;
oppure
abbiamo trattato le persone con tanti altri
mezzi, ma sempre facendo la profezia della cronicità
e puntualmente queste profezie
si avverano.
Con la visione della recovery, che dice “no, qualsiasi sia la tua
situazione, anche disperata,
come nella schizofrenia, puoi recuperare funzionalità”, ebbene si realizza una profezia positiva che,
come tutte le profezie, in certa misura si avvera.
Per cui oggi vediamo che chi viene visto con maggiore ottimismo soddisfa queste profezie.
Abbiamo quindi persone che ancora vedono cose che gli altri non vedono, sentono voci che
altri non sentono, ma sono consulenti pagati in un'ASL impiegati per consigliare come trattare
persone con le stesse affezioni in maniera più umana e ottimistica, e poter realizzare
- invece di profezie negative - delle profezie positive che sono ugualmente
autoavveranti.
La profezia, infatti, bisogna stare attenti dove ci conduce.

Materiale di approfondimento

Recovery e salute mentale

La recovery nella salute mentale

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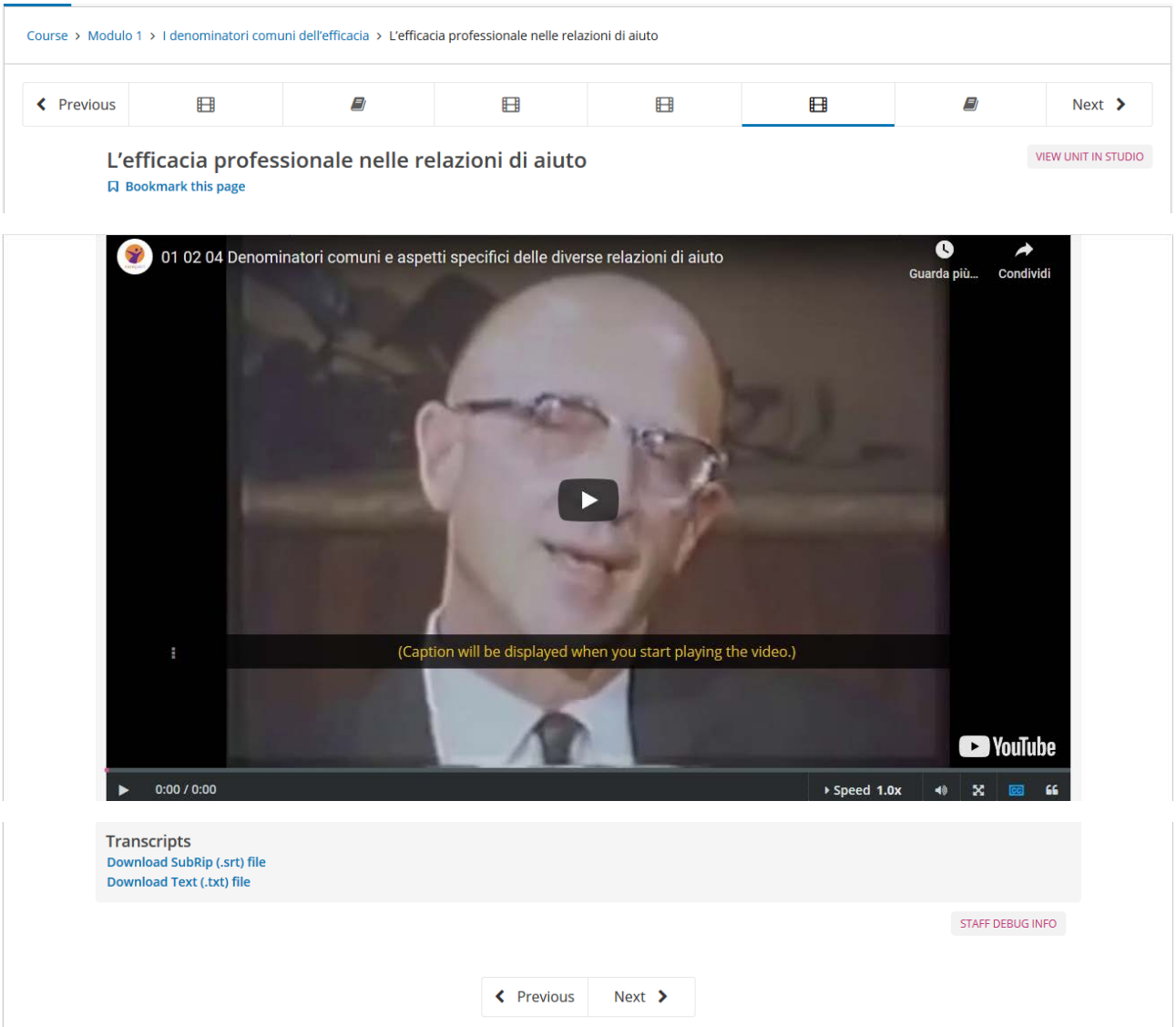

Transcript

Oggi

disponiamo di

una vasta messe di ricerche

ci illustrano

in cosa consiste l'efficacia

professionale per un professionista

che eroga

dei servizi nell'ambito delle relazioni

di aiuto.

La ricerca

parte da

delle ipotesi genialmente formulate dai Carl Rogers,

colui che sarà
il fondatore dell'approccio centrato sulla persona
e uno dei padri della psicologia umanistica.
Nel lontano 1942 Rogers formulò scientificamente
delle ipotesi
e passò alla sua verifica empirica
su quello che costituiva in un professionista le condizioni necessarie e sufficienti per
promuovere il cambiamento.
Queste
erano e sono state confermate fino ad oggi dalle ricerche: la capacità di stabilire
una relazione con l'utente, il cliente, ricca
di un'attitudine di non giudizio,
un'accoglienza
profonda nel suo rispetto della persona dell'utente,
una capacità
sensibile e accurata di ascolto empatico - cioè capire non solo quello che il cliente dice,
ma anche quello che significa per lui
- e anche un'attitudine di autenticità, schiettezza
ed onestà nella relazione.
Queste ipotesi che furono subito confermate
sono state via a via confermate e operanti
in tutte le relazioni di aiuto,
nessuna esclusa,
quindi in questo
Rogers dette un grande contributo
ad un passo avanti delle relazioni di aiuto basate non su convenzioni, ma propriamente
sulle delle basi empiriche e quindi scientifiche.
Credo ancora più eloquente sarà ascoltare direttamente da Carl Rogers in persona
che illustra queste tre condizioni necessarie e sufficienti in un suo famoso filmato:
"From my own years of therapeutic experience I have come to feel that
If I can create the proper
climate, the proper relationship, the proper conditions,

the process of therapeutic movement will almost inevitably occur in my client.

You might ask, what is this climate?

What are these conditions?

Will they exist in the interview with the women I'm about to talk with whom I have

never seen before?

Well let me try to describe very briefly what these conditions are as I see them.

First of all, one question is,

can I be real in the relationship?

This has come to have an increasing amount of importance to me

over the years.

I feel that

the genuineness is another way of describing the quality I would like to have.

I like the term congruence, by which I mean, what I'm experiencing inside is present

in my awareness and comes out through in my communication.

In a sense,

when I have this quality,

I'm all in one piece in the relationship.

There's another word that describes it for me,

I feel that in the relationship

I would like to have a transparency, I would be quite willing for my client that sees all the way through me,

that there would be nothing hidden.

When I'm real in this fashion that I'm trying to describe then,

I know that my own feelings

will often bubble up into awareness and be expressed, but be expressed in ways

that won't impose themselves on my client.

Then the

second question I would have is, will I find myself praising this person,

caring for this person.

I certainly don't want to pretend a caring that I don't feel.

In fact, if I dislike my client persistently, I feel it's better that I should express it.

But I know that the

process of therapy is much more likely to occur,

and constructive

change is much more likely,

if I feel a real spontaneous prising of this individual with whom I am working.

A prising of this person as a separate individual.

You can call it acceptance, you can call it caring,

you can call it a non-possessive love if you wish.

I think any of those terms tend to describe it.

I know that the relationship will prove more constructive if it's present.

And in the third quality, will I be able to understand the inner world of this individual,

from the inside,

will I be able to see it through her eyes,

will I be

sufficiently sensitive

to

move around inside the world of her feelings,

so that I know what it feels like to be her.

So that I can

sense not only the surface meanings but some of the meanings that lie

somewhat underneath the surface.

I know that If I can

let myself sensitively and accurately enter into her world of experience

than change and therapeutic change are much more likely.

Esercizi 2.2

VIEW UNIT IN STUDIO

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Puoi non fare questo esercizio se non lavori nel campo delle relazioni di aiuto.

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Dei denominatori comuni di tutte le relazioni di aiuto che hai appena ascoltato e visto illustrare quali sono le qualità che ti caratterizzano nel tuo lavoro con gli utenti?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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Quali vorresti sviluppare ulteriormente?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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Il tuo posto di lavoro ti offre possibilità per divenire un professionista migliore? E se si come?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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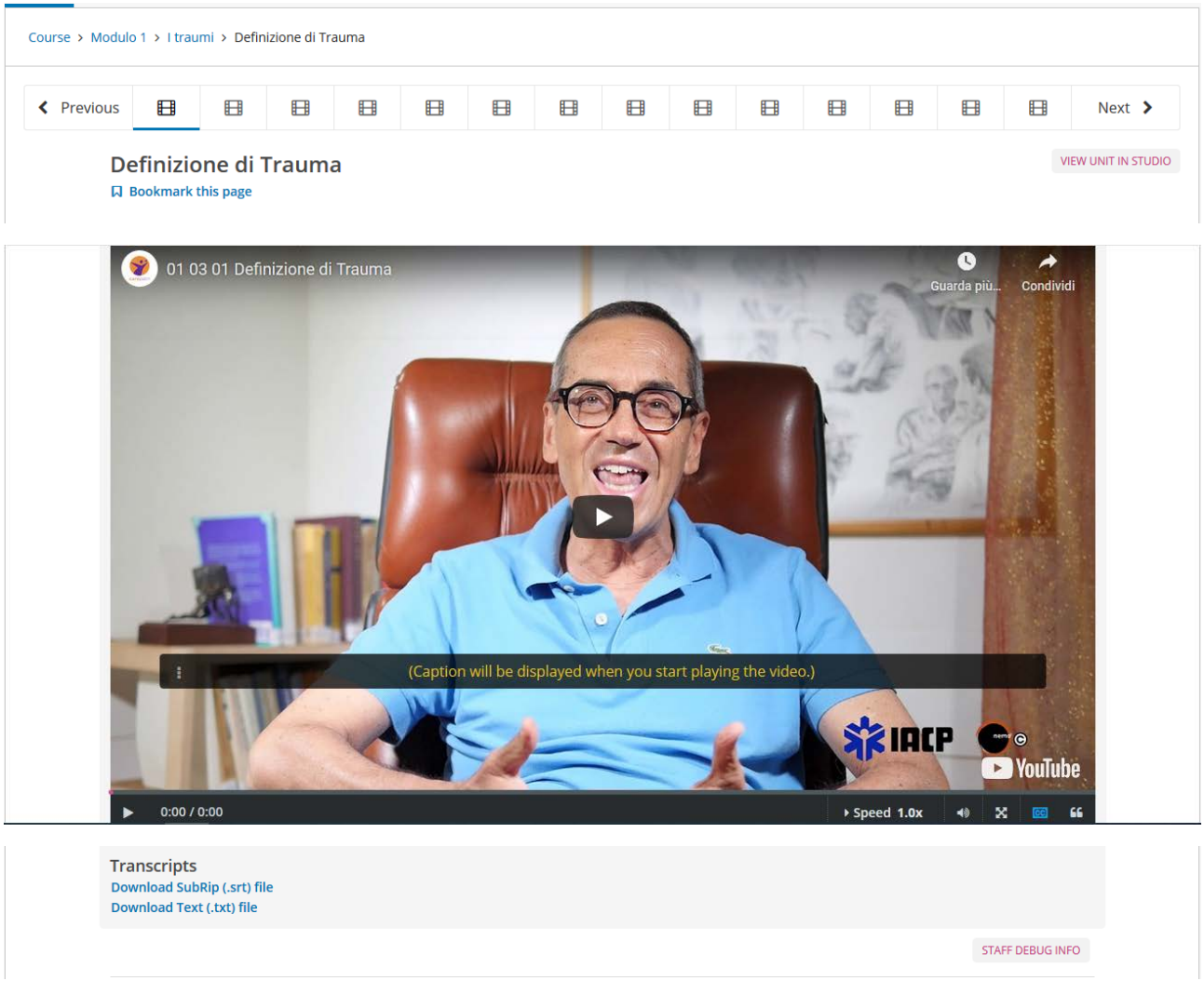

Transcript

Il trauma che cos'è? Come possiamo definirlo?

Il trauma è, in realtà, un'esperienza, un fenomeno

stressante - spesso

improvviso

- che

oltrepassa le possibilità della persona/soggetto

di

reagire e di difendersi dal trauma stesso.

In realtà il trauma è qualcosa che soverchia le forze

di opposizione di una persona che ne è esposta.

Il trauma è stato studiato

in vari modi,

esistono traumi acuti - per esempio dovuti

a catastrofi naturali o tecnologiche - esistono situazioni traumatiche di tipo cronico/ripetuto
- come ad esempio quello a cui sono spesso esposti i bambini
- ma
quello che si può
dire è che la storia del trauma, da un punto di vista clinico, inizia proprio con lo studio
delle nevrosi post-traumatiche, le quali sono state studiate anche da Freud - e quindi nel
contesto della psicanalisi - e sono state riprese poi da altri autori.
Perchè nevrosi post-traumatica? perché dopo le grandi guerre - in particolare in seguito
alla prima guerra mondiale e alle guerre successive - si sono notati molti disturbi da esposizione
a traumi bellici che hanno poi comportato delle conseguenze psicologiche e che in seguito
sono state riprese dai sistemi di classificazione psichiatrica, quindi della psicopatologia,
come disturbo post-traumatico da stress. Questo disturbo post-traumatico da stress
è l'unico disturbo in psichiatria che è certamente e sicuramente dovuto da un fattore esterno;
questo fattore è appunto il trauma.
Non è quindi necessario ad una persona che
si espone, per esempio, ad un terremoto o ad una inondazione, di essere portatore di
una sua debolezza, fragilità o vulnerabilità, perché il trauma è talmente importante e
soverchiante delle forze dell'individuo che di per sé è in grado di indurre delle
conseguenze a livello psicologico e a livello anche fisico. A livello fisico in quanto tra i
sintomi più importanti di quello che oggi si chiama disturbo post-traumatico da stress
ci sono, per l'appunto, i sintomi di tipo neurovegetativo:
sintomi di allerta, di aumentato
arousal, ovvero di aumento della vigilanza e della reattività agli stimoli esterni.
Questo quindi significa che una persona porta dentro di sé anche dei segni oggettivi, e
non soltanto dei sintomi soggettivi, dell'impatto che il trauma ha avuto su di lei.
Il trauma è stato studiato anche dal punto di vista dei meccanismi psicologici,
i quali sono molto importanti:
quello che
ha studiato la psicoanalisi, fin dalle origini,
è stato il fatto che un trauma
- in particolare se precoce, ad esempio nell'infanzia
- è soggetto ad un processo di rimozione;

questa rimozione non significa però che il trauma viene dimenticato,

negato o sepolto, il trauma può ricomparire, essere riattivato, in un momento successivo

- ad esempio nella vita adulta

- magari

per effetto di un altro trauma che per certi versi

richiama il trauma precedente. Questo è un meccanismo in due tempi che Freud aveva studiato

accuratamente secondo cui c'è un primo trauma che, in un certo senso, sensibilizza

ed un secondo trauma che

ripropone al soggetto la condizione di essere vittima, di impotenza

e fragilità in cui si era trovato,

riproponendo così di fatto la situazione riconducendo

a nuovi

sintomi

ed ad una situazione clinica che il soggetto sperimenta come se fosse la prima volta.

Detto questo il trauma del disturbo post-

traumatico da stress si verifica invece in un modo

puntuale e che mette a repentaglio la vita del soggetto.

Può essere causato da motivi bellici, di tortura, per motivi

tecnologici o ambientali,

ma questo trauma è di tipo puntuale e ben riconoscibile nella

vita del soggetto.

Materiale di approfondimento

Psicotraumatologia, Pubblicazioni in lingua italiana

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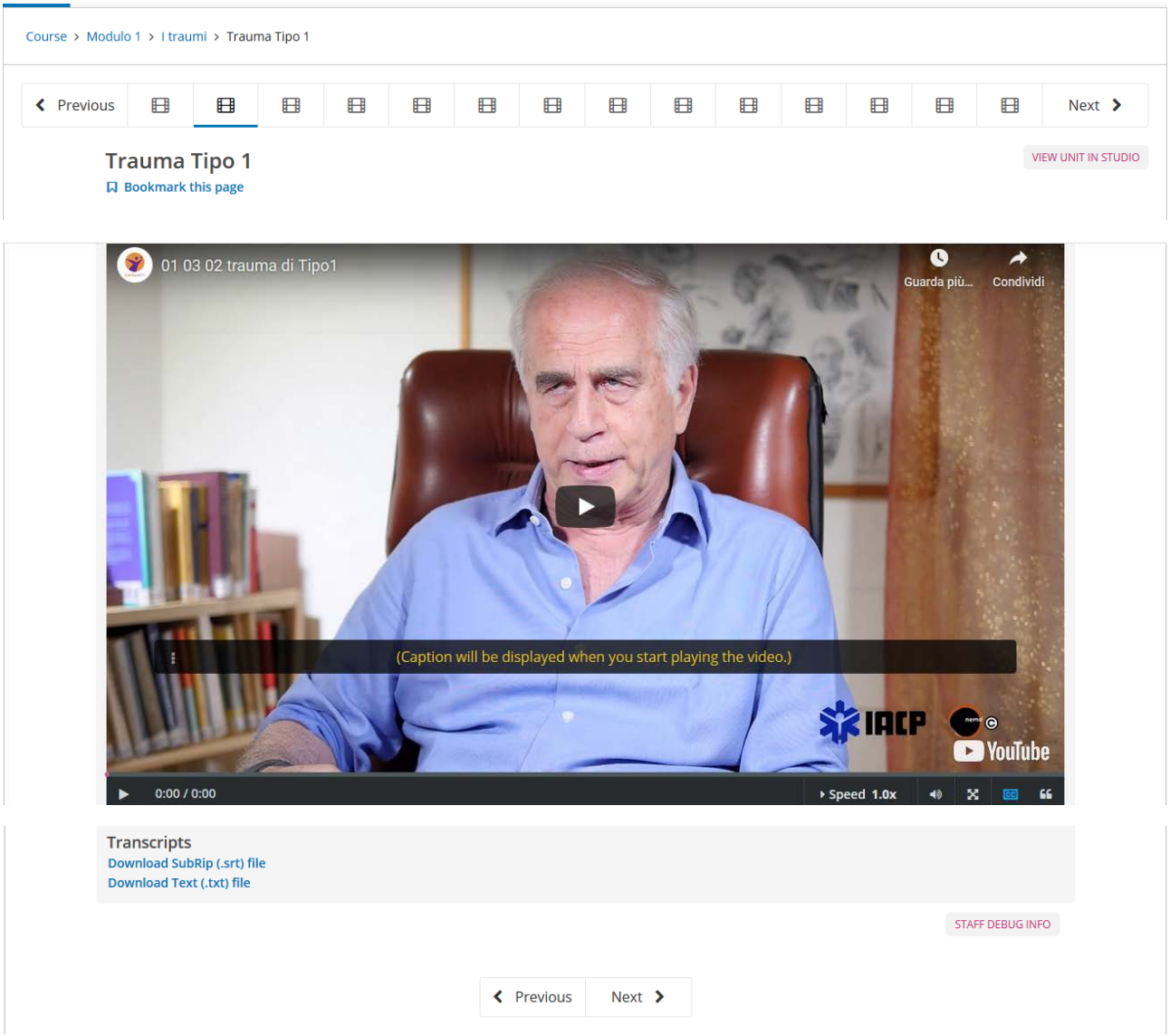


Transcript

Analizziamo il tipo di trauma che può comportare il disturbo alimentare.

Il trauma classico, quello che colpisce una volta, che è un evento particolarmente grave,

in realtà costituisce forse il caso meno frequente anche se è particolarmente importante

per gli effetti devastanti che può produrre su una persona.

Si tratta di eventi gravi

che hanno un aspetto negativo, che può incidere

sulla vita di

una persona tanto da produrre un danno psichico o fisico, oppure di entrambe le nature,

e che può durare

per diversi anni nella vita di una persona.

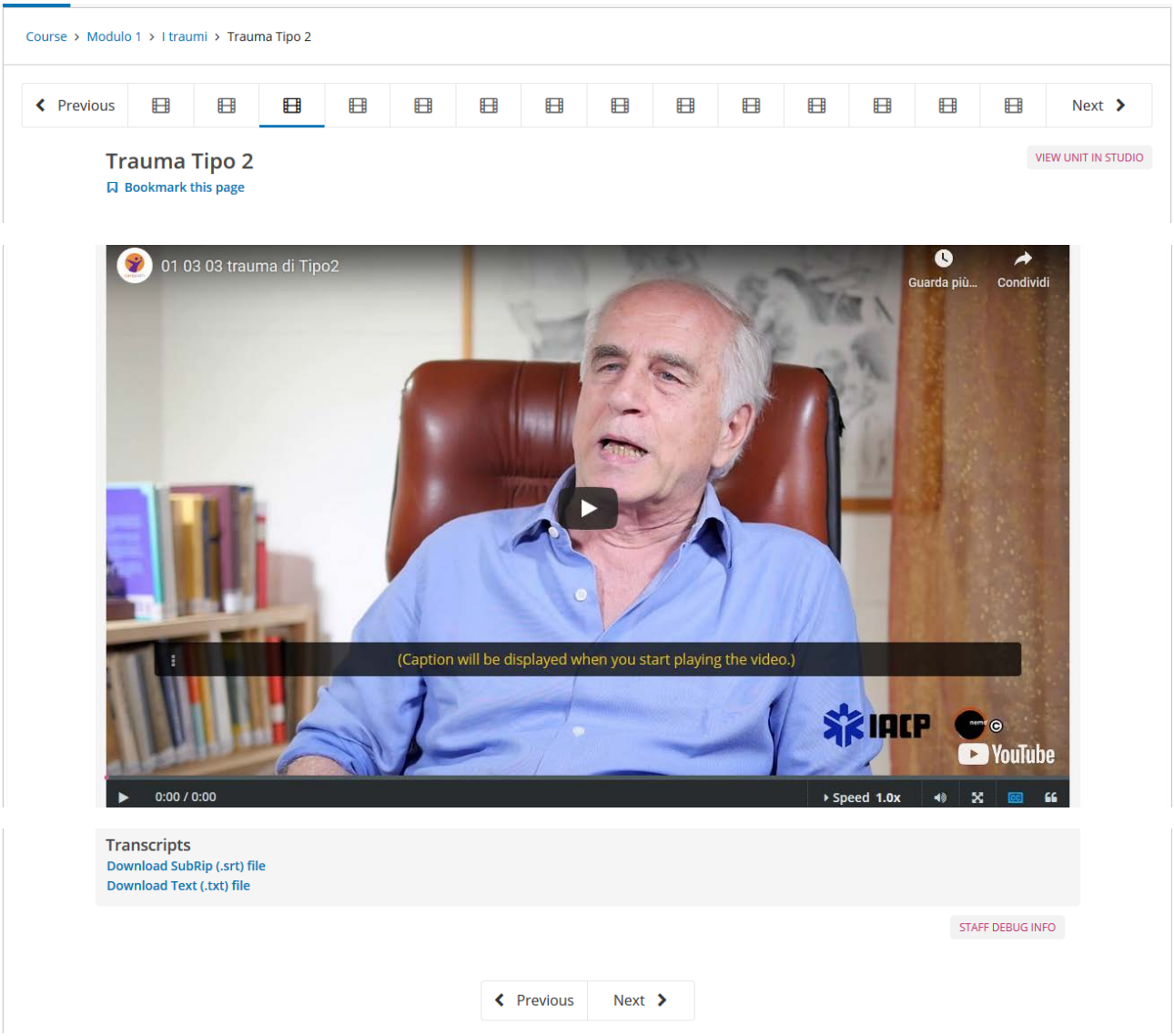
Abitualmente ritroviamo questo trauma in quella che si chiama disturbo post-traumatico da stress,

ma è molto frequente nel disturbo alimentare, in particolare in alcune forme
di disturbo alimentare.
Questo si può suddividere in due parti: - Il trauma fisico, che è quello soprattutto
che può capitare nella vita in momenti o particolarmente drammatici quali lo stupro,
la rapina, la violenza fisica, il combattimento in guerra,
un disastro naturale (come uno
tsunami o un terremoto), un incidente in auto molto grave,
un incidente ferroviario
- Il trauma soprattutto di tipo psichico: quando la vita di una persona viene messa
in pericolo fortemente dalla minaccia di qualcuno, di qualche situazione particolare in cui la
persona può trovarsi,
in cui non derivano
fatti con lesioni fisiche, ma semplicemente
una minaccia così estrema e forte che difficilmente la persona riesce a cancellarla dalla sua
mente nel suo prossimo futuro.
Per le persone soggette al trauma di tipo I, detto anche “trauma focale”,
il trauma è detto “single blow”,
colpisce cioè una volta,
ma
lascia tracce pesanti
e sulla sintomatologia
di tipo alimentare
ha un effetto molto simile a quello del disturbo post-traumatico.
Un trauma di questo genere può avere una serie di conseguenze, tra cui il disturbo alimentare
è uno dei più comuni,
e poi una serie di sintomatologie
piuttosto estese
che
può comportare
una serie di tratti
che, straordinariamente e particolarmente, si trovano tutti presenti
nel disturbo del comportamento alimentare.

Vale a dire il comportamento da disturbo alimentare non è solo un comportamento alimentare,
ma questi sintomi possono accompagnare,
frequentemente
ed in quasi i tutti i casi si ha questa sintomatologia,
tutti i singoli disturbi dell'alimentazione e sono in particolare:
un'autostima bassa, una tendenza molto forte alla depressione,
una immagine del proprio corpo e della sessualità
particolarità distorti,
un alto rischio suicidario, disturbi d'ansia, uso di sostanze alcoliche,
disturbi del sonno, disturbi dissociativi, perdita di memoria, aggressività e disturbi della personalità.
É un corteo sintomatologico che non ci stupisce mai di trovare
nei disturbi alimentari i quali da sintomi
di questo genere o da vere e proprie patologie
che completano il quadro del disturbo i alimentare
e
raramente sono assenti.
Abbiamo, in particolare,
il trauma che lascia una traccia - come
questo trauma di tipo I
- il quale si verifica soprattutto producendo alexithymia, che è un disturbo delle emozioni
che impedisce ad una persona di esprimere aperta le proprie emozioni
con le parole.
La tendenza in questo caso, dopo un trauma di tipo I, è di esprimere emozioni soprattutto
a livello non verbale,
con il proprio corpo,
e queste sensazioni
possono essere
molto gravi
e possono comportare
una disregolazione emotiva, anche notevole, fino al punto in cui la persona
mostra una impulsi
di un certo livello,

e
sappiamo - perché
questo è uno dei riscontri
più frequenti che troviamo
- che esistono delle forme di bulimia nervosa in cui il trauma
di questo tipo (ad esempio l'abuso)
sono
di tale gravità ed entità da produrre
delle sintomatologie
che possono portare ad una perdita di controllo notevole e diffusa a
diversi livelli.
In particolare, soprattutto quanto avviene in una fase precoce dello sviluppo,
quando il trauma è drammatico,
quando le variabili familiari
sono gravi da sostenere e da supportare,
in questi casi
si corre il rischio di bulimia multicomplusiva:
una forma di bulimia
molto grave e pericolosa
in cui insieme ai comportamenti bulimici
si manifestano alterazioni della
personalità del comportamento alimentare e soprattutto impulsività
impulsività che può riguardare
la sessualità,
la
tendenza
ad assumere cibo in maniera incontrollata e senza sentirne il sapore,
ma che ad esempio può comportare-
comportamento tipico di quelle persone attuano
furti nei supermercati, che consumano il cibo nel supermercato e non possono aspettare di
tornare a casa per mangiare anche se avrebbero la possibilità di acquistare cibo.
Una

disinibizione dei propri impulsi che abbiamo visto può riguardare anche la sessualità,
ma soprattutto, più importante e più pericolosa, l'impulsività autolesiva per la quale abbiamo
comportamenti autolesivi quali tagliarsi o tentare il suicidio.
Questo tipo di bulimia, quella multi compulsiva è la più pericolosa conosciuta, in particolare
per l'elevato tasso di suicidi.
Concludendo un trauma di tipo I ha come conseguenza, in particolare se l'ambiente non è supportivo,
questa forma di bulimia che è sicuramente la forma più pericolosa conosciuta in particolare
per il rischio suicidario molto elevato.



Transcript

Affianco del trauma di tipo tradizionale, quello single blow,

che

conosciamo come il grande trauma

che cambia la vita di una persona,

esiste un'altro tipo di trauma che si chiama trauma di tipo II,

ma è soprattutto il trauma

di minore gravità ma che si ripete nel tempo,

con una frequenza tale che le persone iniziano a prevederlo,

ma non possono prevedere esattamente

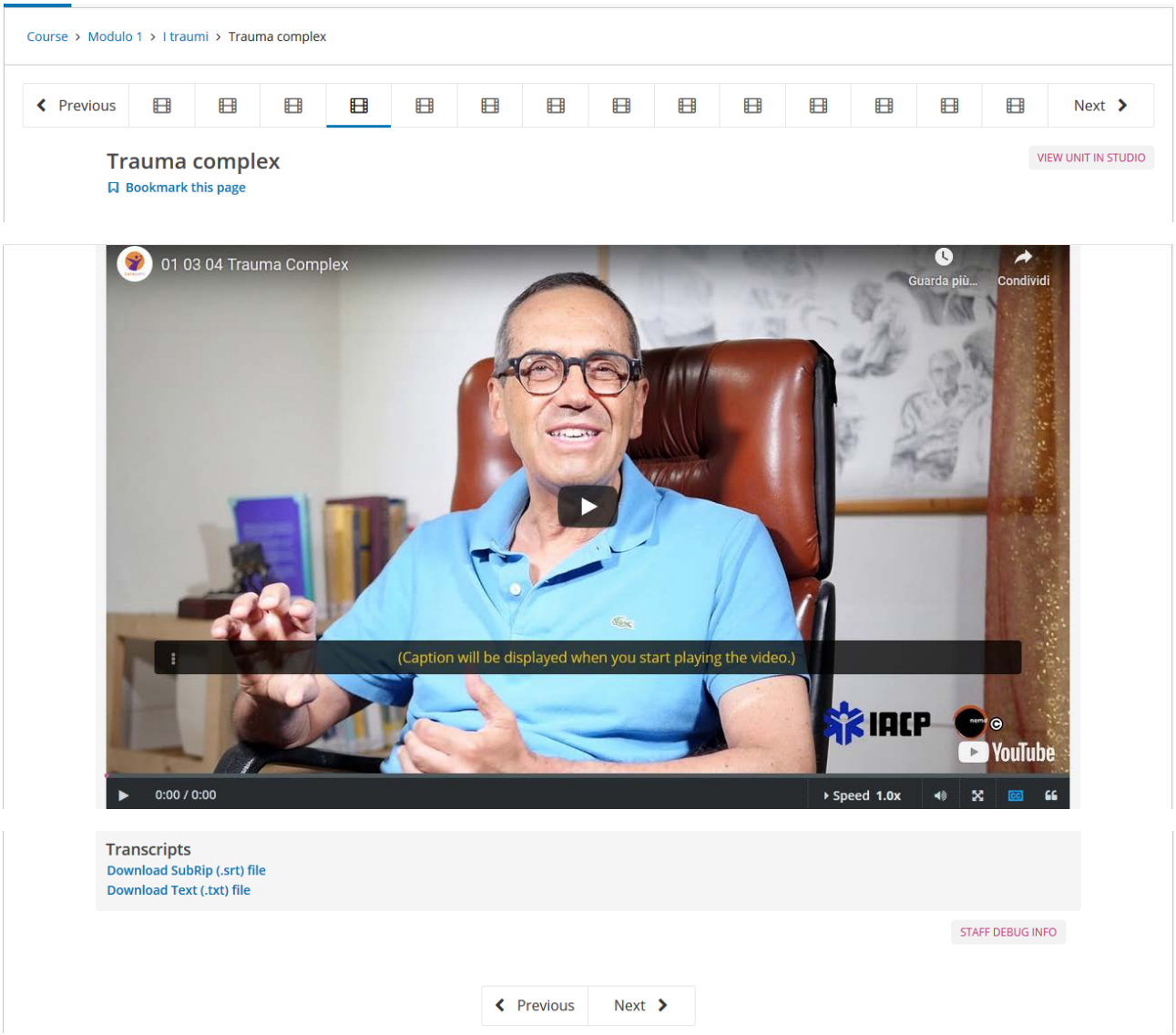
quando avverrà e questa attesa ed aspettativa ha un effetto logorante: produce nel soggetto

una sensazione di impotenza estremamente forte

che da a questi la sensazione di non essere
padrone di se stesso.
In questo tipo di trauma si riscontra frequentemente disturbi alimentari,
può esserci una storia
di conflitti molto violenti nell'ambiente domestico
a cui
il ragazzo, l'adolescente,
a volte il bambino, hanno assistito per lunga parte della loro vita senza conoscerne il
termine; può essere infatti che questo conflitto violento possa sfociare in un vero e proprio
comportamento violento che può produrre
anche danni gravi o addirittura delle perdite.
Questo tipo di trauma che si ripete
crea una situazione di attesa
molto drammatica per la persona, si aspetta
che ci possa essere opposizione
anche se non è detto che avvenga,
tuttavia la traumatizzazione è dovuta all'attesa estremamente forte
e si ripete con tale frequenza
che la vita successiva della persona
può arrivare allo stesso tipo di timore
anchequalora queste esperienze di tipo traumatico sono cessate.
In certi casi si manifesta una tendenza nelle persone a ripetere il tipo di trauma,
per esempio: in una
giovane donna
che ha assistito per tutta la vita alle liti tra padre e madre
a causa dei tradimenti dell'uno verso l'altro,
in tutte le realtà di vita successiva ha
saputo soltanto scegliere
partner che manifestavano comportamenti infedeli, quali tradimenti che
aumentavano in lei il bisogno di scoprire il tradimento vi era o meno; questo tipo di
atteggiamento
in un certo qual modo diventa una ripetizione della previsione dell'evento dannoso

con la paura che si possa verificarsi da un momento all'altro, come se il momento
dell'infanzia non fosse mai passato.
Il trauma di tipo II produce, fra l'altro,
una tendenza al diniego massivo, l'intorpidimento affettivo -
come se la persona tendesse ad eliminare le sensazioni di tipo emotivo
- quindi si tratta di soggetti che si comportano come se fossero "raffreddate", come se non
avessero altre sensazioni
in certi momenti della loro vita;
questo è chiamato numbing che si manifesta come forma di intorpidimento
che è uno degli elementi di base
del cosiddetto disturbo dissociativo: un disturbo in cui la persona perde la capacità
di avvertire
le sensazioni normali,
come se perdesse
delle capacità sensoriali significative,
se si assentasse o non facesse
parte della vita reale di tutti i giorni in alcuni momenti
della sua esistenza.
A questo si accompagna,
soprattutto nei disturbi alimentari
e ancora più
nei disturbi alimentari
in cui si manifesta perdita di controllo quindi anoressia non restrittiva o anoressia
con condotte bulimiche o vere e proprie bulimie,
in questi comportamenti
si nasconde sempre una profonda rabbia:
il soggetto è passivo,
sembra non reagire, ma
quando compie un atto
si percepisce in lui o in lei
una forte rabbia, quali
manifestazioni di aggressività verso l'esterno

sono molto contenute,
ma quando il soggetto prova forti emozioni può esplicitare
la sua forte rabbia fino ad arrivare a veri e propri agiti i quali hanno come conseguenza
anche comportamenti violenti nei confronti di se stessi o degli altri.
Il soggetto manifesta una tristezza incessante, non di tipo intermittente, che è stabile
nella persona
come se
ci fosse stato un trauma infantile che produce una pausa costante la
quale a sua volta produce un senso di disperazione
che comporta una tristezza che si estende
a tutta la vita.
Si tratta, come si è detto, di traumi piccoli
che si accumulano, ma sono stati chiamati
anche traumi complessi o traumi relazionali poiché dipendono
da una serie di relazioni continue che si hanno nei confronti degli altri,
quindi nella vita di una persona può
accadere che chi ha subito questi traumi abbia vissuto nell'ambiente di casa, soprattutto
quello familiare,
momenti traumatici molto forti.
Sono, quindi, traumi costanti che si ripetono e che producono sintomi dissociativi di cui
abbiamo parlato o di regolazioni emotive.



Transcript

La storia del trauma è una storia complessa, fatta di corsi e di ricorsi storici.

Di fatto, negli ultimi venti anni fino ad oggi,

con l'ultima edizione del sistema

di classificazione americano e universalmente noto in psichiatria come DSM5

si è considerato come

possibile disturbo conseguente ad un trauma il disturbo post-traumatico da stress.

In realtà

l'attenzione di ricercatori,

in primis Van der Kolk che ha inaugurato la

questione del trauma complesso,

l'attenzione dei ricercatori si è rivolta ai traumi infantili,

quelli che si sono verificati in un’età del soggetto
in cui
questi si trovava in una
posizione di debolezza, di inferiorità, come per l'appunto normalmente i bambini sono.
Questo tipo di
situazione traumatica, di eventi ai quali può essere esposto il bambino
possono essere riconosciuti, anche dal punto di vista neurobiologico e non soltanto da un punto
di vista psicopatologico, come possibili cause predisponenti allo sviluppo di disturbi psichiatri
che vanno ben oltre il confine del disturbo post-traumatico da stress.
Questi
fenomeni
di
traumi infantili
sono di diverso tipo: possono essere di tipo acuto,
possono essere protratti e ripetuti nel corso dell’infanzia
e vanno sotto il
nome, perl’appunto, di
abusi quando sono dei fenomeni traumatici di tipo positivo - ovvero quando
qualcosa viene commesso sul bambino, come per esempio gli abusi infantili, le violenze
sessuali o fisiche, oppure le violenze psicologiche
- oppure possono essere di tipo
omissivo,
cioè possono essere dovuti a un tipo di neglect, una trascuratezza sia nelle cure psicologiche
che nelle cure fisiche
del bambino portando a dei veri e propri
eventi
e situazioni di maltrattamento.
Il maltrattamento e l’abuso, quindi, sono i fenomeni di cui noi adesso ci occupiamo
quando parliamo di trauma complesso.
Il trauma complesso, complex trauma o trauma evolutivo primario come qualcuno lo chiama,
dovuto spesso al fallimento
delle

figure
di accudimento primario, quindi quelle genitoriali
per esempio
e trauma anche cumulativo - lo psicanalista Masud Khan si è occupato proprio
di questo aspetto del trauma - ovvero tanti piccoli eventi o situazioni traumatiche
o di tipo omissivo o di tipo commissivo che si sono ripetuti durante l'infanzia e che,
cumulativamente, hanno dato luogo ad un clima o dimensione traumatica
della quale il soggetto risentirà
durante la sua età adulta nel momento in cui incontrerà una difficoltà,
un problema o un'altro trauma che richiama il trauma precedente.
Tuttavia questo trauma precedente è un trauma complesso, cioè articolato, che si può estendere
per un periodo temporale molto
importante e lungo, addirittura lungo l'intera infanzia.
Pensiamo a situazioni in cui ci sono famiglie
nelle quali viene vissuto e sperimentato un
clima di paura o di violenza prolungato causato da disturbi o problemi a carico dei dei genitori
- dell'uno o dell'altro
- e che quindi non garantiscono quella serenità, quel senso
di sicurezza e protezione che sono invece molto importanti perché un bambino sviluppi
quella che
si chiama basic trust, che servirà poi ad andare incontro alla vita e alle relazioni
con gli altri in modo tranquillo, aperto e fiducioso.
Il soggetto può non accorgersi di questo, perchè tutte queste situazioni possono più
o meno andare in contro a fenomeni di rimozione, di dimenticanza
e possono
quindi
semplicemente
lavorare dall'interno, in modo sotterraneo,
fino a che poi non si "presenteranno i conti" al soggetto,
perché questa situazione viene a galla, in modo
talvolta anche esplosivo,
ma per effetto di qualche cosa nell'ambiente del soggetto che in età adulta contribuisce

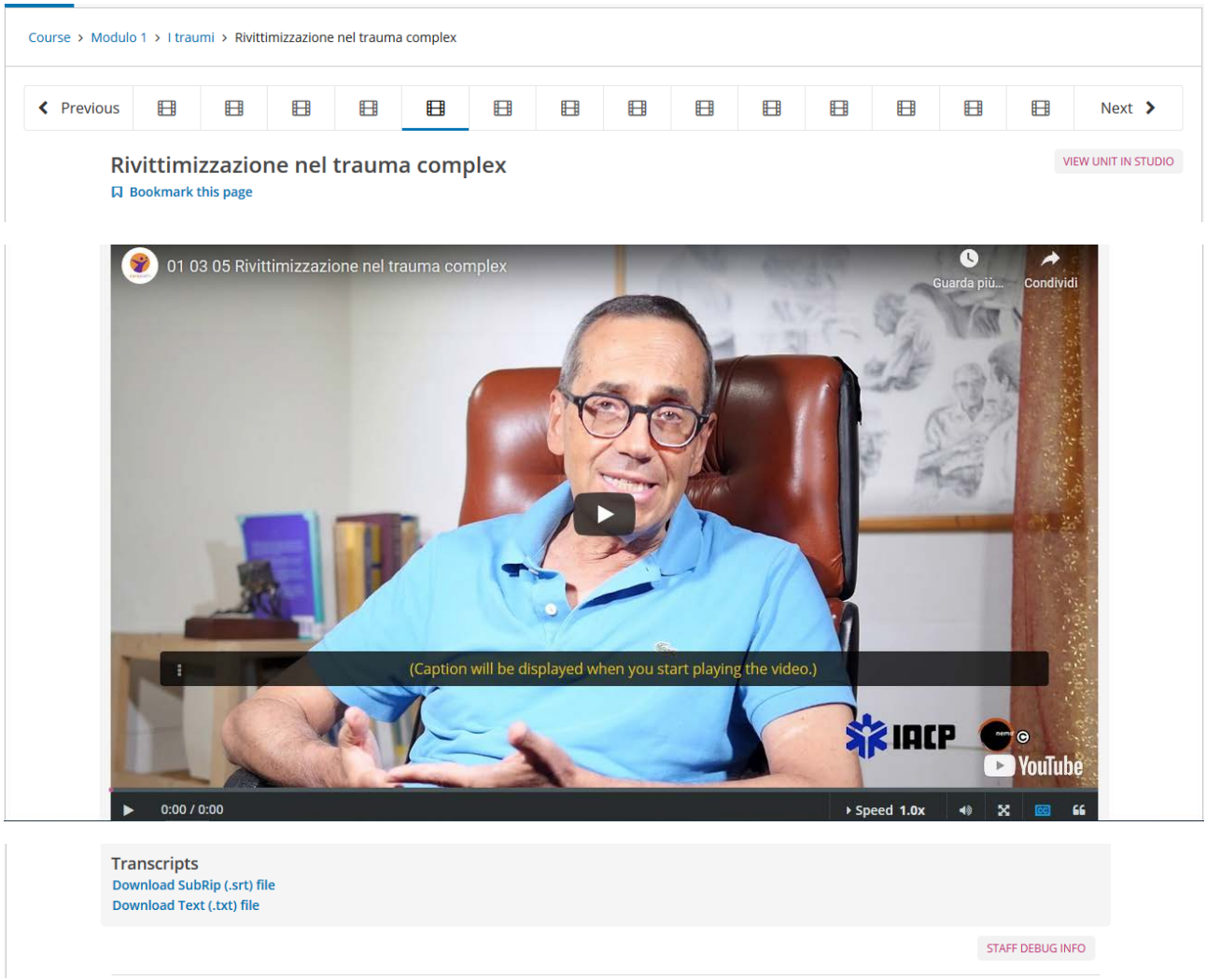
a destrutturarne il clima emotivo

e contribuendo al malessere del soggetto riaprendo così

lo scenario del trauma passato.

Questo perché, come si diceva precedentemente, il trauma attuale può attrarre a sé e richiamare

il trauma passato, come una sorta di attrazione fatale.



Transcript

Quali sono le manifestazioni cliniche del trauma complesso? Si è visto che il trauma complesso porta ad una serie di conseguenze

psicopatologiche che vanno ben oltre il semplice,

per modo di dire, disturbo post traumatico da stress.

Si tratta di conseguenze evolutive che maturano nel tempo e, proprio perchè hanno questa lunga gestazione diversamente dal disturbo postraumatico da stress, si aprono in un arco

di possibilità

patologiche molto più ampio.

A cominciare dai disturbi

della regolazione affettiva,

della emotività,

del comportamento.

Questo significa che spesso queste persone,

che sono state soggette ad un trauma complesso,
sviluppano una impulsività che non è soltanto
di carattere, ma da disturbo, un disturbo che controlla gli impulsi. Si può verificare
e si può
attualizzare in comportamenti di tipo violento, verso gli altri e verso se stessi,
in comportamenti di uso di sostanze
in modo impulsivo e quindi di tipo tossicomanico
o alcolismo.
Un altro ambito molto importante
è quello della regolazione affettiva nel senso
dell'autostima, della possibilità che una persona stabilisca
una fiducia di base
in sé stessa
e quindi anche i possibili sensi di colpa che, in modo
più o meno latente, una persona si porta dietro fin dall'infanzia. Teniamo presente
che un bambino sottoposto ad un abuso, ad esempio sessuale, spesso si sente in colpa
per aver fatto qualche cosa di sporco e non riuscirà, quindi, ad attribuire in modo corretto
la responsabilità di quanto accaduto all'adulto, che invece perpetra l'abuso.
Questi sensi di colpa si possono sviluppare, portare avanti e dare
origine ad una vulnerabilità
di tipo depressivo. La depressione maggiore può essere in età adulta uno degli esiti
di un trauma complesso.
Altri esiti molto importanti sono i disturbi
psicosomatici, infatti le conseguenza di un trauma possono esserci anche sul piano fisico,
ad esempio sulla reattività fisiologica, la iper reattività fisiologica, sul piano
del sistema cardiovascolare (ad esempio fenomeni di tipo cardiotonico, ipertensivo), problemi
della regolazione del dolore e della sua soglia (ad esempio dolori
diffusi in varie parti del corpo),
ipersensibilità agli stimoli dolorosi
e poi ancora i vari disturbi sessuali
che,
dal punto di vista psicosomatico, si vanno poi a collegare a disturbi del controllo

degli impulsi dando così origine a delle vere e proprie forme di perversione e quindi
problemi di discontrollo degli impulsi sessuali.
In ultimo si segnalano i disturbi dissociativi,
per esempio la depersonalizzazione, la derealizzazione i quali sono fenomeni che oggi si riconoscono
con una certa difficoltà intuitiva, ma che si manifestano con un senso di estraneità
che il soggetto prova di fronte alla realtà
e a se stesso.
Questi sono meccanismi di difesa
nei confronti di una realtà che il soggetto sente come, in qualche modo, intollerabile,
che non può sentirsi rivivere addosso
e quindi la dissociazione significa prendere le distanze dalla realtà.
Freud aveva messo in evidenza
questo meccanismo
fondamentale della coazione a ripetere per la quale un soggetto cerca di reincontrare il trauma
non tanto per
subirne ancora
gli effetti negativi, ma quanto per cercare di superarlo.
Questo cercare di superare il trauma significa che alcuni comportamenti
del soggetto
lo possono riportare a rivivere delle situazioni: la situazione classica è quella del bambino,
della vittima rispetto ad un carnefice, che può essere riproposta in età adulta
a ruoli
uguali oppure a ruoli opposti.
L'adulto può cercare di
rivittimizzarsi, cioè creare
delle situazioni in cui si troverà a vivere come vittima
le conseguenze
delle azioni di
altre persone, oppure potrà metter in atto dei comportamenti per i quali egli stesso
si pone come carnefice nei confronti di una vittima.
Questo potrebbe accadere, ad esempio,
in situazioni di violenza sessuale subita da bambino e che magari può diventare in

età più avanzata - in adolescenza o in età adulta -

una situazione che si ripropone,

ad esempio in uno stupro,

una violenza sessuale

nei confronti di una donna

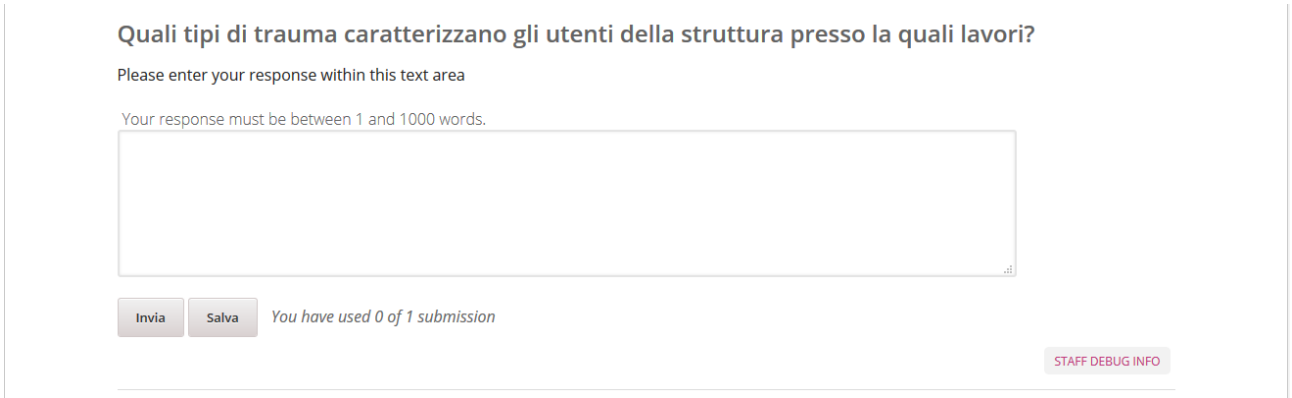
che può essere

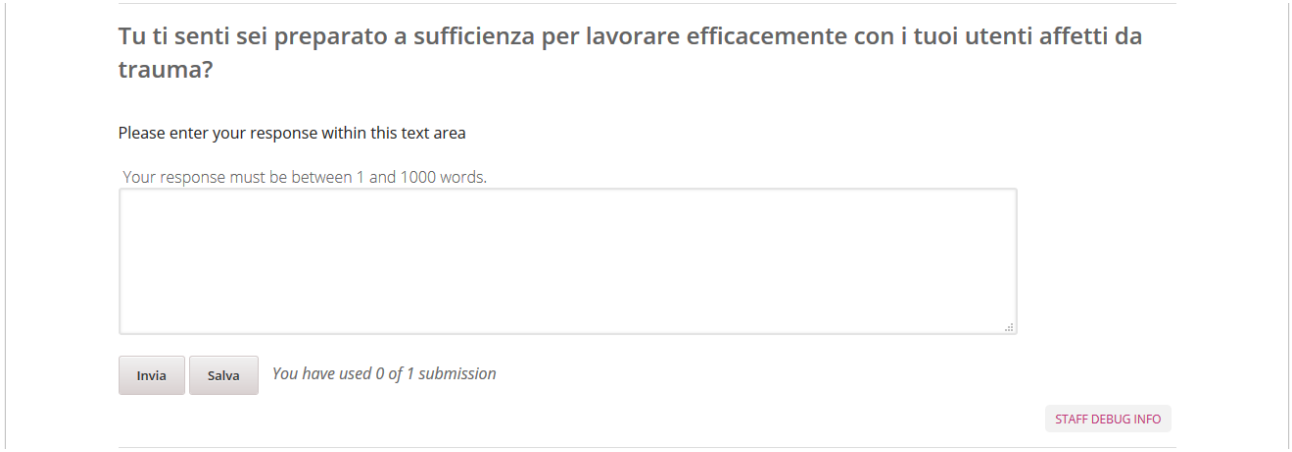
vissuta in prima persona come carnefice oppure riproporsi come vittima,

creando una situazione

in cui in ogni - in ruoli anche contrapposti - il trauma viene rivissuto per cercare di

superarlo in quello che Freud ha chiamato coazione a ripetere.





Quale ruolo espleti nella struttura in cui lavori?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Desideresti ricevere ulteriore formazione e aggiornamento professionale sul trattamento del trauma e su quali tematiche specificatamente?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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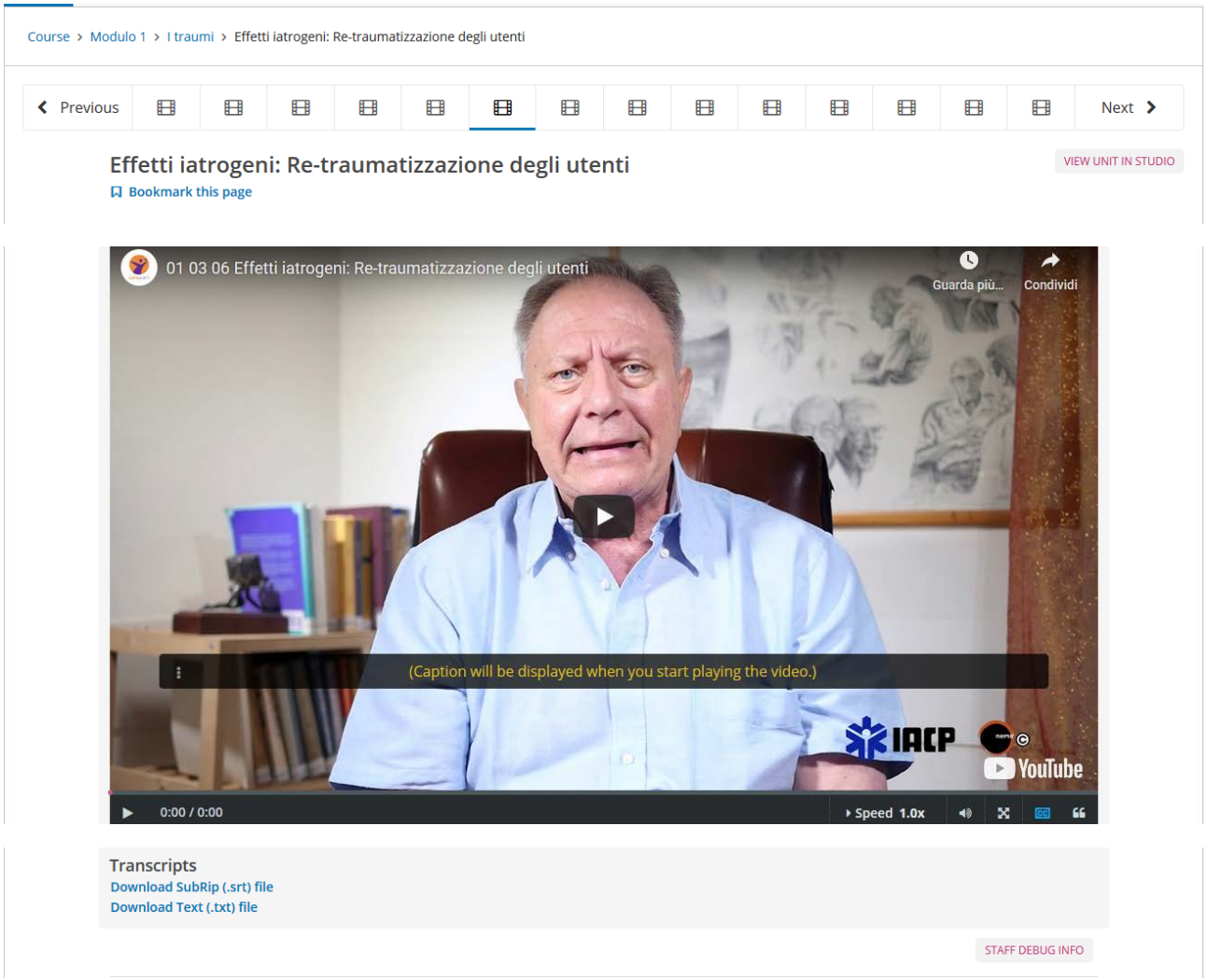

Transcript

La

re-traumatizzazione

è un evento infausto

che vede una persona che già ha sofferto un trauma

avere una ricaduta,

questo principalmente per due motivi.

Uno perchè

per cause naturali

la persona in precedenza

traumatizzata

si trova esposta

a immagini o accadimenti

dove altre persone sono vittime di trauma e questo

fa rivivere al soggetto

il trauma precedentemente esperito.

L'altro

è

invece

un tipo di re-traumatizzazione

che

ha

origine iatrogene

e cioè

sono le cure

che vengono erogate in maniera

disfunzionale,

magari

non per cattiva intenzione degli operatori

ma per semplice ignoranza,

che la persona traumatizzata

invece di essere aiutata dalle

attenzioni e cure che riceve

ne viene

ulteriormente

traumatizzata.

Insomma,

sarebbe come

una

persona

che

arriva ad un pronto soccorso

con una gamba rotta

e i medici la gestiscono malamente per cui

fanno cadere dalla

barella il paziente che si ritrova con due gambe rotte, raddoppiando così il danno;

una vera propria tragedia.
La storia e la sociologia
dei trattamenti
del trauma
ci rivelano che, purtroppo,
non è stato affatto infrequente nel passato -
ovviamente per cattiva volontà, ma per ignoranza -
commettere
tali danni,
con risultati iatrogeni.
Tutto il mondo delle cure,
perché impattano un sistema complessa e delicato come un essere umano,
rischia non solo di impattarlo a fin di bene, ma - anche non volendo - danneggiando
ulteriormente; è vero per i farmaci, è vero per gli interventi chirurgici, è vero per
qualsiasi tipo di relazione di aiuto, se non
erogata in maniera efficace,
diventa
controproducente.
Nella specificità del trauma questo è particolarmente grave perché una persona traumatizzata
è particolarmente
sensibile e
può essere notevolmente danneggiata con una seconda traumatizzazione,
per questo noi oggi
abbiamo appreso dagli errori, le ricerche sono diventate più numerose
e abbiamo
una
vasta conoscenza - che ovviamente progredirà sempre anche in futuro - grazie
alla quale sono state elaborate delle precauzioni per non far correre il rischio alle persone
già traumatizzate di essere traumatizzate nuovamente.
Queste precauzioni sono dette procedure
trauma inform,
centrate sulla persona dell'utente traumatizzato

e che

hanno l’attenzione provocare altri danni.

Puoi non fare questo esercizio se non lavori nel campo dell’offerta di servizi a minori affetti da trauma.

STAFF DEBUG INFO

Nella tua nazione quanto al presente è alto il pericolo di ritraumatizzazione degli utenti?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

nel tuo luogo di lavoro è presente il pericolo di ritraumatizzazione degli utenti?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Da quali variabili scaturisce il rischio di ritraumatizzazione degli utenti?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Tu personalmente pensi di aver ricevuto sufficiente preparazione professionale sul proteggere i tuoi utenti da una ritraumatizzazione conseguente il tuo operato?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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Desideri maggiore formazione e aggiornamento in questo aspetto preventivo?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

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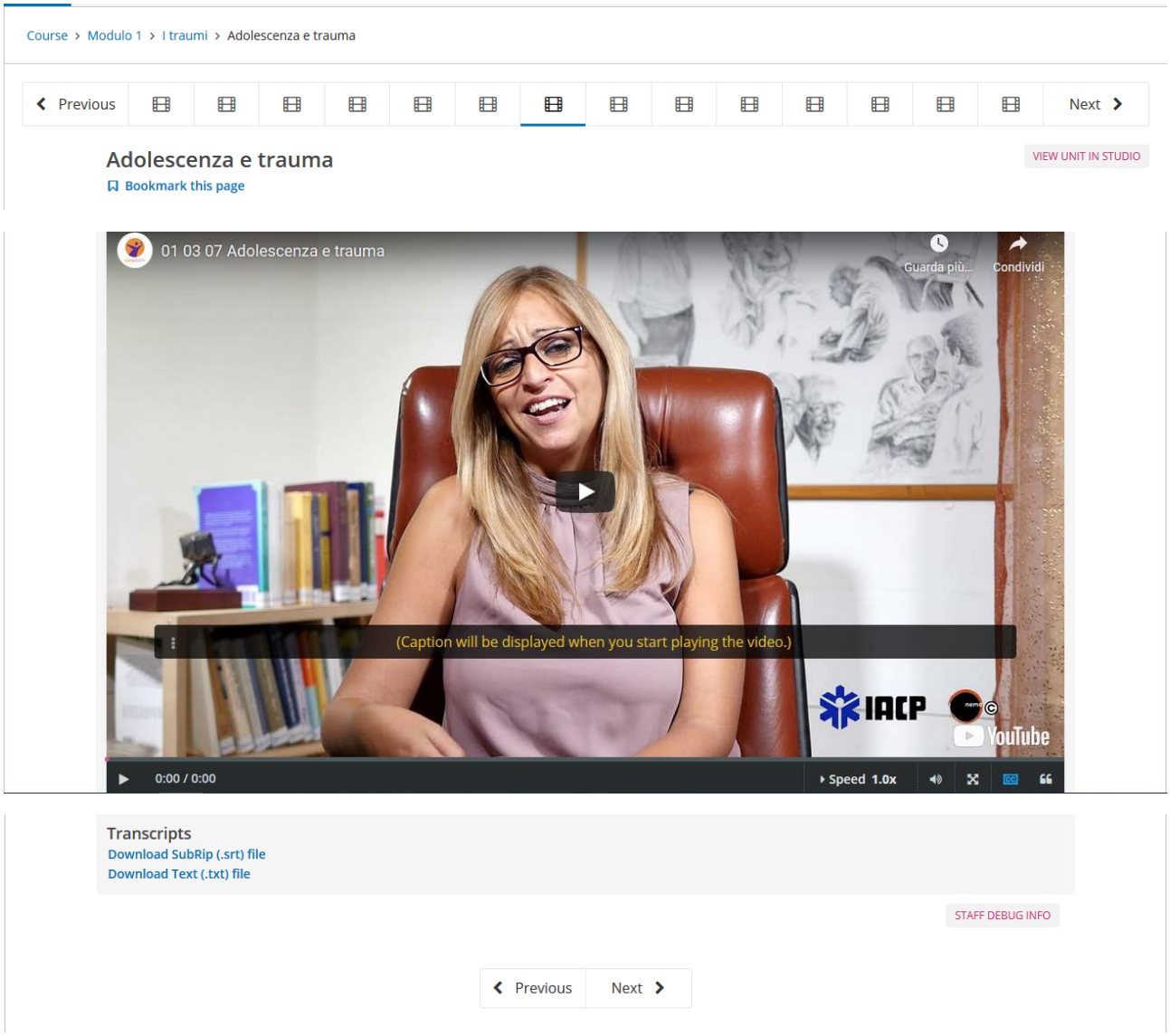
Previous Next



Transcript

L'adolescenza è un periodo del nostro ciclo vitale che, per le sue caratteristiche evolutive, rappresenta un periodo di aumentata vulnerabilità in quanto espone ogni individuo ad importanti esperienze di cambiamento bio-psico-sociali che possono essere vissute con disagio, sofferenza e tutti i malesseri che possono accentuarsi se l'individuo è esposto ad esperienze traumatiche perpetuate soprattutto dalle figure criterio.

Se infatti, come illustrato da Rogers, il bambino cresce in un ambiente facilitato, questo gli permetterà di non replicare il proprio sentire, ne di bloccarlo o congelare le esperienze drammatiche, ma di muoversi nella realtà soddisfando i propri bisogni e valutando le esperienze come piacevoli o spiacevoli a seconda che siano favorevoli o sfavorevoli al proprio sviluppo, avendo innata in sé quella tendenza, che Rogers chiama tendenza attualizzante, che è la capacità di autocomprendersi, autoregolarsi e autorealizzarsi.

Se invece il bambino vive in un ambiente in cui sente che l'apprezzamento dei captive dipende solamente da quanto è egli in grado di aderire alle aspettative, questo gli può comportare di amputare per forza una parte del proprio sé e di quindi di rapportarsi alla realtà costruendosi dei costrutti rigidi, costrutti che saranno ancora più rigidi se costruiti su un senso costante di ambiguità, minacce e paura, se il bambino cresce in un ambiente pulsante.

É proprio in questo nucleo profondo di straniamento tra il proprio percepire, esperire, simbolizzare ed agire che si crea e rafforza quel senso di estraniamento da sè che poi è alla base dell'eziopatogenesi.

Vediamo quindi che il nostro adolescente, che è cresciuto e si è nutrito nel suo contesto relazione, si trova poi esposto ai cambiamenti evolutivi a cui si accennava prima e tutti questi cambiamenti gli determinanti richiedono una sorta di rimodernizzazione interna, di risintonizzazione che coinvolge l'individuo stesso e le sue relazioni più importanti e che gli richiedono di ritrovare un equilibrio che sia sia flessibile, che dinamico rispetto alle esperienze che si vive, ma anche costante rispetto al senso di identità che si è costruito fino a quel momento e tutto questo richiede, quindi, una ridefinizione del proprio concetto di sé.

Vediamo quali sono questi cambiamenti a cui va incontro l'adolescente.

Il primo tra tutti riguardano sicuramente il corpo: il corpo dell'adolescente è un corpo in evoluzione, con la crescita ponderale, la comparsa degli organi sessuali secondari, degli organi riproduttivi e quindi un corpo che richiede una nuova qualità della relazione con esso, un corpo che l'adolescente utilizza come veicolo primario e intermediario per comunicare all'esterno i propri vissuti.

Un corpo, quindi, che sceglie di curare, di abbellire, ma anche di scalfire, di tagliare, di dimenticare; un corpo che sceglie per far parlare di sé.

Allo stesso tempo è un corpo che viene visto dall'esterno, che cattura lo sguardo degli altri, con desiderio o derisione e quindi espone l'adolescente a nuove esperienze, nuove opportunità, ma anche a nuovi rischi.

Ci sono poi dei cambiamenti a livello interpersonale.

In famiglia gli viene richiesto il passaggio dalla dipendenza - fase di accudimento e attaccamento - all'autonomia e alla ricerca di equilibrio tra queste due spinte evolutive apparentemente opposte che hanno una ripercussione sul piano sociale, infatti nell'ambiente esterno cambia il ruolo che il ragazzo ha nel gruppo dei pari con altre figure significative.

Inoltre ci sono dei cambiamenti al livello del cervello, come hanno dimostrato tutte le ultime ricerche.

Il cervello a incontro ad una nuova modificazione, sia strutturale, che funzionale, soprattutto in quelle aree corticali che sono adibite ai processi decisionali.

Tutto questo determina una grande vulnerabilità che, come detto prima, viene ancora di più minata se il soggetto vive delle esperienze traumatiche che vanno a ledere o compromettere quel senso di sicurezza interna, la base sicura di Bolby, che il luogo nostro affettivo di sicurezze in cui i bisogni possono essere sentiti, nominati, appagati, a cui non possiamo fare sempre ritorno e che quindi ci permette di fare quella preziosissima esperienza di crescente autonomia senza però perdere l'amore, ma anzi arricchendosi dagli incontri che facciamo con le altre persone.

La persona che, invece, ha subito un trauma ha bassa capacità di mentalizzazione e non è in grado di autoregolare i propri stati affettivi, non può far altro - come ci dice Bromberg - di isolare quella che è l'esperienza traumatica, tutti i vissuti e contenuti ad essa associati, dissociandosi; la dissociazione patologica - come illustra Caretti- porta ad un impoverimento del soggetto e delle sue risorse perché gli impedisce di ricostruire quelle esperienza traumatiche in una narrazione coerente con la propria storia di vita.

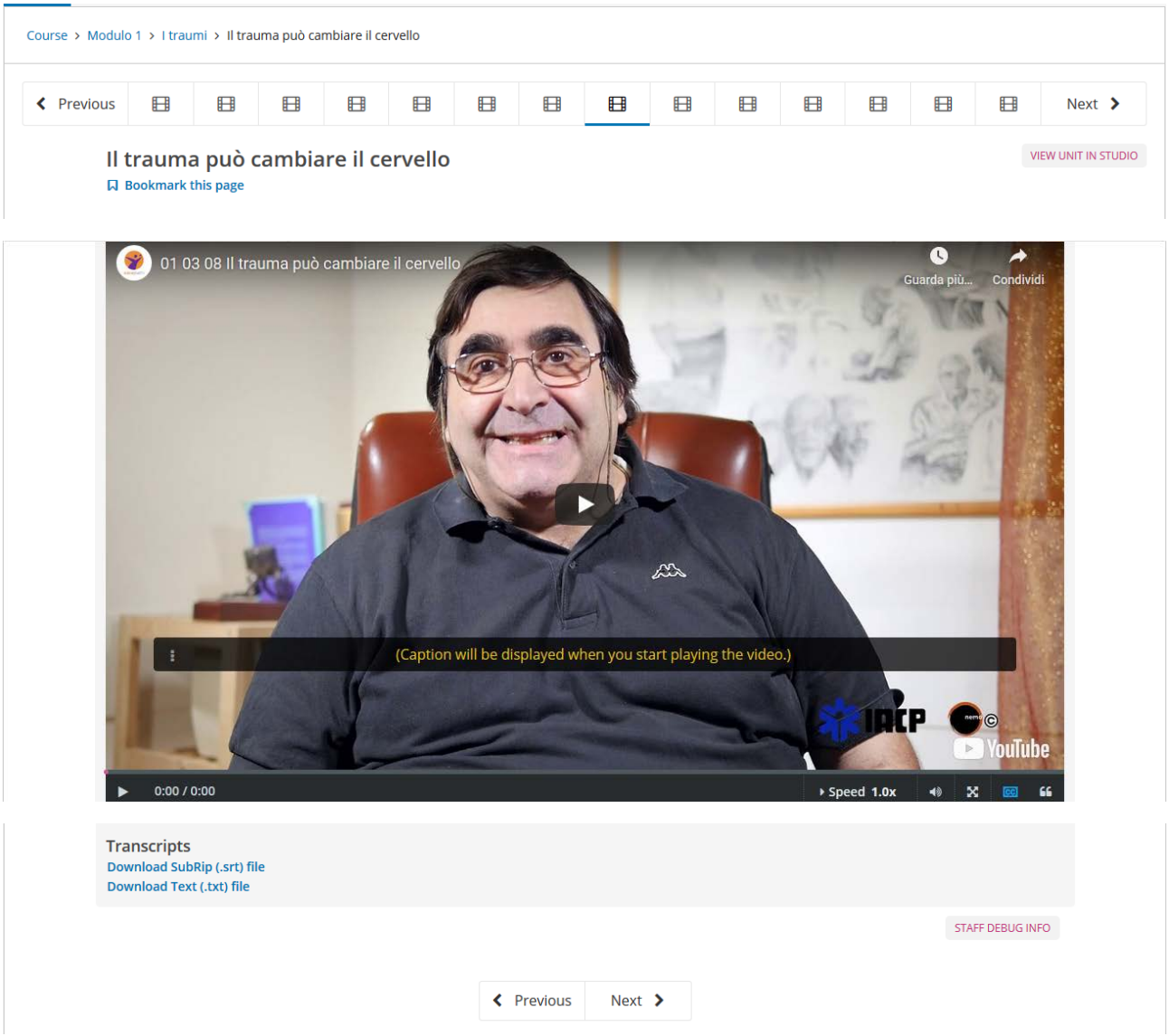
Proprio per questo che

se lavoriamo ad un contatto con ragazzi adolescenti che hanno

un falso di stress emotivo quello che possiamo offrire è lavorare con loro ad una profondità relazionale importante, offrendo loro delle relazioni che siano profonde, basate sull'ascolto, sull'ascolto empatico, sul rispetto profondo di chi sono i ragazzi, sul cercare di capire le esperienze da loro punto di vista cercando di cogliere i significati che loro danno a ciò che vivono e, quindi, offrire dei contesti relazionali in cui il ragazzo può, piano piano, può ricontattare quelle parti di sé, quei bisogni fino a quel momento negati non solo permettendogli di risentirli, ma anche di risintonizzare delle parti di sé, delle esperienze esterne che lui vive fino a quel momento come eccessivamente dissonanti.

Questo è possibile offrendo loro anche dei contesti relazionali nei quali abbiamo verso

di loro uno sguardo diverso, non solo uno sguardo che ci porta ad etichettarli come ragazzi in perenne rivoluzione e lotta col mondo esterno, o come figure apatiche risvegliate solamente dal mondo dei social network, ma di vederli come dei ragazzi con delle caratteristiche, degli strumenti tipici delle loro fasi evolutive, che si muovono curiosi nel mondo, si fanno domande, si danno risposte, esplorano, cercano di dare un senso soggettivo alle loro esperienze, così come poi noi continuiamo a fare da adulti per tutto il resto della nostra vita e quindi avere sempre verso di loro uno sguardo che fa il tifo per loro.



Transcript

Verranno trattati i cambiamenti neurologici che avvengono quando si verifica un trauma,

in qualsiasi persona, ma principalmente negli adolescenti e negli adulti;

negli adolescenti

sono chiaramente più evidenti che rispetto agli adulti.

Lo studio è ripreso da situazioni neurologiche, da ricerche internazionali neurologiche

e

dal lavoro fatto dal Dott.

Petrini e dalla Dott.ssa Mandese della tecnica-processo psicoanalitico mutativo:

una tecnica che ha

una parte psicanalitica e una parte neurologica, completamente in

accordo

con quelle che sono
le ricerche neurologiche internazionali e il rapporto tra neurologia e psicanalisi.
É risaputo che ogni individuo in una situazione di benessere
sviluppa quotidianamente 1400 nuovi neuroni
dalle cellule staminali estrocitaria
sia a livello dell'ippocampo
che al livello olfattivo.
Questo è un aspetto molto importante perchè l'ippocampo è la parte centrale della memoria
del nostro organismo
che viene rievocata in situazioni simili, quindi in situazioni di trauma;
mentre a livello
olfattivo
osserviamo i nostri lobi cerebrali
non sono altro che
un'estroflessione del nostro lobo olfattivo.
Gli animali funzionano con l'olfatto,
noi funzioniamo col pensiero,
quindi il pensiero, nell'uomo,
non è altro che l'olfatto
che si è allargato si è sviluppato in queste
cellule cerebrali.
Pensiamo che l'essere umano ha circa 30.000 geni, troppo pochi per definire tutte le situazioni,
quindi entrano in gioco situazioni familiari, sentimentali, relazionali, culturali e religiose.
afferma che solamente il 70% dei geni è determinato geneticamente
e solo il 30% viene gestito da quelli che sono i fattori esterni.
La differenza di geni
tra un'uomo meschina e un bonobo maschio è del 5%,
tuttavia questa
percentuale è molto rilevante, mettere sullo stesso livello un'uomo e un bonobo non è
equiparabile, a tutti i livelli, da quello sentimentale a quello lavorativo.
Ne risulta che la cultura, la religione, tutte le situazioni esterne, la famiglia, la comunità
in cui si vive sono molto importanti per la formazione di un individuo.

Cosa succede
quando avviene uno stress?
Una situazione stressante, o neglettante (il neglect come si è visto è come uno stress)
non fa altro che bloccare l'attività delle cellule staminali al livello dell'ippocampo
e quindi diviene impossibile sostituire neuroni che normalmente si perdono;
quindi
c'è una perdita neuroni le
nel punto più importante e profondo del cervello che è l'ippocampo.
La regolazione emotivo-cognitiva che accompagna e sostiene queste modifiche
cerebrali
è caratterizzata
da ansie e depressioni
legate
all'amigdala:
un corpicino di piccole dimensioni all'interno del cervello
che sostiene tutte le nostre situazioni emotivo-affettive,
dall'amore, alla sessualità, al mangiare,
a tutto ciò che è importante dal punto di vista affettivo.
Avviene un'alterazione nelle cortecce prefrontali, le quali sono quelle indirizzano i nostri obiettivi:
se decido di andare a teatro a vedere un attore è la corteccia prefrontale
che mi spinge a compiere tale azione, poi la frontale la realizza, ma la corteccia prefrontale
è anche quella degli impulsi, ad esempio quando ho l'impulso di andarmene o di rimanere
in una luogo lo devo alla corteccia prefrontale che la frontale poi reagisce e che comunica
la necessità di rimanere, ad esempio, a causa di un impegno.
Il terzo punto che viene danneggiato è, naturalmente,
l'ippocampo nelle memoria (come abbiamo
già detto la sede della memoria è l'ippocampo).
Studi
longitudinali hanno evidenziato che i traumi non si esprimono attraverso un disturbo
del DSM -5 o del ICD - 10 che si chiama post traumatico da stress,
ma si trasmette
- con i sintomi di ansia e depressione,

a volte situazioni di allucinazione, ma si evidenzia
attraverso modificazioni del senso del sé delle relazioni interpersonali.
Una persona che ha subito un trauma
ha delle limitazioni comportamentali e limitazioni mentali,
cioè la persona sembra non in grado
di esprimersi
nel mondo del lavoro,
degli affetti,
delle relazioni, delle attività,
è come se fosse caduta ad un livello di funzionamento
più basso.
Questo è dovuto al sistema HPA il sistema ippocampale ipofisario e adrenocorticale.
Al livello del cervello si trova una ghiandola che si chiama
ipofisi
dalla quale si irradiano
tutti gli ormoni del nostro organismo.
Il collegamento tra la parte endocrinologica-ormonale
e la parte nervosa
è dato dall'asse
ipotalamo-
ipofisi,
tutto ciò che arriva all'ipotalamo - una zona di centrale importanza, quasi un cervello
più piccolo rispetto la corteccia cerebrale
- viene trasmessa all'ipofisi e da luogo
a delle sensazioni ormai, cioè il segnale nervoso viene trasmesso con sostanze ormonali.
Queste sostanze ormonali
si diramano in tutto l'organismo,
dall'ipofisi,
e controllano
la tiroide,
la sessualità per mezzo delle ghiandole genitali, la sessualità maschile
e femminile con l'ormone maschile (che comunque determina anche la sessualità femminile)

e poi, specialmente,

il rilascio di corticotropina: l'ormone dello stress, o meglio il pre-ormone

dello stress in quanto il vero ormone dello stress è l'ACTH, il cortisolo,

motivo per il quale si somministra cortisone per aiutare l'organismo a reagire quando ci sono malfunzionamenti

fisici, il cortisolo infatti ha gli stessi elementi del cortine.

Anche nel caso di battaglie e guerre l'organismo umano è preparato, infatti il cortisolo - l'ACTH

per la precisione - non fa sentire il dolore,

da luogo a meccanismi di aggressività (come avviene nell'animale)

e questa situazione è una situazione chiaramente di aggressività.

Quando questo meccanismo di attività

viene ripetuto

diventa cronico e si presentano stati di ansia e angoscia

protratti

che dipendono dall'amigdala prima citata.

L'amigdala

è il "comò"

della nostra memoria emotiva, nel senso che conserva tutte

le nostre memorie emotive, come fosse una macchina fotografica della realtà emotiva,

quindi, per esempio, il primo bacio, il primo lavoro, la prima sensazione di benessere,

la prima vittoria in uno sport, sono tutte fotografate nell'amigdala e riemergono quando

si presentano situazioni analoghe; nel momento in cui l'ippocampo

inizia

a secernere cortisolo,

questo si lega con tutti i recettori dell'ippocampo, dell'amigdala e della zona prefrontale

e quando è arrivato ad un livello sufficiente, se la situazione non è cronica,

abbassa il livello ACTH e di CRF (-).

In questo modo l'ippocampo regola le risposte

allo stress.

Quando

invece noi stiamo bene la serotonina gestisce l'area, la serotonina è l'ormone

della felicità, vero è infatti che quando un soggetto è in un momento di depressione

vengono prescritti farmaci serotoninergici.

La serotonina

inibisce comportamenti aggressivi e promuove la socializzazione.

Viene prodotta a partire del triptofano e viene introdotta nella dieta.

La serotonina, insieme all'ossitocina che è l'ormone del legame, è l'ormone più positivo

e utile per l'organismo, nel senso che mentre la serotonina stimola socialità

e relazione con gli altri,

l'ossitocina - liberata dopo 5 secondi di abbraccio con un'altra persona

- è l'ormone

che stimola il legame.

La ricerca sta mettendo in evidenza che attività amate,

pensieri e sentimenti importanti hanno

profondi effetti terapeutici sul nostro corpo,

quindi

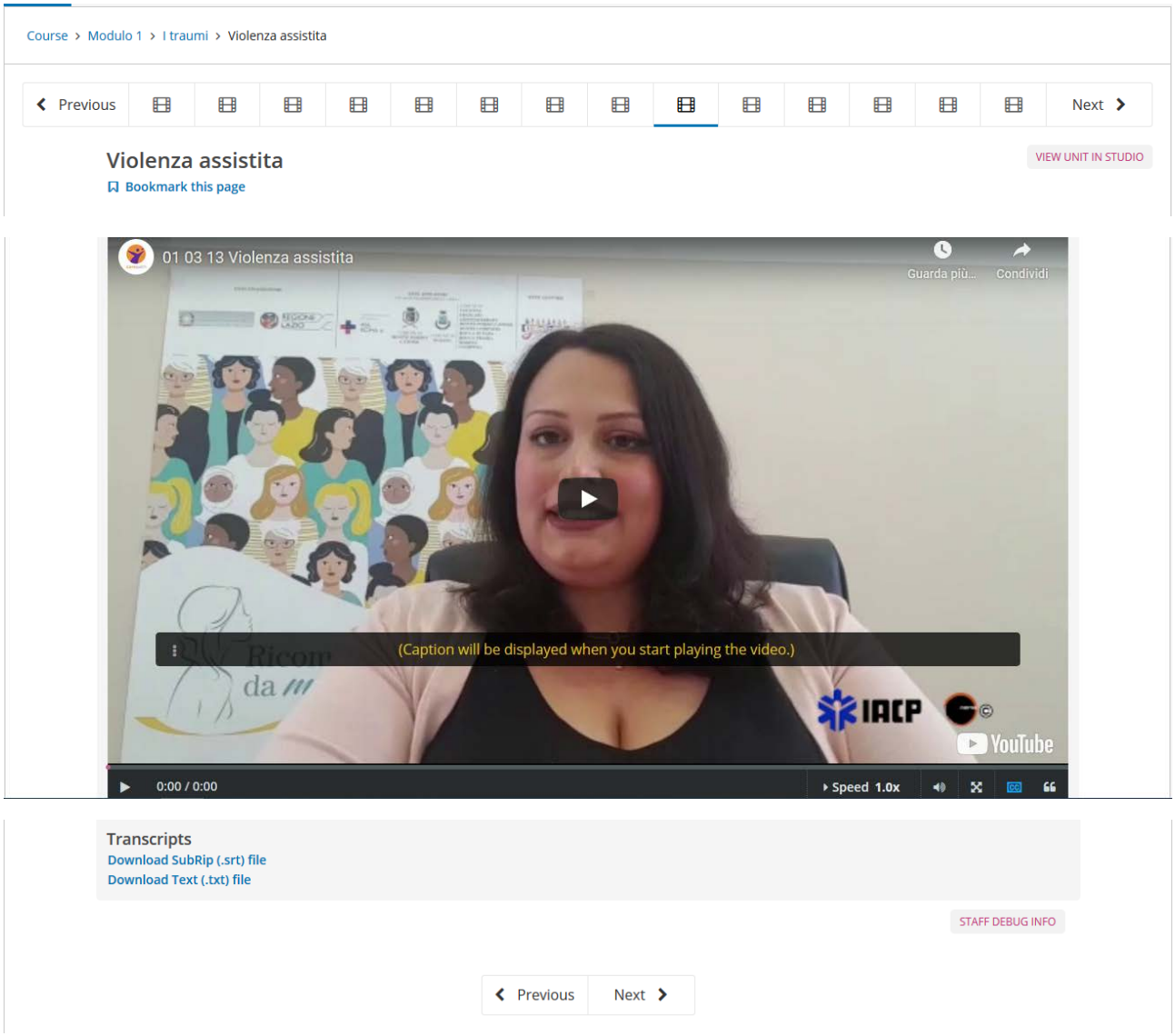
indubbiamente esiste,

nel nostro modo

di essere, una serie di reazioni che vanno a modificare il cervello e che spingono a

modificare il corpo, in qualsiasi situazione sono presenti ormoni legati ai neurormoni

e legati agli stimoli nervosi.



Transcript

Per parlare di minori

vittime di violenza assistente occorre definire cos'è la violenza

assistita nell'ambito familiare.

Ci si riferisce a violenza assistita quando un minore fa esperienza di qualsiasi forma

di maltrattamento

compiuta attraverso atti di violenza fisica, verbale, psicologica,

sessuale ed economica su figure di riferimento o su altre figure affettivamente significative,

adulte o minori.

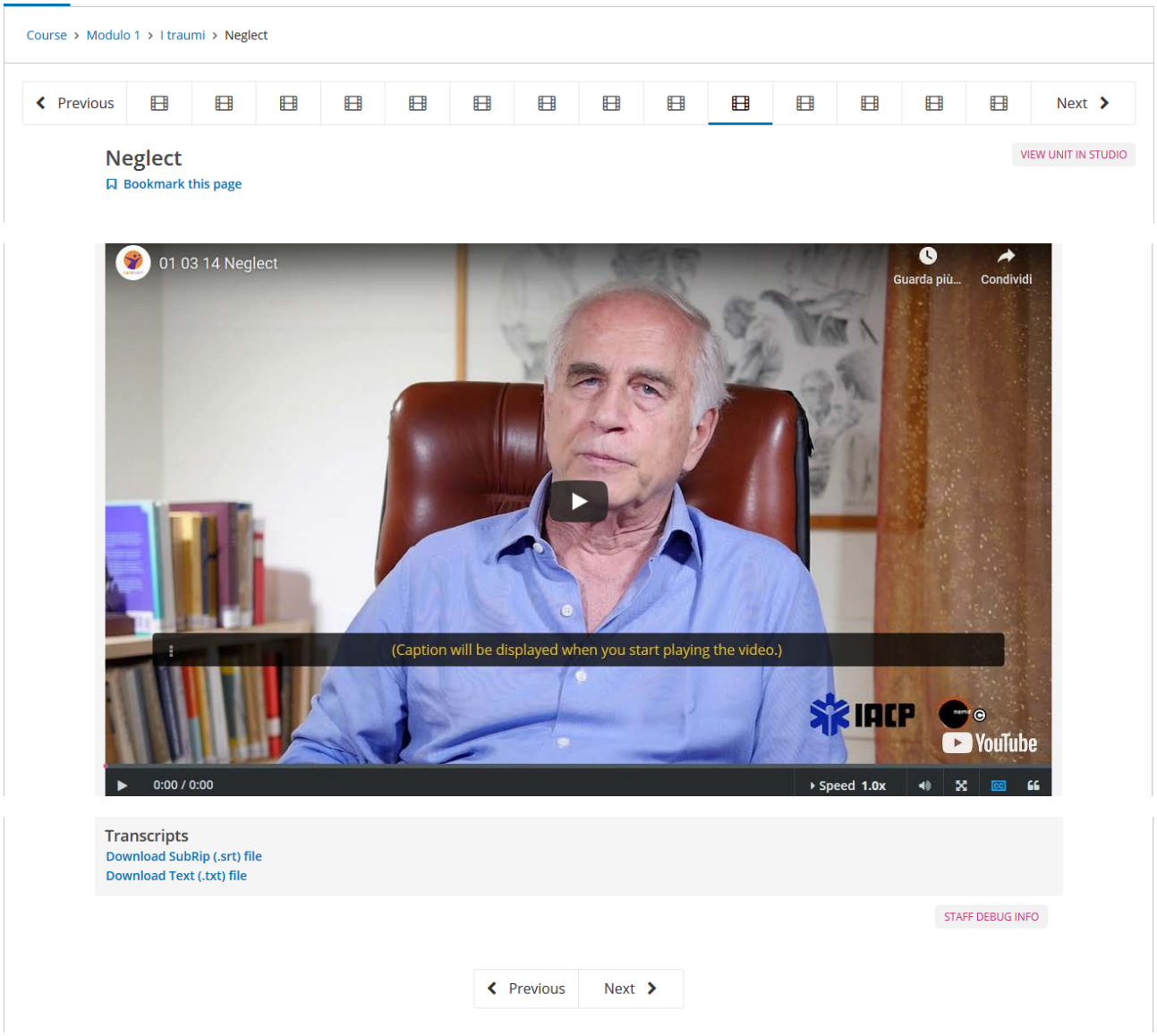
SI includono in questo tipo di violenze anche quelle messe in atto da minori su altri minori,

ma anche da parte di altri membri della famiglia ad esempio su animali domestici; sono

esperienze altamente traumatizzanti per i minori.

Le caratteristiche di queste esperienze possono essere diverse.
La violenza può essere indiretta: la violenza è percepita all'interno del proprio campo percettivo,
quindi non si tratta solo di vedere la violenza, ma anche solamente sentirla.
È opportuno sottolineare ciò perchè molte donne vittime di violenza riportano che i bambini,
quando venivano picchiate, erano in un'altra stanza; in realtà anche in questi
casi si tratta di una forma di violenza diretta nel caso in cui il bambino sentisse.
L'esperienza può essere indiretta
quando il minore è a conoscenza che la violenza
è avvenuta o che sta per avvenire; in questo senso i bambini hanno come delle "antenne":
capiscono quando c'è una tensione in casa tipica
che precede l'episodio di violenza in se.
L'esperienza può altre volte essere non percepita in modo diretto o indiretto,
ma il minore ne può percepire gli effetti;
ad esempio vedere la madre con dei lividi,
o stare a sentire questa aria di violenza nella casa, ebbene in questi casi si tratta di violenza assistita.
Ci sono alcune false credenze sulla violenza assistita.
Il bambino
non è impermeabile rispetto alla violenza che intercorre all'interno della propria famiglia,
anche se l'atto violento non è agito in sua presenza può coglierne l'attuazione,
questo perchè il bambino non è mai spettatore passivo e inconsapevole.
La violenza assistita aumenta il rischio di violenza diretta sui minori; semplicemente
il minore che cerca di difenderà la madre, mettendosi in mezzo, può essere colpito
daparte del padre: in questo caso
la dott.sa Annibali utilizza un'ottica di genere per
parlare di violenza assistita, in quanto nella maggioranza dei casi la violenza è attuata
da parte dell'uomo verso della donna;
non si esclude che la violenza possa essere perpetrata
da parte della madre nei confronti del padre, o comunque da una persona femminile rispetto
ad una maschile, ma statisticamente è un dato meno significativo.
I bambini esposti alla violenza sono cinque a volte più a rischio, rispetto ai bambini
non testimoni di violenza, di diventare violenti in età adulta.
Gli effetti della violenza assistita sono:

un sentimento di paura, ansia, consunzione, tristezza,
vera e propria depressione, sensi di rabbia, colpa, inadeguatezza e vergogna.
I bambini perdono fiducia in sé stessi e negli altri,
possono avere disturbi psicosomatici,
del controllo degli impulsi, difficoltà scolastiche, disturbi dell'apprendimento,
del linguaggio,
del controllo degli sfinteri, difficoltà relazionale e possono sviluppare anche un
disturbo post-traumatico da stress complesso in quanto tale esperienza traumatica si è
sviluppata all'interno di una relazione di fiducia, come quella familiare.
Al livello bio-psico-sociale
gli effetti della violenza assistita si ripercuotono nel comportamento,
nelle emozioni, nella cognizione, nell'area fisica del bambino, ma anche nelle relazioni.
Ciò che si trova a vivere il bambino è un mondo in completo subbuglio,
la violenza diviene la normalità
e per conseguenza la normalità la violenza;
è questo quello che il bambino nella propria normalità:
riconoscerà come normale e fisiologico un comportamento violenti
o, sminuendo in tal senso la propria esperienza drammatica e, probabilmente, reiterando questi
comportamenti.
Occorre sempre di più focalizzarsi sulla violenza assistita e come questa abbia degli
effetti sui minori e sugli adulti che questi minori diventeranno.



Transcript

Il neglect è una forma di trauma

infantile e adolescenziale

che è comune ma molto poco considerata. L'attenzione

verso questo tipo di problematica traumatica molto significativa

è stata rivolta

soltanto in tempi molto recenti; si parla infatti di neglect del neglect: la trascuratezza

della trascuratezza.

Per molto tempo

questo aspetto non è stato considerato un vero proprio trauma,

al massimo una piccola parte dei traumi esistenti.

In realtà oggi si pensa a questo trauma come il più diffuso, il più comunque e quello

che da conseguenze peggiori in termini di durata nel tempo.
Da questo punto di vista il neglect indica il perpetrarsi di comportamenti di omissione
da parte di colori che dovrebbero dare cure
e queste omissioni indicano che manca un imminente
rischio grave di danno, ma una serie
di mancanze che si protraggono per un lungo periodo di tempo.
Si tratta di mancanze che possono, ad esempio, accompagnare la presenza di un trauma di tipo I,
un abuso
potrebbe essere
ben tollerato, o in maniera sufficientemente adeguata,
tuttavia
lo è molto di meno se accanto a sé non si ha un genitore capace
di comprendere
e di aiutare, sostenere e proteggere
il figlio che ha subito questo tipo di trauma.
Il neglect quindi può essere complementare al trauma di tipo I,
di per sé comunque produce dei danni.
Possiamo avere diversi tipi di neglect che possono riguardare
l'assistenza sanitaria,
l'istruzione, la supervisione del ragazzo,
la tutela rispetto ai rischi ambientali,
ai bisogni fisici, al sostegno emotivo
che viene dato soprattutto dalla famiglia o comunque
da chi si prende cura del bambino.
Questo tipo di trascuratezza
può sembrare di scarsa importanza,
ma in realtà da la
sensazione alla persona di non avere nessuna protezione da parte degli altri
e quindi di vivere un ambiente ostile non in grado di garantirgli alcun tipo di sicurezza.
Ovviamente
se si parla di diversi tipi
neglect, che sia di tipo emotivo o di tipo fisico,

ritroviamo due aspetti di completamente diversi.
In alcune situazioni l'emotività viene trascurata in quanto ci si trova di fronte
a caregivers freddi,
distaccati e poco partecipi;
il neglect fisico può riguardare invece l'aspetto
strettamente materiale,
i bisogni di base
e può essere esteso anche ai bisogni educativi
del ragazzo che può non ricevere dai genitori
quelle informazioni necessarie
per vivere in un contesto relazionale.
Esiste inoltre un medical neglect,
ovvero quando c'è un bisogno di curare le proprie patologie,
ma chi dovrebbe prendersi cura del ragazzo o del bambino
non lo fanno e per conseguenza
le patologie possono incrementarsi
e diventare particolarmente pericolose o dannose.
Il moral neglect, ovvero la mancanza di istruzioni per gli aspetti etici e morali
del comportamento etico di una persona.
Le conseguenze di questi tipi di neglect sono dei danni sulla salute pubblica che per lungo
tempo sono stati sottovalutati.
Oggi sappiamo
che l'esposizione
per lungo tempo
a neglect può comportare
non solo le patologie di cui si è già parlato, come il disturbo alimentare,
ma anche addirittura una riduzione della materia grigia della corteccia
e quindi una capacità cognitiva molto diminuita
rispetto a soggetti normali.
Questi dati ci hanno così conti o di quanto sia importante di occuparsi del neglect
e
cercare di ristabilire nel contesto familiare, e individuale,

quel tipo di cure e attenzioni

che danno sicurezza all'individuo

e danno la sensazione di essere protetto e capito.

A conclusione della panoramica sulle patologie trattate, dai disturbi alimentari al neglect,

si segnala che quest'ultimo è particolarmente diffuso in persone che svilupperanno un alimentazione incontrollata

fino alla forma avanzata di perdita completa del controllo.

È necessario pensare ad un rapporto terapeutico in cui si presti particolare attenzione

alla persona e si dimostri di avere interesse verso di lei,

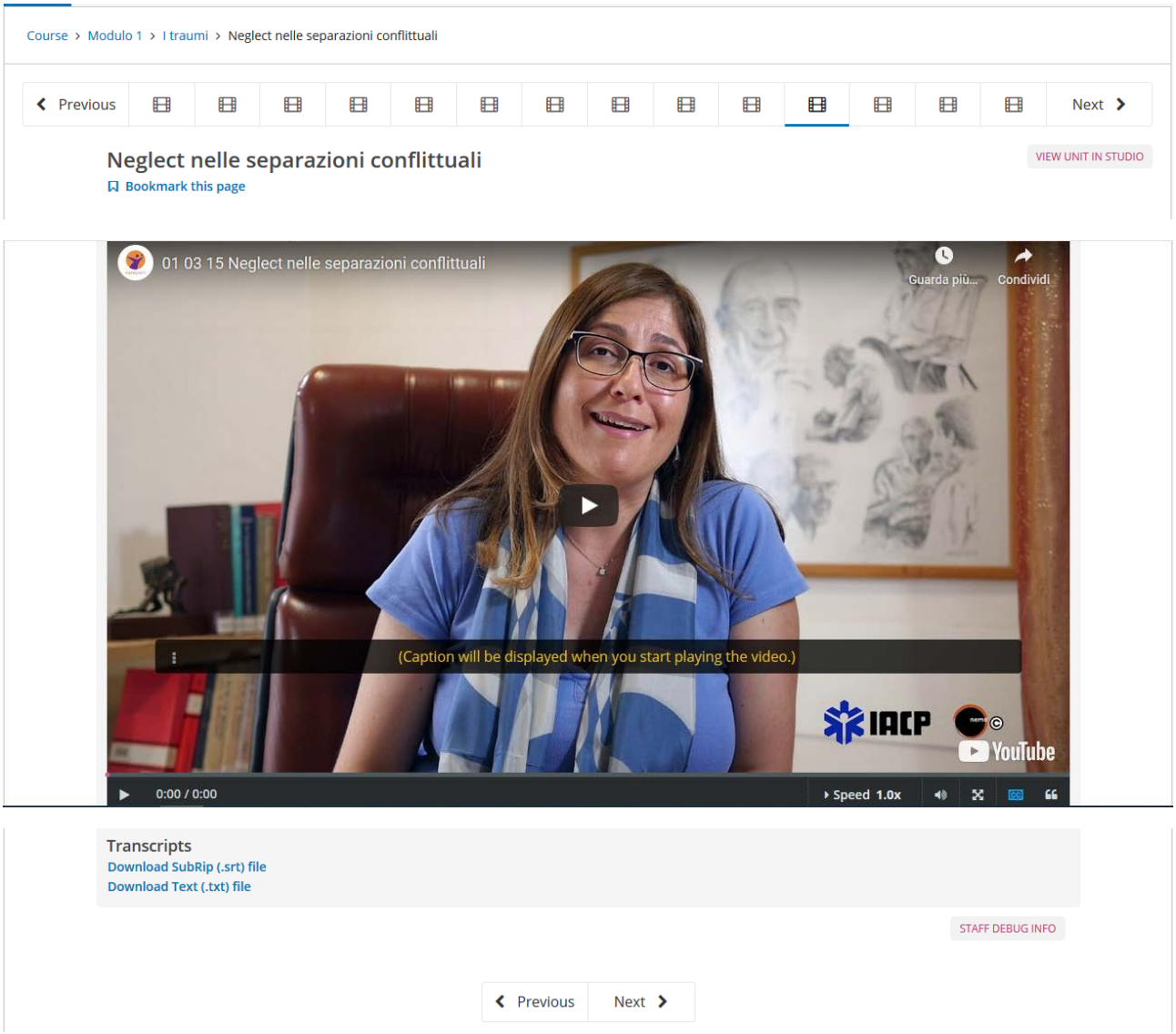
vale a dire un atteggiamento empatico,

di comprensione,

è uno degli elementi più importanti per superare questo trauma,

da poco riconosciuto, ma particolarmente insidioso e non di minore importanza rispetto altri

traumi maggiori.



Transcript

Nelle separazioni conflittuali

i genitori

spesso si “fanno la guerra”

investendo molte energie

nel combattimento dell’altro genitore, visto come un nemico;

in questi contesti la cosa più importante

è vincere.

In queste guerre in realtà

veicolano dei sentimenti di forte rabbia

che ci indicano in realtà di quanto sia complesso,per queste persone,

entrare in contatto

con i sentimenti vissuti e legati al processo separativo;

sentimenti di delusione,

dolore per l'abbandono, per la mancanza, percezione di vuoto, solitudine

e senso di fallimento.

Queste persone in realtà comunicano quanto sia complesso per loro elaborare

quello che si chiama divorzio psichico.

In questo contesto

emerge la figura del minore

che, in quanto tale, andrebbe tutelata;

questo purtroppo non sempre accade in quanto in realtà

il minore diventa il fulcro del conflitto,

ne diventa l'elemento centrale

e quindi

i genitori iniziano a comunica attraverso il minore,

il figlio diventa

il ponte tra i genitori,

il motivo di discussione in quanto ogni genitore litiga

per

cercare

di dichiarare quale sia il bene

del loro figlio.

In questo caso il benessere del minore diventa una scusa

dietro cui si nascondono disappunti,

gelosie

e fastidi personali;

ciò che viene a mancare

è la protezione del minore che deve essere sempre presente,

ma

è necessaria in contesti

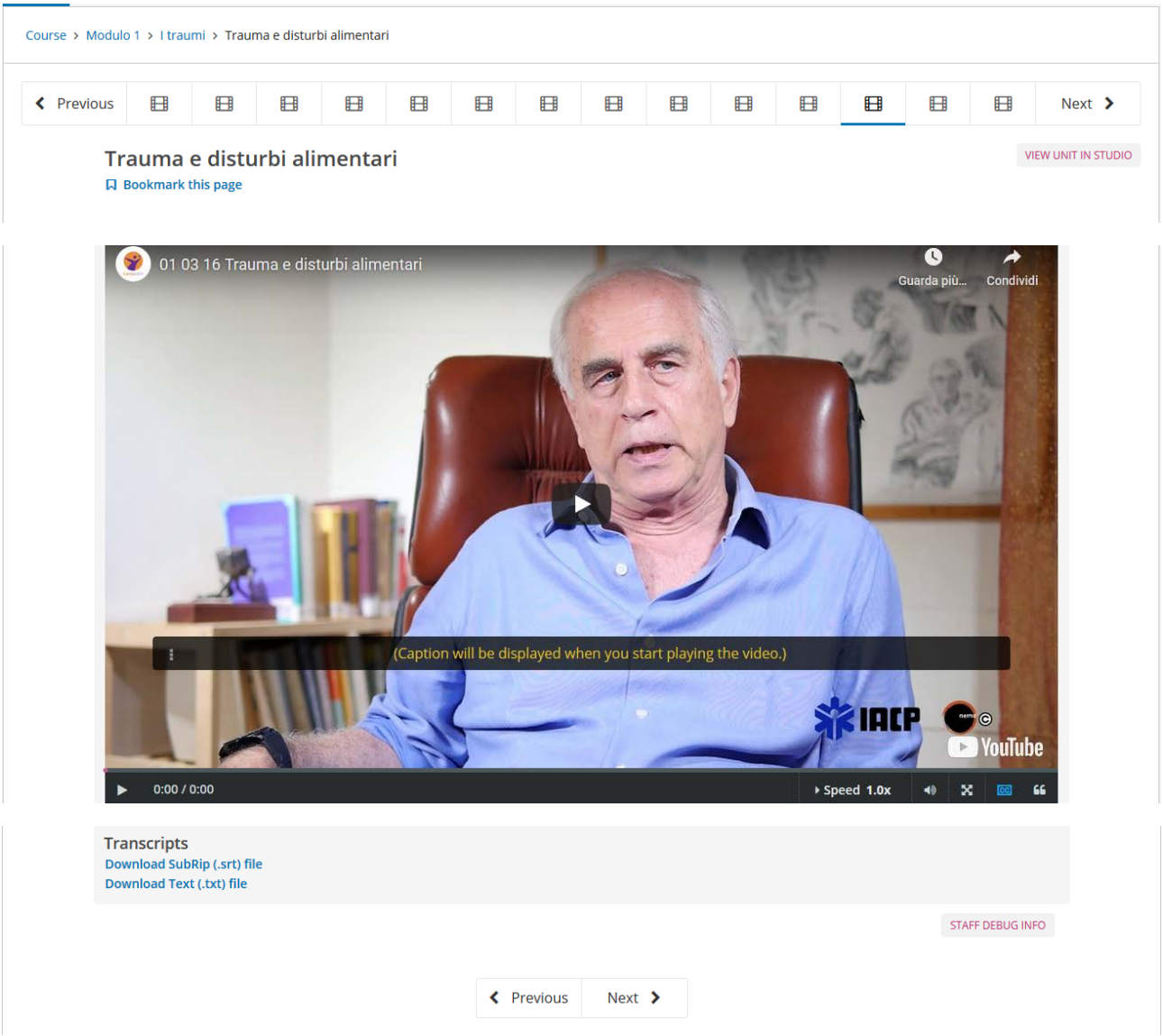
di rottura

come quelli che stiamo vedendo. Quello che potrebbero e dovrebbero fare i genitori

è collaborare e cooperare in tutti gli aspetti legati alla funzione

genitoriale,
nell'ottica di alleggerire il figlio di un peso in quanto i figli, in realtà,
si caricano di un peso in quanto si sentono in colpa per la separazione dei genitori,
si sentono responsabili della loro felicità
in quanto anche sono causa dei loro litigi.
In questo frangente ciò che accade è che il figlio,
in realtà, non viene visto
e qui nasce il trauma del minore:
nel momento di maggiore vulnerabilità
il minore non viene
visto e quindi i suoi bisogni e sentimenti non vengono riconosciuti e per conseguenza accolti.
La separazione è sempre un evento traumatico
in quanto è lesivo,
provoca una spaccatura: una coppia genitoriale che nella mente del
figlio è un nucleo unico che in un certo qual modo
deve spaccarsi,
questa scissione esterna
di padre e madre
produrrà una scissione interna,
tuttavia nella mente del figlio
la coppia genitoriale
non smette di esistere, ma rimane,
solo che perde di forza,
di identità,
di dignità,
di funzione di guida.
Subentrano in questo caso altri fattori
che hanno una carica
molto forte
in senso negativo:
ci sono degli aspetti che ci indicano poi l'entità del trauma,
ad esempio il temperamento del minore

e la sua capacità
di tollerare la frustrazione,
la qualità della relazione e il tipo di attaccamento che i genitori sono
stati capaci di creare
prima dell'evento separativo.
Il fattore che più di tutti ci
dice del trauma e della sua entità è l'età del minore:
più piccolo è il figlio maggiore
sarà l'entità del trauma
e i genitori,
anche inconsapevolmente,
attuano una serie di dinamiche disfunzionali
che intrappolano il minore in un ruolo rigido
dal quale questi non riesce a liberarsi
poiché,
data la sua
giovane età,
non ha ancora quel livello di consapevolezza
e neppure una personalità solida
e capace di liberarsi da solo questo incastro.
Per questo motivo interviene in questi casi un consulente tecnico,
in quanto capace di individuare
il tipo di dinamica che esiste in una famiglia
e di capire quali sono gli interventi da arrivare sulla coppia genitoriale
per liberare il minore.



Transcript

Vediamo ora i disturbi e i comportamenti alimentari di quelli soggetti che hanno

difficoltà ad esprimere le emozioni con le parole le trasmettono soprattutto con il proprio corpo.

Si tratta di una serie di patologie che vanno dall'anoressia all'alimentazione incontrollata che

sono caratterizzate da un interesse esagerato per il proprio corpo

e da un'alimentazione che può essere estremamente limitata

o esageratamente accresciuta.

Questo tipo di pazienti,

in particolare nel caso dell'anoressia, sono soprattutto di

genere femminile.

L'anoressia nervosa è caratterizzata da una grande dimagrimento

che porta le persone ad un peso che può diventare estremamente pericoloso per la vita,

questo dimagrimento è voluto e ricercato dalla persona affetta che considera il suo corpo, invece,
di proporzioni molto maggiori di quello che sono effettivamente.
Nell'anoressia può esserci una restrizione severa,
quindi il cibo che si assume è molto limitato, oppure
il peso viene mantenuto basso attraverso l'assunzione di cibo seguita
da forti condotte di eliminazione che portano
ad eliminare più di quanto si è assunto
e per conseguenza a perdere peso.
Subito dopo viene la
bulimia nervosa.
Una patologia in cui
l'alimentazione è prevalentemente
cospicua,
si presentano episodi di abbuffate,
momenti in cui
il paziente assume una quantità di cibo
ingente
e al tempo stesso, questo paziente però ha la capacità di ridurre
il loro peso corporeo attraverso l'eliminazione
di cibo
e soprattutto
ricorrendo a strumenti o mezzi inappropriati quali il vomito,
l'uso di lassativi o diuretici,
l'uso di sostanze che eliminano l'appetito
o di attività fisica.
In queste persone l'equilibrio del peso si mantiene buono
e fisicamente si mantengono in forma.
L'eccesso opposto si verifica nella
direzione dell'alimentazione incontrollata detta anche.
L'alimentazione incontrollata
è costituita da una modalità di assunzione di cibo
costantemente basata sulle abbuffate,

il ricorso al cibo in maniera continuativa per diverse ore del giorno,
un'alimentazione senza freno,
vengono a mancare le capacità dell'individuo
di ridurre
l'alimentazione
e di ridurre il proprio peso fino ad arrivare a pesi notevoli, dai 150 ai 200 kg,
con un connesso rischio fisico in quanto
il peso eccessivo può causare patologie fisiche
di notevole gravità.
Queste tre patologie si susseguono una dietro l'altra,
hanno
come caratteristica di
passare dall'una all'altra man mano che la capacità
di controllo diminuisce. Nell'anoressia
nervosa il controllo è molto buono
e le persone sono in grado di limitare l'alimentazione
fino a mantenere un peso corporeo estremamente basso.
Quando il controllo diminuisce si passa
alla bulimia nervosa
all'interno della quale,
ragazzi o ragazzi che vivono
questa problematica,
si alimentano - anche molto -
ma mantengono un buon compenso
e hanno una capacità di controllo che emerge successivamente dopo
l'assunzione del cibo, non prima,
e tuttavia permette di mantenere
il peso a livelli accettabili.
Nel terzo tipo, l'alimentazione incontrollata,
la giornata è trascorsa soltanto
alimentandosi,
spesso davanti alla televisione, quasi senza consapevolezza dell'atto ripetitivo e costante nel tempo

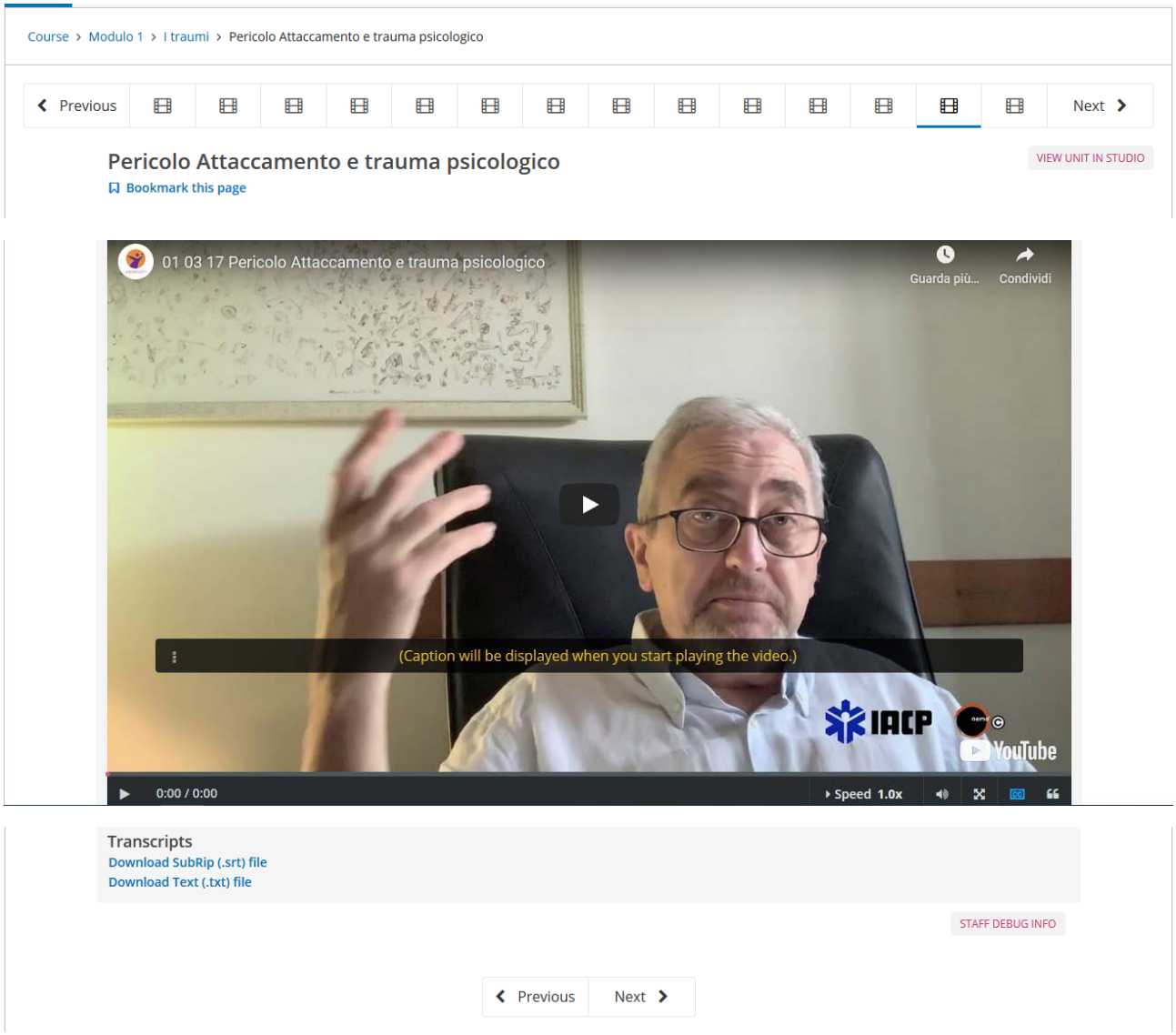
di assunzione di cibo. In comunque, queste tre patologie,

hanno una

serie di aspetti che riguardano tutta l’area emozionale

ed il fatto di esporre a vari tipi

di trauma che possono verificarsi nei disturbi alimentari.



Transcript

L’esposizione a situazioni di pericolo e a minacce

sul piano fisico o psicologico, come malattie, traumi,

condizioni di abbandono,

maltrattamento,

abuso fisico sessuale,

sono esperienze molto comuni,

sia durante l’infanzia che in età adulta.

Queste esperienze

non comportano necessariamente

lo sviluppo di un trauma psicologico,

in quanto

la nostra specie ha delle capacità di adattamento
estremamente
sofisticate,
che permettono di affrontare anche situazioni estreme
senza che queste necessariamente
sviluppino una condizione di trauma psicologico.
Se sono affrontate in modo efficace
queste situazioni pericolose
vengono, in qualche modo,
disarmate nel loro potenziale
disadattivo
permettendo all'individuo di rimanere in una condizione
di salute mentale
e psicologica.
In particolare la nostra specie ha sviluppato, nel corso
del tempo,
delle
capacità di relazione
e dei comportamenti molto sofisticati
che hanno la funzione principale di proteggerci
nei confronti dei pericoli.
Questo
insieme di comportamenti
e di atteggiamenti è definito
con il nome di sistema di attaccamento.
La parola attaccamento
deriva dalla teoria dell'attaccamento
che venne proposta inizialmente negli anni '50
dallo psicoanalista inglese John Bowlby.
La teoria dell'attaccamento sostiene che l'essere umano
ha una predisposizione innata
a sviluppare delle particolari relazioni di attaccamento

con delle figure primarie, spesso i genitori,
che svolgono
la funzione principale
di proteggere nei confronti dei pericoli.
Questa teoria non deriva solo dalle osservazioni psicologiche e psicoanalitiche,
ma da quelle che allora erano
le prime conoscenze che si sviluppavano
nell'ambito dell'etologia,
lo studio del comportamento animale,
della teoria dell'evoluzione
e delle nuove teorie cognitiviste,
sistemiche e cibernetiche.
La teoria dell'attaccamento nasce da un crogiolo di teorie moderne
che negli anni '50 dello scorso secolo iniziavano a diffondersi.
In questa teoria si parla di attaccamento, la cui funzione principale
è quello di proteggere dalle condizioni di pericolo, ma non solo:
la persona che si sente
in una condizione sufficientemente sicura
è sostenuta
ad
esplorare l'ambiente esterno,
conoscendone
le risorse
e imparando anche a prevenire i pericoli che l'ambiente stesso può nascondere.
Queste
funzioni dell'attaccamento sono state studiate sia nei bambini di ogni età
- in particolare in quelli di 1 e 2 anni di vita nel rapporto con la madre
- che nei primati, ed esempio
esistono ricerche degli anni '50 sulle piccole scimmie
resus
che
dimostrano quanto sia importante

anche per i primati
la funzione protettiva
della madre,
più ancora che quella nutritiva.
L'attaccamento viene solitamente suddiviso in: sicuro e insicuro.
Quello sicuro
è caratterizzato da un senso
di sicurezza, fiducia nei confronti dell'ambiente,
di fiducia nelle proprie risorse
e nella possibilità di essere aiutato e protetto in caso di pericolo.
L'attaccamento insicuro
è a sua volta diviso classicamente
in
attaccamento insicuro ambivalente preoccuparti
- nei bambini definito di tipo C -
caratterizzato da una
iperattivazione dell'organismo
con enfasi emotiva,
manifestazioni di rabbia,
paura,
lamentele
rispetto al proprio bisogno di protezione,
difficoltà nella separazione dalla madre;
l'altro tipo di attaccamento insicuro è quello evitante distanziante
- noto anche come tipo A -
al contrario del
precedente, si caratterizza da ipoattivazione, in particolare da una presa di distanza
dalle reazioni emotive
che possono essere
sollecitate da una condizione di pericolo, quindi dalla propria
paura, la rabbia,
il senso di vulnerabilità

che vengono
o inibiti nella loro espressione
(ad esempio con un atteggiamento di apparente indifferenza)
oppure falsificati e trasformati
in espressioni di emozioni opposte (ed esempio sorridere di fronte ad un argomento spaventoso).
QUando
queste modalità di attaccamento sono efficaci
proteggono
dal pericolo
che proviene dall'ambiente
e dalle relazioni nelle quali ci si trova impegnati.
Se
queste strategiesono efficaci
e proteggono sufficientemente
non si verificano condizioni di trauma psicologico
e l'individuo si mantiene in una condizione di relativa sicurezza.
La condizione di trauma psicologico si manifesta quando queste
modalità sono
inefficaci,
ad esempio quando un atteggiamento di inibizione di espressione delle proprie paure, rabbia
o bisogni,
non è sufficiente per protegge l'individuo
dalle minacci ambientali.
Il trauma psicologico è una condizione nella quale tutta l'attività di elaborazione mentale
è influenzata negativamente
da un'esperienza di pericolo passata oppure attuale.
Questo può venire da un evento singolo particolarmente intenso ed improvviso - ad esempio
un trauma fisico
o un abuso -
ma può venire anche da una serie ripetuta di esperienze
che nel loro complesso assumono valore
traumatico:

in questo caso si parla di trauma evolutivo,
è la condizione in cui un bambino,
per esempio, cresce in un gruppo familiare
inadeguato
e trascurante
e nel loro complesso queste esperienze prolungate creano un clima di sviluppo
inadeguato
che può portare ad una condizione comunque di trauma psicologico.
La capacità di adattamento e rielaborazione di una situazione di pericolo potenzialmente traumatica
dipende da alcune caratteristiche.
Dall'individuo, la sua età, maturazione,
personalità
e dalle caratteristiche del suo attaccamento, se sono efficaci o meno a proteggerlo;
la sua forza fisica e condizione di salute
in quanto una persona malata è più fragile
nei confronti dell'elaborazione di una condizione di pericolo.
È molto importante, inoltre,
la disponibilità protettiva delle figure di attaccamento, che una persona che non si
senta sola davanti al pericolo, ma accompagnata da relazioni protettive da parte di persone
disposte a far sentire
protetto
e accompagnato nell'elaborazione
di una esperienza di natura pericolosa.
Un ruolo importante è giocato dal contesto sociale: è fondamentale trovarsi
in un ambiente accogliente, con persone che accolgono e sostengono
con
la loro cultura,
rituali o presenza personale (ad esempio gli amici).
Il processo di adattamento di una condizione di trauma non è immediato ma ha bisogno di tempo,
ad esempio
un lutto significativo - come quello
del coniuge o genitore -

richiede solitamente

uno o due anni per poter essere adeguatamente elaborato,

senza trasformarsi in una condizione

di lutto traumatico.

Quando

un'esperienza potenzialmente traumatica non è elaborata,

solitamente, viene accompagnata da

un'eccessiva iperattivazione

emotiva, con

sogni, incubi,

paure,

senso di minaccia,

reazioni incontrollate

- come nel caso del disturbo post traumatico da stress -

oppure da una situazione di ipoattivazione eccessiva, ovvero una eccessiva presa di distanza

da tutto ciò che riguarda l'esperienza

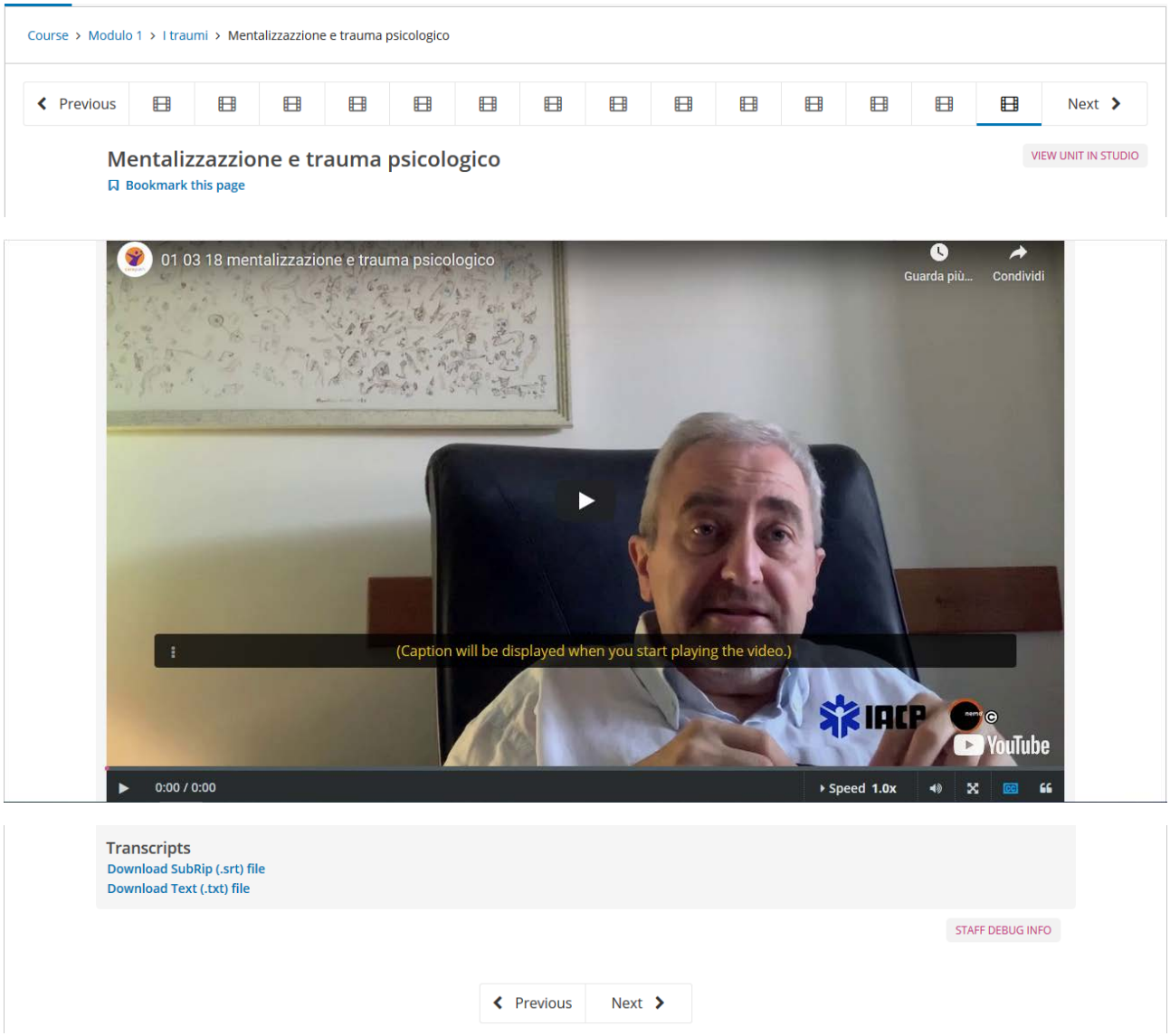
pericolosa,

mancanza di ricordi,

inibizione affettiva,

evitare di parlare o i luoghi che sono legati all'esperienza traumatica.

In presenza di queste due condizioni si può parlare di trauma psicologico.



Transcript

Quando si parla di mentalizzazione si parla di qualche cosa che sembra un scontato,

che viene da molto lontano.

In effetti ogni essere umano,

prima ancora

dello

sviluppo della psicologia,

ad un certo punto della sua vita si pone dei problemi di mentalizzazione;

cioè si pone

il problema di riflettere su se stesso e su gli altri,

considerando che noi e gli altri abbiamo

una mente,

dei pensieri,

sentimenti, bisogni,

aspettative e credenze

che ci influenzano.

Un modo semplice per intendere il concetto di

mentalizzazione

è quello

che corrisponde a considerare

sé stessi e gli altri

in termini di stati mentali.

Queste capacità nella nostra specie

iniziano a configurarsi

attorno ai 4 anni di età,

quando il bambino si rende conte

che

quello che pensa e sente

non è necessariamente capito e condiviso da altre persone,

ad esempio la madre può non conoscere cosa passa nella mente del bambino.

I bambini quando imparano questa

grande novità imparano allo stesso tempo anche

a

utilizzare

una modalità

strategica di adattamento ai problemi

molto utile

e importante; imparano cioè l'importanza della menzogna:

una bugia si può dire se si pensa che la mente degli altri ha una visione

del mondo diversa dalla propria

e gli altri non possono conoscere i pensieri di un individuo.

La mentalizzazione

e i suoi processi sono basati su una serie di

passaggi.

Il primo riguarda il fatto di essere
relativamente
sensibili a percepire
gli stati mentali, ovvero
a rappresentare di noi e degli altri
degli stati mentali (ad esempio capire di essere
allegri, tristi,
di avere aspettative,
pregiudizi)
e
la capacità di interpretare il proprio comportamento e quello degli altri
sulla base
di questi stati mentali
è fondamentale per poter adattarsi
(ad esempio una persona che sta davanti a noi in silenzio:
non pensiamo non abbia
nulla da dire,
pensiamo che la sua mente
sia attraversata
da immagini e pensieri e il suo silenzio non è espressione di vuoto, ma di una serie di stati mentali
che
sono alla base di questo comportamento silenzioso).
Un secondo aspetto importante della mentalizzazione è che
la mentalizzazione di noi stessi
favorisce la regolazione del nostro organismo,
se per esempio ci rendiamo
conto di essere
arrabbiati
e iniziamo a pensare
che qualcosa che si è detto
è relazionato alla rabbia,
il fatto

di rendersene conto,
ricordare,
fare aspettative
e proiezioni sulle conseguenze
di un'azione
apre una strada psicologica per regolare la rabbia che si è attivata in noi.
Il cuore, la respirazione, la produzione di ormoni
legati all'attivazione rabbiosa
cominciano ad essere regolati
da meccanismi di carattere psicologico;
ad esempio potrei sentirmi
in colpa per aver provato rabbia verso qualcuno a cui voglio bene,
questo inibisce l'espressione della rabbia
e regola lo stesso organismo;
si tratta di una funzione fondamentale, tanto è vero
che le persone con scarse capacità
mentalizzazione sono maggiormente esposte
alla disregolazione dell'organismo
(il cuore
batte
più velocemente e in modo irregolare,
le reazioni emotive sono più incontrollate,
e questo può portare a lungo termine
a
malattie
dovute alla disregolazione costante dell'organismo).
Una delle funzioni più importanti del genitore nei confronti dei figli
è quello di essere
mentalizzazione:
pensare
cioè ai figli
anche in relazione a quelli che possono essere

i bisogni, sentimenti,

paure,

calandosi - in un certo senso - nei panni dei figli

e percependo le cose anche dal loro punto di vista.

Ad esempio un bambino di tre anni

vivrà certi argomenti

e interpreterà certe parole o discorsi

con le proprie capacità

di bambino,

da parte dell'adulto è importante

mettersi nei suoi panni.

Questa condizione, che è stata definita mindedness

è una delle condizioni maggiormente

correlata

allo sviluppo sicuro dei figli; è una condizione è basilare

del buon genitore

quello di riuscire

a mettersi nei panni dei figli e percepire i bisogni.

Si osserva giànella madre di un bambino molto piccolo

che, per esempio,

si

mette nei panni del figlio

che piange e si agita, e quindi pensa che possa avere freddo, o fame, dando così voce

ad uno stato del bambino,

come se il figlio a essere in qualche modo pensieri organizzati

e li potesse esprimere.

La capacità di rappresentarsi gli stati mentali dei figli

è una condizione base di fare il genitore.

La mentalizzazione è anche alla base della

capacità di affrontare lo stress e le condizioni potenzialmente pericolose

adattandosi

senza che si sviluppino condizioni di traumi psicologici.

Per esempio:
ad un bambino di fronte ad un
comportamento incoerente del genitore -
che magari ha un gesto di rabbia
o di violenza fisica
o dire cose negative verso il bambino -
la capacità di questo bambino di immaginare lo stato mentale del genitore
agisce come ammortizzatore e permette di considerare
quello che il genitore fa e dice
all'interno di un contesto. (Può pensare
"il babbo
è stanco e quello che dice non corrisponde alla realtà,
il babbo di solito
è affettuoso e mi vuole bene,
ciò che accade ora ha valore
in questo momento ed è legato a stati d'animo particolari ma non è assoluto").
L'atteggiamento appena esposto protegge dagli stati mentali
degli altri
e rende la situazione potenzialmente meno traumatica.
È un fatto che si osserva chiaramente nelle persone adulte con dei bassi
livelli di mentalizzazione,
come il caso
da persone con disturbo borderline della personalità,
sono molto più esposte a continui traumi psicologici,
ciò che avviene a loro non viene
contestualizzato, sottoposto ad un processo di riflessione sufficiente,
per cui tutte diventano
totali, assolute
e
potenzialmente traumatiche.
In alcuni momenti
l'incapacità

dei genitori di porsi nei panni dei figli
può essere particolarmente
pericolosa
e produrre degli atteggiamenti che in un bambino o adolescente
possono
manifestarsi attraverso comportamenti di forte aggressività.
L'aggressività e i comportamenti dettati da questa
possono essere,
in parte,
interpretabili
attraverso il concetto di mentalizzazione.
Se per esempio dei genitori sono costantemente irritati
dai comportamenti di un figlio, se
ad esempio un figlio
pone
un problema
o fa un capriccio
il genitore inizia a rivolgersi
al figlio in modo negativo (magari affermando che sia stupido, malato, non valga nulla),
dal punto di vista del figlio
questo ha di se stesso un'immagine restituita di una persona malata,
disturbata,
incapace,
questo atteggiamento viene tenuto a distanza
da comportamenti aggressivi per cui ogni volta che un adulto si avvicina
ad un bambino in queste condizioni con l'intento di conoscerlo
e di farlo confidare avrà come risposta probabile un atteggiamento
di forte reazione aggressiva,
con la funzione di tenere l'adulto lontano
in quanto potenzialmente traumatico.
Il caso può essere quello di giovani che in classe sono ritenuti incapaci
e vengono più volte punti,

gli insegnanti li ritengono

dei soggetti

negativi

e a casa questi ragazzi hanno genitori che rinforzano

questa idea negativa di se stessi; questi ragazzi

nei confronti degli stessi adulti che cercano

di aiutarli (un educatore, un insegnante) hanno degli atteggiamenti di forte reattività

e rabbia con la funzione di tenere l'altro

lontano

in modo da non ripetere l'esperienza

di sentirsi dipingere come persone sbagliate o negative.

1.I La cornice di riferimento

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Gentili studenti vi informiamo che i materiali di approfondimento non sono obbligatori e non saranno soggetti a valutazione.Vi saremmo grati se poteste visionarli per eventuali vostri feedback.

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La cornice di riferimento

Quali esempi di cambiamento sociale e culturale ti vengono in mente?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Quali aspetti delle società e culture che tu conosci hai visto cambiare ?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Per come la pensi tu e nella tua esperienza, le cose sono veramente interconnesse, oppure no?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Ti vengono in mente alcuni chiari esempi di interconnessione? Oppure no?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

A tuo parere: Le principali variabili per ben comprendere gli esseri umani sono gli aspetti, biologici, quelli psicologici e quelli sociali oppure a tuo avviso ci sono altre importantissime variabili da considerare? se si quali altre variabili?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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1.II Elementi di storia e Sociologia della Conoscenza

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Secondo te gli esseri umani vivono nella realtà oggettiva oppure hanno ragione i sociologhi della conoscenza a sottolineare che quello che gli esseri umani chiamano realtà è in effetti la realtà della loro costruzione dell'esperienza che avviene ed è influenzata dalla cultura, le credenze e i ruoli sociali ecc. di un dato periodo storico e di una specifica cultura e società?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Se la realtà è socialmente costruita e culturalmente influenzata, puoi fare due esempi che chiaramente illustrino il concetto delle credenze ed usi della società in cui vivi che sono già cambiati negli ultimi anni?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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Puoi fare almeno due esempi di due aspetti della tua cultura che sono vissuti in modo molto diverso in altre culture? Quali?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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1.III Brevi cenni sulla sociologia delle cure mediche

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A Tuo modo di vedere negli ultimi 50 anni quali cambiamenti sono avvenuti rispetto al ruolo del medico e quello del paziente nei concetti di malattia e di salute?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

In futuro puoi auspicare almeno due cambiamenti che tu ti auguri prendano piede nel campo della salute e del benessere?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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2.I Promozione dei risultati

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Gentili studenti vi informiamo che i materiali di approfondimento non sono obbligatori e non saranno soggetti a valutazione.Vi saremmo grati se poteste visionarli per eventuali vostri feedback.

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Promozione dei risultati

STAFF DEBUG INFO

Hai appena visto un film di Carl Rogers con la sua utente Gloria, tu che ne pensi?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Quali aspetti positivi a tuo avviso sono presenti in questa interazione di Carl Rogers con Gloria ?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Tu hai delle qualità relazionali simili a quelle illustrate da carl Rogers in questa interazione? Se si quali?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

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2.II Essere un professionista, operare sempre in scienza e coscienza

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STAFF DEBUG INFO

Per te i valori dell'etica e la loro quotidiana applicazione nel lavoro con gli utenti e le relazioni con i familiari degli utenti e con i colleghi quanto sono importanti?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

2.III La bussola del professionista

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STAFF DEBUG INFO

Tu che ne pensi del concetto della bussola del professionista?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Tu hai una tua personale bussola come professionista?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

E' simile o diversa? Come?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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2. IV Progettazione e gestione dei setting di relazioni di aiuto efficaci e alleanze di lavoro efficaci

Progettazione e gestione dei setting di relazioni di aiuto efficaci e alleanze di lavoro efficaci

STAFF DEBUG INFO

Il tuo setting professionale include tutti i fattori menzionati ?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

La strutturazione del tuo lavoro ha un alto livello di efficacia?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Qauli aspetti di efficacia sono presenti e quali pensi sarebbe meglio migliorare per raggiungere una maggior livello di efficacia?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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2.V La resilienza

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VIEW UNIT IN STUDIO

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Tu sei resiliente?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Vorresti migliorare i tuoi livelli di resilienza personale?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Nel tuo lavoro incoraggi e supporti lo sviluppo della resilienza dei tuo utenti? Come?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

La filosofia del tuo luogo di lavoro incoraggia attivamente e facilita la resilienza di utenti?Degli operatori?

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Cosa potrebbe essere migliorato nel tuo luogo di lavoro che protegga e promuova la resilienza di tutti?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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2.VI L'alleanza di lavoro

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STAFF DEBUG INFO

Nel tuo posto di lavoro esiste una buon gioco di squadra tra voi operatori?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Cosa vi impedisce di avere un miglior gioco di squadra sul lavoro? Che cosa potrebbe fare migliorare il vostro gioco di squadra sul lavoro?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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2.VII Supervisione e supervisione tra pari

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Quanto è importante per te avere una buona supervisione?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Quanto di frequente tu ne hai bisogno?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Nel tuo luogo di lavoro avete supervisione a sufficienza?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Avete supervisione tra pari? Quali sono gli aspetti principali sul tuo luogo di lavoro che andrebbe migliorati rispetto alla supervisione e supervisione tra pari

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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3.I Il trauma e il soggetto psicotico

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Il trauma e il soggetto nevrotivo

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3.II Il trauma negli stati limite

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3.III La teoria polivagale

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3.IV Oncologia e trauma

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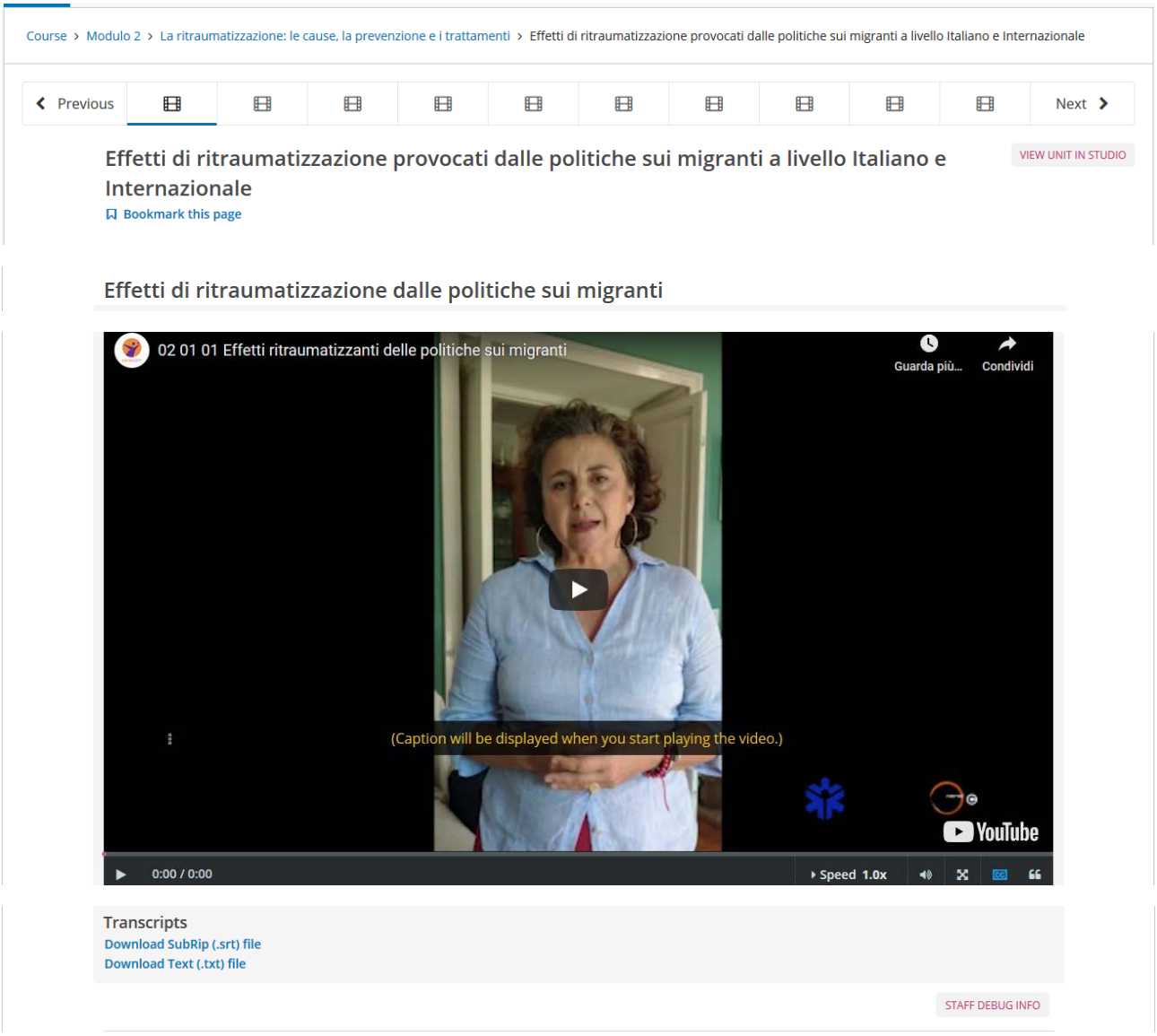


Transcript

lo sprar il sistema di protezione per

richiedenti asilo rifugiati ha

modificato il nome in cipro imi questo a

causa della entrata in vigore della

legge 113 nel 2018 quindi molto

recentemente

dopo tutta una serie di modifiche anche

normative che il nuovo governo

insediatosi nello scorso maggio in

italia ha apportato tutto il tema

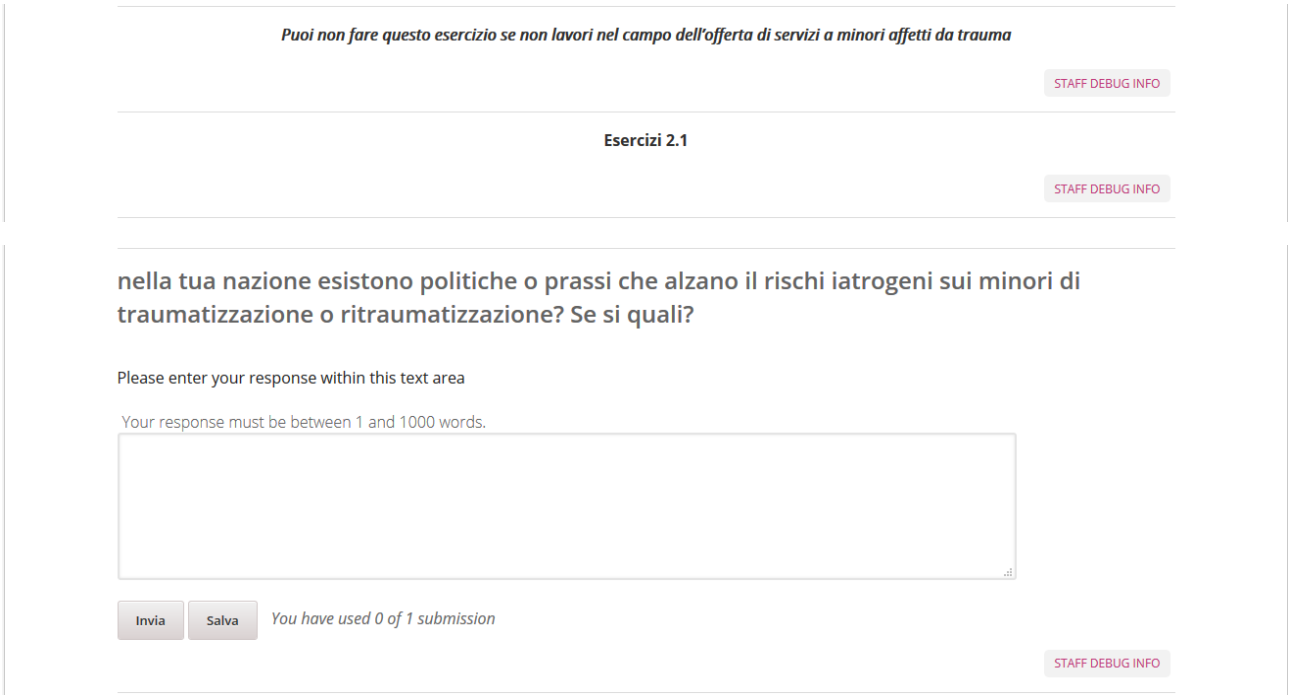
dell'immigrazione del diritto d'asilo e

quindi dell'accoglienza lo sprar è stato
istituito nel 2002 è costituito da una
rete di comuni enti locali che in
collaborazione con le associazioni del
terzo settore e le amg gestiscono su
base volontaria quindi su propria scelta
dei progetti di accoglienza e
integrazione per i richiedenti asilo e
rifugiati
questa rete nel corso degli anni ha
avuto una progressiva e positiva
evoluzione
siamo passati dagli iniziali 1.500 posti
di accoglienza agli attuali 35 mila vi
sono stati diversi passaggi nel corso
della storia dello sprar che ne hanno
determinato alcuni cambiamenti
il primo è stato appunto il momento
della sua istituzionalizzazione
attraverso una legge che lo ha reso
stabile e ordinario come sistema
d'accoglienza centrale in italia laddove
negli anni precedenti non esistevano
altri sistemi di accoglienza strutturati
ma soltanto degli interventi di tipo
emergenziale
un altro momento importante è stato
quando nel 2003 la cosiddetta emergenza
nord africa ha fatto emergere con ancora
più evidenza anche a livello europeo la
efficacia el efficienza del modello
sprar in termini di raggiungimento di

obiettivi di inclusione sociale e
l'integrazione
l'ultimo passaggio è quello appunto più
recente nel quale viene modificata
l'identità dello sprar che non può più
accogliere
a seguito dell'entrata in vigore della
legge di cui parlavo né richiedenti
asilo nei progetti umanitari
anche perché la protezione umanitaria
viene abolita e spa cogliere
esclusivamente minori stranieri non
accompagnati titolari di protezione
internazionale che però costituiscono un
numero residuale rispetto al numero
delle richieste d'asilo e alcuni nuove
alcune nuove tipologie di permesso di
soggiorno ai cosiddetti casi speciali e
quindi lo sprar che adesso appunto si
chiama sipro anni potrà accogliere i
casi speciali per cure mediche
i casi speciali di vittime di tratta
vittime di sfruttamento lavorativo
vittime di violenza domestica vittime di
calamità naturali e persone che si siano
distinte per particolari atti di eroismo
questo sempre riferito agli stranieri
naturalmente non ai cittadini italiani
che hanno altri circuiti di protezione
sociale si può dire quindi che lo strada
assume adesso una identità più di
welfare indirizzato agli stranieri che

non di sistema accogliente e protettivo
nei confronti delle persone qualche modo
afferenti al tema del diritto ad asilo
dunque cambia la propria identità e
potrebbe rappresentare sulla carta anche
un passaggio parzialmente positivo se si
pensa che ci si rivolge comunque alla
protezione di persone con qualche tipo
di fragilità e la difficoltà in questo
momento è costituita dal fatto che il
permesso di soggiorno diventa dirimente
ma non è detto che la persona vittima di
tratta automaticamente possa acquisire
il permesso per caso speciale come
vittima di tratta e lo stesso si può
dire della vittima di sfruttamento
lavorativo e così via
non abbiamo dei criteri quindi precisi
di come dovranno essere queste procedure
e di come far confluire tutte le persone
con questo tipo di vulnerabilità sotto
la definizione anche giuridica di caso
speciale perché solo attraverso la
formalizzazione in un permesso
un giorno per caso speciale quella
persona potrà accedere allo sprar e
quindi usufruire di tutti i servizi di
protezione presa in carico e anche
accompagnamento all'inclusione e
all'integrazione che lo sprar prevede
inoltre non sono stati definiti ancora i
criteri i requisiti in base ai quali una

persona per esempio potrà avere il
permesso per cure mediche per quale
tipologia di disagio mentale fisico di
quale livello di gravità per quale
temporalità questo questa presa in
carico e prevista e dunque ci troviamo
in un momento di transizione molto
critico perché moltissime persone che
fino a pochi mesi fa avevano diritto di
accesso ai progetti sprar cura non
l'hanno più
e viceversa tutti coloro che
apparentemente sulla carta sembrano
poter avere questo accesso in realtà non
sanno o non sappiamo come poter dar loro
diciamo così la pezza d'appoggio con cui
effettivamente usufruire di questo
diritto



Se tu avessi il potere di promuovere il cambiamento nella tua nazione cosa cambieresti per abbassare i rischi iatrogeni di traumatizzazione o ritraumatizzazione nelle politiche in generale e in quelle relative alla salute, assistenza sociale, pari opportunità ecc.?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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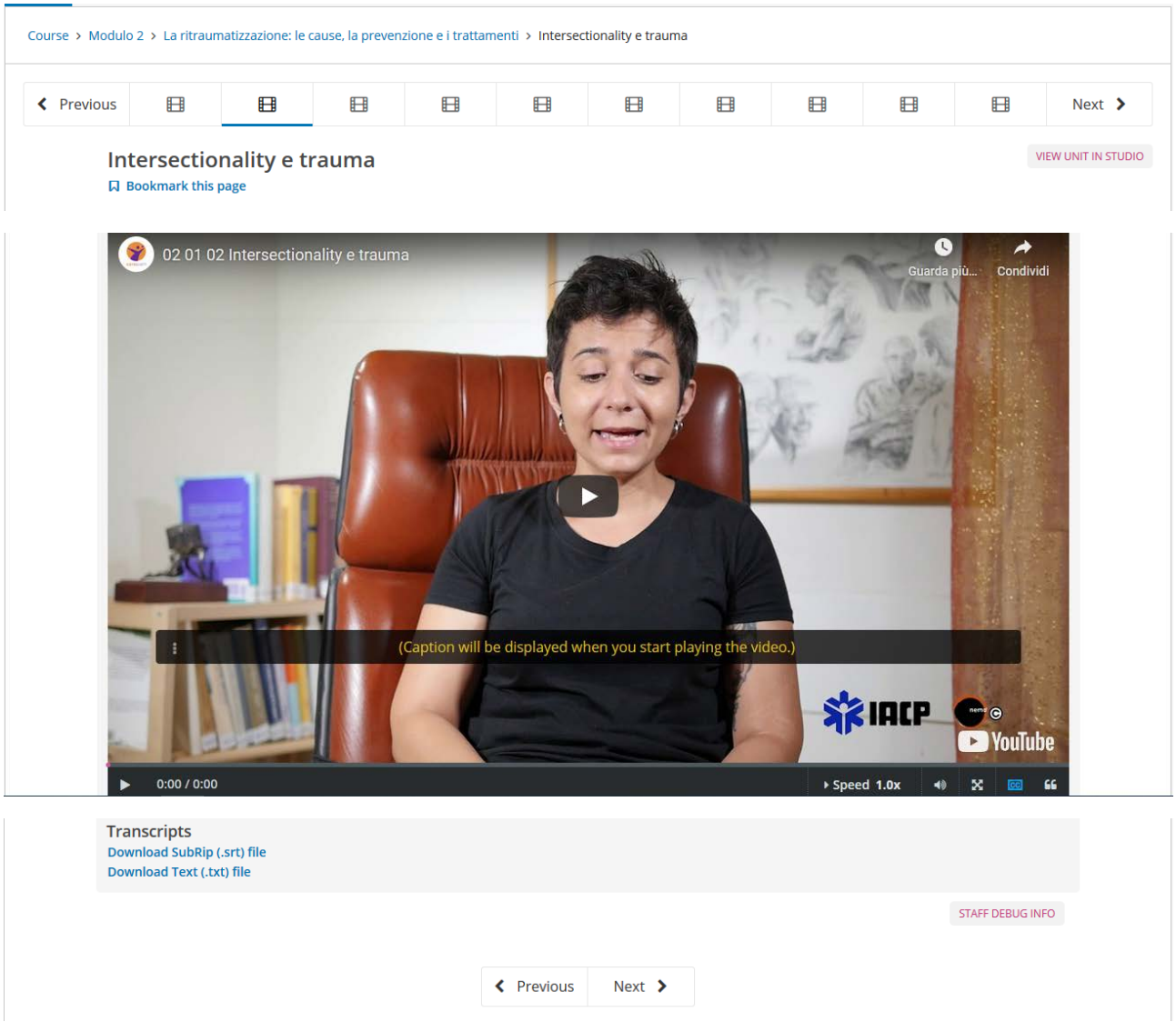


Transcript

Il concetto di intersectionality sviluppato in origine da Kimberly Williams Chrenchsud,

docente di legge, nera e femminista,

potrebbe essere compreso più a fondo da un punto di

vista geografico, geopolitico, globale, transnazionale e postcoloniale;

questo secondo coloro che hanno poi studiato e riutilizzato questo concetto.

Alice Ludvig ha sviluppato elaborati schemi

multidimensionali che includano più livelli di differenza,

quali possono essere il genere, la sessualità, la razza, il colore della pelle, l'etnia, lo stato, la classe, la cultura,

e così via e questo ci da la misura degli innumerevoli livelli

di cui dovremmo tenere conto e prestare attenzione quando ci troviamo in una relazione di aiuto con

persone che afferiscono quelle che vengono comunemente considerate popolazioni minoritarie.

Per citare Audre Lorde
potremmo dire che non c'è nessuna lotta che abbia a che fare
con un solo problema, perchè non viviamo vite fatte di una sola dimensione.
L'internazionalità è sempre più spesso un elemento dello sviluppo di politiche di parità,
la possibilità,
anche grazie al lavoro delle Nazioni Unite e dell'Unione Europea.
SI pensi alle direttive per combattere le discriminazioni
e di tutte le iniziative a livello nazionale, regionale, locale
e alle politiche e al management delle diversità
che ormai in tutte le nazioni dell'Occidente, in moltissime
aziende,
vengono adottate.
Questo non azzera, ovviamente, le ambivalenze, le sofferenze e i silenzi
di chi si trova a vivere condizioni di minoritarietà multiple,
magari dopo aver vissuto situazioni traumatiche proprio a causa minoritarietà.
Sul "fatto quotidiano" del 17 maggio 2018
viene riportata una frase di un ragazzo del Camerun:
"un giorno eravamo in cucina e guardavamo in TV un programma sui migranti LGBTQI,
i miei compagni africani hanno cominciato a dire -
l'Italia è un paese di merda pieno di omosessuali
- ancora una volta non mi sono sentito libero";
Allen ha 22 anni ed è scappato da chi lo picchiava e lo chiamava demonio,
si è lasciato alle spalle il Camerun -
riporta il giornale
- dove essere omosessuale è reato,
per chiedere in Italia la protezione internazionale,
ma la paura è rimasta a lungo la stessa
perché l'omofobia lo ha seguito fino a dentro al hub di Via Mattea Bologna dove è stato accolto
insieme ai suoi connazionali.
I migranti LGBTQI, molto spesso, sono molto giovani,
non possono contare
sul sostegno della propria comunità di origine,

con cui si trovano a migrare,

ma che spesso culturalmente connotate da quella omofobia o transfobia da cui si è sfuggiti.

Non possono neppure essere certi di venire a contatto con realtà multiculturali in cui vivere

serenamente il proprio orientamento sessuale o la propria identità.

Come si sottolinea in più occasioni in alcune interviste di Vincenzo Bramato,

presidente del circolo Arcigay di Bologna,

in alcuni paesi europei- come la Germania

- esistono strutture protette per accogliere chi scappa da persecuzioni a causa del proprio orientamento sessuale,

in cui il personale ha ricevuto una formazione specifica

volta proprio a non riproporre atteggiamenti giudicanti o denigratori che rinverdirebbero lo stigma

e il trauma delle persone.

In Italia , al momento, il modello di accoglienza non prevede queste specificità,

ma esistono realtà virtuose come l'esperimento pilota

avviato nel 2017 a Modena con un piccolo appartamento da sei posti

riservato proprio ai richiedenti asilo LGBTQI,

in più uno sportello per migranti LGBTQI di Verona.

Per questi ragazzi

migranti

in una età evolutiva

afferenti alla comunità LGBTQI

essere parte di una minoranza etnica in un paese che li ospita

è solo una parte del problema.

Sono infatti, molto spesso una minoranza silenzio e spaventata,

anche all'interno della propria comunità di riferimento.

Un trauma dell'invisibilità, per dirla con Rogers,

raddoppiato,

un minority stress - se vogliamo fare riferimento a Vittorio Lingiardi

- che ha un'incongruenza - perarrivare fino a Rogers - raddoppiata;

dunque un rischio raddoppiato per la salute psicofisica di queste persone

e quindi una perdita di capitale umane inestimabile.

Formarsi all'accoglienza significa innanzitutto formarsi sui diritti umani

e sulle specificità
che il migrante
LGBTQI porta con sé nella relazione d'aiuto.
La formazione dovrà quindi essere centrata sulla persona
e accogliere queste specificità conoscendole per risultare veramente inclusivi,
inoltre i servizi rivolti ai migranti,
progettati e forniti senza considerare
molto spesso la variabile dell'orientamento sessuale e dell'identità di genere
ne riducono a volte l'efficacia,
sia per quanto concerne la relazione con l'utente
(e quindi questi ragazzi che non
posso ricevere l'accoglienza che invece potrebbero avere),
ma anche relativamente all'utilità di percorsi formativi o preventivi
(pensiamo ad esempio alle malattie sessualmente trasmissibili,
quanto sia
multidimensionale anche una formazione rispetto a questo aspetto
nel momento in cui abbiamo un'adolescente migrante afferente alla comunità LGBTQI).
Dall'altro lato i servizi forniti proprio dalla comunità LGBT
sono fortemente collegati ad un modello culturale di uomo-gay e donna-lesbica occidentali,
e quindi molto spesso questi modelli non considerano
un modello in cui questi ragazzi che vengono da altre culture
possono davvero riconoscersi.
L'esperienza delle realtà sopra citate
ha provato che i servizi di informazione
di supporto e di counseling forniti dalle istituzioni, ma anche dalle associazioni,
possono non essere efficaci per questi ragazzi;
pertanto
lavorare con queste popolazioni di molteplici minoritarietà
implicherà una riflessione interdisciplinare
sulle prassi delle relazioni d'aiuto. Nella relazione con queste persone
la approfondire delle dimensioni relative all'omosessualità, la bisessualità e la transessualità
nella storia della psichiatria e della psicologia,

il concetto di stigma,

di omofobia, di omofobia interiorizzata,

ma anche a costare tutto questo un costante aggiornamento degli operatori

sulle legislazioni

relative a questi temi,

sia nei paesi di accoglienza che nei paesi di provenienza delle persone che si va ad accogliere.

In più andrebbe continuamente

approfondito e conosciuto, perché in continua evoluzione e variazione, tutto quello che

è relativo alla legislazione

legata all'asilo.

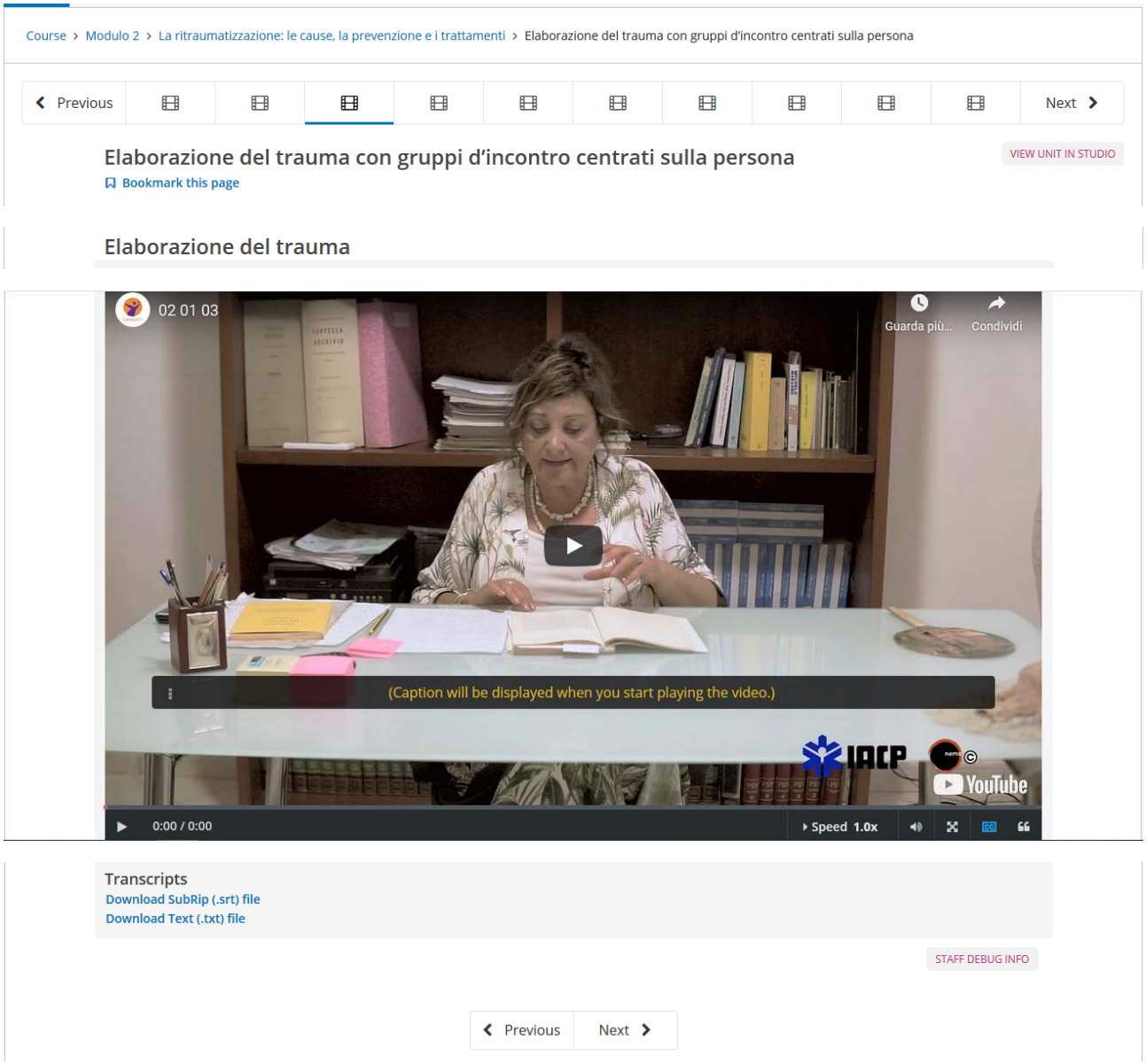
Unitamente alle competenze di ordine più tecnico,

sarà necessario sviluppare e consolidare, dal punto di vista più personale,

un approccio sensibile al genere

e mantenere viva dentro di sé e all'interno del gruppo di lavoro

con cui si accolgono i quesiti ragazzi una riflessione sui diritti umani, come convenzione occidentale.



Transcript

Nella sua attività presso il servizio poliambulatorio di Lampedusa, dal 2001, la dott.ssa Malatino da ormai 25 anni. Lampedusa è sede di sbarchi da parte di uomini e donne che cercano di lasciare la loro terra per trovare un futuro migliore. Nell'affrontare il lavoro con le persone dell'isola si sono presentate occasioni di lavoro anche con i migranti, l'esperienza migratoria è divenuta parte del suo percorso personale e professionale.

Nel 2002 si chiedeva di offrire presso il centro di accoglienza supporto e terapia a persone che, sbarcate sull'isola dopo viaggi molto difficili, lunghi e con notevoli rischi di morte, avessero bisogno di farmaci e il responsabile della struttura chiese di fare una valutazione psichiatrica dei soggetti che sbarcavano sull'isola.

Si mostrò pressoché impossibile valutare la salute psichiatrica di soggetti esposti

e sottoposti ad eventi traumatici così gravi, e che però venivano da cultura diverse non richiedevano l'aiuto o il sostegno di tipo farmacologico, provenendo da contesti questi che non consideravano la medicina occidentale come medicina convenzionale. Ciò che più sosteneva ed aiutava questi soggetti in certi casi era ricorrere a rituali magici e in qualche modo legati al pensiero magico preventivo di cui molti erano portatori.

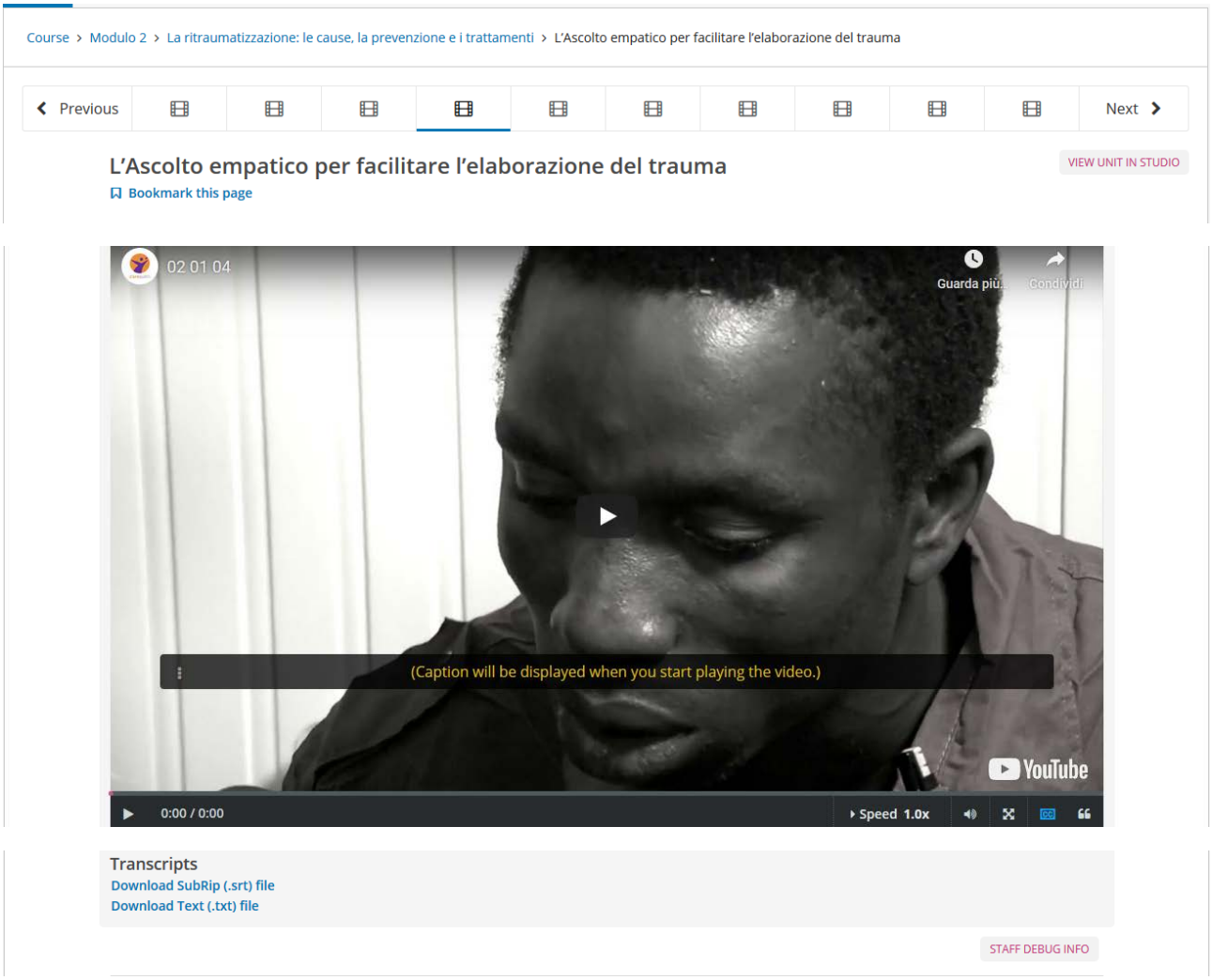
Accogliere tutta questa sofferenza si mostrava particolarmente complesso e allo stesso tempo essere di aiuto e supporto. Fu così che si pensò di organizzare dei gruppi di ascolto.

Questa è stata un'esperienza straordinaria per una psicoterapeuta psichiatra Rogersiana che fino a quel momento aveva condotto gruppi di ascolto legati al modello di Carl Rogers.

In questo tipo di gruppo l'incontro è caratterizzato dal fatto che le persone si siedono in cerchio e si ascoltano reciprocamente, l'elemento fondamentale è l'assenza totale di giudizio e il rispetto assoluto di qualsiasi argomento voglia essere trattato dal gruppo; in questo modo è possibile creare un clima di confidenza che facilita molto la fiducia e aiuta i partecipanti, anche in situazioni emozionali particolarmente problematiche, a rielaborare l'esperienza e contemporaneamente a trovare una forma di solidarietà: rendersi conto del proprio vissuto personale non è necessariamente solo individuale, ma può essere condiviso e compreso da altri soggeti, ciò di per sé favorisce la risoluzione - a volte - della sofferenza, del conflitto o dell'evento doloroso. Questo è quanto è accaduto all'interno di questi gruppi. Un elemento importante e fondamentale è stato trovare l'equilibrio con il mediatore culturale, il traduttore, in quanto il facilitatore non parlava la lingua dei soggetti e le condizioni di base su cui si è trovati ad operare sono state assolutamente proibitive per mancanza di materiali (mancavano sedie) o per situazioni contingenti (alcuni gruppi erano appena scampati dal naufragio e alcuni avevano addosso solo lenzuola di salvataggio).

Nonostante la situazione poco ortodossa, con grande sorpresa, si è constatato che il valore profondo non sta solo nella forma, ma nella sostanza. Di fronte a persone che portavano con sé la loro storia dopo viaggi terribili e lunghi (nel deserto, in Libia, il rischio di annegamento), le esperienze raccontare erano fortemente traumatiche e lo sono state anche per il professionista che ascoltava queste storie, con la difficoltà di uscire anche da questa situazione di sofferenza e di dolore che era diventata anche l'esperienza dello stesso professionista. È stato rievocativo, per il professionista, di un evento - che era stato dimenticato - dell'infanzia di quando una zia era partita e che aveva causato tanto dolore da aver comportato la rimozione

del ricordo. Alla luce di tutto ciò, quando si accoglie
qualcuno che ha vissuto un dramma come questo, la cosa fondamentale è provare a dare sempre l'elemento dell'ascolto, elemento fondamentale della possibilità che qualcuno si apra ed esprima anche i suoi vissuti. Accanto a questo è necessario avere l'accettazione profonda della persona e l'assenza di giudizio perché questo favorisce la fiducia. Inoltre è importante l'empatia, un balsamo per l'anima, il sentire che un'altra persona si mette nei tuoi panni e ascolta profondamente come se sentisse il tuo stesso dolore. Queste sono le tre condizioni fondamentali che detta Carl Rogers per lavorare nei gruppi di incontro e nelle relazioni di aiuto di psicoterapia. A conclusione di questa riflessione sul valore dei gruppi di incontro rogersiani nella rielaborazione del trauma con soggetti migranti è possibile soffermarsi su un aspetto interessante: nessuno ha avuto bisogno di somministrazione di farmaci dopo aver partecipato ai gruppi di ascolto. Quello che ha favorito molto è la naturale dimensione del gruppo che è quello dell'assetto circolare, la circolarità ha riprodotto forse anche un po' parte delle esperienze che i soggetti riescono a vivere nei loro paesi, ad esempio in Eritrea, dove c'è l'usanza che gli anziani e i maschi del villaggio si riuniscono in cerchio intorno ad un grande albero, che viene definito l'albero delle parole. In questo incontro, attraverso le parole, è stato ricostruito il tessuto di una trama strappata.



Transcript

Attraverso lo spezzone di un film, "Orizzonti Mediterranei" di Pina Mandolfo e Maria Grazia Lo Cicero, curato nel 2014 dopo gli eventi dell'ottobre 2013 dove morirono 388 persone nel naufragio dell'isola di Lampedusa.

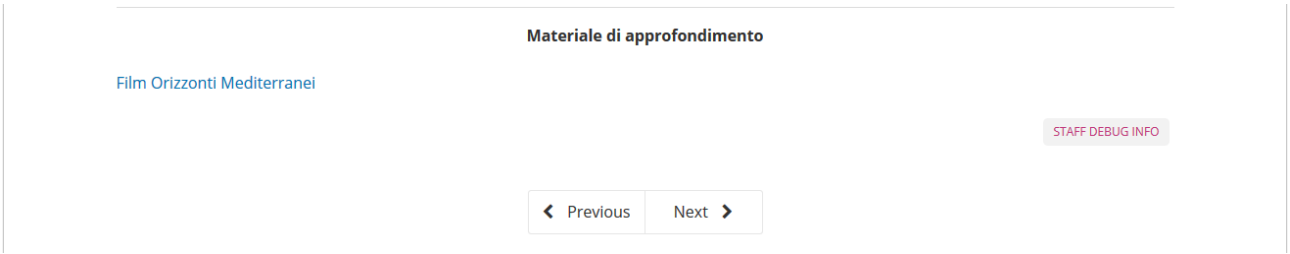
In quel tempo si è pensato di elaborare questo film per dare persone contezza e conoscenza della realtà drammatica dell'esperienza di migrazione.

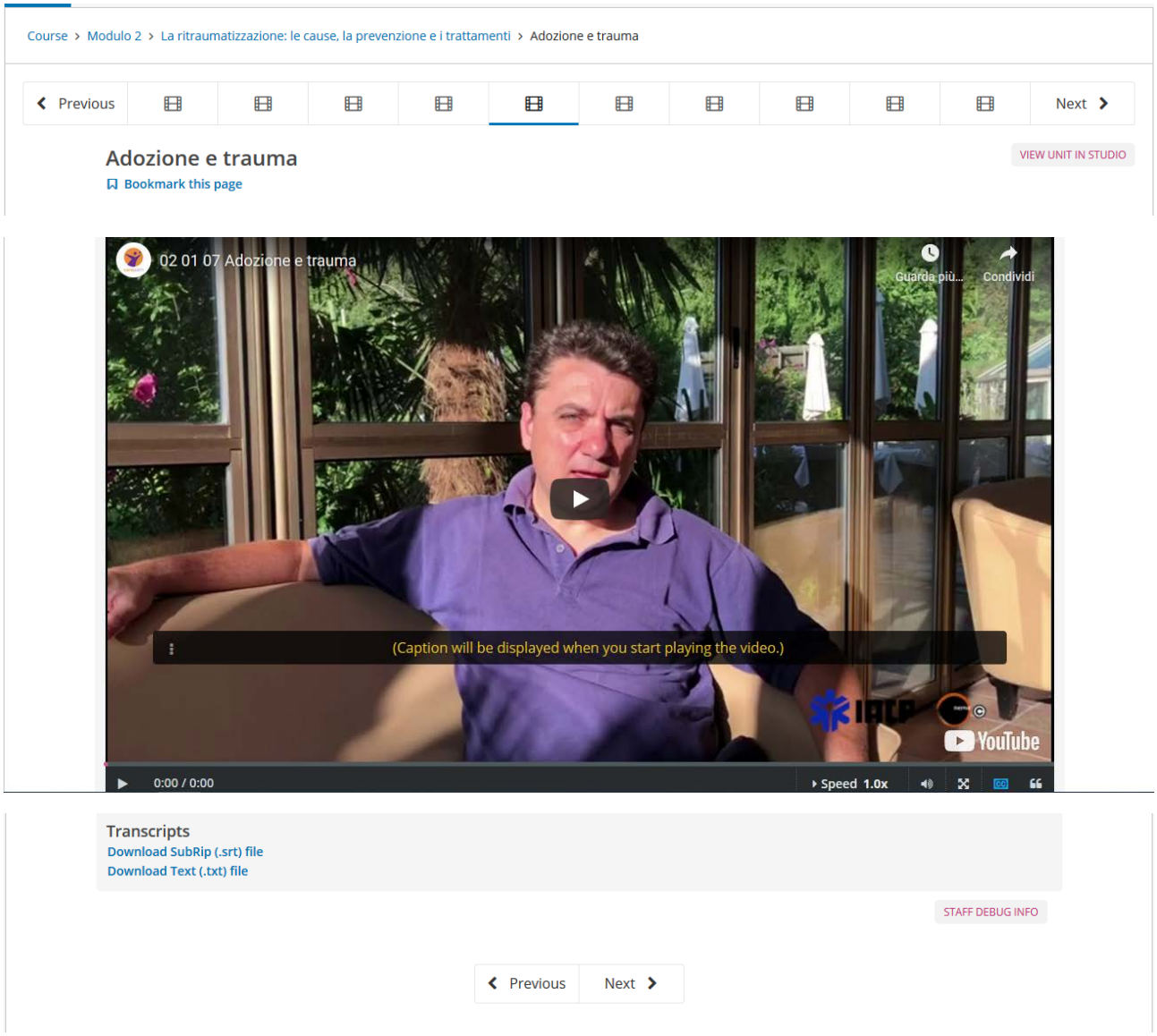
La storia del ragazzo protagonista è una storia che racconta di violenze fisiche e psichiche; la cosa singolare è che questo ragazzo è arrivato accompagnato dalla sorella e questa - anch'essa oggetto di violenza e stupro - non aveva mai parlato con il fratello di questa esperienza, come lui a sua volta era stato violentato e non ne aveva mai parlato con la sorella.

Si è osservato come per lui era fonte di vergogna parlare di questa esperienza, tant'è che aveva chiesto che la sorella non fosse presente, perché lui non voleva che lei lo sapesse, ma un po' - come confessò in seguito - per vergogna di essere un uomo e di essere

stato fatto oggetto di violenze.
Va ricordato che questo ragazzo aveva solamente 16 anni.
Nella testimonianza che il ragazzo rende si ascolta cosa è accaduto nel suo percorso
e come l'unica modalità per lasciare che il suo flusso emozionale non si interrompesse
fosse stata quella di ascoltare senza mai interrompere la narrazione.
Solo in pochi casi, in caso di situazione, qualche cenno del capo o la condivisione di
uno sguardo più profondo, favoriva per lui la possibilità di continuare a parlare della
sua storia.
Si osserva quindi come l'aspetto empatico ha a che fare con la manifestazione di un'empatia
più che verbale situazionale, cioè il contatto visivo, cenni del capo, il corpo che si protendeva
verso di lui.
Questo è stato necessario per aiutarlo a parlare, senza
mai toccarlo; questo perchè per lui il contatto era fonte di vergogna, come fosse un bambino
incapace di esplorare una storia difficile e di sopportarla, lui che era piccolo della
sorella riteneva di dover essere quello che dava sostegno e coraggio alla sorella.
Anche qui si osserva come la delicatezza, il tatto, l'empatia e l'ascolto favoriscono
profondo l'emergenza delle relazioni di condivisione.
Il video ha a che fare con l'esperienza
di ascolto di due storie: quella di una ragazza
o quella di un ragazzo, che sono fratelli.
Questi due fratelli, partiti dall'Eritrea
e approdati a Lampedusa nel 2014, portati al CARA di Mineo
rimanevano presso la struttura per ottenere il permesso di soggiorno,
ma quando si è cercato di intervistarli peravere la possibilità di dare testimonianza
delle loro esperienze e storie ci si è resi conto alla base di questo tipo di racconto
doveva esserci una dimensione di ascolto molto attenta, delicata perché questi due ragazzi
erano stati fatti oggetto di torture e di violenze molti forti e drammatiche.
Ognuno di loro aveva chiesto di parlare in assenza dell'altro.
La storia della ragazza, della sua esperienza di viaggio iniziata per dare possibilità
al fratello di non essere costretto a 16 anni di fare il servizio militare.
Nella sua narrazione si capisce che lei dice una cosa fondamentale: "non posso dimenticare,
non trovo la forza di parlare"; si tratta delle parole chiave e allora l'ascolto è

stato accompagnato con un contatto tra le mani del professionista e quelle della ragazza.
Lavorare con contatto fisico in presenza di queste esperienze è complesso, anzi è preferibile non toccare le persone oggetto di trauma e violenza fisica; in questo specifico ci si è resi conto che la ragazza aveva la necessità di essere profondamente sostenuta per poter raccontare questa storia, così la professionista ha chiesto se poteva prendere le sue mani. Proprio la richiesta, e non l'azione non accettata, ha favorito la possibilità che lei desse il suo assenso.
Con questo contatto si è creato un canale di energia forte e potente, ogni volta che la ragazza doveva parlare di aspetti particolarmente traumatici e dolorosi tendeva a fermarsi e così la professionista stringeva le sue mani provocando così il proseguire del flusso energetico necessario per il prosieguo della storia.
A conclusione di questa esperienza si può affermare che mai il racconto di qualcuno può essere, in presenza di storie di traumi, fatto oggetto di banalizzazione o di esasperazione o di amplificazione, la cosa fondamentale è l'ascolto della storia, come viene raccontata, ascoltando con grande sensibilità e soprattutto empatia e riconoscimento della sofferenza altrui.
Questo è stato l'elemento fondamentale che ha consentito di aver accesso alla espressione emozionale più intensa e profonda di questa profonda nel racconto della sua storia.





Transcript

Adottare un bambino significa vincere sulla natura, in particolare sulla sterilità.

Il gesto di un genitore che adotta un bambino è un gran regalo che il genitore fa, non solo a se stesso in quanto in questo modo finalmente ha un figlio, ma anche al bambino, perché il bambino finalmente trova una famiglia.

Si discute se chiamare il genitore “genitore adottivo” o limitarsi al termine “genitore”.

Chiaramente il genitore adottivo è un genitore a 360° che non ha nulla in meno di un genitore biologico, lo dicono le ricerche, ma soprattutto lo dice la relazione che viene a generarsi tra figlio e genitore.

Avere un figlio adottato ha molte sovrapposizioni con l’avere un figlio biologico.

Per un genitore adottivo sentirsi chiamare babbo è ogni volta una sorpresa, mentre per un genitore biologico è forse scontato.

Questo vuol dire che forse la genitorialità adottiva è persino più intensa di quanto possa essere quella biologica.

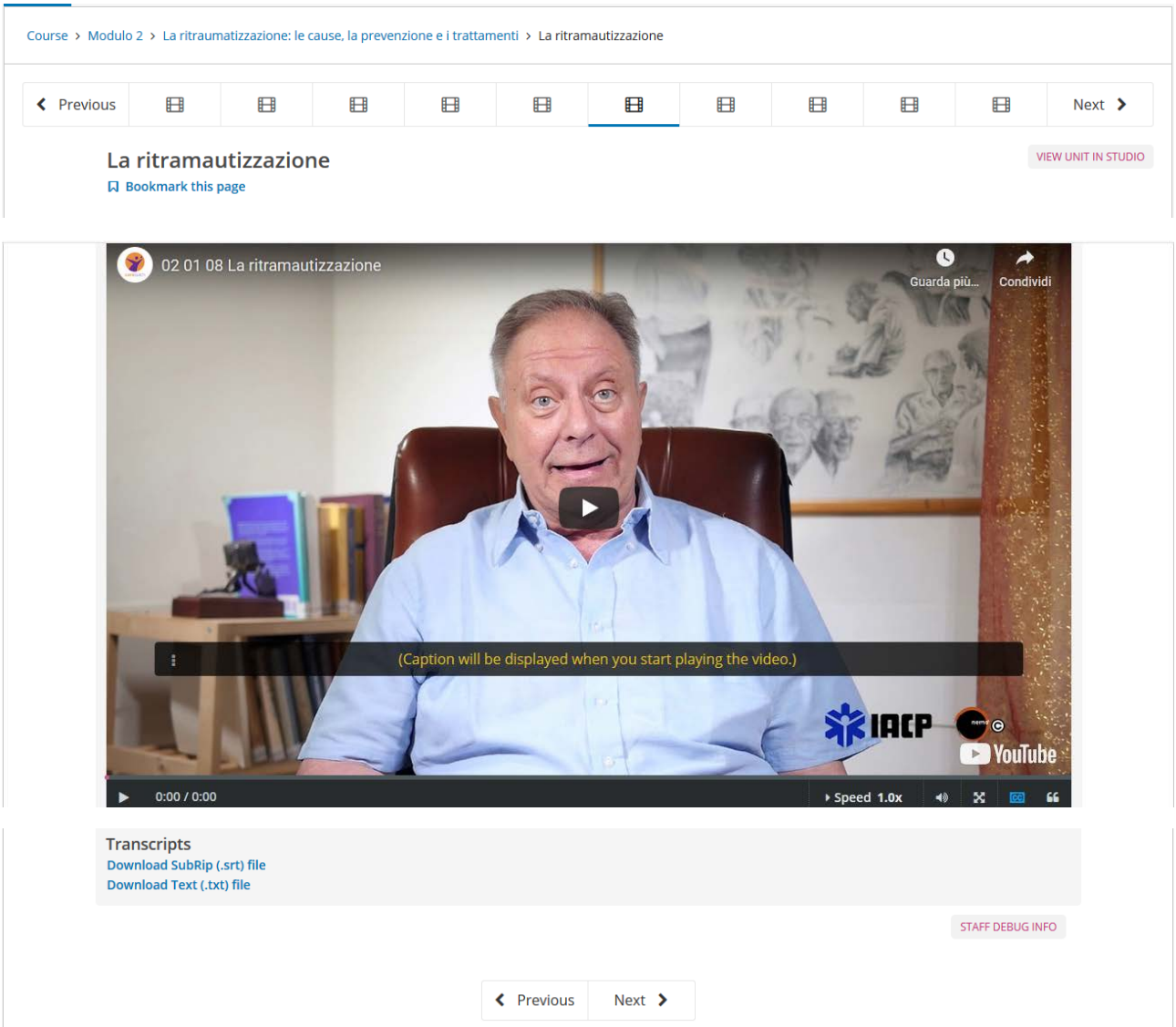
Questo però deve porre comunque delle attenzioni da parte del genitore: il figlio adottato ha il diritto ad essere felice e per essere felice si deve anche considerare quale è stata sua storia, che noi non sempre potremmo conoscere, perchè nessuno ce la racconta e lo stesso figlio non se la ricorda.

Tuttavia si deve prestare attenzione con sensibilità a quelle che sono le problematiche che il bambino può portarsi dietro.

Il bambino, e poi l'adulto, adottato spesso si confronta con temi esistenziali: quali sono state le mie origini?

Perché sono stato abbandonato?

Sono risposte a cui nessuno può dare spiegazioni, ma questo non esclude che la vita è bella e tutti dobbiamo tendere a vivere al meglio



Transcript

I fattori di ritraumatizzazione sono molti, ma principalmente li possiamo dividere in due gruppi.

Quelli che avvengono per cause naturali: come una persona già traumatizzata si trova a rivivere il trauma in quanto esposta a stimoli esterni che sono traumatici (come una catastrofe, o vede persone che vengono traumatizzate, a volte anche vedere un film o un notiziario può essere traumatizzante; quelli in cui il trauma che viene vissuto e sofferto da una persona già traumatizzata, perché gli si offrono dei servizi, delle cura, da parte di persone inesperte o di un'organizzazione non traum oriented, che anche anche non volendo provocano danni ritraumatizzando la persona.

Infatti si chiamano trauma inform tutte quelle cautele e procedure che un operatore, un professionista, una istituzione adottano per prevenire la ritraumatizzare dei propri assistiti.

In passato, purtroppo, abbiamo traumatizzato chi già aveva sofferto un trauma non per

cattiva volontaria, ma per ignoranza.

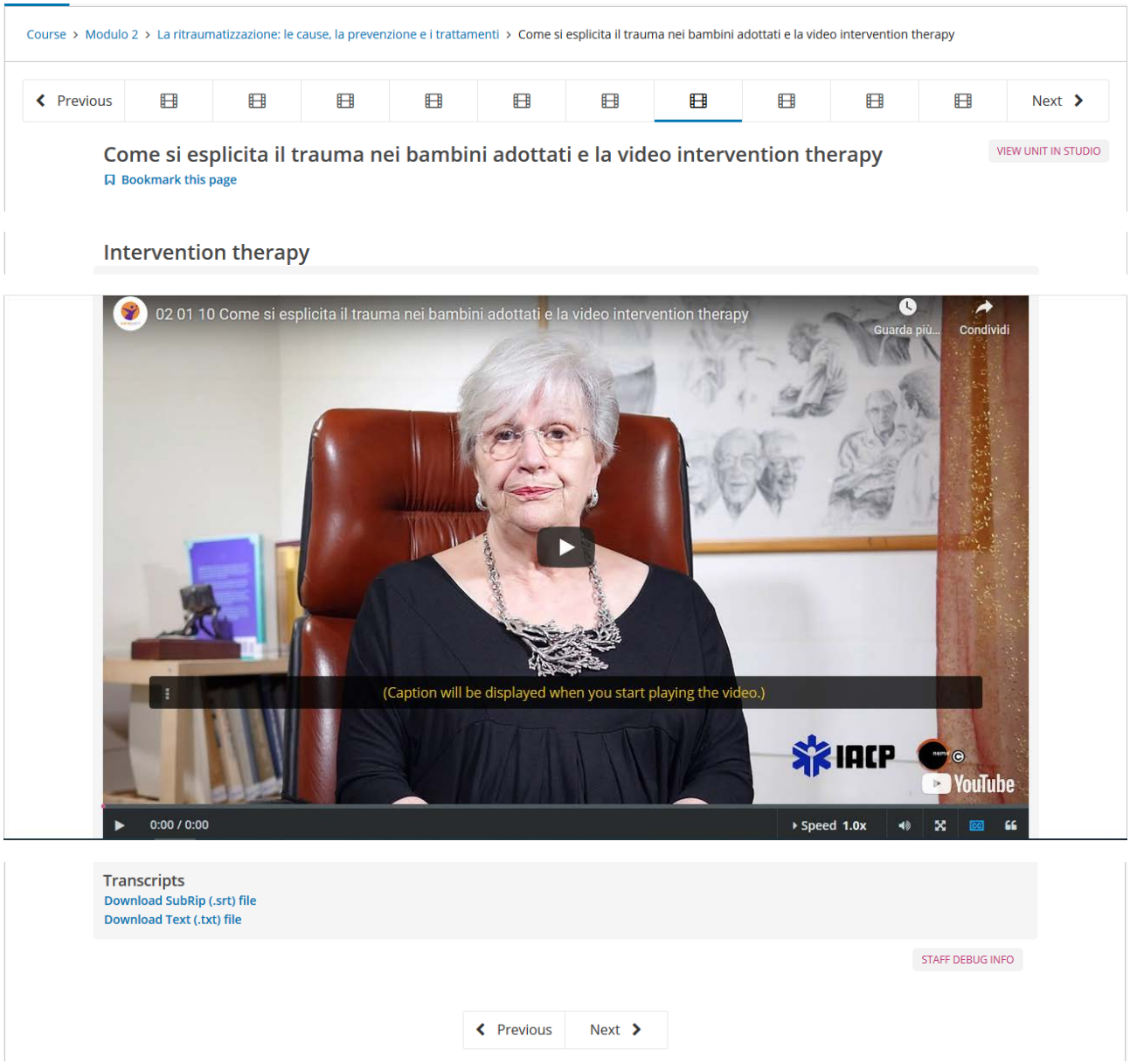
É proprio grazie alle ricerche e alle evidenze cliniche che si è osservato che queste persone, se venivano pressate a fare cose che non volevano fare, se non venivano rispettate nei propri tempi, se venivano forzate a ricordare le loro esperienze traumatiche - ovviamente a fin di bene - pur senza accorgersene si procuravano loro dei danni iatrogeni.

Per cui, con la definizione trauma inform oggi si intende tutte quelle cautele, quella rete di sicurezza sviluppata attraverso le ricerche, che ci han mostrato che è importantissimo, per proteggere le persone già traumatizzate dal pericolo di nuove traumatizzazione, rispettare i loro tempi, centrarsi sull'erogazione di servizi sulla loro persona, sulla loro esigenza e sensibilità, inoltre mai forzare a fare qualcosa che gli utenti non sono disponibili ancora a fare.

Il perchè è molto semplice: abbiamo osservato che persone già traumatizzate hanno bisogno di accoglienza, di benevolenza e dei porti sicuri in cui riprendere le forze e riprendere i loro ritmi di esplorazione che, proprio perché traumatizzati, necessariamente cauta visto la loro pregressa esperienza.

Quindi, fidarsi delle capacità di autoregolazione degli utenti traumatizzati è fondamentale buona cura.

Rispettare le persone - è interessante notare - sembra così semplice è invece spesso difficile nel mondo delle cure.



Transcript

Il sostegno alla genitorialità adottiva nel sostegno post adottivo è importante perché,

nel periodo post adottivo verranno ad evidenziarsi i traumi che i bambini hanno subito durante

il periodo precedente, durante il periodo dell'istituzione, quello in cui sono stati

lasciati dalla propria famiglia o madre, o in istituto o in altre famiglie.

Tutto questo sarà importante per la famiglia che adotterà questi bambini perché di fatto

si ripresenteranno delle difficoltà importanti nella relazione con la nuova famiglia.

Dalla ricerca sappiamo che i traumi hanno la capacità di rompere le relazioni, di renderle

problematiche e difficili, i bambini non fanno eccezione a questo.

Il poter avere consapevolezza della difficoltà che il bambino trova nella nuova famiglia

adottiva può rendere più facile o, perlomeno, più consapevole il genitore del percorso

che si troverà a dover affrontare.
Negli scambi che costituiscono la relazione, negli scambi interattivi, i bambini saranno difficile da gestire, possono dare dei segnali confusi e pochi chiari, sembrare non interessati, assenti.
Tutti questi sono aspetti che andranno analizzati punto per punto e che faranno parte della storia di ogni adottato.
In tal senso noi sappiamo, sempre dalla ricerca, che ogni scambio interattivo è formato da micro eventi che analizzati in dettaglio influenzano la risposta adulto-bambino e bambino-adulto; su questo non fa eccezione il rapporto tra genitore adottante e figlio adottivo.
Per questo sarà estremamente importante l'uso del video, perchè proprio in questa situazione in cui il trauma ha creato dei presupposti di difficoltà alla lettura di aspetti microanalitici interattivi sarà importante poterli filmare, vederli in uno scambio e vedere dove e come si muove il bambino nello scambio interattivo e come può rispondere il genitore.
L'uso del video, quindi, sarà veramente da sottolineare e da raccomandare perché sarà un modo di porre le basi e poter guardare in dettaglio in maniera specifica, momento per momento, tutto quello che accade nello scambio tra bambino e genitore.
La cosa importante da sottolineare è che questo particolare uso del video deve, e dovrà sempre, essere utilizzato e mostrato soltanto da terapeuti specializzati in questo particolare uso; non potrà essere utilizzato da chi non ne ha la specializzazione, data la particolare delicatezza del tema trattato.
Si osserva che, come s'è detto, i bambini adottati hanno una modalità di mandare segnali un po' meno evidente, più breve e confusa, di bambini non adottati.
In questo senso l'uso del video sarà estremamente importante perchè consentirà al genitore, scandendo l'interazione momento per momento, di vedere dove e come il bambino è in grado di agganciarsi relazionalmente a lui.
Questa sarà una pietra miliare nello scambio interattivo e sarà l'inizio della possibile nuova costruzione e di un legame di attaccamento.
Un'altro aspetto molto importante dell'espressione del bambino è l'ipervigilanza.
È molto importante perché ci racconta della sua storia, delle sue paure, dell'incuria e trascuratezza che ha vissuto, ma soprattutto se questo bambino ha subito violenza fisica, forse abuso, o comunque violenza assistita nella migliore delle ipotesi.
L'ipervigilanza è un aspetto per cui il bambino è estremamente focalizzato sull'espressione

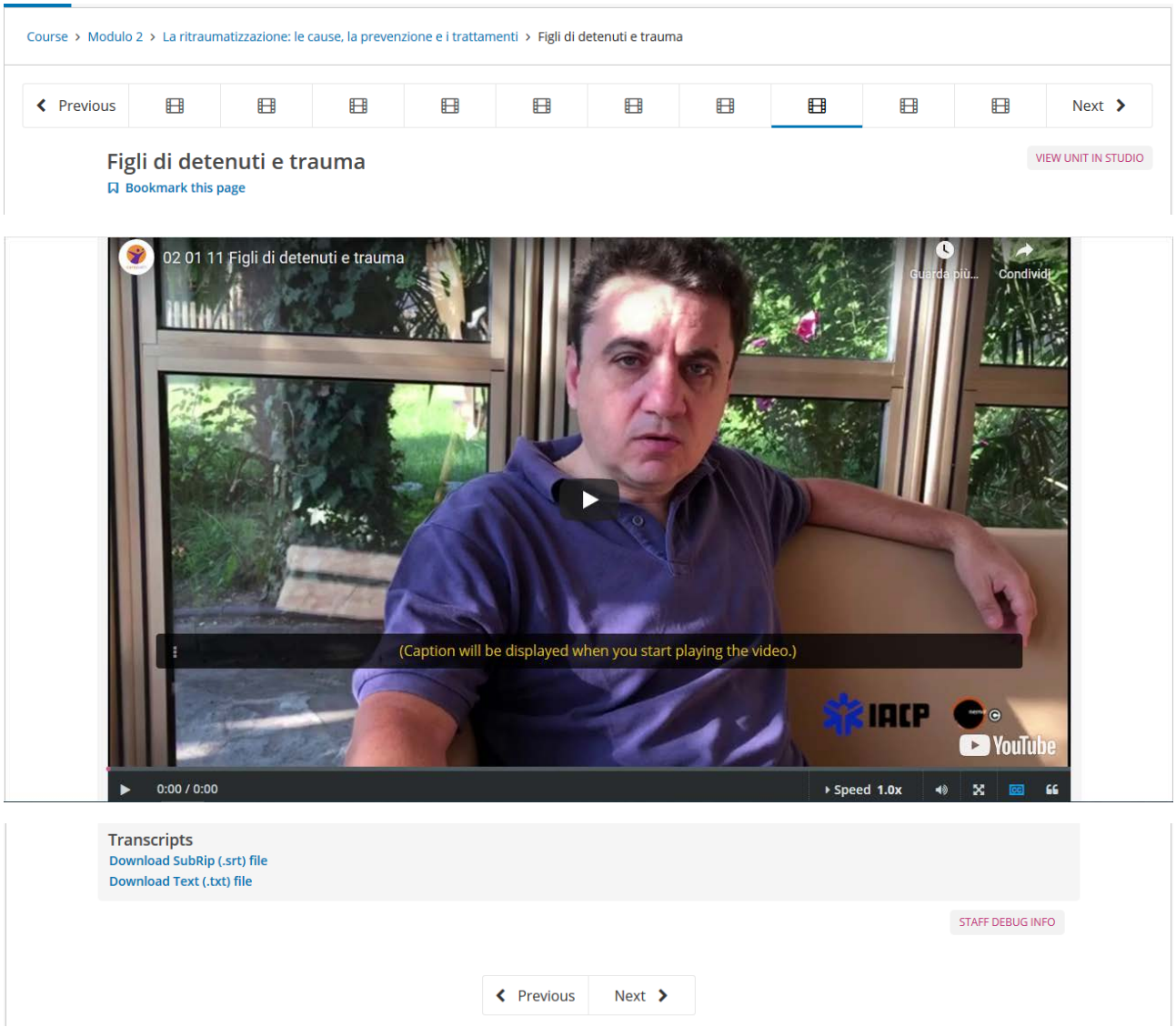
dell’adulto, lo monitora momento per momento per poter leggere attraverso l’espressione dell’adulto se ci sarà qualcosa che potrà essere pericoloso per lui o se quello che sta facendo potrà diventare in qualche modo pericolo o fonte di minaccia.
Indica quindi chiaramente la mancanza di fiducia che il bambino presenta nei confronti dell'adulto, questo tenderà a sparire piano-piano lavorando nella relazione adulto-bambino, ma non sempre in maniera definitiva.
Un’altro aspetto che il bambino presenterà sarà un aspetto di goffaggine affettiva, un aspetto che farà molto soffrire il genitore adottivo perchè sentirà questo bambino mai perfettamente libero nell’esprimere il suo affetto e vicinanza affettiva all’adulto.
Non è responsabilità del bambino, anche questo è un frammento, che si esprime nella relazione, di una storia passata è particolarmente dolorosa.
I bambini sono abituati a non avvicinarsi all’adulto, a far in modo che l’adulto diventi meno pericoloso per sé nella relazione, per cui non sono abituati spesso a toccarlo, abbracciarlo, cosa che nella relazione nuova potrebbe avvenire.
Possiamo quindi assistere a bambini particolarmente vicini, forse troppo, a volte appiccicosi, ma proprio perché non sanno modulare la modalità di avvicinarsi all’adulto, non sanno quando è troppo o troppo poco e sono in un completo disorientamento ed imbarazzo.
Altre volte il bambino si avvicina con un fare estremamente goffo, quasi falso, poco spontaneo, questo è subito monitorato dal genitore che tende ad etichettarlo.
Quello che si raccomanda è vederlo sempre come l’espressione di un momento della storia del bambino, non è mai stato libero di avvicinarsi come avrebbe voluto e come avrebbe sentito ad un adulto, questo rimane ancora in tale modalità poco spontanea e piuttosto goffa.
Un altro aspetto che il genitore troverà sarà la fatica e la difficoltà al sonno e ad avere sempre un sonno estremamente agitato, poco riposante e la difficoltà ad addormentarsi.
Un’ulteriore aspetto si può osservare nella difficoltà di concentrazione, spesso letta come disturbo di apprendimento non meglio identificato:
il bambino non ha disturbo d’apprendimento,
ma la sua modalità ipervigile gli suscita elementi emotivi così difficili, negativi e faticosi che lo distraggono dal compito assegnatogli.
Ancora una volta vedremmo che il bambino è sintonizzato sul volto dell’adulto, la sua espressione, su quello che l’adulto esprime, sulla pericolosità che potrà dimostrare;
tutto ciò renderà difficile al bambino il potersi concentrare.

Tutti questi aspetti però sono estremamente importanti, questi comportamenti sono la narrativa di una storia passata, diranno al genitore adottivo tutto quello che è segnato nella storia del bambino, che forse questo bambino non riesce ad esprimere se non attraverso questi comportamenti;

per cui, forse, è importante pensare che sono informazioni preziose che possono metterci nella condizione di sapere quella parte di passato, assolutamente inconoscibile per noi, ma che ha creato quel cambino così com'è, in quella relazione così com'è con il nuovo genitore adottivo.

Più che situazioni da correggere sono comportamenti da accogliere al massimo, nello pieno delle possibilità di poter leggere cosa ci raccontano di una storia passata che possa diventare, insieme a questo piccolo bambino, oggi una storia insieme.

Come la narrazione del passato possa creare il ponte con la narrativa del presente.



Transcript

Il figlio del detenuto si trova nella condizione di vivere diverse condizioni di difficoltà.

La prima è il fatto di essere deprivato improvvisamente dal proprio genitore e di dover crescere senza di lui.

La seconda è quella di dover vivere in una famiglia che spesso non ha risorse economiche, infatti con l'arresto del genitore viene a mancare, il più delle volte, l'unica fonte di guadagno (per quanto fosse una fonte illecita, ma sufficiente per le necessità quotidiane).

Un'altra tragedia secondaria, ma non meno importante è dovuta al fatto che il bambino si trova immerso in mondo di giudizio:

essere figli di genitori detenuti significa essere figli della colpa;

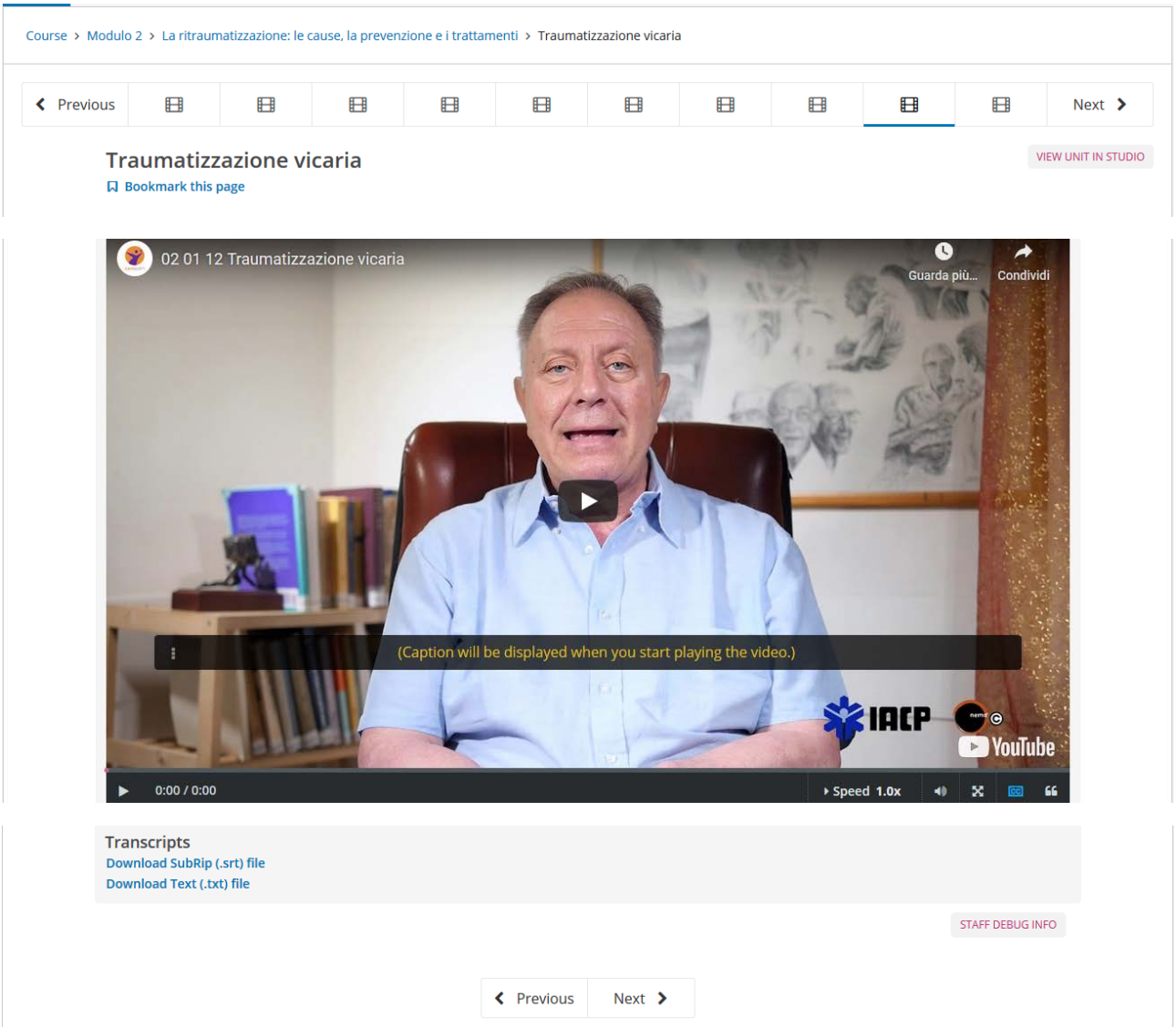
il bambino mano a mano che si relaziona con questo processo sociale

fa suo il giudizio fino a convincersi di essere lui stesso una persona meritevole di punizioni.
Tanto è vero che spesso i figli di genitori detenuti sono bambini agitati, la cui agitazione è dovuta anche al fatto che non ha un genitore - spesso il padre - che lo educa e lo frena nelle sue intemperanze.
È un bambino costretto a vivere da solo, la madre non riesce a far fronte a tutte problematiche che si concentrano sulla sua persone, non potendo più far conto sul contributo del proprio marito.
È una sfida tutta da giocare perchè purtroppo anche gli operatori sociali cadono nella trappola di stigmatizzare il bambino che dovrebbe essere capito ancor di più di bambini, perché vivere da soli con la madre in difficoltà non deve essere assolutamente semplice.
C'è una discussione su come comunicare al bambino che il proprio genitore è stato arrestato.
Tanti genitori, per vergogna o per difficoltà, raccontano al bambino la storia di essere dovuti improvvisamente partire per andare a lavorare.
Chiaramente le bugie hanno le gambe corte e il bambino non è convinto, perché se fino ad allora il padre lavorare tornando a casa ogni giorni non si spiega come mai sia cambiata improvvisamente la mansione lavorativa e sia partito per così tanti giorni, mesi, anni, i natali, i compleanni, così il bambino capisce la bugia.
La cosa migliore da dire ai bambini in questi casi è dire la verità "il babbo ha sbagliato, ha commesso degli errori e purtroppo deve stare in un luogo a rispondere di del suo comportamento, ma sta bene, ci sono tutti i servizi perchè stia bene, stai sereno, lo potrai vedere presto.
Questo è un'altro tema legato ai figli di genitori detenuti: se far vedere o meno il genitore in carcere.
Alcuni operatori sociali sostengono non sia opportuno perchè l'ambiente del carcere non è ambiente tagliato sulle esigenze del bambino.
É vero che entrando in carcere si ha a che fare con poliziotti, ambienti non sempre dignitosi, ma è altrettanto vero che non c'è elemento più importante per un bambino che quello di poter vedere il genitore.
In realtà quindi andrebbero facilitati gli incontri tra detenuti e figli.
Fino a pochi anni fa esistevano ancora dei muri che dividevano i detenuti dai visitatori, oggi molte cose sono cambiate: molti carceri dispongono di una ludoteca o di ambienti più

colorati, con giochi, e gli stessi agenti penitenziari sono molto più preparati nell'accogliere i bambini.

Questo tuttavia non è il tema principale, il tema non è se il bambino va in un ambiente idoneo o meno, ma è quello di facilitare l'incontro tra genitore e figlio.

Tutto ciò viene rivisto ovviamente se il genitore è in carcere per un reato contro il minore.



Transcript

Che cos'è il trauma vicario? È il trauma derivante da assistere persone che sono colpite da traumi; infatti il trauma vicario in genere colpisce coloro che erogano servizi alle persone colpite da traumi naturali (tipo catastrofi) o persone che soffrono di traumi a seguito di violenze perpetrate ai lori danni altri esseri umani,

esempi sono la guerra, gli attentati

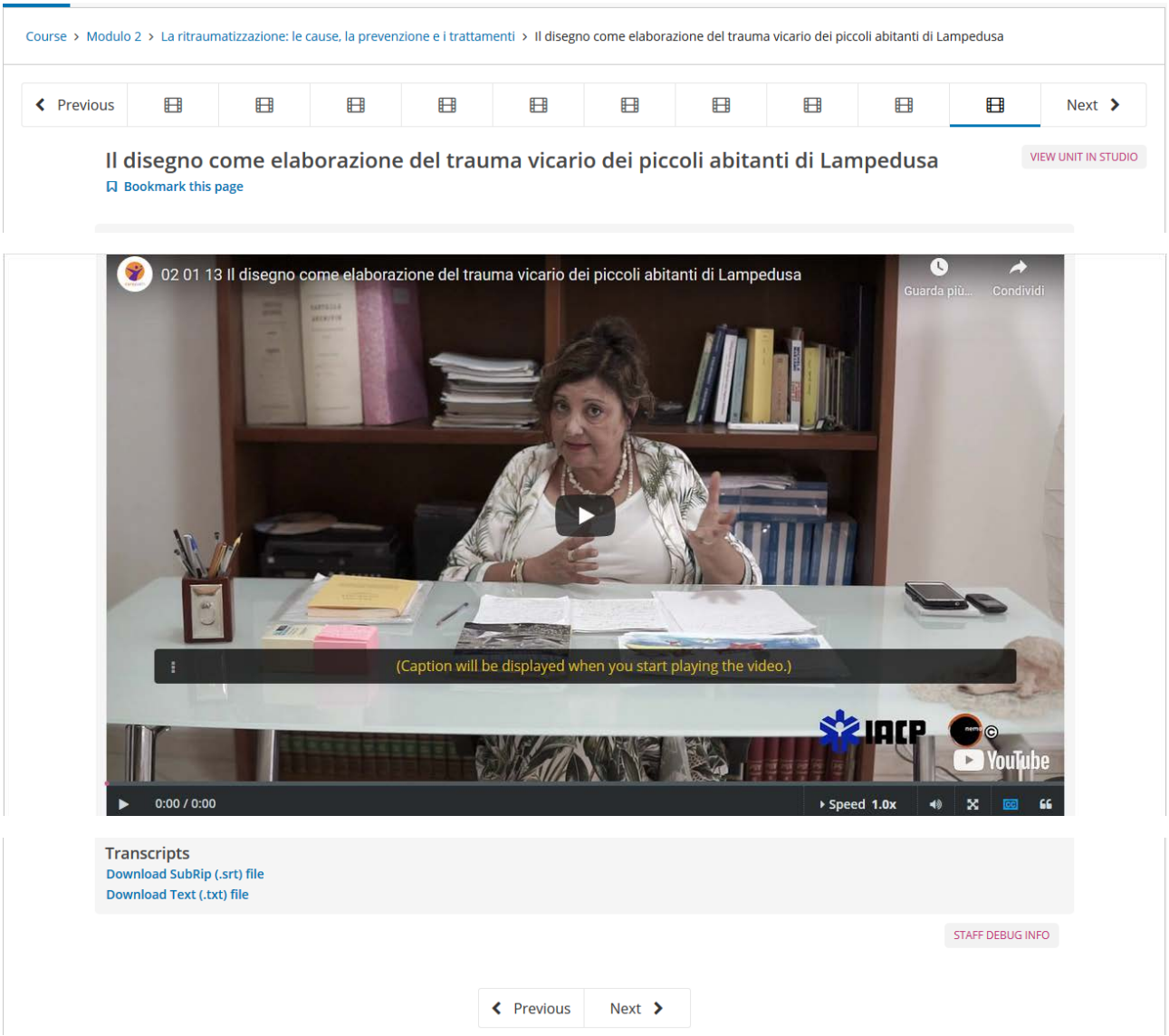
terroristici, ma anche la violenza famigliare o assistere le vittime di violenza sessuale.

Insomma l'operatore con buona volontà si apre e da assistenza, supporto umano e contatto psicologico ad una vittima di trauma, ma questo - giornalmente - nonostante il significato profondo della generosità dell'apertura, anche a livello esistenziale, può incidere

sulla mia salute mentale, le mie forze, il mio metabolismo e diventare fonte di un vero

e proprio trauma con tutte le conseguenze che hanno i traumi.

Per cui è importante per prevenire e diluire l'impatto del trauma vicario che gli operatori
e tutti colori i quali si trovano per il loro lavoro esposti a vittime di traumi o violenze;
i poliziotti ad esempio, o i giornalisti reporter e tutti coloro che a vario motivo sono a contatto
con persone traumatizzate.
È buona regola, quindi, poter prevenire il
trauma vicario, come anche quello più generalmente chiamato burn out che colpisce anch'esso persone
nelle relazioni di aiuto e che colpisce duramente, in particolare, quando non si riesce a ricaricare
le batterie, staccare dal lavoro che è pesante e oneroso oltre che bello, e anche avere un
certo bilancio tra il lavoro - diciamo - umanitario e la propria vita personale, la famiglia,
gli amici e gli svaghi. Insomma è una sfida per tutti coloro che
meritevolmente offrono i loro servizi con passione, generosità, empatia anche estendere
tale rispetto a se stessi,
perchè purtroppo non si può dare agli altri quello che non
si ha, è quindi moralmente doveroso promuovere la propria resilienza, salute e benessere,
perchè se vogliamo dare molto dobbiamo includere con generosità anche la persona che non ci
abbandonerà per ogni ora della nostra vita: noi stessi.



Transcript

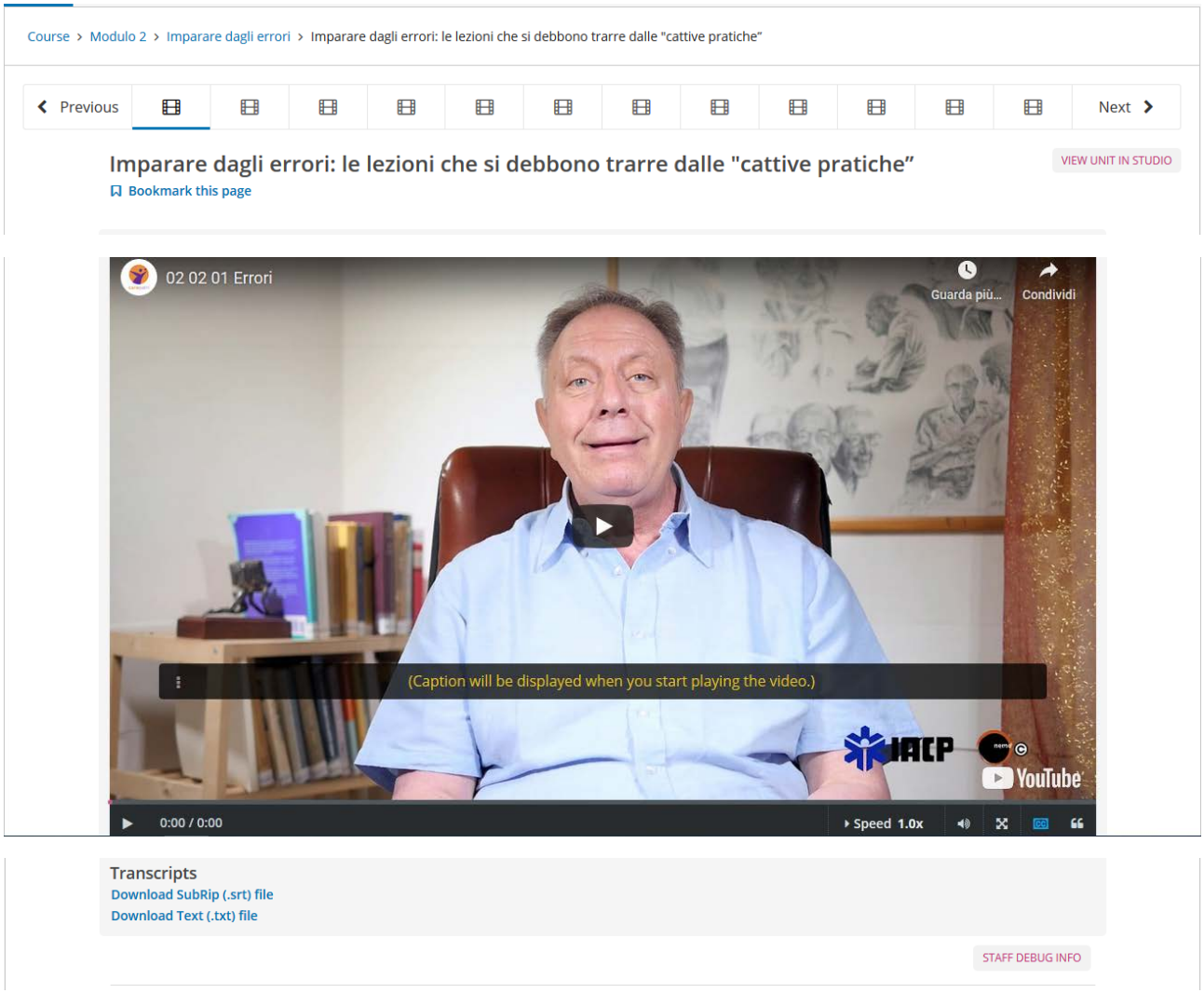
Il 3 ottobre 2013, a Lampedusa, si è verificato un evento di particolare drammaticità.

Un barcone con 500 migranti ha fatto naufragio e 388 di questi hanno perso la vita. Tra questi che hanno perso la vita si riscontrano donne, bambini, molti giovani e per la popolazione di Lampedusa è stato un evento particolarmente traumatico perché tutti gli abitanti si sono ritrovati a prestare soccorso nel mare e a recuperare centinaia di cadaveri e vivere e vedere dimensioni sconvolgenti legate alla tragicità della morte, addirittura è stata ritrovata una mamma che stava partorendo durante il naufragio con il figlio ancora attacato col cordone ombelicale.

Un evento di questo genere inevitabilmente non poteva non produrre l'effetto di un trauma vicario sulla popolazione e quindi si è cercato, in qualche modo, al poliambulatorio di avere quanto più possibilità di ascolto,

visite e supporto alle persone che avevano avuto esperienze di tipo traumatico nel prestare il loro aiuto,
ma una delle situazioni più difficili da gestire è stata quella legata all'esperienza traumatica percepita dai bambini, in particolare delle scuole elementari.
L'immigrazione a Lampedusa è un'esperienza pluriennale e tutti (anche i ragazzi giovani) sanno che spesso viaggi della speranza si risolvono con la perdita della vita, ma i bambini di 6 e 7 anni sono particolarmente sensibili a questo tipo di esperienza e molti di loro hanno iniziato ad avere paure, angoscia, fobie, tutti fenomeni tipici di chi è stato esposto a esperienze traumatiche dove la vita viene messa in pericolo e oggettivamente perduta.
Per questi bambini questo evento era accaduto nel loro mare, un mare che vivono come fonte di gioia, gioco e divertimento; quel mare che rappresentava per loro un elemento di gioia e leggerezza improvvisamente si è trasformato in un mare di morte.
Una delle possibilità che si sono messe in atto per affrontare l'elaborazione di questo trauma vicario dei bambini è stata quella di proporre loro di fare dei disegni, questi disegni adesso mostrano come i bambini rispondo e reagiscono a questo trauma.
Si deve fare una piccola premessa: l'arte è uno strumento potente per rendere tangibili eventi dolori e spaventosi, in sé l'arte produce effetti liberatori e di rielaborazione anche degli eventi traumatici.
Ci si deve chiedere poi cosa sia un evento traumatico dal punto di vista dei bambini.
In questo caso dipende dal tipo di evento, l'evento traumatico ha diverse forme, può essere prodotto dall'uomo (come le guerre e del terrorismo) o determinato dalla natura (uragani e terremoti) e ognuno di questi lascia tracce specifiche e specifiche paure nella mente e nella psiche dei bambini.
Da questo punto di vista è stato necessario nel caso del naufragio di Lampedusa ricomporre la frattura emozionale e interna che i bambini avevano avuto, legata al fatto che questo evento potesse non solo ripresi, ma investire anche le loro famiglie; questo perché un bambino di 6 e 7 anni è difficile comprendere il senso della morte e sappiamo come i bambini riconducono tutto a se stessi.

Questi eventi e storie di morte hanno avuto
l'effetto di produrre in molti bambini la paura di mangiare il pesce (i pesci avevano
mangiato i bambini e le loro mamme) o di andare al mare (nel mare ci potevano essere i cadaveri);
è stato necessario ricostruire questo puzzle della loro dimensione di serenità rispetto
anche all'immaginario che si costruiva nell'isola di Lampedusa.
Questo è stato possibile con il disegno, come si diceva.
Con il disegno è possibile costruire una narrazione di come ogni bambino individualmente
abbia percepito questo evento, perchè l'evento era collettivo ma la percezione era specifica
per ogni bambino.
È stato importante non offrire elementi di consolazione immediata
e risolutivi, ma lasciare che ogni bambini per mezzo dell'elaborazione grafica e verbale
che l'ascolto che ha seguito i disegni, trovasse delle personali soluzioni a quello
che è un elemento fortemente angoscioso come la dimensione della morte e della perdita
che a 6 - 7 anni è l'angoscia più grande per un bambino.



Transcript

Imparare dagli errori, più facile a dirlo che farlo, anche perchè c'è una certa

cultura che ci spinge ad associare alla nozione "ho commesso un errore" un modo di disappunto,

ma anche una certa vergogna: la paura di aver perso la stima dei colleghi - e magari degli

utenti - e quindi una certa inflessione un po' infantilistica che tende a rimuovere

l'errore, a scusarsi dicendo che non è colpa nostra, che è colpa di altri fattori

esterni, insomma con un risultato misero che ci impedisce di vedere del un po' l'ovvio:

che dietro ogni errore noi possiamo trovare un tesoro di saggezza.

Con la giusta attitudine, non difensiva noi possiamo aprirci a imparare dagli errori:

gli errori come maestri che ci aiutano a diventare dei professionisti

che fanno quello che esortano

i loro utenti e clienti a fare, ovvero apprendere dall'esperienza.

È buffa - e tragica - la situazione: noi professionisti della relazione di aiuto ispiriamo

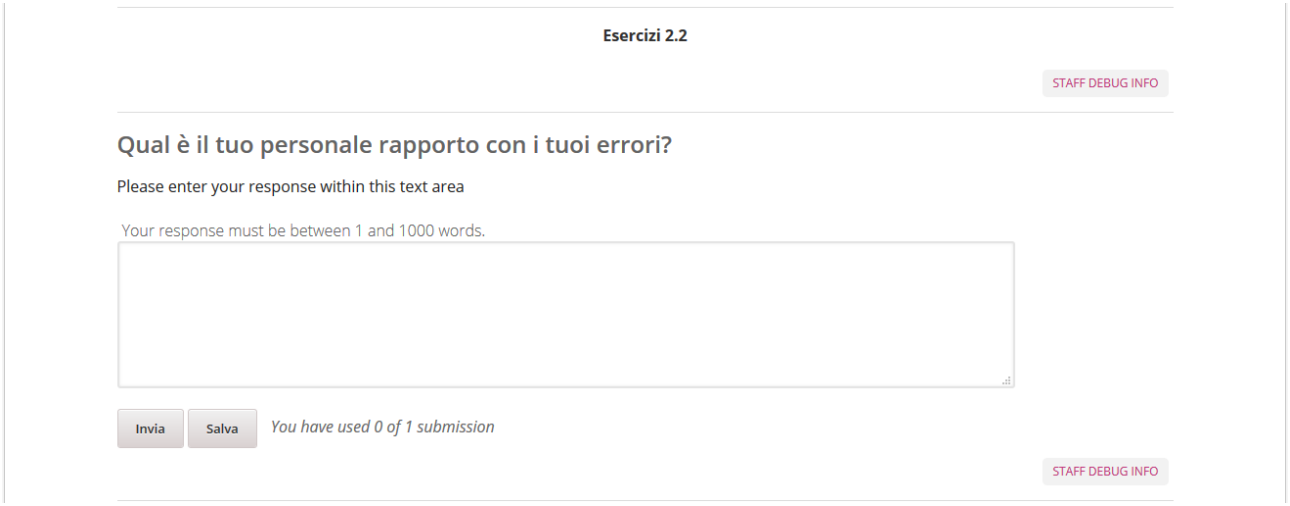
convintamente i nostri clienti d imparare dalle loro esperienze e dai loro errori, ma

questo è valido per i nostri clienti e meno per noi; siamo meno entusiasti noi ad accettare di non difenderci e di ammettere che l'errore è nostro, lo sbaglio è nostro, e così facendo essere aperti all'apprendimento.

Una maniera disfunzionale di costruire l'esperienza dell'errore mi porta a perdere autostima, quando dovrebbe accrescere, come se fosse una cosa un po' pazza che chi prova paura pensa di essere un codardo, ignorando che chi è coraggioso prova paura ma non si fa congelare da questa, e così chi è intelligente e saggio accetta l'errore e impara da esso.

Abbiamo quindi da imparare dai nostri utenti che sono, a volte, più pronti di noi ad accettare con umiltà di imparare dalla loro esperienza e cercare di non commettere sempre gli stessi errori, ma noi siamo condannati ad una vera coazione a ripetere se ci rifiutiamo di ammettere che ridiscendono in io gli errori, perchè così facendo e descrivendoci come vittime ci creiamo una autodefinita situazione di impotenza.

In questo senso diamo il benvenuto agli errori come maestri di saggezza.



Cosa potresti o vorresti fare per aumentare le probabilità che i tuoi errori diventino tuoi maestri e così aiutarci a crescere personalmente e professionalmente?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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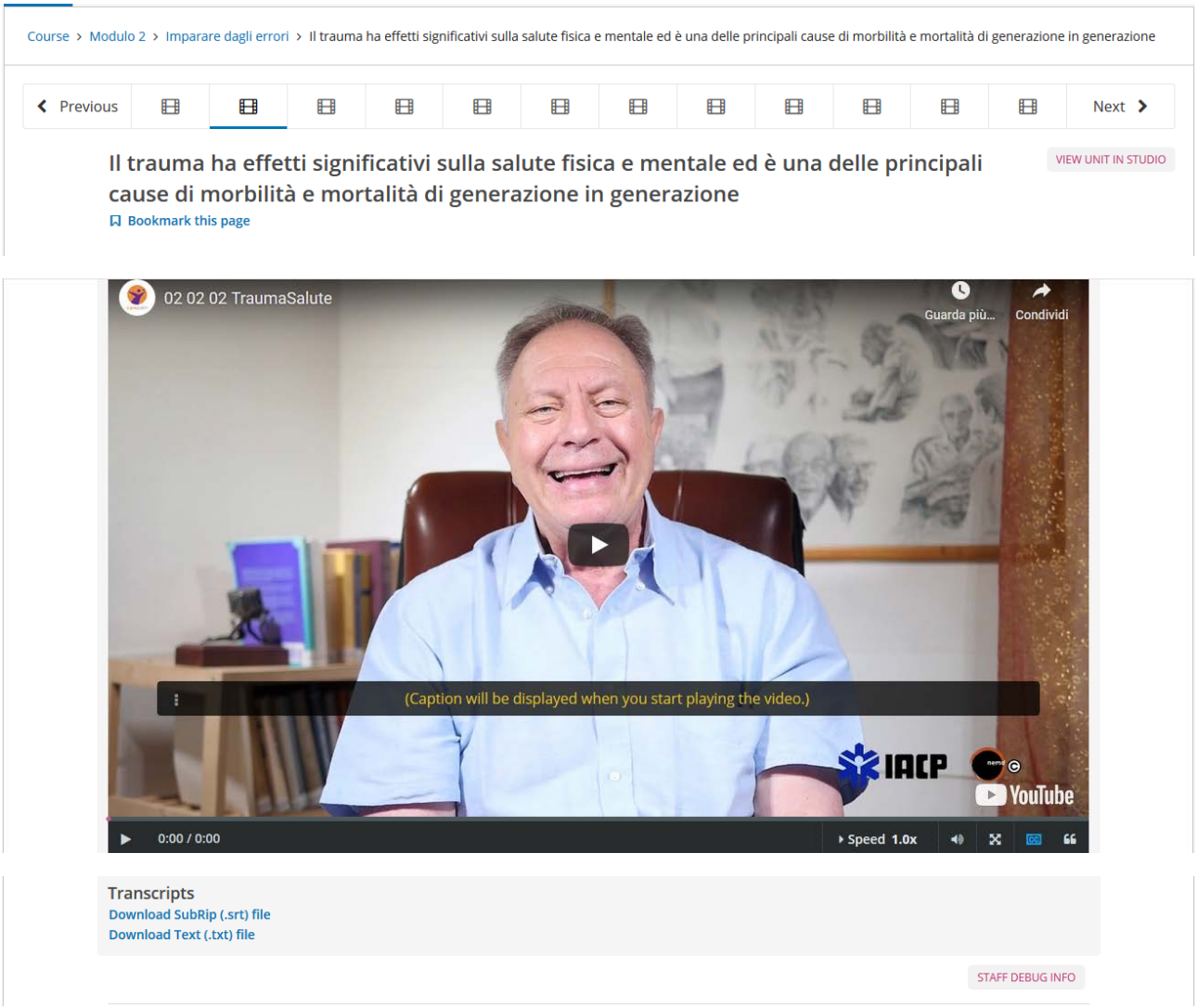


Transcript

Notevole è l'impatto negativo sulla salute fisica e mentale delle persone che soffrono una qualsiasi forma di trauma.

L'Organizzazione Mondiale della Sanità afferma che le varie forme di trauma costituiscono una vera e propria emergenza sanitaria.

Noi vediamo che il capitale umano soffre notevolmente al livello fisico-mentale, in relazione al subire un trauma,

e anche la capacità di contribuire efficacemente alla prosperità

della sua comunità viene compromessa in quanto chi è colpito da trauma è bisognoso di cure

e queste richiedono risorse economiche, finanziarie

ed è anche debilitato nel produrre prosperità

per se stesso, la propria famiglia, comunità e nazione.

Osserviamo anche un altro aspetto molto preoccupante per chi è vittima di trauma:

che non solo

la vittima diventa una persona con danni alla propria salute fisica e mentale, ma sovente,

soprattutto per alcuni tipi di traumi (come essere vittime di violenza o violenza sessuale)

c'è un'alta frequenza di diventare perpetratori e quindi traumatizzare altre persone innocenti

e da vittime divenire aguzzini; un cosa terribile è come il trauma sia un virus che si espande

se non contrastato, prevenuto e curato efficacemente nella comunità: una vera e propria pandemia.

Si potrebbe parlare di pandemie, cioè di qualcosa che si trasmette da individuo a individuo

velocemente in tutta la popolazione che ammonta ad una perdita di capitale umano sempre più

importante.

Dobbiamo anche vedere che in un approccio bio-psico-sociale non possiamo lasciare solo

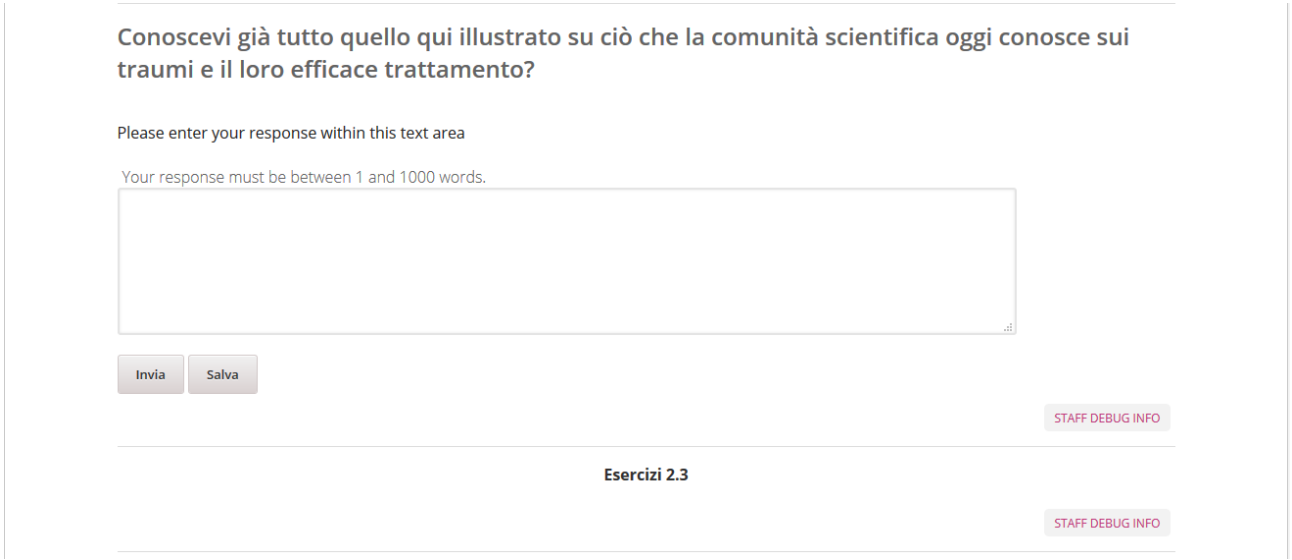
al settore sanitario la prevenzione e cura del trauma, ma è compito della policy e di

quindi tutte le istituzioni - la scuola, il lavoro, le organizzazioni, il mondo della

giustizia minorile - che devono diventare sensibili a queste problematiche e diventare

anche parte di una rete efficace di prevenzione e risoluzione del trauma.

Questo nell'interesse e per il bene di tutti.



Secondo il tuo parere sarebbe auspicabile migliorare questa sezione e aggiungere qualcosa? Se si, Cosa?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva

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Tu hai a disposizione sufficienti aggiornamenti periodici sul trattamento dei traumi e l'espletamento del tuo lavoro?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva

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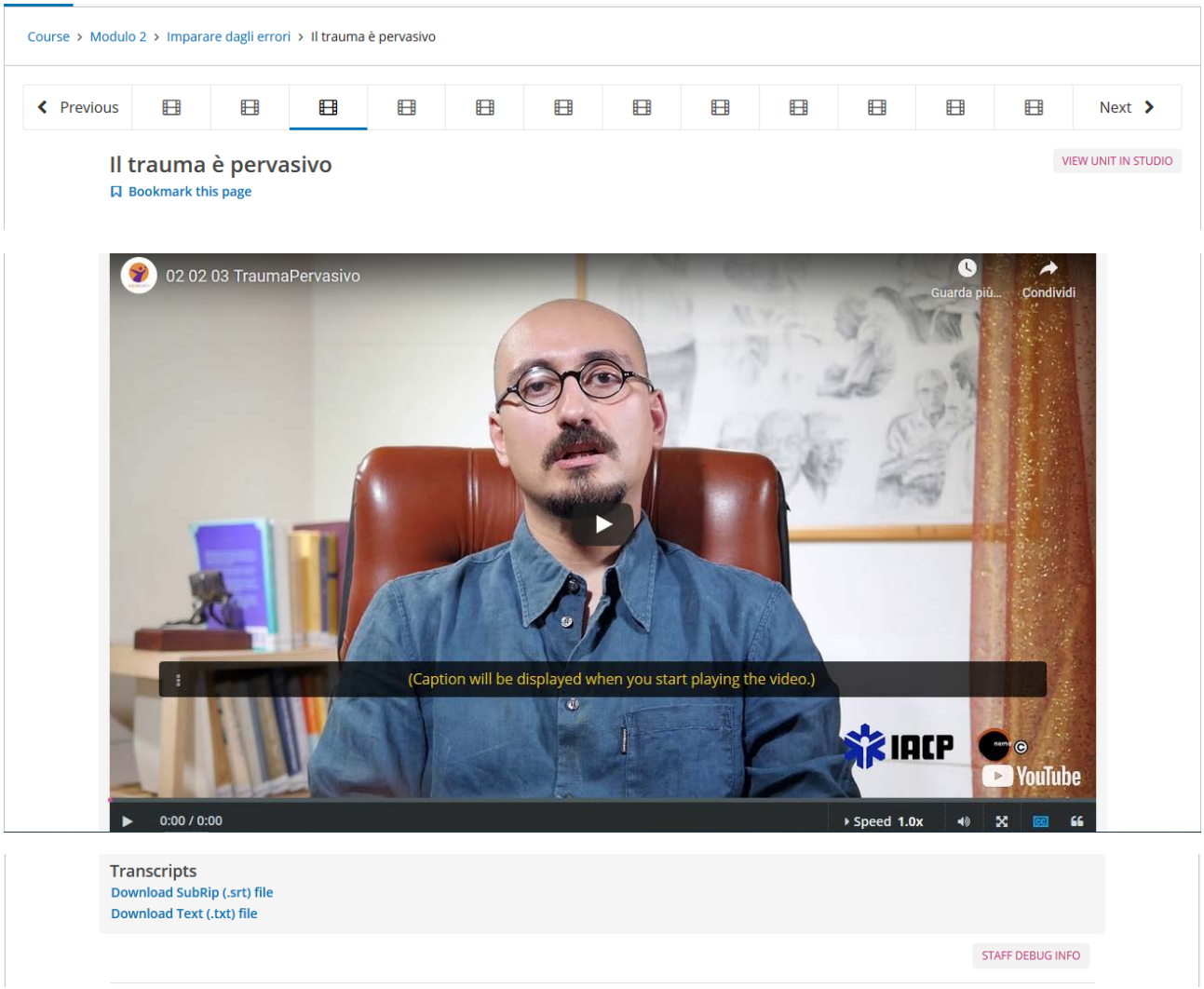


Transcript

Parleremo della pervasività del trauma: si sta scoprendo sempre di più, infatti, che il trauma ha degli effetti importanti sulla comunità e le società.

Un tempo gli studi sul trauma si concentravano più su quegli aspetti dell'acutezza di un trauma e quindi dell'esposizione di un evento di una certa importanza, nel tempo il concetto di trauma si è allargato fino ad includere molti altri aspetti.

Comunque sia il trauma è qualcosa che davvero si mostra in forma pervasiva nelle nostre società: sappiamo che un individuo adulto è stato esposto, o lo sarà in futuro, almeno una volta ad un evento traumatico.

Da alcuni studi, che troverete nell'approfondimento come studi di Benguet, sappiamo che a livello mondiale la percentuale del trauma nelle varie nazioni è molto alta, con variazioni, ma che rimangono comunque percentuali elevate.

È quindi importante oggi andare ad approfondire quali sono gli aspetti che proteggono e quali aumento il rischio di esposizione al trauma.

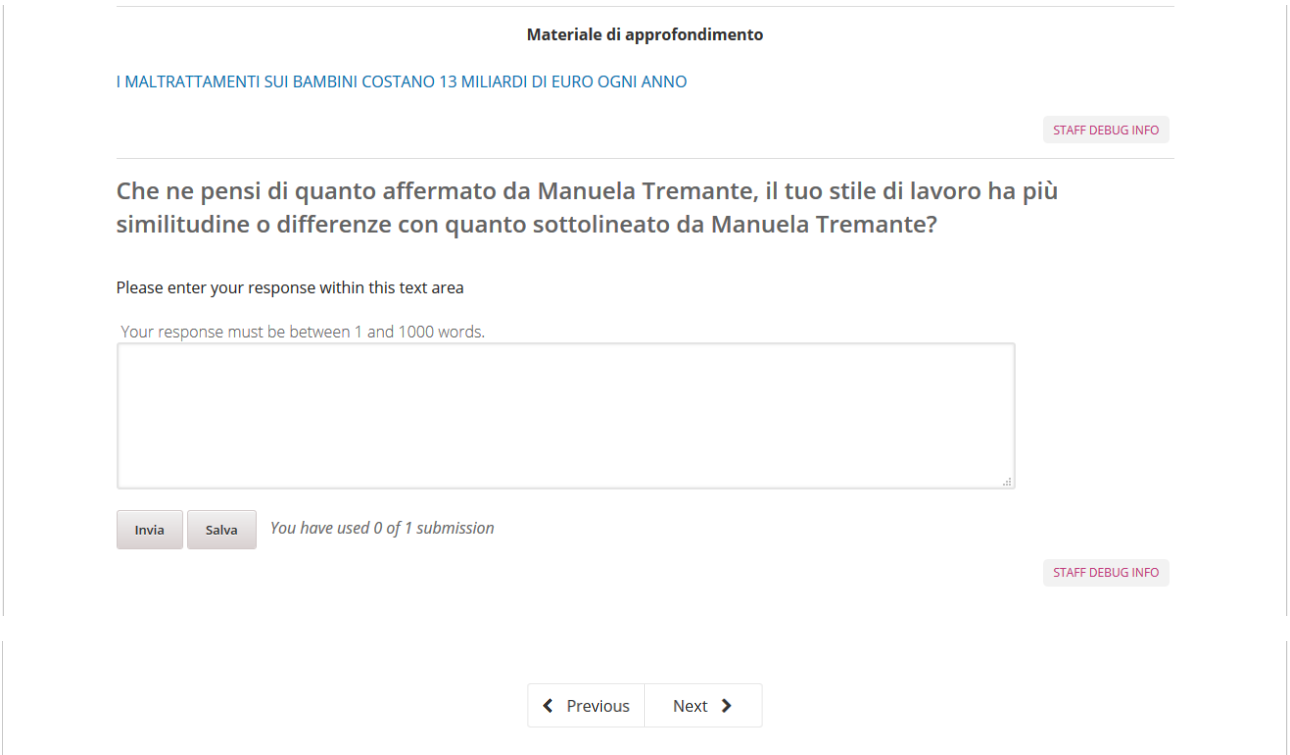
Sappiamo da altri approfondimenti sul tema che il trauma è anche alla base molti dei disturbi cronici che oggi hanno ripercussioni importanti a livello economico e sulla salute pubblica, ma soprattutto vanno anche a inficiare sulle capacità dell'individuo di esprimere le proprie potenzialità e quindi di diventare pienamente un cittadino cosciente ed efficace nella comunità e società in cui vive.

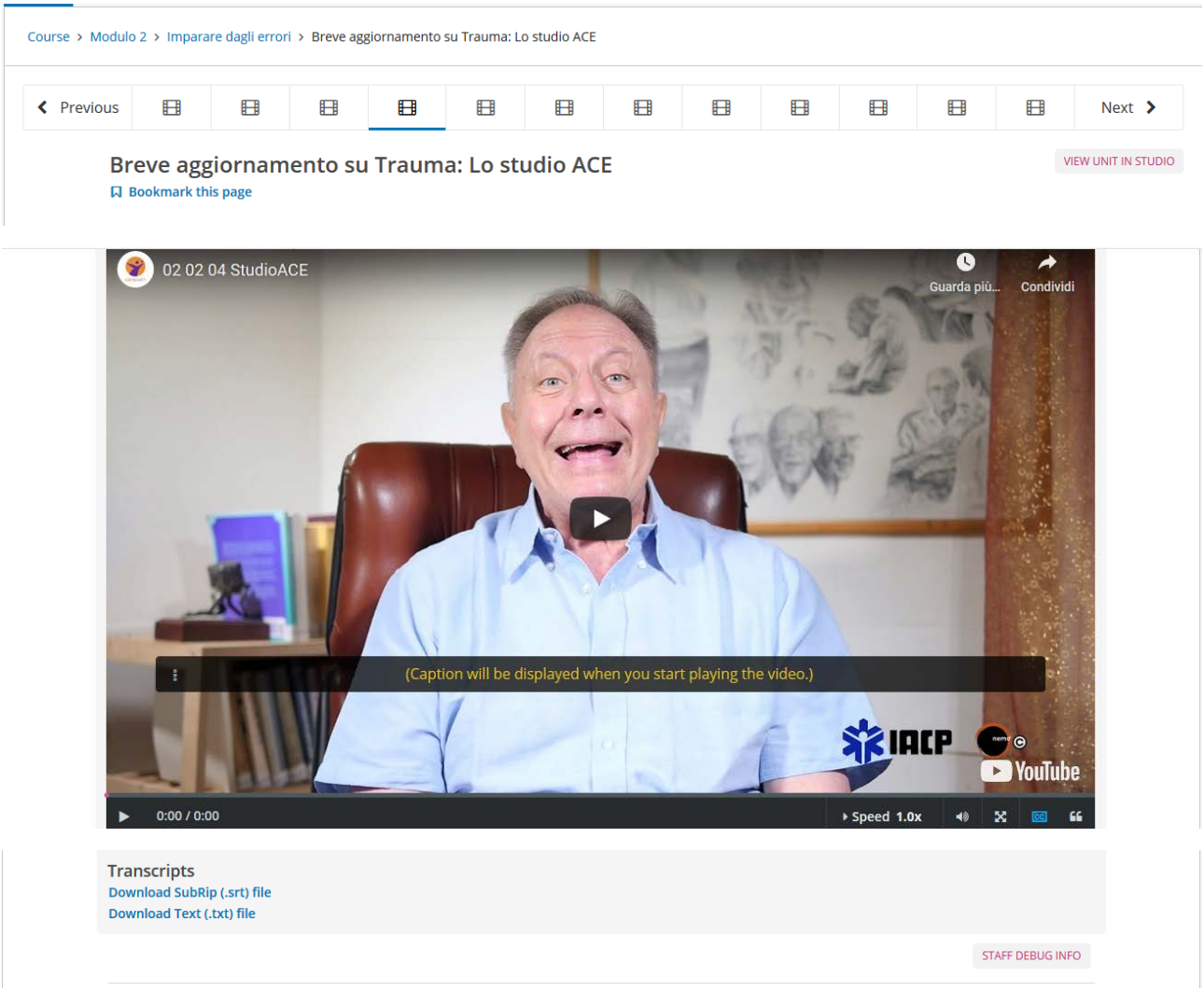
Ancora più importante è il trauma se consideriamo tutti quei traumi che intervengono nel periodo di sviluppo dell'individuo,

infatti è lì, nel momento in cui la persona va a costruire le proprie capacità convinti e, emotive e socio relazionali, che un trauma può andare inficiare potentemente sullo sviluppo di queste capacità,

andando a minare seriamente lo sviluppo futuro dell'individuo.

Sarà quindi fondamentale, e lo è tuttora, approfondire le nostre conoscenze sul trauma, cioè essere informati, proprio come stiamo facendo attraverso questo percorso.





Transcript

Adverse Childhood Experience: su un campione molto vasto della popolazione sono state misurate l'incidenza e i risultati di avere da bambini degli effetti traumatizzanti e le loro conseguenze negative nella vita delle persone, ma andiamo per ordine.

The ACE study, cioè quello che ha studiato le esperienze infantili negativi di una larga fetta della popolazione è stato condotto dalla più grande organizzazione no profit di assicurazioni sanitarie: il Kaiser Permanente un' assicurazione sanitaria privata senza scopo di lucro , in California, ha investito molti milioni di dollari per fare questo studio e che ha beneficiato l'intera comunità scientifica perchè ora sappiamo, e repliche di questo studio e altri simili hanno confermato i dati originali, che mediamente nella popolazione almeno un terzo - quindi ⅓ cittadini - viene colpito nella propria infanzia almeno da un episodio avverso, quindi da un trauma.

Un numero inferiore di cittadini viene colpito da due tipi di traumi,

un numero ancora inferiore ha un numero superiore di traumi.
Più una persona è colpita da traumi multipli e più questa soffre delle conseguenze negative,
come se una coltellata facesse molto male, ma ancora peggio è essere accoltellati più volte.
I traumi sono peggio delle coltellate, perché questi non solo hanno conseguenze
negative - come le coltellate - sull'aspetto fisico e mentale della vittima di tale violenza,
ma sono anche - in qualche maniera - una sorta di virus che porta alcune persone colpite
da traumi
- soprattutto traumi in cui si è vittime di violenza, abuso sessuale etc. -
a divenire in età adulta dei perpetratori.
Inoltre le problematiche di tipo mentale e
di tipo fisico, spesso le due cose sono associate; per spiegare meglio: le persone che sono i
soggette a trauma cercano istintivamente di aggiustarsi al trauma, cioè di fare coping,
gestire l'evento, e alcuni aspetti di questo tipo di gestione dell'evento possono essere
efficaci in un primo momento, ma molto costosi a lungo andare. Ad esempio alcune persone
possono - per gestire gli effetti del trauma - attutire la loro sofferenza con l'ingestione
di alcolici o con l'uso di droghe, che però
creano subito un altro problema, quindi aggravano
la situazione, perchè uno diventa poi alcolizzato o dipendente. Oppure a livello comportamentale
è noto il fatto di evitare il contatto con gli altri, ma isolandosi ci si taglia fuori
dal "rifare le batterie". Oppure praticare promiscuità sessuale, insomma le esperienze
avverse infantili sono una vera piaga sociale e costosissima, perché i costi solo per il
trattamento e le cure sono molto onerosi. Nell'interesse di tutti, tutti debbono impegnarsi
a prevenire e curare efficacemente i traumi che soffriamo da bambini.
Questo non solo
beneficia le vittime, ma tutta la società.

Materiale di approfondimento

ESPERIENZE SFAVOREVOLI INFANTILI LE PREMESSE TEORICHE

STAFF DEBUG INFO

Puoi non fare questo esercizio se non lavori nel campo dell'offerta di servizi a minori affetti da trauma.

STAFF DEBUG INFO

Conoscevi lo studio ACE e i suoi risultati?

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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Nel tuo luogo di lavoro si tiene conto delle conoscenze derivanti dallo studio ACE? Se si quali?

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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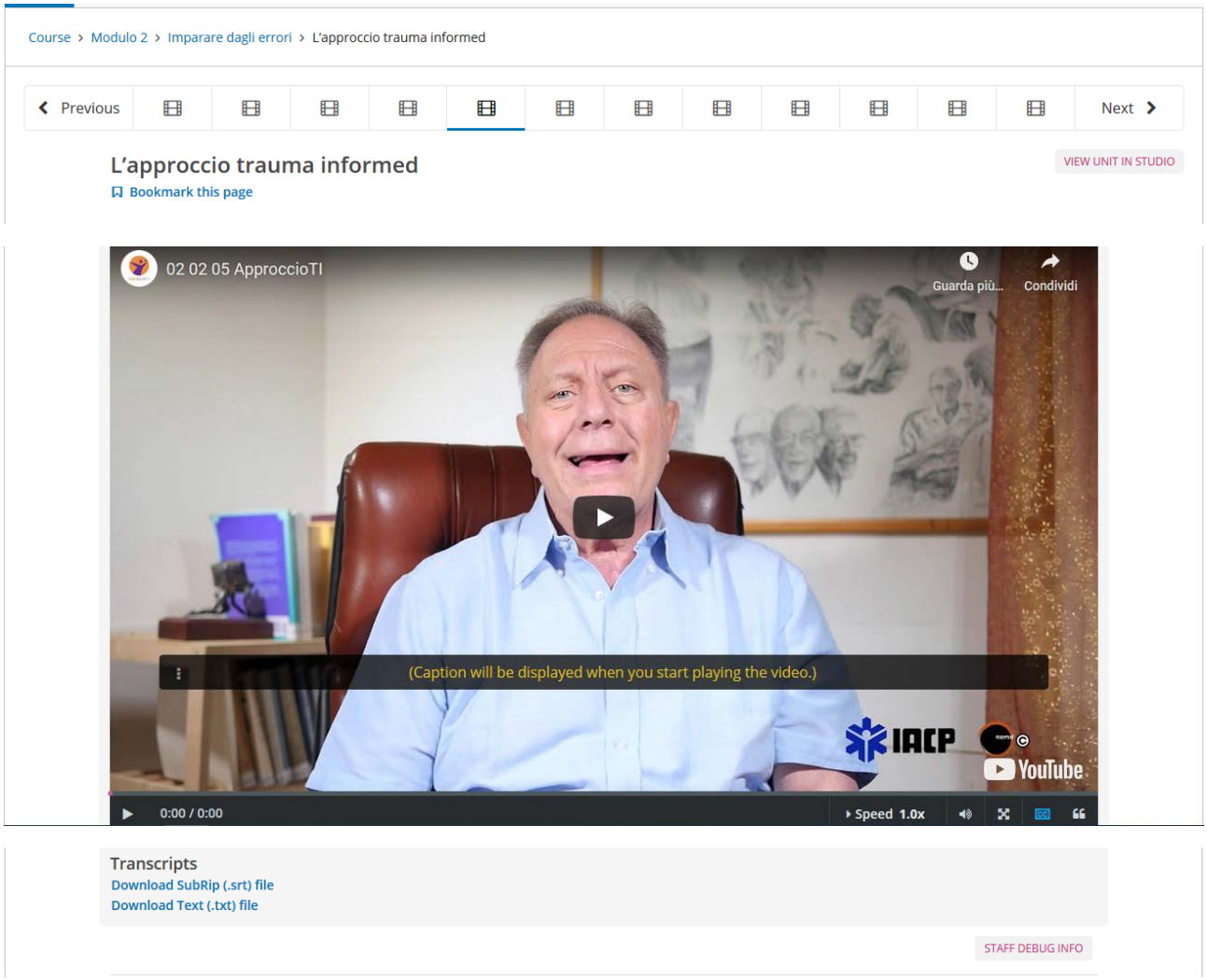


Transcript

Che vuol dire trauma informed? Semplicemente informato sul trauma. É una approccio teso a prevenire la ritraumatizzazione e a offrire servizi e disegnare strutture che abbassino il pericolo di ritraumatizzazione e massimizzano la possibilità di erogare servizi efficaci.
Siamo giunti a definire delle buone pratiche come pratiche trauma informed grazie anche a un'attitudine di apertura e riconoscimento degli errori commessi in passato. Errori, ovviamente, commessi non intenzionalmente, ma per ignoranza,
proprio perché non sapevamo
che alcuni aspetti dei trattamenti in voga allora erano parte del problema e non della soluzione: ad esempio quello di spingere contro la loro volontà utenti a ricordare traumi passati, riesperienziare momenti traumatici e così via.
Oggi, grazie a quanto imparato dagli errori del passato,
abbiamo una serie di direttive,
di parametri che ci aiutano a prevenire i danni e massimizzare i benefici dell'erogazione

di servizi;

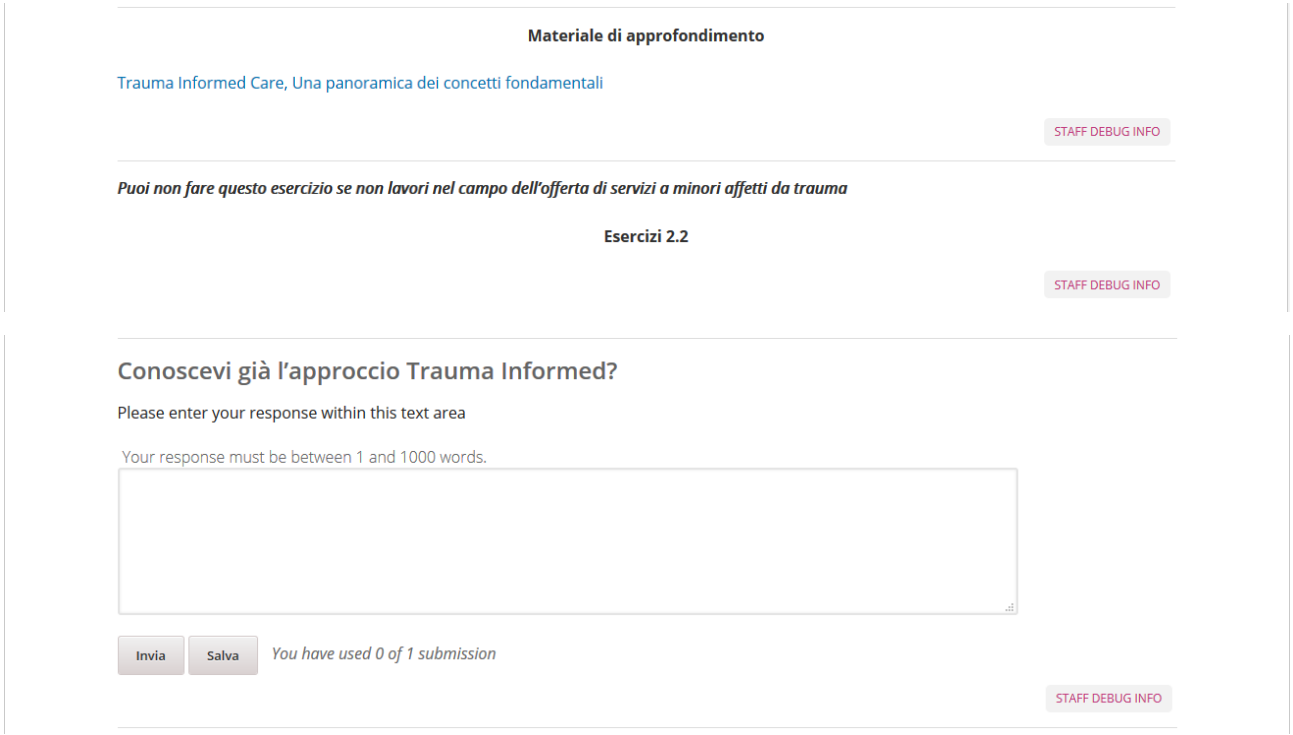
questo non solo in ambito sanitario, della salute mentale,

ma proprio in ogni ambito

i - per esempio la scuola, le organizzazioni, le regolamentazioni della giustizia minorile

o addirittura anche le leggi - insomma Trauma Informed School è una scuola sensibile alla problematica del trauma e quindi anche gli insegnanti sapranno che non sempre uno studente discolo è solo discolo, ma sta esprimendo un disagio dovuto ad un trauma, e quindi sapendo questo avranno strumento di reform, di invio allo psicologo affinché lo studente possa essere aiutato e il problema non diventi più grave di quanto già lo sia.

In fondo avere un approccio trauma informed è non solo doveroso, da un un punto di vista etico, clinico e di salute mentale, ma è anche qualcosa di efficace nel rapporto costi-benefici, perché erogare trattamenti che riducono i danni è nell'interesse non solo delle vittime di traumi ma dell'intera società.



Il tuo luogo di lavoro è trauma informed? Se si da quanti anni?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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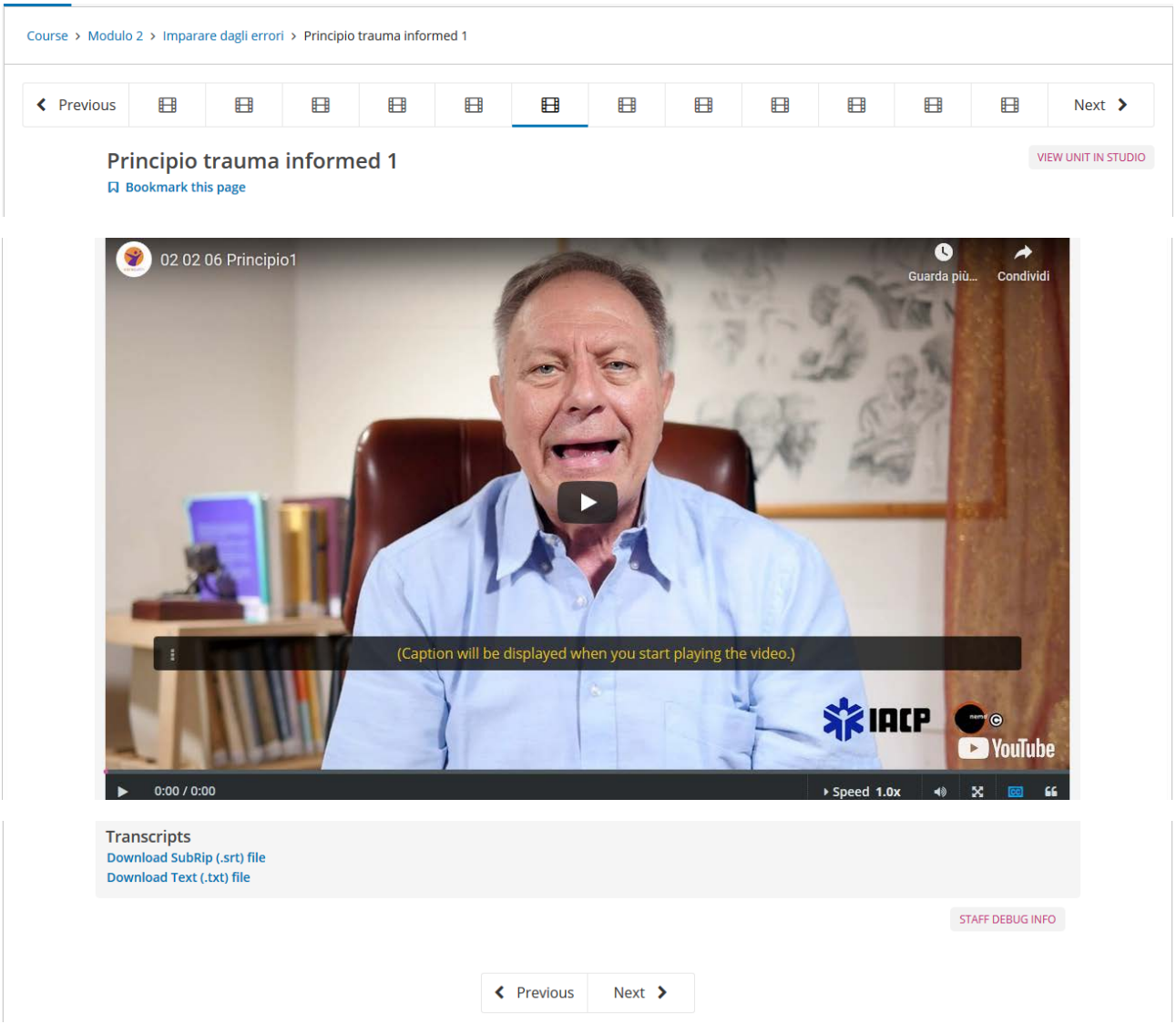


Transcript

I comuni denominatori che sono presenti in ogni struttura, non importa quale, che sia trauma informed, cioè che non rischi di ritraumatizzare chi è stato già colpito da trauma e che offre un porto sicuro, non importa se essa sia una struttura territoriale dedicata alla protezione e promozione della salute, o una scuola, o una organizzazione lavorativa o un istituto per trattamenti specializzati, oppure anche una casa di correzione giovanile parte del sistema giudiziario.

Anche una comunità, per essere trauma informed, deve avere questi comuni denominatori che hanno un filo rosso:

i comuni denominatori sono tutti unificati nel voler comunicare

e assicurare all'utente che ha avuto un trauma

una piena sensazione di sicurezza,

fisica e psicologica, essere un porto sicuro.

Il primo principio trauma informed è che le struttura deve fornire una sicurezza fisica ed emozionale e quindi la persona avrà la certezza, perchè è informata a tal riguardo, ma anche l'esperienza che niente di male, nessun attacco, può essere portato a suoi danni, è un luogo sicuro dove non è necessario stare sul chi vive, in continuo allarme, vivere in ansia.

La struttura trauma informed è anche molto accogliente, in tutti gli aspetti di comunicazione e metacomunicazione e quindi l'utente è benvenuto, si dice proprio "benvenuto, o ben tornato" e sono convinti tutti che la persona dell'utente è una persona a cui si da realmente il benvenuto.

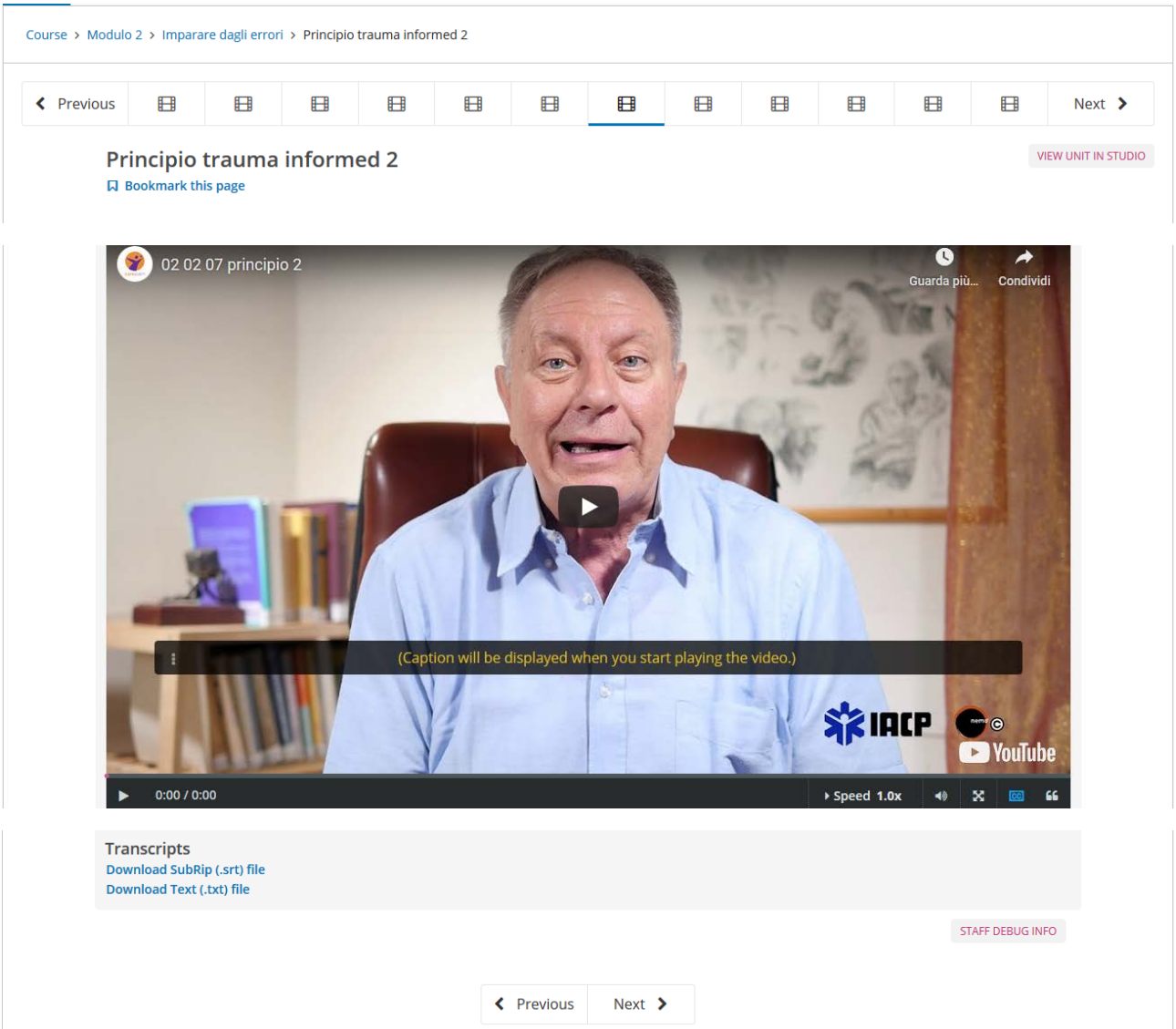
Una struttura per guadagnarsi la fiducia e dare sicurezza agli utenti deve essere coerente, cioè i suoi messaggi a tutti i livelli devono essere congruenti con le proprie azioni e costanti nel tempo.

Solo così la persona dell'utente potrà nutrire e sviluppare reale fiducia e sentire che la struttura è realmente accogliente e un porto sicuro a cui ci si può affidare.

In una struttura trauma informed non ha spazio, non hanno cittadinanza, la violenza, la vergogna e la colpa, aspetti molto problematici che possono acuire o ritraumatizzare chi ha subito già un trauma.

O vivamente una struttura trauma informed assicura anche la confidenzialità e proprio il segreto professionale, la privacy dell'individuo, il quale non verrà esposto a questo tipo di pericoli e di violenze.

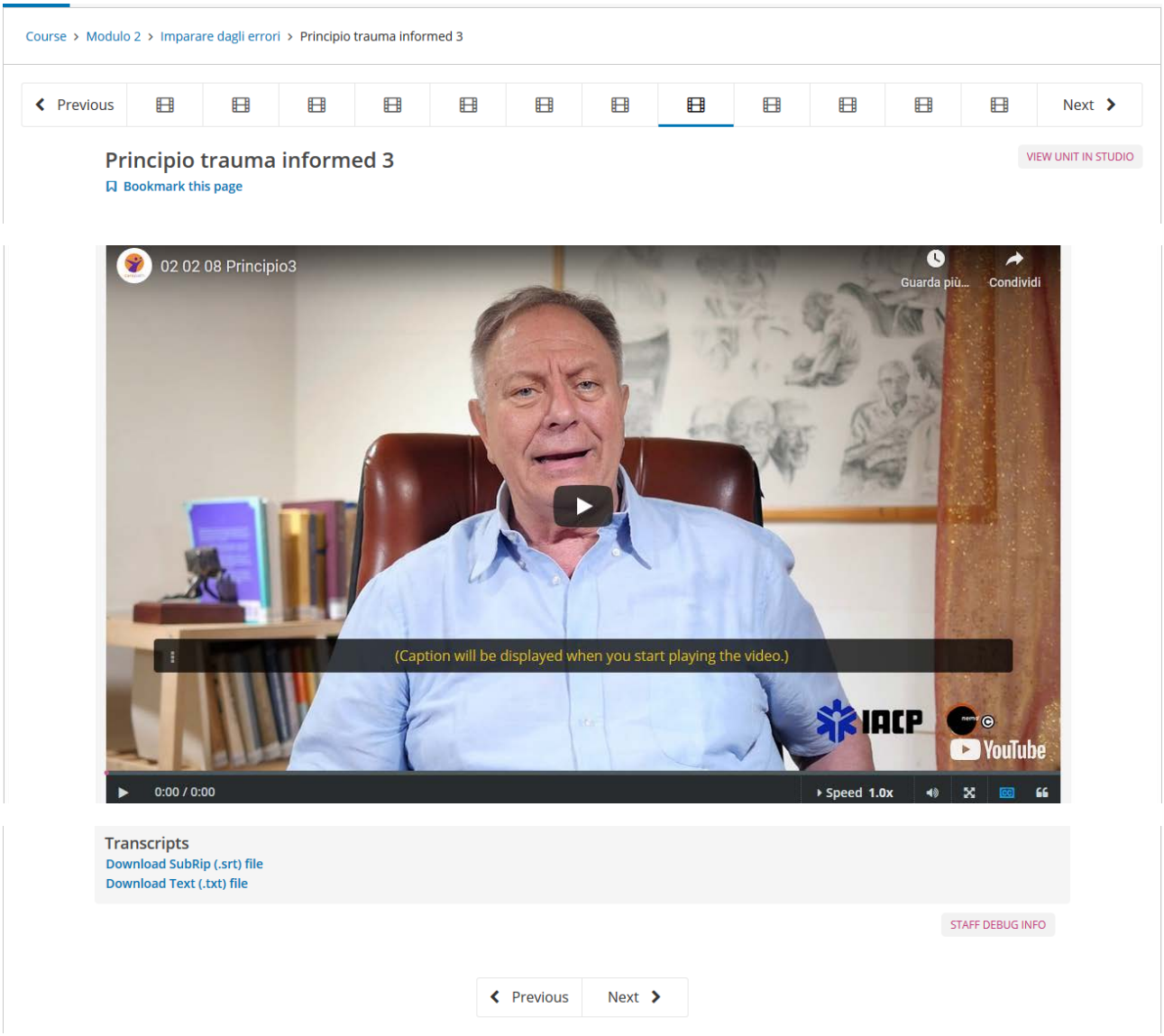
Inoltre il linguaggio di una struttura trauma informed è centrato sulla persona, cioè parlerà un linguaggio chiaro, coerente, che l'utente può comprendere e non dei criptici linguaggi professionali dove occorrono tre lauree per comprendere.



Transcript

Il secondo principio di una organizzazione trauma informed è la collaborazione e la mutualità, per mutualità si intende che l'utente è ingaggiato attivamente alla co creazione dei servizi a lui erogati e quindi il potere personale non è quello tradizionale, come nei modelli meccanicistici-riduzionistici, dove l'utente era il paziente designato; no, qui ha voce in capitolo e il ruolo che assumerà è quello di agenzia attiva nella sua azione di recupero delle sue capacità e potenzialità. Una struttura trauma informed promuoverà il recupero del rispetto per se stessi, un aspetto cruciale per chi è stato vittima di trauma, e anche per la speranza, la recovery,

il recupero del proprio potenziale.
Una struttura come questa metterà sempre in chiaro, soprattutto a se stessa, che il
recupero della salute, della funzionalità di una persona affetta da stress
post traumatico,
da traumi, può avvenire solo attraverso delle relazioni efficaci che i membri del personale
della struttura riescono a stabilire con l'utente.
Insomma un buon gioco di squadra, un'alleanza di lavoro.
Condividere gli aspetti decisionali è un aspetto centrale per assicurare un buon funzionamento
del servizio erogato,
innanzitutto sappiamo bene - lo hanno illustrato le ricerche di
Karasek sullo stress - se io ho degli stimoli stressanti ma ho ampio potere di controllo,
lo stress si abbassa,
se ho poco controllo sulla situazione lo stress si alza; è proprio
questo principio all'opera.
Quindi dare potere decisionale, controllo all'utente significa già parte della cura,
in altre parole, la persona con maggior controllo
è capace di superare meglio le sue condizioni.
Una struttura centrata sul fornire dei servizi trauma informed è una struttura che non incoraggia
eccessive disparità di potere, eccessivi livelli di differenziale di potere tra struttura,
operatori di questa e cliente, ma fa un'attiva azione di empowerment e riconosce alla persona
del cliente il diritto a esercitare un controllo e un potere personale nella co-costruzione
della realtà condivisa.
La struttura trauma informed è sistemica e olistica nel senso
che è ben consapevole
che quello su cui deve operare è proprio la costruzione sociale di una realtà trauma
informed, tutti gli aspetti concorrono a renderla tale
e quindi avrà cura dall'alfa all'omega,
dall'inizio dell'intake, dall'accoglienza
alla persona che ha avuto il trattamento,
come il cliente è accompagnato e aiutato a vivere efficacemente
la fase dell'after care.



Transcript

Il terzo principio è costituito dalla promozione della fiducia e l'offerta sempre presente della trasparenza, elementi importanti per stabilire un buon rapporto, un'alleanza efficace con l'utente. Per raggiungere questo obiettivo è ovviamente di primaria importanza che anche lo staff viva le relazioni interpersonali con gli altri membri dello staff, con il team, con la squadra basate sulla fiducia e la trasparenza

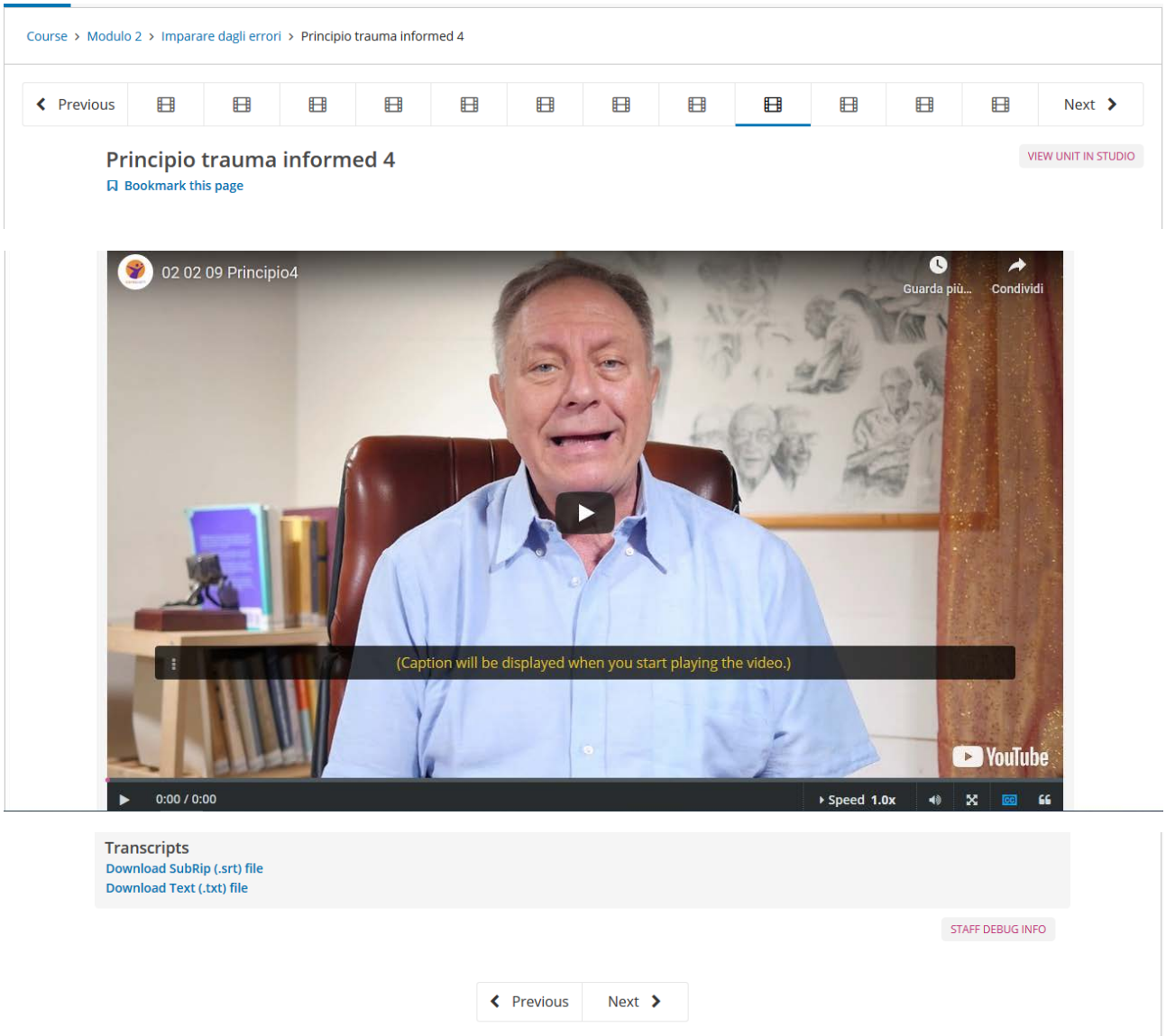
e anche questo nell'ambito delle relazioni

interpersonali vissute dallo staff con gli utenti e con le loro famiglie.

Altro aspetto importante è rispettare i limiti, mantenere i confini, perché innanzitutto proprio avendo dei confini chiari si creano degli spazi chiari, non rispettare i confini significa inquinare i setting e decretarne la loro disfunzione.

La trasparenza è fondamentale e quindi le politiche devono essere chiare, formulate

non in linguaggio burocratese, ma un linguaggio chiaro
e trasparente è un’altro motivo
di chiarezza, cioè tutti devono sapere - soprattutto gli utenti - in che luogo si trovano, quali sono i diritti e quali i doveri, quali sono di ogni aspetto della struttura e del personale che con egli lavora.
Per questo è necessario avere anche molta chiarezza dei ruoli e sapere che i vari professionisti operanti in una struttura hanno competenze varie
e anche erogano diversi aspetti, nessuno
è tuttologo e che quindi, come in un'articolata società, il panettiere fa il pane, lattaio distribuisce il latte, l’ingegnere si ingegna e così via.
Fondamentale per una struttura trauma informed è il rispetto dei diritti e il la promozione attiva dei diritti degli utenti, è quindi fondamentale
ricevere un reale consenso informato
spiegando bene all’utente come si trattano le procedure, l’erogazione dei servizi e facendo di tutto per assicurarsi che la comprensione e il consenso
siano reali e non semplice formalità.



Transcript

Il quarto principio delle strutture trauma informed è basato su azioni di empowerment,

su dare diritto alla scelta e anche alla Co-creazione delle realtà dedicate agli utenti.

Tutto nella struttura offre messaggi

e meta-messaggi centrati su promuovere i punti di forza, la

resilienza degli utenti, la scelta è di promuovere il cambiamento

centrandosi sui punti di forza

e non sulle debolezza o di disfunzione dell'utente.

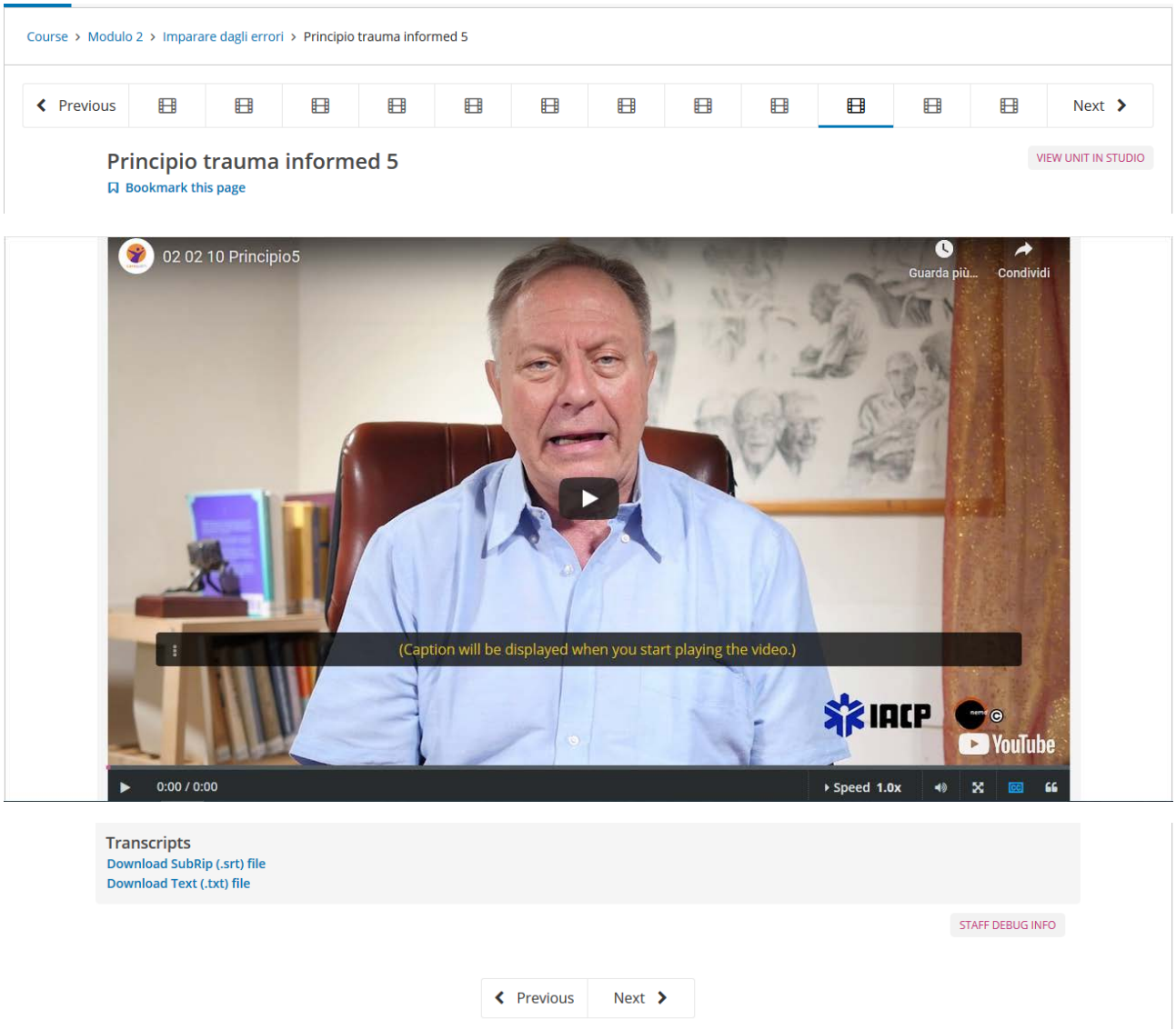
L'enfasi è promuovere la consapevolezza

dell'utente su come in passato ha affrontato,

a volte in modo non efficace, le varie situazioni, insomma il coping.

Si tratta, quindi, di applicare una vera propria filosofia che enfatizza l'utilità di basarsi

sui punti di forza; in altre parole in passato ci si centrava sulle patologie
e la loro riduzione,
ora ci si basa sulla salute, la forza e si cerca di promuovere l'espansione e l'allargamento.
Si valorizza inoltre i ruoli sociali e perchè noi siamo mammiferi sociali e quindi questo
è di vitale importanza per l'identità e lo sviluppo del nostro potenziale.
Obiettivo dichiarato e perseguito coerentemente
è promuovere le capacità di autoregolazione,
di autonomia e autogestione degli utenti, quindi si sottolineerà la possibilità di
crescere anche dalle esperienze traumatiche
non si enfatizza che una persona sia una povera
vittima, ma la sua capacità di resilienza.



Transcript

Il quinto principio è quello del supporto dei pari, quindi un'organizzazione trauma informed farà di tutto per favorire che i propri utenti ricevano il supporto dei loro pari.

Si tratta di una variabile molto importante.

Per stabilire sicurezza e speranza.

Innanzitutto il supporto dei pari aiuta a far sentire

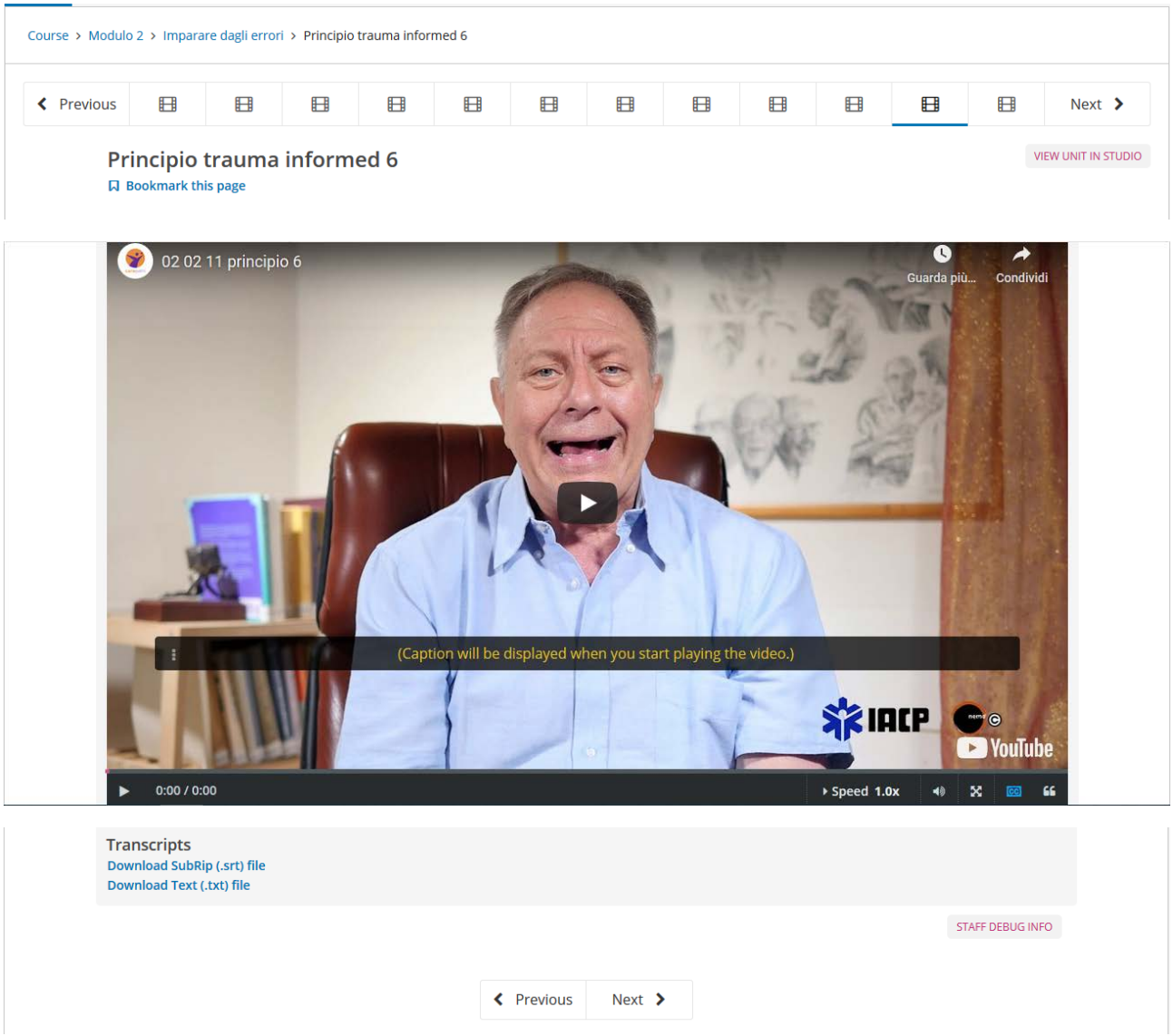
le persone che la ricevono più

sicure e anche a suscitare

la loro speranza, che ci sia la possibilità di stare meglio;

insomma è importante è il supporto dei pari per costruire maggiore fiducia in se stessi e nelle proprie potenzialità, anche autostima.

Il supporto dei pari promuove altresì le possibilità di collaborazione e quindi tutto
ciò che è di positivo nel promuovere il proprio ruolo sociale e sentirsi attivi.
È innegabile che il supporto dei pari porta ad una comunicazione interpersonale che può
veramente avvantaggiarsi della costruzione di narrative
che sono una parte di un puzzle
molto più ricco e che fanno sviluppare
narrative di speranza e di guarigione.



Transcript

Il sesto principio riguarda la sensibilità di una struttura trauma informed a tutti

le tematiche culturali, interculturali

e di genere o quelle che riguardano parte della popolazione

o minoranze per essere

sicura di trattare tutti in maniera accogliente e soprattutto

democratica.

Ovviamente una struttura efficace ed efficiente non avrà costrutti legati al passato di stereotipi

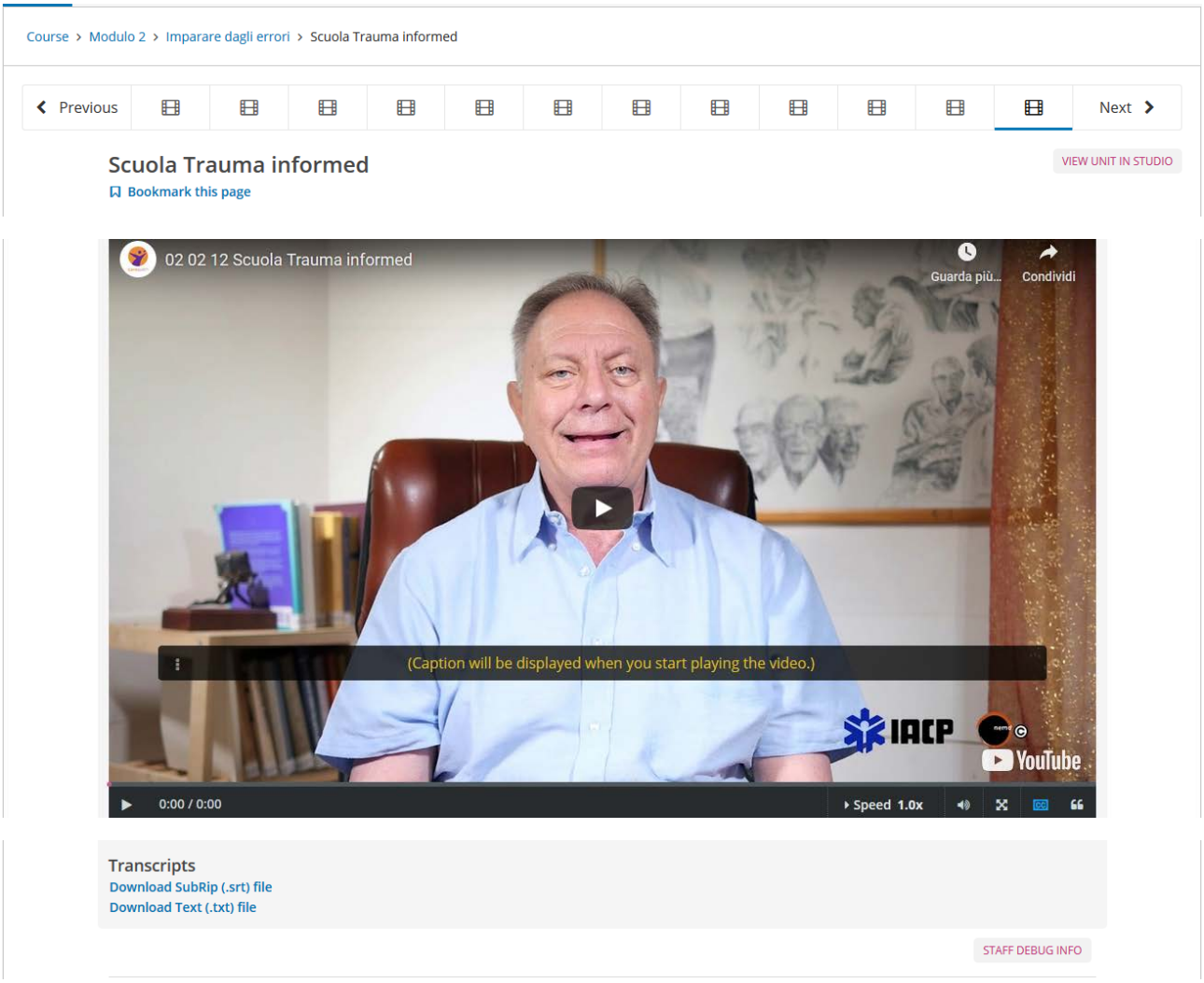
assolutamente ingiusti e distruttivi verso minoranze.

Il servizio erogato sarà, per esempio, molto

sensibile alle diversità di genere e al rispetto

equo delle diversità di genere e poi

una tale sfruttare efficacemente faciliterà l’utilizzo
del background culturale, delle tradizioni,
della cultura e nazione di origine dei suoi utenti.
Costruirà una realtà fedele alla propria filosofia per cui l’organizzazione e le
procedure saranno tutte
non discriminatorie e sensibile alle diversità.
Inoltre saprà riconoscere e affrontare efficiente il trauma storico.
I traumi storici sono costituiti da eventi
di trauma di massa che impattano anche chi
non l’ha vissuto direttamente, facendo un esempio drammatico: l'olocausto, non solo
milioni di poveretti sono stati vittime
del delirio nazista, ma anche i loro figli e nipoti
portino il riverbero di tale bestialità.



Transcript

Le scuole possono fare molto per la prevenzione e gestione efficace

dei traumi e soprattutto

nel prevenire la ritraumatizzazione.

Le scuole sono un punto nevralgico della comunità

e gli insegnanti in modo particolare poiché

vedono continuamente i loro studenti

e hanno frequenti contatti con le loro famiglie.

Inoltre gli insegnanti godo di un certo prestigio, derivante dal loro ruolo, nella comunità.

Per cui se gli insegnanti e tutto il personale scolastico

sono sensibilizzati su quelli che

sono i parametri una scuola trauma informed, e magari hanno

avuto una consulenza da un

esperto che li aiuta a fare quelle migliorie

che renderanno la scuola da scuola ignorante
della problematica a scuola informed sulle problematiche del trauma, ebbene tale scuola
potrà essere non parte del problema, ma parte della soluzione.
Non solo perché gli insegnanti
sensibilizzati sulle problematiche del trauma potranno essere
ben pronti a cogliere segnali
che se non avessero un occhio addestrato potrebbero interpretare
come meri problemi disciplinari, ma invece - essendo insegnanti trauma informed - potranno
essere sensibili fare da riferimento ai loro
allievi e chiedere accertamenti se un loro
studente ha bisogno di supporto professionale se lo studente è o è stato vittima di un
trauma.
Un'altra influenza significativa gli insegnanti possono esercitarla nei confronti dei genitori,
che piano piano diventano dei genitori trauma informed
e potranno dare un notevole contributo
a questo tipo di problematica.
Insomma una scuola trauma informed
è il completamento della vocazione di una scuola, che è avere
e diffondere efficacemente le conoscenze
per funzionare come cittadini proattivi della polis.
Quindi, una scuola trauma informed
è pienamente pronta a realizzare la propria mission di
scuola nel senso migliore del termine.

Puoi non fare questo esercizio se non lavori nel campo dell'offerta di servizi a minori affetti da trauma

Esercizi 2.3

STAFF DEBUG INFO

Nella tua comunità locale ci sono scuole trauma informed? nella tua Nazione?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Ci puoi fornire per favore per aiutarci a migliorare l'utilità di questo corso per gli operatori sul campo,dove possiamo trovare informazioni sulle scuole trauma informed del tuo paese, a livello europeo e mondiale ?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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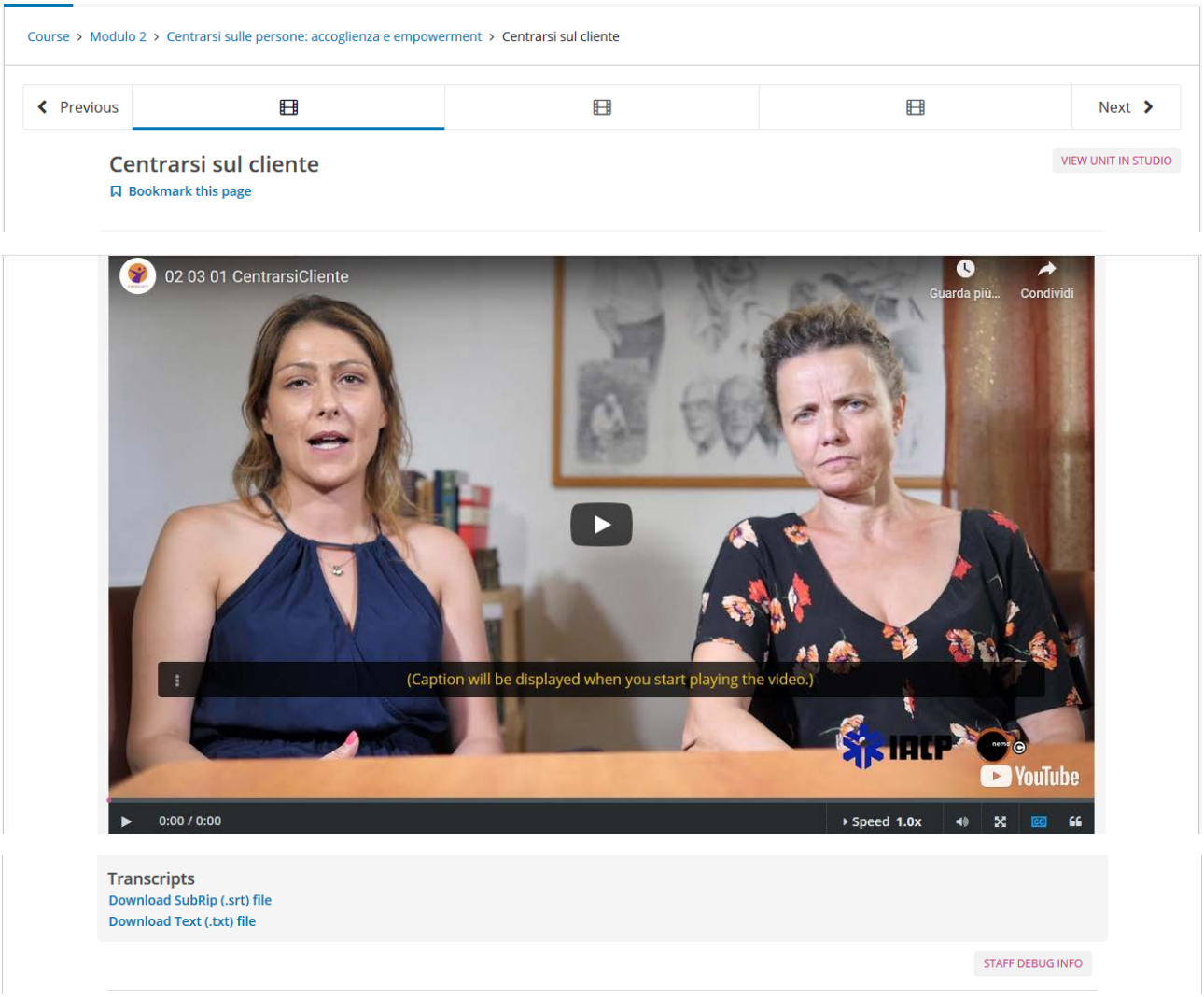

Transcript

Verranno illustrati alcuni insegnamenti tratti dall'esperienza di 20 anni di lavoro nei servizi rivolti a minori e famiglie e che si occupano di creare dei percorsi di aiuto, sostegno e intervento per i minori esposti a situazioni di violenza, violenza assistita, abuso o ad altre situazioni di vissuti traumatici.

Nel corso del tempo le cose più importanti

focalizzate sono state: la necessità e l'importanza di costruire - al di là di competenze tecnico scientifiche - una relazione adeguata a creare un contesto sicuro per il minore.

Il termine sicuro va declinato nella dimensione di ascolto

delle esigenze e dei bisogni e di rispetto,

fondamentale in particolare nelle situazioni in cui il minore esce da esperienze che hanno violato il senso di sicurezza e di rispetto e di continuità della vita, in queste garantire una situazione di rispetto è fondamentale per riprendere un percorso evolutivo.

Corsa vuol dire una dimensione di rispetto? Significa una vera dimensione di ascolto,

ascolto empatico e non una centratura
su protocolli e sulle esigenze degli operatori, ma una centratura
su quello che è il mondo interno
del minore, i suoi bisogni, i tempi del minore, i quali
vanno rispettati dal momento che spesso ci troviamo davanti a minori che hanno sviluppato
una situazione di difesa e protezione di sé.
È quindi importante che l'operatore che
interviene lo faccia non minacciando di abbattere le difese (volendo sapere, portare, fare domande)
ma rispettando un tempo di esposizione del minore, avendo coscienza che la difesa non
è che il modo migliore trovato dal minore per fare fronte ad una forza che è stata
soverchiando. Quindi piano piano, rendendo inutili e meno indispensabili le difese si
potrà andare a incontrare il nucleo del cuore di quel minore.
L'esperienza ce lo mostra é, quindi, importante essere centrati sui bisogni del minore.
Si illustreranno ora le esperienze accumulate dall'attività di assistente sociale che
per 8 anni ha prestato servizio presso il comune di Roma occupandosi di prevenzione,
tutela e sostegno dei minori e delle loro famiglie.
In accordo con quanto detto sopra in riferimento alla necessità di essere centrati sui bisogni
del minore si può allargare questa riflessione alla necessità di essere centrati sulle caratteristiche
e l'unicità di ogni situazione, quindi anche di tutti i soggetti coinvolti, oltre
il minore sicuramente i suoi genitori. Nella quotidianità del lavoro come assistente sociale
ci si occupa principalmente di lavorare con i genitori, in quanto i minori che subiscono
o hanno subito uno o più traumi
solitamente vengono presi in carico e seguiti da specialisti
opportunamente formati per sostenerli in questo processo.
Per quanto riguarda l'attività dell'assistente sociale questi si occupa di accompagnare le
famiglie nel processo di consapevolezza
delle loro difficoltà, criticità, fragilità,
ma anche degli agiti che hanno recato danni e malessere ai propri figli, per poi costruire
anche delle reti di supporto attraverso le quali sostenerli nell'acquisizione e nell'utilizzo
adeguato di responsabilità genitoriali che garantiscano
al minore il suo diritto a crescere
serenamente nella propria famiglia,

in un contesto quindi di protezione e tutela.

Secondo l'esperienza quali sono gli elementi preponderanti di cui si ha bisogno come operatori per lavorare in questo ambito è con queste persone? Sono sicuramente le competenze tecnico professionali scientifiche, ma sicuramente anche competenze e capacità che riguardano di più la sfera personale, ci si riferisce, quindi, a tutto quello che si può racchiudere con l'accezione di "mondo interiore" dell'operatore: le proprie emozioni, pregiudizi, risonanze, proiezioni che tendiamo a fare e facciamo entrando in relazione con gli altri; oltre ad essere professionisti della relazione d'aiuto si è delle persone che incontrano altre persone.

Cosa accade quando ci si trova a lavorare con genitori abusanti o maltrattanti? Non si nasconde di provare a volte, anche spesso, sentimenti o emozioni di rabbia, sdegno, indignazione e anche talvolta di paura; sicuramente quello che si vuole dire è che non si deve far finta che queste emozioni non esistano, fanno parte di noi ed entrerebbero in ogni caso nella relazione di aiuto. L'importante è invece saperle riconoscere, in modo tale da saperle gestire e fare in modo che non vadano ad inficiare la realtà che si ha difronte, ovvero fare in modo che la soggettività personale non sia il linguaggio attraverso il quale si interpreta quello che si ha di fronte, confondendo i piani di realtà o i ruoli. A volte l'operatore, confuso dall emozioni, tenda a porsi come colui che da le direttive e il genitore diventa semplicemente la vittima delle decisioni dell'operatore; questo sicuramente allontana dal garantire la tutela e la protezione dei minori, perché se non si è assolutamente concentrati sulla realtà della situazione affrontata non è possibile ne capire ne percepire i bisogni dei minori e quindi orientare l'intervento.

Per quanto riguarda invece la relazione diretta con il minore, l'intervento dell'assistente sociale in tal caso è più ridotto, ma anche in questo caso ci sono componenti emotive forti, può capitare di voler rispondere al bisogno personale di dare ai minori l'affettività e le cure non ricevute, altre volte tentando di sostituirsi ai professionisti dell'aiuto che li seguono e li aiutano nell'elaborazione dei propri traumi.

Tu hai un' attitudine che ti facilita il mettere la persona dell'utente al centro della relazione professionale?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Se non lavori centrandoti sulla persona del cliente sai dirci perché?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Pensi che ti sarebbe utile ricevere della formazione per essere messo in grado quando lo decidi tu, di lavorare centrandoti sulle persone dei tuoi clienti?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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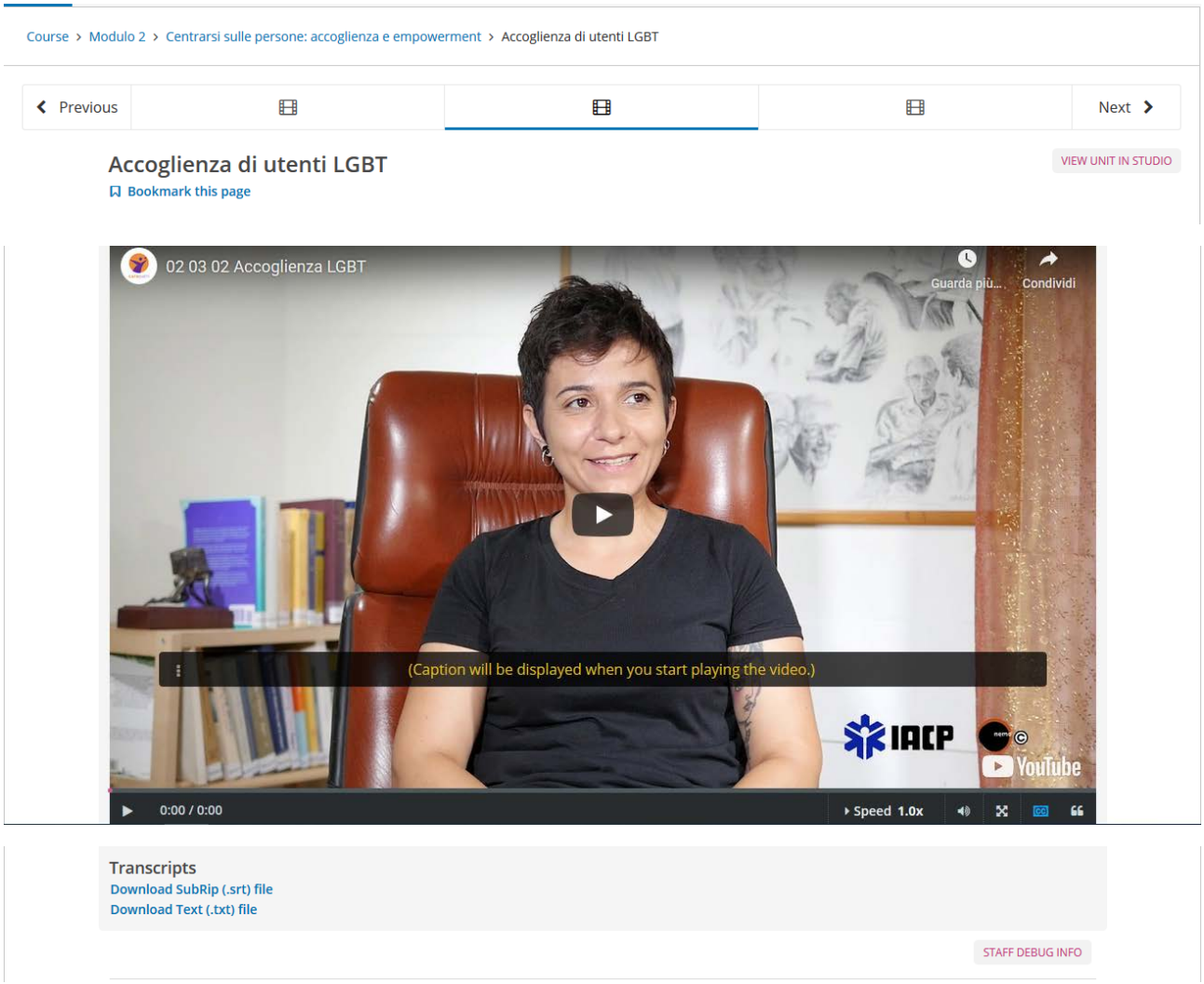

Transcript

la complessa narrativa che vede gli adolescenti LGBTQI crescere in

contesti familiari e sociali che molto spesso disconoscono, denigrano le

dimensioni fondanti della loro identità quali sono

la sessualità e l'affettività

può esitare in una varietà di disagi

psichici un'ampia letteratura scientifica che evidenzia come in una

popolazione non clinica queste persone soffrono in misura significativamente

maggiore di disturbi d'ansia abuso di sostanze disturbo post traumatico da stress

e che abbiano un aumentato a rischio suicidario

i ricercatori e corre l'anno questa maggiore incidenza dei disagi psichici

alle dimensioni del minority stress e dell'omofobia sociale quindi

l'invisibilità e l'indicibilità emergono al contempo come cause e conseguenze di

vissuti traumatici all'interno dell'esperienza di queste persone a

questa è una drammatica realtà i concetti di trovano cumulativo di tra
una relazionale e le concettualizzazioni relative ai disturbi traumatici
evolutivi complessi
esiste quindi una relazione a circolare
tra pregiudizio sociale aspetti del sé dissociati invisibilità ma anche le si
chiesa in una popolazione che vede negata oltre a questa dimensione anche
quella della cittadinanza dell'appartenenza e dell'inclusione
E necessario quindi che chi è deputato all'accoglienza ed al supporto di questi
ragazzi si interroga su come facilitarli di succo acquistare aiutarli a
conquistare per sé diritto di esistenza dignità e diritto alla.
Le ricerche che si susseguono da oltre 50 anni e continuano i documenti vademecum
le linee guida prodotti a seguito di queste ricerche
fanno riferimento alle
dimensioni che seguono
le omosessualità sono varianti normali e positivi della
sessualità umana e non costituiscono di per sé indicatori di disturbi mentali o
di disturbi dello sviluppo abbiamo stesso ritardi le bisessualità sono
oggetto di stigma sociale e questo può avere svariate conseguenze negative nei
percorsi nei processi evolutivi
e effetti e di comportamenti omosessuali
possono essere presenti in vari orientamenti sessuali.
Le persone lgbt sono condurre vite soddisfacenti e felici instaurare
relazioni di coppia durature e formare famiglie solide quanto quelle
eterosessuali. Non esistono ricerche scientifiche che riconducano
l'omosessualità al trauma o la disfunzionalità delle famiglie di origine.
Non è dimostrato che tutti i tentativi terapeutici che abbiano
l'obiettivo di modificare l'orientamento sessuale siano efficaci voi sentite
rischi linee guida rilasciate dalle pieghe nel 2012 rispetto al pratica
psicologico con persone lgbt linea non l'importanza di prendere in
considerazione gli atteggiamenti del relatore di aiuto verso l'omosessualità
e la bisessualità intesi non soltanto come la conoscenza degli effetti dello
stigma su queste persone ma anche come la consapevolezza di quanto i propri

atteggiamenti impliciti ed espliciti rispetto alle ore di sessualità e quindi
la personale competenza su queste tematiche ma anche la personale
personale sguardo su queste tematiche possano influire in ambito di
valutazione e di intervento
I punti in comune che si possono estrapolare da
tutti i documenti finora prodotti possono essere così sintetizzati.
Offrire accettazione e sostegno
mettendo in atto un ascolto rispettoso non giudicate ed
empatico che aiuta l'utente a ridurre il disagio causato dal minority stress
Adottare opportuni accorgimenti nella fase di conoscenza di queste persone
la valutazione deve essere indirizzata alla conoscenza del ragazzo della
ragazza e in tutta la sua complessità considerando le interazioni e le
interconnessioni tra il minority stress la salute mentale e la dimensione
spirituale interiore nonché la posizione dell'orientamento sessuale occupa nel
funzionamento generale dell'individuo.
Favorire e sostenere modalità attive di
coping sappiamo che per gli adolescenti in generale è molto importante sentirsi
agenti attivi nelle proprie esistenze in particolare quando c'è da far fronte a
degli eventi stressanti il relatore d'aiuto dovrà cercare di
aiutare l'utente a favorire delle strategie che tendano all'elaborazione
cognitivo ed emozionale dello stesso comprendere di nuovo la dimensione
fondante nell'adolescenza
il ruolo svolto dalle amicizie dalle comuni ed
alla comunità lgbt sideranno che il minority stress può comportare che
emarginazione ed isolamento
un obiettivo fondamentale è quello di incrementare la
capacità di avvalersi del supporto sociale.
Esplorare e sviluppare l'identità
e dinamiche identitarie costituiscono un aspetto importantissimo
e fondante adolescenza e nell'adolescenza delle
persone lgbt è importante che queste persone possano esplorare ed integrare
senza necessariamente dover scegliere un'identità a scapito della scapito

dell'altra come nel caso della dicotomia maschio femmina.

Comprendre i conflitti e favorire la loro integrazione

la relazione d'aiuto dovrebbe favorire

il dialogo e l'integrazione fra le parti di se eventualmente in conflitto come

può accadere ad esempio nel caso dell'orientamento sessuale e del credo

religioso comprendere i significati sottostanti alle richieste di modificare

l'orientamento sessuale o di fare una terapia riparativa

in questi casi è necessario uno psicoterapeuta opportunamente formato

mondo con un analisi della domanda appropriata accogliendo significano ed

esplorando tale desiderio e riconducendolo a complesse dinamiche

psicologiche familiari e sociali che potrebbero condurre il ragazzo con la

ragazza a considerare inaccettabile un elemento costitutivo della propria

identità.

Comprerete esplorare il processo di camminato.

Cogliere i livelli di minority stress in relazione alle condizioni di

doppia minoranza in cui l'individuo viene discriminato non soltanto a causa

dell'omosessualità della bisessualità ma anche di altre condizioni oggetto di

stigma sociale

Tenere conto del peso che ha il minority stress

nelle dinamiche di coppia ed è importante ricordare che le coppie gay

e lesbiche non sono riconosciute né dalle principali religioni né

dall'ordinamento giuridico di molti paesi connesso a ciò c'è da considerare

tutto quello che è il relativo al omogenitorialità e alla mancanza alla

scarsa regolamentazione giuridica di questo tipo di formazione familiare

Materiale di approfondimento

NCTSN LGBTQ Resources

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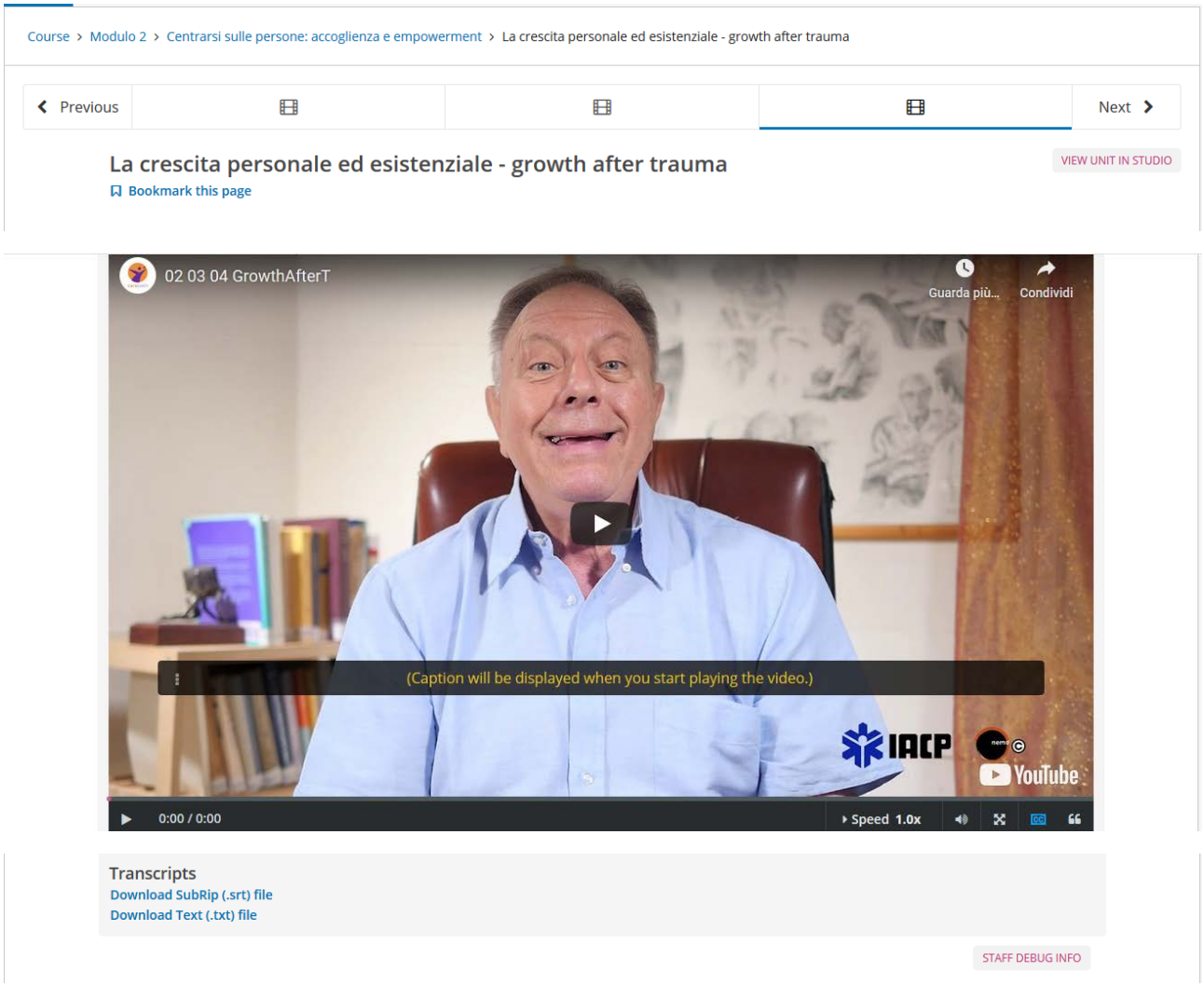

Transcript

Per growth after trauma si intende un fenomeno

di crescita personale che alcuni individui

traumatizzati esperiscono come conseguenza del trauma stesso.

In altre parole, non solo il trauma provoca danni notevoli, gravi all'organismo e alla

psiche degli individui interessati,

però oltre a tutti i danni esiste anche questo fenomeno

che un numero significativo, anche se non maggioritario, di vittime di traumi

esperienza.

Si vuole sottolineare che questo ci parla ancora una volta dell'incredibile resilienza

della specie umana, o forse parla della resilienza

di tutte le forme di vita che si sono sviluppate

nell'evoluzione della vita sul nostro pianeta.

Comunque sia la tragedia del trauma manda in tilt la persona, la "sbatacchia",

la offende e ferisce
e quindi è un vero e proprio terremoto, le cui scosse impattano sia il
piano psichico che il piano fisico di un individuo.
Tuttavia, in tale sconquasso, come succede sovente,
non tutto il male è unicamente a
senso unico perché quando un soggetto è travolto da un trauma
si deve riaggiustare
alla nuova realtà ed alcuni individui
si riaggiustano, si riassestano, crescendo dall'esperienza.
Quindi a livello esistenziale essi vivono
una esperienza di crescita, in altre parole
sono più aperti, più convinti di valori morali e spirituali che vivono in maniera
più significativa e si relazionano alla vita,
con se stessi, gli altri e il mondo con nuovi
e più profondi significati.
Un esempio personale: ricordo la commozione che ho provato leggendo proprio un libro scritto
da un collega - Victor Frankl - che ha avuto a sorte la tragedia e tutti i traumi relativi
ad essere preso, in quanto ebreo, durante il nazismo
ed internato in un campo di sterminio
nazista; ebbene i campi di sterminio, prima di uccidere le persone nel fisico le angariavano
e cercavano di uccidere nella loro dignità umana, tuttavia un numero - anche esiguo - di
persone non solo sopravviveva a livello fisico, nonostante tutti i traumi anche a livello
psichico, ma diventavano persone migliori e quindi, come ci racconta Frankl nel suo
libro "Uno psicologo nei lager" come lui ed altri compagni di campo facessero in quattro
e si privassero del poco cibo per dare
amoroso supporto a persone più sfortunate addirittura
di loro (malate o deboli), rischiavano di essere mandati alle famose docce alla camere
a gas e quindi sterminati.
Chi di questo gruppo è sopravvissuto ed è stato poi liberato alla fine della follia
nazista era diventato, pur nella debolezza fisica e pur traumatizzati, una persona migliore
e con un rapporto più significativo a livello esistenziale con se stesso, gli altri, il
mondo; un aspetto che ci fa meditare e ci infonde forse un po' di speranza.

Materiale di approfondimento

Personality, posttraumatic stress and trauma type: factors contributing to posttraumatic growth and its domains in a Turkish community sample.

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Hai avuto qualche esperienza traumatica da cui nonostante il trauma sei cresciuto a livello personale e esistenziale?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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Hai visto alcuni tuoi clienti traumatizzati crescere a livello umano ed esistenziale ?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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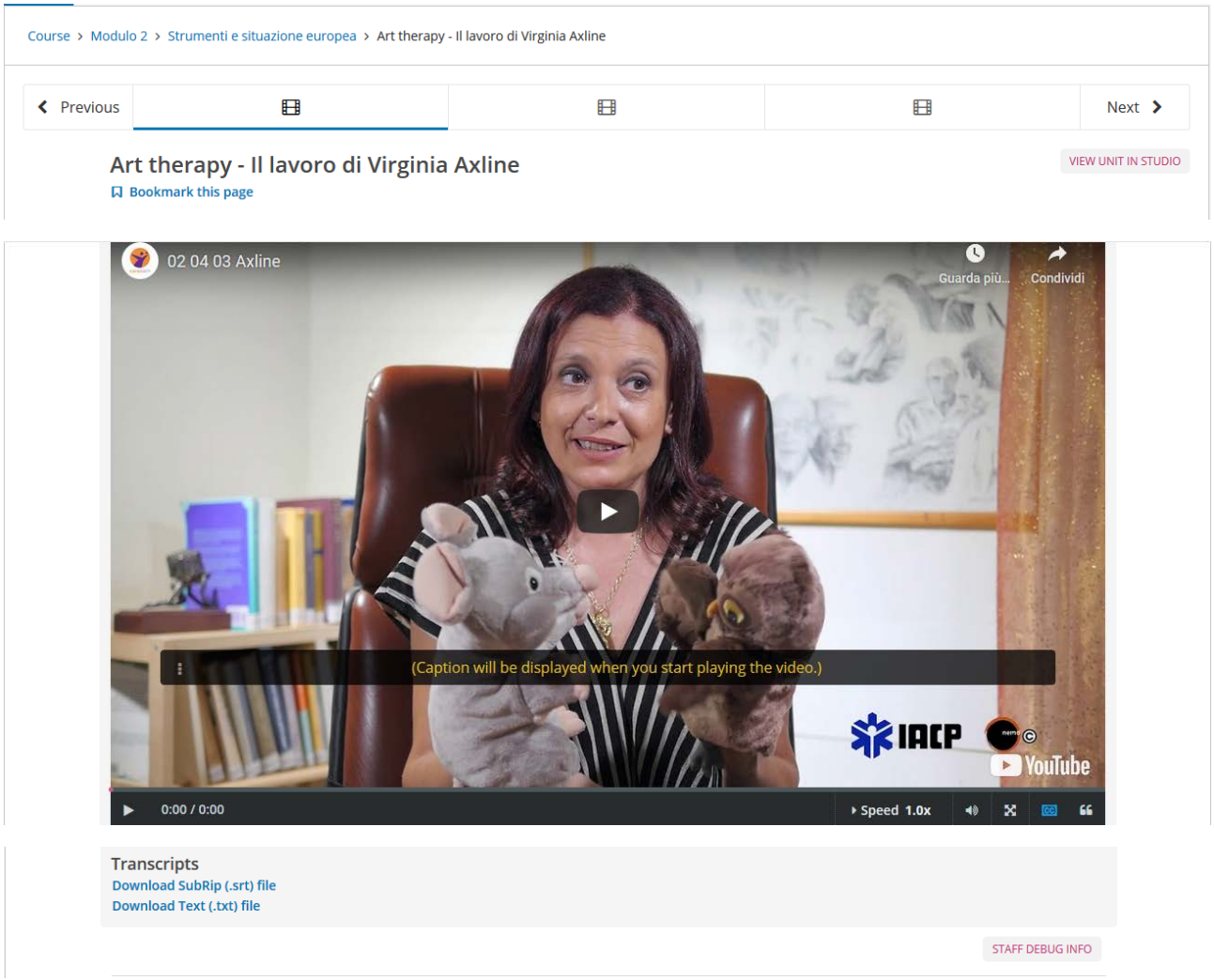

Transcript

Nel lavoro in ambito clinico con bambini traumatizzazione

attraverso un modello di psicoterapia basato

sul gioco denominata play-therapy.

Secondo il modello di Virginia Axline, psicoterapeuta

statunitense allieva di Carl Rogers e che ha trasposto i principi basilari sviluppati

da Rogers nell'ambito della psicoterapia dell'adulto, nel lavoro clinico con i bambini.

Questo lavoro è stato pubblicato nel libro "play therapy" nel 1947.

I postulati evidenziati e delineati da Rogers,

basilari per la comprensione del mondo interno

del bambino, a cui la Axline fa riferimento, parlano di un bambino che ha una tendenza

innata ad attualizzare le potenzialità del suo organismo

e tutti i suoi comportamenti

sono tesi al raggiungimento di questa meta.

Un secondo postulato parla di un bambino in
grado di autoregolarsi perché nessuno meglio di lui conosce ciò che è meglio per se stesso.
Un terzo postulato parla di un bambino che
ricerca attivamente tutte quelle esperienze
che possono esser favorevoli per il suo sviluppo, per l'espressione delle sue o potenziali
e del suo organismo, mentre tenderà a rifiutare tutte quelle esperienze che valuta come sfavorevoli.
In questa ottica la play therapy permette al bambino di
esprimere se stesso nelle migliori
condizioni possibili,
proprio grazie ad un clima calmo, contenitivo e facilitante il
bambino ha la possibilità di esprimere meglio il suo potenziale.
Il clima facilitante che
si realizza nell'ambito della play therapy permette al bambino di rafforzarsi,conoscersi
meglio e di simbolizzare correttamente la sua esperienza
che, in altre parole, vuol
dire dare espressione alle emozioni e ai sentimenti.
L'accesso al mondo interno del bambino è
possibile attraverso dei canali cosiddetti preferenziali che sono: il gioco, il disegno
e la favola. Attraverso questi canali il bambino è in grado di poter esprimere in maniera
più spontanea e libera, in quanto canali che gli appartengono fortemente, ed è cos'è
in grado di esprimere i propri bisogni, vissuti ed emozioni.
Nell'ambito del processo della play therapy il terapeuta starà attento a rimandare e
a riflettere al bambino tutto ciò che emerge attraverso il gioco e quindi sintonizzandosi
con quelle che sono le sue emozioni.
Questo permette al bambino di ampliare la consapevolezza
rispetto al proprio comportamento.
La costruzione del setting nella play therapy
è fondamentale perché è il modo in cui il bambino viene accolto. In questo senso,
per esempio, avere a disposizione molto materiale di gioco permette al bambino di esprimersi
in libertà, di muoversi in libertà dentro
l'ambiente, questa diventa per lui una esperienza
fortemente significativa:

nel momento in cui il bambino si sente libero è maggiormente
facilitato nella autoesplorazione
e, attraverso questa, così avviene il cambiamento, il quale
produce presa di potere personale, l'empowerment.
Ritornando alla costruzione del setting, la
presenza ad esempio di molti materiali, ad esempio fogli di carta, vari colori, plastilina
da modellare, vaschette per la sabbia su cui realizzare scene oppure la presenza di libri,
di favole da poter raccontare o leggere assieme;
insieme alla presenza dei puppets che permettano
al bambino di esprimersi al meglio: come ad esempio l'uso di due pupazzi che il bambino
ed il terapeuta possono indossare, come marionette,
ed indossandoli il bambino li fa diventare
parti di sè e può così interagire col terapeuta, ma facendo parlare il pupazzo come canale
di comunicazione, importante perché così facendo il bambino può aprirsi in modo più
profondo ed efficace.
In questo senso i pupazzi possono interagire
come se fossero entità autonome, è importante che il terapeuta guardi direttamente i pupazzi
e non il bambino, questo lo facilità nel
considerarlo come canale di espressione che
non è se stesso. Il fatto che rappresentino animali è un elemento facilitante perché
per il bambino è più semplice identificarsi con l'animale rispetto che con la figura
umana. Il terapeuta in questo processo con questi
materiali di gioco non farà altro che accompagnare
il bambino in questo percorso e - citando
Axline - durante un percorso di psicoterapia sarà il bambino ad indicare la strada da
seguire e non sarà il terapeuta a dirigerlo. Nel momento in cui infatti il bambino è libero
di esprimersi è possibile l'autoregolazione,
uno dei postulati di Rogers prima citrati.
In questa ottica la play therapy è efficace nel lavoro con bambini che hanno subito esperienze
traumatiche, in quanto la creazione di un clima di sicurezza, contenimento e libertà
permetta al soggetto traumatizzato di esprimere
al meglio se stesso e avviare un processo

di elaborazione della sua esperienza.
L'importanza del gioco è stata ampliamento
rafforzata anche dalle ricerche nell'ambito delle neuroscienze, in particolare significativo
è il contributo di Panksepp, che nel suo libero "l'ecologia della mente" identifica
sette sistemi affettivi di base presenti nei mammiferi.
Tra questi sistemi quello che più
ci interessa è l'identificazione del circuito del gioco, un circuito determinato geneticamente
che media gli effetti positivi nel cervello dei mammiferi.
Panksepp ha riscontrato che
al livello genetico il circuito del gioco è presente in tutti i mammiferi e quindi
li accomuna. Queste ricerche valorizzano l'importanza del gioco per la crescita cognitiva, affettiva,
relazionale del bambino
e si è dimostrato che il gioco facilità le abilità di coping,
ad esempio di cooperazione sociale.
Il fatto che il gioco sia stato confermato
come un'attività spontanea, radicata geneticamente, ci permette di fare delle riflessioni nel
momento in cui abbiamo a che fare con un bambino che non gioca. Un bambino che non gioca è
in qualche modo indicativo di un bambino che
in quel momento esprime un malessere.
La play therapy si configura come un intervento psicoterapeutico altamente efficace con bambini
sofferenti, che portano con sé disagi, ma ancora
di più con bambini che portano con
sé esperienze traumatiche;
in particolar modo la play therapy fa si che il punto di
vista centrale sia quello del bambino,
il quale è considerato come una persona che
può raccontare, condividere ed esprimere tutte le sue emozioni, sentimento, angosce
e paure, però in un contesto protetto, sicuro e rispettoso del bambino stesso e di quelle
che sono le sue peculiarità.
Tutto questo può aiutare il bambino a superare l'esperienza
traumatica e permettergli di crescere in maniera sana.

Matreriale di approfondimento

Virginia Axline, psicologa statunitense è stata allieva e poi collega di Carl Rogers, il padre della Psicoterapia Centrata sul Cliente. Ha applicato i principi della Psicoterapia Centrata sul Cliente adattandola alla realtà e alle esigenze dei bambini servendosi del gioco come mezzo di comunicazione più efficace per questo tipo di clienti. Ha scritto Dibs In Search Of Self (1964), pubblicato in Italia da Mondadori, Storia di Dibs (1969) e La Play Theraphy Edizioni La Meridiana, 2015

La notevole capacità della Axline e la sua fiducia palpabile nelle innate capacità di autoregolazione dei bambini a lei affidati sono un esempio eloquente di come si possa incarnare questa fiducia nelle capacità autopoietiche dei bambini e come una relazione improntata alla fiducia divenga una profezia auto-realizzante."

Dalla Prefazione di Alberto Zucconi al libro di Virginia Axline Play Therapy

"Un bambino di sette anni durante una seduta di play therapy spontaneamente disse a gran voce: 'Oh! Tutti i bambini, almeno per una volta nella vita, dovrebbero avere l'opportunità di buttare tutto fuori senza doversi sentire dire: Non ti azzardare a...! Non ti azzardare a...! Non ti azzardare a...!'

Questo fu il suo modo di definire la play therapy.

Nelle esperienze di play therapy, grazie alla relazione con lo psicoterapeuta, si dà al bambino l'opportunità di conoscere se stesso. Lo psicoterapeuta si comporta in modo tale da comunicare al bambino che questa esperienza gli offre la sicurezza e la possibilità di esplorare liberamente, non solo la play-room con i suoi giocattoli, ma anche l'esplorazione di se stesso nell'ambito della relazione terapeutica.

Qui il bambino avrà l'opportunità di misurarsi con se stesso. Il bambino come risultato di questa esperienza di auto-esplorazione di sé in relazione con gli altri, di auto-espansione e auto-espressione imparerà non solo ad accettare e rispettare se stesso ma anche gli altri e a utilizzare la libertà con senso di responsabilità.

C'è franchezza, onestà e vitale autenticità nel modo in cui i bambini si manifestano nelle esperienze di gioco. I loro sentimenti, atteggiamenti e pensieri emergono, si dispiegano, si muovono e le spigolosità si smussano.

I bambini imparano a comprendere un po' meglio se stessi e gli altri e ad offrire più generosamente accoglienza emozionale a tutte le persone."

(dall'introduzione dell'autrice)

Un classico della letteratura internazionale che ha aperto la terapia al gioco come strumento di **auto-esplorazione dei bambini**.

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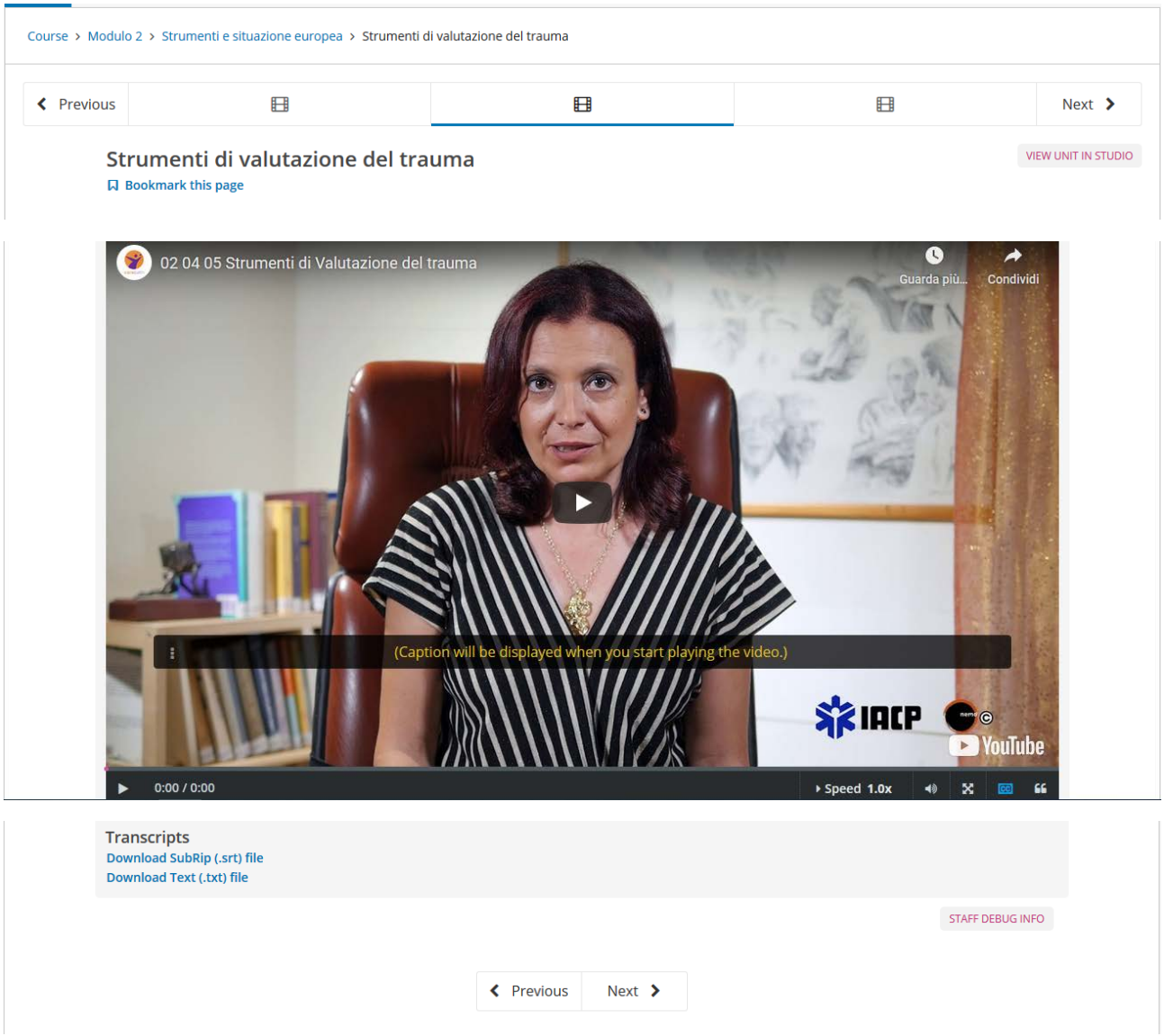


Transcript

Esistono vari strumenti di valutazione del trauma che, come tutti gli strumenti diagnostici, possono essere somministrati esclusivamente da psicologi.

Tra i vari strumenti che esistono vale la pena citare il Test di Wartegg proiettivo, semi strutturato, basato sul disegno.

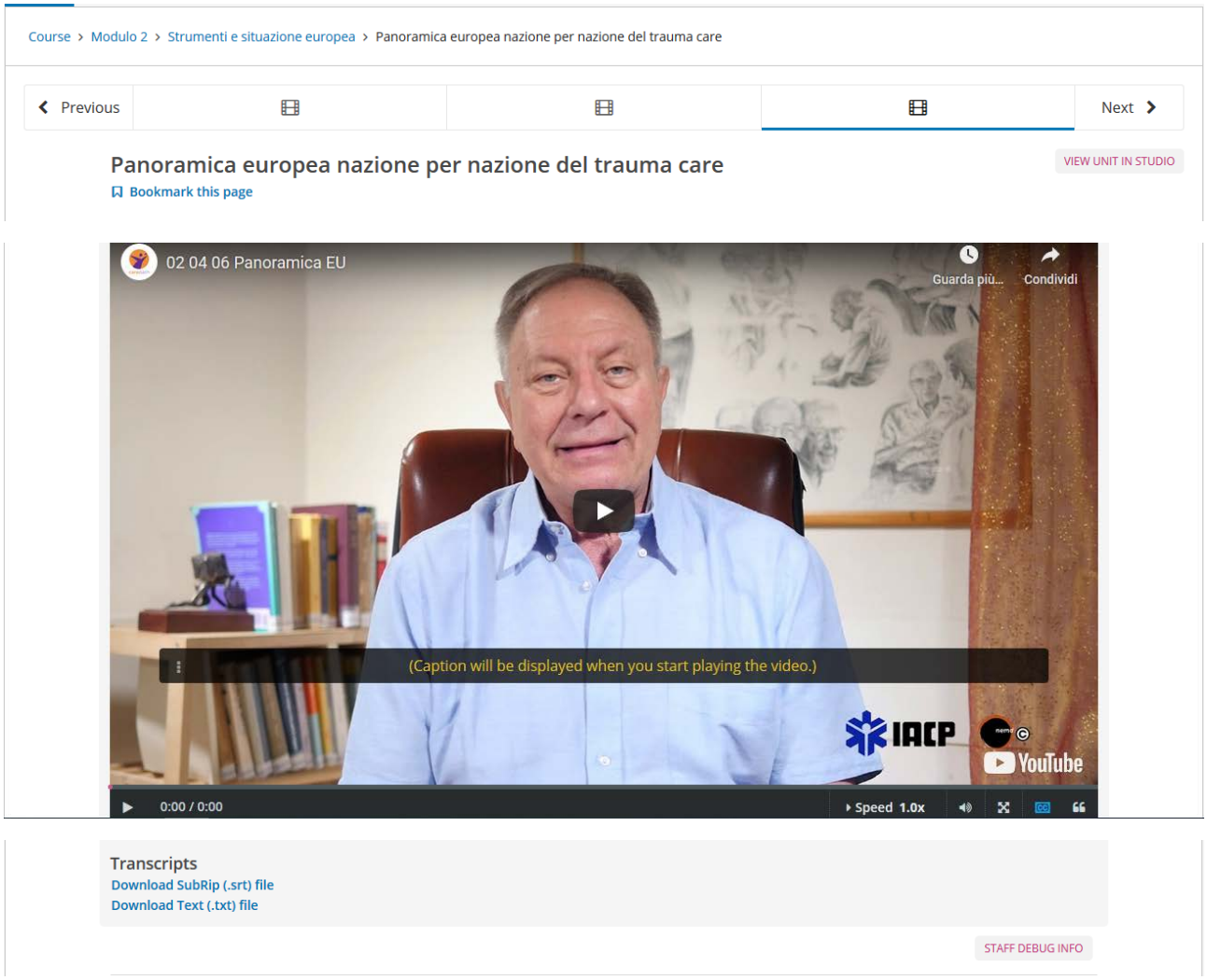
É un test somministrabile dai 4 anni in su, fino all'età adulta.

Si costituisce da un modulo cartaceo sul quale sono rappresentati 8 riquadri delimitati da una cornice nera all'interno dei quali è presente già un piccolo segno stimolo;

la persona che realizza il test dovrà completare un disegno prendendo spunto da quello che è già presente nel riquadro, farlo riquadro per riquadro e fare otto disegni nel complesso.

È uno strumento psicodiagnostico molto semplice da somministrare, anche in termini di tempistica, ed è basato sul disegno, un canale sicuramente preferenziale e facilitante per il bambino,

come accennato in precedenza sulla play therapy.
Essendo un canale preferenziale per il bambino facilità la sua realizzazione.
Il test di Wartegg si basa su un sistema di decodifica ed interpretazione molto accurato.
Nonostante la semplicità di somministrazione il sistema di decodifica è molto articolato
e accurato e fa riferimento a Crisi-Wartegg system: una procedura messa a punto dal professore
Crisi, che, in generale permette di ottenere una descrizione del funzionamento della personalità
dell'individuo a cui è stato somministrato il test.
Rispetto alla specificità del trauma il test consente, attraverso la lettura di determinati
indici, di individuare intanto la presenza di un trauma, in termini di impatto sull'individuo,
e tutto ciò che può scaturire a seguito di aver vissuto un'esperienza traumatica,
questo sia su un piano cognitivo, che relazionale, che affettivo.
Il test di Wartegg non nasce come un test specifico per la valutazione del trauma, però
può dare un contributo significativo in tal senso.
Il report che scaturisce a seguito della decodifica, la quale avviene attraverso una prima fase
in cui i disegni vengono tradotti in sigle, le sigle in indici, e questi letti in configurazione
di indici che delineano e descrivono aspetti di funzionamento della personalità-
La forza di questo test è nella sua semplicità e immediatezza e può dare una descrizione
di quello che è stato l'impatto del trauma sul funzionamento psicologico dell'individuo
stesso.
Accanto al test di Wartegg, che ha natura proiettiva, esistono anche dei questionari
di valutazione del trauma, per citarne alcuni: la Hopkins Symptom Checklist - 2 che è un
questionario messo a punto dall'università di Harvard e che è stato creato per dare
valutare la presenza di sintomi in bambini rifugiati (che hanno quindi vissuto questa
esperienza), un'altro questionario è il Trauma Symptoms Checklist for Young Children
un questionario che viene compilato non direttamente dal soggetto ma dal caregiver, infine il Coping
Responses Inventory
che invece viene somministrato dai 12 anni in su ed è un questionario self report



Transcript

L'Europa è stata teatro di eventi traumatici di massa che hanno impattato negativamente

larghe fasce della popolazione.

Del resto il trauma, in tutte le parti del mondo, è molto diffuso.

I calci sono che circa il 70% della popolazione

subirà nell'arco della propria vita almeno

un evento traumatico,

da questo ne riceverà dann;

è una vera propria pandemia: un'epidemia

diffusissima, e in quanto tale è così grave il danno a livello mentale,

fisico, comportamentale,

sociale, economico che gli effetti dei traumi provocano

che si potrebbe dire sono state

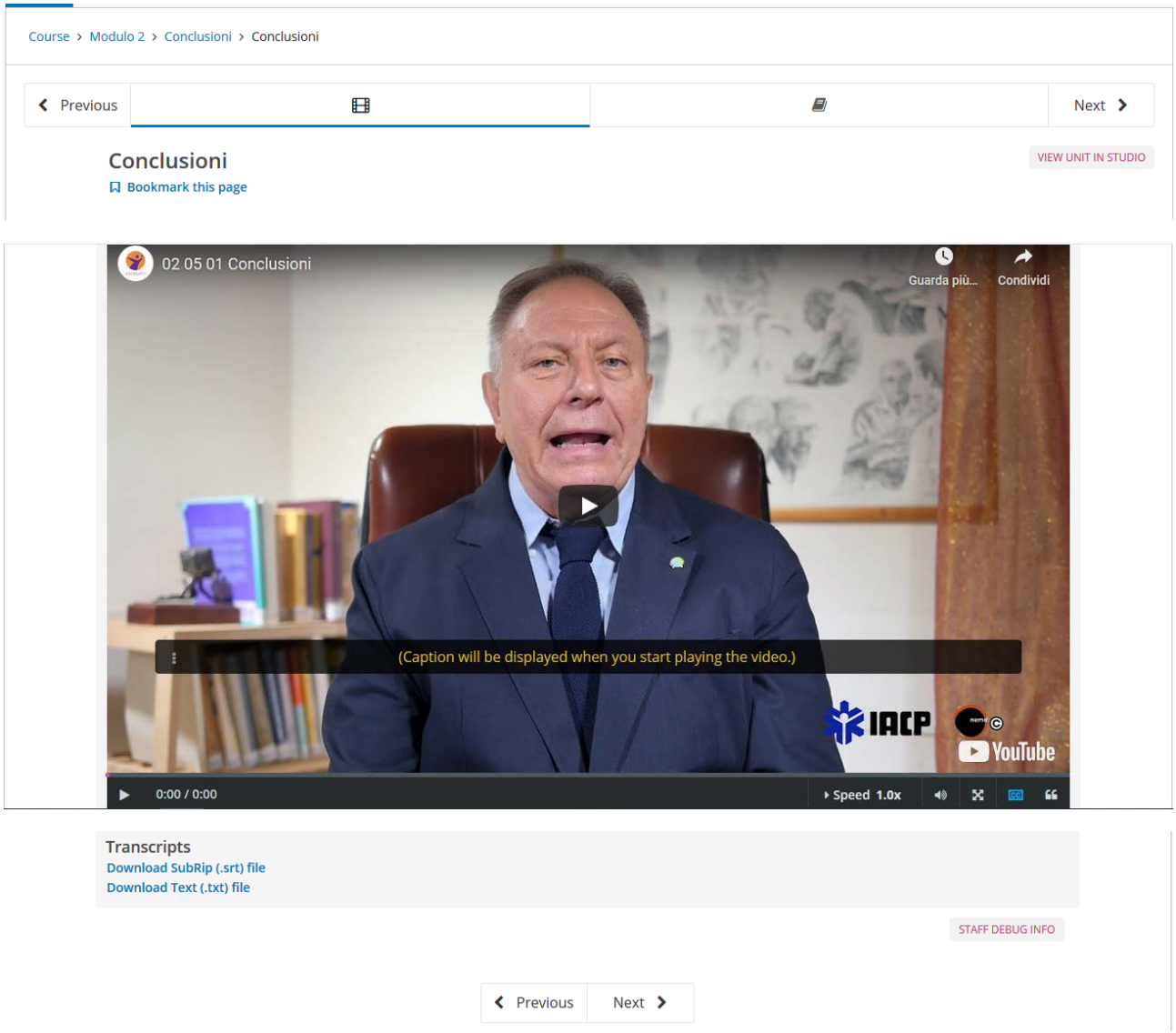
bel allertate le nazioni Europee,

tra le più avanzate al mondo, per investire in ricerche,
know how, finanziamento e sviluppare le skills per gestire efficacemente - come facciamo
per tante altri fenomeni - questa pandemia.
Invece, purtroppo, così non è; incredibile ma vero è quanto poco è stato fatto.
Ci sono delle eccezioni a questa regola, nazioni virtuose - come quelle scandinave - per esempio
in Svezia si sono attrezzati non solo a livello di trattamenti di persone traumatizzate, ma
anche a livello sociale, affrontando con lungimiranza
la problematica per cui in ogni città esiste
una task force dedicata al trauma;
oppure i professionisti - come gli assistenti sociali
- sono ben addestrati durante il loro iter accademico, su come gestire e prevenire queste
tematiche.
Molti altri paesi europei, però, non sono stati altrettanto efficaci.
Basti pensare che il Belgio, dove esiste un ottimo reddito pro capite, un'ottima capacità
di sviluppo, dell'industria, dei servizi, fino a pochi anni fa non possedeva strumenti
per contrastare o aiutare i professionisti a sviluppare le competenze nei loro iter di
costruzione sociale del professionista.
La situazione, quindi, non è oggi assolutamente soddisfacente, con delle variabili - come
l'inghilterra ed in genere le nazioni
di tipo anglosassone - che hanno sviluppato in maniera
lungimirante le possibilità di addestrare e investire risorse nel creare istituzioni
che possano essere di aiuto e trattamento alle persone traumatizzate, ma anche la loro
prevenzione.
Tuttavia in molte nazioni, per esempio in Italia, ancora c'è ancora molto cammino
da compiere prima che sia accettabile
avere una situazione decentemente sotto controllo.
Un lavoro positivo è stato svolto, ovviamente, dalle società di traumatologia che si sono
sviluppate negli ultimi decenni; queste hanno un po'
supplito a quello che sarebbe il
compito degli iter di formazione universitaria delle varie professioni sanitarie a creare
ed offrire training, aggiornamenti
e addirittura delle possibilità di qualificazione dei diplomi

nel trattamento del trauma.

Moltissimo è ancora da fare e questo è un imperativo assolutamente etico, morale, ma soprattutto di salute sociale e di diritti alla salute degli individui.

In Italia l'art. 33 della Costituzione, come tante altre costituzioni europee, dice che la salute è un diritto di ogni cittadino, quindi dobbiamo proteggere e promuovere la salute di tutti: questo è un imperativo.



Transcript

Siamo arrivati alla fine del secondo modulo di questo corso. Vorrei ringraziare sentitamente tutti quelli che hanno contribuito a realizzarlo,

incluso ognuno di voi che ha partecipato e

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negli scopi e gli obiettivi.

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che hanno accettato di lavorare gratuitamente e
dare la propria immagine, il proprio contributo
e anche il proprio materiale per essere condividi gratuitamente e di disseminati attraverso
il portale di questo corso.
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esperienze in questo campo difficile del trattamento dei minori affetti da traumi.
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anche ai suoi colleghi dell'università di Torino, Facoltà di
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Quiz 1

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Q1

16 points possible (graded)

1. Cosa si intende per "relazione d'aiuto?"

- ○ Una relazione affettiva che si basa sull'aiuto di un partner all'altro
- ○ Una relazione che si instaura tra un professionista ed un utente
- ○ Una relazione che soddisfa i bisogni del professionista e dell'utente
- ○ Una relazione tra medico e paziente

2. La teoria generale dei sistemi è stata formulata da:

- ○ Wertheimer
- ○ Maslow
- ○ Rogers
- ○ Von Bertalanffy

3. Cosa è l' OMS?

- ○ Organizzazione Mondiale della Scienza
- ○ Organizzazione Medica Sociale
- ○ Organizzazione Mondiale della Salute
- ○ Organizzazione Mondiale della Sanità

4. L' Approccio centrato sulla Persona è stato fondato da

- ○ C. Rogers
- ○ O. Rank
- ○ J. Bowlby
- ○ A. Maslow

5. Quali tra queste condizioni necessarie all'instaurarsi di una relazione d'aiuto non è stata teorizzata da C.Rogers?

- ○ Empatia
- ○ Accettazione positiva incondizionata
- ○ Resilienza
- ○ Congruenza

6. Alleanza di lavoro

- ○ Riguarda la modalità contrattuale tra professionista e datore di lavoro
- ○ Non riguarda le relazioni d'aiuto del singolo ma solo del gruppo
- ○ E' auspicabile in una relazione d'aiuto
- ○ E' l'insieme di regole poste dal professionista e che l'utente deve rispettare

7. La mancanza di empatia nella relazione d'aiuto

- ○ è indice di professionalità
- ○ serve per capire meglio cosa sta dicendo l'utente
- ○ è un'azione consigliata per prevenire il burn out
- ○ impedisce il realizzarsi di una relazione d'aiuto

8. Cosa si intende per disturbo post-traumatico da stress complesso?

- ○ è una dicitura alternativa del disturbo post traumatico da stress
- ○ è un disturbo derivato da esperienze cronicamente traumatiche
- ○ è una dicitura utilizzata quando i sintomi del disturbo post traumatico da stress perdurano per più di 6 mesi
- ○ è un disturbo derivato da un trauma di gruppo

9. Quali tra le seguenti caratteristiche non sono auspicabili in un sistema di assistenza "Trauma informed Care"?

- ○ Valorizzare il paziente in tutti gli aspetti della cura
- ○ Adottare un linguaggio neutrale e di supporto
- ○ Fare un corretto screening su quale esperienza possa definirsi traumatica
- ○ Formare il personale sul trauma ed i suoi effetti

10. Non si può guarire dal trauma

- ○ Vero
- ○ Falso

11. Quale è il fattore eziopatogenico più comune nello sviluppo del trauma psicologico?

- ○ Esperienza reiterata di incuria fisica e psicologica da parte delle figure di accudimento
- ○ Esperienza in prima persona a catastrofi naturali
- ○ Esperienza in prima persone di morti improvvise
- ○ Esperienza di abuso sessuale infantile

12. Per trauma informed care si intende:

- ○ Un insieme di tecniche che accompagnate all' EMDR facilita la rielaborazione traumatica
- ○ Una tipologia di psicoterapia
- ○ Un' approccio sistemico per l'inquadramento e la presa in carico di persone con vissuto traumatico
- ○ Un reparto ospedaliero specifico per le persone con vissuto traumatico

13. Per violenza assistita si intende:

- ○ Il trauma derivato dall'assistere a eventi catastrofici
- ○ Situazione nella quale un minorenne assiste, direttamente o indirettamente, o percepisce gli effetti di atti di violenza compiuti su figure di riferimento per lui o lei affettivamente significative.
- ○ Tipologia di violenza attuata da un genitore verso l'altro con l'appoggio psicologico e/o materiale (ottenuto attraverso la manipolazione psicologica) di un figlio
- ○ Il trauma derivato dall'assistere a fenomeni di violenza generici

14. Quali sono le azioni di intervento raccomandate in caso di violenza assistita?

- ○ Rilevazione, Protezione, Valutazione, Trattamento
- ○ Osservazione, Valutazione, Trattamento, Mediazione familiare
- ○ Rilevazione, Allontamento dal nucleo familiare, Trattamento,Mediazione familiare, ricollocamento in famiglia
- ○ Allontanamento dal nucleo familiare, Mediazione familiare, ricollocamento in famiglia

15. Secondo il rapporto dell'OMS pubblicato nel 2013 sulla prevenzione del maltrattamento all'infanzia in Europa, quanti sono i minori al di sotto dei 15 anni morti per maltrattamento?

- ○ Tra 800 e 900
- ○ Tra 500 e 600
- ○ Tra 900 e 1000
- ○ Tra i 400 e i 500

16. Il PTSD complex si differenzia dal PTSD per:

- ○ il complex è tipico dell'infanzia
- ○ il complex è presente in casi di violenza all'interno di una relazione di fiducia
- ○ il complex è presente se accanto a sintomi psicologici ci sono sintomi motori
- ○ il complex è presente esclusivamente in donne e minori

Invia

Show Answer

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1.I Danni psicologici e fisici dei traumi nelle donne sopravvissute alla tratta di esseri umani

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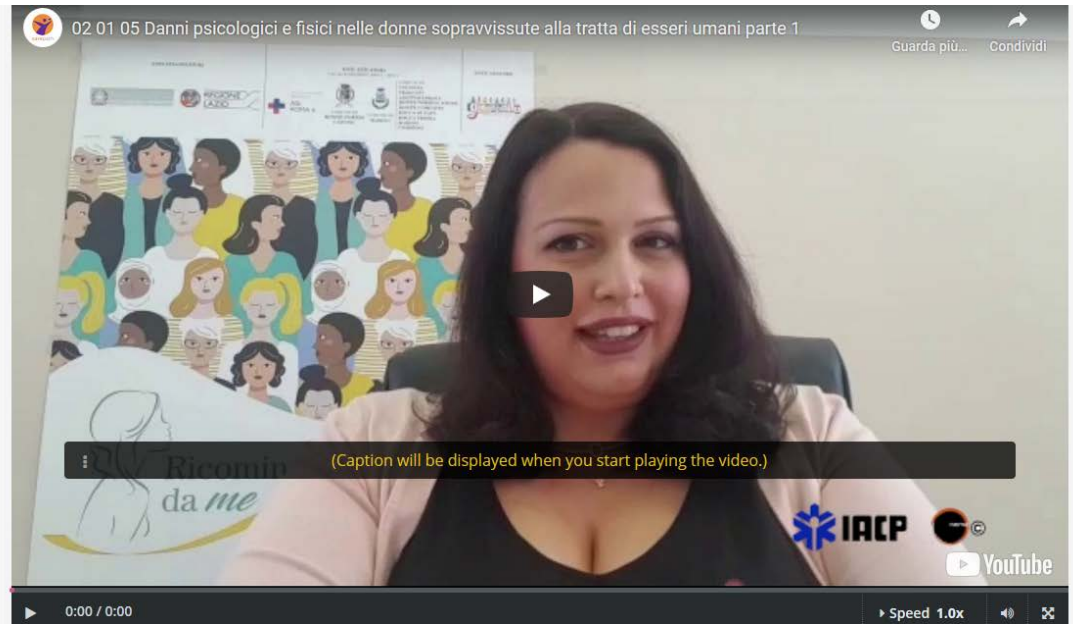
Danni psicologici e fisici dei traumi nelle donne sopravvissute alla tratta di esseri umani - parte 1



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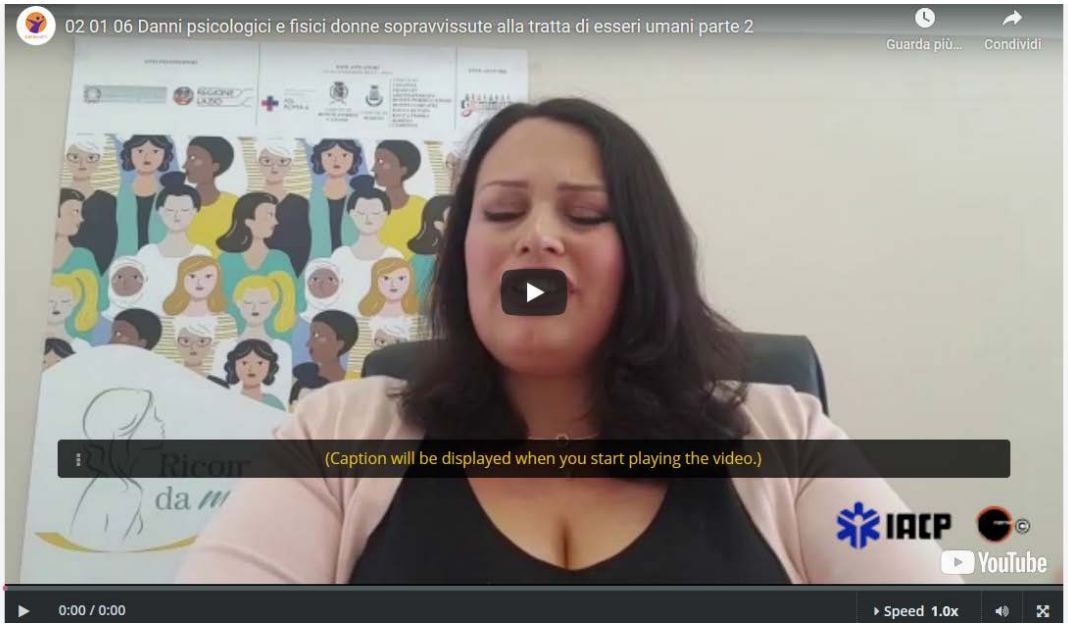
Danni psicologici e fisici dei traumi nelle donne sopravvissute alla tratta di esseri umani - parte 2



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1.II Il trauma dei bambini in adozione rifiutati

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3.I Centrarsi sulle persone non sui traumi!

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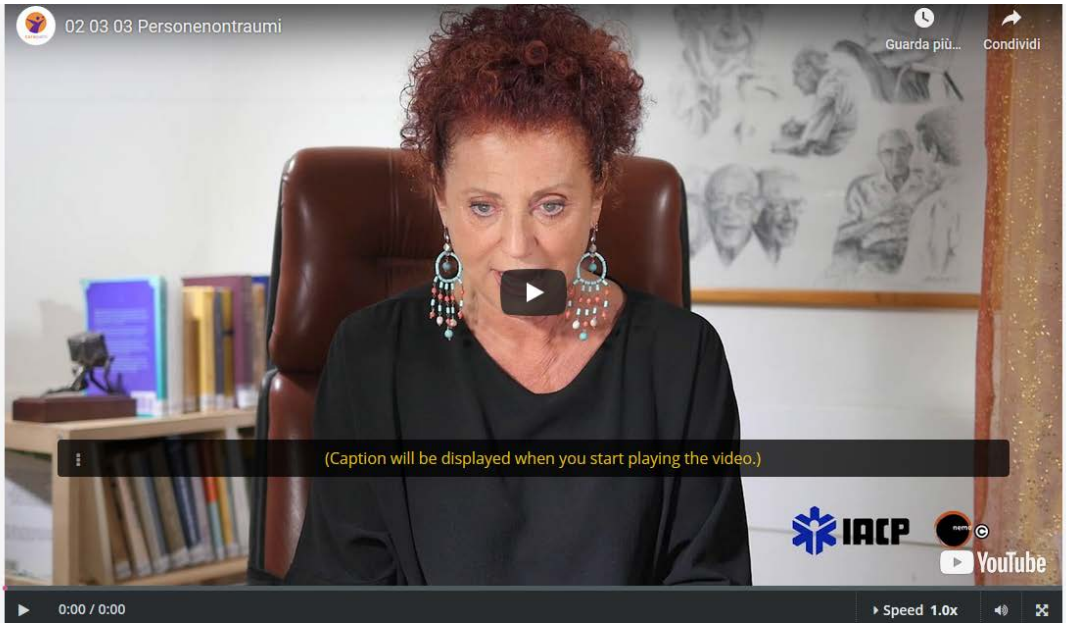

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Che ne pensi di quanto affermato da Manuela Tremante, il tuo stile di lavoro ha più similitudine o differenze con quanto sottolineato da Manuela Tremante?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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3.II Approcci scientificamente validati per minori affetti da trauma

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Modulazione dell'arousal, memoria procedurale ed elaborazione del trauma

Policy brief: CTIPP Position on Evidence-Supported Practices and Policies

Eye movement desensization and reprocessing (E.M.D.R.) e psicoterapia del Disturbo Post-Traumatico da Stress

Sono veramente efficaci le psicoterapie evidence-based?

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3.III Task Force 29

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Evidence-Based Therapy Relationships

Psychotherapy Relationships That Work III

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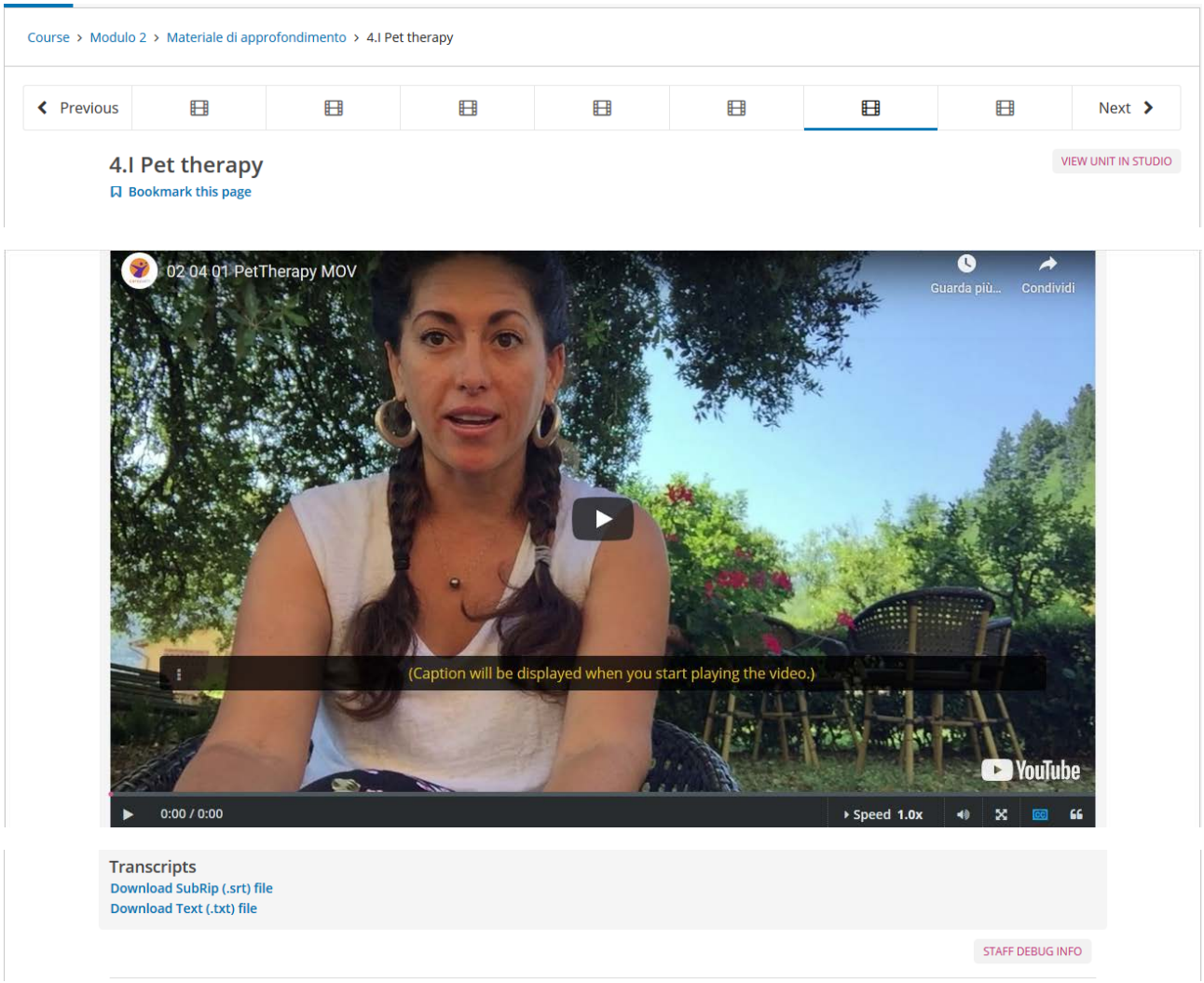

Transcript

Greetings.

I am Shazara Bloomfield and I am the co-founder of Maui Therapy Animals.

At Maui Therapy Animals we utilize animals in a broad range of various activities that provide for motivational, educational and/or recreational benefits to enhance quality of life.

The love of animals is transformational.

At Maui Therapy Animals our mission is to improve social, emotional, and mental functioning with the support of one of our therapy animals.

Animal Assisted Therapy is an effective tool proven to aid children in overcoming emotional trauma.

Animals are incorporated as part of a structured intervention and a child is facilitated to build a safe and trusting relationship.

This method is a goal directed intervention in which a specially trained therapy animal is introduced into the therapy treatment process.

Activities and interactions with animals have been scientifically proven to increase socialization,

elevate mood, release calming endorphins, produce an automatic relaxation response, inspire affection and lift spirits, lessen depression, lower feelings of loneliness and alienation, encourage communication, increase socialization, diminish boredom, and reduce anxiety.

Animal Assisted Therapy and Animal Assisted Activities offer children who have experienced trauma an opportunity to have a meaningful and customized interaction.

Often this approach can reach the inner world of the client where other means do not.

The compassionate approach of one of our trained therapy animals allows for empowerment and meaningful reflection within the client.

Individuals are able to restore a sense of safety and build healthy attachments within relationships.

The human-animal bond has been credited with increasing a sense of self-worth, empathy, psychological well-being and sense of purpose.

Animal therapy per bambini affetti da Trauma

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4.II Il Kids Workshop

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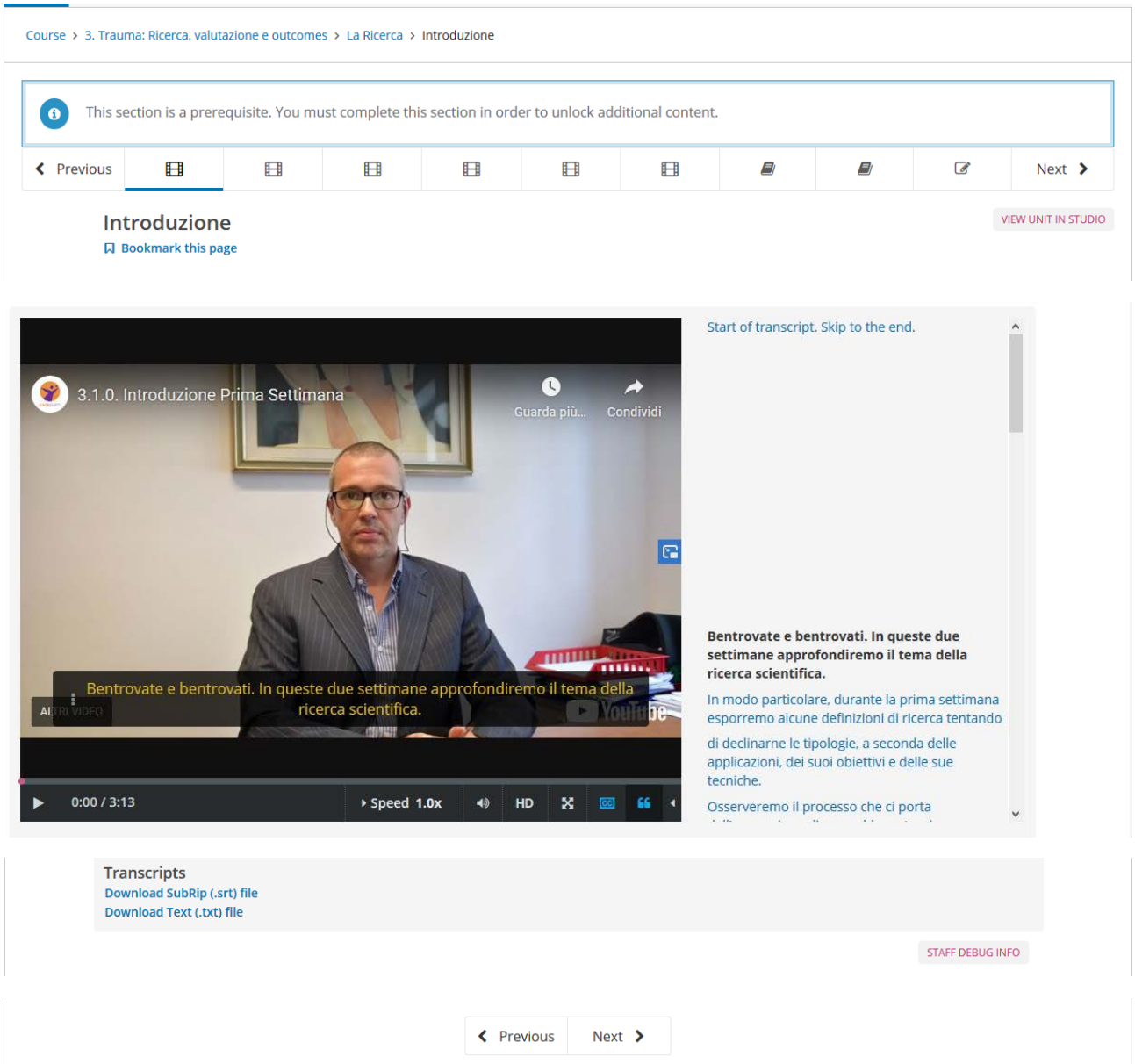
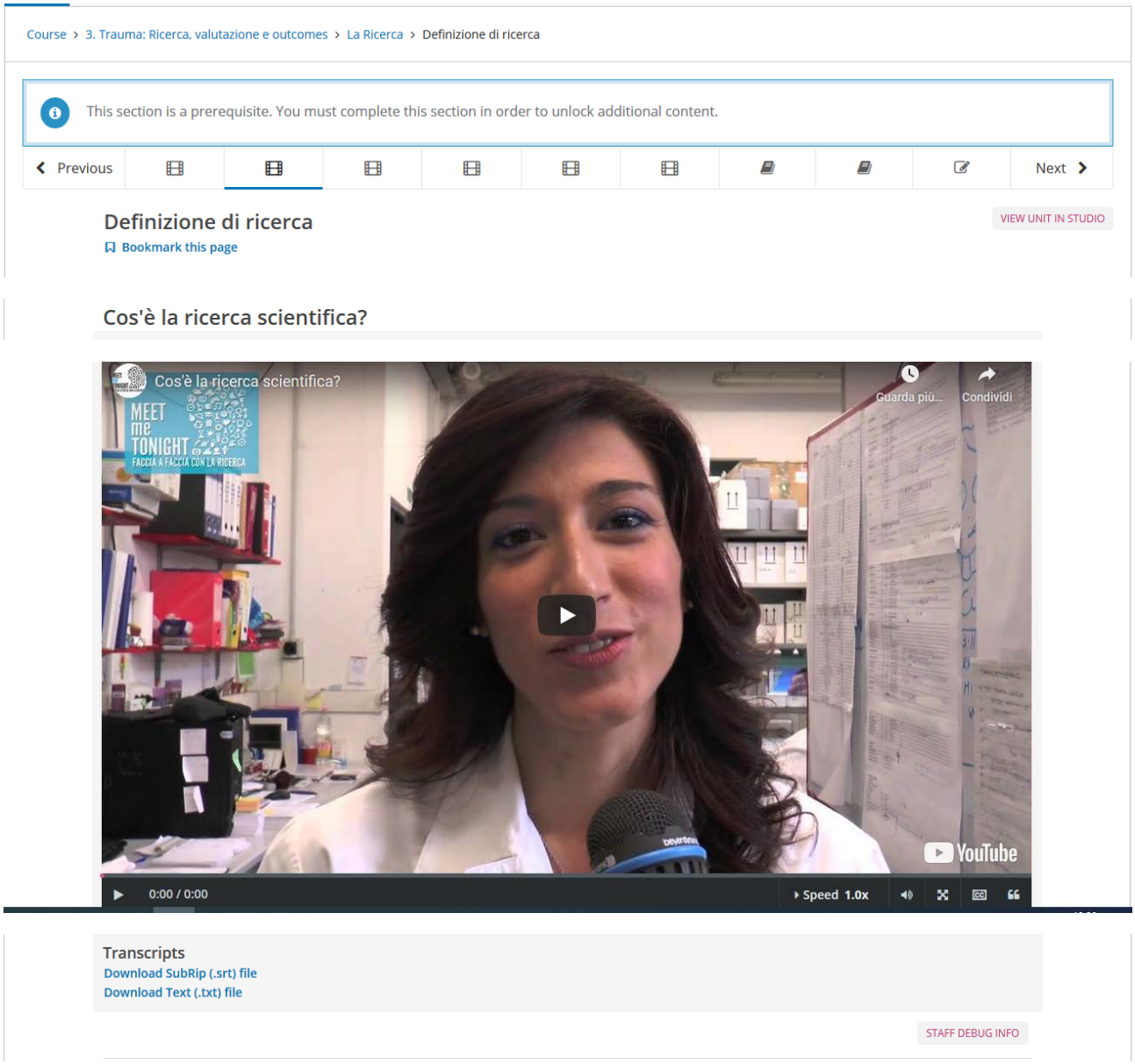


Transcript

Bentrovate e bentrovati. In queste due settimane approfondiremo il tema della ricerca scientifica.
In modo particolare, durante la prima settimana esporremo alcune definizioni di ricerca tentando
di declinarne le tipologie, a seconda delle applicazioni, dei suoi obiettivi e delle sue tecniche.
Osserveremo il processo che ci porta dall'espressione di un problema teorico,
quindi dalla teoria, ai metodi che ci permettono di esplorarlo, producendo dati che in qualche
modo possono essere interpretabili ed utilizzabili. Ecco che allora andremo ad integrare ed approfondire
i principi fondamentali, i limiti ed i benefici di quella che è la Ricerca-Azione, da cui
partiremo ed alcuni colleghi e colleghe ci spiegheranno il senso della Ricerca-Azione,
per arrivare alla ricerca Evidence Based, la ricerca basata sull'evidenza.
Dopodichè, approfondiremo gli aspetti legati ai vantaggi e sfide della integrazione della

Evidence-Based Research (quindi la ricerca basata sull'evidenza) in quella che è la Trauma-Informed Care, proprio del nostro percorso formativo. In particolare, la rilevanza internazionale dell'argomento ci fornisce una prospettiva trasversale su quelli che sono i punti critici ed i punti di forza del trasformare la ricerca in pratica clinica. Qui analizzeremo quelli che sono gli elementi portanti e quelli che sono anche considerati in letteratura aspetti legati alle buone pratiche, di cui alcuni che sono informativi. Ci interrogheremo, e cercheremo di comprendere, quale senso ha, e qual'è il significato di bisogno formativo, e di come questo possa in qualche modo essere avvalorato, preso in considerazione, dall'organizzazione. Non dobbiamo infatti dimenticare che un approccio Trauma-Informed Care ha sicuramente un aspetto, una ricaduta, che è fondamentale in quello che è l'elemento organizzazione e nei singoli membri dell'organizzazione. Di qui, approfitteremo di questo spazio per andare a discutere anche gli aspetti rispetto alla divulgazione scientifica nello sviluppo e nell'implementazione di interventi specifici in Trauma-Informed Care. Arrivando verso la fine del nostro percorso di questa settimana, andremo ad approfondire quelli che sono gli aspetti valutativi nelle organizzazioni, che mettono a punto, o tentano di mettere a punto una procedura o un processo Trauma-Informed Care. Questi infatti possono offrire ai propri dipendenti, ai propri collaboratori, ai propri volontari, elementi formativi e informativi sulla Trauma-Informed Care, come anche offrire quelli che possono essere interventi efficaci rispetto ad elementi legati a quello che è l'evidenza della ricerca in psicoterapia, o meglio in terapia Evidence-Based. Di qui ci accompagneremo e ci porteremo poi sulla seconda settimana che ci permetterà di approfondire ulteriori temi legati alla ricerca.

Non mi resta che augurare a tutte quante voi e a tutti quanti voi una buona settimana di corso e una buona lezione, a nome mio e a nome di tutti i colleghi.



Transcript

Scoperta, incontro e passione- Condivisione, futuro.

Cultura e conoscenza.

Progresso.

Scoperta per un futuro migliore.

Attesa.

Sviluppo e coraggio.

Bella e stimolante.

Difficile ed entusiasmante.

Passione, creatività e dedizione.

Sfida.

Sviluppo.

Futuro. innovazione, costanza, impegno.

Sacrificio ma tanta soddisfazione.

Opportunità.

Progresso.

Comprensione.

Impegno libertà e studio.

Ambizione.

Evoluzione.

Fatica.

Ma anche divertimento.

Curiosità, innovazione, ricchezza.

La ricerca è la natura dell'essere umano, un uomo che non

ricerca è un uomo che non risolve i problemi, è un uomo che non esiste.

La ricerca è curiosità, è desiderio di conoscere la realtà, e soprattutto per

chi l'ha fatta è la gioia impagabile della scoperta.

Non è semplice delimitare i confini di ciò che è ricerca e ciò che non lo è. Nel corso del tempo sono state date molteplici definizioni, vediamone alcune delle più recenti:

«La ricerca cerca semplicemente la risposta a certe domande a cui non è stata finora data una risposta e le risposte dipendono dagli sforzi umani. [...] In realtà la ricerca è

semplicemente il processo per arrivare a soluzioni affidabili a un problema attraverso la raccolta, l'analisi e l'interpretazione pianificate e sistematiche dei dati.» (Singh, 2006, p.1).

«...è un processo creativo di scoperta che si sviluppa secondo un itinerario prefissato e secondo procedure prestabilite che si sono consolidate all'interno della comunità scientifica» (Corbetta, 2015, p.15).

In generale si sta facendo ricerca "nel momento in cui la curiosità e l'intuizione vengono applicate con un approccio sistematico per rispondere a domande rispetto ai fenomeni che si osservano quotidianamente, facendo tesoro delle esperienze e delle conoscenze già acquisite" (Research Italy, 2013).

Ci sono diversi tipi di ricerca che si distinguono in base alla sua applicazione, agli obiettivi e ai metodi di indagine. La ricerca può infatti essere "applicata" o "pura". La ricerca applicata mira a trovare una soluzione per un problema applicativo che deve essere affrontato, mentre la ricerca pura riguarda principalmente le generalizzazioni e la formulazione di una teoria (Kothary, 2004; Singh & Masuku, 2013). A seconda dei suoi obiettivi, la ricerca può essere di tipo descrittivo, esplorativo, correlazionale o esplicativa. La ricerca descrittiva ha l'obiettivo di descrivere un fenomeno, un problema, una situazione.

La ricerca correlazionale ha l'obiettivo di esplorare una relazione tra due o più variabili.

La ricerca esplicativa ha l'obiettivo di spiegare perché certe cose accadono.

La ricerca esplorativa ha l'obiettivo di esaminare la fattibilità di uno studio o di esplorare un'area tematica poco nota.

L'indagine che si desidera avviare necessita di un piano di lavoro determinato da alcune fasi procedurali che si devono compiere in relazione all'indagine stessa, queste fasi di natura progettuale sono conosciute come "disegno di ricerca".

In base alle tecniche utilizzate, la ricerca si può distinguere in:

- Ricerca quantitativa: utilizza un approccio strutturato, ha l'obiettivo di quantificare la variazione o la diversità di un fenomeno, situazione o atteggiamento attraverso un disegno di ricerca ben strutturato, che fornisce dati di natura quantitativa che possono essere analizzati per verificare ipotesi e testare relazioni tra variabili.
- Ricerca qualitativa: utilizza un approccio non strutturato è esplicativa, descrittiva e di natura induttiva con particolare attenzione al contesto e ha l'obiettivo di identificare e descrivere il maggior numero di variazioni possibili di un fenomeno, una situazione o un atteggiamento, comprendendone le motivazioni sottostanti alle variazioni. Quest'ultima implica un «approccio interpretativo e naturalistico al mondo; significa che i ricercatori qualitativi studiano i fenomeni nei loro contesti naturali, tentando di dargli un senso o interpretarli in termini del significato che le persone portano loro» (Denzin & Lincoln, 2011, p. 3). Lo scopo della ricerca qualitativa è di descrivere e comprendere i fenomeni, piuttosto che predirli e/o controllarli (Streubert & Carpenter, 2005).

L'approccio misto, invece, coniuga sia i metodi di indagine della ricerca quantitativa che quelli della ricerca qualitativa. «La ricerca sociale si basa sulla definizione di variabili, sulla ricerca di associazioni tra loro e sul tentativo di capire se e come la variazione di una cosa causa una variazione in un'altra. Alcune variabili comuni che troverete nella ricerca sociale sono età, sesso, etnia, razza, istruzione, reddito, stato civile e occupazione» (Bernard, 2006, pp. 28-29). In primo luogo quindi si trova il concetto di variabile: qualcosa che può assumere più di un valore. In secondo luogo si trova il concetto di "misurazione": infatti le variabili sono misurate dai loro indicatori che sono definiti dai valori della variabile stessa. La misurazione implica quale valore registrare. Qualsiasi ricerca inoltre deve rispettare i principi di validità e affidabilità. Per validità si intende che la ricerca deve avere strumenti di misurazione, dati e risultati accurati; mentre l'affidabilità fa riferimento al fatto di ottenere i medesimi risultati misurandoli più volte con lo stesso strumento.

Bernard (2006) illustra i quattro punti fondamentali che segue il processo di ricerca:

1. In primo luogo, viene formulato un problema teorico (teoria e letteratura scientifica);

2. Successivamente, vengono selezionati unità di analisi e metodo appropriati;

3. Quindi, i dati vengono raccolti e analizzati;

4. Infine, la proposizione teorica con la quale è stata avviata la ricerca è o contestata o supportata.

(Bernard, 2006, p.69)

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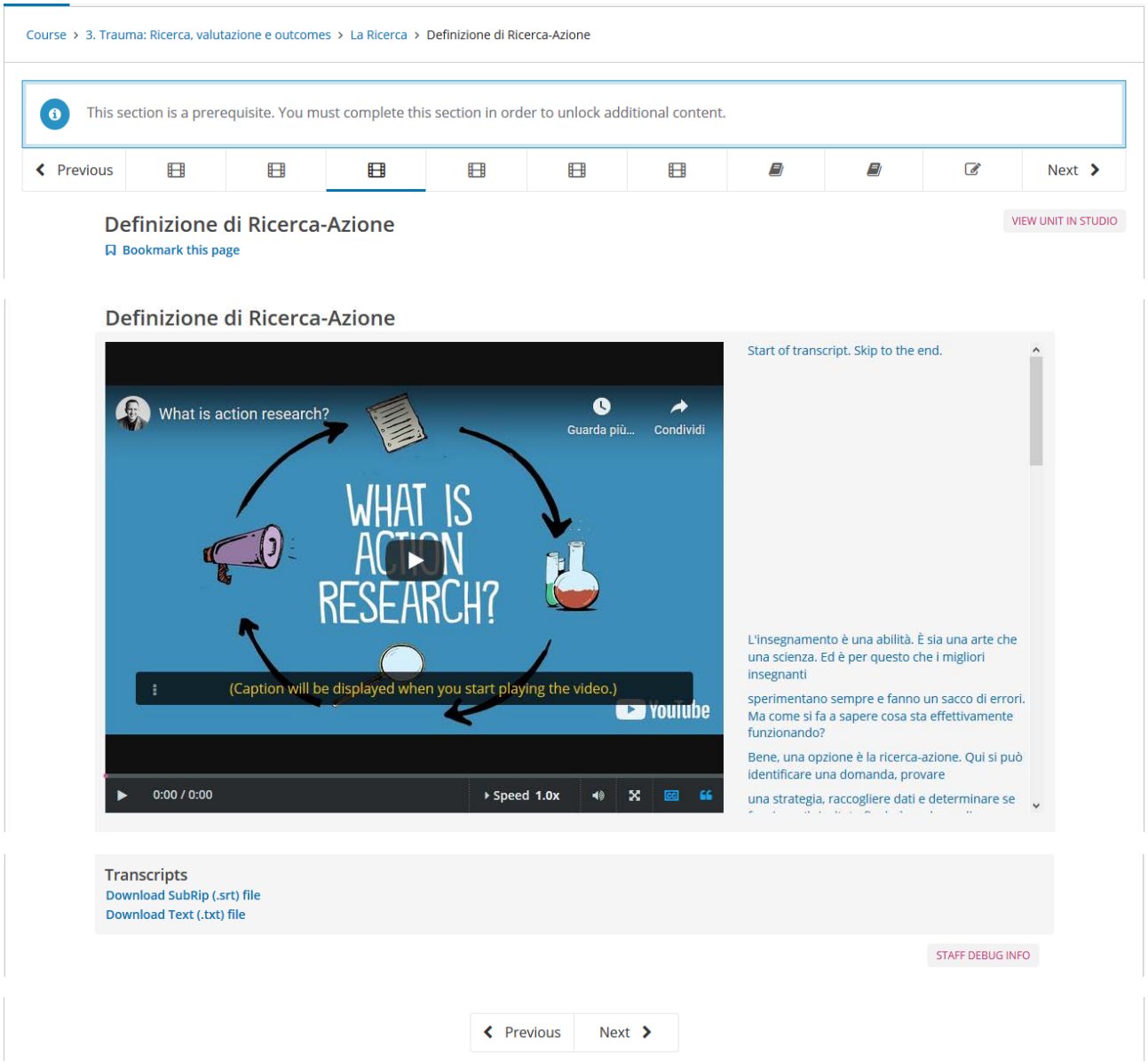


Transcript

L'insegnamento è una abilità. È sia una arte che una scienza. Ed è per questo che i migliori insegnanti sperimentano sempre e fanno un sacco di errori. Ma come si fa a sapere cosa sta effettivamente funzionando?

Bene, una opzione è la ricerca-azione. Qui si può identificare una domanda, provare una strategia, raccogliere dati e determinare se funziona. Il risultato finale è qualcosa di dinamico, innovativo, e legato direttamente alla tua classe.

La ricerca-azione dissolve la barriera tra partecipanti e ricercatori.

In altre parole, l'insegnante partecipa attivamente alla situazione mentre conduce la ricerca. Esistono diversi framework di ricerca-azione,

ma generalmente seguono un processo simile. Si comincia dalla fase 1, la pianificazione della ricerca.

Qui si comincia dalla indagine, dove si definisce una specifica domanda di ricerca.

Deve essere qualcosa che può effettivamente essere testato.

Poi, si conduce una revisione della letteratura per ottenere una comprensione migliore dell'argomento.

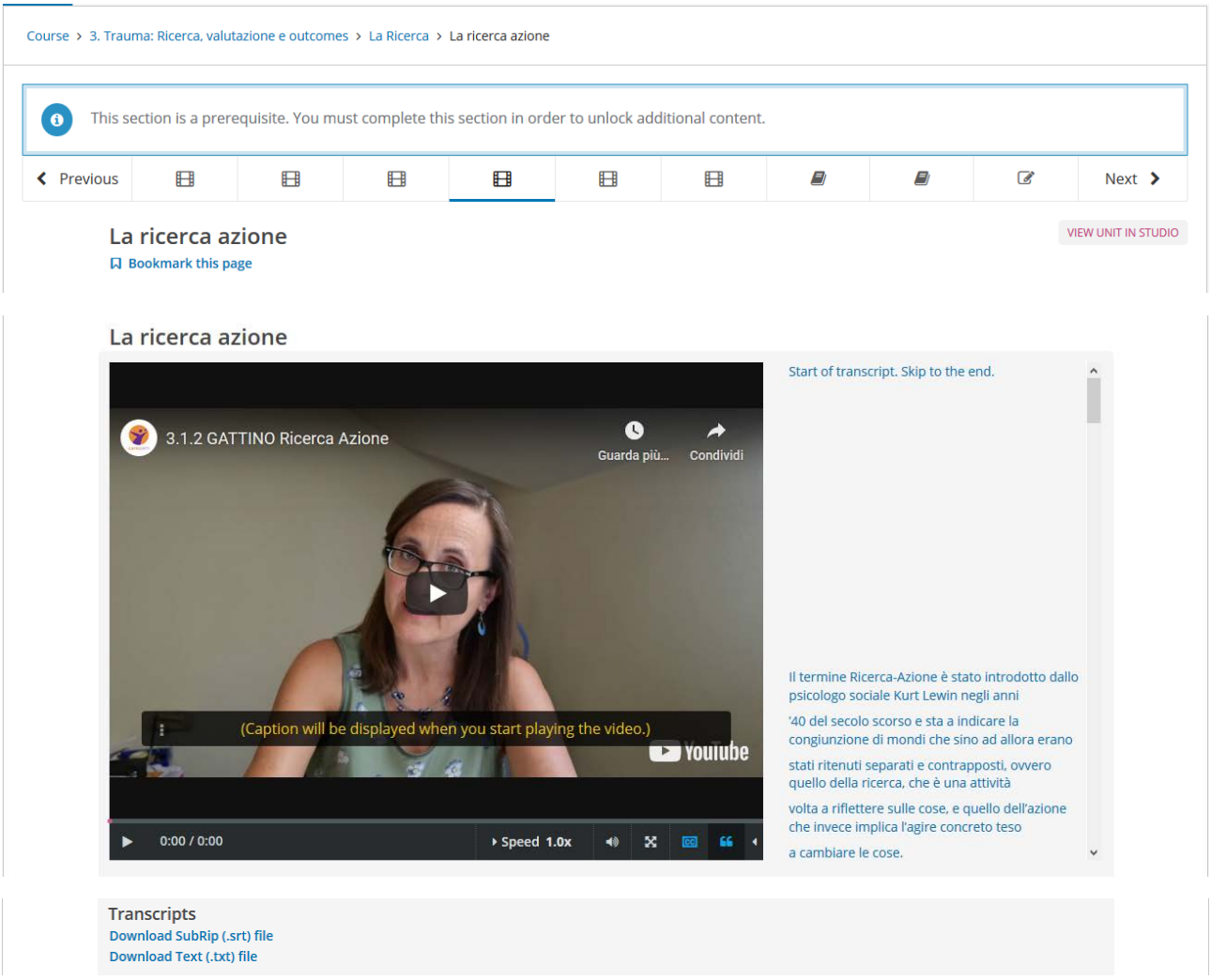
Infine ci si sposta nel processo di disegno, si determinano i metodi di ottenimento dei dati, si considerano i problemi etici, si ottengono i permessi necessari, si creano delle scadenze, e si impostano i sistemi.

Poi ci si sposta nella fase dell'azione. Qui è dove si cominciano numerosi cicli di sperimentazione e raccolta dei dati. La raccolta dei dati potrebbe includere dati qualitativi come osservazioni, artefatti, e interviste, oppure dati quantitativi come sondaggi delle griglie di valutazione, o dati sui risultati. Dopodichè ci si sposta alla analisi. Spesso si comincia organizzando i dati in grafici o classifiche e cercando tendenze specifiche.

Si potrebbe anche discuterne con i pari, scrivere liberamente in un diario o creare una mappa a grappolo prima di scrivere i risultati. Infine si arriva alla conclusione.

Qui è dove si condivide la ricerca con il mondo e si riflette sulla propria pratica.

Questo porterà infine a nuove domande, ed il ciclo continuerà mentre si raffinano le proprie abilità da insegnante migliore e più creativo.



Transcript

Il termine Ricerca-Azione è stato introdotto dallo psicologo sociale Kurt Lewin negli anni ’40 del secolo scorso e sta a indicare la congiunzione di mondi che sino ad allora erano stati ritenuti separati e contrapposti, ovvero quello della ricerca, che è una attività volta a riflettere sulle cose, e quello dell’azione che invece implica l’agire concreto teso a cambiare le cose.

La Ricerca-Azione consente quindi di creare un’alleanza strettissima tra l’aspetto conoscitivo, la Ricerca, e l’aspetto applicativo, l’Azione, ed esprime una trasformazione nel modo di ideare, progettare e fare ricerca nelle scienze umane in cui la complessità dei fenomeni studiati non viene semplificata ma, al contrario, è accolta e tenuta in conto.

La Ricerca-Azione è realizzata da Lewin sempre in gruppo e questo binomio “Ricerca-Azione e gruppo” è dovuto al fatto che il gruppo è quel luogo psicosociale all’interno del quale le persone costruiscono le loro azioni ed è anche uno strumento che può facilitare i processi di cambiamento.

La Ricerca-Azione si può descrivere come una famiglia di metodologie di ricerca il cui obiettivo, come abbiamo detto, è attivare simultaneamente un percorso di azione, ossia di cambiamento, e di ricerca, ovvero di comprensione dei fenomeni.

Questo percorso avviene attraverso un processo flessibile che consiste in una spirale di cicli, ognuno dei quali si struttura in tre momenti successivi: la pianificazione, l'esecuzione e la ricognizione o inchiesta, tesa a valutare i risultati di ogni momento, a preparare una base razionale per il momento successivo e per cambiare, se occorre, il piano di azione originario.

Terminato il primo ciclo di Ricerca-Azione, che cosa accade?

Accade che sono stati analizzati i risultati e anche l'eventuale cambiamento che è stato prodotto rispetto alla situazione iniziale, e fatto tutto ciò il processo ricomincia con un nuovo ciclo, in cui saranno inseriti gli elementi nuovi emersi dall'attività svolta nel ciclo precedente, e così via, fino all'esaurimento della situazione problematica.

La pianificazione, l'esecuzione e la ricognizione sono sorrette da una valutazione critica in cui ci si chiede cosa ha funzionato, cosa non ha funzionato, che cosa si è imparato, e che cosa si può fare in modo diverso rispetto a come si è lavorato in precedenza.

La valutazione critica in ogni ciclo consente di correggere eventuali errori e di riadattare le azioni alle effettive esigenze emerse nel corso della ricerca stessa.

Qual è l'obiettivo che si propone di raggiungere la Ricerca-Azione?

L'obiettivo della Ricerca-Azione è il cambiamento:
cambiamento dei comportamenti, delle consuetudini,
dei contesti e via così.

L'assunzione di base è che lo status quo attuale non consente agli individui di star bene e che soltanto attraverso il cambiamento la situazione può migliorare.

Il cambiamento, quindi, deve essere provocato e poi analizzato e compreso e deve essere duraturo.

Secondo Lewin, affinché il cambiamento sia duraturo deve passare attraverso tre fasi:
la fase di rottura dell'equilibrio (unfreezing) che si ottiene agendo sui fattori di resistenza al cambiamento che spesso sono legati all'adesione alle norme sociali.

Vi è poi una fase di spostamento (moving), ad esempio cambiare e sviluppare nuove credenze, nuovi valori e atteggiamenti sulla base di nuove informazioni, e quindi uno spostamento da una vecchia situazione ad una nuova.

Infine vi è una fase di ricostruzione, di fissazione (re-freezing) in cui la nuova situazione che si è creata si stabilizza intorno a un nuovo equilibrio, ovvero i nuovi valori, atteggiamenti, comportamenti si stabiliscono e si integrano nel resto del sistema.

Un aspetto importante della Ricerca-Azione è il coinvolgimento attivo di coloro ai quali è rivolto l'intervento, che sono contemporaneamente destinatari e attori dell'intervento e devono essere messi nelle condizioni di condividere le finalità della ricerca stessa.

L'assunto di base della Ricerca-Azione è che le persone con cui si lavora siano individui attivi, dotati di capacità e competenze che vadano coinvolti nel processo di ricerca stesso.

Quando si adotta l'approccio della Ricerca-Azione non si può prescindere dal coinvolgere attivamente le persone a cui è rivolto l'intervento e si deve creare una situazione di collaborazione e confronto con i destinatari-attori dell'intervento.

Un altro elemento caratteristica di questa famiglia di metodologie di ricerca che è la Ricerca-Azione è la assenza di un metodo di intervento predefinito da applicare.

Questo infatti viene costruito insieme al gruppo a partire da alcuni principi cruciali e sulla base di quelle che sono le risposte osservate in corso d'opera.

Spesso accade che il modello di partenza venga modificato, dal momento che la scelta della metodologia e delle azioni da attuare sono costruite durante il processo.

Sin qui abbiamo illustrato gli aspetti che definiscono la Ricerca-Azione, vediamo ora quali sono gli elementi che la differenziano dal metodo sperimentale.

Abbiamo detto prima che nella Ricerca-Azione non si ha un intervento prefissato.

Chi adotta questo approccio permette quindi che l'ipotesi emerga nel corso del processo e ne modifica l'andamento attraverso il controllo continuo.

Un altro elemento di differenza è che nella Ricerca-Azione non si cerca di definire rapporti di causalità, di verificare delle ipotesi a partire dalla letteratura e di determinare gli esiti di trattamenti su campioni rappresentativi avendo l'obiettivo di confermare o falsificare teorie generali.

Nella Ricerca-Azione in ogni ciclo il fenomeno su cui si sta intervenendo è messo maggiormente a fuoco.

Non ci si cura della misurabilità delle variabili e l'obiettivo è risolvere i problemi esaminando diverse strade che non si possono anticipare a priori, ma che diventano il risultato e anche lo strumento del gruppo.

Infine, un ulteriore elemento di differenziazione è il modo in cui sono presentati i risultati

finali che, nel caso della Ricerca-Azione, sono illustrati all'intero gruppo, all'intera comunità attraverso forme partecipative, che utilizzano un linguaggio più semplice rispetto a quello tecnico-scientifico che caratterizza i report della ricerca sperimentale.
L'obiettivo che si intende raggiungere attraverso la presentazione dei dati è suscitare nuove valutazioni che consentano di definire eventuali opportunità di miglioramento.
Per chiudere, sulla base di quanto detto sinora possiamo riassumere i principali assunti alla base della Ricerca-Azione, ossia: Il fatto di avere un carattere pratico e contestuale.
La Ricerca-Azione assume infatti come suo oggetto i problemi di un gruppo, di una comunità, e ha quindi una natura contestuale, è cioè una ricerca situata: situata nel contesto;
Un altro aspetto è il fatto che è una ricerca finalizzata al cambiamento e ha una focalizzazione sulla dimensione gruppale più che su quella individuale, sia per quanto riguarda l'analisi dei processi, sia per ciò che concerne la definizione delle soluzioni e dei risultati emersi; Inoltre, la Ricerca-Azione ha una natura multistadiale e ciclica che è data dal disegno della ricerca che si configura come un alternarsi di fasi di conoscenza e azione; Infine, l'altro elemento centrale è quello di porre al centro la partecipazione, in termini di cooperazione, di interdipendenza tra ricercatori e gruppo, tra ricercatori e comunità.

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Tradizionalmente il compito della ricerca è stato quello di estrapolare leggi inscritte nella natura del mondo analizzando i fenomeni in modo oggettivo. Il ricercatore deve mettersi di fronte ai fenomeni che studia in posizione assolutamente neutra. La ricerca è per sua definizione indirizzata alla teoria, tende alla generalità, a costruire modelli il più possibile universalistici. L'azione, invece, nell'esperienza comune è intrisa di motivazioni, di desideri, di emozioni, di saperi spesso poco logici, contraddittori e finalizzati a fare, ottenere, trasformare. L'azione è indirizzata alla pratica, è legata al particolare e al singolare, localistica e situazionale, storicizzata, non sempre prevedibile nella sua origine e nei suoi esiti (Amerio, 2000). La ricerca-azione nasce con l'intento di coniugare queste due dimensioni che tradizionalmente sono state viste come separate e inconciliabili. I due capisaldi della ricerca-azione, che la differenziano dalla ricerca tradizionale, sono la partecipazione e la cooperazione. Elliot la definirebbe così:

«Si potrebbe definire la ricerca-azione come lo studio di una situazione sociale con lo scopo di migliorare la qualità dell'azione al suo interno. In altre parole, essa mira a introdurre una valutazione pratica in situazioni concrete; la validità delle «teorie» o ipotesi che essa genera dipende non tanto da verifiche «scientifiche» della verità, quanto dalla loro utilità nell'aiutare le persone ad agire in modo più intelligente e abile. Nella ricerca azione le «teorie» non sono convalidate indipendentemente e poi applicate alla pratica. Esse sono convalidate attraverso la pratica.» (Elliott, 1994, p.97)

E ancora:

«La situazione-problema deve essere diagnosticata e si deve pianificare e attuare un'azione di rimedio i cui effetti vanno controllati, se si vogliono ottenere dei miglioramenti. Questo processo globale di Analisi-Diagnosi-Pianificazione-Attuazione-Controllo degli effetti è chiamato ricerca-azione [...]» (Elliott, 1994, p.96)

Il modello originario della Ricerca-Azione viene elaborato da Lewin (1946) con lo scopo di comprendere le problematiche esistenti in specifici contesti attraverso la condivisione di saperi tra persone che sono allo stesso tempo sia ricercatori sia soggetti sperimentali. L'azione assume sempre più valore perché diventa un momento in cui si costruisce una conoscenza sul problema. Il processo di cambiamento avviene in tre tappe:

1) Unfreezing (rottura): si rompe l'equilibrio iniziale agendo sui fattori di resistenza legati all'adesione alle norme sociali.

2) Moving (spostamento): gli elementi nuovi e quelli già presenti nel campo si muovono in base alle forze che agiscono all'interno del campo.

3) Refreezing (ricostruzione): la nuova situazione si stabilizza attorno a un nuovo equilibrio.

La ricerca azione è dunque una «raccolta sistematica e analisi dei dati che ha lo scopo di intraprendere azioni e apportare cambiamenti» generando conoscenza pratica condivisibile (Gillis & Jackson, 2002, p.264).

Lo scopo di ogni ricerca azione è di produrre dei cambiamenti sociali attraverso un'azione (o azioni), che è a sua volta obiettivo finale della ricerca (Greenwood & Levin, 1998; Kach & Kralik, 2006; McNiff & Whitehead, 2006; MacDonald, 2012).

I ricercatori che avviano una ricerca-azione lo fanno avendo in mente il presupposto che la realtà viene continuamente creata e ricreata da un processo sociale continuo riconoscendo che, in accordo con Argyris et al (1982), gli elementi cruciali in un approccio di ricerca che funziona all'interno di una specifica situazione sociale sono: collaborazione tra ricercatori e comunità di riferimento; processo di indagine critica; focus sulla pratica sociale; processo di apprendimento riflessivo. Questo necessariamente implica un tipo di ricerca diverso dalla verifica delle ipotesi, che pone maggiore attenzione sulle tematiche della ricerca, necessariamente dichiarate e discusse, per consentire a chiunque sia interessato di sottoporre la ricerca a un esame critico (Checkland & Holwell, 1998).

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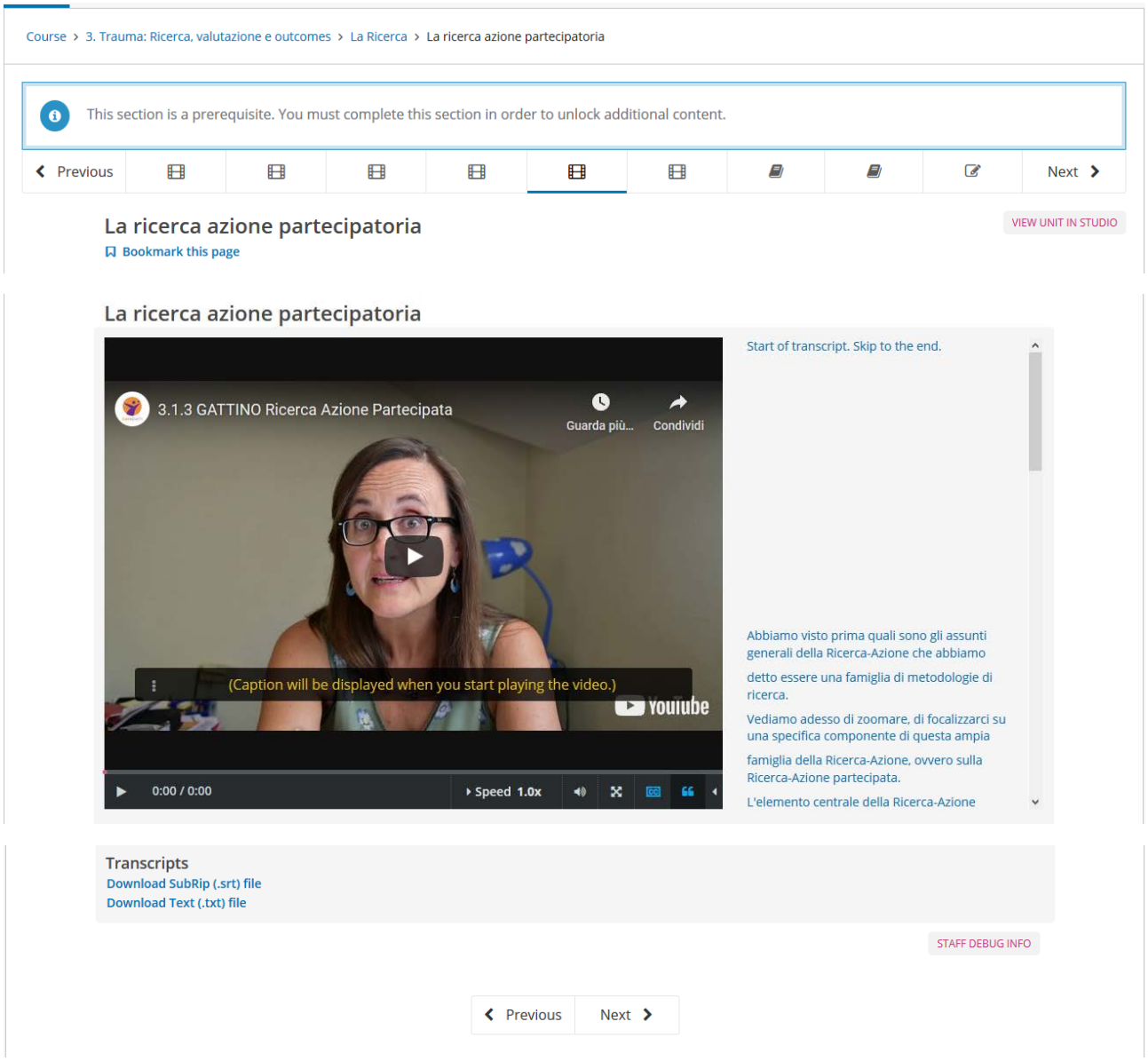


Transcript

Abbiamo visto prima quali sono gli assunti generali della Ricerca-Azione che abbiamo

detto essere una famiglia di metodologie di ricerca.

Vediamo adesso di zoomare, di focalizzarci su una specifica componente di questa ampia

famiglia della Ricerca-Azione, ovvero sulla Ricerca-Azione partecipata.

L'elemento centrale della Ricerca-Azione partecipata è proprio la focalizzazione sull'idea di

una conoscenza condivisa tra il ricercatore ed i destinatari dell'intervento, che sono

contemporaneamente destinatari e attori dell'intervento, e come dicevo, la focalizzazione della Ricerca-Azione

partecipata è quella di considerare che vi è una conoscenza condivisa che serve a progettare

e restituire il senso dell'agire collettivo.

La Ricerca-Azione partecipata considera importante una Ricerca-Azione che è progettata e condotta

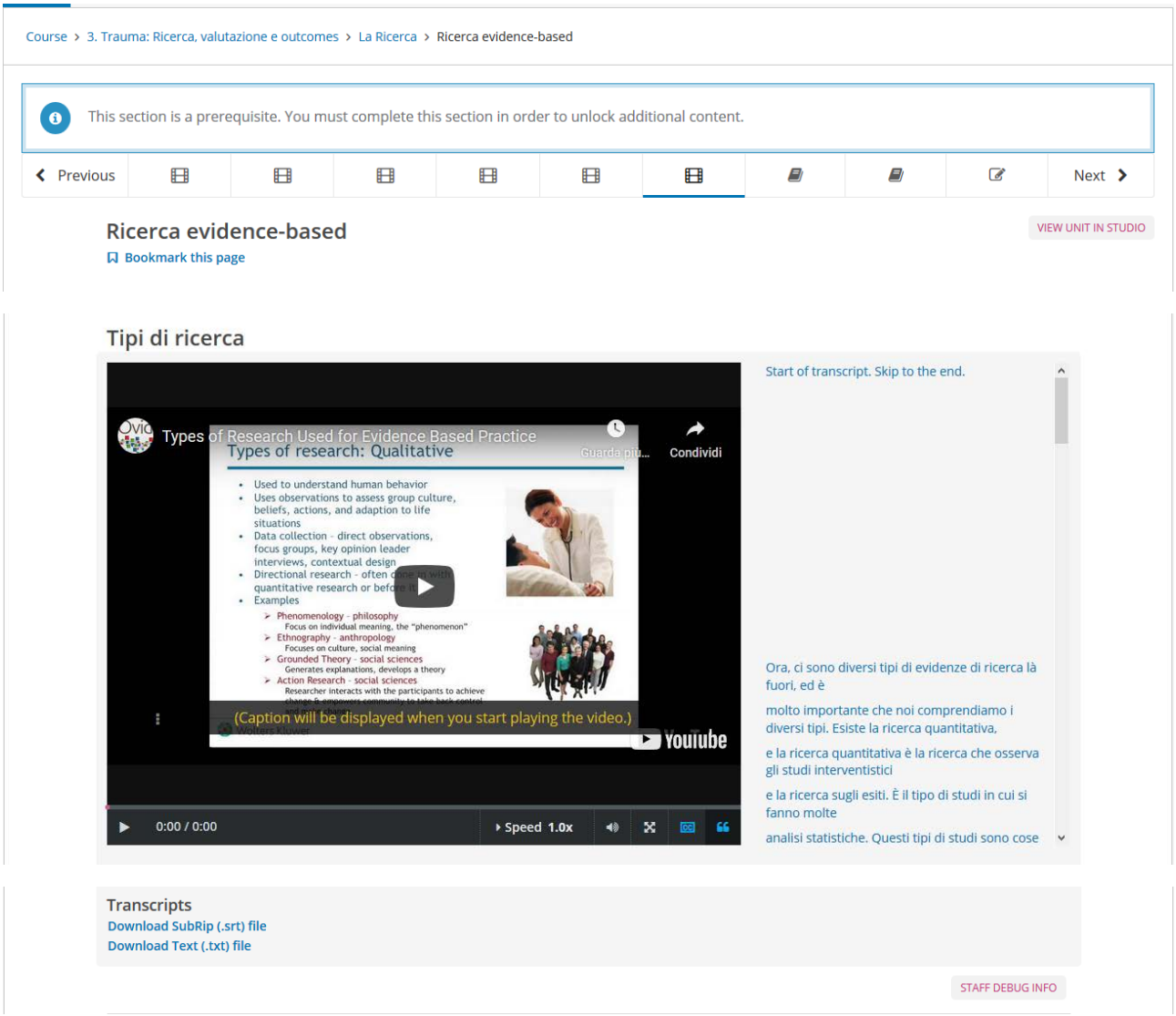
in modo collettivo attraverso la partecipazione di tecnici ma anche di persone che appartengono al contesto in cui si interviene, e che sono in grado di valorizzare saperi locali e saperi esperti facendo emergere la molteplicità dei punti di vista, delle prospettive che sono presenti all'interno di quel contesto specifico.

Alla base degli interventi della Ricerca-Azione partecipata c'è dunque il principio di partecipazione, inteso come strumento e anche obiettivo del cambiamento sociale di intervento.

La Ricerca-Azione partecipata riconosce che il problema nasce da un gruppo che è in difficoltà in uno specifico contesto ed in un momento storico preciso e ben definito.

Il ricercatore quindi constata il problema, non lo suscita, ed il suo ruolo è aiutare il gruppo e la comunità a identificare gli aspetti fondamentali per poter proseguire con l'azione.

Chi adotta l'approccio della Ricerca-Azione partecipata deve quindi creare una situazione di collaborazione e confronto con i cittadini e gli operatori per quanto riguarda sia la definizione dei problemi da indagare e sia lo svolgimento della ricerca e l'impostazione del cambiamento.



Transcript

Ora, ci sono diversi tipi di evidenze di ricerca là fuori, ed è

molto importante che noi comprendiamo i diversi tipi. Esiste la ricerca quantitativa,

e la ricerca quantitativa è la ricerca che osserva gli studi interventistici

e la ricerca sugli esiti. È il tipo di studi in cui si fanno molte

analisi statistiche. Questi tipi di studi sono cose come gli esperimenti clinici (clinical trials),

gli esperimenti randomizzati con gruppo di controllo (randomized control trials, o RCT), gli studi caso-controllo (case-control studies),

ed i livelli più alti sarebbero le meta-analisi e le revisioni sistematiche. Le linee guida per la pratica clinica sono

per la maggior parte basate su analisi quantitative della ricerca. C'è un altro tipo

di ricerca là fuori ed è chiamata ricerca qualitativa, e la ricerca qualitativa

è fatta per comprendere il comportamento umano, come le persone rispondono

alla loro situazione. Quindi, i tipi di ricerca qualitativa che vengono fatti, e vengono spesso fatti nelle scienze infermieristiche e sociali, sono gli studi come la fenomenologia, dove si osserva il fenomeno di star male o di avere una determinata condizione. Significa anche guardare gli studi sui gruppi etnografici, questi sono basati sull'antropologia, quindi guardiamo i gruppi di persone che hanno una determinata condizione. Sappiamo che la ricerca qualitativa è molto molto importante per come eseguiamo le cure, perchè c'è bisogno di assicurarsi che i pazienti stiano avendo una buona esperienza con le cure che stanno ricevendo. Ora, la ricerca secondaria è considerata il livello più alto di ricerca, e questa è la cosa che chiamiamo una revisione sistematica o meta-analisi, e ciò che è diverso di una revisione sistematica e nelle meta-analisi è che portano lo stesso livello di rigore a tutti gli studi di ricerca che sono stati fatti su uno specifico argomento.

Porta lo stesso livello di rigore alla analisi di tutti quegli studi.

Ecco un altro caveat: le revisioni sistematiche sono molto diverse rispetto alle revisioni della letteratura in quanto le revisioni sistematiche e le meta-analisi devono essere revisionate dai pari (peer-reviewed) e questo vuol dire che due o più persone devono valutare tutti gli studi che vengono inclusi in una revisione sistematica o una meta-analisi.

Quando si fa una revisione sistematica c'è anche bisogno di controllare alcune altre cose per esserne sicuri, è importante per come provvediamo a prenderci cura dei nostri pazienti. Bisogna controllare: sono davvero fattibili i risultati della revisione sistematica? Posso davvero implementare questo intervento con una specifica popolazione di pazienti?

Sarà appropriato? È significativo per le popolazioni di pazienti e per la mia pratica come fornitore di assistenza sanitaria? E sarà efficace? Farà davvero la differenza? Sappiamo però che le evidenze di ricerca non vengono create tutte uguali, quindi è davvero importante nel momento in cui i fornitori di assistenza sanitaria esaminano una ricerca, essi hanno il bisogno di determinare che livello di ricerca stanno osservando. Alla base abbiamo tutti gli studi di ricerca originali e questi sono cose come gli studi randomizzati con gruppo di controllo (RCT) e questo tipo di cose. Il livello superiore successivo sarebbero le revisioni sistematiche nelle meta-analisi: di nuovo, le meta-analisi nelle revisioni sistematiche vengono fatte quando

un ricercatore guarda tutte le ricerche originali intorno ad un determinato argomento,

ne fa una valutazione critica ed una sintesi e poi mette tutto insieme

sotto forma di revisione sistematica, quindi questo è considerato il livello più alto di

ricerca nella gerarchia delle evidenze. Ma al livello più alto c'è il supporto alle decisioni

cliniche ("clinical decision support"), ed il supporto alle decisioni cliniche è composto di strumenti che i fornitori di assistenza sanitaria

possono usare, li leggono immediatamente e li mettono in pratica

immediatamente. Ora, perchè questo è importante? Perchè i fornitori di assistenza sanitaria che hanno a che fare

con i pazienti non hanno tempo di leggere cento, duecento, trecento pagine di revisioni

sistematiche o di meta-analisi e poi prendere una decisione su un

paziente: devono leggere le evidenze e metterle in pratica

immediatamente e questo è ciò che fanno gli strumenti di supporto alle decisioni cliniche. Tutti gli

strumenti di supporto alle decisioni cliniche dovrebbero essere basati sulle revisioni sistematiche, sulle meta-analisi,

sui riassunti delle evidenze o sulle evidenze migliori disponibili.

Il termine evidence-based research (EBR) è stato coniato nel 2009 per indicare l'approccio che contrasta la rilevante fonte di spreco nella ricerca biomedica (Robinson, 2009) che era dovuta principalmente agli studi primari effettuati senza una revisione sistematica delle evidenze disponibili. Questo non era considerato né etico né scientifico (Lund, H. et al., 2017). La ricerca evidence-based parte sempre da una revisione sistematica (RS), che prevede quesiti di ricerca predefiniti, criteri di inclusione, metodi di ricerca, procedure di selezione, valutazione di qualità, estrazione dei dati e analisi statistiche (Lund, H. et al., 2017). Le revisioni sistematiche servono a comprendere e a definire le priorità di una ricerca e se essa è necessaria e utile alla comunità o possibile fonte di spreco di risorse in quanto non produce nuove conoscenze scientifiche. Le linee guida suggerite da Evidence, rivista open access della Fondazione GIMBE (Gruppo Italiano per La Medicina Basata sulle Evidenze), per creare un progetto di ricerca evidence-based sono le seguenti:

1) Formulare il quesito di ricerca preliminare e identificare revisioni sistematiche pertinenti;

2) Valutare l'adeguatezza dello scopo, della qualità e dell'aggiornamento della ricerca;

3) Valutare i dettagli relativi a: popolazione, intervento, confronto, outcomes, e range temporali (PICOT);

4) Valutare il metodo utilizzato e i risultati.

In definitiva, i ricercatori dovrebbero utilizzare le revisioni sistematiche per formulare il quesito finale dello studio che vogliono promuovere; giustificare la necessità durante la richiesta di finanziamento e l'approvazione del comitato etico; interpretare i risultati del nuovo studio nel contesto delle evidenze disponibili; formulare raccomandazioni per la ricerca futura. Nel corso del tempo si è assistito ad una crescita esponenziale della ricerca evidence-based, che ha portato alla pubblicazione di circa due milioni di articoli in oltre venti mila riviste. Le motivazioni di questa crescita sono molteplici, da una parte è dovuta alla sua vocazione educazionale (JAMA, 1992) e al cambiamento di paradigma (Pagliaro & Colli, 2014) che ha portato tale pratica, dall'altra si è assistito ai punti di forza che l'evidence-based presenta:

- consentire di produrre conoscenza e guidare la pratica professionale nelle aree dove c'è maggiore incertezza riguardo agli interventi effettuati nella pratica clinica;

- ridurre gli sprechi perché definisce le priorità dei quesiti di ricerca prendendo in considerazione le revisioni sistematiche precedenti;

- consentire di descrivere in modo chiaro i disegni di ricerca (popolazione target, interventi, confronti, outcome);

- produrre aggiornamenti e diffondere revisioni sistematiche;

- integrare le evidenze nella pratica clinica;

- permettere una rivalutazione continua delle proprie conoscenze (GIMBE).

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Esempi di ricerca

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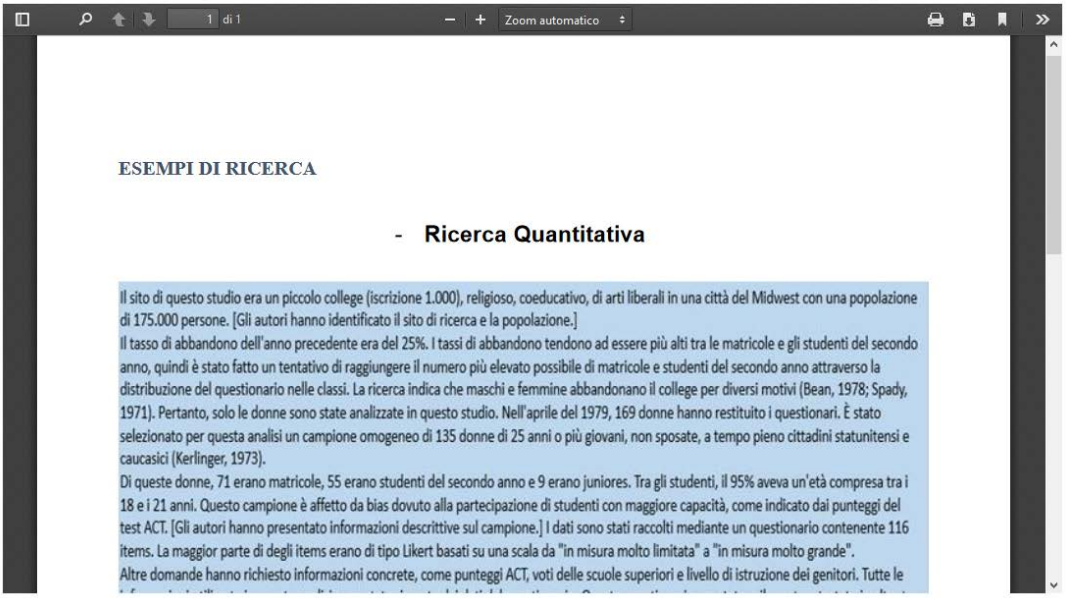

ESEMPI DI RICERCA

- **Ricerca Quantitativa**

Il sito di questo studio era un piccolo college (iscrizione 1.000), religioso, coeducativo, di arti liberali in una città del Midwest con una popolazione di 175.000 persone. [Gli autori hanno identificato il sito di ricerca e la popolazione.]
Il tasso di abbandono dell'anno precedente era del 25%. I tassi di abbandono tendono ad essere più alti tra le matricole e gli studenti del secondo anno, quindi è stato fatto un tentativo di raggiungere il numero più elevato possibile di matricole e studenti del secondo anno attraverso la distribuzione del questionario nelle classi. La ricerca indica che maschi e femmine abbandonano il college per diversi motivi (Bean, 1978; Spady, 1971). Pertanto, solo le donne sono state analizzate in questo studio. Nell'aprile del 1979, 169 donne hanno restituito i questionari. È stato selezionato per questa analisi un campione omogeneo di 135 donne di 25 anni o più giovani, non sposate, a tempo pieno cittadini statunitensi e caucasici (Kerlinger, 1973).
Di queste donne, 71 erano matricole, 55 erano studenti del secondo anno e 9 erano juniores. Tra gli studenti, il 95% aveva un'età compresa tra i 18 e i 21 anni. Questo campione è affetto da bias dovuto alla partecipazione di studenti con maggiore capacità, come indicato dai punteggi del test ACT. [Gli autori hanno presentato informazioni descrittive sul campione.] I dati sono stati raccolti mediante un questionario contenente 116 items. La maggior parte di degli items erano di tipo Likert basati su una scala da "in misura molto limitata" a "in misura molto grande".
Altre domande hanno richiesto informazioni concrete, come punteggi ACT, voti delle scuole superiori e livello di istruzione dei genitori. Tutte le

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Quiz 3.1

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Q3.1

4 points possible (graded)

1. Una ricerca scientifica...

- ○ Dovrebbe sempre tenere conto della conoscenza precedentemente acquisita
- ○ Inizia con la raccolta dei dati
- ○ Permette sempre una fedele registrazione della realtà
- ○ Utilizza sempre un singolo metodo

2. Nella ricerca-azione...

- ○ Il ricercatore deve essere completamente neutrale rispetto all'oggetto di ricerca
- ○ Si tenta di estrapolare leggi iscritte nella natura attraverso l'analisi oggettiva dei fenomeni
- ○ Non andrebbero prodotti cambiamenti sociali nel contesto di ricerca
- ○ La partecipazione e la cooperazione del ricercatore sono incoraggiate

3. Quale di questi passaggi NON è parte di ogni progetto di ricerca evidence-based?

- ○ La valutazione dei risultati
- ○ La convalida della teoria attraverso la pratica
- ○ La formulazione delle ipotesi di ricerca
- ○ La revisione sistematica della letteratura

4. L'elemento centrale della Ricerca-Azione partecipata è:

- ○ La focalizzazione sull'idea di una conoscenza non condivisa tra il ricercatore ed i destinatari dell'intervento
- ○ La focalizzazione sull'idea di una conoscenza condivisa tra il ricercatore ed i destinatari dell'intervento
- ○ La netta e assoluta separazione tra Azione e Ricerca
- ○ La scelta a priori dei problemi da indagare e degli strumenti da utilizzare

Invia

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EBR in TIC/TIP e la sua rilevanza a livello internazionale

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Uno dei temi fondamentali nell'organizzazione dei servizi che si occupano di minori traumatizzati e una delle richieste maggiori che da questi proviene è quello di garantire un'adeguata ed efficace formazione agli operatori sugli interventi evidence-based (Ruzek & Rosen, 2009). Osservando da una prospettiva generale la situazione dell'applicazione dei trattamenti e delle linee guida evidence-based, si può evincere, nonostante la salienza di questa tematica nel campo della salute pubblica, una difformità di implementazione e un'attenzione limitata alla valutazione sistematica e sul lungo temine degli effetti dei programmi di training (Ruzek & Rosen, 2009). Inoltre, da un punto di vista comparativo, Delaney (2006) ha sottolineato un altro aspetto rilevante: a livello internazionale le linee giuda e la loro declinazione in pratiche cliniche di trattamento elettivo variano considerevolmente su base nazionale e tra le diverse nazioni (anche a livello di regolamenti socio-sanitari). Weiner, Schneider & Lyons (2009) si sono occupati dell'analisi delle metodologie evidence-based per il trattamento del trauma nei minori.

Come indicato dagli autori, alcuni di essi sono stati testati attraverso procedure sperimentali e quasi-sperimentali, ma la maggior parte delle metodologie era stata strutturata per popolazioni adulte sebbene applicata anche a popolazioni minorili e valutata con poca o nulla attenzione alle variabili culturali e alla differenziazione dei sottogruppi in base a fattori incidenti sugli outcomes. Da queste osservazioni deriva, quindi, un'interessante sollecitazione alla validazione cross-culturale dei trattamenti, il che può consentire non solo di approfondirne l'efficacia, ma anche di esplorare con attenzione quali possano essere le barriere nella loro applicazione e le esigenze di flessibile adattamento in relazione a specifici sottogruppi o condizioni applicative. Prima Courtois & Gold nel 2009, poi Layne e colleghi (2014) mettono in luce come sia centrale includere nella formazione degli operatori uno specifico focus sul trauma e le sue conseguenze partendo dalla consapevolezza che esso e i sui effetti impattano su tutte le fasi del trattamento tra cui, nello specifico, quelle del coinvolgimento del paziente, l'assessment e la risposta al trattamento. Inoltre, essi sottolineano che, in questo ambito, un ruolo rilevante è ricoperto dalla creazione di standard internazionali e metodi condivisi di formazione degli operatori nell'ambito della Evidence-Based Practice (EBP; Lyon et al., 2011). L'EBP consente all'operatore di selezionare le migliori opzioni operative validate per e adeguate a quella singola situazione basandosi sui bisogni specifici del cliente, i punti di forza e le circostanze (Layne et al., 2014). Affinchè si possa garantire un'adeguata formazione in tale ambito è, quindi, fondamentale che la comunità scientifica definisca delle core competencies, cioè delle conoscenze di base che coloro che operano con persone con una storia traumatica dovrebbero possedere. In particolare, questa attenzione consente di garantire una buona qualità dei servizi erogati, aumentare la responsabilità degli operatori e diffondere un sapere condiviso e, spesso, manualizzato attraverso protocolli, tra le molteplici discipline impegnate in questo campo (psicologia, psicoterapia, scienze sociali, psichiatria, ecc.).

Il National Child Traumatic Stress Network (NCTSN) è una rete di professionisti, componenti familiari, ricercatori e partner internazionali che si occupa di migliorare gli standard di cura e la possibilità di accesso ai servizi per bambini e famiglie. Il NCTSN ha creato un protocollo formativo denominato CCCT (Core Curriculum on Childhood Trauma) (Layne et al., 2011) che enuclea i principali elementi di intervento includendoli in una matrice integrata fondata sull'evidenza, sui concetti fondamentali nell'ambito del trauma e sulle competenze terapeutiche indispensabili per progettare e implementare un intervento efficace per i bambini affetti da trauma e le loro famiglie. Due elementi risultano fondanti: gli obiettivi degli interventi (obiettivi che si desidera raggiungere attraverso l'intervento) e gli elementi pratici (le procedure concrete che si intende applicare per raggiungere i risultati). Questa attenzione alla formazione degli operatori sulle competenze fondanti passa attraverso la definizione di specifici gold standards relativi al training sull'EBP e sui trattamenti evidence-based (EBTT, Evidence-based Trauma Treatment).

Il CCCT include 5 livelli:

a) la base empirica delle conoscenze (Empirical Evidence Base);

b) i concetti fondamentali sul trauma (12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families) che costituiscono il fondamento teoretico dell'intervento;

c) obiettivi dell'intervento;

d) elementi pratici (azioni osservabili messe in atto per raggiungere gli obiettivi);

e) abilità/capacità terapeutiche (con due sottolivelli: 1) procedurale e process-oriented; 2) valutativo).

Il suddetto modello supporta pratiche e competenze evidence-based tra le quali le prassi di assessment e la raccolta delle informazioni, la teoria della pratica, l'applicazione delle risultanze connesse alla letteratura scientifica alla situazione individuale del paziente, la concettualizzazione del caso, la pianificazione dell'intervento. Una task-force, che sta approfondendo e implementando il modello CCCT, ha previsto una sessione specifica di approfondimento delle competenze di analisi statistica e di strutturazione di protocolli d'indagine utili per la validazione di pratiche cliniche. Quello che viene più sottolineato in merito è l'invito a sviluppare sia gli aspetti teorici, sia i metodi di valutazione (multidimensionali), nonché la base empirica accessibile a valutazione e validazione degli interventi (in particolare degli esiti, dei fattori intervenienti e dell'efficacia di interventi centrati sulla situazione specifica della persona).

Anche Briggs e colleghi (2012) identificano come elemento di prioritaria rilevanza il miglioramento degli standard attraverso "[...] lo sviluppo, l'implementazione e la disseminazione evidence-based" (p. 1). La strutturazione di linee guida per l'intervento - che ne identifichino i target ottimali e le metodologie d'identificazione (quale sia l'intervento migliore date alcune condizioni specifiche) e valutazione degli outcomes - è fondamentale e utile per gli operatori e per coloro che si occupano di strutturazione dei servizi. I disegni di ricerca che potrebbero, quindi, risultare utili potrebbero essere quelli che considerano l'interconnessione tra i fattori di rischio e i differenti esiti ai fini di enucleare quali potrebbero essere gli elementi su cui implementare l'intervento, ma anche per, ricorsivamente, includere nuovi aspetti nella dimensione della comprensione teorica del trauma e complessificare il framework di riferimento scientifico. Particolarmente interessante è, infatti, la considerazione che i trattamenti mirati alla riduzione dei sintomi connessi al PTSD hanno anche efficacia nel ridurre difficoltà funzionali non direttamente oggetto di intervento, il che mette in luce quanto un trattamento focalizzato sul trauma possa generare effetti positivi ad ampio spettro (Layne et al, 2010).

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Bisogni formativi nelle organizzazioni che si occupano di tic

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Bryson e colleghi (2017) pongono un'interessante premessa che è utile per distinguere due piani di riflessione applicabili all'analisi e alla valutazione delle tematiche oggetto di questo modulo; gli autori distinguono i trattamenti specifici per il trauma (intese come tecniche di intervento volte a ridurre la sintomatologia connessa al trauma) dalla TIC definita come ottica generale che ha come obiettivo la trasformazione del sistema di cura includendo in quest'ultima una comprensione delle risposte di stress connesse alle esperienze traumatiche a tutti i livelli e in tutte le dimensioni implicate nell'organizzazione dei servizi. Nonostante sia diffusa la richiesta di applicazione di principi fondanti la TIC nei servizi e l'interesse per i vantaggi che questa può comportare, i contributi scientifici sull'implementazione della TIC per l'utenza in età minorile è, purtroppo, scarsa (Bryson et al., 2017). Già Ruzek & Rosen, nel 2009, avevano osservato che la diffusione di trattamenti evidence-based aventi come focus la cura della sintomatologia connessa al PTSD era uno degli elementi chiave su cui erano impegnate le organizzazioni sanitarie che operavano nell'ambito dell'aiuto alle persone vittime di trauma e che, di conseguenza, si era assistito a un aumento della letteratura scientifica che si occupava dei fattori organizzativi legati all'implementazione e diffusione di best-practices. Nonostante ciò, da una precedente analisi della letteratura presentata da Delaney (2006), confermata da Ruzek & Rosen (2009) e dagli stessi Bryson e colleghi (2017) era emersa ed emerge tuttora un'alta variabilità nei tassi di utilizzo di pratiche quali la contenzione e l'isolamento. Inoltre, come indicato da Valenkamp e colleghi (2014), nonché da Bryson e colleghi (2017), pochi sono gli studi che hanno testato efficacia di questi interventi in comparazione con modalità di presa in carico alternativa. La variabilità delle modalità di intervento, secondo Ruzek e Rosen (2009), aprirebbe alla necessità di procedere ad analisi comparative delle linee guida e delle best-practices internazionali al fine di renderle maggiormente fondate nel campo delle proposte di cambiamento organizzativo e a livello di politiche che siano evidence-based oriented. Bryson e colleghi (2017) si propongono, attraverso un contributo di revisione sistematica della letteratura scientifica, di mettere in luce quali fattori rendono efficace l'applicazione della TIC, per quale tipo di utenza, in quali circostanze e in quale direzione e perché.

Le strategie che vengono considerate maggiormente condivise all'interno dei contributi scientifici sono:

1) una leadership orientata al cambiamento;

2) l'utilizzo dei dati di ricerca per informare la pratica;

3) lo sviluppo dell'organico;

4) l'uso di strumenti per prevenire azioni di contenzione e isolamento;

5) i ruoli degli utenti nel contesto di degenza;

6) tecniche di debriefing.

In ragione della necessità di analizzare la complessità applicativa di questi elementi connettendola anche alle peculiarità territoriali e alle specificità organizzative, l'invito degli autori ai servizi che si occupano di applicare la TIC è quello di proseguire nel tentativo di dimostrare, attraverso il processo della ricerca scientifica e in una prospettiva longitudinale, l'efficacia sia degli sforzi e dei cambiamenti compiuti nel migliorare la salvaguardia dei pazienti, sia degli esiti a lungo termine dei trattamenti. In coerenza con quest'ottica, inoltre, Lang e colleghi (2016) sottolineano come sia importante che si raggiunga il consenso su cosa costituisca un servizio trauma-informed e come si possano efficacemente misurare i fattori coinvolti. Innanzitutto, questioni centrali riguardano: come si possa pervenire a una procedura ottimale di screening, come operazionalizzare al meglio i principi fondanti della TIC nel lavoro quotidiano con soggetti esposti a eventi potenzialmente o sicuramente traumatici e quali siano i metodi migliori per potenziare i servizi che di questa popolazione si occupano. Attualmente non sembrano così frequenti le ricerche sull'efficacia del cambiamento delle modalità di presa in carico dei pazienti in un'ottica TIC a livello organizzativo e su come/quanto queste trasformazioni siano utili ai fini degli outcomes di salute per l'utenza che afferisce al servizio. Una sfida sottolineata dai ricercatori potrebbe proprio essere quella dell'integrazione fra ricerca sulle EBPs e best-practices nell'ottica di incrementare la qualità dell'implementazione dell'offerta di servizi (considerata anche l'analisi della dimensione dell'impatto economico di queste iniziative) passando attraverso lo sviluppo delle competenze del personale, delle procedure di screening, della capacità di cambiamento delle policies. Un ruolo determinante in questa direzione può essere svolto dalla leadership che dovrebbe supportare un processo di cambiamento, in alcune situazioni radicale, anche a livello di cultura organizzativa (enfasi, ad esempio, sull'importanza della TIC).

Il training sul trauma è una componente essenziale, ma non sufficiente affinché un'organizzazione sia trauma-informed. Inoltre, come specificato da Kramer e colleghi (2013), importante è anche la collaborazione tra le differenti agenzie che si occupano dell'assistenza ai minori e alle loro famiglie, le quali, possibilmente, condividano i principi della TIC. Su quest'ultimo aspetto, gli autori, ad esempio hanno analizzato efficacia di un training orientato all'acquisizione delle specifiche conoscenze con somministrazioni longitudinali di idonei strumenti di rilevazione (pre e post formazione) nonché una rilevazione sotto forma di follow-up per analizzare quanto queste competenze acquisite abbiano comportato modifiche nella modalità di organizzare il servizio di appartenenza. Su questo specifico aspetto, inoltre, un tema interessante è l'analisi delle barriere incontrate dall'intero staff e la strutturazione di ricerche comparative (con gruppi randomizzati) volte ad esaminare l'utilità delle differenti strategie utilizzate e degli ulteriori bisogni formativi anche longitudinalmente.

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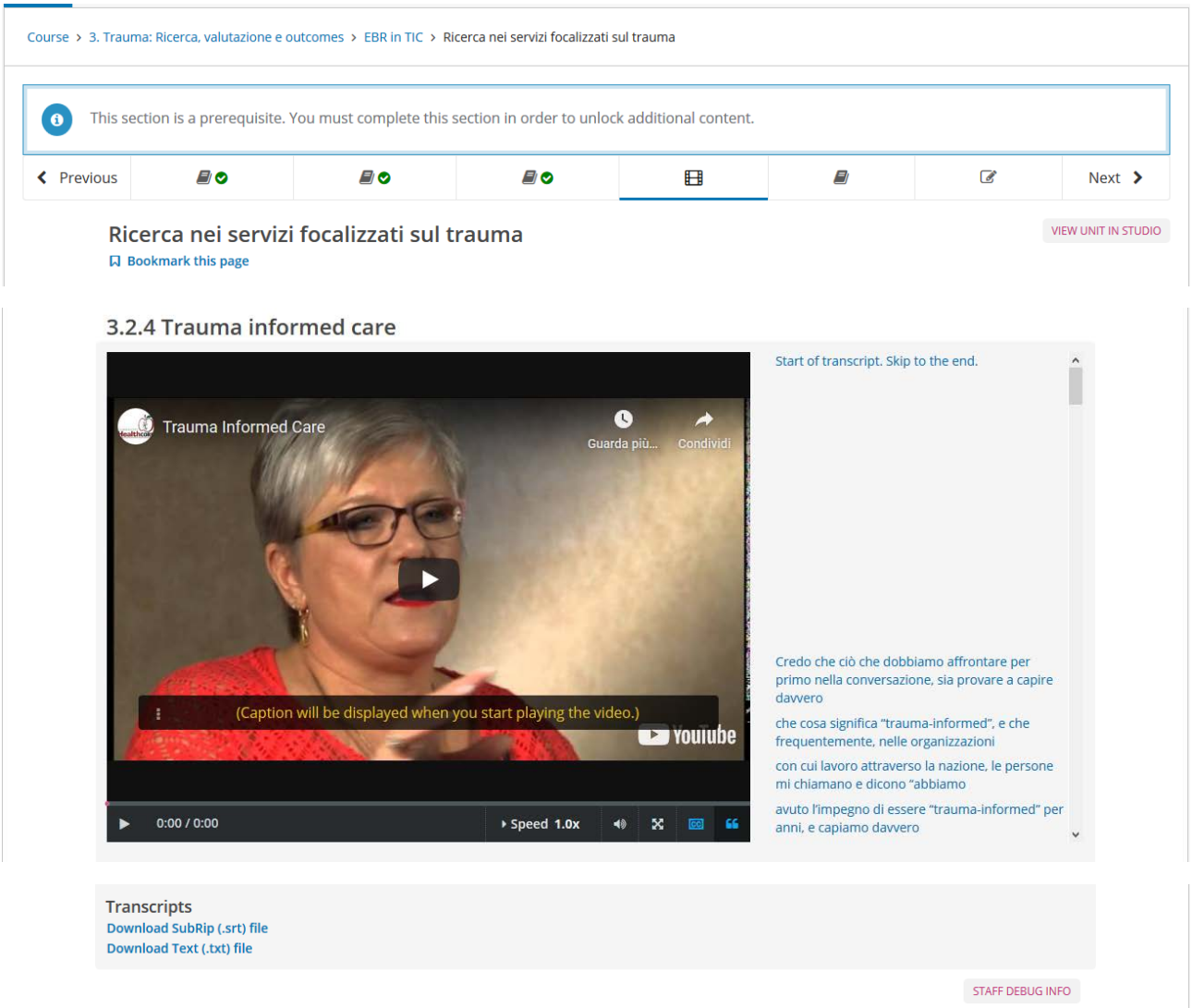
Diffusione della ricerca sul trauma nei settings organizzativi

Ruzek & Rosen (2009), trattando il tema della diffusione della ricerca sul trauma nei settings organizzativi, ne sottolineano la complessità: i modelli che si occupano di disseminazione hanno messo in luce come questa dipenda da molteplici fattori in interazione tra loro a differenti livelli (individuali e organizzativi). Briggs e colleghi (2012) indicano come sia sì riconosciuto il fatto che un cambiamento nell'ambito delle conoscenze rappresenti il primo passaggio verso il cambiamento organizzativo, ma anche che è altrettanto fondamentale la verifica di quanto questo si espliciti attraverso o si traduca in un cambiamento comportamentale. Due aspetti, quindi, risultano importanti: la complessità sistemica e multilivello della disseminazione dei contenuti scientifici nelle organizzazioni e il processo che connette l'ambito delle conoscenze e la messa in pratica di queste attraverso un meccanismo complesso di cambiamento individuale e organizzativo.

Questo processo porta in primo piano una delle resistenze più frequenti all'implementazione di nuove best-practices: il fatto che la scelta della loro applicazione nell'organizzazione è una decisione spesso vissuta come "top-down" e, perciò, come poco partecipata da parte dei clinici (Rohrbach et al, 2006; Ruzek & Rosen, 2009). In questo caso, infatti, il coinvolgimento (commitment) degli operatori nel cambiamento delle loro prassi organizzative è una dimensione nodale. Come suggerito dai contributi degli studiosi, un assetto in cui la concertazione del cambiamento è negoziata dalla leadership con i sottoposti, tenendo conto delle esigenze locali, contribuisce al successo nella loro implementazione (Durlak & DuPre, 2008; Ruzek & Rosen, 2009). Un altro tema centrale è quello per cui le organizzazioni sanitarie spesso non hanno nel loro organico personale specializzato e dedicato alla ricerca di EBPs, allo studio delle best-practices e delle strategie per la loro applicazione e, in particolare, all'analisi e integrazione sistematiche e continue delle risultanze della ricerca scientifica (Berwick, 2003; Ruzek & Rosen, 2009).

A questo proposito, Marvin e Robinson (2018), sottolineano la necessità per le organizzazioni di avere una visione che contempli l'analisi dell'istituzione o del servizio stesso in quanto a capacità di o prontezza nell'accogliere e sostenere gli interventi di cambiamento (quella che in letteratura viene definita "Organizational readiness" e che può essere misurata a livello organizzativo, gruppale e individuale). Occuparsi di questa dimensione nella fase progettuale è sicuramente rilevante per sostenere l'applicazione di nuove pratiche, analizzare le possibili barriere nel processo e sostenere le credenze e gli atteggiamenti positivi verso il cambiamento organizzativo. Una considerazione trasversale a questo tema è quella della centralità che dovrebbe avere la raccomandazione di costruire strategie su misura per il cambiamento in quella specifica organizzazione (Augustsson et al., 2017; Marvin & Robinson, 2018). La ricerca dimostra l'importanza della leadership e della vision manageriale nel co-costruire insieme agli operatori la via del cambiamento e nel condividere una cultura orientata all'applicazione della TIC, attenta, innanzitutto, all'analisi dei bisogni dello staff.



Transcript

Credo che ciò che dobbiamo affrontare per primo nella conversazione, sia provare a capire davvero
che cosa significa "trauma-informed", e che frequentemente, nelle organizzazioni
con cui lavoro attraverso la nazione, le persone mi chiamano e dicono "abbiamo
avuto l'impegno di essere "trauma-informed" per anni, e capiamo davvero
perchè sia così importante, ma davvero non stiamo andando da nessuna parte.
C'è, sai, sappiamo che ci siano dei passi successivi che dobbiamo fare ma
non siamo mai davvero riusciti ad organizzarci e non siamo mai stato capaci
di fare quel passo successivo, e ciò che abbiamo fatto al Consiglio Nazionale, è, abbiamo sviluppato
uno strumento chiamato l'"organizational self-assessment" e con questo strumento abbiamo
preso i pensieri e le idee dai leader del campo, leader del campo come
Roger Fowler e Maxine Harris e Judith Herman e Sandy Blum,
e tentato di sintetizzare il loro lavoro in un modo che esprime le pratiche ed

i principi che esprimono cosa significhi essere trauma-informed, quindi per esempio “prima la sicurezza” o la trasparenza, e, sai, la mutualità e la scelta e la voce ed il controllo e la collaborazione ed il restituire il controllo alle persone nelle loro vite e quindi, quello che abbiamo fatto è creare uno strumento chiamato l’“organizational self-assessment” utilizzando questi pezzi delle pratiche e dei principi per operazionalizzare com’è per una organizzazione spostarsi verso l’essere trauma-informed, e l’OSA è una scala Likert da zero a quattro con un “non applicabile” incluso, abbiamo preso e creato i sette domini della trauma-informed care ed in quei sette domini è dove si catturano questi principi. Sotto ogni dominio esistono diversi standard, e questi standard non sono gli unici ma l’idea dell’OSA è far pensare le organizzazioni in maniera un po’ diversa sul lavoro che fanno. Quindi per esempio, nei sette domini, il primo dominio è “screening e valutazione”, quindi vogliamo avere per le persone una esperienza all’entrata in una agenzia dove viene fatto lo screening, ma vogliamo anche che le persone abbiano l’opportunità di parlare di tutto, di qualsiasi esperienza, in una maniera sensibile e con il tempo. Se sono qualcuno che sta entrando in una organizzazione potrei essere molto molto spaventato o potrei non fidarmi di te se sei il coordinatore degli ingressi ma dove voglio arrivare, quello che vogliamo essere capaci di fare è creare un ambiente in cui le persone si sentono al sicuro nel rispondere ad alcune di queste domande. E le persone devono essere istruite su come porre le domande, devono essere istruite su come stabilire una relazione dalla primissima volta che qualcuno attraversa la porta. Il secondo dominio è “cura e servizi basate sul consumatore” e sono così elettrizzata da Community HealthCore e dal modo in cui stanno pensando al lavoro che fanno ed il numero di pari che stanno venendo istruiti ed utilizzati in modi assolutamente meravigliosi, e non è l’unica parte. I pari possono vedere i servizi sotto una lente molto molto diversa: sappiamo cosa vuol dire passare attraverso un processo di screening e valutazione, sappiamo cosa vuol dire essere incanalati in un gruppo che davvero non sta funzionando per noi, sappiamo cosa vuol dire essere ritraumatizzati dal sistema ed essere capaci di avere quella voce è parte di tutto il lavoro, è un pezzo della cura e dei servizi

basati sul consumatore, ma è guardare le cose da quella prospettiva
veramente orientata al recupero dove è basata sul consumatore, è centrata sulla persona e
che io ho, se sono una persona che sta ricevendo dei servizi ho una opportunità
di dire cosa funziona per me e cosa no. Sto davvero portando quella voce
e mi sto assicurando che i pari, i clienti consumatori, in qualunque modo inquadri
il linguaggio, che le persone abbiano una opportunità di parlare davvero di cosa sta funzionando davvero
nell'organizzazione e cosa non funziona bene. Abbiamo anche parlato di sviluppo della forza lavoro
in una forza lavoro educata e trauma-informed e questo include
l'addestramento clinico, i clinici hanno bisogno di avere un addestramento adeguato per fare il proprio
lavoro ma se sono la receptionist cosa vuol dire per me essere una persona
che lavora in una organizzazione trauma-informed? Ogni
persona fa la differenza, se sono il guidatore del furgoncino, se sono la persona che fa la manutenzione, faccio
la differenza nel creare quella comunità dove le persone sentono di poter
iniziare a guarire. E anche pensare all' "affaticamento da compassione" dello staff, nel
nostro lavoro precedente oggi stavamo parlando del servizio clienti interno, è come
ogni persona nell'organizzazione tratta gli altri. Non puoi avere una organizzazione
trauma-informed se lo staff è così sovraccaricato di lavoro che
sperimentano l'affaticamento da compassione, così, sai, pensando ai bisogni dello staff
ma anche pensando a come questo ha un impatto se non mi sto prendendo cura di me stesso
come faccio ad esserci davvero per un'altra persona? È anche sull'avere una buona supervisione
clinica, stai facendo una supervisione in una maniera trauma-informed invece che fare supervisione
in maniera punitiva? Il dominio 4 è l'evidence-based nelle best practices
emergenti, è il guardare sempre, è il non dire "questa è la cosa che stiamo facendo che è
evidence-based e non guardiamo mai le cose nuove ed emergenti
che si stanno sviluppando". È avere sempre un occhio di riguardo per la roba
buona, e davvero, sai, provvedere l'addestramento per lo staff, usare
best practice eseguite dai pari ed evidence-based, come la "WHAM" Wellness, Whole Health Action
Management, dove i pari stanno davvero aiutando gli altri pari, prendono
il controllo della loro stessa salute fisica. O la "WRAP", Wellness Recovery Action Planning,
è un ottimo strumento trauma-informed da usare che è evidence-based, e poi
creare un ambiente sicuro e riparato. Le persone non possono guarire se non si sentono

al sicuro. Se sei in iper-allerta, se ti senti come se stessi entrando in un
ambiente che non ti accoglie, dove non ti senti al sicuro,
non succederà nulla di buono. Qualcuno mi ha detto, ero in un meeting, e
avevano ridipinto, avevano soltanto ridipinto ed aggiornato l'area della reception, ed uno dei
clienti è venuto e ha detto "Stiamo traslocando?" e la persona ha risposto "No, perchè?" "Beh
abbiamo pensato, se la stavate rendendo così bella era
perchè dovevamo andarcene." e questo è
un indicatore che le persone non si sentivano altamente valorizzate, è stata una grossa lezione per
loro. Le persone devono essere trattate in un posto ed in un modo che dice "ti rispetto,
hai valore", non puoi cominciare a guarire finchè non cominci
a coprire queste cose. E poi il dominio sei è sul costruire un rapporto di partnership con la comunità,
chiunque noi siamo nella comunità, abbiamo bisogno di lavorare per renderla una comunità,
il guarire trauma-informed non avviene in un vuoto quindi se io ricevo ottimi
servizi al tuo programma ma vado, sai, al dipartimento tal dei tali e mi trattano
come se fossi, sai, fango sul fondo della tua scarpa, annulla tutto
il buon lavoro che ho fatto mentre stavo lavorando con te, quindi mettersi per davvero in comunicazione con
la comunità ed aiutare la comunità a capire cosa significhi essere
trauma-informed. E infine, il dominio sette è tutto sul "miglioramento delle performance":
Come sai se ciò che stai facendo fa la differenza?
Se faccio la cosa X funzionerà per me? Questo sta funzionando per le persone che
serviamo? Sto facendo sondaggi sul feedback dei clienti? Sto chiedendo ai clienti il livello di sicurezza
che sentono? Sto sondando il mio staff? E quando ho fatto il sondaggio, faccio
qualcosa riguardo a ciò che ottengo? Ho appena fatto un sondaggio quindi, sai, il modo in cui usiamo l'OSA
è, chiediamo alle organizzazioni, quando iniziano la valutazione, questa è la loro
baseline, e poi chiediamo loro lungo un periodo di tempo di farlo di nuovo, così che loro
possano vedere i progressi che hanno fatto. E poi usiamo una serie di altri strumenti,
uno strumento di monitoraggio delle performance, e una guida di implementazione per aiutare
le organizzazioni ad andare avanti, ma questo è un po' l'OSA in una istantanea, una istantanea
molto veloce, perchè è un processo lungo, l'OSA non è
disegnata perchè le organizzazioni possano dire "okay abbiamo finito ora", non è una
checklist, è un modo di guidare le conversazioni, iniziare a fare

cambiamenti significativi all'interno delle organizzazioni.

La TIC è definibile come un approccio evidence-based per rispondere al trauma che pone il focus sulla capacità (o meno) dei membri dello staff di compartecipare a una visione della presa in carico del paziente traumatizzato come un precursore critico per il successo o il fallimento nell'adottare strategie atte a ridurre il rischio di ri-traumatizzaione dell'utente (Marvin & Volino Robinson, 2018). In questo, fondamentale è l'attenzione ad accogliere la complessità delle storie in cui il trauma può essere generato da esperienze differenti e individuali. Le politiche, le procedure e l'operatività quotidiana possono anche configurarsi come ulteriori esperienze traumatizzanti oppure elicitare risposte connesse al funzionamento individuale della persona traumatizzata, impedendo alla persona di ricevere l'aiuto di cui necessita. Per evitare che queste situazioni si verifichino, generando frustrazione anche nello staff, potrebbe essere utile il ricorso a best-practices appositamente strutturate e riconosciute a livello internazionale (cfr, ad esempio le strategie promosse dalla SAMHSA nel 2014). In sinergia con questo, l'ottica della TIC invita le organizzazioni a considerare quale sia l'impatto per i membri afferenti ai servizi clinici del lavorare con soggetti aventi storie traumatiche (SAMHSA, 2014; Knight, 2015) e come gli operatori possano essere aiutati, attraverso il training e una trauma-informed leadership, a mantenere un buon livello di benessere al lavoro e di efficienza/efficacia dell'intervento (Manderscheid, 2009). Ruzek & Rosen (2009) hanno approfondito i fattori che influenzano il modo in cui i servizi recepiscono le risultanze di ricerca sulle pratiche evidence-based connesse al trattamento del trauma.

Una valutazione attenta delle dimensioni sia della disseminazione di pratiche, sia della ricerca implica l'inclusione nel campo d'analisi di molteplici fattori che possono influenzare l'evoluzione del processo di cura, il rapporto dei pazienti o della potenziale utenza con i servizi, la modalità con la quale i clinici apprendono tecniche di trattamento, i cambiamenti nelle organizzazioni connessi con la trasformazione comportamentale. Sicuramente, secondo la visione degli autori, una sempre più urgente priorità alla base dell'applicazione della ricerca empirica in questo ambito è quella di validare o supportare modalità trattamentali applicabili in un modo economicamente vantaggioso. I ricercatori, in particolare, hanno analizzato il ruolo dei fattori inerenti gli operatori che la ricerca ha messo in luce in connessione agli outcomes. In merito osservano che le valutazioni degli operatori specializzati nello stress legato a eventi traumatici (specificamente coloro che si occupano di PTSD) in merito a una determinata pratica, le loro competenze e caratteristiche (ad esempio il livello di autoefficacia), la loro disponibilità al cambiamento nelle prassi operative (ad esempio nell'adottare una specifica best-practice integrandola nella loro operatività quotidiana) sono fattori incidenti, ma poco studiati a livello empirico. Accessibilità a percorsi di training sulle EBPs e le preoccupazioni sull'applicabilità delle novità nel campo della ricerca alla loro specifica popolazione di riferimento (problema della generalizzabilità dei risultati) risultano essere le variabili maggiormente incidenti sulla loro attitudine verso le pratiche evidence-based indipendentemente dall'orientamento teorico di appartenenza. La modalità di formazione che risulta particolarmente efficace ai fini del cambiamento dei comportamenti di cura sono i percorsi di training intensivo soprattutto quando prevedono la dimostrazione delle competenze necessarie e la possibilità di mettersi alla prova attraverso la partecipazione interattiva alle sessioni (con la disponibilità anche di supervisione su base continuativa e, quindi, al di là del momento formativo in senso stretto ed eventi di training-the-trainers). Per quanto concerne, invece, i fattori d'innovazione gli autori mettono in luce che le percezioni degli operatori e dei pazienti sui trattamenti sono un elemento fondamentale nella loro adozione, in particolare in merito alla loro comprovata efficacia (anche a livello comparativo con altre metodologie).

Tra i fattori sistemici essi osservano come sia particolarmente rilevante, ai fini del successo nell'applicazione di una buona pratica, la disponibilità di approcci multilivello a lungo termine, tra cui la disponibilità di spazi per la supervisione e il supporto a livello amministrativo-organizzativo (Fixsen et al., 2005). Ulteriormente importante è l'osservazione della necessità di supportare empiricamente l'esigenza di creare sistemi di cura trauma-informed (Ko et al., 2008; Ruzek e Rosen, 2009). Inoltre, il monitoraggio dell'implementazione del trattamento è un aspetto risultato centrale per quanto concerne la diffusione, gli effetti, la fedeltà alla procedura di realizzazione delle EBPs (Rosenheck, 2001b; DuFrene, Noell, Gilberton & Duhon, 2005; Durlak & DuPre, 2008; Ruzek e Rosen, 2009). Un aspetto particolarmente interessante è quello analizzato da Rosenheck (2001a) quando sottolinea il processo mutualmente ricorsivo d'interazione tra EBPs (nella loro dimensione generale e prescrittiva) ed esperienze/esigenze locali di applicazione. La finalità del monitoraggio, anche in ragione del suo costo in quanto a risorse economiche e di tempo per i servizi, dovrebbe quindi essere quella di consentire il focalizzarsi prevalentemente sugli elementi cruciali per gli esiti del trattamento e l'efficacia dell'intervento (Ruzek & Rosen, 2009). Una delle domande cruciali potrebbe riguardare quanto le modifiche apportate dal clinico in risposta a esigenze specifiche possa minare, incrementare o lasciare inalterati gli effetti dell'intervento (Ruzek & Rosen, 2009).

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Quiz 3.2

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Q3.2

3 points possible (graded)

1. Una ricerca di Ruzek e Rosen (2009) ha evidenziato che nel contesto internazionale dei trattamenti legati al trauma:

- ○ I trattamenti erano applicati in maniera uniforme attraverso le varie nazioni, evidenziando l'efficacia degli approcci utilizzati
- ○ Le necessità di specifici sottogruppi erano adeguatamente prese in carico
- ○ Gli stessi trattamenti erano ugualmente efficaci in adulti e minori
- ○ I programmi di training erano implementati in maniera difforme, evidenziando la necessità della definizione di core competencies

2. La Trauma-Informed Care...

- ○ Punta a trasformare il sistema di cura, concentrandosi sulla capacità dello staff di partecipare ad una visione della presa in carico del paziente traumatizzato
- ○ Punta a ridurre esclusivamente i sintomi correlati al trauma, concentrandosi sulle tecniche di intervento
- ○ Implementa tecniche quali contenimento ed isolamento
- ○ È utilizzata esclusivamente con minorenni

3. Uno dei vantaggi della divulgazione scientifica nelle organizzazioni che si occupano di trauma è:

- ○ La possibilità di manifestare esclusivo interesse per le questioni legate ai gruppi di lavoro
- ○ La possibilità di iniziare un percorso di implementazione delle più recenti pratiche evidence-based, mirate al miglioramento del benessere di staff e pazienti
- ○ L'implementazione delle evidenze come decisione top-down da parte della leadership
- ○ Il passaggio a trattamenti generici che funzionano per tutti i pazienti

Invia

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Definizioni e premesse

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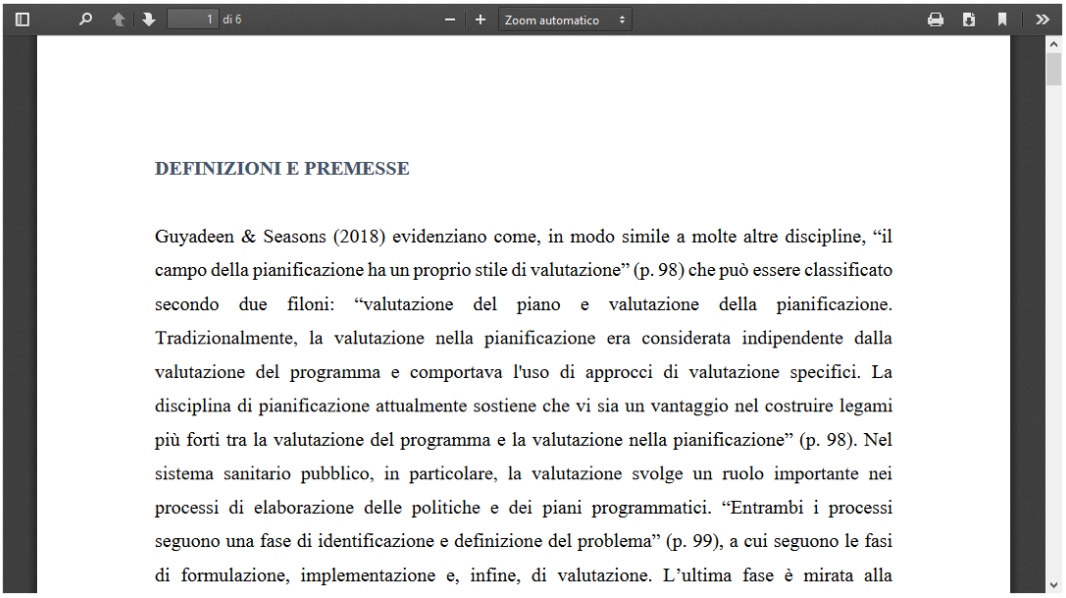

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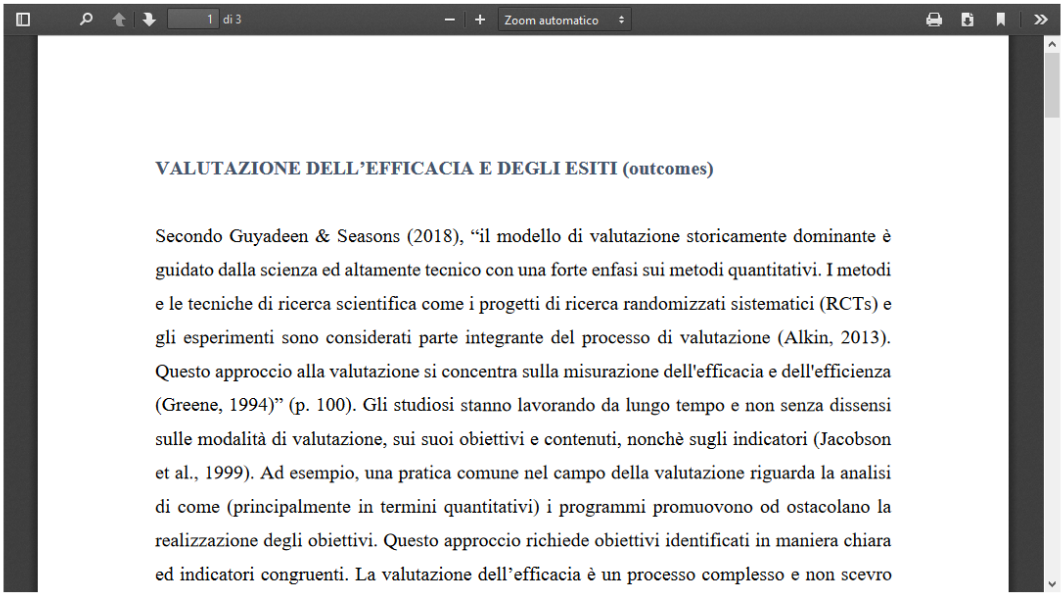
Valutazione dell'efficacia e degli esiti



VALUTAZIONE DELL'EFFICACIA E DEGLI ESITI (outcomes)

Secondo Guyadeen & Seasons (2018), "il modello di valutazione storicamente dominante è guidato dalla scienza ed altamente tecnico con una forte enfasi sui metodi quantitativi. I metodi e le tecniche di ricerca scientifica come i progetti di ricerca randomizzati sistematici (RCTs) e gli esperimenti sono considerati parte integrante del processo di valutazione (Alkin, 2013). Questo approccio alla valutazione si concentra sulla misurazione dell'efficacia e dell'efficienza (Greene, 1994)" (p. 100). Gli studiosi stanno lavorando da lungo tempo e non senza dissensi sulle modalità di valutazione, sui suoi obiettivi e contenuti, nonchè sugli indicatori (Jacobson et al., 1999). Ad esempio, una pratica comune nel campo della valutazione riguarda la analisi di come (principalmente in termini quantitativi) i programmi promuovono od ostacolano la realizzazione degli obiettivi. Questo approccio richiede obiettivi identificati in maniera chiara ed indicatori congruenti. La valutazione dell'efficacia è un processo complesso e non scevro

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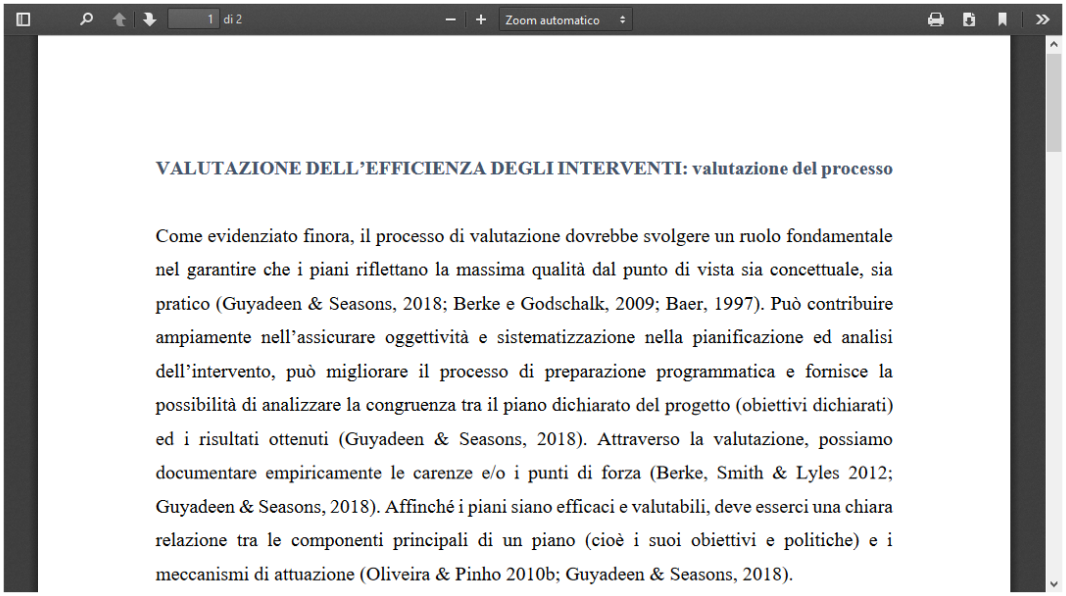
Valutazione dell'efficacia e degli interventi



VALUTAZIONE DELL'EFFICIENZA DEGLI INTERVENTI: valutazione del processo

Come evidenziato finora, il processo di valutazione dovrebbe svolgere un ruolo fondamentale nel garantire che i piani riflettano la massima qualità dal punto di vista sia concettuale, sia pratico (Guyadeen & Seasons, 2018; Berke e Godschalk, 2009; Baer, 1997). Può contribuire ampiamente nell'assicurare oggettività e sistematizzazione nella pianificazione ed analisi dell'intervento, può migliorare il processo di preparazione programmatica e fornisce la possibilità di analizzare la congruenza tra il piano dichiarato del progetto (obiettivi dichiarati) ed i risultati ottenuti (Guyadeen & Seasons, 2018). Attraverso la valutazione, possiamo documentare empiricamente le carenze e/o i punti di forza (Berke, Smith & Lyles 2012; Guyadeen & Seasons, 2018). Affinché i piani siano efficaci e valutabili, deve esserci una chiara relazione tra le componenti principali di un piano (cioè i suoi obiettivi e politiche) e i meccanismi di attuazione (Oliveira & Pinho 2010b; Guyadeen & Seasons, 2018).

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Quiz 3.3

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Q3.3

3 points possible (graded)

1. Secondo Rychetnik, Frommer, Hawe e Shiell (2002), la valutazione si può definire come:

- ○ Un insieme di cambiamenti e di esiti definibili a priori
- ○ La lettura interpretativa dei dati rilevati attraverso una ricerca formale o indagini specifiche
- ○ Il setting sociale, politico e/o organizzativo entro il quale l'intervento è programmato
- ○ Il processo che consente di determinare la valenza di un intervento attraverso il confronto con standard predeterminati ed espliciti

2. Nel valutare l'efficacia di un intervento, quale di queste NON sembra una dimensione significativa? (Rychetnik et al., 2002)

- ○ La pertinenza degli effetti misurati nel contesto di implementazione
- ○ Il numero di interventi svolti dall'organizzazione
- ○ La grandezza degli effetti misurati
- ○ La forza dell'evidenza, determinata da una combinazione del disegno di studio, della qualità metodologica e della precisione statistica

3. La valutazione...

- ○ Permette di documentare empiricamente le carenze ed i punti di forza dei piani di intervento
- ○ Non richiede una integrazione tra metodi di valutazione e piano da valutare
- ○ Dovrebbe evitare di considerare gli interessi delle persone coinvolte nelle decisioni sugli interventi
- ○ Andrebbe portata avanti solo sugli esiti\outcome

Invia

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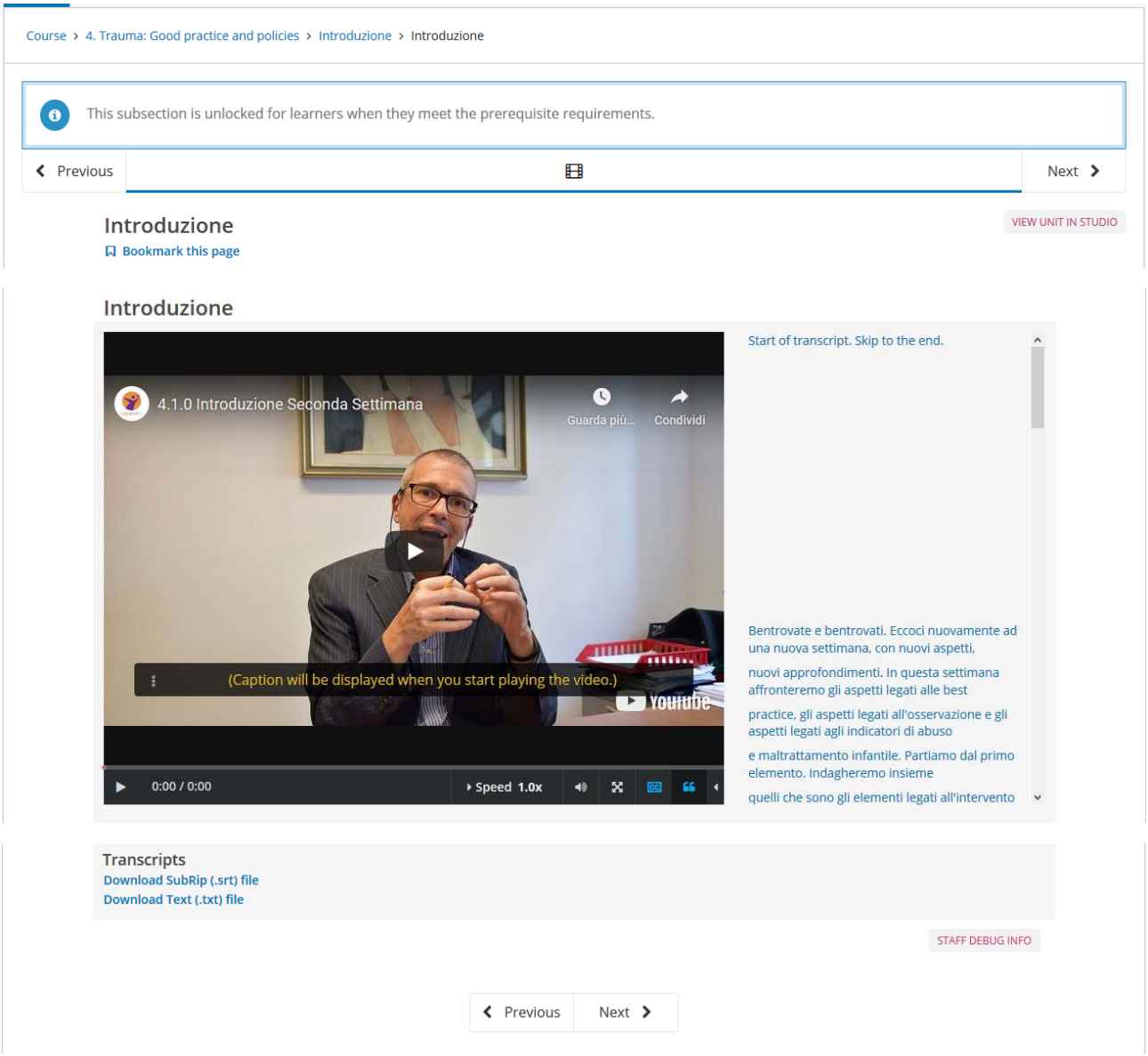

Transcript

Bentrovate e bentrovati. Eccoci nuovamente ad una nuova settimana, con nuovi aspetti, nuovi approfondimenti. In questa settimana affronteremo gli aspetti legati alle best practice, gli aspetti legati all'osservazione e gli aspetti legati agli indicatori di abuso e maltrattamento infantile. Partiamo dal primo elemento. Indagheremo insieme quelli che sono gli elementi legati all'intervento della ricerca e della pratica con particolare attenzione allo sviluppo delle best practice, o delle buone pratiche. Dopo di che esamineremo quelli che sono gli aspetti metodologici della ricerca in Trauma-Informed Care, che ormai abbiamo imparato a comprendere e a leggere, e avremo modo di comprendere ulteriormente come queste si applichino alla pianificazione di una ricerca, come utilizzare il format Trauma-Informed Care nella ricerca, quindi il canale dalla teoria alla pratica. Tenteremo poi ancora di identificare gli elementi che costituiscono una buona proposta di ricerca

andando a vedere quelli che sono aspetti legati ad esempio ad una buona tecnica che è l'osservazione. L'osservazione come strumento clinico, l'osservazione come strumento che può permettere ad un operatore che a diverso titolo collabora o ha intenzione di lavorare o per mille altre ragioni è intenzionato a conoscere e approfondire il tema del Trauma-Informed Care può utilizzare il metodo, lo strumento osservativo, che può essere a sua volta uno strumento importante per comprendere il contesto, e per comprendere anche la persona calata in quel contesto (ricordiamoci il senso del Trauma-Informed Care). E qui indagheremo quelli che sono i requisiti e le applicazioni possibili con l'osservazione clinica e non solo. Proseguiremo poi su quelli che sono gli esempi e i concetti esposti precedentemente come buone pratiche, osservazione e come questi possono essere applicati all'abuso e maltrattamento infantile andando a individuare anche indicatori, tenendo in considerazione che un indicatore è, come tale, un indicatore, non è certo un elemento fondamentale e certo di abuso e maltrattamento, ma un insieme di indicatori possono essere per noi interessanti come elemento da tenere a mente che lì vi può essere un qualche cosa da indagare. Di qui andiamo quindi a vedere quello che è lo screening sulla valutazione del trauma e cercheremo di capire con colleghi e con colleghe quanto uno screening di un trauma possa essere importante ai fini della conoscenza. Chiuderemo poi quello che sono gli aspetti legati al Trauma-Informed Care e collegamenti con la ricerca, e a come vi possa essere un sistema organizzato di processi che va dalla teoria alla pratica. Se nella prima parte, nelle prime due settimane abbiamo discusso e abbiamo affrontato con i colleghi quello che è forse l'aspetto più teorico del trauma, con noi oggi, con queste due settimane abbiamo discusso quella che è la ricerca in evidence-based o action-research in Trauma-Informed Care, di qui in poi vi avvierete verso un nuovo percorso che avrà sempre come filo rosso il trauma ed il Trauma-Informed Care ma da un aspetto un po' diverso, ossia quello legislativo, per affrontare poi i temi legati alla legislazione, alla ricerca e alle policy. Vi auguriamo, a nome mio e a nome di tutti i colleghi un buon proseguimento di percorso, ormai siete arrivati a metà, forse a più di metà del percorso, e a questo punto vi state avviando verso la chiusura del vostro MOOC. Nuovamente, buona prosecuzione, e ci rivedremo alla fine del MOOC.

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Introduzione agli aspetti metodologici di base della ricerca in TIC

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Come indicato da Newman & Ridenour (1998), il modo in cui i ricercatori conducono uno studio e quali conclusioni ne traggono sono molto diversi a seconda dell'approccio adottato nei confronti della realtà. Inoltre, l'epistemologia riguarda lo studio di come conosciamo le cose mentre il metodo riguarda la scelta della tecnica attraverso la quale procedere alla conoscenza dei fenomeni (Bernard, 2006)

Come sottolineato da Lastrucci (1963), la scienza è "un metodo oggettivo, logico e sistematico di analisi dei fenomeni, ideato per permettere l'accumulo di conoscenze affidabili" (p. 6). Questo avviene attraverso tre obiettivi che guidano le scelte del ricercatore (Bernard, 2006):

- L'oggettività: questo implica l'essere espliciti riguardo alle misurazioni, l'attenzione alla metodologia e il riferimento alla revisione fra pari nell'ambito della comunità scientifica
- Il metodo scientifico
- L'affidabilità

La dimensione etica è parte del metodo scientifico e, riferendosi alla ricerca nell'ambito delle scienze umane, una questione centrale è quella riguardante come operazionalizzare fenomeni che per loro natura sono complessi; questo tipo di processo si basa sulla definizione di variabili, sulla ricerca di associazioni o relazioni tra loro e sul tentativo di capire se e come la variazione di una cosa causi una variazione in un'altra (Bernard, 2006). In connessione con questi aspetti un elemento fondante è quello della misurazione e dell'identificazione di indicatori validi e affidabili ed è strettamente connesso alla strutturazione di definizioni operative che "consistono in un insieme di istruzioni su come misurare una variabile che è stata definita concettualmente" (p. 38).

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La ricerca in TIC

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Nell'ambito dalla TIC uno dei concetti fondamentali è quello di utilizzare procedure e concetti scientificamente validati. Da questo punto di vista è fondamentale la promozione di una sinergica interazione tra lavoro clinico e ricerca al fine di indagare gli esiti del trattamento e per valutare i modelli di funzionamento dei servizi in termini di efficacia ed efficienza anche con la formalizzazione di questi aspetti in specifiche linee guida e/o l'attenzione all'adesione dello specifico protocollo agli elementi consolidati nella ricerca internazionale in questo campo (Schäfer et al., 2018).

In questo non è irrilevante il contributo della ricerca scientifica in merito all'analisi delle definizioni della TIC e dei suoi fattori fondanti.

Infatti, a questo proposito, Becker-Blease (2017), Hanson & Lang (2016) e Johnson (2017) evidenziano una serie di aspetti critici relativi alla TIC e di difficoltà applicative, tra cui, ad esempio, l'esistenza di un focus molto presente nella letteratura scientifica sugli aspetti teorici e sui principi fondamentali a discapito di un'attenzione rispetto agli elementi tangibili e alla loro applicabilità nella pratica: "vi è una lacuna su come i professionisti possono trasformare la teoria e i principi nella pratica quotidiana e quindi valutare la loro efficacia "(Becker-Blease, 2017, p.3). l'attenzione alla ricerca è, quindi, utile per la valutazione delle iniziative applicative, dei programmi e dei servizi trauma-informed e se questi siano correlati a risultati positivi rilevanti.

Nel cercare di attuare un proficuo e funzionale interscambio tra gli aspetti concettuali e teorici e quelli applicativi, un rilevante focus dovrebbe essere dedicato all'analisi dell'applicabilità di procedure e indicatori standardizzati sia in capo agli elementi processuali, sia agli esiti ottenuti. La letteratura scientifica sull'argomento sollecita le organizzazioni e le istituzioni a considerare particolarmente rilevante la strutturazione di progetti di ricerca, sia di base sia applicativi, volti ad occuparsi delle modalità di screening (evidence-based screening), all'analisi delle procedure di assessment atte a identificare gli eventi traumatici e le loro peculiarità. Inoltre, a tal fine, risulta importante che vengano implementati studi randomizzati, controllati, su base sperimentale che testino l'efficacia degli interventi trauma-oriented.

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Gli elementi di base per strutturare una buona proposta di ricerca

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Esistono differenti approcci alla strutturazione di un progetto (Leone & Prezza, 1999) in ambito socio-sanitario: a) sinottico-razionale (che implica massima pre-strutturazione dei contenuti), b) concertativo-partecipativo o della progettualità dialogica (in cui è centrale continua negoziazione degli obiettivi fra esperti e destinatari); c) euristico (che prevede una minima strutturazione a priori degli obiettivi).

Da un punto di vista generale, nel processo di ricerca si dovrebbero seguire i seguenti steps:

1. Viene formulato un problema teorico (derivante dall'analisi della teoria e della letteratura scientifica);

2. Vengono selezionati unità di analisi e metodo appropriati;

3. I dati vengono raccolti e analizzati;

4. La proposizione teorica con la quale è stata avviata la ricerca è o contestata o supportata.

Come indicato da Lanzara (1985): "Ogni attore che si ponga il problema dell'innovazione, o semplicemente dell'intervento in una situazione per modificarla, ha di fronte a sé un problema di progettazione" (p. 336). La progettazione è un processo di sistematizzazione; infatti, la strutturazione di un progetto di ricerca è una fase critica e fondamentale che comporta scelte importanti che ne condizionano gli esiti. Inoltre, Leone & Prezza (1999) sottolineano che: "Articolare un progetto tra diversi soggetti, pensare alla coerenza tra diverse parti (scopi, tempi, operatori disponibili...) significa problematizzare la prassi e fare i conti con il limite, con la parzialità, e questo è proprio ciò che in alcuni contesti tende ad essere rimosso" (p. 23) o considerato troppo complesso da un punto di vista applicativo.

Da un punto di vista trasversale, le autrici indicano le tappe fondamentali nella strutturazione di un progetto in campo sociale:

1) Ideazione: fase in cui si ipotizza di realizzare o proporre un progetto

2) Attivazione: verifica risorse, ruoli, problema e strategie, eventuale analisi della domanda (committenza)

3) Progettazione: elaborazione del progetto e strutturazione delle fasi che lo compongono, si stabiliscono i tempi e si definiscono le scelte metodologiche

4) Realizzazione: avvio delle attività, verifica prime ipotesi, modifiche in itinere

5) Verifica: analisi conclusiva dei risultati

Inoltre, nell'ambito della ricerca scientifica, elementi importanti dal punto di vista applicativo sono:

- Definizione e analisi dell'oggetto di ricerca dal punto di vista della letteratura scientifica, esplicitazione del framework teorico
- Individuazione ed esplicitazione delle finalità generali e degli obiettivi specifici dello studio (domanda di ricerca: esplorativa, valutativa, esplicativa)
- Strutturazione delle ipotesi
- Identificazione della popolazione target, del reclutamento dei partecipanti e delle procedure di campionamento
- Procedure di valutazione, definizione degli indicatori, strumenti e tecniche di analisi dei dati raccolti
- Pianificazione dei tempi (cronoprogramma) e analisi della fattibilità (inclusi criticità e limiti)

Nel fare questo si può ricorrere a impianti metodologici di matrice quantitativa, qualitativa, mista in base alla domanda di ricerca.

Ciascuna fase della progettazione comporta che il ricercatore si ponga interrogativi importanti che tengano conto anche degli elementi critici dal punto di vista concettuale e pratico. Il contesto in cui si svolge la ricerca è uno di questi, così come le risorse.

Stante tale complessità, è di fondamentale rilevanza l'attenzione alla formazione del personale anche su questa dimensione e la costante interazione tra i professionisti impegnati nel lavoro clinico e i ricercatori che si occupano di ricerca nella e sulla clinica.

Inoltre, un settore importante che mostra la sua centralità è quello che riguarda la strutturazione e validazione di strumenti che possono essere utilizzati a partire da obiettivi sia di intervento sia di ricerca. Questi possono avere forme differenti ed essere applicabili a target specifici, ragione per cui è fondamentale che tutti gli attori coinvolti nella progettazione e implementazione di un progetto concertino sinergicamente ogni fase prevista nel piano progettuale, scelte metodologiche comprese.

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Quiz 4.1

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Q4.1

3 points possible (graded)

1. La definizione operativa:

- ○ È successiva alla definizione concettuale di una variabile
- ○ È precedente alla definizione concettuale di una variabile
- ○ Non è utile al fine di misurare una variabile
- ○ Viene elaborata durante la misurazione di una variabile

2. Nell'ambito della TIC è fondamentale:

- ○ Imporre una metodologia di intervento agli operatori
- ○ Non tenere conto dei contributi della ricerca scientifica
- ○ Non tenere in considerazione gli aspetti critici e le difficoltà applicative
- ○ Promuovere una sinergica interazione tra lavoro clinico e ricerca

3. In ciascuna fase della progettazione:

- ○ Il ricercatore non dovrebbe porsi interrogativi importanti che tengano conto anche degli elementi critici dal punto di vista concettuale e pratico
- ○ Il ricercatore dovrebbe porsi interrogativi importanti che tengano conto anche degli elementi critici dal punto di vista concettuale e pratico
- ○ Bisogna sempre analizzare i dati
- ○ Non è necessario pianificare le tempistiche

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Buone pratiche nella TIC

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Visti i grandi rischi per la salute fisica e psicologica dovuti all'impatto di eventi traumatici (Adverse Childhood Experiences, ACEs), nel corso degli anni sono stati sviluppati molti interventi volti ad aiutare istituzioni e operatori che assistono persone con storie di trauma al fine di sottolineare il vantaggio dell'adottare un approccio improntato alla TIC (Baker et al., 2016). In particolare, un "approccio TIC guarda una persona in modo olistico, non solo come una lista di problemi che sta vivendo" (Hepburn, 2017, p. 7). Come indicato da molti autori (Bryson et al., 2017; Bridgett, Valentino & Hayden, 2012; Ellis & Boyce, 2011; Perry, 2002; Rothbart, Ziaie, O'Boyle, 1992), un effetto protettivo (effetto tampone) è giocato da una buona cura e relazioni di supporto esercitate da caregivers attenti e proattivi: la sicurezza relazionale riduce gli effetti nocivi del trauma nei bambini. Lo stress traumatico è una condizione comune nel caso dell'ACE e spesso causa manifestazioni cliniche significative (internalizzazione e / o sintomi esternalizzanti) frequentemente riscontrabili in ospedale o nell'ambito delle strutture residenziali dedicate ad adulti e minori (Bryson et al., 2017; Greenwald et al, 2012; Hummer, Dollard, Robst, 2010; Ko et al., 2008). Citando quanto indicato da Elliott e colleghi (2005), i quali hanno affermato che "I servizi informati sul trauma sono quelli in cui l'erogazione del servizio è influenzata dalla comprensione dell'impatto della violenza interpersonale e della vittimizzazione sulla vita e sullo sviluppo di un individuo" (p. 462) e che "Molte procedure e pratiche comuni nelle impostazioni del servizio riattivano le reazioni traumatiche e sono vissute come emozioni non sicure e fonte di debolezza per i sopravvissuti al trauma" (p.446), è possibile ulteriormente sottolineare che le buone pratiche (good practices) dovrebbero essere valutate in base a criteri specifici che sono identificati e dettagliati nella letteratura scientifica e che includono un'attenta valorizzazione dei complessi fattori coinvolti nelle storie traumatiche e nella condizione da esse esitante. Infatti, nelle situazioni in cui il servizio o l'organizzazione si occupi di soggetti che hanno subito traumi, è raccomandata una prospettiva in cui la salute pubblica e l'assistenza sociale siano orientate alla prevenzione e alla riduzione del rischio (Bryson et al., 2017). In questo campo promuovere approcci trauma-informed è una questione centrale: la trauma-informed care (TIC) e la pratica informata sul trauma (TIP) sono paradigmi di trattamento d'elezione perché mirano a trasformare interi sistemi di cura includendo una comprensione dello stress in risposta al trauma in tutti gli aspetti del servizio e concentrandosi sulla priorità della sicurezza e della possibilità di scelta. Inoltre, questa filosofia mira a creare una cultura del trattamento incentrata sulla non violenza, sull'apprendimento e sulla collaborazione in cui l'attenzione è dedicata a tutte le interazioni ambientali e interpersonali (Bryson et al., 2017). Nella revisione sistematica della letteratura, Bryson e colleghi (2017) hanno incluso alcune importanti risultanze:

- "la riduzione della coercizione fisica nelle cure psichiatriche di routine e residenziali" (p. 11) è sottolineata come la riduzione/eliminazione dell'isolamento o delle strategie controllo e coercizione;

- un aspetto fondamentale del TIC è "l'importanza fondamentale dei leader senior che diano priorità alla TIC [...] specialmente quando allo staff è richiesto di adeguarsi a nuovi modi di lavorare" (p. 11)

- i ricercatori sottolineano la necessità di sostenere il personale attraverso una formazione avanzata - in particolare sulle sequele del trauma - la supervisione continua, il coaching e il debriefing

- in questo, è fondamentale ascoltare i pazienti e le famiglie, con particolare attenzione alle loro esperienze, bisogni, priorità per quanto riguarda il processo di trattamento

- l'importanza attribuita all'area di aggiornamento costante dei dati di ricerca e l'analisi degli indicatori di esito sono dimensioni trasversali finalizzate a motivare e informare le prestazioni dei servizi e il miglioramento dell'efficacia

- la letteratura tratta ampiamente "la necessità di allineare la politica e la pratica, formale e informale, con i principi generali della pratica informata sui traumi" (p. 11).

Nonostante la sua sempre più frequente applicazione, la ricerca scientifica sull'efficacia di questo tipo di approccio è ancora carente (Bryson et al., 2017); come sottolineato da Valenkamp, Delaney e Verheij (2014) e da Chandler (2008), si può osservare una mancanza di studi randomizzati e controllati che testino gli interventi ed esplorino i fattori critici implicati nell'attuazione dei trattamenti orientati al TIC. In merito a quanto attualmente indicato a livello internazionale, studi empirici hanno dimostrato quanto sia rilevante la formazione nel fornire al personale un linguaggio comune da utilizzare per quanto riguarda l'esperienza del paziente e particolari interventi da utilizzare con i pazienti affetti da trauma (Bryson et al., 2017). La centralità di questa questione è stata ben evidenziata precedentemente anche da Le Bel, Huckshorn e Caldwell (2008) e da Brown, Baker e Wilcox (2012). Inoltre, una formazione specifica sulle migliori pratiche e la partecipazione dei pazienti alle attività di formazione del personale (ad esempio attraverso il riferire sulle loro esperienze) si sono rivelate utili (Holstead, Lamond, Dalton, Horne & Crick, 2010), così come il coinvolgimento dei minori nel debriefing su aspetti o fasi critici nella fornitura dell'assistenza (Lebel et al., 2008), la condivisione dei dati e il costante monitoraggio delle prestazioni/dei processi (a livello individuale, collettivo e di unità) (Bryson et al., 2017). Un altro punto focale emergente della letteratura scientifica sulle strategie efficaci nell'ambito della TIC è la capacità delle organizzazioni di allineare le politiche e le pratiche ai principi della cura informata sul trauma (Bryson et al., 2017). Secondo questa visione, l'ambiente e la cultura delle organizzazioni sono strumenti terapeutici essi stessi ed entrambi danno un contributo nel costruire una "comunità terapeutica". Di particolare rilevanza sono: 1) l'attenzione a creare uno spazio di trattamento sicuro sia per i pazienti che per il personale e 2) l'inclusione dei principi TIC nelle dichiarazioni di missione e visione. Riassumendo, le principali strategie nel campo della TIC focalizzate da Bryson e colleghi (2017) sono allineate a quelle alla base dell'intervento di riduzione S/R (NASMHPD, National Association of State Mental Health Program Directors) ed entrambe sono presentate nella Tabella 1.

Core strategies in TIC

Bryson e collechi (2017)

- Inclusione nella comunità (Community inclusion)
- Impegno della leadership (Leadership commitment)
- Selezione del modello (Model selection)
- Trasformazione della forza lavoro (Workforce transformation)
- Orientamento al risultato (Outcome orientation)
- Assistenza condivisa (Shared maintenance)

NASMHPD

- Leadership orientata al cambiamento organizzativo (Leadership towards organizational change)
- Utilizzo dei dati per informare la pratica (Use of data to inform practice)
- Riduzione dell'uso di strumenti di segregazione e isolamento (Use of restraint and seclusion reduction tools)
- Sviluppo dello staff di lavoro (Workforce development)
- Migliorare il ruolo dell'utente nel setting ospedaliero (Improve consumer's role in inpatient setting)
- Tecniche di debriefing attive (Vigorous debriefing techniques)

Inoltre, in uno studio di Azeem e colleghi (2011), questi elementi strategici sono stati testati longitudinalmente per analizzare la riduzione dell'uso della contenzione e dell'isolamento. In particolare, gli autori hanno sottolineato che:

✓ la leadership gioca un ruolo fondamentale nel portare il cambiamento della cultura in particolare quando una visione orientata alla TIC è condivisa con tutto lo staff

✓ la raccolta e la condivisione dei dati ha "un ruolo fondamentale nei progetti di miglioramento delle prestazioni" (p. 12) e nei processi di monitoraggio

✓ il training e la formazione continua del personale sui principi dell'assistenza orientata alla recovery, dell'assistenza centrata sulla persona e della TIC con le relative valutazioni delle prestazioni si sono state rivelate aventi effetti rilevanti in senso positivo

✓ un importante focus deve essere dedicato ai principi della prevenzione primaria utilizzando piani di trattamento individuali che includono la storia del trauma e la comunicazione con le strategie del paziente, della famiglia e dello staff

✓ un buon principio per la pratica del TIC è il coinvolgimento del paziente e della famiglia

✓ attività di debriefing di supporto - in particolare per quanto riguarda gli aspetti emotivi e le modifiche necessarie nei piani di trattamento - quali interventi per mitigare l'impatto traumatizzazione e traumatizzazione sono stati implementati efficacemente.

Hanson e Lang (2016) e Johnson (2017), esaminando diversi approcci alla TIC, hanno identificato alcuni temi che potrebbero essere considerati importanti per esplorare gli approcci dei servizi per minori e hanno concluso che è possibile identificare 15 componenti fondamentali della TIC.

I componenti identificati sono stati organizzati in tre livelli (Hanson & Lang, 2016, p. 98):

1. sviluppo della forza lavoro (Workforce Development, WD):

- Formazione richiesta a tutto il personale in consapevolezza e conoscenza dell'impatto dell'abuso o del trauma

- Misurazione della competenza del personale in criteri definiti per dimostrare la conoscenza / pratica sul trauma

- Strategie / procedure per affrontare / ridurre lo stress connesso al trauma secondario tra il personale

- Conoscenze / abilità su come accedere e fare riferimento al le migliori pratiche evidence-based focalizzate sul trauma

2. servizi focalizzati sul trauma (Trauma Focused Services, TFS):

- Uso di misure standardizzate di screening / valutazione evidence-based per identificare la storia e i sintomi o i problemi correlati al trauma

- Inclusione della storia del trauma del bambino nella documentazione / nei file /nel piano di servizio sul caso

- Disponibilità di clinici qualificati per e addestrati in pratiche focalizzate sul trauma evidence-based

3. consegne organizzative (Organizational Delivery,ORG):

- Collaborazione, coordinamento dei servizi e condivisione delle informazioni tra i professionisti all'interno dell'agenzia connessi ai servizi trauma-informed

- Collaborazione, coordinamento dei servizi e condivisione delle informazioni tra i professionisti di altre agenzie legate ai servizi trauma-informed

- Procedure per ridurre il rischio di re-traumatizzazione dell'utente

- Procedure per il coinvolgimento degli utenti e input nella pianificazione del servizio e sviluppo di un sistema trauma-informed

- Fornitura di servizi basati sui punti di forza e promozione di uno sviluppo positivo

- Fornitura di un ambiente fisico positivo e sicuro

- Politiche scritte che includono e supportano esplicitamente i principi trauma-informed

- Presenza di una posizione di leadership definita o di una funzione lavorativa specificamente correlata alla TIC.

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Elementi fondamentali delle buone pratiche

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Analizzando letteratura e protocolli per la valutazione delle pratiche di TIC è quindi possibile concludere che le buone pratiche (potenzialmente trasferibili in differenti contesti) dovrebbero includere:

1) una formazione permanente di tutti i membri dello staff sul trauma e sui suoi correlati. Questa formazione non dovrebbe essere fornita solo a professionisti che lavorano direttamente a livello clinico con gli utenti, ma a tutti coloro che sono inclusi a vario titolo e con diverse funzioni nell'organizzazione

2) un costante aggiornamento dello staff interno sulle pratiche evidence-based (EBP) nella cura del trauma e un'attenzione sull'atteggiamento dei professionisti nei confronti degli EBP

3) collaborazione con esperti del settore al fine di aumentare la disponibilità di providers clinici addestrati

4) l'inclusione di procedure di screening standardizzate ed evidence-based nella pratica clinica e l'uso di misure / strumenti di valutazione specifici e validati per identificare gli eventi traumatici (ACEs)

5) un'attenzione condivisa dedicata alla storia degli utenti e alla sua associazione con sintomi o difficoltà correlati al trauma

6) in linea con il punto precedente, il riconoscimento della specificità della storia di vita di ciascun utente garantita attraverso un ascolto attivo ed empatico da parte di tutto il personale

7) l'inclusione e un'attenta condivisione della storia del trauma dei bambini nella pianificazione dell'intervento o nella concettualizzazione dei casi

8) una valutazione approfondita e un monitoraggio costante delle competenze dello staff (utilizzo di procedure specificatamente progettate)

9) monitoraggio approfondito per mantenere gli standard stabiliti per un buon servizio TIC e, possibilmente, per migliorare gli elementi deficitari

10) l'implementazione di procedure per ridurre lo stress da traumatizzazione secondaria e aumentare il benessere del personale

11) la costruzione e il mantenimento di una buona rete di collaborazione non solo all'interno dei servizi, ma anche con altre agenzie operanti sul campo

12) l'attenzione alla centralità della dimensione comunicativa: l'obiettivo di più alto livello dovrebbe essere quello di avere professionisti attenti e collaborativi nel perseguire obiettivi e nell'applicare procedure condivise e co-costruite

13) l'attenzione alle procedure per ridurre il rischio di ri-traumatizzazione per gli utenti

14) incoraggiare la partecipazione dei pazienti alla progettazione del piano di trattamento

15) per coinvolgere gli utenti nella pianificazione del servizio: attenzione al loro feedback e suggerimenti per migliorare l'organizzazione e i servizi offerti

16) una particolare attenzione al fornire servizi basati sui punti di forza, volti a promuovere fattori per uno sviluppo positivo (ad esempio, resilienza, empowerment)

17) formazione sulle strategie per organizzare un ambiente positivo per gli utenti e per il personale

18) particolare attenzione alle dimensioni fisiche e strutturali del servizio

19) adesione e promozione dei principi della TIC con politiche specifiche e chiare

20) un ruolo centrale assegnato alla dimensione della leadership e alle sue funzioni nell'organizzazione del servizio.

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Elementi critici e sfide

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L'uso di pratiche evidence-based - sebbene sia un argomento particolarmente sottolineato nelle raccomandazioni per l'implementazione delle best practices - è ancora oggi un elemento di resistenza da parte di alcuni professionisti, organizzazioni e ricercatori (Gray, Elhai, Schmidt, 2007): questo dovrebbe essere oggetto di analisi, discussione e attenzione da parte delle organizzazioni che si occupano dell'intervento clinico sul trauma, anche ai fini di creare una definizione cooperativa di standard.

Infatti, sebbene l'approccio TIC stia assumendo un ruolo importante nell'organizzazione dei servizi e nella fornitura di assistenza per le persone traumatizzate al momento, ci sono ancora alcuni ostacoli nella sua applicazione e, ancor prima, nella sua concettualizzazione (Baker, 2016). In particolare si riscontrano carenze in merito a:

una definizione operativa chiara

la presenza di strumenti validati psicometricamente per valutare le dimensioni della TIC.

Per colmare questa lacuna, Baker e colleghi (2016), ad esempio, hanno costruito e validato uno strumento –Attitudes Related to Trauma-Informed Care (ARTIC) Scale - per valutare le attitudini relative alla TIC del personale che lavora in diverse aree di intervento o contesti che si occupano di individui con storie traumatiche. Precedentemente, Fallot e Harris (2009) - nella loro pubblicazione Creating cultures of trauma-informed care (CCTIC): a self-assessment and planning protocol - hanno strutturato un protocollo di autovalutazione e pianificazione (Self-Assessment and Planning Protocol) che comprende sei domini che si implicano modifiche sia a livello di servizi, sia a livello amministrativo o di sistema. L'attenzione alla complessità della situazione applicativa della TIC si costituisce sempre più salientemente come obiettivo sfidante – in un'ottica propulsiva - sia per i singoli operatori, sia per i servizi socio-sanitari nella loro quotidiana interazione e nel loro rapporto con la comunità scientifica di riferimento.

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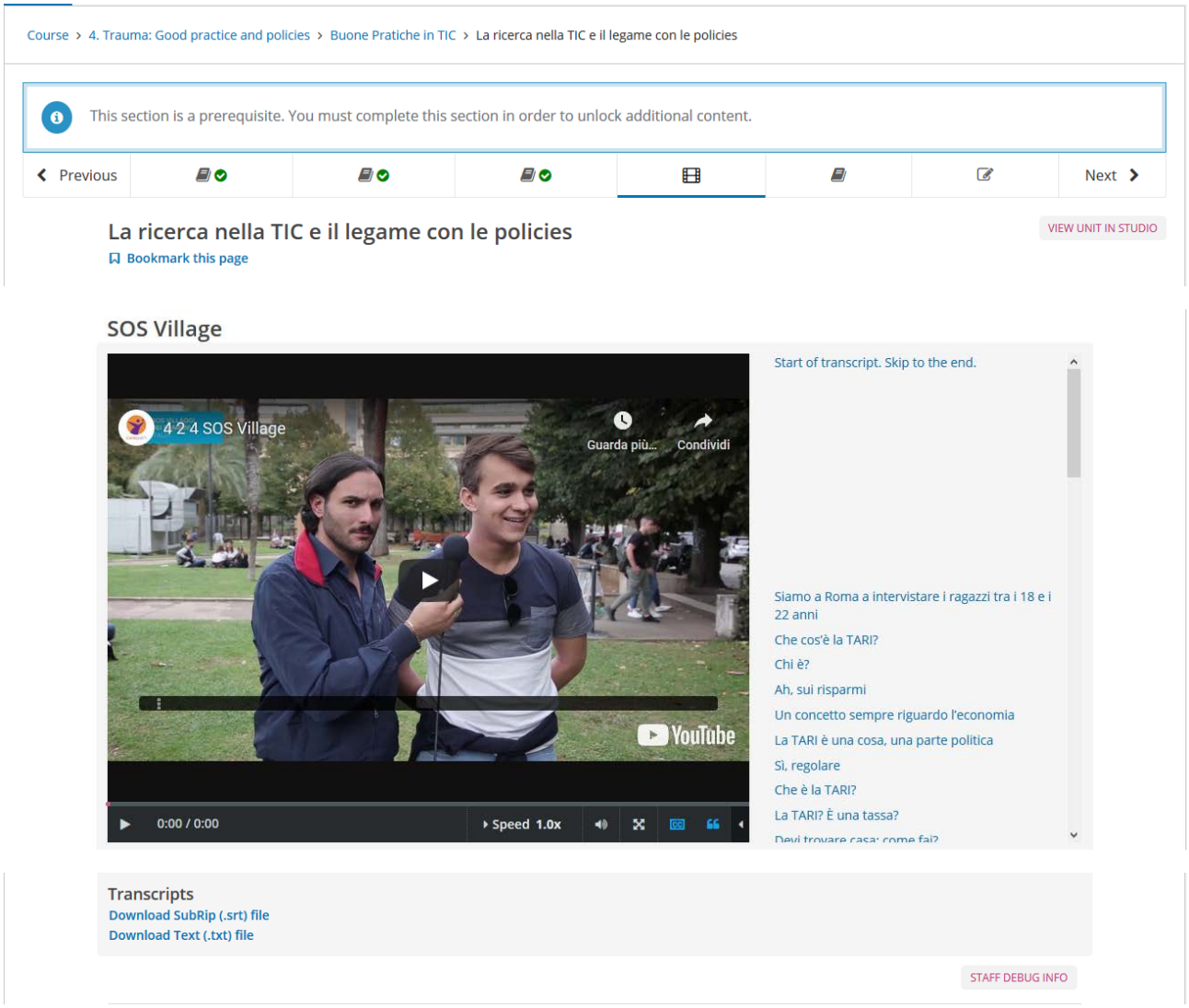

Transcript

Siamo a Roma a intervistare i ragazzi tra i 18 e i 22 anni

Che cos'è la TARI?

Chi è?

Ah, sui risparmi

Un concetto sempre riguardo l'economia

La TARI è una cosa, una parte politica

Sì, regolare

Che è la TARI?

La TARI? È una tassa?

Devi trovare casa: come fai?

Come fai? Come ti muovi?

Con i mezzi

L’ha trovata Giulia

Con l’agenzia immobiliare

Io vivo a casa, con mamma a casa che mi aspetta

tutte le sere

Che tipo di contratto fai?

Cioè, io pago solo, cioè io devo pagare...

Contratti, ok, indeterminati, contratti a

lungo termine

Cioè, ho iniziato adesso Giurisprudenza,

però cioè, ho iniziato adesso! Quindi...

Si fa il 4..?

4 Mesi?

Più 5

Spesi in affitto sono soldi buttati

Tipo l’acqua e la corrente sono compresi nel prezzo

4?

Il conto corrente

Cioè, è più facile un’interrogazione di latino

Mah, non saprei

Dove si depositano i..

Se vuole possiamo parlare di Seneca

Quando hai qualche problema, tu chi chiami?

Giulia

Papà

A Seneca che è morto.. e quindi a mamma e

papà per ora

Ci sono alcune domande a cui è difficile rispondere, però alcuni ragazzi a 18 anni

e un giorno le dovranno affrontare da soli

Care Leavers

Non so cosa sia

I fabbisogni della salute?

Chi sono?

Giocatori del Liverpool

Non so cosa sia, mai sentito

Non ho capito la domanda?

I clerici

Sono dei ragazzi che, arrivati a 18 anni,

che vivono in una Casa Famiglia, devono lasciare la Casa Famiglia e trovare una sistemazione autonoma

Grande!

Che gli possiamo dire a questi ragazzi su?!

Che..un augurio.. che gli vogliamo dire?!

La TIC, in quanto modello che si propone di strutturare l'offerta dei servizi, è implementato in un ampio e variegato range contestuale; Bowen e Murshid (2016) sottolineano come tale paradigma possa essere applicato in egual misura, nei suoi principi fondanti (sicurezza, affidabilità e trasparenza, collaborazione, empowerment, scelta e intersezionalità) alle politiche sociali. Questo, secondo la proposta degli autori, poiché la TIC offre ai professionisti operanti nel campo della salute mentale (specialmente nel settore pubblico) un percorso finalizzato a interrompere le disparità attraverso l'azione clinico-organizzativa che, per la sua dimensione anche etica e deontologica, può assurgere altresì a una più ampia dimensione politica. Già Reeves (2015) aveva messo in luce come l'implementazione diffusa di modelli di cura TIC-oriented possa porre al centro dell'intervento la risposta ai bisogni unici e peculiari dei soggetti presi in carico dai servizi riabilitativi, attenuando le disparità assistenziali sperimentate da questa popolazione in condizione di vulnerabilità.

Recentemente Levy-Carrick e colleghi (2019) hanno sottolineato la disparità di trattamento nell'ambito del trauma come un tema critico nell'organizzazione nazionale dei servizi sanitari a cui l'adozione della TIC può porre – se non totalmente almeno ampiamente - rimedio. Infatti, un punto centrale sottolineato dagli autori è che l'applicazione efficace di questo paradigma sarebbe garantita dalla piena partecipazione delle figure assistenziali alla pianificazione e implementazione delle attività ad ogni step. Infatti, anche De Chesnay e Anderson (2019), nel loro libro "Caring for the vulnerable: Perspectives in nursing theory, practice, and research", hanno evidenziato che la salute mentale ha una precipua natura politica e partecipativa (in particolare da parte dell'utenza). In linea con ciò, l'Organizzazione Mondiale della Sanità ha spesso sollecitato la politica al fine di creare uno spazio collaborativo in cui operatori e gruppi in difesa dei diritti dei fruitori dei servizi di salute mentale (advocacy groups) nonché l'ampia gamma di stakeholders possano impegnarsi nella direzione di una sinergia attenta alle mutue esigenze.

Inoltre, come accade in alcune circostanze, è importante il contributo politico nella decisione di finanziare studi volti ad analizzare e promuovere pratiche evidence-based, nel creare e diffondere standards condivisi e nel definire la razio organizzativa e gli obiettivi comunitari delle organizzazioni e delle istituzioni coinvolte nell'offerta di modelli di cura (Ko et al., 2008; Bateman & Anderson, 2013; Levy-Carrick et al., 2019).

Quanto detto finora riguarda la dimensione generale della politica sanitaria, ma riguarda anche quella locale in risposta a specifiche esigenze territoriali e, ancor più nello specifico, le politiche delle singole organizzazioni o servizi. Infatti, la letteratura che si occupa di TIC suggerisce che, "per attuare l'assistenza informata sul trauma, c'è bisogno di preparazione, valutazione e cambiamento organizzativo (Harris & Fallot, 2001, Rivard, Bloom, McCorkle, & Abramovitz, 2005) [...] L'implementazione di pratiche informate sul trauma è quindi basata sull'utilizzo di dati organizzativi individualizzati per informare la pianificazione e l'implementazione" (Hummer et al., 2010, p. 82). La capacità di supportare le politiche con i dati ricavati da efficaci impianti di ricerca è indubbiamente un elemento strategico prioritario e auspicabile (Levy-Carrick et al., 2019). Ad esempio, a livello di strumenti utili nell'analizzare quanto le policies organizzative siano orientate ai principi della TIC, il protocollo CCTIC elaborato da Fallot and Harris (2009) potrebbe essere particolarmente interessante nella misura in cui enuclea domini e sottodomini coinvolti nella valutazione di servizi e iniziative organizzative nell'ambito della cura del trauma.

In conclusione, quindi, adottare una prospettiva orientata alla TIC implica una sensibilità a quanto sottolineato da Levy-Carrick e colleghi (2019): "Aiutare i nostri pazienti e noi stessi richiederà un cambiamento critico di prospettiva che deve essere introdotto all'inizio della formazione, rafforzato in tutto, modellato dai suoi professionisti più anziani e promosso dalle generazioni future" (p. 107).

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Quiz 4.2

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Q4.2

3 points possible (graded)

1. L'approccio TIC:

- ○ Considera esclusivamente la dimensione psicologica di una persona
- ○ Considera esclusivamente la dimensione fisica di una persona
- ○ Considera esclusivamente la dimensione sociale di una persona
- ○ Promuove una presa in carico olistica della persona

2. Un intervento, per tenere in considerazione le best practices, dovrebbe:

- ○ Promuovere una valutazione approfondita e un monitoraggio costante delle competenze dello staff (utilizzo di procedure specificatamente progettate)
- ○ Evitare di porre attenzione alla storia degli utenti e alla sua associazione con sintomi o difficoltà correlati al trauma
- ○ Evitare di includere procedure di screening standardizzate ed evidence-based nella pratica clinica
- ○ Assicurarsi che lo staff interno continui sempre a eseguire le procedure su cui è stato formato inizialmente

3. Una buona proposta di ricerca...

- ○ Mantiene i suoi obiettivi più generali possibili
- ○ Formula le ipotesi di ricerca sempre dopo la raccolta dei dati
- ○ Effettua una analisi della fattibilità e definisce una timeline
- ○ Prevede sempre un campione stratificato

Invia

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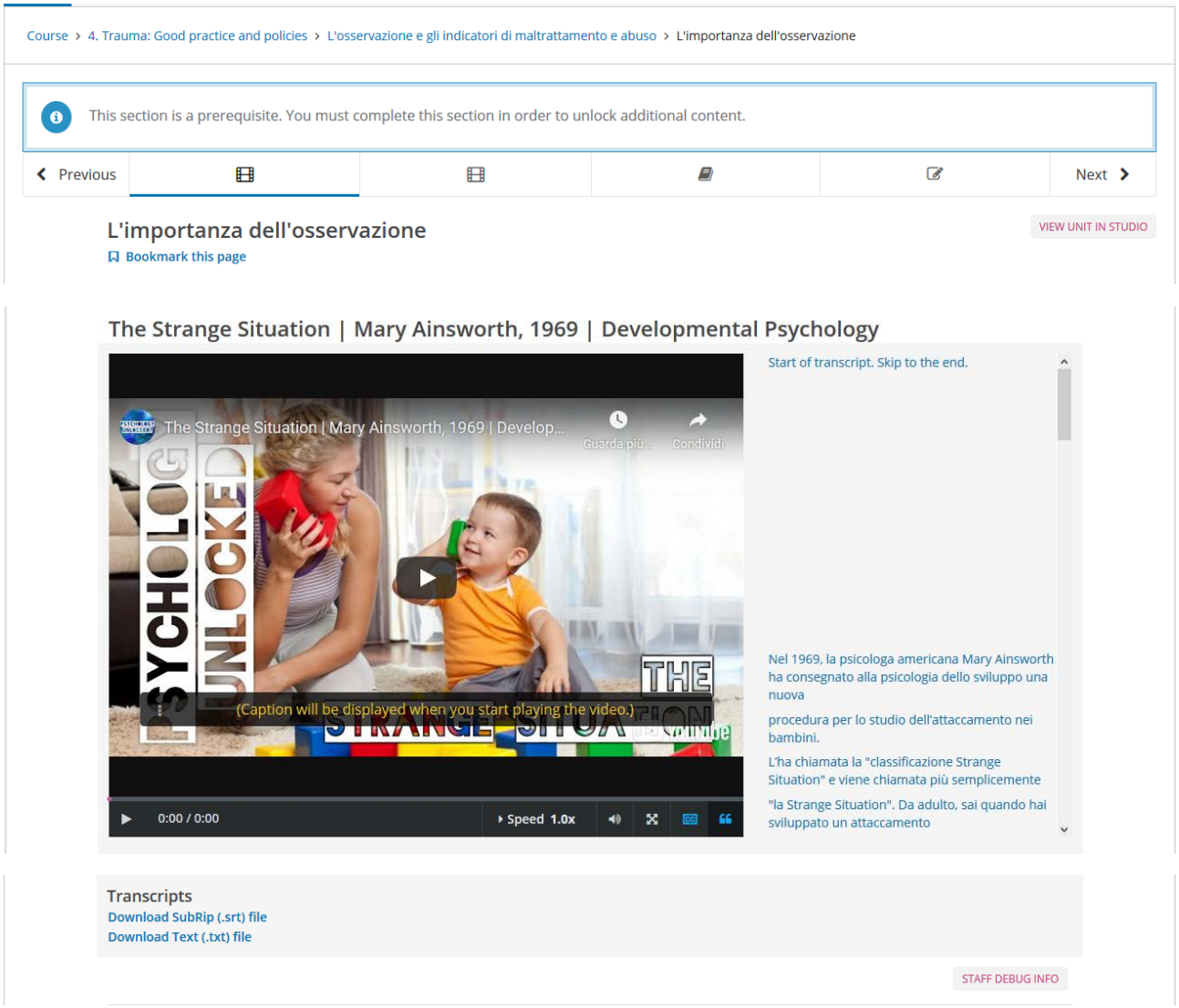

Transcript

Nel 1969, la psicologa americana Mary Ainsworth ha consegnato alla psicologia dello sviluppo una nuova procedura per lo studio dell'attaccamento nei bambini.

L'ha chiamata la "classificazione Strange Situation" e viene chiamata più semplicemente "la Strange Situation". Da adulto, sai quando hai sviluppato un attaccamento verso qualcuno. Sai come ci si sente, E sai come esprimere i tuoi sentimenti in parole. Tuttavia, quando si tratta di neonati e bambini, essi non hanno ancora sviluppato queste abilità, e dunque i ricercatori devono affidarsi a tecniche più sottili.

Come la strange situation, che misura la sicurezza di un attaccamento in bambini da uno a due anni. Una osservazione partecipatoria di 20 minuti durante la quale il ricercatore osserva le risposte comportamentali del bambino ad una serie di scenari.

La Strange Situation di Ainsworth include otto fasi, ognuna della durata di circa tre minuti

All’inizio, la madre, il bambino ed il ricercatore sono tutti insieme nella stanza,

Uno spazio piccolo e dai colori neutri con qualche giocattolo per far giocare il bambino.

Lo sperimentatore esce dopo circa un minuto e la madre ed il bambino rimangono soli per circa

tre minuti. In questa fase

i ricercatori stanno osservando per vedere se il bambino è abbastanza sicuro di sè da esplorare il nuovo ambiente

o se resta vicino alla madre. Uno sconosciuto si unisce al bambino e alla madre all’interno

stanza. I ricercatori registrano la risposta del bambino a questo insolito nuovo arrivato,

che viene lasciato da solo con il bambino quando la madre lascia la stanza.

In questa fase, i ricercatori stanno osservando il comportamento del bambino cercando segni di ansia da separazione.

Tre minuti dopo, la madre ritorna, ed

i ricercatori osservano la risposta di riunione del bambino. Lo sconosciuto lascia la stanza.

Ancora qualche minuto ed anche la madre lascia la stanza - lasciando il bambino da solo

per la prima volta da quando è iniziato l’esperimento. La persona successiva ad entrare nella stanza è lo sconosciuto,

e infine, dopo tre minuti, la madre ritorna e

lo sconosciuto esce, tutto sommato una situazione perfettamente strana per tutti i coinvolti.

Quindi, cosa stavano misurando i ricercatori? Quando la madre era nella stanza con il bambino,

hanno valutato il comportamento del bambino su quattro scale:

"Vicinanza e ricerca del contatto". "Mantenimento del contatto".

"Evitamento della vicinanza e del contatto" e "Resistenza al contatto e alla consolazione".

I comportamenti esploratori del bambino sono anche stati registrati mentre esplorava l’ambiente.

Ainsworth ha riferito che i bambini mostrano uno di tre tipi di attaccamento:

I bambini con attaccamento sicuro mostravano angoscia quando separati dalla loro madre, evitavano

lo sconosciuto quando erano soli, ma erano amichevoli in presenza della madre

ed erano felici quando la madre tornava dall’esterno della stanza.

Il 70% dei bambini studiati rientrava in questa categoria. Il 15% dei bambini mostrava un attaccamento ambivalente

con la loro madre. Questi bambini mostravano una forte angoscia quando

la madre usciva dalla stanza e dimostravano una importante paura dello sconosciuto.

Quando la madre tornava nella stanza, i bambini ambivalenti si avvicinavano alla madre

ma rifiutavano il contatto. Ainsworth ha riferito che un 15% finale

aveva uno stile di attaccamento evitante. Questi bambini non mostrano ansia quando la madre lascia la stanza e giocano felicemente con lo sconosciuto.

Quando la madre torna, i bambini evitanti sembrano a malapena accorgersene.

Nel 1990, Maine e Solomon hanno aggiunto che una percentuale molto piccola di bambini si mostrava inconsistente nel comportamento e hanno definito questo stile di attaccamento come "disorganizzato".

La “ipotesi della sensibilità del caregiver” di Ainsworth suggerisce che le diversità negli stili di attaccamento dipendano dal comportamento della madre verso il bambino durante un periodo critico dello sviluppo.

I clinici e i ricercatori sono costantemente alla ricerca della conoscenza su un particolare fenomeno, in modo più o meno sistematico. Tale desiderio di conoscenza nasce per interesse o per curiosità, da uno sguardo attento, attraverso l'occhio nudo o con l'aiuto di strumenti; utilizzando una sola parola, attraverso l' "osservazione".

Mantovani (1995) infatti definisce l'osservazione come: «[...] una forma di rilevazione finalizzata all'esplorazione di un determinato fenomeno» (p. 84).

L'osservazione è un'attività complessa e impegnativa che richiede:

- tempo;
- libertà intellettuale;
- assenza di pregiudizi e preconcetti,
- consapevolezza di sé;
- capacità di non coinvolgersi;
- capacità di sospendere;
- il giudizio

Nei contesti clinici e di ricerca l'osservazione acquisisce un'importanza rilevante, trasformandosi da metodo semplice e poco scientifico, a metodo flessibile, strutturato e affidabile (Venuti, 2001). Con il progredire degli studi sui bambini, per esempio, si è abbandonato l'utilizzo delle "biografie infantili", per dare spazio all'osservazione sistematica e alla sperimentazione (Bornstein, 2001). Infatti, con il tempo le osservazioni di tipo naturalistico hanno lasciato spazio alle osservazioni standardizzate (Bornstein, 2001).

Si potrebbe affermare, con le parole di Venuti (2001), che l'osservazione "[...] fa da ponte tra un modello esplicativo di riferimento e un successivo processo di analisi e di interpretazione dei dati" (p. 58). Per osservare, quindi, non basta più guardare un gruppo di bambini che interagiscono o videoregistrare i comportamenti tra madre e bambino; in quanto l'osservazione deve fare sempre riferimento ad un modello teorico ed esplicativo, che guiderà il ricercatore a formulare ipotesi e ad analizzare i dati (Venuti, 2001). Cosa osservare, come, dove e quando farlo, dipenderanno dallo scopo della ricerca e dall'approccio teorico di riferimento.

Esistono diversi tipi di osservazione:

- osservazione psicoanalitica, che ha come modello teorico la psicoanalisi;
- osservazione piagetiana, che ha come modello teorico la psicologia dello sviluppo;
- osservazione etologica, che ha come modello teorico l'etologia.

L'osservazione piagetiana è un tipo di osservazione quasi sperimentale, pone le sue basi sugli approcci teorici interazionista, strutturalista, cognitivista e approfondisce lo studio del percorso della vita mentale nel corso dello sviluppo (Vigna, 2002). Non si limita alla registrazione di tutto ciò che il bambino fa, ma è guidata da alcune ipotesi che costituiscono la base della teoria piagetiana. L'osservatore cerca di stabilire un'interazione con l'osservato in un contesto naturale (Petter, 1984; Vigna, 2002). I principi di base di questa osservazione sono due:

1. L'osservatore si adegua allo stadio di sviluppo del bambino e interagendo, modifica le condizioni stesse dell'osservazione;
2. L'osservatore riproduce ripetutamente una stessa situazione di gioco durante un'osservazione per valutare se la reazione del bambino si ripete in presenza di uno stesso stimolo e non è attribuibile a casualità.

I principali contesti applicativi di questo tipo di osservazione sono l'asilo nido e la scuola materna.

L'approccio etologico invece si ispira alla teoria dell'evoluzione di Darwin e al lavoro dell'etologo Lorenz. L'osservazione si definisce etologica quando l'osservatore non influenza in alcun modo il comportamento che è interessato a studiare e annulla il più possibile la propria soggettività. Di norma questa tecnica si applica nell'ambiente naturale in cui un determinato comportamento si manifesta spontaneamente. È possibile, però, utilizzare come ambiente il laboratorio, purché lo si attrezzi in modo da riprodurre un ambiente familiare per il bambino (ad es. una stanza da gioco).

È utile nell'indagine sui primi anni di vita, in cui il linguaggio verbale è ancora assente o

povero, per due ragioni:

1. è più facile definire qual è l'ambiente naturale di vita dei bambini piccoli;
2. i bambini piccoli non sempre si rendono conto di essere osservati e, comunque, non reagiscono modificando il proprio comportamento.

Questo tipo di osservazione mira all'esclusione della soggettività e al raggiungimento dell'obiettività che da sola consente di trarre conclusioni non fuorvianti (Lis & Venuti, 1986). In questo tipo di osservazione sono utilizzate delle procedure che consentono la registrazione e la catalogazione obiettiva e sistematica dei comportamenti, per poterli interpretare successivamente alla luce delle ipotesi iniziali. Tra i punti di forza dell'osservazione etologica emergono:

- un incremento di studi descrittivi del comportamento infantile;
- un'attribuzione di importanza alle ricerche longitudinali, considerate le più idonee a cogliere il processo di cambiamento e il suo significato evolutivo.

Tuttavia, l'enfasi sulla descrizione obiettiva può far dimenticare che quando si osserva è inevitabile operare delle scelte. Inoltre, l'importanza di rilevare micro-comportamenti, descrivibili in modo oggettivo, non può far perdere di vista il significato che un certo comportamento assume in un particolare momento e contesto.

L'osservazione psicoanalitica invece è un tipo di osservazione diretta, cioè di un metodo che non si avvale di alcun strumento al di fuori dell'osservatore stesso. Secondo il modello psicoanalitico non esistono fenomeni previsti in base a una teoria, "l'inatteso" (Bion ,1962) diventa rilevante. L'osservazione in questo caso ha la funzione principale di creare uno spazio dove l'inatteso possa esprimersi. Questo quadro non comporta nessuna intenzionalità da parte dell'osservatore per permettere di cogliere l'intenzionalità conscia e inconscia della persona osservata. Gli ambiti di applicazione sono:

- ricerca psicologica;
- clinica;
- formazione degli psicoterapeuti infantili e degli analisti.

L'osservatore è parte integrante della situazione e osserva sia i comportamenti che le verbalizzazioni, sia gli stati d'animo che le emozioni. Inoltre deve valutare con attenzione i propri stati psicologici come fonte d'informazione sul soggetto osservato, utilizzando la propria somiglianza per differenziare quest'ultimo da sé e accettando la propria presenza.

Infine si può osservare l'intero nucleo familiare attraverso compiti strutturati nel contesto clinico oppure nel proprio ambiente naturale. Questo tipo di osservazione può associarsi al colloquio con la famiglia ed ha l'intento di cogliere come i membri del nucleo interagiscono fra di loro e le comunicazioni a livello verbale e preverbale (forme di intersoggettività implicita).

In definitiva, l'osservazione è uno dei cardini fondanti la professionalità di chi opera in campo educativo e formativo, contribuisce a costituire un "atteggiamento di fondo" che diventa parte integrante del modo di agire professionale, quale elemento basilare della competenza educativa. Non è un semplice strumento, ma un insieme di atteggiamenti, metodologie, strumenti. Questi ultimi possono essere strutturati (videoregistrazione, griglie, checklist ecc.) o non strutturati (ad es. diario di bordo). L'osservatore dovrà quindi formarsi attraverso una fase di training, acquisire competenze e conoscenze specifiche per essere in grado di utilizzare questi strumenti e per rilevare il fenomeno che intende studiare (Venuti, 2001). I dati che si ricavano dall'osservazione possono essere sia qualitativi che quantitativi. Quelli qualitativi hanno una struttura narrativa (Hilliard, 1993), mentre quelli quantitativi si prestano a diverse misurazioni e analisi (per es. misurazione di frequenza e di durata, analisi sequenziali ecc).

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Indicatori di maltrattamento

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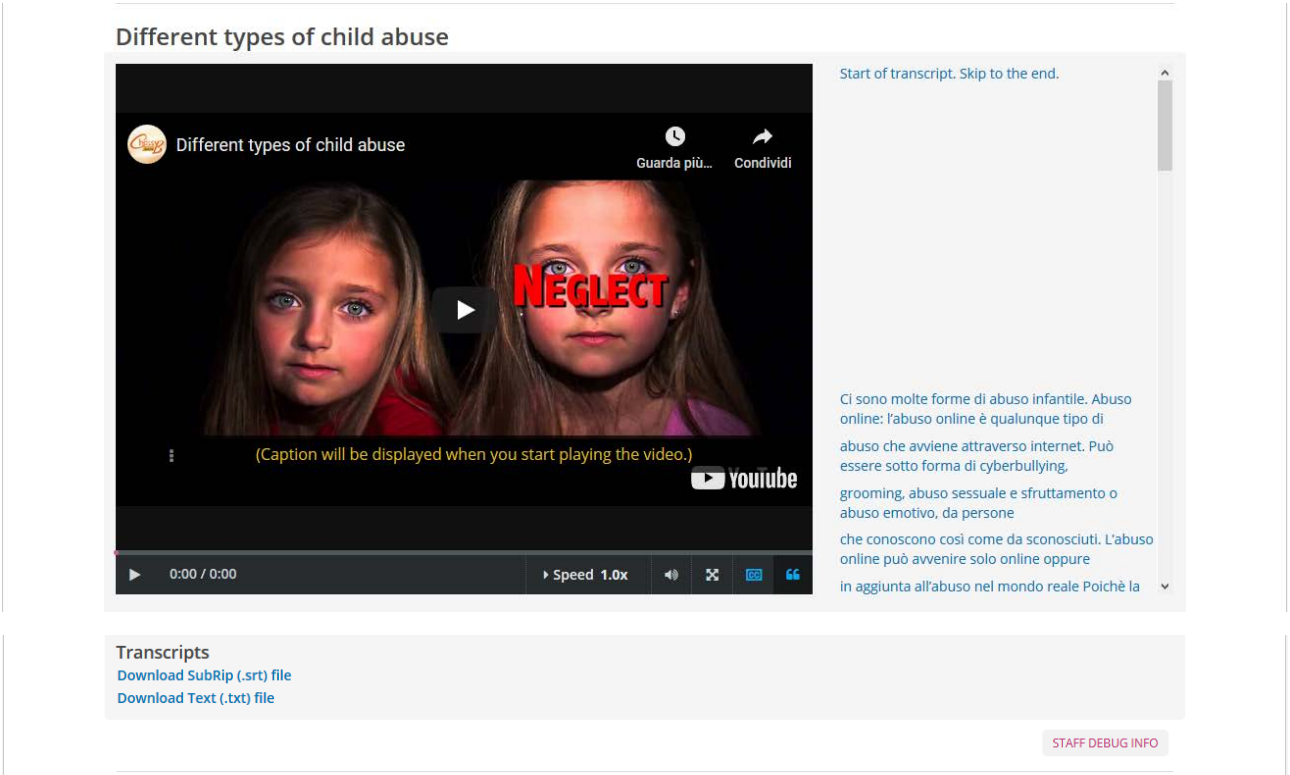
Schimmenti (2018) sottolinea come il trauma costituisca una lacerazione profonda per l'individuo che può impattare sui suoi processi psicologici condizionandone, a molteplici livelli, il funzionamento; in particolare esso comporta conseguenze relativamente al concetto di sé, alle modalità relazionali e al sistema di credenze. Inoltre, l'autore sottolinea che gli studi scientifici hanno messo in luce come spesso gli eventi che possono essere definiti traumatici siano interrelati tra loro e che l'esposizione a molteplici esperienze traumatiche aumenta il rischio di sviluppare una psicopatologia (trauma cumulativo), specialmente nel caso in cui questo sia avvenuto durante l'infanzia e, in particolar modo, nel contesto delle relazioni familiari. Anche Curran e colleghi (2018) mettono in evidenza questo aspetto nella letteratura scientifica, sottolineando come questo comporti:

1. per i soggetti in età infantile che sono stati vittime di molteplici esperienze traumatiche, un incremento nel rischio di esperire depressione e senso di impotenza (Arata et al., 2007) ;
2. a livello longitudinale in età adulta per i soggetti con storie di abuso fisico e psicologico, un decremento dell'autostima e delle capacità di coping rispetto alle emozioni (in particolar modo rabbia e aggressività), aumento di comportamenti sessuali devianti e di difficoltà di adattamento psico-sociale (Sesar et al., 2010);
3. per le vittime di abuso sessuale o fisico un maggiore rischio di avere difficoltà psicosociali e comportamenti asociali o antisociali, sintomi fisici cronici, disturbi ansiosi o depressivi, sintomatologie legate al trauma e alla dissociazione (Higgins e McCabe, 2000).
4. Inoltre, in adolescenza, la ricerca scientifica evidenzia anche un incrementato rischio di sviluppo di comportamenti delinquenziali, di abuso di sostanze e di ricorso a condotte anticonservative, specie nei soggetti con PTSD o storie di poli-vittimizzazione.

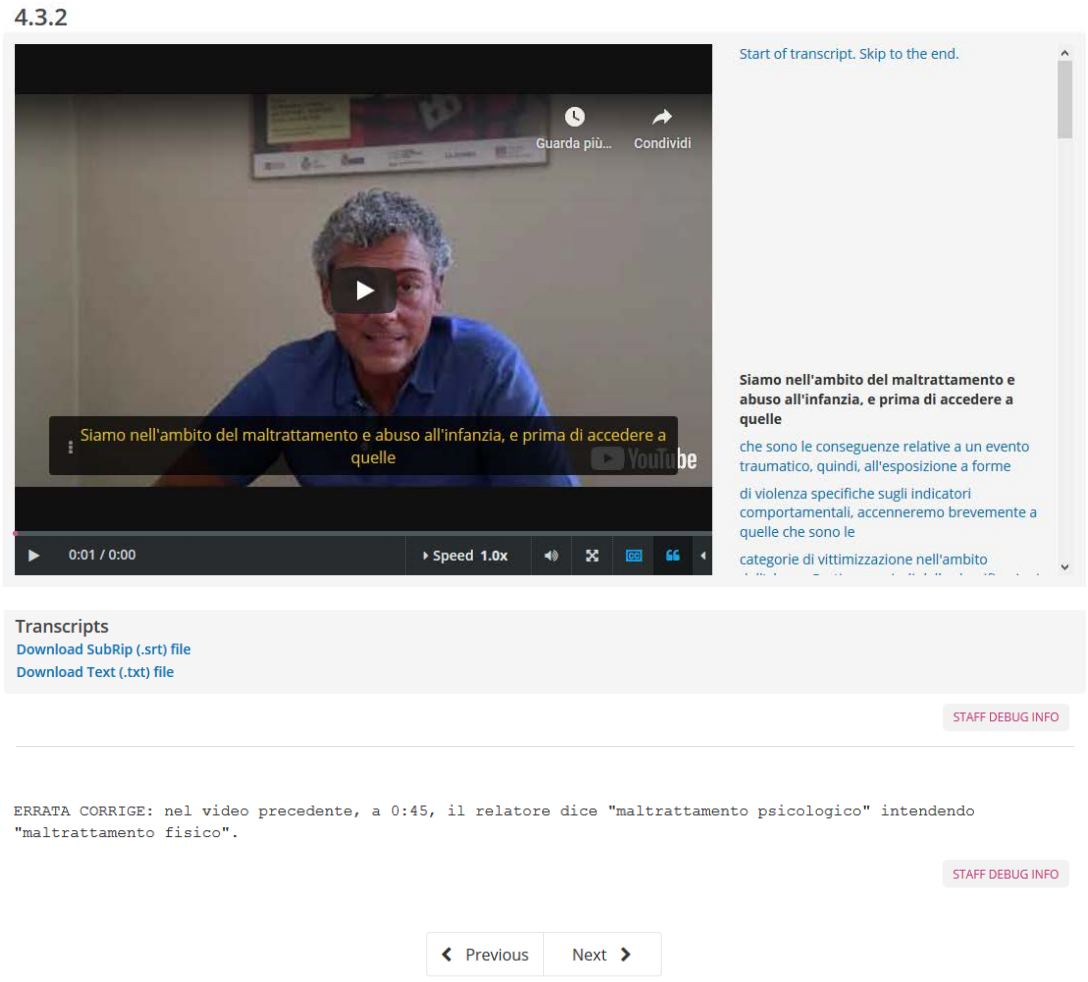
In generale, la ricerca suggerisce, da un punto di vista epidemiologico, la connessione tra trauma e gravità della menomazione; inoltre, se subito durante l'infanzia, esso può comportare gravi e invalidanti conseguenze sullo sviluppo delle capacità sia cognitive, sia emotive, sia sociali (Curran et al., 2018). Un aspetto che sembra particolarmente incidente sullo sviluppo e sugli esiti delle esperienze traumatiche nell'infanzia è la trascuratezza emotiva da parte delle figure di attaccamento – in particolare quelle aventi funzioni genitoriali - per il bambino (emotional neglect) (Schimmenti, 2018). Un'adeguata comprensione dei meccanismi sottostanti alla variabilità individuale nella risposta psicologica al trauma è importante sia per identificare i bambini esposti a rischi di distress a lungo termine, sia per strutturare idonei ed efficaci interventi (Ozer et al., 2003; Alisic et al., 2011). In particolare, è importante sottolineare che i minori reagiscono al trauma con modalità differenti rispetto agli adulti anche in ragione del loro livello di sviluppo e delle loro capacità comprese quelle di gestione dei contenuti mnestici e delle risposte emotive agli accadimenti. Già Lonigan e colleghi (1998) avevano sottolineato l'esigenza che la ricerca scientifica si concentrasse sull'analisi delle reazioni infantili al trauma e dei fattori ad esso associati. Una delle questioni da essi sollevate era la necessità di approfondimento degli indicatori – specificamente validi e affidabili per la popolazione infantile e non semplicemente mutuati dalle condizioni riscontrate in soggetti adulti - in merito alle reazioni normali versus psicopatologiche dei bambini agli eventi avversi. Un'interessante area di indagine è, infatti, quella riguardante la distinzione fra le reazioni tipiche al trauma e quelle condizioni in cui è possibile riscontrare una risposta psicopatologica con un focus particolare a quali sintomi consentano una visione differenziale tra le due condizioni e un miglioramento delle possibilità di efficace assessment da parte dei clinici (Lonigan et al., 1998). La letteratura offre molte informazioni sugli indicatori di maltrattamento e abuso, sottolineando che si tratta di segnali spesso aspecifici che vanno letti con attenzione e prudenza, poiché non sempre indicano esclusivamente la dimensione del maltrattamento. Occorre infatti che gli operatori migliorino sempre di più le loro capacità di cogliere la sofferenza del bambino nei contesti in cui si trovano, offrendogli le adeguate condizioni affinché si possa sentire accolto ed aiutato ad esprimere le sue emozioni e le sue difficoltà. Insieme alle tecniche di osservazione gli operatori possono utilizzare delle griglie di indicatori per approfondire il più possibile il problema. A titolo di esempio si allega il link al documento redatto dal CE.S.P.IM (Centro Servizi per il volontariato Provincia di Imperia) dal titolo "Il Silenzio dei Passerotti. Progetto per il contrasto ed il recupero del maltrattamento e abuso di bambini e bambine", in cui sono visionabili alcuni esempi di indicatori di maltrattamento e abuso



Transcript

Ci sono molte forme di abuso infantile. Abuso online: l'abuso online è qualunque tipo di abuso che avviene attraverso internet. Può essere sotto forma di cyberbullying, grooming, abuso sessuale e sfruttamento o abuso emotivo, da persone che conoscono così come da sconosciuti. L'abuso online può avvenire solo online oppure in aggiunta all'abuso nel mondo reale Poichè la tecnologia è ovunque, i bambini ed i giovani che soffrono per questa forma di abuso potrebbero sentirsi intrappolati e senza un posto in cui scappare, ovunque vadano, come la loro camera da letto, che dovrebbe essere un posto sicuro per loro. Grooming: il grooming è quando un adulto costruisce una connessione con un bambino allo scopo di abusarlo o sfruttarlo sessualmente. Questo può essere fatto online, o nel mondo reale, da uno sconosciuto o qualcuno che conoscono. Abuso sessuale: l'abuso sessuale è quando un bambino viene costretto o persuaso a partecipare in qualunque tipo di atto sessuale, e questo non deve essere necessariamente fisico. A volte il bambino potrebbe non essere cosciente del fatto che ciò che sta succedendo sia abuso o che ciò che sta succedendo è sbagliato. Abuso fisico: l'abuso fisico è fare deliberatamente del male ad un bambino, causando dunque danni come costole rotte, bruciature o tagli. Potrebbe essere calciato, preso a pugni, schiaffeggiato, avvelenato, bruciato, o potrebbero venirgli lanciati degli oggetti. I bambini possono essere scossi, a volte così violentemente che porta alla sua morte.

Neglect\Incuria: L’incuria è un fallimento continuo nel
soddisfare i bisogni più basilari di un bambino. I bambini lasciati affamati, non lavati o non adeguatamente vestiti, non protetti dalle intemperie o non supervisionati sono tutti esempi di bambini trascurati.
L’incuria può anche avvenire sotto forma di un genitore o badante che non protegge
un bambino da altri tipi di abuso. Bullismo:
il bullismo è un comportamento che ferisce qualcun altro, ad esempio gli insulti,
le spinte, la diffusione di pettegolezzi, le minacce o i sabotaggi. Questo può succedere ovunque,
anche nella loro stessa casa, e spesso lungo un periodo di tempo esteso.
L’abuso emotivo, anche conosciuto come abuso psicologico, quando un genitore o un badante
maltratta o trascura emotivamente un bambino in maniera costante, ad esempio
tentando deliberatamente di spaventare o umiliare un bambino oppure isolandolo o
ignorandolo. Comportamento sessuale dannoso: i bambini e le persone giovani che sviluppano un
comportamento sessuale dannoso danneggiano sè stessi e gli altri utilizzando
parole e frasi sessualmente esplicite, contatto inappropriato,
l’utilizzo di violenza sessuale e minacce oppure effettuando sesso penetrativo completo con altri
bambini o adulti. Lo sfruttamento sessuale infantile è un’altra forma di abuso
infantile. I bambini e i giovani che vengono sfruttati sessualmente sono persone vulnerabili
che vengono ingannate o manipolate nel credere di essere in una relazione amorevole, e sicura.
Potrebbe essere offerto loro del denaro o altre ricompense per poi farli finire
in schiavitù. Potrebbero essere stati adescati online e poi essere diventati completamente dipendenti dal
loro abusante, rendendo loro ancora più difficile andarsene.
Anche il traffico di bambini costituisce abuso infantile. I bambini possono essere venduti per manodopera a basso costo,
abuso sessuale, servitù domestica, frode per ottenere indennità e matrimonio forzato.



Transcript

Siamo nell'ambito del maltrattamento e abuso all'infanzia, e prima di accedere a quelle che sono le conseguenze relative a un evento traumatico, quindi, all'esposizione a forme di violenza specifiche sugli indicatori comportamentali, accenneremo brevemente a quelle che sono le categorie di vittimizzazione nell'ambito dell'abuso. Partiamo quindi dalle classificazioni internazionali relative al maltrattamento psicologico, definito anche "Emotional abuse" \ "Psychological abuse", abbiamo poi l'abuso fisico, e infine l'abuso sessuale.

Per maltrattamento psicologico, sono quelle esposizioni a forme di violenza caratterizzate proprio da un danno fisico a cui il bambino va incontro, quindi un evento traumatico molto molto forte perchè ha delle conseguenze sul processo di sviluppo, adesso vedremo a quali faccio riferimento. Per quanto riguarda l'esposizione invece a forme di violenza psicologica facciamo riferimento a insulti, a denigrazioni, a isolamento sociale del bambino, a una certa trascuratezza, e quindi sono quelle forme di violenza meno visibili ma che hanno un impatto psicologico, quindi un evento traumatico, a lungo termine.

Infine per quanto riguarda l'abuso sessuale facciamo riferimento a tutti quegli atti legati alla vittimizzazione, legati ad una esposizione fisica alla violenza, quindi ad un incesto, oppure sfioramenti, toccamenti vari da parte di chi si occupa del bambino in una situazione protetta. Ma vediamo quali sono le conseguenze relative all'abuso che può essere esercitato, delle forme di violenza a carico di un bambino. Vengono definiti in genere indicatori sia comportamentali sia emotivi. Le conseguenze a cui va incontro il bambino durante il suo percorso di sviluppo sono legate ad esempio a disturbi della percezione corporea, quindi della propria immagine corporea, proprio perchè non riesce a comprendere se il suo corpo è bambino o adulto perchè viene erotizzato fin dall'infanzia. Facciamo riferimento a ripetute difficoltà legate al sonno, quindi l'evento traumatico ha un impatto proprio sulla regolazione del ritmo sonno-veglia. Facciamo riferimento anche a disturbi dell'attenzione, e a difficoltà di concentrazione e di attenzione a livello scolastico. Se i bambini sono più piccoli quindi nella fascia 3-5 anni, sono presenti anche disturbi dell'evacuazione. In piena adolescenza facciamo riferimento invece ad altre manifestazioni di disagio che il bambino o il ragazzo esprime come ad esempio disturbi dell'alimentazione, inclusi anoressia e bulimia, atti di aggressività esplicita verso tutti i soggetti che tendono ad esprimere un comportamento di natura attenzionale verso il bambino, quindi il bambino si difende con l'aggressività esplicita. Infine atti di autolesivismo, proprio perchè c'è una sofferenza insita, interna al bambino per l'evento traumatico subito, che quindi reagisce con l'arrecare danno a se stesso oltre che naturalmente ad altri soggetti. Queste alcune delle conseguenze di esposizione ad eventi traumatici nell'infanzia, nella fanciullezza e nella adolescenza, ma sono molteplici quelle indagate dalla letteratura, abbiamo anche difficoltà di apprendimento, isolamento e comportamenti antisociali come uso e abuso di sostanze alcoliche e stupefacenti, comportamenti sessuali promiscui, esposizione a particolari malattie sessualmente trasmissibili. Quindi, questo ci fa comprendere quanto una normale traiettoria di un percorso di sviluppo non va a buon fine perchè chi si occupa del bambino e ha funzione di child care tende ad esprimere quelle forme di maltrattamento fisico accertate in precedenza, quindi legate al picchiare e infliggere volontariamente dolore al bambino, o di natura sessualizzata, quindi, l'erotizzare il corpo del bambino per degli sfoghi personali, o di natura psicologica come l'umiliare, isolare e denigrare il bambino, ha un evento di tipo traumatico sul bambino con le conseguenze che abbiamo appena indicato. Conseguenze che poi sono indicatori di natura

comportamentale ma anche emotiva che altro non esprimono che un disagio che il bambino sta vivendo in quello specifico momento e sul quale è necessario intervenire precocemente prima che le conseguenze diventino sempre più traumatiche ed insite nello sviluppo della personalità del soggetto, con conseguenze di natura, naturalmente, psicopatologica.

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Quiz 4.3

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Q4.3

4 points possible (graded)

1. L'osservazione viene definita come (Mantovani, 1995):

- ○ Una forma di rilevazione finalizzata all'esplorazione di un determinato fenomeno
- ○ Un momento intermedio tra un fenomeno e la sua interpretazione
- ○ La descrizione di una specie all'interno di un catalogo
- ○ Un modo oggettivo e fedele di registrare la realtà

2. Durante l'osservazione, è importante:

- ○ Evitare a tutti i costi di essere coinvolti nell'interazione con l'oggetto dell'osservazione
- ○ Utilizzare sempre strumenti osservativi strutturati
- ○ La velocità di giudizio
- ○ Evitare di farsi influenzare da pregiudizi e preconcetti

3. In un minore, la presenza di indicatori e segni associati a maltrattamento e abuso...

- ○ Può essere dedotta attraverso l'osservazione di emozioni e comportamenti
- ○ Andrebbe considerata senza tener conto dei comportamenti
- ○ Corrisponde, in ogni caso, a situazioni di maltrattamento e abuso
- ○ Si traduce nella decadenza immediata della responsabilità genitoriale

4. Secondo Schimmenti (2018), le esperienze traumatiche...

- ○ Sono sempre facilmente superabili parlando con amici e familiari dell'evento
- ○ Aumentano la probabilità di sviluppare una psicopatologia, particolarmente quando il soggetto è sottoposto ad una esposizione multipla (trauma cumulativo)
- ○ Non provocano danni se si tratta di un singolo evento, grazie alla neuroplasticità
- ○ Andrebbero represse, cercando di non pensarci

Invia

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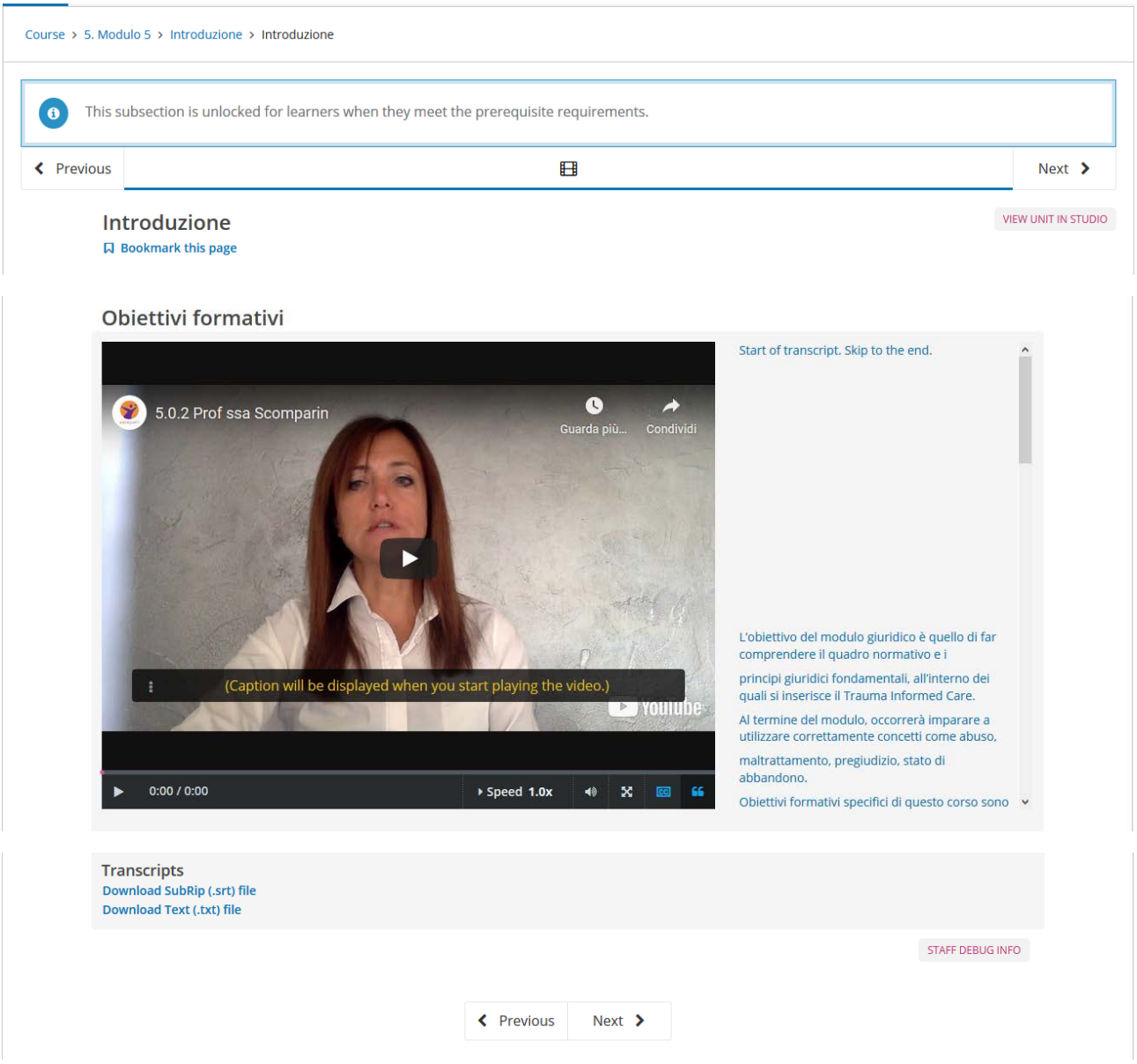

Transcript

L'obiettivo del modulo giuridico è quello di far comprendere il quadro normativo e i principi giuridici fondamentali, all'interno dei quali si inserisce il Trauma Informed Care.
Al termine del modulo, occorrerà imparare a utilizzare correttamente concetti come abuso, maltrattamento, pregiudizio, stato di abbandono.
Obiettivi formativi specifici di questo corso sono conoscere il processo culturale e giuridico che ha portato, a livello mondiale ed europeo, al riconoscimento che le persone di minore età sono soggetti di diritti e che esiste un obbligo per lo Stato di intervenire prontamente ed efficacemente per la loro protezione in caso di maltrattamenti.
Nel modulo giuridico, imparerete anche a conoscere i diritti e i principi fondamentali posti dal quadro normativo internazionale ed europeo vigente in materia di diritti dell'infanzia

e dell’adolescenza,
un quadro all’interno del quale si inserisce il Trauma Informed Care;
con particolare riguardo al diritto di bambini e ragazzi a essere informati ed
essere ascoltati nelle procedure in cui si decida della loro assistenza, delle loro cure
e del loro futuro, anche dopo la cessazione della presa in carico da parte dello Stato.
Nel modulo giuridico imparerete anche a conoscere e comprendere come funzionano i dispositivi
normativi che garantiscono la partecipazione dei minorenni, che abbiano subito maltrattamenti,
ai procedimenti decisionali, siano essi amministrativi o giudiziari, in cui si decida degli interventi
per la loro protezione;
quindi, il diritto ad esempio del minore, capace di discernimento,
di essere ascoltato e, in alcuni casi, il dovere di ottenere anche il consenso del ragazzo
per poter attivare lo strumento di protezione.
Infine, una parte del modulo sarà dedicata
alle ricadute operative sulle politiche sociali e sanitarie del children’s rights based approach
e questo avverrà sia attraverso una panoramica generale, sia attraverso alcuni
casi di studio; quindi, ad esempio, attraverso l’analisi delle politiche di contrasto attivate
contro le pratiche di mutilazione genitale femminile, o contro l’utilizzo delle punizioni
corporali in famiglia, o, ancora, attraverso l’analisi delle politiche che molti Paesi
hanno adottato per nominare un tutore come assistente o supporto ai minori stranieri
non accompagnati.

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Glossario giuridico sul trauma all'infanzia

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Il termine "trauma" non viene comunemente utilizzato nel linguaggio giuridico.

La Convenzione internazionale sui diritti dell'infanzia e dell'adolescenza (CRC) per esempio fa riferimento a "ogni forma di violenza, di oltraggio o di brutalità fisiche o mentali, di abbandono o di negligenza, di maltrattamenti o di sfruttamento, compresa la violenza sessuale" (articolo 19)

ABUSO e MALTRATTAMENTI:

Il Consiglio d'Europa definisce come **abuso all'infanzia (child abuse)**: «gli atti e le carenze che turbano gravemente il bambino, attentano alla sua integrità corporea, al suo sviluppo fisico, intellettivo e morale, le cui manifestazioni sono la trascuratezza e/o le lesioni di ordine fisico e/o psichico e/o sessuale da parte di un familiare o di altri che hanno cura del bambino» (IV Seminario Criminologico – Strasburgo, 1978)

L'Organizzazione mondiale della sanità afferma che: "per **abuso all'infanzia e maltrattamento (child abuse, maltreatment)** debbano intendersi tutte le forme di cattiva salute fisica e/o emozionale, abuso sessuale, trascuratezza o negligenza o sfruttamento commerciale o altro che comportano un pregiudizio reale o potenziale per la salute del bambino, per la sua sopravvivenza, per il suo sviluppo o per la sua dignità nell'ambito di una relazione caratterizzata da responsabilità, fiducia o potere " (Organizzazione Mondiale della Sanità, World Report on Violence and Health, 2002).

Sia gli abusi, sia i maltrattamenti possono concretizzarsi in:

- condotte attive (esempio percosse, lesioni, atti sessuali, sfruttamento)
- condotte omissive (esempio incuria, trascuratezza, negligenza).

L'assenza di evidenze traumatiche nel fisico non esclude l'ipotesi di maltrattamento o abusi. Ad esempio può integrare **abuso** la condotta dell'insegnante / genitore che umilia, svaluta, denigra o violenta psicologicamente un minore o una minaccia, quando costituisca una *violenza psicologica che possa causare un danno alla salute psico-fisica del minore e ne leda la dignità.*

Con i termini **VIOLENZA** e **SFRUTTAMENTO** (**violence and exploitation**) si fa usualmente riferimento a condotte commissive realizzate a danno del minore.

Lo **sfruttamento**, in particolare, può essere di natura economica o di natura sessuale

- articolo 32 (CRC): "Gli Stati parti riconoscono il diritto del fanciullo di essere protetto controllo sfruttamento economico e di non essere costretto ad alcun lavoro che comporti rischi o sia suscettibile di porre a repentaglio la sua educazione o di nuocere alla sua salute o al suo sviluppo fisico, mentale, spirituale, morale o sociale."
- articolo 34, comma 1 (CRC): "Gli Stati parti si impegnano a proteggere il fanciullo contro ogni forma di sfruttamento sessuale e di violenza sessuale."

Il Comitato delle Nazioni Unite per i diritti dell'infanzia e dell'adolescenza stabilisce che per "**violenza**" s'intenda "ogni forma di violenza fisica o mentale, lesione o abuso, trattamento negligente o d'abbandono, maltrattamento o sfruttamento, incluso l'abuso sessuale". Nel linguaggio comune il termine violenza è spesso utilizzato per designare solo il danno fisico e/o il danno intenzionale. Tuttavia, il Comitato pone una forte enfasi sul fatto che la scelta del termine violenza nel presente commento generale non deve essere interpretata in nessun modo come volta a minimizzare l'impatto o il bisogno d'affrontare forme di danno non fisiche e/o non intenzionali (come, fra le altre, l'abbandono e il maltrattamento psicologico) (Il diritto del minore alla libertà da ogni forma di violenza General comment n. 13 (2011) CRC/C/GC/13, 18 aprile 2011).

Infine, con l'espressione **STATO DI ABBANDONO** si indica una situazione di grave e permanente inadeguatezza dei genitori a prendersi cura del minore in conseguenza di una **negligenza (neglect or negligent treatment)** o gravi violenze o sfruttamenti.

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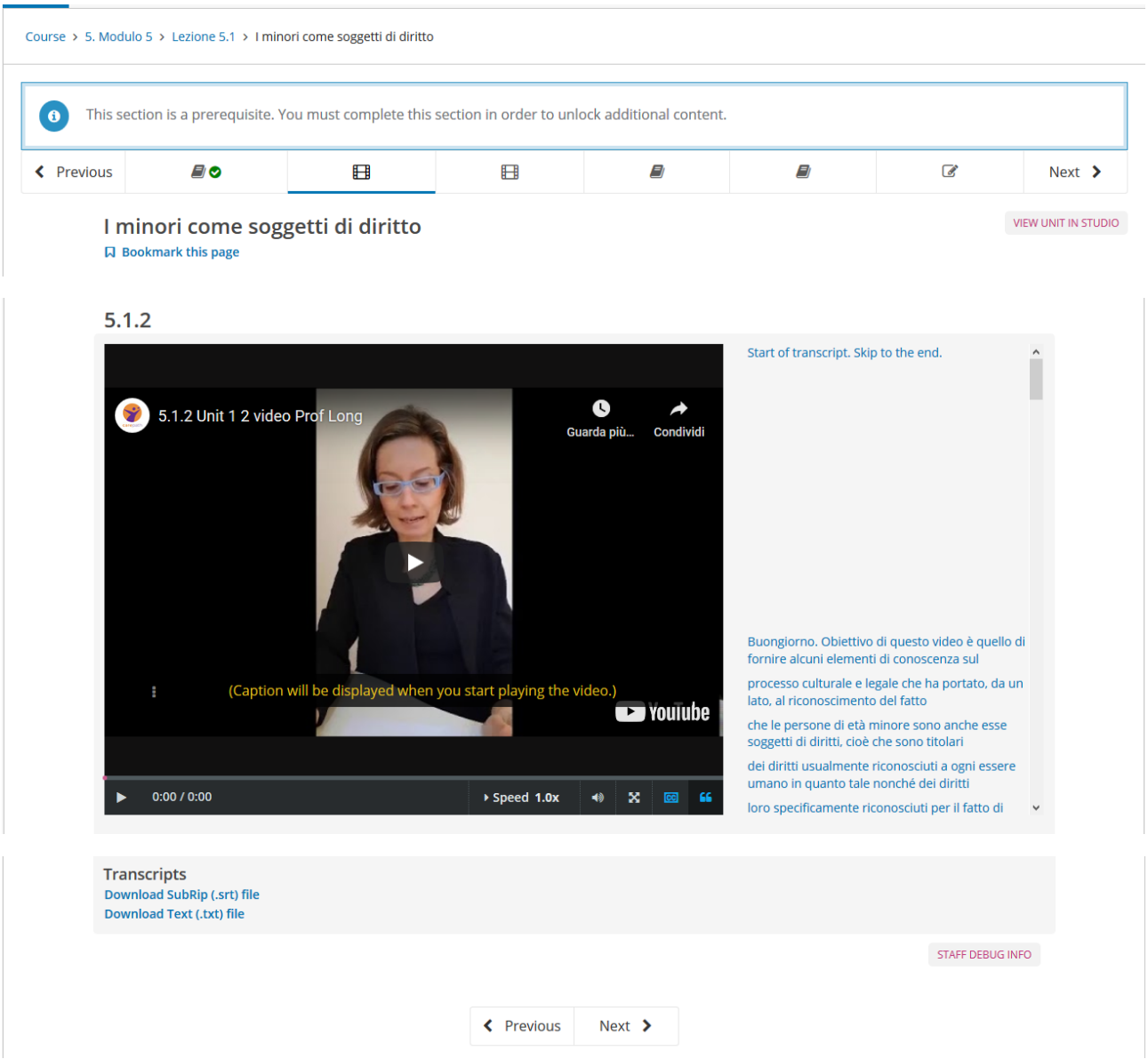

Transcript

Buongiorno. Obiettivo di questo video è quello di fornire alcuni elementi di conoscenza sul processo culturale e legale che ha portato, da un lato, al riconoscimento del fatto che le persone di età minore sono anche esse soggetti di diritti, cioè che sono titolari dei diritti usualmente riconosciuti a ogni essere umano in quanto tale nonché dei diritti loro specificamente riconosciuti per il fatto di essere soggetti in formazione; in secondo luogo, il percorso che ha portato il riconoscimento dell'esistenza di un dovere dello Stato di intervenire a protezione e a promozione dei diritti delle persone di età minore che siano vittime di violenza e maltrattamenti. Per inquadrare l'argomento leggo alcune righe tratte da un libro del 2006, intitolato "La vita e le regole", edito da Feltrinelli in Italia. L'autore è Stefano Rodotà, giurista, politico italiano, tra gli autori

della Carta europea dei diritti fondamentali. Scrive Rodotà:

“la regola giuridica non

può essere pensata come ciò che rimuove il dolore dal mondo, ma come uno dei criteri

che segnano la soglia del dolore tollerabile, personalmente e socialmente.

Mi pare che questo testo ci aiuti a inquadrare il tema della reazione dello Stato di fronte

al maltrattamento dell’infanzia perché evidenzia: anzitutto, che il diritto non è

onnipotente. E questo significa che anche se esistono delle norme giuridiche che reprimono

la violenza e i maltrattamenti nei confronti dell’infanzia e che cercano di prevenirli,

non per questo, purtroppo, violenza e maltrattamenti non si verificano nella pratica.

Oltre a ciò occorre ammettere che non sempre, in concreto, quando queste violenze e maltrattamenti si

verificano lo Stato riesce ad attivare un intervento tempestivo ed efficiente.

Oltre a ciò, le brevi righe del testo di Rodotà ci aiutano a riflettere sulla soglia

per l’intervento dello Stato, in generale per la protezione dei soggetti che si trovano

in gravi condizioni di disagio e poi, nello specifico, a sostegno dei minori vittime di

maltrattamenti. Ecco, questa soglia può essere individuata nell’attacco, nella violazione

della dignità umana. Quindi, l’intervento dello Stato deve verificarsi quando la soglia

del dolore è così alta da pregiudicare la dignità stessa dell’essere umano e la ratio

dell’intervento dello Stato in questi casi deve essere individuata nel generale dovere

di solidarietà sociale che porta, una delle funzioni del diritti, tutela delle libertà

individuali e tutela specifica dei soggetti in condizione di vulnerabilità.

Ma veniamo ora alle tappe fondamentali di questo percorso che ha condotto al riconoscimento

del minore come soggetto di diritti e al dovere dello Stato di protezione dei minori vittime

di maltrattamenti.

Una prima data fondamentale può essere individuata

nel 1874. In quell’anno nella città di New York, negli Stati Unti, si tiene il processo

ai danni di una donna, la madre di una bambina di nome Mary Ellen Wilson.

Il caso di Mary Ellen Wilson è un caso giudiziario che suscita molto clamore perché pone il luce l’inesistenza

di un sistema pubblico di protezione dell’infanzia e fu proprio il caso specifico che portò

alla creazione della prima charity specializzata in materia: la New York Society for the prevention

of Cruelty to children. Cos’era successo?

I vicini di casa avevano

segnalato a una missionaria metodista, di nome Etta Wheeler, che una bambina dell’apparente

età di 5 anni (Mary Ellen, appunto, che risulterà poi avere 10 anni) era vittima di maltrattamenti da parte della madre. Etta Wheeler entra nell'abitazione con la scusa di chiedere aiuto per una vicina che aveva una disabilità cronica. Con la scusa di chiedere aiuto per una vicina
Etta Wheeler entra nella casa dei genitori di Mary Ellen e può così verificare in prima persona la situazione della bambina, che trova effettivamente essere vittima di maltrattamenti, sia di natura fisica, perché presentava ustioni, ematomi, dei tagli sul corpo e anche un abbigliamento non adatto alla stagione; ma anche maltrattamenti di carattere psicologico, perché la bambina per esempio, per molte ore al giorno era spesso costretta a stare rinchiusa in un armadio, nonché non poteva uscire in strada, se non nel cortile del palazzo notte tempo.
Etta Wheeler contatta l'ente locale, cerca di ottenere dalle autorità locali l'allontanamento della bambina dalla casa familiare, ma gli enti locali rifiutano in assenza di un quadro giuridico che tale allontanamento consentisse. Etta Wheeler non demorde: chiede e ottiene l'aiuto di un avvocato specializzato in protezione degli animali dalle crudeltà e utilizzando questo quadro normativo riesce ad ottenere l'obiettivo di allontanare la bambina dalla casa e, come dicevo, nel 1874 viene anche celebrato il processo che si concluderà con la condanna della madre a un anno di reclusione per i maltrattamenti subiti da Mary Ellen.
Andando per tappe molto ampie un'altra data significativa nel processo di affermazione dei diritti dell'infanzia è il 1924. Questa volta siamo in Europa, nella città di Ginevra.
La Società delle Nazioni proclama la Carta, la Dichiarazione cosiddetta "di Ginevra", la Dichiarazione dei diritti del fanciullo. È ancora una Carta che è fortemente incentrata sulle necessità materiali e affettive dei minori e i minori sono concepiti essenzialmente come destinatari passivi dei diritti. Per fare un esempio, la Dichiarazione recita:
"Il fanciullo che ha fame deve essere nutrito; il fanciullo malato deve essere curato".
Occorrerà aspettare qualche decennio per arrivare a una nuova Carta, la Dichiarazione universale de diritti del fanciullo, Dichiarazione di New York del 1959, questa volta nell'ambito delle Nazioni Unite, per arrivare a un documento in cui vengono riconosciuti i minori come soggetti di diritto, e quindi si introduce il concetto che anche il minore, al pari di ogni essere umano, può essere direttamente titolare di diritti. Nel principio primo, per esempio, si legge: "il fanciullo deve godere di tutti i diritti enunciati nella presente dichiarazione". E poi, per esempio, il principio terzo: "il fanciullo ha diritto, sin dalla nascita, a un nome e una nazionalità". Questa formulazione in termini di diritti dell'infanzia viene poi ripresa nel documento più noto a livello mondiale sui diritti dell'infanzia

che è la Convenzione delle Nazioni Unite del 1989.

Ho sottolineato il termine “convenzione”

perché questa rappresenta una prima importante novità rispetto ai documenti del 1924 e del 1959. La Convenzione del 1989 è un documento che è vincolante per gli Stati che l’hanno ratificata, diversamente invece dalla Dichiarazione che è un atto dotato di un’efficacia meramente programmatica e, dunque, persuasiva per gli Stati che ne erano i destinatari.

La Convenzione del 1989 si segnala anche per l’istituzione di un meccanismo di monitoraggio e di controllo che è incentrato sul Comitato dei diritti dei fanciulli che ha sede a Ginevra e che esamina i rapporti periodici che vengono presentati dagli Stati membri sull’implementazione della Convenzione all’interno degli ordinamenti nazionali. Per quanto concerne l’articolato vengono al minore riconosciuti tutti i diritti riconosciuti in generale dalle Carte internazionali agli esseri umani, più alcuni specifici diritti che spettano ai minori in quanto soggetti in formazione. In tema di maltrattamento all’infanzia segnalo, in particolare, l’articolo 19 che tutela “il fanciullo contro ogni forma di violenza” in ambito familiare;

poi l’articolo 34, “protezione contro sfruttamento e violenza sessuale”; il 35 “protezione del minore contro rapimento, vendita e tratta”; il 37 “protezione contro tortura, pene o trattamenti inumani e crudeli”; e poi l’articolo 39,

assai rilevante perché stabilisce che: “Gli Stati parti adottano ogni adeguato provvedimento per agevolare il recupero fisico e psicologico e il reinserimento sociale di ogni fanciullo vittima di maltrattamenti”.

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Il caso Mary Ellen

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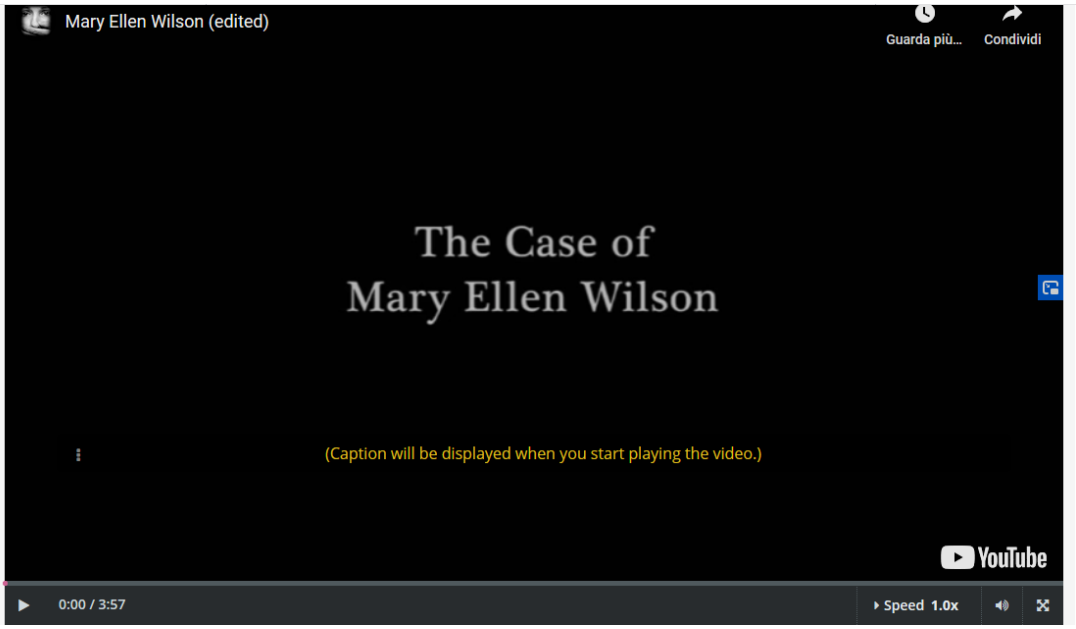
5.1.3



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CAUSA Z E ALTRI contro REGNO

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CAUSA Z E ALTRI contro REGNO UNITO

sentenza10 maggio 2001

IL FATTO

La causa trae origine da una domanda contro il Regno Unito presentata dai ricorrenti il 9 ottobre 1995.

I ricorrenti, Z, A, B e C, erano quattro fratelli di età compresa tra i sette e i tredici anni che lamentavano la violazione degli articoli 3, 6, 8 e 13 della Convenzione europea dei diritti dell'uomo in ragione del fatto che l'autorità locale non aveva adottato misure adeguate per proteggerli dalla negligenza e dagli abusi di cui erano stati vittime.

La famiglia veniva segnalata per la prima volta ai servizi sociali nell'ottobre 1987 dal loro assistente sanitario, preoccupato per le condizioni dei bambini e i problemi tra i coniugi.

La famiglia veniva riesaminata in un ulteriore incontro nel marzo 1988 e, poiché sembrava che le preoccupazioni fossero diminuite, il fascicolo veniva chiuso.

Successivamente, veniva riferito da un vicino che i bambini rimanevano chiusi fuori casa per gran parte della giornata. A ciò si aggiungeva la circostanza, riferita dalla polizia e confermata dal medico di famiglia, secondo cui le camere dei bambini erano sporche e, secondo il medico, le porte delle camere dei bambini erano spesso chiuse a chiave.

In una riunione di professionisti del 4 ottobre 1989, alla quale avevano partecipato i servizi sociali, il dirigente scolastico, i medici dei richiedenti e il personale sanitario, veniva deciso che nessun assistente sociale sarebbe stato incaricato di seguire la famiglia; si stabiliva che la scuola dovesse monitorare il peso dei bambini più grandi e l'assistente sanitario dovesse continuare a visitare regolarmente la famiglia.

Il 13 dicembre 1989, l'assistente sanitario chiedeva che i quattro bambini fossero iscritti nel Registro di protezione del bambino - elenco confidenziale di bambini che sono a rischio continuo di abuso fisico, emotivo o sessuale o negligenza - poiché riteneva che la madre non potesse offrire loro cure adeguate. Questo suggerimento veniva respinto; alla famiglia veniva assegnata un'assistente sociale, la signora M.

In un'ulteriore riunione dei professionisti, il 3 ottobre 1990, l'assistente sociale, M., dichiarava di essere preoccupata per la sporcizia dei ricorrenti e per la mancanza di interesse della madre: i bambini defecavano nella loro camera da letto e spalmavano escrementi sulle loro finestre.

A causa della preoccupazione per i bambini, in una riunione di professionisti del 5 dicembre 1990 veniva presa la decisione di organizzare una conferenza per il caso nel gennaio 1991.

Alla successiva riunione tenutasi il 28 gennaio 1991, la sig.ra M. dichiarava che la camera dei ragazzi non aveva luce, tappeti o giocattoli e che la loro biancheria da letto era bagnata, puzzolente e macchiata di terra. Il loro dirigente scolastico affermava che Z spesso piangeva, A saccheggiava i bidoni della spazzatura della scuola ed era spesso sporco, e B appariva desiderosa di attenzione e affamata.

All'esito di queste dichiarazioni si concludeva tuttavia che, nonostante le numerose preoccupazioni in merito alle capacità accuditive dei genitori dei ricorrenti e alle condizioni della casa, si riteneva che i genitori non trascurassero volontariamente i loro figli e che, data la loro scarsa educazione, stessero facendo ciò che potevano ma che fosse necessario un sostegno continuo per cercare di migliorare la situazione. Veniva comunque deciso di non iscrivere i bambini nel Registro di protezione del bambino.

Il 10 giugno 1992 la madre dei ricorrenti chiedeva aiuto per l'assistenza dei figli, dichiarando che se i bambini non fossero stati allontanati li avrebbe picchiati.

I ricorrenti venivano posti in affidamento di emergenza ed iscritti al Registro di Protezione del bambino sotto le categorie di abbandono e abuso emotivo dopo una riunione di protezione dei bambini del 22 giugno 1992.

L'8 ottobre 1992 l'autorità locale decideva di chiedere l'allontanamento dei bambini. Le ordinanze cautelari venivano emesse il 7 dicembre 1992.

Tutti i ricorrenti venivano visitati dalla dott.ssa Black, una consulente psichiatra infantile, nel gennaio 1993. La consulente dichiarava che i tre bambini più grandi mostravano tutti segni di disturbo psicologico. Z esibiva segni di grave malattia depressiva e si era assunta la responsabilità della sua famiglia e della rottura della stessa. La madre aveva tenuto nei suoi confronti un comportamento descritto come crudele ed emotivamente offensivo. A e B erano stati entrambi identificati come affetti da disturbo da stress post-traumatico. La consulente evidenziava che tutti i bambini erano stati privati di affetto e cure fisiche e qualificava la vicenda come il peggiore caso di negligenza di cui si fosse occupata nella sua carriera professionale.

Nel giugno 1993 i ricorrenti, assistiti da un avvocato, iniziavano un'azione legale contro l'autorità locale. L'avvocato domandava il risarcimento dei danni subiti per negligenza e/o violazione dei doveri legali sostenendo che l'autorità, contrariamente a quanto previsto dalla legge, non aveva tenuto in considerazione il benessere dei fratelli: le autorità locali avrebbero dovuto agire in modo più rapido e l'omesso intervento delle istituzioni aveva fatto sì che i ricorrenti riportassero gravi danni psicologici.

La richiesta veniva respinta sia dal Giudice di primo grado, sia dalla Corte di appello.

I ricorrenti presentavano allora ricorso alla House of Lords.

Il 29 giugno 1995 la House of Lords respingeva il ricorso, ritenendo che non fosse possibile alcuna azione nei confronti dell'autorità locale per negligenza o violazione degli obblighi statutari relativi allo svolgimento di compiti volti al benessere dei bambini ai sensi della legge sui minori del 1989.

LA DECISIONE DELLA CORTE

La Corte afferma all'unanimità che sussiste una violazione dell'articolo 3 della Convenzione; che nessuna questione separata sorge a norma dell'articolo 8 della Convenzione; con dodici voti contro cinque stabilisce che non vi è stata violazione dell'articolo 6 della Convenzione; infine, con quindici voti contro due, decide che sussiste una violazione anche dell'articolo 13 della Convenzione.

IL PERCORSO ARGOMENTATIVO DELLA CORTE

SULLA VIOLAZIONE DELL'ARTICOLO 3 DELLA CONVENZIONE ("nessuno può essere sottoposto a tortura o a trattamenti o punizioni disumane o degradanti")

I ricorrenti affermavano che l'autorità locale non era riuscita a proteggerli da trattamenti inumani e degradanti vietati dall'art. 3 della Convenzione.

La Corte ricorda che l'articolo 3 della Convenzione sancisce uno dei valori fondamentali delle società democratiche e vieta in termini assoluti la tortura e le pene o trattamenti inumani o degradanti. Gli Stati che hanno ratificato la Convenzione europea dei diritti dell'uomo hanno l'obbligo di adottare misure per impedire che le persone sotto la loro giurisdizione siano sottoposte a tortura o a pene o trattamenti inumani o degradanti. Queste disposizioni devono fornire una protezione efficace per i bambini e altre persone vulnerabili e includere misure ragionevoli per prevenire maltrattamenti di cui le autorità sapevano o avrebbero dovuto essere a conoscenza.

Nel caso in esame non vi è alcun dubbio che la negligenza e l'abuso subiti dai quattro figli richiedenti siano tali da poter essere qualificati come trattamenti inumani e degradanti.

Tali trattamenti erano stati portati all'attenzione dell'autorità locale già nell'ottobre 1987.

L'autorità aveva l'obbligo di proteggere i bambini e disponeva di una serie di mezzi a tal fine, tra cui il potere di allontanare i bambini dalla loro casa. I richiedenti, invece, furono allontanati d'urgenza dalla casa familiare, su insistenza della madre, solamente il 30 aprile 1992.

Durante il periodo intermedio di quattro anni e mezzo, i bambini erano stati vittime di una terribile negligenza che aveva determinato lesioni fisiche e psicologiche.

La Corte riconosce che i servizi sociali devono affrontare decisioni difficili e sensibili e riconosce altresì l'importanza del principio secondo cui la vita familiare dovrebbe essere rispettata e preservata.

In questo caso, tuttavia, non vi è dubbio che il sistema non sia riuscito a proteggere i bambini richiedenti da negligenza e gravi abusi per un lungo periodo di tempo.

Pertanto, la Corte riconosce l'esistenza di una violazione dell'articolo 3 della Convenzione.

SULLA VIOLAZIONE DELL'ARTICOLO 13 DELLA CONVENZIONE (Diritto a un ricorso effettivo)

I ricorrenti hanno sostenuto di non aver ricevuto alcun rimedio per il danno da loro subito a causa della mancata tutela da parte dell'autorità locale, facendo leva sull'articolo 13 della Convenzione.

Sul punto la Corte constata che in questo caso i ricorrenti non avevano avuto a disposizione mezzi per ottenere accoglimento delle loro affermazioni secondo cui l'autorità locale avrebbe omesso di proteggerli da trattamenti inumani e degradanti con la possibilità di ottenere un titolo esecutivo per il risarcimento del danno subito.

Conseguentemente, non essendo stato loro offerto un rimedio effettivo in relazione alla violazione dell'articolo 3, sussiste una violazione dell'articolo 13 della Convenzione.

Per contro, avendo constatato la violazione dell'articolo 3, la Corte ritiene che nessuna questione separata sorga in relazione alla VIOLAZIONE DELL'ARTICOLO 8 DELLA CONVENZIONE (Diritto al rispetto della vita privata e familiare).

Parimenti, la Corte ritiene che non vi sia stata alcuna VIOLAZIONE DELL'ARTICOLO 6 DELLA CONVENZIONE (Diritto a un equo processo), posto che ai ricorrenti non è stato impedito in alcun modo pratico di presentare le loro richieste dinanzi ai tribunali nazionali, tanto che il caso è stato contestato fino alla House of Lords e i ricorrenti sono state giuridicamente assistiti a tale scopo.

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La Convenzione delle Nazioni Unite sui diritti dell'infanzia

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Materiale da leggere

La Convenzione delle Nazioni Unite sui diritti dell'infanzia in parole semplici

La Convenzione delle Nazioni Unite sui diritti dell'infanzia (testo integrale)

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Quiz 5.1

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Multiple Choice with Hints and Feedback

5 points possible (graded)

1) Nel linguaggio giuridico è "trauma" all'infanzia:

- ○ ogni forma di violenza fisica e non fisica, anche se non agita con intenzione di procurarla
- ○ solo la violenza fisica e agita con intenzione di procurarla
- ○ solo la violenza fisica, anche se non agita con intenzione di procurarla
- ○ ogni forma di violenza fisica o non fisica, se agita con intenzione di procurarla

2) Nel caso di Mary Ellen Wilson la bambina vittima di maltrattamenti riceve protezione in applicazione del:

- ○ divieto di trattamenti inumani e degradanti
- ○ divieto di punizioni corporali
- ○ divieto di crudeltà sugli animali
- ○ divieto di abusi sui minori

3) Quale tra le seguenti affermazioni è vera?

- ○ Le persone di età minore non sono soggetti di diritti
- ○ Le persone di età minore sono titolari dei soli diritti riconosciuti ad ogni essere umano in quanto tale
- ○ Le persone di età minore sono soggetti di diritti se hanno la capacità di discernimento
- ○ Le persone di età minore sono titolari di specifici diritti loro riconosciuti in quanto persone in formazione

4) Quale fra i seguenti rappresenta uno strumento specifico elaborato nell'ambito del Consiglio d'Europa per la protezione del minore?

- ○ CEDU
- ○ Convenzione di Lanzarote
- ○ Carta sociale europea
- ○ Carta di Nizza

5) Nella sentenza della Corte EDU Z. E ALTRI contro REGNO UNITO, viene riconosciuta la violazione:

- ○ dell'articolo 5 Cedu (Diritto alla libertà e alla sicurezza)
- ○ dell'articolo 3 Cedu (Proibizione della tortura)
- ○ dell'articolo 6 Cedu (Diritto a un equo processo)
- ○ dell'articolo 8 Cedu (Diritto al rispetto della vita privata e familiare)

Invia

Show Answer

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Glossario Organizzazioni e trattati internazionali e dell'UE

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Organizzazione delle Nazioni Unite (ONU) = organizzazione internazionale fondata nel 1945, con l'obiettivo di mantenere la pace e la sicurezza internazionali, sviluppare relazioni amichevoli fra le nazioni, cooperare nella risoluzione dei problemi internazionali e nella promozione del rispetto per i diritti umani, rappresentare un centro per l'armonizzazione delle diverse iniziative nazionali. I Membri dell'ONU sono degli Stati Sovrani; le Nazioni Unite non sono un governo mondiale e non legiferano.

L'ONU, tuttavia, fornisce i mezzi per aiutare a risolvere i conflitti internazionali e formula politiche appropriate su questioni di interesse comune.

Convenzione internazionale sui diritti dell'infanzia (CRC) = trattato internazionale approvato dall'Assemblea Generale delle Nazioni Unite nel 1989 che esprime un consenso su quali sono gli obblighi degli Stati e della comunità internazionale nei confronti dell'infanzia e riconosce per la prima volta che anche i bambini godono di diritti civili, sociali, politici, culturali ed economici.

Comitato ONU sui Diritti dell'Infanzia = istituito dalla Convenzione ONU sui diritti dell'Infanzia allo scopo di esaminare i progressi compiuti dagli Stati parti nell'esecuzione degli obblighi derivanti dal trattato, si compone di 18 esperti di alta moralità e in possesso di una competenza riconosciuta nel settore oggetto della Convenzione. Il compito del Comitato è analizzare i rapporti periodici sull'attuazione della Convenzione che gli Stati parti sono impegnati a presentare in base a quanto previsto dall'art. 44 della Convenzione.

Convenzione europea dei diritti dell'uomo (CEDU) = trattato internazionale mediante il quale gli stati membri del Consiglio d'Europa garantiscono i diritti fondamentali civili e politici non solo ai propri cittadini ma anche a chiunque si trovi sotto la loro giurisdizione. Firmata a Roma il 4 novembre 1950, la Convenzione è entrata in vigore nel 1953.

Corte europea dei diritti dell'uomo (Corte di Strasburgo) = Corte internazionale istituita nel 1959 con sede a Strasburgo. Si pronuncia sui ricorsi individuali o statali inerenti presunte violazioni dei diritti civili e politici stabiliti dalla Convenzione Europea dei Diritti dell'Uomo. Dal 1998, la Corte è Organo permanente e può essere adita direttamente dagli individui.

Consiglio d'Europa = organizzazione internazionale il cui scopo è promuovere la democrazia, i diritti umani, l'identità culturale europea e la ricerca di soluzioni ai problemi sociali in Europa. Fondato il 5 maggio 1949 con il Trattato di Londra ha sede a Strasburgo e include 47 Stati membri, tra cui i 28 membri dell'Unione europea.

Attenzione! Il Consiglio d'Europa è estraneo all'Unione europea e non va confuso con organi di quest'ultima.

Convenzione del Consiglio d'Europa per la protezione dei bambini contro lo sfruttamento e gli abusi sessuali (Convenzione di Lanzarote) = trattato con cui gli Stati membri si accordano per criminalizzare alcune forme di abuso sessuale nei confronti dei bambini. È il primo trattato internazionale che affronta gli abusi sessuali nei confronti dei bambini che avvengono all'interno della famiglia.

Convenzione del Consiglio d'Europa sulla prevenzione e la lotta contro la violenza nei confronti delle donne e la violenza domestica (Convenzione di Istanbul) = trattato internazionale che si propone di prevenire la violenza, favorire la protezione delle vittime ed impedire l'impunità dei colpevoli. È il primo strumento internazionale giuridicamente vincolante a creare un quadro giuridico completo per proteggere le donne contro qualsiasi forma di violenza.

Unione europea = organizzazione economica e politica tra 28 paesi del continente europeo, creata dopo la Seconda guerra mondiale con l'obiettivo di promuovere una maggiore cooperazione economica tra gli Stati membri, è diventata col tempo un'organizzazione volta ad istituire le basi di un'Unione tra i popoli europei, salvaguardare la pace e ricercare l'unità politica e garantire, attraverso un'azione comune, progressi economici e sociali, quali sono la creazione di un mercato unico europeo e il rafforzamento della coesione sociale.

Carta dei Diritti Fondamentali dell'Unione europea (Cosiddetta Carta di Nizza) = proclamata nel corso del Consiglio Europeo di Nizza del 20 dicembre 2000, raccoglie tutti i diritti civili, politici, economici e sociali validi all'interno dell'Unione europea e sancisce il carattere fondamentale e la portata dei diritti umani per i cittadini dell'Unione. Nonostante sia divenuta giuridicamente vincolante solo a seguito dell'entrata in vigore del Trattato di Lisbona, ha ispirato, fin dalla sua origine, l'attività del Parlamento europeo. Con l'entrata in vigore del Trattato di Lisbona, la Carta di Nizza ha il medesimo valore giuridico dei trattati e si pone dunque come pienamente vincolante per le istituzioni europee e gli Stati membri.

Corte di giustizia dell'Unione europea (CGUE – Corte di Lussemburgo) = istituita nel 1952 ha sede a Lussemburgo ed interpreta il diritto dell'UE per garantire che sia applicato allo stesso modo in tutti gli Stati membri e dirime le controversie giuridiche tra governi nazionali e istituzioni dell'UE.

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Una panoramica dei diritti

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VIEW UNIT IN STUDIO

I DIRITTI DEL MINORE NEL DIRITTO INTERNAZIONALE E DELL'UNIONE EUROPEA

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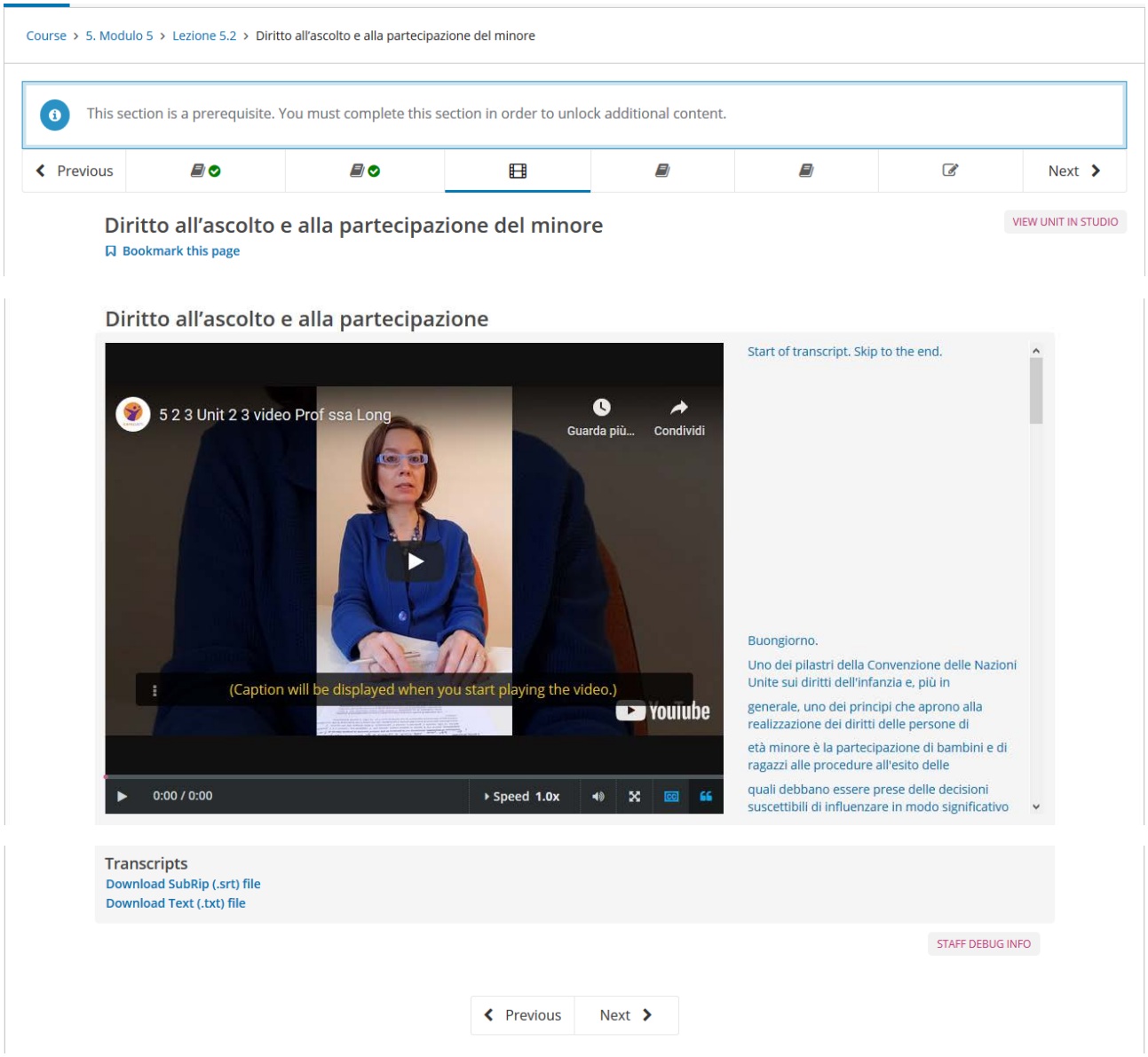

Transcript

Buongiorno.

Uno dei pilastri della Convenzione delle Nazioni Unite sui diritti dell'infanzia e, più in generale, uno dei principi che aprono alla realizzazione dei diritti delle persone di età minore è la partecipazione di bambini e di ragazzi alle procedure all'esito delle quali debbano essere prese delle decisioni suscettibili di influenzare in modo significativo la loro vita.

La Convenzione ONU sui diritti dell'infanzia riconosce il diritto del minore, in quanto essere umano, alla libertà di espressione nell'articolo 12, comma 1; e, nel comma successivo, il comma 2, individua uno degli strumenti che garantiscono la partecipazione del minore alle procedure, in particolare il diritto all'ascolto, da parte del giudice o da parte delle altre autorità amministrative che prenderanno decisioni nell'interesse del minore.

Ma l'ascolto non è l'unico strumento che garantisce la partecipazione del minore alle decisioni che lo riguardino.

La Convenzione europea sull'esercizio dei diritti dei minori, che riguarda specificamente le procedure giudiziarie, all'articolo 3 riconosce il diritto del minore di "ricevere ogni informazione pertinente" e, all'articolo 4 riconosce il diritto del minore di "richiedere [...] la designazione di un rappresentante speciale" qualora tra gli esercenti la responsabilità genitoriale e il minore ci sia un conflitto di interessi, un rappresentante che operi, appunto nelle procedure giudiziarie.

Ma cosa significa in concreto ricondurre l'ascolto del minore alla sua libertà di espressione?

Significa che, se anche è vero che il decisore durante l'ascolto del minore potrà ottenere delle informazioni che gli saranno utili per arrivare alla decisione finale, questa finalità istruttoria dell'ascolto è subordinata rispetto alla valenza principale dell'ascolto che è quella di garantire all'ascoltato la possibilità di esprimersi su un tema così importante per la sua vita.

Da qui alcune conseguenze pratiche che riguardano, per esempio, le modalità di ascolto: questo significa che l'ascolto non potrà essere condotto come un interrogatorio o come un'audizione di un testimone.

Significa però anche, per esempio, che il minore potrà rifiutarsi di essere ascoltato dal giudice.

Essendo l'ascolto un diritto il titolare del diritto può scegliere di non esercitarlo.

O, ancora, per quanto concerne le ragioni per le quali si potrà non procedere all'ascolto: non si potrà motivare il fatto di non aver ascoltato un minore dicendo che tale ascolto risultava nel caso specifico superfluo.

L'unica ragione per la quale l'ascolto potrà essere escluso è ritenere che quell'ascolto sarebbe stato contrario all'interesse della persona di età minore.

Un altro dei pilastri della Convenzione ONU dei diritti dell'infanzia è infatti proprio la protezione del minore e il pilastro della protezione va bilanciato con i diritti del minore alla partecipazione nelle procedure che lo riguardano.

E questa esigenza di bilanciamento si vede anche con riferimento al ruolo che la volontà manifestata dal minore durante l'ascolto svolge nella decisione finale presa dall'autorità.

L'autorità, infatti, non può ritenersi vincolata dalla volontà espressa dal minore.

Può, infatti, avvenire che l'autorità ritenga che la volontà espressa dal minore sia in

realtà contraria al suo interesse.

Pensiamo, per esempio, a una persona di età minore che nel quadro di una procedura civile che riguardi i maltrattamenti in famiglia insista per rivedere il genitore o più in generale l'adulto maltrattante.

In questo caso l'autorità ben potrà negare le visite, continuare a mantenere la sospensione delle visite anche qualora ciò sia contrario alla volontà manifestata dal minore.

È diverso, dunque, rispetto a quanto avviene per il soggetto maggiorenne.

Il soggetto maggiorenne, addirittura, ha il diritto di rifiutare un trattamento sanitario anche qualora da tale rifiuto derivi una morte certa.

Non così per la persona di età minore perché appunto, come dicevo, il diritto di partecipazione e in generale il diritto all'autodeterminazione deve essere bilanciato con il principio del superiore interesse del minore.

L'esigenza di bilanciamento impone, però, all'autorità giudiziaria e in generale alle autorità che prendono decisioni sulla vita del minore, di informare il minore della decisione presa e anche di motivare specificamente sulle ragioni per le quali non è stato possibile aderire alla volontà espressa dal minore stesso durante l'ascolto.

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The children act

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VIEW UNIT IN STUDIO

INTRODUZIONE AL FILM "THE CHILDREN ACT"

Protagonisti del film sono Adam, un diciassettenne che d'accordo con i genitori rifiuta per ragioni religiose la trasfusione di sangue necessaria a salvargli la vita, e Fiona Maye, giudice inglese della famiglia e dei minori, chiamata a decidere se autorizzare i sanitari a procedere comunque alla trasfusione sul ragazzo.

Il film consente di riflettere su due tratti caratterizzanti della disciplina del diritto del minorenne all'ascolto contenuta nell'art. 12 della Convenzione delle Nazioni Unite sui diritti dell'infanzia (CRC).

1) **L'ascolto costituisce lo strumento attraverso cui la persona di età minore esercita la propria libertà di espressione.** Fiona infatti incontra Adam perché vuole "conoscerlo" e non lo "ascolta" con le modalità proprie di un interrogatorio o di un'audizione di un testimone. Non si limita inoltre ad approfondire le ragioni della decisione di rifiutare le trasfusioni, ma chiacchera con lui toccando temi diversi, quali la musica e la poesia.

2) Inoltre, **l'ascolto non vincola il giudice alla volontà del minore**. Nel film infatti Fiona decide in modo opposto alla volontà espressa da Adam durante l'ascolto. Diversamente dalla persona maggiorenne - che ha il diritto di decidere sulla propria vita anche qualora la sua decisione possa determinarne la morte (es. tipico il rifiuto di una trasfusione di sangue salva vita per ragioni religiose) – la persona minore d'età non è titolare di questo diritto in termini assoluti: l'art. 12 della Convenzione delle Nazioni Unite sui diritti dell'infanzia (CRC) stabilisce che chi decide debba tenere conto dell'opinione del minore in modo crescente in funzione dell'età e del grado di maturità del minorenne, ma questo non significa che ne sia vincolato. Se infatti il giudice, o in generale chi è chiamato a prendere una decisione che riguardi un minore, ritiene che la volontà espressa dal minore durante l'ascolto non sia conforme al suo interesse, non solo può ma DEVE decidere in senso contrario.

Il Verdetto - The children act | Trailer Ufficiale Italiano

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Materiale da leggere

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Manuale di diritto europeo in materia di diritti dell'infanzia e dell'adolescenza

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Quiz 5.2

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VIEW UNIT IN STUDIO

Q5.2

5 points possible (graded)

1. Sono punizioni corporali a danno del minore:

- ○ esclusivamente le punizioni fisiche intese a causare dolore al minore
- ○ esclusivamente le punizioni fisiche intese a causare dolore o disagio al minore
- ○ anche azioni non fisiche, come le minacce, volte all'umiliazione del minore
- ○ azioni fisiche o non fisiche, ad eccezione di quelle realizzate per educare i minori

2. Quale tra le seguenti affermazioni è falsa?

- ○ Sono vietati i trattamenti ingiustificatamente differenziati in base all'età
- ○ Sono vietati tutti i trattamenti differenziati in base all'età
- ○ Le persone di età minore hanno il diritto in quanto tali a un trattamento differenziato sulla base dell'età
- ○ Il trattamento dei minori di età deve ispirarsi al principio del superiore interesse del minore

3. Quale fra le seguenti affermazioni sull'ascolto del minore è vera?

- ○ deve essere garantito solo nelle procedure giudiziarie e amministrative che lo riguardano
- ○ può essere condotto come l'audizione di un testimone, ma non come un interrogatorio
- ○ può essere escluso quando l'opinione del minore è superflua
- ○ deve essere garantito solo nelle procedure giudiziarie e non amministrative che lo riguardano

4. In caso di ascolto, l'opinione del minore è vincolante per chi decide?

- ○ Sì
- ○ No, e il decisore può anche non tenerne conto
- ○ Sì se il minore presenta un elevato grado di maturità
- ○ No, ma il decisore deve tenerne conto

5. Quale tra i seguenti rappresenta uno strumento specifico elaborato nell'ambito del Consiglio d'Europa in tema di violenza domestica e violenza assistita?

- ○ Convenzione di Lanzarote
- ○ Convenzione di Istanbul
- ○ Convenzione internazionale sui diritti dell'infanzia e dell'adolescenza (CRC)
- ○ Convenzione sulle relazioni personali riguardanti i minori

Invia

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Glossario giuridico sulla partecipazione dei minori ai procedimenti decisionali

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Vittimizzazione primaria = condotta di abuso, violenza o maltrattamento, che cagiona al minore sofferenze e lesioni fisiche e/o psicologiche.

Vittimizzazione secondaria = sofferenza ulteriore provocata dallo stress del processo in sé, dalla necessità di rievocare, in tale sede, i maltrattamenti, nonché dall'eventuale contatto con l'autore della condotta subita.

Procedimento penale = procedura giurisdizionale tramite cui viene ricercato e penalmente sanzionato l'autore dei maltrattamenti ai danni del minore, qualora costituiscano reato.

Procedimento civile = procedura giurisdizionale in cui, a seguito del maltrattamento, viene valutata l'adeguatezza dell'ambiente famigliare del minore e adottati gli eventuali provvedimenti necessari.

Ascolto del minore = attività del procedimento (civile o penale) per mezzo della quale vengono acquisite le dichiarazioni del minore sui fatti rilevanti per la decisione da prendere.

Consultazione del minore = attività del procedimento (specialmente civile) con cui il minore ha la possibilità di esprimere la propria opinione e il proprio pensiero, prima che il giudice prenda una decisione.

Consenso del minore = garanzia ulteriore rispetto al diritto di esprimere la propria opinione, che consiste nell'obbligo, per il giudice, di ottenere il previo parere favorevole del minore per poter prendere una determinata decisione (ad esempio, affidamento o adozione).

Rappresentante = colui il quale, in caso di assenza, indisponibilità, o situazione di conflitto d'interesse dei genitori, individua gli interessi e le necessità del minore e li tutela all'interno del procedimento.

Difensore = avvocato designato per cercare di ottenere un provvedimento giudiziale il più possibile conforme agli interessi del minore.

Professionisti sociali e sanitari = soggetti esperti in psicologia, psichiatria e sociologia, che assistono il minore maltratto durante i procedimenti che lo riguardano e aiutano il giudice e le parti a valutarne lo stato psico-fisico, nonché le eventuali necessità di protezione.

Provvedimenti cautelari = misure provvisorie, adottate dal giudice, per proteggere l'integrità psico-fisica del minore, in attesa del termine del procedimento e della conseguente decisione definitiva.

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La voce del minore maltrattato nei procedimenti civili e penali

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La voce del minore maltrattato nei procedimenti civili e penali

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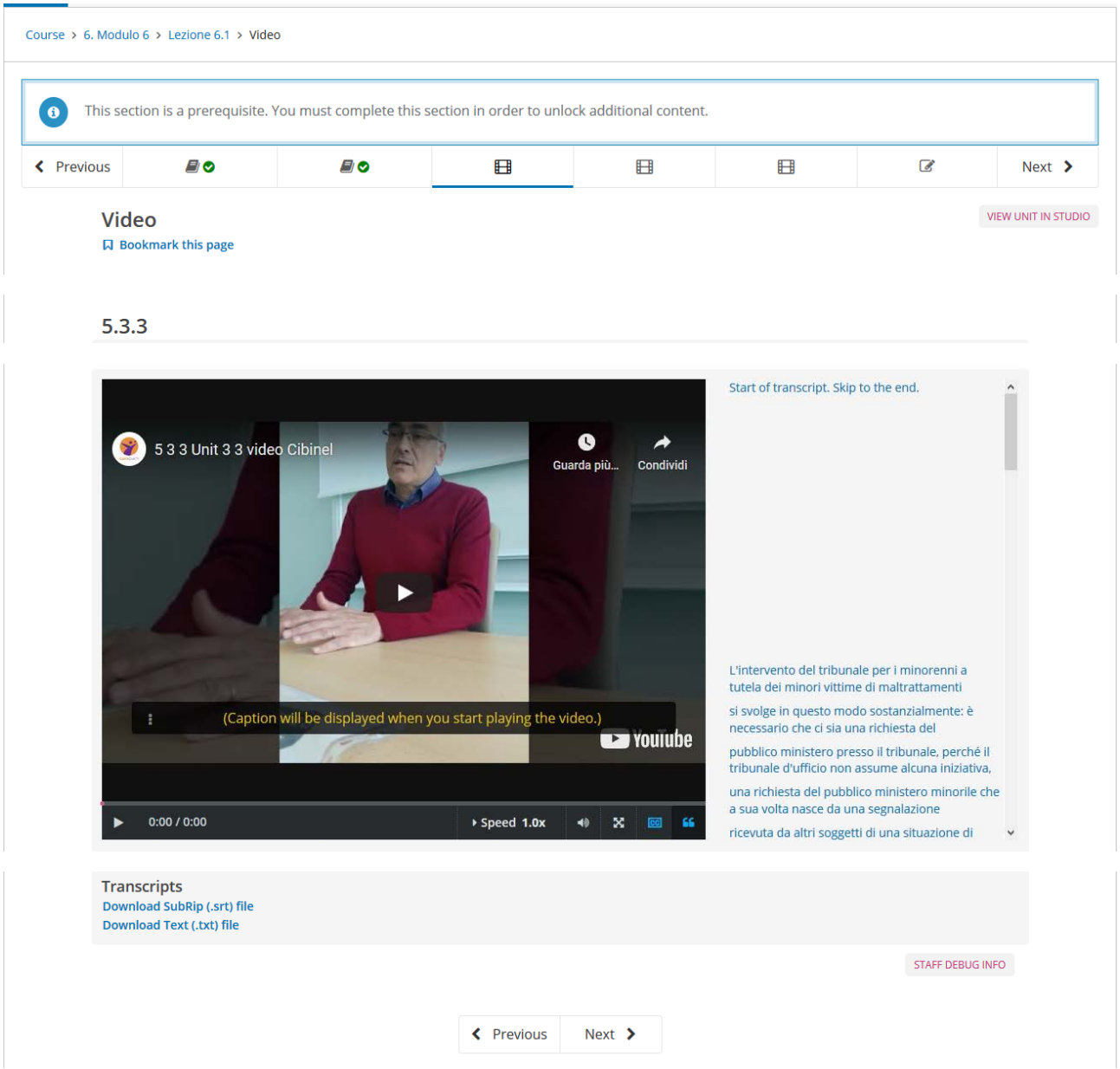


Transcript

L'intervento del tribunale per i minorenni a tutela dei minori vittime di maltrattamenti si svolge in questo modo sostanzialmente: è necessario che ci sia una richiesta del pubblico ministero presso il tribunale, perché il tribunale d'ufficio non assume alcuna iniziativa, una richiesta del pubblico ministero minorile che a sua volta nasce da una segnalazione ricevuta da altri soggetti di una situazione di maltrattamento di cui il minore sia vittima nell'ambito familiare.

Questi altri soggetti, che a loro volta hanno segnalato al pubblico ministero minorile la situazione di maltrattamento, sono i servizi sociali prevalentemente, ma possono anche essere le strutture scolastiche dove il minore si trova, o anche le autorità di polizia giudiziaria che intervengono in situazioni di reato.

C'è poi anche un intervento, ovviamente, dell'autorità giudiziaria penale ma, molto spesso, quando ci sono delle ipotesi di reato, gli interventi sono simultanei: il tribunale per i minorenni interviene per le misure di protezione, l'autorità giudiziaria penale interviene per l'accertamento dei reati.

L'intervento del tribunale è condizionato dal tipo di richiesta che il pubblico ministero ha fatto al tribunale.

Ci sono delle situazioni in cui il pubblico ministero, situazioni molto gravi in cui il pubblico ministero può chiedere un intervento immediato e urgente di allontanamento del minore e il tribunale può disporlo questo intervento; oppure situazioni in cui in partenza lo stesso pubblico ministero chiede al tribunale di fare degli accertamenti per verificare la gravità della situazione denunciata, la veridicità della situazione denunciata e la gravità, e individuare gli interventi ritenuti più opportuni per tutelare il minore.

Nel corso di questi accertamenti,

o subito dopo il provvedimento anche di allontanamento,

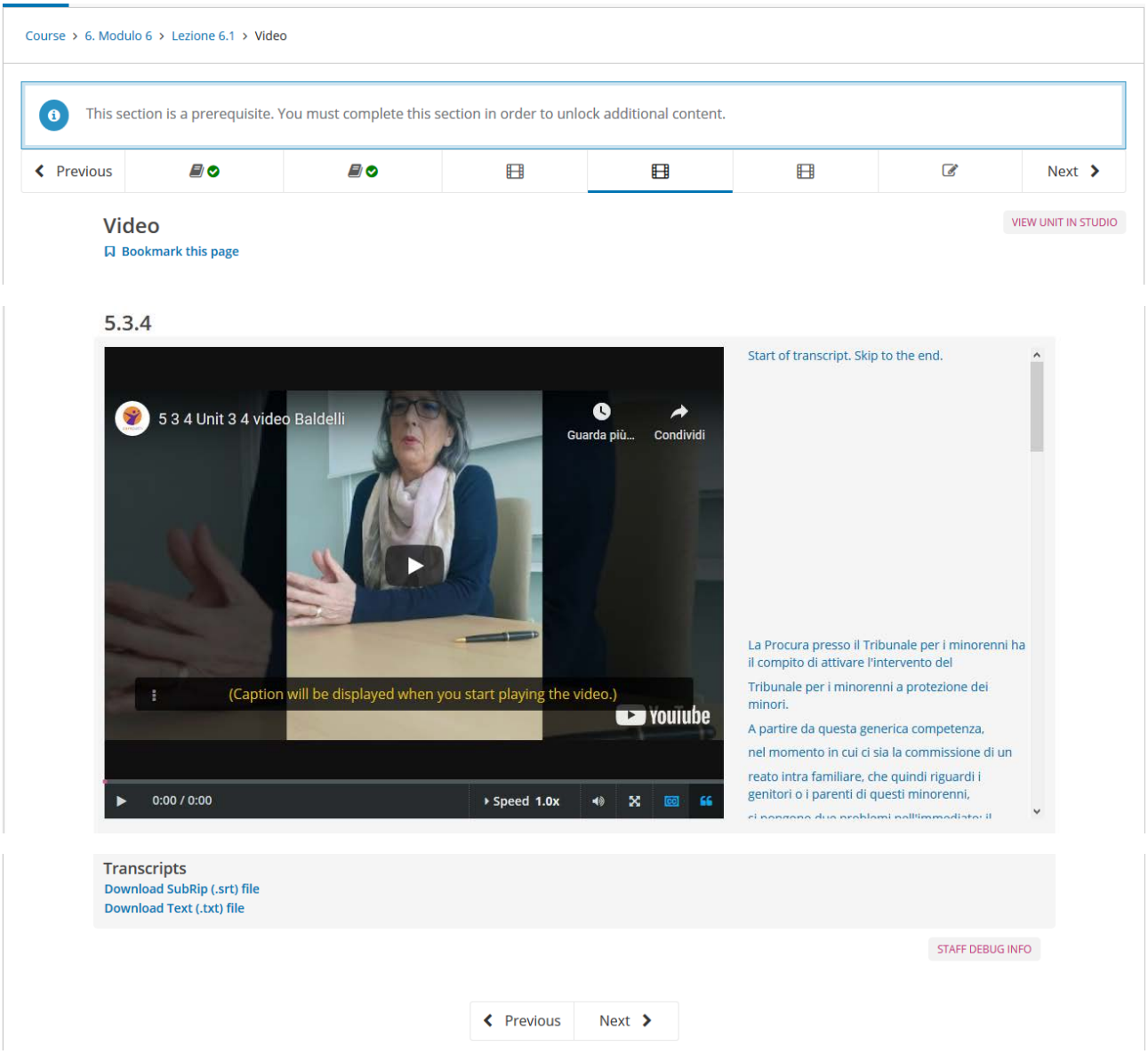
quando è stato necessario adottarlo, quando il tribunale ha ritenuto indispensabile adottare un provvedimento di allontanamento, dicevo nel corso di questo accertamento intervengono i servizi segnalanti, ma intervengono anche altri servizi: intervengono i servizi specializzati di psicologia, intervengono gli stessi genitori necessariamente anche se, ovviamente, il loro intervento è un intervento particolare, ma nell'ambito della procedura la legge prevede che debbano essere sentiti prima che il tribunale adotti dei provvedimenti definitivi a protezione dei minori che sarebbero degli interventi di limitazione della responsabilità dei genitori, o addirittura degli interventi "ablativi" si dice, cioè di decadenza dei genitori dalla responsabilità, sempre che il pubblico ministero abbia fatto richiesta anche di questo tipo di decisione.

Viene sentito anche il minore nell'ambito di questi procedimenti se ha compiuto i 12 anni, dice la legge, oppure non ha ancora compiuto i 12 anni ma viene ritenuto dal giudice in grado di esprimere, di essere, diciamo, sentito e di esprimere una sua valutazione sulla situazione.

Ovviamente è una valutazione che il giudice a sua volta valuterà liberamente per comprendere soprattutto i desideri, sì, ma anche la reale situazione psicologica del minore.

Ripeto, però: si tratta di una reale situazione psicologica del minore che innanzitutto viene stabilita e valutata attraverso l'intervento dei servizi specializzati i quali a loro volta

sentono il minore e riferiscono al giudice quello che il minore è stato in grado, anche a seconda dell'età,
di dire.
Questa è una forma di ascolto, diciamo, del minore "mediata", svolta da altri soggetti, con competenze professionali specifiche, di cui il giudice si avvale per prendere la decisione.



Transcript

La Procura presso il Tribunale per i minorenni ha il compito di attivare l'intervento del Tribunale per i minorenni a protezione dei minori.

A partire da questa generica competenza,

nel momento in cui ci sia la commissione di un

reato intra familiare, che quindi riguardi i genitori o i parenti di questi minorenni,

si pongono due problemi nell'immediato: il primo è quello di coordinarsi con i Procuratori ordinari, che hanno la titolarità del procedimento penale, per evitare delle interferenze che possano danneggiare l'indagine penale,

e il secondo di raccogliere gli elementi, non soltanto

di conoscenza della situazione di pregiudizio grave,

ma anche elementi di conoscenza sulle

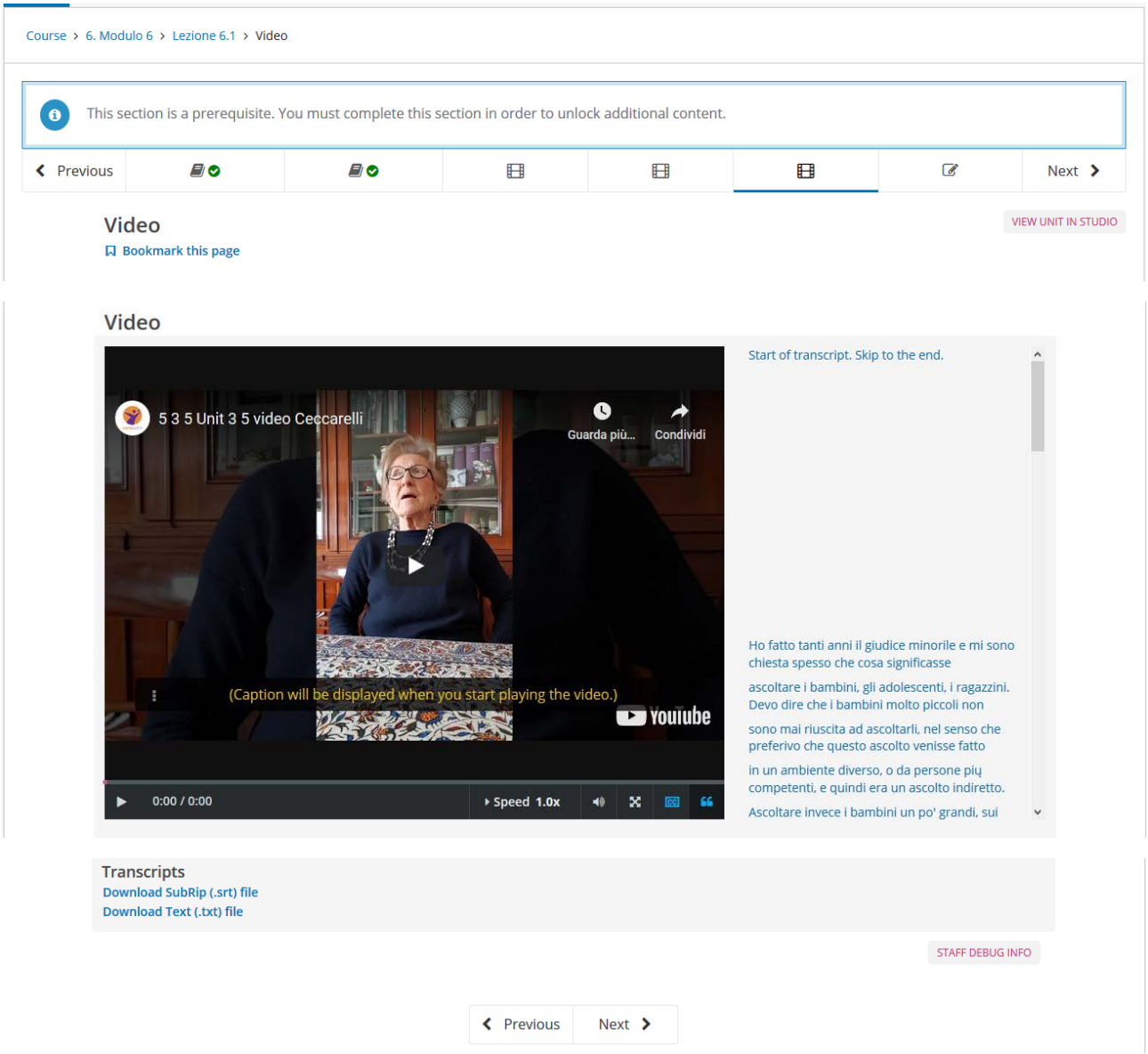
risorse personali e famigliari, eventualmente di altri famigliari o sociali, che siano intorno a questo minorenne; per poi costruire un ricorso al Tribunale per i minorenni, che abbia delle prospettive di intervento adeguate.

La difficoltà principale è quella di contenere i tempi, perché il processo di tutela ha dei tempi suoi, ma anche il processo penale ha dei tempi che non sempre sono governabili. Quello che noi abbiamo cercato di fare è stato di chiedere alle forze di polizia di segnalare, contestualmente, sia alla Procura ordinaria, che è titolare del procedimento penale nei confronti dell'autore di reato, sia alla Procura dei minorenni, che è titolare del potere di protezione della vittima del reato, in modo tale da mettere questi uffici nella condizione di coordinarsi in modo assolutamente tempestivo e immediato, cioè sin dalle prime battute dell'indagine.

Questa modalità, anche supportata da convenzioni che si sono fatte con le diverse Procure, ha consentito di definire chi fa che cosa, quando e come, salvando, appunto, come dicevo prima, le esigenze di percorso penale corretto, ma anche le esigenze di tutela nei confronti del minorenne.

Qualche volta può succedere, soprattutto quando i bambini vengono ricoverati in ospedale e non ci sia un dissenso dei genitori a questo ricovero, qualche volta è possibile che si ritardi l'intervento di protezione e quindi si ritardi l'intervento del Tribunale per i minorenni, potendo però garantire al minorenne una tutela di fatto, attraverso appunto il ricovero in ospedale, permettendo così al pubblico ministero ordinario, titolare del procedimento penale nei confronti dell'autore di reato, di svolgere i propri accertamenti in modo segreto e in modo quindi efficace.

Una volta che poi sia in qualche modo evidente la non rinviabilità di un provvedimento a tutela, può essere addirittura il collega della Procura ordinaria, titolare del procedimento penale, a emettere un provvedimento amministrativo di tutela attraverso la sua polizia giudiziaria, ai sensi dell'articolo 403 del codice civile, cioè mettere in protezione il minorenne, in attesa che poi, con un nostro ricorso, il Tribunale per in minorenni possa ratificare questo strumento di tutela provvisorio.



Transcript

Ho fatto tanti anni il giudice minorile e mi sono chiesta spesso che cosa significasse
ascoltare i bambini, gli adolescenti, i ragazzini. Devo dire che i bambini molto piccoli non
sono mai riuscita ad ascoltarli, nel senso che preferivo che questo ascolto venisse fatto
in un ambiente diverso, o da persone più competenti, e quindi era un ascolto indiretto.
Ascoltare invece i bambini un po' grandi, sui sette, otte, dieci anni, undici, ne ho
avuti parecchi casi.
Erano soprattutto bambini in situazioni familiari estremamente conflittuali, con genitori che
non si decidevano a separarsi, separati, ma in realtà sempre uniti da conflitto, da rivendicazioni,
che si riflettevano pesantemente sui figli.
La cosa che io cercavo di comunicare ai bambini,
in queste situazioni di ascolto, era anzitutto che c'era una persona

che li stava ad ascoltare,
una persona che aveva un compito preciso, che era quello di decidere nel modo migliore per loro,
che necessariamente questo decidere
poteva anche diverso da quello che i bambini
desideravano, da quello che esprimevano.
E, tuttavia, cercavo appunto di comunicare questo.
La decisione dipende dal Tribunale, dipende dal giudice. Il giudice, per mestiere, deve decidere
e quindi tengo conto di tutto quello che tu mi racconti,
cercherò di essere il
più possibile attenta a fare quello che va bene per te
e, però, non sempre la decisione
coinciderà con il tuo desiderio. Questa č una cosa che succede sempre nella vita e quindi
anche rispetto a questo devi abituarti a vivere.
Rispetto ai genitori, io cercavo sempre di salvaguardare l'aspetto positivo del rapporto
loro con i genitori, cioè cercavo di spiegare che il papà - in generale erano i papà che
erano molti prepotenti nei rapporti con i bambini
e quindi li costringevano a fare delle
cose pensando che fossero utili nel loro rapporto conflittuale con l'ex compagna -
cercavo di
dire: guarda il papà non ha nulla contro di te ed è giusto che tu voglia bene al papà;
però sappiamo che ha dei problemi, che non accetta questa situazione.
E quindi dobbiamo essere capaci anche di preservare questa figura del papà.
Quindi, come dire, mai aderire ad atteggiamenti conflittuali del bambino contro;
però anche
cercare di salvaguardare,
come dire, anche la possibilità che il bambino possa dire
di no, non ce la faccio più a stare con questo papà; non ce la faccio più, perché lui
non capisce e quindi, se non capisce alla fine.
Ho in mente la situazione di una bambina che aveva una decina di anni con due genitori,
il padre assolutamente molto molto patologico, e a questo punto il provvedimento č stato:
va bene aspettiamo che il papà cambi, se riuscirà a cambiare, e se non riuscirà a
cambiare, non sarà certamente la bambina che dovrà sopportare tutto questo peso.

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Quiz 6.1

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Q6.1

5 points possible (graded)

1) La "vittimizzazione secondaria" è causata:

- ○ dai maltrattamenti che hanno reso necessario l'intervento dell'autorità giudiziaria
- ○ dallo stress derivante dalla partecipazione del minore alle attività procedimentali
- ○ dallo stress derivante dall'ingresso del minore in un nuovo nucleo famigliare
- ○ dalla reiterazione dei maltrattamenti originariamente subiti

2) Il principio del superiore interesse del minore:

- ○ vale solo nel procedimento penale
- ○ vale solo nel procedimento civile
- ○ obbliga gli Stati a evitare la partecipazione del minore ai procedimenti successivi ai maltrattamenti subiti
- ○ impone al giudice di tenere sempre in considerazione, sopra ogni altro interesse meritevole di tutela, il benessere psico-fisico del minore

3) L'ascolto del minore come testimone:

- ○ deve sempre essere compiuto dal giudice
- ○ è preferibile che sia svolto come ultimo atto del procedimento
- ○ è preferibile che sia svolto fra i primi atti del procedimento
- ○ per saggiare l'attendibilità del dichiarante, è meglio se viene ripetuto almeno due volte

4) L'opinione espressa dal minore nel corso del procedimento

- ○ non è vincolante, ma il giudice deve tenerne conto per decidere
- ○ è sempre vincolante per il giudice
- ○ è vincolante per il giudice, ma solo se il minore ha almeno 14 anni
- ○ è vincolante per il giudice, ma solo se il minore ha una capacità di discernimento adeguata

5) I procedimenti penali e civili instaurati in seguito al maltrattamento del minore:

- ○ sono separati, ma quello civile può cominciare solo dopo quello penale
- ○ affrontano temi diversi e hanno scopi diversi
- ○ sono separati, ma quello civile può cominciare solo se, nel processo penale, il genitore è stato condannato
- ○ hanno lo stesso fine e lo stesso oggetto

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Glossario sulle politiche all'infanzia

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Servizi sociali = gamma di servizi, forniti da enti pubblici o privati, che rispondono a bisogni collettivi e personali. Mentre con il termine "servizi" si intendono servizi standardizzati, universalmente forniti alle persone in quanto membri di una categoria, i "servizi sociali" rispondono a "bisogni specifici" dei beneficiari.

Servizi sociali per bambini e famiglie = serie di misure e di attività che soddisfano bisogni generali o individuali di un minore e/o della sua famiglia. Questo tipo di servizi sono finalizzati a soddisfare i diversi bisogni dei bambini e delle famiglie, come i servizi specializzati e intensivi.

Servizi sociali a misura di bambino = servizi sociali che rispettano, proteggono e realizzano i diritti di ogni bambino, compreso il diritto di accesso alle prestazioni, la partecipazione e la protezione e il principio del superiore interesse del bambino.

Giustizia a misura di minore = sistemi giudiziari che garantiscono il rispetto e l'effettiva attuazione di tutti i diritti dei minori al più alto livello possibile, tenendo in considerazione il grado di maturità e di comprensione del minore. Si tratta di una giustizia accessibile, adeguata all'età, rapida, diligente, adatta alle esigenze del minore e su di esse incentrata, nel rispetto dei diritti del minore, tra cui il diritto al giusto processo, alla partecipazione e alla comprensione del procedimento, al rispetto della vita privata e familiare, all'integrità e alla dignità.

Educazione e cura della prima infanzia (ECEC- Early Childhood Education and Care) = servizio offerto ai bambini dalla nascita all'istruzione primaria soggetto a un quadro di regolamentazione nazionale e al rispetto di una serie di regole di standard minimi e/o di procedure per l'accreditamento. Il servizio comprende i servizi privati, pubblici e del volontariato. I paesi europei presentano soluzioni diverse per garantire l'educazione e la cura dei bambini al di sotto dell'età della scuola dell'obbligo. Tuttavia, L'ECEC sta diventando sempre più parte integrante dei sistemi di istruzione in Europa

Spazio Europeo dell'Istruzione Superiore (European Higher Education Area - EHEA) = progetto che si propone di realizzare un processo di convergenza e di rafforzamento degli studi superiori o universitari in Europa. Questo processo è in linea con le strategie che la Commissione Europea assieme agli Stati Membri dell'Unione ha varato in questi anni per costruire una vera Europa della conoscenza ed ha lo scopo principale di promuovere la mobilità e l'impiego occupazionale degli studenti, migliorare la qualità e rendere i sistemi educativi più competitivi, attrarre studenti (e docenti) dall'Europa e da altre parti del mondo. I mezzi per raggiungere tale obiettivo sono il sostegno a una maggiore comparabilità e compatibilità tra i diversi sistemi e le diverse istituzioni di Istruzione Superiore in Europa, e l'innalzamento della loro qualità.

Assistenza sanitaria a misura di bambino = politiche e pratiche di assistenza sanitaria incentrate sui diritti, i bisogni, le caratteristiche, le risorse e le capacità in evoluzione dei bambini, tenendo conto della loro opinione.

Approccio di assistenza sanitaria a misura di bambino = quadro concettuale e operativo integrato che rispetta appieno i diritti e i bisogni dei bambini in ambito sanitario.

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Ruolo e funzioni del Garante per l'infanzia

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I GARANTI PER L'INFANZIA E L'ADOLESCENZA

Le competenze attribuite dalle diverse leggi istitutive alle Autorità garanti per l'infanzia e l'adolescenza sono riconducibili a diverse azioni: ascolto e partecipazione, promozione e sensibilizzazione, collaborazione, elaborazione di proposte, pareri e raccomandazioni.

L'attività dei Garanti dell'infanzia e dell'adolescenza (Ombudsman for Children) assume oggi un ruolo di primo piano nelle politiche volte a garantire la conoscenza e il rispetto dei diritti dei minori, e consente di dare voce a persone (i minori) che spesso rischiano di essere invisibili: https://www.youtube.com/watch?v=jWiE2jHX5yE.

Le Autorità Garanti, in sintesi:

- vigilano sull'applicazione della Convenzione sui diritti dell'infanzia e dell'adolescenza nel territorio e contribuire a diffondere la conoscenza e la cultura dei diritti dell'infanzia e dell'adolescenza;
- segnalano alle autorità competenti eventuali violazioni di tali diritti;
- verificano che le persone di minore età abbiano pieno accesso ai loro diritti;
- esprimono pareri sulle proposte normative riguardanti i minori di età e sulla tutela dei diritti e lo sviluppo dei soggetti in età evolutiva.

Più nel dettaglio, le funzioni e i poteri delle Autorità garanti (Ombudsman for Children) si possono suddividere in due principali aree.

1) La prima è di carattere generale e riconducibile a interventi di promozione dei diritti delle persone di minore età. I Garanti, per esempio, promuovono la conoscenza e l'affermazione dei diritti individuali, sociali e politici dell'infanzia e dell'adolescenza assumendo ogni iniziativa finalizzata alla loro concreta realizzazione; vigilano sull'applicazione nel territorio della Convenzione sui diritti del fanciullo; esprimono, su richiesta dei competenti organi locali, pareri, proposte e rilievi su progetti di legge, di regolamento e di atti amministrativi in ordine al possibile ed eventuale impatto su bambini e ragazzi.

2) La seconda area di intervento è specifica e riguarda le risposte a segnalazioni di situazioni di singoli minori in difficoltà. I Garanti, infatti, accolgono le segnalazioni provenienti da persone anche di minore età (per un esempio vd. qui), dalle famiglie, dalle scuole, da associazioni ed enti, in ordine a casi di violazione dei diritti; segnalano alle amministrazioni pubbliche competenti i casi di violazione di diritti, conseguenti a atti o fatti ritardati, omessi o comunque irregolarmente compiuti, di cui abbia avuto conoscenza da soggetti pubblici e privati, o da parte di persone singole, anche di minore età.

Quanto al modus operandi , ai Garanti non sono conferiti poteri diretti e incisivi di indagine, di prescrizione e di sanzione. L'azione dei Garanti si estrinseca infatti essenzialmente nella cosiddetta moral suasion, cioè nella persuasione esercitata nei confronti di soggetti pubblici (decisori politici, amministrazioni locali, servizi socio-assistenziali territoriali, autorità giudiziarie) e privati (genitori in conflitto, enti del terzo settore) basandosi sull'autorevolezza del proprio status di autorità di garanzia. Così, per esempio, il Garante può raccomandare alle amministrazioni competenti l'adozione di interventi di aiuto e sostegno, nonché l'adozione, in caso di loro condotte omissive, di specifici provvedimenti; promuovere, presso le amministrazioni competenti, la modifica o la riforma di provvedimenti ritenuti pregiudizievoli per bambini e ragazzi; richiamare le amministrazioni competenti a prendere in considerazione come preminente il superiore interesse del fanciullo.

Le Autorità garanti possono esistere tanto a livello nazionale quanto a livello locale.

In ambito europeo è attiva la Rete europea dei Garanti dell'infanzia e dell'adolescenza (European Network of Ombudsman for Children – sito web: *https://enoc.eu/?page_id=174*) che si riunisce almeno una volta l'anno per discutere temi di interesse comune a livello europeo e individuare linee di intervento condivise.

Le Autorità garanti nazionali collaborano costantemente con la rete internazionale dei garanti delle persone di minore età, con le organizzazioni e gli istituti internazionali di tutela e di promozione dei diritti dei minorenni e le organizzazioni no profit.

Lo scambio con soggetti diversi permette alle Autorità di sviluppare proposte al passo con i tempi e le necessità dei ragazzi.

Uno degli ambiti di intervento dei Garanti concerne i fenomeni di violenza e maltrattamento a danno di persone di età minore (maltrattamento psicologico, maltrattamento fisico, violenza sessuale, trascuratezza, violenza assistita). Sul punto si veda il contributo ENOC. Position Statement on 'Violence against Children", *http://enoc.eu/wp-content/uploads/2014/12/ENOC-position-statement-on-Violence-against-children-2015-FV.pdf*.

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Garante nazionale per l'infanzia e l'adolescenza, Diritto del minore alla partecipazione

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Video

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L'esperienza di un tutore volontario di un minore straniero non accompagnato

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Il tutore volontario come "voce" del minore straniero non accompagnato

Sono molti i minorenni che sono costretti a lasciare il loro Paese per trascorrere la loro infanzia e adolescenza lontano da casa, separati dalle loro famiglie e senza adulti di riferimento che possano assicurarsi che vengano tutelati i loro interessi. La grande maggioranza di loro ha vissuti traumatici legati al percorso migratorio, alla vita prima della migrazione o comunque all'abbandono della o dalla famiglia di origine.

Nel Diritto dell'Unione europea, la Direttiva 2011/95/UE del Parlamento Europeo e del Consiglio definisce il minore straniero non accompagnato (MSNA): "il minore di 18 anni, non appartenente a una nazione dell'Unione Europea o apolide, che giunga nel territorio dello Stato membro senza essere accompagnato da un adulto che ne sia responsabile in base alla normativa o alla prassi dello Stato membro interessato, e fino a quando non sia effettivamente affidato a un tale adulto; il termine include il minore che venga abbandonato dopo essere entrato nel territorio degli Stati membri".

In numerosi ordinamenti europei si sta diffondendo la figura del tutore volontario, un privato cittadino, altamente qualificato, chiamato ad esercitare la rappresentanza legale dei minori arrivati nello Stato da soli e ad assicurare che i loro interessi vengano tutelati, i loro bisogni ascoltati e le loro potenzialità coltivate. L'istituto del tutore volontario rappresenta, in altre parole, un esempio di cittadinanza attiva e dunque uno strumento di politica sociale in favore di persone di età minore.

Carlo Infuso, avvocato torinese, racconta così la sua esperienza di tutore volontario.

"Ho conosciuto V., il mio tutelato, in un'occasione assolutamente ordinaria: mi è stato presentato dalla Comunità che lo ospitava. Mi sono trovato davanti questo ragazzo e devo dire che dopo la presentazione di rito non sapevamo tanto né io né lui che cosa dire. L'ho caricato sul motorino, siamo andati a fare un giro, abbiamo un po' parlato, e pian piano abbiamo cominciato a costruire questo rapporto che oggi direi essere evoluto veramente in un rapporto piacevole, pieno, di fiducia e di piacere reciproco.

V. sta finalmente cominciando la sua vita qui in Italia. Gode della protezione umanitaria, avrà quindi un permesso di soggiorno fino a quando diventa maggiorenne e anche oltre perché gli è stato dato per due anni. Chiederemo appunto che possa proseguire e portare a termine gli studi.

Sta finalmente iniziando a capire l'importanza di imparare l'italiano, cosa che non gli serviva e non aveva assolutamente colto nei suoi aspetti, per sé stesso, per le relazioni con gli altri, per le sue relazioni con me, per le relazioni con i miei amici, per le persone che frequenta attraverso me, che sta cominciando a conoscere e a scoprire. Sta capendo l'importanza di studiare anche da cameriere, dava per scontato che fare il cameriere significasse semplicemente portare a tavola i cibi e invece sta imparando a fare il cappuccino, il cappuccino con il disegno, servire con le doppie posate dal piatto di portata, a destra, a sinistra, i bicchieri per l'acqua, per il vino, come disporre il tovagliolo, eccetera... Sta scoprendo un poco il piacere dell'imparare le cose per imparare le cose proprio per sé stesse.

È molto divertente. È un giovane, un adolescente: pensa tantissimo alla musica, ha l'orecchino, il taglio di capelli... come tutti i ragazzi.

Mi ha stupito, devo dire, una cosa nel mio ruolo di tutore, che è un po' fuori dal ruolo di tutore. Quando si trattava di prendere una decisione iniziale sul dove studiare, sul che cosa studiare, quando V. mi ha detto: "io non ho genitori, tu sei il mio papà italiano, decidi tu per me, perché so che quello che tu decidi per me è sicuramente fatto bene ".

Oggi, a distanza di alcuni mesi, sono contento che V. riesca a dire: "sono contento che abbiamo deciso insieme di fare questo studio, perché è uno scuola che mi piace molto".

Anche il fatto di essere riuscito, forse con piccole cose, con le cose di ogni giorno, un poco a innescare in lui un meccanismo di fiducia negli altri, ha permesso di avere, di costruire, un po' di fiducia in sé stesso e oggi V. probabilmente è in grado di fare piccole scelte che una volta non era in grado di fare, con molta più coscienza, con molta più leggerezza, con molto più impegno rispetto a prima.

È un rapporto tra persone quello che si crea ed è un rapporto che può andare bene o può andare male, nel nostro caso è andato bene, ci ha permesso di costruire.

Posso dire con piacere V. è ospite questo fine settimana a casa mia, stasera preparerà probabilmente lui da mangiare una delle sue cose e ne siamo tutti molto contenti".

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Quiz 6.2

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Q6.2

5 points possible (graded)

1) Nelle situazioni di violenza domestica o in caso di conflitto con i genitori, bambini e ragazzi:

- ○ devono avere accesso a consulenze e consigli medici confidenziali senza il consenso dei genitori, se di età superiore ai 14 anni
- ○ devono avere accesso a consulenze e consigli medici confidenziali senza il consenso dei genitori, indipendentemente dalla loro età
- ○ devono avere accesso a consulenze e consigli medici confidenziali previo consenso dei genitori, indipendentemente dalla loro età
- ○ devono avere accesso a consulenze e consigli medici confidenziali previo consenso dei genitori, se dotati di un elevato grado di maturità

2) La dichiarazione di Bucarest dei bambini dell'Unione Europea è uno strumento volto a mobilitare le istituzioni europee e gli Stati membri a stabilire strutture e meccanismi formali che promuovano il diritto dei bambini e dei giovani:

- ○ ad essere ascoltati in ogni procedura giudiziaria o amministrativa che li concerne
- ○ ricevere o comunicare informazioni o idee senza che vi possa essere ingerenza da parte delle autorità pubbliche e senza limiti di frontiera
- ○ a beneficiare di una protezione particolare e quindi a un trattamento differenziato sulla base dell'età
- ○ a partecipare alle decisioni dell'Unione Europea

3) Quando, secondo la legge, un minore non ha la capacità di dare consenso a un intervento sanitario, questo:

- ○ non può essere effettuato senza l'autorizzazione del suo rappresentante, di un'autorità o di una persona o di un organo designato dalla legge
- ○ non può essere effettuato
- ○ può essere effettuato anche senza l'autorizzazione del suo rappresentante, di un'autorità o di una persona o di un organo designato dalla legge
- ○ può essere effettuato anche senza l'autorizzazione del suo rappresentante, di un'autorità o di una persona o di un organo designato dalla legge se è possibile ricostruire la volontà del minore

4) Il video del Consiglio d'Europa "Tell someone you trust" affronta con modalità adatte ai bambini il tema:

- ○ dell'abuso sessuale
- ○ del bullismo
- ○ della violenza assistita
- ○ delle punizioni corporali

5) Le Autorità garanti per l'infanzia e l'adolescenza esercitano:

- ○ poteri incisivi di indagine
- ○ poteri di prescrizione e di sanzione
- ○ poteri normativi
- ○ poteri di moral suasion

Invia

Show Answer

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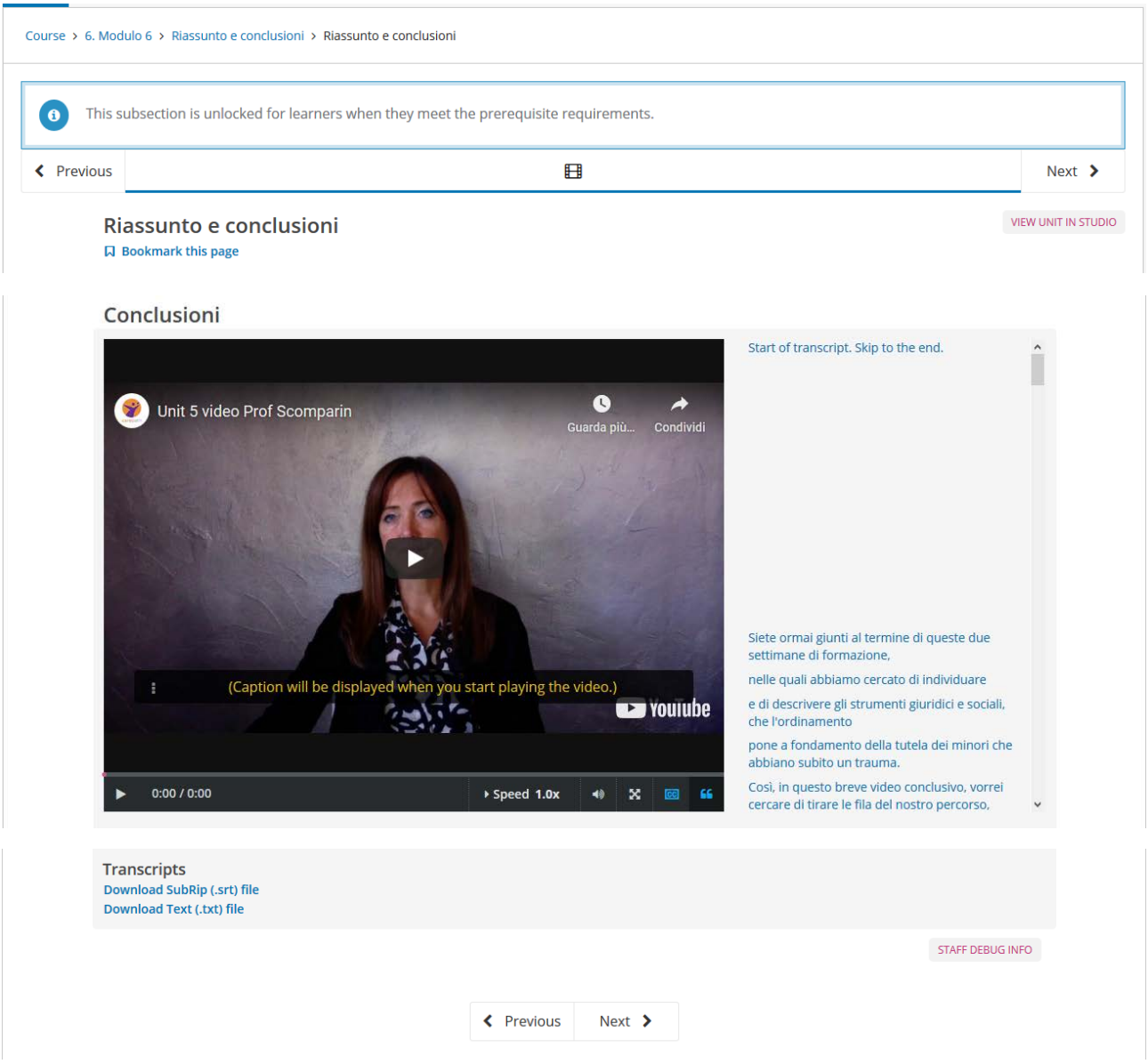


Transcript

Siete ormai giunti al termine di queste due settimane di formazione,

nelle quali abbiamo cercato di individuare

e di descrivere gli strumenti giuridici e sociali, che l'ordinamento

pone a fondamento della tutela dei minori che abbiano subito un trauma.

Così, in questo breve video conclusivo, vorrei cercare di tirare le fila del nostro percorso,

identificando le principali chiavi di lettura delle varie questioni che abbiamo trattato.

In primo luogo, è importante ricordare che la consacrazione dei diritti del minore

è stata una conquista travagliata e per nulla scontata.

Una chiara testimonianza di quanto detto è sicuramente il caso di Mary Ellen Wilson,

che si è concluso positivamente solo grazie alla tenacia di una missionaria metodista

e dell'intuizione di un avvocato:

in quel caso, infatti, per allontanare una minore

da un contesto familiare a dir poco inadeguato, ci si era addirittura dovuti rivolgere alle

leggi in materia di maltrattamento degli animali.

Il che è certamente qualche cosa che può meravigliare.

Ma anche maggiore meraviglia può aver destato

in voi la vicenda a cui fa riferimento la decisione Z. c. Regno Unito della Corte europea

dei diritti dell'uomo,

non fosse altro perché si è verificata oltre cento anni dopo.

Dunque possiamo dire

che, ancora nei primi anni Novanta, l'idea di un obbligo, in capo allo Stato,

di porre rimedio a situazioni familiari problematiche per il benessere di un minore faceva

una certa fatica a radicarsi.

I giudici della Corte europea, in quel caso, hanno dovuto ricavare

un tale dovere dalla Convenzione europea dei diritti dell'uomo, riconoscendolo in sostanza

come un corollario del divieto di trattamenti inumani e degradanti di cui all'art. 3 della Convenzione europea.

Poi c'è un secondo punto importante da ricordare:

è che un decisivo impulso verso il superamento

di lacune giuridiche, che in ogni Stato

sono presenti, è certamente venuto dal diritto

internazionale e dal diritto sovranazionale.

Sicuramente va ricordata la Convenzione di New York,

seguita poi, per quel che ci riguarda più vicino, da molte iniziative del Consiglio

d'Europa, nonché, piụ di recente, anche dell'Unione europea.

Solo attraverso questi strumenti, potremmo dire, la consapevolezza che il minore sia

un autonomo soggetto di diritti, titolare di posizioni giuridiche proprie e indipendenti

rispetto a quelle dei genitori, ha potuto progressivamente affermarsi;

così che oggi

possiamo davvero definirlo un patrimonio comune in ogni ordinamento.

Allo stesso modo, è anche

pacifico che esista un vero e proprio dovere delle autoritā statali di prevenire

e punire oggi eventuali maltrattamenti nei confronti dei minori, come è pacifico che
vi sia un dovere di accompagnare efficacemente chi ha subito un maltrattamento verso un pieno
e totale recupero del proprio benessere psico-fisico.
C'è anche una terza chiave di lettura molto importante.
Il minore è un individuo che presenta
spiccate peculiarità:
la sua personalità è ancora in formazione e,
proporzionalmente all'età, necessita sicuramente di attenzioni che l'adulto di solito non richiede;
a maggior ragione queste
attenzioni speciali sono necessarie quando il minore è stato vittima di abusi e violenze,
magari, ancor di più, in ambito familiare.
In altre parole, potremmo dire
che, per quanto riguarda i minori, i diritti che sono generalmente riconosciuti a ogni
individuo hanno richiesto un'autonoma elaborazione, che tenesse conto delle loro particolari e
delicate condizioni.
Per fare qualche esempio, è vero che il minore
ha diritto di essere ascoltato e di esprimere la propria opinione su ogni questione che lo riguarda;
ma è anche vero che, se necessario per realizzare il suo superiore interesse,
allora la decisione, che alla fine l'ordinamento prende in una procedura che lo riguarda, potrebbe
anche essere diversa da quella che lui ha manifestato come preferibile; e può essere
anche completamente differente dalla volontà che il minorenne ha manifestato.
Poi c'è anche un quarto punto importante da ricordare.
Il cammino verso
la reintegrazione del benessere del minore traumatizzato
può essere un cammino doloroso quasi quanto le
violenze e gli abusi che il minorenne ha subito.
In questo senso, instaurare un procedimento
penale, un procedimento civile, in seguito al maltrattamento, è certamente una condizione
essenziale per il raggiungimento di numerosi e importanti obiettivi: punire chi ha commesso
il fatto, se costituisce reato;
impedire che le condotte di abuso vengano reiterate;
risarcireil danno subito;

quando sia necessario, anche ristabilire un adeguato contesto famigliare.
Ma non va dimenticato che esiste anche un rovescio di questa medaglia,
che è dato dai
sacrifici - spesso altrettanto numerosi - che sono richiesti al minore per affrontare tutti
i passaggi di un procedimento.
Spesso è cruciale ad esempio la sua partecipazione
al procedimento che lo coinvolge;
e questa partecipazione, oltre a essere diritto del
minorenne, è anche importante, addirittura fondamentale, per l'accertamento dei fatti:
esprimendo la sua opinione e raccontando la sua esperienza, la vittima può sempre offrire
al giudice degli elementi importanti per la decisione finale.
Però, come abbiamo visto,
esistono anche dei rischi importanti di vittimizzazione secondaria,
perché,
nel corso di un procedimento,
il minore deve probabilmente ricordare i fatti e quindi i traumi subiti;
deve probabilmente
subire l'esposizione pubblica legata alla sua vicenda processuale;
deve probabilmente,
nel corso del processo, venire anche a contatto diretto con l'autore dell'abuso.
E sono tutti rischi assolutamente importanti e rilevanti.
Poi quando si riveli necessario disporre l'adozione
o anche solo l'affidamento di un minorenne, non va certo dimenticato quanto possa essere
difficile l'inserimento in nucleo famigliare nuovo.
Paradossalmente, potremmo dire, il superamento di un primo trauma,
che è dato dall'abuso,
richiede poi di imboccare un nuovo percorso, che però a sua volta è costellato dal pericolo
di molti altri piccoli traumi.
E poi c'è forse la considerazione più importante.
Spesso accade che nuovi diritti e nuove tutele
richiedano molto tempo e molte energie per affermarsi;
e questo, come abbiamo visto, è accaduto anche per il minore.

Ora che,
però, queste garanzie esistono va probabilmente
compiuto un passo ulteriore:
bisogna acquisire consapevolezza che il diritto, da solo, non basta.
Che le Convenzioni internazionali, sovranazionali, che le direttive europee,
le leggi dei singoli Stati, da sole, non bastano.
Sono il punto di partenza,
sono la base su
cui tutto il resto dev'essere poi costruito.
Ciò che più conta - in questo ambito probabilmente
più che in altri - è come le garanzie, che sono sancite sulla carta, vengono poi attuate,
realizzate, tramite efficienti politiche sociali.
In questo, le amministrazioni centrali e locali
devono certamente farsi carico di promuovere, con iniziative concrete, una cultura del rispetto
dei diritti dei minori;
allo stesso tempo, devono costruire, monitorare, investire,
su servizi specifici per l'infanzia e l'adolescenza;
servizi come gli sportelli di aiuto, i gruppi di sostegno,
autorità di vigilanza e di controllo.
E, in questo, non dimentichiamolo, un ruolo
importante hanno sempre anche il volontariato e le associazioni che promuovono e tutelano
i diritti dei minori,
perché queste associazioni sono sicuramente un tassello fondamentale,
per attuare politiche sociali efficaci ed efficienti.
Anche per limitare poi il rischio di quella vittimizzazione secondaria, di cui abbiamo
parlato, le amministrazioni pubbliche devono avere una adeguata sensibilitā e devono agire
con opportuni investimenti.
Giusto per fare qualche esempio, devono sicuramente allestire
delle aule in tribunale per l'ascolto protetto;
devono sensibilizzare adeguatamente i giudici e gli avvocati;
devono assicurare delle condizioni adeguate per lo svolgimento delle audizioni del minorenne;
devono sicuramente garantire una assistenza psicologica continuativa per

tutto il corso del procedimento.

E naturalmente il contributo dei primi fruitori

di questo corso, cioč i professionisti, sociali e sanitari, che sono deputati a interagire

con il minore, è fondamentale.

Perché questi operatori sono,

siete,

i custodi dei minorenni fuori dai processi,

per il superamento del trauma che č causato dalla vittimizzazione

primaria; ma siete anche i custodi del minorenne dentro i processi,

perché potete rendere

più sopportabile qualcosa

che non potrà mai essere vissuto come ordinario;

e poi siete i custodi dei minorenni anche dopo i processi,

perché dovete fare in modo che il cammino

faticoso verso il recupero della serenità non s'interrompa proprio nel momento in cui dovrebbe

maggiormente accelerare e dare poi i suoi frutti.

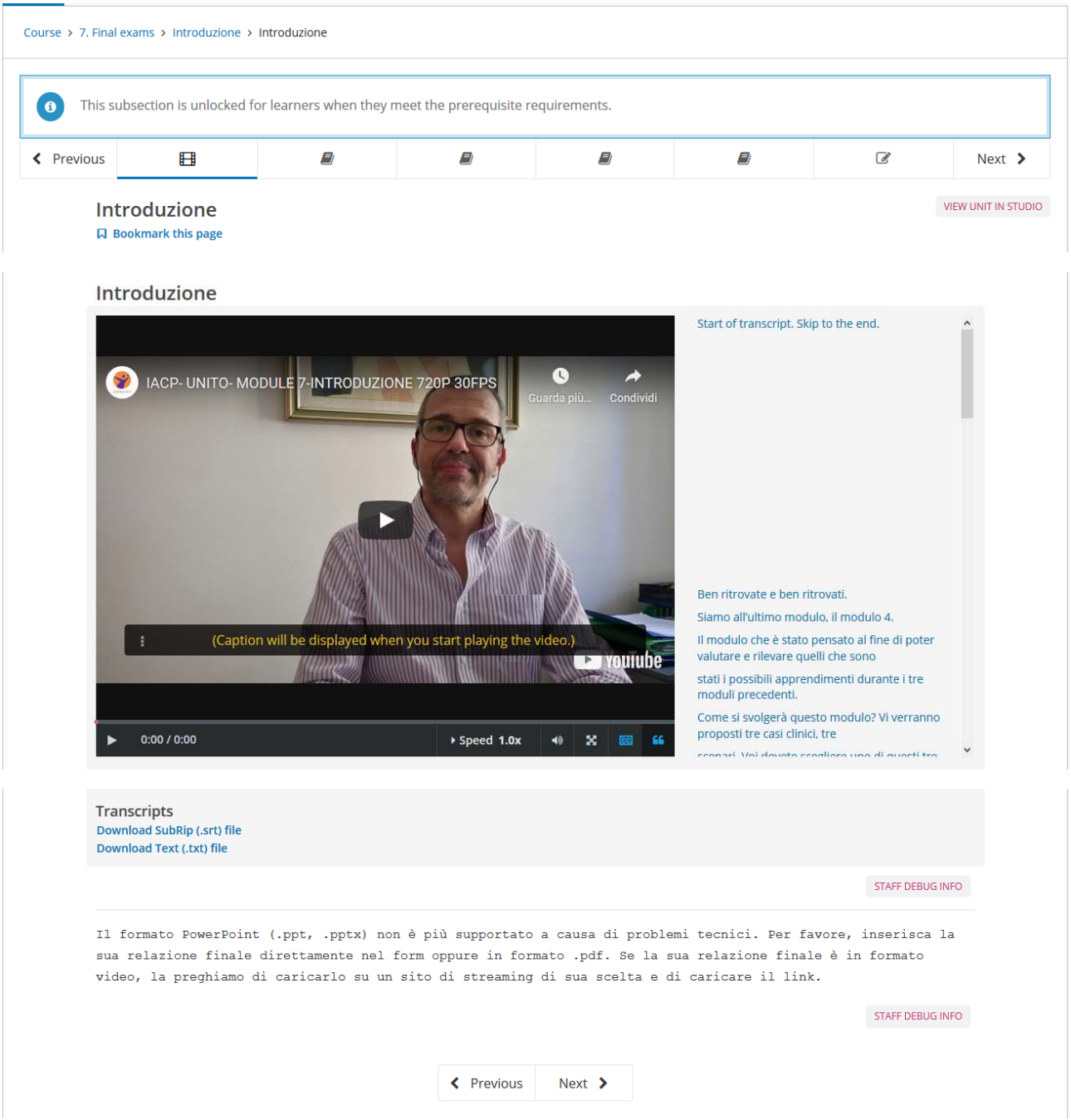
In definitiva, sono moltissime le difficoltà che attendono il bambino o l'adolescente vittima

di maltrattamenti;

ma, come abbiamo cercato di evidenziare fino a questo momento, esistono

anche molti strumenti per aiutarlo ad affrontare queste sfide e a vincerle.

Quindi buon lavoro a tutte e a tutti.



Transcript

Ben ritrovate e ben ritrovati.

Siamo all'ultimo modulo, il modulo 4.

Il modulo che è stato pensato al fine di poter valutare e rilevare quelli che sono

stati i possibili apprendimenti durante i tre moduli precedenti.

Come si svolgerà questo modulo? Vi verranno proposti tre casi clinici, tre

scenari. Voi dovete scegliere uno di questi tre scenari e dopo di che dovrete provare

a rispondere mettendo insieme e integrando le competenze apprese nel modulo uno: la teoria,

nel modulo due: la ricerca, e nel modulo tre la parte legislativa; quelli che sono gli

aspetti rilevanti il TIC, il Trauma Informed Care, e come questo possa essere applicato
ai tre scenari.
Come dovrete produrre questo breve report,
questa breve relazione? Avrete più opzioni. Potrete produrre un file
in PowerPoint, quindi una presentazione; potrete registrare un breve video, quindi utilizzare
questo format o potrete produrre un documento Word oppure un file PDF o ancora potrete utilizzare
altre modalità che vi vengono in mente.
La particolarità, la peculiarità di questo
ultimo modulo è che ci sarà una peer review, ossia valuterete il progetto di un altro partecipante
al corso e il vostro progetto al contempo sarà valutato da un altro partecipante.
Vi sarà una revisione fra pari. L'ultima valutazione però verrà sempre a carico e sarà sempre
a carico di un tutor anziano, di uno dei responsabile del progetto.
Questo possiamo dire che è veramente l'ultimo step che vi richiediamo per poter ottenere
quello che sarà il certificato di partecipazione a questo percorso formativo online.
Una volta che avrete terminato la documentazione e avrete terminato il vostro report, video
o presentazione in Power Point, potrete sottometterlo, vi sarà un abbinamento casuale e anonimo
con un altro studente, dopodiché sarete chiamati anche voi a valutare un documento, un report o un video
Vi sarà poi la submission finale del vostro lavoro e arriverà a quel punto
un senior che provvederà a un ulteriore valutazione e a autorizzare o meno la chiusura del vostro percorso formativo
Speriamo che sia stato un percorso piacevole,
che abbiate potuto apprendere un qualche cosa o comunque confermare e avvalorare un sapere
in più rispetto al Trauma Informed Care. Se avrete piacere potrete anche lasciare dei
brevi video alla fine del vostro percorso, con il vostro nome e cognome, brevi documenti
dove andremo a certificare che voi sarete stati su questo percorso formativo.
A nome mio, Luca Rollè, e di tutto il gruppo di lavoro del progetto Care Path, vi diamo
ancora una volta un grande ringraziamento per essere stati con noi e speriamo di rivedervi
ad una futura edizione.

This subsection is unlocked for learners when they meet the prerequisite requirements.

Istruzioni per la peer assessment

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Durante questa attività le verrà richiesto di analizzare un caso (scegliendo lo scenario che preferisce) da un punto di vista legale, psicologico e/o di ricerca scientifica. Il suo contributo dovrebbe contenere le sue riflessioni alla luce dei principi fondamentali della Trauma Informed Care.

1. Può preparare il suo contributo in

- testo (inserisca semplicemente la risposta nell'area corrispondente) OPPURE
- può effettuare l'upload di un file contenente il suo contributo. **Nota importante - il file dovrebbe essere in formato PDF ed avere una dimensione massima di 5MB.**

Se ha preparato un video può semplicemente inserire il link del video che ha pubblicato per renderlo disponibile alla valutazione.
2. Dopo l'invio del suo contributo, ogni partecipante dovrà valutare almeno un contributo preparato da un altro partecipante. Questo è un passaggio obbligatorio per terminare l'attività.
Nota importante - se c'è bisogno di valutare una risposta contenuta in un file, è necessario scaricare il file ed aprirlo nel proprio dispositivo. Bisogna inoltre assicurarsi che abbia l'estensione .pdf. Se questo non è il caso, bisogna rinominare il file aggiungendo il suffisso .pdf alla fine.
3. La valutazione finale del contributo sarà in ogni caso presa in carico dai coordinatori del progetto. Una volta completata questa fase, il voto finale sarà visualizzabile.

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Scenario 1

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Scenario 1

La minore C.F. di anni 15, viene conosciuta da un servizio territoriale su invio dell'Ospedale.

Frequenta la scuola superiore con discontinuità e scarso rendimento ed è stata accompagnata al Pronto Soccorso a causa dell'ingestione di un quantitativo eccessivo di psicofarmaci.

Dopo l'intervento del Pronto Soccorso, viene reinviata a casa con l'obbligo per tutta la famiglie di seguire un percorso di aiuto e sostegno.

La minore si presenta con un atteggiamento in parte rabbioso, non vuole essere al colloquio né parlare delle sue cose e non capisce il perché di questo invio. Lei dichiara di aver fatto una stronzata insieme alla sua amica ma di sicuro non la ripeterà.

Riconosciuta la immaginabile paura con la quale ha vissuto la "stronzata" cui fa riferimento, e chiariti i termini del colloquio, la ragazza si apre e, dando voce alla fragilità della sua storia, racconta di sé:

i genitori sono separati, anche se non ufficialmente, da alcuni mesi e la mamma è fuori casa. C. trova questo positivo per se, ha un rapporto molto difficile con la madre ed il fatto che sia fuori casa la fa sentire più tranquilla da una parte, anche se le ha fatto perdere una persone che la aiutava a fare dellecose. A lungo, nel corso delle scuole elementari e parte delle medie, questa mamma è stata rabbiosa e l'ha picchiata ed insultata quando si trovava davanti a degli errori o delle cose che lei doveva fare diversamente. Le correzioni di azioni venivano agite con botte, insulti "sei una stronza" "stupida" per arrivare nell'ultimo periodo a squalifiche più significative "sei una puttanella". Però, nell'ultimo anno di vita C. ha iniziato "finalmente" a non subire più le cose ma a rispondere a sua madre e a volte sono arrivate a picchiarsi, cosa che lei ha trovato un buon modo per affrontare i litigi. Il padre è via tutto il giorno per lavoro e C. dice che è una brava persona, che tuttavia tornava a casa la sera e non sembrava interessato alle cose di casa, probabilmente per la stanchezza della giornata. Tra i genitori le cose sembrano un po' fredde e non ci sono momenti nella vita familiare in cui le persone si ritrovano insieme a fare cose. Anche le domeniche vengono trascorse a casa o con la zia (sorella del padre) che per C. è un punto di riferimento.

Quando ha 13 anni C. a scuola inizia a fumare ed insieme alla sua amica conoscono marijuana e fumo. Le piace la sensazione di rilassamento e divertimento che prova quando fuma e ben presto inizia a frequentare un gruppo di persone che condividono lo stesso "interesse" per il fumo.

Dopo qualche mese di continue difficoltà in casa, sua mamma inizia ad essere meno presente e nel pomeriggio esce tutti i giorni e questo permette a C. di essere libera di portare a casa chi vuole e di avere il suo spazio per stare come vuole. Inizialmente lei è contenta di questo e non si informa su questo cambiamento e sulle ragioni che lo hanno determinato, anzi trova che questo sia proprio un vantaggio per la sua vita. Scopre poi un giorno, girando con un'amica, che sua mamma sta frequentando un altro uomo perché li trova seduti in un bar fuori zona in atteggiamenti amorosi.

A questo punto, lei dice, trova finalmente il modo per riuscire ad ottenere tutto ciò che vuole, poiché entra in un gioco di richieste con la madre alle quali la donna non può sottrarsi: C. vuole portare a casa il suo fidanzatino e restare sola e chiede alla madre di lasciarla sola. Inizialmente la donna non vuole ma quando C. le dice che deve per evitare che poi lei spifferi tutto al padre la donna cede e così via, aumentano le richieste di C. e le concessioni della madre: C. porta a casa chi vuole, fuma in casa, le viene concesso l'acquisto di birra e soldi per quello che chiede. Paga tutto questo con la rabbia e gli insulti della donna, che cede ad ogni richiesta seppur facendole sentire tutto il suo disprezzo.

Il padre è all'oscuro di tutto questo. Mentre parla di questo C. ha un atteggiamento di triste trionfo e di grande rabbia.

Ciò va avanti fino al mese di settembre (un anno circa), quando il padre, scoperto il tradimento della moglie, la allontana da casa. A quel punto C. è ancora più libera e resta sola fino al ritorno del padre, inizia a far tardi a scuola o a non andare affatto, fino a quando stando a casa dell'amica e trovando un farmaco che la mamma della sua amica prende, decidono di provarlo insieme. Esattamente a seguito di questo episodio, il papà viene chiamato dalla madre dell'amica che trova le ragazza addormentate sul letto ed in un ostato confusionale e "purtroppo" vengono portate al Pronto Soccorso.

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Scenario 2

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Scenario 2

B. 15 anni, studentessa, figlia maggiore di due; madre imprenditrice, padre disoccupato; vivono nella periferia di una grande città.

Arriva in consultazione a causa di forti ed invalidanti dolori fisici, a carico della metà inferiore del corpo (gambe e addome) non spiegati da alcuna patologia organica (i genitori hanno provveduto a far effettuare tutti i controlli medici).

Questi dolori impediscono a B. di condurre una vita adeguata e soddisfacente per la sua età: andare a scuola con continuità è impossibile e, infatti, rischia di perdere l'anno scolastico; inoltre uscire, praticare uno sport o frequentare i coetanei è molto complicato perché ogni programma potrebbe essere mandato in frantumi da questi improvvisi e lancinanti dolori.

Al primo colloquio la ragazza si presenta molto poco curata, piuttosto schiva (non condivide lo sguardo, parla poco e a bassa voce) e ritirata (resta per tutto il tempo rannicchiata sulla poltrona). Riferisce di aver deciso di chiedere aiuto perché consapevole della necessità di occuparsi di una problematica che la sta "chiudendo in casa".

Mostra una cultura piuttosto vasta, una grande curiosità ed un'intelligenza molto vivace, che sembrano fare da contraltare alla staticità e al ripiegamento del corpo.

Dichiara di non avere idea rispetto a cosa possa aver dato l'avvio a questa sintomatologia, che è comparsa indicativamente con l'arrivo del menarca.

Racconta di avere ottimi rapporti con i membri della propria famiglia, pochissimi amici e di fare molta fatica a stare in gruppo, sia fra pari che in presenza di adulti. Ama molto leggere ed ascoltare musica, studia diverse lingue da autodidatta.

Nel corso del primo anno di psicoterapia, lavorando sul senso invalidante del sintomo e puntando all'empowerment, i dolori fisici vengono circoscritti e mitigati: si presentano soltanto a ridosso del ciclo mestruale e le fanno perdere al massimo uno o due giorni di scuola. Accanto a ciò, però, non vi è ancora contezza dell'origine del sintomo, inoltre compaiono attacchi di panico piuttosto frequenti.

Accanto al lavoro individuale con B., periodicamente, incontro tutto il nucleo familiare che, sebbene esprima preoccupazione per la sofferenza espressa dalla ragazza, le riconosce grandi cambiamenti e grandi risorse messe in campo per tornare a vivere la propria vita in modo soddisfacente.

Dopo circa due anni di lavoro, ormai B. è in grado di gestire gli attacchi di panico, che sono ormai rarissimi e di utilizzare varie strategie (training autogeno, yoga, fantasie guidate, respirazione) per fare fronte ai dolori fisici. Durante la visione di un film, però, come mi riporterà alla seduta successiva, mentre le immagini mostrano una scena di violenza sessuale, la ragazza ha un'improvvisa sensazione di angoscia che racconterà "come un black out interiore". Iniziamo ad esplorare questo suo sentire, cominciando ad avvicinarci a quelli che inizialmente sembrano alla ragazza "frammenti di sogni", poi divengono nebulose immagini che non sa se siano fantasie o ricordi di film o libri.

Lavorando, con tempi e modalità rispettosi della ragazza, delle sue difese e delle sue comprensibili paure, ma anche continuando a supportare e rinforzare le sue risorse, lentamente B. recupera il ricordo dell'abuso subito da una persona cui era affidata, in assenza dei genitori, tra i 3 e i 7 anni. Il recupero del ricordo permette a B. sia di dare l'avvio all'iter per la denuncia e per mettersi in sicurezza (l'abusante frequentava ancora, seppur sporadicamente, la famiglia) sia di iniziare a dare senso alle proprie sofferenze psichiche, fino a quel momento gestite, ma non significate.

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Scenario 3

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Scenario 3

Il minore R. di anni 13, viene conosciuto da un servizio territoriale su invio del Tribunale.

Frequenta la scuola elementare ed è inserito all'interno di una casa famiglia da quando ha 9 anni .

All'incontro è accompagnato dall'educatrice della casa famiglia ed è aperto ed interessato a conoscere le persone con le quali ha un colloquio finalizzato ad una presa in carico. Inizialmente socievole, risponde alle domande, interagisce con le persone, scherza ed è simpatico, quando si parla un po' del motivo del colloquio da voce a tutta la sua confusione: non capisce perché sta lì, cosa dovrebbe fare, cosa si vuole da lui e chiede risposte a queste domande dando voce al disorientamento e a diversi timori (di essere allontanato ancora di più dai genitori, di far loro del male, che qualcuno decida che non potrà frequentarli , etc....).

Dopo un periodo di separazione i genitori oggi vivono insieme, esattamente come quando R. è stato allontanato. Il ragazzo ricorda diversi litigi tra i due, non sono andati molto d'accordo, e diverse volte la mamma, originaria di un paese diverso da quello di residenza, ha cercato di ritornare nella sua famiglia di origine. R. quando la mamma se ne andava era dispiaciuto, ma anche contento perché i litigi per un periodo si interrompevano. Vuole bene ai suoi genitori ed anche ora gli fa piacere passare il tempo con loro.

Li sente tutti i giorni e li vede 1 volta a settimana, quando lo vanno a trovare nella sede della casa famiglia.

Sta lì da un paio d'anni e si trova bene, anche se vorrebbe tornare a vivere a casa, ma non sa se è possibile.

Non ricorda bene il giorno in cui è entrato in casa famiglia, ma sa che fu il padre ad accompagnarlo. La mamma restò a casa a piangere e lui si sentì molto dispiaciuto per lei. Papà è stato più forte, perché lo ha accompagnato, e come sempre lo ha riempito di parole ma non ha pianto.

R. era spaventato quando è entrato in casa famiglia, ma ha trovato delle persone divertenti e simpatiche che lo hanno fatto sentire meno impaurito ed anche con gli altri è stato facile fare amicizia.

R. entra in casa famiglia dopo che un amico dei suoi genitori fa delle avances di natura sessuale, violandolo. Non è lui a dirlo a nessuno, ma ad un certo punto la cosa viene fuori (R. ancora non sa perché) e finisce anche in Tribunale. Quest'uomo era un amico dei genitori e frequentava la casa abbastanza spesso, e lui gli era affezionato e sentiva che anche per questo amico lui era importante: la sera gli raccontava delle storie e a volte il papà gli chiedeva di metterlo a letto.

Quando sono successe delle cose brutte e si sono venute a sapere, il padre ha accompagnato R. in casa famiglia, volendolo proteggere da questo uomo.

R. non sa bene cosa prova per tutto ciò, forse – dice - solo tanta confusione.

In casa famiglia sta bene, a volte si sente però un po' costretto a stare dentro certe regole dure e allora si arrabbia moltissimo e finisce per fare danni, agli oggetti e non alle persone. Non sopporta in particolare che gli vengano messe delle regole che non capisce per sentire i suoi genitori o per vederli, ma per il resto dentro la casa famiglia fa delle cose interessanti (addirittura sport) e sta bene con gli altri. Gli piace avere amici intorno anche se certe volte desidera stare da solo e vorrebbe essere lasciato in pace.

Ha un'educatrice con la quale ha stabilito un rapporto speciale, che si occupa molto di lui e questo gli piace molto.

Ha molte paure su quello che succederà quando uscirà dalla casa famiglia, non perché debba uscire, ma perché* sa che ad un certo punto succederà ma non vuole che queste paure le sappiano i suoi genitori, perché ha paura si dispiacciano e pensino che lui non gli vuole bene.

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Open Response Assessment

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FINAL EXAMS

This assignment has several steps. In the first step, you'll provide a response to the prompt. The other steps appear below the **Your Response** field.

IN PROGRESS

1 Your Response

Enter your response to the prompt. You can save your progress and return to complete your response at any time. **After you submit your response, you cannot edit it.**

The prompt for this section

> Analizzare il caso (Scelga lo Scenario che preferisce) da un punto di vista legale, psicologico e/o della ricerca scientifica.
>
> Realizzare un contributo (che può assumere diverse forme quali, ad esempio: testo, video, presentazione .ppt) che contenga le riflessioni del partecipante alla luce dei principi fondamentali della Trauma Informed Care, in merito allo scenario prescelto.

Your response (optional)

Enter your response to the prompt above.

Save your progress THIS RESPONSE HAS NOT BEEN SAVED.

Sfoglia... Nessun file selezionato. Upload files

You may continue to work on your response until you submit it.

Submit your response and move to the next step

NOT AVAILABLE

2 Assess Peers

NOT AVAILABLE

3 Staff Grade

Your Grade: Not Started

MANAGE INDIVIDUAL LEARNERS VIEW ASSIGNMENT STATISTICS GRADE AVAILABLE RESPONSES

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Domande per valutazione

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	0. Per nulla	1	2	3	4. Moltissimo	5. Non lo so
1. I contenuti sono coerenti con gli obiettivi formativi	○	○	○	○	○	○
1. I contenuti della lezione sono esposti in modo comprensibile	○	○	○	○	○	○
1. Il tempo necessario alla fruizione dei materiali è adeguato	○	○	○	○	○	○
1. Quanto ritiene utile i temi approfonditi nella lezione	○	○	○	○	○	○
1. Quanto ritiene applicabile i temi approfonditi nella lezione	○	○	○	○	○	○
1. Suggerirebbe a un amico/collega/conoscente di frequentare questa lezione	○	○	○	○	○	○
1. Come valuterebbe l'esperienza di questa formazione online?	○	○	○	○	○	○
1. Come giudica il livello del corso CarePath?	○	○	○	○	○	○
1. Si definirebbe soddisfatto da un punto di vista tecnico (audiovideo, pdf etc) del corso CarePath?	○	○	○	○	○	○
1. È stato facile utilizzare la piattaforma di formazione online del corso CarePath?	○	○	○	○	○	○

Invia

View results

Export results to CSV Download CSV

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carepath

Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material
ANNEX 1
–
Italian Version

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

ESEMPI DI RICERCA

- Ricerca Quantitativa

Il sito di questo studio era un piccolo college (iscrizione 1.000), religioso, coeducativo, di arti liberali in una città del Midwest con una popolazione di 175.000 persone. [Gli autori hanno identificato il sito di ricerca e la popolazione.]
Il tasso di abbandono dell'anno precedente era del 25%. I tassi di abbandono tendono ad essere più alti tra le matricole e gli studenti del secondo anno, quindi è stato fatto un tentativo di raggiungere il numero più elevato possibile di matricole e studenti del secondo anno attraverso la distribuzione del questionario nelle classi. La ricerca indica che maschi e femmine abbandonano il college per diversi motivi (Bean, 1978; Spady, 1971). Pertanto, solo le donne sono state analizzate in questo studio. Nell'aprile del 1979, 169 donne hanno restituito i questionari. È stato selezionato per questa analisi un campione omogeneo di 135 donne di 25 anni o più giovani, non sposate, a tempo pieno cittadini statunitensi e caucasici (Kerlinger, 1973).
Di queste donne, 71 erano matricole, 55 erano studenti del secondo anno e 9 erano juniores. Tra gli studenti, il 95% aveva un'età compresa tra i 18 e i 21 anni. Questo campione è affetto da bias dovuto alla partecipazione di studenti con maggiore capacità, come indicato dai punteggi del test ACT. [Gli autori hanno presentato informazioni descrittive sul campione.] I dati sono stati raccolti mediante un questionario contenente 116 items. La maggior parte di degli items erano di tipo Likert basati su una scala da "in misura molto limitata" a "in misura molto grande".
Altre domande hanno richiesto informazioni concrete, come punteggi ACT, voti delle scuole superiori e livello di istruzione dei genitori. Tutte le informazioni utilizzate in questa analisi sono state ricavate dai dati del questionario. Questo questionario era stato sviluppato e testato in altre tre istituzioni prima del suo uso in questo college. [Gli autori hanno discusso lo strumento.]...
Per analizzare i dati sono stati utilizzati regressione multipla e path analysis (Heise, 1969; Kerlinger & Pedhazur, 1973).

(Bean & Creswell, 1980, pp. 321-322)

Ricerca Qualitativa

Lo scopo della ricerca era quello di studiare l'iniziazione al tabagismo di pre-adolescenti (Frohlich, Potvin, Chabot, Corin 2002). Dopo aver ricostruito la prevalenza del tabagismo fra pre-adolescenti in 32 territori del Quebec e aver acquisito informazioni pertinenti sui vincoli e sulle risorse «strutturali» che ora ostacolo, ora autorizzano l'abitudine al fumo di questa popolazione – la presenza di rivendite di sigarette, quella di luoghi pubblici nei quali non è consentito fumare, la presenza di soggetti che controllano il rispetto delle regole che governano la vendita delle sigarette ad adolescenti e il fumo nei luoghi pubblici – le autrici puntano l'attenzione su otto territori nei quali conducono dei focus group. In ciascun territorio i partecipanti vengono reclutati con la mediazione degli insegnanti della scuola di quartiere, mettendo con ciò capo a gruppi di ragazzi e ragazze che – con ogni probabilità – si conoscevano e frequentavano prima del focus group. In questo studio, la reciproca conoscenza dei partecipanti diventa una risorsa e non già un limite, offrendo alle ricercatrici la possibilità di accedere a discorsi che, magari meno «addomesticati», prendevano forma nel contesto di vita dei partecipanti. Questi ultimi, inoltre, forte del sostegno reciproco hanno avuto modo di affrontare con maggiore serenità un tema – l'abitudine al fumo – difficile da discutere di fronte a un interlocutore adulto. La conoscenza del «contesto etnografico» (Cicourel, 1974), dei codici linguistici delle pratiche sociali diffuse nei territori cui i focus group furono ancorati è quanto consentì alle autrici di fronteggiare le difficoltà comunemente associate alla realizzazione di un focus group con un gruppo naturale: il richiamo a esperienze condivise non pienamente esplicitate nel discorso, l'uso di espressioni gergali, il ricorso ad espressioni indicali.

(Cardano, Ortalda, 2017, pp. 242- 243)

DEFINIZIONI E PREMESSE

Guyadeen & Seasons (2018) evidenziano come, in modo simile a molte altre discipline, “il campo della pianificazione ha un proprio stile di valutazione” (p. 98) che può essere classificato secondo due filoni: “valutazione del piano e valutazione della pianificazione. Tradizionalmente, la valutazione nella pianificazione era considerata indipendente dalla valutazione del programma e comportava l'uso di approcci di valutazione specifici. La disciplina di pianificazione attualmente sostiene che vi sia un vantaggio nel costruire legami più forti tra la valutazione del programma e la valutazione nella pianificazione” (p. 98). Nel sistema sanitario pubblico, in particolare, la valutazione svolge un ruolo importante nei processi di elaborazione delle politiche e dei piani programmatici. “Entrambi i processi seguono una fase di identificazione e definizione del problema” (p. 99), a cui seguono le fasi di formulazione, implementazione e, infine, di valutazione. L’ultima fase è mirata alla determinazione del successo dell'intervento e all'identificazione delle aree di miglioramento (Pal, 2014; Guyadeen & Seasons, 2018). Come specificato da Guyadeen & Seasons (2018): “È un processo strutturato che mira a creare e sintetizzare informazioni sugli interventi al fine di formulare giudizi sui cambiamenti risultanti, sulla desiderabilità di un intervento e sul grado di adattamento tra risultati intenzionali e non intenzionali (McDavid & Hawthorn, 2006)” (p. 99) . Il processo di valutazione può concentrarsi anche sull'efficacia dei costi di programmi e piani, e può essere considerato particolarmente importante nelle organizzazioni afferenti al settore pubblico: per motivi di responsabilità politica o legislativa, è richiesto ai pianificatori di dimostrare i benefici delle loro azioni al pubblico e alla comunità (Vedung, 2010; Guyadeen & Seasons, 2018).

Craig e colleghi (2008) mettono in luce “come interventi complessi siano ampiamente usati nel servizio sanitario, nelle pratiche della salute pubblica e in aree di politica sociale che hanno importanti conseguenze sulla salute” (p. 1). Tali iniziative presentano sfide per gli operatori che si occupano di valutazione, che vanno oltre le difficoltà pratiche e metodologiche che ogni valutazione del successo di un’iniziativa deve affrontare. Infatti, “gli interventi complessi sono solitamente descritti come interventi che contengono diversi componenti interagenti” e che hanno molteplici “caratteristiche che i valutatori dovrebbero tenere in considerazione” (Craig et al., 2008, p. 1). In questo, ad esempio, domande chiave nella valutazione di interventi complessi riguardano: tali interventi sono efficaci nella pratica quotidiana? Gli effetti variano

a seconda dei destinatari o dei contesti? Come funziona l'intervento? Quali sono gli elementi chiave e come esercitano i loro effetti?

In via generale, dal punto di vista procedurale e processuale, la *best-practice* consiste nello sviluppare sistematicamente gli interventi. Questo vuol dire che: "la *best-practice* è lo sviluppare interventi sistematicamente, utilizzando le migliori evidenze disponibili e la teoria appropriata, quindi testarli utilizzando un approccio graduale, partendo da una serie di studi pilota mirati a dipanare i principali elementi di incertezza nel disegno progettuale e passando a una valutazione esplorativa e, in seguito, ad una definitiva. I risultati dovrebbero essere divulgati nel modo più ampio e dettagliato possibile, con ulteriori ricerche per monitorare il processo di attuazione" (Craig et al., 2008, p. 2).

Per iniziare a chiarire gli elementi coinvolti in questo complesso processo, Rychetnik, Frommer, Hawe & Shiell (2002) ci forniscono le seguenti definizioni:

- INTERVENTO: può essere definito come un insieme di azioni finalizzate a un obiettivo che comporta un cambiamento o produce esiti (*outcomes*) identificabili. Promuovere un maggior benessere o proteggere lo stato di salute sono gli obiettivi principali degli interventi pubblici di salute, che si distinguono da quelli clinici che sono generalmente rivolti alla prevenzione o al trattamento del disagio negli individui.
- CONTESTO: fa riferimento al setting sociale, politico e/o organizzativo entro il quale l'intervento è programmato/progettato e in cui è implementato e valutato. Le caratteristiche contestuali che vengono considerate rilevanti ai fini di un intervento variano in base al tipo di intervento. Per gli interventi di carattere pubblico nell'ambito della salute risultano importanti i fattori politici e organizzativi, socioeconomici e demografici, nonché ambientali.
- VALUTAZIONE: è il processo che consente di determinare il valore di un intervento attraverso il confronto con standard predeterminati ed espliciti.
- EVIDENZA: l'evidenza implica la lettura interpretativa dei dati rilevati attraverso una ricerca formale o indagini specifiche implementate secondo gli standard propri del metodo scientifico. La Evidence-based practice, infatti, mette in luce e si occupa delle conseguenze desiderate di un intervento e considera centrale l'efficacia (anche in termini di costo) considerando i dati sull'implementazione e gli esiti dell'intervento.

Inoltre, i PROGRAMMI sono composti da insiemi di attività volte a raggiungere un risultato specifico correlato o un insieme di obiettivi (McDavid & Hawthorn, 2006; Pal, 2014; Guyadeen & Seasons, 2018). I programmi sono generalmente pensati come mezzi-fini in cui le risorse vengono trasformate in attività per produrre un risultato desiderato (McDavid & Hawthorn,

2006; Guyadeen & Seasons, 2018). I PIANI, che possono assumere le caratteristiche di una guida, una sorta di visione programmatica e di pianificazione, hanno un ruolo predominante nell'organizzazione di interventi o iniziative per una comunità (Baer 1997; Ryan, 2011; Guyadeen & Seasons, 2018). Possono avere obiettivi complessivi in quanto offrono una visione orientata agli sviluppi futuri: incorporano fatti, obiettivi e politiche che possono essere tradotti in un modello di sviluppo fisico e affrontano molteplici problemi della comunità (Berke et al., 2006). I programmi possono essere parte delle strategie di implementazione di un piano (Guyadeen & Seasons, 2018). Come descritto da Guyadeen & Seasons (2018): "È importante notare che i piani sono strumenti in evoluzione che devono essere sottoposti a revisioni e aggiornamenti continui per rimanere pertinenti ai bisogni, alle conoscenze e alle esperienze in evoluzione (Brody, 2003). A tale riguardo, la valutazione dovrebbe svolgere un ruolo fondamentale nel garantire l'applicabilità e la pertinenza di piani e programmi" (p. 99).

In primo luogo, la valutazione può essere considerata "una disciplina empiricamente orientata che genera informazioni sui programmi" (Guyadeen & Seasons, 2018, p. 99) con lo scopo di migliorarli e/o guidare le decisioni future. In secondo luogo, vi è un'enfasi sia sul funzionamento del programma sia sui risultati. Ovvero, la valutazione non riguarda solo l'efficacia del programma, ma anche il processo. Infatti, è concentrata sul modo in cui i programmi vengono messi in pratica; include una analisi dei metodi organizzativi utilizzati per somministrare il programma, gli input utilizzati (ad es. Risorse), i risultati (ad es. le misure tangibili di un programma), e la sua economicità (Howlett, Ramesh & Perl 2009; Guyadeen & Seasons, 2018). Infine, la valutazione del programma viene utilizzata per tentare di rendere i programmi più efficienti ed efficaci (Weiss, 1998; Guyadeen & Seasons, 2018), e come mezzo per assicurare responsabilità e garanzia della qualità (Cousins et al., 2014; Pal, 2014; Guyadeen & Seasons, 2018).

Per queste ragioni, le decisioni relative agli interventi nel campo della sanità pubblica dovrebbero essere basate su una profonda valutazione dei punti di forza delle innovazioni proposte, ma anche delle debolezze e delle lacune nelle evidenze che ne sostengono la applicazione (Rychetnik et al., 2002). Le guide critiche nel campo della valutazione degli interventi, che identificano e valutano molteplici dimensioni delle evidenze, consentono di dare un adeguato spazio di considerazione per questioni quali la rilevanza e la trasferibilità, fornendo raccomandazioni specifiche e giustificate per la pratica (Rychetnik et al., 2002). Tuttavia, è altrettanto importante bilanciare una valutazione rigorosa e gli scopi complessivi per distinguere tra una valutazione sistematica e rigorosa delle prove disponibili e il complesso

processo sociopolitico che determina le decisioni politiche e pratiche (Rychetnik, Frommer, Hawe & Shiell, 2002).

Inoltre, Rychetnik, Frommer, Hawe & Shiell (2002) sottolineano "la distinzione tra la valutazione delle evidenze e il processo del prendere decisioni politiche od operative sull'attuazione degli interventi. Le evidenze basate sulla ricerca sono solo uno dei numerosi fattori presi in considerazione in queste decisioni" (p. 119). Infatti, gli autori specificano ulteriormente: "gli interventi di sanità pubblica tendono ad essere complessi, programmatici e dipendenti dal contesto. Le prove per la loro efficacia devono essere sufficientemente complete da comprendere tale complessità. La valutazione delle prove deve distinguere tra la fedeltà del processo di valutazione nel rilevare il successo o il fallimento di un intervento e il relativo successo o fallimento dell'intervento stesso. Inoltre, se un intervento non ha successo, l'evidenza dovrebbe aiutare a determinare se l'intervento fosse intrinsecamente difettoso (ovvero, il fallimento del concetto o della teoria dell'intervento), o la mancata consegna (mancata attuazione). Inoltre, una corretta interpretazione delle evidenze dipende dalla disponibilità di adeguate informazioni descrittive sull'intervento e sul suo contesto, in modo tale da poter determinare la trasferibilità delle evidenze" (p. 119).

Come indicato da Craig e colleghi (2008), nella pratica, la valutazione si realizza attraverso una vasta gamma di approcci che limitano la scelta degli interventi da parte dei ricercatori e la loro scelta dei metodi di valutazione. Inoltre, nel campo degli interventi complessi, varie fonti (ad es. la accettabilità politica) possono influenzare notevolmente i ricercatori ed influenzare la modalità di attuazione o adozione di un progetto di valutazione ideale Ancora, i metodi sperimentali sono sempre più ampiamente accettati come metodologie per valutare le *policies*, ma obiezioni politiche o etiche potrebbero limitare il loro utilizzo. La valutazione dovrebbe giocare un ruolo centrale nell'approccio critico agli interventi. Se i pianificatori decidono di utilizzare metodi non sperimentali, dovrebbero essere consapevoli dei loro limiti, interpretare e presentare i risultati con la dovuta cautela. I ricercatori "dovrebbero essere pronti a spiegare ai responsabili delle decisioni politiche o organizzative la necessità di un adeguato lavoro di sviluppo, i pro e i contro degli approcci sperimentali e non sperimentali e i compromessi coinvolti nell'individuazione dei metodi più deboli. Dovrebbero essere pronti a sfidare i decisori istituzionali quando vengono attuati interventi di incerta efficacia in un modo che renderebbe difficile il rafforzamento delle evidenze attraverso una rigorosa valutazione, o quando una modifica della strategia di attuazione aprirebbe la possibilità di una valutazione molto più informativa" (Craig et al., 2008, p. 2).

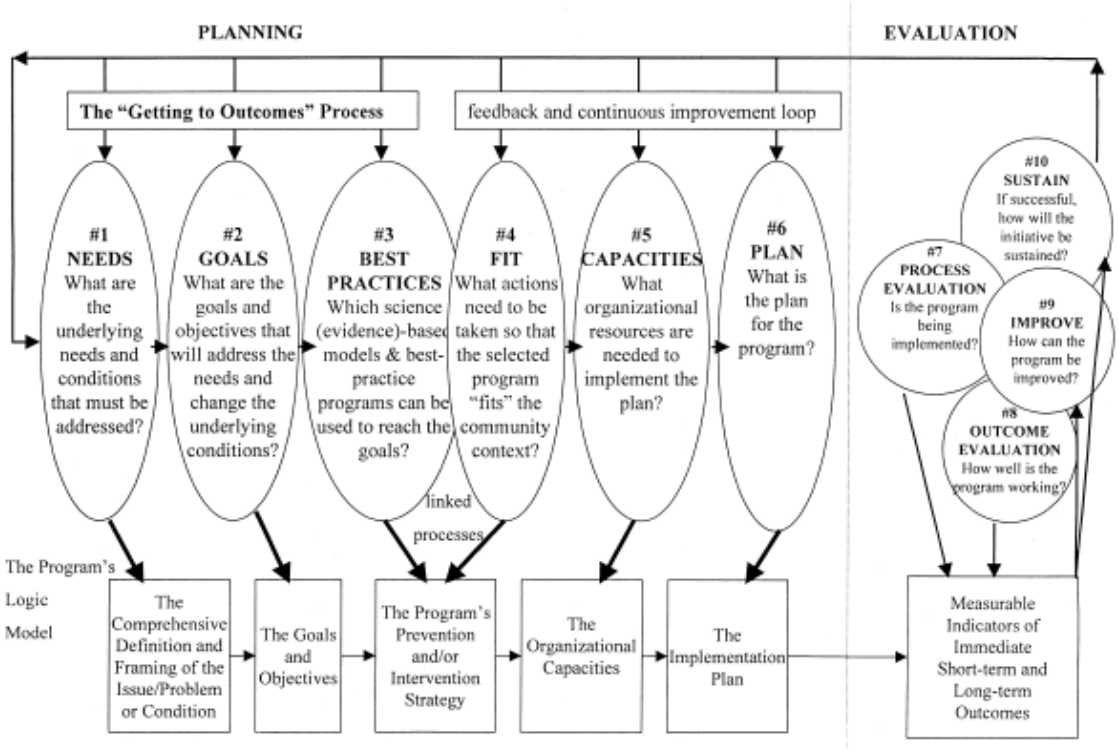
Più specificamente, i ricercatori (Craig et al., 2008) sottolineano che, ai fini di sviluppare un intervento complesso, il processo valutativo dovrebbe seguire una serie di passaggi:

1. Identificazione delle evidenze esistenti in merito: ciò che è già pubblicato o divulgato nella comunità scientifica su interventi simili (revisione sistematica e di alta qualità delle evidenze rilevanti, inclusi i metodi utilizzati per valutare il processo ed i risultati);
2. Identificazione e sviluppo della teoria: la logica dei programmi complessi di intervento, gli esiti previsti ed il modo in cui il cambiamento deve essere raggiunto potrebbero non essere completamente chiari fin dall'inizio. Uno dei primi compiti chiave è "sviluppare una comprensione teorica del probabile processo di cambiamento attingendo a modelli e teorie esistenti, integrate se necessario da nuove ricerche primarie. Questo dovrebbe essere fatto se il ricercatore sta sviluppando l'intervento o valutando uno che è già stato sviluppato" (p. 2);
3. Processo di modellizzazione: la modellizzazione di un intervento complesso prima di una valutazione completa permette ai pianificatori di includere e raccogliere informazioni importanti sulla progettazione sia dell'intervento che della valutazione. Potrebbe essere necessaria una serie di studi per perfezionare progressivamente il progetto prima di intraprendere una valutazione completa. Un altro approccio utile nella fase preliminare del design è una valutazione economica, che può aiutare i proponenti del progetto ad identificare debolezze e portare a perfezionamenti.

Infine, ci sono molti progetti di studio tra cui scegliere e diversi disegni si adattano a domande e circostanze differenti. I ricercatori dovrebbero fare attenzione alle affermazioni generali su quali modelli siano adatti al tipo di intervento e scegliere sulla base delle caratteristiche specifiche dello studio, come la dimensione dell'effetto attesa e la probabilità di selezione o di bias di allocazione. "La consapevolezza dell'intera gamma di approcci sperimentali e non sperimentali dovrebbe portare a compiere scelte metodologiche più appropriate" (Craig et al., 2008, p. 3).

Esistono generalmente due tipi principali di valutazione di un programma: formativo e riepilogativo/globale (*summative evaluation*). Le valutazioni che si concentrano sul miglioramento delle prestazioni di un programma sono conosciute come formative. Una valutazione formativa fornisce feedback al fine di migliorare i risultati dei programmi o aumentarne l'efficienza (McDavid & Hawthorn, 2006; Posavac & Carey, 2007; Guyadeen & Seasons, 2018). Le valutazioni formative generano informazioni per influenzare decisioni immediate su un programma, come il miglioramento delle parti componenti e dei processi (Shadish, Cook & Leviton, 1991; Guyadeen & Seasons, 2018). Le valutazioni che si

concentrano sui risultati, che vengono messe in atto quando un programma è stato finalizzato o è quasi completato, forniscono informazioni su se un programma ha raggiunto o meno i propri obiettivi dichiarati e/o se valga la pena continuare nel processo (McDavid & Hawthorn, 2006; Posavac & Carey 2007; Shadish, Cook & Leviton, 1991; Guyadeen & Seasons, 2018).
Riepilogando, come indicato da Wandersman e colleghi nel 2000, il processo di valutazione è complesso e articolato (Figura 1).



The "Getting to Outcomes" questions contribute to the delineation of the program's logic model structure

Fig. 1. The getting to outcomes framework.

VALUTAZIONE DELL'EFFICACIA E DEGLI ESITI (outcomes)

Secondo Guyadeen & Seasons (2018), "il modello di valutazione storicamente dominante è guidato dalla scienza ed altamente tecnico con una forte enfasi sui metodi quantitativi. I metodi e le tecniche di ricerca scientifica come i progetti di ricerca randomizzati sistematici (RCTs) e gli esperimenti sono considerati parte integrante del processo di valutazione (Alkin, 2013). Questo approccio alla valutazione si concentra sulla misurazione dell'efficacia e dell'efficienza (Greene, 1994)" (p. 100). Gli studiosi stanno lavorando da lungo tempo e non senza dissensi sulle modalità di valutazione, sui suoi obiettivi e contenuti, nonchè sugli indicatori (Jacobson et al., 1999). Ad esempio, una pratica comune nel campo della valutazione riguarda la analisi di come (principalmente in termini quantitativi) i programmi promuovono od ostacolano la realizzazione degli obiettivi. Questo approccio richiede obiettivi identificati in maniera chiara ed indicatori congruenti. La valutazione dell'efficacia è un processo complesso e non scevro dalla responsabilità di compiere rilevanti decisioni: come sottolineano Craig e colleghi (2008), nella valutazione dell'efficacia di un intervento, la randomizzazione deve essere sempre considerata come metodo d'elezione (ad es., per prevenire errori di selezione). Se un trial randomizzato fra gruppi paralleli convenzionale non è appropriato, dovrebbero essere considerati altri progetti randomizzati, o, se un approccio sperimentale non è fattibile, si può prendere in considerazione un progetto quasi sperimentale oppure osservativo.

In merito all'analisi degli esiti dell'intervento, qualora il piano della ricerca sia effettuato conformemente al metodo scientifico, essa ha l'obiettivo di confermare o disconfermare la sussistenza di una relazione causale tra intervento e i suoi effetti e comprendere le ragioni (perché) per cui esso è efficace o meno. Il disegno dello studio definisce inoltre il livello dell'evidenza che ne discende. La revisione sistematica degli studi randomizzati e controllati (*randomised controlled trials* o RCTs) è uno dei metodi che viene maggiormente utilizzato e riconosciuto per fornire il livello migliore di evidenza in merito agli effetti degli interventi di prevenzione e/o trattamento (Rychetnik, Frommer, Hawe & Shiell, 2002). Può essere necessario un follow-up a lungo termine per determinare se i risultati previsti da misure provvisorie o surrogate si verificano o se persistono cambiamenti a breve termine: "sebbene non comuni, tali studi possono essere altamente informativi" (Craig et al., 2008, p. 3).

A proposito dei livelli di evidenza nella valutazione degli interventi di salute pubblica, questi sono oggetto di approfondimento della letteratura scientifica a causa della loro dipendenza dai criteri stabiliti per valutarne la credibilità. In merito, continuano a essere presenti controversie

nel campo dei RCTs applicati all'analisi degli interventi di salute pubblica; esse riguardano prevelentemente la difficoltà nel condurre questi studi a causa della complessità programmatica degli interventi e dell'analisi delle risultanze e del sottostimare il contributo degli studi osservazionali. In particolare, molti interventi pubblici richiedono, per loro natura, strategie di analisi multiple e flessibili a cui difficilmente gli studi basati su modelli RCT "classici" – secondo gli autori - si adattano (specie perche prevedono una standardizzazione troppo rigida dell'intervento e l'assunzione della randomizzazione sulla base di unità individuali). Un punto importante dell'analisi dei ricercatori è quello in cui viene sottolineato che applicare metodologie non-randomizzate ove queste sarebbero, invece possibili, può comportare una rilevante e non sostenibile perdita di rilevanza; ma, seguendo le parole di Rychetnik e colleghi (2002): *"la progettazione dello studio da sola non può essere sufficiente come criterio principale per la credibilità delle prove sugli interventi di sanità pubblica"* (p. 121).

Interpretazione dei risultati

Il processo di valutazione è un elemento rilevante indipendentemente dal fatto che i risultati siano negativi o positivi. Infatti, le prove di un'attuazione adeguata delle procedure previste dal programma di intervento e l'utilizzo di indicatori efficaci nel monitorare il processo di valutazione sono riconosciuti come centrali nella letteratura scientifica (Rychetnik et al., 2002). Le teorie alla base degli interventi, le loro specificazioni (spiegazione e plausibilità) in relazione alle assunzioni sottostanti (le ipotesi), relative alla efficacia e alla funzionalità delle misure dei risultati e degli impatti, sono criteri chiave per la valutazione e l'interpretazione della sua qualità in termini di salute pubblica (Rychetnik et al., 2002).

Seguendo l'analisi di Rychetnik e colleghi (2002), in letteratura sono disponibili approcci multidimensionali per valutare la ricerca sui risultati. Nella valutazione delle prove sull'efficacia dell'intervento tre dimensioni risultano importanti:

1) "la forza dell'evidenza, determinata da una combinazione del disegno dello studio (livello), della qualità metodologica e della precisione statistica" (p. 122);
2) "la grandezza degli effetti misurati" (p. 122);
3) "la pertinenza degli effetti misurati (come osservato nella valutazione) nel contesto di implementazione" (p. 122).

Le valutazioni della qualità su base empirica sono importanti nella misura in cui influenzano le decisioni in merito alla politica o alle pratiche di sanità pubblica. È necessario assicurarsi che l'utilizzo di protocolli di valutazione inadeguati non si traduca in richieste non realistiche o eccessivamente costose. I criteri di valutazione dovrebbero supportare il processo di *decision-*

making ed aiutare a determinare se i risultati misurati comprendono (a) gli interessi delle persone che potrebbero essere coinvolte nel decidere o proporre l'intervento e i destinatari; (b) effetti imprevisti e previsti dell'intervento, benefici o meno; e (c) l'efficienza dell'intervento, nonché la sua efficacia. Sulla prima dimensione è fondamentale il contributo di tutti gli stakeholders, considerata la natura sociale e politica nel campo della salute pubblica. Per questi motivi, figure importanti nel processo di valutazione includono i *decision-maker* e i gruppi bersaglio.

Come sottolineato da Guyadeen & Seasons (2018) esistono modelli di valutazione che pongono una forte enfasi sul pluralismo e sulla comprensione delle diverse parti interessate coinvolte in una valutazione (Greene, 1994); infatti, potrebbero essere considerati critici in quanto direttamente coinvolti (ad es., soldi o interessi personali) nella valutazione. I metodi qualitativi sono spesso usati per migliorare la comprensione dei programmi dalle prospettive degli stakeholder direttamente coinvolti nel programma (Greene, 1994). Le parti interessate sono considerate critiche in quanto sono considerate come aventi una partecipazione diretta (ad esempio, denaro e interessi personali) nella valutazione.

La valutazione partecipatoria (Cousins, 2004), la valutazione dell'empowerment (Fetterman, 2004), la valutazione collaborativa (Rodriguez-Campos, 2012), e più recentemente, la valutazione dello sviluppo (Patton, 2011) potrebbero essere considerati buoni esempi di metodi efficaci in questo campo (Guyadeen & Seasons, 2018).

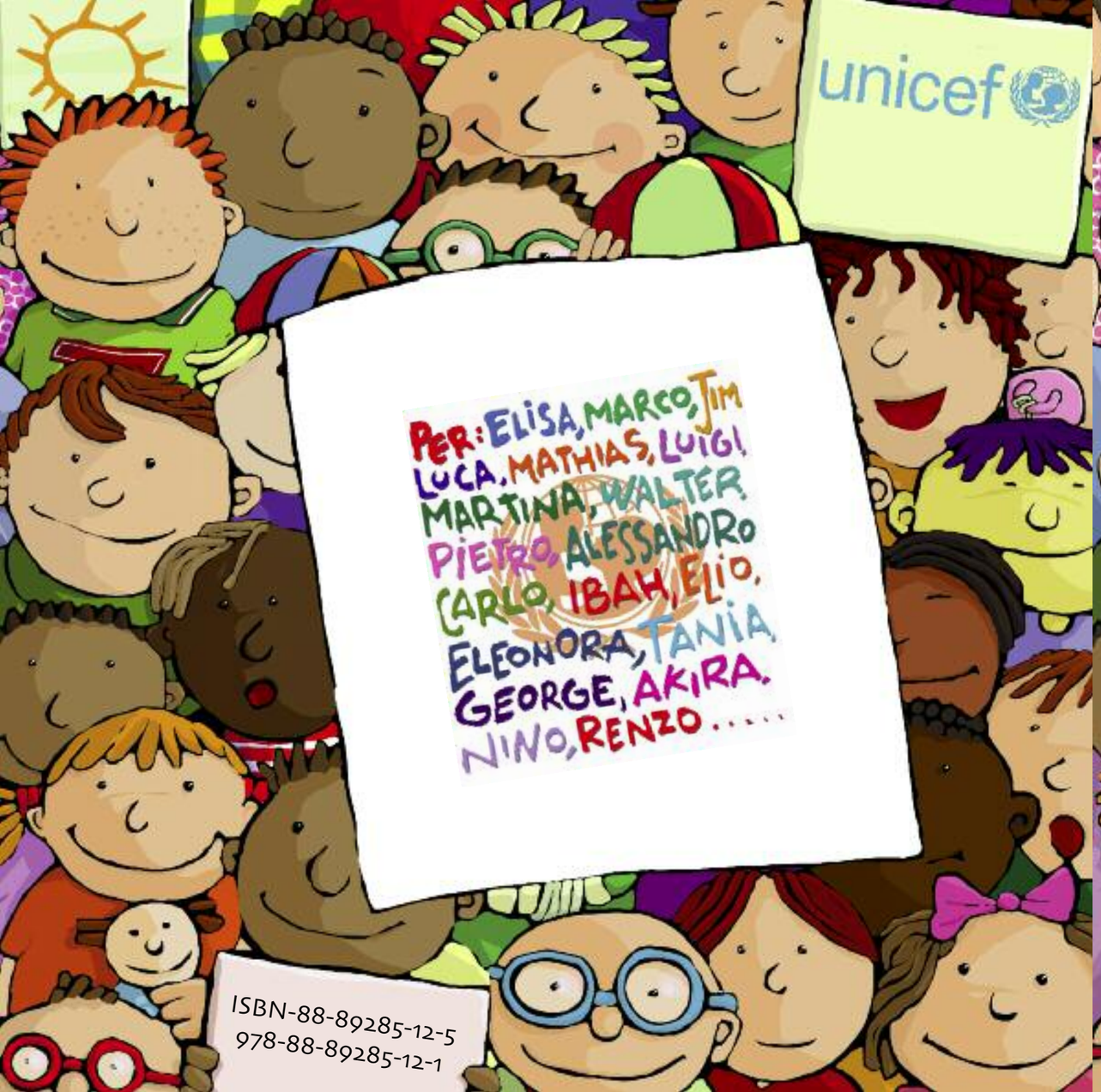
VALUTAZIONE DELL'EFFICIENZA DEGLI INTERVENTI: valutazione del processo

Come evidenziato finora, il processo di valutazione dovrebbe svolgere un ruolo fondamentale nel garantire che i piani riflettano la massima qualità dal punto di vista sia concettuale, sia pratico (Guyadeen & Seasons, 2018; Berke e Godschalk, 2009; Baer, 1997). Può contribuire ampiamente nell'assicurare oggettività e sistematizzazione nella pianificazione ed analisi dell'intervento, può migliorare il processo di preparazione programmatica e fornisce la possibilità di analizzare la congruenza tra il piano dichiarato del progetto (obiettivi dichiarati) ed i risultati ottenuti (Guyadeen & Seasons, 2018). Attraverso la valutazione, possiamo documentare empiricamente le carenze e/o i punti di forza (Berke, Smith & Lyles 2012; Guyadeen & Seasons, 2018). Affinché i piani siano efficaci e valutabili, deve esserci una chiara relazione tra le componenti principali di un piano (cioè i suoi obiettivi e politiche) e i meccanismi di attuazione (Oliveira & Pinho 2010b; Guyadeen & Seasons, 2018).

Complessivamente, esistono due forme generali di valutazione nella pianificazione: (a) valutazione del piano (ad esempio, valutazione della qualità del piano, valutazione dell'implementazione del piano e valutazione dei risultati del piano) e b) valutazione della pianificazione (ad esempio, la valutazione dei processi di pianificazione e della pratica di pianificazione) (Guyadeen & Seasons, 2018). Mentre la valutazione della pianificazione implica la determinazione dell'efficacia del processo di pianificazione, la valutazione del piano dell'intervento e dei relativi risultati implica la valutazione della qualità del piano, il successo della sua attuazione e il raggiungimento dei suoi obiettivi (Morckel, 2010; Guyadeen & Seasons, 2018). Queste forme di valutazione sono simili alla valutazione del programma perché cercano di migliorare il processo decisionale, ma differiscono a causa della loro enfasi sul piano, su come è stato creato e sui risultati generati dal piano (Guyadeen & Seasons, 2018). Inoltre, esistono generalmente tre tipi di valutazione nella pianificazione: ex ante (o a priori), in corso e ex post (Guyadeen & Seasons, 2018). Secondo Oliveira & Pinho (2010), questi tipi di valutazione corrispondono alle diverse fasi della pianificazione, che comprendono la preparazione del piano, l'implementazione e la revisione (cioè, una volta implementato).

L'assistenza sanitaria evidence-based è volta a tenere conto dell'efficienza e dell'efficacia, anche se fino ad oggi le questioni di efficienza non sono state enfatizzate nella medicina basata sull'evidenza. La valutazione delle evidenze sugli interventi di sanità pubblica deve

inevitabilmente determinare se l'efficienza è stata valutata e, in caso affermativo, quanto bene (Rychetnik, Frommer, Hawe & Shiell, 2002). Inoltre, “le decisioni evidence-based sul valore e sull'applicabilità di un intervento si basano sulla conoscenza dell'efficacia di un intervento identico, simile o analogo, solitamente condotto e valutato in un contesto diverso in un momento differente. Per valutare la trasferibilità delle evidenze su un intervento sono necessarie informazioni su (a) l'intervento stesso (b) il contesto di valutazione, e (c) interazioni tra l'intervento e il contesto” (Rychetnik, Frommer, Hawe & Shiell, 2002, p. 123). La fedeltà non è semplice in relazione a interventi complessi. Un elemento che aggiunge complessità è il fatto che la standardizzazione rigorosa delle procedure talvolta danneggia la specificità dell’intervento quando questo è motivato da bisogni locali (Craig et al., 2008). Un punto chiave che deve essere reso chiaro è quanto cambiamento o adattamento sia permesso ed il bisogno di registrare variazioni nell'implementazione in modo che la fedeltà possa essere valutata in relazione al grado di standardizzazione richiesto dal protocollo dello studio. La variabilità nell'implementazione - pianificata o meno – rende ancora più importante che entrambe le valutazioni dei processi e degli esiti siano riportate completamente e che sia fornita una descrizione chiara dell'intervento per consentirne la replicazione (Craig et al., 2008).



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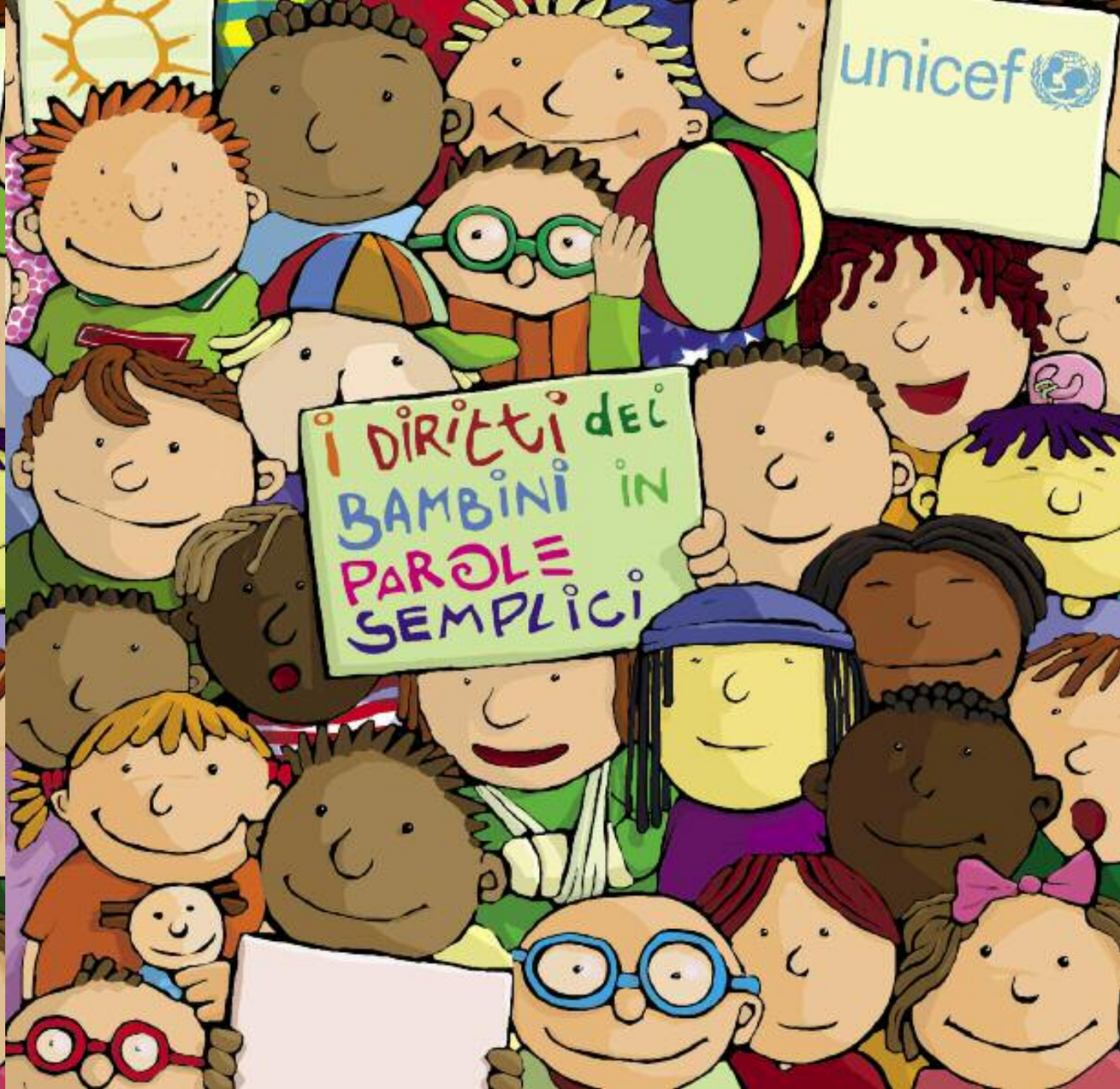

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La Convenzione sui diritti dell'infanzia e dell'adolescenza è composta in tutto da 54 articoli, ma la maggior parte dei restanti articoli riguarda il modo in cui gli adulti e i governi dovrebbero collaborare per assicurarsi che vengano rispettati tutti i diritti di tutti i bambini e i ragazzi. Se vuoi, puoi leggere tu stesso la Convenzione. Discutine con i tuoi amici, i tuoi genitori, i tuoi insegnanti. Se parli dei diritti dei bambini, aiuti anche altri bambini. Più la gente capisce che i bambini e i ragazzi hanno dei diritti, più sarà disposta ad aiutarli ad avere tutto ciò che serve loro per crescere sani, sicuri e liberi.

ARTICOLO 42

Tutti gli adulti e tutte le bambine e i bambini devono sapere che esiste questa Convenzione. Hai il diritto di sapere quali sono i tuoi diritti, e anche gli adulti devono conoscerli.

Dalla prima edizione de *I diritti dei bambini in parole semplici* sono trascorsi alcuni anni, durante i quali abbiamo sperimentato l'efficacia di comunicare anche ai più piccoli i principi sanciti dalla **Convenzione sui diritti dell'infanzia e dell'adolescenza**, attraverso parole semplici e disegni divertenti.

A quasi vent'anni dalla sua approvazione, la Convenzione ci ricorda quali sono i diritti inviolabili dei bambini e i doveri degli adulti nei loro confronti. Per l'UNICEF è importante ribadire questi principi, perché sappiamo che nessun diritto è acquisito per sempre e che ci sono luoghi nel mondo dove non ci sono istituzioni forti, comunità, società e famiglie in grado di difendere i diritti dei più piccoli.

E non è meno importante, evidentemente, ricordare anche in Italia la centralità dei diritti dell'infanzia, rivolgendo a tutti i bambini l'invito a conoscerli e a parlarne. È quanto ci proponiamo con questo libro che, nella sua terza edizione, si è arricchito dei suggerimenti di tanti piccoli lettori che lo hanno letto e apprezzato in tutti questi anni.

Sfogliando le pagine vi accorgerete che il "mondo intorno" è rappresentato attraverso gli occhi dei più piccoli, è visto dal loro particolare punto di osservazione. È questa l'azione che dobbiamo cercare di promuovere sempre: costruire un mondo a misura di bambino.

Le parole, i disegni, i colori, la carta di questa pubblicazione sono pensati per comunicare con i bambini. Noi adulti dobbiamo impegnarci a promuovere i loro diritti, per un'infanzia che sia ovunque sana, protetta e libera.

Vincenzo Spadafora
Presidente
Comitato Italiano per l'UNICEF

ARTICOLO 38

Hai il diritto di essere protetto in tempi di guerra. Se hai meno di quindici anni non devi far parte di un esercito, né partecipare a battaglie.

ARTICOLO 39

Se sei stato ferito o trascurato in qualsiasi maniera, per esempio in guerra, hai diritto a un trattamento speciale e ad attenzioni speciali.

ARTICOLO 40

Hai il diritto di difenderti se sei stato accusato di aver commesso un crimine. La polizia, gli avvocati e i giudici in aula devono trattarti con rispetto e assicurarsi che tu capisca tutto quello che sta succedendo.

ARTICOLO 37

Anche se fai qualcosa di sbagliato, a nessuno è permesso punirti in una maniera che ti umili o ti ferisca gravemente. Non devi mai essere rinchiuso in prigione, se non come rimedio estremo; e se vieni messo in prigione hai diritto ad attenzioni speciali e a visite regolari dalla tua famiglia.

Questa è la traduzione di un opuscolo pubblicato dall'UNICEF nel Regno Unito. È il frutto del lavoro di un gruppo di bambini che hanno riscritto con parole loro alcuni articoli della Convenzione sui diritti dell'infanzia e dell'adolescenza del 1989, quelli più attinenti alla realtà che li riguarda, per spiegarli ai coetanei di tutto il mondo.

Sapevi di avere dei diritti?
Sapevi che esiste una Convenzione sui diritti dell'infanzia e dell'adolescenza?

I tuoi diritti stabiliscono quello che ti è permesso fare, e quello che deve fare chi si occupa di te per assicurarti felicità, salute e sicurezza. Certo, anche tu hai delle responsabilità nei confronti degli altri bambini e degli adulti, per assicurare il rispetto dei loro diritti.

Una Convenzione è un accordo fra nazioni che vogliono obbedire alle stesse leggi. Si dice che il governo di una nazione ratifica una convenzione quando accetta di obbedire alla legge scritta nella convenzione stessa.

Lo Stato italiano ha ratificato la Convenzione sui diritti dell'infanzia e dell'adolescenza il 27 maggio 1991. Ciò significa che il nostro governo deve assicurarsi che ogni bambino abbia tutti i diritti elencati nella Convenzione.

Ciascun articolo della Convenzione spiega uno dei tuoi diritti.
La Convenzione sui diritti dell'infanzia e dell'adolescenza è stata scritta per gli avvocati, perciò nemmeno per gli adulti è facile e comprensibile.
Abbiamo deciso di scegliere i diritti che ci sembravano più importanti e spiegarli con parole nostre.

Hai il diritto di sapere quali sono i tuoi diritti: lo dice l'articolo 42!

ARTICOLO 34

Hai il diritto di essere protetto dagli abusi sessuali. Ciò significa che nessuno può fare nulla al tuo corpo contro la tua volontà; per esempio, nessuno può toccarti o scattarti foto o farti dire cose che non vuoi dire.

ARTICOLO 35

A nessuno è permesso rapirti o venderti.

ARTICOLO 32

Hai il diritto di essere protetto dal lavorare in luoghi o in condizioni che possano danneggiare la tua salute o impedire la tua istruzione. Se il tuo lavoro produce un guadagno, devi essere pagato in modo adeguato.

Hai il diritto di essere protetto dalle droghe illegali e dalle attività volte a produrre e spacciare droghe.

ARTICOLO 33

ARTICOLO 1

Chi ha meno di 18 anni ha tutti i diritti elencati nella Convenzione.

ARTICOLO 2

Ogni bambino ha i diritti elencati nella Convenzione; non ha importanza chi è, né chi sono i suoi genitori, non ha importanza il colore della pelle, né il sesso, né la religione, non ha importanza che lingua parla, né se è un disabile, né se è ricco o povero.

ARTICOLO 3

Quando un adulto ha a che fare con te, deve fare quel che è meglio per te.

Tutti devono riconoscere che hai il diritto di vivere.

Articolo 6

ARTICOLO 30

Se appartieni a una minoranza hai il diritto di mantenere la tua cultura, professare la tua religione e parlare la tua lingua.

Hai il diritto di giocare.

ARTICOLO 31

ARTICOLO 28

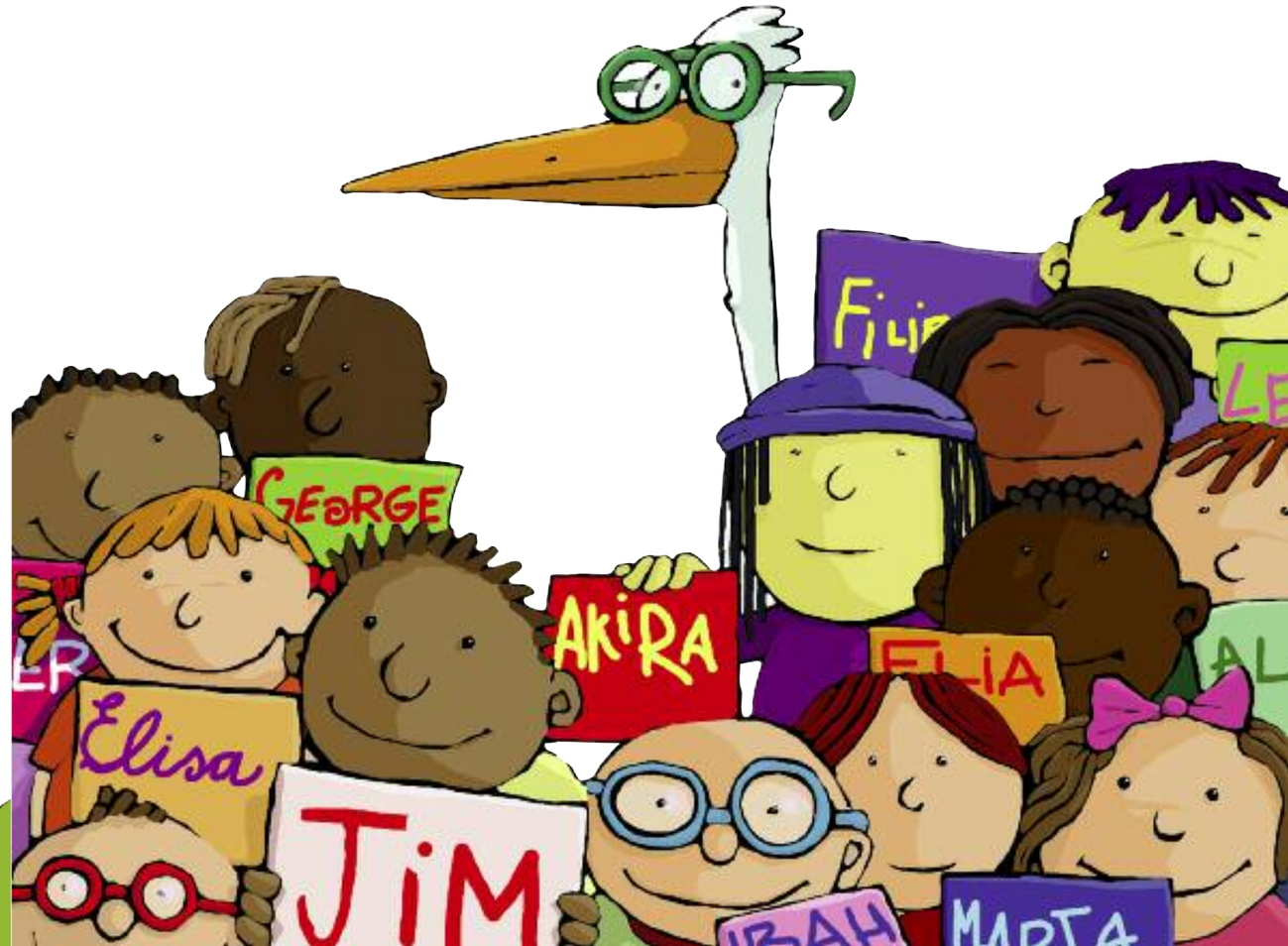
Hai il diritto di ricevere un'istruzione. Devi ricevere un'istruzione primaria, che dev'essere gratuita. Devi anche poter andare alla scuola secondaria.

ARTICOLO 29

Lo scopo della tua istruzione è di sviluppare al meglio la tua personalità, i tuoi talenti e le tue capacità mentali e fisiche. L'istruzione deve anche prepararti a vivere in maniera responsabile e pacifica, in una società libera, nel rispetto dei diritti degli altri e nel rispetto dell'ambiente.

ARTICOLO 7

Hai il diritto di avere un nome, e al momento della tua nascita il tuo nome, il nome dei tuoi genitori e la data devono venire scritti. Hai il diritto di avere una nazionalità e il diritto di conoscere i tuoi genitori e di venire accudito da loro.



Articolo 9

Non devi venire separato dai tuoi genitori, a meno che non sia per il tuo bene. Per esempio, i tuoi genitori potrebbero farti del male o non prendersi cura di te.
Inoltre, se i tuoi genitori decidono di vivere separati, dovrai vivere con uno solo di essi, ma hai il diritto di poter contattare facilmente l'altro.

Articolo 24

Hai il diritto di godere di una buona salute. Ciò significa che devi ricevere cure mediche e farmaci quando sei malato.
Gli adulti devono fare di tutto per evitare che i bambini si ammalino, in primo luogo nutrendoli e prendendosi cura di loro.

Articolo 27

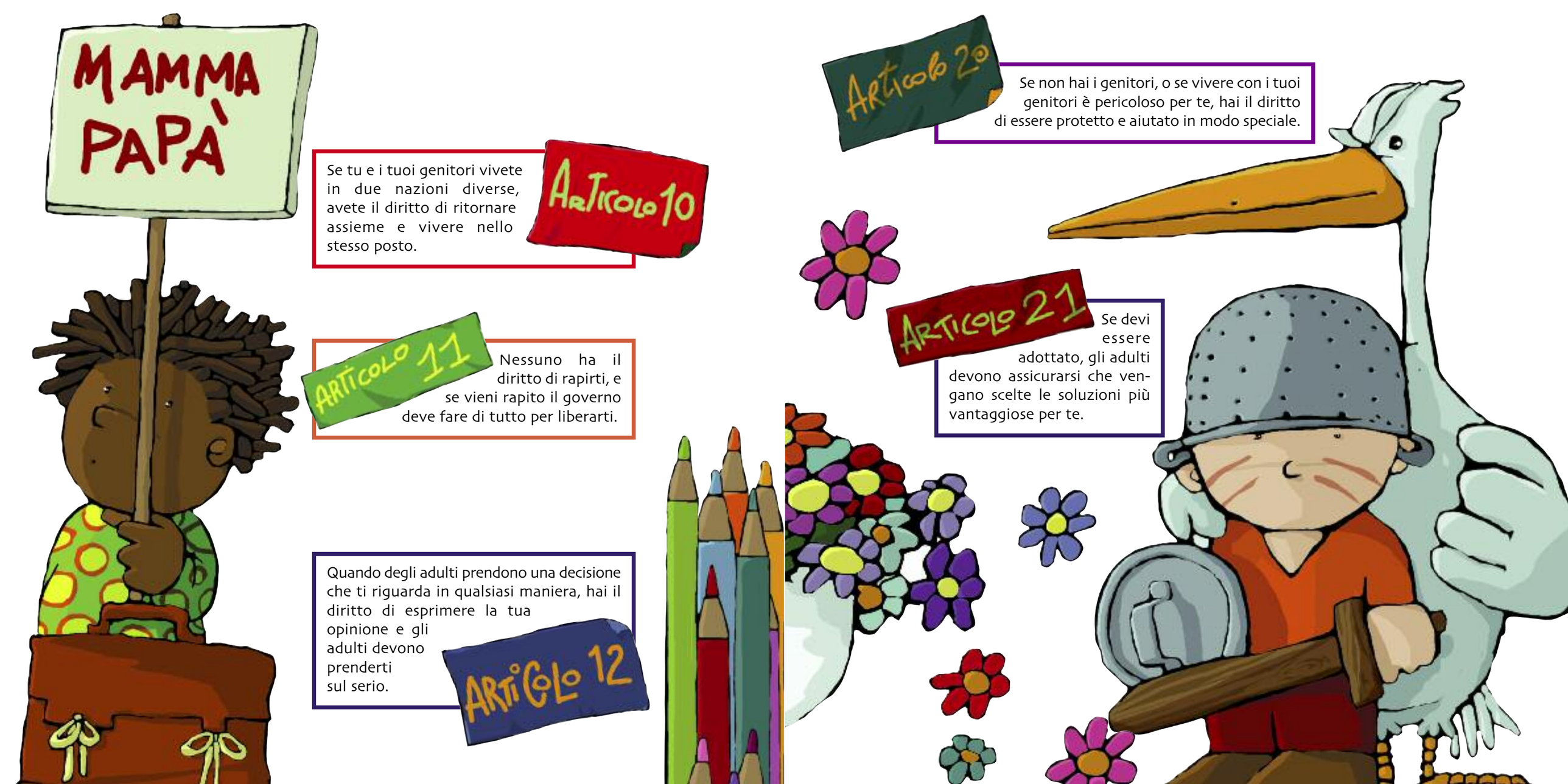
Hai diritto a uno standard di vita sufficientemente buono. Ciò significa che i tuoi genitori hanno l'obbligo di assicurarti cibo, vestiti, un alloggio, ecc.
Se i tuoi genitori non possono permettersi queste cose, il governo deve aiutarli.

ARTICOLO 22

Se sei un rifugiato (cioè se devi lasciare la tua nazione perché viverci sarebbe pericoloso per te) hai il diritto di essere protetto e aiutato in modo speciale.

ARTICOLO 23

Se sei un disabile, fisico o psichico, hai diritto a cure speciali e a un'istruzione speciale, che ti permettano di crescere come gli altri bambini.



ARTICOLO 10

Se tu e i tuoi genitori vivete in due nazioni diverse, avete il diritto di ritornare assieme e vivere nello stesso posto.

ARTICOLO 11

Nessuno ha il diritto di rapirti, e se vieni rapito il governo deve fare di tutto per liberarti.

ARTICOLO 12

Quando degli adulti prendono una decisione che ti riguarda in qualsiasi maniera, hai il diritto di esprimere la tua opinione e gli adulti devono prenderti sul serio.

ARTICOLO 20

Se non hai i genitori, o se vivere con i tuoi genitori è pericoloso per te, hai il diritto di essere protetto e aiutato in modo speciale.

ARTICOLO 21

Se devi essere adottato, gli adulti devono assicurarsi che vengano scelte le soluzioni più vantaggiose per te.

ARTICOLO 18

I tuoi genitori devono collaborare per allevarti e devono fare quel che è meglio per te.

ARTICOLO 19

Nessuno deve farti del male in nessun modo. Gli adulti devono assicurarsi che tu sia protetto da abusi, violenze o negligenze. Nemmeno i tuoi genitori hanno il diritto di farti del male.

ARTICOLO 13

Hai il diritto di imparare e di esprimerti per mezzo delle parole, della scrittura, dell'arte e così via, a meno che queste attività non danneggino i diritti degli altri.

ARTICOLO 14

Hai il diritto di pensare quello che vuoi e di appartenere alla religione che preferisci. I tuoi genitori devono aiutarti a distinguere fra ciò che è giusto e ciò che è sbagliato.

ARTICOLO 15

Hai il diritto di incontrare altre persone, fare amicizia con loro e fondare delle associazioni, a meno che ciò non danneggi i diritti degli altri.

Hai il diritto di avere una vita privata. Per esempio, puoi tenere un diario che gli altri non hanno il diritto di leggere.

ARTICOLO 16

articolo 17

Hai il diritto di raccogliere informazioni dalle radio, dai giornali, dalle televisioni, dai libri di tutto il mondo.
Gli adulti devono assicurarsi che tu riceva delle informazioni che puoi capire.

Convention on the Rights of the Child

Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989

entry into force 2 September 1990, in accordance with article 49

Preamble

The States Parties to the present Convention,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Bearing in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance,

Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

Considering that the child should be fully prepared to live an individual life in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity,

Bearing in mind that the need to extend particular care to the child has been stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular in articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in article 10) and in the statutes and relevant instruments of specialized agencies and international organizations concerned with the welfare of children,

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth",

Recalling the provisions of the Declaration on Social and Legal Principles relating to the Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally; the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) ; and the Declaration on the Protection of Women and Children in Emergency and Armed Conflict, Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration,

Taking due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child, Recognizing the importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries,

Have agreed as follows:

PART I

Article 1

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2

1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 4

States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

Article 5

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Article 6

1. States Parties recognize that every child has the inherent right to life. 2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 7

1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and. as far as possible, the right to know and be cared for by his or her parents.

2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

Article 8

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.

2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

Article 9

1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.

2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.

3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests.

4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

Article 10

1. In accordance with the obligation of States Parties under article 9, paragraph 1, applications by a child or his or her parents to enter or leave a State Party for the purpose of family reunification shall be dealt with by States Parties in a positive, humane and expeditious manner. States Parties shall further ensure that the submission of such a request shall entail no adverse consequences for the applicants and for the members of their family.

2. A child whose parents reside in different States shall have the right to maintain on a regular basis, save in exceptional circumstances personal relations and direct contacts with both parents. Towards that end and in accordance with the obligation of States Parties under article 9, paragraph 1, States Parties shall respect the right of the child and his or her parents to leave any country, including their

own, and to enter their own country. The right to leave any country shall be subject only to such restrictions as are prescribed by law and which are necessary to protect the national security, public order (ordre public), public health or morals or the rights and freedoms of others and are consistent with the other rights recognized in the present Convention.

Article 11

1. States Parties shall take measures to combat the illicit transfer and non-return of children abroad.

2. To this end, States Parties shall promote the conclusion of bilateral or multilateral agreements or accession to existing agreements.

Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 13

1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.

2. The exercise of this right may be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:

(a) For respect of the rights or reputations of others; or

(b) For the protection of national security or of public order (ordre public), or of public health or morals.

Article 14

1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.

2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

Article 15

1. States Parties recognize the rights of the child to freedom of association and to freedom of peaceful assembly.

2. No restrictions may be placed on the exercise of these rights other than those imposed in conformity with the law and which are necessary in a democratic society in the interests of national security or public safety, public order (ordre public), the protection of public health or morals or the protection of the rights and freedoms of others.

Article 16

1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.

2. The child has the right to the protection of the law against such interference or attacks.

Article 17

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health.

To this end, States Parties shall:

(a) Encourage the mass media to disseminate information and material of social and cultural benefit to the child and in accordance with the spirit of article 29;

(b) Encourage international co-operation in the production, exchange and dissemination of such information and material from a diversity of cultural, national and international sources;

(c) Encourage the production and dissemination of children's books;

(d) Encourage the mass media to have particular regard to the linguistic needs of the child who belongs to a minority group or who is indigenous;

(e) Encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being, bearing in mind the provisions of articles 13 and 18.

Article 18

1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.

2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.

3. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Article 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 20

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

2. States Parties shall in accordance with their national laws ensure alternative care for such a child.

3. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Article 21

States Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall:

(a) Ensure that the adoption of a child is authorized only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary;

(b) Recognize that inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin;

(c) Ensure that the child concerned by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption;

(d) Take all appropriate measures to ensure that, in inter-country adoption, the placement does not result in improper financial gain for those involved in it;

(e) Promote, where appropriate, the objectives of the present article by concluding bilateral or multilateral arrangements or agreements, and endeavour, within this framework, to ensure that the placement of the child in another country is carried out by competent authorities or organs.

Article 22

1. States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.

2. For this purpose, States Parties shall provide, as they consider appropriate, co-operation in any efforts by the United Nations and other competent intergovernmental organizations or non-governmental organizations co-operating with the United Nations to protect and assist such a child and to trace the parents or other members of the family of any refugee child in order to obtain information necessary for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his or her family environment for any reason , as set forth in the present Convention.

Article 23

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development

4. States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 25

States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 26

1. States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.

2. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

Article 27

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.

3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.

4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

Article 28

1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:

(a) Make primary education compulsory and available free to all;

(b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;

(c) Make higher education accessible to all on the basis of capacity by every appropriate means;

(d) Make educational and vocational information and guidance available and accessible to all children;

(e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.

3. States Parties shall promote and encourage international cooperation in matters relating to education, in particular with a view to contributing to the elimination of ignorance and illiteracy

throughout the world and facilitating access to scientific and technical knowledge and modern teaching methods. In this regard, particular account shall be taken of the needs of developing countries.

Article 29

1. States Parties agree that the education of the child shall be directed to:

(a) The development of the child's personality, talents and mental and physical abilities to their fullest potential;

(b) The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;

(c) The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own;

(d) The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin;

(e) The development of respect for the natural environment.

2. No part of the present article or article 28 shall be construed so as to interfere with the liberty of individuals and bodies to establish and direct educational institutions, subject always to the observance of the principle set forth in paragraph 1 of the present article and to the requirements that the education given in such institutions shall conform to such minimum standards as may be laid down by the State.

Article 30

In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.

Article 31

1. States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.

2. States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.

Article 32

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

2. States Parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, States Parties shall in particular:

(a) Provide for a minimum age or minimum ages for admission to employment;

(b) Provide for appropriate regulation of the hours and conditions of employment;

(c) Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

Article 33

States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

(a) The inducement or coercion of a child to engage in any unlawful sexual activity;

(b) The exploitative use of children in prostitution or other unlawful sexual practices;

(c) The exploitative use of children in pornographic performances and materials.

Article 35

States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

Article 36

States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

Article 37

States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;

(d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 38

1. States Parties undertake to respect and to ensure respect for rules of international humanitarian law applicable to them in armed conflicts which are relevant to the child.

2. States Parties shall take all feasible measures to ensure that persons who have not attained the age of fifteen years do not take a direct part in hostilities.

3. States Parties shall refrain from recruiting any person who has not attained the age of fifteen years into their armed forces. In recruiting among those persons who have attained the age of fifteen years but who have not attained the age of eighteen years, States Parties shall endeavour to give priority to those who are oldest.

4. In accordance with their obligations under international humanitarian law to protect the civilian population in armed conflicts, States Parties shall take all feasible measures to ensure protection and care of children who are affected by an armed conflict.

Article 39

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

Article 40

1. States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.

2. To this end, and having regard to the relevant provisions of international instruments, States Parties shall, in particular, ensure that:

(a) No child shall be alleged as, be accused of, or recognized as having infringed the penal law by reason of acts or omissions that were not prohibited by national or international law at the time they were committed;

(b) Every child alleged as or accused of having infringed the penal law has at least the following guarantees:

(i) To be presumed innocent until proven guilty according to law;

(ii) To be informed promptly and directly of the charges against him or her, and, if appropriate, through his or her parents or legal guardians, and to have legal or other appropriate assistance in the preparation and presentation of his or her defence;

(iii) To have the matter determined without delay by a competent, independent and impartial authority or judicial body in a fair hearing according to law, in the presence of legal or other appropriate assistance and, unless it is considered not to be in the best interest of the child, in particular, taking into account his or her age or situation, his or her parents or legal guardians;

(iv) Not to be compelled to give testimony or to confess guilt; to examine or have examined adverse witnesses and to obtain the participation and examination of witnesses on his or her behalf under conditions of equality;

(v) If considered to have infringed the penal law, to have this decision and any measures imposed in consequence thereof reviewed by a higher competent, independent and impartial authority or judicial body according to law;

(vi) To have the free assistance of an interpreter if the child cannot understand or speak the language used;

(vii) To have his or her privacy fully respected at all stages of the proceedings.

3. States Parties shall seek to promote the establishment of laws, procedures, authorities and institutions specifically applicable to children alleged as, accused of, or recognized as having infringed the penal law, and, in particular:

(a) The establishment of a minimum age below which children shall be presumed not to have the capacity to infringe the penal law;

(b) Whenever appropriate and desirable, measures for dealing with such children without resorting to judicial proceedings, providing that human rights and legal safeguards are fully respected. 4. A variety of dispositions, such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate both to their circumstances and the offence.

Article 41

Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of the child and which may be contained in:

(a) The law of a State party; or

(b) International law in force for that State.

PART II

Article 42

States Parties undertake to make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike.

Article 43

1. For the purpose of examining the progress made by States Parties in achieving the realization of the obligations undertaken in the present Convention, there shall be established a Committee on the Rights of the Child, which shall carry out the functions hereinafter provided.

2. The Committee shall consist of ten experts of high moral standing and recognized competence in the field covered by this Convention. The members of the Committee shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution, as well as to the principal legal systems.

3. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.

4. The initial election to the Committee shall be held no later than six months after the date of the entry into force of the present Convention and thereafter every second year. At least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to States Parties inviting them to submit their nominations within two months. The Secretary-General shall subsequently prepare a list in alphabetical order of all persons thus nominated, indicating States Parties which have nominated them, and shall submit it to the States Parties to the present Convention.

5. The elections shall be held at meetings of States Parties convened by the Secretary-General at United Nations Headquarters. At those meetings, for which two thirds of States Parties shall constitute

a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

6. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election if renominated. The term of five of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these five members shall be chosen by lot by the Chairman of the meeting.

7. If a member of the Committee dies or resigns or declares that for any other cause he or she can no longer perform the duties of the Committee, the State Party which nominated the member shall appoint another expert from among its nationals to serve for the remainder of the term, subject to the approval of the Committee.

8. The Committee shall establish its own rules of procedure.

9. The Committee shall elect its officers for a period of two years.

10. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee. The Committee shall normally meet annually. The duration of the meetings of the Committee shall be determined, and reviewed, if necessary, by a meeting of the States Parties to the present Convention, subject to the approval of the General Assembly.

11. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.

12. With the approval of the General Assembly, the members of the Committee established under the present Convention shall receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide.

Article 44

1. States Parties undertake to submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have adopted which give effect to the rights recognized herein and on the progress made on the enjoyment of those rights

(a) Within two years of the entry into force of the Convention for the State Party concerned;

(b) Thereafter every five years.

2. Reports made under the present article shall indicate factors and difficulties, if any, affecting the degree of fulfilment of the obligations under the present Convention. Reports shall also contain sufficient information to provide the Committee with a comprehensive understanding of the implementation of the Convention in the country concerned.

3. A State Party which has submitted a comprehensive initial report to the Committee need not, in its subsequent reports submitted in accordance with paragraph 1 (b) of the present article, repeat basic information previously provided.

4. The Committee may request from States Parties further information relevant to the implementation of the Convention.

5. The Committee shall submit to the General Assembly, through the Economic and Social Council, every two years, reports on its activities.

6. States Parties shall make their reports widely available to the public in their own countries.

Article 45

In order to foster the effective implementation of the Convention and to encourage international co-operation in the field covered by the Convention:

(a) The specialized agencies, the United Nations Children's Fund, and other United Nations organs shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies, the United Nations Children's Fund and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite the specialized agencies, the United Nations Children's Fund, and other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities;

(b) The Committee shall transmit, as it may consider appropriate, to the specialized agencies, the United Nations Children's Fund and other competent bodies, any reports from States Parties that contain a request, or indicate a need, for technical advice or assistance, along with the Committee's observations and suggestions, if any, on these requests or indications;

(c) The Committee may recommend to the General Assembly to request the Secretary-General to undertake on its behalf studies on specific issues relating to the rights of the child;

(d) The Committee may make suggestions and general recommendations based on information received pursuant to articles 44 and 45 of the present Convention. Such suggestions and general recommendations shall be transmitted to any State Party concerned and reported to the General Assembly, together with comments, if any, from States Parties.

PART III

Article 46

The present Convention shall be open for signature by all States.

Article 47

The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

Article 48

The present Convention shall remain open for accession by any State. The instruments of accession shall be deposited with the Secretary-General of the United Nations.

Article 49

1. The present Convention shall enter into force on the thirtieth day following the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.

2. For each State ratifying or acceding to the Convention after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the deposit by such State of its instrument of ratification or accession.

Article 50

1. Any State Party may propose an amendment and file it with the Secretary-General of the United Nations. The Secretary-General shall thereupon communicate the proposed amendment to States Parties, with a request that they indicate whether they favour a conference of States Parties for the purpose of considering and voting upon the proposals. In the event that, within four months from the date of such communication, at least one third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any

amendment adopted by a majority of States Parties present and voting at the conference shall be submitted to the General Assembly for approval.

2. An amendment adopted in accordance with paragraph 1 of the present article shall enter into force when it has been approved by the General Assembly of the United Nations and accepted by a two-thirds majority of States Parties.

3. When an amendment enters into force, it shall be binding on those States Parties which have accepted it, other States Parties still being bound by the provisions of the present Convention and any earlier amendments which they have accepted.

Article 51

1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.

2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.

3. Reservations may be withdrawn at any time by notification to that effect addressed to the Secretary-General of the United Nations, who shall then inform all States. Such notification shall take effect on the date on which it is received by the Secretary-General

Article 52

A State Party may denounce the present Convention by written notification to the Secretary-General of the United Nations. Denunciation becomes effective one year after the date of receipt of the notification by the Secretary-General.

Article 53

The Secretary-General of the United Nations is designated as the depositary of the present Convention.

Article 54

The original of the present Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Secretary-General of the United Nations. IN WITNESS THEREOF the undersigned plenipotentiaries, being duly authorized thereto by their respective governments, have signed the present Convention.

carepath

Empowering public authorities and professionals towards trauma-informed leaving care support

I DIRITTI DEL MINORE NEL DIRITTO INTERNAZIONALE E DELL'UNIONE EUROPEA

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

UNIVERSITÀ DEGLI STUDI DI TORINO

REGIONE CALABRIA

IACP

Eurochild
Putting children at the heart of Europe

ReadLab
Research Innovation and Development Lab

ERGO
EMPOWERING CHILDREN & YOUNG PEOPLE

CORDELIA ALAPÍTVÁNY
CORDELIA FOUNDATION

e-trikala

Obiettivi formativi

02

unità

Conoscere i diritti e i principi fondamentali posti dal quadro normativo internazionale e dell'Unione europea, con particolare riguardo al diritto di bambini e ragazzi a essere informati e a partecipare alle procedure che li riguardino

Chi è il minore?

carepath

La Convenzione internazionale sui diritti dell'infanzia (CRC) stabilisce che "si intende per fanciullo ogni essere umano avente un'età inferiore a diciott'anni" (art. 1).

Anche il diritto del Consiglio d'Europa, per la maggior parte degli strumenti riguardanti i minori, adotta la definizione di minore della CRC.

Nell'ambito dell'Unione Europea non esiste una definizione di "minore" e quindi si ricorre alla definizione posta dalla CRC.

Quadro di riferimento

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CONTESTO INERNAZIONALE

- Organizzazione delle Nazioni Unite - ONU
  - Convenzione internazionale sui diritti dell'infanzia- CRC

CONTESTO EUROPEO

- Unione europea
  - Carta dei diritti fondamentali dell'Unione europea (Carta di Nizza)
  - Corte di giustizia dell'Unione europea (CGUE – Corte di Lussemburgo)
- Consiglio d'Europa
  - Convenzione di Lanzarote
  - Convenzione di Istanbul
  - Convenzione europea dei diritti dell'uomo (CEDU)
    - Corte europea dei diritti dell'uomo (CEDU -Corte di Strasburgo)

DIRITTI E LIBERTA' DEL MINORENNE

Tutti gli individui, e dunque anche i minorenni, godono delle libertà e dei diritti civili riconosciuti dagli strumenti (convenzioni, trattati, dichiarazioni) sui diritti umani, in particolare la Carta dei diritti fondamentali dell'UE (Carta di Nizza) e la Convenzione europea dei diritti dell'uomo (CEDU).

LIBERTÀ E DIRITTI FONDAMENTALI

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- LIBERTÀ E DIRITTI CIVILI FONDAMENTALI
- DIRITTI ECONOMICI, SOCIALI E CULTURALI

LIBERTÀ E DIRITTI CIVILI FONDAMENTALI

- Sono detti «di prima generazione» e si considerano **fondamentali** poiché la loro violazione danneggia profondamente la vita di una persona.
- Impongono agli Stati da un lato di non interferire nella sfera privata dell'individuo, dall'altro di attivarsi per garantire il rispetto della persona umana: per esempio il diritto al rispetto della vita familiare (articolo 8 CEDU) obbliga gli Stati a non separare i figli dai genitori tranne il caso in cui ciò sia strettamente necessario per la protezione dei minori stessi, ma anche ad attivarsi per promuovere lo sviluppo delle relazioni tra genitori e figli

Diritto al rispetto della vita familiare

Ogni individuo ha diritto al rispetto delle relazioni familiari

così come vissute nelle pratica

(il minore ha, per esempio, il diritto ad crescere in famiglia e di mantenere contatti con entrambi i genitori dopo la separazione tra loro)

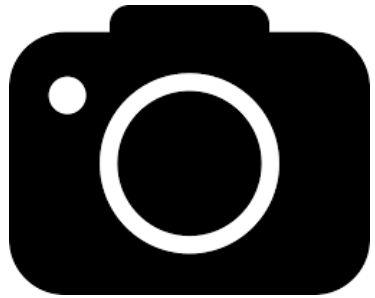
Norme di riferimento:

- Articolo 7 (diritto al rispetto della vita familiare) Carta dei diritti fondamentali dell'UE (Carta di Nizza)
- Articolo 8 (diritto al rispetto della vita familiare) CEDU
- Articoli 8 e 9 Convenzione internazionale sui diritti dell'Infanzia (CRC)

Diritto al rispetto della vita privata

La nozione di «**vita privata**» elaborata dalla giurisprudenza della Corte di Strasburgo è una nozione ampia che include numerosi aspetti dell'identità di un individuo

(per esempio l'integrità fisica e morale della persona, il nome, l'immagine, la riservatezza e la protezione dei dati personali)

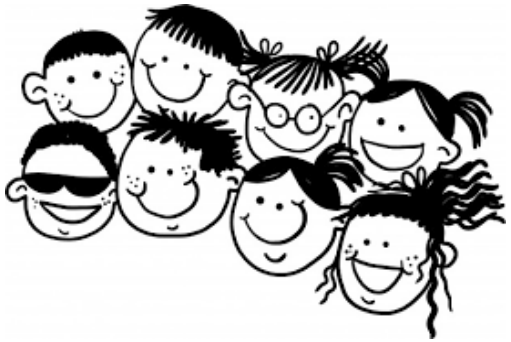


Norme di riferimento:

- Articolo 7 (diritto al rispetto della vita privata) Carta dei diritti fondamentali dell'UE (Carta di Nizza)
- Articolo 8 (diritto al rispetto della vita privata) CEDU
- Articolo 16 Convenzione internazionale sui diritti dell'Infanzia (CRC)

Non discriminazione

Sono vietati i trattamenti **ingiustificatamente differenziati** in base al sesso, alla razza, al colore della pelle, all'origine etnica o sociale, alle caratteristiche genetiche, alla lingua, alle convinzioni o alla religione, alle opinioni politiche o di altro genere, all'appartenenza a una minoranza nazionale, alla situazione finanziaria, alla nascita, alla disabilità, all'età o all'orientamento sessuale.



Norme di riferimento:

- Articolo 7 (diritto al rispetto della vita privata) Carta dei diritti fondamentali dell'UE (Carta di Nizza) Articoli 20 (uguaglianza davanti alla legge) e 21 (non discriminazione) Carta dei diritti fondamentali dell'UE (Carta di Nizza)
- Articolo 14 CEDU; articolo 1 del Protocollo n. 12 della CEDU (non discriminazione)
- Articolo E (non discriminazione) Carta sociale europea (CSE)
- Articolo 8 (diritto al rispetto della vita privata) CEDU
- Articolo 2 Convenzione internazionale sui diritti dell'Infanzia (CRC)

Principio del superiore interesse del minore

carepath

… MA ATTENZIONE!!!

Bambini e ragazzi hanno diritto in quanto minori a beneficiare di una protezione particolare e quindi a un trattamento differenziato sulla base dell'età

Norme di riferimento:

Articolo 3 Convenzione internazionale sui diritti dell'Infanzia (CRC)

ESEMPIO N. 1

Il giudice che debba decidere l'affidamento dei figli minorenni dopo la separazione/divorzio dei genitori dovrà decidere sulla base di ciò che è meglio nell'esclusivo interesse del minore e non dei genitori

Libertà di espressione

Ad ogni individuo deve essere riconosciuta la libertà di opinione e la libertà di ricevere o comunicare informazioni o idee senza che vi possa essere ingerenza da parte delle autorità pubbliche e senza limiti di frontiera (Articolo 10, comma 1 CEDU)

Norme di riferimento:

- Articolo 11 Carta dei diritti fondamentali dell'UE (Carta di Nizza)
- Articolo 10 CEDU
- Articolo 24 comma 1 Carta dei diritti fondamentali dell'UE (Carta di Nizza)
- Articolo 12, comma 1 Convenzione internazionale sui diritti dell'Infanzia (CRC)

Diritto del minorenne di essere ascoltato

«Il minorenne ha diritto di essere ascoltato in ogni procedura giudiziaria o amministrativa che lo concerne, sia direttamente, sia tramite un rappresentante o un organo appropriato, in maniera compatibile con le regole di procedura della legislazione nazionale.» (Articolo 12 Convenzione internazionale sui diritti dell'infanzia e dell'adolescenza - CRC)

Per approfondimenti sul diritto all'ascolto del minore si veda il contributo
Unit_2_3_video_Prof.ssa_Long

Norme di riferimento:

- Articolo 12 Convenzione internazionale sui diritti dell'Infanzia
- Articoli 3 e 6 Convenzione europea sull'esercizio dei diritti dei minori

Diritto del minore alla protezione contro la violenza e lo sfruttamento

«Il minore ha diritto ad contro ogni forma di violenza, di oltraggio o di brutalità fisiche o mentali, di abbandono o di negligenza, di maltrattamenti o di sfruttamento, compresa la violenza sessuale» (articolo 19, comma 1 Convenzione internazionale sui diritti dell'Infanzia - CRC)

sentenza Corte EDU, Z. e altri contro Regno Unito

Norme di riferimento:

- Articoli 2 (diritto alla vita), 3 (trattamenti inumani o degradanti) e 8 (integrità fisica) CEDU; Protocollo n. 1 alla CEDU, articolo 2 (diritto all'istruzione)
- Articoli 7 (diritto a una speciale protezione contro i pericoli fisici e morali) e 17 (diritto a una tutela) Carta sociale europea (CSE)
- Convenzione sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale (Convenzione di Lanzarote).
- Convenzione sulla prevenzione e la lotta contro la violenza nei confronti delle donne e la violenza domestica (Convenzione di Istanbul)
- Direttiva relativa alla lotta contro l'abuso e lo sfruttamento sessuale dei minori e la pornografia minorile (2011/93/UE)

ESEMPIO N. 2: violenza assistita

La violenza non produce danni soltanto quando viene agita, ma anche quando i bambini ne diventano testimoni.

Guardare, ascoltare, vivere l'angoscia, esserne investiti, contagiati e sovrastati senza poter far nulla. Significa esporre un bambino a qualsiasi forma di maltrattamento, compiuto attraverso atti di violenza fisica, verbale, psicologica, sessuale ed economica, su figure di riferimento o su altre figure affettivamente significative all'interno di ambienti domestici e familiari. Questa è violenza assistita.

Un fenomeno ancora sommerso, quasi "invisibile", contraddistinto da segnali plurimi, i cui effetti possono essere devastanti sullo sviluppo fisico, cognitivo e comportamentale dei bambini

(Save the Children, https://www.savethechildren.it/campagne/abbattiamo-il-muro-del-silenzio)

I bambini che assistono ad un atto di violenza lo subiscono
https://www.youtube.com/watch?v=aNbVwD86JqU

Norme di riferimento:

Articolo 19 Convenzione sui diritti dell'Infanzia e dell'Adolescenza (CRC)

Articolo 17 Carta sociale europea (CSE)

The story of a child witness
https://www.youtube.com/watch?v=hYX8cRkiklE

ESEMPIO N. 3: Punizioni corporali

È punizione corporale

- qualsiasi punizione per la quale viene utilizzata la forza fisica, allo scopo di infliggere un certo livello di dolore o di afflizione, non importa quanto lieve
- forme di punizioni non fisiche ugualmente crudeli e degradanti, per esempio, le punizioni che mirano a denigrare il bambino, umiliarlo, sminuirlo, disprezzarlo, farlo diventare un capro espiatorio, minacciarlo, spaventarlo o schernirlo (Comitato ONU sui diritti dell'infanzia, Commento Generale n.8 del 2006)

Raise your hand against smacking!

https://www.youtube.com/watch?v=FB6_Og-x6Cw

Norme di riferimento:

Articolo 3 CEDU.

Articoli 19, 28, paragrafo 2, e 37 Convenzione internazionale sui diritti dell'Infanzia (CRC)

ESEMPIO N. 4: abuso sessuale

È abuso sessuale a danno di un minorenne il coinvolgimento in attività sessuali, fisiche o psicologiche realizzato:

- facendo uso di coercizione, forza o minaccia
- approfittando di una posizione riconosciuta di fiducia, autorità o influenza sul minore, anche in ambito familiare
- Approfittando di una situazione di particolare vulnerabilità del minore, in particolare in ragione di una disabilità fisica o mentale o di una situazione di dipendenza

(Articolo 18, paragrafo 1, Convenzione del Consiglio d'Europa sulla protezione dei minori dallo sfruttamento e dagli abusi sessuali – cosiddetta Convenzione di Lanzarote)

Qui non si tocca!
https://www.youtube.com/watch?v=ZNmu7plH5c8

Norme di riferimento:

- Articoli 32 e 34 Convenzione internazionale sui diritti dell'Infanzia (CRC)
- Convenzione di Lanzarote

DIRITTI ECONOMICI, SOCIALI E CULTURALI E CONDIZIONI DI VITA ADEGUATE

carepath

Rappresentano diritti di cosiddetta «seconda generazione» che ogni Stato è chiamato a soddisfare per ovviare alle diseguaglianze sociali, agli squilibri economici, agli svantaggi causati dalla natura, dall'età ecc.

La loro realizzazione concreta (purtroppo!) avviene gradualmente e compatibilmente con i problemi economico-strutturali cui ogni Stato deve far fronte.

Diritto alla salute

«La salute è uno stato di completo benessere fisico, mentale e sociale e non semplicemente un'assenza di malattia o infermità»

(Organizzazione Mondiale della Sanità, 1948)

Norme di riferimento:

- Articolo 35 (accesso all'assistenza sanitaria) Carta dei diritti fondamentali dell'UE (Carta di Nizza)
- Articolo 25 Dichiarazione Universale dei Diritti dell'Uomo
- Articoli 24, 25 e 26 Convenzione internazionale sui diritti dell'infanzia e dell'adolescenza (CRC
- Articolo 2 (diritto alla vita) e articolo 3 (diritto all'integrità fisica) CEDU
- Articolo 11 (diritto alla protezione della salute) e articolo 13 (diritto all'assistenza sociale e medica) Carta sociale europea (CSE)
- Articolo 6 Convenzione europea per la protezione dei diritti dell'uomo e la dignità dell'essere umano riguardo alle applicazioni della biologia e della medicina, cosiddetta «Convenzione di Oviedo»

Diritto all'istruzione

«istruzione deve essere gratuita almeno per quanto riguarda le classi elementari e fondamentali. L'istruzione elementare deve essere obbligatoria. L'istruzione tecnica e professionale deve essere messa alla portata di tutti e l'istruzione superiore deve essere egualmente accessibile a tutti sulla base del merito.»

(articolo 26 Dichiarazione Universale dei Diritti Umani)

Il diritto all'istruzione non si riferisce solo all'apprendimento delle materie scolastiche fondamentali ma deve essere concepito in un senso più ampio. L'istruzione deve cercare di favorire lo sviluppo della personalità del bambino, delle sue qualità e delle sue attitudini mentali e fisiche.

(Convenzione internazionale sui diritti dell'infanzia e dell'adolescenza)

Norme di riferimento:

Articolo 14 Carta dei diritti fondamentali dell'UE (Carta di Nizza)

Articoli 28 e 29 Convenzione internazionale sui diritti dell'infanzia e dell'adolescenza (CRC)

Articolo 17 CEDU

Articolo 2 del Protocollo n. 1 CEDU

carepath

MANUALE

Manuale di diritto europeo in materia di diritti dell'infanzia e dell'adolescenza

FRA
EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

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EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

EUROPEAN COURT OF HUMAN RIGHTS
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CONSEIL DE L'EUROPE

Manuale di diritto europeo in materia di diritti dell'infanzia e dell'adolescenza

Prefazione

Il presente manuale sul diritto europeo in materia di diritti dell'infanzia e dell'adolescenza nasce da una redazione congiunta dell'Agenzia dell'Unione europea per i diritti fondamentali (FRA) e del Consiglio d'Europa con la cancelleria della Corte europea dei diritti dell'uomo. Si tratta del quarto di una serie di manuali sul diritto europeo elaborati di concerto dalle nostre organizzazioni. I precedenti manuali erano dedicati al diritto europeo in materia di non discriminazione, asilo, frontiere e immigrazione, e protezione dei dati.

Ci siamo imbarcati in questo nuovo progetto congiunto in occasione delle celebrazioni del 25° anniversario della Convenzione delle Nazioni Unite sui diritti del fanciullo, che è stata ratificata da tutti gli Stati europei, per gettare luce sul ruolo che la normativa europea ricopre nel garantire ai minori il godimento dei loro diritti universali.

I minori sono titolari di diritti a pieno titolo. Il presente manuale pertanto mira a sensibilizzare e migliorare le conoscenze delle norme di legge che proteggono e promuovono questi diritti in Europa. Il Trattato sull'Unione europea (TUE) impone all'Unione l'obbligo di promuovere la protezione dei diritti del minore. La Carta dei diritti fondamentali dell'Unione europea (UE), i regolamenti e le direttive dell'UE oltre che la giurisprudenza della Corte di giustizia dell'UE (CGUE) hanno contribuito a definire ulteriormente la protezione dei diritti dei minori. Nell'ambito del Consiglio d'Europa un nutrito *corpus* di convenzioni affronta specifici aspetti della protezione dei diritti del minore, che vanno dai diritti e dalla sicurezza dei minori nel cyberspazio all'adozione. Queste convenzioni contribuiscono ad arricchire la tutela offerta ai minori nell'ambito della Convenzione europea dei diritti dell'uomo e della Carta sociale europea, comprese la giurisprudenza della Corte europea dei diritti dell'uomo (Corte EDU) e le decisioni del Comitato europeo dei diritti sociali (CEDS).

Il presente manuale è destinato a professionisti legali non specializzati, giudici, magistrati e autorità responsabili della protezione dei minori, nonché ad altre figure professionali e organizzazioni impegnate nell'offrire la tutela legale dei diritti del minore.

Desideriamo ringraziare il prof. Ton Liefaard, LL.M., Simona Florescu, JD., Margaret Fine, il prof. Karl Hanson, la prof.ssa Ursula Kilkelly, la dott.ssa Roberta Ruggiero, la prof.ssa Helen Stalford e il prof. Wouter Vandenhole per il contributo offerto alla stesura del presente manuale. La nostra gratitudine va anche a tutti coloro che hanno fornito assistenza e suggerimenti per tutto il corso della sua preparazione.

Snežana Samardžić-Marković

Direttrice generale del settore
Democrazia - Consiglio d'Europa

Michael O'Flaherty

Direttore dell'Agenzia dell'Unione
europea per i diritti fondamentali

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Acronimi

APCE	Assemblea parlamentare del Consiglio d'Europa
CdE	Consiglio d'Europa
CEDS	Comitato europeo dei diritti sociali
CEDU	Convenzione per la salvaguardia dei diritti dell'uomo e delle libertà fondamentali (più comunemente nota come Convenzione europea sui diritti dell'uomo, CEDU)
CEE	Comunità economica europea
CGUE	Corte di giustizia dell'Unione europea (denominata Corte di giustizia europea (GC) fino a dicembre 2009)
Corte EDU	Corte europea dei diritti dell'uomo
CPT	Comitato europeo per la prevenzione della tortura e delle pene o trattamenti inumani o degradanti
CRC	Convenzione delle Nazioni Unite sui diritti del fanciullo
CRD	Direttiva sui diritti dei consumatori
CRPD	Convenzione delle Nazioni Unite sui diritti delle persone con disabilità
CSE	Carta sociale europea
ECOSOC	Consiglio economico e sociale delle Nazioni Unite
ECPT	Convenzione europea per la prevenzione della tortura e delle pene o trattamenti inumani o degradanti
FCNM	Convenzione quadro del Consiglio d'Europa per la protezione delle minoranze nazionali
FRA	Agenzia dell'Unione europea per i diritti fondamentali
GC	Grande Camera (della Corte europea dei diritti dell'uomo)
GPSD	Direttiva sulla sicurezza generale dei prodotti
GRETA	Gruppo di esperti sulla lotta contro la tratta di esseri umani

ICCPR	Patto internazionale delle Nazioni Unite relativo ai diritti civili e politici
ICERD	Convenzione internazionale sull'eliminazione di tutte le forme di discriminazione razziale
ICESCR	Patto internazionale relativo ai diritti economici, sociali e culturali
OIL	Organizzazione internazionale del lavoro
ONU	Nazioni Unite
SEE	Spazio economico europeo
TCN	Cittadini di un paese terzo
TFUE	Trattato sul funzionamento dell'Unione europea
TSD	Direttiva sulla sicurezza dei giocattoli
TUE	Trattato sull'Unione europea
UCPD	Direttiva relativa alle pratiche commerciali sleali tra imprese e consumatori nel mercato interno
UE	Unione europea
UNHCR	Alto Commissario delle Nazioni Unite per i rifugiati

Come usare il manuale

Il presente manuale offre una panoramica dei diritti fondamentali dei minori negli Stati membri dell'Unione europea (UE) e del Consiglio d'Europa (CdE). Esso ha una portata ampia, poiché riconosce che i minori sono beneficiari di tutti i diritti umani/fondamentali nonché oggetto di regolamenti speciali, in virtù delle loro caratteristiche specifiche. Quella dei diritti dell'infanzia e dell'adolescenza è una sfera trasversale del diritto. Il manuale si sofferma sugli aspetti del diritto che sono d'importanza specifica per i minori.

È' volto ad assistere i professionisti legali che non sono specializzati nel campo del diritto dei minori; è destinato ad avvocati, giudici, pubblici ministeri, assistenti sociali e altre figure professionali che collaborano con le autorità nazionali oltre che a organizzazioni non governative (ONG) e altri organismi che potrebbero dover affrontare problematiche legali relative a questi soggetti per la prima volta. Esso rappresenta un punto di riferimento per quanto concerne sia il diritto dell'UE sia il diritto del Consiglio d'Europa in materia e illustra come ciascun tema sia disciplinato dal diritto dell'UE, dalla Convenzione europea sui diritti dell'uomo (CEDU), dalla Carta sociale europea (CSE) e da altri strumenti del Consiglio d'Europa. Ogni capitolo è introdotto da una tabella delle disposizioni legali applicabili secondo i due distinti sistemi giuridici europei. Il diritto di ciascun sistema è quindi presentato in successione, in relazione ai vari temi trattati. In questo modo il lettore può cogliere le convergenze e le divergenze dei due sistemi giuridici. Dove necessario, si fa riferimento alla Convenzione delle Nazioni Unite sui diritti del fanciullo (CRC) e ad altri strumenti internazionali.

I professionisti appartenenti ai paesi terzi che fanno parte del Consiglio d'Europa e sono pertanto membri della CEDU possono accedere alle informazioni riguardanti il proprio paese visitando direttamente le sezioni del Consiglio d'Europa. I professionisti degli Stati membri dell'UE devono invece consultare tutte e due le sezioni, in quanto questi Stati sono vincolati a entrambi gli ordinamenti giuridici. I lettori che necessitano di maggiori informazioni su un particolare argomento possono reperire una bibliografia più specialistica nella sezione del manuale riservata agli "Approfondimenti".

Il diritto della CEDU è riportato tramite brevi riferimenti a determinati casi esaminati dalla Corte europea dei diritti dell'uomo (Corte EDU) riguardanti le tematiche trattate dal manuale. I casi sono stati selezionati tra le sentenze e le decisioni della Corte EDU concernenti i diritti dei minori.

Il diritto dell'UE è illustrato attraverso il riferimento alle misure legislative adottate, alle disposizioni pertinenti dei trattati, in particolare alla Carta dei diritti fondamentali dell'Unione europea, come interpretate nella giurisprudenza della Corte di giustizia dell'Unione europea (CGUE, denominata Corte di giustizia o CG fino a dicembre 2009).

La giurisprudenza presentata o citata nel presente manuale offre esempi tratti da un ampio *corpus* giurisprudenziale della Corte EDU e della CGUE. Il manuale comprende, per quanto possibile, considerato il suo ambito di applicazione limitato e la sua natura di documento introduttivo, gli sviluppi registrati in ambito legale fino al 1°gennaio 2015, benché siano stati inclusi, nei limiti del possibile, anche argomenti più recenti.

Il manuale è composto da un'introduzione, che spiega brevemente il ruolo dei due sistemi giuridici come stabilito dalla CEDU e dal diritto dell'UE, e da 10 capitoli che riguardano le seguenti tematiche:

- libertà e diritti civili;
- uguaglianza;
- questioni riguardanti l'identità personale;
- vita familiare;
- accoglienza eterofamiliare e adozione;
- protezione dei minori contro la violenza e lo sfruttamento;
- diritti economici, sociali e culturali;
- immigrazione e asilo;
- tutela dei consumatori e dei dati;
- diritti dei minori nella sfera della giustizia penale e dei procedimenti alternativi.

Ogni capitolo tratta un argomento distinto, mentre riferimenti incrociati ad altre questioni e capitoli permettono di meglio comprendere il quadro giuridico applicabile. I punti salienti sono sintetizzati all' inizio di ogni capitolo.

1

Introduzione al diritto europeo in materia di diritti dei minori: contesto e principi chiave

UE	Argomenti trattati	CdE
Direttiva sulla libera circolazione (2004/38/CE), articolo 2, paragrafo 2, lettera c)	Il "minore" come titolare dei diritti	Convenzione sulla lotta contro la tratta degli esseri umani, articolo 4, lettera d) Convenzione del Consiglio d'Europa sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale (Convenzione di Lanzarote), articolo 3, lettera a) Corte EDU, *Marckx c. Belgio,* n. 6833/74, 1979 (la minore ricorrente aveva sei anni quando la Corte ha emesso la sentenza)
Direttiva relativa ai giovani sul lavoro (94/33/CE), articolo 3	Protezione dei giovani sul luogo di lavoro	CSE (riveduta), articolo 7 (diritto dei bambini e degli adolescenti ad una tutela)
Carta dei diritti fondamentali, articolo 14, paragrafo 2 (diritto all'istruzione)	Diritto di accedere gratuitamente all'istruzione obbligatoria	
Carta dei diritti fondamentali, articolo 21 (non discriminazione)	Divieto di discriminazione sulla base dell'età	

UE	Argomenti trattati	CdE
Carta dei diritti fondamentali, articolo 32 (divieto del lavoro minorile e protezione dei giovani sul luogo di lavoro) Direttiva relativa alla lotta contro l'abuso e lo sfruttamento sessuale dei minori e la pornografia minorile (2011/93/UE) Direttiva sulla tratta (2011/36/UE)	**Divieto di sfruttamento del lavoro minorile**	CSE (riveduta), articolo 7 (diritto dei bambini e degli adolescenti ad una tutela)
Carta dei diritti fondamentali dell'UE, articolo 24 (diritti del bambino) Trattato sull'Unione europea, articolo 3, paragrafo 3	**Protezione dei diritti dei minori (in generale)**	
Carta dei diritti fondamentali dell'Unione europea, articolo 7 (rispetto della vita privata e della vita familiare)	**Diritto al rispetto della vita privata e della vita familiare**	CEDU, articolo 8 (diritto al rispetto della vita privata e familiare) Convenzione europea sullo statuto giuridico dei figli nati fuori matrimonio Convenzione europea sull'adozione dei minori (riveduta) Convenzione sulle relazioni personali riguardanti i minori Convenzione sull'esercizio dei diritti dei minori Corte EDU, *Maslov c. Austria*, n. 1638/03, 2008, (espulsione del richiedente, condannato per reati penali quand'era minorenne)
CGUE, C-413/99, *Baumbast e R c. Secretary of State for the Home Department*, 2002 CGUE, C-200/02, *Kunqian Catherine Zhu e Man Lavette Chen c. Secretary of State for the Home Department*, 2004 CGUE, C-148/02, *Carlos Garcia Avello c. Stato belga*, 2003 CGUE, C-310/08, *London Borough of Harrow c. Nimco Hassan Ibrahim e Secretary of State for the Home Department* [GS], 2010 CGUE, sentenza C–480/08, *Maria Teixeira c. London Borough of Lambeth e Secretary of State for the Home Department*, 2010	**Libertà di circolazione**	

Questo capitolo introduttivo spiega in che modo si è sviluppato il diritto in materia di diritti dei minori, quali sono i principi chiave che ne guidano l'applicazione e quali aspetti preponderanti dei diritti dei minori sono trattati nel diritto dell'UE. Esso getta le basi per un'analisi più approfondita per argomenti riportata nei seguenti capitoli.

1.1. Concetti essenziali

Punto saliente

- La legislazione europea sui diritti dei minori si basa sulle misure esistenti a livello nazionale e internazionale.

1.1.1. Campo di applicazione della legislazione europea sui diritti dei minori

Quando si cita la "legislazione europea sui diritti dei minori", si fa essenzialmente riferimento alle fonti primarie del diritto (trattati, convenzioni, diritto derivato e giurisprudenza) introdotte dal Consiglio d'Europa e dall'Unione europea (UE). Ove opportuno, si fa riferimento ad altre fonti europee che influenzano lo sviluppo della legislazione europea sui diritti dei minori, tra cui documenti strategici, linee guida o altri strumenti non vincolanti di importanza fondamentale.

I minori sono titolari di diritti, piuttosto che solo soggetti da tutelare. Sono beneficiari di tutti i diritti umani/fondamentali nonché oggetto di regolamenti speciali, in virtù delle loro caratteristiche specifiche. Buona parte della giurisprudenza europea deriva da controversie avviate da genitori o altri rappresentanti legali di minori, in considerazione della limitata capacità giuridica di questi ultimi. Pur avendo l'obiettivo di illustrare il modo in cui la legislazione si adatta alle esigenze e agli interessi specifici dei minori, il presente manuale evidenzia altresì l'importanza dei genitori/tutori o di altri rappresentanti legali e fa riferimento, ove opportuno, alle situazioni in cui diritti e responsabilità sono conferiti prevalentemente alle persone che si prendono cura dei minori. In tali casi si adotta l'approccio della Convenzione delle Nazioni Unite sui diritti del fanciullo (CRC)[1],

1 Nazioni Unite (ONU), Assemblea generale (1989), Convenzione sui diritti del fanciullo, 20 novembre 1989.

secondo cui le responsabilità genitoriali devono essere esercitate considerando preminente l'interesse superiore del minore e in maniera corrispondente allo sviluppo delle sue capacità.

1.1.2. Il "minore" come titolare dei diritti

Nell'ambito del diritto internazionale, l'articolo 1 della CRC stabilisce che "si intende per fanciullo ogni essere umano avente un'età inferiore a diciott'anni". Questo è il parametro giuridico utilizzato attualmente, anche in Europa, per definire un minore.

Nell'ambito del diritto dell'UE, non esiste una singola definizione formale di "minore" in alcuno dei trattati, nel diritto da esso derivato o nella giurisprudenza. La definizione di minore può variare considerevolmente ai sensi del diritto dell'UE, a seconda del contesto normativo. Per esempio, la direttiva dell'UE che disciplina i diritti dei cittadini dell'Unione e dei loro familiari di circolare liberamente nel territorio degli Stati membri definisce i "minori" come "i discendenti diretti di età inferiore a 21 anni o a carico"[2], avallando essenzialmente un concetto biologico ed economico anziché una nozione di minoranza.

Alcune normative dell'UE attribuiscono ai minori diritti differenti a seconda dell'età. La direttiva 94/33/CE relativa alla protezione dei giovani sul lavoro (la "direttiva sui giovani lavoratori")[3], per esempio, che disciplina l'accesso dei minori all'occupazione formale negli Stati membri dell'UE e le sue condizioni, distingue tra "giovani" (un termine generale per indicare tutte le persone di età inferiore a 18 anni), "adolescenti" (ogni giovane di almeno 15 anni che non ha ancora compiuto 18 anni, e che non ha più obblighi scolastici a tempo pieno) e "bambini" (ovvero tutti i giovani che non hanno ancora compiuto 15 anni, ai quali è ampiamente fatto divieto di intraprendere un'occupazione formale).

Altri settori del diritto dell'Unione, in particolare quelli in cui l'attività dell'UE integra l'azione degli Stati membri (quali la previdenza sociale, l'immigrazione

2 Direttiva 2004/38/CE del Parlamento europeo e del Consiglio, del 29 aprile 2004, relativa al diritto dei cittadini dell'Unione e dei loro familiari di circolare e di soggiornare liberamente sul territorio degli Stati membri, che modifica il regolamento (CEE) n. 1612/68 e abroga le direttive 64/221/CEE, 68/360/CEE, 72/194/CEE, 73/148/CEE, 75/34/CEE, 75/35/CEE, 90/364/CEE, 90/365/CEE e 93/96/CEE, GU L 158 del 30 aprile 2004 e GU L 158 del 29 aprile 2004, articolo 2, paragrafo 2, lettera c).

3 Direttiva 94/33/CE del 20 agosto 1994 relativa alla protezione dei giovani sul lavoro, GU L 216 del 20.8.1994, articolo 3.

e l'istruzione), demandano all'ordinamento giuridico nazionale la responsabilità di stabilire chi sia un minore. In genere, in tali contesti si adotta la definizione della CRC.

Nell'ambito del diritto del Consiglio d'Europa, la maggior parte degli strumenti riguardanti i minori adotta la definizione di minore della CRC. Tra gli esempi figurano l'articolo 4, lettera d), della Convenzione del Consiglio d'Europa sulla lotta contro la tratta di esseri umani[4] o l'articolo 3, lettera a), della Convenzione del Consiglio d'Europa sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale (Convenzione di Lanzarote).[5]

La Convenzione europea dei diritti dell'uomo (CEDU) non fornisce una definizione di minore, ma il suo articolo 1 obbliga gli Stati a riconoscere i diritti della Convenzione a "ogni persona" sottoposta alla loro giurisdizione. L'articolo 14 della CEDU assicura il godimento dei diritti riconosciuti nella Convenzione "senza nessuna discriminazione", comprese quelle fondate sull'età.[6] La Corte europea dei diritti dell'uomo (Corte EDU) ha accolto ricorsi da parte e a nome di minori indipendentemente dalla loro età.[7] Nella sua giurisprudenza ha accettato la definizione di minore fornita dalla CRC,[8] avallando il concetto di "ogni essere umano avente un'età inferiore a diciott'anni".

Lo stesso vale per la Carta sociale europea (CSE) e la sua interpretazione da parte del Comitato europeo dei diritti sociali (CEDS).[9]

4 Consiglio d'Europa, Convenzione sulla lotta contro la tratta di esseri umani, STCE n. 197, 15 maggio 2005.

5 Consiglio d'Europa, Convenzione sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale, STCE n. 201, 25 ottobre 2007.

6 Corte europea dei diritti dell'uomo (Corte EDU), sentenza 10 giugno 2010, *Schwizgebel c. Svizzera* (n. 25762/07). Cfr. anche FRA e Corte EDU (2010), pag. 102.

7 Cfr., per esempio, Corte EDU, sentenza 13 giugno 1979, *Marckx c. Belgio* (n. 6833/74), in cui la minore ricorrente aveva sei anni quando la Corte ha emesso la sentenza.

8 Corte EDU, sentenza 20 gennaio 2009, *Güveç c. Turchia* (n. 70337/01); Corte EDU, sentenza 9 ottobre 2012, *Çoşelav c. Turchia* (n. 1413/07).

9 Comitato europeo dei diritti sociali (CEDS), 20 ottobre 2009, *Defence for Children International (DCI) c. Paesi Bassi* (ricorso n. 47/2008), punto 25.

1.2. Contesto della legislazione europea sui diritti dei minori

Finora la maggior parte della legislazione europea sui diritti dei minori è stata sviluppata dall'UE e dal Consiglio d'Europa. Oltre all'ONU, anche altre istituzioni internazionali quali la Conferenza dell'Aia sul diritto internazionale privato hanno adottato strumenti importanti che continuano a informare lo sviluppo del diritto europeo. Benché abbiano operato separatamente l'uno dall'altro, questi quadri internazionali sono sempre più interconnessi.[10] La cooperazione interistituzionale tra il Consiglio d'Europa e l'UE è particolarmente forte.

1.2.1. Unione europea: sviluppo della legislazione sui diritti dei minori e aree di protezione contemplate

In passato la legislazione sui diritti dei minori nell'UE si è sviluppata in maniera frammentaria. Storicamente, la legislazione europea sui minori era in ampia misura finalizzata ad affrontare aspetti specifici riguardanti i minori di iniziative economiche e politiche di più ampia portata, per esempio nell'ambito della tutela dei consumatori [11] e della libera circolazione delle persone.[12] Tuttavia, più di recente, i diritti dei minori sono stati trattati all'interno di un programma più coordinato dell'UE, sulla base di tre importanti pietre miliari:

- l'introduzione della Carta dei diritti fondamentali dell'Unione europea;
- l'entrata in vigore del trattato di Lisbona nel dicembre 2009;
- l'adozione della comunicazione della Commissione europea "Riservare ai minori un posto speciale nella politica esterna dell'UE" e degli orientamenti del Consiglio dell'UE in materia di promozione e tutela dei diritti del bambino.

10 Cfr., per esempio, il capitolo 5, che illustra il modo in cui il diritto di famiglia dell'UE che disciplina la sottrazione transfrontaliera di minori opera con la Convenzione dell'Aia del 25 ottobre 1980 sugli aspetti civili della sottrazione internazionale di minori (Convenzione dell'Aia sulla sottrazione di minori).

11 Per esempio, la direttiva 2009/48/CE del Parlamento europeo e del Consiglio, del 18 giugno 2009, sulla sicurezza dei giocattoli (GU L 170 del 30.6.2009), che stabilisce misure di sicurezza per i giocattoli destinati ai bambini.

12 Per esempio, la direttiva 2004/38/CE.

La prima pietra miliare è stata l'introduzione della Carta dei diritti fondamentali dell'UE nel 2000.[13] Il 1° dicembre 2009, con l'entrata in vigore del trattato di Lisbona, è stato conferito alla Carta lo stesso valore giuridico vincolante dei trattati dell'UE (articolo 6 del trattato sull'Unione europea, TUE). La Carta obbliga l'Unione e i suoi Stati membri a tutelare i diritti da essa sanciti nell'attuazione del diritto dell'UE. La Carta dei diritti fondamentali dell'UE contiene i primi riferimenti dettagliati ai diritti dei minori a livello costituzionale dell'UE, anche attraverso il riconoscimento del diritto dei minori di accedere gratuitamente all'istruzione obbligatoria (articolo 14, paragrafo 2), il divieto di qualsiasi forma di discriminazione fondata sull'età (articolo 21) nonché il divieto di sfruttamento del lavoro minorile (articolo 32). Degno di nota è il fatto che la Carta contenga una disposizione dedicata ai diritti del minore (articolo 24), che sancisce tre principi fondamentali dei diritti dei minori: il diritto di esprimere liberamente la propria opinione in funzione della loro età e della loro maturità (articolo 24, paragrafo 1), il diritto a che il loro interesse superiore sia considerato preminente in tutti gli atti relativi ai minori (articolo 24, paragrafo 2) e il diritto di intrattenere regolarmente relazioni personali e contatti diretti con i due genitori (articolo 24, paragrafo 3).

La seconda pietra miliare è rappresentata dal trattato di Lisbona, che, come precedentemente indicato, è entrato in vigore il 1° dicembre 2009.[14] Questo strumento ha introdotto importanti cambiamenti istituzionali, procedurali e costituzionali nell'UE modificando il TUE e il precedente trattato che istituisce la Comunità europea (ora "trattato sul funzionamento dell'Unione europea", TFUE).[15] Tali modifiche hanno rafforzato il potenziale dell'UE di compiere progressi riguardo ai diritti dei minori, non da ultimo individuando la "tutela dei diritti del minore" come un obiettivo generale dichiarato dell'UE (articolo 3, paragrafo 3, del TUE) e come un aspetto importante della politica di relazioni esterne dell'UE (articolo 3, paragrafo 5, del TUE). Anche il TFUE contiene riferimenti più specifici ai minori, che permettono all'UE di adottare misure legislative volte a combattere lo sfruttamento sessuale e la tratta di esseri umani (articolo 79, paragrafo 2, lettera d), e articolo 83, paragrafo 1)).

13 UE (2012), Carta dei diritti fondamentali dell'Unione europea (GU C 326 del 26.10.2012).

14 UE (2007), Trattato di Lisbona che modifica il trattato sull'Unione europea e il trattato che istituisce la Comunità europea, firmato a Lisbona (GU C 306 del 17.12.2007, pagg. 1–271).

15 Cfr. le versioni consolidate delle Comunità europee (2012), trattato sull'Unione europea (TUE) e trattato sul funzionamento dell'Unione europea (TFUE), GU 2012 C 326 del 26.10.2012.

È stato così possibile adottare sia la direttiva relativa alla lotta contro l'abuso e lo sfruttamento sessuale dei minori e la pornografia minorile,[16] sia la direttiva concernente la prevenzione e la repressione della tratta di esseri umani e la protezione delle vittime,[17] contenente a sua volta disposizioni volte ad affrontare le esigenze specifiche dei minori vittime di tratta. Analogamente, la più recente direttiva che istituisce norme minime in materia di diritti, assistenza e protezione delle vittime di reato dedica molte delle sue disposizioni ai minori.[18]

La terza importante pietra miliare è stata posta a un livello politico più strategico, inizialmente nell'ambito del programma dell'UE sulla cooperazione esterna e in seguito in relazione a questioni interne. Nello specifico, il Consiglio dell'UE e la Commissione europea hanno rispettivamente adottato gli "Orientamenti dell'UE in materia di promozione e tutela dei diritti del bambino"[19] e la comunicazione "Riservare ai minori un posto speciale nella politica esterna dell'UE"[20], al fine di integrare i diritti dei minori in tutte le attività svolte dall'UE con i paesi terzi. Analogamente, nel 2011 la Commissione ha adottato il programma UE per i diritti dei minori, che delinea le principali priorità per lo sviluppo della legislazione e della politica sui diritti dei minori negli Stati membri dell'UE.[21] Nell'ambito del programma avrebbero dovuto essere presi in considerazione anche i processi legislativi pertinenti ai fini della tutela dei minori, quali la suddetta adozione della direttiva sui diritti delle vittime.

Più recentemente, questa iniziativa è stata integrata dall'adozione, da parte della Commissione, di una strategia globale volta ad aiutare gli Stati membri a impegnarsi nella lotta contro la povertà e l'esclusione sociale attraverso l'attuazione di una serie di interventi sin dalla prima infanzia (destinati ai bambini in età prescolare e della scuola primaria).[22] Né questa specifica iniziativa, né il programma

16 Direttiva 2011/93/UE, GU L 335 del 17.12.2011, pag. 1.

17 Direttiva 2011/36/UE (GU L 101 del 15.4.2011, pag. 1).

18 Direttiva 2012/29/UE (GU L 315 del 15.4.2012, pag. 57).

19 Consiglio dell'Unione europea (2007), *Orientamenti dell'UE in materia di promozione e tutela dei diritti del bambino*, Bruxelles, 10 dicembre 2007.

20 Commissione europea (2008), *Riservare ai minori un posto speciale nella politica esterna dell'UE: Comunicazione della Commissione al Consiglio, al Parlamento europeo, al Comitato economico e sociale europeo e al Comitato delle regioni*, COM (2008) 55 final, Bruxelles, 5 febbraio 2008.

21 Commissione europea (2011), *Programma UE per i diritti dei* minori*: Comunicazione della Commissione al Parlamento europeo, al Consiglio, al Comitato economico e sociale europeo e al Comitato delle regioni*, COM (2011) 0060 final, Bruxelles, 15 febbraio 2011.

22 Commissione europea (2013), *Investire nell'infanzia per spezzare il circolo vizioso dello svantaggio*, raccomandazione 2013/112/UE, Bruxelles.

sono giuridicamente vincolanti; tuttavia, sono entrambi significativi nella misura in cui definiscono il modello per la normativa e l'approccio metodologico dell'UE nei confronti della legislazione sui diritti dei minori, un modello che, oltre a essere fermamente associato alla CRC, si colloca nell'ambito di un'etica di tutela, partecipazione e non discriminazione dei minori.

L'UE può legiferare solo qualora gliene sia stata attribuita la competenza dai trattati (articoli da 2 a 4 del TFUE). Poiché i diritti dei minori sono un ambito intersettoriale, la competenza dell'UE deve essere determinata caso per caso. Finora, gli ambiti attinenti ai diritti dei minori in cui l'UE ha ampiamente legiferato sono i seguenti:

- tutela dei dati e protezione dei consumatori;
- asilo e migrazione;
- cooperazione in materia civile e penale.

L'articolo 6, paragrafo 1, del TUE e l'articolo 51, paragrafo 2, della Carta dei diritti fondamentali dell'UE stabiliscono che la Carta non estende le competenze dell'UE né modifica o introduce competenze nuove o compiti nuovi per l'UE. Le disposizioni della Carta si applicano alle istituzioni e agli Stati membri dell'UE esclusivamente nell'attuazione del diritto dell'Unione. Sebbene per l'UE siano sempre vincolanti, le disposizioni della Carta diventano giuridicamente vincolanti per gli Stati membri solo quando essi agiscono nel campo di applicazione del diritto dell'Unione.

Ciascuno dei capitoli riportati di seguito contiene una breve panoramica delle competenze dell'UE negli ambiti trattati nel rispettivo capitolo.

1.2.2. Consiglio d'Europa: sviluppo della legislazione sui diritti dei minori e aree di protezione contemplate

Diversamente dall'UE, fin dalla sua istituzione, il Consiglio d'Europa ha il chiaro mandato di proteggere e promuovere i diritti umani. Il principale trattato sui diritti umani del Consiglio d'Europa, ratificato da tutti i suoi Stati membri, è la Convenzione per la salvaguardia dei diritti dell'uomo e delle libertà fondamentali (o Convenzione europea dei diritti dell'uomo, CEDU), che contiene specifici

riferimenti ai minori. I principali sono i seguenti: l'articolo 5, paragrafo 1, lettera d), prevede la detenzione regolare di un minore decisa allo scopo di sorvegliare la sua educazione; l'articolo 6, paragrafo 1, limita il diritto a che la causa di una persona sia esaminata equamente e pubblicamente quando lo esigono gli interessi dei minori; l'articolo 2 del Protocollo n. 1 prevede il diritto all'istruzione e stabilisce che gli Stati rispettino le convinzioni religiose e filosofiche dei genitori nell'istruzione dei figli. Inoltre, tutte le altre disposizioni generali della CEDU sono applicabili a chiunque, minori compresi. Alcune di esse si sono rivelate particolarmente pertinenti per i minori, nella fattispecie l'articolo 8, che garantisce il diritto al rispetto della vita privata e familiare, e l'articolo 3, che vieta la tortura nonché pene e trattamenti inumani e degradanti. Avvalendosi di approcci interpretativi che si concentrano sugli obblighi positivi insiti nelle disposizioni della CEDU, la Corte EDU ha sviluppato un ampio *corpus* giurisprudenziale in materia di diritti dei minori, che contiene frequenti riferimenti alla CRC. Detto questo, la Corte EDU esamina i ricorsi caso per caso e, di conseguenza, non offre una panoramica esaustiva dei diritti dei minori nell'ambito della CEDU.

L'altro importante trattato sui diritti umani del Consiglio d'Europa, la Carta sociale europea (CSE[23], riveduta nel 1996[24]), sancisce la tutela dei diritti sociali, prevedendo disposizioni specifiche per i diritti dei minori. Nella fattispecie, contiene due disposizioni particolarmente importanti per i diritti dei minori. L'articolo 7 stabilisce l'obbligo di proteggere i minori dallo sfruttamento economico. L'articolo 17 impone agli Stati di prendere tutte le misure necessarie e appropriate per garantire ai bambini le cure, l'assistenza, l'istruzione e la formazione di cui necessitano (compreso l'insegnamento primario e secondario gratuito), a proteggere i bambini e gli adolescenti dalla negligenza, dalla violenza o dallo sfruttamento e ad assicurare protezione dei bambini privati del loro sostegno familiare. Il comitato europeo dei diritti sociali (CEDS), composto da esperti indipendenti che valutano la conformità del diritto e della prassi nazionale alla CSE attraverso una procedura di reclami collettivi o nell'ambito di una procedura nazionale di presentazione di relazioni, è incaricato di controllare l'applicazione della Carta.

23 Consiglio d'Europa, Carta sociale europea, STCE n. 35, 18 ottobre 1961.

24 Consiglio d'Europa, Carta sociale europea (riveduta), STCE n. 163, 3 maggio 1996.

Inoltre il Consiglio d'Europa ha adottato molti trattati che si occupano di una serie di questioni specifiche attinenti ai diritti dei minori. Tra questi figurano:

- la Convenzione europea sullo statuto giuridico dei figli nati fuori matrimonio;[25]
- la Convenzione sull'adozione dei minori, riveduta nel 2008;[26]
- la Convenzione sulle relazioni personali riguardanti i minori;[27]
- la Convenzione sull'esercizio dei diritti dei minori;[28]
- la Convenzione del Consiglio d'Europa sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale (convenzione di Lanzarote).[29]

Infine, a livello politico è importante rilevare che nel 2006 il Consiglio d'Europa ha avviato il suo programma "Costruire un'Europa per e con i bambini e le bambine", un piano d'azione trasversale volto ad affrontare questioni riguardanti i diritti dell'infanzia, tra cui l'adozione di strumenti per la definizione di norme in vari settori.[30] Le priorità attuali si concentrano su quattro aree strategiche[31]:

- promuovere servizi e sistemi a misura di bambino;
- eliminare tutte le forme di violenza contro i minori;
- garantire i diritti dei minori in situazioni di vulnerabilità;
- promuovere la partecipazione del minore.

L'obiettivo principale del programma del Consiglio d'Europa sui diritti del bambino è sostenere l'attuazione, da parte di tutti i suoi Stati membri, di norme internazionali nel settore dei diritti dei minori, e in particolare promuovere l'attuazione

25 Consiglio d'Europa, Convenzione europea sullo statuto giuridico dei figli nati fuori matrimonio, STCE n. 85, 15 ottobre 1975.

26 Consiglio d'Europa, Convenzione sull'adozione dei minori (riveduta), STCE n. 202, 27 novembre 2008.

27 Consiglio d'Europa, Convenzione sulle relazioni personali riguardanti i minori, STCE n. 192, 15 maggio 2003.

28 Consiglio d'Europa, Convenzione europea sull'esercizio dei diritti dei minori, STCE n. 160, 25 gennaio 1996.

29 Consiglio d'Europa, Convenzione sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale, STCE n. 201, 25 ottobre 2007.

30 Per maggiori informazioni, cfr. http://www.coe.int/t/dg3/children/.

31 Consiglio d'Europa, Comitato dei ministri (2011), Strategia del Consiglio d'Europa sui diritti del bambino (2012-2015), CM (2011)171 final, 15 febbraio 2012.

della CRC, evidenziandone i principi essenziali: la non discriminazione, il diritto alla vita e allo sviluppo, l'interesse superiore del minore come considerazione preminente dei responsabili decisionali e il diritto del minore a essere ascoltato.[32]

Nell'ambito del programma sono stati adottati alcuni strumenti sui diritti dei minori che integrano con orientamenti pratici le misure giuridiche europee vincolanti, tra cui:

- le Linee guida per una giustizia a misura di minore;[33]
- le Linee guida per un'assistenza sanitaria a misura di bambino;[34]
- la raccomandazione sulle strategie nazionali integrate per la protezione dei minori dalla violenza;[35]
- la raccomandazione sui diritti dei bambini e i servizi sociali adatti ai bambini e alle loro famiglie;[36]
- la raccomandazione sulla partecipazione dei bambini e dei giovani di età inferiore ai 18 anni.[37]

In tal modo, il programma ha assicurato la centralità dell'Europa nella definizione di norme sui diritti dell'infanzia e ha inoltre spianato la strada, con vari mezzi, al fine di garantire che la voce dei minori rivesta un ruolo fondamentale per il suddetto processo. Il programma intende altresì sostenere l'attuazione della CEDU e della CSE nonché promuovere gli altri strumenti giuridici di cui il Consiglio d'Europa dispone attualmente in relazione all'infanzia (partecipazione, protezione e diritti), ai giovani e alla famiglia.[38]

32 *Ibid.*

33 Consiglio d'Europa, Comitato dei ministri (2010), *Linee guida per una giustizia a misura di minore*, 17 novembre 2010.

34 Consiglio d'Europa, Comitato dei ministri (2011), *Linee guida per un'assistenza sanitaria a misura di bambino*, 21 settembre 2011.

35 Consiglio d'Europa, Comitato dei ministri (2009), Raccomandazione CM/Rec(2009)10 del Comitato dei ministri agli Stati membri sulle strategie nazionali integrate per la protezione dei minori dalla violenza, 18 novembre 2009.

36 Consiglio d'Europa, Comitato dei ministri (2011), Raccomandazione CM Rec(2011)12 sui diritti dei bambini e i servizi sociali adatti ai bambini e alle loro famiglie, 16 novembre 2011.

37 Consiglio d'Europa, Comitato dei ministri (2012), Raccomandazione CM/Rec(2012)2 del Comitato dei ministri agli Stati membri sulla partecipazione dei bambini e dei giovani di età inferiore ai 18 anni, 28 marzo 2012.

38 Consiglio d'Europa, Comitato dei ministri (2011), *Strategia del Consiglio d'Europa sui diritti del bambino (2012-2015)*, CM (2011)171 final, 15 febbraio 2012.

1.3. La legislazione europea sui diritti dei minori e la Convenzione delle Nazioni Unite sui diritti del fanciullo

Punto saliente

- La legislazione europea sui diritti dei minori si basa in ampia misura sulla Convenzione delle Nazioni Unite sui diritti del fanciullo (CRC).

Il fatto che tutti gli Stati membri dell'UE e del Consiglio d'Europa siano firmatari della Convenzione delle Nazioni Unite sui diritti del fanciullo indica l'importanza attribuita alla CRC a livello europeo. La convenzione impone effettivamente obblighi giuridici comuni agli Stati europei con un effetto a catena sul modo in cui le istituzioni europee sviluppano e applicano i diritti dei minori.

La CRC è così diventata il termine di paragone per lo sviluppo della legislazione europea sui diritti dei minori, con il risultato che il Consiglio d'Europa e l'UE fanno sempre più spesso riferimento alla sua influenza. In particolare, l'integrazione dei principi e delle disposizioni della CRC nella giurisprudenza e in strumenti vincolanti a livello europeo conferisce una forza maggiore alla Convenzione, schiudendo canali di applicazione più efficaci per chi cerca di invocare i diritti dei minori in Europa, come si evince dagli esempi specifici forniti in tal senso nel presente manuale.

L'Unione europea non è e non può diventare una firmataria della CRC poiché la Convenzione non è dotata di meccanismi giuridici che permettano a organismi diversi dagli Stati di aderirvi. Tuttavia, l'Unione attinge ai "principi generali del diritto dell'UE" (principi scritti e non scritti derivanti dalle tradizioni costituzionali comuni degli Stati membri) per integrare e orientare le interpretazioni dei suoi trattati (articolo 6, paragrafo 3, del TUE). Le sentenze della Corte di giustizia dell'Unione europea (CGUE) hanno confermato che non deve esistere un conflitto tra gli obblighi derivanti dall'adesione all'UE e gli obblighi che gli Stati membri sono tenuti a rispettare in virtù delle loro costituzioni nazionali e degli impegni internazionali assunti in materia di diritti umani.[39] Poiché tutti gli Stati membri

39 Cfr., per esempio, Corte di giustizia dell'Unione europea (CGUE), sentenza 14 maggio 1974, causa C-4/73, *J. Nold, Kohlen- und Baustoffgroßhandlung c. Commissione delle Comunità europee*.

hanno ratificato la CRC, l'UE è tenuta a rispettare i principi e le disposizioni da essa sanciti, almeno in relazione alle questioni rientranti nel suo ambito di competenza (quale definito dai trattati dell'UE).

Questo obbligo è rafforzato da altri trattati dell'UE e, in particolare, dalla Carta dei diritti fondamentali dell'Unione europea. L'articolo 24 della Carta è ispirato direttamente dalle disposizioni della CRC, tra cui alcune che sono assurte al rango di "principi della CRC", segnatamente il principio dell'interesse superiore del minore (articolo 3 della CRC), il principio della partecipazione del minore (articolo 12 della CRC) e il diritto del minore di vivere e/o di intrattenere rapporti con i suoi genitori (articolo 9 della CRC).

L'importanza della CRC nell'orientare lo sviluppo dei diritti dei minori nell'UE è riconosciuta nel programma per i diritti dei minori della Commissione, in cui si legge che "le norme e i principi ivi contenuti devono continuare a guidare le politiche e le azioni dell'Unione che possono incidere sui diritti dei minori".[40] In tale ottica, gli strumenti legislativi riguardanti i minori sono accompagnati, quasi senza eccezioni, o da un riferimento esplicito alla CRC o da un riferimento più implicito ai principi sui diritti dei minori, quali "l'interesse superiore", il diritto del minore a partecipare a decisioni che lo riguardano o il diritto alla protezione dalla discriminazione.

Il Consiglio d'Europa, al pari dell'UE, non è un'organizzazione giuridicamente obbligata ad attenersi alla CRC, sebbene tutti i suoi Stati membri siano parti individuali firmatarie della convenzione. Tuttavia, la CEDU non può essere interpretata isolatamente, bensì in armonia con i principi generali del diritto internazionale. Devono essere prese in considerazione tutte le pertinenti norme del diritto internazionale applicabili nelle relazioni tra gli Stati contraenti della CEDU, in particolare quelle riguardanti la protezione universale dei diritti umani. Gli obblighi che gli Stati contraenti della CEDU sono tenuti a rispettare nell'ambito dei diritti dei minori devono più specificamente essere interpretati alla luce della CRC.[41] Anche il CEDS, nelle sue decisioni, ha fatto espressamente riferimento alla CRC.[42] Inoltre, le attività di definizione di norme e di elaborazione dei trattati del Consiglio

40 Commissione europea (2011), *Programma UE per i diritti dei minori*, COM (2011) 0060 final, Bruxelles.

41 Corte EDU, sentenza 4 ottobre 2012, *Harroudj c. Francia* (n. 43631/09), punto 42.

42 CEDS, sentenza 7 dicembre 2004, *World Organisation against Torture (OMCT) c. Irlanda*, (ricorso n. 18/2003), punti 61-63; CEDS, sentenza 20 ottobre 2009, *Defence for Children International (DCI) c. Paesi Bassi*, (ricorso n. 47/2008), punto 25.

d'Europa sono influenzate dai principi e dalle disposizioni della CRC. Per esempio, le *Linee guida per una giustizia a misura di minore*[43] sono direttamente informate da una serie di disposizioni della CRC, al pari dei commenti generali del Comitato delle Nazioni Unite sui diritti dell'infanzia di cui sono corredate.[44]

1.4. Interpretazione e applicazione della legislazione europea sui diritti dei minori: il ruolo delle Corti europee

1.4.1. Corte di giustizia dell'Unione europea

La CGUE emette sentenze riguardo molti tipi di azioni giuridiche. Nelle cause riguardanti i diritti dei minori, finora la CGUE si è pronunciata principalmente in via pregiudiziale (articolo 267 del TFUE).[45] Si tratta di procedure nel cui ambito una corte o un tribunale nazionale chiedono alla CGUE di fornire un'interpretazione del diritto primario dell'UE (ad esempio i trattati) o del diritto derivato dell'UE (ad esempio decisioni, normative) che è pertinente per una causa nazionale pendente dinanzi alla corte o al tribunale nazionale in questione.

Fino a qualche anno fa, la CGUE si era pronunciata solo su alcune cause riguardanti i diritti dei minori. Tuttavia, con l'adozione di misure legislative più esplicite sui diritti dei minori e di un programma più rilevante per i diritti dei minori, è probabile che in futuro i diritti dei minori figurino più regolarmente negli elenchi delle sentenze della CGUE.

La CGUE ha pronunciato la maggior parte delle sue sentenze sui diritti dei minori nel contesto della libera circolazione e della cittadinanza dell'UE, settori in cui l'Unione vanta una lunga competenza. In quest'ambito la CGUE ha espressamente

43 Consiglio d'Europa, Comitato dei ministri (2010), *Linee guida per una giustizia a misura di minore*, 17 novembre 2010.

44 Cfr. Nazioni Unite (ONU), Comitato sui diritti dell'infanzia (2007), *Commento generale n. 10 (2007): I diritti dell'infanzia e dell'adolescenza in materia di giustizia minorile*, 25 aprile 2007; ONU, Comitato sui diritti dell'infanzia (2009), *Commento generale n. 12 (2009): Il diritto del minore di essere ascoltato*, CRC/C/GC/12, 1° luglio 2009; e ONU, Comitato sui diritti dell'infanzia (2013), *Commento generale n. 14 (2013) sul diritto del minore a che il suo interesse superiore sia tenuto in primaria considerazione:* (articolo 3, paragrafo 1), CRC/C/GC/14, 29 maggio 2013.

45 L'unica eccezione è costituita da un ricorso d'annullamento: CGUE, sentenza 27 giugno 2006, causa C-540/03, *Parlamento europeo c. Consiglio dell'Unione europea* [GS].

riconosciuto che i minori godono a titolo individuale dei benefici associati alla cittadinanza dell'UE, estendendo loro, in tal modo, il permesso di soggiorno autonomo nonché i diritti sociali e all'istruzione sulla base della nazionalità dell'UE.[46]

La CGUE è ricorsa direttamente alla CRC per stabilire come dovesse essere interpretato il diritto dell'UE in relazione ai minori solo una volta, ovvero nella causa *Dynamic Medien GmbH c. Avides Media AG*. Questa causa riguarda la legalità delle restrizioni tedesche in materia di etichettatura su videocassette e DVD importati, che erano già stati sottoposti a controlli analoghi nel Regno Unito. La CGUE ha concluso che i controlli dei contrassegni effettuati dalla Germania costituivano una restrizione legittima delle disposizioni dell'UE sulla libera circolazione delle merci (che altrimenti precludono processi normativi doppi di questa natura), poiché erano volti a tutelare il benessere dei minori. La CGUE ha sostenuto la sua decisione facendo riferimento all'articolo 17 della CRC, che incoraggia gli Stati firmatari a elaborare principi direttivi adatti a proteggere il minore dalle informazioni e dai materiali mediatici che nuocciono al suo benessere.[47] Si applicano tuttavia requisiti di proporzionalità riguardo alle procedure di controllo istituite per proteggere i minori, che devono essere facilmente accessibili e devono potersi concludere entro termini ragionevoli.[48]

In altri casi, in particolare nel contesto delle cause riguardanti la sottrazione transfrontaliera di minori, per fondare le sue decisioni, la CGUE ha alluso ai principi generali sui diritti dei minori, contenuti anche nelle disposizioni della CRC (quali l'interesse superiore del minore e il suo diritto a essere ascoltato).[49]

A prescindere da ciò, l'UE è sempre stata cauta nell'attribuire una forza decisiva alla CRC, in particolare in settori politicamente più sensibili quali il controllo

46 Cfr. CGUE, sentenza 17 settembre 2002, causa C-413/99, *Baumbast e R c. Secretary of State for the Home Department*; CGUE, sentenza 19 ottobre 2004, causa C-200/02, *Kunqian Catherine Zhu e Man Lavette Chen c. Secretary of State for the Home Department*, CGUE, sentenza 2 ottobre 2003, causa C-148/02, *Carlos Garcia Avello c. Stato belga;* CGUE, sentenza 23 febbraio 2010, causa C-310/08, *London Borough of Harrow c. Nimco Hassan Ibrahim e Secretary of State for the Home Department* [GS], CGUE, sentenza 23 febbraio 2010, causa C-480/08, *Maria Teixera c. London Borough of Lambeth e Secretary of State for the Home Department*. Si tornerà nuovamente su queste cause ai capitoli 8 e 9.

47 CGUE, sentenza 14 febbraio 2008, causa C-244/06, *Dynamic Medien Vertriebs GmbH c. Avides Media AG*, punti 42 e 52.

48 *Ibid.*, punti 49 e 50.

49 CGUE, sentenza 22 dicembre 2010, causa C-491/10 PPU, *Joseba Andoni Aguirre Zarraga c. Simone Pelz*. Cfr., più avanti, il capitolo 5.

dell'immigrazione,[50] benché nella recente giurisprudenza si stia assistendo a un cambiamento in tal senso, come discusso nei capitoli successivi. Dall'adozione della Carta dei diritti fondamentali dell'UE, i riferimenti della CGUE ai suoi articoli sui diritti dei minori spesso sono ricchi di riferimenti alla CRC, in virtù della somiglianzatra le disposizioni.

1.4.2. La Corte europea dei diritti dell'uomo

La Corte EDU si pronuncia essenzialmente su ricorsi individuali presentati in conformità degli articoli 34 e 35 della CEDU. La competenza della Corte si estende a tutte le questioni concernenti l'interpretazione e l'applicazione della Convenzione e dei suoi protocolli (articolo 32 della CEDU).

Diversamente dalla CGUE, la Corte EDU ha una vasta giurisprudenza sui diritti dei minori. Benché molti casi rientranti nell'ambito dell'articolo 8 della CEDU sul diritto al rispetto della vita privata e familiare siano esaminati dalla prospettiva dei diritti dei genitori anziché di quelli dei minori, i casi contemplati da altre disposizioni sostanziali non coinvolgono necessariamente i genitori e si concentrano più chiaramente sui diritti dei minori interessati, come il diritto alla protezione da trattamenti inumani o degradanti (articolo 3 della CEDU) o al diritto ad un equo processo (articolo 6 della CEDU).

Sebbene faccia spesso riferimento alla CRC quando esamina i ricorsi presentati da o a nome di minori, la Corte EDU non attribuisce sistematicamente un'importanza decisiva alla Convenzione. In alcuni casi, i principi sui diritti dei minori enunciati dalla CRC hanno influenzato profondamente il ragionamento della Corte EDU, in particolare per quanto riguarda l'interpretazione dell'articolo 6 della CEDU (diritto a un equo processo) in relazione al trattamento dei minori in conflitto con la legge (cfr. il capitolo 11). In altri ambiti, l'approccio della Corte EDU può discostarsi leggermente da quello della CRC, per esempio per quanto riguarda il diritto dei minori di essere ascoltati in giudizio (cfr. il capitolo 2). In alcuni casi, invece, la Corte EDU si è espressamente basata sulla CRC.

50 CGUE, sentenza 27 giugno 2006, causa C-540/03, *Parlamento europeo c. Consiglio dell'Unione europea* [GS].

Esempio: il caso *Maslov c. Austria*[51] riguarda l'espulsione del ricorrente, che era stato condannato per una serie di reati penali commessi quando era minorenne. Per quanto riguarda le misure di espulsione nei confronti di un minore autore di reati, la Corte EDU ha stabilito che nell'obbligo di tenere conto dell'interesse superiore del minore figura anche l'obbligo di agevolarne il reinserimento, in linea con l'articolo 40 della CRC. La Corte EDU ha ritenuto che non sarebbe stato possibile reinserire il minore rescindendo i suoi legami familiari e sociali attraverso l'espulsione.[52] La CRC è stata dunque uno dei motivi utilizzati per considerare l'espulsione come una sproporzionata ingerenza nei diritti del ricorrente ai sensi dell'articolo 8 della CEDU (rispetto della vita privata e familiare).

1.5. Comitato europeo dei diritti sociali

Il CEDS è composto da 15 esperti indipendenti e imparziali che valutano la conformità del diritto e della prassi nazionale alla CSE attraverso la procedura dei reclami collettivi o nell'ambito della procedura nazionale di presentazione di relazioni.[53] Le organizzazioni nazionali e internazionali designate possono presentare ricorsi collettivi nei confronti degli Stati contraenti che hanno accolto la procedura dei reclami. Finora i ricorsi hanno riguardato l'eventuale violazione, da parte degli Stati, dei diritti dei minori ai sensi della CSE su questioni quali lo sfruttamento economico dei minori,[54] l'integrità fisica dei minori,[55] i diritti dei minori migranti in materia di salute[56] e l'accesso all'istruzione da parte di minori disabili.[57]

51 Corte EDU, sentenza 23 giugno 2008, *Maslov c. Austria* [GC] (n. 1638/0323).

52 *Ibid.*, punto 83.

53 Per maggiori informazioni consultare il sito web del CEDS: www.coe.int/t/dghl/monitoring/socialcharter/ECSR/ECSRdefault_en.asp.

54 CEDS, sentenza 9 settembre 1999, *International Commission of Jurists (ICJ) c. Portogallo*, (ricorso n. 1/1998).

55 CEDS, sentenza 7 dicembre 2004, *World Organisation Against Torture (OMCT) c. Grecia*, (ricorso n. 17/2003).

56 CEDS, sentenza 23 ottobre 2012, *Defence for Children International (DCI) c. Belgio* (ricorso n. 69/2011).

57 CEDS, sentenza 3 giugno 2008, *Mental Disability Advocacy Center (MDAC) c. Bulgaria* (ricorso n. 41/2007), punto 35.

Esempio: nel caso *International Commission of Jurists (ICJ) c. Portogallo*[58], si era sostenuto che, sebbene rispettasse l'età minima di 15 anni per l'ammissione al lavoro fissata dall'articolo 7, paragrafo 1, della CSE, la normativa portoghese non era adeguatamente applicata. Il CEDS ha dichiarato che la CSE ha l'obiettivo e la finalità di proteggere i diritti non solo in teoria, ma anche in pratica, e che pertanto la suddetta normativa deve essere applicata efficacemente. Avendo constatato che in Portogallo un numero considerevole di minori aveva un'occupazione irregolare, il CEDS ha ritenuto che tale situazione costituisse una violazione dell'articolo 7, paragrafo 1, della CSE.

58 CEDS, sentenza 9 settembre 1999, *International Commission of Jurists (ICJ) c. Portogallo*, (ricorso n. 1/1998).

2 Libertà e diritti civili fondamentali

UE	Argomenti trattati	Consiglio d'Europa
Carta dei diritti fondamentali, articoli 10 (libertà di religione) e 14 (diritto all'istruzione)	**Libertà di pensiero, di coscienza e di religione**	CEDU, articoli 9 (libertà di religione) e 14 (divieto di discriminazione); articolo 2 del Protocollo n. 1 (diritto dei genitori di provvedere all'istruzione dei figli secondo le loro convinzioni) Corte EDU, *Dogru c. Francia,* n. 27058/05, 2008 (indossare il velo islamico in una scuola secondaria statale) Corte EDU, *Kervanci c. Francia,* n. 31645/04, 2008 (indossare il velo islamico in una scuola secondaria statale) Corte EDU, *Grzelak c. Polonia,* n. 7710/02, 2010 (alternative all'istruzione religiosa nelle scuole primarie e secondarie) Corte EDU, *Lautsi e altri c. Italia* [GC], n. 30814/06, 2011 (esposizione di crocifissi nelle scuole pubbliche)
Carta dei diritti fondamentali, articolo 11 (libertà di espressione)	**Libertà di espressione e d'informazione**	CEDU, articolo 10 (libertà di associazione) Corte EDU, *Handyside c. Regno Unito,* n. 5493/72, 1976 (divieto di diffusione di un libro destinato ai minori) Corte EDU, *Gaskin c. Regno Unito,* n. 10454/83, 1989 (accesso al fascicolo redatto durante l'infanzia)

UE	Argomenti trattati	Consiglio d'Europa
Carta dei diritti fondamentali dell'UE, articolo 24 (diritti del bambino) CGUE, sentenza C-491/10 PPU, *Joseba Andoni Aguirre Zarraga c. Simone Pelz*, 2010 (diritto di essere ascoltato, sottrazione internazionale di minori)	**Diritto di essere ascoltato**	CEDU, articolo 6 (equo processo) Convenzione europea sull'esercizio dei diritti dei minori, articoli 3, 4, 6 e 7 Corte EDU, *Sahin c. Germania* [GC], n. 30943/96, 2003 (diritto del minore di essere ascoltato in giudizio nei procedimenti relativi al diritto di visita)
Carta dei diritti fondamentali, articolo 12 (libertà di riunione e di associazione)	**Diritto alla libertà di riunione e di associazione**	CEDU, articolo 11 (libertà di riunione pacifica e libertà d'associazione) Corte EDU, *Christian Democratic People's Party c. Moldova*, n. 28793/02, 2006 (partecipazione a una riunione in un luogo pubblico)

Tutti godono delle libertà e dei diritti civili sanciti in vari strumenti, in particolare la Carta dei diritti fondamentali dell'UE e la Convenzione europea dei diritti dell'uomo (CEDU), quali interpretate dalla Corte europea dei diritti dell'uomo (Corte EDU). Al di là della Carta, nessun altro strumento giuridico dell'UE prende espressamente in considerazione i diritti civili discussi nel presente capitolo, poiché si applicano ai minori. Tuttavia, per quanto riguarda il Consiglio d'Europa, nel corso degli anni si è assistito a un ampio sviluppo dell'ambito di applicazione e dell'interpretazione di questi diritti civili, in particolare attraverso la giurisprudenza della Corte EDU.

Il presente capitolo fornisce una panoramica delle libertà elencate al titolo II della Carta dei diritti fondamentali dell'UE nella misura in cui incidono sui diritti dei minori. Inoltre, analizza il diritto del minore alla libertà di pensiero, di coscienza e di religione (paragrafo 2.1), alla libertà di espressione e d'informazione (paragrafo 2.3), al diritto del minore di essere ascoltato (paragrafo 2.4) e al diritto alla libertà di riunione e di associazione (paragrafo 2.5).

2.1. Libertà di pensiero, di coscienza e di religione

Punti salienti

- La libertà di pensiero, di coscienza e di religione, garantita dalla Carta dei diritti fondamentali dell'UE e dalla CEDU, include il diritto di cambiare religione o convinzione, così come la libertà di manifestare la propria religione o la propria convinzione mediante il culto, l'insegnamento, le pratiche e l'osservanza dei riti.
- I genitori hanno il diritto di provvedere all'educazione e all'istruzione dei loro figli secondo le loro convinzioni religiose, filosofiche e pedagogiche.
- I genitori hanno il diritto e il dovere di guidare il minore nell'esercizio del suo diritto alla libertà di pensiero, di coscienza e di religione in maniera che corrisponda allo sviluppo delle sue capacità.

2.1.1. Il diritto del minore alla libertà di religione

Nell'ambito del diritto dell'UE, l'articolo 10 della Carta dei diritti fondamentali dell'UE garantisce a ogni persona il diritto alla libertà di pensiero, di coscienza e di religione. Tale diritto include la libertà di cambiare religione o convinzione, così come la libertà di manifestare la propria religione o la propria convinzione individualmente o collettivamente, in pubblico o in privato, mediante il culto, l'insegnamento, le pratiche e l'osservanza dei riti. Il diritto all'obiezione di coscienza è riconosciuto secondo le leggi nazionali che ne disciplinano l'esercizio (articolo 10, paragrafo 2 della Carta dei diritti fondamentali dell'UE).

Nell'ambito del diritto del Consiglio d'Europa, l'articolo 9 della CEDU garantisce a ogni persona il diritto alla libertà di pensiero, di coscienza e di religione. Dalla giurisprudenza della Corte EDU sono state ricavate tre dimensioni del diritto alla libertà di religione: la dimensione interna, la libertà di cambiare religione o convinzione e la libertà di manifestare la propria religione o la propria convinzione. Le prime due dimensioni sono assolute e gli Stati non possono limitarle in alcun modo.[59] La libertà di manifestare la propria religione o la propria convinzione può essere limitata se tali restrizioni sono stabilite dalla legge, perseguono un

59 Corte EDU, sentenza 23 ottobre 1990, *Darby c. Svezia* (n. 11581/85).

obiettivo legittimo e costituiscono misure necessarie in una società democratica (articolo 9, paragrafo 2, della CEDU).

Nella sua giurisprudenza, la Corte EDU si è occupata della libertà di pensiero, di coscienza e di religione dei minori principalmente in relazione al diritto all'istruzione e al sistema scolastico statale. Un argomento che è stato oggetto di un ampio dibattito pubblico nei paesi europei è la religione nelle scuole.

Esempio: i casi di *Dogru c. Francia* e *Kervanci c. Francia*[60] riguardano l'espulsione dal primo anno di una scuola secondaria statale francese di due ragazze, di 11 e 12 anni di età, in seguito al loro rifiuto di togliere il velo durante le lezioni di educazione fisica. La Corte EDU ha osservato che la limitazione del diritto delle ricorrenti a manifestare le loro convinzioni religiose aveva la finalità di preservare gli imperativi della laicità nelle scuole pubbliche. A parere delle autorità nazionali, indossare un velo, in particolare il velo islamico, non era compatibile con la pratica dello sport per ragioni di sicurezza e di igiene. La Corte EDU ha ritenuto la suddetta conclusione ragionevole, poiché la scuola aveva soppesato le convinzioni religiose delle ricorrenti e gli imperativi della protezione dei diritti e delle libertà altrui e dell'ordine pubblico. Ha pertanto stabilito che l'ingerenza nella libertà delle studentesse di manifestare la loro religione era giustificata e proporzionata all'obiettivo perseguito. La Corte non ha dunque riscontrato alcuna violazione dell'articolo 9 della CEDU.

Esempio: il caso *Grzelak c. Polonia*[61] riguarda l'impossibilità di uno studente dispensato dall'istruzione religiosa di frequentare un corso di etica e di ricevere la relativa valutazione. Durante il suo intero percorso d'istruzione primaria e secondaria (ovvero tra i sette e i 18 anni), il ricorrente non aveva ricevuto alcuna istruzione religiosa, conformemente alla volontà dei suoi genitori, che erano agnostici dichiarati. A causa dello scarso numero di studenti interessati, non era mai stato organizzato alcun corso di etica eil ricorrente aveva ricevuto pagelle e certificati scolastici in cui alla rubrica "religione/etica" al posto di un voto figurava una barra. La Corte EDU ha ritenuto che l'assenza di un voto di "religione/etica" sulle pagelle scolastiche del ragazzo rientrasse nell'ambito dell'aspetto negativo della libertà di

60 Corte EDU, sentenza 4 dicembre 2008, *Dogru c. Francia* (n. 27058/05); Corte EDU, sentenza 4 dicembre 2008, *Kervanci c. Francia* (n. 31645/04) (consultabile in francese).

61 Corte EDU, sentenza 15 giugno 2010, *Grzelak c. Polonia* (n. 7710/02).

pensiero, di coscienza e di religione, in quanto le pagelle avrebbero potuto indicare la sua mancata affiliazione religiosa. Si trattava pertanto di una forma di stigmatizzazione immotivata. La disparità di trattamento tra non credenti interessati a frequentare un corso di etica e studenti che seguivano le lezioni di religione non era dunque oggettivamente e ragionevolmente giustificata, né sussisteva un nesso ragionevole di proporzionalità tra i mezzi impiegati e lo scopo perseguito. Lo Stato aveva oltrepassato il proprio margine di apprezzamento in materia poiché era stata violata l'essenza stessa del diritto del ricorrente di non manifestare la sua religione o le sue convinzioni, in violazione dell'articolo 14 della CEDU in combinato disposto con l'articolo 9 della CEDU.

2.2. I diritti dei genitori e la libertà di religione dei loro figli

La legislazione europea tratta i diritti dei genitori nel contesto della libertà di religione dei loro figli in maniera diversa dalla CRC.

Nell'ambito della legislazione dell'UE, deve essere accordato il dovuto rispetto al diritto dei genitori di provvedere all'educazione e all'istruzione dei figli secondo le loro convinzioni religiose, filosofiche e pedagogiche, in particolare per quanto riguarda la libertà di creare istituti di insegnamento (articolo 14, paragrafo 3, della Carta).

Nell'ambito del diritto del Consiglio d'Europa, in particolare l'articolo 2 del Protocollo n. 1 della CEDU, gli Stati devono tenere conto delle convinzioni (religiose) dei genitori nell'esercizio delle funzioni che assumono nel campo dell'educazione e dell'insegnamento. Secondo la giurisprudenza della Corte EDU, questo dovere ha un'ampia portata, poiché si applica non solo al contenuto e all'attuazione dei programmi scolastici, ma anche allo svolgimento di tutte le funzioni assunte da uno Stato[62]. Comprende l'organizzazione e il finanziamento dell'istruzione pubblica, la definizione e la pianificazione del programma di studio, la diffusione in maniera obiettiva, critica e pluralista delle informazioni o delle conoscenze che

62 Cfr. la pertinente giurisprudenza della Corte EDU: Corte EDU, sentenza 7 dicembre 1976, *Kjeldsen, Busk Madsen e Pedersen c. Danimarca* (nn. 5095/71, 5920/72 e 5926/72); Corte EDU, sentenza 18 dicembre 1996, *Valsamis c. Grecia* (n. 21787/93); Corte EDU, sentenza 29 giugno 2007, *Folgerø e altri c. Norvegia* [GC] (n. 15472/02); Corte EDU, sentenza 9 ottobre 2007, *Hasan e Eylem Zengin c. Turchia* (n. 1448/04); Corte EDU, sentenza 18 marzo 2011, *Lautsi e altri c. Italia* [GC] (n. 30814/06).

figurano nel programma (vietando in tal modo allo Stato di perseguire uno scopo di indottrinamento che potrebbe essere considerato irrispettoso delle convinzioni religiose e filosofiche dei genitori) nonché l'organizzazione dell'ambiente scolastico, compresa la presenza di crocifissi nelle aule delle scuole pubbliche.

Esempio: il caso *Lautsi e altri c. Italia*[63] riguarda l'esposizione di crocifissi nelle aule delle scuole pubbliche. Una mamma aveva contestato la presenza di crocifissi nelle aule della scuola pubblica frequentata dai suoi figli perché a suo parere violava il principio di laicità conformemente al quale intendeva educarli. La Grande Camera della Corte EDU ha ritenuto che la decisione relativa alla presenza di crocifissi nelle aule delle scuole pubbliche rientrasse tra le funzioni assunte dallo Stato nell'ambito dell'educazione e dell'insegnamento e ricadesse nella sfera di applicazione della seconda frase dell'articolo 2 del Protocollo n. 1 della CEDU. La Corte ha sostenuto che questa decisione rientrava in linea di principio nel margine di valutazione dello Stato convenuto e che non esiste un consenso europeo sulla presenza dei simboli religiosi nelle scuole pubbliche. È vero che la presenza dei crocifissi nelle aule delle scuole pubbliche (un simbolo che rinvia indubbiamente al cristianesimo) conferisce alla religione maggioritaria del paese una visibilità preponderante nell'ambiente scolastico. Tuttavia, ciò non è di per sé sufficiente a denotare un processo di indottrinamento da parte dello Stato convenuto. A parere della Corte EDU, un crocifisso appeso al muro è un simbolo essenzialmente passivo al quale non può essere attribuita un'influenza sugli allievi paragonabile a quella che può avere un discorso o la partecipazione ad attività religiose. Di conseguenza, la Grande Camera ha concluso che, nel decidere di mantenere i crocifissi nelle aule della scuola pubblica frequentata dai figli della ricorrente, le autorità avevano agito entro i limiti del loro potere discrezionale e pertanto avevano rispettato il diritto dei genitori ad assicurare l'educazione e l'insegnamento conformemente alle loro convinzioni religiose e filosofiche.

Nell'ambito del diritto internazionale, l'articolo 14, paragrafo 2, della CRC prevede che gli Stati contraenti rispettino il diritto e il dovere dei genitori di guidare il minore nell'esercizio del suo diritto alla libertà di pensiero, di coscienza e di religione in maniera che corrisponda allo sviluppo delle sue capacità. Pertanto, diversamente dall'articolo 14, paragrafo 3, della Carta dei diritti fondamentali dell'UE, la CRC tutela l'esercizio della libertà del minore stesso. Nell'ambito della

63 Corte EDU, sentenza 18 marzo 2011, *Lautsi e altri c. Italia* [GC] (n. 30814/06).

CRC i genitori hanno il diritto di fornire consigli e orientamento non conformemente alle loro convinzioni, bensì a quelle dei figli. La formulazione dell'articolo 14, paragrafo 2, della CRC è in linea con il concetto generale di responsabilità genitoriali della Convenzione: le responsabilità genitoriali devono essere esercitate in maniera corrispondente allo sviluppo delle capacità del minore (articolo 5 della CRC) e considerando preminente il suo interesse superiore (articolo 18, paragrafo 1, della CRC).

2.3. Libertà di espressione e d'informazione

Punti salienti

- Sia la Carta dei diritti fondamentali dell'UE sia la CEDU garantiscono il diritto alla libertà di espressione, che include la libertà di opinione e la libertà di ricevere o di comunicare informazioni o idee senza che vi possa essere ingerenza da parte delle autorità pubbliche.
- Il diritto alla libertà d'informazione non include il diritto di accesso a fascicoli riguardanti il collocamento extrafamiliare di minori.
- Subordinare l'accesso a fascicoli riguardanti il collocamento extrafamiliare di minori al consenso dell'informatore potrebbe essere compatibile con l'articolo 8 (diritto al rispetto della vita privata e familiare) della CEDU qualora un organo indipendente fosse incaricato di adottare la decisione definitiva sull'accesso.

Nell'ambito del diritto dell'UE, il diritto alla libertà di espressione include la libertà di opinione e la libertà di ricevere o di comunicare informazioni o idee senza che vi possa essere ingerenza da parte delle autorità pubbliche e senza limiti di frontiera (articolo 11 della Carta dei diritti fondamentali dell'UE).

Nell'ambito del diritto del Consiglio d'Europa, la libertà di espressione è garantita dall'articolo 10 della CEDU e può essere limitata solo se la restrizione è prevista dalla legge, persegue uno degli obiettivi legittimi elencati all'articolo 10, paragrafo 2, ed è necessaria in una società democratica.

Nella sua giurisprudenza la Corte EDU ha sottolineato che "[l]a libertà di espressione costituisce uno dei fondamenti essenziali di una società [democratica], una delle condizioni basilari per il progresso di tale società e per il pieno sviluppo di ogni singola persona [...] si estende non solo alle "informazioni" o alle "idee"

accolte con favore o considerate come inoffensive o indifferenti, ma anche a tutte quelle informazioni o idee che disturbino, sconvolgano o inquietino lo Stato o una parte della popolazione."[64]

Esempio: nel caso *Handyside c. Regno Unito,*[65] la Corte EDU aveva ritenuto che il divieto di divulgazione del libro intitolato "*Little Red School Book*" imposto dalle autorità fosse conforme all'eccezione prevista dall'articolo 10, paragrafo 2, della CEDU sulla protezione della morale. Il caso riguarda il diritto di ricevere informazioni adeguate all'età e alla maturità di un bambino, aspetto del diritto alla libertà di espressione che è particolarmente pertinente per i minori. Il libro, che era stato tradotto dal danese, era stato scritto per bambini in età scolare e metteva in discussione una serie di norme sociali, riguardanti ad esempio la sessualità e gli stupefacenti. Alcuni passaggi del libro potrebbero essere interpretati dai giovani, in una fase critica del loro sviluppo, come un incoraggiamento a indulgere in attività precoci per loro dannose o addirittura indurli a commettere taluni reati penali. Pertanto, secondo la Corte EDU, i giudici inglesi competenti "erano autorizzati, nell'esercizio del loro margine discrezionale, a pensare che all'epoca il libro avrebbe avuto effetti nocivi sulla morale di molti dei bambini e adolescenti che lo avessero letto."[66]

Altri casi relativi ai minori che rinviano all'articolo 10 della CEDU riguardano il diritto di accesso alle informazioni di minori collocati fuori dalla famiglia.

Esempio: il caso *Gaskin c. Regno Unito*[67] riguarda una persona che aveva trascorso al di fuori della famiglia la maggior parte dell'infanzia, periodo durante il quale l'autorità locale aveva costituito un fascicolo riservato su di essa. Tra le informazioni contenute nel suddetto fascicolo figuravano relazioni redatte da medici, insegnanti, agenti di polizia, funzionari addetti alla sorveglianza di individui affidati in prova al servizio sociale e/o in regime di semi-libertà, operatori sociali, assistenti sanitari, genitori affidatari e personale scolastico. Quando il ricorrente aveva chiesto di accedere a tale fascicolo al fine di avviare un'azione giudiziaria per danni personali

64 Cfr., per esempio, Corte EDU, sentenza 7 dicembre 1976, *Handyside c. Regno Unito* (n. 5493/72), punto 49.

65 *Ibid.*

66 *Ibid.*, punto 52.

67 Corte EDU, sentenza 7 luglio 1989, *Gaskin c. Regno Unito* (n. 10454/83).

nei confronti dell'autorità locale, la sua richiesta era stata respinta. La riservatezza di tali informazioni era stata garantita nel pubblico interesse al fine di assicurare il corretto funzionamento del servizio di collocamento dei minori, che sarebbe stato altrimenti compromesso se in futuro gli informatori fossero stati riluttanti a esprimersi con franchezza nelle loro relazioni. La Corte EDU ha riconosciuto l'interesse primario delle persone affidate alla pubblica assistenza in giovane età "a ricevere le informazioni necessarie a conoscere e comprendere la loro infanzia e gli anni della loro formazione."[68] Benché sia necessario garantire la riservatezza dei fascicoli pubblici, un sistema che ne subordini l'accesso al consenso dell'informatore, come nel Regno Unito, potrebbe in linea di principio essere compatibile con l'articolo 8 della CEDU laddove gli interessi di chiunque cerchi di consultare documenti relativi alla sua vita privata siano salvaguardati nel caso in cui un informatore non sia disponibile o rifiuti abusivamente il consenso. In tal caso, un organo indipendente deve essere incaricato di adottare la decisione definitiva sull'accesso. Nella fattispecie, il ricorrente non aveva la possibilità di avvalersi di tale procedura e la Corte ha riscontrato una violazione dei diritti del ricorrente ai sensi dell'articolo 8 della CEDU. La Corte EDU non ha tuttavia riscontrato una violazione dell'articolo 10 della CEDU, ribadendo che il diritto di ricevere informazioni implica che uno Stato non possa impedire a una persona di ricevere informazioni che altri desiderano o potrebbero desiderare comunicarle, ma non obbliga uno Stato a comunicare tali informazioni alla persona in questione.

68 *Ibid.*, punto 49.

2.4. Diritto di essere ascoltato

Punti salienti

- Nell'ambito della legislazione dell'UE, i minori hanno il diritto di esprimere liberamente la propria opinione. Questa viene presa in considerazione sulle questioni che li riguardano in funzione della loro età e della loro maturità.
- La CEDU non prescrive l'obbligo assoluto di ascoltare un minore in giudizio. Per stabilire l'opportunità di procedere in tal senso si devono valutare le circostanze specifiche di ogni caso, tenendo conto dell'età e del grado di maturità del minore.
- Nell'ambito del diritto delle Nazioni Unite, il diritto dei minori di esprimere liberamente la loro opinione su ogni questione che li interessa è stato riconosciuto come uno dei principi generali della Convenzione sui diritti del fanciullo.

Ai sensi della legislazione dell'Unione, l'articolo 24, paragrafo 1, della Carta dei diritti fondamentali dell'UE stabilisce che i minori possono esprimere liberamente la propria opinione e che questa viene presa in considerazione sulle questioni che li riguardano in funzione della loro età e della loro maturità. Questa è una disposizione di applicabilità generale e non è limitata a procedimenti specifici. La CGUE ha interpretato il significato di questa disposizione in combinato disposto con il regolamento Bruxelles II *bis*.

Esempio: la causa *Joseba Andoni Aguirre Zarraga c. Simone Pelz*[69] riguarda il trasferimento di una minore dalla Spagna alla Germania in violazione di sentenze di affidamento. La CGUE era stata chiamata a stabilire se i giudici tedeschi (ossia i giudici del paese in cui la minore era stata trasferita) potevano opporsi all'esecuzione di una decisione del giudice spagnolo (il paese d'origine) a motivo del fatto che la minore non era stata ascoltata e pertanto erano stati violati l'articolo 42, paragrafo 2, lettera a), del regolamento (CE) n. 2201/2003 (Bruxelles II *bis*) e l'articolo 24 della Carta dei diritti fondamentali dell'UE. La minore si era opposta al ritorno quando aveva espresso il proprio parere nell'ambito del procedimento dinanzi al giudice tedesco. La CGUE ha dichiarato che, sebbene ascoltare un minore in giudizio non sia un diritto assoluto, qualora reputi necessario agire

69 CGUE, sentenza 22 dicembre 2010, causa C-491/10 PPU, *Joseba Andoni Aguirre Zarraga c. Simone Pelz.*; cfr. anche il paragrafo 5.4, che esamina più approfonditamente questa sentenza nonché il funzionamento del regolamento Bruxelles II bis.

in tal senso, un giudice deve offrire al minore una possibilità concreta ed effettiva di esprimersi. Ha altresì stabilito che il diritto di un minore di essere ascoltato, sancito sia dalla Carta che dal regolamento Bruxelles II *bis*, richiede che siano messe a disposizione di tale minore le procedure e condizioni legali che gli consentano di esprimere liberamente la sua opinione e che quest'ultima sia raccolta dal giudice. Il giudice deve inoltre adottare, in funzione dell'interesse superiore del minore e alla luce delle circostanze di ogni caso di specie, tutte le misure appropriate ai fini di una siffatta udienza. Tuttavia, conformemente alla sentenza della CGUE, le autorità del paese in cui la minore era stata trasferita (la Germania) non potevano opporsi al ritorno della minore sulla base di una violazione del suo diritto di essere ascoltata nel paese d'origine (la Spagna).

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU non ritiene che il diritto al rispetto della vita privata e familiare (articolo 8 della CEDU) contempli sempre l'obbligo di ascoltare il minore in giudizio. Di norma, spetta ai giudici nazionali valutare gli elementi di prova ottenuti, compresi i mezzi utilizzati per accertare i fatti pertinenti. I giudici nazionali non sono sempre tenuti ad ascoltare un minore in giudizio sulla questione della visita a un genitore che non ha diritti di affidamento. La questione deve essere valutata alla luce delle circostanze specifiche di ogni caso, nel rispetto dell'età e del grado di maturità del minore interessato. Inoltre, nell'ambito dell'elemento procedurale dell'articolo 8, la Corte EDU si farà spesso carico di garantire che le autorità abbiano adottato le misure adeguate affinché le loro decisioni siano corredate delle necessarie garanzie.

Esempio: nel caso *Sahin c. Germania,*[70] la madre aveva vietato qualsiasi tipo di contatto tra il ricorrente e la figlia di quattro anni. Il tribunale regionale tedesco aveva stabilito che permettere al padre di vedere la figlia sarebbe stato dannoso per quest'ultima a causa della situazione altamente conflittuale esistente tra i genitori. Il giudice aveva preso questa decisione senza sentire se la bambina volesse continuare a vedere suo padre. Quanto al diritto di un minore di essere ascoltato in giudizio, la Corte EDU aveva rinviato alla perizia presentata dinanzi al tribunale regionale tedesco. Dopo alcuni incontri con la bambina, la madre e il ricorrente, l'esperta

70 Corte EDU, sentenza 8 luglio 2003, *Sahin c. Germania* (n. 30943/96), punto 73. Per quanto riguarda l'aspetto specifico dei giudizi nazionali che sono tenuti a valutare gli elementi di prova ottenuti, nonché la pertinenza degli elementi di prova che gli imputati cercano di addurre, cfr. anche Corte EDU, sentenza 22 aprile 1992, *Vidal c. Belgio* (n. 12351/86), punto 33.

aveva ritenuto che un eventuale interrogatorio avrebbe potuto esporre la minore a un rischio, che non avrebbe potuto essere evitato attraverso l'adozione di misure speciali in tribunale. La Corte EDU ha constatato che, nel caso di specie, i requisiti procedurali impliciti all'articolo 8 della CEDU, che sanciscono il diritto di un minore a essere ascoltato in giudizio, non comportavano l'obbligo di sottoporre la minore a un interrogatorio diretto sul suo rapporto con il padre.

Esempio: nel caso *Sommerfeld c. Germania,*[71] la figlia tredicenne del ricorrente aveva espresso chiaramente il desiderio di non vedere il padre e si era comportata di conseguenza per alcuni anni. I giudici nazionali erano del parere che obbligarla a vedere il ricorrente avrebbe seriamente turbato il suo equilibrio emotivo e psicologico. La Corte EDU ha convenuto che il processo decisionale aveva garantito la necessaria protezione degli interessi del ricorrente.[72]

Il diritto dei minori di esprimere liberamente la loro opinione è previsto anche dalla Convenzione europea sull'esercizio dei diritti dei minori.[73] Obiettivo della suddetta convenzione è promuovere i diritti dei minori riconoscendo loro diritti procedurali specifici nei procedimenti in materia di famiglia dinanzi a un'autorità giudiziaria, in particolare nei procedimenti aventi per oggetto l'esercizio delle responsabilità genitoriali, quali la residenza e il diritto di visita nei confronti dei figli. Tra i diritti procedurali che riconosce ai minori, l'articolo 3 della convenzione garantisce loro il diritto di essere informati e di esprimere la propria opinione nei procedimenti. L'articolo 4 riconosce al minore il diritto di richiedere la designazione di un rappresentante speciale nei procedimenti che lo riguardano dinanzi a un'autorità giudiziaria. In linea con l'articolo 6, le autorità devono assicurarsi che il minore abbia ricevuto tutte le informazioni pertinenti, consultare il minore personalmente, nei casi che lo richiedono, e permettere al minore di esprimere la propria opinione.

Nell'ambito del diritto internazionale, l'articolo 12, paragrafo 1, della CRC afferma che un minore capace di discernimento ha il diritto di esprimere liberamente la sua opinione su ogni questione che lo interessa. Le opinioni del minore devono essere prese debitamente in considerazione tenendo conto della sua età e del

71 Corte EDU, sentenza 8 luglio 2003, *Sommerfeld c. Germania* [GC] (n. 31871/96).

72 *Ibid.*, punti 72 e 88.

73 Consiglio d'Europa, Convenzione europea sull'esercizio dei diritti dei minori, STE N. 160, 1996.

suo grado di maturità. L'articolo 12, paragrafo 2, della CRC prescrive inoltre che al minore sia data la possibilità di essere ascoltato in ogni procedimento giudiziario o amministrativo che lo concerne, sia direttamente, sia tramite un rappresentante o un organo appropriato, in maniera compatibile con le regole di procedura della legislazione nazionale.

Il Comitato sui diritti dell'infanzia dell'ONU ha sottolineato che gli Stati contraenti devono garantire direttamente questo diritto oppure adottare nuove normative o rivedere le leggi esistenti affinché il minore possa beneficiare appieno di tale diritto.[74] Devono inoltre fare in modo che il minore riceva tutte le informazioni e gli orientamenti necessari a prendere una decisione a favore del suo interesse superiore. Il Comitato rileva altresì che il minore ha la facoltà di non esercitare tale diritto; può scegliere di esprimere il proprio parere, ma non è obbligato a farlo.

2.5. Diritto alla libertà di riunione e di associazione

Punti salienti

- Sia la Carta dei diritti fondamentali dell'UE sia la CEDU garantiscono la libertà di riunione pacifica e la libertà d'associazione.
- Questo diritto protegge le persone e permette loro di promuovere le loro cause insieme ad altri.

Nell'ambito del diritto dell'UE, l'articolo 12 della Carta dei diritti fondamentali dell'Unione stabilisce che ogni persona ha diritto alla libertà di riunione pacifica e alla libertà di associazione a tutti i livelli, segnatamente in campo politico, sindacale e civico, il che implica il diritto di ogni persona di fondare sindacati insieme con altri e di aderirvi per la difesa dei propri interessi.

Nell'ambito del diritto del Consiglio d'Europa, l'articolo 11, paragrafo 1, della CEDU garantisce il diritto alla libertà di riunione e di associazione fatte salve le restrizioni di cui all'articolo 11, paragrafo 2.

74 ONU, Comitato sui diritti dell'infanzia, *Commento generale n. 14 (2013) sul diritto del minore a che il suo interesse superiore sia tenuto in primaria considerazione* (articolo 3, paragrafo 1), CRC/C/GC/14, 29 maggio 2013.

La Corte EDU ha espressamente riconosciuto il diritto dei minori di partecipare a riunioni in un luogo pubblico. Come ha rilevato la Corte nel caso *Christian Democratic People's Party c. Moldova*, vietare a genitori e figli di partecipare a eventi, in particolare di contestare la politica statale in materia di insegnamento, equivale a violare la loro libertà di riunione.

Nell'ambito del diritto internazionale, sia i singoli minori sia le organizzazioni per l'infanzia possono avvalersi della protezione offerta dall'articolo 15 della CRC, che sancisce il diritto alla libertà di associazione e alla libertà di riunirsi pacificamente. Ai sensi della suddetta disposizione, è stata garantita la protezione internazionale di un'ampia varietà di forme associative in cui sono coinvolti minori.

3 Uguaglianza e non discriminazione

UE	Argomenti trattati	Consiglio d'Europa
Carta dei diritti fondamentali, titolo III (uguaglianza), comprendente gli articoli 20 (uguaglianza davanti alla legge), 21 (non discriminazione) e 23 (parità tra donne e uomini)	**Uguaglianza e non discriminazione**	CEDU, articolo 14; Protocollo n. 12 della CEDU, articolo 1 (non discriminazione) CSE (riveduta), articolo E (non discriminazione)
Direttiva sull'uguaglianza razziale (2000/43/CE)	**Divieto di discriminazione sulla base della razza e dell'origine etnica**	Corte EDU, *D.H. e altri c. Repubblica ceca* [GC], n. 57325/00, 2007 (collocazione di alunni di origine rom in scuole speciali) Corte EDU, *Oršuš e altri c. Croazia,* n. 15766/03, 2010 (classi separate per bambini rom nelle scuole primarie) Convenzione quadro per la protezione delle minoranze nazionali (FCNM), articoli 4 e 12
Carta dei diritti fondamentali, articolo 45 (libertà di circolazione e di soggiorno) CGUE, C-200/02, *Kunqian Catherine Zhu e Man Lavette Chen c. Secretary of State for the Home Department*, 2004 (diritti di soggiorno di genitori cittadini di un paese terzo)	**Divieto di discriminazione sulla base della nazionalità e dello status di immigrazione**	Corte EDU, *Ponomaryovi c. Bulgaria,* n. 5335/05, 2011, tasse scolastiche per i residenti temporanei) Convenzione quadro per la protezione delle minoranze nazionali, articolo 4 e articolo 12, paragrafo 3

UE	Argomenti trattati	Consiglio d'Europa
Direttiva sulla parità di trattamento in materia di occupazione (2000/78/CE)	Divieto di discriminazione sulla base dell'età	CEDU, articolo 14; Protocollo n. 12 della CEDU, articolo 1 (non discriminazione)
CGUE, C-303/06, *S. Coleman c. Attridge Law e Steve Law* [GS], 2008	Divieto di discriminazione sulla base di altri motivi oggetto di protezione	Corte EDU, *Fabris c. Francia* [GC], n. 16574/08, 2013 (diritti di successione di figli nati fuori dal matrimonio)

Il diritto di non subire discriminazioni è uno dei principi fondamentali di una società democratica. Sia l'UE sia il Consiglio d'Europa hanno svolto un ruolo determinante ai fini dell'interpretazione di questo principio. Le istituzioni dell'UE hanno adottato una serie di direttive che sono estremamente importanti per le questioni riguardanti i minori. La Corte EDU ha sviluppato un ampio *corpus* giurisprudenziale sul diritto di non subire discriminazioni a norma dell'articolo 14 CEDU sul divieto di discriminazione, in combinato disposto con altri articoli della Convenzione.

Il comitato europeo dei diritti sociali (CEDS) ritiene che la funzione dell'articolo E della Carta sociale europea (CSE) sulla non discriminazione sia simile a quella dell'articolo 14 CEDU: non ha un'esistenza indipendente e deve essere combinato con una delle disposizioni sostanziali della CSE.[75]

Il presente capitolo tratta i principi dell'uguaglianza e della non discriminazione, prestando particolare attenzione ai motivi di discriminazione per i quali è stata elaborata una specifica giurisprudenza sui minori. Innanzitutto fornisce informazioni di carattere generale sul diritto europeo in materia di non discriminazione (paragrafo 3.1); successivamente illustra la questione dell'uguaglianza e della discriminazione dei minori sulla base dell'origine etnica (paragrafo 3.2), della nazionalità e dello status d'immigrazione (paragrafo 3.3), dell'età (paragrafo 3.4) e di altri motivi oggetto di protezione, tra cui il genere, la lingua e l'identità personale (paragrafo 3.5).

75 CEDS, sentenza 15 giugno 2005, *Syndicat des Agrégés de l'Enseignement Supérieur (SAGES) c. Francia*, (ricorso n. 26/2004), punto 34.

3.1. Diritto europeo in materia di non discriminazione

Punti salienti

- Il diritto dell'UE e del Consiglio d'Europa proibiscono la discriminazione in base al sesso, alla razza, al colore della pelle, all'origine etnica o sociale, alle caratteristiche genetiche, alla lingua, alle convinzioni o alla religione, alle opinioni politiche o di altro genere, all'appartenenza a una minoranza nazionale, alla situazione finanziaria, alla nascita, alla disabilità, all'età o all'orientamento sessuale.[76]
- Se rileverà una disparità nel trattamento riservato a persone che si trovano in situazioni significativamente simili, la Corte EDU verificherà l'esistenza di una giustificazione oggettiva e ragionevole. Qualora non riscontri tale giustificazione, la Corte EDU riterrà discriminatorio il trattamento, in violazione dell'articolo 14 CEDU sul divieto di discriminazione.

Nell'ambito del diritto dell'UE, il divieto di discriminazione sancito dall'articolo 21 della Carta dei diritti fondamentali dell'UE è un principio autonomo valido anche in situazioni in cui non si applica nessun'altra disposizione della Carta. Tra i motivi elencati nella presente disposizione in base alla quale la discriminazione è proibita si annoverano il sesso, la razza, il colore della pelle, l'origine etnica o sociale, le caratteristiche genetiche, la lingua, le convinzioni o la religione, le opinioni politiche o di altro genere, l'appartenenza a una minoranza nazionale, la situazione finanziaria, la nascita, la disabilità, l'età o l'orientamento sessuale. I motivi contemplati dall'articolo 19 del TFUE, invece, sono solo il sesso, la razza o l'origine etnica, la religione o le convinzioni personali, la disabilità, l'età e l'orientamento sessuale.

Alcune direttive dell'UE vietano la discriminazione nei settori dell'occupazione, del sistema di previdenza sociale e dei beni e servizi, che sono tutti potenzialmente pertinenti per i minori. La direttiva 2000/78/CE del Consiglio, che stabilisce un quadro generale per la parità di trattamento in materia di occupazione e di condizioni di lavoro (direttiva sulla parità di trattamento in materia di

76 Per una panoramica del diritto europeo in materia di non discriminazione, costituito dalle direttive dell'UE contro la discriminazione nonché dall'articolo 14 e dal Protocollo n. 12 della CEDU, cfr. FRA e Corte EDU (2011) e l'aggiornamento della giurisprudenza luglio 2010–dicembre 2011.

occupazione),[77] vieta le discriminazioni fondate sulla religione o le convinzioni personali, gli handicap, l'età o le tendenze sessuali. La direttiva 2000/43/CE del Consiglio, che attua il principio della parità di trattamento fra le persone indipendentemente dalla razza e dall'origine etnica (direttiva sull'uguaglianza razziale), vieta la discriminazione sulla base della razza o dell'origine etnica non solo nel contesto dell'occupazione e dell'accesso ai beni e ai servizi, ma anche in relazione al sistema di previdenza sociale (compresa la protezione sociale, la sicurezza sociale e l'assistenza sanitaria) e all'istruzione.[78] Altre direttive applicano il principio della parità di trattamento fra uomini e donne sia in materia di occupazione e impiego (direttiva sulla parità di trattamento fra uomini e donne),[79] sia per quanto riguarda l'accesso a beni e servizi e la loro fornitura (direttiva sulla parità di trattamento tra uomini e donne in materia di accesso ai beni e ai servizi).[80]

Nell'ambito del diritto del Consiglio d'Europa, il divieto di discriminazione si applica nell'esercizio di qualsivoglia diritto e libertà fondamentale di cui alla CEDU (articolo 14), nonché nell'esercizio di qualsivoglia diritto garantito dalla legislazione nazionale o in qualsiasi atto promulgato da un'autorità pubblica (articolo 1 del Protocollo n. 12 della CEDU). Il Protocollo n. 12, tuttavia, ha un'applicabilità limitata; infatti è stato ratificato solo da un esiguo numero di Paesi e sulla sua base non sono ancora state adottate decisioni riguardanti i minori. Le disposizioni enunciate in entrambi gli strumenti comprendono un elenco non esaustivo di motivi di discriminazione vietati: il sesso, la razza, il colore, la lingua, la religione, le opinioni politiche o quelle di altro genere, l'origine nazionale o sociale, l'appartenenza a una minoranza nazionale, la ricchezza, la nascita o ogni altra condizione. Dove rileverà una disparità di trattamento tra persone che si trovano in situazioni significativamente simili, la Corte EDU verificherà se tale disparità possa essere oggettivamente e ragionevolmente giustificata.[81]

L'articolo E della CSE fornisce a sua volta un elenco non esaustivo di motivi di discriminazione vietati: la razza, il colore della pelle, il sesso, la lingua, la religione, le

77 Direttiva 2000/78/CE del Consiglio (GU L 303 del 2.12.2000). Tutti gli strumenti giuridici dell'UE sono disponibili sul portale online EUR-Lex, che permette di accedere al diritto dell'Unione europea: http://eur-lex.europa.eu/homepage.html.

78 Direttiva 2000/43/CE del Consiglio, del 29 giugno 2000, che attua il principio della parità di trattamento fra le persone indipendentemente dalla razza e dall'origine etnica (GU L 180 del 19.7.2000).

79 Direttiva 2004/113/CE del Consiglio (GU L 373 del 21.12.2004, pag. 37).

80 Direttiva 2006/54/CE (rifusione) (GU L 204 del 26.7.2006).

81 Per una panoramica della giurisprudenza della Corte EDU, cfr. FRA e Corte EDU (2011) nonché l'aggiornamento della giurisprudenza luglio 2010–dicembre 2011.

opinioni politiche o ogni altra opinione, l'ascendenza nazionale o l'origine sociale, la salute, l'appartenenza ad una minoranza nazionale o la nascita. L'appendice al suddetto articolo chiarisce che la differenza di trattamento fondata su un motivo oggettivo e ragionevole comprende il requisito di una certa età o una determinata capacità di accedere a talune forme d'istruzione[82] e pertanto non è considerata discriminatoria.

Ai sensi dell' articolo 4 della Convenzione quadro per la protezione delle minoranze nazionali[83] (FCNM), le parti garantiscono ad ogni persona appartenente ad una minoranza nazionale il diritto all'eguaglianza di fronte alla legge e ad una eguale protezione da parte della legge; è inoltre vietata ogni discriminazione basata sull'appartenenza ad una minoranza nazionale. Le parti s'impegnano altresì ad adottare, se necessario, misure adeguate in vista di promuovere, in tutti i settori della vita economica, sociale, politica e culturale, un'eguaglianza piena ed effettiva tra le persone appartenenti ad una minoranza nazionale e quelle appartenenti alla maggioranza.

I paragrafi riportati di seguito analizzano motivi di discriminazione specifici che assumono particolare rilievo per i minori.

3.2. Divieto di discriminazione sulla base della razza o dell'origine etnica

Punti salienti

- La razza e l'origine etnica sono motivi di discriminazione vietati.
- Sia l'UE che il Consiglio d'Europa si occupano della discriminazione dei rom nei settori dell'istruzione, dell'occupazione, dell'assistenza sanitaria e dell'alloggio.
- La sovrarappresentazione o la segregazione di bambini appartenenti a un gruppo etnico specifico in scuole o classi speciali possono essere oggettivamente giustificate solo se si predispongono adeguate garanzie per indirizzare i bambini in tali scuole o classi.

82 Consiglio d'Europa, Carta sociale europea (riveduta) (1996), Rapporto esplicativo, paragrafo 136.

83 Consiglio d'Europa, Convenzione-quadro per la protezione delle minoranze nazionali (FCNM), STE n. 157, 1995.

Nell'ambito del diritto dell'UE, la direttiva sull'uguaglianza razziale vieta la discriminazione sulla base della razza o dell'origine etnica non solo nel contesto dell'occupazione e dei beni e servizi, ma anche in relazione all'accesso al sistema di previdenza sociale, all'istruzione e alla sicurezza sociale. I rom, come gruppo etnico particolarmente numeroso e vulnerabile, rientrano pienamente nell'ambito di applicazione della direttiva. Un contributo fondamentale all'offensiva contro la discriminazione nei confronti dei rom a livello di Unione europea è venuto dall'adozione del quadro dell'UE per le strategie nazionali di integrazione dei rom fino al 2020[84], cui ha fatto seguito il monitoraggio annuale delle strategie nazionali degli Stati membri dell'UE svolto dalla Commissione. La direttiva sull'uguaglianza razziale copre almeno quattro settori fondamentali che sono importanti per i bambini rom: istruzione, occupazione, assistenza sanitaria e alloggio. Per conseguire la piena parità nella pratica, in alcune circostanze può essere necessaria un'azione positiva a favore dei rom, in particolare in questi quattro settori fondamentali.[85]

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha emesso alcune sentenze epocali sulla disparità di trattamento riservata ai bambini rom nel sistema d'istruzione. I casi in questione sono stati analizzati ai sensi dell'articolo 14 in combinato disposto con l'articolo 2 del Protocollo n. 1 della CEDU. La Corte EDU ha ritenuto che la sovrarappresentazione o la segregazione di bambini rom in scuole o classi speciali potrebbe essere oggettivamente giustificata solo predisponendo adeguate garanzie per indirizzare i bambini in tali scuole o classi, quali ad esempio test appositamente concepiti per gli alunni rom e idonei alle loro esigenze, una valutazione e un monitoraggio appropriati dei progressi compiuti grazie a cui sia possibile procedere alla loro integrazione nelle classi normali non appena sarà stato posto rimedio alle difficoltà di apprendimento e misure positive volte a contrastare le difficoltà di apprendimento. In assenza di misure efficaci contro la segregazione, potrebbe pertanto non essere giustificato prolungare la segregazione educativa degli alunni rom da una scuola ordinaria con un programma regolare.[86]

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84 Commissione europea (2011), *Quadro dell'UE per le strategie nazionali di integrazione dei Rom fino al 2020: Comunicazione della Commissione al Parlamento europeo, al Consiglio, al Comitato economico e sociale europeo e al Comitato delle regioni*, COM (2011) 173 final, Bruxelles, 5 aprile 2011.

85 Commissione europea (2014), *Relazione congiunta sull'applicazione della direttiva 2000/43/CE del Consiglio, del 29 giugno 2000, che attua il principio della parità di trattamento fra le persone indipendentemente dalla razza e dall'origine etnica e della direttiva 2000/78/CE del Consiglio, del 27 novembre 2000, che stabilisce un quadro generale per la parità di trattamento in materia di occupazione e di condizioni di lavoro*, Relazione della Commissione al Parlamento europeo e al Consiglio, COM(2014) 2 definitivo, Bruxelles, 17 gennaio 2014.

86 Corte EDU, sentenza 30 maggio 2013, *Lavida e altri c. Grecia* (n. 7973/10) (consultabile in francese).

Esempio: nel caso *D.H. e altri c. Repubblica ceca*[87], la Corte EDU ha constatato che un numero sproporzionato di alunni rom era stato collocato, senza alcuna giustificazione, in scuole speciali destinate a minori con difficoltà di apprendimento. La Corte aveva espresso preoccupazione riguardo sia al programma più basilare offerto in tali scuole sia alla segregazione causata da questo sistema. Gli alunni rom avevano quindi ricevuto un'istruzione che aggravava le loro difficoltà e comprometteva il loro successivo sviluppo personale, anziché aiutarli a integrarsi nel sistema scolastico tradizionale e a sviluppare le capacità che avrebbero facilitato la loro vita tra la popolazione maggioritaria. La Corte EDU ha riscontrato una violazione dell'articolo 14 della Convenzione in combinato disposto con l'articolo 1 del Protocollo n. 1.

Esempio: nel caso *Oršuš e altri c. Croazia*[88], la Corte EDU ha esaminato l'esistenza di classi separate per bambini rom all'interno delle scuole primarie ordinarie. In linea di principio, la prassi di collocare temporaneamente gli alunni in una classe separata in funzione dell'insufficiente padronanza della lingua d'istruzione non è di per sé discriminatoria. Si può ritenere che l'adozione di tale prassi sia finalizzata ad adeguare il sistema d'istruzione alle esigenze speciali di studenti con difficoltà linguistiche. Tuttavia, laddove tale collocazione riguardi in misura sproporzionata o esclusiva i membri di uno specifico gruppo etnico, devono essere predisposte adeguate garanzie. Per quanto riguarda la collocazione iniziale in classi separate, la Corte EDU ha rilevato che tale collocazione non rientrava in una prassi generale volta ad affrontare i problemi degli studenti con un'insufficiente padronanza linguistica e che i bambini non erano stati sottoposti a test specifici per verificare la loro conoscenza della lingua. Quanto al programma offerto loro, ad alcuni alunni non erano stati riservati programmi specifici (quali lezioni di lingua speciali) che consentissero loro di acquisire le competenze linguistiche necessarie nel più breve tempo possibile. Analogamente, non esisteva una procedura di trasferimento o monitoraggio volta a garantire il trasferimento immediato e automatico nelle classi miste degli alunni rom non appena questi avessero raggiunto una sufficiente padronanza linguistica. La Corte EDU ha pertanto riscontrato una violazione dell'articolo 14 della CEDU in combinato disposto con l'articolo 2 del Protocollo n. 1.

87 Corte EDU, sentenza 13 novembre 2007, *D.H. e altri c. Repubblica ceca* [GC] (n. 57325/00), punti 206–210.

88 Corte EDU, sentenza 16 marzo 2010, *Oršuš e altri c. Croazia* [GC] (n. 15766/03), punto 157.

Il CEDS ritiene che, sebbene le politiche scolastiche a favore dei bambini rom possano essere affiancate da strutture flessibili per rispecchiare l'eterogeneità del gruppo e possano tenere conto del fatto che alcuni gruppi conducono uno stile di vita itinerante o semi-itinerante, non devono esistere scuole separate per gli alunni rom.[89]

Ai sensi dell'articolo 4, paragrafi 2 e 3, della Convenzione quadro per la protezione delle minoranze nazionali, le misure speciali adottate per promuovere l'eguaglianza effettiva delle persone appartenenti a minoranze nazionali non sono considerate discriminatorie. Conformemente all'articolo 12, paragrafo 3 della suddetta convenzione, le parti s'impegnano inoltre espressamente a promuovere l'uguaglianza delle opportunità nell'accesso all'educazione a tutti i livelli per le persone appartenenti a minoranze nazionali. Il comitato consultivo della Convenzione quadro per la protezione delle minoranze nazionali esamina periodicamente la parità di accesso all'istruzione dei bambini rom in linea con detta disposizione.[90]

3.3. Divieto di discriminazione sulla base della nazionalità e dello status di immigrazione

Punti salienti

- La portata della protezione contro la discriminazione sulla base della nazionalità è più limitata nell'ambito del diritto dell'UE che in quello del Consiglio d'Europa.
- Nell'ambito del diritto dell'UE, la protezione contro la discriminazione sulla base della nazionalità è accordata solo ai cittadini degli Stati membri dell'UE, conformemente a quanto stabilito dall'articolo 45 (libertà di circolazione e di soggiorno) della Carta dei diritti fondamentali dell'Unione europea.
- La CEDU garantisce il godimento dei diritti a ogni persona sottoposta alla giurisdizione di uno Stato membro.

89 CEDS, Carta sociale europea (riveduta) – Conclusioni 2003 (Bulgaria), articolo 17, paragrafo 2, pag. 53.

90 Cfr. Consiglio d'Europa, comitato consultivo della Convenzione-quadro per la protezione delle minoranze nazionali, *Commentary on Education under the Framework Convention for the Protection of National Minorities* (2006) (Commento sull'istruzione ai sensi della Convenzione quadro per la protezione delle minoranze nazionali), ACFC/25DOC(2006)002.

Nell'ambito del diritto dell'UE, la protezione contro la discriminazione sulla base della nazionalità è particolarmente rilevante nel contesto della libera circolazione delle persone. I cittadini di paesi terzi (ovvero coloro che sono cittadini di uno Stato che non è membro dell'UE) godono del diritto alla parità di trattamento a grandi linee negli stessi ambiti previsti dalle direttive contro la discriminazione allorché ottengono lo status di "soggiornante di lungo periodo". La direttiva sui cittadini dei paesi terzi prevede, tra gli altri requisiti, che l'ottenimento di tale status sia subordinato a un periodo di soggiorno legale di cinque anni).[91] Inoltre, a talune condizioni, la direttiva 2003/86/CE relativa al diritto al ricongiungimento familiare (direttiva sul ricongiungimento familiare)[92] permette ai cittadini di paesi terzi che soggiornano legalmente in uno Stato membro di farsi raggiungere dai familiari (cfr. anche il paragrafo 9.5).

Esempio: la causa *Chen*[93] doveva stabilire se la figlia di una cittadina di un paese terzo avesse il diritto di soggiornare sul territorio di uno Stato membro dell'UE essendo nata in un altro Stato membro e avendone ottenuto la cittadinanza. La madre, dalla quale dipendeva, era una cittadina di un paese terzo. La CGUE ha ritenuto che, se uno Stato membro subordina l'ottenimento della cittadinanza al rispetto di determinate condizioni e queste sono soddisfatte, un altro Stato membro non può successivamente mettere in discussione tale diritto qualora la madre e la figlia presentino domanda di soggiorno. La CGUE ha confermato che uno Stato membro non può negare il diritto di soggiorno al genitore che ha la custodia di un figlio che è un cittadino dell'UE poiché tale rifiuto priverebbe di qualsiasi effetto utile il diritto di soggiorno di quest'ultimo.

Nell'ambito del diritto del Consiglio d'Europa, la CEDU garantisce il godimento dei diritti a tutti coloro che sono sottoposti alla giurisdizione di uno Stato membro, indipendentemente dal fatto che ne siano o meno cittadini, anche alle persone che vivono al di fuori del territorio nazionale, nelle zone soggette al controllo effettivo dello Stato. Per quanto riguarda l'istruzione, la Corte EDU ritiene pertanto che la disparità di trattamento fondata sulla nazionalità e sullo status di immigrazione potrebbe costituire una discriminazione.

91 Direttiva 2003/109/CE del Consiglio, del 25 novembre 2003, relativa allo status dei cittadini di paesi terzi che siano soggiornanti di lungo periodo (GU L 16 del 23.1.2004, pag. 44).

92 Direttiva 2003/86/CE del Consiglio, del 22 settembre 2003, relativa al diritto al ricongiungimento familiare (GU L 251 del 3 ottobre 2003, pag. 12).

93 CGUE, sentenza 19 ottobre 2004, causa C-200/02, *Kunqian Catherine Zhu e Man Lavette Chen c. Secretary of State for the Home Department*.

Esempio: il caso *Ponomaryovi c. Bulgaria*[94] riguarda la questione di cittadini stranieri privi di permessi di soggiorno permanenti costretti a pagare tasse per l'iscrizione alla scuola secondaria. In linea di principio, era necessario circostanziare l'ampio margine di apprezzamento di cui godono di norma gli Stati quando adottano misure generali in materia economica o sociale per due ragioni:

- il diritto all'istruzione è espressamente sancito dalla CEDU;
- l'istruzione è un tipo di servizio pubblico molto particolare, che svolge funzioni sociali di vasta portata.

A parere della Corte EDU, il margine di apprezzamento aumenta con il livello di istruzione in maniera inversamente proporzionale rispetto all'importanza di detta istruzione per gli interessati e per la società in generale. Pertanto, se l'obbligo per i cittadini stranieri di versare tasse (più elevate) per l'istruzione primaria è difficile da giustificare, a livello universitario tale requisito potrebbe essere pienamente giustificato. Considerata l'importanza dell'istruzione secondaria per lo sviluppo personale e l'integrazione sociale e professionale, è opportuno esaminare con maggiore attenzione la proporzionalità della disparità di trattamento per quel livello d'istruzione. La Corte ha precisato di non avere stabilito se uno Stato è autorizzato o meno a privare tutti i migranti irregolari dei benefici in termini di istruzione che fornisce ai suoi cittadini e a talune categorie limitate di stranieri. Nel valutare le circostanze del caso di specie, la Corte ha rilevato che non trovava applicazione alcuna considerazione riguardo alla necessità di arrestare o invertire il flusso dell'immigrazione illegale. I ricorrenti non avevano cercato di abusare del sistema d'istruzione bulgaro: erano arrivati nel paese in giovane età, in seguito al matrimonio della loro madre con un cittadino bulgaro, e pertanto non avevano avuto altra scelta che frequentare la scuola in Bulgaria. Era stato pertanto violato l'articolo 14 della CEDU in combinato disposto con l'articolo 2 del Protocollo n. 1 della CEDU.

94 Corte EDU, sentenza 21 giugno 2011, *Ponomaryovi c. Bulgaria* (n. 5335/05), punto 60.

3.4. Divieto di discriminazione sulla base dell'età

Punto saliente

- La discriminazione in base all'età è vietata sia dal diritto dell'UE sia della CEDU.

Nell'ambito del diritto dell'UE, l'articolo 21 della Carta dei diritti fondamentali dell'UE cita espressamente "l'età" tra i motivi di discriminazione vietati. L'articolo 24 annovera i diritti del minore tra i diritti fondamentali tutelati. Nell'ambito della vigente legislazione dell'UE in materia di non discriminazione, la protezione contro la discriminazione fondata sull'età è più limitata rispetto alla protezione fondata sulla razza e sull'origine etnica o sul sesso. Attualmente l'età è tutelata solo nel contesto dell'accesso all'occupazione, analogamente all'orientamento sessuale, alla disabilità e alla religione o alle convinzioni personali.

La direttiva sulla parità di trattamento in materia di occupazione è applicabile ai minori che sono legalmente autorizzati a lavorare. Sebbene la Convenzione dell'Organizzazione internazionale del lavoro sull'età minima di ammissione al lavoro,[95] ratificata da tutti gli Stati membri dell'UE, fissi un'età minima di 15 anni, tra gli Stati membri dell'UE permangono differenze riguardo alla suddetta età minima.[96] Ai sensi dell'articolo 6 della direttiva sulla parità di trattamento in materia di occupazione, gli Stati membri possono giustificare le disparità di trattamento collegate all'età. Tali disparità non costituiscono discriminazione laddove siano oggettivamente e ragionevolmente giustificate da una finalità legittima e i mezzi per il conseguimento di tale finalità siano appropriati e necessari. Per quanto riguarda i bambini e i giovani, tali disparità di trattamento possono comprendere, ad esempio, la definizione di condizioni speciali di accesso all'occupazione e alla formazione professionale, di occupazione e di lavoro, onde favorire l'inserimento professionale o assicurare la protezione degli stessi.

95 Rete europea di esperti giuridici in materia di non discriminazione, O'Dempsey, D. e Beale, A. (2011), *Age and employment*, Commissione europea, Direzione generale della Giustizia. Lussemburgo, Ufficio delle pubblicazioni.

96 Organizzazione internazionale del lavoro (1973), Convenzione n. 138 sull'età minima di ammissione al lavoro.

Nell'ambito del diritto del Consiglio d'Europa, l'articolo 14 della CEDU e l'articolo 1 del Protocollo n. 12 della CEDU non menzionano espressamente "l'età" nell'elenco di motivi di discriminazione vietati. La Corte EDU ha tuttavia esaminato casi di discriminazione fondata sull'età in relazione a vari diritti tutelati della CEDU e, di conseguenza, ha implicitamente analizzato l'età fra i motivi rientranti in "ogni altra condizione". Nei casi *D.G. c. Irlanda*[97] e *Bouamar c. Belgio,*[98] ad esempio, la Corte EDU ha riscontrato una disparità di trattamento tra adulti e minori in materia di detenzione nei rispettivi sistemi giudiziari nazionali, pertinente ai fini dell'applicazione della Convenzione. Tale disparità di trattamento è scaturita dalla scopo della detenzione, punitivo per gli adulti e preventivo per i minori. La Corte ha pertanto riconosciuto "l'età" tra i possibili motivi di discriminazione.

3.5. Divieto di discriminazione sulla base di altri motivi oggetto di protezione

Punto saliente

- Altri motivi di discriminazione, quali la disabilità o la nascita, sono stati trattati nella giurisprudenza europea riguardante i minori.

Nell'ambito del diritto dell'UE, l'articolo 21 della Carta dei diritti fondamentali dell'UE vieta anche la discriminazione fondata su altri motivi particolarmente rilevanti per i minori, quali il sesso, le caratteristiche genetiche, la lingua, la disabilità o l'orientamento sessuale. Almeno per quanto riguarda la disabilità, la CGUE ha ammesso che l'UE tutela anche dalla cosiddetta "discriminazione per associazione", ossia la discriminazione nei confronti di una persona che è associata a un'altra avente le caratteristiche protette (ad esempio la madre di un minore disabile).

97 Corte EDU, sentenza 29 febbraio 1988, *Bouamar c. Belgio* (n. 9106/80) (cfr. anche il paragrafo 11.2.2).

98 Corte EDU, sentenza 16 maggio 2002, *D.G. c. Irlanda* (n. 39474/98) (cfr. anche il paragrafo 11.2.2).

Esempio: nella causa *S. Coleman c. Attridge Law e Steve Law,*[99] la CGUE ha osservato che la direttiva sulla parità di trattamento in materia di occupazione contiene talune disposizioni volte a tener conto specificamente delle esigenze dei disabili. Tuttavia, tale constatazione non permette di concludere che il principio della parità di trattamento in essa sancito debba essere interpretato in senso restrittivo, vale a dire nel senso che esso vieterebbe soltanto le discriminazioni dirette fondate sulla disabilità e riguarderebbe esclusivamente le persone che siano esse stesse disabili. Secondo la CGUE, la direttiva non si applica a una determinata categoria di persone, ma alla natura stessa della discriminazione. Un'interpretazione che ne limiti l'applicazione alle persone disabili rischierebbe di privare tale direttiva di una parte importante del suo effetto utile e di ridurre la tutela che essa dovrebbe garantire. La CGUE ha concluso che la direttiva deve essere interpretata nel senso che il divieto di discriminazione diretta ivi previsto non è limitato alle persone disabili. Di conseguenza, qualora un datore di lavoro tratti un lavoratore che non sia esso stesso disabile in modo meno favorevole rispetto al modo in cui è trattato un altro lavoratore in una situazione analoga, a causa della disabilità del figlio, al quale presta la parte essenziale delle cure di cui quest'ultimo ha bisogno, un siffatto trattamento viola il divieto di discriminazione diretta enunciato dalla direttiva.

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU si è occupata della discriminazione nei confronti dei minori in una serie di situazioni diverse da quelle già indicate, quali la discriminazione fondata sulla lingua[100] o sulla filiazione.[101]

Esempio: nel caso *Fabris c. Francia,*[102] il ricorrente aveva presentato ricorso sostenendo di non aver potuto beneficiare di una legge introdotta nel 2001 che riconosceva a favore dei figli "adulterini" i medesimi diritti successori dei figli legittimi, una legge approvata dopo la sentenza pronunciata dalla Corte EDU nella causa *Mazurek c. Francia* [103] nel 2000. La Corte ha ritenuto che lo scopo legittimo della tutela dei diritti ereditari del fratello e della sorella unilaterali del ricorrente non fosse tale da prevalere sul diritto del ricorrente di

99 CGUE, sentenza 17 luglio 2008, causa C-303/06, *S. Coleman c. Attridge Law e Steve Law* [GS].

100 Corte EDU, sentenza 7 febbraio 2013, *Fabris c. Francia* [GC] (n. 16574/08).

101 Corte EDU, sentenza 23 luglio 1968, *Caso "Relating to certain aspects of the laws on the use of languages in education in Belgium" c. Belgio* (nn. 1474/62, 1677/62, 1691/62, 1769/63, 1994/63 e 2126/64).

102 Corte EDU, sentenza 1° febbraio 2000, *Mazurek c. Francia* (n. 34406/97).

103 *Ibid.*

ottenere una parte della successione materna. Nel caso di specie, la disparità di trattamento è stata discriminatoria in quanto priva di una giustificazione oggettiva e ragionevole. La Corte EDU ha riscontrato una violazione dell'articolo 14 della CEDU in combinato disposto con l'articolo 1 del Protocollo n. 1 della CEDU.[104]

Per quanto riguarda i minori disabili, il comitato europeo dei diritti sociali ritiene che l'applicazione dell'articolo 17, paragrafo 2, della CSE sia accettabile per operare una distinzione tra minori disabili e non disabili. Dovrebbe tuttavia essere la norma a integrare i minori disabili nelle scuole ordinarie, che dovrebbero adottare disposizioni volte a permettere di provvedere alle loro esigenze speciali, mentre le scuole specializzate dovrebbero costituire l'eccezione.[105] Inoltre, occorre impartire un'istruzione e una formazione sufficienti ai minori che frequentano istituti scolastici speciali conformi all'articolo 17, paragrafo 2, della CSE affinché, in proporzione, nelle scuole specializzate completi la propria istruzione un numero di alunni equivalente a quello degli studenti che frequentano scuole ordinarie.[106] Ulteriori approfondimenti sui diritti dei minori in relazione all'istruzione sono contenuti al paragrafo 8.2.

Nell'ambito del diritto delle Nazioni Unite, l'articolo 2 della CRC vieta la discriminazione nei confronti dei minori sulla base di un elenco non esaustivo di motivi, citando espressamente fra questi la "nascita". L'articolo 2 sancisce che:

> *1. Gli Stati parti s'impegnano a rispettare i diritti enunciati nella presente Convenzione e a garantirli a ogni fanciullo che dipende dalla loro giurisdizione, senza distinzione di sorta e a prescindere da ogni considerazione di razza, di colore, di sesso, di lingua, di religione, di opinione politica o altra del fanciullo o dei suoi genitori o rappresentanti legali, dalla loro origine nazionale, etnica o sociale, dalla loro situazione finanziaria, dalla loro incapacità, dalla loro nascita o da ogni altra circostanza.*
>
> *2. Gli Stati parti adottano tutti i provvedimenti appropriati affinché il fanciullo sia effettivamente tutelato contro ogni forma di discriminazione o di sanzione motivate dalla condizione sociale, dalle attività, opinioni professate o convinzioni dei suoi genitori, dei suoi rappresentanti legali o dei suoi familiari.*

104 Corte EDU, sentenza 7 febbraio 2013, *Fabris c. Francia* [GC] (n. 16574/08).

105 CEDS, sentenza 4 novembre 2003, *International Association Autism Europe (IAAE) c. Francia*, (ricorso n. 13/2002).

106 CEDS, sentenza 3 giugno 2008, *Mental Disability Advocacy Center (MDAC) c. Bulgaria* (ricorso n. 41/2007).

4 Questioni riguardanti l'identità personale

UE	Argomenti trattati	Consiglio d'Europa
	Registrazione della nascita e diritto al nome	Corte EDU, *Johansson c. Finlandia,* n. 10163/02, 2007 (rifiuto di registrare un nome che altre persone avevano precedentemente avuto il permesso di utilizzare) Convenzione quadro per la protezione delle minoranze nazionali, articolo 11 (diritto di utilizzare il proprio cognome nella lingua originale) Convenzione europea sull'adozione dei minori (riveduta), articolo 11, paragrafo 3 (mantenimento del nome originale di un minore adottato)
	Diritto all'identità personale	CEDU, articoli 6 (equo processo) e 8 (diritto al rispetto della vita privata e familiare) Corte EDU, *Gaskin c. Regno Unito,* n. 10454/83, 1898 (rifiuto di accedere ai fascicoli redatti durante l'infanzia) Corte EDU, *Mizzi c. Malta,* n. 26111/02, 2006, (impossibilità di disconoscere la paternità) Corte EDU, *Mennesson c. Francia,* n. 65192/11, 2004 (maternità surrogata in cui il padre biologico è il padre committente) Corte EDU, *Godelli c. Italia,* n. 33783/09, 2012 (elementi non identificativi sulla madre biologica) Convenzione europea sull'adozione dei minori (riveduta), articolo 22

UE	Argomenti trattati	Consiglio d'Europa
	Furto d'identità	Corte EDU, *K.U. c. Finlandia*, n. 2872/02, 2008 (pubblicazione di un annuncio su Internet all'insaputa della vittima)
CGUE, C-200/02, *Kunqian Catherine Zhu e Man Lavette Chen c. Secretary of State for the Home Department*, 2004 (diritto di soggiorno del principale responsabile dell'assistenza di un minore, cittadino dell'UE) CGUE, C-34/09, *Gerardo Ruiz Zambrano c. Office National de l'Emploi (ONEm)*, 2011 (diritti di soggiorno di cittadini di paesi terzi con figli minorenni cittadini dell'UE)	Cittadinanza	Corte EDU, *Genovese c. Malta*, n. 53124/09, 2011 (rifiuto arbitrario della cittadinanza a figli nati fuori dal matrimonio) Convenzione europea sulla nazionalità Convenzione del Consiglio d'Europa sulla prevenzione della condizione di apolide in relazione alla successione di Stati
	Identità come membri di una minoranza nazionale	Convenzione-quadro per la protezione delle minoranze nazionali, articolo 5, paragrafo 1 (mantenimento degli elementi essenziali dell'identità)

In generale i problemi legati all'identità personale non sono stati affrontati a livello dell'UE alla luce della competenza limitata dell'Unione in quest'ambito. La CGUE si è tuttavia incidentalmente pronunciata sul diritto al nome (in particolare sul diritto a vedere riconosciuto anche in altri paesi il nome che è stato riconosciuto in uno Stato membro dell'UE) dalla prospettiva del principio della libertà di circolazione. La CGUE si è pronunciata in materia di cittadinanza e soggiorno anche alla luce dell'articolo 20 del TFUE. Il Consiglio d'Europa, dal canto suo, ha interpretato e sviluppato l'applicazione di alcuni diritti fondamentali nell'ambito dell'identità personale, in particolare attraverso la giurisprudenza della Corte EDU. Pertanto, ad eccezione di alcuni ambiti in cui i problemi legati all'identità personale sono stati affrontati a livello dell'UE, i paragrafi riportati di seguito riguardano esclusivamente il diritto del Consiglio d'Europa.

Il presente capitolo non fa riferimento a un diritto fondamentale specifico. Fornisce piuttosto uno spaccato delle questioni relative ai diritti fondamentali riguardanti l'identità, quali la registrazione della nascita e il diritto al nome (paragrafo 4.1), il diritto all'identità personale (paragrafo 4.2), il furto d'identità (paragrafo 4.4), il

diritto alla cittadinanza (paragrafo 4.5) e l'identità di minori appartenenti a minoranze nazionali (paragrafo 4.6). Alcune questioni correlate sono trattate in altri capitoli, in particolare quelle riguardanti l'abuso sessuale (capitolo 7.1.3) o la protezione dei dati (capitolo 10). Alcuni di questi diritti, come il diritto al nome, sono stati essenzialmente rivendicati come diritti genitoriali, ma l'approccio potrebbe essere facilmente trasposto ai minori stessi, considerate le implicazioni per i loro propri diritti.

4.1. Registrazione della nascita e diritto al nome

Punto saliente

- Il rifiuto di registrare un bambino con un nome che non è inadeguato e di cui è già stata autorizzata l'attribuzione potrebbe costituire una violazione dell'articolo 8 della CEDU (diritto al rispetto della vita privata e familiare).

Diversamente dai trattati ONU (ad esempio l'articolo 24, paragrafo 2, del Patto internazionale relativo ai diritti civili e politici (ICCPR), l'articolo 7, paragrafo 1, della CRC e l'articolo 18 della Convenzione sui diritti delle persone con disabilità (CRPD)), gli strumenti europei sui diritti fondamentali non sanciscono espressamente il diritto alla registrazione della nascita subito dopo la nascita o il diritto al nome sin dalla nascita.

Nell'ambito del diritto dell'UE, la questione del diritto al nome è stata affrontata dalla prospettiva della libertà di circolazione. La CGUE sostiene che la libertà di circolazione vieta a uno Stato membro dell'UE di rifiutare di riconoscere il cognome di un minore registrato in un altro Stato membro di cui il minore è cittadino o in cui il minore è nato e ha soggiornato.[107]

Nell'ambito del diritto del Consiglio d'Europa, il rifiuto di registrare la nascita di un minore può sollevare un problema ai sensi dell'articolo 8 della CEDU.

107 Cfr. CGUE, sentenza 2 ottobre 2003, causa C-148/02, *Carlos Garcia Avello c. Stato belga*; CGUE, sentenza 14 ottobre 2008, causa C-353/06, *Stefan Grunkin e Dorothee Regina Paul* [GC].

Innanzitutto, la Corte EDU ha ritenuto che il nome, quale strumento per identificare le persone all'interno delle loro famiglie e della comunità, rientri nell'ambito di applicazione del diritto al rispetto della vita privata e familiare sancito dall'articolo 8 della CEDU.[108] La scelta del nome[109] e del cognome del figlio[110] da parte dei genitori rientra nella sfera privata di questi ultimi. La Corte ha ritenuto che il rifiuto delle autorità statali di registrare un determinato nome sulla base del probabile danno o pregiudizio che tale nome potrebbe arrecare al minore non costituisse una violazione dell'articolo 8 della CEDU.[111] Tuttavia, il rifiuto di registrare un bambino con un nome che non è inadeguato e di cui è già stata autorizzata l'attribuzione potrebbe costituire una violazione dell'articolo 8 della CEDU.

Esempio: nel caso *Johansson c. Finlandia,*[112] le autorità finlandesi si erano rifiutate di registrare il nome "Axl Mick" poiché la grafia non rispettava la pratica nazionale in materia di nomi. La Corte EDU ha ammesso che era necessario tenere in debita considerazione l'interesse superiore del minore e che era nel pubblico interesse preservare la pratica nazionale in materia di nomi. Ha tuttavia riscontrato che il nome era stato ufficialmente registrato in altri casi e pertanto non poteva essere ritenuto inadeguato per un bambino. Poiché in Finlandia l'attribuzione del nome era già stata autorizzata e non si era asserito che tale nome avesse avuto conseguenze negative sulla preservazione dell'identità culturale e linguistica del paese, la Corte EDU ha concluso che le considerazioni sul pubblico interesse non prevalevano sull'interesse di registrare il bambino con il nome prescelto. La Corte ha concluso asserendo che vi era stata una violazione dell'articolo 8 della CEDU.

La Corte EDU ha altresì stabilito che la regola secondo la quale il cognome del marito è attribuito ai figli legittimi al momento dell'iscrizione dei neonati nei registri dello stato civile non costituisce di per sé una violazione della CEDU. Tuttavia, l'impossibilità di derogarvi è stata ritenuta eccessivamente rigida e discriminatoria

108 Corte EDU, sentenza 24 ottobre 1993, *Guillot c. Francia* (n. 22500/93), punto 21.

109 Corte EDU, sentenza 7 gennaio 2014, *Cusan e Fazzo c. Italia* (n. 77/07), punto 56.

110 Corte EDU, sentenza 6 settembre 2007, *Johansson c. Finlandia* (n. 10163/02), punto 28; Corte EDU, sentenza 24 ottobre 1993, *Guillot c. Francia* (n. 22500/93), punto 22.

111 Corte EDU, sentenza 24 ottobre 1993, *Guillot c. Francia* (n. 22500/93), punto 27.

112 Corte EDU, sentenza 6 settembre 2007, *Johansson c. Finlandia* (n. 10163/02).

nei confronti delle donne, e pertanto ha costituito una violazione dell'articolo 14 in combinato disposto con l'articolo 8 della CEDU.[113]

L'articolo 11 della Convenzione quadro per la protezione delle minoranze nazionali stabilisce che ogni persona appartenente a una minoranza nazionale ha il diritto di utilizzare il suo cognome (il suo patronimico) ed i suoi nomi nella lingua minoritaria oltre che il diritto al loro riconoscimento ufficiale, secondo le modalità previste dal sistema giuridico.

L'articolo 11, paragrafo 3, della Convenzione europea sull'adozione dei minori (riveduta) prevede la possibilità per gli Stati contraenti di mantenere il cognome originale del minore adottato (Convenzione sull'adozione).[114] Si tratta di un'eccezione al principio generale secondo cui il rapporto giuridico tra il minore adottato e la sua famiglia d'origine è cessato.

4.2. Diritto all'identità personale

Punti salienti

- Il diritto di conoscere le proprie origini rientra nella sfera della vita privata di un minore.
- Ai fini dell'accertamento della paternità occorre bilanciare attentamente l'interesse del minore a conoscere la propria identità, l'interesse del presunto padre e l'interesse generale.
- I parti anonimi possono essere ammissibili ai sensi dell'articolo 8 della CEDU (diritto al rispetto della vita privata e familiare) a patto che il minore possa almeno ottenere informazioni non identificative su sua madre e che esista la possibilità di chiedere la rinuncia al segreto da parte della madre.
- Un figlio adottivo ha il diritto di accedere a informazioni riguardanti le sue origini. Ai genitori biologici può essere accordato il diritto giuridico di non divulgare la loro identità, ma ciò non si configura come un veto assoluto.

Nell'ambito del diritto del Consiglio d'Europa, a parere della Corte EDU l'articolo 8 della CEDU include il diritto all'identità e allo sviluppo personale. I dettagli

113 Corte EDU, sentenza 7 gennaio 2014, *Cusan e Fazzo c. Italia* (n. 77/07), paragrafo 67.

114 Consiglio d'Europa, Convenzione europea sull'adozione dei minori (riveduta), STCE n. 202, 2008.

sull'identità di una persona e l'interesse a ottenere le informazioni necessarie a scoprire la verità su aspetti importanti della propria identità personale, compresa l'identità dei propri genitori,[115] sono stati ritenuti pertinenti ai fini dello sviluppo personale. La nascita, e in particolare le sue circostanze, attengono alla vita privata del minore. "[L]e informazioni riguardanti aspetti estremamente personali dell'infanzia, dello sviluppo e della storia di un individuo possono costituire una fonte principale di informazioni sul suo passato e sui suoi anni di formazioni"[116] e, di conseguenza, l'impossibilità di accedere a tali informazioni da parte del minore solleva un problema ai sensi dell'articolo 8 della CEDU.

Nell'ambito del diritto internazionale, l'articolo 8 della CRC garantisce un livello di protezione elevato e piuttosto dettagliato del diritto a preservare l'identità del minore. Tutela la preservazione dell'identità del minore da ingerenze illegali, ivi compresa la sua nazionalità, il suo nome e le sue relazioni familiari, così come riconosciute dalla legge. Garantisce inoltre "un'adeguata assistenza e protezione" se il minore è illegalmente privato degli elementi costitutivi della sua identità o di alcuni di essi affinché tale identità sia ristabilita il più rapidamente possibile.

4.2.1. Accertamento della paternità

Nell'ambito del diritto del Consiglio d'Europa, i minori hanno presentato ricorso alla Corte EDU in merito all'impossibilità di accertare l'identità dei loro padri naturali. A parere della Corte EDU, l'accertamento del rapporto giuridico tra un minore e il presunto padre naturale rientrava nella sfera della vita privata (articolo 8 della CEDU). La filiazione è un aspetto fondamentale dell'identità di una persona.[117] L'interesse di un minore ad accertare la paternità deve tuttavia essere bilanciato con gli interessi del presunto padre e con l'interesse generale. Di fatto, l'interesse del minore ad avere certezza giuridica sulla propria filiazione paterna non prevarica l'interesse del padre a respingere la presunzione legale di paternità.

Esempio: nel caso *Mikulić c. Croazia,*[118] la ricorrente era nata da una relazione non matrimoniale e aveva avviato un'azione giudiziaria nei confronti del presunto padre ai fini dell'accertamento della paternità. La parte avversa si era rifiutata in più occasioni di sottoporsi al test del DNA disposto

115 Corte EDU, sentenza 13 febbraio 2003, *Odièvre c. Francia* [GC] (n. 42326/98), punto 29.

116 Corte EDU, sentenza 7 luglio 1989, *Gaskin c. Regno Unito* (n. 10454/83), punto 36.

117 Corte EDU, sentenza 26 giugno 2014, *Mennesson c. Francia* (n. 65192/11), punto 96.

118 Corte EDU, sentenza 7 febbraio 2002, *Mikulić c. Croazia* (n. 53176/99), punto 64–65.

dal giudice e, di conseguenza, l'azione giudiziale per l'accertamento della paternità si era inutilmente protratta per circa cinque anni. La Corte EDU ha stabilito che, se l'ordinamento nazionale non obbliga i presunti padri a sottoporsi a test medici, gli Stati devono prevedere strumenti alternativi che consentano la rapida individuazione dei padri naturali da parte di un'autorità indipendente. Nel caso della ricorrente ha riscontrato una violazione dell'articolo 8 della CEDU.

Esempio: nel caso *Mizzi c. Malta,*[119] il presunto padre non aveva potuto disconoscere la paternità di una bambina partorita dalla moglie poiché il termine di sei mesi stabilito dalla legge per la contestazione della paternità era scaduto. La Corte EDU ha esaminato il caso ai sensi sia dell'articolo 6 (diritto a un equo processo) che dell'articolo 8 (rispetto della vita privata e familiare) della CEDU. Ha osservato che l'introduzione di un limite temporale entro cui un presunto padre deve procedere all'accertamento della paternità per disconoscere un figlio è finalizzata a garantire la certezza del diritto e a tutelare l'interesse del minore a conoscere la sua identità. Ciononostante, tali finalità non prevalgono sul diritto del padre di avere l'opportunità di disconoscere la paternità. In questo caso, l'impossibilità pratica di disconoscere la paternità sin dalla nascita aveva rappresentato un onere eccessivo a carico del presunto padre, in violazione del suo diritto di accesso a un tribunale e a un equo processo sanciti dall'articolo 6 della CEDU. Aveva inoltre costituito un'ingerenza sproporzionata nei suoi diritti ai sensi dell' articolo 8 della CEDU.[120]

Gli interessi di un minore che vuole accertare la paternità e gli interessi del padre biologico possono talvolta coincidere, com'è avvenuto nel caso di un padre che, a causa della sua mancanza di capacità giuridica, non poteva avviare un'azione giudiziaria a livello nazionale per costituire un rapporto di filiazione con il figlio. La Corte EDU ha stabilito che non era nell'interesse superiore di un minore nato fuori dal matrimonio che il suo padre biologico non fosse in grado di avviare un'azione giudiziaria per vedere riconosciuta la sua paternità e che il minore dipendesse dunque completamente dalla discrezionalità delle autorità statali per l'accertamento della sua filiazione.[121]

119 Corte EDU, sentenza 12 gennaio 2006, *Mizzi c. Malta* (n. 26111/02).

120 *Ibid.*, punti 112–114.

121 Corte EDU, sentenza 21 giugno 2011, *Krušković c. Croazia* (n. 46185/08), punti 38–41.

Le autorità possono avere l'obbligo positivo di intervenire nel procedimento per l'accertamento della paternità nell'interesse superiore del minore qualora il rappresentante giuridico (in questo caso la madre) del minore non sia in grado di rappresentare adeguatamente il minore, per esempio a causa di una grave disabilità.[122]

Per quanto riguarda il caso specifico del riconoscimento della filiazione tra genitori committenti e figli nati da maternità surrogata, la Corte ha ammesso in linea di principio che gli Stati hanno un ampio margine di apprezzamento poiché a livello europeo non esiste un consenso in materia di autorizzazione o riconoscimento della filiazione negli accordi di maternità surrogata. Tuttavia, il fatto che la filiazione sia un aspetto fondamentale dell'identità di un minore riduce il margine di apprezzamento.

Esempio: il caso *Mennesson c. Francia*[123] riguarda il rifiuto delle autorità francesi di iscrivere nel registro francese delle nascite i figli nati da maternità surrogata negli Stati Uniti per motivi di ordine pubblico. La Corte EDU non ha riscontrato violazioni del diritto dei ricorrenti al rispetto della vita familiare, concludendo che non era stato in alcun modo loro impedito di godere della vita familiare in Francia e che gli ostacoli amministrativi che avrebbero potuto incontrare non erano stati insormontabili. Quanto al diritto al rispetto della vita privata dei minori, la Corte ha attribuito grande importanza al loro interesse superiore. In particolare ha sottolineato che l'uomo che avrebbe dovuto essere registrato come il padre dei bambini sul certificato era anche il loro padre biologico. Negare il rapporto giuridico di filiazione con il figlio quando è stata accertata la filiazione biologica e quando il genitore interessato rivendica il pieno riconoscimento non può essere ritenuto un atto conforme all'interesse superiore dei minori. La Corte ha pertanto riscontrato una violazione dell'articolo 8 della CEDU in merito al reclamo riguardante il rispetto della "vita privata" dei minori.[124]

122 Corte EDU, sentenza 14 febbraio 2012, *A.M.M. c. Romania* (n. 2151/10), punti 58–65 (consultabile in francese).

123 Corte EDU, 26 giugno 2014, *Mennesson c. Francia* (n. 65192/11).

124 *Ibid.*, punto 100; cfr. anche Corte EDU, sentenza 26 giugno 2014, *Labassee c. Francia* (n. 65941/11), punto 79.

4.2.2. Accertamento della maternità: parto anonimo

Nell'ambito del diritto del Consiglio d'Europa, l'interesse del minore a conoscere le sue origini, e in particolare sua madre, deve essere bilanciato con altri interessi privati e pubblici, quali gli interessi della famiglia o delle famiglie interessate, l'interesse pubblico di evitare aborti clandestini, l'abbandono di minori o la protezione della salute. I casi in cui la madre biologica decide di rimanere anonima, ma il minore può quantomeno ottenere informazioni non identificative sulla madre biologica e ha la possibilità di chiedere la rinuncia al segreto da parte della madre, potrebbero essere conformi all'articolo 8 della CEDU.[125]

> Esempio: nel caso *Godelli c. Italia,*[126] la ricorrente era stata abbandonata alla nascita dalla madre, che non aveva consentito di essere nominata sul certificato di nascita. La ricorrente non poteva accedere a elementi non identificativi riguardanti le sue origini né ottenere la divulgazione dell'identità di sua madre. La Corte EDU ha riscontrato una violazione dell'articolo 8 della CEDU poiché lo Stato non aveva garantito un giusto equilibrio tra gli interessi concorrenti della madre biologica e della figlia.

4.3. Accertamento delle proprie origini: adozione

Al diritto del minore a conoscere le proprie origini è stata attribuita una particolare rilevanza nel contesto dell'adozione. Le garanzie sostanziali connesse all'adozione, al di là del diritto di conoscere le proprie origini, sono trattate al paragrafo 6.3.

Nell'ambito del diritto del Consiglio d'Europa, l'articolo 22, paragrafo 3, della Convenzione europea sull'adozione dei minori (riveduta) è una disposizione piuttosto solida sul diritto del minore adottato di accedere alle informazioni sulle proprie origini in possesso delle autorità. Permette agli Stati contraenti di accordare ai genitori d'origine il diritto giuridico di non divulgare la loro identità purché ciò non equivalga a un veto assoluto. L'autorità competente deve essere in grado di stabilire se tale diritto prevale sul diritto dei genitori d'origine e se sia quindipossibile divulgare informazioni identificative alla luce delle circostanze

125 Corte EDU, sentenza 13 febbraio 2003, *Odièvre c. Francia* [GC], n. 42326/98, paragrafi 48–49.

126 Corte EDU, sentenza 25 settembre 2012, *Godelli c. Italia* (n. 33783/09), paragrafo 58.

e dei rispettivi diritti in gioco. In caso di adozione piena, il minore adottato deve poter almeno ottenere un documento attestante la data e il luogo di nascita.[127]

Nell'ambito del diritto internazionale, la Convenzione dell'Aia sull'adozione internazionale prevede la possibilità per il minore adottato di accedere alle informazioni relative all'identità dei suoi genitori con l'assistenza appropriata, ma conferisce a ogni Stato contraente la facoltà di autorizzare o meno tale accesso.[128]

4.4. Furto d'identità

Punto saliente

- I minori devono essere protetti dal furto d'identità in maniera concreta ed effettiva.

Il furto d'identità riguarda situazioni in cui il nome di un minore è utilizzato a sua insaputa.

Per quanto riguarda il diritto del Consiglio d'Europa, la Corte EDU ha esaminato il furto d'identità ai sensi dell'articolo 8 della CEDU sul rispetto della vita privata e familiare. Ha stabilito che gli Stati sono tenuti a garantire la protezione concreta ed effettiva dei minori dal furto d'identità; gli Stati devono adottare misure efficaci per identificare e perseguire l'autore del reato.[129]

Esempio: nel caso *K.U. c. Finlandia*[130] era stato pubblicato un annuncio su un sito di incontri su Internet a nome di un ragazzino di 12 anni, a sua insaputa. L'annuncio indicava l'età, il numero di telefono e la descrizione fisica del ragazzino e, inoltre, conteneva un link a una pagina web in cui figurava una sua fotografia. L'annuncio, a sfondo sessuale, lasciava intendere che il ragazzino fosse alla ricerca di una relazione intima con un coetaneo o con

127 Consiglio d'Europa, Convenzione europea sull'adozione dei minori (riveduta), STCE n. 202, 2008, articolo 22.

128 Conferenza dell'Aia sul diritto internazionale privato, Convenzione sulla protezione dei minori e sulla cooperazione in materia di adozione internazionale, 29 maggio 1993, articolo 30, paragrafo 2.

129 Corte EDU, sentenza 2 dicembre 2008, *K.U. c. Finlandia* (n. 2872/02), punto 49.

130 Corte EDU, sentenza 2 dicembre 2008, *K.U. c. Finlandia* (n. 2872/02).

un adulto, esponendolo in tal modo all'attenzione dei pedofili. L'identità della persona che aveva pubblicato l'annuncio non poteva essere rivelata dal fornitore di servizi a causa degli obblighi imposti dalla legislazione in vigore. A parere della Corte EDU, l'obbligo positivo di cui all'articolo 8 della CEDU, che prevede non solo la criminalizzazione dei reati, ma anche lo svolgimento di efficaci attività di indagine e perseguimento, assume un'importanza ancora maggiore quando a essere minacciato è il benessere fisico e morale di un minore. Nel caso di specie, la Corte ha ritenuto che, esponendolo ad approcci da parte di pedofili su Internet, l'annuncio costituiva una minaccia per il benessere fisico e morale del minore. Era dunque stato violato l'articolo 8 della CEDU.

Gli aspetti connessi al furto d'identità sono strettamente correlati alla pornografia infantile e all'adescamento di minori in rete, questioni affrontate al paragrafo 7.2.3.

4.5. Diritto alla cittadinanza

Punti salienti

- Il diritto di soggiorno nell'Unione di minori che sono cittadini dell'UE non deve essere privato di alcun effetto utile negando diritti di soggiorno al loro genitore o ai loro genitori.
- La CEDU non garantisce il diritto alla cittadinanza, ma un rifiuto arbitrario della cittadinanza potrebbe rientrare nel campo di applicazione dell'articolo 8 della CEDU (diritto al rispetto della vita privata e familiare) a causa del suo impatto sulla vita privata di una persona.

Nell'ambito del diritto dell'UE, l'articolo 20, paragrafo 1, del TFUE conferisce lo status di cittadino dell'UE a chiunque abbia la cittadinanza di uno Stato membro dell'Unione. La CGUE si è pronunciata sull'efficacia del diritto di soggiorno di minori che hanno la cittadinanza dell'UE, ma non la nazionalità dello Stato membro dell'UE in cui soggiornano. La controversia verteva sul rifiuto di riconoscere i diritti di soggiorno nell'Unione a un genitore che aveva la custodia di un figlio che era cittadino dell'UE. La CGUE ha stabilito che il rifiuto di riconoscere i diritti di soggiorno a un genitore che ha effettivamente la custodia di un minore priva di qualsiasi effetto utile il diritto di soggiorno di quest'ultimo. Di conseguenza, il genitore che ha effettivamente la custodia di un minore ha il diritto di soggiornare

con quest'ultimo nello Stato membro ospitante.[131] Questi aspetti sono trattati più dettagliatamente al paragrafo 9.5.

Nell'ambito del diritto del Consiglio d'Europa, la CEDU non garantisce il diritto alla cittadinanza.[132] Tuttavia, un rifiuto arbitrario della cittadinanza potrebbe essere contemplato dall'articolo 8 della CEDU a causa del suo impatto sulla vita privata di una persona, in cui rientrano aspetti dell'identità sociale di un minore,[133] nella fattispecie l'identità di un minore nella società.

> Esempio: nel caso *Genovese c. Malta*, era stata negata la cittadinanza maltese a un minore nato al di fuori del matrimonio in un paese diverso da Malta da madre non maltese e padre maltese legalmente riconosciuto. Il rifiuto della cittadinanza non configurava di per sé una violazione dell'articolo 8 della CEDU. Il diniego arbitrario della cittadinanza motivato dalla nascita al di fuori del matrimonio, tuttavia, sollevava questioni di discriminazione. Una disparità di trattamento arbitraria fondata su questo motivo deve essere giustificata da ragioni molto serie. In assenza di tali ragioni era stata riscontrata una violazione dell'articolo 8 in combinato disposto con l'articolo 14 della CEDU.[134]

Le disposizioni dei trattati sul diritto di acquisizione della cittadinanza accordano un'importanza fondamentale alla prevenzione della condizione di apolide. La Convenzione europea sulla nazionalità contiene disposizioni dettagliate sull'acquisizione giuridica della nazionalità da parte dei minori e limita le possibilità per i minori di perdere la cittadinanza.[135] La Convenzione del Consiglio d'Europa sulla prevenzione della condizione di apolide in relazione alla successione di Stati contiene l'obbligo di evitare l'apolidia alla nascita (articolo 10) e sancisce il diritto di acquisire la nazionalità dello Stato successore in caso di apolidia (articolo 2).[136] Anche l'articolo 12 della Convenzione europea sull'adozione dei minori (riveduta) ribadisce l'importanza di evitare l'apolidia; gli Stati devono agevolare

131 CGUE, sentenza 19 ottobre 2004, causa C-200/02, *Kunqian Catherine Zhu e Man Lavette Chen c. Secretary of State for the Home Department*, punti 45-46.

132 Corte EDU, sentenza 23 gennaio 2002, *Slivenko e altri c. Lettonia* [GC], decisione sull'ammissibilità, (n. 48321/99), punto 77.

133 Corte EDU, sentenza 11 ottobre 2011, *Genovese c. Malta* (n. 53124/09), punto 33.

134 *Ibid.*, paragrafi 43–49.

135 Consiglio d'Europa, Convenzione europea sulla nazionalità, STE n. 166, 1997, articoli 6 e 7.

136 Consiglio d'Europa, Convenzione sulla prevenzione della condizione di apolide in relazione alla successione di Stati, STCE n. 200, 2006.

l'acquisizione della loro nazionalità da parte di un minore adottato da uno dei loro cittadini e la perdita della nazionalità a seguito dell'adozione è subordinata al possesso o all'acquisizione di un'altra nazionalità.

Nell'ambito del diritto internazionale, sia l'articolo 7 della CRC che l'articolo 24, paragrafo 3, dell'ICCPR garantiscono il diritto ad acquisire una nazionalità.

4.6. Identità di minori appartenenti a minoranze nazionali

Punto saliente

- Un minore appartenente a una minoranza nazionale ha il diritto di avere una vita culturale propria, di professare e praticare la propria religione e di usare la propria lingua.[137]

Il diritto dell'UE non dedica una particolare attenzione all'identità dei minori che appartengono a minoranze nazionali dal punto di vista dei diritti fondamentali. Inoltre, nell'UE non esiste una giurisprudenza fondamentale che rafforzi le norme del Consiglio d'Europa.

Nell'ambito del diritto del Consiglio d'Europa, l'articolo 5, paragrafo 1, della Convenzione quadro per la protezione delle minoranze nazionali afferma espressamente che gli Stati contraenti s'impegnano a preservare gli elementi essenziali dell'identità delle persone appartenenti a minoranze nazionali, cioè la loro religione, la loro lingua, le loro tradizioni ed il loro patrimonio culturale. La Convenzione quadro per la protezione delle minoranze nazionali non contiene disposizioni specifiche riguardanti i minori. La questione della lingua nell'istruzione è trattata al paragrafo 8.2.

Nell'ambito del diritto internazionale, l'articolo 30 della CRC garantisce a un fanciullo autoctono o che appartiene a una minoranza nazionale il diritto "di avere una propria vita culturale, di professare e di praticare la propria religione o di far uso della propria lingua" insieme agli altri membri del suo gruppo.

137 Per quanto riguarda altri aspetti dei diritti economici, sociali e culturali, cfr. di seguito il capitolo 8.

5 Vita familiare

UE	Argomenti trattati	CdE
Carta dei diritti fondamentali, articolo 7 (diritto al rispetto della vita familiare)	**Diritto al rispetto della vita familiare**	CEDU, articolo 8 (diritto al rispetto della vita familiare)
Carta dei diritti fondamentali, articolo 24 (diritti del bambino) Regolamento in materia di obbligazioni alimentari (4/2009)	**Diritto di essere allevato dai genitori**	Corte EDU, *R.M.S. c. Spagna,* n. 28775/12, 2013 (privazione dei contatti con la figlia)
Carta dei diritti fondamentali, articolo 24, paragrafo 3 (diritto di intrattenere contatti con i due genitori) Regolamento Bruxelles II bis (2201/2003) Direttiva sulla mediazione (2008/52/CE)	**Diritto di intrattenere contatti con entrambi i genitori**	Convenzione sulle relazioni personali riguardanti i minori

UE	Argomenti trattati	CdE
Direttiva sull'accesso alla giustizia (2002/8/CE) (accesso alla giustizia nelle controversie transfrontaliere)	**Separazione dei genitori**	Corte EDU, *Levin c. Svezia*, n. 35141/06, 2012 (limitazione dei diritti di contatto) Corte EDU, *Schneider c. Germania,* n. 17080/07, 2011 (contatti tra un minore e il padre non legalmente riconosciuto) Corte EDU, *Sommerfeld c. Germania* [GC], n. 31871/96, 2003 (contatti tra padre e figlia) Corte EDU, *Mustafa e Armağan Akin c. Turchia,* n. 4694/03, 2010 (contatti tra fratelli dopo l'attribuzione dell'affidamento) Corte EDU, *Vojnity c. Ungheria,* n. 29617/07, 2013 (limitazione dell'accesso sulla base delle convinzioni religiose)
Carta dei diritti fondamentali, articolo 24 (diritti del bambino) Regolamento Bruxelles II bis (2201/2003) CGUE, C-211/10 PPU, *Doris Povse c. Mauro Alpago*, 2010 (certificato di esecuzione)	**Sottrazione di minori**	Convenzione sulle relazioni personali riguardanti i minori Corte EDU, *Neulinger e Shuruk c. Svizzera* [GC], n. 41615/07, 2010 (sottrazione di minore a opera della madre) Corte EDU, *X c. Lettonia* [GC], n. 27853/09, 2013 (fondato rischio in caso di rimpatrio di una minore ai sensi della Convenzione dell'Aia)

La legislazione europea, a livello sia di UE che di Consiglio d'Europa, sancisce il diritto al rispetto della vita familiare (articolo 7 della Carta dei diritti fondamentali dell'UE; articolo 8 della CEDU). La competenza dell'UE in materia di vita familiare riguarda le controversie transfrontaliere, tra cui il riconoscimento e l'esecuzione di sentenze negli Stati membri. La CGUE si occupa di questioni quali l'interesse superiore del minore e il diritto alla vita familiare sanciti dalla Carta dei diritti fondamentali dell'UE in relazione al regolamento Bruxelles II *bis*. La giurisprudenza della Corte EDU riguardante la vita familiare riconosce diritti interdipendenti quali il diritto alla vita familiare e il diritto del minore a che il suo interesse superiore sia considerato preminente. Riconosce altresì che talvolta i diritti dei minori sono in conflitto tra loro. Il diritto del minore al rispetto della vita familiare, ad esempio, può essere limitato al fine di tutelare il suo interesse superiore. Inoltre, il Consiglio d'Europa ha adottato vari altri strumenti che disciplinano questioni connesse al contatto, all'affidamento e all'esercizio dei diritti dei minori.

Il presente capitolo esamina il diritto del minore al rispetto della vita familiare e i diritti associati, in particolare il contenuto e la portata di tali diritti nonché gli obblighi giuridici associati e la loro interazione con altri diritti. Tra gli aspetti specifici trattati figurano il diritto al rispetto della vita familiare e le sue limitazioni (paragrafo 5.1), il diritto del minore a essere allevato dai suoi genitori (paragrafo 5.2), il diritto di intrattenere contatti con entrambi i genitori (paragrafo 5.3) e la sottrazione di minori (paragrafo 5.4).

5.1. Diritto al rispetto della vita familiare

Punti salienti

- Gli Stati hanno obblighi positivi di garantire il godimento effettivo da parte dei minori del diritto al rispetto della vita familiare.
- Ai sensi del diritto sia dell'UE che del Consiglio d'Europa, le autorità giudiziarie e amministrative devono tenere conto dell'interesse superiore del minore in qualsiasi decisione riguardante il diritto del minore al rispetto della sua vita familiare.

Il diritto del minore al rispetto della vita familiare comprende una serie di diritti compositi, quali il diritto del minore a essere allevato dai suoi genitori (paragrafo 5.2), il diritto di intrattenere contatti con entrambi i genitori (paragrafo 5.3), il diritto a non essere separato dai genitori, a meno che ciò non sia nel suo interesse superiore (paragrafo 5.4 e capitolo 6) e il diritto al ricongiungimento familiare (capitolo 9).

Ai sensi del diritto sia dell'UE che del Consiglio d'Europa, il diritto al rispetto della vita familiare non è assoluto, ed è soggetto a una serie di limitazioni. Tali limitazioni, come precisano le spiegazioni relative alla Carta dei diritti fondamentali dell'UE[138], sono identiche a quelle previste dalla corrispondente disposizione della CEDU, nella fattispecie l'articolo 8, paragrafo 2, che recita: "[Non può esservi ingerenza di una autorità pubblica nell'esercizio di tale diritto a meno che tale ingerenza] sia prevista dalla legge e costituisca una misura che, in una società democratica, è necessaria alla sicurezza nazionale, alla pubblica sicurezza, al benessere economico del paese, alla difesa dell'ordine e alla prevenzione

138 Parlamento Europeo, Consiglio dell'Unione Europea, Commissione Europea (2007), "Spiegazioni riguardanti la Carta dei Diritti Fondamentali dell'UE", 2007/C 303/02, OJ 2007 C 303, 14 Dicembre 2007, pp. 17–35, vedi spiegazioni relative all'Art. 7.

dei reati, alla protezione della salute o della morale, o alla protezione dei diritti e delle libertà altrui".[139]

La Carta dei diritti fondamentali dell'UE integra espressamente in tale diritto l'obbligo di considerare preminente l'interesse superiore del minore (articolo 24, paragrafo 2).[140] Benché l'obbligo di considerare l'interesse superiore del minore non sia espressamente sancito dalla CEDU, la Corte EDU lo incorpora nella sua giurisprudenza.[141]

5.2. Diritto del minore a essere cresciuto dai suoi genitori

Punti salienti

- Il diritto dell'UE disciplina gli aspetti procedurali del diritto del minore a essere cresciuto dai suoi genitori.
- Ai sensi della CEDU, gli Stati hanno obblighi sia negativi che positivi di rispettare il diritto alla vita familiare dei minori e dei loro genitori.

Il diritto dei minori a conoscere l'identità dei loro genitori e il diritto a esserne cresciuti sono due componenti fondamentali del diritto dei minori al rispetto della vita familiare. In certa misura tali diritti sono interdipendenti: il diritto dei minori a conoscere i loro genitori è garantito attraverso le cure genitoriali. Tuttavia, talvolta tali diritti non sono gli stessi, ad esempio, per i minori che sono stati adottati o che sono nati a seguito della procreazione medicalmente assistita. In questo caso il diritto è più strettamente associato al diritto all'identità del minore, che si esprime attraverso la conoscenza della sua parentela biologica, ed è pertanto esaminato al capitolo 4. Il presente paragrafo si concentra invece sul secondo diritto: il diritto del minore a essere cresciuto dai suoi genitori.

139 Consiglio d'Europa, Convenzione per la salvaguardia dei diritti dell'uomo e delle libertà fondamentali, STE n. 5, 4 novembre 1950, articolo 8.

140 CGUE, sentenza 5 ottobre 2010, causa C-400/10 PPU, *J. McB. c. L. E.*.

141 Cfr., per esempio, Corte EDU, sentenza 25 gennaio 2000, *Ignaccolo-Zenide c. Romania* (n. 31679/96), punto 94.

Il diritto dell'UE non contiene disposizioni riguardanti il campo di applicazione materiale del diritto a essere allevati dai genitori. Gli strumenti dell'UE possono trattare aspetti transfrontalieri, come il riconoscimento e l'esecuzione di sentenze negli Stati membri. Il regolamento (CE) n. 4/2009 relativo alla competenza, alla legge applicabile, al riconoscimento e all'esecuzione delle decisioni e alla cooperazione in materia di obbligazioni alimentari (regolamento in materia di obbligazioni alimentari), ad esempio, si applica alle domande transfrontaliere di alimenti derivanti da rapporti di famiglia.[142] Definisce norme comuni per tutta l'Unione, volte a garantire il recupero dei crediti alimentari anche qualora il debitore o il creditore si trovino in un altro paese.

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha sottolineato che l'articolo 8 della CEDU stabilisce essenzialmente l'obbligo di non ingerenza nella vita familiare da parte dello Stato.[143] Tuttavia, gli Stati hanno anche l'obbligo positivo di adottare le misure necessarie sia per sostenere i genitori e le famiglie che per proteggere i minori da potenziali abusi.[144] I minori devono essere separati dai loro genitori solo in casi eccezionali. In tali circostanze, occorre fare tutto il possibile per preservare le relazioni personali e, ove opportuno, "ricostruire" la famiglia. Gli Stati godono di un ampio margine di apprezzamento quando prendono la decisione iniziale di separare i minori dai loro genitori.[145] È però necessario sottoporre a un esame più rigoroso altre eventuali limitazioni, quali le restrizioni ai diritti di visita dei genitori, nonché eventuali salvaguardie giuridiche volte a garantire l'effettiva protezione del diritto dei genitori e dei minori al rispetto della loro vita familiare. Tali ulteriori limitazioni comportano il rischio che i rapporti familiari tra un minore e uno o entrambi i genitori siano di fatto ridotti. Analogamente, quando si tratta di separare le madri dai neonati, le ragioni avanzate dallo Stato devono essere straordinariamente convincenti.[146]

Il margine di apprezzamento diminuisce con la quantità di tempo durante il quale i minori sono separati dai loro genitori e le autorità statali devono presentare

142 Consiglio dell'Unione europea (2008), regolamento (CE) n. 4/2009 del Consiglio, del 18 dicembre 2008, relativo alla competenza, alla legge applicabile, al riconoscimento e all'esecuzione delle decisioni e alla cooperazione in materia di obbligazioni alimentari (GU L 7 del 10.1.2009) (regolamento in materia di obbligazioni alimentari).

143 Corte EDU, sentenza 18 giugno 2013, *R.M.S. c. Spagna* (n. 28775/12), punto 69.

144 *Ibid.*, punto 69 e segg.

145 Corte EDU, sentenza 13 marzo 2012, *Y.C. c. Regno Unito* (n. 4547/10), punto 137.

146 Corte EDU, sentenza 12 luglio 2001, *K. e T. c. Finlandia* [GC] (n. 25702/94), punto 168.

forti validi motivi per sostenere la loro decisione di mantenere la separazione.[147] La Corte EDU valuta l'equità del processo decisionale e stabilisce se è stata data l'opportunità di perorare la propria causa a tutte le parti interessate.

> Esempio: nel caso *R.M.S. c. Spagna,*[148] la ricorrente lamentava di essere stata privata di ogni contatto con la figlia da quando quest'ultima aveva tre anni e 10 mesi a causa della sua situazione socioeconomica. Nel rilevare una violazione dell'articolo 8 della CEDU, la Corte ha sottolineato che le autorità amministrative spagnole avrebbero dovuto prendere in considerazione misure meno drastiche anziché prendere in carico la bambina. LaCorte ha altresì affermato che il compito degli enti di assistenza sociale è proprio quello di aiutare le persone in difficoltà, di fornire loro orientamento e consigli, ad esempio sui differenti tipi di prestazioni sociali disponibili, sulla possibilità di accedere all'edilizia sociale e su altri mezzi con cui superare le loro difficoltà, come la ricorrente aveva inizialmente cercato di fare. La Corte EDU ha pertanto concluso che le autorità spagnole non hanno compiuto sforzi adeguati e sufficienti a garantire il diritto della ricorrente a vivere con sua figlia.[149]

Nell'ambito del diritto internazionale, l'articolo 5 della CRC stabilisce che "Gli Stati parti rispettano la responsabilità, il diritto e il dovere dei genitori, [...] di dare al fanciullo, in maniera corrispondente allo sviluppo delle sue capacità, l'orientamento e i consigli adeguati all'esercizio dei diritti che gli sono riconosciuti dalla presente Convenzione." Inoltre, l'articolo 9 della CRC afferma che il fanciullo deve essere separato dai suoi genitori contro la sua volontà e che tutte le parti interessate devono avere la possibilità di partecipare alle deliberazioni riguardanti tale situazione. Le Linee guida dell'ONU sull'accoglienza eterofamiliare avvalorano ulteriormente i diritti dei minori che si trovano in tali circostanze e i corrispondenti obblighi degli Stati.[150]

147 Corte EDU, sentenza 13 marzo 2012, *Y.C. c. Regno Unito* (n. 4547/10), punto 137.

148 Corte EDU, sentenza 18 giugno 2013, *R.M.S. c. Spagna* (n. 28775/12),

149 *Ibid*, punti 86 e 93.

150 Consiglio per i diritti umani delle Nazioni Unite (2009), *Linee guida dell'ONU sull'accoglienza eterofamiliare*, doc. ONU A/HRC/11/L.13, 15 giugno 2009.

5.3. Diritto di intrattenere contatti con entrambi i genitori

Punti salienti

- Il diritto del minore di intrattenere contatti con entrambi i genitori sussiste in tutte le forme di separazione genitoriale, siano esse collegate alla famiglia o sancite dallo Stato.
- Ai fini del processo volto a garantire il diritto del minore a intrattenere contatti con i genitori e ad assicurare il ricongiungimento familiare, occorre considerare preminente l'interesse superiore del minore tenendone debitamente in considerazione le opinioni in funzione della sua età e del suo grado di maturità.

La portata del diritto a intrattenere contatti con i genitori varia a seconda del contesto. Qualora la decisione di separarsi sia presa dai genitori, il campo di applicazione è più ampio e di norma limitato solo dall'interesse superiore del minore. Nel caso di una separazione sancita dallo Stato, derivante ad esempio dall'espulsione o dalla detenzione di un genitore, le autorità statali agiscono per tutelare un interesse protetto e devono garantire un giusto equilibrio tra gli interessi delle parti e l'obbligo di tutelare l'interesse superiore del minore. Il diritto del minore di intrattenere contatti con entrambi i genitori è applicabile in ambedue i casi.

Nell'ambito del diritto dell'UE, l'articolo 24, paragrafo 3, della Carta dei diritti fondamentali dell'UE riconosce espressamente il diritto del minore di intrattenere contatti diretti con *i due* genitori. La formulazione della disposizione precisa il contenuto del diritto, in particolare il significato di "contatti", che devono essere intrattenuti *regolarmente*, permettere lo sviluppo di *relazioni personali* e avvenire sotto forma di *contatti diretti*. L'articolo contiene tuttavia un ammonimento: il diritto del minore a intrattenere contatti con i genitori è espressamente limitato dal suo interesse superiore. Come precisa la nota esplicativa alla Carta, questa disposizione è espressamente informata dall'articolo 9 della CRC.

In linea con le competenze dell'UE (cfr. il capitolo 1), è stata dedicata una particolare attenzione alla cooperazione giudiziaria (con l'obiettivo di creare uno spazio di libertà, sicurezza e giustizia in cui sia garantita la libera circolazione delle persone). Due strumenti dell'UE sono particolarmente rilevanti: il regolamento (CE)

n. 2201/2003[151] del Consiglio (regolamento Bruxelles II bis) e la direttiva del Parlamento europeo e del Consiglio 2008/52/CE (direttiva sulla mediazione).[152] Dalla prospettiva dei diritti, il regolamento Bruxelles II *bis* è un dispositivo importante. In primo luogo, si applica a *tutte* le decisioni in materia di responsabilità genitoriale, indipendentemente dallo stato coniugale. In secondo luogo, le norme sulla competenza (determinate perlopiù dalla residenza abituale del minore) sono espressamente informate dall'interesse superiore del minore e, in terzo luogo, il regolamento presta una particolare attenzione a garantire il rispetto delle opinioni dei minori.[153]

La giurisprudenza della CGUE, nei casi di trasferimento illecito di un minore in seguito a una decisione presa unilateralmente da uno dei genitori, è stata innanzitutto finalizzata a rispettare il diritto fondamentale del minore di intrattenere regolarmente relazioni personali e contatti diretti con i due genitori (articolo 24, paragrafo 3, della Carta), poiché la Corte afferma che tale diritto s'identifica innegabilmente con l'interesse superiore del bambino. A parere della CGUE, una misura che impedisca al minore di intrattenere regolarmente relazioni personali e contatti diretti con i suoi due genitori potrebbe essere giustificata soltanto da un altro interesse del minore di importanza tale da comportarne il prevalere sull'interesse sotteso al citato diritto fondamentale.[154] In quest'ambito rientra l'adozione di provvedimenti provvisori o cautelari ai sensi dell'articolo 20 del regolamento Bruxelles II *bis*. La Corte ha stabilito che una valutazione equilibrata e ragionevole di tutti gli interessi in gioco, da effettuarsi sulla base di considerazioni oggettive riguardanti la persona stessa del minore e il suo ambiente sociale, deve essere compiuta, in linea di principio, nell'ambito di un procedimento in forza delle disposizioni del regolamento Bruxelles II *bis*.[155]

151 Parlamento europeo, Consiglio dell'Unione europea (2008), direttiva 2008/52/CE del Parlamento europeo e del Consiglio, del 21 maggio 2008, relativa a determinati aspetti della mediazione in materia civile e commerciale (GU L 136 del 24.5.2008, pag. 3) (*direttiva sulla mediazione*).

152 Consiglio dell'Unione europea (2003), regolamento (CE) n. 2201/2003 del Consiglio, del 27 novembre 2003, relativo alla competenza, al riconoscimento e all'esecuzione delle decisioni in materia matrimoniale e in materia di responsabilità genitoriale, che abroga il regolamento (CE) n. 1347/2000 (GU L 338 del 23.12.2003) (Bruxelles II *bis*).

153 Cfr. per esempio, il regolamento (CE) n. 2201/2003 del Consiglio, preambolo (considerando 5, 12, 13 e 19 e articolo 8, articolo 41, paragrafo 2, lettera c), e articolo 42, paragrafo 2, lettera a)).

154 CGUE, sentenza 23 dicembre 2009, causa C-403/09 PPU, *Jasna Detiček c. Maurizio Sgueglia*, punto 59.

155 *Ibid.*, punto 60.

Esempio: la causa di *E. c. B.*[156] verte sulla controversia tra E. (il padre) e B. (la madre) in relazione alla competenza dei giudici del Regno Unito per quanto riguarda la determinazione del luogo di residenza abituale del loro figlio S. e il diritto di visita del padre. I genitori avevano sottoscritto un accordo dinanzi a un giudice spagnolo che attribuiva l'affidamento alla madre e riconosceva il diritto di visita al padre. In seguito la madre aveva chiesto una riduzione dei diritti di visita concessi al padre con tale accordo. Il padre aveva presentato un ricorso dinanzi al medesimo giudice ai fini dell'esecuzione dell'accordo spagnolo. La madre aveva riconosciuto di aver prorogato la competenza del giudice spagnolo e aveva cercato di trasferire ai giudici dell'Inghilterra e del Galles la competenza prorogata. Nell'ambito dell'appello presentato dal padre, la Corte d'Appello aveva sottoposto alla CGUE alcune questioni riguardanti l'interpretazione dell'articolo 12, paragrafo 3, del regolamento Bruxelles II *bis*. La CGUE ha stabilito che, quando un'autorità giurisdizionale è adita conformemente all'articolo 12, paragrafo 3, del regolamento Bruxelles II *bis*, l'interesse superiore del minore può essere tutelato solo mediante un esame, caso per caso, della questione se la proroga di competenza considerata sia conforme a tale interesse superiore. Una proroga di competenza è applicabile solo allo specifico procedimento per il quale è adita l'autorità giurisdizionale la cui competenza è prorogata. Con l'archiviazione definitiva del procedimento all'origine della proroga di competenza, tale competenza viene meno, a vantaggio dell'autorità giurisdizionale che gode di una competenza generale ai sensi dell'articolo 8, paragrafo 1, del regolamento Bruxelles II *bis*.

Per quanto riguarda la potestà genitoriale, il regolamento Bruxelles II *bis* coesiste con la Convenzione dell'Aia concernente la competenza, la legge applicabile, il riconoscimento, l'esecuzione e la cooperazione in materia di potestà genitoriale e di misure di protezione dei minori.[157] Conformemente all'articolo 61, il regolamento Bruxelles II *bis* prevale sulla Convenzione dell'Aia: (a) se il minore in questione ha la sua residenza abituale nel territorio di uno Stato membro o (b) per quanto riguarda il riconoscimento e l'esecuzione di una decisione emessa dal giudice competente di uno Stato membro nel territorio di un altro Stato membro,

156 CGUE, sentenza 1° ottobre 2014, causa C-436/13, *E. c. B.* (sintesi adattata da http://cases.iclr.co.uk)

157 Organizzazione mondiale per la cooperazione transfrontaliera in materia civile e commerciale (1996), Conferenza dell'Aia sul diritto internazionale privato, Convenzione dell'Aia concernente la competenza, la legge applicabile, il riconoscimento, l'esecuzione e la cooperazione in materia di potestà genitoriale e di misure di protezione dei minori, 19 ottobre 1996.

anche se il minore risiede abitualmente nel territorio di uno Stato non membro che è parte contraente della Convenzione dell'Aia. Di conseguenza, una questione chiave ai sensi del regolamento Bruxelles II *bis* è la determinazione della residenza abituale del minore.

> Esempio: nella causa *Mercredi c. Chaffe,*[158] la Court of Appeal (England and Wales) aveva adito la CGUE riguardo al trasferimento di una bambina di due mesi dal Regno Unito all'isola francese della Riunione. La CGUE ha stabilito che la nozione di "residenza abituale", ai sensi degli articoli 8 e 10 del regolamento Bruxelles II *bis*, corrisponde al luogo che denota una certa integrazione del minore in un ambiente sociale e familiare. Laddove la situazione riguardi un/a neonato/a che soggiorna con la madre solo da pochi giorni in uno Stato membro – diverso da quello della sua residenza abituale – nel quale è stato/a portato/a, devono essere presi in considerazione, da un lato, la durata, la regolarità, le condizioni e le ragioni del soggiorno nel territorio di tale Stato membro nonché del trasferimento della madre in detto Stato e, d'altro lato, tenuto conto segnatamente dell'età del minore, l'origine geografica e familiare della madre nonché i rapporti familiari e sociali che madre e minore intrattengono in quello stesso Stato membro.

Particolarmente rilevanti per il godimento del diritto a intrattenere contatti con entrambi i genitori nelle controversie transfrontaliere sono anche gli strumenti relativi alla regolamentazione dell'accesso alla giustizia che spiegano come gestire controversie complesse, quali la direttiva 2002/8/CE del Consiglio (direttiva sull'accesso alla giustizia) intesa "a miglior[are] l'accesso alla giustizia nelle controversie transfrontaliere attraverso la definizione di norme minime comuni relative al patrocinio a spese dello Stato in tali controversie".[159] La suddetta direttiva è volta a migliorare l'accesso alla giustizia nei procedimenti civili transfrontalieri attraverso la definizione di norme minime comuni relative al patrocinio a spese dello Stato, a garantire, a talune condizioni, un livello adeguato di patrocinio a spese dello Stato alle persone che sono incapaci di sostenere le spese processuali a causa della loro situazione finanziaria nonché a promuovere

158 CGUE, sentenza 22 dicembre 2010, causa C-497/10 PPU, *Barbara Mercredi c. Richard Chaffe*.

159 Consiglio dell'Unione europea (2003), direttiva 2002/8/CE del Consiglio, del 27 gennaio 2003, intesa a migliorare l'accesso alla giustizia nelle controversie transfrontaliere attraverso la definizione di norme minime comuni relative al patrocinio a spese dello Stato in tali controversie (GU L 26 del 31.1.2003) (direttiva sull'accesso alla giustizia).

la compatibilità delle norme nazionali in materia e a prevedere meccanismi di cooperazione tra le autorità degli Stati membri.

Nell'ambito del diritto del Consiglio d'Europa, il diritto di ogni minore di intrattenere contatti con entrambi i genitori è implicito all'articolo 8 della CEDU. Pur affermando che il godimento da parte del genitore e del figlio della reciproca compagnia costituisce un elemento fondamentale della vita familiare,[160] la Corte EDU sottolinea altresì che tale diritto può essere limitato dall'interesse superiore del minore (cfr. paragrafo 5.4 e capitolo 6). Questo diritto è al centro del processo decisionale giudiziario in materia di affidamento e intrattenimento di contatti tra i minori e i genitori.

La Corte EDU ha espressamente o implicitamente fatto riferimento all'interesse superiore del minore nell'ambito dell'affidamento e dei contatti tra il minore e i genitori in una serie di casi.

Esempio: nel caso *Schneider c. Germania*,[161] il ricorrente aveva avuto una relazione con una donna sposata e sosteneva di essere il padre biologico di suo figlio, il cui padre legalmente riconosciuto era il marito della madre. A parere del ricorrente, la decisione dei giudici nazionali di respingere la sua richiesta di avere contatti con il minore e di essere informato sulla sua crescita in ragione del fatto che non era il padre legittimo del bambino, né aveva una relazione con lui, costituiva una violazione dei suoi diritti ai sensi dell'articolo 8 della CEDU. Nel riscontrare una violazione del suddetto articolo, la Corte EDU si è concentrata sulla mancata considerazione accordata dai giudici nazionali all'eventualità che, nelle circostanze particolari del caso, l'intrattenimento di contatti tra il bambino e il ricorrente fosse nell'interesse superiore del minore.[162] Per quanto riguarda la richiesta del ricorrente di essere informato sullo sviluppo personale del bambino, la Corte ha stabilito che i giudici nazionali non avevano addotto ragioni sufficienti per giustificare la loro ingerenza ai sensi dell'articolo 8, paragrafo 2,[163] e che, pertanto, tale ingerenza non costituiva una misura necessaria "in una società democratica".

160 Corte EDU, sentenza 12 luglio 2001, *K. e T. c. Finlandia* [GC] (n. 25702/94), punto 151.

161 Corte EDU, sentenza 15 settembre 2011, *Schneider c. Germania* (n. 17080/07).

162 Cfr. anche Corte EDU, sentenza 21 dicembre 2010, *Anayo c. Germania* (n. 20578/07), punti 67 e 71.

163 Corte EDU, sentenza 15 settembre 2011, *Schneider c. Germania* (n. 17080/07), punto 104.

Esempio: nel caso *Levin c. Svezia*,[164] la ricorrente, una madre di tre figli in affido eterofamiliare, sosteneva che le restrizioni al suo diritto di intrattenere contatti con i figli violassero il suo diritto al rispetto della vita familiare. La Corte EDU si è concentrata sull'obiettivo delle restrizioni ai contatti, ossia la tutela dell'interesse superiore dei minori. Nel caso di specie, i minori erano trascurati mentre erano affidati alla ricorrente e, quando avevano contatti con la madre, mostravano forti reazioni negative. Nel sostenere che non sussisteva alcuna violazione dell'articolo 8 della CEDU, la Corte ha rilevato che l'ingerenza nei diritti della ricorrente era stata proporzionata allo scopo legittimo perseguito (l'interesse superiore dei minori) e rientrava nel margine di discrezionalità delle autorità nazionali.

Esempio: nel caso *Sommerfeld c. Germania*,[165] il ricorrente aveva presentato ricorso riguardo alle restrizioni al suo diritto di intrattenere contatti con la figlia, che aveva costantemente espresso l'intenzione di non volere rimanere in contatto con lui. In particolare, a parere del ricorrente il mancato ottenimento di una perizia psicologica da parte dei giudici nazionali costituiva un vizio di procedura. Non avendo riscontrato alcuna violazione dell'articolo 8 della CEDU, la Corte EDU ha concluso che il giudice nazionale era nella posizione ideale per valutare le dichiarazioni della figlia del ricorrente e per stabilire se aveva potuto prendere autonomamente una decisione.

Esempio: nel caso *Mustafa e Armağan Akin c. Turchia*,[166] i ricorrenti (un padre e un figlio) sostenevano che le prescrizioni di un provvedimento di affidamento adottato dal giudice nazionale avessero violato i loro diritti ai sensi dell'articolo 8 della CEDU. Tali prescrizioni impedivano al figlio di avere contatti con sua sorella, che era stata affidata alla madre. Inoltre, il padre non poteva avere contatti con entrambi i figli contemporaneamente perché il figlio poteva vedere la madre nello stesso momento in cui lui poteva vedere la figlia. La Corte EDU ha ritenuto che la decisione del tribunale nazionale di separare fratello e sorella costituisse una violazione del diritto dei ricorrenti al rispetto della loro vita familiare, poiché non solo non permetteva ai due fratelli di frequentarsi, ma impediva anche al padre di godere della compagnia di entrambi i figli contemporaneamente.

164 Corte EDU, sentenza giovedì 15 marzo 2012, *S.N. c. Svezia* (n. 35141/06), punti 57 e 69; Corte EDU, sentenza 12 luglio 2001, *K. e T. c. Finlandia* [GC] (n. 25702/94), punto 151.

165 Corte EDU, sentenza 8 luglio 2003, *Sommerfeld c. Germania* [GC] (n. 31871/96), punto 72.

166 Corte EDU, sentenza 6 aprile 2010, *Mustafa e Armağan Akin c. Turchia* (n. 4694/03).

Nell'ambito del processo decisionale riguardante l'affidamento e l'intrattenimento di contatti tra i minori e i genitori, la Corte EDU vieta altresì la discriminazione incompatibile con l'articolo 14 della CEDU.

Esempio: nel caso *Vojnity c. Ungheria,*[167] il ricorrente sosteneva che gli fosse stato negato il diritto di visita al figlio in ragione delle sue convinzioni religiose.[168] Nel rilevare una violazione dell'articolo 14 in combinato disposto con l'articolo 8 della CEDU, la Corte EDU ha osservato l'assenza di elementi attestanti che le convinzioni religiose del ricorrente comportassero pratiche pericolose o esponessero suo figlio a danni fisici o psicologici.[169] Le decisioni dei giudici nazionali di revocare i diritti di visita del ricorrente avevano reso impossibile qualsiasi forma di contatto nonché qualsivoglia proseguimento della vita familiare, benché la totale interruzione dei contatti possa essere giustificata solo in circostanze eccezionali.[170] La Corte EDU ha pertanto stabilito che non vi fosse alcun ragionevole rapporto di proporzionalità tra la revoca totale dei diritti di visita del ricorrente e la finalità perseguita, ossia la tutela dell'interesse superiore del minore.[171]

Esempio: nel caso *Salgueiro da Silva Mouta c. Portogallo,*[172] il ricorso era stato presentato da un padre che rivendicava la potestà genitoriale sulla figlia. Il ricorrente sosteneva che, nel procedimento nazionale, le autorità portoghesi avevano respinto la sua richiesta e affidato la potestà genitoriale alla madre in ragione del suo orientamento sessuale. La Corte EDU ha rilevato che le autorità nazionali avevano di fatto revocato l'affidamento al padre in ragione della sua omosessualità, una decisione priva di una giustificazione oggettiva e ragionevole. La Corte ha concluso che era stato violato l'articolo 8 in combinato disposto con l'articolo 14 della CEDU.

Inoltre, il diritto del minore a intrattenere contatti con entrambi i genitori è espressamente sancito dalla Convenzione del Consiglio d'Europa sulle relazioni personali

167 Corte EDU, sentenza 12 febbraio 2013, *Vojnity c. Ungheria* (n. 29617/07), punto 22.

168 *Ibid.*, punto 38.

169 Corte EDU, sentenza 12 febbraio 2013, *Vojnity c. Ungheria* (n. 29617/07); cfr. anche Corte EDU, sentenza 30 novembre 2010, *P.V. c. Spagna* (n. 35159/09) (consultabile in francese e spagnolo).

170 *Ibid.*, punto 41.

171 *Ibid.*, punto 43.

172 Corte EDU, sentenza 21 dicembre 1999, *Salgueiro da Silva Mouta c. Portogallo* (n. 33290/96).

riguardanti i minori.[173] L'articolo 4, paragrafo 1, della suddetta convenzione afferma che "un minore ed i suoi genitori devono avere il diritto di ottenere e mantenere regolari relazioni personali tra loro". I principi generali da applicare nella giurisprudenza in materia di contatti tra genitori e figli sottolineano il diritto del minore a essere informato, consultato e a esprimere la sua opinione e la necessità di tenere tale opinione nella dovuta considerazione. L'articolo 6 della Convenzione del Consiglio d'Europa sull'esercizio dei diritti dei minori[174] individua inoltre i requisiti che devono contraddistinguere il processo decisionale giudiziario, tra cui figurano i seguenti obblighi giuridici: esaminare se l'autorità giudiziaria dispone di informazioni sufficienti al fine di prendere una decisione nell'interesse superiore del minore; garantire il diritto del minore a ricevere informazioni sul processo e sui suoi esiti; e offrire ai minori interessati uno spazio sicuro in cui possano esprimere liberamente le proprie opinioni in maniera adeguata alla loro età e maturità.

Possono verificarsi situazioni in cui i minori sono separati da un genitore per motivi di altra natura, ad esempio a seguito della carcerazione di un genitore. La Corte EDU si è occupata di una situazione simile nel caso *Horych c. Polonia,*[175] in cui ha affrontato la questione delle condizioni in cui il ricorrente, classificato come detenuto pericoloso, aveva ricevuto visite dalle figlie minori. La Corte ha osservato che le visite dei minori in carcere richiedono misure speciali e potrebbero essere subordinate a condizioni specifiche a seconda della loro età, dei possibili effetti sul loro stato o benessere emotivo e della situazione personale dell'individuo destinatario della visita.[176] La Corte ha aggiunto che gli obblighi positivi dello Stato ai sensi dell'articolo 8 comprendono il dovere di garantire condizioni adeguate e quanto più prive di stress possibile per ricevere visite da parte di minori, in considerazione delle conseguenze pratiche della carcerazione. [177]

Infine, il diritto dei minori privati della libertà di mantenere contatti con i loro genitori è rafforzato da determinate disposizioni delle Linee guida del Consiglio

173 Consiglio d'Europa, Convenzione sulle relazioni personali riguardanti i minori, STE n. 192, 15 maggio 2003. Cfr. anche Organizzazione mondiale per la cooperazione transfrontaliera in materia civile e commerciale (1996), Conferenza dell'Aia sul diritto internazionale privato, Convenzione dell'Aia concernente la competenza, la legge applicabile, il riconoscimento, l'esecuzione e la cooperazione in materia di potestà genitoriale e di misure di protezione dei minori.

174 Consiglio d'Europa, Convenzione europea sull'esercizio dei diritti dei minori, STE N. 160, 25 gennaio 1996.

175 Corte EDU, sentenza 17 aprile 2012, *Horych c. Polonia* (n. 13621/08).

176 *Ibid.*, punto 131.

177 *Ibid.*, punto 131.

d'Europa per una giustizia a misura di minore.[178] Le suddette linee guida affermano espressamente il diritto dei minori privati della libertà di "mantenere contatti regolari e significativi con i genitori [e] la famiglia" (articolo 21, lettera a)) (cfr. anche il capitolo 11).

Nell'ambito del diritto internazionale, il diritto di intrattenere contatti con entrambi i genitori è sancito dall'articolo 9, paragrafo 3, della CRC: "Gli Stati parti rispettano il diritto del fanciullo separato da entrambi i genitori o da uno di essi di intrattenere regolarmente rapporti personali e contatti diretti con entrambi i genitori, a meno che ciò non sia contrario all'interesse preminente del fanciullo."

5.4. Trasferimento transfrontaliero illegittimo di minori – sottrazione di minori

Punti salienti

- Nei casi riguardanti i trasferimenti illegittimi in violazione degli accordi di affidamento, la Corte EDU prevede l'adozione di un approccio basato sui diritti dei minori: l'articolo 8 della CEDU (diritto al rispetto della vita privata e familiare) deve essere interpretato alla luce della Convenzione dell'Aia e della CRC.
- Il diritto dell'UE prevede più espressamente che il minore sia ascoltato nei procedimenti riguardanti il suo ritorno in seguito a un trasferimento illecito o mancato rientro.

Per sottrazione di minore s'intende una situazione in cui un minore è trasferito o trattenuto oltre i confini nazionali in violazione degli accordi di affidamento esistenti (articolo 3 della Convenzione dell'Aia sugli aspetti civili della sottrazione internazionale di minori[179] [Convenzione dell'Aia]). La Convenzione dell'Aia prevede l'immediato rientro nel loro Stato di residenza abituale dei minori illecitamente trasferiti o trattenuti (articolo 11, paragrafo 1). I giudici dello Stato di resi-

178 Consiglio d'Europa, Comitato dei ministri (2010), *Linee guida per una giustizia a misura di minore*.

179 Organizzazione mondiale per la cooperazione transfrontaliera in materia civile e commerciale (1980), Conferenza dell'Aia sul diritto internazionale privato, Convenzione dell'Aia del 25 ottobre 1980 sugli aspetti civili della sottrazione internazionale di minori, 25 ottobre 1980.

denza abituale deliberano sul merito della controversia relativa all'affidamento. I giudici dello Stato da cui il minore è stato trasferito devono ordinarne il ritorno entro un termine di sei settimane dalla data in cui è stata presentata l'istanza di rientro (articolo 11). La Convenzione dell'Aia si fonda sul principio dell'interesse superiore del minore. Nell'ambito di tale convenzione, la presunzione è che il trasferimento illecito di un minore sia di per sé dannoso e che lo *status quo ante* debba essere ripristinato quanto prima per evitare il consolidamento giuridico di situazioni illegali. A pronunciarsi in materia di diritti di affidamento e di visita devono essere i giudici competenti nel luogo di residenza abituale del minore anziché quelli del paese nel quale il minore è stato illecitamente trasferito. Gli articoli 12, 13 e 20 della Convenzione dell'Aia prevedono alcune limitate eccezioni al meccanismo di ritorno. L'articolo 13 contiene le disposizioni da cui è scaturita la maggior parte delle vertenze giudiziarie a livello sia nazionale che internazionale. Tale articolo stabilisce che lo Stato in cui il minore è stato trasferito può opporsi al suo ritorno qualora sussista un fondato rischio, per il minore, di essere esposto, per il fatto del suo ritorno, a pericoli fisici e psichici, o comunque di trovarsi in una situazione intollerabile (articolo 13, lettera b)). Uno Stato può altresì rifiutarsi di ordinare il ritorno del minore qualora accerti che quest'ultimo si oppone al ritorno o che ha raggiunto un grado di maturità tale da consentirgli di esprimere il suo parere (articolo 13, paragrafo 2).

Nell'ambito del diritto dell'UE, lo strumento più importante che disciplina la sottrazione di minori tra gli Stati membri dell'UE è il regolamento Bruxelles II *bis*,[180] che s'ispira in ampia misura alle disposizioni della Convenzione dell'Aia. Detto regolamento integra la Convenzione dell'Aia e prevale su di essa nei casi di sottrazione di minore all'interno dell'UE (considerando 17 e articolo 60, lettera e)). Benché la Convenzione dell'Aia rimanga lo strumento principale in materia di sottrazione di minori, sotto taluni aspetti il regolamento Bruxelles II *bis* ha "rafforzato" le norme di competenza a favore delle autorità giurisdizionali di origine/dello Stato di residenza abituale. Analogamente alla Convenzione dell'Aia, il regolamento Bruxelles II *bis* prevede che l'autorità giurisdizionale dello Stato nel quale il minore aveva la residenza abituale immediatamente prima del trasferimento illecito o del mancato rientro conservino la competenza nei casi di sottrazione di minore. Il regolamento mantiene le stesse eccezioni al meccanismo di ritorno previste dalla Convenzione sulla sottrazione di minori.

180 Consiglio dell'Unione europea (2003), regolamento (CE) n. 2201/2003 del Consiglio, del 27 novembre 2003, relativo alla competenza, al riconoscimento e all'esecuzione delle decisioni in materia matrimoniale e in materia di responsabilità genitoriale, che abroga il regolamento (CE) n. 1347/2000 (GU L 338 del 23.12.2003).

Tuttavia, diversamente dalla Convenzione dell'Aia, il regolamento Bruxelles II *bis* prevede che lo Stato di residenza abituale rimanga competente a pronunciarsi sul merito della controversia relativa all'affidamento anche dopo l'emanazione di un provvedimento contro il ritorno in applicazione dell'articolo 13, lettera b), della Convenzione dell'Aia e dell'articolo 11, paragrafi 6–8, del regolamento Bruxelles II *bis*. Il trasferimento di competenza dello Stato in cui il minore è stato trasferito può avvenire solo in due situazioni, previste dall'articolo 10 del regolamento Bruxelles II *bis*. La prima situazione attribuisce la competenza ai giudici dello Stato di rifugio qualora il minore abbia acquisito la residenza abituale in tale Stato e ciascuna persona titolare del diritto di affidamento abbia accettato il trasferimento o mancato rientro.[181] La seconda situazione si verifica se: il minore ha acquisito la residenza abituale nello Stato in cui è stato trasferito; è trascorso un periodo di un anno da quando il genitore cui è stato sottratto il minore ha avuto conoscenza, o avrebbe dovuto avere conoscenza, del luogo in cui il minore si trovava; il minore si è integrato nel nuovo ambiente; e ricorre almeno una delle quattro ulteriori condizioni elencate all'articolo 10, lettera b), del regolamento Bruxelles II *bis*.[182]

Come per tutti gli altri strumenti giuridici dell'UE, il regolamento Bruxelles II *bis* deve essere interpretato conformemente alle disposizioni della Carta dei diritti fondamentali dell'UE, in particolare all'articolo 24. La CGUE ha avuto l'opportunità di chiarire l'interpretazione dell'articolo 24 della Carta nel contesto delle sottrazioni di minori. Come già discusso al paragrafo 2.4, nella causa *Aguirre Zarraga*, la CGUE ha stabilito che il diritto del minore di essere ascoltato, sancito dall'articolo 24 della Carta, richiede che siano messe a disposizione di tale minore le procedure e condizioni legali che gli consentono di esprimere liberamente la sua opinione e che quest'ultima sia raccolta dal giudice.[183] Secondo la CGUE, tuttavia,

181 Articolo 10, lettera a), del regolamento Bruxelles II *bis*.

182 L'articolo 10, lettera b), del regolamento Bruxelles II *bis* enumera le quattro condizioni alternative elencate di seguito: (i) entro un anno da quando il titolare del diritto di affidamento ha avuto conoscenza, o avrebbe dovuto avere conoscenza, del luogo in cui il minore si trovava non è stata presentata alcuna domanda di ritorno del minore dinanzi alle autorità competenti dello Stato membro nel quale il minore è stato trasferito o dal quale non ha fatto rientro; (ii) una domanda di ritorno presentata dal titolare del diritto di affidamento è stata ritirata e non è stata presentata una nuova domanda entro il termine di cui al punto i); (iii) un procedimento dinanzi all'autorità giurisdizionale dello Stato membro nel quale il minore aveva la residenza abituale immediatamente prima del trasferimento o del mancato rientro è stato definito a norma dell'articolo 11, paragrafo 7; (iv) l'autorità giurisdizionale dello Stato membro nel quale il minore aveva la residenza abituale immediatamente prima dell'illecito trasferimento o del mancato ritorno ha emanato una decisione di affidamento che non prevede il ritorno del minore.

183 CGUE, sentenza 22 dicembre 2010, causa C-491/10 PPU, *Joseba Andoni Aguirre Zarraga c. Simone Pelz*. Per quanto riguarda gli aspetti relativi alla partecipazione del minore nel caso di specie, cfr. inoltre l'analisi al paragrafo 2.4.

spetta ai soli giudici nazionali dello Stato di residenza abituale del minore esaminare la legittimità delle loro decisioni alla luce della Carta dei diritti fondamentali dell'UE e del regolamento Bruxelles II *bis*. Conformemente al principio della fiducia reciproca, gli ordinamenti giuridici degli Stati membri devono fornire una tutela equivalente ed effettiva dei diritti fondamentali. Di conseguenza, le parti interessate devono sottoporre eventuali questioni riguardanti i diritti umani alle autorità giurisdizionali competenti a pronunciarsi sul merito della controversia relativa all'affidamento in conformità del regolamento. La CGUE ha stabilito che i giudici dello Stato membro in cui il minore era stato trasferito illecitamente non potevano opporsi all'esecuzione di una decisione certificata che prescriveva il ritorno del minore, poiché l'accertamento della sussistenza di una violazione delle suddette disposizioni era di competenza esclusiva dei giudici dello Stato membro d'origine.

Esempio: la causa *Povse c. Alpago*[184] riguarda il trasferimento illecito di una bambina in Austria da parte della madre. I giudici austriaci avevano respinto la domanda presentata dal padre per il ritorno della figlia in Italia, rilevando che sussisteva un grave rischio di danno per la minore. Nel frattempo, su richiesta del padre, il giudice italiano aveva stabilito che avrebbe mantenuto la competenza a pronunciarsi sul merito della controversia relativa all'affidamento e aveva emanato un provvedimento di ritorno della minore in Italia nonché un certificato di esecuzione sulla base dell'articolo 42 del regolamento Bruxelles II *bis*. Il caso era stato deferito alla CGUE da un giudice austriaco in seguito all'appello interposto dalla madre contro la domanda di esecuzione del certificato e il conseguente provvedimento di ritorno della minore in Italia. La CGUE ha stabilito che, una volta emesso il certificato di esecuzione, il paese in cui il minore è stato trasferito (nel caso di specie l'Austria) non può opporsi al ritorno, poiché il certificato è automaticamente dotato di efficacia esecutiva. La CGUE ha inoltre deciso che, nella fattispecie, solo i giudici italiani erano competenti a pronunciarsi sul grave rischio per l'interesse superiore della minore comportato dal ritorno. Supponendo che dovessero considerare tale rischio giustificato, i suddetti giudici hanno mantenuto la competenza esclusiva di sospendere il loro provvedimento di esecuzione.[185]

184 CGUE, sentenza 1°luglio 2010, causa C-211/10, *Doris Povse c. Mauro Alpago*.

185 Un ricorso basato sugli stessi fatti è stato successivamente presentato alla Corte EDU e dichiarato inammissibile. Cfr. Corte EDU, sentenza 18 giugno 2013, *Povse c. Austria* (n. 3890/11), decisione di inammissibilità.

Nell'ambito del diritto del Consiglio d'Europa, la Convenzione europea sul riconoscimento e l'esecuzione delle decisioni in materia di affidamento dei minori e sul ristabilimento dell'affidamento dei minori[186] e la Convenzione sulle relazioni personali riguardanti i minori[187] contengono tutele volte a impedire il trasferimento illegittimo dei minori e ad assicurare la restituzione dei minori.[188]

La Corte EDU si occupa spesso di casi di sottrazione di minore e, in tali occasioni, interpreta l'articolo 8 della CEDU ispirandosi generalmente alle disposizioni della Convenzione dell'Aia. Ciononostante, in tali casi la Corte EDU conduce inevitabilmente un'analisi dell'interesse superiore del minore. Due sentenze fondamentali della Grande Camera riflettono la posizione della Corte in materia.

Esempio: il ricorso *Neulinger e Shuruk c. Svizzera*[189] è stato presentato da una madre che aveva trasferito il figlio da Israele alla Svizzera in violazione degli accordi esistenti in materia di tutela. In seguito al ricorso presentato dal padre ai sensi della Convenzione dell'Aia, le autorità svizzere avevano disposto il ritorno del minore in Israele. A parere degli esperti e dei giudici nazionali, il ritorno del minore in Israele avrebbe potuto essere concepibile solo se il bambino fosse stato accompagnato dalla madre. La misura in questione rientrava nel margine di discrezionalità concesso alle autorità nazionali competenti in materia. Tuttavia, per valutare l'osservanza dell'articolo 8 della CEDU, era altresì necessario tenere conto di tutti gli sviluppi intercorsi dalla sentenza del Tribunale federale che ordinava il ritorno del minore. Nel caso di specie, il minore era un cittadino svizzero e si era integrato bene nel Paese, in cui risiedeva ininterrottamente da circa quattro anni. Benché la sua età gli permettesse di avere ancora una notevole capacità di adattamento, un nuovo trasferimento avrebbe probabilmente avuto gravi conseguenze per lui e doveva essere valutato rispetto ai benefici che il minore avrebbe verosimilmente potuto trarne. Era altresì degno di nota che al diritto di visita del padre fossero state imposte restrizioni

186 Consiglio d'Europa, Convenzione sulle relazioni personali riguardanti i minori, STE n. 192, 15 maggio 2003.

187 *Ibid.*, articolo 10, lettera b), e articolo 16, rispettivamente; Consiglio d'Europa, Convenzione europea sul riconoscimento e l'esecuzione delle decisioni in materia di affidamento dei minori e sul ristabilimento dell'affidamento dei minori, STE n. 105, 20 maggio 1980, articolo 8.

188 Consiglio d'Europa, Convenzione europea sul riconoscimento e l'esecuzione delle decisioni in materia di affidamento dei minori e sul ristabilimento dell'affidamento dei minori, STE n. 105, 20 maggio 1980.

189 Corte EDU, sentenza 6 luglio 2010, *Neulinger e Shuruk c. Svizzera* [GC] (n. 41615/07).

prima del trasferimento del minore. Inoltre, nel frattempo il padre si era risposato due volte e aveva avuto un'altra figlia, a favore della quale non versava però gli alimenti. La Corte EDU dubitava che tali circostanze sarebbero state favorevoli al benessere e allo sviluppo del minore. Quanto alla madre, il suo ritorno in Israele avrebbe potuta esporla al rischio di incorrere in sanzioni penali, quali ad esempio la condanna a una pena detentiva. Era evidente che tale situazione sarebbe stata contraria all'interesse superiore del minore, poiché la madre era probabilmente l'unica persona con cui intratteneva contatti. Il rifiuto della madre di tornare in Israele, pertanto, non era totalmente ingiustificato. Inoltre, il padre non aveva mai vissuto da solo con il figlio e non lo vedeva da quando il bambino era stato trasferito in Svizzera, all'età di due anni. La Corte EDU non era dunque convinta che tornare in Israele sarebbe stato nell'interesse superiore del minore. Per quanto riguarda la madre, un ritorno in Israele avrebbe costituito un'ingerenza sproporzionata nel suo diritto al rispetto della propria vita familiare. Di conseguenza, l'eventuale esecuzione della decisione che dispone il ritorno del secondo ricorrente in Israele costituirebbe una violazione dell'articolo 8 della CEDU.

Esempio: nel caso *X c. Lettonia*,[190] la madre sosteneva che il ritorno della figlia in Australia, da cui era stata illecitamente trasferita, l'avrebbe esposta a un danno grave. Nello stabilire se le decisioni dei giudici nazionali avessero garantito un giusto equilibrio tra gli interessi concorrenti in gioco, nell'ambito del margine di apprezzamento concesso agli Stati in materia occorreva considerare preminente l'interesse superiore della minore. Per giungere a un'interpretazione armoniosa della CEDU e della Convenzione dell'Aia, i fattori in grado di costituire un'eccezione al ritorno immediato della minore ai sensi degli articoli 12, 13 e 20 della Convenzione dell'Aia dovevano essere tenuti effettivamente in considerazione dallo Stato richiesto, che doveva adottare una decisione che fosse sufficientemente ragionata su questo punto, e successivamente valutata alla luce dell'articolo 8 della CEDU. Tale articolo imponeva alle autorità nazionali un obbligo procedurale, conformemente al quale i giudici, nell'ambito dell'esame di una domanda di ritorno di un minore, erano tenuti a valutare le sostenibili affermazioni di un "fondato rischio" al quale sarebbe stata esposta la minore in caso di ritorno e a emettere una decisione specificamente moti-

190 Corte EDU, sentenza 26 novembre 2013, *X c. Lettonia* [GC] (n. 27853/09), punti 101, 106, 107 e 115–119.

vata. Quanto all'esatta natura del "fondato rischio", l'eccezione di cui all'articolo 13, lettera b), della Convenzione dell'Aia riguardava solo le situazioni che vanno oltre ciò che un minore potrebbe ragionevolmente tollerare. Nel caso di specie, la ricorrente aveva presentato alla corte d'appello lettone un certificato rilasciato da uno psicologo attestante che la minore avrebbe potuto subire un trauma qualora fosse stata immediatamente separata dalla madre. Benché spettasse ai giudici nazionali verificare l'esistenza di un "fondato rischio" per la minore e la perizia psicologica fosse direttamente collegata all'interesse superiore della minore, il tribunale regionale si era rifiutato di esaminare le conclusioni di tale perizia alla luce delle disposizioni dell'articolo 13, lettera b), della Convenzione dell'Aia. Al tempo stesso, i giudici nazionali non avevano valutato se per la madre fosse possibile seguire la figlia in Australia e intrattenere contatti con lei. I giudici nazionali non avevano preso effettivamente in considerazione le affermazioni della ricorrente e, di conseguenza, il processo decisionale previsto dalla legge lettone non aveva rispettato i requisiti procedurali prescritti dall'articolo 8 della CEDU e la ricorrente aveva subito un'ingerenza sproporzionata nel suo diritto al rispetto della propria vita familiare.

6 Accoglienza eterofamiliare e adozione

UE	Argomenti trattati	CdE
Carta dei diritti fondamentali, articolo 7 (vita familiare) e articolo 24 (diritti del minore) Regolamento Bruxelles II bis (2201/2003)	**Accoglienza eterofamiliare**	CEDU, articolo 8 (diritto al rispetto della vita privata e familiare) CSE (riveduta), articolo 17 (diritto dei bambini e degli adolescenti ad una tutela sociale, giuridica ed economica) Corte EDU, *Wallová e Walla c. Repubblica ceca,* n. 23848/04, 2006 (collocamento al di fuori della famiglia a causa della mancanza di un'abitazione idonea) Corte EDU, *Saviny c. Ucraina,* n. 39948/06, 2008 (collocamento al di fuori della famiglia a causa di problemi socioeconomici) Corte EDU, *B. c. Romania (n. 2),* n. 1285/03, 2013 (coinvolgimento dei genitori nel processo decisionale) Corte EDU, *B.B. e F.B. c. Germania*, nn. 18734/09 e 9424/11, 2013 (vizi di procedura nel processo decisionale) Corte EDU, *Olsson c. Svezia (n. 1),* n. 10465/83, 1988 (esecuzione di un'ordinanza di collocamento fuori della famiglia) Corte EDU, *T. c. Repubblica ceca,* n. 19315/11, 2014 (importanza di intrattenere contatti)

UE	Argomenti trattati	CdE
Carta dei diritti fondamentali dell'UE, articolo 24 (diritti del bambino)	**Adozione**	Convenzione europea sull'adozione dei minori (riveduta) Corte EDU, *Pini e altri c. Romania*, nn. 78028/01 e 78030/01, 2004 (priorità dell'interesse del minore nell'adozione) Corte EDU, *Kearns c. Francia*, n. 35991/04, 2008 (consenso dei genitori all'adozione). Corte EDU, *E.B. c. Francia* [GC], n. 43546/02, 2008 (possibilità di adozione da parte di una donna lesbica) Corte EDU, *Gas e Dubois c. Francia*, n. 25951/07, 2012 (possibilità di adozione da parte di una coppia gay) Corte EDU *X e altri c. Austria* [GC], n. 19010/07, 2013 (adozione coparentale da parte di una coppia omosessuale) Corte EDU, *Harroudj c. Francia*, n. 43631/09, 2012 (kafala e adozione)

Ogni minore ha diritto al rispetto della vita familiare, un diritto riconosciuto ai sensi dell' articolo 7 della Carta dei diritti fondamentali dell'UE e dell'articolo 8 della Convenzione europea dei diritti dell'uomo (CEDU) (cfr. il capitolo 5). Sia la legislazione dell'UE sia il diritto del Consiglio d'Europa riflettono l'importanza delle relazioni familiari per il minore, fra cui rientra anche il diritto del minore a non essere privato del contatto con i genitori, a meno che ciò non sia contrario al suo interesse superiore.[191] È difficile trovare il giusto equilibrio tra l'intento di garantire la permanenza del minore presso la famiglia d'origine (in linea con il rispetto della vita familiare) e l'esigenza di tutelare la sua integrità personale. Quando è allontanato dalla sua famiglia, un minore può essere collocato in affidamento o in accoglienza residenziale. La vita familiare non si conclude con questa separazione e richiede il mantenimento dei contatti allo scopo di sostenere il ricongiungimento familiare qualora ciò risponda all'interesse superiore del minore. In talune circostanze si procederà all'allontanamento permanente attraverso l'adozione. Ai fini dell'adozione è necessario rispettare rigorosi requisiti.

Obiettivo del presente capitolo è quello di esaminare il diritto europeo in materia di accoglienza alternativa. Il diritto dell'UE, principalmente attraverso il

191 UE (2012), Carta dei diritti fondamentali dell'Unione europea (GU C 326 del 26.10.2012), articolo 24, paragrafo 3.

regolamento Bruxelles II *bis*, si occupa degli aspetti procedurali transfrontalieri connessi al collocamento dei minori in accoglienza eterofamiliare. Il suddetto regolamento deve essere interpretato conformemente alla Carta dei diritti fondamentali dell'UE, in particolare l'articolo 24. La Corte EDU ha a sua volta sviluppato un ampio *corpus* giurisprudenziale riguardo alle questioni sia sostanziali che procedurali inerenti il collocamento dei minori in accoglienza eterofamiliare.

Il paragrafo 6.1 inizia introducendo alcuni dei principi generali che disciplinano la situazione dei minori privati dell'assistenza familiare, il paragrafo 6.2 illustra la legislazione concernente il collocamento del minore in accoglienza eterofamiliare e il paragrafo 6.3 esamina le norme europee in materia di adozione.

6.1. Accoglienza alternativa: principi generali

Punti salienti

- L'accoglienza eterofamiliare è una misura di protezione temporanea.
- Il diritto internazionale conferma che l'accoglienza su modello familiare deve essere privilegiata rispetto all'accoglienza residenziale.
- I minori hanno diritto ad essere informati e ad esprimere il loro parere riguardo al collocamento in accoglienza eterofamiliare.

Nell'ambito del diritto dell'UE, del Consiglio d'Europa e del diritto internazionale, considerati nel loro complesso, emergono sei ampi principi riguardanti l'accoglienza eterofamiliare.

Innanzitutto, l'accoglienza eterofamiliare è una misura di protezione che garantisce la sicurezza temporanea dei minori e ne agevola il ritorno presso le loro famiglie, ove possibile.[192] Idealmente, quindi, si configura come una soluzione temporanea. Talvolta si tratta invece di una misura di protezione in attesa del

192 ONU, Assemblea generale, *Linee guida dell'ONU sull'accoglienza eterofamiliare*, 24 febbraio 2010, A/RES/64/142, punti 48–51; ONU, Comitato sui diritti dell'infanzia (2013), *Commento generale n. 14 (2014), Il diritto del minore a che il suo interesse superiore sia tenuto in primaria considerazione (articolo 3, paragrafo 1)*, documento ONU CRC/C/GC/14, 29 maggio 2013, paragrafi 58–70.

ricongiungimento familiare, per esempio dei minori migranti separati o non accompagnati dalle loro famiglie.[193] In altri casi è una misura di protezione attuata in attesa di sviluppi nell'ambito della vita familiare, per esempio di miglioramenti della salute di un genitore o di disposizione di sostegno ai genitori.

In secondo luogo, il diritto internazionale conferma che l'accoglienza sul modello familiare (ad esempio, l'affidamento) è la forma ottimale di accoglienza alternativa al fine di garantire la protezione e lo sviluppo dei minori, come affermano le Linee guida dell'ONU sull'accoglienza eterofamiliare e la Convenzione dell'ONU sui diritti delle persone con disabilità (CRPD), di cui l'UE è parte.[194] La convenzione CRPD afferma espressamente che "gli Stati parti s'impegnano, qualora i familiari più stretti non siano in condizioni di prendersi cura di un minore con disabilità, a non tralasciare alcuno sforzo per assicurare una sistemazione alternativa all'interno della famiglia allargata e, ove ciò non sia possibile, all'interno della comunità in un contesto familiare".[195] L'accoglienza eterofamiliare (ad esempio l'accoglienza residenziale) "dovrebbe essere limitata ai casi dove tale opzione risulti appropriata, necessaria e costruttiva per il bambino coinvolto e per i suoi interessi".[196]

In terzo luogo, il diritto del minore ad avere un tutore o un rappresentante è fondamentale al fine di tutelare i suoi diritti più ampi.[197] Benché il diritto dell'Unione non preveda espressamente l'obbligo generale di nominare un tutore per i minori privati dell'assistenza genitoriale, sono almeno sette le direttive dell'UE che impongono la nomina, da parte degli Stati membri, di un tutore per i minori in contesti differenti, alcuni dei quali riguardano direttamente i minori privati dell'assistenza genitoriale.[198] Tale *corpus* giurisprudenziale è peraltro corroborato dalle Linee guida dell'ONU sull'accoglienza eterofamiliare (riguardanti, in ge-

193 ONU, Assemblea generale, Convenzione sui diritti del fanciullo, 20 novembre 1989, articolo 22; ONU, Comitato sui diritti dell'infanzia (2005), *Commento generale n. 6 (2005), Trattamento dei bambini separati dalle proprie famiglie e non accompagnati, fuori dal loro paese d'origine*, doc. ONU CRC/GC/2005/6, 1 settembre 2005, paragrafi 81–83.

194 ONU, Assemblea generale, *Linee guida dell'ONU sull'accoglienza eterofamiliare*, 24 febbraio 2010, A/RES/64/142, punti 20–22; Comitato sui diritti dell'infanzia (2006), *Commento generale n. 7 (2005), Attuazione dei diritti del bambino nella prima infanzia*, doc. ONU CRC/C/GC/7/Rev.136 (b), 20 settembre 2006, paragrafo 18. Nazioni Unite, Convenzione sui diritti delle persone con disabilità (CRPD), 13 dicembre 2006, articolo 23, paragrafo 5 (cfr. anche l'articolo 7).

195 ONU, Convenzione sui diritti delle persone con disabilità (CRPD), 13 dicembre 2006, articolo 23, paragrafo 5.

196 ONU, Assemblea generale, *Linee guida dell'ONU sull'accoglienza eterofamiliare*, 24 febbraio 2010, A/RES/64/142, paragrafo 21.

197 FRA (2014a), pag. 31.

198 *Ibid.*, pag. 14.

nerale, i minori privati dell'assistenza genitoriale), dalla CRC (specialmente per quel che riguarda i minori non accompagnati) e dalla Convezione del Consiglio d'Europa sulla lotta contro la tratta di esseri umani.[199] Nella maggior parte dei casi il ruolo di un tutore legale è salvaguardare l'interesse superiore del minore, tutelare il suo benessere generale e integrare la sua limitata capacità giuridica (e, talvolta, anche esercitare la rappresentanza legale).[200]

In quarto luogo, l'articolo 24 della Carta dei diritti fondamentali dell'UE comporta implicitamente l'obbligo giuridico di adottare misure positive volte a garantire che il processo decisionale sul collocamento di un minore sia orientato dal principio del suo interesse superiore[201] e dalle sue opinioni.[202] I commenti generali numero 5 e 14 del comitato sui diritti dell'infanzia,[203], al pari delle Linee guida dell'ONU sull'accoglienza eterofamiliare, sottolineano la necessità di garantire sia il diritto del minore di essere informato, riguardo anche ai suoi diritti e alle opzioni a sua disposizione, sia il diritto del bambino "di essere consultato e di vedere la propria volontà presa in considerazione, nel rispetto delle sue capacità".[204]

In quinto luogo, i più ampi diritti dei minori sanciti dalla Carta dei diritti fondamentali dell'UE, dalla CEDU e dalla CRC rimangono applicabili anche ai casi di accoglienza eterofamiliare (affidamento o accoglienza residenziale). In quest'ambito rientrano i loro diritti civili e politici (ovvero i loro diritti al rispetto della vita privata, alla libertà di espressione e alla libertà di religione e alla protezione da tutte

199 ONU, Assemblea generale (2010), *Linee guida dell'ONU sull'accoglienza eterofamiliare*, 24 febbraio 2010, A/RES/64/142, paragrafi 100–103; ONU, Comitato sui diritti dell'infanzia (2005), *Commento generale n. 6 (2005), Trattamento dei bambini separati dalle proprie famiglie e non accompagnati, fuori dal loro paese d'origine*, doc. ONU CRC/GC/2005/6, 1 settembre 2005, paragrafi 33–38; Consiglio d'Europa, Convenzione sulla lotta contro la tratta di esseri umani, STCE n. 197, 16 maggio 2005, articolo 10, paragrafo 4.

200 FRA (2014a), pag. 15.

201 ONU, Comitato sui diritti dell'infanzia (2009), *Commento generale n. 12 (2009), Il diritto del bambino e dell'adolescente di essere ascoltato*, doc. ONU CRC/C/GC/12, 20 luglio 2009, paragrafo 97.

202 ONU, Comitato sui diritti dell'infanzia (2013), *Commento generale n. 14 (2013), Il diritto del minore a che il suo interesse superiore sia tenuto in primaria considerazione (articolo 3, paragrafo 1)*, doc. CRC/C/GC/14, 29 maggio 2013.

203 ONU, Assemblea generale (2010), *Linee guida dell'ONU sull'accoglienza eterofamiliare*, 24 febbraio 2010, A/RES/64/142, paragrafo 6.

204 ONU, Comitato sui diritti dell'infanzia, *Commento generale n. 14,* paragrafo 15, lettera g), 29 maggio 2013; *Commento generale n. 5*, paragrafo 24, 27 novembre 2003

le forme di violenza) nonché i loro diritti socioeconomici (compresi i loro diritti all'istruzione, all'assistenza sanitaria e alla partecipazione alla vita culturale).[205]

Infine, l'articolo 4 della CRC prevede che gli Stati adottino "tutti i provvedimenti legislativi, amministrativi e altri" per attuare la convenzione. Tale prescrizione si applica anche al contesto dell'accoglienza eterofamiliare. Analogamente, l'articolo 17, paragrafo 1, lettera c), della Carta sociale europea (CSE) riveduta prevede che le parti prendano tutte le misure necessarie e appropriate miranti ad assicurare una protezione e un aiuto speciali nei confronti del bambino o dell'adolescente, temporaneamente o definitivamente privato del suo sostegno familiare.

Nell'ambito del diritto dell'UE, la CGUE ha stabilito che il regolamento Bruxelles II *bis* si applica alle decisioni di collocare un minore in accoglienza eterofamiliare. Come osservato al capitolo 5, il regolamento Bruxelles II bis integra nel suo approccio i principi sui diritti dei minori, sottolineando che occorre tenere in considerazione, tra l'altro, la necessità di garantire parità di condizioni a tutti i minori, l'interesse superiore del minore e il suo diritto di essere ascoltato.[206] A tale proposito, i "motivi di non riconoscimento delle decisioni relative alla responsabilità genitoriale", quali enunciati all'articolo 23 del regolamento Bruxelles II *bis*, sono rivelatori. L'articolo 23 stipula che le decisioni non sono riconosciute nei casi seguenti:

> *"(a) se, tenuto conto dell'interesse superiore del minore, il riconoscimento è manifestamente contrario all'ordine pubblico dello Stato membro richiesto; (b) se, salvo i casi d'urgenza, la decisione è stata resa senza che il minore abbia avuto la possibilità di essere ascoltato, in violazione dei principi fondamentali di procedura dello Stato membro richiesto [...]."*

Ai sensi del regolamento, la competenza giurisdizionale è determinata sulla base della residenza abituale del minore, con alcune limitate eccezioni, tra cui l'interesse superiore del minore (articoli 8, 12 e 15 del regolamento Bruxelles II *bis*).

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU afferma che la famiglia è l'ambiente naturale per la crescita e il benessere dei minori. Tuttavia, qualora

205 Carta dei diritti fondamentali dell'Unione europea, articoli 3–4, 7, 10–11, 14 e 24; CEDU, in particolare l'articolo 8; e CRC, articoli 13–14, 16, 19, 28, 29, 24, 31 e 37; ONU, Assemblea generale (2010), *Linee guida dell'ONU sull'accoglienza eterofamiliare*, 24 febbraio 2010, A/RES/64/142, sezione 2.

206 Regolamento Bruxelles II *bis*, preambolo. Cfr. anche il capitolo 5.

la famiglia non possa fornire al minore l'accoglienza e la protezione richieste, potrebbe rendersi necessario affidare il bambino all'accoglienza alternativa. Tale allontanamento del minore dalla famiglia costituisce un'ingerenza nel diritto al rispetto della vita familiare. La Corte EDU ha spiegato che nella maggior parte dei casi il collocamento di un minore in un contesto di assistenza eterofamiliare deve essere inteso come una misura temporanea e che, in ultima analisi, il minore deve ricongiungersi alla sua famiglia in osservanza del diritto al rispetto della vita privata e familiare di cui all'articolo 8 della CEDU.[207]

Benché la CEDU non imponga agli Stati l'obbligo specifico di fornire ai minori accoglienza e protezione, l'articolo 17 della CSE prevede che le parti prendano "tutte le misure necessarie e appropriate miranti ad assicurare una speciale protezione e l'aiuto dello Stato nei confronti del bambino o dell'adolescente, temporaneamente o definitivamente privato del suo sostegno familiare".[208]

6.2. Collocamento dei minori in accoglienza eterofamiliare

Punti salienti

- Nell'ambito del diritto del Consiglio d'Europa, il collocamento di un minore in un contesto di accoglienza eterofamiliare deve essere previsto dalla legge, perseguire un obiettivo legittimo ed essere necessario in una società democratica. L'autorità competente deve addurre motivazioni pertinenti e sufficienti.
- Nell'ambito del diritto del Consiglio d'Europa, il processo decisionale deve attenersi a determinate garanzie procedurali.

Nell'ambito del diritto del Consiglio d'Europa,[209] il collocamento del minore in un contesto di accoglienza eterofamiliare è compatibile con l'articolo 8 della CEDU

207 Corte EDU, sentenza 14 gennaio 2003, *K.A. c. Finlandia* (n. 27751/95). Il comitato dei ministri del Consiglio d'Europa ha avallato tale approccio nella sua raccomandazione in merito ai diritti dei minori che vivono in istituti di custodia, adottata il 16 marzo 2005.

208 Consiglio d'Europa, Carta sociale europea (riveduta), STE n. 163, 1996, articolo 17, paragrafo 1, lettera c).

209 Il collocamento dei minori in contesti di accoglienza eterofamiliare è inoltre oggetto di dibattito politico in seno al Consiglio d'Europa da molti anni. Cfr., ad esempio, la risoluzione (77)33 del comitato dei ministri sull'affidamento dei minori, adottata il 3 novembre 1977.

solo quando è conforme alla legge, persegue un obiettivo legittimo (quale la protezione dell'interesse superiore del minore) ed è considerato necessario in una società democratica. Quest'ultimo aspetto prevede che i giudici forniscano motivazioni sia pertinenti che sufficienti a sostegno dei mezzi utilizzati per il conseguimento dell'obiettivo perseguito.

Esempio: nel caso *Olsson c. Svezia (n. 1)*,[210] i ricorrenti avevano presentato ricorso riguardo alla decisione di collocare i loro tre figli al di fuori della famiglia. Ritenendo che la decisione sull'affidamento rientrasse nell'ambito del margine di apprezzamento dello Stato, la Corte EDU si era concentrata sulle modalità di esecuzione dell'ordinanza di collocamento. A parere della Corte, la decisione sull'affidamento avrebbe dovuto essere considerata una misura temporanea, da sospendere non appena le circostanze lo avessero permesso, giacché l'adozione non era contemplata. Le misure prese avrebbero pertanto dovuto essere coerenti con l'obiettivo ultimo di riunire la famiglia naturale. In tale ottica, la Corte EDU aveva osservato che le autorità nazionali avevano collocato i minori presso famiglie affidatarie separate, a una distanza considerevole gli uni dagli altri e dai genitori. Sebbene le autorità avessero agito in buona fede nell'esecuzione dell'ordinanza di collocamento, la Corte ha ritenuto inaccettabile che il luogo in cui sarebbero stati collocati i minori fosse stato determinato da difficoltà amministrative quali la mancanza di famiglie affidatarie adeguate o di contesti di accoglienza eterofamiliare appropriati. In un ambito così essenziale come il rispetto della vita familiare, tali considerazioni non potevano svolgere che un ruolo secondario. Di conseguenza, nel rilevare una violazione dell'articolo 8 della CEDU, la Corte EDU ha dichiarato che le misure adottate dalle autorità nell'esecuzione dell'ordinanza di collocamento non erano suffragate da motivazioni sufficienti a renderle proporzionate al legittimo scopo perseguito ai sensi dell'articolo 8.

Più di recente, la Corte EDU si è pronunciata sul merito delle decisioni di collocare i minori in contesti di accoglienza eterofamiliare ai sensi dell'articolo 8 della CEDU.

210 Corte EDU, sentenza 24 marzo 1988, *Olsson c. Svezia (n. 1)* (n.10465/83).

Esempio: nel caso *Wallová e Walla c. Repubblica ceca*[211] i ricorrenti avevano presentato ricorso riguardo al collocamento dei loro cinque figli in due diversi centri di accoglienza per minori, determinato dall'inadeguatezza della loro abitazione. I bambini erano stati affidati ai centri di accoglienza nel 2002 sulla base dell'instabilità economica dei genitori e le ordinanze di collocamento erano state revocate quando la loro situazione economica e abitativa era migliorata. La Corte EDU ha rilevato che la decisione di collocare i minori al di fuori della famiglia era stata determinata dalla mancanza di un'abitazione adeguata e che, di conseguenza, avrebbe potuto essere adottata una misura meno drastica per affrontare la loro situazione. Il diritto ceco prevedeva la possibilità di monitorare le condizioni di vita e di igiene della famiglia e di fornirle consigli sul modo di migliorare la situazione, ma questa opzione non era stata utilizzata. Pur essendo pertinenti, le motivazioni addotte per collocare i minori al di fuori della famiglia non erano sufficienti e le autorità non si erano impegnate abbastanza per aiutare i ricorrenti a superare le loro difficoltà con misure alternative. Nel concludere che era stato violato l'articolo 8 della CEDU, la Corte aveva inoltre preso atto delle conclusioni del comitato sui diritti dell'infanzia dell'ONU, il quale aveva osservato che il principio della considerazione preminente dell'interesse superiore del minore non era ancora stato adeguatamente definito e tradotto in tutte le normative, le sentenze e le politiche ceche riguardanti i minori.

Esempio: nel caso *Saviny c. Ucraina*,[212] i figli dei ricorrenti erano stati collocati al di fuori della famiglia a causa della mancanza di mezzi finanziari dei genitori e sulla scorta della conclusione del giudice nazionale, secondo cui le loro caratteristiche personali mettevano in pericolo la vita, la salute e l'educazione morale dei figli. Nell'esaminare il caso, la Corte EDU aveva messo in discussione l'adeguatezza degli elementi di prova sui quali le autorità nazionali avevano basato le loro conclusioni e aveva ritenuto insufficienti le informazioni disponibili sul livello di assistenza sociale offerto. Tali informazioni sarebbero state pertinenti al fine di valutare se le autorità avessero assolto il compito di tenere unita la famiglia e se avessero esaminato a sufficienza l'efficacia di alternative meno drastiche prima di cercare di separare i figli dai loro genitori. Inoltre, i minori non erano stati ascol-

211 Corte EDU, sentenza 26 ottobre 2006, *Wallová e Walla c. Repubblica ceca* (n. 23848/04) (consultabile in francese).

212 Corte EDU, sentenza 18 dicembre 2008, *Saviny c. Ucraina* (n. 39948/06).

tati dai giudici in alcuna fase del procedimento. In sintesi, benché fossero pertinenti, le motivazioni fornite dalle autorità nazionali per giustificare l'allontanamento dei figli dei ricorrenti non erano sufficienti a legittimare tale grave ingerenza nella vita familiare dei ricorrenti. La Corte ha concluso asserendo che vi era stata una violazione dell'articolo 8 della CEDU.

Ai sensi dell'articolo 8 della CEDU, la Corte EDU prevede che il processo decisionale riguardante il rispetto della vita familiare osservi talune garanzie procedurali. Essa afferma che il processo decisionale (procedimenti amministrativi e giudiziari) che comporta l'adozione di misure di ingerenza nella vita familiare deve essere equo e assicurare il dovuto rispetto degli interessi tutelati dall'articolo 8. Ai sensi dell'articolo 8 si esamina se "i genitori siano stati coinvolti nel processo decisionale [...] in misura sufficiente a garantire la necessaria protezione dei loro interessi".[213] Coinvolgere i genitori significa, tra l'altro, aggiornarli periodicamente sugli sviluppi, garantire che possano partecipare alle decisioni che li riguardano[214] e, in talune circostanze, ascoltare i minori interessati.[215]

Esempio: nel caso *B. c. Romania (n. 2)*,[216] la ricorrente era stata più volte sottoposta a trattamenti presso istituti psichiatrici nei quali era stata condotta dalla polizia in seguito alla diagnosi di schizofrenia paranoide. I suoi figli non vivevano più con lei ed erano stati collocati in un centro di accoglienza a causa della malattia della madre. La Corte EDU doveva stabilire se, considerata la serietà delle decisioni da adottare riguardo al collocamento dei minori al di fuori della famiglia, nel complesso il processo decisionale garantisse in misura sufficiente la necessaria protezione degli interessi dei genitori. A tale proposito, la Corte ha osservato che alla ricorrente, che soffriva di un grave disturbo mentale, non erano stati assegnati né un avvocato né un curatore che la rappresentassero durante il procedimento e, di conseguenza, per lei era stato impossibile partecipare al processo decisionale riguardante il collocamento dei figli minorenni. Inoltre, nel corso dei 12 anni precedenti al raggiungimento della maggiore età da parte dei due minori, la situazione della ricorrente e quella dei suoi figli erano state esaminate solo due volte da un giudice e non esistevano prove che

213 Corte EDU, sentenza 8 luglio 1987, *W. c. Regno Unito* (n. 9749/82), punto 64.

214 Corte EDU, sentenza 19 febbraio 2013, *B. c. Romania (n. 2)* (n. 1285/03); Corte EDU, sentenza 14 marzo 2013, *B.B. e F.B. c. Germania* (nn. 18734/09 e 9424/11).

215 Corte EDU, sentenza 24 febbraio 1995, *McMichael c. Regno Unito* (n. 16424/90).

216 Corte EDU, sentenza 19 febbraio 2013, *B. c. Romania (n. 2)* (n. 1285/03).

fossero intercorsi contatti periodici tra gli assistenti sociali e la ricorrente, che avrebbero altrimenti rappresentato uno strumento atto a illustrarne il parere alle autorità. Alla luce delle suddette constatazioni, la Corte ha concluso che il processo decisionale riguardante il collocamento in accoglienza eterofamiliare dei figli della ricorrente non aveva adeguatamente protetto i suoi interessi e, pertanto, erano stati violati i suoi diritti ai sensi dell'articolo 8 della CEDU.

Esempio: nel caso *B.B. e F.B. c. Germania*,[217] in seguito alle affermazioni della figlia dodicenne dei ricorrenti, secondo cui lei e il fratello di otto anni erano stati ripetutamente picchiati dal padre, la potestà genitoriale sui due figli era stata trasferita al tribunale dei minori e i bambini erano stati collocati in un centro di accoglienza per i minori. Il tribunale distrettuale aveva pronunciato una sentenza piena che trasferiva la potestà genitoriale dai ricorrenti all'Ufficio della gioventù, basando la sua decisione sulle testimonianze dirette dei minori. Circa un anno dopo, in occasione del primo incontro successivo con i genitori, la ragazzina aveva ammesso di avere mentito riguardo alle percosse subite e i figli erano stati infine restituiti ai genitori. Nel valutare la doglianza dei ricorrenti, secondo cui le autorità non avevano esaminato adeguatamente i fatti pertinenti, la Corte EDU ha sottolineato che un'errata valutazione da parte dei professionisti non implicava necessariamente che le misure adottate fossero incompatibili con l'articolo 8 della CEDU. La decisione riguardante il collocamento dei minori poteva essere valutata solo alla luce della situazione illustrata a suo tempo alle autorità nazionali. Nell'ambito della sua valutazione, la Corte EDU ha ritenuto significativo sia che il tribunale distrettuale si fosse basato solo sulle dichiarazioni dei minori, sebbene i ricorrenti avessero presentato perizie mediche dalle quali non emergeva alcun segno di maltrattamento, sia che la Corte d'appello non avesse riascoltato i minori. Poiché all'epoca dell'udienza di merito i minori erano stati collocati al sicuro fuori dalla famiglia, non sussisteva una situazione d'urgenza e i giudici avrebbero potuto avviare un'indagine d'ufficio sui fatti in questione, atto che invece non avevano compiuto. In sintesi, i giudici tedeschi non avevano addotto motivi sufficienti per giustificare la loro decisione di revocare la potestà genitoriale dei ricorrenti, in violazione dell'articolo 8 della CEDU.

217 Corte EDU, sentenza 14 marzo 2013, *B.B. e F.B. c. Germania* (nn. 18734/09 e 9424/11).

Anche quando sono collocati in contesti di accoglienza eterofamiliare, i bambini conservano il diritto di intrattenere contatti con i loro genitori. Tale diritto è stato riconosciuto ai sensi della CEDU.[218] La Corte EDU afferma infatti che i contatti reciproci tra genitori e figli costituiscono un elemento fondamentale della vita familiare ai sensi dell'articolo 8. Poiché il collocamento del minore in un contesto di accoglienza eterofamiliare dovrebbe di norma costituire una misura temporanea, il mantenimento delle relazioni familiari è essenziale al fine di garantire l'effettivo ricongiungimento del minore con la loro famiglia.[219] Ai sensi della CEDU, da tali principi scaturiscono obblighi positivi, quali evidenziati dai casi illustrati di seguito.

Esempio: nel caso *T. c. Repubblica ceca*,[220] la Corte EDU ha esaminato se i diritti di un padre e di una figlia (ricorrenti) fossero stati violati dal collocamento in accoglienza eterofamiliare della minore e si è inoltre pronunciata sul mancato impegno delle autorità a favorire i contatti tra i due. La minore era stata collocata in un istituto specializzato in seguito alla morte della madre e dopo che le domande del padre per ottenerne l'affidamento erano state respinte a causa delle preoccupazioni sulla personalità di quest'ultimo. Successivamente, quando aveva chiesto di trascorrere le vacanze con la figlia, questa possibilità gli era stata negata; inoltre, quando un centro terapeutico aveva concluso che le visite non giovavano alla bambina poiché la figlia aveva paura di lui, era terminato ogni contatto. In seguito i giudici avevano stabilito che i due ricorrenti avrebbero potuto intrattenere contatti solo per iscritto, conformemente al volere della bambina. La Corte EDU ha evidenziato tra l'altro l'interesse del minore a mantenere legami con la famiglia, fuorché in casi particolarmente estremi in cui ciò sia contrario al suo interesse superiore. Nell'esaminare la decisione di collocare la minore in un contesto di accoglienza eterofamiliare, la Corte EDU ha constatato con soddisfazione che le autorità nazionali avevano ponderato attentamente la loro decisione, adottata dopo aver esaminato perizie psicologiche e psichiatriche e avere tenuto conto del volere della bambina. Per quanto riguarda la decisione di collocare in accoglienza eterofamiliare la bambina, non era pertanto stato violato l'articolo 8 della CEDU. La Corte ha aggiunto che l'articolo 8 era però stato violato a seguito delle restrizioni imposte ai contatti tra i ricorrenti, in particolare a causa della scarsa lungimiranza delle decisioni di negare i contatti con il padre da parte dell'istituto

218 Corte EDU, sentenza 24 marzo 1988, *Olsson c. Svezia (n. 1)* (n. 10465/83).

219 Corte EDU, sentenza 22 giugno 1989, *Eriksson c. Svezia* (n. 11373/85).

220 Corte EDU, sentenza 17 luglio 2014, *T. c. Repubblica ceca* (n. 19315/11) (consultabile in francese).

residenziale presso cui era collocata la bambina, poiché, in ultima analisi, tali decisioni riducevano le possibilità di un ricongiungimento familiare.

Esempio: nel caso *K.A. c. Finlandia*,[221] i figli del ricorrente erano stati affidati all'accoglienza alternativa in seguito al sospetto che fossero stati oggetto di abusi sessuali. Durante il collocamento dei minori al di fuori della famiglia, i contatti intercorsi tra loro e i genitori erano stati scarsi ed erano stati compiuti pochi sforzi per pianificare il loro ricongiungimento. Nell'esaminare il caso, la Corte EDU ha osservato che lo Stato aveva l'obbligo positivo di favorire il ricongiungimento familiare non appena fosse stato ragionevolmente possibile, tenendo conto dell'obbligo di proteggere l'interesse superiore del minore. Secondo la Corte EDU, le rigorose restrizioni al diritto del ricorrente di fare visita ai figli riflettevano l'intenzione dell'ente di assistenza sociale di rafforzare i legami tra i minori e la famiglia affidataria anziché di ricongiungerli alla famiglia d'origine. Tale decisione era stata adottata nonostante fosse stato rilevato un miglioramento nella situazione del padre. La Corte ha riscontrato una violazione dell'articolo 8 CEDU.

6.3. Adozione

Punti salienti

- L'adozione garantisce il collocamento in accoglienza eterofamiliare ai minori che non possono rimanere con le loro famiglie biologiche.
- L'interesse superiore del minore deve essere considerato preminente nell'ambito dell'adozione.
- Né l'UE né il Consiglio d'Europa sanciscono il diritto all'adozione, ma, per rispondere all'interesse superiore del minore, il processo di adozione deve rispettare determinati criteri.[222]

Per quanto riguarda il diritto internazionale, l'interesse superiore del minore deve essere considerato preminente nei casi di adozione. Oltre al principio dell'interesse superiore, anche altri principi generali della CRC ne orientano e informano l'attuazione nel contesto dell'adozione: la non discriminazione, il diritto alla

221 Corte EDU, sentenza 14 gennaio 2003, *K.A. c. Finlandia* (n. 27751/95).

222 In merito all'interesse del minore a conoscere le proprie origini nel contesto dell'adozione, cfr. il capitolo 4.

vita, la sopravvivenza e lo sviluppo nonché il rispetto delle opinioni dei minori.[223] Particolarmente pertinente è il commento generale n. 14 del comitato sui diritti dell'infanzia dell'ONU sul "diritto del minore a che il suo interesse superiore sia tenuto in primaria considerazione".[224]

Analogamente, uno degli obiettivi della Convenzione dell'Aia sulla protezione dei minori e la cooperazione in materia di adozione internazionale è "di stabilire delle garanzie, affinché le adozioni internazionali si facciano nell'interesse superiore del minore e nel rispetto dei diritti fondamentali che gli sono riconosciuti nel diritto internazionale".[225]

Nell'ambito del diritto dell'UE, i diritti e gli obblighi giuridici associati di cui all'articolo 24 della Carta dei diritti fondamentali dell'UE sono applicabili all'adozione nella misura in cui siano contemplati dall'UE.

Nell'ambito del diritto del Consiglio d'Europa, il diritto al rispetto della vita familiare sancito all'articolo 8 della CEDU è applicabile e invocato nei casi di adozione. Sull'argomento esistono anche due convenzioni specifiche del Consiglio d'Europa: la Convenzione europea sull'adozione dei minori[226] e la Convenzione europea sull'adozione dei minori (riveduta).[227] Tali strumenti richiedono un approccio all'adozione basato sui diritti dei minori. La Convenzione europea sull'adozione dei minori (riveduta), per esempio, stipula che "[l]'autorità competente autorizza l'adozione solo qualora sia appurato che l'adozione risponderà all'interesse superiore del minore".[228] Analogamente, la Corte EDU sottolinea che, in talune circostanze, tra cui l'adozione, l'interesse superiore del minore può prevalere su quello del genitore.[229] La Convenzione europea sull'adozione dei minori (rivedu-

223 CRC, articoli 2, 3, 6 e 12. Cfr. anche ONU, Comitato sui diritti dell'infanzia (2010), Linee guida generali concernenti la forma e il contenuto dei rapporti periodici che gli Stati parti devono presentare conformemente all'articolo 44, paragrafo 1, lettera b), della Convenzione sui diritti del fanciullo, doc. ONU CRC/C/58/Rev.2, 23 novembre 2010, paragrafi 23–27.

224 ONU, Comitato sui diritti dell'infanzia (2013), *Commento generale n. 14 (2013), Il diritto del minore a che il suo interesse superiore sia tenuto in primaria considerazione*, CRC/C/GC/14, articolo 3, paragrafo 1.

225 Conferenza dell'Aia sul diritto internazionale privato, Convenzione dell'Aia sulla protezione dei minori e sulla cooperazione in materia di adozione internazionale, 29 maggio 1993, articolo 1, lettera a).

226 *Ibid.* Questa convenzione è stata aperta alla firma nel 2008 ed è entrata in vigore nel 2011.

227 Consiglio d'Europa, Convenzione europea sull'adozione dei minori (riveduta), STCE n. 202, 27 novembre 2008.

228 *Ibid*, articolo 4, paragrafo 1.

229 Corte EDU, sentenza 22 giugno 2004, *Pini e altri c. Romania* (nn. 78028/01 e 78030/01).

ta) prescrive inoltre che l'adozione non sia autorizzata dall'autorità competente senza "il consenso del minore ritenuto dotato di una sufficiente capacità di discernimento secondo le disposizioni del diritto interno".[230] Inoltre, qualora non sia considerato dotato della sufficiente capacitàˆ di discernimento, il minore sarà "per quanto possibile, consultato e saranno presi in considerazione il suo volere e le sue opinioni tenendo conto del suo grado di maturità".[231]

Esempio: nel caso *Pini e altri c. Romania*,[232] due coppie italiane avevano presentato ricorso poiché le autorità rumene non avevano dato esecuzione alla decisione di un giudice rumeno riguardo alla loro adozione di due bambini rumeni. In violazione dei provvedimenti del giudice, l'istituto privato presso cui i bambini risiedevano in Romania si era rifiutato di consegnarli ai ricorrenti. La Corte EDU ha stabilito che la relazione tra i ricorrenti e i loro figli adottivi rientrava nella sfera della vita familiare ai sensi dell'articolo 8 della CEDU anche se non avevano mai vissuto insieme né avevano instaurato legami emotivi. Nell'esaminare il caso, la Corte EDU ha interpretato l'articolo 8 alla luce della CRC e della Convenzione dell'Aia, rilevando che l'obbligo positivo delle autorità di fare in modo che i ricorrenti fossero in grado di instaurare legami familiari con i loro figli adottivi era limitato dall'interesse superiore del minore.[233] A tale proposito, la Corte ha stabilito che, a seconda della sua natura e gravità, l'interesse del minore può prevalere su quello del genitore. Inoltre, nel non riscontrare alcuna violazione dell'articolo 8, la Corte ha sottolineato che, in una relazione basata sull'adozione, è importante che l'interesse superiore del minore prevalga su quello dei genitori, poiché la finalità dell'adozione è donare una famiglia a un bambino, non un bambino a una famiglia.[234]

Esempio: nel caso *Kearns c. Francia*,[235] la Corte EDU ha ritenuto compatibile con la CEDU il fatto che una donna irlandese, che aveva autorizzato l'adozione della figlia in Francia, non potesse revocare il suo consenso formale all'adozione allo scadere di un periodo di due mesi. La Corte EDU ha

230 Consiglio d'Europa, Convenzione europea sull'adozione dei minori (riveduta), STCE n. 202, 27 novembre 2008, articolo 5, paragrafo 1, lettera b).

231 *Ibid.*, articolo 6.

232 Corte EDU, sentenza 22 giugno 2004, *Pini e altri c. Romania* (nn. 78028/01 e 78030/01).

233 *Ibid.*, punto 155.

234 *Ibid.*, punto 156.

235 Corte EDU, sentenza 10 gennaio 2008, *Kearns c. Francia* (n. 35991/04).

innanzitutto sottolineato che il rifiuto opposto dalle autorità nazionali alla richiesta di restituzione della bambina perseguiva il legittimo obiettivo di proteggere le libertà e i diritti altrui, nel caso di specie quelli della bambina.[236] Quanto all'imposizione di un limite temporale per la revoca del consenso, la normativa francese era finalizzata a conseguire un giusto equilibrio e a garantire la proporzionalità tra gli interessi concorrenti della madre biologica, della bambina e della famiglia adottiva. In tale processo, doveva essere considerato preminente l'interesse superiore della minore.[237] Dagli elementi di prova presentati alla Corte è emerso che era nell'interesse superiore della minore beneficiare quanto più rapidamente possibile di relazioni stabili all'interno di una nuova famiglia ed erano state adottate tutte le misure necessarie affinché la ricorrente comprendesse le implicazioni esatte del suo gesto. Alla luce delle suddette considerazioni, la Corte ha stabilito che la Francia aveva ottemperato ai suoi obblighi positivi nei confronti della ricorrente ai sensi dell'articolo 8 della CEDU.

La Corte EDU ha inoltre affermato che il processo decisionale in materia di adozione deve essere attuato coerentemente al divieto di discriminazione di cui all'articolo 14 della CEDU. In particolare, la Corte EDU ha esaminato se l'esclusione dei ricorrenti dall'ammissibilità all'adozione sulla base dell'orientamento sessuale o dell'età fosse compatibile con l'articolo 14 in combinato disposto con l'articolo 8. Nell'ambito di tale valutazione ha ribadito che il dovere di adottare misure proporzionate al fine di proteggere l'interesse superiore del minore ha un'importanza fondamentale.

Esempio: nel caso *Schwizgebel c. Svizzera*,[238] alla ricorrente, una donna non coniugata di 47 anni, era stata negata la possibilità di adottare un secondo bambino sulla base della differenza di età tra lei e il minore che intendeva adottare. La ricorrente sosteneva di essere stata discriminata sulla base dell'età. La Corte EDU ha ritenuto che, nel caso della ricorrente, la decisione di non autorizzare l'adozione perseguiva il legittimo obiettivo di proteggere il benessere e i diritti del minore.[239] Considerati la mancanza di un consenso europeo riguardo al diritto di adozione da parte di un genitore non coniugato, i limiti inferiori e superiori d'età degli adottanti e la differenza

236 *Ibid.*, punto 73.

237 *Ibid.*, punto 79.

238 Corte EDU, sentenza 10 giugno 2010, *Schwizgebel c. Svizzera* (n. 25762/07).

239 *Ibid.*, punto 86.

d'età tra l'adottante e il minore e il conseguente ampio margine di apprezzamento dello Stato in quest'ambito, nonché la necessità di tutelare l'interesse superiore dei minori, il rifiuto di autorizzare l'adozione di un secondo bambino non violava il principio della proporzionalità.[240] La Corte ha pertanto reputato oggettiva e ragionevole la giustificazione fornita dal governo e ha ritenuto che la disparità di trattamento lamentata dalla ricorrente non fosse stata discriminatoria ai sensi dell'articolo 14 della CEDU.

Esempio: il caso *E.B. c. Francia*[241] riguarda il rifiuto delle autorità nazionali di concedere l'autorizzazione all'adozione alla ricorrente, una donna lesbica convivente con la compagna, intenzionata ad adottare un bambino in qualità di persona non coniugata.[242] La Corte ha ribadito che, di per sé, l'articolo 8 della CEDU non conferiva il diritto né di costituire una famiglia né di adottare. Un ricorso per discriminazione poteva tuttavia rientrare nel più vasto campo di applicazione di un determinato diritto, anche nel caso in cui l'oggetto della questione non riguardasse uno specifico diritto conferito dalla CEDU.[243] Poiché il diritto francese consentiva l'adozione di un minore da parte di un soggetto non sposato, tale diritto non poteva essere negato a una persona per motivi discriminatori. Come stabilito dai giudici nazionali, la ricorrente presentava delle qualità umane ed educative incontestabili, il che serviva sicuramente l'interesse superiore del minore, nozione chiave degli strumenti internazionali rilevanti.[244] A parere della Corte, l'orientamento sessuale della ricorrente aveva svolto un ruolo determinante nel rifiuto delle autorità di concederle l'autorizzazione all'adozione, decisione che aveva comportato un trattamento discriminatorio rispetto ad altre persone non sposate aventi il diritto di adottare ai sensi della normativa nazionale.[245]

Esempio: nel caso *Gas e Dubois c. Francia*[246] la Corte doveva stabilire se le coppie omosessuali avessero lo stesso diritto all'adozione coparentale delle coppie eterosessuali. Le ricorrenti erano una coppia omosessuale che

240 *Ibid.*, punto 97.

241 *Ibid.*, punto 49.

242 Corte EDU, sentenza 22 gennaio 2008, *E.B. c. Francia* [GC] (n. 43546/02).

243 *Ibid.*, punti 41–48.

244 *Ibid.*, punto 95.

245 *Ibid.*, punto 96.

246 Corte EDU, sentenza 15 marzo 2012, *Gas e Dubois c. Francia* (n. 25951/07).

aveva contratto un'unione civile. Insieme avevano cresciuto una figlia, che era stata concepita grazie alla procreazione assistita ed era stata data alla luce da una delle due conviventi nel 2000. La domanda di adozione semplice presentata dall'altra convivente era stata respinta perché l'adozione avrebbe privato la madre biologica della bambina dei suoi diritti genitoriali, eventualità che sarebbe stata contraria sia alle intenzioni della ricorrente che all'interesse superiore del minore. Ai sensi del diritto francese, un'adozione semplice non comporta il trasferimento dei diritti dei genitori biologici al genitore adottivo solo nel caso in cui una persona adotti il/la figlio/a del proprio coniuge. Le ricorrenti sostenevano di avere subito un trattamento discriminatorio rispetto alle coppie eterosessuali sia sposate che non sposate. Nell'esaminare se le ricorrenti fossero state discriminate rispetto a una coppia sposata, la Corte EDU ha concluso che il matrimonio conferisce uno status particolare e comporta conseguenze sociali, personali e giuridiche; pertanto, non si poteva affermare che le ricorrenti si trovassero in una situazione significativamente simile a quella delle coppie sposate. Per quanto riguarda il confronto con le coppie eterosessuali non sposate, la Corte ha concluso che, conformemente alle disposizioni dell'ordinamento francese, sarebbe negata l'autorizzazione all'adozione semplice anche a una coppia eterosessuale che abbia contratto un'unione civile in una situazione comparabile. La Corte EDU non ha dunque ravvisato alcuna disparità di trattamento sulla base dell'orientamento sessuale e, di conseguenza, non ha riscontrato alcuna violazione dei diritti delle ricorrenti sanciti dalla convenzione.

Esempio: il caso *X e altri c. Austria*[247] riguarda un ricorso presentato da una coppia omosessuale che era stata discriminata rispetto alle coppie eterosessuali riguardo all'adozione coparentale. La prima e la terza ricorrente vivevano una relazione stabile e la prima ricorrente voleva adottare il secondo ricorrente, che era il figlio della terza ricorrente. Come nel caso *Gas e Dubois*, la Corte EDU non ha ritenuto che la situazione delle ricorrenti fosse assimilabile a quella di una coppia sposata nella quale uno dei coniugi desideri adottare il figlio dell'altro. La Corte EDU ha tuttavia riconosciuto che la situazione delle ricorrenti era assimilabile a quella di una coppia eterosessuale non sposata. Sebbene la legislazione austriaca permetta l'adozione coparentale alle coppie eterosessuali non sposate, il codice civile austriaco stabilisce che chiunque adotti un minore sostituirà il genitore bio-

247 Corte EDU, sentenza 19 febbraio 2013, *X e altri c. Austria* [GC] (n. 19010/07).

logico dello stesso sesso. Questo significa che per le coppie omosessuali è giuridicamente impossibile accedere all'adozione coparentale. La Corte ha concluso che, in tali condizioni, le ricorrenti erano state vittime di una disparità di trattamento a causa del loro orientamento sessuale e che il governo non aveva fornito motivi sufficientemente solidi e convincenti, in violazione dell'articolo 14 in combinato disposto con l'articolo 8 della CEDU.

Infine, la Corte EDU concentra la sua attenzione anche sul merito di attenersi allo spirito e alla finalità del diritto internazionale per quanto riguarda il processo decisionale in materia di adozione.

Esempio: nel caso *Harroudj c. Francia*[248] le autorità francesi avevano respinto l'istanza in cui la ricorrente chiedeva l'adozione piena di una bambina algerina che era stata abbandonata alla nascita e le era stata affidata mediante lo strumento della *kafala* (tutela dei minori ai sensi del diritto islamico). Tale rifiuto era stato motivato dal fatto che il codice civile francese stabilisce che non può essere adottato un minore il cui paese di origine vieta l'adozione (non ammessa dal diritto algerino) e dal fatto che la *kafala* aveva già conferito alla ricorrente la potestà genitoriale che le permetteva di prendere decisioni nell'interesse superiore della minore. Un successivo ricorso era stato respinto poiché l'ordinamento nazionale era conforme alla Convenzione dell'Aia sulla protezione dei minori e la cooperazione in materia di adozione internazionale e poiché l'articolo 20 della CRC riconosceva che la *kafala* tutelava l'interesse superiore del minore al pari dell'adozione. Nell'esaminare il ricorso della ricorrente, la Corte EDU aveva rammentato il principio secondo il quale, una volta instaurato un legame familiare, lo Stato deve agire in modo da permettere a tale legame di svilupparsi e garantire una protezione giuridica che renda possibile l'integrazione del minore nella famiglia, ricordando altresì la necessità di interpretare la CEDU in armonia con i principi generali del diritto internazionale. Nella sua valutazione la Corte EDU ha evidenziato la volontà dei giudici francesi di rispettare lo spirito e la finalità delle convenzioni internazionali, tra cui la Convenzione dell'ONU sui diritti del fanciullo. La *kafala* era riconosciuta nell'ordinamento francese e la ricorrente poteva esercitare la potestà genitoriale e adottare decisioni nell'interesse della minore. Ad esempio, aveva la possibilità di redigere un testamento a favore della bambina, superando le difficoltà derivanti dalle restrizioni all'adozione. In conclusione, ovviando

248 Corte EDU, sentenza 4 ottobre 2012, *Harroudj c. Francia* (n. 43631/09).

in tal modo gradualmente al divieto di adozione, lo Stato convenuto, che intendeva favorire l'integrazione dei minori di origine straniera senza recidere immediatamente il legame con le leggi del Paese d'origine, ha mostrato rispetto nei confronti del pluralismo culturale, garantendo il giusto equilibrio tra l'interesse pubblico e quello della ricorrente. La Corte EDU non ha dunque ravvisato alcuna violazione dei diritti della ricorrente.

7 Protezione dei minori contro la violenza e lo sfruttamento

UE	Argomenti trattati	Consiglio d'Europa
Direttiva relativa alla lotta contro l'abuso e lo sfruttamento sessuale dei minori e la pornografia minorile (2011/93/UE)	**Violenza nelle scuole, a casa e in altri contesti**	CEDU, articoli 2 (diritto alla vita), 3 (trattamenti inumani o degradanti) e 8 (integrità fisica); Protocollo n. 1 alla CEDU, articolo 2 (diritto all'istruzione) Corte EDU, *Kayak c. Turchia,* n. 60444/08, 2012 (accoltellamento nei pressi di una scuola) Corte EDU, *O'Keeffe c. Irlanda* [GC], n. 35810/09, 2014 (abusi sessuali a scuola) Corte EDU, *Campbell e Cosans c. Regno Unito,* n. 7511/76 e n. 7743/76, 1982 (punizioni corporali) CSE (riveduta), articoli 7 (diritto a una speciale protezione contro i pericoli fisici e morali) e 17 (diritto a una tutela) CEDS, *World Organisation against Torture (OMCT) c. Belgio*, ricorso n. 21/2003, 2003 (divieto di ricorso alle punizioni corporali in Belgio) Convenzione sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale (Convenzione di Lanzarote). Convenzione sulla prevenzione e la lotta contro la violenza nei confronti delle donne e la violenza domestica (Convenzione di Istanbul)

UE	Argomenti trattati	Consiglio d'Europa
Carta dei diritti fondamentali, articolo 5, paragrafo 2 (lavoro forzato o obbligatorio) Direttiva relativa ai giovani sul lavoro (94/33/CE) Direttiva sulla tratta (2011/36/UE)	**Lavoro forzato**	CEDU, articolo 4 (libertà dalla schiavitù, dal lavoro forzato e obbligatorio) Corte EDU, *C.N. e V. c. Francia*, n. 67724/09, 2012, (schiavitù; obblighi positivi dello Stato) CSE (riveduta), articolo 7, paragrafo 10 (protezione dei minori contro i pericoli fisici e morali) Convenzione del Consiglio d'Europa sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale (Convenzione di Lanzarote)
Carta dei diritti fondamentali, articolo 5, paragrafo 3 (proibizione della tratta di esseri umani) Direttiva sulla tratta (2011/36/UE)	**Tratta di minori**	CEDU, articolo 4 (libertà dalla schiavitù) Corte EDU, *Rantsev c. Cipro e Russia*, n. 25965/04, 2010 (inadempimento da parte dello Stato dell'obbligo di indagare sulle denunce di presunta tratta di esseri umani) Convenzione del Consiglio d'Europa sulla lotta contro la tratta degli esseri umani
Direttiva sulla tratta (2011/36/UE)	**Pornografia minorile**	CEDU, articolo 8 (diritto al rispetto della vita privata) Corte EDU, *Söderman c. Svezia* [GC], n. 5786/08, 2013 (riprese segrete di un minore) CSE (riveduta), articolo 7, paragrafo 10 (protezione dei minori contro i pericoli fisici e morali) Convenzione del Consiglio d'Europa sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale (Convenzione di Lanzarote) Convenzione sulla criminalità informatica
	Minori appartenenti a una minoranza	Corte EDU, *Centre for Legal Resources per conto di Valentin Câmpeanu c. Romania* [GC], n. 47848/08, 2014 (decesso di un giovane con grave disabilità in un istituto statale)
Decisione 2010/48/CE del Consiglio	**Minori con disabilità**	Corte EDU, *Nencheva e altri c. Bulgaria* [GC], n. 48609/06, 2013 (decesso di un minore in un istituto statale)
Decisione 2007/698/CE della Commissione	**Minori scomparsi**	Corte EDU, *Zorica Jovanović c. Serbia*, n. 21794/08, 2013 (diritto all'informazione)

La protezione dei minori, in senso lato, riguarda tutte le misure concepite per garantire l'esercizio dei diritti dei minori. In senso stretto, si riferisce ai diritti dei minori di vivere protetti da qualsiasi forma di violenza. Il diritto internazionale impone agli Stati l'obbligo di adottare provvedimenti che garantiscano ai minori il beneficio di godere di una protezione adeguata e di provvedere affinché i loro diritti all'integrità fisica e alla dignità siano effettivamente assicurati. Il dovere di protezione dello Stato può assumere varie forme, a seconda dello specifico rischio di violenza cui è esposto un minore e dell'autore di tali violenze. I doveri dello Stato, pertanto, sono più evidenti allorché i minori si trovano sotto l'autorità e il controllo dello Stato, per esempio quando sono affidati a istituti di assistenza pubblici. Ciò avviene quando il rischio di violenza è elevato. Lo Stato potrebbe avere più difficoltà ad adempiere il proprio dovere di protezione quando i minori sono esposti alla violenza di privati, per esempio i familiari.

La principale competenza dell'Unione Europea in questo settore riguarda i reati che presentano una dimensione transnazionale (articolo 83 del Trattato sul Funzionalmento dell'Unione Europea (TFUE)). Per questo motivo sono state emanate specifiche misure legislative in materia di pornografia minorile e tratta degli esseri umani. L'UE ha inoltre adottato una legislazione che obbliga gli Stati membri a configurare come reati varie forme di abuso sessuale. A livello di Consiglio d'Europa, la Convenzione europea dei diritti dell'uomo (CEDU), principalmente tramite gli articoli 2, 3 e 8, esplicita gli obblighi degli Stati in relazione a un ampio ventaglio di atti che costituiscono una forma di violenza contro i minori. Anche il CEDS è intervenuto in questa sfera, attraverso sia la sua procedura di segnalazione sia il meccanismo dei reclami collettivi. Sono inoltre entrate in vigore specifiche convenzioni del Consiglio d'Europa, in particolare la Convenzione del Consiglio d'Europa sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale (Convenzione di Lanzarote),[249] e sono stati costituiti gli organi di vigilanza incaricati di controllarne la messa in atto.

Il presente capitolo analizza gli aspetti specifici della violenza contro i minori e la risposta elaborata dalla comunità internazionale. Il paragrafo 7.1 prende in esame il fenomeno della violenza a casa, a scuola e in altri contesti, e si sofferma su aspetti specifici quali le punizioni corporali, gli abusi e gli episodi di incuria nei confronti dei minori, e la violenza sessuale. Il paragrafo 7.2 si occupa dei casi di sfruttamento di minori che sono contrassegnati da un'evidente dimensione transnazionale, compresi la tratta di esseri umani (finalizzata al lavoro forzato

249 Consiglio d'Europa, Convenzione sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale, STCE n. 201, 25 ottobre 2007.

o allo sfruttamento sessuale), la pornografia minorile e l'adescamento. Infine, il paragrafo 7.3 riporta esempi di abusi di minori in cui le vittime si trovano in situazioni particolarmente vulnerabili.

7.1. Violenza a casa, nelle scuole o in altri contesti

Punti salienti

- Gli Stati hanno l'obbligo di garantire che i minori siano efficacemente protetti da violenze e pregiudizi in qualsiasi contesto.
- Gli Stati sono obbligati a definire un quadro giuridico adeguato a garantire la protezione dei minori.
- Gli Stati devono condurre indagini efficaci a fronte di segnalazioni di presunti abusi/violenze/pregiudizi nei confronti di minori.

Nell'ambito del diritto dell'UE,[250] il principale strumento giuridico in questa sfera, emanato sulla base degli articoli 82 e 83 del TFUE, è la direttiva 2011/93/UE relativa alla lotta contro l'abuso e lo sfruttamento sessuale dei minori e la pornografia minorile.[251]

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU e il CEDS hanno sviluppato una nutrita giurisprudenza nella sfera della protezione dei minori contro la violenza in tutti i contesti. Inoltre, specifiche convenzioni del Consiglio d'Europa (come la Convenzione di Lanzarote) forniscono dettagliate garanzie a tutela dei minori contro specifiche forme di violenza.

7.1.1. Portata della responsabilità statale

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha passato in esame le più gravi forme di violenza contro i minori previste da vari articoli della CEDU, in particolare gli articoli 2 e 3. La Corte ha individuato chiari obblighi incombenti

250 Direttiva 2011/93/UE del Parlamento europeo e del Consiglio, del 13 dicembre 2011, relativa alla lotta contro l'abuso e lo sfruttamento sessuale dei minori e la pornografia minorile (GU L 335 del 17.12.2011, pag. 1).

251 *Ibid.*

agli Stati membri ogniqualvolta un minore sia affidato a istituzioni poste sotto la loro autorità.[252] Analogamente, se una determinata condotta o situazione raggiunge un grado di severità tale da poter essere qualificata come trattamento inumano o degradante ai sensi dell'articolo 3, lo Stato è obbligato a tutelare il minore da maltrattamenti, compresi i trattamenti somministrati da cittadini privati. Casi di negligenza di lungo termine da parte dei genitori,[253] di abusi sessuali ripetuti ad opera di insegnanti,[254] di stupri[255] o di punizioni corporali[256] sono stati riconosciuti come pertinenti all'ambito di applicazione dell'articolo 3 della CEDU.

In caso di decesso, uno Stato può essere considerato responsabile ai sensi dell'articolo 2 della CEDU anche se la morte è stata inflitta da un privato cittadino e non da un pubblico ufficiale. Gli obblighi positivi degli Stati variano da caso a caso, mentre rimane fondamentale l'obbligo di assicurare una protezione *efficace* dei minori contro la violenza. In caso di gravi forme di maltrattamento, gli obblighi positivi comprendono il diritto ad apprestare disposizioni efficaci in ambito penale, che siano sostenute dal sistema di attuazione della legge.[257] Gli Stati devono inoltre adottare misure e salvaguardie speciali per la tutela dei minori.[258]

In più occasioni la Corte EDU si è trovata a esaminare casi concernenti forme di violenza somministrate ai danni di minori da parte di privati cittadini in istituti di istruzione, abitazioni private o altri luoghi gestiti da attori non statali in cui era sorta la questione se potesse configurarsi una responsabilità dello Stato. Ancora più importante è osservare che la Corte ha stabilito che uno Stato non può esimersi dal dovere di tutelare i minori delegando l'amministrazione di importanti servizi pubblici (come l'istruzione) a privati cittadini[259]. Nei casi concernenti la determinazione della responsabilità statale, la Corte EDU solitamente ha tracciato una distinzione tra l'obbligo di tutela generale dello Stato, laddove il rischio non sia chiaramente identificabile, e uno specifico obbligo di tutela, quando la vittima sia chiaramente identificabile. Nel primo caso, la Corte EDU ha verificato

252 Corte EDU, sentenza 18 giugno 2013, *Nencheva e altri c. Bulgaria* (n. 48609/06) (consultabile in francese).

253 Corte EDU, sentenza 10 maggio 2001, *Z e altri c. Regno Unito* [GC] (n. 29392/95).

254 Corte EDU, sentenza 28 gennaio 2014, *O'Keeffe c. Irlanda* [GC] (n. 35810/09).

255 Corte EDU, sentenza 4 dicembre 2003, *M.C. c. Bulgaria* (n. 39272/98).

256 Corte EDU, sentenza 25 aprile 1978, *Tyrer c. Regno Unito* (n. 5856/72).

257 Corte EDU, sentenza 4 dicembre 2003, *M.C. c. Bulgaria* (n. 39272/98), punto 150.

258 Corte EDU, sentenza 28 gennaio 2014, *O'Keeffe c. Irlanda* [GC] (n. 35810/09), punto 146.

259 Corte EDU, sentenza 28 gennaio 2014, *O'Keeffe c. Irlanda* [GC] (n. 35810/09), punto 150; Corte EDU, sentenza 25 marzo 1993, *Costello-Roberts c. Regno Unito* (n. 13134/87), punto 27.

se l'assenza di un intervento statale non abbia determinato un rischio concreto di violenza per la vittima di minore età.

Esempio: il caso *Kayak c. Turchia*[260] riguarda la morte per accoltellamento di un ragazzino di 15 anni per mano di un altro adolescente in prossimità di una scuola. La Corte EDU ha stabilito che tutte le scuole hanno l'obbligo di proteggere gli alunni iscritti da ogni forma di violenza. Nel caso di specie la Corte ha riconosciuto la Turchia responsabile, in forza dell'articolo 2 della CEDU, della mancata protezione del diritto alla vita del figlio e fratello dei ricorrenti, non avendo posto in essere all'epoca alcun sistema di sorveglianza efficace. In assenza di un siffatto sistema, un adolescente è riuscito a impossessarsi di un coltello, sottraendolo alla cucina della scuola, e a utilizzarlo per colpire la vittima.

Esempio: il caso *O'Keeffe c. Irlanda*[261] riguarda gli abusi sessuali commessi negli anni 1970 in una scuola nazionale irlandese. In Irlanda all'epoca le scuole nazionali erano gestite e amministrate dalla Chiesa, ma riconosciute e finanziate dallo Stato. La ricorrente, che all'epoca era un'alunna della scuola, aveva subito circa 20 episodi di abusi sessuali da parte di uno degli insegnanti, abusi che tuttavia aveva denunciato alle autorità statali soltanto nel 1998, dopo essere venuta al corrente che lo stesso insegnante aveva abusato anche di altri minori. La Corte EDU doveva stabilire se lo Stato potesse essere considerato responsabile degli atti di violenza che all'epoca non erano stati denunciati alle autorità. La Corte ha dapprima constatato che gli abusi cui era stata sottoposta la ricorrente ricadevano nell'ambito di applicazione dell'articolo 3 della CEDU. Successivamente, sulla base di varie relazioni, la Corte EDU ha riscontrato che lo Stato avrebbe dovuto essere a conoscenza dei potenziali rischi di abusi su minori nelle scuole. All'epoca non esistevano procedure adeguate che avrebbero consentito a un minore o a un genitore di rivolgersi direttamente allo Stato per denunciare gli abusi. Non esistevano nemmeno meccanismi di supervisione del trattamento dei minori da parte degli insegnanti. La Corte EDU ha pertanto concluso che l'Irlanda aveva violato gli obblighi positivi discendenti dall'articolo 3 della CEDU, non avendo predisposto un meccanismo efficace di tutela dei minori dagli abusi nelle scuole.

260 Corte EDU, sentenza 10 luglio 2012, *Kayak c. Turchia* (n. 60444/08) (consultabile in francese).
261

Secondo la Corte EDU, gli Stati devono anche condurre efficaci indagini a fronte di denunce di maltrattamenti o decesso, indipendentemente dal fatto che tali atti siano stati perpetrati da agenti statali[262] o da privati cittadini. Un'indagine è efficace se, al ricevimento di una denuncia da parte di una vittima o dei suoi successori, lo Stato mette a punto una procedura in grado di portare all'identificazione e alla punizione dei responsabili degli atti di violenza contrari all'articolo 2 o all'articolo 3 della CEDU.

Nell'ambito della CSE, i diritti dei minori di protezione da abusi e maltrattamenti ricadono prevalentemente nell'ambito di applicazione degli articoli 7 e 17.

Inoltre, ai sensi della convenzione di Lanzarote, gli Stati devono prevedere come reati varie forme di abuso sessuale e sfruttamento sessuale perpetrati nei confronti di minori[263]. La convenzione prevede altresì che gli Stati adottino misure legislative o di altra natura per impedire gli abusi sessuali nei confronti di minori, organizzando campagne di sensibilizzazione, formando esperti, informando i minori dei rischi di abuso e consentendo alle persone a rischio di perpetrare abusi ai danni di minori di accedere alla consulenza di uno specialista. Inoltre, ai sensi degli articoli 4 e 5 della Convenzione del Consiglio d'Europa sulla protezione e la lotta contro la violenza nei confronti delle donne e la violenza domestica (convenzione di Istanbul),[264] gli Stati si impegnano ad adottare speciali misure legislative e a condurre indagini in relazione ad atti di violenza perpetrati nei confronti delle donne. L'articolo 22 della convenzione di Istanbul obbliga gli Stati a fornire servizi di supporto specializzati alle donne vittime di violenza domestica e ai loro bambini.

Nell'ambito del diritto internazionale, la CRC è lo strumento giuridico fondamentale per garantire la tutela dei minori a livello statale. Ai sensi dell'articolo 19 della convenzione, gli Stati parti sono tenuti ad adottare ogni misura legislativa, amministrativa, sociale ed educativa per tutelare il fanciullo contro ogni forma di violenza. Il comitato delle Nazioni Unite sui diritti dell'infanzia ha emanato un importante volume di osservazioni e raccomandazioni generali che interpretano gli obblighi degli Stati discendenti dalla CRC. Per esempio, il commento generale

262 Corte EDU, sentenza 28 ottobre 1998, *Assenov e altri c. Bulgaria* (n. 24760/94).

263 Consiglio d'Europa, Convenzione sulla protezione dei minori contro lo sfruttamento e l'abuso sessuale, STCE n. 201, 25 ottobre 2007.

264 Consiglio d'Europa, Convenzione del Consiglio d'Europa sulla prevenzione e la lotta contro la violenza nei confronti delle donne e la violenza domestica, STCE n. 210, 11 maggio 2011.

n. 13 descrive le misure atte a tutelare i minori contro ogni forma di violenza.[265] Il commento generale n. 5, d'altro canto, si riferisce alle misure volte ad rendere la CRC effettiva negli ordinamenti e nelle politiche nazionali e a supervisionarne l'attuazione.[266]

7.1.2. Punizioni corporali

È definita, in generale, punizione corporale qualsiasi azione di punizione fisica intesa a causare dolore o disagio a qualcuno. L'espressione riguarda prevalentemente le punizioni inflitte a un fanciullo con le mani o con un oggetto, ma può comportare anche azioni non fisiche, come le minacce, che abbiano lo stesso risultato finale, ovvero l'umiliazione del bambino.[267]

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha esaminato denunce di punizioni corporali comminate come forma di misura disciplinare prevalentemente ai sensi dell'articolo 3 della CEDU. La Corte EDU ha accertato una violazione di tale disposizione quando la misura raggiungeva il grado di severità previsto dall'articolo 3.[268] Le misure di punizione corporale che non superano la soglia di gravità stabilita dall'articolo 3 possono comunque ricadere nell'ambito di applicazione dell'articolo 8, che tutela il diritto all'integrità fisica e morale. Tuttavia, la Corte EDU non ha finora riscontrato violazioni dell'articolo 8 nei casi di punizioni corporali. Il ricorso alla punizione corporale nelle scuole statali può anche infrangere i diritti dei genitori di crescere i propri figli secondo le proprie convinzioni filosofiche, previsto dall'articolo 2 del Protocollo n. 1 alla CEDU.[269]

265 ONU, Comitato sui diritti dell'infanzia (2011), *Commento generale n. 13*, CRC/C/GC/13, 18 aprile 2011.

266 ONU, Comitato sui diritti dell'infanzia (2003), *Commento generale n. 5*, CRC/GC/2003/5, 27 novembre 2003.

267 ONU, Comitato sui diritti dell'infanzia, *Commento generale n. 8 (2006), Il diritto del bambino di essere protetto dalle punizioni corporali e da altre forme crudeli o degradanti di punizione* (articolo 19; articolo 28, paragrafo 2; e articolo 37, tra gli altri) (Quarantaduesima sessione, 2006), ONU doc. CRC/C/GC/8, 2 marzo 2007.

268 Corte EDU, sentenza 25 aprile 1978, *Tyrer c. Regno Unito* (n. 5856/72).

269 Corte EDU, sentenza 25 febbraio 1982, *Campbell e Cosans c. Regno Unito* (n. 7511/76 e n. 7743/76), punto 38.

Esempio: i casi *Campbell e Cosans c. Regno Unito*[270] riguardano la sospensione dalla scuola di due ragazzi che si erano rifiutati di accettare punizioni corporali. La Corte EDU non ha riscontrato una violazione dell'articolo 3 della CEDU, perché i ragazzi non erano di fatto stati sottoposti a punizioni corporali. Ha tuttavia accertato una violazione dell'articolo 2 del Protocollo n. 1 della CEDU, per il fatto che, autorizzando le punizioni corporali, lo Stato convenuto non aveva rispettato le convinzioni filosofiche dei genitori. La Corte ha altresì riscontrato la violazione del diritto all'istruzione, sancito dall'articolo 2 del Protocollo n. 1 della CEDU, di uno dei due ragazzi, che era stato sospeso dalla scuola.

La CSE non contempla un divieto esplicito di punizione corporale. Nonostante ciò, il CEDS ha interpretato in tal senso il disposto dell'articolo 17 della CSE.[271] Essendo competente a vigilare sull'osservanza dell'articolo 17 da parte degli Stati, attraverso sia la procedura di presentazione di relazioni, sia la procedura dei reclami collettivi, il CEDS ha riscontrato che alcuni Stati contraenti infrangono tale disposizione poiché non proibiscono tutte le forme di punizione corporale. In tre casi simili presentati dall'associazione "Association for the Protection of All Children (APPROACH) Ltd." rispettivamente contro Belgio,[272] Repubblica ceca[273] e Slovenia[274], il CEDS ha accertato una violazione dell'articolo 17 della CSE, poiché questi Stati erano privi di una legislazione che vietasse in maniera esplicita e generale tutte le forme di punizione corporale dei minori che possono pregiudicarne l'integrità fisica, la dignità, lo sviluppo o il benessere psicologico.[275] Il CEDS ha anche stabilito che le leggi che proibiscono le punizioni corporali dei minori devono essere applicate a talune forme di assistenza alternativa come l'assistenza istituzionale, la presa a carico in famiglie di accoglienza e le scuole materne. Si deve rammentare a tale proposito che nel 2004 l'Assemblea parlamentare del

270 Corte EDU, sentenza 25 febbraio 1982, *Campbell e Cosans c. Regno Unito* (n. 7511/76 e n. 7743/76).

271 Cfr., per esempio, CEDS, sentenza 7 dicembre 2004, *World Organisation against Torture (OMCT) c. Belgio* (ricorso n. 21/2003); CEDS, Conclusioni XVI-2, Polonia, articolo 17, paragrafo 65.

272 CEDS, sentenza 29 maggio 2015, *Association for the Protection of All Children (APPROACH) c. Belgio* (ricorso n. 98/2013), punto 49.

273 CEDS, sentenza 29 maggio 2015, *Association for the Protection of All Children (APPROACH) c. Repubblica ceca* (ricorso n. 96/2013).

274 CEDS, sentenza 27 maggio 2015, *Association for the Protection of All Children (APPROACH) c. Slovenia* (ricorso n. 95/2013).

275 CEDS, 27 maggio 2015, *Association for the Protection of All Children (APPROACH) c. Slovenia* (ricorso n. 95/2013), punto 51.

Consiglio d'Europa ha emanato una raccomandazione con cui invitava tutti gli Stati contraenti a proibire le punizioni corporali.[276]

Nell'ambito del diritto internazionale, le punizioni corporali sono indirettamente considerate una forma di violenza nei confronti dei minori che rientra nel campo di applicazione dell'articolo 19, dell'articolo 28, paragrafo 2, e dell' articolo 37 della CRC. Inoltre, il comitato sui diritti dell'infanzia ha emanato il commento generale n. 8/2006, con cui invitava gli Stati ad adottare misure appropriate contro tutte le forme di punizione corporale.[277]

7.1.3. Abusi sessuali

La tratta degli esseri umani e la pornografia minorile sono esaminati, rispettivamente, nei paragrafi 7.2.2 e 7.2.3.

Gli abusi sessuali nei confronti di minori possono assumere varie forme, comprese le molestie, le strusciate e i toccamenti, l'incesto o lo stupro. Gli abusi ai danni di minori possono aver luogo in vari contesti, compresi gli ambienti domestici, le scuole, gli istituti assistenziali, le chiese, ecc. I minori sono particolarmente vulnerabili agli abusi sessuali, poiché spesso si trovano sotto l'autorità e il controllo degli adulti e hanno meno opportunità di accesso ai meccanismi di denuncia.

Nell'ambito del diritto dell'UE, la direttiva 2011/93/UE, che riprende ampiamente l'approccio della convenzione di Lanzarote, cerca di armonizzare le sanzioni penali minime applicabili a vari reati di abuso sessuale di minori negli Stati membri.[278] Ai sensi dell'articolo 3 di tale direttiva, gli Stati membri devono adottare misure di carattere penale per garantire la punibilità di varie forme di abuso sessuale, tra cui indurre un bambino ad assistere ad atti sessuali e compiere atti sessuali con un minore. La direttiva prevede pene più elevate se gli atti sono commessi da persone che abusano di una posizione di fiducia nei confronti di minori particolarmente vulnerabili e/o fanno uso di coercizione. Inoltre, gli Stati membri devono garantire che l'azione penale contro persone sospettate di abusi su

276 Consiglio d'Europa, Assemblea parlamentare (2004), raccomandazione 1666 (2004), per la messa a bando a livello europeo delle punizioni corporali contro i bambini, 23 giugno 2004.

277 ONU, Comitato sui diritti dell'infanzia (2008), *Commento generale n. 8 (2006): Il diritto del bambino di essere protetto dalle punizioni corporali e da altre forme crudeli o degradanti di punizione (articolo 19; articolo 28, paragrafo 2; e articolo 37, tra gli altri),* CRC/C/GC/8, 2 marzo 2007.

278 Direttiva 2011/93/UE del Parlamento europeo e del Consiglio, del 13 dicembre 2011, relativa alla lotta contro l'abuso e lo sfruttamento sessuale dei minori e la pornografia minorile (GU L 335 del 17.12.2011, pag. 1).

minori scatti automaticamente e che le persone condannate per reati di abuso sessuale siano interdette dall'esercizio di attività professionali che comportano contatti diretti o regolari con minori. La direttiva prevede anche disposizioni relative a procedimenti a misura di minore e garantisce la protezione delle vittime minorenni nei tribunali.

La direttiva 2011/93/UE è correlata alla decisione quadro n. 2009/315/GAI[279] relativa all'organizzazione e al contenuto degli scambi fra gli Stati membri di informazioni estratte dal casellario giudiziario. Pur non essendo specificatamente rivolta ai minori, la decisione colma un'importante lacuna nel sistema di protezione, garantendo alle autorità degli Stati membri di avere accesso alle informazioni dei condannati registrate nel casellario giudiziario. È così facilitata l'identificazione di individui condannati per abusi sessuali in cerca di un lavoro presso istituzioni che operano con minori in altri Stati membri.

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha esaminato casi di abusi sessuali alla luce degli articoli 3 e 8 della CEDU. Le denunce generalmente riguardano la mancata adozione da parte degli Stati di misure appropriate per proteggere i minori dagli abusi. Per quanto riguarda l'articolo 3, la Corte EDU ha anche valutato se gli Stati avessero condotto indagini efficaci in relazione alle denunce di abuso sessuale. Le denunce di abusi ai danni di minori presentate ai sensi dell'articolo 8 riguardano l'impatto di tali azioni sull'integrità fisica della vittima e sul diritto al rispetto della vita familiare. Talvolta, la distinzione degli obblighi degli Stati previsti dall'articolo 3 e dall'articolo 8 è poco chiara, dal momento che la Corte EDU ricorre a ragionamenti analoghi per individuare violazioni dell'uno e dell'altro articolo. Occorre notare, tuttavia, che i casi rientranti nell'ambito di applicazione dell'articolo 8 sono stati più frequenti in situazioni di allontanamento/presa a carico ingiustificati e dell'impatto delle denunce di abuso di minori sulla famiglia. Queste situazioni sono esaminate nel capitolo 5.

Esempio: nel caso *M.C. c. Bulgaria*[280] la ricorrente era una ragazza di 14 anni che dichiarava di essere stata stuprata da due persone dopo essere uscita di casa una sera. La denuncia della ragazzina era stata archiviata dalle autorità locali, perlopiù per il fatto che non erano stati riscontrati segni di

279 Decisione quadro 2009/315/GAI del Consiglio, del 26 febbraio 2009, relativa all'organizzazione e al contenuto degli scambi fra gli Stati membri di informazioni estratte dal casellario giudiziario (GU L 93 del 7.4.2009, pagg. 23–32).

280 Corte EDU, sentenza 4 dicembre 2003, *M.C. c. Bulgaria* (n. 39272/98).

violenza fisica. La Corte EDU ha osservato che le denunce di stupro rientrano nel campo di applicazione dell'articolo 3 della CEDU e che lo Stato convenuto era tenuto a condurre un'indagine efficace in presenza di una denuncia di questo genere. Per accertare se le autorità bulgare avessero condotto un'indagine inadeguata, la Corte EDU si è fondata su elementi di prova che dimostravano che esse tendevano ad archiviare i casi in cui la vittima non era in grado di dimostrare di essersi fisicamente opposta allo stupro. La Corte ha ritenuto che questo livello di prova fosse in contrasto con le realtà fattuali che riguardano le vittime degli stupri e pertanto fosse tale da compromettere l'efficacia delle indagini delle autorità, in violazione dell'articolo 3 della CEDU.

Inoltre, la convenzione di Lanzarote disciplina in dettaglio il diritto dei minori di essere tutelati dagli abusi sessuali. Questa convenzione, adottata nel quadro del Consiglio d'Europa, è soggetta a ratifica da parte degli Stati non europei. Si tratta di un documento vincolante supportato da una pletora di strumenti non giuridicamente vincolanti, il cui scopo è assicurarsi ulteriormente che gli Stati approntino misure efficaci contro l'abuso di minori.[281]

7.1.4. Violenza domestica e incuria nei confronti di minori

Molti casi di violenza domestica contengono segnalazioni di abuso sessuale. A tale proposito, gli obblighi degli Stati discendenti dal diritto internazionale sono simili a quelli riportati nel precedente paragrafo 7.1.3

Nell'ambito del diritto del Consiglio d'Europa, sono state solitamente le madri a denunciare alla Corte EDU l'incapacità dello Stato di adempiere il proprio obbligo di protezione da pregiudizi sancito dalla CEDU. I casi di violenza domestica sollevavano questioni in relazione agli articoli 2, 3 e 8 della suddetta Convenzione. Gli Stati devono adempiere i propri obblighi positivi che prevedono l'adozione di misure

281 Tra gli esempi figurano: Consiglio d'Europa, Comitato dei ministri (2001), raccomandazione Rec (2001) 16 sulla protezione dei minori contro lo sfruttamento sessuale, 31 ottobre 2001; Consiglio d'Europa, Assemblea parlamentare (1996), risoluzione n. 1099 (1996) sullo sfruttamento sessuale dei minori, 25 settembre 1996; Consiglio d'Europa, Assemblea parlamentare (2000), risoluzione n. 1212 (2000) sullo stupro nei conflitti armati, 3 aprile 2000; Consiglio d'Europa, Assemblea parlamentare (2002), risoluzione n. 1307 (2002) sullo sfruttamento sessuale dei bambini: tolleranza zero, 27 settembre 2002.

efficaci contro la violenza domestica e l'esecuzione di indagini efficaci in caso di verosimili sospetti di violenza domestica o negligenza nei confronti di un minore.

Esempio: nel caso *Kontrová c. Slovacchia*,[282] la richiedente era stata aggredita fisicamente dal marito in più occasioni. Si era pertanto rivolta alla polizia, ma successivamente aveva ritirato la denuncia. In un secondo tempo, il marito aveva intimorito la donna minacciando che avrebbe ucciso i loro figli. Un parente aveva riferito l'episodio alla polizia. Nonostante ciò, a distanza di qualche giorno dall'incidente, il marito della ricorrente aveva ucciso i suoi due figli e si era poi sparato. La Corte EDU ha dichiarato che gli obblighi positivi di uno Stato emergono nella sfera dell'articolo 2 della CEDU ogniqualvolta le autorità sono al corrente o dovrebbero essere al corrente dell'esistenza di un rischio concreto e immediato per la vita di una persona chiaramente identificata. In questo caso, le autorità slovacche avrebbero dovuto essere consapevoli di tale rischio, in virtù delle precedenti comunicazioni tra la ricorrente e la polizia. Gli obblighi positivi della polizia avrebbero dovuto sfociare in una registrazione della denuncia penale della ricorrente, nell'avvio di un'indagine penale e del relativo procedimento penale, nella creazione di un registro adeguato delle chiamate di emergenza e in un intervento atto a verificare la veridicità della rivelazione della ricorrente che il marito deteneva un'arma da fuoco. La polizia, al contrario, non aveva adempiuto i suoi obblighi e la conseguenza diretta di tali mancanze era stata la morte dei figli della ricorrente, in palese violazione dell'articolo 2 della CEDU.

Esempio: il caso *Eremia c. Repubblica di Moldova*[283] riguarda la denuncia di una madre e delle sue due figlie dell'incapacità delle autorità di proteggerle dal comportamento violento e abusivo del relativo marito e padre. La Corte EDU ha stabilito che, nonostante fossero al corrente degli abusi subiti dalla ricorrente, le autorità non avevano adottato misure efficaci per proteggere la donna da nuove violenze domestiche. Ha altresì constatato che, a dispetto dei devastanti effetti psicologici sulle figlie, che erano costrette ad assistere alla violenza del padre contro la ricorrente tra le mura domestiche, poco o nulla era stato fatto per impedire il ripetersi di tali comportamenti. La Corte ha riscontrato che le autorità moldave non avevano adeguatamente ottemperato ai propri obblighi ai sensi dell'articolo 8 CEDU.

282 Corte EDU, sentenza 31 maggio 2007, *Kontrová c Slovacchia* (n. 7510/04).

283 Corte EDU, sentenza 28 maggio 2013, *Eremia c. Repubblica di Moldova* (n. 3564/11).

Sempre in relazione alla CEDU sono stati avviati casi di negligenza nei confronti di minori sia presso le istituzioni statali che in ambiente domestico. Gli obblighi che incombono alle autorità in situazioni di incuria dei genitori nei confronti dei figli minorenni sono analoghi a quelli concernenti i casi illustrati poc'anzi. Da un lato, lo Stato deve approntare meccanismi efficaci di tutela dei minori; dall'altro lato, le autorità statali devono intervenire per proteggere i minori in situazioni segnalate di negligenza nei loro confronti o quando dispongano di elementi sufficienti a dimostrare una situazione di negligenza, sia in ambito domestico, sia in istituti gestiti da privati.[284] I casi di negligenza nelle istituzioni statali pongono in capo alle autorità l'obbligo diretto di tutelare i minori provvedendo affinché ricevano un'adeguata assistenza (medica), e affinché le strutture cui sono affidati siano adeguate e/o il personale sia addestrato a far fronte alle esigenze dei minori.[285]

Anche la convenzione di Istanbul è rilevante.[286] Pur non essendo specificamente diretta ai minori, contiene svariati riferimenti ai soggetti minorenni. In primo luogo, ai sensi dell'articolo 3, lettera f), con il termine "donne" sono da intendersi anche le ragazze di meno di 18 anni, pertanto tutte le disposizioni della convenzione si applicano a loro. In secondo luogo, ai sensi dell'articolo 2, paragrafo 2, le parti contraenti sono incoraggiate ad applicare la convenzione a tutte le vittime di violenza domestica, compresi dunque i minori. Nella maggior parte dei casi, infatti, i bambini sono testimoni delle violenze perpetrate entro le mura domestiche e ne sono gravemente colpiti.[287] Infine, le disposizioni della convenzione riguardanti nello specifico i minori comprendono gli obblighi per lo Stato di adottare misure atte a rispondere ai bisogni delle vittime minorenni, a sensibilizzare i minori e a proteggere i minori testimoni di violenze.

Analogamente, ai sensi dell'articolo 17 della CSE, gli Stati sono tenuti a vietare ogni forma di violenza nei confronti dei minori e ad adottare adeguate disposizioni di diritto civile e penale.

284 Corte EDU, sentenza 10 maggio 2001, *Z e altri c. Regno Unito* [GC] (n. 29392/95).

285 Corte EDU, sentenza 18 giugno 2013, *Nencheva e altri c. Bulgaria* (n. 48609/06) (consultabile in francese).

286 Consiglio d'Europa, Convenzione del Consiglio d'Europa sulla prevenzione e la lotta contro la violenza nei confronti delle donne e la violenza domestica, STCE n. 210, 11 maggio 2011.

287 FRA (2014c), pagg. 134-135. Cfr. anche UNICEF (2006).

Le questioni della violenza domestica e dell'incuria nei confronti dei minori sono state affrontate in vari strumenti non giuridicamente vincolanti del Consiglio d'Europa.[288]

7.2. Sfruttamento dei minori, pornografia minorile e adescamento di minori

Punto saliente

- Le autorità statali hanno il dovere di collaborare e operare efficacemente insieme, anche nello svolgimento delle indagini, per proteggere i minori dalle violenze.

7.2.1. Lavoro forzato

Nell'ambito del diritto dell'UE sono vietati la schiavitù, la servitù e il lavoro forzato o obbligatorio (articolo 5, paragrafo 2, della Carta dei diritti fondamentali dell'Unione europea). È altresì vietato il lavoro minorile (articolo 32 della Carta). La direttiva 94/33/CE rappresenta il principale strumento giuridico che vieta il lavoro minorile.[289] Solo in casi eccezionali gli Stati sono autorizzati a prevedere un'età minima per l'ammissione al lavoro inferiore all'età in cui termina la scuola dell'obbligo (articolo 4, paragrafo 2). Gli Stati devono garantire che i giovani ammessi al lavoro possano beneficiare di condizioni di lavoro adatte (articoli 6 e 7). Inoltre, i minori possono essere impiegati soltanto per lo svolgimento di talune attività, tra cui servizi domestici poco pesanti o attività di carattere sociale e culturale (articolo 2, paragrafo 2, e articolo 5). La direttiva definisce altresì specifiche misure di protezione da adottare nei casi di lavoro minorile (Sezione III).

288 Tra gli esempi figurano: Consiglio d'Europa, Comitato dei ministri (1985), raccomandazione R (85) 4 sulle vittime delle violenze in ambito familiare, 26 marzo 1985; Consiglio d'Europa, Comitato dei ministri (1990), raccomandazione R (90) 2 sui provvedimenti sociali relativi alla violenza entro le mura domestiche, 15 gennaio 1990; Consiglio d'Europa, assemblea Parlamentare (1998), raccomandazione 1371 (1998) sull'abuso e l'abbandono dei bambini, 23 aprile 1998.

289 Direttiva 94/33/CE del Consiglio, del 22 giugno 1994, relativa alla protezione dei giovani sul lavoro (GU L 216 del 20.8.1994).

È frequente che i casi di lavoro forzato imposto a minori siano collegati alla tratta di minori.[290] La direttiva 2011/36/UE relativa alla prevenzione e la repressione della tratta di esseri umani annovera il lavoro forzato tra le forme di sfruttamento minorile (articolo 2, paragrafo 3).[291] I minori vittime di tratta ai fini dell'impiego nel lavoro forzato sono protetti dalla direttiva alla stregua delle vittime della tratta orientata ad altri scopi (come lo sfruttamento sessuale, cfr. il paragrafo 7.1.3).[292]

Nell'ambito del diritto del Consiglio d'Europa, l'articolo 4 della CEDU vieta in termini perentori ogni forma di schiavitù, servitù, lavoro forzato o obbligatorio. La Corte EDU definisce "lavoro forzato o obbligatorio" un lavoro o servizio che è imposto a chiunque sotto minaccia di punizione, contro la volontà della persona interessata e che la persona interessata non si è offerta spontaneamente di svolgere.[293] La servitù comprende, inoltre, l'obbligo per il "servo" di vivere presso la proprietà di un'altra persona e l'impossibilità di modificare la sua situazione.[294] La servitù rappresenta pertanto una forma aggravata di lavoro forzato.

Nei casi concernenti le denunce di lavoro forzato, la Corte EDU determina dapprima se tali segnalazioni rientrino nell'ambito di applicazione dell'articolo 4 della CEDU.[295] Successivamente, esamina se gli Stati abbiano ottemperato ai propri obblighi positivi di mettere a punto un quadro legislativo e amministrativo che vieti, punisca e persegua efficacemente i casi di lavoro forzato o obbligatorio, servitù e schiavitù.[296] Quanto all'aspetto procedurale dell'articolo 4, la Corte EDU valuta se le autorità nazionali hanno condotto un'indagine efficace in relazione alle segnalazioni di asserito lavoro forzato o servitù.[297]

290 Direttiva 2011/36/UE del Parlamento europeo e del Consiglio, del 15 aprile 2011, concernente la prevenzione e la repressione della tratta di esseri umani e la protezione delle vittime (GU L 101 del 15.4.2011, pag. 1), considerando 11.

291 Direttiva 2011/36/UE del Parlamento europeo e del Consiglio, del 15 aprile 2011, concernente la prevenzione e la repressione della tratta di esseri umani e la protezione delle vittime (GU L 101 del 15.4.2011, pag. 1).

292 Cfr. anche FRA (2015c), pagg. 40–41.

293 Corte EDU, sentenza 26 luglio 2005, *Siliadin c. Francia* (n. 73316/01), punto 116.

294 *Ibid.*, punto 123.

295 Corte EDU, sentenza 11 ottobre 2012, *C.N. e V. c. Francia* (n. 67724/09), punto 70.

296 *Ibid.*, punto 104 e segg.

297 Corte EDU, sentenza 13 novembre 2012, *C.N. c. Regno Unito* (n. 4239/08), punti 70–82.

Esempio: il caso *C.N. e V. c. Francia*[298] riguarda le denunce di lavoro forzato presentate da due sorelle originarie del Burundi. Dopo la morte dei genitori, le ragazze erano state affidate alle cure della zia e della sua famiglia in Francia. Per quattro anni avevano vissuto nel seminterrato della casa della zia, in condizioni presumibilmente pessime. La sorella maggiore non frequentava la scuola e trascorreva tutto il tempo a eseguire i lavori domestici e a prendersi cura del figlio disabile della zia. La sorella minore frequentava la scuola e lavorava per la zia e la sua famiglia nel pomeriggio, dopo la scuola e dopo aver fatto i compiti. Le due sorelle hanno dichiarato dinanzi alla Corte EDU di essere state tenute in servitù e obbligate a svolgere un lavoro forzato. La Corte EDU ha constatato che la prima ricorrente era stata effettivamente sottoposta a lavoro forzato, dal momento che era stata costretta a lavorare sette giorni alla settimana senza percepire una remunerazione né avere diritto a una vacanza. Inoltre, era stata tenuta in servitù perché aveva avuto l'impressione che la sua situazione fosse definitiva, senza possibilità di riscatto. La Corte EDU ha altresì appurato che lo Stato non aveva ottemperato ai suoi obblighi positivi, dacché il quadro giuridico in essere non offriva una protezione effettiva alle vittime del lavoro obbligatorio. Per quanto riguarda l'obbligo procedurale di avviare un'indagine, la Corte EDU ha stabilito che i requisiti dell'articolo 4 CEDU erano stati soddisfatti, poiché le autorità avevano prontamente condotto un'indagine indipendente, che aveva permesso di identificare e punire i responsabili. La Corte EDU ha invece respinto le accuse di lavoro forzato della seconda ricorrente, sottolineando che la ragazza aveva potuto frequentare la scuola e aveva avuto la possibilità di fare i compiti.

La CSE garantisce il diritto dei minori a una protezione contro i pericoli fisici e morali che risultano direttamente e indirettamente dal loro lavoro (articolo 7, paragrafo 10). Il CEDS ha osservato che lo sfruttamento domestico o lavorativo dei minori, compresa la tratta ai fini dello sfruttamento del lavoro, dev'essere proibito a livello nazionale.[299] Gli Stati parti della CSE devono garantire non soltanto di disporre della legislazione necessaria per prevenire lo sfruttamento e proteggere i bambini e gli adolescenti, ma anche che tale legislazione abbia efficacia nella pratica.[300]

298 Corte EDU, sentenza 11 ottobre 2012, *C.N. e V. c. Francia* (n. 67724/09).

299 CEDS, Conclusioni 2004, Bulgaria, pag. 57.

300 CEDS, Conclusioni 2006, Albania, pag. 61; Conclusioni 2006, Bulgaria, pag. 113.

La convenzione di Lanzarote stipula inoltre che gli Stati devono prevedere come reati ogni forma di sfruttamento sessuale perpetrata nei confronti di minori.

7.2.2. Tratta di minori

Nell'ambito del diritto dell'UE, l'articolo 83 del TFUE annovera la tratta degli esseri umani tra le sfere in cui il Parlamento europeo e il Consiglio hanno potere legislativo. L'articolo 5, paragrafo 3, della Carta dei diritti fondamentali dell'Unione europea contiene un'esplicita proibizione della tratta degli esseri umani. Il contributo dell'UE è valutato in questa sede, poiché si tratta di un tema di dimensioni transnazionali.

La direttiva 2011/36/UE concernente la prevenzione e la repressione della tratta di esseri umani e la protezione delle vittime rappresenta il primo strumento adottato dal Parlamento europeo e dal Consiglio sulla base dell'articolo 83 del TFUE.[301] L' articolo 2, paragrafo 1, della suddetta direttiva definisce tratta di esseri umani "il reclutamento, il trasporto, il trasferimento, l'alloggio o l'accoglienza di persone, compreso il passaggio o il trasferimento dell'autorità su queste persone, con la minaccia dell'uso o con l'uso stesso della forza o di altre forme di coercizione, con il rapimento, la frode, l'inganno, l'abuso di potere o della posizione di vulnerabilità o con l'offerta o l'accettazione di somme di denaro o di vantaggi per ottenere il consenso di una persona che ha autorità su un'altra, a fini di sfruttamento". Scopo della direttiva è stabilire norme minime relative alla definizione dei reati e alle sanzioni nell'ambito della tratta di esseri umani (articolo 1). La direttiva nel suo complesso interessa i minori, poiché contiene alcune disposizioni specificamente destinate a questa categoria, relative cioè all'assistenza e al sostegno delle vittime minorenni della tratta di esseri umani e alla tutela dei minori nei procedimenti penali (articoli 13-16).[302] A seguito di una valutazione specialistica di ciascuna vittima devono essere adottate specifiche misure di sostegno (articolo 14, paragrafo 1). Gli Stati nominano un tutore per rappresentare l'interesse superiore del minore (articolo 14, paragrafo 2) e forniscono sostegno alla famiglia del minore (articolo 14, paragrafo 3). Nel corso dei procedimenti penali, i minori hanno diritto ad avere un rappresentante, ad avere accesso alla consulenza legale gratuita, e ad essere ascoltati in audizione in locali adatti e da operatori formati a tale scopo (articolo 15, paragrafi 1-3). Ulteriori misure di

301 Direttiva 2011/36/UE del Parlamento europeo e del Consiglio, del 15 aprile 2011, concernente la prevenzione e la repressione della tratta di esseri umani e la protezione delle vittime (GU L 101 del 15.4.2011, pag. 1).

302 Disposizioni dettagliate sono reperibili in FRA e Corte EDU (2014), pag. 222.

protezione comprendono la possibilità che l'udienza sia condotta a porte chiuse e che il minore sia ascoltato in aula indirettamente, ricorrendo alle tecnologie di comunicazione (articolo 15, paragrafo 5).[303]

Anche la direttiva 2004/81/EC affronta il tema della tratta di minori.[304] Tramite questo strumento, le vittime della tratta possono ottenere titoli di soggiorno da parte degli Stati membri ospitanti, purché collaborino alle indagini penali. La direttiva si applica ai minorenni soltanto nella misura decisa dagli Stati membri.[305]

In termini di applicazione della legge, l'ufficio europeo di polizia (Europol) e l'unità di cooperazione giudiziaria dell'Unione Europea (Eurojust) rivestono un ruolo importante nel garantire la cooperazione tra Stati membri ai fini dell'identificazione e del perseguimento delle reti della criminalità organizzata dedite alla tratta di esseri umani. Le relative disposizioni per la tutela delle vittime minorenni a livello di UE sono esaminate nel paragrafo 11.3 del presente manuale.

Nell'ambito del diritto del Consiglio d'Europa, la CEDU non prevede disposizioni specifiche sulla tratta di esseri umani. Tuttavia, la Corte EDU interpreta l'articolo 4 della CEDU nel senso che esso vieta la tratta di esseri umani.[306] La Corte ha adottato la medesima definizione di tratta di esseri umani contenuta nell'articolo 3, lettera a), del Protocollo addizionale della Convenzione delle Nazioni Unite contro la criminalità transnazionale organizzata per prevenire, reprimere e punire la tratta di persone, in particolare di donne e bambini (Protocollo di Palermo) e nell'articolo 4, lettera a), della Convenzione del Consiglio d'Europa sulla lotta contro la tratta di esseri umani.[307] La Corte EDU valuta dapprima se una situazione particolare implichi un'accusa credibile di tratta di esseri umani e, quindi, se rientri nell'ambito di applicazione dell'articolo 4. In caso affermativo, l'analisi della Corte EDU segue la procedura descritta nel paragrafo 7.2.1: la Corte, cioè,

303 Cfr. FRA (2015b), pag. 79.

304 Direttiva 2004/81/CE del Consiglio, del 29 aprile 2004, riguardante il titolo di soggiorno da rilasciare ai cittadini di paesi terzi vittime della tratta di esseri umani o coinvolti in un'azione di favoreggiamento dell'immigrazione illegale che cooperino con le autorità competenti (GU L 261 del 6.8.2004, pagg. 19–23).

305 *Ibid*, articolo 3.

306 Corte EDU, sentenza 7 gennaio 2010, *Rantsev c. Cipro e Russia*, (n. 25965/04), punto 282.

307 ONU, Protocollo addizionale della Convenzione delle Nazioni Unite contro la criminalità organizzata transnazionale (UNCTOC) per prevenire, reprimere e punire la tratta di persone, in particolare di donne e bambini, New York, 15 novembre 2000; Consiglio d'Europa, Convenzione del Consiglio d'Europa sulla lotta contro la tratta di esseri umani, STCE n. 197, 16 maggio 2005.

esamina se il quadro giuridico dello Stato convenuto offra una protezione efficace contro la tratta di esseri umani, se lo Stato abbia assolto i propri obblighi positivi nelle circostanze particolari del caso e se le autorità abbiano condotto un'indagine efficace a seguito delle segnalazioni di asserita tratta di esseri umani.

Esempio: il caso *Rantsev c. Russia e Cipro*[308] è stato avviato dal padre di una giovane ragazza russa morta in circostanze sospette a Cipro. La ragazza si era recata a Cipro con un visto di artista di cabaret. Dopo quello che è apparso come un tentativo di fuga, la ragazza è deceduta cadendo dal balcone di un appartamento di proprietà di conoscenti del suo datore di lavoro. Il padre della ragazza ha denunciato sia la Russia sia Cipro, dichiarando in sostanza che le autorità non avevano adeguatamente indagato in merito alle circostanze che avevano portato alla morte della figlia. In quest'occasione la Corte EDU ha stabilito per la prima volta che la tratta di esseri umani ricade nell'ambito di applicazione dell'articolo 4 CEDU. Cipro, pur avendo un quadro giuridico adeguato per reprimere la tratta di esseri umani, aveva violato l'articolo 4, poiché le prassi amministrative che impongono a un datore di lavoro di versare garanzie finanziarie per le ballerine di cabaret non offrivano una protezione efficace contro la tratta di esseri umani e lo sfruttamento. Inoltre, nelle specifiche circostanze del caso, le autorità cipriote avrebbero dovuto essere al corrente del fatto che la figlia del ricorrente era a rischio di diventare vittima della tratta. La Corte ha dichiarato che la polizia non aveva adottato misure adeguate per proteggere la sig.ra Rantseva dallo sfruttamento. La Corte ha infine accertato una violazione dell'articolo 4 da parte della Russia, poiché le autorità russe non avevano condotto indagini appropriate a seguito della denuncia di una presunta tratta di esseri umani.

Il CEDS è del parere che la tratta di esseri umani costituisca una grave violazione dei diritti umani e della dignità umana, equiparandola a una nuova forma di schiavitù.[309] Ai sensi dell'articolo 7, paragrafo 10, gli Stati hanno l'obbligo di introdurre una legislazione che configuri la tratta come un reato.[310] La legislazione

308 Corte EDU, sentenza 7 gennaio 2010, *Rantsev c. Cipro e Russia*, (n. 25965/04). Il caso non riguarda la morte di un minore; merita tuttavia una menzione in assenza di casi esaminati dalla Corte EDU in materia di tratta di minori e in considerazione della minaccia specifica posta dalla tratta di minori.

309 CEDS, sentenza 12 settembre 2014, *Federation of Catholic Family Associations in Europe (FAFCE) c. Irlanda* (ricorso n. 89/2013), punto 56.

310 CEDS, Conclusioni XVII-2 (2005), Polonia, pag. 638.

deve essere supportata da un adeguato meccanismo di controllo, da sanzioni, e da un piano d'azione volto a contrastare la tratta e lo sfruttamento sessuale dei minori.[311]

A livello di trattati, la Convenzione del Consiglio d'Europa sulla lotta contro la tratta di esseri umani rappresenta lo strumento fondamentale per contrastare questo fenomeno.[312] Alla luce della più ampia partecipazione al Consiglio d'Europa e del fatto che la Convenzione sulla lotta contro la tratta di esseri umani può essere ratificata anche da Stati non appartenenti al Consiglio d'Europa,[313] essa integra la direttiva 2011/35/UE ed è utile per contrastare questo fenomeno negli Stati firmatari della Convenzione, siano questi Stati membri dell'UE o meno, sulla base di norme e obblighi comuni. L'attuazione della Convenzione è monitorata da un gruppo di esperti indipendenti (il Gruppo di esperti sulla lotta contro la tratta di esseri umani, GRETA), che periodicamente valuta la situazione in ciascun paese e pubblica relazioni. Sulla base di tali relazioni, il comitato delle parti, il pilastro politico del meccanismo di controllo previsto dalla Convenzione, adotta le raccomandazioni destinate agli Stati parti e concernenti le misure da intraprendere per mettere in atto le conclusioni del GRETA e il monitoraggio dei progressi compiuti.

7.2.3. Pornografia minorile e adescamento di minori

Nell'ambito del diritto dell'UE, la direttiva 2011/93/UE rappresenta il principale strumento giuridico che affronta la questione della pornografia minorile.[314]. Nella direttiva si definisce pornografia minorile o materiale pedopornografico come: "i) il materiale che ritrae visivamente un minore in atteggiamenti sessuali espliciti, reali o simulati; ii) la rappresentazione degli organi sessuali di un minore per scopi prevalentemente sessuali; iii) il materiale che ritrae visivamente una persona che sembra un minore in atteggiamenti sessuali espliciti, reali o simulati, oppure la rappresentazione per scopi prevalentemente sessuali degli organi sessuali di una persona che sembra un minore; oppure iv) immagini realistiche di

311 CEDS, sentenza 12 settembre 2014, *Federation of Catholic Family Associations in Europe (FAFCE) c. Irlanda* (ricorso n. 89/2013), punto 57.

312 Consiglio d'Europa, Convenzione sulla lotta contro la tratta di esseri umani, STCE n. 197, 15 maggio 2005.

313 Per esempio, la Bielorussia ha aderito alla Convenzione il 26 novembre 2013.

314 Direttiva 2011/93/UE del Parlamento europeo e del Consiglio, del 13 dicembre 2011, relativa alla lotta contro l'abuso e lo sfruttamento sessuale dei minori e la pornografia minorile (GU L 335 del 17.12.2011, pagg. 1–14).

un minore in atteggiamenti sessuali espliciti o immagini realistiche degli organi sessuali di un minore, per scopi prevalentemente sessuali."[315] L'articolo 5 della direttiva introduce l'obbligo per gli Stati membri dell'UE di adottare le misure necessarie per garantire che siano puniti la produzione intenzionale, l'acquisto o il possesso, la distribuzione, la diffusione, la trasmissione, l'offerta, la fornitura o la messa a disposizione di materiale pedopornografico, oltre che l'accesso consapevole di questo tipo di contenuti.

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha in più occasioni esaminato casi di pornografia minorile alla luce dell'articolo 8 CEDU.

> Esempio: il caso *Söderman c. Svezia* è stato presentato da una ragazza il cui patrigno aveva tentato di filmarla mentre faceva la doccia.[316] La ragazza sosteneva che la Svezia fosse priva di un quadro giuridico adeguato a tutelare la sua vita privata. La Corte EDU ha stabilito che, conformemente ai suoi obblighi positivi, lo Stato è tenuto a istituire un quadro legislativo adeguato a fornire una tutela ai cittadini vittime di abusi come la ricorrente. Poiché il caso riguardava soltanto un tentativo di filmare la ricorrente, la Corte EDU ha sostenuto che il suddetto quadro legislativo non deve necessariamente prevedere sanzioni penali. È sufficiente che i rimedi a disposizione di una vittima, a livello civile o penale, siano efficaci. In merito ai fatti del caso, la Corte EDU ha dichiarato che la ricorrente non disponeva di efficaci rimedi di diritto penale o civile per tutelarsi dal tentativo del patrigno di filmarla, riscontrando dunque una violazione dell'articolo 8 della CEDU.

L'articolo 9 della Convenzione del Consiglio d'Europa sulla criminalità informatica[317] impone agli Stati parti l'obbligo di definire come reato l'offerta o la messa a disposizione, la distribuzione, la trasmissione, il procurare o il possesso di pornografia infantile o la produzione di questo tipo di materiali attraverso un sistema informatico. Un requisito importante è che questa condotta debba essere intenzionale. Il rapporto esplicativo della Convenzione stabilisce che il termine "materiale pornografico" dipende dalle norme nazionali riguardanti i materiali classificati come osceni, incompatibili con la morale pubblica o comunque

315 *Ibid.*, articolo 2, lettera c).

316 Corte EDU, sentenza 12 novembre 2013, *Söderman c. Svezia* [GC] (n. 5786/08).

317 Consiglio d'Europa, Convenzione sulla criminalità informatica, STE n. 185, 23 novembre 2001.

corrotti.[318] Al di là di questo, l'obbligo di definire come reato tali condotte non riguarda soltanto il materiale che ritrae visivamente un minore, ma anche il materiale che ritrae visivamente una persona che sembra un minore in atteggiamenti sessuali espliciti.[319]

Oltretutto, ai sensi degli articoli 21-23 della convenzione di Lanzarote, gli Stati sono obbligati ad adottare misure legislative per definire varie forme di pornografia minorile. Secondo l'articolo 21, reclutare e costringere un minore a partecipare a spettacoli pornografici e assistere a spettacoli pornografici che comportano la partecipazione di un minore sono condotte che devono essere previste come reati. Conformemente all'articolo 22, deve essere parimenti previsto come reato l'obbligare un minore ad assistere ad abusi sessuali o attività sessuali. Infine, l'articolo 23 impone l'obbligo di applicare la legislazione penale in relazione alla proposta, da parte di un adulto, di un incontro a scopo sessuale con un minore mediante l'utilizzo delle tecnologie dell'informazione e della comunicazione. Il comitato di Lanzarote ha adottato un parere al riguardo, invitando gli Stati parti della convenzione a valutare l'opportunità di estendere il reato di adescamento ai casi in cui l'abuso sessuale non scaturisca da un incontro con la persona adulta ma sia commesso online.[320]

7.3. Gruppi ad alto rischio

Punto saliente

- I minori vittime di scomparsa forzata (nota anche come "sparizione forzata" nel diritto internazionale) hanno il diritto di preservare o ristabilire la propria identità.

7.3.1. Minori appartenenti a una minoranza

Nell'ambito del diritto del Consiglio d'Europa, i casi della Corte EDU vertenti nello specifico su episodi di violenza ai danni di minori appartenenti a una minoranza

318 Rapporto esplicativo al Consiglio d'Europa della Convenzione del Consiglio d'Europa sulla criminalità informatica, paragrafo 99.

319 Consiglio d'Europa, Convenzione sulla criminalità informatica, STE n. 185, 23 novembre 2001, articolo 9, paragrafo 2.

320 Parere del comitato di Lanzarote sull'articolo 23 della Convenzione di Lanzarote e la relativa nota esplicativa, 17 giugno 2015.

(fuori dal contesto della tratta di esseri umani e del lavoro forzato) sono alquanto limitati. Essi riguardano perlopiù la segregazione nelle scuole e la discriminazione, due fenomeni che sono trattati nel paragrafo 3.2.

> Esempio: nel caso *Centre of Legal Resources on behalf of Valentin Câmpeanu c. Romania*, una ONG ha presentato ricorso a nome di un giovane ragazzo rom morto in un istituto statale.[321] Il ragazzo aveva un'infezione da HIV e un grave handicap intellettivo. Le condizioni in cui viveva nell'istituto erano terribili: la struttura era priva di riscaldamento, biancheria da letto o indumenti, il ragazzo non riceveva alcun tipo di assistenza dal personale, ecc. In assenza di parenti stretti della vittima, una ONG ha presentato a suo nome una denuncia di violazione dei diritti stabiliti dagli articoli 2, 3, 5, 8, 13 e 14 della CEDU. La grande camera ha deciso che, nelle circostanze eccezionali del caso (l'estrema vulnerabilità del ragazzo rom e la mancanza di parenti prossimi noti), la ONG era legittimata a rappresentare il ricorrente deceduto. Nel merito, la Corte EDU ha riscontrato una violazione dell'ambito materiale dell'articolo 2. Le autorità nazionali sono state riconosciute responsabili del decesso del sig. Câmpeanu, avendolo assegnato a un istituto dov'era morto di stenti, a causa di un'alimentazione, una sistemazione e un'assistenza medica inadeguate. La Corte EDU ha inoltre accertato una violazione dell'articolo 2, dovuta al fatto che le autorità rumene non avevano condotto un'indagine efficace sulla morte del sig. Câmpeanu.

Per quanto riguarda i minori accolti presso istituti di assistenza, la raccomandazione del Consiglio d'Europa Rec(2005)5 supporta la decisione che l'assegnazione di un minore non deve essere fondata su motivazioni discriminatorie.[322]

7.3.2. Minori con disabilità

Nell'ambito del diritto dell'UE, l'UE ha firmato la Convenzione sui diritti delle persone con disabilità (CRPD), il primo trattato internazionale nella sfera dei diritti umani cui ha aderito l'UE.[323] La CRPD prevede disposizioni specifiche sui mi-

321 Corte EDU, sentenza 17 luglio 2014, *Centre for Legal Resources per conto di Valentin Câmpeanu c. Romania* [GC] (n. 47848/08).

322 Consiglio d'Europa, Comitato dei ministri (2005), raccomandazione Rec (2005)5 sui diritti dei bambini ospiti di istituti, 16 marzo 2005.

323 Consiglio dell'Unione europea (2009), decisione 2010/48/CE del Consiglio, del 26 novembre 2009, relativa alla conclusione, da parte della Comunità europea, della convenzione delle Nazioni Unite sui diritti delle persone con disabilità (GU L 23/35 del 27.1.2010).

nori. Gli Stati membri dell'UE e l'UE stessa si sono impegnati a garantire il pieno godimento dei diritti umani da parte dei minori con disabilità, sulla base dell'uguaglianza con gli altri minori. Ai sensi dell'articolo 16 della CRPD, essi adottano specifiche misure per proteggere i minori con disabilità da ogni forma di abuso e sfruttamento.[324]

Nell'ambito del diritto del Consiglio d'Europa, i casi della Corte EDU riguardanti minori con disabilità hanno sollevato svariate questioni, tra cui il consenso, gli obblighi positivi degli Stati in termini di protezione dal decesso e dai maltrattamenti, e le condizioni di vita nelle strutture a gestione statale.

Esempio: il caso *Nencheva e altri c. Bulgaria*[325] riguarda la morte di 15 bambini e adolescenti in una struttura per persone con disabilità fisiche e mentali. La Corte EDU ha stabilito che i minori erano stati affidati alle cure di un istituto pubblico specializzato posto esclusivamente sotto il controllo dello Stato. Le condizioni di vita dei minori nell'istituto erano terribili, in assenza di cibo, medicinali, indumenti e riscaldamento. Le autorità competenti erano state allertate della situazione in più occasioni e, di conseguenza, erano al corrente o avrebbero dovuto essere al corrente dei rischi di decesso. La Corte EDU ha riscontrato una violazione dell'ambito materiale dell'articolo 2 della CEDU, poiché le autorità non avevano adottato le misure necessarie a proteggere la vita dei minori posti sotto la loro sorveglianza. Inoltre, le autorità bulgare non avevano condotto un'indagine efficace in relazione alla morte dei figli dei ricorrenti. Nelle particolari circostanze del caso, le autorità bulgare avrebbero dovuto avviare un'indagine penale *ex officio*. L'indagine è stata considerata vana per svariate ragioni: era stata avviata a distanza di due anni dalla morte dei minori, si era protratta per un periodo irragionevolmente lungo, non aveva riguardato la morte di tutti i minori e non aveva chiarito tutti gli elementi pertinenti implicati.

324 Cfr. anche il paragrafo 3.5.

325 Corte EDU, sentenza 18 giugno 2013, *Nencheva e altri c. Bulgaria* (n. 48609/06) (consultabile in francese).

7.4. Minori scomparsi

Nell'ambito del diritto dell'UE, la Commissione europea ha istituito un nuovo numero verde (116000) per i bambini scomparsi.[326] Questo servizio raccoglie le segnalazioni di minori scomparsi e le trasferisce alle autorità di polizia, offre orientamento e sostegno alle persone responsabili del minore scomparso, e assiste le autorità nelle indagini.

Nell'ambito del diritto del Consiglio d'Europa, la sparizione forzata di minori è stata esaminata alla luce dell'articolo 8 CEDU.

> Esempio: nel caso *Zorica Jovanović c. Serbia*,[327] un neonato era asseritamente deceduto in ospedale poco dopo la nascita, ma il suo corpo non era mai stato consegnato ai genitori. La madre ha denunciato l'incapacità dello Stato di trasmetterle informazioni sul destino del figlio, tra cui la causa della presunta morte o l'ora e il luogo della sua sepoltura. La Corte EDU ha statuito che la continua mancata trasmissione da parte di uno Stato di informazioni credibili alla madre sul destino del figlio costituiva una violazione del diritto della donna al rispetto della vita familiare.[328]

Nell'ambito del diritto delle Nazioni Unite, l'articolo 25, paragrafo 1, lettera b), della Convenzione internazionale per la protezione di tutte le persone dalla sparizione forzata[329] stipula che gli Stati sono tenuti a prevenire e punire "la falsificazione, l'occultamento o la distruzione di documenti attestanti la vera identità" dei bambini sottoposti a sparizione forzata o i cui genitori sono sottoposti a sparizione forzata. Gli Stati devono altresì prendere le misure necessarie a rintracciare e identificare questi bambini e restituirli alle loro famiglie d'origine. In considerazione della necessità di tutelare il diritto dei minori a mantenere o ristabilire la propria identità, compresa la nazionalità, il nome e i rapporti familiari riconosciuti dalla legge, gli Stati istituiscono procedimenti legali per rivedere e annullare l'adozione o il collocamento dei bambini che hanno all'origine una sparizione forzata (articolo 25, paragrafo 4). La convenzione ribadisce due dei principi generali

326 Decisione della Commissione (2007), decisione 2007/698/CE della Commissione, del 29 ottobre 2007, recante modifica della decisione 2007/116/CE per quanto riguarda l'introduzione di altri numeri riservati che iniziano con "116" (GU L 284 del 30.10.2007, pag. 31).

327 Corte EDU, sentenza 26 marzo 2013, *Zorica Jovanović c. Serbia* (n. 21794/08).

328 *Ibid.*, punto 74.

329 ONU, Convenzione internazionale per la protezione di tutte le persone dalle sparizioni forzate, 20 dicembre 2006.

che soggiaciono ai diritti dei minori: il fatto che l'interesse superiore del bambino debba essere una considerazione prioritaria, e il diritto del bambino di esprimere liberamente le proprie opinioni (articolo 25, paragrafo 5). Nonostante siano relativamente pochi gli Stati europei ad avere ratificato questa convenzione, la sua importanza per il quadro normativo europeo non dovrebbe essere trascurata.[330]

330 Al 19 febbraio 2015 avevano ratificato questa convenzione 9 Stati membri dell'UE su 28 (Austria, Belgio, Spagna, Francia, Germania, Lituania, Paesi Bassi, Portogallo e Slovacchia). Avevano inoltre ratificato la convenzione i seguenti Stati membri del Consiglio d'Europa: Serbia, Montenegro, Bosnia-Erzegovina, Armenia e Albania.

8

Diritti economici, sociali e culturali e condizioni di vita adeguate

UE	Argomenti trattati	Consiglio d'Europa
Carta dei diritti fondamentali, articolo 14 (Diritto all'istruzione) Direttiva qualifiche (2011/95/UE) CGEU, C-413/99, *Baumbast e R c. Secretary of State for the Home Department*, 2002 (diritto dei figli di migranti alla prosecuzione degli studi).	**Diritto all'istruzione**	CEDU, Protocollo n. 1, articolo 2 (diritto all'istruzione) CEDU (riveduta), articolo 17 (diritto all'istruzione) Corte EDU, *Catan e altri c. Repubblica di Moldavia e Russia* [GC], n. 43370/04, n. 8252/05 e n. 18454/06, 2012 (lingue nelle scuole) Corte EDU, *D.H. e altri c. Repubblica ceca* [GC], n. 57325/00, 2007; Corte EDU, *Oršuš e altri c. Croazia* [GC], n. 15766/03, 2010 (discriminazione di bambini di origine rom nelle scuole) Corte EDU, *Ponomaryovi c. Bulgaria*, n. 5335/05, 2011 (discriminazione sulla base dello status di immigrato) Convenzione-quadro per la protezione delle minoranze nazionali, articolo 12, paragrafo 3, e articolo 14 Convenzione europea sullo statuto giuridico dei lavoratori migranti

UE	Argomenti trattati	Consiglio d'Europa
Carta dei diritti fondamentali dell'UE, articolo 35 (accesso all'assistenza sanitaria) Direttiva qualifiche (2011/95/UE), articolo 29 (prestazioni essenziali per figli di migranti)	**Diritto alla salute**	CSE (riveduta), articolo 11 (diritto alla protezione della salute) e articolo 13 (diritto all'assistenza sociale e medica) CEDU, articolo 2 (diritto alla vita) e articolo 3 (diritto all'integrità fisica) Corte EDU, *Oyal c. Turchia*, n. 4864/05, 2010 (infezione da HIV di un neonato) Corte EDU, *Iliya Petrov c. Bulgaria*, n. 19202/03, 2012 (gravi lesioni in una centralina di energia elettrica) Corte EDU, *Centre for Legal Resources per conto di Valentin Câmpeanu c. Romania* [GC], n. 47848/08, 2014, (decesso in un istituto) Corte EDU, *Glass c. Regno Unito*, n. 61827/00, 2004 (consenso informato) Corte EDU, *M.A.K e R.K. c. Regno Unito*, n. 45901/05 e n. 40146/06, 2010 (trattamento senza il consenso genitoriale) CEDS, *International Federation of Human Rights Leagues (FIDH) c. Francia*, ricorso n. 14/2003, 8 settembre 2004, (assistenza medica per figli di migranti) CEDS, *Defence for Children International (DCI) c. Belgio*, ricorso n. 69/2011, 2012 (minori in situazione irregolare) Convenzione sui diritti dell'uomo e la biomedicina (Convenzione di Orvieto), articoli 6 e 8
Carta dei diritti fondamentali dell'UE, articolo 34, paragrafo 3 (diritto alla sicurezza sociale e all'assistenza sociale)	**Diritto all'abitazione**	CSE (riveduta), articolo 16 (diritto della famiglia ad una tutela sociale, giuridica ed economica), articolo 17 (diritto dei bambini e degli adolescenti ad una tutela sociale, giuridica ed economica) e articolo 31 (diritto all'abitazione) Corte EDU, *Bah c. Regno Unito*, n. 56328/07, 2011 Corte EDU, *Connors c. Regno Unito*, n. 66746/01, 2004
Carta dei diritti fondamentali dell'UE, articolo 34 (sicurezza sociale e assistenza sociale)	**Diritto a uno standard di vita adeguato e diritto alla sicurezza sociale**	CSE (riveduta), articoli 12–14 (diritto alla sicurezza sociale, all'assistenza sociale e medica, diritto ad usufruire di servizi sociali), articolo 16 (diritto della famiglia ad una tutela sociale, giuridica ed economica) e articolo 30 (diritto alla protezione contro la povertà e l'emarginazione sociale) CEDS, *European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) c. Francia*, ricorso n. 82/2012, 2013 (sospensione degli assegni familiari per assenteismo scolastico) Corte EDU, *Konstantin Markin c. Russia* [GC], n. 30078/06, 2012 (congedo parentale)

I diritti economici, sociali e culturali (diritti ESC), più spesso riferiti in un contesto europeo come diritti socioeconomici o diritti sociali, comprendono i diritti correlati all'attività lavorativa e il diritto all'istruzione, alla salute, all'abitazione, alla sicurezza sociale e, più in generale, a condizioni di vita adeguate. I diritti culturali sono rimasti poco indagati e trattati nella comunità scientifica e nella giurisprudenza. Alcuni aspetti riguardanti questa sfera dei diritti sono trattati nel paragrafo 4.6, che si occupa dell'identità dei minori appartenenti a una minoranza, e nel paragrafo 8.2, nella parte riguardante il diritto all'istruzione.

Norme esplicite sui diritti ESC nel contesto europeo si possono riscontrare prevalentemente nella Carta sociale europea e nella Carta dei diritti fondamentali dell'UE, benché la CEDU e i suoi protocolli prevedano anch'essi alcune disposizioni fondamentali, come il divieto del lavoro forzato e il diritto all'istruzione. Oltretutto, la Corte EDU ha stabilito che non esiste uno spartiacque che separa la sfera dei diritti sociali ed economici dall'ambito disciplinato dalla Convenzione[331] e ha riconosciuto che i diritti ESC rientrano tra i diritti civili garantiti dalla CEDU. In tal senso, per esempio, l'accesso all'assistenza sanitaria è fatto rientrare nel divieto di tortura e di inflizione di pene o trattamenti inumani o degradanti (articolo 3 della CEDU).[332]

Il capitolo analizza i diritti ESC che riguardano in particolare i minori: il diritto all'istruzione (paragrafo 8.2); il diritto alla salute (paragrafo 8.3); il diritto all'abitazione (paragrafo 8.4) e il diritto a uno standard di vita adeguato e alla sicurezza sociale (paragrafo 8.5).

8.1. Approcci ai diritti economici, sociali e culturali

Punti salienti

- Per assicurare la protezione dei diritti sociali è fondamentale garantire la disponibilità di risorse adeguate.
- Gli elementi essenziali dei diritti sociali sono la disponibilità, l'accessibilità, l'adattabilità e l'accettabilità.

331 Corte EDU, sentenza 9 ottobre 1979, *Airey c. Irlanda* (n. 6289/73), punto 26.

332 Cfr., per esempio, Corte EDU, *Factsheet on Prisoners' health-related rights* (Scheda informativa sui diritti in materia di salute dei carcerati), febbraio 2015, e *Factsheet on Health* (Scheda in materia di salute), aprile 2015.

Nell'ambito del diritto dell'UE, i diritti ESC sono stati inclusi nella Carta dei diritti fondamentali dell'UE sullo stesso piano dei diritti civili e politici. Tuttavia, l'articolo 52 della Carta distingue tra diritti e principi; le disposizioni relative ai principi sono limitate nelle modalità con cui possono essere "invocate dinanzi a un giudice".

Nell'ambito del diritto del Consiglio d'Europa, il CEDS osserva che, quando la realizzazione di un diritto è eccezionalmente complessa e particolarmente costosa da risolvere, tale progressiva realizzazione è valutata sulla base di tre criteri: "l'adozione di provvedimenti per raggiungere gli obiettivi della Carta entro un termine ragionevole, con progressi tangibili e in misura coerente con un massiccio ricorso alle risorse disponibili".[333] Introduce altresì un ordine di priorità, rammentando agli Stati l'impatto che le loro scelte avranno per i gruppi con accresciute vulnerabilità oltre che per altri soggetti interessati.[334]

Il CEDS, sia pur nel contesto specifico del diritto alla sicurezza sociale, ritiene che alcune tappe involutive siano ammissibili se finalizzate a garantire il mantenimento e la sostenibilità del sistema di sicurezza sociale esistente, purché non compromettano il quadro fondamentale di un sistema di sicurezza sociale nazionale o non neghino agli individui l'opportunità di godere della tutela offerta da tale sistema contro gravi rischi sociali ed economici.[335] La Corte EDU ammette anch'essa la possibilità di tappe involutive, ma esamina se il metodo scelto sia ragionevole e adatto al raggiungimento dello scopo legittimo perseguito.[336]

Nel contesto del diritto all'istruzione, il CEDS, in linea con l'approccio del comitato per i diritti economici, sociali e culturali delle Nazioni Unite, ha adottato il quadro analitico di disponibilità, accessibilità, accettabilità e adattabilità.[337] La distinzione tra disponibilità e accessibilità è ripresa anche nella giurisprudenza della Corte EDU. I criteri o gli elementi essenziali della disponibilità, accessibilità,

333 CEDS, sentenza 4 novembre 2003, *International Association Autism Europe (IAAE) c. Francia* (ricorso n. 13/2002), punto 53; applicato in CEDS, sentenza 11 settembre 2013,*European Action of the Disabled (AEH) c. Francia* (ricorso n. 81/2012), punti 94-99.

334 CEDS, sentenza 4 novembre 2003, *International Association Autism Europe (IAAE) c. Francia* (ricorso n. 13/2002), punto 53.

335 CESD, sentenza 23 maggio 2012, *General Federation of Employees of the National Electric Power Corporation (GENOP-DEI) e Confederation of Greek Civil Servants' Trade Unions (ADEDY) c. Grecia* (ricorso n. 66/2011), punto 47.

336 Corte EDU, sentenza 24 giugno 2014, *Markovics e altri c. Ungheria*, decisione di inammissibilità (n. 77575/11, n. 19828/13 e n. 19829/13), punti 37 e 39.

337 CEDS, sentenza 3 giugno 2008, *Mental Disability Advocacy Center (MDAC) c. Bulgaria* (ricorso n. 41/2007), punto 37.

accettabilità e adattabilità guidano l'analisi che segue, nella misura in cui è disponibile una giurisprudenza pertinente.

8.2. Diritto all'istruzione

Punti salienti

- I limiti all'accessibilità dell'istruzione devono essere prevedibili, perseguire uno scopo legittimo ed essere giustificati e non discriminatori.
- L'accettabilità dell'istruzione, che richiede rispetto per le convinzioni religiose e filosofiche dei genitori, non esclude la possibilità di avere un'istruzione religiosa o sessuale nelle scuole.
- L'adattabilità impone l'adozione di misure speciali per minori con disabilità e la possibilità che i bambini e gli adolescenti appartenenti a una minoranza studino e siano istruiti nella loro lingua.
- I bambini hanno diritto all'istruzione, indipendentemente dalla nazionalità o dallo status di migranti.

Nell'ambito del diritto dell'UE, l'articolo 14, paragrafo 2, della Carta dei diritti fondamentali dell'UE garantisce a ogni persona il diritto all'istruzione, compresa la "facoltà di accedere gratuitamente all'istruzione obbligatoria". L'articolo 14, al paragrafo 3, garantisce la libertà di creare istituti di insegnamento così come il diritto dei genitori di provvedere all'educazione e all'istruzione dei loro figli secondo le loro convinzioni religiose, filosofiche e pedagogiche.

Nell'ambito del diritto del Consiglio d'Europa, l'articolo 2 del Protocollo n. 1 alla CEDU garantisce il diritto all'istruzione. La Corte EDU chiarisce che questo articolo non obbliga gli Stati a rendere disponibile l'istruzione, ma sancisce il diritto ad accedere agli istituti di insegnamento esistenti in un determinato momento.[338] Inoltre, il diritto all'istruzione comprende anche la possibilità di trarre profitto dall'istruzione ricevuta, vale a dire il diritto di ottenere, in conformità con le norme in vigore in ciascuno Stato, e nell'una o nell'altra forma, un riconoscimento ufficiale

338 Corte EDU, sentenza 23 luglio 1968, *Caso "Relating to certain aspects of the laws on the use of languages in education in Belgium" c. Belgio* (nn. 1474/62, 1677/62, 1691/62, 1769/63, 1994/63 e 2126/64), punto 4.

degli studi compiuti.[339] Questo diritto tuttavia non è assoluto: i limiti devono essere prevedibili per le persone coinvolte e devono perseguire uno scopo legittimo. Sono consentite misure disciplinari, compresa la sospensione o l'espulsione da un istituto di insegnamento, purché tali provvedimenti soddisfino le condizioni previste per i limiti ammissibili. Per valutare se queste forme di esclusione dall'istruzione comportino la negazione del diritto all'istruzione saranno considerati fattori quali le salvaguardie procedurali, la durata dell'esclusione, i tentativi di reintegrazione, e l'adeguatezza dell'istruzione alternativa proposta.[340]

Esempio: nel caso *Catan e altri c. Repubblica di Moldovia e Russia*,[341] la Corte EDU ha esaminato la politica linguistica introdotta nelle scuole dalle autorità separatiste della Transinstria. L'obiettivo di questa politica linguistica era la russificazione della popolazione. Dopo la chiusura forzata delle scuole di lingua moldava (dove si utilizzava l'alfabeto latino), i genitori erano stati costretti a scegliere se mandare i propri figli nelle scuole dove era previsto l'insegnamento in una combinazione artificiale di lingua moldava e alfabeto cirillico, sulla base di materiali didattici prodotti in epoca sovietica, o se mandarli in scuole meno attrezzate e situate in luoghi disagiati, esposti al rischio di essere soggetti a molestie e intimidazioni lungo il percorso. La chiusura forzata delle scuole e le conseguenti molestie sono state considerate un'interferenza ingiustificata nel diritto dei bambini all'istruzione, di portata tale da configurare una violazione dell'articolo 2 del Protocollo n. 1 alla CEDU.[342]

Nell'ambito del diritto all'istruzione, i genitori hanno il diritto al rispetto delle proprie convinzioni religiose e filosofiche. Tuttavia, secondo la Corte, la definizione e pianificazione del programma di studi rientrano, in linea di principio, nelle competenze dello Stato.[343] È anche possibile che informazioni o conoscenze di tipo religioso o filosofico siano integrate nel programma di studi, a condizione che siano trasmesse in maniera obiettiva, critica e pluralistica.[344] Per salvaguardare il pluralismo, le differenze di carattere quantitativo e qualitativo dell'insegna-

339 *Ibid.*

340 Corte EDU, sentenza 11 gennaio 2011, *Ali c. Regno Unito* (n. 40385/06), punto 58.

341 Corte EDU, sentenza 19 ottobre 2012, *Catan e altri c. Repubblica di Moldavia e Russia* [GC] (n. 43370/04, n. 8252/05 e n. 18454/06).

342 *Ibid.*, punti 141–144.

343 Corte EDU, sentenza 29 giugno 2007, *Folgerø e altri c. Norvegia* [GC] (n. 15472/02), punto 84.

344 *Ibid.*, punto 84.

mento di una determinata religione o filosofia devono essere bilanciate, offrendo ai genitori la possibilità di esentare i propri figli, in parte o in toto, da questo tipo di insegnamento, per esempio con l'esenzione da talune ore di lezione o da un intero corso di religione.[345] Per le modalità con cui la Corte EDU ha gestito la questione da una prospettiva di non discriminazione, cfr. il paragrafo 2.1.[346]

Ai sensi dell'articolo 17, paragrafo 2, della CSE riveduta, gli Stati si impegnano "a prendere [...] tutte le misure necessarie e appropriate miranti [...] ad assicurare ai bambini ed agli adolescenti un insegnamento primario e secondario gratuito, favorendo una regolare frequentazione scolastica".[347] Inoltre, il CEDS ha stabilito che, ai sensi di tale disposizione, gli Stati contraenti dovrebbero provvedere affinché anche i minori illegalmente presenti sul loro territorio abbiano accesso all'istruzione.[348]

Inoltre, gli istituti di insegnamento devono essere accessibili a chiunque, senza discriminazioni.[349] Il CEDS ha dichiarato anche che l'integrazione di minori con disabilità nelle scuole ordinarie dovrebbe essere la norma e l'insegnamento in scuole speciali l'eccezione.[350] Gli Stati non godono di un ampio margine di discrezionalità per quanto riguarda la scelta del tipo di scuola per le persone con disabilità: per questi alunni la scuola di accoglienza deve dunque essere una scuola ordinaria.[351]

Le situazioni riguardanti un trattamento differenziato nell'istruzione sulla base della nazionalità, lo status di immigrante o l'origine etnica sono esaminate nel capitolo 3.

Ai sensi della giurisprudenza del CEDS, l'educazione sessuale e alla salute riproduttiva dev'essere parte integrante del programma di studi ordinario.[352] Gli Stati, pur godendo di un ampio margine di discrezionalità nella determinazio-

345 *Ibid.*, punti 85–102 e parere divergente.

346 Corte EDU, sentenza 15 giugno 2010, *Grzelak c. Polonia* (n. 7710/02).

347 La CSE del 1961 non contiene disposizioni sul diritto all'istruzione.

348 CEDS, sentenza 11 settembre 2012, *Médecins du Monde – International c. Francia* (ricorso n. 67/2011).

349 Sulla questione dei minori con disabilità, cfr. i capitoli 3 e 7.

350 CEDS, sentenza 3 giugno 2008, *Mental Disability Advocacy Center (MDAC) c. Bulgaria* (ricorso n. 41/2007), punto 35.

351 CEDS, sentenza 11 settembre 2013, *European Action of the Disabled (AEH) c. Francia* (ricorso n. 81/2012), punto 78.

352 CEDS, sentenza 30 marzo 2009, *International Centre for the Legal Protection of Human Rights (INTERIGHTS) c. Croazia* (ricorso n. 45/2007), punto 47.

ne dell'adeguatezza culturale dei materiali didattici utilizzati, devono garantire un'educazione sessuale e alla salute riproduttiva non discriminatoria, che non perpetui o rafforzi l'esclusione sociale e non neghi la dignità umana. I materiali didattici non devono rinsaldare stereotipi umilianti, per esempio nei confronti di persone di orientamento non eterosessuale.[353]

Infine, il principio dell'adattabilità dell'istruzione prevede, per esempio, che per i minori con disabilità che sono inseriti in scuole ordinarie, siano adottati "provvedimenti che consentano di rispondere ai loro bisogni speciali"[354] (cfr. anche il paragrafo 3.5).

Inoltre, ai sensi dell'articolo 12, paragrafo 3, della Convenzione quadro per la protezione delle minoranze nazionali, le parti si impegnano a promuovere l'uguaglianza delle opportunità nell'accesso all'educazione a tutti i livelli per le persone appartenenti a minoranze nazionali (cfr. anche il capitolo 3).[355] Nel caso dei minori appartenenti alle minoranze nazionali, l'articolo 14 della convenzione sancisce il diritto di apprendere la lingua minoritaria e di ricevere un insegnamento in questa lingua.[356] La Corte EDU ha confermato che il diritto all'istruzione implica il diritto a ricevere un insegnamento nella lingua nazionale o in una delle lingue nazionali.[357]

8.2.1. Diritto all'istruzione dei figli di migranti

Nell'ambito del diritto dell'UE, il diritto fondamentale all'istruzione dei minori, indipendentemente dallo status di migranti, è riconosciuto praticamente in tutte

353 *Ibid.*, punti 59 e 61.

354 CEDS, sentenza 3 giugno 2008, *Mental Disability Advocacy Center (MDAC) c. Bulgaria* (ricorso n. 41/2007), punto 35.

355 Cfr. a questo proposito Consiglio d'Europa, Comitato consultivo della Convenzione-quadro per la protezione delle minoranze nazionali (2006), Commentary on Education under the Framework Convention for the Protection of National Minorities, ACFC/25DOC(2006)002, parte 2.1.

356 Per ulteriori chiarimenti cfr. Consiglio d'Europa, Comitato consultivo della Convenzione-quadro per la protezione delle minoranze nazionali (2006), Commentary on Education under the Framework Convention for the Protection of National Minorities, ACFC/25DOC(2006)002, parte 2.3 e Commento tematico n. 3: *The language rights of persons belonging to national minorities under the Framework Convention*, 2012, ACFC/44DOC(2012)001 rev, parte VI, *Language Rights and Education.*

357 Corte EDU, sentenza 19 ottobre 2012, *Catan e altri c. Repubblica di Moldavia e Russia* [GC] (n. 43370/04, n. 8252/05 e n. 18454/06), punto 137.

le sfere del diritto in materia di migrazione dell'UE.[358] Detto ciò, l'UE non ha la competenza necessaria per determinare i contenuti o la portata delle disposizioni nazionali in materia di istruzione. L'UE tutela invece il diritto dei figli dei migranti di accedere all'istruzione con lo stesso trattamento o, a seconda dello status, con un trattamento simile ai cittadini nazionali. La direttiva studenti (2004/114/CE) disciplina le condizioni di ammissione dei cittadini di paesi terzi per motivi di studio, scambio di alunni, tirocinio non retribuito o volontariato.[359] L'ammissione comprende l'ingresso e il soggiorno di cittadini di paesi terzi per un periodo superiore a tre mesi. I requisiti generali di ammissione per un minore comprendono la presentazione di un titolo di viaggio valido, l'autorizzazione dei genitori per il soggiorno in questione, un'assicurazione di malattia e, se richiesto dallo Stato, il pagamento delle tasse dovute per l'esame della domanda di ammissione.[360] Gli alunni, per esempio, devono dimostrare di partecipare a un programma di scambio fra scuole messo in atto da un'organizzazione riconosciuta dallo Stato membro.[361]I tirocinanti non retribuiti devono esibire le prove richieste dallo Stato membro per dimostrare che disporrà, durante il soggiorno, di risorse sufficienti per provvedere al suo sostentamento, agli studi e al suo ritorno.[362] L'accesso da parte di studenti di istituti di insegnamento superiori alle attività economiche, inclusa l'occupazione, è soggetto a restrizioni.[363]

I figli di cittadini dell'UE che si trasferiscono in un altro Stato membro dell'UE in virtù della legislazione sulla libera circolazione beneficiano dei diritti più favorevoli in questo ambito. Essi cioè hanno il diritto a essere ammessi a frequentare i corsi d'insegnamento generale, di apprendistato e di formazione professionale

358 Per esempio, articolo 27 della direttiva 2011/95/UE del Parlamento europeo e del Consiglio, del 13 dicembre 2011, recante norme sull'attribuzione, a cittadini di paesi terzi o apolidi, della qualifica di beneficiario di protezione internazionale, su uno status uniforme per i rifugiati o per le persone aventi titolo a beneficiare della protezione sussidiaria, nonché sul contenuto della protezione riconosciuta (rifusione) (direttiva qualifiche) (GU L 337 del 20.12.2011, pagine 9–268).

359 Direttiva 2004/114/CE del Consiglio relativa alle condizioni di ammissione dei cittadini di paesi terzi per motivi di studio, scambio di alunni, tirocinio non retribuito o volontariato (direttiva studenti).

360 *Ibid.*, articolo 6.

361 *Ibid*, articolo 7.

362 *Ibid*, articolo 10.

363 *Ibid*, articolo 17.

alle stesse condizioni previste per i cittadini di tale Stato,[364] siano essi corsi di natura pubblica e privata, e con riferimento all'istruzione obbligatoria e non obbligatoria. La Corte di giustizia dell'Unione europea ha sempre interpretato questo diritto in senso estensivo, per garantire pari accesso all'istruzione, ma anche a benefici sociali di più ampio respiro correlati all'istruzione, oltre che a qualsiasi altro beneficio mirante a facilitare la frequentazione dell'insegnamento. Per esempio, nella causa *Casagrande*, il figlio di un lavoratore migrante è riuscito ad accedere a un sussidio scolastico soggetto a particolari condizioni di reddito in virtù della normativa sulla libera circolazione nell'UE.[365]

Inoltre, la legislazione introdotta negli anni 1970 obbliga gli Stati membri a fornire corsi di lingua supplementari ai figli dei cittadini migranti dell'UE, sia nella lingua dello Stato ospitante sia nella lingua madre, al fine di favorirne l'inserimento nello Stato ospitante e nel paese d'origine, nel caso in cui dovessero farvi ritorno.[366] Se da un lato la normativa sembra offrire un generoso e prezioso sostegno integrativo ai minori dopo l'ammissione a una scuola nello Stato ospitante, la sua attuazione nei paesi dell'UE è notoriamente lacunosa e sempre meno pratica, alla luce del ventaglio delle diverse lingue implicate.[367]

Esempio: la questione esaminata nella causa *Baumbast e R c. Secretary of State for the Home Department*[368] riguardava il diritto delle due figlie di un lavoratore migrante tedesco, che si era trasferito nel Regno Unito con la moglie colombiana e le due figlie, di continuare a frequentare la scuola in questo paese anche dopo che il padre aveva lasciato il Regno Unito per

364 Regolamento (UE) n. 492/2011/CE del Parlamento europeo e del Consiglio, del 5 aprile 2011, relativo alla libera circolazione dei lavoratori all'interno dell'Unione (GU L 141 del 27.5.2011, pagg. 1–12), articolo 10; e direttiva 2004/38/CE del Parlamento europeo e del Consiglio, del 29 aprile 2004, relativa al diritto dei cittadini dell'Unione e dei loro familiari di circolare e di soggiornare liberamente nel territorio degli Stati membri, che modifica il regolamento (CEE) n. 11612/68 ed abroga le direttive 64/221/CEE, 68/360/CEE, 72/194/CEE, 73/148/CEE, 75/34/CEE, 75/35/CEE, 90/364/CEE, 90/365/CEE e 93/96/CEE (direttiva sulla libera circolazione) (GU L 158 del 30.4.2004, pagg. 77–123), articolo 24, paragrafo 1.

365 CGUE, sentenza 3 luglio 1974, causa C-9/74, *Donato Casagrande c. Landeshauptstadt München*. Successivamente confermato in cause quali CGUE, sentenza 26 febbraio 1992, causa C-3/90, *M.J.E. Bernini c. Minister van Onderwijs en Wetenschappen*.

366 Direttiva 77/486/CEE del Consiglio, del 25 luglio 1977, relativa alla formazione scolastica dei figli dei lavoratori migranti (GU L 199 del 6.8.1977, pagg. 32–33). Si noti che i figli dei cittadini migranti di paesi terzi sono esclusi da questo ambito di applicazione.

367 La Commissione riferisce in merito all'applicazione della direttiva 77/486/CEE (COM(84) 54 final e COM(88) 787 final).

368 CGUE, sentenza 17 settembre 2002, causa C-413/99, *Baumbast e R c. Secretary of State for the Home Department*.

trasferirsi in un paese terzo, lasciando moglie e figlie. La Corte doveva stabilire se la moglie e le figlie erano autorizzate a rimanere nello Stato ospitante nonostante il sig. Baumbast (da cui erano scaturiti i diritti di soggiorno della famiglia) avesse di fatto rinunciato al proprio status di lavoratore migrante dell'UE. Il fattore decisivo per la Corte era il fatto che le bambine si erano integrate nel sistema scolastico dello Stato ospitante e che sarebbe stato dannoso e sproporzionato sradicarle in questo momento cruciale del loro percorso. La Corte ha confermato che il fatto di garantire la continuità dell'istruzione dei figli è talmente importante da poter effettivamente "ancorare" il soggiorno di una famiglia (che altrimenti non godrebbe del diritto di soggiorno) nello Stato ospitante per tutta la durata degli studi dei figli di un migrante.

La decisione *Baumbast* è stata seguita nelle cause successive[369] ed è stata codificata nell'articolo 12, paragrafo 3, della direttiva 2004/38/CE (Direttiva sulla libera circolazione).[370]

In linea generale, i figli di cittadini di paesi terzi possono accedere all'istruzione *statale* alle stesse condizioni dei cittadini dello Stato ospitante, mentre non hanno diritto di godere dei benefici associati come gli assegni di mantenimento.[371] Alcuni strumenti dell'UE in materia di immigrazione, tuttavia, si spingono oltre la tutela della mera parità di accesso, imponendo agli Stati membri di attivare meccanismi

369 CGUE, sentenza 23 febbraio 2010, causa C-480/08, *Maria Teixeira c. London Borough of Lambeth e Secretary of State for the Home Department*; CGUE, sentenza 23 febbraio 2010, causa C-310/08, *London Borough of Harrow c. Nimco Hassan Ibrahim e Secretary of State for the Home Department* [GC].

370 Direttiva 2004/38/CE del Parlamento europeo e del Consiglio, del 29 aprile 2004, relativa al diritto dei cittadini dell'Unione e dei loro familiari di circolare e di soggiornare liberamente sul territorio degli Stati membri, che modifica il regolamento (CEE) n. 1612/68 e abroga le direttive 64/221/CEE, 68/360/CEE, 72/194/CEE, 73/148/CEE, 75/34/CEE, 75/35/CEE, 90/364/CEE, 90/365/CEE e 93/96/CEE (GU L 158 del 30.4.2004), articolo 2, paragrafo 2, lettera c) e articolo 12, paragrafo 3.

371 Direttiva sulla qualifica di rifugiato (direttiva 2011/95/UE), articolo 11; direttiva soggiornanti di lungo periodo (direttiva 2003/109/CE), articolo 14; direttiva 2003/86/CE relativa al ricongiungimento familiare, articolo 14; direttiva protezione temporanea (2001/55/CE); direttiva accoglienza (2013/33/UE), articolo 14, lettera c); direttiva rimpatri (2008/115/CE).

per garantire il dovuto riconoscimento e la trasferibilità delle qualifiche straniere, anche in assenza di prove documentali (articolo 28 della direttiva qualifiche).[372]

I diritti all'istruzione dei figli dei richiedenti asilo sono ancora più deboli: questi soggetti hanno diritto ad accedere al sistema d'istruzione dello Stato ospitante a condizioni *simili* ma non necessariamente alle *medesime* condizioni che si applicano per i cittadini di quel paese.[373] In tal senso, l'istruzione potrebbe essere fornita in centri di accoglienza anziché nelle scuole e le autorità possono posticipare il pieno accesso alla scuola dei figli dei richiedenti asilo per un periodo massimo di tre mesi dalla data di deposito della domanda d'asilo. Qualora l'accesso al sistema educativo non sia possibile a causa della situazione specifica del minore, gli Stati membri sono tenuti a offrire altre modalità d'insegnamento (articolo 14, paragrafo 3, della direttiva sulle condizioni di accoglienza).[374]

Ai sensi del diritto del Consiglio d'Europa, l'articolo 2 del Protocollo n. 1 è stato usato in combinato disposto con l'articolo 14 per garantire l'accesso dei figli dei migranti all'istruzione (cfr. anche il paragrafo 3.3).

Esempio: nel caso *Ponomaryovi c. Bulgaria*,[375] la Corte EDU ha esaminato l'obbligo per due studenti russi di una scuola superiore privi di un permesso di soggiorno permanente di versare le tasse scolastiche. La Corte ha concluso che, in questo caso, il requisito del versamento delle tasse per la scuola secondaria era stato discriminatorio e, quindi, in contrasto con l'articolo 14 della CEDU, letto in combinato disposto con l'articolo 2 del Protocollo n. 1 alla CEDU.[376]

372 Direttiva 2011/95/UE del Parlamento europeo e del Consiglio, del 13 dicembre 2011, recante norme sull'attribuzione, a cittadini di paesi terzi o apolidi, della qualifica di beneficiario di protezione internazionale, su uno status uniforme per i rifugiati o per le persone aventi titolo a beneficiare della protezione sussidiaria, nonché sul contenuto della protezione riconosciuta (rifusione) (direttiva qualifiche) (GU L 337 del 20.12.2011, pag. 9).

373 Direttiva sulle condizioni di accoglienza (2013/33/UE). Si rammenta che, ai sensi della direttiva sulla qualifica di rifugiato (2011/95/UE, articolo 27), i minori beneficiari di protezione internazionale (che hanno ottenuto diritti di soggiorno di più lungo termine) possono accedere all'istruzione secondo le stesse modalità previste per i cittadini dello Stato ospitante.

374 Direttiva 2013/33/UE del Parlamento europeo e del Consiglio, del 26 giugno 2013, recante norme relative all'accoglienza dei richiedenti protezione internazionale (rifusione) (direttiva accoglienza) (GU L 180 del 29.6.2013, pagg. 96–116).

375 Corte EDU, sentenza 21 giugno 2011, *Ponomaryovi c. Bulgaria* (n. 5335/05).

376 Cfr. anche il paragrafo 3.3.

La CSE tutela i diritti all'istruzione dei figli dei migranti sia direttamente (articolo 17, paragrafo 2), sia indirettamente, imponendo restrizioni ai diritti all'occupazione dei minori, per consentirgli di godere appieno dei vantaggi dell'istruzione obbligatoria (articolo 7).

Inoltre, la Convenzione europea sullo statuto giuridico dei lavoratori emigranti[377] ribadisce il diritto dei figli dei migranti di accedere all'istruzione generale e alla formazione professionale nello Stato ospitante "sulla stessa base e alle stesse condizioni dei cittadini di questo Stato" (articolo 14, paragrafo 1).

Nell'ambito del diritto internazionale, la parità di accesso all'istruzione dei figli dei migranti è riconosciuta dalla Convenzione sulla protezione dei diritti dei lavoratori migranti e dei membri delle loro famiglie (articolo 30).[378]

L'articolo 28 della CRC stabilisce che tutti i fanciulli hanno diritto all'insegnamento obbligatorio gratuito. Secondo l'articolo 29, paragrafo 1, lettera c), tale diritto va ben oltre la parità di accesso all'istruzione e include disposizioni concernenti lo sviluppo dell'identità culturale del fanciullo, la sua lingua e i valori del suo paese d'origine.

377 Consiglio d'Europa, Convenzione europea sullo statuto giuridico dei lavoratori emigranti, STE n. 93, 1977.

378 Convenzione delle Nazioni Unite sulla protezione dei diritti di tutti i lavoratori emigranti e dei membri delle loro famiglie, 18 dicembre 1990.

8.3. Diritto alla salute

Punti salienti

- Gli Stati hanno l'obbligo positivo di adottare misure contro gravi rischi per la salute, di cui le autorità sono o dovrebbero essere consapevoli.
- In caso di decesso di una persona, le autorità statali devono avviare un'indagine efficace.
- Ai sensi della CSE, i minori che si trovano illegalmente nel paese in questione hanno diritto all'assistenza sanitaria e non limitatamente all'assistenza medica urgente.
- Il principio di accettabilità dell'assistenza sanitaria richiede il consenso informato o un'autorizzazione.
- Conformemente al diritto dell'UE e alla CSE, i figli dei migranti hanno diritto, fatte salve alcune limitazioni, all'assistenza sociale e medica.

Nell'ambito del diritto dell'UE, l'articolo 35 della Carta dei diritti fondamentali dell'UE garantisce il diritto di ottenere cure mediche.

I figli dei cittadini dell'UE migranti possono accedere all'assistenza sociale e sanitaria alla stessa stregua dei cittadini dello Stato membro ospitante, dopo i primi tre mesi di soggiorno nel paese.[379] Diritti analoghi, per quanto limitati alle cosiddette "prestazioni essenziali", sono disponibili per i figli dei cittadini di paesi terzi che hanno acquisito un permesso di soggiorno permanente in uno Stato membro[380]. Per quanto riguarda i figli dei rifugiati e dei richiedenti asilo, gli Stati membri provvedono affinché essi ricevano adeguata assistenza sociale, alla stregua dei cittadini dello Stato membro in questione; anche in questo caso, tuttavia, tale assistenza può essere limitata alle "prestazioni essenziali" (articolo 29 della direttiva qualifiche). La legislazione impone agli Stati membri l'obbligo di fornire ai figli di migranti in condizione di vulnerabilità l'accesso a un'assistenza sanitaria sufficiente. Per esempio, i minori che hanno subito violenze o torture devono ricevere misure di assistenza sufficienti per rispondere alle loro esigenze fisiche e psicologiche (capo IV, articolo 21, articolo 23, paragrafo 4, e articolo 25

379 Direttiva sulla libera circolazione, articolo 24.

380 Direttiva 2003/109/CE del Consiglio, del 25 novembre 2003, relativa allo status dei cittadini di paesi terzi che siano soggiornanti di lungo periodo (GU L 16 del 23.1.2004), articolo 11, paragrafo 4.

della direttiva sull'accoglienza rifusa). La direttiva qualifiche contiene disposizioni simili per i figli dei migranti in condizioni di vulnerabilità.

Nell'ambito del diritto del Consiglio d'Europa, la CEDU non garantisce espressamente un diritto all'assistenza sanitaria o un diritto alla salute. In varie circostanze, tuttavia, la Corte EDU si è occupata di una serie di casi in materia di salute. In primo luogo, la Corte esamina le situazioni che possono mettere in pericolo la vita dei minori. Inoltre la Corte individua l'obbligo positivo per lo Stato di adottare misure preventive nei confronti dei rischi gravi per la salute, di cui è al corrente o dovrebbe essere al corrente.

Esempio: nel caso *Oyal c. Turchia*, lo Stato non aveva preso le misure preventive necessarie ad evitare la diffusione dell'HIV attraverso trasfusioni di sangue. Di conseguenza, un neonato era stato infettato dal virus HIV in seguito a trasfusioni di sangue effettuate in un ospedale statale. Nonostante sia stata offerta una somma a titolo di risarcimento, la Corte ha constatato che, in mancanza di una totale copertura medica per il trattamento e per le cure necessarie per minore interessato durante tutta la sua vita, lo Stato non aveva offerto un risarcimento soddisfacente e, pertanto, aveva violato il diritto alla vita (articolo 2 della CEDU).[381] Ha altresì ordinato allo Stato turco di provvedere a una totale e gratuita copertura medica della vittima durante tutta la sua vita.

Esempio: nel caso *Iliya Petrov c. Bulgaria*,[382] un ragazzino di undici anni ha riportato gravi lesioni dopo essersi introdotto in una centralina di energia elettrica, situata in un parco giochi dove bambini e adolescenti erano soliti incontrarsi. La porta della centralina non era chiusa a chiave. La Corte EDU ha sostenuto che lo sfruttamento della rete elettrica è un'attività che rappresenta un rischio elevato per le persone che si trovano in prossimità delle centraline. Lo Stato è dunque obbligato a introdurre un'adeguata regolamentazione, ivi compreso un sistema per controllare la corretta applicazione delle norme di sicurezza. La Corte ha stabilito che la mancata messa in sicurezza della centralina elettrica da parte dello Stato, che pure

381 Corte EDU, sentenza 23 marzo 2010, *Oyal c. Turchia* (n. 4864/05), punti 71–72.

382 Corte EDU, sentenza 24 aprile 2012, *Iliya Petrov c. Bulgaria* (n. 19202/03) (consultabile in francese).

era consapevole dei problemi di sicurezza, equivaleva a una violazione del diritto alla vita (articolo 2 della CEDU).[383]

Tra gli obblighi positivi degli Stati rientra inoltre l'obbligo di provvedere al trattamento dei minori che si trovano in una situazione vulnerabile e che sono affidati alle autorità statali (cfr. anche il capitolo 6 e la sezione 7.3).

Esempio: il caso *Centre for Legal Resources per conto di Valentin Câmpeanu c. Romania*[384] riguardava un adolescente rom positivo all'HIV e con una grave disabilità mentale, che soffriva anche di tubercolosi, polmonite ed epatite, morto all'età di 18 anni. Il ragazzo aveva vissuto tutta la vita in un istituto di assistenza statale. La Corte EDU ha riscontrato gravi errori nelle decisioni adottate riguardo alle cure e al trattamento del ragazzo, oltre che una continua incapacità del personale medico di fornirgli un'assistenza e cure mediche adeguate. Era stato quindi violato l'articolo 2 della CEDU.[385]

Inoltre, in assenza di un'emergenza, la Corte EDU ha stabilito che un trattamento medico avviato senza il consenso dei genitori rappresenta una violazione dell'articolo 8 della CEDU.

Esempio: nel caso *Glass c. Regno Unito*[386] un ragazzo con una grave disabilità era stato trattato con diamorfina, nonostante le ferme obiezioni della madre. La Corte ha riscontrato che, in assenza dell'autorizzazione di un giudice, la decisione delle autorità ospedaliere di travalicare le obiezioni della madre alla terapia proposta configurava una violazione dell'articolo 8 della CEDU.[387]

Esempio: nel caso *M.A.K. e R.K. c. Regno Unito*,[388] una bambina di nove anni era stata fotografata e sottoposta a prelievi del sangue senza il consenso dei genitori, nonostante le espresse richieste del padre di non ef-

383 *Ibid.*

384 Corte EDU, sentenza 17 luglio 2014, *Centre for Legal Resources per conto di Valentin Câmpeanu c. Romania* [GC] (n. 47848/08). Cfr. anche la descrizione di questa sentenza della Corte EDU nel capitolo 7.

385 Cfr. anche il paragrafo 7.

386 Corte EDU, sentenza 9 marzo 2004, *Glass c. Regno Unito* (n. 61827/00).

387 *Ibid.*, punto 83.

388 Corte EDU, sentenza 23 marzo 2010, *M.A.K. e R.K c. Regno Unito* (n. 45901/05 e n. 40146/06).

fettuare esami medici sulla figlia quando la bambina si trovava da sola in ospedale. In assenza di un'emergenza medica, lo svolgimento di questi interventi medici senza il consenso genitoriale è stato considerato una violazione del diritto della bambina all'integrità fisica ai sensi dell'articolo 8 della CEDU.[389]

In conformità agli articoli 6 e 8 della Convenzione sui diritti dell'uomo e la biomedicina[390], quando un minore non ha la capacità giuridica di dare consenso a un intervento medico, questo non può essere effettuato senza l'autorizzazione del suo rappresentante, fatta eccezione per le situazioni d'urgenza. Se, da un lato, la Convenzione non prevede il consenso del minore nel caso in cui quest'ultimo non abbia la capacità giuridica per concederlo, dall'altro essa stabilisce che il parere del minore sia preso in considerazione "come un fattore determinante, in funzione dell'età e del suo grado di maturità" (articolo 6, paragrafo 2).

Inoltre, ai sensi dell'articolo 11 della CSE, le parti concordano di adottare adeguate misure volte a prevedere consultori e servizi d'istruzione riguardo al miglioramento della salute ed allo sviluppo del senso di responsabilità individuale in materia di salute.[391] L'assistenza medica e sociale è garantita dall'articolo 13 della CSE a coloro che non dispongono di risorse sufficienti e che non sono in grado di procurarsi tali risorse con i propri mezzi o di riceverli da un'altra fonte. Infine, nel 2011 il comitato dei ministri ha adottato orientamenti specifici in materia di minori sull'assistenza sanitaria a misura di bambino.[392]

Come illustrato negli esempi a seguire, il CEDS è del parere che i figli dei migranti che si trovano illegalmente nel territorio di un Paese hanno diritto all'assistenza sanitaria e non limitatamente all'assistenza medica urgente. La CSE fa svariati riferimenti ai diritti dei minori all'assistenza sociale e ai servizi sanitari (articoli 11, 12, 13, 14, 16 e 17), che si applicano indipendentemente dallo status di migrante.

389 *Ibid.*, punto 79.

390 Consiglio d'Europa, Convenzione per la protezione dei diritti dell'uomo e della dignità dell'essere umano nei confronti dell'applicazione della biologia e della medicina: Convenzione sui diritti dell'uomo e la biomedicina, STE n. 164, 4 aprile 1997.

391 Per quanto concerne l'educazione sessuale e alla salute riproduttiva, v. sopra, alla voce "Istruzione" (paragrafo 8.2).

392 Consiglio d'Europa, Comitato dei ministri (2011), *Guidelines on child-friendly health care* (Linee guida per un'assistenza sanitaria a misura di bambino), 21 settembre 2011.

Esempio: la decisione del CEDS nel caso *International Federation of Human Rights Leagues (FIDH) c. Francia*[393] riguardava l'adozione da parte della Francia di una legge che aboliva l'esenzione dal pagamento delle cure mediche concessa agli immigrati in situazione irregolare e con redditi estremamente bassi e che imponeva oneri per l'assistenza sanitaria. Il CEDS ha stabilito che gli individui di minore età, compresi i minori non accompagnati, devono ricevere cure mediche gratuite.

Esempio: nel caso *Defence for Children International (DCI) c. Belgio,*[394] il CEDS ha riscontrato una violazione dell'articolo 17 della CSE per via delle limitazioni all'assistenza medica poste nei confronti di migranti minorenni privi di documenti. Il comitato ha confermato il diritto dei migranti minorenni illegalmente presenti sul territorio di un paese a ricevere un'assistenza sanitaria che vada oltre l'assistenza medica urgente e che comprenda l'assistenza primaria e secondaria, oltre che il sostegno psicologico.[395] Ha altresì dichiarato che la mancanza di strutture di accoglienza per minori stranieri illegalmente presenti sul territorio di un paese ne ostacola l'accesso all'assistenza sanitaria. Ha constatato inoltre che le cause di malattia possono essere eliminate soltanto se i minori ricevono un alloggio o sono affidati alle cure di una famiglia adottiva. Di conseguenza, ha riscontrato una violazione dell'articolo 11, paragrafi 1 e 3, della CSE, dovuta alla mancanza di un alloggio e dell'affido familiare.[396]

Analogamente, la Convenzione europea sullo statuto giuridico dei lavoratori emigranti[397] stabilisce che ai lavoratori migranti che sono legalmente occupati nel territorio di un altro Stato e ai loro familiari sia garantito pari accesso all'assistenza sociale e medica (articolo 19).

Nell'ambito del diritto internazionale, disposizioni più esaustive sul diritto alla salute si trovano nell'articolo 12 della Convenzione internazionale sui diritti economici,

393 CEDS, sentenza 8 settembre 2004, *International Federation of Human Rights Leagues (FIDH) c. Francia* (ricorso n. 14/2003), punti 35–37.

394 CEDS, sentenza 23 ottobre 2012, *Defence for Children International (DCI) c. Belgio* (ricorso n. 69/2011).

395 *Ibid.*, punto 128.

396 *Ibid.*, punti 116–118.

397 Consiglio d'Europa, Convenzione europea sullo statuto giuridico dei lavoratori emigranti, STE n. 93, 1977.

sociali e culturali (ICESCR)[398] e nell'articolo 24 della CRC. Questi strumenti sottolineano l'importanza della prevenzione e delle cure. Il comitato delle Nazioni Unite sui diritti dell'infanzia ribadisce l'importanza di garantire l'accesso al migliore standard possibile in materia di assistenza sanitaria e nutrizione durante la prima infanzia,[399] oltre che l'accesso degli adolescenti all'informazione sessuale e riproduttiva.[400] Chiarisce altresì che il diritto dei minori alla salute comporta il diritto di controllare la propria salute e il proprio corpo, compresa la libertà sessuale e riproduttiva di compiere scelte responsabili.[401] Incoraggia gli Stati a considerare l'opportunità di consentire ai minori di dare il proprio consenso a taluni trattamenti e interventi medici senza il permesso di un genitore, un tutore o un guardiano, quali i test per l'HIV e i servizi di salute sessuale e riproduttiva, compresa l'educazione e l'orientamento in relazione a salute sessuale, contraccezione e aborto sicuro.[402]

398 ONU, Assemblea generale, Convenzione internazionale sui diritti economici, sociali e culturali, 16 dicembre 1966, Nazioni Unite, Serie dei trattati, vol. 993, pag. 3.

399 ONU, Comitato sui diritti dell'infanzia (2006), *Commento generale n. 7 (2005), Attuazione dei diritti del bambino nella prima infanzia"*, doc. ONU CRC/C/GC/7/Rev.1, paragrafo 27.

400 ONU, Comitato sui diritti dell'infanzia (2003), *Commento generale n. 4 (2003), Salute e lo sviluppo degli adolescenti nel contesto della Convenzione sui diritti dell'infanzia,* doc. ONU CRC/GC/2003/4, paragrafo 28.

401 ONU, Comitato sui diritti dell'infanzia (2013), *Commento generale n. 15 (2013) sul diritto del minorenne al più alto standard di salute possibile (articolo 24)*, doc. ONU CRC/C/GC/15, paragrafo 24.

402 *Ibid.*, paragrafo 31.

8.4. Diritto all'abitazione

Punti salienti

- Il diritto a un'abitazione di livello sufficiente è garantito dall'articolo 31 della CSE.
- Il CEDS ritiene che debba essere fornito un adeguato riparo ai minori che risiedono irregolarmente in un paese e che le condizioni di vita in queste strutture devono garantire la dignità umana.
- Secondo la Corte EDU, l'esistenza di un'abitazione inadeguata non giustifica l'affidamento a un istituto di assistenza.

Nell'ambito del diritto dell'UE, l'articolo 34, paragrafo 3, della Carta dei diritti fondamentali dell'UE contiene un riferimento all'assistenza abitativa nel contesto della lotta contro l'esclusione sociale e la povertà. La direttiva sull'uguaglianza razziale cita l'alloggio tra i beni e servizi disponibili al pubblico la cui fornitura o l'accesso ai quali deve essere garantito su base non discriminatoria.[403] In materia di benefici abitativi, i soggiornanti di lungo periodo hanno diritto a un trattamento non differenziato. Il diritto dell'UE, tuttavia, cerca di garantire, per esempio in relazione alla riunificazione familiare, che i familiari non costituiscano un onere per i sistemi di assistenza sociale degli Stati membri.[404] La direttiva sul ricongiungimento familiare prevede che il soggiornante titolare di un permesso di soggiorno per un periodo di validità pari o superiore a un anno e con una fondata prospettiva di ottenere il diritto di soggiornare in modo stabile dimostri, al momento della presentazione della domanda di ricongiungimento familiare, di disporre di un alloggio considerato normale per una famiglia analoga nella stessa regione. L'alloggio deve corrispondere alle norme generali di sicurezza e salubrità in vigore nello Stato membro interessato.[405]

Nell'ambito del diritto del Consiglio d'Europa, la CEDU non prevede un diritto all'alloggio ma, se uno Stato decide di offrire un'abitazione, è tenuto a farlo senza discriminazioni.

403 Direttiva 2000/43/CE del Consiglio, del 29 giugno 2000, che attua il principio della parità di trattamento fra le persone indipendentemente dalla razza e dall'origine etnica, articolo 3.

404 Cfr. anche FRA e Corte EDU (2014), pag. 201.

405 Direttiva 2003/86/CE del Consiglio, del 22 settembre 2003, relativa al diritto al ricongiungimento familiare (direttiva sul ricongiungimento familiare), articolo 7, paragrafo 1, lettera a).

Esempio: nel caso *Bah c. Regno Unito*[406] la ricorrente, che risiedeva regolarmente nel Regno Unito, aveva ottenuto l'autorizzazione a ospitare il figlio a condizione che quest'ultimo non richiedesse alcuna assistenza finanziaria alle autorità pubbliche. Poco dopo l'arrivo del figlio, la ricorrente aveva presentato domanda di assegnazione di un alloggio di edilizia residenziale pubblica. Tuttavia, poiché il figlio godeva di un permesso di soggiorno condizionato, le autorità pubbliche avevano rigettato la richiesta di esaminare con priorità la sua condizione di persona involontariamente priva di alloggio con un minore a carico, cui ordinariamente la ricorrente avrebbe avuto diritto. Alla fine le autorità avevano aiutato la donna a trovare un nuovo alloggio e, in un secondo tempo, le avevano offerto un alloggio sociale. La ricorrente ravvisava una discriminazione nel rifiuto delle autorità di garantirle l'accesso a un alloggio in via prioritaria. La Corte EDU, pur riconoscendo la legittimità di fissare criteri per l'assegnazione di risorse limitate come l'edilizia residenziale pubblica, ha stabilito che tali criteri non devono essere arbitrari o discriminatori. Non vi era stata arbitrarietà nel rifiuto delle autorità di esaminare con priorità la domanda della ricorrente, che aveva accolto il figlio nel paese ospitate nella piena consapevolezza della condizione legata al suo permesso di ingresso. Oltretutto, la ricorrente non era mai stata di fatto priva di un alloggio e, nell'eventualità in cui si fosse manifestato il rischio per madre e figlio di rimanere senza un'abitazione, sussistevano altri obblighi di legge che imponevano alle autorità l'obbligo di assistenza. Di conseguenza, non è stata ravvisata alcuna violazione dell'articolo 14 della CEDU in combinato disposto con l'articolo 8 della CEDU.

La Corte EDU esamina altresì i casi di espulsione delle famiglie rom dai campi nomadi.[407] A tale proposito, la Corte ha indirettamente affrontato la questione della qualità dell'alloggio, stabilendo che l'inadeguatezza di un alloggio non giustifica l'affidamento di minori a istituti di assistenza[408] (cfr. anche i paragrafi 5.2. e 6.2.).

Il diritto a un'abitazione di livello sufficiente è garantito dall'articolo 31 della CSE. Il CEDS afferma che per abitazione di livello sufficiente ai sensi dell'articolo 31, paragrafo 1, si intende un alloggio sicuro dal punto di vista igienico e sanitario, ossia dotato di tutti i servizi di base tra cui l'acqua potabile, il riscaldamento,

406 Corte EDU, sentenza 27 settembre 2011, *Bah c. Regno Unito* (n. 56328/07).

407 Corte EDU, sentenza 27 maggio 2004, *Connors c. Regno Unito* (n. 66746/01).

408 Corte EDU, sentenza 26 ottobre 2006, *Wallová e Walla c. Repubblica ceca*, (n. 23848/04), punti 73-74 (consultabile in francese); Corte EDU, sentenza 21 giugno 2007, *Havelka e altri c. Repubblica ceca*, (n. 23499/06), punti 57-59 (consultabile in francese).

i servizi igienici e l'allacciamento alla rete fognaria, e un impianto elettrico; l'alloggio deve essere inoltre strutturalmente sicuro, non sovraffollato e con un contratto certo tutelato dalla legge.[409] Gli sgomberi sono ammessi se giustificati, se effettuati in condizioni che rispettino la dignità umana e se è disponibile un alloggio alternativo.[410] Le condizioni di vita in un alloggio "devono essere tali da garantire un'esistenza compatibile con la dignità umana" "[...] [e] devono rispondere a requisiti di sicurezza, salute e igiene, garantiti tra l'altro dall'esistenza di servizi di base come l'acqua potabile, un'illuminazione sufficiente e il riscaldamento. I requisiti fondamentali di un alloggio temporaneo comprendono anche la sicurezza delle immediate vicinanze."[411]

Per quanto concerne l'alloggio per minori stranieri che si trovano in una situazione di irregolarità, il CEDS è del parere che sia l'incapacità di fornire un alloggio, sia la fornitura di un alloggio di livello non sufficiente in strutture alberghiere equivalgono a una violazione dell'articolo 17, paragrafo 1, della CSE.[412] Inoltre, ai sensi dell'articolo 31, paragrafo 2, della CSE, per prevenire il problema dei senzatetto, gli Stati sono tenuti a fornire un alloggio adeguato ai minori che si trovano in una situazione di irregolarità senza ricorrere alle strutture di accoglienza.[413]

409 CEDS, sentenza 20 ottobre 2009, *Defence for Children International (DCI) c. Paesi Bassi* (n. 47/2008), punto 43.

410 CEDS, sentenza 7 dicembre 2005, *European Roma Rights Centre (ERRC) c. Italia* (ricorso n. 27/2004), punto 41; CEDS, sentenza 11 settembre 2012, *Médecins du Monde – International c. Francia*, (ricorso n. 67/2011), punti 74–75 e 80.

411 CEDS, sentenza 20 ottobre 2009, *Defence for Children International (DCI) c. Paesi Bassi* (n. 47/2008), punto 62.

412 CEDS, sentenza 23 ottobre 2012, *Defence for Children International (DCI) c. Belgio*, (ricorso n. 69/2011), punti 82–83. Cfr. anche FRA (2010), pag. 30.

413 CEDS, sentenza 20 ottobre 2009, *Defence for Children International (DCI) c. Paesi Bassi* (n. 47/2008), punto 64.

8.5. Diritto a uno standard di vita adeguato e diritto alla sicurezza sociale

Punti salienti

- L'accesso all'assegno familiare e al congedo parentale deve essere di carattere non discriminatorio.
- Nell'ambito del diritto dell'UE, la copertura previdenziale dei giovani lavoratori assunti con contratti di apprendistato non deve essere così modesta da escludere questa categoria di lavoratori dalla gamma di tutele generale.
- Ai sensi della CSE, la sospensione dell'assegno famigliare in caso di assenteismo scolastico rappresenta un limite sproporzionato al diritto del nucleo familiare alla tutela economica, sociale e legale.

Nell'ambito del diritto dell'UE, l'articolo 34, paragrafo 1, della Carta dei diritti fondamentali dell'UE stipula che "[l]'Unione riconosce e rispetta il diritto di accesso alle prestazioni di sicurezza sociale e ai servizi sociali" in casi che rientrano nelle tradizionali sfere della sicurezza sociale quali la maternità, la malattia, gli infortuni sul lavoro, la dipendenza o la vecchiaia, oltre che la perdita del posto di lavoro. Il diritto si estende a chiunque risieda o si sposti legalmente all'interno dell'Unione. Il diritto all'assistenza sociale è riconosciuto per garantire un'esistenza dignitosa a tutti coloro che non dispongano di risorse sufficienti e per lottare contro l'esclusione sociale e la povertà. Tutti questi aspetti sono qualificati dalle "modalità stabilite dal diritto [dell'Unione] e le legislazioni e le prassi nazionali" (articolo 34, paragrafo 1, della Carta).

La Corte di giustizia dell'Unione europea sostiene che, se ai cittadini di uno Stato membro è semplicemente chiesto di risiedere nello Stato membro per poter richiedere l'indennità di educazione per i figli, non si può esigere dai cittadini di altri Stati membri dell'UE di produrre un regolare documento di soggiorno per accedere agli stessi benefici.[414] Rifiutare il congedo parentale a talune categorie di persone, tra cui le madri committenti che abbiano avuto un figlio mediante un

414 CGUE, sentenza 12 maggio 1998, causa C-85/96, *María Martínez Sala c. Freistaat Bayern*, punti 60–65.

contratto di maternità surrogata, è discriminatorio.[415] Lo stesso dicasi per gli uomini dipendenti pubblici cui è rifiutato il congedo parentale, se le loro mogli non lavorano o esercitano una professione, a meno che le stesse, a causa di grave malattia o disabilità, non siano incapaci di provvedere all'educazione di un bambino.[416] Analogamente, gli Stati membri devono istituire un regime di congedo parentale in caso di nascita di gemelli, che assicuri ai genitori di ricevere un trattamento specifico rispondente alle loro esigenze. A tal fine è possibile determinare la durata del congedo parentale in base al numero di figli nati e prevedere altre forme di assistenza quali un sostegno materiale o un aiuto finanziario.[417]

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha esaminato un presunto caso di discriminazione nella concessione di un congedo parentale e degli assegni familiari in Russia.

> Esempio: nel caso *Konstantin Markin c. Russia*,[418] il congedo parentale è stato rifiutato a un militare di carriera dell'esercito russo, pur essendo un istituto concesso alle persone di sesso femminile appartenenti all'arma. A parere della Corte, il rifiuto di concedere ai militari di sesso maschile il congedo parentale non è ragionevole né giustificato. Né il contesto specifico delle forze armate né le affermazioni concernenti l'esistenza di un rischio per l'efficienza operativa dell'arma o le argomentazioni riguardanti il ruolo speciale devoluto alle donne in relazione alla maternità o le concezioni tradizionali prevalenti nel Paese sono stati considerati utili a giustificare la differenza di trattamento. La Corte ha pertanto riscontrato una violazione dell'articolo 14 in combinato disposto con l'articolo 8 della CEDU.

Gli articoli 12-14 della CSE contengono disposizioni più ampie sul diritto alla sicurezza sociale, all'assistenza sociale e medica, e al diritto ad usufruire di servizi sociali. L'articolo 16 della CSE menziona esplicitamente le prestazioni sociali e familiari come strumento per promuovere la tutela economica, giuridica e sociale della vita di famiglia. L'articolo 30 della CSE sancisce il diritto alla protezione contro la povertà e l'emarginazione sociale. Talune rivendicazioni in materia di

415 CGUE, sentenza 18 marzo 2014, causa C-363/12, *Z c. A Government Department e The Board of Management of a Community School* [GS].

416 CGUE, sentenza 16 luglio 2015, causa C-222/14, *Konstantinos Maïstrellis c. Ypourgos Dikaiosynis, Diafaneias kai Anthropinon Dikaiomaton*, punto 53.

417 CGUE, sentenza 16 settembre 2010, causa C-149/10, *Zoi Chatzi c. Ypourgos Oikonomikon*, punti 72–75.

418 Corte EDU, sentenza 22 marzo 2012, *Konstantin Markin c. Russia* [GC] (n. 30078/06).

sicurezza sociale ricadono nell'ambito di applicazione dell'articolo 1, Protocollo n. 1 alla CEDU, purché la legislazione nazionale non generi un interesse di natura proprietaria, prevedendo il pagamento, di diritto, della prestazione assistenziale, subordinato o meno al precedente pagamento dei contributi.[419]

L'articolo 12 della CSE impone agli Stati di stabilire o mantenere un regime di sicurezza sociale e di adoperarsi per elevare progressivamente il livello di tale regime.

Ai sensi dell'articolo 16 della CSE gli Stati sono tenuti a garantire la tutela economica, giuridica e sociale della vita di famiglia per mezzo di strumenti appropriati. I mezzi primari dovrebbero essere le prestazioni familiari e le prestazioni per figli a carico, purché rientrino nell'ambito della previdenza sociale e siano disponibili a tutta la popolazione o subordinati a requisiti di reddito. Queste prestazioni devono costituire un'adeguata integrazione del reddito per un numero consistente di famiglie. Il CEDS valuta l'adeguatezza delle prestazioni familiari (parentali) con particolare riguardo per il reddito mediano equivalente (Eurostat).[420] Il CEDS è del parere che l'assenza di un regime generale di prestazioni familiari non sia conforme alla CSE.[421]

Il CEDS ammette, tuttavia, che il pagamento delle prestazioni per figli a carico possa essere subordinato alla residenza dei figli.[422] È del parere che la mera introduzione di una tutela estremamente limitata contro i rischi sociali ed economici nei contratti di apprendistato prevista per gli adolescenti (di età compresa tra 15 e 18 anni, che avevano diritto esclusivamente a prestazioni di malattia in natura e a una copertura assicurativa per gli infortuni sul lavoro al tasso dell'1 %) escluda di fatto una specifica categoria di lavoratori (minorenni) dalla gamma generale di tutele offerta dal regime di previdenza sociale. Essa pertanto viola l'obbligo dello Stato di elevare progressivamente il livello del regime di sicurezza sociale.[423]

La sospensione dell'assegno famigliare in caso di assenteismo scolastico rappresenta inoltre un limite sproporzionato al diritto del nucleo familiare alla tutela economica, sociale e legale.

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419 Corte EDU, sentenza 7 luglio 2011, *Stummer c. Austria* [GC] (n. 37452/02), punto 82.

420 CEDS, Conclusioni 2006, Estonia, pag. 215.

421 CEDS, Conclusioni 2011, Turchia, articolo 16.

422 CEDS (2007), Conclusioni XVIII-1, Introduzione generale, pag. 11.

423 CESD, sentenza 23 maggio 2012, *General Federation of Employees of the National Electric Power Corporation (GENOP-DEI) e Confederation of Greek Civil Servants' Trade Unions (ADEDY) c. Grecia* (ricorso n. 66/2011), punto 48.

Esempio: in una denuncia contro la Francia, l'EUROCEF (*European Committee for Home-Based Priority Action for the Child and the Family*, il comitato europeo per un'azione prioritaria in favore del fanciullo e della famiglia in ambiente domestico) sosteneva che la sospensione delle prestazioni familiari applicata per contrastare l'assenteismo scolastico rappresentasse una violazione del diritto delle famiglie alla tutela sociale, legale ed economica sancita dall'articolo 16 della CSE. Il comitato, ritenendo il provvedimento sproporzionato rispetto allo scopo perseguito, ha osservato che la misura contestata di sospendere ed eventualmente revocare le prestazioni familiari fa ricadere esclusivamente sui genitori la responsabilità di perseguire l'obiettivo della riduzione dell'assenteismo scolastico e accresce la vulnerabilità economica e sociale delle famiglie interessate.[424]

La Convenzione europea sullo statuto giuridico dei lavoratori emigranti[425] stabilisce che ai lavoratori migranti che sono legalmente occupati nel territorio di un altro Stato e ai loro familiari sia garantito pari accesso all'assistenza sociale (articolo 18) e ad altri "servizi sociali" che favoriscono l'integrazione di questi individui nello Stato ospitante (articolo 10). Analogamente, la Convenzione europea di sicurezza sociale tutela i diritti dei rifugiati e degli apolidi ad accedere alle prestazioni di sicurezza sociale nello Stato ospitante (compresi gli assegni per figli a carico).[426]

Nell'ambito del diritto internazionale, il diritto a uno standard di vita adeguato è sancito dall'articolo 11 dell'ICESCR e dall'articolo 27 della CRC.

424 CEDS, sentenza 19 marzo 2013, *European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) c. Francia* (ricorso n. 82/2012), punto 42.

425 Consiglio d'Europa, Convenzione europea sullo statuto giuridico dei lavoratori emigranti, STE n. 93, 1977.

426 Consiglio d'Europa, Convenzione europea sulla sicurezza sociale, STE n. 78, 1972.

9 Immigrazione e asilo

UE	Argomenti trattati	Consiglio d'Europa
TFUE, articolo 21 Carta dei diritti fondamentali, articolo 45 (libertà di circolazione) Direttiva sulle condizioni di accoglienza (2013/33/UE) Direttiva rimpatri (2008/115/CE) Direttiva sulle procedure di asilo (2013/32/UE) Regolamento di Dublino (n. 604/2013) Direttiva qualifiche (2011/95/UE) Direttiva sulla libera circolazione (2004/38/CE) CGUE, C-648/11, *The Queen, su istanza di MA e altri c. Secretary of State for the Home Department*, 2013 (trasferimenti Dublino) Regolamento sul Codice frontiere Schengen (n. 562/2006), allegato VII, paragrafo 6	**Ingresso e soggiorno**	CEDU, articolo 8 (vita familiare)
Direttiva sulle procedure d'asilo (2013/32/UE), articolo 25, paragrafo 5	**Accertamento dell'età**	

UE	Argomenti trattati	Consiglio d'Europa
TFUE, articolo 67, articolo 73 e articolo 79, paragrafo 2, lettera a) Direttiva sul ricongiungimento familiare (2003/86/CE) Direttiva qualifiche (2011/95/UE), articolo 31 Direttiva sulle condizioni di accoglienza (2013/33/UE) Direttiva sulla protezione temporanea (2001/55/CE) Regolamento di Dublino (n. 604/2013) Direttiva rimpatri (2008/115/CE), articolo 13	**Ricongiungimento familiare e minori separati**	CEDU, articolo 8 (diritto al rispetto della vita privata e familiare) Corte EDU, *Şen c. Paesi Bassi*, n. 31465/96, 2001 (bilanciamento dei diritti) Corte EDU, *Jeunesse c. Paesi Bassi*, [GC], n. 12738/10, 2014 (vita familiare, interesse superiore del minore)
Direttiva sulle condizioni di accoglienza (2013/33/UE), articolo 11 Direttiva rimpatri (2008/115/CE), articolo 17	**Trattenimento di minori**	Corte EDU, *Mubilanzila Mayeka e Kaniki Mitunga c. Belgio*, n. 13178/03, 2006 (trattenimento in vista dell'espulsione) Corte EDU, *Popov c. Francia*, n. 39472/07 e n. 39474/07, 2012, (trattenimento in vista dell'espulsione) Corte EDU, *Kanagaratnam c. Belgio*, n. 15297/09, 2011, (trattenimento in vista dell'espulsione)
Direttiva sulla libera circolazione (2004/38/CE), preambolo (considerando 24), articolo 7, articolo 12, articolo 13 e articolo 28, paragrafo 3, lettera b)	**Espulsione**	Corte EDU, *Gül c. Svizzera*, n. 23218/94, 1996 (espulsione del nucleo familiare) Corte EDU, *Boultif c. Svizzera*, n. 54273/00, 2001 (espulsione di minori) Corte EDU, *Tarakhel c. Svizzera*, n. 29217/12, 2014 (espulsione di minori)
Carta dei diritti fondamentali dell'Unione europea, articoli 47–48 (diritto a un ricorso effettivo e a un giudice imparziale, presunzione di innocenza e diritti della difesa) Direttiva sulle procedure d'asilo (2013/32/UE), articoli 7 e 25 Direttiva vittime (2012/29/UE), articolo 8	**Accesso alla giustizia**	CEDU, articolo 13 (diritto a un ricorso effettivo) Corte EDU, *Rahimi c. Grecia*, n. 8687/08, 2011 (ricorsi effettivi per migliorare le condizioni di detenzione)

L'UE è esplicitamente competente a legiferare nel settore della migrazione e dell'asilo. Le disposizioni per i figli dei migranti disciplinano una gamma di situazioni, tra cui la migrazione di lungo periodo per motivi di lavoro, l'asilo e la protezione sussidiaria, nonché la situazione dei migranti irregolari. Oltre alla tutela cui hanno diritto i figli dei migranti ai sensi dell'articolo 24 della Carta dei diritti fondamentali dell'UE, gli articoli 18 e 19 della stessa sanciscono il diritto all'asilo e alla protezione in caso di allontanamento, di espulsione e di estradizione. L'UE si è occupata altresì delle esigenze specifiche dei minori non accompagnati, anche in relazione ad aspetti giuridici quali la tutela legale e la rappresentanza legale, l'accertamento dell'età, l'identificazione dei familiari e il ricongiungimento con la famiglia, le procedure d'asilo, il trattenimento e l'espulsione, oltre che ad aspetti riguardanti le condizioni di vita dei minori, compresi l'alloggio, l'assistenza sanitaria, l'istruzione e la formazione, la religione, le norme e i valori culturali, lo svago e il divertimento, e l'interazione sociale e le esperienze di razzismo.[427]

Nell'ambito del sistema del Consiglio d'Europa, sono quattro in particolare le convenzioni che sanciscono i diritti dei migranti minorenni in vari contesti: la CEDU, la CSE, la Convenzione europea sullo statuto giuridico dei lavoratori emigranti e la Convenzione europea sulla nazionalità. Questo capitolo si occupa perlopiù dell'attuazione delle disposizioni della CEDU, in particolare l'articolo 3 (protezione da trattamenti inumani o degradanti), l'articolo 5 (privazione della libertà) e l'articolo 8 (diritto al rispetto della vita privata e familiare), da soli o in combinato disposto con l'articolo 14 (non discriminazione). Tali disposizioni sono usate a sostegno del diritto dei migranti, rifugiati e richiedenti asilo minorenni e dei loro familiari al ricongiungimento familiare, all'accesso alla giustizia e a un soggiorno stabile nello Stato ospitante.

A livello internazionale, alcune disposizioni della CRC definiscono i diritti dei minori nel contesto della migrazione e dell'asilo e hanno contribuito allo sviluppo di misure legali a livello europeo. In particolare, l'articolo 7 protegge il diritto dei minori all'iscrizione nei registri dello stato civile, alla cittadinanza e all'assistenza genitoriale; l'articolo 8 tutela il diritto del fanciullo a preservare la propria identità, compresa la sua nazionalità, il suo nome e le sue relazioni familiari; l'articolo 9 garantisce che i fanciulli separati intrattengano contatti diretti con entrambi i genitori, a meno che ciò non sia contrario al loro interesse preminente; l'articolo 22, infine, garantisce ai fanciulli con lo status di rifugiati il diritto a ricevere una protezione e un'assistenza speciali. Infine, la Convenzione delle Nazioni

427 Cfr. anche FRA (2010); FRA (2011a), pagg. 27–38; FRA (2011b), pagg. 26–30.

Unite sullo status di rifugiati,[428] unitamente al suo protocollo del 1967, è universalmente considerata il fulcro della legislazione internazionale in materia di protezione dei rifugiati.

I seguenti paragrafi si riferiscono in particolare all'ingresso e al soggiorno (paragrafo 9.1); all'accertamento dell'età (paragrafo 9.2); al ricongiungimento familiare per i minori separati (paragrafo 9.3); al trattenimento (paragrafo 9.4); all'espulsione (paragrafo 9.5) e all'accesso alla giustizia (paragrafo 9.6).

9.1. Ingresso e soggiorno

Punti salienti

- I cittadini dell'UE hanno diritto alla libera circolazione all'interno dell'UE.
- Le decisioni relative all'ingresso e al soggiorno di un minore devono essere adottate nell'ambito di meccanismi e procedure appropriati e nell'interesse superiore del minore.

Nell'ambito del diritto dell'UE, la natura e l'ambito di applicazione dei diritti dei minori sono estremamente diversi e variano in base alla cittadinanza del minore e ai genitori, e a seconda che il minore si sia trasferito con i genitori o in maniera autonoma.

La migrazione di cittadini dell'UE è disciplinata da vari strumenti giuridici. I diritti garantiti ai cittadini dell'UE sono di ampio respiro e mirano a stimolare una mobilità ottimale attraverso l'Unione. In primo luogo, l'articolo 21 del TFUE stabilisce che i cittadini dell'UE e i loro familiari hanno il diritto di circolare e di soggiornare liberamente nel territorio di un qualsiasi Stato membro dell'UE. Inoltre, una volta raggiunto lo Stato ospitante, essi hanno il diritto di essere trattati alla stregua dei cittadini di quello Stato per quanto concerne l'accesso alle prestazioni lavorative, sociali e assistenziali, alla scuola, all'assistenza sanitaria ecc. e le relative

428 ONU, Assemblea generale, *Convenzione sullo status di rifugiati*, 28 luglio 1951, Nazioni Unite, Serie dei trattati, vol. 189, pag. 137.

condizioni di accesso.[429] L'articolo 45 della Carta dei diritti fondamentali dell'UE garantisce anch'esso il diritto per i cittadini dell'UE di circolare liberamente nel territorio degli Stati membri.

I diritti dei minori di circolare liberamente assieme a genitori/tutori cittadini dell'UE sono altresì disciplinati dalla direttiva sulla libera circolazione,[430] la quale stipula che i familiari hanno il diritto di entrare nel territorio di uno Stato ospitante e di soggiornarvi, indipendentemente dal fatto che viaggino con il cittadino dell'UE migrante o in un momento successivo (articolo 5, paragrafo 1). Ai sensi di tale strumento, si intendono per "familiare" i figli biologici del cittadino dell'UE (o del suo coniuge o partner) di età inferiore a 21 anni o che siano a suo carico (articolo 2, paragrafo 2). Può trattarsi di cittadini sia dell'UE sia di un paese terzo, purché la persona con cui si sono trasferiti sia un cittadino dell'Unione. Nei primi tre mesi successivi al trasferimento, il diritto della famiglia al soggiorno è incondizionato; successivamente, i cittadini dell'UE che desiderano tenere con sé i figli nel paese ospitante devono dimostrare di disporre di risorse economiche sufficienti e di un'assicurazione malattia (articolo 7). I figli e altri familiari del cittadino dell'UE che si trasferisce in un altro Stato membro acquisiscono automaticamente il diritto al soggiorno permanente se hanno soggiornato per cinque anni in via continuativa assieme al cittadino dell'Unione nello Stato membro ospitante (articolo 16, paragrafo 2, e articolo 18). A quel punto non sono più soggetti a condizioni in termini di risorse economiche e di assicurazione malattia.

La libertà di circolazione di cittadini di paesi terzi che non appartengono alla famiglia di un cittadino dell'UE è soggetta a maggiori restrizioni. Questa sfera è disciplinata in parte dal diritto dell'UE e in parte dalla legislazione nazionale in materia di immigrazione.

Nel contesto delle procedure di tutela internazionale, i minori sono considerati "persone vulnerabili" la cui situazione specifica negli Stati membri deve essere

429 Sono state imposte alcune restrizioni sui migranti provenienti dalla Croazia, il paese che per ultimo ha aderito all'UE, per un periodo transitorio che termina nel giugno 2015, con la possibilità per gli Stati membri di estendere al 2020 il periodo di applicazione di tali restrizioni.

430 Si noti che le disposizioni pertinenti della direttiva si applicano anche nel SEE. Cfr. anche l'accordo sullo Spazio economico europeo, 2 maggio 1992, parte III, libera circolazione delle persone, dei servizi e dei capitali, e l'accordo tra la Comunità europea ed i suoi Stati membri, da una parte, e la Confederazione svizzera, dall'altra, sulla libera circolazione delle persone, firmato a Lussemburgo il 21 giugno 1999, entrato in vigore il 1° giugno 2002 (GU L 114 del 30.4.2002, pag. 6).

presa in considerazione nell'applicazione del diritto dell'UE.[431] Ciò impone agli Stati l'obbligo di individuare e attivare le misure specifiche di cui, in particolare, potrebbero aver bisogno i minori richiedenti asilo nel momento in cui entrano nel paese ospitante. L'articolo 24 della Carta dei diritti fondamentali dell'Unione europea, che sancisce i diritti dei bambini, si applica ai requisiti di ingresso e di soggiorno dell'*acquis* dell'UE in materia di asilo. Esso stabilisce che, in tutti gli atti relativi ai minori, siano essi compiuti da autorità pubbliche o da istituzioni private, gli Stati membri si adoperino affinché l'interesse superiore del minore sia considerato preminente. Più in particolare, il principio dell'interesse superiore del minore soggiace all'attuazione della direttiva 2013/32/UE recante procedure comuni ai fini del riconoscimento e della revoca dello status di protezione internazionale (direttiva sulle procedure d'asilo)[432] e del regolamento che stabilisce i criteri e i meccanismi di determinazione dello Stato membro competente per l'esame di una domanda di protezione internazionale presentata in uno degli Stati membri da un cittadino di un paese terzo o da un apolide (regolamento Dublino), laddove essi si riferiscono ai minori.[433] Entrambi i testi contengono inoltre garanzie specifiche per i minori non accompagnati, compresa la rappresentanza legale. Il regolamento (CE) n. 562/2006 sul Codice frontiere Schengen obbliga le guardie di frontiera a verificare la sussistenza della potestà genitoriale nei confronti del minore, soprattutto nel caso in cui il minore sia accompagnato da un adulto soltanto e vi siano seri motivi di ritenere che il minore sia stato illegalmente sottratto alla custodia della persona o delle persone che esercitano legalmente la potestà genitoriale nei suoi confronti. In tal caso, le guardie di frontiera devono svolgere ulteriori indagini, al fine di individuare incoerenze o contraddizioni nelle informazioni fornite. In caso di minori che viaggiano senza accompagnatore, le guardie di frontiera devono assicurarsi, mediante verifiche approfondite dei documenti di viaggio e dei giustificativi, che i minori non lascino il territorio

431 Cfr., in particolare, la direttiva sulle condizioni di accoglienza (2013/33/UE), articolo 21, e la direttiva sui rimpatri (2008/115/CE), articolo 3, paragrafo 9.

432 Direttiva 2013/32/UE del Parlamento europeo e del Consiglio, del 26 giugno 2013, recante procedure comuni ai fini del riconoscimento e della revoca dello status di protezione internazionale (rifusione) (GU L 180 del 29.6.2013, pag. 60), articolo 25, paragrafo 6.

433 Regolamento (UE) n. 604/2013 del Parlamento europeo e del Consiglio, del 26 giugno 2013, che stabilisce i criteri e i meccanismi di determinazione dello Stato membro competente per l'esame di una domanda di protezione internazionale presentata in uno degli Stati membri da un cittadino di un paese terzo o da un apolide (rifusione) (GU L 180 del 29.6.2013, pagg. 31–59), articolo 6.

contro la volontà della persona o delle persone che esercitano la potestà genitoriale nei loro confronti.[434]

Nell'ambito del diritto del Consiglio d'Europa, gli Stati hanno il diritto, in virtù di un consolidato principio di diritto internazionale e fatti salvi gli obblighi derivanti dai trattati (compresa la CEDU), di controllare l'ingresso, il soggiorno e l'espulsione dei non cittadini. Il diritto al rispetto della vita privata e familiare di cui all'articolo 8 della CEDU è spesso invocato come scudo contro l'espulsione in casi concernenti minori che, altrimenti, sarebbero considerati come non bisognosi di protezione internazionale, compresa la protezione sussidiaria. Sono state riscontrate violazioni dell'articolo 8 in casi riguardanti minori, poiché la separazione forzata da parenti stretti può avere un forte impatto sul loro equilibrio e sulla loro identità scolastica, sociale ed emotiva.[435]

9.2. Accertamento dell'età[436]

Punti salienti

- Le procedure di accertamento dell'età devono tener conto dei diritti del minore.
- L'accertamento dell'età si riferisce alle procedure attraverso cui le autorità cercano di determinare l'età legale di un migrante per individuare le procedure e le norme da seguire in materia di immigrazione.

Nell'ambito del diritto dell'UE, l'articolo 25, paragrafo 5, della direttiva sulle procedure d'asilo consente agli Stati membri di effettuare visite mediche, purché siano eseguite "nel pieno rispetto della dignità della persona con l'esame meno invasivo possibile ed effettuato da professionisti nel settore medico qualificati". Tale disposizione prevede altresì che il minore sia informato, in una lingua che capisce, della possibilità che la sua età possa essere determinata attraverso una visita medica e che il minore acconsenta allo svolgimento della visita medica. Il

434 Regolamento (CE) n. 562/2006 del Parlamento europeo e del Consiglio, del 15 marzo 2006, che istituisce un codice comunitario relativo al regime di attraversamento delle frontiere da parte delle persone (codice frontiere Schengen) (GU L 105 del 13.4.2006), allegato VII, paragrafo 6.

435 Corte EDU, sentenza 21 dicembre 2001, *Şen c. Paesi Bassi* (n. 31465/96) (consultabile in francese); Corte EDU, sentenza 1° dicembre 2005, *Tuquabo-Tekle e altri c. Paesi Bassi* (n. 60665/00).

436 Cfr. anche FRA e Corte EDU (2014), sezione 9.1.2.

rifiuto di sottoporsi alla visita medica finalizzata all'accertamento dell'età non è un motivo sufficiente per respingere la domanda di protezione internazionale.

La natura e l'ambito di applicazione dei metodi di accertamento dell'età utilizzati nell'UE variano di Paese in Paese.[437] Nel Regno Unito, per esempio, la magistratura ha rivisto le procedure nazionali sull'accertamento dell'età e, nel caso *Merton*, ha definito i requisiti procedurali minimi per l'accertamento dell'età quando una persona dichiara di essere un minore senza accompagnamento.[438] Tra i requisiti si annoverano il diritto del richiedente asilo di essere informato in merito ai motivi del rigetto o alle obiezioni della persona incaricata di condurre il colloquio.[439] I giudizi nazionali hanno inoltre menzionato la necessità di applicare il beneficio del dubbio nei casi di accertamento dell'età, benché tale posizione sia stata interpretata da alcuni giudici nazionali come una mera valutazione "indulgente" delle prove anziché un principio formale di "beneficio del dubbio".[440]

Nell'ambito del diritto del Consiglio d'Europa, non vi sono disposizioni specifiche o una giurisprudenza della Corte EDU sui diritti dei minori nell'ambito delle procedure di accertamento dell'età. Tuttavia, il ricorso a prassi particolarmente invasive in tal senso potrebbe sollevare un problema ai sensi degli articoli 3 o 8 della CEDU. L'articolo 3 è stato interpretato in modo da comprendere un'ampia gamma di scenari che potrebbero essere considerati disumani o degradanti, compresi gli esami fisici invasivi sui minori.[441] Ai sensi dell'articolo 8, applicato al contesto dell'immigrazione, le autorità potrebbero legittimamente interferire con il diritto di un minore alla vita privata e condurre accertamenti dell'età, se l'ingerenza è prevista dalla legge e necessaria per tutelare uno degli scopi legittimi di cui all'articolo 8, paragrafo 2, della CEDU.

Nell'ambito del diritto internazionale, l'articolo 8 della CRC obbliga gli Stati a rispettare il diritto del fanciullo a preservare la propria identità. Ciò implica l'obbligo

437 Per una panoramica dei vari metodi applicati in ciascun paese, cfr. le seguenti linee guida "European Asylum Support Office Guidelines on Age Assessment Practice in Europe", Lussemburgo, 2014. Cfr. anche FRA (2010), pagg. 53–55.

438 Regno Unito, Corte d'Appello, sentenza 14 luglio 2003, *R (su istanza di B) c. The Mayor and Burgesses of the London Borough of Merton* [2003], EWHC, 1689.

439 Cfr. anche FRA (2010), pagg. 61–66.

440 Regno Unito, Corte d'Appello, sentenza 20 dicembre 2011, *R (su istanza di CJ) c. Cardiff County Council* [2011] EWCA Civ 1590, riconfermata in Regno Unito, Upper Tribunal, sentenza 26 marzo 2013, *R (su istanza di MK) c. Wolverhampton City Council* [2013] UKUT 00177 (IAC).

441 Corte EDU, sentenza 1 febbraio 2011, *Yazgül Yilmaz c. Turchia* (n. 36369/06) (consultabile in francese).

di assistere il fanciullo nel ristabilire la sua identità, anche confermando l'età del bambino. Le procedure di accertamento dell'età, tuttavia, dovrebbero rappresentare l'ultima risorsa.

In ogni caso, le procedure nazionali di accertamento dell'età dovrebbero essere guidate dal principio dell'interesse superiore del minore. Il comitato delle Nazioni Unite sui diritti dell'infanzia sostiene che l'accertamento dell'età dovrebbe tener conto dell'aspetto fisico del fanciullo e della sua maturità psicologica. La visita medica deve essere eseguita con metodi scientifici, in piena sicurezza, con modalità giuste e rispettose del bambino e del suo sesso, e, evitando il rischio di violazione dell'integrità fisica del minore e osservando il debito rispetto della dignità umana.[442]

9.3. Ricongiungimento familiare e minori separati[443]

Punti salienti

- Le disposizioni a livello europeo intervengono prevalentemente sul ricongiungimento sicuro dei minori con i genitori, nel paese ospitante o nel paese d'origine.
- Nel determinare quali familiari debbano essere ricongiunti al nucleo familiare sarà data priorità ai genitori del minore e/o ai principali responsabili della sua assistenza.
- I casi di ricongiungimento familiare devono essere ispirati al principio dell'interesse superiore del minore.

Nell'ambito del diritto dell'UE, lo strumento fondamentale è la direttiva sul ricongiungimento familiare, che impone agli Stati membri l'obbligo di autorizzare l'ingresso e il soggiorno dei genitori del minore non accompagnato che siano cittadini di paesi terzi, nelle situazioni in cui il ricongiungimento con i genitori all'estero non rappresenti l'interesse superiore del minore. In assenza di un genitore, gli Stati membri possono autorizzare l'ingresso e il soggiorno del tutore legale

442 Commento generale n. 6 (2005) "Trattamento dei bambini separati dalle proprie famiglie e non accompagnati, fuori dal loro paese d'origine", (V)(a)(31)(A).

443 Cfr. anche FRA e Corte EDU (2014), sezione 5.3 sul ricongiungimento familiare.

del minore o di altro familiare.[444] La definizione e i diritti correlati alla "famiglia" sono pertanto più generosi nei confronti dei minori non accompagnati rispetto alla maggior parte delle altre categorie di figli di migranti.

Quanto ai minori richiedenti asilo, la direttiva qualifiche sottolinea la necessità di provvedere, per quanto possibile, affinché i minori non accompagnati siano alloggiati presso familiari adulti nello Stato ospitante, che i fratelli siano alloggiati assieme e che i familiari assenti siano rintracciati quanto prima, effettuando le operazioni in sicurezza e in via confidenziale (articolo 31). La direttiva sulle condizioni di accoglienza contiene disposizioni simili per i minori non accompagnati che non hanno ancora acquisito lo status di rifugiato (articolo 24).

La direttiva 2001/55/CE del Consiglio, del 20 luglio 2001, sulle norme minime per la concessione della protezione temporanea in caso di afflusso massiccio di sfollati e sulla promozione dell'equilibrio degli sforzi tra gli Stati membri che ricevono gli sfollati e subiscono le conseguenze dell'accoglienza degli stessi (direttiva sulla protezione temporanea), cerca anche di accelerare il ricongiungimento dei familiari (compresi i minori) che sono stati separati a causa di circostanze connesse all'afflusso massiccio dal loro paese d'origine (articolo 15).[445] Questa direttiva, tuttavia, non è stata ancora resa effettiva; perché possa essere "attivata", è necessaria una decisione del Consiglio e questa decisione deve ancora essere adottata.

L'articolo 24, paragrafo 3, della direttiva sulle condizioni di accoglienza (rivista) stabilisce altresì che gli Stati membri inizino a rintracciare i familiari del minore non accompagnato, se necessario anche con l'assistenza di organizzazioni internazionali o altre organizzazioni competenti, quanto prima, non appena sia manifestata la volontà di chiedere la protezione nazionale, sempre tutelando l'interesse superiore del minore. Nei casi in cui sussistano rischi per la vita o l'integrità del minore o dei suoi parenti stretti, in particolare se questi sono rimasti nel paese di origine, la raccolta, il trattamento e la diffusione delle informazioni relative a queste persone sono effettuate in via confidenziale, in modo da non mettere in pericolo la loro sicurezza. Inoltre, ai sensi dell'articolo 31, paragrafo 5, della direttiva qualifiche (rifusa), il riconoscimento della protezione

444 Articolo 10, paragrafo 3, lettere a) e b) rispettivamente.

445 Direttiva 2001/55/CE del Consiglio, del 20 luglio 2001, sulle norme minime per la concessione della protezione temporanea in caso di afflusso massiccio di sfollati e sulla promozione dell'equilibrio degli sforzi tra gli Stati membri che ricevono gli sfollati e subiscono le conseguenze dell'accoglienza degli stessi (GU L 212 del 7.8.2001).

internazionale per il minore non deve interferire con l'inizio o il proseguimento delle operazioni di rintracciamento.

In aggiunta a ciò, il regolamento di Dublino stabilisce che, se un minore non accompagnato ha uno o più parenti presenti in un altro Stato membro che possono occuparsi di lui/lei, gli Stati membri provvedono, ove possibile, al ricongiungimento del minore con tali parenti, purché ciò sia nell'interesse superiore del minore (articolo 8). Il regolamento contiene altresì l'obbligo per gli Stati membri di rintracciare i parenti che si trovino nel territorio degli Stati membri, sempre tutelando l'interesse superiore del minore (articolo 6). Inoltre, la direttiva sulle condizioni di accoglienza stabilisce la necessità di iniziare a rintracciare i familiari del minore, se necessario con l'assistenza di organizzazioni internazionali o altre organizzazioni competenti (articolo 24). Quest'ultima forma di assistenza è contemplata anche dal regolamento di Dublino (articolo 6).

Il principio dell'interesse superiore del minore deve sempre essere applicato al momento di adottare una decisione sul ricongiungimento familiare. Per esempio, i genitori devono poter dimostrare di essere in grado di esercitare i propri doveri genitoriali nei confronti del minore. I giudici nazionali riterranno illegittimo il rimpatrio di un minore nel suo Paese d'origine se le autorità non avranno accertato che in quel paese siano stati adottati provvedimenti adeguati per accogliere e assistere il minore (direttiva rimpatri, articolo 10, paragrafo 2).

Nell'ambito del diritto del Consiglio d'Europa, l'articolo 8 della CEDU non conferisce ai genitori migranti e ai loro figli il diritto assoluto di scegliere dove vivere. Le autorità nazionali possono infatti legittimamente rimpatriare o rifiutare l'ingresso ai familiari, purché non vi siano ostacoli insormontabili alla costruzione della vita familiare altrove.[446] Tali decisioni devono sempre rappresentare una risposta proporzionata a questioni generali di ordine pubblico, compreso il desiderio di rimpatriare o impedire l'ingresso di un genitore che è stato coinvolto in attività criminali.

446 Corte EDU, sentenza 12 giugno 2012, *Bajsultanov c. Austria* (n. 54131/10); Corte EDU, sentenza 5 aprile 2005, *Latifa Benamar e altri c. Paesi Bassi, decisione di inammissibilità* (n. 43786/04).

Esempio: nel caso *Şen c. Paesi Bassi* la Corte EDU ha confermato che, nel tracciare uno spartiacque tra i diritti del minore/della famiglia e i generali interessi di ordine pubblico, occorre tenere in considerazione tre fattori: l'età dei minori; la loro situazione nel paese d'origine; e il grado di effettiva dipendenza dai genitori.

Esempio: il caso *Jeunesse c. Paesi Bassi*[447] riguarda il rifiuto delle autorità olandesi di consentire a una donna del Suriname sposata a un cittadino olandese, con il quale aveva avuto tre figli, di soggiornare nei Paesi Bassi in virtù dei suoi vincoli familiari in questo paese. La Corte EDU ha ritenuto che le autorità interne non avessero prestato sufficiente attenzione alle conseguenze che avrebbe avuto per i figli della ricorrente e per i loro interessi superiori la decisione di negare alla loro madre il permesso di soggiorno. La Corte EDU ha riscontrato una violazione dell'articolo 8 della CEDU in ragione del fatto che non era stato raggiunto un giusto equilibrio tra gli interessi personali della ricorrente e della sua famiglia di mantenere la vita familiare nei Paesi Bassi e gli interessi di ordine pubblico del governo di controllare l'immigrazione.

Nell'ambito del diritto internazionale, un minore ha il diritto di non essere separato dalla sua famiglia a meno che questa separazione non sia considerata necessaria nell'interesse preminente del fanciullo (articolo 9, paragrafo 1, della CRC). L'articolo 10 della CRC stabilisce che un fanciullo i cui genitori risiedono in Stati diversi ha diritto a spostarsi da un paese all'altro per intrattenere contatti regolari con entrambi i genitori, o per ricongiungersi a loro, nel rispetto della legislazione nazionale in materia di immigrazione. L'interesse superiore del fanciullo, sancito dall'articolo 3 della CRC, deve essere alla base di tutte le decisioni concernenti il ricongiungimento familiare con un minore o un minore non accompagnato.[448]

447 Corte EDU, sentenza 3 ottobre 2014, *Jeunesse c. Paesi Bassi* [GC] (n. 12738/10).

448 Secondo l'UNICEF, in relazione alle richieste di ricongiungere il fanciullo alla sua famiglia nel paese ospitante, i giudici nazionali devono altresì garantire che i genitori non stiano sfruttando la situazione per ottenere un permesso di soggiorno in quel pese. Cfr. UNICEF, Judicial impementation of Art. 3 of the CRC in Europe (Attuazione giudiziaria dell'articolo 3 della CRC in Europa), pag. 104. Cfr. anche Alto Commissario delle Nazioni Unite per i rifugiati (UNHCR), *Guidelines on Determining the Best Interests of the Child*, maggio 2008.

9.4. Trattenimento

Punti salienti

- La legislazione europea ammette il trattenimento di minori in un contesto migratorio solo come misura estrema.
- Le autorità nazionali sono tenute a fornire ai minori un alloggio alternativo adeguato.

Nell'ambito del diritto dell'UE, l'articolo 11 della direttiva sulle condizioni di accoglienza (rivista) stabilisce che i minori possono essere trattenuti solo come ultima risorsa e solo dopo ci sia stato accertato che misure alternative meno coercitive non possono essere applicate in maniera efficace. A tale trattenimento deve farsi ricorso per un periodo di durata più breve possibile ed deve essere fatto il possibile perché i minori trattenuti siano rilasciati e ospitati in alloggi idonei. I minori trattenuti devono poter avere la possibilità di svolgere attività di svago, compresi il gioco e attività ricreative consone alla loro età. Secondo il medesimo articolo, anche i minori non accompagnati sono trattenuti soltanto in circostanze eccezionali ed vengono prese tutte le misure necessarie siano rilasciati il più rapidamente possibile. I minori non accompagnati non sono mai trattenuti in istituti penitenziari, ma deve essergli fornita una sistemazione in istituti dotati di personale e strutture consoni a soddisfare le esigenze di persone della loro età. Deve essere garantita loro una sistemazione separata dagli adulti.

L'articolo 17 della direttiva rimpatri prevede il trattenimento di minori e famiglie la cui domanda di asilo sia stata respinta, a determinate condizioni. Nel caso dei minori non accompagnati, tuttavia, la direttiva stabilisce che siano sistemati in istituti dotati di personale e strutture consoni a soddisfare le esigenze di persone della loro età. Non esiste finora un filone giurisprudenziale della GCUE che riguardi nello specifico il trattenimento di minori.

Nell'ambito del diritto del Consiglio d'Europa, il trattenimento di migranti minorenni è stato esaminato alla luce degli articoli 3 e 5 della CEDU.

Esempio: il caso *Mubilanzila Mayeka e Kaniki Mitunga c. Belgio*[449] riguarda un minore non accompagnato sottoposto a una misura di trattenimento. Una bambina di cinque anni è stata trattenuta in un centro di transito per adulti per due mesi, senza adeguato supporto. La bambina, sprovvista dei necessari documenti di viaggio, proveniva dalla Repubblica democratica del Congo e cercava di ricongiungersi alla madre, cui era stato riconosciuto il diritto di asilo in Canada. La bambina era stata successivamente rimpatriata nella Repubblica democratica del Congo, nonostante non vi fossero in quel paese familiari che potessero occuparsi di lei. La Corte EDU ha stabilito che, non essendoci stato alcun rischio che la bambina cercasse di sottrarsi alla sorveglianza delle autorità belghe, il suo trattenimento in un centro chiuso per adulti è stato superfluo. La Corte EDU ha altresì osservato che avrebbero potuto essere intraprese altre misure (il suo inserimento in un centro specializzato o l'affido a una famiglia) più adatte a garantire l'interesse superiore della fanciulla sancito dall'articolo 3 della CRC. La Corte EDU ha riscontrato una violazione degli articoli 3, 5 e 8 della CEDU.

Altri casi hanno messo in rilievo l'illegittimità del trattenimento, anche quando il minore in questione era accompagnato da un genitore.

Esempio: nel caso *Muskhadzhiyeva e altri c. Belgio*,[450] la Corte EDU ha stabilito che il trattenimento protratto nell'arco di più mesi in un centro di transito chiuso di una madre e dei suoi quattro figli, di età compresa tra sette mesi e sette anni, costituiva una violazione dell'articolo 3 della CEDU. Nel raggiungere tali conclusioni, la Corte ha attirato l'attenzione sul fatto che il centro era "inadeguato per ospitare minori", con gravi conseguenze per la loro salute psichica.

Esempio: il caso *Popov c. Francia,*[451] riguardante il trattenimento amministrativo di una famiglia per due settimane in attesa della loro espulsione in Kazakistan, conferma questa sentenza. La Corte EDU ha infatti riscontrato una violazione dell'articolo 3 della Corte EDU per il fatto che le autorità francesi non avevano soppesato le inevitabili conseguenze negative sui

449 Corte EDU, sentenza 12 ottobre 2006, *Mubilanzila Mayeka e Kaniki Mitunga c. Belgio* (n. 13178/03).

450 Corte EDU, sentenza 19 gennaio 2010, *Muskhadzhiyeva e altri c. Belgio* (n. 41442/07) (consultabile in francese).

451 Corte EDU, sentenza 19 gennaio 2012, *Popov c. Francia* (nn. 39472/07 e 39474/07).

due bambini (di cinque mesi e tre anni) del trattenimento in un centro di detenzione in condizioni considerate "inadatte alla presenza di minori".[452] Ha altresì riscontrato una violazione dell'articolo 5 e dell'articolo 8 con riferimento all'intera famiglia e una violazione dell'articolo 37 della CRC, che stabilisce che "ogni fanciullo privato di libertà sia trattato con umanità e con il rispetto dovuto alla dignità della persona umana e in maniera da tener conto delle esigenze delle persone della sua età".[453]

Esempio: analogamente, nel caso *Kanagaratnam c. Belgio*,[454] il trattenimento di una madre richiedente asilo e dei suoi tre figli in un centro di detenzione per stranieri irregolari per quattro mesi equivale a una violazione degli articoli 3 e 5 della CEDU. Nonostante il fatto che i bambini fossero accompagnati dalla madre, la Corte ha ritenuto che, trattenendoli in un centro di detenzione, le autorità belghe li avessero esposti a sentimenti di angoscia e di inferiorità e si fossero assunte il rischio, in modo pienamente consapevole, di compromettere il loro sviluppo.[455]

Nell'ambito del diritto internazionale, l'articolo 9, paragrafo 4, della CRC stabilisce che, in caso di trattenimento di un minore, le autorità statali sono tenute a fornire ai genitori del minore informazioni riguardanti il luogo dove si trovano.[456]

452 *Ibid*., punto 95.

453 *Ibid*., punto 90.

454 Corte EDU, sentenza 13 dicembre 2011, *Kanagaratnam c. Belgio* (n. 15297/09) (consultabile in francese).

455 Il comitato europeo per la prevenzione della tortura e delle pene o trattamenti inumani o degradanti (CPT), nella sua 19a relazione generale, ha descritto le salvaguardie per i migranti irregolari privati della loro libertà e le ulteriori tutele previste per i minori. Cfr. anche *20 years of combating torture, 19th General Report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)*, 1°agosto 2008–31 luglio 2009.

456 Sulle tutele internazionali per i minori in situazione di trattenimento cfr. *Rapporto del relatore speciale sulla tortura e altri trattamenti o pene crudeli, disumani e degradanti*, 5 marzo 2015, A/HRC/28/68.

9.5. Espulsione[457]

Punti salienti

- La vulnerabilità dei figli dei migranti all'espulsione è intrinsecamente legata allo status di residenza dei loro genitori nel paese ospitante.
- Il principio dell'interesse superiore dovrebbe orientare tutte le decisioni relative all'espulsione dei migranti minorenni e delle loro famiglie/dei responsabili della loro assistenza.
- Il diritto dell'UE contempla situazioni in cui i migranti minorenni possono rimanere in un paese ospitante nonostante lo status giuridico dei loro genitori, in particolare allo scopo di terminare gli studi o qualora la costruzione di una vita familiare altrove fosse difficile.

Nell'ambito del diritto dell'UE, come per altre sfere della legislazione dell'UE in materia di migrazione, le norme che disciplinano l'espulsione dei minori variano a seconda della loro cittadinanza, della cittadinanza dei loro genitori e del contesto del loro trasferimento. Una volta che un minore ottiene l'autorizzazione ad accedere a uno Stato membro in virtù della legislazione sulla libera circolazione nell'UE, vi sono buone probabilità che possa rimanere in quel Paese, anche se il cittadino dell'UE con cui si era trasferito originariamente non ha più diritto a soggiornare o decide di andarsene.

In particolare, ai sensi della direttiva sulla libera circolazione, i figli e altri familiari possono rimanere nel paese ospitante dopo il decesso del cittadino dell'Unione con cui si erano inizialmente trasferiti (articolo 12, paragrafo 2), purché abbiano soggiornato nello Stato ospitante per almeno un anno prima del decesso del genitore. Analogamente, possono rimanere nel paese ospitante, in linea di principio, anche dopo la partenza del genitore. In entrambi i casi, tuttavia, se il figlio o familiare è cittadino di un paese terzo, il diritto a soggiornare in questo Paese è subordinato alla loro capacità di dimostrare di disporre di risorse economiche sufficienti a mantenersi. Devono anche possedere un'assicurazione malattia (articolo 7).

457 Detta anche rimpatrio, allontanamento o estradizione, a seconda del contesto legale. Ai fini del presente capitolo, il termine espulsione sarà usato per indicare l'allontanamento illecito di uno straniero o di un altro soggetto da uno Stato. Cfr. anche FRA e Corte EDU (2014), sezione 5.4 sul ricongiungimento familiare – protezione dall'espulsione.

Le norme sono ancora più permissive nel caso di figli iscritti presso strutture scolastiche nel Paese ospitante. In questi casi i minori e i genitori o tutori che ne hanno l'effettivo affidamento sono autorizzati a rimanere nel Paese ospitante dopo la partenza del cittadino dell'Unione dallo Stato membro ospitante o il suo decesso, indipendentemente dalla cittadinanza del minore (articolo 12, paragrafo 3). Se originariamente si è ritenuto che questo ulteriore diritto correlato al percorso scolastico si applicasse soltanto ai figli di famiglie con risorse sufficienti a mantenersi,[458] successivamente la giurisprudenza ha confermato che esso si estende anche ai figli che beneficiano di un supporto di previdenza sociale per potersi dedicare agli studi.[459]

Inoltre, hanno diritto a rimanere nel Paese ospitante anche i familiari e, in particolare, il genitore non avente la cittadinanza di uno Stato membro e divorziato dal coniuge cittadino dell'UE, se ha ottenuto l'affidamento dei figli o beneficia del diritto di visita ai figli se le visite devono obbligatoriamente essere effettuate nel Paese ospitante (articolo 13, paragrafo 2, lettere b) e d)).

La Corte si è fondata direttamente sullo status di cittadino dell'Unione di cui all'articolo 20 del TFUE per accordare ai genitori di un minore che siano cittadini di un Paese terzo il permesso di lavorare e soggiornare nello Stato membro dell'UE di cittadinanza del minore. In questo modo il minore può godere dei diritti correlati al suo status di cittadino dell'UE, se in caso contrario il minore sarebbe costretto a lasciare l'UE per accompagnare i genitori.[460] La giurisprudenza della CGUE indica, tuttavia, che "la mera circostanza che possa apparire auspicabile al cittadino di uno Stato membro, per ragioni economiche o per mantenere l'unità familiare nel territorio dell'Unione, che i suoi familiari, che non possiedono la cittadinanza di uno Stato membro, possano soggiornare con lui nel territorio dell'Unione, non basta di per sé a far ritenere che il cittadino dell'Unione sia costretto ad abbandonare il territorio dell'Unione qualora un tale diritto non gli venga concesso".[461]

458 CGUE, sentenza 17 settembre 2002, causa C-413/99, *Baumbast e R c. Secretary of State for the Home Department*.

459 CGUE, sentenza 23 febbraio 2010, causa C-480/08, *Maria Teixeira c. London Borough of Lambeth e Secretary of State for the Home Department*; CGUE, sentenza 23 febbraio 2010 [GS], causa C-310/08, *London Borough of Harrow c. Nimco Hassan Ibrahim e Secretary of State for the Home Department*. L'istruzione dei figli dei migranti è esaminata anche al paragrafo 8.2.

460 CGUE, sentenza 8 marzo 2011, causa C-34/09, *Gerardo Ruiz Zambrano c. Office National de l'Emploi (ONEm)*.

461 CGUE, sentenza 15 novembre 2011, causa C-256/11, *Murat Dereci e altri c. Bundesministerium für Inneres*, punto 68. Cfr. anche la sentenza della Corte 8 novembre 2012, causa C-40/11, *Yoshikazu Iida c. Stadt Ulm* Cfr. anche FRA e Corte EDU (2014), pag. 125–127.

La direttiva sulla libera circolazione stabilisce esplicitamente che qualsiasi misura di allontanamento di minori adottata in circostanze eccezionali dovrebbe essere conforme alla CRC (considerando 24). Inoltre, l'articolo 28, paragrafo 3, lettera b), ribadisce il divieto di allontanamento nei confronti di un minore, salvo quando sia necessario nell'interesse del bambino, secondo quanto contemplato dalla CRC.

Per quanto riguarda i minori richiedenti asilo la cui domanda sia stata respinta, la direttiva rimpatri specifica che le decisioni riguardanti il rimpatrio dei minori non accompagnati devono essere adottate tenendo conto dell'interesse superiore del minore (articolo 10). Oltretutto, prima di allontanare un minore non accompagnato dal territorio di uno Stato membro, le autorità di tale Stato membro si accertano che questi sarà ricondotto ad un membro della sua famiglia, a un tutore designato o presso adeguate strutture di accoglienza nello Stato di rimpatrio (articolo 10, paragrafo 2).

Quando i minori richiedenti asilo sono trasferiti in un altro Stato membro ai fini della valutazione della domanda di asilo, il regolamento di Dublino stabilisce che l'interesse superiore del minore deve orientare l'attuazione di tali decisioni (articolo 6). Il regolamento fornisce anche un elenco di fattori per assistere le autorità nell'individuazione dell'interesse superiore del minore, tra cui le possibilità di ricongiungimento familiare; il benessere e lo sviluppo sociale del minore; le considerazioni di sicurezza, in particolare se sussiste un rischio che il minore sia vittima della tratta di esseri umani; l'opinione del minore, secondo la sua età e maturità.

Esempio: nella causa *The Queen, su istanza di MA e altri c. Secretary of State for the Home Department*,[462] la CGUE doveva stabilire quale Stato fosse competente nel caso di un minore non accompagnato che aveva presentato più domande di asilo in vari Stati membri dell'UE e che non aveva alcun familiare presente in altri Stati membri dell'UE. La CGUE ha chiarito che, in mancanza di un familiare che si trovi legalmente in uno Stato membro, è competente a esaminare la domanda lo Stato membro nel quale si trova il minore. Così facendo, la CGUE si è richiamata all'articolo 24, paragrafo 2, della Carta dei diritti fondamentali dell'Unione europea, in base al quale, in tutti gli atti relativi ai minori, l'interesse superiore del minore deve essere considerato preminente.

462 CGUE, sentenza 6 giugno 2013, causa C-648/11, *The Queen, su istanza di MA e altri c. Secretary of State for the Home Department*.

Nell'ambito del diritto del Consiglio d'Europa, in linea di principio gli Stati sono autorizzati a interferire con il diritto al rispetto della vita familiare di cui all'articolo 8, paragrafo 2, della CEDU.

Esempio: il caso *Gül c. Svizzera*[463] riguarda un ricorrente che viveva in Svizzera con la moglie e la figlia e al quale, insieme ai suoi familiari, erano stati concessi diritti di soggiorno per motivi umanitari. Il ricorrente desiderava richiamare in Svizzera il figlio minorenne, che era rimasto in Turchia, ma le autorità svizzere avevano respinto la domanda, perché non godeva dei mezzi sufficienti per sostenere la sua famiglia. La Corte EDU ha sostenuto che, lasciando la Turchia, il ricorrente si era intenzionalmente separato dal figlio. I recenti viaggi in Turchia del richiedente dimostrano che i motivi inizialmente considerati per la richiesta di asilo politico in Svizzera erano venuti meno. Non sussistevano più ostacoli che impedivano alla famiglia di stabilirsi nel Paese d'origine, dove il figlio minorenne aveva sempre vissuto. Pur riconoscendo le gravi difficoltà in cui la famiglia versava dal punto di vista umanitario, la Corte non ha riscontrato una violazione dell'articolo 8 della CEDU.

Esempio: nel caso *Üner c. Paesi Bassi*[464] è stata ribadita la necessità di tenere in considerazione l'impatto che l'espulsione avrebbe sui bambini membri di una famiglia al momento di stabilire se l'espulsione rappresenta una risposta proporzionata. Si deve pertanto considerare: "il miglior interesse dei minori eventualmente coinvolti (in particolare la loro difficoltà a integrarsi nel Paese verso cui il genitore è espulso) e la solidità dei legami sociali, culturali e familiari coltivati dall'individuo nel paese di residenza e in quello di destinazione".

Esempio: il caso *Tarakhel c. Svizzera*[465] riguarda il rifiuto delle autorità svizzere di esaminare la domanda di asilo di una coppia afgana e dei loro sei figli, e la decisione di rinviarli in Italia. La Corte EDU ha accertato che, alla luce della situazione attuale del sistema di accoglienza in Italia, e in assenza di dettagliate e affidabili informazioni riguardo alla specifica struttura di destinazione, le autorità svizzere non possedevano sufficienti garanzie che, se i ricorrenti fossero stati rinviati in Italia, sarebbero stati accolti in

463 Corte EDU, sentenza 19 febbraio 1996, *Gül c. Svizzera* (n. 23218/94).

464 Corte EDU, sentenza 18 ottobre 2006, *Üner c. Paesi Bassi*, (n. 46410/99), punti 57–58. Cfr. anche Corte EDU, sentenza 2 agosto 2001, *Boultif c. Svizzera* (n. 54273/00).

465 Corte EDU, sentenza 4 novembre 2014, *Tarakhel c. Svizzera* [GC] (n. 29217/12).

condizioni adeguate rispetto all'età dei minori. La Corte EDU ha pertanto dichiarato che, se le autorità svizzere avessero rinviato i ricorrenti in Italia in virtù del regolamento di Dublino II, senza prima aver ottenuto dalle autorità italiane garanzie individuali sull'adeguatezza delle condizioni di accoglienza rispetto all'età dei minori e sul mantenimento dell'unità familiare, esse sarebbero incorse in una violazione dell' articolo 3 della CEDU.

Nell'ambito del diritto internazionale, in caso di detenzione, imprigionamento, esilio, espulsione o morte di uno o entrambi i genitori, o del fanciullo, uno Stato fornisce dietro richiesta ai genitori, o al fanciullo, le informazioni essenziali concernenti il luogo dove si trovano il familiare o i familiari, a meno che la divulgazione di tali informazioni possa mettere a repentaglio il benessere del fanciullo (articolo 9, paragrafo 4, della CRC).

9.6. Accesso alla giustizia[466]

Punto saliente

- I figli dei migranti hanno diritto a un rimedio efficace.

Nell'ambito del diritto dell'UE, i diritti dei minori di accedere alla giustizia in un contesto migratorio sono sanciti da una serie di strumenti diversi. In primo luogo, il diritto a un ricorso effettivo e a un giudice imparziale è stabilito dall'articolo 47 della Carta dei diritti fondamentali dell'UE. È compreso in questo articolo il diritto di un individuo a che la sua causa sia esaminata equamente, pubblicamente ed entro un termine ragionevole da un giudice indipendente e imparziale, con la facoltà di ogni individuo di farsi consigliare, difendere e rappresentare in maniera adeguata (articolo 48). Per i figli dei migranti, tali garanzie sono rafforzate da una serie di disposizioni legislative secondarie. In particolare, il regolamento di Dublino impone agli Stati membri l'obbligo di garantire che un minore non accompagnato sia rappresentato da qualcunoche possieda le necessarie qualifiche e che abbia accesso al contenuto dei documenti pertinenti della pratica del minore (articolo 6). Disposizioni analoghe sono contenute nella direttiva qualifiche (articolo 31) e nella direttiva sulle procedure d'asilo (articolo 25). Il diritto dei minori

466 Cfr. anche FRA e Corte EDU (2014), sezione 4.5 sulla consulenza legale nei casi di asilo e sulle procedure di rimpatrio.

alla rappresentanza legale è altresì rafforzato dal diritto di accesso ai servizi di assistenza alle vittime e a specifici servizi di assistenza riservati, di cui all'articolo 8 della direttiva 2012/29/UE che istituisce norme minime in materia di diritti, assistenza e protezione delle vittime di reato (Direttiva sui diritti delle vittime).[467]

Tuttavia, i diritti associati all'accesso alla giustizia non sono privi di limiti e possono essere subordinati a determinate condizioni correlate all'età. Per esempio, la direttiva sulle procedure d'asilo consente agli Stati membri di "astenersi dal nominare un rappresentante [legale], se il minore non accompagnato raggiungerà presumibilmente l'età di 18 anni prima che sia presa una decisione in primo grado" (articolo 25, paragrafo 2).

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU si è espressa sull'applicabilità dell'articolo 6 (diritto a un equo processo) della CEDU nei casi concernenti decisioni sull'ingresso, il soggiorno e l'espulsione di stranieri[468]. Tuttavia, in determinate circostanze è possibile invocare l'articolo 13 della CEDU (diritto a un ricorso efficace).

Esempio: il caso *Rahimi c. Grecia*[469] riguarda le condizioni in cui un migrante minorenne proveniente dall'Afghanistan, che era arrivato in Grecia illegalmente, era stato costretto a vivere in un centro di trattenimento, dal quale successivamente era stato allontanato in vista dell'espulsione. Nel riscontrare una violazione dell'articolo 13 della CEDU, la Corte EDU ha osservato che la brochure informativa fornita al ricorrente non indicava la procedura da seguire per poter presentare ricorso al capo della polizia. Inoltre, la brochure informativa che faceva riferimento ai rimedi disponibili al ricorrente per lamentare le condizioni di detenzione cui era stato sottoposto, non era redatta in una lingua a lui comprensibile. Rifacendosi alle relazioni del comitato europeo per la prevenzione della tortura e delle pene o trattamenti inumani o degradanti (CPT), la Corte EDU ha preso atto dell'assenza in Grecia di un'autorità indipendente deputata all'ispezione delle strutture di detenzione gestite dalle autorità di polizia. Ha altresì osservato che non esiste un'autorità imparziale che possa rendere efficaci i rimedi

467 Direttiva 2012/29/UE del Parlamento europeo e del Consiglio, del 25 ottobre 2012, che istituisce norme minime in materia di diritti, assistenza e protezione delle vittime di reato (GU L 315 del 14.11.2012, pag. 57).

468 Corte EDU, sentenza 5 ottobre 2000, *Maaouia v. Francia* [GC] (n. 39652/98).

469 Corte EDU, sentenza 5 aprile 2011, *Rahimi c. Grecia* (n. 8687/08) (consultabile in francese).

previsti. Di conseguenza, la Corte ha riscontrato una violazione dell'articolo 3, dell'articolo 5, paragrafi 1 e 4, e dell'articolo 13 della CEDU.

La CSE stabilisce che gli Stati promuovono lo sviluppo legale (oltre che sociale ed economico) della famiglia (articolo 16). Inoltre, in virtù dell'articolo 19, paragrafo 1, gli Stati s'impegnano a mantenere "adeguati servizi gratuiti" e a garantire che i lavoratori migranti e le loro famiglie ricevano informazioni esatte in materia di emigrazione e immigrazione. Un obbligo analogo in materia di "informazioni" (fondamentali per l'accesso dei migranti alla giustizia) è previsto dall'articolo 6 della Convenzione europea sullo statuto giuridico dei lavoratori emigranti, benché le più ampie disposizioni sul diritto di accesso ai giudici e alle autorità amministrative (articolo 26) siano riservate esclusivamente ai lavoratori migranti anziché ai loro familiari.[470]

Vale la pena notare, inoltre, che il Consiglio d'Europa ha elaborato orientamenti estremamente esaustivi sulla giustizia a misura di minore, che precisano in che modo tutti i procedimenti giudiziari e amministrativi, compresi i procedimenti in materia di immigrazione, devono essere adattati per rispondere alle esigenze dei minori.[471]

Nell'ambito del diritto internazionale, l'articolo 37 della CRC è particolarmente importante per i migranti minorenni privati di libertà, poiché garantisce a questi soggetti il diritto ad avere rapidamente accesso a un'assistenza giuridica o a ogni altra assistenza adeguata, nonché il diritto di contestare la legalità della loro privazione di libertà dinanzi a un Tribunale o altra autorità competente, indipendente e imparziale, che devono adottare una decisione sollecita in materia.

470 Consiglio d'Europa, Convenzione europea sullo statuto giuridico dei lavoratori emigranti, STE n. 93, 1977.

471 Consiglio d'Europa, Comitato dei ministri (2010), *Linee guida per una giustizia a misura di minore*, 17 novembre 2010.

10 Tutela dei consumatori e protezione dei dati personali

UE	Argomenti trattati	Consiglio d'Europa
Carta dei diritti fondamentali, articolo 38 TFUE, articolo 169 Direttiva sui diritti dei consumatori (2011/83/UE) Direttiva relativa alle pratiche commerciali sleali tra imprese e consumatori (2005/29/CE) Direttiva sulla sicurezza generale dei prodotti (2001/95/CE) Direttiva sulla sperimentazione clinica (2001/20/CE) CGUE, C-244/06, *Dynamic Medien Vertriebs GmbH c. Avides Media AG*, 2008 (vendita di DVD tramite Internet) CGUE, C-36/02, *Omega Spielhallen- und Automatenaufstellungs-GmbH c. Oberbürgermeisterin der Bundesstadt Bonn*, 2004 (licenza per un gioco) Regolamento 536/2014 sulla sperimentazione clinica dei medicinali per uso umano Direttiva relativa ai prodotti alimentari destinati a un'alimentazione particolare (2009/39/CE) Direttiva sulla sicurezza dei giocattoli (2009/48/CE) Direttiva concernente i prodotti che, avendo un aspetto diverso da quello che sono in realtà, compromettono la salute o la sicurezza dei consumatori (87/357/CEE)	Protezione dei minori come consumatori	Convenzione europea sulla televisione transfrontaliera

UE	Argomenti trattati	Consiglio d'Europa
Direttiva sull'esercizio delle attività televisive senza frontiere (89/552/CEE) Direttiva sui servizi di media audiovisivi (2010/13/UE)		
Carta dei diritti fondamentali, articolo 7 (rispetto della vita privata e della vita familiare), articolo 8 (protezione dei dati di carattere personale) e articolo 52 (ambito di applicazione e interpretazione dei diritti e dei principi) TFUE, articolo 16 Direttiva sulla protezione dei dati (95/46/CE)	**Minori e tutela dei dati**	CEDU, articolo 8 (diritto al rispetto della vita privata e familiare) Corte EDU, *K.U. c. Finlandia*, n. 2872/02, 2008 (pubblicazione di un annuncio su Internet) Corte EDU, *Avilkina e altri c. Russia*, n. 1585/09, 2013 (divulgazione di dossier medici) Convenzione sulla protezione delle persone rispetto al trattamento automatizzato di dati a carattere personale

In questo capitolo saranno esaminate la legislazione e la giurisprudenza europee nella sfera della protezione dei consumatori e della tutela dei dati. A livello dell'UE esistono una nutrita legislazione e giurisprudenza, dal momento che il TFUE definisce espressamente la competenza dell'UE in tali ambiti. Il contributo del Consiglio d'Europa in questo ambito è più limitato. A livello dei trattati, vi sono due importanti convenzioni sui mezzi d'informazione e sulla tutela dei dati. La Corte EDU si è inoltre espressa in alcuni casi riguardanti la tutela dei dati personali.

Nei seguenti paragrafi saranno esaminati aspetti specifici della legislazione sui consumatori relativa ai minori (paragrafo 10.1) e alla tutela dei dati (paragrafo 10.2). Per ciascuno di questi aspetti si analizzeranno il quadro giuridico generale e la sua applicabilità nel caso dei minori, oltre che le norme specifiche per la tutela dei minori, se del caso.

10.1. Protezione dei minori come consumatori

Punti salienti

- Secondo la Corte di giustizia dell'Unione europea, il miglior interesse dei minori come consumatori e la tutela dei loro diritti prevalgono rispetto ai requisiti di interesse pubblico per il quale è giustificato limitare la libera circolazione di beni, persone, servizi e capitali.
- I minori come consumatori devono ricevere informazioni pertinenti per poter essere in grado di considerare tutti gli elementi rilevanti e fare una scelta informata.
- Sono inique le prassi commerciali non conformi al principio della diligenza professionale che possono influenzare le decisioni di natura commerciale dei consumatori adulti e non.
- I minori possono essere inseriti in sperimentazioni cliniche soltanto se si prevede che il medicinale somministrato avrà un beneficio diretto, che sia superiore ai rischi.
- La legislazione dell'UE e del Consiglio d'Europa limita l'esposizione dei minori alle attività di commercializzazione, senza tuttavia vietare questa pratica.
- I minori hanno diritto a una tutela specifica, che prevede la protezione da pubblicità e da programmi di televendita che potrebbero causare loro pregiudizi di natura morale o fisica.
- È vietato l'uso della pubblicità commerciale nei programmi per bambini.

10.1.1. Diritti dei consumatori

Nell'ambito del diritto dell'UE i principali pilastri della tutela dei consumatori sono sanciti all'articolo 169, paragrafo 1, del TFUE e all'articolo 38 della Carta dei diritti fondamentali dell'Unione europea. La Corte di giustizia ha riconosciuto che il miglior interesse del minore prevale sui requisiti di ordine pubblico, giustificando dunque l'esistenza di limitazioni alle libertà del mercato comune.

Esempio: la causa *Dynamic Medien*[472] riguarda la vendita tramite Internet in Germania di DVD di cartoni animati giapponesi. Nel Regno Unito i cartoni animati erano stati classificati nella categoria "vietati ai minori di 15 anni". L'autorità tedesca competente aveva considerato i cartoni animati non idonei. La questione pregiudiziale sottoposta alla Corte di giustizia era se il divieto in vigore in Germania fosse contrario al principio della libera circolazione. La Corte ha appurato che lo scopo principale della legislazione tedesca era quello di proteggere i minori da informazioni che potessero nuocere al loro benessere. Ha quindi stabilito che la restrizione alla libera circolazione di merci non era sproporzionata nella misura in cui non eccedeva quanto necessario per conseguire l'obiettivo della tutela dei minori perseguito dallo Stato membro in questione.

Esempio: la causa *Omega*[473] riguarda la gestione di un "laserdromo" in Germania. Il gioco che si svolgeva nel "laserdromo" prevedeva che si colpissero i sensori fissati sui giubbotti indossati dai giocatori. L'attrezzatura per il gioco era fornita da una società britannica ed era stata commercializzata legalmente, insieme al modello di gioco, nel Regno Unito. Il gioco era stato vietato in Germania perché contrario a valori fondamentali quali la dignità umana. La Corte di giustizia ha appurato che la limitazione imposta dalle autorità tedesche non era contraria al diritto dell'UE, poiché era stata correttamente giustificata da motivi di ordine pubblico.

Il più recente processo di revisione della legislazione dell'UE in materia di consumatori è sfociato nell'adozione della direttiva 2011/83/EU (direttiva sui diritti dei consumatori), che mira ad armonizzare completamente le legislazioni nazionali sui contratti di vendita a distanza e sui contratti negoziati al di fuori dei locali commerciali, oltre che su altre tipologie di contratti conclusi dai consumatori.[474] L'intenzione è raggiungere un equilibrio tra un elevato livello di tutela dei consumatori e la competitività delle imprese. La direttiva, ai sensi dell'articolo 3, paragrafo 3, lettera a), non si applica ai contratti per i servizi sociali, compresi

472 CGUE, sentenza 14 febbraio 2008, causa C-244/06, *Dynamic Medien Vertriebs GmbH c. Avides Media AG*.

473 CGUE, sentenza 14 ottobre 2004, causa C-36/02, *Omega Spielhallen- und Automatenaufstellungs-GmbH c. Oberbürgermeisterin der Bundesstadt Bonn*.

474 Direttiva 2011/83/UE del Parlamento europeo e del Consiglio, del 25 ottobre 2011, sui diritti dei consumatori, recante modifica della direttiva 93/13/CEE del Consiglio e della direttiva 1999/44/CE del Parlamento europeo e del Consiglio e che abroga la direttiva 85/577/CEE del Consiglio e la direttiva 97/7/CE del Parlamento europeo e del Consiglio (GU L 304 del 22.11.2011, pag. 64). La direttiva avrebbe dovuto essere stata applicata entro il 13 dicembre 2013.

gli alloggi popolari, l'assistenza all'infanzia e il sostegno alle famiglie e alle persone temporaneamente o permanentemente in stato di bisogno, ivi compresa l'assistenza a lungo termine. I servizi sociali comprendono, tra gli altri, i servizi per i bambini e i giovani, i servizi di assistenza per le famiglie, per i genitori soli e le persone anziane e i servizi per i migranti. La direttiva dedica un'attenzione specifica alle informazioni precontrattuali. Gli "obblighi di informazione" sono fondati sul presupposto che se i consumatori, compresi i minori, riceveranno informazioni adeguate, essi saranno in grado di considerare tutti gli elementi pertinenti e prendere decisioni informate.

10.1.2. Pratiche commerciali illecite nei confronti di minori

Nell'ambito della legislazione dell'UE, la direttiva 2005/29/CE relativa alle pratiche commerciali sleali tra imprese e consumatori nel mercato interno[475] riguarda la totalità delle pratiche commerciali tra imprese e consumatori (sia offline che online, e concernenti sia merci che servizi). La direttiva inserisce i minori nella categoria dei "consumatori vulnerabili" (articolo 5, paragrafo 3). Non sono ammesse decisioni commerciali prese nell'ambito di pratiche commerciali che comportano il ricorso a molestie, coercizione o informazioni ingannevoli, e i consumatori minorenni hanno il diritto di prendere le proprie decisioni liberamente. La direttiva vieta le attività di commercializzazione di prodotti, compresa la pubblicità, che ingenerano confusione con un altro prodotto o con il marchio di un concorrente, e introduce l'obbligo di fornire ai consumatori tutte le informazioni necessarie in maniera chiara e comprensibile, e con la tempestività necessaria per consentire ai consumatori di prendere una decisione di natura commerciale (articoli 6 e 7).

10.1.3. Sicurezza del prodotto

Nell'ambito del diritto dell'UE esiste un quadro legislativo esaustivo che garantisce che soltanto i prodotti sicuri e comunque conformi possano essere immessi sul mercato. In particolare, la direttiva 2001/95/CE relativa alla sicurezza generale dei prodotti dedica un'attenzione specifica alla sicurezza dei minori, includendoli nella categoria di consumatori che possono essere particolarmente vulnerabili ai

475 Direttiva 2005/29/CE del Parlamento europeo e del Consiglio, dell'11 maggio 2005, relativa alle pratiche commerciali sleali tra imprese e consumatori nel mercato interno e che modifica la direttiva 84/450/CEE del Consiglio e le direttive 97/7/CE, 98/27/CE e 2002/65/CE del Parlamento europeo e del Consiglio e il regolamento (CE) n. 2006/2004 del Parlamento europeo e del Consiglio (GU L 149 dell'11.6.2005, pag. 22).

rischi presentati dai prodotti in esame (considerando 8 della direttiva). Pertanto, la sicurezza dei prodotti dev'essere valutata tenendo conto di tutti gli aspetti pertinenti, in particolare delle categorie di consumatori cui sono destinati i prodotti.

La direttiva 87/357/CEE tratta specificamente della sicurezza dei prodotti e riguarda il ravvicinamento delle legislazioni degli Stati membri relative ai prodotti che, avendo un aspetto diverso da quello che sono in realtà, compromettono la salute o la sicurezza dei consumatori.[476] La direttiva vieta la commercializzazione, l'importazione e la fabbricazione di prodotti che possono essere confusi con prodotti alimentari ma che non sono commestibili. Gli Stati membri devono effettuare controlli per evitare che prodotti di questo genere siano commercializzati. Se uno Stato membro vieta un prodotto in virtù di questa direttiva, deve darne comunicazione alla Commissione e fornire informazioni dettagliate da trasmettere agli altri Stati membri. Il problema della sicurezza dei giocattoli in particolare è affrontato in maniera più esaustiva nel paragrafo 10.1.6.

10.1.4. Sperimentazioni cliniche su minori

Nell'ambito del diritto dell'UE, la direttiva 2001/20/CE[477] concernente il ravvicinamento delle disposizioni legislative relative all'applicazione della "buona pratica clinica" nell'esecuzione della sperimentazione clinica di medicinali ad uso umano riconosce i bambini come una fascia di popolazione particolarmente bisognosa di tutela, in grado di dare validamente il proprio consenso informato ad una sperimentazione clinica (considerando 3). I bambini possono partecipare a sperimentazioni cliniche soltanto se la somministrazione del medicinale reca un beneficio diretto superiore ai rischi (considerando 3). Le sperimentazioni cliniche devono tutelare al massimo le persone (articolo 4).

Analogamente, il regolamento (UE) n. 536/2014 sulla sperimentazione clinica di medicinali per uso umano contiene disposizioni specifiche per i minori appartenenti alla fascia della popolazione vulnerabile (articolo 10, paragrafo 1). Scopo del

476 Direttiva 87/357/CEE del Consiglio, del 25 giugno 1987, concernente il ravvicinamento delle legislazioni degli Stati Membri relative ai prodotti che, avendo un aspetto diverso da quello che sono in realtà, compromettono la salute o la sicurezza dei consumatori (GU L 192 dell'11.7.1987, pag. 49).

477 Direttiva 2001/20/CE del Parlamento europeo e del Consiglio, del 4 aprile 2001, concernente il ravvicinamento delle disposizioni legislative, regolamentari ed amministrative degli Stati membri relative all'applicazione della buona pratica clinica nell'esecuzione della sperimentazione clinica di medicinali ad uso umano (GU L 121 dell'1.5.2001, pag. 34).

regolamento è sostituire gradualmente la direttiva 2001/20/CE.[478] Esso prescrive un'attenta valutazione delle domande di autorizzazione alla sperimentazione clinica effettuata su minori. Il rappresentante legale del minore deve fornire il consenso informato alla sperimentazione clinica, così come il consenso del minore, se questi è in grado di formarsi un'opinione propria (articolo 29, paragrafi 1 e 8). Il regolamento definisce condizioni specifiche per la conduzione di sperimentazioni cliniche sicure sui minori e per l'acquisizione del loro consenso informato (articolo 32). Si tratta cioè di provvedere affinché non siano riconosciuti incentivi o benefici finanziari al soggetto, ad eccezione di un'indennità compensativa per le spese e i mancati guadagni direttamente connessi alla partecipazione alla sperimentazione clinica; affinché la sperimentazione clinica sia finalizzata a studiare trattamenti per una condizione clinica che colpisce solo i minori; e affinché vi siano motivi scientifici per ritenere che la partecipazione alla sperimentazione clinica rechi: al minore interessato un beneficio diretto superiore ai rischi e agli oneri associati; o determinati benefici alla popolazione rappresentata dal minore interessato e che tale sperimentazione clinica comporti solo un rischio e un onere minimi per tale minore rispetto al trattamento standard applicato alla sua condizione. È possibile eseguire la sperimentazione clinica su minori senza prima ottenerne il consenso informato o senza ottenere il consenso dei loro rappresentanti legali esclusivamente in situazioni di emergenza (articolo 35, paragrafo 1).

10.1.5. Cibo destinato a lattanti e bambini piccoli

Nell'ambito del diritto dell'UE, la direttiva *2009/39/CE relativa ai prodotti alimentari destinati ad un'alimentazione particolare*[479] si sofferma sulla composizione nutrizionale e la sicurezza dei cibi fabbricati specificamente per lattanti e bambini di età inferiore a 12 mesi. Le sue disposizioni riguardano alimenti per lattanti e alimenti di proseguimento, alimenti a base di cereali destinati ai lattanti e ai bambini e additivi presenti in alimenti per lattanti e bambini. La direttiva si prefigge lo scopo di garantire la sicurezza dei prodotti e di fornire ai consumatori prodotti adatti e informazioni adeguate. Specifica, tra le altre cose, che un utilizzo nutrizionale particolare risponde a esigenze nutrizionali particolari di alcune categorie di persone, compresi i lattanti e i bambini nella prima infanzia in buona salute (articolo 1, paragrafo 3, lettera c)).

478 Regolamento (UE) n. 536/2014 del Parlamento europeo e del Consiglio, del 16 aprile 2014, sulla sperimentazione clinica di medicinali per uso umano e che abroga la direttiva 2001/20/CE (GU L 158 del 27.5.2014, pag. 1).

479 Direttiva 2009/39/CE del Parlamento europeo e del Consiglio, del 6 maggio 2009, relativa ai prodotti alimentari destinati ad un'alimentazione particolare (GU L 124 del 20.5.2009, pag. 21).

10.1.6. Sicurezza dei giocattoli

Nell'ambito del diritto dell'UE, la direttiva 2009/48/CE sulla sicurezza dei giocattoli[480] all'articolo 2 definisce i giocattoli "prodotti progettati o destinati, in modo esclusivo o meno, a essere utilizzati per fini di gioco da bambini di età inferiore a 14 anni".[481] L'allegato I fornisce un elenco non esaustivo di oggetti che non sono considerati giocattoli, ma che potrebbero ingenerare confusione. L'articolo 2, paragrafo 2, elenca alcuni giocattoli che sono esclusi dal suo raggio d'azione. La direttiva inoltre rafforza i requisiti di salute e sicurezza limitando i quantitativi di talune sostanze chimiche che possono essere contenute nei materiali usati per la fabbricazione dei giocattoli (articolo 10).[482]

10.1.7. Minori e pubblicità

Nell'ambito del diritto dell'UE, la direttiva 2010/13/UE relativa ai servizi di media audiovisivi (direttiva sui servizi di media audiovisivi)[483] ha ampliato l'ambito di applicazione della disciplina legale della direttiva 89/552/CEE relativa al coordinamento di determinate disposizioni legislative, regolamentari e amministrative degli Stati Membri concernenti l'esercizio delle attività televisive (direttiva sulla televisione senza frontiere). La direttiva sui servizi di media audiovisivi disciplina la quantità, la qualità e i contenuti delle pratiche di commercializzazione cui possono essere esposti i minori, regolamentando la durata della pubblicità (articoli 20, 24 e 27). Essa vieta l'inserimento di prodotti nei programmi per minori (articolo 11) e autorizza gli Stati membri a vietare l'esibizione del logo di una

480 Direttiva 2009/48/CE del Parlamento europeo e del Consiglio, del 18 giugno 2009, sulla sicurezza dei giocattoli (GU L 170 del 18.6.2009, pag. 170).

481 *Ibid*., articolo 2, paragrafo 1.

482 La Commissione europea ha altresì stipulato "accordi volontari" con industrie/commercianti di giocattoli per migliorare la sicurezza dei giocattoli. Per ulteriori informazioni cfr. http://ec.europa.eu/growth/sectors/toys/safety/index_en.htm.

483 Direttiva 2010/13/CEE del Parlamento europeo e del Consiglio, del 10 marzo 2010, relativa al coordinamento di determinate disposizioni legislative, regolamentari e amministrative degli Stati membri concernenti la fornitura di servizi di media audiovisivi (direttiva sui servizi di media audiovisivi) (GU L 95 del 15.4.2010, pag. 1).

sponsorizzazione durante i programmi per bambini (articolo 10, paragrafo 4).[484] La direttiva sui servizi di media audiovisivi mira a conciliare la tutela dei minori con altri importanti valori democratici, tra cui la libertà di espressione, sostenendo che tale tutela è possibile tramite l'indispensabile coinvolgimento della responsabilità genitoriale (considerando 48 e 59).

L'applicazione effettiva della direttiva sui servizi di media audiovisivi è integrata dalle raccomandazioni del 1998[485] e del 2006[486] sulla tutela dei minori e della dignità umana.

Nell'ambito del diritto del Consiglio d'Europa, la Convenzione europea sulla televisione transfrontaliera[487] è stata il primo trattato internazionale a creare un quadro giuridico per la libera circolazione dei programmi televisivi transfrontalieri in Europa. La convenzione tutela nello specifico i minori e i giovani (articolo 7, paragrafo 2), per esempio vietando la trasmissione di materiali pornografici e violenti e di programmi che incitano all'odio razziale. Definisce inoltre norme riguardanti la pubblicità e disciplina l'orario di trasmissione e la durata degli spot pubblicitari.

484 Per una panoramica più generale del funzionamento della direttiva sui servizi di media audiovisivi cfr.: COM(2012)203 final, Relazione della Commissione al Parlamento europeo, al Consiglio, al Comitato economico e sociale europeo e al Comitato delle Regioni sull'applicazione della direttiva 2010/13/UE "Direttiva sui servizi di media audiovisivi", Bruxelles, 4 maggio 2012, e il relativo documento di lavoro dei servizi della commissione: SWD(2012)125 final, Commission Staff Working Document attached to the First Report from the Commission to the European Parliament, the Council, The European Economic And Social Committee And The Committee of the Regions on the Application of Directive 2010/13/EU 'Audiovisual Media Services', Bruxelles, 4 maggio 2012.

485 Raccomandazione del Consiglio 98/560/CE, del 24 settembre 1998, concernente lo sviluppo della competitività dell'industria dei servizi audiovisivi e d'informazione europei attraverso la promozione di strutture nazionali volte a raggiungere un livello comparabile e efficace di tutela dei minori e della dignità umana (GU L 270 del 7.10.1998).

486 Raccomandazione 2006/952/CE del Parlamento europeo e del Consiglio, del 20 dicembre 2006, relativa alla tutela dei minori e della dignità umana e al diritto di rettifica relativamente alla competitività dell'industria europea dei servizi audiovisivi e d'informazione in linea (GU L 378 del 27.12.2006).

487 Consiglio d'Europa, Convenzione europea sulla televisione transfrontaliera, STE n. 132, 5 maggio 1989. Modificata dalle disposizioni del Protocollo, STE n. 171, 1 marzo 2002.

10.2. Minori e protezione dei dati personali

Punti salienti

- Nell'ambito del diritto dell'UE e del Consiglio d'Europa, la protezione dei dati personali è riconosciuta come un diritto fondamentale.
- Il diritto al rispetto della vita privata e familiare, del proprio domicilio e della propria corrispondenza (articolo 8 della CEDU) comprende il diritto alla protezione dei dati personali.
- I minori, tra i diritti correlati ai dati personali, godono del diritto di opporsi al trattamento dei dati che li riguardano, salvo in casodi motivi preminenti e legittimi.

10.2.1. Diritto dell'Unione europea in materia di protezione dei dati

Nell'ambito del diritto dell'UE, l'Unione è competente a legiferare in materia di protezione dei dati (articolo 16 del TFUE).[488] L'articolo 8, paragrafo 2, della Carta dei diritti fondamentali dell'Unione europea contiene una serie di principi fondamentali in materia di protezione dei dati (trattamento secondo il principio di lealtà, in base al consenso o a un altro fondamento legittimo previsto dalla legge, diritto di accesso e di rettifica), mentre il paragrafo 3 del medesimo articolo stabilisce che il rispetto delle norme in materia di protezione dei dati sia soggetto al controllo di un'autorità indipendente. Il diritto alla protezione dei dati personali sancito dall' articolo 8 può essere limitato nel rispetto della legge e allo scopo di rispettare i principi di una società democratica quali le libertà e i diritti degli altri (articolo 52 della Carta).[489]

La protezione dei dati personali si è affermata come una delle principali sfere del diritto dell'UE in relazione alla vita privata. Lo strumento principe in questo ambito è la direttiva 95/46/CE relativa alla tutela delle persone fisiche con riguardo

488 Per una panoramica generale della legislazione dell'UE in materia di protezione dei dati, cfr.: FRA e Consiglio d'Europa (2014).

489 CGUE, sentenza 24 novembre 2011, cause riunite C-468/10 e C-469/10, *Asociación Nacional de Establecimientos Financieros de Crédito (ASNEF) e Federación de Comercio Electrónico y Marketing Directo (FECEMD) c. Administración del Estado*, punto 48; CGUE, sentenza 29 gennaio 2008, causa C-275/06, *Productores de Música de España (Promusicae) c. Telefónica de España SAU*, punto 68.

al trattamento dei dati personali, nonché alla libera circolazione di tali dati (direttiva sulla tutela dei dati).[490]

Poiché il trattamento dei dati avviene in spazi chiusi non aperti al pubblico, i minori e altre persone interessate sono solitamente all'oscuro del fatto che i loro dati sono oggetto di trattamento. Per contrastare la vulnerabilità delle persone interessate, il diritto dell'UE riconosce ai minori (e ad altre persone interessate) specifici diritti individuali tra cui il diritto a essere informati del fatto che i loro dati sono raccolti, il diritto di accesso ai dati conservati e di conoscere i dettagli del trattamento, il diritto di opporsi a un trattamento illecito, il diritto di rettifica, cancellazione e congelamento dei dati.

I responsabili del trattamento devono fornire informazioni adeguate sul trattamento dei dati (articoli 10 e 11 della direttiva sulla protezione dei dati). Se considerata dalla prospettiva dei minori, tale disposizione implica che la lingua e il formato delle informazioni devono essere adattati al livello di maturità e di comprensione dei minori. Come requisito minimo, le informazioni fornite devono menzionare le finalità del trattamento e l'identità e i recapiti del responsabile del trattamento (articolo 10, lettere a) e b), della direttiva sulla protezione dei dati).

La direttiva sulla protezione dei dati prevede che le persone interessate acconsentano al trattamento dei dati, indipendentemente dalla delicatezza dei dati trattati (articoli 7, 8 e 14). Una procedura di consenso a misura di minore implica che si tenga conto delle capacità *in fieri* del bambino e quindi di un suo progressivo coinvolgimento. Il primo passo prevede che il rappresentante legale del minore si consulti con il diretto interessato prima di autorizzare il trattamento; successivamente, il consenso va ottenuto sia dal rappresentante legale che dal minore; infine, il consenso si richiede unicamente al minore quando questi è adolescente.

Le persone interessate hanno diritto di cancellare i dati, compresa la possibilità di eliminare o espungere i dati su richiesta, nonché il diritto di opporsi al trattamento dei dati personali. Quest'ultima possibilità è cresciuta in importanza per i minori, in ragione dell'enorme volume di dati personali riguardanti i minori che circolano e sono disponibili attraverso i media sociali. Benché la Corte di giustizia dell'Unione europea non abbia ancora esaminato casi concernenti i minori, in una recente controversia che ha interessato un ricorrente adulto, questaha

490 Direttiva 95/46/CE del Parlamento europeo e del Consiglio, del 24 ottobre 1995, relativa alla tutela delle persone fisiche con riguardo al trattamento dei dati personali, nonché alla libera circolazione di tali dati (direttiva sulla tutela dei dati) (GU L 281 del 23.11.1995).

dichiarato che il diritto a opporsi si applica in particolare a dati e informazioni che "risultino inadeguati, non siano o non siano più pertinenti, ovvero siano eccessivi in rapporto alle finalità suddette e al tempo trascorso".[491] La Corte ha altresì dichiarato che occorre ricercare un giusto equilibrio tra l'esercizio di tale diritto e altri diritti fondamentali.

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha interpretato l'articolo 8 della CEDU come un riconoscimento del diritto alla protezione dei dati personali. La Corte esamina situazioni in cui emerge il problema della protezione dei dati, tra cui l'intercettazione di comunicazioni,[492] varie forme di sorveglianza,[493] e la protezione dalla conservazione dei dati personali da parte di autorità pubbliche.[494] Inoltre, la Corte EDU ha stabilito che la legislazione nazionale deve introdurre misure adeguate per assicurare la disponibilità di ricorsi giurisdizionali contro violazioni dei diritti di protezione dei dati.

Esempio: nel caso *K. U. c. Finlandia*,[495] il ricorrente, un minore, aveva denunciato la pubblicazione a suo nome di un annuncio a sfondo sessuale su un sito Internet di incontri. Il provider del servizio Internet si era rifiutato di rivelare l'identità della persona che aveva postato le informazioni, ritenendosi vincolato dagli obblighi di riservatezza previsti dalla legislazione finlandese. Il ricorrente lamentava l'assenza nella legislazione finlandese di strumenti adeguati a consentirgli di tutelarsi contro le azioni commesse da un privato che aveva pubblicato in Internet dati compromettenti che lo riguardavano. La Corte EDU ha stabilito che gli Stati sono soggetti a obblighi positivi, che comprendono tra l'altro l'adozione di misure atte a garantire il rispetto della vita privata, anche nelle relazioni tra individui. Nel caso di specie, ha ritenuto che la tutela concreta ed effettiva del ricorrente richiedeva che fossero prese misure efficaci per identificare e perseguire

491 CGUE, sentenza 13 maggio 2014, causa C-131/12, *Google Spain SL e Google Inc. c. Agencia Española de Protección de Datos (AEPD) e Mario Costeja González* [GS], punto 93.

492 Cfr., per esempio: Corte EDU, sentenza 2 agosto 1984, *Malone c. Regno Unito* (n. 8691/79); Corte EDU, sentenza 3 aprile 2007, *Copland c. Regno Unito* (n. 62617/00).

493 Cfr., per esempio: Corte EDU, sentenza 6 settembre 1978, *Klass e altri c. Germania* (n. 5029/71); Corte EDU, sentenza 2 settembre 2010, *Uzun c. Germania* (n. 35623/05).

494 Cfr., per esempio: Corte EDU, sentenza 26 marzo 1987, *Leander c. Svezia* (n. 9248/81); Corte EDU, sentenza 4 dicembre 2008, *S. e Marper c. Regno Unito* [GC] (nn. 30562/04 e 30566/04).

495 Corte EDU, sentenza 2 dicembre 2008, *K.U. c. Finlandia* (n. 2872/02). Cfr., più avanti, il capitolo 4.

l'autore del fatto. Non essendo stata tale protezione garantita dallo Stato, la Corte ha riscontrato una violazione dell'articolo 8 della CEDU.[496]

Esempio: il caso *Avilkina e altri c. Russia*[497] riguarda la divulgazione dei dossier medici di una bambina di due anni a un magistrato, in seguito alla richiesta di quest'ultimo di informazioni circa tutti i rifiuti di trasfusioni di sangue opposti dai testimoni di Geova. Pur riconoscendo che gli interessi di un'indagine giudiziaria potrebbero prevalere rispetto agli interessi di un paziente e della comunità in generale a tutelare la riservatezza delle informazioni mediche, la Corte ha tuttavia osservato che la ricorrente non era indagata o imputata in un procedimento penale. Inoltre, gli operatori sanitari che avevano avuto in cura la ricorrente avrebbero potuto richiedere l'intervento dell'autorità giudiziaria per effettuare la trasfusione, se avessero temuto che la paziente si trovava in pericolo di vita. In assenza di ragioni pressanti di natura sociale per richiedere la divulgazione di informazioni mediche riservate riguardanti la ricorrente, la Corte EDU ha riscontrato una violazione dell'articolo 8 della CEDU.

Esempio: nel caso *S. e Marper c. Regno Unito*,[498] le impronte digitali e campioni di DNA prelevati a un ragazzino di undici anni sospettato di tentata rapina sono stati conservati senza limiti di tempo, anche dopo che il ragazzino era stato assolto. Considerata la natura e la quantità delle informazioni personali contenute nei campioni di cellule e profili di DNA, la loro conservazione equivaleva in sé a un'ingerenza nel diritto al rispetto della vita privata del ricorrente. I principi fondamentali degli strumenti pertinenti del Consiglio d'Europa nonché il diritto e la prassi in vigore presso gli altri Stati contraenti richiedono che la conservazione dei dati sia proporzionata allo scopo per il quale essi sono raccolti e limitata nel tempo, in particolare nell'ambito della pubblica sicurezza. La protezione offerta dall'articolo 8 della CEDU sarebbe indebolita in modo inaccettabile qualora si consentisse, nel settore della giustizia penale, l'utilizzo ad ogni costo di moderne tecniche scientifiche e ciò senza operare un attento bilanciamento tra i vantaggi che esse possono offrire e i fondamentali interessi che sono collegati al rispetto della vita privata. A tale proposito, il carattere generale

496 FRA e Consiglio d'Europa (2014), pag. 122.

497 Corte EDU, sentenza 6 giugno 2013, *Avilkina e altri c. Russia* (n. 1585/09).

498 Corte EDU, sentenza 4 dicembre 2008, *S. e Marper c. Regno Unito* [GC] (nn. 30562/04 e 30566/04).

e indifferenziato con cui opera il meccanismo di conservazione dei dati in Inghilterra e Galles è particolarmente sorprendente, poiché autorizza la conservazione dei dati a tempo indefinito qualunque sia la natura o la gravità del reato di cui una persona di qualsiasi età è sospettata. La conservazione dei dati personali potrebbe essere particolarmente dannosa nel caso di minori, in considerazione della loro situazione specifica e dell'importanza del loro sviluppo e della loro integrazione nella società. In conclusione, la conservazione dei dati personali costituiva un'ingerenza sproporzionata nel diritto del ricorrente al rispetto della vita privata.

La Convenzione del Consiglio d'Europa sulla protezione delle persone rispetto al trattamento automatizzato di dati a carattere personale[499] (convenzione n. 108) si applica a tutti i trattamenti di dati effettuati nel settore sia pubblico che privato e tutela gli individui, inclusi i minori, da abusi che potrebbero essere compiuti nel corso dell'elaborazione dei dati personali. La convenzione n. 108 è corredata di un protocollo addizionale che disciplina l'istituzione di autorità di controllo e i flussi transfrontalieri di dati personali verso Paesi terzi.[500]

I principi sanciti nella convenzione n. 108 in relazione al trattamento dei dati personali riguardano l'ottenimento e l'elaborazione automatica dei dati personali in maniera leale e legittima, la loro conservazione per fini determinati e legittimi, e il divieto di utilizzo di questi dati in modo incompatibile con tali fini. I dati personali infine non devono essere conservati per un periodo superiore al necessario. questi principi riguardano altresì la qualità dei dati. In assenza di adeguate garanzie previste dalla legge, è vietato il trattamento di dati "sensibili" tra cui i dati che rivelano l'origine razziale, le opinioni politiche, le convinzioni religiose, nonché i dati a carattere personale relativi alla salute, alla vita sessuale o a condanne penali. La convenzione sancisce altresì il diritto dell'individuo, compreso il minore, di essere informato riguardo alla conservazione di informazioni che lo riguardano e di chiederne la rettifica, se del caso. Le restrizioni dei diritti stabiliti nella convenzione sono possibili solo quando sono in gioco interessi superiori, quali la sicurezza o la difesa dello Stato.

499 Consiglio d'Europa, Convenzione sulla protezione delle persone rispetto al trattamento automatizzato di dati a carattere personale, STE n. 108, 28 gennaio 1981.

500 Consiglio d'Europa, Protocollo addizionale alla Convenzione sulla protezione delle persone rispetto al trattamento automatizzato di dati a carattere personale, concernente le autorità di controllo e i flussi transfrontalieri di dati, concernente le autorità di controllo ed i flussi transfrontalieri, STE n. 181, 8 novembre 2001.

Nell'ambito del diritto internazionale, il diritto alla protezione dei dati è integrato nel diritto dei minori alla vita privata, che è sancito dall'articolo 16 della CRC. Questo articolo stabilisce che nessun fanciullo sarà oggetto di interferenze arbitrarie o illegali nella sua vita privata, nella sua famiglia, nel suo domicilio o nella sua corrispondenza, e neppure di affronti illegali al suo onore e alla sua reputazione. Questo diritto deve essere rispettato da tutti, compreso il rappresentante legale del minore.

11

Diritti dei minori nella sfera della giustizia penale e dei procedimenti alternativi (stragiudiziali)

UE	Argomenti trattati	Consiglio d'Europa
Carta dei diritti fondamentali, articolo 47 (diritto a un ricorso effettivo e a un giudice imparziale), articolo 48 (presunzione di innocenza e diritto alla difesa) e articolo 49 (principi della legalità e della proporzionalità dei reati e delle pene) Direttiva sul diritto all'interpretazione e alla traduzione (2010/64/UE) Direttiva sul diritto all'informazione (2012/13/UE) Direttiva sull'accesso a un difensore (2013/48/UE)	**Garanzie relative a un equo processo**	CEDU, articolo 6 (equo processo) Corte EDU, *T. c. Regno Unito* [GC], n. 24724/94, 1999 (minori in tribunale) Corte EDU, *Panovits c. Cipro*, n. 4268/04, 2008 (accesso a un difensore)
Carta dei diritti fondamentali, articolo 4 (tortura, trattamenti inumani o degradanti) e articolo 6 (diritto alla libertà)	**Trattenimento**	CEDU, articolo 3 (tortura, trattamenti inumani o degradanti) e articolo 5 (diritto alla libertà) Corte EDU, *Bouamar c. Belgio*, n. 9106/80, 1988 (detenzione per fini educativi) Corte EDU, *D.G. c. Irlanda*, n. 39474/98, 2002 (detenzione per fini educativi) Corte EDU, *Nart c. Turchia*, n. 20817/04, 2008 (detenzione preventiva). Corte EDU, *Güveç c. Turchia*, n. 70337/01, 2009 (condizioni di detenzione)

UE	Argomenti trattati	Consiglio d'Europa
Direttiva sui diritti delle vittime (2012/29/UE) CGUE, C-105/03, *Procedimento penale a carico di Maria Pupino* [GC], 2005 (comparsa di testimoni minorenni in tribunale)	**Testimoni e vittime minorenni**	CEDU, articolo 3 (tortura, trattamenti inumani o degradanti) e articolo 8 (vita privata) Corte EDU, *Kovač c. Croazia*, n. 503/05, 2007 (testimoni minorenni) Corte EDU, *S.N. c. Svezia*, n. 34209/96), 2002 (testimoni minorenni) Corte EDU, *R.R. e altri c. Ungheria*, n. 19400/11, 2012 (esclusione della famiglia dai programmi di protezione delle vittime)

I diritti dei minori nell'ambito di procedimenti di giustizia minorile riguardano i soggetti accusati, perseguiti o condannati per aver commesso reati penali, oltre che i minori che partecipano a procedimenti giudiziari o di natura analoga in qualità di vittime e/o testimoni. La posizione dei minori nell'ambito della giustizia minorile è disciplinata da disposizioni generali in materia di diritti umani, che si applicano indifferentemente agli adulti e ai minori.

Questo capitolo contiene una panoramica delle norme europee riguardanti i minori implicati in procedimenti giudiziari o stragiudiziali. In particolare, esamina le garanzie in materia di equo processo, compresa la partecipazione efficace e l'accesso a un difensore, i diritti dei minori responsabili di reati in stato di detenzione, compresa la detenzione preventiva (garanzie sostanziali e procedurali), le condizioni di detenzione e la tutela da maltrattamenti, oltre che la protezione di testimoni e vittime minorenni. La protezione è particolarmente rilevante nel caso degli strumenti alternativi al procedimento giudiziario, che dovrebbero essere incoraggiati ogniqualvolta questi possano servire al meglio l'interesse superiore del minore.[501] Nel caso dei minori sono valorizzati gli obiettivi di giustizia penale quali l'integrazione sociale, l'istruzione e la prevenzione delle recidive.[502]

501 Consiglio d'Europa, Comitato dei ministri (2010), Linee guida per una giustizia a misura di minore, 17 novembre 2010, paragrafo 24.

502 Cfr. anche, Consiglio d'Europa, Comitato dei ministri (2008), raccomandazione CM/Rec(2008)11 del comitato dei ministri agli Stati membri sulle norme europee per i rei minori oggetto di sanzioni o di altri provvedimenti, 5 novembre 2008, parte I.A.2.

11.1. Garanzie relative a un equo processo

Punti salienti

- Nei procedimenti penali i minori hanno il diritto di essere trattati in maniera giusta e adeguata alla loro età.
- I procedimenti giudiziari dovrebbero essere adattati alle esigenze dei minori, in modo da garantirne una partecipazione efficace.
- I minori hanno il diritto di usufruire di un avvocato fin dalle tappe iniziali del procedimento penale e dal primo interrogatorio di polizia.

In questo paragrafo, oltre a definire brevemente i requisiti generali di un processo equo a livello dell'UE e del Consiglio d'Europa, si vuole prestare particolare attenzione alle garanzie per un processo equo disponibile ai minori.

Il diritto ad un equo processo rappresenta un pilastro fondamentale di una società democratica. I minori sospettati o accusati di aver commesso un reato hanno il diritto ad un equo processo e godono delle medesime garanzie di qualsiasi altra persona che abbia compiuto atti contrari alla legge. Le garanzie per un processo equo si applicano dal primo interrogatorio del minore e sono assicurate nel corso del processo. I minori responsabili di azioni contrarie alla legge, tuttavia, sono particolarmente vulnerabili e, di conseguenza, possono necessitare di ulteriori tutele. Gli organismi dell'UE hanno elaborato criteri specifici per garantire che i bisogni di questi minori siano effettivamente soddisfatti.

Nell'ambito del diritto dell'UE, svariate disposizioni della Carta dei diritti fondamentali dell'Unione europea sanciscono diritti imprescindibili di accesso alla giustizia, che sono il fondamento delle garanzie per un processo equo per adulti e minori. L'articolo 47 tratta nello specifico del diritto a un ricorso effettivo e a un giudice imparziale, definendo obblighi che assumono una particolare rilevanza per i minori, quali il diritto a che una causa sia esaminata equamente, pubblicamente ed entro un termine ragionevole, oltre che la facoltà di farsi consigliare, difendere e rappresentare. È altresì contemplato il diritto al patrocinio a spese dello Stato. I principi della legalità e proporzionalità dei reati e delle pene sanciti all'articolo 49 sono parimenti importanti per i minori. Inoltre, alcune direttive dell'UE prevedono specifiche garanzie per un equo processo nei procedimenti

penali: la direttiva sul diritto all'interpretazione e alla traduzione,[503] la direttiva sul diritto all'informazione[504] e la direttiva sull'accesso a un difensore.[505] Le prime due direttive non contemplano garanzie specifiche per i minori, sebbene la direttiva sul diritto all'informazione contenga disposizioni che disciplinano, più in generale, il caso di persone vulnerabili sospettate o accusate di un reato. Al contrario, le disposizioni che riguardano i minori presenti nella direttiva sull'accesso a un difensore sono esaminate nel paragrafo 11.2.2.

Anche in assenza di disposizioni specifiche relative ai minori, gli Stati membri devono osservare la Carta dei diritti fondamentali dell'UE quando si tratta di applicare le disposizioni delle suddette direttive. Pertanto, principi quali l'interesse superiore del minore, sancito all'articolo 24, devono essere tenuti in debita considerazione qualora un minore sia soggetto a una qualsiasi delle disposizioni delle direttive. Ad oggi, non sono stati portati all'attenzione della Corte di giustizia europea casi che riguardano l'interpretazione dell'articolo 24 della Carta in combinato disposto con una delle summenzionate direttive.[506]

Di particolare rilievo è la proposta della Commissione europea di una direttiva sulle garanzie procedurali per i minori indagati o imputati in procedimenti penali,[507] che garantisce l'obbligatorietà del difensore in tutte le fasi del procedimento penale. Stabilisce altresì che i minori hanno diritto a ottenere informazioni tempestive circa i propri diritti, a godere dell'assistenza dei genitori (o di figure adeguate) e ad essere sottoposti a interrogatorio a porte chiuse. Inoltre, i minori privati di libertà dovrebbero godere del diritto a un'istruzione, un orientamento

503 Direttiva 2010/64/CE del Parlamento europeo e del Consiglio, del 20 ottobre 2010, sul diritto all'interpretazione e alla traduzione nei procedimenti penali (GU L 280 del 26.10.2010, pag. 1).

504 Direttiva 2012/13/CE del Parlamento europeo e del Consiglio, del 22 maggio 2012, sul diritto all'interpretazione e alla traduzione nei procedimenti penali (GU L 142 dell'1.6.2012, pag. 1).

505 Direttiva 2013/48/UE del Parlamento europeo e del Consiglio, del 22 ottobre 2013, relativa al diritto di avvalersi di un difensore nel procedimento penale e nel procedimento di esecuzione del mandato d'arresto europeo, al diritto di informare un terzo al momento della privazione della libertà personale e al diritto delle persone private della libertà personale di comunicare con terzi e con le autorità consolari (GU L 294 del 6.11.2013, pag. 1)

506 La Corte di giustizia europea si è occupata dell'interpretazione dell'articolo 24 nell'ambito di procedimenti concernenti la sottrazione internazionale di minori (cfr. il paragrafo 5.4).

507 Commissione europea (2013), Proposta di direttiva del Parlamento europeo e del Consiglio sulle garanzie procedurali per i minori indagati o imputati in procedimenti penali (COM(2013) 822 final, Bruxelles, 27.11.2013).

e una formazione professionale adeguati, così come a un'assistenza medica appropriata, e della possibilità di essere detenuti separatamente dagli adulti.[508]

Nell'ambito del diritto del Consiglio d'Europa, le garanzie per un processo equo della CEDU sono esplicitate all'articolo 6, che genera anche la più copiosa giurisprudenza della Corte EDU. L'articolo 6, paragrafo 1, della CEDU elenca espressamente alcune garanzie per un processo equo: il diritto a che la causa sia esaminata equamente e pubblicamente e a che la sentenza sia resa pubblicamente (a meno che ciò non sia contrario, tra le altre cose, agli interessi dei minori); il diritto a che la causa sia esaminata entro un termine ragionevole; il diritto a che la causa sia esaminata da un tribunale indipendente e imparziale;[509] il diritto a che la causa sia esaminata da un tribunale costituito per legge. Fondandosi sul concetto di equo processo, la Corte EDU ha elaborato le seguenti garanzie: parità di mezzi e contraddittorio; facoltà di non rispondere; accesso a un difensore; partecipazione efficace; presenza alle udienze; decisioni motivate. Inoltre, ogni persona accusata di un reato è presunta innocente fino a quando la sua colpevolezza non sia stata legalmente accertata (articolo 6, paragrafo 2, della CEDU).

Ogni accusato di un reato gode dei seguenti diritti minimi: il diritto a essere informato, nel più breve tempo possibile e in una lingua a lui comprensibile, dei motivi dell'accusa formulata a suo carico (articolo 6, paragrafo 3, lettera a), della CEDU); il diritto di disporre del tempo e delle facilitazioni necessarie a preparare la sua difesa (articolo 6, paragrafo 3, lettera b), della CEDU); il diritto ad avere l'assistenza di un difensore di sua scelta (articolo 6, paragrafo 3, lettera c), della CEDU); il diritto a esaminare o far esaminare i testimoni (articolo 6, paragrafo 3, lettera d), della CEDU); il diritto a farsi assistere gratuitamente da un interprete (articolo 6, paragrafo 3, lettera e), della CEDU). Tali garanzie si applicano indifferentemente ad adulti e minori. Tuttavia, tra gli aspetti di particolare rilievo per i minori, e che hanno generato una giurisprudenza concernente i minori, si annoverano il diritto a una partecipazione efficace e il diritto di accesso ad un difensore. Pertanto, in questo capitolo ci si soffermerà soprattutto su queste due specifiche garanzie per un processo equo.

508 Cfr. anche il paragrafo 11.2. Di particolare rilievo per la tutela dei minori può essere anche Commissione europea (2013), proposta di direttiva del Parlamento europeo e del Consiglio sull'ammissione provvisoria al patrocinio a spese dello Stato per indagati o imputati privati della libertà personale e sull'ammissione al patrocinio a spese dello Stato nell'ambito di procedimenti di esecuzione del mandato d'arresto europeo (COM(2013) 824 final, Bruxelles, 27.11.2013).

509 Corte EDU, sentenza 24 agosto 1993, *Nortier c. Paesi Bassi* (n. 13924/88); Corte EDU, sentenza 2 marzo 2010, *Adamkiewicz c. Polonia* (n. 54729/00).

Particolarmente importanti per i minori indagati/imputati sono le Linee guida del Consiglio d'Europa per una giustizia a misura di minore.[510] Pur non essendo giuridicamente vincolanti, esse rappresentano un passo intermedio verso l'obiettivo che i procedimenti giudiziari, inclusi quelli inseriti nel sistema di giustizia penale, tengano conto delle esigenze specifiche dei minori. Partendo dalla giurisprudenza della Corte EDU e da altre norme giuridiche europee e internazionali tra cui la Convenzione delle Nazioni Unite sui diritti dell'infanzia, esse rappresentano un utile strumento per i professionisti alle prese con minori. Ai sensi del capitolo I, paragrafo 1, le linee guida si occupano dei diritti e dei bisogni del minore nei procedimenti giudiziari (penali e non solo) nonché nei sistemi a essi alternativi. Di specifico rilievo per i minori coinvolti in procedimenti penali è il diritto a che le informazioni sulle imputazioni a loro carico siano comunicate sia al minore sia ai genitori in modo tale che essi comprendano l'esatta accusa (capitolo IV.A, punto 1, paragrafo 5); il diritto a essere interrogato in presenza di un avvocato o di uno dei genitori o di un'altra persona di fiducia (capitolo IV.C, paragrafo 30); il diritto a un processo rapido (capitolo IV.D, punto 4) e il diritto a essere ascoltati o interrogati con modalità adeguate allo stato di minore (capitolo IV.D, punto 5).

Nel giugno 2014 l'APCE ha adottato una risoluzione sulla giustizia minorile a misura di bambino, in cui sottolinea la necessità di garantire ai minori responsabili di atti contrari alla legge un trattamento garante dei diritti e adeguato alla loro età.[511] L'APCE esorta gli Stati membri ad applicare le norme internazionali in materia di diritti umani nel settore della giustizia minorile, ivi comprese le Linee guida del Consiglio d'Europa per una giustizia a misura di minore, e a conformare la legislazione e la prassi nazionali a tali norme. L'APCE raccomanda altresì di ricorrere alla privazione della libertà soltanto come ultima istanza e per un periodo di tempo il più breve possibile, di fissare a 14 anni l'età minima della responsabilità penale, senza ammettere eccezioni in presenza di reati gravi, e di introdurre un sistema di giustizia minorile specializzato, che preveda meccanismi di *diversion* volti a evitare il processo giudiziale, misure non detentive e l'intervento di professionisti qualificati.

Nell'ambito del diritto internazionale, l'articolo 40 della CRC riconosce a ogni fanciullo sospettato, accusato o riconosciuto colpevole di reato penale il diritto

510 Consiglio d'Europa, Comitato dei ministri (2010), Linee guida per una giustizia a misura di minore, 17 novembre 2010.

511 Assemblea parlamentare del Consiglio d'Europa, Risoluzione 2010 (2014), "Child-friendly juvenile justice: from rhetoric to reality" (Giustizia minorile a misura di bambino: dalla retorica alla realtà).

a un trattamento equo e che tenga conto della sua età. L'obiettivo fondamentale della giustizia minorile, secondo il disposto dell'articolo 40 della CRC, consiste nel reinserire i fanciulli nella società, dove possano svolgere un ruolo costruttivo. Il paragrafo 2 del medesimo articolo della CRC riconosce il diritto dei fanciulli a un equo processo e ad alcune garanzie supplementari, tra cui il diritto a godere dell'assistenza dei genitori, il diritto di ricorso e il diritto a che la loro vita privata sia pienamente rispettata in tutte le fasi della procedura.

Altri strumenti hanno sviluppato i principi del processo equo e il diritto a un trattamento adeguato all'età sanciti nella CRC, tra cui il ricorso alla privazione della libertà come provvedimento di ultima risorsa e per una durata più breve possibile (cfr. l'articolo 37, lettera b), della CRC). Particolarmente importanti al riguardo sono le regole minime delle Nazioni Unite relative all'amministrazione della giustizia minorile (Regole di Pechino),[512] le Linee guida delle Nazioni Unite per la prevenzione della delinquenza giovanile (Linee guida di Riyadh)[513] e le Regole delle Nazioni Unite per la protezione dei minori privati della libertà (o "Regole dell'Avana").[514] Le regole di Pechino forniscono orientamenti dettagliati sull'attuazione dei requisiti per un processo equo e del trattamento a misura di minore sanciti dall'articolo 40 della CRC, compresi gli obiettivi della giustizia minorile, la tutela della vita privata, le indagini e il procedimento, la custodia preventiva, il giudizio e la relativa decisione, e il trattamento in istituzione e non. Le regole dell'Avana riguardano il trattamento di minori privati della libertà e comprendono norme concernenti la definizione di privazione della libertà, custodia cautelare e detenzione preventiva, condizioni degli istituti di custodia minorile, procedure disciplinari, metodi di screening e uso della forza o della coercizione, meccanismi di denuncia, meccanismi di ispezione e monitoraggio e reinserimento dei minori. Infine, le linee guida di Riyadh forniscono orientamenti dettagliati sulle politiche finalizzate alla prevenzione della delinquenza minorile.

L'UNCRC ha emanato un commento generale (n. 10)[515] sulla giustizia minorile, che offre dettagliati orientamenti su come interpretare e attuare la CRC per quanto

512 ONU, Assemblea generale (1985), regole minime delle Nazioni Unite per l'amministrazione della giustizia minorile, doc. ONU ris. dell'AG n. 4033,19 novembre 1985.

513 ONU, Assemblea generale (1990), linee guida delle Nazioni Unite per la prevenzione della delinquenza giovanile, doc. ONU ris. dell'AG 45/112, 14 dicembre 1990.

514 ONU, Assemblea generale (1990), regole delle Nazioni Unite per la protezione dei minori privati della libertà, documento ONU ris. dell'AG 45/113, 14 dicembre 1990.

515 ONU, Comitato sui diritti dell'infanzia (2007), *Commento generale n. 10 – I diritti dell'infanzia e dell'adolescenza in materia di giustizia minorile*, CRC/C/GC/07, 25 aprile 2007.

riguarda la giustizia minorile. Questo documento esamina i principi fondamentali della giustizia minorile, tra cui il diritto a una partecipazione efficace nell'ambito del diritto a un equo processo (cfr. anche il paragrafo 11.1.1), l'uso della privazione della libertà come provvedimento di ultima risorsa e per una durata più breve possibile, il ricorso a misure alternative ai procedimenti giudiziari (*diversion*) e la prevenzione della delinquenza minorile, l'introduzione del principio dell'interesse superiore del bambino e del principio della non discriminazione nel sistema di giustizia minorile, e i limiti di età. L'UNCRC raccomanda di fissare a 12 anni l'età minima per la responsabilità penale o di portarla a un'età preferibilmente superiore. Raccomanda altresì di riconoscere a tutti i minori il diritto a essere giudicati in base alle norme della giustizia minorile e proibisce che ragazzi di 16 e 17 anni siano trattati come adulti criminali in caso di reati gravi. Anche altri commenti generali, per esempio concernenti il diritto a essere ascoltati (che è collegato al diritto a una partecipazione efficace ai procedimenti giudiziari) e la protezione da ogni forma di violenza, sono rilevanti per la giustizia minorile.[516]

11.1.1. Partecipazione efficace

Nell'ambito del diritto dell'UE, l'articolo 47 della Carta dei diritti fondamentali dell'UE stipula garanzie simili a quelle fornite dall'articolo 6 della CEDU, compreso il diritto a che la causa sia esaminata equamente, pubblicamente ed entro un termine ragionevole da un giudice indipendente e imparziale, il diritto alla rappresentanza legale e il diritto a un ricorso effettivo. La proposta di direttiva sulle garanzie procedurali per i minori indagati o imputati in procedimenti penali contempla il diritto ad una partecipazione efficace, oltre che il diritto alla rappresentanza legale.[517]

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha elaborato, ai sensi dell'articolo 6, specifici obblighi per garantire la partecipazione efficace dei minori nei procedimenti penali. In linea di principio, nel corso del procedimento si dovrebbe tener conto dell'età del minore, del suo livello di maturità e delle sue capacità emotive.[518] Esempi concreti di obblighi in materia di "partecipazione

516 ONU, Comitato sui diritti dell'infanzia (2009), *Commento generale n. 12 (2009) – Il diritto del bambino e dell'adolescente di essere ascoltato*, CRC/C/GC/12, 1 luglio 2009; ONU, Comitato sui diritti dell'infanzia (2011), *Commento generale n. 13 (2011),* relativo al diritto del fanciullo alla libertà da tutte le forme di violenza, CRC/C/GC/13, 18 aprile 2011.

517 Commissione europea (2013), Proposta di direttiva del Parlamento europeo e del Consiglio sulle garanzie procedurali per i minori indagati o imputati in procedimenti penali (COM(2013) 822 final, Bruxelles, 27.11.2013).

518 Corte EDU, sentenza 16 dicembre 1999, *T. c. Regno Unito* [GC] (n. 24724/94), punto 61.

efficace" sono rappresentati dalla presenza del minore alle udienze, dalla sua partecipazione a udienze a porte chiuse, da restrizioni alla pubblicità del caso, dalle misure prese per garantire che il minore sia consapevole degli interessi in gioco e da una riduzione delle formalità durante le udienze. Finora la Corte EDU non ha statuito che la fissazione di una soglia eccessivamente bassa per l'età minima per la responsabilità penale costituisca di per sé una violazione dell'articolo 6 della CEDU. Nel valutare se un minore sarebbe stato in grado di partecipare efficacemente a un procedimento nazionale, la Corte EDU esamina le circostanze concrete di ciascun caso.

Esempio: il caso *T. c. Regno Unito*[519] riguarda l'omicidio di un bambino di due anni da parte di due ragazzini di dieci anni. I due ragazzini erano stati sottoposti a un processo pubblico, che era stato seguito con enorme attenzione dagli organi d'informazione. In quell'occasione erano stati introdotti alcuni accorgimenti per modificare il procedimento giudiziario, accorciando cioè i tempi delle udienze, autorizzando la presenza dei genitori accanto all'imputato e allestendo un'area gioco durante le interruzioni, ecc. Nonostante ciò, l'imputato e il suo compagno erano stati giudicati da un giudice penale ordinario e la maggior parte delle rigide formalità del procedimento penale erano state mantenute. La Corte EDU ha stabilito che il ricorrente non era stato messo nelle condizioni di partecipare efficacemente al procedimento, a causa della risonanza data alle udienze associata all'elevato livello di attenzione mediatica, oltre che della sua limitata capacità di collaborare con i suoi avvocati e di fornire testimonianze adeguate. Erano stati pertanto violati i suoi diritti ai sensi dell'articolo 6 della CEDU.

Il riconoscimento del diritto a una partecipazione efficace costituisce anche il fulcro delle Linee guida del Consiglio d'Europa su una giustizia a misura di minore. La giustizia per i minori, compresa la giustizia minorile, dovrebbe essere "accessibile, adeguata all'età, rapida, diligente, adatta alle esigenze e ai diritti del minore e su di essi incentrata, nel rispetto dei diritti del minore, tra cui il diritto al giusto processo, alla partecipazione e alla comprensione del procedimento, al rispetto della vita privata e familiare, all'integrità e alla dignità".[520] Le linee guida forniscono specifici orientamenti sul trattamento da riservare ai minori nel corso di procedimenti di giustizia minorile o di altro genere. I minori devono avere

519 Corte EDU, sentenza 16 dicembre 1999, *T. c. Regno Unito* [GC] (n. 24724/94).

520 Consiglio d'Europa, Comitato dei ministri (2010), Linee guida per una giustizia a misura di minore, 17 novembre 2010, paragrafo II. C.

accesso ai tribunali e ai procedimenti giudiziari e i loro diritti all'assistenza e alla rappresentanza legale, oltre che il diritto di essere ascoltati e di esprimere le proprie opinioni, devono essere salvaguardati; si devono evitare ritardi ingiustificati, i procedimenti devono essere organizzati con modalità a misura di minore (con implicazioni per l'ambiente e il linguaggio) e devono essere poste in essere garanzie per raccogliere prove e dichiarazioni fornite dai minori.[521]

11.1.2. Accesso alla giustizia

Nell'ambito del diritto dell'UE, la direttiva sull'accesso a un difensore (2013/48/UE)[522] - che dovrà essere recepita entro il 27 novembre 2016 - contiene riferimenti diretti ai minori nei considerando 52 e 55 del preambolo e nell'articolo 5, paragrafi 2–4. Ai sensi del considerando 55 e dell'articolo 5, paragrafo 2, qualora un minore sia privato della libertà personale, il titolare della responsabilità genitoriale dovrebbe essere informato quanto prima e dovrebbe ricevere comunicazione dei relativi motivi, a meno che ciò non sia contrario all'interesse superiore del minore. In tale evenienza, è opportuno che sia informato un altro adulto idoneo. Secondo l'articolo 2, la direttiva si applica agli indagati e imputati dal momento in cui sono informati di aver commesso un reato fino alla conclusione del procedimento, vale a dire fino al giudizio definitivo di colpevolezza o innocenza. Inoltre, conformemente all'articolo 3, paragrafo 3, il diritto di avvalersi di un difensore comporta il diritto di indagati/imputati di incontrare in privato il difensore che li assiste e di comunicare con questi, anche prima del primo interrogatorio, oltre che il diritto alla presenza e alla partecipazione effettiva del proprio difensore durante gli interrogatori e il diritto alla presenza del proprio difensore nei seguenti atti di indagine o di raccolta delle prove.

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU afferma che il diritto di accesso a un avvocato figura tra gli elementi fondamentali del processo equo.[523] Ogni persona accusata di reato ha il diritto di essere difesa da un avvocato fin dalle primissime fasi delle indagini di polizia. Tale diritto può essere limitato in circostanze eccezionali, purché tale restrizione non pregiudichi in-

521 *Ibid.*, capitolo D.

522 Direttiva 2013/48/UE del Parlamento europeo e del Consiglio, del 22 ottobre 2013, relativa al diritto di avvalersi di un difensore nel procedimento penale e nel procedimento di esecuzione del mandato d'arresto europeo, al diritto di informare un terzo al momento della privazione della libertà personale e al diritto delle persone private della libertà personale di comunicare con terzi e con le autorità consolari (GU L 294 del 6.11.2013, pag. 1).

523 Corte EDU, sentenza 27 novembre 2008, *Salduz c. Turchia* [GC] (n. 36391/02), punto 51.

debitamente i diritti dell'accusato. La Corte EDU è del parere che ciò potrebbe verificarsi quando le dichiarazioni rese dall'accusato senza avere accesso a un avvocato servano per fondare la sua condanna.[524] L'esame della Corte EDU se a un ricorrente sia stato efficacemente concesso l'accesso a un avvocato è più rigoroso nel caso dei minori.[525]

Esempio: il caso di *Panovits c. Cipro*[526] riguarda un ragazzo di 17 anni, accusato di omicidio e rapina. Il ragazzo era stato portato alla stazione di polizia, accompagnato dal padre. Successivamente era stato arrestato e trasferito in una stanza separata per l'interrogatorio, senza l'assistenza del padre o di un avvocato. Durante l'interrogatorio, il padre era stato informato del diritto del ricorrente a contattare un avvocato. Pochi minuti dopo, l'uomo aveva appreso che, nel frattempo, il figlio aveva confessato di aver commesso il reato. La Corte EDU ha riscontrato che, in considerazione dell'età, non si poteva pensare che il ricorrente fosse al corrente del proprio diritto a una rappresentanza legale prima di rilasciare qualsiasi dichiarazione. Era altrettanto improbabile che egli potesse essere ragionevolmente consapevole delle conseguenze di un interrogatorio condotto senza l'assistenza di un legale nell'ambito di un procedimento penale per omicidio. Nonostante le autorità abbiano dimostrato in ogni occasione di essere disposte a consentire al ricorrente di essere assistito da un avvocato, se questi l'avesse richiesto, esse non avevano messo il ragazzo al corrente del suo diritto a richiedere l'assegnazione d'ufficio di un avvocato senza oneri a suo carico, se necessario. Non vi sono prove che dimostrino che il ricorrente o il padre abbiano espressamente o inequivocabilmente rinunciato al proprio diritto all'assistenza legale. Pertanto la Corte ha riscontrato una violazione dell'articolo 6, paragrafo 3, lettera c), in combinato disposto con l'articolo 6, paragrafo 1, della CEDU.

524 *Ibid.*, punto 62.

525 *Ibid.*, punto 60.

526 Corte EDU, sentenza 11 dicembre 2008, *Panovits c. Cipro* (n. 4268/04).

11.2. Diritti dei rei minori in relazione alla detenzione

Punti salienti

- Un minore può essere privato della sua libertà soltanto come misura di ultima istanza e della più breve durata possibile.
- I minori detenuti devono essere trattati in maniera consona all'età e nel rispetto della loro dignità.
- I minori non dovrebbero essere detenuti assieme agli adulti.

Ogni persona ha diritto alla libertà. La privazione della libertà pertanto costituisce un'eccezione e comprende ogni forma di collocazione in un istituto per decisione di un'autorità giudiziaria o amministrativa, senza che il minore sia autorizzato a lasciare l'istituto a suo piacimento.[527] Data l'importanza di tutelare i diritti dei minori, compreso il loro interesse superiore, nel caso dei minori le situazioni che prevedono misure di privazione della libertà dovrebbero essere esaminate da questa particolare prospettiva.

Per quanto le circostanze che possono sfociare nella detenzione siano varie, questo paragrafo tratta esclusivamente il caso di minori che vengono in contatto con i sistemi della giustizia penale.

Gli strumenti internazionali affermano universalmente che la detenzione deve rappresentare una misura di ultima istanza. Ciò significa che le autorità statali, ogniqualvolta si trovino nella posizione di decidere se ricorrere alla detenzione per un minore, dovrebbero innanzitutto considerare in maniera adeguata le alternative disponibili per tutelare l'interesse superiore del fanciullo oltre che per facilitarne il reinserimento nella società (articolo 40, paragrafo 1, della CRC). Tra le alternative possibili si annoverano: "le cure, l'orientamento, la supervisione, i consigli, la libertà condizionata, il collocamento in famiglia, i programmi di formazione generale e professionale" (articolo 40, paragrafo 4, della CRC). Il ricorso alla detenzione dovrebbe essere vagliato soltanto nell'eventualità in cui

527 Regola 21.5 del Consiglio d'Europa, Comitato dei ministri (2008), Raccomandazione CM/Rec(2008)11 sulle norme europee per i rei minori oggetto di sanzioni o di altri provvedimenti, 5 novembre 2008.

i provvedimenti alternativi non fossero praticabili. Inoltre, la detenzione dovrebbe essere ordinata esclusivamente per la più breve durata possibile e nel rispetto di adeguate garanzie sostanziali e procedurali. In considerazione dell'età e della vulnerabilità, i minori posti in stato di detenzione godono di speciali diritti e garanzie.

11.2.1. Forme di detenzione (garanzie sostanziali e procedurali)

Nell'ambito del diritto dell'UE, l'attuale quadro giuridico che disciplina i procedimenti di giustizia penale non include uno strumento vincolante sulla detenzione dei minori.

Nell'ambito del diritto del Consiglio d'Europa, l'articolo 5 della CEDU stabilisce che ogni persona ha diritto alla libertà. La detenzione è una situazione eccezionale che dovrebbe essere prevista dalla legge e non applicata in maniera arbitraria. La detenzione inoltre deve essere giustificata da una delle sei situazioni esaustivamente elencate all'articolo 5, paragrafo 1, lettere da a) a f). La detenzione di minori che sono venuti in contatto con il sistema di giustizia penale può essere giustificata nei seguenti casi: a) detenzione in seguito a condanna da parte di un tribunale competente; c) detenzione preventiva; d) detenzione finalizzata in particolare alla sorveglianza della loro educazione. Gli ultimi due casi meritano di essere analizzati, poiché hanno dato origine a obblighi specifici da parte delle autorità statali.

Detenzione preventiva

L'espressione "detenzione preventiva" si riferisce a situazioni in cui un soggetto è trattenuto in stato di arresto o di custodia cautelare da parte della polizia perché sospettato di aver commesso un reato. La detenzione preventiva inizia quando il soggetto è trattenuto dalla polizia e termina con la decisione nel merito del caso da parte di un tribunale di primo grado.[528] Benché i minori godano delle medesime garanzie degli adulti, la Corte EDU ha stabilito una serie di ulteriori principi per rafforzare la posizione dei minori nei procedimenti penali a livello nazionale.

La Corte EDU ha generalmente interpretato l'articolo 5, paragrafo 1, lettera c), e l'articolo 5, paragrafo 3, nel senso che prevedono il trattenimento di una persona in via preventiva soltanto in presenza di un ragionevole sospetto che la

528 Corte EDU, sentenza 22 maggio 2012, *Idalov c. Russia* (n. 5826/03), punto 112.

stessa abbia compiuto un reato. Inoltre, la detenzione preventiva non dovrebbe protrarsi oltre un periodo di tempo ragionevole e la sua necessità dovrebbe essere riconsiderata a intervalli ragionevoli. Maggiore la durata del trattenimento, più fondate devono essere le ragioni mosse dalle autorità per giustificarne l'applicazione. Secondo la giurisprudenza della Corte EDU, una persona accusata di un reato deve essere sempre rilasciata in attesa di processo, a meno che lo Stato non possa dimostrare che vi sono ragioni "rilevanti e sufficienti" che giustificano il proseguimento della detenzione.[529]

La Corte EDU ha individuato quattro fondamentali ragioni accettabili per rifiutare il versamento della cauzione al detenuto nei casi di custodia preventiva, vale a dire i casi in cui vi sia rischio di fuga, pregiudizio dell'amministrazione della giustizia, compimento di altri reati o turbamento dell'ordine pubblico. Inoltre, il proseguimento della detenzione preventiva dovrebbe essere strettamente necessario e lo Stato è tenuto a esaminare tutti i fatti, vagliando l'esistenza o meno di un genuino criterio di interesse pubblico che imponga una misura protratta di privazione della libertà.[530]

Nei casi che riguardano minori, la Corte EDU stabilisce che le autorità statali debbano prestare particolare attenzione all'età del minore nel bilanciare le relative argomentazioni a favore e contro la detenzione preventiva; la custodia precautelare deve essere utilizzata come ultima istanza e per una durata più breve possibile.[531] Ciò implica l'obbligo da parte delle autorità di vagliare alternative alla detenzione preventiva.[532] Inoltre, le autorità statali dovrebbero mostrare particolare diligenza a che una causa concernente un minore sia esaminata entro un periodo di tempo ragionevole.[533]

529 Corte EDU, sentenza 24 luglio 2003, *Smirnova c. Russia* (n. 46133/99 e n. 48183/99), punto 58.

530 *Ibid.*, punti 58–59; Corte EDU, sentenza 18 marzo 2008, *Ladent c. Polonia* (n. 11036/03), punto 55.

531 Corte EDU, sentenza 19 gennaio 2012, *Korneykova c. Ucraina* (n. 39884/05), punti 43-44. Corte EDU, sentenza 10 gennaio 2006, *Selçuk c. Turchia* (n. 21768/02), punti 35–36; Corte EDU, sentenza 13 novembre 2012, *J.M. c. Danimarca* (n. 34421/09), punto 63.

532 Corte EDU, sentenza 9 luglio 2013, *Dinç e Çakır c. Turchia* (n. 66066/09), punto 63 (consultabile in francese); Corte EDU, sentenza 20 gennaio 2009, *Güveç c. Turchia* (n. 70337/01), punto 108.

533 Corte EDU, sentenza 3 marzo 2011, *Kuptsov e Kuptsova c. Russia* (n. 6110/03), punto 91.

Esempio: nel caso *Nart c. Turchia*,[534] il ricorrente, un ragazzo di 17 anni, è stato arrestato perché sospettato di aver rapinato un piccolo negozio di generi alimentari. Il ragazzo è stato trattenuto in detenzione cautelare, in un carcere per adulti, per 48 giorni. La Corte EDU, considerando in particolare che il ricorrente era minorenne, ha stabilito che "la detenzione cautelare dei minori dovrebbe essere utilizzata come misura di *extrema ratio*; dovrebbe essere quanto più breve possibile e, laddove la detenzione sia strettamente necessaria, i minori dovrebbero essere tenuti separati dagli adulti".[535] In questo caso particolare le autorità hanno tentato di giustificare la detenzione cautelare sulla base dello "stato degli elementi di prova", ma la Corte EDU ha riscontrato che questa motivazione non può da sola giustificare la durata della detenzione lamentata dal ricorrente. Di conseguenza, la Corte ha accertato una violazione dell'articolo 5, paragrafo 3, della CEDU.

Detenzione finalizzata alla sorveglianza dell'educazione del minore

Questa forma di trattenimento è stata ordinata in situazioni in cui il minore presenta un particolare bisogno di sorveglianza a scopo educativo, perché manifesta una personalità disturbata e comportamenti violenti. L'articolo 5, paragrafo 1, lettera d), della CEDU riguarda prevalentemente forme di detenzione che esulano dall'ambito di applicazione del sistema della giustizia minorile.

Esempio: il caso *Bouamar c. Belgio*[536] riguarda il collocamento di un minore in penitenziario in nove occasioni, per periodi di circa 15 giorni ciascuno. Il ricorrente era un adolescente con una personalità disturbata e comportamenti violenti. Il governo belga aveva dichiarato di aver collocato il ragazzo in penitenziario allo scopo di sorvegliarne l'educazione. La Corte EDU ha osservato che il trattenimento provvisorio in un penitenziario di per sé non rappresenta una violazione dell'articolo 5, paragrafo 1, lettera d), purché le autorità perseguano lo scopo di inserire il minore in una struttura rieducativa. Tuttavia, la Corte EDU ha appurato che nel caso del ricorrente le autorità non avevano dimostrato di avere avuto l'intenzione o la possibilità di trasferirlo in un istituto dove avrebbe potuto godere di una sorveglianza a scopo educativo. Di conseguenza, la Corte ha accertato una violazione dell'articolo 5, paragrafo 1, lettera d), della CEDU.

534 Corte EDU, sentenza 6 maggio 2008, *Nart c. Turchia*, (n. 20817/04).

535 *Ibid.*, punto 31.

536 Corte EDU, sentenza 29 febbraio 1988, *Bouamar c. Belgio* (n. 9106/80).

Esempio: la causa *D.G. c. Irlanda*[537] riguarda la collocazione di un ragazzo violento in un centro di detenzione. La Corte EDU ha stabilito che il concetto di "inserimento in struttura rieducativa" non deve essere rigorosamente equiparato all'insegnamento scolastico. L'inserimento in una struttura rieducativa implica svariati aspetti di godimento dei diritti genitoriali da parte delle autorità locali, a beneficio e tutela della persona interessata. La Corte EDU ha dichiarato che le autorità nazionali sono autorizzate a collocare provvisoriamente un minore in una struttura penitenziaria in attesa di individuare una struttura adatta, purché ciò avvenga in tempi rapidi. Nel caso del ricorrente, il requisito della rapidità non era stato soddisfatto, poiché il ragazzo era stato trasferito in una struttura idonea oltre sei mesi dopo il rilascio dal penitenziario. Di conseguenza, la Corte ha accertato una violazione dell'articolo 5, paragrafo 1, lettera d), della CEDU.

Ricorso alla detenzione, tempestività dell'esame e accesso a un difensore

La Corte EDU richiede alle autorità nazionali particolare diligenza nell'esaminare i casi che riguardano minori trattenuti in stato di detenzione. Oltre alle garanzie summenzionate, le autorità statali devono accertarsi che i minori abbiano il diritto di contestare la legittimità della detenzione a intervalli ragionevoli e che abbiano accesso a un avvocato durante il procedimento atto ad accertare la legittimità della loro detenzione. Questi ricorsi legali devono altresì essere esaminati dai tribunali nazionali, che devono giungere rapidamente a una decisione. La Corte trae queste garanzie procedurali dal disposto dell'articolo 5, paragrafo 4, della CEDU.

Esempio: nel caso *Bouamar c. Belgio*, [538] la Corte EDU ha riscontrato una violazione dell'articolo 5, paragrafo 4, perché: le udienze per la determinazione della legittimità della detenzione del ricorrente si sono tenute senza che fossero presenti i suoi avvocati; i giudici non si sono espressi rapidamente sul caso; non è stata presa di fatto alcuna decisione sulla "legittimità della detenzione", poiché i giudici nazionali hanno rigettato le richieste del ricorrente in quanto infondate.

537 Corte EDU, sentenza 16 maggio 2002, *D.G. c. Irlanda* (n. 39474/98).

538 Corte EDU, sentenza 29 febbraio 1988, *Bouamar c. Belgio* (n. 9106/80).

11.2.2. Condizioni detentive

Nell'ambito del diritto dell'UE, l'articolo 4 della Carta dei diritti fondamentali dell'UE proibisce la tortura e i trattamenti inumani o degradanti. Tuttavia, poiché la Carta si applica soltanto nell'ambito del diritto dell'UE, per poter vincolare gli Stati membri in tal senso questa disposizione dev'essere collegata a un altro strumento giuridico dell'UE relativo alla detenzione. Finora la Corte di giustizia europea non ha esaminato cause concernenti l'articolo 4 della Carta.

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha appurato che il trattenimento di minori in stato di detenzione assieme ad adulti potrebbe costituire una violazione dell'articolo 3[539] o dell'articolo 5 della CEDU.[540] Inoltre, anche l'assenza di un'assistenza medica adeguata in carcere potrebbe sollevare rilievi in relazione all'articolo 3.[541] Altri aspetti che potrebbero dar adito a doglianze in relazione all' articolo 3 comprendono lo spazio disponibile in cella, l'illuminazione e le attività ricreative.[542] Nel valutare la compatibilità delle condizioni di detenzione con il disposto dell'articolo 3 della CEDU, la Corte EDU spesso fa affidamento su una serie di norme elaborate dal Comitato europeo per la prevenzione della tortura e delle pene o trattamenti inumani o degradanti (CPT), che monitora le condizioni detentive nell'ambito della Convenzione europea per la prevenzione della tortura e delle pene o trattamenti inumani o degradanti, effettuando visite sul posto negli Stati membri del Consiglio d'Europa.[543]

> Esempio: nel caso *Güveç c. Turchia*,[544] un ragazzino di quindici anni è stato arrestato per sospetta appartenenza al partito dei lavoratori del Kurdistan (PKK). Per ordine della Corte per la sicurezza statale il ricorrente è stato trattenuto in un carcere per adulti per cinque anni. La Corte EDU ha osservato che la detenzione del ricorrente era contraria alle norme e agli obblighi incombenti sulla Turchia ai sensi dei trattati internazionali, compreso tra gli altri l'articolo 37, lettera c), della CRC, che stabilisce che ogni fanciullo privato di libertà deve essere detenuto separatamente dagli adulti. La Corte ha altresì osservato che il ricorrente aveva iniziato ad avere problemi

539 Corte EDU, sentenza 20 gennaio 2009, *Güveç c. Turchia* (n. 70337/01).

540 Corte EDU, sentenza 6 maggio 2008, *Nart c. Turchia* (n. 20817/04).

541 Corte EDU, sentenza 20 gennaio 2009, *Güveç c. Turchia* (n.70337/01); Corte EDU, sentenza 14 novembre 2013 (deferita alla GC il 24 marzo 2014) *Blokhin c. Russia* (n. 47152/06).

542 Corte EDU, sentenza 3 marzo 2011, *Kuptsov e Kuptsova c. Russia* (n. 6110/03), punto 70.

543 Cfr., per esempio, Corte EDU, sentenza 20 gennaio 2009, *Güveç c. Turchia* (n. 70337/01).

544 *Ibid*.

psicologici in carcere, in conseguenza dei quali aveva ripetutamente tentato il suicidio. In aggiunta, le autorità non avevano provveduto a fornire al ricorrente adeguate cure mediche. Di conseguenza, in considerazione dell'età del ricorrente, della durata della sua detenzione in carcere assieme a persone adulte, dell'incapacità delle autorità statali di fornire al ricorrente adeguate cure mediche per i suoi problemi psicologici e della mancata adozione di misure volte a prevenire i suoi ripetuti tentativi di suicidio, la Corte EDU ha riscontrato una palese evidenza di trattamento inumano e degradante nei confronti del ricorrente, e dunque una violazione dell'articolo 3 della CEDU.

Il CEDS ha costantemente interpretato l'articolo 17 della CSE nel senso che, in caso di detenzione di minori, questi dovrebbero essere tenuti separati dagli adulti.

Le norme del Comitato europeo per i rei minori oggetto di sanzioni o di altri provvedimenti forniscono orientamenti dettagliati sulle condizioni detentive. Stabiliscono altresì che i minori non dovrebbero essere detenuti in istituti per adulti, bensì in strutture apposite a loro destinate.[545]

Nell'ambito del diritto internazionale, la CRC contiene una disposizione distinta sulla privazione della libertà dei minori, in cui si prevede che il fanciullo privato della libertà sia separato dagli adulti, a meno che si ritenga preferibile il contratio nel suo interesse preminente (articolo 37, lettera c), della CRC). Questo stesso articolo stipula altresì che i minori, in linea di principio, hanno diritto a rimanere in contatto con la sua famiglia per mezzo di corrispondenza e visite.

11.2.3. Protezione da abusi e maltrattamenti

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha ripetutamente dichiarato che le autorità nazionali sono responsabili della protezione delle persone in stato di arresto dalla morte, dagli abusi o da maltrattamenti causati da altri detenuti o dalle autorità stesse. Gli obblighi degli Stati in tal senso sono particolarmente rigidi, poiché i detenuti si trovano sotto l'autorità e il controllo dello Stato.[546] Oltre ad adottare misure ragionevoli per proteggere i detenuti, le auto-

545 Consiglio d'Europa, Consiglio dei ministri (2008), Raccomandazione CM/Rec(2008)11 sulle norme europee per i rei minori oggetto di sanzioni o di altri provvedimenti, 5 novembre 2008, regola 59.1.

546 Corte EDU, sentenza 13 giugno 2002, *Anguelova c. Bulgaria* (n. 38361/97); Corte EDU, sentenza 6 ottobre 2005, *H.Y. e Hü.Y. c. Turchia* (n. 40262/98).

rità statali devono anche condurre indagini efficaci in caso di denunce di asseriti maltrattamenti o decessi.

Esempio: il caso *Coselav c. Turchia* riguarda il suicidio in carcere di un adolescente[547] che in più occasioni in precedenza aveva tentato, senza successo, di togliersi la vita. Dopo questi tentativi le autorità l'avevano trasferito da un'ala del carcere riservata ai minori a una struttura penitenziaria per adulti. La Corte, una volta stabilito che le autorità erano al corrente o dovevano essere al corrente dell'esistenza di un pericolo concreto e immediato per la vita del figlio dei ricorrenti, ha appurato che esse non avevano adottato misure ragionevoli per impedire il rischio di suicidio. La Corte EDU si è soffermata in particolare a considerare l'età del ragazzo e il fatto che fosse stato destinato a un'ala del carcere riservata agli adulti, ritenendo quindi violato l'articolo 2 della CEDU sotto il profilo sostanziale. La Corte EDU ha accertato una violazione del medesimo articolo 2 anche sotto il profilo procedurale, stigmatizzando che le autorità non avevano condotto un'indagine efficace sulla morte del figlio dei ricorrenti. Le ragioni a sostegno di tale rilievo sono le seguenti: le autorità non avevano prontamente avvisato i ricorrenti della morte del figlio; gli inquirenti non avevano mosso alcun passo per accertare le presunte omissioni delle autorità nel prevenire il suicidio; il procedimento amministrativo successivamente avviato aveva avuto una durata eccessiva.

11.3. Tutela dei minori vittime e testimoni

Punto saliente

- I minori vittime e testimoni hanno diritto a essere protetti da vittimizzazioni secondarie, a ricevere cure e a essere reinseriti, oltre che a partecipare in maniera efficace ai procedimenti penali e alternativi.

Nell'ambito del diritto dell'UE e del Consiglio d'Europa, la posizione dei minori vittime e testimoni è stata riconosciuta.

547 Corte EDU, sentenza 9 ottobre 2012, *Çoşelav c. Turchia*, (n. 1413/07).

Nell'ambito del diritto dell'UE, la direttiva sui diritti delle vittime (2012/29/UE)[548] riconosce esplicitamente la posizione delle vittime minorenni. Stabilisce che, se la vittima è un minore, sia innanzitutto considerato l'interesse superiore del minore e si proceda a una valutazione individuale. Inoltre, si privilegia un approccio rispettoso delle esigenze del minore, che ne tenga in considerazione età, maturità, opinioni, necessità e preoccupazioni. La direttiva mira altresì a garantire che il minore e il titolare della potestà genitoriale o altro eventuale rappresentante legale siano informati in merito a eventuali misure o diritti specificamente vertenti sui minori (articolo 1, paragrafo 2). Le vittime minorenni hanno anche il diritto di essere sentiti nel corso del procedimento penale e gli Stati membri sono tenuti a garantire che questi stessi possano fornire elementi di prova. Quando la vittima da sentire è un minore, si tengono in debito conto la sua età e la sua maturità (articolo 10, paragrafo 1). Inoltre, la direttiva mira a proteggere la vita privata e l'identità delle vittime minorenni nel corso del procedimento penale, tra l'altro al fine di evitare la vittimizzazione secondaria (articolo 21, paragrafo 1, cfr. anche l'articolo 26). Inoltre, la direttiva prevede una disposizione specifica sul diritto alla protezione delle vittime minorenni durante il procedimento penale (articolo 24) che tratta della registrazione audiovisiva delle audizioni del minore vittima di reato e del loro utilizzo come prova nei procedimenti penali; della nomina di rappresentanti speciali; e del diritto alla rappresentanza legale nel caso sussista un conflitto di interessi tra il minore vittima di reato e i titolari della potestà genitoriale. La direttiva inoltre contiene varie disposizioni per la protezione delle vittime in generale, tra cui l'accesso ai servizi di assistenza alle vittime. Nel caso di minori o di altri gruppi vulnerabili, dovrebbero essere messi a disposizione servizi di assistenza specialistici (cfr. il capitolo 38 della risoluzione che accompagna la direttiva).[549]

Prima di essere sostituita dalla direttiva sui diritti delle vittime, la decisione quadro 2001/220/GAI relativa alla posizione della vittima nel procedimento penale si occupava, tra le altre cose, del tema della partecipazione delle vittime, dei diritti delle vittime e dell'equo trattamento. Pur non menzionando esplicitamente i minori, riconosceva tuttavia la particolare posizione delle vittime vulnerabili. Ai sensi di questa decisione quadro, la Corte di giustizia dell'Unione europea ha stabilito che i minori possono essere qualificati come vulnerabili alla luce dell'età e della natura delle infrazioni di cui ritengono di essere state vittime. Essi hanno

548 Direttiva 2012/29/UE del Parlamento europeo e del Consiglio, del 25 ottobre 2012, che istituisce norme minime in materia di diritti, assistenza e protezione delle vittime di reato (GU L 315 del 14.11.2012, pag. 57).

549 Cfr. anche FRA (2014b), pag. 36.

quindi diritto a misure di tutela specifiche, tra cui il diritto a essere sentiti fuori dall'aula di un tribunale, prima che inizi il processo.[550] La Corte ha altresì dichiarato che tutte le misure adottate per proteggere le vittime devono essere concepite in modo da garantire comunque all'imputato un equo processo. In altre parole, la tutela delle vittime e dei testimoni non può mettere a repentaglio il diritto delle persone a un equo processo (cfr. anche gli esempi della giurisprudenza della Corte EDU).[551]

Esempio: nella causa *Pupino*,[552] un'insegnante di scuola materna italiana è stata condannata per maltrattamento nei confronti di un alunno. Ai sensi del codice di procedura penale italiano, di norma i testimoni devono deporre la propria testimonianza in tribunale, nel corso del processo. In talune circostanze, tuttavia, la testimonianza di una persona può essere assunta dinanzi a un giudice prima del dibattimento attraverso una speciale procedura (incidente probatorio). Nella specie il pubblico ministero aveva chiesto al giudice nazionale di autorizzare i bambini in età infantile a rendere la loro deposizione nelle fasi precedenti il dibattimento, ma il giudice aveva negato l'autorizzazione. Per la prima volta la Corte di giustizia ha dato una sua interpretazione di alcune disposizioni relative alla comparsa di minori in qualità di vittime e testimoni nell'ambito di un procedimento penale. La Corte ha sottolineato che la decisione quadro 2001/220/GAI impone agli Stati membri l'obbligo di garantire la tutela specifica delle vittime vulnerabili, per cui il giudice nazionale deve avere la possibilità di autorizzare le vittime vulnerabili a rendere la loro deposizione secondo modalità che permettano di garantirne la tutela, ad esempio al di fuori dell'udienza pubblica e prima della tenuta di quest'ultima. La Corte ha statuito: "Tuttavia, indipendentemente dalla questione se la circostanza che la vittima di un'infrazione penale sia un minore basti, in linea di massima, per qualificare tale vittima come particolarmente vulnerabile ai sensi della decisione quadro, non può essere contestato che qualora, come nella causa principale, bambini in età infantile sostengano di aver subito maltrattamenti, per giunta da parte di un'insegnante, tali bambini possano essere così qualificati alla

550 CGUE, sentenza 16 giugno 2005, causa C-105/03, *Procedimento penale a carico di Maria Pupino* [GS], punto 53.

551 CGUE, sentenza 16 giugno 2005, causa C-105/03, *Procedimento penale a carico di Maria Pupino* [GS]. Cfr. anche CGUE, sentenza 21 dicembre 2011, causa C-507/10, *Procedimento penale a carico di X*.

552 CGUE, sentenza 16 giugno 2005, causa C-105/03, *Procedimento penale a carico di Maria Pupino* [GS].

luce, in particolare, della loro età, nonché della natura e delle conseguenze delle infrazioni di cui ritengono di essere stati vittime".[553] La Corte ha altresì stabilito che tutte le misure riguardanti la tutela e la prevenzione della vittimizzazione secondaria devono essere definite in modo tale da garantire all'indagato un processo equo.[554]

Nell'ambito del diritto del Consiglio d'Europa, la Corte EDU ha dichiarato che lo Stato ha il dovere di tutelare gli interessi delle vittime. Ciò vale in particolare per le vittime che partecipano nei procedimenti penali in qualità di testimoni. I loro interessi ai sensi delle disposizioni della CEDU, tra cui l'articolo2 e l'articolo 8, devono essere bilanciati rispetto agli interessi della difesa.[555] La Corte EDU si è pronunciata in più occasioni in merito a reati a sfondo sessuale in cui minori hanno deposto le proprie testimonianze contro i presunti responsabili delle violenze. Questa giurisprudenza dimostra che la Corte riconosce che i procedimenti penali aventi a oggetto reati sessuali sono spesso considerati dalla vittima come supplizi, in particolare quando quest'ultima non è disposta a confrontarsi con l'indagato, e che questa reazione è particolarmente evidente nel caso dei minori.[556] Di conseguenza, la Corte ha accettato che, in questi casi, siano adottate misure volte a tutelare le vittime minorenni. Tuttavia, si fa presente che tali misure non possono mettere a repentaglio l'esercizio adeguato ed efficace dei diritti dell'indagato, e le autorità giudiziarie possono pertanto essere tenute ad adottare provvedimenti atti a controbilanciare le difficoltà in cui la difesa si trovi a operare.[557]

Esempio: nel caso *Kovač c. Croazia*,[558] una ragazza di 12 anni ha deposto dinanzi a un magistrato inquirente, accusando il ricorrente di aver commesso atti indecenti nei suoi confronti. Durante questa deposizione il ricorrente non era presente né rappresentato, né aveva avuto la possibilità di contestare le dichiarazioni della vittima. La Corte EDU ha ribadito che, di norma, tutte le deposizioni devono essere fornite in presenza dell'indagato nel corso di una pubblica udienza, allo scopo di garantire il contraddittorio

553 *Ibid.*, punto 53.

554 *Ibid.*, punto 59.

555 Corte EDU, sentenza 26 marzo 1996, *Doorson c. Paesi Bassi* (n. 20524/92).

556 Corte EDU, sentenza 2 luglio 2002, *S.N. c. Svezia* (n. 34209/96), punto 47.

557 Corte EDU, sentenza 10 novembre 2005, *Bocos-Cuesta c. Paesi Bassi* (n. 54789/00); Corte EDU, sentenza 27 gennaio 2009, *A.L. c. Finlandia* (n. 23220/04); Corte EDU, sentenza 24 aprile 2007, *W. c. Finlandia* (n. 14151/02); Corte EDU, sentenza 12 luglio 2007, *Kovač c. Croazia* (n. 503/05).

558 Corte EDU, sentenza 12 luglio 2007, *Kovač c. Croazia* (n. 503/05).

rio. Se le dichiarazioni rilasciate durante l'indagine di polizia o l'inchiesta giudiziaria sono utilizzate come prove, di per sé questo fatto non è in contrasto con l'articolo 6 della CEDU, purché all'indagato sia data un'adeguata e appropriata opportunità di porre domande al testimone in questione e di esaminarne le deposizioni, sia al momento della deposizione sia in una fase successiva del procedimento. Nel caso di specie, le dichiarazioni della vittima rappresentavano l'unica prova diretta dei fatti contestati al ricorrente, e queste prove sono state decisive per la decisione del giudice di emettere una sentenza di condanna. Tuttavia, il ricorrente non era stato in grado di contestare né ottenere dai giudici nazionali una risposta in merito alla sua lagnanza al riguardo. Oltretutto, le effettive dichiarazioni della vittima non erano mai state lette nel corso del dibattimento. Al contrario, il giudice si era limitato a osservare che la vittima confermava la dichiarazione resa dinanzi al magistrato inquirente. Di conseguenza, la Corte EDU ha concluso che il ricorrente era stato privato del diritto a un equo processo, in violazione dell'articolo 6, paragrafo 1, in combinato disposto con l'articolo 6, paragrafo 3, lettera d), della CEDU.

Esempio: nel caso *S.N. c. Svezia*,[559] un ragazzino di dieci anni ha testimoniato alla polizia di avere subito abusi sessuali dal ricorrente. Il ragazzo è stato sottoposto a due interrogatori da parte di un ispettore di polizia con una solida esperienza in materia di casi di abuso ai danni di minori. Il primo colloquio è stato videoregistrato, mentre del secondo è disponibile una registrazione audio. L'avvocato del ricorrente non ha presenziato al secondo colloquio, ma ha concordato con l'ispettore di polizia le questioni che avrebbero dovuto essere discusse. Nel corso del processo, il tribunale distrettuale ha ascoltato le registrazioni dei colloqui con il ragazzino, senza sentirlo personalmente. Il giudice ha condannato il ricorrente facendo affidamento quasi interamente sulle testimonianze del ragazzino. La Corte d'appello ha confermato la condanna. Questa ha riscontrato che i colloqui di polizia rappresentavano una prova sufficiente su cui stabilire la colpevolezza del ricorrente, pur ammettendo l'assenza di prove tecniche a sostegno delle accuse del minore, che a volte risultavano imprecise. La Corte EDU riconosce che, nei casi concernenti reati sessuali, non sempre è possibile ricorrere al controinterrogatorio di un testimone e che, in queste situazioni, le deposizioni dei testimoni devono essere trattate con estrema attenzione. Nonostante le dichiarazioni del bambino fossero di fatto l'unica

559 Corte EDU, sentenza 2 luglio 2002, *S.N. c. Svezia* (n. 34209/96)

prova della colpevolezza dell'imputato, nel complesso il processo è stato equo. La videoregistrazione è stata mostrata nel corso del dibattimento e nelle udienze di appello e la trascrizione del secondo colloquio è stata letta dinanzi al giudice distrettuale; inoltre, la registrazione audio è stata ascoltata dalla Corte d'appello. Ciò ha dato al ricorrente sufficienti opportunità per esaminare le deposizioni del minore e mettere in discussione la sua credibilità nel corso del procedimento penale. Di conseguenza, non è stata accertata una violazione dell'articolo 6, paragrafo 3, lettera d), della CEDU.

La giurisprudenza della Corte EDU non si occupa soltanto di conciliare la protezione delle vittime minorenni e il diritto dell'indagato a un equo processo, bensì anche della protezione del diritto alla vita dei testimoni e delle loro famiglie, compresi i minori, ai sensi dell'articolo 2 della CEDU, come emerge dal seguente esempio.

Esempio: il caso *R.R. e altri c. Ungheria*[560] riguarda un detenuto che in un dibattimento pubblico aveva reso testimonianza in merito alle sue attività di traffico di stupefacenti e che era stato inserito assieme alla moglie e ai due figli in un programma ufficiale di protezione dei testimoni dal rischio di ritorsioni. Quando le autorità si erano accorte che il detenuto era ancora in contatto con le cerchie criminali, avevano escluso il testimone e la sua famiglia dal suddetto programma, per violazione delle relative condizioni. Invocando l'articolo 2 della CEDU, la famiglia sosteneva che la loro esclusione dal programma di protezione dei testimoni aveva messo le loro vite a rischio di ritorsioni da parte della mafia. La Corte ha riconosciuto che l'inserimento dei ricorrenti nel programma di protezione dei testimoni e la collaborazione del capofamiglia con le autorità implicavano una situazione di rischio per la vita dei ricorrenti, dal momento che era stata messa originariamente in atto tale misura. Poiché la cancellazione della loro protezione dal programma non era stata giustificata da una diminuzione di tale rischio, ma da una violazione delle condizioni di partecipazione al programma, la Corte non era del parere che le autorità avessero dimostrato che il rischio era venuto meno. Inoltre, non era irragionevole supporre che, dopo il ritiro delle identità di copertura della famiglia, le loro vere identità e il luogo in cui si trovavano sarebbero stati accessibili a chiunque desiderasse nuocergli. In tal modo, le autorità avevano potenzialmente esposto la famiglia a un pericolo per la vita, in violazione dell'articolo 2 della CEDU.

560 Corte EDU, sentenza 4 dicembre 2012, *R.R. e altri c. Ungheria* (n. 19400/11).

L'articolo 31 della convenzione di Lanzarote indica quali misure generali di tutela dovrebbero adottare gli Stati membri per proteggere i diritti e gli interessi delle vittime, compresi i loro bisogni speciali in qualità di testimoni, in tutte le fasi delle indagini e dei procedimenti penali (articolo 31, paragrafo 1). Tra le misure elencate si annoverano la trasmissione di informazioni sui loro diritti, sulla disponibilità di servizi e sullo svolgimento generale delle indagini o del procedimento penale, la protezione della loro vita privata e della loro sicurezza (comprese informazioni sulla rimessa in libertà della persona imputata e condannata) e la garanzia che siano evitati i contatti diretti tra le vittime e gli autori di reato nell'ambito dei locali dei servizi d'indagine e degli edifici giudiziari. L'articolo 31 prevede altresì che le vittime abbiano accesso a un'assistenza legale (articolo 31, paragrafo 3). Le informazioni devono essere fornite in maniera adatta all'età e al grado di maturità delle vittime, nonché in una lingua che possano comprendere (articolo 31, paragrafo 6).

Anche le *Linee guida del Consiglio d'Europa sulla giustizia a misura di minore* [561] sono attente alla posizione dei minori in qualità di vittime e testimoni, in particolare quando questi siano chiamati a deporre nell'ambito di un procedimento giudiziario. Il documento invita gli Stati membri a "fare ogni sforzo per consentire ai minori di testimoniare negli ambienti più favorevoli possibili e nelle condizioni più favorevoli, tenendo conto della loro età, grado di maturità e livello di comprensione, nonché delle eventuali difficoltà di comunicazione che potrebbero avere".[562] A tal fine dovrebbero essere coinvolti professionisti qualificati e, per esempio, dovrebbero essere incoraggiate le dichiarazioni audiovisive. I minori dovrebbero inoltre avere la possibilità di testimoniare nelle cause penali senza la presenza del presunto autore del reato. Le linee guida riconoscono altresì che questo approccio a misura di minore dovrebbe tuttavia rispettare il diritto di altre parti di contestare le dichiarazioni del minore. Inoltre, esse stabiliscono che la vita privata e familiare dei testimoni minorenni dovrebbe essere protetta (sezione IV, paragrafo a.9), e che il procedimento dovrebbe preferibilmente svolgersi a porte chiuse.

Nell'ambito del diritto internazionale, la posizione delle vittime minorenni è esplicitamente riconosciuta dall'articolo 39 della CRC. Questa disposizione stipula che gli Stati parti adottano ogni adeguato provvedimento per agevolare il recupero

561 Consiglio d'Europa, Comitato dei ministri (2010), *Linee guida per una giustizia a misura di minore*, 17 novembre 2010. Cfr. anche FRA (2015b).

562 Consiglio d'Europa, Comitato dei ministri (2010), *Linee guida per una giustizia a misura di minore*, 17 novembre 2010, paragrafo 64.

fisico e psicologico e il reinserimento sociale delle vittime minorenni. Tale recupero e reinserimento devono svolgersi in condizioni tali da favorire la salute, il rispetto della propria persona e la dignità del fanciullo.

È importante notare inoltre che le Nazioni Unite hanno adottato le "Linee guida sulla giustizia nelle questioni che coinvolgono minori vittime e testimoni di reato".[563] Questo documento invita a trattare le vittime e i testimoni minorenni in modo "rispettoso della sensibilità del minore", nel senso di "un approccio che tiene nella dovuta considerazione il diritto del minore a essere protetto e che tiene conto dei bisogni e punti di vista del minore".[564] Le linee guida forniscono orientamenti molto dettagliati su come attivare tali aspetti. Nel suo commento generale il comitato sui diritti dell'infanzia dell'ONU ha anch'esso sottolineato l'importanza di tali linee guida ai sensi dell'articolo 12 della CRC (diritto a essere ascoltato).[565] Secondo il comitato, le vittime minorenni e i testimoni minorenni di un reato devono avere l'opportunità di esercitare pienamente i propri diritti di esprimere liberamente le proprie opinioni, il che in particolare "implica che deve essere fatto tutto il possibile per garantire che un minorenne vittima e/o testimone sia consultato sulle questioni riguardanti il coinvolgimento nel caso in esame e che gli sia permesso di esprimere liberamente, e nel modo che gli è proprio, opinioni e preoccupazioni riguardanti il suo coinvolgimento nel processo penale".[566] Il comitato precisa altresì che il "diritto del minorenne vittima e testimone è correlato al diritto di essere informato sulle questioni quali la disponibilità di servizi sanitari, psicologici e sociali, sul ruolo di un minorenne vittima e/o testimone, sui modi in cui è condotto 'l'interrogatorio', sui meccanismi di sostegno esistenti per il minorenne al momento della presentazione di una denuncia e la partecipazione a indagini e procedimenti giudiziari, i luoghi ed gli orari specifici delle audizioni, la disponibilità di misure di protezione, la possibilità di ricevere il risarcimento e le disposizioni per il ricorso".[567]

563 ONU, Consiglio economico e sociale delle Nazioni Unite (ECOSOC), risoluzione 200/20, *Linee guida sulla giustizia nelle questioni che coinvolgono minori vittime e testimoni di reato*, 22 luglio 2005.

564 *Ibid.*, paragrafo 9, lettera d).

565 ONU, Comitato sui diritti dell'infanzia (2009), *Commento generale n. 12 (2009), Il diritto del bambino e dell'adolescente di essere ascoltato*, CRC/C/GC/12, 1° luglio 2009, paragrafi 62–64.

566 *Ibid.,* paragrafo 63.

567 *Ibid.,* paragrafo 64.

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Come reperire la giurisprudenza delle corti europee

Corte europea dei diritti dell'uomo: banca dati della giurisprudenza "HUDOC"

La **banca dati** "**HUDOC**" offre accesso gratuito alla giurisprudenza della Corte EDU: http://HUDOC.echr.coe.int.

La banca dati è disponibile in inglese e in francese e comprende un motore di ricerca di facile impiego che permette di reperire agevolmente la giurisprudenza desiderata.

Sulla pagina "**Help**" **(Aiuto)** del portale "HUDOC" sono disponibili lezioni video e manuali per gli utenti. Per ricevere informazioni dettagliate ed esempi su come usare i filtri e le funzioni di ricerca, l'utente può posizionare il puntatore del mouse su ? alla destra di ogni campo di ricerca.

I riferimenti alla giurisprudenza contenuti in questo manuale forniscono al lettore informazioni esaurienti che permettono di reperire facilmente il testo completo della sentenza o della decisione citate.

Prima di avviare una ricerca, occorre tenere presente che le impostazioni predefinite mostrano le sentenze della Grande Camera e della Camera a partire dall'ultima sentenza pubblicata. Per effettuare una ricerca in altre raccolte, per esempio nelle decisioni, l'utente deve spuntare l'apposita casella nel campo "**Document Collections**" **(Raccolte di documenti)** che compare nella parte superiore sinistra dello schermo.

Il modo più semplice per reperire un caso è inserire il numero di domanda nel campo "Application Number" (Numero di domanda) della sezione "**Advanced Search**" **(Ricerca avanzata)** che compare nella parte superiore destra dello schermo e successivamente cliccare sul pulsante blu "Search" (Cerca).

Per consultare ulteriore giurisprudenza riguardante altre questioni, per esempio in materia di minori, l'utente può utilizzare il **campo** "**Search**" **(Cerca)** indicato con una lente di ingrandimento sulla parte superiore destra dello schermo. Nel campo "Search" (Cerca), l'utente può effettuare una ricerca digitando:

- una singola parola (per esempio "minori")
- un'espressione (per esempio "minori richiedenti asilo")
- il titolo di un caso
- uno Stato
- un'espressione booleana (per esempio minori IN accoglienza alternativa)

Per facilitare l'utente e' possibile effettuare una **ricerca booleana semplice (Simple Boolean search)** cliccando sulla freccia che compare all'interno del **campo** "**Search**" **(Cerca)**. La ricerca booleana semplice offre sei possibilità di ricerca: "this exact word or phrase" (questa esatta parola o espressione), "all of these words" (tutte queste parole), "any of these words" (una di queste parole), "none of these words" (nessuna di queste parole), "near these words" (simile a queste parole), "free Boolean search" (ricerca booleana libera).

Una volta comparsi i risultati della ricerca, l'utente può facilmente restringere i risultati utilizzando i filtri che compaiono nel campo "**Filters**" **(Filtri)** sulla parte sinistra dello schermo, per esempio "Language" (Lingua) o "State" (Stato). I filtri possono essere utilizzati singolarmente o in combinazione al fine di restringere ulteriormente i risultati della ricerca. Il filtro "Keywords" (Parole chiave) può essere uno strumento utile, poiché spesso comprende termini estratti dal testo della CEDU ed è direttamente collegato al ragionamento e alle conclusioni della Corte.

Esempio: trovare la giurisprudenza della Corte sulla questione dell'espulsione dei richiedenti asilo che può esporre tali persone al rischio di tortura o di pene o trattamenti inumani o degradanti ai sensi dell'articolo 3 CEDU.

1) Innanzitutto l'utente digita l'espressione "richiedenti asilo" nel **campo** "**Search**" **(Cerca)** e clicca sul pulsante blu "**Search**" (Cerca).

2) Dopo la visualizzazione dei risultati della ricerca, l'utente seleziona quindi il "3" all'interno del filtro "Violation" (Violazione) del campo "**Filters**" (**Filtri**) al fine di restringere i risultati a quelli connessi alle violazioni di cui all'articolo 3.

3) L'utente può dunque selezionare le rilevanti parole chiave nell'ambito del filtro "**Keywords**" (Parole chiave) al fine di restringere i risultati a quelli che sono pertinenti per l'articolo 3, quali le parole chiave "(Articolo 3) Proibizione della tortura".

Per i casi più significativi, sul portale "HUDOC" è disponibile un riassunto della sentenza costituito da una nota descrittiva e da una presentazione concisa degli elementi di fatto e di diritto, in cui viene dato risalto agli aspetti di interesse giuridico. Qualora sia presente una riassunto, nei risultati figurerà un collegamento assieme al collegamento al testo della sentenza o alla decisione. In alternativa, l'utente può effettuare esclusivamente una ricerca di massime giuridiche spuntando la casella "Legal Summaries" (Sintesi giuridiche) nel campo "**Document collections**" **(Raccolte di documenti)**.

Qualora di un determinato caso siano state pubblicate traduzioni non ufficiali, nei risultati figurerà un collegamento sotto la voce "**Language versions**" (Versioni in altre lingue) assieme al collegamento al testo della sentenza o alla decisione. Il portale "HUDOC" fornisce anche collegamenti a siti Internet di terzi su cui sono presenti altre traduzioni della giurisprudenza della Corte EDU. Per maggiori informazioni, consultare "Language versions" (Versioni in altre lingue) nella sezione "Help" (Aiuto) del portale "HUDOC".

Corte di giustizia dell'Unione europea: banca dati della giurisprudenza "CURIA"

La **banca dati della giurisprudenza** "**CURIA**" offre accesso gratuito alla giurisprudenza della CG/CGUE: http://curia.europa.eu.

Il motore di ricerca è disponibile in tutte le lingue ufficiali dell'UE.[568] La lingua puo essere selezionata nel riquadro che appare sullo schermo in alto a destra. Il motore di ricerca può essere utilizzato per cercare informazioni in tutti i documenti connessi a cause definite e pendenti presso la Corte di giustizia, il Tribunale e il Tribunale della funzione pubblica.

All'indirizzo http://curia.europa.eu/common/juris/it/aideGlobale.pdf# è disponibile una sezione **Aiuto**. È presente una pagina di aiuto anche per ogni riquadro di ricerca, alla quale si può accedere cliccando sull'icona e che contiene informazioni utili volte ad aiutare l'utente a utilizzare lo strumento nel miglior modo possibile.

Il modo più semplice per reperire una causa specifica consiste nell'inserire il numero completo della causa nel riquadro di ricerca denominato **Numero di causa** e poi cliccare sul pulsante verde "Cerca". È anche possibile cercare una causa utilizzando una parte del numero di causa. Per esempio, digitando "122" nel campo "Numero di causa" si trovano le cause n. 122 di tutti gli anni nonché trattate dinanzi a tutti e tre gli organi giurisdizionali: Corte di giustizia, Tribunale e/o Tribunale della funzione pubblica.

In alternativa, è altresì possibile utilizzare il campo **Nome delle parti** per effettuare una ricerca con il nome corrente di una causa. Si tratta in genere del nome delle parti in causa indicato in forma semplificata.

Per contribuire a restringere i risultati della ricerca sono disponibili complessivamente 16 campi di ricerca multifunzionali. I differenti campi di ricerca sono di facile impiego e possono essere utilizzati in varie combinazioni. Spesso i campi sono dotati di elenchi di ricerca ai quali si può accedere cliccando sull'icona corrispondente e selezionando i termini di ricerca disponibili.

Per ricerche più generali, utilizzando il campo **Parole del testo** si ottengono risultati basati su ricerche di parole chiave in tutti i documenti pubblicati nella Raccolta della giurisprudenza dal 1954 e, dal 1994, nella Raccolta della giurisprudenza – Funzione pubblica (RaccFP).

568 Lingue disponibili dal 30 aprile 2004: spagnolo, danese, tedesco, greco, inglese, francese, italiano, olandese, portoghese, finlandese e svedese; dal 1° maggio 2004: ceco, estone, lettone, lituano, ungherese, polacco, slovacco e sloveno; dal 1°gennaio 2007: bulgaro e rumeno; dal 30 aprile 2007: maltese; dal 31 dicembre 2011: irlandese; misure temporanee di deroga sono state stabilite dal regolamento (CE) n. 920/2005 del Consiglio e dal regolamento (UE) n. 1257/2010. Il diritto derivato dell'UE in vigore alla data dell'adesione della Croazia è attualmente in corso di traduzione e verrà pubblicato gradualmente sulla Gazzezzetta ufficiale edizione speciale.

Per effettuare ricerche in settori più specifici, si può utilizzare il campo **Materia**. A tal fine occorre cliccare sull'icona alla destra del campo e selezionare dall'elenco la/e materia/e pertinente/i. I risultati della ricerca mostreranno quindi un elenco alfabetico dei documenti selezionati connessi alle questioni giuridiche trattate nelle decisioni della Corte di giustizia, del Tribunale e del Tribunale della funzione pubblica nonché nei pareri degli Avvocati generali.

Il portale "CURIA" dispone inoltre di strumenti aggiuntivi della giurisprudenza:

Accesso alla giurisprudenza per numero di causa: questa sezione è una raccolta che consente di individuare informazioni per ogni causa trattata dinanzi a uno dei tre organi giurisdizionali. Le cause sono presentate in ordine numerico, in base al loro deposito presso le rispettive cancellerie. È stabilito un collegamento attraverso il numero di causa. È possibile accedere alla sezione "Accesso alla giurisprudenza per numero di causa" all'indirizzo http://curia.europa.eu/jcms/jcms/Jo2_7045/;

Repertorio della giurisprudenza: questa sezione offre una classificazione sistematica delle massime della giurisprudenza sui punti essenziali di diritto illustrati nella pronuncia considerata. Tali massime si basano il più fedelmente possibile sul testo stesso della pronuncia. La sezione "Repertorio" è disponibile all'indirizzo http://curia.europa.eu/jcms/jcms/Jo2_7046/;

Note di dottrina alla giurisprudenza: questa sezione contiene gli estremi di pubblicazione delle note di dottrina alla giurisprudenza dei tre organi giurisdizionali dalla data della loro istituzione. La giurisprudenza è classificata per singola giurisdizione in ordine cronologico di pubblicazione, secondo il numero di causa. Gli estremi di pubblicazione sono in lingua originale. La sezione "Note di dottrina alla giurisprudenza" è disponibile all'indirizzo http://curia.europa.eu/jcms/jcms/Jo2_7083/;

Banca dati di giurisprudenza nazionale: questa banca dati esterna, alla quale è possibile accedere tramite il portale "CURIA", offre accesso alla giurisprudenza nazionale pertinente relativa al diritto dell'Unione. La banca dati si basa su una raccolta della giurisprudenza degli organi giurisdizionali nazionali degli Stati membri dell'UE, effettuata mediante uno spoglio selettivo di riviste giuridiche e di contatti diretti con numerosi organi giurisdizionali nazionali. La "Banca dati di giurisprudenza nazionale" è disponibile in inglese e in francese all'indirizzo http://curia.europa.eu/jcms/jcms/Jo2_7062/.

Strumenti giuridici menzionati

Strumenti legali delle Nazioni Unite

Per i trattati delle Nazioni Unite, compresa la CRC e i relativi organi di controllo, cfr.: www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx.

Per le convenzioni della Conferenza dell'Aia sul diritto internazionale privato relative alla protezione internazionale delle relazioni familiari e patrimoniali dei minori cfr.:
https://www.hcch.net/en/instruments/conventions.

Strumenti giuridici del Consiglio d'Europa

Tutti gli strumenti giuridici del Consiglio d'Europa sono disponibili online all'indirizzo http://conventions.coe.int/Treaty/. Per informazioni sullo stato di recepimento degli strumenti giuridici del Consiglio d'Europa da parte degli Stati membri dell'UE, cfr. il link "International obligations" (Obblighi internazionali) sul sito Internet della FRA al seguente indirizzo: http://fra.europa.eu/en/publications-and-resources/data-and-maps/int-obligations.

	Titolo
Diritti dei minori/diritti civili	
Convenzione per la salvaguardia dei diritti dell'uomo e delle libertà fondamentali	Convenzione per la salvaguardia dei diritti dell'uomo e delle libertà fondamentali, così come modificata dai protocolli n. 11 e n. 14, STE n. 005, Roma, 4.11.1950, pagg. 1–15.
Protocollo addizionale alla Convenzione per la salvaguardia dei diritti dell'uomo e delle libertà fondamentali	Protocollo addizionale alla Convenzione per la salvaguardia dei diritti dell'uomo e delle libertà fondamentali, modificato dal protocollo n. 11, STE n. 009, Parigi, 20.3.1952, pagg. 1–3.
Protocollo n. 12 alla Convenzione per la salvaguardia dei diritti dell'uomo e delle libertà fondamentali	Protocollo n. 12 alla Convenzione per la salvaguardia dei diritti dell'uomo e delle libertà fondamentali, STE n. 177, Roma, 4.11.2000, pagg. 1–3.
Convenzione europea sull'esercizio dei diritti dei minori	Convenzione europea sull'esercizio dei diritti dei minori, STE n. 160, Strasburgo, 25.1.1996, pagg. 1–10.
Convenzione europea sullo status giuridico dei minori nati al di fuori del matrimonio	Convenzione europea sullo status giuridico dei minori nati al di fuori del matrimonio, STE n. 085, Strasburgo, 15.10.1975, pagg. 1–5.
Convenzione sui diritti dell'uomo e la biomedicina	Convenzione per la protezione dei diritti dell'uomo e della dignità dell'essere umano nei confronti dell'applicazione della biologia e della medicina: Convenzione sui diritti dell'uomo e la biomedicina, STE n. 164, Oviedo, 4.4.1997, pagg. 1–12.
Questioni riguardanti l'identità personale	
Convenzione-quadro per la protezione delle minoranze nazionali	Convenzione-quadro per la protezione delle minoranze nazionali, STE n. 157, Strasburgo, 1.2.1995, pagg. 1–10.
Convenzione europea sulla nazionalità	Convenzione europea sulla nazionalità, STE n. 166, Strasburgo, 6.11.1997, pagg. 1–13.
Convenzione del Consiglio d'Europa sulla prevenzione della condizione di apolide in relazione alla successione di Stati	Convenzione del Consiglio d'Europa sulla prevenzione della condizione di apolide in relazione alla successione di Stati, STCE n. 200, Strasburgo, 19.5.2006, pagg. 1–7.
Vita familiare e assistenza genitoriale	
Convenzione sulle relazioni personali riguardanti i minori	Convenzione sulle relazioni personali riguardanti i minori, STE n. 192, Strasburgo, 15.5.2003, pagg. 1–13.
Convenzione europea sull'adozione dei minori (riveduta)	Convenzione europea sull'adozione dei minori (riveduta), STCE n.: 202, Strasburgo, 27.11.2008, pagg. 1–11.
Convenzione europea sul riconoscimento e l'esecuzione delle decisioni in materia di affidamento dei minori e sulla ristabilimento dell'affidamento dei minori	Convenzione europea sul riconoscimento e l'esecuzione delle decisioni in materia di affidamento dei minori e sulla ristabilimento dell'affidamento dei minori, STE n. 105, Lussemburgo, 20.5.1980, pagg. 1–12.

Protezione dei minori contro la violenza e lo sfruttamento	
Convenzione del Consiglio d'Europa per la protezione dei bambini contro lo sfruttamento e gli abusi sessuali	Convenzione del Consiglio d'Europa per la protezione dei bambini contro lo sfruttamento e gli abusi sessuali, STCE n. 201, Lanzarote, 25.10.2007, pagg. 1–21.
Convenzione europea per la prevenzione della tortura e delle pene o trattamenti inumani o degradanti	Convenzione europea per la prevenzione della tortura e delle pene o trattamenti inumani o degradanti, STE n. 126, Strasburgo, 26.11.1987, pagg. 1–9.
Convenzione sulla criminalità informatica	Convenzione europea sulla criminalità informatica, STE n. 185, Budapest, 23.11.2001, pagg. 1–27.
Convenzione del Consiglio d'Europa sulla lotta contro la tratta degli esseri umani	Convenzione del Consiglio d'Europa sulla lotta contro la tratta di esseri umani, STCE n. 197, Varsavia, 16.5.2005, pagg. 1–21.
Convenzione del Consiglio d'Europa sulla prevenzione e la lotta contro la violenza nei confronti delle donne e la violenza domestica	Convenzione del Consiglio d'Europa sulla prevenzione e la lotta contro la violenza nei confronti delle donne e la violenza domestica, STCE n. 210, Istanbul, 11.5.2011, pagg. 1–31.
Diritti economici, sociali e culturali	
Carta sociale europea	Carta sociale europea, STE n. 035, Torino, 18.10.1961, pagg. 1–18.
Carta sociale europea (riveduta)	Carta sociale europea (riveduta), STE n. 163, Strasburgo, 3.5.1996, pagg. 1–29.
Questioni riguardanti la migrazione e l'asilo	
Convenzione europea sul rimpatrio dei minori	Convenzione europea sul rimpatrio dei minori, STE n. 071, L'Aja, 28.5.1970, pagg. 1–9.
Convenzione europea sullo statuto giuridico dei lavoratori emigranti	Convenzione europea sullo statuto giuridico dei lavoratori emigranti, STE n. 093, Strasburgo, 24.11.1977, pagg. 1–14.
Convenzione europea di sicurezza sociale	Convenzione europea di sicurezza sociale, STE n. 078, Parigi, 14.12.1972, pagg. 1–42.
Codice europeo di sicurezza sociale	Codice europeo di sicurezza sociale, STE n. 048, Strasburgo, 16.4.1964, pagg. 1–33.
Sicurezza e protezione dei dati	
Convenzione sulla protezione delle persone rispetto al trattamento automatizzato di dati a carattere personale	Convenzione sulla protezione delle persone rispetto al trattamento automatizzato di dati a carattere personale, STE n. 108, Strasburgo, 28.1.1981, pagg. 1–10.
Convenzione europea sulla televisione transfrontaliera	Convenzione europea sulla televisione transfrontaliera, STE n. 132, Strasburgo, 5.5.1989, pagg. 1–20.

Strumenti giuridici dell'UE

Tutti gli strumenti giuridici dell'UE sono disponibili online all'indirizzo http://eur-lex.europa.eu.

	Titolo
Non discriminazione	
Direttiva sull'uguaglianza razziale 2000/43/CE	Direttiva 2000/43/CE del Consiglio, del 29 giugno 2000, che attua il principio della parità di trattamento fra le persone indipendentemente dalla razza e dall'origine etnica (GU L 180 del 19.7.2000, pagg. 22–26).
Direttiva sulla parità di trattamento in materia di occupazione 2000/78/CE	Direttiva 2000/78/CE del Consiglio, del 27 novembre 2000, che stabilisce un quadro generale per la parità di trattamento in materia di occupazione e di condizioni di lavoro (GU L 303 del 2.12.2000, pagg. 16–22).
Direttiva sulla parità di trattamento nell'accesso a beni e servizi (2004/113/CE)	Direttiva 2004/113/CE del Consiglio, del 13 dicembre 2004, che attua il principio della parità di trattamento tra uomini e donne per quanto riguarda l'accesso a beni e servizi e la loro fornitura (GU L 373 del 21.12.2004, pagg. 37–43).
Vita familiare e assistenza genitoriale	
Regolamento Bruxelles II bis (CE) n. 2201/2003	Regolamento (CE) n. 2201/2003 del Consiglio, del 27 novembre 2003, relativo alla competenza, al riconoscimento e all'esecuzione delle decisioni in materia matrimoniale e in materia di responsabilità genitoriale, che abroga il regolamento (CE) n. 1347/2000 (GU L 338 del 23.12.2003, pagg. 1–29)
Regolamento (CE) n. 4/2009 in materia di obbligazioni alimentari	Regolamento (CE) n. 4/2009 del Consiglio, del 18 dicembre 2008, relativo alla competenza, alla legge applicabile, al riconoscimento e all'esecuzione delle decisioni e alla cooperazione in materia di obbligazioni alimentari (GU L 7 del 10.1.2009, pagg. 1–79)
Direttiva 2008/52/CE sulla mediazione	Direttiva 2008/52/CE del Parlamento europeo e del Consiglio, del 21 maggio 2008, relativa a determinati aspetti della mediazione in materia civile e commerciale (GU L 136 del 24.5.2008, pagg. 3–8).
Direttiva 2002/8/CE sull'accesso alla giustizia	Direttiva 2002/8/CE del Consiglio, del 27 gennaio 2003, intesa a migliorare l'accesso alla giustizia nelle controversie transfrontaliere attraverso la definizione di norme minime comuni relative al patrocinio a spese dello Stato in tali controversie (GU L 26 del 31.1.2003, pagg. 41–47).

Protezione dei minori contro la violenza e lo sfruttamento	
Direttiva 94/33/CE relativa ai giovani sul lavoro	Direttiva 94/33/CE del Consiglio, del 22 giugno 1994, relativa alla protezione dei giovani sul lavoro (GU L 216 del 20.8.1994, pagg. 12–20).
Direttiva sulla tratta (2011/36/UE)	Direttiva 2011/36/UE del Parlamento europeo e del Consiglio, del 5 aprile 2011, concernente la prevenzione e la repressione della tratta di esseri umani e la protezione delle vittime, e che sostituisce la decisione quadro del Consiglio 2002/629/GAI (GU L 101 del 15.4.2011, pagg. 1–11).
Direttiva relativa alla lotta contro l'abuso e lo sfruttamento sessuale dei minori e la pornografia minorile (2011/93/UE)	Direttiva 2011/93/UE del Parlamento europeo e del Consiglio, del 13 dicembre 2011, relativa alla lotta contro l'abuso e lo sfruttamento sessuale dei minori e la pornografia minorile, e che sostituisce la decisione quadro 2004/68/GAI del Consiglio (GU L 335 del 17.12.2011, pagg. 1–14).
Direttiva sulle vittime (2012/29/UE)	Direttiva 2012/29/UE del Parlamento europeo e del Consiglio, del 25 ottobre 2012, che istituisce norme minime in materia di diritti, assistenza e protezione delle vittime di reato e che sostituisce la decisione quadro 2001/220/GAI (GU L 315 del 14.11.2012, pagg. 57–73).
Direttiva sui titoli di soggiorno per le vittime della tratta di esseri umani (2004/81/CE)	Direttiva 2004/81/CE del Consiglio, del 29 aprile 2004, riguardante il titolo di soggiorno da rilasciare ai cittadini di paesi terzi vittime della tratta di esseri umani o coinvolti in un'azione di favoreggiamento dell'immigrazione illegale che cooperino con le autorità competenti (GU L 261 del 6.8.2004, pagg. 19–23).
Decisione 2007/698/CE della Commissione	Decisione della Commissione, del 29 ottobre 2007, recante modifica della decisione 2007/116/CE per quanto riguarda l'introduzione di altri numeri riservati che iniziano con "116" [notificata con il numero C(2007)5139] (Testo rilevante ai fini del SEE) (2007/698/EC) (GU L 284 del 30.10.2007, pagg. 31–32).
Migrazione e asilo, compresi i diritti sociali dei minori migranti	
Direttiva sulle procedure di asilo (2013/32/UE)	Direttiva 2013/32/UE del Parlamento europeo e del Consiglio, del 26 giugno 2013, recante procedure comuni ai fini del riconoscimento e della revoca dello status di protezione internazionale (GU L 180 del 29.6.2013, pagg. 60–95).
Regolamento (UE) n.604/2013 di Dublino	Regolamento (UE) n. 604/2013 del Parlamento europeo e del Consiglio, del 26 giugno 2013, che stabilisce i criteri e i meccanismi di determinazione dello Stato membro competente per l'esame di una domanda di protezione internazionale presentata in uno degli Stati membri da un cittadino di un paese terzo o da un apolide (GU L 180 del 29.6.2013, pagg. 31–59).

Direttiva qualifiche (2011/95/UE)	Direttiva 2011/95/UE del Parlamento europeo e del Consiglio, del 13 dicembre 2011, recante norme sull'attribuzione, a cittadini di paesi terzi o apolidi, della qualifica di beneficiario di protezione internazionale, su uno status uniforme per i rifugiati o per le persone aventi titolo a beneficiare della protezione sussidiaria, nonché sul contenuto della protezione riconosciuta (GU L 337 del 20.12.2011, pagg. 9–26).
Regolamento (UE) n. 492/2011	Regolamento (UE) n. 492/2011 del Parlamento europeo e del Consiglio, del 5 aprile 2011, relativo alla libera circolazione dei lavoratori all'interno dell'Unione (GU L 141 del 27.5.2011, pagg. 1–12).
Direttiva sulla libera circolazione (2004/38/CE)	Direttiva 2004/38/CE del Parlamento europeo e del Consiglio, del 29 aprile 2004, relativa al diritto dei cittadini dell'Unione e dei loro familiari di circolare e di soggiornare liberamente nel territorio degli Stati membri, che modifica il regolamento (CEE) n. 1612/68 ed abroga le direttive 64/221/CEE, 68/360/CEE, 72/194/CEE, 73/148/CEE, 75/34/CEE, 75/35/CEE, 90/364/CEE, 90/365/CEE e 93/96/CEE (Testo rilevante ai fini del SEE) (GU L 158 del 30.4.2004, pagg. 77–123).
Direttiva 77/486/CEE del Consiglio sull'istruzione dei bambini dei lavoratori migranti	Direttiva 77/486/CE del Consiglio, del 25 luglio 1977, relativa alla formazione scolastica dei figli dei lavoratori migranti (GU L 199 del 6.8.1977, pagg. 32–33).
Direttiva sul ricongiungimento familiare (2003/86/CE)	Direttiva 2003/86/CE del Consiglio, del 22 settembre 2003, relativa al diritto al ricongiungimento familiare (GU L 251 del 3.10.2003, pagg. 12–18).
Direttiva sulla protezione temporanea (2001/55/CE)	Direttiva 2001/55/CE del Consiglio, del 20 luglio 2001, sulle norme minime per la concessione della protezione temporanea in caso di afflusso massiccio di sfollati e sulla promozione dell'equilibrio degli sforzi tra gli Stati membri che ricevono gli sfollati e subiscono le conseguenze dell'accoglienza degli stessi (GU L 212 del 7.8.2001, pagg. 12–23).
Direttiva sulle condizioni di accoglienza (2013/33/CE)	Direttiva 2013/33/UE del Parlamento europeo e del Consiglio, del 26 giugno 2013, recante norme relative all'accoglienza dei richiedenti protezione internazionale (GU L 180 del 29.6.2013, pagg. 96–116).
Direttiva rimpatri (2008/115/CE)	Direttiva 2008/115/CE del Parlamento europeo e del Consiglio, del 16 dicembre 2008, recante norme e procedure comuni applicabili negli Stati membri al rimpatrio di cittadini di paesi terzi il cui soggiorno è irregolare (GU L 348 del 24.12.2008, pagg. 98–107).

Direttiva sui soggiornanti di lungo periodo (2003/109/CE)	Direttiva 2003/109/CE del Consiglio, del 25 novembre 2003, relativa allo status dei cittadini di paesi terzi che siano soggiornanti di lungo periodo (GU L 16 del 23.1.2004, pagg. 44–53).
Regolamento (CE) n. 562/2006 relativo al codice frontiere Schengen	Regolamento (CE) n. 562/2006 del Parlamento europeo e del Consiglio, del 15 marzo 2006, che istituisce un codice comunitario relativo al regime di attraversamento delle frontiere da parte delle persone (codice frontiere Schengen) (GU L 105 del 13.4.2006, pagg. 1–32).
Consumatori e protezione dei dati personali	
Direttiva sui diritti dei consumatori (2011/83/UE)	Direttiva 2011/83/UE del Parlamento europeo e del Consiglio, del 25 ottobre 2011, sui diritti dei consumatori, recante modifica della direttiva 93/13/CEE del Consiglio e della direttiva 1999/44/CE del Parlamento europeo e del Consiglio e che abroga la direttiva 85/577/CEE del Consiglio e la direttiva 97/7/CE del Parlamento europeo e del Consiglio (GU L 304 del 22.11.2011, pagg. 64–88).
Direttiva 87/357/CEE concernente i prodotti che, avendo un aspetto diverso da quello che sono in realtà, compromettono la salute o la sicurezza dei consumatori	Direttiva 87/357/CEE del Consiglio, del 25 giugno 1987, concernente il ravvicinamento delle legislazioni degli Stati Membri relative ai prodotti che, avendo un aspetto diverso da quello che sono in realtà, compromettono la salute o la sicurezza dei consumatori (GU L 192 dell'11.7.1987, pagg. 49–50).
Direttiva sulle vendite a distanza (97/7/CE)	Direttiva 97/7/CE del Parlamento europeo e del Consiglio, del 20 maggio 1997, riguardante la protezione dei consumatori in materia di contratti a distanza - Dichiarazione del Consiglio e del Parlamento europeo sull'articolo 6, paragrafo 1 – Dichiarazione della Commissione sull' articolo 3, paragrafo 1, primo trattino (GU L 144 del 4.6.1997, pagg. 19–27).
Direttiva sulla sicurezza generale dei prodotti (2001/95/CE)	Direttiva 2001/95/CE del Parlamento europeo e del Consiglio, del 3 dicembre 2001, relativa alla sicurezza generale dei prodotti (GU L 11 del 15.1.2002, pagg. 4–17).
Direttiva 2009/39/CE relativa ai prodotti alimentari destinati a un'alimentazione particolare	Direttiva 2009/39/CE del Parlamento europeo e del Consiglio, del 6 maggio 2009, relativa ai prodotti alimentari destinati ad un'alimentazione particolare (rifusione) (Testo rilevante ai fini del SEE) (GU L 124 del 20.5.2009, pagg. 21–29).
Direttiva sulla sicurezza dei giocattoli (2009/48/CE)	Direttiva 2009/48/CE del Parlamento europeo e del Consiglio, del 18 giugno 2009, sulla sicurezza dei giocattoli (Testo rilevante ai fini del SEE) (GU L 170 del 30.6.2009, pagg. 1–37).

Direttiva sull'esercizio delle attività televisive senza frontiere (89/552/CEE)	Direttiva 89/552/CEE del Consiglio, del 3 ottobre 1989, relativa al coordinamento di determinate disposizioni legislative, regolamentari e amministrative degli Stati Membri concernenti l'esercizio delle attività televisive (GU L 298 del 17.10.1989, pagg. 23–30).
Direttiva sui servizi di media audiovisivi (2010/13/UE)	Direttiva 2010/13/UE del Parlamento europeo e del Consiglio, del 10 marzo 2010, relativa al coordinamento di determinate disposizioni legislative, regolamentari e amministrative degli Stati membri concernenti la fornitura di servizi di media audiovisivi (Testo rilevante ai fini del SEE) (GU L 95 del 15.4.2010, pagg. 1–24).
Direttiva sulla protezione dei dati (95/46/CE)	Direttiva 95/46/CE del Parlamento europeo e del Consiglio, del 24 ottobre 1995, relativa alla tutela delle persone fisiche con riguardo al trattamento dei dati personali, nonché alla libera circolazione di tali dati (GU L 281 del 23.11.1995, pagg. 31–50).
Direttiva 2002/58/CE relativa al trattamento dei dati personali e alla tutela della vita privata nel settore delle comunicazioni elettroniche	Direttiva 2002/58/CE del Parlamento europeo e del Consiglio, del 12 luglio 2002, relativa al trattamento dei dati personali e alla tutela della vita privata nel settore delle comunicazioni elettroniche (direttiva relativa alla vita privata e alle comunicazioni elettroniche) (GU L 201 del 31.7.2002, pagg. 37–47).
Direttiva relativa alle pratiche commerciali sleali tra imprese e consumatori (2005/29/CE)	Direttiva 2005/29/CE del Parlamento europeo e del Consiglio, dell'11 maggio 2005, relativa alle pratiche commerciali sleali tra imprese e consumatori nel mercato interno e che modifica la direttiva 84/450/CEE del Consiglio e le direttive 97/7/CE, 98/27/CE e 2002/65/CE del Parlamento europeo e del Consiglio e il regolamento (CE) n. 2006/2004 del Parlamento europeo e del Consiglio (direttiva sulle pratiche commerciali sleali) (Testo rilevante ai fini del SEE) (GU L 149 dell'11.6.2005, pagg. 22–39).
Direttiva sulla sperimentazione clinica (2001/20/CE)	Direttiva 2001/20/CE del Parlamento europeo e del Consiglio, del 4 aprile 2001, concernente il ravvicinamento delle disposizioni legislative, regolamentari ed amministrative degli Stati membri relative all'applicazione della buona pratica clinica nell'esecuzione della sperimentazione clinica di medicinali ad uso umano (GU L 121 dell'1.5.2001, pagg. 34–44).
Regolamento 536/2014 sulla sperimentazione clinica dei medicinali per uso umano	Regolamento (UE) n. 536/2014 del Parlamento europeo e del Consiglio, del 16 aprile 2014, sulla sperimentazione clinica di medicinali per uso umano e che abroga la direttiva 2001/20/CE (Testo rilevante ai fini del SEE) (GU L 158 del 27.5.2014, pagg. 1–76).

Giustizia penale e procedimenti alternativi	
Direttiva sul diritto all'interpretazione e alla traduzione (2010/64/UE)	Direttiva 2010/64/CE del Parlamento europeo e del Consiglio, del 20 ottobre 2010, sul diritto all'interpretazione e alla traduzione nei procedimenti penali (GU L 280 del 26.10.2010, pagg. 1–7).
Direttiva sul diritto all'informazione (2012/13/UE)	Direttiva 2012/13/UE del Parlamento europeo e del Consiglio, del 22 maggio 2012, sul diritto all'informazione nei procedimenti penali (GU L 142 dell'1.6.2012, pagg. 1–10).
Direttiva sull'accesso a un difensore (2013/48/UE)	Direttiva 2013/48/UE del Parlamento europeo e del Consiglio, del 22 ottobre 2013, relativa al diritto di avvalersi di un difensore nel procedimento penale e nel procedimento di esecuzione del mandato d'arresto europeo, al diritto di informare un terzo al momento della privazione della libertà personale e al diritto delle persone private della libertà personale di comunicare con terzi e con le autorità consolari (GU L 294 del 6.11.2013, pagg. 1–12)
Carta dei diritti fondamentali	Carta dei diritti fondamentali dell'Unione europea (GU C 326 del 26.10.2012, pagg. 391–407).
Minori con disabilità	
Decisione 2010/48/CE del Consiglio	Decisione 2010/48/CE del Consiglio relativa alla conclusione, da parte della Comunità europea, della convenzione delle Nazioni Unite sui diritti delle persone con disabilità (GU L 23 del 27.1.2010, pagg. 35–36).

Numerose informazioni sull'Agenzia dell'Unione europea per i diritti fondamentali sono disponibili su Internet. È possibile accedervi attraverso il sito Internet della FRA (fra.europa.eu).

Ulteriori informazioni sulla giurisprudenza della Corte europea dei diritti dell'uomo sono disponibili sul sito web della Corte: echr.coe.int. Il portale di ricerca HUDOC consente di accedere alle sentenze e decisioni in inglese e/o francese, le traduzioni in altre lingue, riassunti, comunicati stampa e altre informazioni sul lavoro della Corte.

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Bambini e adolescenti sono titolari di diritti a pieno titolo. Sono beneficiari di tutti i diritti umani e fondamentali nonché oggetto di regolamenti speciali, in virtù delle loro caratteristiche specifiche. Il presente manuale si prefigge lo scopo di illustrare in che modo il diritto e la giurisprudenza europei tengono conto degli interessi e delle esigenze specifici dei minori. Evidenzia altresì l'importanza del ruolo svolto dai genitori e dai tutori o da altri rappresentanti legali e fa riferimento, ove opportuno, alle situazioni in cui diritti e responsabilità sono conferiti prevalentemente alle persone che si prendono cura dei minori. Il manuale mira a sensibilizzare e migliorare le conoscenze delle norme di legge che proteggono e promuovono questi diritti in Europa. Esso rappresenta un punto di riferimento per quanto concerne sia il diritto dell'Unione europea (UE) sia il diritto del Consiglio d'Europa (CdE) in materia e illustra come ciascun tema sia disciplinato dal diritto dell'UE, compresa la Carta dei diritti fondamentali dell'Unione europea, oltre che dalla Convenzione europea sui diritti dell'uomo (CEDU), dalla Carta sociale europea (CSE) e da altri strumenti del Consiglio d'Europa. Il manuale è destinato a professionisti legali non specializzati, giudici, magistrati e autorità responsabili della protezione dei minori, nonché ad altre figure professionali e organizzazioni impegnate nell'offrire una protezione legale dei diritti dell'infanzia e dell'adolescenza. Illustra la giurisprudenza principale, riportando una sintesi delle principali sentenze sia della Corte di giustizia dell'Unione europea (CGUE) sia della Corte europea dei diritti dell'uomo (Corte EDU).

AGENZIA DELL'UNIONE EUROPEA PER I DIRITTI FONDAMENTALI
Schwarzenbergplatz 11 – 1040 Vienna – Austria
Tel. +43 (1) 580 30-60 – Fax +43 (1) 580 30-693
fra.europa.eu – info@fra.europa.eu

CONSIGLIO D'EUROPA
67075 Strasburgo Cedex – Francia

CORTE EUROPEA DEI DIRITTI DELL'UOMO
Tel. +33 (0) 3 88 41 20 18 – Fax +33 (0) 3 88 41 27 30
echr.coe.int – publishing@echr.coe.int

DIVISIONE DEI DIRITTI DEI BAMBINI
Tel. +33 (0) 388 41 25 07 – Fax +33 (0) 90 21 52 85
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carepath

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towards trauma-informed leaving care support

La voce del minore maltrattato nei procedimenti civili e penali

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

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e-trikala

Obiettivi formativi

03

unità

Illustrare gli spazi partecipativi del minore maltratto nei procedimenti civili e penali che lo riguardano e gli strumenti volti a garantirne la sicurezza e il benessere psico-fisico

Principali fonti internazionali ed europee

- Convenzione internazionale sui diritti dell'infanzia (CRC)

COUNCIL OF EUROPE
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- Convenzione europea sull'esercizio dei diritti dei minori (Conv. Strasburgo)
- Convenzione di Lanzarote
- Convenzione europea dei diritti dell'uomo (CEDU)

- Carta dei diritti fondamentali dell'Unione europea (Carta di Nizza)
- Direttiva 2011/36/UE in materia di tratta di esseri umani
- Direttiva 2012/29/UE sui diritti delle vittime nei procedimenti penali
- Direttiva 2011/93/UE in materia di abuso, sfruttamento sessuale dei minori e pornografia minorile

Contesti di coinvolgimento del minore

1. Procedimento penale

Obbligo delle autorità statali di **prevenire** e **punire** violenze e abusi ai danni dei minori (vittimizzazione primaria)

Artt. 3-7 CRC; art. 3 CEDU; art. 18 e ss. Conv. Lanzarote; artt. 2-10 Direttiva n. 36; artt. 3-17 Direttiva n. 93

Prevenzione

Introduzione di **reati** penali per le condotte di violenze e abusi verso i minori

Repressione

Ricerca e **punizione** degli autori di violenze e abusi verso i minori

2. Procedimenti civili

Quando uno o entrambi i **genitori** sono direttamente autori del maltrattamento, o comunque l'hanno consentito

Necessità di garantire al minore un **ambiente familiare** sicuro e sereno

Art. 9 CRC; art. 8 CEDU

Prescrizioni ai genitori

Affidamento del minore ad altro nucleo famigliare

Collocamento in comunità

Adozione del minore

- Video Baldelli
- Video Ceccarelli
- Video Cibinel

- Video Cibinel
- Video Baldelli

Rapporti fra procedimento penale e procedimento civile

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Procedimento penale

obiettivo → individuare e punire l'autore del condotta subita dal minore, se questa costituisce reato

Procedimento civile

obiettivo → verificare l'adeguatezza del contesto famigliare del minore ed eliminare eventuali situazioni pregiudizievoli

Sono due **strade separate e indipendenti** → condotte che non costituiscono reato possono rivelare una situazione famigliare compromessa, tanto da giustificare ugualmente l'intervento del giudice civile

3. Procedure extragiudiziali

Quando il rapporto, o il legame familiare, fra l'autore della condotta e la vittima minorenne appaiono **recuperabili**

Art. 13 Conv. Strasburgo; art. 12 Direttiva n. 29

Per evitare procedure penali/civili maggiormente intrusive, che potrebbero compromettere definitivamente il **risanamento** del rapporto

- Mediazione
- Tentativo di conciliazione
- Ulteriori strumenti volti al riavvicinamento

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Principio del superiore interesse del minore

Vale per ogni sede procedimentale e impone di anteporre il **benessere** psico-fisico del minore a qualsiasi altra esigenza meritevole di tutela

Art. 3 CRC; art. 6 Conv. Strasburgo

Giudice deve acquisire ogni **informazione** necessaria per conoscere i fatti in questione e il contesto socio-famigliare del minore

Decisione giudiziale deve essere sempre orientata alla miglior tutela possibile degli interessi del minore

- Video Ceccarelli
- Video Long

Il diritto all'ascolto del minore nel procedimento

Il pensiero del minore deve tendenzialmente essere conosciuto dal giudice e tenuto in considerazione per la decisione

Art. 12 CRC; art. 3 Conv. Strasburgo

Garanzie **partecipative** del minore nei procedimenti che lo riguardano

MA

Necessari strumenti procedimentali di **protezione** per evitare la «vittimizzazione secondaria»

Garanzie partecipative del minore-vittima

1. Diritto alla comprensione e all'informazione

Art. 31 Conv. Lanzarote; art. 3 Conv. Strasburgo; artt. 3-4 Direttiva n. 29

Garanzia presupposto → solo chi è dotato di **conoscenze adeguate** può partecipare proficuamente alla procedura decisionale in cui sono coinvolti i suoi interessi

Cosa?

- significato del procedimento in atto
- decisione che deve essere presa
- diritti e protezioni a disposizione del minore
- ruolo che sarà chiamato a svolgere
- possibili conseguenze delle sue dichiarazioni e/opinioni

Chi?

- autorità giudiziaria
- difensore
- rappresentante
- professionista sociale o sanitario

Come?

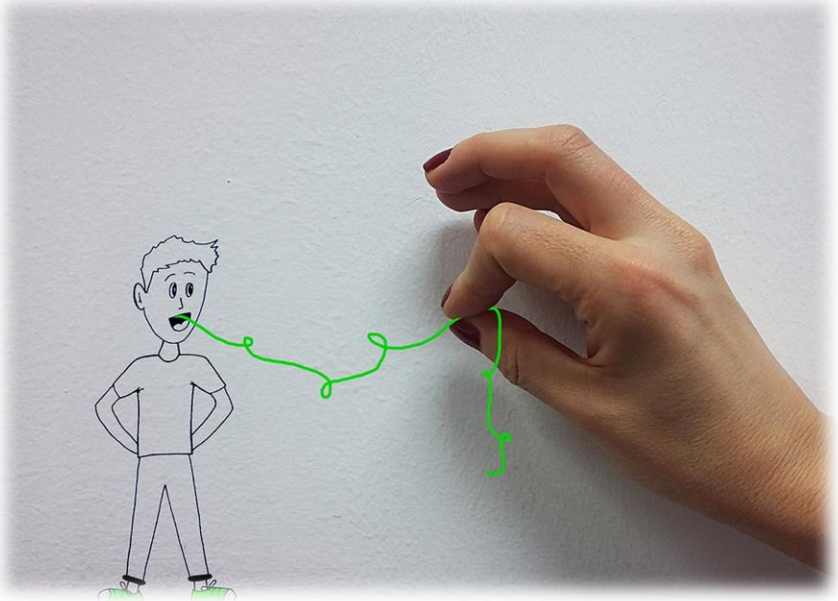
linguaggio e concetti adatti alla età e alla capacità di discernimento del minore

2. Diritto all'ascolto sui fatti oggetto del procedimento

Il minore può essere chiamato a rendere **dichiarazioni** su fatti di sua conoscenza, rilevanti per la decisione da prendere

Processo penale

Minore come testimone del maltrattamento subito, per accertare la responsabilità dell'autore del reato



Processi civili

Minore come testimone delle condotte subite e dei rapporti famigliari, per stabilire se sottrarlo all'ambiente famigliare d'origine, o alla vicinanza di uno dei genitori

Contesto a forte rischio di «vittimizzazione secondaria»

- Video Ceccarelli
- Video Cibinel
- Video Long

3. Diritto di essere consultato in merito alla decisione da prendere

Prima che una decisione venga presa, il minore ha diritto di esprimere la propria **opinione** sulle varie questioni affrontate nel procedimento

Art. 12 CRC; art. 3 Conv. Strasburgo

Processo penale

- avvio del procedimento
- applicazione di misure provvisorie contro l'imputato, o per la protezione del minore
- accesso dell'imputato a riti premiali, o messa alla prova
- valore delle prove acquisite

Processi civili

- sottrazione dalla famiglia
- allontanamento di uno dei genitori
- affidamento ad altro nucleo famigliare
- adozione

Spesso, l'opinione è sostituita dalla più forte garanzia del consenso

Procedure extragiudiziali

Consenso/richiesta del minore per l'avvio del tentativo di mediazione e risanamento del rapporto

Obbligatorietà e peso dell'opinione dipendono da capacità di discernimento

Strumenti di protezione dentro al procedimento

1. Presenza di figure di supporto

Art. 12 CRC; art. 31 Conv. Lanzarote; artt. 9-10 Conv. Strasburgo; art. 24 Direttiva n. 29

Rappresentante (se mancano i genitori, o sono in conflitto di interessi)

individua e tutela gli interessi esistenziali del minore

Difensore

sceglie la strategia giuridica più adeguata per ottenere un provvedimento conforme agli interessi esistenziali del minore

Professionista sociale o sanitario (psicologo, psichiatra, assistente sociale)

- salvaguardia il minore dalla «vittimizzazione secondaria»
- aiuta giudice, genitori, difensori a comprendere esigenze e fragilità del minore
- contribuisce al superamento del trauma derivante dalla violenza subita

Queste figure possono eventualmente essere designate dal giudice

2. Riservatezza

Art. 16 CRC; art. 8 CEDU; art. 21 direttiva n. 29

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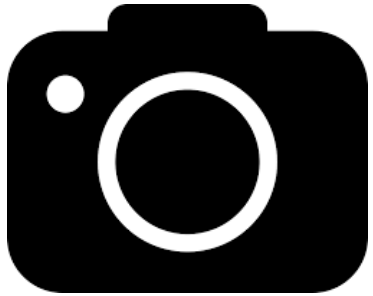
Procedimento senza **pubblico**

se necessario per tutelare la riservatezza del minore si può procedure in udienza a porte chiuse

Limitazione alla diffusione di **immagini** e **informazioni**



Limiti alle **domande** rivolgibili al minore durante il procedimento

divieto di porre domande sulla vita privata non attinenti ai fatti oggetto del procedimento

3. Ragionevole durata

Il rischio di «vittimizzazione secondaria» è legato anche alla durata del procedimento

Art. 7 Conv. Strasburgo

conflitto di valori

la decisione va presa nel più breve tempo possibile per evitare al minore stress continuo e prolungato

non possono però essere completamente sacrificati gli altri interessi del minore e degli ulteriori soggetti coinvolti nella decisione

necessità di **bilanciamento**

4. Protezioni durante l'audizione (parte I)

Quando il minore deve rendere dichiarazioni sui maltrattamenti subiti, sui suoi rapporti con l'autore della condotta, sul suo ambiente famigliare

Art. 31 Conv. Lanzarote; art. 18 e ss. Direttiva n. 29; Corte EDU, 2.7.2002, S.N. c. Svezia

⇩

accorgimenti da prendere se viene stimato un rischio di «vittimizzazione secondaria»

Luogo di audizione

audizione può avvenire in un luogo diverso dalla ordinaria aula di udienza

⇩

casa del minore, ufficio del giudice, studio dell'avvocato, stanza apposita per l'audizione dei minori

Chi rivolge le domande?

le domande al minore possono non essere rivolte direttamente dai difensori delle parti, ma dal giudice, o dall'esperto

⇩

i difensori rischiano di essere aggressivi, potrebbero approfittare delle fragilità del minore o, più semplicemente, non hanno esperienza nell'audizione dei minori

4. Protezioni durante l'audizione (parte II)

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Procedere il **prima possibile** all'audizione ed evitare più ripetizioni

L'attesa dell'audizione e più ripetizioni accrescono il rischio di stress, mentre i ricordi del fatto si attenuano

⇩

ascoltare il minore durante le prime fasi del procedimento, evitando poi di sentirlo di nuovo più avanti

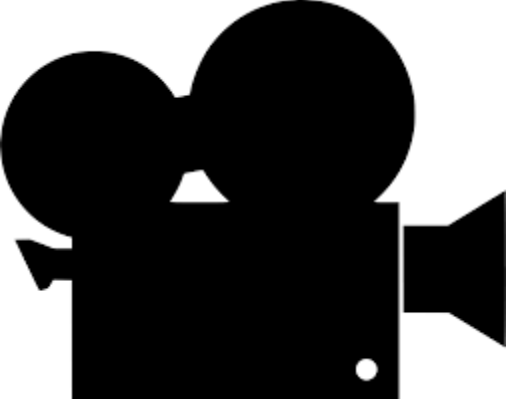
Prevenzione dal **contatto** con imputato, genitore in conflitto di interessi, loro difensori

Il contatto visivo con questi soggetti può stressare e intimorire il minore dichiarante

⇩

- impianto citofonico con vetro-specchio
- trasmissione da altro locale in video conferenza
- domande preparate dai difensori ma rivolte da giudice o esperto in ambiente protetto

necessità di bilanciare interesse del minore con diritto delle parti di difendersi e di far valere le proprie ragioni



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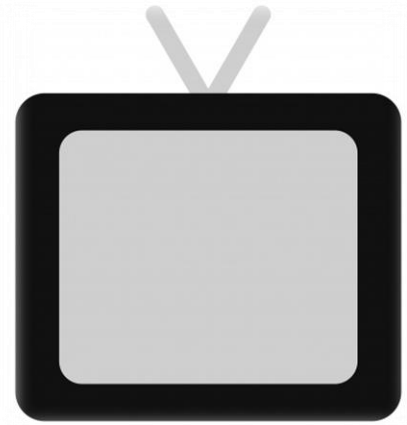
Materiale video sull'ascolto del minore



Esempio di sala d'ascolto in un tribunale italiano

La preparazione del minore alla testimonianza
(video 1 e video 2)

La testimonianza di un bambino sull'omicidio della sorella

5. Protezione durante espressione dell'opinione o del consenso

Art. 6 Conv. Strasburgo

Quando il minore deve esprimere la propria volontà o addirittura il proprio consenso sul tema della decisione che il giudice deve prendere

La libera manifestazione dell'**opinione** o del **consenso** potrebbe essere pregiudicata dalla presenza dei soggetti direttamente interessati, come genitori, difensori, imputati

Giudice può sentire ciò che il minore vuole dire al di fuori dell'aula di udienza, o comunque in mancanza degli altri protagonisti del procedimento

- Video Ceccarelli
- Video Long

- Video Baldelli
- Video Cibinel

6. Tutela integrità psico-fisica in corso di procedimento

Artt. 20-21 CRC; art. 31 Conv. Lanzarote; art. 18 Direttiva n. 29

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Prima che la decisione definitiva venga presa, possono essere adottati **provvedimenti cautelari** provvisori per la tutela del minore

Provvedimenti nei confronti dell'**autore** del maltrattamento

- custodia in carcere/arresti
- limitazione responsabilità genitoriale
- allontanamento dalla casa famigliare
- divieto di avvicinamento alla vittima

(limitazione responsabilità genitoriale, allontanamento dalla casa famigliare) → se genitore della vittima

Provvedimenti nei confronti del **minore**

- affidamento provvisorio
- allontanamento da casa famigliare

→ se il maltrattamento è avvenuto all'interno del nucleo famigliare

7. Assistenza extra procedimentale

Art. 39 CRC; art. 31 Conv. Lanzarote; artt. 8-9 Direttiva n. 29

Sostegno **psicologico** ed **emotivo** al minore anche fuori dal procedimento in corso

Video Cibinel

La «vittimizzazione secondaria» va combattuta assistendo il minore anche prima e dopo gli atti del procedimento a cui partecipa

Punizione del colpevole ed eventuale risanamento dell'ambiente famigliare non bastano

necessario supporto *extramoenia* per il superamento del trauma derivante dal maltrattamento subito («vittimizzazione primaria»)

Queste esigenze vengono spesso assicurate tramite la presa in carico del minore da parte dei servizi sociali

Riassunto sul ruolo del professionista sociale o sanitario

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Nel procedimento

- valutazione sul grado di protezione necessario
- assistenza durante la partecipazione del minore agli atti procedimentali
- partecipazione all'audizione/consultazione del minore
- valutazione su capacità testimoniale/ attendibilità del minore
- partecipazione a tentativi di conciliazione
- valutazione su capacità di discernimento
- valutazione dell'ambiente familiare

⇩

<u>fine principale</u> → prevenire vittimizzazione secondaria e fornire al giudice le conoscenze utili per la sua decisione

Fuori dal procedimento

- sostegno psicologico ed emotivo al minore
- verifiche sull'eventuale nuovo contesto famigliare (provvisorio o definitivo)

⇩

<u>fine principale</u> → superamento del trauma derivante dal maltrattamento subito e ripristino dell'equilibrio famigliare eventualmente infranto

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Altri materiali utili

Guidelines on child-friendly justice
(Council of Europe)

Handbook for professionals and policymakers on justice in matters involving child victims and witnesses of crime
(United Nations)

Guidelines on children in contact with the justice system
(International Association of Youth and Family Judges and Magistrates)

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Empowering public authorities and professionals towards trauma-informed leaving care support

Gli effetti sulle politiche sociali e sanitarie riguardanti minorenni maltrattati di un approccio centrato sui diritti fondamentali di bambini e ragazzi

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

04

unità

Obiettivi formativi

Comprendere le ricadute operative sulle politiche sociali e sanitarie di un approccio centrato sui diritti fondamentali di bambini e ragazzi e in particolare sui loro diritti di partecipazione

Quadro legislativo vs. politiche

Le politiche sono una componente essenziale del quadro ordinamentale di contrasto delle violenze sui minori: la presenza di una legislazione adeguata che vieti tali violenze NON è sufficiente!

"troppo spesso vediamo che leggi rimangono nei libri ma che molti bambini rimangono ai margini della società (…), grandemente esposti alle violenze e agli abusi"

(Rima Salah, Vice Direttrice Esecutiva, UNICEF, cit. in United Nations Secretary, *General's Study on Violence against Children,* 2006)

Le politiche sociali e sanitarie & i diritti di partecipazione

Bambini e ragazzi contribuiscono a determinare le politiche:

- partecipando attivamente ai processi decisionali sul loro specifico caso (es. mediante colloqui/lettere all'assistente sociale o al giudice responsabile del loro caso, partecipazione diretta a incontri in cui si prendono decisioni sul suo caso, presenza di un rappresentante speciale)
- partecipando come gruppo alla definizione delle priorità e delle azioni di contrasto alle violenze sui minori (es. istituzione di consigli consultivi di ragazzi, coinvolgimento di ragazzi nella formazione dei professionisti dei servizi per l'infanzia, coinvolgimento dei ragazzi in studi e ricerche sul funzionamento dei servizi all'infanzia)

Il contesto familiare

«Una famiglia in cui i bambini e gli adolescenti possono esprimere liberamente le proprie opinioni e in cui queste sono prese seriamente in considerazione… **gioca un ruolo di prevenzione di tutte le forme di violenza in casa e in famiglia**»

Programmi pubblici di educazione dei genitori che affrontino:

- la relazione di mutuo rispetto tra genitori e bambini;
- il coinvolgimento di bambini e ragazzi nei processi decisionali;
- le strategie per gestire opinioni conflittuali all'interno della famiglia

Fonte: Comitato sui diritti dell'infanzia, *Commento generale n.12*

ESEMPIO N. 1

A livello mondiale ed europeo esistono plurime iniziative di sensibilizzazione, **anche rivolte specificamente ai genitori**, volte ad affermare l'illegittimità di ogni punizione corporale delle persone di età minore

I minori «fuori famiglia»

devono essere «in grado di esprimere le proprie opinioni e … a queste sia dato il giusto peso, sulle questioni riguardanti il loro collocamento, le regole della cura nelle famiglie e case affidatarie e la loro vita quotidiana» (Comitato sui diritti dell'infanzia, *Commento generale n. 12*)

devono essere consultati in vista di decisioni che riguardino per esempio:

- la scelta dei tempi e del luogo del loro collocamento "fuori famiglia"
- i membri della famiglia con cui mantenere i contatti durante il collocamento extrafamiliare, la frequenza e le modalità di tali contatti
- i progetti sul loro futuro
- le revisioni periodiche sulla loro situazione (SOS, Children's Villages International/ISS, Guidelines for the Alternative Care of Children: A UN Framework, Geneva, 2009)

I minori «fuori famiglia»

Da un punto di vista generale occorrono:

- un organo di monitoraggio (quale il garante per l'infanzia) che deve poter accedere senza impedimenti alle strutture assistenziali per ascoltare direttamente le opinioni e preoccupazioni dei minori
- consigli rappresentativi dei bambini e ragazzi partecipano all'ideazione e attuazione delle politiche e regole della struttura in cui sono ospitati
- formazione dei professionisti alla partecipazione di bambini e adolescenti, anche coinvolgendo come formatori i minori stessi

Fonte: Comitato sui diritti dell'infanzia, *Commento generale n.12*

ESEMPIO N. 2

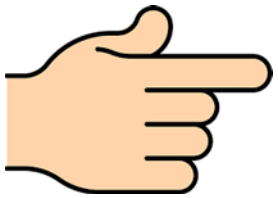
In alcuni Paesi europei si sono sviluppate reti informali di ragazzi ospiti ed ex-ospiti di comunità, case famiglia, famiglie affidatarie, coinvolti in un percorso di partecipazione e cittadinanza attiva con la finalità di:

- creare momenti di aggregazione, di confronto e arricchimento reciproco tra i partecipanti
- contribuire a migliorare le politiche relative all'accoglienza extrafamiliare e le azioni da intraprendere per sostenere i giovani durante la delicata fase di "uscita" dai sistemi di accoglienza.

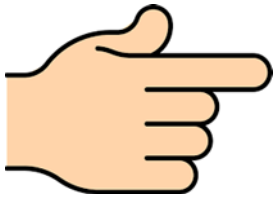
E' attualmente in fase di costituzione una rete europea, la *Care Leavers Europe*

Fonte: *http://www.agevolando.org/leavecare-livelife/*

Una delle preoccupazioni più ricorrenti dei ragazzi «fuori famiglia» è il futuro dopo il compimento della maggiore età, cui consegue – spesso – la cessazione della presa in carico (anche economica) da parte dello Stato



Per un'azione concreta di sensibilizzazione del Care Leavers Network italiano sulla difficoltà per i care leavers di rendersi autonomi alla maggiore età: si veda il video «18 anni e (non) sentirli»



Per un'azione concreta di un ombudsman: si veda il video dell'Ombudsman irlandese «Young person in residential care makes complaint to Ombudsman for Children»

Le cure sanitarie

Bambini e ragazzi devono sempre essere **coinvolti** nelle discussioni e decisioni relative alla loro salute

(Unicef- Save The Children, *Every child's right to be heard*, 2009)

devono anzitutto ricevere **informazioni** adeguate, secondo l'età e la capacità di comprensione (art. 4 Carta di EACH, *European Association for Children in Hospital*)

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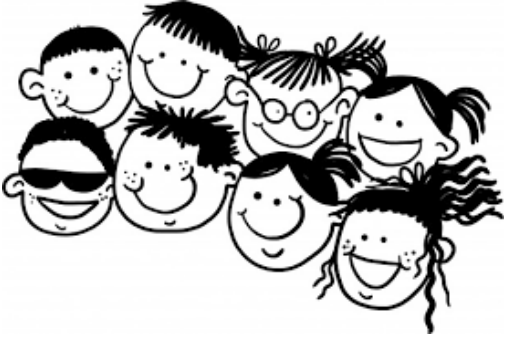
Nelle situazioni di violenza domestica o in caso di conflitto con i genitori, bambini e ragazzi devono avere «accesso a **consulenze** e consigli medici confidenziali senza il consenso dei genitori, indipendentemente dalla loro età, laddove necessario per la loro sicurezza e il loro benessere» (Comitato sui diritti dell'infanzia, *Commento generale n.12*)

«Quando, secondo la legge, un minore non ha la capacità di dare **consenso** a un intervento, questo non può essere effettuato senza l'autorizzazione **del suo rappresentante**, di un'autorità o di una persona o di un organo designato dalla legge. Il **parere di un minore** è preso in considerazione come un fattore **sempre più determinante, in funzione della sua età e del suo grado di maturità**»

(art. 6 comma 2° Convenzione europea per la protezione dei diritti dell'uomo e la dignità dell'essere umano riguardo alle applicazioni della biologia e della medicina, cosiddetta «Convenzione di Oviedo»)



«La partecipazione del minore contribuisce non solo a promuovere il suo sano sviluppo e il suo benessere, ma anche a migliorare le politiche, i servizi sanitari e le prassi destinati all'infanzia e all'adolescenza» (Codice del diritto del minore alla salute e ai servizi sanitari, 2013)

Possibili strumenti includono:

- Sistemi di feedback da parte degli utenti
- Ricerche e consultazioni che abbiamo come destinatari e/o attori I minorenni
- Coinvolgimento di consigli/parlamenti di minori per lo sviluppo di standard e indicatori per servizi sanitari rispettosi dei diritti dell'infanzia
- Coinvolgimento di minori in ispezioni e monitoraggio [Unicef- Save The Children, *Every child's right to be heard*, 2009, p.98]

Le situazioni di violenza

Gli Stati dovrebbero:

- consultare bambini e adolescenti, con particolare attenzione ai gruppi svantaggiati e marginalizzati, per lo sviluppo e l'attuazione di misure legislative politiche, educative e altre per affrontare tutte le forme di violenza (Comitato sui diritti dell'infanzia, *Commento generale n.12*)
- stabilire per i minori che subiscono violenze un facile accesso agli individui o alle organizzazioni alle quali poter riferire in maniera sicura e confidenziale le proprie esperienze (Comitato sui diritti dell'infanzia, *Commento generale n.12*)
- istituire autorità indipendenti a garanzia dei diritti di tutti i minori e in particolare di quelli che abbiano subito violenze

ESEMPIO N. 3

Il video del Consiglio d'Europa "Tell someone you trust" affronta con un linguaggio e modalità adatti ai bambini il tema dell'abuso sessuale su minori **incoraggiando i bambini a denunciare le violenze subite**

ESEMPIO N. 4

The Italianaire è un video cartoon realizzato con la partecipazione di cinque ragazzi residenti in Italia e provenienti dall'Egitto, facilitati da *Save the Children*, finalizzato a **informare e sensibilizzare i minori egiziani** che vivono in tre governatorati ad alto tasso di emigrazione minorile in Egitto **circa le condizioni di vita in Italia dei minori migranti egiziani**

ESEMPIO N. 5

Il video del Consiglio d'Europa "Beat Bullying" mostra gli effetti del **bullismo** con un linguaggio e modalità adatti ai **bambini**, che vengono altresì incoraggiati ad assumere un **ruolo da protagonisti nel contrasto** dello stesso

«Il diritto di bambini e ragazzi di essere ascoltati può giocare un ruolo preventivo contro ogni forma di violenza a scuola, in famiglia, a scuola e in strutture assistenziali»

(European Network of Ombudspersons for Children (ENOC), *Position Statement on 'Violence against Children'*, 2015)

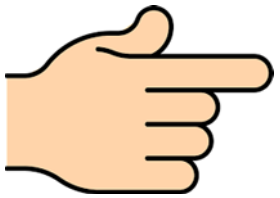
Gli adulti devono garantire la partecipazione del minore ai processi decisionali prendendo sempre tutte le precauzioni necessarie a ridurre il rischio di violenza o qualsiasi altra conseguenza negativa che possa derivare dalla partecipazione stessa

(Comitato sui diritti dell'infanzia, *Commento generale n.12*)

Conclusioni

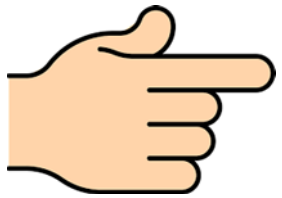
Occorre un **approccio integrato** e in particolare:

- attenzione non solo al contrasto ma soprattutto alla **prevenzione** delle violenze contro i minori
- promozione di una **cultura di rispetto dei diritti di bambini e ragazzi**
- **formazione** specifica **dei professionisti** che operano a contatto con i minorenni sui temi della protezione e dei diritti di partecipazione
- **servizi** per l'infanzia e l'adolescenza creati e gestiti "**a misura di minore**"
- sportelli/linee di aiuto facilmente accessibili ai minori che subiscono violenze



Fonte: Council of Europe, *Policy Guidelines on Integrated National Strategies for the Protection of Children from Violence*, 2009. In senso analogo European Network of Ombudspersons for Children (ENOC), *Position Statement on 'Violence against Children"*, 2015.

«Bambini e ragazzi hanno una conoscenza privilegiata delle loro vite, dei loro bisogni e delle loro preoccupazioni, così come idee e opinioni che derivano dal loro proprio vissuto…. **Decisioni adottate dopo aver considerato il punto di vista fornito direttamente dai minorenni saranno più adeguate, più efficaci e più sostenibili»**



Fonte: The Save the Children Found, *Every Child's Right To Be Heard, a resource guide on the UN Committee on the Rights of the Child general comment no.12*, London, 2011

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Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material
ANNEX 2
–
Italian Version

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

The British
Psychological Society
Promoting excellence in psychology

Practice Guidelines

Third edition

August 2017

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Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.

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Preface

This Third Edition of the Practice Guidelines replaces the second edition published in 2009. Legislation, practice and technology have moved on since then and these changes are captured in the new guidance.

This edition of the guidelines was produced through the British Psychological Society's Professional Practice Board by a working group drawn from the range of Member Networks across The Society whose members are engaged in professional practice, as well as representatives from relevant expert reference groups of The Society, in particular areas of practice. Further information is available in ***Appendix 3: How this document has been developed.***

These Practice Guidelines aim to define good practice for all psychologists whether registered, chartered or in training and offer guidance for decision making. The Guidelines have been designed for broad application across the full range of applied psychology.

The first part of the guidance (sections 1–3) set out considerations for psychologists on different contexts of practice. The second part of the guidance (sections 4–8) sets out guidance for psychologists on how to manage work with clients.

It is recognised that in addition psychologists may require more detailed guidance for some particular roles and responsibilities or for particular situations in which they work. Further information is available in the ***Appendices***.

The Society expects that the guidelines will be used to form a basis for consideration, with the principles being taken into account in the process of decision-making, together with the needs of others and the specific circumstances. No guidance can replace the need for psychologists to use their own professional judgement. Effective practice means exercising this professional judgement in a defensible way that does not put clients or the public at risk, or undermine, or call into question the reputation of the profession as a whole.

The Guidelines will be reviewed in accordance with Society policy within a maximum period of five years in order to reflect current legislation, evidence and practice contexts. Psychologists using the Practice Guidelines should do so in conjunction with the ***BPS Code of Ethics and Conduct*** and the ***BPS Code of Human Research Ethics***, as necessary.

Glossary of terms

Client

The Society's *Code of Ethics and Conduct* uses the term person or people throughout, this is in recognition of the fact that the document is generic and may be used by all psychologists; academics, researchers, students and practitioners alike.

Throughout this Practice Guidelines document the term 'client' is used and refers to any person or persons with whom a psychologist interacts on a professional basis.

For example, the 'client' may be a couple, a family group, an educational institution, a community organisation or group or a private or public organisation including a court, an individual (sometimes referred to as, for example, athlete, child/young person, patient, prisoner, coachee, service user, stakeholder, leader, or student), who are in receipt of the services of the psychologist.

Psychologist

Throughout this Practice Guidelines document the term 'psychologist' is used and refers to all psychologists whether registered, chartered or in training who provide psychological services across the full range of applied psychology, in any context of practice.

1. How psychologists work

1.1 Legal and professional obligations of psychologists

Psychologists' professional practice is impacted upon and governed by a range of legislation and regulation. Particular psychological disciplines may also need to consider additional legislation, regulation and guidelines. It is the psychologist's responsibility to ensure they are aware of the legislation and guidelines that govern their particular area of practice as well as the terms of their employment or terms contracted with a commissioner of their services.

Psychologists are also advised to consider membership of a union or similar body to ensure they have access to appropriate representation, support and legal advice should they be subject to a complaint or disciplinary action, or require support for example with an employment grievance, which may be related to concerns over quality and standards of psychological service provision.

Further information is available in the ***Appendices***. Important examples to note are:

Health and Care Professions Council (HCPC) Registration

It is a statutory requirement for all psychologists wishing to practice using one of the titles protected by the HCPC to register with the HCPC. Unregistered psychologists offering services to the public in any of the domains regulated by the HCPC may commit an offence by doing so, even if they refrain from using protected titles, provided intent to deceive can be proved. The Society's position is that it is in the interests of both the public and the profession for all psychologists providing services in a regulated domain to be registered with the HCPC.

Professional competence

Psychologists should value the continuing development and maintenance of high standards of competence in their practice and the importance of working within the recognised limits of their knowledge, skill, training, education, and experience. Psychologists should consider advances in the evidence base, the need to maintain technical and practical skills and knowledge and the limits of their competence. This is stipulated in both the ***BPS Code of Ethics and Conduct*** and the ***HCPC Standards of Proficiency***.

Professional indemnity insurance

The UK Government has introduced legislation (The Health Care and Associated Professions (Indemnity Arrangements) Order 2014) which now makes it mandatory for health professionals to have a professional indemnity arrangement in place. The HCPC has made having such an arrangement in place a condition of registration.

This may be achieved either through the employer or through a privately arranged policy. An employer's insurance may provide cover only for a negligence claim but not for the costs of a disciplinary hearing. It is the psychologist's responsibility to check carefully that

they have cover in place that meets their personal/professional needs. Further information is available in the ***Society document: Career Support and Development***

Disclosure and Barring Service (DBS) Checks

Psychologists working in certain fields, for example with children or in healthcare, will need to demonstrate they have had a satisfactory criminal records check at the appropriate level for the nature of the work undertaken.

Applicants will be provided with a certificate to demonstrate this. Applicants cannot request a check personally, this can be requested by a psychologist's employer. For psychologists practising independently the Society offers this as a service to members. Further information is available on the ***Society Website: https://beta.bps.org.uk/Practice-Guidelines***

Equality Act 2010

This Act protects people against unfair treatment, promotes equality and prevents discrimination against any of nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. Respect is a core ethical value for psychologists and a commitment to equality of opportunity is embedded in all aspects of psychological practice. Psychologists, where they operate in an organisational context, must also seek to encourage and influence others in ensuring that equality of opportunity is embedded in all thinking and all practice relating to access to services for client groups and recruitment and employment practices.

Providers of service to the public must also make reasonable adjustments for people who have a disability under the Act. This requirement is anticipatory so requires consideration, and adjustment where reasonable, of any barriers which may prevent a person with a disability from using a service.

Data Protection Act 1998

The Data Protection Act defines personal and sensitive personal data, and data must be processed in accordance with eight principles. It gives individuals the right to know what information is held about them and provides a framework to ensure that personal information is handled properly.

Good information governance is at the heart of safe practice. It encompasses physical data security, access controls and acceptable use, data quality, and records management, among other things. Psychologists must have appropriate security to prevent any personal data held from being accidentally or deliberately compromised. In most circumstances, independent practitioners will also need to register as a data controller with the Information Commissioner's Office.

Further information is available in ***Section 7.1: Information governance, Appendix 1: Relevant legislation*** and ***Society Document: Data Protection Act 1998 – Guidelines for Psychologists.***

Freedom of Information Act 2000

The Freedom of Information Act 2000 provides public access to information held by public authorities. Public authorities include government departments, local authorities, the NHS, State schools and police forces.

It does this in two ways:

- public authorities are obliged to publish certain information about their activities; and
- members of the public are entitled to request information from public authorities.

The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland, and by UK-wide public authorities based in Scotland. Information held by Scottish public authorities is covered by Scotland's own Freedom of Information (Scotland) Act 2002.

This legislation permits information to be withheld from disclosure in certain prescribed circumstances, for example information provided in confidence, related to law enforcement or where it relates to personal matters.

Health and Safety at Work Act 1974

This Act places a duty on all employers 'to ensure, so far as is reasonably practicable, the health, safety and welfare at work' (Part 1, Section 2.1) of all their employees. Employees themselves also have obligations under the legislation.

Working together to safeguard children guidance

The Government website provides statutory guidance on inter-agency working to safeguard and promote the welfare of children. Statutory guidance is issued by law; it must be followed unless there is a good reason not to. All organisations, including charities, are expected to comply with this government inter-agency statutory guidance. Psychologists have a duty of care to both their clients and the public. Any allegations of abuse, either ongoing or historic, must be taken seriously and consideration must be given about breaking confidentiality especially in cases where other vulnerable people may be at risk. Further information is available in ***Section 4: Safeguarding***.

Mental Capacity Act 2005

The Mental Capacity Act (2005) provides a clear and comprehensive framework with regard to capacity and consent for all individuals aged 16 years and above in England and Wales.

There are five key principles set out in the Act which underpin practice (quoted from legislative source):

(i) A person must be assumed to have capacity unless it is established that he lacks capacity.

(ii) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(iii) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(iv) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
(v) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

In Scotland the Adults with Incapacity (Scotland) Act 2000 applies and in Northern Ireland the Mental Capacity Act (Northern Ireland) 2016 is used.

Mental Health Act 1983 as amended 2007

The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

The Act sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients. The Code of Practice[1] provides statutory guidance for mental health professionals on how they should carry out their responsibilities in practice under the MHA. Although the Act allows for people to be compulsorily detained and treated without their consent if required, empowerment and involvement of patients as far as is possible is required by the Code of Practice.

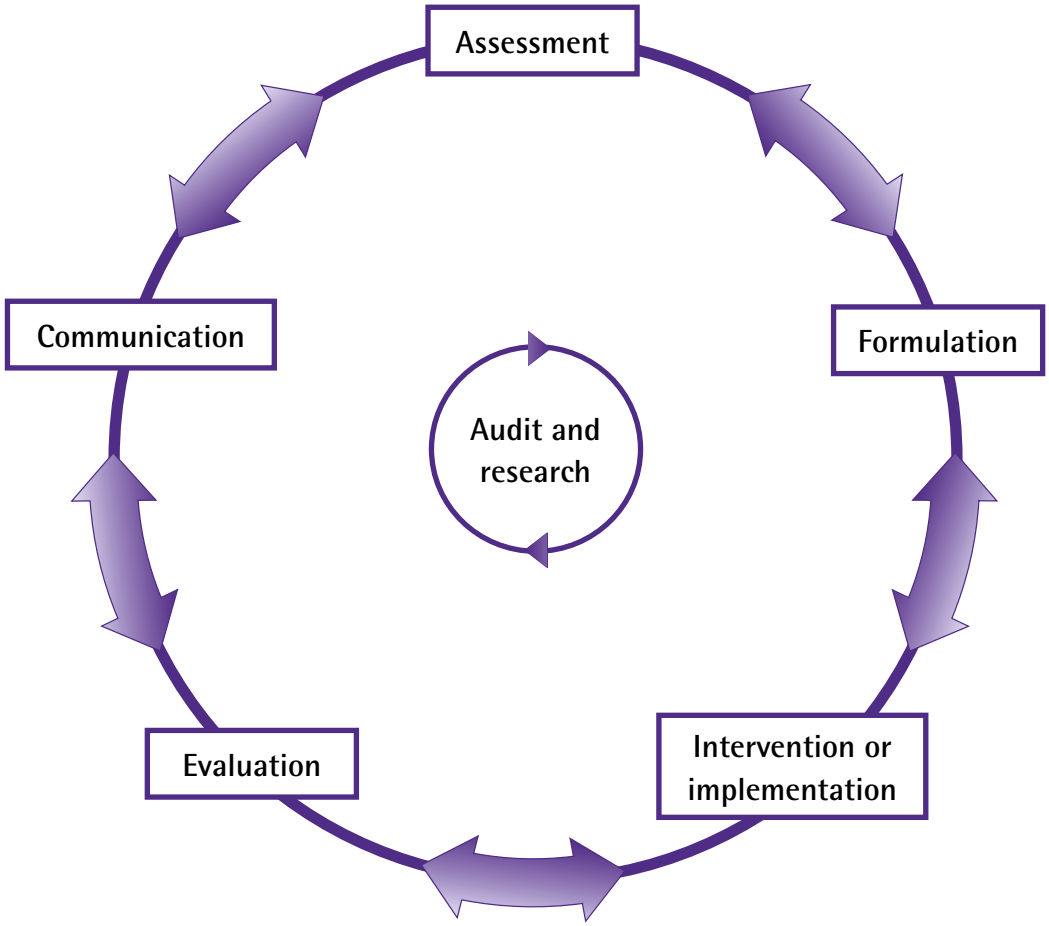
Those involved in working with people subject to provisions of the MHA, including psychologists, must understand and give consideration to the five key principles set out in the Code:
(i) least restrictive option and maximising independence;
(ii) empowerment and involvement;
(iii) respect and dignity;
(iv) purpose and effectiveness; and
(v) efficiency and equity.

1.2 Cycle of professional practice

The professional practice of psychologists is underpinned by four key ethical values – Respect, Competence, Responsibility and Integrity – and five core skills:

- **assessment** and establishment of agreements with the client;
- **formulation** of client needs and problems;
- **intervention or implementation** of solutions;
- **evaluation** of outcomes; and
- **communication** through reporting and reflecting on outcomes.

These core competencies flow and inform each other as illustrated below.



Assessment and establishment of agreements with the client

Assessment of psychological processes and behaviour is derived from the theory and practice of both academic and applied psychology. It includes both assessing change and stability, and comparison with others. Assessment procedures used will depend heavily on the practice context and may include:

- the development and use of psychometric tests following best practice;
- the application of systematic observation and measurement of behaviour in a range of contexts and settings;
- devising structured assessment strategies for individual clients, teams and organisations; and
- the use of a range of interview processes with clients, carers, other stakeholders and other professionals.

Results of these assessments are integrated within the context of the historical, dynamic and developmental processes that will have shaped the client as well as future aspirations or needs. Psychologists have the ability to assess the suitability of different measurement procedures, depending on the purpose for which the assessment is needed, as well as being competent to devise and use context-specific procedures.

Formulation of client needs and problems

Formulation is the summation and integration of the knowledge that is acquired by the assessment process. This will draw on psychological theory and research to provide a framework for describing a client's needs. Because of their particular training in the relationship of theory to practice, psychologists will be able to draw on a number of models to meet needs or support decision-making. This process provides the foundation from which actions derive. What makes this activity unique to psychologists is the knowledge base, experience and information on which they draw. The ability to access, review, critically evaluate, analyse and synthesise data and knowledge from a psychological perspective is one that is distinct to psychologists, both academic and applied.

Intervention or implementation of solutions

This will be the stage where the client's needs, as described by formulation, begin to be met. This may involve the use of psychological models or approaches to, for example, facilitate change, solve a problem or improve the quality of a relationship. All these interventions, or implementation of solutions, are tests of the provisional hypotheses contained in the formulation, and are subject to repeated modification in the light of experience and new data.

Evaluation of and reflecting on outcomes

Evaluation is used to measure the effectiveness of activities and interventions both during and after their implementation. The results of any evaluation and reflection will impact the next steps taken by a psychologist.

Although employers and others may demand certainty about outcomes, psychologists should always be careful to make it clear that they are able to provide only interpretations of behaviour, and advice and guidance, rather than necessarily predicting future behaviours.

Communication through reporting

Communication skills are integral to all aspects of a psychologist's role. Effective communication skills are essential in relation to all aspects of work with others. Communication skills include communication with clients, all forms of electronic and verbal communication, professional letters and reports, and the dissemination of research findings.

Audit and research

Audit and research underpin the cycle, as they help to inform all stages of professional practice.

Audit aims to evaluate how close assessment, formulation, intervention and implementation are against a set of previously given standards of practice. Audit also evaluates how protocols and procedures, for example related to consent or recording of activity, have been followed.

Research provides the evidence base for the practice of psychology. Research methods in psychology vary from qualitative observation to quantitative scientific method, so it is important to distinguish the nature and quality of the evidence underpinning any knowledge or techniques being applied. In general, basic research develops theories, models and data to describe and explain psychological processes and structures, while primary research develops and evaluates ways of using psychological knowledge to intervene with people, organisations, processes or technologies to achieve desired effects. Secondary research consolidates other research to identify higher order trends and directions.

1.3 Reflective practice

One of the key processes that should be encouraged for psychologists is having a complex understanding of self in the context of others. The HCPC requires reflection in the record of continued professional development in order to retain continued registration.

Psychologists will need to make decisions about clients which may have a profound impact on their lives. Decision-making is often subject to various competing biases. Psychologists should be aware of the possibility that they may be influenced by considerations which are not driven by professional knowledge, skills or experience. Maintaining awareness of these biases is important when trying to think through dilemmas.

Sources of influence and bias may include:

- **Cognitive Biases –** Over 150 have been described[2,3,4] including salience (how readily something comes to mind), confirmation bias (the human tendency to look for evidence that confirms their belief and to ignore other evidence), loss aversion (risky behaviour to avoid loss), beliefs about disclosure (tendency to be more honest when they believe their actions will be known by others), and dissonance reduction (justifying actions if consequences are considered worth it).
- **Personal Experience –** the experience of the psychologist may affect how they view or treat a client or situation. This may include current or historical trauma, or the kind of organisation and culture with which they are most familiar. Interventions which may be appropriate in one context may be ineffective and cause distress in another.
- **Motivation –** the original reasons for undertaking the profession may change or be challenged due to fatigue or experience within the profession which may affect the psychologist's viewpoint.
- **Health –** psychologists should be mindful of the potential effect of health conditions or medications which they may be taking, on their practice.
- **Control over the psychologist's own practice –** this refers to clarity and openness in the management of the psychologist's business and maintaining the professional's autonomy in their interactions with clients.
- **Pro bono public work –** psychologists are encouraged, and personally motivated to

engage with such work, while being mindful of impact on the value that is placed on the profession as a whole.

- **An unethical environment –** maintaining self-recognition of what the appropriate ethical standard should be, irrespective of the prevailing situation.
- **Environment –** political realities may lead the psychologist to make compromises; while there is nothing wrong with compromises, their constant use may mean a decline in overall standards.

The literature is generally pessimistic about the ability of practitioners to overcome some of these biases, considering them to be inherent in human thinking patterns. By being aware of and acknowledging them, it can be possible to manage their influence. For example, biases can be levelled out by presenting information in different ways, by engaging the perspectives of people with different experiences and expectations, or by priming thinking with different examples.

A key factor in developing and maintaining these skills is the use of consultation or supervision and having a space where it is possible to open up thinking to the mind of another with a view to extending knowledge about the self.

It is important that psychologists from all disciplines look after their own wellbeing. This is not only important for them as individuals, but also for the quality of the care they give their clients. In their practice and, for example, within their CPD plans and supervision psychologists should consider self-care and how they can maintain their own wellbeing.

It is also important for psychologists to evaluate effectiveness of practice, by welcoming feedback from clients. This can be difficult due to fears of criticism but reflective practitioners are eager to improve and welcome any feedback that will support this process.

1.4 Continuing professional development

Continuing professional development (CPD) is the professional and work-related aspect of lifelong learning. It is an integral part of the process of adapting to change, and essential for maintaining and enhancing professionalism and competence. The Society provides an online facility to record CPD, further information is available on the ***Society website: http://beta.bps.org.uk/Practice-Guidelines***.

- CPD is both a professional expectation and an individual responsibility to taking a structured and self-managed approach to further learning through:
  - actively engaging in a range of CPD
  - maintaining a record of CPD
  - applying learning from CPD to professional practice.
- There is a range of formal and informal learning activities that may be used for CPD and it is recommended that psychologists engage in a mix of CPD activities.
- Professional development is not purely about inputs (i.e. undertaking CPD activities); it also requires a reflective, outcomes-based approach which focuses on the learning gained from CPD and its application to current or future practice, together with the associated benefits for clients and the services provided.

- All members who are registered with the HCPC are required to comply with their CPD requirements as a condition of continued professional registration. Further information is available in ***Appendix 2: Websites and further information***

Mentoring

Psychologists may seek a mentoring relationship with colleagues in order to focus their attention on skills to add to their competencies. Psychologists taking on the role of mentor often support the psychologist with their career path. Early career psychologists may find it beneficial to be mentored by a more experienced psychologist.

1.5 Consultation/supervision

Consultation or supervision is considered an essential part of good practice as a psychologist. There is no legal requirement for supervision, although it is considered an ethical and professional expectation to engage in appropriate consultation in order to support effective practice. Provision of this is therefore an important underpinning to good quality service delivery. The Society's position is, for safe and effective practice in clinical and mental health settings, or with other vulnerable groups, supervision is a requirement of practice.

The objectives of consultation/supervision are:

- to provide practitioners with consultation on their work with clients;
- to enhance the quality and competence of practice offered to all clients;
- to offer psychologists intellectual challenge enabling reflection, transformational learning and psychological support to maximise their responsibility for appropriate self-care; and
- to contribute to the CPD of both psychologist and supervisor by developing competence in the use and practise of supervision.

All aspects of practice are appropriate for discussion in supervision, including research activity, administrative and managerial work, service developments, team working, teaching and the process of supervising others. Supervision is not personal therapy and nor is it a form of, or substitute for, line management or appropriate training.

For psychologists working in a wide range of settings such as therapeutic and organisational settings, supervision is a core component of the psychologist's CPD. For some areas of practice, the nature of supervision changes over time. This may be unique to each psychologist and the context of their application. Expectations should be agreed from the outset and reviewed at appropriate intervals.

Forms of consultation/supervision

Supervision may take the form of clinical supervision, mentoring, coaching, supervision on placement/work setting, tutorials and peer support. Psychologists may engage in one to one supervision; group supervision (facilitated or non-facilitated) or peer supervision and any of these may be face to face or virtual. Whilst it should not be a substitute for line management, a psychologist's supervisor may also be their line manager.

Those working in independent practice, or in the absence of service-based supervision, should seek supervision from appropriately qualified and experienced personnel as appropriate. Peer supervision (individual or group) may be an appropriate way to find collegial support.

Psychologists may select different supervisors, depending on their preferred supervisory style, nature, orientation and their needs at the time. Particularly for experienced psychologists, this may be from an experienced colleague from outside their profession, professional specialty or organisation. Psychologists could also invite supervision from experts by experience for whom they provide services, where appropriate to the context of practice.

The Society maintains the Register of Applied Psychology Practice Supervisors (RAPPS), which recognises psychologists with special expertise in supervision and supervisory practice. Further information is available on the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines***.

Amount of supervision

While there is a specified number of supervision sessions for trainees (e.g. for their Chartered status) which varies across different sub-disciplines of psychology, no definitive amount of supervision is specified as part of CPD. To determine both the quantity and nature of the supervision, the psychologist may consider their need for supervision from various perspectives: their own assessment of need, the competencies required for their practice; the context of their work; organisational requirements; and the support available. For psychologists in employment the arrangements for consultation/supervision should be agreed after considering these factors in consultation with the employer.

Roles and responsibilities of the supervisor

Psychologists undertaking supervision should ensure that they are sufficiently experienced, competent and appropriately trained to provide supervision. Psychologists are often called upon to supervise non-psychologists, in which case these guidelines would also apply.

In supervision, the psychologist as supervisor needs be aware of their own competence in relation to the work of the psychologist and, where necessary, recommend additional supervisors who may have the appropriate level of expertise. Psychologists may offer consultancy supervision to professional colleagues, organisations and stakeholders in line with their competencies.

Psychologists should avoid personal relationships between the supervisor and psychologist which could adversely affect integrity and objectivity.

Psychologists providing consultation/supervision should do so in line with the guidance in other relevant sections of these Practice Guidelines.

Issues of power and control

The nature of supervision itself creates a power imbalance, even between peers. Both the person providing supervision and the person receiving it need to be aware of this.

The supervisory leadership relationship should be both informative and reflective. Psychologists in leadership roles as supervisors should provide regular, informative feedback to the psychologist as well as motivating them to reflect on their own practice, continue to self-assess and improve self-awareness.

1.6 Leadership

Psychologists at any stage of their career are likely to find themselves in a position where they are required to demonstrate or model leadership. This may be an integral part of their practitioner work or may arise through being a leader of a team, including leading in Society work. Leadership is widely quoted and described in the context of leading change as, *'accepting responsibility to create conditions that enable others to achieve shared purpose in the face of uncertainty'*[5]. Furthermore, leaders 'can create conditions interpersonally, structurally, and/or procedurally'[6]. These descriptors highlight the often complex process of psychological change through clinical intervention and also through leading others.

Contemporary leadership styles are generally more aligned to working *within* a team or a system rather than being directive. Leading as a psychologist is likely to include dealing with highly complex information and systems whatever the context. Leading in this way demands high levels of skill in developing, managing and maintaining professional relationships. This may include communicating complex and sensitive information, and reflexivity to enable individuals and teams to co-formulate around difficulty and challenge.

2. Where psychologists work

2.1 Working environment

When undertaking work with clients, psychologists need to give consideration to providing an environment which is welcoming, accessible, safe, and offers privacy. Although choice of workspace is not always available, it is important wherever work takes place with clients that psychologists consider:

- whether lighting, acoustics, heating and seating are comfortable;
- whether confidential conversations may be audible to others;
- whether there are arrangements to ensure client and practitioner safety, for example through easy access to another member of staff if a difficulty arises;
- whether access and exits are safe, well-lit and in areas which are likely to be overseen;
- that reasonable adjustments can be made to support effects of special needs and/or disability;
- whether the setting is culturally acceptable to clients; and
- whether there are facilities and equipment suitable for the clients, for example lavatories, play materials for children.

Where context of practice allows, psychologists could seek the assistance of relevant workplace representatives, for example their trade union representative or human resources staff, in situations where appropriate workplace conditions are not being provided. However, it is acknowledged that sometimes the ideal workspace may not be available or that psychologists may not have access to these workplace representatives due to their context of practice and psychologists should, within the limits of safe practice, be able to adapt to situations within local constraints in order to provide the best service for clients.

Sometimes, it is important to work with clients in representative environments in order to understand behavioural drivers. This will apply if the psychologist's task is to understand behaviours in such environments and provide support, for example through the use of technology, design of procedures, training or team design. Psychologists should consider carefully how to create representative conditions without causing harm. Equally it may sometimes be necessary for psychologists to work in a client's own context as that is where any intervention may be formulated or put in place. Psychologists should ensure they follow the relevant health and safety guidelines in place at their working location even if that location is not their usual place of work.

There may be a temptation to make assumptions about what sort of environment is most suitable, comfortable and culturally appropriate for clients, however it is helpful to ask them and endeavour to make appropriate adjustments to meet their needs.

Lone working

Many psychologists practise in a lone worker workplace and on occasion visit clients in their own homes. When working at home, it is necessary to ensure the proper insurance

and protocols for this type of work, as well as manage boundaries between personal and private space. When working alone, the Suzy Lamplugh Trust recommends always ensuring that someone else has access to schedules and contact details for clients. Psychologists may also want to put in place a 'code word call', where should they fail to answer or speak the correct code word, the police are alerted. This is just an example of an additional safety practice, and there may be different ideas for ensuring personal safety when lone working. However, the important point is to think about keeping safe, have a plan and stick to it. Further information is available in ***Appendix 2: Websites and further information.***

Harassment and bullying

Bullying is behaviour that may take the form of actions or comments that are offensive, which are intended to humiliate, undermine, demean or injure the recipient. It may target an individual or group of individuals and is a form or abuse that may be explicit and therefore obvious, or it may be insidious, an experience recognised only by the recipient and harder to notice by others. Bullying may be vertical (i.e. between managers/supervisors and staff) or horizontal (i.e. between colleagues). Clients may also experience bullying by professionals. While bullying may involve a misuse of power and be committed in the workplace by a manager, supervisor or senior colleagues (sometimes known as downwards bullying), it should be borne in mind that it is not uncommon for senior staff to be bullied by those whose work they oversee.[7] What can be legitimately classified as bullying may take into account the particular personal sensitivities and characteristics of the person suffering the alleged bullying.

Harassment can be defined as actions or comments that are unwanted and which may be related to age, disability, gender reassignment, race, sex, sexual orientation, religion or belief or any other personal characteristic of the recipient. Harassment occurs when someone engages in unwanted conduct in relation to the aforementioned characteristics and that conduct has the purpose or effect of violating the other person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for the other person.

The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Psychologists with concerns over the above behaviour should seek the support of their supervisor, line manager or other appropriate senior staff member, accredited trade union workplace representative or human resources department. Further information is available in ***Appendix 2: Websites and further information.***

Whistleblowing

Whistleblowing is the disclosure of wrong doing (beyond normal managerial channels) and is important as it is a critical way not only of seeking justice for the individual or individuals affected, but also of developing inside information within organisations about incorrect or unfair practices,[8] thereby increasing the evidence required for corrective action to take place.

A whistle-blower is protected by law (the Public Interest (Disclosure) Act 1998) if:

1. They are a worker (this includes trainees and can include self-employed personnel servicing an organisation in certain circumstances).
2. They are acting in the public interest.
3. The disclosure relates to past, present or likely future wrongdoing which involves one or more of the following:
    - criminal offences (which may include fraudulent actions);
    - a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
    - a miscarriage of justice has occurred, is occurring or is likely to occur;
    - the health or safety of any individual has been, is being or is likely to be endangered;
    - the environment has been, is being or is likely to be damaged; or
    - information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

If the individual has been victimised or if they have lost their job due to whistleblowing, the legislation provides them with the right to take a case to an employment tribunal. Whistleblowing is a complex legal area and it is important that anyone considering it considers appropriate advice, for example from an accredited trade union workplace representative or helpline. The relevant human resources department which will have a policy relating to this, or it may be appropriate to seek formal legal advice. Some organisations such as NHS Trusts have a nominated Director responsible for dealing with disclosure issues who may be contacted directly. The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Further information is available in ***Appendix 2: Websites and further information.***

Psychologists can inform on all aspects of the establishment of workplace cultural norms that promote positive managerial and leadership behaviour and can help facilitate the development of cultures that support the disclosure of inappropriate practices. Psychologists are also appropriately qualified to support workers who have been subject to bullying or harassment or who are contemplating or indeed have already 'blown the whistle'. Whistleblowing, and even the prospect of such, can create traumatic responses in workers[9] and can lead to retaliation as a consequence. Empirical evidence highlights the link between whistleblowing and the devastating effects on health that may follow, such as depression, anxiety and symptoms relating to post-traumatic stress[10]. Psychologists are able to work with affected employees and in a consultative capacity with organisations to manage work-related stress disorders caused by these incidents of bullying, harassment and whistleblowing to lessen the risk of absenteeism and to facilitate a return to work following a period of absence. Further information is available in ***Section 8: How to respond when things go wrong.***

2.2 Working in the digital age

Digital media continues to advance in terms of choice and functionality. It is becoming increasingly common for psychologists in particular when working with clients to make use of the internet and/audio-visual technology. These technologies require the psychologist to ensure that the network used is as secure as reasonably possible and, as far as is feasible, assures privacy to their clients.

There can be no guarantee of security when using the internet, and voice over internet protocol (VOIP) services such as 'Skype' or 'FaceTime' are no different, as they use the same data infrastructure as the rest of the internet.

Most, if not all, VOIP systems encrypt the voice into waveforms during digital transit across the internet, and it would be impossible to eavesdrop on these data packets in real time. However, the information is potentially vulnerable to eavesdropping/compromise before encryption by the speaker's system, and after decryption by the listener's system. This will depend upon the security measures in place for the end user's (speaker and listener) own networking infrastructures, be that a company, institution or home user. If an end user's computer has been compromised by any form of malware, then there will be a risk of eavesdropping, data theft and/or denial of service.

The risk for eavesdropping on VOIP systems is no more or less than that of traditional analogue phone systems, and both would require specialist knowledge, equipment and software to be achieved. However, it is recommended that only fit-for-purpose VOIP systems are used, and that public networks, such as Social Media sites, are avoided for VOIP communications. Further information is available on the ***Society website: http://beta.bps.org.uk/Practice-Guidelines***.

Some employers may have their own rules about which media are acceptable to use. The USA has the Health Insurance Portability and Accountability Act (HIPAA) which sets standards for security for electronic data. There is no such provision in the UK to date, and so psychologists must satisfy themselves that any media used to communicate personal data is secure. This is a rapidly changing area and so technology-specific guidance has not been provided in this document. Further information is available in ***Section 7.1: Information governance*** and ***Appendix 2: Websites and further information.***

The use of online 'Apps', computer assisted decision-making and artificial intelligence in psychological practice and research is evolving rapidly. When recommending or using computerised systems psychologists should pay due regard to peoples' health, wellbeing and safety being mindful of Clinical Safety Evaluations, Medical Device Evaluations and other relevant guidance such as NICE.

Use of social media

Many psychologists are using social media, networking sites or blogs to communicate with friends, family, professionals, colleagues and clients. This specific guidance therefore addresses the use of social media by psychologists, and provides practical advice for using them responsibly. Further information is available in ***Appendix 2: Websites and further information.***

Psychologists should:

- Remember that social networking sites are generally public and permanent. Once something is posted online, it remains traceable even if it is later deleted.
- Keep their professional and personal life as separate as possible. This may be best achieved by having separate accounts for work-related communications to those for friends/family.
- Consider whether, in their context of practice, it is appropriate to accept 'friend' requests from current or past clients, if necessary, decline the request via more formal means of communication. It is highly unlikely to be appropriate to accept in a clinical or forensic context.
- Be minded to act responsibly at all times and uphold the reputation of the profession, whether identified as a psychologist or not on the social media platform.
- Be aware that social networking sites may update their services and that privacy settings can be reset to a default that deletes personalised settings.
- Remember that images posted online by family or friends may be accessible, as they may not have set privacy settings as tightly.
- Be minded that social networking sites can make it easier to engage (intentionally or unintentionally) in professional misconduct.
- Report the misconduct of other psychologists on such social networking sites to any relevant parties (such as the employer or the HCPC).
- Be aware of their employer's social media policy.

Psychologists should not:

- Establish inappropriate relationships with clients online.
- Discuss work-related or confidential issues online in any non-secure medium.
- Publish pictures of clients online, where they are classified as clinical records.
- Use social networking sites for whistle-blowing or raising concerns.
- Post defamatory comments about individuals or institutions. Defamation law can apply to any comments posted on the web, irrespective of whether they are made in a personal or professional capacity.

2.3 Working for the court

Psychologists may be asked to act as professional or expert witnesses in court. The main difference between an expert witness and an ordinary witness (i.e. a witness to fact), is that the former are able to give an opinion, whereas ordinary witnesses can give only factual evidence. A professional witnesses' remit can cross the boundary of both fact and opinion.

Psychologists are responsible for ensuring they are sufficiently competent and expert in offering an opinion. It is not appropriate for trainee or assistant psychologists to act as expert witnesses. Indications of competence in respect of the knowledge required by the court, and expertise within a specialised field, may include:

- qualifications and/or degree(s) in the areas(s) in question;
- a number of years of post-doctoral/post-qualification experience;
- academic, professional and scientific publications in relevant areas;
- demonstrations of professional practice, competence, specialist knowledge and expertise with a bearing upon the issues in the case; and

- current experience in applying psychology in the area of claimed expertise.

It follows that a psychologist with trainee or assistant status is unlikely to have the necessary experience and qualifications to be retained as an expert witness by a legal firm. However, trainees or assistants who have written reports on individuals in the course of their employment may be required to give evidence (for example, at a tribunal). If so, they should bear in mind that only qualified psychologists should give evidence of opinion, and that their supervisor is responsible for the professional quality of their work in this situation as in all others.

Psychologists instructed as experts need to ensure that they can provide an independent and impartial opinion, and that their independence is clear to all. Any potential conflicts of interest should be made explicit and should be reported as soon as they arise. This can extend to being asked to provide an expert report on someone the psychologist is providing with therapy as an 'Applicant', 'Claimant' or 'Complainer'. This dual relationship is an unacceptable conflict.

When lawyers seek to introduce expert psychological evidence, it is the judge in the case who decides whether an individual has the requisite expertise to give evidence with the potential to be relevant to the case. The judge also decides whether what the expert asserts is relevant and, therefore, admissible in law.

Expert evidence in civil court proceedings is governed by Part 35 of the Civil Procedure Rules 1998, and its associated practice direction. This rule makes clear that an expert's overriding duty is to help the court on matters within their expertise and that this duty overrides the expert's duty to the person from whom they are receiving instructions. Any report must be written in accordance with the criteria in Practice Direction 35.

Further information is available in ***Society documents: Psychologists as Expert Witnesses: Guidelines and Procedure*** and ***Psychologists as Expert Witnesses in the Family courts in England and Wales.***

2.4 Working for defence and security organisations

Psychologists may work with defence and security interests in many different capacities. This may include supporting military or security personnel to perform their roles through the development of skills and behaviours, supporting the mental health and wellbeing of people affected by threats, activities and events in this context, and offering advice and consultancy. It is also UK Defence practice to enlist uniformed psychologists for roles associated with psychology. However, in general, psychologists in defence will be in a civilian role and therefore not under military command.

While there is a strong sense of common culture within the defence and security sectors, there are also important variations. For example, each of the armed forces has its own organisational culture resulting in different attitudes and behaviours. There are also differences within different sectors of each organisation. All these differences are very important to the individuals concerned, forming a large part of their sense of identity.

Psychologists working with these populations should ensure they investigate and acknowledge cultural differences, particularly when working with other national cultures. They should also take careful account of the environments in which people are living and working. Psychologists can be working with civilians and/or members of the armed forces who are operating in life threatening environments and are required to make decisions under extraordinary pressure. It is usually invalid to extrapolate from behaviour in benign conditions to behaviour under threat, hardship and stress.

3. Who psychologists work with

3.1 Working with Experts by Experience

In relevant services it is best practice for psychologists to work collaboratively with clients and Experts by Experience in developing and delivering all aspects of psychological services. In mental health, the Government is committed to shared decision-making and the principle 'no decision about me without me'[11]. This applies from work with an individual client through to changes in government policy relevant to the services provided by psychologists. Psychologists should develop services, policies and guidelines in collaboration with the people who use their services.

In professional practice it is important and helpful to work collaboratively with clients and, where relevant, others in order to ensure that the application of psychological research and theory is understood by and adapted appropriately to the client group and context, which may differ from the populations on which the research was based.

3.2 Working with assistants/interns

Many graduate psychologists take up assistant psychologist positions on either a paid or an unpaid basis.

The following (non-exhaustive) list provides examples of activities which can be carried out by assistant psychologists/interns. This list can guide those who are working as assistant psychologists/interns to request or refuse a task or assignment, as well as assist those who are practising and supervising to observe boundaries and limitations:

- research, audit and service evaluation;
- literature searches, developing and maintaining training packs, information leaflets, libraries of equipment, and other tasks necessary to the efficient running of the service;
- assessment of individuals and groups, for example, direct observations, formal psychometric testing, semi-structured interviews, and writing appropriate reports;
- delivery of interventions with individuals, groups and organisations;
- undertaking supportive work with carers, family members, employers, human resources professionals, team members, health staff and other professionals;
- delivering training for other professionals (if and when competent to do so); or
- promoting applied psychology services by providing relevant information to referrers, commissioners and others.

An assistant psychologist/intern should not be employed to:

- substitute for qualified applied psychologists; or
- undertake solely administrative or clerical duties for which a clerical assistant should be employed.

In occupational settings, the issue of appropriate supervision and guidance is of particular importance when the needs of individuals and organisational demands need to be balanced. Appropriate mechanisms need to be in place to ensure that no assistant psychologist/intern is, for instance, put in a position where they have to design or decide on any materials or processes which could have a potential harmful impact on individuals or groups or to an organisation (such as potential loss of profit or revenue).

In clinical and forensic settings, there are some additional limitations, related to the clear delineation between qualified and assistant psychologist/intern, as follows:

- An assistant psychologist should carry out only prescribed interventions with individuals or in groups, and should write reports only when under close supervision of the primary, qualified psychologist. Any report should be signed as having been written 'under the supervision of' followed by the name, registration status and job title of the qualified psychologist.
- When an assistant psychologist is called to give evidence in a legal setting, such as a tribunal, the qualified psychologist remains responsible for the professional quality of the assistant's work. This means the qualified psychologist should attend the hearing also, as there may be questions which an assistant cannot answer. Both should bear in mind that an assistant is not qualified to give evidence of opinion.
- An assistant psychologist should not undertake tasks in areas where there is not a competent supervisor.
- An assistant psychologist should not carry out the duties of a care assistant.

The managing or supervising psychologist has a responsibility to ensure that assistant psychologists are not given work to do that is over and above their level of competence. Further information is available in ***Society Document: Applied practitioner psychologist internship programmes and unpaid voluntary assistant psychologist posts.***

3.3 Working with trainee psychologists

The Society's standards related to working with trainees across the domains of applied psychology are set out in the Standards for accreditation of training programmes. These set out: the required core competencies that trainees need to develop, the curriculum and assessment requirements that programme providers need to deliver against, and the requirements of supervised practice; expectations around trainees' understanding of and ability to work ethically and legally; selection and recruitment of trainees; personal and professional development of trainees whilst in training; academic staffing and leadership for accredited programmes; and expectations in relation to quality management. Psychologists working with trainees as practice educators should familiarise themselves with these standards and adhere to them in their work with trainees. Further information is available on the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines.***

3.4 Working with multiple clients

Psychologists will sometimes be in situations where their client will not be one clear individual or group, for example, a psychologist may be employed by an organisation to

provide assessment or psychological support for employees. Psychologists need to consider and be mindful of the demands that this might place on their ethical practice and how this might lead to conflicts of interest.

Identification of the following client hierarchy may be considered[12],[13]:

- Primary client – the person or persons with whom the psychologist is interacting directly: the recipient of a psychological service.
- Commissioning stakeholders – the organisation or overall commissioning body that has sought the psychologist.
- Others affected by the primary client's actions – the customers of the organisation or service, or the personal acquaintances, friends and family of the primary client. In some circumstances, this will be the general public or larger groups interested in the outcomes of the intervention.

The psychologist's role will be mainly to the primary client and then the commissioning stakeholder. It is paramount that issues around boundaries and sharing of information are made explicit and addressed appropriately through a clear contracting agreement. Further information is available in ***Section 3.5: Working with other professionals***, ***Section 5: Making and maintaining agreements*** and ***Section 7: Managing data and confidentiality.***

Within each of the levels of the hierarchy, varying allegiances to associates (friends, family, acquaintances, colleagues) will need to be attended to, as will consideration of the impact of professional activity on the reputation of the profession and all those concerned.

3.5 Working with other professionals (including in multi-agency settings)

In order to meet the complex needs of clients fully, psychologists will often be required to work collaboratively with other professionals from their own or other agencies.

Such collaborative working will be for the benefit of clients and/or the promotion of the safety and protection of the public or the benefit of the organisation, and is required by national policy and legislation in a number of areas in which psychologists work. Engaging in partnerships drawing on a wide range of services and agencies enables psychologists to address identified community issues with the optimum use of resources.

Where appropriate to their context of practice, and consistent with the requirements of psychological practice, psychologists should:

- Work together with colleagues to develop a shared view of the aims and objectives of work at all levels. They should respect the professional standing and views of other colleagues and commit themselves to joint working.
- Make it clear to other professional colleagues what can be expected of them in collaborative work, the work that will be done, and the point at which the work will be terminated.
- Ensure that there are explicit agreements about information-sharing and confidentiality and its limits, and that these are adhered to.

- Practise and encourage in others full and open communication with colleagues/ agencies to support effective collaboration within the boundaries of the agreed limits on information-sharing and confidentiality,
- Demonstrate their commitment to involving clients in multi-agency work, finding ways to engage them and retaining the central principle of better outcomes for clients as the rationale for multi-professional and multi-agency work, as long as this is consistent with public safety.
- Be sensitive to the effects of clients receiving contradictory advice from different professionals or agencies and should work towards a co-ordinated view wherever possible.

3.6 Boundaries in professional relationships

Psychologists seek to establish good relationships and trust with their clients, other professionals, organisations and the community. They are aware of the complexity of professional relationships and the need to observe their boundaries. Multiple relationships occur when a psychologist is in a professional role with a client or colleague and at the same time is in another role with the same person or group e.g. as a supervisor, sports club member or co-author in a publication or where a psychologist is asked to work at a school where their child is a pupil.

Psychologists should:

- Ensure that the relationship reflects the appropriate context within which the practice is taking place.
- Be aware of the issues of multiple relationships and professional boundaries which may lead to (real or perceived) conflicts of interest or ethical considerations.
- Clarify for clients and other relevant stakeholders when these issues might arise.

When acting as leaders in practitioner or managerial roles, psychologists should maintain an awareness of the importance of respect for boundary and power issues within leadership relationships. In particular, an awareness of the possible abuse of these relationships should be maintained at all times. It is important that psychologists explicitly define the boundary of the relationship and negotiate and respect the responsibility that each holds in relation to it. Where psychologists are in a position of power/leadership with individuals, it is particularly important that they exercise caution and consider the possible issues which may arise from developing a personal relationship with these individuals. It may be necessary to seek further supervision where appropriate, with additional peers as necessary.

Psychologists have a duty of care towards their clients, who may be vulnerable, and should maintain a professional emotional distance from clients, services users or relatives and should not enter into an intimate or sexual relationship with any clients, service users or relatives they come into contact with as part of practice. Psychologists should also be aware that their duty of care can continue after a client practitioner relationship has ended.

As far as is reasonably practical, psychologists should not enter into a professional relationship with someone with whom they already have, or have had, a close personal

relationship. This includes family members and friends. Where there is no reasonable alternative, such as a lack of availability of other professionals, and it is acceptable in the particular context of practice, the psychologist should make every effort to remain professional and objective while working with the individual they know or have known. In such circumstances, at the earliest possible opportunity, this should be disclosed and discussed with a manager, where there is one, and supervisor and a note should be made in client records.

A range of psychologists work with people who initially have accessed the services in a dependent position, and have then transitioned to becoming partners and colleagues in service and policy development and design. The nature of the work becomes more collegiate and the psychologist holds multiple roles including facilitating participation, adapting communication and advocacy.

3.7 Working with children and young people

When seeking to work with children and young people, psychologists should consider how they can develop ways of communicating with the child or young person that will be most effective in ensuring they can express their views and feelings.

In most instances psychologists will use their specialist professional training and experience working with children, young people and families in order to understand the developmental needs of the child or young person in question; where a psychologist does not have specialist training that has included children and young people then there would be an expectation that advice or supervision should be sought before working with a child, young person, or their family. Similarly, work with children, young people and their families should take account of wider systemic factors outside of the child or young person; this will usually involve the child's family and may also include their school, and other settings.

As with adult clients, there can be misunderstandings and confusions about the role of a psychologist, the nature of the work being undertaken, and the possible outcomes of the work. It is essential to ask the children and young people about their understanding of what is happening on a regular basis (this may be appropriate at each session) and address any confusion that has arisen.

When working with children and young people, psychologists are advised to ensure that they have ascertained who has parental responsibility and that those with parental responsibility are aware of their planned involvement, if this is appropriate. Psychologists working with children, young people and families need to be aware that young people who are deemed to be competent to make their own decisions: 'Gillick competent'[14] can give their own consent to involvement with a psychologist, and that if a young person gives consent under these circumstances, then parental consent is not required. Similarly, a young person who is 'Gillick competent' can give consent even if parents have declined to give consent; such young people can also ask that parents are not informed of any involvement, and this should be respected by the psychologist; an example here would be in a school setting where a young person may give their own consent to see a psychologist

and may ask for parents not to be informed. Psychologists also need to be aware that where separated or divorced parents share parental responsibility, one parent can give consent.

3.8 Working with people with intellectual disabilities and impaired cognitive abilities

Psychologists are likely to work at some point with a range of people whose cognitive abilities are either temporarily or permanently altered, either by organic or developmental changes. Appropriate assessment of the abilities and skills is required, so that adaptions can be made to further interventions, treatments or management. The implications of the cognitive abilities on the person, their family and the reason for psychology involvement, will need to be considered.

Psychologists working with people with intellectual (learning) disabilities will need to consider adaptations to their approach to ensure the service they are offering is clearly understood, and is adapted to the individual's preferences, strengths and needs. This can include considering adaptations to oral or written communication, psychological assessment, intervention, and outcome evaluation.

Psychologists will need to be flexible and to make reasonable adjustments to their usual practice to ensure an appropriate service is offered. Psychologists should ensure their work is person-centred and respectful of the individual's needs, whether that work involves working with the individual with intellectual disabilities directly, or whether it also includes, or even may predominantly involve, working indirectly with family, carer or professional systems around the individual.

Psychologists will need to be mindful of the range of complex factors that often affect people with intellectual disabilities (e.g. communication needs, poorer mental and physical health outcomes and healthcare service experiences, unemployment, disempowerment, social isolation and exclusion, including experiences of bullying, abuse and hate crime, being overrepresented in the prison population, among others) and, therefore, the specific policy and practice guidance that applies. Further information is available in ***Section 4.2: Safeguarding adults at risk of harm*** and ***Section 6.3: Informed consent with people who may lack capacity.***

3.9 Working with detained people

Where clients are detained involuntarily there will always be a legal framework within which professionals must practise, and they should be aware of how their work fits into that framework. Involuntary detention is not only covered by professional rules and national legislation, but also by international agreements.

Psychologists should be aware that having the approval of one's employer is not necessarily a guarantee that practice is either ethical or legal, as described for example in the Hoffman report[15]. Where practitioners have doubts about the legal or ethical acceptability of employer demands, they should seek advice from an accredited workplace trade union representative, a human resources department, or appropriate helpline. They should

follow their organisation's guidelines on raising concerns at work. Seeking advice outside the immediate setting is helpful as colleagues within the workplace may be subject to the same pressures as they are.

Under the headings below, the role of the practitioner can be seen to be key to the way that detained persons are understood, and this can have a great impact on the way that their cases are handled by the detaining authority. The practitioner therefore has considerable power, whereas the client has very little. This power imbalance should always be borne in mind by practitioners dealing with detained persons. They should also bear in mind that the imbalance can be implicit as well as explicit.

Prisoners

Putting psychological pressure on detained persons to obtain a confession to an offence is illegal under the UN Convention on Torture[16]. In this context, 'psychological pressure' could well include such things as telling indeterminate-sentence prisoners who maintain innocence that they are unlikely to be released unless they engage with an intervention that relies on acknowledgement of guilt. Decisions about release are not the role of the practitioner, unless they are directly involved with, or are a member of the release authority, with a delegated role in the formal decision-making process. An approach to engagement such as this would not be considered beneficial to the client. However, those instructed by any party to the formal Parole Board decision-making process may properly be asked to give an opinion on suitability for release.

Practitioners dealing with detained offenders who have committed violent or sexual offences should guard against being morally judgemental. It is routine for practitioners in this field to encounter offenders who have committed very unpleasant acts with whose victims they can readily identify. Psychologists should be mindful that their own views about a client do not impact on their work.

Care should be taken when working with detained persons whose literacy is poor or whose first language is not English, and who cannot read a report which has been written about them. Even clients who are literate in English will probably not be familiar with psychological terminology, and may need considerable time to read and fully digest a report. People who are detained can also have cognitive challenges or intellectual disabilities which might make this process more difficult.

Persons detained under immigration legislation

Detained people may be afraid of raising a particular topic in case it is misunderstood, or too embarrassed because of cultural standards. For example, in some cultures it is difficult or unacceptable to discuss sexual matters, but sexual violence has been suffered by many asylum seekers in conflict zones, and some discussion of it may be essential in assessing their case. Even within the same culture there can be considerable generational differences.

Psychologists should guard against unwarranted interpretations of psychological evidence by commissioners or authority figures. For example, reporting that someone's story shows inconsistencies may give the impression that they are lying. This may be the case, but inconsistencies alone are insufficient proof of this. It is commonplace for evidence to be

inconsistently reported when people have been through traumatising experiences in areas of conflict, as is often the case with persons detained under immigration legislation.

Practitioners should take particular care in dealing with detained persons whose first language is not English. The opportunities for misunderstanding in both directions should be obvious, and in many cases the correct procedure will be to interview with the help of an interpreter. Failing to use interpreters when it was clearly appropriate to do so could inappropriately compromise the quality of the psychologist's work.

Mental Health Detentions

Mental Health Act 1983 as amended 2007 (England and Wales)
Under the Mental Health Act (MHA) a person can only be detained for treatment if that person is suffering from a mental disorder of a nature of degree that makes it appropriate for them to receive medical treatment in hospital. In the Act 'mental disorder' is defined as 'any disorder or disability of mind'. This definition is very broad but the *Code of Practice* provides guidance on clinically recognised conditions that fall within its meaning. Major categories of mental illness (e.g. affective disorders, schizophrenia and organic mental disorders) are included along with personality disorders, autistic spectrum disorders and learning disabilities (the latter only if accompanied by abnormally aggressive or seriously irresponsible behaviour). Dependence on alcohol or drugs is not considered a mental disorder under the MHA.

In the Act, all 'medical treatment' including psychological interventions is for the purpose of alleviating, or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations. The medical treatment must be required for the health and safety of the client or for the protection of others. This means that the primary purpose of psychological interventions offered and provided to detained persons has to be to reduce the risks that their mental disorder presents to the detained person or others; as once those risks are reduced or minimised the client will no longer require detention and can progress to a less restrictive environment. This requirement points to the importance of an individualised formulation of a client's treatment needs that includes a careful assessment of the risks to self and others (see section on Risk Assessment, p.32).

Under the MHA appropriate medical treatment must be available. This is described as the 'appropriate medical treatment test' in the *Code of Practice*. Such treatment must have the *purpose* of alleviating or preventing a worsening of the disorder or its symptoms or manifestations, even if it cannot be shown in advance that the treatment is likely to have an effect for a particular patient. Thus, appropriate medical treatment need not be likely to achieve those purposes. That is, purpose is not the same as likelihood. The nature and degree of the patient's mental disorder and all the patient's particular circumstances are all relevant to whether the treatment is appropriate.

The appropriate medical treatment test is designed to ensure that patients are not detained for treatment unless they are actually to be offered appropriate treatment for their mental disorder. Thus, the MHA requires only that appropriate treatment is available to a detained patient. The patient's refusal to accept treatment is not an obstacle to detention, so long as appropriate treatment is available.

This has particular relevance for psychological therapies. The Code at chapter 23.20 states:

> *In particular, psychological therapies and other forms of medical treatments which, to be effective, require the patient's cooperation are not automatically inappropriate simply because a patient does not currently wish to engage with them. Such treatments can potentially remain appropriate and available as long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to engage.*

Whilst the availability test of appropriate medical treatment applies to psychological interventions in the same way as for other forms of treatment, it is important for psychologists to avoid placing pressure on clients to participate in such treatment. In order for there to be an effective therapeutic alliance there needs to be trust and this only develops in the absence of coercion. Psychological therapy works when the client decides they are ready for therapy and freely consents to it. There is an inevitable power differential in favour of the clinician. Thus, every attempt should be made to emphasise patient involvement and choice and to avoid coercion in a manner consistent with the *Code of Practice* empowerment and involvement and respect and dignity principles. Further information is available in ***Section 6: Obtaining informed consent.***

The Mental Health Act 2007, which amended the MHA 1983, introduced approved clinicians (AC) who may be drawn from a defined group of professions, including practitioner psychologists listed in the register maintained by the Health and Care Professions Council. ACs are approved by the appropriate national authority to act as an approved clinician for the purposes of the MHA 1983. Responsible clinicians (RC) are ACs who have overall responsibility for an allocated patient's case. The Code of Practice at chapter 36.3 says that a patient's RC should be the available AC with the most appropriate expertise to meet the patient's main assessment and treatment needs. At chapter 36.5 the Code says that where psychological therapies are central to a patient's treatment then it may be appropriate for a professional with particular expertise in this area to act as the RC.

Chapter 39 of the *Code of Practice* provides guidance on the circumstances in which potential conflicts of interest may prevent designated professionals from making an application for or recommendations supporting a patient's detention or guardianship. The potential conflicts of interest dealt with in the Code involve financial, business, professional and personal issues.

The Mental Health (Scotland) Act 2015.

This act, together with the Mental Health (Care and Treatment) (Scotland) Act 2003 sets out the law for detaining patients and restricting patients. For patients to be detained, this has to be considered by the Mental Health Tribunal for Scotland. This applies, for example, to those detained in the NHS who are not subject to a court (forensic) decision.

Restricted patients are 'detained in hospital under a compulsion order with a restriction order'. They have usually committed an offence punishable by imprisonment but as a result of mental disorder are not imprisoned but ordered to be detained in hospital for treatment, without limit of time. They are dealt with through a programme of treatment and rehabilitation – the aim being to prevent recurrence of offending by dealing with the mental disorder'.

Risk assessment

When dealing with detained people seeking release, such as parole applicants or patients seeking release from a mental health tribunal, risk assessment (usually for violence risk) will be a prime consideration. Psychologists should bear in mind that risk assessment is not prediction. Risk assessment instruments are rarely more than about 70 per cent accurate when predicting reconviction and many items on commonly used risk-assessment schedules are of poor predictive value.[17] Psychologists should also bear in mind that risk-assessment instruments are better at identifying low-risk than high-risk individuals[18],[19]. A statement of risk is not a prediction about an individual, but a statement based on the behaviour of a criterion group with which that individual is being compared. Risk is statistical by its very nature, and the value of such comparisons depends upon the individual's similarity to the criterion group upon which the risk assessment instrument was developed. Accuracy may be greatly reduced if the similarity is low[20]. It may be better to think of risk assessment as a process of identifying those risk factors which need to be monitored and controlled if supervision of the individual is to be reduced or withdrawn.

3.10 Working with people who are, or would like to be employed

Psychologists are sometimes commissioned to deliver psychological assessment or training with employees and potential employees. Psychologists should take particular care over the advice provided in follow-up reports, as employers are not trained professionals and may misinterpret advice or psychometric testing results. For example, citing a reading ability level using age is misleading, and could be interpreted as incompetent for the role, when in reality the role does not require a high reading level or a reasonable adjustment could be provided.

Similarly, psychologists should ensure that the tools they are using to assess competence or suitability are appropriate for the role, and have good reliability and validity. Any tools devised by the psychologist are likely to be interpreted by the employer as professional and authoritative, where there is ambiguity or multiple interpretations, this must be made clear, so that decisions about peoples' employment are not made in error.

There are people who work or who would like to work, who may experience cognitive difficulties caused by a range of factors, for example intellectual disabilities, dementia, acquired brain injury. Sometimes this information is known and needs to be considered when assessing and advising. At other times, this possibility of a cognitive or intellectual impairment needs to be considered. The impact of this can be far reaching, in terms of ongoing or future employment, access to benefits and of course associated psychological adjustments for the person and the people around them. Further information is available in ***Section 7: Managing data and confidentiality*** and ***Society Document: Psychological Assessment of Adults with Specific Performance Difficulties at Work.***

3.11 Working with cultural difference

It is expected that all psychologists will have the necessary skills and abilities to work with all sections of the community.

Psychologists need to be aware of stereotypical beliefs and assumptions which manifest in thinking about culture and ethnic groups. Psychologists should bear in mind the history of racism and the early development of Western psychology[21] and culturally biased testing in favour of white, middle-class children. Psychologists need to recognise that multi-ethnic groups are not homogenous groups and there are wide regional and local differences among these groups which can be split by language, dialect and regional variations. Each ethnic community has a distinct identity and religious focus may also vary within and across communities.

Race is not a biologically meaningful concept to apply to people, and even the artificial divisions between the so-called racial groups are nebulous and unstable, biologically, socially and physically.[22]

Psychologists need to understand the discrimination suffered by people from diverse and/or minority ethnic and religious backgrounds as a result of:

- the interchangeable use of the terms race, culture and ethnicity leading either to the perception of black and minority culture, race and ethnicity as unitary or an assumption that knowing about these cultures solves the problem of equality, fairness and availability of services;
- the maintenance of the colour-blind approach in service where 'one size fits all', resulting in a lack of formal recognition of the varied diverse needs as well as these needs being ignored, unacknowledged or assumed to be the same;
- the lack of appropriate culturally relevant psychological therapy available to certain Black and Minority Ethnic (BME) communities;
- being discriminated against on grounds of 'special' needs, effectively considered as 'cultural pathology'; and
- experiencing instances of indirect, subtle, or unintentional discrimination often called 'micro-aggressions'.

It would be expected that all practising psychologists should develop a productive working relationship with culturally and linguistically diverse groups of people by:

- avoiding different types of biases and find new ways (verbally and non-verbally) to build rapport and respect;
- using and working with trained interpreters in assessment, formulation and intervention work as well as research work;
- being aware of the impact of culture, ethnicity and religion in assessment, formulation and intervention processes and the use of norm-referenced tests which do not include minority ethnic groups as part of their standardisation;
- pre-assessing and pre-incorporating ethnic identity (including its fine gradations, region, class and generation) which can have impacts on processes and outcomes of psychological work;
- acknowledging their own ethnocentricity and possible underlying socially conditioned prejudice to people who are 'different'; psychologists need to acknowledge that people can change, irrespective of their differences and psychological distress;
- relooking at current models of mental health which traditionally reflect Western

constructions, and incorporating other world views of psychological wellbeing; and
- understanding and respecting the different concepts of health and illness that exist within different ethnicities, including newly arrived people from Europe and refugees from Syria, Turkey, Somalia etc.

Psychologists need to: address the different life situations and life circumstances experienced by users who wish to use mental health services; hear their voices based on their personal experiences; and act and respond accordingly in a human way.

3.12 Working with people of faith, religion and spirituality

In working with clients who hold a variety of values and religious and spiritual beliefs which may be different from their own, psychologists should consider the following:

- Psychologists should respect clients' values and spiritual beliefs and need to be mindful that their personal beliefs should not be an impediment to engaging with the client.
- Spiritual beliefs are very often beneficial to the client's wellbeing and may be helpful to be incorporated into any intervention to achieve a positive impact where appropriate.
- In some circumstances the client's faith belief may be harmful or detrimental to themselves or others.

3.13 Working with sexual and gender minorities

Psychologists are committed to the fair treatment and inclusion of people who are intersex, people who do not identify as heterosexual and/or people who do not identify with their natally-assigned sex. This section provides guidance to address specific issues in support of these heterogeneous populations. In these guidelines we use the term 'sexual minority(ies)' to refer to individuals whose romantic attraction or sexual attraction is other than heterosexual (different from the majority in the surrounding society), and the term 'gender minorities' to refer to transgender, genderqueer and intersex individuals.

When working with gender and sexual minorities, psychologists are encouraged to:

- remember that sexual and gender minority identities are not indicative of mental health disorders;
- understand that attitudes towards sex, sexuality and gender are located in a changing social, cultural, and political context, and to reflect on their own understanding of these concepts and how it may impact their practice;
- reflect on the limits of their practice when working with certain sexual and gender minority clients, and to consider appropriate referral and training when necessary;
- understand how social stigmatisation (e.g. prejudice, discrimination and violence) poses risks to gender and sexual minority clients;
- consider engaging with the wider socio-political context regarding sexual and gender minorities in order to reduce social stigma;
- be knowledgeable about the diversity of sexual and gender minority identities and practices;

- use the preferred language of the sexual and gender minority individuals;
- understand the unique and particular circumstances and challenges facing clients with diverse gender and sexual identities and practices;
- understand the diversity of forms of relationships and families in gender and sexual minority clients;
- be aware of the potential challenges facing sexual and gender minority clients in their relationships and families;
- be mindful of the intersections between sexual and gender minority and socio-cultural/economic status;
- recognise the particular challenges experienced by gender and sexual minorities with physical and/or mental health difficulties;
- recognise the diversity of developmental pathways for sexual and gender minority children and adults;
- recognise the needs and issues of young people from gender and sexual minorities, and their particular vulnerabilities;
- support the self-determination of their clients in the development of their identities and practices; and
- avoid attempting to change gender or sexual minorities on the basis that they can be 'cured' or because of stigmatising theory, personal, religious and/or socio-cultural beliefs.

Working with racially and ethnically diverse Lesbian, Bisexual, Gay, Trans*, Queer (LGBTQ) populations

Black and minority ethnic (BME) LGBTQ people have to negotiate between the values and beliefs of the mainstream and minority ethnic cultures. Cultural differences in norms, beliefs, and values can be a source of psychological stress[23],[24],[25]. There may be no particular sexual and ethnic minority group to which a BME LGBTQ person can anchor their identity and obtain acceptance and support. This may be a particular issue for BME LGBTQ youth who are exploring their sexuality and sexual identity.

When offering psychological services to racially and ethnically diverse LGBTQ populations, it is not sufficient for a psychologist simply to identify the racial and ethnic identity and background of the client. Ethnic minority status can complicate and exacerbate the issues, challenges and difficulties the client experiences. The client can be affected by the way their ethno-culture community view and understand sex, sexuality and gender. The issue of racism within the LGBTQ community is also an important issue to consider[26],[27],[28],[29]. Sensitivity to the complex dynamics associated with factors such as cultural values about gender roles, religious and procreative beliefs, degree of individual and family acculturation, and the personal and cultural history of discrimination or oppression is also important. All of these factors may have a significant impact on identity integration and psychological and social functioning[30],[31],[32],[33],[34].

Further information is available in ***Society Document: Guidelines and Literature Review for Psychologists Working Therapeutically with Sexual and Gender Minority Clients.***

3.14 Working with people who may be socially excluded

Social exclusion refers to the extent to which individuals are denied access to the prevailing social system and the right to participate in key areas of social, economic and cultural life. This exclusion occurs due to constraints and restrictions rather than as a matter of choice. Exclusion is typically a result of poverty and/or belonging to a social minority group. The impact of social exclusion has been well documented and leads to the perpetuation of cycles of inequality for individuals and groups. These cycles of inequality are perpetuated in terms of income, health, opportunity, relationships and life-span. Further information is available in ***Society Document: Socially inclusive practice.***

Social inclusion is the process where the needs of all members of communities and the groups which constitute them are recognised, prioritised and met, resulting in these individuals feeling valued and respected. Promoting social inclusion is a broader task than promoting equality and tackling discrimination and stigma. It requires psychology professionals to address wider structural issues in society which maintain excluding processes and power differentials.

The range of individuals and groups who may experience disadvantage and exclusion is not limited to the protected characteristics outlined in the Equality Act. For example, people may also experience exclusion because of their age, they are a carer or are in care, they have a low income or low educational achievement, or their cognitive ability is compromised.

When working towards social inclusion psychologists are encouraged to:

- acknowledge, understand and respect the diversity of the communities in which they practise;
- make adjustments where possible and needed, to enable people to fully participate, e.g. to communication, access to services, adaptation to materials and psychological assessment and interventions;
- recognise that they have a professional duty actively to promote equality and opportunity;
- recognise the shame and distress caused by discrimination, and the impact of discrimination on wellbeing;
- acknowledge and respond to the trauma and distress caused by exclusion;
- move beyond the level of the individual and recognise that social exclusion is a structural issue, and that inclusion will be achieved only by structural changes in society and broad policy initiatives;
- acknowledge that there is a responsibility to highlight the links between structural societal factors and mental health problems;
- make employers, policy-makers, clients and the general public aware of situations where policies, practice and the distribution of resources are oppressive, unfair, harmful or illegal;
- challenge social conditions, both as individuals and collectively, that contribute to social exclusion and stigmatisation;
- make services accessible in terms of time, space, familiarity and comfort; make reasonable adjustments to services to meet individuals' needs; people need to be able

to get to places, get into places, feel welcomed to places and feel that they belong in places;

- recognise that inclusive services reflect the communities they serve in terms of the identities and diversity of the staff team;
- recognise the range of interventions that can improve clinical and social outcomes and use influence to ensure these services are commissioned;
- emphasise social outcomes and participation alongside clinical outcomes;
- maintain an emphasis on empowering clients to achieve their social goals; and
- identify natural sources of support and reciprocal relationships for individuals within their communities, and seek out opportunities to help individuals transition out of formal mental health services.

4. Safeguarding

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect[35]. This guidance addresses safeguarding of both children and adults.

Abuse takes many forms and cuts through various domains of life. The categories below are often referred to in investigation/legislation context and are not mutually exclusive with e.g. emotional abuse featuring in the other domains of abuse. Abuse can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

- Physical abuse – is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This could include hitting, poisoning, deprivation of food, water or liberty, rough handling or exposure to heat or cold, amongst other things.
- Sexual violence and abuse – sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding. Sexual violence and abuse can take many forms and may include non-contact sexual activities such as: indecent exposure, stalking, grooming or being made to look at, or be involved in the production of sexually abusive material, or being made to watch sexual activities.
- Psychological/emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, blaming, controlling, intimidation or coercion amongst other things.
- Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not, or could not, consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property of inheritance.
- Institutional abuse is the mistreatment or neglect by a regime or individuals, in settings which people who may be at risk reside in or use. Institutional abuse may occur when routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. It may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services and includes a failure to ensure the necessary preventative and/or protective measures are in place.
- Neglect is the persistent failure to meet basic physical and/or psychological needs. It may involve a parent or carer failing to provide adequate food, clothing and shelter, failing to provide or unresponsiveness to, basic emotional needs or failing to protect from physical harm.

Psychologists are in a particularly relevant position to identify interactions or circumstances that affect health and development. This applies not only to psychologists who undertake direct work with children and vulnerable adults in a variety of settings; but also to those who work with clients, seen for instance in clinics, hospitals or prisons, who may make historical disclosures of abuse or raise concerns about child protection or the welfare of people within their families or communities. Safeguarding is thus the responsibility of all psychologists whatever their role.

4.1 Safeguarding children

The Society endorses *Working Together to Safeguard Children* – A guide to inter-agency working to safeguard and promote the welfare of children[36]. Safeguarding children is the responsibility of everyone.

The guidance defines safeguarding children as protecting children from maltreatment and preventing impairment of children's physical or mental health or development (physical, intellectual, emotional, social and behavioural). Promotion of welfare is defined as ensuring that children grow up in circumstances consistent with the provision of safe and effective care, and taking action to enable all children to have the best life chances.

Child protection within safeguarding refers to the activity that is undertaken to protect specific children who are suffering or likely to suffer significant harm. For the purposes of child protection legislation children are those who have not yet reached their 18th birthday. The child's needs are paramount, and the needs and wishes of each child be they a baby or infant or an older child, should be put first, so every child receives the support they need before a problem escalates.

The policy of Working Together is underpinned by two key principles: (a) safeguarding is everyone's responsibility and for services to be effective each professional and organisation should play their full part; and (b) safeguarding requires a child-centred approach based on a clear understanding of the needs and views of children.

Where there are concerns that a child is at risk of harm, such concerns should normally be communicated following the psychologist's work-place safeguarding protocol. Where this is not applicable, concerns about a child's welfare can be made directly to the local authority children's social care team.

Psychologists should:

- be alert to the heightened vulnerability/possible need for early intervention support for a child who: has a disability, has additional needs (including special educational needs), is a young carer, is showing signs of engaging in anti-social or criminal behaviour, has returned home from care and/or is showing early signs of abuse and/or neglect.
- be alert to heightened vulnerability where a child is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence.
- consider the potential impacts of parental/carer ill-health on the family and whether this creates any significant negative impacts or risks for children within that family;

- be aware that if an adult has responsibilities for children outside the home setting, such as working with children, their mental ill-health and/or their health more generally upon the adult's capacity to work safely;
- be aware that children within the same family can be treated differently (one child may be singled out for abuse);
- be aware/seek to understand how children can come to abuse other children;
- recognise that some professionals use their position to abuse children and vulnerable people; and
- challenge institutional abuse in its many forms.

Psychologists should be aware of situations of risk which require additional consideration, notably:

- sexual exploitation, which involves exploitative situations, contexts and relationships without the child recognising the harm on account of their age/understanding, social/economic and/or emotional vulnerability;
- internet abuse, which can involve cyber bullying, exposure to pornography or violence and exploitation of young people;
- domestic violence which may expose a child to violence directly or indirectly;
- shame-based abuse where children or young people may be physically assaulted or murdered because of bringing perceived 'shame' to their families or breaking cultural expectations of 'honour'; and
- Trafficking, any child transported for exploitative reasons is considered to be a trafficking victim, whether or not they have been forced or deceived. This is partly because it is not considered possible for children to give informed consent. Even when a child understands what has happened they may still appear to submit willingly to what they believe to be the will of their parents or accompanying adults.

Psychologists should have a knowledge and understanding of services for children in need and how to access them. Psychologists confronted with child abuse in any form should contribute to whatever actions are needed to safeguard children and promote their welfare. The needs/interests of adults should not be allowed to take precedence ahead of the needs of the child. Psychologists should work co-operatively with parents/carers unless this is inconsistent with ensuring the child's safety and ensure that the child's view is sought, heard and communicated. Psychologists should share appropriate information in a timely way, discuss any concerns and help analyse information so that an assessment can be made of the child's needs and circumstances. Psychologists should contact the children's services or social services department at the appropriate local authority (in some cases this role has been delegated to a multi-agency safeguarding hub) if they are concerned about a child or a vulnerable adult.

Managing cases of alleged historical abuse

There is a growing recognition that a disclosure of non-recent abuse may reveal current risks to others from an alleged perpetrator. Psychologists have a duty of care to their clients, and in the safeguarding of others. This may place psychologists in complex positions when trying to negotiate and balance their duties and responsibilities.

Psychologists who work with adult clients who disclose non-recent sexual abuse, should recognise that there may be current and ongoing risks posed by the alleged perpetrator to others. Not sharing concerns beyond the consulting room could mean that other children and young people could be at risk.

A client's allegations should be taken seriously, regardless of their presenting problems or mental health diagnosis.

Lack of access to children identified through familial relationships, work or volunteering roles should not eliminate concerns about risk, given opportunities for abuse to occur within communities.

It is crucial that psychologists seek advice from colleagues, particularly colleagues in safeguarding services, within the organisation and also from other agencies tasked with leading on safeguarding (i.e. social services). Psychologists working with clients without a referral and where no stakeholder agency is involved should seek advice from senior experienced colleagues on how to proceed. Psychologists need to be alert to the possibility that abuse may be organised, severe and complex.

There may be times when, in the interests of supporting a client's psychological readiness for disclosure, consultation may continue without requiring identifying details to be provided to the psychologist. It is important that a clients' lack of readiness to disclose does not become an obstacle to receiving psychological help. Further information is available in ***Society Document: Guidance document on the management of disclosures of non-recent (historic) child sexual abuse.***

Where the disclosure is made by the perpetrator of the abuse, risk assessment should be made regarding the context of the setting of the disclosure but there may be a professional obligation to disclose the criminal offence in order to safeguard other potential victims as above.

4.2 Safeguarding adults at risk of harm

The Care Act 2014 brought in new legislation regarding the safeguarding of all vulnerable adults. In some regions there is a move away from the term 'vulnerable adult' towards the concept of an adult at risk of harm.

An adult at risk of harm is a person aged 18 or over with need for care or support, who is experiencing, or is at risk of, abuse or neglect, and as a result of their needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The needs referred to here may cover a variety of personal or life circumstances including (but not limited to) cognitive impairment, age, disability, illness, injury or mental health condition.

The legal context

There is no set piece of legislation for adult safeguarding. It is a mix of criminal law, case law and welfare law. The Care Act 2014, updated in 2016, brought in the first legal framework for safeguarding adults in a single act. It contains a range of regulations and statutory guidance, which form the base upon how social care will develop in the future.

It enshrines the new statutory principle of wellbeing and it makes it the responsibility of local authorities to promote wellbeing when carrying out any of their care and support functions. The act specifies the rights of those who need care and support, their carers, and the funding system for care and support. It recognises that this cannot be achieved by any single agency. Every organisation and person who comes into contact with a child or adult has a responsibility and a role to play to help to keep children and adults safe. Further information is available in ***Appendix 1: Relevant legislation.***

Modern slavery

An important area of concern is modern slavery. The Government website provides details about the government's work to end modern slavery, including details about how to refer victims into the national referral mechanism (NRM). Modern slavery is a serious crime. It encompasses slavery, servitude, and forced or compulsory labour and human trafficking. Modern slavery victims can often face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation.

A person is trafficked if they are brought to (or moved around) a country by others who threaten, frighten, hurt and force them to do work or other things they don't want to do.

A victim of slavery is entitled to help and protection from the UK Government (this is called the National Referral Mechanism), all support is provided on a confidential basis, and support to talk to the police. The National Referral Mechanism has been put in place to identify victims of trafficking and refer them to organisations that will offer help and support. Further information is available in ***Appendix 2: Websites and further information.***

Responding to concerns

Safeguarding adults means:

- Protecting the rights of adults to live in safety, free from abuse and neglect.
- People and organisations working together to prevent and stop both the risks and experience of abuse or neglect.
- People and organisations making sure that the adult's wellbeing is promoted including, where appropriate, taking fully into account their views, feelings and beliefs in deciding on any action.
- Recognising that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances and therefore potential risks to their safety and wellbeing.

Providers' safeguarding arrangements should always promote the adult's wellbeing. Being safe is only one of many things that adults want for themselves and there can be challenges in balancing safety and freedom in a way which protects and fulfils human rights. Providers, and other professionals where relevant, should work with the adult to establish what being safe means to them and how that can be best achieved.

Care and support means different things in every case. The fundamental standard on safeguarding is that children and adults using services must be protected from abuse and improper treatment. Providers should establish and operate systems and processes

effectively to ensure this protection and to investigate allegations of abuse as soon as they are aware of them.

The standard states that care or treatment must not:

- Discriminate on the grounds of any of the protected characteristics of the Equality Act 2010;
- Include acts intended to control or restrain an adult or a child that are not necessary to prevent, or not a proportionate response to, a risk of harm to them or another person if the adult or child was not subject to control or restraint;
- Be degrading to the adult or the child;
- Significantly disregard the needs of the adult or the child for care or treatment.

The standard goes on to state that no adult or child must be deprived of their liberty for the purposes of receiving care or treatment without lawful authority.

Safeguarding Adults Boards were established to help and safeguard adults with care and support needs The Safeguarding Adult Board must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies, according to the values of 'Making Safeguarding Personal' Guide 2014[37]. Making safeguarding personal is not just for people with capacity, it is just as important for people who lack capacity. The Guide specifies outcomes that people might want including to be and to feel safe, to maintain or get friends, to know that this won't happen to anyone else or to be able to protect self in the future.

The following are not outcomes:

- Harm or abuse is substantiated/unsubstantiated.
- The person is receiving increased monitoring or care.

The role of the Care Quality Commission[38] is to monitor, inspect and regulate services to make sure that they meet the fundamental standards of quality and care. The Commission works alongside Safeguarding Adults Boards and Safeguarding Children Boards to share information and intelligence where appropriate to help them identify risks. This includes providing appropriate advice and support to people at risk of radicalisation in sectors such as healthcare and education.

4.3 Terrorism and extremism

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ('specified authorities' listed in Schedule 6 to the Act), in the exercise of their functions, to have 'due regard to the need to prevent people from being drawn into terrorism'. Depending on where the psychologist works, these duties may have relevance in the course of their employment. The term 'due regard' as used in the Act means that the authorities should place an appropriate amount of weight on the need to prevent people being drawn into terrorism when they consider all the other factors relevant to how they carry out their usual functions.

The current UK definition of 'terrorism' is given in the Terrorism Act 2000. In summary, this defines terrorism as an action that endangers or causes serious violence to a person/ people; causes serious damage to property; or seriously interferes or disrupts an electronic system. The use or threat must be designed to influence the government or to intimidate the public and is made for the purpose of advancing a political, religious or ideological cause. People suspected of being involved in such activity must be referred to the police.

'Extremism' is defined in the Prevent Strategy[39] as vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty, and mutual respect and tolerance of different faiths and beliefs. Definitions of extremism can also include calls for the death of members of our armed forces, whether in this country or overseas.

While it is recognised there is no single profile associated with extremism, identity is considered to be central, and risk screening is based on assessment in relation to two general pathways into extremism – criminal and non-criminal. Disengagement follows a similar process. This is a contentious area of practice. Psychologists should ensure they focus on their core role, working in a non-stigmatising way, and avoiding profiling based on characteristics such as race, religion, ethnicity or any other aspect. The psychologist should carefully weigh relevant professional obligations and seek and follow appropriate local and employer guidance. Further information is available in ***Appendix 2: Websites and further information.***

5. Making and maintaining agreements

Both client and psychologist benefit by having arrangements for the work clearly set out from the start. Psychologists should be aware that all professional engagements are ultimately governed by the law of contract. A legally enforceable contract can arise as a result of the parties' entering into a written agreement, but can also arise as a result of a verbal agreement between the contracting parties.

A contract arises if the following are present:

- one of the parties (the offeror) had made an offer to the other party (the offeree);
- the offeree accepts the offeror's offer;
- there is consideration (i.e. something of value) passing from each party to the other, e.g. the offeror provide services to the offeree; the offeree pays the offeror;
- the parties intended to create a legal binding arrangement; and
- the terms of the contract are sufficiently certain.

While this does not mean that all client engagements are made subject to an agreed contract document, it does mean that in the worst-case scenario of a complaint against a psychologist being made, it will be very helpful for the psychologist to be able to demonstrate that they have met their professional obligations to their client. This will be best done by demonstrating that an agreement was made by both parties who knew what they were agreeing to, that the parties had the legal capacity to make such an agreement and that what they were agreeing to is permitted under the law. Where the client does not have the capacity, best interest decisions need to be made in accordance with the Mental Capacity Act. Further information is available in ***Section 6: Obtaining informed consent***.

Psychologists may wish to include the following when making agreements:

- the role and function of the psychologist;
- the psychologist's relevant qualifications, areas of expertise and ways of working;
- relevant limitations of the psychologist's practice, e.g. assessments not accepted or types of activity not undertaken;
- where the psychologist is appointed to work with a third party, the psychologist should make clear their obligations to each of the clients concerned and each client's obligations under the agreement and ensure that there are no conflicts or ambiguities;
- the extent of the psychologist's power and responsibilities when acting on behalf of other agencies;
- obligations in relation to duty of care and safeguarding, and related limitations to confidentiality;
- how confidentiality of client information and data is assured and any limitations to that confidentiality;
- how conflicts of interest will be managed if applicable;
- the client's, or other party's, rights of access to stored information;
- the use of any one-way viewing screens or video or audio recording and the security of any recorded material;

- the nature of psychological activities involved, the reasons for undertaking them and information about the likely outcomes;
- the availability of the psychologist to the client;
- details of fees, together with application of VAT if non-clinical services, or expenses to be billed in connection with the work undertaken;
- what is expected from the client as their contribution to the engagement with the psychologist, expectations for payment and consequences of non-payment;
- ownership of intellectual property rights;
- what might cause a breach of the agreement;
- the rights of each party to withdraw from the agreement and the consequences to any financial agreement;
- recourse to dispute resolution or law;
- the equality and justice aspects of social policies and their possible impact;
- external ethical scrutiny and approval of the engagement, where appropriate; and
- arrangements to terminate the retainer.

In advance of any psychological assessment, the client should be made aware of the availability of services, and the existence of any waiting lists for intervention.

For some approaches, intervention follows an evolving path, unique to each client and his or her life circumstances, which cannot be precisely predicted in advance. Clients should be made aware of this uncertainty, and predictions should be made on the best judgments. It is recognised that it is sometimes unrealistic and undesirable to provide detailed information on all aspects of psychological intervention, and consent should be obtained to a general strategy rather than specific procedures. Further information is available in this document or the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines.***

5.1 The practitioner's right to withdraw their service

There are circumstances in which a psychologist may decide to terminate the agreement for provision of psychological services. The circumstances may be personal or professional.

The personal circumstances may include but will not be restricted to leaving employment in a psychological service, incidences of illness or family commitments.

The professional issues may relate to service structural changes, safety, or provision of most appropriate service.

In these circumstances, psychologists will, as far as possible, work to ease the transition of service provision and give as much notice as is practical in the particular situation.

5.2 Referrals

Where a psychologist finds themselves unable to come to an agreement with a client, the psychologist may refer the client to a suitably qualified colleague. Psychologists will both make and receive referrals when working in services with other professionals.

In making referrals, psychologists should consider the needs of the client and to the best of their knowledge refer to another professional with the appropriate skills and experience.

In receiving referrals, the psychologist should consider whether the referral is appropriate for psychology, establish the client's understanding of the purpose of the referral, and consider as far as possible prior to meeting the client whether the referral falls appropriately within their own areas of practice.

5.3 Representation of the qualifications and status of the psychologist

HCPC registration and BPS Chartered Status

Psychologists are encouraged to state their registration with the HCPC and protected title(s). This will provide assurance that the psychologist meets national standards of training and professional skills.

Use of the 'consultant' title

The term 'consultant' generally does not have a formal definition. Within the medical field it is used by doctors who have considerable experience and proven expertise demonstrated through examination within their respective Royal Colleges.

While there is no clear comparable grading structure for psychologists outside the NHS (within the NHS, the consultant title is used by psychologists who are employed in Band 8C, 8D and 9 positions), the use of this title would be seen to reflect both seniority and specialist expertise.

There is a difference between a 'consultant' psychologist and a psychologist who provides consultations in their context of practice. The Society expects that psychologists should be honest and accurate in representing their professional affiliations and qualifications, including such matters as knowledge, skill, training, education and experience.

The Society's position is that this would be applicable in any situation where expert knowledge or skills is being marketed or promoted, whether or not this is for financial gain. Further information is available in ***Society Document: Guidance on the use of the title 'Consultant Psychologist'.***

6. Obtaining informed consent

Psychologists should always ensure that they have sought and received the consent of those they work with, given of their own free will, without undue influence.

The concept of informed consent relates to the client's right to choose whether to receive psychological services, and to make this choice on the basis of the best information available presented in the most appropriate way. The principles apply, whether the psychologist works in the public, private or voluntary sector or in independent practice.

Psychologists should obtain the informed consent of the client in an appropriate manner prior to undertaking any assessment, intervention or research activities. In all circumstances, common sense and ethical practice should apply when considering the approach to gaining informed consent from those with whom the psychologist is working.

This section refers, in the main, to consent with adults with capacity. Further information on informed consent with discrete communities where further consideration may be needed is available in ***Sections 6.1 to 6.4***.

Obtaining informed consent involves a process which is dynamic and is relevant to the specific assessment, intervention or decision being made at that time. When there are substantive changes in the intervention or when the psychologist has reason to consider the client may no longer consent, consent should be reviewed. Psychologists should ensure that their clients are enabled to play an active role in this process. Clients should be encouraged to ask questions whenever they are in doubt.

Psychologists should be aware that a client's desire for help, and the immediate impact of the psychologist's supportive listening, may affect the client's ability to make informed choices about the help they wish to receive. They should also be aware that their own desires to help a client may bias their presentation of information, such as the probability of successful outcomes.

Psychologists should be aware of the complexities of obtaining informed consent to treatment due to the perceived power, status and authority of the professional psychologist. It may not be clear if the consent given is freely given by the client or, for example, is part of a pattern of compliance towards authority figures. Equally, a client may say that they understand the explanation given by the psychologist, and accept a plan for intervention, in order to avoid the discomfort of being seen not to understand the psychologist's complex language and ideas.

Obtaining informed consent is particularly difficult when the client is obliged to undertake the psychological intervention as part of an employment process or performance measure where they may have obligations under their employment contract; or when detained.

There should ideally be an ongoing dialogue between client and psychologist, as part of the process of joint decision-making. At any point, the client should feel free to ask questions about the impact of the treatment and withdraw consent to continue.

Psychologists should attempt to intervene against the express wish of a client only after careful consideration and in line with relevant legislation, policies and professional practice.

Provision of information for informed consent

In order to ensure that the client has all the information necessary to make an informed decision about whether to take part or not in a psychological activity, they must be provided with relevant information, such as that listed below, in a format that is designed to meet their specific needs.

The psychologist should consider providing information about the following:

- what the psychological activity involves, as far as this is consistent with the model of interaction, e.g. there will be limits in the use of some non-directive therapies and psychometric assessments;
- the benefits of the activity, either directly to the client in the case of assessment or intervention, or indirectly in the case of systemic intervention, or to potential theoretical advances or service improvement;
- any alternative assessment or treatment options and their known availability;
- foreseeable risks and how minor or serious they may be, for example the potential to feel worse at stages during therapeutic interventions;
- what might be the benefits and potential costs and risks to them of engaging or not engaging in the proposed psychological activity; and
- the client's right to withdraw their consent from assessment, treatment or intervention at any stage, along with information about any likely consequences of such withdrawal.

Consent to involvement of others

Psychologists have an obligation to ensure that prospective clients are informed of the extent and limitations of confidentiality with respect to anticipated services, the purposes of any assessment, the nature of the procedures to be employed or the intended uses of any product such as notes or recordings, before the assessment or intervention starts. Further information is available in ***Section 7: Managing data and confidentiality.***

The psychologist should ask the prospective client: whom they would wish to be informed of their assessment or treatment, if anyone; and the information they are willing to share where communication is essential, for example to the referring agent or organisation, management or court. Wherever appropriate, including in the law, the client should have copies of reports or letters or be given feedback so that they are kept fully informed.

If it is deemed necessary to move from individual contact to include others this should where possible be done with the client's prior consent.

Psychologists may be asked to provide consultancy or advice to colleagues about an identified client, without that person's knowledge or when the client has indicated that they do not want to have direct contact with the psychologist. In these circumstances, the psychologist will need to consider their potential involvement and the need for consent.

A psychologist who draws upon the work of other professionals in preparing a report, should seek their consent, where possible and if not already in disclosed records, to include that material and should acknowledge its source in the report.

If a report is requested which draws upon previous or concurrent investigations of a client in other contexts, for example NHS records in the preparation of a report for the court, the client's consent or relevant authority's consent for that information to be used should be sought.

If psychologists wish to use reports on clients which have been compiled by other professionals, they should do so only with the consent of those professionals and use the reports only in the context for which the report was specifically provided.

Information on and consent to record-keeping

Express consent must be sought in advance for the use of video, audio recording or one-way screens, with a clear explanation of the purpose of these. Further information is available in ***Section 7.1: Information governance***

6.1 Informed consent for court

When a psychologist is instructed to give evidence in court, it is the court that should be informed and whose authority should be sought for the work undertaken. When serving as a witness in the legal arena, the psychologist is responsible to the court, rather than to either party.

6.2 Informed consent with children and young people

All children and young people, whatever their age or status, have a right to express their views freely and be involved in any decision-making that affects their lives, which includes judicial and administrative proceedings[40]. Therefore, psychologists who seek to work with children or young people must gain their informed consent. This applies whether the child or young person or another agent with legitimate responsibility for the child or young person has made the request for involvement. Any direction or guidance provided by parents or other caregivers must be 'in accordance with the child's evolving capabilities' and support the 'exercise by the child of his or her rights'[41]. The onus is then on the adults to provide appropriate support to enable the child or young person to express their views and contribute to decision-making.

Every psychologist should consider how they can:

- provide an accessible explanation to the child or young person about their work as a psychologist;
- offer a clear reason for their possible involvement;
- provide an opportunity for the child or young person to talk about what working with the psychologist might involve.
- discuss and agree how information is recorded and possibly shared with others with an awareness that young people who are 'Gillick competent' can consent to information not being shared with parents;

- discuss how the child or young person will be kept safe;
- ensure that the child or young person has understood the psychologist's role and has given their informed consent;
- ensure the child or young person understands they can withdraw their consent at any point;
- ensure their practice acknowledges and respects the culture, community and context of the child or young person.

Occasionally, a disagreement over consent may arise between parent/carer and child or young person and/or between parents/carers. The psychologist would make every effort to resolve the difference of views, perhaps seeking, with agreement, involvement of an appropriate family member and/or a colleague, although as discussed above, a young person who is 'Gillick competent' can legitimately request that family members (including parents) are not involved or informed of any involvement. If the disagreement is not resolved, the psychologist should draw on their professional experience to act in the best interest of the child or young person seeking consultation and support through appropriate channels, including safeguarding and legal departments, and consultation with appropriate colleagues including other professionals.

6.3 Informed consent with people who may lack capacity

It is likely that psychologists at some stage within their careers will be working with people who lack capacity to consent to assessment or treatment. This could be because of a wide range of difficulties such as intellectual disability, brain injury, dementia, severe mental health difficulties, and neurological conditions. As a result, it will often be necessary to make a judgment about a client's ability to give informed consent. This should include whether the person is able to:

- understand the information relevant to the decision (e.g. psychological treatment);
- retain that information;
- use or weigh that information as part of the process of making the decision; and
- communicate their decision (whether by talking, using sign language or any other means.)

The Mental Capacity Act 2005 contains 5 key principles which it is important to understand:

1. A presumption of capacity;
2. Individuals being supported to make their own decisions;
3. Individuals have the right to make 'unwise' decisions;
4. Anything done on behalf of a person with a mental capacity issue should be in their best interests; and
5. An intervention should be on the basis of the 'less restrictive option' weighed up in the particular circumstances of the case.

The Mental Capacity Act Code of Practice[42] expands upon these points (and indeed all aspects of the Act), highlighting the need to assist a client in making a decision for

themselves (with the use, for example, of memory aids, simplified resources, etc.). It should also be noted that the fact that a person is able to retain the information relevant to a decision for a short period does not prevent them from being regarded as able to make the decision.

The Mental Capacity Act (2005) provides a clear framework for what to do if a person lacks capacity to make a range of decisions, including consenting to treatment. The principle of 'best interest' must be followed, and the Act states clearly who needs to be consulted in relation to making such a decision and ensuring that the individual's wishes are considered.

It is good practice to give full information (possibly using adapted resources) to clients even when they are not deemed able to give informed consent. The psychologist must, so far as reasonably practicable, permit and encourage the client to participate, or to improve their clients' ability to participate, as fully as possible in any act done for the client and in any decision affecting them.

In some circumstances, it is possible that there may be others who have been given legal authority for decision-making on behalf of others, such as Power of Attorney for Health and Welfare or Deputyships for Health and Welfare. It is important to note that patients might also have created Property and Affairs Lasting Powers of Attorney. Those acting under a Property and Affairs power alone will not have authority to make decisions in relation to a patient's treatment. If someone is a Health and Welfare Attorney or Deputy, those persons will be able to make those decisions on behalf of others. It is also necessary to ensure that the client has not made an Advance Decision to refuse treatment prior to the loss of capacity, although this is unusual in relation to psychological treatment.

In some clinical contexts, particularly relating to brain injury, intellectual disabilities and dementia, issues related to capacity and best interest are particularly prevalent. Psychologists practising in these areas need to ensure sufficient knowledge and expertise. Further information is available in ***Society Document: Guidance on determining the best interests of adults who lack the capacity to make a decision for themselves.***

6.4 Informed consent with people as employees

Tripartite arrangements where an employer commissions and pays for an assessment or intervention, such as diagnostic assessments for neurodiversity and cognitive functioning return to work assessments, or coaching, potentially give the employer access to data that they will struggle to interpret, or may misinterpret, for example test scores and details of personal life. It is important that the psychologist protects the employee by giving the employer only what they need to know and can reasonably require for the purpose of employment.

The Psychologist should consider whether they will be gathering information that is not usually held by an employer, or is not held routinely for all employees, for example IQ scores and childhood experiences. If so, the psychologist should consider abridging documentation so that the employer receives only the information they 'need to know',

and the employee can if necessary hold a full copy for future reference. This prevents discrimination against employees who are subject to in depth assessment for reasons related to illness, neurodiversity or disability from being unfairly compared to their peers. It also prevents complex psychological information from being held by those who are not qualified to interpret it.

Agreements should be made explicitly about the information which can be shared with the commissioning organisation. In order to aid transparency, information should normally be sent to the client prior to being shared with the organisation.

6.5 Informed consent with detained persons

Prisoners

Informed consent may be harder to obtain when a client is detained. Psychologists working with detained persons should be aware that, as well as UK law, the UK is signatory to a number of conventions on the treatment of detained persons. These conventions not only outlaw physical ill-treatment, but also certain kinds of psychological pressure. For example, it is contrary to the UN Convention on Torture to apply psychological pressure to elicit a confession, or compliance with a regime. In this context, 'psychological pressure' could include making progression contingent on compliance with a particular aspect of the regime. Practitioners should be particularly mindful of the power imbalance in forensic contexts, which is far more acute than is generally found in non-justice system based settings. Only offenders detained in secure hospitals can be required to comply with assessments or treatments under involuntary detention sections of the Mental Health Act.

Mental Health Detentions

For psychologists there can be potential conflicts of interest or what could be better termed 'competing duties of care' between the roles of Responsible Clinician (RC) (for further information on this role see Section 3.5) (including the duty to detain or otherwise compel participation in treatment) and that of psychologist (including, principally, the duty to establish freely-given consent wherever possible to enhance the efficacy of the therapeutic intervention). The MHA Code at chapter 24.34 (medical treatment) states that permission given by a patient to a particular treatment 'under any unfair or undue pressure' is not consent (p.257).

Good outcomes for psychological therapies are associated with positive therapeutic alliances and good working relationships between therapists and patients. The potential for even perceived abuse of power and the inherent power differential between an RC and a detained patient subject to the MHA runs a risk of rupturing this relationship or it becoming coercive. Psychologist RCs must therefore remain aware of and give full consideration to any potential competing duties of care between the RC and psychological therapist roles when providing psychological treatments to patients over whom they have compulsory powers.

The main issues to be considered by psychologist RCs when addressing potential competing duties of care in this context include the following:

1. Psychological treatments (with the possible exception of indirect interventions delivered by proxies such as paid staff and carers) are more likely to be effective when informed consent is obtained. As such, RCs acting as psychological therapists should utilise all reasonable and ethical attempts to obtain consent from patients before proceeding with psychological treatment. The *Code* at chapter 24.34–24.39 (p.257) provides guidance on obtaining consent.
2. The Act permits psychological treatment to be given without consent and the Code provides guidance on how to proceed with treatment in these circumstances (chapter 24.40–24.44, pp.257–258). There may be circumstances, especially when significant risks to others or self have been identified, when it is considered to be necessary for a psychologist RC to proceed with providing psychological treatment without consent. In such circumstances then there should be, where practicable, prior discussion with the MDT involved in the patient's treatment and care about the risks involved. Careful consideration should be given to the availability and merits of another suitably qualified member of the team providing the psychological treatment required with the RC remaining in overall charge of the client's care.
3. There may be situations where it is judged that informed consent cannot be clearly obtained, or where it would appear another available practitioner would be more likely to achieve a more effective outcome (perhaps due to the power differential between patient and RC). In such situations the psychologist RC is advised to refer on to other members of the treatment team who are able to provide the psychological treatment needed, while the RC remains in charge of overall care.

7. Managing data and confidentiality

7.1 Information governance

Psychologists should follow local and national guidance and statutory responsibilities regarding management of data. Psychologists should make, keep and disclose information in records only in accordance with national policy and legislation, and the policies and procedures of the organisation(s) they are employed by/working in collaboration with. Further information is available in ***Section 1.1: Legal and professional obligations of psychologists, Appendix 1: Relevant legislation*** and ***Appendix 2: Websites and further information.***

Psychologists must bear in mind the potential impact of the information in their records on all who may have access to such records, for example, the client, other professionals, managers, authorised carers, etc. Where possible, distinction should be made between fact, observation and opinion, and judgemental comments should be avoided. Psychologists are responsible for holding their records securely to ensure the confidentiality of the information contained within them and to control access to them. Further information is available in ***Society Guidance: Guidelines on the use of Electronic Health Records.***

This guidance applies to all record-keeping on clients, their relatives, carers and/or associates, and their organisations, regardless of the media in which information is held, e.g. written notes and reports, audio- and video-recordings, paper and electronic records, etc.

Records made, kept or accessed by psychologists should be:

- systematic and appropriately detailed;
- in clear language/format;
- accurate;
- up to date; and
- relevant to professional work and to the purpose for which they were collected.

Clients have a legal right to access records concerning them, and this right is enshrined in legislation. Additionally, it is good practice for clients to be given feedback on their content. Sharing records with clients supports the collaborative approach of psychologists and enables clients to have full and effective involvement. Client access to records will be restricted to information about themselves and not third parties. Restrictions will also apply when disclosure would place the clients or others at risk of serious harm.

In tripartite arrangements involving an employer access to information should be governed by agreements made explicitly about the information which can be shared with the commissioning organisation.

Shared records

In some organisations in which psychologists work single, multi-professional, client-based records are held. Such records are designed as shared documents (paper or electronic),

the function of which is primarily to facilitate inter-professional communication to ensure the safe and effective delivery of high quality services. Such records may be shared among organisations/agencies to facilitate care and/or exceptionally, to safeguard the client or others, including the general public. In some contexts, clients have the right to object to their data being disclosed to a third party even someone who might provide essential healthcare. Psychologists should be aware of local codes and policies. Further information is available in ***Section 3.5: Working with other professionals***, ***Section 7: Managing data and confidentiality*** and ***Appendix 2: Websites and further information.***

Psychologists should include in the shared record all information about their work with clients and related others which is required to ensure appropriate multi-professional care and to safeguard the client and relevant others, including the general public.

Third-party and sensitive material should be clearly marked. There should be clarity/clear communication within the multi-professional team about what is and is not shared with the client if there are safeguarding concerns. A system needs to be established about how suspicions and causes of concern are recorded and/or shared.

Where shared records are held, other professionals involved with the clients will have access to such records. This should be explained to the clients at the onset of engagement with them.

The use of sealed envelopes is no longer considered good practice following the findings from serious untoward incident investigations where the existence of sealed envelopes compromised care.

Assessment materials

Psychologists should be mindful at all times of the confidential nature of assessment materials. Many assessment measures are invalidated by prior knowledge of their specific content and objectives. Psychologists who use these materials are required to respect their confidentiality and to avoid their release into the public domain (unless this is explicitly allowed in the nature of the instrument and by the test publisher). Psychologists should, therefore, take reasonable steps to prevent misuse of test data and materials by others. Further information is available from ***Appendix 2: Websites and further information.***

In many organisations, there is only one shared records system. In these cases, it is necessary for psychologists to be able to use the shared records system to hold raw data from psychometric assessment. The results of psychometric assessment will be incorporated into reports which explain their context and appropriate interpretation, and which are included in the shared institutional record. In relation to the visibility of the psychometric instrument and the raw data to other members of the multidisciplinary team who are not psychologists, the onus is on the other professionals not to interpret information where they are unqualified to do so, just as the psychologist would not interpret, for example, physical healthcare test results they are unqualified to interpret. Psychologists may consider whether it is appropriate to mark assessment materials so their nature is clear.

Additional data

Psychologists may wish to keep separate notes to aid their work but which are not intended for sharing with others or to be part of the permanent client record. These notes, often called process notes, which are written for the purposes of reflection on practice, should be anonymised with no other identifying links e.g. initials, appointment time, so that these notes therefore are clearly not part of the client record. Process notes may, for example, be used for reflection and supervision. If process notes are made to assist in compilation of a report, the material should be incorporated, as relevant, into the final report and the process notes then destroyed.

Long-term illness, incapacity or death of a psychologist

Most organisations will have procedures in place in the event of illness, incapacity or death of a psychologist. Psychologists in independent practice are advised to make a professional will and to appoint a professional executor, probably an experienced colleague, whose role it would be to take charge of client records, to inform the clients involved and, where appropriate and practicable, to make provision for continuity of the service provided.

Retention and destruction of records

Psychologists' records should be held securely for as long as they are required for the purpose of psychological work. Psychologists must follow legal requirements, national and local policy frameworks and procedures regarding the retention or disposal of records after the psychologist's work is concluded. Psychologists should ensure that they keep up to date with requirements.

For independent practitioners general guidance is that many independent psychologists keep records relating to contact with adults for 7 years, and follow NHS guidance in relation to children. Where the records derive from work undertaken within an organisation, the maintenance of these records is determined by the organisation's policies and legal requirements.

Retention and destruction of health records, both paper and electronic, is covered in the NHS code of practice for records management. Generally speaking, retention is until age 26 for people seen as children; 20 years after the last contact for adults, and 8 years after death if the death occurred while the person was in the care of the NHS. There are specific requirements for mental health services depending on the nature of the contact.

In education settings, Local authorities generally retain Education Health and Care Plans for 35 years after the case has been closed. Other records are retained until the child is 25.

All records must be destroyed under confidential conditions following organisational procedures or for independent practitioners using a destruction service or process which meets industry standards for document management and can provide the appropriate certification.

7.2 Confidentiality

Clients are entitled to expect that the information they give to psychologists about themselves and others will remain confidential. Psychologists have a duty not to disclose

such information except as discussed below and to bring their confidentiality practice to the attention of their clients, employers, managers and any other professionals involved.

Psychologists have a duty to inform involved parties of their confidentiality standards and practice at the point of first contact. Clients should be informed of the limits of confidentiality where information about them may be shared and confidentiality breached, for example for reasons of safeguarding, requirements of the law, and public protection.

Psychologists have a duty to be aware of the content of any other relevant guidelines and of any other policy guidelines which set out local expectations.

Use of client data for audit must follow the Caldicott principles, which, designed for the NHS, provide helpful guidance for any setting in terms of when it is appropriate to use with client-identifiable data and when anonymised data should be used[43]. Generally under data protection legislation, it is necessary to obtain specific informed consent for the use of client data for particular purposes, and to inform clients of the purposes for which their data is being collected and how it will be used. Further information is available in ***Appendix 2: Websites and further information.***

Disclosure of information

If disclosure of information is deemed necessary, psychologists should obtain specific informed consent from their clients, making the consequences of disclosure as clear and unbiased as possible. There are a number of circumstances where this might not be possible or may not apply: for example where the health, safety, security or welfare of the client or someone else may otherwise be put at risk; and if there are legal or safeguarding responsibilities, such as the need to avoid 'tipping off'. If confidentiality is broken without consent, the client should be told what has been said and to whom, unless such disclosure may expose the client or others to serious harm or is contrary to legal or safeguarding obligations.

Psychologists who are faced with the difficult decision as to whether to disclose information without a client's consent must weigh carefully the arguments for and against disclosure. The responsibility for this decision lies with the individual psychologist although they may seek advice and guidance from appropriate sources such as their employing organisation's Information Governance or Data Protection Lead, Clinical Governance Lead, Caldicott Guardian, Safeguarding named and designated professionals, or legal departments. These other professionals can be the most helpful sources of advice in difficult disclosure situations. Independent practitioners may wish to consult the legal helpline of their professional indemnity insurer.

Circumstances may emerge where clients may present a risk to others or to themselves, or be at risk from others whom they wish to protect. It is then necessary to discuss the importance of disclosure and to encourage it, for example to partners of HIV positive clients, and to employers if a client's mental health status presents a risk to others via driving, handling machinery or interaction in a working situation, for example, flight deck crew. Disclosure without consent, or against the client's expressed wish may be necessary in situations in which failure to disclose appropriate information would expose the client, or

someone else, to a risk of serious harm (including physical or sexual abuse) or death.

The psychologist must weigh up the needs and interests of their own client against the wider welfare, protection and safeguarding of the public.

Disclosure to clients' employers, insurance companies and others

Psychologists have a duty to ensure, at first contact, that clients understand the purpose of any assessment undertaken at the request of employers, the DVLA or insurance companies, and of the psychologist's obligation to disclose the results of that assessment. In the case of assessment for fitness to work or to drive, they should obtain the client's written consent.

Psychologists should consider what each party involved needs to know, gaining understanding and agreement on which aspects will be fed back, in advance. For example, the full detailed and raw scores obtained by a psychologist in recruitment assessment processes may be unsuitable for an employer to receive in full. The commissioning body should be made aware of the decision-making data that they originally requested, in the case of an employer this could include strengths and weaknesses, and recommendations for employer actions, for example.

Primary clients should be advised about and able to preview, with opportunity to ask questions first, any data that will be sent to an employer about them. Bear in mind that the informed consent difficulties still stand and that an employee or potential employee can withdraw consent for the employer to be informed of any part of their results.

This can be very difficult to manage in practice, and requires psychologists to make these agreements with their commissioners before they start the work, so that all are informed of the risks in the service delivery. Further information is available in ***Section 3.4: Working with multiple clients.***

Disclosure after a client's death

After a client's death, relatives or other authorities may seek access to the psychologist's records. In the first instance, the psychologist is advised to follow organisational procedures where they exist which usually deal with the administrative proofs required such as proof of death, proof of kinship and right to access the material requested.

A psychologist's duty of confidentiality continues after a client has died. The psychologist will need to weigh up the circumstances around the request for disclosure and what personal information is being sought. If there has been a specific request by the client for their information to remain confidential, their wishes should usually be respected. If the psychologist is unaware of any instructions from the client, when considering requests for information the following should be taken into account:

- the purpose of the disclosure;
- whether the disclosure of information is likely to cause distress to, or be of benefit to, the client's partner or families;
- the permission of a surviving relative or next of kin is not required, and does not authorise disclosure of confidential information, although the views of those who were close to the client may help the psychologist decide if disclosure is appropriate;

- whether the disclosure will also disclose information about the client's family or anyone else; and
- whether the information is already public knowledge or can be anonymised or coded.

There may be circumstances where the disclosure of information is required, for example:
- to support an inquest or fatal accident inquiry;
- where the disclosure is required by law, is authorised under section 251 of the NHS Act 2006, or is justified in the public interest, such as for education or research;
- in the case of national confidential inquiries or for local clinical audit; and
- when a person has a right of access to records under the Access to Health Records Act 1990 or Access to Health Records (Northern Ireland) Order 1993.

7.3 Confidentiality when safeguarding

In exceptional circumstances it may be necessary to breach the client's confidentiality with or without their immediate knowledge or consent. This would be the case where there are significant risks to the client's psychological wellbeing; where the alleged perpetrator may be a current risk to others or where there is risk of jeopardising a potential investigation. Any decision to breach confidentiality cannot be taken lightly, but can be justified and accounted for if made in good faith because of safeguarding concerns. This is supported by professional guidance. The focus of any intervention including any breach of confidentiality must be on promoting a proportionate, measured approach to balancing the risk of harm with respecting the client's capacity to consent, their choices and preferred outcome for their own life circumstances.

Specified authorities may need to share personal information to ensure, for example, that a person at risk of radicalisation is given appropriate support. When considering sharing personal information, the specified authority should take account of the following:
- necessity and proportionality: personal information should be shared only where it is strictly necessary to the intended outcome and proportionate to it. Key to determining the necessity and proportionality of sharing information will be the professional judgement of the risks to an individual or the public;
- consent: wherever possible the consent of the person concerned should be obtained before sharing any information about them;
- power to share: the sharing of data by public sector bodies requires the existence of the power to do so, in addition to satisfying the requirements of the Data Protection Act 1998 and the Human Rights Act 1998; and
- Data Protection Act and the Common Law Duty of Confidentiality: in engaging with non-public bodies, the specified authority should ensure that they are aware of their own responsibilities under the Data Protection Act and any confidentiality obligations that exist.

In relation to health sector staff, government guidance states it is important that staff understand how to balance client confidentiality with the duty to report. They should also be made aware of the information-sharing agreements in place for sharing information with other sectors, and get advice and support on confidentiality issues when responding

to potential evidence that someone is being drawn into terrorism, either during informal contact or consultation and treatment.

7.4 Confidentiality for the court

Psychologists acting as expert or professional witnesses have a duty to disclose all of the evidence used to reach their opinion where directed by the court to do so.

This could include:

- the details of any tests and assessments administered with professional colleagues;
- notes made during report writing; and
- referenced academic articles or studies.

No information relating to an assessment or report should be disclosed outside the relevant proceedings without agreement. Psychologists should normally seek permission from the instructing party to disclose any information to another health care professional.

Where instructed directly by the court, the Crown Prosecution Service, Procurator Fiscal or a solicitor, the psychologist is required to report or comment on any or all aspects of the case that appear to the psychologist, as an expert in the field, to be relevant or pertinent. In such circumstances, the psychologist is not in a position to offer confidentiality to any person, and should make this position clear to any party with whom they have contact during psychological investigations or assessment.

In these circumstances, it will be important that the psychologist makes sure they are up to date with the legislation and policy guidance regarding public and media access to information available to whichever court or tribunal their instruction arises from. The psychologist will need this awareness so that they can explain to the adult or child concerned what the limits of privacy are in these legal circumstances. They will need to make clear to the client which information needs to be made accessible, by whom and under what circumstances. Only when the client understands this, can they give informed consent.

There are different levels of access to sensitive information in different legal contexts; this will include testimony, documents and professional and expert reports. Many proceedings typically take place in open court, to which the public has access. In these cases, there is a presumption in favour of providing information and documents to third parties which were relied upon by the court in reaching its decision, though not the entire court file.

Where court papers and other materials are received in electronic format, psychologists should ensure that these are stored in a secure, password-protected format. This may require the addition of additional security for documents that arrive in an unsecured form. Where psychologists submit reports in an electronic format they should ensure that these are in a secure, password-protected format.

Psychologists working with clients who are the subject of court proceedings may need to be careful to ensure that they keep all records which may be of relevance to the court process until it is clear that the court has reached a final conclusion, including any appeal that may have been heard.

With few exceptions, applications in the family court are heard in private, with only those immediately involved being allowed to attend and access information. It is possible, however, for duly accredited members of the media to attend hearings in the family court, subject to the power to exclude them on specified grounds.

In most family court proceedings, media representatives have no entitlement to receive or peruse court documents referred to in the course of evidence, submissions or judgment. If media representatives wish to see documents referred to in the family court they may apply to the judge for disclosure but they are subject to strict guidance in terms of what information they can divulge into the public domain.

7.5 Confidentiality with children and young people

When beginning direct work with a child or young person, the psychologist should discuss and agree who will have access to the information arising from the work, with direct reference to principles of 'Gillick competence'. In undertaking this discussion it is helpful to acknowledge that there may be those adults (e.g. parents/carers, other relevant professionals such as teachers, social workers, counsellors) who may have a supportive interest in the work and may wish to have appropriate access to information but the wishes of a 'Gillick competent' young person should take precedence unless there are safeguarding concerns.

Parents or those with legal responsibility may be made aware of this agreement if appropriate, although a young person deemed to be Gillick competent is able to agree to work with a psychologist independently. Those with parental responsibility do not have an automatic right of access to the psychologist's records by making a subject access request under data protection legislation.

The nature and purposes of any work will vary and this will determine how and to whom information will be shared, however the child or young person should always be made aware of who will have access to what and for what purpose and due consideration given to the wishes of a 'Gillick competent' young person about who can have access to information about any involvement with a psychologist. The child or young person should be fully aware of the content of any shared information, including as appropriate, copies of the documents. Whatever is agreed about information sharing including work where information is confidential, the psychologist must ensure the child or young person knows and understands that if there is a risk of harm the psychologist must follow safeguarding procedures.

7.6 Confidentiality with detained persons

When detained persons give informed consent to the collection of information, they do so for a specific purpose and for use by specific people. The use of such information for a different purpose or for use by different people would require separate consent. Thus, although a psychologist may interview and write a report on a detained person, consent for that purpose cannot be taken as allowing a third party access to the psychologist's records on that person, such as notes on (or recordings of) the interview. If psychologists are

put under pressure to reveal such information, they should seek the advice of colleagues including for example those responsible for governance or data protection. They should bear in mind that they have a legal duty to be aware of and comply with data protection legislation and professional confidentiality rules.

7.7 Confidentiality obligations during training

During training, no academic/training documents should identify clients to whom they relate (even by means for example of initials, service name or date of appointment) as any such potential identifiers could be used to trace the client and therefore make the document a part of the clinical record and subject to the relevant provisions of data protection legislation. This includes published reports, case studies prepared for trainee assessments and any articles or publications. Tutors and supervisors should communicate this to their trainees. Trainees should be clearly instructed to both make and keep separately those records which are part of the provision of psychological service and which belong to the service organisation and are subject to its policies and procedures; and papers which are anonymised and are part of the trainee's academic learning, and belong to the trainee and are subject to the training provider's policies and procedures.

Express consent should be obtained by trainees before audio- or video-recording their interactions with clients. If the client is unable to give informed consent, it is unlikely to be appropriate for the recording to be made. Careful consideration should be given before any material is recorded if the client is party to any legal proceedings or family or employment disputes. If material is to be used for purposes other than client care (including teaching and research), the client should be informed of the purposes of the recording. It should be made clear to clients how the material will be used and to whom it will be disclosed, for example, trainee students, other researchers, and supervisors.

The trainee and the client should come to an agreement about how long recorded material should be kept. The general principle is that recordings will be kept for as long as needed to fulfil the purpose for which the client has given consent and no longer. The security of the material must be maintained, and it must be destroyed at the agreed time limit if no longer required.

Informed consent is required before client material in an identifiable format may be published in case studies, presentations or other research reports. It is becoming common practice for clinical material in professional doctorate portfolios to be stripped out before the thesis is placed in online institutional repositories.

8. How to respond when things go wrong

8.1 Managing conflict with a client

Conflict with a client suggests that someone's expectations are not being met. The first objective should be to restore agreement or agree to make changes. The well prepared psychologist will have a client agreement in place and will be able to review the experience against the agreement with the client to address this question. Further information is available in ***Section 5: Making and maintaining agreements***. Even in the absence of an agreement, the psychologist would be advised to enquire with the client where their expectations are unmet or raise their own unmet expectations with the client. This can be an opportunity to put a belated agreement in place.

It may be that the parties agree to set aside the agreement and bring it to an early close. Agreeing to disagree may be a better outcome for psychologist and client who cannot restore agreement. Take account of any need for onward referral either within the service or elsewhere or back to the original referrer, and depending on the nature of the work setting, any financial obligations in closing the work.

The psychologist may find it helpful to consult with appropriate colleagues in preparation for the conversations with the client, such as line or service managers, those with other relevant organisational responsibilities, and supervisors. There may be more general lessons to be drawn as part of reflective practice in relation to the quality of the client agreement for future use.

8.2 Transparency and duty of candour

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 duty of candour (regulation 20) requires all health and adult social care providers registered with the Care Quality Commission to be open with people when things go wrong. Psychologists need to be aware of the terminology relating to this regulation including:

- openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered;
- transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators; and
- candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Psychologists also have a responsibility to ensure that they engage in open and transparent communications with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. Guidance from the Care Quality Commission on duty of candour outlines the specific requirements that providers must follow when things go wrong with care and treatment, including informing people about

the incident, providing reasonable support, providing truthful information, and making an apology. Psychologists are instrumental in supporting organisations to promote a culture that encourages candour, openness and honesty at all levels. Further information is available in ***Appendix 2: Websites and further information.***

8.3 Managing conflict in team settings

Dealing with breakdowns in working relationships, professional disagreements and fitness to practise concerns

As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues (including relating to consultation/supervision or line management) by clear communication, relevant evidence and collaboratively working through the issues in reasoned argument within the context of respectful relationships.

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

Where there is serious or continual disagreement, both parties need to take whatever action is appropriate in their professional context, consulting other experienced professionals as necessary.

Supervisors and line managers have professional obligations concerning professional standards, ethical practice and 'fitness to practise' issues. If line managers or supervisors have any concerns regarding performance in these areas, they have a duty to discuss these with the psychologist and, if necessary, address the matters by in the first instance following appropriate employment policies and procedures, or in the case of an independent practitioner, making a report to the HCPC.

Working in multi-professional or multi-agency contexts

Psychologists may find themselves in conflict with the approaches to work taken by other individual colleagues or by the multi-professional team or agency.

Psychologists should bring to the awareness of the multi-professional team or agency any difficulty in the group working together which may impact on the psychologist's ability to function effectively and ethically in their role. Such issues are best addressed when guided by national and local policy and current legislation before proceeding with multi-professional/multi-agency collaboration. Further information is available in ***Appendix 1: Relevant legislation.***

The psychologist may also have cause for concern about the ability of the team to provide for the needs of the client owing to interpersonal difficulties between members of the multi-agency or multidisciplinary team that might have an indirect impact on the client. As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues by clear communication, relevant evidence and collaboratively

working through the issues in reasoned argument within the context of respectful relationships.

If the situation remains unresolved for any reason, for example because it is judged not to be an issue for active management, the psychologist must make a judgement about whether their involvement in the team is helpful to the client or the working of the team. If not, the psychologist should consult with an appropriate colleague about whether they should disengage from that team.

A psychologist may also experience concerns about the competence or ethical practice of individual colleagues involved in joint working. These concerns may relate to the competence of the colleague to carry out a particular intervention, the appropriateness of an intervention for a particular client or problem, the nature of the relationship between a colleague and his or her client (e.g. potential abuses of power).

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

If they conclude that misconduct has occurred, psychologists should bring the matter to the attention of those charged with the responsibility to investigate such concerns, generally in the first instance an employer or in the case of an independent practitioner, the HCPC. Further information is available in ***Section 2.1: Working environment.***

8.4 Supporting a colleague when a complaint has been made

The receipt of a complaint or allegation can be distressing for all concerned, not least for the person who is the subject of the complaint or allegation. It is important that they receive advice and support from appropriate persons. Any potential conflicts of interest should be considered. It may be that a psychologist is not best placed to offer support and guidance as they may be called as a witness in the complaints process. Encourage colleagues to seek advice from an experienced colleague or supervisor where appropriate.

The psychologist should also be encouraged to seek the support of an accredited workplace trade-union representative who is skilled at supporting people in these situations and can access legal advice if necessary. Legal advice can also be obtained from the professional indemnity insurance broker, and sometimes from household insurance policies where the householder has taken out the legal advice additional option.

Complaints are an increasingly normal occurrence and must be handled in a professional manner. The complaint investigator or professional body will need the psychologist's version of events and any evidence before any conclusions are reached. Psychologists should support colleagues to respond promptly, objectively, factually and honestly to the complaint. The content of the complaint should always be held in confidence.

8.5 If the client remains unhappy

If any conflict or issue as referred to in this section cannot be resolved, it may be appropriate to advise a client or other individual that that they have a right to raise any concerns about a psychologist with the Health and Care Professions Council, further details of which can be found at www.hcpc-uk.org

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Role	Name
Chair of the Practice Guidelines Working Group	Nicola Gale
Academics, Researchers and Teachers in Psychology	Simon Goodson
Children, Young People and their Families	Katie Hunt
Clinical Psychology	Tejinder Kondel and Ste Weatherhead
Coaching Psychology	Paul Philipps
Community Psychology	Ho Law
Counselling Psychology	Helen Nicholas
Crisis, Disaster & Trauma	John Durkin
Defence and Security	Fiona Butcher and Karen Carr
Education and Child Psychology	Charmian Hobbs
Ethics	Martin Fisher
Expert Witness Advisory Group	David Crighton
Forensic Psychology	Robert Forde
Health Psychology	Andrew Haig-Ferguson
Independent Practice	Sonya Wallbank and Jill Wilkinson
Informatics	Graham Fawcett
Intellectual Disabilities	Kate Theodore
Mental Capacity Advisory Group	Gemma Gray

Role	Name
Mental Health Act Advisory Group	John Taylor
Neuropsychology	Katherine Carpenter
Northern Ireland	Alison Clarke
Occupational Psychology	Nancy Doyle, Julie Freeborn, Almuth McDowell and Rainer Kurtz
Older People	Carolien Lamers
Prevent	Clare Fuller
Psychology of Sexualities	Jimmy Couzens
Psychotherapy	Ho Law
Race and Culture	Zenobia Nadirshaw
Safeguarding Advisory Group	Gill Evans, Liz McMonagle and Anne Peake
Scotland	Louise Richards
Social Inclusion	Anna Daiches
Sport and Exercise Psychology	Lee Ann Sharp
Wales	Nicola Massie
Experts by Experience	Joanne Hemmingfield and Simon Mudie
Legal Support	Stephen Pearson, Freeths LLP
Administrator	Emma Smith
Editorial Support	Sally Anderson
Policy Advisor (Professional Practice)	Hannah Farndon

Appendix 1 – Relevant legislation

Unless otherwise stated, Acts can be found on the government website http://www.legislation.gov.uk/

United Kingdom and England

Care Act 2014

An Act to make provision to reform the law relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding adults from abuse or neglect; to make provision about care standards; to establish and make provision about Health Education England; to establish and make provision about the Health Research Authority; to make provision about integrating care and support with health services; and for connected purposes.

Care Standards Act 2000

An Act to establish a National Care Standards Commission; to make provision for the registration and regulation of children's homes, independent hospitals, independent clinics, care homes, residential family centres, independent medical agencies, domiciliary care agencies, fostering agencies, nurses agencies and voluntary adoption agencies; to make provision for the regulation and inspection of local authority fostering and adoption services; to make provision for the registration, regulation and training of those providing child minding or day care' to make provision for the protection of children and vulnerable adults; to amend the law about children looked after in schools and colleges.

Children Act 1989

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Children and Families Act 2014

An Act to make provision about children, families, and people with special educational needs or disabilities; to make provision about the right to request flexible working; and for connected purposes.

Data Protection Act 1998

An Act to make new provision for the regulation of the processing of information relating to individuals, including the obtaining, holding, use or disclosure of such information. The Act states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- fairly and lawfully processed;

- processed for limited purposes;
- adequate, relevant and not excessive;
- accurate and up to date;
- not kept for longer than is necessary;
- processed in line with your rights;
- secure; and
- not transferred to other countries without adequate protection.

Equality Act 2010

An Act to make provision to require Ministers of the Crown and others when making strategic decisions about the exercise of their functions to have regard to the desirability of reducing socio-economic inequalities; to reform and harmonise equality law and restate the greater part of the enactments relating to discrimination and harassment related to certain personal characteristics; to enable certain employers to be required to publish information about the differences in pay between male and female employees; to prohibit victimisation in certain circumstances; to require the exercise of certain functions to be with regard to the need to eliminate discrimination and other prohibited conduct; to enable duties to be imposed in relation to the exercise of public procurement functions; to increase equality of opportunity; to amend the law relating to rights and responsibilities in family relationships; and for connected purposes.

Health and Social Care Act 2012

An Act to establish and make provision about a National Health Service Commissioning Board and clinical commissioning groups and to make other provision about the National Health Service in England; to make provision about public health in the United Kingdom; to make provision about regulating health and adult social care services; to make provision about regulating health and social care workers; to make provision about public involvement in health and social care matters, scrutiny of health matters by local authorities and co-operation of health care services; to make other provision about information relating to health or social care to make other provision about health care; and for connected purposes.

Mental Capacity Act 2005

An Act to make new provision relating to persons who lack capacity; to establish a superior court of record called the Court of Protection in place of the office of the Supreme Court called by that name; to make provision in connection with the Convention on the International Protection of Adults signed at the Hague on 13th January 2000; and for connected purposes.

Mental Health Act 1983 as amended 2007

An Act to consolidate the law relating to mentally disordered persons. The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

Offender Rehabilitation Act 2014

An Act to make provision about the release, and supervision after release, of offenders; to make provision about the extension period for extended sentence prisoners; to make provision about community orders and suspended sentence orders; and for connected purposes.

Official Secrets Act 1989

An Act to replace section 2 of the Official Secrets Act 1911 by provisions protecting more limited classes of official information.

Regulation of Investigatory Powers Act (RIPA) 2000/Investigatory Powers Act 2016

An Act to make provision for and about the interception of communications, the acquisitions and disclosure of data relating to communications, the carrying out of surveillance, the use of human intelligence sources and acquisitions of the means by which electronic data protected by encryption or passwords may be decrypted or accessed; equipment interference, bulk personal datasets and other information; to make provision about the treatment of material held as a result of such interception, equipment interference or acquisition or retention; to establish the Investigatory Powers Commissioner and other Judicial Commissioners and make provision about them and other oversight arrangements; to make further provision about investigatory powers and national security; to amend sections 3 and 5 of the Intelligence Services Act 1994.

Safeguarding Vulnerable Groups Act 2006

An Act to make provision in connection with the protection of children and vulnerable adults. Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.

Northern Ireland

Children Act 1989 – NI has a Criminal Justice Children's Order 1998

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Criminal Justice (Northern Ireland) Act 2013

An Act to amend the law relating to sex offender notification, sexual offences prevention orders and human trafficking; to provide for the destruction, retention, use and other regulation of certain fingerprints and DNA samples and profiles; to provide for the release on license of persons detained under Article 45(2) of the Criminal Justice (Children) (Northern Ireland) Order 1998.

Criminal Justice (Northern Ireland) Order 2008 and Public Protection Arrangements in Northern Ireland (PPANI)

The Criminal Justice (NI) Order 2008 introduced a new sentencing framework, including extended and indeterminate sentences for public protection to reduce the risk of dangerous sexual and violent offenders being released into the community until the risk they pose is considered by the parole commissioners to be at a manageable level. The Public Protection Arrangements in Northern Ireland (PPANI) contained within the Criminal Justice (NI) Order 2008, place a duty on a number of agencies, within the criminal justice sector and elsewhere, to cooperate in the interest of better assessment and management of risk posed by serious sexual and violent offenders.

Justice Act (Northern Ireland) 2015

An Act to provide for a single jurisdiction for county courts and magistrates' courts; to amend the law on committal for trial; to provide for prosecutorial fines; to make provision in relation to victims and witnesses in criminal proceedings and investigations; to amend the law on criminal records and live links; to provide for violent offences prevention orders; to make other amendments relating to the administration of civil and criminal justice; and for connected purposes.

Mental Capacity Act (Northern Ireland) 2016

This Act fused mental health and mental capacity law into a single piece of legislation. The Act provides a framework for broader decision-making which includes: a statutory presumption of capacity, a requirement to support decision-making, mechanisms to allow individuals to plan for times that they do not have capacity, and safeguards to protect the rights of individuals when compulsory interventions or substitute decisions are required. It will remove the ability for someone to be treated for a mental health condition against his or her wishes if he or she retains the capacity to refuse such treatment, thus putting it on a par with the rights that individuals currently enjoy to make decisions regarding physical health treatment.

The Parole Commissioners' Rules (Northern Ireland) 2009

The Parole Commissioners for Northern Ireland are an independent body responsible for making decisions on the release and recall of prisoners sentenced to life, indeterminate custodial sentences, and extended custodial sentences, as well as the recall of prisoners serving determinate sentences.

The Sexual Offences (Northern Ireland) Order 2008

The Sexual Offences (Northern Ireland) Order 2008 lowered the age of sexual consent from 17 to 16 and incorporated significant changes to the law in relation to sexual offences in Northern Ireland; better protection for young people and people with a mental disorder from sexual abuse and exploitation; and sought to clarify issues surrounding consent in sexual assault cases and rape.

Scotland

Adoption and Children (Scotland) Act 2007

An Act of the Scottish Parliament to restate and amend the law relating to adoption; to make other provision in relation to the care of children; to enable provision to be made in relation to allowances in respect of certain children; and for connected purposes.

Adults with Incapacity (Scotland) Act 2000

An Act of the Scottish Parliament to make provision as to the property, financial affairs and personal welfare of adults who are incapable by reason of mental disorder or inability to communicate; and for connected purposes.

Adult Support and Protection (Scotland) Act 2007

An Act of the Scottish Parliament to make provision for the purposes of protecting adults from harm; to require the establishment of committees with functions relating to the safeguarding of adults who are at risk of harm; to amend the law relating to incapable adults; to allow the Public Guardian to intervene in court proceedings; to amend the law relating to mentally disordered persons; and for connected purposes

Children (Scotland) Act 1995

An Act to reform the law of Scotland relating to children, to the adoption of children and to young persons who as children have been looked after by a local authority; to make new provision as respects the relationship between parent and child and guardian and child in the law of Scotland; to make provision as respects residential establishments for children and certain other residential establishments; and for connected purposes.

Children and Young People (Scotland) Act 2014

An Act of the Scottish Parliament to make provision about the rights of children and young people; to make provision about investigations by the Commissioner for Children and Young People in Scotland; to make provision for and about the provision of services and support for or in relation to children and young people; to make provision for an adoption register; to make provision about children's hearings, detention in secure accommodation and consultation on certain proposals in relation to schools; and for connected purposes.

Mental Health (Scotland) Act 2015

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

Mental Health (Care and Treatment) (Scotland) Act 2003

An Act of the Scottish Parliament to restate and amend the law relating to mentally disordered persons; and for connected purposes.

Protection from Abuse (Scotland) Act 2001

An Act of the Scottish Parliament to enable a power of arrest to be attached to interdicts

granted to protect individuals from abuse; to regulate the consequences of such attachment; and for connected purposes.

Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005

An Act of the Scottish Parliament to make it an offence to meet a child following certain preliminary contact and to make other provision for the purposes of protecting children from harm of a sexual nature, including provision for implementing in part Council Framework Decision 2004/68/JHA; and to make further provision about the prevention of sexual offences.

Protection of Vulnerable Groups (Scotland) Act 2007

An Act of the Scottish Parliament to bar certain individuals from working with children or certain adults; to require the Scottish Ministers to keep lists of those individuals; to make further provision in relation to those lists; to establish a scheme under which information about individuals working or seeking to work with children or certain adults is collated and disclosed; to amend Part 5 of the Police Act 1997; to amend the meaning of school care accommodation service in the Regulation of Care (Scotland) Act 2001; and for connected purposes

Public Bodies (Joint Working) (Scotland) Act 2014

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

Regulation of Care (Scotland) Act 2001

An Act of the Scottish Parliament to establish the Scottish Commission for the Regulation of Care and the Scottish Social Services Council; to make provision for the registration and regulation of care services and for the registration, regulation and training of social service workers; to enable local authorities to provide and maintain residential accommodation in which nursing is provided; to make further provision as respects persons who have been looked after by local authorities; to amend the definition of 'place of safety' in the Children (Scotland) Act 1995.

Smoking, Health and Social Care (Scotland) Act 2005

To amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council, the provision of information to the Council and the minimum frequency of inspection of care services by the Commission to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to amend the Public Health (Scotland) Act 1897 to introduce a right of appeal in certain cases under that Act; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland

Social Care (Self-directed Support) (Scotland) Act 2013

An Act of the Scottish Parliament to enable local authorities to provide support to certain carers; to make provision about the way in which certain social care services are provided by local authorities; and for connected purposes.

Vulnerable Witnesses (Scotland) Act 2004

An Act of the Scottish Parliament to make provision for the use of special measures for the purpose of taking the evidence of children and other vulnerable witnesses in criminal or civil proceedings; to make provision about the admissibility of expert psychological or psychiatric evidence as to subsequent behaviour of the complainer in criminal proceedings in respect of certain offences to make provision about the admissibility of certain evidence bearing on the character, conduct or condition of witnesses in proceedings before a sheriff relating to the establishment of grounds of referral to children's hearings; to abolish the competence test for witnesses in criminal and civil proceedings; and for connected purposes.

Wales

The Mental Health (Wales) Measure 2010

This measure places new legal duties on local health boards and local authorities in Wales in relation to the assessment and treatment of mental health problems. The Measure became law in December 2010 and there are 4 parts to it which are as follows:

- Part 1 ensures that there are more mental health services are available within primary care.
- Part 2 makes sure all patients in secondary services have a Care and Treatment plan.
- Part 3 enables all adults discharged from secondary services to refer themselves back to those services.
- Part 4 supports every in-patient to have help from an independent mental health advocate if wanted.

Social Services and Well-being (Wales) Act 2014

An Act of the National Assembly for Wales to reform social services law; to make provision about improving the wellbeing outcomes for people who need care and support and carers who need support; to make provision about co-operation and partnership by public authorities with a view to improving the wellbeing of people; to make provision about complaints relating to social care and palliative care; and for connected purposes.

Violence against women, Domestic Abuse and Sexual Violence (Wales) Act 2015

An Act of the National Assembly for Wales to improve arrangements for the prevention of gender-based violence, domestic abuse and sexual violence; to improve arrangements for the protection of victims of such abuse and violence; to improve support for people affected by such abuse and violence; and to require the appointment of a National Adviser on gender-based violence, domestic abuse and sexual violence.

Well-being of Future Generations (Wales) Act 2015

An Act of the National Assembly for Wales to make provision requiring public bodies to do things in pursuit of the economic, social, environmental and cultural wellbeing of Wales in

a way that accords with the sustainable development principle; to require public bodies to report on such action; to establish a Commissioner for Future Generations to advise and assist public bodies in doing things in accordance with this Act; to establish public services boards in local authority areas; to make provision requiring those boards to plan and take action in pursuit of economic, social, environmental and cultural wellbeing in their area; and for connected purposes.

Appendix 2 – Websites and further information

British Psychological Society – www.bps.org.uk

The Society website has guidance, advice and further information on many topics not covered in these guidelines as well as those mentioned.

Psychologists working in clinical fields will also need to take account of Clinical Guidelines produced by NICE in England and Wales https://www.nice.org.uk/ or SIGN in Scotland http://www.sign.ac.uk/

1.1 Legal and professional obligations of psychologists

HCPC – http://hcpc-uk.org
The Health and Care Professions Council website has lots of information about professional registration including the standards of proficiency for the seven protected titles and information about indemnity insurance

Information Commissioner's Office – https://ico.org.uk/
The ICO website contains lots of useful information for organisations, private practitioners and the public regarding the rights and responsibilities under the data protection and Freedom of Information Acts.

DBS Checks – https://www.gov.uk/disclosure-barring-service-check
The government website provides helpful information for employers regarding these checks.

1.2 Continuing professional development

The HCPC has provided guidance regarding CPD for registrants. http://www.hcpc-uk.org/cpd

2.1 Working environment

Lone Working

Suzy Lamplugh Trust – http://www.suzylamplugh.org/

The Suzy Lamplugh Trust campaigns for personal safety and has lots of advice for people working alone to help to keep safe. They have some good advices and resources available.

Harassment and Bullying

ACAS – http://www.acas.org.uk/
The Advisory, Conciliation and Arbitration Service (ACAS) is a statutory organisation providing help and advice for employers and employees. They have produced guidance on several topics including harassment and bullying aimed separately at employers and employees.

Whistleblowing

Whistleblowing for employees – https://www.gov.uk/whistleblowing

The government has produced some guidance for employees surrounding whistleblowing including what to do and what to expect.

2.2 Working in the digital age

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – http://www.hhs.gov/hipaa/

This American act makes provisions for health information privacy. The government website provides information for professionals regarding this act.

N.B This Act is ONLY law for practice in America.

Social Media

The HCPC has provided guidance regarding the use of social media by professional psychologists.

http://www.hcpc-uk.org/Assets/documents/100035B7Social_media_guidance.pdf

3. Safeguarding

Statutory guidance Working together to safeguard children – https://www.gov.uk/government/publications/working-together-to-safeguard-children–2
Statutory guidance on inter-agency working to safeguard and promote the welfare of children.

Getting it Right for Every Child (GIRFEC) and the Early Years Framework – http://www.maternal-and-early-years.org.uk/getting-it-right-for-every-child-principles-and-values
This is an NHS Scotland approach which establishes the principle of giving all children and young people the best possible start in life as a priority for all services.

UK Government Guidance – https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care
No Secrets sets out a code of practice for the protection of vulnerable adults.

It explains how commissioners and providers of health and social care services should work together to produce and implement local policies and procedures. They should collaborate with the public, voluntary and private sectors and they should also consult clients, their carers and representative groups. Local authority social services departments should co-ordinate the development of policies and procedures.

Protection of vulnerable adults scheme (POVA) – http://www.scie.org.uk/publications/guides/guide03/law/adults.asp
Individuals should be referred to, and included on, the POVA list if they have abused, neglected or otherwise harmed vulnerable adults in their care or placed vulnerable adults

in their care at risk of harm. By making statutory checks against the list, providers of care must ensure they do not offer such individuals employment in care positions. POVA checks are requested as part of disclosures from the Criminal Records Bureau.

Prevention and Protection in Partnership 2015 – https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf

This policy from Northern Ireland is for all organisations working with, or providing services to, adults across the statutory, voluntary, community, independent and faith sectors. It sets clear and proportionate safeguarding expectations across the range of organisations.

Modern Slavery and the national referral mechanism (NRM) – https://www.gov.uk/government/collections/modern-slavery
These pages provide details about the government's work to end modern slavery, including details about how to refer victims into the NRM.

Let's talk about it – http://www.ltai.info/about/
Let's Talk About It is an initiative designed to provide practical help and guidance to the public in order to stop people becoming terrorists or supporting terrorism.

4. Managing data and confidentiality

Information Commissioners Office – https://ico.org.uk/
The Information Commissioners Office produces guidance with regards to data sharing and the Data protection and Freedom of information Acts.

HCPC guidance on confidentiality – http://www.hcpc-uk.co.uk/assets/documents/100023F1GuidanceonconfidentialityFINAL.pdf
The HCPC has provided guidance on confidentiality for registrants.

NHS – https://digital.nhs.uk/article/402/Information-Governance
The NHS has produced guidance regarding Information Governance and security for NHS and partner organisations. The NHS has codes of practice for Records management and Confidentiality.

Caldicott Report – https://www.gov.uk/government/publications/the-information-governance-review
A review was commissioned in 1997 by the Chief Medical Officer of England owing to increasing concern about the ways in which patient information is being used in the NHS in England and Wales and the need to ensure that confidentiality is not undermined. Such concern was largely due to the development of information technology in the service, and its capacity to disseminate information about patients rapidly and extensively. A committee was established under the chairmanship of Dame Fiona Caldicott. The Caldicott Report highlighted six key principles, and made 16 specific recommendations. In 2012 Dame Caldicott produced a follow up report which made 26 further recommendations including the addition of a seventh principle.

Psychological Testing Centre – http://ptc.bps.org.uk/ptc/guidelines-and-information

The PTC website contains lots of guidance about psychometric testing and the management of data generated from those tests.

5. Transparency and duty of candour

Care Quality Commission – http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
The CQC has produced Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare with regards to duty of candour.

Appendix 3 – How this document has been developed

In developing these guidelines, the overall aim and scope of the guidelines was considered at length, and the decision arrived at that they should be applicable to all psychologists irrespective of registration status or practice context. The guidelines have therefore been written in a way which it is hoped is inclusive of the various contexts of practice. Drawing on a broad stakeholder group for the development work, the guidelines aim to cover all the important considerations for practice. It is however recognised they cannot cover every circumstance and also that new issues arise which will require careful consideration by the individual psychologist.

The Practice Guidelines development Working Group was constituted to include all of the member networks of the Society whose members engage in practice, including the HCPC registered practitioners. It included representatives of the Society's national branches in Scotland, Wales and Northern Ireland, in order to ensure applicability to the different national contexts. It also included representation from the expert working groups of the Society's Professional Practice Board and others on specialist topics of practice.

The content of the guidelines has been developed from a combination of revision of the previous edition in the light of professional consensus on current expectations of a good standard of practice of psychology; inclusion of key points from other Society guidance on specific topics with reference to further guidance; and in some cases development of new material drawing on the professional experience of our members or outside professionals in the field. The working group has not used systematic methods to search for or assess the evidence for the material included. Recommendations have been included based on working group consensus. Where there are known areas of professional difference of opinion this has been stated.

A draft of the guidelines was circulated for Society wide consultation and one month allowed for comment. This included circulation to Experts by Experience (psychology service user representatives) with whom the Society works in various contexts. The Guidelines were also sent for comment to the Health and Care Professions Council as the statutory regulator for practitioner psychologists. Comments received were considered carefully by the Working Group and changes made to the text of the guidelines where considered necessary. The annotated audit sheet of the comments received and disposal was provided to a meeting of the Society's Professional Practice Board to assist its consideration of the draft guidelines, by way of final peer scrutiny. The guidelines were reviewed by the Society's legal advisers prior to publication. Final approval of the guidelines was given by the Society's Board of Trustees.

The guidelines will be reviewed and updated in accordance with Society policy after five years or sooner if circumstances indicate this is needed.

To ensure clarity and presentation in a user friendly format, the Guidelines have been edited by professional staff within the Society and the format designed by the Society's Preparation for Print specialists. Where considered helpful, links have been made to

additional web based resources, both to assist practitioner development and to provide up to date information in areas where there is frequent change. Organisational providers of psychological services are encouraged to review how these guidelines are used in practice and feed back to the Society any barriers to application.

In ensuring an appropriate level of independence in the production of these Guidelines, the Society has ensured its conflict of interest policy has been complied with and that no member of the working group's input has been compromised by a conflict of interest. No member has received any form of remuneration other than reimbursement of travel and subsistence expenses in accordance with Society policy. The large size of the working group and peer scrutiny and challenge, as well as the robust consultation process, guards against the potential for any one member or small group of members inappropriately to bias the Guidelines.

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel: 0116 254 9568 Fax 0116 247 0787 E-mail: mail@bps.org.uk Website: www.bps.org.uk

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“*RECOVERY* E SALUTE MENTALE”

Dr. Fabrizio Starace

Direttore
DSM-DP, AUSL Modena

Definizione

La Riabilitazione Psichiatrica e' quell'insieme di interventi mirati a migliorare il funzionamento di persone con disabilita' psichiche, in modo di essere in grado di svolgere un ruolo valido con successo e soddisfazione nell'ambiente di vita scelto con il minor sostegno continuativo possibile.

(Anthony, Farkas, Cohen, Gagne, 2002)

La Riabilitazione Psichiatrica

approccio atto a favorire i percorsi di ***Recovery*** dalla malattia mentale grave.

Recovery

Un processo di cambiamento attraverso cui l'individuo migliora la propria salute e benessere, vive in modo "self-directed" e si impegna a viere al meglio delle proprie potenzialità

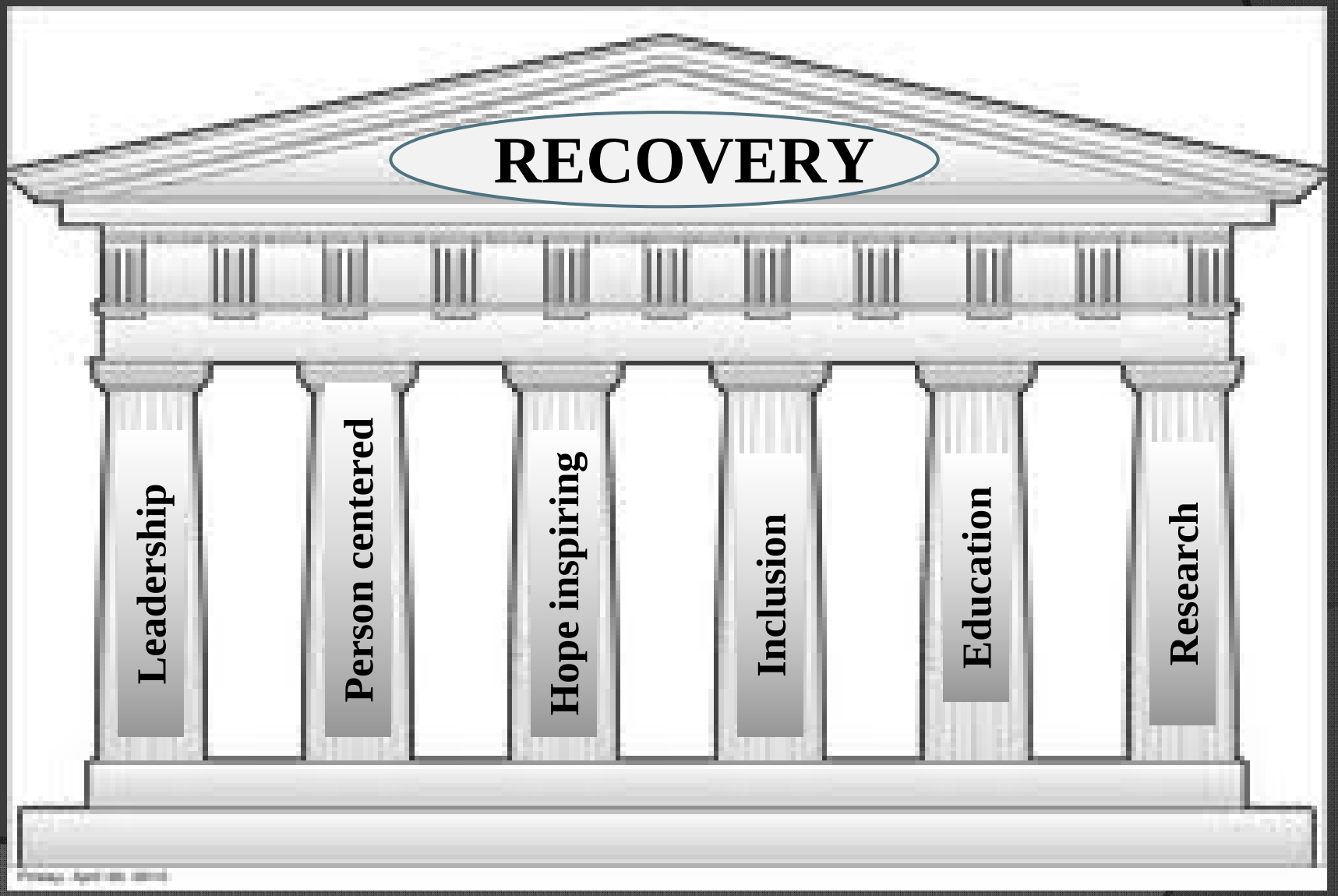
SAMHSA: Substance Abuse and Mental Health Services Administration, www.samhsa.gov

Recovery Support Strategic Initiative

SAMHSA ha individuato 4 maggiori dimensioni che supportano la Recovery

- Health: superare e gestire un disturbo/sintomi (i.e. astinenza da alcohol-sostanze, prendere decisioni consapevoli e per la propria salute)
- Home: un luogo sicuro dove vivere
- Purpose: attività significative (i.e. lavoro, studio, tempo libero)
- Community: sentirsi parte di una rete sociale (i.e. amici, famiglia)

The Irish Menatal Health Services MenataHealth Commission 2008



Principles Of Mental Health recovery-oriented practice

- Uncità dell'individuo
- Scelte individuali e indipendenti (*real choices*)
- Diritti e atteggiamento proattivo
- Dignità e rispetto
- Comunicazione e partnership con i Servizi
- Continua valutazione e misurazione della pratica clinica orientata alla recovery

Herefordshire partnership NHS Foundation Trust
«Recovery Principles in the UK»

La “Recovery” dalla malattia mentale grave

Esempi di “Recovery”:

- Ripresa dai danni di un terremoto
- Ripresa dalla crisi economica
- Ripresa da un infarto/ictus

E’ opinione diffusa che.....

L’esito della Schizofrenia sia:

- **20-30%** ritorno sostanziale al livello di funzionamento premorboso dopo un primo periodo di malattia acuta
- **20%** continuo e progressivo deterioramento
- **50-60%** decorso più variabile ma a lungo termine, senza miglioramenti né peggioramenti

Definizione di Recovery

“ Condurre una vita produttiva e soddisfacente anche in presenza delle limitazioni imposte dalla malattia mentale.

E’ lo sviluppo, personale e unico, di nuovi significati e propositi man mano che le persone evolvono oltre la catastrofe della malattia mentale.’

Anthony, 1993

- **Clinincal Recovery**

Concetto che deriva dall'esperienza degli operatori della Salute Mentale e prevede la remissione dei sintomi e il ripristino del funzionamento sociale. In altre parole «il ritorno alla *normalità*»

- **Personal Recovery**

Concetto che emerge dalle conoscenze di persone con esperienza diretta di disturbi mentali. Si focalizza sul processo attivo di costruzione di un'esperienza di vita significativa, così come definita dalle persone stesse.

Rethink Mental Illness (UK). www.rethink.org

Studi di follow-up a lungo termine

(Harding et al. 1992; Liberman and Kopelowitz 2005)

		tasso di Recovery
USA Chicago	cronici	45%
USA Iowa	cronici	46%
OMS internazionale	1° episodio	48%
Svizzera Berna	cronici	53%
Germania Bonn	misti	53%
Svizzera Zurigo	cronici	57%
Giappone aree urbane	1° episodio	64%
USA Vermont	cronici	68%
USA New York	1° episodio	74%
Nova Scotia Halifax	1° episodio	89%
Australia Melbourne	1° episodio	91%
USA Los Angeles	1° episodio	93%

Il “Recovery Movement”

Soprattutto nei paesi anglosassoni, negli ultimi 30 anni una serie di fattori concomitanti hanno determinato la nascita e lo sviluppo del

“Recovery Movement”

Il “Recovery Movement”

1. La deistituzionalizzazione e l’integrazione nella vita comunitaria
2. Il desiderio degli utenti psichiatrici di avere maggior controllo sul proprio destino, sostenuto da ricerche scientifiche condotte da utenti sulle effettive possibilita’ di recovery dalla malattia mentale grave
3. Il crescente movimento per i diritti umani
4. La disponibilita’ di psicofarmaci meglio tollerati

REMISSIONE sintomatologica nella Schizofrenia

"Remission in Schizophrenia: Proposed Criteria and Rationale for Consensus"

Andreasen NC, Carpenter WT, Kane JM, Lasser RA, Marder SR, Weingerber DR., Am J Psychiatry, 2005; 162: 441-9

Criteri per la REMISSIONE nella Schizofrenia

La gravità dei sintomi è valutata per tutti gli 8 sintomi della PANSS come LIEVE (3), MOLTO LIEVE (2) o ASSENTE (1)

- **P1** Deliri
- **P2** Disorganizzazione concettuale
- **P3** Comportamento allucinatorio
- **N1** Ottusità affettiva
- **N4** Fuga sociale apatica/passiva
- **N6** Mancanza di spontaneità e di fluidità nell'eloquio
- **G5** Manierismi ed atteggiamenti abnormi
- **G9** Insolito contenuto del pensiero

1. Assente
2. Molto lieve
3. Lieve
4. Moderato
5. Media gravità
6. Grave
7. Molto grave

per ALMENO 6 MESI

Criteri operativi di Recovery

(Liberman, Kopelowitz, Ventura and Gutkind, 2002)

1. Remissione o stabilizzazione dei sintomi
2. Lavorare o studiare in contesti normali
3. Vivere indipendente: autoresponsabilizzazione per la gestione del denaro e dei farmaci
4. Attivita' di tempo libero in contesti normali
5. Relazioni sociali al di fuori dei "ghetti"/setting psichiatrici; buone relazioni con i familiari
6. Definire e raggiungere obiettivi ritenuti rilevanti per la persona

Miglioramenti mantenuti per almeno DUE ANNI

Recovery e Salute Mentale

- E’ possibile nel tempo;
- Rappresenta un processo multidimensionale, altamente individualizzato e non lineare che puo’ essere descritto ed obbiettivato;
- Puo’ essere raggiunto con o senza l’intervento professionale;
- Ha molteplici indicatori di esito sia soggettivi che oggettivi al di la’ della riduzione dei sintomi

Farkas: World Psychiatry, 2007

Ricerca sulla Recovery nella «malattia mentale grave»

QUALI-tativa:

Fattori FAVORENTI/OSTACOLANTI la Recovery

Fattori PREDITTIVI per la Recovery

QUANTI-tativa:

Si puo' misurare la Recovery?

Ricerca *QUALITATIVA* sulla RECOVERY

La prospettiva dei professionisti della salute mentale

Recovery come ESITO:

riduzione della sintomatologia causa di stress e “ritorno al livello di funzionamento premorboso”

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

1. Fattori familiari o abitativi
2. Abuso di sostanze
3. Durata ridotta del periodo di psicosi non trattata (DUP)
4. Buona risposta iniziale agli antipsicotici
5. Aderenza al trattamento
6. Terapia di supporto con una buona alleanza terapeutica
7. Buon funzionamento neurocognitivo
8. Assenza della Deficit Syndrome
9. Buona storia premorbosa
10. Possibilita' di un trattamento completo, coordinato e continuativo

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

1. Relazioni familiari – Fattori abitativi

Famiglia supportiva con aspettative di miglioramento realistiche e molti rinforzi per i sempre maggiori progressi

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

2. Abuso di sostanze

- Interruzione terapia farmacologica per paura di interazioni negative con sostanze assunte o per problemi di memoria (causati dalle sostanze)
- Saltare gli appuntamenti previsti dal programma di trattamento
- Minori risorse (casa, mezzo di trasporto) per recarsi agli appuntamenti
- Conseguenze sociali e finanziarie dell' uso di sostanze
- Aggravamento psicopatologia e ricadute

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

3. Durata della psicosi non trattata

E’ il piu’ importante predittore di recupero sintomatologico e funzionale tra le variabili precedenti l’inizio del trattamento

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

4. Risposta iniziale ai farmaci

Un miglioramento sintomatologico rapido (< 3 gg) rappresenterebbe un indicatore prognostico premorboso di minore compromissione del neurosviluppo

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

5. Aderenza al trattamento

Scarsa compliance impedisce la stabilizzazione a breve e medio termine nelle aree:

- Psicopatologia
- Riospedalizzazioni
- Rapporti interpersonali
- Uso di alcool sostanze
- Comportamenti violenti / criminali
- Qualita' della vita in generale

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

6. Sostegno da parte dei terapeuti

   Alleanza terapeutica, terapia di sostegno, sforzi e coinvolgimento personale da parte del terapeuta, con un approccio direttivo ma anche empatico

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

7. Fattori neurocognitivi

- Normali funzioni esecutive, memoria di lavoro verbale, abilita' visuopercettive
- Ridotti apprendimento verbale, fluenza verbale e processamento visivo precoce
- Sviluppo, da parte dei soggetti in recovery, di abilita', conoscenze e strategie necessarie per un adattamento al contesto comunitario, compensando il loro rallentamento delle suddette funzioni cognitive

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

8. Presenza di sintomi negativi

Deficit nel comportamento interpersonale relativamente alle aspettative sociali

Sintomi Negativi correlati al grado di disabilita' nel funzionamento di ruolo sociale e lavorativo

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

9. Storia premorbosa

Predittori di esito peggiore:

- Sesso maschile
- Eta' di esordio precoce
- Esordio graduale
- Scarsi precedenti lavorativi
- Scarso livello di funzionamento sociale precedente
- Lungo periodo prodromico

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

9. Storia premorbosa

Migliore prognosi di recovery per i soggetti con un piu' alto livello di funzionamento scolastico, lavorativo e sociale precedenti l'esordio.

FATTORI CHIAVE DELLA RECOVERY NELLA SCHIZOFRENIA
(LIBERMAN & KOPELOWITZ, 2005)

10. Accessibilita’ alle cure

Continuative, orientate alla persona, coordinate, integrate (antipsicotici e interventi psicosociali)

10 Guiding Principles to Recovery

SAMHSA's working definition

SAMHSA: Substance Abuse and Mental Health Services Administration. www.samhsa.gov

La prospettiva degli UTENTI

Recovery come ***PROCESSO***

Recovery

“ Condurre una vita produttiva e soddisfacente anche in presenza delle limitazioni imposte dalla malattia mentale.

Sviluppo, personale e unico, di nuovi significati e propositi man mano che le persone evolvono oltre la catastrofe della malattia mentale.’

Anthony, 1993

L'ESPERIENZA DI RECOVERY

L'esperienza di Recovery dalla malattia mentale implica non solo il recuperare un ruolo valido, ma anche il riprendersi dagli effetti dell' aver ricevuto una diagnosi di malattia mentale (es.: discriminazione, perdita della capacita' di autodeterminarsi, effetti negativi della disoccupazione, progetti di vita distrutti) al pari del riprendersi dagli effetti della malattia in se'

Anthony et al, 2002; Davidson et al, 2005

L'ESPERIENZA DI RECOVERY

Similmente ai sopravvissuti ad un trauma, i soggetti con malattie mentali gravi possono avere l'esperienza che le loro vite sono cambiate irrevocabilmente; tuttavia accettano la sfida di incorporare l'esperienza di malattia in una nuova identita'

Anthony et al, 2002; Davidson et al, 2005

RECOVERY:

DAL PUNTO DI VISTA DELL' UTENTE

RECOVERY: DAL PUNTO DI VISTA DEGLI UTENTI

1. Essere trattati con dignita’ e rispetto
2. Speranza di un futuro migliore
3. Soddisfazione per il fatto di condurre una vita significativa
4. Senso di benessere nonostante la persistenza di sintomi e disabilita’
5. Empowerment nel prendere decisioni sul trattamento
6. Autoefficacia e autostima
7. Esercitare i propri diritti/doveri di cittadino
8. Integrazione nella comunita’

LA RICERCA QUALITATIVA SUL RECOVERY: ASPETTI COMUNI NELLE ESPERIENZE PERSONALI

1. Ricevere sostegno dagli altri
2. Rinnovata speranza e impegno
3. Accettare la malattia e ridefinire il Se'
4. Coinvolgimento in attivita' significative e sviluppo di ruoli sociali validi
5. Gestione dei sintomi
6. Controllo e responsabilita'
7. Superare lo stigma
8. Esercitare i diritti/doveri di cittadinanza

LA RICERCA QUALITATIVA SUL RECOVERY: ASPETTI COMUNI NELLE ESPERIENZE PERSONALI

1. Ricevere sostegno dagli altri

Avere qualcuno che crede nella persona, la incoraggia e le e' vicina anche nei momenti piu' difficili

Sostegno da: persone, animali, FEDE

LA RICERCA QUALITATIVA SUL RECOVERY: ASPETTI COMUNI NELLE ESPERIENZE PERSONALI

2. Rinnovata speranza e impegno

Avere speranza e credere nella possibilita’ di un rinnovato senso di se’ e in nuovi scopi.

La speranza va incanalata in desiderio e impegno di procedere, in Recovery

LA RICERCA QUALITATIVA SUL RECOVERY: ASPETTI COMUNI NELLE ESPERIENZE PERSONALI

3. Accettare la malattia e ridefinire il Se'

Il Recovery ha un andamento curvilineo tra gli opposti della mancanza completa di insight e l'engulfment

Accettare la propria malattia ma non l'identita' (e lo stigma) di paziente psichiatrico, ridefinendosi e accettando la situazione come una delle sfide della vita

LA RICERCA QUALITATIVA SUL RECOVERY: ASPETTI COMUNI NELLE ESPERIENZE PERSONALI

4. Coinvolgimento in attivita' significative e sviluppo di ruoli sociali validi

Attivita' significative e gratificanti che danno il senso di fare qualcosa che ha valore per la comunita' (trovare la propria "nicchia" nella comunita')

Maggiore significato e scopo della propria vita curando i propri interessi, studiando, lavorando, dedicandosi ad attivita' spirituali.

LA RICERCA QUALITATIVA SUL RECOVERY: ASPETTI COMUNI NELLE ESPERIENZE PERSONALI

5. Gestione dei sintomi

Attraverso farmaci, terapie strategie personali di coping

Sintomi sotto controllo: senso di liberta’

La persona uasa i trattamenti, i servizi, i farmaci o le abilita’ di coping in maniera attiva

LA RICERCA QUALITATIVA SUL RECOVERY: ASPETTI COMUNI NELLE ESPERIENZE PERSONALI

6. Controllo e responsabilita’

Riprendere il controllo sulla propria vita incrementa il senso di autoefficacia.

Per potersi di nuovo prendere delle responsabilita’ e’ fondamentale avere le opportunita’ e delle opzioni significative da cui scegliere

LA RICERCA QUALITATIVA SUL RECOVERY: ASPETTI COMUNI NELLE ESPERIENZE PERSONALI

7. Superare lo stigma

Interno ed esterno

Devastanti conseguenze sociali dello stigma

Empowerment: aumento del senso di autoefficacia e dell'autostima. Sviluppo della capacita' di resilienza allo stigma e lotta contro di esso.

LA RICERCA QUALITATIVA SUL RECOVERY: ASPETTI COMUNI NELLE ESPERIENZE PERSONALI

8. Esercitare i diritti/doveri di cittadinanza

Partecipare come membro a pieno titolo della societa', con responsabilita' e dando contributi personali.

Lavorare, pagare le tasse, votare, fare volontariato, partecipare ad altre attivita' civiche.

Bisogno di Advocacy per le barriere legali, burocratiche, materiali che implica la partecipazione alla vita civile per una persona con disabilita'

La ricerca *QUANTITATIVA* sul RECOVERY

RICERCA *QUANTITATIVA* SUL RECOVERY

1. Recovery Assessment Scale

   RAS – Corrigan et al., 1999

   41 items – 5 costrutti

   1. Fiducia in se stessi e speranza
   2. Disponibilità a chiedere aiuto
   3. Orientamento ad obiettivi ed al successo
   4. Fiducia negli altri
   5. Non sentirsi dominati dai sintomi

SCALA DI VALUTAZIONE del RECOVERY (RAS)

Troverà ora alcune affermazioni su come a volte le persone si sentono rispetto a se stessi e alla propria vita.

Per favore legga con attenzione ogni frase e indichi se lei è completamente in disaccordo(1), in disaccordo(2), non è sicuro(3), d'accordo(4), o è completamente d'accordo(5).

	Completamente in disaccordo	In disaccordo	Non è sicuro	D'accordo	Completamente d'accordo
1. Desidero farcela	1	2	3	4	5
2. Ho un progetto riguardo a come star bene	1	2	3	4	5
3. Ho degli obiettivi nella vita che voglio raggiungere	1	2	3	4	5
4. Credo di poter raggiungere i miei attuali obiettivi	1	2	3	4	5
5. Ho uno scopo di vita.	1	2	3	4	5

Fattori psicologici del Recovery
indagati dalla RAS

1. Fiducia in se stessi e speranza (11, 14, 15, 16, 20, 22, 24, 25, 36)
2. Disponibilità a chiedere aiuto (30, 31, 32)
3. Orientamento ad obiettivi ed al successo (1, 2, 3, 4, 5)
4. Fiducia negli altri (6, 37, 39, 40)
5. Non sentirsi dominati dai sintomi (27, 28, 29)

Ricerca *QUANTITATIVA* sulla RECOVERY

Recovery Knowledge Inventory (Bedregal et al. 2006)

Valutazione della CONOSCENZA e delle ATTITUDINI dei professionisti della salute mentale riguardo alla Recovery

.

Aree valutate:

1) Ruoli e responsibilita' nel Recovery
2) Non linearita' del processo di Recovery
3) I ruoli della autodefinizione e dei pari nel Recovery
4) Aspettative rispetto al Recovery

Intervista semi-strutturata

1. **Come è cominciato tutto ciò?**
2. **In che modo si è accorto/a di avere un problema?**
3. **Come ha cercato di far fronte a questa situazione problematica? In quale modo ha cercato di aiutare se stesso/a a risolvere i suoi problemi? (pensieri e azioni)**
4. **Quali sono le persone a cui ha chiesto aiuto? Perché ha scelto loro? In che modo l'hanno aiutato/a?**
5. **Come ha vissuto la sua richiesta di aiuto al servizio?**
6. **Quale tipo di aiuto ricevuto è stato per lei più utile?**

Intervista semi-strutturata

7. Chi o cosa può influire/ha influito maggiormente nel suo percorso di guarigione?
8. Quali sono stati i fattori che hanno ostacolato il percorso di guarigione?
9. Ci può descrivere se ci sono stati degli eventi o momenti "speciali" che hanno contribuito al suo miglioramento?
10. Cosa significa per Lei "guarigione"?
11. Come è cambiata l'idea su se stesso durante il percorso di guarigione?

Intervista semi-strutturata

12. **Com’è cambiata, se è cambiata, l’idea degli altri su di Lei durante il percorso guarigione?**
13. **Come descriverebbe il Suo percorso dagli esordi del disturbo ad oggi?**
14. **Come immagina il Suo futuro?**

Temi comuni nelle interviste

1. L’esperienza di malattia
2. Aspettative e delusioni
3. Il cambiamento
4. Definizioni di “Recovery”
5. I fattori coinvolti
6. Descrizione del “viaggio”
7. Aspettative per il futuro

Temi comuni

1. L’esperienza di malattia
   a. i fattori scatenanti
   b. una strada scivolosa
   c. il crollo
   d. la richiesta di aiuto
   e. i supporti ricevuti (famiglia, amici, il servizio)
   f. il trauma del ricovero in reparto di psichiatria

Temi comuni

2. Aspettative e delusioni
    a. aspettare di venire aiutati
    b. rendersi conto del fallimento
    c. l’incertezza

Temi comuni

3. Il cambiamento
    a. Mettersi alla prova
    b. acquisire abilita’
    c. la scoperta di se’

Temi comuni

4. Definizioni di “Recovery”
    a. La frattura tra il “prima” e il “dopo”
    b. il benessere
    c. la resilienza

Temi comuni

5. I fattori coinvolti
    a. Il ruolo e il valore dei pari
    b. Raccontare e raccontare di se’
    c. Le connessioni

Temi comuni

6. Descrizione del “viaggio”
    a. Un viaggio continuo
    b. il tempo perduto
    c. La perdita di opportunita’

Temi comuni

7. Aspettative per il futuro
    a. mantenere il benessere
    b. la speranza di opportunita’
    c. un cauto ottimismo
    d. pragmatismo
    e. essere orientati a obiettivi a breve termine

Conclusioni

1. Gli utenti sono in grado di raccontare esperienze personali
2. Importanza della partecipazione consapevole degli utenti nella valutazione e nella trasformazione qualitativa dei servizi
3. La sicurezza in se' e le aspettative positive, insieme ad un atteggiamento orientato agli obiettivi, sono gli elementi maggiormente correlati al recovery

Conclusioni II

4. Il raccogliere le esperienze dirette di vita – di malattia e di recovery – rappresenta una modalita' insostituibile per avere veramente accesso a quel "laboratorio" dove, per la formula del Recovery, si mescolano ingredienti ancora in parte sconosciuti. Gli utenti e i carer sono gli esperti in parte inconsapevoli: anche grazie ai loro contributi i professionisti della salute mentale imparano come fornire i migliori interventi orientati al recovery.

Conclusioni III

5. La Recovery dalla malattia mentale grave, vivendo la vita con soddisfazione

e’ possibile !

VALORI-CHIAVE CHE SUPPORTANO IL PROCESSO DI RECOVERY

- *Orientamento alla persona*
- *Coinvolgimento della persona*
- *Autodeterminazione/scelta*
- *Potenziale di crescita*
- *Il servizio si focalizza su:*
  - *piena esperienza umana delle persone, non "casi"*
  - *Partnership, non compliance*
  - *Scelta, non coercizione*
  - *Impegno alla speranza, non rassegnazione*

Pratica orientata al Recovery

(Davidson et al., 2009)

- Primarieta' della partecipazione
- Favorire l'accesso e il coinvolgimento
- Garantire la continuita' della cura
- Utilizzare una valutazione basata sui punti di forza
- Offrire una pianificazione individualizzata del percorso di Recovery
- Fungere da "guida per il Recovery"
- Conoscere e sviluppare l'inclusione comunitaria
- Identificare e affrontare le barriere al Recovery

“La disabilita’ e’ da dove partiamo, la Recovery e’ la nostra destinazione e la Riabilitazione la strada che percorriamo”

(R.P. Liberman, 2008)

Refocus Project

RETHINK

Rethink è il principale ente nazionale benefico in UK per la Salute Mentale, opera per aiutare chiunque sia affetto da una grave patologia mentale ad ottenere una migliore qualità di vita, offrendo la speranza, la possibilità di acquisire autonomia attraverso servizi di assistenza efficaci, il sostegno, la promozione del cambiamento attraverso una maggiore consapevolezza e conoscenza della malattia mentale.

REFOCUS

è un programma di ricerca di 5 anni, fondato dal National Institute of Health Research (Ref RP-PG-0707-10040), allo scopo di sostenere lo sviluppo, all'interno dei Team di Salute Mentale sul territorio, di un orientamento teso alla Recovery del paziente. Una parte del programma REFOCUS è il REFOCUS Trial (ISRCTN02507940), che valuterà l'efficacia dell'intervento REFOCUS a livello dei Servizi di Salute Mentale di comunità. L'intervento previsto dal trial dura 18 mesi

© Section for Recovery, Institute of Psychiatry, King's College London, 2011

Recovery secondo Rethink

“Un processo di cambiamento profondamente personale e unico, delle proprie attitudini, dei valori, dei sentimenti, degli obiettivi, delle capacità e del ruolo. Consiste nel vivere la vita con soddisfazione, speranza e partecipazione, anche con le limitazioni causate dalla malattia”

Refocus Study

Lo studio REFOCUS implica la sperimentazione di un nuovo approccio volto ad aiutare i Servizi di Salute Mentale a diventare maggiormente orientati verso la Recovery del paziente.

- Prevede un training alla Recovery per i Team
- Rethink utilizza e coinvolge fra i suoi trainers anche utenti con esperienza diretta dei Servizi.
- Refocus prevede sessioni di riflessione, supervisione individuale e di gruppo all'interno dei Team, sessioni di riflessione che coinvolgono anche i responsabili dei Team

Authors: Victoria Bird, Mary Leamy, Clair Le Boutillier, Julie Williams and Mike Slade.

Refocus Study

Presuppone di comprendere meglio insieme agli utenti alcune cose che li riguardano

Dal manuale Refocus:

- I tuoi valori – ciò che vorresti noi conoscessimo di te, in modo che possiamo rispettarli nel nostro lavoro insieme
- Le tue preferenze di cura – come vorresti che noi impostassimo il tuo progetto terapeutico
- I tuoi punti di forza – così possiamo capire le tue specifiche abilità, quali supporti hai nella tua vita e quali ti piacerebbe avere
- I tuoi obiettivi – cosa ti interessa, così che possiamo lavorare insieme per ottenerlo

Le strategie:

Conoscenza della Recovery, approfondite informazioni cliniche e personali degli utenti, conoscenza dei valori personali degli utenti e del Team, lavoro in partnership, training individualizzati alla Recovery, applicazione del Coaching, valorizzazione delle capacità individuali (Skills-Talents), supporto al raggiungimento di obiettivi

cambio della pratica

RECOVERY INDIVIDUALE

Manuale Refocus:
Interventi in aggiunta alle cure standard

Relazioni che contribuiscono alla Recovery

- Sviluppo di conoscenza condivisa sul concetto di personal Recovery
- Approfondimento dei valori individuali (operatori, utenti)
- Progetti in partnership

Pratiche di lavoro

- Indagare valori e preferenze di trattamento
- Valutare le risorse e abilità degli utenti
- Supportare il raggiungimento degli oboettivi

Valori che supportano la Recovery (Refocus Project):

VALORE 1

Supportare la Recovery personale è il primo e il principale obiettivo dei Servizi di Salute Mentale. Intervenire in una situazione di crisi o dedicarsi ai fattori di rischio potrebbe talvolta essere prioritario, ma deve essere orientato sull'obiettivo principale di sostenere la Recovery.

VALORE 2

Interventi saranno principalmente indirizzati ad identificare, elaborare e supportare gli obiettivi personali del paziente

evitare di imporre significati e congetture cliniche su ciò che è importante, offrire un supporto che sia compatibile con i valori del paziente su cui lavorare per conseguire i suoi obiettivi di vita.

Valori che supportano la Recovery (Refocus Project):

VALORE 3

I Servizi di Salute Mentale svolgono adeguatamente la loro funzione se i pazienti sono responsabili delle loro stesse vite.

L'obiettivo primario degli operatori della Salute Mentale non consiste nel guarire i pazienti o condurli alla Recovery.

Il lavoro prioritario consiste nell'aiutare i pazienti a sviluppare e utilizzare capacità che li rendano autonomi nella loro vita.

Lavorare in Partnership

«Lavorare in partnership è una parte centrale dell'intervento finalizzato alla Recovery del paziente. Ciò comporta che i team sviluppino e sperimentino modi di relazionarsi agli utenti del servizio come se fossero loro collaboratori»

Esempi dal manuale Refocus:

- Attività Team-Utenti per aiutare la comunità, es.: un progetto di tutela o di rinnovo
- Collaborazione diretta con gli utenti per sostenere i cambiamenti pro-Recovery all'interno del team
- Facilitare il passaggio degli utenti dal partecipare ad un gruppo sociale al guidare il gruppo
- Audit o un progetto di formazione condotto da un utente
- Organizzare insieme un gruppo per la Recovery con l'aiuto di un membro dello staff e di un utente del servizio
- Sondare le abilità dello staff e degli utenti e quindi provare ad organizzare insieme un talent show

Il Coaching

Il Coaching è uno specifico stile interpersonale per incoraggiare e sostenere la Recovery del paziente. I vantaggi dell'approccio che utilizza coaching sono:

- Parte dal presupposto che il paziente sia o sarà in grado di gestire la sua vita. La capacità di essere responsabili di se stessi è un dato di fatto.
- L'attenzione è concentrata verso il facilitare il processo di Recovery piuttosto che sul paziente in sè. Coaching riguarda il modo in cui i pazienti possono vivere con il disturbo mentale, non la cura del disturbo stesso.

Il Coaching

Il Coaching è uno specifico stile interpersonale per incoraggiare e sostenere la recovery del paziente. I vantaggi dell'approccio che utilizza coaching sono:

- Lo scopo del coach è di attivare questa capacità di autogestirsi, piuttosto che di risolvere i problemi al posto del paziente. Questo induce ad amplificare i punti di forza e le relazioni di sostegno già esistenti, piuttosto che a creare dei deficit.
- Lo scopo del coaching è diretto a raggiungere gli obiettivi dell'utente del servizio, non quelli del coach.
- Entrambi i partecipanti devono fornire un contributo attivo affinché la relazione funzioni.

REACH© il coaching per l'approccio alla Recovery del paziente comporta 5 stadi:

- Riflessione: processo attivo nel quale un membro del team lavora con il paziente al fine consentirgli di analizzare e di prendersi le responsabilità per attività e cambiamenti
- Esplorare: esplorare la questione/problema/compito e le relative opzioni a disposizione
- Agree outcomes: concordare i risultati desiderati, utile "a far scattare" le risorse dell'utente
- Commitment to action: impegno diretto verso le azioni necessarie (come, quando etc.)
- Hold to account: presa di responsabilità da parte dell'utente; possibile utilità di dare feed-back

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facebook.com/animazione.sociale

Direzione e redazione
Franco Floris (direttore responsabile - franco.floris@gruppoabele.org), Roberto Camarlinghi (vice direttore - rcamarlinghi@gruppoabele.org), Laura Carletti (laura.carletti@gruppoabele.org), Francesco Caligaris (fra.caligaris@gmail.com), Francesco d'Angella (francesco.dangella.as@gmail.com).

Segreteria di redazione
Gianluca Borio (animazionesociale@gruppoabele.org), Daniele Croce (daniele.croce.as@gmail.com)

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Maestro è chi insegna l'amore per il sapere

Educare è questo: sospingere verso l'apertura di altri mondi

Intervista a
Massimo Recalcati
a cura di
Roberto Camarlinghi

Se c'è qualcosa che resta insostituibile della scuola, è la funzione di animare il rapporto del soggetto con il sapere. La posta in gioco dell'insegnamento è ancora tutta qui: nell'introdurre l'allievo in un rapporto vitale con il sapere. Nel rendere il sapere un oggetto in grado di muovere il desiderio: il desiderio di sapere, di approfondire, di capire. Se nella nostra vita ciò è accaduto, è perché abbiamo incontrato un maestro, un insegnante che ha amato il sapere e – amandolo – ce lo ha reso desiderabile. Un maestro che è stato capace di generare in noi quel trasporto amoroso verso la cultura che rimane il più grande antidoto per non smarrirsi nella vita.

Dalle scuole elementari all'università, tutti gli insegnanti che portiamo con noi nella memoria hanno un tratto fondamentale che li accomuna e che prescinde dai contenuti del loro insegnamento: amavano il sapere e – amandolo – ce lo hanno reso desiderabile. I maestri che hanno lasciato un segno nella nostra vita sono quelli che – incarnando il desiderio di sapere – hanno mobilitato in noi il desiderio di apprendere. Perché il gesto del maestro non è mai riempire le teste come recipienti, ma produrvi il vuoto e mantenere vivo il desiderio di sapere.
Per questo è insensato l'approccio che distingue l'istruzione dall'educazione. Educare è sospingere verso l'apertura di mondi, promuovendo in ognuno – bambino o ragazzo – la ricerca della propria via singolare di accesso al sapere e al mondo. Educare è accendere il desiderio, quel desiderio che non è da confondere con il godimento immediato, ma con l'amore per l'altro, per il sapere, per l'altrove.
Sono i temi della ricerca di Massimo Recalcati, tra i più noti psicoanalisti in Italia, contenuti nel suo ultimo libro *L'ora di lezione. Per un'erotica dell'insegnamento*, edito da Einaudi. Lo abbiamo seguito in alcune recenti conferenze, provando a cogliere le linee essenziali della sua ricerca.

Perché la scuola è centrale nell'educare

Negli ultimi tempi lei si è dedicato al tema della scuola, a come possiamo immaginarla, alla funzione educativa che malgrado tutto riveste. Inizierei da qui, dalla sua idea di educazione...

Il problema dell'educazione è «come si diventa soggetti». E la scuola svolge una funzione decisiva nell'aiutare bambini e ragazzi in questo percorso. Provo a spiegarmi partendo da un episodio che mi ha molto turbato.
Una collega francese mi ha raccontato che, in un asilo francese di periferia, un'educatrice aveva portato con sé il figlio molto piccolo. Lo aveva messo in una stanza a fianco a quella dove si svolgevano le attività quotidiane del gruppo classe, ma quando è rientrata nella stanza lo ha trovato morto, ucciso da un altro bambino che era stato lasciato fuori dalle attività.
Perché parto da questa scena? Perché esiste oggi una *cattiva retorica* che investe il tema dell'educare. La cattiva retorica consiste nel *ritenere che il bambino sia già un soggetto*. Invece non è così e quest'episodio lo mostra bene: il bambino lasciato solo è Caino, ammazza il fratello. I bambini – lo dico in modo brutale – non sono soggetti e il problema dell'educazione è *rendere possibile la loro soggettivazione*, a partire da una posizione che ci fa esistere inizialmente come oggetti, con tendenze che non riusciamo a governare, dove la violenza è parte costitutiva dell'essere umano.
Nella scena dell'asilo non dobbiamo vedere semplicemente una regressione dall'umano al bestiale, ma la presenza nell'umano di qualcosa che si manifesta come tendenza aggressiva, spinta all'odio invidioso, alla distruzione dell'altro. Il punto scabroso è che uccidere il proprio fratello non appartiene al mondo animale, ma al mondo umano.
E allora cos'è l'educazione se non educare a rinunciare alla violenza come soluzione delle difficoltà dei rapporti? Se non educare a passare *dalla violenza alla conversazione*, dalla legge brutale della forza a quella dialogica della parola?
Questo è il movimento dell'educazione o, come preferisco dire, il *movimento dell'umanizzazione della vita*, da cui dipende il nostro poter diventare soggetti. La nostra

vita si umanizza nella misura in cui rinuncia alla violenza e accoglie la legge della parola. È uno dei compiti più difficili che incombe sugli esseri umani: saper rinunciare alla violenza in nome del riconoscimento dell'Altro come prossimo, come essere singolare. È un riconoscimento che non è mai indolore perché ci obbliga ad accettare che «Io non sono tutto», che la mia vita non esaurisce quella del mondo e degli altri. Significa sopportare quella che Freud considerava una «frustrazione narcisistica», necessaria per riconoscersi appartenenti a una comunità umana.

Dal chiuso della famiglia all'aperto del mondo

In questo cammino di umanizzazione la scuola – lei dice – esercita una funzione insostituibile.

Sì, la funzione fondamentale della scuola risiede nel *promuovere la legge della parola*, l'incontro con altri mondi. Ed è qui che assume un senso la sua dimensione obbligatoria. La scuola – si sa – è scuola dell'obbligo. Si manifesta come obbligazione, dunque come trauma. Per tutti noi la scuola è stata un trauma, un trauma obbligatorio: il trauma della separazione dalla famiglia, il trauma – direbbe Jaques Lacan – della «dematernalizzazione della lingua». Andare a scuola significa infatti riconoscere che la lingua materna non esaurisce il mondo. E dunque la scuola è innanzitutto questo taglio traumatico, simbolico, che introduce il soggetto dal legame intimo, di sangue – che pure è fondamentale alla vita – a una dimensione più allargata di legame. La scuola sancisce l'obbligo di rivolgersi al mondo, staccandosi dal clan di appartenenza.
Il trauma della scuola è dunque *un trauma virtuoso*, benefico e necessario, perché obbliga il soggetto a decentrarsi, a non restare incapsulato nel proprio Io. La scuola porta dal chiuso della famiglia all'aperto del mondo, in cui tocca imparare a vivere. È veramente un passaggio – se si può dire così – dalla lingua materna all'alfabeto. C'è un libro di uno scrittore che amo molto, Andrea Bajani, che è proprio su questo valore straordinario delle lettere dell'alfabeto. S'intitola *La vita non è in ordine alfabetico*. Imparare le lettere dell'alfabeto – dice Bajani – significa imparare mondi, imparare a costruire mondi. L'apprendimento dell'alfabeto è lo svezzamento, è il vero svezzamento; avere in bocca non la tetta, ma la parola.
Allora la scuola non è solo il trauma di abbandonare la lingua materna, ma è anche *la possibilità dell'incontro*. Incontro con che cosa? Incontro con altri mondi, altre voci, altre parole. Qui sta veramente l'importanza della scuola, di ciò che resta della scuola, di ciò che deve restare della scuola.

Noi ci formiamo attraverso gli incontri

La scuola è fondamentalmente un luogo di incontri. E gli incontri sono decisivi per la nostra vita perché – lei ha detto recentemente – la forma della nostra vita è il risultato degli incontri che abbiamo fatto.

Che cosa dà forma a una vita? Attraverso cosa ci siamo formati? La vita si forma attraverso la contingenza pura degli incontri. Noi abbiamo la forma che gli incontri che abbiamo avuto hanno fabbricato. Ancora più precisamente, noi siamo – tutti noi siamo – il modo attraverso il quale abbiamo dato una forma agli incontri che ci hanno formato.
Da questo punto di vista, la scuola è *luogo elettivo della formazione*. Perché a scuola si

fanno incontri tra le generazioni, si fanno incontri con le istituzioni, si fanno incontri tra pari. La scuola è luogo di incontri, però gli incontri non sono tutti buoni. Ci sono buoni e cattivi incontri e sia i buoni che i cattivi incontri lasciano un segno. Noi siamo il segno che ha lasciato su di noi l'incontro buono o cattivo.
Se dovessimo dare una definizione molto semplice dell'incontro buono e dell'incontro cattivo, potremmo dire che il *cattivo incontro* è fondamentalmente l'incontro che chiude il mondo, che chiude la possibilità di accesso al mondo. Quando facciamo un cattivo incontro il mondo perde ossigeno, perde l'orizzonte. Il *buon incontro* invece è l'incontro che allarga l'orizzonte del mondo, cioè mi fa vedere – attraverso chi incontro – che il volto del mondo è un altro rispetto a quello che fino a quel momento avevo conosciuto.
Il buon incontro – e bisogna essere disponibili a fare buoni incontri – è l'incontro che apre e moltiplica i mondi. Da questo punto di vista ogni buon incontro è un incontro d'amore. Gli incontri formativi, gli incontri che danno forma alla vita, i buoni incontri, sono sempre incontri d'amore, perché sono incontri che, spalancando i mondi, spalancano la nostra vita. La nostra vita non è più come prima.
Questi incontri nella scuola si fanno attraverso gli insegnanti innanzitutto, ma si fanno anche attraverso i libri. La lettura di un libro può essere in sé un incontro che lascia il segno. Dopo la lettura che feci da ragazzino del mio primo libro, *Il sergente nella neve* di Mario Rigoni Stern, ho ancora nelle narici l'odore di grasso che lasciava la mitragliatrice arroventata. Quel libro per me è stato il libro che mi ha insegnato che esistono i libri, che esiste la letteratura, cioè che esiste la possibilità di fare esistere più mondi.
Dunque il buon incontro apre i mondi, li spalanca e spalancando i mondi apre la nostra vita.

Insegnare che il sapere si può amare

In questo contesto è fondamentale l'incontro con il maestro, con l'insegnante. Colui che ha la funzione insostituibile di mediare l'incontro con qualcosa di decisivo nel nostro percorso di umanizzazione: il sapere.

Insegnante significa «colui che sa lasciare il segno». C'è insegnamento quando qualcuno lascia in noi un segno: un segno che dà forma alla nostra vita. Ma di cosa è fatto questo segno, così decisivo nella formazione della vita? Di cosa è fatto il segno che un insegnante sa lasciare nell'allievo? Noi sappiamo che questo segno non è fatto di sapere. Cioè non è un contenuto, un concetto, una nozione, non è un oggetto teorico. Gli insegnanti che non abbiamo dimenticato, quelli che abbiamo incontrato e che hanno avuto un ruolo decisivo nella nostra formazione, noi li ricordiamo non per quello che ci hanno insegnato, non per il «cosa» hanno insegnato, ma per la *forma* con cui hanno insegnato, per lo stile con cui hanno insegnato.
Quello che è indimenticabile, negli insegnanti che non abbiamo mai dimenticato, nei segni che il loro insegnamento ha impresso nelle nostre anime, è il loro *stile*. Un insegnante che lascia un segno, un insegnante degno di questo nome, è un insegnante che innanzitutto ama quello che insegna, cioè entra in un rapporto fisico, corporeo, erotico con il sapere. E dunque fa del sapere non qualcosa di astratto, aereo, semplicemente intellettuale, mentale, ma fa del sapere un corpo, fa del sapere un corpo erotico.

Questa è una delle grandi doti di un insegnante: *trasformare tutti gli oggetti teorici* che trasmette ai suoi allievi – la serie di Fibonacci, la deriva dei continenti, una lingua straniera, le poesie di Giovanni Pascoli, i sette re di Roma... – *in corpi erotici*. Se questa trasformazione avviene, se avviene nella parola dell'insegnante, genera una seconda trasformazione che accade questa volta nell'allievo. L'allievo non è più un recipiente da riempire, la sua testa non è una zucca vuota da colmare, ma *l'allievo* – grazie alla trasformazione del libro in corpo, dell'oggetto teorico in corpo erotico – *si trasforma a sua volta in amante.*

Chi di noi non ha vissuto almeno una volta quest'esperienza: sentirsi amante del sapere che il maestro trasmette? Amante non significa «essere riempito», ma «essere svuotato e messo in movimento». Quando c'è un incontro – a qualunque livello – che è formativo per noi, noi ci sentiamo messi in movimento. Dove c'è un buon incontro c'è messa in moto della vita, la vita si anima. Allora l'allievo si forma attraverso il vuoto più che il pieno. Questo mi pare un punto importante.

La scena inaugurale del gesto del maestro

La buona scuola, scrive infatti nel suo libro, è quella che «sa testimoniare non soltanto di sapere il sapere, ma anche che il sapere si può amare, si può trasformare in corpo erotico» (p. 35).

Sì, il buon insegnante è colui che sa fare del sapere un oggetto del desiderio in grado di mettere in moto la vita, di allargarne l'orizzonte. È colui che introduce gli allievi in un rapporto vitale con il sapere, che rende possibile l'incontro con la dimensione erotica del sapere. In questo – credo – consiste tutta la posta in gioco della partita dell'insegnamento. E direi anche – ma su questo possiamo tornarci dopo – il ruolo che la scuola può giocare nella prevenzione delle tossicomanie o di qualunque altra forma di godimento immediato.

Il buon insegnante fa del sapere un oggetto del desiderio in grado di mettere in moto la vita e di allargarne l'orizzonte. Qui risiede anche il ruolo che la scuola può giocare nella prevenzione.

Nell'incontro tra insegnante e allievo, non si tratta di riempire le teste con un sapere già costituito, ma di aprire dei buchi in quelle teste perché si metta in moto un movimento verso il sapere. Questa è la *strategia educativa fondamentale*, che trova la sua matrice nel gesto che Socrate compie nei confronti di Agatone. Noi in Occidente, nella nostra tradizione, abbiamo infatti questa scena madre, da cui scaturisce veramente il gesto del maestro, il gesto dell'insegnante. La si trova in apertura di uno dei più bei e giustamente famosi dialoghi di Platone, *Il Simposio*.

Agatone dà un banchetto dove invita artisti, teatranti, intellettuali, scrittori, filosofi a parlare dell'amore, del mito di Eros. Socrate è uno degli ospiti più attesi, ma mentre si sta recando al banchetto si perde. Accade ogni tanto ai filosofi di perdersi nei propri pensieri. Socrate si è perduto in un cortile perché la Verità, come gli capitava spesso, lo ha visitato. Un servo assiste alla scena e riferisce ad Agatone. Così, quando Socrate

arriva al simposio, Agatone sa il perché del ritardo. La verità gli ha parlato, dunque Socrate sa. Perciò Agatone chiede a Socrate di sedersi vicino a lui affinché il sapere che la verità gli ha trasmesso possa essere travasato nella sua testa: «Stai vicino a me – gli dice Agatone – e parlami e travasa in me tutta la potenza del tuo sapere».
Questa è l'illusione che tutti noi, in quanto allievi, abbiamo attraversato con i nostri maestri. Questa è anche l'illusione della scuola quando pensa che la trasmissione del sapere sia fondamentalmente un'attività di riempimento. Ma Socrate – ecco il gesto – risponde ad Agatone: «Guarda che io sono vuoto come te, e come te desidero sapere». Socrate si offre dunque ad Agatone come amante del sapere, non come detentore del sapere. Ed è questo passaggio – dalla proprietà al desiderio, dal detenere il sapere al tendere al sapere – che costituisce il maestro. Agatone si trasforma così da coppa vuota ad amante del sapere: questo è il miracolo dell'insegnamento. Dove c'è insegnamento l'allievo diventa amante del sapere.

Il miracolo dell'ora di lezione

Questo miracolo può avvenire – e spesso avviene – nell'ora di lezione, che lei individua come «il vero cuore della scuola» (p. 7), fatto appunto di incontri col sapere che possono essere avventure profonde, esperienze non solo intellettuali ma emotive.

Sì, se dovessi dire che cosa rimane insostituibile della scuola, qual è il suo nucleo resistente, direi che è il tempo dell'ora di lezione. Perché il tempo dell'ora di lezione è *il tempo dell'incontro*, perché l'ora di lezione spalanca i corpi, spalanca le porte, spalanca le finestre, spalanca i libri, spalanca la vita. Un'ora di lezione può davvero cambiare la vita.
Spesso l'obiezione che raccolgo è: ma come si può far nascere il desiderio nel campo dell'obbligo? È un grande tema della scuola questo. Perché la scuola è sempre scuola dell'obbligo in fondo, però è lì che si gioca la partita del desiderio. Come si può far esperienza della libertà, dell'erotismo del sapere, laddove ci sono i programmi, ci sono i calendari, ci sono le verifiche, laddove esiste un dispositivo, un *automaton*, che imprigiona sia gli allievi che gli insegnanti? Come far emergere la luce dell'incontro nel grigiore del dispositivo obbligatorio?
Eppure, per quanto l'ora di lezione segua la scansione imposta dai programmi, non è mai prevedibile, nei suoi effetti, da nessun regolamento. Se noi esaminiamo più da vicino questo tema dell'insegnamento, dobbiamo riconoscere che *il miracolo può sempre avvenire,* nella misura in cui il maestro ama il sapere e – amandolo – lo rende desiderabile all'allievo, lo trasforma in corpo erotico. È la dimensione dialettica della didattica, capace di mobilitare il desiderio di sapere.
Invece cosa succede a volte nella scuola? Che valutiamo ottimi – parlo adesso come professore universitario – quegli esami in cui gli allievi riproducono, clonano, plagiano il sapere che devono studiare. A chi diamo 30? A chi riferisce con esattezza le mie parole o le parole del testo che ha studiato. La valutazione nella scuola si fonda sul *modello del plagio*, del conformismo. Ma in questo modo non c'è nessuna possibilità per gli allievi di apprendere in modo singolare, soggettivo, il sapere che viene trasmesso. La devianza, l'irregolarità, l'anomalia, la bizzarria, la stramberia, cioè lo stile singolare viene soffocato da questa modalità di concepire la valutazione. E invece dovrebbe essere valorizzato.

Favorire l'emergere dello stile singolare

Lo stile singolare, le attitudini, le vocazioni, le anomalie sono i punti di forza del soggetto, lo psicoanalista lo sa bene. Penso a uno dei miei primi casi: la madre che portava il figlio adolescente mi diceva: «Guardi, non fa altro che pensare alla morte, me lo faccia smettere di pensare». E io le rispondevo: «Signora, smettere di pensare è peggio della morte». Ecco, la ruminazione di questo ragazzo sulla morte, che può sembrare sintomatica, se non viene normalizzata, ma presa e girata nel verso giusto, si trasforma in un punto di forza.

I punti in cui le piante sono storte, non allineate, non sono i punti che noi dobbiamo raddrizzare, come riteneva una vecchia pedagogia autoritaria che aveva trasmesso questa *rappresentazione botanica dell'educazione*: raddrizzare le viti storte. Al contrario noi dobbiamo amare la stortura, amare l'anomalia, la bizzarria, la stramberia dei nostri figli perché lì c'è un tesoro. Lo dice anche il poeta: «Dai diamanti non nasce niente, dal letame nascono i fiori». In fondo l'educazione è dare la parola alla vite storta, non è produrre un tipo uniforme.

Il modello botanico dell'educazione era il modello a cui dichiarò di ispirarsi il mio maestro supplente di seconda elementare. Io sono stato forse uno degli ultimi bocciati agli esami di seconda elementare, allora esistevano ancora. E ho in mente quest'uomo che, il primo giorno in cui è entrato in classe, ci ha guardati – all'epoca eravamo solo bambini, non c'erano ancora le classi miste, tutti con la giubba nera – e ci ha detto: «Voi siete delle viti storte, io sono il paletto e il filo di ferro che vi raddrizzerà!».

Questo supplente non era da meno dell'altra maestra, una donna severa, sempre vestita di nero, che incarnava tutto quello che non deve fare un bravo insegnante. Ricordo che un giorno, nel tempo della conversazione, ci chiese: «Bambini, secondo voi che cosa rende bello il fuoco?». E allora ci fu un dibattito tra di noi, c'era chi alzava la mano e diceva «il fuoco è bello perché permette di stare attorno e di parlare», «il fuoco è bello perché si fanno le caldarroste», «il fuoco è bello perché porta la luce nel buio». Lei con disprezzo a ogni risposta scuoteva la testa e diceva «no, no, no». Scartava ogni tipo di interpretazione della bellezza del fuoco perché ci indicava di possedere lei la sola risposta possibile. Che alla fine, con aria saccente, ci svelò: «Il fuoco è bello... perché si muove!».

Cito questi due episodi perché sono esempi di un *modello disciplinare*, io dico botanico per riprendere la metafora della pianta della vite da raddrizzare. Questo modello – che era il modello educativo psicopedagogico pre '68 – contiene in sé l'idea che la soggettivazione sia mettere la divisa. Raddrizzare tutte le viti significa annullare la stortura che rende la vite – ma potremmo dire la vita – una vita unica.

Amare la stortura della vite

Il modello botanico per certi versi è tornato in auge nell'ultimo periodo. Del resto l'avversione per ciò che ha rappresentato il '68 è stata più volte dichiarata da chi ha fatto le recenti riforme della scuola...

Il '68 ha introdotto una discontinuità – per come la giudico io – vitale, positiva, fondamentale. Una generazione di figli ha preso la parola e ha introdotto nell'educazione il *tema della libertà*. Questo è stato un tempo decisivo nella nostra storia, sebbene in effetti l'eredità di questo grande passaggio si sia snaturata recentemente. Perché nel post

'68 – gli anni '70 in particolare – la scuola era un luogo di sperimentazione straordinario, un luogo di grandi trasformazioni collettive. Mentre oggi questa grande eredità del '68 è stata tradita.
Oggi siamo di fronte alla scuola delle «tre i», come sbandierava qualche tempo fa un ministro della Repubblica che fa il paio con i miei maestri delle elementari. Ma direi che nella scuola delle «tre i» – impresa, informatica, inglese – al centro non sono più tanto le viti storte da raddrizzare, ma le informazioni da immagazzinare. Il nuovo modello educativo psicopedagogico è fondato sul *principio di prestazione*: l'obiettivo è rafforzare le competenze a risolvere i problemi piuttosto che a saperseli porre. È un modello che implica una *rappresentazione* – diciamo così – *computeristica* della soggettivazione: le teste funzionano come computer e bisogna immettervi più *files* possibili. In questo modello il sapere non ha più rapporti con la vita, ma deve solo trasmettere le competenze per rendere quella vita capace di prestazioni.
Nella scuola di oggi abbiamo l'esasperazione del principio di prestazione, dove non c'è posto per la singolarità nel processo di apprendimento, ma predomina un sapere anonimo e robotizzato da assimilare. Qual è l'alternativa secondo me vitale? L'alternativa – dicevo – è *amare la stortura della vite*, pensare che là dove ciascun allievo è anomalo rispetto alla misura, lì è il tesoro. Questo è un grande insegnamento con i nostri ragazzi: dove un bambino, un ragazzino, mostra di essere diverso dagli altri, lì è il suo potenziale. Dove il soggetto soffre nei suoi sintomi, lì è la sua verità.
Si tratta di ribaltare la prospettiva con cui si guardano i bambini, i ragazzi, i giovani. L'educazione non è condurre l'anomalia alla normalità, ma *l'educazione è potenziare l'anomalia*, potenziare il sintomo, potenziare la stortura, potenziare la differenza. Ecco perché quando vedo ragazzi che hanno 10 in tutte le discipline resto sempre perplesso; per me quello è il segno che è in atto una macchinizzazione del sapere. Gli esseri umani hanno sempre attitudini e talenti, non possono eccellere in tutte le materie. Quando accade, è il segno che c'è un problema: un problema di prestazione, di conformismo, di far felici i genitori, di non saper tollerare una frustrazione.
Allora direi che uno dei compiti della scuola è far emergere i talenti, far emergere le attitudini, far emergere le differenze, far emergere i desideri. Favorire cioè una *soggettivazione del sapere* e non un'assimilazione passiva e conformistica.

Memorizzare il sapere e sospendere la memoria

A questo proposito nel libro lei richiama i due tempi fondamentali della didattica: la memoria e l'oblio: «Il movimento della conoscenza implica la memoria», ossia l'acquisizione del sapere che ci viene trasmesso, «ma solo al fine di sospenderla per rendere possibile un atto nuovo, una soggettivazione inedita del sapere» (pp. 61-62). Può spiegarci di più?

C'è un gesto di un grande pittore, Emilio Vedova, che merita qui raccontare. Vedova è stato anche professore all'Accademia di Belle Arti di Venezia. Quando notava uno dei suoi allievi paralizzato di fronte alla tela vuota, interveniva intingendo lo spazzolone in un secchio di colore e dando un deciso colpo sulla tela. Questo aveva l'effetto di mettere in moto l'allievo. Prima del colpo di spazzolone l'allievo era intimidito, oppresso, inibito dal bianco della tela. Dopo il colpo di spazzolone qualcosa si disinibisce, si mette in movimento, comincia a respirare.

Che cosa fa Vedova? Che cos'è questo gesto? Non è semplicemente un modo per togliere quel senso di venerazione che il soggetto ha nei confronti della tela bianca. Non è semplicemente questo, è qualcosa di più sottile. Il principio da cui Vedova parte è pensare che *la tela vuota, come la pagina bianca* – la tela vuota per un pittore, la pagina bianca per uno scrittore, il silenzio per un musicista – *sono in realtà stracolme*. Per uno scrittore la pagina non è mai bianca, ma nella pagina bianca si deposita tutta la storia della letteratura: Kafka, Joyce, Proust… E dunque l'inibizione è un effetto di questa stratificazione.
Come posso io scrivere qualcosa se tutto è già stato scritto? Se prima di me c'è Beckett, c'è Dante... Lo stesso vale per la pittura: come posso io osare dipingere se prima di me ci sono stati Picasso, Klee, Tintoretto? Impossibile! E allora l'operazione di Vedova è fare in modo che questo bianco sia davvero bianco, che questo vuoto sia davvero vuoto, che questo silenzio sia davvero silenzio. Rende dunque possibile il gesto creativo, perché qual è *la condizione del gesto creativo*? Non è la memoria di tutto quello che è stato fatto, perché se noi ricordiamo tutto il rischio è di non poter generare mai niente di nuovo.
Pennac sostiene che «è bello insegnare ai bambini le poesie a memoria». Io ero un bambino che non aveva mai voluto impararne una, però capisco la bellezza dell'imparare a memoria oggi. Imparare a memoria – dice Pennac – è come gettare i nostri figli nel fiume della lingua; non importa il contenuto, importa che capiscano che noi apparteniamo alla dimensione del linguaggio, che abbiamo una provenienza, una casa comune. Va bene, purché non si pensi che imparare a memoria esaurisca l'apprendimento. Anzi potremmo dire che per apprendere davvero bisogna dimenticare ciò che si impara. Perché ci sia davvero apprendimento bisogna che tutto ciò che abbiamo appreso a un certo punto venga disattivato per rendere possibile un gesto singolare, un gesto creativo.
Questa idea la troviamo in tanti diari. Van Gogh, Klee conoscevano perfettamente la storia dell'arte. La loro tela era popolata da una ragnatela di nomi, di citazioni, di opere già viste. Ma per poter generare il nuovo occorre che tutta questa memoria venga ad un certo punto disattesa. Questo riguarda anche i temi dei ragazzi al liceo o le tesi di laurea.
Finché è troppo presente l'ombra del padre, finché è troppo presente l'ombra della memoria, è impossibile generare il nuovo. E dunque la condizione della creazione è la possibilità di accedere ad un oblio, ad un punto di dimenticanza, che è ciò che Vedova realizza attraverso questo gesto.

Apprendere non è fare come il maestro

Ogni processo creativo, di apprendimento singolare – lei dice – eredita la memoria, ma non la ripete, bensì la sospende per provare a dire qualcosa di proprio.

Sì, potremmo esprimere questo punto anche dicendo che ci vuole un maestro, ma l'apprendimento non è fare *come* il maestro. Questo mi pare un punto decisivo. Il bravo insegnante non è colui che chiede di imitarlo, ma colui che *promuove un accesso soggettivo al sapere*.
C'è una scena sull'apprendimento che si trova in un grande libro di filosofia, *Differenza e ripetizione*, di Gilles Deleuze. La scena è questa. Sulla spiaggia c'è un maestro di nuoto con il suo piccolo allievo. Il maestro spiega al bambino gli stili: la rana, lo stile libero, il dorso. Il bambino ripete i mo-

vimenti – l'apprendimento è fatto anche di questo: trasmissione di competenze, di tecniche, di sapere. Però poi arriva il momento in cui il maestro dice al bambino: «Adesso entra nel mare». È questo momento, in cui il bambino sperimenta l'impatto con l'onda, che davvero gli fa acquisire il sapere che il maestro gli ha trasmesso.
Questo significa che non esiste trasmissione del sapere se l'allievo fa come il maestro. Non può fare come il maestro. Perché quando arriva l'onda cosa accade? Che l'allievo deve resettare tutto il sapere che ha immagazzinato, farlo proprio e rispondere – nella contingenza dell'incontro – all'onda che scompagina il sapere astratto della trasmissione. Chiaramente l'onda è un'immagine della vita. Noi abbiamo imparato sì gli stili, ma inventiamo un nostro stile – un nostro modo di fare la rana, il dorso, lo stile libero – solo quando impattiamo l'onda.
Allora ne deduciamo che non c'è trasmissione del sapere senza maestro, ci vuole il maestro; ma non c'è apprendimento se la trasmissione è fare come il maestro. Il maestro è fondamentale, ma non si tratta di fare come il maestro; si tratta di inventare un proprio stile, cioè di *dimenticare* – mentre lo riconosciamo – *il maestro*. Noi non possiamo fare senza il maestro, la formazione non è uccidere il maestro, come dicono alcuni. Fare a meno del maestro è qualcosa a cui possiamo arrivare solo se abbiamo avuto un maestro. Allora benedetto sia il maestro, benedetto sia l'incontro con un maestro, almeno uno nella vita, dalle scuole elementari sino all'università.
Devo dire che nella mia pratica di professore una delle cose che più mi emoziona ancor oggi è quando, nelle tesi di laurea o di dottorato, sento che qualche mio allievo – che io riconosco come allievo, dunque che parla la mia lingua fondamentalmente, nelle cui parole riconosco le mie fatalmente – a un tratto pronuncia parole nuove. Ci sono dei momenti in cui alzo gli occhi perché sento che lui parla, lei parla in un'altra lingua. A partire dalla mia lingua può parlare un'altra lingua. E questa è una grande emozione per un maestro, per un professore. L'emozione più grande è quando sentiamo sorgere dalla lingua della didattica un'altra lingua che è la lingua del soggetto, che è il soggetto come differenza assoluta.

Non aver paura di inciampare

Su questo punto lei, citando Pier Aldo Rovatti, afferma che «l'insegnamento ha a che fare con la soggettivazione» e che «insegnare significa, né più né meno, insegnare a qualcuno a divenire un soggetto» (p. 110). Questo significa che l'impronta del maestro non è e non dev'essere un calco, sebbene ogni insegnamento porti con sé questo rischio. Come evitarlo?

Direi trasmettendo, insieme al sapere, la consapevolezza che non si potrà mai dire né sapere tutto. Un bravo maestro sa, mentre trasmette il sapere, *preservare il limite del sapere*. Limite da intendere non come insufficienza del sapere, ma come condizione profonda, umana del sapere. Un bravo maestro, mentre insegna, mentre trasmette il sapere, coltiva questo punto centrale, questo mistero che abita il sapere, cioè l'impossibilità di sapere tutto il sapere. Che non si risolve assimilando tutti i libri di tutte le biblioteche del mondo, ma mantenendo una tensione costante verso il sapere. Perché se anche sapessimo a memoria tutti i libri di tutte le biblioteche del mondo, non avremmo comunque realizzato una appropriazione esaustiva del sapere. Perché il limite del sapere non è esterno al sapere. Il

limite del sapere abita il sapere, è un punto interno al sapere.
Un grande allievo di Lacan, Moustapha Safouan, racconta che un bravo insegnante si distingue da come reagisce quando, prima di salire in cattedra, inciampa. È un test, dice. C'è l'insegnante che immediatamente si ricompone, facendo finta che non sia accaduto nulla. Questo, dice Safouan, non è un modello interessante. Poi c'è l'insegnante che si ricompone e, nel mentre si ricompone, con sguardo sadico cerca nell'aula chi si è permesso di sorridere per bacchettarlo. Nemmeno questa, dice, è la posizione auspicabile. Il bravo insegnante, conclude, è quello che inciampa e fa dell'inciampo il tema della lezione. Ecco, qui abbiamo la qualità dell'insegnante. I bravi maestri sanno inciampare. Non temono la propria insufficienza, anche perché la mancanza, come detto, non è loro, ma del sapere. È il sapere che manca. E l'insegnante custodisce la mancanza del sapere.
Per questa ragione Giovanni Gentile ha potuto affermare che, solo quando usciva dall'aula con la sensazione di aver appreso qualcosa che a lui stesso sfuggiva prima di cominciare, poteva considerare che quella era stata davvero un'ora di lezione.

L'inciampo mette in ricerca

A proposito di questo inciampo voglio fare un'ultima, personale evocazione di maestro. Ricordo che quando entrai all'università Statale di Milano, agli inizi degli anni '80, volevo assolutamente frequentare il corso di Mario Dal Prà. Lui insegnava storia della filosofia, io arrivavo a filosofia con un curriculum scolastico tormentatissimo: bocciato più volte, con un diploma di esperto in coltivazioni di piante tropicali in serre calde, insomma un percorso totalmente irregolare. Mi si diceva che Dal Prà fosse all'ultimo anno di insegnamento, così inserii il suo corso sebbene la guida dell'università lo indicasse come «vivamente sconsigliato per le matricole».
Il corso era sulla *Scienza della logica* di Hegel e io che arrivavo dalla floricoltura non avevo gli strumenti concettuali per affrontare un simile argomento. Però decisi di frequentare lo stesso e ricordo questo omino piccolo, che arrivava con sottobraccio i testi di Hegel – in tedesco e in italiano – e li commentava. E il commento del maestro, come sempre accade, illumina anche il testo più incomprensibile. Dove c'è insegnamento, c'è la luce, bisogna diffidare degli insegnanti oscuri. Il bravo insegnante è chiaro, strutturalmente chiaro, perché porta la luce sul testo. E allora anche il testo più denso, più tortuoso, come la *Scienza della logica*, nelle parole di Dal Prà si scioglieva e diventava luminoso.
Ma non tutto, ecco la grandezza del maestro. C'erano dei momenti – mentre commentava il testo – in cui si fermava, alzava gli occhi al cielo e poi diceva: «Qui dobbiamo fermarci. Chissà Hegel cosa ha visto...». E non proseguiva, inciampava sul testo. L'effetto su di noi era che, appena finita la lezione, ci precipitavamo sul punto dove il maestro era inciampato. Perché l'inciampo rende prezioso l'oggetto su cui si inciampa, ancora più dell'oggetto che si trasmette. Perché è lì che si gioca la vera partita. Allora la forza del maestro è, per un verso, portare la luce nel testo, per l'altro preservare l'impossibile da dire nel testo. Ma è questo impossibile che mantiene vivo il desiderio di sapere.

La cultura al posto della droga

Per concludere, lei prima accennava che una scuola capace di rendere il sapere

un oggetto di desiderio è una scuola che fa prevenzione. Può argomentare quest'idea?

Dicevo prima che il primo miracolo che ogni insegnamento degno di questo nome opera è trasformare gli oggetti teorici in corpi erotici. Il bravo maestro è quello capace di erotizzare il rapporto con il sapere, di incarnare il desiderio di sapere, di trasformare il libro in un corpo, di far venire voglia di toccarlo, penetrarlo, annusarlo. Questo genera una seconda trasformazione: l'allievo diventa amante del sapere. Il maestro, incarnando il desiderio di sapere, mette in movimento l'allievo. Questa trasformazione dell'allievo in amante del sapere è fondamentale nell'insegnamento. L'ultima metamorfosi rappresenta la vera posta in gioco della formazione: *trasformare i corpi in libri*. È questa la sublimazione che accompagna le grandi e straordinarie trasformazioni dell'adolescenza.
Forse è un po' visionario quello che dico. Cosa vuol dire far diventare un corpo un libro? Vuol dire che il corpo dell'altro – sia esso il corpo sessuale della mia compagna di banco, sia esso il corpo del mondo, il corpo della città, ogni legame – diventa *qualcosa che merita la nostra attenzione*, la nostra cura, che non si può leggere in fretta, che non si può ridurre a strumento per il mio godimento immediato, ma *bisogna dedicargli tempo*. La lettura di un libro non è un mangiare ingordo, la lettura esige tempo, sospensione, pausa, e soprattutto cura. Allora trasformare il corpo, il corpo di chi amo, il corpo del mondo in un libro è l'effetto più alto di una formazione. E questo è – se vogliamo – un altro nome dell'amore, che in fondo è il nome più alto dell'incontro.
Pasolini diceva che c'è droga, cioè uso strumentale e dissipativo del corpo, dove non c'è cultura. La droga viene al posto della cultura, la droga è l'esito di un «desiderio di morte» che si afferma sullo sfondo di un grande «vuoto di cultura». Quando non c'è cultura, non c'è linguaggio, non c'è parola, non c'è insegnamento, noi abbiamo la droga. La droga come simbolo di una relazione con il corpo orientata solo dal godimento dissipativo. La funzione della scuola allora è *mettere la cultura sopra la droga*. È un podio strano, la cultura sopra la droga. Eppure educare è questo: mettere l'amore per l'*eteros*, per l'altro, per il sapere, per l'altrove in cima a tutto. Riccardo Massa, che è stato un grande pedagogista in Italia, insisteva su questa etimologia del termine educare: portare altrove, cioè sospingere verso l'eteros, verso l'apertura di mondi.
Allora direi che veramente, se c'è un ruolo che la scuola può giocare nella prevenzione, non è dato dai corsi e corsetti che si fanno sulle tossicomanie e sull'anoressia. Né è dato dal professore che si mette a fare lo psicologo con i ragazzi – questa è un'altra retorica cattivissima del nostro periodo. Ma a un professore direi: spiega Ungaretti, spiega Montale, spiega le equazioni, spiegale bene! Fa' in modo che questi oggetti siano vivi, appassionino, tengano sveglie le persone! Così previeni, così salvi. Non metterti a raccogliere in classe i segreti dei tuoi alunni, come ho sentito dire da un insegnante. No, spiega Hegel, spiega Spinoza, fa' in modo che l'insegnamento di Hegel e Spinoza sia un insegnamento vivo. Questo salva, per come vedo io le cose. Non l'insegnante psicologo del disagio, ma l'insegnante testimone del carattere erotico della cultura. Questa è per me la prevenzione primaria.

Massimo Recalcati psicoanalista, è membro dell'Associazione lacaniana italiana di psicoanalisi, direttore scientifico dell'IRPA (Istituto di ricerca di psicoanalisi applicata) e docente all'università di Pavia.

Produrre Servizi è tutelare diritti

Ritrovare nella storia dei Servizi le ragioni e le possibilità per andare oltre la crisi

di
Franca Olivetti Manoukian

I Servizi sociali e sanitari da troppi anni sembrano affannati da varie crisi collegate a riduzioni di finanziamenti e di organici, a delegittimazioni e contrapposizioni ideologiche, a nostalgie di un welfare mai raggiunto e incitamenti verso ri-organizzazioni di cui non si vede il senso. A chi sta dalla parte dei Servizi, a chi pensa che possano contribuire alla qualità della vita di singoli e famiglie, tocca oggi raccogliere idee, motivazioni, cooperazioni per andare oltre questa lunga epoca di crisi e per riaffermare la centralità dei Servizi pubblici e privati nel progetto di una società democratica. Perché produrre Servizi – non dimentichiamolo mai – è tutelare diritti.

Produrre servizi, tutelare diritti: due verbi e due complementi oggetto che potrebbero, dovrebbero in modo immediato sintetizzare in che cosa consistono le funzioni dei Servizi sociali territoriali, le ragioni della loro esistenza. Sono scritti separati da una virgola. Viene così simbolizzato che appaiono come due aspetti giustapposti. Potrebbero essere congiunti da una lettera «e»: connessione assai leggera, che pesa più o meno come una virgola. Preferirei inserire una «è», terza persona dell'indicativo presente del verbo essere che ha un significato affermativo. Produrre servizi è tutelare diritti.

La tutela di diritti è un bene per tutti

Questa è l'ipotesi che mi propongo di assumere e sviluppare: oggi più che mai, in tempi di trasformazioni che ci sovrastano, di crisi più subite che capite, ciò che i Servizi sono in grado di produrre costituisce un contributo centrale rispetto alle possibilità di garantire i diritti soggettivi, quelli più visibilmente violati perché inscritti in «indecenti» situazioni di svantaggio e quelli più normalmente disattesi per impliciti, taciti accordi di mantenere silenzio.
La salvaguardia di quelli che vengono anche qualificati come diritti umani (*human rights, droits de l'homme*) poggia solo in casi estremi su sanzioni (che comunque non possono intrinsecamente restituire l'integrità fisica e psichica della persona che porterà su di sé segni indelebili delle violazioni subite). Le modalità repressive con cui si tende in altri campi a ottenere il rispetto dei diritti hanno meno peso in questo ambito, probabilmente perché le prove di comportamenti lesivi sono più sottili e opinabili e varie e variabili (secondo le diverse culture) sono anche le stesse interpretazioni di ciò che è stato compiuto.
Per lo più accade che la tutela dei diritti soggettivi venga attivata in situazioni singolari, ma è bene ricordare che non è soltanto a vantaggio di un'unica situazione: riguarda tante situazioni analoghe, ma soprattutto costituisce una riaffermazione che ha un peso sociale e ha ricadute per tutta la società. Eppure siamo continuamente interpellati sulla domanda di quanto nelle nostre vite collettive sia diffusa *la convinzione che la tutela dei diritti soggettivi riguarda tutti* e non può trovare effettivo mantenimento e sostegno se non nel *riconoscimento dell'esistenza di legami intrinseci* e di una cultura condivisa inscritta nelle stesse differenze e dissimmetrie.

Un nuovo progetto sociale

I Servizi territoriali nelle loro diverse articolazioni sono stati istituiti con la finalità di tutelare diritti che, scritti nella Carta costituzionale italiana del 1948, non trovavano, con il trascorrere degli anni, effettiva considerazione e applicazione. Erano – e sono – diritti indicati nei *principi fondamentali* (art. 2, 3, 4) e ribaditi nei *rapporti etico-sociali* (in particolare art. 32 finalizzato alla tutela della salute come fondamentale diritto dell'individuo e interesse della collettività), ma la loro traduzione doveva misurarsi con un quadro sociale fortemente perturbato e segnato da blocchi e contrapposizioni di schieramenti cristallizzati per decenni.

* | Volentieri anticipiamo alcuni contenuti del volume di Franca Olivetti Manoukian, *Oltre la crisi. Cambiamenti possibili nei Servizi socio-sanitari*, in uscita presso Guerini e Associati, Milano 2015. Ringraziamo l'autrice e l'editore per la disponibilità e collaborazione.

Nel secondo dopoguerra, grazie anche alle nuove configurazioni delle relazioni internazionali, si andavano mobilitando aperture a evoluzioni modernizzanti rispetto agli assetti sociali consolidati, orientate allo sviluppo economico e politico in senso democratico.
In questo quadro, avanzano e si condensano tensioni verso una concezione più democratica della vita sociale. Un primo indizio di attenzione ai modi di vivere dei cittadini è presente in quella legge Fanfani del 1958 con cui la tutela della salute viene affidata a uno specifico Ministero (scorporata quindi dal Ministero dell'Interno).
L'istituzione della Scuola media unica agli inizi degli anni '60 dà un segnale forte di una scelta politica collettiva di rimuovere le barriere tendenti a separare, già nell'iter scolastico di base, le appartenenze a una classe sociale e a predefinire le scelte successive verso un lavoro operaio o impiegatizio modesto o verso studi e carriere professionali più elevati.
Alla fine di quel decennio viene approvato il decreto di liberalizzazione degli accessi all'università, grazie al quale qualsiasi titolo di scuola media superiore consente di iscriversi a tutte le facoltà universitarie. Le contestazioni studentesche e gli scioperi del '68 e '69 sono espressioni e conferme di movimenti che introducono e sostengono cambiamenti decisivi negli assetti legislativi e istituzionali tendenti a garantire a «tutti» i cittadini la tutela dei diritti di cittadinanza.
Si rende più legittima e improrogabile la definizione di un nuovo quadro normativo che renda più pregnante l'obbligo di considerare gli esseri umani «uguali», degni di godere delle stesse prerogative di dignità e di rispetto, al di là delle differenze di genere (uomini e donne), di età (adulti e «minori»), di integrità fisica e mentale, di razza e collocazione sociale; un quadro che dia nuova esigibilità ai cosiddetti diritti soggettivi – al lavoro, alla casa, alla salute, alla crescita e all'educazione e istruzione.
La ricostruzione e la ripresa economica nel nostro Paese hanno contribuito a maturare e promuovere una maggiore attenzione a come questi diritti potessero effettivamente essere esercitati: goduti.

La nascita dei Servizi territoriali

I Servizi nascono entro questo clima sociale [1]. Hanno pertanto le loro radici entro movimenti sociali evolutivi e costituiscono elementi di innovazione entro una dinamica sociale rivolta all'instaurare nuove interazioni, a socializzare nuovi modelli di convivenza, a introdurre nuove forme di regolazione dei rapporti tra singoli e gruppi.
Compaiono come *istituzioni* che hanno come scopo prioritario quello di dare consistenza e rappresentatività a forze vive presenti nel contesto sociale perché sia possibile creare e mantenere nel tempo un nuovo ordine che ci si propone di realizzare. Sono espressione e deposito di valori che marcano modi di pensare e di agire individuali e insieme tendono a rappresentare quello che è considerato «bene comune».
Con le forti spinte ideologiche che li sostengono, i Servizi in quegli anni rappresentano effettivamente la volontà diffusa di realizzare una società più umana e giusta, capace

1 | Una lettura delle premesse ideali e culturali da cui hanno preso vita i Servizi e una analisi dell'avvio delle loro attività è stata proposta da me stessa in un libretto a cui sono affezionata: *Stato dei Servizi* (il Mulino, Bologna 1988).

di contrastare emarginazioni e devianze e di promuovere inclusione e partecipazione verso un ben-essere accessibile a tutti: un sogno, un progetto sociale ideale e luminoso. Rappresentano e presentano forti istanze di trasformazione in particolare nei confronti di istituzioni educative, sanitarie e assistenziali, amministrative.

Non a caso si pongono e sono visti da vari gruppi come protagonisti di cambiamenti sociali: in particolare di cambiamenti rispetto ai modi con cui la società affronta – affrontava o non affrontava – devianze, emarginazioni, esclusioni, distanze dalla «normalità». Lottano per l'affermazione e la realizzazione di modalità più umane di trattare il disagio, per la creazione di condizioni più rispettosamente attente alle persone e alle dimensioni relazionali. Pongono in primo piano la tutela dei diritti di tutti coloro che sono portatori di «diversità», di mancanze-menomazioni rispetto alla «normalità», i diritti di tutte quelle persone che la società tende a porre ai margini e quindi a escludere dalla partecipazione.

L'idea guida è quella di contrastare delle pratiche tradizionalmente adottate per trattare situazioni di disabilità, come la cecità o la sordità, malattie mentali, disturbi dell'apprendimento e maltrattamenti in ambito familiare, discriminazioni e violenze sulle donne, tossicodipendenze, ecc. Non si deve più ricorrere a repressione e reclusione, istituzionalizzazione e isolamento; va contestata ogni impostazione amministrativa e tecnicistica, vanno esclusi interventi «autoritari», strutturalmente non rispettosi dei diritti alla crescita personale, alla partecipazione sociale, alla salute, al lavoro, alla famiglia. I Servizi si devono rivolgere a tutti: non solo ad alcune categorie sociali [(2)].

Una alternativa alle istituzioni totali

Allo «stato nascente» i Servizi socio-sanitari territoriali si pongono come *istituzioni anti-istituzionali*, come nuove formazioni sociali intermedie che tendono alla demolizione delle istituzioni più tradizionali e consolidate, chiuse e ingabbiate entro schemi di funzionamento dominati dalle esigenze di sottomissione dei singoli e di controllo totale dei comportamenti, di inibizione e schiacciamento di ogni autonomia e iniziativa individuale.

Appare più evidente che le varie istituzioni che si occupano di disagi sociali, nelle configurazioni rigide e autoritarie via via assunte nel tempo, sono sempre più lontane dalle evoluzioni culturali che si vanno affermando: tendono all'autoconservazione più che alla funzione di regolazione dei rapporti e di mantenimento di valori collettivi [(3)].

Per chi si trova a lavorare nei Servizi ogni apparato organizzativo rimanda agli assetti con cui le istituzioni funzionano e intervengono. Per contrastare le istituzioni sembra imprescindibile rifiutare disegni e funzionamenti organizzativi su cui si reggono quotidianamente i trattamenti dei disturbi, i rapporti con gli utenti e tra gli operatori, le attività

2 | Per una analisi della complessa funzione sociale delle istituzioni segnalo il libro di Ota de Leonardis, *Le istituzioni. Come e perché parlarne* (Carocci, Roma 2001).

3 | È proprio in quegli anni che ha tanto successo la traduzione italiana, curata da Franco e Franca Basaglia, del libro di Ervin Goffman, *Asylums. Le istituzioni totali: meccanismi dell'esclusione e della violenza* (Einaudi, Torino 1968). Parallelamente, finisce per essere posta in secondo piano la funzione positiva delle istituzioni, quella che consente di vivere in una società che non sia del tutto in balìa di rapporti di forza, che qualifica come civile la convivenza perché accetta l'esistenza dell'altro.

interne e con l'esterno. In questo senso, nella nascita dei Servizi sono inscritte diffidenze verso tutto ciò che presentifica la funzione repressiva delle istituzioni: la *struttura organizzativa* ne è la più immediata traduzione che va demolita o di cui si può fare a meno, per evitare di esserne condizionati.
Qualificare questi nuovi Servizi come «territoriali» esprime la scelta di ancorarli a una prossimità che possa rendere la loro attività ben vigile e pronta. Insediandosi nei diversi contesti sociali è possibile per i Servizi tradurre concretamente la tutela dei diritti soggettivi in iniziative collettive ben identificabili, di per se stesse «rivoluzionarie» rispetto all'esistente. Anche a fronte di interessi e posizioni contrastanti si tratta di abolire le scuole speciali, di chiudere orfanotrofi e brefotrofi, di svuotare gli istituti, di demolire i manicomi. Si tratta di instaurare modalità relazionali più aperte e simmetriche con le donne, con le famiglie e con i bambini stessi.
In prima linea sono i Servizi socio-sanitari come i consultori (istituiti con una legge specifica nel 1975) e in seguito i Servizi di salute mentale e quelli per le tossicodipendenze, che riuniscono professionisti di varie provenienze ed estrazioni: assistenti sociali, medici, psicologi, infermieri, psichiatri, a volte pedagogisti e sociologi. E si va anche a tentare di promuovere integrazioni tra sociale e sanitario.
Si costituiscono a livello locale, in qualche area del Nord Italia, alcuni Consorzi socio-sanitari di zona; si sostengono collegamenti tra Servizi dei Comuni e neo-nate Unità sanitarie locali; si attivano e vengono sostenute cooperative a cui vengono affidate attività da svolgere in strutture diurne e semi-residenziali ritenute opportune e necessarie per particolari situazioni, ad esempio di ragazzi difficili, di tossicodipendenti o di malati mentali.

La poca attenzione ai fattori organizzativi

Nelle considerazioni che sto aprendo sul decollo dei Servizi nel nostro Paese ho più volte fatto ricorso, non a caso, alle parole *istituzione* e *organizzazione*. Non sono sinonimi. Senza addentrarmi in approfondimenti, mi pare comunque opportuno indicare una distinzione di massima tra i due concetti.
Consideriamo le *istituzioni* come entità aventi un'esistenza sovra-individuale, collettiva, caratterizzate da una intrinseca permanenza, indipendente dagli individui che nel tempo le hanno fondate e ne fanno parte; rappresentano un immaginario in cui è depositato un bene comune; definiscono confini e appartenenze, cornici simboliche che strutturano comportamenti e interazioni. Esse tuttavia lasciano molti vuoti che diventano aree di marginalità ed esclusione sociale e nel loro perpetuarsi tendono a distanziarsi dalla realtà che cambia in modo disordinato e accelerato.
Possiamo riferirci alle *organizzazioni* come realtà sociali costituite da relazioni tra singoli e gruppi finalizzate al raggiungimento di obiettivi collegati ai mandati istituzionali in modi che possono variare nel tempo. Sono pertanto più direttamente connesse al produrre e a come produrre, e più esposte alle contingenze, al mutare di condizioni economiche e culturali, di competenze e tecnologie e all'esigenza di verificare il proprio funzionamento attraverso riscontri e rimandi rilevabili nel contesto sociale.
Nelle fasi iniziali di vita dei Servizi nel nostro Paese appare prevalente e dominante l'investimento per solidificare la loro esistenza sul piano *istituzionale*. È importante che ci siano e che in tal modo dimostrino l'impegno per la tutela dei diritti di tutti i cittadini, anche dei «diversi». Quello che producono è scontato, comunque positivo.

Non so se questa ipotesi che sto proponendo sia percorribile. Si può comunque constatare come il lavoro attribuito ai Servizi, tanto complesso e impegnativo per chi è direttamente implicato, in quegli anni sia *ben poco considerato dal punto di vista organizzativo*. La possibilità di introdurre azioni e interventi decisamente differenti da quelli tradizionalmente messi in atto sembra immediata, affidata alle condivisioni ideali e alle motivazioni militanti.

La sola articolazione per l'organizzazione del lavoro a cui si fa esplicito riferimento nelle definizioni normative è l'*équipe*, che viene richiamata e raccomandata come se fosse un dispositivo-chiave per il funzionamento del Servizio. Non è chiaro, tuttavia, quanto sia vista come dispositivo operativo necessario per lo svolgimento delle attività o quanto esprima l'idea di un funzionamento di gruppo concorde e armonico.

Non va dimenticato che in quegli anni il gruppo, il piccolo gruppo di lavoro, il gruppo faccia a faccia, è nell'immaginario collettivo la traduzione più immediata (privilegiata e da privilegiare) della possibilità di interagire in rapporti simmetrici, di prendere parte attiva, di riconoscersi ed emanciparsi e di sperimentare micro contesti «democratici» e anche di produrre in modo creativo ed efficace insieme. Sono diffuse varie idealizzazioni. Si sottolinea la *centralità del riconoscersi «noi» come determinante per il buon lavoro*.

Gli operatori sono animati da intense motivazioni ideali, che soprattutto nei primi tempi sembrano quasi poter sopperire a competenze professionali approssimative. Si teorizza persino l'opportunità che nei Servizi venga individuato un *operatore unico*, a garanzia di interazioni aperte ed empatiche con gli utenti, non condizionate da distanziazioni e asimmetrie che rischiano di riproporre prescrizioni e interventi autoritari.

Probabilmente all'epoca[4] ci si è appoggiati e fermati all'idea che *per la tutela dei diritti fosse essenziale e decisivo realizzare e mantenere l'esistenza dei Servizi,* la loro articolazione decentrata e diffusa, le sedi e le dotazioni di organici di cui potevano disporre, il sostegno che ottenevano dagli amministratori locali, la loro legittimazione: non altrettanti investimenti sembra che siano stati indirizzati a considerare gli aspetti di realizzazione del lavoro «produttivo di servizi» e delle relative esigenze di coordinamento e controllo.

La moltiplicazione di disagi e di servizi

Agli inizi degli anni '90 quando a livello politico e amministrativo sembra che si vada concretizzando la possibilità di instaurare anche in Italia un *welfare state* di cui si parla da anni come meta da raggiungere, gli assetti di prosperità economica cominciano a manifestare alcune crepe. La società mostra sempre più fragilità, squilibri, contraddizioni e mostra soprattutto l'emergere di fenomeni poco o nulla governabili.

Cresce il disagio; o meglio, non sappiamo bene se cresca in realtà o se non sia la sua rilevazione a essere più attenta, grazie anche alla diffusione dei Servizi sociali e socio-sanitari. Infatti, quando si diffondono dei modelli di benessere, di salute, di vita familiare, di successo lavorativo, si notano molto di più e si sopportano sempre di meno carenze,

4 | Mi riferisco in particolare alle concettualizzazioni introdotte dal libro di Richard Norman, *La gestione strategica dei servizi* (ETAS, Milano 1985), e che ho ripreso nel mio *Produrre servizi* (il Mulino, Bologna 1998).

disfunzioni e malesseri. Aumenta la percezione del disagio e corrispondentemente cresce la richiesta di eliminarlo.
In questo quadro va diffondendosi anche la *produzione di divulgazioni di saperi* di tipo medico, psicologico, pedagogico. Paradossalmente, il diffondersi di conoscenze in strati molto larghi di popolazione non porta maggiori capacità e competenze nell'affrontare la complessità di varie situazioni relazionali e familiari difficili, o meglio induce una *acculturazione ambigua.*
I disagi che si fanno avanti premono per una crescita dei Servizi, per un loro potenziamento attraverso sedi più numerose e adeguate, dislocazioni sempre più accessibili, attraverso l'apertura di nuovi e più specifici ambiti di intervento collegati a problematiche emergenti (consultori per la menopausa, per i disturbi del comportamento alimentare, per adolescenti, per preparazione alla nascita, per percorsi di IVG...), dotazioni di competenze professionali più approfondite e di strumentazioni più sofisticate .
L'accesso ai Servizi di persone e famiglie con disturbi e patologie gravi, disabilità motorie e intellettive notevolmente invalidanti, maltrattamenti e abusi – e non solo in condizioni di deprivazione economica e culturale – richiede competenze consistenti di operatori, assistenti sociali ed educatori dotati di motivazioni e capacità relazionali empatiche, ma anche specialisti preparati in campo diagnostico e terapeutico, psicologi, medici, psichiatri e neuropsichiatri, nonché terapisti della riabilitazione. Il funzionamento in équipe si va frammentando in diversi interventi specialistici, in ambulatori, ciascuno strutturato secondo specifiche impostazioni metodologiche e collocato più o meno implicitamente entro gerarchie che riservano maggior peso a chi ha posizioni professionali e istituzionali più forti e elevate.
Chi lavora nei Servizi si trova così investito sempre più di richieste, perché la società, l'opinione pubblica, «vede» queste difficoltà e insieme presenta pretese, esige «risposte adeguate». Questa locuzione (*risposte adeguate*) diventa quasi una parola d'ordine in tutti i Servizi, ma è carica di elementi ambigui. Nel complessificarsi delle situazioni di disagio che arrivano ai Servizi e, parallelamente, nella diversificazione dei servizi per farvi fronte, gli interventi rischiano di «rispondere» al destinatario che l'operatore tende a privilegiare perché questo corrisponde al mandato del Servizio in cui lavora. Ma in quest'ottica di individualizzazione scivola via l'attenzione alla tutela dei diritti, intesa come costruzione di condizioni sociali in cui *tutti* possano ritrovarsi considerati soggetti a pieno titolo.

La strada dell'aziendalizzazione

Per quel che mi è possibile ricostruire, credo che le leggi 502/1992 e 517/1993 segnino un punto di svolta nella vita dei Servizi socio-sanitari nel nostro Paese. Vengono emanate effettivamente come «riforma della riforma sanitaria». Più che per le singole definizioni in esse contenute sono significative per l'impostazione che le caratterizza. Esprimono una sorta di *inversione di tendenza* per molti aspetti riconducibile a una crescente preoccupazione per l'espandersi della spesa pubblica e per l'esigenza di porvi freno.
Non si intende rinunciare a una ipotetica politica di welfare, ma la si incanala su due binari che sembrano da un lato mantenere linee strategiche congruenti con la scelte passate e dall'altro corrispondere alle nuove esigenze. Si ridisegna per tutta l'area sanitaria e socio-assistenziale un governo decentrato, affidato alle Regioni, e al tempo stesso si definisce per i Servizi

un assetto organizzativo/amministrativo in grado di esercitare funzioni di controllo della spesa e di verifiche di efficienza, in modo analogo a quello che accade nelle imprese industriali e commerciali.
È a questo punto che si registra una *più consistente attenzione all'organizzazione* dei Servizi sanitari e socio-assistenziali. Già ci si era avviati su questa strada quando, tra la fine degli anni '80 e l'inizio degli anni '90, da parte di alcuni Comuni si era delegata l'attività qualificabile come sanitaria alle Unità socio-sanitarie locali e quando alcune Regioni si orientavano a togliere dalla denominazione degli enti l'aggettivazione «socio». È tuttavia diventata più visibile dopo le leggi 502 e 517 che richiedevano la trasformazione delle USSL o USL in ASL, *aziende sanitarie locali*, separandole dalle aziende ospedaliere. In seguito si è avuto un succedersi di disegni e ridisegni organizzativi collegati ad accorpamenti, a ritiri delle deleghe, a varie esternalizzazioni a enti e cooperative, a costituzione di aziende speciali con declinazioni differenti.
In questo clima si è diffusa una sorta di acculturazione all'impostazione organizzativa dominante in aziende industriali; si sono acquisiti nel linguaggio corrente dei termini come «obiettivi», «budget», «flow chart», «lay out», «core business», «vision» che presentificano la cosiddetta *aziendalizzazione*. La stessa parola «azienda» rimanda immediatamente a una sorta di *assimilazione della produzione di servizi a qualsiasi tipo di produzione industriale, produzione di beni con uso di impianti e macchinari*. E questo ha un duplice risvolto. Si assume e si diffonde un'impostazione complessiva che è incardinata su un modello fordista, impregnato di razionalità astratta, incentrato sulla divisione a tutti i livelli, in settori, in uffici, in competenze operative a seconda delle categorie e degli inquadramenti, sulla definizione di regolamenti e procedure sempre più minute, sui controlli formali, sul privilegiare le comunicazioni dall'alto al basso e scoraggiare le interazioni orizzontali: un'impostazione verticistica che induce deresponsabilizzazioni diffuse.
L'altra ricaduta è una sorta di *apprezzamento idealizzato del funzionamento delle organizzazioni «private»* come garante di efficienza e di capacità di innovazione/adattamento, e parallelamente una delegittimazione del «pubblico» come imprigionato in una corazza di inerzie e adempimenti inderogabili, inevitabilmente statico e autoreferenziale.
Ambedue questi aspetti si può ipotizzare che per alcuni anni abbiano contribuito a non sostenere le identificazioni degli operatori a livello di base con i Servizi pubblici, con i Comuni e con le ASL come enti locali finalizzati a tutelare salute e benessere. È come se si fosse alimentata una scissione tra «privato efficiente» e «pubblico inefficiente» e si fosse sottovalutata la centralità – per chi lavora in un'organizzazione che produce servizi – del condividerne le finalità, i valori che danno senso e qualità all'operare quotidiano con i destinatari.
È forse interessante ricordare che, nelle stesse imprese produttrici di beni, alla fine del secolo scorso si cominciava a mettere in discussione il modello aziendale tradizionalmente acquisito per ricercare assetti meno rigidi, più mobili e aperti, per introdurre e sviluppare una nuova cultura [5]. Allora perché è stato tanto privilegiato il

5 | Norman R., *Ridisegnare l'impresa. Quando la mappa cambia il paesaggio*, ETAS, Milano 2002.

riferimento all'azienda? Perché si è assunto un modello che stava per essere superato? Forse chiamare *azienda* una qualsiasi organizzazione produttiva significa imprimere un'impostazione in cui il risultato economico deve essere assunto come assolutamente prioritario.
Ma è questa la maggiore finalità delle organizzazioni dei Servizi, che anche quando sono private hanno comunque una funzione pubblica?

La divaricazione dell'area sanitaria

È andata individuandosi un'area di Servizi qualificabile come «sanitaria» che, con differenze tra le diverse Regioni, è stata in vari modi separata e orientata in senso più specificamente aziendalistico. Essa ha un mercato entro cui sono presenti diversi soggetti privati e pubblici che erogano un'ampia gamma di attività, anche avvalendosi di competenze specialistiche, altamente specialistiche, a cui i cittadini si rivolgono potendo scegliere liberamente.
Il funzionamento organizzativo di quest'area è fortemente regolato da disposizioni normative cogenti che dovrebbero garantire la qualità dei servizi forniti da ospedali e case di riposo, da comunità e Servizi ambulatoriali. Per usufruirne è necessario che i cittadini seguano le procedure previste e dimostrino di avere le prerogative e le documentazioni che confermino le loro richieste.
Entro questa impostazione si erogano prestazioni, azioni/risposta entro un rapporto interindividuale tra singolo destinatario e singolo operatore che – psicologo o fisioterapista o infermiere della salute mentale – è comunque qualcuno che «cura» e pertanto prescrive, inquadra, definisce, decide. Al contempo, è proprio in questo contesto che si aprono nuove elaborazioni sui contenuti dell'attività sanitaria, verso una concezione olistica, che mette al centro la persona e che distingue il «curare» come mettere in campo terapie finalizzate alla guarigione e il «prendersi cura» come mobilitazione di ascolti e attenzioni in una comunicazione ravvicinata tra operatore e persona che soffre e che è portatrice di disturbi e problemi di salute fisica e psichica.
Non solo. Mentre si rafforzano regolamentazioni e moltiplicazioni dei controlli finalizzati a migliorare la produttività, cioè a ottenere a tutti i livelli interventi qualitativamente accettabili col minimo dei costi, ci si scontra con rigidità sostenute da varie istanze anche sindacali. Là dove per le inerzie inscritte nel settore pubblico risulta difficile introdurre variazioni specifiche nell'organizzazione del lavoro e nella retribuzione o in genere nel trattamento del personale, si ricorre alle cosiddette «esternalizzazioni».
Con questo neologismo (anche un po' astruso) si vuole indicare quella produzione che viene posta fuori dall'ambito in cui finora è stata realizzata. Gli interventi nei confronti di situazioni di sofferenza e malessere possono essere spostati dai Servizi pubblici per essere delegati ad altri sistemi produttivi, privati, gestiti con criteri di maggiore efficienza, ricorrendo ad altri contratti di lavoro, spesso precari, e a selezioni sommarie con scarse verifiche delle competenze professionali. Si pone l'interrogativo se questa sia una sorta di «privatizzazione che priva», nel senso che trascura il mandato istituzionale della tutela della salute psico-fisica e degli altri diritti soggettivi, o se sia invece una consegna di finalità pubbliche ad altri attori sociali con cui si collabora proprio per poterle realizzare in modo più efficace.

Le ambivalenze nelle regolamentazioni

Le diverse sfaccettature delle configurazioni che si vanno consolidando nei Servizi sono rese più evidenti dall'ampliarsi e complessificarsi delle malattie croniche, delle disabilità permanenti, delle patologie oncologiche, di tutte quelle situazioni in cui si vive con esigenze di cure molteplici e diversificate, messe a disposizione da più professionisti, specialisti, collocati anche in sedi differenti e con modalità di lavoro tra loro disomogenee per stili e strumenti, per documentazioni e orari. Vengono proposte e sviluppate, in più ambiti e da più gruppi, iniziative rivolte alla *umanizzazione* dei Servizi come se fosse necessario contrastare il funzionamento vigente per realizzare quello che sostanzialmente è il compito primario di queste organizzazioni.

In quest'area, cosiddetta della *cronicità*, che col passare del tempo, proprio grazie ai progressi della medicina, sta crescendo (e che secondo le stime dell'Oms costituisce circa la metà delle richieste di cura presenti oggi nella società occidentale), si avverte più chiaramente l'importanza dell'*integrazione* tra Servizi di cura e di riabilitazione, tra professionisti di area strettamente sanitaria e professionisti di area psico-sociale, tra ospedale e territorio, tra Servizi pubblici che forniscono attività diagnostiche, interventi su patologie in fasi acute e Servizi tendenzialmente messi a disposizione da cooperative per assistenza domiciliare, ospitalità residenziale o semi-residenziale di persone anziane e disabili.

Contemporaneamente ci si orienta anche ad attribuire a chi si rivolge ai Servizi contrattualità e capacità e, riservando soltanto alle situazioni più strettamente ospedaliere la denominazione di *pazienti,* si introduce l'idea che siano dei *clienti*, non tanto perché debbano avere sempre ragione, quanto per modificare il sostantivo più tradizionalmente utilizzato – *utenti* (denominazione più connotata entro una cultura amministrativa) – e richiamare uno stile di lavoro e di rapporto più simmetrico, più attento e sollecito.

Nell'evoluzione del sistema organizzativo dei Servizi sanitari sembrano pertanto presenti delle componenti ambivalenti se non quasi contrastanti: tra impianti lavorativi rivolti a standardizzare da un lato e iniziative per umanizzare e personalizzare dall'altro, tra spinta a modificare le organizzazioni pubbliche e adottare affidamenti di interventi al privato, tra classificazioni di categorie di destinatari e valorizzazione delle loro capacità di scelta.

Accanto a questi movimenti oscillanti va segnalato anche che da un lato si tendono a modificare i rapporti tra Servizi e cittadini per fare in modo che questi ultimi abbiano maggior voce in capitolo, siano più ascoltati nei loro desideri e nelle loro attese, siano sempre più «persone al centro»; d'altro lato gli operatori che sono poi in contatto diretto con loro sono inquadrati in tempi sempre più compressi, in procedure sempre più codificate, funzionali a verifiche e valutazioni ed esposte al rischio di diventare impersonali.

E la tutela dei diritti che i servizi sono chiamati a produrre, come si realizza in questo quadro? La domanda resta aperta. Probabilmente si è andata infiltrando una divaricazione tra produrre servizi e tutelare diritti.

La legge 328 e la riforma del Titolo V

La legge 328 del 2000, arrivata dopo molti anni di attesa di un atto istituzionale che riformasse tutto il sistema socio-assistenziale,

costituisce una presa di posizione forte per la legittimazione degli attori e degli interventi che si occupano di difficoltà sociali e per la definizione di orientamenti più aperti alle complessità che si tratta di affrontare. Si disegna un «sistema integrato di interventi e servizi sociali» e quindi è ben presente l'importanza di riconsiderare nell'insieme tutto ciò che si agita in questo campo. Al di là del richiamo ai diritti di cittadinanza che forse è un po' formale e un po' rapido, alcuni elementi mi sembrano da sottolineare come particolarmente rilevanti:

- la considerazione e il riconoscimento dell'esistenza nel contesto sociale di più soggetti istituzionali e non, pubblici e privati che possono farsi parte attiva nel contrasto ai disagi sociali;
- la gestione degli interventi in diverse forme, dirette e indirette;
- la valorizzazione delle iniziative e delle risorse che possono essere messe in campo da più parti e in più forme;
- la rappresentazione degli interventi nel sociale come realizzazioni che richiedono delle progettazioni, ovvero degli investimenti in idee ed elaborazioni, e anche delle verifiche e valutazioni di impatto;
- la centralità dell'integrazione tra diversi attori sociali e tra diversi interventi.

Si ha qui una ricomposizione di dimensioni istituzionali e organizzative che sembrerebbe poter orientare o ri-orientare positivamente delle ricomposizioni feconde per l'operatività dei Servizi. Costituisce un passaggio innovativo che probabilmente ha avuto ricadute meno importanti e penetranti di quel che ci si sarebbe potuti aspettare per diverse ragioni.

Soltanto un anno dopo, nel 2001, veniva promulgata la riforma del Titolo V della Costituzione che ricolloca sostanzialmente la legge 328 in un nuovo assetto istituzionale e ne indebolisce la portata e la pregnanza. L'area socio-assistenziale viene attribuita alle competenze delle Regioni che sono legittimate ad assumere delle scelte diverse anche rispetto alla allocazione delle risorse e alla definizione e programmazione degli interventi. Ogni Regione, dopo alcuni anni, predispone una legge di riordino delle politiche sociali che riprende e traduce la 328 con definizioni e interpretazioni differenti, ispirate a diversi indirizzi e rivolte a diverse declinazioni attuative, spesso orientate dai modelli di welfare già praticati e da visioni condivise dalle diverse componenti partitiche presenti nel governo locale.

La sorte dei Piani di zona

Ci si può chiedere quanto i Servizi e gli operatori, quelli appartenenti agli Enti pubblici ma anche quelli del terzo settore o del cosiddetto privato sociale e del volontariato, abbiano colto le componenti innovative del nuovo dettato istituzionale e abbiano visto la possibilità di farne leva per incrementare e migliorare i sottosistemi organizzativi e gli stessi interventi.

Pensiamo in particolare a un dato che potrebbe apparire un dettaglio, ma anche un indizio a cui ripensare: quanto e come è stata assunta la realizzazione del *Piano di zona*, un dispositivo in cui si condensano in modo significativo elementi caratterizzanti di una rinnovata prospettiva con cui intervenire nel sociale? Un Piano traduce in termini operativi delle linee di indirizzo rilevanti per dare nuovo impulso alla considerazione e alle strategie di azione rispetto ai problemi sociali: la prima è quella di ancorarsi al territorio, ovvero alla realtà socio-economica e culturale in cui si vive, di cui si può avere una conoscenza ravvicinata e con cui si può attivare e mantenere rapporti continuativi nel tempo. Questo dà confini all'operare ma

al tempo stesso facilita connessioni.
Il termine Piano può rimandare a processi di programmazione gerarchizzati e rigidi, ma si può anche ipotizzare che intenda esprimere l'importanza di una formalizzazione scritta di un lavoro programmatorio a cui nel testo si dà più volte il nome di *progettazione*. Si danno esplicite indicazioni per organizzare i servizi, per rilevare dati, per «stimolare le risorse locali di solidarietà e auto-aiuto», per «responsabilizzare i cittadini nella programmazione e nella verifica dei servizi», per realizzare integrazioni a livello operativo e di sistema.
Mi risulta, tuttavia, che i Piani di zona siano stati visti con diversi atteggiamenti: inizialmente, soprattutto da alcuni, con entusiasmo e con impegno a darne traduzione operativa, da altri come adempimenti a cui era necessario sottostare o come tavoli su cui cercare di attribuire (o accaparrare) risorse finanziarie. Ci si è scontrati con varie difficoltà, con Comuni portatori di interessi non univoci, con rapporti tra cooperative e ONLUS influenzati da giochi di potere, con associazioni di volontariato poco propense a inserirsi con contributi specifici.
Forse soltanto in alcuni casi felici, attraverso i Piani di zona, si è riusciti – mi sembra – a costituire un ambito realistico di ridefinizione di condizioni per garantire per tutti più adeguate tutele dei diritti soggettivi, proprio attraverso una migliore e più mirata organizzazione concordata e integrata.
Si può considerare questo un indizio con cui interrogare i Servizi?
Nel corso del tempo, sedimentate, affievolite e cristallizzate le originarie motivazioni ideali, non si è forse depositata una cultura in cui le dimensioni istituzionali hanno assunto un peso, più nel senso di mantenere attese di trovare sostegni e legittimazioni che di suscitare idee e iniziative, di far cogliere possibilità di intraprendere?

Le ricadute della «crisi»

Intorno al 2008 dagli Stati Uniti rimbalzano in Europa e nel nostro Paese una serie di fenomeni che vengono complessivamente descritti come «crisi» e che danno ulteriore accelerazione e ampiezza a trasformazioni già in corso, che scuotono un ordine sociale a cui si è abituati e che collegano immediatamente accadimenti a livello globale con vicende della quotidianità.
A livello individuale e familiare si avvertono come imminenti e possibili perdite di ricchezza, di collocazione sociale per sé e per i propri figli: si percepiscono con angoscia rischi incombenti del venir meno di condizioni di abitazione e di lavoro e anche di salute propria o dei propri parenti anziani. È serpeggiante un malessere sociale che sempre meno è prerogativa soltanto di alcuni strati sociali: sul piano collettivo tende a essere minimizzato o impacchettato (vi si dedicano infatti a livello governativo vari «pacchetti» di misure); ciascuno individualmente cerca di contrastarlo, anche di negarlo, in attesa che prima o poi il ciclone passi.
Tutto questo si riversa sui Servizi in termini di maggior numero di persone e famiglie che ad essi accedono (o cercano di accedere), di pesantezza dei problemi che vengono portati (intrecci di difficoltà economiche e relazionali), di diversi rapporti tra operatori e destinatari (manifestazioni di rivendicazioni cariche di aggressività), di attese che non trovano risposte. Forse soprattutto *si richiede ai Servizi di cambiare*. Da parte dei vertici organizzativi vengono sollecitate e talvolta anche imposte modificazioni sostanziali rivolte a ridurre la spesa e a far fronte comunque al malcontento diffuso. Da parte della gente sono sempre più forti le pretese di veder soddisfatti i propri diritti, da quelli di essere tempestivamente

ascoltati nelle proprie difficoltà a quelli di essere difesi dagli sfratti, aiutati a pagare un mutuo, ottenere un sussidio. I Servizi, costituitisi come fautori di cambiamenti per realizzare maggiore equità, diventano uno degli avamposti più attaccati per esprimere risentimenti e impotenze.

A fronte di un'esigenza di contenimento del debito pubblico tutte le organizzazioni dei Servizi vengono inglobate indistintamente entro quel sistema – o quell'aggregato – chiamato welfare, per anni considerato come una méta da raggiungere per ogni paese democratico e che oggi non appare più edificabile. Si cerca di qualificarlo in altri modi (welfare locale, welfare mix, welfare di comunità, welfare territoriale), forse per rendere meno laceranti tagli e riduzioni di spesa o anche per richiamare confini e riaggiustamenti con cui prospettare il raggiungimento di una maggior efficienza.

Gli irrigidimenti nel funzionamento

La riforma del Titolo V della Costituzione, che dà ampio spazio alle autonomie locali, se da un lato crea opportunità per nuove combinazioni, dall'altro ha avuto esiti imprevisti rispetto alle attese: le Regioni si sono rivelate nel tempo organismi governativi troppo distanziati dalle problematiche dei diversi territori e soprattutto troppo differenziate nell'ampiezza, nelle risorse da investire e negli orientamenti, creando disparità nelle possibilità di fruizione dei servizi da parte dei cittadini e probabilmente rendendo ancor più evidenti squilibri tra territori, inadempienze e assenze.

L'adozione del cosiddetto modello «aziendale» attraverso interventi di razionalizzazione definiti (imposti) dall'alto un po' in tutti gli enti pubblici e importato anche in cooperative e fondazioni, ha portato irrigidimenti nel funzionamento, appesantimento di rendicontazioni e controlli di tipo quantitativo/formale, attenzioni alle esecuzioni di quanto prescritto.

In particolare credo si sia sottovalutato quanto in tutto questo assetto abbia influito la considerazione dei singoli come variabile dipendente: personale classificato in categorie collocate entro linee gerarchiche e anche utenti, pazienti, clienti individuati per patologie e disturbi dei diversi organi e per aree corrispondenti a caratteristiche strutturali (anziani, adulti, minori...). L'investimento nelle relazioni con i destinatari rischia di essere deviato verso la preoccupazione di non conformarsi a procedure e protocolli, di essere colti in fallo e di subirne spiacevoli conseguenze.

A che cosa sono ispirati questi mutamenti organizzativi con cui ci si attrezza per rispondere ai mutamenti più generali?

È come se fossero acquisiti culturalmente come positivi e risananti dei criteri istituzionali e organizzativi già presenti e utilizzati. Non pare abbiano ottenuto riscontri interessanti – nel senso anche di aver segnalato scelte da scoraggiare –, ma si continua a privilegiare, confermare e quasi rinforzare:

- il *ridimensionamento delle funzioni pubbliche*, minimizzandone e sottovalutandone

la portata per la vita di tutti: si sostiene una sorta di spostamento di attività dai Servizi pubblici perché le medesime attività possono essere svolte da Servizi privati con maggiori competenze e soprattutto con maggiore attenzione ai costi. Il risparmio rimane il criterio per il funzionamento dei Servizi e la privatizzazione diventa la garanzia di una buona gestione. La funzione sociale di integrazione e ricomposizione resta in secondo piano;

• la *centralità della produttività:* si esige efficienza o più efficienza e non solo da parte dei vertici dell'organizzazione, che hanno il compito di promuoverne un buon funzionamento, ma anche da parte dell'opinione pubblica al cui giudizio direttamente o indirettamente l'organizzazione è esposta; per questo è necessario dimostrare tangibilmente che le spese diminuiscono o non aumentano e da qui si decidono limitazioni e valutazioni. È irrilevante se questo comporta *gravi disconoscimenti dei diritti soggettivi* e ricadute in termini di aumento di tensioni e stratificarsi di conflittualità.

Inedite prospettive di pensiero e azione

Contemporaneamente l'impoverimento generalizzato con cui si è costretti a confrontarsi apre altri scenari. *Arrivano segnali di nuove iniziative che introducono inedite e inaudite prospettive di pensiero e azione in diversi territori*, che costituiscono sperimentazioni molto interessanti e costruttive.

Nell'orizzonte generale, rispetto a quel che ho richiamato fin qui, sembrano avere un peso limitato perché appaiono come frammenti, come esperienze circoscritte sostenute da alcuni fattori, in particolare di tipo culturale e relazionale. Sono esperimenti di cui tenere attentamente conto per trarne apprendimenti. In particolare credo che abbiano messo in luce che:

• il lavoro nel sociale implica una *centratura sul territorio*, riguarda tutti coloro che lo abitano: è lì che si manifestano i disagi ed è lì che sono presenti *risorse non pensate* e non immaginate mobilitabili, *generative di ulteriori risorse*; questo porta a «scoprire» che tra Servizi e cittadini sono possibili diverse interazioni, diversi scambi tra ciò che può essere messo a disposizione e ciò di cui si può usufruire con vantaggio reciproco; è pertanto cruciale l'*investimento nelle relazioni di fiducia* e nelle comunicazioni tra cittadini e Servizi e tra Servizi;

• *i problemi* di singoli e famiglie *vanno identificati*, distinti con specifici accorgimenti conoscitivi e *collegati a questioni trasversali* con diverse elaborazioni: questo consente di disporre di rappresentazioni più realistiche delle difficoltà, di attivare responsabilizzazioni a livello individuale e collettivo, motivazioni e cooperazioni;

• sono pensabili e sviluppabili connessioni tra gruppi e aree anche molto diverse e distanti tra loro; *vanno costruite convergenze per affrontare i problemi* perché si può apprezzare l'efficacia (e non soltanto l'efficienza) di ciò che viene intrapreso solo attraverso visioni orientate da valori sufficientemente condivisi; la costruzione di legami è in divenire e va accompagnata nella ricerca di un «bene comune», che non si osa quasi neppur più nominare.

È a partire da riconsiderazioni e riletture di questi orientamenti che mi sembra possibile aprirsi a proposte evolutive.

Franca Olivetti Manoukian, psicosociologa, è formatrice e consulente dello studio Aps di Milano: olivettimanoukian@studioaps.it

A un giovane operatore della salute mentale

Lettera aperta per riconoscerci in una storia che parla al futuro

di
Peppe Dell'Acqua

Nel numero 286 di Animazione Sociale, Eugenio Borgna, maestro di una psichiatria dell'ascolto e del colloquio, ha invitato a «rifondare la psichiatria come scienza umana». E ha rivolto il suo appello alla nuova generazione di operatori della salute mentale, senza il cui apporto – ha detto – «la grande rivoluzione basagliana rischia di svuotarsi e di perdere le sue ragioni d'essere». Come rivista, ci è subito venuto in mente di chiedere a un altro maestro, Peppe Dell'Acqua, di proseguire il discorso. Ne è nata questa «lettera aperta», rivolta a chiunque operi nel campo della cura e anche a tutti i cittadini e le cittadine con cui sempre più bisogna imparare a parlare.

Marco Cavallo, che tu forse conosci, ha insistito molto perché ti scrivessi. Di recente abbiamo fatto visita agli internati dei sei OPG (Ospedali psichiatrici giudiziari) che ora stanno per chiudere, siamo stati in viaggio per due settimane e abbiamo incontrato tantissime persone.
Sono più di quarant'anni che andiamo in giro e di cose ne abbiamo viste, di storie ne abbiamo ascoltate, di persone belle e generose ne abbiamo conosciute tante. Abbiamo condiviso con loro l'attesa del cambiamento, la sorpresa per le impensabili scoperte, la commozione delle storie ritrovate.
Continuiamo a incontrare persone, e soprattutto giovani, che raccontano delle difficoltà quotidiane, di chiusure, di assenze, di vuoti, di solitudini. Ci dicono di rinnovate resistenze a un cambiamento semplicemente urgente e quanto mai ovvio. Lamentano la mancanza di una qualsiasi tensione etica, che suppongono essere stata il motore delle lotte di quegli anni.
La lettura della recente intervista a Eugenio Borgna sul numero 286 di questa rivista [1] mi ha stimolato a scriverti. Con Borgna condivido l'indignazione per una psichiatria indifferente ai valori dell'interiorità, ridotta alle psicofarmacologie, distante dai luoghi, dalle voci, dalla vita delle persone.

L'insostenibile grigiore delle psichiatrie

È da tempo che sento parlare del grigiore delle psichiatrie che oggi tengono il campo. «Le mani alla gola degli schizofrenici», per dirla con David Cooper, continuano a soffocare emozioni, parole, passioni. Una scena, questa, che oggi si mostra quasi ovunque senza veli e senza vergogna alcuna.
I giovani, più degli altri, rischiano di essere annientati (o di svanire) in questo scenario. Parlo dei giovani che vivono l'esperienza della psicosi e dei tanti giovani che come te si apprestano a fare questo mestiere. I primi rischiano la vita, i secondi, anche! E non ho bisogno di dirti cosa voglio intendere. Studenti di medicina, di psicologia, specializzandi, infermieri, tecnici, educatori quando scelgono di occuparsi dei *malati di mente* sono entusiasti, curiosi, disposti a mettersi in gioco.
Li vedo generosi e desiderosi di cogliere il senso etico, politico e umano di questo lavoro. Hanno occhi che guardano e orecchie che ascoltano.
Accade che al primo impatto con le accademie, con i servizi di salute mentale vuoti e insensati, come troppo spesso accade, con diagnosi e cura che divengono bunker e ricorrono routinariamente alla contenzione, con strutture residenziali e sedicenti comunità terapeutiche, dove domina la miseria della gerarchia, dell'infantilizzazione e dell'intrattenimento senza fine sono tentati di fuggire. Possono restare solo a costo di perdere la luce dei loro sguardi, diventare sordi e accettare la condanna a pratiche indicibili e alla solitudine quotidiana.
Nel corso del tempo, un tempo sempre più breve, rischiano di perdere ogni curiosità, ogni desiderio. Arrivando nei luoghi della psichiatria, sperimentano lo sgomento dell'assenza. Per poter sopravvivere, sono costretti a prendere distanza. L'*inferno* che si presenta quotidianamente ai loro occhi diventerà invisibile. Non si può sopportare di stare in quella scena se non c'è mai un

1 | Borgna E., *La terza rivoluzione che serve alla psichiatria*, in «Animazione Sociale», 286, 2014.

povero diavolo o un buon cristiano che condivide con noi quel dolore, quella fatica, che ci aiuti a continuare. Non si può che impedirsi quella visione, l'inferno non può che essere cancellato alla nostra vista e l'accettazione delle cose così come sono, immutabili e impenetrabili, diventa l'unica possibilità per sopravvivere. Ecco, per questo Marco Cavallo mi spinge a scriverti. Le cose che voglio dirti mi assalgono e rischio di essere confuso e di annoiarti. Ma un qualche punto in premessa devo segnarlo: riconoscerci in una storia che possiamo condividere e cogliere insieme il senso di quanto negli anni passati è accaduto.

Chissà se ti hanno mai parlato di Gorizia

Allora dicevo, nel corso del viaggio abbiamo attraversato 10 regioni e siamo stati accolti in 16 città. Nelle università, nelle piazze, negli ospedali abbiamo incontrato persone. Parlato e ascoltato tantissimi giovani che ci chiedevano di questo nostro mestiere desiderosi di cominciare. Il loro valore è inestimabile e pure, nella trascuratezza e nella disattenzione, rischiano di perdersi, di divenire invisibili. Avrebbero bisogno, per non scomparire nel grigiore delle psichiatrie, di sentirsi vicini gli uni agli altri. Fanno fatica a trovare luoghi e modi per raccontarsi; per dirsi delle incertezze, delle frustrazioni, dei successi inaspettati e della gioia che sempre il lavoro quotidiano con le persone è capace di restituire. Avrebbero bisogno di trovare parole intorno alle quali costruire un dialogo, un conflitto, uno scontro, la capacità stessa di confrontarsi, di condividere, di opporsi, di disobbedire. Abbiamo bisogno tutti di riflettere sulle nostre storie, di frequentare esperienze e conoscere pratiche che ci aiutino a vedere che «si può».

Ecco mi piacerebbe parlare con te, di come ricominciare. È urgente.

Ma forse prima sarebbe bene che tu mi dicessi delle tue esperienze, delle tue conoscenze, dei tuoi punti di vista. Chissà se ti hanno mai parlato di Gorizia. Nelle facoltà di medicina, di psicologia, di infermieristica, di assistenza sociale e nelle scuole di specializzazione e di riabilitazione psichiatrica è difficile trovare corsi, seminari, ricerche legati alla storia del cambiamento, alle possibilità di cura e di emancipazione che sono nate dalle prime porte aperte dell'ospedale goriziano. I riferimenti vengono cercati altrove, si studiano malattie, modelli di servizi, assetti sociali e politici che non tengono conto della scelta di campo che il nostro Paese ha fatto abbandonando il modello manicomiale, restituendo diritti, e scommettendo sulle possibilità dei singoli. Ovunque si insegna La Psichiatria e ovunque domina la freddezza del paradigma medico, troppo spesso mutuato da assetti culturali e sanitari di altri paesi.

Chissà cosa ti hanno raccontato della *storia della malattia mentale*? E del *malato*? Della legge 180? Della chiusura dei manicomi? Dei diritti? Delle ritrovate cittadinanze?

La salute mentale è altro dalla psichiatria

So per certo che nelle nostre scuole è raro sentire parlare di salute mentale, che non è psichiatria! L'insegnamento dominante delle psichiatrie la ignora, oppure la incorpora e la snatura. Così il dipartimento di salute mentale, in alcune regioni, diventa dipartimento di psichiatria e i servizi territoriali di salute mentale, ambulatori di psichiatria. È chiaro che non è la stessa cosa. I nomi tradiscono la persistenza di modelli che avremmo dovuto abbandonare

e comunque una sorda resistenza al cambiamento.
Salute mentale è mettere in campo le persone con le loro singolari esistenze; cogliere l'insieme delle relazioni, delle tensioni, dei conflitti di una comunità; portare le risorse e le cure dalle istituzioni, dagli ospedali (mi riferisco qui alle strutture residenziali, ai «repartini» ospedalieri e non ultimo oggi agli OPG) nel territorio; spostare l'attenzione dalla malattia all'individuo (alla persona, al cittadino) e alle sue peculiari dis/abilità; muovere da azioni individuali ad azioni collettive nei confronti delle persone con disturbo mentale e dei loro contesti. Incontrare e «creare» esistenze.
Quando ti parlo di cambiamento voglio intendere che i manicomi non ci sono più e siamo oggi impegnati, con la chiusura degli OPG, ad abbandonare per sempre gli ultimi residui dei dispositivi di internamento ottocenteschi; le persone che vivono l'esperienza del disagio mentale possono contare, se pure tra mille ostacoli, sui loro diritti riconquistati; le imprese sociali, le cooperative, nate proprio dalle macerie del manicomio, dove riescono a tener fede alle ragioni della loro origine e sono in grado di stare sul mercato e produrre lavoro, rendono concrete le speranze di crescita e di emancipazione di tantissimi; ovunque, bene o male, i servizi territoriali sono stati organizzati ed è possibile trovare Centri di salute mentale attivi e presenti quotidianamente a sostegno della vita delle persone; le associazioni di persone con disturbo mentale creano protagonismo, partecipazione e ripropongono la dimensione politica delle esperienze, delle diversità, delle fragilità; in tanti luoghi dell'abitare e in tanti laboratori, è possibile oggi coltivare il valore della relazione, la bellezza degli spazi e degli oggetti; la qualità dei lavori e delle produzioni dimostra che è possibile curare senza contenzioni, con le porte aperte, con programmi abilitativi personalizzati, con percorsi di formazione e di inserimento lavorativo reali, con il sostegno e il coinvolgimento dei familiari, con l'appoggio puntuale, anche economico, nella vita quotidiana, con la possibilità per le persone di vivere identità plurali. Con la possibilità di guarire.

Perché la legge 180 fa così fatica?

Molti mi chiedono: ma cosa è accaduto veramente, come mai dopo tanti anni la legge 180 fa tanta fatica, perché tante differenze? Non è semplice rispondere, ordini di discorso diversi si sovrappongono e creano grovigli difficili da sciogliere.
Che cosa è stata la riforma dell'assistenza psichiatrica in Italia, o meglio che cosa avrebbe dovuto essere se non un simultaneo tentativo di attraversare la dimensione etica, disciplinare, politica e amministrativa? Che cosa vediamo oggi, o dovremmo vedere, se non il radicale cambiamento delle organizzazioni del lavoro e delle pratiche, dei luoghi e dei tempi, delle tecniche e degli indirizzi disciplinari, della disposizione strategica delle risorse in campo?
A ben guardare, è la disposizione incerta, incompleta, approssimativa dei servizi di salute mentale nel territorio la chiave di lettura di ciò che è accaduto e accadde. La distanza (o la vicinanza) dalla vita delle persone, i riferimenti culturali e disciplinari im/mutati, in una sola parola l'organizzazione e le sue forme permettono di cogliere il senso e le ragioni delle buone pratiche (e ancora meglio dei fallimenti).
Ho avuto la fortuna di vivere a Trieste l'attenzione quotidiana, frenetica e ossessiva allo smontamento dell'ospedale psichiatrico.

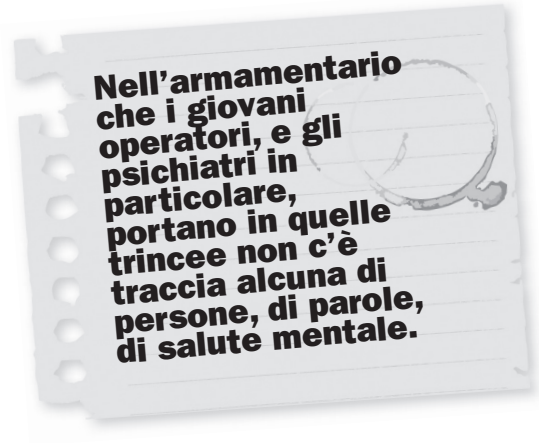
La rassicurante stabilità del sistema manicomiale si è dovuta tradurre nella ricerca incerta di modi e parole differenti, nella «banalità» del lavoro quotidiano, nel riconoscimento prima di tutto dell'irruzione dei bisogni delle *persone* sulla scena. I s*oggetti* non potevano più essere accantonati. È a partire da qui che sono nati i servizi di salute mentale e la loro capacità di radicarsi nel territorio e di operare criticamente sui modelli medici e psicologici dominanti, di produrre davvero protagonismo, di vedere la «persona non la malattia». È qui, credo, che bisogna giocare per uscire dal grigiore e dal pessimismo che oggi tanto si respira nei servizi e nelle accademie. L'organizzazione del lavoro ha dovuto piegarsi alla presenza dei soggetti e i linguaggi del quotidiano hanno cominciato a tessere un lessico *familiare,* capace di riconoscere e sostenere le molteplici identità, di ascoltare, di accogliere.

Il dottore domina ancora la scena

Sono sempre più convinto che è necessario trovare indirizzi, percorsi, visioni da condividere, alleanze e reti per formare associazioni, lavorare sempre insieme agli altri, fare gruppo. Bisogna avere la capacità di convergere e orientare lo sguardo verso orizzonti etici che insieme si riconoscono. I giovani operatori, al contrario, vengono avviati allo specialismo esasperato, all'accettazione acritica di tecniche e modelli, a «difendersi» all'ombra di mansionari, di posizioni di garanzia, di protocolli. L'idea che tu debba diventare il *bravo dottore* è ancora profondamente radicata nelle scuole e nei servizi. Si propone e si riproduce quotidianamente nella separazione di compiti e funzioni, in un circolo vizioso che porta a pensare che i centri di salute mentale debbano essere poco più che uno studio medico associato con un infermiere che risponde al telefono e tiene gli appuntamenti.

Per fortuna il tempo non è passato invano e le persone oggi chiedono di guarire. Mettono impietosamente in luce il fallimento di questi sistemi. Richiedono consapevolmente un ascolto singolare e un altrettanto singolare percorso di cura e di emancipazione. Chiedono di vedere valorizzati i loro faticosi e unici percorsi di ripresa. Vogliono essere aiutati e sostenuti nell'attraversare cruciali e rischiosi punti di svolta nella loro esistenza. Cominciano a disegnare, con la loro domanda, servizi popolati da una molteplicità di operatori, servizi che essi pretendono orientati alla guarigione, alla ripresa appunto, al sostegno delle loro vite e dei loro sogni. Anche nel tempo lungo.

In molti professionisti della salute mentale l'adesione entusiastica al processo di chiusura dell'ospedale psichiatrico si materializzò in un rafforzamento arrogante del modello medico, delle tecniche, dei farmaci, del dottore che domina la scena: finalmente psichiatri, psicologi, infermieri (con i loro sindacati) potevano liberarsi dal fardello del controllo sociale, proprio della psichiatria (manicomiale), della pericolosità, delle ruvidezze che da questo momento dovevano essere delegati a un confuso e misero sociale. Potevano finalmente ritrovare la *purezza della psichiatria medica* nel camice bianco inamidato di fresco, nei servizi ospedalieri, negli ambulatori, nelle cliniche private, negli istituti residenziali. Potevano affermare con l'ingannevole credibilità scientifica appena conquistata, fuori dal manicomio, l'indispensabile e irrinunciabile ricorso alle porte blindate, alle contenzioni, alle dosi eroiche dei trattamenti farmacologici.



Le evidenze contano più delle scelte di campo

Mi chiedi dei risultati oggettivi, degli esiti dei trattamenti, se le persone stanno meglio. Vuoi poter valutare i vantaggi dei modelli che ti vado proponendo. Mi richiami spesso all'*evidence based* per uscire dalle incertezze e dalle perplessità che ti assalgono.

Le possibilità nuove ed estese di ripresa, di integrazione, di emancipazione sono quanto mai evidenti. La presenza sulla scena, sempre più evidente, delle persone che vivono l'esperienza del disturbo mentale allude a prospettive inaspettate. Forme originali di abitare, di lavoro e di socialità possono realizzarsi ovunque. Ma più che le *evidenze*, sono le *scelte di campo* che danno conto dei cambiamenti e dei risultati. Potrei dirti per brevità della «porta aperta». La porta aperta, dicevamo in manicomio, e continuiamo a dire nel mondo di fuori, per l'esercizio della cittadinanza. La porta aperta per un'*etica* della dignità, dell'inviolabilità del corpo, del rifiuto della violenza. La porta aperta per un *lavoro di cura* che (finalmente) può farsi nella considerazione dell'altro, nell'incontro, nella conversazione.

I libri di psichiatria che devi studiare parlano di un mondo pulito, silenzioso, geometrico. La Ragione domina la follia dal giorno stesso della nascita della psichiatria. Nella copiosa letteratura psichiatrica non si trova ombra di una sofferenza, di un dolore umanamente comprensibile, non un odore, non un grido, non una voce, non un silenzio. Non una prepotenza subita o esercitata. Emozioni e sentimenti raggelano nel linguaggio della clinica, i sintomi si sostituiscono alle persone. Si costruiscono così spazi e trattamenti nella stessa rarefatta atmosfera di irrealtà dei manuali di psichiatria. La quotidianità dei luoghi dove vivono *veramente* gli operatori, chiusi negli ambulatori e impegnati in prima linea ad affrontare la domanda di aiuto delle persone con disturbo mentale scompare. I giovani vengono avviati a questo mestiere come uno scalcinato esercito mandato al fronte della normalità per difendere tutti noi dalla follia in trincee fangose, fredde e ingenerose. Nell'armamentario che i giovani operatori, e gli psichiatri in particolare, portano in quelle trincee non c'è traccia alcuna di persone, di parole, di salute mentale. Soltanto la presenza incontrastata di una Psichiatria che vuole apparire «moderna» senza riuscire a liberarsi dalle antiche impresentabili origini.

La non oggettivazione è il confine invalicabile

Bisognerebbe ampliare conoscenze sui diritti, sugli assetti normativi e legislativi, sulle politiche di salute mentale; si dovrà sempre più valorizzare il sapere disciplinare collegandolo a quanto accade in termini trasformativi nella realtà dei servizi; occorrerà essere capaci di attraversare gli ambiti scientifici anche per proporre visioni che si allontanino dall'abusato ricorso al paradig-

ma clinico-medico. Bisogna muovere dalla consapevolezza delle nostre esperienze e dichiarare che molti dei servizi di salute mentale, così come sono organizzati oggi, hanno scarsa valenza di cura e non sono in grado di dispiegare le enormi potenzialità dimostrate dalle buone esperienze innovative e da un assetto legislativo unico al mondo.

Ti sto dicendo che devi finalmente rischiare di diventare protagonista. Una vasta schiera di giovani operatori non ancora del tutto «contaminata» dalla psichiatria, deve poter entrare in gioco e maturare conoscenze anche in opposizione alla formazione accademica grigia e, per tanti di voi, mi dite, insoddisfacente.

Ci sono azioni, trattamenti, posizioni che segnano drammaticamente il campo e bisogna scegliere da quale parte stare. Il rifiuto ostinato della contenzione, della «porta chiusa» e più in generale di tutte le forme inerti e stupide di oggettivazione rappresenta il discrimine, il confine invalicabile.

Con umiltà e abbandonando la confortevolezza dei *luoghi comuni* occorre tornare sulle parole, ora a rischio di sparizione, che dettero inizio ai grandi cambiamenti negli Stati Uniti, in Europa e nel nostro paese. A fronte delle conoscenze certe apprese dallo studio della clinica dei disturbi mentali, bisogna ripensare al mondo dell'esperienza, a quanto accade veramente nella nostra quotidianità, alla fatica dell'incontro con l'altro. La *messa tra parentesi della malattia*, per esempio, ha restituito allo sguardo e all'ascolto uomini e donne nel divenire della loro esistenza; ha reso possibile narrare e ascoltare.

Essere con le persone rende finalmente *comprensibile* la loro sofferenza. Le sottrazioni e le miserie di tanti servizi di salute mentale, una volta svelate, non possono non diventare il punto di partenza, faticoso e contraddittorio, per impegnarsi in pratiche di cambiamento intorno alla corporeità, alla materialità, alla tangibilità delle persone.

Cerchiamo insieme come ricominciare

Uno psichiatra, ed è la prima volta che accadeva, cerca di prendere le distanze dalla cultura e dal paradigma biologico-clinico (che ha prodotto e riprodotto il manicomio). Insieme ad altri giovani, si sta interrogando sulla in/comprensibilità del malato di mente reso muto dalla rozzezza della persistenza dell'armamentario positivista. Quando gli toccherà di entrare nel manicomio non potrà non vedere.

Il 16 novembre 1961, Franco Basaglia entra nel manicomio di Gorizia.

Per me è l'inizio del cambiamento che sto cercando di dirti. Una storia che tutte le volte che la racconto si traduce in presente e comincia a parlarmi di futuro.

Peppe Dell'Acqua, psichiatra, collaboratore di Franco Basaglia dal 1971, per molti anni direttore del Dipartimento di salute mentale di Trieste, insegna psichiatria sociale all'Università di Trieste ed è direttore della Collana «180. Archivio critico della salute mentale» dell'editore alpha beta Verlag di Merano: peppedellacqua@alice.it.

Quest'inserto esplora un concetto innovativo nella salute mentale:

la *recovery*, un termine di difficile traduzione, ma di grande pregnanza. In italiano si può esprimere con «ripresa di sé». Non significa necessariamente guarigione clinica, bensì enfatizza il viaggio che ciascuno compie nel costruirsi una vita al di là della malattia. Proprio qui è il potenziale innovativo racchiuso in questo termine. Anche se i sintomi permangono, si può comunque star meglio, migliorare la propria vita. Come? A dircelo sono le stesse persone con esperienza di disturbo mentale severo: accettando la propria condizione, ridefinendo un senso di sé, imparando a chiedere aiuto nei momenti in cui si sente la crisi arrivare, negoziando coi servizi le cure, partecipando alla vita sociale con il lavoro e altre forme di inclusione.
Com'è intuibile, il concetto di recovery non nasce dalla psichiatria biologica, oggi dominante, di cui anzi rappresenta la sfida più grande. Nasce invece dal movimento degli ex utenti, dall'ascolto dei racconti delle persone che hanno fatto i conti con la sofferenza, dal riconoscere dignità ai mille modi con cui i soggetti provano a superare le loro crisi, psicotiche o depressive. È dunque un concetto che dalle frontiere della salute mentale prova a farsi strada. Incontrando fatalmente la resistenza della psichiatria medica, purtroppo ancora preda di quello che nell'inserto viene definito «pessimismo kraepeliniano».
Emil Kraepelin è lo psichiatra tedesco che, tra '800 e '900, ha sostenuto l'oggettività della malattia mentale, ritenendo irrilevante (ai fini della comprensione e della cura) il modo in cui essa viene soggettivamente interpretata. «Kraepelin – ha scritto Eugenio Borgna – è rimasto estraneo all'arcipelago infinito della vita interiore dei pazienti. Nell'orizzonte kraepeliniano del discorso, la schizofrenia si trasforma in una malattia, in una realtà clinica, che segue le sue proprie leggi naturali: insensibile, dolorosamente insensibile a qualsiasi articolazione, a qualsiasi sollecitazione, ambientale e interpersonale, psicoterapeutica e socioterapeutica».
Le «leggi naturali» della malattia mentale sono quelle della «prognosi negativa» e della «cronicità». Due miti che la recovery sfata, illuminando come le persone interagiscano attivamente col proprio disturbo (e nell'interagirvi ne influenzino il decorso) e coltivino il desiderio di costruirsi una vita *oltre e nonostante* il disturbo mentale. Per i servizi di cura è oggi vitale confrontarsi su questi terreni, per continuare a porsi a servizio della salute delle persone e dei territori.
Le riflessioni di quest'inserto riprendono e rielaborano i contenuti del prezioso volume *Guarire si può*, curato da Izabel Marin e Silva Bon (uscito presso l'editore alpha beta Verlag, nella collana «180»).

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Nella storia della salute e della malattia mentale, è successo che a un certo punto abbiano cominciato a parlare i diretti interessati. E quando i soggetti portatori del problema riescono a farsi sentire, il problema viene a ridefinirsi. Dai loro racconti emerge che il disturbo psichico è un'esperienza attraversabile e dunque la cronicità non è un destino. Che la salute mentale è la capacità di riprendere in mano la propria vita e non per forza l'assenza di sintomi. Che se è difficile arrivare alla guarigione clinica, è comunque indispensabile perseguire una miglior qualità della vita. E – non da ultimo – che ai servizi di salute mentale spetta accompagnare le persone nei loro viaggi verso la «riconquista di sé». Un'idea potente, che in questi anni abbiamo imparato a chiamare «recovery».

Roberto Mezzina

Vivere al di là della malattia
Il viaggio per riprendersi la propria vita

Nella salute mentale si è fatta strada in questi anni l'idea di recovery. Significa «ripresa di sé» e rimanda al viaggio compiuto da ciascuno per costruirsi una vita al di là del disturbo mentale, anche severo. È un concetto che nasce dall'ascolto delle persone che hanno imparato a convivere con la propria sofferenza, senza farsene inchiodare ma prendendo coscienza dei margini di libertà che comunque sempre rimangono. Costituisce una sfida all'ideologia medica perché non si focalizza sulla malattia, ma mette in luce quel che occorre per vivere fuori dalla sua ombra. Come tale interroga oggi i servizi, gli operatori, le politiche.

Il concetto di *recovery* attraversa oggi culture e pratiche della salute mentale e rappresenta la sfida più grande all'ideologia medica, nel momento in cui sottolinea il ruolo attivo delle persone e i fattori di significanza connessi alle loro storie, alle loro vite.
È un concetto ormai entrato con forza nelle politiche e nei documenti ufficiali, anche dell'Oms (dalla *Mental Health Declaration di Helsinki* 2005 al nuovo *Action Plan europeo*), e appare centrale nel saldare le esperienze nate dalla deistituzionalizzazione della psichiatria e delle sue istituzioni, con il sapere che emerge dai processi di *empowerment* (acquisizione di potere) ed emancipazione delle persone.
A partire dalla deistituzionalizzazione, a Trieste come in altre esperienze sul territorio nazionale, gli utenti dei servizi hanno infatti riguadagnato non solo un livello di potere, ma anche la possibilità di «dire», di avere la parola. E oggi chiedono che sia riconosciuto il valore dell'esperienza sofferente, sia pure come diversità.

Cosa si intende con recovery?

Vi sono miriadi di definizioni di recovery, che fanno sì che il significato del termine di volta in volta muti sulla base delle intuizioni di studiosi, ricercatori, operatori, esperti «per esperienza», familiari e formatori. In inglese il verbo *to recover* significa riaversi, ripren-

dersi, recuperarsi. E *recovering* è il percorso o processo che si compie. In italiano, nonostante l'origine latina del termine, non vi è nessuna parola che abbracci e in un lampo ci faccia cogliere questa accidentata polisemia.

Recovery non è la guarigione clinica

Si tende a identificare recovery con «guarigione», ma è corretto? In realtà la parola guarigione rimanda a un concetto forse ancora troppo medico, che non contiene nulla del *senso* dello star male. Benché la guarigione rappresenti la più alta aspirazione di coloro che soffrono, di qualunque malattia si tratti, questa parola rischia di risultare fuorviante in psichiatria in quanto nessuna lesione biologica o alterazione anatomica è dimostrata.
La psichiatria risulta inadeguata se propone una comprensione del fenomeno ancora all'interno del modello medico-biologico di malattia-menomazione (*illness-impairment*) e disabilità (*disability*). La sregolazione di alcuni circuiti neurotrasmettitoriali non spiega infatti nulla della complessa condizione di disturbo severo, della sua esperienza soggettiva e del suo oggettivo corso o decorso.
Da cosa si dovrebbe guarire ancora non è chiaro. Dalla malattia mentale, dalle psicosi, dalla schizofrenia in particolare? O dall'esperienza dell'essere paziente, ovvero dallo stigma, dagli esiti negativi e dagli aspetti disumanizzanti che i trattamenti psichiatrici troppo spesso comportano?
Guarigione richiama alla mente soprattutto un esito finale: un accadere biologico, favorito o addirittura determinato da terapie e cure, il che ripropone un nesso causale col lavoro terapeutico che non solo è difficile da dimostrare, ma che diventa ingiusto misconoscimento della complessità di tutti i fattori in gioco, in particolare di quelli soggettivi. In tal senso il concetto di guarigione mostra i suoi limiti, e giustamente la psichiatria inglese sottolinea che recovery non è cure, cioè non è il prodotto delle terapie psichiatriche quali esse siano.

Recovery è il viaggio nel ricostruirsi una vita al di là della malattia

Anche in senso psicodinamico, la psichiatria ha spesso delineato, utilizzando il suo linguaggio e i suoi codici, una psicogenesi della malattia. Ma non è descritto il processo attraverso cui la guarigione si realizza, e il tempo della guarigione rimane misterioso ancor più di quello dell'ammalamento. Su queste questioni non possiamo far altro che emettere ancora dei balbettii.
Cos'è allora recovery? Potremmo dire che questo termine enfatizza il viaggio compiuto da ciascuno nel ri-costruirsi una vita al di là della malattia. La recovery è presa di coscienza di sé e dei propri problemi, ma soprattutto dei propri obiettivi di esistenza. Il che significa uscire dal modello medico, di delega totale del corpo e della psiche ai tecnici per il trattamento della malattia.
Si tratta dunque di un concetto che dobbiamo riconoscere come emergente al di fuori del mondo professionale, che ci piaccia o no, e che solo in un secondo tempo e con non poche forzature si può inquadrare nei codici della psicologia o della psichiatria.

Riguadagnare controllo sulla propria vita

Quali sono gli indicatori della recovery? Scomparsa dei sintomi, oppure fiducia in se stessi, autostima, autodeterminazione, empowerment?

Alla base un diverso rapporto con il sintomo

Al di là della definizione medica di guarigione, il concetto di recovery pone il tema del cambiamento del rapporto col proprio problema o col proprio disturbo: riguadagnare il controllo su ciò che ti accade e in senso più ampio sulla tua vita, migliorarne la qualità, vivere la vita più positivamente. «Progetto di sé» è forse l'espressione che descrive nel modo migliore tale processo.

Il contributo scientifico maggiore all'idea di questo tipo di percorso lo si deve a John Strauss, che ha descritto il processo di elaborazione dell'esperienza psicotica come rapporto tra il sé e i sintomi, tra la soggettività del malato e l'oggettività, in un certo senso, della malattia. Nel percorso di recovery la persona in sé è il fattore determinante, con le sue capacità di *coping*, di resilienza e di affrontamento della malattia, ma anche di cambiamento personale, di accettazione di sé e di contemporanea assunzione di responsabilità.

A riguardo scrive Larry Davidson [(1)]

> L'esperienza di recovery dalla malattia mentale implica un processo di recupero o di sviluppo di un ruolo valido e di un senso di identità positivo al di là della propria disabilità, e quindi la ricostruzione della propria vita nella comunità più ampia nonostante le limitazioni imposte da tale disabilità.

È questa forse una delle migliori definizioni: in essa si compie il passaggio dal «riprendersi dal disturbo» al «riprendersi la propria vita», scompaginando le carte della psichiatria. Eppure nemmeno questa riesce a esprimere a fondo la complessità e la ricchezza del termine, l'ampio alone semantico di un oggetto scientifico che corre talora il rischio di essere interpretato come un costrutto contraddittorio, ambiguo e nebuloso.

Lo sviluppo di un nuovo senso del sé

La questione della recovery rende più chiaro il modo in cui i soggetti si relazionano alla malattia, la direzionano, non vi soggiacciono più passivamente. Vivere «fuori dalla malattia», dal suo alone, dalla sua ombra, ne è l'obiettivo vero. Anche nella catastrofe vissuta della crisi, nell'abisso dello star male, vengono descritti dalle persone come dialetticamente compresenti sentimenti positivi e ricostruttivi: la ripresa è già contenuta nella lotta contro la malattia, o meglio nelle capacità del soggetto di affrontarla.

Se la malattia è invariabilmente descritta come non-libertà e non-scelta, come trappola per il soggetto, la recovery non può che consistere in un processo di apertura

1 | Davidson L., Strauss J. S., *Sense of Self in Recovery from Severe Mental Illness*, in «British Journal of Medical Psychology», 65, 1992, pp. 131-145.

di possibilità. Vengono apprezzate le cose importanti per tutti: riavere una famiglia, avere amici con cui uscire, saper affrontare le relazioni interpersonali. E questo non coincide necessariamente con il superamento definitivo dei sintomi e con la sospensione delle terapie. Coincide invece con il riprendersi in mano la vita, ri-acquistare potere, assumere un nuovo ruolo come quello di «ex» paziente, quindi mettere alle spalle ma anche fare tesoro dell'esperienza, valorizzarla. Il tutto nel mentre si va a sviluppare «un nuovo sé» o meglio un «senso del sé», come afferma Strauss.
Spesso capita che questo processo comporti il lottare per la propria autoaffermazione anche contro la psichiatria: il malato «che si mette di traverso» al servizio rappresenta questa posizione in modo esemplare. Occorre in tal caso per gli operatori accogliere il conflitto come elemento di trasformazione, capire e negoziare, trovare altre strade.
Dove emerge il soggetto, dove si vede la persona e si assottiglia la malattia (e la psichiatria), si intravede così la possibilità di ridare valore all'esperienza sofferente come percorso personale e come significato interpersonale rivolto alla nostra vita sociale e alle possibilità di coesistenza.

Fenomenologia del percorso di recovery

Qual è la fenomenologia del percorso di recovery?

La recovery è un processo, come la vita

La recovery non è un esito, ma un processo, come la vita. Niente è definitivo, tutto è una lotta. Prima ancora che essere un costrutto psicologico o clinico, fa riferimento a *elementi di base dell'esperienza umana*, a ciò che ci unisce e ci rende partecipi dell'esperienza altrui. La recovery è il percorso che la gente compie nel superare eventi gravi dell'esistenza come lutti, malattie, separazioni: tutto ciò che cambia la vita in maniera irreversibile e rispetto a cui siamo chiamati a cambiare.
È un cambiamento, anche parziale ma definitivo, del rapporto con la malattia: i punti di svolta sono rappresentati di solito da eventi precisi, ma anche da cambiamenti di atteggiamento. La recovery non è pertanto un processo graduale e progressivo, ma va avanti a salti, a volte retrocede, per poi ripartire; ciò che conta è la corrente che spinge.
C'è dunque una *direzionalità, ma non una linearità,* ossia ci sono molte strade diverse che conducono a un diverso rapporto con la «malattia». La difficoltà per le persone, ma anche per chi cura, è saper riconoscere e valorizzare i passaggi, i salti qualitativi del percorso. Anche quando la persona sembra ferma, si arresta o arretra, può voler dire che sta raccogliendo le sue energie, in una progressiva accumulazione di risorse e di miglioramenti minimali non visibili, che rendono possibile poi un salto.

BOX
DOPO MESI DI SILENZIO GIANFRANCO INIZIA A RACCONTARE
È il caso dell'esperienza emblematica e straordinaria di Gianfranco, che dopo otto mesi di silenzio totale, improvvisamente, senza alcun motivo apparente e nessuna nostra aspet-

tativa, inizia a parlare e a raccontare come ha passato il suo tempo a guardare la vita che scorreva davanti ai suoi occhi e le persone che frequentavano il Centro. Questo l'ha aiutato a pensare a se stesso e poi a maturare il salto, a essere pronto a tornare. Abbiamo ripreso la sua narrazione stupefacente in una lunga video-intervista in cui ricapitola la sua vita e le sue relazioni, e ci dice quanto sia stato importante per lui quel periodo di apparente passività e immutabilità.

Il soggetto riemerge dalla malattia

I racconti delle persone, e a volte la nostra stessa esperienza nel lavoro che facciamo, sembrano così illuminare, in modi talora intuitivi, che cosa voglia dire ripresa, e in un certo senso guarigione.

Forse, in maniera pre-riflessiva, possiamo dire che la recovery «si vede» dal riemergere del soggetto, delle sue speranze, aspettative di vita, sogni, progetti. Pensiamo a tutte le volte che vediamo emergere delle persone dalla malattia, che sembra quasi assottigliarsi e scomparire. Ci sono persone che vediamo migliorare inaspettatamente, dopo molto tempo e molte sofferenze; e persone che prendono coscienza dei propri problemi e finalmente sono in grado di analizzarli e situarli nella propria storia. E poi ci sono i mille modi che le persone dimostrano di avere per uscire da una crisi, chiudendo capitoli della propria vita o riconnettendosi a temi lungamente dimenticati. A volte ci sorprendono, uscendo dal linguaggio dei sintomi e presentandoci una lunga lista di consapevolezze.

L'idea di recovery, ossia l'emersione del soggetto come evento che segna una svolta nel percorso terapeutico o nel rapporto col servizio o nella sua stessa esistenza, ci ha affascinato da quando a Trieste, postazione d'avanguardia delle trasformazioni anche della fenomenologia della domanda psichiatrica, abbiamo visto in essa l'esito di quella che Franco Rotelli ha chiamato la «deistituzionalizzazione della malattia» e non solo degli istituti che contenevano e oggettivavano il malato.

Che cosa rende possibile la recovery?

Si possono individuare diversi livelli che rendono possibile la recovery:

• *personale*: la recovery è qui vista come imparare a vivere «nonostante i sintomi», o comunque minimizzandone l'impatto, tentando di autogestirsi. «La vita nonostante i sintomi» era uno dei grandi insegnamenti della scuola della deistituzionalizzazione: le persone pur all'interno di condizioni di malattia e di diversità potevano stare nella comunità, avere una vita normale, avere diritto a una risposta ai propri bisogni primari e di relazione;

• *familiare*: questo livello sottolinea l'importanza del coinvolgimento della famiglia in un percorso di cambiamento che non riguarda soltanto il «paziente designato» ma i suoi familiari, che riconoscono che «il suo problema è – in qualche modo – anche il nostro». Spesso questo percorso mostra lo sviluppo di importanti consapevolezze sociali, partecipative e comunitarie, se non politiche in senso lato;

• *comunitario*: l'accento è qui sul riconoscimento della valenza partecipativa, del contributo di integrazione e di solidarietà che ogni membro di una comunità o di una data società può dare verso chi soffre o ha sofferto di problemi di salute mentale;

• *servizi e operatori*: le indicazioni al riguardo sono quelle di cambiare atteggiamenti,

sviluppare sensibilità, affiancare un percorso personale alla formazione professionale, ribellarsi a ciò che è dato per scontato, alle condizioni di lavoro talvolta disumanizzanti, all'istituzionalizzazione delle persone, alla lesione dei loro diritti difendendoli attivamente insieme alle persone stesse.

La recovery pone il tema del potere nel rapporto con i servizi

L'attraversare le esperienze dentro alvei protetti e aperti rappresenta per molti il terreno favorevole della recovery. Questo chiama in causa i servizi, i loro atteggiamenti, ciò che dovrebbero soprattutto garantire.

Il potere, tema ben noto in psichiatria

Oggi s'impone certamente un'ottica più ottimistica, una visione fondata sulla certezza che esistono opportunità che i servizi devono poter garantire, utili a favorire la «ripresa». Ne sono esempi le situazioni di convivenza promosse dai servizi di salute mentale, il sostegno spontaneo di pazienti ad altri in crisi, la presenza qualificata dei familiari come interlocutori, l'alto grado di coinvolgimento di tutti gli attori nei programmi terapeutici.

Queste opportunità chiedono ai servizi di muoversi *oltre la relazione istituzionale,* perché solo così si apre la possibilità per chi è curato di recuperare una reale decisionalità riguardo alla propria vita. Ciò implica dover affrontare la questione del potere: un tema ben noto in psichiatria – fin dal passaggio fondamentale dal rapporto di dominio/controllo all'assistenza e alla relazione terapeutica – ma che non smette mai di riproporsi.

Nel solco della deistituzionalizzazione, il rapporto istituzionale – soggetto-oggetto di trattamento, curante-curato – è diventato gradualmente un'interazione sempre più complessa. Si sono favorite tutte le modalità di partecipazione informale alla vita dei nuovi servizi di comunità, sulla base di una tendenziale reciprocità nei rapporti, includendo via via nel campo tutte le figure che potessero rendere più articolata tale bipolarità (familiari, cittadini, volontari...).

Così i servizi oggi spesso tessono una rete partecipativa a partire da sé: è un network di scambi e di processi di «adozione», dove sono scambiate non merci ma valori d'uso e relazioni, mettendoli a disposizione e facendoli arrivare a chi per solito ne è escluso. Del resto, solo una pratica psichiatrica in cui le persone siano valorizzate come soggetti, dotati di una loro contrattualità, e in cui i loro bisogni, le loro aspettative, i loro obiettivi siano la sostanza dei progetti terapeutici, può produrre consenso alle cure, fiducia, collaborazione, coinvolgimento nei programmi individuali da parte di ciascuno e dunque (ulteriore passaggio) opportunità di partecipazione collettiva alla vita di un servizio e alla sua trasformazione.

C'è una recovery dalla malattia, ma anche dai trattamenti

Il flusso comunicativo che viene così favorito nel servizio, in particolare nel Centro di salute mentale (nei momenti formali dei colloqui, degli incontri, delle riunioni,

nel lavoro terapeutico individuale, familiare o di gruppo, oppure in una molteplicità di situazioni e occasioni informali), innesca sicuramente forme di partecipazione. Si creano momenti di aggregazione spontanea ai quali si affiancano momenti di auto-aiuto tra persone, in cui spesso il servizio mette in campo risorse integrative. Il «bisogno di relazioni» si pone ormai come centrale. E nella dimensione della relazione, che sia formalmente definibile come terapeutica o di aiuto, il punto è *adoperarsi a trattare in modo paritario e reciproco*. L'assunzione del rischio, del trattare la persona «come se» fosse fino in fondo in grado di stare nelle regole della relazione, è spesso necessaria.
Al riguardo ha scritto Shula Ramon che c'è una recovery dalla malattia ma anche dai trattamenti, dalla mancanza di capacità personali ma anche dalla carenza di opportunità per attività valide. L'attenzione dei servizi va così alle esperienze vissute che si oppongono ai saperi degli esperti, al guardare le persone come attori, al considerare la qualità della loro vita sociale, con particolare riferimento alla vita quotidiana che è la dimensione dove accade la recovery.

Costruire l'accesso ai diritti

In tal senso la recovery non può essere vista come un percorso solo individuale, altrimenti vi sarebbe di nuovo sottesa un'etica del riscatto dell'individuo da una condizione, la malattia, vista ancora come colpa. Non diversamente da come – nel linguaggio del potere – la riabilitazione è rieducazione.
Nonostante l'enfasi sulla singolarità e sulla soggettività, recovery è certamente un *fatto interpersonale e sociale*. Proprio in quanto attiene all'individuo, si colloca nella globalità della sua esperienza di vita dentro un contesto sociale e culturale determinato. La dimensione sociale e partecipativa, in queste storie, indica che la persona sta emergendo dall'isolamento, dalla rottura di significato e comunicazione che si traduce in de-socializzazione.
Si può percepire allora l'emergere di un sé sociale, una condizione di cittadinanza «vissuta» che è l'intima natura sociale della recovery. Ovviamente (ma non tanto per la psichiatria) le risorse materiali – il reddito, la casa, il lavoro – ne sono veicolo fondamentale (neanche a dirlo) perché rappresentano opportunità e costruiscono identità e contrattualità sociale.
Ecco perché è preferibile legare insieme «recovery ed emancipazione», per sottolineare l'aspetto di non-libertà che è connesso alla condizione di malattia e di assenza di diritti. Benché forme di recovery siano possibili ovunque e anche nelle condizioni più estreme, essa si compie e s'invera solo là dove la libertà ha i suoi prerequisiti fondamentali (ossia in uno stato di godimento di diritti). Ecco perché «cittadinanza» è la parola che ormai viene più frequentemente associata a recovery per dotare il processo di senso e qualità.

Quanto devono ancora modificarsi i servizi?

Il problema è come oggi le pratiche di salute mentale e di riabilitazione possano contribuire alla piena realizzazione del diritto a una cura che non sia sanzione, del

diritto a un reddito, a una casa, a un lavoro, a una partecipazione attiva alla vita civile e sociale. Quanto debbono ancora modificarsi i servizi perché siano davvero «centrati sull'utente»?

Riconoscere la prospettiva dell'utente

Il lavoro di trasformazione delle pratiche e delle discipline appare lungo: è necessario stabilire forme di partecipazione attiva degli utenti ai servizi di comunità e rafforzare i legami con le istanze e i soggetti della vita sociale, per un pieno coinvolgimento nella promozione di salute mentale (dai familiari agli operatori dei servizi sociali, sanitari e giudiziari, via via fino al corpo sociale). Non è un'operazione indolore perché va a toccare il nodo dei poteri e deve pertanto partire dal riconoscimento che la prospettiva dell'utente, come soggetto e attore del proprio percorso di integrazione sociale e di emancipazione, è di fondamentale orientamento.
Nessuno spiega a sufficienza come buone linee guida basate sulla recovery siano in grado di trasformare i servizi, che sono istituzioni dominate in modo materiale dalla loro logica interna e dalle loro strutture di potere, ma soprattutto dal paradigma medico-biologico. Cosa occorre dunque per un loro cambiamento? Una buona dose di senso comune? Scelte etiche? Una formazione ad hoc? La sola risposta, a mio avviso, è ancora una volta nella possibilità di agire una deistituzionalizzazione, forse in forme nuove e differenti, basate sul riconoscimento del contributo dell'utente nel servizio e sulla spinta delle energie trasformative verso la salute possibile. Ma non è ancora abbastanza.

Assumere come centrale la qualità della vita

In servizi orientati alla recovery, i concetti di inclusione sociale e cittadinanza sono centrali. La partecipazione, i diritti, il potere e l'inclusione sociale sono strettamente intrecciati col ruolo dei servizi di salute mentale comunitari nel supportare i cambiamenti individuali, come agenzie che forniscono o catalizzano risorse e opportunità. Mentre l'approccio tradizionale al trattamento e alla guarigione enfatizza il sollievo dai sintomi e la prevenzione delle ricadute, per l'approccio orientato alla recovery la qualità della vita diventa centrale e il miglioramento sintomatico al contrario ha un ruolo variabile.
Certamente va precisato che la recovery può accadere con o senza l'aiuto professionale, o addirittura nonostante questo. I punti di svolta delle persone spesso coincidono comunque con aspetti dell'intervento del servizio, o del programma terapeutico personalizzato, o della presa in carico. E ciò ha certo a che fare con le *opportunità offerte e le risorse messe in moto*; ma si può inverare un senso terapeutico e riabilitativo solo se il servizio riesce a sostenere e potenziare il senso di autodirezione e responsabilità della persona nel percorso.

Diventare servizi «attraversabili»

Il servizio è orientato alla recovery se è «attraversabile», se cioè in esso la persona trova non le regole istituzionali che impoveriscono, sminuiscono e comprimono il soggetto in crisi, ma dei punti e delle persone di riferimento, un'accoglienza calda e

partecipe, una disponibilità a occuparsi dei problemi di vita e non solo dei disturbi. L'attraversamento del servizio è connesso alla recovery, nel senso che l'offerta terapeutica e di risorse strumentali è orientata a dare degli stimoli, che però, se non si è in grado di cogliere, restano imposti, estrinseci. Il servizio può allora fare emergere una rete di supporto e renderla utilizzabile oltre che visibile, sviluppando un intervento di mediazione importante, per attivare l'aiuto e fare avvicinare la rete. La cura implica a sua volta l'assunzione di me operatore come soggetto che opera in un campo comune (mio e dell'altro), dove l'altro può «avanzare» e acquistare potere. Ma ciò comporta accettare che questi sia depositario di un sapere di trasformazione, e quindi un mettersi di lato, di fianco, per permettere una soggettivazione dell'altro. Perché emerga il soggetto, occorre che si metta in discussione il terapeuta, con le sue certezze.
Ciò che deve guarire è allora innanzitutto la relazione tra chi assiste e chi è assistito. Recuperare il significato del termine *assistenza*: far da testimone, da segnapassi, da registratore del percorso, e al tempo stesso aiutare, sostenere. Non agire su, ma agire con. Per Basaglia tale «reciprocità» si basa sul fatto che il terapeuta è messo in discussione dal malato, come il malato dal terapeuta. Occorre che ognuno si renda riconoscibile all'altro, che anche l'operatore si metta in gioco e si soggettivizzi con il malato, uscendo dal rapporto istituzionale.

Mantenere un'apertura sul possibile

Agire la deistituzionalizzazione è cambiare i rapporti di potere: si dà centralità ai bisogni dell'utente, senso ai suoi gesti, e «per vederli» si riduce la distanza nella relazione curante-curato. Perché la soggettività dell'utente emerga, quella dell'operatore deve entrare in gioco, confrontarsi con essa: il progetto terapeutico-riabilitativo nasce all'interno di una nozione nuova di contratto tra l'utente e il servizio.
Per i servizi di salute mentale tutto ciò si traduce in accessibilità e flessibilità, tali da garantire un lungo periodo di sostegno se necessario, continuità di relazione e accesso a possibilità di scelta e opportunità (anche quelle di fallire e ritentare). Una relazione ispirata dunque non alla distanza «terapeutica», ma al coinvolgimento e alla personalizzazione nel cercare insieme un senso, al dare fiducia, al «rischiare» insieme e quindi al mantenere un'apertura sul possibile. Il che vuol dire offrire speranza e aspettative, ma anche riconoscere le competenze, i desideri e i valori.
La recovery non consiste nell'insegnare nuove tecniche in un processo di oggettivazione e omologazione dell'esperienza individuale in qualche modello preformato di guarigione, come hanno cercato di fare in questi anni tentativi maldestri di «meccanizzare» in un dispositivo semplice e schematico le «fasi del viaggio». L'idea che vi sia una sorta di «sciamano» o perfetto insegnante dev'essere rigettata: dobbiamo credere nella recovery come nella verità personale di ciascuno [(2)].

2 | È bene riflettere su come la recovery rischi di diventare una definizione accattivante, usata per creare l'illusione del cambiamento, e perciò una bella favola, un'ideologia (o peggio una sorta di religione), mentre i servizi psichiatrici restano chiusi nei loro paradigmi. Una parola aggiunta all'equivoco della riabilitazione, come riparazione dal danno iatrogeno operato dalle psichiatrie.

Saper riconoscere la salute nella malattia

Il processo dialettico della recovery/guarigione non accade senza rimarcare una linea d'ombra, un chiaroscuro, in una totalità d'esperienza, dove c'è salute e malattia, il cui fulcro è la possibilità di riappropriazione di entrambe da parte del soggetto. Salute e malattia: parole importanti, pilastri concettuali che rimandano al celebre testo di Franca Ongaro Basaglia: *Salute/malattia. Le parole della medicina*. In esso l'autrice afferma che la clinica ha precluso la presenza partecipe della soggettività del malato; e la malattia ha sostituito nella medicina la globalità sano-malato che siamo, ovvero ha separato la malattia dalla vita e dall'ambiente. Dice:

> Se la guarigione avviene, si tratta della guarigione di un corpo ignaro di sé, dei propri bisogni, delle proprie malattie e della propria salute, privato di ogni possibilità di partecipare e lottare per ottenerla […]. Una cura diversa non può che muoversi in questa direzione, offrendo una terapia che sia contemporaneamente stimolo a una riappropriazione di sé e alla comprensione della misura in cui abbiamo incorporato la logica che ci determina. Perché l'unica premessa a una possibilità di cura per la malattia dell'uomo è un rapporto diverso, soggettivo, partecipato nella vita e, quindi, nella malattia. Solo comprendendo che il valore dell'uomo – sano o malato – va oltre il valore della salute e della malattia, si può capire come la malattia, al pari di ogni altra contraddizione umana, può essere usata come strumento di appropriazione o di alienazione da sé, quindi come strumento di liberazione o di dominio [3].

Ciò che è peculiare per gli esseri umani, diceva Franco Basaglia, è che la salute e la malattia sono in una continua relazione e tensione dialettica. Saper riconoscere la salute nella malattia: in questo senso «una psichiatria di vita e non di morte» deve riconoscere la soggettività delle persone e aiutarle a scoprire un senso nella loro esperienza. Aiutarle non solo a recuperare un nuovo senso della propria vita, ma anche a chiedersi come si inscrive la malattia, come «crisi», nella propria storia e in quale continuità si pone, invece di intenderla come una frattura, come alienazione da se stessi.

Una persona con esperienza di disturbo psichico una volta ha detto: «La guarigione non esiste, esiste il miglioramento della propria vita». Queste parole ci indicano la strada da percorrere.

3 | Ongaro Basaglia F., *Salute/malattia. Le parole della medicina*, Edizioni alpha beta Verlag, Merano (Bz) 2012, pp. 66-76.

Izabel Marin

Se la prognosi negativa è un mito da sfatare

Gli elementi fondamentali del processo di recovery

Le pratiche della psichiatria sono ancora spesso ispirate dal famigerato «paradigma kraepeliniano», secondo il quale la schizofrenia è una malattia cronica e la prognosi è un deterioramento progressivo. In realtà, già negli anni della deistituzionalizzazione, alcune importanti ricerche hanno messo in luce come la cronicità e la prognosi negativa siano miti da sfatare. Ma è stato soprattutto quando hanno cominciato a prendere parola i diretti interessati che si è compreso quanto sia sbagliato congelare le persone nel ruolo di «malati». Dai loro racconti i servizi possono, debbono imparare.

Il termine inglese *recovery* ricopre un'ampia gamma di significati: per l'*Oxford Dictionary* spazia dal concetto di «riguadagnare possesso o controllo» a quello di mettersi al sicuro per via legale, fino a definire «il riprendersi» o «il riaversi», come quando si dice di una persona che dopo uno svenimento «si è riavuta» o dopo un'esperienza disabilitante «si è ripresa». In questi casi, in inglese si usa dire che la persona ha avuto una «recovery».

Quello che intendiamo oggi con recovery nel campo della salute mentale è un'idea di riappropriazione in prima persona del processo che porta le persone con un disturbo mentale severo ad attraversarlo e a superarne le maggiori difficoltà esistenziali, sociali, psichiche.

È un'idea emersa a partire dagli anni '90, che si è poi diffusa e consolidata nel primo decennio di questo secolo, entrando in uso a pieno diritto nell'ambito della salute mentale. Tant'è che si parla oggi di recovery da un disturbo mentale grave con un valore programmatico che la distingue dalle nozioni più tradizionali, come quella di «guarigione clinica».

* | I due articoli di Izabel Marin ospitati nell'«Inserto» riprendono e rielaborano contenuti pubblicati nel volume *Guarire si può*, curato insieme a Silva Bon e pubblicato dall'editore alpha beta Verlag di Merano nella collana «180. Archivio critico della salute mentale». Ringraziamo l'autrice, l'editore e i direttori della collana (in particolare Peppe Dell'Acqua) per la collaborazione nel produrre quest'inserto (*NdR*).

Gli studi epidemiologici di riferimento

L'attenzione al processo in prima persona e all'impegno del soggetto costituisce la novità e la particolarità dell'idea corrente di recovery, ma è bene ricordare quale sia stato il terreno preparatorio su cui si è innestata questa nuova prospettiva.

La cronicità non è un destino

Di recovery in salute mentale, infatti, si parlava già prima che emergesse la declinazione attuale di tale concetto; basti ricordare la celebre ricerca di Richard Warner (1991), intitolata *Recovery from Schizophrenia* e ormai considerata un classico. Ma in cosa si distingue l'uso della parola recovery da parte di Warner, nella stagione delle grandi ricerche epidemiologiche degli anni '80, dal significato attuale del termine? La differenza è che, allora, si parlava di «guarigione» dal punto di vista del ricercatore, cioè di un osservatore esterno che aveva il problema di definire in qualche modo una «misura di esito», di *outcome*. E infatti si adottavano criteri – condivisi tra i ricercatori – per definire la «funzionalità» di una persona o da un punto di vista clinico («guarigione clinica», misurata in base alla scomparsa di certi sintomi) o da un punto di vista sociale («guarigione sociale», secondo criteri occupazionali, abitativi o di autosufficienza).

In ogni caso, la definizione di recovery in quel contesto era un problema del ricercatore (epidemiologo, clinico o sociologo che fosse). Cionondimeno quella stagione di ricerca è stata molto importante come terreno preparatorio per il cambiamento di mentalità che ci interessa. Le ricerche di quel periodo, infatti, come quelle di Warner e Ciompi, Harding [(1)], Strauss, Carpenter, sono state una specie di colpo di grazia, dal punto di vista scientifico, all'idea di «cronicità» e/o di esito degenerativo come *destino* associato alla diagnosi di schizofrenia.

La cronicità è un «artefatto sociale»

Si può dire, insomma, che il famigerato «paradigma kraepeliniano» – la concezione della schizofrenia come malattia cronica per la quale la prognosi è un deterioramento progressivo – sia stato scientificamente affossato proprio in quegli anni.

Sempre nello stesso arco di tempo (seconda metà degli anni '80), studiosi come Ciompi e Harding hanno discusso l'idea di cronicità come «artefatto sociale» e McGlashan ha potuto concludere, sulla base di una revisione selettiva dei più importanti studi di *follow-up* del periodo (gli studi sul decorso a lungo termine), che «un gran numero di pazienti guarisce dalla schizofrenia» e che «la certezza della prognosi negativa nella schizofrenia è un mito».

1 | Lo studio condotto da Harding è il più lungo realizzato negli Stati Uniti. La ricerca è durata 32 anni e ha coinvolto 269 persone con disturbo psicotico severo, attraverso interviste periodiche nel loro contesto di vita e nell'ambito dei programmi di riabilitazione. I ricercatori hanno trovato che circa due terzi dei soggetti corrispondevano ai criteri oggettivi della recovery (che sono: la persona non assume farmaci, non presenta più sintomi né comportamenti che potrebbero indicarla come «paziente con disturbo mentale»; la persona lavora, ha buone capacità relazionali con gli altri e non è ricoverata in ospedale psichiatrico) e/o del miglioramento significativo (per cui le condizioni della persona rispettano tutti i suddetti criteri di inclusione tranne uno).

Nella loro analisi della nozione di «cronicità», Harding e i suoi collaboratori (1987) evidenziano la difficoltà di separare gli effetti residuali del disturbo mentale – ad esempio i sintomi negativi come l'apatia o il ritiro sociale – da una miriade di fattori ambientali e psicosociali, che vanno dagli effetti del processo di istituzionalizzazione all'identificazione con il ruolo del malato, dal mancato accesso ai programmi di riabilitazione alle ridotte opportunità economiche e sociali, dagli effetti collaterali dei trattamenti farmacologici al ruolo delle aspettative sfavorevoli degli operatori. Il *pessimismo kraepeliniano* continua a funzionare come una profezia che si autoavvera: la perdita della speranza costituisce il contesto esistenziale delle persone con disturbo mentale.

Un concetto emerso sull'onda lunga della de-istituzionalizzazione

Non va dimenticato che questa apertura di possibilità positive in campo scientifico ha risentito del clima di apertura di possibilità pratiche legate ai processi di de-istituzionalizzazione avviati in precedenza con la crisi del «paradigma dell'internamento».

Occorre inoltre sottolineare che, una volta che si sono aperte, tanto sul piano scientifico quanto sul piano pratico, le possibilità di uscita dalla rassegnazione, dalle stanze ammuffite e bloccate della «cronicità» e della istituzionalizzazione, il problema inevitabilmente si è spostato.

Non si tratta più di un problema di ricerca o di osservazione esterna su un «esito», un outcome (per quanto sia importante anche questo aspetto). Non è più soltanto un problema di cosa possano fare i soggetti di cura – i servizi, gli operatori – per colmare di buoni interventi quegli spazi di possibilità positive (sebbene anche questo sia rilevante). Ma è un problema che investe *chi* diventa soggetto, protagonista attivo e non ricettore, capace di muovere i passi necessari per sottrarsi al «mito» della cronicità e della «prognosi negativa» per il disturbo mentale severo.

Ed è qui, su questo punto, che si innesta l'emergere dell'idea di recovery come *assunzione su di sé* del percorso necessario per uscire dalla propria difficoltà, da parte del soggetto che vive in prima persona l'esperienza del disturbo mentale.

L'esperienza personale è oggi la prima fonte degli studi sulla recovery

A dare impulso all'idea della recovery come visione (e prassi) trasformativa è stato il movimento degli ex-utenti psichiatrici. La comparsa sulla scena sia di racconti di esperienze vissute in prima persona, sia dell'organizzazione degli utenti (con la costituzione di gruppi di auto mutuo aiuto e di *empowerment* collettivo) ha inciso fortemente su quella che oggi si può definire una pratica orientata alla recovery.

Quando si leggono gli scritti di una pioniera del movimento americano dei «sopravvissuti psichiatrici»[(2)] o ex utenti, come Judi Chamberlin, o di protagonisti

2 | Negli Stati Uniti il termine *survivor* (sopravvissuto) è stato utilizzato dal movimento degli ex utenti psichiatrici per distinguerlo dai termini «paziente» o «malato di mente», e connotarlo con una valenza attiva e politicizzata nella lotta contro lo stigma e gli effetti iatrogeni dell'istituzionalizzazione psichiatrica, di cui essi si sono sentiti profondamente vittime.

nell'elaborazione e diffusione dell'idea di recovery come Patricia Deegan o Ron Coleman, si percepisce la forza di persuasione di argomenti e analisi radicati nel profondo dell'esperienza vissuta.
Così, la prima fonte della letteratura sulla recovery è oggi colui o colei che ha attraversato dall'interno difficoltà mentali e ha *trovato la strada* per venirne fuori. Sono le persone stesse che, avendo vissuto sulla propria pelle prima l'esperienza della malattia e della istituzionalizzazione, poi l'esperienza del faticoso impegno per uscirne, hanno cominciato a descrivere l'esperienza e a comunicarla agli altri. D'altro canto, anche gli operatori che hanno cominciato a scrivere sul tema hanno sottolineato la decisività dell'ascolto, da parte loro, delle testimonianze in prima persona dei soggetti in recovery.

Cosa vuol dire essere in recovery?

La nozione di recovery da un disturbo mentale severo è diventata centrale in alcune esperienze innovative negli Stati Uniti e in Gran Bretagna, influenzando un cambiamento nella cultura dei servizi.

Un percorso di ridefinizione di sé

In un documento inglese di indirizzo programmatico degli anni '90 si legge la seguente definizione:

> La recovery da un disturbo mentale severo si riferisce a un processo attivo, dinamico e altamente individuale attraverso cui una persona assume la responsabilità della propria vita e sviluppa uno specifico insieme di strategie rivolte non solo a fronteggiare i sintomi, ma anche le minacce secondarie della disabilità, che comprendono stigma, discriminazione ed esclusione sociale. Un aspetto critico di tale processo è (…) lo sviluppo di un senso di se stessi come «altro dall'essere disabile».

Questa definizione di recovery offre dunque due importanti indicazioni: da un lato, i tentativi e le strategie per fronteggiare i sintomi e le difficoltà sono intesi come modalità attive sviluppate *dal soggetto*; dall'altro, tali modalità attive sono viste come parte di un più ampio insieme di abilità soggettive, dove il fuoco del problema si sposta dai «sintomi» in quanto tali alla possibilità che la persona ha di riappropriarsi di un'identità personale e sociale che vada oltre quella definita dal ruolo di «malato mentale» o «disabile».
Per usare le parole di Patricia Deegan (1988), leader del *Mental Health Consumer Movement* negli Stati Uniti, il processo di recovery non implica che le persone vengano «aggiustate», come si aggiusta una macchina; si tratta piuttosto di ristabilire attivamente un nuovo modo di ridefinirsi come persone. Il percorso di ridefinizione di sé è segnato da una nuova consapevolezza delle proprie condizioni, che non comporta il ripristino di quelle precedenti il disturbo, né tantomeno l'accettazione passiva del disturbo e delle sue limitazioni. I racconti «dal di dentro» dell'esperienza della sofferenza psichica indicano come sia possibile, nonostante il disturbo, riconquistare una identità sociale significativa e riprendere in mano la propria vita.

«Io non sono guarita: io ho vinto»

In questo cambio di prospettiva, sono le persone stesse a poter giudicare meglio l'estensione del loro processo di recovery. Per gli autori del movimento degli ex utenti o *survivors*, la «disabilità» psichica è soltanto *uno degli aspetti dell'intera vita* della persona. Nasce così l'espressione «essere in recovery» in riferimento alle persone con una condizione di disturbo mentale severo e prolungato che hanno superato del tutto o in parte gli effetti devastanti che ne conseguono, anche se non sono completamente scomparse le manifestazioni sintomatiche.
William Anthony (1993), uno dei primi ricercatori nel campo della riabilitazione psichiatrica a diffondere l'idea di recovery come valore programmatico per i servizi di salute mentale, la definisce così:

> La recovery è un modo soddisfacente di vivere la propria vita che comporta lo sviluppo di nuovi significati e motivazioni, nel crescere come persona al di là degli effetti catastrofici del disturbo mentale.

Questi effetti sono spesso di natura sociale e includono le barriere imposte da una condizione di svantaggio e di stigma, che vanno dalla mancanza di accesso alle opportunità, alla perdita di un ruolo socialmente valido, alla rottura dei legami affettivi più significativi. Per Sally Clay, che lavora come «difensore» (*advocate*) e sostenitrice del movimento degli ex utenti psichiatrici negli Stati Uniti, la lotta contro lo stigma è un elemento caratterizzante del proprio percorso. Lo stigma, scrive, non deve essere una vergogna per chi ne è segnato, ma un distintivo d'onore:

> L'esperienza della follia è una ferita che ha cambiato la mia vita e mi ha permesso di aiutare gli altri e di conoscere maggiormente me stessa. Sono orgogliosa di tali risultati. Io non sono guarita: io ho vinto.

Il paradosso della guarigione nonostante il persistere della malattia

Molte persone con esperienza di recovery indicano che il maggiore guadagno che hanno avuto nel loro processo di ripresa è stato quello di accettare il proprio disturbo e di incorporare la propria esperienza all'interno di un ridefinito senso di sé. Emblematico è l'esempio riportato da Patricia Deegan, docente e ricercatrice sul tema della recovery e dell'empowerment. Basandosi sulla propria esperienza condivisa con altre persone, afferma (1988, p. 98):

> Il nostro percorso di guarigione è profondamente segnato dall'accettazione delle nostre limitazioni. Ma adesso, invece che essere disperati, troviamo nelle limitazioni personali il terreno dal quale far nascere le nostre uniche possibilità. Questo è il paradosso della guarigione: accettando quello che non possiamo fare o essere, iniziamo a scoprire cosa possiamo fare e chi possiamo essere

Il ridefinirsi come persona implica la ridefinizione del problema mentale come *parte integrante* della propria vita. Lo sviluppo di una nuova percezione di se stessi e di una propria identità diventa uno degli aspetti chiave su cui verte tutto il processo

di guarigione. Il senso di sé è una componente fondamentale dell'essere umano ed è caratterizzato dallo sforzo attivo che le persone compiono per far fronte agli eventi e alle difficoltà, per sviluppare nuove competenze maturate dalla propria esperienza e per vivere la propria vita in modo soddisfacente.

Il processo che porta alla riconquista di sé

Se il disturbo mentale severo è stato descritto come «la malattia del sé», caratterizzata non soltanto da un profondo sconvolgimento cognitivo ed emotivo, ma anche da una trasformazione della propria identità percepita interiormente da sé ed esteriormente dagli altri (Estroff, 1989), nel processo di recovery la riscoperta e la riconquista di un sé attivo costituisce uno dei passaggi necessari da compiere.

Alla base un nuovo senso di sé

In una ricerca che è stata una pietra miliare in questo campo, condotta da Davidson e Strauss nel 1992 presso l'Università di Yale (in cui sono state intervistate 66 persone con diagnosi di schizofrenia), si è sottolineata l'importanza della ricostruzione del senso di sé nel processo di recovery da un disturbo mentale severo. Nell'articolo a compendio dell'intera ricerca (Davidson, Strauss, 1992) gli autori riprendono la nozione di «senso di sé» da un insieme di studi degli anni '80 in diversi settori che comprendono la psicologia medica, sociale e antropologica.
Queste ricerche suggeriscono, in particolare, che il senso di sé svolge una funzione nel modo in cui si affrontano malattie somatiche, eventi di vita stressanti e depressione. Un rafforzato senso di sé può aiutare a migliorare vari aspetti del disturbo e sostenere gli sforzi per fronteggiare e adattarsi a un contesto di malattie croniche o di eventi di vita critici; in questi casi, la persona sente di poter realizzare qualcosa (senso di autoefficacia), di avere un controllo sulle proprie emozioni (luogo interno di controllo) e di avere stima di sé.
Ma se ciò è vero nel caso di patologie non psichiatriche, a maggior ragione diventa imprescindibile esplorare questi elementi all'interno delle condizioni di interesse psichiatrico, visto che «lo scenario del sé» è il luogo stesso della sofferenza mentale. Gli autori sottolineano (*ivi,* p. 132):

> Lungi dall'essere soltanto una nozione teoretica (...), il senso di sé si presenta come la componente principale nell'esperienza quotidiana di chi soffre di un disturbo mentale grave. È una componente che le persone con questi disturbi spesso descrivono come un fattore chiave nei processi di sviluppo del disturbo e del suo cambiamento.

Scoprire parti di sé non toccate dal disturbo

Un *primo aspetto* del senso di sé nel processo di guarigione riguarda il fatto che la persona si rende conto di poter avere un senso attivo di sé anche se continua a esperire una disfunzione dovuta al proprio disturbo. Per alcune persone ciò può significare una riscoperta di parti di sé non toccate dal disturbo e che possono essere quindi utilizzate indipendentemente da esso.

Questo graduale risveglio comporta un'intuitiva apertura, un rudimentale «avvertire se stessi». La traccia comune nelle varie esperienze è una *nascente consapevolezza* di questi aspetti di se stessi finora sconosciuti, che può includere la sensazione di poter fare qualcosa *di più* e *di meglio* di quello che si sta facendo. In questa scoperta contano *le piccole cose che accadono,* come uscire dalla stanza dove si era rinchiusi a causa della propria paura e dei sintomi, guardarsi intorno, accettare un aiuto da parte delle persone «significative», come operatori, familiari, amici.
Tutto ciò è importante per rafforzare la fiducia nelle proprie potenzialità: una nuova consapevolezza di sé come persona potenzialmente capace comporta il progressivo sviluppo di un senso di speranza, che apre la strada alla sensazione di poter migliorare la propria condizione che accompagnerà poi l'intero processo di recovery.

Fare un inventario delle proprie forze e debolezze

Un *secondo aspetto* è il procedere a una sorta di inventario delle proprie forze e delle proprie debolezze: «prendere le misure» di quello che si può o non si può fare e sentirsi più sicuri nell'affrontare nuove situazioni che possono rappresentare una sfida. Un inventario personale si può fare inizialmente a livello elementare, immaginandosi in un'azione semplice («posso uscire dalla stanza e partecipare alla riunione?»), fino a un livello più elevato di riflessione («posso riprendere a lavorare a tempo pieno?»). Ciò può determinare l'inizio di un percorso in cui raffigurarsi mentalmente il proprio futuro o il recupero di abilità dimenticate, come per esempio riprendere in mano un progetto interrotto prima del disturbo. In questa situazione la persona incomincia a fare le «provviste di forze» e si attrezza gradualmente con gli «ingredienti necessari» per raggiungere i propri obiettivi, talvolta anche quelli all'apparenza più semplici.
Questo aspetto del processo di recovery, che rappresenta la preparazione a un'azione successiva, può anche avere un periodo di evoluzione lenta: dalla consapevolezza di poter essere una persona attiva alla realizzazione di un obiettivo desiderato. Il punto critico è rappresentato dal sostegno degli altri, in quanto la persona è ancora vulnerabile e ha bisogno di tempo, di essere compresa e sostenuta.

Esercitarsi nelle azioni e riflettere sui risultati ottenuti

A questo punto, il processo di riscoperta delle proprie capacità di riattivarsi comporta l'esercitarsi nelle azioni e il riflettere sui risultati ottenuti, incorporandoli nelle azioni successive. La persona può scoprire di essere capace di prendersi cura di sé e agire a proprio beneficio, smettendo di essere soltanto il «recettore» della volontà altrui. Comincia a percepire di essere una persona capace di scopo, azione e responsabilità mettendosi alla prova e svolgendo piccoli compiti che, anche se all'apparenza semplici o ordinari, implicano la scoperta di abilità e di aree di efficacia.
Sebbene il processo di scoperta di sé come persona più attiva e autonoma non appaia stabile e costante nella vita di chi attraversa un disturbo mentale severo, i piccoli successi agiscono a favore di una graduale costruzione di autonomia. Attraverso le esperienze di successo, la persona può scoprire di avere la capacità, anche

inaspettata, di allargare la propria rete di conoscenze, di condividere momenti di socialità, di prendere iniziative che riguardano la propria vita.

Imparare a conoscere e gestire le proprie risposte emotive

Come negli altri aspetti sopra indicati, lo sviluppo di una nuova capacità di avvalersi della propria esperienza serve come strumento prezioso per monitorare, governare e compensare il disturbo nel proprio contesto sociale. Sentirsi più solidi perché sostenuti dalla propria esperienza può avere la funzione di «rifugio» dal disturbo, per evitare di stare nuovamente male, oppure può servire per combattere gli effetti secondari come l'ansia, lo stress e lo stigma nel contesto sociale in cui si vive. Imparare dalla propria esperienza a distinguere se stessi dal disturbo porta a riconoscere quelli che possono essere definiti i «segnali» (o i «campanelli di allarme») derivanti dalla tensione e dai fattori di stress nello sforzo interattivo con gli altri.
Come nel campo delle malattie fisiche, il ruolo del senso di autoefficacia, del controllo sulle proprie emozioni e dell'autostima aiuta a combattere stati prolungati di disturbi somatici e di eventi di vita stressanti, così anche per la persona con un disturbo mentale severo l'autopercezione di essere capace di gestire l'ansia e lo stress può contribuire ad aumentare le competenze nel prendere parte più attiva nel proprio progetto di vita, nello sviluppare strategie quotidiane per fronteggiare i problemi, nell'imparare a esercitare autocontrollo sui sintomi, incrementando le proprie capacità di mantenere gli impegni nel contesto sociale e lavorativo.

Un cambio di atteggiamento verso il proprio disturbo

John Strauss è stato uno dei primi ricercatori a sostenere la cruciale importanza del ruolo attivo delle persone con un disturbo mentale severo nell'interagire e influenzare il decorso del loro disturbo.

Non ci si considera più vittime impotenti della malattia

In un suo recente scritto (2008), Strauss sostiene che sta ancora cercando di rispondere alla domanda che gli aveva posto, quindici anni prima, una donna intervistata per la sua ricerca: «Perché il medico non mi chiede mai cosa faccio «io» per aiutare me stessa?», vale a dire perché si informa soltanto sui sintomi, il lavoro, le relazioni sociali, il trattamento, senza chiederle mai quale sia il suo apporto personale nel far fronte al problema? Ecco il commento di Strauss:

> Questa donna ha sollevato la questione della soggettività. Non considera se stessa una vittima impotente della malattia, né tanto meno un oggetto i cui sentimenti e le cui azioni sono irrilevanti per il proprio percorso, sia nei momenti di crisi sia nel processo di ripresa.

L'*autodeterminazione* e *la volontà di stare meglio* sono entrambi elementi nello sviluppo di un senso di sé attivo e possono rappresentare un punto di svolta nel

processo di recovery. Questi aspetti di se stessi, sostiene Strauss, possono essere considerati come un cambiamento di atteggiamento verso il proprio disturbo: molte persone «dopo un prolungato periodo di sofferenza non si sono semplicemente rassegnate a dover convivere con un disturbo, ma desideravano costruirsi una vita oltre e nonostante il proprio disturbo mentale».

Si prende parte attiva alle decisioni che riguardano la propria salute

Nell'affrontare la questione del cambiamento nel modo di percepire se stessi in rapporto alla propria vita, ai propri sintomi e alle proprie condizioni, Ron Coleman considera «la scelta» una delle pietre miliari dell'esperienza di guarigione. Incrementare le decisioni che riguardano se stessi, assumere i rischi delle scelte che si fanno sono aspetti di un atteggiamento propositivo nell'interazione con i propri problemi, come pure nell'interazione con gli altri. Scrive Coleman (2001):

> Dobbiamo avere fiducia nello smettere di essere malati per cominciare a essere in guarigione. La strada della guarigione richiede non solo che facciamo le nostre scelte, ma anche che prendiamo la responsabilità di tutte le nostre scelte, buone e cattive.

Affinché le persone possano avere controllo sulla propria vita, in modo da riguadagnare un ruolo propositivo ed efficace, tuttavia, devono essere fornite loro opportunità di scelta e di contrattazione nel rapporto con i servizi e con le persone coinvolte nel processo di aiuto. Parlando dell'utilizzo dei farmaci nel suo percorso di recovery, Pat Deegan (2007) riassume così la sua visione delle cose: «l'esperto medico» e «l'esperto cliente» sono entrambi seduti in una stanza e nessuna delle due parti è meno importante dell'altra, devono condividere le informazioni in modo da poter arrivare alla migliore decisione possibile sul trattamento da intraprendere.
Le persone devono quindi essere coinvolte in tutti gli aspetti della pianificazione, dello sviluppo e dell'implementazione dei servizi che le riguardano, così come devono essere coinvolte anche negli aspetti della vita sociale che esulano dal trattamento e dalla riabilitazione. Solo questo coinvolgimento sostanziale può portare a un *empowerment* e a un senso di controllo sul proprio ambiente e sulla propria vita.

Il ruolo degli «altri significativi»

«La recovery è un'esperienza profondamente umana, facilitata dalle risposte profondamente umane degli altri», scrive William Anthony (1993). Se la comprensione del ruolo svolto dalla persona è essenziale per comprendere il suo processo di guarigione, è altrettanto fondamentale capire come gli altri possano avere un ruolo rilevante in tale processo.

Il sé non esiste senza la convalida degli altri

Nelle diverse ricerche sulla recovery, la presenza degli «altri significativi» è un denominatore comune per la capacità che essi hanno avuto di stimolare, sostenere

e mantenere una presenza costante, anche nei momenti più critici della vita delle persone che stanno lottando per riprendersi: «Il sé non esiste senza la convalida da parte degli altri», afferma Coleman.
Per le persone con esperienza di recovery i fattori decisivi dell'aiuto risultano essere il contenuto e la qualità percepita delle relazioni di vicinanza, sia per quanto riguarda i familiari che gli amici. I familiari rappresentano talvolta l'unico contatto sociale conservato dalla persona in grave difficoltà, che vive una condizione di isolamento.
Il sostegno dei familiari, anche quando è difficile da riconoscere, può essere d'aiuto nel superare la resistenza alla socialità (per esempio, vincere la vergogna di «essere diventate persone con una sofferenza mentale»), così come può essere utile nel cercare di ristabilire un contatto scandito dai semplici gesti della quotidianità ordinaria (anche se le circostanze non sono ordinarie).

Il supporto emotivo come fattore di svolta

Gli aspetti pratici, come base elementare del sostegno, vanno messi in relazione con i significati emotivi della presenza dell'altro. Molte persone con esperienza di recovery hanno sostenuto che la cosa più importante per loro nella relazione con un parente, un operatore sociale o un amico è avvenuta quando «si sono sentite prese sul serio» (Strauss, 2008).
In una prospettiva di reciprocità, il supporto emotivo viene a essere determinante quando il familiare è stato capace di cambiare se stesso durante il processo di recovery, sentendosi «maturare in qualche modo assieme» al proprio parente, mettendosi direttamente in gioco, in un percorso di crescita che coinvolge entrambe le parti.
Sia dalla letteratura sulla riabilitazione psichiatrica, sia da quella sulle esperienze vissute, risulta che uno dei «fattori di svolta» – tanto centrale quanto periferico – nel processo di recovery sia stata la presenza di persone capaci di «trasmettere la speranza». Saper trasmettere la speranza è quanto definisce la relazione di aiuto, che si tratti di familiari, amici, operatori o pari.
Come racconta Patricia Deegan (1993, p. 97):

> Potrei ricordarmi un momento specifico in cui una piccola e fragile fiamma di speranza e coraggio ha illuminato la nostra oscurità e la nostra disperazione. Anche quando abbiamo ceduto, là stavano quelli che ci amavano e che non cedevano. Loro non ci hanno mai abbandonato. (...) Il loro amore per noi è stato come un costante invito, un richiamo a essere qualcosa di più della nostra autocommiserazione e disperazione. Il miracolo è che gradualmente abbiamo incominciato a sentire e a rispondere a questo amorevole invito.

L'efficacia dell'approccio del sostegno paritario

L'«altro significativo» è rappresentato spesso dalla figura del «pari» (*peer support*), cioè dalle persone che hanno vissuto l'esperienza di un disturbo mentale e si sono riprese o si stanno riprendendo, e offrono il loro aiuto, appunto paritario, attraverso la testimonianza e la condivisione della propria esperienza.

L'efficacia dell'approccio del sostegno paritario passa attraverso l'esempio, che rende presente e concreta la speranza di farcela. Le persone che raccontano di questo aspetto dell'aiuto sottolineano come diventi molto difficile continuare a non nutrire speranze quando si è circondati da altre persone ugualmente in difficoltà che stanno facendo passi in avanti nel loro processo di guarigione.
Anche per Coleman (2001) la dimensione «condivisa» ha giocato un ruolo fondamentale nel proprio percorso, dal momento in cui è arrivato nel gruppo degli uditori di voci:

> Ho sentito valorizzato il mio sé. (...) Credo che il più grosso cambiamento che mi sia capitato nel gruppo sia stato che ho smesso di essere Ron Coleman lo schizofrenico e sono diventato Ron Coleman che sente le voci, e per quanto questo fosse solo l'inizio del processo di guarigione, era già un buon inizio.

Gli operatori non come tecnici, ma come alleati

Per quanto riguarda l'aiuto ricevuto dagli operatori di un servizio, nel racconto delle persone con esperienza di recovery, è determinante l'attenzione ricevuta, *genuina* e *diversa* rispetto a quella considerata convenzionale o formale, perché diretta alle persone in quanto tali e non come «pazienti». Come sostiene Davidson (2003):

> Il prendersi cura di qualcuno in modo genuino non è qualcosa che può essere prescritto, richiede che l'operatore offra se stesso in un modo che non deriva soltanto dalle sue responsabilità come operatore, ma è basato sul suo rendersi conto dell'umanità comune di entrambe le persone. Sebbene questa distinzione possa sembrare sfuggente o astratta, essa fa la differenza per chi si trova dal lato di chi riceve l'aiuto.

Per Alain Topor (2006), l'operatore fa «qualcosa di diverso» rispetto al ruolo atteso se stabilisce un rapporto di reciprocità e di condivisione di responsabilità e di interessi comuni. Significa che l'operatore va oltre quello che può essere considerato il suo compito istituzionale, non si comporta secondo un copione atteso, o secondo la solita routine formalizzata, bensì si mette in gioco sul piano personale e fa conoscere aspetti di se stesso. In altre parole, gli operatori sono considerati d'aiuto «quando costruiscono un rapporto positivo con la persona, un rapporto spesso descritto come di amicizia».
In ogni caso, quel che sembra caratterizzare l'aiuto dell'altro nel percorso di guarigione di una persona è la possibilità di diventare un suo «alleato», che si tratti di un pari o di un operatore.
Per spiegare il ruolo degli operatori nel gruppo di uditori di voci di cui fa parte, Ron Coleman (2001) scrive:

> Quando gli operatori conducono il gruppo, la cosa che cerco sempre di fargli comprendere è che loro sono «parte» del gruppo; se non sono uditori di voci, allora il loro ruolo è di essere degli alleati. Non sono lì come tecnici, sono lì come alleati.

Il ruolo delle risorse materiali e sociali

Nella letteratura recente, è stata sottolineata l'importanza dei fattori sociali e ambientali come facilitatori nei processi di recovery.
Come possono le persone riguadagnare potere sulla loro vita e un ruolo nella società, se non hanno adeguate possibilità materiali, risorse economiche e culturali per ricostruire la propria identità sociale?

Spesso le persone subiscono una perdita di ruolo e identità sociale

Come scrive Peppe Dell'Acqua (2013), per chi soffre di un disturbo mentale severo è molto difficile soddisfare l'elenco dei «normalissimi bisogni» che tutti abbiamo: avere un reddito o svolgere attività significative; avere una sistemazione abitativa; lavorare con soddisfazione; essere parte della comunità; non essere discriminati; dare senso alla propria esistenza.
I contesti sociali, nella misura in cui ostacolano l'accesso ai diritti di cittadinanza, favoriscono il processo di interiorizzazione del ruolo di malato e la condivisione dei pregiudizi della società. Di conseguenza, le persone diventano più isolate socialmente e più esposte allo stigma. Come afferma Deegan, riferendosi alla diagnosi di schizofrenia ricevuta a 18 anni:

> La mia identità era ridotta a una malattia agli occhi delle persone che si occupavano di me. Era soltanto una questione di tempo perché incominciassi a interiorizzare questa visione stigmatizzata e disumana di me stessa.

Il processo di identificazione nel ruolo del malato mentale è un processo sociale e interpersonale: implica che una persona che «ha» un disturbo mentale finisce per «diventare» il proprio disturbo.
Questa progressiva perdita di ruolo e di identità è segnalata come un cambiamento significativo da molte persone che attraversano un prolungato periodo di malessere. Le persone cessano di lavorare, si ritirano dalle scuole, perdono contatti con la famiglia e con gli amici. In questo modo perdono i loro ruoli sociali validi e le identità accettabili che ne derivano. Talvolta, quello di paziente è uno dei pochi ruoli che rimangono.

La centralità del lavoro nel percorso di recovery

Perciò, nel concettualizzare il processo di recovery, bisogna prestare attenzione anche alla dimensione sociale del processo di ricostruzione materiale dei diritti di cittadinanza. Essere disoccupato, non avere una casa, non avere una fonte minima di reddito costituiscono *evidenti ostacoli* per le persone che stanno lottando per riprendersi.
In questa prospettiva, il lavoro può essere considerato uno dei più importanti fattori di facilitazione del processo di guarigione: costituisce una risorsa estremamente importante in quanto permette alla persona di uscire dallo status di malato e di assistito. Il lavoro provvede non soltanto a un guadagno economico, ma offre struttura e scopo, opportunità di socializzazione e di sviluppo di nuove relazioni

sociali, di valori e significati e di piena cittadinanza [3]. Nel riguadagnare un senso di appartenenza nella comunità, va anche sottolineata l'importanza degli impegni delle persone nei «compiti di sviluppo sociale»: la lotta per fare fronte allo stigma e alla discriminazione sociale, l'aiuto agli altri e il lavoro di volontariato, la partecipazione a gruppi di auto-aiuto e per lo sviluppo e il cambiamento delle politiche in salute mentale sono attività altrettanto gratificanti e significative.

La guarigione come processo dinamico e aperto

In quanto detto finora, è implicita una concezione della recovery come processo aperto, complesso, che richiede del tempo. In contrasto con la dicotomia statica guarito/non guarito, si delinea un'idea di recovery come processo che concerne l'intera vita della persona.

La recovery è un processo, come la vita

Questa visione è stata sostenuta da un numero consistente di ricercatori, molti dei quali con un'esperienza personale di disagio mentale. Per esempio Rae Unzicker, nel suo resoconto autobiografico (1989), quando le chiedono che cosa le abbia cambiato la vita, risponde:

> Per me, e credo per molti altri, è raramente una sola cosa. La recovery è un processo, così come lo è la vita.

Nella prospettiva delle persone che hanno attraversato l'esperienza del disturbo mentale e di quanti hanno superato nel lungo periodo l'esperienza della istituzionalizzazione, la guarigione non è intesa quindi come un prodotto finale, ideale o statico. Spesso è descritta come un'attitudine, un modo di vivere e di sentire, una visione o un'esperienza, anziché un ritorno alla normalità o alla salute (Davidson, 2003). Questo modo di definire la recovery come un processo vitale e dinamico è espresso frequentemente, nella letteratura del movimento degli ex utenti psichiatrici, con l'espressione *essere in recovery* piuttosto che *essere recovered*, cioè essere guariti. Come sottolinea Patricia Deegan (1993), la recovery

> è un processo non perfettamente lineare, a volte il nostro percorso è fatto di errori e fallimenti, si scivola indietro, ci si riorganizza per ripartire da capo. L'obiettivo è affrontare la sfida delle nostre difficoltà e stabilire un nuovo e rafforzato senso di integrità e di scopo nella vita, all'interno e oltre i limiti del disturbo.

3 | Le opportunità di lavoro, di perseguire i propri interessi e disporre di denaro sufficiente per invitare un amico a cena, ad esempio, possono essere elementi di grande supporto. I movimenti per la deistituzionalizzazione hanno sottolineato l'importanza della restituzione dei diritti di cittadinanza e della costruzione di alternative nei contesti reali di vita delle persone. Perché quanto più le persone hanno accesso ai diritti di cittadinanza, tanto più possono ricostruire una identità sociale e riguadagnare un ruolo nelle relazioni sociali.

E, come la vita, può implicare passi avanti e ricadute

Secondo quanto afferma anche William Anthony (1993), parlare di processo dinamico e aperto offre un'immagine di costruzione continua, di percorsi basati su una serie di passi progressivi che possono

> implicare crescita e ricaduta, periodi di veloci e di lenti cambiamenti. Mentre la tendenza può essere verso l'alto, l'esperienza del giorno per giorno non è sempre direzionata. Intensi sentimenti possono sopraffare improvvisamente, così come momenti di introspezione o periodi di crescita possono accadere inaspettatamente. Il processo di recovery è tutt'altro che sistematico e pianificato.

Ma è nella concettualizzazione di Ron Coleman che l'idea di processo viene argomentata in modo più esplicito, quando l'autore propone la distinzione tra recovery e mantenimento (maintenance). Con quest'ultimo termine Coleman si riferisce alla pratica istituzionale della psichiatria, secondo cui l'esito migliore è visto come una condizione sostanzialmente statica, in cui la preoccupazione del servizio non va oltre la riduzione del rischio di «ricaduta» del paziente, «congelandolo» in tal modo nel ruolo di malato. Al contrario, la recovery come processo dinamico comporta lo sviluppo delle persone verso nuovi traguardi di appropriazione di sé e perciò anche di riduzione della dipendenza dal servizio.

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Manuela Ciambellini, Anita Eusebi, Luca Negrogno, Fabrizio Starace

La cittadinanza è ancora terapeutica
L'esperienza del Social point a Modena

Da Basaglia in poi abbiamo imparato a vedere le persone che vivono il dolore della mente come persone e non come diagnosi, come malattia. Persone che faticosamente guadagnano margini, a poco a poco più ampi, di libertà. Libertà intesa come possibilità di godere di diritti, di esprimere bisogni, di alimentare desideri, di scoprire i propri sentimenti, in una parola di vivere. Questa libertà è il singolare prodotto di quella stagione ed è quanto di più salutare si possa immaginare. «La libertà è terapeutica», si diceva allora. Oggi potremmo dire che lo è «la cittadinanza», la parola che meglio esprime l'idea di recovery.

Nella vita quotidiana delle persone con disagio psichico, dei loro familiari e degli operatori che lavorano per la salute mentale di comunità, temi come il lavoro, l'abitare, la qualità delle relazioni di vicinato e del «capitale sociale» assumono un ruolo fondamentale nel determinare un migliore decorso della malattia mentale.
A sua volta, il conseguimento di prognosi positive per la persona ha effetti trasformativi sull'immagine collettiva della malattia e della persona con disabilità, non più considerata un peso, ma una potenziale risorsa. È quindi indispensabile costruire progetti di cittadinanza, orientati alla recovery e al miglioramento della qualità della vita. Come *Social point*.

Un progetto d'inclusione nella comunità

Attivo a Modena dal 2006, Social point è un progetto nato dall'iniziativa delle realtà del terzo settore, attualmente finanziato dal Dipartimento di salute mentale e dipendenze patologiche (DSM-DP) dell'Azienda USL di Modena (dopo un periodo di sperimentazione quadriennale, finanziato dalla Fondazione Cassa di risparmio di Modena). L'AUSL ne ha assegnato la gestione al Consorzio di solidarietà sociale, in partnership con il Centro servizi del volontariato, l'associazione di familiari e amici di pazienti psichiatrici «Insieme a Noi»,

l'associazione di utenti «Idee in circolo» e l'ARCI. Inizialmente operativo solo nei comuni di Modena, Sassuolo e Castelfranco, dall'aprile 2012 è stato esteso a tutti i Distretti della provincia.
Nella fase di avvio l'obiettivo era *creare proposte di socializzazione e tempo libero* per gli utenti dei servizi di salute mentale la cui condizione non consentiva percorsi riabilitativi di tipo occupazionale, *in modo da alleggerire il carico assistenziale* dei centri diurni e delle famiglie. Negli anni successivi, Social point si è confrontato a tutto tondo sulla salute mentale come tema che riguarda non solo pochi «addetti ai lavori» o qualche utente e i suoi familiari, ma tutti i cittadini. Il progetto si è così sviluppato su *tre livelli di intervento*:
• facilitazione dell'inclusione sociale di persone con disagio psichico tramite attività di volontariato e tempo libero, mirando a valorizzare risorse individuali e collettive in modo che l'identità non sia monopolizzata dall'esperienza di malattia;
• sensibilizzazione, formazione e informazione del territorio sui temi legati alla salute mentale;
• diffusione di un'idea positiva di salute mentale come oggetto di responsabilità collettiva e creatrice di capitale sociale per il territorio.
Se dunque inizialmente il progetto rispondeva al bisogno di una riduzione del «carico», in una seconda fase si è diffusa la cultura per cui *il tempo libero e la cittadinanza attiva sono opportunità da offrire* alla popolazione che accede ai servizi di salute mentale, *indipendentemente* da quanto i singoli pesino sui servizi e sulle famiglie.

Da utenti dei servizi a volontari del territorio

Parallelamente a questa presa di consapevolezza da parte degli operatori, è stata necessaria una riflessione sulle modalità di lavoro sia con gli utenti che con il territorio. La prassi insegna che, se gli operatori del servizio vogliono lavorare in ottica di *empowerment* e *recovery,* sono inevitabilmente indotti a rivedere il modello operativo.
L'evoluzione del modello di lavoro ha riguardato innanzitutto gli obiettivi condivisi con gli utenti. Il cittadino con disagio psichico che arriva al servizio Social point è chiamato a riflettere – insieme agli operatori – sui propri interessi, su ciò che gli piace fare, sugli ambiti in cui sente di avere più esperienza.
In un primo incontro si valuta l'interesse a partecipare alle attività proposte dalle realtà del territorio; quindi si procede all'attivazione della rete di soggetti dell'associazionismo presente in modo capillare nella comunità (circoli, polisportive, associazioni di volontariato anche non direttamente interessate ai temi della salute mentale), verificando la possibilità di inserimento di nuovi volontari.
In termini di finalità, viene facilitato un processo di empowerment, *costruendo con l'utente una proposta di impegno attivo del tempo libero e valorizzando la scelta e la responsabilità individuale*.
Gli operatori favoriscono momenti in cui l'utente «mette tra parentesi» la propria situazione critica (che lo definisce in maniera univoca come soggetto di bisogno e oggetto di cure) e arricchisce la propria autorappresentazione attraverso momenti

di libero sviluppo di attitudini personali creative, in un contesto paritario e di «normalità».
Contemporaneamente, l'operatore lavora per promuovere e radicare nel territorio e nei servizi in rete un pensiero diffuso volto a valorizzare il sapere e le risorse, e non solo a evidenziare i problemi dei cittadini con disagio psichico. È fondamentale – in queste occasioni di incontro con le realtà del territorio – parlare di «guarigione possibile» e di «miglioramento della qualità di vita». Obiettivi – questi – che il lavoro degli operatori di Social point mostra essere concretamente raggiungibili.
Se infatti ci si prende cura dei contesti relazionali in cui le persone vengono inserite, si osserva come emergano da parte loro particolari abilità, risorse, capacità attive e propositive. Ciò fa sì che anche gli utenti portatori delle condizioni patologiche più gravi possano trarre grande beneficio, oltre che dalla realizzazione di progetti riabilitativi individuali, dal mutamento di percezione che il contesto sociale ha di loro.

Il lavoro con la rete delle risorse territoriali

L'operatore di Social point è chiamato quindi a intervenire sulla facilitazione di processi piuttosto che sulla creazione di singoli progetti, come accadeva prevalentemente in precedenza. Centrale diventa in questo senso il lavoro con la rete delle risorse territoriali.

Aiutare le associazioni ad accogliere le persone con disagio psichico

Un primo tema su cui ci si è concentrati nel lavoro con le risorse territoriali è stato l'accoglienza del disagio. Dai volontari delle organizzazioni aderenti emergeva la richiesta di approfondimento e sostegno.
In questa fase, in collaborazione con il Centro servizi per il volontariato, si sono svolti interventi formativi finalizzati alla decostruzione degli stereotipi sul disagio e a valorizzare la persona inserita in attività di volontariato.
Le associazioni di volontariato, superati i timori iniziali, hanno mostrato un significativo miglioramento delle modalità relazionali e di accoglienza. Si è reso evidente come le esperienze di cittadinanza attiva degli utenti abbiano permesso di costruire una competenza sul disagio psichico che diviene poi patrimonio del territorio e si restituisce alla comunità come capitale sociale permanente.
Questo crea una risorsa che il mondo del volontariato impiega per la propria *mission*: coltivare le proprie competenze relazionali permette infatti di essere più efficaci nel costruire comunità solidali e coese. Spesso, gli inserimenti di persone con disagio, *in virtù dell'incremento di riflessività* che richiedono sulle modalità comunicative dell'organizzazione, finiscono per *aumentare lo «stato di salute»* dell'organizzazione di volontariato stessa.
Emerge così la doppia finalità del lavoro di Social point: da un lato realizzare l'empowerment della persona con disagio psichico costruendo insieme a lei, con la massima personalizzazione possibile, una proposta di impegno attivo del tempo; dall'altro restituire consapevolezza al territorio della responsabilità condivisa nei confronti della salute della comunità.

Promuovere una diversa concezione del tempo libero

La funzione di «facilitatore di spazi relazionali» reali è diventata sempre più determinante nel qualificare la prassi operativa di Social point. Pur partendo da invii da parte dei Centri di salute mentale (Csm) – cui storicamente è affidato un mandato volto a evidenziare le «carenze» dell'utente, il dis-funzionamento, la dis-abilità – l'operatore di Social point lavora secondo un diverso approccio, volto a valorizzare le capacità invece delle disabilità delle persone e a lasciare spazio a ciascuno per esprimere scelte e responsabilità [(1)].

Questo cambio di approccio è avvenuto gradualmente da parte degli operatori di Social point. E quando è stato condiviso con gli operatori dei servizi di salute mentale nei tavoli di coordinamento (dove si definiscono le modalità di erogazione del servizio e si determinano le caratteristiche dei soggetti beneficiari, cioè si «oggettiva» il bisogno su cui si interviene) si è presentata talvolta una certa difficoltà di comunicazione.

In ambito psichiatrico è ancora diffusa una considerazione delle attività di socializzazione come strumenti per *riempire il tempo* di utenti dei centri diurni o come alternative a inserimenti lavorativi non praticabili. Una sorta di «intrattenimento», così come efficacemente descritto da Benedetto Saraceno [(2)]. Ma quest'ottica è sempre più stridente rispetto a una metodologia globale di progettualità sociosanitaria, coerente con i principi dell'empowerment e della recovery.

Inoltre in alcuni operatori dei servizi era presente l'idea secondo cui alcuni utenti, caratterizzati da un funzionamento troppo compromesso, non avrebbero mai potuto fruire delle possibilità offerte da Social point, «poco protette» perché realizzate sul territorio e non nei centri, e troppo «difficili» perché esposte alla partecipazione di «normali» cittadini, portatori di aspettative troppo alte rispetto alle «social skills» delle persone con disagio. Considerazioni e valutazioni che segnalavano, da un lato, una resistenza culturale e organizzativa al processo innovativo in corso, dall'altro una modalità assistenziale che rischiava di cristallizzare gli utenti ai livelli di disabilità associati alla malattia, anche quando la malattia era in remissione.

Certo è innegabile che alcune attività, che richiedono oggettivamente particolari caratteristiche per essere svolte, risultano inadatte per alcune persone. Nondimeno anche persone dalle abilità sociali gravemente compromesse hanno evidenziato gli effetti positivi dello sviluppo di una soggettività costruita sulle proprie risorse e sulla propria partecipazione attiva. Questo non ha invalidato le valutazioni tecniche e mediche sul funzionamento delle persone, ma le ha corredate di altre importanti considerazioni e prospettive [(3)].

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1 | Il Dsm-Dp di Modena ha incluso il Progetto Social point in un più ampio programma di orientamento dei servizi alla recovery e di acquisizione e applicazione dei principi dell'*International Classification of Functioning*.

2 | Saraceno B., *La fine dell'intrattenimento. Manuale di riabilitazione psichiatrica*, Etas, Milano 1995.

3 | Anche alcuni inserimenti in progetti collettivi molto «difficili» per competenze richieste hanno ottenuto effetti inaspettati con persone segnate da diagnosi funzionali gravi, considerate «senza speranza» dagli operatori più «conservatori». Significativa in tal senso l'esperienza di emancipazione delle persone collocate in soluzioni abitative nell'ambito «Progetto residenze».

Tutti chiamati in causa come persone

In un percorso orientato a sostenere l'accesso ai diritti di cittadinanza attiva da parte dei cittadini con disagio psichico, è cruciale che questi possano riappropriarsi dell'esperienza che vivono, riconoscendosi soggetti e non semplicemente utenti del percorso.

Oltre lo stigma dell'identità di utente

Ciò costituisce una sfida assolutamente critica per la persona con disagio poiché, già nella costruzione sociale della propria «malattia», entrano in gioco elementi che definiscono in maniera asimmetrica la sua relazione con il contesto circostante, che sia familiare o di cura.

L'«identità» di utente porta con sé una carica stigmatizzante della quale il mondo della malattia mentale è inevitabilmente permeato: per questo, sul piano culturale, non ci si può esimere dall'affrontare le rappresentazioni collettive della salute mentale e della malattia.

In Social point, lontano dalle abitudini «istituzionalizzanti» che si sviluppano nei *setting* assistenziali di salute mentale tradizionali, le persone con disagio, indipendentemente dal loro «livello di funzionamento» e dalle loro etichette diagnostiche, sono stimolate e guidate nella realizzazione di finalità concrete e «vere», utili e positive, condivise da altri cittadini che partecipano a tali attività. In questi contesti tutti sono chiamati in causa in quanto «persone», al di là di una loro eventuale malattia. E ciascuno, in quanto consapevole della propria esperienza e di un proprio sapere, può contribuire a *innescare un processo di cambiamento culturale*.

Da utenti a soci: nasce «Idee in circolo»

In linea con queste premesse, si è sempre più accentuata, negli anni, la consapevolezza da parte degli operatori di Social point che il lavoro di sensibilizzazione, promozione, formazione e informazione del territorio non poteva più fare a meno del *coinvolgimento diretto* degli utenti, in particolare di quelli definiti «esperti», ossia di coloro che hanno attraversato l'esperienza di malattia e sono ora in grado di metterla a disposizione della comunità.

Così, nel 2011, si è deciso di costituire l'associazione «Idee in circolo», fondata e gestita da cittadini in maggior parte con disagio psichico, per promuovere assieme a chiunque abbia voglia di collaborare una cultura di inclusione e cittadinanza attiva nel territorio modenese. La decisione è maturata sulla base delle *assemblee periodiche* di un gruppo di lavoro, denominato «Le parole ritrovate» [4], composto da utenti, operatori, volontari, familiari.

Le assemblee sono state il luogo in cui, forse per la prima volta, utenti del servizio

4 | Nel 2009 Social point è entrato nel movimento «Le Parole ritrovate», nato a Trento nel 1993 con l'idea che «non si tratta semplicemente di dare la parola a chi non l'ha sinora avuta, si tratta piuttosto di ritrovare assieme le parole». Dal 2009 Social point partecipa ai coordinamenti nazionali e agli incontri annuali, organizzando a Modena assemblee e convegni (www.leparoleritrovate.com).

di salute mentale hanno sentito di poter pubblicamente e liberamente esprimere le proprie esperienze in maniera incisiva e determinante per gli altri. E la grande carica del movimento è cresciuta man mano che sono aumentate le occasioni di confronto: sapere che l'apporto di ciascuno modifica sensibilmente il risultato del lavoro di gruppo ha costituito un importante elemento di spinta per mettersi in gioco personalmente.
Il confronto di gruppo ha provocato inoltre un'apertura e una *consapevolezza del peso delle proprie parole* che risulta essere una novità dirompente nell'esperienza di alcuni degli utenti coinvolti: le parole assumono «un peso specifico», per alcuni mai provato.

Potenza delle assemblee: si ritrova insieme la voce

La dimensione assembleare e paritaria, come metodologia, influisce positivamente sul livello di stigma esterno e internalizzato, e dunque sulla capacità dei cittadini con disagio psichico di riappropriarsi di un proprio progetto di vita complessivo. Il confronto collettivo [5] permette infatti di sottrarre il «sintomo» all'oggettivazione tecnica e di ricostruirne il senso in un percorso di vita collettivamente dotato di significato, condiviso, dialettizzato dalla lettura e dall'ascolto comune, alla pari. Le esperienze personali, una volta raccontate e messe in circolo, diventano vettori di consapevolezze collettive nuove, che vanno a «scomporre» gli oggetti costruiti dalle istituzioni.
Accanto a questi momenti assembleari, gli operatori di Social point hanno cercato di facilitare anche l'avvio di alcuni *gruppi di auto mutuo aiuto*, con l'idea di formare, nel tempo, *utenti facilitatori*. Il metodo di base, definito del «fareassieme», costituisce una forza trasformatrice perché permette a ciascuno di realizzare quella partecipazione responsabile al lavoro collettivo e di aprire la propria visuale sull'altro come persona da accogliere con la propria esperienza.

Il recupero di una contrattualità sociale

Questo approccio rende protagonisti i soggetti coinvolti ed evita la riduzione degli utenti e della loro sofferenza a semplici «oggetti» nelle mani delle pratiche assistenziali. Di qui è maturata la consapevolezza sempre che il lungo e difficile percorso della cura verso la guarigione (recovery) non passa solo attraverso la presa in carico da parte dei servizi, ma anche attraverso il recupero di un proprio ruolo sociale.
L'azione sul contesto sociale e culturale di riferimento, che vede proprio i soggetti «esclusi» come protagonisti attivi, dotati di contrattualità sociale e impegnati a svolgere vari livelli di interlocuzione per realizzare iniziative di promozione della

5 | Nelle assemblee – sempre aperte a tutti e sempre in cerchio per potersi reciprocamente ascoltare – il confronto verte su temi scelti dalle persone, dentro un filo rosso che per il 2015 è «resistere». Nelle assemblee si dà voce alle storie delle persone, alle loro emozioni e forme di espressione, alle loro angosce e disperazioni, ma anche alle loro speranze e guarigioni possibili. Il confronto collettivo permette di distruggere l'infinita serie di pregiudizi e incomprensioni con cui si tende a svuotare di animo le esperienze di vita di chi attraversa la sofferenza psichica. Smarcandosi dal destino che l'etichetta di «persona con malattia mentale» disegna per molti.

propria condizione, è allora un'azione importante che ricolloca i soggetti deboli in una chiara posizione di cittadinanza attiva.
Il protagonismo di cui si è fatta e si continua a fare concretamente esperienza nelle assemblee diventa stimolo costante alla rivendicazione di una posizione di rilievo nei confronti di tutta la cittadinanza e di un ruolo di sensibilizzazione nei confronti della comunità. Nelle riflessioni collettive, l'attenzione passa così dalla malattia alle condizioni sociali, culturali ed economiche che favoriscono l'emarginazione e l'isolamento: diventa progressivamente chiaro a molti che lo sforzo per la riappropriazione della propria salute passa per un esercizio collettivo di organizzazione e di sensibilizzazione volto ad aumentare la coscienza comune.
Su questo terreno germogliano le iniziative pubbliche e si sviluppano le progettualità rivolte alla comunità, in cui gli utenti iniziano a esprimersi pubblicamente, portando il punto di vista dei cittadini che usufruiscono dei servizi di salute mentale.

Per una settimana in città si parla di salute mentale

Significativo, da questo di vista, il progetto «MÀT - Settimana della salute mentale», promossa dal Dipartimento di salute mentale e dipendenze patologiche dell'AUSL di Modena dal 2011 è collocata a cadenza annuale nella seconda metà di ottobre.
Si tratta di una settimana di dibattiti, conferenze, eventi artistici e culturali aperti a tutta la cittadinanza, dislocati in diverse aree di Modena e della provincia, per sensibilizzare il territorio sui temi della salute mentale e implementare la lotta al pregiudizio e allo stigma che gravano su chi soffre di disagio psichico.

La costruzione partecipata dell'iniziativa

L'evento si svolge sulla base di un percorso di progettazione partecipata, in collaborazione con le associazioni Idee in circolo e Insieme a Noi, e vede il coinvolgimento di partner istituzionali e di un'ampia rete di soggetti dell'associazionismo di utenti, familiari e operatori dei servizi di salute mentale, del volontariato, del privato sociale e imprenditoriale, della scuola e dell'università, delle fondazioni.
La prima edizione ha visto per la prima volta operatori del servizio di salute mentale e volontari delle associazioni collaborare fianco a fianco nelle fasi di ideazione, progettazione e realizzazione dell'iniziativa. L'edizione successiva ha registrato la definizione di una vera e propria convenzione tra il Dipartimento di salute mentale e le associazioni di utenti e familiari al fine di sviluppare un percorso partecipativo finalizzato alla costruzione «comunitaria» dell'evento, secondo una formula organizzativa via via più strutturata e organica.
L'iniziativa si pone come forma di «innovazione sociale» di grande importanza per il territorio: si tratta di un percorso di costruzione partecipata che ha stimolato empowerment organizzativo nel Dipartimento di salute mentale e promosso processi di integrazione tra i servizi pubblici e i soggetti del territorio a vario titolo interessati al tema della salute mentale nei suoi aspetti tecnici, scientifici, politico-sociali, artistici e culturali.

La malattia mentale smette di essere tabù

La Settimana rientra tra gli strumenti messi in campo per intervenire innanzitutto sulle rappresentazioni negative e stigmatizzanti della malattia mentale e delle persone che ne soffrono. La malattia mentale, di fronte agli utenti e ai familiari che si organizzano per promuovere eventi culturali e di sensibilizzazione, smette di essere un tabù per la comunità. Il disagio diviene piuttosto una condizione attraversabile, «che può colpire tutti» [6], dalla quale si può uscire facendo affidamento sulle risorse tecnico-professionali e solidaristiche presenti sul territorio.

MÀT costituisce un'occasione per sperimentare e mostrare pubblicamente la possibilità di percorsi di «empowerment» per le persone seguite dai servizi. È il momento culminante in cui assumono visibilità i progetti personalizzati di inclusione sociale e i progetti collettivi di cittadinanza attiva, rivolti a utenti, che quotidianamente arricchiscono il lavoro clinico e terapeutico dei servizi di salute mentale, conferendogli ampiezza di respiro e di prospettiva.

Più in generale, l'iniziativa si colloca all'interno di un'azione che va così a modificare la rappresentazione sociale dei disturbi mentali e l'espressione stessa della domanda di salute mentale da parte della popolazione.

Si delineano nuove politiche di salute mentale

Dal lavoro si è sviluppata una nuova consapevolezza delle pratiche rivolte all'inclusione di individui e gruppi in condizioni di esclusione sociale. È emersa una modalità nuova di rilevazione dei bisogni e di confronto pubblico sulle politiche di salute mentale, in cui il dialogo tra erogatori e utenti delle prestazioni risulta decisivo per la costruzione di politiche pubbliche più incisive e orientate alla promozione dell'inclusione sociale delle persone con disagio.

Dall'analisi condivisa dei bisogni è emerso infatti che l'articolazione tradizionale dei servizi terapeutici e riabilitativi non è ancora sufficientemente orientata a una reale «ri-contrattualizzazione» delle persone con disagio (ossia a sostenere la loro contrattualità) e queste spesso, anche anni dopo gli episodi più acuti, continuano a restare «a carico» delle famiglie o comunque «cronicizzate» in situazioni segnate da impossibilità di esercitare diritti di cittadinanza, da difficile accesso alle opportunità del territorio, da scarso capitale sociale, da esclusione dal mercato del lavoro, da poca disponibilità di beni e di risorse durevoli, da condizioni gravi di esclusione sull'asse della casa e del lavoro.

Insomma, per le persone trattate dai servizi psichiatrici c'è ancora il rischio che si prospettino traiettorie esistenziali fatte di cronicità, esclusione sociale, povertà, in una «spirale del disagio» che finisce spesso per inghiottire la maggior parte delle famiglie.

La Settimana, ma più ancora il lungo processo che porta alla sua costruzione, ha dunque anche l'obiettivo di incidere sui decisori pubblici. Mostrando che le poli-

6 | In effetti in questi anni nel territorio modenese vi è stato un incremento costante del numero di cittadini trattati dai servizi di salute mentale (fonte, *Relazione annuale,* Dipartimento salute mentale e dipendenze patologiche dell'AUSL di Modena).

tiche più adatte per affrontare la malattia mentale non sono l'istituzionalizzazione e la moltiplicazione di posti letto in istituzioni pubbliche o private, o residenze «protette» in cui collocare gli utenti per tutta la vita, bensì la creazione di luoghi, opportunità e competenze di inclusione sociale.

I segni di un nuovo welfare

La Settimana costituisce il laboratorio e la sintesi degli elementi di innovazione e cambiamento culturale che il Dipartimento di salute mentale ha condotto negli ultimi anni.

Màt è il prodotto concreto di quei principi di «sussidiarietà orizzontale e verticale» che dovrebbero caratterizzare il nuovo volto dei sistemi di welfare; sistemi capaci di superare impostazioni tradizionalmente (e sempre più insostenibilmente) assistenzialistiche e di implementare forme di partecipazione orientate alla promozione attiva del benessere collettivo. Il passaggio cioè da prestazioni «sanitarizzanti» a prestazioni indirizzate alla progettazione di comunità, alla creazione di prodotti relazionali e sociali, è il futuro cui allude questa sperimentazione.

L'impatto sulla riduzione dello stigma e sul cambiamento culturale nella comunità è perseguito a partire dal metodo ideativo, progettuale e organizzativo degli eventi, secondo cui utenti, volontari e familiari delle associazioni hanno assunto una posizione di protagonismo e insieme di collaborazione con gli operatori del Dipartimento di salute mentale.

Per i servizi si tratta di un modello di lavoro nuovo: coloro che ricevono prestazioni non sono più solo fruitori passivi, consumatori di prestazioni e determinanti di costi per l'amministrazione pubblica, ma divengono essi stessi promotori di processi, collaboratori dei servizi, figure di mediazione tra i professionisti e i cittadini che portano al servizio la loro domanda di salute.

L'impostazione di tale percorso di costruzione partecipata ha dovuto confrontarsi con gli inevitabili aspetti inerziali espressi da alcuni segmenti delle istituzioni, ma ha condotto allo sviluppo di una nuova forma di riflessione condivisa sui bisogni espressi e sulle prassi attraverso cui si erogano i servizi sanitari, di interlocuzione con chi direttamente fruisce di tali servizi, con setting e finalità diverse da quelle tradizionali della «cura», e la conseguente riformulazione della relazione tra tecnici e utenti.

Sempre più i servizi che vogliano rispondere ai nuovi bisogni di salute mentale dovranno essere accessibili a tutti, non evocare il timore associato all'immagine stereotipata del «paziente psichiatrico» socialmente escluso e pericoloso. La sperimentazione dei progetti di inclusione sociale sviluppati «dal basso», dalle associazioni di utenti e familiari, ha mostrato che un approccio non fondato sulla disabilità ma sulla valorizzazione della libertà di scelta e del recupero della contrattualità sociale riduce significativamente il livello di esclusione e attiva percorsi innovativi di socializzazione. È questo l'orizzonte verso cui incamminarsi.

Izabel Marin

Progettare servizi orientati alla recovery

Come i servizi possono favorire la «ripresa di sé»

Le persone con disturbi mentali anche gravi raccontano come sempre, persino nei momenti più bui, permanga comunque una parte di sé che resiste alla malattia, che cerca i modi per contenerne gli effetti catastrofici, che prova a ricercare nuove possibilità di vita. Questi racconti offrono indispensabili indicazioni ai servizi, che sempre più devono saper accompagnare il viaggio che le persone compiono per costruirsi una vita dentro e oltre la sofferenza. Orientarsi alla recovery significa, per un servizio, consentire ai soggetti di negoziare la propria cura, includersi nella società, abitare identità differenti.

C'è ancora molto da imparare sui processi di *recovery* e sui servizi orientati a sostenere le persone in tali processi. Tuttavia, in questi anni abbiamo iniziato a capire meglio che cosa favorisce e che cosa ostacola il possibile cambiamento nella vita delle persone, in particolare rispetto alla pratica dei servizi di salute mentale.

Se infatti da una parte le persone devono attingere alle proprie personali risorse per determinare un miglioramento della propria condizione, dall'altra un servizio consapevole di quali siano gli strumenti più utili da offrire faciliterà e renderà più rapida la loro ripresa.

Pertanto ci focalizzeremo ora sui fattori relazionali e sociali che sono apparsi più rilevanti nel contesto triestino, tenendo conto del ruolo che hanno avuto i servizi [(1)].

Il riferimento, oltre all'esperienza pratica dei servizi di salute mentale, è alle ricerche condotte in questi anni sulla recovery, basate sull'ascolto delle persone con esperienze di sofferenza mentale [(2)].

1 | Nel patrimonio di esperienze della deistituzionalizzazione a Trieste – dalla chiusura dell'ospedale psichiatrico in poi – si possono ritrovare alcuni prerequisiti per il funzionamento di un servizio territoriale orientato ai processi di ripresa e di guarigione.

2 | Nella rubrica «I diari degli operatori» di questo numero sono riportati alcuni stralci di storie di persone in recovery. Per una lettura più ampia e articolata si rimanda al volume *Guarire si può. Persone e disturbo mentale* (Edizioni alpha beta Verlag, Merano 2013), curato da Izabel Marin e Silva Bon (*NdR*).

Assumere un'altra idea di guarigione

Nella definizione che i soggetti intervistati danno della propria recovery è determinante l'aspetto processuale, che la caratterizza come «un cammino di ricerca e di costruzione ancora aperto», «un processo lungo, doloroso, e possibile».

Non più il contrario di malattia

Le persone si percepiscono nettamente migliorate rispetto a una condizione iniziale di perdita di sé, si ritrovano con una capacità nuova di vivere la propria realtà e le relazioni sociali.

Tra i significati che assume la recovery c'è quindi la capacità di controllo sulle crisi – e perciò dei sintomi – in un processo in cui si impara a «convivere con una debolezza». La guarigione non è più contrapposta a uno stato di «malattia». La ridefinizione di se stessi come persone, di cui il disturbo mentale è semplicemente una parte, può essere inteso come uno degli aspetti più profondi della recovery.

Quello che accomuna tutte le testimonianze raccolte è il ruolo del servizio di salute mentale nel sostenere e nello stimolare gli sforzi personali verso un processo di cambiamento della propria condizione. Dai racconti emerge che il servizio ha avuto un importante ruolo come promotore di processi ri-abilitativi, di *empowerment*, di svolte significative per la ripresa.

I punti di svolta sono associati spesso a eventi di natura sociale: incontri significativi con altre persone che stanno vivendo la stessa esperienza, ma anche con un operatore, uno psichiatra, un amico. Oppure sono legati a fattori strutturali, per esempio aver trovato un lavoro soddisfacente o aver ripreso un ruolo lavorativo abbandonato con la comparsa del disturbo, avere una casa per sé o essere tornati a vivere in famiglia.

Guarire è stare bene nel sociale

È altrettanto importante osservare quanto sia rilevante la dimensione sociale della recovery in tutti gli aspetti che riguardano la ricostituzione di uno stato di benessere psichico. La recovery non avviene nella solitudine: è un processo intersoggettivo in continuo cambiamento. È nel contesto sociale che la dimensione più strettamente soggettiva si convalida e diventa sostanziale.

Come viene rilevato da recenti ricerche in questo ambito, i contesti comunitari sono ambiti di potenziale sviluppo della partecipazione attiva che fanno guadagnare senso di appartenenza, diventando quindi fattori di recovery. I contesti di «rete» e di «comunità» rappresentano supporti sociali fondamentali dove sentirsi inclusi, accettati, agenti attivi e cittadini.

Per la maggior parte delle persone, la ricostruzione di una rete sociale avviene, in un primo tempo, a partire dal Centro di salute mentale (Csm): per alcuni, la rete di conoscenze si allarga poi effettivamente al di fuori del contesto del servizio, mentre altri hanno ancora bisogno di usufruire del suo supporto.

La dimensione sociale acquista significato in relazione al ruolo dei servizi nella

misura in cui essi riescono a sostenere le persone nel loro contesto di vita, sia nell'attivare l'aiuto della propria rete di persone significative, sia nell'attrarre risorse umane e materiali per la creazione di opportunità sociali miranti all'inserimento in contesti di normalità [3].

Attrezzarsi per accogliere la domanda di aiuto

Il primo contatto con un servizio psichiatrico è descritto dalla maggior parte degli intervistati come un'esperienza drammatica, perché strettamente connessa alla presenza di pregiudizi per i luoghi di cura, spesso percepiti come stigmatizzanti. La persona sembra andare incontro a una sorta di catastrofe personale prima di accettare un aiuto.

Questa esperienza, che può significare «varcare una soglia» e sancisce il proprio timore di essere pazzi, pone il servizio di fronte al bisogno di attrezzarsi per accogliere la domanda di aiuto in cui la costruzione di un rapporto di fiducia, necessario a stabilire un'alleanza terapeutica, è l'elemento essenziale.

In tal senso, un servizio orientato al dialogo e all'ascolto «va incontro» alla persona avvicinandosi concretamente ai suoi bisogni e la considera come soggetto attivo e corresponsabile nel trattamento, che passa attraverso una corretta informazione e una negoziazione su programmi e scelte terapeutiche da intraprendere.

I *luoghi* del contatto, nell'andare «verso la persona», sono i suoi luoghi di vita: l'abitazione, il quartiere, il posto di lavoro; i *contenuti* della presa in carico sono l'insieme di soggettività, rapporti sociali, condizioni materiali di vita [4].

Nel momento in cui la persona entra in contatto con il servizio di salute mentale, nonostante la drammaticità del vissuto di mancata speranza e di isolamento sociale in cui si trova, si apre nei suoi confronti una nuova costellazione di risposte necessarie per cominciare a ricomporre i tasselli della propria storia e a infrangere «il muro nella comunicazione con il mondo».

Questo spiraglio rappresenta spesso un punto di svolta nella propria condizione. Se il momento drammatico è caratterizzato dall'isolamento, la guarigione incomincia nella riscoperta della possibilità di comunicare.

Favorire l'accettazione del disturbo

In relazione allo stigma percepito nei confronti dei luoghi di cura, man mano che si sviluppano possibilità concrete e condivise sul piano dell'aiuto la drammaticità dell'impatto si attenua. Si deve anche tener conto del fatto che, nel linguaggio in uso

3 | Il ruolo dei servizi di salute mentale in relazione alla dimensione sociale della recovery è sottolineato in un documento importante, curato da Larry Davidson e colleghi: A *Practical Guide to Recovery-Oriented Practice. Tools for Transforming Mental Health Care*, Oxford University Press, Oxford 2008. Il documento individua principi guida per la pratica dei servizi orientati alla recovery.

4 | Cfr. Dell'Acqua P., Mezzina R., *Risposta alla crisi. Strategie ed intenzionalità dell'intervento nel servizio psichiatrico territoriale*, in «Per la salute mentale», 1, 1988.

nei servizi triestini, non ha un ruolo determinante quello che da Basaglia in poi si è chiamato «etichettamento» diagnostico. Ciò vuol dire che il problema dello stigma non è strettamente associato all' «etichetta» clinica sovrapposta alla singola persona. La situazione è diversa pertanto da quella prospettata nella tradizione anglosassone discussa dalla *labeling theory*. In quel caso, l'autostima della persona dipende dall'accettazione o dal rifiuto della diagnosi in quanto etichetta clinica: tra i soggetti che accettano l'etichettamento (diagnosi) si verifica una bassa autostima; per contro, nei soggetti che rifiutano la diagnosi del disturbo mentale grave, sono riscontrabili livelli più alti di autostima e maggiore indifferenza ai livelli dello stigma [(5)].

Se invece non prevale lo stigma «da etichettamento» diagnostico, la percezione della persona presa in carico può focalizzarsi sulle limitazioni concrete che il disturbo pone alla propria autostima e sulle difficoltà relazionali che possono essere affrontate nell'interazione con operatori che non hanno bisogno della tipica distanza difensiva rappresentata dall'etichettamento diagnostico.

Questo non vuol dire che le persone non possano scontrarsi con il rischio di invalidazione o discriminazione che anche all'interno di questo rapporto si genera. Tuttavia, il contesto più dialettico e diretto – non mediato dalla «distanza» diagnostica – permette che l'accettazione e la consapevolezza del disturbo e dei limiti a esso correlati aumentino in qualche misura la capacità di autodeterminazione e il senso di autocontrollo, nel riconoscimento e nella gestione delle difficoltà sul piano della funzionalità sociale.

Ricollocare la persona in una dimensione intersoggettiva e di opportunità

Un esempio di attenuazione dell'impatto con il servizio è dato dall'esperienza di Matteo, che per un periodo lavora come centralinista presso il Csm che lo ha in carico. Quell'esperienza a Matteo è servita per «sdrammatizzare il muro contro muro», dal momento che lui stesso diventa parte del servizio.

La nuova prospettiva permette di rompere e scardinare la resistenza tradotta nella polarità semplificata «psichiatra contro malato». Matteo rivendica la sua collocazione di «malato lontano dal credo psichiatrico», e tuttavia quella vicinanza attutisce il suo impatto con l'istituzione:

> Col tempo, iniziando a conoscerli, ho visto che sono meno fermi in questa loro convinzione, e lentamente anch'io ho attenuato i miei pregiudizi nei confronti della psichiatria.

Non per questo Matteo è meno critico rispetto ai suoi diritti e ai suoi problemi. Non per questo tutti devono lavorare come centralinisti in un Centro di salute mentale.

5 | Warner R. et al., *Acceptance of the Mental Illness Label by Psychotic Patients. Effects on Functioning*, in «American Journal of Orthopsychiatry», 3, 1989.

Le risposte del servizio, oltre al supporto medico farmacologico [6], vanno nella direzione dell'offerta di aiuti materiali, di mezzi e strumenti, di contesti e occasioni di aggregazione e di socializzazione, posti in connessione tra luoghi, attività e persone significative. Questi aspetti dell'aiuto, che determinano in parte il processo di ricostruzione di un «ritorno alla vita», sono mirati a ricollocare la persona in una dimensione intersoggettiva e di opportunità in cui compiere un percorso di riappropriazione di sé. Significano ritrovare un senso della possibilità di riavere ruoli e competenze sociali: per esempio aiuto nella ricerca o nel mantenimento di un lavoro, utilizzo del sussidio economico finalizzato alla formazione, supporto giuridico per la tutela della genitorialità.
Il servizio, nell'attivare e attrarre risorse materiali, umane e sociali, vuole offrire opportunità che la persona può cogliere e utilizzare, in una sorta di «attraversamento» personale che la stessa fa del servizio, in cui alcune risorse vengono «apprese» e utilizzate nel proprio percorso, e altre no. Attraversare il servizio può significare provare a fare un inventario personale delle proprie forze e delle proprie debolezze che, come affermano Davidson e Strauss [7], costituisce uno degli aspetti principali dello sviluppo del senso di sé: «prendere le misure» di quello che si può o non si può realizzare, per sentirsi più sicuri nell'affrontare nuove situazioni che possono rappresentare una sfida.

Sostenere le reti sociali informali

Circa il ruolo delle persone significative nel processo di recovery, è importante considerare i vari e diversi livelli di supporto della rete sociale. La chiave per comprendere il ruolo dell'altro sembra essere la qualità e l'intensità della relazione. Se parliamo della rete sociale estesa, la sua importanza va considerata in quanto «potenzialità» di rapporti e possibilità di scambio che la persona riconosce come un valore in particolari momenti di bisogno.
Ma la rete sociale ampia non è necessariamente una garanzia di supporto sociale. Il supporto dell'altro significativo spesso avviene all'interno di una relazione che ha componenti di intimità, spontaneità, durevolezza. Quando, all'interno di una rete, qualcuno viene considerato come persona significativa, si potrebbe dire che

6 | In relazione all'utilizzo degli psicofarmaci come supporto al percorso di ripresa, è importante conoscere, dal punto di vista delle persone, se e come sono stati utili per il loro miglioramento. Quello che risulta importante dai racconti è il modo in cui l'utilizzo dello psicofarmaco diventa una risorsa terapeutica: quando viene indicato come strumento di consapevolezza sul proprio percorso; quando esiste la possibilità di scegliere e decidere assieme al medico il dosaggio o la sospensione a seconda del bisogno; quando l'assunzione permette di avere una qualità di vita soddisfacente. Il racconto di Nina riassume tutte queste caratteristiche: «I farmaci di per sé, se non vengono usati bene o se vengono usati come unico aiuto, servono a ben poco. Però inseriti in un percorso di psicoterapia, o in un rapporto positivo con lo psichiatra, sono fondamentali, perché ti danno la possibilità di riuscire a fermarti e riprendere quel minimo di lucidità che serve per uscire dalla crisi. Quando uno non capisce assolutamente niente, ha delle allucinazioni, non può vivere la comprensione».
7 | Sono concetti sviluppati nel mio precedente articolo contenuto in quest'«Inserto»: *Se la prognosi negativa è un mito da sfatare.*

si è stabilita una relazione di confidenza, considerata come fattore di protezione della salute mentale.
Dai racconti emergono alcune figure che presentano tali caratteristiche relazionali: l'amica di Nina «che c'è e ci sarà sempre», il padre di Nicola e quello di Anna, come figure che offrono protezione e allo stesso tempo sono capaci di cambiare il proprio atteggiamento, creando situazioni di confidenza, di «intimità» e di «calore». Anche gli operatori sono menzionati quando riescono a stabilire una relazione autentica con la persona all'interno di un complesso di risposte ai bisogni, producendo, a partire dalla relazione, uno scatto nella situazione circostante.
Dalle capacità del servizio di innescare percorsi di inclusione sociale emersi dai racconti e, in generale, dalle esperienze delle persone in recovery che troviamo nelle pubblicazioni, si comprende la chiara necessità di continuare a sostenere le reti sociali informali e di rendere centrale lo sviluppo dell'empowerment di chi usufruisce o ha usufruito di un servizio.

Promuovere gruppi di condivisione

Nelle relazioni interne alla dimensione del servizio, per alcune persone è stato importante partecipare a momenti di interazione e di scambio informale, piccoli gruppi spontanei o facilitati dalla presenza attiva degli operatori. Questo contesto di accoglienza e di reciprocità permette alla persona di riaprirsi gradualmente, di guardarsi attorno, di misurarsi con gli altri attraverso il confronto e il dialogo, di riattivarsi come soggetto.
I momenti di incontro quotidiano possono svilupparsi nell'organizzazione di piccoli gruppi di auto-aiuto, dove poter condividere le proprie esperienze e trovare percorsi comuni per far fronte ai problemi. Le risorse che il servizio mette a disposizione per promuovere aggregazione e socializzazione sono state apprezzate quando hanno permesso ad alcune persone di sviluppare nuove conoscenze e amicizie, e di conseguenza maturare relazioni che esulano dal contesto stesso del servizio.
I gruppi talvolta possono diventare risorse sociali importanti per le persone in alcuni momenti del loro processo di recovery; possono inoltre svilupparsi in forme più organizzate di supporto tra pari.
Queste reti informali di sostegno reciproco nascono, si allargano, si differenziano e nell'evoluzione di questo processo includono e si fanno attraversare da chi ha bisogno di fare un percorso collettivo, di acquisire potere. I club di volontariato, i gruppi sportivi e culturali, e in particolar modo il gruppo di volontariato di donne hanno avuto un'importante risonanza per le persone: hanno significato ritrovarsi in una dimensione di accettazione e di condivisione di «orizzonti comuni» favorevoli alla ridefinizione di sé.

Supportare la rete familiare

Quanto agli interventi relativi alla rete familiare, essi possono essere incisivi fin dai primi contatti con le diverse situazioni.

Il contributo dei familiari è fondamentale per la ricostruzione della storia di vita del loro parente in quanto conoscono il «prima» del disturbo e possono aiutarlo a ricostruire un «dopo», il loro futuro.
Anche se sostenere i propri cari può rappresentare un'esperienza positiva, l'impatto in termini di gravosità, soggettiva e oggettiva, è molto alto. In *User Empowerment in Mental Health*, documento dell'Organizzazione Mondiale della Sanità del 2010, è stato rilevato che il 95% dei *carers* sono familiari, di cui l'82% donne (per il 90% madri). Il 29% dei carers familiari è impegnato nelle attività di supporto per più di cinquanta ore settimanali.
I familiari hanno dunque bisogno di sostegno, di informazioni condivise e di affidabilità. Il familiare può essere orientato all'inserimento in specifici programmi di supporto, come nel caso del gruppo di familiari di persone con disturbo mentale severo. Questi programmi possono essere utili, innanzitutto, per permettere di uscire da un isolamento della propria situazione e per con-dividere problemi in comune con gli altri familiari. In tal senso, l'aiuto alla famiglia va nella direzione di un orientamento psico-educativo, per favorire uno sviluppo di adeguate strategie per far fronte ai problemi, che permettano loro di poter avere:
• una migliore gestione dello stress relativo ai momenti di marcata difficoltà del proprio parente;
• un aumento della consapevolezza e del controllo sulle proprie capacità di dare risposte e sulle proprie emozioni;
• una riflessione sul proprio stile di vita e di relazione;
• la possibilità anche di prendere distanza da quei problemi che non sono capaci di risolvere da soli.
Il lavoro di supporto ai familiari di persone considerate ad alto carico è strutturato, oltre che da colloqui e consulenze, attraverso un programma di formazione e di riflessione a carattere psico-educativo, svolto in gruppo. Ogni anno il Dsm di Trieste, oltre a curare la pubblicazione di manuali e opuscoli informativi, organizza due corsi di formazione per circa venti familiari di persone con una storia più lunga di disturbo mentale, che durano ognuno dieci incontri con cadenza settimanale. Da circa dieci anni almeno una volta all'anno si organizza un corso di formazione e sostegno anche per familiari di persone all'esordio.
In particolare, nell'intervento con i familiari va considerato come specifico tema di intervento lo stigma connesso al disturbo mentale, per due motivi fondamentali: in primo luogo perché lo stigma può essere percepito dalla persona all'interno del proprio nucleo familiare, e in secondo luogo perché la famiglia può diventare protagonista nella lotta allo stigma e alla discriminazione, includendo la partecipazione e la promozione di attività orientate a modificare i pregiudizi e affermare il pieno diritto all'inclusione sociale dei propri parenti nella comunità.

Per una Carta dei servizi orientati alla recovery

In conclusione, desideriamo riportare l'esito di un lavoro che ha coinvolto – in un confronto ripetuto nel tempo – diversi soggetti che partecipano alla vita dei quattro

Centri di salute mentale del Dsm di Trieste: utenti, operatori, familiari e volontari. Risultato del lavoro è stata nel 2014 la realizzazione di un testo intitolato *Carta della Recovery. I servizi di salute mentale e la guarigione*[8].

Uno strumento per ripensare i servizi nel movimento della società

La Carta della Recovery vuol essere «un nuovo strumento dei servizi di salute mentale che si rinnovano, per rispondere alle nuove domande delle persone e alla realtà che si trasforma». Appare infatti necessario ripensare ai servizi di salute mentale nel movimento di una società in continua trasformazione. Servono una nuova creatività e capacità di progettare, di agire.

I ruoli e i bisogni delle persone con disagio mentale e delle loro famiglie si sono modificati nel tempo, grazie anche alle forme di associazionismo di utenti e familiari. Domande di aiuto più esplicite e chiare e la consapevolezza dell'importanza di tutelare i propri diritti sono effetti del cambiamento. Il protagonismo di persone e famiglie è parte integrante della complessità di un servizio orientato alla guarigione, e arricchisce l'offerta delle risposte che esso può dare. I servizi devono essere capaci di aiutare le persone ad attivare e utilizzare le risorse individuali e quelle esterne per conquistare uno stato di salute generale. Il tal senso, la guarigione diventa un diritto e acquista una dimensione sociale e politica.

Occorrono allora servizi, e i cittadini devono rivendicarli laddove essi non esistono o sono inefficienti, che garantiscano un'accoglienza e un percorso di cura adeguati, relazioni di aiuto fondate sulla reciprocità, risorse economiche per favorire inserimenti nella società, politiche sociali e culturali che contrastino lo stigma e la discriminazione, il pregiudizio tuttora dominante che l'individuo sofferente di un disturbo mentale sia «pericoloso», «incomprensibile», «inguaribile», «improduttivo» e «irresponsabile». È questa la dimensione sociale del concetto di recovery.

Una Carta nata dal desiderio di diffondere salute mentale

La Carta della Recovery nasce per essere uno strumento applicato dai servizi che si rinnovano a fronte di una maturazione delle persone conquistata nel tempo, che è pure maturazione delle domande, e delle risposte.

Nasce dai racconti delle persone le cui esperienze fanno capire che cosa aiuta e che cosa ostacola il processo di ripresa. Nasce dal fatto che nel tempo le persone siano riuscite ad assumersi delle responsabilità, a ricavare degli spazi di confronto riconosciuti, affrontando sfide come l'organizzazione del convegno annuale «Impazzire si può». Nasce dall'incontro con persone provenienti da altri paesi dove si parla di empowerment e di recovery non da ieri. Nasce dalla suggestione di creare un documento che si completi con le idee di molti e che possa servire a tutti.

8 | La *Carta della Recovery* è frutto di una ricerca partecipata iniziata nel 2011 quando a Trieste si imbastiva la seconda edizione del convegno annuale «Impazzire si può - viaggio nelle guarigioni possibili», condotta da un gruppo composto da esperti per esperienza ed esperti per professione. Nel 2013 i contenuti della Carta sono stati discussi e validati in un percorso di formazione congiunta nei quattro centri di salute mentale triestini, prendendo a modello il metodo del focus group, con la partecipazione di circa cento persone, per la maggior parte fruitori dei servizi.

Nasce da questo periodo complicato nel mondo che cambia velocemente e che porta via cose conquistate in tanti anni, con passione e fatica. Nasce dal desiderio di conoscere le realtà del nostro Paese dove le leggi per la salute mentale sono applicate in maniera disomogenea, determinando divergenze nelle pratiche a volte molto marcate. Nasce dal desiderio che la salute, compresa la salute mentale, rimanga pubblica, gratuita e per tutti.
Nasce per poter domandare che cosa pensano della guarigione anche ai più difficili, i ribelli, i riottosi, che non stanno poi così «meglio», i disperati.

Le dodici caratteristiche di un servizio orientato alla recovery

La Carta individua in dodici punti chiave le caratteristiche del servizio orientato alla recovery, ripercorrendo e riassumendo in modo efficace diversi argomenti di cui si è trattato poco sopra.

1. | **I servizi centrati sulla persona** Il servizio di salute mentale orientato alla recovery privilegia la soggettività della persona (utente) e interviene utilizzando un ampio ventaglio di risposte personalizzate. Il progetto personalizzato che mira a un cambiamento importante deve essere un «vestito tagliato su misura», che fa suoi i bisogni, i valori, le preferenze della persona. Condivisione del percorso e assunzione della responsabilità da parte di tutti gli attori coinvolti sono punti di forza del progetto. I servizi devono attrezzarsi per mettere in campo le necessarie risorse materiali, umane e relazionali affinché ogni decisione utile al processo di emancipazione della persona sia condivisa.

2. | **L'accoglienza** Il servizio di salute mentale orientato alla recovery si interroga quotidianamente sui luoghi, i modi, i gesti, le parole, i significati dell'accoglienza. Accogliere è aprire una porta, materiale o simbolica, e farlo in maniera accogliente è far sentire chi entra il benvenuto, in un posto ospitale, dove possa essere a suo agio.

3. | **La crisi e la ripresa** Il servizio di salute mentale orientato alla recovery è attrezzato per affrontare la crisi, quel momento quando la persona è sicura di non farcela. Fronteggiare la crisi è offrire accoglienza, vicinanza, ascolto, condivisione, aiuto farmacologico accompagnando la persona fino alla ripresa. È far sentire che ci si può appoggiare, che non si è soli, che è possibile uscirne.

4. | **La formazione per tutti** Il servizio di salute mentale orientato alla recovery investe nella formazione e la promuove. La formazione per tutti i soggetti coinvolti nei servizi intreccia i saperi e le pratiche, da quelli professionali acquisiti dagli operatori a quelli risultanti dall'esperienza diretta delle persone che hanno provato il disagio mentale. È necessario inserire nell'agenda della formazione per gli operatori dei moduli formativi che prevedano la partecipazione di «persone con esperienza» in veste di docenti, per condividere i saperi (sulle leggi, sui diritti, sulla comunicazione, sull'accoglienza, sulla valutazione dei servizi). L'operatore deve inoltre poter accedere a un tipo di formazione che lo stimoli ad ascoltare la persona senza determinarne i bisogni a priori, a usare parole che portino rispetto e non infantilizzino, e a investire passione e amore nel proprio lavoro. È necessario creare e

finanziare corsi formativi specifici per le persone con disagio mentale. In questo modo il sapere e gli strumenti tecnici rafforzano le conoscenze acquisite attraverso l'esperienza diretta, e si può creare una vera e propria professionalità.

5. | **L'inserimento lavorativo e l'inclusione sociale** Il servizio di salute mentale orientato alla recovery sostiene e promuove una cultura del lavoro vero, qualificato e remunerato, e dell'inclusione sociale. Le offerte lavorative per le persone che sono inserite in percorsi di formazione/lavoro devono ampliarsi e poter soddisfare le diverse capacità individuali. Il lavoro va quindi ulteriormente diversificato. Bisogna liberarsi dal preconcetto che le persone fragili siano destinate a svolgere lavori semplici. Per raggiungere tale obiettivo è necessario educare i potenziali datori di lavoro all'importanza di promuovere una cultura di inclusione all'interno del sistema lavorativo. Solo rinunciando a preconcetti stigmatizzanti il datore di lavoro è capace di scegliere bene anche per se stesso. Per le persone che attraversano l'esperienza del disagio mentale, inclusione sociale significa anche assumere un ruolo attivo rispetto agli strumenti e alle risorse necessarie a ricostruire una propria identità sociale e un senso di appartenenza e partecipazione alla vita della comunità, al di fuori dal contesto dei servizi di salute mentale.

6. | **Lo stigma e l'oppressione interiore** Il servizio di salute mentale orientato alla recovery deve saper contrastare situazioni in cui prevale lo stigma e il pregiudizio. Il pregiudizio sul disturbo mentale – e lo stigma che ne deriva – rimane un fenomeno devastante nella vita delle persone che stanno affrontando questo disagio. È talmente radicato nella società e nel modo di vedere e percepire le persone con problemi mentali, che le stesse lo interiorizzano come se fosse reale, convivendo con una sorta di oppressione interiore. I servizi devono perciò sviluppare una cultura della fragilità come risorsa, investendo nella formazione degli operatori, creando opportunità reali di inserimento nel lavoro e nella comunità, diffondendo la speranza che dal disturbo mentale si può guarire.

7. | **La rete sociale e le persone significative** Il servizio di salute mentale orientato alla recovery deve essere capace di sollecitare la formazione di una rete di persone significative attorno alla persona con disagio mentale, favorendo così la ricostruzione dei legami sociali. Supportare le persone nello sviluppare relazioni di fiducia e renderle in grado di recuperare il senso di appartenenza a una comunità, deve essere uno degli obiettivi fondamentali perseguiti dal servizio. Gli operatori di un servizio di salute mentale sono parte integrante della rete sociale degli utenti. L'attenzione offerta deve essere genuina e differire da quella considerata convenzionale o formale. Gli operatori sono di aiuto quando non danno risposte automatiche e predefinite, ma cercano di conoscere le persone, di venir loro incontro. I familiari vanno supportati come parte integrante del processo di ricostruzione di capacità relazionali e di aiuto genuino. L'importanza della dimensione collettiva del reciproco aiuto è ampiamente riscontrata nella letteratura sulla recovery. L'amicizia è parte di questa dimensione: occuparsi di qualcuno è il primo passo verso una relazione di reciprocità. Avere una relazione di amicizia, passare del tempo assieme, dedicare

la propria attenzione all'altro, sono tutti aspetti fondamentali per la persona che ha un'esperienza di prolungato disturbo mentale.

8. | **Il sostegno tra pari** Il servizio di salute mentale orientato alla recovery deve offrire spazi di ascolto e di accoglienza dove le persone che frequentano i servizi quotidianamente, e quelle che vi sono accolte temporaneamente, possano sentirsi a proprio agio e aprirsi al dialogo, recuperando la volontà di partecipare alla vita di gruppo. Le persone con esperienza di disagio mentale possono collaborare con i servizi in qualità di «facilitatori», mettendo a disposizione le proprie conoscenze e i saperi acquisiti al fine di aiutare chi sta compiendo i primi passi verso la guarigione. Il supporto tra pari (*peer work*) non si sostituisce, ma si affianca al servizio. Si agevola così la costruzione di un ponte comunicante tra la persona e il servizio, tra il dentro e il fuori, per tramite di un linguaggio più immediato e condiviso nella pratica. I gruppi di auto mutuo aiuto sono spesso fondamentali nel processo di guarigione. Permettono alle persone di imparare a raccontarsi, confrontarsi e condividere le proprie difficoltà con gli altri. Consentono inoltre di ricostruire reti sociali e legami di amicizia e di vincere il senso di inadeguatezza e di oppressione interiore. I servizi dovrebbero perciò favorirne l'avvio prevedendo la presenza di persone con esperienza che fungano da facilitatori.

9. | **Gli spazi** Il servizio di salute mentale orientato alla recovery ha tra le sue priorità la questione degli spazi. Gli spazi sono una conquista di libertà, come un luogo sempre aperto a tutti, dove però ciascuno può ritagliarsi un proprio angolo di intimità se sta male, può sentirsi protetto e al sicuro. Uno spazio dovrebbe essere bello e decoroso. Dovrebbe essere un ambiente di condivisione continua di interessi e passioni. Dovrebbe essere divertente, offrire possibilità di svago e distrazione, ma anche di impegno culturale e creativo che si conformi ai desideri di ognuno. È qui che si possono vincere la solitudine e la noia, investendo sia umanamente che economicamente nell'offerta di varie attività all'interno dei servizi. I servizi possono essere vissuti/visti come luoghi stigmatizzanti. Si sente la necessità di analizzare e mettere criticamente in discussione la percezione generale e culturale che «all'esterno» si ha del disagio mentale e delle persone che ne soffrono.

10. | **L'utilizzo degli psicofarmaci** Il servizio di salute mentale orientato alla recovery incoraggia le persone a fare un utilizzo consapevole dei farmaci, considerati un dispositivo transitorio del percorso. C'è una differenza tra l'assumere un farmaco, e utilizzarlo. L'assunzione implica passività, utilizzare è farne uso con consapevolezza, per stare meglio. Serve una farmacologia adeguata ai bisogni della persona, che non ne annulli i desideri e la volontà anche nel momento di crisi. Serve una farmacologia che non impedisca di esprimere i propri sentimenti, i propri pensieri, che permetta di crearsi la propria indipendenza senza soggiacere all'arbitrio di estranei.

11. | **L'advocacy e l'associazionismo** Il servizio di salute mentale orientato alla recovery promuove e sostiene la creazione di gruppi trasversali di protagonismo, le associazioni di cittadini utenti e di familiari, i comitati di partecipazione come interlocutori per il rinnovamento dei linguaggi e degli strumenti del lavoro nel

campo della salute mentale. È indispensabile che le istituzioni competenti tutelino i diritti delle persone che soffrono di un disagio mentale. Le associazioni di utenti e di familiari che si occupano della difesa dei diritti e della lotta per la promozione della salute mentale, sono cruciali per denunciare per esempio i soprusi, i servizi inefficienti, le misure di sottrazione e di contenzione. Nel processo di guarigione è di fondamentale importanza per le persone, soprattutto nei momenti di grave difficoltà, poter avere fiducia negli operatori dei servizi e nelle figure di supporto più significative. La persona deve poter scegliere di affidare a queste figure la cura dei propri figli, dei propri beni e la tutela delle proprie volontà da far rispettare nei momenti in cui non è in condizione di farlo da sé.

12. | **I comitati etici** Il servizio di salute mentale orientato alla recovery promuove e sostiene la costituzione di comitati etici formati anche da persone esperte per esperienza, che possano indicare e valutare che cosa faciliti e che cosa ostacoli i percorsi di guarigione, e garantire in tal modo il rispetto dei diritti delle persone negli interventi di salute mentale. Una delle attività del comitato etico dovrebbe essere quella di favorire una ricerca partecipata – esperti e persone con esperienza e loro familiari insieme – sui temi della salute mentale. Una ricerca critica e innovativa che aiuti a migliorare la comprensione dei problemi che riguardano da vicino le persone e, più generalmente, il funzionamento dei servizi stessi.

In conclusione, il testo vuole rappresentare un primo passo nel lungo percorso della definizione di linee guida che raccolgano idee, principi e pratiche condivise nei servizi orientati alla recovery/guarigione. Ci auguriamo che possa essere un viaggio che molti avranno voglia di intraprendere, nella convinzione che molto c'è ancora da imparare, condividere e mettere in pratica.

GLI AUTORI

Manuela Ciambellini è coordinatrice del Social point di Modena: manuelaciambellini@gmail.com
Izabel Marin è assistente sociale nel Servizio abilitazione e residenze del Dipartimento di salute mentale di Trieste: izabel.marin@aas1.sanita.fvg.it
Roberto Mezzina è direttore del Dipartimento di salute mentale di Trieste dell'Azienda per l'assistenza sanitaria (AAS) 1 triestina: roberto.mezzina@aas1.sanita.fvg.it
Luca Negrogno è dottorando in sociologia presso l'Università di Urbino: luca.negrogno@gmail.com
Fabrizio Starace è direttore del Dipartimento di salute mentale e Dipendenze patologiche dell'AUSL di Modena: f.starace@ausl.mo.it
Anita Eusebi è giornalista scientifica freelance, collabora con Forum Salute Mentale e Màt: anita.eusebi@unicam.it
L'editing dell'«Inserto» è stato curato da **Anita Eusebi** insieme alla **redazione di Animazione Sociale**.

IL PROGETTO

Nel documento base del II Appuntamento nazionale degli operatori sociali (convocato da Animazione Sociale a Torino l'8-9 novembre 2013), pubblicato nel nr. 277 del 2013, si legge: «La logica della mancanza, del deficit, del danno ha creato distanze enormi. Per cui oggi chi ha un problema molte volte viene ai servizi solo se è costretto... perché la risposta che rischia di sentirsi dire è "adesso ti dico dove non funzioni". Ma le persone sanno già dove non funzionano, piuttosto hanno bisogno di sentirsi chiedere "dimmi in quale momento della tua vita sei riuscito a fare delle cose". Oggi allora diventa cruciale costruire interazioni che sostengano *processi di capacitazione* nei destinatari dei nostri servizi. Per cui chiediamoci: che spazio facciamo al loro sapere informale nel costruire i nostri servizi? Quanto li coinvolgiamo nel comprendere i loro problemi e nel cercare le risposte?» (p. 27). In questa logica di lavoro il concetto di *recovery* si rivela fecondo per riformulare le pratiche professionali quotidiane.

Il limite nella quotidianità dell'educare

Una risorsa a volte inaspettata dentro situazioni difficili

di
Giulia Zanardi

Chi svolge un lavoro educativo è spesso confrontato con i limiti: quelli emergenti nella propria storia, quelli dei contesti in cui opera, quelli delle persone con cui lavora quotidianamente in una prospettiva educativa. Di fronte ai limiti che nascono da un reale che ci resiste, per tutti il rischio è duplice: quello di negarli chiusi in un narcisismo onnipotente, ma anche di subirli in modo passivo. Ci può essere una terza via da percorrere come educatori, dotata di maggiore generatività, ed è quella di sostare nei limiti, esplorarli con lucidità, da ricercatori attenti a intravedere le possibilità non viste in ogni situazione, per aprirsi a nuovi mondi relazionali.

Quello del limite è divenuto solo di recente oggetto di una maggiore attenzione e di una comune riflessione su come, in quanto uomini e donne, possiamo misurarci con il reale e le sue resistenze alla nostra azione.
Osservando i contesti nei quali ci muoviamo risulta infatti evidente come il limite costituisca un tema «caldo» e assolutamente attuale, che chiama in causa, attraversa e interroga tanto le relazioni tra persone, gruppi e culture, quanto gli attuali stili di vita e il sistema socioeconomico su cui questi si reggono.
Per la nostra società, dunque, il limite costituisce un tema col quale è necessario confrontarsi e un varco da riconoscere e attraversare per poter immaginare scenari futuri possibili e sostenibili, uscendo da atteggiamenti di onnipotenza ma anche di impotenza.
In quest'ottica, le pagine che seguono vogliono essere un contributo alla riflessione sulla valenza attivante e generativa che il limite può assumere, in particolare in riferimento all'azione di quanti – come operatori sociali, e in particolare come educatori – si misurano quotidianamente col limite: quello che caratterizza i contesti di lavoro e le storie delle persone incontrate, ma prima ancora quello che impregna i loro vissuti umani e professionali.
Una riflessione al fianco di chi educa, dunque, alla luce della nuova ricerca multidisciplinare che, anche nell'ambito delle scienze umane, sempre più vede nel limite il doppio volto della «barriera insuperabile» e della «soglia di ingresso».

Fragili in quanto umani e figli del tempo

Il termine *limite* richiama, già nella sua etimologia [1], due dimensioni solo apparentemente inconciliabili: barriera *e* ingresso; via inaccessibile *e* via d'accesso privilegiata; invalicabilità *e* possibilità di superamento. Si tratta delle due facce del limite con cui chiunque è chiamato, prima o poi, a confrontarsi nei diversi ambiti, individuali e collettivi, della propria vita.
Tale doppio volto assume una grande rilevanza per chi, come l'educatore, lavora a stretto e quotidiano contatto con situazioni di estrema fragilità e delicatezza: in questi contesti, diventa fondamentale che l'incontro-scontro con la propria limitatezza – e con la percezione che il limite ci avvolge, ma al contempo ci apre ad altro – avvenga consapevolmente e sia accompagnato da quella capacità riflessiva che consente di fare della propria esperienza soggettiva, sociale e lavorativa un'imprescindibile fonte di conoscenza. Questo nella convinzione che «per guardare ai vissuti degli altri è indispensabile avere consapevolezza dei propri» [2]: l'educatore deve avere chiara l'importanza di lavorare innanzitutto su se stesso prima ancora che con l'altro.
Prima di addentrarci nello specifico della riflessione, per delinearne meglio i confini è importante ribadire che il limite si configura al tempo stesso come carattere fisiologico della condizione esistenziale umana (quindi intima e biografica) e come attributo del contesto socio-culturale nel quale come uomini e donne ci muoviamo.

1 | Il termine deriva dal latino *limes*, vocabolo utilizzato dai romani per indicare le pietre – considerate sacre e inamovibili – che segnavano i confini, e dunque la frontiera, la linea di demarcazione oltre la quale non era lecito spingersi; al contempo limes era la via che consentiva di penetrare nei territori di recente conquista o da conquistare. In questa accezione, si lega anche al latino *limen*, che indica la soglia.
2 | Iori V. (a cura di), *Quaderno della vita emotiva*, FrancoAngeli, Milano 2009, p. 43.

Dentro la fragilità prende forma l'esistenza

«I limiti sono propri di qualsiasi forma di esistenza» [3]. Così scriveva nel 1993 Piero Bertolini, padre della pedagogia fenomenologica, sottolineando con forza gli elementi di contingenza e necessità storica che caratterizzano ogni forma di vita. L'uomo è sempre e comunque un essere storicamente collocato e la sua libertà di scelta deve scendere a patti con l'insieme delle condizioni sociali e culturali, in fondo esistenziali, in cui si trova immerso [4].

La limitatezza, secondo Bertolini, è il fondamento della natura sociale dell'uomo, poiché evidenzia che egli non basta a se stesso e che l'altro gli è in qualche misura necessario per conoscere sé e la realtà esterna.

La tendenza a ricercare la relazione con l'altro sarebbe conseguenza e prova della «impossibilità per il singolo individuo di esistere autonomamente, ovvero al di fuori di un qualsiasi rapporto con l'altro» [5], poiché «è dall'incontro con l'altro che l'Io è in grado di cogliere o di comprendere tanto la realtà di se medesimo quanto la realtà del mondo» [6].

La nostra quotidianità, intessuta di relazioni, grida dunque sempre il nostro bisogno dell'altro. Per usare il linguaggio di Vittorino Andreoli, la fragilità è «origine della voglia di legame, di comprensione, di solidarietà e di amore» [7].

Lo scenario delineato chiama in causa l'educatore, fragile per professione in quanto inserito in una quotidianità lavorativa fatta, per l'appunto, di relazioni e in cui la relazione diviene il principale e «debole» – poiché non prescrittivo – strumento di intervento. «Limitato» in quanto essere umano e in quanto professionista dell'aiuto che si confronta quotidianamente con circostanze e storie di vita che lo mettono duramente alla prova, non è infrequente che l'educatore sperimenti un senso di inadeguatezza e impotenza, di fallimento e sconfitta: la percezione di fragilità può emergere prepotentemente per uno sbaglio, un percorso di recupero fallito, una scelta dell'utente non condivisa.

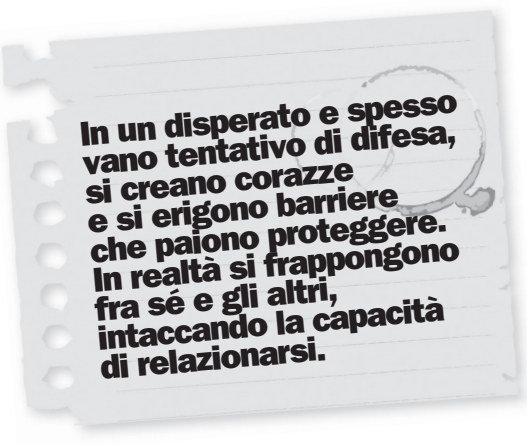
Il limite in una società che chiede perfezione

Se la limitatezza si configura come una caratteristica che accomuna tutti gli esseri umani, sorge spontanea una domanda: perché mai risulta oggi così difficile accettarla come parte integrante di sé?

Fra le molte motivazioni, una, alla quale molti autori [8] rivolgono la propria attenzione, spicca per importanza e influenza: si tratta dell'illusione di onnipotenza che abita e corrode ogni ambiente di vita. Esiste infatti un'implicita (anche se non così tanto) richiesta di perfezione da parte di una società impostata sull'idea che «vai bene» solo se hai successo, se spicchi fra i tanti.

Per rispondere alla domanda di perfezione (e meritare dunque affetto, stima, considerazione), si vive come «sotto la presenza di un giudice implacabile» [9], apprendendo fin dalla più tenera età a mascherare le proprie zone d'ombra e tutto ciò che in sé è indice di debolezza e fragilità.

3 | Bertolini P., Caronia L., *Ragazzi difficili*, La Nuova Italia, Scandicci 1993, p. 81.
4 | Bertolini P., *L'esistere pedagogico*, La Nuova Italia, Scandicci 2002, p. 154.
5 | Ivi, p. 191.
6 | Ibidem.
7 | Andreoli V., *L'uomo di vetro*, Rizzoli, Milano 2008.
8 | Si veda Augelli A., *Tonalità emotive e paesaggi interiori nell'esperienza educativa*, in «Animazione Sociale», agosto/settembre, 2007, pp. 59-60.
9 | Peter R., *Onora il tuo limite*, Cittadella, Assisi 1997, p. 8.



Si tratta di meccanismi che lavorano in profondità e di cui raramente si è consapevoli e che fanno sì che, anche quando si raggiunge un certo grado di consapevolezza, riscoprire le parti di sé più scomode costituisca comunque una sofferenza: il limite, quando riemerge, può divenire totalizzante, poiché ci si identifica a tal punto con esso da non essere più in grado di vedere e valorizzare le risorse e gli aspetti positivi di sé, come anche dei contesti in cui si opera.

Volti del limite nel lavoro dell'educatore

Anche la quotidianità dell'educare e del prendersi cura dell'altro è fatta di una complessità di sentimenti ed esperienze che espongono l'educatore all'incontro con le proprie fragilità. Ragionando attorno alla difficile presa d'atto di questa nudità interiore, Alessandra Augelli [10] individua alcuni dei volti che il limite assume nella pratica dell'educare.

• *Il prevalere del senso di impotenza.* Si manifesta nelle situazioni in cui ci si sente privi di strumenti e risorse, dunque impreparati ad affrontare le richieste del contesto lavorativo. Come evidenzia Daniele Bruzzone, «non sempre si può fare tutto (non sempre, anzi, si può fare qualcosa), non sempre tutti ce la fanno» [11], e ciò genera una diffusa sensazione di inutilità e inadeguatezza.

• *L'inganno del dono totale di sé.* Può accadere, soprattutto agli inizi del percorso professionale, di venire talmente coinvolti dalle storie che si incontrano da spendersi totalmente per l'altro, dimenticando di tutelarsi e di avere cura anche di se stessi. È la questione della «giusta distanza». Un equilibrio (sempre da re-inventare) fra eccessivo coinvolgimento e freddo distacco – in altre parole, la capacità di tracciare sani confini fra sé e l'altro – è necessario per la riuscita di ogni percorso, oltre che per la salvaguardia della propria salute psicofisica.

• *L'abbandonarsi a sensi di colpa.* Non tutti i percorsi che un educatore intraprende hanno esito positivo. Concedersi di sbagliare, accettare anche le sconfitte è forse l'aspetto più difficile e controverso dell'educare. Si ha la sensazione di non aver fatto abbastanza e ci si assume in toto la responsabilità dell'accaduto, alimentando un'ansia di fallimento che porta a ingigantire gli ostacoli più che a favorire crescita e consapevolezza di sé.

• *La frustrazione per un «grazie» che non arriva.* Se in ogni relazione è insita la necessità di ricevere un riscontro rispetto al proprio manifestarsi in quanto persona, un ringraziamento è conferma e riconoscimento del lavoro svolto, la prova che si è

10 | Augelli A., *Tonalità emotive e paesaggi interiori*, cit., pp. 59-60.

11 | Iori V., *Quaderno della vita emotiva*, cit., p. 155.

agito correttamente. Quando i «grazie» vengono a mancare, la sensazione può divenire di grande frustrazione per l'educatore che, faticando a scorgere il risultato del lavoro, vede indebolirsi entusiasmo e motivazione e, di conseguenza, fiducia nel proprio quotidiano operare.

• *Il sentirsi falliti nel prendere atto delle scelte altrui.* L'educatore può offrire un'opportunità di cambiamento, ma esso si concretizza solo se l'utente accetta e sceglie di accoglierlo. L'azione educativa non può mai essere imposta con la forza e ciò implica, per l'educatore, la non scontata capacità di attenersi alle scelte fatte dall'utente anche quando non le condivide. In altri termini, la capacità di riconoscere all'altro il proprio spazio di autonomia e azione.

• *Il lasciarsi travolgere dalla mancanza di senso.* La sofferenza spesso rimane priva di senso e viene percepita come ingiusta e inaccettabile. Perché accadono certe cose? E perché a lui/lei e non a me? Sono domande che dicono la paura, la fragilità, la difficoltà di guardare in faccia un dolore che, privo di un perché, richiama al fatto che chiunque, educatore compreso, può esserne colpito. Rassegnazione e rinuncia all'azione si rivelano spesso diretta conseguenza dell'inconscio rifiuto di una sofferenza alla quale lo stesso educatore può rivelarsi impreparato.

Osservare sé e l'altro con tenerezza

Le esperienze e i sentimenti elencati in precedenza sono fortemente destabilizzanti, mettono cioè in crisi la propria immagine di sé, rendendo concreto il rischio di «rompersi». Di fronte a tale rischio, la reazione più frequente e immediata è la fuga, che porta a ignorare il proprio sentire, a metterlo a tacere e a comportarsi come se niente fosse. Qual è la conseguenza di questa modalità di relazionarsi col limite, in altre parole con un'immagine di sé che non coincide con le proprie aspettative? Augelli sostiene che

> « l'esperienza del limite e della fragilità, quando non è assunta, quando non è profondamente compresa, crea corazze, che apparentemente danno sicurezza e protezione, ma in realtà rischiano di fare ancor più male. [12] »

In un disperato e spesso vano tentativo di difesa, si creano corazze e si erigono barriere che apparentemente proteggono ma in realtà si frappongono fra sé e gli altri, intaccando la capacità di relazionarsi. Dal momento che, come visto, è proprio la relazione a richiamarci alla nostra umanità, e dunque alla nostra insufficienza, risulta chiaro che l'unico modo per preservare una determinata immagine di noi stessi sembra negare la relazione stessa, e con essa il nostro bisogno degli altri.

Queste corazze, per quanto riguarda il ruolo educativo, possono assumere forme diverse, come l'isolamento, la spersonalizzazione (che porta a dare una risposta meramente tecnica ai bisogni delle persone), la deresponsabilizzazione (che, di fronte agli insuccessi e agli ostacoli, porta a ricercarne le cause fuori da sé e per cui, di fatto, è sempre colpa di qualcun altro) [13].

L'esito comune è l'accumularsi di un malessere che rischia di compromettere la capacità di agire con consapevolezza il proprio ruolo. Non è un caso che questa professione sia oggi annoverata fra quelle maggiormente a rischio di *burn-out*, una sindrome da affaticamento ed esaurimento

12 | Ivi, p. 150.

13 | Gherardi V., *Le vie di fuga dalla professionalità*, in Gherardi V., Manini M., *Didattica generale*, Clueb, Bologna 2001, pp. 28-30.

psicofisico fra le cui cause possiamo immaginare un sentire negativo che, non trovando uno sbocco verso l'esterno e una possibilità di elaborazione, finisce per influenzare negativamente gesti, scelte e relazioni.

Fare del limite una chiave di comprensione dell'uomo

Cosa ha a che fare tutto questo con la professione educativa?
Un educatore che non sappia farsi carico delle proprie fragilità non sarà in grado di guardare con tenerezza alle fragilità dell'altro. Riconciliandosi con la propria umanità e debolezza saprà invece farsi vicino a chi soffre. Infatti, «perché uno si fermi vicino a un ammalato deve sapere di potersi ammalare» [14].
Non c'è modo di incontrare l'altro e di comprenderne il dolore, la sofferenza, le difficoltà se non riconoscendo la propria fragilità, il fatto che in quella stessa situazione ci si sarebbe potuti, ci si può e ci si potrà trovare a propria volta.
«Fuori del limite l'uomo perde ogni possibilità di comprensione» [15], infatti

> « si può capire che un altro si senta debole, fragile, diverso, tremante di sgomento, solo lasciando affiorare il ricordo di tutte le volte – o di almeno una volta – nelle quali noi stessi ci siamo sentiti deboli, fragili, diversi, tremanti di sgomento. [16] »

L'uomo «perfetto», che sottostà alle regole della società della perfezione, non è in grado di accogliere la propria e l'altrui fragilità, perché la fragilità è un'esperienza che gli è estranea. Ecco allora l'importanza, anche per l'educatore, di accettare i propri limiti: solo imparando a convivere serenamente con se stesso egli potrà stare serenamente con gli altri. L'accettazione del limite, in quest'ottica, è presupposto di relazioni sane, legami autentici, capacità di stare insieme. Etty Hillesum, in un contesto e in un'epoca diversi da quelli attuali, scriveva: «Avevo imparato a leggere in me stessa, e così ero in grado di leggere anche negli altri» [17]. L'educatore è chiamato a «leggere» se stesso, a intraprendere un percorso che, se portato a compimento, gli consentirà di comprendere dentro uno sguardo e un moto di tenerezza le persone che incontra.
In questo senso, il prendersi cura del proprio limite si presta a una doppia lettura: una interna (accogliere la naturale debolezza e fragilità che ci contraddistingue personalmente in quanto esseri umani) e una «esterna»: il limite, infatti, è anche il confine che separa e differenzia le persone le une dalle altre, e come tale richiede di essere accettato e rispettato, riconoscendo che si è tutti portatori di visioni del mondo, schemi mentali, valori assolutamente parziali e soggettivi, che possono anche non essere condivisi. Significa riconoscere che esiste qualcuno o qualcosa di «altro» da me, le cui caratteristiche ed esperienze di vita possono portare a scelte e comportamenti altri rispetto a quelli per me più adeguati.

L'intervento educativo accetta il vincolo che è l'altro

L'educatore deve essere consapevole del fatto che le persone che incontra e accompagna possiedono le proprie caratteristiche di personalità, le proprie idee e convinzioni, i propri valori di riferimento, che possono anche (e spesso accade) non coinci-

14 | Andreoli V., cit.
15 | Peter R., *Onora il tuo limite*, cit., p. 17.
16 | Iori V. (a cura di), *Quaderno della vita emotiva*, cit., p. 119.
17 | Hillesum E., *Diario 1941-1943*, Adelphi, Milano 1985, p. 208.

dere con i suoi. Il suo compito non è trasformare l'altro nella persona che crede debba essere, ma, invece, aiutarlo a trovare in sé gli strumenti e la forza per cambiare, in una direzione che non è l'educatore a stabilire, ma che il soggetto, pur accompagnato, dovrà trovare da solo.
In questo senso, il fallimento, il rifiuto, una scelta della persona non condivisa sono da leggere come espressione di un'alterità e di un'autonomia mai ingabbiabili .
La competenza dell'educatore implica la capacità di riconoscere che l'altro non è mai una «tabula rasa», un vaso vuoto da riempire o un pezzo di argilla da modellare, ma un soggetto che concorre nel determinare il risultato del percorso educativo: quest'ultimo, dunque, non dipende solo dall'azione dell'educatore, ma anche e soprattutto dalla disponibilità della persona, delle persone a co-partecipare, dal loro desiderio di cambiare, dai loro tempi di maturazione.
Riconoscere questo significa rinunciare alla presunzione di onnipotenza con cui tanti operatori si vivono in relazione alle persone che accompagnano, per restituire ad esse il ruolo di protagoniste del proprio percorso umano.
«Perché il suo lavoro si riveli efficace», scrive Bertolini in riferimento ai «ragazzi difficili» (ma il discorso è estendibile ai diversi campi d'azione), l'educatore «deve riconoscere nel ragazzo, nel ragazzo concreto e in carne e ossa, il primo vincolo ai suoi progetti e alle sue azioni» [18].
Ancora una volta siamo chiamati a rispettare i confini posti dalla natura e, fra essi, la libertà di scelta e le specificità delle decisioni prese dalle singole persone che affianchiamo.

Il fragile equilibrio fra superamento e accettazione

Finora si è argomentata l'importanza di rispettare i propri limiti naturali, di accettare di non poter sempre dare il meglio o fare ciò che ci si era prefissati. Ciò che si è voluto suggerire è che passare dal riconoscimento e dall'accettazione della propria limitatezza costituisce, per chi educa, una tappa imprescindibile della propria crescita umana e professionale. Tale predisposizione accettante non può, tuttavia, divenire pretesto per l'immobilità o per la passiva rassegnazione nei confronti degli eventi.
Come evidenziato, infatti, il termine «limite» sottende, oltre all'idea di invalicabilità, anche quella di soglia, passaggio e, dunque, di possibile evoluzione, spostamento, attraversamento. Se è innegabile che il limite sia costitutivo della condizione umana – e dunque non possa mai essere del tutto colmato – tuttavia è proprio il limite a delineare uno spazio in cui l'educatore può intervenire con passione e competenza per favorire l'evoluzione delle situazioni e alleggerirne le fatiche.
La constatazione della propria limitatezza, allora, non deve diventare una scusa, una giustificazione che esonera dallo spendersi in ciò che si fa, ma, al contrario, essa implica l'interrogarsi su cosa è possibile fare delle proprie fragilità, con l'obiettivo di imparare a discernere le situazioni in cui i limiti riservano uno spazio di intervento – e possono dunque essere «spostati» – da quelle in cui è preferibile non interferire, poiché ciò costituirebbe una forzatura.
Di fronte al limite, insomma, l'educatore può scegliere «tra lo slancio del superamento e la prudenza dell'accettazione» [19].
Anche «arrestarsi di fronte a un limite non

18 | Bertolini P., Caronia L., cit., p. 82.
19 | Iori V. (a cura di), *Quaderno della vita emotiva*, cit., p. 158.
20 | Ibidem.

è sempre indice di impotenza: talvolta esprime una sapienza che solo l'esperienza *pensata* della cura sa generare» [20].
In altre parole, invece che essere vissuto come un peso di cui disfarsi o farsi carico, il limite può diventare qualcosa di generativo, a patto, però, di guardarlo in faccia e lasciarsi interrogare, per comprendere come esso possa essere «maneggiato» e messo a frutto.
Alla luce di ciò, la consapevolezza del limite può costituire fonte di equilibrio rispetto ai rischi del delirio d'onnipotenza e del senso d'impotenza. Non esistono ricette o formule universalmente valide che consentano di raggiungere tale equilibrio; ognuno dovrà trovare la personale misura fra le due spinte opposte: l'impulso a oltrepassare i propri limiti da un lato e la capacità di capire quando fermarsi dall'altro.

Quali strumenti per la cura di sé

Alla luce di quanto detto, risulta evidente, per l'educatore, l'esigenza di prendersi cura di sé per poter aiutare gli altri. Questo implica un occhio di riguardo per i risvolti emotivi del lavoro, allo scopo di acquisire sempre più dimestichezza nel muoversi all'interno dei propri «paesaggi interiori» [21].
Micaela Filippini descrive la cura di sé come «un percorso di crescita interiore che spinge l'educatore a ripartire da sé per rilanciarsi nel mondo del lavoro educativo» [22].
È, dunque, innanzitutto un percorso di autoanalisi, che fa dell'esperienza soggettiva dell'educatore un'imprescindibile fonte di conoscenza. Concretamente significa sviluppare una riflessione sugli interventi educativi realizzati e sui loro effetti (positivi e negativi), sul proprio modo di relazionarsi con le persone in situazioni difficili, sui sentimenti, le fatiche, i successi e gli insuccessi, in modo che ogni aspetto del lavoro possa divenire fonte di crescita personale e professionale.
Promuovere la riflessione rispetto alla propria azione consente di prendere atto dei propri limiti, allo scopo di gestirli con attenzione e «tenerli sotto controllo». Ciò implica non fermarsi alle apparenze, ma scavare nelle cose e negli eventi e coglierne l'essenza, il significato più profondo.
Tale capacità va allenata e messa alla prova. A tal fine, l'educatore dispone di strumenti che implicano un continuo travaso tra riflessione in solitudine e lavoro di gruppo.

Condividere con altri l'esperienza del limite

Un primo strumento è la *supervisione professionale*, che dà la possibilità a un'*équipe* di riprendere e rielaborare – periodicamente e sotto la guida di un esperto – il proprio operato, riflettendo sulle situazioni, sulle emozioni di difficile espressione, sui fallimenti e sugli eventuali intoppi verificatisi. È un luogo di vera e propria «manutenzione» [23] che «permette di gestire consapevolmente le proprie azioni, affiancando alla dimensione del fare quella del *pensare insieme* suggerita dal gruppo di lavoro» [24]. Si rivela quindi uno strumento prezioso per lavorare in gruppo sul limite, fino a creare un clima di apertura e disponibilità fra gli operatori, essenziale affinché ciascuno si senta libero di esprimere dubbi

21 | Augelli A., cit., p. 57.
22 | Filippini M., *Aver cura di sé*, in «Note di pastorale giovanile», aprile, 2009.
23 | Biolcati R., Sagliaschi S., *Promozione del benessere e prevenzione*, in Pani R., Biolcati R., Sagliaschi S., *Psicologia clinica e psicopatologia per l'educazione e la formazione*, il Mulino, Bologna 2009, p. 203.
24 | Ivi, p. 204.

e difficoltà, senza paura di mostrare le proprie debolezze.
La condivisione delle fragilità può aprirsi anche a eventuali *occasioni di confronto esterne al contesto lavorativo*, con persone e gruppi non direttamente connessi al lavoro educativo. Le possibilità possono essere molteplici: una psicoterapia, un percorso spirituale, la pratica di una disciplina orientale, tutto ciò che risulti funzionale all'acquisizione di una maggiore familiarità con la natura umana del proprio limite. Può essere arricchente anche il confronto con le realtà sociali che si muovono alla ricerca di varchi per andare oltre, mettendo in discussione gli attuali stili di vita e di sviluppo socio-economico.

Un inesauribile percorso di apprendimento

Non meno importanti sono gli strumenti di *autoanalisi*: chi opera a contatto con la sofferenza e il disagio sociale, infatti, non può esimersi dal «lavorare» su se stesso. La scrittura è il primo, per importanza ed efficacia, di questi strumenti: la pratica del *diario professionale* è non a caso diffusa fra i professionisti dell'educazione. Oltre alle esigenze di natura pratica cui risponde, la scrittura ha una valenza formativa: trasferire sulla carta i pensieri e le emozioni consente, infatti, di dar loro una forma, di definirli con maggiore chiarezza, di guardarli dall'esterno e secondo nuove prospettive, di riprenderli con maturato distacco.
Secondo Duccio Demetrio, ripercorrendo la propria storia è possibile comprendere l'inevitabilità del dolore, la finitudine dell'umano e, in definitiva, riappacificarsi con se stessi, che non vuol dire mettere a tacere dubbi e inquietudini, ma piuttosto dare loro voce, esternarli per comprenderli nella loro essenza. L'autobiografia, insomma, come rivisitazione dei propri vissuti, riconciliazione con gli stessi e occasione di miglioramento, trasformazione e crescita personale.
La costante auto-formazione dell'educatore, tuttavia, non si limita al fare luce nei meandri della propria interiorità, ma guarda anche all'esterno, alla necessità di *formazione permanente* che caratterizza ogni ruolo che richieda una preparazione – la quale non può esaurirsi sui banchi di scuola o sui testi universitari, ma necessita di essere costantemente aggiornata e messa in discussione. In particolare, per quanto riguarda l'educatore, si tratta di documentarsi sui bisogni sociali e culturali emergenti, sulle situazioni di maggiore urgenza, sulle normative che regolano gli interventi, sulle teorie e sui modelli educativi recenti.

Un tempo per pensare nelle organizzazioni

Alla luce di quanto sottolineato, risulta fondamentale che le strutture lavorative immaginino e predispongano spazi, tempi e modalità che permettano agli operatori – che quotidianamente si fanno carico di parte delle sofferenze di chi accompagnano – di esprimere i propri vissuti. In altre parole, uno spazio di rielaborazione di quanto incontrato e sperimentato. Spesso e volentieri la centralità di questa dimensione non viene colta, e il lavoro dell'educatore si riduce a un qualcosa di meramente esecutivo e prestazionale. È invece rilevante che gli educatori rivendichino un

> « tempo per pensare e riflettere, per interrogare quello che si fa e discernere. Un tempo per pensare, non solo i singoli atti, bensì la relazione che li lega, che intreccia ogni filo del lavoro nel tessuto, intelligente e affettivamente connotato, della cura. [25] »

25 | Filippini M., *Aver cura di sé*, cit.

Il limite da peso a risorsa nel lavoro

In conclusione, alla luce delle riflessioni proposte, è possibile identificare *tre principali modalità* attraverso cui il limite può divenire risorsa del lavoro educativo.

Accettare la vulnerabilità Come più volte sottolineato, esiste un rapporto profondo e indissolubile fra vulnerabilità e relazione, per cui non esiste vera relazione senza previa e continua accettazione della vulnerabilità. Ciò significa che riconoscere la propria umanità – e con essa la possibilità della sofferenza e del fallimento nella propria vita – è l'unico vero modo per farsi vicini a chi soffre e, dunque, relazionarsi autenticamente. Solo imparando a stare serenamente con se stesso, e accettando la propria piccolezza e le proprie insufficienze, l'educatore potrà sviluppare un atteggiamento di autentica compassione (dal latino *cum* e *patior*, «patire con» l'altro) nei confronti dell'altrui fragilità.

Valorizzare il fallimento «A volte un limite o un fallimento ci dicono su cosa dobbiamo lavorare» [26]: modi di dire, un po' inflazionati ma certamente veritieri, vogliono che sia cadendo che si impara a rialzarsi e sbagliando che si impara a correggersi. Anche per l'educatore è importante comprendere e accettare che il suo percorso è un continuo «errare», fatto di successi, ma anche necessariamente di cadute – errori, insicurezze, sentimenti negativi – e che ciascuno di questi elementi è fondamentale per costruire e riaggiustare *in itinere* la prassi lavorativa. L'errore, allora, non è sbagliare, quanto piuttosto non trovare alcun valore nel fallimento. Il limite, se accolto, può aprire potenziali spazi di riflessione e mobilitazione delle proprie risorse in vista di un miglioramento, dinamiche di cui non ci sarebbe alcun bisogno se tutto andasse sempre per il meglio.

Aprirsi all'indefinitezza È importante sviluppare un atteggiamento di «autentica disponibilità all'esistenza» [27] e agli avvenimenti, belli e brutti, che possono caratterizzarla: l'assunzione del limite impone una rinnovata visione del mondo e delle cose, a partire dalla presa di coscienza che non è possibile tenere sempre tutto sotto controllo. Tale consapevolezza è centrale per l'educatore, poiché apre alla possibilità di vivere la progettazione educativa non come un qualcosa di definito meccanicamente, di stabilito dall'alto e calato sull'utente, ma come un evolversi continuo, aperto alle possibilità, ai mutamenti e alle deviazioni determinate da una molteplicità di variabili: prima fra tutte la presenza stessa delle persone nei loro contesti di vita, con le loro caratteristiche, scelte e visioni del mondo.
La missione dell'educatore, in definitiva, è educare al limite se stesso e, conseguentemente, l'altro, dando il proprio contributo affinché i soggetti incontrati sentano come importante e concreta la prospettiva di un cambiamento, ma allo stesso tempo sappiano anche amare la propria limitatezza, in quanto massima espressione della loro umanità. E vedere in essa non più una mancanza, ma la propria forza.

Giulia Zanardi, studentessa del Corso di laurea magistrale in Progettazione e gestione dell'intervento educativo nel disagio sociale, presso l'Università di Bologna: giulia.zanardi4@studio.unibo.it

26 | Contini M., *Figure di felicità*, La Nuova Italia, Scandicci 1988, p. 63.
27 | Ivi, p. 177.

Il farsi del viaggio educativo con il bambino

Ancoraggi nella relazione educativa con storie di fatica di bambini e ragazzi

di
Gilda Vischia

Se ogni viaggio è un'esplorazione della vita, che viaggio è quello di un educatore professionale a fianco di bambini e ragazzi segnati da difficoltà? Per attraversare il corso dell'età evolutiva il bambino cerca adulti significativi che si mettano a servizio del suo irrinunciabile andare incontro al futuro. Dove sta la specificità del viaggio a fianco di un «adulto altro» come un educatore, e come si integra con la diversità degli interventi di altri operatori in un contesto sanitario? Quale mappa orienta le scelte dell'educatore nel cercare la strada insieme al bambino, se ogni viaggio di crescità è una storia da costruire?

Da circa vent'anni svolgo la mia attività in un servizio sanitario pubblico territoriale di neuropsichiatria dell'infanzia e dell'adolescenza, rivolto alla fascia evolutiva compresa tra gli 0 e i 18 anni con disagio nella relazione e nell'apprendimento e problematiche comportamentali.
L' esperienza professionale –, nell'aver osservato e accompagnato lo spirito iniziatico dei bambini, dai 3 agli 11 anni, e le tappe del loro processo di crescita che, tra gli 11 e i 14 anni, si apre all'adolescenza – ha suscitato in me domande, dubbi e pensieri nei termini di una viva *interrogatio*. Credo che la brezza del desiderio di testimoniare la complessa condizione umana di chi cerca la propria strada identitaria sia scaturita dall'esperienza di legame con loro.
Attingendo da questo sentimento di gratitudine, mi sono avvicinata a questo lavoro di ripensamento, di significazione:

« In fondo quello che dobbiamo fare per apprendere è diventare esploratori, e lo scopo dell'esplorazione non è di scoprire se l'esplorazione è una buona cosa, ma di ricavarne informazioni su ciò che si esplora. (Bateson,1984) »

Volevo ripercorrere la mia mappa di viaggio e ripensare ai «naviganti», ai luoghi e alle storie incontrate.

Interrogarsi per dare senso alla relazione

Il termine educatore dà adito a una rosa di possibilità di intendimenti o a un *mare magnum* di fraintendimenti. Educare a che cosa? Sembra ancora ignoto, misterioso, l'agognato complemento. Potrebbe essere semplice: l'educatore fa educazione. Ma questo non ci definisce ancora, condizionati dal fatto che oggi numerose strutture, oratoriali e ricreative, non poche volte usano il nome «educatore» per indicare un adulto che intrattiene i bambini: un adulto intrattenitore.
In questi anni si sono fatti vari bozzetti e ritratti dell'educatore professionale, a seconda del contesto in cui opera e a seconda delle trasformazioni avvenute nel panorama sociale o sanitario.
A volte, per «comodità», l'identificazione dell'educatore professionale è collocata dentro un ruolo pensato nel *binomio educatore-attività*, cosicché l'azione educativa viene fatta corrispondere a un elenco, una declinazione di «cose da fare». Il contenuto dei progetti educativi stilati corrisponde a un mansionario di operazioni e attività, dove la persona in crescita viene suddivisa in obiettivi ed elenchi di sotto-obiettivi a breve, medio e lungo termine, perdendo così di vista la globalità della persona e il suo tragitto personale di crescita. Fotocopie dell'essere umano, di cui si pietrificano aspirazione e desiderio. Di un ideale di essere umano.
Ma è davvero questo il senso del lavoro educativo? Stilare una cronaca di azioni? Sembra già tutto previsto dall'adulto, come in una biografia già tracciata.

Distinguere dove porta la corrente

La risposta delle istituzioni sanitarie e sociali, di fronte alla complessità di questa funzione educativa, si è orientata allo sforzo, a volte, di annacquarla, altre di demonizzarla, altre ancora di caricaturarla: l'educatore è quello che «bada all'altro» andando a domicilio, quello che fa fare i lavoretti, quello che accompagna sul territorio, che aiuta a fare i compiti e così via, con l'assegnazione di un ruolo di custodia. L'educatore ha avuto in alcuni casi e in alcuni ambiti le vicissitudini istituzionali dello «straniero» da integra-

re, con la sua cultura sconosciuta e quindi sospetta. In altre esperienze lavorative, l'educatore è stato inteso come un tuttologo dell'inventiva e del divertimento.
Queste sono alcune delle «onde emotive» che fremono nel viaggio educativo e che accomunano gli educatori. Non è sufficiente ripetere che educare è una questione complessa, possiamo dire invece che è complessa perché fa sviluppare intorno una complessità di movimenti, fantasie, aspettative, ideali, realtà, luoghi comuni, stereotipi. Onde in superficie che hanno in realtà correnti e mulinelli sotterranei, meno visibili ma più profondi, che fanno parte della vita professionale. In fondo, la profondità di una professione è data dallo spessore che le si evidenzia intorno.
La pluralità di queste domande ci sta aiutando sempre più a mettere a fuoco che il lavoro di definire e distinguere per individuarci è veramente un lavoro impegnativo. Sembra che le rappresentazioni mentali che ruotano intorno all'educatore, a volte, siano rimaste cristallizzate e abbiano influenzato le possibilità di un cambiamento reale. L'ambivalenza che ne deriva in alcuni casi non è rimasta solo a livello di rappresentazione mentale, ma ricade anche sulla realtà operativa della professione.
Se un educatore cammina sul filo delle rappresentazioni istituzionali e assume nel suo operato una posizione di ambivalenza, rischia di non avere un suo spazio interno chiaro, disponibile ad accogliere i movimenti evolutivi reali del bambino, costitutivi per la sua crescita. Il costante «mandato» del far fare attività, legato all'educatore, ci muove una domanda fondamentale che proviamo a esplorare: *come si pone l'educatore nella relazione con il bambino*? Cosa ne fa delle comunicazioni del bambino? Cosa ne fa dell'inattività del bambino, della iperattività? Che tipo di modello gli offre?

Il farsi soggetto di ogni bambino

Penso che l'educatore possa mettersi in contatto con le comunicazioni del bambino solamente quando riesce a tenere *distinte dentro di sé le sue emozioni e le emozioni del bambino*.
Il continuo lavoro di distinguere è quello che aiuta a differenziare via via l'adulto dal bambino, il bambino dall'adulto e a mantenere la relazione di legame. Legame che si specifica e si definisce nella sua vicinanza e distanza e nella sua temperatura.
Il lavoro educativo è fatto da questa capacità di entrare nel livello della comunicazione del bambino e uscire, cioè *identificarsi* per aiutare il bambino a cercare e a trovare i suoi spazi di definizione e *disidentificarsi* per mantenere un pensiero sulla relazione.
Viene rovesciata la prospettiva dell'intervento educativo: il bambino, in quest'ottica, non sarà «oggetto» destinatario di esperienze ludiche pensate e proposte dall'adulto, ma sarà il *soggetto autore di esperienze e pensieri*. Il bambino non sarà «a servizio» di atelier o laboratori strutturati, ma sarà l'*adulto «a servizio» della relazione* come esperienza: di come il bambino si separa e si ricongiunge con gli adulti, di come il bambino si mette in relazione con gli oggetti, del suo rapporto con il gioco, di come esprime i suoi moti d'animo, emozioni e sentimenti, di come si mette in relazione con l'adulto, di come utilizza il suo linguaggio espressivo, quale canale sceglie per investire le sue rappresentazioni, il corpo, il disegno, la parola, se interagisce con il gruppo dei pari.
I «materiali» educativi, gli «strumenti operativi», individuabili in questa nostra ricerca, sono quindi da rintracciare nelle dimensioni relazionali che si mettono «in gioco» e nei pensieri che via via vengono fuori e si costruiscono nel farsi della relazione.

È interessante notare come oggi spuntino tante figure professionali che si occupano di relazione. Come se la relazione fosse il male oscuro che ci preoccupa e ci fa sentire inadeguati, impreparati, incapaci e allora culturalmente *ci «togliamo fuori» dalla relazione continuando a delegare esperti.* Abbiamo comunque capito che la relazione è un bene su cui dobbiamo investire. E la relazione è qualcosa che sta in mezzo fra il bambino e l'adulto.

Per comprendere ci vuole risonanza

Allora, riprendendo il compito che ci siamo dati, possiamo delineare un adulto che vada verso una dimensione dell'*ascolto*. Un educatore che sia capace di mettere in sordina lo strumento verbale a vantaggio, per esempio, di modalità espressive corporee dei bambini. Non un educatore quindi che suggerisca norme di condotta o anticipi soluzioni per correggere il disagio o appianare la difficoltà, ma un educatore empatico che si metta in contatto con la sua capacità di *risonanza* e la utilizzi per comprendere cosa sta avvenendo, all'interno della comunicazione, attraverso la manifestazione della difficoltà del bambino. Un educatore, potremmo dire, che abbia il compito di accordare le corde dello strumento-relazione attraverso un'attitudine all'ascolto.
La scommessa e la complessità del lavoro dell'educatore professionale consistono in un delicato e paziente lavoro di tenere distinti e insieme i diversi livelli che si mettono in moto in una professione d'aiuto, il livello personale e il livello professionale che vengono messi «in gioco» nella dimensione relazionale.
In questo affascinante e complesso mestiere la cosa fondamentale è tenere viva *la disposizione ad andare incontro* all'Altro. Principio fondante delle professioni d'aiuto. Essere interessati all'Altro quindi, investendolo di un'aspettativa a ritrovare il suo corso d'acqua. Che c'è, sempre. Magari da sgelare o da far emergere, come un fiume carsico.
Costruire la competenza relazionale dell'educatore professionale significa essere disponibili a guardare dentro i livelli della relazione per ri-generarsi in atti di chiarezza, per scrollarsi di dosso quelle pigrizie e quegli indugi mentali che arrugginiscono i pensieri, rendendoli a volte anacronistici. Attraverso questi atti di riformulazione si rispetta il flusso di nuove forme di identità e si accolgono i cambiamenti e le metamorfosi che si generano dal di dentro della relazione, inaspettate e insospettate, cioè nuove: «Sono complessi i processi mentali che si devono compiere perché l'osservare diventi fonte di apprendimento» (Bick, 1964).
Dato lo strapazzamento e l'abuso della parola «educare», nell'intento di dar fede alla sua complessità, teniamo come punto di partenza la sua etimologia, che vuole dire «tirar fuori».

L'attesa è l'incipit di un pensiero fecondo

Nel corso della mia esperienza mi sono trovata più volte a chiedermi quale fosse, quale potesse essere, quale avrebbe dovuto essere, quale sarebbe diventato l'*ob-jectum* da tirar fuori.
Tradurlo, nel suo obiettivo e nella sua possibilità di dinamica, mi faceva pensare a un contenitore e a un contenuto, a una persona accolta e a una che accoglie. Istituzionalmente, a qualcuno che arriva da fuori e a qualcuno che aspetta dentro. A due. Metaforicamente, a un ambiente e a una materia. Una materia e una forma in un flusso continuo, in una vicendevole influenza costitutiva. Diceva Michelangelo che nella

pietra è già inscritta la forma. Rispettare la vena della pietra, nella relazione di cura, significa *respectare* nel senso pieno etimologico: volgersi a guardare il volto dell'Altro. Il maieuta falegname Geppetto non ha forse «tirato fuori» dalla materia del legno suo figlio Pinocchio? Non è questo il senso di dare alla luce? Non è questa l'azione del tirar fuori quando Geppetto scolpisce i sensi a Pinocchio? Geppetto *fa* Pinocchio partendo dall'ascolto della voce-sonorità del legno. È nell'accogliere quello stupore, quei picchiettii sonori, nel registrarlo dentro di sé, nel tenerlo in considerazione, nel tendere l'orecchio a dove proviene quella voce, nell'interrogarsi sul *chi è* che parla.; è dentro questo sussulto, questo stupore, questo sentimento di incredulità e di meraviglia, di sorpresa e di attesa, l'*incipit* di un pensiero educativo fecondo.
Poi, in un tempo successivo a questo, Geppetto comincia a osservare la materia legno da vicino. Solamente dentro queste premesse ha inizio l'*atto creativo* di intaglio della gemma educativa a lasciare che l'altro sia con la venatura del suo legno.
Ecco che allora l'*attesa* assume un valore, un senso. Non è forse l'azione educativa un'attesa? Qui si sustanzia la funzione educativa.

Riconoscere i movimenti trasformativi

Attualmente circola una cultura «educativa» che inseguendo *performances* è impegnata a sottolineare continue mancanze, a vedere il mezzo bicchiere vuoto, e trascura la consapevolezza di che cosa abbiamo e delle tappe di cammino che abbiamo percorso. Come osserva Donata Fabbri:

> « Forse non si è ancora a sufficienza capito che la complessità non è un qualcosa di così inoffensivo e tranquillo come altre teorie scientifiche, non si è ancora capito che la complessità tocca quello che c'è di più profondo o doloroso in noi: il nostro modo di ragionare e di conoscere. (Fabbri, 1990, p. 29) »

La collocazione degli educatori professionali nel comparto terapisti della riabilitazione, quali psicomotricisti, logopedisti, fisioterapisti, ha costituito un'altra tappa di messa a fuoco del ruolo educativo. Nei cambiamenti legislativi c'è dentro anche quello che ci si aspetta da un ruolo. Siamo invitati a fare un altro atto di de-costruzione per cercare di vedere, con l'aggiunta del compito riabilitativo, i pezzi di cui è fatto questo puzzle professionale.
Lo suggerisce la definizione stessa dell'azione di ri-abilitare, rendere abile, che potremmo decodificare orientativamente come *rendere capace*. Capacità è anche l'unità di misura di un liquido. Liquido pensato quindi dentro a qualcosa che contenga, dentro un contenitore. Contenitore che ha una forma propria. Liquido, quindi, che ha una misura. Aldo Carotenuto, nel libro *Le rose nella mangiatoia*, si chiede:

> « Cosa significa raccogliere acqua in un'ampolla? Raccoglierla in un'ampolla significa delimitare l'illimitato, dare forma a ciò che non ne ha, plasmare in una forma. La differenza tra l'uomo e l'animale risiede nel fatto che solo per il primo lo sforzo evolutivo è consistito nell'ordinare il mondo, nel dargli una forma. (Carotenuto, 1990, pp. 142-143) »

Capacità di avere una forma significa definirsi: non una forma costretta e imposta da condizionamenti, ma che prende corpo e si sviluppa nelle trasformazioni che si generano nel processo di cura. Processo che, teniamolo bene in mente, ha quindi una sua dinamica, ha un dentro e un fuori, parti visibili e forze invisibili, qualcosa di chiaro e qualcosa di misterioso, qualcosa che capiamo e qualcosa che si nasconde, qualcosa che vediamo e qualcosa che sentiamo. Può

aiutarci il linguaggio del cinema: c'è uno spazio inquadrato e c'è un fuori campo che dialogano con lo spettatore. Questi movimenti dialoganti del dentro e del fuori, nel processo di cura, sono la sua dinamica.

La fiducia per non perdere la rotta

La meta del compito educativo, da segnare sulla mappa del viaggio di cura, è quella di essere d'aiuto alla persona a trovare la propria capacità, l'unità di misura. La propria definizione-limite, che ne è anche il proprio contenuto. Il ruolo professionale educativo, in questo ambito istituzionale sanitario, è un ruolo di *accompagnamento all'evoluzione* dell'identità. Ribattezzare con se stessi questo patto educativo ci aiuta ad andare alla fonte del nostro compito professionale, per riattingervi una forza di consapevolezza che è il senso più vero e faticoso, doloroso e gioioso nell'esperienza del viaggiare con la storia degli altri.

Credo, con convinzione, che il sentimento che accompagna e caratterizza questa specifica professione d'aiuto sia, prendendo a prestito il titolo di un libro, *navigare l'incertezza* per farcene qualcosa. Non c'è una procedura delineata, il conforto di uno spartito musicale da seguire o di una ricetta. Il testo sacro, viene da dire, è la persona che incontreremo con la verità della sua storia, lo spartito sono le emozioni che, come le onde del mare, si muoveranno durante il viaggio della relazione educativa. Incontreremo sentimenti di sconcerto, di spiazzamento, ci sentiremo destabilizzati, inquieti, ma siamo chiamati a navigare tenendo il timone della barca, non perdendo di vista la rotta, e avendo cura dei passeggeri naviganti. Non ci è dato di sapere se l'imprevisto sarà una tempesta o una bonaccia di vento. Non si può sapere, *a priori*, la variabilità delle condizioni del mare durante l'intero viaggio. Non si sa quante volte dovremo buttare l'ancora e ormeggiare la barca. E aspettare, tremanti dell'incognita anche, ma fiduciosi.

Sappiamo che dentro a ogni persona esiste un bambino autentico e lì dobbiamo *curare* l'orientamento del nostro intervento educativo affinché diventi per ciascuno «evento educativo» di avveramento. In ciascuno di noi, bambino e adulto, esistono dei *luoghi* da cercare per ascoltarli e farli parlare, per poter comunicare e poterci capire.

« Ciò che abbellisce il deserto, disse il piccolo principe, è che nasconde un pozzo in qualche luogo... (Saint-Exupéry, 1987, p. 104) »

Questa fiducia di base è il *sapere* della premessa educativa dell'educatore professionale.

Il legame spazio dell'autonomia

Il paradigma del lavoro educativo è la competenza relazionale costituita dall'ascolto empatico, dalla capacità di distinguere, dalla capacità di attesa, dalla consapevo-

lezza e dall'assunzione dell'incertezza.
Costruire la competenza relazionale del lavoro educativo vuol dire aprire la prospettiva di una professione maieutica. L'identità dell'educatore poggia sulla competenza relazionale. Una relazione che *educe*, cioè «tira fuori» tracce, segni, forme, disegni, significati, punti di approdo, paesaggi mentali. Una relazione che riconosce le intenzioni, cioè le «tensioni verso» la coscienza del rappresentarsi dentro le differenze necessarie per individuarsi, cioè per riconoscersi come individui: io, io con l'altro, l'altro e non io, io e non l'altro, noi, l'altro, lui. Una relazione che accompagna i passaggi evolutivi della dipendenza, indipendenza e interdipendenza, volti a differenziarsi per individuarsi.
Dentro l'istituzione sanitaria il ruolo pensato come «specifico» per far raggiungere l'autonomia e la socializzazione del bambino è il ruolo dell'educatore. Se l'autonomia è qualcosa da raggiungere, è necessario pensare a un luogo di partenza da cui uscire, da cui muoversi, da cui partire. Il primo pensiero che ho incontrato in questi anni è stato questo *pensiero-scoglio*. Scoglio che può essere un luogo di partenza, di arrivo, di sosta o di salvataggio, a seconda del punto in cui il bambino si trova nella sua traversata.
Se l'autonomia è luogo di approdo, è impensabile non figurarsi un «da dove vengo?». Ecco, in questi anni mi è stato necessario accompagnare i bambini a cercare quel luogo di partenza, a vedere se c'era, se c'era stato, se c'era ancora, se rimaneva una traccia consapevole. Ancora un luogo di legame: l'attaccamento.
È in questa fase che l'educatore si può trovare *fra due sponde*: da una parte il bisogno del bambino, dall'altra il mandato di autonomia e socializzazione di cui, pur prescritto come punto di arrivo, non si scorge nemmeno l'orizzonte. Ci si può sentire come impigliati dentro una rete di bisogni: del bambino, dell'istituzione e del ruolo educativo. Come se la sopravvivenza di un bisogno dovesse farne morire un altro. Ci si sente dibattuti, come un pesce fuor d'acqua.
Qui si gioca la responsabilità dell'azione educativa che ha la funzione di *fare da ponte* tra, possiamo dire, il mandato istituzionale assegnato e il bisogno emotivo espresso dal bambino in quel momento. È necessario, quindi, porci domande sul bambino e sull'adulto: su quale bambino abbiamo in mente (che sia) e su quale adulto abbiamo in mente (di essere).
Una relazione è educativa e d'aiuto quando è portatrice consapevolmente della possibilità trasformativa ed espressiva del bambino in crescita, la accompagna, la sostiene e la riconosce.

Il rispetto per l'andatura del bambino

Per essere d'aiuto al bambino è necessario anche saper tenere emotivamente nella relazione: si profila un educatore che affina la capacità di *sopportare i momenti di confusione*, di sostare nei momenti di vuoto e nelle apparenti incrostazioni delle non ispirazioni, di accogliere gli intagli delle contraddizioni, le lacerazioni dei «non so», del patire i tempi morti, le densità dei silenzi come nebbie padane, la comparsa dei punti di luce, gli andirivieni delle incertezze, di cavalcare «il peregrino dubbio», di indossare le rabbie della solitudine, il timore del bello. La relazione educativa è fatta da tutti questi traghettamenti reali e interiori, tra esitazione e trepidazione, tra struggimento e felicità.
Orientarci a questo livello di riflessione aiuta a trasformare i luoghi comuni in

luoghi di senso per ridefinire la tappa di percorso evolutivo del bambino e specificare il progetto educativo, discutendolo e confrontandolo, passo dopo passo, con gli operatori coinvolti. È necessario *rispettare l'andatura del bambino* per evitare il rischio di uno scollamento fra quello che hanno in mente gli adulti e quello che sta già facendo il bambino.
Mi viene alla mente, per esempio, tutto il lavoro che fa il bambino nella fase iniziale di messa alla prova della relazione, quando è impegnato a «studiare» l'adulto, la sua affidabilità e capacità di tenuta: il bambino a volte esce ripetutamente dalla stanza, abbandonando l'adulto per andare a rifornirsi affettivamente della presenza del genitore o accompagnatore; spesso chiede di portare a casa un oggetto per sé, chiede che il suo gioco rimanga intatto e custodito per la volta seguente.
All'insegna di queste comunicazioni del bambino, l'educatore ha una funzione precisa da svolgere: creare *una base sicura* all'interno di un sentimento di continuità relazionale. Un lavoro educativo che legga costantemente i bisogni emotivi del bambino e che attraversi, simbolicamente, le prove della storia del «lupo e i tre porcellini», per sentire se la relazione tiene. E la relazione *tiene* solo dopo che si sono create queste condizioni di base: di stabilità e di sicurezza e un ambiente di fiducia di cui il bambino fa esperienza e in cui si sperimenta.

Nuovi significati verso nuove rappresentazioni

Ci sono delle *tappe da percorrere* prima di arrivare all'autonomia e perché questa autonomia sia un pensiero su di sé che parta realmente dal bambino: sono le tappe costitutive del processo di crescita del bambino.
La funzione educativa nella relazione con il bambino si sostanzia, inoltre, nel prendere in considerazione il gesto stereotipato del bambino per muoverlo alla rappresentazione.
Come *guardare con uno sguardo nuovo* la rappresentazione del bambino?
Per fare l'esperienza di questo sguardo «in movimento» è necessario ascoltare, con un orecchio interiore, il riverbero emotivo che il bambino ci com-muove. Questo riverbero diventa spazio di immagini, di significati che inaspettatamente emergono e si affacciano nella relazione. E la nutrono e la fanno vivere, la fanno esistere. Questo *spazio di significati* è il punto vitale della relazione educativa: il nodo d'innesto.
Possiamo pensare, per esempio, al momento in cui spontaneamente un oggetto di un gioco ricorrente, un segno grafico reiterato, una parola ripetuta, una mimica ostinata, muove una suscitazione o un'associazione inaspettata e insospettata, nuova. Come se quel «solito», quello «stesso» oggetto o segno o parola o silenzio o mimica si sganciano, si liberano dalla capsula, dal giogo di un significato, e ricevono la luce di uno sguardo nuovo che fa gemmare un'intuizione e risplendere un altro significato di senso: *un senso trovato*.
Di frequente, se si pensa all'esperienza educativa, si presentano momenti o incontri che paiono infiniti, dentro a un noto e conosciuto, come imprigionati in un fermo immagine, come se «nel gesto in cui ciascuna fu sorpresa, in quello restò fissata», come disse il poeta Ovidio.
Momenti che sembrano risentire di un *significato-incantesimo*, dove il tempo, il bambino e l'adulto paiono cristallizzati.
A questo punto, dobbiamo essere prudenti perché a volte i nostri stereotipi, i nostri sguardi spenti o stanchi, le nostre paure, le nostre difese ottuse, le nostre emozioni

congelate, ci impediscono di cogliere i movimenti insiti nella relazione o, semplicemente, di leggere il fermo immagine. Può esserci d'aiuto Eugenio Montale quando scrive:

> « Non domandarci la formula che mondi possa aprirti, sì qualche storta sillaba e secca come un ramo. Codesto solo oggi possiamo dirti, ciò che *non* siamo, ciò che *non* vogliamo. »

È proprio a *questo punto* che, per tacitare questi turbamenti, a volte spuntano le parole-targhette come palette di un vigile ammonitore: aggressivo, reattivo, ipercinetico, non collaborante e via di questo passo. Oppure è a *questo punto* che entriamo in contatto con questo spazio congelato in attesa che si sgeli. Come suggeriscono alcuni autori:

> « Questo spazio impone capacità di manutenzione e di salvaguardia e in cambio ci dà informazioni e testimonianze che nessuno strumentario scolastico di osservazione sistematica e di valutazione oggettiva potrà fornire. Gli elementi che permetterà di incontrare non potranno essere esportati se non dopo essere stati interrogati, compresi. (Cerioli, Antonietti, 1995, p. 96) »

È accompagnando questo tempo di «sgelamento» che potremo rinvenire il bambino: la funzione dell'intervento educativo a volte è nel riconoscere semplicemente che «per il momento è così», lasciando aperta però la possibilità di un cambiamento.
Per accompagnare i passaggi di crescita del bambino è necessario anche all'educatore osservarsi nei suoi cambiamenti, svilupparsi, crescere perché in una relazione educativa avviene una *trasformazione per entrambi*: il bambino e l'adulto. Questo paziente lavoro mentale di «ri-costruzione» va nel senso di far uscire una forma di rappresentazione condivisa e utile, affinché il bambino possa sapere dove mettersi e si possa «ritrovare». Tenere presenti e insieme questi piani differenti ci aiuta a vedere la complessità e la ricchezza di cui «è fatto» un bambino impegnato nell'impresa di crescere.

Un gruppo per pensare la progettualità

È necessario pensare al *contesto* in cui è inserito l'intervento educativo. Se l'istituzione sanitaria ha previsto l'inserimento dell'educatore nell'organico, ci sta in fondo dicendo che la strada della tutela della salute mentale deve integrare la via medico-clinica e la via educativa per andare verso la storia del bambino e comprenderla, per un progetto di cura pensato in funzione del suo processo di crescita.
La responsabilità dell'azione educativa non si esaurisce nel rapporto con il bambino, ma riguarda anche i «momenti di scalo» tra gli operatori coinvolti, per tenere a mente una rotta di navigazione che non perda di vista il bambino intero. Interagendo e confrontando in una dimensione dialettica e di reciprocità le differenze operative, si coltiva, all'interno dell'istituzione sanitaria, una cultura reale della diversità come risorsa, della differenza come occasione di arricchimento, come espressione della unicità e della molteplicità.
È auspicabile un gruppo di lavoro che si assuma la funzione di pensare ed elaborare. Quando il gruppo di lavoro, come quello a cui qui si fa riferimento, è composto da ruoli eterogenei, ha da tenere insieme più linguaggi: quello medico-clinico, quello educativo, quello tecnico-riabilitativo. Il lavoro di pensare, nella pratica operativa, si trasforma in un lavoro di «tenere nella mente» e di apprendere la differenza che fa la ricchezza e la ricchezza che fa la differenza. Sarà una responsabilità democratica, individuale e collegiale, nei confronti del gruppo operativo, fondata sul dialogo,

sull'ascolto e sulla pazienza per «fare una mente» intorno al progetto di cura. Una responsabilità non fondata sulle contrapposizioni, rigidità e atteggiamenti di potere e di disparità, ma che si mette in gioco in una relazione dinamica flessibile e trasformativa, che può crescere.

I bambini ci raccontano storie di vita

Uno strumento basilare nel lavoro educativo è *il lavoro di scrittura*: una trascrizione come atto di ripensamento, di rimessa a fuoco e di progettualità. Dov'è finito il taccuino delle annotazioni, fedele compagno di viaggio degli artisti di un tempo, di scrittori o poeti dell'anima? Chi parlerà più della biografia dei processi educativi?
Il lavoro educativo è, abbiamo visto, qualcosa che si costruisce nel tempo. Non avvalendoci di protocolli scientifici che ricavano un dato numerico tecnico espresso in percentuale, a servizio del processo personale svolto e compiuto dal bambino, sembra una fatica di Ercole individuare uno strumento riconosciuto a *misurare* quantificamente, quindi visibilmente, l'intervento educativo in ambito sanitario.
Scrivere ci consente di convertire l'esperienza vissuta in una forma di rappresentazione perché ci permette di de-scrivere le sequenze del processo di costruzione del bambino. Attraverso questo delicato lavoro di montaggio dei movimenti, delle scoperte, delle soste, degli andirivieni, degli spostamenti, dei paesaggi mentali del bambino, documentiamo la sua evoluzione e gli restituiamo la sua storia. In quest'ottica, il ruolo educativo circostanzia, attraverso il mezzo della scrittura, la sua funzione di costruire e restituire senso. Quindi una narrazione che utilizza un linguaggio che non assolutizzi il bambino, ma accompagni le sue immagini, le sue parole-frasi, i disordini, la confusione e la chiarezza, le difficoltà e le conquiste, che avvalori l'impresa del bambino che smonta e rimonta, disfa e costruisce. L'utilizzo della metafora, che fa lavorare insieme due mondi vicini e accosta campi di conoscenze, può essere nel nostro lavoro una risorsa per far nascere qualcosa che possiamo vedere figurativamente e per aiutarci a comunicare e condividere il processo del bambino.
Una narrazione, possiamo dire, che sostenga lo sforzo conoscitivo del bambino e rispetti il suo personale e autentico processo di crescita. In questa nostra riflessione *la metafora del navigare* è stata d'aiuto per cercare di individuare e non perdere «ancoraggi» possibili.
Il nostro viaggio ha esplorato la mappa della relazione che «si fa» ambiente educativo accompagnando le possibilità evolutive del bambino che «gioca» con i suoi pensieri, che si trasformano in punti di vista, idee, concetti e valori per crescere e comunicare.

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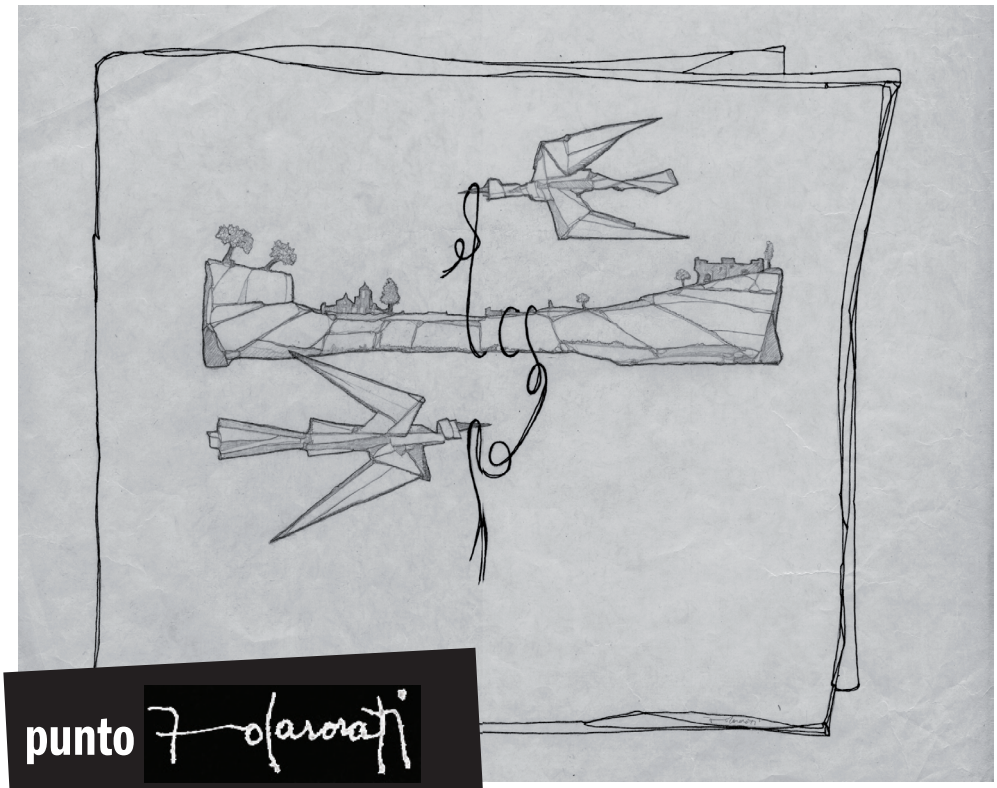
Gilda Vischia, educatrice professionale, lavora nell'Unità operativa di neuropsichiatria dell'infanzia e dell'adolescenza di Varese: gilvi@libero.it



punto 7 casorati

« Non ho mai capito la differenza tra un quadro astratto e uno figurativo.
Per me la pittura è sempre la stessa e quando guardo un quadro di un artista o dipingo una tela quello che conta sono la composizione delle immagini, i rapporti dei colori fra di loro, l'idea pittorica nel suo insieme e guardare il quadro da molto vicino per godermi l'andamento delle pennellate.
E se qualcuno mi domandasse perché io non faccia allora della pittura astratta, gli risponderei che forse non ne sarei capace, che sento la necessità di usare delle figurazioni, che, in fin dei conti, mi piace raccontare delle cose ed usare delle immagini tratte non dalla realtà ma da antiche memorie sovrapposte e che arrivano non so come nella mia testa. »

Illustrazione e testo di
Francesco Casorati
Collina imbrigliata, 1996,
matita e penna.

«Case» della coesione sociale nei territori/1

Il manifesto delle Case del quartiere

Coordinamento delle Case del quartiere di Torino

SOSTE DI **DISCUSSIONE**

La coesione sociale è una costruzione collettiva nei territori, nella quale convergono l'investimento pubblico, la competenza degli operatori professionali, la disponibilità delle reti sociali che innervano i territori, l'allestimento di luoghi fisici che i cittadini vedono come simboli della vivibilità dei territori. Il «manifesto delle Case del quartiere» di Torino ci permette di aprire un confronto, al di là delle etichette, tra le molteplici sperimentazioni in Italia.

Negli ultimi anni a Torino sono stati aperti spazi comuni, laboratori sociali e culturali in cui s'incrociano attività e persone, luoghi nei quali si esprimono pensieri e vissuti collettivi, che avviano esperienze di partecipazione, coinvolgimento e auto-organizzazione, spazi che oggi hanno un nome: Case del quartiere.

Luoghi che si abitano, si vivono e si usano, che nascono da una storia di una città attiva e creativa, che ha visto già nei decenni precedenti sperimentazioni di luoghi capaci di innescare pensieri e progetti e di coinvolgere parte della cittadinanza. Alla fine degli anni Novanta, dalle proposte di politiche urbane innovative e dagli stimoli delle istituzioni europee che spingevano ad adottare approcci nuovi, nascono spazi di uso pubblico che superano le politiche settoriali e lavorano insieme ai cittadini per mettere in comunicazione centri e periferie.

La Città di Torino raccoglie questi stimoli e nel 2007 nasce, in una zona periferica della città, la prima Casa del quartiere: Cascina Roccafranca. Negli anni seguenti si sviluppano nuove esperienze in altri quartieri della città, attraverso storie e percorsi diversi ma con una base comune: spazi a uso pubblico riqualificati, grazie alla collaborazione tra istituzioni pubbliche, fondazioni bancarie, imprese sociali, associazioni e cittadini, luoghi che diventano spazi per la cittadinanza.

Da maggio 2012 la Città ha invitato i soggetti gestori delle Case a *riunirsi intorno a un tavolo* con il proposito di coordinare le attività attraverso il consolidamento di una rete per mettere in comune saperi, esperienze e progetti.

Presente e futuro in un documento-manifesto

Un primo risultato del percorso di costruzione della rete è la stesura del «Manifesto delle Case del quartiere». Un documento che raccoglie gli elementi che caratterizzano questi nuovi spazi nella città, riaffermando l'importanza di pratiche sociali e culturali consolidate, ma soprattutto evidenziando quegli aspetti d'innovazione che le rendono caratteristiche e uniche nel ricco panorama delle offerte culturali che la città offre. Un manifesto che racconta il presente e nello stesso tempo le prospettive per il futuro, un utile strumento di lavoro, che consente alle Case di confrontarsi tra loro con quel che hanno realizzato fino a oggi e di tracciare un percorso per crescere e svilupparsi in futuro.

L'idea delle Case nasce da una convinzione: le persone sono portatrici di bisogni, ma anche di competenze e disponibilità che possono essere messe a disposizione della comunità per soddisfare esigenze collettive.

Sono esigenze che nascono dalle difficoltà di vivere in modo dignitoso, da bisogni primari insoddisfatti come il lavoro e la salute, dall'essere soli nell'affrontare le difficoltà della vita quotidiana, dalla mancanza di relazioni significative, dalla necessità di dare senso e significato alla propria vita; ma anche dal desiderio di continuare a sentirsi attivi, di partecipare alla socialità del quartiere, di essere protagonisti della propria vita, di poter contare nelle decisioni che riguardano la

Comunità, di vivere uno spazio politico dove costruire soluzioni possibili e condivise.
Le Case possono contribuire a creare una coscienza collettiva che renda consapevoli le persone della propria situazione, e possa stimolarle a essere cittadini attivi, autonomi, solidali e responsabili.
Essere cittadini oggi è, infatti, uno dei modi in cui si partecipa alla cosa pubblica, una modalità nuova che si realizza non nella sfera della rappresentanza istituzionale, bensì nel fare cose concrete, nella partecipazione alla soluzione dei problemi che interrogano il singolo e la collettività, nel cercare di dare risposte non solo alle proprie necessità, ma partendo da queste per comprenderle in quelle di altri.
Questo nuovo modo di concepire il rapporto fra città e cittadini, non più fondato sul rapporto dare/avere, operatore/utente, ideatore/utilizzatore, ma sullo scambio di competenze ed esperienze, trova espressione nelle Case in cui attività e iniziative non sono solo «per» i cittadini, ma anche «con» i cittadini, che si prendono cura dei propri bisogni, integrando le risorse pubbliche con quelle di tempo, di capacità, di relazioni, di vissuti e di idee di cui sono portatori.
Veniamo dunque ai *dieci punti* del Manifesto così come sono emersi da molteplici momenti di confronto fra gli operatori.

1 | **Luoghi aperti a tutti i cittadini**

Le Case sono organizzate per accogliere, attraverso attività interculturali, tutti i cittadini dai più piccoli agli anziani, senza discriminazione di genere, nazionalità, estrazione sociale e appartenenza religiosa. Si impegnano a soddisfare esigenze differenti, con un'attenzione specifica ai diversi livelli sociali e culturali delle persone. Esse promuovono iniziative popolari, curando la qualità delle proposte e coniugando cultura con socialità. Non si rifanno a un'ideologia con riferimenti a simboli, bandiere e movimenti, ma rispettano i differenti orientamenti culturali. Si riconoscono, invece, in valori universali come la libertà di espressione, il diritto di partecipare alla vita sociale e politica, l'uguaglianza tra le persone, la giustizia sociale, lo spirito di solidarietà e il rispetto dei diritti umani.

2 | **Spazi di partecipazione attiva**

Le Case promuovono la partecipazione alla vita sociale e culturale dei quartieri attraverso differenti forme di cittadinanza attiva e di volontariato. Sono luoghi in cui si ricercano e si sperimentano nuovi modi di fare welfare, sviluppando le reti di prossimità, attraverso la ricerca pratica di soluzioni collettive a bisogni e attese comuni.
Sono spazi capaci di accogliere e sostenere: la singola persona, valorizzandone le competenze e sostenendone il mettersi in gioco; i gruppi informali che sviluppano interessi comuni, favorendone la nascita, la crescita e l'autonomia; le associazioni, i gruppi di associazioni, gli enti e le istituzioni, rafforzandone l'identità e la missione.

3 | **Luoghi accessibili e generativi di incontri**

Le Case possono contribuire a creare una coscienza collettiva che stimoli gli abitanti a essere cittadini attivi, solidali e responsabili.

Accoglienti, curate e attrattive, le Case del quartiere sono innanzitutto costruite attorno a criteri di accessibilità.
• *Economica*, anzitutto. Offrono attività gratuite e praticano prezzi popolari e contenuti.
• *Organizzativa*, poi. Sono organizzate in modo «leggero», permettono cioè un accesso libero alle strutture, un contatto diretto con gli operatori e la possibilità di ottenere informazioni in modo semplice e non burocratico.
• *Culturale*, infine. Hanno una visione aperta, non ideologicamente schierata, rispettosa dei diversi orientamenti politici democratici, delle diversità culturali e di genere.
Trattasi dunque di luoghi della quotidianità, che permettono di sentirsi a casa, in una dimensione sociale aperta, dove è possibile «stare» socializzando e dove si può «fare» partecipando alle attività o diventando i promotori di progetti e iniziative.
Nell'insieme favoriscono in modo intenzionale le relazioni fra le persone, la conoscenza, l'incontro e il confronto fra le realtà che vi operano, fra i progetti che si realizzano, e creano le condizioni per far nascere sinergie e collaborazioni.

4 | **Spazi di tutti ma sede esclusiva di nessuno**
Come una piazza, aperta e ospitale, ogni centro accoglie numerose organizzazioni dando loro uno spazio per attività e incontri, con l'attenzione che non prevalga un uso esclusivo. I locali e gli spazi sono organizzati e strutturati per rispondere alle differenti necessità degli utilizzatori, mentre le attività dei gruppi si svolgono in libertà e autonomia, contribuendo nel loro insieme alla progettualità complessiva e alla costruzione di un'identità comunitaria.

5 | **Contenitori di progettualità molteplici**
Come vivi contenitori, pensati e organizzati, le Case sono in grado di raccogliere e valorizzare un mix di attività e iniziative culturali, artistiche, sociali e ricreative, sportelli d'informazione e consulenza, corsi a pagamento, laboratori gratuiti, servizi per famiglie, spettacoli, conferenze, mostre.
Le strutture accompagnano e supportano i soggetti che intendono promuovere al loro interno progetti ed eventi, mettendo a disposizione competenze, spazi, idee e risorse perché questi possano realizzarsi in modo adeguato e soddisfacente, con un sempre maggiore livello di autonomia e auto organizzazione. Più da vicino, sono un punto di formazione e promozione artistica e culturale, poiché riconoscono nella creatività e nell'espressione artigianale uno strumento potente per generare comunità e futuro.
Le diverse realtà della rete trovano la loro forza negli elementi che le uniscono e che le diversificano come la specificità che nasce dalle singole storie, territori e persone.

6 | **Gli operatori competenti artigiani sociali**
Ogni Casa è gestita da gruppi di lavoro in grado di svolgere funzioni progettuali e organizzative, coordinati da figure di responsabilità in grado di curare la regia complessiva attivando modelli gestionali partecipati.
Gli operatori sono artigiani sociali, che agiscono e sviluppano la propria professionalità attraverso l'apprendimento che nasce dall'esperienza e dalla sua analisi, da percorsi formativi, dall'attivazione di scambi e sperimentazioni. Essi sono stimolati a sviluppare competenze in diversi ambiti: sociale, relazionale, culturale, organizzativo e amministrativo, sviluppando le capacità di accogliere, ascoltare, accompagnare e motivare i cittadini a essere protagonisti della vita socio-culturale della comunità.

7 | **Luoghi intermedi fra il pubblico e il privato**
Le Case sono il risultato di azioni di «amministrazione condivisa» per la rigenerazione di beni comuni urbani, frutto della collaborazione tra Amministrazione comunale e cittadini attivi.
In tal modo svolgono un'importante funzione pubblica, essendo luoghi privilegiati di sviluppo di cittadinanza e di costruzione di reti sociali, di cui le Amministrazioni pubbliche condividono le azioni, le linee guida e le modalità di lavoro.
Luoghi di aggregazione ma anche strumento per costruire nuovo «welfare urbano», le Case del quartiere sono spazi condivisi in cui i bisogni personali possono essere soddisfatti in modo collettivo, in cui viene dunque sollecitata la partecipazione e la relazione, dove è più che mai evidente la produttività del fare insieme.

8 | **La sostenibilità economica fa leva sull'intraprendenza**
Le Case sono progettate per tendere alla sostenibilità economica. In tale logica sviluppano competenze imprenditoriali nella gestione delle risorse, nella lotta agli sprechi, nello sviluppo di attività commerciali accessorie e funzionali al progetto, nel coinvolgimento diretto dei cittadini, promuovendo iniziative di fundraising e di contribuzione collettiva.
Non sono, però, interessate a raggiungere la completa autosostenibilità economica, che comporterebbe il rischio di cadere in logiche economiche di mercato e di snaturare la vocazione popolare e sociale del progetto. Per queste ragioni e per la funzione pubblica che esse svolgono, è indispensabile un sostegno da parte di enti pubblici e privati nel finanziare parte dei servizi che rispondono ai diritti di uguaglianza e pari opportunità.

9 | **Il radicamento e le collaborazioni territoriali**
Le Case fanno parte del territorio in cui nascono e si determinano. Sviluppano – al loro interno e con le realtà con cui s'incontrano, siano esse profit o no profit – la capacità di generare ponti, confrontare pensieri e metodi, attivare sinergie

nuove. Esse creano l'ambiente adeguato per costruire relazioni e legami sociali: privilegiano l'attivazione delle reti attraverso il fare insieme, lo sviluppo di progettualità comuni, la relazione tra le persone, i gruppi e i progetti.
Nell'ottica di allargare la propria azione a tutto il territorio, esse cercano la collaborazione con le realtà e le strutture presenti nel quartiere in una prospettiva progettuale di «casa diffusa», capace di esprimersi al di là dei propri spazi.

10 | Governance condivisa con gli attori locali

Le Case sono gestite da diversi soggetti radicati nel territorio: associazioni di primo e di secondo livello, fondazioni o cooperative, in alcuni casi frutto di un vero e proprio percorso partecipativo che ha coinvolto nella fase istitutiva numerosi attori locali.
Sono strutture organizzative in grado di contribuire alla riqualificazione del quartiere coinvolgendo le diverse realtà locali, valorizzandone il lavoro, le iniziative, la capacità di rapportarsi con i cittadini, riconoscendo tutto questo come un effettivo patrimonio spendibile per costruire in modo corresponsabile una risposta locale orientata a migliorare e sviluppare il territorio.
In definitiva, una Casa è un modello gestionale capace di apprendere dall'esperienza, di verificare costantemente la rispondenza delle varie iniziative attivate, di cogliere e analizzare bisogni e aspettative, di aggiornare continuamente il proprio progetto adattandolo alle nuove esigenze.

Le Case del quartiere, attualmente nove, coprono quasi completamente il territorio della città di Torino: *Cascina Roccafranca* a Mirafiori Nord (www.cascinaroccafranca.it), *Casa del quartiere di San Salvario* (www.casadelquartiere.it), *Bagni pubblici di via Agliè* in Barriera di Milano (https://bagnipubblici.wordpress.com), *Hub Cecchi Point* nel quartiere Aurora (www.cecchipoint.it), *Casa nel Parco* a Mirafiori Sud (www.casanelparco.it), *SpazioQuattro* a San Donato (www.piuspazioquattro.it), *Barrito* in zona Nizza Millefonti (www.barrito.to.it), *Bossoli83* nella zona Lingotto (www.bossoli83.it) e *Casa di quartiere Vallette* (http://i74010.wix.com/casadiquartiere).

Storie di recovery

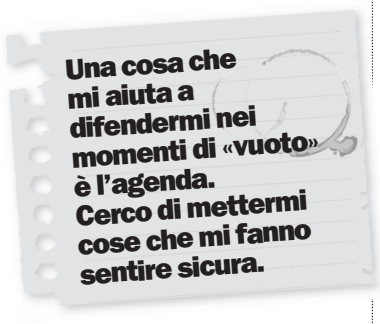
Il lungo viaggio verso la ripresa di sé

A cura di Izabel Marin

Le persone che hanno vissuto su di sé l'esperienza del disagio mentale hanno cose importanti da dire: sui propri percorsi individuali, sui momenti frammentati di malessere e di benessere, sull'esperienza acquisita attraverso la propria sofferenza. Da qui l'importanza di ascoltare le loro storie. Ne proponiamo due – quella di Silva e quella di Pietro – raccolte dopo e durante le loro esperienze di cura nei Centri di salute mentale di Trieste. Per quanto diverse, raccontano la possibilità di riconquistare la propria «salute mentale». Per un'ampia raccolta di storie si rimanda al volume *Guarire si può* (a cura di Izabel Marin e Silva Bon), nella collana «180. Archivio critico della salute mentale» dell'editore alpha beta Verlag di Merano (Bz).

Silva e l'importanza dell'agenda

Il trauma della mia vita è stata la separazione. Ho sempre dato molta importanza alla famiglia, e quindi, se fosse dipeso da me, non avrei mai rotto il matrimonio. In coincidenza con la separazione c'è stato il primo episodio di ricovero in ospedale.
Avevo incominciato ad avere un senso di insicurezza, a sentire voci, come se gli altri mi parlassero, mi guidassero. Tutto ciò è degenerato alla fine di un anno scolastico, l'anno in cui poi mi sono separata, a



settembre. Ero molto stanca per la fine del lavoro a scuola, ma soprattutto per un anno di tensione in famiglia.

Per motivi compositi e complessi in quel momento rappresentavo l'anello debole di una catena: i miei figli (uno di 14 anni, l'altro di 16) non hanno potuto scegliere di stare con me, in qualche modo sono stati ricattati e sono rimasti col padre. Ho subìto il dramma dell'abbandono della famiglia, dei figli, della casa. Ancora adesso non riesco a liberarmi da quel ricordo.
Tutta la solitudine nella quale ero piombata, pur vivendo in famiglia, ho cominciato a vincerla proprio nel momento del primo ricovero. Ho iniziato a riflettere e a parlare dei miei problemi. A ripensare al passato e a segnare mentalmente tutte le cose che avrei voluto fare in futuro per me, invece di vivere solo per gli altri.
Il periodo in cui ho cominciato a essere curata al Centro di salute mentale di Barcola (Ts) ha rappresentato un momento di ripresa. È stato un periodo molto faticoso, con un'andatura da gambero, un po' avanti e un po' indietro. Adesso ho l'impressione che anche questi momenti di crisi siano dei passaggi positivi, prima vissuti come una regressione, una sconfitta, ma dopo il recupero, alcuni giorni dopo, mi sembra che tutto sia comunque un andare avanti nel percorso di guarigione.

Mi è stato d'aiuto soprattutto il modo di parlare dei medici e degli operatori, per cui sono riuscita a capire il percorso della malattia, il senso dello stare bene e dello stare male, dell'andare a fondo. Sono stata aiutata prima di tutto a ricostruire un progetto per la mia vita. Ho ritrovato interessi intorno a cose già concretamente avviate e che durante gli ultimi anni del matrimonio avevo abbandonato.
Al Csm, oltre a una certa scansione temporale dei colloqui, più frequente rispetto a quelli che possono essere sostenuti con il medico privato, ho trovato tutto un insieme di agganci, di progetti, per esempio il «gruppo donne di Barcola», che portiamo avanti da tre anni. Il gruppo si è organizzato intorno a letture di testi che proponevamo io e un'amica, insegnante pure lei. Andavo là dopo una giornata faticosa di lavoro e mi chiedevo «ce la faccio ad andare a Barcola con l'autobus oggi pomeriggio?». Ma ogni volta ritornavo a casa molto più rilassata. Con alcune persone di questo gruppo ho costruito rapporti veri di amicizia, riuscendo a scoprire da un lato problemi simili ai miei, dall'altro possibilità diverse e nuove di farvi fronte.

Una cosa che mi aiuta a difendermi nei momenti di «vuoto» è l'importanza dell'agenda. Programmo la mia vita. Poi sono disposta anche a cambiare tutto: se c'è l'imprevisto magari tutto quello che ho programmato va a monte, però, da quando sono sola, ho raccolto tutta la mia vita nelle agende. Anno per anno sono sempre più fitte di appuntamenti e di cose da fare e che mi interessa fare. Questo mi aiuta a coprire certe assenze. Cerco di fare delle cose che mi piacciono, che mi fanno sentire sicura.
Ultimamente ho vissuto un piccolo episodio di sofferenza psichica in coincidenza con il capodanno. In questi casi, prima di stare male veramente cerco di rivolgermi a un medico, prendo delle medicine che ho a casa. Ho imparato. Quest'anno sono andata con il taxi, di mia scelta, al Servizio di diagnosi e cura, pensando molto consapevolmente che mi avrebbe aiutato. La mattina dopo sono tornata a casa e ho ripreso la vita normale. L'importante è riuscire a capire in anticipo che si ha bisogno di aiuto.

La timidezza mi condiziona moltissimo quando sto male. Fa parte di questo processo di ricostruzione impegnarsi per vincerla. Per esempio, arrossisco come una bambina e nei rapporti sociali questo inibisce anche l'interlocutore, quindi dopo mi colpevolizzo e dico: gli altri stanno male in mia compagnia. Adesso mi ascolto, mi analizzo, sono consapevole che i momenti di tensione, di imbarazzo accadono più frequentemente in concomitanza con le crisi.

Nei momenti in cui sono socialmente più debole, ho questo rossore, questo imbarazzo, magari mi viene la paura di uscire di casa. Ma se non esco il problema diventa più assillante, lo collego con la crisi e cerco di tenerlo sotto controllo. Il rossore è come un handicap, è come essere balbuziente. Quando si scatena, è più forte di me e mi fa sentire sconfitta. La mia autostima cade verticalmente. È un circolo vizioso: io mi disistimo e la paura del rossore diventa più assillante. Ora mi sembra un poco alla volta di saper controllarmi di più. Guarire per me è riuscire a vincere questa timidezza.

Leggo questo mio percorso come un cammino. Non ho raggiunto nessun traguardo, ma mi propongo, come un imperativo, la volontà di continuare a lavorare su me stessa, di migliorare. Mi piacerebbe moltissimo costruire un rapporto migliore con i miei figli, nel senso di far loro capire quel poco che io ho capito troppo tardi.

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Pietro e l'addomesticamento della «cosa»

Per me è stato come combattere con una cosa che non si conosce. Non ti fa mangiare, non ti fa dormire. Stavo malissimo, non riuscivo nemmeno più a uscire di casa. Da oltre due anni avevo interrotto il lavoro, e nello stato mentale in cui mi trovavo non sentivo neppure il desiderio di tornare a lavorare. Solo l'idea di alzarmi, fare anche le più piccole cose, era diventato un ostacolo insormontabile. Per me la vita «normale» era finita. Il momento di rottura è stata la malattia di mio padre, ma forse anche prima c'era qualcosa che covava, un rapporto conflittuale con i genitori, un percorso non proprio imposto, ma mediato dalla loro volontà, per cui i figli vengono «costruiti», sono sempre un po' manipolati, e così è difficile che poi prendano la loro strada.

Il mio malessere, la mia depressione, e la malattia di mio padre erano strettamente legate, come in un circolo vizioso, perché dovevo accudirlo nelle sue esigenze primarie, in quanto invalido totale, e cercare di andare avanti con l'aiuto di mia madre. A un certo punto ho dovuto distaccarmi un po'. Distacco non vuol dire abbandono, è anche un processo interno. Sentivo che dovevo allontanarmi da mio padre, dalla pesante situazione che si presentava ventiquattr'ore al giorno. Credo sia stato questo il cambiamento più importante che ho fatto, la scelta che si è rivelata decisiva. Ho dovuto trovare un equilibrio tra la mia salute e quella di mio padre, in modo da non ricadere nel malessere. Qualche volta bisogna imparare a dire no, a guardarsi dentro. Se ritengo che qualcosa non vada bene per me, devo riuscire a dire di no, a costo di litigare. Darmi totalmente porterebbe a una ricaduta: posso dare fino a quando me la sento, poi devo pensare anche a me stesso. Ciò non significa non avere amore per i propri genitori, ma imparare a patteggiare.
Ho affittato una casa – e anche questo è stato uno sprone, un impegno da prendere con me stesso. Metterla a posto, farci dei lavori ha costituito infatti una responsabilità, un modo per non rimanere sempre bloccato con la testa al pensiero della malattia. Era uno spostamento d'attenzione, che mi ha fatto prendere un'altra strada. Ma fondamentale è stato l'aver trovato una soluzione sul lavoro.

In questo percorso il supporto del Centro di salute mentale si è rivelato determinante. Parlando col medico, infatti, abbiamo maturato insieme l'ipotesi di adottare un orario part-time, che mi avrebbe evitato una stanchezza eccessiva, cambiando al contempo sede di lavoro. Inizialmente c'era un po' di smarrimento da parte mia, ne parlavamo ma non ci potevo ancora credere. Poi, pian piano, sono cominciate ad arrivare le conferme che tutto il progetto era realizzabile.
Ho dovuto scontrarmi, però, con le opinioni degli altri. Ridurre l'orario lavorativo viene considerato un cedimento, una perdita, non solo di una parte dello stipendio. Tuttavia è un lavoro che devi fare con te stesso: devi vedere che cosa è meglio per te, perché non sempre ciò che va bene agli altri va bene anche a te.
In questo processo è stato di grande aiuto per me il sostegno del Centro di salute

Definirmi guarito no, credo sia sbagliato. Diciamo che ho imparato ad addomesticare «la cosa». Non la scaccio, ma l'accetto.

mentale. Soltanto la figura di un professionista può aiutare. I familiari non sanno cosa sia questa «cosa», non sanno come sostenerti. A volte possono addirittura creare una situazione peggiore, perché spronare può ottenere l'effetto opposto. Aiutare cercando di spronare l'altro ad andare avanti fa peggiorare, perché in quel momento ti senti sull'orlo di un burrone e uno che ti sprona è come se ti spingesse giù. E poi ognuno ha un proprio tempo per poter uscire dal malessere, se non completamente, almeno per migliorare. Ognuno a un certo punto sente uno scatto, un clic, come un interruttore che si accende. Sentirsi dire: «Dai, su che ce la fai...» non serve a niente.

Prima di rivolgermi ai servizi, per circa un anno sono andato privatamente da un dottore e anche da una psicologa. È stato forse l'anno più brutto, perché ancora non sapevo cosa fare, a chi rivolgermi. Inizialmente pensavo di avere un male fisico, non pensavo alla testa, per cui andavo a fare tutti gli esami a livello organico per vedere se c'era qualcosa che non andava: l'elettroencefalogramma, l'elettrocardiogramma, l'analisi del sangue, delle urine, tutti gli esami possibili e immaginabili. Ma risultava tutto regolare. Infine, dopo circa un anno, sono approdato al Centro di salute mentale, non ricordo bene per quale strada.

La prima sensazione non è stata negativa. Chi inizia ad affidarsi al servizio pubblico lo associa subito ai «matti», si pensa al manicomio, perché la malattia psichica è sempre vista con pregiudizio. Io ci sono andato con l'idea di voler conoscere anche quella dimensione, per vedere che aiuto potevo ricevere.

A quel punto ho potuto fare un confronto tra i colloqui con lo psicologo del Centro di salute mentale e quelli in privato. Si parla sempre di quello che è successo, ma nel privato ci sono orari precisi e quando scade il tempo ti devi alzare e andare via, anche se sei sotto pressione o se devi ancora concludere: e questo sicuramente non è una buona cosa. Uscendo ti dici: cosa ho capito oggi? Eppure devi pagare. Finisce l'ora e devi pagare.

Sono rimasto stupito invece con lo psicologo del Centro, perché mi dava la sua disponibilità, aveva pazienza, non guardava l'orologio, facevo con lui una chiacchierata, senza premura. Senti il lato umano, la calma e la disponibilità dell'altro. Non ho avuto bisogno del servizio per trovare casa, ma è stato di grande aiuto – come dicevo – per il rapporto con il lavoro. Nella mia impossibilità di gestire la situazione, i servizi sono stati un tramite, hanno fatto un po' le mie veci per poter portare avanti determinate istanze nell'ambito del lavoro: contatti, certificati medici sul mio stato di salute e poi l'avvio della procedura di domanda di part-time indicando un possibile lavoro alternativo.

Definirmi guarito no, credo sia sbagliato. Non direi mai una parola definitiva, è una cosa un po' così, di volta in volta, non si può dare una definizione esatta. Diciamo che va meglio di prima. Inizi a conoscere un po' la «cosa», a lavorare sul sintomo, sulle cose che prima ti colpivano, ti aggredivano e da cui non sapevi come difenderti. Si ripresentano situazioni che hai già conosciuto, però ora sai addomesticarle.

I sintomi si presentano comunque, non riesci a cacciarli via del tutto: l'ansia, come fattore psicosomatico, la paralisi, la perdita del tatto. I sintomi possono venire ancora a farti visita, ma li accogli, non li scacci; perché se li scacci via possono tornare con più forza, se invece li accetti dici: «Sei venuto a trovarmi? Va bene, accomodati». È una forma di maggiore controllo, cerchi di capire un po' meglio come intervenire. È terribile quando non conosci la «cosa». Però se è «addomesticata» fa male in maniera diversa, in un altro modo, è un altro tipo di sofferenza. La «cosa» ti abbatte, ti butta giù, ma impari a dire: «No, sono più forte di te, anche se ci sei io comunque vado avanti».

Izabel Marin assistente sociale, lavora nel servizio abilitazione e residenze del Dipartimento di salute mentale di Trieste: izabel.marin@aas1.sanita.fvg.it

Il circolo No.à. nella Torino nascosta ai pellegrini

La piola social dove il pasto è a 1 euro

Roberto Camarlinghi

ANDAR PER **LOCANDE**

Quando in bici cerco il 154 di corso Regina Margherita, percorro la via che i pellegrini della Sindone non vedranno mai. Perché questo tratto di città, sulle mappe date ai turisti nei giorni di Ostensione (19 aprile-24 giugno), è segnato con una riga rossa. Come dire: «Di qui non passate».

A Porta Palazzo, nel grande ventre

Siamo a Porta Palazzo, cuore multietnico della città, da sempre il «grande ventre» che a Torino accoglie la migrazione. Un tempo dal Sud, oggi dal mondo. Qui hanno messo radici le grandi istituzioni caritatevoli della città, perché dove c'è migrazione c'è miseria. Il Cottolengo, l'Opera Giulia di Barolo, il Sermig poco distante. E i grandi santuari di devozione cittadina: Maria Ausiliatrice, dove Don Bosco iniziò le sue attività a favore dei ragazzi, la Consolata. Proprio di fronte, l'ex ospedale psichiatrico, il «manicomio delle donne» come si diceva fino agli anni '60. Un quartiere denso insomma, di storia e umanità.

Anche il Circolo *No.à. - Gioia e Rivoluzione* a suo modo prosegue una tradizione – su un versante laico e civile – di attenzione agli ultimi della città. Tentando la sfida di far convivere, in questo interno cortile dove sembra di entrare in una cartolina anni '20, le diverse anime della città. Quella emarginata, quella artistica, quella musicale. E quella che va matta per gli spaghetti alici e broccoli o per gli hamburger di fassone piemontese qui proposti a prezzi imbattibili. La sfida insomma di fare città, perché una città respira se le sue tante anime si parlano.

È la prima volta che entro in questo capannone di 300 mq che nei secoli è stato tante cose. A inizio '900 *boita* (in piemontese bottega artigiana), poi proprietà del Torino Calcio e dopo del Consolato di Birmania, quindi officina meccanica, oggi circolo Arci con cucina. Ci vengo perché ne ho sentito parlar bene. Qui si fa buon cibo, buona musica, buon teatro, e si produce socialità diffusa.

Su facebook gira un post che indica il No.à. tra le 10 migliori *piole* della città. Le piole, a Torino, sono le osterie di una volta, posti semplici, frequentati da ceti sociali molto diversi, con il pergolato (*tòpia*) e l'uva americana (*uva fròla*).

Una locanda che di giorno è mensa popolare

Proprio nella tòpia del No.à. mi siedo con Andrea Casa e Renato Piccolo, due dei soci fondatori, in una tiepida serata di primavera. E mi faccio raccontare anzitutto l'aspetto sociale del locale. Perché qui, ogni giorno, dal 15 dicembre al 30 aprile, si è dato da mangiare a 50 persone inserite nel programma Emergenza freddo del Comune di Torino.

«Nel progetto ci siamo capitati un po' per caso. All'ultimo il circolo Arci che doveva occuparsi dei pasti ha dato forfait. Così siamo subentrati noi. È un progetto impegnativo, ma che davvero ha senso. Del resto la nostra volontà è sempre stata quella di non essere solo circolo culturale e ludico-ricreativo, ma di attivarci nel sociale».

Gli orari di accoglienza sono legati agli orari dei dormitori: «Noi diamo merenda e cena. Merenda dalle 15 alle 17, cena dalle 17 alle 19. Perché alle 19 le persone devono già rientrare nei dormitori. Alle 20 apriamo il locale a tutti». Per la verità non tutte sono persone collegate ai dormitori. «Il Comune di Torino inizialmente ci ha chiesto di occuparci di 30 senza dimora, poi di aggiungere 10 persone del quartiere in difficoltà. Noi abbiamo accettato e abbiamo deciso di aprire ad altre 10, così siamo arrivati a 50».

Ma l'emergenza non finisce certo col freddo, è costante in questa zona. «Questo è un quartiere difficile, complesso.

«Offrire il pasto a un euro a disoccupati, anziani, persone in difficoltà. È un nostro vecchio sogno, una risposta alla povertà del quartiere».

Per questo terremo aperto anche nel mese di luglio e agosto, quando alcune mense comunali e private chiudono. L'obiettivo è dare da mangiare a 100 persone al giorno, stiamo attrezzando la cucina».

La vera novità, tuttavia, è in vista dopo l'estate. Offrire il pasto a un euro per disoccupati, anziani e persone in difficoltà economica. «È un nostro vecchio sogno. Il modo migliore per sostenere la popolazione qua intorno, che spesso viene a chiederci aiuto. Stiamo provando a realizzarlo grazie al sostegno del Banco alimentare, della Coop e di altri supermercati che ci danno i prodotti e con il finanziamento delle Fondazioni e del Comune. Un'ora fa abbiamo saputo che la Chiesa Valdese ha considerato questo progetto come destinatario dei fondi dell'8 x 1000».

Dialogo e fermezza con gli spacciatori

Sui muri sono scritte le due parole chiave del circolo. Gioia e rivoluzione. Chiediamo che senso abbiano oggi. «Noi siamo non violenti nel dna. Ci rifacciamo ai valori del nuovo umanesimo. *Gioia* è cercare di avere lo spirito positivo nonostante le difficoltà. *Rivoluzione* è trasmettere nel quotidiano modelli diversi di comportamento. Quando siamo arrivati qua, avevamo gli spacciatori di fronte. La popolazione ci diceva "siete pazzi, non cambierete mai nulla, sono 20 anni che proviamo a mandarli via". Dopo un anno sono venuti a dirci "vi chiediamo scusa, siete stati bravi"».

Cos'è cambiato? «La differenza l'ha fatta il nostro modo di comunicare. Siamo sempre intervenuti cercando il dialogo, pur mantenendo la fermezza nei principi. Poi è chiaro, questi sono spacciatori, mettersi in conflitto con noi non fa comodo a loro. Perché noi da subito abbiamo chiamato i carabinieri, però non li chiamavamo chiusi nel locale, siamo sempre usciti a dirglielo in faccia: "Ragazzi, o la smettete o dobbiamo chiamare le forze dell'ordine". Loro a volte facevano gli spavaldi: "Ma figurati, dai fallo". E noi per 2-3 volte l'abbiamo fatto davanti a loro».

«Siamo in una zona molto difficile. Molti si lamentano, ma questa è anche una zona piena di odori, di colori, di cultura, è bello star qua. Sei a Porta Palazzo, il mercato aperto più grande d'Europa, un'esperienza unica sul piano delle sensazioni e degli incontri. Sì ci sono aspetti negativi, ma dove non li trovi? Certo, per il circolo questa cosa non paga, "Io in quella zona non ci vengo perché è pericoloso", ci dicono alcuni. Hai voglia a dire "Guarda che io sono tre anni che esco alle 3 di notte in bicicletta, a volte con l'incasso addosso, e non mi è mai successo niente". Mai. Tutti i giorni in tre anni. In bici poi, neanche in macchina riparato dall'abitacolo».

Una programmazione aperta all'inatteso

Anche il No.à. si propone come spazio di incontri, di mescolanze. «Dalle 20 in poi si può venire a mangiare, a bere, ad ascoltare musica. Alle 21.30 di solito inizia una serata a tema. Al lunedì e mercoledì c'è la scuola di comicità. Facciamo tanti spettacoli di teatro il venerdì e sabato. E poi concerti, laboratori di danza, di yoga, di autodifesa. Il martedì si è formato un gruppo di lettura. L'idea però è di non predeterminare troppo gli spazi, altrimenti fai un circolo chiuso. Abbiamo sempre detto "gli spazi teniamoceli un po' liberi, così se arriva qualcuno e ci dice di aver bisogno del circolo per due ore per fare le prove, glielo dai e ti conosci". E dagli incontri nascono le novità. Per esempio adesso stiamo collaborando a un progetto di *Contact Improvisation*, che è la danza spontanea, libera, e nell'arco di 2-3 mesi siamo arrivati a 35-40 persone».

Si potrebbe definire il circolo No.à. una sorta di «Casa del quartiere», come a Torino ne sono sorte tante (nove) in questi anni. Un presidio di socialità e un ventilatore di energie fresche. Esco dal circolo che è sera, mi guardo intorno. E questo tratto di via che i pellegrini della Sindone non vedranno mai mi appare un pezzo di Torino che merita raccontare.

Circolo Arci No.à. (nonviolenza attiva) - Gioia e Rivoluzione - corso Regina Margherita 154 - Torino - infoarcinoa@gmail.com

Roberto Camarlinghi è giornalista di Animazione Sociale: rcamarlinghi@gruppoabele.org

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Psicotraumatologia

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Marinella Malacrea*

ESPERIENZE SFAVOREVOLI INFANTILI
LE PREMESSE TEORICHE

1. La violenza all'infanzia[1]

L'Organizzazione Mondiale della Sanità ha presentato a Bruxelles il 3 ottobre 2002 il Primo Rapporto Mondiale su Violenza e Salute, che ha dato avvio alla Campagna globale per la prevenzione della violenza. Il principio base di questa iniziativa, che si profila come innovativa e importante quanto la Convenzione ONU sui diritti del fanciullo, è che *la violenza è un primario problema di salute pubblica nel mondo intero e che bisogna fare congrui investimenti in ogni nazione per prevenirla e curarne le conseguenze.*

Almeno 4 dei 7 capitoli di cui si compone il Rapporto[2] (Abuso e trascuratezza nell'infanzia da parte di genitori e datori di cure, Violenza sessuale, Violenza giovanile, Violenza da parte di partner intimi) attestano la centralità del problema della violenza sui minori. I principali messaggi del Rapporto, a partire dalla già citata affermazione di base, attestano che:

- in aggiunta alla morte e alla disabilità, la violenza contribuisce a una varietà di altre conseguenze sulla salute (alcool, droga, fumo, disturbi alimentari e del sonno, HIV e malattie sessualmente trasmesse)
- la violenza è prevenibile, non è un problema sociale intrattabile o una parte inevitabile della condizione umana
- la violenza è il risultato dell'interazione di fattori individuali, familiari, comunitari e strutturali
- un approccio scientifico di salute pubblica basato sulla prevenzione può contribuire a ridurre la violenza.

Colpisce innanzitutto la novità culturale costituita dalla determinazione a "dare il giusto nome alle cose", riconoscendo, in accordo con l'attuale ricerca che lo conferma ad ogni livello (sociologico, medico, psicologico), l'esistenza per gran parte dell'umanità di condizioni gravemente turbative del benessere e dei processi di sviluppo, non dovute a fatalità, ma a processi di trauma e vittimizzazione, tanto più pericolosi quanto più l'insidia risiede nelle relazioni, come quelle familiari, naturalmente preposte a dare benessere.

Come rileva lo stesso Rapporto su Violenza e Salute, esiste un'incontestabile correlazione tra culture locali dei popoli e principi di allevamento e cura dei piccoli per quanto concerne ciò che è ritenuto lecito e corretto per gli adulti che esercitano tali funzioni, e le differenze in proposito nel mondo sono certamente rilevanti; eppure c'è generale accordo trasversalmente alle culture che comportamenti di abuso nei confronti dell'infanzia non devono essere tollerati ed esiste anche una sostanziale unanimità che di abuso si tratti almeno quando si parla di pratiche disciplinari dure e di abuso sessuale.

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* Neuropsichiatria infantile, psicoterapeuta, responsabile attività clinica Centro TIAMA, responsabile tecnico scientifico Progetto Equal TIAMA (IT-G2LOM-023).

[1] Si veda anche il sito www.centrotiama.it, sezione 'Perché TIAMA'.

[2] **RAPPORTO SU VIOLENZA E SALUTE** (WORLD HEALTH ORGANIZATION (2002) *World Report on Violence and Health*, Geneve, Switzerland)

- VIOLENZA GIOVANILE
- ABUSO E TRASCURATEZZA NELL'INFANZIA DA PARTE DI GENITORI E DATORI DI CURE
- VIOLENZA DA PARTE DI PARTNER INTIMI
- ABUSO DEGLI ANZIANI
- VIOLENZA SESSUALE
- VIOLENZA AUTODIRETTA
- VIOLENZA COLLETTIVA

Ricordiamo quindi la definizione ampia dell'Organizzazione Mondiale della Sanità, che nel 1999 dichiarava: *"Per maltrattamento all'infanzia (child abuse or maltreatment) si intendono tutte le forme di cattiva cura (ill-treatment) fisica e affettiva, di abusi sessuali, di trascuratezza o di trattamento trascurante, di sfruttamento commerciale o altre, che comportano un pregiudizio reale o potenziale per la salute del bambino, la sua sopravvivenza, il suo sviluppo o la sua dignità nel contesto di una relazione di responsabilità, di fiducia o di potere"*.

Si tratta di una definizione che ha il vantaggio di superare i problemi relativi sia alla intenzionalità o meno dei comportamenti commissivi od omissivi sia circa le cause o le conseguenze delle azioni e che, inoltre, non esclude forme di violenza che possono verificarsi in contesti anche extrafamiliari. E' tuttavia fuor di dubbio che la violenza e l'abuso assumono prevalentemente le caratteristiche di fenomeni intrafamiliari che come è noto restano spesso segreti e non visibili.

Con la consapevolezza che la violenza rappresenta un fenomeno composito e multiforme, le cui diverse manifestazioni non si presentano quasi mai separate o scindibili, analizziamone le principali forme: trascuratezza, maltrattamento fisico, maltrattamento psicologico e abuso sessuale.

Va posta inoltre attenzione all'emergenza di forme nuove di violenza quali la riduzione in schiavitù, la prostituzione, il coinvolgimento nella pornografia o la emarginazione derivante dalla immigrazione clandestina.

Per *trascuratezza* si intende la grave e/o persistente omissione di cure nei confronti del bambino o gli insuccessi in alcune importanti aree dell'allevamento che hanno come conseguenza un danno significativo per la salute o per lo sviluppo e/o un ritardo della crescita in assenza di cause organiche. L'estremo della trascuratezza è l'abbandono (morale e/o materiale).

Per *maltrattamento fisico*, si intende la presenza di un danno fisico dovuto ad aggressioni fisiche, maltrattamenti, punizioni corporali o gravi attentati all'integrità fisica e alla vita[3].

Per *maltrattamento psicologico*, si intende una relazione emotiva caratterizzata da ripetut**e** e continu**e** pressioni psicologiche, ricatti affettivi, indifferenza, rifiuto, denigrazione e svalutazioni che danneggiano o inibiscono lo sviluppo di competenze cognitivo-emotive fondamentali quali l'intelligenza, l'attenzione, la percezione, la memoria.

Per *abuso sessuale*, si intende il coinvolgimento di un minore in atti sessuali, con o senza contatto fisico, a cui non può liberamente consentire in ragione dell'età e della preminenza dell'abusante, lo sfruttamento sessuale di un bambino o adolescente, la prostituzione infantile e la pornografia.

Negli anni '90 un autore americano, Felitti[4], e il suo staff di ricerca, hanno opportunamente introdotto nel complesso dibattito su maltrattamenti e abusi nell'infanzia la nozione di *Esperienze Sfavorevoli Infantili* (ESI) per indicare quell'insieme di situazioni vissute nell'infanzia che incidono significativamente sui processi di attaccamento e che si possono definire come 'incidenti di percorso' negativi più o meno cronici rispetto all'ideale percorso evolutivo sia sul piano personale che relazionale. Esse comprendono tutte le forme di abuso all'infanzia subito in forma diretta, come abuso sessuale, maltrattamento psicologico, fisico, trascuratezza; e le condizioni subite in forma indiretta che rendono l'ambito familiare impredicibile e malsicuro, come per esempio alcolismo o tossicodipendenza dei genitori, malattie psichiatriche e soprattutto violenza assistita, cioè il coinvolgimento del minore, attivo e/o passivo, in atti di violenza compiuti su figure di riferimento per lui affettivamente significative.

Nella stessa linea si pone l'attenzione recentemente sviluppata dagli studiosi nei confronti dell'*abuso* e della *trascuratezza emozionale*, che sono definiti come modi di relazione pericolosi tra il datore di cura e il bambino, anche se non implicano contatto fisico. O'Hagan[5] (1995)

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[3] Vedi www.centrotiama.it, sezione 'Centro di documentazione', tabella UNICEF.

[4] Felitti V.J., Anda R.F., Nordernberg D., Williamson D.F., Spitz A.M., Edwards V., Koss M.P., Marks J.S. (2001) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. In: Franey K., Geffner R., Falconer R. (Eds) *The cost of child maltreatment: who pays? We all do*, S.Diego, CA: Family Violence and Sexual Assault Institute.

[5] O'HAGAN, K.P. (1995) Emotional and psychological abuse: problems of definition, *Child Abuse and Neglect*, 19, 4, 449-461.

distingue opportunamente tra l'abuso emozionale e il maltrattamento psicologico: se il primo, infatti comporta da parte dell'adulto una reazione emozionale stabile, ripetitiva e inappropriata all'esperienza del bambino, il secondo, nella sua forma di denigrazione verbale, critiche e svalutazioni, si configura più come risposta comportamentale e attiva. L'intenzione di nuocere al bambino è irrilevante nella definizione. Si tratta di forme di mal-trattamento che non comportano interazioni segrete, e sono quindi facilmente oggetto di osservazione; nonostante la loro diffusione e frequenza, l'abuso e la trascuratezza emozionale sono forme spesso misconosciute e sottovalutate di abuso all'infanzia. Il maggiore problema nasce dal fatto che abuso e trascuratezza emozionale avvengono, in misura gravemente dannosa per il bambino, anche se i datori di cura (quasi sempre i genitori) non sono consapevoli della pericolosità del loro comportamento. Un altro problema è costituito dal fatto che non esiste, nel campo dell'abuso emozionale, una netta soglia tra ciò che è abuso e ciò che non lo è, a differenza da altre forme di abuso all'infanzia (pensiamo al maltrattamento fisico, o all'abuso sessuale). In questi casi esiste una sorta di continuum, all'interno della relazione genitori-figli, dal "buono" al "maladattivo" al dannoso al punto da meritare la definizione di "abuso". Per contro, studi mirati alla rilevazione del pensiero comune sia nei professionisti della legge o del sociale sia nella gente comune, all'interno di una condivisa appartenenza culturale, ha dimostrato sorprendentemente che c'è alta convergenza di pareri circa quali comportamenti o quali espressioni verbali costituiscano abuso emozionale.

Glaser[6] (2002) propone di passare da definizioni che individuano specifici comportamenti dei genitori con i figli a definizioni che implicano atteggiamenti più trasversali all'intera relazione genitori-figli. L'autrice individua le seguenti aree di rischio: indisponibilità, trascuratezza, non responsività emozionale; qualificazioni negative e mistificanti del bambino; interazioni con il bambino inappropriate o incongrue rispetto alla fase evolutiva; mancato riconoscimento e mancata consapevolezza dell'individualità del bambino e dei confini psicologici; mancata promozione dell'adattamento sociale del bambino.

. L'abuso emozionale è, abbastanza comprensibilmente, quasi una costante nei casi di maltrattamento e di trascuratezza fisica; alcuni autori hanno stimato al 90% la sua compresenza nelle altre forme di abuso (Claussen, Crittenden, 1991[7]). Il dato che più preoccupa è relativo al fatto che proprio la compresenza di tale componente è predittiva dei successivi danni evolutivi che il bambino maltrattato manifesterà, ben più della gravità del mal-trattamento subìto.

2. L'esperienza traumatica

Un'attenzione globale a tutte le forme di Esperienze Sfavorevoli Infantili è anche, e soprattutto, in linea con il più moderno sviluppo delle conoscenze sul complesso delle situazioni di cattiva cura nei confronti dei bambini e sulla patogenesi delle conseguenze dannose ad esse correlate.

Ciò che le accomuna, e rende anche così poco differenziabili le loro conseguenze in termini di sintomi e comportamenti, è il fatto che producendo un danno importante nei processi di attaccamento deformano traumaticamente l'assetto della personalità, con riflessi tangibili anche a livello organico.

Gli studi neurobiologici sullo sviluppo mentale infantile dicono con sicurezza che l'esperienza dà direttamente forma alle strutture cerebrali e che (al contrario di quanto si è per lungo tempo creduto) il cibo esperienziale per la mente non è la intensa stimolazione sensoria, ma l'esistenza di legami in cui, nella comunicazione collaborativa, si sviluppi la sintonizzazione tra la mente del bambino e quella del genitore (Siegel, 1999[8]; Siegel, in press[9]) e la mente impari le basi e i metodi

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[6] GLASER, D. (2002) Emotional abuse and neglect (psychological maltreatment): a conceptual framework, *Child Abuse and Neglect*, 26, 697-714.

[7] CLAUSSEN, A., CRITTENDEN, P. (1991) Physical and psychological maltreatment: relations among types of maltreatment, *Child Abuse and Neglect*, 15, 5-18.

[8] SIEGEL, D.J. (1999) The Developing Mind. Tr. It. La mente relazionale, Raffaello Cortina, Milano, 2001.

[9] SIEGEL, D.J. (in press) An interpersonal neurobiology of psychotherapy: the developing mind and the resolution of trauma.

dell'auto promozione e dell'auto organizzazione. Se proprio i legami sono invece fonte di esperienze negative e traumatiche, ne risulta una inadeguatezza del processo di sviluppo del bambino che può trovare espressione in tutte le aree di funzionamento cognitivo ed emotivo.

Perry (Perry et al[10], 1995) sottolinea la possibilità, soprattutto nei bambini piccoli, che i circuiti neuroendocrini attivati dal trauma divengano permanenti, alterando la plasticità cerebrale e condizionando la personalità del futuro adulto. Bremner[11] in un articolo recente (2003) riprende e dettaglia lo stesso concetto: lo stress in età precoce è associato con alterazione duratura nei circuiti cerebrali e nel sistema che media la risposta allo stress (asse ipotalamo-ipofisi-corticosurrenale sistema nor-adrenergico). Anche altri sistemi cerebrali di fondamentale importanza per gli esiti comportamentali vengono alterati, come i sistemi delle benzodiazepine, degli oppioidi endogeni, della dopamina e dei neuropeptidi, con ricadute sul funzionamento dell'ippocampo, dell'amigdala, della corteccia prefrontale. Proprio queste permanenti alterazioni starebbero alla base del mantenimento delle reazioni post traumatiche, che si manifestano come PTSD, depressione e altre psicopatologie.

Il problema che subito si pone è quello di definire in qualche modo che cosa si intenda per esperienza traumatica. Alcune precisazioni interessanti a questo proposito sono fornite da L. Terr[12] (1991), che definisce il trauma come il risultato mentale di un "colpo" o una serie di "colpi" improvvisi che destabilizzano temporaneamente il giovane, e che fanno fallire le ordinarie strategie con cui si affrontano gli eventi esterni e le operazioni difensive. Questo concetto non include solo quelle condizioni segnate da un'intensa reazione di sorpresa, ma anche quelle caratterizzate da una precedente previsione. Tutti i traumi infantili, che derivano ovviamente dall'esterno e non possono nascere esclusivamente nel pensiero del bambino, causano una serie di cambiamenti nelle modalità di funzionamento psicologico. L'autrice suddivide due tipologie di trauma con diverse caratteristiche: quello di primo tipo, che è la conseguenza di un evento unico e improvviso, e quello di secondo tipo, che invece deriva da un abuso prolungato e ripetuto. Mentre nei traumi di primo tipo c'è la tendenza a ritornare sul ricordo, di solito completo, dettagliato e ben impresso, per tentare un rimaneggiamento retrospettivo e una rivalutazione cognitiva, nei traumi di secondo tipo più facilmente la vittima ricorre al diniego e alla paralisi psicologica. Analoghe riflessioni emergono dal lavoro di Glaser (2000), che distingue invece tra trauma acuto (overwhelming experience) e stress cronico.

Si può affermare che mentre nel trauma acuto il soggetto si comporta nei confronti dell'esperienza traumatica come nei confronti di un corpo estraneo da espellere attraverso l'equivalente di una florida reazione infiammatoria, nel trauma o stress cronico ciò non avviene. Questa differenza è tanto più evidente quanto più è precoce l'esperienza sfavorevole. Infatti molte situazioni di abuso e trascuratezza, benché sicuramente produttrici di uno stato emozionale gravemente negativo, non vengono percepite dal bambino come sopraffacenti nel modo delle tipiche esperienze traumatiche. Ciò accade spesso proprio a causa della cronicità della vittimizzazione infantile, che rende l'esperienza paradossalmente predicibile e quindi perversamente funzionale alla continuità del sé, che, come è noto, è una componente fondamentale dello stato di benessere psichico. Ma l'assenza dello sconvolgimento acuto non ha alcuna valenza protettiva, anzi apre la strada a un effetto pervasivo a carico dei processi di regolazione psicologici e biologici presenti nel bambino, dando luogo a reazioni più complesse e ancor più nefaste del disturbo da stress post traumatico. Si parla in questi casi di "trauma interno all'identità" opposto al "trauma esterno all'identità" che caratterizza le situazioni di trauma acuto.

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[10] Perry B., Pollard R., Blakley T., Baker W., Vigilante D. (1995) Childhood trauma, the neurobiology of adaptation and "use-dependent" development of the brain: how "states" become "traits", *Infant Mental Health Journal*, 16, 271-291.

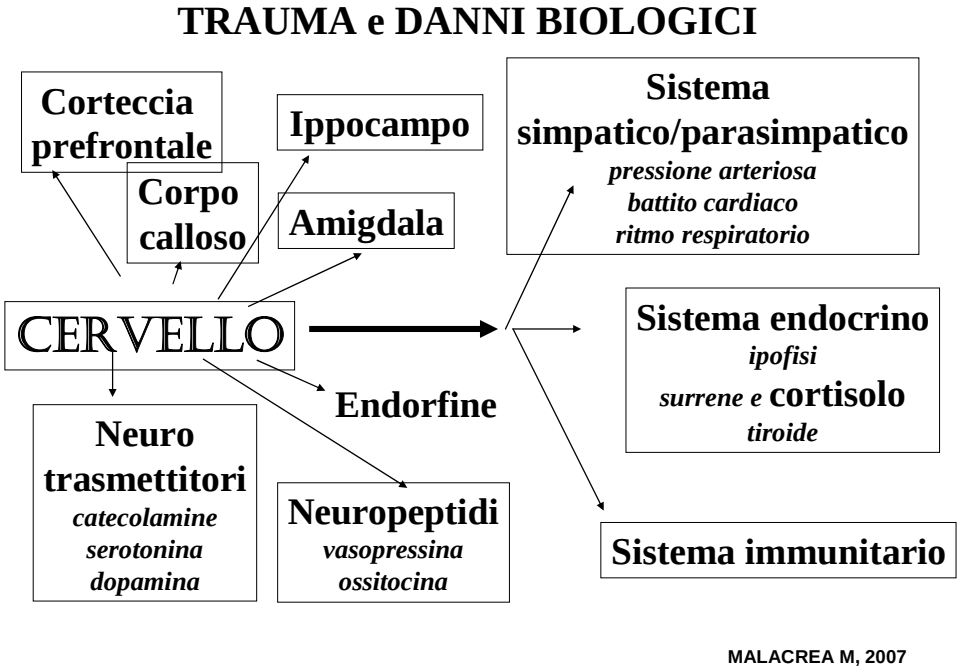
[11] Bremner J.D. (2003) Long-term effects of childhood abuse on brain and neurobiology, *Child and Adolescent Psychiatric Clinic of North America*, 12 (2), 271-292.

[12] TERR, L. (1991), "Childhood traumas: an outline and overview". In *American Journal of Psychiatry*, 148, pp. 10-20.

3. La biologia della risposta al trauma

Vale la pena di fare un accenno a questo tema (Glaser, 2000, Malacrea, 2004[13]), accenno forzatamente breve e superficiale.

3.1. Le esperienze negative - stress - in ragione della loro intensità e durata producono *effetti somatici registrabili*, a partire da una sostanziale e automatica modificazione degli equilibri fisiologici, con ricaduta sull'asse ipotalamo-pituitario-surrenalico, sul sistema nervoso autonomo (simpatico/parasimpatico), sul complesso dei neurotrasmettitori e sul sistema immunitario.



In particolare si producono importanti conseguenze a livello cerebrale:

3.1.1 Vengono sollecitati il sistema delle catecolamine (adrenalina e noradrenalina, dopamina) e della serotonina, centrali nella reazione 'fight or flight'. Se ripetuta, tale sollecitazione provoca un danno nel funzionamento della corteccia prefrontale, sede della memoria operativa, della concentrazione, dell'efficienza comportamentale sul versante cognitivo. Provoca anche una disregolazione del sistema attivazione/inibizione delle risposte comportamentali affettive. A causa della tossicità dovuta all'accumulo di catecolamine, la persistenza delle situazioni di stress provoca a lungo termine una diminuzione del volume cerebrale, di aree del corpo calloso (fondamentale connessione tra gli emisferi), con espansione dei ventricoli cerebrali.

3.1.2 Per diminuire l'esposizione all'iperattivazione di quei neurotrasmettitori, soprattutto quando alla loro presenza non può far seguito alcuna utile reazione di fuga dal pericolo o di attacco e neutralizzazione dell'agente traumatico (impotenza intrinseca delle situazioni di stress cronico), vengono messi in campo sistemi compensatori. Essi sono essenzialmente di due tipi:

a) prevale l'attivazione del sistema dopaminergico e poiché i recettori della dopamina coincidono in diverse aree cerebrali con quelli degli oppioidi, vengono sollecitati il

[13] Malacrea M. (2004) La terapia nell'abuso all'infanzia: le ragioni teoriche dell'evidenza clinica, *Connessioni*, anno VIII, n.14, 81-100.

nervo vago e il sistema parasimpatico, che agiscono sulla percezione dello stimolo traumatico. Attraverso la produzione paradossa di endorfine (solitamente attivate da esperienze di conforto, ma qui attivate paradossalmente in presenza di disagio e pericolo) si ottiene uno "spegnimento" della reazione 'fight or flight', con importanti conseguenze sul piano fisico ("congelamento", diminuzione del ritmo cardiaco) e mentale (dissociazione).

b) viene attivata l'iperproduzione di cortisolo e glucocortisolo, riconosciuto come l'"ormone dello stress", in quanto media il coping nelle situazioni traumatiche. Esso agisce deprimendo la reazione allo stress, provocando adattamento allo stesso. Nei casi in cui la situazione è dominabile tale reazione è temporanea fino alla risoluzione dell'esperienza negativa, ma nei casi cronici, in cui la fonte del disagio è forte e incontrollabile, avviene una pericolosa disregolazione della produzione di cortisolo, sia con sopraelevazione costante dei valori di base sia con lo slivellamento in basso degli stessi.

3.1.3 I sistemi compensatori, che sono facilmente connettibili a difese psichiche, sono anch'essi pericolosi, se eccessivi in quantità e durata: il primo perchè impedisce la reazione all'evento traumatico e quindi di sottrarsi ad esso, ma ancor più per il suo carattere massivo, che comporta da un lato grande dispiego di energie psichiche per ottenere il disimpegno dalla realtà e dall'altro inaccessibilità ai fattori relazionali di conforto; il secondo perchè, essendo l'eccesso di cortisolo tossico per i neuroni, provoca danni a vari livelli cerebrali, sia diminuendo globalmente il volume del cervello - sinergicamente alle catecolamine - sia rendendo inefficienti particolari aree come l'ippocampo, sede in cui vengono integrati i differenti aspetti della memoria. E' altresì evidente che i due sistemi di spegnimento competono l'uno con l'altro e non configurano scelte definitive ma due stati pronti a virare dando luogo automaticamente all'altro.

3.1.4 Lo stress cronico modifica in modo permanente la regolazione del sistema soglia - spegnimento - riattivabilità, dove 'soglia' concerne la quantità di stimolo necessaria a produrre una risposta da stress, 'spegnimento' riguarda la capacità del soggetto di estinguere la reazione, 'riattivabilità' rappresenta l'attitudine a tornare in stato di eccitazione dopo lo spegnimento anche in assenza di congruo stimolo. Per fare alcuni esempi, il soggetto che resta abitualmente in stato di allarme, a causa di esperienze traumatiche pregresse, potrà sviluppare nel tempo una sempre maggiore fragilità di fronte agli stimoli ambientali (abbassamento della soglia della reazione da stress) con conseguente instabilità psicofisica e incremento delle occasioni di riattivazione traumatica (aumento della riattivabilità). Al contrario, potrà anche avvenire che la cronicità degli eventi stressanti induca nel soggetto una depressione della reazione, che porta al misconoscimento della situazione minacciosa (innalzamento della soglia) con tardività delle reazioni di compenso; anche questo insieme può essere facilitato dalla ripetizione di situazioni simili, con diminuzione della possibilità di scegliere meccanismi di reazione diversi (aumento della riattivabilità). E' evidente che ogni distorsione, in più o in meno, del fisiologico sistema soglia - spegnimento - riattivabilità è dannoso.

3.1.5 Lo stress cronico attiva in modo permanente alcune aree cerebrali e ne disattiva altre. Ad esempio è stata dimostrata una maggiore sollecitazione del lobo frontale destro, specializzato per l'espressione di sentimenti negativi, di tristezza, a scapito del lobo frontale sinistro, connesso a emozioni positive, come la gioia; viene ipersollecitata l'amigdala, sede in cui viene percepita la paura; viene disattivato l'ippocampo, sede dell'integrazione dei ricordi.

3.2 *Sul piano psicologico* il riflesso di quanto sopra è costituito da modelli operativi interiorizzati (MOI) caratteristici e riconoscibili.

Ciò è vero sia sul piano del sistema di significati che determina il comportamento del soggetto traumatizzato, sia sul piano delle condotte relazionali, sia sul piano delle strategie difensive. Tipicamente chi è stato vittima di esperienze traumatiche, specie se croniche, ha interiorizzato una 'filosofia' basata sull'assunto di un "mondo malevolo", opposta quindi alla "fiducia di base" e orientata alla messa in atto di 'profezie che si autodeterminano' nelle relazioni significative, quanto più comportano intimità e dipendenza. Sentirsi impotenti e traditi dai più prossimi, induce un iperallarme che genera diffidenza e propensione a strumentalizzare, da un lato: con ovvie conseguenze di espulsione da parte della maggioranza degli altri; d'altro canto, la moltiplicazione delle esperienze negative conseguenti a quei comportamenti, porta il soggetto a ipotizzare una più o meno oscura colpa originaria, che se, da un certo punto di vista, dà qualche senso al proprio destino infausto, è fonte di un profondo e corrosivo malessere e di distonia con l'autoimmagine (il ‘sé come bene danneggiato/svalutato’). La 'cattiva stella' delle vittime di esperienze traumatiche comporta dunque che la distorsione dei modelli operativi interiorizzati le renda candidate ideali al ripetersi senza fine di altre, e congruenti, esperienze traumatiche (abbandono, tradimento, espulsione, aggressione e quant'altro) che perpetuano un quadro di 'deserto affettivo', se non di 'giungla affettiva', rinforzando a spirale per il soggetto la credibilità e l'impermeabilità proprio dei MOI distorti e funesti.

3.3 In tutti questi aspetti, si evidenzia che la *reazione al trauma* è pericolosa quanto il trauma stesso, non soltanto per la sua qualità, come vedremo poco oltre, ma per il fatto che essa scatta istantanea, automatica, ripetitiva, cortocircuitando la possibilità della mente di far fronte allo stimolo traumatico in modo non disfunzionale e condizionando le espressioni relazionali della vittima.

D'altro canto per convivere con l’idea di un "mondo malevolo", reso certo dai modelli operativi interiorizzati sopra descritti, e continua fonte di ripetitive esperienze traumatiche, è inevitabile l'adozione di movimenti difensivi. Sappiamo che anche tali movimenti difensivi sono, nelle vittime, caratteristici e riconoscibili: di più, privi di alternative sul piano neuropsicologico. Quanto già descritto in termini di mediatori chimici nel punto 1), si esprime, psicologicamente parlando, attraverso comportamenti improntati all'ipereccitazione (hyperarousal) o all'iperadattamento o al congelamento dissociativo:

3.3.1 Il primo può essere descritto come uno stato di allarme permanente, di attivazione e instabilità psichica continua, che non trova scarico in comportamenti utili e finalizzati di attacco o fuga, a cui fisiologicamente dovrebbe corrispondere: pensiamo all'immagine di un cavo elettrico scoperto, pronto a dare indifferenziatamente la scossa a chi si avvicini, con un alto grado di imprevedibilità. Spesso lo scarico è su se stessi, capace di produrre sintomi fisici e psichici, fissati o alternanti. In ogni caso gravemente deficitaria è la regolazione delle emozioni e dei comportamenti, i sistemi di autocontrollo sono permanentemente a rischio di scompenso. La sensibilizzazione del sistema noradrenergico condiziona la stimolazione di funzioni psicologiche, cognitive, comportamentali mediate dallo stesso sistema, e spiega la natura dei sintomi di questi bambini traumatizzati: iperattività, ansia, comportamento impulsivo, disturbi del sonno ecc. Questo tipo di risposta è più comunemente visto nei maschi adulti e nei bambini più grandi.

3.3.2 L’iperadattamento si basa sull'ipersecrezione di cortisolo, che abbassa la reazione allo stimolo stressante. Ne possono derivare apparenti equilibri, con serie conseguenze di depressione delle risorse cerebrali preziose per la crescita. I bambini sottoposti a gravi esperienze di deprivazione mantengono il livello di base del cortisolo elevato: si vedano ad esempio gli studi compiuti sui bambini ospiti dei brefotrofi della Romania, citati in Glaser, 2000. Questo stato è significativamente connesso a una aumentata vulnerabilità allo stress: paradossalmente, i soggetti iperadattati non hanno consolidato i propri sistemi omeostatici di fronte alle difficoltà della vita, ma sono sempre sull’orlo della sopraffazione degli stessi.

Hart et al.[14] (1995), studiando le reazioni dei bambini maltrattati ai conflitti in ambiente scolastico, hanno rilevato che, quando intervengano circostanze di stress momentaneo, questi soggetti sopprimono la secrezione del cortisolo. Resnik et al. (1995), studiando le donne vittime di stupro, hanno constatato che quelle portatrici di pregresse esperienze traumatiche avevano un livello di cortisolo basso dopo l'evento, al contrario di quelle non traumatizzate nell'infanzia, che avevano l'atteso aumento della secrezione di cortisolo. Se ne deduce che specie nei soggetti già sensibilizzati da precedenti esperienze traumatiche anche piccoli fattori aggiuntivi di stress possano travolgere la capacità di affrontarlo e indurre reazioni di 'spegnimento' massive, con soppressione anomala della secrezione del cortisolo. A quel punto accade il viraggio all'altro sistema di 'spegnimento' dell'attivazione post traumatica, mediato dal disimpegno psicologico dalla realtà attraverso difese di tipo dissociativo.

3.3.3 La terza via difensiva, quella che cortocircuita la percezione dell'evento stressante (attraverso la produzione paradossa di endorfine), impedendo allo stimolo di attivare qualsiasi risposta, si manifesta in varie forme, solo apparentemente contraddittorie. I bambini piccoli e le femmine, e più in generale quanto più impotente si sente l'individuo, più frequentemente attivano, con una iperreattività che porta fino alla sensibilizzazione, la risposta di "congelamento" fisico e di dissociazione mentale. Si ha quindi un aumento del tono vagale, con i correlati fisiologici che ne seguono (diminuzione della frequenza cardiaca, della pressione ecc.) e, in virtù della produzione paradossa di oppioidi, una alterazione della percezione del dolore, del senso del tempo, dello spazio, della realtà. È interessante che Perry utilizzi proprio la diminuzione della frequenza cardiaca come metodo non invasivo per misurare la dissociazione.

I bambini traumatizzati usano spesso meccanismi di congelamento come risposta all'angoscia. Quando il bambino sperimenta una situazione-stimolo connessa al trauma (connessione di cui egli spesso non è consapevole), si sente profondamente angosciato, e si immobilizza cognitivamente e spesso anche fisicamente. Quando l'adulto gli chiede qualcosa, si comporta come se non avesse sentito, o si rifiuta di aderire alla richiesta. Ciò solitamente attiva altre richieste da parte dell'adulto, spesso accompagnate da ostilità e minacce di punizioni. Queste caratteristiche verbali e non verbali della minaccia fanno sentire il bambino ancora più insicuro e impotente; l'ansia conseguente potrà attivare una più profonda dissociazione. Tutto questo processo spesso non è correttamente interpretato e ciò porta a errori diagnostici, per cui questi bambini sono etichettati come oppositivi e provocatori (cioè con disturbi della condotta). In altri casi la reazione di congelamento può essere male interpretata come assenza di sofferenza psicologica, o come indice di buon adattamento.

3.3.4 Ancora più interessante è notare che, al di là delle apparenze, non c'è sostanziale differenza tra i soggetti che mettono in atto comportamenti di estraniazione, di evitamento marcato, di dissociazione dei ricordi, dei pensieri, degli affetti, e persino delle funzioni fisiche (pensiamo a varie forme di scarico somatico fino a certi arresti della crescita verificatisi in circostanze di trauma nell'infanzia), mostrandosi congelati, e i soggetti che raggiungono lo stesso obiettivo di 'decerebrazione', di anestesia, di non pensiero ricorrendo a una iperattività non finalizzata od ostile. La verifica sul livello di cortisolo corrispondente a questi diversi comportamenti ci è di suggestivo aiuto, in quanto, come sopra detto, l'eccessiva soppressione dell'"ormone dello stress" in circostanze di per sé stressanti ci informa sul fatto che al tentativo di adattamento si è sostituita la fuga dalla realtà; e abbiamo dati certi che al basso livello di cortisolo corrisponde spesso un atteggiamento ritirato e distante, ma anche le esplosioni di aggressività si accompagnano alla stessa soppressione. Ciò accade ad esempio in molte situazioni che possono simulare il disturbo

[14] Hart J, Gunnar M, Cicchetti C (1995) Salivary cortisol in maltreated children. Evidence of relations between neuroendocrine activity and social competence, *Development and Psychopathology*, 7, 11-26.

da deficit attentivo (ADHD), ma anche nei casi in cui sembra persa la competenza sociale e il soggetto agisce aggressivamente in modo antisociale e oppositivo (Hart et al.,1995; McBurnett et al., 2000[15]). E' del resto ben comprensibile che il disimpegno mentale abbia un costo altissimo in termini di sensibilità agli altri, di sviluppo di intelligenza emotiva e di capacità di sintonizzazione con l'ambiente relazionale. Questo meccanismo difensivo non soltanto espone il soggetto all'esperienza traumatica senza resistenza, ma distoglie energie preziose dai loro fisiologici scopi.

3.3.5 Ancora più funesti appaiono poi tutti questi sistemi di difesa quando, come spesso avviene, si alternano nello stesso soggetto come in un vortice, rendendo il suo funzionamento incomprensibile e imprevedibile per chi deve prendersene cura e per il soggetto stesso, che non può che ricavarne una più acuta autosvalutazione. L'immagine di un'auto con acceleratore schiacciato a tavoletta (l'ipereccitazione), con il freno a mano contemporaneamente al massimo (l'iperadattamento) e magari con guidatore svenuto (dissociazione e scompenso della regolazione), può rendere abbastanza realisticamente l'idea dell'effetto dei meccanismi difensivi post traumatici. È importante notare che questo complesso intreccio di reazioni è evidente anche nei bambini, che contrariamente a quanto comunemente si crede, quanto più sono piccoli, tanto più sono sensibili al trauma: negli studi di Perry (Perry et al, 1995) la maggior parte di bambini traumatizzati con PTSD (Post-Traumatic Stress Disorder) mostrano un misto di risposte dissociative e di ipereccitazione.

3.4. Il funzionamento psicologico post traumatico è *riattivabile*. La sovrastimolazione, come avviene nel trauma, di importanti circuiti neuronali durante lo sviluppo, porta alla sensibilizzazione di alcuni di questi, che saranno attivati non solo dal trauma, ma anche da ricordi specifici, sotto varia forma, del trauma stesso. La reattività poi potrà generalizzarsi, sicché il sistema di risposta al trauma del cervello infantile sarà attivato in continuazione anche quando il pericolo non sarà effettivamente presente. Ciò avviene non soltanto a riguardo di esperienze o memorie in qualche modo affini a quelle precedenti negative, ma anche in circostanze che per altri soggetti non vittime non evocherebbero reazioni da stress, mentre nella vittima inducono allarme. E' noto come immagini, sensazioni, eventi non rievocativi della precedente esperienza traumatica e non nuovamente traumatici in sé, possano scatenare reazioni intense di malessere, con tutto il corteo difensivo descritto nel punto precedente. In particolare, persino esperienze in sé positive, ma che comportano intimità e intensità dei legami, e cioè circostanze in cui il soggetto traumatizzato sente aumentare la propria vulnerabilità, possono diventare non raramente riattivatori traumatici. Infatti, ciò è il riflesso comportamentale di quella distorsione del sistema soglia - spegnimento - riattivabilità descritto più sopra.

La riattivabilità del funzionamento post traumatico appare in tutta la sua gravità se aggiungiamo anche che esso neurofisiologicamente cortocircuita la corteccia frontale, e quindi l'elaborazione superiore, verbale, propria di questa sede. Suggestivi studi sperimentali comprovano che l'evocazione di vividi ricordi post traumatici taglia fuori l'attivazione dell'area di Broca dell'emisfero sinistro, connessa al linguaggio e quindi ai processi di simbolizzazione.

Se ne deduce che la possibilità di modificare il sistema soglia - spegnimento - riattivabilità è assai ridotta se vengono inabilitate proprio le funzioni superiori che sarebbero in grado di modularlo.

4. Le conseguenze patologiche

4.1 Ciò che accomuna le diverse situazioni sopra descritte è la loro capacità di produrre una *vasta gamma di esiti patologici*. Il fatto che la maggior parte delle ESI abbia come teatro la famiglia ha come corollario spesso la loro cronicità e quindi una maggiore possibilità di produrre

[15] McBurnett K, Lahey B, Rathouz P, Loeber R (2000) Low salivary cortisol and persistent aggression in boys referred for disruptive behavior, *Archives of General Psychiatry*, 57(1), 38-43.

in coloro che ne sono vittime gravi e invalidanti conseguenze sul piano fisico e psicologico Si tratta di esperienze spesso capaci di superare le naturali risorse di "resilienza" e adattamento dei soggetti, tanto più se ancora in formazione, e di dar luogo a importanti sofferenze che si trascinano nel tempo dando luogo a patologie che si manifestano dopo mesi, anni o nell'età adulta. Va inoltre tenuto conto che quegli adulti, diventati genitori, corrono un alto rischio di trasmissione intergenerazionale delle condotte maltrattanti/abusanti..

Le statistiche dimostrano che il 50% delle giovani tossicodipendenti e a condotta socialmente deviante e un terzo delle pazienti psichiatriche ambulatoriali è un ex-vittima di abuso sessuale non trattata (Gelinas,1983[16]; Malacrea, Lorenzini, 2002[17]). Possiamo da qui facilmente inferire quanto peso specifico sulla patologia adulta possa essere attribuito al complesso di tutte le forme di abuso nell'infanzia, e ancor più al complesso delle Esperienze Sfavorevoli Infantili, che magari non si sono concretizzate in maltrattamenti attivi e puntualmente riconoscibili, ma hanno dato luogo a un 'mal-trattamento' diffuso, attraversato spesso da tutti quei fattori più sopra individuati da Glaser per l'abuso emozionale. Si tratta di gruppi di popolazione certo molto più estesi delle sole vittime di abuso sessuale.

L'AACAP (American Academy of Child and Adolescent Psychiatry) propone uno schema dei sintomi e dei comportamenti che possono presentarsi nei bambini abusati (significativamente correlabili alle reazioni post traumatiche di hyperarousal, depressione, dissociazione), individuando le seguenti categorie:

- *sintomi da angoscia*, come paura, fobie, insonnia, incubi, problemi somatici (come enuresi, encopresi, prurito vaginale o anale, anoressia, obesità, cefalea, mal di stomaco), PTSD;
- *reazioni dissociative* e sintomi isterici, come periodi di amnesia, sogno ad occhi aperti, stati simili alla trance, attacchi isterici, disturbo da personalità multipla;
- *depressione*, manifestata sotto forma di bassa autostima, condotte suicidarie, automutilazioni;
- *disturbi del comportamento sessuale* (sia da 'preoccupation' sia da 'distress').

Rispetto invece alla fase temporale di comparsa, le conseguenze dell'abuso sono suddivise da Violato[18] (1994, ma anche da Malacrea e Vassalli, 1990[19]) in tre sottotipi: effetti iniziali (quelli che si manifestano entro i due anni dalla fine dell'abuso), effetti che si prolungano a medio termine, infine gli effetti a lungo termine (quelli che si manifestano dopo più di due anni dalla fine dell'abuso e non sono necessariamente presenti fin dall'inizio).

4.2 Ma vediamo più nel dettaglio le *conseguenze sintomatiche* delle esperienze sfavorevoli infantili.

Innanzitutto l'abuso può portare all'*aggravamento di comportamenti* che, se non sono preoccupanti in se stessi poiché si verificano nella maggior parte dei bambini, lo diventano se si presentano molto frequentemente. Pensiamo, a questo proposito, a difficoltà di addormentamento, fobie e paure, comportamenti regressivi (enuresi, ecc.), richiesta maggiore di attenzione, difficoltà scolastiche (Wells, McCann, et al., 1995[20] ; Hibbard e Hartman, 1992[21]).

In base alle ricerche più recenti, la *depressione* risulta essere il disturbo con maggiore incidenza tra i bambini e gli adolescenti che hanno subito esperienze sfavorevoli infantili (Chapman et al.,

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[16] GELINAS, D. (1983), "The persisting negative effects of incest". In *Psychiatry*, 46, pp. 312-332.
[17] Malacrea M., Lorenzini S. (2002) *Bambini abusati. Linee guida nel dibattito internazionale*, Raffaello Cortina, Milano.
[18] VIOLATO, C. (1994), "The effects of childhood sexual abuse and developmental psychopathology". In *Canadian Journal of Behavioral Science*, 23, pp. 282-299.
[19] MALACREA, M., VASSALLI, A. (1990) (a cura di), *Segreti di famiglia*. Raffaello Cortina, Milano.
[20] WELLS, R., MCCANN, J., ADAMS, J., VORIS, J., ENSIGN, J. (1995), "Emotional, behavioral, end physical symptoms reported by parents of sexually abused, nonabused, and allegedly abused prepubescent female". In *Child Abuse and Neglect*, 19(2), pp. 155-163.
[21] HIBBARD, R., HARTMAN, G. (1992), "Behavioral problems in alleged sexual abuse victims". In *Child Abuse and Neglect*, 4(1), pp. 223-230.

2004[22]). Può accadere che questo stato depressivo esiti in un suicidio o in un tentativo di suicidio: è stata riscontrata una frequenza di tentati suicidi 13 volte superiore alla frequenza relativa alla popolazione di pari età (il 32% degli abusati ha tentato il suicidio) e una frequenza ancora maggiore di pensiero suicidarlo (il 43% degli abusati). La tendenza suicidaria può poi comparire in forme più coperte: per esempio, le ricerche riguardo alla tossicodipendenza hanno rilevato che, nella popolazione di donne che hanno corso il pericolo di morire di overdose, il 72% ha riferito di aver subito una qualche forma di abuso sessuale.

L*'ansia* costituisce un altro dei principali sintomi appartenenti al gruppo delle disfunzioni emotive. Può prendere la forma di uno stato di *ipervigilanza* verso i pericoli nell'ambiente non sempre oggettivamente giustificato.

L'ansia può essere trasposta nell'eccessiva preoccupazione per il corpo. Spesso ci si riferisce a questi problemi con i termini psicosomatico o *somatizzazione*, che suggeriscono l'intreccio tra il disagio psicologico e la salute fisica. I problemi che sono più spesso associati agli episodi di abuso sono: cefalea, mal di stomaco, nausea, disturbi del sonno, anoressia, asma; ma molti altri sintomi di malessere fisico compaiono in questi casi e non trovano spiegazioni fisiologiche (Briere, 1992[23]). In un campione di quasi 5900 adolescenti e adulti Sachs-Ericsson et al. (2005) hanno rilevato la presenza di problemi di salute nell'anno precedente l'indagine. Nei soggetti che erano stati vittime di abuso fisico o sessuale o grave trascuratezza nell'infanzia è emersa una correlazione con i problemi di salute. Il fattore di mediazione tra l'esperienza infantile e il ripetuto accesso a prestazioni mediche era costituito dall'attribuzione a malattia fisica dei sintomi somatici conseguenti al funzionamento postraumatico. Tuttavia non è soltanto la 'lettura' che il paziente tende a dare dei suoi disturbi somatici a provocare una morbilità aumentata, a questo punto per lo più priva di base organica. Le complesse alterazioni post traumatiche del funzionamento cerebrale e, di conseguenza, di tutto l'albero di trasmissione dal cervello agli organi, possono ben rendere ragione di effettivi malfunzionamenti con base organica. Ben documentate, ad esempio, sono le disfunzioni tiroidee.

Anche la *dissociazione* è una delle possibili risposte al trauma. Si tratta di un meccanismo difensivo particolarmente funzionale in concomitanza con l'abuso. Consente di risolvere conflitti inconciliabili, di sfuggire dalle costrizioni della realtà, di isolarsi da esperienze catastrofiche, proteggendo il sé, di sfuggire al dolore, anche fisico, grazie all'effetto analgesico. Tuttavia quando diventa un meccanismo automatico si innesta la patologia, provocando una frattura nel senso dell'identità e della continuità della memoria e dell'integrazione del sé. I disturbi psicopatologici che ne derivano possono essere collocati in uno spettro che va dall'amnesia psicogena a stati di fuga e di depersonalizzazione fino alla grave sindrome da personalità multipla (Ross, 1985). *Il singolo sintomo che maggiormente definisce il disturbo dissociativo è la presenza di stati di simil trance*, in cui il bambino è assente, spesso a occhi sbarrati, e non sembra in contatto con l'ambiente

4.3 Già nel suo testo del 1992, Judith Herman[24] insisteva per la necessità di una nuova concettualizzazione delle conseguenze dei traumi non circoscritti (come quelli per cui si è definita la PTSD) ma ripetuti e prolungati, capaci perciò di provocare profonde deformazioni della personalità e grande vulnerabilità alla ripetizione di eventi simili. Propone quindi la definizione di *"disturbo post-traumatico da stress complesso"* per indicare il limite estremo di gravità di una vasta gamma di esiti, che vanno da quello fuggevole e non bisognoso di cura a quello derivante appunto da eventi traumatici ripetuti e prolungati.

Per la precisione e la completezza del quadro diagnostico che disegna e quindi per il prezioso contributo che fornisce a riguardo della comprensione dei soggetti vittime di abusi nell'infanzia, si

[22] Chapman D.P., Whitfield C.L., Felitti V.J., Dube S.R., Edwards V.J., Anda R.F. (2004) Adverse childhood experiences and the risk of depressive disorders in adulthood, *Journal of Affective Disorders*, 82 (2), 217-25.
[23] Briere J., "Child abuse trauma", Sage Publications ,1992
[24] HERMAN, J. L., (1992), *Trauma and recovery: the aftermath of violence.* Basic Books, New York.

ritiene utile riportare nel dettaglio la descrizione data dall'autrice del Disturbo Post-Traumatico da Stress Complesso, che si articola sui seguenti *criteri*:

- Una storia di sottomissione a controllo totalitario per periodi prolungati (mesi o anni). Esempi includono: ostaggi, prigionieri di guerra, sopravvissuti a campi di concentramento e sopravvissuti di alcune sette religiose. Altri esempi includono coloro che sono soggetti a sistemi totalitari nella vita sessuale e domestica, inclusi i sopravvissuti alla violenza domestica, all'abuso sessuale o fisico subito nell'infanzia e allo sfruttamento sessuale organizzato.
- Alterazione nella regolazione degli affetti, inclusi
    - stato disforico continuo
    - preoccupazione suicidaria cronica
    - autolesionismo
    - rabbia esplosiva o eccessivamente inibita (possono alternarsi)
    - sessualità compulsiva o eccessivamente inibita (possono alternarsi)
- Alterazioni dello stato di coscienza, inclusi
    - amnesia o ricordi intrusivi degli eventi traumatici
    - episodi dissociativi transitori
    - depersonalizzazione/derealizzazione
    - rivivere esperienze, sia sotto forma di sintomi intrusivi da disturbo post-traumatico da stress sia sotto forma di ruminazione cognitiva e preoccupazione continua
- Alterazioni nella percezione del Sé, inclusi
    - senso d'impotenza o paralisi dell'iniziativa
    - vergogna, colpa e auto-denigrazione
    - senso di contaminazione o di stigmatizzazione
    - sensazione di essere completamente diversi dagli altri (può includere sentirsi speciali, estrema solitudine, credenza che nessuno possa comprenderci, o senso d'identità non umana)
- Alterazioni nella percezione dell'abusante, inclusi
    - preoccupazioni nella relazione con l'abusante (inclusi i pensieri di vendetta)
    - attribuzione irrealistica di potere assoluto all'abusante (attenzione: il giudizio di realtà sul potere dell'abusante da parte della vittima può essere più realistico di quello che ha il clinico)
    - idealizzazione o gratitudine paradossale
    - convinzione di intrattenere con l'abusante una relazione speciale o supernaturale
    - accettazione del sistema di credenze o delle razionalizzazioni dell'abusante
- Alterazioni nei rapporti con gli altri, inclusi
    - isolamento e ritiro
    - frantumazione delle relazioni intime
    - ricerca continua di un salvatore (può alternarsi con l'isolamento e il ritiro)
    - fallimenti ripetuti nella capacità di autoproteggersi
- Alterazioni nel sistema dei significati, inclusi
    - perdita di un senso di fiducia durevole

- senso d'impotenza e di disperazione

L'adozione di questo modello di comprensione e descrizione delle conseguenze psicopatologiche dei traumi gravi e continuativi permette, secondo Herman, di evitare il pericoloso 'balletto' dell'attribuzione di un'etichetta psichiatrica "altra" a questa complessa sindrome. L'autrice analizza le tre principali sindromi attribuite alle vittime di trauma, e cioè *il disturbo psicosomatico, il disturbo di personalità borderline e il disturbo di personalità multipla*, rilevando l'impossibilità di arrivare in questi casi a precise definizioni diagnostiche, rimanendo i quadri sintomatologici per molti aspetti embricati trasversalmente alle tre sindromi. Il maggior rischio di una diagnosi psichiatrica non corretta e specifica come disturbo post-traumatico complesso è il ritardo nel ritrovare la connessione tra sofferenza psichica e quadro originante degli eventi, chiave per il processo riparativo.

4.4 Possiamo domandarci se è possibile distinguere le conseguenze dannose di cui stiamo trattando correlandole a specifiche forme di mal-trattamento.

Un recente lavoro di Tamiazzo[25] (2006) analizza le principali conseguenze a breve, medio e lungo termine dei mal-trattamenti sullo sviluppo e adattamento dell'individuo suddivise in base alla tipologia di mal-trattamenti.

I dati presentati sono stati ottenuti dall'esame e integrazione dei risultati di diverse ricerche relative all'argomento (Trickett e McBride-Chang, 1995; Cole e Putnam, 1992; DiLillo, 2001; Walzer e coll., 1999; Coffey e coll., 1996a, 1996b; Liem e Boudewyn, 1999; Gibson e Hartshorne, 1996; Hildyard e Wolfe, 2002; Kendall-Tackett e Eckenrode, 1996; Hoffman-Plotkin e Twentyman, 1984; Salzinger e coll., 1993; Dodge e coll., 1995; Haskett e Kistner, 1991; Salzinger e coll., 2001; Lopez e Heffer, 1998; Malinosky-Rummel e Hansen, 1993)[26]. In realtà, si tratta di una suddivisione ancora incerta e provvisoria, in quanto, nonostante i numerosi studi, i vari autori non sono riusciti a dimostrare con certezza le specifiche conseguenze di ciascuna forma di mal-trattamento; in particolar modo a causa del fatto che raramente le varie tipologie si presentano isolatamente ed è quindi estremamente difficile studiare la loro singola manifestazione.

In quest'area di studio del mal-trattamento permane dunque una certa confusione e la tabella 1, riportata nel testo di Tamiazzo, ha come intento principale quello di chiarire il più possibile le idee relativamente a questo tema.

Tabella 1. Maltrattamenti ed esiti comportamentali

	MALTR. FISICO	**MALTR. PSICOLOGICO**	**TRASCURATEZZA**	**ABUSO SESSUALE**
1^ infanzia	Aggressività con rifiuto pari/Ritiro sociale con rifiuto pari. Atteggiamenti negativi e poco cooperativi. Comportamenti esternalizzati (maschi) e internalizzati (femmine)	Compromissione del legame di attaccamento (insicuro). Scarsa autostima e fiducia negli altri. Scarso sviluppo delle abilità adattive e sociali.	Compromissione del legame di attaccamento (insicuro). Comportamenti internalizzati (ritiro e isolamento sociale). Scarso controllo dell'emotività e impulsività. Problemi nel linguaggio espressivo.	Comportamen-ti internalizzati. Forti sentimenti di impotenza, vergogna e colpa. Disturbi psicosomatici.

[25] Tamiazzo G (2005) *Maltrattamento infantile e successive difficoltà di adattamento nel ciclo di vita*, tesi universitaria non pubblicata, in www.progettotiama.it .
[26] Vedi Tamiazzo G, 2005, in www.progettotiama.it.

2^ infanzia	Ai problemi già presenti nel periodo precedente si aggiungono le difficoltà scolastiche. Errori nel processamento dell'informazione sociale.	Si aggiungono i problemi scolastici, in particolare difficoltà cognitive e di problem-solving. Difficoltà e ritardi nello sviluppo fisico e intellettivo.	Si aggiungono i problemi scolastici (in misura maggiore rispetto alle altre forme), in particolare deficit cognitivi e mancanza di creatività e flessibilità nel problem-solving. Ritiro sociale.	Si aggiungono comportamenti esternalizzati e comportamenti sessuali inappropriati.
Adolescenza	Peggioramento dei problemi scolastici e delle difficoltà relazionali.	Peggioramento dei problemi scolastici, dell'autostima e della fiducia negli altri. Sviluppo di uno stile di interazione passivo, ritirato ed eccessivamente reattivo.	Peggioramento dei problemi scolastici (più che nelle altre tipologie) e in particolare dei deficit cognitivi. Rappresentazione negativa di sé e degli altri. Scarsità di interazioni sociali.	Idee suicide e comportamenti autolesivi. Si aggravano i problemi comportamentali e le difficoltà relazionali.
Età adulta	Permangono i comportamenti internalizzati ed esternalizzati, gli atteggiamenti aggressivi ed antisociali e si manifestano depressione ed ansia (in particolare nelle donne).	Lo stile relazionale evolve o nella depressione oppure nei disturbi della condotta (iperattività, impulsività). Ulteriore peggioramento della stima in sé stessi e della fiducia negli altri.	Isolamento e ritiro sociale. Incapacità di entrare in relazione con gli altri. Profondi deficit cognitivi.	Permangono i comportamenti internalizzati ed esternalizzati, gli atteggiamenti aggressivi ed antisociali e si manifestano depressione, ansia e disturbi somatici (in particolare nelle donne). Difficoltà nelle relazioni intime e nell'assunzione del ruolo parentale. Senso di solitudine e incapacità di utilizzare il supporto sociale.

5. Le conseguenze sull'adattamento sociale

5.1 Molte persone vittime di esperienze sfavorevoli infantili, pur non presentando gravi sintomi psicopatologici, sperimentano ugualmente *difficoltà in diverse aree sociali ed interpersonali* le quali, essendo meno visibili al mondo esterno, il più delle volte vengono sottovalutate e non vengono prese in considerazione (vedi punto 4.4) (Gentile, 2005[27]). Non solo nei macroscopici gruppi patologici sopra citati, ma anche in aree meno studiate, andrebbero ricercate correlazioni tra fallimenti e sofferenze e le Esperienze Sfavorevoli Infantili, adottando come 'chiave di lettura' delle difficoltà proprio la permanenza nel tempo dei modelli operativi interni distorti (il 'mondo malevolo') e dei funzionamenti post traumatici costanti e/o riattivabili conseguenti a tali esperienze, come già sopra descritto.

Ad esempio, chi opera nelle iniziative mirate al recupero scolastico e alla qualificazione finalizzata all'inserimento lavorativo di adolescenti e preadolescenti, incrocia in gran parte dell'utenza situazioni ascrivibili a questa tipologia di mal-trattamento. Ancora, sarebbe di grande interesse se a margine delle rilevazioni relative all'esclusione sociale e alla povertà, si facesse una specifica ricerca sull'esistenza, alla base dei multipli fallimenti sociali dei soggetti interessati, di condizioni antiche di forme multiple di abuso, che possano pesare come una sorta di 'marchio

[27] Gentile G (2005) *Abuso-maltrattamento all'infanzia e disagio sociale: proposta di intervento con ragazzi adolescenti*, tesi universitaria non pubblicata, in www.progettotiama.it. Per tutte le voci bibliografiche citate nel paragrafo 5 si veda la suddetta tesi.

negativo' che impedisce alle persone di fruire delle risorse, anche quando inserite in società affluenti.

L'effetto distruttivo, che la relazione precoce con un adulto mal-trattante ha su tutte le successive interazioni sociali, può portare a un aumento del rischio di isolamento e di rifiuto sociale nel bambino e nell'adulto. In questi soggetti verrebbero, infatti, a mancare le competenze sociali e un sistema emozionale equilibrato che, in situazioni normali, consentono di sperimentare quei sentimenti di fiducia, confidenza e tranquillità che, a loro volta, permettono di costruire legami sicuri e duraturi non solo per quanto riguarda le relazioni intime, ma anche in tutte le altre relazioni sociali, in modo particolare nell'ambito accademico e professionale. In particolare, quando le esperienze sfavorevoli sono state continue e frequenti nel corso dei primi anni di vita, nel percorso di crescita del bambino si registra una grande difficoltà a fidarsi delle altre persone, egli è particolarmente sensibile al rifiuto e tende ad agire in modo smisurato alle valutazioni negative, percezione questa che può portare al rifiuto relazionale e all'isolamento dell'individuo.

Queste gravi conseguenze, che si evidenziano già a un'età molto precoce, perdurano, il più delle volte, per tutto il corso della vita provocando enormi carenze nelle capacità di adattamento e di interazione sociale del soggetto adulto.

5.2 Questi bambini nel loro percorso di crescita sperimentano frequenti *insuccessi e fallimenti a livello scolastico* e relazionale e si ritrovano poi, nel mondo adulto, privi di quelle competenze cognitive, sociali e relazionali che sono fondamentali per affrontare le difficoltà della vita ed adattarsi ad esse.

Numerosi studi, infatti, dimostrano che i soggetti maltrattati hanno delle prestazioni scolastiche peggiori rispetto a quelli non maltrattati; in particolare essi vengono spesso descritti da genitori e insegnanti come carenti di motivazioni intrinseche, poco inclini ad apprendere e incapaci di stimare adeguatamente le proprie capacità.

Ad esempio, Leiter e Johnsen (1994) hanno analizzato gli effetti di abuso e trascuratezza sulle prestazioni scolastiche ed hanno dimostrato un sostanziale deficit tra i bambini maltrattati in un'ampia gamma di risultati scolastici: test standardizzati, media dei voti, probabilità di abbandono scolastico, assenza e velocità di apprendimento. In un'altra ricerca (1997), gli stessi autori, hanno condotto un'analisi longitudinale per indagare il declino delle prestazioni scolastiche tra bambini abusati e trascurati. Essi hanno individuato relazioni significative tra maltrattamento e declino in diverse prestazioni scolastiche. Con il passare degli anni hanno inoltre registrato un aumento del rischio di declino nelle prestazioni in particolar modo nell'apprendimento di compiti cognitivi e nel grado di partecipazione e di integrazione scolastica.

Un interessante studio di Shonk e Cicchetti (2001) suggerisce che è l'influenza negativa esercitata dal maltrattamento sullo sviluppo delle competenze individuali a provocare gli elevati livelli di insuccesso scolastico e i problemi comportamentali dei bambini maltrattati; successivamente, questo disadattamento scolastico e comportamentale aumenta il rischio di abbandono accademico e di fallimenti sociali e professionali a lungo termine.

I numerosi insuccessi scolastici a cui vanno incontro i bambini vittime di esperienze sfavorevoli infantili sono principalmente dovuti alla loro situazione di distonia, impredicibilità, violenza familiare che non consente un'adeguata acquisizione delle competenze scolastiche, sociali e di resilienza che consentono di impegnarsi e di affrontare i compiti che vengono proposti.

5.3 A questo punto è molto semplice comprendere perché spesso i bambini con esperienze di maltrattamento presentino grosse difficoltà nelle *interazioni sociali* con i propri pari e vengano rifiutati dai compagni di classe. Infatti, tra tutte le problematiche che questi soggetti presentano nel loro funzionamento, il più delle volte troviamo anche un modello interattivo, in genere, caratterizzato da alti livelli di aggressività, dalla carenza di atteggiamenti prosociali e di avvicinamento ai pari.

Alcuni autori (Haskett e Kistner, 1991; Darwish, Esquivel, Houtz e Alfonso, 2001) hanno dimostrato che l'effetto pervasivo del maltrattamento sulle relazioni con i pari si evidenzia già ad un'età molto precoce. Questi autori hanno infatti analizzato la qualità delle interazioni in bambini

in età prescolare. I loro risultati mostrano che i soggetti maltrattati appaiono più ritirati, possiedono scarse abilità nell'avviare interazioni con i pari, esibiscono una più alta proporzione di comportamenti negativi nell'interazione con gli altri bambini, presentano una certa difficoltà nel mantenere l'autocontrollo ed hanno un gran numero di problemi comportamentali. I pari, inoltre, considerano questi bambini poco desiderabili come compagni di gioco.

Il rifiuto da parte dei pari quindi è un'esperienza che i bambini maltrattati iniziano a sperimentare molto precocemente, sin dalle loro prime interazioni, e che, nella gran parte dei casi, si ripeterà durante tutto il loro percorso scolastico e, più tardi, anche nelle loro interazioni adulte.

A questo proposito, un interessante studio di Salzinger, Feldman, Hammer e Rosario (1993) ha messo in evidenza che esperienze sfavorevoli infantili sono fortemente associate ad una più alta probabilità di rifiuto da parte dei pari. All'interno della classe, i soggetti maltrattati ottengono spesso una bassa reputazione sociale, ricevono poche scelte positive da parte dei compagni e molte negative: hanno, quindi, pochi scambi positivi nelle relazioni con i pari e il loro comportamento sociale è spesso percepito come negativo.

Anche Bolger e Patterson (2001) hanno dimostrato la relazione tra maltrattamento e rifiuto dei pari e, in più, hanno trovato un'interessante legame tra il rifiuto e la cronicità del maltrattamento: più il maltrattamento è perdurato negli anni, più alta è la percentuale di rifiuto dei bambini.

Un dato importante che emerge da alcuni studi è quello della trascuratezza come la forma di esperienza sfavorevole infantile più devastante per lo sviluppo del bambino. Ad esempio, Hoffman-Plotkin e Twentyman (1984) hanno trovato che i bambini trascurati sono, in genere, caratterizzati da un più basso numero di interazioni sociali rispetto ai soggetti che hanno subito altre forme di maltrattamento. Anche lo studio di Kendall-Tackett e Eckenrode (1996) ha rivelato che i bambini trascurati hanno i risultati scolastici peggiori e che i loro problemi disciplinari e relazionali aumentano costantemente nel corso di tutti gli anni scolastici.

Per quanto riguarda la spiegazione dei motivi per cui questi bambini vengono spesso rifiutati dai propri compagni, la maggioranza degli autori chiama in causa i problemi comportamentali, l'aggressività, le condotte antisociali ed esternalizzate che caratterizzano questi soggetti. Altri, invece, vedono nella difficoltà di regolare gli stati emotivi e nella tendenza ad attribuire ad altri intenzioni ostili le cause principali del rifiuto. In realtà, è molto probabile che questi fattori agiscano insieme.

5.4 E' interessante notare come da molti studi emergano delle *differenze in base al genere* in relazione alle conseguenze del maltrattamento; sembra cioè che maschi e femmine reagiscano in modi diversi alle esperienze precoci di maltrattamento. In generale, si evidenzia un migliore adattamento e funzionamento per il genere femminile, l'unica eccezione si riscontra nell'area emotiva in cui i maschi appaiono più controllati rispetto alle femmine.

Ad esempio, Bolger e Patterson (2001) hanno trovato che gli effetti del maltrattamento sui comportamenti aggressivi sono molto più evidenti nei soggetti di sesso maschile e questo gioca sicuramente a sfavore dell'integrazione di questi bambini nell'ambiente scolastico e di gioco.

Invece, per quanto riguarda l'espressione dei propri sentimenti una ricerca interessante è quella di Alessandri e Lewis (1996) i quali hanno esaminato l'espressione di orgoglio e vergogna di bambini maltrattati e non maltrattati in età prescolare di fronte a successi o insuccessi nella risoluzione di compiti. I risultati hanno mostrato uno specifico effetto-genere: le bambine maltrattate esprimono più vergogna in caso di insuccesso e meno orgoglio in caso di successo, sia rispetto alle bambine non maltrattate, sia rispetto ai maschi, maltrattati e non. Per quanto riguarda i bambini, essi esprimono livelli inferiori sia di vergogna che di orgoglio rispetto a tutti gli altri soggetti.

Si potrebbe, quindi, affermare che gli esiti negativi del maltrattamento vadano ad incidere più profondamente sul sistema comportamentale nei maschi e su quello emotivo nelle femmine; in altre parole, i bambini maltrattati incorrerebbero più frequentemente in problemi di condotte esternalizzate, mentre le bambine in problemi di condotte internalizzate.

5.5 Le ricerche principalmente focalizzate sulle *conseguenze sull'adattamento sociale in età adolescenziale e adulta* sono ancora poche, ma studi recenti hanno dimostrato che i soggetti adulti sopravvissuti ad abuso e/o maltrattamento spesso presentano grandi difficoltà in quest'area, hanno relazioni di bassa qualità, soffrono di disfunzioni nelle relazioni intime e presentano un concetto di sé particolarmente distorto, soprattutto per quanto riguarda la stima in sé stessi.

Drapeau e Perry (2004) suggeriscono che importanti aspetti dei traumi infantili vengono spesso internalizzati andando a colpire desideri, affetti e comportamenti dell'adulto e possono, quindi, giocare un ruolo cruciale per lungo tempo.

Anche Cole e Putnam (1992) si sono concentrati sugli effetti dell'incesto sul sé e sul funzionamento sociale in una prospettiva di sviluppo che va dall'infanzia all'età adulta. Essi hanno dimostrato che l'abuso sessuale provoca delle importanti deviazioni nei processi di definizione, regolazione e integrazione del sé, oltre che una compromissione delle capacità di sperimentare sensazioni di fiducia e confidenza nelle relazioni interpersonali, determinandole in quantità e qualità. Anche Lopez ed Heffer (1998) hanno esaminato l'impatto dell'abuso fisico sul concetto di sé e sulle competenze sociali in studenti universitari ed hanno, inoltre, valutato il ruolo della percezione del supporto genitoriale come mediatore delle conseguenze dell'abuso sull'adattamento sociale. Come predetto dagli autori, le analisi rivelano che i soggetti con una storia di abuso fisico hanno un concetto di sé estremamente basso.

Si è visto in precedenza come lo sviluppo delle emozioni possa essere gravemente compromesso da esperienze di maltrattamento in età infantile e diversi studiosi hanno dimostrato che questo effetto si protrae per tutta la vita.

McGee, Wolfe e Olson (2001) hanno esaminato la relazione tra maltrattamenti multipli, attribuzioni di colpa e adattamento in soggetti adolescenti. I risultati della ricerca mostrano, nel loro insieme, che la percezione e le attribuzioni che il soggetto maltrattato costruisce sulla sua esperienza di maltrattamento sono fondamentali nel determinare l'adattamento successivo. In particolare, più sono confuse e conflittuali peggiori saranno i problemi comportamentali osservabili.

Anche Liem e Boudewyn (1999) hanno dimostrato che l'abuso infantile e tutte le sue conseguenze sullo sviluppo possono provocare nell'adulto sentimenti di autocolpevolizzazione che, a loro volta, predicono un orientamento interpersonale caratterizzato dal bisogno di controllo sugli altri, da ipersensibilità ai giudizi delle altre persone, da ostilità e paranoia interpersonali e dalla vulnerabilità allo sfruttamento da parte degli altri.

E' interessante notare come molti degli studi esaminati mettano in evidenza il fatto che le conseguenze evidenziate non possono essere attribuite al basso stato socioeconomico dei soggetti, in quanto, comparati con un gruppo di controllo di uguale stato socioeconomico, essi si differenziano ugualmente da quest'ultimo a causa delle esperienze sfavorevoli infantili subìte.

6. Le conseguenze sulla salute

Una rassegna della letteratura che dobbiamo a Kendall-Tackett [28] (2001) mette a fuoco il fatto che le vittime di ESI soffrono spesso di *problemi di salute* per molto tempo dopo che l'abuso è terminato: è evidente che tale condizione avrà *conseguenze importanti sull'attività scolastica e lavorativa*.

Questi soggetti sono malati più di frequente e vanno più spesso dal dottore, lamentano più sintomi, sono meno inclini a descrivere il loro stato di salute come buono, sono sottoposti a chirurgia più frequentemente, sono maggiormente a rischio di avere una o più sindromi da dolore cronico. Nel suo studio sulle Esperienze Sfavorevoli Infantili, Felitti et al. (2001) documentano che i soggetti che hanno sperimentato quattro o più eventi sfavorevoli nell'infanzia sono maggiormente

[28] Kendall-Tackett K. (2002) The health effects of childhood abuse: four pathways by which abuse can influence health, *Child Abuse and Neglect*, 26, 715-729.

a rischio di un'ampia gamma di condizioni che comprendono: l'ischemia cardiaca, il cancro, l'infarto, la bronchite cronica, l'enfisema, il diabete, le fratture ossee e l'epatite. Dopo aver documentato la frequenza più alta di questi problemi, il passo seguente è capire perché ciò accada. Kendall-Tackett adotta un modello di quattro percorsi attraverso cui le esperienze infantili traumatiche possono influenzare la salute: percorsi comportamentali, sociali, cognitivi ed emotivi. È possibile subire l'influenza da ciascuno dei quattro percorsi o da tutti, e i diversi tipi si influenzano a vicenda, formando una complessa matrice di inter-relazioni, ognuna delle quali ha ricadute significative sulla salute.

6.1 *I percorsi a livello comportamentale*

Gli adulti vittime di maltrattamenti nell'infanzia sono più inclini a intraprendere attività dannose e pericolose, tutte ovviamente dannose per la salute.

Corrono maggiori rischi di abusare di alcool e droghe: ad esempio donne sopravvissute all'abuso sessuale avevano 10 volte più probabilità di avere una storia di dipendenza da sostanze e 2 volte più probabilità di essere alcolizzate rispetto al gruppo di controllo. Anche il fumo è più diffuso fra coloro che hanno una storia di abusi infantili.

Anche l'obesità è più comune fra gli adulti vittime di abuso nell'infanzia. In uno studio di 131 pazienti con una storia di incesto, il 60% erano più di 22 kg in sovrappeso, rispetto al 28% del gruppo di controllo. Anche se i risultati degli studi non sono tutti concordi, emerge che un numero significativamente maggiore di donne con bulimia riporta episodi di abuso sessuale da parte del genitore.

Fra gli adulti sopravvissuti ad abusi infantili sono molto comuni anche i tentativi di suicidio e l'ideazione suicidaria. In un campione europeo, il 43% di vittime di CSA avevano ideazione suicidaria e il 14% aveva compiuto tentativi di suicidio.

I comportamenti sessuali ad alto rischio sono la forma più documentata di comportamenti autolesivi nelle vittime di abuso sessuale, dato valido per i maschi e per le femmine e coerente attraverso la varietà di orientamenti sessuali. Le giovani donne con un passato di abusi sessuali (particolarmente se con rapporto completo) riportavano età più precoci di inizio dell'attività sessuale consensuale e percentuali più alte di gravidanze in adolescenza, di aborti, di partner sessuali multipli, di rapporti non protetti e di malattie sessualmente trasmissibili.

Gli adulti vittime di abusi infantili spesso hanno problemi di sonno. In uno studio su vittime di abusi infantili di lingua tedesca, il 68% ha riportato di avere disturbi di sonno, con il 45% che raccontava di incubi ripetuti. Le persone che dormono poco in modo cronico sono più soggette a infezioni e malattie e hanno più probabilità di avere incidenti e difficoltà del sonno possono anche preannunciare il corso più grave e cronico di una depressione.

6.2 *I percorsi a livello sociale*

Per mantenere relazioni sociali positive e reciproche occorre saper interpretare i segnali sociali, farsi valere e trovare persone che non sfruttino e abusino degli altri. Queste capacità sono significativamente influenzate da esperienze infantili sfavorevoli, che portano spesso a vivere successivamente relazioni di sfruttamento o di vittimizzazione, isolamento dagli altri, insoddisfazione delle relazioni in corso.

Gli adulti che sopravvivono all'abuso possono adottare uno dei due seguenti stili interpersonali: evitante o intrusivo. Le persone con uno stile evitante hanno pochi legami interpersonali e pochi amici, sono meno inclini ad essere coinvolti in relazioni con gli altri e a sposarsi. Le persone con uno stile intrusivo hanno estremo bisogno di vicinanza. Questi due pattern comuni fra gli adulti vittime di abusi infantili sono stati anche connessi con i comportamenti relativi alla salute.

Le persone il cui stile primario è evitante, caratterizzato da una scarsa interdipendenza, da una bassa rivelazione di sé e da poco calore, possono avere problemi perché sono troppo arroganti e ostili per seguire prescrizioni mediche e consigli di promozione della salute (per esempio fare esercizio fisico) e di autoprotezione (come per esempio indossare le cinture di sicurezza). Quelle con uno stile di intrusivo, che comporta il focalizzarsi sugli altri ed escludere sé, possono avere problemi di salute perché non riescono ad occuparsi di sé.

Anche la rivittimizzazione è relativamente comune fra gli adulti che sopravvivono ad abusi infantili.

Per esempio, le donne con una storia di abusi sessuali nell'infanzia hanno più probabilità di essere violentate o abusate in ambito domestico e sul lavoro da adulte. Trascuratezza fisica e qualunque tipo di abuso sessuale sono le più frequenti premesse della rivittimizzazione. La rivittimizzazione è ancora più frequente nei campioni patologici. In uno studio con 93 donne adulte che si presentavano al pronto soccorso psichiatrico, viene messo in luce che l'abuso sessuale era correlato a rischi maggiori di tentativi di violenza, di stupri e di aggressioni fisiche.

Queste esperienze influenzano la salute nell'immediato attraverso le ferite e il rischio di morte e accrescono la possibilità di contrarre una serie di malattie sessualmente trasmissibili. Si può produrre anche uno stato cronico di stress, che può portare le vittime a cercare un'automedicazione attraverso l'abuso di sostanze, il cibo e il fumo. Inoltre lo stress cronico può portare all'elevazione dei livelli di trigliceridi nel sangue, di colesterolo, di glucosio e di insulina, i quali sono tutti legati a problemi cardiovascolari e al diabete.

All'estremo delle distorsioni comportamentali sta l'essere senza fissa dimora ('homeless'). Sono state trovate fra i senzatetto percentuali doppie di storie di abusi sessuali e quasi doppie di violenza fisica, rispetto a quelle rilevate fra gli intervistati con fissa dimora ugualmente sostenuti dall'assistenza pubblica. Questa condizione ha effetti negativi sulla salute in molti modi: fame e malnutrizione, esposizione all'inclemenza del tempo, mancanza di cure mediche, di igiene quotidiana, maggior rischio di lesioni fisiche e di abuso di sostanze sono significativamente correlate a maggiore incidenza di malattie del fegato, ictus, lesioni, traumi, deficienze alimentari, malattie mentali, ipertensione, malattie polmonari e circolatorie.

6.3 *I percorsi a livello cognitivo*

Le credenze e gli atteggiamenti che modellano l'esistenza quotidiana di una persona possono avere un impatto importante sulla salute.

Quando i bambini subiscono abusi sviluppano modelli operativi interni tali per cui vedono il mondo come un posto pericoloso. Poiché sono stati impotenti in passato, essi tendono a sovrastimare i pericoli e le avversità nel loro ambiente circostante e a sottostimare la loro percezione di autoefficacia e del proprio valore nell'affrontare pericoli reali o percepiti. Questi pensieri possono anche influenzare la salute: quando le persone vedono un evento o una circostanza come negativa, il loro corpo rilascia il cortisolo, che a livelli costantemente elevati può sopprimere il sistema immunitario, rallentare la cicatrizzazione delle ferite e danneggiare il cervello.

La fiducia interpersonale può anche influenzare quanto a lungo vive una persona. Alti livelli di fiducia aumentano le aspettative di vita, si associano con punteggi migliori di autovalutazione della salute e della soddisfazione di vita. In uno studio, le vittime di abusi sessuali manifestavano nel complesso una minore soddisfazione della loro condizione di salute. In diversi studi le vittime di abuso si descrivono in salute in percentuale minore rispetto al gruppo di controllo.

6.4 *I percorsi a livello emotivo*

Le emozioni negative sono potenziali minacce per la vita.

La depressione è una delle conseguenze più frequenti di abusi passati. Gli adulti che subiscono un abuso sessuale nell'infanzia hanno quattro volte più rischi di sviluppare una depressione maggiore rispetto agli altri. E' stato rilevato anche che l'abuso sessuale infantile forniva un contributo alla varianza nella depressione indipendentemente dagli altri eventi negativi nell'infanzia. I loro sintomi includono disturbi del sonno, fatica cronica, sconforto e attacchi di pianto.

La depressione è un immunosoppressore ben conosciuto ed è dimostrato che può influenzare il sistema immunitario anche a livello dei globuli bianchi, in modo particolare nei soggetti che hanno una depressione maggiore, che tendono ad avere livelli di cortisolo eccessivamente alti. La depressione può influenzare i comportamenti di prevenzione e autoprotezione, può avere anche un impatto negativo sul sonno, riducendo i tempi del sonno di quarta fase (delta) e incrementando il

sonno nella fase REM, che indica un accresciuto arousal. Le donne che soffrono di depressione maggiore sono più a rischio di problemi cardiaci come l'infarto. I soggetti depressi sono 3 volte più a rischio di mortalità cardiaca, di evoluzione da angina instabile ad infarto. Le persone depresse hanno le stesse probabilità di avere un attacco di cuore delle persone con disfunzione ventricolare o con grave arteriosclerosi coronarica. Un altro studio ha rilevato che la depressione è legata in modo significativo alla qualità di vita successiva a un infarto del miocardio. La depressione maggiore presenta spesso un alto indice di comorbilità con il PTSD.

Più dell'80% delle vittime di abusi sessuali nell'infanzia riportano di avere sintomi post-traumatici che comprendono: l'ipervigilanza, i pensieri intrusivi e improvvisi flashback intrusivi dell'esperienza di abuso. L'abuso nell'infanzia sembra rendere le persone più vulnerabili a sviluppare PTSD quando si trovano esposti nella vita presente ad eventi stressanti. Il PTSD è stato descritto come un disordine con alta comorbilità e si presenta frequentemente insieme alla depressione, ai disturbi di ansia, all'abuso di alcol o droghe, al fumo. Il PTSD può condizionare anche i legami sociali: le persone hanno più probabilità di divorziare e avere problemi familiari, di commettere o di tentare suicidio e hanno meno probabilità di completare gli studi. Il PTSD può anche portare a problemi di sonno (specialmente di insonnia e incubi cronici) che possono accrescere il rischio di ferite o di morte come conseguenza di incidenti in casa, sul lavoro o in auto.

6.5 *Implicazioni cliniche*

Come si vede, la "salute" dipende da una rete complessa di comportamenti, pensieri, emozioni e connessioni sociali che non solo si influenzano a vicenda, ma influenzano anche la salute stessa. Le esperienze sfavorevoli infantili possono influire sulla salute ad uno o più di questi livelli e questi percorsi possono variare in ciascun singolo paziente. Chi opera nel campo sanitario deve impegnarsi per trovare un approccio che affronti tutti questi percorsi, evitando l'attuale scissione fra i trattamenti per la salute mentale e comportamentale e le cure per la salute fisica.

Trauma Informed Care

An Overview
of Fundamental Concepts
A Primary Prevention Tool

Created by Huckshorn, Stromberg, LeBel, 2004

Una panoramica
dei concetti fondamentali
Uno strumento di prevenzione primaria

"National Executive Training Institute (NETI). (2005). *Training curriculum for reduction of seclusion and restraint. Draft curriculum manual.* Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental Health Planning (NTAC)"

Traduzione di Mariagnese Cheli

A cura di

Kevin Huckshorn, Delaware Director of Divsion of Substance Abuse and Mental Health

Janice Lebel, Director of program management for the MA Dept of Mental Health's child & adolescent division

Nan Stromberg,

ntacinfo@nasmhpd.org

Contenuti

- Definizione di Cura informata sul trauma e di Trauma
- Prevalenza & Implicazioni
- Sistemi Trauma informati & Trauma Insensibili
- Impegno organizzativo
- Valutazione del Trauma e Modelli di Cura

Che cosa è un trauma?

- Definizione (NASMHPD, 2004): *National Association of State Mental Health Program Directors*

Un'esperienza di violenza interpersonale come l'abuso sessuale, il maltrattamento fisico, la trascuratezza grave, perdita e / o violenza assistita, terrorismo e / o disastri

Vorrei attirare la vostra attenzione sul fatto che non stiamo parlando solo di violenza fisica, perché qui si noterà che in questa definizione sono inclusi l'abbandono e la perdita di persone significative.

Che cosa è un trauma?

DSM-IV-TR (APA, 2000)

"Un evento che la persona ha vissuto, cui ha assistito o con il quale si è confrontata che ha comportato morteo o minaccia di morte o lesioni gravi o pericolo per l'integrità fisica propria e/o di altri ".

La risposta della persona comprende paura intensa, impotenza o orrore (Ibid)

Tipi di trauma che hanno conseguente gravi e persistenti sulla salute mentale:

- Di solito non è un unico evento ad esempio stupro, calamità naturali
- Sono di natura interpersonale: intenzionali, prolungati, ripetuti e gravi
- Si verificano durante l'infanzia e l'adolescenza e possono protrarsi

(Terr, 1991; Giller, 1999)

La letteratura degli ultimi 5 anni converge nel ritenere che i traumi più dannosi sullo sviluppo e che provocano gravi e persistenti problemi di salute mentale di solito non hanno carattere episodico e non si tratta di singoli eventi. Piuttosto, sono eventi che si verificano spesso all'interno di uno schema ripetitivo. Ovviamente ciò non significa che uno stupro, la perdita improvvisa di un familiare, un terribile incidente o una catastrofe naturale non comportino conseguenze o segni e sintomi derivanti da quella specifica esperienza traumatica. Qui si vuole approfondire gli effetti, sullo sviluppo, di esperienze traumatiche ripetitive e non di singoli eventi. Il principio generale è che si devono collocare tali esperienze nel contesto della storia peculiare dell'individuo.
Questi eventi sono il più delle volte di natura interpersonale, sono intenzionali hanno cioè lo scopo di danneggiare l'altra persona.Sono prolungati, ripetuti, come ho detto prima, e gravi. Spesso iniziano durante l'infanzia, l'adolescenza e continuano in età adulta.

Definizione di Trauma Informed Care
Il trattamento Salute Mentale che è diretto a:
- una conoscenza approfondita degli effetti neurologici, biologici, psicologici e sociali del trauma e della violenza sul singolo
e,
- la constatazione di un'alta prevalenza di esperienze traumatiche nei pazienti in cura presso i servizi di salute mentale. (Jennings, 2004)

Il Trauma Informed Care è un termine relativamente recente in letteratura negli ultimi cinque o sei anni, anche se molti professionisti negli USA e in altri paesi hanno lavorato su questi problemi per molti anni. La cura dei traumi ha avuto un forte impulso dopo la seconda guerra mondiale, per l'elevata incidenza e prevalenza di PTSD nei soldati e dagli studi sulla violenza domestica.
Questi due diversi campi di studio si sono riuniti in questi ultimi anni per approfondire l'effetto complessivo del trauma e della violenza sugli esseri umani e sui pazienti con gravi e persistenti problemi di salute mentale.
Il Trauma Informed Care è una prospettiva di studi che intende approfondire la conoscenza degli effetti neurologici, biologici, psicologici e sociali del trauma e della violenza sull'essere umano, partendo dal presupposto che vi è un'alta prevalenza di esperienze traumatiche nelle persone in carico ai servizi di salute mentale.
Questo non è comunemente conosciuto e riconosciuto, quindi ho intenzione di spiegare meglio questa affermazione

Prevalenza del Trauma & Implicazioni

L'esposizione al Trauma nella Popolazione generale
- Fino a poco tempo, l'esposizione a eventi traumatici era concepito unilateralmente come un evento raro (guerra, disastro)
(Kessler et al., 1995)

La ricerca recente ha cambiato questa prospettiva. Gli studi compiuti negli ultimi dieci anni indicano che l'esposizione al trauma è comune anche nella classe media (Ibid)

- Il 56% della popolazione adulta riporta almeno un evento di natura traumatica (Ibid)

Ciò che noi ora sappiamo, in termini di popolazione generale, è che le esperienze di natura traumatica sono molto più diffuse di quanto abbiamo mai pensato. Gli studi effettuati nell'ultimo decennio indicano che l'esposizione trauma è abbastanza comune, anche nella classe media. Il 56% della popolazione adulta, in uno studio fatto da Kessler nel 1995, riporta almeno un evento traumatico

Prevalenza del Trauma nella popolazione in carico ai centri pubblici di salute metale
- 90% dei pazienti in carico ai servizi pubblici di salute mentale sono stati esposti (Muesar et al, in corso di stampa, Muesar et al, 1998.)
- La maggior parte ha molteplici esperienze di natura traumatica
(Ibid)
- Il 34-53% ha ricevuto abuso sessuale o fisico nell'infanzia
(Kessler et al, 1995; MHA NY & NYOMH 1995)
- Il 43-81% riferisce un certo tipo di vittimizzazione
(Ibid)

Muesar e colleghi riferiscono % allarmanti. Il 90% dei pazienti seguiti dai servizi pubblici di salute mentale sono stati esposti a traumi. La maggior parte ha avuto molteplici esperienze traumatiche.

Il 34% e fino al 53% delle persone che cercano un trattamento clinico riferisce un abuso sessuale e/o fisico e fino all'81% segnala un qualche tipo di vittimizzazione.

Prevalenza del Trauma sulla salute mentale
- Il 97% delle donne senza fissa dimora con SMI è reduce da esperienze di grave abuso sessuale e fisico – nell'87% dei casi l'abuso è accaduto sia in epoca infantile che in età adulta
(Goodman et al., 1997)
- Gli attuali tassi di PTSD nelle persone con SMI variano dal 29 al 43%
(CMHS / HRANE, 1995; Jennings & Ralph, 1997)
- Ci troviamo di fronte a una epidemia nella popolazione in cura presso il sistema sanitario statunitense
(Ibid)

Il 97% delle donne senza fissa dimora con gravi malattie mentali ha subito gravi abusi fisici e sessuali e l'87% di queste persone hanno avuto queste esperienze sia da bambini che da adulti. Gli attuali tassi di PTSD in persone con gravi malattie mentali in questo studio è salito al 43%, un dato significativamente superiore a quanto indicato nel DSM-IV. Sembra che il PTSD sia un'epidemia nella popolazione in cura nel sistema pubblico di salute mentale, in questo ampio studio fatto nella Carolina del Sud. Quindi, come potete vedere, la questione del trauma, anche se deve ancora essere ulteriormente studiata, sembra avere un impatto nella maggioranza dei nostri pazienti.

Prevalenza del Trauma
Che cosa questo significa ...
- La maggior parte di adulti e bambini in degenza nei reparti psichiatrici presenta storie di traumi
(Cusack et al, Muesar et al, 1998; Lipschitz et Al., 1999, NASMHPD, 1998)
"I professionisti potrebbero pensare che l'abuso costituisca un problema ulteriore per la persona, piuttosto che il problema centrale ... "
(Hodas, 2004)

Significa che ora abbiamo bisogno di integrare le nostre conoscenze con la constatazione che la maggior parte dei bambini, giovani e adulti che entrano nei nostri sistemi di cura hanno vissuto un trauma significativo nella loro vita e che esperienze traumatiche significative hanno probabilmente complicato i sintomi e i

segni del disagio psichico. I professionisti sanno constatando che il trauma, piuttosto che essere un problema aggiuntivo in realtà è il problema centrale.

Impatto del trauma nel ciclo di vita
- Gli effetti sono neurologici, biologici, psicologici e sociali in natura, tra cui:
- Cambiamenti nella neurobiologia del cervello
- Compromissione sociale, emotiva e cognitiva
- L'adozione di comportamenti a rischio per la salute (disturbi alimentari, tabagismo, tossicodipendenza, autolesionismo, promiscuità sessuale, esposizione a violenza)
- Deficit gravi e persistenti nel comportamento, nella salute e problemi sociali, morte precoce

(Felitti et al, 1998; Herman, 1992)

L'impatto del trauma sulla vita compre effetti neurologici, biologici psicologici e sociali. Ora siamo in grado di osservare i cambiamenti della neurobiologia del cervello. Una conseguenza è anche la generale riduzione delle abilità sociali, emotive e cognitive; in altre parole, il modo di relazionare con gli altri, il modo di sentire e il modo di pensare sono domini colpiti dal trauma. Le persone reduci da gravi traumi sembrano adottare tassi più alti di comportamenti a rischio per la salute. Solo poche settimane fa, il Consiglio Direttivo del NASMHPD ha avuto un incontro dove si è discusso dei tassi di morbosità e mortalità delle persone che sono in cura presso i servizi pubblici di salute mentale. Si è concluso che le persone con gravi malattie mentali sembrano morire molto prima (15-20 anni o forse più) rispetto alla popolazione generale. Questo è un problema significativo.

Impatto del trauma sullo sviluppo

La capacità di formare relazioni sane dipende in larga misura dalle competenze sociali apprese
- L'apprendimento di abilità sociali dei bambini è direttamente correlato alle caratteristiche del loro ambiente
- Ambienti caotici = competenze disfunzionali
- La violenza insegna ritiro, ansia, sfiducia, reazione eccessive e / o aggressività, problemi nel comportamento
- I comportamenti estremi sono radicati nella disregolazione degli stati emotivi

(NF Commission, 2003; SG Report, 1999; Hodas, 2004; Saxe, 2003)

Un paio di osservazioni riguardanti l'impatto del trauma sullo sviluppo. La ricerca ha dimostrato che la capacità di formare relazioni sane è fortemente dipendente dalle abilità sociali, di solito acquisite dai caregivers. L'apprendimento delle abilità sociali nei bambini è ovviamente direttamente correlato alle caratteristiche ambientali. Stiamo anche vedendo che la violenza, crescere in ambienti violenti produce ritiro sociale, ansia, sfiducia, reazione eccessive o ciò che noi chiamiamo iper-vigilanza e/o aggressività come meccanismi di adattamento, e che i comportamenti estremi, gravemente problematici sono radicati in stati emotivi disregolati. La persona non ha imparato a gestire le proprie emozioni, fondamentalmente un compito normale dello sviluppo che tutti abbiamo bisogno di apprendere precocemente.

Bambini traumatizzati: Osservazioni ed esperienze
- Appaiono trascurati e ansiosi
- Sono difficili da gestire e sostenere
- Sono emotivamente molto reattivi
- Hanno difficoltà "ad assestarsi" dopo le esplosioni
- Tendono a essere rivendicativi
- Non si assumono la responsabilità del comportamento
- Ripetono gli stessi errori più e più volte

(Hodas, 2004)

Desidero solo che vi ricordiate che molto spesso i pazienti adulti in cura nei centri di salute mentale provengono dai servizi per l'infanzia. Hodas, Direttore del State Medical for the Children's System in Pennsylvania, ritiene che trauma e comportamento abbiano una relazione diretta in molte di queste situazioni e che, molto spesso, le esperienze traumatiche e gli stili di vita caotici che questi bambini hanno appreso sono in effetti strategie comportamentali. Così è, anche se questi comportamenti ci appaiono (come adulti e professionisti) molto problematici e molto danneggianti, per quel bambino hanno un significato e sono stati incorporati come strategia di coping comportamentale.

Il Nucleo del problema: Evitamento della Vergogna e dell'Umiliazione
- Gilligan, nella sua ricerca sui detenuti ha identificato i vissuti di vergogna / umiliazione come elemento chiave della violenza. Egli dice:

"Il motivo psicologico alla base dei comportamenti violenti è il desiderio di allontanare o eliminare i sentimenti di vergogna e umiliazione – vissuti dolorosi che possono divenire intollerabili e sostituiti con ... un sentimento di orgoglio "

(Hodas, 2004

Un'altra questione fondamentale emersa di recente riguarda i vissuti prevalenti, come la vergogna e l'umiliazione. Gilligan, nella sua nota ricerca, ha identificato la vergogna e l'umiliazione come vissuti fondamentali nei comportamenti violenti. "... Talvolta, l'aggressività e la violenza sono una strategia con la quale i bambini o le persone dominate da vergogna e/o umiliazione riprendono il controllo del proprio ambiente.
James Garborino che ha scritto Lost Boys e altre pubblicazioni ha inoltre individuato questi vissuti come un problema molto critico in termini predittivi della violenza, spesso l'unico modo che un bambino o un adolescente ha a disposizione quando è dominato dal caos.

Cosa succede quando la vittima del trauma è isolata?
- Alcuni studi hanno rilevato che i bambini isolati hanno esperito trascuratezza, senso di vulnerabilità e di vergogna
- Sentirsi in balia dei ricordi del trauma (abuso) originale
- Esprime sentimenti di paura, rifiuto, rabbia e agitazione (verbale ed espressiva)
(Wadeson et al, 1976; Martinez, 1999; Mann et al, 1993; Ray et al, 1996)

Alcuni studi hanno rilevato che i bambini isolati e privi di adeguato sostegno hanno vissuto una rilevante condizione di vulnerabilità, abbandono e vergogna. La maggior parte di loro ha riferito di ricordare più volte l'abuso originale che avevano subito; che hanno sperimentato ed espresso sentimenti di paura, rifiuto e di rabbia dopo l'evento traumatico.

Cosa succede quando la vittima del trauma è isolata?
- Riferisce di aver ricevuto punizioni
- Confusione sull'uso personale della forza
- Non si sente protetta dai pericoli
- Nutre sentimenti di amarezza e di rabbia dopo circa 1 anno dall'esperienza
(Wadeson et al, 1976; Martinez, 1999; Mann et al 1993; Mohr, 1999; Ray et al., 1996)

Molti adulti riferiscono di essere stati puniti; di sentirsi confusi circa l'uso personale della forza, di non capire cosa stesse accadendo e di sentirsi spaventati e spaventosi.

Non si sono sentiti protetti e in alcuni casi documentano sentimenti di amarezza e di rabbia un anno dopo l'evento.

Trauma Informed Care Systems – Principi-Guida

- Integrano la filosofia di cura che guida tutti gli interventi clinici
- Sono basati sulla letteratura corrente
- Includono la prospettiva della vittima
- Sono orientati dalla ricerca scientifica e dalle prove di efficacia
- Riconoscono che gli interventi coercitivi producono ulteriore vittimizzazione e che pertanto devono essere evitati

(Fallot & Harris, 2002; Ford, 2003; Najavits, 2003)

Un sistema trauma informato di cura integra gli approcci filosofici sulla cura e pratica interventi che hanno finalità congruenti con i principi ispiratori. Le prassi di cura si basano sulla letteratura attuale e comprendono la prospettiva del superstite. Il sistema di assistenza Trauma informato dedica tempo e spazio al paziente per apprendere il modo in cui vive il trattamento, quali sono i problemi che sta affrontando e valuta assieme a lui/lei l'efficacia degli interventi attuati. Dedica tempo e spazio al bambino, all'adulto e alla famiglia per ottenere il loro feedback. I Sistemi TIC sono molto attenti ad attuare pratiche aggiornate ai risultati delle più recenti ricerche e alle prove di efficacia.
Con questo intendo il fatto di dare attenzione costante agli interventi attuati, al perché del loro utilizzo e all'importanza dell'evidenza scientifica.
Infine, i sistemi di assistenza trauma informati riconoscono che l'intervento coercitivo in quanto tale causa trauma e isolamento nelle persone che hanno già avuto esperienze traumatiche e che quindi sono da evitare a tutti i costi.

Trauma Informato sistemi di assistenza - Caratteristiche principali

- Riconoscimento degli alti tassi di PTSD e altri disturbi psichiatrici relativi a esposizione al trauma nei bambini e negli adulti con SMI / SED
- Valutazione diagnostica precoce e riflessiva mirata al trauma nei pazienti gravemente compromessi e refrattari al trattamento

(Fallot & Harris, 2002; Cook et al, 2002; Ford, 2003; Cusack et al)

La diagnosi trauma-focused è rivolta anche ai pazienti che non sono in grado di identificare una esperienza traumatica vita, nell'ottica della diagnosi differenziale.

Sistemi di assistenza Trauma Informati - Caratteristiche principali
- Riconoscimento che i pazienti in trattamento sono frequentemente reduci da esperienze traumatiche, sia apertamente che segretamente
- Riconoscimento che la maggior parte del personale sanitario che si occupa di salute mentale non è formata sul trauma e sulle sue conseguenze, non lo riconosce e non lo tratta

(Fallot & Harris, 2002; Cook et al, 2002; Ford, 2003; Cusack et al,; Jennings, 1998; Prescott, 2000)

In altre parole, il personale sanitario non è in grado di mentalizzare le prassi quotidiane d'intervento e la struttura in cui lavora con "gli occhi del paziente", mettendosi nei suoi panni o in quelli della famiglia. Inoltre che la maggior parte del personale che lavora nell'ambito della salute mentale è disinformata sul trauma, sui suoi effetti. Non riconosce il trauma e pertanto non lo affronta.

Sistemi di assistenza Trauma Informati - Caratteristiche principali
- Valorizzare il paziente in tutti gli aspetti della cura
- Adottare un linguaggio neutrale e di supporto
- Individuare approcci personalizzati e flessibili
- Evitare che il paziente si senta umiliato

(Fallot & Harris, 2002; Cook et al, 2002; Ford, 2003; Cusack et al, Jennings, 1998; Prescott, 2000)

Sistemi di assistenza Trauma informati mettono il paziente al centro della cura. Adottano un linguaggio neutro e solidale, centrato sulla persona e non sulle etichette diagnostiche. Creano progetti individuali e flessibili nel pieno rispetto della persona.

Sistemi di assistenza Trauma Informati - Caratteristiche principali
- Sensibilizzazione / formazione del personale sul trauma, le sue conseguenze e il trattamento
- I servizi sono aperti a soggetti esterni:
- avvocati e consulenti clinici
- Formazione e supervisione nella valutazione e nel trattamento delle persone con storie di traumi

(Fallot & Harris, 2002; Cook et al, 2002; Ford, 2003; Cusack et al, Jennings, 1998; Prescott, 2000)

I Sistemi di assistenza Trauma informati sviluppano una forte consapevolezza sulle prassi d'intervento con i pazienti reduci da esperienze traumatiche e provvedono a garantire una costante formazione del personale in merito a questo. Sono aperti a soggetti esterni come gli avvocati della difesa e i consulenti clinici favorendo una collaborazione e fornendo loro feedback sul lavoro svolto. Incentivano la supervisione in modo da fornire un trattamento aggiornato e appropriato.

Sistemi di assistenza Trauma Informati - Caratteristiche principali
- Concentrarsi su ciò che è successo piuttosto su ciò che è sbagliato in te (Bloom, 2002)
- Formulare domande su eventuali vittimizzazioni attuali
- Affrontare glia spetti relativi alla sicurezza e i rischi per aiutare la persona a e individuare un piano di sicurezza
- Formulare le domande in modo sensibile e rispettoso
- Valutare l'affidabilità di pazienti psicotici e deliranti, sapendo che se le domande sono formulate in modo appropriato, anch'essi sono in grado di riferire esperienze traumatiche
(Rosenburg, 2002)

(Fallot & Harris, 2002; Cook et al, 2002; Ford, 2003; Cusack et al, Jennings, 1998; Prescott, 2000)

Nei Sistemi di assistenza Trauma informati le persone vengono avvicinate alla loro esperienza traumatica attraverso domande rispettose e sensibili. Si chiede "cosa ti è successo". L'ambiente dovrebbe essere tranquillo e riservato perché molto spesso si tratta di eventi difficili da raccontare e a volte questa è la prima occasione in cui il

paziente avverte un interesse verso la sua esperienza traumatica. Domande esplorative sul trauma possono essere rivolte anche a pazienti psicotici e deliranti, ma esse devono essere adattate e potrebbe essere necessario più tempo a disposizione per compiere un follow-up completo.

Sistemi insensibili al trauma

- I pazienti sono etichettati come manipolativi, bisognosi, in cerca di attenzione
- Uso improprio o eccessivo del potere
- Cultura del segreto – chiusura verso l'esterno e scarso monitoraggio del personale
- Il personale ritiene di essere il garante delle regole o di avere un ruolo-chiave in questo

(Fallot & Harris, 2002)

Vi invito a leggere le cartelle cliniche di molti reparti psichiatrici per verificare come il personale è stato addestrato a scrivere sui pazienti: descritti spesso come eccessivamente dipendenti, bisognosi di cure e attenzione, manipolativi, non collaboranti, aggressivi, non conformi alle regole. Vorrei sostanzialmente richiamare la vostra attenzione sul fatto che il personale avrà bisogno di formazione in materia di cura dei traumi, sugli approcci umanistici e olistici centrati sulla persona e sui suoi punti di forza.

Sistemi insensibili al trauma

- Scarso uso di pratiche alternative (incluse quelle farmacologiche) meno restrittive
- Enfasi sulla "complicità" piuttosto che sulla collaborazione
- Tendenza a punire e a svalutare il personale che poi "trasferisce" la mancanza di rispetto ai destinatari degli interventi.

- (Fallot & Harris, 2002)

Vedrete poco uso di interventi non restrittivi e alternativi ad eccezione di farmaci e quando si chiede al personale che cosa intendono per intervento non restrittivo, il più delle volte indicheranno quello farmacologico.
Sono le istituzioni che enfatizzano il rispetto piuttosto che la collaborazione, che sono imprigionate in molte regole e procedure pretese da molti interlocutori. Le regole e il loro rispetto sono l'argomento principale con gli utenti. Sole le istituzioni che indeboliscono e svalutano il proprio personale che poi "trasferiscono" la mancanza di rispetto verso i destinatari del servizio.

Sistemi insensibili al trauma - Caratteristiche correlate
- Alti tassi di pregiudizio
- Minore adesione al trattamento
- Alti tassi di denunce dei pazienti
- Più elevati tassi di turnover del personale, insoddisfazione professionale e burn-out
- Prolungamento dei trattamenti / aumento della recidiva

(Fallot & Harris, 2002; Massachusetts DMH, 2001; Huckshorn, 2001)

Impegno organizzativo nei Sistemi di cura formati sul Trauma

L'adozione di una politica sul trauma include:
- Impegno a valutare in modo appropriato il trauma
- Attenzione a evitare prassi d'intervento traumatizzanti
- Il coinvolgimento attivo degli amministratori
- Risorse disponibili per modificare e migliorare il sistema delle prestazioni
- Dare priorità alla formazione del personale

(Fallot & Harris, 2002; Cook et al, 2002)

Per organizzare un sistema di cura formato sul trauma è necessario un impegno forte dell'apparato dirigenziale. Questo non può essere fatto dal personale.
Gli amministratori e i dirigenti devono fornire le direzione, l'attenzione e le risorse per sostenere questo processo di cambiamento di grandi dimensioni. La formazione del personale è una priorità per sostenere il cambiamento.

Impegno organizzativo nei Sistemi di cura formati sul Trauma

- Personale esperto in grado di fornire consulenza sul trauma
- Personale specializzato per il sostegno del personale, se indicato

(Fallot & Harris, 2002; Cook et al, 2002)

Il personale che lavora con pazienti traumatizzati ha la necessità di usufruire facilmente a consulenza o a sostegno. Quello che abbiamo trovato in molti casi, girando per il Paese, sono operatori a loro volta traumatizzati. Hanno assistito agli stessi tipi di violenza, a volte sono stati vittime di violenza e non hanno ricevuto aiutoo. Quindi, i sistemi di cura che sono trauma formati si prendono cura del loro personale.

Impegno organizzativo nei Sistemi di cura formati sul Trauma

- La valutazione dei dati orienta la pianificazione del trattamento nel quotidiano lavoro clinico
- La sicurezza del personale e dei pazienti è un obiettivo prioritario
- Potere e controllo sono ridotti al minimo per favorire il coinvolgimento e l'integrazione

(Fallot & Harris, 2002; Cook et al, 2002)

Trauma Assessment- Scopi

- Identifica un trauma passato o attuale, la violenza, gli abusi, e valuta le sequele correlate
- Fornisce linee guida cliniche per i sintomi attuali e il recupero
- Riduce al minimo il pericolo di ri-vittimizzazioni

(Cook et al, 2002; Fallot & Harris, 2002; Maine BDS, 2000)

Ci sono diversi tipi di valutazioni del trauma attualmente utilizzate. Una buona valutazione del trauma vi aiuterà a definire un contesto per comprendere e curare la sintomatologia attuale.

Valutazione del trauma - Strumenti di misurazione per aumentare l'affidabilità diagnostica
– Post-Traumatic Diagnostic Scale for adults (Foa et al., 1997)
– Child PTSD Symptom Scale (Foa et al., 2001)
– Trauma Symptom Checklist for Children (Briere, 1995)
– Child Stress Disorders Checklist, CSDC (Saxe, 2003)

Questi sono solo alcuni strumenti di valutazione del trauma validi e affidabili.

Valutazione del trauma
- Follow-up continuo, preferibilmente effettuato dallo stesso clinico

(Ibid)

La valutazione del trauma richiede follow-up, preferibilmente con lo stesso clinico o con qualcuno che ha sviluppato un rapporto con la persona. Questi non sono argomenti facili da discutere e per molti potrebbe essere la prima volta che qualcuno esplora il trauma.

Valutazione del trauma
Deve includere:
Type: sexual, physical, emotional abuse or neglect, exposure to disaster
Age: when the abuse occurred
Who: perpetrated the abuse

- Valutazione dei sintomi come: dissociazione, flashback, iper-vigilanza, intorpidimento, selfinjury, ansia, depressione, scarso rendimento scolastico, problemi della condotta, problemi della sfera alimentare ecc.

(Ibid)

Valutazione del trauma

- Risultati e "risposte positive" devono essere esplorati e inclusi nella pianificazione, altrimenti la valutazione è inutile
- Non enfatizzare l'importanza dell'impegno terapeutico durante intervista
- Per i bambini, la valutazione è effettuata attraverso il gioco e l'osservazione del comportamento

(Ibid)

Il colloquio dovrebbe essere effettuato poco dopo il ricovero o subito dopo.
A volte non è facile, ma in generale, la maggior parte dei pazienti ha bisogno di essere avvicinata molto rapidamente al momento del ricovero per molte ragioni. Una è quella di gestire il rischio. L'importanza di creare una alleanza terapeutica durante la valutazione del trauma non può essere sottovalutata e, di nuovo, è necessario ricorrere a personale abbastanza bravo a creare una buona accoglienza.

Valutazione del trauma Altri fattori da valutare

- Precedenti ricoveri e cure farmacologiche anche obbligatorie
- Esperienze individuali in regime di ricovero ospedaliero
- Vissuti di paura, rabbia, impotenza e dissociazione,
- Senzatetto, dipendenza, violenza domestica
- Reazioni alla rivelazione (abbandono, protezione, riconoscimento?)
- Interesse a collaborare per la propria sicurezza e provvedere alla propria protezione

Preoccupazioni immediate che richiedono un intervento
- Esperienze traumatiche in corso, partner violento
- Mancanza di sicurezza in casa, comunità o trattamento imposto
- Se necessario, collaborare con altri servizi e agenzie (abusi su bambini, anziani, violenza domestica)

LGBTQ ISSUES AND CHILD TRAUMA

RESOURCE TYPE

Fact Sheet

TRAUMA TYPE

Sexual Abuse

LANGUAGE

English

AUDIENCE

POPULATION

LGBTQ Youth

NCTSN RESOURCE

Resource Description

Offers an introduction to the *Safe Places, Safe Spaces* video. This fact sheet gives a brief overview for working with LGBTQ youth as well as a synopsis of the video, and suggested resources.

Published in 2015

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Related Resources

Safe Places, Safe Spaces: Creating Welcoming and Inclusive Environments for Traumatized LGBTQ Youth Video

Introduces the viewer to the needs of lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth who have experienced trauma.

view

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CLINICAL RESEARCH ARTICLE

Personality, posttraumatic stress and trauma type: factors contributing to posttraumatic growth and its domains in a Turkish community sample

Ayse Nuray Karanci[1]*, Sedat Işıklı[2], Ahmet Tamer Aker[3], Ervin İzmit Gül[1], Burçak Başbuğ Erkan[4], Hivren Özkol[1] and Hayal Yavuz Güzel[2]

[1]Department of Psychology, Middle East Technical University, Ankara, Turkey; [2]Department of Psychology, Hacettepe University, Ankara, Turkey; [3]Medical School Department of Psychiatry & Centre for Psychological Trauma and Disaster Studies, Kocaeli University, Kocaeli, Turkey; [4]Department of Statistics, Middle East Technical University, Ankara, Turkey

Background: Posttraumatic growth (PTG) is conceptualized as a positive transformation resulting from coping with and processing traumatic life events. This study examined the contributory roles of personality traits, posttraumatic stress (PTS) severity and their interactions on PTG and its domains, as assessed with the Posttraumatic Growth Inventory Turkish form (PTGI-T). The study also examined the differences in PTG domains between survivors of accidents, natural disasters and unexpected loss of a loved one.
Methods: The Basic Personality Traits Inventory, Posttraumatic Diagnostic Scale, and PTGI-T were administered to a large stratified cluster community sample of 969 Turkish adults in their home settings.
Results: The results showed that conscientiousness, agreeableness, and openness to experience significantly related to the total PTG and most of the domains. The effects of extraversion, neuroticism and openness to experience were moderated by the PTS severity for some domains. PTG in relating to others and appreciation of life domains was lower for the bereaved group.
Conclusion: Further research should examine the mediating role of coping between personality and PTG using a longitudinal design.

Keywords: *Domains of posttraumatic growth*; *personality traits*; *posttraumatic stress*; *traumatic event types*

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Although negative aftermaths of traumatic events have been studied extensively, interest in the positive changes following traumatic events, referred to as posttraumatic growth, stress-related growth, or benefit finding, have captured the interest of researchers relatively more recently (Calhoun & Tedeschi, 1999; Helgeson, Reynolds, & Tomich, 2006; Larner & Blow, 2011; Park & Helgeson, 2006). Posttraumatic growth (PTG) is defined as positive psychological change experienced/reported as a result of an individual's struggle to cope with traumatic events (Calhoun & Tedeschi, 1999; Morris, Shakespeare-Finch, Rieck, & Newbery, 2005; Tedeschi, 1999; Tedeschi & Calhoun, 2004). Research showed that PTG is reported following various types of traumatic life events, such as natural disasters (e.g., Cieslak et al., 2009; Karanci & Acarturk, 2005), accidents (e.g., Nishi, Matsuoka, & Kim, 2010; Shakespeare-Finch & Armstrong, 2010) and loss of a loved one (e.g., Davis, Michael, & Vernberg, 2007; Taku, Calhoun, Cann, & Tedeschi, 2008a).

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Tedeschi and Calhoun (2004), in their functional descriptive model, proposed that PTG results from a metaphorically seismic event, shaking the fundamental schemas, beliefs and goals of the individual. This is followed first by automatic ruminations about the event and later with more deliberate ruminations, which leads to schema change and narrative development, and potentially to PTG. The Posttraumatic Growth Scale (PTGI: Tedeschi & Calhoun, 1996) is one of the most frequently used instruments for the assessment of post-traumatic growth. It taps five domains of PTG, namely appreciation of life; relating to others; personal strength; new possibilities; and spiritual growth (Taku, Cann, Calhoun, & Tedeschi, 2008b; Tedeschi & Calhoun, 2004).

Schaefer and Moos (1992), offered a comprehensive model on the determinants of positive changes following traumatic events, which explains positive change with respect to different factor clusters, covering pre-trauma (i.e., individual and environmental) resources, trauma characteristics (i.e., severity of exposure, impact) and post trauma factors (i.e., coping and appraisals). Schaefer and Moos's (1992) model clearly points out that pre-trauma characteristics, such as personality traits will have an effect on how the trauma impacts the individual. Thus, the present study examined the role of personality traits as a pre-trauma variable and the impact of the trauma as manifested in posttraumatic symptomatology, and finally their joint effects in predicting PTG and its domains.

Research focusing on personality as a pre-trauma variable has shown that openness to experience (Linley & Joseph, 2004; Tedeschi & Calhoun, 1996; Zoellner, Rabe, Karl, & Maercker, 2008), agreeableness and conscientiousness (Garnefski, Kraaij, Schroevers, & Somsen, 2008; Linley & Joseph, 2004), extraversion (Garnefski et al., 2008; Sheikh, 2004; Tedeschi & Calhoun, 1996; Val & Linley, 2006), and neuroticism (Evers et al., 2001; Garnefski et al., 2008) are correlated with PTG. Tedeschi and Calhoun (1996) showed that the personality traits of extraversion, openness to experience and optimism are specifically positively related with the dimensions of new possibilities and personal strength. However, there are also some studies failing to find a relationship between personality and PTG, like for optimism (Bostock, Sheikh, & Barton, 2009). Helgeson et al. (2006), in their meta-analysis on benefit finding, failed to find a relationship between neuroticism and PTG. In other studies, however, an inverse significant relationship was found between neuroticism and PTG (Evers et al., 2001; Garnefski et al., 2008). Zoellner et al. (2008), found that for motor vehicle accident survivors with high PTSD higher levels of optimism, and lower levels of openness was related to higher PTG, whereas for those with low levels of PTSD, lower levels of optimism, and higher levels of openness were related to PTG. Thus, in general research seems to support the role of some personality traits in shaping PTG. However, the contributory roles of different personality traits in domains of PTG and the interaction of personality traits with traumatic stress in contributing to PTG and its domains has not been extensively researched, and this is one of the aims of the present study.

Tedeschi and Calhoun (2004), in their model of PTG proposed that the more seismic the event the more likely it is to experience positive outcomes. This is related to the necessity to process the event and to search for meaning. Several studies, in agreement with the PTG model, have shown that individuals may experience both posttraumatic stress and PTG at the same time (Levine, Laufer, Hamama-Raz, Stein, & Solomon, 2008; Loiselle, Devine, Reed-Knight, & Blount, 2011; Morrill et al., 2008; Tedeschi & Calhoun, 1996). Morris et al. (2005) showed that there are moderate to strong correlations between PTSD symptoms and each domain of PTG. Although the direction of the relationship was positive for most domains, only for the appreciation of life domain they noted a negative relationship between growth and post-traumatic symptomatology.

Thus, it is important to examine the relationship of PTS symptoms and different domains of PTG. In one study with motor vehicle accident survivors, it was found that survivors without PTSD reported higher growth in the perception of personal strength and survivors with PTSD reported higher growth in the perception of appreciation of life and spiritual change (Nishi et al., 2010). Zoellner et al. (2008) found no differences in PTG total score between respondents with different levels of distress (conceptualized with levels of PTSD as measured by Clinician-Administered PTSD Scale). However, for sub-domains of PTG, they reported that those without PTSD had higher scores in perception of personal strength than the PTSD group, whereas those with PTSD scored higher in appreciation of life and spiritual change as compared to the non-PTSD group. Thus, it seems that the level of posttraumatic stress may have an influence on which domain growth is experienced within. Lower posttraumatic distress seems to be related with higher growth in the personal strength domain, whereas higher distress seems to be related with more growth in the appreciation of life and spiritual change domains (Nishi et al., 2010; Zoellner et al., 2008). One of the aims of the present study was to examine how posttraumatic symptomatology relates to the domains of PTG.

Although PTG and its domains have been studied extensively with survivors of different kinds of traumatic events, to our knowledge there are very few studies (e.g., Shakespeare-Finch & Armstrong, 2010) examining survivors of different types of traumatic events in the same study. Thus, one aim of the present study is to examine growth in the domains of PTG amongst the survivors of different types of traumatic events (i.e., accidents, natural

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disasters and unexpected death of a loved one). Death of a loved one, physical threat and life transition problems seem to lead to higher levels of PTG (Cummings & Swickert, 2010; Ickovics et al., 2006). The only study in which survivors of three types of events were compared in the same study showed that the bereaved group had higher growth in relating to others and appreciation of life domains as compared to survivors of sexual assault.

The purpose of the present study was to examine the contributory roles of personality traits, posttraumatic symptomatology and their interactions in PTG and its domains in a large community sample of adults, from a predominantly Muslim country, Turkey, experiencing diverse traumatic events. A secondary aim was to examine whether the survivors of different types of traumatic events differ in the domains of PTG. For this aim, the most frequently experienced events by the current sample, namely accidents, natural disasters and unexpected death of a loved one were used.

Based on previous research, it was hypothesized that openness (e.g., Linley & Joseph, 2004), agreeableness, conscientiousness (e.g., Garnefski et al., 2008; Linley & Joseph, 2004) and extraversion (e.g., Garnefski et al., 2008; Sheikh, 2004; Tedeschi & Calhoun, 1996) will be positively, whereas neuroticism will be negatively (e.g., Evers et al., 2001) related to PTG total. We also predicted that posttraumatic symptoms will have a positive relationship with the PTG total (e.g., Loiselle et al., 2011; Tedeschi & Calhoun, 1996). Since the role of personality traits and PTS severity on sub-domains of PTG have not been extensively studied in the literature, we made no specific predictions for the sub-domains of PTG and also for the impact of the types of traumatic events on the sub-domains of PTG. Thus, we aimed to explore the impact of personality traits, posttraumatic symptoms and their interactions on PTG and its domains. Similarly, we aimed to evaluate differences in domains of PTG between the survivors of accidents, natural disasters, and bereavement.

Method

Participants and procedure

The present study is part of a large scale study on the prevalence of traumatic events, posttraumatic stress disorder, posttraumatic growth. The participants were 969 adults, from a stratified cluster community sample provided by the Turkish Statistical Institute (TURKSTAT) for Ankara, the capital city, Kocaeli, in the Marmara region devastated by the 1999 earthquakes and Erzincan, with an experience of a devastating earthquake in 1991, in eastern Turkey. TURKSTAT used the data from the address based census information to provide a random sample of households. The calculation of the sample size was based on an expectation of 60% trauma prevalence and 5% error rate, based on the method suggested by Sümbüloğlu and Sümbüloğlu (1987), 700 households from Ankara, 600 from Kocaeli and 500 from Erzincan, with a total of 1,800 were drawn. Demographic characteristics of the total sample and the three provinces are given in Table 1.

Instruments

The Socio-Demographic Information Form had questions on participants' demographic features (age, sex, years of education, marital status: single/engaged, married, widow/er, divorced, other), work status (employed, unemployed, other), income (rated on a 5-point scale by the participant; 1: very low to 5: very high), previous history of mental illness (Yes/No), if yes then the type of treatment received (psychological treatment; medication; other) and whether they are currently receiving psychiatric treatment (Yes/No).

The Posttraumatic Diagnostic Scale (PDS) is a 49-item self-report instrument, developed by Foa, Cashman, Jaycox, and Perry (1997), to assess posttraumatic stress symptoms, based on the criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision (APA, 2000). The scale assesses the lifetime experience of various traumatic events, the most distressing event for the individual, and the potential PTSD diagnosis. For the present study, the severity of posttraumatic stress symptoms, assessed with 17 items (posttraumatic symptom severity scale-PTS) rated on a 3-point scale (total score ranging between 0 and 51) was used. The psychometric properties of the scale have been reported to be adequate (Foa et al., 1997).

The scale was adapted into Turkish by Isikli (2006), with satisfactory psychometric properties (Duru, 2006; Isikli, 2006). For the present study, the Cronbach's alpha value for the PTS, which was used as an indicator of posttraumatic distress was 0.90. In the present study the type of most distressing traumatic event chosen by the participants was used as "the type of traumatic event", the PTS score (total of 17 items) was used as a measure reflecting the severity of posttraumatic stress symptoms as a potential predictor of PTG and its sub-domains.

The Posttraumatic Growth Inventory (PTGI) is a 21-item scale, designed to measure the positive changes experienced after major life stressors (Tedeschi & Calhoun, 1996). Items are rated on 6-point scales (0 = I did not experience this change, 5 = I experienced this change to a very great degree). The reliability (Cronbach's alpha) coefficients of each factor were reported to be satisfactory.

Dirik and Karanci (2008) provided the Turkish translated version of the scale. For the present study the original five-factor model of PTG was tested with Confirmatory Factor Analysis (CFA) using EQS6.1 (Bentler, 1995; Byrne, 2006). Based on the robust statistics, the

Table 1. Demographic characteristics of the sample ($N = 969$)

	Total sample		Ankara ($N = 302$)		Erzincan ($N = 248$)		Kocaeli ($N = 419$)	
	%	Mean (SD)	%	Mean (SD)	%	Mean (SD)	%	Mean (SD)
Education (years)		8.3 (4.4)		9.8 (4.5)		7.7 (4.2)		7.7 (4.3)
Age		41.8 (15.8)		42.0 (15.9)		40.7 (15.0)		42.3 (16.3)
Sex								
Female	63		62		68		62	
Male	37		38		32		38	
Marital status								
Single/engaged	18.3		18		17.7		19.4	
Married	69.2		68.5		69.8		69.5	
Widow/er	9.3		8.6		11.3		8.6	
Divorced	2.4		3.6		1.2		2.1	
Other	0.8		0.7		0		0	
Work status								
Employed	29.8		34.1		23.4		30.5	
Non-employed	69.5		64.9		76.2		68.7	
Other	0.4		0.3		0.4		0.5	
Income*								
Very low	11.5		10.9		14.5		10.0	
Low	25.3		23.8		29.4		23.9	
Medium	54.0		50.7		51.2		58.0	
Above medium	8.3		13.2		4.0		7.2	
Very high	0.8		1.3		0.8		0.5	
Mental illness								
No	82.1		83.4		80.6		82.1	
Yes	16.8		15.6		19.4		16.2	
Psychological therapy	1.2		1.7		1.6		0.7	
Medication	12.8		12.3		14.1		12.4	
Other	2.7		1.7		4.0		2.6	
Currently in treatment								
Yes	5.8		5.0		6.9		5.7	
No	10.2		9.6		12.1		9.5	
Types of event								
Accident	11.0		16.6		8.1		8.8	
Natural disaster	28.1		8.9		22.6		45.1	
Death/illness	40.6		49.7		46.4		30.1	

*Income was rated on a five point scale by the participants.

hypothesized model fit our data very well (S-Bχ^2(179, $N = 1{,}253$) = 829.876, $p < 0.001$, $CFI = 0.98$; $RMSEA = 0.054$; *C.I.* 0.050, 0.058). The reliability (Cronbach's alpha) coefficients for the present sample were, new possibilities ($\alpha = 0.81$), relating to others ($\alpha = 0.84$), personal strength ($\alpha = 0.79$), spiritual change ($\alpha = 0.63$), and appreciation of life ($\alpha = 0.83$).

The Basic Personality Traits Inventory (BPTI) was developed by Gençöz and Öncül (in press) after identifying 226 commonly used adjectives in the Turkish culture to define different personality traits obtained from a sample of 100 participants. These adjectives were then administered to 510 participants to rate their own personalities on a 5-point scale. Factor analysis with varimax rotation yielded five factors in agreement with the literature and a sixth factor reflecting negative valence (e.g., being rude; insincere, having no manners). Forty-five items which had the highest loadings on the factors were chosen to form the BPTI. The 45 items inventory was then administered to a sample of 454 university students to evaluate the factor structure and psychometric properties. The test–retest (3 weeks) coefficients were between 0.74 and 0.84. The correlations of the personality dimensions with self-esteem, coping strategies and social support, STAI-S and STAI-T and PANAS supported its validity. The reliability

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(Cronbach's alpha) coefficients for each subscale were found to be adequate.

Since the scale was developed and validated originally in a university student sample, exploratory factor analysis, with varimax rotation was used for the present community sample. As in the original, six factors, accounting for 44.96% of the total variance were obtained. The factors were agreeableness (15.96%); conscientiousness (9.68%), extraversion (6.66%), neuroticism (4.76%), negative valence (4.53%) and openness to experience (3.37%). Cronbach's alpha internal consistency coefficients of agreeableness, conscientiousness extraversion, neuroticism, negative valence, and openness to experience were 0.83, 0.78, 0.78, 0.76, 0.59 and 0.67 respectively for the present sample. Since the Cronbach's alpha for the negative valence dimension was relatively low, and since it is not a dimension researched in the literature, it was not included in the analysis of the present study.

Procedure

After obtaining approval from the Ethics Committee of Middle East Technical University (METU), fourth year students of the Psychology Departments of METU, Hacettepe and Kocaeli Universities were trained in administering the instruments. Subsequently, participants were visited in their homes based on the addresses provided by the TURKSTAT and were informed about the purposes of the study. They were asked to sign an informed consent form. When the household was contacted, first a list of all individuals above the age of 18 living in the household was obtained. Using the number of adults in a household and the last digit of the survey instrument, the Kish Table (Kish, 1965), providing a method for the random selection of an individual from a household, was used to determine the participant to be included from each household. The inclusion criteria were living in the household for at least 1 year and being 18 or above. Only one adult from each household was included in the sample. When the person chosen was not at home, an appointment was made to visit the household again. If the participant could not be reached in three visits, the procedure was discontinued. A total of 1,800 households were visited in the three provinces over a 6 month period in 2009. We were successful in reaching 1,253 out of 1,800 (69.61%) who accepted to participate. This rate seems to be quite expectable since some could not be contacted after three separate visits and some addresses were not occupied. Out of these 1,253, 1,055 (58.6%) reported to have experienced at least one traumatic event in their lives based on the list of events given in the PDS of Foa et al. (1997), and finally 969 (53.8%) chose one traumatic event that distressed them the most and the present study sample is comprised of these 969 participants. The administration took about 30 min. Participants were informed that they could stop any time and for those who expressed that they were still very distressed due to a traumatic event, we gave a list of mental health facilities that had accepted to give support to study participants.

Statistical methods

After inspection of the data and data cleaning procedures, correlation analysis and hierarchical multiple regression analysis were conducted using the SPSS 15.0 program (SPSS Inc., 2006). Six separate hierarchical multiple regression analyses were conducted to evaluate how well personality traits, posttraumatic stress (PTS) severity and their interaction terms predicted the total PTG score and its sub-domains while statistically controlling for the socio-demographic variables. The criterion variables were the total PTG score and the scores of the five sub-domains. The socio demographic variables (age, sex, and years of education) were taken as control variables in order to control for their possible confounding effects on the predictors and were entered into the equation with enter method in the first block. Personality traits (extraversion, conscientiousness, agreeableness, neuroticism, and openness) were entered into the second block, with the stepwise method. In the third block, posttraumatic stress (PTS) severity was entered into the regression model. It was hypothesized that personality traits would moderate the relationship between PTS severity and PTG scores. Therefore, the five two-way interaction terms (personality traits $\times$ PTS) were entered as a set in the final step. If there would be a coefficient not equal to zero at 0.05 then the reduced model was conducted. Finally, a simple slope analysis was conducted for significant interaction terms (Aiken & West, 1991; Jose, 2008).

To evaluate the differences in PTG domains between survivors of three different kinds of traumatic events (i.e., accidents, natural disasters and bereavement) a one-way multivariate analysis of variance (MANOVA) was conducted.

Results

Predictors of PTG and its domains: regression analyses

The Pearson product–moment correlations among the major predictors and criterion measures are presented in Table 2. As can be seen from the table, among the personality traits conscientiousness and agreeableness had significant correlations with all the domains and the total PTG. PTS severity had significant positive correlations with the total PTG score and most of its sub-domains.

Six separate hierarchical multiple regression analyses were conducted to evaluate how well personality traits,

Table 2. Correlation matrix and descriptive data of the variables used in hierarchical regression analysis

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. PTG	–	0.83*	0.84*	0.78*	0.79*	0.82*	0.05	0.19*	0.21*	0.08*	0.19*	0.19*
2. New possibilities		–	0.70*	0.52*	0.57*	0.65*	0.05	0.13*	0.20*	0.11*	0.20*	0.20*
3. Personal strength			–	0.55*	0.59*	0.63*	0.08*	0.20*	0.18*	0.05	0.23*	0.19*
4. Spiritual change				–	0.47*	0.57*	−0.04	0.15*	0.15*	0.11*	0.02	0.24*
5. Appreciation of life					–	0.54*	0.09*	0.15*	0.16*	0.02	0.18*	0.06
6. Relating to other						–	0.05	0.14*	0.18*	0.02	0.15*	0.10*
7. Extraversion							–	0.21*	0.20*	−0.21*	0.38*	−0.16*
8. Conscientiousness								–	0.45*	−0.02	0.38*	0.02
9. Agreeableness									–	0.04	0.40*	0.13*
10. Neuroticism										–	−0.08*	0.37*
11. Openness to experience											–	−0.05
12. PTS severity												–
M	2.24	1.49	2.4	2.9	2.4	1.9	3.7	4.1	4.3	2.7	3.7	11.1
SD	1.2	1.3	1.5	1.7	1.7	1.3	0.8	0.6	0.5	0.8	0.7	10.3
N	962	962	962	962	962	962	969	969	969	969	969	924

*$p < 0.05$, one-tailed.
Note: PTG, total score of posttraumatic growth; PTS, total score of posttraumatic stress.

posttraumatic stress severity and their interaction terms predicted the total PTG score and its sub-domains while statistically controlling for the socio-demographic variables (see statistical methods section for details).

Total PTG

The variables in the final model (Table 3) accounted for 14% of the total variance in the total PTG, $R^2 = 0.14$, $F_{(14,901)} = 10.4$, $p < 0.001$. Thus, in the overall model, personality traits, PTS severity, and their interactions accounted for a significant portion of the variance in the total PTG score, after controlling for the socio-demographic variables.

Conscientiousness, agreeableness, openness to experience, posttraumatic stress symptom severity appeared significantly related to the total PTG score. Of the five two-way interaction terms entered at block four of the hierarchical regression, only PTS × extraversion interaction was significant, indicating that the regression of PTS severity on total PTG score varies as levels of extraversion vary. The slopes of the high and low levels of extraversion (Fig. 1) were found to be significant (simple slope = 0.03, $t = 5.7$, $p < 0.001$; simple slope = 0.011, $t = 2.2$, $p < 0.05$, respectively).

New possibilities

The variables in the final model (Table 3) accounted for 18% of the total variance in the score of new possibilities, $R^2 = 0.18$, $F_{(14,901)} = 12.5$, $p < 0.001$. Thus, in the overall model, personality traits, PTS severity, and their interactions accounted for a significant portion of the variance in the score of new possibilities while controlling for the socio-demographic variables. Agreeableness, openness to experience and PTS severity appeared significantly related to new possibilities. Of the five two-way interaction terms entered at block four of the hierarchical regression, only PTS × extraversion interaction was significant, indicating that the regression of PTS severity on the score of new possibilities varies as levels of extraversion vary.

The slopes of high and low levels of extraversion (Fig. 2) were found to be significant (simple slope = 0.03, $t = 5.9$, $p < 0.001$; simple slope = 0.01, $t = 2.8$, $p < 0.01$, respectively).

Spiritual change

The variables in the final model (Table 3) accounted for 13% of the total variance in the score of spiritual change, $R^2 = 0.13$, $F_{(14,901)} = 9.3$, $p < 0.001$. Thus, in the overall model, personality traits, PTS severity, and their interactions together accounted for a significant portion of the variance in the score of spiritual change while controlling for the socio-demographic variables.

Conscientiousness, agreeableness, and posttraumatic stress symptom severity appeared significantly related to the score of spiritual change. Of the five two-way interaction terms, only PTS × extraversion and PTS × neuroticism interactions were significant, indicating that regression of PTS severity on the score of spiritual change varies as levels of extraversion and neuroticism vary.

The slopes of high and low level of extraversion (Fig. 3) were found to be significant (simple slope = 0.05, $t = 6.3$, $p < 0.001$; simple slope = 0.02, $t = 2.7$, $p < 0.01$, respectively).

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Table 3. Summary of hierarchical regression of personality traits, PTS severity and their interaction terms on PTG total score and PTG sub-domains, while statistically controlling for the socio-demographic variables[a]

		PTG total score		New possibilities		Spiritual change		Relating to others		Personal strength		Appreciation of life	
Step	Variables	R^2 change	β	R^2 change	β	R^2 change	β	R^2 change	β	R^2 change	β	R^2 change	β
1	The socio-demographic variables	0.03*		0.06*		0.04*		0.01*		0.02*		0.01*	
2	Personality traits	0.07*		0.08*		0.04*		0.05*		0.08*		0.05*	
	Extraversion		0.01		−0.02		−0.05		−0.01		0.03		0.10
	Conscientiousness		0.18*		0.13		0.25*		0.08		0.24*		0.20*
	Agreeableness		0.33*		0.33*		0.38*		0.42*		0.17		0.37*
	Neuroticism		0.01		0.05		0.01		−0.05		−0.02		0.02
	Openness to experience		0.18*		0.28*		−0.09		0.16*		0.36*		0.16
3	Posttraumatic stress (PTS) severity	0.03*	0.02*	0.03*	0.02*	0.03*	0.04*	0.01*	0.02*	0.02*	0.03*	0.001	0.01
4	Interaction terms	0.01*		0.01		0.02*		0.02*		0.01		0.01*	
	PTS × extraversion		0.09*		0.10*		0.12*		0.09*		0.11*		0.01
	PTS × conscientiousness		−0.03		−0.02		0.01		−0.09*		−0.03		−0.02
	PTS × agreeableness		0.02		−0.01		0.03		0.07		0.01		−0.01
	PTS × neuroticism		−0.04		0.04		−0.11*		−0.09*		−0.01		−0.03
	PTS × openness to experience		0.05		0.03		0.07		0.001		0.03		0.12*

[a]Age, sex, and years of education were used as control variables.
*$p < 0.05$.

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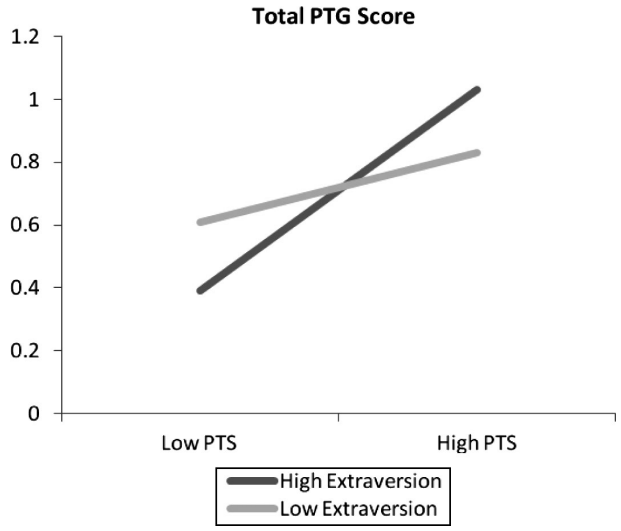

Fig. 1. The interaction of PTS severity and extraversion on the total PTG score.

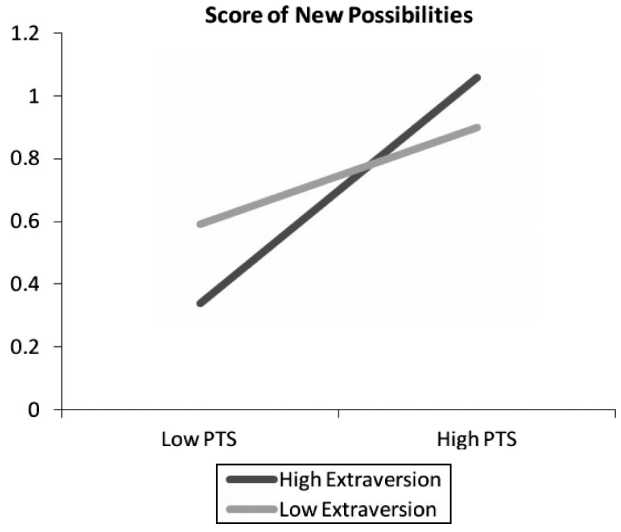

Fig. 2. The interaction of PTS severity and extraversion on the score of new possibilities.

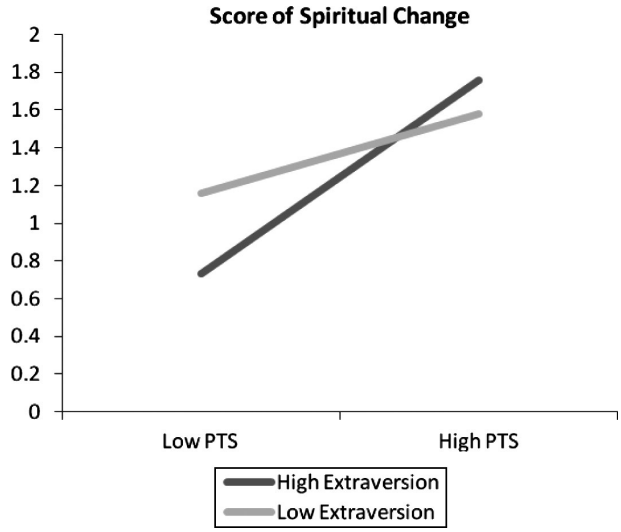

Fig. 3. The interaction of PTS severity and extraversion on the score of spiritual change.

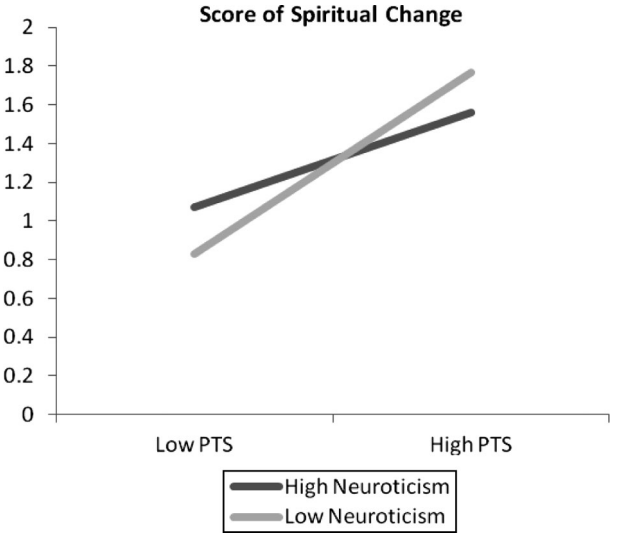

Fig. 4. The interaction of PTS severity and neuroticism on the score of spiritual change.

The slopes of high and low level of neuroticism (Fig. 4) were also found to be significant (simple slope $=0.02$, $t=3.6$, $p<0.001$; simple slope $=0.05$, $t=5.3$, $p<0.01$, respectively).

Relating to others

The variables in the final model (Table 4) accounted for 9% of the total variance of score of relating to others, $R^2=0.09$, $F_{(14,901)}=5.9$, $p<0.001$. Thus, in the overall model, personality traits, PTS severity, and their interactions together accounted for a significant portion of the variance in the score of relating to others while controlling for the socio-demographic variables.

Agreeableness, openness to experience and posttraumatic stress symptom severity appeared significantly related to the score of relating to others. Of the five two-way interaction terms entered at block four of the hierarchical regression, PTS $\times$ extraversion, PTS $\times$ conscientiousness and PTS $\times$ neuroticism interactions were significant, indicating that regression of PTS severity on the score of relating to others varies as levels of extraversion, conscientiousness and neuroticism varies.

The slope of high level of extraversion (Fig. 5) was found to be significant (simple slope $=0.02$, $t=3.3$, $p<0.001$). However, the slope of low level of extraversion was not significant (simple slope $=0.01$, $t=0.89$, $p>0.05$).

Result of the simple slope analysis (Fig. 6) revealed a significant slope of low level of conscientiousness (simple slope $=0.02$, $t=3.4$, $p<0.01$) but not for high

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Table 4. Means and standard deviations on the dependent variables for the three groups

	Relating to others		Personal strength		Appreciation of life		Spiritual change		New possibilities	
Type of event	M	SD	M	SD	M	SD	M	SD	M	SD
A	1.6	1.3	2.3	1.5	2.7	1.6	2.2	1.5	1.5	1.4
ND	2.0	1.4	2.4	1.4	2.7	1.5	2.7	1.4	1.4	1.3
DLO	1.7	1.3	2.4	1.4	2.1	1.6	2.5	1.5	1.4	1.3

Note: A, accident; ND, natural disaster; DLO, death of loved one.

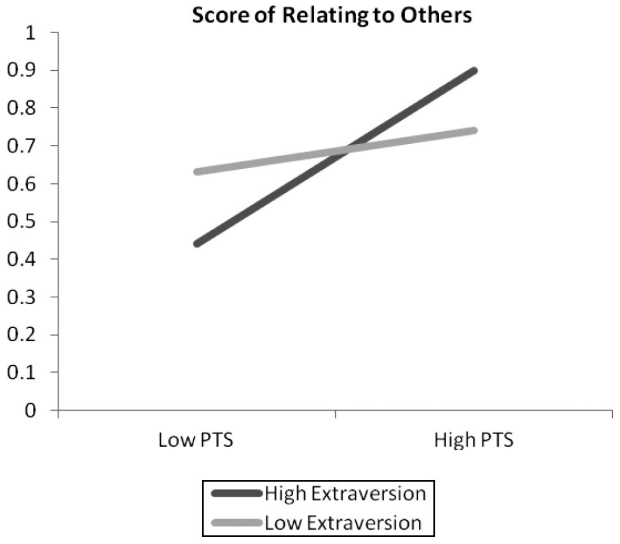

Fig. 5. The interaction of PTS severity and extraversion on the score of relating to others.

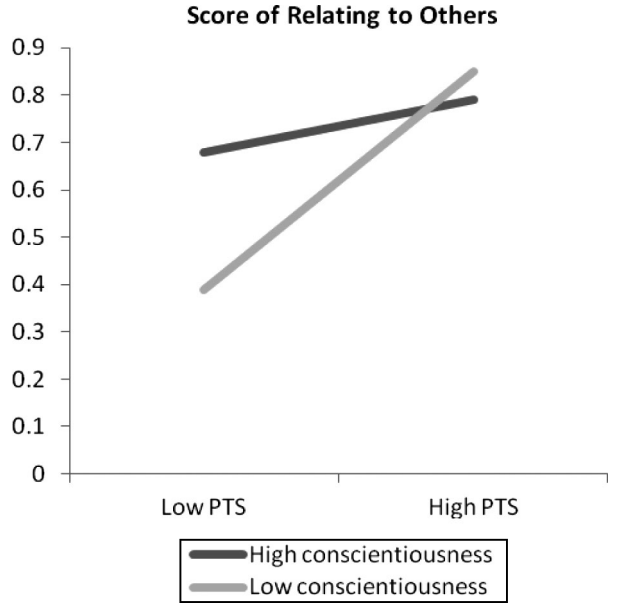

Fig. 6. The interaction of PTS severity and conscientiousness on the score of relating to others.

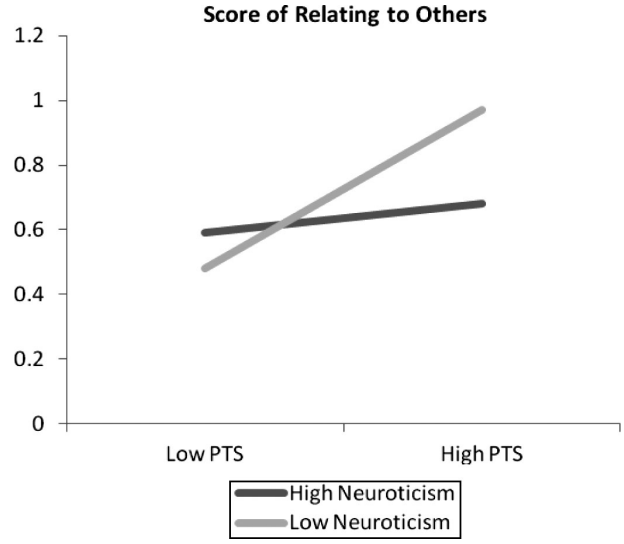

Fig. 7. The interaction of PTS severity and neuroticism on the score of relating to others.

level of conscientiousness (simple slope $=0.01$, $t=0.83$, $p>0.05$).

The slope of low level of neuroticism (Fig. 7) was found to be significant (simple slope $=0.02$, $t=4.2$, $p<0.001$). However, the slope of high level of neuroticism was not found to be significant (simple slope $=0.004$, $t=0.63$, $p>0.05$).

Personal strength

The final model (Table 3) accounted for 13% of the total variance of the score of personal strength, $R^2=0.13$, $F_{(14,901)}=9.1$, $p<0.001$. Conscientiousness, openness to experience and posttraumatic stress symptom severity were related to personal strength. Only the PTS $\times$ extraversion interaction was significant, indicating that regression of PTS severity on the score of personal strength varies as levels of extraversion vary.

The slopes of high and low level of extraversion (Fig. 8) were found to be significant (simple slope $=0.04$, $t=5.8$, $p<0.001$; simple slope $=0.02$, $t=2.7$, $p<0.01$, respectively).

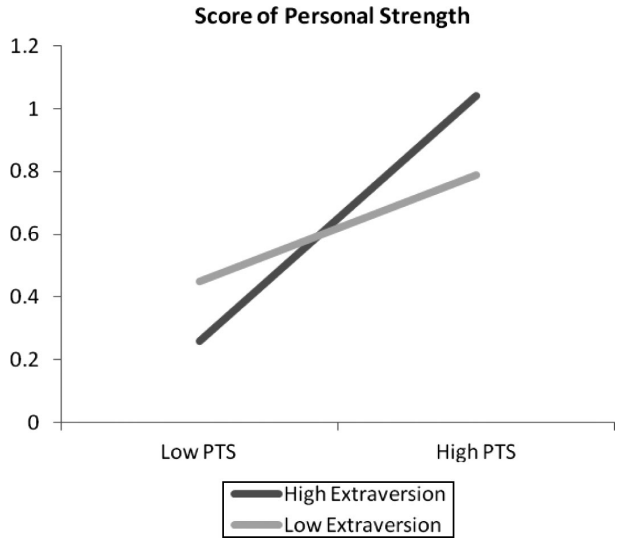

Fig. 8. The interaction of PTS severity and extraversion on the score of personal strength.

Appreciation of life

The variables in the final model (Table 3) accounted for 7% of the total variance of score of appreciation of life, $R^2 = 0.07$, $F_{(14,901)} = 5.1$, $p < 0.001$. Thus, in the overall model, personality traits, PTS severity, and their interaction together accounted for a significant portion of the variance in the score of appreciation of life while controlling for the socio-demographic variables.

Conscientiousness and agreeableness appeared significantly related to the score of appreciation of life. Of the five two-way interaction terms only PTS × openness was significant, indicating that regression of PTS severity on the score of appreciation of life varies as levels of openness to experience vary.

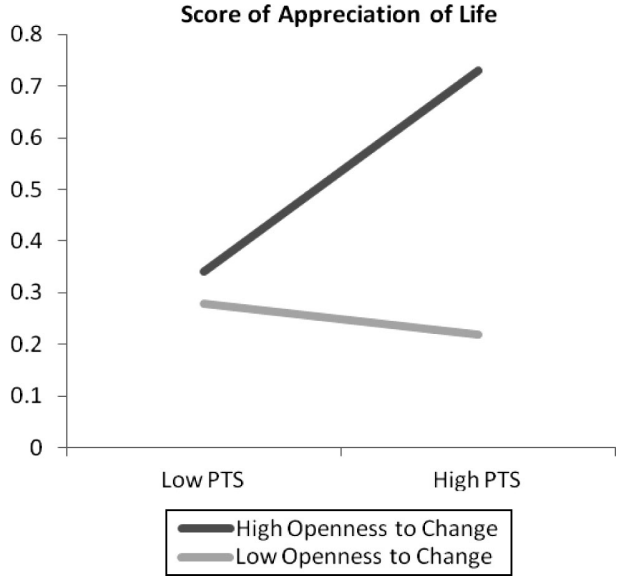

Fig. 9. The interaction of PTS severity and openness to change on the score of appreciation of life.

The slope of the high level of openness to change (Fig. 9) was found to be significant (simple slope = 0.02, $t = 2.3$, $p < 0.01$). However, the slope of the low level of openness to experience was not found to be significant (simple slope = −0.002, $t = 0.45$, $p > 0.05$).

Effects of the type of event experienced

The three most frequently experienced traumatic events by our sample were, accidents (11%; $N = 107$), natural disasters (28.1%; $N = 272$) and unexpected death of a loved one (40.6%; $N = 393$). A one-way multivariate analysis of variance (MANOVA) was conducted to determine the effect of being a survivor of these three types of traumatic events on the five domains of the PTG. Significant differences were found among the three types of events on the dependent measures, Wilks' $\Lambda = 0.89$, $F_{(10,1518)} = 8.8$, $p < 0.001$. The multivariate η^2 based on Wilks' Λ was not found to be strong, 0.06. Table 4 contains the means and the standard deviations of the dependent variables for the three groups.

Analysis of variances (ANOVA) on each dependent variable was conducted as follow-up test to the MANOVA. Using the Bonferroni method, each ANOVA was tested at the 0.01 level. The ANOVA on relating to others and appreciation of life score were significant, $F_{(2,763)} = 6.1$, $p < 0.01$, $\eta^2 = 0.02$; $F_{(2,763)} = 16.5$, $p < 0.01$, $\eta^2 = 0.04$, respectively. On the other hand the ANOVA on personal strength, spiritual change and new possibilities were not significant.

Post hoc analysis to the univariate ANOVA for relating to others and appreciation of life scores consisted of conducting pairwise comparisons to find significant differences between types of events in terms of the score of two sub-domains of PTG. Each pairwise comparison was tested at the 0.01 divided by 3 or 0.003 level. There were significant differences between group of natural disaster and group of death of loved one in terms of relating to other score (Table 4). Additionally, the group of accident and the group of natural disaster had significantly higher scores on appreciation of life than the group of death of loved one.

Discussion

The primary goal of the current study was to explore the contributory roles of personality traits, posttraumatic stress severity (PTS) and their interactions on PTG and especially its domains in a large community sample from Turkey exposed to various types of traumatic events. A secondary aim was to examine the differences in PTG domains in individuals exposed to three different kinds of traumatic events. The results revealed that some personality traits do have a facilitative role on PTG total and its domains. PTS severity also had a contributory role in PTG total and all the domains except for the appreciation of life. Furthermore, an important contribution of the

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present study was to show that some personality traits have a contributory role on the total PTG and its domains depending on PTS severity.

Personality traits are posited to be important in shaping ones' responses to traumatic events (Morris et al., 2005; Tedeschi & Calhoun, 1996). Our findings indeed supported this view by showing that conscientiousness, agreeableness and openness are robust predictors of the total PTG and almost all of the domains. When we examine the relationship of specific personality traits with specific domains of PTG, extraversion seems to exert an influence on all domains except the appreciation of life domain moderated by the PTS severity. For all the domains, participants with high extraversion experience more growth when they also experience high PTS severity. This may be related to the coping strategies of individuals with extraversion, using more support-seeking, problem-solving and cognitive restructuring (Connor-Smith & Flachsbart, 2007). Thus, under high PTS severity, extraversion may help individuals to cope with the traumatic aftermaths of an event by using more functional coping strategies and thus lead to higher growth in almost all domains. However, when the PTS severity is low, extraversion seems to have a suppressing effect on PTG. Under low PTS severity, individuals with high extraversion may not feel the need to activate their coping resources and thus not achieve much growth because they do not feel the need to engage in problem-solving or seeking-social support. It is important to note that the beneficial effect of having high extraversion under high PTS severity or having the trait of extraversion is not related to the appreciation of life domain, which may imply that this domain is related to some other personality traits.

Conscientiousness appeared significant for the spiritual change, personal strength and appreciation of life domains. Furthermore, for the relating to others domain, conscientiousness interacted with PTS severity, showing that high conscientiousness is facilitative of growth in relating to others domain irrespective of PTS severity, whereas for low conscientiousness high PTS severity is needed for growth in this domain. Conscientiousness involves high levels of self-regulation, persistence, impulse control, achievement orientation, and self-discipline (McCrae & John, 1992). This trait has been found to be related to problem-solving and cognitive restructuring coping styles (Connor-Smith & Flachsbart, 2007). Thus, it is understandable that conscientiousness will facilitate the processing of the traumatic event and directly coping with the event, rather than avoiding and thus relate to growth perceptions in the relating to others domain irrespective of level of PTS severity. However, individuals who are low on this trait seem to need a high traumatic impact to try to deal with the event and thus report PTG only when they experience high distress.

Agreeableness was related to all domains of PTG, except the personal strength domain. Agreeableness involves trust, altruism, compliance, and tenderminded-ness (McCrae & John, 1992). It has been shown to be related with high levels of both perceived and received social support (Bowling, Beehr & Swader, 2005; Tong et al., 2004). Thus, it seems that, except for the personal strength domain, this trait likely facilitates PTG by making the individual accept the traumatic event and seek social support in order to deal with its aftermath.

Neuroticism, which involves negative emotionality, self-consciousness, physiological reactivity to stress, and behavioral inhibition (McCrae & John, 1992) appeared significant for the spiritual change and relating to others domains moderated by PTS severity. Connor-Smith and Flachsbart (2007), in their meta-analysis reported that neuroticism predicted wishful thinking, withdrawal and emotion focused coping. All these strategies point to the fact that individuals high on neuroticism may use avoidance coping that may hinder the processing of the event which is essential for growth. For both the spiritual change and the relating to others domains low neuroticism facilitated growth under high PTS severity. For the relating to others domain individuals high in neuroticism showed the same PTG irrespective of PTS severity levels. However, those with low neuroticism had a higher PTG under high PTS severity. Thus, low neuroticism seems to facilitate coping and processing under high PTS severity for relating to others. However, interestingly for the spiritual change domain, both high and low neuroticism related to higher PTG under high PTS severity. Although future research needs to focus on the coping strategies of individuals with low and high neuroticism, our findings seem to point out that this trait has a negative impact on growth in the spiritual and the relating to others domains as distinct from other domains of growth.

Openness related to new possibilities, relating to others, personal strength domains. Furthermore, those with high openness showed higher levels of growth in the appreciation of life domain under high PTS severity. Openness entails being interested in new situations, new experiences and ideas. Individuals who are high on openness are intellectually curious, imaginative and emotionally responsive (Costa & McCrae, 1985). Since cognitive processing is essential for PTG (Tedeschi & Calhoun, 2004), it can be expected that individuals showing openness are more likely to be ready to cognitively process the traumatic event and its meaning and thus show more growth in all domains. For the appreciation of life, openness seems to facilitate growth only when PTS severity is high, indicating that this trait helps individuals to process the event related struggles when there is a higher traumatic impact. However, when the PTS severity is low, high openness does not seem to have a facilitative effect on the appreciation of life.

Taken together the findings relating personality traits to domains of growth seem to point out that rather than having very distinct effects on specific domains, conscientiousness, agreeableness and openness are facilitators of growth in almost all domains of PTG. Therefore, in future research it will be valuable to examine how these personality traits relate to PTG by examining cognitive processing and coping strategies unique to these traits. However, the effects of extraversion and neuroticism seems to depend on PTS severity. High extraversion is facilitative for growth in all domains, except for appreciation of life under high PTS severity. Similarly, neuroticism has a role on two domains of PTG, namely spiritual change and the relating to others, and this effect depends on the level of PTS severity. High neuroticism seems to be unfavourable under both high and low PTS severity, whereas when PTS severity is high low neuroticism fosters growth in these two domains. These findings modify previous findings of a negative relationship between neuroticism and PTG (Evers et al., 2001; Garnefski et al., 2008) by showing that this negative relationship is more pronounced only under high PTS severity conditions and only for some domains of growth.

PTS severity appeared significant for the total PTG and all the domains, except the appreciation of life. This finding supports the model of PTG, positing a role for the seismicity of the event to create room for processing and thus positive transformations (Tedeschi & Calhoun, 2004) and is in line with previous research findings (Levine et al., 2008; Morrill et al., 2008; Tedeschi & Calhoun, 1996). PTS severity was not significant only for the appreciation of life domain. Morris et al. (2005) reported a negative relationship between PTS severity and the appreciation of life domain, whereas the relationship was positive for all the other domains. In the present study, although PTS severity did not directly relate to this domain, openness to experience interacted with PTS severity only for this domain, showing that under high PTS severity individuals who are high in openness report more growth. Thus, it seems that growth in appreciation of life occurs when high PTS severity is experienced by individuals who are more open to process their experiences.

In the current sample we compared growth in the five domains of PTG among individuals who experienced three distinct types of events, namely accidents, natural disasters and unexpected death of a loved one. Previous research on the impact of different kinds of events on the domains of PTG is quite rare (e.g., Shakespeare-Finch & Armstrong, 2010) and thus it was difficult to make specific predictions. The only study comparing survivors of different types of events in the same study, showed that the bereaved group had higher growth than survivors of sexual assault in relating to others and appreciation of life domains (Shakespeare-Finch & Armstrong, 2010). Our results also showed that the type of event had a significant impact on only two domains, namely the relating to others and the appreciation of life domains. Natural disaster survivors had significantly higher growth in relating to others as compared to those who lost a loved one. Also, natural disaster and accident survivors had higher scores in the appreciation domain as compared to the bereaved group. Since in our sample reporting of sexual assault or other types of physical assault were very low we ended up comparing events which are relatively less benign as compared to assault victimization. Therefore, within our three groups, it is understandable that the bereaved group showed less growth in the relating to others and the appreciation of life domains. It seems less likely to endorse growth in the appreciation of life after experiencing the sudden loss of a loved one, since the bereaved may be struggling with feelings of guilt, knowing that the loved one can no longer enjoy life. On the other hand, the 1999 Marmara earthquake was followed by extensive media coverage of devastation and help from volunteers (Dogan, 2011; Sumer, Karanci, Berument & Gunes, 2005), and thus it is understandable that those who survived a natural disaster report more growth in the appreciation of life and relating to others domains. Similarly, survivors of accidents experience a threat to life and thus may feel that life is a gift and thus show more growth in the appreciation of life.

Since the types of events were not purposefully selected in the present study to yield differences in PTG domains, and the types of events most frequently endorsed by a community sample were analyzed the results do not seem to provide a clear distinction between the survivors of these three types of events.

Study limitations

The present study has some shortcomings that should be acknowledged. Firstly, due to the cross-sectional design no causal inferences can be drawn from the results. The study utilized a self-report instrument administered face to face with trained interviewers. This face to face reporting may have increased the report of some more benign events like accidents and natural disasters and may have suppressed the reporting of certain other types of events like violence and sexual abuse which are more difficult to report to interviewers who are complete strangers to the respondent. Another limitation was the use of a personality measure specifically developed to be used in Turkey. Although our results on personality traits were in line with previous research findings, the use of a newly developed personality scale can be considered a limitation. Lastly, although we have used the Kish method to ensure a random sampling from households, our sample had an overrepresentation of women and the unemployed. This may be related to fact that males and

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the employed were more reluctant to accept participation due to time constraints.

Conclusions

The current study involved a large community sample, representing adults from different walks of life and thus provides valuable insights into the positive transformations in the aftermath of diverse traumatic events and the effects of personality and posttraumatic stress severity on domains of growth. As a whole, our findings supported the importance of some personality traits, like openness, agreeableness and conscientiousness in facilitating PTG and some of its domains. Furthermore, the results showed that the impacts of extraversion, neuroticism and openness on growth depends on the survivor's PTS severity. Thus, the results show that some personality traits are unique predictors of some domains, and that some personality traits are only helpful under high or low PTS severity conditions. In order to understand how personality relates to PTG and its sub-domains the possible mediating roles of coping strategies and types of traumatic events using longitudinal designs are recommended. An understanding of coping processes can provide useful guidelines for clinicians for facilitating PTG in survivors of traumatic events.

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Conflict of interest and funding

There is no conflict of interest in the present study for any of the authors.

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***A. Nuray Karanci**
Department of Psychology
Middle East Technical University
TR-06571 Ankara
Turkey
Tel: +90 312 210 31 27
Fax: +90 312 210 79 75
Email: karanci@metu.edu.tr

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LE RELAZIONI PERICOLOSE

Save the Children

INDAGINE SULLO STATO DEL MALTRATTAMENTO E DELL'ABUSO INTRAFAMILIARE

Testo redatto da:
Valeria Confalonieri
Francesca Romana Marta

Si ringraziano per la collaborazione:
ACP, Associazione Culturale Pediatri
Ambulatorio BAMBI, Torino
CRDBM, Centro Regionale per la Diagnostica del Bambino Maltrattato, Padova
CISMAI, Coordinamento Italiano Servizi Maltrattamento all'Infanzia
CNOAS, Consiglio Nazionale Ordine Assistenti Sociali, Roma
Codice Rosa, Grosseto
Cooperativa Paradigma, Torino
Fiocchi in Ospedale, con le operatrici di:
APS Mitades, Milano; Pianoterra, Napoli; Il Melograno Centro informazione maternità e nascita, Bari; Archè, Roma.
GIADA, Gruppo Interdisciplinare Assistenza Donne e bambini Abusati, Bari
ISS, Istituto Superiore di Sanità
RIMMI, Rete Interaziendale Milano Materno Infantile, Milano
SVDeD, Soccorso Violenza Sessuale e Domestica, Milano

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LE RELAZIONI PERICOLOSE

QUANDO LA FAMIGLIA DIVENTA UN AMBIENTE OSTILE ALLO SVILUPPO LIBERO E POSITIVO DI BAMBINI E BAMBINE

Indagine sullo stato del maltrattamento e dell'abuso intrafamiliare

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INTRODUZIONE E RINGRAZIAMENTI

Le relazioni familiari rappresentano una componente molto rilevante nel determinare la qualità della crescita di un bambino o di una bambina nei primissimi anni di vita. Nella complessità che contraddistingue le azioni umane all'interno di una piccola comunità di affetti si possono identificare comportamenti che hanno un contenuto potenzialmente dannoso, non solo per l'integrità fisica e psicologica immediata di una persona, ma anche per le condizioni di sviluppo e di crescita futura. Alcuni comportamenti maltrattanti nell'ambito familiare hanno effetti traumatici e irreversibili sullo sviluppo di bambini e bambine e la maggior parte dei danni indotti da questi comportamenti può avvenire nei primissimi anni di vita.

Le relazioni pericolose da questo punto di vista sono spesso quelle più intime: quelle tra partner e quelle tra genitori e figli. Nell'ambito della strategia 2016-2018 di Save the Children il fenomeno della violenza ai danni dei bambini e delle bambine nelle sue diverse forme e manifestazioni ha assunto un peso centrale.

L'attenzione pubblica in questi anni si è molto e giustamente concentrata sulle forme di sfruttamento e violenza che hanno per vittime bambini e ragazzi durante i percorsi migratori, negli ambienti educativi, in rete, nei rapporti tra pari.
Più complesse e opache sono la dinamica e la diagnosi di comportamenti a rischio che maturano all'interno delle mura domestiche, specie quando le vittime sono persone che non sono in grado di rappresentare verbalmente il proprio disagio anche perché ancora non inserite in un circuito di servizi educativi e sociali che ne possa monitorare il benessere e l'equilibrio.

Il termine stesso di violenza può risultare riduttivo e non evocare condizioni che di fatto, magari in modo più sottile e ambiguo, sono violente a tutti gli effetti. L'Organizzazione Mondiale della Sanità[1] nel termine **maltrattamento infantile** include tutte le forme di maltrattamento fisico ed emotivo, abuso sessuale, trascuratezza (neglect) e sfruttamento: qualsiasi comportamento che implichi un **danno immediato o potenziale alla salute, alle possibilità di sviluppo e alla dignità** del bambino. In questo quadro la ricerca condotta da Save the Children si propone tre principali obiettivi:

- **capire e conoscere** meglio il fenomeno, giovandosi del lavoro di analisi e di ricerca che molti attori a diversi livelli hanno prodotto sia in Italia sia in Europa;
- **rafforzare la potenza della luce già accesa su questo fenomeno** ancora in larga parte sommerso: la diffusione del maltrattamento è da quantificare nella sua reale estensione, facendo emergere situazioni grigie, migliorando e affinando gli strumenti di analisi, coordinando le competenze, collaborando con gli attori chiave;
- **identificare linee di azione pertinenti alla sua natura e alla sua mission istituzionale**, anche con lo scopo di accrescere le competenze di analisi e di intervento dei suoi operatori sul campo.

Per questa ragione il testo si rivolge a un pubblico vasto, composto da persone che lavorano a fianco dei bambini e delle bambine, a istituzioni e servizi, a professionisti e ricercatori che sanno bene quanto questa materia sia al tempo stesso cruciale e sfuggente. L'intento è quello di contribuire a migliorare il coordinamento tra i professionisti e gli operatori del settore, accrescere la sensibilità e potenziare gli strumenti di sostegno mirato e personalizzato alle famiglie in difficoltà.

Un ringraziamento a tutte le persone che a vario titolo e nei diversi centri o nell'ambito delle loro attività hanno dedicato il loro tempo e condiviso con noi la loro esperienza, attraverso incontri diretti, contatti telefonici o via mail, uniti dal desiderio comune di lavorare affinché più nessun bambino e bambina, e adulto, sia costretto a subire maltrattamento o abuso in una qualunque delle forme possibili.
Un particolare ringraziamento all'Associazione Culturale Pediatri (ACP) e al Coordinamento Italiano dei Servizi contro il Maltrattamento e l'Abuso all'Infanzia (CISMAI), che hanno offerto a questo lavoro più di un semplice contributo, impegnandosi a definire un profilo di collaborazione pratica e produttiva.

Non è stato possibile raggiungere e prendere contatto con tutti coloro – e sono davvero numerosi – che in questi anni hanno lavorato sull'argomento in Italia raccogliendo dati o attivando procedure e progetti. Ce ne scusiamo e proprio per la natura dinamica e flessibile di questo lavoro di ricerca, procederemo ad aggiornamenti e integrazioni delle informazioni in nostro possesso, nella speranza di un continuo e progressivo approfondimento, allargamento della rete e della collaborazione e ottenimento, insieme, di obiettivi comuni e risultati concreti.

Raffaela Milano
Direttore Programmi Italia Europa, Save the Children

Note

1. http://www.who.int/topics/child_abuse/en/

LAVORARE SUL MALTRATTAMENTO IN ITALIA

Il maltrattamento sui bambini e le bambine è un problema di salute pubblica (OMS, 2012) che colpisce in Italia quasi 100.000 fra bambini e ragazzi. Si consuma nella maggior parte dei casi in famiglia, quindi in un contesto di relazioni intime e affettive, che dovrebbero costituire le basi della sicurezza e dell'attaccamento di ogni essere umano; proprio per questo le conseguenze sono più gravi sulle personalità in evoluzione perché compromettono la possibilità di sviluppare fiducia in sé stessi e nel mondo degli adulti.

Le conseguenze traumatiche della violenza sono inversamente proporzionali all'età: più un bambino è piccolo, più gravi sono i danni sullo sviluppo psico-fisico ed emotivo. Lo sappiamo dalle ricerche internazionali e nazionali, dai dati, anche se spesso non confrontabili nel nostro Paese, dalle varie fonti e dall'esperienza diretta degli operatori dei servizi socio-sanitari. Questo aspetto pone l'attenzione sull'assoluta necessità di intercettare precocemente le situazioni di violenza e di valutare attentamente il rischio per poter intervenire adeguatamente sul contesto familiare. I dati dell'ultima ricerca Cismai-Terres des Homme (2015) rilevano purtroppo che i bambini e ragazzi in carico ai servizi sociali perché a rischio o vittime di maltrattamento arrivano all'attenzione dei servizi in età adolescenziale (11-17 anni: 54,2 ‰), mentre la fascia di età più delicata 0-3 anni è quella che arriva in percentuale più bassa: solo il 29‰. Questo significa che i bambini piccoli, vittime di maltrattamento o in gravi situazioni di rischio, non vengono intercettati precocemente e si consumano quindi già danni significativi in questa fascia di età particolarmente delicata e importante per lo sviluppo evolutivo.

Il CISMAI da più di 20 anni cerca di mantenere viva l'attenzione sul fenomeno della violenza ai danni dei bambini e dei ragazzi promuovendo cultura, formazione e stimolando la politica su questi temi.
Lavorare sul maltrattamento significa prima di tutto investire sulla cultura del contrasto alla violenza, che si concretizza nel mettere in atto interventi di prevenzione. In questa direzione la capacità di intercettare i segnali di rischio deve essere sempre più attenta e competente: è indispensabile una formazione più adeguata sulla violenza a tutte quelle professioni che sono in prima linea – medici, insegnanti, educatori, già all'interno dei programmi universitari e delle scuole di specializzazione.
Il CISMAI sottolinea la **ineludibilità della prevenzione** e della protezione dei bambini attraverso la promozione di una proposta di una legge, presentata al VII Congresso, come passo concreto per portare il nostro Paese in linea con gli stati che hanno previsto da tempo una politica organica su questo tema. Una legge che sistematizzi in maniera strutturale a livello nazionale le misure su questa materia, le azioni e gli interventi da mettere in atto per contrastare efficacemente il **maltrattamento**. L'attivazione di un sistema nazionale di sorveglianza non è più procrastinabile, come è stato sottolineato da tempo dal CISMAI e da altri soggetti, per la costruzione di servizi orientati alla prevenzione e l'applicazione degli strumenti di sostegno alla genitorialità fragile, come l'Home Visiting, su cui una Commissione CISMAI ha lavorato, identificando i requisiti di qualità necessari per questi interventi e stilando delle apposite linee guida.
L'altro cardine su cui investire è la formazione **mirata e specialistica che garantisca la cura dei bambini che hanno vissuto esperienze traumatiche**. Una grande risorsa è rappresentata infatti dalla competenza degli operatori, e in questo il CISMAI continuerà il suo impegno promuovendo formazione, linee guida per gli operatori, confronto scientifico sulle tecniche più aggiornate di protezione e cura dei bambini maltrattati, collaborazioni con altri soggetti che perseguono le stesse finalità nel contrasto del maltrattamento all'infanzia in tutte le sue forme. Bisogna investire sulla qualità dei percorsi protettivi e riparativi; questo significa anche contrastare il rischio del maltrattamento istituzionale: evitare percorsi di tutela farraginosi, mancanza di progettazione, interventi tardivi, permanenze senza fine in comunità.
Per questo deve continuare ed essere garantita la formazione degli operatori che si occupano di maltrattamento e abuso, in particolare nel diffondere la cultura dell'approccio al trauma, per favorirne il riconoscimento e scegliere i trattamenti più adeguati.
I nostri 100 centri, pubblici e privati, molti dei quali hanno partecipato attivamente a questo lavoro, rappresentano una realtà attenta e competente, in grado, non solo di riconoscere precocemente nei bambini più piccoli segnali di disagio e di danno che esperienze familiari inadeguate possono provocare, ma anche di attivare percorsi di sostegno e cura mirati per loro e per le loro famiglie.

Gloria Soavi
Presidente CISMAI

I PEDIATRI DI FAMIGLIA: RESPONSABILITÀ E DIFFICOLTÀ

Noi pediatri siamo presenti in questa ricognizione di dati, storie e prassi di prevenzione, riconoscimento e cura.
Ci siamo perché abbiamo collaborato a mettere insieme informazioni, anche se in alcuni casi solo parziali, per cercare di avere un quadro di modalità di lavoro e possibilità concrete di azione contro il maltrattamento infantile nell'ambito della nostra attività ambulatoriale e nelle diverse realtà regionali.
Ma ci siamo anche con tutte le nostre responsabilità e tutte le nostre difficoltà rispetto alla capacità di promuovere interventi tempestivi, di organizzare una prevenzione primaria e secondaria intelligente, di passare dalla cultura del sospetto a quella della solidarietà, di sostenere e amplificare responsabilità parentali e genitoriali.

Sappiamo quali siano gli effetti dell'abuso e del maltrattamento con cui fare i conti quando l'adulto di riferimento viola confini mentali e corporei del bambino. Ci hanno spiegato più volte l'esperienza di umiliazione, di mortificazione, di morte psichica vissuta anche in casi non estremi. Ci hanno detto che l'umiliazione è in grado di sconfiggere rabbia e dolore, forze vive con le quali si può riorganizzare una speranza di crescita. Abbiamo capito che la vergogna ammutolisce, distrugge, toglie la parola.

Sappiamo bene anche che dobbiamo essere parte di una rete che deve essere strutturata, intelligente, preparata, motivata, dove lo spazio di ascolto deve affinarsi ed essere capace di intuire, di mettere insieme indizi. Ma anche di immaginare il dolore, oltre la violenza o il sopruso.
Siamo consapevoli di luoghi comuni che fanno fatica a sradicarsi nei servizi, nella società, nei media, sempre più spesso coinvolti in questo ambito, sempre più disattenti alla profondità dei problemi, sempre alla ricerca di scoop e situazioni plateali. Spesso anche noi ci nascondiamo per non vedere o perché diventa troppo complesso vedere.

L'indagine ci interpella fortemente come singoli, ma anche in quanto appartenenti a gruppi di lavoro o a società scientifiche. È una sollecitazione ulteriore a una professionalità che deve comprendere non solo l'approfondita conoscenza di fenomeni e problemi, ma anche il confronto diretto, continuo, costante, ravvicinato, attento, profondo con tutto quello che c'è sul territorio e che può essere di aiuto in situazioni sempre difficili, complesse, dolorose.

Ci rammenta anche che i bambini hanno il diritto di trovare professionisti in ogni momento consapevoli dei loro bisogni: "il bisogno di sviluppare costanti relazioni di accudimento; il bisogno di protezione fisica e sicurezza, e relativa normativa; il bisogno di esperienze modellate sulle differenze individuali; il bisogno di esperienze appropriate al grado di sviluppo; il bisogno di definire dei limiti, di fornire una struttura e delle aspettative; il bisogno di comunità stabili e di supporto, e di continuità culturale; il bisogno di un futuro" (B. Brazelton, *Medico e Bambino,* 2004;7:458).

Federica Zanetto
Presidente Associazione Culturale Pediatri

NOTA SUL METODO DI LAVORO

Save the Children ha approfondito, attraverso una **ricognizione di tipo qualitativo e documentario**, la conoscenza della fenomenologia riguardante il maltrattamento ai danni di donne in gravidanza e di bambini e bambine nei primi tre anni di vita.

Obiettivi della ricognizione:

- **rafforzare la conoscenza** del fenomeno;
- **ampliare l'area e la qualità della sensibilizzazione** sociale nei confronti del maltrattamento nel contesto familiare;
- **identificare aree di intervento** programmatico, di advocacy e di ulteriore approfondimento.

In questo quadro, il lavoro si è concentrato su 4 azioni:

- **raccogliere materiale** e acquisire una base di documentazione riguardante dati (anche di livello territoriale), analisi, progetti, ricerche e iniziative;
- **definire un quadro degli attori** che lavorano sul maltrattamento in Italia quanto più possibile articolato e completo;
- **identificare le prassi** e approfondire singoli aspetti ed esperienze di lavoro, con il contributo di personalità e istituzioni che abbiano sviluppato un patrimonio rilevante di conoscenze e interventi sull'argomento;
- **approfondire il periodo 0-3 anni** focalizzando l'attenzione verso i maltrattamenti commessi nella fase precedente all'ingresso nella scuola dell'infanzia, nella quale possono prodursi danni per la salute e lo sviluppo fisico, psicologico ed emotivo e l'identificazione può essere ancora più difficile.

Il documento, che nasce con l'idea di una continua possibilità di aggiornamento, è il frutto dell'integrazione di più fasi di lavoro.

- **Consultazioni preliminari:** sono stati organizzati incontri e confronti con figure di rilievo in questo ambito sul piano nazionale ed è stata organizzata una consultazione permanente con un gruppo di lavoro[2]. Al lavoro di questo gruppo di consultazione si è integrato il lavoro della costituenda Rete Fiocchi in Ospedale che, tra gli altri obiettivi, ha quello di coordinare risorse professionali e prassi positive per la tutela dei diritti dei più piccoli, a cominciare dalla prevenzione di ogni forma di abuso e maltrattamento[3].
- **Raccolta dati e consultazione di professionisti e organizzazioni:** è stata avviata una raccolta di dati sui casi di maltrattamento in gravidanza e nei primi tre anni di vita, con particolare riferimento al territorio italiano. La raccolta ha incluso sia una ricerca di dati disponibili online e pubblicazioni scientifiche sia il contatto diretto con organizzazioni e professionisti del settore[4].
- **Elaborazione di profili tematici su:** maltrattamento in gravidanza, maltrattamento tra 0 e 3 anni, diagnostica del maltrattamento, gestione del trauma del bambino, depressione post-partum e maltrattamento.
- **Inventario di prassi:** nell'assenza di un sistema applicato di protocolli nazionali, è sembrato utile focalizzare l'attenzione su alcune prassi di lavoro messe in atto da realtà ospedaliere e servizi di diagnosi e recupero post-traumatico.

Note

[2.] Dora Artiaco, CISMAI, Napoli; Nunzia Bartolomei, CNOAS, Roma; Carla Berardi, ACP, Perugia; Maurizio Bonati, IRCCS Istituto di Ricerche Farmacologiche Mario Negri, Milano; Simonetta Cavalli, assistente sociale, ex direttivo CNOAS; Peppe Cirillo, ACP, Napoli; Roberta Luberti, medico e psicoterapeuta, Firenze; Marilisa Martelli, Presidente AISMI, Bologna; Grazia Tiziana Vitale, psicologa, GIADA, Ospedale Pediatrico Giovanni XXIII, Bari.

[3.] L'adesione alla Rete si fonda sulla condivisione di 5 priorità: intervento precoce, offerta attiva, sostegno dei genitori, tutela del diritto a uno sviluppo sano e sereno, conoscenza scientifica e ricerca.

[4.] Ambulatorio BAMBI, Torino; Associazione Culturale Pediatri (ACP); Associazione Ospedali Pediatrici Italiani (AOPI); Associazione Italiana Salute Mentale Infantile; Centro Regionale per la diagnostica del Bambino Maltrattato Unità di Crisi di Bambini e Famiglia, Azienda Ospedaliera di Padova; CISMAI; Consiglio Nazionale Ordine Assistenti Sociali (CNOAS); Cooperativa Paradigma, Torino; Fondazione Pangea Onlus, Roma; GAIA, Azienda Ospedaliero Universitaria Meyer, Firenze; GIADA, Azienda Ospedaliero Universitaria Policlinico – Giovanni XXIII di Bari; ISTAT; Istituto Superiore della Sanità (ISS)-Progetto Revamp; Progetto Intovian (maltrattamento 0-3 anni); Progetto Rebecca (depressione post-partum); Progetto "Switch off" (orfani di femminicidio); Rete Codice Rosa, Toscana; Rete Ospedali Umbria (Spoleto, Foligno, Orvieto); Soccorso Violenza Sessuale e Domestica SVSeD, Milano; Società Italiana per lo Studio dello Stress Traumatico; Terre des Hommes; Unione Nazionale Camere Minorili (UNCM); Dipartimento di psicologia, Università Cattolica di Milano.

Foto: Clare Hewitt per Save the Children

CAPITOLO 1

1. DEFINIZIONE E ANALISI DEL FENOMENO

1.1 FENOMENOLOGIA E FISIONOMIA DEL MALTRATTAMENTO

Il termine "maltrattamento", nell'impostazione di questa ricognizione, racchiude in sé diversi aspetti e si riferisce ad azioni indirizzate sia alle donne incinte sia alle bambine e ai bambini di età da 0 a 3 anni.
Secondo l'Organizzazione Mondiale della Sanità "l'abuso infantile o il maltrattamento comprendono tutte le forme di maltrattamento fisico e/o psico-emozionale, di abuso sessuale, di trascuratezza o di trattamento negligente, di sfruttamento commerciale od altro, con conseguente danno reale o potenziale alla salute, alla sopravvivenza, allo sviluppo o alla dignità del bambino nel contesto di un rapporto di responsabilità, di fiducia o di potere"[5].
Come indicato nell'aggiornamento più recente della Classificazione Internazionale delle Malattie (ICD10), si possono così individuare le principali forme di maltrattamento:

- la trascuratezza grave e l'abbandono, in cui non si segue lo sviluppo del bambino nei diversi aspetti (salute, educazione e formazione, sviluppo psico-emozionale, nutrimento, protezione, ambiente di vita sicuro);
- il maltrattamento fisico, con un danno fisico attuale o potenziale causato da azioni o mancanza delle stesse, e può esprimersi attraverso l'aggressione fisica, anche accompagnata dall'uso di armi e oggetti contundenti, l'utilizzo di punizioni corporali. Fra le forme di maltrattamento fisico rientra il trauma cranico abusivo, che comprende la sindrome del bambino scosso (*Shaken Baby Syndrome*) tra le sotto-forme e può essere causa di danni anche molto gravi, a volte mortali;
- l'abuso sessuale;
- l'abuso psico-emozionale, che include il non provvedere a un ambiente d'appoggio e adatto allo sviluppo del minore, in modo che il bambino possa sviluppare le competenze sociali e psico-emozionali;
- le altre forme di maltrattamento, fra cui:
  - la Sindrome di Munchausen per Procura, in cui l'adulto simula sintomi o produce una malattia (con la somministrazione di farmaci o altro) nel bambino comportando indagini ed esami;
  - la violenza assistita, a cui possono associarsi il trauma della perdita o della grave infermità del genitore, oltre che effetti derivanti dalla scarsa attitudine all'esercizio delle cure parentali riscontrato nelle mamme soggette a continui accessi di violenza da parte del proprio compagno/marito[6];
  - lo sfruttamento, commerciale o di altro genere;
  - il *chemical abuse* (abuso di sostanze) riferito all'assunzione da parte dei bambini di sostanze tossiche (come farmaci, droghe, alcol).

1.2 I LIMITI E GLI INDICATORI PER L'IDENTIFICAZIONE PRECOCE

Il termine maltrattamento evoca un pensiero diverso dal termine violenza, più facilmente associato a quadri di aggressione fisica o abuso grave, e allarga lo sguardo a comportamenti che forse un tempo non venivano considerati come maltrattanti. Quando un comportamento può configurarsi come maltrattamento? Ci sono indicatori di effetto, intensità, ripetitività, durata? Il tema del limite assume importanza nel riconoscimento del confine tra un comportamento maltrattante e un comportamento non a rischio, e nel far uscire da un quadro di "normalità" atteggiamenti e azioni che normali non sono e possono produrre effetti dannosi, anche irreversibili. Lo stesso concetto di limite rappresenta un tema cruciale in chiave di consapevolezza della persona maltrattante circa la natura e le conseguenze, anche gravi, delle sue azioni.

I confini stabiliti dal codice penale e dalla giurisprudenza in tema di maltrattamento fanno riferimento a uno "stato di sofferenza e mortificazione inflitto alla persona offesa in regime di continuità temporale (abitualità)"[7]. Tuttavia, trattandosi di una condizione non sempre riscontrabile in termini di parametri obiettivi, qualora il maltrattamento si produca senza lesioni fisiche diagnosticabili *prima facie* e indiscutibilmente in sede clinica, è molto importante un lavoro di definizione quanto più possibile chiaro e condiviso di che cosa si intenda per comportamenti maltrattanti e abusanti, quali siano le conseguenze di tali comportamenti e come si possano prevenire, riconoscere e gestire.

1.3 DONNE INCINTE E BAMBINI SOTTO I TRE ANNI

I maltrattamenti interni alla vita familiare si configurano come un sistema coordinato di azioni di attacco e difesa che non si esauriscono nei singoli gesti o comportamenti, ma tendono a permeare la quotidianità della vita, influenzando le interazioni, indebolendo la concentrazione sui compiti di cura, ingenerando spirali ritorsive e producendo conseguenze irreversibili sullo sviluppo dei bambini e delle bambine.

Donne incinte e bambini fino a 3 anni risultano essere un target particolarmente esposto quando si parla di maltrattamento.

Quello della gravidanza è un periodo che si è rivelato cruciale per il manifestarsi di forme di insofferenza e aggressività intra-familiare, proprio in ragione di una condizione di maggiore vulnerabilità della donna, con una riduzione della sua autonomia tanto emotiva che finanziaria, che può essere vissuta dal partner come un'opportunità per affermare più agevolmente potere e controllo sulla compagna. Si stima che oltre il 20% dei maltrattamenti intra-familiari ai danni delle donne abbia inizio proprio in gravidanza specie nel secondo e terzo trimestre, ed essi, se iniziati prima, continuino nel 70% e si verifichino episodi più frequenti e gravi di quelli già in precedenza avvenuti nel 17% dei casi[8].

Relazioni pericolose con il proprio compagno #storiedaiservizi*

Veronica è una giovane donna che da poco è diventata mamma di due gemelli: già dagli ultimi mesi della gravidanza si rivolgeva alle operatrici di Fiocchi in Ospedale, inviata dalla ginecologa dell'ospedale, perché si sentiva soffocata dal marito che controllava ogni suo spostamento e le impediva di uscire per fare la spesa, chiamare le amiche e muoversi in autonomia. La vita di coppia si era complicata da quando lei era rimasta incinta e lei stessa si era stupita di come premure e attenzioni del compagno si fossero, nel giro di poche settimane, trasformate in divieti e soprusi, dando vita a una situazione di ansia e preoccupazione che raggiungeva per la ragazza momenti davvero critici. Con Veronica sono state promosse fin da subito attività di incontro e supporto psicologico e il suo caso è stato portato all'attenzione dei servizi antiviolenza, ma un parto leggermente pre-termine non ha permesso l'incontro faccia a faccia tra la donna e l'operatrice del centro antiviolenza. Quando Giovanni e Mirko sono venuti al mondo, Veronica è entrata in difficoltà nella gestione dei bambini: agli incontri fissati in ospedale per monitorare la crescita adeguata dei gemelli da parte dell'équipe medica, la donna si è presentata trasandata e i bambini, a loro volta, apparivano poco curati nell'aspetto e nell'igiene personale. Così è stata inserita in un percorso di incontri di supporto psicologico. Ma quella stessa notte Veronica è arrivata in pronto soccorso in ambulanza perché uno dei gemelli era diventato cianotico: il neonato aveva ingerito un rigurgito e, nonostante il padre fosse intervenuto in maniera corretta disostruendo le vie respiratorie, Mirko aveva bisogno di rimanere in osservazione per escludere l'insorgenza di danni cerebrali. A un mese dall'accaduto, Veronica è rientrata in un programma di assistenza domiciliare fornito dal Comune di residenza della famiglia, in cui operatrici perinatali si recano a casa per aiutarla nella gestione dei neonati. Veronica ha incontrato l'operatrice del centro antiviolenza della sua città e ha iniziato un percorso di sostegno, condiviso con i servizi sociali. Mirko, fortunatamente, non ha subito alcun danno dall'episodio.

* Tutti i nomi riportati nelle storie sono di fantasia.

Altrettanto significativo e critico è il periodo delle prime fasi di sviluppo del bambino, nel corso del quale il maltrattamento può causare danni allo sviluppo del cervello[9], con effetti negativi sulla crescita dal punto di vista fisico, cognitivo, emotivo e sociale[10].

Il maltrattamento può avere un impatto diverso a seconda del momento della vita e di sviluppo del bambino: vi possono essere rischi e danni durante la gravidanza e la nascita, da una crescita ridotta ed effetti sullo sviluppo del cervello, a un basso peso alla nascita fino alla morte; nei primi anni di vita vi possono essere sia danni indiretti conseguenti ad atti violenti contro la madre, sia maltrattamenti intenzionali, con danni sullo sviluppo del cervello, rischi di ritardo nello sviluppo e altri possibili problemi di salute collegati allo stress che si possono presentare in epoche successive della vita[11].

Il maltrattamento in questo periodo rischia di rimanere ancora più nascosto, perché agìto contro persone con una fragilità maggiore o un margine di autonomia molto basso. Inoltre, i comportamenti violenti nei confronti della donna possono iniziare o peggiorare durante la gravidanza[12].

Vi sono dunque diversi elementi di rischio e conseguenze dei maltrattamenti subìti sia per la mamma sia per il bambino/a in questo particolare arco temporale, che vanno identificati tempestivamente per la messa in opera di interventi pertinenti di prevenzione e presa in carico.

DAL PUNTO DI VISTA DELLA MAMMA, CON RIPERCUSSIONI SUL BAMBINO/A:

- azioni violente, abusi e maltrattamenti che si compiono nel contesto familiare ai danni della **futura o neomamma** possono compromettere l'integrità fisica (di mamma e bambino/a), la salute fetale e le possibilità di sviluppo del nascituro, la capacità della mamma di vivere in modo sereno e positivo la gravidanza, il parto e le fasi successive alla nascita del bambino, nonché la sua capacità di esercitare la sua funzione di protezione e cura, e avere danni indiretti sul bambino che si trova ad assistere e/o a essere coinvolto;

- azioni rivolte contro la donna durante il **periodo della gravidanza**, con episodi che possono essere acuiti dal presentarsi della gravidanza o insorgere per la prima volta in questo periodo;

- "omicidi di genere" o femminicidi ai danni di donne madri, ovvero violenze sulle donne con esito fatale, che nel caso di donne madri comporta la delicata e drammatica conseguenza dei cosiddetti **"orfani di femminicidio"**, doppiamente vittime, sia di possibile violenza assistita sia in quanto resi orfani di mamma, e con un padre che potrebbe esserne il responsabile;

- fenomeno della **depressione post-partum**, che può essere un fattore di rischio di maltrattamento da parte della mamma nei confronti del figlio (incapacità genitoriale; difficoltà di gestione dello stress e delle richieste del bambino/a; trascuratezza collegata a mancanza di cure anche rispetto a se stesse).

DAL PUNTO DI VISTA DEL BAMBINO E DELLA BAMBINA:

- il maltrattamento fino ai tre anni di vita nelle sue diverse forme si verifica in un **periodo considerato cruciale per lo sviluppo** psicofisico e di tutte le potenzialità[13]; a questo si aggiunge la possibile maggiore difficoltà nell'individuazione di maltrattamenti in questa fascia di età in cui la relazione del bambino con il mondo esterno è ancora molto limitata, dal punto di vista della verbalizzazione e comunicazione, e in cui i contatti con soggetti esterni alla famiglia sono più ristretti (si consideri che il tasso medio di copertura della domanda per quanto riguarda gli asili nido e le altre strutture integrative non arriva al 13%, con punte al di sotto del 3% come in Calabria[14]), e si limitano, quando contattati, ai pediatri e/o ai pronto soccorso e agli ospedali in caso di ricoveri;

- le **conseguenze a medio e lungo termine del trauma** sulla salute, come prima riportato, ma anche l'influenza sul comportamento successivo dei bambini vittima di maltrattamento, con rischio maggiore sia di comportamenti maltrattanti sia di esserne vittime[15].

CATENE DI POSSIBILI CORRELAZIONI

Foto: Lucia Zoro per Save the Children

Note

[5.] World Health Organization, 1999, *Report of the Consultation on Child Abuse Prevention*, Geneva, 29-31 March 1999, WHO/HSC/PVI/99.1

[6.] CISMAI, *Requisiti minimi degli interventi nei casi di violenza assistita da maltrattamento sulle madri*, 2005.

[7.] Art. 572 c.p. e L. 172/2012.

[8.] Chiara Patruno, *La violenza in gravidanza*, 2014.

[9.] http://resourcecentre.savethechildren.se/library/how-violence-and-neglect-leave-their-mark-childs-brain; http://static1.square-space.com/static/54982e51e4b0e6ee18599b2f/t/57207cd2356fb0ae213dba5a/1461746903358/Brain%2BInfographic_WEB-1.pdf

[10.] World Health Organization, ISPCAN, *Preventing Child Maltreatment: a guide to taking action and generating evidence*, 2006.

[11.] United Nations Children's Fund, *Hidden in Plain Sight: A statistical analysis of violence against children*, UNICEF, New York, 2014.

[12.] ISTAT, *La violenza contro le donne dentro e fuori la famiglia. Anno 2014*, 5 giugno 2015.

[13.] Irwin LG, Siddiqi A, Hertzman C. *Early Child Development: A Powerful Equalizer. Final Report*, Commission on the Social Determinants of Health. Geneva: WHO, 2007. Gruppo di Lavoro per la Convenzione sui Diritti dell'Infanzia e dell'Adolescenza, *I diritti dell'infanzia e dell'adolescenza in Italia. 7° Rapporto di aggiornamento sul monitoraggio della Convenzione sui diritti dell'infanzia e dell'adolescenza in Italia 2013-2014. Garantire il diritto di tutti i bambini alle opportunità di sviluppo cognitivo, emotivo e sociale nei primi anni di vita.*

[14.] ISTAT, *Asili nidi e altri servizi socio-educativi per la prima infanzia: il censimento delle unità di offerta e la spesa dei Comuni*, 4 novembre 2016.

[15.] World Health Organization, *Regional office for Europe. Investing in children: the European child maltreatment prevention action plan 2015-2020*, Regional Committee for Europe, 64th session, settembre 2014.

Foto: Louis Leeson per Save the Children

CAPITOLO 2

2. PANORAMICA SU DATI E INIZIATIVE

2.1 OLTRE LA METÀ DEI BAMBINI NEL MONDO SUBISCE QUALCHE FORMA DI VIOLENZA

Complessivamente viene stimato che ogni anno, nel mondo, i bambini sottoposti a una qualche forma di violenza siano fra 500 milioni e 1,5 miliardi[16]. Se si considera che i bambini e gli adolescenti nel mondo ammontano a circa 2 miliardi e 200 milioni[17], si può capire l'enormità di questa cifra.

Ogni 5 minuti, secondo altre stime, un bimbo muore a causa di un evento violento, 120 milioni di ragazze e 73 milioni di ragazzi sono vittime di violenza sessuale e circa 1 miliardo di bambini subisce con regolarità punizioni fisiche[18].

La cifra di oltre 1 miliardo di bambini ritorna anche in un lavoro pubblicato nel 2016, che ha preso in esame 112 studi con dati provenienti da quasi la metà dei Paesi nel mondo (96) e ha indicato una stima di oltre 1 miliardo di bambini da 2 a 17 anni che ha sperimentato situazioni di violenza nell'anno 2014. Da notare che non è stato possibile formulare stime nei piccoli da 0 a 1 anno per il numero troppo ridotto di studi che riportavano questo gruppo di età[19].

2.2 USA: I PIÙ COLPITI SONO I PICCOLISSIMI

Una pubblicazione statunitense[20] sul maltrattamento infantile negli USA riferita al 2015 dice che sono state 680.000 le vittime di abuso e trascuratezza tra i bambini. I più piccoli sembrano essere i più vulnerabili (più di un quarto, 27,7%, con meno di 3 anni), e i tassi maggiori sono nella fascia di età sotto l'anno (24,2 per 1.000 bambini nella popolazione della stessa età); le forme di maltrattamento più comuni sono la trascuratezza (75,3%) e l'abuso fisico (17,2%); gli abusi sessuali rappresentano l'8,4%. Aumentano i casi mortali rispetto all'anno precedente, con una stima nazionale di 1.670 morti per abuso e trascuratezza (in quattro casi su cinque era coinvolto un genitore, 77,7%), nella maggior parte dei casi in bambini con meno di 3 anni (74,8%, una percentuale leggermente superiore al 2014).

La ricerca mostra una crescita del fenomeno negli ultimi 5 anni.

Maltrattamento dei bambini e delle bambine negli USA - anni 2011 e 2015 [21]

Fenomeno	2011	2015	variazione %
Bimbi/e considerati dai servizi	3.081.000	3.358.000	+9
Bimbi/e vittime di maltrattamento	658.000	683.000	+3,8

Tipologia di maltrattamento bambini e bambine USA - anno 2015

Fenomeno	%
Trascuratezza	75,3
Abusi fisici di tipo non sessuale (lesioni, fratture, ustioni, intossicazioni)	17,2
Abusi sessuali	8,4

2.3 TROPPI BAMBINI E BAMBINE MALTRATTATI IN EUROPA RISPETTO ALLE POSSIBILITÀ DI RISPOSTA DEI SERVIZI

Spostando l'attenzione al panorama europeo, l'Ufficio Regionale Europeo dell'Organizzazione Mondiale della Sanità (OMS) ha pubblicato nel 2013 l'*European report on preventing child maltreatment*[22]. Il testo sottolinea il carico rappresentato dal maltrattamento infantile, le sue cause, le sue conseguenze, si sofferma sulla prevenzione e sulla strada da percorrere in Europa, sottolineando come il maltrattamento sia una questione non solo sociale ma anche di salute pubblica, e propone un approccio di salute pubblica per prevenirlo.

Vengono riportati alcuni dati sull'estensione del maltrattamento: ogni anno nella regione europea muoiono a causa di maltrattamenti almeno 850 bambini con meno di 15 anni e questa cifra potrebbe essere una sottostima dei numeri reali; inoltre i tassi di mortalità sono più alti nei bambini sotto i 5 anni. La prevalenza del maltrattamento dei bambini nella regione europea avrebbe percentuali del 9,6% per l'abuso sessuale, 22,9% per quello fisico e 29,1% per quello psicologico, mentre la prevalenza della trascuratezza fisica sarebbe del 16,3% e di quella emotiva del 18,4%. Viene anche calcolato che, considerando la popolazione di bambini in Europa, queste cifre suggerirebbero che 18 milioni di bambini abbiano subito abuso sessuale, 44 milioni fisico e 55 milioni mentale.

Il tema viene ripreso l'anno successivo sempre dall'OMS Europa nel documento *Investing in children: the European child maltreatment prevention action plan* 2015-2020[23], che commenta come i numeri percentuali riferiti ai bambini sottoposti ai diversi tipi di maltrattamento superino le possibilità di una risposta efficace da parte dei servizi di protezione dell'infanzia.

Lo stesso documento sottolinea come il maltrattamento, insieme con altre condizioni difficili nell'infanzia, sia una causa possibile di livelli di stress dannosi con effetti negativi sullo sviluppo cerebrale e possa portare a comportamenti dannosi per la salute fisica e mentale, risultati peggiori dal punto di vista educativo e sociale e trasmissione intergenerazionale della violenza.

Foto: Stuart Sia per Save the Children

Inoltre un bambino maltrattato può maturare un rischio maggiore di essere sia vittima sia autore di violenza. Il documento pone poi tre obiettivi da perseguire, che coprono gli ambiti della maggiore visibilità e raccolta di informazioni (misurazione di incidenza e prevalenza, indagini sul maltrattamento infantile, relazioni sulla sua riduzione e sul miglioramento del benessere mentale dei bambini), di un rinforzo nelle azioni di prevenzione con piani nazionali attraverso partnership e azioni multisettoriali, e di una riduzione del rischio di maltrattamento dei bambini e delle sue conseguenze con un rinforzo dei sistemi sanitari, con azioni declinate su diversi aspetti e ambiti.

Nel 2015 un ulteriore documento, sempre dell'OMS Europa, ha focalizzato l'attenzione sui **programmi di prevenzione, in supporto all'implementazione delle attività di prevenzione nei sistemi sanitari e attraverso attività multisettoriali**[24].

Impegni e alleanze internazionali contro il maltrattamento di bambini e bambine

Sul versante delle iniziative volte a contrastare la violenza nell'infanzia, a luglio del 2016 è stata presentata la Global Partnership to End Violence Against Children, un'**alleanza globale perché abbia fine la violenza nei confronti dei bambini** con lo scopo di sostenere le iniziative di prevenzione della violenza, protezione dell'infanzia e aiuto a rendere le società sicura per i bambini[25]. Il tutto in linea con gli impegni dell'Agenda 2030, l'impegno degli Stati nei confronti delle diverse forme di violenza nell'ambito degli Obiettivi di Sviluppo Sostenibile (Sustainable Develpment Goals).

Sempre nel 2016 è stato presentato INSPIRE[26], una risorsa per tutti coloro che lavorano per contrastare la violenza contro l'infanzia, governi, società civile, settore privato. Si tratta di una selezione di **sette strategie basate sulle prove migliori disponibili** per aiutare Paesi e comunità nei programmi di prevenzione e servizi per ridurre la violenza contro l'infanzia: implementazione e rinforzo delle leggi; norme e valori; ambienti sicuri; supporto a genitori e a chi si prende cura dei bambini; sostegno al reddito delle famiglie; servizi di risposta e supporto; competenze educative e di vita.

2.4 IN ITALIA: MOLTE INIZIATIVE E MOLTO SOMMERSO

Anche in Italia vi sono una **diffusa sensibilità e interesse** sul tema e **numerose iniziative** sui versanti della rilevazione/epidemiologia del fenomeno, della prevenzione, del riconoscimento, della presa in carico, della formazione di operatori, della nascita di reti fra ospedali.
Negli ultimi anni sono stati prodotti studi e ricerche che hanno provato a dare un quadro della situazione dal punto di vista quantitativo, arrivando a stime campionarie sui casi di maltrattamento. Ma sussiste la difficoltà di una raccolta dati di livello nazionale, che sia rappresentativa di tutto il territorio; inoltre i dati raccolti si riferiscono ai casi considerati certi o comunque arrivati a una segnalazione o a una presa in carico, comunque di accertamento del maltrattamento. Resta fuori il sommerso rappresentato dai casi che non vengono intercettati o che non sono neanche riconosciuti come maltrattamento.

Il **IV Piano nazionale di azione e di interventi per la tutela dei diritti e lo sviluppo dei soggetti in età evolutiva**[27] riporta come "Purtroppo sul fenomeno del maltrattamento e dell'abuso all'infanzia non si dispone di dati raccolti stabilmente nel quadro di un sistema di sorveglianza nazionale"[28].

Qui di seguito vengono riportati alcuni **dati e informazioni tratti da pubblicazioni, ricerche e attività in ambito nazionale o in alcune aree italiane** realizzate negli ultimi anni, dove, quando possibile, viene isolata la componente relativa alla fascia di età 0-3 anni. Si tratta di dati difficilmente comparabili, per diverse modalità di approccio o finalità della ricerca, o diversa classificazione e suddivisione delle fasce di età interessate o delle tipologie di maltrattamento, che tuttavia forniscono un quadro, seppur parziale, delle molteplici attività svolte o in atto e di alcune lacune e necessità comuni riscontrate. Accanto alle ricerche mirate a definire e quantificare la diffusione del maltrattamento sul territorio italiano, vi sono **progetti e campagne che coprono l'area della formazione, della sensibilizzazione, del miglioramento degli strumenti di rilevazione e di intercettazione**.

LA PRIMA PORTA DI ACCESSO: I PRONTO SOCCORSO E LE STRUTTURE SANITARIE

Alcuni studi effettuati in Italia sul maltrattamento hanno valutato **i casi dei bambini arrivati in pronto soccorso**.
Un lavoro retrospettivo pubblicato nel 1999 aveva riscontrato, tramite questionario sull'attività del 1997 in 68 pronto soccorso pediatrici di 16 regioni italiane, oltre 400.000 casi di maltrattamento sospettati o segnalati, e le tipologie più frequenti erano il maltrattamento fisico, l'abuso sessuale e la trascuratezza[29].
Uno studio dell'Italian Child Maltreatment study group (IChilMa) sui pronto soccorso di alcuni ospedali italiani, pubblicato nel 2005, ha riscontrato una prevalenza del 2% di bambini fra quelli arrivati in pronto soccorso in cui vi era un sospetto di maltrattamento[30].
Infine, in un lavoro pubblicato nel 2016 è stata verificata l'efficacia di una formazione specifica degli operatori e costituzione di un gruppo interdisciplinare in un ospedale italiano sul miglioramento dell'intercettazione dei casi di maltrattamento[31].
La frequenza dei casi identificati prima (fra gennaio 2010 e dicembre 2011) e dopo l'intervento (tra gennaio 2013 e dicembre 2014) è passata da 7 casi su 10.000 a 8 casi su 10.000. Nel periodo post formazione i bambini arrivati al pronto soccorso pediatrico sono stati quasi 54.000, di età media 2,1 + 0,9 anni, poco meno della metà maschi, e fra questi sono stati diagnosticati 45 casi di maltrattamento, di cui circa un terzo maschi e di età media 9,1 + 3,6 anni[32].

Il progetto REVAMP-Repellere Vulnera Ad Mulierem et Puerum ("Controllo e risposta alla violenza su persone vulnerabili: la donna e il bambino, modelli di intervento nelle reti ospedaliere e nei servizi socio-sanitari in una prospettiva europea" CCM 2014 finanziato dal Ministero della Salute) si è posto come obiettivo quello di armonizzare e valutare l'efficacia dei protocolli che vengono seguiti per riconoscere, accogliere, prendere in carico e accompagnare i casi di violenza su donne e bambini, dato il ruolo svolto dai servizi sanitari nella rilevazione e contrasto al maltrattamento[33] attraverso l'identificazione di elementi minimi comuni, conformi alle linee guida dell'Organizzazione Mondiale della Sanità e alle prove di efficacia[34].
Nell'ambito del materiale prodotto dal progetto REVAMP vi è anche un'analisi delle Schede di Dimissione Ospedaliera per i ricoveri (SDO) e dei flussi di Emergenza Urgenza (EMUR) per i pronto soccorso (per questi ultimi quelli relativi a Piemonte, Toscana, Abruzzo e Sardegna)[35].

Sotto l'anno di vita il rischio è più alto

Nelle Schede di Dimissione Ospedaliera (SDO) del 2012 vi sono stati **in Italia 485 casi di aggressione o abuso in età pediatrica (0-14 anni) con ricovero ospedaliero, di cui 183 con diagnosi di abuso o maltrattamento su minore (circa il 38%); di questi il 48,8% aveva meno di 5 anni e il gruppo con rischio maggiore era quello con meno di 1 anno** (tasso medio di ricovero pari a 53,0 per milione di residenti, a fronte di 26,6 per milione nella fascia 1-4 anni e alla media generale pediatrica pari a 21,4 per milione).

Dalle SDO, nelle diagnosi di abuso le forme più frequenti erano l'abuso sessuale e fisico, anche se il maltrattamento, l'abuso emotivo e quello psicologico insieme erano simili come frequenza all'abuso fisico; la frequenza di *Shaken Baby Syndrome* era di 1 caso ogni 20 ricoveri per abuso.

Dai flussi emergenza e urgenza – **EMUR del 2012**, relativi a Piemonte, Toscana, Abruzzo (anche se parziali) e Sardegna nel 2012 risultano accertati **682 casi di violenza interpersonale o abuso su minore in età da 0 a 14 anni e di questi il 17% (116 casi) aveva diagnosi di maltrattamento o abuso**. Il tasso medio era 96,7 accessi l'anno al pronto soccorso per milione di residenti da maltrattamento o abuso (considerando solo Piemonte, Toscana e Sardegna); questo dato **proiettato alla popolazione porta a 805 accessi in pronto soccorso di bambini da 0 a 14 anni per abuso o maltrattamento**. Non sono purtroppo ancora stati elaborati dati specifici per la fascia di età 0-3 anni.

Rispetto alle tipologie, oltre **un terzo dei bambini aveva subito violenza sessuale, circa 1 su 5 abuso fisico, quasi 1 su 10 maltrattamento o trascuratezza e 1 su 20 *Shaken Baby Syndrome***. Gli autori del lavoro sottolineano la questione della sottorilevazione, valutando i dati rilevati attraverso i flussi EMUR rispetto alle prevalenze di violenza su bambini riportate da lavori pubblicati.

La sottorilevazione è pari al 90%

Secondo quanto calcolato dagli autori, considerando la regione con una maggiore completezza nella rilevazione, ci sarebbe una sottorilevazione pari al 90%, e quindi sarebbe registrato solo un caso ogni 10 di quelli attesi della prevalenza d'abuso osservabile in pronto soccorso secondo i dati di letteratura scientifica (compreso lo studio IChilMa).

Infine, sempre attraverso il Progetto REVAMP, nel 2014 sono stati registrati i dati relativi a 4 centri di pronto soccorso (due a Genova, uno a Forlì e uno a Torino)[36] secondo lo standard europeo Injury Data Base (IDB) in modalità analitica (Full Data Set – FDS). Le rilevazioni sono state realizzate utilizzando un modulo specifico (Modulo FDS IDB – Violenza) con una raccolta di informazioni sulla causa dell'incidente che ha portato al pronto soccorso insieme con una caratterizzazione dell'evento violento e del contesto[37]. Sono stati rilevati 47 casi di aggressione o maltrattamenti in bambini da 0 a 14 anni (29 maschi e 18 femmine), con i casi più numerosi nei bambini di età maggiore. Rispetto alla fascia di età di interesse della presente indagine, **tra i bambini da 0 a 1 anno vi era un solo caso, mentre tra quelli da 2 a 5 anni sono stati registrati 4 casi**. Rispetto all'autore dell'aggressione, andando a cercare i casi verificatisi in ambito domestico, **quelli da parte del genitore rappresentavano il 27% e quelli da parte di un altro parente o familiare il 7%**. Nel 2015 la rilevazione IDB violenza è stata estesa a tutti i centri di Pronto Soccorso del REVAMP. I dati sono in fase di analisi.

UN PASSO IMPORTANTE: IMPARARE A RICONOSCERE

Il Progetto Europeo Intovian[38], avviato alla fine del 2012 e concluso nel 2015, si poneva l'obiettivo di migliorare l'efficacia dei servizi sanitari europei nella prevenzione e diagnosi precoce di abuso e trascuratezza nei bambini e neonati. In questa direzione ha sviluppato uno strumento di screening, con una specificità di interesse rispetto alla presente indagine in quanto focalizzato in particolare sulla fascia di età 0-3 anni.

La proposta del progetto partiva dal fatto che in questo primo periodo della vita sono previsti in diversi Paesi protocolli di medicina preventiva che offrono occasioni di contatto fra la famiglia e i più piccoli e gli operatori sanitari, e costituiscono conseguentemente una favorevole opportunità per l'osservazione e la rilevazione di eventuali situazioni di sospetto[39]. È stato quindi prodotto lo "Strumento di screening per l'identificazione di famiglie a rischio o con problemi già accertati di abuso e trascuratezza nei confronti di bambini e neonati", o Strumento "Intovian". Tale strumento è formato da una lista di controllo di 5 elementi su fattori di rischio per violenza fisica e/o psicologica, trascuratezza e modelli relazionali disfunzionali o di abuso fra il bambino o neonato e chi si prende cura di lui (*caregiver*).

L'obiettivo generale è che lo Strumento Intovian venga utilizzato come supporto (senza sostituire altri strumenti o esami) nella prima fase di valutazione dei piccoli in età 0-3 anni nel corso della visita presso i servizi sanitari ed è stato ideato e sperimentato per un utilizzo nell'ambito delle cure primarie, come pediatria di famiglia e consultori, o terziarie, come ospedali e pronto soccorso.

In Italia la sperimentazione dello Strumento Intovian è stata realizzata presso **l'ospedale di Pescara, per 6 mesi, nel pronto soccorso**, dove in media ogni anno vi sono circa 3.600 accessi di bambini nella fascia di età 0-3 anni, dopo un corso di formazione per il personale medico e infermieristico del pronto soccorso stesso; viene riferita l'identificazione di **18 casi (14 maschi e 4 femmine), con diagnosi e/o sospetto di maltrattamento fisico (11 casi, di cui 2 *Shaken Baby Syndrome*), trascuratezza (6 casi) e sindrome di Munchausen (1 caso)**[40].

Foto:Adam Hinton per Save the Children

QUASI 100MILA LE PICCOLE VITTIME DI MALTRATTAMENTO. UN TEMA DI SALUTE PUBBLICA

Nel **2012** è stata realizzata da CISMAI e Terres des Hommes una prima quantificazione nazionale del maltrattamento sui minori[41]. Il lavoro è stato effettuato nei primi sei mesi del 2012 con l'invio di un questionario ai Comuni, che lo hanno successivamente inviato ai Servizi Sociali. **I dati si riferiscono al 31 dicembre 2011**. È stato possibile raccogliere e utilizzare **le risposte di 31 Comuni**, raggiungendo una popolazione di quasi 50.000 minori in carico ai Servizi Sociali: circa 1 minore su 6 fra quelli assistiti dai Servizi Sociali è vittima di maltrattamento, 1 su 100 della popolazione di minori residenti, da cui gli autori dell'indagine affermano essere plausibile vi fossero quasi 100.000 minori vittime di maltrattamento, considerando la popolazione al momento dell'indagine.

Il maltrattamento era la causa dell'intervento dei Servizi Sociali nel 15,46% dei minori presi in carico. Rispetto alle tipologie, la percentuale maggiore era rappresentata dai casi di **trascuratezza materiale e/o affettiva (52,7%), seguita da violenza assistita (16,6%), maltrattamento psicologico, abuso sessuale, patologia delle cure e maltrattamento fisico**.

Più ampia e articolata l'indagine promossa dall'Autorità Garante per l'Infanzia e realizzata dalle due organizzazioni nel **2015** con la collaborazione dell'ANCI e dell'ISTAT[42].
In questo caso il lavoro ha coinvolto **oltre 200 Comuni, coprendo un quarto della popolazione minorile residente in Italia (2,4 milioni)**. È stato rilevato che 47,7 minorenni su 1.000 erano seguiti dai Servizi Sociali (un totale di 457.453) e, selezionando fra i dati la fascia 0-3, i bambini di età fino ai 3 anni presi in carico dai Servizi sarebbero 29 su 1.000.
In totale viene stimato in 91.272 il numero di minorenni vittime di maltrattamento: circa 1 bambino ogni 5 di quelli seguiti dai Servizi Sociali sarebbe vittima di maltrattamento. Rispetto alle tipologie, tenendo conto della possibile compresenza, **la causa più frequente di maltrattamento (47,1%) è rappresentata da trascuratezza materiale e affettiva, che unita alla patologia delle cure come discura o ipercura (8,4%) supera il 50%, quindi più di un bambino su due; la seconda forma più comune è la violenza assistita, quasi un bambino su cinque (19,4%); seguono il maltrattamento psicologico (13,7%) e fisico (6,9%) e l'abuso sessuale (4,2%)**[43].

L'ultima indagine nazionale nell'ambito dell'attività diagnostica del maltrattamento e abuso sui bambini realizzata da Terre des Hommes e pubblicata alla fine del **2016**[44] ha puntato l'attenzione in particolare su **cinque centri italiani** che si sono distinti per l'impegno e la qualità del lavoro di prevenzione, diagnostica e trattamento dei casi di maltrattamento materno e infantile in Italia[45].
Sono state raccolte informazioni su organizzazione e modalità di lavoro dei diversi centri e alcuni dati relativi ai **casi esaminati nel periodo 2011-2015**. La suddivisione in fasce di età non contempla quella 0-3 anni, ma è possibile isolare i dati relativi al primo anno di vita e quelli da 1 a 5 anni.
A Torino sono stati confermati in quel periodo 39 casi nel primo anno di vita e 200 casi fra 1 e 5 anni (che coprono insieme il 46% dei casi, 7% bambini con meno di 1 anno); a Milano i casi valutati sono stati 24 sotto l'anno e 222 da 1 a 5 anni (28% dei casi, 3% nel primo anno); a Padova valutati 90 casi con meno di 1 anno e confermati 86, valutati 158 casi da 1 a 5 anni e confermati 133 (in totale la percentuale di casi confermati è pari al 45% di cui 18% sotto l'anno); a Firenze confermati 42 casi di meno di 1 anno e 110 da 1 a 5 anni (39%, di cui 11% sotto l'anno di vita); a Bari sono stati valutati 25 casi di meno di 1 anno e 120 da 1 a 5 anni (27%, di cui 5% sotto l'anno).

I più piccoli nei casi rilevati dai 5 centri esaminati 2011-2015

Centri	1-5 anni	≤ 1 anno
Ambulatorio BAMBI – Torino	46%	7%
SVSeD Policlinico – Milano	28%	3%
CRDBM – Padova	45%	18%
GAIA, Meyer – Firenze	39%	11%
GIADA, Policlinico – Bari	27%	5%

Pur considerando che in due centri erano i casi valutati (non quelli confermati) e quindi una possibile parziale sovrastima, unendo questi dati, **fra il 2011 e il 2015 ci sono stati 216 casi di maltrattamento o abuso in piccoli con meno di 1 anno e 785 casi da 1 a 5 anni (1.001 casi complessivi sotto i 5 anni). Quindi circa 1.000 casi in cinque anni, che significa in media ogni anno circa 200 bambini con meno di 5 anni maltrattati o abusati giunti all'attenzione di personale sanitario**, e questo solo in cinque aree circoscritte, per quanto punti di riferimento anche regionali, del territorio italiano. Rispetto alle tipologie di maltrattamento le percentuali sono abbastanza variabili da centro a centro e non è possibile estrapolare il dato sul tipo di maltrattamento più frequente nelle diverse fasce di età[46].

IL LAVORO DI CAMPO. TRE STORIE ITALIANE

Milano, Servizio Soccorso Violenza Sessuale e Domestica (SVSeD), Fondazione IRRCS Ca' Granda Ospedale Maggiore Policlinico

Il SVSeD di Milano **ha collaborato a questa raccolta di informazioni elaborando i dati relativi alla fascia di età 0-3 anni nel periodo compreso fra il 2011 e il 2015**. I casi provenivano per la maggior parte dalla città di Milano (84), ma anche dalla provincia (38 casi) e da fuori provincia (16 casi). In totale **nei cinque anni sono stati accertati 138 casi, 48 maschi e 90 femmine, di cui 24 fino a 1 anno di età** (tab. 1).
La forma di **maltrattamento più frequente** (tenendo presente che in alcuni casi sono presenti insieme più tipi di maltrattamento) è rappresentata dall'**abuso sessuale (64 casi), seguito dalla violenza assistita (51 casi)** (tab. 2). Tuttavia, se vengono considerati solo **i casi in cui vi è stata una singola forma di violenza, quella assistita diventa la tipologia prevalente** (44 casi, rispetto ai 34 di violenza sessuale) (tab. 3).

Il numero di casi di maltrattamento e di violenza sessuale sulle donne ha subito un costante incremento negli ultimi anni. Nel 2015 sono state viste presso il SVSeD per violenza sessuale e domestica 806 donne e 1.037 nel 2016. Per quanto riguarda le **donne in gravidanza**, sono stati isolati i dati per l'anno 2015 e 2016. **Tra queste, le donne in gravidanza erano 25 nel 2015 e 34 nel 2016, per un totale di 59 su 1.843. Inoltre, 354 donne nel 2015 e 445 nel 2016 che si erano presentate al Servizio SVSeD avevano figli (799 su 1.843, pari al 43%** delle donne arrivate per episodi di violenza), dato che può fare presumere condizioni di violenza assistita e rischio di maltrattamento anche dei bambini.

Tab. 1 - Policlinico di Milano. Casi di maltrattamento per età tra il 2011 e il 2015

	Età				Sesso	
	0-12 mesi	1 anno	2 anni	3 anni	Maschi	Femmine
2011	7	4	12	13	11	25
2012	8	7	6	13	14	20
2013	4	8	13	12	18	19
2014	3	1	5	10	4	15
2015	2	1	2	7	1	11
	24	21	38	55	48	90
Totale	138				138	

Tab. 2 - Policlinico di Milano. Casi per tipologia di maltrattamento

Fisico	Sessuale	Psico-emozionale	Assistito	Trascuratezza
5	16	9	16	0
10	19	9	6	3
6	8	9	26	0
5	12	8	1	2
2	9	5	2	1
28	64	40	51	6
Totale	189			

Tab. 3 - Policlinico di Milano. Casi per tipologia di maltrattamento singola

	Fisico	Sessuale	Psico-emozionale	Assistito	Trascuratezza	Totale
2011	4	8	0	15	0	27
2012	4	12	1	5	0	22
2013	0	4	0	23	0	27
2014	3	5	0	0	2	10
2015	1	5	0	1	0	7
Totale	12	34	4	44	2	93

Padova, Centro Regionale per la Diagnostica del Bambino Maltrattato[47]

Ogni anno giungono all'attenzione del Centro Regionale per la Diagnostica del Bambino Maltrattato (CRDBM) circa 120-150 tra bambini e ragazzi per una valutazione, per un totale di 564 casi nel quinquennio 2011-2015. Tra questi, circa 1 bambino su 4 ha meno di 3 anni e il maltrattamento è sospettato nel primo anno di vita (categoria 0 anni) in circa 30 casi su 100.
I piccoli sono distribuiti per sesso con un rapporto maschi/femmine[48] di 92 (si consideri che tale dato ha valore 105 nella popolazione generale) con una lieve prevalenza del sesso femminile (52% femmine).
Quasi la metà dei casi (42%) proviene da territori al di fuori del bacino di riferimento (provincia di Padova), quali altre province della Regione Veneto o altre Regioni. Il fenomeno dell'attrazione da altre province o regioni si osserva nei casi più gravi, oppure in casi particolarmente complessi in cui la definizione della diagnosi richiede l'ausilio di un centro specialistico di III livello, per esempio per una *second opinion* su di un caso.
Il maltrattamento viene confermato nell'87% dei casi ed escluso nel restante 13%. Le forme di maltrattamento più frequentemente diagnosticate nella primissima infanzia sono l'*Abusive Head Trauma* (trauma cranico abusivo, comprensivo di altre forme di maltrattamento quali la sindrome del bambino scosso, *Shaken Baby Syndrome*, o la sindrome da scuotimento-impatto, *Shaken-Impact Baby Syndrome*) nel 22% dei casi, il *Chemical Abuse* (che consiste nella somministrazione di sostanze al bambino, farmaci, sostanze stupefacenti o altre sostanze tossiche) nel 19% e la trascuratezza grave nel 18%.
Secondo l'esperienza maturata al Centro, quanto più precoce è il maltrattamento, tanto più gravi saranno gli esiti in termini di danno alla salute, allo sviluppo e alla stessa sopravvivenza del bambino. I bambini che subiscono un maltrattamento in questi periodi critici per lo sviluppo potranno presentare un ritardo dello sviluppo ed esiti permanenti sia motori che cognitivi. È conoscenza consolidata che tali alterazioni si osservano non solo nei bambini che subiscono violenza fisica (*Abusive Head Trauma*) o violenza psicologica (Abuso Psicoemozionale o Violenza Assistita), ma anche nei casi in cui c'è una mancanza o assenza di cure amorevoli adeguate, come nei casi di trascuratezza grave (*child neglect*).

Tab.4 - Casi esaminati dal CRDBM di Padova nel periodo 2011 - 2015

	n° Casi di sospetto	n° Casi confermati
Totale casi 0-18	564	490
Casi 0-3 anni (% sul totale dei casi)	138 (25%)	118 (24%)
Distribuzione per età in anni (n° assoluto e %)		
0	41 (30%)	33 (28%)
1	36 (26%)	34 (29%)
2	25 (18%)	20 (17%)
3	36 (26%)	31 (26%)
Tot.	138 (100%	118 (100%)
Distribuzione per sesso (n° assoluto e %)		
F	72 (52%)	61 (52%)
M	66 (48%)	57 (48%)
Distribuzione per residenza		
Provincia	80	66
Fuori Provincia	58	52
Distribuzione per numero di maltrattamenti (casi)		
Singolo	_	97 (82%)
Multiplo	_	21 (18%)
Distribuzione per tipo di maltrattamento (forme)		
Abusive Head Trauma	28 (20%)	33 (22%)
Maltrattamento fisico	33 (24%)	17 (11%)
Chemical Abuse	10 (7%)	29 (19%)
Asfissia	0	2 (1%)
Abuso sessuale	20 (15%)	5 (3%)
Abuso psicoemozionale	2 (1%)	4 (3%)
Trascuratezza grave	19 (14%)	28 (19%)
Sindrome di Muchausen per Procura	0	2 (1%)
Violenza Assistita	17 (12%)	17 (11%)
Bambino conteso/conflittualità di coppia	4 (3%)	15 (10%)
Altro	6 (4%)	0
Totale forme di maltrattamento	139 (100%)	152* (100%)

* Il numero delle forme di maltrattamento confermate è superiore alle forme sospettate, poiché vengono sospettate meno forme di maltrattamento di quante ne vengano diagnosticate, con casi in cui vengono diagnosticate più forme di maltrattamento contemporaneamente.

Grosseto, Codice Rosa

In Toscana, dal 2014 il Codice Rosa è attivo in tutte le Aziende sanitarie e ospedaliere. Indica un percorso di accesso al pronto soccorso specifico per le vittime di maltrattamento o abuso, donne, uomini, bambini, persone vulnerabili. Una volta assegnato questo codice viene attivato un gruppo formato da personale sanitario (composto da medici, infermieri, psicologi, assistenti sociali, centro antiviolenza, eccetera) e dalle forze dell'ordine. Nella tabella 5 sono riportati i dati estratti dagli accessi Codice Rosa negli anni dal 2012 al 2015. Da tenere presente, nella lettura della tabella, che il numero di ASL e aziende ospedaliere i cui dati sono inseriti (e quindi il campione di riferimento) si è modificato nel corso degli anni, aumentando di numero (nel 2012 i dati si riferiscono solo a cinque ASL, nel 2013 a otto ASL e due Aziende Ospedaliere, nel 2014 e 2015 al totale delle Aziende Sanitarie e Ospedaliere della Toscana) e che nel 2012 si parlava di casi pediatrici, mentre negli anni successivi di minori. Pur tenendo presenti i limiti di cui sopra, complessivamente **dal 2012 al 2015 vi sono stati 1.268 accessi Codice Rosa di casi pediatrici/minori** (542 maschi e 675 femmine, 2 non noto, dati riferiti solo al 2013, 2014 e 2015, quindi su 1.219 casi). Nella tabella 6 è mostrata un'estrapolazione dei dati, dove disponibili (dal 2013 dunque), rispetto alle fasce di età. Non vi è una divisione fino ai 3 anni, ma da 0 a 2 e da 3 a 6 anni; tuttavia è possibile evincere un quadro del numero dei casi di maltrattamento nei bambini piccoli (ricordando sempre che nel 2013 la rilevazione non copre ancora tutte le ASL e Aziende Ospedaliere). Considerando la **fascia 0-2 anni, sono stati rilevati in totale 113 casi** (di cui **17 fra 0-1 anno** negli **anni 2014 e 2015**, dato non disponibile per il 2013 in cui erano raggruppati i casi nella fascia di età 0-2 anni), e un totale di **296 casi di maltrattamento o abuso in età 0-6 anni**.
I dati preliminari di Codice Rosa relativi al primo semestre del 2016 indicano 254 accessi in pronto soccorso di minori (nel 2015 erano stati in totale 426 nei 12 mesi), ma non ci sono ancora le specifiche per età[49].

Tab. 5 - Casi pediatrici/minori, Regione Toscana

	Maltrattamento	Abuso	Totale	Maschi	Femmine
2012	37	12	49	–	–
2013	293	59	352	152	200
2014	355	86	441	205	236
2015	373	53	426	187	239
Totale	1.058	210	1.268	542	675

Tab. 6 - Casi suddivisi per fasce di età, Regione Toscana

	0-1 anno	1-2 anni	0-2 anni	3-6 anni	Totale (0-6 anni)
2013	–	–	32	45	77
2014	7	34	41	69	110
2015	10	30	40	69	109
Totale	17	64	113	183	296

Shaken Baby Syndrome

Fra le diverse possibili forme di maltrattamento, nella fascia 0-3 anni assume importanza quella che viene **definita sindrome da scuotimento (*Shaken Baby Syndrome*)**, o ***Abusive Head Trauma*** a includere insieme con lo scuotimento la possibilità di trauma da impatto. Nell'aprile del 2016 la Società italiana di neonatologia (SIN), Terre des Hommes e SVS DAD onlus (SVS Donna Aiuta Donna) hanno lanciato una **campagna di sensibilizzazione**[50], con materiale informativo e locandine per far capire i rischi e le conseguenze dello scuotimento del bambino, scatenato per esempio dal pianto, che rappresenta nei neonati e piccini l'unica forma di comunicazione per diverse necessità e disagi. Le conseguenze neurologiche dello scuotimento possono essere molto gravi, anche mortali, e viene riportata, non essendo disponibili dati certi, una **stima di incidenza in Italia di 3 casi ogni 10.000 bambini con meno di 1 anno** (negli Stati Uniti circa 50.000 bambini l'anno)[51]. La SIN indica come in genere le vittime siano bambini tra i 4 e i 6 mesi, sia perché questo è un periodo che richiede cure costanti che possono esasperare chi si occupa del piccolo sia perché da un lato la testa è pesante rispetto al corpo e dall'altro i muscoli del collo non sono ancora in grado di sostenerla. La SIN riporta inoltre che il **25-30% delle vittime muore e il 15% sopravvive senza esiti**[52].
Sempre nel 2016 un lavoro italiano che ha preso in considerazione gli aspetti clinici e medico-legali dell'*Abusive Head Trauma* ha indicato che quest'ultimo rappresenta la **causa di morte per maltrattamento in età infantile più comune nei Paesi industrializzati**. Viene indicato come al momento non siano disponibili in Italia dati pubblicati su incidenza e prevalenza e che la **maggior parte delle vittime abbia meno di 1 anno, più spesso meno di 6 mesi**[53].

Depressione post-partum

La depressione post-partum rappresenta una condizione della madre che può avere ripercussioni negative anche sul benessere dei figli e risulta importante il riconoscimento tempestivo e la gestione adeguata. Nel 2014 nell'ambito delle attività del Progetto biennale *Depressione in gravidanza e post-partum*: *modello organizzativo in ambito clinico, assistenziale e riabilitativo*, progetto finanziato dalla Regione Lombardia e svolto dall'Azienda Ospedaliera Fatebenefratelli e Oftalmico di Milano in collaborazione con l'Osservatorio Nazionale sulla salute della Donna (O.N.Da) e con la partecipazione dell'Associazione Progetto Itaca, sono state realizzate Linee Guida per la gestione della depressione in gravidanza e nel post-partum[54]. Il progetto si era avviato con un'**indagine conoscitiva in Lombardia su 500 uomini e 500 donne** e ha riportato che **1 genitore su 3 ha detto di aver sofferto o che la propria partner ha avuto una depressione post-partum**, soprattutto con il primo figlio, ma **meno del 50% ne ha parlato con il proprio medico**. Gli obiettivi comprendevano far nascere un modello organizzativo di presa in carico per la depressione perinatale (per rilevare e trattare rapidamente ed efficacemente), sensibilizzare l'opinione pubblica, supportare i papà e promuovere attività di formazione degli operatori sanitari. Nell'ambito dell'iniziativa vi era anche l'offerta di un'**assistenza domiciliare specialistica alle neomamme e ai neonati, attraverso un'équipe multidisciplinare** (psichiatra, psicologo, pediatra, volontaria)[55].

Foto: Caroline Trutmann Marconi per Save the Children

PEDIATRI CHE SOSPETTANO

La capacità di medici e pediatri di riconoscere i segnali di un possibile maltrattamento ai danni di bambini e bambine rappresenta un aspetto cruciale. Forse ancora più importante nella fascia di età 0-3 anni, quando il pediatra può essere l'unica o una delle poche figure all'esterno della famiglia a venire in contatto con il bambino o la bambina e in generale con il nucleo familiare.

2012, una verifica sui pediatri a Milano. Alla fine del 2012 Terre des Hommes e SBAM-Sportello Bambino Adolescente Maltrattato della Clinica Mangiagalli di Milano hanno condotto un'indagine che ha coinvolto medici di famiglia, pediatri di base e ospedalieri[56]. È stato inviato un questionario a 1.000 medici e 170 pediatri a Milano e dintorni per raccogliere informazioni sull'esperienza di casi di maltrattamento o abuso e sulla conoscenza del tema. I questionari raccolti utilizzabili sono stati **259, di cui 72 di pediatri**, pari al 42,3% del campione di questa categoria professionale (contro i 134, pari al 13,4%, dei questionari utilizzabili dei medici); in 53 questionari non era indicata la professione.

Oltre la metà degli intervistati ha dichiarato di sospettare situazioni di maltrattamento. Fra le risposte raccolte si segnala che il **65,63% degli intervistati ha dichiarato di sospettare situazioni di maltrattamento, abuso o trascuratezza/incuria** e per il 78,63% la fascia di età più a rischio di fratture da maltrattamento fisico è quella da 0 a 5 anni. **In totale vengono segnalati 318 casi** (3 casi circa per ciascun medico) e **la tipologia di maltrattamento più frequente è la patologia delle cure (175 casi), seguita dal maltrattamento fisico (81 casi) e dall'abuso sessuale (62 casi)**.

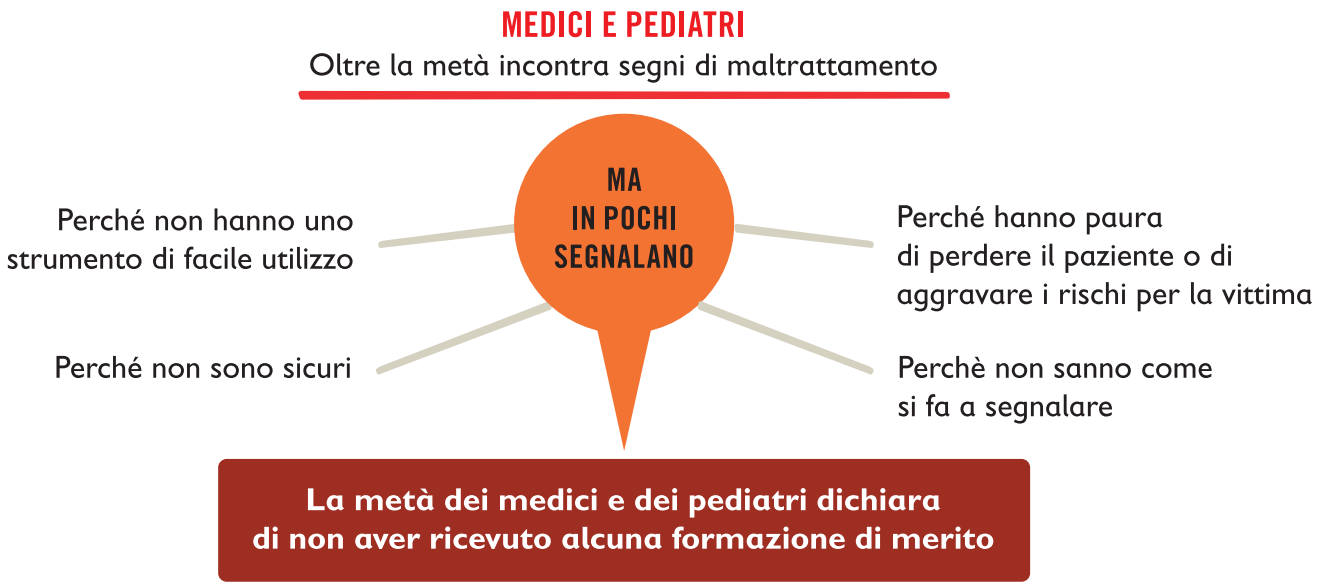
Fra gli intervistati che hanno risposto affermativamente alla domanda sull'aver mai sospettato situazioni di maltrattamento, abuso o trascuratezza/incuria, il **51,49% ha segnalato la situazione, mentre il 48,51% non lo ha fatto** e i motivi principali per cui è stato deciso di non segnalare erano il non avere elementi di sospetto sufficientemente forti (55,1%), non sapere a chi segnalare e come (18,3%) e avere timore delle conseguenze sul contesto familiare (13,6%).

Viene indicato che se la quasi totalità degli intervistati non ha a disposizione un modulo prestampato per la segnalazione (94,04%), la maggior parte afferma che averne uno potrebbe essere di aiuto (89,34%). Inoltre, un approfondimento sulla **formazione scientifica** ha fatto emergere che **circa la metà degli intervistati negli ultimi tre anni non ha partecipato ad alcun evento formativo sul tema e il 75,59% non ha mai partecipato a un corso di formazione sul maltrattamento, nonostante l'89,05% senta il bisogno di essere aggiornato**.

2013-2014, una verifica sui pediatri di Perugia. Nel 2013-2014 è stata svolta un'indagine, analoga a quella appena descritta, nella provincia di Perugia che ha coinvolto **134 operatori sanitari partecipanti a corsi di formazione specifici sul maltrattamento infantile**[57] cui è stata chiesta la compilazione di un questionario[58]. **Il 17% circa (23 su 134) ha segnalato un sospetto caso di abuso, e sempre al 17% circa è capitato di sospettare un caso di abuso ma di decidere di non segnalarlo. Nella maggioranza dei casi (43,48%) non si segnala perché le conoscenze nel merito non sono adeguate per avere la certezza**; in secondo luogo non si segnala perché non si è certi che la segnalazione sia adeguata (21,74%) o perché non emerge una storia di abuso familiare in modo chiaro (17,39%); **il 4,35% ha risposto di non aver segnalato perché non sapeva a chi indirizzare la segnalazione**.

Rispetto all'avere un modulo guida prestampato per la diagnosi, la risposta è stata negativa per la quasi totalità dei partecipanti (99,25%). Infine, il 96,27% sente la necessità di aggiornamento su cause, diagnosi e cura dell'abuso nel bambino, forse anche perché **negli ultimi tre anni l'82,09% non ha partecipato ad alcun corso o conferenza e il 57,46% non ha letto nessun articolo**; inoltre **il 95,52% degli intervistati non ha mai partecipato a un corso di perfezionamento sul maltrattamento**.

2015, un test nazionale. Nel 2015 è stata condotta un'ulteriore ricerca da Terre des Hommes, Società Italiana di Cure Primarie Pediatriche (SICuPP) e SVSeD su 500 medici in tutta Italia[59]. Sono stati raccolti **398 questionari da cui emerge che il 61% degli intervistati ha avuto casi di sospetto maltrattamento e il 57% di chi si è confrontato con questa situazione ha attivato la segnalazione**; viene riportato che il **16% teme che segnalare equivalga a perdere il paziente**. Inoltre il **59% vede positivamente la possibilità di avere un collega esperto cui inviare i casi sospetti** sia per sentirsi più sicuro (59%) sia per una protezione più completa dei bambini (76%). **Sulla formazione, la metà circa dice di non averne mai avuta e il 93% la vorrebbe**.



QUANDO A ESSERE COLPITE SONO LE MAMME

Nel 2015 l'**ISTAT** ha pubblicato un'indagine sulla sicurezza delle donne[60]. All'interno del quadro fornito vi sono i dati riguardanti la violenza assistita e la violenza in gravidanza. Nel totale delle violenze subìte da donne con figli, l'ISTAT segnala un **aumento della percentuale dei figli che erano presenti e hanno assistito alla violenza** del padre contro la madre rispetto a un'indagine precedente del 2006, che **passa dal 60,3% al 65,2% del 2014**, un dato che l'ISTAT definisce preoccupante poiché questi figli maschi hanno una probabilità maggiore di essere loro stessi violenti con le loro compagne e le figlie femmine di essere vittime. Nel 22,2% dei casi hanno assistito spesso alla violenza (21,4% nel 2006) e nel 25% dei casi ne sono stati anche coinvolti. E anche in questo caso assistiamo a un aumento di quasi 10 punti percentuali rispetto al 15,9 del 2006.

Quando più fattori di rischio si combinano. Una trascuratezza con tanti responsabili #storiedaiservizi

Dora è cresciuta in una casa famiglia da cui è scappata quando aveva 17 anni insieme a un uomo da cui ha avuto un figlio: oggi Teo ha 3 anni ed è cardiopatico per cui, fin da neonato, ha richiesto un'attenzione particolare in termini di cure, medicinali, nutrizione e regolarità dei ritmi della sua giornata. Il papà di Teo non l'ha riconosciuto alla nascita e pertanto Dora è sola nell'affrontare la crescita del bambino: non c'è una rete di riferimento, una famiglia che la sostenga e quindi Dora ricerca e accetta relazioni con uomini, sperando di trovare in questi un sostegno e una garanzia anche per Teo. Ma fino a oggi tali relazioni sono risultate in qualche caso pericolose per Dora e anche per Teo che ha assistito a momenti di litigio violento con percosse agìte e subìte da parte della sua mamma.

Considerando i dati sulle donne in gravidanza, **se nel 2006 nel 10,2% dei casi le donne sono state sottoposte a violenza da parte del partner anche quando erano incinte, la percentuale nella rilevazione del 2014 sale all'11,8%**. Nei casi di violenza **durante la gravidanza** l'ISTAT riporta inoltre **nel 5,9% dei casi la violenza è iniziata e nell'11,3% è aumentata**.

Orfani di omicidio di genere o femminicidio

Nell'ambito della violenza domestica e assistita si inserisce il drammatico capitolo degli orfani di femminicidio, che oltre a essere stati testimoni, o a essere direttamente coinvolti negli episodi di violenza, perdono la madre. Nella sola **Toscana in 10 anni (dal 2006) sono 30 i minori rimasti senza mamma** uccisa dal padre nell'ambito degli 88 casi di femminicidio[61] e a settembre 2016 è stato presentato alla Camera dei Deputati il primo studio su questi casi, bambini rimasti senza madre, morta, e senza padre, perché suicida (30% dei casi) o in carcere. Dal **2000, in 15 anni, è stato stimato un numero di circa 1.600 orfani di femminicidio** (417 negli ultimi tre anni, 180 minori), affidati a nonni, zii, servizi[62]. I dati sono stati presentati da Anna Costanza Baldry, responsabile scientifica del **progetto Switch-off**[63], del Dipartimento di Psicologia della Seconda Università di Napoli con la collaborazione di DiRe (Donne in rete contro la violenza) e due partner stranieri, dati presentati insieme con le Linee Guida prodotte dal progetto stesso.
Nell'ambito delle Linee Guida vengono anche riportati i risultati di un lavoro di ricerca in Italia con **interviste realizzate a 123 orfani: nell'81% dei casi gli intervistati avevano già assistito a violenze contro la madre e nel 41% dei casi i figli erano presenti al momento della morte** (di cui il 71% ha ascoltato quello che succedeva, il 52% ha visto e il 44% ha poi visto il corpo senza vita della mamma).
Sempre sugli orfani di femminicidio nel 2015 è stato pubblicato uno studio italiano che ha valutato il numero di **femminicidi in Italia fra l'1 gennaio 2012 e il 31 ottobre 2014** con ricerche online e sui giornali, contandone 319, circa 1 ogni 3 giorni (126 nel 2012, 134 nel 2013 e 59 nel 2014)[64]. Complessivamente i figli delle donne uccise rimasti **orfani erano 417** (153 nel 2012, 173 nel 2013 e 91 nel 2014), di cui **180 minorenni. Il 12,47% dei figli ha assistito all'omicidio e più della metà di questi (57,69%) era minorenne; in alcuni casi è stato ucciso anche il figlio (18 casi, 4,32%), e fra questi uno su due era un minorenne. L'omicidio è stato commesso dal padre nel 38,56% dei casi e i figli il cui padre è a sua volta morto dopo aver ucciso la madre erano l'11,75% (gli orfani minorenni il 42,86%)**. Nello studio viene inoltre sottolineato il tema del **destino di questi orfani** e l'importanza di studi per capire cosa succeda loro, quale sia il trattamento psicologico più adeguato e quali le decisioni migliori rispetto ai contatti con il padre, se autore dell'omicidio, e su dove farli vivere.

Orfani di crimini domestici: la legge

Il 21 aprile 2016 è stata presentata alla Camera dei Deputati la proposta di legge n.3772 "Modifiche al codice civile, al codice di procedura penale e altre disposizioni in favore degli orfani di crimini domestici".

La proposta, come emendata in Commissione Giustizia a gennaio 2017, prevede una serie di agevolazioni per "*i figli minori o i figli maggiorenni economicamente non autosufficienti rimasti orfani di un genitore a seguito di omicidio commesso in danno del genitore dal coniuge, anche legalmente separato o divorziato, dalla parte dell'unione civile, anche se l'unione civile è cessata, o da persona che è o è stata legata da relazione affettiva e stabile convivenza*".

Tra le altre cose, la proposta prevede che gli orfani di crimini domestici abbiano accesso al patrocinio a spese dello Stato anche in deroga ai limiti di reddito previsti dalla legge, per le spese legali di tutti i procedimenti derivanti dal reato; che possano vedersi liquidare, a titolo di "provvisionale", il 50% del presumibile danno da parte del giudice penale al momento della condanna del responsabile, senza dover attendere l'esito del successivo procedimento civile; che l'indagato per il delitto sia sospeso dalla pensione di reversibilità e dalla successione ereditaria e che tale esclusione sia resa definitiva dalla sentenza di condanna.

La proposta prevede inoltre una dotazione di 2 milioni di euro annui da dedicare a borse di studio, iniziative di orientamento, formazione, assistenza sanitaria e psicologica agli orfani, il 70% della quale sarebbe destinata ad interventi in favore dei minori. Al momento di chiudere il testo si è in attesa dell'approvazione da parte della Camera.

Foto: Simon Edmunds per Save the Children

Note

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[17] UNICEF, *Ogni bambino conta*, 2014.
[18] http://www.end-violence.org/
[19] Hillis S, Mercy J, Amobi A, et al. *Global prevalence of past-year violence against children: a systematic review and minimum estimates*, Pediatrics 2016; 137(3):e20154079.
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[23] World Health Organization, Regional office for Europe, *Investing in children: the European child maltreatment prevention action plan 2015-2020*, Regional Committee for Europe, 64th session, settembre 2014.
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[28] Il Piano indica, tra le fonti utili per l'acquisizione di dati e informazioni sul tema, l'indagine dell'Autorità Garante per l'Infanzia e l'Adolescenza, CISMAI, Terre des Hommes, *Indagine nazionale sul maltrattamento dei bambini e degli adolescenti in Italia. Risultati e prospettive*, 2015.
[29] Marchi AG, Gaeta G, *I quadri clinici più frequenti dell'abuso del bambino*, Riv Ital Pediatr (IJP) 1999; 25:696-700.
[30] Palazzi S, de Girolamo G, Liverani T, on behalf of ItChilMa, *Observational study of suspected maltreatment in Italian pediatric emergency departments*, Arch Dis Child 2005; 90:406-410.
[31] Milano GP, Vianello FA, Cantoni B et al., *New program for identification of child maltreatment in emergency department: preliminary data*, Italian Journal of Pediatrics 2016; 42:66.
[32] Il dato riporta l'età media ± la deviazione standard. La deviazione standard indica la dispersione dei dati intorno alla media; un valore più ampio corrisponde a una maggiore variabilità dell'età nel gruppo considerato e viceversa.
[33] http://www.iss.it/binary/casa/cont/ProgViol2014.pdf
[34] Il progetto ha coinvolto 7 regioni (Nord Piemonte, Lombardia, Liguria, Centro Toscana, Lazio, Sud Basilicata e Sicilia) con la partecipazione di diverse unità operative (E.O. Galliera di Genova, Istituto Superiore di Sanità, Azienda Ospedaliero Universitaria – Città della Salute e della Scienza di Torino, ASL TO2-Ospedale San Giovanni Bosco e Ospedale Maria Vittoria, Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico-Milano, IRCCS G. Gaslini di Genova, ASL Sud-Est Toscana (ex ASL 9 Grosseto ed ex ASL 7 Siena, IRCCS Bambino Gesù – Ospedale Pediatrico di Roma, Centro Pediatrico Bambino Gesù Basilicata – AOR "San Carlo" di Potenza, ARNAS Di Cristina, Benfratelli di Palermo, ASP Trapani, ASL TO3 – Servizio Sovrazonale di Epidemiologia – Piemonte, Agenzia Regionale di Sanità della Toscana, Dipartimento di Epidemiologia del Servizio Sanitario Regionale – Regione Lazio). Fra le attività svolte era prevista anche la rilevazione dei dati relativi a eventi violenti in pronto soccorso secondo modalità di registrazione e codifica dello standard europeo Injury Data Base (IDB).
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[36] Trinca S, Debbia C, Cremonesi P et al., *Studio della Violenza/aggressione altrui sui bambini attraverso i dati raccolti con il Full Data Set – IDB (FDS) nel 2014*, Progetto REVAMP "Controllo e risposta alla violenza su persone vulnerabili: la donna e il bambino, modelli di intervento nelle reti ospedaliere e nei servizi socio-sanitari in una prospettiva europea" CCM 2014 finanziato dal Ministero della Salute.
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[41] CISMAI, Terre des Hommes, *Maltrattamento sui bambini: quante le vittime in Italia? Prima indagine nazionale*

quali-quantitativa sul maltrattamento a danno di bambini, a cura di Andrea Bollini-CISMAI, Federica Giannotta-Terre des hommes, Antonella Angeli-CISMAI, 2012.

42. Autorità Garante per l'Infanzia e l'Adolescenza, CISMAI, Terre des Hommes, *Indagine nazionale sul maltrattamento dei bambini e degli adolescenti in Italia. Risultati e prospettive*, 2015.

43. L'indagine ha quindi proposto 5 raccomandazioni: raccolta dati a livello nazionale e creazione di banche dati; istituzione di un organismo di coordinamento interistituzionale e di un Piano nazionale di contrasto, prevenzione e cura; adozione di linee guida nazionali su prevenzione e protezione della violenza; armonizzazione degli strumenti di rilevazione precoce; attribuzione delle risorse necessarie per le misure di contrasto, prevenzione e cura.

44. Terre des Hommes, *Maltrattamento e abuso sui bambini: una questione di salute pubblica. Indagine nazionale sull'attività diagnostica del fenomeno delle eccellenze ospedaliere di: Piemonte, Lombardia, Veneto, Toscana e Puglia*, 2016.

45. Si tratta dell'Ambulatorio Bambi, Ospedale Regina Margherita di Torino; dello SVSeD, Fondazione IRRCS Ca' Granda Ospedale Maggiore Policlinico di Milano; del Centro Regionale del Veneto per la Diagnostica del Bambino Maltrattato (CRDBM), Azienda Ospedaliera Universitaria di Padova; del progetto GAIA, Azienda Ospedaliero-Universitaria Meyer di Firenze e del progetto GIADA, Azienda Ospedaliero Universitaria Policlinico – Giovanni XXIII di Bari.

46. Nelle raccomandazioni finali Terre des Hommes e i suoi partner chiedono: almeno un centro ospedaliero pediatrico referente per il territorio in ogni Regione; équipe multidisciplinari e specializzate, dotazioni strumentali e facilities per le diagnosi; il maltrattamento come materia di studio curriculare nelle Facoltà di Medicina e Chirurgia; il maltrattamento inserito nel Piano Nazionale di Prevenzione Sanitaria.

47. Di Melissa Rosa-Rizzotto.

48. Rapporto maschi/femmine = (N. maschi/N. femmine) *100.

49. http://www.regione.toscana.it/zh_TW/web/toscana-notizie/dettaglio-notizia/-/asset_publisher/mk54xJn9fxJF/content/codice-rosa-dal-2012-oltre-12-000-accessi-nei-pronto-soccorso-della-toscana;jsessionid=38E1F659E372F7F0DB9C44AFE96C5972.web-rt-as01-p2

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55. http://www.ondaosservatorio.it/ondauploads/2015/12/Comunicato-stampa-Depressione-perinatale-Lombardia-03_12_15.pdf

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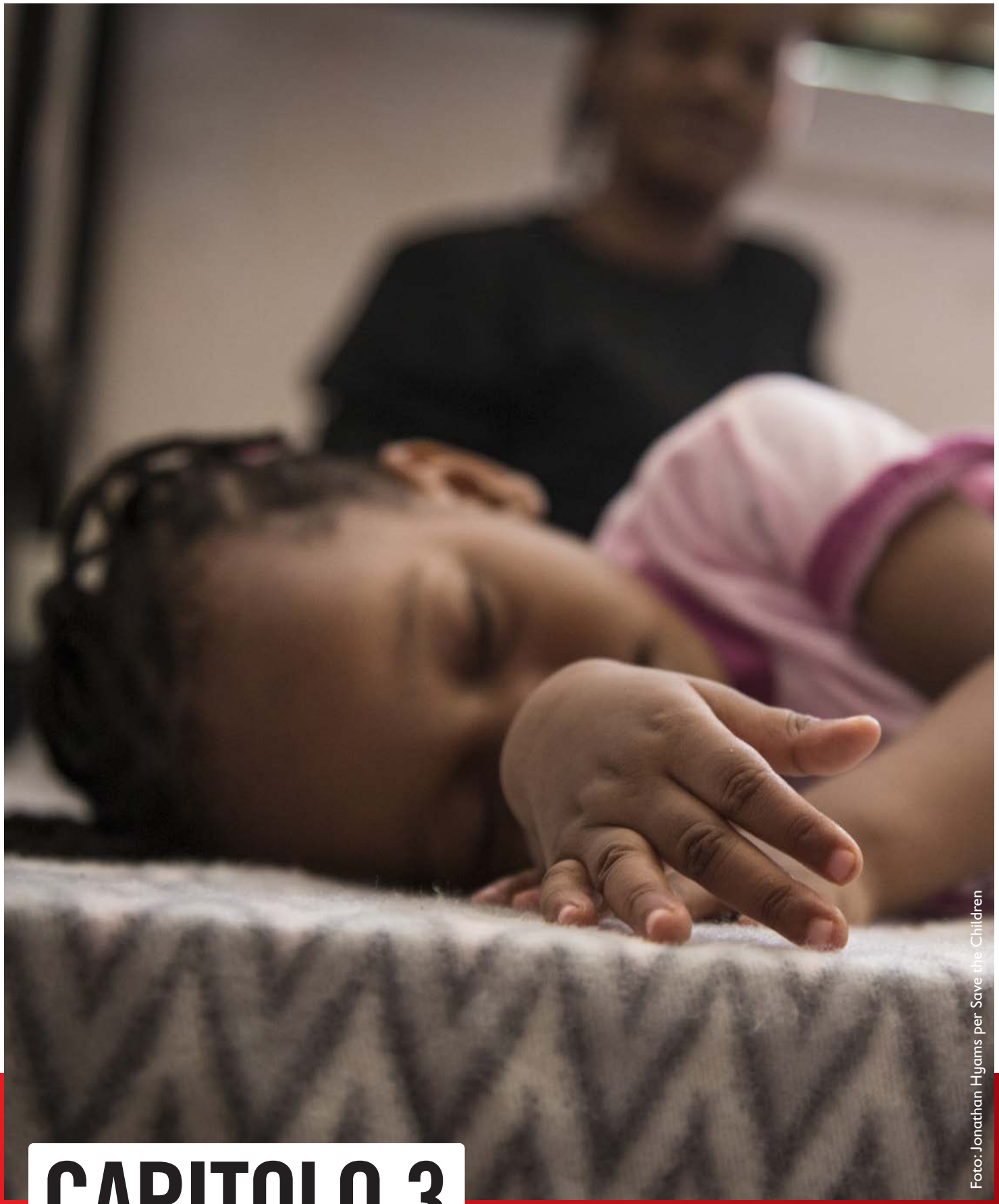

Foto: Jonathan Hyams per Save the Children

CAPITOLO 3

3. CON LE MANI IN PASTA. CONVERSAZIONI CON ALCUNI PROFESSIONISTI SU REGOLE, PRASSI, NODI DOLENTI

In Italia sono numerose e molto interessanti le storie di persone, organizzazioni e progetti che, soprattutto nell'ultimo decennio, hanno segnato l'intervento di contrasto al maltrattamento di donne incinte, bambine e bambini piccoli e piccolissimi. Come spesso capita, in un sistema molto frastagliato sul piano territoriale, si distinguono esperimenti di successo e tentativi coraggiosi fatti da persone che lavorano in ambiente sociale e sanitario.

Intento di questa parte del lavoro è quello non solo di dare riconoscimento a questo lavoro, ma anche di accendere una luce di ottimismo programmatico su una materia delicata e complessa come quella dei comportamenti maltrattanti in contesti particolarmente opachi e impermeabili allo sguardo sociale, come sono le famiglie.

Naturalmente, le persone e le storie che andremo a raccontare non sono esaustive del panorama italiano. Non è sempre semplice raggiungere le esperienze concrete specie quando non hanno l'opportunità di essere particolarmente pubblicizzate e visibili. La natura di questo lavoro è tuttavia proprio quella di uno slancio conoscitivo iniziale, al quale dovranno poi con pazienza e sistematicità aggiungersi e integrarsi nuove informazioni e materiale.

Grazie alle testimonianze professionali di:

Giussy Barbara, ginecologa, SVSeD, Milano.

Carla Berardi, pediatra di famiglia, Associazione Culturale Pediatri, Perugia.

Paola Di Blasio, psicologa, Dipartimento di Psicologia, Università Cattolica, Milano.

Vittoria Doretti, medico, anestesia e rianimazione, Codice Rosa, Grosseto.

Sabrina Farci, psicologa e psicoterapeuta, Cooperativa PARADIGMA, Torino.

Alessandra Kustermann, ginecologa, SVSeD, Milano.

Melissa Rosa-Rizzotto, medico di comunità, Centro Regionale per la Diagnostica del Bambino Maltrattato Unità di Crisi di Bambini e Famiglia, Azienda Ospedaliera di Padova.

Santo Rullo, psichiatra, Roma.

3.1 LA BABELE DEI PROTOCOLLI E DELLE LINEE GUIDA

In Italia esiste una legislazione piuttosto ricca riguardante la tutela delle vittime effettive e potenziali di comportamenti maltrattanti che si rifà ad accordi quadro e convenzioni internazionali di tutela dei diritti dei bambini o di contrasto alla violenza e allo sfruttamento di donne e minori.

Le fattispecie di reato perseguibili e previste dalle leggi nazionali hanno a che vedere con maltrattamenti in famiglia o verso fanciulli; omicidio; istigazione o aiuto al suicidio; percosse; lesione personale; pratiche di mutilazione degli organi genitali femminili; sequestro di persona; violenza sessuale; violenza sessuale di gruppo; violenza privata; minaccia; atti persecutori (*stalking*).

L'Italia ha ratificato nel 2013 la cosiddetta Convenzione di Istanbul sulla prevenzione e la lotta contro la violenza nei confronti delle donne e la violenza domestica. Nello stesso anno ha varato la legge 119/2013 «Disposizioni urgenti in materia di sicurezza e per il contrasto della violenza di genere, nonché in tema di protezione civile e di commissariamento delle Province»; il Piano d'azione nazionale straordinario contro la violenza sessuale e di genere 2015/2017. Per non parlare dei diritti dei bambini e del contrasto a ogni forma di violenza, abuso e sfruttamento di bambini e ragazzi, per i quali fin dal 1991 l'Italia ha ratificato la Convenzione ONU sui diritti dell'infanzia con apposita legge 176.

Tuttavia, le linee guida e i protocolli attuativi di questa vasta materia legislativa trovano un'applicazione molto discontinua

sul territorio nazionale e sovente anche nell'ambito del medesimo territorio regionale o della stessa città. Spesso l'iniziativa è affidata alla buona volontà o allo spirito d'iniziativa del singolo ed è molto complicato attivare procedure di sorveglianza e di monitoraggio dei casi sospetti.

DONNE COLPITE E BAMBINI TESTIMONI

Il piano regionale antiviolenza della Regione Lombardia, ci dicono Alessandra Kustermann e Giussy Barbara, ginecologhe del Soccorso violenza sessuale e domestica (SVSeD) di Milano, è stato approvato nel novembre 2015 dal Consiglio regionale e ha due obiettivi principali: 1) prevenire e far emergere il fenomeno della violenza contro le donne; 2) accogliere, sostenere, proteggere e accompagnare all'autonomia le donne vittime di violenza. È stato inoltre formalizzato e reso operativo nel piano quadriennale antiviolenza **l'Osservatorio Regionale Antiviolenza** (O.R.A.) per il monitoraggio del fenomeno e la conoscenza del percorso di valutazione e presa in carico delle donne che si rivolgono ai centri antiviolenza. Il sistema O.R.A. prevede la compilazione di una scheda per ogni donna che viene presa in carico dal Centro Antiviolenza. Le informazioni e i dati inseriti nel sistema informatico sono resi anonimi e accessibili solo alle operatrici dei centri antiviolenza. I dati raccolti consentono alla Regione Lombardia una conoscenza specifica del bisogno sul territorio per una migliore valutazione degli interventi, dell'appropriatezza dei servizi erogati e per la programmazione/pianificazione delle azioni.

Nel centro antiviolenza SVSeD di Milano, dicono ancora Alessandra Kustermann e Giussy Barbara, si utilizza un **sistema cartaceo e informatico di registrazione ed elaborazione dei dati** dei casi di violenza che giungono in valutazione, per fini statistici e di studio/ricerca. Nel database sono registrati anche episodi di maltrattamento in gravidanza. Attraverso il sistema O.R.A. i dati sugli accessi per violenza vengono trasmessi alla Regione Lombardia. In pronto soccorso **l'assegnazione di uno specifico codice SDO (Schede Dimissione Ospedaliera) identifica gli accessi delle donne vittime di violenza sessuale o domestica. Un ulteriore codice identifica lo stato di gravidanza.**

La segnalazione della presenza di figli è prevista sia dal sistema O.R.A. sia dal database cartaceo/informatico del Centro. Il follow-up dei casi è gestito in accordo con la donna vittima di violenza e si avvale della collaborazione di psicologhe, assistenti sociali, medici legali, avvocati, ed è anche previsto un follow-up dei figli che hanno assistito alla violenza.

La Regione Toscana, racconta Vittoria Doretti, medico anestesista della ASL di Grosseto e promotrice di Codice Rosa, utilizza il cosiddetto **Codice Rosa** per la raccolta dei dati sulle violenze ai danni delle donne. Il **Codice Rosa scatta al livello ospedaliero**. Nei casi di maltrattamento avviene immediatamente l'attivazione di un percorso "Codice Rosa", con un lavoro di squadra che prevede la collaborazione, tra l'altro, di ostetriche adeguatamente formate. Lo sforzo principale è quello di ragionare insieme su quale possa essere il percorso e quali le soluzioni e alternative da proporre anche e soprattutto alle donne che non dichiarano la violenza subìta, persone con cui stabilire un contatto, una confidenza e un rapporto di fiducia.

Per quanto riguarda le segnalazioni, dice Doretti, si registrano ancora difficoltà di tipo tecnico sulle quali si sta lavorando. Infatti, al momento non c'è nell'applicativo di pronto soccorso la possibilità di segnalazione della violenza di genere (certa o sospetta); quindi tutto ciò che non viene registrato con la dicitura "violenza altrui" sfugge alle statistiche. Per esempio, se una donna accede in pronto soccorso riferendo di aver urtato contro un mobile, nel verbale di triage si riferirà un accesso per "incidente domestico"; in questo caso se l'operatore ha il dubbio che si tratti di violenza domestica, non ha comunque la possibilità di segnalarlo. **La segnalazione della presenza di figli avviene al momento della valutazione iniziale** di pronto soccorso, al fine di regolamentare e ottimizzare la presa in carico successiva da parte dei Servizi Sociali, che si occupano del percorso di aiuto e supporto dopo la dimissione e provvedono al follow-up dei casi seguiti.

Per quanto riguarda il **follow-up**, prosegue Doretti, la preoccupazione è alta per il periodo successivo al parto. Il modello organizzativo di Codice Rosa, che è essenzialmente una rete, promuove un raccordo forte anche con pediatri e ostetriche per la gestione del dopo parto. Se c'è stata una segnalazione all'autorità giudiziaria, di solito si tratta di situazioni talmente gravi che le donne in genere sono già ospiti di una casa rifugio. Ma negli altri casi la difficoltà del follow-up è altissima: dopo il parto si allontanano, si perdono, quindi occorre attivare una rete forte di sorveglianza e sostegno. È un lavoro molto delicato, perché è difficile capire quando si entra in una situazione di maltrattamenti perseguibili d'ufficio, che mettono a rischio anche il bambino. È una linea di confine estremamente delicata e il pediatra, o l'ostetrica, o il ginecologo che sospetta non può prendere la decisione da solo.

BAMBINE E BAMBINI: TRACCE DI MALTRATTAMENTO CHE RISCHIANO DI PERDERSI

Il maltrattamento dei bambini come tema di salute pubblica rappresenta il cuore dell'azione del Centro Regionale per la diagnostica del Bambino Maltrattato di Padova. Secondo Melissa Rosa-Rizzotto, medico di comunità presso

Foto: Jonathan Hyams per Save the Children

il Centro, il nuovo approccio al maltrattamento quale problema di salute e l'inserimento delle sindromi da maltrattamento all'interno della Classificazione Internazionale delle Malattie dell'Organizzazione Mondiale della Sanità, già a partire dagli anni Ottanta, e successivamente la ridefinizione delle diverse forme del 1993, hanno fatto sì che la comunità scientifica internazionale, analogamente ad altre patologie che colpiscono i bambini, ne individuasse i sintomi e i segni clinici caratteristici e definisse i protocolli diagnostici e diagnostico-terapeutici che permettessero di formulare la diagnosi di maltrattamento e di escludere possibili diagnosi differenziali.
A livello nazionale non esistono linee guida condivise per il percorso diagnostico in ambito sanitario[65], soprattutto per quanto riguarda i percorsi assistenziale dei pazienti e delle loro famiglie, che prevedono l'integrazione tra i servizi ospedalieri e di cure primarie e i servizi sanitari e sociali, spesso limitando le indicazioni al problema della segnalazione all'Autorità.

In Italia non esistono vere e proprie linee guida nazionali sul maltrattamento e abuso nell'infanzia, spiega Carla Berardi, pediatra di Perugia, anche se alcune indicazioni in merito sono contenute nel Piano Sanitario Nazionale e nel Progetto Obiettivo Materno Infantile. **Esistono diverse linee guida regionali** – che tuttavia non specificano in dettaglio le modalità di azione per la fascia 0-3 anni – che riguardano la diagnosi – come formulare il sospetto e come poi confermarlo – e la presa in carico. Sulla modalità di segnalazione le linee guida regionali danno indicazioni diverse a seconda dell'organizzazione delle risorse del territorio. Un esempio può essere rappresentato dal progetto PIUMA nato nella Regione Umbria (ma ce ne sono altri in Italia), con l'intento di rendere disponibile un'**équipe multidisciplinare a cui si possa fare riferimento per la segnalazione**. Se il professionista, per esempio il pediatra di libera scelta, si trova di fronte a un sospetto di maltrattamento e non osa fare la denuncia ai Servizi Sociali o al Tribunale per i Minorenni o alla Procura, può usare come intermediaria questa équipe, che ha la **funzione di esaminare il caso, confermare/avvalorare il sospetto e quindi facilitare la segnalazione: viene così data più forza al singolo professionista, maggiore sicurezza per segnalare**.

Figure cruciali: il pediatra di famiglia

Nella fascia di età 0-3 anni il pediatra svolge un importante compito di educazione della coppia genitoriale su tutti gli aspetti dell'accudimento del bambino. Questa è un'ottima opportunità per sostenere i genitori anche nell'affrontare condizioni di stress determinate da quelli che Barton Schmitt chiama "i sette peccati mortali del bambino", mortali nel senso che possono provocarne il maltrattamento e la morte: il pianto, i risvegli notturni, l'ansia da separazione, i normali comportamenti esplorativi, il normale comportamento oppositivo, il normale rifiuto del cibo e le difficoltà nel toilet-training[67]. Il bambino che non dorme o che rifiuta il cibo è un bambino che stressa chi si prende cura di lui e quindi rischia di essere maltrattato. Schmitt propone che **il pediatra anticipi ai genitori che potrebbero incontrare queste difficoltà e dia indicazioni su come affrontarle**, in modo che sappiano come comportarsi senza andare in stress, con il rischio di far del male al bimbo. Per fare un esempio, rispetto al pianto del bambino la letteratura dimostra chiaramente che la sindrome del bambino scosso (*Shaken Baby Syndrome*) è collegata al pianto[68]. È molto importante che il pediatra sappia che c'è questo rischio e prima ancora che il bambino inizi a piangere, già dalla prima visita, informi i genitori che il piccolo piangerà, e piangerà molto e non andrà scosso.
La letteratura ha dimostrato che questo intervento è efficace[69].
Oltre a queste azioni preventive sulla popolazione generale, **il pediatra dovrebbe saper individuare l'eventuale esistenza di fattori di rischio aggravanti**, legati alle condizioni sociali (come isolamento sociale, conflitto genitoriale, perdita del lavoro) o alle caratteristiche dei genitori (dipendenze, depressione, comportamenti violenti, essere stati maltrattati da piccoli, eccetera) e inviare la famiglia ai servizi territoriali per ricevere aiuto.
Un altro aspetto fondamentale è la **formazione del pediatra sui segni e sintomi con cui può manifestarsi il maltrattamento**, così da renderlo capace di riconoscere il fenomeno e di segnalarlo, perché siano messe in atto tutte le misure necessarie perché il bambino sia tutelato e sfugga a ulteriori episodi di violenza, realizzando quella che si può definire prevenzione secondaria.
Il pediatra deve quindi essere formato a individuare i fattori di rischio, a intervenire su questi con guide anticipatorie[70] o inviando le famiglie ai servizi territoriali, a riconoscere i segni e sintomi del maltrattamento e a compilare una corretta segnalazione. Inoltre è necessario che lavori in rete con i servizi sul territorio per ricevere tutte le informazioni utili a una conoscenza adeguata delle famiglie.

Carla Berardi

Se un bambino arriva all'ospedale di Perugia con una frattura sospetta, prosegue Berardi, **il medico di pronto soccorso può compiere una ricerca per controllare se è già stato ricoverato negli altri ospedali territoriali per altri traumi, ma non c'è una segnalazione specifica**. Nella scheda di accesso al pronto soccorso (PS) se c'è una lesione traumatica di solito è prevista la possibilità di segnalarne la dinamica, sottolineando se è compatibile con la lesione, ma raramente viene fatto. Se l'abuso sessuale, fisico, la trascuratezza causano lesioni fisiche importanti, il bambino viene portato in PS. Qui non viene dedicata attenzione alla diagnosi differenziale tra lesione da

trauma accidentale o da trauma intenzionale, mentre **è dimostrato che l'utilizzo di una scheda specifica, dettagliata, facile da compilare con una crocetta ma che cattura l'attenzione degli operatori, aumenta moltissimo la capacità di riconoscimento e la segnalazione dei casi di maltrattamento**[66]. Non solo: qualora la scheda venisse a mancare, l'attenzione del personale, ormai abituato a usarla, rimane alta.

I casi di abuso noti purtroppo sono pochi, conclude Berardi, **perché raramente vengono sospettati, o addirittura non segnalati anche in caso di sospetto e quindi non diagnosticati**. Di conseguenza non c'è una situazione a regime, una prassi codificata rispetto al follow-up. A Perugia nei casi di maltrattamento l'ospedale di solito informa il pediatra, poi il bambino segue il suo percorso e sarà il pediatra a tenersi informato ma, molto spesso, il follow-up che il pediatra riesce a fare è piuttosto scarso: le informazioni che tornano sul proseguo della situazione del bambino sono scarsissime e raramente è coinvolto nel percorso di recupero e di cura.

3.2 OSSERVARE, ASCOLTARE, VERIFICARE. LA CENTRALITÀ DELLA DIAGNOSI

Uno dei nodi cruciali del maltrattamento delle bambine e dei bambini, specie in età molto precoci, è quello della diagnostica. Avere a disposizione un'adeguata sensibilità alla diagnosi significa essere in grado di esplorare il quadro clinico, stabilendo collegamenti significativi e profondi con le informazioni riguardanti l'ambiente, le relazioni, le condizioni socio-economiche, le dinamiche di conflittualità e le tensioni interne al nucleo familiare.

Foto: Save the Children

RICONOSCERE I SEGNI

Secondo la definizione generale, spiega Melissa Rosa-Rizzotto, **si parla di maltrattamento quando è possibile diagnosticare "un danno alla salute, allo sviluppo, alla dignità e alla sopravvivenza del bambino"** dovuto ad agìti o a mancanza di cure amorevoli, adeguate e sufficienti a garantire lo sviluppo del bambino. In questa logica, non c'è maltrattamento se non c'è un danno documentabile, che si possa rilevare o mediante un esame clinico accurato o mediante l'esecuzione di indagini e accertamenti bio-umorali, strumentali o funzionali (comportamentali).

Ci sono segni, sintomi, aspetti comportamentali e/o funzionali che, non singolarmente, ma considerati nel loro insieme, possono portare a una diagnosi differenziale di maltrattamento, anche molto precocemente. Per esempio, nel caso della sindrome del bambino scosso un segno che si osserva abbastanza precocemente quando si instaura tale forma di maltrattamento è un aumento disarmonico della circonferenza

cranica che cresce abnormemente, se messa a confronto coi restanti parametri di crescita (lunghezza e peso). Poiché tali parametri vengono abitualmente valutati dal pediatra al bilancio di salute del lattante, **con la semplice misurazione della circonferenza della testa è possibile sospettare uno scuotimento e avviare il bambino a un percorso diagnostico per confermare o escludere la diagnosi e per prevenire nuovi episodi di maltrattamento, che potrebbero essere anche letali**.

Un'altra sindrome molto frequente nella fascia di età 0-3 anni è il cosiddetto *neglect*, cioè la trascuratezza. Tale sindrome, che ha esiti gravissimi sullo sviluppo del bambino se non diagnosticata, presenta quale segno precoce la scarsa crescita e, dal punto di vista funzionale, la difficoltà ad alimentarsi: tali segni sono comuni a molte patologie della primissima infanzia ed è richiesto anche in questo caso un percorso di diagnosi differenziale accurato, che comprenda il maltrattamento tra le ipotesi diagnostiche.

CONSAPEVOLEZZA E COLLABORAZIONE PER DIAGNOSI E PRESA IN CARICO

Per migliorare il riconoscimento dei casi, prosegue Melissa Rosa-Rizzotto, è necessario prima di tutto che il medico specialista che osserva il bambino che presenta un segno o un sintomo specifico (per esempio crescita della circonferenza cranica, scarsa crescita, sanguinamento vaginale, emorragie retiniche) inserisca il maltrattamento all'interno delle possibili diagnosi differenziali e possa eventualmente **avvalersi di strutture specialistiche o équipe di riferimento con cui confrontarsi per la diagnosi definitiva**.
Una possibile strada è **introdurre nel curriculum formativo delle scuole di Medicina un corso sulla diagnosi del maltrattamento**[71]. Nell'esperienza di Padova, un corso di questo tipo – che l'Università di Padova ha proposto e propone tra i corsi a scelta libera degli studenti del IV e V anno di corso, a partire dal 2004 – ha sensibilmente aumentato la consapevolezza dei giovani medici sul tema e ha reso più precoce il sospetto diagnostico.
Una volta formulata la diagnosi, conclude Rosa-Rizzotto, per i singoli casi si avviano percorsi e trattamenti sanitari specifici, presa in carico integrata sanitaria e socio-sanitaria, azioni di tutela e conseguenti follow-up specifici, sia per valutare l'evoluzione del quadro clinico a distanza mediante controlli sanitari periodici, sia per attivare, se necessario, adeguati progetti terapeutico riabilitativi, sia infine per valutare le risorse del nucleo familiare e per prevenire le ricadute. **Questi percorsi** possono in taluni casi risultare difficoltosi poiché **richiedono una stretta collaborazione tra le diverse istituzioni coinvolte e una forte integrazione tra sociale e sanitario**.

3.3 CHE SUCCEDE DOPO?

Uno degli elementi critici rilevati nelle conversazioni e negli incontri con i professionisti del contrasto al maltrattamento e abuso sui bambini, riguarda gli esiti di una diagnosi di maltrattamento. Che cosa succede dopo che a un bambino o a una bambina sono stati diagnosticati danni da maltrattamento agìto all'interno della famiglia? Esistono percorsi stabiliti e facilmente accessibili? Quanto durano le prese in carico e che cosa occorre perché la presa in carico scatti effettivamente? Chi verifica che le prese in carico siano o meno andate a buon fine?

Purtroppo non è semplice dare risposte univoche a queste domande. Ma si è cercato almeno di identificare alcuni passi essenziali tra quelli che vanno compiuti una volta che il sospetto di maltrattamento si è trasformato in diagnosi.

LE FASI DI INTERVENTO

Sabrina Farci, psicologa e psicoterapeuta della Cooperativa Paradigma di Torino spiega che **esistono linee guida a cui fanno riferimento i centri Italiani sia pubblici sia privati aderenti al CISMAI (Coordinamento Italiano dei Servizi contro il Maltrattamento e l'Abuso all'Infanzia) e che offrono riferimenti uniformi per la presa in carico e la terapia dei casi di maltrattamento**[72].

Ci possono poi essere a livello regionale protocolli sulla presa in carico operativa per cercare di coordinare il lavoro delle varie istituzioni che entrano in campo: scuola, servizi sociali, istituzioni giudiziarie. In Piemonte, come in altre regioni, esistono, all'interno dei servizi, équipe specialistiche sul maltrattamento e l'abuso ai minori. C'è un'accurata letteratura e un'ampia casistica sugli esiti post traumatici del maltrattamento[73].

I NODI DELLA PRESA IN CARICO TERAPEUTICA

La terapia delle vittime di abuso e maltrattamento, dice ancora Farci, **è il segmento della presa in carico purtroppo più carente sul piano operativo**. Infatti se il livello di intervento per la segnalazione, protezione e valutazione delle vittime può essere ritenuto sufficientemente adeguato, non è così per la presa in carico terapeutica. Purtroppo i servizi territoriali riescono a farsi carico della prima parte di intervento di valutazione e protezione della vittima, in alcuni casi della valutazione della recuperabilità genitoriale; molto meno, se non quasi mai, riescono a far fronte alla presa in carico terapeutica. In alcuni casi la cura è delegata a centri convenzionati (del privato sociale) oppure a professionisti privati, soltanto una piccola parte riesce a essere presa in carico dal servizio pubblico. **Questo significa che molte delle vittime non hanno una terapia psicologica**. È ampiamente documentato[74], tuttavia, che l'unico strumento per contenere gli esiti post traumatici dell'abuso e del maltrattamento è proprio la terapia dei soggetti traumatizzati. Se questo non avviene il rischio della trasmissione intergenerazionale dell'abuso è considerevole.
Anche il follow-up è previsto, ma non in modo strutturato, per i soggetti che hanno avuto una presa in carico terapeutica, non per gli altri. Di solito si tratta di una rivalutazione clinica del soggetto attraverso una batteria di test psicologici. Quello che si cerca di fare con il centro di Paradigma, conclude Farci, è una **valutazione all'ingresso dei bambini in comunità e una valutazione in uscita dalla comunità** (al termine del percorso educativo e terapeutico). I servizi pubblici, solitamente, fanno una rivalutazione nel passaggio di scuola (da elementari a medie per esempio), ma questo vale praticamente solo per i bambini che hanno una certificazione secondo la legge 104 del 1992 per il sostegno scolastico.

Per quanto attiene **i disturbi più frequenti che si riscontrano nei bambini e nelle bambine vittime di maltrattamento**, Farci indica che il quadro clinico che spesso manifestano i bambini vittime di maltrattamento e abuso è il **disturbo post traumatico da stress** (semplice o complesso), che presenta sintomi di riattivazione traumatica quali: aggressività, disturbi del sonno, disturbi dell'attenzione e della concentrazione, flashback traumatici, sessualizzazione traumatica, sintomi dissociativi, problematiche alimentari e altri. Le patologie che questi soggetti possono sviluppare da adulti, in particolare laddove non sia stata effettuata una terapia psicologica, possono essere problemi nella sfera della sessualità, disturbi alimentari e del sonno, abuso di sostanze alcoliche o stupefacenti, tentativi anticonservativi, disturbi di personalità.

Foto: Riccardo Venturi per Save the Children

3.4 SE I SERVIZI NON PARLANO TRA LORO

Un ultimo nodo che emerge dalle conversazioni, è quello della comunicazione e del coordinamento tra i diversi servizi. Questo elemento si delinea con particolare chiarezza sia nel lavoro dei pediatri sia nel lavoro psicologico e psichiatrico di chi si occupa, per esempio, di depressione perinatale. La depressione perinatale, che si distingue dal *maternity blues* per la sua persistenza nel tempo e per l'importanza dei suoi sintomi, colpisce le neo mamme in una percentuale che varia tra il 5 e il 15%[75]. Tra gli elementi che contribuiscono ad accrescere il rischio di maltrattamento alcuni possono essere rintracciati precocemente favorendo il coordinamento tra i servizi che si occupano per esempio di dipendenze, di patologie neurologiche, di sostegno socio-economico, di contrasto della violenza domestica.

Rompere il circolo vizioso dell'isolamento #storiedaiservizi

Sara è una bimba di tre anni e nel parlare con la maestra della scuola materna racconta del pomeriggio in cui ha trovato la mamma svenuta in bagno. Daniela infatti, fortemente dipendente dall'alcool, era entrata in coma etilico e aveva perso coscienza mentre era a casa con la bambina. Quando Sara ha cominciato a gridare, sono arrivati i vicini di casa che hanno prestato i primi soccorsi e chiamato l'ambulanza. Dopo la degenza, Daniela è stata presa in carico dai servizi sociali su indicazione e con il sostegno dalla dirigente scolastica della scuola di Sara: il percorso è stato lungo e non facile. La donna infatti ha più volte interrotto la frequenza del nucleo operativo alcolisti, trovandosi così costretta a cominciare ogni volta la terapia dall'inizio. Il marito di Daniela, una persona disponibile, ma molto povera di strumenti economici e culturali, lavora fuori città e non riesce a supportare la moglie come pure vorrebbe. Un giorno Daniela si è resa conto che la piccola Sara iniziava a manifestare insofferenza e disagio attraverso comportamenti molto aggressivi, sia nei confronti dei coetanei, sia nei confronti della mamma. E che proprio a causa di questo atteggiamento la bambina, dopo essere stata completamente isolata dai compagni dell'asilo, era stata segnalata dalla scuola ai servizi di neuropsichiatria territoriali. Daniela ha cercato quindi aiuto presso lo Spazio Mamme e ha ripreso in modo più continuativo e fruttuoso il percorso di fuoriuscita dalla dipendenza, lasciandosi guidare dagli assistenti sociali e attivandosi nella ricerca di supporto psicologico per lei e Sara.

In caso di famiglie con condizioni di rischio per maltrattamento già in carico ai servizi, dice Carla Berardi, sarebbe utilissimo che questi informassero il pediatra che segue i bambini e i ragazzi di queste famiglie. Il pediatra deve essere informato di ogni condizione di rischio dei suoi pazienti. **Se si ha in cura un bambino i cui genitori sono tossicodipendenti, il Servizio Sociale o il SerT devono informare il pediatra**, come pure se c'è una situazione di povertà, di isolamento sociale, di violenza familiare, in modo che sappia come comportarsi con quella famiglia e come muoversi per lavorare sui fattori di rischio. L'esperienza di coordinamento tra un piccolo gruppo di pediatri/servizi sociali che si sta facendo a Perugia – e che probabilmente esiste in altre realtà italiane – sarebbe da realizzare, oltre che con gli assistenti sociali, anche con il SerT-Servizi per le Tossicodipendenze e con le forze dell'ordine (se intervengono in casi di violenza familiare, se ci sono bambini avvisino il pediatra così che possa valutare se i minorenni sono vittime a loro volta di maltrattamento e/o di violenza assistita).

La letteratura scientifica, sostiene Paola Di Blasio, psicologa dell'Università Cattolica di Milano, ha dimostrato una **correlazione tra psicopatologia della madre e del padre (tra cui depressione materna) e rischio di violenza**. Tutta la letteratura parla però di fattori di rischio che possono concorrere e non di fattori causali.
Una revisione della letteratura pubblicata nel 2015 su questo tema[76] illustra bene l'inter-gioco tra fattori di rischio e di protezione nella processuale maltrattante, evidenziando come siano necessarie diverse condizioni di rischio e l'assenza di fattori protettivi per poter predire l'insorgenza di un eventuale maltrattamento.

Mamme che non parlano del loro dolore #storiedaiservizi

Marco è nato agli inizi di dicembre: pochi giorni dopo le dimissioni, è stato ricoverato d'urgenza perché aveva avuto convulsioni notturne di cui non erano chiare le cause. Attraverso il colloquio con i medici dell'ospedale e le operatrici di Fiocchi in Ospedale, la mamma, Giovanna, ha ricostruito gli avvenimenti che hanno portato poi alla crisi del neonato: il latte artificiale era stato preparato in maniera scorretta, con pochissima acqua rispetto alle dosi previste, causando crisi fortunatamente rientrate grazie all'intervento dei sanitari. Giovanna, incontrando le psicologhe, è stata poi in grado di raccontare che, nonostante momenti di sconforto e agitazione, pianti notturni e momenti di stanchezza, non era riuscita a chiedere aiuto né al marito, né a professionisti esterni. Gli stati di malessere erano già iniziati dalla gravidanza e il marito, spesso fuori casa per lavoro, non si era accorto di quanto la donna si trovasse in difficoltà e

aveva semmai addebitato i momenti di stanchezza al fatto che Marco arrivasse a pochi anni di distanza dal primogenito. Sia Giovanna che il marito sono stati poi supportati nel trovare momenti di ascolto e di confronto che li aiutassero a superare i sensi di colpa causati dal grave pericolo che avevano fatto correre al bambino e dal non essersi resi conto in tempo di una situazione che necessitava di sostegno: Marco è stato dimesso dalla terapia intensiva neonatale dopo due settimane di degenza, nascendo una seconda volta, insieme con i suoi genitori.

Secondo Santo Rullo, psichiatra romano, **è dimostrato in letteratura** – **ma ancor più nella prassi clinica** – **che molti casi di infanticidio sono connessi alla depressione post-partum**, così come esistono conseguenze in età adolescenziale della depressione post-partum della mamma, soprattutto in termini di disregolazione emotiva e di sviluppo di competenze relazionali ed empatiche. Le strade da percorrere sono essenzialmente un ampliamento e un miglioramento delle attività di accompagnamento alla nascita con attività mirate oltre che a informare e sensibilizzare anche a riconoscere eventuali segni di depressione perinatale; sensibilizzazione e formazione dei padri sulle modalità migliori per supportare le proprie compagne; aumento dell'informazione e della sensibilizzazione sulla possibilità di parto in anonimato nel caso di gravi problematiche neurologiche che possono essere aggravate dall'interazione con un neonato; sensibilizzazione dei servizi di salute mentale e maggiore coordinamento tra i servizi di salute mentale e i servizi sociali e i servizi per la salute riproduttiva.

Il progetto Slalom
Un esperimento di sostegno coordinato a mamme vittime di depressione perinatale

Il progetto[77], realizzato a Milano, ha intercettato **circa 30 nuclei familiari a rischio** segnalati dai servizi sociali con madri affette da depressione post-partum, nuclei che sono poi stati seguiti nel progetto nell'arco di due anni (2011-2013). Sono state attuate azioni coordinate (approccio multidimensionale) su diverse aree di bisogno, rivolte sia al/ai minori e ai singoli genitori sia al nucleo familiare allargato. I risultati dell'intervento – anche in considerazione della casistica particolarmente grave a causa di problemi mentali, tossicodipendenza, esperienze traumatiche presenti spesso in entrambi i genitori – sono stati positivi e molto incoraggianti, poiché hanno evidenziato non solo un miglioramento nello stato di salute psichica di uno o entrambi i genitori ma anche la riduzione o la scomparsa di ansia, stress, insicurezza e frustrazione nella relazione col bambino.

Il Progetto Slalom ha previsto una serie di azioni, secondo un approccio multidisciplinare, al fine di:

1. prevenire i rischi di evoluzione del *baby blues* verso la depressione post-partum e il rischio di maltrattamenti nei confronti dei neonati alla luce della letteratura scientifica secondo cui circa il 70% di donne sperimenta[78], nei primi giorni dopo il parto, sintomi di baby blues (che provocano tristezza, pianto, irritabilità, ansia, aumento della sensibilità, affaticamento, disturbi del sonno, dell'appetito e cambiamenti nell'umore) e secondo cui le donne con tali sintomi sono a rischio di sviluppare una depressione[79] con conseguente rischio di trascurare o maltrattare i propri bambini;

2. sostenere l'instaurarsi di una buona relazione di attaccamento tra madre e figlio, evitando che i genitori (padre o madre) – a causa delle loro fragilità – vengano "sostituiti" da altre figure della rete familiare estesa; favorire inoltre la ricostituzione e il riequilibrio delle reti di supporto informali e amicali;

3. favorire la condivisione dell'esperienza della nascita e della genitorialità con altri genitori, l'acquisizione delle competenze educative e il rinforzo della stima di sé.

Sono stati realizzati percorsi di supporto ai genitori, attraverso diversi interventi, riassumibili in attività di supporto a domicilio (*home visiting*) nei mesi prima e dopo la nascita del bambino "intrecciata" e connessa con:

- un ciclo di consultazione psicologica rivolto al genitore, alla coppia e/o alla famiglia allargata, allo scopo di valutare i fattori critici e sostenere i processi riequilibranti, offrendo un trattamento terapeutico specifico volto al superamento delle riattivazioni traumatiche, laddove necessario;
- una consulenza sociale, al fine di sostenere la riacquisizione di autostima e capacità di agire in un nuovo equilibrio esistenziale che comprende il figlio (inserimento al nido del bambino, il ritorno al lavoro della madre, individuazione e attivazione di reti di supporto *ad hoc*);
- la realizzazione di uno spazio di incontro in cui si svolgono diverse attività rivolte ai genitori/neogenitori, madri o padri con bambini, altri *caregiver* (zii/zie, nonni/e, affidatari eccetera), incontri di gruppo per genitori (scuola genitori – *self help*) gruppi di parola. Queste attività sono rivolte sia ai genitori in situazione di rischio sostenuti dalle azioni di cui sopra sia ai genitori/neogenitori per i quali non viene identificata una specifica fragilità.

Paola Di Blasio

Foto: Erika Pineros per Save the Children

Note

[65.] Esistono alcuni documenti per problemi specifici, per specifiche sotto-forme, come per esempio la semeiotica fisica dell'abuso sessuale nei bambini prepubere: Maria Rosa Giolito, Gruppo di lavoro per l'abuso e il maltrattamento dell'infanzia, *L'abuso sessuale nei bambini prepuberi: Requisiti e raccomandazioni per una valutazione appropriata*, Il Pensiero Scientifico Editore, 2010.

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[71.] Come già suggerito nel dossier di Terre des Hommes, *Maltrattamento e abuso sui bambini: una questione di salute pubblica. Indagine nazionale sull'attività diagnostica del fenomeno delle eccellenze ospedaliere di: Piemonte, Lombardia, Veneto, Toscana e Puglia*, 2016.

[72.] http://cismai.it/category/documenti/linee-guida-cismai/

[73.] Caretti V, Capraro G. (a cura di), *Trauma e Psicopatologia*, Astrolabio Ed. 2008; Herman Judith Lewis, *Guarire dal Trauma*, Ed. Magi 2005; Liotti G, Farina B, *Sviluppi Traumatici, Eziopatogenesi, Clinica e Terapia Della Dimensione Dissociativa*, Raffaello Cortina Editore, 2011; Malacrea M. Trauma e riparazione. Cortina, Milano 1998; Lanius R, Vermetten E, Pain C. L'impatto del trauma infantile sulla salute e sulla malattia. L'epidemia nascosta. Fioriti Editori, 2012.

[74.] Cancrini L, *La cura delle infanzie infelici*, Raffaello Cortina, Milano, 2012; Cirillo S, Di Blasio P, *Come interrompere il ciclo ripetitivo dell'abuso attraverso la terapia della famiglia*, C.B.M. Argomenti 2, Novembre 1991; De Zulueta Felicity, *Dal dolore alla violenza*, Cortina, Milano, 1999; Malacrea M (1994) *L'effetto terapeutico della "validation" nel caso di abuso sessuale ai bambini,* In: Roccia C, Foti C, *L'Abuso sessuale sui minori. Educazione sessuale, prevenzione, trattamento,* Edizioni Unicopoli 1994: 159-178; Malacrea M, *La terapia nell'abuso all'infanzia: le ragioni teoriche dell'esperienza clinica*, Connessioni, VIII (14), 81-100, 2004; Malacrea M, *Trauma e riparazione*, Cortina, Milano 1998; De Zulueta Felicity, *Dal dolore alla violenza,* Cortina, Milano, 1999.

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[76.] Procaccia R, *Psicopatologia e genitorialità*, Unicopli, "Tra rischio e protezione: la valutazione delle competenze parentali", 2015.

[77.] Un progetto realizzato dal Centro per il bambino maltrattato-CBM (Progetto Slalom) con finanziamento della Fondazione Cariplo e svolto in collaborazione con la Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico (Mangiagalli), l'Azienda Ospedaliera San Paolo, Polo Universitario (Dipartimento Salute Mentale) e l'ASL di Milano.

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Foto: Sandy Maroun per Save the Children

CAPITOLO 4

4. SCHEDE DI LAVORO DA TORINO, MILANO, SPOLETO, FOLIGNO, ORVIETO E BARI

Un tentativo interessante è stato quello di identificare alcuni esperimenti di lavoro – progetti o servizi – che sembrerebbero funzionanti, accessibili sul piano operativo, sostenibili sul piano economico e organizzativo e abbastanza stabili nel tempo. Le persone che ce li hanno raccontati, e che ringraziamo per la disponibilità, sono professionisti della sanità ma con una grande capacità di guardare oltre l'aspetto clinico per identificare linee strategiche di più vasta portata.

Gian Vincenzo Zuccotti
pediatra,
Ospedale dei Bambini,
V. Buzzi, Milano

Elena Coppo
pediatra,
Ambulatorio BAMBI,
Torino

Sara Ceccarelli
pediatra,
Ospedale di Terni

Maria Grazia Foschino Barbaro
Psicologa-psicoterapeuta,
responsabile del Servizio di Psicologia – GIADA,
Ospedale Pediatrico "Giovanni XXIII", Bari

4.1 UN AMBULATORIO PER LORO

Elena Coppo, pediatra, Ambulatorio BAMBI - Torino

Il servizio BAMBI è nato nel 2002 per iniziativa di Fulvia Negro, pediatra del pronto soccorso dell'Ospedale Infantile Regina Margherita di Torino, per soddisfare la necessità di prestare assistenza mirata a bambini e bambine che giungevano in pronto soccorso (PS) perché vittime di maltrattamento e abuso. Questi bambini necessitano, infatti, di spazi dedicati diversi dal PS e di tempi più lunghi, che spesso non sono quantificabili a priori. A volte è necessario molto tempo per ottenere la fiducia di un bambino che è stato violato o maltrattato e quindi il suo consenso a essere visitato. È molto importante che il bambino acconsenta alla visita e non si proceda ad alcuna manovra forzandolo e quindi sottoponendolo a ulteriore violenza.

Attualmente lavorano nell'ambulatorio BAMBI due pediatri del pronto soccorso e un medico legale, una psicologa dedicata. L'ambulatorio si avvale della collaborazione del servizio di psicologia ospedaliero, degli infermieri pediatrici, del servizio di Assistenza Sociale e della Direzione Sanitaria; in caso di necessità l'ambulatorio usufruisce del servizio di Neuropsichiatria Infantile dell'ospedale. Il servizio è operativo 24h/24h. Durante il giorno dispone di un medico di guardia attivo, quindi si avvale degli infermieri dedicati che sono disponibili anche in reperibilità 24h/24h e dell'équipe dei medici di PS che sono comunque stati formati a gestire queste situazioni di emergenza.

In fase di triage al PS l'infermiere è stato formato a riconoscere e segnalare al medico di guardia quelli che in letteratura specifica si chiamano "red flags", bandiere rosse, cioè i segni di allarme che devono porre in allerta su un ipotetico problema di maltrattamento (per esempio ritardo al ricorso alle cure, incongruenza del racconto, incongruenza tra le lesioni e il racconto o incongruenza tra l'età del bambino e le lesioni riportate). Non vi è purtroppo una rete informatica con gli altri ospedali, per cui l'unico modo per sapere se i bambini siano già stati visitati in altri ospedali è contattare direttamente i colleghi, cosa che viene fatta nei casi in cui non è chiaro il quadro sanitario, o se il bambino sia stato visitato molte volte in PS per traumi ripetuti. Se il bambino vittima di violenza ha bisogno di cure sanitarie, queste vengono proseguite in ospedale; se è necessario fare una segnalazione all'Autorità Giudiziaria, l'ambulatorio Bambi se ne occupa direttamente. Vi sono inoltre accordi con il territorio per cui i bambini, una volta dimessi dall'ospedale, sono presi in carico

dai servizi territoriali. La stessa cosa accade quando i bambini vengono inviati in famiglie affidatarie. I pediatri di famiglia contattano l'ambulatorio anche per dirimere un dubbio, per condividere un pensiero. Sono inoltre in atto progetti di formazione specifica per i pediatri di famiglia sul maltrattamento e l'abuso. Nell'ambito della formazione, per anni sono stati realizzati e vengono svolti tuttora corsi di formazione per personale sanitario.
Dall'inizio delle attività nel 2002 il personale di BAMBI ha visitato circa 1.900 bambini, e quest'anno sono stati valutati 148 bambini. Si tratta di un numero considerevole se si pensa che la maggior parte di loro è stata segnalata all'Autorità Giudiziaria.
I bambini che giungono in osservazione sono inviati dal PS, da altri ospedali, dai medici di famiglia, dalle forze di polizia o direttamente dall'Autorità Giudiziaria. Sotto molti punti di vista l'ambulatorio è considerato un punto di riferimento regionale per i casi di violenza, anche se non va dimenticato l'enorme contributo che hanno altri centri territoriali, come per esempio Cappuccetto Rosso.
Fra i casi arrivati al BAMBI, la percentuale dei più piccoli, fra 0-1 anno, è del 7%. Se si considera la fascia di età 1-5 anni la percentuale è del 39%.
Le tipologie di maltrattamento più comuni nei bambini piccoli vedono al primo posto quello di tipo fisico: si tratta di fratture, lividi, morsicature e varie forme di trauma cranico non accidentale compresa la *Shaken Baby Syndrome*. Vi sono inoltre le forme di grave incuria e nell'ultimo periodo anche casi di lattanti con intossicazione da droghe. Penso che il numero maggiore di casi non rifletta un reale aumento di incidenza del fenomeno, ma sia dovuto alla maggiore attenzione che si pone al problema e alla maggiore sensibilità degli operatori.

4.2 IL MALTRATTAMENTO DEI PIÙ PICCOLI AL CENTRO DELL'AZIONE DELLA RETE INTERAZIENDALE MILANESE

Gian Vincenzo Zuccotti, pediatra, Ospedale dei Bambini, V. Buzzi - Milano

A Milano è stata avviata l'esperienza della RIMMI, la Rete Interaziendale Milano Materno Infantile, che ha diverse funzioni. Una è quella di evitare le ridondanze, cioè non far ripetere accertamenti, visite, esami già eseguiti. Un'altra funzione è far emergere le eccellenze e quelle che sono le criticità presenti nella città e nella Regione. Sicuramente fra le criticità c'è quella del maltrattamento, nel senso che non c'è ancora un vero e proprio servizio che si faccia carico della prevenzione e della gestione del maltrattamento infantile, di ordine psicologico, fisico e quant'altro. Si sta lavorando su questo aspetto con il progetto di un centro che si dovrà occupare appunto del maltrattamento infantile, per provare a dare una risposta ed entrare in rete. Questo centro è rappresentato dall'Ospedale dei Bambini, V. Buzzi, che si vuole mettere a disposizione di tutta la rete cominciando da Milano, per poi ampliare il servizio a tutta la Regione Lombardia.
Il progetto dovrebbe essere a regime entro la fine 2017. È prevista una fase di formazione, che partirà dai pronto soccorso e dalle pediatrie, anche con qualche pediatria di famiglia, sui segni, su come dare rilievo a queste situazione e su come gestirle. Quindi attualmente non c'è ancora nulla, ma è una delle criticità che sono state rilevate ed è una delle prime cose che si sta cercando di far partire all'interno della RIMMI. I casi di maltrattamento sono intercettati solo se molto evidenti; ma c'è una vastissima area di sommerso che è molto più difficile da intercettare, quindi è importante un percorso che si occupi di capire i diversi casi e come occorre muoversi, perché vengano posti in atto i passi adeguati.

4.3 OSPEDALI IN RETE. LE COSE SEMPLICI POSSONO ESSERE LE MIGLIORI

Sara Ceccarelli, pediatra, Ospedale di Terni

La rete dei pronto soccorso di alcuni ospedali in Umbria è ancora una struttura *in fieri* partita ufficialmente nel 2013-14 all'interno dell'ospedale di Spoleto, dove è stata riorganizzata un'équipe multidisciplinare già presente da anni, che però nell'ultimo periodo, dato il turnover del personale, aveva visto una riduzione della sua attività almeno a livello ospedaliero. Dell'équipe fanno parte un pediatra, un'assistente sociale, una psicologa, un pediatra di territorio e di volta in volta i vari specialisti di riferimento da attivare nei singoli casi. L'équipe di contrasto al maltrattamento e abuso all'infanzia, questo il suo nome, cerca di collaborare con la rete sociale territoriale – assistenti sociali dei vari Comuni e servizi sanitari, pediatri di libera scelta, scuole, eccetera – così da poter effettuare una gestione a 360 gradi del soggetto vittima di abuso a partire dalla sua intercettazione/diagnosi, fino alla sua presa in carico con la creazione di un piano assistenziale *ad hoc* e la possibilità di avere poi un feedback delle varie situazioni trattate.

Foto: Francesco Alesi per Parallelozero

Essendo il territorio dell'USL Umbria2 molto vasto (di essa fanno parte gli ospedali di Foligno, Spoleto e Orvieto, logisticamente distanti tra loro) si è pensato che il progetto potesse diventare più ambizioso, mettendo in "Rete" tutto il territorio di riferimento. Sono stati istituiti corsi di formazione annuali nei quali sono stati cooptati sia pediatri di libera scelta, sia assistenti sociali, sia specialisti ospedalieri medici, infermieri, ostetriche delle varie branche specialistiche (pronto soccorso, pediatria, radiologia, ginecologia, eccetera), così da creare nelle varie sedi nuovi punti di riferimento, esportando il modello spoletino, anche se la prima équipe sarebbe rimasta poi l'elemento trainante e il riferimento per tutti.
Questo esperimento ha portato alla produzione di un documento aziendale che vuole regolamentare tale *modus operandi* così da chiarire bene le modalità di attivazione dell'équipe, della diagnosi, dell'eventuale segnalazione, della presa in carico, della creazione di un sistema di protezione per il minore con vari livelli di controllo dell'operato.

Attualmente quindi gli ospedali in rete sono tre, ma si sta verificando la possibilità di un ampliamento a un quarto ospedale. Il passo avanti che si è potuto fare è chiedere una piccola modifica sul programma utilizzato per il pronto soccorso che evidenzi accessi multipli in modo tale che questo risulti facilmente evidente all'operatore per favorire l'intercettazione dei casi, che come è noto tendono a peregrinare tra i vari ospedali. Rimangono scoperti però tutti gli altri pronto soccorso della Regione.

Altro obiettivo fondamentale è andare avanti con la formazione; in medicina non esiste diagnosi se non si conosce e il maltrattamento e l'abuso all'infanzia non esulano da questa regola. Laddove la formazione è stata fatta, è stato più alto il numero delle diagnosi effettuate o almeno dei casi di sospetto venuti a galla. La formazione deve coinvolgere tutto il personale che ha la possibilità di entrare in contatto con il paziente pediatrico, così da aumentare le possibilità di diagnosi. Tutto questo lavoro ha portato a un incremento dei casi diagnosticati e presi in carico. Fino a oggi i casi intercettati nella fascia di età 0-3 anni sono stati circa 15, per lo più trascuratezza, abuso psicologico, 3 casi di sospetto abuso sessuale al vaglio della magistratura.

La forza dell'équipe è la multidisciplinarità. Il progetto prevede per l'équipe di riferimento una reperibilità di 12 ore dal lunedì al venerdì, in cui può essere contattata per eventuali dubbi o segnalazioni dal pediatra territoriale, o dalla scuola, o dai servizi che si prendono carico dei bambini.

4.4 FARE EMERGERE IL SOMMERSO. L'ESPERIENZA DI GIADA IN PUGLIA

Maria Grazia Foschino Barbaro, psicologa-psicoterapeuta responsabile del Servizio di Psicologia, GIADA, Ospedale Pediatrico "Giovanni XXIII" - Bari

Nella Regione Puglia da anni è attiva una rete di contrasto alla violenza all'infanzia organizzata in due distinte componenti, una interna all'Azienda Ospedaliera Policlinico "Giovanni XXIII" di Bari e l'altra esterna che copre il territorio regionale. La rete intraospedaliera, in particolare, è tesa alla rilevazione delle condizioni di sommerso del maltrattamento e si avvale del lavoro di vari soggetti e, in particolare:

1) del **gruppo funzionale** interdisciplinare composto da diversi medici specialisti (dirigente psicologo come responsabile scientifico, medico di direzione sanitaria, pediatra, ortopedico, radiologo, medico di pronto soccorso, ginecologo, neonatologo, chirurgo, medico legale) che si occupa di effettuare revisioni sui percorsi diagnostico-terapeutici nonché della definizione dei percorsi formativi e degli indirizzi strategici;

2) dell'**équipe dedicata** (composta da quattro psicologi, due assistenti sociali e un informatico) attiva all'interno del servizio di psicologia dell'ospedale pediatrico "Giovanni XXIII" di Bari dal 2009 grazie a finanziamenti regionali, che svolge, oltre all'attività di diagnosi e trattamento delle forme di violenza all'infanzia, anche funzione di collegamento tra i vari specialisti attivati e la rete dei referenti aziendali;

3) della **rete interdisciplinare di referenti** costituita da un medico e un infermiere di tutte le Unità Operative del "Giovanni XXIII" e da alcune Unità Operative del Policlinico (Neonatologia e Terapia Intensiva, Ginecologia e Ostetricia, Medicina Legale e Pronto Soccorso); da diversi anni i referenti delle varie UU.OO. vengono inseriti in percorsi formativi aziendali tesi a potenziare le abilità dei vari referenti nell'individuazione dei casi sommersi di violenza all'infanzia.

La sua funzione principale è quella di rilevare il sommerso, anche attraverso l'identificazione precoce dei fattori di rischio della genitorialità e l'avvio tempestivo di interventi di supporto; in aggiunta a questo lavoro, in una percentuale inferiore di casi, il gruppo è chiamato a intervenire su bambini o adolescenti che giungono in ospedale a seguito di violenze subìte; in questi casi, sin dall'accesso al pronto soccorso, viene attivato un codice di accesso preferenziale alle prestazioni erogate.

Foto: Louise Dyring Mbae per Save the Children Denmark

Nell'ambito del servizio di psicologia sono stati messi a punto diversi protocolli, alcuni dei quali indipendenti alla violenza, che consentono di rilevare alcuni indicatori di disagio dei bambini; per esempio, è stato definito un protocollo diagnostico-terapeutico per i piccoli pazienti che presentano ritardo dell'accrescimento, disturbi della minzione, dolori di varia natura e sintomi psicosomatici che prevede, oltre agli accertamenti di natura medica, una consulenza psicologica poiché tali quadri clinici potrebbero essere associati a condizioni di violenza e/o inadeguatezza genitoriale. Sono stati predisposti anche protocolli per le malattie croniche in quanto alcune patologie di questo tipo rappresentano condizioni che affaticano la genitorialità e che possono determinare condizioni di violenza all'infanzia.

Nei casi di particolare trascuratezza, oltre all'avvio di procedure osservative tese a valutare la relazione genitore-bambino, si prende contatto con il pediatra di famiglia, per verificare se il piccolo sia stato regolarmente sottoposto ai bilanci di salute e per avere il suo punto di vista, oppure si contattano i servizi sociali del territorio, per verificare se vi sia già una presa in carico.
Nei casi in cui in ospedale venga ricoverato un bambino adottato o collocato in comunità, che in quanto tale è stato esposto a esperienze infantili sfavorevoli, si provvede all'attivazione di un particolare protocollo intraospedaliero che prevede la valutazione della qualità della vita del piccolo e l'eventuale avvio di un supporto in favore dei genitori teso a potenziare le loro capacità di affrontare in maniera adeguata le esperienze traumatiche vissute dal bambino.
Tra le azioni messe in atto, ci sono le segnalazioni ai servizi territoriali, nei casi di fragilità familiare, mentre nei casi di particolare gravità e rischio vengono rivolte alla Procura presso il Tribunale per i Minorenni e/o Procura Ordinaria così che possano essere avviate tutte le azioni di tutela.

La definizione e attuazione di questi protocolli intraospedalieri ha permesso di affinare e potenziare le capacità di rilevazione del sommerso passando dal 4% dei casi riferibili a condizione di violenza sull'intera popolazione dei casi osservati, al 26% dei casi dopo l'istituzione dell'équipe dedicata e l'avvio di una metodologia di lavoro che prevede un sistematico raccordo con i referenti delle varie UU.OO. dell'Azienda; se si considera che l'80% dei dati deriva da rilevazioni effettuate nel contesto ospedaliero e il restante 20% da bambini che vengono osservati in regime ambulatoriale, si comprende la forza della rete intraospedaliera costruita negli anni.

Nel 2009 è stata costituita una rete sanitaria extraospedaliera su tutto il territorio regionale. È stata creata una rete con gli ospedali di tutta la Regione dotati di pediatrie, attorno alle quali sono state inserite tutte le specialità rilevanti: Direzione Medica di Presidio, ginecologia, chirurgia, ortopedia, radiologia, pronto soccorso, medicina legale, psicologia e servizi sociali ospedalieri. Pertanto, in ogni ospedale dove è presente la pediatria, a cui è stata affidata la funzione di coordinamento, sono state costituite le Unità Funzionali Interdisciplinari Ospedaliere GIADA (UFIO) composte da un medico e un infermiere referenti già in servizio, opportunamente formati, che svolgono funzione di osservatori. Nei territori dove sono presenti ospedali con le pediatrie, inoltre, sono state costituite le Unità Funzionali Interdisciplinari Territoriali (UFIT) con pediatri di famiglia, psicologi e assistenti sociali dei consultori familiari e neuropsichiatri infantili.
In favore delle reti UFIO e UFIT sono stati realizzati, per i primi anni, percorsi formativi sulla violenza all'infanzia coinvolgendo le varie ASL, nonché percorsi formativi specialistici interdisciplinari che hanno favorito la costituzioni delle reti informali, prezioso strumento di lavoro in un ambito così delicato quale quello della violenza all'infanzia. Negli anni sono state, inoltre, realizzate formazioni specialistiche rivolte ad alcune discipline sanitarie quali, per esempio, quella sull'abuso sessuale rivolta ai ginecologi e quella sul maltrattamento fisico e sulla *Shaken Baby Syndrome* per i radiologi.

Con D.G.R. n. 1878 del 30.11.2016, la Regione Puglia ha approvato le "Linee guida regionali in materia di maltrattamento e violenza nei confronti delle persone minori per età", patrocinate dal CISMAI, con l'obiettivo di rendere omogeneo, sul territorio regionale, il percorso di presa in carico di bambine e bambini, di adolescenti vittime di violenza attraverso l'implementazione degli assetti organizzativi che favoriscono ed agevolano il confronto e l'integrazione tra professionisti e servizi per il raggiungimento di obiettivi condivisi negli interventi di rilevazione, protezione, tutela, cura. Il Documento rappresenta il frutto di un lavoro di approfondimento scientifico ed operativo che ha visto la collaborazione concreta e fattiva, oltre che degli Uffici regionali, della Garante regionale per i diritti dell'infanzia e dell'adolescenza e del Gruppo GIADA.

Le Linee guida hanno previsto una riorganizzazione, su scala regionale, dei servizi che si occupano di violenza all'infanzia; nello specifico ha predisposto tre livelli di intervento, di seguito riportati:

- I LIVELLO - **EQUIPE INTEGRATE MULTIDISCIPLINARI TERRITORIALI**, presenti in ogni Ambito Territoriale/ Distretto sociosanitario e costituite da 1 assistente sociale di ambito territoriale, 1 psicologo del Consultorio familiare del Distretto e 1 educatore. L'équipe potrà avvalersi, in base alla specificità di ogni caso, delle competenze di altri professionisti dei servizi (NPI, Ser.D., UEPE, CSM, USSM, eccetera) e/o ospedalieri e della collaborazione degli insegnanti di riferimento del minorenne. Tale équipe svolge un primo livello di presa in carico nonché interventi di prevenzione e contrasto della violenza e, nei casi più complessi, attiva il Centro Specialistico di riferimento per la cura del trauma, per gli approfondimenti diagnostici della situazione traumatica, la supervisione, l'elaborazione e la realizzazione del progetto di intervento psicoterapeutico.

- II LIVELLO - **CENTRI SPECIALISTICI PER LA CURA DEL TRAUMA INTERPERSONALE**, presente in ogni ASL della Regione, composte da psicologi-psicoterapeuti con riconosciuta esperienza pluriennale e formazione specifica in materia di maltrattamento/violenza, prevedendo in ogni caso la presenza di almeno uno psicologo dell'età evolutiva. Tale équipe svolge funzioni di consulenza, supporto e supervisione alle équipe territoriali di riferimento già costituite con particolare attenzione alla fase di valutazione diagnostica, di costruzione del progetto di intervento e della realizzazione degli interventi psicoterapeutici. L'équipe potrà avvalersi di altre competenze, quali quelle del medico pediatra, del neuropsichiatra infantile, del ginecologo.

- III LIVELLO - **STRUTTURE E CENTRI ALTAMENTE SPECIALIZZATI PER IL TRATTAMENTO DEI MINORENNI VITTIME DI VIOLENZA**, individuato nell'équipe GIADA (della quale sono già stati sopra descritte composizione e funzioni) attiva presso il Servizio di Psicologia dell'Ospedale Pediatrico "Giovanni XXIII" dell'Azienda Ospedaliero Universitaria Policlinico "Giovanni XXIII" di Bari. GIADA oltre a essere componente del Coordinamento regionale in materia di violenza nei confronti dei minorenni garantisce la presa in carico delle situazioni che presentano particolare complessità.

Foto: Mark Ellis per Save the Children

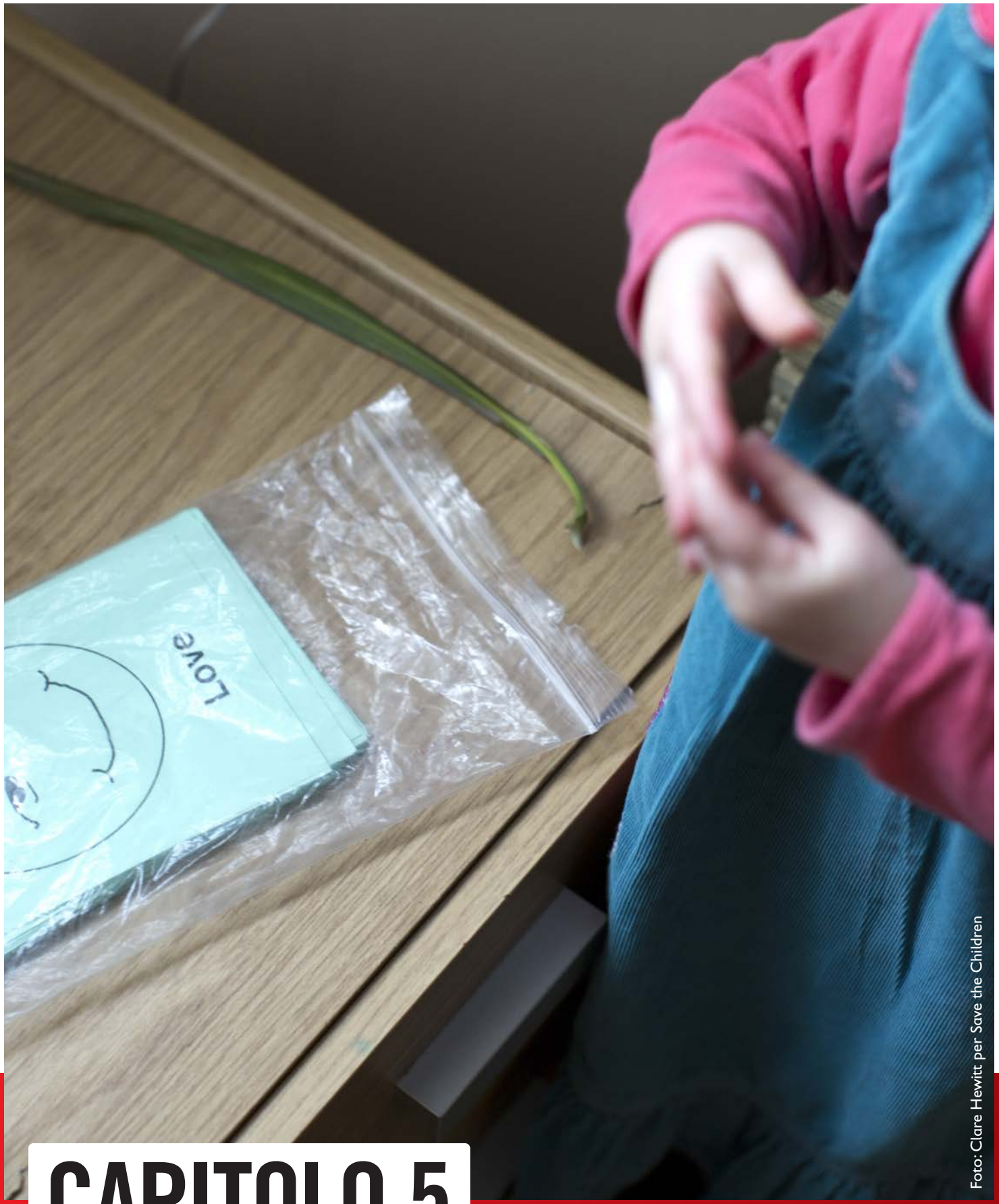

Foto: Clare Hewitt per Save the Children

CAPITOLO 5

5. SCIOGLIERE QUALCHE NODO. CONCLUSIONI E RACCOMANDAZIONI

In Italia non mancano iniziative e solide basi di appoggio di tipo legislativo per prevenire e contrastare il maltrattamento di bambine e bambini. Mentre quello che sembra **più carente è la macchina attuativa, il coordinamento delle risorse e dei servizi, l'armonizzazione delle politiche sanitarie con quelle sociali**.
La mole di opacità del fenomeno del maltrattamento infantile è tale che sembrerebbe quasi una conseguenza involontaria della consapevolezza che, una volta identificato un caso sospetto, non si sappia bene come andare avanti, o non si abbia la certezza del percorso. Il nostro Paese sarebbe in grado di gestire questo tipo di fenomeno e come dovrebbe attrezzarsi per farlo?

Sulla base di questa considerazione generale, si possono indicare **quattro livelli** prioritari sui quali lavorare per cominciare a sciogliere qualche nodo.

1. **IL LIVELLO SANITARIO:** il maltrattamento dei bambini e della bambine va considerato **una questione di salute pubblica**, e quindi trattato in termini di informazione, prevenzione, formazione di profili professionali, approfondimento diagnostico, ricerca e tecnologia, protocolli di intervento sanitario e investimenti economici e finanziari in ricerca, professionalità, coordinamento.

2. **IL LIVELLO SOCIALE:** il maltrattamento dei bambini e delle bambine richiede un'azione di cura sociale sulla riduzione della solitudine della famiglie, sull'accoglienza, sul sostegno alla genitorialità, alle neomamme e neopapà, alle famiglie che hanno già figli e si allargano, al delicato periodo del post-partum, di prevenzione di forme di depressione, di intervento precoce su fragilità esistenti o potenziali, di accompagnamento.

3. **IL LIVELLO CULTURALE:** il maltrattamento delle bambine e dei bambini è una questione di conoscenza, di consapevolezza, di competenza e di cultura sociale. Conoscenza da parte dei genitori, e di chi si prende cura delle bambine e dei bambini, dei comportamenti a rischio; formazione da parte di chi a vario titolo si relaziona con la bambina e il bambino e con le famiglie, come pediatri, medici, operatori sociali, educatori, insegnanti; cultura sociale nel senso di cambiamento della cultura pubblica e del modo di intendere, di sentire, della sensibilità nei confronti di tali comportamenti, che deve portare a una maggiore capacità di cogliere segnali, di osservare con una lente diversa il proprio comportamento e quello altrui, di indirizzare e chiedere aiuto.

4. **IL LIVELLO POLITICO:** il maltrattamento di bambine e bambini richiede un'attenzione e una continuità di azione di contrasto a ogni livello – nazionale, regionale e locale – che non può risentire dei capovolgimenti di fronte di un governo nazionale o di una giunta. Il contrasto a ogni forma di maltrattamento, anche interno alla famiglia talora più nascosto, rappresenta oltre che una forma di tutela di diritti fondamentali anche un ambito di salvaguardia del benessere di un Paese, uno strumento per emancipare le generazioni, un investimento sul futuro delle classi dirigenti politiche, culturali, economiche, scientifiche del Paese. Una priorità analoga a quella dell'istruzione e della salute.

A partire dai risultati della ricerca e da queste considerazioni Save the Children raccomanda:

AL GOVERNO, AL PARLAMENTO E ALL'AUTORITÀ GARANTE PER L'INFANZIA E L'ADOLESCENZA

- di **garantire in tempi rapidi l'istituzione di un sistema nazionale di rilevazione**, analisi e distribuzione dei dati relativi al maltrattamento dei bambini in Italia;
- di **sviluppare una strategia generale nazionale di contrasto** e presa in carico riguardante tutte le forme di violenza e di maltrattamento contro i bambini;
- di **incentivare riforme che promuovano una continuità di intervento** sulle politiche di prevenzione e contrasto al maltrattamento intrafamiliare ai danni di donne incinte e bambini, garantendo la costanza e la certezza delle azioni sul piano regionale e locale, anche nei periodi di crisi politica, di vacanza degli organi elettivi e di quelli nominati, anche in presenza di piani di rientro che gravino sui bilanci sanitari delle Regioni.

AL MINISTERO DELLA SALUTE E ALLE REGIONI NELL'AMBITO DELLE RISPETTIVE COMPETENZE:

- di introdurre la prevenzione del maltrattamento nel Piano Sanitario Nazionale e nel Piano nazionale di prevenzione sanitaria e di garantire, su tutto il territorio nazionale, il diritto a cure tempestive, di alto livello qualitativo e di durata congrua alla gravità del problema, ai minori vittime di maltrattamento, così come indicato tra l'altro, nei nuovi LEA firmati dal Presidente del Consiglio lo scorso gennaio;
- di promuovere la creazione di sistemi di vigilanza – sul modello delle *red flags* sperimentate in alcune esperienze locali – condivisi; dal sistema sanitario regionale e/o dalle singole ASL territoriali, per favorire il monitoraggio di casi di **maltrattamento** attraverso l'uso di strumenti semplici fin dal momento della refertazione di pronto soccorso;
- di incentivare – anche con forme di premialità per le Regioni virtuose – la creazione di reti interospedaliere tra i pronto soccorso – specie quelli pediatri e ostetrici – per favorire il controllo dei pellegrinaggi ospedalieri nei casi di bimbi o donne incinte soggetti con frequenza ad accettazione per traumi/lesioni sospette;
- di incentivare, con adeguate azioni di riforma e investimento, la promozione quantitativa e qualitativa dei consultori familiari in modo omogeneo sul territorio nazionale, così da garantire l'azione efficace di questi presidi territoriali, eccellenti in termini di prevenzione della violenza;
- di favorire l'omogeneizzazione delle procedure di accertamento, diagnosi e segnalazione all'interno dei pronto soccorso – a cominciare da quelli ostetrici e pediatrici – attraverso la messa in atto di specifici protocolli e l'utilizzo di modulistiche dedicate e facilmente applicabili che favoriscano la segnalazione e promuovano tutte le dovute forme di accertamento, dal punto di vista sia diagnostico sia giuridico;
- di diffondere i contenuti di piani regionali, protocolli, linee guida riguardanti il contrasto alla violenza di genere intra ed extra familiare e al maltrattamento di bambini e bambine, attraverso campagne di informazione, sensibilizzazione a tappeto nelle scuole, nei luoghi di grande affluenza di pubblico come centri commerciali, grandi store alimentari, centri sportivi, strutture ricreative, ecc.

AL MINISTERO DELL'ISTRUZIONE, DELL'UNIVERSITÀ E DELLA RICERCA:

- di rendere obbligatoria nella definizione dei percorsi curricolari di medici e personale sanitario della medicina di emergenza, neonatologia, pediatria, ostetricia e ginecologia, psichiatria e psicologia un'azione formativa specifica sul tema del maltrattamento di bambini, bambine e donne incinte sui temi della diagnostica, presa in carico e recupero.

ALL'ANCI E AGLI ENTI LOCALI:

- di monitorare con apposite mappature territoriali l'offerta di servizi e opportunità per il contrasto alle situazioni di disagio familiare;
- di identificare, di concerto con Regioni e Governo, risorse aggiuntive per il potenziamento e la qualificazione dei servizi sociali territoriali e per la creazione di vere e proprie Conferenze dei servizi territoriali; tali Conferenze permetterebbero l'incontro periodico e il coordinamento territoriale dei servizi che sovrintendono alla sicurezza e al benessere sociale sul territorio cittadino (servizi di contrasto alle dipendenze, servizi sociali, consultori familiari, pediatri di famiglia, servizi del privato sociale, presidi delle forze dell'ordine);
- di promuovere – di concerto con Regioni e Governo – modalità innovative di servizio all'infanzia che contemplino la possibilità di veri e propri hub educativi, dove alla componente strettamente educativa si integri un'attività costante di sostegno e promozione della genitorialità, anche a scopo di prevenzione di comportamenti maltrattanti e violenti all'interno della famiglia.

Foto: Save the Children

APPENDICE

Materiali per l'informazione e il lavoro comune

Gli abusi sulle donne in gravidanza e sui minori nella legislazione penale

Gli abusi fisici e psicologici sulla madre in gravidanza e sul minore sono penalmente perseguibili e i diversi comportamenti in cui essi si sostanziano vengono puntualmente definiti dalla legislazione penale.

Per gli **ABUSI FISICI** rilevano, tra gli altri, i seguenti reati:

PERCOSSE (ART. 581 C.P.)

"Chiunque percuote taluno, se dal fatto non deriva una malattia nel corpo o nella mente, è punito, a querela della persona offesa, con la reclusione fino a sei mesi o con la multa fino a euro 309. Tale disposizione non si applica quando la legge considera la violenza come elemento costitutivo o come circostanza aggravante di un altro reato."

Questo reato si ha quando dal fatto non deriva un'alterazione dello stato psico-fisico della vittima, contrariamente a quanto avviene per le lesioni. Vengono quindi considerate percosse le azioni violente che producono soltanto sensazioni fisiche di dolore, ma non alterazioni, sia pure lievi, all'integrità della persona, ad esempio schiaffi che non provocano ecchimosi.

LESIONE PERSONALE E CIRCOSTANZE AGGRAVANTI (ARTT. 582 E 583 C.P.)

"Chiunque cagiona ad alcuno una lesione personale, dalla quale deriva una malattia nel corpo o nella mente, è punito con la reclusione da sei mesi a tre anni. (…)"

"La lesione personale è grave e si applica la reclusione da tre a sette anni:

1. *se dal fatto deriva una malattia che metta in pericolo la vita della persona offesa, ovvero una malattia o un'incapacità di attendere alle ordinarie occupazioni per un tempo superiore ai quaranta giorni;*
2. *se il fatto produce l'indebolimento permanente di un senso o di un organo;*

La lesione personale è gravissima, e si applica la reclusione da sei a dodici anni, se dal fatto deriva:

1. *una malattia certamente o probabilmente insanabile;*
2. *la perdita di un senso;*
3. *la perdita di un arto, o una mutilazione che renda l'arto inservibile, ovvero la perdita dell'uso di un organo o della capacità di procreare, ovvero una permanente e grave difficoltà della favella;*
4. *la deformazione, ovvero lo sfregio permanente del viso;"*

Evento del reato è la lesione personale, la quale non deve essere necessariamente derivare da un'azione violenta, potendo essere stata causata anche da omissione o contagio.

ABUSO DEI MEZZI DI CORREZIONE E DISCIPLINA (ART.571 C.P.)

"Chiunque abusa dei mezzi di correzione o di disciplina in danno di una persona sottoposta alla sua autorità, o a lui affidata per ragione di educazione, istruzione, cura, vigilanza o custodia, ovvero per l'esercizio di una professione o di un'arte, è punito, se dal fatto deriva il pericolo di una malattia nel corpo o nella mente, con la reclusione fino a sei mesi. Se dal fatto deriva una lesione personale, si applicano le pene stabilite negli articoli 582 e 583, ridotte a un terzo; se ne deriva la morte, si applica la reclusione da tre a otto anni."

Per la consumazione del reato è previsto il dolo specifico, ossia la volontà, da parte dell'agente, di commettere il fatto per un fine educativo.

MALTRATTAMENTO CONTRO FAMILIARI E CONVIVENTI (ART. 572 C.P.)

"Chiunque, fuori dei casi indicati nell'articolo precedente, maltratta una persona della famiglia o comunque convivente, o una persona sottoposta alla sua autorità o a lui affidata per ragioni di educazione, istruzione, cura, vigilanza o custodia, o per l'esercizio di una professione o di un'arte, è punito con la reclusione da due a sei anni.
Se dal fatto deriva una lesione personale grave [c.p. 583], si applica la reclusione da quattro a nove anni; se ne deriva una lesione gravissima, la reclusione da sette a quindici anni; se ne deriva la morte, la reclusione da dodici a ventiquattro anni."

L'elemento oggettivo del reato è costituito da sofferenze fisiche e morali reiterate, tali che i singoli atti vessatori siano uniti tra loro da un legame di abitualità e sostenuti da una costante volontà di porli in essere da parte dell'agente. Quest'ultimo è una persona che fa parte del nucleo familiare della vittima o che comunque è convivente con la stessa, o al quale la vittima è affidata per ragioni di cura o custodia. Responsabili di questo reato possono quindi essere anche insegnati ed educatori.

INFANTICIDIO IN CONDIZIONI DI ABBANDONO MATERIALE E MORALE (ART. 578 C.P.)

"La madre che cagiona la morte del proprio neonato immediatamente dopo il parto, o del feto durante il parto, quando il fatto è determinato da condizioni di abbandono materiale e morale connesse al parto, è punita con la reclusione da quattro a dodici anni.
A coloro che concorrono nel fatto di cui al primo comma si applica la reclusione non inferiore ad anni ventuno. Tuttavia, se essi hanno agito al solo scopo di favorire la madre, la pena può essere diminuita da un terzo a due terzi.
Non si applicano le aggravanti stabilite dall'articolo 61 del codice penale."

Questa norma individua un reato specifico, per il quale, date le condizioni descritte, è previsto un minor rigore rispetto all'omicidio.

OMICIDIO PRETERINTENZIONALE (ART. 584 C.P.)

"Chiunque, con atti diretti a commettere uno dei delitti preveduti dagli articoli 581 e 582, cagiona la morte di un uomo, è punito con la reclusione da dieci a diciotto anni."

Il caso previsto da questo reato è quello in cui la morte scaturisce da atti miranti a provocare percosse o lesioni, quindi come conseguenza che va oltre le intenzioni dell'agente.

OMICIDIO (ART.575 C.P.)

"Chiunque cagiona la morte di un uomo è punito con la reclusione non inferiore ad anni ventuno."

Aggravante per i reati commessi in danno di minori, in loro presenza (violenza assistita) o in danno di donne in gravidanza (art. 61, n. 11-quinquies c.p.).

"Aggravano il reato quando non ne sono elementi costitutivi o circostanze aggravanti speciali le circostanze seguenti:
(…) 11-quinquies) l'avere, nei delitti non colposi contro la vita e l'incolumità individuale, contro la libertà personale nonché nel delitto di cui all'articolo 572, commesso il fatto in presenza o in danno di un minore di anni diciotto ovvero in danno di persona in stato di gravidanza."

Questa aggravante, che include la violenza assistita, è stata introdotta dalla c.d. Legge sul femminicidio (DL n. 93/2013 convertito in L. 119/2013 "disposizioni urgenti in materia di sicurezza e per il contrasto della violenza di genere, nonché in tema di protezione civile e di commissariamento delle province") ed è applicabile a tutti i reati sopra previsti.

Relativamente agli **ABUSI PSICOLOGICI** rilevano in particolare, ma non esclusivamente, le seguenti figure di reato:

VIOLENZA PRIVATA (ART. 610 C.P.):

"Chiunque, con violenza o minaccia, costringe altri a fare, tollerare, od omettere qualche cosa è punito con la reclusione fino a quattro anni.
La pena è aumentata se concorrono le condizioni prevedute dall'articolo 339."

Il reato punisce condotte che minacciano la libertà psicologica dell'individuo a fronte di una minaccia intimidatoria, di conseguenza si realizza quando la volontà della vittima è limitata o condizionata dal comportamento violento o intimidatorio dell'agente. È prevista un'aggravante se il reato è commesso in determinate circostanze, ad esempio con l'uso di armi o da più persone.

RIDUZIONE IN SCHIAVITÙ (ART. 600 C.P.):

"Chiunque esercita su una persona poteri corrispondenti a quelli del diritto di proprietà ovvero chiunque riduce o mantiene una persona in uno stato di soggezione continuativa, costringendola a prestazioni lavorative o sessuali ovvero all'accattonaggio o comunque al compimento di attività illecite che ne comportino lo sfruttamento ovvero a sottoporsi al prelievo di organi, è punito con la reclusione da otto a venti anni.
La riduzione o il mantenimento nello stato di soggezione ha luogo quando la condotta è attuata mediante violenza, minaccia, inganno, abuso di autorità o approfittamento di una situazione di vulnerabilità, di inferiorità fisica o psichica o di una situazione di necessità, o mediante la promessa o la dazione di somme di denaro o di altri vantaggi a chi ha autorità sulla persona."

Un riferimento a parte meritano le principali norme rilevanti in materia di **ABUSO SESSUALE**:

VIOLENZA SESSUALE E AGGRAVANTI (ART. 609-BIS E 609-TER C.P.)

"Chiunque, con violenza o minaccia o mediante abuso di autorità, costringe taluno a compiere o subire atti sessuali è punito con la reclusione da cinque a dieci anni.
Alla stessa pena soggiace chi induce taluno a compiere o subire atti sessuali:

1. abusando delle condizioni di inferiorità fisica o psichica della persona offesa al momento del fatto;

2. traendo in inganno la persona offesa per essersi il colpevole sostituito ad altra persona.

Nei casi di minore gravità la pena è diminuita in misura non eccedente i due terzi."

"La pena è della reclusione da sei a dodici anni se i fatti di cui all'articolo 609-bis sono commessi:

1. nei confronti di persona che non ha compiuto gli anni quattordici;

2. con l'uso di armi o di sostanze alcoliche, narcotiche o stupefacenti o di altri strumenti o sostanze gravemente lesivi della salute della persona offesa;

3. da persona travisata o che simuli la qualità di pubblico ufficiale o di incaricato di pubblico servizio;

4. su persona comunque sottoposta a limitazioni della libertà personale;

5. nei confronti di persona che non ha compiuto gli anni sedici della quale il colpevole sia l'ascendente, il genitore anche adottivo, il tutore;

5 bis. all'interno o nelle immediate vicinanze di istituto d'istruzione o di formazione frequentato dalla persona offesa;

5 ter. nei confronti di donna in stato di gravidanza;

5 quater. nei confronti di persona della quale il colpevole sia il coniuge, anche separato o divorziato, ovvero colui che alla stessa persona è o è stato legato da relazione affettiva, anche senza convivenza;

5 quinquies. se il reato è commesso da persona che fa parte di un'associazione per delinquere e al fine di agevolarne l'attività;

5 sexies. se il reato è commesso con violenze gravi o se dal fatto deriva al minore, a causa della reiterazione delle condotte, un pregiudizio grave.

La pena è della reclusione da sette a quattordici anni se il fatto è commesso nei confronti di persona che non ha compiuto gli anni dieci."

ATTI SESSUALI CON MINORENNE (ART. 609-QUATER C.P.)

"Soggiace alla pena stabilita dall'articolo 609-bis chiunque, al di fuori delle ipotesi previste in detto articolo, compie atti sessuali con persona che, al momento del fatto:

1. non ha compiuto gli anni quattordici;

2. non ha compiuto gli anni sedici, quando il colpevole sia l'ascendente, il genitore, anche adottivo, o il di lui convivente, il tutore, ovvero altra persona cui, per ragioni di cura, di educazione, di istruzione, di vigilanza o di custodia, il minore è affidato o che abbia, con quest'ultimo, una relazione di convivenza.

Fuori dei casi previsti dall'articolo 609-bis, l'ascendente, il genitore, anche adottivo, o il di lui convivente, il tutore, ovvero altra persona cui, per ragioni di cura, di educazione, di istruzione, di vigilanza o di custodia, il minore è affidato, o che abbia con quest'ultimo una relazione di convivenza, che, con l'abuso dei poteri connessi alla sua posizione, compie atti sessuali con persona minore che ha compiuto gli anni sedici, è punito con la reclusione da tre a sei anni.
Non è punibile il minorenne che, al di fuori delle ipotesi previste nell'articolo 609-bis, compie atti sessuali con un minorenne che abbia compiuto gli anni tredici, se la differenza di età tra i soggetti non è superiore a tre anni.
Nei casi di minore gravità la pena è diminuita in misura non eccedente i due terzi.
Si applica la pena di cui all'articolo 609-ter, secondo comma, se la persona offesa non ha compiuto gli anni dieci."

Questa norma parifica nella punizione alla violenza sessuale i rapporti sessuali tra chiunque e un minore di 14 anni. L'età del minore sale a 16 anni se il responsabile ha con lo stesso rapporti di ascendenza, tutela, affidamento, educazione o cura o convivenza. Esclusi dalla punibilità i minorenni che compiono atti sessuali con minorenni ultratredicenni se la differenza di età non supera i tre anni.

CORRUZIONE DI MINORENNE (ART. 609-QUINQUIES C.P.)

"Chiunque compie atti sessuali in presenza di persona minore di anni quattordici, al fine di farla assistere, è punito con la reclusione da uno a cinque anni.
Salvo che il fatto costituisca più grave reato, alla stessa pena di cui al primo comma soggiace chiunque fa assistere una persona minore di anni quattordici al compimento di atti sessuali, ovvero mostra alla medesima materiale pornografico, al fine di indurla a compiere o a subire atti sessuali.
La pena è aumentata:

a. se il reato è commesso da più persone riunite;

b. se il reato è commesso da persona che fa parte di un'associazione per delinquere e al fine di agevolarne l'attività;

c. se il reato è commesso con violenze gravi o se dal fatto deriva al minore, a causa della reiterazione delle condotte, un pregiudizio grave.

La pena è aumentata fino alla metà quando il colpevole sia l'ascendente, il genitore, anche adottivo, o il di lui convivente, il tutore, ovvero altra persona cui, per ragioni di cura, di educazione, di istruzione, di vigilanza o di custodia, il minore è affidato, o che abbia con quest'ultimo una relazione di stabile convivenza."

Organizzazioni regionali: l'esperienza dei pediatri

Il materiale, le testimonianze e i racconti raccolti parlano di numerose attività e iniziative nei confronti del maltrattamento che possono trovare declinazioni diverse in diverse Regioni del territorio italiano. Nell'ambito del maltrattamento nei primissimi anni di vita la figura del pediatra di famiglia può assumere un ruolo determinante, proprio per il suo rapporto privilegiato non solo con il suo assistito ma anche con il contesto familiare, nel riconoscimento di situazioni di rischio o nel sospetto di condizioni di maltrattamento, intercettazione precoce e segnalazione, per una presa in carico del bambino e gestione adeguata e tempestiva.

È stata quindi svolta una piccola indagine attraverso la raccolta delle risposte a quattro domande da parte di alcuni referenti regionali dell'Associazione Culturale Pediatri (ACP)[1], che hanno potuto mettere insieme informazioni, in alcuni casi solo parziali, rispetto al territorio regionale, per cercare di avere un quadro delle modalità di lavoro e possibilità concrete di azione contro il maltrattamento infantile nell'ambito della loro attività ambulatoriale.

Pediatri di famiglia e maltrattamento

Nella sua Regione:
1. Ci sono linee guida/protocolli/indicazioni di prassi da seguire per l'intercettazione/rilevazione/gestione dei casi di maltrattamento? Quali/a quando risalgono?
2. Cosa deve fare un pediatra di fronte a un caso sospetto o evidente di maltrattamento?
3. Cosa viene realmente fatto/è possibile fare nei casi sospetti o evidenti di maltrattamento?
4. Quali prassi vengono seguite dal pediatra nei casi con condizioni che espongono al rischio di maltrattamento, per prevenire?

Qui di seguito vengono riportate le risposte relative alla situazione da loro percepita e vissuta in alcune Regioni italiane.

A) Emilia Romagna

Dal 2013 nella Regione Emilia Romagna sono disponibili le "Linee di indirizzo regionali per l'accoglienza e la cura di bambini e adolescenti vittime di maltrattamento/abuso", adottate con Delibera della Giunta Regionale n.1677/28 novembre 2013 e presentate agli operatori il 24 febbraio 2014. Successivamente sono stati prodotti i primi due "Quaderni del professionista", strumenti di lavoro a supporto dei sanitari: 1 - Maltrattamento e abuso sul minore. Raccomandazioni per la valutazione clinica e medico-legale; 2 - Fratture e abuso. Raccomandazioni per il percorso diagnostico, entrambi presentati e distribuiti agli operatori il 1 ottobre 2014[2]. Nelle Linee è indicato come e quando si devono attivare i diversi nodi della rete dei servizi, fra cui il pediatra di famiglia, per il contrasto al maltrattamento/abuso sul minore, e che cosa devono fare. A cascata, ciascuna ASL ha aggiornato i protocolli/le procedure/le istruzioni operative nel proprio territorio, o li ha prodotti nei rari casi in cui non fossero presenti, in modo da rendere concretamente applicate le Linee di indirizzo. La Regione ha seguito/sta seguendo questa ricaduta monitorandola, e rendendo l'applicazione delle Linee e la formazione degli operatori su di esse oggetto di verifica per il raggiungimento degli obiettivi di budget delle ASL.

L'azione del pediatra, di fronte a un caso sospetto o evidente di maltrattamento, dipende dalla situazione, cioè dalla gravità e urgenza dell'intervento, come indicato nelle stesse Linee:
a. può prendere contatto con il Servizio Sociale (SS) competente per territorio e insieme con il SS verificare ed eventualmente condividere i passi successivi (eventuale segnalazione all'Autorità Giudiziaria);
b. può prendere contatto con il pronto soccorso (PS) pediatrico ospedaliero di riferimento ed effettuare un invio del minore con motivazione formale di "necessità di effettuare approfondimenti diagnostici urgenti nell'interesse del minore", preavvisando dell'arrivo, segnalando i propri sospetti e verificando poi che il minore sia puntualmente pervenuto in PS;
c. a Bologna, ove è presente un Centro Specialistico di II° livello ("Il Faro") incardinato nel Dipartimento di cure primarie dell'AUSL di Bologna cui gli operatori possono rivolgersi, il pediatra può prendere contatto direttamente con il centro per una consulenza sul caso, eventualmente concordando anche il percorso successivo.
Nella maggior parte dei casi il percorso scelto dai pediatri di famiglia è l'invio in ospedale, al PS pediatrico. A Bologna in special modo, anche perché il PS pediatrico del S. Orsola è quello di riferimento per il maltrattamento/abuso sul minore per l'Area Metropolitana, sancito anche da una Procedura interaziendale fra AUSL di Bologna e Az. Ospedaliero Universitaria di Bologna Policlinico S. Orsola relativo alla violenza sessuale ("Percorso Sanitario integrato in caso di violenza sessuale/sospetto abuso sessuale a carico di minori") la cui ultima revisione risale al 28.01.2013. Numerosi sono anche i raccordi con il Centro specialistico "Il Faro". Decisamente più rari, per quanto risulta, i rapporti di attivazione diretta dei SS non mediati attraverso l'ospedale o "Il Faro".
Nei casi che presentano maggiore rischio di maltrattamento i percorsi rimangono gli stessi anche nel caso di attivazione dei Servizi con finalità di prevenzione: fondamentalmente l'attivazione dell'Ospedale (e/o in alternativa del Centro specialistico "Il Faro" a Bologna, soprattutto nei casi più sfumati) resta la via preferenziale seguita dal Pediatra di famiglia.

B) Lazio

Non ci sono linee guida regionali ufficiali. Esistono però materiali on line, protocolli, linee guida, indicazioni, anche di elevata qualità, prodotti da enti o associazioni, purtroppo applicati in realtà limitate e in genere poco pubblicizzate e di conseguenza poco conosciute[3]. Alcune ottime iniziative attuate si sono interrotte e non sono più operative. Esistono prassi in alcune ASL o territori, nate da rapporti personali o da corsi di formazione locali, da cui sono nate alcune "reti" più o meno formali, note a pochi, ma comunque utili (per esempio rapporti tra Pediatri ASL RM3 exD e un Commissario referente del Commissariato di zona) e altre più strutturate (Azienda USL Roma D- Area Tutela Salute della Donna e del Bambino - Servizio Prevenzione e Cura Abuso e Maltrattamento all'Infanzia, dal 2004 a oggi - Centro "Il Mandorlo"- Corsi di formazione).
Di fronte a un caso sospetto o evidente di maltrattamento il pediatra deve informare l'Autorità Giudiziaria, riferendo alla Procura presso il Tribunale per i Minorenni (e/o il Servizio Sociale) a seconda della situazione che si trova davanti. Deve riferire solo ciò che gli è stato comunicato, riportandolo fedelmente, per iscritto, specificando che il paziente/genitore (o altri) riferisce che "..." senza aggiungere interpretazioni personali o commenti. È opportuno inoltre specificare che "si sta riferendo quanto venuto a conoscenza nell'esercizio della propria professione, nell'esclusivo interesse del minore senza volere recare nocumento ad alcuno". Qualsiasi dubbio, anche minimo, andrebbe condiviso. Non è il pediatra a decidere se sia importante o no, devono solo segnalare. Indicazioni precise per i pediatri sono contenute in pubblicazioni su riviste scientifiche accreditate[4].
Tutto quanto appena indicato può essere fatto dal pediatra, ma la realtà è che viene fatto molto poco. La stragrande maggioranza dei pediatri di famiglia non ha sufficienti conoscenze sull'argomento e non sa con certezza a quale organismo rivolgersi. Può aver timore di compromettere il rapporto con la famiglia in caso di errore. Di fatto le segnalazioni da parte di pediatri su eventuali sospetti di abuso sono pochissime[5]. I pediatri che hanno seguito una qualche formazione sull'argomento (pochi in realtà) cercano di seguire le indicazioni ricevute dai docenti: effettuare un attento esame obiettivo davanti a un testimone; rivolgersi al servizio TSMREE (Tutela Salute Mentale e Riabilitazione in Età Evolutiva); segnalare ai Servizi Sociali; stilare il referto; rivolgersi a un centro di secondo livello per approfondire. La variabilità delle situazioni però è tale che ne è difficile l'applicazione. È fondamentale agire all'interno di una rete, che si è riusciti a costruire, o in cui ci si è inseriti. La rete serve a sostenere il pediatra, che non può e non deve essere lasciato solo, e a inserire il bambino in un percorso prestabilito che lo accompagni e lo protegga da traumi durante accoglienza, sorveglianza, diagnosi e presa in carico. A Roma, nella RM3-ex RMD, da qualche anno una Neuropsichiatra Infantile è il riferimento, contattabile telefonicamente, che "aiuta" a gestire il caso. Nel sospetto di un danno fisico o psichico ci si rivolge (per visite, radiografie, eccetera), ai servizi dedicati dell'Ospedale Pediatrico Bambino Gesù, del Policlinico Umberto I o di altra struttura pediatrica. Anche il pediatra più formato e aggiornato, nel sospetto di maltrattamento ha bisogno di aiuto da chiunque possa supportarlo in un momento così delicato per il bambino (l'ospedale, i servizi sociali, la ASL, eccetera).
Nei casi con condizioni che espongano al rischio di maltrattamento, sulla base alle risposte ricevute, i comportamenti appaiono molto variabili, cambiano a seconda delle situazione, delle conoscenze, delle competenze e della sensibilità dei pediatri: contattare il Tribunale per i Minorenni, parlare con l'Assistente sociale, gli psicologi che sono stati consultati, l'Asilo Nido o la Scuola; effettuare un accurato esame obiettivo; aprire un colloquio per cercare di capire; avere la massima disponibilità con i genitori e accogliere eventuali segnalazioni; sorvegliare per intercettare i segnali del bambino; collaborare strettamente coi servizi territoriali.
Il pediatra dovrebbe essere solo un facilitatore, una figura percepita dai genitori come positiva, alleata del bambino.
I genitori stessi dovrebbero esser resi consapevoli della forte rilevanza del problema "violenza sui minori".

C) Lombardia

Vi sono linee-guida NICE (National Institute for Health and Care Excellence) abbastanza recenti alle quali si fa riferimento. Di fronte a un caso sospetto o evidente di maltrattamento, per quanto riguarda i fatti di rilevanza penale (maltrattamenti in famiglia, abuso sessuale, corruzione di minorenne, violenza assistita, trascuratezza grave, eccetera) ci si deve attenere al Codice di P.P. (obbligo di denuncia e/o referto), per quanto riguarda questioni di pregiudizio l'interlocutore è costituito dai Servizi Sociali che sono il tramite col Tribunale per i Minorenni. Di solito la procedura standard viene seguita.
Il problema è semmai a monte, cioè la rilevazione, si stanno facendo continui momenti formazione, c'è un gruppo di lavoro all'interno dell'ACP nazionale. Nei casi con condizioni che espongono al rischio di maltrattamento, sul territorio vi sono diverse opportunità per aiutare le famiglie e, in particolare, le mamme di bambini piccoli. Opportunità inserite in progetti più articolati di promozione della salute.

D) Sicilia

Ci sono le Linee Guida della Regione Sicilia del 2012. Il pediatra di fronte a un caso sospetto o evidente di maltrattamento deve fare la segnalazione alla Procura minorile presso il Tribunale per i Minorenni, che avvierà il percorso giudiziario. Parallelamente il Tribunale attiva i Servizi Sociali del Comune e i servizi di NPIA (Neuropsichiatria dell'Infanzia e dell'Adolescenza) dedicati alla presa in carico del minore e del nucleo familiare. Nei casi con condizioni che espongono al rischio di maltrattamento il pediatra deve segnalare all'équipe dell'ASL che si occupa del maltrattamento e che dovrebbe essere attiva in ogni distretto. Presso ASP Palermo e Messina è attiva e si occupa proprio della prevenzione del maltrattamento. Se già in atto va segnalato come prima indicato.

E) Toscana

In tutta la Regione Toscana è attivo il Codice Rosa nei pronto soccorso (PS) con coinvolgimento in particolare, oltre al personale di PS, ai pediatri del PS, del 118, delle UU.OO. di Pediatria, delle ginecologie e in raccordo con gli assistenti sociali le attività consultoriali e i Centri antiviolenza. Codice Rosa prevede un protocollo con le Forze dell'Ordine e la Procura che ogni ASL ha siglato. Punto di riferimento per la Regione per quanto riguarda i minori è l'Azienda Ospedaliera Meyer.
Diverse realtà hanno attivo il progetto MIRIAM e a Livorno c'è il Centro di Coordinamento Zonale (CCZ) sulla violenza situato presso il Consultorio, che coinvolge un po' tutti i settori ASL che possono incontrare situazioni di violenza o si occupano della presa in carico (in particolare per i minori il gruppo Abusi della UFSMIA-Unità Funzionale Salute Mentale Infanzia e Adolescenza). In caso di situazioni di violenza su un minore le indicazioni sono quella di segnalazione immediata alla Procura; in caso di maltrattamenti gravi o abusi sessuali è sufficiente il sospetto. Sarà poi la Procura a predisporre gli accertamenti necessari. In questa fase infatti c'è il rischio di inquinare le prove o compromettere comunque indagini delicatissime. Nei casi più incerti o dove ci sono situazioni nell'immediato meno gravi che consentono un'indagine da parte dei Servizi Sociali (violenza assistita, bambini trascurati, eccetera) il riferimento è il Servizio Sociale o il responsabile del Centro di coordinamento zonale. Azioni di prevenzione importante sono indirizzare ai Servizi Consultoriali per un sostegno alla genitorialità in particolare nel post-partum e in caso di conflittualità familiare dato che sono i momenti più delicati per lo sviluppo di situazioni di violenza. Da non sottovalutare il problema della violenza nelle coppie di giovani adolescenti dove si cerca come CCZ di fare un'opera di prevenzione in raccordo con le Scuole, in quanto è altamente predittiva di violenza familiare in futuro. Fondamentale la formazione, che dove è stata fatta ha consentito una sensibilizzazione e un'attenzione altissima da parte dei colleghi di segnali che altrimenti sarebbero passati inosservati. Intervenire in fasi molto iniziali aiuta a evitare situazioni più gravi e soprattutto ha più probabilità di successo. È uscita recentemente una delibera regionale (5 dicembre 2016 del.1260) che riorganizza il Codice Rosa facendolo passare da Progetto a Rete Clinica e che prevede nuclei operativi in ogni PS, ma anche un referente della rete territoriale. In questa riorganizzazione sarebbe opportuno coinvolgere sia le pediatrie ospedaliere sia i pediatri di famiglia sia quelli di Comunità (là dove sono presenti).

F) Umbria

Non ci sono linee guida regionali. In Umbria, nel piano sanitario 2009-2011, si è tentato di promuovere un progetto organizzativo a cui è stato dato il nome PIUMA (Progetto Integrato Unità Multidisciplinare Abuso), realizzato con il contributo del Dipartimento per le Pari Opportunità. Il progetto promuoveva la costruzione, nel rispetto delle reciproche competenze, di stabili forme di intesa, comuni e condivise, tra il sistema integrato dei Servizi Sociali comunali e dei Servizi Sanitari delle ASL con il sistema giudiziario per rendere sempre più tempestivi e congrui i percorsi di tutela da attivare.
Gli obiettivi generali del Progetto PIUMA erano:

1. individuare le attività di protezione, di cura e di sostegno (sociali, educative, psicologiche, sanitarie) in favore di minori vittime di abuso e sfruttamento sessuale, da realizzare in modo integrato;
2. garantire un adeguato coordinamento inter istituzionale fra i soggetti pubblici;
3. assicurare un'appropriata integrazione tra i vari sistemi dei servizi e le professionalità coinvolte nella gestione del modello di intervento, a favore delle vittime di abuso e sfruttamento sessuale.

Nell'ambito del Progetto PIUMA c'è stato un momento formativo rivolto a medici e infermieri del pronto soccorso e della clinica pediatrica dell'azienda ospedaliera di Perugia. Sono stati svolti altri percorsi formativi rivolti a psicologi, pediatri e altri operatori territoriali. Dal progetto PIUMA doveva nascere un'équipe multidisciplinare (assistente sociale, psicologo, neuropsichiatra infantile, radiologo, pediatra, ortopedico, eccetera) a cui si potesse fare riferimento per la segnalazione. L'obiettivo era favorire la segnalazione e individuare i percorsi assistenziali. Attualmente l'équipe è composta da uno psicologo e un assistente sociale con efficacia limitata: non è reperibile 24 ore su 24 né tutti i giorni della settimana. Non tutti i pediatri sono stati informati dell'attività di questa équipe e i colleghi della provincia di Terni non ne conoscono l'esistenza. Non esiste un metodo comune e/o un protocollo condiviso per l'intercettazione, rilevazione e gestione del bambino maltrattato (abuso fisico, psichico e *neglect*).

G) Valle d'Aosta

Come linee guida/protocolli/indicazioni di prassi da seguire per l'intercettazione/rilevazione/gestione dei casi di maltrattamento vi sono diversi documenti[6]. In Valle d'Aosta, su una popolazione totale circa 128.000 abitanti, la popolazione in età 0-18 anni è pari a circa 19.000 e quella in età 0-6 anni circa 6.000. Il numero di casi segnalati di maltrattamento e abuso conclamati negli ultimi anni è di poche unità/anno. Da notare che sono prevalentemente segnalati dalla scuola, poi dalla pediatria ospedaliera e, in maniera eccezionale, dalla pediatria di famiglia. A quest'ultima spetta soprattutto il compito di individuare un'area grigia più estesa di situazioni di trascuratezza, disagio sociale e/o psicologico del minore in assenza di segni di maltrattamento, in modo da poter attivare tutte le risorse che la comunità può offrire a sostegno di una famiglia "critica". La difficoltà per tutti gli operatori è rappresentata dalla delicatezza del distinguere e mettere in atto un ventaglio più o meno esteso di azioni, dal caso che necessita di monitoraggio e accompagnamento, fino a quello di vero e proprio maltrattamento o abuso. Per questo la Regione Aut. Valle d'Aosta ha istituito un Gruppo di Coordinamento Interistituzionale composto da: 2 assistenti sociali, 2 dirigenti scolastici, 1 coordinatore di Asilo Nido, 2 psicologi, 2 pediatri (di cui uno ospedaliero e uno territoriale), 1 assistente sanitaria, 1 ginecologo, 1 medico di pronto soccorso, 1 medico legale, 1 operatore dell'Ufficio Minori della Divisione Anticrimine della Questura e 1 operatore della Sezione Minori della Squadra Mobile della Questura. Ha il compito di sostenere e accompagnare il singolo operatore sociale, sanitario, scolastico e socio educativo nel difficile percorso di valutazione, segnalazione e denuncia, eventualmente anche in urgenza, del caso di minore in situazione critica. In caso di dubbio o di necessità di approfondimento, è possibile richiedere una consulenza in merito al Gruppo di Coordinamento Interistituzionale, attraverso un contatto telefonico o e-mail[7].

Notizie biografiche e informazioni sui Centri consultati

Giussy Barbara

Dirigente medico, Specialista in Ostetricia e Ginecologia. Ha seguito un Corso di formazione in consulenza sessuale e sessuologia clinica, Scuola AISPA (Associazione Italiana sessuologia e psicologia Applicata), Milano. Lavora presso la Fondazione IRCCS CA' Granda Ospedale Maggiore Policlinico di Milano e presso il Servizio Soccorso Violenza Sessuale e Domestica (SVSeD).

Carla Berardi

Pediatra di libera scelta presso la AUSL di Perugia, è presidente della Associazione Culturale Pediatri (ACP) "Umbria", socia CISMAI e referente per il Maltrattamento e l'Abuso all'infanzia del Centro per la Salute del Bambino-Onlus di Trieste. Specializzata in Pediatria presso l'Università Cattolica del Sacro Cuore di Roma, ha conseguito il Corso di Perfezionamento in Pediatria di Comunità presso l'Università di Padova e il Master Internazionale in Protezione della Comunità e Promozione della Sicurezza presso le Università di Padova, Oporto, Parigi XII e Karolinska Institutet di Stoccolma. Ha svolto uno stage presso il Suspected Child Abuse and Neglect Program del Sick Children Hospital di Toronto. È stata consulente scientifico della Provincia di Perugia per il progetto "Prevenzione, trattamento e recupero nei casi di maltrattamento e abuso di minori" e consulente del Comune di Perugia su progetti per la prevenzione del maltrattamento. Ha istituito e coordinato l'Équipe multidisciplinare di riferimento per i casi di maltrattamento e abuso ai minori della AUSL di Perugia. Ha coordinato il Censimento Multifonte sul maltrattamento ai minori nel comune di Perugia, ricerca presentata alla Conferenza Mondiale sulla prevenzione della Violenza Familiare tenutasi a Banff, Canada. Autrice del volume "Prevenzione trattamento e recupero dei casi di maltrattamento e abuso ai minori" e di varie pubblicazioni sul tema del maltrattamento; relatore a congressi e docente in corsi di formazione sul tema dell'abuso ai minori; è stata consulente scientifico, coordinatore e docente nel progetto formativo della Provincia di Perugia per la prevenzione, trattamento e recupero dei casi di abuso ai minori; è docente presso il Settore Formazione Specifica in medicina Generale sul tema maltrattamento.

Ha fatto parte della Commissione Consultiva per la prevenzione e la cura del maltrattamento sui minorenni dell'Autorità Garante per l'infanzia e l'adolescenza.

Sara Ceccarelli

Medico chirurgo, specializzata in pediatra, ha lavorato presso l'azienda Usl Umbria 2, PO Spoleto, UO Pediatria e da settembre 2016 lavora presso S.C. Terapia Intensiva Neonatale, Neonatologia, Pediatria Azienda Ospedaliera S. Maria di Terni in qualità di Dirigente Medico di primo livello disciplina neonatologia/pediatria. Da maggio 2012 è segretario della sezione regionale della Società Italiana di Pediatria (SIP). Nel 2013-2014 ha seguito il Corso di perfezionamento post laurea: "I Maltrattamenti e gli abusi sui minori: Prevenzione, individuazione precoce, presa in carico" presso l'Università Cattolica del Sacro Cuore, Ospedale A. Gemelli, Roma. Nel 2014 è stata organizzatrice e docente del I corso aziendale "Maltrattamenti e abuso in età pediatrica" e nel 2015 docente e nella segreteria scientifica del II corso aziendale sul maltrattamento e l'abuso all'infanzia. Fa parte della Società Italiana di Pediatria (SIP) e della Società Italiana di Neonatologia (SIN).

Federica Collini

Medico chirurgo, specialista in Medicina Legale, è consulente Medico Legale presso il Servizio SVSeD, Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Milano. Ha frequentato il V.I.P. (Violence Intervention Center) diretto dalla Prof.ssa Heger Heppenstall Astrid, Los Angeles (CA). Dal 2013 consulente Tecnico per conto del Tribunale Ordinario di Milano, successivamente del Tribunale Ordinario di Monza e del Tribunale per i Minorenni di Brescia. Sempre dal 2013 svolge attività di collaborazione per il "Sistema di Protezione Internazionale per Richiedenti Asilo e Rifugiati" del Comune di Milano e per la Stima dell'Età.

Elena Coppo

Medico Chirurgo specialista in Pediatria, dal 2002 è Dirigente medico a tempo indeterminato presso Azienda Ospedaliera Città della Salute e della Scienza di Torino - Presidio OIRM. Dal 2006 fa parte dell'équipe multidisciplinare "Bambi" abuso e maltrattamento, di cui è responsabile dal 2014. Nel 2010 ha conseguito il Master di I livello di Criminologia e Psicologia investigativa presso SSF Rebaudengo. È docente del corso di formazione aziendale ASO OIRM-S.Anna su abuso e maltrattamento all'infanzia ed è stata docente di diversi corsi di formazione su abuso e maltrattamento all'infanzia per operatori sanitari e insegnanti. Ha inoltre partecipato al tavolo di coordinazione progetto "Care and Protect" del Comune di Torino per la coordinazione di Intervento delle Forze dell'Ordine nei casi di abuso su minore.

Paola Di Blasio

Psicologa e Psicoterapeuta, perito del Tribunale, è direttore del Dipartimento di Psicologia dell'Università Cattolica di Milano dal 2014 e professore ordinario di Psicologia dello Sviluppo presso la Facoltà di Psicologia dell'Università Cattolica di Milano dal 1994; è componente del collegio docenti del Dottorato di Ricerca in Psicologia della comunicazione e dei processi linguistici dell'Università Cattolica di Milano dal 1999 e incaricata dell'insegnamento di Psicologia delle relazioni Traumatiche, Laurea Magistrale in Psicologia dello Sviluppo e della Comunicazione dell'Università Cattolica di Milano dal 2009.
È direttore del CRIdee, Centro di Ricerca sulle Dinamiche Evolutive ed Educative, e coordinatore della Laurea Magistrale in Psicologia delle Sviluppo e della Comunicazione.
Dal 1999 è direttore della rivista "Maltrattamento e abuso all'infanzia", Franco Angeli e dal 2000 condirettore con G. Attili della Collana "Psicologia dello sviluppo sociale e clinico", Unicopli, Milano. Dal 2010 è componente del comitato di direzione della rivista Psicologia Clinica dello Sviluppo, Il Mulino, Bologna.
È componente del Comitato Esecutivo dell'Associazione Italiana di Psicologia (AIP) e ha coordinato per l'unità italiana il programma di ricerca Europeo Concerted Actn on the Preention of Child Abuse in Europe promosso dal Comitato Biomedical and Health Research Programme della Comunità Europea.
È componente dei seguenti gruppo di consulenti: Regione Lombardia, per l'elaborazione di Linee guida in materia di trascuratezza, maltrattamenti e abuso sessuale in danno all'infanzia e all'adolescenza; Prefettura di Milano, per la elaborazione di un protocollo d'intesa per l'adozione di interventi coordinati nell'attività di contrasto all'abuso sessuale di minori e nella tutela dei minori vittime di abuso sessuale; Centro Nazionale di Documentazione e Analisi per l'Infanzia e l'Adolescenza, Ministero del Lavoro e delle Politiche Sociali, Istituto degli Innocenti di Firenze, per l'elaborazione di un piano di lavoro per attività informative e di formazione sul tema della prevenzione e della protezione dalla violenza all'infanzia e per la messa a punto di una metodologia di monitoraggio per la raccolta dati nazionale sulla violenza ai danni dell'infanzia.

È socio fondatore nel 1984 del Centro per il Bambino Maltrattato e la Cura della Crisi Familiare (C.b.M.) di Milano, Presidente dello stesso dal 1994 al 2003 e componente del Consiglio di Amministrazione dal 2004 al 2016.

Vittoria Doretti

Laureata in Medicina e Chirurgia e specializzata in Cardiologia e in Anestesia e Rianimazione, è Direttore f.f. UOC Promozione ed Etica della Salute - Direzione Sanitaria, Azienda USL Toscana sud est, Referente Salute e Medicina di Genere Azienda USL Toscana sud est e Referente Scientifico Progetto Regionale Codice Rosa - Regione Toscana. Ha conseguito un Master di II livello in "Bioetica- L'incontro di filosofia, medicina, diritto, biologia" facoltà di Lettere e Filosofia, e un Master Interfacoltà di II Livello in SCIENZE FORENSI (Criminologia-Investigazione-Security-Intelligence) presso La Sapienza Università di Roma abilitata come "Criminologa Esperta in Scienze Forensi. È docente nel percorso formativo regionale (L.R. 259 "Dalla affettività alla maternità e paternità consapevole) che coinvolge oltre 500 operatori consultoriali toscani e fa parte del Gruppo di Coordinamento aziendale (delibera AUSL 9 n° 202 del 21/04/2008) per la "Predisposizione di azioni strategiche per la prevenzione e l'assistenza alle vittime della violenza di genere" e del Tavolo di lavoro Regionale presso la Direzione Regionale all'Assessorato al Diritto alla politiche di Solidarietà sulla Violenza alle Donne. Fra i diversi incarichi ricoperti, dal I° gennaio 2010 dirige la fase sperimentale per il "Progetto Codice Rosa" e nel giugno 2011 il Codice Rosa diviene Progetto Regionale con diffusione alle altre ASL toscane, prima in forma sperimentale (2012) e poi a regime con il nuovo Piano socio sanitario regionale, processo a cui ha collaborato ed è Referente Scientifico e Membro del Gruppo di lavoro Regionale. In seguito alla del.reg. 1260 del 5/12/2016 che ha istituito la rete clinica di codice rosa, è stata nominata Responsabile della Rete Regionale di Codice Rosa.

Paola Facchin

Professore Associato di Pediatria presso l'Università degli Studi di Padova, Responsabile dell'Unità di Epidemiologia e Medicina di Comunità della stessa Università, del Programma Regionale della Patologia in Età Pediatrica, del Coordinamento Regionale delle Malattie Rare e del Centro Regionale per la Diagnostica del Bambino Maltrattato. Docente di Medicina di Comunità nel corso di laurea di Medicina e Chirurgia dell'Università di Padova. Direttore della Scuola Medica di Specializzazione in Medicina di Comunità, Università di Padova, Coordinatrice dell'indirizzo Scienze della Programmazione Sanitaria della Scuola di Dottorato in Medicina dello Sviluppo e Scienze della Programmazione Sanitaria, della stessa Università. Coordinatrice del Master Internazionale Congiunto "International Master on Community Protection and Safety Promotion" con le Università di Stoccolma, Parigi, Porto e Padova. Membro del Consiglio Superiore di Sanità dal 2006 al 2009, di più Commissioni ministeriali e regionali sulla salute e i servizi per l'infanzia ed età evolutiva, sulla sicurezza, sul contrasto del maltrattamento e per la protezione del bambino e adolescente, sulle cure palliative. Coordinatore del Tavolo tecnico interregionale permanente sulle Malattie Rare. Membro dell'Organismo Nazionale di Coordinamento e Monitoraggio per lo sviluppo delle reti di riferimento europee ERN per le malattie rare.
Ha ricoperto e ricopre numerosi incarichi a livello internazionale, tra i quali: Rappresentante per l'Italia presso il Gruppo di esperti sulle malattie rare della Commissione Europea. Membro del Working Group on Health Indicators, European Union Rare Diseases Task Force, DG SANCO European Commission; Membro dei Gruppi di Partner della Joint Action Europea Coding and classification sulla Classificazione e codifica della Malattie Rare per la stesura del nuovo ICD11; Membro del Comité Scientifique Directeur de la Fondation Euromediterranée sur les Droits de l'Enfant et la Securité Humaine, Fondazione supportata dalla Fondazione Hariri (Libano), Casa Reale del Marocco, Presidenza della Repubblica Francese, Unione Europea, con la partecipazione di OMS e UNESCO; Councilor for Education and Training dell'ISPCAN (International Society Prevention Child Abuse and Neglect); Consultant dell'OMS per il tema Human Security, Head Quarter di Ginevra e Regione Est-Mediterraneo; Membro quale contributor dei surveys "World Perspective on Child Abuse", della società ISPCAN (International Society Prevention Child Abuse and Neglect).
Responsabile di numerosi progetti di ricerca finanziati dal CNR, MURST, ISS, OMS, Unione Europea, Ministero della Salute, Regione Veneto e Fondazioni private. Lecturer, Invited Speeker e Chairperson in numerosi convegni e meeting internazionali. Membro del Scientific Board di numerosi Congressi Scientifici internazionali. Autore di circa 350 pubblicazioni edite a stampa.

Sabrina Farci

Psicologa psicoterapeuta, specializzata in psicoterapia dell'età evolutiva, ha una formazione sul maltrattamento e l'abuso e da quasi 20 vent'anni si occupa di questi temi sul versante clinico, terapeutico, forense e della formazione. Ha lavorato dal 1997 al 2005 presso il Centro studi Hansel e Gretel di Moncalieri, dal 2007 collabora in qualità di psicoterapeuta presso la Cooperativa Paradigma, nel 2008 socio fondatore dell'associazione Il Melo, centro studi per la cura del bambino e della famiglia di Torino.

Maria Grazia Foschino Barbaro

Psicologa-psicoterapeuta, dal 1983 lavora presso l'Ospedale Pediatrico Giovanni XXIII di Bari e dal 1999 è Responsabile del Servizio di Psicologia. Nel 2000 costituisce GIADA (Gruppo Interdisciplinare Assistenza Donne e bambini Abusati) per la diagnosi e l'intervento precoce delle condizioni di abuso infantile e dal 2009 ne è la responsabile scientifica. Dirige la scuola di Psicoterapia Cognitiva (AIPC, Associazione Italiana di Psicoterapia Cognitiva) di Bari e svolge da anni attività di formazione a livello regionale e nazionale sul tema della violenza all'infanzia e del disagio infantile. È componente del Consiglio Direttivo CISMAI, al cui interno si è occupata prevalentemente delle attività di formazione. Recentemente ha contribuito alla redazione delle Linee guida della Regione Puglia in materia di maltrattamento ai danni delle persone di minore età. Si occupa prevalentemente di: special needs adoptions, disturbi traumatici dello sviluppo, psicopatologia dell'infanzia e dell'adolescenza, cure palliative pediatriche, sostegno alla genitorialità, psicoterapia. Autrice di numerosi articoli e libri sul maltrattamento infantile, ha vinto diversi premi scientifici nazionali.

Alessandra Kustermann

Dirigente medico specialista in ostetricia e ginecologia, è direttore della Ginecologia e Ostetricia dell'U.O.C. PS, accettazione ostetrico-ginecologica e Soccorso Violenza Sessuale e Domestica – Fondazione Irccs Ca' Granda Ospedale Maggiore Policlinico di Milano. In precedenza è stata Responsabile dell'Unità Semplice di Diagnosi Prenatale e del Soccorso Violenza Sessuale e Domestica Fondazione IRCCS Ospedale Maggiore Policlinico, Mangiagalli e Regina Elena. È stata membro del Comitato Scientifico contro "la violenza sulle donne" dell'ordine degli avvocati di Milano (2015-2016), del "Tavolo Regionale Antiviolenza" per Regione Lombardia per il Soccorso Violenza Sessuale e Domestica (2015) e del comitato scientifico per "Premio per tesi di laurea e dottorato sul tema del contrasto alla violenza contro le donne" presso la segreteria della Delegazione CDE - Camera dei Deputati (2015). Dal 2012 è membro del "Gruppo di approfondimento tecnico (GAT) di Medicina di genere" per Regione Lombardia per il Pronto Soccorso Ostetrico/Ginecologico. Dal 2006 al 2009 è stata membro del Consiglio Superiore di Sanità. È stata relatrice o docente a oltre 350 congressi scientifici e corsi di formazione nazionali e internazionali sui temi di diagnosi prenatale, patologia della gravidanza, medicina di genere, violenza sessuale e domestica e ha oltre 100 pubblicazioni sui temi della diagnosi prenatale, della patologia della gravidanza, della violenza sessuale e domestica. Ha ricevuto i seguenti premi e riconoscimenti: nel 2016 premiazione Rosa Camuna della Regione Lombardia per il Soccorso Violenza Sessuale e Domestica, Fondazione IRCCS CA' Granda ospedale Maggiore Policlinico di Milano; nel 2010 Medaglia d'oro del Comune di Milano consegnata in occasione della festività di Sant'Ambrogio; nel 2008 Premio "SIGILLO LONGOBARDO" dal Consiglio Regionale della Lombardia; nel 2007 Medaglia d'oro di Riconoscenza della Provincia di Milano al Soccorso Violenza Sessuale della Clinica Mangiagalli, Fondazione IRCCS Ospedale Maggiore Policlinico, Mangiagalli e Regina Elena.

Melissa Rosa Rizzotto

Medico chirurgo, specialista in Medicina di Comunità e Dottore di Ricerca in Medicina dello Sviluppo e Scienze della Programmazione, presso l'Università degli Studi di Padova. Dirigente medico presso l'Azienda Ospedaliera di Padova, Coordinamento Malattie Rare; medico referente del Centro Regionale per la Diagnostica del Bambino Maltrattato della stessa Azienda. Membro del Gruppo di lavoro per l'abuso e il maltrattamento dell'infanzia che ha prodotto il documento "L'abuso sessuale nei bambini prepuberi. Requisiti e raccomandazioni per una valutazione appropriata", patrocinato dal Ministero per la Salute. Membro del Comitato Tecnico Scientifico dell'Indagine promossa da Terre des Hommes "Maltrattamento e abuso sui bambini: una questione di salute pubblica" il cui dossier è stato presentato nel novembre 2015, alla Biblioteca Giovanni Spadolini, Senato della Repubblica a Roma.
Dal 2004, Tutor ai corsi curricolari per la facoltà di Medicina e Chirurgia dell'Università degli Studi di Padova "Diagnosticare il maltrattamento ai minori: dalla teoria alla pratica" e "La famiglia maltrattante e i bambini maltrattati". Responsabile scientifico di numerosi corsi di formazione per personale sanitario (medici, infermieri, altre professioni sanitarie) in tema di maltrattamento e abuso. Junior e Senior researcher in progetti di ricerca nazionali (maltrattamento, paralisi cerebrali infantili, organizzazione delle scuole di specializzazione di Medicina (MIUR)). Ha partecipato a convegni scientifici nazionali e internazionali in qualità di relatore (ISPCAN, AHT, International Society on Brain Injury).
Autore di più di 100 pubblicazioni edite a stampa.

Giovanni Visci

Medico chirurgo, specializzato in Clinica Pediatrica e in Neuropsichiatria Infantile. Ha lavorato come pediatra ospedaliero e ha diretto l'UOC di Pediatria dell'Ospedale di Pescara e il Dipartimento Materno – infantile della ASL di Pescara fino al 2011. Attualmente lavora presso l'Associazione Focolare di Maria Regina onlus Scerne di Pineto (TE), è consulente scientifico dei progetti-obiettivo europei Daphne contro l'abuso sui minori (INTOVIAN e SPEAK-UP) e contro la violenza

alle donne e lo stalking (Progetti nazionali SUPPORT, ADRIA e PARES); ha diretto per anni il "Corso di formazione per operatori di contrasto alla violenza contro le donne e i bambini"; docente di corsi di formazione e aggiornamento professionale per pediatri e personale sanitario. È coordinatore dell'équipe terapeutica del Centro Primavera.
Collabora in qualità di tecnico con l'Assessorato alla Sanità della Regione Abruzzo dove ha partecipato a diverse commissioni tecnico–scientifiche, tra le quali quella che ha messo a punto il programma vaccinale regionale. Ha collaborato con la stesura del capitolo "La rilevazione precoce del maltrattamento infantile in pronto soccorso" al volume "La prevenzione del maltrattamento all'infanzia" pubblicato nel 2017 da F. Angeli editore. Ha pubblicato diversi lavori di argomento pediatrico, alla stesura di un volume sulla "Programmazione Sanitaria dell'assistenza pediatrica regionale" (1993) e di un volume su "Infanzia maltrattata" (G.P. Di Nicola, autrice) pubblicato da Edizioni Paoline nel 2001.

Gian Vincenzo Zuccotti

Laureato in Medicina e Chirurgia, specializzato in Pediatria, in Neonatologia-Patologia Neonatale e in Malattie Infettive, è Direttore della Clinica Pediatrica dell'Università di Milano, Ospedale dei Bambini V. Buzzi, Direttore del Dipartimento Pediatrico Ospedale dei Bambini V. Buzzi e Direttore ad interim della Clinica Pediatrica Ospedale Luigi Sacco. Prorettore ai rapporti con le Istituzioni Sanitarie. Ha ricoperto il ruolo di presidente della Società Italiana di Pediatria (SIP) lombarda.
È stato componente AIFA, Working Group dedicato all'età pediatrica, membro del Ministero della Salute per la Commissione Unica per la Dietetica e la Nutrizione, membro della Commissione Nazionale AIDS e membro della Commissione Nazionale per la Sicurezza Alimentare dal 2011.

Ambulatorio BAMBI

L'Ambulatorio BAMBI su abusi e maltrattamento sull'infanzia è nato nel 2002 presso l'Ospedale Infantile Regina Margherita di Torino. È stato fondato da Fulvia Negro, pediatra del pronto soccorso, per assistere i bambini vittime di maltrattamento e abuso. Presso il servizio BAMBI lavorano due pediatri che afferiscono al pronto soccorso e un medico legale, una psicologa dedicata e la collaborazione del servizio di psicologia ospedaliero, infermieri pediatrici; BAMBI collabora strettamente con il servizio di Assistenza Sociale e la Direzione Sanitaria; in caso di necessità può usufruire del servizio di NPI Ospedaliero.
Il servizio è operativo 24h/24h. Durante il giorno dispone di un medico di guardia attivo, quindi si avvale degli infermieri dedicati che sono disponibili anche in reperibilità 24h/24h e dell'équipe dei medici di pronto soccorso che sono comunque stati formati a gestire queste situazioni di emergenza. Dall'inizio delle attività nel 2002 in BAMBI sono stati visitati circa 1.900 bambini e la maggior parte di loro è stata segnalata all'Autorità Giudiziaria. I bambini che giungono all'osservazione di BAMBI sono inviati direttamente dal pronto soccorso, da altri ospedali, dai medici di base, dalle Forze di Polizia o direttamente dall'Autorità Giudiziaria.

http://www.cittadellasalute.to.it/?option=com_content&view=article&id=3413:bambi-ambulatorio&catid=141

Associazione Culturale Pediatri-ACP

L'Associazione Culturale Pediatri (ACP) è una libera associazione, costituita a Milano il 5/9/1974, che ha come finalità l'aggiornamento, la formazione professionale e la diffusione della cultura dell'età evolutiva.
Raccoglie 1.500 pediatri italiani. La composizione percentuale dei soci ACP vede una prevalenza di pediatri di famiglia (circa il 65%), accanto a pediatri ospedalieri, universitari e di comunità.
Gli iscritti sono riuniti in gruppi affiliati distribuiti nelle diverse realtà regionali.
ACP partecipa a tavoli istituzionali e gruppi di lavoro multidisciplinari.
Si è dotata di un codice etico di comportamento che investe sia i singoli pediatri sia l'Associazione stessa. Dal 1994 pubblica Quaderni acp, rivista di politica sanitaria e sociale dell'infanzia e di aggiornamento e strumenti didattici di ausilio per il pediatra nella risoluzione dei problemi clinici.
La rivista viene pubblicata senza introiti pubblicitari. I gruppi locali ACP svolgono, sia autonomamente sia in collaborazione con l'Associazione Nazionale, attività di formazione, ricerca, educazione sanitaria, definizione di protocolli diagnostico-terapeutici, valutazione di qualità delle cure, supporto a programmi di cooperazione nazionale e internazionale.

http://www.acp.it

Centro Regionale per la Diagnostica del Bambino Maltrattato - Unità di Crisi per Bambini e Famiglie

La storia del Centro Regionale per la Diagnostica del Bambino Maltrattato (CRDBM)–Unità di Crisi per Bambini e Famiglie (Azienda Ospedaliera di Padova, Dipartimento per la Salute della Donna e del Bambino) inizia nel 1986, quando viene creata la prima Unità di Crisi per Bambini Maltrattati, all'interno del Dipartimento di Pediatria.
Il primo gruppo di lavoro è formato da 2 pediatri, 1 neuropsichiatra infantile e 1 medico legale che, in stretta collaborazione con i colleghi di altri Reparti del Dipartimento e dell'Ospedale, forniscono consulenza e supporto nei casi in cui si sospetti

una forma di maltrattamento o abuso ai minori. Tale prima Unità, nel corso degli anni, è stata ampliata, arricchita di specializzazioni nella delicata materia e il personale dedicato ha guadagnato riconoscimento a livello nazionale e internazionale.
Dall'organizzazione del congresso dell'ISPCAN nel 1993 ad Abano (congresso durante il quale si costituisce in Italia il CISMAI), all'incarico di occuparsi, per l'ufficio di Copenaghen della Regione Europea dell'Organizzazione Mondiale della Sanità (OMS), del tema della protezione del bambino nei 57 Paesi della Regione nel 1996, e in seguito alla realizzazione a Padova del First Meeting On Strategies for Child Protection nel 1998, in cui si comincia ad affrontare il maltrattamento come priorità di sanità pubblica. Le politiche definite nel corso di tali incontri vengono assunte dall'Head Quarter OMS di Ginevra per le linee guida mondiali in tema di maltrattamento e di violenza. All'Unità di Crisi di Padova viene conferito il riconoscimento di Best Practice di riferimento per l'approccio clinico medico ai bambini maltrattati e riceve l'incarico di predisporre l'istruttoria tecnica per la realizzazione della World Consultation on Child Abuse Prevention nel 1999, che ha ridefinito la nosologia delle sindromi da maltrattamento.
Con l'aumentare progressivo dell'attività e sulla base dell'esperienza nazionale e internazionale maturata, a partire dal 2000 e negli anni a seguire viene istituito con apposita normativa regionale e poi implementato e avviato un servizio specifico, l'attuale Centro per la Diagnostica del Bambino Maltrattato, che viene dotato di personale specializzato e struttura dedicata, per la diagnosi e cura delle vittime di maltrattamento, all'interno di una struttura ospedaliera di III livello.
Unitamente all'attività clinica, sono stati avviati e implementati specifici percorsi sia di formazione universitaria a livello internazionale e locale, sia di formazione continua per i professionisti sanitari in diverse regioni italiane.
Il Centro è dotato di una struttura di due piani dedicata, all'interno del perimetro dell'Azienda Ospedaliera di Padova, con ambulatori e stanze di degenza per attività di outpatient e di inpatient. Gestisce 3 letti di degenza ordinaria specifica per maltrattamento e 1 letto di day-hospital (al di fuori delle degenze pediatriche), oltre che tutta l'attività ambulatoriale e di consulenza in loco e a distanza per la rete ospedaliera regionale e sovraregionale. Il funzionamento della rete di assistenza regionale è regolato da apposite delibere regionali, che definiscono la tipologia di prestazioni erogabili, la modalità di esecuzione; livelli di responsabilità e compensi tariffari. Svolge attività clinica di diagnosi di sospetto maltrattamento e di presa in carico delle vittime. Il personale operante è in parte appartenente a un'équipe dedicata, in parte ad altri reparti o servizi dell'ospedale, ma si è nel tempo specializzato nella materia.
I casi provengono da Reparti di pronto soccorso o da altri reparti ospedalieri dell'Azienda Ospedaliera di Padova, della rete ospedaliera regionale ed extraregionale, Servizi per minori e famiglia del Distretto Territoriale dell'Azienda Sanitaria di residenza, Medico di Medicina Generale, Pediatra di Libera Scelta, Servizi Sociali dei Comuni, Servizi Scolastici, Forze dell'Ordine, Autorità Giudiziaria (Tribunale Ordinario e/o Tribunale per i Minorenni), un membro della rete familiare (accesso diretto con preselezione dei casi).
Presso il Centro vengono svolti progetti e attività di ricerca epidemiologici sulla frequenza delle forme di maltrattamento e sulle conseguenze a breve, medio e lungo termine, oltre che ricerche sperimentali sullo sviluppo cerebrale e dei tratti di sostanza bianca e sulla regolazione dell'asse ipotalamo-ipofisi-corticosurrene e la catena dello stress. Vengono svolti corsi di formazione pre-laurea (esiste dal 2004 un corso specifico sul maltrattamento nel piano di studi degli studenti di Medicina e Chirurgia con 4CFU) e post-laurea nonché di formazione continua per le professioni sanitarie.

http://www.sdb.unipd.it/centro-regionale-la-diagnostica-del-bambino-maltrattato

Codice Rosa

Il Codice Rosa è un percorso dedicato di accesso e accoglienza al pronto soccorso per tutte le vittime di violenza: donne, minori, anziani, omosessuali. Secondo un'ottica Gender Sensitive. Viene assegnato insieme a quello di gravità (che non sostituisce) e la sua assegnazione attiva il gruppo operativo formato dal personale sanitario e non (medici, infermieri, assistenti sociali, psicologi, Centro antiviolenza, etc.) e dalle forze dell'ordine. Vengono prestate immediatamente cure mediche e supporto psicologico, nel rispetto della riservatezza, e avviata se necessario una presa in carico territoriale che coinvolge assistenti sociali, consultorio e centro antiviolenza, vi è inoltre un'azione sinergica con la Procura della Repubblica e le forze dell'ordine, per avviare indagini o monitorare situazioni a rischio.
Nato nel 2010 nell' ex Azienda USL 9 di Grosseto, si è progressivamente esteso ad altre aziende sanitarie, fino al completamento della diffusione a livello regionale da gennaio 2014.
Lo scopo principale di Codice Rosa è il coordinamento e la messa in rete delle istituzioni e delle competenze in gioco per garantire una risposta efficace alle vittime fin dal pronto soccorso. Vi sono inoltre collaborazioni per la prevenzione e il contrasto alla violenza.
Dal 2012 (anno in cui è iniziata la sperimentazione di Codice Rosa in cinque Aziende sanitarie, di Arezzo, Lucca, Prato, Viareggio e Grosseto) al primo semestre del 2016 sono stati registrati oltre 12.000 accessi in pronto soccorso, di cui poco più di 1.600 bambini[8].

http://www.regione.toscana.it/-/codice-rosa

Cooperativa Paradigma

Cooperativa Paradigma onlus di Torino, dal 1987, sviluppa sia modelli scientifici di intervento sia progetti sociali a favore di persone disabili e di minori. Il costante sviluppo parallelo delle due prospettive di lavoro garantisce la promozione di una cultura sociale attenta a fornire risposte puntuali, soddisfacenti e continuative alle persone di cui si prende cura. Tre sono le aree sviluppate in quasi 30 anni di attività: tutela dei minori, che con il progetto Casa Base, si occupa di bambini e

adolescenti che hanno subìto maltrattamenti nell'ambito familiare con due comunità di accoglienza per minori, un'équipe clinica e terapeutica che si occupa della presa in carico psicologica dei bambini e della valutazione di recuperabilità dei genitori; disabilità che racchiude i servizi dedicati alle persone con disabilità e le loro famiglie e che ha sviluppato il progetto "La Fabbrica del Chinino" e formazione che tramite l'Agenzia Riflessi promuove percorsi formativi per medici, psicologi e operatori sociali.

http://www.cooperativaparadigma.org/

Coordinamento Italiano dei Servizi contro il Maltrattamento e l'Abuso all'Infanzia-CISMAI

Il Coordinamento Italiano dei Servizi contro il Maltrattamento e l'Abuso all'Infanzia (CISMAI) è stato costituito nel 1993 su iniziativa di alcuni centri attivi in Italia nella tutela e cura dei minori. Si tratta di un'associazione con caratteristiche di pluridisciplinarità e di riflessione teorica a partire dalla pratica dell'esperienza sul campo. L'obiettivo è "costituire una sede permanente di carattere culturale e formativo nell'ambito delle problematiche inerenti le attività di prevenzione e trattamento della violenza contro i minori, con particolare riguardo all'abuso intrafamiliare" (art.1 Statuto).
Le attività del CISMAI comprendono il coordinamento e lo scambio fra centri, servizi pubblici e privati che lavorano nella prevenzione e trattamento e abuso contro i minori; l'identificazione di linee guida per la presa in carico e la definizione di protocolli di intervento, la promozione di contatti e scambi con forze politiche ed istituzionali per la segnalazione di priorità di azione; la promozione di convegni, seminari, dibattiti, ricerche, pubblicazioni, corsi di formazione; il contatto e la collaborazione con Associazioni nazionali e internazionali impegnate nella difesa dei diritti dei bambini e delle bambine.
Fanno parte del CISMAI oltre 60 centri e servizi del settore pubblico e del terzo settore e oltre 70 professionisti soci individuali.
Il CISMAI partecipa a organismi per l'indirizzo nazionale della politica sull'infanzia, quali il primo Osservatorio Nazionale Minori, la Commissione nazionale contro gli Abusi all'Infanzia, il Comitato ex art. 17 L. 269/98 sorto per coordinare le attività contro lo sfruttamento e gli abusi sessuali sui minori nel biennio 1999-2000; ha partecipato ai lavori dell'Osservatorio Nazionale Infanzia e a riunioni di consultazione e a progetti del Centro Nazionale di Documentazione sull'Infanzia e l'Adolescenza e con l'Istituto degli Innocenti di Firenze: è stato consulente della Regione Abruzzo per le linee guida regionali su abuso e maltrattamento all'infanzia; fa parte del PIDIDA – Per I Diritti dell'Infanzia e Dell'Adolescenza (coordinamento di associazioni curato dall'UNICEF); partecipa al Gruppo di lavoro per la Convenzione sui Diritti dell'Infanzia e dell'Adolescenza, coordinato da Save the Children; è socio del Child Rights Information Network (CRIN); è partner nazionale dell'International Society Prevention Child Abuse and Neglect (ISPCAN).

http://cismai.it/

Gruppo Interdisciplinare Assistenza Donne e bambini Abusati - GIADA

GIADA nasce nel 2000 come unità funzionale trasversale all'Unità Operativa di Ostetricia e Ginecologia dell'Ospedale "Di Venere" e al Servizio di Psicologia dell'Ospedale Pediatrico "Giovanni XXIII". Nel 2005 si è sviluppato trasversalmente a tutte le unità operative dell'Ospedale Pediatrico e ad alcune Unità Operative del Policlinico (Neonatologia e Terapia Intensiva, Ginecologia e Ostetricia, Medicina Legale e Pronto Soccorso).
Nel 2009, la Giunta regionale ha adottato GIADA inserendolo fra gli obiettivi strategici della Regione finanziando un'équipe dedicata, al fine di potenziare le attività di prevenzione, diagnosi precoce e cura dei bambini/adolescenti e famiglie in condizioni di rischio e/o di violenza, oltre che per mettere in atto un'esperienza pilota di rete regionale interdisciplinare e interistituzionale sanitaria in grado di fronteggiare il fenomeno della violenza sui minorenni.
Le attività di GIADA riguardano: assistenza psicologica e sociale, pediatrica e specialistica delle condizioni di rischio e di violenza sui minorenni; osservatorio ospedaliero sullo stress interpersonale acuto e cronico; accompagnamento giudiziario; consulto specialistico, anche a distanza, agli operatori dell'area materno–infantile su specifici e qualificati quesiti critici; ricerca e formazione di base e specialistica, anche con AUDIT clinici; attività di prevenzione dei pericoli per la salute associati alle violenze online; campagne di sensibilizzazione sui diritti dell'infanzia.
L'accesso all'assistenza può avvenire in condizione di: urgenza-emergenza, ricovero programmato e regime ambulatoriale, anche su invio dei servizi territoriali (sociali e sanitari) o dell'autorità giudiziaria.
Dal 2013 condivide un protocollo operativo con la Procura Ordinaria e Minorile di Bari e con le Forze dell'Ordine per la raccolta di sommarie informazioni (L. 172/2012) e assicura assistenza psicologica nel corso dell'escussione delle vittime e dei testimoni di minore età; tale azione ha permesso di arricchire la collaborazione già avviata con il Tribunale per i Minorenni di Bari per la presa in carico dei minori e delle loro famiglie.
Dal 2013 nell'ambito del Piano Strategico Regionale per la Promozione della Salute nelle Scuole è stato strutturato un Progetto di formazione e prevenzione sulle tematiche della violenza sessuale online, cyber bullismo, adescamento online.
Le azioni progettuali svolte in collaborazione con i referenti regionali GIADA e la Polizia Postale, sono rivolte alle scuole della Regione e coinvolgono insegnanti, alunni e genitori.
Dal 2016 GIADA è Centro di Riferimento Regionale ("Linee guida regionali in materia di maltrattamento e violenza nei confronti delle persone minori per età" D.G.R. n. 1878 del 30.11.2016).
GIADA è inserito all'interno di una rete regionale di servizi sanitari ospedalieri e territoriali, di servizi sociali, di servizi scolastici e servizi del privato sociale.

http://www.giadainfanzia.it/

Rete Interaziendale Milano Materno Infantile-RIMMI

La Rete Interaziendale Milano Materno Infantile (RIMMI) è formata da tutte le strutture, i servizi e le risorse professionali con attività significativa di prevenzione e assistenza nell'area materno-infantile di Milano. Si propone di progettare e sperimentare una modalità organizzativa per integrare le risorse nell'assistenza materno infantile presenti nella città di Milano. La mission è "sviluppare un'offerta di servizi sanitari e sociosanitari attraverso un'organizzazione a rete in grado di coinvolgere tutte le componenti del processo assistenziale, in risposta ai bisogni delle donne, delle madri, dei neonati, dei bambini e degli adolescenti (età pediatrica da 0 a 18 anni)". La RIMMI coinvolge i servizi del territorio e i centri specialistici e vi partecipano: ATS Città Metropolitana di Milano; ASST (Aziende Socio Sanitarie Territoriali) e IRCCS (Istituti di Ricovero e Cura a Carattere Scientifico): ASST Fatebenefratelli Sacco, ASST Pini/Cto; ASST Grande ospedale metropolitano Niguarda, ASST Santi Paolo e Carlo, Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Fondazione IRCCS Istituto Nazionale dei Tumori, Fondazione IRCCS Istituto Neurologico Carlo Besta. Un'altra componete della RIMMI è rappresentata dagli ambulatori dei pediatri di libera scelta e dei medici di medicina generale, con pazienti da 0 a 18 anni, e collaborano con collegamenti funzionali e la condivisione di Percorsi diagnostico terapeutici e assistenziali.

http://www.regioni.it/dalleregioni/2016/09/22/lombardia-rete-interaziendale-milano-materna-infantile-gallera-diventera-modello-per-tutta-la-regione-478248/

Soccorso Violenza Sessuale e Domestica-SVSeD

Il centro Soccorso Violenza Sessuale e Domestica (SVSeD) di Milano è attivo dal 1996 presso la Fondazione IRRCS Ca' Granda Ospedale Maggiore Policlinico (Clinica Ostetrico Ginecologica, "Luigi Mangiagalli"). SVSeD è il primo centro antiviolenza pubblico in Italia e dal 1998 è centro di riferimento regionale per i problemi della violenza alle donne e ai minori. Il servizio offre supporto sanitario, psicologico e sociale a favore delle persone, di qualunque età, che hanno subito violenza sessuale e domestica. SVSeD è un centro antiviolenza pubblico dove chi subisce violenza trova soccorso, comprensione e aiuto in emergenza e viene seguito nel lungo periodo da un'équipe multidisciplinare composta da operatori esperti. Offre assistenza sanitaria 24/24h per 365 gg/anno, accoglienza e informazioni da parte del personale sanitario e psicosociale.
L'équipe multidisciplinare del Centro è composta da ginecologhe, medici legali, chirurghi pediatrici, psicologhe, psicoterapeute, assistenti sociali, infermiere, ostetriche (tutti gli specialisti coinvolti hanno una specifica esperienza nella diagnosi e nella terapia delle vittime di violenza adulte e minori).
Grazie all'ausilio degli avvocati penalisti e civilisti di SVS Donna Aiuta Donna onlus, SVSeD è in grado di garantire a tutte le vittime, che non abbiano già consultato un avvocato, una consulenza e un'assistenza legale gratuita. I minori che arrivano a SVSeD, specialmente se la violenza sessuale e il maltrattamento sono avvenuti in ambito familiare, hanno bisogno di un percorso psicosociale dedicato, che spesso richiede anche il successivo coinvolgimento dei servizi territoriali in base alle decisioni del Tribunale per i Minorenni. Anche per tale motivo i rapporti con Forze dell'Ordine, Polizia Locale e Procura presso il Tribunale Ordinario e presso il Tribunale per i Minorenni sono tenuti costantemente dai collaboratori del Centro.
Complessivamente, dal 1996 a tutto il 2015, SVSeD ha offerto assistenza a 7.815 vittime di violenza sessuale e domestica.
Nel 2016 le vittime di violenza assistite dal personale SVSeD sono state 1.037.

http://www.policlinico.mi.it/DiCosaHaiBisogno/SVSeD.html

Foto: Luca Muzi per Save the Children

Note

[1.] Si ringraziano: Federica Zanetto, presidente ACP e i pediatri Massimo Farneti, Annamaria Falasconi, Raffaella Schirò, Beppe Primavera, Rosa Maranto, Sandro Bianchi, Marco Debernardi, Marisa Bechaz, Enrica Gerace, Maria Grazia Fois.

[2.] http://www.saluter.it/news/regione/maltrattamento-e-abuso-sui-minori-le-raccomandazioni-per-lassistenza-e-il-vdeo-del convegno-dell1-ottobre

[3.] Ordine degli Psicologi del Lazio – Linee Guida per le perizie in caso di abuso sui minori. 2008 (http://cismai.it/ordine-degli-psi-cologi-del-lazio-linee-guida-per-le-perizie-in-caso-di-abuso-sui-minori/); Procedura aziendale sulla violenza sui minori. 2016 (http://www.scamilloforlanini.rm.it/html/incontri_pediatrici/urg_ped_violenza_minori.pdf); Protocollo sull'ascolto del minore – Tribunale per i minorenni di Roma ed Ordine degli Avvocati di Roma Gli intervenuti. 2007 (http://cismai.it/protocollo-sullascolto-del-minore-tribunale-per-i-minorenni-di-roma-ed-ordine-degli-avvocati-di-roma-gli-intervenuti/); Atti della Giunta Regionale e degli Assessori Deliberazione 19 novembre 2013, n. 395 Approvazione modello di "Protocollo per l'adozione di interventi coordinati di prevenzione e intervento nei casi di maltrattamento e abuso all'infanzia "28/11/2013 - BOLLETTINO UFFICIALE DELLA REGIONE LAZIO - N. 98 (http://www.oaslazio.it/doc/DGR_nov_2013_protocollo.pdf); Piano regionale di interventi per il contrasto degli abusi e maltrattamento a danno dei minori (http://www.socialelazio.it/binary/prtl_socialelazio/tbl_news/PSR_Piano_contrasto_abusi_e_maltrattamenti.pdf).

[4.] *Identificare e gestire i casi di maltrattamento: il ruolo del pediatra*, Quaderni ACP 2011; 18(6): 276; *L'ascolto del minore, parte offesa di abuso sessuale*, Quaderni ACP 2012; 19(5): 227-230; *Prevalenza e rischio di violenza verso i bambini con disabilità*, Quaderni ACP 2014; 21(2): 69; *L'abuso sessuale, qualche appunto per il pediatra delle cure primarie*, Quaderni ACP 2014; 21(2): 70-73; *Il maltrattamento fisico: quali conoscenze per il pediatra*, Quaderni ACP 2014; 21(5): 198-204; *Nati per non essere maltrattati,* Quaderni ACP 2016; 4: 169-70; *Maltrattamento e abuso sul minore. Raccomandazioni per la valutazione clinica e medico-legale,* Regione Emilia Romagna; *Fratture e abuso. Raccomandazioni per il percorso diagnostico*, Regione Emilia Romagna; Quaderni ACP 2016; 23(2):d.2.

[5.] http://terredeshommes.it/comunicati/rima-indagine-di-terre-des-hommes-sbam-su-medici-e-pediatri-6-su-10-sospettano maltrattamenti-a-danno-dei-minori-ma-1-su-2-non-li-denuncia/.

[6.] Deliberazione G.Reg. Aut.VdA n.1114 del 27/04/2007; Documento PROCEDURA PER LA SEGNALAZIONE NELLE SITUAZIONI DI SOSPETTO MALTRATTAMENTO O VIOLENZA SUL MINORE a cura del Gruppo di Coordinamento Interistituzionale sul maltrattamento e l'abuso. Gennaio 2008 aggiornato a dicembre 2016; *Documento Parole, emozioni e… ascoltiamo i bambini. Suggerimenti e indicazioni per insegnanti e per chi lavora con bambini e adolescenti,* prodotto da operatori educativi scolastici ed operatori socio-sanitari del gruppo di Coordinamento Interistituzionale su Maltrattamento e Abuso, 2011.

[7.] www.regione.vda.it/servsociali/minori/attivita_i/gruppo_maltrattamento_e_abuso_i.asp

[8.] http://www.regione.toscana.it/zh_TW/web/toscana-notizie/dettaglio-notizia/-/asset_publisher/mk54xJn9fxJF/content/codice-rosa-dal-2012-oltre-12-000-accessi-nei-pronto-soccorso-della-toscana;jsessionid=38E1F659E372F7F0DB9C44A-FE96C5972.web-rt-as01-p2

GLOSSARIO DEGLI ACRONIMI

ACP: Associazione Culturale Pediatri

AIPC: Associazione Italiana di Psicoterapia Cognitiva

ANCI: Associazione nazionale Comuni Italiani

AOPI: Associazione ospedali Pediatrici Italiani

CBM: Centro per il bambino maltrattato

CISMAI: Coordinamento Italiano Servizi Maltrattamento all'Infanzia

CRDBM: Centro Regionale per la Diagnostica del Bambino Maltrattato, Padova

DiRe: Donne in rete contro la violenza

EMUR: flussi Emergenza Urgenza (schede)

FIMP: Federazione Italiana Medici Pediatri

GIADA: Gruppo Interdisciplinare Assistenza Donne e bambini Abusati

ISS: Istituto Superiore di Sanità

ISTAT: Istituto Nazionale di Statistica

IChilMa: Italian Child Maltreatment study group

NPI: neuropsichiatria infantile

OMS: Organizzazione Mondiale della Sanità (World Health Organization, WHO)

O.N.Da: Osservatorio Nazionale sulla salute della Donna

O.R.A.: Osservatorio Regionale Antiviolenza

PIUMA: Progetto Integrato Unità Multidisciplinare Abuso

PS: pronto soccorso

RIMMI: la Rete Interaziendale Milanese Materno Infantile

SBAM: Sportello Bambino Adolescente Maltrattato

SDO: Schede di Dimissione Ospedaliera

SerT: Servizi per le Tossicodipendenze

SICuPP: Società Italiana di Cure Primarie Pediatriche

SIMG: Società Italiana di Medicina Generale e delle Cure Primarie

SIN: Società Italiana di Neonatologia

SIP: Società Italiana di Pediatria

SVSeD: Soccorso Violenza Sessuale e Domestica

WHO: World Health Organization (Organizzazione Mondiale della Sanità, OMS)

Save the Children
è la più importante organizzazione internazionale indipendente, dedicata dal 1919 a salvare i bambini in pericolo e a promuovere i loro diritti, subito e ovunque, con coraggio, passione, efficacia e competenza.

Opera in oltre 120 Paesi per garantire a tutti i bambini salute, protezione, educazione, sviluppo economico, sicurezza alimentare e promuovere la partecipazione di tutti i minori. Inoltre risponde alle emergenze causate da conflitti o catastrofi naturali.
Save the Children è stata costituita in Italia alla fine del 1998 come Onlus e ha iniziato le sue attività nel 1999. Oggi è una Ong riconosciuta dal Ministero degli Affari Esteri.

Oltre all'importante impegno a livello internazionale Save the Children Italia sviluppa programmi che hanno l'obiettivo di migliorare la vita dei bambini e delle bambine che vivono sul nostro territorio con interventi nell'ambito della lotta alla povertà minorile, della protezione dei minori a rischio di sfruttamento (come i minori stranieri non accompagnati), dell'educazione e della scuola, dell'uso sicuro delle nuove tecnologie, della tutela dei minori nelle emergenze.

Save the Children

Save the Children Italia Onlus
Via Volturno 58 -00185 Roma
tel + 39 06 480 70 01
fax +39 06 480 70 039
info.italia@savethechildren.org

www.savethechildren.it

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Trauma and trauma care in Europe

Ingo Schäfer[a], Manoëlle Hopchet[b], Naomi Vandamme[c], Dean Ajdukovic[d], Wissam El-Hage[e], Laurine Egreteau[f], Jana Darejan Javakhishvili[g], Nino Makhashvili[h], Astrid Lampe[i], Vittoria Ardino[j], Evaldas Kazlauskas[k], Joanne Mouthaan[l], Marit Sijbrandij[*m], Małgorzata Dragan[n], Maja Lis-Turlejska[o], Margarida Figueiredo-Braga[p,q], Luísa Sales[r], Filip Arnberg[s], Tetiana Nazarenko[t], Natalia Nalyvaiko[u], Cherie Armour[v] and Dominic Murphy[w]

[a]Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany; [b]Belgian Institute for Psychotraumatology, Brussels, Belgium; [c]Belgian Institute for Psychotraumatology, Trauma Center Limburg, Hasselt, Belgium; [d]Department of Psychology, Faculty of Humanities and Social Sciences, University of Zagreb, Zagreb, Croatia; [e]UMR 1253, iBrain, Université de Tours, CHRU de Tours, Inserm, Tours, France; [f]Laurine Egreteau, CHRU de Tours, Clinique Psychiatrique Universitaire, Tours, France; [g]Institute of Addiction Studies, Faculty of Arts and Science, ILia State University, Tbilisi, Georgia; [h]Business School, ILia State University, Tblisi, Georgia; [i]Department of Medical Psychology and Psychotherapy, University Medical Hospital Innsbruck, Innsbruck, Austria; [j]Dipartimento di Scienze dell'Uomo, Urbino University, Urbino, Italy; [k]Center for Psychotraumatology, Institute of Psychology, Vilnius University, Vilnius, Lithuania; [l]Department Clinical Psychology, Institute of Psychology, Leiden University, Leiden, The Netherlands; [m]Faculty of Behavioural and Movement Sciences, VU University Amsterdam, Amsterdam, The Netherlands; [n]Faculty of Psychology, University of Warsaw, Warsaw, Poland; [o]Faculty of Psychology, SWPS University of Social Sciences and Humanities, Warsaw, Poland; [p]Faculty of Medicine, University of Porto, Porto, Portugal; [q]Centre for Social Studies (CES) of the University of Coimbra, Coimbra, Portugal; [r]Department of Psychiatry of the Military Hospital of Coimbra, Centre of Trauma (CES) of the University of Coimbra, Coimbra, Portugal; [s]National Centre for Disaster Psychiatry, Department of Neuroscience, Psychiatry, Uppsala University, Uppsala, Sweden; [t]Non-Governmental organization 'Ukrainian Society of Overcoming the Consequences of Traumatic Events' (USOCTE), Kyiv, Ukraine; [u]International Institute of Depth Psychology, Non-Governmental organization 'Ukrainian Society of Overcoming the Consequences of Traumatic Events' (USOCTE), Kyiv, Ukraine; [v]School of Psychology, Institute of Mental Health Sciences, Faculty of Life & Health Sciences, Ulster University, Coleraine, Northern Ireland, UK; [w]Research Department, Combat Stress, Leatherhead, UK & King's Centre for Military Health Research, Department of Psychological Medicine, King's College London, London, UK

ABSTRACT

The European countries have a long history of exposure to large-scale trauma. In the early 1990s the increasing awareness of the consequences of trauma within the mental health community led to the foundation of local societies for psychotraumatology across Europe and the European Society of Traumatic Stress Studies (ESTSS), which celebrated its 25th anniversary in 2018. The focus of this article is to describe the current state of care for survivors of trauma in the 15 European countries where ESTSS member societies have been established. Brief descriptions on the historical burden of trauma in each country are followed by an overview of the care system for trauma survivors in the countries, the state-of-the-art of interventions, current challenges in caring for survivors and the topics that need to be most urgently addressed in the future. The reports from the different countries demonstrate how important steps towards a better provision of care for survivors of trauma have been made in Europe. Given the cultural and economic diversity of the continent, there are also differences between the European countries, for instance with regard to the use of evidence-based treatments. Strategies to overcome these differences, like the new ESTSS training curricula for care-providers across Europe, are briefly discussed.

Trauma y Atenciones de Trauma en Europa

Los países Europeos tienen una larga historia de exposición a traumas de larga escala. A principios de la década de 1990, la creciente conciencia de las consecuencias del trauma dentro de la comunidad de salud mental condujo a la fundación de las sociedades locales para la psicotraumatología en Europa y la Sociedad Europea de Estudios de Estrés Traumático (ESTSS), la cual celebra en el 2018 su 25° aniversario. El enfoque de este artículo es describir el estado actual de la atención de los sobrevivientes de traumas en los 15 países Europeos, donde las sociedades miembros de la ESTSS se han establecido. Las descripciones breves sobre la carga histórica de trauma en cada país son seguidas por una descripción general del sistema de atención para sobrevivientes de trauma en el país, el estado de la técnica de las intervenciones, los desafíos actuales en el cuidado de sobrevivientes y los temas que necesitan ser abordados con mayor urgencia en el futuro. Los reportes de los diferentes países demuestran los pasos importantes que se han dado en Europa en la entrega de atención para los sobrevivientes de trauma. Dada la diversidad cultural y económica del continente, hay también diferencias entre los países Europeos, por ejemplo en relación al uso de tratamientos basados en la evidencia. Las estrategias para

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HIGHLIGHTS

- Important steps towards a better provision of care for victims of trauma were made in the European countries.
- In 2018, ESTSS celebrates its 25th anniversary.
- Strategies to promote a better practice include new ESTSS curricula for professionals across Europe.

CONTACT Ingo Schäfer i.schaefer@uke.de Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany

[*]In close collaboration with fellow NtVP Board members Miriam Lommen, Marie-Louise Meewisse, Trudy Mooren and Maartje Schoorl.

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resolver estas diferencias, como el nuevo curriculum de entrenamiento de la ESTSS para los proveedores de atención a lo largo de Europa son discutidas brevemente.

欧洲的创伤和创伤护理

欧洲国家有遭受大规模创伤的久远历史。在20世纪90年代早期，精神卫生界内越来越意识到创伤的后果，导致了在欧洲各个地区性创伤心理学会和欧洲创伤应激研究学会（European Society of Traumatic Stress Studies；ESTSS）的成立，该学会将于2018年庆祝其成立25周年。本文旨在描述在已建立ESTSS子协会的15个欧洲国家中创伤幸存者护理的当前状况。首先是对每个国家创伤的历史负担的简要描述，之后概述了各国创伤幸存者的护理系统的概述，干预措施的最新技术，护理幸存者面临的的当前挑战以及将来最迫切需要解决的问题。来自不同国家的报告展示了，在欧洲是如何实现为创伤幸存者提供更好的护理。鉴于大陆的文化和经济多样性，欧洲国家之间也存在差异，例如在循证治疗的使用上。我们简要讨论了克服这些差异的策略，例如为跨欧洲的护理服务提供者的新ESTSS培训课程。

1. Introduction

Exposure to trauma is common (Kessler et al., 2017) and its consequences on the individuals and communities affected can hardly be overestimated. In Europe, as in other regions of the world, a high burden of trauma is related to human-made events. In the twentieth century, military conflict took place during every single year in the European region and many of them affected numerous countries (see Table 1). Mass traumatization was also related to military conflicts associated with European colonialism, or conflicts in other continents where European military forces were involved in conflicts (see Table 2). Another massive burden of trauma across Europe resulted from the Holocaust and, throughout most of the twentieth century, from the political oppression by the Soviet communism. Trauma has occurred and still occurs in many societal contexts. For example, these include the familial and institutional abuse of children, different forms of gender-based violence in the European societies, various forms of institutional violence (i.e. in detention facilities of some countries) and also large-scale disasters and terror attacks that struck individual countries. Finally, over the last decades, an increasing number of migrants have reached the European countries, due to war and violence in their homeland (Hall & Olff, 2016; Kartal & Kiropoulos, 2016; Knaevelsrud, Stammel, & Olff, 2017; Munz & Melcop, 2018).

In the last two decades of the twentieth century, the increasing awareness of the consequences of trauma in the mental health community led to the foundation of local working groups and societies for psychotraumatology in several European countries. The European Society of Traumatic Stress Studies (ESTSS), which celebrated its 25th anniversary this year, was founded in 1993. Over two decades, ESTSS was an organization that included both member societies and individual members, which in the first years mainly came from western European countries. Recently, ESTSS has developed into an umbrella organization of the European societies for traumatic stress. This change is the result of a strategic plan that has been pursued over a longer period of time (Gersons, 2013). The ESTSS board consists of representatives from all member societies, which facilitates the work towards common strategic aims, such as promoting a standard curriculum for training in psychotrauma across Europe. In 2018, ESTSS com-

Table 1. Examples of military conflicts in Europe.

Year	Military conflict	Countries affected
1914–1918	First World War	Paneuropean
1917–1922	Soviet revolution	Former Soviet countries
1936–1939	Spanish civil war	Spain
1939–1945	Second World War	Paneuropean
1944–1953	Lithuanian partisan war against Soviet occupation	Lithuania
1968–1998	The Northern Ireland Troubles	UK, Republic of Ireland
1991–2000	Wars following the dissolution of former Yugoslavia	Slovenia, Croatia, Bosnia and Herzegovina Serbia, Montenegro, Kosovo
Since 1990	Military conflicts/wars in the South and North Caucasus	Georgia, Armenia, Azerbaijan and Russia (including North Caucasian region of Russia)
2008	Russian-Georgian war	Georgia, Russia
Since 2014	Conflict in East Ukraine	Ukraine, Russia

The list of military conflicts and countries involved is not all inclusive.

Table 2. Examples of military conflicts outside of Europe.

Year	Military conflict	European countries affected
1945–1949	War in the former Dutch East Indies	The Netherlands
1946–1954	Vietnam war	France
1954–1962	Algeria war	France
1950–1953	Korean war	Belgium, France, Greece, Luxembourg, Netherlands, UK
1961–1974	Portuguese Colonial War in Africa	Portugal
1979–1987	Afghanistan war	Former Soviet countries, UK
1990–1991	Gulf war	Belgium, Denmark, France, Germany, Greece, Hungary, Italy, Netherlands, Norway, Poland, Portugal, Romania, Spain, Sweden, UK
2001–2014	Afghanistan war	Albania, Belgium, Croatia, Czech Republic, Denmark, France, Georgia, Germany, Italy, Lithuania, Norway, Poland, Portugal, Romania, Russia, Spain, Sweden, UK, etc.

The list of military conflicts and countries involved is not all inclusive.

prised of 13 member societies that included 15 European countries and regions. These included Austria, Belgium, Croatia, Georgia, Germany, Lithuania, Italy, The Netherlands, Poland, Portugal, Sweden, the German-speaking and the French-speaking part of Switzerland, Ukraine and the UK (www.estss.org). Moreover, ESTSS had 12 additional affiliated societies and institutions in 2018. The society is constantly working towards the inclusion of further European societies and actively supports the formation of new societies in countries where they do not exist yet, as currently happened in Finland where the Finish Society for Psychotraumatology was launched in 2018.

While a series of articles at the occasion of ESTSS' twentieth anniversary focused on the inspiring and often also entertaining recollections of former presidents on the development of ESTSS (Lueger-Schuster, 2013b), the focus of this article is on the current member societies of ESTSS and on the development of trauma care in the respective countries. After some reflections on the historical burden of trauma in each country, representatives from all the national societies describe the structure of care organizations for trauma survivors, the state-of-the-art of interventions, current challenges in caring for survivors and the topics that need to be most urgently addressed in their countries in the future.

2. Psychotraumatology in Belgium

Five to eight million deaths, perhaps even 10: this was the devastating toll of the conquest and colonial exploitation of the Belgian Congo with King Leopold II, between the 1880s and the First World War (Hochshild, 1998). All traces of this Genocide remained secret until the early 1980s. Concerning the historical burden of the two World Wars (Manfred, 2015), it is the First World War more than the Second World War which, in the collective memory, constitutes a great trauma because of the looting of the country and the massacre of more than six thousand civilians. Recent events that stay more broadly in the mind of the Belgian people include the Heysel Drama in 1985 and the Dutroux affair with the sexual abuse, sequestration and death of young children and adolescents in 1996. In March 2016, the terrorist attacks at the national airport and in the metro of Brussels caused the death of 35 persons (Deschepper et al., 2018). Psychosocial structures vary across the country and have little or no coordination between them. One of the reasons is a difference between the functioning of French- and Flemish-speaking communities. Some structures can be found in both the French- and the Flemish-speaking communities. For instance, Public Welfare Centres and police victim services can be found in both of them. The integration of a psychosocial dimension into emergency and intervention plans was formalized in 2006. For the last 20 years, psychotherapists and other clinicians working in private practices started to specialize in trauma care for survivors. More and more specifically trained psychologists are working in hospitals and mental health centres. Recently, the development of outpatient trauma treatment centres linked to hospitals is evident. Some centres for the provision of trauma care for refugees were established in Brussels and cover the Dutch- as well as the French-speaking part of the country. In 2017, the High Council on Health received a Ministerial request for an opinion on the psychological care and support of persons following terrorist incidents or related disasters.

Until recently, there were no trauma-focused intervention methods in use in Belgium. The main therapeutic currents, for instance cognitive behavioural therapy (CBT) and psychodynamic therapies, were putting their own accents on working with trauma. In 2006, the BIP (Belgian Institute for Psychotraumatology) started the first psychotraumatology course. More trauma centres were created in the following years in principle cities, mainly Antwerp and Brussels. The course is organized in collaboration with two Universities. BIP organizes conferences in collaboration with other institutes or centres in Belgium. An independent Belgian trauma society needs to be created in the near future.

Current challenges in caring for trauma survivors concern the coordination of different support services. The political system in Belgium involves varying responsibilities at several levels, which makes decision-making complex. More visibility through studies on the positive impact and benefits of qualified trauma-focused care will be important. Finally, a well-structured national accreditation system should be put in place in order to continue provision of quality care for trauma survivors.

Among the topics to be most urgently addressed in the future is accessibility of services which is limited due to long waiting lists before survivors get access to psychological care in the Belgium mental health care system. Moreover, new ways of thinking about specialized trauma-care structures are needed.

3. Psychotraumatology in Croatia

The still living burden of the Second World War psychotrauma in Croatia has merged with the trauma of the Homeland War (1991–1995). Throughout the whole post-World War period there was no awareness of the consequences of trauma exposure, the issue was present neither in the health nor in public discourse. Consequently, no specific care was developed and provided. In contrast, the war in the 1990s brought about a high level of awareness of trauma and posttraumatic stress disorder (PTSD). Decades later the war-affected population reports 18% prevalence of PTSD (Priebe et al., 2010). This may be

partly due to lack of effective early trauma interventions and a number of hindering social factors, such as the prolonged economic crisis that affected more the vulnerable populations. The spin-off effect of massive trauma at the social level is a new understanding of the impact of traumatic events on physical and psychological health, as well as on communities (Corkalo Biruski, Ajdukovic, & Löw Stanic, 2014; Lončar & Henigsberg, 2007), which in turn facilitates access to specialized services by people exposed to trauma in everyday life.

Trauma survivors have access to psychiatric services in major hospitals, while veterans receive help within the three specialized regional centres and the National Centre for Psychotrauma. The cost of services are covered by universal national health insurance. Several non-governmental organizations with qualified staff provide supportive therapy to survivors of sexual assault, traffic accidents and other life threatening incidents, as well as domestic violence. The Polyclinic for the Protection of Children based in Zagreb specializes in working with traumatized children. Other facilities focus on prevention and support in the immediate aftermath of traumatic incidents, such as the Crisis Response Network maintained by the Society for Psychological Assistance (SPA).

The psychiatrists' first treatment choice is psychopharmacology. The prevalent therapeutic approach in psychiatric services for veterans is group therapy. Some veterans have been attending such groups for over 25 years. Low use of evidence-based trauma-focused therapies reflects (Schnyder et al., 2015) the prevailing traditional approach in Croatian psychiatry. Hence, traumatized populations still have poor access to effective, evidence-based trauma treatments. Training in trauma-focused CBT and EMDR is offered to practitioners, but this is not fully integrated into the helping system. With the existing high level of competencies in dynamic psychotherapy and psychopharmacology (Britvić et al., 2012), the challenge remains to develop a more stepwise approach to trauma-informed services, increase public awareness of risk and resilience factors, and to expand treatment choices to include evidence-based trauma-focused therapies and make them more available to the general populations in need. The Croatian Society for Traumatic Stress (CSTS) has been working on this challenge since it was founded in 2011 by organizing training workshops. It is currently promoting the ESTSS certified training in psychotrauma for mental health providers. One of the ambitions is to further integrate such training into university curricula so that future generations of mental health professionals are able to provide state-of-the-art care to traumatized people. Similarly, basic and intermediate levels of trauma-related knowledge and skills will be made more available to first responders and other health professionals.

4. Psychotraumatology in France

According to the World Mental Health survey, 72.7% of the French population has been exposed to traumatic events in their lifetime (Husky, Lépine, Gasquet, & Kovess-Masfety, 2015). Intimate partner violence, serious illness of a child and rape were the events associated with highest risk of PTSD. While rape is underreported in France, each year nearly 100,000 individuals claim to be survivors of rape or attempted rape and 500,000 claim to be survivors of intimate partner violence. A fifth of the French population was exposed to war-related events (mainly the Second World War). The twenty-first century was scarred by numerous Islamism extremist attacks, of which the November 2015 Paris attacks have been the bloodiest to date, resulting in more than 264 dead and 914 injured individuals. Traffic fatalities decreased in the past decades, reaching 5.1 per 100,000 inhabitants per year.

Since 1995, medico-psychological emergency units (CUMP for 'Cellules d'Urgence Médico-Psychologiques') are deployed in the case of mass casualty situations and provide immediate psychological support and care. These units were very effective after terror attacks in Paris and Nice, supporting thousands of survivors over many weeks (Hirsch et al., 2015). Psychological assistance aims at providing survivors with an entry point to psychological health care and giving them a first sense of relief, even though they do not provide psychological follow-up care (Vandentorren et al., 2018). In order to ensure long-term high-quality trauma care to all survivors in need across the country, President Emmanuel Macron in November 2017 announced the creation of about 10 ambulatory services specialized in trauma care. These services are aimed at providing medical and psychological care to survivors (minors or adults) that have experienced violence or any traumatic event during their lifetime.

The traditional psychodynamic approach is gradually but slowly replaced by structured trauma-focused psychotherapies, such as CBT or EMDR, and also new technologies (e-PTSD) are being introduced (Bourla, Mouchabac, El Hage, & Ferreri, 2018). However, the provision and access to treatment remain limited by the fact that there is a limited number of experienced trained trauma therapists and that care centres are not always clearly identified or equitably distributed across the country.

The challenges in caring for survivors are to achieve universal access to prevention, improve access to trauma-focused psychotherapies and ensure coordination of specialized care and support. One major challenge is to expand public funding of structured psychotherapies by trained psychologists. It is advisable to ease access to structured trauma-focused

therapies as part of mental health care programmes in compliance with international guidelines. In the end, patients should benefit from personalized treatment strategies for their trauma-related disorders, based on objective information.

The future ambulatory care services specialized in trauma will have to structure the organization of care, to establish a single French umbrella society (involving the national trauma centre and psychotrauma societies such as AFORCUMP-SFP, ALFEST and ABC des Psychotraumas), to be involved in qualifying training curricula, and to set up a French certification committee connected to the ESTSS accreditation committee, in order to meet modern European and international standards.

5. Psychotraumatology in Georgia

Georgia is a post-Soviet country, with a population of approximately 3.3 million. Since becoming independent in the early 1990s, it went through a prolonged series of civil war and ethnic-political conflicts followed by a war with Russia in 2008 and loss of control over more than 20% of the country's territory. Ongoing social, political and economic crises create pressure on the population, 20.6% of whom live under the poverty level and 7.3% of whom are internally displaced. Among the conflict-affected population, 23.3% suffer from PTSD symptoms, 14.0% from depression, 10.4% from anxiety and 12.4% have more than one mental health condition (Makhashvili et al., 2014). In addition, the population still suffers from the inter-generational effects of trauma related to the Soviet invasion and totalitarian past (Javakhishvili, 2014, 2018).

The large proportion of conflict-affected population led to the build-up of trauma care capacities and corresponding institutional developments, i.e. trauma-focused torture victim rehabilitation centres (GCRT), functional since 2000, with the head office in the capital city Tbilisi and branches in eastern and western Georgia. The multidisciplinary teams provide free of charge care for their clients that include forced migrants, ex-prisoners and others. There are a number of non-governmental organizations providing trauma-informed psychosocial services to socially disadvantaged groups, including forced migrants, domestic violence survivors and other target groups.

The Georgian Society of Psychotrauma (GSP) was founded in 2007 with the support of ESTSS. GSP builds capacity within the local professional community and has introduced such evidence-based treatment methods as Trauma-Focused CBT, Brief Eclectic Psychotherapy for PTSD (BEPP) and EMDR, as well as other relevant psychosocial interventions. Since 2008, GSP regularly conducts an annual international multidisciplinary conference 'Trauma and Society'. To assure capacity building and good quality care, an innovative Master Program in Mental Health was founded in 2012 at Ilia State University in Tbilisi, under the lead and with a main perspective on psychotraumatology.

The mental health treatment gap is about 90% in the country. There is a predominant focus on hospital care; community-based services are under-developed. Common mental disorders are under-recognized and under-treated by the state services. There is a need to develop a trauma-informed primary health care system, enlarge the trauma care infrastructure and establish corresponding referral pathways. Another challenge is low awareness of one's own mental health condition. According to a recent study, of those who suffered from mental health symptoms, only 24.8% sought care, 19.6% acknowledge mental health problems but did not seek care, and 54% did not acknowledge mental health problems (Chikovani et al., 2015).

Since most trauma survivors belong to socially disadvantaged groups who are often exposed to multiple traumatization as well as a series of everyday life stressors, we rarely find among these patients simple PTSD. The most widespread trauma-related condition are complex posttraumatic disorders. Therefore, the most urgent need is to evaluate effective methods of addressing complex trauma conditions. From 2016 to 2018, within the framework of an Erasmus Plus cooperation, the Trauma-Focused Cognitive-Behavioural Therapy Train of Trainers (ToT) module was developed, piloted and adapted to the Georgian cultural context in cooperation with Cardiff University. It has proved its effectiveness in the treatment of not only simple but also complex trauma-related disorders. There is a need to collect strong evidence to further prove the effectiveness of these approaches.

6. Psychotraumatology in the German-speaking countries

As in many European countries, the largest historical burden of trauma in Austria, Germany and Switzerland comes from the two twentieth century World Wars and the Holocaust. Over the decades, the different roles of the three countries in these catastrophic events had an influence on the perception of their traumatic impact. In contrast to Switzerland, discourses in Germany and Austria had been more focused on their role as perpetrators and their responsibility for these events. In general, Switzerland has been much less concerned by the two twentieth century World Wars than Germany and Austria. It took a longer time before the trans-generational consequences of war and displacement on parts of the German and Austrian population were also discussed (e.g. Glück, Tran, & Lueger-Schuster, 2012,

Kuwert, Brähler, Glaesmer, Freyberger, & Decker, 2009). Another population that requires expertise on psychotraumatology in the three countries is that of the refugees (e.g. Knaevelsrud et al., 2017; Spiller et al., 2017).

Services for trauma survivors are organized in a similar way in the three German-speaking countries. Non-governmental organizations play an important role in the psychosocial response to disaster and other mass incidents. Some of them also provide care for survivors of individual trauma in the form of local 'crisis intervention units' that closely collaborate with other emergency services. Specialized counselling agencies, usually funded by the local municipal authorities, offer low-threshold services for survivors of childhood abuse, sexual assault and domestic violence. In all three countries, there are also growing networks of clinical outpatient services for survivors of interpersonal violence that are frequently located at psychiatric hospitals. Psychotherapists in private practice play an important role for the treatment of posttraumatic disorders in both children and adults. Moreover, in each of the three German-speaking countries, a larger number of hospitals offer specialized inpatient care for patients with posttraumatic disorders.

The German-speaking Society for Psychotraumatology (DeGPT), the common trauma society of the three German-speaking countries (Germany, Austria and Switzerland), has developed curricula for the training of professionals in different settings (e.g. staff in counselling services, psychotherapists for children and adults) in trauma-related practices. The curricula for psychotherapists have been recognized by important national bodies, like the national chambers of physicians and psychotherapists in Germany. At present, about 50 training institutes in Germany, Austria and Switzerland offer the curricula. The society also coordinates the national German guideline for the treatment of PTSD. Such activities have contributed to the dissemination of evidence-based practices in different settings. However, as in other European countries (Kazlauskas et al., 2016), many psychotherapists still do not feel competent to deal with traumatized populations. As a result, patients can face substantial problems to find adequate help, for instance in the form of trauma-focussed interventions for individuals with PTSD.

The prevention of trauma in different settings remains a challenge. Recently, initiatives in all three German-speaking countries addressed the problem of institutional violence, e.g. in foster care settings, but more efforts are needed to sustainably implement preventive efforts and bodies like the independent commissioner into childhood sexual abuse in Germany (Bergmann, 2011). The dissemination of trauma-informed practices in all parts of the health care system and the social sector is another urgent issue. Finally, the provision of adequate care for the considerable number of migrants from contexts of war and persecution in the German-speaking countries is a challenge for the years to come.

7. Psychotraumatology in Italy

Trauma permeates the history of Italy: war, terrorism, major mass disasters, abuse and maltreatment deeply affected the Italian society across time and generations. During the Second World War, many Italians experienced the effects of torture and deportation leaving a scattered society (Favaro, Rodella, Colombo, & Santonastaso, 1999). In the 1970s, the Italian society faced the 'dark period' of *Brigate Rosse*, a terroristic group who caused many deaths and created a deep sense of fear in the population. Domestic violence is the most common crime against children; indeed, child abuse and maltreatment is a major public health problem. A recent report (Autorità Garante per l'Infanzia, CISMAI and Terre des Hommes, 2016) revealed that each year 950 children are exposed to sexual abuse. In the past year, the percentage of maltreatment and abuse increased by 6%. Italy has also experienced a significant number of natural disasters, like floods and earthquakes, that potentially increased the prevalence of post-traumatic syndromes in the communities. There are no robust data about the actual burden of such traumatic experiences and their effects on the society today.

Italian health and social care systems have not yet fully embraced a trauma-informed approach. This led to fragmented responses to the needs of survivors, especially in terms of preventive initiatives. There is some resistance to implement routine screening and assessment tools for the early detection and prevention of post-traumatic syndromes. For this reason, the system responds late and mainly to traumatization that became complex as a result of missed accurate diagnoses. It is a challenge to acquire a systemic vision of care for traumatized populations, with shared policies and protocols.

Exposure-based therapies are rarely used; EMDR is the only widely implemented intervention in the social care system at all levels. Other trauma-focused therapies (Ehring et al., 2014) – such as trauma-focused CBT or Narrative Exposure Therapy (NET; Schauer, Neuner, & Elbert, 2011) – struggle to be disseminated. Clinicians are asked to integrate different treatment approaches with a good understanding of assessment and psychoeducation techniques. Training of health and social care professionals is a key issue. In Italy, trauma is still seen as a 'psychologist/psychotherapist business', undermining the importance of multidisciplinarity. Furthermore, a synergy between clinical work and research should be

promoted to investigate the outcomes of treatment and to adapt service models accordingly.

There are a few important strategic points the Italian Society of Traumatic Stress Studies (SISST) should consider for the future. Highly traumatized migrants and refugees are one of the priorities requiring a long-term preventive plan to fight longer-term consequences for the society. The second point is the promotion of a more articulated reasoning about the implementation of evidence-based therapies. Furthermore, epidemiological studies are warranted to determine the actual prevalence and incidence of traumatic events in Italian society. Finally, another crucial issue is a comprehensive training in psychotraumatology. The new ESTSS certification represents a good opportunity for trauma-informed capacity building initiatives in the near future.

8. Psychotraumatology in Lithuania

The burden of trauma in Lithuania was largely influenced by the political situation in Europe in the twentieth century. Large-scale traumas associated with the two World Wars, the Holocaust and the prolonged Soviet occupation had a significant impact on the Lithuanian population, marked with suffering and oppression for several generations. Interest in trauma and trauma research in Lithuania was started soon after the collapse of the Soviet Union in the 1990s and several studies explored posttraumatic effects of political violence in the country (Kazlauskas & Zelviene, 2016).

Survivors of traumatic events can seek treatment for mental disorders in the public mental health care system, which includes about 100 primary mental health centres spread across the country, and in more severe cases in psychiatric hospitals. Several non-governmental organizations and crisis centres in the biggest cities in Lithuania are providing help for survivors of interpersonal violence, including psychosocial support and psychotherapy. Additionally, psychotherapists in private practice are also available for trauma survivors. Despite these positive developments, care organizations for trauma survivors are not developed in Lithuania and evidence-based trauma-focused treatments for trauma survivors are not available in the public mental health care system.

Mental health professionals are increasingly aware of the negative effects of trauma on individuals and are interested in learning new ways to help trauma survivors. There is significant progress regarding the implementation of evidence-based trauma-focused treatments, such as EMDR and BEPP, in Lithuania recently. The numbers of therapists trained in trauma-focused treatments are growing, but these treatments are not offered in the public health care system and are available predominantly in private practice which is expensive and not covered by national health care insurance.

Despite the high prevalence of traumatic experiences in Lithuania (Kazlauskas & Zelviene, 2016), it was reported that PTSD is not identified in the Lithuanian national health care system (Kazlauskas, Zelviene, & Eimontas, 2017). The lack of acknowledgment of trauma and PTSD in Lithuania is a major barrier for the development of treatments for trauma survivors in the country.

Future directions of the trauma field in Lithuania include ensuring access to evidence-based treatments for trauma survivors. There is a need of trainings for practitioners to update their knowledge about the impact of trauma, with a particular focus on how to diagnose stress-related disorders and how to provide trauma-focused treatments. Finally, health care and social policy changes on the national level are needed to acknowledge trauma survivors and include evidence-based treatments in the health care of survivors exposed to various traumas, particularly children and adolescents. The Lithuanian trauma society is taking an active role in raising awareness about the effects of trauma to facilitate the further development of care for trauma survivors.

9. Psychotraumatology in the Netherlands

The Second World War marks the largest historical burden and the starting point for psychotrauma care in the Netherlands. Occupation by German and Japanese (in the former Dutch East Indies) armed forces and subsequent post-colonial wars led to over 250,000 military and civilian lives lost. Public awareness for the psychological effects of wartime and other traumatic experiences started around 1975, with the awareness of the Holocaust. In response, Foundation Center ’45 was funded, first focusing on Second World War concentration camp survivors, but soon extending their services to other traumatized populations. The focus on post-war reconstruction, tensions between interest groups and an emphasis on heroics and the resistance, together with a poorly developed mental health care, contributed to this late societal response (Vermetten & Olff, 2013). Subsequent national and international disasters, such as the 1992 Bijlmermeer airplane disaster and the 2000 Enschede fire explosion, further increased professional and public awareness of psychotrauma, and fuelled the establishment of the Dutch Society of Psychotraumatology in 2006.

Mental health care for trauma-related disorders is covered by health insurance at little or no additional personal costs. Facilities for trauma care have been integrated at many levels of health care. Routinely, the first step for individuals with trauma-related symptoms is to consult their general practitioner for referral to secondary health care organizations.

A national standard of care for trauma- and stressor-related disorders is currently underway (Kwaliteitsontwikkeling GGZ, 2018).

Trauma-focused treatment is increasingly offered next to interventions directed at emotion regulation, day-night structure and social support (Vermetten & Olff, 2013). Examples are EMDR, CBT, NET, BEPP and Imagery Rescripting. There is a growing role for E-health interventions (e.g. Olff, 2015). Some institutions use treatment intensification (EMDR or CBT), with preliminary positive effects (Van Woudenberg et al., 2018; Zepeda Méndez, Nijdam, Ter Heide, van der Aa, & Olff, 2018). Although not yet implemented, other treatment innovations include hormonal enhancers (D-cycloserin, cortisol, oxytocin; e.g. Thomaes et al., 2016).

Effective treatment for PTSD due to events in adulthood in fairly well functioning patients seems available, as well as special services and care for the military and the police. One of the greatest practical challenges are the long waiting lists in secondary mental health care, limiting accessibility to care for vulnerable patient groups, such as individuals with multiple (childhood) traumatization, patients with severe physical, neurocognitive and/or psychiatric comorbidities or severe psychosocial problems, and (asylum seeking) refugees. The latter in particular experience difficulties accessing evidence-based care due to stigma, requirement of referral by general practitioners, and language and cultural barriers. Moreover, research on the (cost-)effectiveness of treatments for these target groups is relatively lacking (e.g. Sijbrandij et al., 2017), as well as on improving symptom recovery and treatment adherence of current PTSD treatments.

Topics which should be urgently addressed in the future include improving treatment outcome for specific target groups, i.e. patients with childhood trauma; implementing treatment for target groups that are currently excluded from regular PTSD treatments; family- or system-oriented interventions to prevent inter-generational consequences of trauma and enhance opportunities for social support; evaluation of e-mental health interventions for PTSD and comorbid disorders, including blended treatment options administered within routine clinical practice; increased use of transdiagnostic treatment options for trauma-exposed patients targeting a variety of psychopathology limiting psychosocial functioning; and the use of low-intensity interventions, carried out by non-professional helpers to increase coverage of mental health interventions.

10. Psychotraumatology in Poland

The recognition of the socio-psychological consequences of the Second World War in Poland is an extremely important issue. Poland belongs to the part of Europe which Snyder (2010) called the 'Bloodlands'. The number of ethnic Poles and Polish Jews who died or were murdered in connection to the Second World War amounted to about six million. Poland lost about 17% of its pre-war population (Materski & Szarota, 2009). Moreover, the Soviet invasion and the subsequent imposition of a communist regime led to large groups of people being persecuted. Many survivors of the war (e.g. resistance movement members, people deported to Siberia) were not even recognized as survivors, and speaking about many aspects of war experiences could lead to prosecution. Very little attention has been paid to Second World War issues in medicine and psychology, in comparison to the volume of analogous research in western countries (Lis-Turlejska, Szumiał, & Drapała, 2018). Psychological help for survivors of the war was practically absent, and the need is still not recognized today. Since the collapse of communism, neither war nor other traumas have been recognized on a broader scale. Research has been conducted on the consequences of the great flood of 1997 (Strelau & Zawadzki, 2005), however, other traumatic events, including the death of the president and other governmental officials in the Smolensk plane crash in 2010, have not yet been the subject of psychological research.

There is no coherent care system in Poland for survivors of various traumatic events. A number of crisis intervention centres provide help for 'families in crisis' – mainly for survivors of domestic violence (www.spoleczenstwoobywatelskie.gov.pl). There are non-governmental organizations working with survivors of trauma (e.g. battered women, abused children, survivors of crime). However, they are all underfunded and their capacity is limited. Access to psychotherapy under national health insurance is also limited. Despite the fact that there are many psychotherapists working privately, mainly in larger cities, there are still very few professionals who are specialized in psychotraumatology.

Crisis intervention is probably the most widely offered help to trauma survivors. Practitioners have the opportunity to be trained in different approaches in psychotherapy, including CBT, prolonged exposure therapy and EMDR. However, there is no clear emphasis on evidence-based treatments and they are not widely used in practice. There is also a lack of research on the effectiveness of trauma therapy. The issue of prevention is neglected in general, except training for professional groups (e.g. flight crews, emergency services).

Currently, the most important challenge is to increase access to professional care, specifically increasing access to therapists who offer evidence-based interventions. However, education of the general population about the importance of help seeking and potential benefits out of it is also crucial. It is necessary to further develop research on the

psychosocial consequences of both the Second World War and other large-scale traumatic events. It is also important to encourage the teaching of contemporary curricula on abnormal psychology, including content specific to trauma. This seems to be the most urgent task, alongside further development of the trauma care system and promotion of good practices in psychological care and psychotherapies for trauma survivors.

11. Psychotraumatology in Portugal

A colonial war of 13 years has left to Portugal an individual and collective traumatic heritage (Maia, McIntyre, Pereira, & Ribeiro, 2011). The consequences remain to this day through the intergenerational transmission of trauma (Dias, Sales, Cardoso, & Kleber, 2014). Throughout the years, clinicians, academics and other professionals discussed the psychosocial consequences and reactions to this trauma. Later, the coordinated response to two major accidents promoted a national approach to survivors of crisis and disaster. In 2009, the Centre for Social Studies of the University of Coimbra created the Centre of Trauma (CT), a society that brings together the country's leading organizations who directly deal with potentially traumatic events. Since 2010, CT is a full member of ESTSS.

In Portugal, the National Authority for Civil Protection provides central technical guidance to the organizations who deliver services to survivors of disasters or catastrophes. It is a governmental entity which coordinates the interventions developed and implemented by the different professional groups and organizations (fire fighters, medical emergency services, etc.). Clinical care to trauma survivals is provided by the National Health Service in the first place, but in cooperation with organizations (both non-governmental and governmental) who are specialized in trauma therapies and relevant psychosocial interventions. There is a core team of trained and certificated psychotherapists within CT whose service is accessible to people in need.

The most widespread therapy methods in Portugal are CBT, EMDR, Psychodrama and brief supportive psychotherapeutic strategies. Psychopharmacotherapy is also frequently used alone or in combination with psychological interventions. Treatment takes place in public and private health institutions. A number of governmental and non-governmental organizations currently invests in building the capacity of their staff in trauma care and designing and implementation of preventive interventions. CT is responsible for regular organization of conferences, seminars and the delivery of a biannual psychotrauma course. The course equips professionals from different fields with relevant knowledge and skills.

Professional and organizational preparation and knowledge to treat trauma consequences at the individual, family and social level needs to be optimized and updated. Minorities and refugees at risk may benefit from more integrated assistance. The ability to effectively respond to disasters and catastrophes through the provision of acute trauma care and coordination among the different organizations that are involved in disaster management has to be improved. There is room for improvement regarding the identification of populations at risk, screening for trauma related disorders and responding to the needs of the health care system. Family doctors and nurses, firemen and other professional groups have to be trained to assure their trauma-informed professional performance.

The topics to be addressed in the near future include creating a national plan for PTSD prevention and psychosocial interventions in case of crisis and disaster, as well as founding a network for specific treatment responses to trauma-related disorders, namely PTSD. Good practices have to be disseminated and young researchers and clinicians need to be motivated to work in the field of psychotraumatology. Finally, more effective and organized strategies to address potentially traumatic contexts such as unemployment, marital violence, cyber bulling and road accidents need to be developed, and the cooperative and coordinated work with national and European entities needs to be further increased.

12. Psychotraumatology in Sweden

The Swedish population has enjoyed peace for over 200 years. For a long time, the country did not experience the same increase in attention to psychotraumatology as other European countries with afflicted veteran soldiers from the nineteenth century wars. The impetus for trauma-informed services has instead come from disasters, large accidents and the increased attention to interpersonal abuse. A harrowing bus crash involving 12-year-olds on a school trip in 1988 (Arnberg et al., 2011) became the initiating event for the public organization of crisis support after large-scale events. Events such as the 1994 Estonia ferry disaster in the Baltic sea (e.g. Arnberg, Hultman, Michel, & Lundin, 2013) and the 2004 Southeast Asia tsunami (e.g. Michélsen, Therup-Svedenlöf, Backheden, & Schulman, 2017), both leading to hundreds of Swedish casualties, as well as the recent deployment of Swedish peacekeeping forces around the world, have highlighted the psychosocial consequences of trauma. More recently, the refugee crisis has set off many activities related to culturally informed trauma services.

In Sweden, every municipality has a psychosocial crisis team and there are psychosocial disaster contingency teams at the larger hospitals. A major step forward was the legislation passed in 2000 that

mandates employers to ensure that they have adequate knowledge of and plans for crisis support for their employees. Beyond the acute crisis support, however, access to qualified treatment of chronic traumatization varies across the country. In some regions there are dedicated trauma clinics; in others, there are trauma teams within the psychiatric services. Some regions lack both dedicated trauma clinics and teams.

The acute crisis interventions that are available in Sweden include Psychological First Aid, various forms of unstructured crisis support and a variety of debriefing methods including psychological debriefing (Witteveen et al., 2012). As for the treatment of PTSD, the Swedish National Board of Health and Welfare issues guidelines for public health care. In their latest guidelines from 2017 (The Swedish National Board of Health and Welfare, 2017), trauma-focused psychological treatments were given the highest priority; selective serotonin reuptake inhibitors (SSRIs) were prioritized as a potential but not necessary option for adults with PTSD, although they probably are the most widely used treatment in the country.

Several challenges lie ahead. The use of ineffective preventative interventions remains and the provision of psychosocial support beyond the acute phase is very limited, partly due to compartmentalized organizations. Further development of acute interventions in health care would benefit from robust evidence for early interventions. Trauma-related problems in patients too often go undetected in health care assessments (Al-Saffar, Borgå, & Hällström, 2002). In addition, access to prioritized treatments is underdeveloped in many parts of Sweden: the concentration of relevant competence in metropolitan areas is a salient issue in this country due to its large rural areas.

Another challenge related to the treatment of PTSD is that a large proportion of therapists are due for retirement in the next five years. It will become important for the field to continue to attract younger professionals. It is hoped that a stronger professional community, aided by the Swedish Society for Psychotrauma, can prevent fragmentation of the many regional initiatives, particularly in light of the many refugees across the country, and serve as a force for increasing the quality of and access to trauma treatments.

13. Psychotraumatology in Ukraine

The historical burden of trauma in Ukraine mainly consists of man-made catastrophes. They include the famines in the years 1933 and 1947, the Second World War, the explosion of the Chernobyl nuclear power station, and the current military conflict with Russia, which is officially called 'Anti Terrorist Operation (ATO)'. All events that happened during the Soviet times were hushed up and psychological support has never been provided to the people in need. It was not until the Maidan revolution and the beginning of the current war that psychological services in Ukraine were organized for victims of mass violence.

In Ukraine, care organizations for trauma survivors are currently under development. It presupposes an effective coordination of governmental and non-governmental organizations and professional institutions. The non-governmental organization Ukrainian Society for Overcoming the Consequences of Traumatic Events (USOCTE) was created to reach that aim. This professional organization aims at the development of crisis intervention services as well as capacity for provision of trauma-focused psychological therapies in Ukraine, in accordance with the international standards. Currently, USOCTE provides psychological help to wounded ATO soldiers and veterans, as well as other people who suffer from consequences of the ATO: those living in the ATO zone, internally displaced persons, families of killed soldiers and participants of the Maidan revolution. USOCTE is also engaged in developing training programmes for psychologists and psychoeducational materials for the general population. The methods used in trauma care are EMDR, CBT and the SEE FAR CBT treatment protocol of the Israeli coalition of trauma.

These treatments are offered in a strictly structured way. All clients sign an agreement, which determines the focus of the therapy. According to that agreement, a client has a right to attend 12 free-of-charge sessions. The first sessions are devoted to a detailed diagnostic interview, psycho-education on the signs and nature of posttraumatic disorders and providing information on therapeutic approaches. The following stabilization phase is intended to create a sense of safety by means of different techniques. It is followed by the trauma-focused interventions mentioned above. The final phase of treatment has the aim to integrate the experiences into daily life, assess the results and adapt to the achieved changes.

Challenges in this work are the very high level of psychological disturbance among the people living close to the conflict zone, and their reluctance to acknowledge this and to ask for psychological support (Roberts et al., 2017). It should also be mentioned that women are especially vulnerable on the front-line territory, and suffer multiple problems including high levels of psychological violence. These problems are often not recognized and the population has a tendency to believe that the end of military activities will solve all problems.

To overcome the consequences of the current military conflict in Ukraine, USOCTE is confronted with a number of tasks. They include building up a multilevel system of psychological assistance with the support of governmental and non-governmental organizations as well as monitoring and evaluating the activities of specialists in the psychological field on a regular basis. Moreover, the local communities need to be involved in supporting the aggrieved. Finally, there is a need for a more intensive cooperation and sharing of experiences with international organizations.

14. Psychotraumatology in the UK and Northern Ireland

The 2014 Adult Psychiatric Morbidity Study (APMS) provides the most comprehensive estimates of PTSD within the UK, although the sample is of English residents only (Fear, Bridges, Hatch, Hawkins, & Wessely, 2014). APMS found a PTSD prevalence of 4.4%, with similar rates observed between men and women. PTSD rates in women declined with increasing age; 12.5% of 16–24-year-old women had PTSD. In contrast, in men PTSD remained roughly consistent until declining from age 65. Northern Ireland (NI) has historically experienced a sustained period of political conflict known as the Troubles. The NI Study of Health and Stress identified that NI has one of the highest global rates of PTSD with lifetime and 12 month prevalence rates of 8.8 and 5.1%, respectively (Bunting et al. 2013). Lifetime prevalence in NI females (11%) was substantially higher than the rates in NI men (6.4%). Although there is no specific information on prevalence rates in Scotland and Wales, it is anticipated they are similar to English rates.

The UK's mental health services are provided by the National Health Service (NHS). Although regional variations exist, the first point of access is via family doctors. Community services, often available via self-referral, typically treat survivors of single incident traumas where a diagnosis of PTSD is present without co-morbid problems (e.g. substance misuse). Treatment of more complex cases (e.g. survivors of child abuse, refugees, etc.) is via specialist mental health teams. NHS treatment complies with best practice guidelines compiled by the National Institute for Health Care and Excellence. A range of other non-governmental organizations exist that are staffed by qualified health professionals and offer support to sub-populations of trauma survivors (e.g. survivors of domestic abuse, veterans, etc.). In NI, a Regional Trauma Service is under development to address the mental health legacy of the Troubles.

Interventions to treat PTSD in the UK are typically trauma-focused psychological therapies such as, but not limited to, trauma-focused CBT, EMDR and prolonged exposure (NICE, 2005). In addition, psychopharmacology support is given to manage co-morbid mental health presentations. Increasingly, e-technologies are being developed to help provide cost-effect support that also promote accessibility. For example, an online guided self-help tool for PTSD has been developed and internet-based video technologies have been successfully used to deliver PTSD treatments with much reduced therapist time required. Some providers also utilize compressed therapy where 16–-20 hours of TF-CBT are delivered over a week.

Currently, whilst there is often some delay in accessing specialist mental health assessment services, the biggest bottleneck is in the provision of specialist services for more complex cases of PTSD. Also, whilst APMS has shown that help-seeking for PTSD is improving, the majority of people with PTSD in the UK still do not seek any help.

Whilst, the UK has made considerable efforts to improve the public understanding of mental health, more needs to be done. Additionally, organizations which routinely expose staff to trauma (such as the emergency services, military and child social workers) need to address the issue of PTSD as a result of chronic trauma exposure as there has been limited work done on this topic.

15. Conclusion

The perspectives above show that important steps towards a better provision of care for survivors of trauma have been taken in the European countries. Given the cultural and economic diversity of the continent, there are still some differences between the countries, for instance with regard to the use of evidence-based treatments. Effective treatments have many elements in common (Schnyder et al., 2015) and the treatment of choice is often based on culture and history. The dissemination of evidence-based knowledge and skills has always been a priority of ESTSS (Ajdukovic, 2013, Bisson, 2013, Olff, 2013) and further strategic steps towards this aim have been made recently. In 2018, the first of a series of new ESTSS curricula, the 'Advanced Training in Treating Posttraumatic Disorders in Adults', was approved by the board. The curriculum comprises 120 hours of training and 20 hours of case supervision. It has a strong focus on evidence-based approaches and provides knowledge and skills for the treatment of acute stress disorder, non-complex PTSD and complex posttraumatic disorders (for more detail see www.estss.org). The curriculum has already been adopted by several member societies who are building up local structures to offer the trainings or adopt their national curricula to meet the requirements of the ESTSS curriculum. Other

curricula, for instance for the treatment of trauma-related disorders in children and adolescents, and more basic curricula to promote the idea of trauma-informed care among different groups of professionals, are currently being developed.

The country reports presented in this paper show that many countries share similar challenges and have topics in common that need to be addressed. These topics include, among others, the prevention of trauma, the promotion of trauma-informed practices in the whole health care system and standards of care for groups with special needs, including refugees and internally displaced people. Of increasing importance in the field of mental health is the involvement of trauma survivors in mental health care teams (Van der Schrieck-De Loos, 2013). It was beyond the scope of this paper to describe the large amount of research in the field of psychotraumatology in the European countries, which represents a significant proportion of the global research activities in this field (Olff, 2018). However, similar to the differences with regard to the use of evidence-based treatments, these activities are not evenly distributed between the different European countries. It is part of ESTSS's mission to stimulate and promote research Europe wide.

The current structure of ESTSS allows for a more direct exchange between the member societies and thereby provides the opportunity to effectively address such common issues. It has always been the aim of the society to provide a platform for all professionals in Europe in the field of psychotraumatology to connect, to develop together training and research, guidelines and actions where needed. ESTSS is constantly working towards this aim, for instance by identifying successful models in individual countries or regions and disseminating these experiences among all others. A recent example of this exchange is a series of movies providing information on the consequences of trauma and effective treatments tailored to the needs of the public, professionals from the health care system and trauma survivors that can be downloaded from the ESTSS website. They were developed by a national society (DeGPT) and translated into 10 European languages with the help of other member societies.

ESTSS can look back on 25 years of advocacy for the field of psychotraumatology in Europe. The first European Conference on Traumatic Stress, which can be considered one of the roots of ESTSS, was held three decades ago (Ørner, 2013). During these years, ESTSS has developed a unique profile as a truly international professional society that integrates the diversity of the European countries and greatly benefits from their cultural richness (Lueger-Schuster, 2013a; Olff, 2013). An important part of the society's success story are the ESTSS conferences that attract delegates from all parts of the world. Other important activities included projects like the European Network of Traumatic Stress (TENTS; Bisson, 2013) and the *European Journal of Psychotraumatology* (EJPT). EJPT has become an important platform for the dissemination of knowledge related to psychological trauma and, thanks to the relentless efforts of its founding editor Miranda Olff, has become one of the journals with the highest impact in the field (Olff, 2018).

Over the years, ESTSS had fruitful collaborations with large societies from other regions of the world. There is also a strong involvement of ESTSS in the global collaboration of trauma societies, an initiative that had initially been proposed by the International Society for Traumatic Stress Studies (ISTSS; Schnyder et al., 2017) and developed to a collaboration of all large trauma societies on an equal basis. It already has the function of a global umbrella for defined projects and holds promise to become a more formal global structure.

Only about half of the more than 40 countries on the European continent have established local trauma societies so far, most of which are members of ESTSS. In the coming decades, it will remain one of the most important aims of ESTSS to support the formation of new societies in countries where they do not exist yet, and to provide a common platform and a professional home for trauma specialists from the whole European region.

In their articles at the occasion of the twentieth anniversary of ESTSS, several former presidents described what some of them called the 'infancy and adolescence' of the society (Schnyder, 2013, Turner, 2013). At the age of 25 years, ESTSS has become a young adult. The society has 'grown up' and, with the latest change of its structure, has completed a developmental process that made it stronger and prepared it for the tasks ahead. This would not have been possible without the enthusiasm of a large number of dedicated colleagues from all over Europe. They invested their time and energy over the last 25 years to make the society what it is today. We congratulate ESTSS on its 25th birthday and strongly believe that it will successfully continue its 'adult life' for the good of psychotraumatology in Europe.

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ORCID

Evaldas Kazlauskas http://orcid.org/0000-0002-6654-6220
Marit Sijbrandij http://orcid.org/0000-0001-5430-9810
Małgorzata Dragan http://orcid.org/0000-0001-8221-2012
Margarida Figueiredo-Braga http://orcid.org/0000-0003-2374-4371
Filip Arnberg http://orcid.org/0000-0002-1317-2093
Cherie Armour http://orcid.org/0000-0001-7649-3874
Dominic Murphy http://orcid.org/0000-0002-9596-6603

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MODULAZIONE DELL'AROUSAL, MEMORIA PROCEDURALE ED ELABORAZIONE DEL TRAUMA: IL CONTRIBUTO CLINICO DEL MODELLO POLIVAGALE E DELLA PSICOTERAPIA SENSOMOTORIA

Giovanni Tagliavini

Centro di Salute Mentale, via San Carlo 7 – Arona (NO)

Riassunto

La disregolazione degli stati emozionali e di *arousal* (attivazione corporea) è un problema ubiquitario, spesso grave nei pazienti con traumi complessi e puo' essere considerata uno dei segni distintivi di avvenuta traumatizzazione. Le radici profondamente somatiche della disregolazione dell'arousal richiedono interventi clinici specifici, non mediati in senso esclusivo dalla parola e che si basino su riflessioni cliniche differenti dagli usuali fondamenti delle *talking therapies*.

In questo articolo si prenderanno in considerazione un vertice di osservazione prettamente neuroanatomico/psicofisiologico (la teoria polivagale di Stephen Porges) ed un vertice clinico/operativo (la psicoterapia sensomotoria di Pat Ogden) che rappresentano due tra le proposte più convincenti per affrontare efficacemente i problemi della disregolazione affettiva e delle "tracce somatiche" rappresentate dalle memorie traumatiche di tipo procedurale.

Parole chiave: teoria polivagale, psicoterapia sensomotoria, trauma complesso, disregolazione dell'arousal, memorie traumatiche, memoria procedurale, elaborazione del trauma

AROUSAL MODULATION, PROCEDURAL MEMORY, AND TRAUMA PROCESSING: CLINICAL INSIGHTS FROM THE POLYVAGAL MODEL AND SENSORIMOTOR PSYCHOTHERAPY

Abstract

Arousal and emotional disregulation is a common and often serious problem in complex trauma patients: it can be considered as one of the most significant signs of traumatization. The somatic roots of arousal disregulation need specific clinical interventions which go beyond the exclusive use of words. These interventions are based on ideas which differ from those coming from the traditional "talking therapies".

In this paper I will focus on two main topics: the first one, Stephen Porges' Polyvagal theory, is more anatomically and psychobiologically oriented; the second one, Pat Ogden's Sensorimotor Psychotherapy, is more oriented to clinical work. Both of them represent convincing and useful approaches that deal with the arousal disregulation and the "somatic traces" of the procedurally-stored traumatic memories.

Key-words: polyvagal theory, sensorimotor psychotherapy, complex trauma, arousal disregulation, traumatic memories, procedural memory, trauma processing

Scopo del presente articolo è presentare alcune osservazioni: a) sull'importanza della disregolazione dell'arousal nei disturbi legati a traumi; b) sul fatto che tale disregolazione rappresenti un segno specifico di traumatizzazione ed una delle manifestazioni del ricordo traumatico, non elaborato e inscritto nel corpo come "memoria somatica" implicita, procedurale; c) sulle possibilità di elaborazione del trauma attraverso una specifica attenzione agli stati di arousal, modulandoli tramite approcci terapeutici specifici, centrati sul corpo.

Nella mia personale esperienza il modello polivagale di Porges e la psicoterapia sensomotoria rappresentano strumenti operativi molto efficaci: il primo come descrizione dei substrati anatomici e delle manifestazioni di regolazione e disregolazione dell'arousal, la seconda come modalità di cura *body-centred* esauriente e convincente per tali tipi di disturbi.

Gli osservatorî dai quali opero sono due: il primo è un Centro di Salute Mentale che permette ancora agli psichiatri (in termini di tempo, riflessione, collaborazione tra colleghi ed équipe multiprofessionale) di agire anche come psicoterapeuti; il secondo è una piccola pratica ambulatoriale privata di alcune ore settimanali. Nella prima situazione gli aspetti sintomatologici legati a traumi si presentano in modo multiforme e trasversalmente a molti differenti quadri diagnostici[1]: solo alcuni pazienti che vedo in tale contesto sono quindi "primariamente post-traumatici" e con disturbi dissociativi; nella seconda situazione clinica mi è invece possibile selezionare situazioni di franchi disturbi traumatici complessi e dissociativi, lavorando in modo più selettivo.

In entrambe le popolazioni di pazienti, si è dimostrato di grande utilità clinica valutare in modo dinamico gli stati di arousal, utilizzando la loro regolazione e disregolazione a scopi terapeutici.

1. Sintomi post-traumatici e disregolazione dell'arousal

Il termine arousal (traducibile in italiano, ma non in modo soddisfacente, con "attivazione" o "stato di attivazione") si riferisce alla possibilità e alle modalità dell'organismo di essere reattivo rispetto a stimoli di varia natura, modificando parametri che sono solitamente misurabili, come la frequenza cardiaca, il ritmo respiratorio, la vasodilatazione e la vasocostrizione, la motilità intestinale, l'increzione ormonale, la conducibilità elettrica della cute, il diametro pupillare, ecc.

La vigilanza, ovvero il "rimanere svegli", è strettamente correlata all'arousal, così come ad uno dei principali substrati anatomici della vigilanza, rappresentato dalla formazione reticolare ascendente (FRA). La FRA è una proiezione verso la corteccia dei centri regolatori dell'arousal che sono collocati anatomicamente nel tronco dell'encefalo, cioè nella parte cerebrale che secondo la descrizione di MacLean di cervello trino (*triune brain*) definiamo protorettiliana, deputata alle reazioni più viscerali di conservazione e di sopravvivenza (MacLean 1984).

Il cervello protorettiliano è capace di reagire in modo rapido a stimoli di tipo pericolo/minaccia; per comunicare con il corpo utilizza il sistema nervoso autonomo o neurovegetativo,

[1] Colgo l'occasione per sottolineare che il problema di una diagnosi formale, più specifica e più sensibile, dei disturbi traumatici complessi e dissociativi in ambiti ad accesso universale come un CSM o un Pronto Soccorso Psichiatrico è ancora un tema aperto, che acutamente necessita di ricerche e di trial clinici, soprattutto per evitare l'utilizzo improprio e superficiale di altre diagnosi (in particolare quella di psicosi e di disturbo borderline di personalità) e di strumenti di cura non idonei.

formato da una parte (orto-)simpatica e da una parte parasimpatica. Ciò può avvenire senza che sia strettamente necessario coinvolgere le strutture superiori, rappresentate dal sistema limbico (o cervello paleomammaliano) e dalla corteccia (o cervello neomammaliano). Tuttavia gli stimoli che raggiungono una sufficiente intensità saranno processati non solo dal cervello protorettiliano nel senso di una modulazione dell'arousal fisiologico, ma anche a livello limbico, nel senso dell'arousal emozionale, e a livello corticale, nel senso dell'attivazione cognitiva e associativa.

Ad esempio, un forte ed improvviso rumore causerà una velocissima attivazione nel sistema simpatico, scatenata dal cervello rettiliano, seguita temporalmente da una emozione di paura (cervello paleomammaliano) attivata dal sistema limbico, seguita da una valutazione consapevole della situazione da parte della corteccia (cervello neomammaliano). È a partire dalla corteccia che iniziano una serie di azioni legate alla valutazione consapevole del livello di pericolosità del rumore percepito: una cosa sarà rendersi conto che il rumore è stato causato da un aereo di passaggio, altra cosa sarà rendersi conto che il rumore è quello del soffitto che sta crollando per un terremoto.

Il cervello in toto si sviluppa nel senso di una ricchissima connettività all'interno di ogni struttura e tra questi tre differenti "cervelli". Si sviluppa anche nel senso di una capacità regolatoria, soprattutto inibitoria, agita dalle strutture superiori su quelle inferiori, come già definito da John Hughlings Jackson nella seconda metà del XIX secolo.

È ormai assodato, anche empiricamente, che l'evento o gli eventi traumatici esercitano il loro potenziale patogeno alterando la reciproca e armonica connessione tra differenti strutture cerebrali, alterando innanzitutto le capacità auto-regolatorie del sistema nervoso sia centrale che autonomo (per una trattazione dell'argomento vedi Frewen e Lanius 2006).

La disregolazione degli stati di arousal è uno dei segni più chiari di avvenuta traumatizzazione. L'evento traumatico acuto causa un sovraccarico imponente e patogeno (meccanismo del "troppo in troppo poco tempo") per i sistemi neurobiologici di regolazione, mediante le note caratteristiche di situazione soverchiante, minacciosa per la vita e che causa impotenza. Anche sistemi biologicamente sani e maturi hanno un punto di rottura: ovvero ogni persona è potenzialmente traumatizzabile all'aumentare dell'intensità dell'evento traumatico (Herman 1992).

Se l'evento accade in età precoce non è necessario che abbia una grande intensità, in quanto il sistema nervoso è ancora in una fase di sviluppo (un neonato ha ad esempio ancora ampie parti di sistema nervoso da mielinizzare) ed eventi "meno traumatici" agiranno comunque in modo traumatizzante. Allo stesso modo, sono da considerare patogeni in infanzia gli eventi persistenti di maltrattamento, i pattern di attaccamento disfunzionale o la trascuratezza grave in quanto interferiscono con l'obiettivo maturativo fondamentale del sistema nervoso: quello di creare connessioni (*wiring*) che permettano un funzionamento il più possibile capace di essere stabile in modo dinamico, riuscendo a rispondere in modo efficace e armonico a vari tipi di stimoli potenzialmente disregolanti.

In quest'ottica, quindi, è traumatizzante ciò che causa una disregolazione cronica, più o meno intensa, dell'arousal fisiologico, emotivo, comportamentale: ciò può avvenire sia attraverso una sorta di "rottura" su sistemi regolatori in precedenza abbastanza maturi, sia attraverso un danno allo sviluppo di tali sistemi (eventi precoci).

L'arousal disregolato causa una dissociazione di aree cerebrali normalmente collegate tra loro, obiettivabile con gli strumenti di neuroimaging (Lanius et al. 2005) e in alcuni casi anche all'EEG (Teicher et al. 1997). Solitamente questa dissociazione è funzionale e transitoria, come ad esempio nei *flashbacks*. Nei casi di grave e precoce traumatizzazione, maltrattamento e neglect,

è ipotizzabile che tale dissociazione abbia anche basi organiche a livello di alterata connettività e sviluppo del sistema nervoso centrale (Perry 2005).

Troviamo all'opera un meccanismo dissociativo nel senso di "non associazione", di mancata connessione tra aree cerebrali deputate (ma impossibilitate) ad elaborare efficacemente lo stimolo, che rimarrà quindi, a vario titolo e in vario modo, memoria traumatica iscritta nel corpo, non processata, "corpo estraneo" non integrabile (Freud 1893-5).

Questi funzionamenti cerebrali dissociati (o non associati) sono stati visualizzati mediante risonanza magnetica funzionale e gli stati caratterizzati da disregolazione dell'arousal nel senso dell'iperattivazione (iperarousal) sono neurologicamente distinguibili dagli stati di ipoattivazione (ipoarousal) (v. infra e cfr. Lanius et al. 2003). In entrambi i casi è compromessa la connettività tra corteccia prefrontale e strutture sottocorticali, con conseguenti problemi di inibizione dell'iperattivazione sottocorticale (in particolare dell'amigdala), difficoltà nella discriminazione dello stimolo e nella mentalizzazione dell'esperienza. L'area di Broca, deputata al linguaggio, risulta inoltre funzionalmente disattivata. Ogni volta che, in seduta, emergono a vario titolo frammenti dell'esperienza traumatica si verificherà nel paziente un riproporsi di questi pattern di funzionamento cerebrale, durante i quali la verbalizzazione non potrà essere un elemento terapeutico efficace, in quanto non è realmente a disposizione, vista la disconnessione prefrontale e la disattivazione dell'area di Broca: da qui l'osservazione già freudiana di non integrabilità (attraverso la parola) di parti dell'esperienza traumatica.

Per ipotizzare di raggiungere tale scopo è necessario percorrere strade che non passino attraverso un'impossibile elaborazione verbale, ma che piuttosto osservino e aiutino il corpo a trovare modalità di elaborazione e integrazione somatica del trauma, visto innanzitutto come fattore di dissociazione e di disregolazione dell'arousal. Se utilizziamo quest'ultimo elemento come marker, la distinzione tra PTSD, o trauma semplice, e Complex Trauma è soprattutto di tipo quantitativo più che qualitativo ed è legata alla valutazione di quanto intensa e pervasiva sia la disregolazione (Ford et al. 2005).

Per questi motivi le terapie orientate sul corpo, come la Sensorimotor Psychotherapy, che identificano nella regolazione dell'arousal uno degli obiettivi di cura principali, sono applicabili ed efficaci rispetto a tutto lo spettro dei disturbi legati a traumatizzazione. Inoltre, a differenza delle psicoterapie "tradizionali", non richiedono in modo obbligato l'utilizzo della verbalizzazione, consapevoli del fatto che una parte profonda dell'effetto patogeno del trauma risiede proprio nel fatto che la possibilità di verbalizzazione è ostacolata.

2. Il modello polivagale di Porges

Secondo la visione neurofisiologica classica il sistema nervoso autonomo viene suddiviso in sistema (orto-)simpatico e sistema parasimpatico. In questo modello i due sistemi hanno funzioni opposte e tra loro equilibrantisi, come i due piatti di una bilancia.

Il sistema simpatico ha funzione attivante e catabolica (utilizzo dell'energia), aumenta l'arousal, attiva le reazioni di orientamento verso il pericolo (focalizzazione dell'attenzione e dello stato di coscienza), predisponendo il corpo alle reazioni dette di "evitamento attivo" come quelle di attacco o fuga (*fight or flight*) mediate da adrenalina e noradrenalina: avverranno quindi tutte le concomitanti reazioni fisiologiche da stimolo adrenergico a partire dall'aumento della frequenza cardiaca. A livello emozionale (limbico) tale attivazione è legata a paura, terrore (fuga) o rabbia (attacco). La situazione di iperattivazione simpatica, detta iperarousal, può arrivare fino al cosidetto *freeze ipertonico* con completo blocco e irrigidimento muscolare, descritto come la

situazione "dell'alce illuminato dai fari della macchina", che resta paralizzato dalla luce improvvisa degli abbaglianti e rimane bloccato in mezzo alla carreggiata, incapace di muoversi.

Il sistema parasimpatico, all'opposto, ha funzioni di risparmio e ripristino dell'energia (anaboliche), diminuisce l'arousal, rallenta la frequenza cardiaca, facilita il riposo e la digestione. Agisce attraverso il nervo vago, a trasmissione colinergica. Facilita i sistemi d'azione dell'attaccamento, della socializzazione e della sottomissione, inibendo le reazioni di difesa a mediazione simpatica. La situazione di iperattivazione parasimpatica, detta ipoarousal, attiva le reazioni dette di "evitamento passivo", con senso di distacco, abbassamento del livello e restrizione del campo di coscienza con *numbing* emozionale e sensoriale. L'ipoarousal può arrivare fino a stati dissociativi franchi con grave alterazione o perdita delle sensazioni somatiche, depersonalizzazione, derealizzazione, perdita di coscienza. Altra reazione da ipoarousal intenso è la cosiddetta immobilità tonica, o "finta morte" (*feigned death*) scatenata da situazioni di estremo pericolo, senza possibilità di fuga, durante la quale l'animale sembra senza vita. Essendo una reazione spesso utilizzata dall'opossum è detta anche "*playing possum*". Tale reazione è presente anche negli esseri umani ed è alla base delle situazioni di totale passività e incapacità di reagire di fronte ad un'aggressione o ad un pericolo vissuto come assolutamente soverchiante e insormontabile. Tale reazione è automatica, non è legata in alcun modo ad una scelta consapevole e non va scambiata per un atteggiamento consenziente di accettazione della situazione di aggressione che si sta vivendo (Clerici e Veneroni 2011; Nijenhuis et al. 1998). A livello emozionale, l'attivazione parasimpatica è correlabile alla colpa e alla vergogna.

Potremmo definire "binario" questo modello classico del sistema nervoso autonomo, mentre Stephen Porges, neuroscienziato e psicofisiologo di Chicago, ha proposto nel 1994 un modello tripartito, detto polivagale, utilizzando dati di laboratorio e seguendo linee di argomentazione che hanno basi di tipo anatomico, filogenetico e neurofisiologico (Porges 2007).

La teoria polivagale presuppone una separazione in due parti del sistema vagale (vedi **tabella 1**). La prima parte è filogeneticamente più antica, viene detta tratto dorso-vagale e nasce dal nucleo motore dorsale del vago nel midollo allungato. Corrisponde, per distribuzione e funzioni, al sistema vagale come descritto dalla neurofisiologia "classica".

Tabella 1. *I tre stadi filogenetici del sistema polivagale (da Porges 2001)*

Stadio filogenetico	Componenti del Sistema Nervoso Autonomo	Funzione comportamentale	Sede dei neuroni motori inferiori
III	Vago mielinizzato (*complesso ventro-vagale*)	Comunicazione sociale, autoregolazione ed effetto calmante, inibisce l'influenza adrenergica del sistema simpatico	Nucleo ambiguo
II	Sistema simpatico-adrenergico	Mobilizzazione (evitamento attivo)	Gangli paravertebrali
I	Vago non mielinizzato (*complesso dorso-vagale*)	Immobilizzazione (evitamento passivo, fino a immobilità tonica/ *feigned death*)	Nucleo motore dorsale del vago

Il secondo sistema, detto ventro-vagale, è presente solo nei mammiferi ed è quindi molto più recente in senso evolutivo. A differenza del sistema dorso-vagale è composto soprattutto da fibre mielinizzate, funzionalmente più efficaci, origina dal nucleo ambiguo e innerva il viso, la laringe e il cuore. Ha una funzione fondamentale nel modulare gli stati affettivi e il comportamento sociale, essendo coinvolto nella mimica e nella regolazione della voce, legandole allo stato neurovegetativo, in particolare alla variabilità della frequenza cardiaca e ad alcune funzioni dell'asse ipotalamo-ipofisi. Diminuisce la reattività del sistema simpatico e dei sistemi di azione legati a difesa, attacco e fuga. Possiamo quindi dire che mediante il contatto con l'altro (vista/voce/udito) il sistema ventro-vagale regola, calmandolo, il sistema simpatico.

Per questi motivi Porges parla delle diverse parti del sistema nervoso autonomo come "substrati filogenetici di un sistema nervoso sociale" (Porges 2001) e, in particolare, definisce l'innervazione ventro-vagale come "*social engagement system*" (sistema di coinvolgimento sociale; Porges 2003). Tale sistema è gia presente alla nascita ed è evidente la sua importanza nella regolazione dell'interazione diadica tra madre-neonato, mediando parte delle modalità di attaccamento.

Poiché il sistema ventro-vagale necessita di maturazione (mielinizzazione), cioé di un ambiente favorevole, è ipotizzabile che la qualità delle cure precoci del caregiver influenzi la qualità del funzionamento futuro dell'individuo anche a livello di regolazione del sistema nervoso autonomo. In effetti, in bambini molto precocemente maltrattati o trascurati sono rilevabili, anche a distanza di anni, alterazioni talora gravi a livello di funzioni viscerali coordinate dal cervello protorettiliano (disregolazione dell'arousal, della frequenza cardiaca e respiratoria, alterate percezioni ed elaborazioni degli stimoli, in particolare fame, sonno, sete, dolore, propriocezione; Perry 2005).

Dal punto di vista dell'interpretazione dei comportamenti, il sistema polivagale propone la presenza di 3 livelli di attivazione (per una analisi più approfondita, con schemi grafici e descrizione delle vie anatomiche e dei neurotrasmettitori coinvolti, vedi Porges 2001):

1) *Situazione di ambiente sicuro:* vi è una prevalenza del sistema ventro-vagale sul sistema simpatico e sul sistema dorso-vagale. Non sono necessarie reazioni di evitamento né di tipo attivo né di tipo passivo. L'interazione sociale è il mediatore fondamentale della modulazione autonomica. Vengono facilitati i sistemi d'azione dell'attaccamento, della socializzazione, del gioco e dell'esplorazione (van der Hart et al. 2006) che permettono una maturazione e una crescita del sistema nervoso, attraverso la neuroplasticità cerebrale, presente anche in età adulta (Doidge 2007);
2) *Situazione di ambiente insicuro:* il pericolo percepito attiva il sistema simpatico, facilitando le reazioni di evitamento attivo, in quel momento adattive in quanto danno la possibilità di attaccare o di fuggire in modo più efficace. Il sistema ventro-vagale viene inibito in quanto le reazioni che media non sono adattive in questa situazione: non serve stare vis á vis con il caregiver se un predatore incombe e mi minaccia. In caso di eccessiva attivazione il sistema simpatico può portare a reazioni disadattive nel senso dell'iperarousal (paura incontrollabile, panico, blocco/*freezing* ipertonico);
3) *Situazione di pericolo di vita:* in tali situazioni le reazioni attacco o fuga non sono una opzione percorribile in quanto la minaccia è soverchiante e insormontabile. Viene facilitata l'antica via vagale (sistema dorso-vagale) con le reazioni di evitamento passivo (sottomissione, *freezing* passivo, *numbing*, dissociazione, immobilità tonica e *feigned death*) che talora possono essere adattive in quanto i predatori tendono a non attivarsi o a non infierire

nei confronti di prede ferme o morte, fino addirittura a non notarle. La iperattivazione disadattiva di tale sistema viene detta ipoarousal.

Da tale descrizione è evidente come il modello polivagale offra una descrizione molto interessante, basata su aspetti neurofisiologici e neuroanatomici, anche quando applicata alla disregolazione traumatica dell'arousal,. Attraverso la tripartizione di Porges è possibile descrivere le reazioni che avvengono durante molte situazioni traumatizzanti e che traumaticamente si ripetono nel corpo ad ogni riattivazione delle memorie traumatiche (sedute di terapia comprese).

Il modello polivagale offre altresì una modalità di comprensione e sviluppo di possibilità terapeutiche legate alla possibilità di "agganciare" il paziente a livello dello stato di arousal che sta vivendo, comprendendone, almeno in parte, manifestazioni e dinamiche. Si possono così proporre modalità di cura *body-centred* e fondate neurofisiologicamente: questo è il caso della Psicoterapia Sensomotoria.

3. La Psicoterapia Sensomotoria (Sensorimotor Psychotherapy) per la cura del trauma

La Psicoterapia Sensomotoria (da qui in avanti, per brevità: PS) è un approccio clinico centrato sul corpo (*body-oriented*) sviluppato da Pat Ogden negli anni '80. Un'importante parte delle radici della PS si fonda, in termini di ispirazione concettuale e di modalità operative, sulla collaborazione avuta con Ron Kurtz, pioniere delle terapie centrate sul corpo e fondatore negli anni '70 della Hakomi Therapy (Kurtz 1997).

La PS presenta grande flessibilità e versatilità clinica e può essere utilizzata come strumento a sé stante oppure in collegamento all'approccio clinico preferito dal terapeuta. È applicabile a molteplici problemi e diagnosi cliniche, dai disturbi di personalità ai disturbi di asse I. Ha ottenuto particolare successo in campo psicotraumatologico, grazie alle solide basi teoriche e alla capacità di rimanere agganciata ai principali caposaldi epistemologici del settore, dandone un'interpretazione e un'applicazione originale ed efficace. I più grandi esperti di trauma a livello mondiale hanno accolto entusiasticamente nel 2006 la pubblicazione del volume Trauma and the Body (Ogden et al. 2006; di prossima pubblicazione la traduzione italiana) nel quale Ogden, Pain e Minton hanno raccolto e sistematizzato i concetti fondamentali della PS e la loro esperienza clinica e didattica.

Come il balletto classico e la meditazione buddista, entrambe praticate per anni da Pat Ogden, la PS presenta aspetti di notevole efficacia, uniti a grande eleganza pratica ed attenzione alle *nuances* del rapporto terapeutico: tutto ciò necessita di un training specifico[2] e di una certa esperienza (anche pregressa) nel clinico, che deve coltivare caratteristiche personali di attenzione, capacità di osservazione, ascolto e *mindfulness*.

[2] Gli standard per il training sono stati fissati dal Sensorimotor Psychotherapy Institute e prevedono 3 livelli di formazione (Livello I: Training per la cura del trauma; Livello II: Attaccamento, Sviluppo e Trauma; Livello III: Training per la Certificazione delle Abilità Cliniche). Nel dicembre 2010 è iniziata a Milano la prima parte del primo corso italiano di Livello I, organizzato da Psicosoma di Michele Giannantonio e Maria Puliatti (vedi Risorse Internet). Nel presente scritto non mi propongo in alcun modo di dare informazioni sulla PS che possano sostituire anche in minima parte un training formale, a cui rimando i lettori.

3a. Psicoterapia Sensomotoria e approccio bottom-up

In un bell'articolo su PS ed elaborazione del ricordo traumatico, Ogden e Minton (2000) affermano che i due aspetti essenziali della PS sono: "1) regolare gli stati emozionali e sensomotori attraverso la relazione terapeutica; 2) insegnare al paziente ad autoregolarsi attraverso il contatto, il *tracking* e l'articolazione dei processi sensomotori attraverso la *mindfulness*".

In una seduta di PS il paziente è invitato dal terapeuta a dare meno importanza al flusso narrativo degli eventi (che spesso per i pazienti traumatizzati sregola intensamente l'arousal), a entrare in uno stato di *mindfulness,* tener conto delle proprie sensazioni corporee (contatto) e, invece che parlarne, a osservarne modalità di espressione, qualità e intensità (*tracking*), permettendone lo sviluppo o in senso libero e spontaneo oppure attraverso piccoli "esperimenti" (articolazione).

La regolazione che il terapeuta offre costantemente attraverso il *social engagement* presente nella relazione diadica permette la creazione di un contenitore nel quale il paziente pian piano scopre che può contattare le proprie sensazioni profonde in modo sempre più sicuro e non minaccioso, fino a sviluppare una capacità di attenzione, osservazione e curiosità per le dinamiche delle proprie sensazioni, emozioni e pensieri, che va sotto la nota definizione di *mindfulness*.

Questo tipo di lavoro è definito, anatomicamente, *bottom-up* (dal basso in alto), in quanto il focus dell'attenzione è basato innanzitutto sugli aspetti "bottom" legati alle manifestazioni del cervello proto-rettiliano (troncoencefalico) in termini di sensazioni, movimenti involontari e impulsi al movimento volontario. Viene preferita un'elaborazione che parte dalle sensazioni e ne studia, a salire, gli influssi sulle emozioni (sistema limbico) e sugli aspetti cognitivi (neocorteccia), al contrario delle "*talking therapies*" tradizionali che invece hanno una direzione top-down (dall'alto in basso), corteccia → sistema limbico → tronco dell'encefalo.

Utilizzare come chiave d'accesso le sensazioni somatiche significa dirigersi direttamente verso le memorie procedurali, cioè verso quelle modalità di funzionamento del sistema nervoso che percepiscono e strutturano il momento presente senza richiedere aspetti consapevoli: l'esempio classico è quello di andare in bicicletta, azione complessa (ciclo a feedback percezione-valutazione-movimento) che solo all'inizio, quando stavamo imparando, era sotto un minuzioso e poco efficace controllo consapevole, ma che poi è diventata via via "automatica", sotto il controllo di memorie procedurali sottocorticali.

Caratteristica nota degli eventi traumatizzanti è la capacità di rimanere inscritti all'interno del corpo attraverso memorie procedurali difficilmente elaborabili, cariche di una sensorialità eccessiva e disregolante: gli aspetti fondanti della PS sono in sintonia con possibilità efficaci di raggiungere ed elaborare, attraverso il corpo, gli aspetti procedurali traumatici.

3b. La finestra di tolleranza dell'arousal e il Modulation Model

La definizione proposta da Siegel (1999) di "finestra di tolleranza" (*window of tolerance*) della regolazione dell'arousal, viene sviluppata in Psicoterapia Sensomotoria aggiungendo una più precisa prospettiva clinica, che Ogden ribattezza "Modulation Model".

Secondo Siegel lo stato di arousal può venire reso graficamente come in **figura 1**: al di sopra o al di sotto delle linee parallele in grassetto vi sono stati di disregolazione (iper- o ipo-arousal), che non portano ad alcuna elaborazione del trauma, ma anzi favoriscono il riesperire traumatico (l' "eterno ricominciare" di Janet) e/o ne sono l'epifenomeno psicofisiologico.

Tra le 2 righe in grassetto abbiamo invece uno stato ottimale di regolazione dell'arousal,

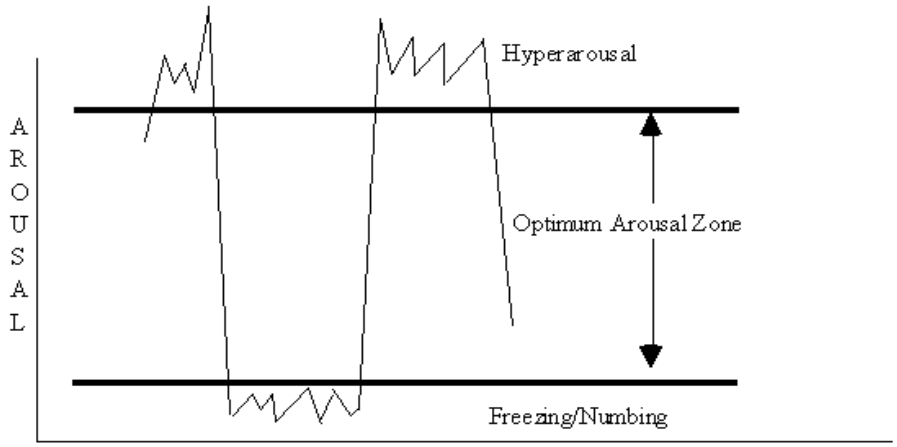

Figura 1. *La finestra di tolleranza (Optimum Arousal Zone), da Ogden e Minton (2000)*

caratterizzato innanzitutto dalla possibilità del soggetto di mantenere un atteggiamento *mindful* rispetto al momento presente, extra- e intra-corporeo.

La parte superiore della figura rappresenta gli stati di iperarousal, nei quali un'eccessiva attività simpatica rende disponibili solo le modalità di evitamento attivo, o di attacco/fuga. La corteccia prefrontale diventa funzionalmente scollegata dalle strutture sottocorticali e non riesce a modularle in senso inibitorio. Il paziente può trovarsi bloccato in sensazioni di paura e terrore, di necessità di fuggire letteralmente dal posto in cui si trova (studio del terapeuta compreso), con tachicardia, sudorazione, agitazione, contrazione muscolare e altri segni di iperattivazione adrenergica. È spesso in questo stato che avvengono i fenomeni di riviviscenza o *flashbacks*, che sono sintomi dissociativi positivi. Il collegamento corticale compromesso e la eccessiva focalizzazione dell'attenzione su aspetti di pericolo imminente impediscono tuttavia l'elaborazione delle memorie traumatiche.

Nella parte inferiore della figura localizzaziamo invece la disregolazione nel senso dell'ipoarousal, con freeze, numbing, dissociazione, immobilità tonica. Il paziente si sente progressivamente o improvvisamente distante, non in contatto, separato dalla presenza dell'altro (terapeuta compreso) da sensazioni varie che vanno dalla vista sfocata, alla presenza di una nebbia o di un vetro trasparente, alla vista telescopica "a cannocchiale". Aumentando di intensità si possono avere sensazioni di progressiva derealizzazione e depersonalizzazione, fino alla autoscopia (visione di se stessi e della situazione dall'esterno del proprio corpo) o a stati confusionali e angosciosi. Se la disattivazione somatica prevale sulla componente dissociativa si possono avere sbadigli, capogiri, nausea, sonnolenza, fino ad uno stato di torpore, di sonno o di collasso/svenimento. La documentazione RMN presentata da Lanius, Hopper e Menon (2003) su uno stato di ipoarousal mostra un cervello quasi completamente "spento", come una città di notte, vista dall'alto durante un black-out.

L'aspetto di non partecipazione, resa, dissociazione e disattivazione rende impossibile una seppur minima elaborazione dei contenuti traumatici che si stanno intensamente manifestando:

è da ricordare infatti che l'ipoarousal rappresenta una situazione di totale sopraffazione, agita dal ricordo o dall'emozione traumatica sui sistemi di difesa, per cui "saltano" sia le possibilità di autoregolarsi attraverso il sistema del *social engagement* (sistema ventro-vagale) che le possibilità offerte dal sistema simpatico (evitamento attivo). Il paziente si trova nella situazione della preda senza via di scampo e, somaticamente, si arrende.

L'ipoarousal si può manifestare subito dopo momenti di iperarousal, secondo la cosiddetta risposta bifasica al trauma, oppure può emergere in via diretta, tramite una disregolazione primaria nel senso dell'ipoarousal. Alcuni pazienti, avendo avuto traumatizzazioni cariche di ipoarousal (confinamento, prigionia, abusi sotto l'influsso di alcool o sedativi) rivivono nuovamente la scena traumatica attraverso la ipoattivazione/disattivazione.

3c. Stabilizzazione, accesso alle memorie traumatiche ed elaborazione

Compito primario di cura è la stabilizzazione (fase 1 della terapia del trauma), evitando che il paziente "esca" dalla finestra di tolleranza. Come succede per una utile cassetta degli attrezzi, la PS offre varie modalità per espandere la finestra di tolleranza, aumentandone l'ampiezza e permettendo così al paziente di avere una maggior tolleranza di sensazioni, emozioni e ricordi e pensieri legati al trauma, riuscendo sempre meglio ad evitare gli stati di franca disregolazione dell'arousal. Una finestra più ampia significa anche la possibilità di mantenere un buon livello di *mindfulness* anche a fronte di sensazioni intense, come quelle evocate dalle componenenti traumatiche.

Obiettivo terapeutico è altresì non rimanere bloccati in un'eterna fase di stabilizzazione e, sviluppando l'idea di finestra di tolleranza all'interno del Modulation Model della PS, Ogden giustamente nota che la zona perfettamente centrale, che sembrerebbe una posizione ideale, è, ai fini dell'elaborazione traumatica (fase 2 del trattamento), una situazione "troppo sicura" (vedi **figura 2**) in quanto permette stabilità, a costo però di rimanere fissati nello *statu quo*, senza progressi.

Questo stato dell'arousal descrive una situazione di sostanziale non elaborazione del trauma che Myers nei primi anni del XX secolo, lavorando con i soldati della prima guerra mondiale, e più recentemente van der Hart e colleghi hanno definito "personalità apparentemente normale", una parte dissociativa della personalità che si prende cura delle faccende quotidiane ma che evita di avvicinarsi e di integrarsi a una o più parti emozionali della personalità che contengono ricordi e sentimenti traumatici (Myers 1916a, 1916b; van der Hart et al. 2006).

Dal punto di vista della PS, se vogliamo favorire momenti di elaborazione delle memorie traumatiche durante una seduta, dovremo lavorare somaticamente in modo che la situazione dell'arousal risulti, mutuando una definizione di Bromberg (2006), "sicura, ma non troppo sicura" (vedi **figura 2**).

Grazie alle possibilità di regolazione tramite la relazione terapeutica precedentemente sviluppate, si lavorerà insieme al paziente per raggiungere la zona ai margini della finestra di tolleranza (sia in alto, al confine dell'iper-arousal, che in basso, al confine dell'ipo-arousal), restando sul "confine", stabilito da un livello di sufficiente *mindfulness*: tale situazione, oltre ad ampliare ulteriormente la finestra, è la più feconda per l'elaborazione dei ricordi traumatici in quanto facilita l'attivazione stato-specifica delle memorie procedurali legate al trauma (Ogden 2009).

La memoria procedurale, detta anche implicita, funziona in modo completamente diverso dalla memoria esplicita, consapevole, detta anche narrativa o autobiografica. Come Siegel (1999) ha ben descritto, la memoria procedurale è rappresentata da stati somatici ed emozionali

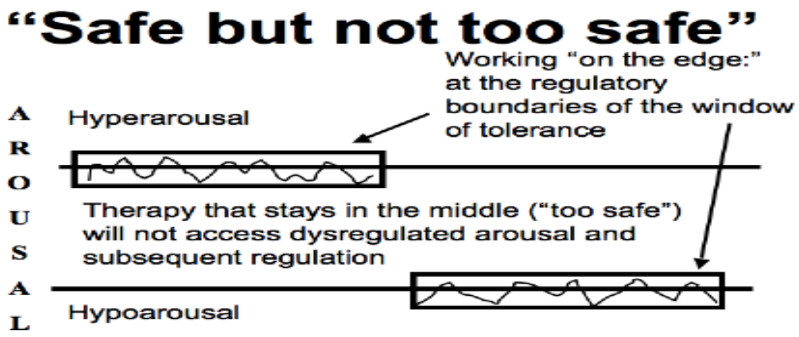

Figura 2. *"Sicuro ma non troppo sicuro": una terapia che resta al centro ("troppo sicura") non riuscirà ad accedere all'arousal disregolato e alle successive possibilità di regolazione. È necessario lavorare "sul limite", ai confini della regolazione della finestra di tolleranza (da Ogden 2009)*

sottocorticali "che non portano con sé la sensazione che stiamo ricordando qualcosa […]: agiamo, sentiamo, immaginiamo senza riconoscere l'influenza della passata esperienza sulla nostra realtà presente".

La modalità stato-specifica di attivazione della memoria (non necessariamente traumatica) è esemplificata da un esperimento abbastanza noto durante il quale è stato chiesto a volontari in uno stato di ebbrezza alcoolica di svolgere quattro compiti mnemonici. I soggetti, tornati sobri, svolgevano male tre compiti su quattro, ma i risultati miglioravano e ricordavano meglio se bevevano nuovamente alcool, se tornavano cioè nel precedente, specifico, stato somatico (Goodwin et al. 1969).

Allo stesso modo, *mutatis mutandis,* possiamo affermare che restando al centro della regolazione dell'arousal ("da sobri") non è possibile avere un accesso completo alla memoria traumatica. Al contrario, nel momento in cui il paziente osserva in modo sufficientemente consapevole e non giudicante (*mindful*) le sensazioni corporee legate ad un ricordo traumatico e raggiunge, senza sregolarsi, uno stato di arousal simile a quello allora sperimentato, si attiva uno specifico pattern psicofisiologico stato-specifico che agisce come la chiave giusta per "aprire le porte" della memoria procedurale legata a quello specifico evento traumatizzante.

Ciò rappresenta una situazione preziosissima a livello terapeutico in quanto potremmo dire che ci si trova di fronte alla memoria procedurale traumatica nella sua interezza, vissuta in uno stato che è plasmabile e trattabile, nella misura in cui si riesca a restare insieme al paziente in uno stato di arousal sufficientemente regolato e si utilizzino strategie specifiche.

Si apre a questo punto la fase di vera e propria elaborazione del trauma (fase 2), che la PS affronta ritornando a Janet e all'idea di "ricordo traumatico come azione incompleta", così come esposto anche da Van der Hart, Nijenhuis e Steele (2006):

> [L'ultimo] obiettivo, forse il più difficile, è completare le azioni con lo scopo di risolvere i ricordi traumatici. I ricordi traumatici sono una forma speciale ed estremamente costosa di azioni incomplete:

"Questi pazienti ... stanno continuando l'azione, o meglio un tentativo di azione che iniziò quando successe l'evento; e si esauriscono in un eterno ricominciare" (Janet 1919/1925, p. 663). La risoluzione dei ricordi traumatici può essere un compito lungo e arduo e necessita di molti passi, piccoli e ripetuti.

Con la sua carica devastante e soverchiante, l'evento traumatizzante ha impedito in passato un pieno ed efficace dispiegarsi di azioni di difesa e di protezione da parte della vittima. La sequenza di tali azioni è rimasta abortita e rimane bloccata in memorie somatiche procedurali, recuperabili nel momento in cui si riattivano stati di arousal specifici. In PS le strategie terapeutiche da utilizzare in questa fase sono raggruppate sotto la definizione di *sequencing* (sequenziamento).

Aiutare il corpo a completare e terminare tali sequenze di azioni porta il paziente a realizzare ciò che Janet (1919) definisce "atti di trionfo", che si concretizzano in movimenti specifici agiti dal paziente. Quando vengono messi in atto con *mindfulness e* all'interno di un adatto contenitore terapeutico *body-oriented* come la Psicoterapia Sensomotoria, gli atti di trionfo hanno un potente, profondo e talora risolutivo effetto terapeutico, altrimenti non raggiungibile.

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Autore per la corrispondenza: Giovanni Tagliavini, giotagliavini@yahoo.it

Policy Brief

CTIPP
Campaign for Trauma-Informed Policy and Practice

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CTIPP Position on Evidence-Supported Practices and Policies

Why does CTIPP need a position on this issue?

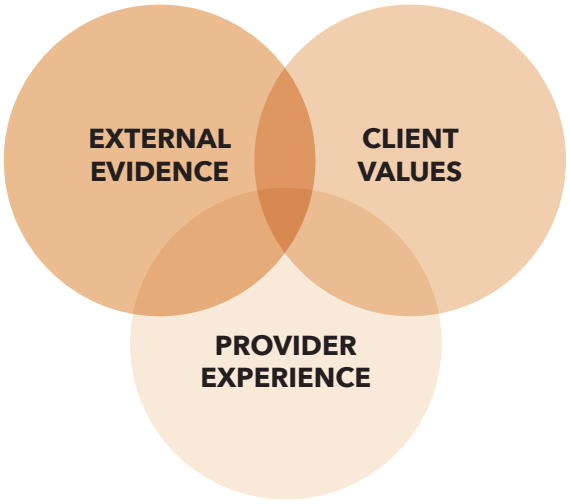
Policymakers and practitioners are often faced with deciding between different options. Scientific evidence is an important criteria for making policy and resource allocation decisions. Even when answers are incomplete, the best course of action is generally to use what we *do* know while we are gathering additional information.

However, real life situations are messy and complicated. Interventions designed to address this complexity are hard to evaluate using traditional methods - controlling the environment, changing one variable at a time, measuring the results, and seeking causal relationships. As a result, much research is conducted on problems and solutions that can be studied in controlled environments. This can skew the evidence base and subsequent policy decisions towards those options. In addition, potentially profitable interventions often receive far more research attention than equally promising interventions that hold less potential for profit.

Moreover, the field of trauma and resilience is in a period of experimentation. The evidence connecting toxic stress and trauma and a range of health and social problems is strong enough to warrant action. Addressing trauma can be beneficial in a wide variety of settings, as can efforts to prevent trauma and build resilience. However, we are not yet in a position to determine exactly what interventions are most effective for what groups under what conditions. Even well-studied interventions have often not been tested in a variety of populations or settings. At this stage, innovative solutions should be encouraged and evaluated as rigorously as possible.

What is CTIPP's position on evidence-supported practices?

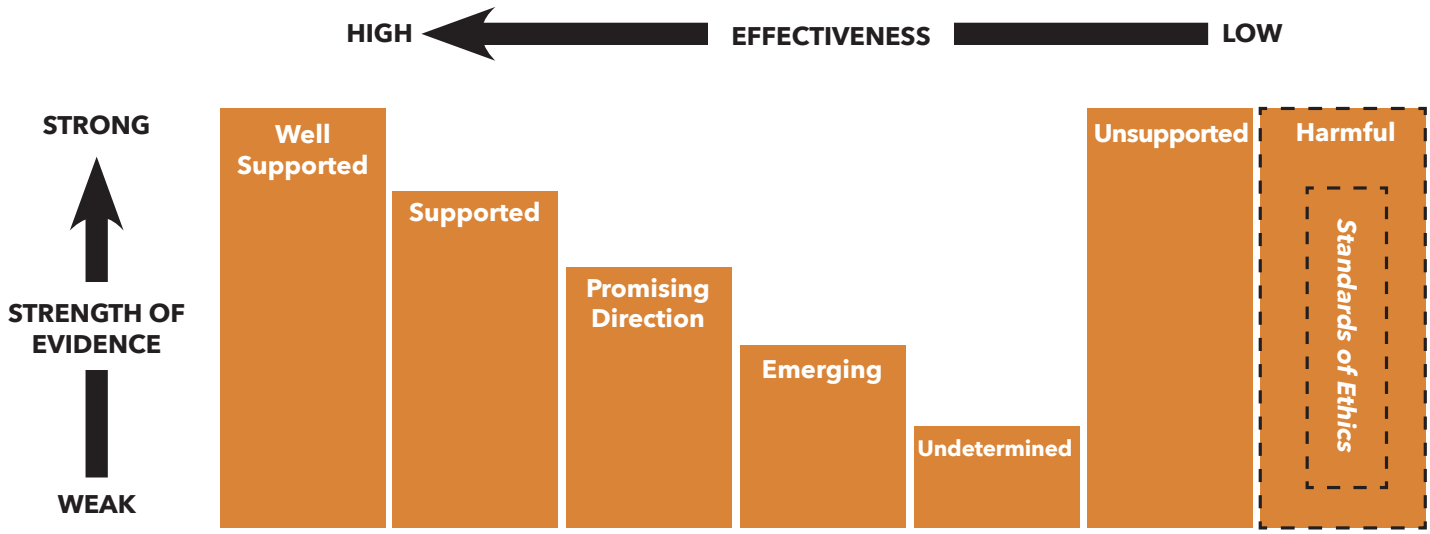
CTIPP understands that evidence-supported practice requires the integration of the current best available evidence with individual practitioner expertise and the values and preferences of service recipients. Clearly, even well-researched interventions will not be successful if providers or service recipients find them unacceptable on other grounds. When funding decisions are being made, CTIPP supports the use of the best available evidence relevant to the context and desired outcomes as expressed by providers and service recipients. When available evidence is insufficient, as determined by a thoughtful and thorough exploration, modification of existing approaches or development of novel strategies is warranted.



Evidence-supported practice requires integration of evidence, provider experience, and client values and preferences.

Evaluation of new or adapted approaches is highly desirable, and should be tailored to intervention characteristics, population served, and setting. Because resources to conduct formal evaluations are not always available, a range of methodologies should be promoted, including collection of experiential evidence from practitioners (sometimes called "practice-based evidence.")

What framework for evidence does CTIPP use?



Centers for Disease Control and Prevention continuum of evidence-supported practices

There are a variety of terms used to indicate different levels of *evidence*, depending on the rigor of evaluation methods used and capacity to rule out competing possibilities. The most common term, "evidence-based practice," indicates that the intervention has been tested for a particular application using the most rigorous design possible in the circumstances. An intervention is called *effective* if it can reliably produce the effect in a given setting. Evidence of effectiveness for one application does not necessarily generalize to others. For example, an intervention found to be effective in preventing addiction relapse is not necessarily effective in preventing people from initiating use. Likewise, a program that is effective with white men will not necessarily work with women or people of color. Since programs vary on both *strength of evidence* and *effectiveness*, CTIPP uses the continuum recommended by the Centers for Disease Control. This continuum shows varying levels of evidence that can be relevant in different situations. It also reminds us to be aware that potentially harmful consequences should always be factored into policy decisions.

> *"Evidence of effectiveness for one application does not necessarily generalize to others."*

What does CTIPP recommend to policymakers?

CTIPP recommends that:

- *Public policy should reflect the highest level of research evidence available* and appropriate for a given application of an intervention in a given set of circumstances, taking into consideration the history and context of the group to be impacted and the desired outcomes.
- *Policymakers should avoid mandating particular program or intervention models*. Instead, local flexibility in selection or development of models consistent with available evidence should be encouraged to allow for cultural, historical, geographic, and resource diversity.
- *If a community determines that available evidence-based programs are not applicable* to their circumstances, a waiver of evidence-based requirements should be available, with appropriate proviso to evaluate the approach that is adopted and sufficient resources to do so.
- *Service recipient values and preferences and provider experience* should be factored into the selection of approaches.
- *Standards for evidence should reflect research methods feasible* for the particular research question, resources available and population involved.
- *New program initiatives should encourage innovation to meet local needs*, and should include funding to gather data on effectiveness, feasibility, acceptance, and utility.
- *Potentially harmful effects* of an intervention should always be considered in making policy and resource allocation decisions.

Additional Resources

American Psychological Association definition of evidence-based practices in psychology.
http://www.apa.org/practice/guidelines/evidence-based-statement.aspx

Centers for Disease Control and Prevention. *Understanding Evidence. A Guide to the Continuum of Evidence of Effectiveness.*
https://www.cdc.gov/violenceprevention/pdf/understanding_evidence-a.pdf

National Rehabilitation Information Center. *More than a nice thing to do: Using practice-based evidence for outcome evaluation in native youth programs.*
https://www.naric.com/?q=en/content/more-nice-thing-do-using-practice-based-evidence-outcome-evaluation-native-youth-programs

Promising Practices Network. *What is an evidence-based practice?*
http://www.promisingpractices.net/briefs/briefs_evidence_based_practices.asp

Sackett, DL et al. *Evidence-based medicine: what it is and what it isn't.*
https://www.bmj.com/content/312/7023/71?eaf%252523R5

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Michele Giannantonio

Eye Movement Desensitization and Reprocessing (E.M.D.R.) e psicoterapia del Disturbo Post-Traumatico da Stress: considerazioni critiche e linee di tendenza

Sito Internet: www.psicotraumatologia.com
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Riassunto

L'Eye Movement Desensitization and Reprocessing (EMDR) è una forma di psicoterapia relativamente recente nota soprattutto per la sua discussa efficacia nella psicoterapia del Disturbo Post-Traumatico da Stress (PTSD), ma anche per l'accesa polemica che ruota attorno ad essa. Nel presente articolo viene valutata la più recente letteratura sull'efficacia dell'EMDR nella psicoterapia del PTSD, prestando una particolare attenzione alla comparazione con altre forme di psicoterapia ed alle critiche concettuali e metodologiche che sono state rivolte a questa metodica. Una review della letteratura porta con un ragionevole grado di certezza ad affermare l'efficacia dell'EMDR nella psicoterapia del PTSD. È invece necessaria ancora molta ricerca per dipanare le incertezze relative ai meccanismi specifici sui quali si basa l'efficacia dell'EMDR. Vengono infine accennate alcune attuali linee di tendenza nell'evoluzione dell'EMDR.

Summary

Eye Movement Desensitization and Reprocessing (EMDR) is a relatively recent model of psychotherapy known especially for its controversial effectiveness in Post-Traumatic Stress Disorder (PTSD) psychotherapy, but also for the intense polemic centred on it. In the present article the most recent literature about effectiveness of EMDR in PTSD psychotherapy is evaluated, paying a particular attention to the comparison with other forms of psychotherapy and to the conceptual and methodological criticisms addressed

to this psychotherapeutic approach. A review of literature leads to assert - with a reasonable degree of certainty - EMDR efficacy. On the contrary, extensive research is still required to dispel doubts concerning the specific mechanisms on which the efficacy of EMDR is based. Finally, some of the current trends in EMDR development are mentioned.

Cenni storici

L'Eye Movement Desensitization and Reprocessing (EMDR) è un approccio psicoterapico creato dalla Psicologa americana Francine Shapiro nel 1987. Chiamato inizialmente "EMD", era originariamente concepito come uno strumento utile a persone con Disturbo Post-Traumatico da Stress (PTSD) in quanto l'impiego di determinati movimenti oculari sembrava consentire un rapido ed efficace effetto decondizionante nei confronti delle memorie traumatiche presentate dai reduci di guerra e dalle vittime di stupro. Successivamente la metodica è stata via via affinata concettualmente ed empiricamente, mutando il nome in "EMDR" nel momento in cui la Shapiro si è resa conto che la procedura da lei creata produceva molto di più di una semplice desensibilizzazione, modificando profondamente la rete di informazioni e ricordi connessa al trauma oggetto dell'intervento (Shapiro, 1995). Questa comprensione si è accompagnata ad una più fine articolazione della metodica. L'EMDR, inoltre, si è trasformata progredendo su due versanti: 1) da un lato, con un approccio estremamente pragmatico, ha incorporato al suo interno spunti teoretici ed applicativi provenienti da differenti paradigmi psicoterapeutici allo scopo di potenziarne l'efficacia e la flessibilità (Shapiro, 1995); 2) dall'altro lato, il punto precedente ha consentito l'applicabilità della metodica ben oltre i limiti dell'originario ambito del PTSD.

Attualmente nei differenti Paesi del mondo le persone che hanno effettuato un training organizzato dall'EMDR Institute sono circa 30.000. In Italia i primi corsi

sull'EMDR sono stati condotti nel febbraio 1999 e sono attualmente coordinati dall'Associazione per l'EMDR in Italia[1], a sua volta riconosciuta e patrocinata dalla EMDR Europe.

Il dibattito attuale sull'EMDR

L'EMDR è - per così dire - nell'occhio del ciclone. Sono ormai moltissimi i clinici che la utilizzano, aumentano le pubblicazioni che la riguardano, ma contemporaneamente prolificano le critiche rivolte alla metodica ed alle ricerche orientate a valutarne l'efficacia terapeutica, comparendo saltuariamente toni indecorosi. Probabilmente si tratta di una questione mutifattoriale, ed alcuni degli elementi più importanti coinvolti nella diatriba mi paiono essere i seguenti. Innanzitutto, il dibattito pro o contro l'EMDR sembra avere assunto per molte persone un aspetto ideologico e, si sa, l'ideologia non va d'accordo con la ricerca scientifica. Inoltre, sono state prodotte alcune critiche sulla base dell'applicazione dell'EMDR, ma senza seguire i protocolli previsti dalla ricerca, portando a risultati negativi circa l'efficacia della metodica (Shapiro, 1999). A molti clinici l'EMDR è sembrata una tecnica troppo fredda, meccanicistica e semplicistica, laddove si tratta invece di un approccio creativo alla psicoterapia (Goldwurm, 2000). Altri autori, poi, hanno pensato che si volesse proporre l'EMDR come una psicoterapia magica sempre funzionante in una sola seduta; tale equivoco si è generato probabilmente a causa della prima pubblicazione della Shapiro (Shapiro 1989), laddove l'autrice sosteneva di avere appunto ottenuto risultati importanti nei confronti del PTSD con interventi di una sola seduta nel 100% dei soggetti (risultati, però, mai più replicati). Tale visione parziale dei fatti sarebbe poi

[1] Associazione per l'EMDR in l'Italia, Via Paganini n° 50 – 20030 – Bovisio Masciago (MI), tel/fax

stata ulteriormente avvallata dall'autorevole consenso di Joseph Wolpe (cit. in Butler, 1993; Shapiro, 2000). Una tale concezione eccessivamente magnanima nei confronti dell'EMDR, però, non è certo quella più attuale e condivisa (Shapiro, 1995, 1999). Molto recentemente è stata nuovamente pubblicata una ricerca che compara una singola seduta di EMDR con una singola seduta di intervento comportamentale basato sull'esposizione (Rogers et al., 1999). Questa non fa che fomentare le incomprensioni ed i settarismi, qualunque siano i risultati a cui portano ricerche concepite in questo modo.

Dai fautori dell'EMDR, inoltre, sono anche state pubblicate alcune ricerche metodologicamente dubbie o francamente fragili, che non hanno fatto altro che attirare gli strali dei critici.

Per ultimo, ma non per importanza, è da osservare che un metodo che si propone come più efficace o più rapido nella terapia di alcuni disturbi psicologici e che è supportato da un efficacissimo meccanismo di diffusione commerciale non può non essere valutato come un rivale, soprattutto in una realtà sociale, come il Nord America, dove le spese per la psicoterapia sono pagate dalle assicurazioni.

Alcuni basi teoriche e cliniche dell'EMDR

L'impiego dell'EMDR ha portato la sua creatrice ad adottare come modello esplicativo dei cambiamenti ottenuti quello della *elaborazione accelerata dell'informazione*. Impiegando l'EMDR in psicoterapia, ed in particolare nel trattamento del PTSD, si ha frequentemente l'impressione che la metodica riattivi un meccanismo innato ed ecologico, presente in ogni persona, di elaborazione delle informazioni a contenuto emotivamente pregnante. Il caso ipotetico migliore, quello al

quale la "filosofia" dell'intervento si ispira, è rappresentato dalla situazione in cui il terapeuta rappresenta solamente un *facilitatore* di un processo che il paziente gestisce in modo completamente autonomo, senza interferenze di sorta. Si presume, cioè, che il paziente possieda potenzialmente tutte le risorse necessarie per rielaborare emotivamente e cognitivamente un evento traumatico. In realtà, in molte situazioni cliniche, questo è semplicemente un modello di ispirazione al quale bisogna tendere asintoticamente. Un intervento terapeutico più direttivo e ben più supportato teoreticamente è infatti indispensabile laddove la rielaborazione del target di intervento non proceda autonomamente ed efficacemente (i.e.: Manfield, 1998, Parnell, 1999). A tale scopo, sono state create molteplici tecniche d'intervento che vengono racchiuse sotto l'unico termine di "cognitive interwave", ovvero "intervento cognitivo integrativo". Lo scopo di queste strategie è molteplice: rendere i ricordi emotivamente meno disturbanti e quindi rielaborabili; introdurre informazioni mancanti che producano una differente comprensione degli eventi sui quali si lavora; aiutare la persona a fruire di risorse delle quali dispone ma che risultano di accesso difficoltoso o al momento impossibile; accelerare il processo terapeutico; agevolare cambiamenti terapeutici che stentano a generalizzarsi (Lipke, 2000; Shapiro, 1995, 1999).

La ricerca ha dimostrato come alcuni tipi di stimolazione prodotti dal terapeuta attivino il processo della elaborazione accelerata delle informazioni. In particolare, i movimenti oculari orizzontali generati seguendo il movimento delle dita del terapeuta, sono stati il primo tipo di stimolazione individuata, casualmente, per questo scopo. È per questo motivo che l'EMDR deve il suo nome ai movimenti oculari. In realtà, il prosieguo della ricerca e della pratica clinica sta dimostrando come siano efficaci anche altri tipi di stimolazione alternata, ovvero rivolta contemporaneamente al target di intervento e ad uno stimolo esterno ritmico bilaterale proposto dal terapeuta: altri tipi di

movimento oculare, tamburellamenti sul dorso o sul palmo delle mani, rumori proposti alternatamente ad entrambe le orecchie, l'osservazione di una luce che scorre su una barra luminosa (per una rassegna sulla ricerca sulla stimolazione alternata, Lipke, 2000). L'individuazione di questi dispositivi elicitatori di un'accelerazione nell'elaborazione delle informazioni è certamente la caratteristica distintiva maggiore dell'EMDR, quella che ha attirato l'interesse ma anche lo scetticismo di molti clinici. L'utilità di stimolazioni duali è una scoperta di notevole rilevanza clinica per almeno due motivi: 1) si sono dimostrate notevolmente efficaci e 2) sono provviste di notevole flessibilità. Il terapeuta, infatti, può modificarle molto liberamente adattandole all'andamento del processo terapeutico, sostituendole con altri tipi di stimolazione se ciò è utile a risolvere difficoltà nel processo rielaborativo. Durante la continua calibrazione del processo terapeutico, inoltre, al terapeuta è consentito verificare direttamente o indirettamente l'efficacia del dispositivo impiegato. L'osservazione della comunicazione metaverbale del paziente, unitamente ai riscontri verbali che egli fornisce, sono le fonte sulle quali la stimolazione duale viene continuamente calibrata.

La procedura d'intervento per il Disturbo Post-Traumatico da Stress (PTSD): il protocollo standard per adulti e adolescenti

L'EMDR è nata come terapia elettiva del PTSD ed ha modellato la struttura fondante della propria procedura di intervento (nonché le proprie basi teoriche) su questa patologia. I protocolli di intervento rivolti ad altre patologie (adeguatamente validati o meno) sono l'adattamento dell'originale protocollo per il PTSD. Non si tratta però di un limite metodologico dell'EMDR o di un residuo storico della sua evoluzione. L'EMDR, infatti, è e resta innanzitutto un intervento efficace sugli eventi traumatici o altamente stressanti, e come tale interviene su questi target di intervento adattando le

proprie procedure alle peculiarità con le quali gli eventi traumatici o altamente stressanti si manifestano all'interno delle differenti manifestazioni psicopatologiche. Il trauma, infatti, più che essere connesso in modo privilegiato al PTSD, sembra doversi considerare un elemento trasversale di parte significativa della psicopatologia (Bremner, Vermetten, Southwich, Krystal, Charney, 1998; Briere, 1997; Williams, Joseph, 1999). Considerando, infine, che il protocollo EMDR per il PTSD negli adulti e negli adolescenti connesso ad un singolo evento traumatico è senza dubbio quello maggiormente consolidato e verificato sperimentalmente, farò riferimento dettagliatamente solo a questo protocollo, semplicemente accennando in seguito ad ulteriori applicazione dell'EMDR.

La procedura-tipo o algoritmo di intervento consta di otto fasi specifiche, composte di elementi "non specifici" (relazione terapeutica, elementi psicoeducazionali, etc.), di elementi genuinamente specifici (movimenti oculari o altri tipi di stimolazione adeguata, sequenzialità degli interventi effettuati) ed elementi mutuati – direttamente o indirettamente - da altre tradizioni di ricerca (assessment cognitivo e ristrutturazione, esposizione graduale, abreazione, assecondamento delle libere associazioni, valorizzazione di immagini a contenuto simbolico, manipolazione delle immagini mentali, tecniche provenienti dalla tradizione della terapia ipnotica ed altro ancora).

Nelle fasi iniziali viene raccolta l'anamnesi del paziente, viene valutata l'opportunità dell'intervento e la presenza di condizioni indispensabili per evitare di ritraumatizzare il paziente o generare un *drop-out*. In seguito viene spiegato e calibrato il procedimento terapeutico, e viene verificata la possibilità di raggiungere una condizione di sicurezza psicofisiologica, eventualmente in sinergia con tecniche di rilassamento, di ipnosi e/o di autoipnosi (esercizio del "luogo sicuro").

La fase dell'assessment è di particolare importanza, ed è caratterizzata dalla

costruzione di un'accurata *baseline* articolata sulle componenti cognitive, emotive, sensoriali del trauma, con una particolare attenzione rivolta alle sensazioni fisiche. Un accesso olistico alla memoria traumatica massimizza la probabilità che abbia effetto l'intervento terapeutico successivo. In particolare, l'enfasi posta sulle sensazioni fisiche è in accordo con la ricerca traumatologica attuale che evidenzia un massiccia e cruciale presenza della componente cenestesica e, in senso lato, *implicita*, nella memorizzazione dei traumi (Bremner, et al., 1998; van der Kolk, 1996; van der Kolk, Fisler, 1995). Le difficoltà di acceso ai ricordi (evitamento, dissociazione, intrusività, frammentazione, razionalizzazione, banalizzazione, etc.) sono elementi decisivi nella calibrazione delle modalità d'intervento.

La fase della desensibilizzazione consiste nell'applicazione della stimolazione alternata più adeguata al paziente che ha avuto accesso al materiale traumatico. All'interno di questa fase si deve includere ogni forma di risposta che il paziente esibisce nei confronti dell'intervento, e tipicamente: associazioni verso altri ricordi, prese di coscienza, cambiamento delle differenti componenti sensoriali costitutive del ricordo del trauma, modificazione di convinzioni, abreazioni, e così via. Il compito del terapeuta è di stimolare la rielaborazione spontanea del trauma, intervenendo solo se strettamente necessario, evitando interpretazioni o commenti interferenti, ma anche arbitrarie manipolazioni della direzione della rielaborazione autonoma del trauma. Esistono alcune importanti eccezioni a questa regola di procedura: 1) se il paziente è in difficoltà ed in particolare se il processo rielaborativo è in stallo; 2) se il paziente è sopraffatto dalle emozioni; 3) se il paziente manca delle risorse cognitive ed emotive per affrontare il problema; 4) se, piuttosto che eliminare "chirurgicamente" un trauma, dobbiamo anche ricorrere ad un modello "riparativo" o "integrativo" relativamente ad esperienze di vita assenti, come nel caso dell'incuria e dell'abuso, sessuale, fisico o

psicologico (Giannantonio, 2000, a, b; Leeds, 1998). Durante il processo di rielaborazione il terapeuta si ferma periodicamente, calibrando il proprio procedimento su quanto può comprendere della rielaborazione che sta avvenendo nel paziente, fermandosi tipicamente quando ha l'impressione che sia terminato uno *step* rielaborativo oppure se il paziente appare essere in stallo. A questo punto il paziente viene invitato a verbalizzare quanto sta accadendo dentro di lui sotto forma di pensieri, sensazioni, emozioni e connessioni ad altri ricordi. Questo consente normalmente di comprendere la modalità e la direzione della rielaborazione in atto, fornendo inoltre le informazioni necessarie al terapeuta per agevolare la ripresa del processo nell'eventualità che questi sia impossibilitato.

Quando il coinvolgimento emotivo è notevolmente ridotto o eliminato si interviene agevolando la ristrutturazione cognitiva delle cognizioni disfunzionali (o inadeguate rispetto al tempo presente) che usualmente sono associate ad un trauma. Nello specifico, viene utilizzata una "cognizione positiva" già evidenziata nella fase di assessment, ovvero quello che il paziente vorrebbe realisticamente riuscire a pensare su di sé mentre accede al trauma (i.e.: "Ora sono al sicuro" oppure "Non è stata colpa mia", mentre accede al ricordo di un incidente automobilistico). Attraverso la stimolazione alternata si intende integrare il materiale mnestico originario con nuove informazioni che precedentemente erano inaccessibili emozionalmente e/o cognitivamente (Lipke, 2000). Effettuata l'installazione si verifica l'eventuale presenza residua di sensazioni negative presenti mentre il paziente accede al trauma originario unitamente alla cognizione positiva. Se la ristrutturazione cognitiva non è completa viene ripetuta o modificata. Se sussistono ancora ricordi percepibili somaticamente, questi diventano il target d'intervento da stimolare per mezzo della stimolazione alternata. Spesso l'intervento su questi residui sensoriali connette il paziente a ricordi variamente collegati al trauma dal

quali si è partiti, portando l'intervento a dirigersi su una rete mnestica coinvolta nel disturbo presentato dal paziente. Ottenuto questo obiettivo o, come più comunemente avviene, al termine della seduta, il paziente viene invitato ad interrompere la fase di rielaborazione orientando la piena attenzione verso il proprio luogo sicuro. In questo modo si intende evitare che la rielaborazione del trauma proceda senza soluzione di continuità al termine della seduta, magari in presenza di ricordi altamente disturbanti. Il paziente viene infine invitato a monitorare sé stesso fra una seduta e l'altra e a riferire successivamente l'eventuale presenza di elementi connessi alla rielaborazione in atto del trauma (pensieri, emozioni, sensazioni, ricordi, sogni, etc.).

L'inizio di ogni seduta di EMDR dovrebbe poi iniziare con una rivalutazione dell'opportunità di proseguire il lavoro sul target di intervento della seduta precedente. In particolare, è necessario effettuare un nuovo assessment cognitivo, emotivo, percettivo e sensoriale del target sul quale si sta lavorando, per valutare l'opportunità di un intervento ulteriore o di uno spostamento del focus d'intervento. Potrebbe essere che l'intervento termini con la rielaborazione di un singolo evento traumatico, ma in realtà questa eventualità non è certo la più frequente. Il trattamento di un evento traumatico sovente porta il paziente a riferire di altri episodi stressanti o francamente traumatici variamente connessi al target di partenza, all'interno di una vera e propria rete mnestica.

Il protocollo standard di intervento per il PTSD prevede, inoltre, che sia clinicamente necessario rielaborare gli eventi traumatici passati, ma intervenire anche sulle situazioni contingenti attuali che fungono da *triggers* nei confronti degli eventi traumatici e, infine, sulle ipotetiche situazioni future che si presumano possano riattivare i comportamenti disfunzionali connessi alle originarie esperienze traumatiche. Di conseguenza, è teoreticamente corretto e clinicamente efficace considerare come target d'intervento non tanto il singolo evento che il paziente riferisce - appunto - come

traumatico, quanto piuttosto il ricordo in questione all'interno di una specifica rete mnestica, con connessioni al passato, al presente ed al futuro. Questa non è un'opzione teoretica arbitraria, ma la formalizzazione di una necessità metodologica evidenziata regolarmente dai pazienti. Di fatto, l'EMDR consente frequentemente di potere ripercorrere gli elementi costituitivi nella produzione di ciò che definiamo comunemente "traumatico", ovvero di evidenziarne l'etiologia psicobiologica multifattoriale (Briere, 1997; Carlson, Dalemberg, 2000).

Efficacia dell'EMDR nella psicoterapia del PTSD: certezze, dubbi e prospettive di ricerca

Fino a pochi anni fa la ricerca sull'efficacia della psicoterapia del PTSD era estremamente esigua (Shapiro, 1995). Negli ultimi anni, invece, questo settore ha collezionato un crescente numero di pubblicazioni sull'efficacia delle psicoterapie, e l'EMDR è uno degli approcci terapeutici che vanta il maggior numero di conferme di efficacia nella psicoterapia del PTSD. Nonostante le vivaci polemiche ed incomprensioni, questo stato di cose ha consentito all'EMDR nel 1995 di essere considerata "trattamento probabilmente efficace" (valutazione A/B) nella terapia del PTSD dalla Task Force on Psychological Intervention dell'American Psychological Association. Questa attribuzione di efficacia è spartita solo con lo Stress Inoculation Training e con le terapie basate sull'esposizione (Chambless et al., 1998). Più recentemente, l'EMDR è stata riconosciuta efficace nel trattamento del PTSD anche dall'International Society for Traumatic Stress Studies all'interno della pubblicazione delle sue linee guida per il trattamento del PTSD (Chemtob, Tolin, van der Kolk, Pitman, 2000).

Al di là di ogni ragionevole dubbio, l'EMDR risulta essere una psicoterapia efficace per il PTSD, come dimostrano innanzitutto recenti reviews sull'efficacia dell'EMDR e studi meta-analitici sull'efficacia di differenti approcci terapeutici al PTSD, sia farmacologici che psicoterapeutici (Cahill, Carrigan, Frueh, 1999; Maxfield, 2000; Shepherd, Stein, Milne, 2000; Van Etten, Taylor, 1998), sebbene il meccanismo esatto del suo funzionamento sia al momento oscuro ed oggetto di speculazione (vedi oltre; per una rassegna sulle teorie al riguardo, Shapiro, 1995). A tale conclusione si arriva anche se vengono adottati rigidi criteri di selezione nella valutazione della metodologia delle ricerche (Shepherd, et al., 2000). Infatti, sono attualmente disponibili alcune ricerche ben strutturate sull'efficacia dell'EMDR nel PTSD, che sembrano non essere vanificate da sostanziali critiche metodologiche (i.e.: Marcus, Marquis, Sakai, 1997; Rothbaum, 1997; Scheck et al., 1998; Wilson, Becker, Tinker, 1995, 1997), con follows-up fino a 15 mesi (Wilson et al., 1997); con ciò tali studi si differenziano da una parte non irrilevante di letteratura sull'EMDR, anedottica o sprovvista di adeguata o verificabile evidenza sperimentale (Shepherd et al., 2000), diventata bersaglio (a volte correttamente) di alcuni critici. Fra le ricerche più accreditate alcune sono caratterizzate dalla presenza di valutatori indipendenti dell'efficacia dell'intervento con l'EMDR o con altri interventi o dell'inclusione in una lista d'attesa (Carlson, Chemtob, Rusnak, Hedlund, Muraoka, 1998; Rogers et al., 1999; Rothbaum, 1997; Scheck et al., 1998; Vaughan et al., 1994). Le ricerche, globalmente considerate, hanno dimostrato l'efficacia dell'EMDR in una grande varietà di situazioni traumatiche connesse al PTSD: guerre recenti o lontane nel tempo, incidenti e ustioni, violenze sessuali attuali o pregresse, calamità naturali, lutti, azioni terroristiche.

Sintetizzo succintamente alcuni dati provenienti da alcune fra le pubblicazioni di maggior rilievo e che non verranno ripresi nel prosieguo.

Rothbaum (1997). Un campione di 21 donne vittime di stupro è stato trattato con quattro sedute di EMDR da 90 minuti a cadenza settimanale. L'assessment pre- e post-trattamento (a tre mesi) è stato effettuato da un valutatore indipendente all'oscuro sul tipo di intervento effettuato. Strumenti psicodiagnostici utilizzati: PTSD Symptom Scale (PSS; Foa, Riggs, Dancu, Rothbaum, 1993), Impact of Event Scale (IES; Horowitz, Wilner, Alvarez, 1979), Rape Aftermath Symptom Test (RAST; Kilpatrick, 1988), State-Trait Anxiety Inventory (STAI; Spielberger, Goruch, Lushene, 1970), Back Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, Erbaugh, 1961), Dissociative Experience Scale (DES; Bernstein, Putnam, 1986) più altri reattivi psicodiagnostici meno noti. Il 90% dei soggetti non ha più soddisfatto i criteri per la diagnosi di PTSD, contro il 12% dei soggetti di controllo, cioè una lista di attesa. Un valutatore esterno ha valutato l'elevato grado di adeguamento al protocollo EMDR.

Wilson et al. (1995, 1997). Un campione di 80 soggetti vittime di traumi (di cui 37 con diagnosi di PTSD) sono stati trattati con tre sedute da 90 minuti di EMDR, con attribuzione randomizzata ad un terapeuta, con assessment pre- e post-trattamento effettuato da un valutatore indipendente. Strumenti psicodiagnostici utilizzati: IES, STAI, Symptom Check List (SCL 90-R; Derogatis, 1992), misurazioni soggettive di intensità del disagio e della ristrutturazione cognitiva (SUDS: Subjective Units of Disturbance Scale e VOC: Validity of Cognition Scale) e Post-Traumatic Stress Disorder Interview (PTSD-I; Watson, Juba, Manifold, Kucala, Anderson, 1991). L'EMDR è risultata globalmente efficace rispetto ai soggetti in attesa di trattamento nei controlli effettuati a 30 e 90 giorni. A 15 mesi di distanza è stata registrata una riduzione dell'84% delle diagnosi di PTSD.

Marcus et al. (1997). Un campione di 67 soggetti con diagnosi di PTSD è stato trattato con assegnazione randomizzata con tre sedute da 90 minuti di EMDR. Un

valutatore indipendente ha valutato la condizione pre- e post-trattamento attraverso: SCL-90, BDI, STAI, SUD, IES, Modified PTSD-Scale (Falsetti, Resnick, Resnick, Kilpatrik, 1993). Il 100% dei soggetti vittime di un solo trauma e l'80% dei soggetti pluritraumatizzati non hanno più soddisfatto i criteri per la diagnosi di PTSD, risultati molto superiori rispetto al controllo, ovvero al trattamento standard del Kaiser Permanente Hospital, composto da terapia individuale (o cognitiva, o comportamentale o psicodinamica) più terapia farmacologica, più terapia di gruppo (riferirsi alla pubblicazione per maggiori precisazioni).

Scheck et al. (1998). 60 donne di età compresa fra i 16 ed i 25 anni, vittime di stupro, sono state assegnate in modo randomizzato a due sedute di EMDR o di "ascolto attivo" (Gordon, 1974). La valutazione pre- e post-trattamento è stata effettuata in modo indipendente attraverso i seguenti strumenti: BDI, STAI, Penn Inventory for Posttraumatic Stress Disorder (Hammarberg, 1992), IES, The Posttraumatic Stress Disorder Interview (PTSD-I; Watson et al., 1991), Tennessee Self-Concept Scale (Roid, Fitts, 1991). L'EMDR si è dimostrata più efficace dell'ascolto attivo su tutti i parametri. Nonostante la brevità dell'intervento, i valori registrati dai soggetti trattati con EMDR sono risultati, per tutti gli strumenti utilizzati, non significativamente diversi da quelli della popolazione generale o da quelli dei gruppi normativi trattati con successo.

Le ricerche citate sono alcune fra quelle che hanno contribuito ad ottenere i recenti ed autorevoli riconoscimenti dell'efficacia dell'EMDR. Ciò che invece è più controverso relativamente all'EMDR nella psicoterapia del PTSD riguarda i seguenti ambiti:

1. Presenza di studi che indicano l'EMDR come inefficace o di efficacia dubbia.
2. Supposta maggiore efficacia dell'EMDR rispetto ad altre psicoterapie.
3. Supposta maggiore velocità di intervento dell'EMDR rispetto ad altre psicoterapie.

4. Specificità delle componenti dell'EMDR e loro efficacia terapeutica.

Risultati dubbi o assenti dell'EMDR

A parte le pubblicazioni fondate su presupposti ideologi contrari all'EMDR o su conoscenze di terza mano - che non verranno prese in considerazione (i.e.: Thaler, Lalich, 1996) - esistono alcune pubblicazioni che indicano l'EMDR come inefficace o di efficacia dubbia nella psicoterapia del PTSD, specialmente nel trattamento dei reduci del Vietnam (i.e. Boudewyns, Hyer, 1996; Boudewyns, Stwertka, Hyer, Albrecht, Sperr, 1993; Devilly, Spence, Rapee, 1998; Pitman et al., 1996). In realtà questi studi, globalmente considerati, incappano in uno o più dei seguenti problemi: 1) impiegano solo una o due sedute di EMDR nel trattamento di reduci del Vietnam, ottenendo - ovviamente - risultati nulli o dubbi, oppure 2) trattano con l'EMDR solo uno o due episodi traumatici in soggetti che devono essere considerati, intrinsecamente, pluritraumatizzati (Shapiro, 1999). Studi ben condotti impieganti 12 sedute per ogni soggetto (Carlson et al., 1998), dimostrano la notevole efficacia dell'EMDR con i reduci del Vietnam, poiché ad un follow-up di nove mesi il 75% dei soggetti trattati non soddisfavano più i criteri per la diagnosi di PTSD. Diversi altri studi, invece, sembrano dimostrarne l'inefficacia o l'efficacia dubbia dell'EMDR, ma impiegando protocolli di intervento per il PTSD o le per fobie errati o liberamente modificati (cfr. Shapiro, 1999, 2000 per una rassegna più approfondita) o, infine, ci sono dubbi sulle competenze professionali impiegate (Shapiro, 1995, 1999, 2000). Alcuni autori, aprioristicamente, valutano negativamente le riserve mostrate dalla Shapiro quando sostiene che l'inefficacia di alcune ricerche può essere dovuta all'incompetenza dei terapeuti. Ma questo, invece, può essere verosimile. L'EMDR è solo apparentemente una tecnica di facile applicazione (Goldwurm, 2000), ed anche terapeuti che hanno seguito l'iter di

formazione ufficiale possono essere inefficaci o dannosi, come si evince anche alla ricerca di Wilson et al. (1995, 1997) laddove, nonostante si confermi globalmente un'ottima efficacia dell'EMDR nel trattamento del PTSD e delle memorie traumatiche in generale, un'analisi dell'efficacia per ogni singolo terapeuta ha mostrato che uno di essi è stato in parte poco efficace ed in parte dannoso (Wilson, 2000).

EMDR ed altre psicoterapie nella psicoterapia del PTSD

Lo studio meta-analitico di Van Etten e Taylor (1998) indica che l'EMDR ha una efficacia uguale a quella dello *Stress Inoculation Training*, ma porta i pazienti a non soddisfare più la diagnosi di PTSD in un tempo minore (4.6 contro 14.8 sedute). L'EMDR sembra essere ugualmente efficace delle terapie comportamentali basate sull'*esposizione* (Boudewyns et al., 1993) e del *training di abituazione immaginativa* accoppiato al rilassamento muscolare (Vaughan et al. 1994), più efficace del *biofeedback* (Foa, Meadows, 1997; Carlson et al, 1998) e dello *ascolto attivo* nella tradizione di Carl Rogers (Scheck et al., 1998), meno efficace della variante cognitivo-comportamentale rappresentata dal *Trauma Treatment Protocol* (Devilly, Spence, 1999). L'EMDR è risultata meno efficace degli *SSRIs* nel trattamento della depressione associata al PTSD (Van Etten, Taylor, 1998), ed inoltre la sua efficacia in questo ambito varia notevolmente all'interno degli studi (Maxfield, 2000) e non è ancora adeguatamente compresa (Cahill et al., 1999). Rispetto alla terapia comportamentale basata sull'esposizione, l'EMDR si è dimostrata superiore nel ridurre i sintomi intrusivi (Van Etten, Taylor, 1998; Rogers et al., 1999) e più confortevole per i pazienti (Rogers et al., 1999). Nello studio di Van Etten, Taylor (1998), attraverso la confrontazione fra 61 studi sulla psicoterapia e la farmacoterapia del PTSD, emerge che l'EMDR, insieme alla terapia comportamentale (esposizione in vivo, immaginativa e mista), sembra essere

l'intervento più efficace se paragonato ad un ampio spettro di altre forme di intervento: supporto psicologico, ascolto attivo, psicoterapia psicodinamica, ipnotica e training di rilassamento (Van Etten, Taylor, 1998); le pubblicazioni utilizzate per la comparazione con gli ultimi tre di questi approcci sono comunque estremamente ridotte, e quindi i risultati non possono assolutamente considerarsi definitivi. Nonostante l'apparenza di una sostanziale equivalenza rispetto ai risultati delle terapie comportamentali o cognitivo-comportamentali, l'EMDR sembra ottenere i medesimi risultati in tempi sensibilmente inferiori (i.e.: Foa, Rothbaum, Riggs, Murdock, 1991; per una rassegna di comparazioni: Shapiro, 1995, 1999, 2000). In ogni caso, l'evidenziazione di definitive ed univoche differenze in quest'ultimo ambito è attualmente impossibile poiché l'EMDR è stata confrontata con differenti modelli di intervento comportamentale o cognitivo-comportamentale a causa dell'assenza di omogeneità fra questi approcci terapeutici (Shapiro, 2000). L'EMDR, invece, dal 1995 in poi ha adottato un unico protocollo di intervento per il PTSD (anche se Rosen, 1999, nega tale evidenza) e quindi, laddove tale protocollo sia stato applicato correttamente e da terapeuti adeguatamente formati, gli studi degli ultimi cinque anni rappresentano un corpus di letteratura omogeneo. Inoltre, la quasi totalità delle affermazione sulla differente efficacia fra EMDR e tecniche cognitivo-comportamentali si basa su comparazioni effettuate paragonando molteplici ricerche dove si applica uno o l'altro metodo (Cahill et al., 1999).

Valutazione di componenti specifiche dell'EMDR

Sono state effettuate ricerche impiegando alcune varianti dell'EMDR allo scopo di valutare l'efficacia di alcune sue componenti specifiche, innanzitutto i movimenti oculari.

Sanderson e Carpenter (1992), hanno confrontato il risultato del trattamento di alcuni soggetti fobici sottoposti 1) a EMDR e 2) ad una situazione simile all'EMDR, ma con l'istruzione di tenere gli occhi chiusi. Hanno riscontrato risultati positivi paragonabili in entrambe le condizioni. Dalla descrizione della ricerca, però, sembra si possa dedurre che il protocollo EMDR non sia stato correttamente impiegato, in particolare non rispettando per la prescrizione di applicare i movimenti oculari ad ogni nuova associazione mentale prodotta dal soggetto (Lipke, 2000). Agli stessi risultati di Sanderson e Carpenter (1992) porta lo studio di Acierno et al. (1994) condotto su un soggetto sofferente di molteplici fobie, ma applicando l'EMDR con la prescrizione al soggetto di restare ancorato all'immagine target durante i movimenti oculari, processo che non è EMDR. Da altri problemi procedurali sembra essere affetto lo studio di Boudewyns e Hyer (1996), che porta agli stessi risultati dei due precedenti (Lipke, 2000).

Gosselin e Mattews (1995) e Feske e Goldstein (1997) hanno confrontato il trattamento dell'ansia in generale, nel primo lavoro, e del Disturbo di Panico, nel secondo, trattate con EMDR e EMDR con la variante rappresentata dalla fissazione delle dita del terapeuta, senza che venissero mai mosse. In entrambi gli studi i soggetti hanno ottenuto miglioramenti da entrambe le condizioni sperimentali, ma con una differenza significativa di efficacia dei movimenti oculari rispetto alla fissazione delle dita. Nello studio di Boudewyns et al. (1993) con i reduci del Vietnam, invece, la sottrazione dei movimenti oculari non ha prodotto risultati clinici positivi nei soggetti, come si deduce anche da Montgomery e Ayllon (1994).

Sono a conoscenza di un unico studio che manipoli volontariamente la componente cognitiva e, nello specifico, che elimini la ricerca della cognizione positiva dal protocollo EMDR e la conseguente fase di installazione della cognizione positiva. La

ricerca di Cusack, Spates (1999) effettua questa operazione e non trova una differenza significativa rispetto all'efficacia del protocollo standard, giungendo alla conclusione che l'aspetto cognitivo è superfluo nel protocollo standard EMDR. In effetti, avviene non di rado, specialmente con un PTSD legato ad un episodio singolo e senza comorbilità (come nel campione degli autori), che l'installazione della cognizione positiva risulti ridondante per l'efficacia dell'intervento. Se però il soggetto ha vissuto più esperienze traumatiche e/o si è in presenza di comorbilità (tipicamente, in presenza di Disturbi di Personalità), si nota frequentemente che l'installazione della cognizione positiva è una fase cruciale dell'intervento, in quanto porta il soggetto a rivolgere spontaneamente la direzione della propria attenzione verso altri ricordi traumatici oppure verso problematiche che rendono impossibile la completa risoluzione del target di intervento. Di conseguenza, ritengo errata la deduzione di Cusack e Spates, poiché è corretto che il protocollo standard includa la fase da loro eliminata in quanto massimizza la probabilità di efficacia dell'intervento nel PTSD in generale.

Altre forme di stimolazione alternata

Devilly, Spence e Rapee (1998) hanno sottoposto alcuni reduci del Vietnam con PTSD a due sedute di EMDR e ad una variante di EMDR, senza movimenti oculari, ma con l'attenzione rivolta ad una fonte luminosa lampeggiante ad intervalli irregolari. In entrambi i casi si sono raggiunti miglioramenti rispetto ai controlli, con una differenza non significativa di maggiore efficacia dei movimenti oculari.

Renfrey e Spates (1994) in soggetti con PTSD hanno paragonato l'efficacia di tre diverse condizioni: 1) EMD (la vecchia modalità di applicazione dell'attuale EMDR), 2) EMD senza movimenti oculari provocati dall'osservazione delle dita bensì provocati dall'osservazione di una barra luminosa con una luce oscillante tra i due lati e 3) EMD

con osservazione di una luce fissa. Nell'immediato, tutte le e tre le condizioni hanno prodotto risultati positivi, ma senza differenze significative fra le tre condizioni. Al follow-up la condizione EMD standard si è dimostrata superiore, ma il campione esiguo non consente conclusioni definitive.

Wilson, Silver, Covi, Foster (1996) hanno applicato a soggetti portatori di memorie traumatiche tre differenti condizioni: EMDR, movimenti alternati delle dita dei pazienti al tempo di un metronomo al posto dei movimenti oculari e condizione di quiete al posto dei movimenti oculari. Solo la prima condizione ha prodotto risultati positivi. Al contrario, Bauman e Melynk (1994) riportano risultati positivi nella riduzione dell'ansia ottenuti dalla sostituzione dei movimenti oculari con il tamburellamento alternato su un tavolo delle dita indice dei soggetti, sincronicamente ad un metronomo. In modo simile, Pitman et al. (1996), non hanno riscontrato differenze di efficacia fra i movimenti oculari e il tamburellamento alternato da parte del terapeuta sulle dita del paziente.

Alcuni autori (i.e. Lohr, Lilienfed, Tolin, Herbert, 1999), constatando differenze dubbie o assenti fra EMDR e EMDR senza movimenti oculari, ma provvisto di altre forme di stimolazione alternata (tamburellamenti) o con fissazione dell'attenzione, concludono che i movimenti oculari non sono necessari per l'EMDR. La conclusione è errata per il fatto che molte situazioni scelte per studiare l'aspetto specifico dei movimenti oculari, ovvero la loro sostituzione con altre stimolazioni ritmiche, dimenticano che le medesime stimolazione sono impiegate dai terapeuti EMDR in alternativa ai movimenti oculari, in quanto ritenute efficaci (Shapiro, 1995; Lipke, 2000). Inoltre, il fatto che sia possibile ottenere risultanti anche con la semplice fissazione di un punto luminoso (Devilly et al., 1998), invece di portare inevitabilmente a pensare che i movimenti oculari siano inutili, dovrebbe indurre alla valutazione della

eventualità che l'accesso ad un ricordo traumatico congiuntamente ad un elemento nuovo con funzione distraente (la luce luminosa) possa contribuire alla parziale modificazione di un evento traumatico, per esempio intervenendo a livello dello rigida associazione esistente fra elementi percettivi ricordati e risposte emozionali e psicofisiologiche. In effetti, ci sono indicazioni che portano a considerare realistica questa eventualità, come ad esempio la tecnica messa a punto da F. Ochenberg, laddove il terapeuta conta a voce alta da 1 a 100 mentre il paziente ha accesso al trauma, tecnica che sembra avere un effetto parzialmente decondizionante nei confronti di un trauma (Ochenberg, 1996). La tradizione della psicoterapia ipnotica, inoltre, impiega da molti anni e con efficacia la rottura di schemi associativi come strumento di desensibilizzazione nei confronti di un trauma (Phillips, Frederick, 1995). In attesa di verifiche sperimentali più precise, sembra verosimile che la funzione distraente sia una componente non specifica dell'EMDR, parzialmente responsabile della sua efficacia.

Non mi sembra quindi lecito concluedere, come Lohr et al. (1999), che l'efficacia dell'EMDR sia semplicemente dovuta 1) a fattori non specifici e 2) ad elementi mutuati dalla tradizione cognitivo-comportamentale, nello specifico l'esposizione immaginativa presente nella desensibilizzazione sistematica e nel flooding e 3) ad elementi di immaginazione mentale guidata, propria di altre tradizioni, mentre 4) i movimenti oculari sarebbero semplicemente stati aggiunti per creare una caratteristica distintiva della metodica. Infatti, sebbene sia estremamente verosimile che parte dell'efficacia dell'EMDR sia dovuta ad elementi non specifici (come avviene per ogni forma di psicoterapia), l'esposizione immaginativa impiegata dall'EMDR nel protocollo standard per il PTSD è diversa significativamente da quella della tradizione cognitivo-comportamentale, che tende ad essere ininterrotta e con elevati livelli emozionali (Rogers et al., 1999). Nell'EMDR, infatti, l'immagine del trauma viene adottata come

punto di partenza delle libere associazioni mentali del paziente che, di norma, si rivolgono a molte altre immagini, contenuti di pensiero ed emozioni. Non si tratta, cioè, di un meccanismo di abituazione o di inibizione reciproca rivolto ad una sequenza fissa di immagini, dalla quale non ci si deve spostare. Ciò che addirittura succede con relativa frequenza è che il pazienti si distacchi molto rapidamente dall'immagine scelta come target per rivolgersi ad altro, producendo comunque una desensibilizzazione nei confronti dell'immagine di partenza. Quindi, sebbene sia verosimile che l'abituazione generata dall'esposizione sia in parte implicata nel processo terapeutico dell'EMDR, non può essere considerata l'elemento fondamentale della sua efficacia.

L'eventualità che l'efficacia dell'EMDR sia dovuta all'impiego di tecniche di immaginazione guidata, poi, è priva di ogni sostegno. Tali tecniche possono essere impiegate ed anche con grande efficacia (i.e.: Parnell, 1999) ma solo quando il processo rielaborativo spontaneo del paziente si è bloccato o il paziente è sovrastato dalle emozioni. Nei casi rimanenti, da parte del terapeuta non è prevista alcuna manipolazione dell'immaginazione del paziente, che può per giunta essere anche assente, senza compromissione del processo.

Non mi sembra neppure che si possa concludere, come Lohr et al. (1999), che in attesa della piena, perfetta e completa comprensione di ogni elemento costitutivo dell'EMDR, non ci sia giustificazione clinica per la sua applicabilità. Se pure è vero che ci sia ancora molto da comprendere circa i meccanismi di funzionamento dell'EMDR, la sua efficacia è sostenuta da molte pubblicazioni, e non si vede perché si debbano richiedere all'EMDR prerogative mai pretese nei confronti di nessun altro approccio psicoterapeutico affinché lo si possa impiegare. D'altronde, come affermano gli stessi autori, **la forza e la precisione delle verifiche che vengono richieste all'EMDR è commensurabile alla forza del clamore che ha suscitato la sua presunta efficacia**

(ibid., p. 200), ma questa, più che scienza, è ideologia.

Considerando globalmente gli studi effettuati per valutare l'efficacia di alcune componenti specifiche dell'EMDR emerge un quadro complesso e contraddittorio che necessita certamente di ulteriori approfondimenti. In ogni caso, ciò che invece si evince con chiarezza è che i movimenti oculari prodotti dal movimento delle dita del terapeuta non sono certamente l'unico tipo di stimolazione alternata capace di produrre l'accelerazione dell'informazione comportante decondizionamento e rielaborazione delle memorie traumatiche. È possibile che si sia solo all'inizio della scoperta di dispositivi induttori di elaborazione accelerata delle informazioni (Lipke, 2000). In particolare, sarà forse opportuno considerare acceleratori di informazioni a valenza traumatica anche particolari stati di coscienza modificati (Giannantonio, 2000b; Parnell, 1999).

Riferendomi esclusivamente all'EMDR, la ricerca futura dovrà certamente sottoporre a controllo i tipi di stimolazione alternata che vengono abitualmente utilizzati dai terapeuti EMDR in alternativa ai movimenti oculari, attualmente supportati dall'evidenza sperimentale in modo variabile.

Nodi teoretici e limiti delle ricerche

1) Innanzitutto il problema della comorbilità. La maggior parte delle ricerche esclude dai campioni di trattamento molti soggetti che presentano diagnosi o problemi addizionali oltre al PTSD (i.e.: disturbi psicotici in atto o recenti o schizofrenia: Carlson et al., 1998; Cusack, Spates, 1999; Devilly et al., 1998; Rogers et al., 1999; Vaughan et al., 1994; rischio di suicidio: Devilly et al., 1998; Marcus et al., 1997; Wilson et al., 1995, 1997; Disturbo Ossessivo-Compulsivo: Carlson et al., 1998; Cusack, Spates, 1999; Rogers et al., 1999; Vaughan et al., 1994; Disturbi di Personalità: Carlson et al.,

1998; Rogers et al., 1999; Vaughan et al. 1994; Disturbo Borderline di Personalità: Cusack, Spates, 1999; Disturbi Dissociativi: Marcus et al., 1997; Rogers et al., 1999; Wilson et al, 1995, 1997; abuso di alcool e/o di stupefacenti in atto o recente: Carlson et al., 1998; Cusack, Spates, 1999; Marcus et al., 1995; Rothbaum, 1997; Wilson et al., 1995, 1997). I casi in cui la comorbilità è riportata in modo quantificabile (anche per i Disturbi dell'Umore e per ulteriori Disturbi d'Ansia oltre al PTSD) rappresentano una percentuale troppo esigua per permettere conclusioni anche semplicemente provvisorie (Van Etten, Taylor, 1998). Le scelte metodologiche di restrizione dei campioni sono certamente corrette, nel momento in cui si vuole rendere il campione il più omogeneo possibile, ma in questo modo non esistono ancora elementi indiscutibili che affermino l'efficacia dell'EMDR in presenza di comorbilità. Considerando, inoltre, che la presenza di comorbilità nel PTSD è piuttosto elevata (Briere, 1997; Yule, Williams, Joseph, 1999), ciò induce a considerare in modo condizionale i risultati relativi alla terapia del PTSD, che potrebbero variare anche considerevolmente e poliedricamente in funzione della presenza di altre patologie. Inoltre, potrebbero essere necessari importanti cambiamenti nel protocollo terapeutico.

A ciò si deve aggiungere, infine, la considerazione che non è affatto detto che l'algoritmo diagnostico impiegato dal DSM-IV per la diagnosi di PTSD sia effettivamente esaustivo per la sua valutazione e comprensione (Bremner et al., 1998; Briere, 1997). Queste ultime due precisazioni valgono, ovviamente, per ogni forma di psicoterapia che voglia verificare la propria efficacia nella psicoterapia del PTSD.

2) Il punto 1) si collega necessariamente ad una esigenza di ampio respiro, ovvero alla necessità di effettuare assessment molto più articolati ed approfonditi allo scopo di enucleare le differenze di risposta all'EMDR presentate da differenti gruppi di individui. Ciò richiede anche campioni consistenti (Shapiro, 2000).

3) Nell'ambito dell'applicazione dell'EMDR in età infantile, e quindi con importanti adeguamenti procedurali della metodica, attualmente non esiste ancora la stessa mole di evidenze cliniche disponibile invece per i soggetti adulti.

4) È necessario che si inizino a pubblicare ricerche che non si riferiscano solo all'obiettivo di non soddisfare più i criteri per la diagnosi di PTSD. Se per questo obiettivo l'EMDR è verificata, non lo è affatto per il **completo** superamento delle articolate conseguenze dei traumi abitualmente presenti in soggetti con PTSD. Ciò renderà molto più complessa la ricerca in quanto l'ottenimento di ambiziosi obiettivi a vasto raggio comporta l'adozione di maggiore creatività e deviazione dai protocolli standard di intervento (Manfield, 1998; Parnell, 1999). Queste precisazioni si intendono rivolte anche ad ogni altro approccio terapeutico rivolto al PTSD.

5) Deve essere ancora abbondantemente compreso attraverso quali meccanismi si esplica l'efficacia dell'EMDR, poiché le molte teorie attualmente esistenti non sembrano essere totalmente convincenti o esaustive (per una rassegna, Shapiro, 1995). Anche le recenti ricerche e i tentativi di interpretazione di tipo psicobiologico (i.e. Levin, Lazrove, van der Kolk, 1999), per quanto utili ed affascinanti, sembrano condurci verso la comprensione di *cosa* succede quando si supera un trauma, *come* è organizzato cerebralmente un evento traumatico, ma non ci dicono nulla della natura dello specifico intervento impiegato a scopo terapeutico, ovvero l'EMDR, se non che è efficace. Gli stessi cambiamenti a livello psicobiologico, infatti, potrebbero essere raggiunti con differenti dispositivi psicoterapeutici (Giannantonio, 2000b).

6) Deve essere dimostrato se il protocollo EMDR per il PTSD ha la medesima efficacia in presenza di PTSD parziale o subclinico (Yule, Williams, Joseph, 1999). Pur essendo estremamente verosimile, tale assunto deve essere maggiormente verificato, anche se ci sono certamente importanti conferme in questo senso (i.e.: Scheck et al.,

1998; Wilson et al., 1995, 1997). Molto meno verificata è l'efficacia dell'EMDR nei confronti degli eventi traumatici o altamente stressanti presenti in modo trasversale in molte altre patologie, ma in assenza di PTSD o di PTSD subclinico.

7) È necessaria una maggiore quantità di ricerche che utilizzi follows-up a lunga distanza.

Sviluppi contemporanei dell'EMDR

Osservando la letteratura recente sull'EMDR fino ad arrivare al congresso dell'EMDR International Association tenutosi a Toronto nel settembre 2000, sembra si possano scorgere le seguenti linee di tendenza nell'evoluzione dell'EMDR.

1) Approfondimento della tecnica di intervento nel PTSD e attenzione rivolta ad una maggiore accuratezza nella metodologia della ricerca.
2) Ricerche orientate all'indagine della componente psicobiologica del meccanismo di funzionamento dell'EMDR.
3) Pubblicazioni essenzialmente finalizzate a difendere l'EMDR dalle frequenti critiche che le vengono rivolte.
4) Approfondimento di ulteriori ambiti clinici in cui l'EMDR sembra dimostrarsi efficace: Disturbo di Panico, Fobia Sociale e Specifica, Disturbo di Dismorfismo Corporeo, Disturbo Ossessivo-Compulsivo, Disturbi dell'Alimentazione, Disturbi Sessuali, Disturbi Dissociativi, Disturbi di Personalità, comportamenti di addiction (per una elencazione più analitica degli ambiti di applicazione e di ricerca attuali: Shapiro, 1995, 1999; Lipke, 2000).
5) Si stanno sempre più evidenziando i limiti intrinseci di un approccio alla psicoterapia essenzialmente rivolto alla rielaborazione di singoli eventi

traumatici ed avente la pretesa di essere virtualmente compatibile con ogni tradizione di psicoterapia. Il confronto con soggetti pluritraumatizzati, con frequente comorbilità con Disturbi Dissociativi e di Personalità, per esempio, sta portando molti autorevoli esponenti del mondo dell'EMDR ad incorporare nelle proprie procedure operative e nella comprensione teoretica del processo clinico le risorse provenienti dalla migliore tradizione della psicoterapia ipnotica (i.e.: Phillips, Frederick, 1995). In particolare, il modello della "Terapia degli Stati dell'Io" (Watkins, Watkins, 1997), implementato dall'EMDR, viene attualmente sperimentato nella terapia dei Disturbi Dissociativi, di Personalità, di Panico, Ossessivo-Compulsivo, Alimentari. In definitiva, l'EMDR sembra stia mutando, implicitamente o esplicitamente, in un vero approccio alla psicoterapia in senso lato, con un sempre maggiore apporto teoretico necessario per la sua applicazione, ed in questo modo diventando probabilmente un corpus di conoscenze e procedure incommensurabile con alcune tradizioni cliniche.

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Il Ruolo Terapeutico, 2005, 98: 103-114

Sono veramente efficaci le psicoterapie *evidence-based*?

Paolo Migone
Condirettore della rivista *Psicoterapia e Scienze Umane*

Sappiamo che negli ultimi tempi si parla sempre più della necessità di verificare empiricamente l'efficacia della psicoterapia, cioè di differenziare il più possibile le terapie che "funzionano" da quelle che "non funzionano" (o la cui efficacia non è ancora stata dimostrata - cosa, tra l'altro, ben diversa dalla *dimostrata inefficacia*). Una delle conseguenze di questi sviluppi è la compilazione degli elenchi dei cosiddetti *Empirically Supported Treatments* (EST), cioè dei trattamenti supportati empiricamente o *evidence-based* (basati sulle evidenze), che sarebbero le uniche terapie che funzionano mentre tutte le altre non dovrebbero più essere praticate (inutile dire che tra queste terapie dichiarate "inutili" vi sarebbero quasi tutte le terapie psicoanalitiche). Vorrei discutere qui questa problematica, della quale mi sono sempre interessato, e riporterò parti di relazioni che ho tenuti a vari convegni o corsi su questo argomento (ad esempio al XI Congresso Nazionale della *Società Italiana di Terapia Cognitiva e Comportamentale* [SITCC] tenuto a Bologna il 19-22 settembre 2002, al convegno "Una svolta nella validazione dei risultati e dei processi delle psicoterapie" organizzato dal Dipartimento di Psicologia dell'Università di Firenze il 17 maggio 2003, a un corso di formazione organizzato dal CEFPAS della Regione Sicilia a Caltanissetta il 16-18 marzo 2004, alla IX Riunione Scientifica Annuale della *Società Italiana di Epidemiologia Psichiatrica* [SIEP] a Nocera Inferiore il 28-29 ottobre 2004, e così via).
La mia posizione è che occorre molta cautela nell'aderire alla logica della *Evidence-Based Medicine* (EBM) trasferita troppo acriticamente o frettolosamente ad una "psicoterapia basata sulle evidenze", in quanto è alto il rischio che si trascurino alcuni importanti problemi che possono generare fraintendimenti e ricadute pericolose per la pratica della psicoterapia. Gli EST infatti stanno diffondendosi sempre di più tra gli operatori e amministratori della salute mentale, come uno dei tentativi di risposta al comprensibile bisogno di *accountability*, di maggiore *cost-effectiveness* e di altre importanti esigenze etiche e scientifiche.
Tra gli autori che hanno maggiormente approfondito questa problematica vi è Drew Westen, un ricercatore estremamente attento sia alle questioni metodologiche e statistiche delle ricerche sperimentali che alle *nuances* della clinica (si veda ad esempio il suo articolo del 1999 sullo statuto scientifico dei processi inconsci, dal titolo "Freud è davvero morto?", uscito nel n. 4/2001 di *Psicoterapia e Scienze Umane*). In un recente lavoro pubblicato su una rivista molto autorevole [Westen D. & Morrison K., A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies, *Journal of Consulting and Clinical Psychology*, 2001, 69, 6: 875-899] ha

preso in considerazione gli studi sperimentali sulla psicoterapia della depressione, del panico e dell'ansia generalizzata ed ha riesaminato la base empirica delle psicoterapie brevi manualizzate, distinguendo la risposta iniziale dalla genuina efficacia, e la terapia degli "stati" psicologici dalla terapia dei disturbi o delle diatesi. La sua conclusione è che questi trattamenti brevi manualizzati tendono a produrre una notevole risposta positiva iniziale di indubbia significatività clinica, ma che la maggior parte dei pazienti rimangono subclinicamente sintomatici, hanno ricadute o richiedono un ulteriore trattamento entro due anni. Inoltre è dimostrato che i tipici studi di efficacia escludono ben i 2/3 dei pazienti che nella pratica clinica reale si presentano per richiedere una terapia, a causa della comorbilità (cioè della presenza simultanea di più diagnosi) che peraltro è molto frequente e che inevitabilmente porta a terapie più lunghe.
Io prenderò in esame non solo questo articolo di Westen, ma anche alcune parti di un altro suo lavoro di natura più concettuale che è uscito pochi mesi fa [Westen D., Morrison K. & Thompson-Brenner H., The empirical status of empirically supported psychotherapies: assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, 2004, 130: 631-663]. Come scrivevo a p. 8 del mio editoriale del n. 1/2004 di *Psicoterapia e Scienze Umane*, l'aspetto interessante è che "Westen non si pone contro gli EST o contro la psicoterapia basata sulle prove di efficacia, anzi, si muove all'interno della stessa cornice scientifica. Ed è proprio con la rigorosa logica della ricerca empirica che Westen dimostra la fallacia di molte conclusioni a cui il movimento della psicoterapia *evidence-based* rischia di arrivare. Westen cioè non si pone scioccamente contro l'esigenza di ricerca empirica sull'efficacia della psicoterapia, anzi, ne è uno dei più accesi sostenitori, e muove la sua critica proprio allo scopo di perfezionare questo campo di ricerca, per arrivare ad individuare psicoterapie che siano ancor più efficaci, 'veramente efficaci', se così si può dire".
Conoscendo Westen, ho seguito la stesura di questo secondo articolo avvenuta nel corso degli ultimi cinque anni (tanto ci è voluto per scrivere questo lungo articolo), e, come avevo preannunciato nel mio editoriale del n. 1/2004 prima citato, abbiamo deciso di farlo uscire in italiano sul n. 1/2005 di *Psicoterapia e Scienze Umane*. Questo articolo di Westen serve anche da discussione critica del documento ufficiale dell'*American Psychological Association* (APA) in cui sono stati pubblicati appunto gli elenchi degli EST, documento che avevo tradotto in italiano e fatto uscire nel n. 3/2001 [Chambless D.L. & Ollendick T.H., Gli interventi psicologici validati empiricamente: controversie ed evidenze empiriche. *Psicoterapia e scienze umane*, 2001, XXXV, 3: 5-46 - una sintesi di questo lavoro è su Internet]. Si voleva cioè far conoscere al lettore italiano questa problematica nel modo più completo possibile, per poi facilitare un dibattito approfondito (la stessa operazione fu fatta una ventina di anni fa per un altro importante fenomeno che allora irrompeva nel mondo della psichiatria, il DSM-III, che fu presentato in anteprima nel n. 4/1983 e poi discusso criticamente nei numeri successivi della rivista).
Va ricordato che l'esigenza di compilare e diffondere elenchi di tecniche psicoterapeutiche supportate empiricamente è nata in realtà da esigenze comprensibili e ammirevoli, soprattutto dalla realistica preoccupazione che, anche a causa della *managed care*, per la terapia di disturbi come la depressione e l'ansia venissero utilizzate linee guida che prediligevano solo trattamenti farmacologici, mentre esistevano prove documentate in favore delle psicoterapie. Fu così che nel 1995

l'APA pubblicò due controversi rapporti di una *Task Force* che separavano gli EST dalle terapie a lungo termine e meno strutturate, praticate in genere dai clinici nella pratica reale, e da allora vari autori raccomandarono che i clinici dovessero ricevere un training primariamente in questi trattamenti di breve durata e supportati empiricamente, dato che le altre forme di terapia erano "meno essenziali e superate".
Sempre in questo contesto, Seligman, analizzando il famoso "Progetto del *Consumer Report* sulla psicoterapia" del 1995 [tradotto in italiano in *Integrazione nelle psicoterapie e nel counseling*, 1997, I, 1/2 - vedi segnalazione su *Psicoterapia e Scienze Umane*, n. 2/1998, pp. 171-172], portò alla attenzione della comunità psicoterapeutica la distinzione tra "efficacia" ed "efficienza". Come è noto, gli studi sulla efficacia (*efficacy*) misurano il risultato di una terapia sotto condizioni strettamente controllate, come in laboratorio, usando gruppi di controllo, distribuzione randomizzata dei pazienti nei gruppi, accurato training dei terapeuti secondo un manuale psicoterapeutico, durata standardizzata della terapia, ecc. Gli studi sulla efficienza (*effectiveness*) invece misurano il risultato di una terapia sotto le condizioni meno controllate della pratica clinica reale di tutti i giorni, non nel laboratorio. Mentre gli studi sulla efficacia enfatizzano la validità "interna", gli studi sulla efficienza enfatizzano la validità "esterna" o ecologica, cioè la generalizzabilità dei risultati alla popolazione generale, nella pratica clinica reale. Uno dei più grossi problemi incontrati dai ricercatori in psicoterapia infatti è quello di mantenere alta non solo la efficacia ma anche la efficienza, poiché una terapia che risulta efficace solo in laboratorio ma non nella pratica clinica reale è inutile, dato che lo scopo della ricerca empirica non è certo quello di pubblicare articoli su riviste scientifiche ma di contribuire, tramite questi, alla disseminazione di tecniche efficaci nella pratica clinica quotidiana, con beneficio di tutti i potenziali pazienti e non solo di quelli inclusi negli studi sperimentali.
Vediamo ora in che cosa consiste la metodologia degli EST. Gli EST condividono le seguenti caratteristiche: 1) i pazienti vengono scelti per l'inclusione nello studio allo scopo di massimizzare la omogeneità e minimizzare la presenza di condizioni concomitanti che potrebbero aumentare la variabilità della risposta terapeutica; 2) le tecniche terapeutiche vengono designate tipicamente per disturbi in Asse I (cioè per sindromi cliniche e non per disturbi di personalità - per chi non avesse familiarità con il DSM-III e il DSM-IV, nell'Asse I sono elencate le sindromi cliniche, ad esempio la depressione, l'ansia ecc., mentre nell'Asse II vi sono i disturbi di personalità); 3) le valutazioni del risultato mettono a fuoco soprattutto il sintomo che è al centro di interesse della rispettiva ricerca; 4) le terapie sono di durata breve e prefissata; 5) vengono seguiti fedelmente manuali di psicoterapia. In genere si dice che queste caratteristiche rendono lo studio "pulito", che questa è "buona scienza", e che l'esperimento è neutrale rispetto alla teoria di ogni singolo approccio terapeutico.
Ma in realtà, sostiene Westen, gli assunti su cui poggia la ricerca sugli EST non sono teoricamente neutri e, paradossalmente, alcuni di essi non solo *non sono supportati empiricamente*, ma anche *sono stati dimostrati falsi* proprio sulla base della stessa ricerca empirica. Vediamo quindi come Westen argomenta questa sua tesi, discutendo uno per uno quelli che lui ritiene essere gli assunti di base impliciti nella metodologia degli EST. Questi assunti sono i seguenti:
1) I processi psicologici sono altamente malleabili (mentre è dimostrato che non lo sono, nel senso che occorre molto tempo per modificarli)

Se i disturbi psicologici non fossero modificabili facilmente essi non sarebbero candidati per una terapia breve. I dati raccolti dalla meta-analisi condotta da Westen sugli EST per i disturbi depressivi e l'ansia generalizzata suggeriscono che gran parte delle vulnerabilità psicologiche è resistente al cambiamento. Inoltre, mentre fino a tempi relativamente recenti vi erano ancora dati equivoci sulla differenza tra terapie lunghe e brevi, ora è dimostrato che più lungo è il trattamento (due anni o più), più esso è efficace, cioè più i risultati si consolidano.

2) La maggior parte dei pazienti hanno un solo sintomo o possono essere trattati come se lo avessero (mentre presentano sintomi plurimi e comorbilità)

Il fatto che i pazienti possano avere un solo sintomo è un assunto fondamentale della metodologia degli EST. Non solo non è vero che la maggior parte dei pazienti hanno solo un sintomo, ma è vero il contrario, cioè che la maggior parte dei pazienti che vediamo presentano comorbilità. La comorbilità Asse I-Asse II (cioè la compresenza di sindromi cliniche e disturbi di personalità) varia dal 50% al 90% a seconda gli studi, per la maggior parte dei disturbi.

Questo fatto è inquietante anche alla luce del fatto che la metodologia degli EST implicitamente adotta un modello della comorbilità che quasi tutti i ricercatori in psicoterapia e psicopatologia di fatto rinnegherebbero, e precisamente che la maggior parte dei pazienti presentano disturbi multipli a caso, non correlati l'uno con l'altro. Può ben essere che, come molti difensori della metodologia degli EST sostengono, il miglior modo di trattare la comorbilità sia quello di affrontare un disturbo per volta usando manuali in sequenza, uno dopo l'altro fino a che vengono "estirpati" tutti i sintomi (ad esempio uno per la depressione, uno per l'ansia, uno per il disturbo da stress post-traumatico [PTSD], e così via). Ma questa può non essere la strategia migliore nelle seguenti condizioni: a) nel caso che disturbi in Asse I apparentemente diversi siano il riflesso di una sottostante causa comune, come ad esempio nel caso di depressione o ansia entrambe originate da vulnerabilità al rifiuto interpersonale o dalla tendenza a provare umore negativo; b) nel caso che disturbi in Asse I sorgano da tratti di personalità in Asse II che creano vulnerabilità alle ricadute; c) nel caso che la compresenza di sintomi multipli possa generare proprietà emergenti non riducibili alla somma delle caratteristiche dei singoli sintomi. I dati raccolti da Westen suggeriscono che queste condizioni sono molto frequenti.

Un altro fattore problematico è il fatto che condizioni subcliniche sono altrettanto frequenti delle condizioni cliniche in Asse I per le quali sono stati formulati i manuali, e non è ancora chiaro in che misura condizioni cliniche e subcliniche rispondono agli stessi interventi. La presenza di condizioni subcliniche rende indispensabile che il ricercatore osservi non solo le diagnosi categoriali in Asse I (ad esempio una depressione) ma anche la varietà di condizioni subcliniche che permangono dopo il trattamento. Queste condizioni subcliniche non solo sono variabili importanti per il risultato, ma la loro conoscenza permette di capire meglio se il trattamento ha inciso sulla diatesi (cioè la predisposizione) che rende il paziente vulnerabile alle ricadute. Per esempio, se si studia l'efficacia della terapia della anoressia nervosa bisognerebbe anche osservare il comportamento della paziente in generale, dato che, ad esempio, pazienti "guarite" dall'anoressia possono continuare a mostrare peculiarità nello stile alimentare (spezzettare il cibo in piccoli pezzi, mangiare solo certi alimenti, ecc.), nella dieta (monitorare eccessivamente le calorie della dieta), nell'immagine corporea, e così via.

In conclusione, occorrerebbe conoscere meglio i reali problemi che hanno i pazienti e che li motivano a chiedere aiuto, e questa relativa assenza di informazioni è un problema per la ricerca in psicoterapia. Di fatto, la tendenza a focalizzare la ricerca solo su disturbi definiti dal DSM-IV ha virtualmente eliminato tutta quella ricerca in psicoterapia su problemi minori come l'ansia di parlare in pubblico o l'assertività che una volta dominavano praticamente tutta la ricerca in psicoterapia.

3) I sintomi psicologici possono essere trattati a prescindere dalla personalità di chi li presenta (mentre è dimostrato che la personalità gioca un ruolo rilevante)

Anche questo assunto, come il precedente, è essenziale per la metodologia degli EST, soprattutto a causa della manualizzazione (che, tranne eccezioni, non permette un trattamento dei problemi della personalità) e della brevità del trattamento (che è indispensabile per esigenze di ricerca) [per un approfondimento sui manuali di psicoterapia, vedi la mia rubrica del n. 51/1989 del *Ruolo Terapeutico*]. Ma, come ben sappiamo, non esiste alcuna teoria della personalità che suggerisca che importanti tratti della personalità possano essere modificati in una terapia che dura poche sedute (ad esempio da 6 a 20) di 45 minuti l'una. Si prenda ad esempio l'unica terapia per i disturbi di personalità che rientra negli EST, la *Dialectical Behavior Therapy* (DBT) della Linehan per i borderline: questa tecnica dura un anno, ma in questo anno si riesce soprattutto a ridurre i sintomi parasuicidari (ad esempio le automutilazioni), mentre la depressione, l'angoscia e i sentimenti di vuoto non diminuiscono in un anno, e non vi sono dati che dimostrino l'efficacia a lungo termine della DBT (per ammissione della stessa Linehan, la DBT dovrebbe durare almeno un altro anno - per un approfondimento sulla DBT della Linehan, vedi il mio articolo sul n. 3/2004 di *Psicoterapia e Scienze Umane*).

Se l'assunto quindi è che un disturbo in Asse I può essere trattato indipendentemente dalla personalità sottostante, abbiamo dati che dimostrano il contrario: i disturbi d'ansia e dell'umore sono correlati a variabili che da sempre vengono considerate variabili di personalità (come ad esempio l'umore negativo), e diverse diatesi di personalità (come vulnerabilità alla perdita e all'insuccesso) predispongono alla depressione. Non solo, ma vi sono indicazioni secondo cui la presenza di comorbilità in Asse I è un indicatore della presenza di patologia in Asse II, nel senso che più vi sono disturbi multipli in Asse I più aumenta la probabilità che siano presenti disturbi in Asse II.

Inoltre, il significato dei sintomi in Asse I varia considerevolmente a seconda del tipo di disturbo di personalità sottostante. Ad esempio, la depressione in un borderline è diversa non solo quantitativamente, ma anche qualitativamente dalla depressione in un paziente non borderline. Riguardo al trattamento, come è noto i pazienti trattati per un disturbo in Asse I migliorano meno se hanno un disturbo in Asse II, soprattutto borderline. Questo problema spesso è stato concettualizzato in termini di comorbilità in Asse II che funge da variabile moderatrice, ma il concetto di comorbilità qui può essere fuorviante perché implica che le variabili di personalità siano una aggiunta ai sintomi di Asse I che sono essenzialmente distinti da esse. Sarebbe come studiare l'effetto della aspirina come terapia della febbre e considerare "comorbide" la meningite, l'influenza o l'appendicite, che verrebbero concepite come variabili che moderano il rapporto tra la terapia (l'aspirina) e il risultato (l'abbassamento della febbre). Più corretto invece è considerare la depressione e l'ansia come segnali che qualcosa non va, a causa ad esempio di *life*

events (come una perdita), o variabili temperamentali o di personalità di lunga durata (come l'attivazione di vulnerabilità caratterologiche).

4) I pazienti sono capaci e disponibili a riferire all'inizio della terapia quale è il loro problema (mentre spesso il problema responsabile del disturbo viene compreso a trattamento avanzato)

Questo aspetto è essenziale per la metodologia degli EST, che prevede che i pazienti si presentino con un insieme di sintomi identificabili (che tipicamente soddisfano i criteri di una diagnosi in Asse I). In realtà i pazienti spesso presentano quadri sfumati, che richiedono una formulazione diagnostica più approfondita che non semplicemente contare un numero minimo di criteri diagnostici. In un tipico studio di EST, il paziente viene valutato due volte, una prima volta brevemente al telefono quando vi è il primo contatto dove si valuta la sua appropriatezza per lo studio in questione, e una seconda volta in modo più esteso per la valutazione pre-trattamento. Poi il paziente va nello studio del terapeuta assegnatogli che inizia a trattarlo convinto che la diagnosi sia corretta e primaria.

Nella realtà clinica invece le cose vanno in modo abbastanza diverso. Se il paziente ha più di un sintomo, e se i sintomi sono collegati a un problema di personalità, il clinico deve cominciare con una valutazione approfondita non solo dei sintomi e della loro storia, ma del paziente e della sua storia. Il sintomo o i sintomi che il paziente identifica inizialmente possono non diventare affatto il *focus* del trattamento nel tempo. Tanto per fare un esempio, molti giovani omosessuali che non hanno ancora accettato o riconosciuto la loro omosessualità soffrono di depressione, ansia o idee suicidarie, e questi sintomi possono sembrare i sintomi bersaglio. In questi casi, possono passare settimane o mesi prima che il paziente sia capace di riconoscere o accettare la fonte stressante sottostante (la non accettazione della propria omosessualità e i relativi conflitti con le pressioni ambientali). Tutti abbiamo visto giovani omosessuali trattati da medici generici o psichiatri che cercavano di curare la loro depressione con dei farmaci, come pure abbiamo visto tanti pazienti che si lamentavano di depressione o ansia per poi scoprire, solo in seguito, che essi non avevano mai elaborato la perdita di un importante rapporto affettivo. Non sappiamo in che misura situazioni come queste sono responsabili di gran parte della sintomatologia manifesta incontrata nella pratica clinica quotidiana, ma la metodologia degli EST non prevede la loro esistenza o le ritiene irrilevanti per due motivi: 1) limitare il numero di sedute (ad esempio a un numero che va da 6 a 16) e prescrivere quel numero in anticipo è utile per standardizzare la terapia e poter quindi fare ricerca, ma rende molto difficile una esplorazione approfondita e una flessibilità nell'approccio terapeutico e quindi anche una sua maggiore efficacia; 2) la manualizzazione presuppone che la stessa tecnica (ad esempio identificare e combattere le credenze patogene) funzionerà indipendentemente dalla specificità del caso. Sebbene questo possa funzionare per certi sintomi e terapie (soprattutto in trattamenti basati sulla esposizione comportamentale per sintomi d'ansia), è difficile immaginare che le stesse tecniche utili per aiutare una persona con sentimenti cronici di inadeguatezza sarà sempre ottimale per un paziente che lotta con una omosessualità non accettata, che è stato abbandonato dalla moglie, che soffre per le sequele di un abuso sessuale, che lotta contro i significati dell'invecchiamento nel contesto di una personalità narcisistica e così via, anche se tutti condividono la diagnosi di "Depressione maggiore".

Un corollario dell'assunto che i pazienti possano effettivamente conoscere e riferire cosa li faccia soffrire è che i sintomi devono essere compresi letteralmente, cioè che il *focus* della terapia deve essere sulla sintomatologia manifesta. Secondo questa concezione, un disturbo alimentare è un problema col cibo e non con il controllo egli impulsi o con la regolazione affettiva, un disturbo depressivo è un problema con l'umore e con una cognitività depressiva e non un problema con un lutto non risolto o con il mantenimento di una relazione significativa, e così via. Questo assunto, come si può ben vedere, non è teoricamente neutrale ma deriva dalla teoria della terapia comportamentale.

5) Gli elementi di una terapia efficace sono separabili gli uni dagli altri e possono essere sommati (mentre è dimostrato che una psicoterapia non può essere "smantellata", nel senso che il suo significato è diverso dalla semplice somma delle sue parti)

L'assunto secondo cui gli ingredienti di una terapia possano essere separati gli uni dagli altri permette ad esempio che i ricercatori paragonino un approccio strettamente comportamentale per curare il panico ad un approccio combinato cognitivo-comportamentale. Questo assunto può anche andare bene per certi disturbi ma non per altri. Meno la terapia è strutturata (come ad esempio una terapia dinamica a lungo termine), e meno utile può essere la strategia dello smantellamento perché il corso della terapia non può essere prescritto così facilmente. Il problema è che più un manuale diventa una guida generale e non un insieme di prescrizioni "passo dopo passo" che insegna "cosa fare" in ogni momento quasi in modo algoritmico, meno i ricercatori possono trarre inferenze utili dai dati.

Le cose si complicano ulteriormente se in una terapia riuscita sono implicate le variabili relazionali tra paziente e terapeuta, cosa peraltro dimostrata da tutte le ricerche sul processo di cui si è a conoscenza. Per esempio, i ricercatori non possono misurare facilmente quanto i pazienti si sentono capiti, contenuti, criticati ecc., perché queste variabili interazionali dipendono dalle interpretazioni del comportamento del terapeuta da parte del paziente.

6) Gli elementi efficaci di una terapia possono essere manualizzati e gli interventi specificati nel manuale sono causalmente correlati al risultato (mentre alcuni studi, utilizzando il *Psychotherapy Process Q-set* [PQS], hanno dimostrato non solo che vengono usati interventi appartenenti a manuali diversi, ma anche che spesso non vi è correlazione tra il risultato e gli interventi prescritti dal manuale)

La manualizzazione è indispensabile nella metodologia degli EST, perché permette la standardizzazione del trattamento e il controllo delle variabili potenzialmente confondenti. Ma sappiamo che la manualizzazione può rendere gli interventi del terapeuta rigidi e difficili da correggere.

Alcune ricerche recenti, per esempio, utilizzando il PQS hanno misurato alcune variabili del processo dalle trascrizioni di terapie brevi sia psicodinamiche che cognitive. Uno dei meriti del PQS è quello di misurare quanto una terapia aderisce in realtà all'approccio psicodinamico, cognitivo-comportamentale o altro, correlando il processo terapeutico osservato con quello di sedute prototipiche, ideali, come descritte da esperti di ciascun approccio. Alcuni autori, ad esempio, hanno trovato non solo che terapeuti di entrambi gli approcci usano tecniche dell'altro approccio, ma che in entrambi i tipi di terapia il risultato positivo era associato all'uso di tecniche proprie del prototipo empirico della

psicoterapia psicodinamica. In questo studio cioè l'uso da parte di terapeuti cognitivi di tecniche cognitive non era correlato col risultato.

Le conclusioni di Westen: gli assunti di base degli EST non sono teoricamente neutrali e non sono stati testati o sono stati testati ma dimostrati falsi

Dopo aver preso in rassegna la discussione critica di questi assunti impliciti della metodologia degli EST, colpiscono due fatti, dice Westen: 1) essi non sono teoricamente neutrali, ma rispecchiano gli assunti fondamentali della terapia cognitivo-comportamentale, per lo meno della terapia cognitivo-comportamentale degli anni 1960-70 quando questi assunti cominciarono a definire cosa poteva essere considerato un valido studio sul risultato e quindi a influenzare le decisioni per la pubblicazione e il finanziamento delle ricerche (e questi assunti oggi non sono più accettati, anche in modo esplicito, da molti esponenti stessi del movimento di terapia cognitivo-comportamentale); 2) gran parte di questi assunti sono empiricamente testabili, ma molti di essi non sono stati mai testati o sono stati testati e in un modo o nell'altro sono stati dimostrati falsi.

Dopo aver discusso gli assunti di base impliciti nella metodologia degli EST, vediamo ora i risultati empirici di questi studi, e prendiamo come esempio paradigmatico uno studio sulla psicoterapia della depressione ben progettato, condotto con la metodologia degli EST.

Riesame di un tipico studio su un EST per la depressione

I ricercatori di questo studio condotto con la metodologia degli EST [Thase *et al*., Relapse after cognitive behavior therapy of depression: Potential implications for longer courses of treatment. *American Journal of Psychiatry*, 1992, 149: 1046-1052] hanno valutato 130 pazienti depressi, dei quali 54 sono stati scartati e 76 sono stati considerati adatti allo studio e inclusi nella ricerca. Il tasso di inclusione in questo caso quindi è stato del 58%, che, come sanno bene i ricercatori, è abbastanza alto perché è circa il doppio di quello tipico di questo ricerche controllate. Tra i pazienti inclusi, 64 (81%) hanno completato lo studio. Di questi 64, alla fine della terapia 23 sono stati considerati "totalmente guariti" e 27 "parzialmente guariti", raggiungendo un tasso di guarigione completa di circa il 36% e un tasso di guarigione parziale leggermente maggiore, del 42% (mentre gli insuccessi erano il 22%). Leggendo i dati in un altro modo, si può dire che circa il 18% dei pazienti depressi inizialmente valutati (che erano 130) hanno completato la terapia e sono guariti completamente, e che il 21% hanno completato la terapia e sono guariti parzialmente (i pazienti guariti, totalmente [23] o parzialmente [27], sono stati 50, il 38,5% dei 130 iniziali, e gli insuccessi il 61,5%).

A un anno di *follw-up*, 16 dei 50 pazienti totalmente o parzialmente guariti hanno avuto una ricaduta di depressione maggiore, riducendo quindi a 34 i pazienti guariti almeno parzialmente dopo un anno. Questi sono il 26% del campione iniziale dei 130 esaminati, e il 45% di quelli che sono stati inclusi nello studio (dopo averne escluso cioè circa la metà a causa di condizioni concomitanti sfavorevoli che li rendevano candidati non adatti). Se poi si allarga la definizione di ricaduta, e la si intende non solo come una ricaduta di depressione maggiore, ma anche come un disturbo dell'umore diagnosticabile che comunque necessita di ulteriore trattamento, il numero dei pazienti che rimanevano guariti totalmente o parzialmente cade a 29, cioè il 38% di quelli che iniziarono la terapia e il 22% di quelli inizialmente valutati (ma andrebbe qui visto attentamente anche come reagirono al placebo i pazienti del gruppo di controllo dopo un anno, cosa accadde

ai pazienti dopo due anni, cosa accadde ai pazienti non trattati neanche col placebo cioè esclusi dallo studio, come era il funzionamento sociale e lavorativo di questi pazienti dopo la terapia, e così via).
Potremmo chiederci come reagirebbe un consumatore della psicoterapia se sapesse che ha solo il 22% di probabilità di migliorare dalla depressione dopo un anno dalla fine della terapia. Eppure questo reperto non è raro, e questo è un esempio di uno studio tra i meglio progettati. E' un prototipo di tutti gli studi di questo tipo, ma differisce solo in un aspetto dagli altri studi: il tasso di successo qui trovato è *circa il doppio* di quello trovato in un normale studio ben progettato per l'efficacia della terapia manualizzata a breve termine per la depressione.

Conclusioni

Come accennavo all'inizio, è consigliabile molta prudenza nell'usare il termine di psicoterapie "validate" o "supportate empiricamente", in quanto questo termine si riferisce solo a un determinato tipo di terapie studiate in laboratorio, per disturbi spesso monosintomatici o senza la comorbilità tipica di gran parte dei pazienti che si incontrano nella pratica reale, quindi la loro generalizzabilità è dubbia [vedi anche il libro di Roth & Fonagy del 1996 *Psicoterapie a prova di efficacia* (Roma: Il Pensiero Scientifico, 1997) e il mio editoriale del n. 4/1999 della *Rivista Sperimentale di Freniatria*, intitolato "Psicoterapia e servizi di salute mentale"]. Ironicamente, si può dire che i pazienti che vediamo nella nostra pratica clinica quotidiana assomigliano molto di più ai pazienti che vengono esclusi dagli studi sugli EST che a quelli che vengono inclusi. La metodologia degli EST (sperimentazioni randomizzate e controllate, utilizzo di campioni omogenei, standardizzazione della tecnica tramite manuali, e verifica delle ipotesi causali tramite strategie di "smantellamento") ha costituito il *gold standard* della ricerca in psicoterapia per un paio di decenni, ma questa metodologia riflette un misto di buona scienza (applicazione sofisticata del disegno sperimentale) e di una serie di assunti empiricamente non corretti per molti disturbi e tipi di terapie. Non è un caso che molti di questi studi ci hanno ripetutamente messo di fronte al "verdetto di Dodo" (da *Alice nel paese delle meraviglie*) di cui ci ha parlato Luborsky - "Tutti hanno vinto e ognuno deve ricevere un premio" - cioè al paradosso della equivalenza tra tutte le psicoterapie [per un approfondimento, rimando alla mia rubrica del n. 66/1994 del *Ruolo Terapeutico*, e a una mia *review* sulla ricerca in psicoterapia, che è anche su Internet al sito http://www.psychomedia.it/spr-it/artdoc/migone96.htm].
La meta-analisi di Westen sugli studi sperimentali sulla psicoterapia della depressione, del panico e dell'ansia generalizzata ha mostrato che se è vero che vi è una iniziale risposta positiva, i pazienti rimangono subclinicamente sintomatici e hanno ricadute entro due anni di *follw-up*, per cui richiedono ulteriore trattamento. Vi è ragione di ritenere quindi che questi pazienti abbiano bisogno di terapie più prolungate di quelle accettabili dalla metodologia degli EST, e del resto chi ha esperienza clinica sa che tratti di personalità e stati affettivi generalizzati (come la depressione e l'ansia) non possono essere modificati nel giro di poche ore. Una ricerca del gruppo di Maj, pubblicata nel 1992 sull'*American Journal of Psychiatry*, ha rilevato che il tasso di ricadute oltre i 5 anni nei pazienti con depressione maggiore è ben superiore del 50%, e colpisce a questo riguardo come siano pochi gli studi di *follw-up* che vadano oltre i 5 anni, in modo da poter capire le reale efficacia di un trattamento. In certe aree della medicina la risposta terapeutica a breve termine viene chiamata "risposta iniziale", e occorrono ulteriori

ricerche per stabilire la effettiva guarigione, mentre nella ricerca in psicoterapia una buona risposta iniziale è stata spesso confusa con una genuina efficacia. Nessun ricercatore sul cancro ad esempio oserebbe dire che una terapia è efficace senza un *follow-up* di almeno 5-10 anni. Questa analogia tra la ricerca sul cancro e sulla psicoterapia qui non viene fatta in modo casuale, perché alcuni sostenitori degli EST hanno affermato che nessuno avrebbe dubbi se scegliere tra un oncologo che segue la letteratura sulla *Evidence-Based Medicine* e un altro che invece si basa solo sulla propria esperienza clinica. Ma, se si guarda bene a questa analogia, è anche vero che una terapia contro il cancro che non garantisce risultati oltre i due anni viene subito scartata, cosa che non avviene in psicoterapia.

Quale può essere dunque una possibile soluzione ai problemi qui discussi, in che modo può essere migliorato il campo della ricerca in psicoterapia? Una possibilità, suggerisce Westen, è di implementare anche studi di tipo diverso da quelli tipici degli EST. Una volta Cronbach, in un articolo del 1957 su *American Psychologist*, disse che vi sono due discipline di psicologia scientifica, una di ricerca "sperimentale" e una di ricerca "correlazionale". La prima metodologia, sperimentale, che si può definire "dal basso all'alto" (*bottom-up*), è quella propria degli EST e di gran parte della ricerca in psicoterapia degli ultimi due decenni. La seconda metodologia prevede invece un approccio alternativo, "dall'alto al basso" (*top-down*), secondo il quale si osservano le strategie terapeutiche usate da clinici esperti nella loro pratica clinica quotidiana, e tramite strumenti sofisticati e ben validati le si correlano con specifiche variabili del risultato. Si possono poi esaminare variabili potenzialmente moderatrici come la comorbilità o i tratti di personalità, e *solo in un secondo momento* studiare sperimentalmente, uno per uno, con la metodologia tradizionale, quegli interventi che sembrano correlati con un risultato positivo. Questa metodologia implicherebbe quindi l'utilizzo della pratica clinica reale come laboratorio iniziale da cui partire, e poi in un secondo momento il ricorso a ricerche più sofisticate per affinare le indagini e verificare singole ipotesi [sul rapporto tra clinica e ricerca, vedi anche la mia rubrica del n. 88/2001 del *Ruolo Terapeutico*, dal titolo "La dicotomia tra clinica e ricerca in psicoterapia: due scienze separate?"].

La proposta di Westen quindi è di percorrere entrambe le strade della ricerca in psicoterapia, in modo sinergico e dialettico, perché entrambe possono essere portatrici di dati utili: a volte la ricerca dovrebbe guidare la pratica clinica, e altre volte la pratica clinica dovrebbe guidare la ricerca, avendo entrambe limiti e pregi.

Paolo Migone

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Evidence-Based Therapy Relationships: Research Conclusions and Clinical Practices

John C. Norcross
University of Scranton

Bruce E. Wampold
University of Wisconsin, Madison

In this closing article of the special issue, we present the conclusions and recommendations of the interdivisional task force on evidence-based therapy relationships. The work was based on a series of meta-analyses conducted on the effectiveness of various relationship elements and methods of treatment adaptation. A panel of experts concluded that several relationship elements were demonstrably effective (alliance in individual psychotherapy, alliance in youth psychotherapy, alliance in family therapy, cohesion in group therapy, empathy, collecting client feedback) while others were probably effective (goal consensus, collaboration, positive regard). Three other relationship elements (congruence/genuineness, repairing alliance ruptures, and managing countertransference) were deemed promising but had insufficient evidence to conclude that they were effective. Multiple recommendations for practice, training, research, and policy are advanced.

Keywords: psychotherapy relationship, treatment outcome, meta-analysis, alliance, evidence-based practice

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Will be to arrive where we started
And know the place for the first time.
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Having traversed more than a dozen meta-analyses and arrived at the end of this special issue, we have a final opportunity to present the interdivisional task force conclusions and to reflect on its work. Like the tireless traveler in Eliot's poem, we have rediscovered the therapy relationship and know it, again, for the first time.

This closing article presents the conclusions and recommendations of the second Task Force on Evidence-Based Therapy Relationships. These statements reaffirm and, in several instances, update those of the earlier task force (Norcross, 2001, 2002). We then offer some final thoughts on what works, what does not work, and clinical practice.

Conclusions of the Task Force

◆ The therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment.

◆ The therapy relationship accounts for why clients improve (or fail to improve) at least as much as the particular treatment method.

◆ Practice and treatment guidelines should explicitly address therapist behaviors and qualities that promote a facilitative therapy relationship.

◆ Efforts to promulgate best practices or evidence-based practices (EBPs) without including the relationship are seriously incomplete and potentially misleading.

◆ Adapting or tailoring the therapy relationship to specific patient characteristics (in addition to diagnosis) enhances the effectiveness of treatment.

◆ The therapy relationship acts in concert with treatment methods, patient characteristics, and practitioner qualities in determining effectiveness; a comprehensive understanding of effective (and ineffective) psychotherapy will consider all of these determinants and their optimal combinations.

◆ Table 1 summarizes the task force conclusions regarding the evidentiary strength of (a) elements of the therapy relationship primarily provided by the psychotherapist and (b) methods of adapting psychotherapy to particular patient characteristics.

◆ The conclusions do *not* by themselves constitute a set of practice standards but represent current scientific knowledge to be understood and applied in the context of all the clinical evidence available in each case.

Recommendations of the Task Force

General Recommendations

1. We recommend that the results and conclusions of this second task force be widely disseminated in order to enhance awareness and use of what "works" in the therapy relationship.

John C. Norcross, Department of Psychology, University of Scranton; Bruce E. Wampold, Department of Counseling Psychology, University of Wisconsin, Madison.

Portions of this article are adapted, by special permission of Oxford University Press, from a chapter of the same title by the same authors in J. C. Norcross (Ed.), 2011, *Psychotherapy relationships that work* (2nd ed.). New York, NY: Oxford University Press. The book project was cosponsored by the APA Division of Psychotherapy.

Correspondence regarding this article should be addressed to John C. Norcross, PhD, Department of Psychology, University of Scranton, Scranton, PA 18510-4596. E-mail: norcross@scranton.edu

Table 1
Task Force Conclusions

	Elements of the relationship	Methods of adapting
Demonstrably effective	Alliance in individual psychotherapy	Reactance/resistance level
	Alliance in youth psychotherapy	Preferences
	Alliance in family therapy	Culture
	Cohesion in group therapy	Religion and spirituality
	Empathy	
	Collecting client feedback	
Probably effective	Goal consensus	Stages of change
	Collaboration	Coping style
	Positive regard	
Promising but insufficient	Congruence/genuineness	Expectations
Research to judge	Repairing alliance ruptures	Attachment style
	Managing countertransference	

2. Readers are encouraged to interpret these findings in the context of the acknowledged limitations of the task force's work.

3. We recommend that future task forces be established periodically to review these findings, include new elements of the relationship, incorporate the results of non-English language publications (where practical), and update these conclusions.

Practice Recommendations

4. Practitioners are encouraged to make the creation and cultivation of a therapy relationship, characterized by the elements found to be demonstrably and probably effective, a primary aim in the treatment of patients.

5. Practitioners are encouraged to adapt or tailor psychotherapy to those specific patient characteristics in ways found to be demonstrably and probably effective.

6. Practitioners are encouraged to routinely monitor patients' responses to the therapy relationship and ongoing treatment. Such monitoring leads to increased opportunities to reestablish collaboration, improve the relationship, modify technical strategies, and avoid premature termination.

7. Concurrent use of evidence-based therapy relationships *and* evidence-based treatments adapted to the patient is likely to generate the best outcomes.

Training Recommendations

8. Training and continuing education programs are encouraged to provide competency-based training in the demonstrably and probably effective elements of the therapy relationship.

9. Training and continuing education programs are encouraged to provide competency-based training in adapting psychotherapy to the individual patient in ways that demonstrably and probably enhance treatment success.

10. Accreditation and certification bodies for mental health training programs should develop criteria for assessing the adequacy of training in evidence-based therapy relationships.

Research Recommendations

11. Researchers are encouraged to progress beyond correlational designs that associate the frequency of relationship behaviors with patient outcomes to methodologies capable of examining the complex associations among patient qualities, clinician behaviors, and treatment outcome. Of particular importance is disentangling the patient contributions and the therapist contributions to relationship elements and, ultimately, outcome.

12. Researchers are encouraged to examine the specific mediators and moderators of the links between the relationship elements and treatment outcome.

13. Researchers are encouraged to address the observational perspective (i.e., therapist, patient, or external rater) in future studies and reviews of "what works" in the therapy relationship. Agreement among observational perspectives provides a solid sense of established fact; divergence among perspectives holds important implications for practice.

Policy Recommendations

14. APA's Division of Psychotherapy, Division of Clinical Psychology, and other practice divisions are encouraged to educate its members in the benefits of evidence-based therapy relationships.

15. Mental health organizations as a whole are encouraged to educate their members about the improved outcomes associated with using evidence-based therapy relationships, as they frequently now do about evidence-based treatments.

16. We recommend that the American Psychological Association and other mental health organizations advocate for the research-substantiated benefits of a nurturing and responsive human relationship in psychotherapy.

17. Finally, administrators of mental health services are encouraged to attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations.

What Works

The process by which the preceding conclusions on which relationship elements are demonstrably and probably effective require some elaboration, as these tend to be the most cited and controversial findings of the task force. These conclusions represent the consensus of expert panels composed of five judges who independently reviewed and rated the empirical evidence. They evaluated, for each relationship element, the previous research summary and the new meta-analysis according to the following criteria: number of empirical studies; consistency of empirical results; independence of supportive studies; magnitude of association between the relationship element and outcome; evidence for causal link between relationship element and outcome; and the ecological or external validity of research. Their respective ratings of demonstrably effective, probably effective, or promising but insufficient research to judge were then combined to render a consensus. In this way, we added a modicum of rigor and consensus to the process, which was admittedly less so in the first task force.

The consensus deemed six of the relationship elements as demonstrably effective, three as probably effective, and three as promising but insufficient research to judge. As members of that consensus panel, we were impressed by the skepticism and precision of the raters (as scientists ought to be). At the same time, were also impressed by the disparate and perhaps elevated standards against which these relationship elements were evaluated.

Consider the evidentiary strength required for psychological treatments to be considered demonstrably efficacious in two influential compilations of evidence-based practices. The Division of Clinical Psychology's Subcommittee on Research-Supported Treatments (www.div12.org/PsychologicalTreatments/index.html) requires two between-groups design experiments demonstrating that a psychological treatment is either (a) statistically superior to pill or psychological placebo or to another treatment or (b) equivalent to an already established treatment in experiments with adequate sample sizes. The studies must have been conducted with treatment manuals and conducted by at least two different investigators. The typical effect size of those studies was often smaller than the effects for the relationship elements reported in this special issue. For listing in SAMHSA's National Registry of Evidence-based Programs and Practices (www.nrepp.samhsa.gov), only evidence of statistically significant behavioral outcomes demonstrated in at least one study, using an experimental or quasi-experimental design, that has been published in a peer-reviewed journal or comprehensive evaluation report is needed. The intervention must be accompanied by implementation materials, training, and support resources that are ready to use by the public. By these standards, practically all of the dozen relationship elements in this journal issue would be considered demonstrably effective, if not for the requirement of a randomized clinical trial, which is neither clinically nor ethically feasible for the vast majority of these elements (as explicated in the introductory article in this issue).

In important ways, the criteria for relationship elements are more rigorous. Whereas the criteria for designating treatments as evidence-based relies on only one or two studies, the evidence for relationship elements discussed here are based on comprehensive meta-analyses of many studies (in excess of 50 in several cases), spanning various treatments and research groups. The studies used to establish evidence-based treatments are, however, clinical trials, which are often designated as the "gold standard" for establishing evidence. Nevertheless, these studies are often plagued by confounds, such as researcher allegiance and bogus comparisons. The point here is not to denigrate the criteria used to establish evidence-based treatments but to underscore the robust scientific standards by which the relationship elements have been evaluated.

A further research complication, but a clinical strength, concerns responsiveness. Research on the effectiveness of the psychotherapy relationship is constrained by therapist responsiveness—the ebb and flow of clinical interaction. Responsiveness refers to therapist behavior that is affected by emerging context and occurs on many levels, including choice of a treatment method, case formulation, strategic use of the self, and then adjusting those to meet the emerging, evolving needs of the client at any given moment (Stiles, Honos-Webb, & Surko, 1998). Effective psychotherapists are responsive to the different needs of their clients, providing varying levels of relationship elements in different cases, and within the same case, at different moments. Successful responsiveness can confound attempts to find naturalistically observed linear relations of outcome with therapist behaviors (e.g., cohesion, positive regard). Because of such problems, the statistical relations between the relationship and outcome cannot always be trusted. By being clinically attuned and flexible, psychotherapists make it more difficult in research studies to discern what works.

What Does Not Work

Translational research is both prescriptive and proscriptive—it tells us what works and what does not. In the following section, we

highlight those therapist relational behaviors that are ineffective, perhaps even hurtful, in psychotherapy.

One means of identifying ineffective qualities of the therapeutic relationship is to simply reverse the effective behaviors. Thus, what does not work includes a low quality alliance in individual psychotherapy, lack of cohesion in group therapy, and discordance in couple and family therapy. Paucity of empathy, collaboration, consensus, and positive regard predict treatment drop out and failure. The ineffective practitioner will resist client feedback, ignore alliance ruptures, and discount his or her countertransference.

Another means of identifying ineffective qualities of the relationship is to scour the research literature and conduct polls of experts. Here are six behaviors to avoid according to that research (Duncan, Miller, Wampold, & Hubble, 2010) and a Delphi poll (Norcross, Koocher, & Garofalo, 2006):

◆ *Confrontations.* Controlled research trials, particularly in the addictions field, consistently find a confrontational style to be ineffective. In one review (Miller, Wilbourne, & Hettema, 2003), confrontation was ineffective in all 12 identified trials. By contrast, expressing empathy, rolling with resistance, developing discrepancy, and supporting self-efficacy, characteristic of motivational interviewing, have demonstrated large effects with a small number of sessions (Lundahl & Burke, 2009).

◆ *Negative processes.* Client reports and research studies converge in warning therapists to avoid comments or behaviors that are hostile, pejorative, critical, rejecting, or blaming (Binder & Strupp, 1997; Lambert & Barley, 2002). Therapists who attack a client's dysfunctional thoughts or relational patterns need, repeatedly, to distinguish between attacking the person versus her behavior.

◆ *Assumptions.* Psychotherapists who assume or intuit their client's perceptions of relationship satisfaction and treatment success are frequently inaccurate. By contrast, therapists who specifically and respectfully inquire about their client's perceptions frequently enhance the alliance and prevent premature termination (Lambert & Shimokawa, pp. 72–79, this issue).

◆ *Therapist-centricity.* A recurrent lesson from process-outcome research is that the client's observational perspective on the therapy relationship best predicts outcome (Orlinsky, Ronnestad, & Willutzki, 2004). Psychotherapy practice that relies on the therapist's observational perspective, while valuable, does not predict outcome as well. Therefore, privileging the client's experiences is central.

◆ *Rigidity.* By inflexibly and excessively structuring treatment, the therapist risks empathic failures and inattentiveness to clients' experiences. Such a therapist is likely to overlook a breach in the relationship and mistakenly assume she has not contributed to that breach. Dogmatic reliance on particular relational or therapy methods, incompatible with the client, imperils treatment (Ackerman & Hilsenroth, 2001).

◆ *Procrustean bed.* As the field of psychotherapy has matured, using an identical therapy relationship (and treatment method) for all clients is now recognized as inappropriate and, in select cases, even unethical. The efficacy and applicability of psychotherapy will be enhanced by tailoring it to the unique needs of the client, not by imposing a Procrustean bed onto unwitting consumers of psychological services. We should all avoid the crimes of Procrustes, the legendary Greek giant who would cut the long limbs of clients or stretch short limbs to fit his one-size bed.

We can optimize therapy relationships by simultaneously using what works *and* studiously avoiding what does not work.

Concluding Thoughts

In the culture wars of psychotherapy that pit the therapy relationship against the treatment method (Norcross & Lambert, pp. 4–8, this issue), it is easy to chose sides, ignore disconfirming research, and lose sight of our superordinate commitment to patient benefit. Instead, let us conclude, like T. S. Eliot, by "arriving where we started" and underscoring three incontrovertible but oft-neglected truths about psychotherapy relationships.

First, the interdivisional taskforce was commissioned in order to augment patient benefit. We continue to explore what works in the therapy relationship and what works when we adapt that relationship to (nondiagnostic) patient characteristics. That remains our collective aim: improving patient success, however measured and manifested in a given case.

Second, psychotherapy is at root a human relationship. Even when "delivered" via distance or on a computer, psychotherapy is an irreducibly human encounter. Both parties bring themselves—their origins, culture, personalities, psychopathology, expectations, biases, defenses, and strengths—to the human relationship. Some will judge that relationship a precondition of change and others a process of change, but all agree that it is a relational enterprise.

Third, how we create and cultivate that powerful human relationship can be guided by the fruits of research. As Carl Rogers (1980) compellingly demonstrated, there is no inherent tension between a relational approach and a scientific one. Science can, and should, inform us about what works in psychotherapy, be it a treatment method, an assessment measure, a patient behavior, or, yes, a therapy relationship.

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John C. Norcross
University of Scranton

Bruce E. Wampold
University of Wisconsin, Madison

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◆ Adapting or tailoring the therapy relationship to specific patient characteristics (in addition to diagnosis) enhances the effectiveness of treatment.

◆ The therapy relationship acts in concert with treatment methods, patient characteristics, and practitioner qualities in determining effectiveness; a comprehensive understanding of effective (and ineffective) psychotherapy will consider all of these determinants and their optimal combinations.

◆ Table 1 summarizes the task force conclusions regarding the evidentiary strength of (a) elements of the therapy relationship primarily provided by the psychotherapist and (b) methods of adapting psychotherapy to particular patient characteristics.

◆ The conclusions do *not* by themselves constitute a set of practice standards but represent current scientific knowledge to be understood and applied in the context of all the clinical evidence available in each case.

Recommendations of the Task Force

General Recommendations

1. We recommend that the results and conclusions of this second task force be widely disseminated in order to enhance awareness and use of what "works" in the therapy relationship.

John C. Norcross, Department of Psychology, University of Scranton; Bruce E. Wampold, Department of Counseling Psychology, University of Wisconsin, Madison.

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Correspondence regarding this article should be addressed to John C. Norcross, PhD, Department of Psychology, University of Scranton, Scranton, PA 18510-4596. E-mail: norcross@scranton.edu

Table 1
Task Force Conclusions

	Elements of the relationship	Methods of adapting
Demonstrably effective	Alliance in individual psychotherapy	Reactance/resistance level
	Alliance in youth psychotherapy	Preferences
	Alliance in family therapy	Culture
	Cohesion in group therapy	Religion and spirituality
	Empathy	
	Collecting client feedback	
Probably effective	Goal consensus	Stages of change
	Collaboration	Coping style
	Positive regard	
Promising but insufficient	Congruence/genuineness	Expectations
Research to judge	Repairing alliance ruptures	Attachment style
	Managing countertransference	

2. Readers are encouraged to interpret these findings in the context of the acknowledged limitations of the task force's work.

3. We recommend that future task forces be established periodically to review these findings, include new elements of the relationship, incorporate the results of non-English language publications (where practical), and update these conclusions.

Practice Recommendations

4. Practitioners are encouraged to make the creation and cultivation of a therapy relationship, characterized by the elements found to be demonstrably and probably effective, a primary aim in the treatment of patients.

5. Practitioners are encouraged to adapt or tailor psychotherapy to those specific patient characteristics in ways found to be demonstrably and probably effective.

6. Practitioners are encouraged to routinely monitor patients' responses to the therapy relationship and ongoing treatment. Such monitoring leads to increased opportunities to reestablish collaboration, improve the relationship, modify technical strategies, and avoid premature termination.

7. Concurrent use of evidence-based therapy relationships *and* evidence-based treatments adapted to the patient is likely to generate the best outcomes.

Training Recommendations

8. Training and continuing education programs are encouraged to provide competency-based training in the demonstrably and probably effective elements of the therapy relationship.

9. Training and continuing education programs are encouraged to provide competency-based training in adapting psychotherapy to the individual patient in ways that demonstrably and probably enhance treatment success.

10. Accreditation and certification bodies for mental health training programs should develop criteria for assessing the adequacy of training in evidence-based therapy relationships.

Research Recommendations

11. Researchers are encouraged to progress beyond correlational designs that associate the frequency of relationship behaviors with patient outcomes to methodologies capable of examining the complex associations among patient qualities, clinician behaviors, and treatment outcome. Of particular importance is disentangling the patient contributions and the therapist contributions to relationship elements and, ultimately, outcome.

12. Researchers are encouraged to examine the specific mediators and moderators of the links between the relationship elements and treatment outcome.

13. Researchers are encouraged to address the observational perspective (i.e., therapist, patient, or external rater) in future studies and reviews of "what works" in the therapy relationship. Agreement among observational perspectives provides a solid sense of established fact; divergence among perspectives holds important implications for practice.

Policy Recommendations

14. APA's Division of Psychotherapy, Division of Clinical Psychology, and other practice divisions are encouraged to educate its members in the benefits of evidence-based therapy relationships.

15. Mental health organizations as a whole are encouraged to educate their members about the improved outcomes associated with using evidence-based therapy relationships, as they frequently now do about evidence-based treatments.

16. We recommend that the American Psychological Association and other mental health organizations advocate for the research-substantiated benefits of a nurturing and responsive human relationship in psychotherapy.

17. Finally, administrators of mental health services are encouraged to attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations.

What Works

The process by which the preceding conclusions on which relationship elements are demonstrably and probably effective require some elaboration, as these tend to be the most cited and controversial findings of the task force. These conclusions represent the consensus of expert panels composed of five judges who independently reviewed and rated the empirical evidence. They evaluated, for each relationship element, the previous research summary and the new meta-analysis according to the following criteria: number of empirical studies; consistency of empirical results; independence of supportive studies; magnitude of association between the relationship element and outcome; evidence for causal link between relationship element and outcome; and the ecological or external validity of research. Their respective ratings of demonstrably effective, probably effective, or promising but insufficient research to judge were then combined to render a consensus. In this way, we added a modicum of rigor and consensus to the process, which was admittedly less so in the first task force.

The consensus deemed six of the relationship elements as demonstrably effective, three as probably effective, and three as promising but insufficient research to judge. As members of that consensus panel, we were impressed by the skepticism and precision of the raters (as scientists ought to be). At the same time, were also impressed by the disparate and perhaps elevated standards against which these relationship elements were evaluated.

Consider the evidentiary strength required for psychological treatments to be considered demonstrably efficacious in two influential compilations of evidence-based practices. The Division of Clinical Psychology's Subcommittee on Research-Supported Treatments (www.div12.org/PsychologicalTreatments/index.html) requires two between-groups design experiments demonstrating that a psychological treatment is either (a) statistically superior to pill or psychological placebo or to another treatment or (b) equivalent to an already established treatment in experiments with adequate sample sizes. The studies must have been conducted with treatment manuals and conducted by at least two different investigators. The typical effect size of those studies was often smaller than the effects for the relationship elements reported in this special issue. For listing in SAMHSA's National Registry of Evidence-based Programs and Practices (www.nrepp.samhsa.gov), only evidence of statistically significant behavioral outcomes demonstrated in at least one study, using an experimental or quasi-experimental design, that has been published in a peer-reviewed journal or comprehensive evaluation report is needed. The intervention must be accompanied by implementation materials, training, and support resources that are ready to use by the public. By these standards, practically all of the dozen relationship elements in this journal issue would be considered demonstrably effective, if not for the requirement of a randomized clinical trial, which is neither clinically nor ethically feasible for the vast majority of these elements (as explicated in the introductory article in this issue).

In important ways, the criteria for relationship elements are more rigorous. Whereas the criteria for designating treatments as evidence-based relies on only one or two studies, the evidence for relationship elements discussed here are based on comprehensive meta-analyses of many studies (in excess of 50 in several cases), spanning various treatments and research groups. The studies used to establish evidence-based treatments are, however, clinical trials, which are often designated as the "gold standard" for establishing evidence. Nevertheless, these studies are often plagued by confounds, such as researcher allegiance and bogus comparisons. The point here is not to denigrate the criteria used to establish evidence-based treatments but to underscore the robust scientific standards by which the relationship elements have been evaluated.

A further research complication, but a clinical strength, concerns responsiveness. Research on the effectiveness of the psychotherapy relationship is constrained by therapist responsiveness—the ebb and flow of clinical interaction. Responsiveness refers to therapist behavior that is affected by emerging context and occurs on many levels, including choice of a treatment method, case formulation, strategic use of the self, and then adjusting those to meet the emerging, evolving needs of the client at any given moment (Stiles, Honos-Webb, & Surko, 1998). Effective psychotherapists are responsive to the different needs of their clients, providing varying levels of relationship elements in different cases, and within the same case, at different moments. Successful responsiveness can confound attempts to find naturalistically observed linear relations of outcome with therapist behaviors (e.g., cohesion, positive regard). Because of such problems, the statistical relations between the relationship and outcome cannot always be trusted. By being clinically attuned and flexible, psychotherapists make it more difficult in research studies to discern what works.

What Does Not Work

Translational research is both prescriptive and proscriptive—it tells us what works and what does not. In the following section, we

highlight those therapist relational behaviors that are ineffective, perhaps even hurtful, in psychotherapy.

One means of identifying ineffective qualities of the therapeutic relationship is to simply reverse the effective behaviors. Thus, what does not work includes a low quality alliance in individual psychotherapy, lack of cohesion in group therapy, and discordance in couple and family therapy. Paucity of empathy, collaboration, consensus, and positive regard predict treatment drop out and failure. The ineffective practitioner will resist client feedback, ignore alliance ruptures, and discount his or her countertransference.

Another means of identifying ineffective qualities of the relationship is to scour the research literature and conduct polls of experts. Here are six behaviors to avoid according to that research (Duncan, Miller, Wampold, & Hubble, 2010) and a Delphi poll (Norcross, Koocher, & Garofalo, 2006):

◆ *Confrontations.* Controlled research trials, particularly in the addictions field, consistently find a confrontational style to be ineffective. In one review (Miller, Wilbourne, & Hettema, 2003), confrontation was ineffective in all 12 identified trials. By contrast, expressing empathy, rolling with resistance, developing discrepancy, and supporting self-efficacy, characteristic of motivational interviewing, have demonstrated large effects with a small number of sessions (Lundahl & Burke, 2009).

◆ *Negative processes.* Client reports and research studies converge in warning therapists to avoid comments or behaviors that are hostile, pejorative, critical, rejecting, or blaming (Binder & Strupp, 1997; Lambert & Barley, 2002). Therapists who attack a client's dysfunctional thoughts or relational patterns need, repeatedly, to distinguish between attacking the person versus her behavior.

◆ *Assumptions.* Psychotherapists who assume or intuit their client's perceptions of relationship satisfaction and treatment success are frequently inaccurate. By contrast, therapists who specifically and respectfully inquire about their client's perceptions frequently enhance the alliance and prevent premature termination (Lambert & Shimokawa, pp. 72–79, this issue).

◆ *Therapist-centricity.* A recurrent lesson from process-outcome research is that the client's observational perspective on the therapy relationship best predicts outcome (Orlinsky, Ronnestad, & Willutzki, 2004). Psychotherapy practice that relies on the therapist's observational perspective, while valuable, does not predict outcome as well. Therefore, privileging the client's experiences is central.

◆ *Rigidity.* By inflexibly and excessively structuring treatment, the therapist risks empathic failures and inattentiveness to clients' experiences. Such a therapist is likely to overlook a breach in the relationship and mistakenly assume she has not contributed to that breach. Dogmatic reliance on particular relational or therapy methods, incompatible with the client, imperils treatment (Ackerman & Hilsenroth, 2001).

◆ *Procrustean bed.* As the field of psychotherapy has matured, using an identical therapy relationship (and treatment method) for all clients is now recognized as inappropriate and, in select cases, even unethical. The efficacy and applicability of psychotherapy will be enhanced by tailoring it to the unique needs of the client, not by imposing a Procrustean bed onto unwitting consumers of psychological services. We should all avoid the crimes of Procrustes, the legendary Greek giant who would cut the long limbs of clients or stretch short limbs to fit his one-size bed.

We can optimize therapy relationships by simultaneously using what works *and* studiously avoiding what does not work.

Concluding Thoughts

In the culture wars of psychotherapy that pit the therapy relationship against the treatment method (Norcross & Lambert, pp. 4–8, this issue), it is easy to chose sides, ignore disconfirming research, and lose sight of our superordinate commitment to patient benefit. Instead, let us conclude, like T. S. Eliot, by "arriving where we started" and underscoring three incontrovertible but oft-neglected truths about psychotherapy relationships.

First, the interdivisional taskforce was commissioned in order to augment patient benefit. We continue to explore what works in the therapy relationship and what works when we adapt that relationship to (nondiagnostic) patient characteristics. That remains our collective aim: improving patient success, however measured and manifested in a given case.

Second, psychotherapy is at root a human relationship. Even when "delivered" via distance or on a computer, psychotherapy is an irreducibly human encounter. Both parties bring themselves—their origins, culture, personalities, psychopathology, expectations, biases, defenses, and strengths—to the human relationship. Some will judge that relationship a precondition of change and others a process of change, but all agree that it is a relational enterprise.

Third, how we create and cultivate that powerful human relationship can be guided by the fruits of research. As Carl Rogers (1980) compellingly demonstrated, there is no inherent tension between a relational approach and a scientific one. Science can, and should, inform us about what works in psychotherapy, be it a treatment method, an assessment measure, a patient behavior, or, yes, a therapy relationship.

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Psychotherapy Relationships That Work III

John C. Norcross
University of Scranton

Michael J. Lambert
Brigham Young University

This article introduces the journal issue devoted to the most recent iteration of *evidence-based psychotherapy relationships* and frames it within the work of the Third Interdivisional American Psychological Association Task Force on Evidence-Based Relationships and Responsiveness. The authors summarize the overarching purposes and processes of the Task Force and trace the devaluation of the therapy relationship in contemporary treatment guidelines and evidence-based practices. The article outlines the meta-analytic results of the subsequent 16 articles in the issue, each devoted to the link between a particular relationship element and treatment outcome. The expert consensus deemed 9 of the relationship elements as demonstrably effective, 7 as probably effective, and 1 as promising but with insufficient research to judge. What works—and what does not—in the therapy relationship is emphasized throughout. The limitations of the task force work are also addressed. The article closes with the Task Force's formal conclusions and 28 recommendations. The authors conclude that decades of research evidence and clinical experience converge: The psychotherapy relationship makes substantial and consistent contributions to outcome independent of the type of treatment.

Clinical Impact Statement

Question: What, specifically, is effective in the powerful psychotherapy relationship? ***Findings:*** Clinicians can use these meta-analytic conclusions and the practice recommendations of the Task Force on Evidence-Based Relationships and Responsiveness to provide what works in the relationship and simultaneously to avoid what does not work. ***Meaning:*** Based on original meta-analyses, experts deemed nine of the relationship elements as demonstrably effective, seven as probably effective, and one as promising. ***Next Steps:*** Future directions are to disseminate these findings to practice communities, to implement them in training programs, and to examine the interrelations of the effective elements of the relationship.

Keywords: psychotherapy, therapeutic relationship, psychotherapy outcome, meta-analysis, evidence-based practice

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Ask patients what they find most helpful in their psychotherapy. Ask practitioners which component of psychotherapy ensures the highest probability of success. Ask researchers what the evidence favors in predicting effective psychological treatment. Ask psychotherapists what they are most eager to learn about (Tasca et al., 2015). Ask proponents of diverse psychotherapy systems on what point they can find commonality. The probable answer, for all these questions, is the *psychotherapy relationship*, the healing alliance between the client and the clinician.

In 1999, the American Psychological Association (APA) Division of Psychotherapy first commissioned a task force to identify, operationalize, and disseminate information on empirically supported therapy relationships. That task force summarized its findings and detailed its recommendations in a 2001 special issue of this journal, *Psychotherapy*, and in a 2002 book (Norcross, 2002). In 2009, the APA Division of Psychotherapy along with the Division of Clinical Psychology commissioned a second task force on evidence-based therapy relationships to update the research base and clinical practices on the psychotherapist–patient relationship. A second edition of the book (Norcross, 2011) and a second special issue of this journal, appearing in 2011, did just that.

Our aim for the third task force and the third iteration of this special journal issue, *Evidence-Based Psychotherapy Relationships III*, is to build upon and update the first two task forces in the research evidence for the impacts of relational elements, the number of those elements reviewed, and the rigor of the meta-analyses. In short, this issue summarizes the best available

John C. Norcross, Department of Psychology, University of Scranton; Michael J. Lambert, Department of Psychology, Brigham Young University.

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Correspondence concerning this article should be addressed to John C. Norcross, Department of Psychology, University of Scranton, Scranton, PA 18510-4596. E-mail: norcross@scranton.edu

research and clinical practices on numerous facets of the therapy relationship.

In this article, we frame this special issue on evidence-based psychotherapy relationships within the work of the Third Interdivisional APA Task Force on Evidence-Based Relationships and Responsiveness, which was cosponsored by the Society for the Advancement of Psychotherapy (APA Division 29) and the Society for Counseling Psychology (APA Division 17). We begin by summarizing the overarching purposes and processes of the Task Force and trace the devaluation of the therapy relationship in contemporary treatment guidelines and evidence-based practices. We provide a numerical summary of the meta-analytic results and the evidentiary strength of the subsequent 16 articles in the issue, each devoted to a particular relationship element. We then emphasize what works—and what does not—in the relationship. Prominent limitations of the task force work are highlighted. We present the formal conclusions and recommendations of the Third Interdivisional Task Force. Those statements, approved by the 10 members of the Steering Committee, refer to the work in both this special issue on therapy relationships and another volume on treatment adaptations or relational responsiveness (Norcross & Wampold, 2019).

The Third Interdivisional Task Force

The dual purposes of the Interdivisional APA Task Force on Evidence-Based Relationships and Responsiveness were to identify effective elements of the therapy relationship and to determine effective methods of adapting or tailoring therapy to the individual patient on the basis of his or her transdiagnostic characteristics. In other words, the Task Force was interested in both what works in general and what works for particular patients.

For the purposes of our work, we again adopted Gelso and Carter's (1985, 1994) operational definition of the relationship: The *therapeutic relationship* is the feelings and attitudes that the therapist and the client have toward one another, and the manner in which these are expressed. This definition is quite general, and the phrase "the manner in which it is expressed" potentially opens the relationship to include everything under the therapeutic sun (for an extended discussion, see Gelso & Hayes, 1998). Nonetheless, it serves as a concise, consensual, theoretically neutral, and sufficiently precise definition.

Treatment methods and the therapeutic relationship constantly shape and inform each other. Both clinical experience and research evidence point to a complex, reciprocal interaction between the interpersonal relationship and the instrumental methods. The relationship does not exist apart from what the therapist does in terms of method, and we cannot imagine any treatment methods that would not have some relational impact. Put differently, treatment methods are relational acts (Safran & Muran, 2000).

For historical and research convenience, the field has distinguished between relationships and techniques. Words like "relating" and "interpersonal behavior" describe *how* therapists and clients behave toward each other. By contrast, terms like "technique" or "intervention" describe *what* is done by the therapist. In research and theory, we often treat the how and the what—the relationship and the intervention, the interpersonal and the instrumental—as separate categories. In reality, of course, what one does and how one does it are complementary and inseparable. Trying to remove the interpersonal from the instrumental may be acceptable in research, but it is a fatal flaw when the aim is to extrapolate research results to clinical practice (see the 2005 special issue of *Psychotherapy* on the interplay of techniques and therapeutic relationship). In other words, the value of a treatment method is inextricably bound to the relational context in which it is applied.

The Task Force applies psychological science to the identification and promulgation of effective psychotherapy. It does so by expanding or enlarging the typical focus of evidence-based practice to therapy relationships. Focusing on one area—in this case, the therapeutic relationship—may unfortunately convey the impression that this is the only area of importance. We review the scientific literature on the therapy relationship and provide clinical recommendations based on that literature in ways, we trust, that do not degrade the simultaneous contributions of treatment methods, patients, or therapists to outcome.

An immediate challenge to the Task Force was to establish the inclusion and exclusion criteria for the elements of the therapy relationship. We readily agreed that the traditional features of the therapeutic relationship—the alliance in individual therapy, cohesion in group therapy, and the Rogerian facilitative conditions, for example—would constitute core elements. We further agreed that discrete, relatively nonrelational techniques were not part of our purview; therapy methods were considered for inclusion if their content, goal, and context were inextricably interwoven into the emergent therapy relationship. We settled on several "relational" methods (e.g., collecting real-time client feedback, repairing alliance ruptures, facilitating emotional expression, and managing countertransference) because these methods are deeply embedded in the interpersonal character of the relationship itself. As "methods," it also proves possible to randomly assign patients to one treatment condition with the method (for instance, feedback or rupture repairs) and other patients to a treatment without them. But which relational behaviors to include and which to exclude under the rubric of the *therapy relationship* bedeviled us, as it has the field.

We struggled on how finely to slice the therapy relationship. As a general rule, we opted to divide the meta-analytic reviews into smaller chunks so that the research conclusions were more specific and the practice and training implications more concrete.

We consulted psychotherapy experts, the research literature, and potential authors to discern whether there were sufficient numbers of studies on a particular relationship element to conduct a systematic review and meta-analysis. Three relational elements—therapist humor, self-doubt/humility, and deliberate practice—exhibited initial research support but not a sufficient number of empirical studies for a meta-analysis. Five new relationship behaviors surpassed our research threshold, and thus, we added the real relationship, self-disclosure, immediacy, emotional expression, and treatment credibility.

Once these decisions were finalized, we commissioned original meta-analyses on the relationship elements. Authors followed a comprehensive chapter structure and specific guidelines for their meta-analyses. The analyses quantitatively linked the relationship element to psychotherapy outcome. Outcome was primarily defined as distal posttreatment outcomes. Authors specified the outcome criterion when a particular study did not use a typical end-of-treatment measure; indeed, the type of outcome measure was frequently analyzed as a possible moderator of the overall

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effect size. This emphasis on distal outcomes sharpened our focus on "what works" and countered the partial truth that some of the meta-analyses examining predominantly proximal outcome measures in earlier iterations of the task force merely illustrated that "the good stuff in session correlates with other good stuff in session." We have responded to that criticism in these articles while also explicating several consequential process linkages.

When the meta-analyses were finalized, the 10-person Steering Committee (identified in the Appendix) independently reviewed and rated the evidentiary strength of the relationship element according to the following criteria: number of empirical studies, consistency of empirical results, independence of supportive studies, magnitude of association between the relationship element and outcome, evidence for causal link between relationship element and outcome, and the ecological or external validity of research. Using these criteria, experts independently judged the strength of the research evidence as *demonstrably effective*, *probably effective*, *promising but insufficient research to judge*, *important but not yet investigated*, or *not effective*.

We then aggregated the individual ratings to render a consensus conclusion on each relationship element. These conclusions are presented later in this article, as are 28 recommendations approved by all members of the Steering Committee. Our deliberations relied on expert opinion referencing best practices, professional consensus using objective rating criteria, and, most importantly, meta-analytic reviews of the research evidence. But these were all human decisions—open to cavil, contention, and revision.

This Issue

Following this introductory article are 16 articles on particular facets of the psychotherapy relationship and their relation to treatment outcome. Except for this introduction, each article uses identical major headings and consistent structure, as follows:

Introduction (untitled): Introduce the relationship element in a couple of reader-friendly paragraphs.

Definitions and Measures: Define in theoretically neutral language the relationship element. Identify any highly similar constructs from diverse theoretical traditions. Review the popular measures used in the research and included in the ensuing meta-analysis.

Clinical Examples: Provide a couple of concrete examples of the relationship behavior under consideration.

Results of Previous Reviews: Offer a quick synopsis of the findings of previous meta-analyses and systematic reviews on the topic.

Meta-Analytic Review: Compile all available empirical studies linking the relationship behavior to treatment outcome (distal, end-of-treatment outcome); report results of the literature search, preferably by means of a PRISMA flowchart if space allows; include only actual psychotherapy studies (not analogue studies); use a random-effects model; report the effect size as both weighted *r* and *d* (or *g*); provide a summary table for individual studies (if <50; if >50, provide a supplemental online appendix); perform and report a test of homogeneity (*Q* and *I*); include a fail-safe statistic to address the file-drawer problem; and provide a table or funnel plot for each study in the meta-analysis (if fewer than 50 studies).

Mediators and Moderators: Present the results of the potential mediators and moderators of the association between the relationship element and treatment outcome.

Patient Contributions: Address the patient's contribution to that relationship and the distinctive perspective he or she brings to the interaction.

Limitations of the Research: Point to the major limitations of the research conducted to date.

Diversity Considerations: Outline how diversity (e.g., gender, race/ethnicity, sexual orientation, and socioeconomic status) fares in the research studies and the meta-analytic results.

Therapeutic Practices: Highlight the practice implications from the foregoing research, primarily in terms of the therapist's contribution and secondarily in terms of the patient's perspective. Go beyond the numerical data to provide practical, bulleted clinical practices.

(Three sections of the book chapters—landmark studies, evidence for causality, and training implications—were jettisoned for these journal articles in the interest of space. Readers can access these sections and more methodological details in the book itself; Norcross & Lambert, 2019).

Insisting on quantitative meta-analyses for all articles (with one exception) enables direct estimates of the magnitude of association in the form of effect sizes. These are standardized difference between two group means, say psychotherapy and a control, divided by the (pooled) standard deviation. The resultant effect size is in standard deviation units. Both Cohen's *d* and Hedges's *g* estimate the population effect size.

The meta-analyses in this issue used the weighted *r* and its equivalent *d* or *g*. Most of the articles analyzed studies that were correlational in nature; for example, studies that correlated the patient's ratings of empathy during psychotherapy with their outcome at the end of treatment. The correlation coefficients (*r*) were then converted into *d* or *g*. We did so for consistency among the meta-analyses, enhancing their interpretability (square *r* for the amount of variance accounted for) and enabling direct comparisons of the meta-analytic results to one another as well as to *d* (the effect size typically used when comparing the relative effects of two treatments). In all of these analyses, the larger the magnitude of *r* or *d*, the higher the probability of patient success in psychotherapy based on the relationship variable under consideration.

Table 1 presents several practical ways to interpret *r* and *d* in behavioral health care. By convention (Cohen, 1988), an *r* of .10 in the behavioral sciences is considered a small effect, .30 a medium effect, and .50 a large effect. By contrast, a *d* of .30 is considered a small effect, .50 a medium effect, and .80 a large effect. Of course, these general rules or conventions cannot be dissociated from the context of decisions and comparative values. There is little inherent value to an effect size of 2.0 or 0.2; it depends on what benefits can be achieved at what cost (Smith, Glass, & Miller, 1980).

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Table 1
Practical Interpretation of d and r Values

d	*r*	Cohen's benchmark	Type of effect	Percentile of treated patients[a]	Success rate of treated patients (%)[b]
1.00			Beneficial	84	72
.90			Beneficial	82	70
.80	.50	Large	Beneficial	79	69
.70			Beneficial	76	66
.60			Beneficial	73	64
.50	.30	Medium	Beneficial	69	62
.40			Beneficial	66	60
.30			Beneficial	62	57
.20	.10	Small	Beneficial	58	55
.10			No effect	54	52
.00	0		No effect	50	50
−.10			No effect	46	48
−.20	.10		Detrimental	42	45
−.30			Detrimental	38	43

Note. Adapted from Cohen (1988); Norcross, Hogan, Koocher, and Maggio (2017); and Wampold and Imel (2015).
[a] Each effect size can be conceptualized as reflecting a corresponding percentile value; in this case, the percentile standing of the average treated patient after psychotherapy relative to untreated patients. [b] Each effect size can also be translated into a success rate of treated patients relative to untreated patients; a *d* of .80, for example, would translate into approximately 70% of patients being treated successfully compared with 50% of untreated patients.

Given the large number of factors contributing to patient success, and the inherent complexity of psychotherapy, we do not expect large, overpowering effects of any one relationship behavior. Instead, we expect to find a number of helpful facets. And that is exactly what we find in the following articles—beneficial, small-to-medium-sized effects of several elements of the complex therapy relationship.

For example, Elliott, Bohart, Watson, and Murphy (2018) conducted a meta-analysis of 82 studies that investigated the association between therapist empathy and patient success at the end of treatment. Their meta-analysis, involving a total of 6,138 patients, found a weighted mean *r* of .28. As shown in Table 1, this is a medium effect size. The corresponding *d* was .58. Relative to studies that compare one psychotherapy with another psychotherapy (where typical *d*s tend to be less than .20; Lambert, 2013; Wampold & Imel, 2015), a *d* of .58 is quite high. These numbers translate into happier and healthier clients; that is, clients with more empathic therapists tend to progress more in treatment and experience greater improvement.

Therapy Relationship

Recent decades have witnessed the controversial compilation of practice guidelines and evidence-based treatments in mental health. In the United States and other countries, the introduction of such guidelines has provoked practice modifications, training refinements, and organizational conflicts. Insurance carriers and government policymakers increasingly turn to such guidelines to determine which psychotherapies to approve and fund. Indeed, along with the negative influence of managed care, there is probably no issue more central to clinicians than the evolution of evidence-based treatments in psychotherapy (Barlow, 2000; Norcross, Hogan, Koocher, & Maggio, 2017).

Efforts to promulgate evidence-based psychotherapies have been noble in intent and timely in distribution. They are praiseworthy efforts to distill scientific research into clinical applications and to guide practice and training. They wisely demonstrate that, in a climate of accountability, psychotherapy stands up to empirical scrutiny with the best of health-care interventions. And within psychology, these have proactively counterbalanced documents that accorded primacy to biomedical treatments for mental disorders and largely ignored the outcome data for psychological therapies. On many accounts, then, the extant efforts addressed the realpolitik of the socioeconomic situation (Messer, 2001; Nathan & Gorman, 2015).

At the same time, many practitioners and researchers alike have found these recent efforts to codify evidence-based treatments seriously incomplete. Although scientifically laudable in their intent, these efforts largely ignored the therapy relationship and the person of the therapist. Practically all treatment guidelines have followed the antiquated medical model of identifying only particular treatment methods for specific diagnoses: Treatment A for Disorder Z. If one reads the documents literally, disembodied providers apply manualized interventions to discrete *DSM* and ICD disorders. Not only is the language offensive on clinical grounds to some practitioners, but the research evidence is weak for validating treatment methods in isolation from specific therapists, the therapy relationship, and the individual patient.

Suppose we asked a neutral scientific panel from outside the field to review the corpus of psychotherapy research to determine what is the most powerful phenomenon we should be studying, practicing, and teaching. Henry (1998, p. 128) concluded that such a panel,

> would find the answer obvious, and *empirically validated*. As a general trend across studies, the largest chunk of outcome variance not attributable to preexisting patient characteristics involves individual therapist differences and the emergent therapeutic relationship between patient and therapist, regardless of technique or school of therapy. This is the main thrust of decades of empirical research.

What is missing in treatment guidelines, now across 5 decades of research, are the person of the therapist and the therapeutic relationship.

Person of the Therapist

Most practice or treatment guideline compilations depict interchangeable providers performing treatment procedures. This stands in marked contrast to the clinician's and the client's experience of psychotherapy as an intensely interpersonal and deeply emotional experience. Although efficacy research has gone to considerable lengths to eliminate the individual therapist as a variable that might account for patient improvement, the inescapable fact of the matter is that it is simply not possible to mask the person and the contribution of the therapist (Castonguay & Hill, 2017; Orlinsky & Howard, 1977). The curative contribution of the person of the therapist is, arguably, as evidence based as manualized treatments or psychotherapy methods (Hubble, Wampold, Duncan, & Miller, 2011).

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Multiple and converging sources of evidence indicate that the *person* of the psychotherapist is inextricably intertwined with the outcome of psychotherapy. A large, naturalistic study estimated the outcomes attributable to 581 psychotherapists treating 6,146 patients in a managed care setting. About 5% of the outcome variation was due to therapist effects and 0% was due to specific treatment methods (Wampold & Brown, 2005).

Quantitative reviews of therapist effects in psychotherapy outcome studies show consistent and robust therapist effects, probably accounting for 5%–8% of psychotherapy outcome effects (Barkham, Lutz, Lambert, & Saxon, 2017; Crits-Christoph et al., 1991). The Barkham study combined data from four countries, 362 therapists, 14,254 clients, and four outcome measures. They found that about 8% of the variance in outcome was due to the therapist, so-called *therapist effects*. Moreover, the size of the therapist effect was strongly related to initial client severity. The more disturbed a client was at the beginning of therapy, the more it mattered which therapist the client saw.

A controlled study examining therapist effects in the outcomes of cognitive–behavioral therapy is instructive (Huppert et al., 2001). In the Multicenter Collaborative Study for the Treatment of Panic Disorder, considerable care was taken to standardize the treatment, the therapist, and the patients to increase the experimental rigor of the study and to minimize therapist effects. The treatment was manualized and structured, the therapists were identically trained and monitored for adherence, and the patients were rigorously evaluated and relatively uniform. Nonetheless, the therapists significantly differed in the magnitude of change among caseloads. Effect sizes for therapist impact on outcome measures ranged from 0% to 18%. Despite impressive attempts to experimentally render individual practitioners as controlled variables, it is simply not possible to mask the person and the contribution of the therapist.

Even when treatments are effectively delivered with minimal therapist contact (King, Orr, Poulsen, Giacomantonio, & Haden, 2017), their relational context includes interpersonal skill, persuasion, warmth, and even, on occasion, charisma. Self-help resources typically contain their developers' self-disclosures, interpersonal support, and normalizing concerns. Thus, it is not surprising that the relation between treatment outcome and the therapeutic alliance in Internet-based psychotherapy is of the same strength as that for the alliance–outcome association in face-to-face psychotherapy (Flückiger, Del Re, Wampold, & Horvath, 2018). Therapist effects are strong, ubiquitous, and sadly ignored in most guidelines on what works.

Therapeutic Relationship

A second omission in most treatment guidelines has been the decision to validate only the efficacy of treatment methods or technical interventions, as opposed to the therapy relationship or therapist interpersonal skills. This decision both reflects and reinforces the ongoing movement toward high-quality, comparative effectiveness research on brand-name psychotherapies. "This trend of putting all of the eggs in the 'technique' basket began in the late 1970s and is now reaching the peak of influence" (Bergin, 1997, p. 83).

Both clinical experience and research findings underscore that the therapy relationship accounts for as much, and probably more, of the outcome variance as particular treatment methods. Meta-analyses of psychotherapy outcome literature consistently reveal that specific treatment methods account for 0%–10% of the outcome variance (Lambert, 2013; Wampold & Imel, 2015), and much of that is attributable to the investigator's therapy allegiance (Cuijpers et al., 2012; Luborsky et al., 1999).

Even those practice guidelines enjoining practitioners to attend to the therapy relationship do not provide specific, evidence-based means of doing so. For example, the scholarly and comprehensive review on treatment choice from Great Britain (Department of Health, 2001) devotes a single paragraph to the therapeutic relationship. Its recommended principle is that "Effectiveness of all types of therapy depends on the patient and the therapist forming a good working relationship" (p. 35), but no evidence-based guidance is offered on which therapist behaviors contribute to or cultivate that relationship.

All of this is to say that treatment guidelines give short shrift—some would say lip service—to the person of the therapist and the emergent therapeutic relationship. The vast majority of current attempts are thus seriously incomplete and potentially misleading, both on clinical and empirical grounds.

Limitations of the Work

A single task force can accomplish only so much work and cover only so much content. As such, we wish to acknowledge publicly several necessary omissions and unfortunate truncations in our work.

The products of the third Task Force probably suffer first from content overlap. We may have cut the "diamond" of the therapy relationship too thin at times, leading to a profusion of highly related and possibly redundant constructs. Goal consensus, for example, correlates highly with collaboration, which is considered in the same article, and both of those are considered parts of the therapeutic alliance. Collecting client feedback and repairing alliance ruptures, for another example, may represent different sides of the same therapist behavior, but these too are covered in separate meta-analyses. Thus, to some the content may appear swollen; to others, the Task Force may have failed to make necessary distinctions.

Another lacuna in the Task Force work is that we may have neglected, relatively speaking, the productive contribution of the client to the therapy relationship. Virtually all of the relationship elements in this issue represent mutual processes of shared communicative attunement (Orlinsky, Ronnestad, & Willutzki, 2004). They exist in the human connection, in the transactional process, rather than solely as a therapist (or client) variable. We encouraged authors to attend to the chain of events among the therapist's contributions, the patient processes, and eventual treatment outcomes. Nevertheless, this limitation proves especially ironic in that the moderator analyses of several meta-analyses in this special issue indicated the patient's perspective of the relationship proves more predictive of their treatment outcome than the therapist's.

As with the previous two task forces, the overwhelming majority of research studies meta-analyzed were conducted in Western developed nations and published in English-language journals. The literature searches are definitely improving in accessing studies conducted internationally, but most authors did not translate articles published in other languages. An encouraging exception were

the authors of the alliance meta-analysis (this issue), who included studies published in English, Italian, German, and French languages.

Researcher allegiance may have also posed a problem in conducting and interpreting the meta-analyses. Of course, we invited authors with an interest and expertise in a relationship element, but in some cases, the authors might have experienced conflicts of interest due to their emotional, academic, or financial interests. The use of objective meta-analytic guidelines, peer review, and transparent data reporting may have attenuated the effects of their allegiance, but it remains a strong human propensity in any discipline.

Another prominent limitation across these research reviews is the difficulty of establishing causal connections between the relationship behavior and treatment outcome. The only meta-analyses that contain randomized clinical trials (RCTs) capable of demonstrating a causal effect are collecting client feedback and repairing appliance ruptures. With these two exceptions, all of the meta-analyses in this issue reported the association and prediction of the relationship element to psychotherapy outcome. These were overwhelmingly correlational designs. It is methodologically difficult to meet the three conditions needed to make a causal claim: nonspuriousness, covariation between the process variable and the outcome measure, and temporal precedence of the process variable (Feeley, DeRubeis, & Gelfand, 1999). We still need to determine when the therapeutic relationship is a mediator, moderator, or mechanism of change in psychotherapy (Kazdin, 2007).

There is much confusion between relational factors related to outcome and those are characteristics or actions of effective therapists. Consider the example of empathy. There are dozens of studies and several meta-analyses now that indicate that empathy, as expressed or perceived in a session, is reliably related to psychotherapy outcome; that is called a total correlation. We do not know if that correlation is due to the patient (verbal and cooperative patients elicit empathy from their therapist and also get better) or the therapist (some therapists are generally more empathic than others, across patients, and these therapists achieve better outcomes).

Of all the relationship behaviors reviewed in this journal issue, only two (feedback and alliance ruptures) have addressed this disaggregation by means of RCTs and only one (alliance in individual therapy; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012) by other statistical means. And it turns out, the evidence is strong that it is the therapist who is important—therapists who generally form stronger alliances generally have better outcomes, but not vice versa (Del Re et al., 2012). It is largely the therapist's contribution, not the patient's contribution, that relates to therapy outcome (Baldwin, Wampold, & Imel, 2007; Wampold & Imel, 2015). Unfortunately, we do not know if this is true of empathy or most of the other relational elements.

At the same time as we acknowledge this limitation, let us remain mindful of several considerations about causation. First, in showing that these facets of a therapy relationship precede positive treatment outcome, we can certainly state that the relationship is, at a minimum, an important predictor and antecedent of that outcome. Second, dozens of lagged correlational, unconfounded regression, structural equation, and growth curve studies suggest that the therapy relationship probably casually contributes to outcome (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Klein et al., 2003; alliance article, this issue). Third, some of the most precious behaviors in life are incapable on ethical grounds of random assignment and experimental manipulation. Take parental love as an exemplar. Not a single RCT has ever been conducted to conclusively determine the causal benefit of parents' love on their children's functioning, yet virtually all humans aspire to it and practice it. Nor can we envision an institutional review board ever approving a grant proposal to randomize patients in a psychotherapy study to an empathic, collaborative, and supportive therapist versus a nonempathic, authoritarian, and unsupportive therapist. We warn against an either/or conclusion on the ability of the therapy relationship to cause patient improvement.

A final interesting drawback to the present work involves the paucity of attention paid to the disorder-specific and treatment-specific nature of the therapy relationship. It is premature to aggregate the research on how the patient's primary disorder or the type of treatment impacts the therapy relationship, but there are early links. For example, in the treatment of severe anxiety disorders (generalized anxiety disorder and obsessive–compulsive disorder) and substance abuse, the relationship may well exert less impact (Flückiger et al., 2012; Graves et al., 2017) than in other disorders, such as depression. The therapeutic alliance in the National Institute of Mental Health Treatment of Depression Collaborative Research Program, in both psychotherapy and pharmacotherapy, emerged as the leading force in reducing a patient's depression (Krupnick et al., 1996). The therapeutic relationship probably exhibits more impact in some disorders and in some therapies than others (Beckner, Vella, Howard, & Mohr, 2007; Bedics, Atkins, Harned, & Linehan, 2015). As with research on specific psychotherapies, it may no longer suffice to ask, "Does the relationship work?" but "How does the relationship work for this disorder and this treatment method?"

Conclusions of the Task Force on Evidence-Based Relationships and Responsiveness

The psychotherapy relationship makes substantial and consistent contributions to patient outcome independent of the specific type of psychological treatment.

The therapy relationship accounts for client improvement (or lack of improvement) as much as, and probably more than, the particular treatment method.

Practice and treatment guidelines should explicitly address therapist behaviors and qualities that promote a facilitative therapy relationship.

Efforts to promulgate best practices and evidence-based treatments without including the relationship and responsiveness are seriously incomplete and potentially misleading.

Adapting or tailoring the therapy relationship to specific patient characteristics (in addition to diagnosis) enhances the effectiveness of psychological treatment.

Adapting psychological treatment (or responsiveness) to transdiagnostic client characteristics contributes to successful outcomes at least as much as, and probably more than, adapting treatment to the client's diagnosis.

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The therapy relationship acts in concert with treatment methods, patient characteristics, and other practitioner qualities in determining effectiveness; a comprehensive understanding of effective (and ineffective) psychotherapy will consider all of these determinants and how they work together to produce benefit.

Table 2 summarizes the Task Force conclusions regarding the evidentiary strength of (a) elements of the therapy relationship primarily provided by the psychotherapist and (b) methods of adapting psychotherapy to patient transdiagnostic characteristics.

The preceding conclusions do *not* constitute practice or treatment standards but represent current scientific knowledge to be understood and applied in the context of the clinical evidence available in each case.

Recommendations of the Task Force on Evidence-Based Relationships and Responsiveness

General Recommendations

1. We recommend that the results and conclusions of this third Task Force be widely disseminated to enhance awareness and use of what "works" in the psychotherapy relationship and treatment adaptations.

2. Readers are encouraged to interpret these findings in the context of the acknowledged limitations of the Task Force's work.

3. We recommend that future task forces be established periodically to review these findings, include new elements of the relationship and responsiveness, incorporate the results of non-English language publications (where practical), and update these conclusions.

Practice Recommendations

4. Practitioners are encouraged to make the creation and cultivation of the therapy relationship a primary aim of treatment. This is especially true for relationship elements found to be demonstrably and probably effective.

5. Practitioners are encouraged to assess relational behaviors (e.g., alliance, empathy, and cohesion) vis-à-vis cutoff scores on popular clinical measures in ways that lead to more positive outcomes.

6. Practitioners are encouraged to adapt or tailor psychotherapy to those specific client transdiagnostic characteristics in ways found to be demonstrably and probably effective.

7. Practitioners will experience increased treatment success by regularly assessing and responsively attuning psychotherapy to clients' cultural identities (broadly defined).

8. Practitioners are encouraged to routinely monitor patients' satisfaction with the therapy relationship, comfort with responsiveness efforts, and response to treatment. Such monitoring leads to increased opportunities to reestablish collaboration, improve the relationship, modify technical strategies, and investigate factors external to therapy that may be hindering its effects.

9. Practitioners are encouraged to concurrently use evidence-based relationships *and* evidence-based treatments adapted

Table 2
Task Force Conclusions Regarding the Evidentiary Strength of Elements of the Therapy Relationship and Methods of Adapting Psychotherapy

Evidentiary strength	Elements of the relationship	Methods of adapting
Demonstrably effective	Alliance in individual psychotherapy Alliance in child and adolescent psychotherapy Alliances in couple and family therapy Collaboration Goal consensus Cohesion in group therapy Empathy Positive regard and affirmation Collecting and delivering client feedback	Culture (race/ethnicity) Religion/spirituality Patient preferences
Probably effective	Congruence/genuineness Real relationship Emotional expression Cultivating positive expectations Promoting treatment credibility Managing countertransference Repairing alliance ruptures	Reactance level Stages of change Coping style
Promising but insufficient research	Self-disclosure and immediacy	Attachment style
Important but not yet investigated		Sexual orientation Gender identity

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to the whole patient, as that is likely to generate the best outcomes in psychotherapy.

Training Recommendations

10. Mental health training and continuing education programs are encouraged to provide competency-based training in the demonstrably and probably effective elements of the therapy relationship.

11. Mental health training and continuing education programs are encouraged to provide competency-based training in adapting psychotherapy to the individual patient in ways that demonstrably and probably enhance treatment success.

12. Psychotherapy educators and supervisors are encouraged to train students in assessing and honoring clients' cultural heritages, values, and beliefs in ways that enhance the therapeutic relationship and inform treatment adaptations.

13. Accreditation and certification bodies for mental health training programs are encouraged to develop criteria for assessing the adequacy of training in evidence-based therapy relationships and responsiveness.

Research Recommendations

14. Researchers are encouraged to conduct research on the effectiveness of therapist relationship behaviors that do not presently have sufficient research evidence, such as self-disclosure, humility, flexibility, and deliberate practice.

15. Researchers are encouraged to investigate further the effectiveness of adaptation methods in psychotherapy, such as to clients' sexual orientation, gender identity, and attachment style, that do not presently have sufficient research evidence.

16. Researchers are encouraged to proactively conduct relationship and responsiveness outcome studies with culturally diverse and historically marginalized clients.

17. Researchers are encouraged to assess the relationship components using in-session observations in addition to postsession measures. The former track the client's moment-to-moment experience of a session and the latter summarize the patient's total experience of psychotherapy.

18. Researchers are encouraged to progress beyond correlational designs that associate the frequency and quality of relationship behaviors with client outcomes to methodologies capable of examining the complex causal associations among client qualities, clinician behaviors, and psychotherapy outcomes.

19. Researchers are encouraged to examine systematically the associations among the multitude of relationship elements and adaptation methods to establish a more coherent and empirically based typology that will improve clinical training and practice.

20. Researchers are encouraged to disentangle the patient contributions and the therapist contributions to relationship elements and ultimately outcome.

21. Researchers are encouraged to examine the specific moderators between relationship elements and treatment outcomes.

22. Researchers are encouraged to address the observational perspective (i.e., therapist, patient, or external rater) in future studies and reviews of "what works" in the therapy relationship. Agreement among observational perspectives provides a solid sense of established fact; divergence among perspectives holds important implications for practice.

23. Researchers are encouraged to increase translational research and dissemination on those relational behaviors and treatment adaptations that already have been judged effective.

24. Researchers are encouraged to examine the effectiveness of educational, training, and supervision methods used to teach relational skills and treatment adaptations/responsiveness.

Policy Recommendations

25. APA's Society for the Advancement of Psychotherapy, the APA Society for Counseling Psychology, and all divisions are encouraged to educate their members on the benefits of evidence-based therapy relationships and responsiveness.

26. Mental health organizations as a whole are encouraged to educate their members about the improved outcomes associated with higher levels of therapist-offered evidence-based therapy relationships, as they frequently now do about evidence-based treatments.

27. We recommend that the APA and other mental health organizations advocate for the research-substantiated benefits of a nurturing and responsive human relationship in psychotherapy.

28. Finally, administrators of mental health services are encouraged to attend to and invest in the relational features and transdiagnostic adaptations of their services. Attempts to improve the quality of care should account for relationships and responsiveness, not only the implementation of evidence-based treatments for specific disorders.

What Works

Table 3 summarizes the meta-analytic associations between the relationship elements and psychotherapy outcomes. As seen there,

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Table 3
Summary of Meta-Analytic Associations Between Relationship Components and Psychotherapy Outcomes

Relationship element	Number of studies (*k*)	Number of patients (*N*)	Effect size		Consensus on evidentiary strength
			r	*d* or *g*	
Alliance in individual psychotherapy	306	30,000+	.28	.57	Demonstrably effective
Alliance in child and adolescent therapy	43	3,447	.20	.40	Demonstrably effective
Alliances in couple and family therapy	40	4,113	.30	.62	Demonstrably effective
Collaboration	53	5,286	.29	.61	Demonstrably effective
Goal consensus	54	7,278	.24	.49	Demonstrably effective
Cohesion in group therapy	55	6,055	.26	.56	Demonstrably effective
Empathy	82	6,138	.28	.58	Demonstrably effective
Positive regard and affirmation	64	3,528		.28	Demonstrably effective
Congruence/genuineness	21	1,192	.23	.46	Probably effective
The real relationship	17	1,502	.37	.80	Probably effective
Self-disclosure and immediacy	21	~140	NA	NA	Promising but insufficient research
Emotional expression	42	925	.40	.85	Probably effective
Cultivating positive expectation	81	12,722	.18	.36	Probably effective
Promoting treatment credibility	24	1,504	.12	.24	Probably effective
Managing countertransference	9	392 therapists	.39	.84	Probably effective
Repairing alliance ruptures	11	1,318	.30	.62	Probably effective
Collecting and delivering client feedback	24	10,921		.14–.49[a]	Demonstrably effective

Note. NA = not applicable; the chapter used qualitative meta-analysis, which does not produce effect sizes.
[a] The effect sizes depended on the comparison group and the feedback method; feedback proved more effective with patients at risk for deterioration and less effective for all patients.

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the expert consensus deemed nine of the relationship elements as demonstrably effective, seven as probably effective, and one as promising but insufficient research to judge. We were heartened to find the evidence base for all research elements had increased, and in some cases substantially, from the second edition (Norcross, 2011). We were also impressed by the disparate and perhaps elevated standards against which these relationship elements were evaluated.

Compare the evidentiary strength required for psychological treatments to be considered demonstrably efficacious in two influential compilations of evidence-based practices. The Division of Clinical Psychology's Subcommittee on Research-Supported Treatments (www.div12.org/PsychologicalTreatments/index.html) requires two between-groups design experiments demonstrating that a psychological treatment is either (a) statistically superior to pill or psychological placebo or to another treatment or (b) equivalent to an already established treatment in experiments with adequate sample sizes. The studies must have been conducted with treatment manuals and conducted by at least two different investigators. The typical effect size of those studies was often smaller than the effects for the relationship elements reported in this series of articles. For listing in SAMHSA's National Registry of Evidence-Based Programs and Practices (www.nrepp.samhsa.gov), which will be soon discontinued, only evidence of statistically significant behavioral outcomes demonstrated in at least one study, using an experimental or quasi-experimental design, that has been published in a peer-reviewed journal or comprehensive evaluation report is needed. By these standards, practically all of the relationship elements in this journal issue would be considered demonstrably effective, if not for the requirement of an RCT, which proves neither clinically nor ethically feasible for most of the relationship elements.

In several ways, the effectiveness criteria for relationship elements are more rigorous. Whereas the criteria for designating treatments as evidence-based rely on only one or two studies, the evidence for relationship elements presented here is based on comprehensive meta-analyses of many studies (in excess of 40 studies in the majority of meta-analyses), spanning various treatments, a wide variety of treatment settings, patient populations, treatment formats, and research groups. The studies used to establish evidence-based treatments are, however, RCTs. RCTs are often plagued by confounds, such as researcher allegiance, cannot be blinded, and often contain bogus comparisons (Luborsky et al., 1999; Mohr et al., 2009; Wampold, Baldwin, Holtforth, & Imel, 2017; Wampold et al., 2010). The point here is not to denigrate the criteria used to establish evidence-based treatments, but to underscore the robust scientific standards by which these relationship elements have been operationalized and evaluated. The evolving standards to judge evidence-based treatment methods are now moving away from the presence of an absolute number of studies to the presence of meta-analytic evidence (Tolin, McKay, Forman, Klonsky, & Thombs, 2015), a standard demonstrated repeatedly in this journal issue.

Consider as well the strength or magnitude of the therapy relationship. Across thousands of individual outcome studies and hundreds of meta-analytic reviews, the typical effect size difference (*d*) between psychotherapy and no psychotherapy averages .80–.85 (Lambert, 2010; Wampold & Imel, 2015), a large effect size. The effect size (*d*) for any *single* relationship behavior in Table 3 ranges between .24 and .80. The alliance in individual psychotherapy, for example, demonstrates an aggregate *r* of .28 and a *d* of .57 with treatment outcome, making the quality of the alliance one of the strongest and most robust predictors of successful psychotherapy. These relationship behaviors are robustly effective components and predictors of patient success. We need to proclaim publicly what decades of research have discovered and what hundreds of thousands of practitioners have witnessed: The relationship can heal.

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It would probably prove advantageous to both practice and science to sum the individual effect sizes in Table 3 to arrive at a total of relationship contribution to treatment outcome, but reality is not so accommodating. Neither the research studies nor the relationship elements contained in the meta-analyses are independent; thus, the amount of variance accounted for by each element or construct cannot be added to estimate the overall contribution. For example, the correlations among the person-centered conditions (empathy, warmth/support, and congruence/genuineness) and the therapeutic alliance are typically in the .50s (Nienhuis et al., 2018; Watson & Geller, 2005). Many of the studies within the adult alliance meta-analysis also appear in the meta-analyses on collaboration and goal consensus, perhaps because a therapeutic alliance measure, subscale, or item was used to operationalize collaboration. Unfortunately, the degree of overlap between all the measures (and therefore relationship elements) is not available but bound to be substantial (Norcross & Lambert, 2014). Whether each relationship element is accounting for the same outcome variance or whether some of the elements are additive remains to be determined.

We present the relationship elements in this journal issue as separate, stand-alone practices, but every seasoned psychotherapist knows this is certainly never the case in clinical work. The alliance in individual therapy and cohesion in group therapy never act in isolation from other relationship behaviors, such as empathy or support. Nor does it seem humanly possible to cultivate a strong relationship with a patient without ascertaining her feedback on the therapeutic process and understanding the therapist's countertransference. All the relationship elements interconnect as we try to tailor therapy to the unique, complex individual. While these relationship elements "work," they work together and interdependently.

In any case, the meta-analytic results in this book probably underestimate the true effect due to the responsiveness problem (Kramer & Stiles, 2015; Stiles, Honos-Webb, & Surko, 1998). It is a problem for researchers but a boon to practitioners, who flexibly adjust the amount and timing of relational behaviors in psychotherapy to fit the unique individual and singular context. Effective psychotherapists responsively provide varying levels of relationship elements in different cases and, within the same case, at different moments. This responsiveness tends to confound attempts to find naturalistically observed linear relations of outcome with therapist behaviors (e.g., cohesion and positive regard). As a consequence, the statistical relation between therapy relationship and outcome cannot always be trusted and tends to be lower than it actually is. By being clinically attuned and flexible, psychotherapists ironically make it more difficult in research studies to discern what works.

The profusion of research-supported relationship elements proves, at once, encouraging and disconcerting. Encouraging because we have identified and measured potent predictors and contributions of the therapist that can be taught and implemented. Disconcerting because of the large number of potent relational behaviors that are highly intercorrelated and are without much organization or rationale.

Several researchers have clamored for a more coherent organization of relationship behaviors that could guide practice and training. One proposal would arrange the relational elements in a conceptual hierarchy of helping relationships (Horvath, Symonds, Flückiger, Del Re, & Lee, 2016). Superordinate, high-level *Descriptive Constructs* describe the way of therapy. Featured here are the alliance, cohesion, and empathy as global ways of being in therapy. Below that are *Strategies* for managing the relationship, such as positive regard, self-disclosure, managing emotional expression, promoting credibility, collecting formal feedback, and resolving ruptures. Then there are *Therapist Qualities*—more about the person than a strategy or skill. Exemplars are flexibility, congruence, and reactivity in responding to countertransference. The Strategies and the Therapist Qualities overlap of course, for example, in the personal quality of reactivity in responding to countertransference and in the Strategy of managing countertransference. Finally, on the bottom of the hierarchy, come *Client Contributions*. These describe the client's attachment style, preferences, expectations, coping styles, culture, reactance level, and diagnosis (all these may serve as reliable markers to adapt therapy and are featured in Volume 2 of *Psychotherapy Relationships That Work*; Norcross & Wampold, 2019). Horvath and colleagues' (2016) four-level structure of the helping relationship provides greater organization and perhaps clarity.

That organization will assuredly benefit from multivariate meta-analyses conducted on several relationship constructs simultaneously. However, too few studies exist to allow meta-analytic reviews of multiple relationship elements (e.g., measures of the therapeutic alliance, therapist empathy, and client expectations for improvement). Future multivariate meta-analyses could elevate the expectations for future scholarship, as most of these relationship variables share substantial variance and could inform conceptual schemes on their interrelations.

As the evidence base of therapist relationship behaviors develops, we will know more about their effectiveness for particular circumstances and conditions. A case in point is the meta-analysis on collecting and delivering client feedback (Lambert, 2018). The evidence is quite clear that adding formal feedback helps clinicians effectively treat patients at risk for deterioration ($d = .49$), whereas it is not needed in cases that are progressing well (see Table 3). How well, then, does relationship feedback work in psychotherapy? It depends; it depends on the purpose and the circumstances.

The strength of the therapy relationship also depends in some instances on the client's principal disorder. The meta-analyses occasionally find some relationship elements less efficacious with some disorders, usually substance abuse, severe anxiety, and eating disorders. Most moderator analyses usually find the relationship equally effective across disorders, but that conclusion may be due to the relatively small number of studies for any single disorder and the resulting low statistical power to find actual differences. And, of course, it gets more complicated as patients typically present with multiple, comorbid disorders.

Our point is that each context and patient needs something different. "We are differently organized," as Lord Byron wrote. Empathy is demonstrably effective in psychotherapy, but suspicious patients respond negatively to classic displays of empathy, requiring therapist responsiveness and idiosyncratic expressions of empathy. The need to adapt or personalize therapy to the individual patient is covered in detail in the other half of the Task Force's work on evidence-based responsiveness (Norcross & Wampold, 2019).

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What Does Not Work

Translational research is both prescriptive and proscriptive; it tells us what proves effective and what does not. We can optimize therapy relationships by simultaneously using what works and studiously avoiding what does not work. Here, we briefly highlight those therapist relational behaviors that are ineffective, perhaps even hurtful, in psychotherapy.

One means of identifying ineffective qualities of the therapeutic relationship is to reverse the effective behaviors identified in these meta-analyses. Thus, what does not work are poor alliances in adult, adolescent, child, couple, and family psychotherapy, as well as low levels of cohesion in group therapy. Paucity of collaboration, consensus, empathy, and positive regard predict treatment drop out and failure. The ineffective practitioner will not seek or be receptive to formal methods of providing client feedback on progress and relationship, will ignore alliance ruptures, and will not be aware of his or her countertransference. Incongruent therapists, discreditable treatments, and emotional-less sessions detract from patient success.

Another means of identifying ineffective qualities of the relationship is to scour the research literature (Duncan, Miller, Wampold, & Hubble, 2010; Lambert, 2010) and conduct polls of experts (Koocher, McMann, Stout, & Norcross, 2015; Norcross, Koocher, & Garofalo, 2006). In a previous review of that literature in 2011 (Norcross & Wampold, 2011), we recommended that practitioners avoid several behaviors: Confrontations, negative processes, assumptions, therapist–centricity, and rigidity. To that list we add *cultural arrogance*. Psychotherapy is inescapably bound to the cultures in which it is practiced by clinicians and experienced by clients. Arrogant impositions of therapists' cultural beliefs in terms of gender, race/ethnicity, sexual orientation, and other intersecting dimensions of identity are culturally insensitive and demonstrably less effective (Soto, Smith, Griner, Rodriguez, & Bernal, 2019). By contrast, therapists expressing cultural humility and tracking clients' satisfaction with cultural responsiveness markedly improve client engagement, retention, and eventual treatment outcome.

Concluding Reflections

The future of psychotherapy portends the integration of the instrumental and the interpersonal, of the technical and the relational in the tradition of evidence-based practice (Norcross, Freedheim, & VandenBos, 2011). *Evidence-based psychotherapy relationships* align with this future and embody a crucial part of evidence-based practice, when properly conceptualized. We can imagine few practices in all of psychotherapy that can confidently boast that they integrate as well "the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006) as the relational behaviors in this special issue. We are reminded daily that research can guide how to create, cultivate, and customize that powerful human relationship.

Of course, that research knowledge serves little practical purpose if psychotherapists do not know it and if they do not enact the specific behaviors to enhance these relationship elements. The meta-analyses are complete now, but not the tasks of dissemination and implementation. Members of the Task Force Steering Committee plan to share these results widely in journal articles, public presentations, training workshops, and professional websites. A Society for the Advancement of Psychotherapy initiative, *Teaching and Learning Evidence-Based Relationships: Interviews with the Experts* (societyforpsychotherapy.org/teaching-learning-evidence-based-relationships), is underway to assist students and educators in these evidence-based therapy relationships.

The three interdivisional APA task forces originated to augment patient benefit. We continue to explore what works in the therapy relationship (and what works when we adapt that relationship to transdiagnostic patient characteristics). That remains our goal: improving patient outcomes, however measured and manifested in a given case. A dispassionate analysis of the avalanche of meta-analyses in this journal issue reveals that multiple relationship behaviors positively associate with, temporally predict, and perhaps causally contribute to client outcomes. This is reassuring news in a technology-driven and drug-filled world (Greenberg, 2016).

To repeat one of the Task Force's conclusions: The psychotherapy relationship makes substantial and consistent contributions to outcome independent of the type of treatment. Decades of research evidence and clinical experience converge: The relationship works! These effect sizes concretely translate into healthier and happier people.

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Appendix

Steering Committee Members of the Third Interdivisional APA Task Force on Evidence-Based Relationships and Responsiveness

Franz Caspar, PhD, University of Bern
Melanie M. Domenech Rodriguez, PhD, Utah State University
Clara E. Hill, PhD, University of Maryland
Michael J. Lambert, PhD, Brigham Young University
Suzanne H. Lease, PhD, University of Memphis (representing APA Division 17)
James W. Lichtenberg, PhD, University of Kansas (representing APA Division 17)
Rayna D. Markin, PhD, Villanova University (representing APA Division 29)
John C. Norcross, PhD, University of Scranton (chair)
Jesse Owen, PhD, University of Denver
Bruce E. Wampold, PhD, University of Wisconsin and Modum Bad Psychiatric Center

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    - Questionnaire
- 1. Elméleti alap
  - Bevezetés
    - Bevezető és nyilatkozat
  - Elméleti alap
    - Mi a segítő kapcsolat?
    - A hatalmi különbség, a tanult passzivitás kockázata, a passzív páciensektől az aktív állampolgárokig
    - Megküzdés
  - A hatékonyság közös nevezői
    - A betegségre, vagy a belső lehetőségek fejlesztésére fókuszáljunk
    - Az emberközpontú szemlélet nagyobb hatékonyságot és jobb költség-haszon arányt von maga után
    - Felépülés
    - A szakmai hatékonyság a segítő kapcsolatokban_ a különböző segítő kapcsolatok közös nevezői és konkrét jellemzői

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  - A trauma típusai
  - II. típusú trauma
  - Összetett trauma
  - Reviktimizáció komplex trauma esetén
  - Újratraumatizáció
  - A kamaszkor és a trauma
  - A trauma változásokat okozhat az agyban
  - Erőszakészlelés
  - Elhanyagolás
  - Elhanyagolás a válási procedúra során

- Trauma és táplálkozási zavarok
- Veszély, kötődés és lelki trauma
- Mentalizáció és a trauma

- 2. Egészség és jóllét megőrzése és támogatása
  - Retraumatizáció:Okok, Megelőzés és Kezelés
    - A menekültekkel kapcsolatos politikai kérdések retraumatizációs hatása Olaszországban és nemzetközi szinten
    - Interszekcionalitás és trauma
    - Trauma feldolgozása emberközpontú csoportterápiával
    - Empatikus hallgatás traumafeldolgozást segíti
    - Örökbefogadás és trauma
    - Újratraumatizáció
    - Örökbefogadás és trauma
    - Bebörtönzött emberek gyermekei és a trauma
    - Másodlagos traumatizáció
    - Másodlagos trauma feldolgozása művészet által Lampedusaban
  - Tanuljunk hibáinkból!
    - Tanuljunk hibáinkból
    - A traumának súlyos hatásai vannak a fizikai és mentális egészségre, és generációról generációra ez a fő oka a morbiditásnak és halandóságnak
    - A trauma mindent áthat
    - Egy traumával kapcsolatos aktualitás
    - Trauma tudatos megközelítés
    - 1. traumatudatos alapelv
    - 2. traumatudatos alapelv
    - 3. traumatudatos alapelv
    - 4. traumatudatos alapelv
    - 5. traumatudatos alapelv

- 6. traumatudatos alapelv
- Traumatudatos iskolák
- Koncentráljunk az emberekre: Gondoskodás és felvértezés
  - Biztonságos menedéket nyújtunk a kliens számára a traumafeldolgozáshoz
  - LMBTQ kliensek üdvözlése
  - Személyiségfejlődés szükségessége: Trauma utáni növekedés
- Európai eszközök és helyzetek
  - Művészetterápia - Virgina Axline
  - Trauma kiértékeléséhez eszközök
  - Traumatudatos ellátás Európában országonként

- Összefoglaló
  - Következtetések
  - Bibliográfia
- Quiz 1
  - Quiz
  - Quiz 1

3. TRAUMA: kutatás, értékelés, eredmények

- Kutatás
  Prerequisite: Quiz 1
  Quiz
- Bizonyítékokon alapuló kutatás a tic/tip, avagy traumatudatos ellátásban
  Prerequisite: Kutatás
  Quiz
- Bizonyítékon alapuló kutatás
  Prerequisite: Bizonyítékokon alapuló kutatás a tic/tip, avagy traumatudatos ellátásban
  Quiz

4. TRAUMA: jó gyakorlatok és intézkedések

- A traumatudatos ellátás kutatás módszertani szempontjai
  Prerequisite: Bizonyítékon alapuló kutatás
  Quiz
- A traumatudatos ellátás bevált gyakorlatai: A tapasztalati tényeken alapuló bevált gyakorlatok átadhatósága
  Prerequisite: A traumatudatos ellátás kutatás módszertani szempontjai
  Quiz
- A megfigyelés és a bántalmazás indikátorai
  Prerequisite: A traumatudatos ellátás bevált gyakorlatai: A tapasztalati tényeken alapuló bevált gyakorlatok átadhatósága
  Quiz

5. Jogi keretek és alapelvek

- Bevezető
  Prerequisite: A megfigyelés és a bántalmazás indikátorai
- 5.1. Lecke
  Prerequisite: A megfigyelés és a bántalmazás indikátorai
  Quiz
- 5.2. Lecke
  Prerequisite: 5.1. Lecke
  Quiz

- 6.Modul (két hét)
  - 1. Lecke
    Prerequisite: 5.2. Lecke
    Quiz
  - 2. Lecke
    Prerequisite: 1. Lecke
    Quiz
  - Konklúziók
    Prerequisite: 1. Lecke
- 7. Final exams
  - Introduction
    Prerequisite: 2. Lecke
    Final Exam

- 7. Final exams
  - Introduction
    Prerequisite: 2. Lecke
    Final Exam

- Értékelés
  - Teszt
    Kérdőív

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Questionnaire

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CarePath MOOC-HUx

Üdvözlünk Carepath közösségében! Mielőtt elkezdjük a kurzust szeretnénk ha kitöltenéd számunkra az alábbi kérdőívet! Köszönjük

Email (MOOC email) *

La tua risposta

Ország *

La tua risposta

Képzettség *

- ◯ Érettség
- ◯ Alap diploma
- ◯ Mester diploma
- ◯ Altro:

Jelenlegi munkahely *

- ◯ Oktató/Tanár
- ◯ szociális munkás
- ◯ pszichológus
- ◯ egészségügyi szakember
- ◯ diák
- ◯ pszichiáter
- ◯ Altro:

Munkahely *

- ◯ Egészségügyi intézmény
- ◯ szociális ellátó
- ◯ alapítvány
- ◯ civil szervezet
- ◯ menekültekkel foglalkozó szervezet
- ◯ non profit szervezet
- ◯ gazdasági szervezet/forprofit
- ◯ Altro:

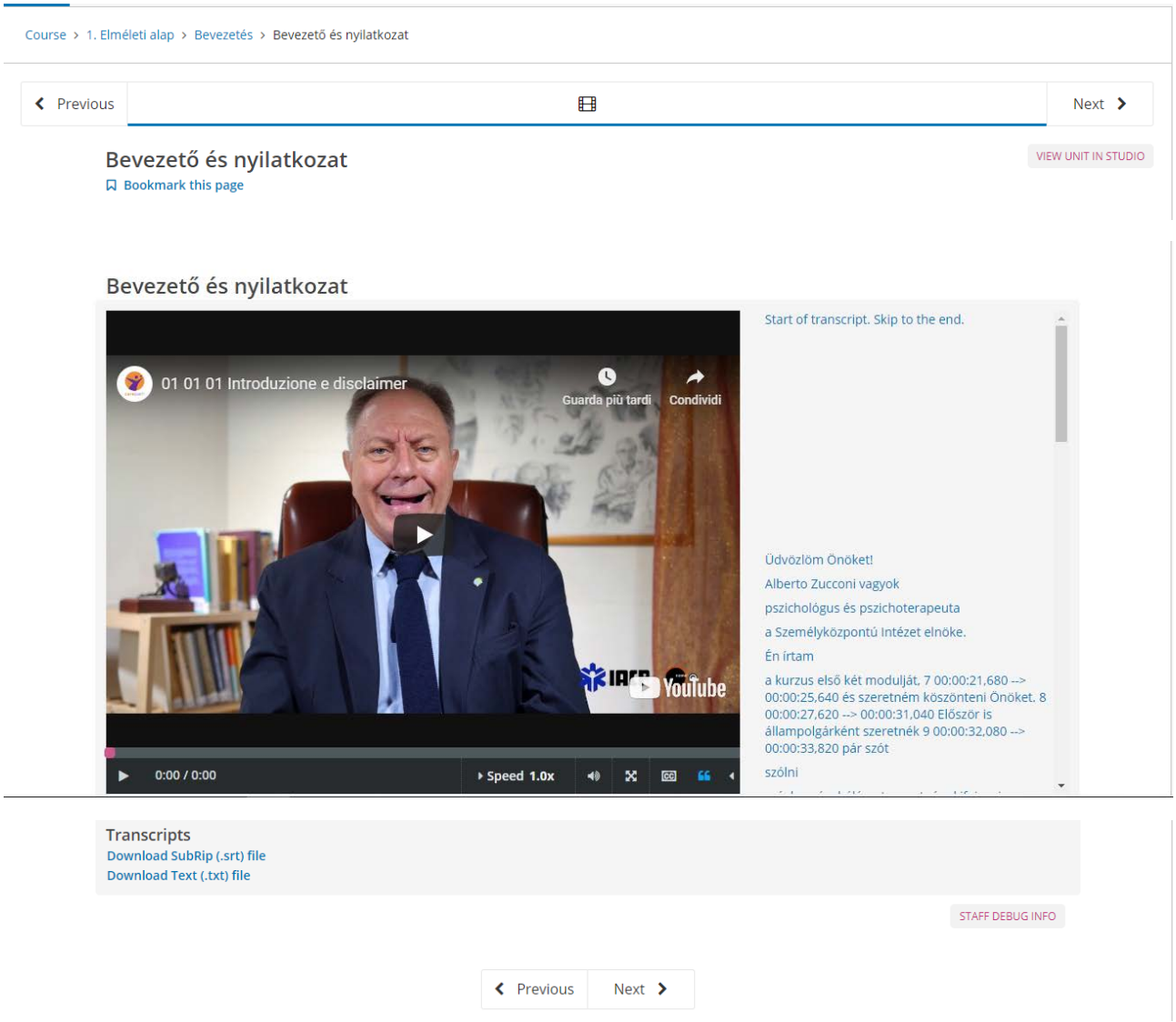
Részt vettél már traumával kapcsolatos képzésen? *

- igen
- nem

Mióta foglalkozol traumatizált csoportokkal? *

- 1-2
- 3-5
- 6-9
- 10 és több
- soha

Invia



Transcript

Üdvözlöm Önöket!

Alberto Zucconi vagyok

pszichológus és pszichoterapeuta

a Személyközpontú Intézet (IACP) elnöke.

Én írtam

a kurzus első két modulját,

és szeretném köszönteni Önöket.

Először is állampolgárként szeretnék

pár szót

szólni

méghozzá a hálámat szeretném kifejezni

Őszintén szeretnék köszönetet mondani mindnyájuknak,

akik a traumatizált kiskorúak védelméért

és segítéséért dolgoznak.

Ez egy nagyon fontos,

érzékeny, és olykor igen

nehéz munka.

Mind tisztában vagyunk

azzal,

hogy a szenvedő emberekkel való munka

olykor fájdalmat okozhat

és kiégéshez vezethet.

Ezért

őszinte hálámat szeretném kifejezni,

hiszen

az Önök munkája

a nemzet és a közösség nagy értékű erőforrását védi: a humántőkét, azaz az embereket.

A traumatizált embereknek szükségük van

minden lehetséges gondoskodásra és segítségre ahhoz,

hogy teljes jogú és aktív tagként visszakerülhessenek a közösségbe,

és

hasznosak lehessenek mind saját maguk, mint a közösség többi tagja számára.

Szeretnék kiemelni valamit, ami talán egyértelmű, de jobb kihangsúlyozni:

ez a kurzus

sok igen különböző hátterű, szakmai előtörténetű és készségű szakembernek szól,

akiket a hatályos törvények, a különböző szakterületek

etikai kódexei

és a szervezeteik belső szabályzatai kötnek.

Arra kérem Önöket, hogy tegyenek mindent úgy, ahogyan tudják, hogy tenniük kell, annak az iránymutatása alapján, akinek felelősséggel tartoznak,

és ne lépjék át a határokat, mert azzal biztosan nem segítenek az ügyfeleiknek.

Hadd adjak mindehhez még egy magától értetődő dolgot

hogy a helyzet még komplikáltabb legyen, a jogi szabályozás nem egységes

az egyes európai államok között, ez a kurzus pedig

különböző országoknak szól, különböző nyelveken.

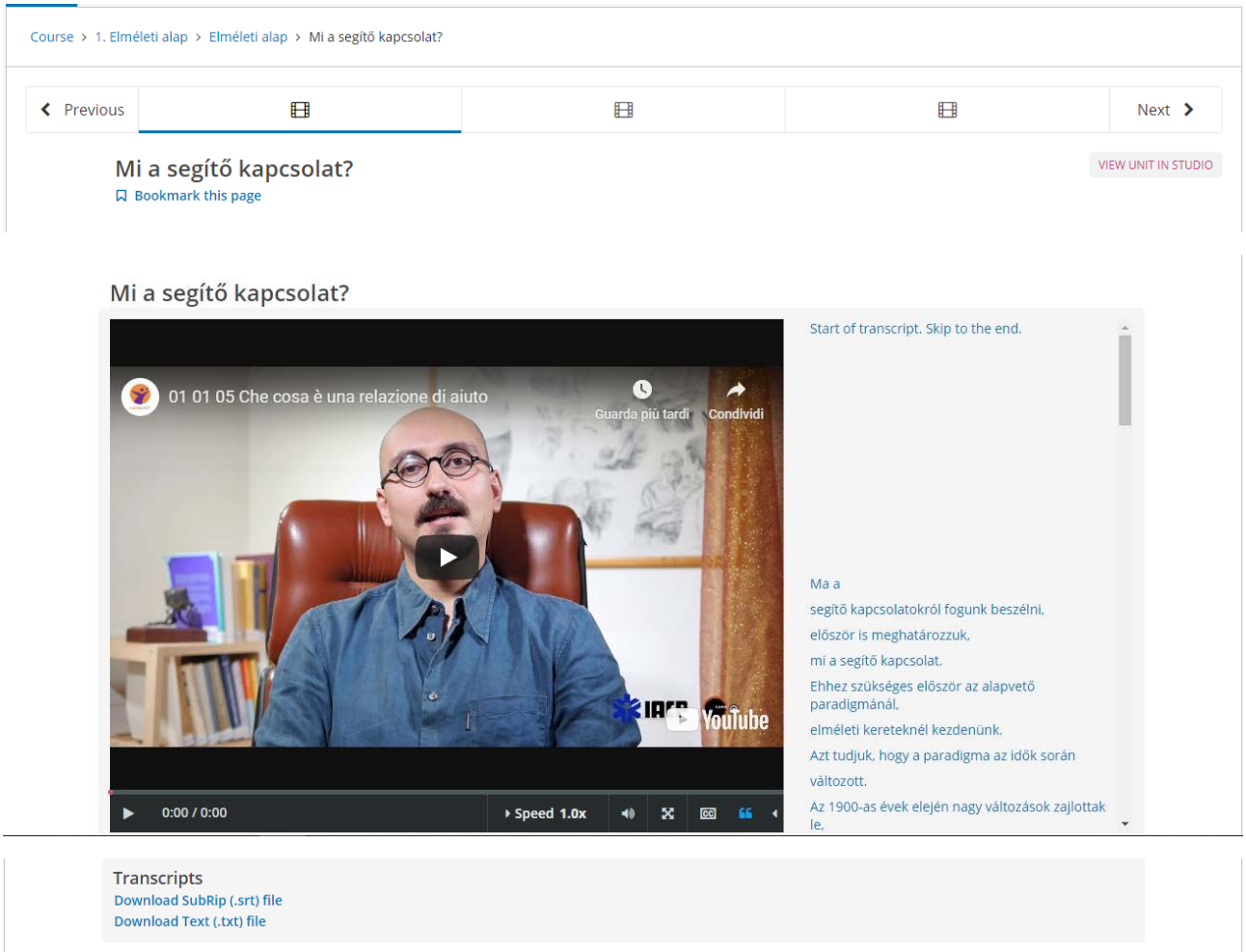
A cél az, hogy a szakemberek azt is megtanulják,

hogy a határok betartása azt is jelenti, a hatékony. unkavégzés előfeltétele.

Még egyszer köszönöm,

hogy velünk tartanak ebben a kalandban, és köszönöm a napi munkájukat,

amit odaadással végeznek.



Transcript

Ma a

segítő kapcsolatokról fogunk beszélni,

először is meghatározzuk,

mi a segítő kapcsolat.

Ehhez szükséges először az alapvető paradigmánál,

elméleti kereteknél kezdenünk.

Azt tudjuk, hogy a paradigma az idők során

változott.

Az 1900-as évek elején nagy változások zajlottak le,

és egy redukcionista-mechanisztikus paradigmáról a holisztikus és rendszerszemléletű paradigmára váltottunk.

A segítő kapcsolat értelmezése is változott.

A redukcionista-mechanisztikus paradigmában

a segítő kapcsolat aszimmetrikus volt: az értelemalkotás lehetősége a szakember kezében volt,

aki a saját valóságát kényszerítette rá a páciensére,

ezáltal passzívvá téve őt.

Az új paradigma meghonosodásával

sok minden megváltozott.

Mivel tudjuk,

hogy a megértéshez a kapcsolatok központi fontosságúak: nem az egyes részek fontosak, hanem azok a kapcsolatok,

amelyekben ezek a részek

egy egésszé állnak össze.

Mi a segítő

kapcsolat az új paradigma alapján?

Mi lehet ?

Ennek meghatározásában segítenek Carl Rogers 1951-ben írott szavai.

Rogers munkássága nagyban hozzájárul ahhoz, hogy a segítő kapcsolatot az új szemlélet alapján tudjuk értelmezni.

A következőket írja: „A segítő kapcsolat egy olyan kapcsolat, amelyben a résztvevők

legalább egyikének a célja, a másik fejlődésének,

érésének támogatása

és annak előmozdítása,

hogy az illető megfelelőbb és integráltabb

módon tudjon cselekedni és viselkedni.

A segítő kapcsolatot egy olyan szituációként is meg lehet határozni,

amelyben az egyik résztvevő megpróbálja a másik személy(ek)ből nagyobb mértékben előhívni

a személyes erőforrásait, és számára az önkifejezés teljesebb fokát elősegíteni.

A fő gondolatok itt a lehetőségek kiaknázása, a támogatás és az erőforrások.

Így az

új szemlélet, amellyel a segítő kapcsolatokra

tekintünk,

a két résztvevőt

egyenrangú kapcsolatba helyezi,

amiből az következik, hogy a szakember nem szakértő,

az értelemalkotás nem az ő kezében van,

hanem a szerepe a másik emberben már meglévő

erőforrások előhívásának támogatása.

Így a segítő képes egy működőképesebb, közös valóságkonstruálási folyamatot előmozdítani

a kliens számára,

amelyben elkíséri őt, elfogadva és tiszteletben tartva azt, ahol az ügyfél tart.

Mikre van szüksége egy segítő kapcsolattal dolgozó szakembernek?

Mindenképpen szükségünk van tudásra, egy olyan elméleti tudásanyagra,

amelyre támaszkodhatunk,

illetve

tudnunk kell azt is, hogy hogyan alkalmazzuk ezt a tudást.

Tehát az elméleteket konkréttá kell tenni, alkalmazni kell, illetve azt is tudnunk kell, hogy miként alkalmazzuk őket a kapcsolatban.

Emellett, mivel a kapcsolat fókusza magának a kapcsolatnak a minőségén van,

a szakembernek azt is szükséges tudnia, hogy hogyan legyen jelen, hogy hogyan ültesse gyakorlatba mindezeket a feltételeket

és minőségeket, amelyek a segítő kapcsolatot működtetik és hatékonnyá teszik.

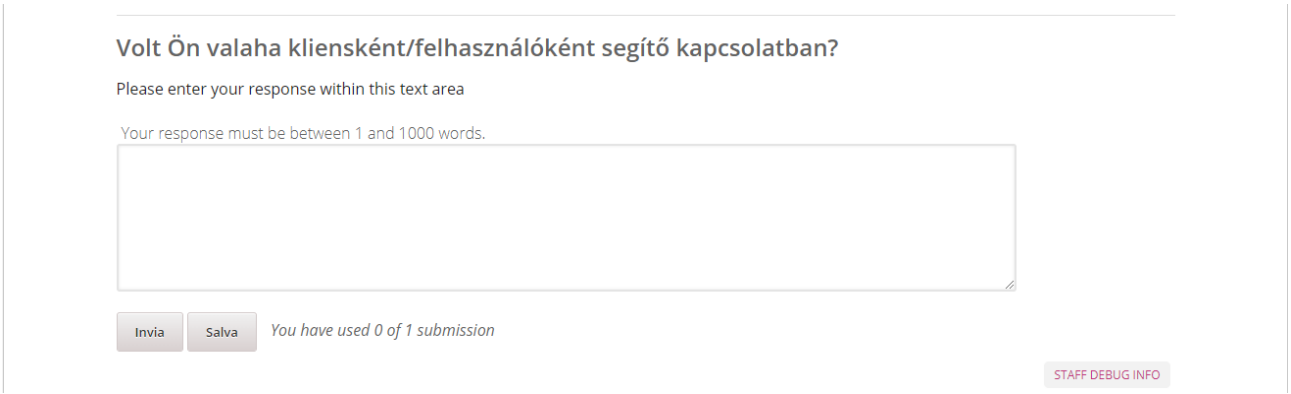
Ezek közül az első minőség az önazonosság;

a második az arra való képesség, hogy a világot másnak a nézőpontjából lássuk; a harmadik pedig,

hogy az ügyfelet ne ítéljük meg, hanem képesek legyünk tisztelni és befogadni őt úgy, ahogy van.

Ha mindez lehetséges, ha ezt a három feltételt a szakember foganatosítja, az az ügyfélben

előmozdítja a változás és a benne rejlő lehetőségek 63 00:04:45,400 --> 00:04:46,360 megvalósításának folyamatát.



Ha igen, a segítő kapcsolat mely aspektusait találta különösen pozitívnak és előre mozdítónak?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Melyeket nem találta előre mozdítónak?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

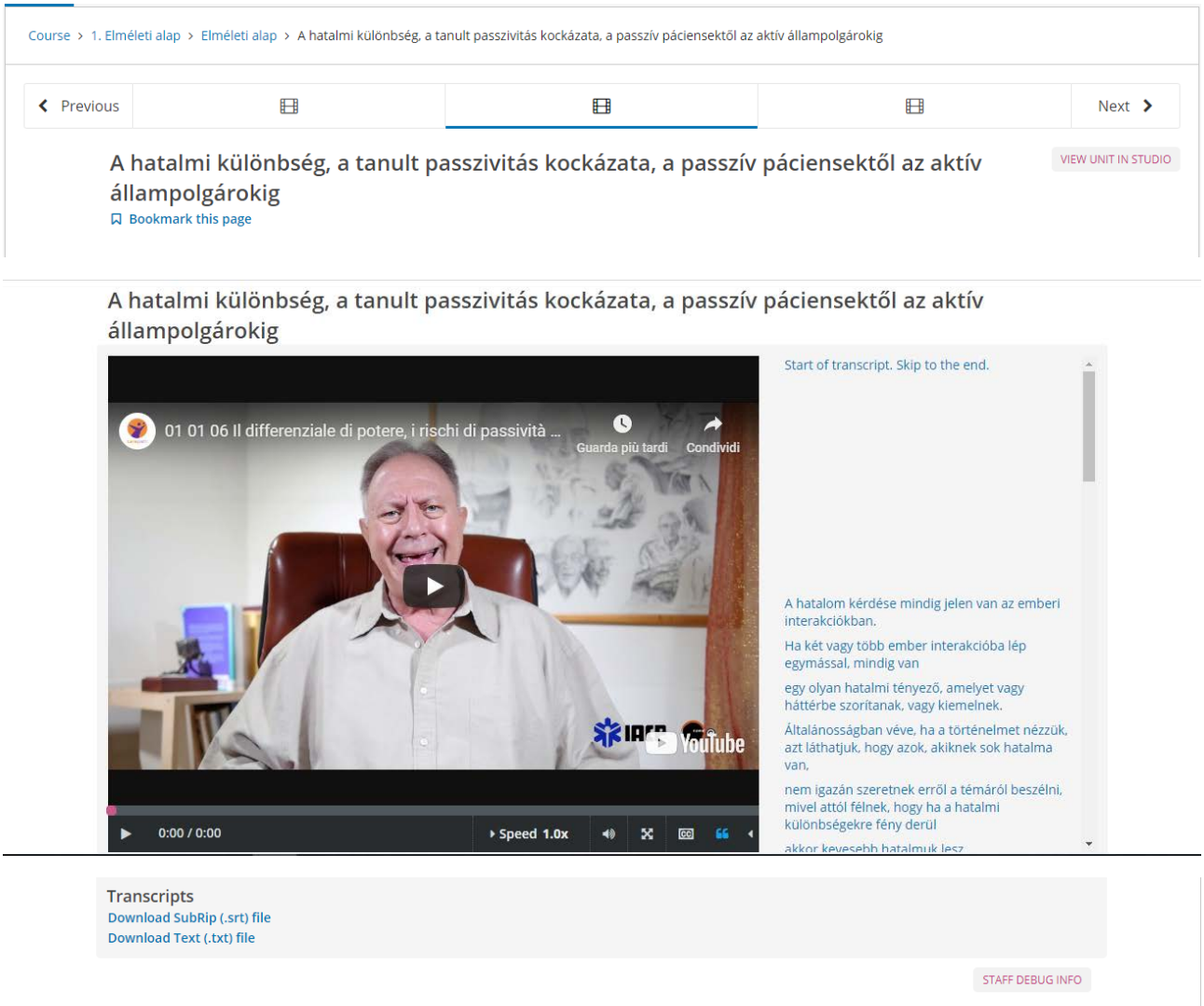
Ha Ön még nem volt kliensként/felhasználóként segítő kapcsolatban, a segítő kapcsolatnak mely aspektusai tűnnek pozitívnak és előre mozdítónak, és melyek nem?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO



Transcript

A hatalom kérdése mindig jelen van az emberi interakciókban.

Ha két vagy több ember interakcióba lép egymással, mindig van

egy olyan hatalmi tényező, amelyet vagy háttérbe szorítanak, vagy kiemelnek.

Általánosságban véve, ha a történelmet nézzük, azt láthatjuk, hogy azok, akiknek sok hatalma van,

nem igazán szeretnek erről a témáról beszélni, mivel attól félnek, hogy ha a hatalmi különbségekre fény derül

akkor kevesebb hatalmuk lesz.

Nyilvánvaló módon mindig,

minden segítői kapcsolatban vannak hatalmi különbségek.

A szakembernek, a szakértőnek,

annak, aki a szolgáltatást nyújtja, több hatalma van van a szolgáltatás

felhasználójánál /az ügyfélnél / a páciensnél, vagy bárhogy is nevezzük az adott személyt. Miért?

Mivel a szakember olyasmit tud, amit az ügyfél nem tud pontosan,

illetve mivel a szakember olyasvalamit kínál az ügyfélnek, amire annak szüksége van.

Továbbá a szakember határozza meg

a feltételeket (a segítő kapcsolat működésére és kialakítására vonatkozó szabályokat),

és akár magát a szolgáltatásnyújtást is felfüggesztheti.

Összefoglalva,

mindig van hatalmi különbség a szolgáltatás nyújtói és igénybe vevői között.

A múltban, a redukcionista-mechanisztikus paradigmában,

a különböző segítő kapcsolatokban a hatalmi különbségek igen nagyok voltak.

Láthattuk, az Ottawai Karta által lefektetett új paradigma és a biopszichoszociális paradigma fényében is,

hogy ez nem volt célravezető,

mivel a túlzott hatalmi különbségek a szolgáltatás igénybevevőit passzív szerepbe helyezik, ami pedig nem segíti

a szolgáltatás céljainak elérését.

Így ma a tendencia az, hogy a felhasználóra, az ügyfél személyére fókuszálunk,

és az ügyfelek készségének, kreativitásának és ellenállóképességének fejlesztését ösztönző

tevékenységek által támogatjuk a változást.

A kutatások egyértelműen azt mutatják, hogy ez nagyon hasznos,

mivel így a segítő kapcsolat jobb eredményeket képes produkálni kevesebb idő alatt,

és például az egészség és jólét területén alacsonyabb lesz a mellékhatások és visszaesések aránya.

A világ is egyre inkább képes befogadni azt a bizonyított tényt, hogy mindenki nyer azzal,

ha a hatalmat megosztják, és ha a célok eléréséhez mindenki hozzájárul.

Mindez társadalmi szinten is igaz:

az aktív, tudatos polgárok jóval nagyobb mértékben járulnak hozzá a társadalmi környezetükhöz és a valóság közösségi konstruálásához,

egy fenntartható valóság és fenntartható kapcsolatok építéséhez.

Ez a gyermekeknek nyújtott szolgáltatások esetén is igaz. A gyerekek kis emberek, nem olyan valakik,

akik nem értik a dolgokat és nem képesek válaszolni. Az a társadalmi konstrukció, amely szerint a gyerekek csak

„kis aranyos emberkék”, igen elavult.

Supporting Material

BPS Practice Guidelines (Third Edition)

STAFF DEBUG INFO

You can skip the following exercise in case you are not working in any role in the field of offering services to traumatized minors.

STAFF DEBUG INFO

Mit gondol Ön a segítő kapcsolatokban a segítő és a kliens közötti hatalmi különbségről?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Lehetnek a túl nagy hatalmi különbségnek nemkívánatos hatásai? Ha igen, mik?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Napi munkájában próbál aktívan tudatában lenni az Ön és a kliensei közötti hatalmi különbség mértékének?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Ha figyel a hatalmi különbség mértékére, miért figyel erre a segítő kapcsolatban?

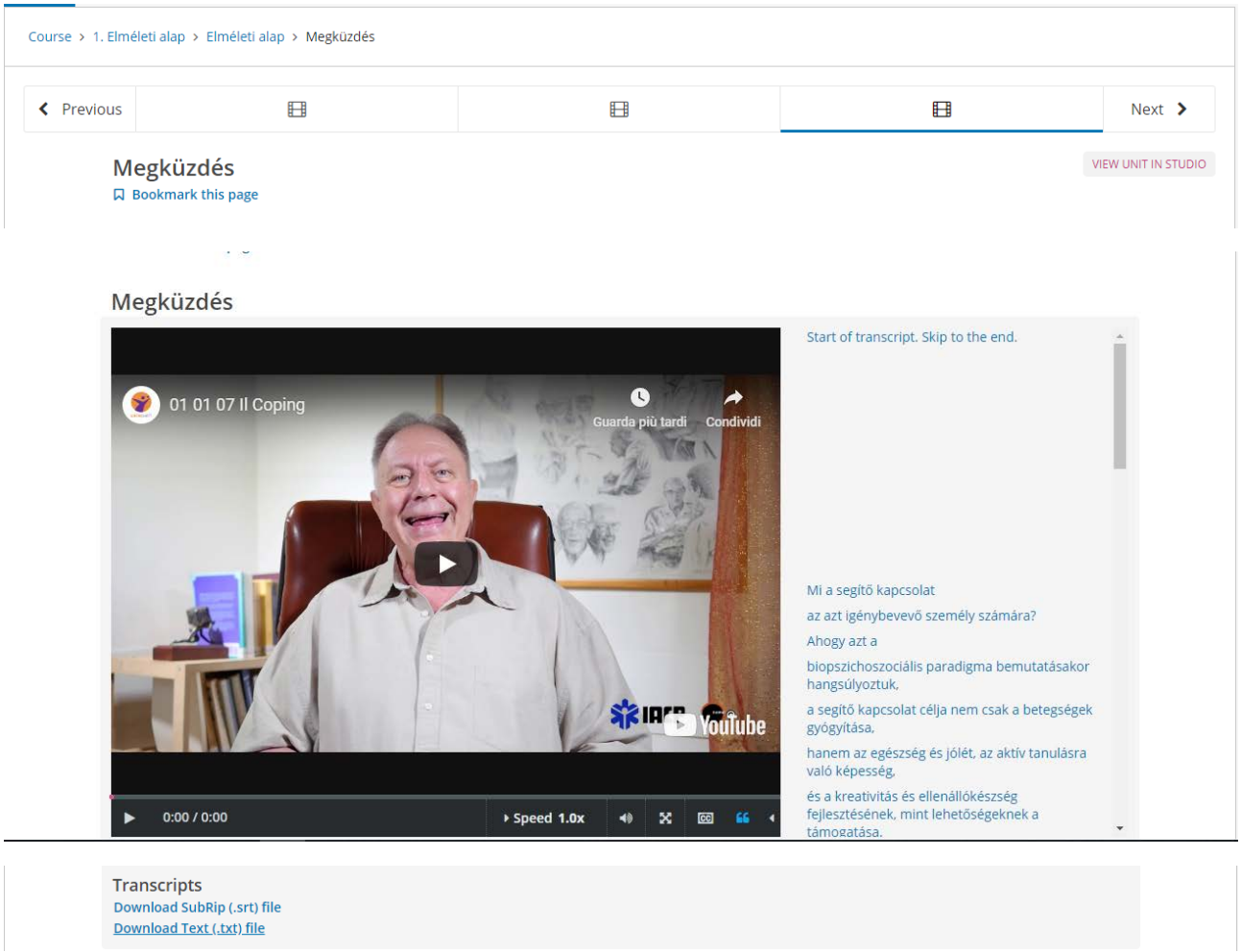
Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Previous Next



Transcript

Mi a segítő kapcsolat

az azt igénybevevő személy számára?

Ahogy azt a

biopszichoszociális paradigma bemutatásakor hangsúlyoztuk,

a segítő kapcsolat célja nem csak a betegségek gyógyítása,

hanem az egészség és jólét, az aktív tanulásra való képesség,

és a kreativitás és ellenállókészség fejlesztésének, mint lehetőségeknek a támogatása.

Az emberi lények e veleszületett képességét más néven

megküzdési képességnek nevezhetjük. Ez tulajdonképpen azt jelenti, hogy tudjuk, hogyan kezeljük az élet által adott körülményeket,

még pontosabban, hogy hogyan kezeljük jobban a kapcsolatunkat saját magunkkal,

másokkal és a körülöttünk lévő világgal.

Az köztudott, hogy a segítő kapcsolatok területén,

ami a hatékony szakembert illeti,

az alkalmazott megközelítés másodlagos. Amire a hatékonysághoz szükség van, azok olyan minőségek,

mint a képesség arra, hogy őszinte, mély tisztelettel és előítélet nélkül tudjanak az ügyfelükhöz viszonyulni;

hogy empatikusan megértsék nem csak azt, amit az ügyfél mond, hanem az érzéseit,

és az általa alkotott értelmezéseket is; illetve hogy önazonosan és őszintén tudjanak hozzá kapcsolódni.

Ám ahhoz, hogy ez a folyamat hasznos legyen a felhasználó/ügyfél/páciens számára,

neki is részt kell vennie ebben a közösen alakított csapatjátékban.

A segítő kapcsolatokban azokat az ügyfeleket lehet „hatékonynak” tekinteni,

akik őszinték és motiváltak a változásban, talán mivel nem érzik jól magukat,

és nem akarnak tovább szenvedni. Továbbá képesnek kell lenniük

pszichológiai kapcsolatot létesíteni a velük dolgozó szakemberrel, és érzékelni azokat a kapcsolati minőségeket,

amiket a szakember tesz bele a kapcsolatba.

Ezek a készségek idővel fejlődnek, ahogy a kitartás

és a hibákból való tanulás képessége is, illetve a bátorság, hogy belássuk hibáinkat,

és a bölcsesség forrásává alakítsuk őket.

Látható tehát, hogy a megküzdés egy optimális működési folyamat,

és a szakember és az ügyfél csapatmunkájának eredménye, akik azért dolgoznak,

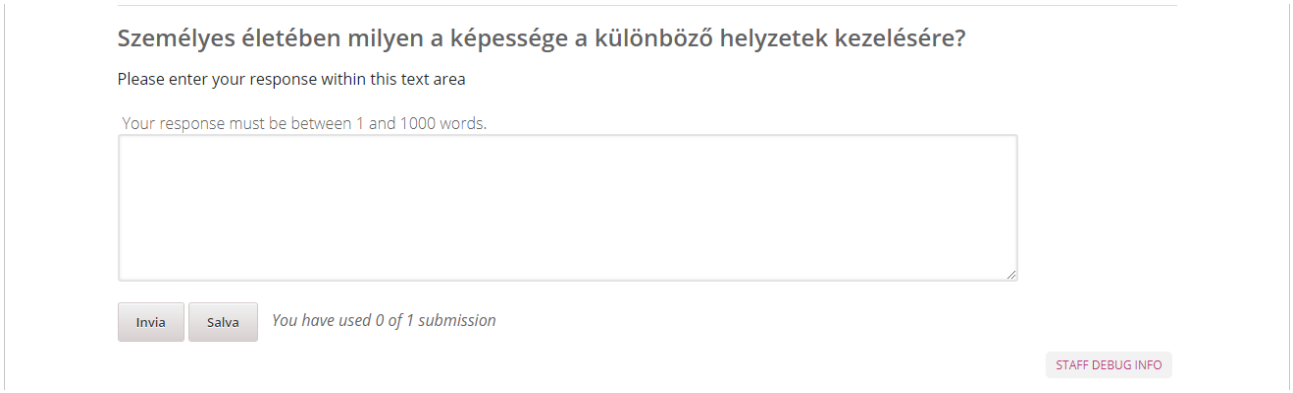
hogy az ügyfél elérje az olyan kitűzött célokat, mint a jobb életminőség, és a mindannyiunkban

ott rejlő,

velünk született, a génjeinkbe kódolt belső lehetőségek nagyobb mértékű megvalósítása.

Ezt a minket körülvevő környezeti hatások, illetve az élethez való hozzáállásaink függvényében

tudjuk jobban, vagy kevésbé megvalósítani.



Személyes életében milyen a képessége a különböző helyzetek kezelésére?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Mit tehetne, és szeretne majd tenni, hogy növelje a megküzdési képességét személyes és szakmai szinten egyaránt?

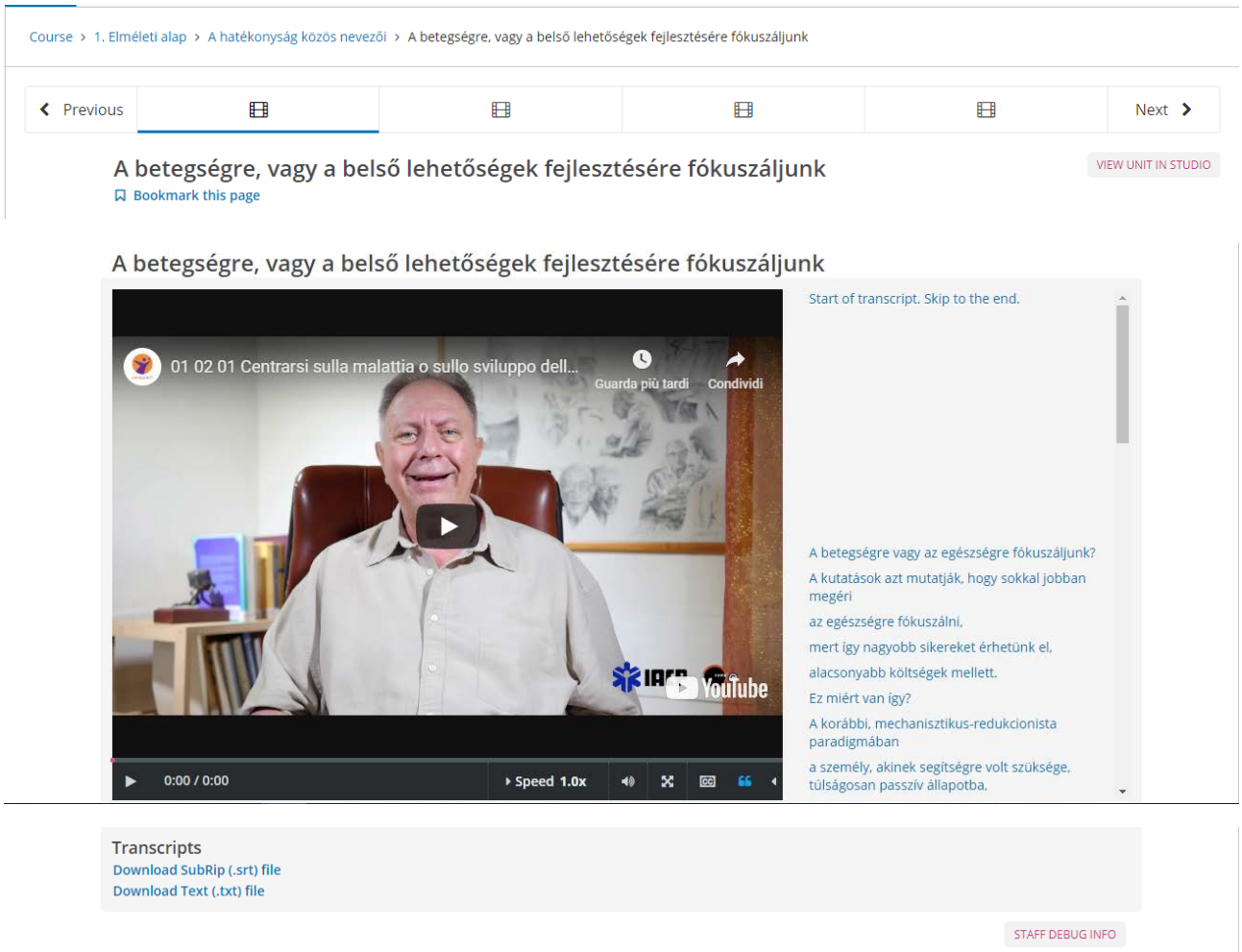
Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Previous Next



Transcript

A betegségre vagy az egészségre fókuszáljunk?

A kutatások azt mutatják, hogy sokkal jobban megéri

az egészségre fókuszálni,

mert így nagyobb sikereket érhetünk el,

alacsonyabb költségek mellett.

Ez miért van így?

A korábbi, mechanisztikus-redukcionista paradigmában

a személy, akinek segítségre volt szüksége, túlságosan passzív állapotba,

szerepbe került

ez egy fajta

felvett passzivitás volt. Ennek a kockázata sokkal alacsonyabb

az új paradigmában, mivel az arra ösztönzi az embert, hogy használja a saját erejét,

és lépjen olyan partneri kapcsolatra a szakemberrel, amelyben a döntéshozási hatalmat

megosztják.

A kutatások azt is szemléltetik, hogy az egészséget és jólétet védelmező

és támogató

megközelítés

jobb eredményeket hoz az igénybevevők számára.

Példa lehet

műtét előtt álló

páciensek proaktív, jó kapcsolata a kórházi dolgozókkal.

Az új modellel az eredmény

kevesebb kórházban töltött nap,

és a műtét utáni negatív következmények alacsonyabb aránya,

erősebb immunrendszer,

és nagyobb fokú együttműködés az orvosokkal és nővérekkel az előírások tekintetében,

pl. gyógyszer rendszeres bevétele, stb.

Az új modellben az egészségügyi intézményekkel pereskedő,

és orvosokat váltogató

felhasználók aránya is csökkent.

Ez az új modell nem csak a felhasználók és családjaik számára pozitív,

hanem a társadalom egésze számára, hiszen az olyan társadalom, amelyben az emberek nagyobb mértékben meg tudják valósítani a belső lehetőségeiket

azt vonja maga után, hogy az emberek kevésbé betegek, hosszabb ideig élnek, és kevésbé hajlamosak a betegségekre – végső soron egy jobb életminőségű társadalmat hozva létre.

Összefoglalva, az egészség és jólét támogatásával mindenki nyer,

és az eredmények magukért beszélnek.

You can skip the following exercise in case you are not working in any role in the field of helping relationships.

STAFF DEBUG INFO

Önnek mi a véleménye: a személyre helyezett fókusz valóban, kutatásokban dokumentálhatóan jobb eredményeket hoz, vagy ezek csak idealista, de nem túl pragmatikus emberek szép szavai?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Munkastílusa és mindennapi munkagyakorlata természetessé teszi a kliens személyére való fókuszálást, vagy ehhez nagy erőfeszítést kell tennie?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Amikor személyközpontúan dolgozik, érez ettől megelégedettséget?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Hogy értékeli a saját képességét a klienscentrikusságra, személyközpontúságra?

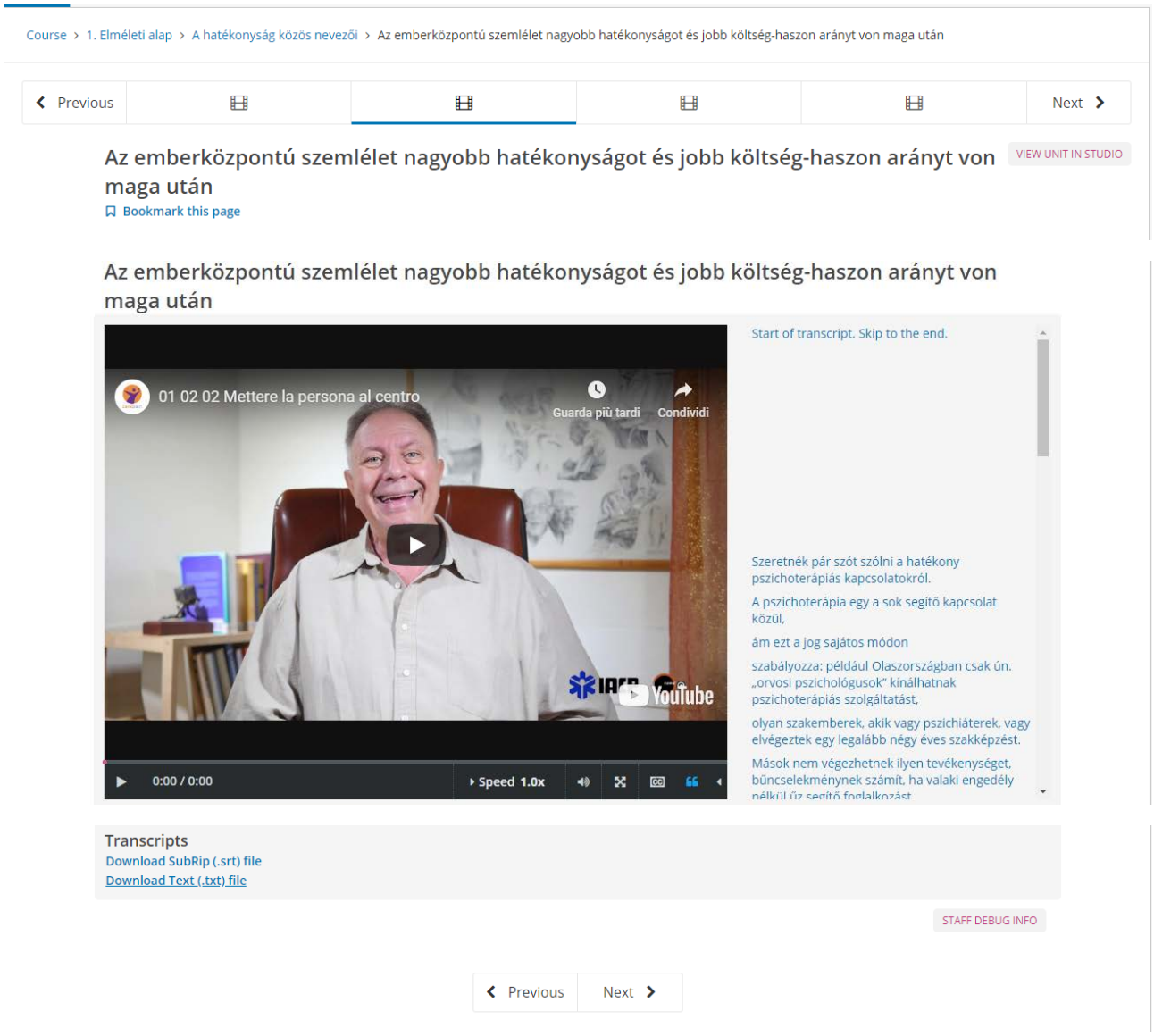
Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Previous Next



Transcript

Szeretnék pár szót szólni a hatékony pszichoterápiás kapcsolatokról.

A pszichoterápia egy a sok segítő kapcsolat közül,

ám ezt a jog sajátos módon

szabályozza: például Olaszországban csak ún. „orvosi pszichológusok" kínálhatnak pszichoterápiás szolgáltatást,

olyan szakemberek, akik vagy pszichiáterek, vagy elvégeztek egy legalább négy éves szakképzést.

Mások nem végezhetnek ilyen tevékenységet, bűncselekménynek számít, ha valaki engedély nélkül űz segítő foglalkozást,

mivel minden olyan kezelés, ami – jó – hatással van egy ember egészségére, kárt is okozhat, ha az azt végző nincs megfelelően tisztában annak alkalmazásával.

tehát

Rengeteg kutatás mutatja azt, hogy a pszichoterápia hatékonysága nem az alkalmazott elméleti megközelítéstől függ,

hanem sokkal inkább a különböző pszichoterápiás irányzatokban dolgozó terapeuták kapcsolódási képességeitől,

a kapcsolatba beletett minőségektől, és itt is ugyanazok a változók,

tényezők fontosak, mint más segítő kapcsolatokban.

Egy pszichoterapeuta nem az általa alkalmazott konkrét elméleti modell miatt hatékony,

hanem akkor, ha képes ügyfeléhez nagy fokú elfogadással,

tisztelettel, ítéletnélküliséggel kapcsolódni,

illetve

ha nem csak

meghallgatja, amit a felhasználó/páciens/ügyfél mond, hanem tud empátiával fordulni felé

és nyitott az kliens személyes értelmezéseire.

A hatékony szakember továbbá képes őszinte, spontán és transzparens módon kapcsolódni az ügyfélhez.

Ám mindez önmagában nem elég, mivel, mint minden segítő kapcsolat, a pszichoterápiás kapcsolat is

csapatmunka, egy olyan közös építkezés, amelyhez az ügyfél aktívan hozzájárul

– enélkül nem működik.

Mindamelett

Fontos a motiváció is, amit gyakran az biztosít, hogy az ügyfél nem érzi jól magát, így motivált a változásra;

a képesség a pszichoterapeutával kialakítható pszichológiai kapcsolatban való részvételre;

valamint

a képesség arra, hogy az ügyfél érzékelje, hogy a szakember

rendelkezik a tisztelet, empatikus figyelem és őszinteség

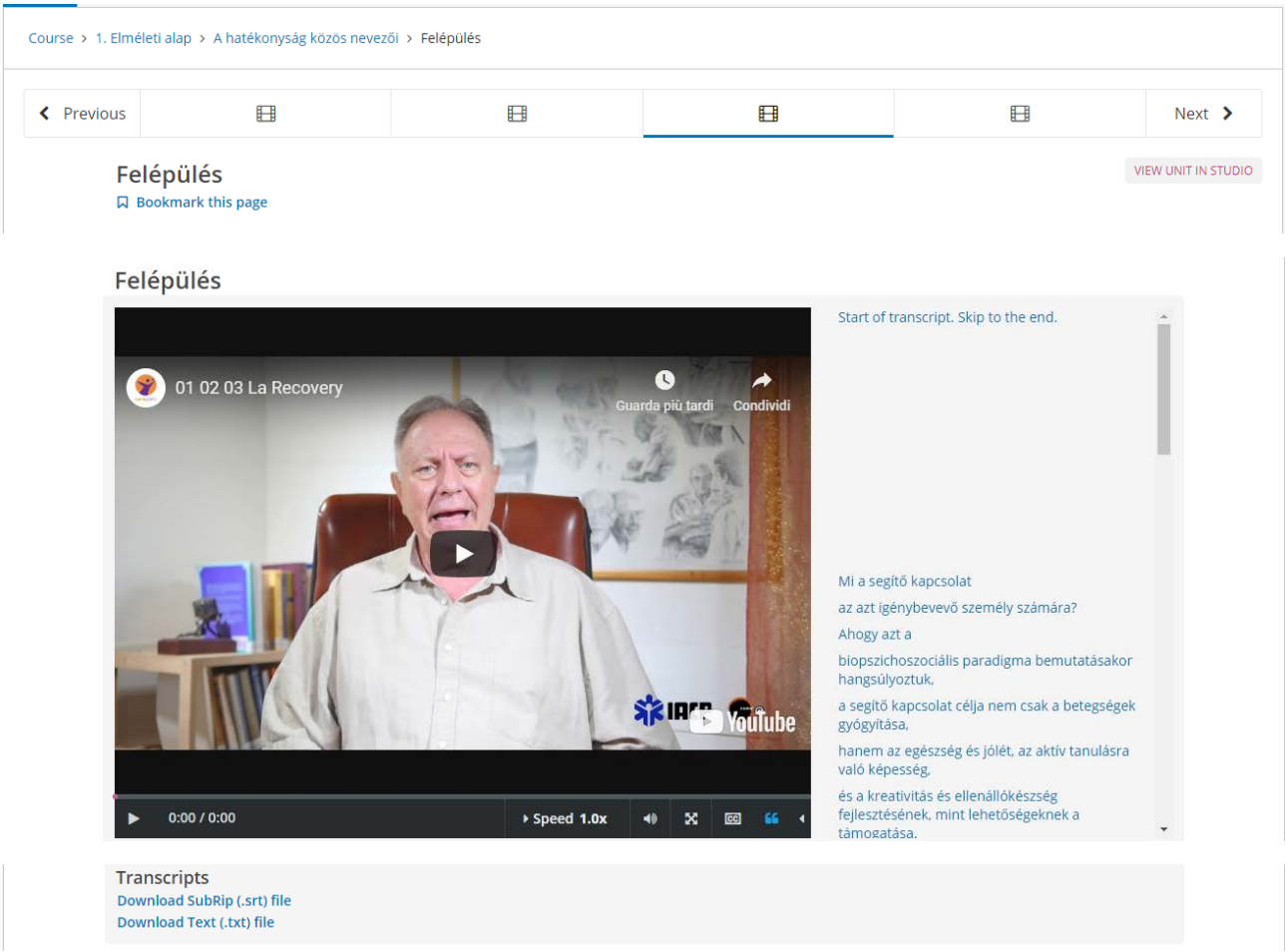
alapvető minőségeivel.

Így a kapcsolat igen pozitív és jóval hatékonyabb eredményeket hozhat,

mint ha az ugyanazon problémával rendelkező embert pusztán gyógyszerekkel,

vagy sehogy nem kezeljük.

Összefoglalva, a pszichoterápia és a segítő kapcsolatok területén az igazán jó orvosság a hatékony kapcsolat.



Transcript

Mi a segítő kapcsolat

az azt igénybevevő személy számára?

Ahogy azt a

biopszichoszociális paradigma bemutatásakor hangsúlyoztuk,

a segítő kapcsolat célja nem csak a betegségek gyógyítása,

hanem az egészség és jólét, az aktív tanulásra való képesség,

és a kreativitás és ellenállókészség fejlesztésének, mint lehetőségeknek a támogatása.

Az emberi lények e veleszületett képességét más néven

megküzdési képességnek nevezhetjük. Ez tulajdonképpen azt jelenti, hogy tudjuk, hogyan kezeljük az élet által adott körülményeket,

még pontosabban, hogy hogyan kezeljük jobban a kapcsolatunkat saját magunkkal,

másokkal és a körülöttünk lévő világgal.

Az köztudott, hogy a segítő kapcsolatok területén,

ami a hatékony szakembert illeti,

az alkalmazott megközelítés másodlagos. Amire a hatékonysághoz szükség van, azok olyan minőségek,

mint a képesség arra, hogy őszinte, mély tisztelettel és előítélet nélkül tudjanak az ügyfelükhöz viszonyulni;

hogy empatikusan megértsék nem csak azt, amit az ügyfél mond, hanem az érzéseit,

és az általa alkotott értelmezéseket is; illetve hogy önazonosan és őszintén tudjanak hozzá kapcsolódni.

Ám ahhoz, hogy ez a folyamat hasznos legyen a felhasználó/ügyfél/páciens számára,

neki is részt kell vennie ebben a közösen alakított csapatjátékban.

A segítő kapcsolatokban azokat az ügyfeleket lehet „hatékonynak” tekinteni,

akik őszinték és motiváltak a változásban, talán mivel nem érzik jól magukat,

és nem akarnak tovább szenvedni. Továbbá képesnek kell lenniük

pszichológiai kapcsolatot létesíteni a velük dolgozó szakemberrel, és érzékelni azokat a kapcsolati minőségeket,

amiket a szakember tesz bele a kapcsolatba.

Ezek a készségek idővel fejlődnek, ahogy a kitartás

és a hibákból való tanulás képessége is, illetve a bátorság, hogy belássuk hibáinkat,

és a bölcsesség forrásává alakítsuk őket.

Látható tehát, hogy a megküzdés egy optimális működési folyamat,

és a szakember és az ügyfél csapatmunkájának eredménye, akik azért dolgoznak,

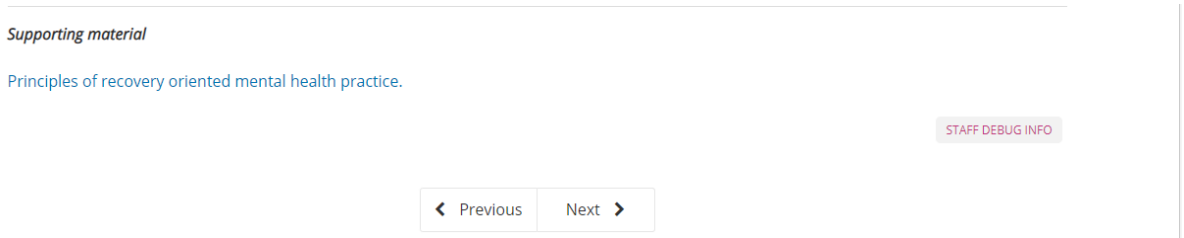
hogy az ügyfél elérje az olyan kitűzött célokat, mint a jobb életminőség, és a mindannyiunkban

ott rejlő,

velünk született, a génjeinkbe kódolt belső lehetőségek nagyobb mértékű megvalósítása.

Ezt a minket körülvevő környezeti hatások, illetve az élethez való hozzáállásaink függvényében

tudjuk jobban, vagy kevésbé megvalósítani.



Transcript

Manapság

Nagy mennyiségű

kutatási anyag

illusztrálja,

hogy a szakmai hatékonyság

mit jelent

a segítő kapcsolatok

területén dolgozó, szolgálatás nyújtó szakemberek

esetében.

Ezeket a kutatásokat

jóval ezelőtt indították,

Carl Rogers hipotézisei alapján,

aki az

személyközpontú megközelítés megalkotója

és a humanisztikus pszichológia egyik atyja.

1942-től kezdődően Rogers először hipotéziseket

állított fel

majd empirikusan kezdte bizonyítani,

hogy milyen feltételek szükségesek alapvetően egy szakember számára ahhoz, hogy hatékonyan tudja

a változást elősegíteni.

Ezeket időközben

kutatások is alátámasztották: képesség a bizalomteli

kapcsolat kialakítására a klienssel;

a szakember ítélkezéstől mentes,

elfogadó és

mély tiszteletet tanúsító hozzáállása a kliens személye irányába;

képesség

az érzékeny és pontos, empatikus odafigyelésre és meghallgatásra – ami azt jelenti, hogy nem csak azt értjük meg, amit a kliens mond,

hanem azt is, hogy mindaz számára mit jelent;

illetve végül, de nem utolsósorban, az autentikusság

és őszinteség a kapcsolatban.

Ezek a hipotézisek, amelyeket a pszichoterápiával kapcsolatos kutatások megerősítettek,

később hatékonynak bizonyultak

az összes

segítő kapcsolat

esetén.

Rogers nagymértékben hozzájárult

a segítő kapcsolatok jelentős fejlődéséhez, elgondolásai stabilan, a tudományban gyökereznek, nem a metafizikában,

és egyértelművé tette azt az értékrendet, ami ennek a szemléletnek az alapját képezi.

Úgy vélem, a legtisztább forrás az, ha magának Carl Rogers-nek a gondolatait olvassuk,

aki ezt a három alapvetően szükséges feltételt egyik ismert filmjében mutatja be:

„Sokéves terápiás tapasztalatom során azt kezdtem érezni, hogy ha képes vagyok

megteremteni a megfelelő légkört

a megfelelő kapcsolatot, és a megfelelő feltételeket,

a fejlődés majdnem mindig megtörténik a kliensben.

Megkérdezhetik, hogy mi ez a légkör

és mik ezek a feltételek.

Létrejönnek-e egy olyan nővel folytatott beszélgetésben,

akivel még soha nem találkoztam?

Engedjék meg, hogy röviden összefoglaljam, mik is ezek a feltételek, ahogy én látom őket.

Az első kérdés,

hogy lehetek-e természetes egy ilyen kapcsolatban.

Ez különösen fontossá vált számomra az évek folyamán.

Úgy érzem,

hogy a

hitelesség a minőségi munka fontos tényezője

A kongruencia kifejezést szeretem használni, ami azt jelenti, hogy amit belül megtapasztalok,

az jelen van a tudatomban és a kommunikációm során jön a felszínre.

Bizonyos értelemben,

amikor ez megtörténik,

teljes mértékben jelen vagyok a kapcsolatban.

Van egy másik szavam is ennek kifejezésére,

ez pedig a transzparencia.

Úgy érzem, hogy a terápiás kapcsolatban szeretnék transzparens lenni. Szeretném biztosítani a klienseimnek, hogy „átlássanak” rajtam

hogy semmi, de semmi ne maradjon rejtve.

És ha ilyen természetes vagyok... megpróbálom leírni...

akkor a saját érzéseim gyakran tudatossá válnak,

és anélkül jutnak kifejezésre,

hogy a kliensre rakódnának.

A

második kérdés az, hogy észreveszem-e magamon, hogy dicsérem ezt a személyt,

gondoskodom róla.

Természetesen nem akarok színlelni olyasmit, amit nem érzek.

Sőt, ha tartósan nem kedvelem a kliensem, úgy érzem, hogy jobb, ha ezt ki is fejezem.

De tudom,

hogy a terápiás fejlődés sokkal nagyobb valószínűséggel történik meg,

és az építő jellegű

változásnak is nagyobb a valószínűsége,

ha valódi, spontán nagyrabecsülést érzek azzal a személlyel kapcsolatban, akivel dolgozom.

A független egyén nagyrabecsülését értem ezalatt.

Nevezhetjük elfogadásnak. Nevezhetjük gondoskodásnak.

Vagy nevezhetjük birtoklás nélküli szeretetnek is, ha úgy tetszik.

Azt hiszem, hogy ezen meghatározások bármelyike használható.

Tudom, hogy az a kapcsolat fog építőnek bizonyulni, ami a jelen pillanaton alapul.

És a harmadik kérdés, hogy képes leszek-e megérteni ennek az egyénnek

a belső világát kívülről?

Képes leszek-e az ő szemén keresztül látni a dolgokat?

Kellően érzékeny

leszek-e

ahhoz,

hogy érzelemvilágát megértsem,

hogy tudjam, milyen érzés lehet most „neki lenni”?

Hogy ne csak

a felszíni jelentést érzékeljem, hanem azokból is néhányat, melyek valahol mélyen,

az alatt rejtőzködnek.

Tudom, hogy ha

érzékenyen és pontosan engedem bele magamat a kliens élményvilágába,

akkor a változásnak és a terápia működésének sokkal nagyobb a valószínűsége.”

Supporting material

Wampold BE. How important are the common factors in psychotherapy? An update. World Psychiatry. 2015;14(3):270–7.

A segítő kapcsolatok imént hallott közös tényezői közül mely minőségek jellemzőek az Ön, kliensekkel végzett munkájára?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO

Mit szeretne még fejleszteni?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

A munkahelye kínál Önnek lehetőséget arra, hogy jobb szakemberré válhasson? Ha igen, hogyan?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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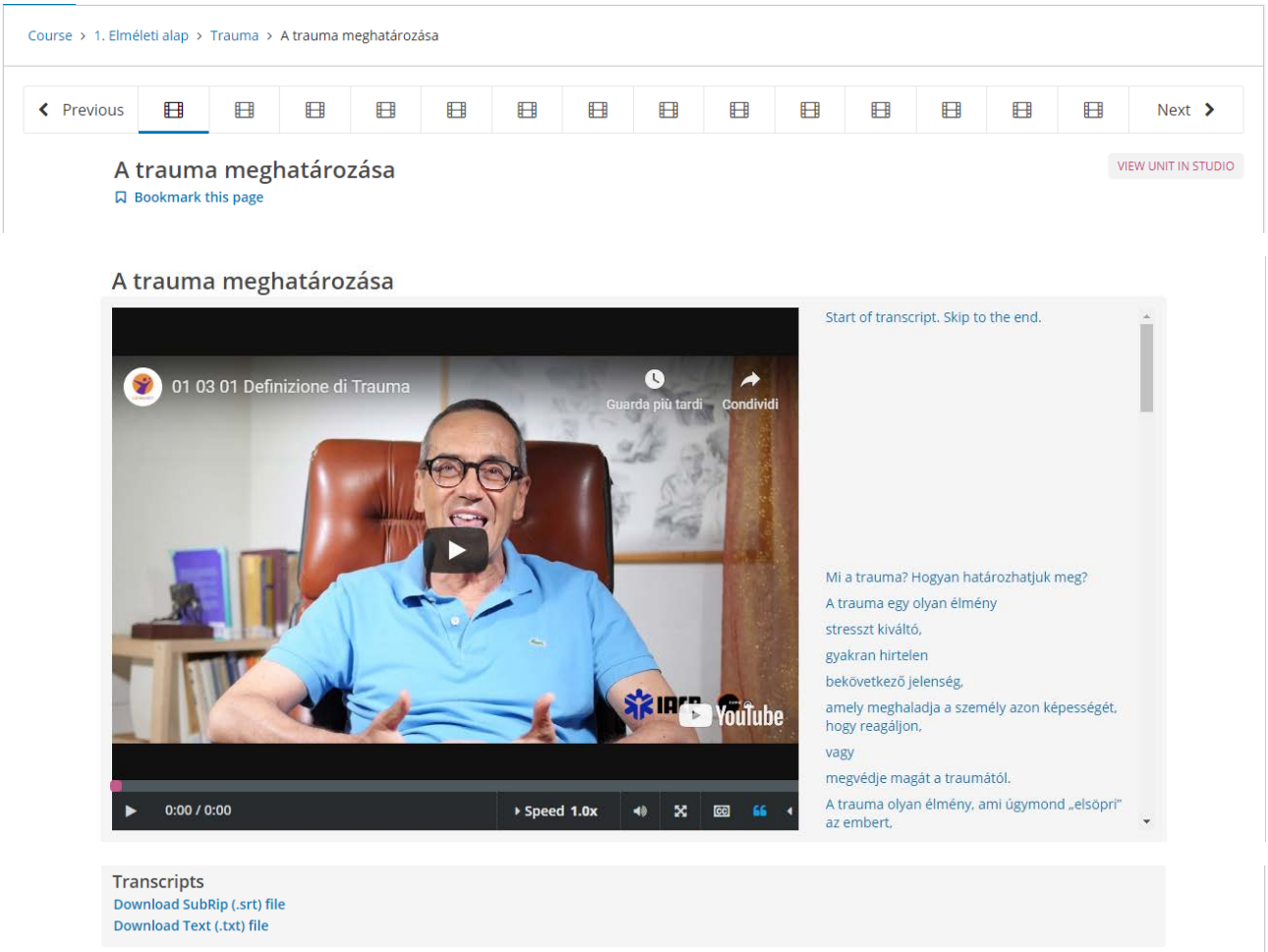


Transcript

Mi a trauma? Hogyan határozhatjuk meg?

A trauma egy olyan élmény

stresszt kiváltó,

gyakran hirtelen

bekövetkező jelenség,

amely meghaladja a személy azon képességét, hogy reagáljon,

vagy

megvédje magát a traumától.

A trauma olyan élmény, ami úgymond „elsöpri" az embert,

túllép a tűrőképességén.

A traumát sokféleképpen

tanulmányozták már.

Vannak akut traumák – például a

természeti vagy technológiai katasztrófák által előidézettek; és vannak a krónikus/ismétlődő traumatikus helyzetek –

aminek például gyakran vannak kitéve gyerekek.

Klinikai

szempontból

a trauma története a poszttraumás neurózisok kutatásával kezdődött,

amelyekkel Freud – a pszichoanalízis keretében foglalkozott – majd később mások is tanulmányoztak.

A pszichoanalitikusok, a kezdetek óta sok, az I. Világháború és az azt követő háborúk traumái

által okozott mentális zavart figyeltek meg, amit aztán a pszichiátriai klasszifikációs rendszerek beépítettek és a poszttraumás stressz zavar pszichopatológiájaként írták le.

később.

A poszttraumás stressz zavar

az egyetlen olyan pszichiátriai zavar, amelyet bizonyosan külső hatás vált ki.

Ez a hatás pedig maga a trauma.

A személy számára nem természetes, hogy gyenge, törékeny vagy sérülékeny – hiszen mindez önmagában elég ahhoz, hogy

pszichés és fiziológiai következményei legyenek.

Ha váratlanul éri a trauma, például egy földrengés vagy egy árvíz, elsöpri az alkalmazkodó képességet.

A fizikai szinten megjelenő tüneteknél ma azonban az a lényeg, hogy – bár vannak neurovegetatív tünetek, mint a

készenlét, az emelkedett izgalmi szint, az éberség, a külső ingerekre adott reakciókészség megemelkedett szintje – ezek a poszttraumás stressz zavart alkotják.

Mindez azt jelenti, hogy a személy objektív tüneteket, jeleket is hordoz és nem csak szubjektíveket a trauma következményeként.

A trauma pszichés mechanizmusait is vizsgálták

amelyek igen

fontosak.

A pszichoanalízis a kezdetektől fogva azt tanulmányozta,

hogy a trauma

– főleg, ha korai gyerekkorban következik be –

egy elfojtási folyamaton megy át.

Ez az elfojtás azonban nem jelenti azt, hogy a traumát az azt elszenvedő elfelejti,

tagadja vagy végleg magába temeti. A trauma később újra jelentkezhet, újra aktiválódhat,

például felnőtt korban,

esetleg

egy másik trauma miatt, amely valahogy

előhívja az előző traumát. Ez egy kétlépéses mechanizmus, amit Freud behatóan vizsgált.

Eszerint van egy elsődleges trauma, ami bizonyos értelemben érzékenyíti az embert,

és van egy másodlagos trauma

ami az elszenvedőben újrateremti az áldozattá válás,

erővesztettség és törékenység állapotát.

Így ez újrateremti a helyzetet, és új

tünetekhez

vezet.

Mindez egy olyan helyzetet eredményez, amelyben a kliens úgy érzi, mintha az lenne az első alkalom, hogy a traumát megéli.

Ugyanakkor a poszttraumás stressz zavar esetén

a trauma egy egyszeri konkrét alkalom hatására következik be,

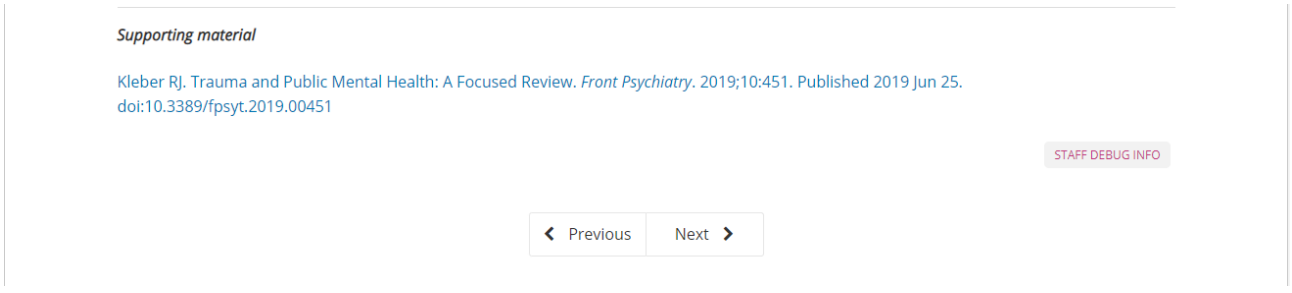
általában olyan módon, ami veszélyezteti az elszenvedő életét

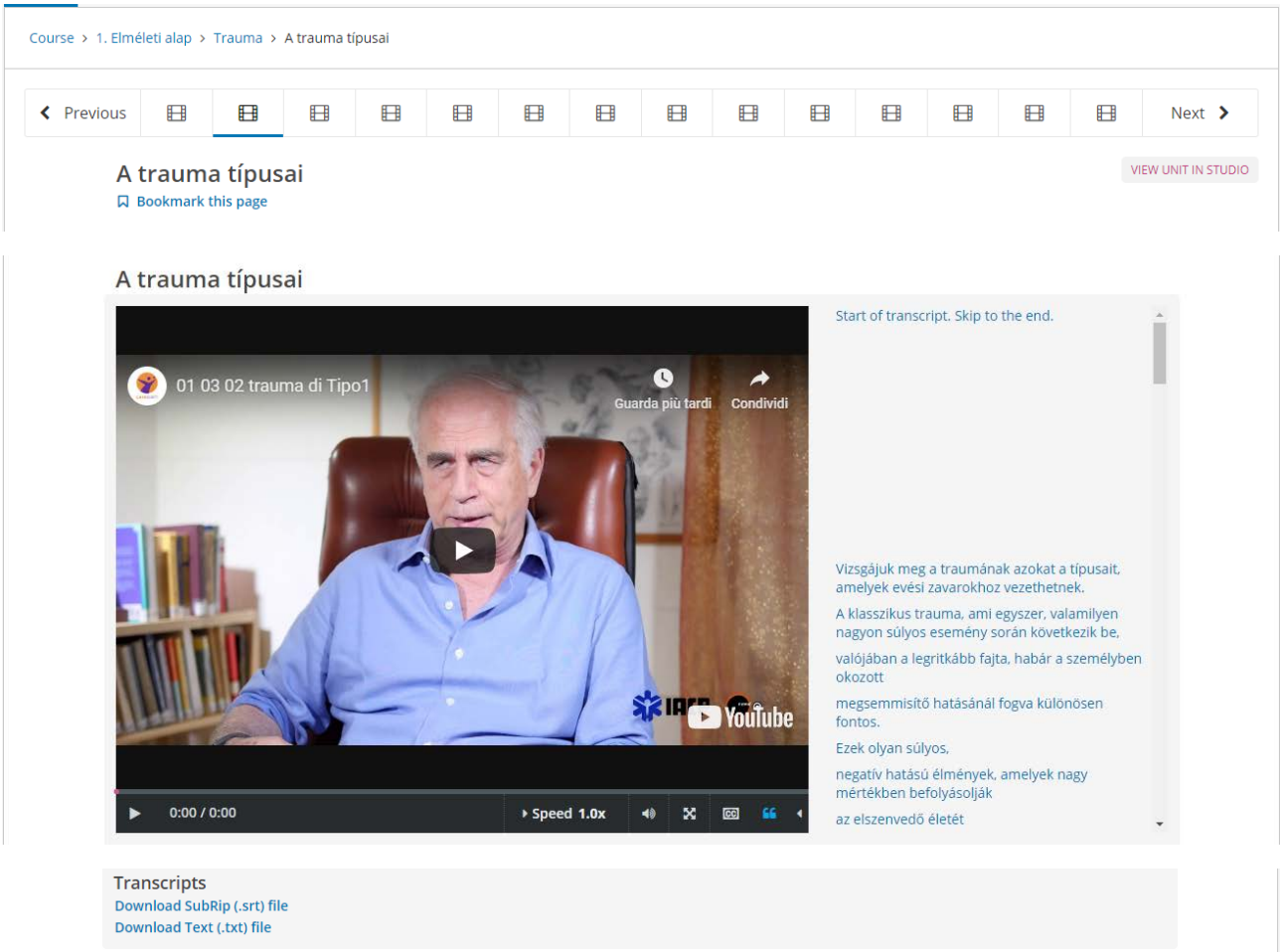
Kiválthatja háború, kínzás,

technológiai vagy környezeti katasztrófák.

Az ilyen trauma egyszeri előfordulású, és könnyen azonosítható

az elszenvedő életében.





Transcript

Vizsgájuk meg a traumának azokat a típusait, amelyek evési zavarokhoz vezethetnek.

A klasszikus trauma, ami egyszer, valamilyen nagyon súlyos esemény során következik be,

valójában a legritkább fajta, habár a személyben okozott

megsemmisítő hatásánál fogva különösen fontos.

Ezek olyan súlyos,

negatív hatású élmények, amelyek nagy mértékben befolyásolják

az elszenvedő életét

olyan pszichés és/vagy fizikai károkat okoznak,

amelyek

több évig is eltarthatnak.

Általában ezzel a fajta traumával találkozunk a poszttraumás stressz zavar esetén,

de az evési zavarok bizonyos típusainál is

igen gyakori.

Ezt a típusú traumát két részre lehet osztani: fizikai trauma,
amely különösen nehéz helyzetekben fordul elő,
mint pl. nemi erőszak, rablás, fizikai erőszak, háborús harc,
természeti katasztrófák
(pl. cunami vagy földrengés), vagy súlyos autó -
vagy vasúti baleset esetén.
Az elsősorban pszichés típusú trauma lehet: ha valaki
fenyegetve érzi magát valaki más által
egy olyan helyzetben,
ahol nincsen
fizikai sérülés, ám a
fenyegetettség érzése annyira szélsőségesen erős, hogy az illetőnek nehéz azt a közeli jövőben
kitörölnie az elméjéből.
Az első típusú trauma vagy „fókuszált trauma”
esetén a trauma egy egyszeri élmény,
az illető csak egyszer tapasztalja meg,
de
mély nyomokat hagy.
Az evéssel
kapcsolatos tünetek esetén
nagyon hasonló a hatása a poszttraumás stressz zavaréhoz.
Az I. típusú traumának több következménye lehet, amelyek közül az evési zavar
az egyik leggyakoribb,
de jelentkezhet egy sor olyan más,
igen sokféle
tünet
formájában
is
amelyek az
evészavaros viselkedésben is megtalálhatóak.
Más szóval az evészavaros viselkedés nem csak kifejezetten az evéssel kapcsolatos viselkedésben
nyilvánul meg,

hanem azt gyakran,
az esetek túlnyomó többségében kíséri sok egyéb tünet
és jellemző is. Ezek a következők lehetnek:
alacsony önértékelés, nagyon erős hajlam a depresszióra,
torzult önkép az illető saját testét és
szexualitását illetően,
magas öngyilkossági kockázat, szorongásos zavarok, alkoholhasználat,
alvászavarok, disszociatív zavarok, emlékezetvesztés, agresszió és személyiségzavarok.
A tünetek ezen hosszú sora nem meglepő;
az evészavarok sosem léteznek csak önmagukban, mindig ilyen és
ehhez hasonló tünetekkel vagy olyan egyéb patológiákkal járnak együtt,
amelyek kiegészítik őket.
Nagyon ritka,
hogy ezek ne lennének jelen.
Van egy bizonyos
trauma, amely
elsősorban alexitímiát
okoz: egy olyan érzelmi zavart,
amely meggátolja az embert a érzelmek szavakban történő
kifejezésében.
A tendencia ebben az esetben, I. típusú trauma elszenvedése után az, hogy az illető az érzelmeket főként
nonverbálisan fejezi ki,
a testével.
Ezek az érzetek
nagyon erősek
lehetnek,
és az érzelmi
önreguláció̱ra való képesség súlyos hiányával járhatnak. Olyannyira, hogy az illető
egy impulzust fejez ki
egy bizonyos szinten
illetve
mivel

az egyik
leggyakrabban kapott visszajelzés,
a bulimia nervosa egyes eseteiben
ez a típusú trauma (pl. bántalmazás)
annyira
súlyos és erőteljes,
hogy a tünetei
nagy mértékű és széles körű kontrollvesztéshez vezethetnek,
több szinten.
Ha a trauma súlyos és a fejlődés korai szakaszában következik be,
ha komoly
változók vannak
a támogatandó családban,
felmerül a
multiimpulzív bulimia veszélye is
Ez a bulimiának egy igen súlyos
és veszélyes formája,
amelyben a bulimiás viselkedés váltakozhat
vagy együtt járhat
más evészavaros viselkedésekkel, valamint erős impulzivitással,
főleg a
szexualitásra
és a
kontrollálhatatlan
evési kitörésekre vonatkozóan. Mindez pl.
olyan viselkedésekhez is vezethet,
hogy az illető lop a boltban,
és az ételt ott helyben, a boltban el is fogyasztja – nem képes megvárni, hogy
hazaérjen vele, akkor is, ha lenne rá módja, hogy az ételt megvásárolja.
Ez az
impulzusok feletti kontroll elvesztése, ami a szexualitás terén is megnyilvánulhat,
de legfőként és legveszélyesebben az önkárosító késztetések formájában jelentkezik,

mint pl. a falcolás vagy öngyilkossági kísérletek.

Ez, a multiimpulzív bulimia a bulimia legveszélyesebb ismert formája főként

a hozzá kapcsolódó magas öngyilkossági arány miatt.

Összefoglalva, az I. típusú trauma következménye lehet az ilyen típusú bulimia, főleg ha az illető környezete nem támogató.

A bulimiának ez a legveszélyesebb ismert formája, főként a hozzá kapcsolódó

igen magas öngyilkossági arány miatt.

Supporting material

https://www.nctsn.org/what-is-child-trauma/trauma-types

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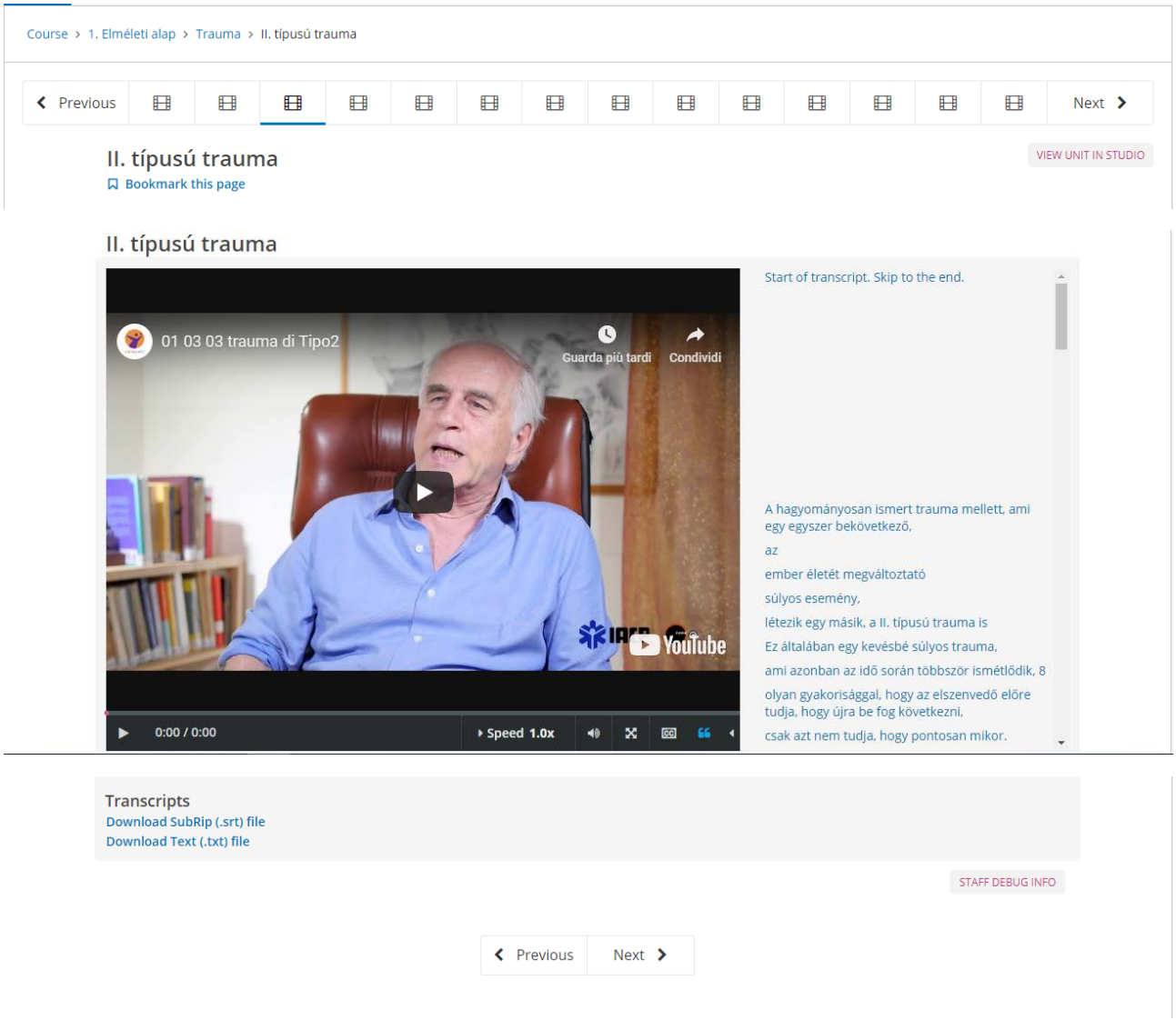


Transcript

A hagyományosan ismert trauma mellett, ami egy egyszer bekövetkező,

az

ember életét megváltoztató

súlyos esemény,

létezik egy másik, a II. típusú trauma is

Ez általában egy kevésbé súlyos trauma,

ami azonban az idő során többször ismétlődik, 8

olyan gyakorisággal, hogy az elszenvedő előre tudja, hogy újra be fog következni,

csak azt nem tudja, hogy pontosan mikor.

Ez a várakozás erős „korróziós” hatással van az elszenvedőre: : az erőtlenség

és tehetetlenség szélsőségesen erős érzéseket kelt benne,

az önrendelkezés teljes

hiányát okozva.

Az ilyen típusú trauma esetén – az evészavarok itt is gyakran megtalálhatóak következményként –

az előtörténetben előfordulhat,

hogy a gyerek vagy kamasz hosszú időn keresztül

szemtanúja volt

erőszakos konfliktusoknak

az otthoni környezetben, anélkül, hogy tisztában lett volna azzal, hogy mi történik.

Előfordulhat, hogy ez az erőszakos konfliktus erőszakos viselkedéshez vezet,

amely komoly károkat

vagy veszteségeket okozhat

Az ilyen fajta ismétlődő trauma

súlyos következménye,

hogy az elszenvedő előre látja és várja a traumatikus eseményt,

és aztán olyan helyzetekben is ellenségességet vár,

ahol az nem feltétlenül áll fenn.

A traumát a nagyon erős

és gyakori ismétlődés okozza

amely az illető életében

ugyanazt a félelmet aktiválja azután is 32

hogy a traumatikus, ismétlő esemény már megszűnt. 33

Egyes esetekben az elszenvedők hajlamosak megismételni a traumát.

Például ha egy

fiatal nő

egész gyerekkorában azt látta, hogy a szülei hogyan veszekednek egymással amiatt,

hogy egyikőjük megcsalta a másikat,

felnőttként csak olyan partnereket

választ,

akik ugyanúgy megcsalják.

Ezek a cserben hagyások felerősítik a nő igényét arra, hogy kiderítse, a hűtlenség valóban megtörtént-e vagy sem.

Az ilyen viselkedés

a kárt okozó esemény, azaz a megcsalás előrevetítését okozza,

és a fiatal nő folyamatosan attól fél, hogy az egyik pillanatról a másikra, bármikor megtörténhet;

mintha azokat a pillanatokat élné át újra, amiket gyerekként elszenvedett.

Az ilyen II. típusú trauma többek között

a tagadásra való nagyon erős hajlamot és érzelmi érzéketlenséget vonja maga után –

mintha az illető az érzelmeit megszüntetné.

Így az ilyen emberek hajlamosak úgy viselkedni, mintha nagyon „hűvösek" lennének,

mintha az életük

bizonyos pillanataiban nem lennének érzéseik.

Ezt az érzelmek beszűkülésének hívjuk, ami a

disszociatív zavarok egyik alapeleme

Az ilyen zavar esetén az ember elveszti a képességét a hétköznapi érzések érzékelésére

mintha fontos

érzékelési

képességét

vesztené el

vagy mintha nem lenne jelen,

élete bizonyos pillanataiban nem lenne

ott az életében.

Ezt egy elfojtott,

mély düh kíséri,

főként az evészavarok esetén, azon belül is

legfőképp az olyan esetekben,

ahol kontrollvesztés áll fenn, úgymint a korlátozó anorexia

a bulimiás viselkedéssel társuló anorexia

vagy

bulimia esetén

Az elszenvedő passzív,

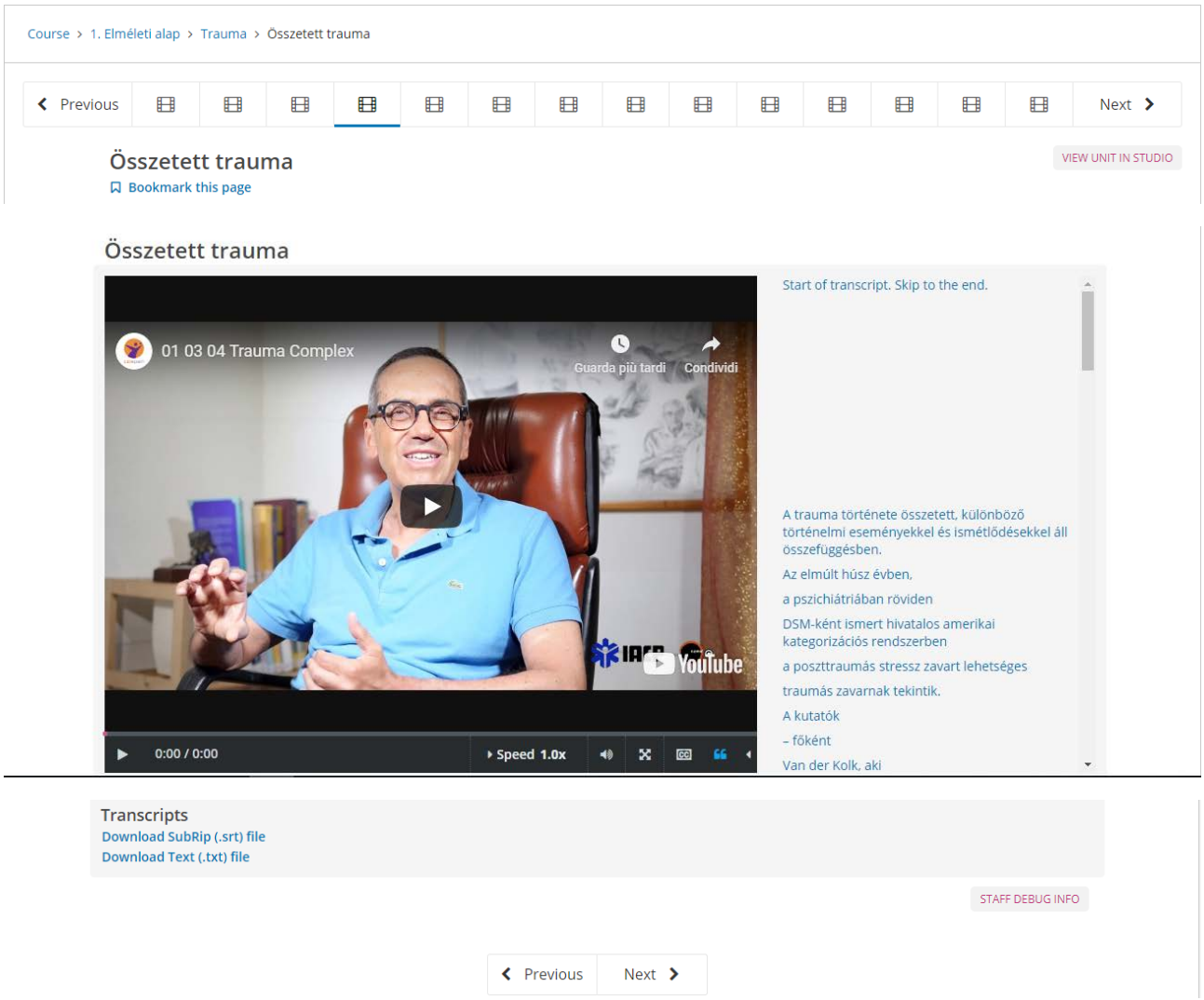
láthatólag nem reagál,

de ha csinálnak valamit,

erős düh figyelhető

meg bennük.

A külvilág elleni agresszió megnyilvánulásait erősen
magában tartja,
de ha az illető erős érzelmeket él át,
ez az erős harag kifejeződést nyerhet
és erőszakos viselkedést eredményezhet önmaga vagy mások irányában.
Az elszenvedő folyamatos, nem múló – nem időszakos – szomorúságot érez,
mintha
egy olyan
gyerekkori trauma történt volna, amely
az egész életére
kiterjedő kétségbeesést
okoz.
Ahogy korábban leírtuk,
ezek összegyűlő, egymásra rakódó
kisebb traumák. Nevezik ezt komplex vagy kapcsolati traumának is,
mivel az illetőnek másokkal kialakított folyamatos kapcsolataival állnak összefüggésben.
Előfordulhat, hogy az ilyen traumákat átélők
erősen traumatikus pillanatokat élnek át
az otthoni környezetben, főként
a családban.
Így ezek folyamatos traumák, amelyek újra és újra felbukkannak, és disszociatív tüneteket
vagy túlzott érzelmi regulációt vonnak maguk után, ahogy ezt korábban leírtuk.



Transcript

A trauma története összetett, különböző történelmi eseményekkel és ismétlődésekkel áll összefüggésben.

Az elmúlt húsz évben,

a pszichiátriában röviden

DSM-ként ismert hivatalos amerikai kategorizációs rendszerben

a poszttraumás stressz zavart lehetséges

traumás zavarnak tekintik.

A kutatók

– főként

Van der Kolk, aki

komplex trauma kérdését útjára indította

– figyelmet a gyerekkori traumákra fordította.

Azokra, amelyek olyan életkorban történtek,

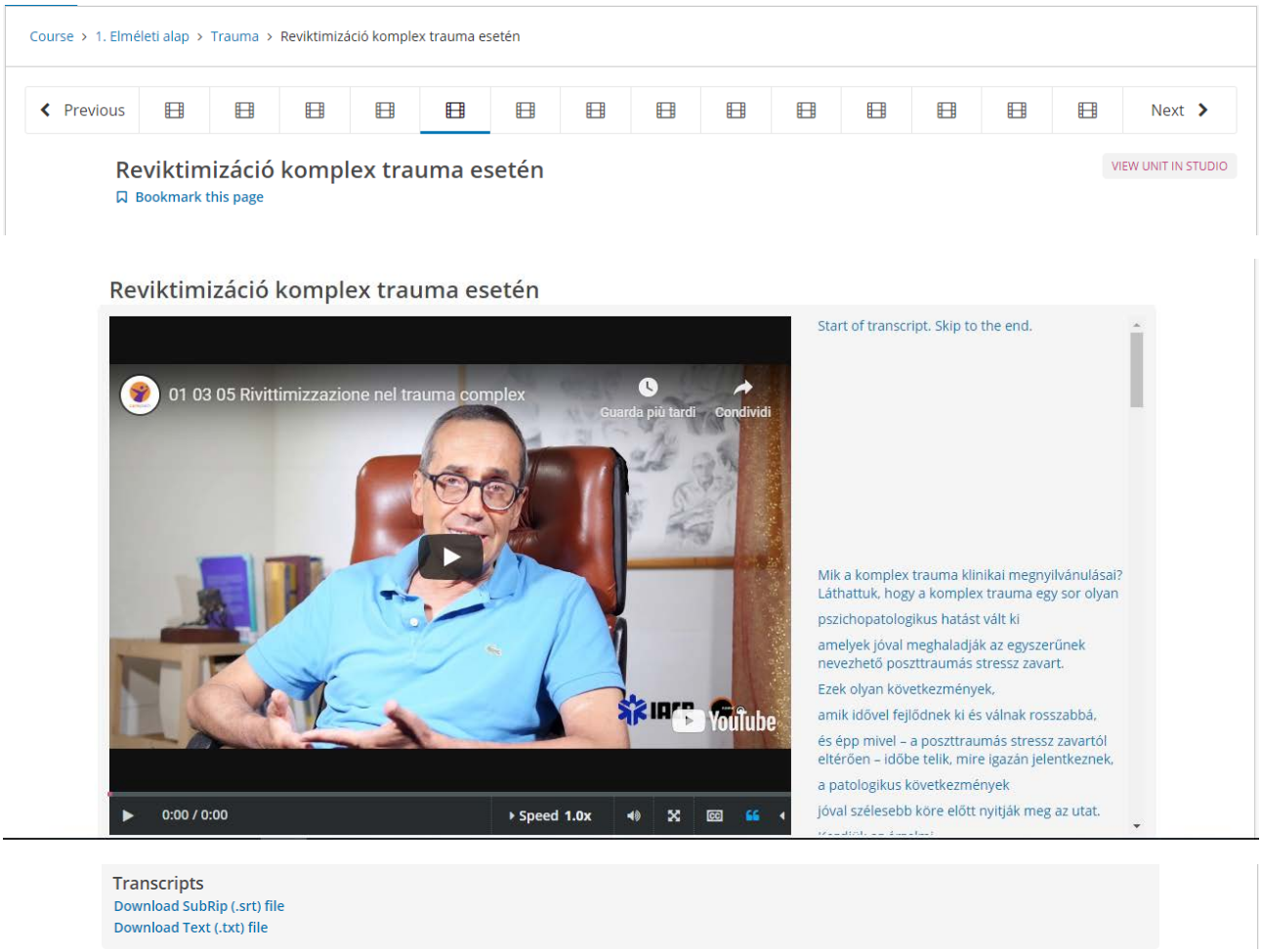
amikor
az elszenvedő
egy gyenge vagy alárendelt helyzetben volt – ahogy a gyermekek általában.
Az ilyen típusú
traumatikus helyzetek és események, amelyeket gyerekek szenvednek el,
pszichopatológiai és
neurobiológiai szempontból is okai lehetnek a poszttraumás stressz zavaron túl
még rengeteg más pszichiátriai zavarra való hajlam kialakulásának.
A
gyermekkori
trauma
több
típusú lehet: lehet akut,
lehet időben elhúzódó vagy ismétlődő a gyermekkor során,
és általában
bántalmazás formáját öltik,
az „elkövető” traumatikus események esetén.
Példái ennek, ha szexuális, fizikai vagy pszichés erőszakot
követnek el a gyermek ellen.
A „elhanyagoló
típusú traumák
példái az elhanyagolás különböző formái,
legyen szó
a gyermekről való
pszichés vagy fizikai gondoskodás hiányáról,
amelyek bántalmazó eseményekhez vagy helyzetekhez vezetnek.
A komplex trauma esetén
rossz bánásmódról és bántalmazásról beszélünk.
A komplex trauma, vagy ahogy egyesek hívják, az elsődleges fejlődési trauma,
gyakran
az elsődleges
gondozók,

pl. szülők alkalmatlanságának a következménye.
Ez gyakran
halmozott trauma. Masud Khan pszichoanalitikus épp ezzel a típusú traumával foglalkozik:
amely a gyermekkor során ismétlődő több kisebb eseményből
vagy elhanyagoló/elkövető típusú traumatikus helyzetből tevődik össze,
és amely egy olyan traumatikus alapzöngét vagy dimenziót teremt,
amit az elszenvedő egész
életében érezni fog, amikor nehézségekkel, 53
problémákkal, vagy elsődleges traumát előhívó más traumával találja szembe magát. 54
Ám ez az első trauma olyan komplex trauma, 55 00:03:55,400 --> 00:03:57,400 ami egy nagyon hosszú
és meghatározó időszakon át húzódhat, akár az ember egész gyerekkorán át.
Olyan családokban például,
ahol a szülők
(az egyik vagy mindkettő) problémái miatt a gyerek/ek hosszú időn keresztül
félelemmel és erőszakkal teli légkörben élnek.
Az a légkör nem biztosítja számukra azt a nyugalmat, védelmet és biztonságérzetet,
amire egy gyereknek óriási szüksége van az alapvető bizalom kialakításához-
ez pedig
elengedhetetlen ahhoz, hogy a gyerek később nyugalommal, nyitottan és magabiztosan
nézzenek szembe az élettel és a kapcsolataikkal.
Az is előfordulhat, hogy az elszenvedő mindennek nincs tudatában,
mert az ilyen élményeket a psziché gyakran elfojtja vagy a felejtés fátylát borítja rá,
így
azok
csak belül,
a felszín alatt fejtik ki hatásukat, amíg egyszer csak
„be nem nyújtják a számlát” az illetőnek.
Ezek az élmények gyakran robbanásszerűen
törnek a felszínre,
valami olyan körülmény miatt, ami destabilizálja
az elszenvedő érzelmi állapotát,
kellemetlen számára,

és általa újraéli a múltbeli traumatikus helyzetet.

Ennek az oka az, hogy amint korábban is említettük,

az aktuális trauma felidézheti a múltban elszenvedett traumát.



Transcript

Mik a komplex trauma klinikai megnyilvánulásai? Láthattuk, hogy a komplex trauma egy sor olyan

pszichopatologikus hatást vált ki

amelyek jóval meghaladják az egyszerűnek nevezhető poszttraumás stressz zavart.

Ezek olyan következmények,

amik idővel fejlődnek ki és válnak rosszabbá,

és épp mivel – a poszttraumás stressz zavartól eltérően – időbe telik, mire igazán jelentkeznek,

a patologikus következmények

jóval szélesebb köre előtt nyitják meg az utat.

Kezdjük az érzelmi

szabályozás,

az érzelmek

és a viselkedés zavaraival.

A komplex trauma által

érintett emberek
gyakran olyan mértékben és módon impulzívak,
ami nem pusztán személyiségjegy, hanem pszichés zavarnak, az impulzusokat érintő zavarnak felel meg.
Megnyilvánulhat
erőszakos viselkedésben önmaga vagy mások felé,
vagy különböző
szerek impulzív használatában úgymint drogfüggőség
vagy alkoholizmus.
Egy másik igen fontos terület
az érzelmi önszabályozás képessége az önértékelés formájában
Képesség arra,
hogy az ember kifejlesszen
egy alapvető bizalmat önmaga irányába,
illetve a gyerekkor óta többé-kevésbé látensen hordozott bűntudat.
Fontos észben tartani,
hogy a bántalmazást, főleg pl. szexuális bántalmazást elszenvedő gyermek gyakran érez bűntudatot,
amiért valami mocskosat tett, és nem lesz képes a felelősséget megfelelő módon a felnőttnek,
a bántalmazás elkövetőjének tulajdonítani.
Az ilyen bűntudat depresszióra való hajlamot
hozhat létre az emberben.
A komplex trauma egyik lehetséges felnőttkori következménye
a major depresszió.
További fontos, lehetséges következmények
a különböző pszichoszomatikus zavarok. A traumának a hatásai fizikai szinten is jelentkezhetnek,
pl.: fiziológiai reaktivitás, hiperreaktivitás,
szív- és érrendszeri problémák (pl. szívproblémák, magas vérnyomás)
a fájdalomszabályozás és fájdalomküszöb zavarai
(pl. az egész testben elszórt fájdalomérzés),
hiperérzékenység a fájdalmas behatásokra,
illetve különböző szexuális zavarok,
amik
pszichoszomatikus szempontból szexuális impulzuskontroll-zavarok

és a perverzió változatos formáiban
nyilvánulhatnak meg.
Végezetül pedig meg kell említenünk a disszociatív zavarokat,
mint pl. a deperszonalizáció-derealizáció, amely jelenséget ma még relatíve nehezen ismerik fel.
Az ebben szenvedő ember egy fajta idegenséget,
elkülönültséget él meg
önmagával és a valósággal szemben.
Ez tulajdonképpen egy védelmi mechanizmus
egy olyan valóság ellen, amit az illető valamiért annyira elviselhetetlennek él meg,
hogy úgy érzi, nem képes visszatérni az életbe,
és a disszociáció által inkább egy távolságot ékel be önmaga és a valóság közé.
Freud leírta továbbá az ismétlési kényszer
alapvető mechanizmusát,
amely nem más, mint hogy az ember újra és újra megpróbálja szembetalálni magát a traumával
– nem azért, hogy
újra elszenvedje
a negatív következményeit, hanem hogy megpróbálja azt feloldani.
A trauma feloldására irányuló ilyen típusú késztetés következménye, hogy az illetőt a viselkedése olyan helyzetekbe sodorja,
amelyekben újraéli a traumatikus helyzeteket. A klasszikus esetben az elkövető áldozata egy gyermek
ám ezt felnőttkorban ugyanilyen vagy fordított
szerepleosztásban
is újra átélheti.
A felnőtt tehát vagy megpróbálja újra-
legitimizálni magát azzal, hogy olyan helyzeteket hoz létre,
amelyekben más emberek tettei következményének
az áldozata
lesz
vagy ő maga lesz az elkövető,
aki egy áldozat ellenében cselekszik.
Ez történhet pl.
a gyerekként elszenvedett szexuális bántalmazás esetében

amely később, kamasz- és felnőttkorban válik inkább

ismétlődő helyzetté.

Például

szexuális erőszak

esetén azt

megélheti

elkövetőként vagy újrateremtheti áldozatként.

A lényeg, hogy még fordított szerepleosztásban is

a psziché célja, hogy a helyzet újraélése által megpróbálja feloldani

az elszenvedett traumát. Freud ezt nevezi ismétlési kényszernek.

Milyen szerepet tölt be a munkahelye struktúrájában?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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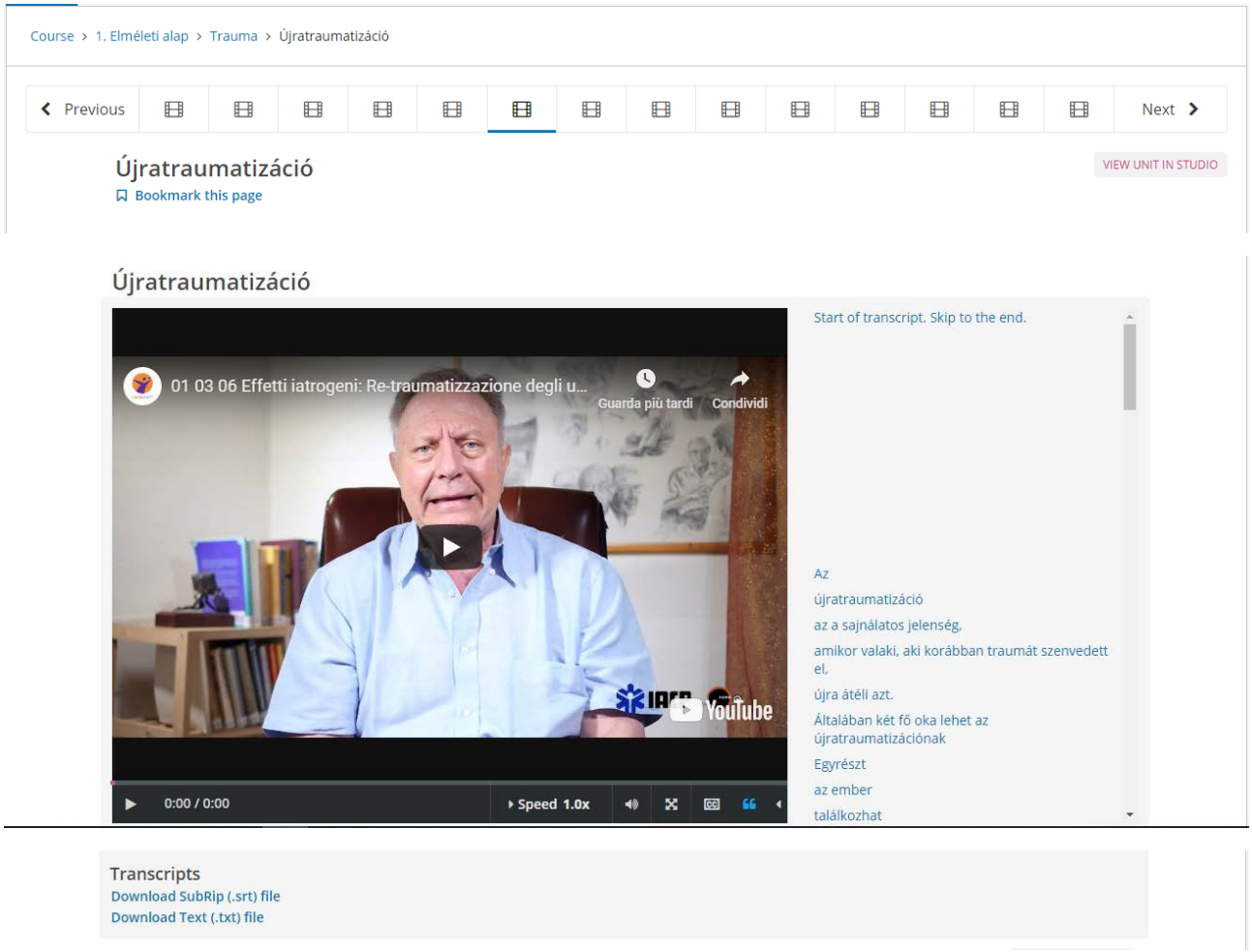
Szeretne további képzésekben, szakmai továbbképzésben részesülni a trauma kezelésével kapcsolatban, és ha igen, milyen konkrét problémákra fókuszálva?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

STAFF DEBUG INFO



Transcript

Az

újratraumatizáció

az a sajnálatos jelenség,

amikor valaki, aki korábban traumát szenvedett el,

újra átéli azt.

Általában két fő oka lehet az újratraumatizációnak

Egyrészt

az ember

találkozhat

olyan

képekkel

vagy eseményekkel, amelyekben

más személyek szenvednek el traumát,

de amelyek következtében
az illető újraéli a saját, korábban elszenvedett traumáját.
A másik
a jatrogén,
azaz
gyógyítást célzó
kezelés
következtében
kialakuló újratraumatizáció.
Ez
olyankor
fordul elő,
ha a
kezelést
helytelenül végzik a szakemberek vagy
intézményi dolgozók,
nem feltétlenül rossz szándékból, inkább tudatlanságból.
Így a kezelés és a segítő
intézmény ahelyett, hogy támogatná,
újratraumatzálja a
35
a már eredetileg 36
is traumatizált személyt.
Egyszerű példa
lehet
az a helyzet,
amikor
valaki törött lábbal érkezik a sürgősségi osztályra,
ám az orvosok
rosszul kezelik,
leejtik a hordozóágyról,
aminek következtében már nem egy, hanem két törött lába lesz,

dupla sérülés: kész tragédia.

A trauma kezelésének

eddigi

történetéből

kiderül hogy sajnos a

múltban egyáltalán nem volt ritka dolog, hogy –

természetesen tudatlanságból, nem pedig rossz szándékból –

a gyógyítást célzó

kezelés

újratraumatizációt okozott.

A teljes segítő intézményrendszer esetén,

mivel az embert, mint rendkívül komplex és érzékeny lényt próbálja kezelni,

fennáll a veszélye annak, hogy nem csak pozitív, de negatív módon is hatással lehet az ellátottakra, és akaratán kívül további sérüléseket okozhat számukra.

Ez vonatkozik a gyógyszerekre, a műtétekre

és minden fajta segítő kapcsolatra. Az olyan szolgáltatás, amelyet

nem megfelelően hajtanak végre

ellenkező

hatást válthat ki.

A trauma esetében ez kifejezetten komoly kérdés, hiszen a traumatizált ember

különösen

érzékeny és

nagy mértékben sérülhet egy második traumatizáció által.

Szerencsére mára már

tanultunk ezekből a hibákból, egyre

több

és több

és pontosabbak a kutatáoks, és jelentős tudásra tettünk szert – amelyet a jövőben tovább bővítünk – ennek köszönhetően

elővigyázatosabban tudunk eljárni, meg tudjuk állapítani a kényes pontokat,

hogy elkerüljük az eleve traumatizált emberek újbóli traumatizálását.

Ezek az óvintézkedések

a traumatudatos gyakorlatok,

amik a szolgáltatás traumatizált igénybe vevőjét helyezik a középpontba,

és

figyelnek arra, hogy mi okozhat esetleg további sérüléseket.

Ön úgy érzi, elég szakmai képzést kapott ahhoz, hogy megvédje klienseit a munkája során esetlegesen fellépő újratraumatizációs kockázatoktól?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

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Szeretne több képzést, információt kapni ennek a megelőzésével kapcsolatban?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

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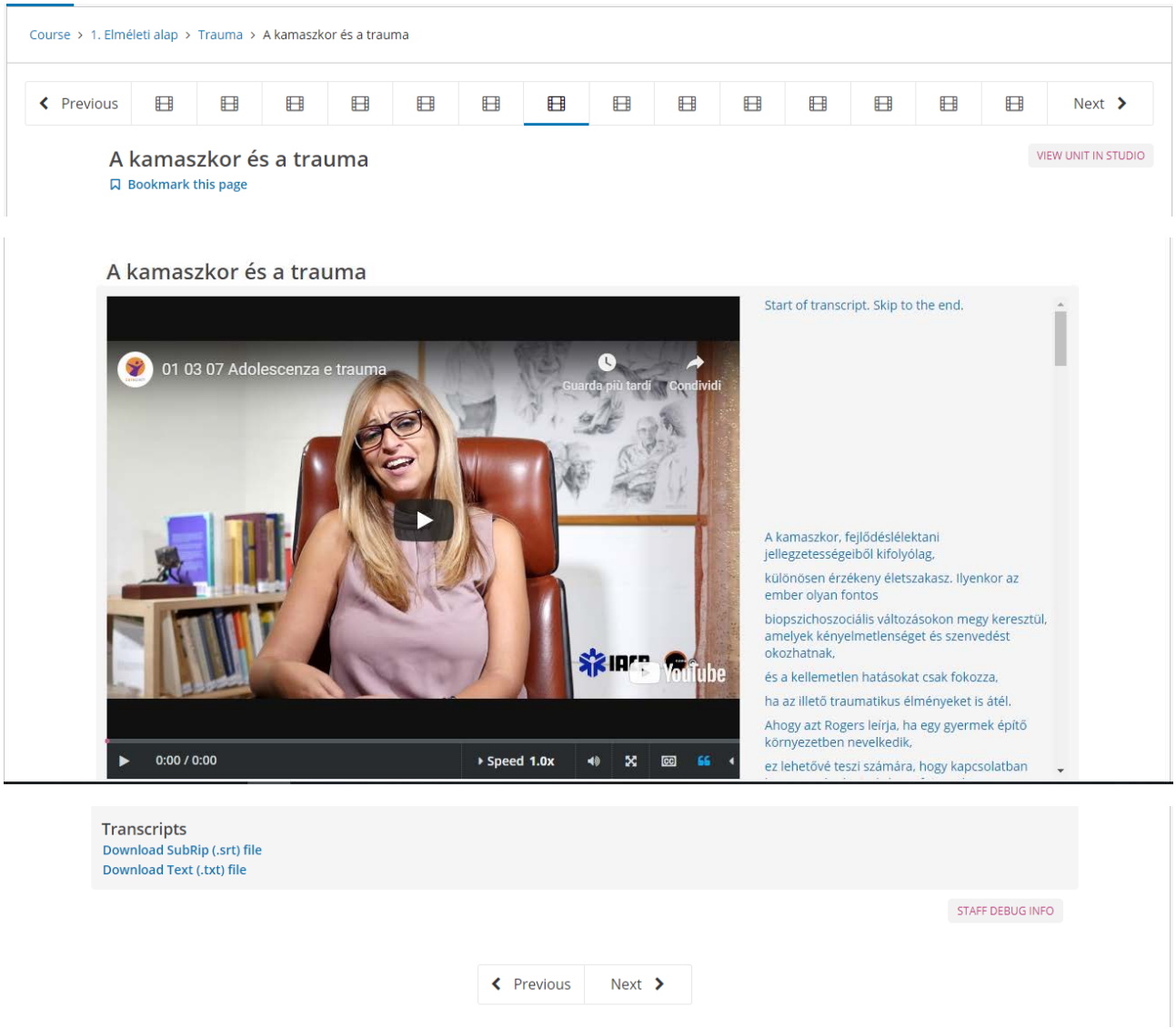


Transcript

A kamaszkor, fejlődéslélektani jellegzetességeiből kifolyólag,

különösen érzékeny életszakasz. Ilyenkor az ember olyan fontos

biopszichoszociális változásokon megy keresztül, amelyek kényelmetlenséget és szenvedést okozhatnak,

és a kellemetlen hatásokat csak fokozza,

ha az illető traumatikus élményeket is átél.

Ahogy azt Rogers leírja, ha egy gyermek építő környezetben nevelkedik,

ez lehetővé teszi számára, hogy kapcsolatban legyen az érzéseivel, és ne fojtsa el vagy „fagyassza le” a traumatikus élményeket,

hanem túllendüljön és folytassa az életet

miközben kielégíti a saját szükségleteit és kellemesként vagy kellemetlenként értékeli az élményeit attól függően,

hogy azok jótékony hatással vannak-e a fejlődésére, vagy sem. Rogers ezt a veleszületett képességet

hívja aktualizáló vagy önmegvalósító tendenciának, ami nem más, mint a képesség önmagunk megértésére, az önszabályozásra és a bennünk rejlő lehetőségek kibontakoztatására.

Ezzel szemben, ha egy gyermek az őt körülvevő környezetben azt érzékeli, hogy a róla gondoskodók elfogadása

teljes mértékben annak a függvénye, hogy megfelel-e az ő elvárásaiknak, , akkor internalizálhatja ezeket az elvárásokat,

erőszakkal lehasítva önnön énje egyes részeit,

egy ideális,

mereven felépített én érdekében.

Ez a folyamatos bizonytalanságra,

fenyegetettségre és félelemre épült „én-építmény" egyre merevebbé válik, ahogy a gyermek

a kiszámíthatatlan környezetben nevelkedik.

És pontosan ebben a mély elidegenedettség érzésben – az érzékelés és a tapasztalás között - a cselekvés és a tett jön létre, ami

Pontosan ez a mély, a tapasztalás, megélés, szimbolizálás közötti elidegendettség az, amely

a patogenezis alapját képezi

Láthatjuk tehát, hogy az a tizenéves, aki támogató kapcsolati környezetben nevelkedik,

a korábban említett fejlődési változásokon megy keresztül.

A meghatározó tényezők ezen változásai egy fajta belső újrarendeződést tesznek szükségessé,

egy olyan áthangolódást, ami magában foglalja az önmagáról és a legfontosabb kapcsolatairól alkotott képet.

Ez tulajdonképpen az egyén identitásának újradefiniálása.

Lássuk, milyen változásokkal néz szembe a kamasz.

Legelőször ezek a testen jelentkeznek. Egy kamasz teste folyamatos fejlődésben van:

a dolgok mérete megnő, a nemi szervek kinézete és a másodlagos nemi jellegek kialakulásával a teste megváltozik.

Ezek olyan változások, amelyek hatására a kamasznak új fajta kapcsolatra van szüksége a testével és önmagával.

A test válik a tizenéves fiatal elsődleges és közvetlen eszközévé,

hogy az élményeit kommunikálja a külvilág felé.

Ez a változó test olyan, amit lehet gondozni és kicsinosítani,

vagy karcolni, vagdosni,

esetleg megfeledkezni róla: olyan test ez, ami a figyelem középpontjába helyezi magát.

Ugyanakkor ez a test kívülről mások számára is látható, magára vonja mások tekintetét,

vágyakat vagy gúnyolódást vált ki, és így a kamaszt új élményeknek,

új lehetőségeknek és új veszélyeknek teszi ki.

Vannak továbbá az interperszonális szintű változások.

A családon belül a kamasztól azt várják, hogy mozduljon el a függéstől – a gondoskodás és ragaszkodás szakaszától –

az önállóság irányába. Az e között a két,

látszólag ellentétes fejlődési állapot közötti egyensúly keresésének megvannak a társas következményei.

A külső környezetben a fiatalnak a kortársai között és más fontos

kapcsolati személyek viszonylatában betöltött szerepe változni kezd.

A kutatások azt is

láthatóvá teszik, hogy agyi szinten is bekövetkeznek változások, mind strukturálisan, mind funkcionálisan, főként

a döntéshozatali folyamatokban érintett agykérgi területeken.

Mindez természetesen nagy fokú sebezhetőséget teremt, amit, ahogy korábban említettük, tovább fokoz,

ha az illető traumatikus élményeket él át, amelyek károsítják vagy aláássák

a Bowlby által leírt belső biztonságérzetet, biztonságos bázist.

Ez a belső, érzelmi biztonsági középpontunk, amit éreznünk, megneveznünk, táplálnunk kell, ahova nem térhetünk

mindig vissza, de ami lehetővé teszi számunkra, hogy átéljük azt a fontos élményt,

hogy a szeretet elvesztése nélkül fejleszthetjük önállóságunkat, és a más emberekkel való kapcsolatok során

gazdagíthatjuk önmagunkat.

Ám ha valaki traumát él át, akkor gyenge mentalizációs képessége lesz, és nem képes

az érzelmi állapotai önszabályozására; ahogy Bromberg írja,

semmi mást nem tud tenni a traumatikus élmény és az ahhoz kapcsolódó élmények és tartalmak kizárása érdekében,

mint hogy disszociálja magát tőlük. Ez a patológiás disszociáció – ahogy Caretti bemutatja –

az illető állapotának romlásához és erőforrásai kimerüléséhez vezet, mivel nincs meg a lehetősége arra, hogy a traumatikus élményeket

egy koherens narratíva segítségével valahogy átdolgozza és beépítse az élete történetébe.

Ezért ha

érzelmi stresszel küzdő tizenévesekkel dolgozunk,

a legjobb és a legfontosabb,

amit nyújthatunk nekik, az egy igazán mély, empatikus odafigyelésen

és meghallgatáson alapuló kapcsolat, illetve mély tisztelet a személyük iránt. Továbbá az,

hogy megpróbáljuk az élményeiket az ő szemszögükből megérteni, megérteni azokat a jelentéseket,

amiket ők hoztak létre az élményeik értelmezésére, illetve hogy egy olyan kapcsolati környezetet nyújtunk számukra,

amelyben a kamasz lassanként újra kapcsolatba léphet azokkal a részeivel, szükségleteivel, amiket addig megtagadott.

Így nem csak újra érezhetik, hanem újra is hangolhatják ezeket a részeiket

és azokat a külső élményeket, amiket korábban túlságosan kellemetlennek éltek meg.

Ez úgy lehetséges, ha a kamasznak egy olyan kapcsolati környezetet nyújtunk,

amiben másként tekintünk rájuk. Nem csak folyamatos fejlődésben lévő,

a külvilággal küszködő fiúkként és lányokként, vagy csak közösségi média iránt érdeklődő apatikus figurákként látjuk őket,

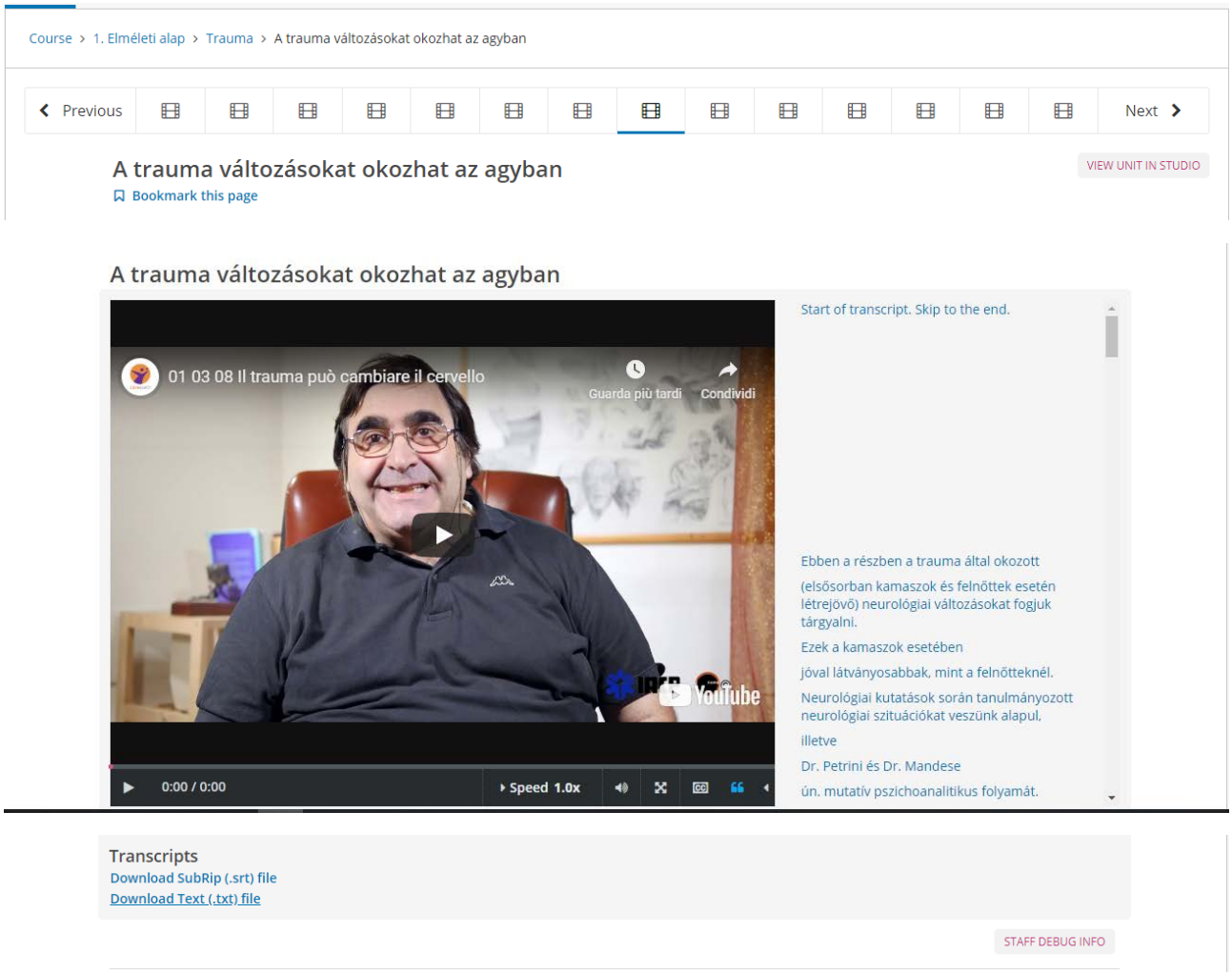
hanem olyan gyermekekként, akik a fejlődési szakaszuknak megfelelő jellemzőkkel

és eszközökkel rendelkeznek, akik aktívan mozognak a világban,

kérdeznek, válaszolnak, felfedeznek, és próbálnak személyes értelmet találni az élményeiknek.

Ahogy mi, felnőttek is tesszük ezt egész hátralévő életünkben,

és ezért nagyon fontos az, hogy szurkoljunk nekik.



Transcript

Ebben a részben a trauma által okozott

(elsősorban kamaszok és felnőttek esetén létrejövő) neurológiai változásokat fogjuk tárgyalni.

Ezek a kamaszok esetében

jóval látványosabbak, mint a felnőtteknél.

Neurológiai kutatások során tanulmányozott neurológiai szituációkat veszünk alapul,

illetve

Dr. Petrini és Dr. Mandese

ún. mutatív pszichoanalitikus folyamat.

Ez egy olyan módszer, ami

mind pszichoanalitikus, mind neurológiai elemekkel rendelkezik,

figyelembe veszi

a

nemzetközi neurológiai kutatások eredményeit, valamint a neurológia és a pszichoanalízis közötti kapcsolatot.

Közismert, hogy egészséges állapotban

az ember naponta 1400 új neuront fejleszt

ösztrogén-alapú őssejtekből,

hippokampusz és érzékszervi

szinten egyaránt.

Ez fontos tényező, mivel a hippokampusz a memória központi eleme,

az a terület,

ami előhívja az ismerős helyzeteket, így a traumatikusakat is.

Míg

érzékszervi szinten

megfigyelünk, az agylebenyek

nem többek,

mint az érzékszervi lebenyünk kivezető csatornái.

Az állatok a szagérzékelésüket használják,

mi a gondolkodásunkat

Ebből következően, az emberi gondolkodás

nem különbözik a szaglószervi érzékeléstől

amely továbbfejlődött ezekben az agysejtekben

Úgy hisszük, hogy az ember körülbelül 30.000 génnel rendelkezik, ami túl kevés ahhoz,

hogy minden helyzetet meghatározzunk, beleértve a lehetséges családi, érzelmi, kapcsolati, kulturális és vallási helyzeteket.

A kutatások szerint a géneknek csak 70%-a genetikailag meghatározott,

míg 30%-át külső tényezők alakítják.

Egy kistermetű férfi

és egy hím bonobó között a genetikai különbség csupán 5%,

ám ez a

kevés rendkívül fontos. Egy emberi férfit és egy bonobót aligha lehetne

összetéveszteni egymással. Az emberek számára

a személyes fejlődéshez rendkívül fontos a kultúra, a vallás,

a külső helyzetek, a család és a közösség, amiben élünk.

Mi történik

stressz hatására?

A stressz vagy az elhanyagolás (ahogy láthattuk, az elhanyagolás is stressznek számít)

blokkolja az őssejtek aktivitását a hippokampuszban,

így lehetetlenné válik a szokványos módon elvesző neuronok pótlása;

így

neuronveszteség jön létre

az agy legfontosabb és legmélyebb területén, a hippokampuszban.

Az ezeket az agyi változásokat kísérő kognitív és érzelmi

szabályozó folyamatokat

az amigdalához

köthető szorongás

és a depresszió

jellemzi:

ez sejtek egy kisebb csoportja az agyban,

ez támogatja az összes érzelmi-kapcsolati helyzetet,

a szeretettől a szexualitáson át az evésig,

beleértve mindent, ami érzelmi szempontból fontos a számunkra.

Változás történik a prefrontális kéregben is, ami a céljaink irányításával függ össze:

ha úgy döntök, hogy színházba megyek megnézni egy előadást, akkor a prefrontális kéreg

adja a késztetést, majd a homloklebeny (frontális lebeny) végzi el a cselekvést.

A prefrontális kéreg vezérli az impulzusokat is, például ha arra van késztetésem, hogy elmenjek valahonnan, vagy ott maradjak,

akkor ezért a prefrontális kéreg a felelős, a homloklebeny pedig reagál erre és kommunikálja

a szükségét annak, hogy maradjak, például valamilyen kötelezettség miatt.

A harmadik, károsodást elszenvedő terület

a hippokampusz és a memória (ahogy korábban már említettük

a hippokampusz a memória központja).

Longitudinális

vizsgálatok bebizonyították, hogy a traumák nem feltétlenül jelentkeznek

a DSM-5 vagy az ICD-10 által meghatározott poszttraumás stressz zavarnak nevezett zavar formájában,

hanem megnyilvánulhatnak

szorongás és depresszió,

olykor hallucinációk útján is,

illetve láthatóvá válnak az énérzet, énkép és az interperszonális kapcsolatok szintjén bekövetkező változásokként is.

A traumát elszenvedett személy

viselkedési és mentális korlátozásokkal él,

pl. az illető nem tűnik képesnek

az önkifejezésre

a munka

vagy a kapcsolatok

területén –

– mintha egy alacsonyabb szinten tudna csak funkcionálni.

Ez a

HPA (hipotalamusz-agyalapi mirigy-mellékvesekéreg) tengely miatt van.

Az agyalapi mirigyből indulnak

ki a hormonok

és jutnak el

a test különböző részeibe.

A hormonális (endokrin) rész

és az idegi rész

közötti összeköttetést

a hipotalamusz-

agyalapi mirigy tengely biztosítja. 97

Minden, ami eljut a hipotalamuszba – ami egy központi fontosságú terület, olyan,

mintha külön kis agy lenne az agyban –

utána átkerül az agyalapi mirigybe,

és érzeteket okoz, azaz az idegi jel hormonanyagok által közvetítve jut el a céljába.

Ezek a hormonanyagok

átszövik a testet,

az agyalapi mirigytől kiindulva,

és ezek irányítják

a pajzsmirigyet,

a szexualitást a nemi mirigyeken keresztül – a férfi
és női szexualitást egyaránt a férfi hormonon keresztül (ami a női szexualitást is meghatározza).
Illetve a
kortikotropin felszabadulását, ami egy stresszhormon, jobban mondva egy stressz előhormon,
mivel maga a stresszhormon az ACTH – a kortizol.
Ezért adnak a betegeknek kortizont a testi reakciók elősegítésére fizikai zavarok esetén;
a kortizol ugyanazokból az összetevőkből áll, mint a pro-opiomelanokortin (POMC).
Az ember szervezete a háborúkra is fel tud készülni: a kortizol (pontosabban az ACTH) egyik hatása,
hogy az ember nem érzi a fájdalmat,
illetve az agresszió mechanizmusait váltja ki
(ahogy állatoknál is).
Ha ezek a mechanizmusok és folyamatok
ismétlődnek,
krónikussá válhatnak, és elhúzódó szorongásos és félelemteli állapotot
okozhatnak,
a korábban említett amigdalától függően.
Az amigdala
a memóriánk „fiókos szekrénye”
abban az értelemben, hogy itt raktározódik
az összes érzelmi töltettel bíró emlékünk – mintha az érzelemvilágunk fényképezőgépe lenne.
Például az első csók, az első munkahely, a jólét első érzései,
az első sportgyőzelem – ezeket az amigdala mind lefényképezi, majd előhívja,
ha hasonló helyzetekben találjuk magunkat; pl., ha a hippokampusz
elkezd
kortizolt termelni.
Ez a kortizol hozzákapcsolódik a hippokampusz, az amigdala és a prefrontális kéreg receptoraihoz,
és ha eléri a megfelelő szintet – ha a helyzet nem krónikus –,
akkor a hatására csökken az ACTH és CRF szint.
Így tehát a stresszre adott válaszainkat a hippokampusz
szabályozza.
Amikor
jól vagyunk, a szerotonin veszi át az irányítást a terület fölött,

ami a boldogságérzés hormon – depresszió esetén

szerotonerg gyógyszereket írnak fel a betegnek.

A szerotonin

gátolja az agresszív viselkedést és elősegíti a szocializációt.

Triptofánból állítják elő, és napi szinten szedni kell.

A szerotonin a oxitocinnal együtt – ami a kötődési hormon – a legpozitívabb

és leghasznosabb hormon a szervezet számára. A szerotonin elősegíti a szocializációt

és a társas kapcsolatokat,

az oxitocin pedig – ami egy 5 másodperces öleléstől is felszabadul –

a kötődést

támogatja.

A kutatások azt mutatják, hogy a szeretetteli tevékenységek,

fontos gondolatok és érzések

mélyen gyógyító hatással lehetnek a testünkre is.

A

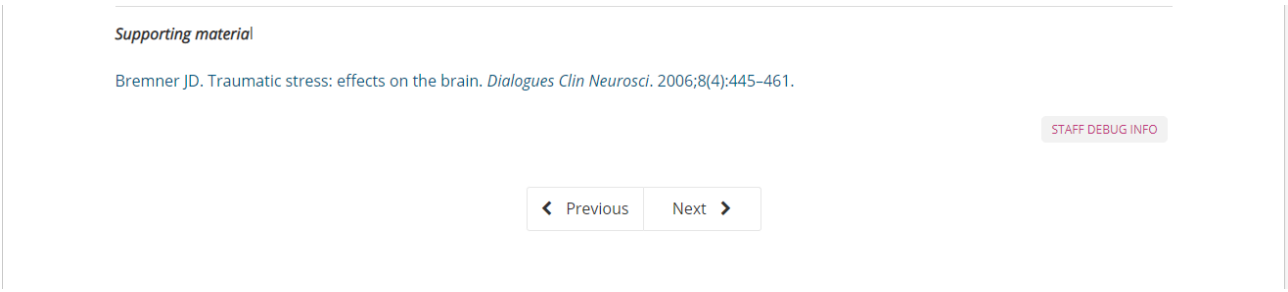
lényünkben

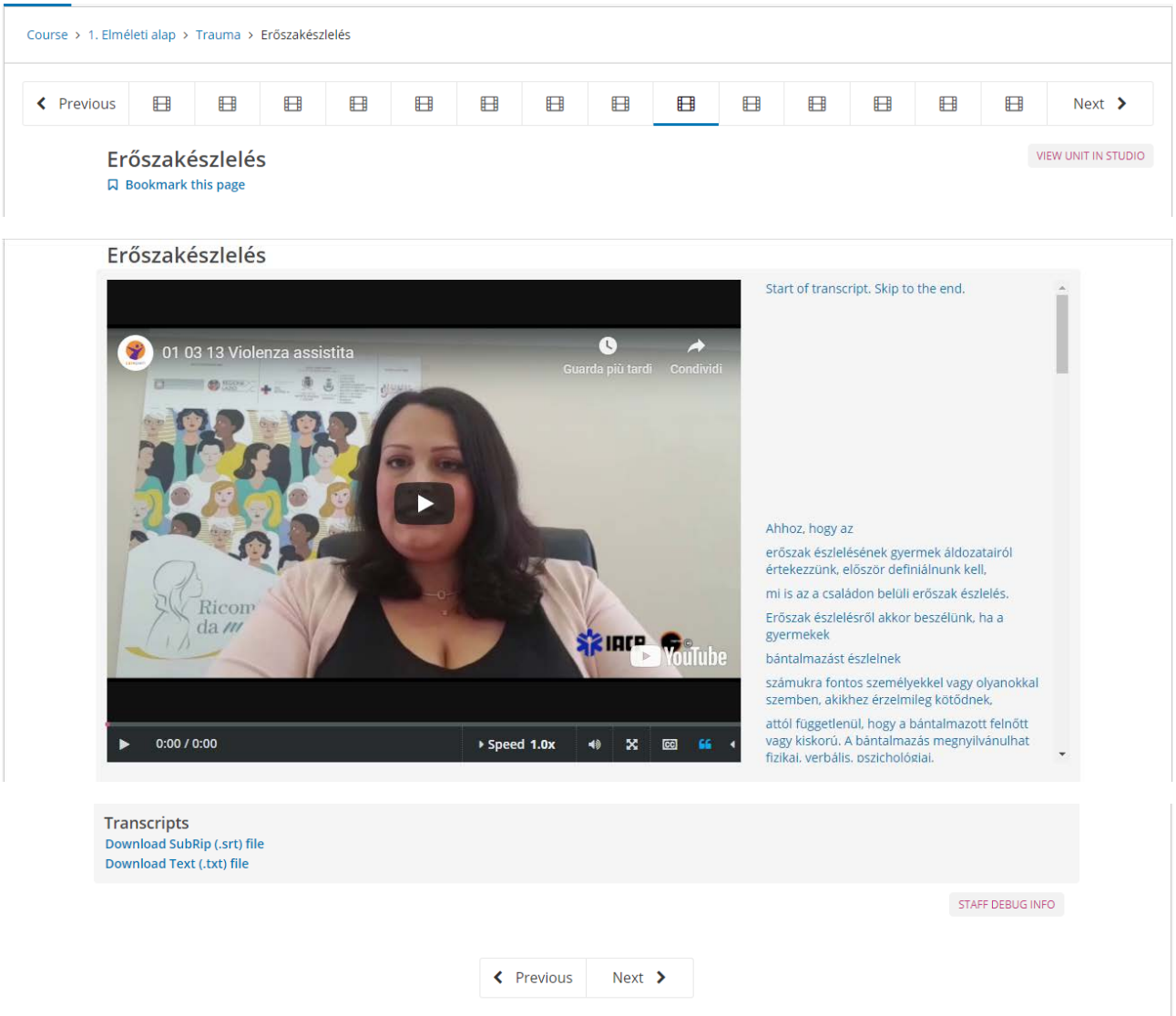
tehát

egy sor olyan reakció játszódik le amik megváltoztatják az agyat, és egyben a testet is,

minden olyan helyzetben, amikor neurohormonokhoz

és idegi ingerekhez kötődő hormonok vannak jelen.





Transcript

Ahhoz, hogy az

erőszak észlelésének gyermek áldozatairól értekezzünk, először definiálnunk kell,

mi is az a családon belüli erőszak észlelés.

Erőszak észlelésről akkor beszélünk, ha a gyermekek

bántalmazást észlelnek

számukra fontos személyekkel vagy olyanokkal szemben, akikhez érzelmileg kötődnek,

attól függetlenül, hogy a bántalmazott felnőtt vagy kiskorú. A bántalmazás megnyilvánulhat fizikai, verbális, pszichológiai,

szexuális vagy gazdasági erőszak formájában.

Ide tartozik a kiskorúak által kiskorúak ellen elkövetett bántalmazás,

de az is, ha valamelyik családtag a háziállatot bántalmazza. Ezek mind

olyan hatással vannak a gyermekekre, amelyek nagy mértékben traumatizálják őket.

Ezen hatások jellege eltérő lehet.

Az erőszaknak van közvetett formája is. Mivel az erőszak észlelhető dolog,

nemcsak szemtanúja, de fültanúja is lehet valaki.

Ezt azért kell hangsúlyozni, mert sok bántalmazott nő állítja, hogy gyermeke

egy másik szobában volt, amikor elszenvedte az ütéseket. A valóságban azonban

ezek az esetek is a közvetlen erőszak változatai, még akkor is, ha a gyermekek nem látják, csak hallják.

Ezek az átélt helyzetek akkor lehetnek közvetettek

ha a gyermekek tisztában vannak azzal,

hogy erőszak történt vagy fog történni. A gyermekeknek ugyanis „antennájuk" van ehhez:

érzékelik azt a tipikus feszültséget a házban,

amely az erőszakos események kirobbanásának előfutára szokott lenni.

Ezeket az eseményeket néha nem közvetlenül vagy közvetve észlelhetik,

hanem akár a bántalmazás hatásai is feltűnhetnek nekik:

például, ha ütésnyomokat látnak az édesanyjukon,

vagy ha megérzik az erőszak atmoszféráját a házban. Így ezekben az esetekben is erőszak észlelésről van szó.

Van néhány tévhit az erőszak észleléssel kapcsolatban.

A gyermekek

nem immunisak a saját családjukon belül történő erőszakkal szemben.

Még akkor is érzékelik az erőszakos cselekedetet, ha az nem az ő jelenlétükben történik,

hiszen a gyermekek sohasem csak passzív, öntudatlan megfigyelők.

Az erőszak észlelés a gyermekek ellen elkövetett közvetlen bántalmazás kockázatát is növeli.

Például az édesanyját védeni próbáló gyermeket

könnyen megütheti az apa, amikor a gyermek a szülei közé áll.

Dr. Annibali az erőszak észlelés esetében

ezt a nemi felosztást használja, ugyanis a legtöbb esetben férfiak

követnek el erőszakot nők ellen.

Ez nem zárja ki azt,

hogy anyák is bántalmazhatnak apákat, vagy általánosságban nők

férfiakat, de statisztikai szempontból ez sokkal ritkább eset.

A bántalmazásnak kitett gyermekek ötször nagyobb valószínűséggel lesznek erőszakos felnőttek azon társaikhoz képest,

akik nem voltak bántalmazás szemtanúi gyermekként.

Az erőszak észlelés hatásai a következők lehetnek:

félelemérzet, szorongás, túlterheltség érzése, szomorúság,

komoly depresszió, düh, bűntudat, alkalmatlanság vagy szégyen érzete.

A gyermekek elvesztik a bizalmat magukkal és másokkal szemben,

különböző pszichoszomatikus zavarok alakulhatnak ki náluk,

valamint indulatkezelési problémákkal, tanulási nehézségekkel,

nyelvi gondokkal,

székletvisszatartási és szociális nehézségekkel,

de akár poszttraumás stressz zavarral is küzdhetnek,

ha ez a traumatikus esemény egy olyan bizalmi közegben történik, mint a család.

Biopszichológiai szinten

az erőszak észlelés visszatükröződik a gyermek viselkedésében,

érzelmeiben, kognitív készségeiben, fizikalitásában és kapcsolataiban is.

A gyermek a teljes zűrzavar világában nő fel és az

erőszak természetessé

válik számára.

A gyermek az erőszakos viselkedést

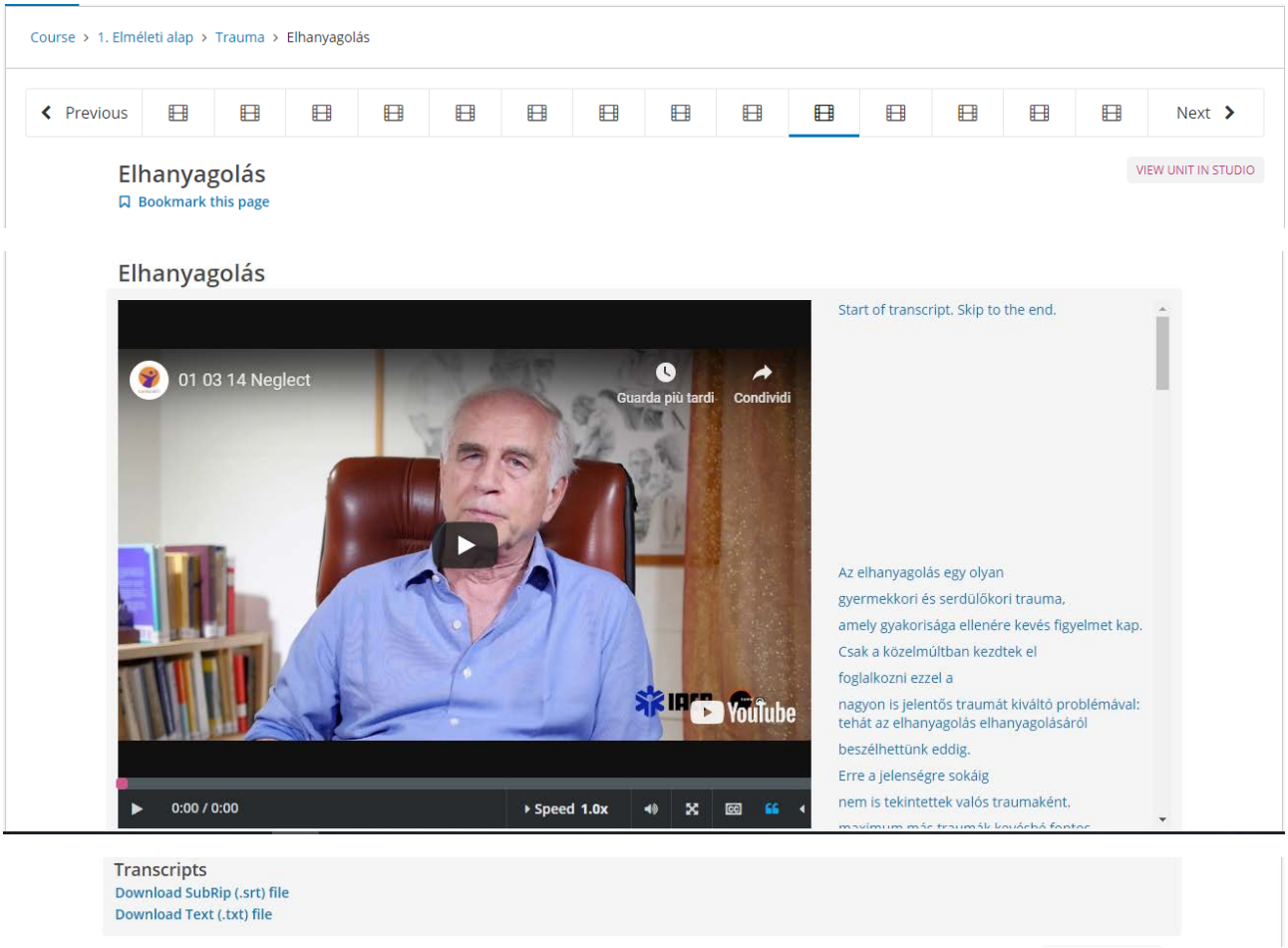
normálisnak és szükségszerűnek fogja tartani,

vagy saját nehéz tapasztalatait redukálva, maga is meg fogja ismételni ezeket a

viselkedési mintákat.

Egyre inkább szükséges figyelmet fordítani az erőszak észlelésre, és arra,

milyen hatással van ez a gyermek jelenére, és a későbbi felnőtt énjére.



Transcript

Az elhanyagolás egy olyan

gyermekkori és serdülőkori trauma,

amely gyakorisága ellenére kevés figyelmet kap.

Csak a közelmúltban kezdtek el

foglalkozni ezzel a

nagyon is jelentős traumát kiváltó problémával: tehát az elhanyagolás elhanyagolásáról

beszélhettünk eddig.

Erre a jelenségre sokáig

nem is tekintettek valós traumaként.

maximum más traumák kevésbé fontos részeként.

A valóságban azonban mára már ez számít a legelterjedtebb traumatípusnak, és úgy gondoljuk,

hosszútávon ennek vannak a legsúlyosabb következményei.

Ebből a szempontból az elhanyagolás pont azok részéről jelez mulasztást,

akiknek a törődés lenne a fő feladatuk.
Ezek a mulasztások – még ha nincs is
fenyegető kár kockázata – számos
hiányosságot jelezhetnek, amelyek hosszú ideig elhúzódhatnak.
Ezen hiányosságok sok, egyes típusú trauma kísérői lehetnek.
Egy bántalmazást
például többé-kevésbé el lehet viselni,
akkor viszont már nem,
ha hiányzik
az olyan szülő, aki képes
megérteni,
segíteni vagy támogatni
a traumát elszenvedő gyermekét.
Az elhanyagolás tehát az egyes típusú trauma része lehet,
de önmagában is nagy károkat okozhat.
Az elhanyagolásnak különböző típusai vannak,
amelyek vonatkozhatnak az egészségre,
oktatásra, gyermekfelügyeletre,
védelemre – figyelembe véve a környezeti kockázatokat –,
a fizikai szükségletekre, valamint az érzelmi támogatásra,
amely legtöbbször vagy a családtól, vagy azoktól érkezik,
akik a gyermek gondját viselik.
Az ilyen típusú elhanyagolás

talán nem tűnik olyan jelentősnek,
de valójában azt az érzést közvetíti az adott személy felé, hogy senki sem védi meg őt,
emiatt pedig azt érzi, hogy egy elutasító közegben van, ahol nincs számára garantálva a biztonság.
Tehát
Ha az elhanyagolás különböző
típusairól beszélünk, legyen az érzelmi vagy fizikai,
két teljesen különböző aspektust figyelhetünk meg.
Néhány esetben a gondviselő hanyagolja el a gyermek érzelmeit

a hideg,

közönyös és nemtörődöm

viselkedésével. A fizikai elhanyagolás ezzel szemben

az anyagi szempontokra vonatkozik,

továbbá az alapvető szükségletek kielégítésére,

vagy a gyermek oktatására,

a gyermek

elegendő információval

való ellátására.

Létezik az orvosi elhanyagolás is,

amelyről akkor beszélünk, ha fennáll egy kezelést igénylő betegség,

azonban azok a személyek, akik a gyermek ellátásért felelősek nem foglalkoznak ezzel.

Ennek következtében a betegség súlyosbodhat,

emiatt pedig különösen veszélyes

vagy ártalmas lehet

Emellett beszélhetünk morális elhanyagolásról, vagy máshogy fogalmazva arról, ha egy gyermek nem kapja meg a viselkedésére vonatkozó

etikai és morális instrukciókat.

Az ilyesfajta típusú elhanyagolások következményei a közegészségre mért károk, amelyeket sokáig

alábecsültek.

Mára már tudjuk,

hogy a hosszútávú

elhanyagolás

nem csupán a korábban említett betegségekhez vezethet, mint például a táplálkozási zavarok,

hanem az agykérgi szürkeállomány csökkenéséhez is,

ezáltal pedig alacsonyabb

kognitív képességekhez

a normál populációhoz képest. Ez az adat bizonyítja, mennyire fontos, hogy foglalkozzunk az elhanyagolással,

hogy újra

stabilizálhassuk az érintettek családi és egyéni környezetét.

Továbbá olyan

ellátással és

figyelemmel rendelkezzünk, amely biztonságérzetet ad a gyerekeknek, akik ezáltal érzik, hogy megvédik és megértik őket.

A kezelt betegségek (a táplálkozási zavaroktól kezdve az elhanyagolásig) összefoglalásának konklúziójaként meg kell említeni,

hogy az elhanyagolás rendkívül gyakori probléma olyan embereknél, akik a későbbiekben valamilyen kontroll nélküli étrendet alakítanak ki,

amely végül az önuralom teljes elvesztésébe torkollik.

Náluk fontos lehet egy terápiás kapcsolat, amely keretén belül különös figyelmet fordítanak

az adott személyre: az irántuk mutatott őszinte érdeklődéshez

empatikus hozzáállás párosul, amely segíti

a kliens problémáinak megértését.

Ez az egyik legfontosabb aspektusa annak, hogyan lehet hatékonyan bánni ezzel

a nemrég felismert, de különösen alattomos traumával,

amely nem kevésbé jelentős, mint bármely más nagy trauma.

Supporting material

Child abuse and neglect

STAFF DEBUG INFO

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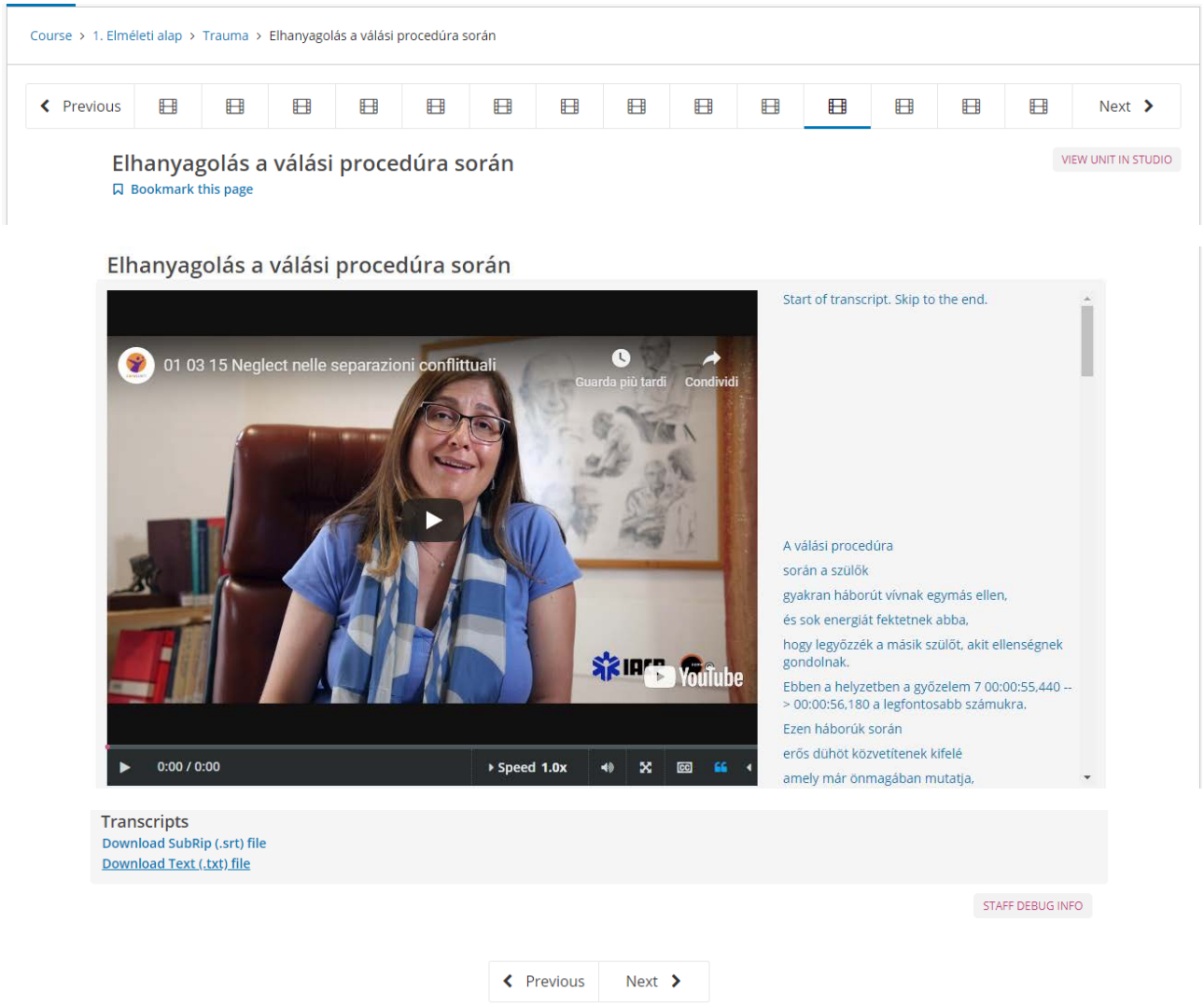


Transcript

A válási procedúra

során a szülők

gyakran háborút vívnak egymás ellen,

és sok energiát fektetnek abba,

hogy legyőzzék a másik szülőt, akit ellenségnek gondolnak.

Ebben a helyzetben a győzelem 7 00:00:55,440 --> 00:00:56,180 a legfontosabb számukra.

Ezen háborúk során

erős dühöt közvetítenek kifelé

amely már önmagában mutatja,

milyen nehéz szembenézniük

a váláshoz köthető érzelmeikkel.

Olyan érzelmekről beszélünk,

mint a csalódás, fájdalom, elhagyatottság, üresség érzése, magány

és a kudarc.

Gyakran hangoztatják is, mennyire bonyolult számukra feldolgozni

az úgynevezett pszichológiai válás folyamatát.

Ebben az esetben

a gyermek lesz az a szereplő,

aki leginkább védelemre szorul.

Sajnos azonban ez sokszor nem valósul meg,

ugyanis a gyermek gyakran a konfliktus gyújtópontjába kerül.

Központi szereplő lesz

emiatt pedig

a szülők a kiskorún keresztül kezdenek kommunikálni.

A gyermek így

a híd szerepét tölti be a két szülő között,

de egyben ő lesz a vita forrása is, hiszen mindkét szülő

azt állítja,

hogy a

gyermek érdekében

harcolnak egymással.

Az ilyen esetekben a gyermek jóléte kifogássá válik,

amely mögött a csalódás,

a féltékenykedés

és a személyes harag

rejtőzik.

Ezzel pont a gyermek védelmezése marad el, amelyre mindig szükség lenne,

különösen

ilyen nehéz

időszakban.

A szülőknek ideális esetben együtt kellene működniük az összes olyan területen, amelyek a szülői szerepeket érintik,

annak érdekében, hogy könnyítsenek a gyermekre nehezedő terheken.

Hiszen a gyermek

vállára hatalmas teher nehezedik:

bűnösnek érzi magát a szülei válása miatt,

úgy gondolja, neki kellene gondoskodnia a szülei boldogságáról,

valamint abban is vétkesnek érzi magát, hogy ő ad okot a szülők vitáira.

Így a valóságban ennél a pontnál az történik

hogy a gyermekre senki sem figyel igazán.

És itt kezdődik a trauma.

Ebben a rendkívül sebezhető pillanatban

a gyermek nem kap elég figyelmet,

szükségleteit és érzéseit nem ismerik fel, nem fogadják el és nem teljesítik.

A válás mindig traumatikus esemény,

hiszen károkat és törést okoz.

A szülői pár a gyermek elméjében

mindig egy egybefüggő entitás, amelyet valahogy hirtelen

ketté kell szakítani.

Az apa és az anya

részre történő szakítása

egy belső szakadást is eredményez.

A gyermek elméjében azonban 64 00:04:02,940 --> 00:04:04,140 a szülői pár

nem szűnik meg létezni, hanem fennmarad.

Csupán veszít az erejéből,

identitásából,

méltóságából

és elveszti az iránymutató szerepét.

Ilyenkor vannak más tényezők is

amelyek

további

terhet jelenthetnek.

Ezek a tényezők – mint például a

gyermek természete,

frusztrációtűrő

képessége

a szülőkkel való kapcsolat minősége, valamint a kötődés típusa,

amelyet a szülők még a válás előtt

alakítottak ki – befolyásolják a trauma mértékét

Az összes tényező közül

a gyermek kora árulkodik leginkább a traumáról és annak mértékéről:

minél kisebb a gyerek, annál nagyobb

a trauma.

A szülők

– akár öntudatlanul is

számos diszfunkcionális dinamikát indítanak be, amelyek a gyermeket

előre meghatározott szerepbe kényszerítik.

Ebből nem tudja kiszabadítani magát,

hiszen

korából

adódóan

még nincs meg az ahhoz szükséges öntudata

vagy szilárd személyisége,

hogy ki tudjon törni ebből a csapdából.

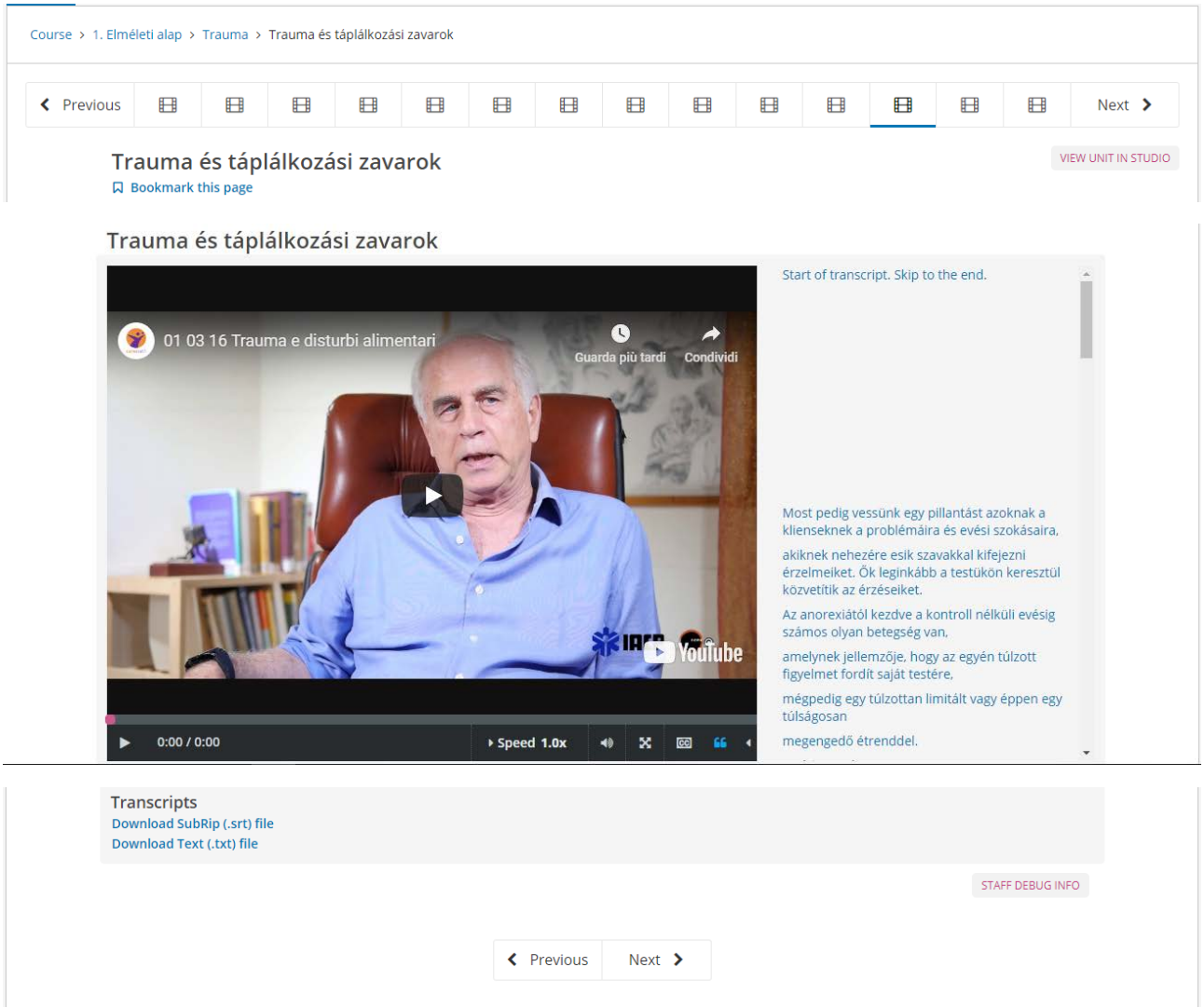
Ilyen esetekben szakmai tanácsadásra van szükség.

A tanácsadó felismeri a családban

jelen lévő dinamikákat és látja,

milyen típusú közbelépésre van szükség ahhoz,

hogy a gyermek megszabaduljon terheitől.



Transcript

Most pedig vessünk egy pillantást azoknak a klienseknek a problémáira és evési szokásaira,

akiknek nehezére esik szavakkal kifejezni érzelmeiket. Ők leginkább a testükön keresztül közvetítik az érzéseiket.

Az anorexiától kezdve a kontroll nélküli evésig számos olyan betegség van,

amelynek jellemzője, hogy az egyén túlzott figyelmet fordít saját testére,

mégpedig egy túlzottan limitált vagy éppen egy túlságosan

megengedő étrenddel.

Az érintettek

– különösen az anorexia esetében –

túlnyomórészt nők.

Az anorexia nervosa jellemzője a jelentős fogyás, amely rendkívül súlyos, akár életveszélyes súlyvesztéshez is vezethet.

Az érintett személy vágyik erre a súlyvesztésre, hiszen úgy gondolja, hogy testének mérete sokkal nagyobb, mint valójában.

Az anorexiában érintetteket számos korlátozás jellemzi. Erősen limitált az élelmiszer-bevitel, esetenként

pedig a testsúlyukat azzal akarják alacsonyan tartani, hogy evés után kompenzálni próbálnak.

Az anorexiában érintetteket számos korlátozás jellemzi.

Erősen limitált az élelmiszer-bevitel,

esetenként pedig a testsúlyukat azzal akarják alacsonyan tartani, hogy evés után kompenzálni próbálnak.

Ennek célja,

hogy több kalóriától szabaduljanak meg, mint amennyit elfogyasztottak,

ezzel pedig súlyvesztést érjenek el.

Ebbe a témakörbe

tartozik a bulimia nervosa is.

Ez egy olyan betegség,

amely nagyban hat

a táplálkozásra.

A betegség mértéktelen evési szakasszal kezdődik,

melyben a beteg

nagy mennyiségű ételt fogyaszt el

rövid időn belül.

A beteg testsúlyt

a bevitt étel

kiürítésével tud veszíteni.

Ehhez

különböző módszereket használ, mint például hánytatás,

hashajtó vagy vizelethajtó használata,

étvágycsökkentő gyógyszerek,

illetve kimerítő fizikai tevékenységek végzése.

in this people balance of weight remains good

And physically it stays in shape

Pont ellenkező irányú folyamat történik,

a kontroll nélküli evés,

a falászavar

esetében.
Mértéktelen evés, folyamatos, rohamokban jelentkező falási kényszer,
az étel folyamatos bevitele a nap jelentős részében,
és megállás nélküli étkezés jellemzi ezt a betegséget,
amely során az egyén
képtelen arra, hogy csökkentse az élelmiszer-bevitelt
vagy a testsúlyát.
A végén akár a 150 – 200 kg-t is elérhetik,
ez pedig rengeteg egészségügyi kockázatot rejt magában,
hiszen a túlsúly számos komoly
testi betegséget okozhat.
Ezek a betegségek egymás után jelentkeznek.
Jellemző rájuk,
hogy egymásnak adják át
a kilincset hiszen az önkontroll egyre csökken.
Az anorexia nervosánál ezzel ellentétben
a kontroll nagyon erős,
így az érintettek képesek minimalizálni az élelmiszer-bevitelt
annak érdekében, hogy megőrizzék extrém alacsony testsúlyukat.
Ha az önkontroll elkezd csökkenni,
akkor Bulimia nervosáról beszélhetünk.
Az ezzel küzdő
gyerekek vagy fiatalok
esznek – néha akár sokat is –,
jól működő jutalmazási rendszert tartanak fenn,
jól működő jutalmazási rendszert tartanak fenn,
és képesek a kontrollra, amely azonban csak
az étkezés után jelentkezik.
Ez lehetővé teszi számukra,
hogy súlyukat a számukra megfelelő szinten tartsák.
A harmadik típusú kontroll nélküli evési zavarnál
az egész napot evéssel

töltik,

gyakran a televízió előtt anélkül, hogy tudatában lennének

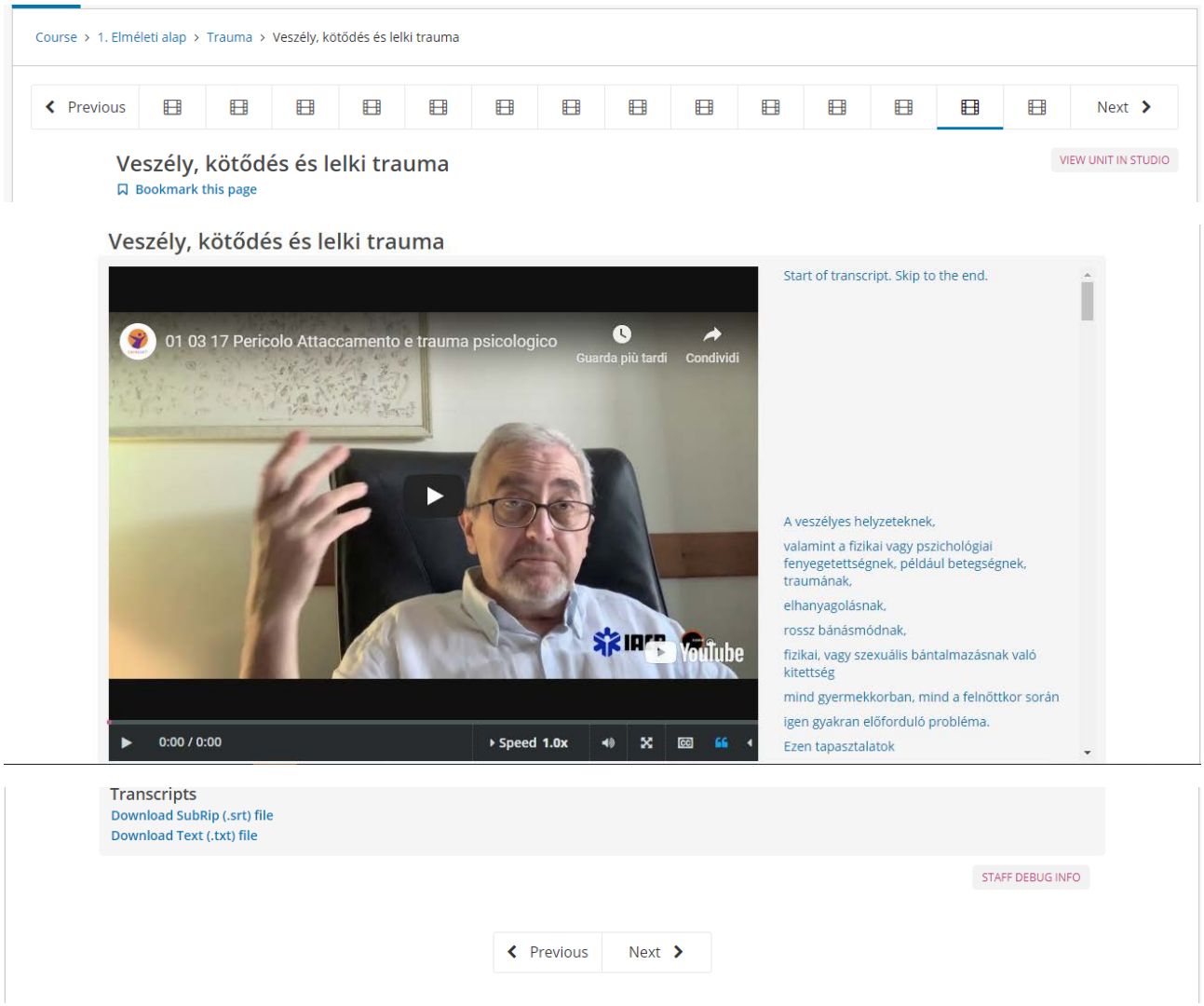
a repetitív és folyamatos élelmiszer-bevitelnek.

Mindegyik

betegségről elmondható, hogy számos, súlyos következménnyel járhatnak a beteg érzelmi világára,

és számos különböző traumára mutathatnak rá,

amelyek a táplálkozási zavarokhoz vezethettek.



Transcript

A veszélyes helyzeteknek,

valamint a fizikai vagy pszichológiai fenyegetettségnek, például betegségnek, traumának,

elhanyagolásnak,

rossz bánásmódnak,

fizikai, vagy szexuális bántalmazásnak való kitettség

mind gyermekkorban, mind a felnőttkor során

igen gyakran előforduló probléma.

Ezek a tapasztalatok

nem szükségszerűen

vezetnek trauma kialakulásához

Az

emberi faj

rendkívül kifinomult
alkalmazkodóképességgel rendelkezik,
ami lehetővé teszi, hogy szélsőséges helyzetekkel
nézzünk szembe anélkül,
hogy lelki trauma alakulna ki azok hatására.
Ha a veszélyt jelentő helyzeteket
hatékonyan kezeljük,
meg tudjuk
akadályozni a helytelen alkalmazkodást,
ezzel
lehetővé téve az egészséges
mentális és
pszichológiai állapot fenntartását.
Fajunk,
az idő múlásával,
személyes
készségeket
és igazán kifinomult
viselkedést fejlesztett ki, amelyeknek fő feladata,
hogy megóvjon minket a különböző veszélyektől.
Ezeket a
viselkedési és magatartási mintákat
nevezzük
kötődési rendszernek.
A kötődés szó
a kötődéselméletből származik,
amelyet először az 1950-es években javasolt
az angol pszichoanalitikus John Bowlby.
A kötődéselmélet szerint az emberek
olyan veleszületett hajlammal jönnek a világra,
amely elősegíti a kötődési kapcsolatok kialakulását
az elsődleges személyekkel – elsősorban a szülőkkel –,

akiknek

fő feladata

a veszély elleni védelem.

Ebben az elméletben kötődésről beszélünk, amelynek fő,

de nem kizárólagos

funkciója a veszélyes helyzetek elleni védelem nyújtása:

amikor az egyén úgy érzi, hogy kellően biztonságos helyzetben van

és támogatják őt külső környezete felderítésében,

felfedezheti azt

és megtanulhatja hogyan előzheti meg

meg annak esetleges rejtett veszélyeit.

Ezeket a kötődési mintákat

minden korosztályú gyereknél – különös tekintettel az egy-, kétévesek és anyjuk kapcsolatára – valamint főemlősöknél is vizsgálták.

Ebben az elméletben kötődésről beszélünk

amelynek fő, de nem kizárólagos funkciója a veszélyes helyzetek elleni védelem: 60 00:03:03,640 --> 00:03:05,260 amikor az egyén úgy érzi,

hogy kellően biztonságos helyzetben van

és támogatják

őt

külső környezete felderítésében,

felfedezheti

azt

és megtanulhatja hogyan előzheti meg annak esetleges rejtett veszélyeit.

Ezeket a

kötődési mintákat minden korosztályú gyereknél

– különös tekintettel az egy-, kétévesek és anyjuk kapcsolatára –

valamint főemlősöknél is vizsgálták.

Az 1950-es évektől kezdve végeznek kutatásokat

kis rézuszmajmokon.

Ezek a

kutatások bizonyították

mennyire fontos
az anya védelmező szerepe –
a főemlősök esetében
még fontosabb, mint a táplálási funkciója.
A kötődési típusokat két kategóriába tudjuk sorolni: biztonságos és bizonytalan.
A biztonságos kötődést
a biztonság érzése,
a környezet és források
iránti bizalom,
valamint veszély esetén segítség és védelem jellemzi.
A bizonytalan kötődés
egyik fajtája
a
bizonytalan-ambivalens/ellenálló –
C típusú –
kötődési forma
Ebben az esetben a test túlzott
érzelmi aktivitással reagál;
jellemzőek a düh és félelem
megnyilvánulásai,
panaszkodás a
védelem hiányára,
nehézségek az anyától való szeparáció során.
A bizonytalan kötődés másik típusa a bizonytalan-elkerülő kötődés –
más néven A típusú –,
amelyet,
az előzőtől eltérően, hipoaktiváció jellemez. Különösen azáltal,
hogy a gyermekek elhatárolódnak
a veszélyes körülmények
hatására megjelenő érzelmi reakcióktól –
így a félelemtől, a haragtól,
a sebezhetőség érzésétől –,

továbbá
ezek kimutatását gátolják kifejezéseikben is
(például látszólagos közömbös viselkedés),
vagy megmásítják azokat és ellentétes
érzelmi kifejezésekké alakítják őket (például mosolyognak, amikor ijesztő témával szembesülnek).
A hatékony
kötődés
megvéd
minket a
környezetünkből
vagy a kapcsolatainkból jövő veszélyekkel szemben.
Ha ezek
a stratégiák megfelelően működnek
és kellően védelmezők,
nem áll fenn a lelki trauma lehetősége,
és az egyén viszonylagos biztonságban marad.
Lelki trauma akkor alakulhat ki, amikor ezek
a stratégiák
nem működnek megfelelően.
Például amikor félelem, harag
vagy a szükségletek kifejezésének gátoltsága
nem tudja megfelelően védelmezni az egyént
a környezeti veszélyekkel szemben.
Lelki trauma esetén a mentális folyamatokat
negatívan befolyásolja
a múltbeli vagy jelenlegi veszélyek tapasztalata.
Ezt kiválthatja egy különösen intenzív és hirtelen esemény – például
fizikai trauma
vagy bántalmazás elszenvedése –,
de olyan tapasztalatok sorozatából is származhat,
amelyek együttesen
traumatikus értéket képviselnek.

Ebben az esetben fejlődési traumáról beszélünk.

Ez olyan helyzetben állhat fenn,

amikor például a gyermek

nem megfelelő,

elhanyagoló családi környezetben

nő fel, és ezek az elhúzódó tapasztalatok összességében

olyan alkalmatlan

fejlődési környezetet teremtenek, amely lelki trauma kialakulásához vezet.

A veszélyhelyzet okozta potenciálisan traumatikus helyzethez való alkalmazkodás és annak

feldolgozásának képessége

bizonyos személyes jellemzőitől függ.

Ilyenek az egyén életkora, érettsége, személyisége és

kötődésének jellemzői, függetlenül attól, hogy ezek megvédik-e az őt;

fizikai ereje és egészségi állapota is fontosak, hisz

egy beteg ember sérülékenyebb, könnyebben alakulnak ki nála

veszélyeztető helyzetek.

Nagyon fontos továbbá

a védelmet nyújtó kötődések rendelkezésre állása, az olyan személynél, akinek veszélyhelyzetben nem kell egyedül éreznie magát, hanem olyan emberekkel

van körülvéve, akik védelmező kapcsolatot tudnak nyújtani, akik biztosítják, hogy valamilyen védett helyzetben vagyunk és velünk vannak, hogy egy veszélyes élményt feldolgozzunk.

A társas kontextus is jelentős szerepet játszik: alapvető fontosságú, hogy

az egyén barátságos környezetben találja magát, olyan emberek között,

akik barátsággal fogadják és kultúrájukkal, rituáléiikkal, vagy személyes jelenlétükkel

nyújtanak támogatást (pl. barátok)

A traumatikus helyzethez való alkalmazkodás nem azonnal történik, időre van

szükség például a gyász folyamatához.

A házastárs vagy szülő elvesztése okozta gyász megfelelő feldolgozásához,

ahhoz, hogy az ne váljon traumás gyásszá,

általában egy-két év szükséges

Ha

egy potenciálisan traumás élmény nem kerül feldolgozásra,

azt jellemzően túlzó érzelmi hiperaktiváció jellemzik

álmokkal, rémálmokkal,

félelmekkel

„Nem tudom, fenyegetettség érzésem van”

kontrollálhatatlan reakciók –

ahogyan az a poszttraumás stressz zavar esetén is jelentkezik –

vagy pedig szélsőséges hipoaktivitást vált ki, pl. túlzó távolság tartása

mindentől, ami a veszélyes helyzettel kapcsolatos,

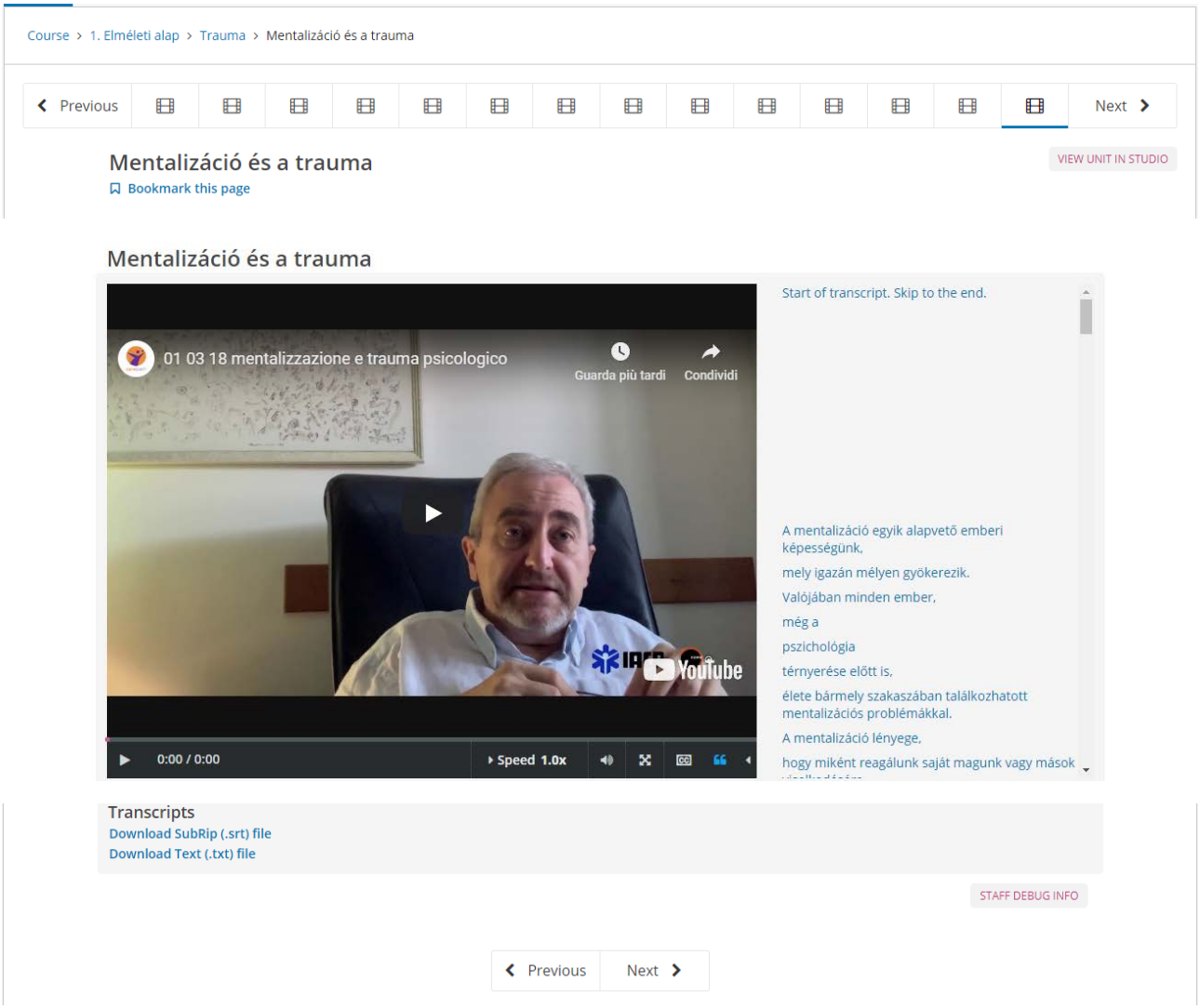
emlékek hiánya

affektív gátlás,

a traumatizáló helyzettel kapcsolatos beszéd, vagy helyszínek kerülése.

Ennek a két tényezőnek (hyper- vagy hypoaktiváció) a jelenléte esetén beszélhetünk pszichés traumáról.

A két feltétel valamelyikének a teljesülése esetén beszélünk pszichés traumáról.



Transcript

A mentalizáció egyik alapvető emberi képességünk,

mely igazán mélyen gyökerezik.

Valójában minden ember,

még a

pszichológia

térnyerése előtt is,

élete bármely szakaszában találkozhatott mentalizációs problémákkal.

A mentalizáció lényege,

hogy miként reagálunk saját magunk vagy mások viselkedésére

átgondolva azt, hogy éppen

mi jár saját magunk

és a másik fejében.
gondolataink, érzéseink,
szükségleteink, elvárásaink és meggyőződéseink is
mind befolyásolnak bennünket.
A mentalizáció fogalmát úgy lehet könnyen
megérteni,
hogy magunk
és mások aktuális állapotára
egy mentális állapotként
tekintünk.
Ez a képesség
körülbelül
négyéves korban alakul ki,
amikor a gyermek rájön,
hogy
mások nem feltétlenül tudják és értik,
mit gondol és érez.
Például az anya nem mindig tudja, hogy mi zajlik gyermeke fejében.
Amikor a gyerekek
elsajátítják ezt a képességet,
megtanulják a
problémákhoz való alkalmazkodás
nagyon hasznos
és fontos stratégiai módját is;
megtanulják
a hazugság fontosságát.
Akkor alakul ki a hazudás képessége, amikor már tudjuk,
hogy mások eltérően látják a világot,
emiatt pedig nem tudhatjuk mi jár a másik fejében.
A mentalizáció
és folyamatai egymásra épülő lépések sorozatán
alapszanak.

Érzékenységünk alakulásának
első állomása
a különböző mentális állapotok
felismerése,
saját és mások mentális állapotának
értelmezése (például megértjük, hogy mit jelent
boldognak és
szomorúnak lenni, elvárásokkal rendelkezni,
vagy előítéletesnek lenni)
illetve
olyan képességekkel való rendelkezés,
amelyek segítségével értelmezni tudjuk magunk
és mások viselkedését mentális állapotuk alapján.
Mindezek szükségesek másokhoz való adaptívitásunk kialakításához
(például, ha valaki csendben áll előttünk,
nem arra gondolunk rögtön,
hogy nincs mondanivalója,
hanem sokkal inkább arra,
hogy az elméje
tele van képekkel és gondolatokkal. Így a hallgatásuk nem az üresség egyik kifejezőeszköze,
hanem egy sor mentális állapot,
amely alapja a csendes viselkedés).
A mentalizáció egy másik fontos aspektusa,
hogy saját magunk mentalizációja segíthet
testünk szabályozásában.
Például ilyen az a szituáció,
amikor realizáljuk,
hogy mérgesek vagyunk,
és rájövünk,
hogy
a haragunk abból ered,
mert valaki

mondott valamit, ami rosszul esett.
Maga a tény,
hogy ezt sikerült felismernünk, emlékeznünk rá,
elvárásokat támasztanunk és kivetítenünk a következményeket,
egy teljesen új
pszichológiai utat nyit meg bennünk a haragkezelés terén.
Harag érzetekor a szívműködést, a légzést és a hormontermelést
pszichológiai folyamatok
kezdik el
irányítani.
Például, ha
lelkiismeret-furdalást érzünk amiért megharagudtunk valakire,akit szeretünk,
a bűntudat szabályozza testünk működését és
meggátolja a harag érzetének kimutatását.
Ez olyannyira alapvető funkciója szervezetünknek,
hogy a rossz mentalizációs
képességekkel rendelkezők jobban ki vannak téve
a különböző testi rendellenességeknek
(pl. gyorsabb,
szabálytalan
szívverés,
kontrollálatlan érzelmi reakciók,
melyek a test folyamatos szabályozási zavarai miatt
hosszú
távon
betegségek kialakulásához vezethetnek).
A szülők egyik legfontosabb funkciója
gyermekeik
mentalizációja.
Nagyon fontos, hogy úgy tudjanak tekinteni
gyermekeikre,
mint szükségletekkel,

érzésekkel és félelmekkel
rendelkező lényekre,
bele tudják képzelni magukat gyerekeik helyébe
és megpróbálják a világot az ő szemszögükből nézni.
Például, egy hároméves gyereket
csak bizonyos témák érdekelnek,
különböző szavakat és beszélgetéseket pedig 115 00:06:10,860 --> 00:06:12,080 csak az ő,
gyermeki képességei keretein belül fog tudni értelmezni.
Ezért fontos, hogy a szülő bele tudja
képzelni magát a gyerek helyébe.
Ezt az állapotot (pszichológiai) tudatosságnak is nevezik,
amely szorosan összefügg
a gyerek
egészséges fejlődésével. Ehhez pedig
az is szükséges,
hogy a
szülő képes legyen gyereke helyébe képzelni magát és megértse igényeit.
Megfigyelték, hogy a kisgyermekes édesanyák,
akik
azonosulni
tudnak
síró vagy nyugtalan gyermekük állapotával, megértik, hogy a kicsi valószínűleg fázik vagy éhes.
A gyermekek így közvetítik állapotukat,
mintha képesek lennének gondolatok rendezésére
és kifejezésére.
A gyermek mentális állapotának megértése
a szülőség egyik alapvető feltétele.
A mentalizáció olyan alapvető képesség,
amely segít megbirkózni a stresszel és a potenciálisan
veszélyes helyzetekkel anélkül,
hogy kialakulna bármiféle lelki trauma.
Például,

ha egy gyermek
a szülő következetlen viselkedésével szembesül,
aki talán dühösen,
fizikai erőszakkal reagál,
vagy negatív üzenetet közvetít a gyermek felé,
a gyermek képessége, hogy megértse a szülő mentális állapotát
lengéscsillapítóként működik számára. Rávezeti a gyereket arra,
hogy a szülő miért viselkedik
úgy az adott pillanatban. Ezt gondolhatja például:
„Apa fáradt,
és amit mond, nem felel meg a valóságnak.
Apa általában
gyengéd és szeret engem.
A most zajló
események csak a jelen pillanatban igazak
és az adott állapotához kapcsolódnak, de ez nem állandó.” Ez a hozzáállás megvédheti a gyermeket
mások mentális állapotának
negatív hatásaitól és így az adott helyzet kevésbé marad traumatikus élmény.
Az alacsony
mentalizációjú
felnőtteknél
és a borderline személyiségzavarban szenvedőknél
egyértelműen megállapítható, hogy sokkal jobban ki vannak téve a folyamatos traumáknak.
A velük történteket nem teszik
kontextusba, nem veszik megfelelően górcső alá,
így az események
traumatizálóként
is
hathatnak rájuk.
Bizonyos esetekben
különösen veszélyes lehet,
ha a szülő nem képes a gyermeke

helyébe képzelni

magát.

Ezzel olyan magatartást válthat ki a gyermekben vagy a serdülőben,

amely

rendkívül agresszív viselkedésben nyilvánulhat meg.

Ez az agresszivitás és az azt követő magatartás

értelmezhető

részben

a mentalizáció

fogalmán keresztül.

Ha a szülőket folyamatosan irritálja

a gyermek viselkedése –

például, ha a gyermek

problémát

okoz

vagy rosszul viselkedik –,

akkor a szülő

negatív módon befolyásolhatja a gyermeket, ha azt mondja, hogy a gyermek buta, pszichésen beteg vagy értéktelen.

Ez azt a képet

alakítja ki a gyerekben,

hogy ő zavart,cselekvőképtelen és

nincs rendben.

Emiatt a hozzáállás miatt távol tartja magát másoktól.

Lehet, hogy amikor egy felnőtt közel szeretne kerülni a gyerekhez,

meg szeretné ismerni őt, azt szeretné, hogy a gyerek megbízzon benne,

a gyerek

agresszívan fog reagálni,

hogy távol tartsa magától a felnőttet

és ezzel együtt elkerülje a lehetséges traumák ismétlődését.

Ez előfordulhat olyan fiatalok körében, akiknek problémái vannak a

tanulással, osztályt kell ismételniük

és a tanárok

visszahúzó erőként

tekintenek rájuk,

ráadásul otthon a szüleik is

ráerősítenek erre a negatív képre.

Ezért ezek a gyerekek igen hevesen, haraggal reagálnak arra, ha egy felnőtt –

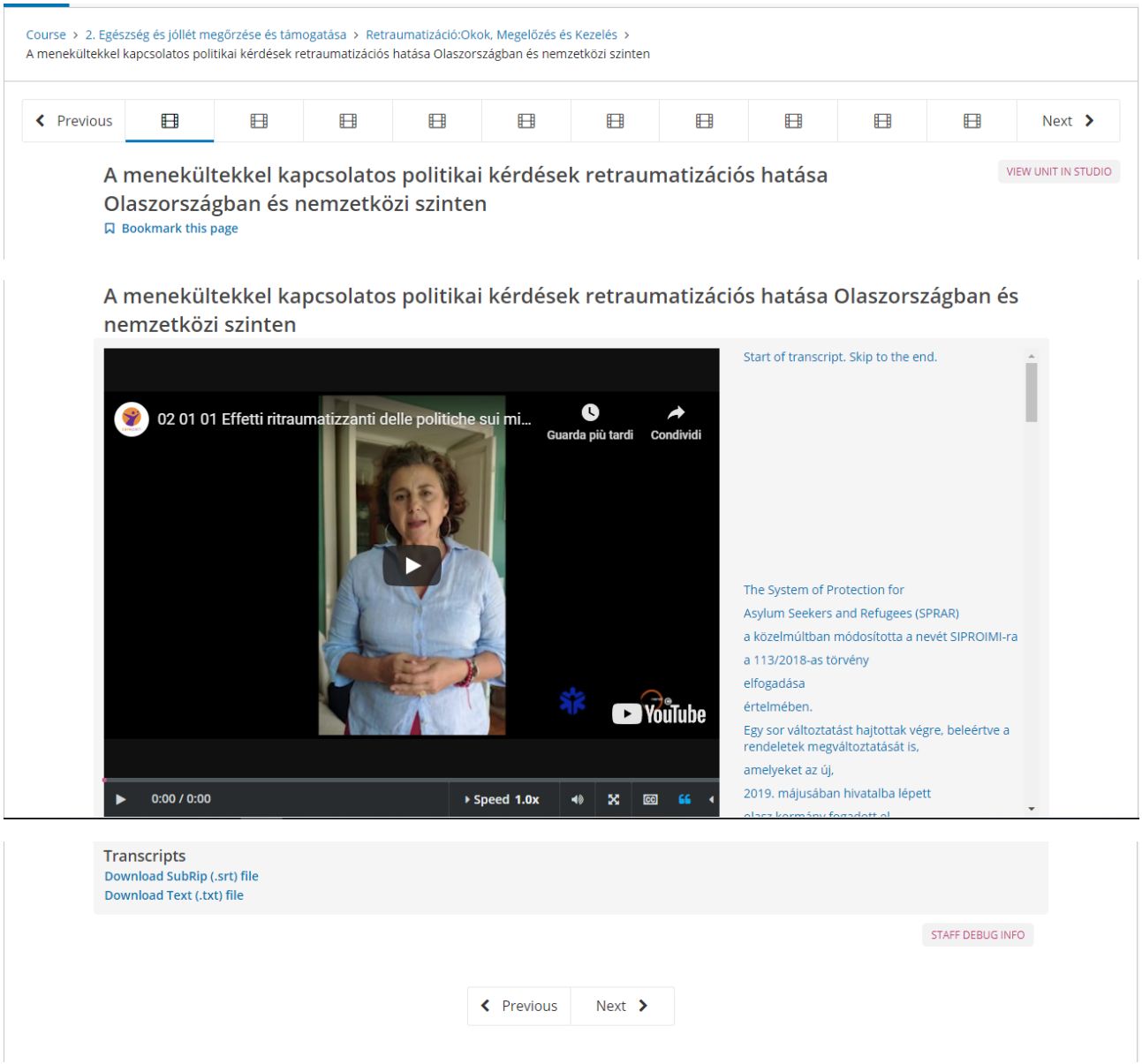
például egy nevelő vagy tanár -– segíteni akar nekik.

A céljuk,

hogy távol tartsák maguktól

a felnőttet és ne ismétlődjön meg

az a negatív tapasztalat, miszerint ők értéktelenek.



Transcript

The System of Protection for

Asylum Seekers and Refugees (SPRAR)

a közelmúltban módosította a nevét SIPROIMI-ra

a 113/2018-as törvény

elfogadása

értelmében.

Egy sor változtatást hajtottak végre, beleértve a rendeletek megváltoztatását is,

amelyeket az új,

2019. májusában hivatalba lépett

olasz kormány fogadott el

a bevándorlás, a menekültek jogai és a befogadás
kérdéseivel kapcsolatban.
A SPRAR-t 2002-ben hozta létre
a helyi önkormányzatok és hatóságok hálózata,
harmadik szektorbeli
és a nem kormányzati szervezetekkel együttműködve.
A SPRAR önkéntes alapon (saját belátása szerint)
intézi a menedékkérők és
menekültek befogadását és integrációját
célzó projekteket.
Az évek során a hálózat
progresszív és pozitív fejlődésen
ment keresztül:
a kezdeti 1500 befogadóhely
jelenleg 35 000-ra tehető.
A SPRAR történetében
több szakasz is volt,
amely jelentős számú változást hoztak magukkal.
Az első egy olyan törvényi
intézményesítés volt,
amely stabilabbá és szabályszerűbbé tette
az integrált befogadási központi rendszert
Olaszországban. Azt megelőzően
nem voltak strukturált
befogadói rendszerek,
csupán
sürgősségi intézkedések.
Egy másik fontos momentum
2003-ban volt, amikor az
úgynevezett észak-afrikai szükséghelyzet során
a SPRAR modell hatékonysága
és eredményessége

kiemelkedett a
társadalmi integráció és az integráció célkitűzéseinek
elérése szempontjából,
európai szinten is.
Az utolsó szakasz a legfrissebb,
amely során a SPRAR profilját is
módosítani kellett. E szerint
a menedékkérőket
többé
már nem lehet befogadni,
mert megszüntették a humanitárius
védelem intézményét.
A törvény szerint csak a
kísérő nélküli külföldi kiskorúakat,
a nemzetközi védelem alatt állókat
(akiknek száma a menedékjogi kérelmezőkéhez
viszonyítva igen kevés) és néhány
új típusú tartózkodási engedéllyel
rendelkezőket fogadhatnak be.
A SPRAR,
jelenlegi nevén SIPROIMI
speciális gyógykezeléseket nyújt,
az emberkereskedelem,
munkaerő-kizsákmányolás,
családon belüli erőszak és természeti katasztrófák áldozatainak,
valamint azoknak,
akik kitűntek valamilyen hőstettel.
Főleg a külföldieket segítik,
nem az olaszokat,
hiszen nekik saját társadalmi védőhálójuk van.
Elmondható, hogy a SPRAR
jelenlegi célja

a külföldiek jólétének biztosítása,
és nem a menedékkérők
befogadása
és a védelmezése.
A szervezet profiljában
bekövetkező ezen változások
pozitív képet tükröznek,
hiszen fő motivációjuk
az elesettek
védelme.
Jelenleg a legnagyobb nehézséget az okozza,
hogy a rászorulóknak
tartózkodási engedéllyel kell rendelkezniük,
ám ez akkor nem szükséges,
ha valaki
embercsempészet áldozata. Ebben az esetben automatikusan
megkapja az engedélyt. Ugyanez a helyzet
a kizsákmányolás áldozataival is.
Nincs pontos kritérium,
hogy az eljárásoknak miként kellene zajlaniuk,
vagy hogyan lehetne 96 00:04:02,389 --> 00:04:09,200 ezekre az áldozatokra,
akár jogilag is, 98 00:04:09,200 --> 00:04:13,920 „speciális esetként” tekinteni.A rászorulók
csak egy különleges tartózkodási
engedély megkapása után
férhetnek hozzá a SPRAR-hoz
és vehetik igénybe a szervezett nyújtotta
szolgáltatásokat.
Még nem
határozták meg
azokat a kritériumokat és feltételeket,
amelyek alapján egy személy
jogosult lehet

egészségügyi ellátásra:

mikor, milyen szellemi vagy fizikai

probléma és milyen súlyossági szint

esetén láthatnak el valakit.

Ezért a szervezet

egy igen kritikus, átmeneti időszakot él át,

mivel sokak,

akik pár hónappal ezelőtt

részvételi jogosultsággal rendelkeztek a SPRAR projektekben,

mára elvesztették azt.

Másrészről,

azok, akik

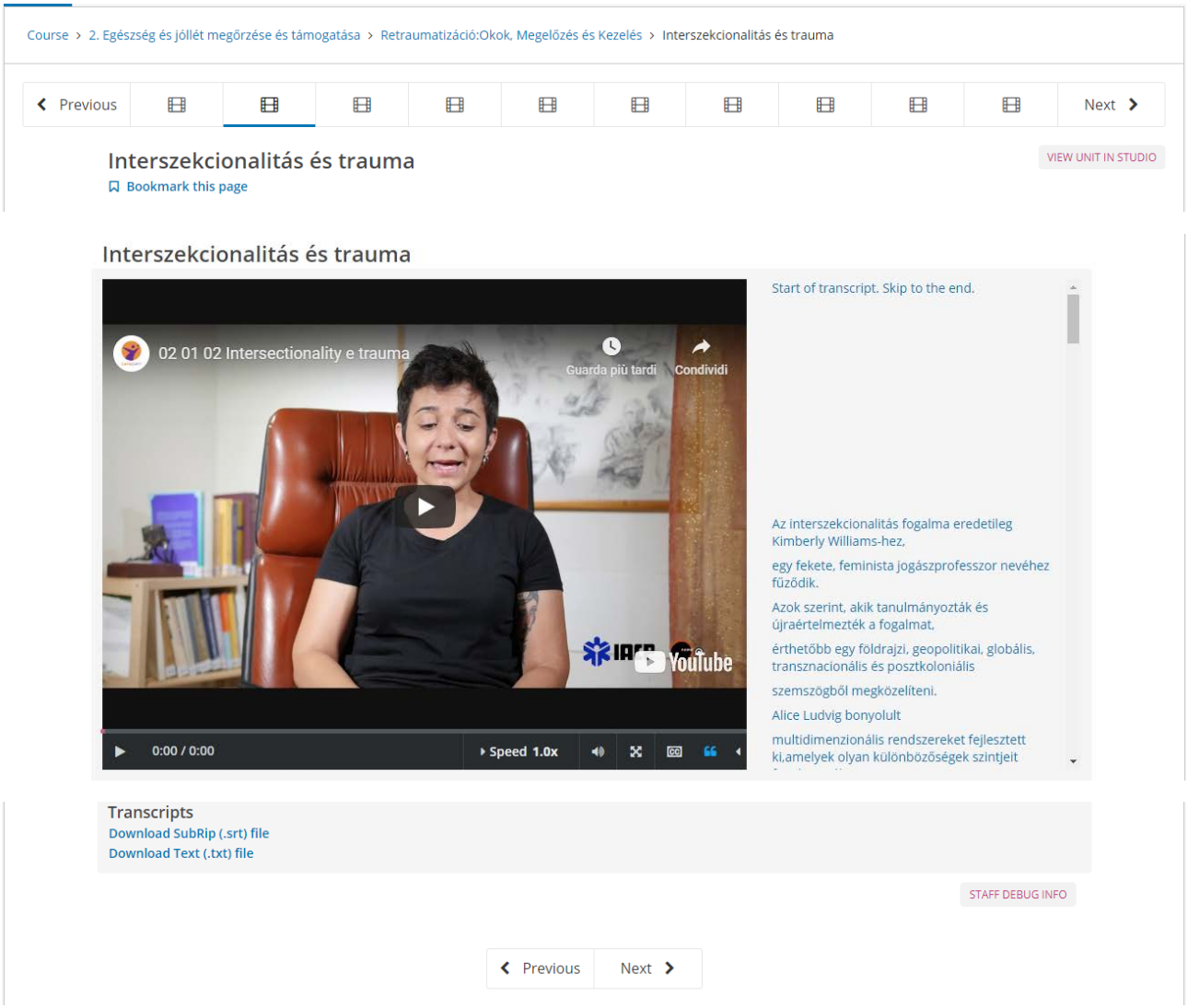
jogosultak lennének a szolgáltatás használatára,

valójában nem tudják

miként nyújtsanak „megfelelő bizonyítékokat”,

hogy megkaphassák

a szolgáltatás igénybevételének jogát.



Transcript

Az interszekcionalitás fogalma eredetileg Kimberly Williams-hez,

egy fekete, feminista jogászprofesszor nevéhez fűződik.

Azok szerint, akik tanulmányozták és újraértelmezték a fogalmat,

érthetőbb egy földrajzi, geopolitikai, globális, transznacionális és posztkoloniális

szemszögből megközelíteni.

Alice Ludvig bonyolult

multidimenzionális rendszereket fejlesztett ki,amelyek olyan különbözőségek szintjeit fogalmazzák meg,

mint a nem, szexualitás, faj, bőrszín, etnikai hovatartozás, státusz, osztály, kultúra stb.

Ezzel azt a számtalan szintet mérjük,

amelyet figyelembe kell vennünk és amelyre ügyelnünk kell, ha segítő kapcsolatban

állunk olyan személyekkel, akik kisebbségekhez tartoznak.

Audre Lorde-t idézve

we could say that there is no struggle to do azt mondhatjuk, hogy nincs olyan, hogy egyetlen problémával kűzdünk,

With one problem, because we don' lives made of one dimension mivel az életünk sem egyetlen dimenzióbol áll"

Az Egyesült Nemzetek Szövetségének

és az Európai Uniónak hála,

az esélyegyenlőségi politika alakulásának egyre fontosabb eleme a nemzetköziség.

Gondoljunk csak a megkülönböztetés elleni küzdelemre irányuló irányelvekre,

az összes nemzeti, regionális és helyi szintű kezdeményezésre,

politikára és diverzitás-menedzsmentre,

amelyet minden nyugati ország

és számos vállalat is

magáévá tett már.

Ez természetesen nem jelenti azt, hogy megszűnt a bizonytalanság és a szenvedés azok számára,

akik egyszerre több kisebbséghez is tartoznak,

és akik ebből fakadóan traumatikus helyzeteket élnek át.

2018. május 17-én a „napilapban" megjelent

egy kameruni fiú mondata:

„egyik nap a konyhában voltunk, és egy LMBTQI bevándorlókról szóló TV-műsort néztük,

mire az afrikai barátaim azt mondták,

hogy Olaszország egy szar ország, teli homoszexuálisokkal.

Újból azt éreztem, hogy nem vagyok szabad."

Allen 22 éves, aki elmenekült azok elől, akik megverték és démonnak nevezték,

így hátrahagyva Kamerunt -

ahol bűnnek számít homoszexuálisnak lenni

írja az újság -,

hogy nemzetközi védelmet kérjen Olaszországban.

Ugyanakkor nem tűnt el a félelme,

mert a homofóbia egészen a Bolognában található Mattea utcáig követte őt,

ahol honfitársaival együtt szállást kaptak.

Az LMBTQI migránsok gyakran nagyon fiatalok.

Nem számíthatnak

a származási országukban lévő közösség támogatására,

így kivándorlásra kényszerülnek,

de a homofóbia és transzfóbia, ami elől menekültek, gyakran kulturális szempontól is megkülönbözteti őket.

Abban sem lehetnek biztosak, hogy olyan multikulturális világgal találkoznak,

amely megengedi nekik, hogy békében megélhessék szexuális orientációjukat vagy nemi identitásukat.

Vincenzo Bramato, a bolognai Arcigay közösség elnöke

már számos interjúban hangsúlyozta,

hogy néhány európai országban, pl. Németországban,

olyan védett intézmények fogadják azokat,akiket üldöznek a szexuális orientációjuk miatt és emiatt menekülésre kényszerülnek,

ahol a dolgozók speciális képzést kapnak.

A képzés során megtanulják, hogyan kerüljék az ítélkező viselkedést,amely újraélesztené ezekben az emberekben a

stigmatizációt és a traumát.

Jelenleg Olaszországban nem írja elő a menekülteket fogadó rendszer az ehhez hasonló képzéseket,

azonban van néhány pozitív példa,

ilyen például a 2017-ben indított modenai teszt program,

amely keretében kizárólag LMBTQI menedékkérőknek biztosítottak egy 6 fős apartmant,

és ilyen az LMBTQI bevándorlási segélyszolgálat Veronában.

Ezeknek a menekülésre kényszerült,

fejlődésben lévő gyermekeknek,

akik tagjai

az LMBTQI közösségnek,

a probléma csak egy szeletét képezi az,

hogy ők egy etnikai kisebbséghez tartoznak egy befogadó országban.

Sono infatti, molto spesso una minoranza silenzio e spaventata, Ők nagyon gyakran származási országukban is egy néma és

megfélemlített kisebbségnek számítanak.

Ahogy Rogers fogalmaz,

ez a dupla láthatatlan trauma.

A kisebbségi stressz miatt – Vittorio Lingiardira hivatkozva –

dupla akkora

kockázatnak van kitéve ezek az embereknek a mentális és fizikai egészségüket tekintve.

Megvan annak a kockázata, hogy értékes embereket veszítünk el személyükben.

A befogadással kapcsolatos oktatásba

elsősorban

az emberi jogi oktatás

és az LMBTQI menekülteknek a segítő kapcsolat keretében biztosított speciális bánásmód tartozik.

Az oktatásnak emberközpontúnak kell lennie,

üdvözölnie kell az egyes emberek sajátosságokait, és tisztában kell lenni velük ahhoz, hogy valóban befogadók lehessenek.

A migránsokat célzó szolgáltatások,

amelyeket gyakran a

különböző szexuális orientációk és nemi identitások figyelembevétele nélkül alakítanak ki,

nem lesznek kellőképpen hatásosak

a kliens és segítő kapcsolatát tekintve.

(ez a fajta többlettudás nélkül nem részesülnek

megfelelő fogadtatásban ezek a gyerekek),

Ugyanez a helyzet az oktatás és megelőzés terén is

(például ha a szexuális úton terjedő betegségekről beszélünk,

akkor

szükséges a többszempontú megközelítés,

ha klienseink között vannak olyanok, akik egyben az LMBTQI közösség tagjai).

Másrészről, az LMBT közösség által kínált szolgáltatások

erősen kapcsolódnak a nyugati meleg férfiak és leszbikus nők kulturális modelljéhez,

és ezek a modellek nem feltétlenül olyanok,

amellyel ezek, a más kultúrából érkező fiatalok teljes mértékben

azonosulni tudnak.

A korábban említett valóságok megélése

bebizonyította, hogy az intézmények vagy akár

nonprofit szervezetek által kínált támogató tájékoztatási és tanácsadói szolgáltatások

nem igazán hatékonyak ezek a gyerekek esetében.

Ezért

szükséges a segítő kapcsolatok gyakorlatára

interdiszciplinárisan reflektálni,

főleg, ha olyan emberekkel dolgozunk, akik egyszerre több kisebbség tagjai. A segítő kapcsolatokról szóló oktatási anyagnak

tartalmaznia kell a homoszexualitás, biszexualitás és transzszexualitás különböző formáit

a pszichiátria és pszichológia fogalomtárát is felhasználva.

Szót kell ejteni a stigma,

homofóbia, internalizált homofóbia fogalmakról,

ugyanakkor folyamatosan tájékoztatni kell a szolgáltatókat

az ehhez kapcsolódó

jogszabályokról,

a fogadó országban és a kliensek származási országában egyaránt.

Emellett el kell mélyíteni

a menedék kérelemmel kapcsolatos

jogszabályi tudást,

mert az folyamatosan

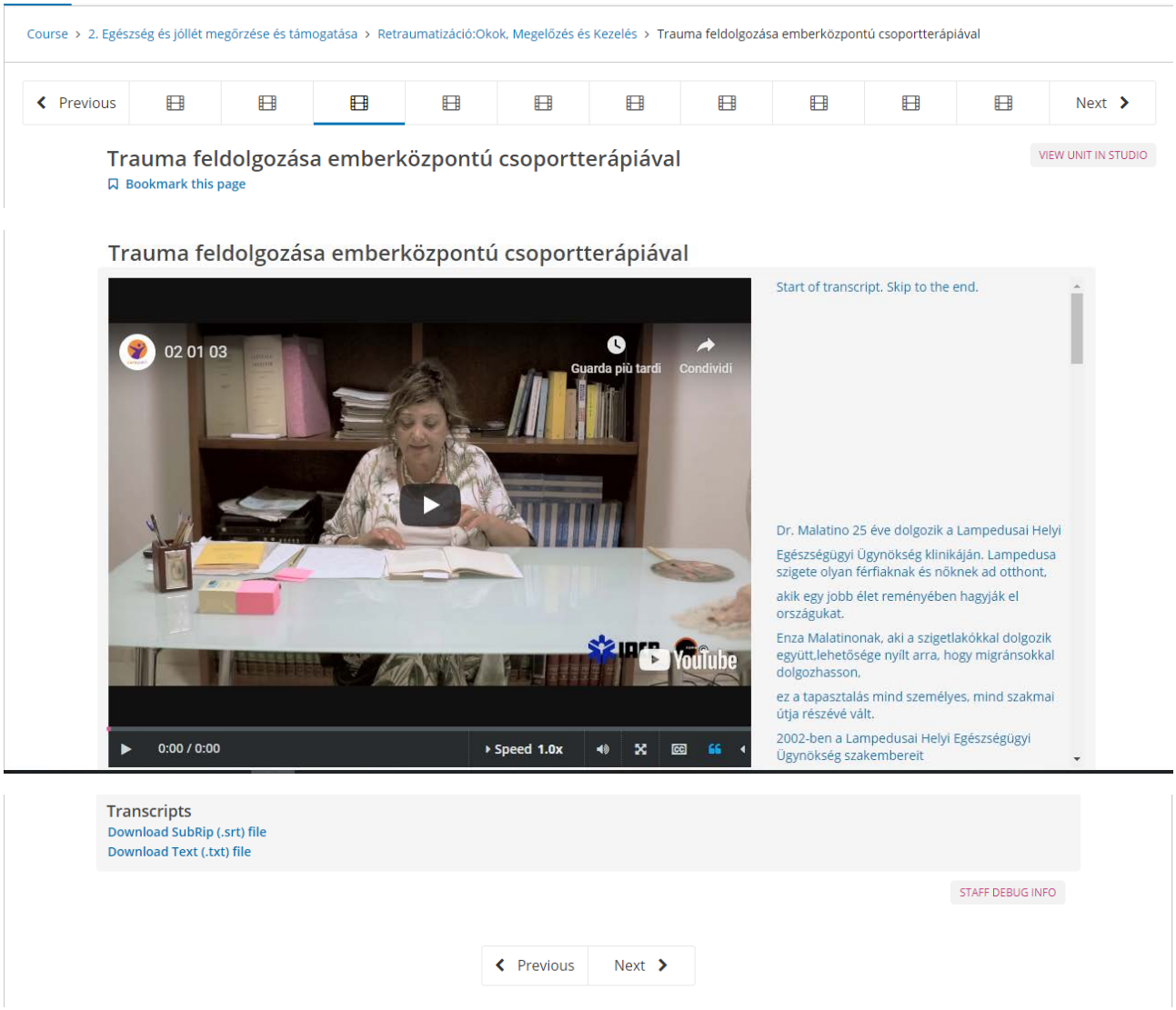
változik.

A gyakorlati képességek mellett fontos fejleszteni és beépíteni egy nemi szempontból érzékeny megközelítést

egy személyesebb szemszögből is,

és reflektálni az emberi jogokra, saját magunkban illetve a munkacsoporton belül is,

amely a szolgáltatást nyújtja a fiataloknak.



Transcript

Dr. Malatino 25 éve dolgozik a Lampedusai Helyi

Egészségügyi Ügynökség klinikáján. Lampedusa szigete olyan férfiaknak és nőknek ad otthont,

akik egy jobb élet reményében hagyják el országukat.

Enza Malatinonak, aki a szigetlakókkal dolgozik együtt,lehetősége nyílt arra, hogy migránsokkal dolgozhasson,

ez a tapasztalás mind személyes, mind szakmai útja részévé vált.

2002-ben a Lampedusai Helyi Egészségügyi Ügynökség szakembereit

arra kérték, hogy biztosítsanak támogató szolgáltatásokat és terápiás lehetőséget befogadóközpontokban, ahol olyan embereknek van szüksége kezelésre, akik nagyon nehéz

és hosszú út után kötöttek ki a szigeten, és akik közül voltak olyanok, akik halálos veszélynek is ki voltak kitéve.

A helyi egészségügyi ügynökség arra kért fel, hogy adjak pszichiátriai szakvéleményt azokról az emberekről, akik a szigeten kötöttek ki.

Szinte lehetetlen volt megállapítani azoknak a klienseknek a pszichiátriai egészségügyi állapotát,

akiket ennyire súlyos traumák értek. Mivel más kultúrkörből érkeztek,

nem kértek farmakológiai segítséget vagy támogatást, hiszen olyan kontextusból jöttek,

ahol a nyugati orvoslás számukra nem számított konvencionálisnak.

Ehelyett a saját kultúrájukon alapuló

bizonyos esetekben mágikus rituálék segítették és támogatták az klienseket.

Rendkívül összetett feladatnak bizonyult a rengeteg szenvedést átélt klienseknek segítséget és támogatást nyújtani.

Ezért döntöttem úgy, hogy olyan csoportokat szervezek,ahol meghallgathatják egymást.

Ez nekem, mint pszichiáterként és pszichoterapeutaként végzett szakembernek, aki a Carl Rogers emberközpontú megközelítést tanulta, rendkívüli élmény volt.

Ezeken a csoportterápiákon

az emberek körben ülnek,

és meghallgatják egymást. Az alapelv az ítélkezés teljes mellőzése

és a mély tisztelet bármely téma iránt, amit a csoport meg kíván vitatni.

Így lehetővé válik egy olyan bizalmi légkör megteremtése, amely nagyban segíti a résztvevőket,

még rendkívül problematikus érzelmi állapotban is, hogy újra feldolgozhassák az élményt,

és egyben szolidaritásra leljenek a többi résztvevőben.

nem feltétlenül egyéni élmény az, ha valaki tisztába kerül saját személyes tapasztalataival, de, ha másokkal is megoszthatja, az közös élménnyé válik.

Már ez önmagában néha elhozza a szenvedés,

a konfliktus vagy a fájdalmas esemény feloldását.

Ez történt ezekben a csoportokban is. Fontos és alapvető eleme volt a csoportos terápiának, hogy megtalálják a közös hangot a kulturális mediátorral

- a tolmáccsal - mivel a facilitátor nem beszélte a résztvevők nyelvét, és a körülmények,

amelyek között dolgoznia kellett, rendkívül korlátozottak voltak. Többek között azért, mert nem álltak rendelkezésükre

eszközök (székek), vagy az aktuális helyzet miatt (néhány csoport nem sokkal azelőtt élt túl egy hajótörést,

néhányan pedig csak pokrócban voltak).

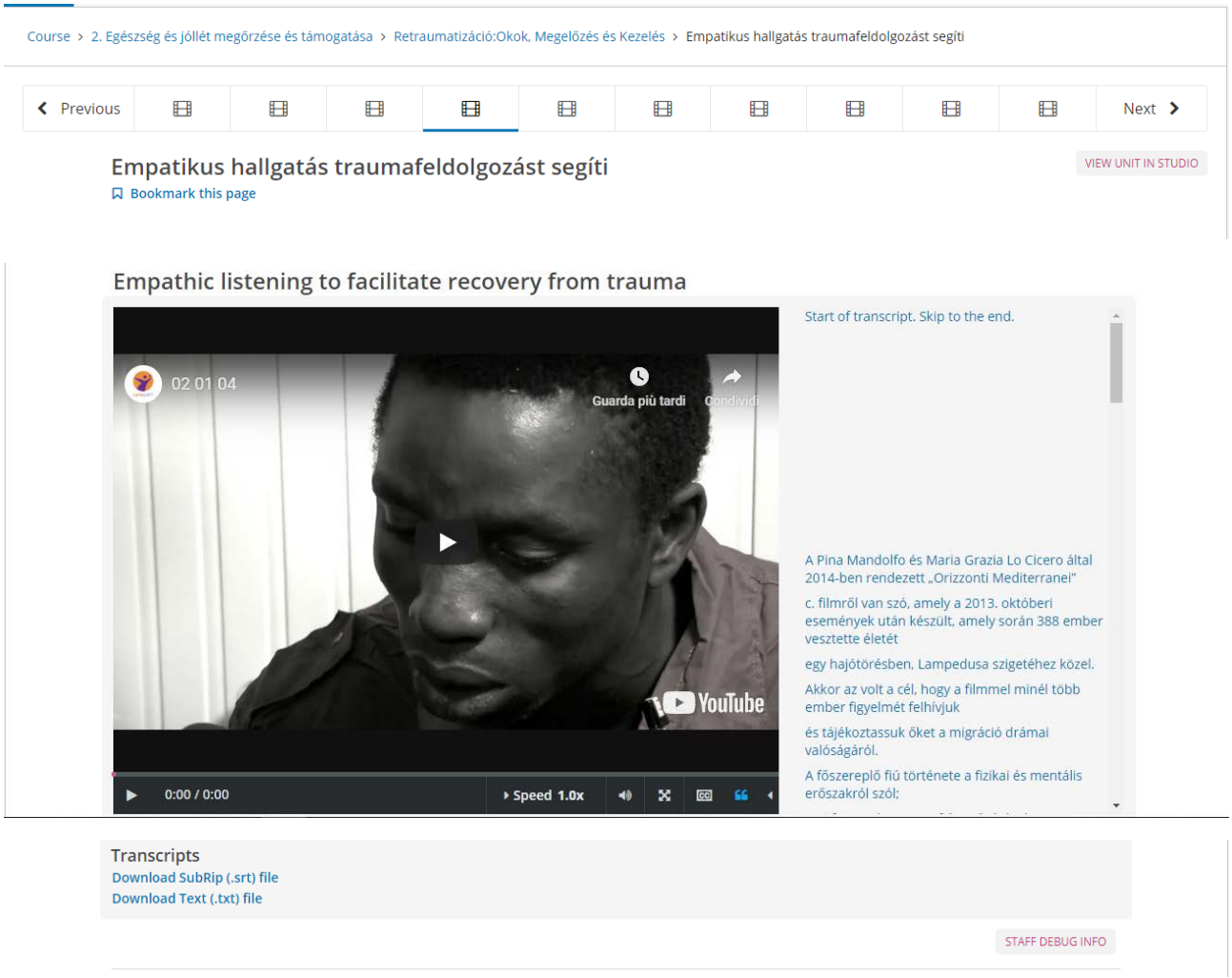
A szokatlan helyzet ellenére meglepetten tapasztaltam,

hogy a mély értékek nem a külsőségekben, hanem a tartalomban rejtőznek.

Amikor olyan emberekkel dolgozunk, akik megosztják történeteiket

hosszú és borzalmas útjaikról (átkelés a líbiai sivatagon, vállalni a fulladás kockázatát), a megosztott élmények

azon szakemberek számára is rendkívül traumatikusak, akik meghallgatják őket.
Számukra az okoz nehézséget, hogy hogyan tudnak kikerülni ezekből, a gondolatban megélt helyzetekből,
miután napi szinten hallgatták a nehézségekről és szenvedésről szóló beszámolókat.
Nekem pl. felszínre jött egy elfeledett gyermekkori élményem,
amikor az egyik nagynéném meghalt, és annyira fájdalmas volt a veszteség, hogy kitöröltem az élményt.
Mindezek fényében, amikor befogadunk valakit,
aki ehhez hasonló traumát élt át, létfontosságú az empatikus hallgatás felajánlása,
hogy felkínáljuk a lehetőségét annak, hogy megnyíljanak a túlélők
és megosszák élményeiket. Továbbá fontos, hogy mély elfogadással legyünk
a személy iránt és ne ítélkezzünk, mert ezáltal tudunk feléjük bizalmat kiépíteni.
Az empátia pedig a lélek balzsamja, az az érzés, amikor egy másik ember
megpróbál belehelyezkedni a helyzetünkbe, meghallgat minket és megpróbálja átérezni a fájdalmunkat.
Carl Rogers kutatása szerint ez a három alapállapot szükséges ahhoz,
hogy változást érjünk el segítő kapcsolatokban és csoportterápiában is.
A migránsok traumafeldolgozására irányuló Rogers-i csoportterápiának értékét szemléltetheti az a tény,
hogy senki sem kért gyógyszeres támogatást, miután részt vett az egymást meghallgatására
épülő csoportos foglalkozásokon.
Értékelték a csoport természetességét, a kerek formát.
A köralakúság talán egy kicsit reprodukálta azt az élményt, amit a kliensek saját országukban tapasztaltak,
például Eritreában, ahol az idős falubéliek
és férfiak összegyűlnek egy körben egy hatalmas fa körül,
amit ők a szavak fájának neveznek. Ennél a találkozásnál állítják újra helyre szavakkal
a félbeszakadt történeteket.



Transcript

A Pina Mandolfo és Maria Grazia Lo Cicero által 2014-ben rendezett „Orizzonti Mediterranei”

c. filmről van szó, amely a 2013. októberi események után készült, amely során 388 ember vesztette életét

egy hajótörésben, Lampedusa szigetéhez közel.

Akkor az volt a cél, hogy a filmmel minél több ember figyelmét felhívjuk

és tájékoztassuk őket a migráció drámai valóságáról.

A főszereplő fiú története a fizikai és mentális erőszakról szól;

ami fontos, hogy ez a fiú a nővérével együtt érkezett,

aki szintén erőszak és nemi erőszak áldozata lett - de ezt az öccsének sosem mondta el...

Ahogy a fiú is átesett nemi erőszakon, de sosem mondta el a

nővérének.

Neki nagyon szégyenteli volt erről az élményről beszélni, annyira, hogy

amikor erről beszélt, azt kérte, hogy a nővére ne legyen jelen, mert nem akarta, hogy

megtudja, mi történt vele. Ezt később mondta el nekünk. Szégyenkezett, hogy férfi létére

ilyen erőszak áldozata lett.

Azt fontos tudni, hogy egy 16 éves fiúról van szó.

A történetében megtudjuk, hogy mi történt vele, és hogy

hogyan tudjuk őt hagyni szabadon megosztani, az érzelmei áramlásának megszakítása nélkül

és nem beleszólni az ő narratívájába.

Néhány apró gesztus, bólintás, vagy

mély pillantás elég volt neki ahhoz,

hogy meg tudja osztani a történetét.

Ezáltal azt figyeltük meg, hogy az empátia inkább szituációs mint verbális,

pl. szemkontaktus, bólintások, testünkkel a fiú felé fordulás formájában

tudta őt segíteni.

Ez fontos volt abban, hogy segítsük a megosztását,

érintés nélkül; számára a testi kontaktus a szégyen forrása volt, olyan volt, mint egy gyerek.

Ugyan ő volt a két testvér közül a fiatalabb,

úgy érezte, hogy neki kéne a férfinak lennie, az erős félnek, aki támaszt és bátorítást nyújt a nővére számára.

Jól megfigyelhető, hogy az érzékenység, a tiszteletteli hozzáállás, az empátia és a meghallgatás

hogyan segíti a megosztást a segítő kapcsolatban.

A videóban két történet meghallgatásának

az élménye szerepe: az egyik egy lányról szól, a másik

két fivérről.

A két fivér Eritreából indult el

és 2014-ben érkezett Lampedusa-ra, ahol Mineo-ba kerültek a CARA

központba. Ott maradtak, hogy letelepedési engedélyt kapjanak,

és amikor megpróbáltuk meginterjúvolni őket a célból, hogy dokumentálhassuk

a történeteiket és élményeiket, rá kellett jönnünk, hogy az ilyen típusú történeteket

figyelmes hallgatással, óvatos, érzékeny figyelemmel lehet csak megközelíteni,

mert ez két fiú kínzást és szörnyű, drámai erőszakot szenvedett el.

Mindketten azt kérték, hogy a másik ne legyen jelen, amikor elmondja, mi történt vele.

A lány azért akart útnak indulni, hogy az öccsét ne kényszerítsék

16 évesen katonai szolgálatra.

A narratívájának van egy alapvető, visszatérő központi eleme: „Nem tudom elfelejteni,

De nem találom az erőt ahhoz, hogy elmondjam”. Ezek kulcsszavak voltak. A meghallgatást nála a segítő finom kontaktussal, kézfogással kísérte.

Ilyen élmények esetén a fizikai kontaktus használata összetett kérdés, általában nem javasolt fizikai és nemi erőszak áldozatai esetén, de ebben a konkrét helyzetben valahogy ráéreztem, hogy a lánynak mély megtartásra volt szüksége ahhoz, hogy elmondja a történetét. Ezért a szakember megkérdezte, hogy megfoghatja-e finoman a kezét. Az érintés előtt a kérdés létrehozta a lehetőségét annak, hogy a lány megengedje.

Az ilyen kontaktussal egy erős energiacsatornát hoztunk létre, és minden olyan részletnél, ami kifejezetten traumatikus és fájdalmas volt, a lány általában megállt, hogy a szakember megfogja a kezét, és az érzései tovább áramolhassanak.

Az érintés energiát adott neki ahhoz, hogy folytassa a történetét.

Egy ilyen tapasztalat után az ember rádöbben, hogy mennyire erőteljes dolog az, ha valakit, aki traumát szenvedett el, meghallgatunk; ennek a jelentőségét nem lehet túlbecsüli, és nem szabad trivializálni.

Ez a legfontosabb: meghallgatni a történetet úgy, ahogyan azt elmondják.

Nagy fokú érzékenységgel, és mindenek felett a másik szenvedése iránti empátiával, annak elismerésével.

Ez volt az az alapvető tényező, amely lehetővé tette az ilyen mélységű érzelmi megnyílást és az ilyen típusú történetek megosztását.

Supporting material

Mediterranean Horizon Film:

https://www.youtube.com/watch?v=WI-6aHKku5c

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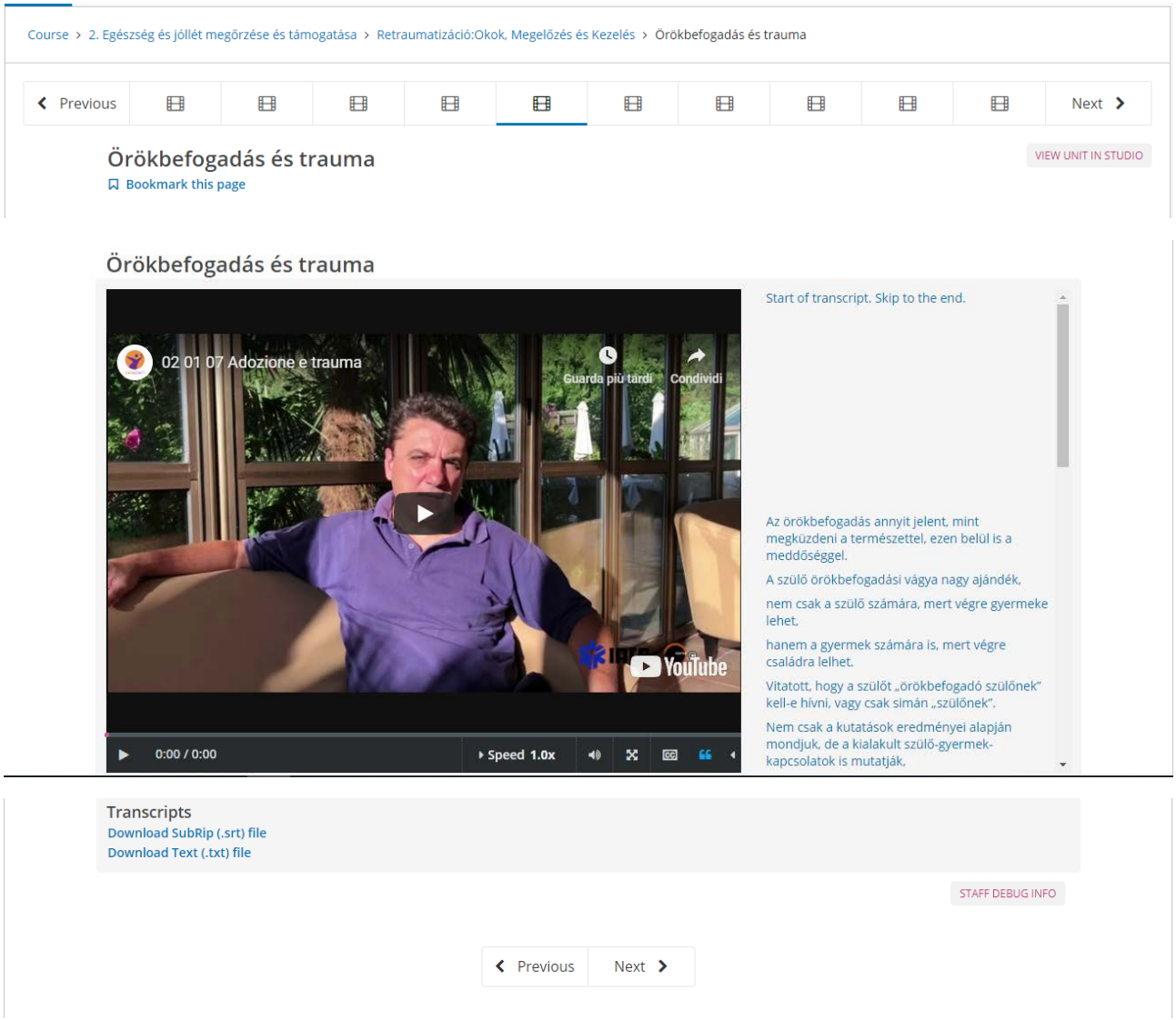


Transcript

Az örökbefogadás annyit jelent, mint megküzdeni a természettel, ezen belül is a meddőséggel.

A szülő örökbefogadási vágya nagy ajándék,

nem csak a szülő számára, mert végre gyermeke lehet,

hanem a gyermek számára is, mert végre családra lelhet.

Vitatott, hogy a szülőt „örökbefogadó szülőnek" kell-e hívni, vagy csak simán „szülőnek".

Nem csak a kutatások eredményei alapján mondjuk, de a kialakult szülő-gyermek-kapcsolatok is mutatják,

hogy teljes értékű szülők az örökbefogadó szülők is, és semmivel sem kevesebbek,

mint a biológiai szülők.

Rengeteg átfedés van az örökbefogadott gyermek és a biológiai gyermek között.

Az örökbefogadó szülőnek mindig meglepő, ha apának szólítják,

míg a biológiai szülőnél ez adott.

Ez azt is jelentheti, hogy örökbefogadó szülőnek lenni intenzívebb élmény,

mint biológiai szülőnek lenni.

Mindenesetre arra kell figyelnie a szülőnek,

hogy az örökbefogadott gyermeknek joga van a boldogsághoz,

és hogy ehhez figyelembe kell vennie a gyermek történetét. Amit nem ismerhetünk mindig,

mert senki sem mondta el nekünk, a gyermek pedig nem emlékszik rá.

Érzékenyen kell megközelíteni a problémákat,

amelyeket a gyermek magával hozhatott.

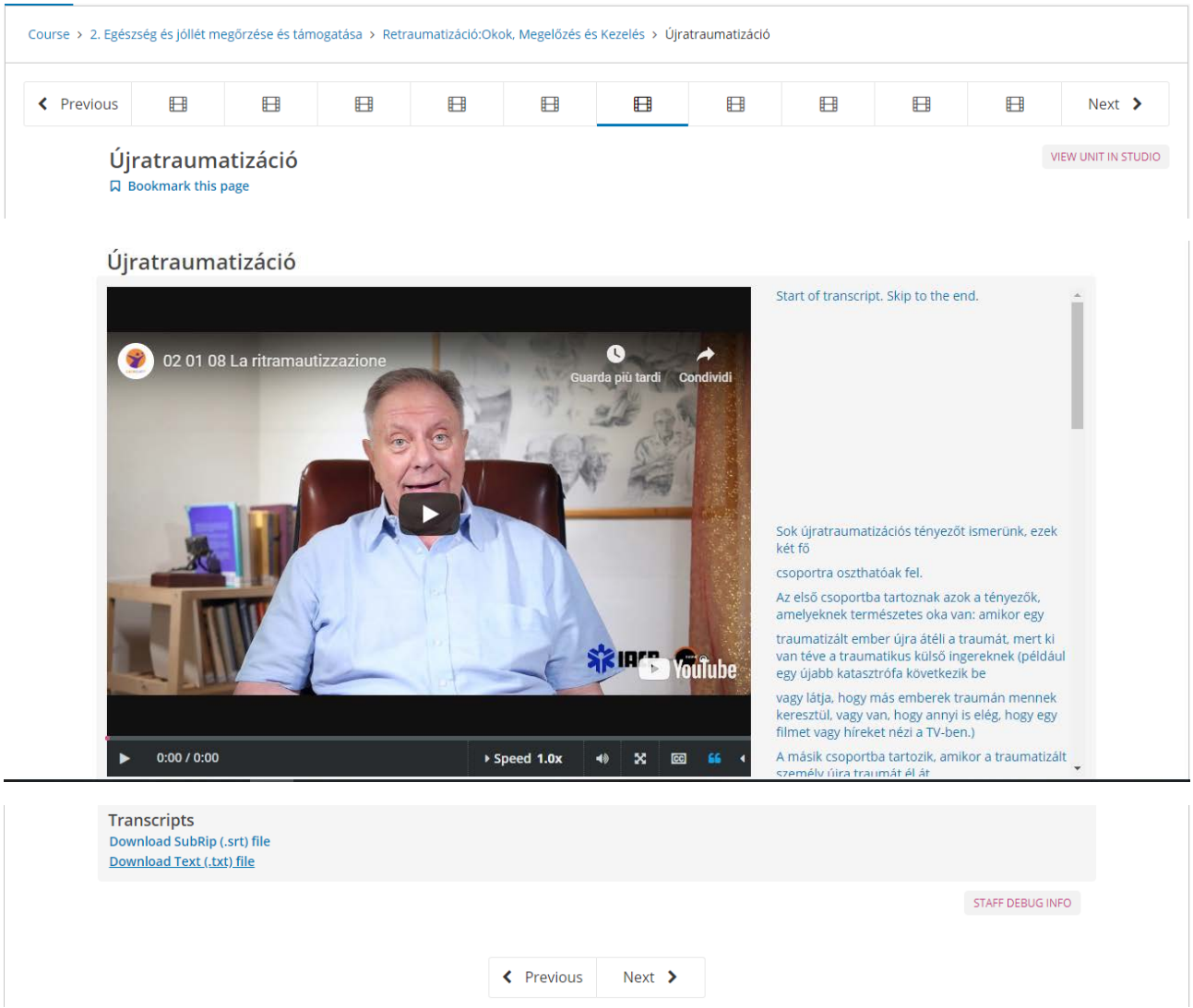
Az örökbefogadott gyermek gyerekkorában és felnőttként is gyakran szembesül a léte körüli kérdésekkel:

mik a gyökereim?

Miért hagytak el?

Ezek olyan kérdések, amelyeket senki sem tud megválaszolni, azonban nem zárják ki azt, hogy az élet szép,

és küzdenünk kell a jobb életért.



Transcript

Sok újratraumatizációs tényezőt ismerünk, ezek két fő

csoportra oszthatóak fel.

Az első csoportba tartoznak azok a tényezők, amelyeknek természetes oka van: amikor egy

traumatizált ember újra átéli a traumát, mert ki van téve a traumatikus külső ingereknek (például egy újabb katasztrófa következik be

vagy látja, hogy más emberek traumán mennek keresztül, vagy van, hogy annyi is elég, hogy egy filmet vagy híreket nézi a TV-ben.)

A másik csoportba tartozik, amikor a traumatizált személy újra traumát él át,

mert a szolgáltatást vagy ellátást tapasztalatlan személy

vagy nem traumákra szakosodott szervezet végzi, és akaratlanul is 9 00:01:19,020 --> 00:01:22,620 újratraumatizálja a hozzá fordulót.

Azokat a biztosítékokat és folyamatokat, amelyeket az szervezők, szakemberek

vagy egy intézmény elfogadnak annak érdekében, hogy megakadályozzák klienseik újraumatizációját, trauma tudatos ellátásnak nevezzük.

A múltban sajnos, nem rosszindulatból, hanem tudatlanságból, túl gyakran újratraumatizálódtak azok,

akik korábban már elszenvedtek traumát.

A kutatásoknak és klinikai bizonyítékoknak köszönhetően megfigyeltük,

hogy a kliensek tudtuk nélkül jatrogén sérülést szenvedtek el, amikor

olyasmire kényszerítették őket, amit nem akartak megtenni; ha nem tartották tiszteletben azt,

ha még nem álltak készen valamire, vagy sürgették őket; vagy kényszerítették, hogy traumatikus élményeket idézzenek fel, természetesen jó cél érdekében.

A trauma tudatos ellátás definíciója alatt azt, a kutatás során kialakított biztonsági hálót, illetve

mindazokat az óvintézkedéseket értjük,amik rávilágítottak arra, hogy mennyire fontos

a traumatizált embereket újabb traumáktól megvédeni.

A trauma tudatos ellátás alapja, hogy tiszteljük a kliensek tempóját, hogy emberközpontú szolgáltatásokat kínáljunk,

tiszteletben tartsuk a szükségleteiket és érzékenységüket, és mindenekfelett ne kényszerítsük őket olyasmire,

amire nem állnak még készen.

Ennek oka nagyon egyszerű: megfigyeltük, hogy a már traumatizált személyeknek elfogadásra,

kedvességre és biztonságos menedékre van szükségük, ahol újra erőre kaphatnak,

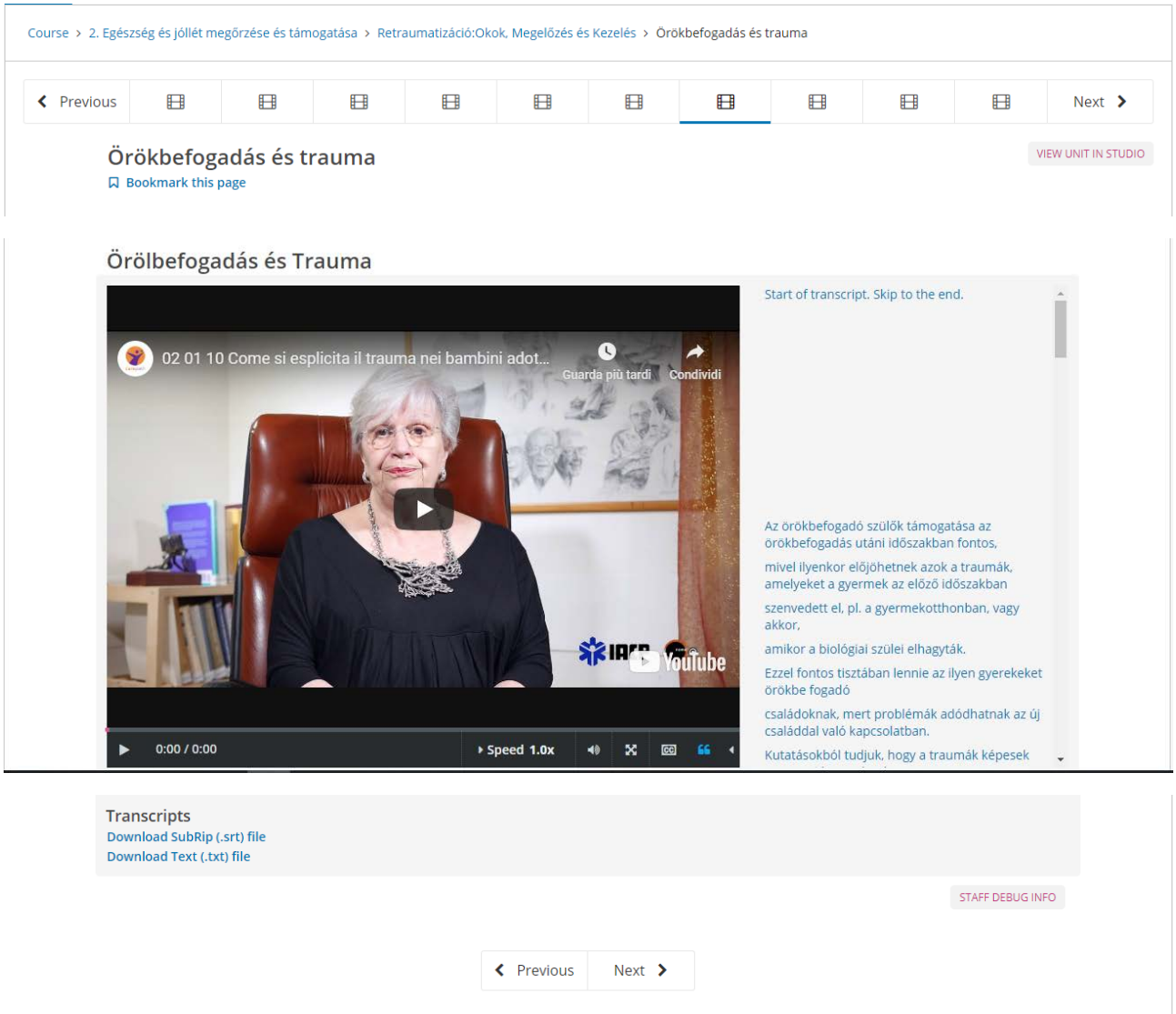
hogy saját ritmusukban tudják folytatni a felfedezést, és pontosan azért, mert traumatizáltak, 27 00:03:42,019 --> 00:03:44,620 körültekintőnek kell lennünk.

A jó ellátás érdekében

fontos bíznunk

a traumatúlélők

önszabályozási képességében.



Transcript

Az örökbefogadó szülők támogatása az örökbefogadás utáni időszakban fontos,

mivel ilyenkor előjöhetnek azok a traumák, amelyeket a gyermek az előző időszakban

szenvedett el, pl. a gyermekotthonban, vagy akkor,

amikor a biológiai szülei elhagyták.

Ezzel fontos tisztában lennie az ilyen gyerekeket örökbe fogadó

családoknak, mert problémák adódhatnak az új családdal való kapcsolatban.

Kutatásokból tudjuk, hogy a traumák képesek megtörni kapcsolatokat,

problémássá és nehézzé tenni őket; ez alól a gyerekek sem kivételek.

Ha az örökbefogadó szülők tisztában vannak azokkal a nehézségekkel, amiken a gyermek

az új családban keresztülmegy, az megkönnyítheti a dolgukat -

vagy legalább tisztábban láthatják, mi történik.

Az interakciókban - amikből a kapcsolat felépül - a gyermek

nehezen kezelhetővé válhat, zavaros, nem egyértelmű jeleket adhatnak, úgy tűnhet, hogy nem érdeklődnek,

vagy nincsenek jelen.

Az összes ilyen tényezőt pontról pontra át kell venni, ez

hozzátartozik minden örökbefogadás történetéhez.

Tudjuk azt is, szintén kutatásokból, hogy minden interakciós

esemény kisebb mikroeseményekből áll, amiket ha részletesen elemzünk,

látható, hogy hatással vannak a felnőtt-gyerek és gyerek-felnőtt válaszokra.

Ilyenkor a videók használata nagyon hasznos lehet. Az ilyen helyzetekben,

amelyekben a trauma olyan körülményeket hozott létre, amelyek megnehezítik az interakciók mikortényezőinek „leolvasását”,

fontos és hasznos videóval rögzíteni őket, hogy utólag meg lehessen figyelni az interakciókat,

és látni lehessen, hogy a gyermek hogyan mozdul, és a szülő hogyan reagál.

A videó használata tehát fontos és ajánlott eszköz.

Segít lefektetni az alapokat, és részleteiben, mozzanatról-mozzanatra

megfigyelni mindent, ami a gyermek és a szülő közötti interakcióban történik.

Fontos azonban hangsúlyozni, hogy az ilyen típusú videót

mindig csak ennek az eszköznek a használatában kifejezetten képzett terapeuta használja;

akik nem végeztek ilyen irányú szakképzést, azok a helyzet érzékenységéből fakadóan,

ne használják.

Ahogy korábban említettük, megfigyelhető az, hogy az örökbe fogadott gyerekek máshogy

küldenek jeleket; kevésbé egyértelműek, rövidebbek és zavarosabbak a nem örökbefogadott társaikhoz képest.

Ezért a videó rendkívül fontos lehet a szülőnek, mert lehetővé teszi a számára -

az inteakciók pillanatról-pillanatra megfigyelésével - hogy lássa,

a gyermek mikor és hogyan tud kapcsolódni hozzá.

Ez mérföldkő lesz a köztük lévő interakciókban és kapcsolatban, és lehetővé válik

az új szülői kötődés kialakítása.

Egy másik fontos tényező a gyermek hiperébersége,

Ami a hátteréről, a félelmeiről, a gondoskodás hiányáról,

az elhanyagolásról szolgál információval. Főleg akkor markáns, ha a gyermek fizikai erőszakot,

bántalmazást élt át, vagy annak volt szemtanúja.

A hiperébersége az, amikor a gyermek szélsőséges mértékben,

minden pillanatban figyeli a felnőtt minden rezdülését, mozdulatát, hogy le tudja olvasni,

ha valami számára veszélyeset lát,

hogy olyasmit csinál-e a felnőtt, ami számára fenyegető.

Egyértelműen jelzi azt, hogy a gyermek nem bízik a felnőttben.

Ez lassanként elmúlik, ahogy dolgoznak a szülő-gyermek kapcsolaton,

de nem mindig tűnik el teljesen.

A gyermekre ezen kívül jellemző lehet egy fajta érzelmi esetlenség,

ami az örökbefogadó szülőknek sok fájdalmat okozhat, mert úgy érezhetik, hogy a gyermek

soha nem fogja tudni teljesen szabadon kifejezni az érzéseit, az érzelmi közelségét a felnőtthöz.

Ez nem a gyermek felelőssége; ezt is múltból, a korábbi élményeiből hozza,

főleg, ha kimondottan fájdalmas történetet élt át.

A gyermekek hozzászoknak ahhoz, hogy ne közelítsenek a felnőtthöz, hogy így

a felnőtt kevesebb veszélyt jelentsen számukra.

Nincsenek hozzászokva a gyakori érintésekhez, ölelgetéshez, ami pedig az új kapcsolatban megtörténhet.

Így lehet, hogy az új szülő közeledése túl sok nekik.

De mivel nem tudják, hogyan navigálják a felnőttel a kapcsolatot, hogyan közelítsék meg,

ahogy azt sem, hogy mikor túl sok vagy túl kevés a közelség, teljesen dezorientáltak lesznek és zavarban érzik magukat.

Máskor a gyermek lehet, hogy nagyon esetlenül, szinte mesterkéltnek ható módon közeledik,

amit a szülő azonnal érzékel, és hajlamos ezt megcímkézni.

Fontos az, hogy az ilyen megnyilvánulást is mindig a gyermek hátterének a tükrében lássuk:

sosem volt meg a szabadságuk ahhoz, hogy úgy és akkor közeledjenek

a felnőtthöz, ahogy és amikor akartak, ezért ebben még igen esetlenek és kicsit mesterkéltek lehetnek.

További tényező, amivel a szülők találkozhatnak, a fáradtság és az alvási nehézségek:

nyugtalan alvás, elalvási nehézség, és a kipihentség hiánya.

Jelentkezhetnek koncentrációs nehézségek is, amiket gyakran,

jobb híján, tanulási zavarnak titulálnak:

pedig a gyermeknek nem lenne baja a tanulással,

csak a hiperébersége sok nehéz, kimerítő érzelmi lenyomatot aktivál,

amik elvonják a figyelmét a rá bízott feladatokról.

Az látható, hogy a gyermek a felnőttet nézi, az arcát, az

arckifejezését fürkészi, hogy letapogassa, ha esetleg veszély fenyeget;

és emiatt persze nehéz neki koncentrálni.

Az összes ilyen jelenség rendkívül fontos: ezek a viselkedések a gyermek múltjának a történetét

hordozzák, mindent elmondanak az örökbefogadó szülőnek a gyermek hátteréről, amit a gyermek

talán máshogy nem, csak ezeken a viselkedéseken keresztül

tud kifejezni.

Hasznos tehát úgy tekinteni ezekre, mint értékes információkra, amik

hozzásegítenek bennünket a gyermek múltja egy részének megértéséhez, amiről egyébként

semmit nem tudhatunk azon kívül, ahogy az új szülővel való

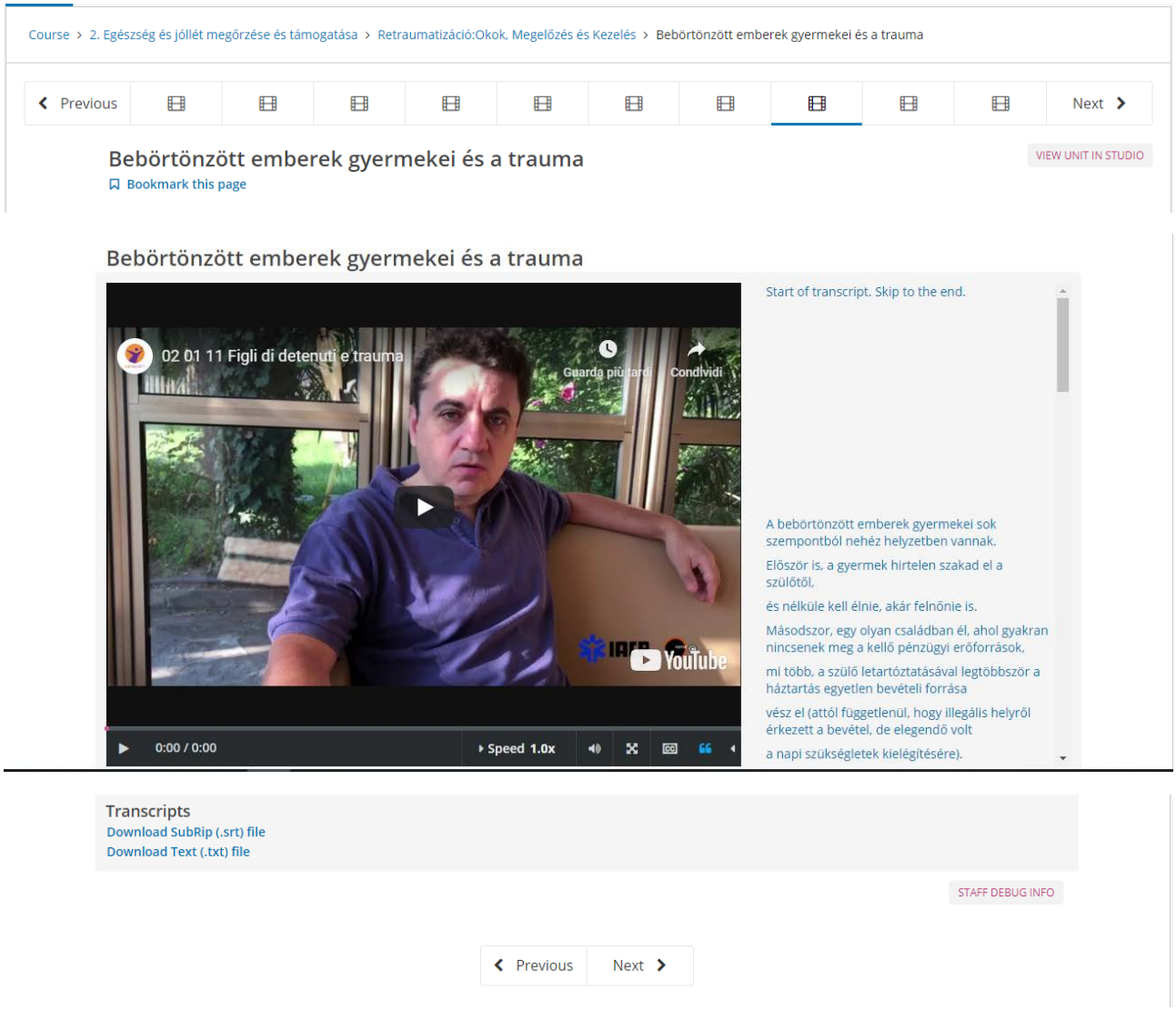
kapcsolatban megnyilvánul.

Korrigálandó helyzetek helyett ezekre a viselkedésekre tekintsünk inkább lehetőségként a gyermek múltjának

megértésére és elfogadására, amikkel együtt szőhetünk

egy új, közös történetet.

A múltbeli történet így köthető össze az új történettel.



Transcript

A bebörtönzött emberek gyermekei sok szempontból nehéz helyzetben vannak.

Először is, a gyermek hirtelen szakad el a szülőtől,

és nélküle kell élnie, akár felnőnie is.

Másodszor, egy olyan családban él, ahol gyakran nincsenek meg a kellő pénzügyi erőforrások,

mi több, a szülő letartóztatásával legtöbbször a háztartás egyetlen bevételi forrása

vész el (attól függetlenül, hogy illegális helyről érkezett a bevétel, de elegendő volt

a napi szükségletek kielégítésére).

Egy újabb másodlagos, de ugyanolyan fontos 9 00:00:50,420 --> 00:00:55,160 tragédia pedig az, hogy a gyermek

stigmatizáció áldozatává válik.

Bebörtönzött ember gyermekének lenni annyit jelent,

mint a bűntudat gyermekének lenni. Ahogy a gyermek elkezd a társadalmi nyomásnak engedni,

saját maga is ítéletet hoz, és úgy érezheti, hogy ő is megérdemli a büntetést.

A bebörtönzött szülők gyermekei gyakran problémás gyermekek,

ami többek között azért van, mert nincsen velük szülő - gyakran az apa -,

aki nevelné őket.

Ők olyan gyermekek, akik arra kényszerülnek, hogy egyedül éljenek, mert az anya gyakran nem tud megbirkózni a problémákkal

és nem támaszkodhat többé

a férje támogatására.

Ez egy teljesen új kihívás, és sajnos a szociális munkások is néha abba a hibába esnek,

hogy stigmatizálják a gyermeket, akinek pedig megértésre és még több odafigyelésre lenne szüksége,

mert nem könnyű nehézségek közepette egyedül élni az anyával.

Különböző vélemények vannak arról, hogy hogyan kell elmondani a gyermeknek,

hogy letartóztatták a szülőjét.

Sok szülő szégyenből vagy nehézségből kitalál egy történetet a gyermekeinek arról, hogy a távol lévő szülő

egy új munkahely miatt nem tud velük lenni.

Természetesen a hazugság gyorsan lelepleződik, mivel a gyermeket nem lehet arról meggyőzni,

hogy egy munkahelyváltás miatt miért ment el az apja hirtelen

több napra, hónapra, évre, és hagy ki születésnapokat és ünnepeket, mikor előtte minden nap hazament a munkából.

A gyermek megérzi, hogy hazudtak neki.

A legjobb dolog, ha elmondjuk neki az igazságot „...apa hibát követett el,

ami miatt egy olyan helyen kell lennie, ahol felelnie kell a tetteiért. Nem kell megijedned,

mert jól van,

és hamarosan meglátogathatjuk.”

Egy újabb nehéz kérdés merül fel a bebörtönzött emberek gyermekeinél:

látogassák-e a szülőt a börtönben vagy sem.

Néhány szociális munkás azt mondja, hogy a látogatás nem helyénvaló, mert a börtönbeli környezet

nem olyan hely, ami egy gyerek szükségleteinek megfelelő. 39 00:03:46,960 --> 00:03:54,920 Ha az ember belép a börtönbe, rendőrökkel és méltatlan környezettel találkozik.

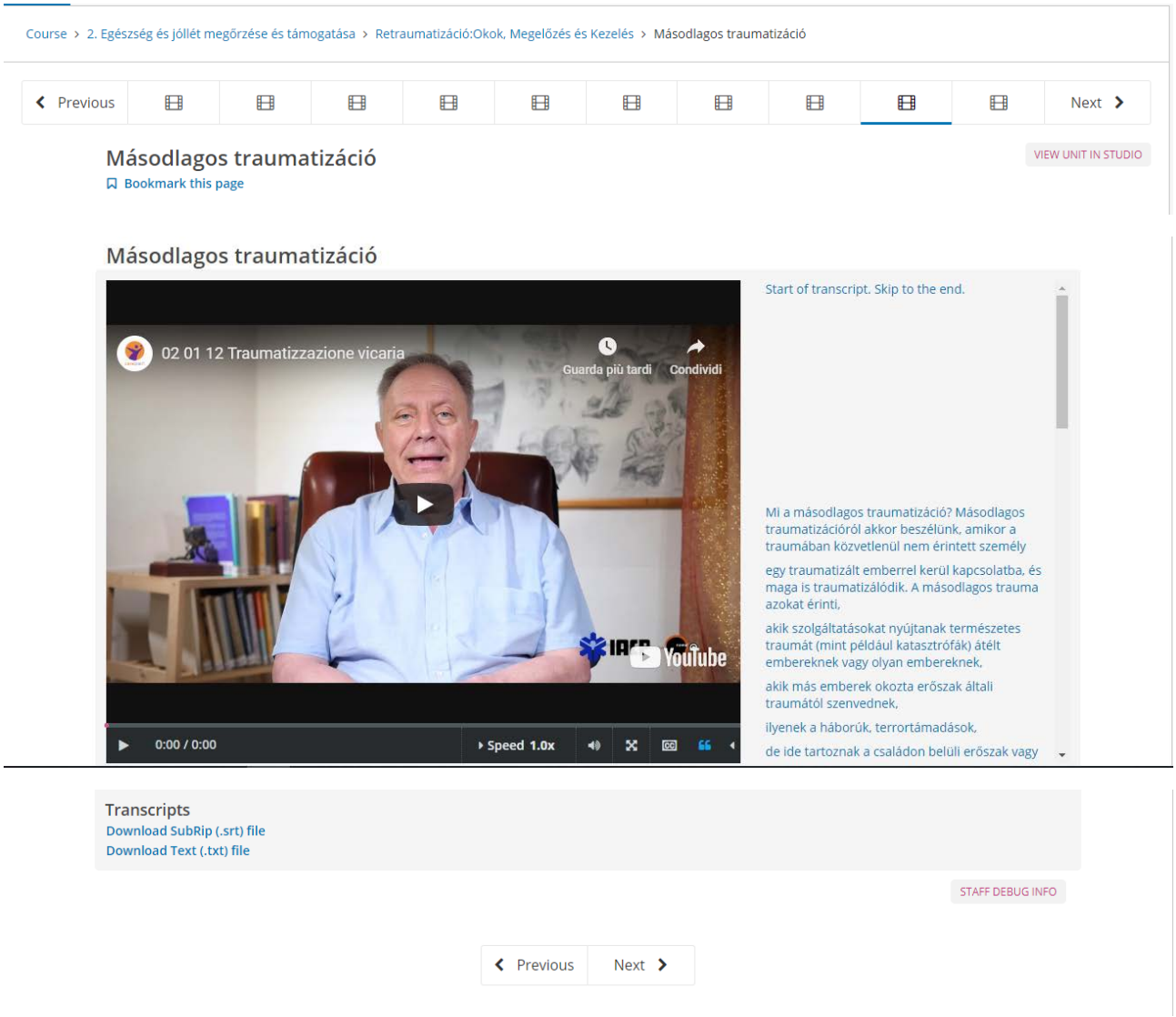
Ugyanakkor fontos a gyermek számára,

hogy lássa a szülőt,

ezért meg kell teremteni a bebörtönzött ember és gyermeke találkozásának megfelelő körülményeit.

Pár évvel ezelőtt még egy fal választotta el a bebörtönzött embereket a látogatóiktól,

de mára sok minden megváltozott: sok börtönnek van játékszobája vagy színesebb terme játékokkal, és a börtönőrök is sokkal jobban fel vannak készítve
a gyermeklátogatókra.
Mégsem az a legfontosabb kérdés, hogy a gyermek egy megfelelő környezetben találkozzon szülőjével, hanem az, hogy létre jöhessen ez a találkozás.
Ez igaz minden olyan esetre, ahol a szülő nem azért van börtönben, mert bántotta volna gyermekét.



Transcript

Mi a másodlagos traumatizáció? Másodlagos traumatizációról akkor beszélünk, amikor a traumában közvetlenül nem érintett személy

egy traumatizált emberrel kerül kapcsolatba, és maga is traumatizálódik. A másodlagos trauma azokat érinti,

akik szolgáltatásokat nyújtanak természetes traumát (mint például katasztrófák) átélt embereknek vagy olyan embereknek,

akik más emberek okozta erőszak általi traumától szenvednek,

ilyenek a háborúk, terrortámadások,

de ide tartoznak a családon belüli erőszak vagy pl. a szexuális erőszak áldozatainak esetei is.

Összefoglalva, a segítő szakember napi szinten jóindulattal kapcsolódik a trauma túlélőihez, segítséget, támogatást nyújt, pszichológiai kapcsolatot teremt,

de az általa segítettek történetei mély nyitottsága, embersége

következtében hatással lehetnek a segítő saját

mentális egészségére, és traumatizálhatják

őt magát is.

Fontos megelőznünk és csökkentenünk a másodlagos trauma hatását, amelynek azok a szakemberek és szociális munkások vannak kitéve,

akik trauma vagy erőszak áldozataival dolgoznak.

Ilyenek például az egészségügyi dolgozók, rendőrök, tűzoltók, újságírók, önkéntesek és mindazok, akik különböző okok miatt

kapcsolatba kerülnek traumatizált emberekkel.

A másodlagos trauma, és általánosabban

a kiégés megelőzése rendkívül fontos, amely szintén hatással van 18 00:02:34,800 --> 00:02:43,000 a segítő szakmákban dolgozókra. Főleg akkor nehéz megbirkózni vele,

ha nem tudunk feltöltődni vagy határt szabni a munkának, amit egyszerre élünk meg nehéznek és gyönyörűnek. Fontos megtalálnunk

a munka és a magánélet közti egyensúlyt, és ahhoz, hogy hatékony segítő szakemberek legyünk, ápolnunk kell a saját magánéletünket is, és hagynunk kell időt a családra,

barátokra és arra, hogy jól érezzük magunkat. Kihívást jelent mindazoknak, akik szenvedéllyel,

nagylelkűen és empátiával segítő szolgáltatásokat nyújtanak,

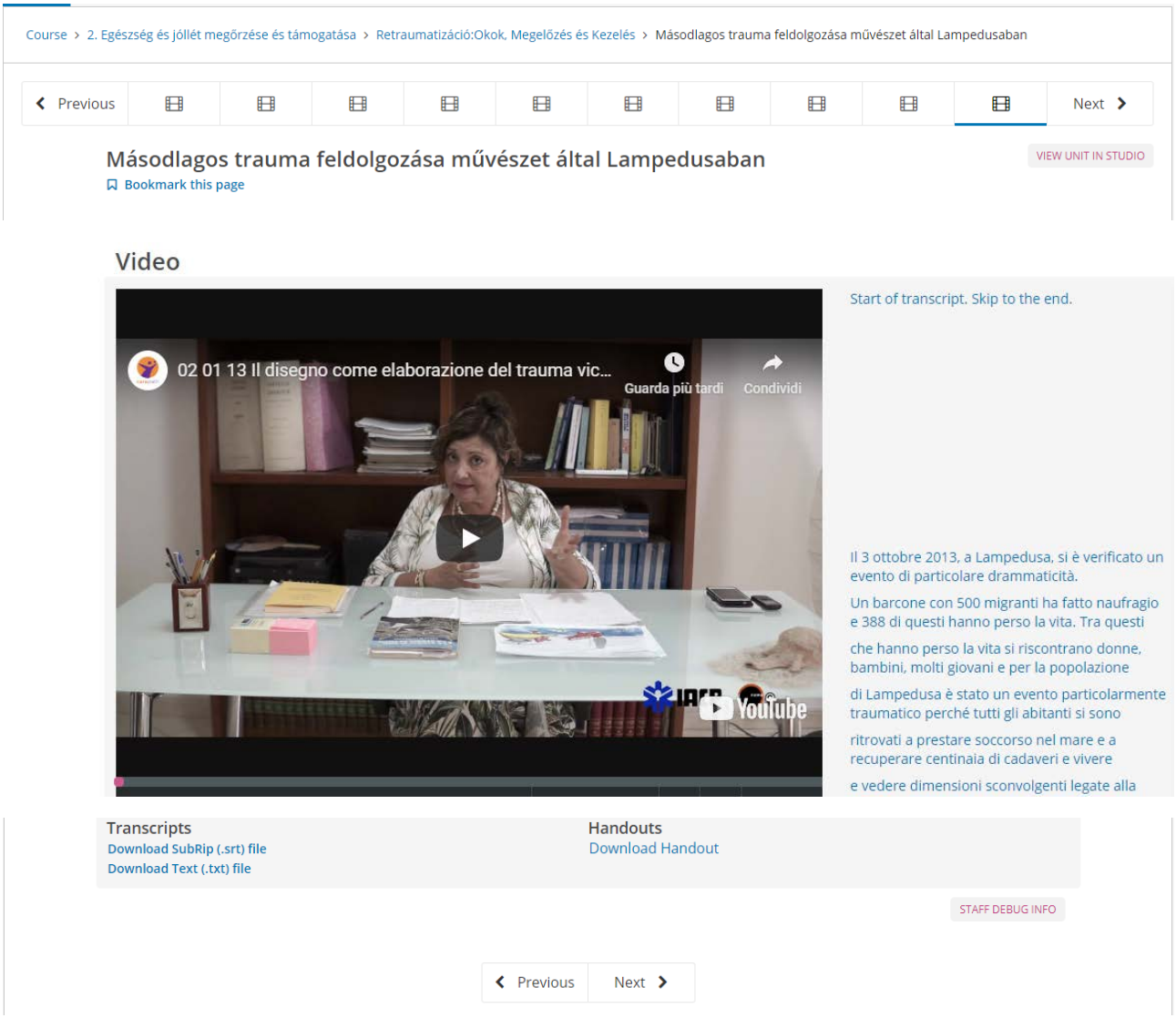
hogy önmagukkal is foglalkozzanak,

mert csak akkor lehet adni, ha van miből.

Éppen ezért fontos erkölcsileg, etikailag és szakmailag is, hogy megőrizzük ellenállóképességünket, egészségünket és jóllétünket:

ha sokat szeretnénk adni azoknak, akikkel dolgozunk, akkor azzal az emberrel is jól kell bánnunk,

akivel életünk minden egyes óráját töltjük – magunkkal.



Handhout

A rajzolás, mint a Lampedusa gyermeknépessége által elszenvedett másodlagos trauma feldolgozásának eszköze/

2013. október 3-án megrázóan drámai események történtek Lampedusán. Egy 500 bevándorlót szállító hajó elsüllyedt, és 388-an életüket vesztették a balesetben. Az elhunytak között sok nő, gyermek és fiatal volt. Lampedusa lakosságát különösen megviselték az események, miután hiába próbálkoztak a fuldoklók mentésével, ugyanakkor több száz holttestet kellett kiemelniük a vízből. Az áldozatok között egy édesanyát is találtak, akit épp szülés közben ért a hajótörés, a nőt a köldökzsinór még összekötötte a babával.

Hasonló tragédia szemtanújának lenni sokkoló tapasztalat, mely másodlagos traumát okozott azokban, akik látták a borzasztó eseményeket. Alapítványunk a helyi egészségügyi szolgálattal együtt igyekezett segítséget nyújtani a traumatizált lakosságnak úgy, hogy meghallgatta és támogatta az embereket. Az egyik legnehezebb feladat a traumát elszenvedett gyermekek, különösen az általános iskolások kezelése volt.

A lampedusaiak mindennapjaihoz (beleértve a fiatalokat is) több éve hozzátartozik a bevándorlás, és mindenki tisztában van vele, hogy az utazások, melyekbe nagy reményekkel vágnak bele a menekülők, gyakran halállal végződnek. De a 6-7 évesek különösen ki vannak téve az ilyen tragédiákkal való szembesülésből adódó traumáknak: sokuk félni kezd, aggódik, fóbiái lesznek. Ezek a gyerekek tehát olyan, tipikus reakciókat produkálnak, melyek az életveszélyes helyzetekkel történő találkozásokból adódnak.

A helyzetet súlyosbítja, hogy a tragikus események színterévé az a tenger vált, melyet addig az öröm, a játék és a szórakozás megtestesítőjeként érzékeltek. A tenger, amely addig a könnyedséget és a boldogságot jelentette a legtöbbüknek, hirtelen a halál tengerévé változott.

Ezen másodlagos traumák feldolgozására a rajz lehet az egyik lehetséges eszköz. A gyerekrajzok képet adnak arról, hogyan reagálnak és válaszolnak a kicsik a traumára.

Itt meg kell említeni azt az előfeltevést, mely szerint a művészet segítségével hatékonyan alakíthatók kézzelfoghatóvá a fájdalmas és félelmetes események, az alkotásnak ugyanakkor felszabadító hatása van, és általa átdolgozhatók a traumatikus események.

A következő lépésben azt a kérdést kell feltennünk, hogy mi számít traumának a gyermek szempontjából. Ez függ az esemény típusától, illetve attól, hogy milyen formában jelenik meg: lehet olyasmi, amit emberek okoznak (mint például a háború és a terrorizmus), és lehet olyasmi, amit a természet idéz elő (mint a hurrikánok, földrengések, tornádók). Ezen események specifikus nyomokat és félelmeket hagynak maguk után a gyermekek lelkében.

A lampedusai tragédia kapcsán szükséges volt begyógyítani azokat az érzelmi töréseket, melyeket a gyerekek elszenvedtek. Egy ilyen esemény után az élet nem folytatódhatott a régi kerékvágásban, és ez minden családot érintett. A gyerekek nehezen értik a halál fogalmát, emellett hajlamosak mindent magukra venni. Többen például nem mertek halat enni, arra gondolva, hogy a halak korábban megették az elhunyt gyerekeket és szüleiket. Voltak, akik nem mertek többet lemenni a partra, mert féltek, hogy esetleg újabb holttesteket látnak. Fontos feladat volt tehát megnyugtatóan újrarendezni a valóságról alkotott, széttöredezett képzeteiket, ebben pedig a rajzolás segített.

Most pedig szeretnénk bemutatni néhányat a gyerekek rajzai közül. Íme, a reprezentációk, amelyeket a kicsik az élményeikből alkottak: Ez itt Lampedusa szigete, nem messze pedig a tenger, tele halottakkal. Halott gyerekek, hátukon iskolatáskával, és anyák, akik elvesztették a pénztárcájukat. A hátizsák és a pénztárca mint az iskolába járás szimbóluma jelenik meg. Egy anya, aki egy kislány kezét fogja, míg az apák távolabb, a víz alatt fuldokolnak. A csónak, mely a biztonságot jelenti.

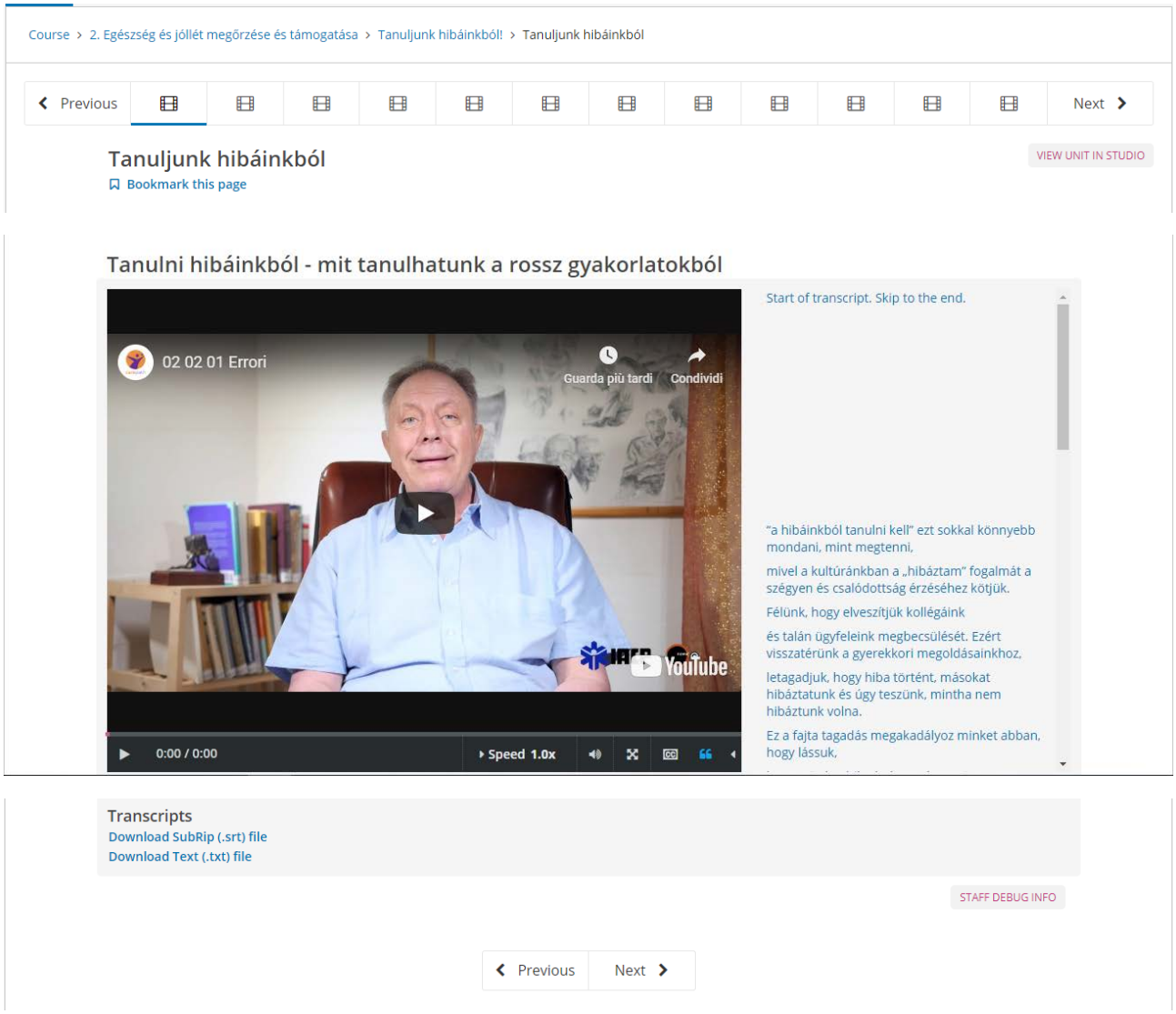
Egy másik gyermek rajzán csak két alakot látunk: mintha egy anya és egy apa lenne életveszélyben, miközben a csónak lángokban áll. (Az eset tényleg megtörtént, valóban kigyulladt egy csónak.) Az apát és az

anyát fekete színű tenger veszi körül, az ég tele van keresztekkel és halottakkal. Láthatjuk, hogy a tenger a halál tengerévé változott.

Egy másik gyermek a lampedusai reptéren sorakozó koporsókon keresztül érzékelte a halált, ilyen képsorokat gyakran mutattak a tévében. Feltűnik, hogy a koporsók különböző színűek és méretűek, a gyerekekéi kisebbek és sötétebbek, és a tenger is nagyon sötét.

Ez egy másik rajz, melyen megjelenik a szorongás, azonban kevésbé intenzív és erőteljes formában. Lehetséges, hogy a családban korábban is felmerült már a halál témája, és az, hogy egy család elveszthet egy gyermeket. Itt a halál személyesebb és egyben katartikusabb formát ölt. Az égen angyalok és csillagok láthatók, mintha ezekké alakulnának azok, akik eltávoztak.

A rajzokon keresztül láthatóvá vált az a narratíva, melybe az egyes gyerekek a tapasztalataikat rendezték. Míg magát az eseményt kollektíven élték át, mindenki különféleképpen, egyedien érzékelte a történéseket. Fontos volt, hogy ne ajánljuk fel az azonnali vigasz elemeit, hanem megengedjük a gyermekeknek, hogy megtalálják személyes megoldásaikat a rajzbéli, beszédbeli kifejezésen és feldolgozáson, és annak meghallgatásán keresztül, így képesek legyenek választ adni arra, ami egy 6-7 éves gyermek egyik legnagyobb szorongása: a halál és a veszteség miatti félelem.



Transcript

“a hibáinkból tanulni kell” ezt sokkal könnyebb mondani, mint megtenni,

mivel a kultúránkban a „hibáztam” fogalmát a szégyen és csalódottság érzéséhez kötjük.

Félünk, hogy elveszítjük kollégáink

és talán ügyfeleink megbecsülését. Ezért visszatérünk a gyerekkori megoldásainkhoz,

letagadjuk, hogy hiba történt, másokat hibáztatunk és úgy teszünk, mintha nem hibáztunk volna.

Ez a fajta tagadás megakadályoz minket abban, hogy lássuk,

hogy minden hiba bölcsességet rejt.

Akkor, ha megfelelő hozzáállással nem védekezünk, hanem nyitottak vagyunk arra, hogy tanuljunk hibáinkból.

Hibáink tanítóinkká válhatnak és segíthetnek nekünk jobb szakemberekké válni.

Ezt az üzenetet,

hogy tanuljunk hibáinkból, gyakran közvetítjük klienseink felé is.

Egyben humoros és tragikus, hogy mi, segítő szakemberekként arra biztatjuk

klienseinket, hogy tanuljanak hibáikból,

és ezt a hozzáállást sokkal inkább képviseljük feléjük, mint saját magunk felé. Kevésbé vagyunk lelkesek,

ha rólunk van szó, hogy ne védjük magunkat, és valljuk be, hogy hibáztunk,

és mindeközben maradjunk nyitottak a tanulásra.

Kissé ellentmondásos, hogy a hibákhoz úgy viszonyulunk, hogy azok csökkentik önbizalmunkat, miközben annak,

hogy tanulunk a hibáinkból, növelnie kéne azt.

Hasonlóképpen, akik félnek, gyávának hiszik magukat, pedig akik bátrak, azok is félnek,

csak ez nem tántorítja el őket a cselekvéstől; a bölcsek pedig elfogadják ha hibáznak és tanulnak belőle.

Tanulhatnánk a klienseinktől, ők gyakran sokkal készségesebbek, alázatosan elfogadják hibáikat

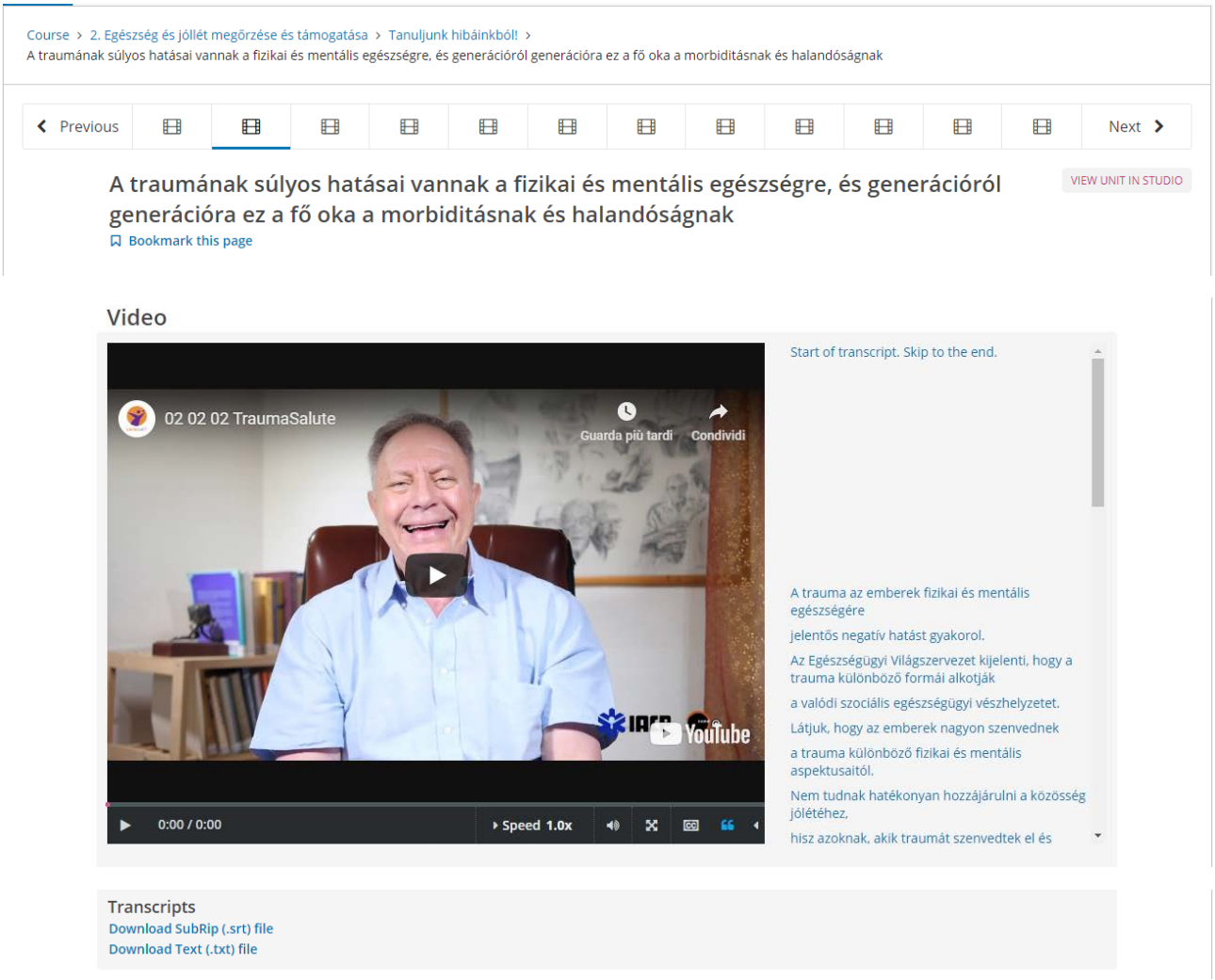
és tanulnak belőlük, megpróbálják legközelebb nem újra elkövetni azokat.

Újra és újra ugyanabba a hibába esünk,

ha nem ismerjük el, hogy hibáztunk. Attól félünk, hogy, ha bevalljuk a hibáinkat, akkor áldozatként határozzuk meg magunkat,

és így tehetetlen helyzetbe kerülünk.

Üdvözöljük hibáinkat a bölcsesség mestereiként!



Transcript

A trauma az emberek fizikai és mentális egészségére

jelentős negatív hatást gyakorol.

Az Egészségügyi Világszervezet kijelenti, hogy a trauma különböző formái alkotják

a valódi szociális egészségügyi vészhelyzetet.

Látjuk, hogy az emberek nagyon szenvednek

a trauma különböző fizikai és mentális aspektusaitól.

Nem tudnak hatékonyan hozzájárulni a közösség jólétéhez,

hisz azoknak, akik traumát szenvedtek el és szenvednek annak hatásától, ellátásra van szüksége.

Ez jelentős gazdasági erőforrásokat emészt fel,

és a trauma által az áldozatok azon képessége is sérül,ami által

családjuk, közösségük és nemzetük jólétéhez hozzájárulhatnak.

Egy másik fontos jelenséget is megfigfyelhetünk a trauma áldozatainál:

nem csak az áldozat fizikai

és mentális egészsége romlik, de gyakran,

főleg a trauma bizonyos típusainál (mint például fizikai és szexuális erőszak áldozatainál)

nagy a valószínűsége annak, hogy ők maguk válnak elkövetőkké, és ők maguk traumatizálnak aztán más embereket.

Az áldozatból elkövetővé válás borzalmas, ami alapján mondjuk hogy a trauma olyan, mint egy vírus,

amely terjed, ha nem küzdenek ellene, nem kezelik és nem előzik meg hatékonyan a közösségben: valódi járványként működik.

A járvány egyénről egyénre fertőz,

és gyorsan elterjed a lakosság körében, ami nagy emberi veszteségekhez

vezet.

A bio-pszichoszociális megközelítés esetén, nem tolhatjuk a trauma

megelőzésének és kezelésének felelősségét egyedül az egészségügyi szektorra.

Politikai feladatról lévén szó minden intézménynek: családoknak, iskoláknak, szakszervezetnek,

a fiatalkorúak igazságszolgáltatási rendszerének és a jogszabályoknak is érzékennyé kell válnia ezekre a problémákra,

és részesévé kell válniuk a hatékony megelőzési és gyógyítási hálózatnak.

Ez mindenki érdeke és mindenki jólétét szolgálja.

Support material

Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 3, Understanding the Impact of Trauma. Available from:

https://www.ncbi.nlm.nih.gov/books/NBK207191.

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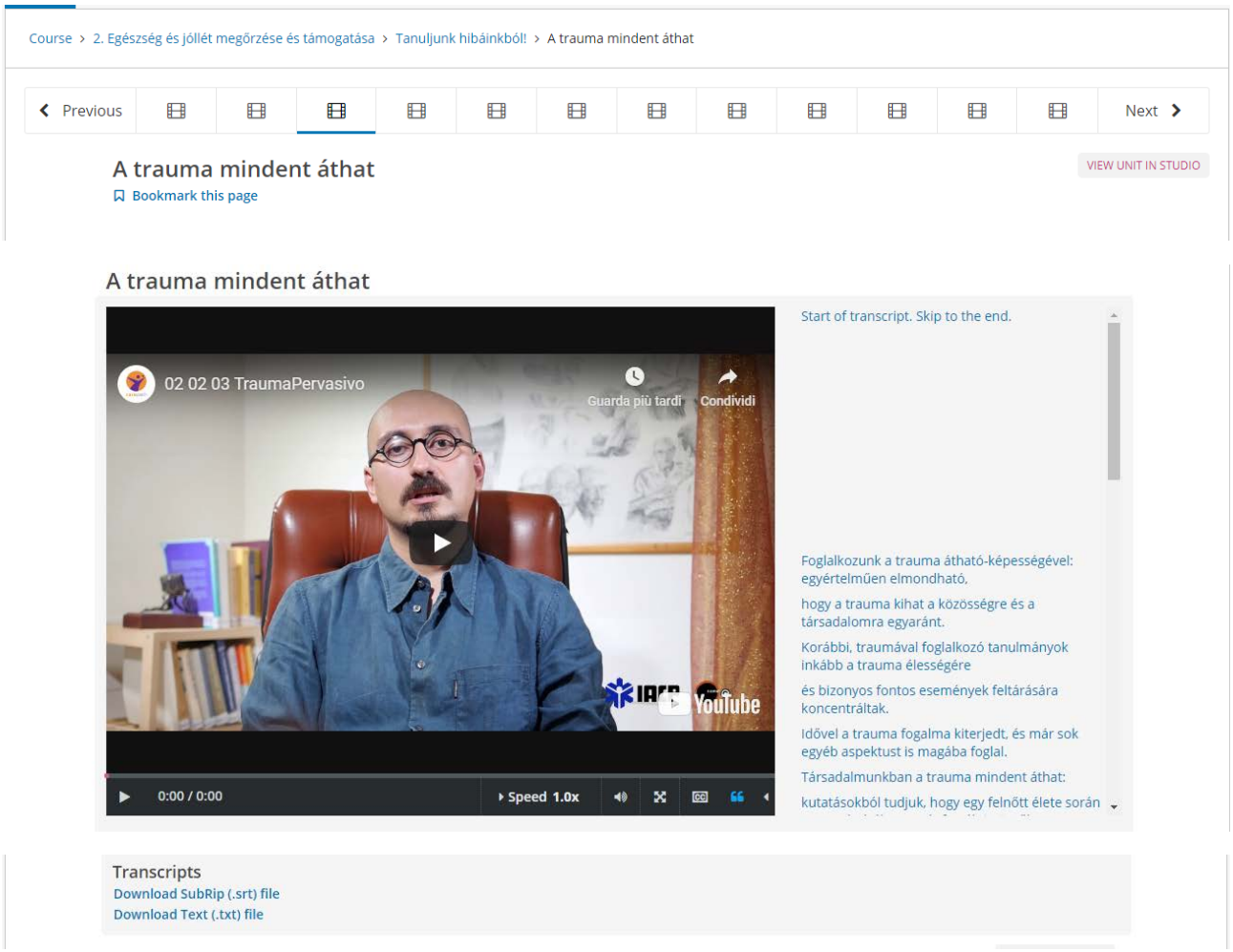


Transcript

Foglalkozunk a trauma átható-képességével: egyértelműen elmondható,

hogy a trauma kihat a közösségre és a társadalomra egyaránt.

Korábbi, traumával foglalkozó tanulmányok inkább a trauma élességére

és bizonyos fontos események feltárására koncentráltak.

Idővel a trauma fogalma kiterjedt, és már sok egyéb aspektust is magába foglal.

Társadalmunkban a trauma mindent áthat:

kutatásokból tudjuk, hogy egy felnőtt élete során vagy már átélt, vagy át fog élni a jövőben

legalább egy traumatikus eseményt.

Néhány tanulmányból, mint például a Benguet részletes tanulmányából

megtudtuk, hogy ugyan nagy a változatosság abban, hogy milyen traumáról van szó,de világ összes országában

rendkívül magas az emberek által átélt trauma aránya.

Ezért fontos tudnunk, hogy jelenleg milyen tényezők védik az embereket a traumáktól,

és mi növeli a traumának való kitettséget.

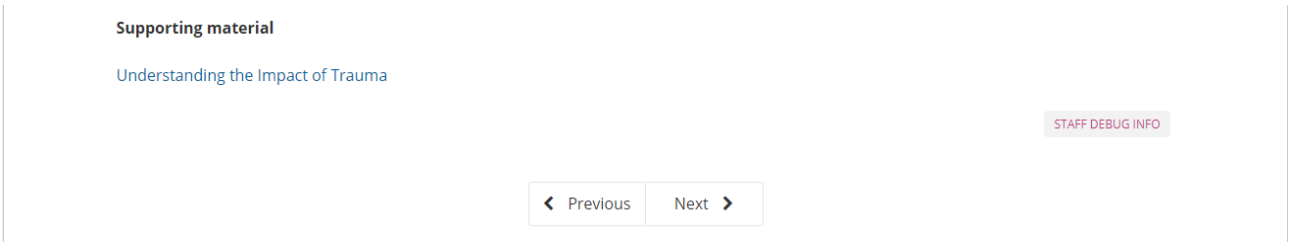
Tanulmányokból tudjuk, hogy sok, a gazdaságra és a közegészségre mérhető hatással bíró krónikus betegség gyökerezik valamilyen traumában.

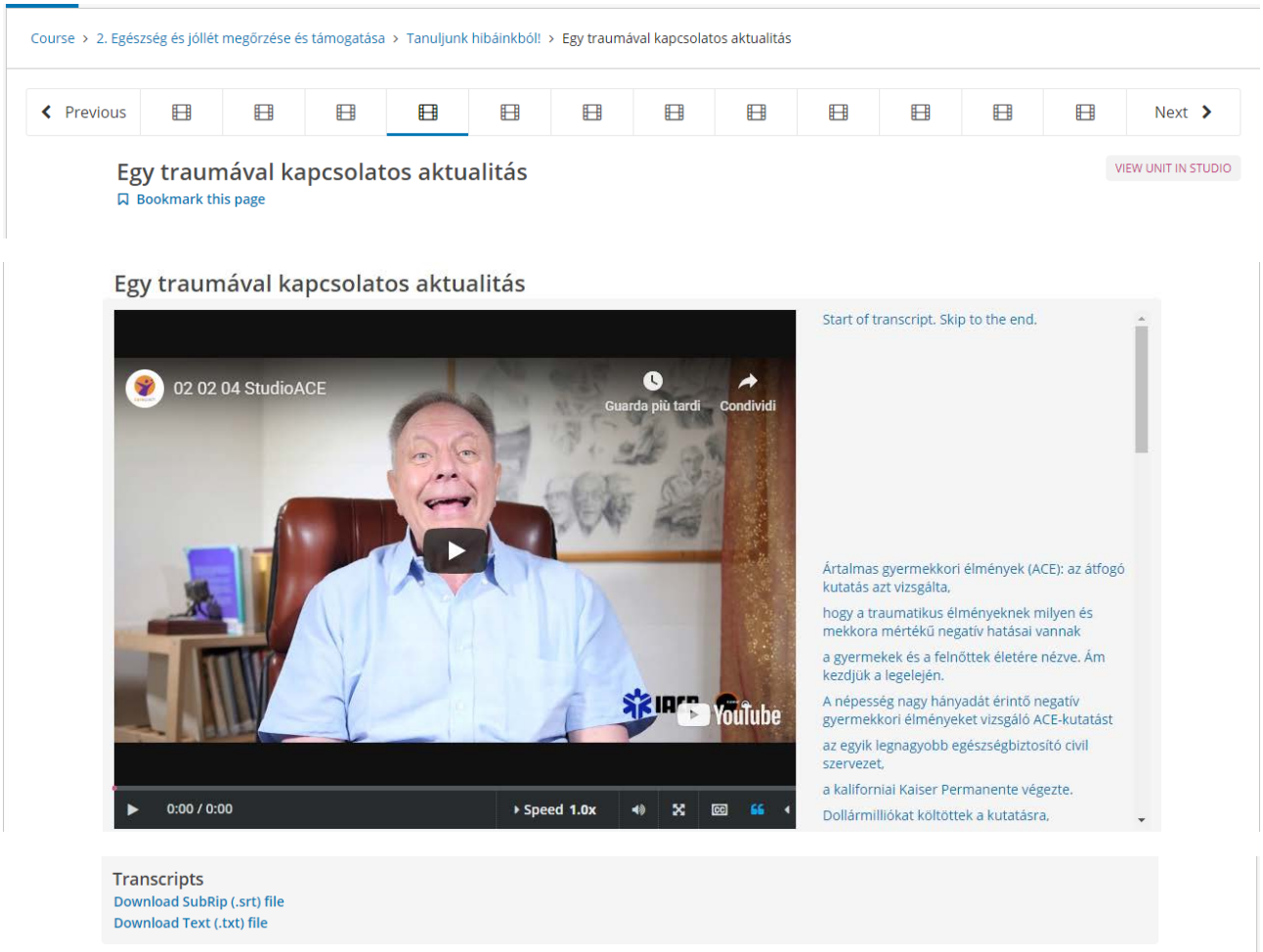
A legrosszabb mégis az, hogy a trauma hátráltatja az egyén abban,
hogy megvalósítsa belső lehetőségeit, és ezáltal tudatos,
teljes értékű tagjává váljon a közösségnek és a társadalomnak, amelyben él.

A trauma még fontosabb, ha figyelembe vesszük azokat a traumákat,melyek a pszichológiai fejlődés azon érzékeny időszaka során merülnek fel,
amikor az ember érzelmi és
szociális készségei kifejlődnek.

A trauma erőteljesen befolyásolhatja ezen képességek fejlődését,
súlyosan megnehezítve
az egyén jövőbeni fejlődését.

Ezért létfontosságú ma, hogy elmélyítsük a traumáról való tudásunkat,
és hogy tisztában legyünk a témával, mint ahogy azt ebben a képzésben is tesszük.





Transcript

Ártalmas gyermekkori élmények (ACE): az átfogó kutatás azt vizsgálta,

hogy a traumatikus élményeknek milyen és mekkora mértékű negatív hatásai vannak

a gyermekek és a felnőttek életére nézve. Ám kezdjük a legelején.

A népesség nagy hányadát érintő negatív gyermekkori élményeket vizsgáló ACE-kutatást

az egyik legnagyobb egészségbiztosító civil szervezet,

a kaliforniai Kaiser Permanente végezte.

Dollármilliókat költöttek a kutatásra,

amely az egész tudóstársadalom javára válik, mivel már most sokkal többet tudunk erről a témáról, és a megismételt kutatások is bizonyították az eredeti adatokat:

átlagosan a társadalom harmadát - tehát minden harmadik embert - ért gyermekkora során

valamilyen káros élmény vagy trauma.

Valamivel kevesebben vannak azok,

akiket kétfajta trauma ért,

és még kevesebben azok, akiket kettőnél több trauma ért gyermekkorában.

Minél több trauma ér egy embert, annál jobban fog szenvedni a negatív következményektől.

Akár egy késszúrás: már egy szúrás is rettenetesen fáj, nem hogy több.

A traumák rosszabbak, mint a heget hagyó késszúrások,

mert nem csak hogy az áldozat fizikai és mentális állapotára nézve járnak negatív következményekkel,

hanem akár vírusnak is nevezhetnénk őket,

amelyek miatt

a főleg erőszak, szexuális bántalmazás, stb. áldozatai

könnyebben válhatnak maguk is elkövetővé.

A mentális és fizikai problémákról sokszor elhangzott már,

hogy összefüggésben állnak. Mit is jelent ez?

Azok az emberek, akik valamilyen traumát éltek át, ösztönösen próbálnak azzal megbirkózni.

Az elején lehet, hogy hatásos ez a fajta traumakezelés,

de hosszú távon ára van. Egyesek például

annak reményében, hogy kezelni tudják az átélt trauma hatásait,

alkoholhoz vagy kábítószerekhez nyúlnak,

ami aztán további problémákhoz vezet:

a helyzet még súlyosabbá válik, fennáll annak veszélye, hogy alkoholistává vagy drogfüggővé válnak.

Ami a viselkedést illeti, köztudott, hogy az áldozat ilyenkor kerüli a kapcsolatot másokkal, elszigeteli magát,

így „nem tud feltöltődni”. A nemi élet is háttérbe szorul. Röviden

elmondható, hogy a káros gyermekkori élmények valós és igen költséges társadalmi terhet jelentenek,

mivel a kezelés és ellátás rendkívül drága. Ezért mindenkinek érdeke, hogy megelőzzük,

vagy legalábbis hatékonyan kezeljük a gyermekkor során átélt traumákat.

Ez nem csak

az áldozatoknak jó, hanem a társadalomnak is.

Supporting material

About the CDC-Kaiser ACE Study

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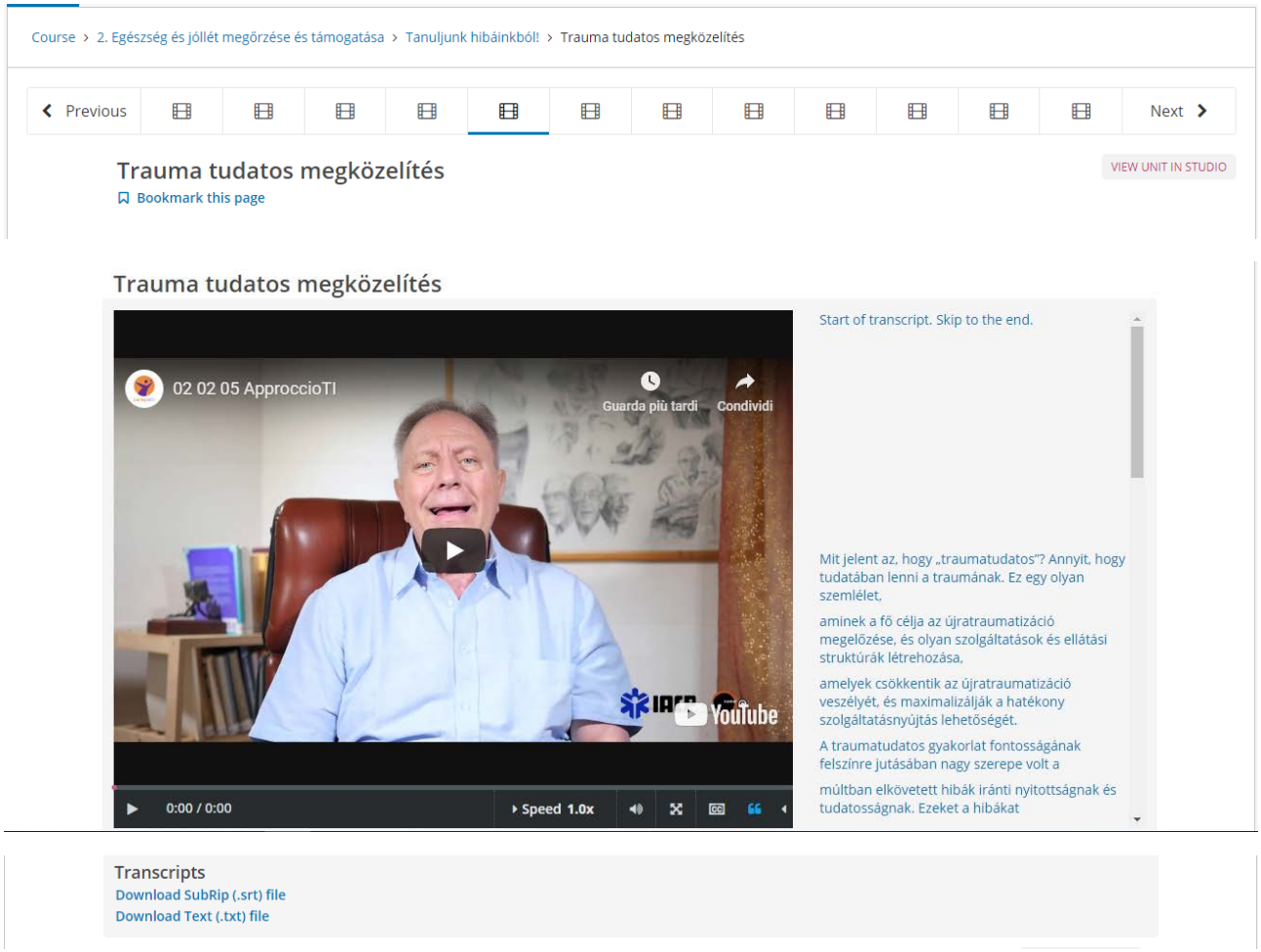


Transcript

Mit jelent az, hogy „traumatudatos"? Annyit, hogy tudatában lenni a traumának. Ez egy olyan szemlélet,

aminek a fő célja az újratraumatizáció megelőzése, és olyan szolgáltatások és ellátási struktúrák létrehozása,

amelyek csökkentik az újratraumatizáció veszélyét, és maximalizálják a hatékony szolgáltatásnyújtás lehetőségét.

A traumatudatos gyakorlat fontosságának felszínre jutásában nagy szerepe volt a

múltban elkövetett hibák iránti nyitottságnak és tudatosságnak. Ezeket a hibákat

természetesen nem szándékosan követtük el, hanem tudatlanságból,

mivel akkor még nem tudtuk,

hogy a kínált kezelések bizonyos aspektusai a probléma, és nem a megoldás része voltak:

például amikor azt erőltettük, hogy a kliensek az akaratuk ellenére felidézzék és újra átéljék

a múltbeli traumáikat, stb.

Ma már, köszönhetően mindannak, amit a múltbéli hibákból tanultunk,

új irányelvekre támaszkodhatunk,

amelyek összetevői segítenek nekünk megelőzni a károkozást és maximalizálni a nyújtott szolgáltatás

jótékony hatását.

Ez nem csak az egészségügyre, a mentális egészségre vonatkozik,

hanem az intervenciók minden területére:

pl. iskolák, szervezetek, a fiatalkorúak igazságszolgáltatása,

sőt, még a törvényekre is. A traumatudatos iskola olyan iskola, ami

érzékeny a traumával kapcsolatos problémákra, és ahol a tanárok tisztában vannak vele, hogy egy rossz magatartású diák

nem feltétlenül szimplán rossz, hanem esetleg valamilyen traumából fakadó diszkomfortot fejez ki,

és így pl. beajánlhatja az iskolai pszichológushoz, hogy a diák

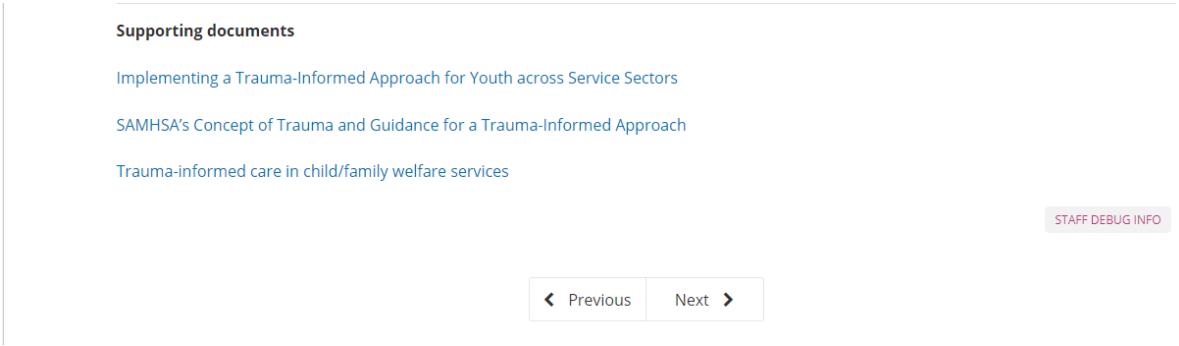
segítséget kapjon, ha szüksége van rá, megelőzve ezzel, hogy a probléma még nagyobbá váljon.

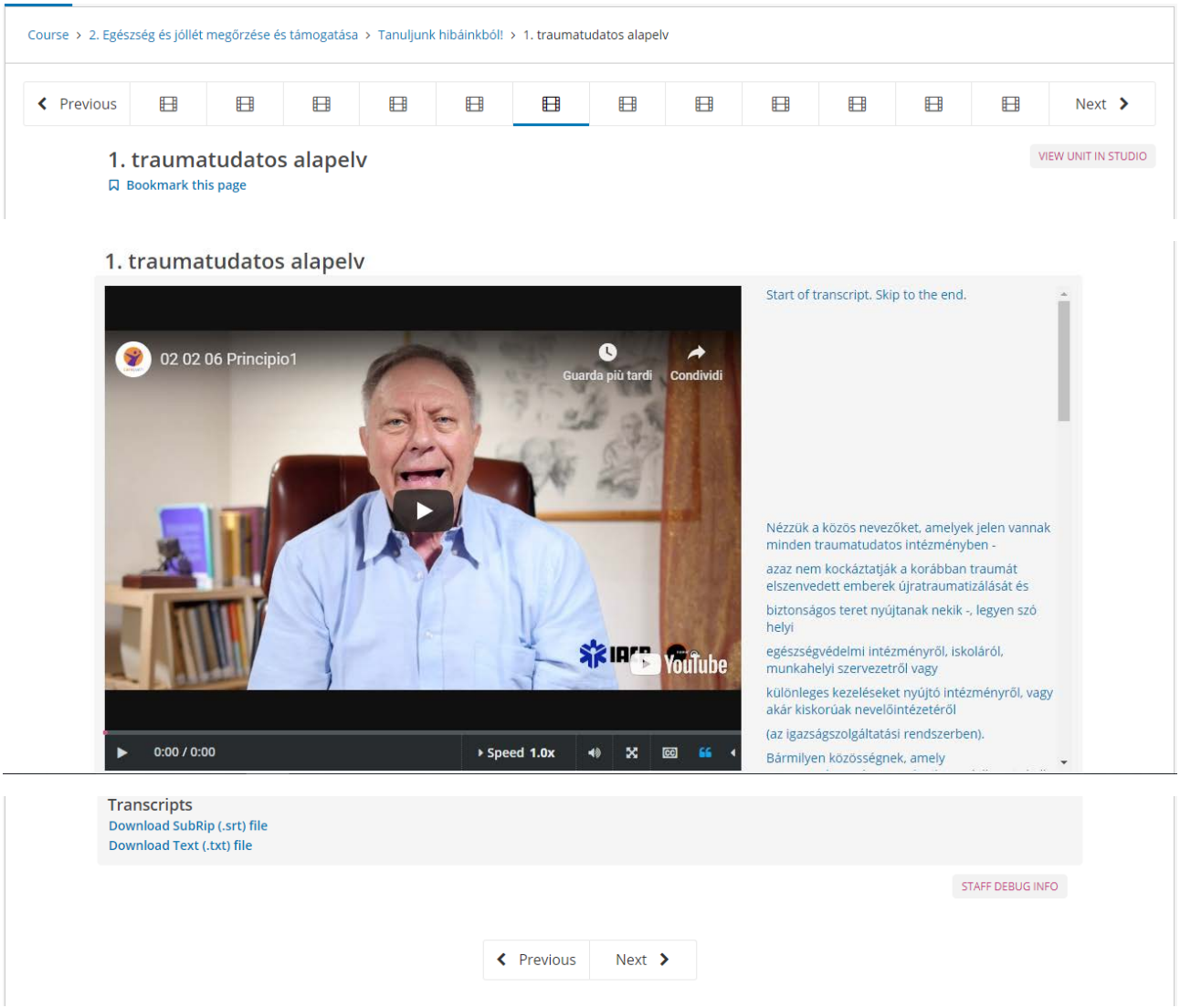
A traumatudatos szemlélet tehát nem csak kötelesség etikai, klinikai és

mentális egészségügyi szempontból, hanem költséghatékony is:

a károkat minimalizáló kezelések nem csak az áldozatok, hanem

a szélesebb társadalom javát is szolgálják.





Transcript

Nézzük a közös nevezőket, amelyek jelen vannak minden traumatudatos intézményben -
azaz nem kockáztatják a korábban traumát elszenvedett emberek újratraumatizálását és
biztonságos teret nyújtanak nekik -, legyen szó helyi
egészségvédelmi intézményről, iskoláról, munkahelyi szervezetről vagy
különleges kezeléseket nyújtó intézményről, vagy akár kiskorúak nevelőintézetéről
(az igazságszolgáltatási rendszerben).
Bármilyen közösségnek, amely traumatudatosságra törekszik, rendelkeznie kell
ezekkel a közös nevezőkkel.
Ezeknek az alapelveknek a célja, hogy kommunikálják
és biztosítsák a traumatizált személy részére,
hogy pszichésen és fizikailag is teljesen biztonságban érezze magát,
hogy ez egy megbízható, biztonságos tér.

A traumatudatosság első alapelve az, hogy az adott intézménynek biztosítania kell egy olyan fizikai és érzelmi biztonságot, amiben az illető megbízhat, amire támaszkodhat, és azt érezheti, hogy semmi rossz nem fog történni, senki nem fogja megtámadni, bántani. Hogy egy olyan biztonságos helyen van, ahol nem kell folyamatos készültségben, szorongásban léteznie.

A traumatudatos intézményben a kommunikáció minden aspektusa kedves, kényelmes, a metakommunikációt is beleértve; a klienst szívesen látják, és mindenki szívélyesen üdvözli, és érezteti vele, hogy szívesen látják.

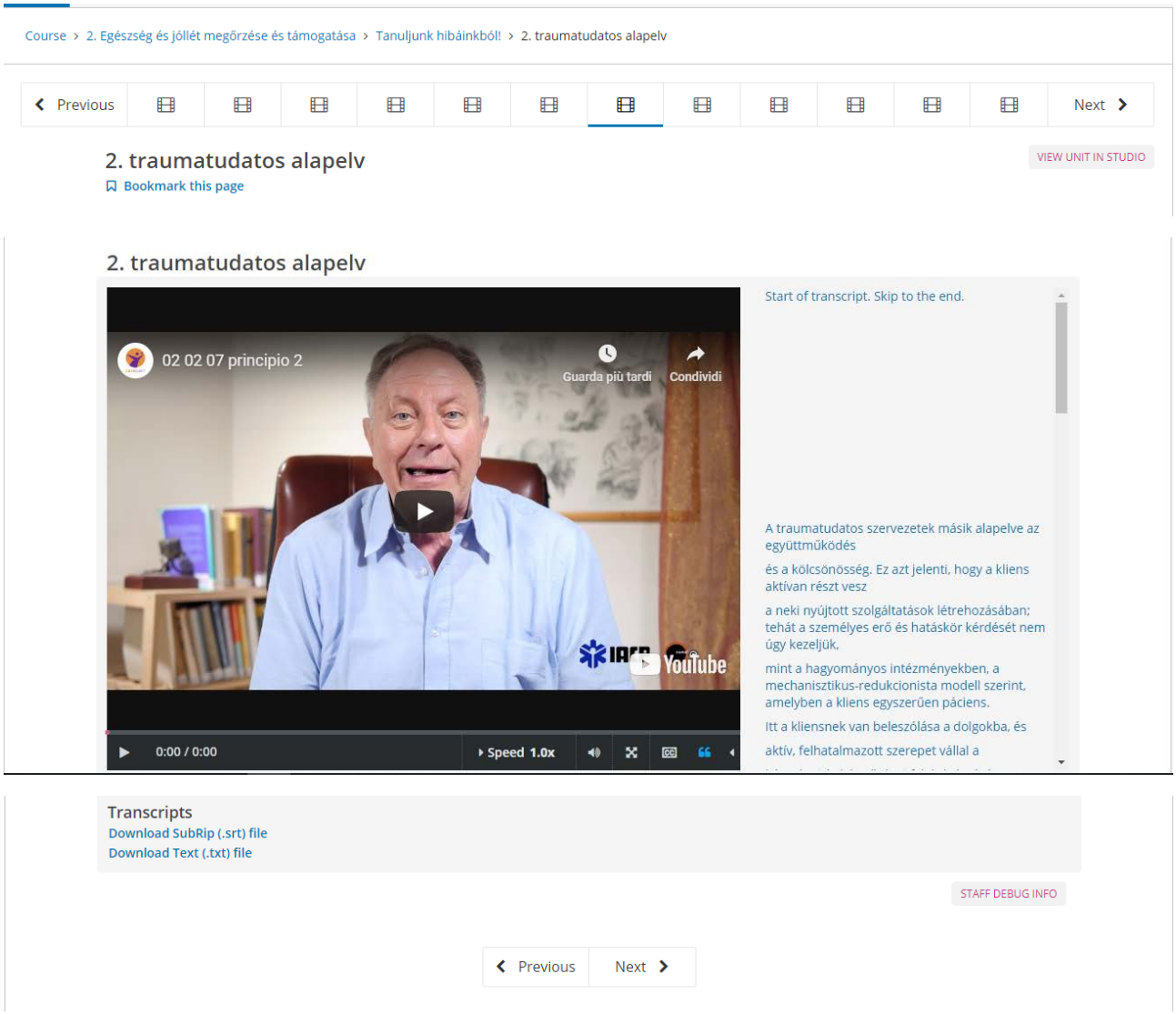
Az intézményben ahhoz, hogy az elnyerje a kliensek bizalmát és biztonságérzetet nyújtson számukra, nagy fokú integritásnak kell jelen lennie, és a közvetített üzeneteknek mindig összhangban kell lenniük a cselekedetekkel.

A kliens csak így tud valódi bizalmat kifejleszteni, és azt érezni, hogy az intézmény valóban szívesen látja, és hogy az egy olyan biztonságos hely, amelyre támaszkodhat.

A traumatudatos intézményben nincs helye az erőszaknak, a szégyennek, bűntudatnak és más problematikus dolgoknak, amik csak ronthatnak a kliens állapotán vagy újratraumatizálhatják.

Egy traumatudatos intézmény a szakmai titoktartást is garantálja: hogy a klienssel kapcsolatos bizalmas, érzékeny információkat nem oszt meg másokkal.

Végezetül pedig a traumatudatos intézmény egyértelmű, könnyen érthető nyelven kommunikál a klienssel, amit az könnyen megért, nem pedig olyan szakmai nyelven, amit csak képzett szakemberek értenek.



Transcript

A traumatudatos szervezetek másik alapelve az együttműködés

és a kölcsönösség. Ez azt jelenti, hogy a kliens aktívan részt vesz

a neki nyújtott szolgáltatások létrehozásában; tehát a személyes erő és hatáskör kérdését nem úgy kezeljük,

mint a hagyományos intézményekben, a mechanisztikus-redukcionista modell szerint, amelyben a kliens egyszerűen páciens.

Itt a kliensnek van beleszólása a dolgokba, és

aktív, felhatalmazott szerepet vállal a

készségei és lehetőségei feltárásának és visszaszerzésének folyamatában.

A traumatudatos szervezet támogatja

az öntisztelet visszaszerzését,

ami a traumaáldozatok esetében rendkívül fontos,

ahogy a remény és

a személyben rejlő lehetőségek tudatának visszaszerzése is.

Az ilyen intézmény tisztában van azzal, hogy

a poszttraumás stresszel élő emberek esetében az egészség és a

működőképes élet visszaszerzése

csak a szervezet munkatársai és a kliens között kialakított

jól működő kapcsolatok által lehetséges:

tehát csapatmunka, hatékony együttműködés által.

A döntéshozatali folyamat megosztása a klienssel központi fontosságú abban,

hogy a nyújtott szolgáltatások valóban hatékonyak lehessenek.

Karasek kutatásaiból tudjuk, hogy a stressz úgy működik,

hogy ha stresszes impulzusok érnek, de ugyanakkor kellő mértékben irányítani tudjuk a dolgokat,

a stresszszint lecsökken;

ám ha kicsi a beleszólásunk a helyzet alakulásába, a stresszszint megemelkedik. Itt is

ezzel az alapelvvel dolgozunk.

Tehát az, hogy a döntéshozás erejét a kliens kezébe is adjuk, már önmagában a kezelési-gyógyulási folyamat

része; más szóval, a több irányítási lehetőséggel rendelkező

ember jobban képes felülkerekedni a nehézségein.

A traumatudatos szolgáltatásokra törekvő intézmény nem támogatja

a nagy hatalmi különbségeket az intézmény munkatársai

és a kliensek között, hanem aktívan és tudatosan a kliens megerősítésére törekszik

és elismeri a jogát arra, hogy önrendelkezően irányítson és személyes erejét gyakorolja

a közös valóság együttes létrehozásának folyamatában.

A traumatudatos intézmény rendszerszinten és holisztikusan gondolkozik abban az értelemben,

hogy tisztában van azzal, hogy

a traumatudatosság létrehozásához

az intézmény minden szintjét és részét be kell vonni,

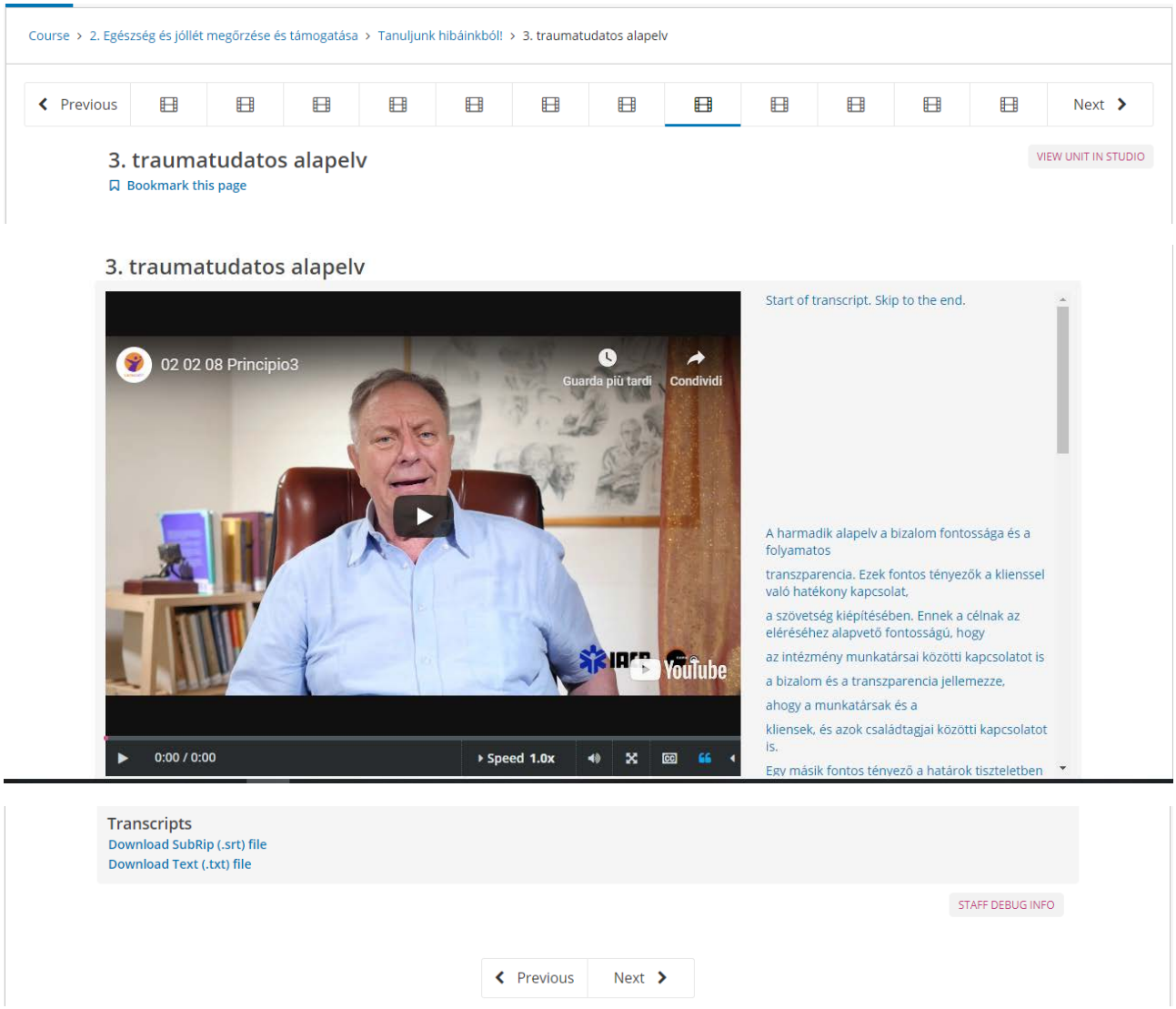
a kezdetektől a folyamatok végéig:

a kliensek felvételének kezdetétől, a fogadástól

kezdve a kezelést végző személyeken át

a kezelés utáni jó funkcionálást biztosító

utógondozási szakaszig.



Transcript

A harmadik alapelv a bizalom fontossága és a folyamatos
transzparencia. Ezek fontos tényezők a klienssel való hatékony kapcsolat,
a szövetség kiépítésében. Ennek a célnak az eléréséhez alapvető fontosságú, hogy
az intézmény munkatársai közötti kapcsolatot is
a bizalom és a transzparencia jellemezze,
ahogy a munkatársak és a
kliensek, és azok családtagjai közötti kapcsolatot is.
Egy másik fontos tényező a határok tiszteletben tartása, mivel elsősorban
az egyértelmű határok által tudunk tiszta bizalmi teret létrehozni. A határok
tiszteletben tartásának hiánya megmérgezi a környezetet és diszfunkciót teremt.
A transzparencia alapvető fontosságú, ezért a szabályoknak egyértelműeknek kell lenniük,
és bürokratikus nyelvezet helyett érthető, transzparens nyelven kell őket megfogalmazni.

Az egyértelműség amiatt is

fontos, hogy mindenki - főleg a kliens – tudja, hogy mi a szerepe,

mik a jogai és kötelességei, mik az intézmény és a vele dolgozó

munkatársak jellemzői.

Tehát a szerepeknek is tisztáknak kell lenniük, és észben kell tartani, hogy az intézményben dolgozó

különböző szakemberek különböző készségekkel rendelkeznek,

a kezelés más-más részeivel foglalkoznak, és senki nem

foglalkozik mindennel egyszerre. Ahogy a pék a kenyeret süti, a tehenész

tejet termel, a mérnök műszaki terveket készít, stb.

Alapvető fontosságú még a traumatudatos intézményben a jogok tiszteletben tartása és a kliens

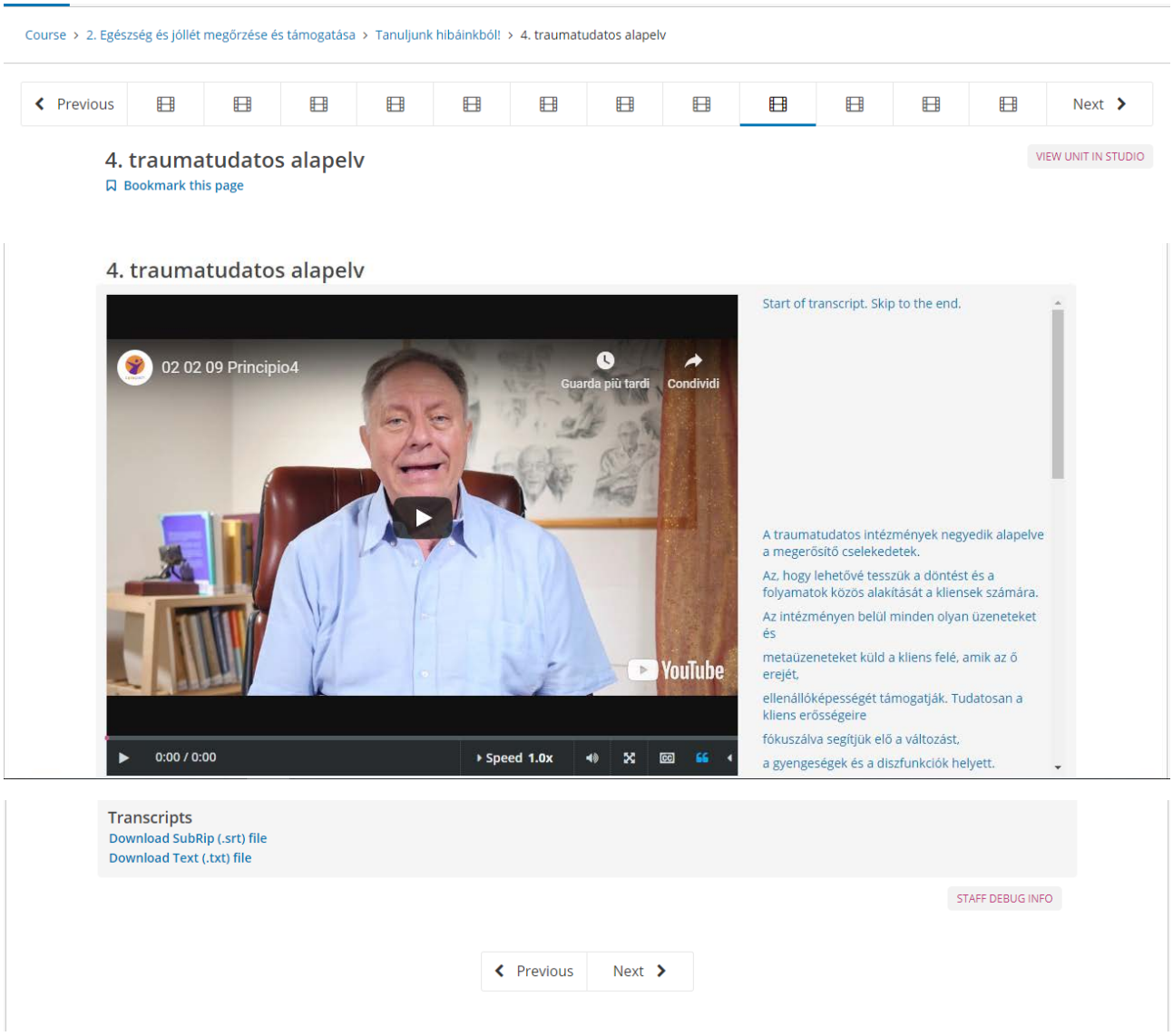
jogainak aktív támogatása. Ezért mindenképpen

ki kell kérni a kliens tájékozott hozzájárulását,

alaposan el kell neki magyarázni, hogy milyen kezelésben fog részesülni, a különböző eljrásokat, a kezelés menetét;

mindent meg kell tenni annak érdekében, hogy valóban megértse és úgy adja a hozzájárulását,

ne pedig puszta formalitásként.



Transcript

A traumatudatos intézmények negyedik alapelve a megerősítő cselekedetek.

Az, hogy lehetővé tesszük a döntést és a folyamatok közös alakítását a kliensek számára.

Az intézményen belül minden olyan üzeneteket és

metaüzeneteket küld a kliens felé, amik az ő erejét,

ellenállóképességét támogatják. Tudatosan a kliens erősségeire

fókuszálva segítjük elő a változást,

a gyengeségek és a diszfunkciók helyett.

A hangsúly a megküzdésen, annak tudatosításán van, hogy

a kliens a múltban hogyan kezelte a különböző

helyzeteket, ha hatékonyan, ha nem.

Azt a filozófiát alkalmazzuk tehát, hogy a kliens

erős pontjaira fókuszálunk. A múltban a fókusz inkább a patológiákon és

azok csökkentésén volt;

most viszont az egészségre, az erősségekre koncentrálunk, és igyekszünk a fejlődésüket, jobbulásukat elősegíteni.

Ez a társadalomban betöltött szerepet is erősíti, és mivel szociális lények vagyunk,

ez alapvető fontosságú a megfelelő identitás kialakításában és a belső lehetőségeink kibontakoztatásában.

Folyamatosan azért a célért dolgozunk,

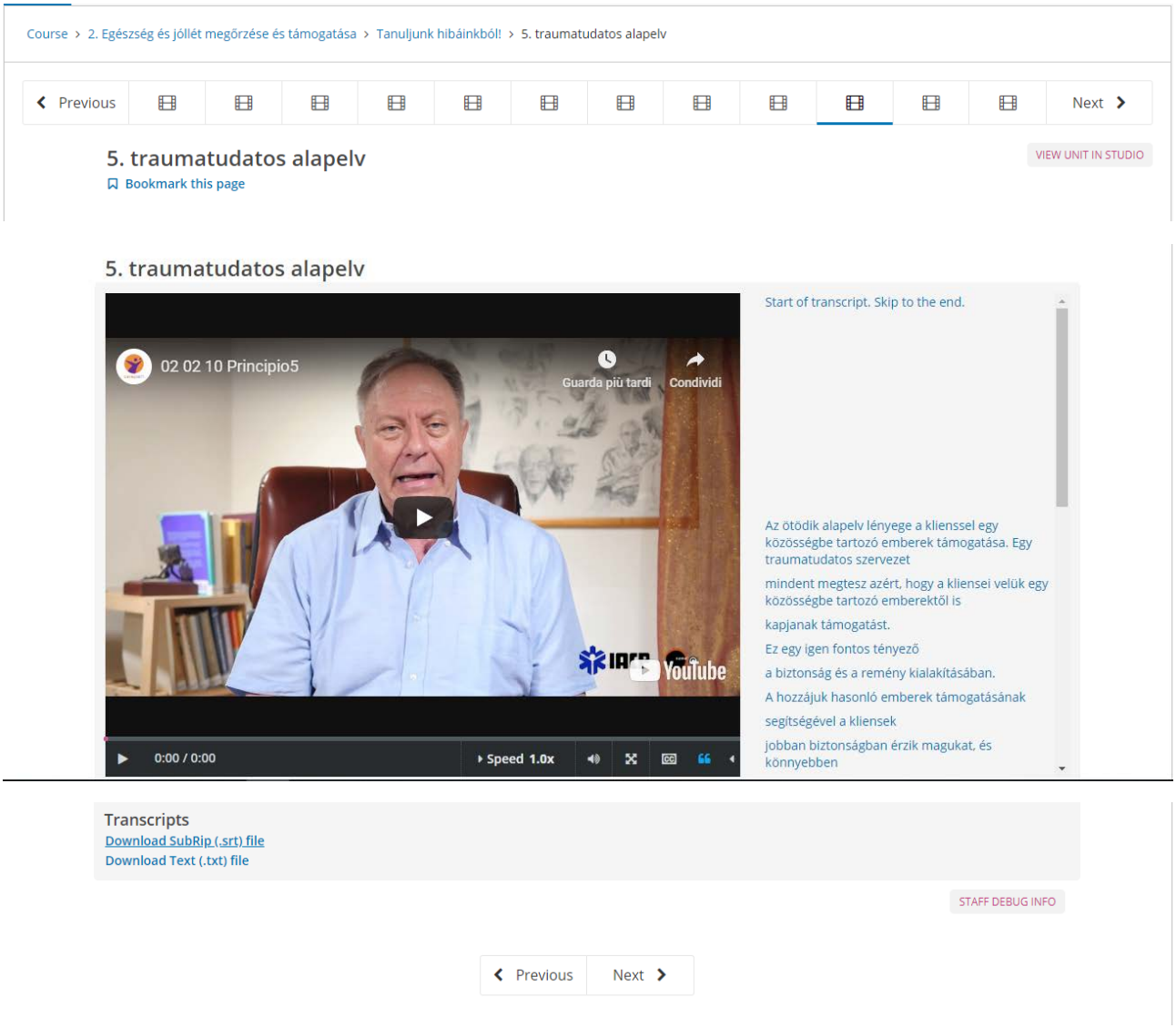
hogy erősítsük a kliens készségeit és önregulációs képességét,

az önállóságát, és önmaga és az élete ellátásának és menedzselésének képességét. Ez a hangsúlyt a

traumatikus élmények utáni továbblépésre helyezi:

nem azt hangsúlyozzuk, hogy ő egy szerencsétlen áldozat,

hanem az ellenállóképességét.



Transcript

Az ötödik alapelv lényege a klienssel egy közösségbe tartozó emberek támogatása. Egy traumatudatos szervezet

mindent megtesz azért, hogy a kliensei velük egy közösségbe tartozó emberektől is

kapjanak támogatást.

Ez egy igen fontos tényező

a biztonság és a remény kialakításában.

A hozzájuk hasonló emberek támogatásának

segítségével a kliensek

jobban biztonságban érzik magukat, és könnyebben

megszületik bennük a remény arra, hogy van javulás.

Az ilyen típusú támogatás fontos a megfelelő önbizalom és magabiztosság kiépítéséhez,

ahhoz, hogy a kliens bízni tudjon magában.

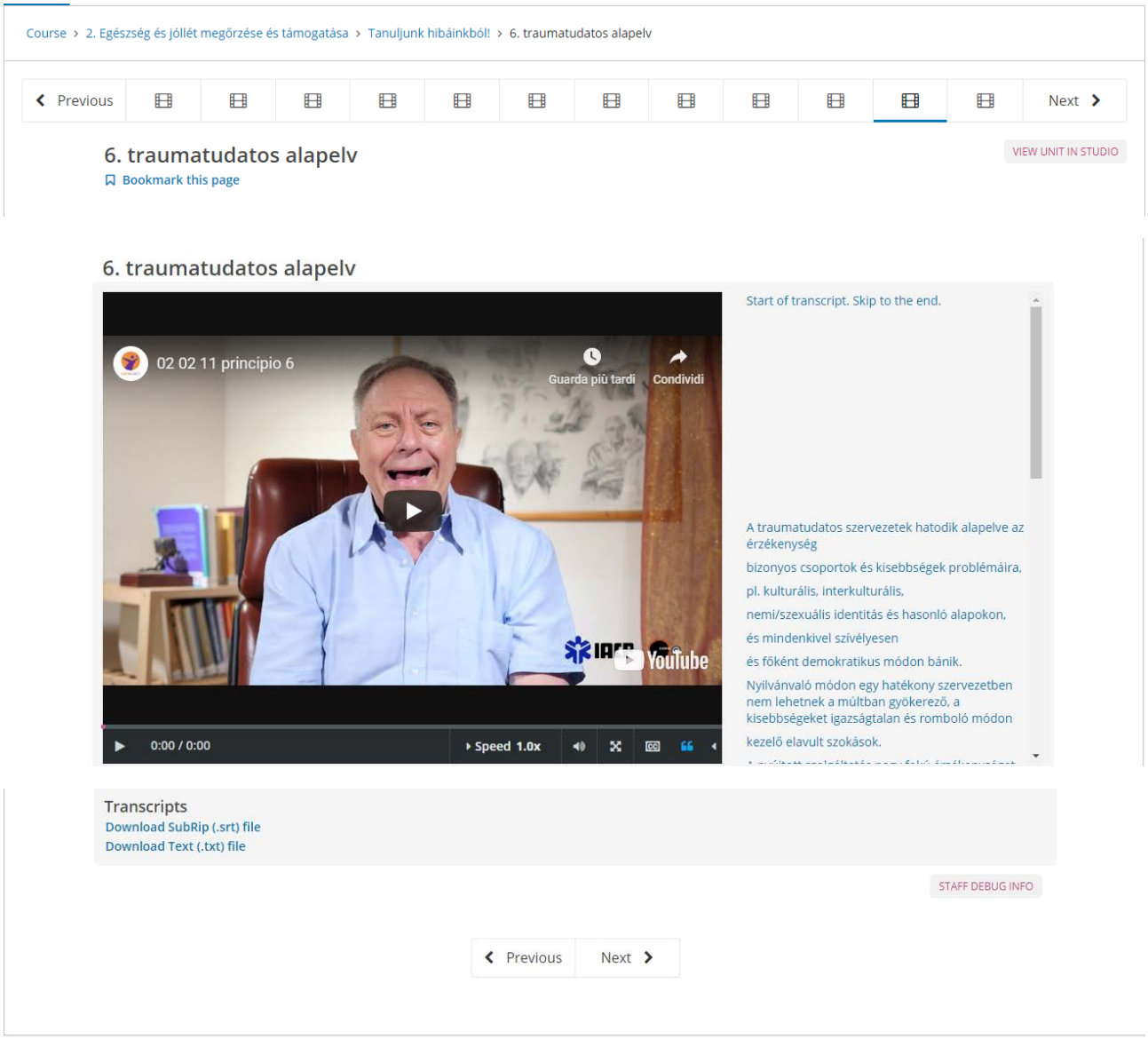
A klienssel egy közösségbe tartozó emberek támogatása elősegíti az együttműködések kialakulását, illetve általában véve a kliens társadalmi beágyazódását és aktivitását.

Egyértelmű, hogy az ilyen típusú támogatás olyan interperszonális kommunikációra teremt lehetőséget, amelynek segítségével támogató narratívák születhetnek:

hogy egy nagyobb háló,

közösség része vagyok, és hogy

van remény a javulásra, gyógyulásra.



Transcript

A traumatudatos szervezetek hatodik alapelve az érzékenység

bizonyos csoportok és kisebbségek problémáira,

pl. kulturális, interkulturális,

nemi/szexuális identitás és hasonló alapokon,

és mindenkivel szívélyesen

és főként demokratikus módon bánik.

Nyilvánvaló módon egy hatékony szervezetben nem lehetnek a múltban gyökerező, a kisebbségeket igazságtalan és romboló módon

kezelő elavult szokások.

A nyújtott szolgáltatás nagy fokú érzékenységet tanúsít

a nemi diverzitás felé,

tiszteletben tartja a nemi egyenjogúságot,

valamint a kliensek kultúrájának és

származási országának kultúráját,

hagyományait.

Az ilyen szervezet a saját filozófiájával harmóniában lévő teret hoz létre:

a szervezet és az eljárások

diszkriminációmentesek és érzékenyek a diverzitásra.

Továbbá képes felismerni és hatékonyan kezelni a történelmi traumákat is.

A történelmi traumák

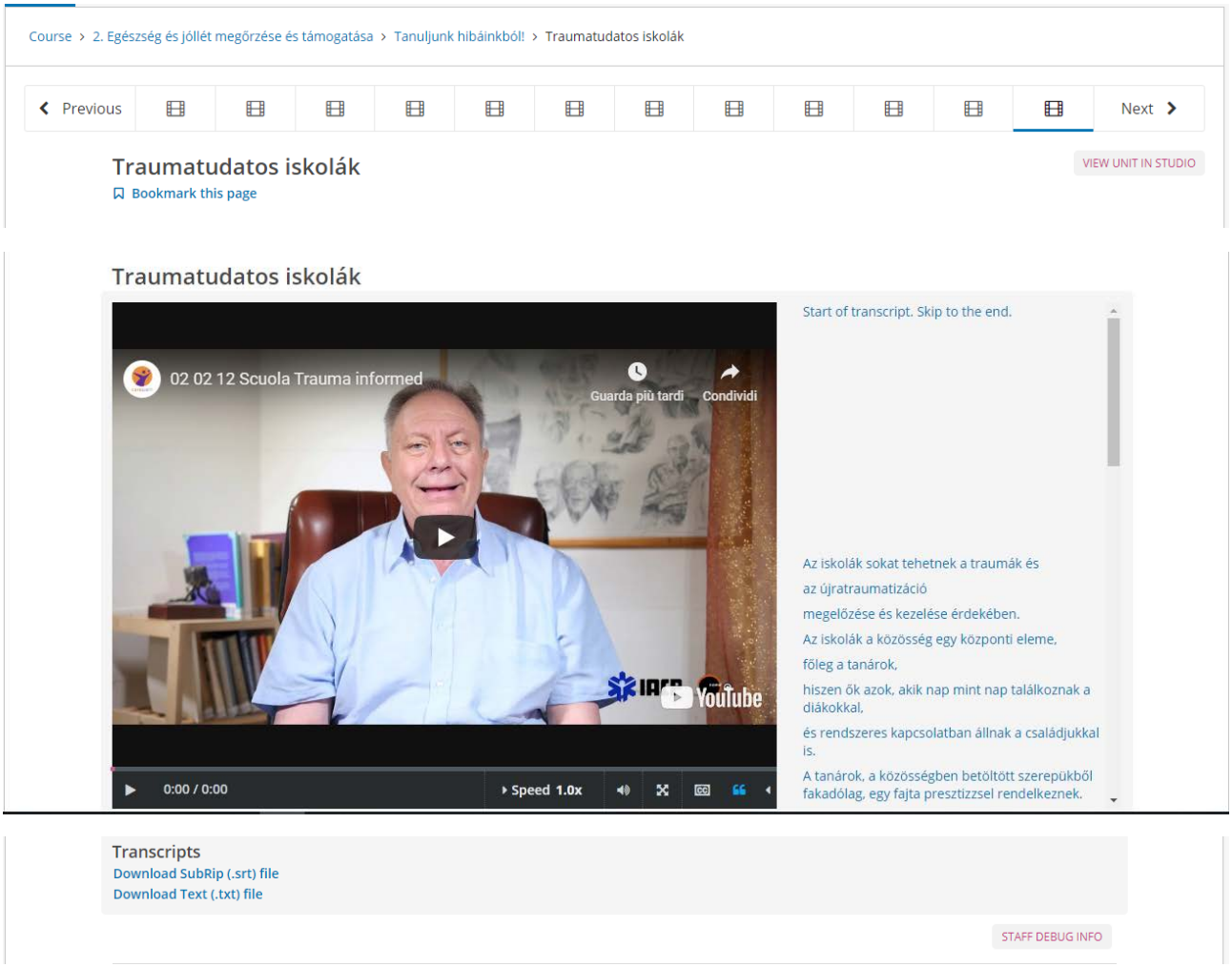
traumatikus közösségi eseményekben gyökereznek, és

azokra is hatással vannak, akik nem élték át őket közvetlenül. Egy drámai példa erre pl. a Holokauszt,

ami nem csak az annak közvetlenül áldozatul esett milliókra hatott,

hanem az ő gyermekeik és unokáik is

viselik az eredeti traumatikus esemény kigyűrűző hatásait.



Transcript

Az iskolák sokat tehetnek a traumák és

az újratraumatizáció

megelőzése és kezelése érdekében.

Az iskolák a közösség egy központi eleme,

főleg a tanárok,

hiszen ők azok, akik nap mint nap találkoznak a diákokkal,

és rendszeres kapcsolatban állnak a családjukkal is.

A tanárok, a közösségben betöltött szerepükből fakadólag, egy fajta presztizzsel rendelkeznek.

Ezért ha a tanárokat és minden iskolai munkatársat

érzékenyítünk és tájékoztatunk a

traumatudatos iskola jellemzőiről, és emellé

egy olyan szakember segítségét és tanácsait

ajánljuk fel számukra, aki segít nekik fejlesztéseket, változtatásokat bevezetni

(annak érdekében, hogy a traumákra vak iskola

traumatudatossá váljon), akkor az az iskola

onnantól kezdve a probléma helyett a megoldás részévé válik.

Nem csak amiatt, hogy az arra

érzékenyített tanárok

észlelni fogják azokat a jeleket,

amiket a megfelelő tudás nélkül pusztán

magatartásbeli problémáknak értelmeznének, hanem mert - traumatudatos tanárként -

a diákjaikat beajánlhatják

a megfelelő szakemberhez, aki

meg tudja állapítani, hogy a diák valóban

szenvedett-e el traumát.

A másik terület, ahol a tanároknak nagy hatása lehet, a szülők.

Lassanként ők is traumatudatos szülőkké válhatnak,

és nagyban hozzájárulhatnak

ennek az egész kérdéskörnek a megoldásához.

Összefoglalva, a traumatudatos iskola

valóban teljesíti az iskolák kitűzött feladatát:

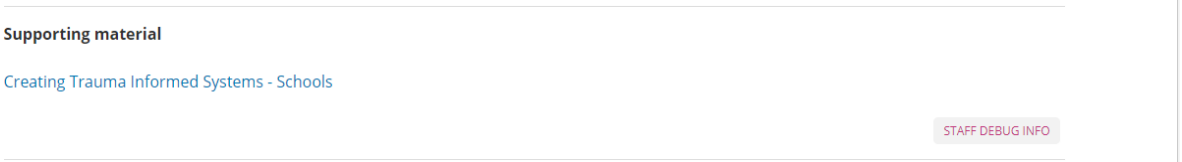
hogy rendelkezzen azzal a tudással és megossza azt,

amellyel a diákok a társadalom proaktív tagjaivá válhatnak.

Tehát a traumatudatos iskola

képes teljes mértékben, a lehető legjobb formában

betölteni az iskola küldetését.



Vannak traumatudatos iskolák az Ön helyi közösségében, vagy az országában?

Please enter your response within this text area

Your response must be between 1 and 1000 words.

Invia Salva *You have used 0 of 1 submission*

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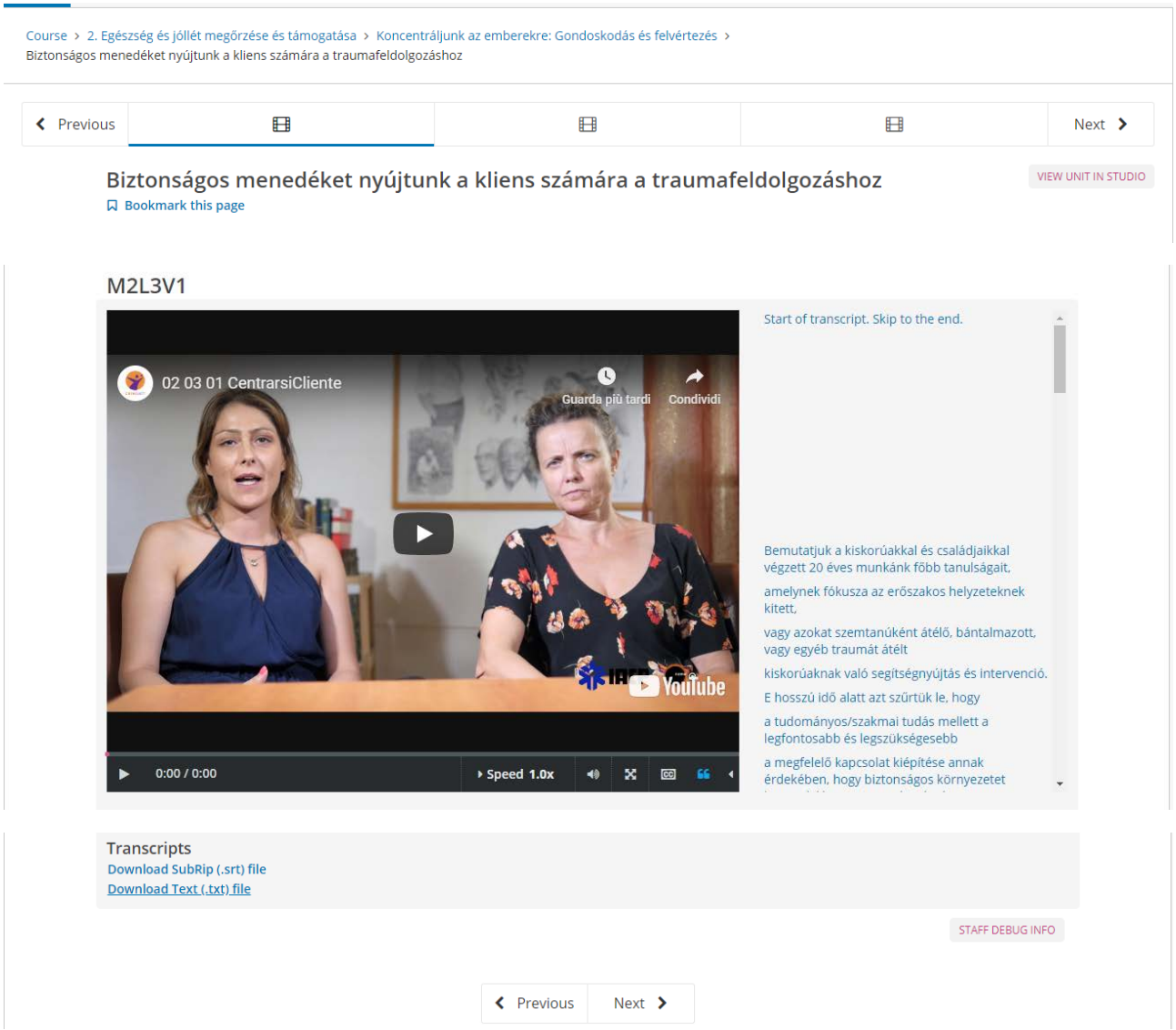


Transcript

Bemutatjuk a kiskorúakkal és családjaikkal végzett 20 éves munkánk főbb tanulságait,

amelynek fókusza az erőszakos helyzeteknek kitett,

vagy azokat szemtanúként átélő, bántalmazott, vagy egyéb traumát átélt

kiskorúaknak való segítségnyújtás és intervenció.

E hosszú idő alatt azt szűrtük le, hogy

a tudományos/szakmai tudás mellett a legfontosabb és legszükségesebb

a megfelelő kapcsolat kiépítése annak érdekében, hogy biztonságos környezetet hozzunk létre a gyermek számára.

A biztonságos környezet alappillérei

a szükségeletek figyelmes meghallgatása és a tisztelet.

Ezek még inkább fontosak olyan esetekben, ha a kiskorú

a biztonságérzetét, önmaga tiszteletét és az életbe vetett hitét romboló helyzeteket élt át.

Ilyenkor mindennél fontosabb a mélységes tisztelet ahhoz, hogy a pszichés és személyes fejlődés folytatódhasson.

Mit jelent ez a tisztelet? Ebben a kontextusban a tisztelet nem más, mint a figyelem,

az empatikus figyelem és meghallgatás.

Azt jelenti, hogy a protokollok és a szakember igényeinek priorizálása helyett

a kiskorú belső világára helyezzük

a hangsúlyt: a szükségleteire, a saját tempójára,

amit tiszteletben kell tartani, hiszen sok esetben olyan gyerekekről van szó,

akik erős önvédelmi mechanizmusokat fejlesztettek ki.

Ezért fontos, hogy a szakember ne akarjon

beférkőzni a védelmi határok mögé (kérdések erőltetésével, stb.),

hanem tartsa tiszteletben a gyermek saját tempóját, annak tudatában,

hogy az adott védelmi mechanizmus a gyermek legjobb stratégiája olyan élmények ellen,

amelyek túl erősek voltak a számára. Ezt betartva, lassan haladva a védelmi vonalak egyre kevésbé lesznek szükségesek,

és el fogunk jutni a gyermek szívének, érzéseinek a közepébe.

A tapasztalat azt mutatja, hogy fontos a gyermek szükségleteire fókuszálni.

Most pedig bemutatjuk a Róma tartományban élő kiskorúak és családjaik

körében, megelőzés, védelem és támogatás formájában

80 éve végzett szociális segítségnyújtási munkánk tapasztalatait.

Ahogy az imént is elmlítettük, fontos a gyermek szükségleteire fókuszálni,

ám legalább ugyanilyen fontos és szükséges figyelembe venni azt, hogy

minden helyzet, minden eset más és más. Szintén fontos

tekintetbe venni a gyermek szüleit is. Szociális asszisztensként a mindennapi munkánk

középpontjában elsősorban a szülők állnak, mivel a traumát elszenvedett

kiskorúakkal általában más,

az ő segítésükben megfelelően képzett

szakember foglalkozik.

A szociális munkás feladata, hogy kísérje a családokat

a nehézségeikre, kríziseikre,

törékenységükre való reflektálás folyamatában,

ahogy annak tudatosításában is, hogy mely viselkedéseik okoztak károkat és szenvedést a gyermeküknek.

Segít nekik továbbá kapcsolatokat kiépíteni, hogy támogassa őket a

megfelelő szülői felelősség kifejlesztésében,

amely lehetővé teszi a gyermek számára, hogy

egy nyugodt, biztonságos,

támogató környezetben nőjön fel.

Tapasztalatunk szerint az e területen dolgozó szakembereknek

a feltétlenül szükséges tudományos és szakmai tudáson és képességeken túl

személyes készségekkel, önismerettel is

rendelkezniük kell. Ez a szakember saját

belső világával kapcsolatos: a saját érzései, előítéletei,

benyomásai, projekciói, amik nekünk is vannak.

Hiszen amellett, hogy segítő szakemberek vagyunk,

mi is emberek vagyunk, akik másik emberekkel találkoznak.

Mi történik, amikor bántalmazó

szülőkkel kell dolgoznunk? Ez nehéz lehet számunkra is:

haragot, felháborodást, megotránkozást,

és olykor félelmet érezhetünk; a lényeg, hogy

nem kell úgy tennünk, mintha nem éreznénk ezeket. Ezek

a részünk, és belekerülnek a segítő kapcsolatba is. Ami fontos, az az,

hogy megtanuljuk felismerni őket, hogy kezelni tudjuk őket, hogy ne vigyük bele őket

a helyzetekbe, amikkel dolgozunk. Fontos, hogy ne a szubjektív érzéseinken

keresztül értelmezzük azt, amivel dolgozunk,

ne keverjük össze a szerepeket. Előfordul, hogy a segítő, akin eluralkodnak az érzései, olyan szerepet vesz fel,

amelyben utasításokat ad, és a szülő alárendelődik a szakember döntéseinek.

Ez semmiképpen nem segíti elő a gyermekek védelmét, hiszen

ha nem fókuszálunk teljes mértékben a helyzetre, amivel dolgozunk,

akkor nem tudjuk megérteni és felmérni a gyermek szükségleteit, és megfelelően megtervezni a szakmai intervenciót.

Ami a gyermekkel való közvetlen kapcsolatot illeti, a szociális munkás intervenciós hatásköre

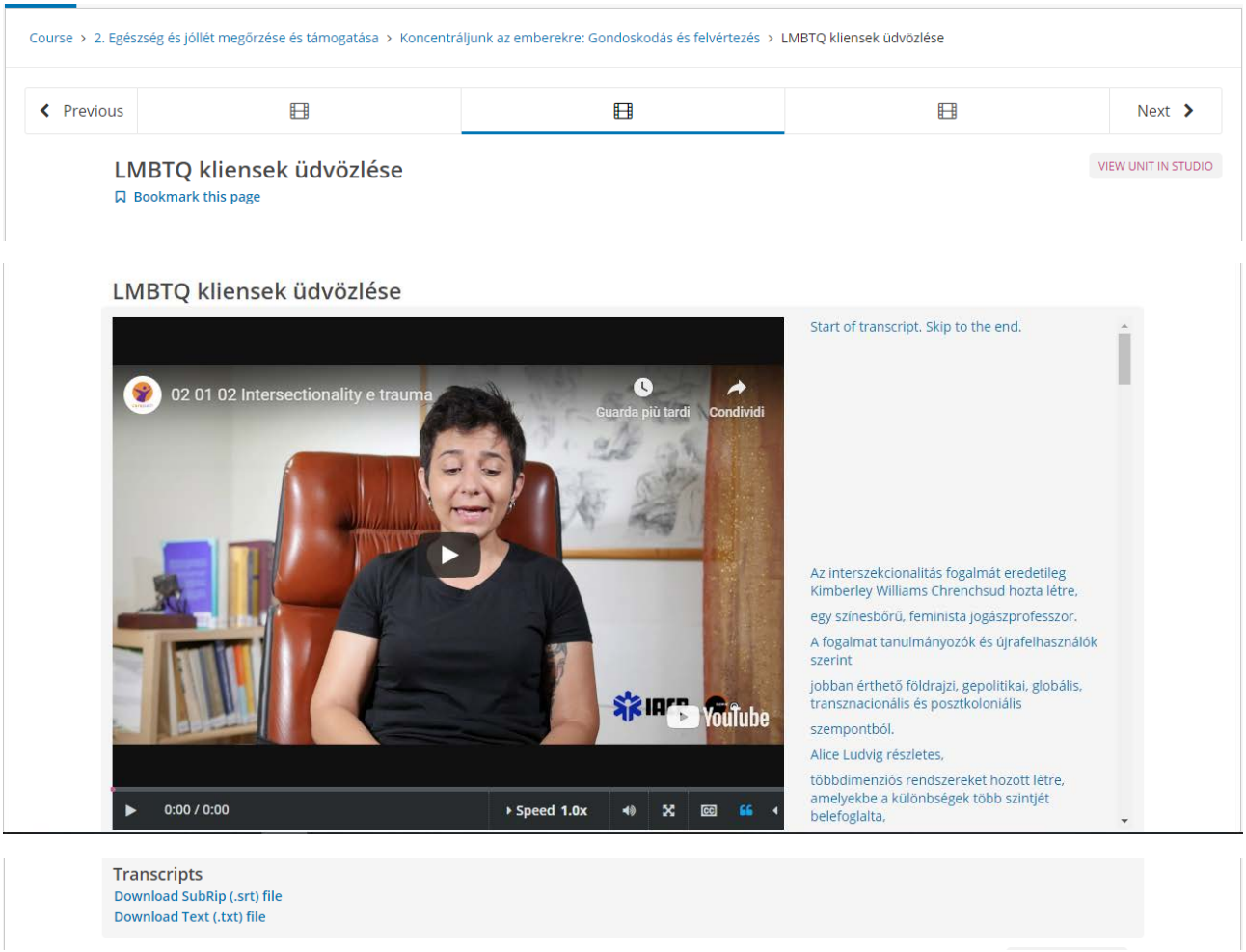
limitáltabb.

Erős érzelmi töltet lehet jelen ezekben a helyzetekben;

előfordulhat, hogy a szociális munkás a saját személyes szükségletére akar azzal válaszolni, hogy gyengédséget és törődést ad

azoknak a gyerekeknek, akiknek nem volt részük ilyenben; máskor pedig lehet, hogy túlságosan

hangsúlyozza a klinikai szaksegítő szerepét, aki klinikailag segít a gyermeknek feldolgozni a traumáit.



Transcript

Az interszekcionalitás fogalmát eredetileg Kimberley Williams Chrenchsud hozta létre,

egy színesbőrű, feminista jogászprofesszor.

A fogalmat tanulmányozók és újrafelhasználók szerint

jobban érthető földrajzi, gepolitikai, globális, transznacionális és posztkoloniális

szempontból.

Alice Ludvig részletes,

többdimenziós rendszereket hozott létre, amelyekbe a különbségek több szintjét belefoglalta,

úgymint a nemi identitás, szexuális orientáció, rassz, bőrszín, etnicitás, státusz, társadalmi osztály, kultúra, stb.

Ez az a számtalan tényező,

amelyet figyelembe kell vennünk és amire oda kell figyelnünk, amikor az általánosságban kisebbségeknek

nevezett csoportokba tartozó emberekkel vagyunk segítői kapcsolatban.

Audre Lorde-t idézve

azt mondhatnánk, hogy az élet

nem csak egyetlen tengely mentén zajlik, hanem többdimenziósan.
A nemzetköziség egyre inkább a része az
egyenlőségi szakpolitikáknak,
hála az ENSZ és az Európai Unió munkájának is.
Egyre több a diszkriminációellenes
irányelv nemzeti, regionális és helyi szinteken egyaránt,
és a nyugati államokban
egyre több vállalat tesz megáévá a diverzitást
figyelembe vevő
szabályzatokat.
Ez persze nem közömbösíti azoknak a bizonytalanságát és szenvedését,
akik többszörösen kisebbségi helyzetben élnek,
és adott esetben épp a kisebbségi státuszuk miatt kellett traumatikus eseményeket átélniük.
Egy 2018. másuj 17-i „napilapban”
egy kameruni fiútól idéznek:
„egyik nap a könyhában ültünk és egy tévéműsort néztünk LMBTQI migránsokról,
amikor az afrikai társaim azt mondták:
- Olaszország egy szar ország, tele homokosokkal -
én pedig ismét nem éreztem magam szabadnak.
Allen 22 éves, és azért hagyta el Kamerunt, mert megverték és démonnak nevezték.
Az újság szerint
Kamerunban
a homoszexualitás bűnnek számít,
ezért kért nemzetközi védelmet Olaszországban.
Ám sajnos ugyanazzal a félelemmel kell élnie,
mivel a homofóbia egészen a bolognai Mattea utcáig követte,
ahol más kameruniakkal együtt fogadták.
Az LMBTQI migránsok igen gyakran igen fiatalok.
Nem számíthatnak
a származási országuk támogatására,
ezért kell útnak indulniuk,
de sokszor megkülönbözteti őket az a homofóbia vagy transzfóbia, amitől menekülnek.

Nem lehetnek benne biztosa, hogy olyan multikulturális helyzetbe fognak kerülni,

ami lehetővé teszi, hogy békésen megéljék a szexuális orientációjukat vagy nemi identitásukat.

Ahogy a Vicenzo Bramato által készített interjúkban többször hangsúlyozták,

aki a bolognai Arcigay közösség elnöke,

egyes európai országokban - pl. Németországban -

léteznek olyan védett intézmények, ahol kifejezetten a szexuális/nemi hovatartozásuk miatti üldözés elől menekülő embereket fogadnak.

Ezeken a helyeken a munkatársak speciális képzést kapnak annak biztosítására,

hogy nehogy ítélkező vagy lealacsonyító hozzáállással közeledjenek ezekhez az emberekhez, ami újraélesztené az áldozaták által átélt stigmát

és traumát.

Olaszországban jelenleg a fogadórendszer nincs felkészülve az ilyen esetekre,

de hálisten vannak pozitív kezdeményezések. Ilyen pl. az a 2017-ben

Modenában indított kísérleti eljárás, ahol egy hat fős lakást hoztak létre

kifejezetten LMBTQI menedékkérők számára,

illetve van egy LMBTQI migránssegítő szolgáltatás Veronában.

Az ilyen LMBTQI migráns gyerekek számára,

akik

még egy érzékeny korban

vannak,

az, hogy egy befogadó országban etnikai kisebbségnek számítanak,

csak része a problémának.

Ők gyakran még a saját származási országukban is

egy félelemben élő, néma kisebbségnek számítanak.

A Rogers által megfogalmazott láthatatlan trauma

így megduplázódik.

Vittorio Lingiardi által megfogalmazott kisebbségi stressz

duplán érinti őket:

így a mentális és fizikai egészségük is duplán veszélyeztetett,

az eredmény pedig humántőke szempontból óriási veszteség.

A fogadó szolgálatokban való munkára felkészítés elsősorban emberi jogi képzést jelent,

amibe beletartoznak

azok a speciális helyzetek és igények is,

amiket az LMBTQI migránsok hoznak magukkal a segítő kapcsolatba.

A képzésnek tehát személyközpontúnak kell lennie,

és ahhoz, hogy igazán befogadó legyen, a szakembernek ismernie kell és pozitívan kell hozzáállnia az ilyen speciális körülményekhez.

Az, hogy a migránsoknak szóló szolgáltatások

tervezésénél és nyújtásánál

nem veszik figyelembe a szexuális orientáció és nemi idetitiás lehetséges sokféleségét,

csökkenti a szolgáltatás hatékonyságát,

mind a klienssel való kapcsolat

(sok olyan gyerek és fiatal van,

akik nem kapnak olyan fogadást, amilyet kapniuk kellene),

mind a képzések és megelőzési utak hasznosságának tekintetében

(pl. gondoljunk a szexuális úton terjedő

betegségekre, vagy arra, hogy

többdimenziósan kell tudnunk kezelni egy esetet,

ha a kliens egy LMBTQI, kamasz korú migráns).

Másrészt viszont azt is fontos megjegyezni, hogy az LMBTQI közösség által

nyújtott szolgáltatások a legtöbbször egy nyugati meleg férfiakon és leszbikus nőkön alapuló kulturális modellel dolgoznak,

ami gyakran

nem veszi figyelembe azt, hogy ezek a fiatalok más kulturális modelleket hoznak magukkal,

és nem tudnak a szolgáltatással azonosulni.

Mindezen okok miatt

az ilyen intézmények és civil szervezetek

által nyújtott információk és segítő szolgáltatások

nem feltétlenül hasznosak az ilyen gyermekek számára.

Az ilyen, többszörösen kisebbségi

státuszú emberekkel való munka

szükségessé teszi az interdiszciplináris reflexiót

a segítő kapcsolatok gyakorlatára. A segítő kapcsolatokra felkészítő, szakembereknek szóló képzéseknek

ki kéne térnie az olyan eshetőségekre, mint a homoszexualitás, biszexualitás, transzneműség;

a stigma a fogalma a pszichiátria és pszichológia történetében;

a homofóbia,

internalizált homofóbia,

valamint a szolgáltatást nyújtóknak folyamatosan

továbbképzéseket kéne nyújtani

az ezekhez a témákhoz kötődő jogszabályi változásokról,

mind a befogadó, mind a származási ország tekintetében.

Végezetül pedig folyamatosan követni kellene

a menedékkérőkkel kapcsolatos

jogszabályi környezet

változásait, mivel

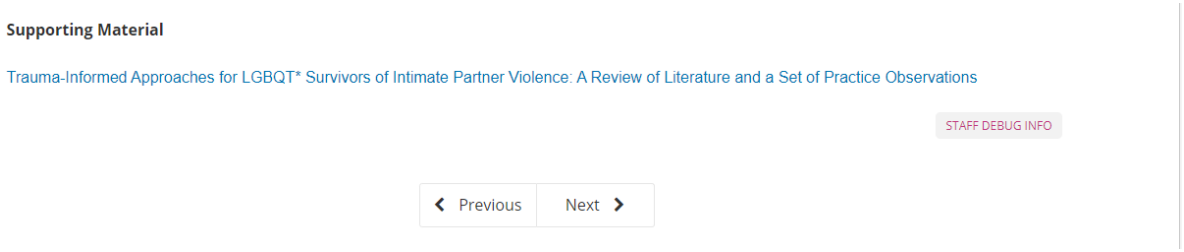
az folyamatosan fejlődik és változik.

A konkrétabb szakmai készségek mellett szükséges személyes szinten is kifejleszteni és elsajátítani egy

olyan szemléletet, ami érzékeny a nemi és szexuális identitások sokszínűségére, és tisztában az emberi jogokkal,

mind az ilyen fiatalokkal dolgozó egyéni szakemberek,

mind a szervezetek számára.



Transcript

A trauma utáni fejlődés arra a jelenségre utal,

amit egyes traumatizált emberek

a trauma eredményeképp átélnek.

Tehát a trauma nem csak jelentős testi és pszichés károkat okoz az

érintettek számára,

hanem emellett létezik ez a jelenség is,

amelyről a traumatúlélők nagy része, ha nem a többsége,

szintén beszámol.

Ez egyértelmű példája az emberi faj rezilienciájának;

habár a bolygónkon kifejlődött

összes életforma

rezilienciájáról is beszélhetnénk.

Ettől függetlenül a trauma tragédiája súlyos hatással van az azt átélőre; nagy csapás lehet,

ami fájdalmat és károkat okoz az illetőnek.

Egy valóságos földrengés, amelynek az utóhatásai

kihatnak az emberre pszichés és fizikai síkon egyaránt.

Ám még az ilyen nagy megrázkódtatásokról is

elmondható, hogy nem kizárólag

romboló hatással rendelkeznek. A trauma által súlytott

embernek meg kell küzdenie az élménnyel,

az az által létrehozott új élethelyzetekkel,

és így az alkalmazkodás által fejlődést is átélhet az élmény hatására.

Az áldozatok egzisztenciális

fejlődésen mennek keresztül, más szóval

nyitottabbakká válnak, szorosabban kapcsolódnak az értékrendjükhöz, a számukra fontos morális és spirituális dimenziókhoz;

jobban jelen vannak az életben, életigenlőbbek lesznek,

és jelentőségtelibben, mélyebben kapcsolódnak

önmagukhoz, másokhoz és a világhoz.

Egy példa: emlékszem azokra az érzésekre, amiket egy

egy kollégám, Victor Frankl könyve olvasása közben éltem át, aki súlyos tragédiát és traumákat élt át:

zsidóként a nácik elfogták

és koncentrációs táborba zárták.

Ezekben a táborokban, mielőtt az embereket megölték, a maradék

emberi méltóságuktól is megfosztották őket. Ám volt néhány ember,

aki nem csak fizikailag élte ezt túl, hanem az összes tauma ellenére

pszichésen is; és jobb emberekké váltak. És ahogy Frankl leírja,

„Az ember az értelemre irányuló kérdéssel szemben” c. könyvében, a hozzá hasonló foglyok mindent megtettek,

a saját kevés kis élelmüket is odaadták azért,

hogy szerető gondoskodást nyújtsanak

a náluk szerencsétlenebb foglyoknak, akik, mivel betegek vagy gyengék voltak, jobban ki voltak téve a veszélynek,

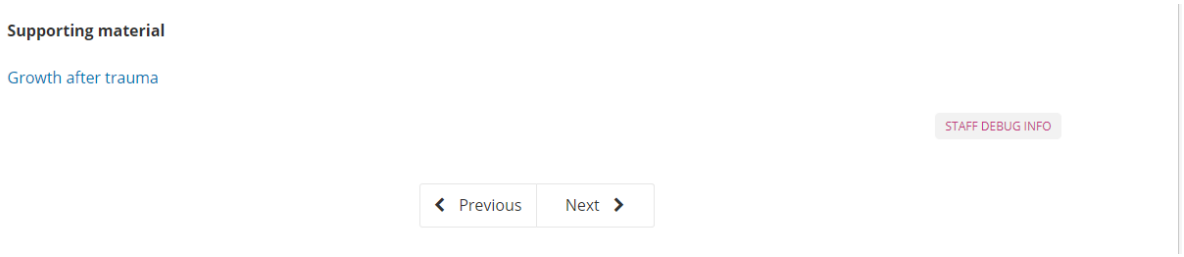
hogy elviszik őket a gázkamrába.

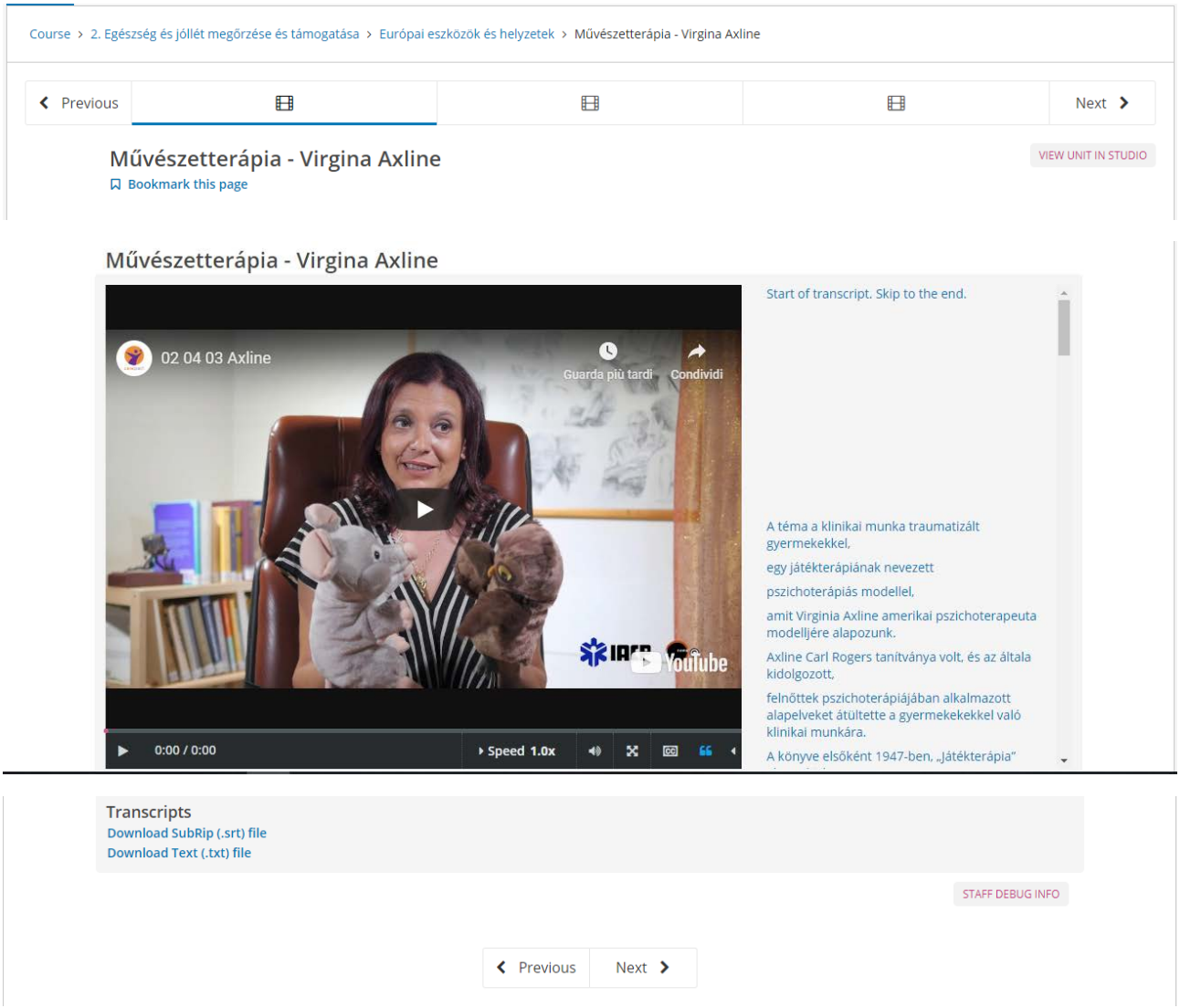
Azok, akik túlélték, és felszabadultak a nácik ámokfutása végén,

jobb emberekké váltak. A fizikai gyengeségük és pszichés traumáik ellenére

mélyebb kapcsolatot alakítottak ki egzisztenciális szinten magukkal, másokkal

és a világgal. Ez elgondolkodtató és reménykeltő mindannyiunk számára.





Transcript

A téma a klinikai munka traumatizált gyermekekkel,

egy játékterápiának nevezett

pszichoterápiás modellel,

amit Virginia Axline amerikai pszichoterapeuta modelljére alapozunk.

Axline Carl Rogers tanítványa volt, és az általa kidolgozott,

felnőttek pszichoterápiájában alkalmazott alapelveket átültette a gyermekekkel való klinikai munkára.

A könyve elsőként 1947-ben, „Játékterápia” címmel jelent meg.

Az alaptétel, amit Rogers is kifejez,

és ami Axline a gyermekek belső világának megértésére irányuló munkáját is megalapozza az,

hogy minden gyermekben ott van a veleszületett késztetés

a belső lehetőségei kibontakoztatására, 12 00:01:08,940 --> 00:01:10,890 és minden viselkedéssel

efelé a cél felé törekszik.

A második alaptétel a gyermek
önregulációra való képességéről szól: senki nem tudhatja rajta kívül, hogy mi a legjobb neki.
A harmadik pedig az, hogy a gyermek
aktívan keresni fogja az olyan élményeket,
amelyek előmozdítják a fejlődését és a lehetőségei kibontakoztatását;
miközben a számára kedvezőtlennek ítélt élményeket kerülni igyekszik.
A játékterápia lehetővé teszi a gyermeknek,
hogy a lehető legjobb
körülmények között fejezze ki magát.
A biztonságos, megtartó, őt szolgáló térben
a gyermeknek több esélye van a lehetőségei kifejezésére.
Ez a megengedő környezet,
amit a játékterápia hoz létre, lehetővé teszi a gyermeknek, hogy megerősödjön, hogy jobban
megismerje magát, és hogy megfelelően szimbolizálja az élményeit:
más szóval, hogy
kifejezést találjon az érzéseinek.
A gyermek belső világához
a játékon, a rajzoláson, a mesén keresztül
férhetünk hozzá. Ezeken a csatornákon keresztül a gyermek spontánabb,
szabadabb módon, számára ismerős médiumokon keresztül
tudja kifejezni a szükségleteit, az élményeit és az érzéseit.
A játékterápia során a terapeuta figyelmesen
visszatükrözi a gyermeknek mindazt, ami belőle a játék közben felszínre jön, és
ráhangolódik a gyermek érzéseire.
Így fejlődik a gyermek tudatossága
a saját viselkedésére.
Fontos, hogy minél több féle játékanyag legyen elérhető
a játékterépia során a gyermek számára. Ez teszi lehetővé, hogy a gyermek igazán
szabadon fejezze ki magát,
hogy szabadon mozogjon
a terápia helyszínét adó környezetben.
Ami igazán fontos:

a változás akkor történik meg,
amikor az önfelfedezés folyamata által
szabadnak érzi magát,
és megszületik benne egy fajta önrendelkezés, személyes erő.
Visszatérve a terápiás környezet kialakítására:
fontos, hogy legyenek különböző játékeszközök, pl. papírlapok, különböző színes rajzeszközök, gyurma,
homoktálcás jelenetfelállító eszköz, könyvek,
mesekönyvek, színezők, amiket együtt színezhetünk vagy olvashatunk;
illetve babák, amik a legjobban
lehetővé teszik a gyermeknek, hogy kifejezze magát. Pl. az egyik babát ő fogja,
a másikat odaadja a terapeutának,
és így a babák közvetítésén keresztül
gyakran könnyebben tud a gyermek kommunikálni a terapeutával.
A baba válik a kommunikációs csatornává, és a segítségével a gyermek
mélyebben és jobban meg tud nyílni.
A babák önálló lényekként
vannak interakcióban egymással. Fontos, hogy a terapeuta közvetlenül a babákat
figyelje, ne a gyermeket: ez megerősíti
a babák közvetett kifejezőeszközként
betöltött szerepét. Az, hogy ezek állatfigurák, szintén segítő tényező,
mert a gyermeknek könnyebb egy állattal azonosulni,
mint egy emberfigurával. Ebben a folyamatban a terapeuta
ezekkel a játékeszközökkel a gyermeket
követi. Axline szavaiva élve,
a pszichoterápiás folyamatban a gyermek mutatja az utat,
a terapeuta nem kitűzi azt, hanem követi. Sőt, az önszabályozás akkor válik lehetővé,
amikor a gyermek szabaddá válik kifejezni magát.
Ez Rogers korábban említett alaptételeinek egyike.
A játékterápia azért hatékony a traumatikus élményeket átélt gyermekek esetén,
mert a biztonságos, megtartó és szabadságot támogató tér
lehetővé teszi a traumatizált gyermek számára,
hogy a lehető legjobban kifejezze magát

és elkezdje feldolgozni az élményeit.

A játék fontosságát 80 00:07:02,279 --> 00:07:10,349 tovább hangsúlyozzák egyes neurológiai kutatások, főként

Panksepp eredményei, aki „az elme ökológiájáról” szóló anyagában

az emlősök hét alapvető érzelmi rendszerét határozza meg.

Ezek közül minket most leginkább

a "játék-idegpálya" érdekel, amely egy olyan, genetikailag meghatározott idegpálya,

ami pozitív hatásokat generál az emlősök agyában.

Panksepp arra jött rá, hogy

genetikailag a játék-idegpálya

minden emlősnél megtalálható. Ezek a kutatások a játéknak a kognitív, érzelmi

és kötődési fejlődésben betöltött

fontos szerepét hangsúlyozzák. Fejleszti továbbá

a megküzdési képességet és a társas együttműködés készségét is.

Az, hogy tudományosan bizonyított tény az, hogy

a játék egy spontán, genetikailag kódolt tevékenység, elgondolkodtatja a szamekbert,

ha olyan gyermekkel van dolga, aki nem akar játszani. Az, hogy egy gyermek nem akar játszani,

egyértelműen valamilyen

belső nehézségre mutat rá.

A játékterápia olyan pszichoterápiás intervenciós eszköz, ami valamivel enyhébb

nehézségekkel küzdő gyermekeknél is

hatékony, de még inkább hatékony 100 00:08:46,750 --> 00:08:48,840 traumát átélt gyermekek esetén.

A játékterápia arra hívja fel a figyelmet, hogy

a gyermeket hasznos olyan személyként kezelni,

aki egy védett, biztonságos környezetben

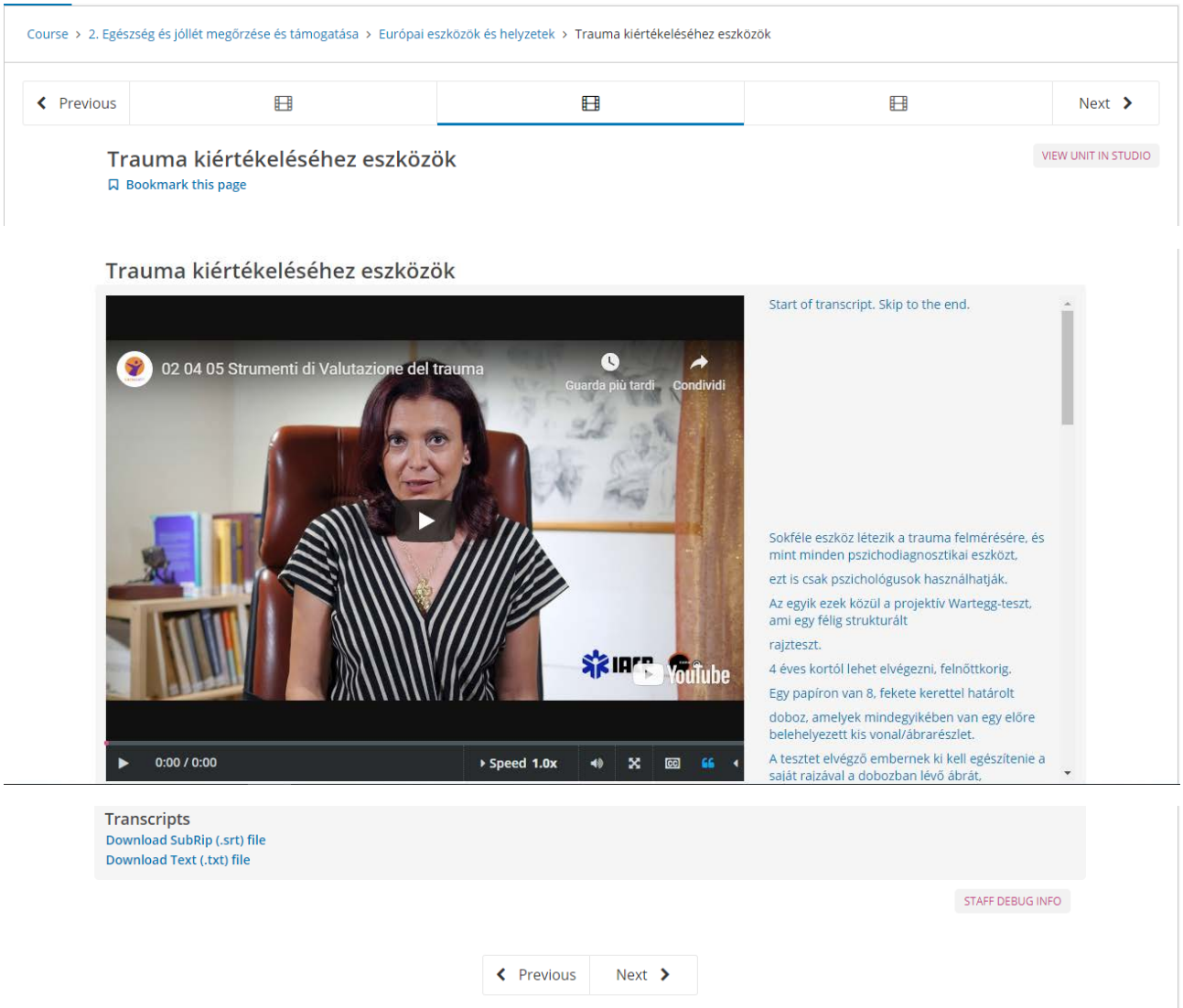
képes elmondani, megosztani, kifejezni az érzéseit,

félelmeit, szorongásait, ha őt és a személyes

szükségleteit, jellemzőit tiszteletben tartják.

Mindez segít a gyermeknek feldolgozni a traumatikus élményt,

és egészséges felnőtté válni.



Transcript

Sokféle eszköz létezik a trauma felmérésére, és mint minden pszichodiagnosztikai eszközt,

ezt is csak pszichológusok használhatják.

Az egyik ezek közül a projektív Wartegg-teszt, ami egy félig strukturált

rajzteszt.

4 éves kortól lehet elvégezni, felnőttkorig.

Egy papíron van 8, fekete kerettel határolt

doboz, amelyek mindegyikében van egy előre belehelyezett kis vonal/ábrarészlet.

A tesztet elvégző embernek ki kell egészítenie a saját rajzával a dobozban lévő ábrát,

annak felhasználásával, ami már eleve a dobozban volt. Ezt mind a nyolc dobozzal el kell végeznie.

Nagyon könnyen használható pszichodiagnosztikai eszköz, az időt tekintve is,

és mivel rajz-alapú, ami a gyermekek egyik kedvelt kommunikációs formája, a játékterápiához hasonlóan

nagyon jól használható gyerekeknél.

Az, hogy a rajz eleve egy gyerekek által kedvelt eszköz, elősegíti a használatát.

A Wartegg-teszt nagyon pontos és alapos értelmezés és dekódolás alapján működik.

Az eszköz használatának egyszerűsége ellenére az értelmezése nagyon specifikus,

és a Crisi Wartegg-rendszerre alapul, amit Crisi professzor dolgozott ki.

A lényege röviden, hogy segít egy képet alkotni arról, hogy hogyan működik a tesztet elvégző

ember személyisége.

A teszt segítségével, bizonyos jelek leolvasása által

meg lehet állapítani a trauma jelenlétét, annak az illetőre gyakorolt hatása által,

illetve annak a lehetséges következményeit. Ha az ember traumát él át,

az kognitív, érzelmi és szociális szinteken is hatással van rá.

A Wartegg-tesztet eredetileg nem kifejezetten a trauma felmérésére hozták létre,

de ehhez a területhez is képes nagyban hozzájárulni.

A teszt alapján egy jelentés készül; ennek az első fázisa

során a rajzokat betűszavakra „fordítják le”,

és ezek konfigurációi adnak információt a személyiség működéséről.

A teszt erőssége az egyszerűsége és könnyen elérhetősége, illetve az,

hogy betekintést nyújt abba, hogy milyen hatása volt a traumának az illető

pszichés működésére.

A Wartegg-teszt mellett léteznek traumaspecifikus kérdőívek is,

mint pl. a Hopkins Tünetellenőrző Lista (Hopkins Symptom Checklist - HSCL) - 2, amit a Harvard

Egyetemen fejlesztettek ki

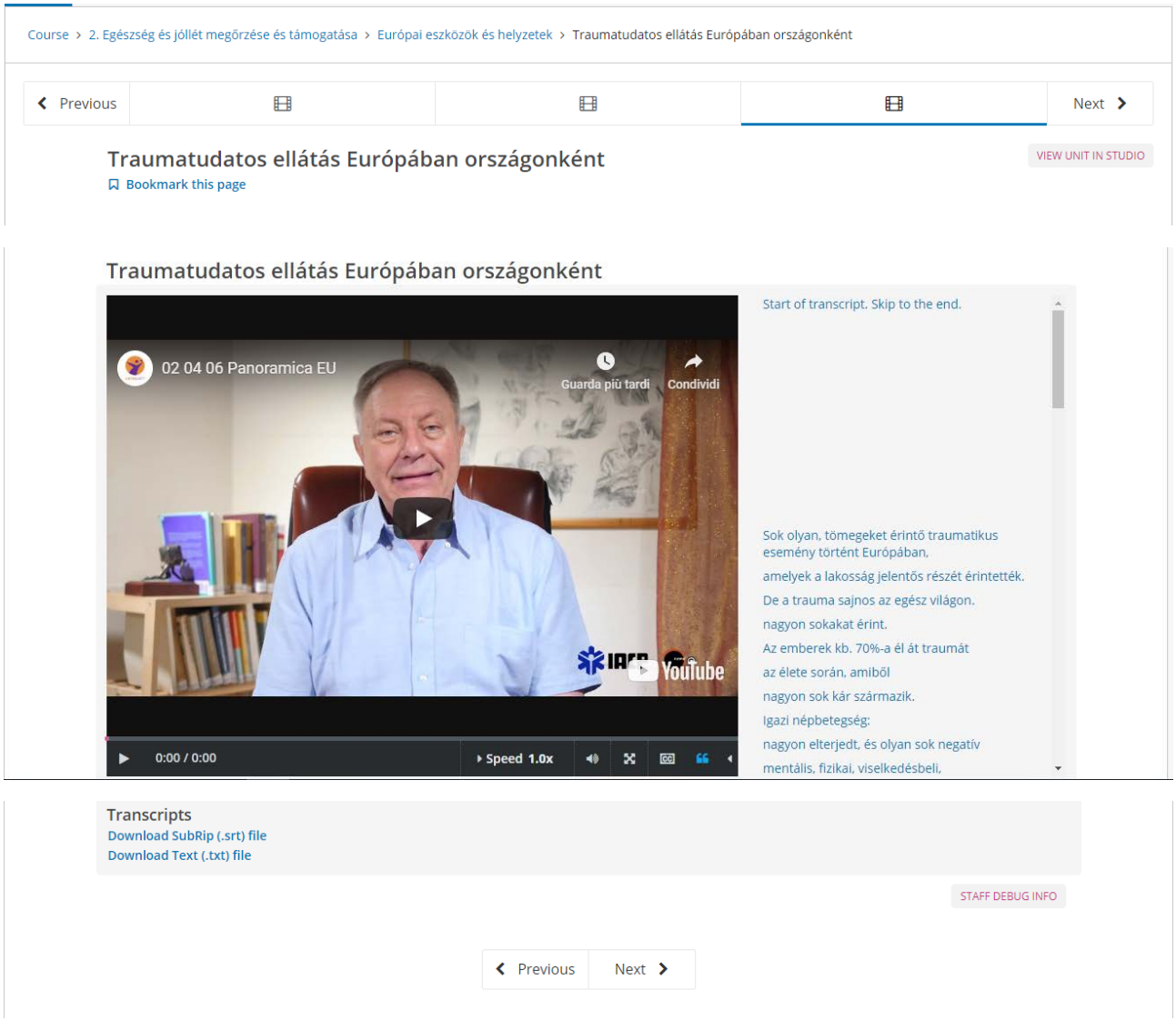
a trauma tüneteinek felmérésére menekült gyerekeknél (akik éltek át traumát).

Egy másik ilyen kérdőív a Traumatünetek Ellenőrző Listája Kisgyermekek számára (Trauma Symptom Checklist for Young - TSCYC),

amit nem a közvetlenül a vizsgált gyermek, hanem a gondozója tölt ki; végül pedig a Megküzdési Válaszok Listája

(Coping Responses Inventory),

amit 12 éves kortól lehet elvégezni, és amely egy önellenőrző kérdőív.



Transcript

Sok olyan, tömegeket érintő traumatikus esemény történt Európában,

amelyek a lakosság jelentős részét érintették.

De a trauma sajnos az egész világon.

nagyon sokakat érint.

Az emberek kb. 70%-a él át traumát

az élete során, amiből

nagyon sok kár származik.

Igazi népbetegség:

nagyon elterjedt, és olyan sok negatív

mentális, fizikai, viselkedésbeli,

szociális és gazdasági hatása van,

hogy az emberben felmerül a kérdés:

vajon Európa országai, amelyek a világ

legfejlettebb országai közé tartoznak, miért nem fektetnek több erőforrást

olyan kutatásokba, készségfejlesztésekbe, amelyekkel hatékonyan lehetne kezelni ezt a népbetegséget -

ahogy ezt sok más jelenséggel meg is tesszük.

Ám sajnos a trauma esetében ez nem így van. Szinte hihetetlen, hogy mennyire kevés intézkedés történt ezügyben.

Vannak azért kivételek, pl. a skandináv országok:

Svédországban nem csak a traumatizált emberek hatékony kezelése terén vannak jól felkészüve, hanem

társadalmi szinten is előrelátóan

kezelik a problémát. Minden városban működik egy

traumaszolgálat, ahol

a szakemberek - pl. a szociális munkások - jól képzettek

az ilyen típusú problémák

megelőzésében.

Ám sok más európai ország nem volt ugyanilyen hatékony.

Például Belgium, ahol remek az egy főre jutó átlagjövedelem, jó a fejlettség,

az ipar, a szolgáltatások, stb., pár évvel ezelőttig nem fejlesztett ki

hatékony képzési módokat arra, hogy friss, hatékony tudással és készségekkel ruházza fel a segítő szakembereket.

Az egyetemeken a megszerezhető szaktudás nem volt kellőképpen korszerű ahhoz,

hogy a segítő szakembereket olyan tudással lássa el, amelyel igazán hatékonyan tudnák kezelni az ilyen típusú problémákat.

Tehát a helyzet nem teljesen kielégítő, olyan kivételekkel, mint pl. Anglia és általában az angolszász országok,

amelyek előrelátó módon kellő erőforrásokat fektettek be

a szakemberek képzésébe és a képzési lehetőségek tágításába.

Ennek köszönhetően megfelelő ellátást tudnak biztosítani a traumatizált embereknek,

és a prevencióban is hatékonyak.

Ám sok országban, mint pl. Olaszországban is, még hosszú utat kell megtenni

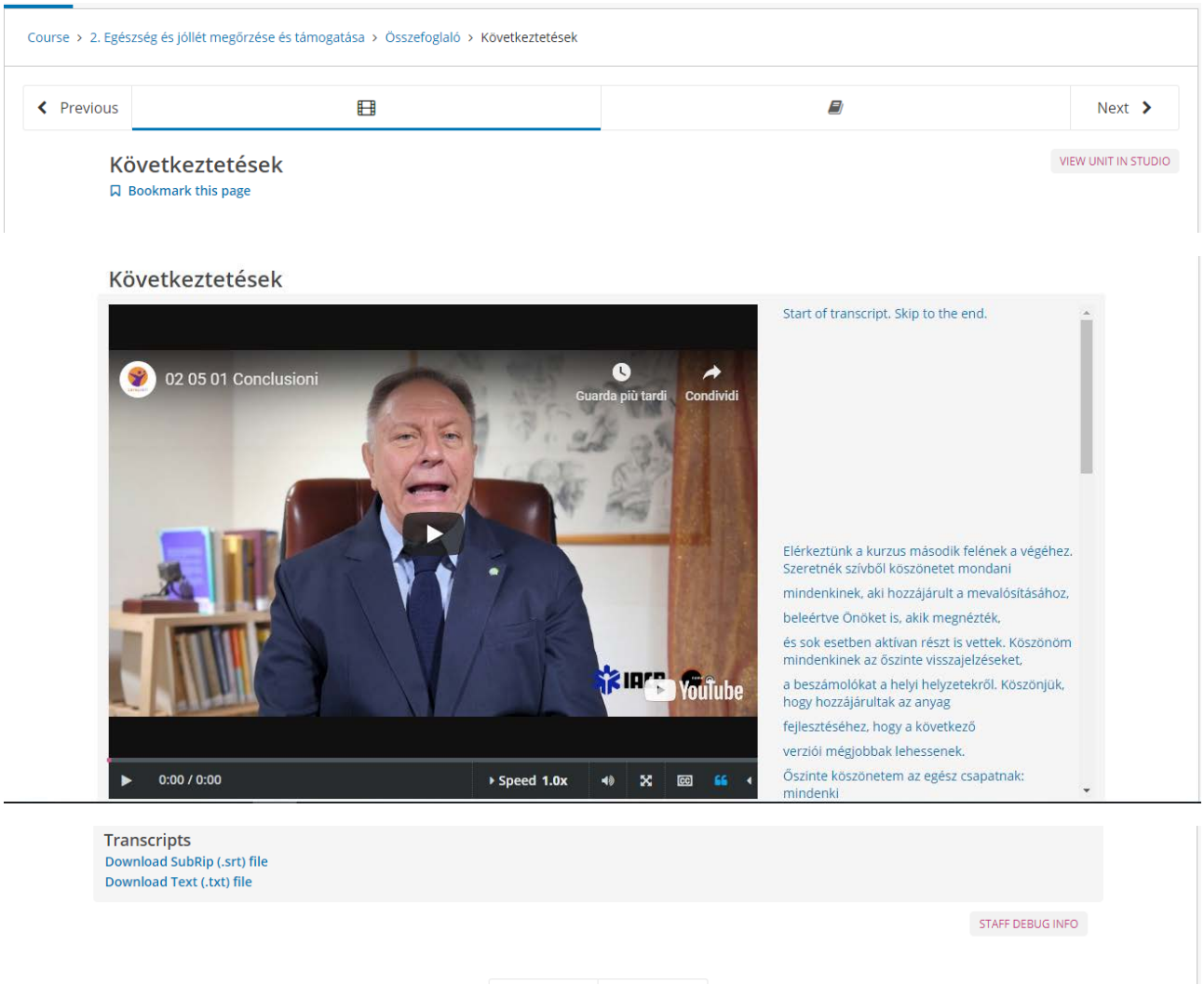
az elfogadható színvonalú szolgáltatásokig

és a helyzet kellő lefedettségéig.

Történtek persze pozitív előrelépések, pl. az elmúlt évtizedekben létrejött

traumaorientált szervezetek formájában; ezek részben

kiváltották azt az oktatási munkát, aminek
az egyetemeken kellene zajlania a különböző egészségügyi szakemberek képzésében.
Ezek képzéseket, továbbképzéseket,
és képesítést adó kurzusokat kínálnak
a traumakezelés témájában.
Sok munka van még hátra, ám mindez morális kötelességünk,
ugyanakkor a szociális, egészséghez kapcsolódó jogokról is szó van.
Az olasz alaptörvény 33. cikke sok más európai alaptörvényhez hasonlóan kimondja,
hogy minden polgárnak joga van az egészséghez, ezért kötelességünk megvédeni és fejleszteni
Európa egészségét: ez egy egészséges kötelesség.



Transcript

Elérkeztünk a kurzus második felének a végéhez. Szeretnék szívből köszönetet mondani

mindenkinek, aki hozzájárult a mevalósításához,

beleértve Önöket is, akik megnézték,

és sok esetben aktívan részt is vettek. Köszönöm mindenkinek az őszinte visszajelzéseket,

a beszámolókat a helyi helyzetekről. Köszönjük, hogy hozzájárultak az anyag

fejlesztéséhez, hogy a következő

verziói mégjobbak lehessenek.

Őszinte köszönetem az egész csapatnak: mindenki

teljes erőbedobással és odaadással dolgozott azért, hogy létrejöhessen ez a projekt,

hogy megvalósuljnanak azok a célok, amikben hiszünk.

Köszönet minden, az intézeten kívüli kollégának,

aki pro bono munkájával,

vagy egyéb hozzájárulással tett hozzá az anyaghoz,

pl. megengedte, hogy a kurzus portálján
ingyenesen közzétegyük az általa létrehozott anyagokat.
Köszönet az IACP minden munkatársának, akik teljes szívvel
dolgoztak, hogy megosszák tudásukat és tapasztalatukat
a traumatizált gyermekek ellátása terén.
Köszönet a velünk együttműködő szervezeteknek is,
illetve a CarePath projektpartnereinknek, akik a teljes folyamat alatt
támogattak bennünket.
Végezetül pedig nagy köszönet a Torinói Egyetem
munkatársainak és a projektmenedzsernek, Luca Rollè-nek,
aki az egyik legjobb projektmenedzser, akikkel a különböző európai projektek során
együtt dolgoztunk.
Köszönjük a Torinói Egyetem pszichológia kara
többi fantasztikus munkatársának is,
akik mindent megtettek a munkánk megkönnyítése és előmozdítása érdekében.
Egy szó mint száz, köszönjük a sok befektetett munkát, és jó tanulást kíánunk a többi a modulhoz!

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Quiz 1

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Q.1

15 points possible (graded)

1. Mi a segítő kapcsolat?

- Érzelmi alapú kapcsolat, amelynek alapja, hogy az egyik partner segíti a másikat
- Egy szakember és a szolgáltatás igénybevevője közötti kapcsolat
- Olyan kapcsolat, amely kielégíti mind a szakember, mind a szolgáltatás igénybevevőjének szükségleteit
- Orvos-páciens kapcsolat

2. Az általános rendszerelmélet megalkotója:

- Wertheimer
- Maslow
- Rogers
- Von Bertalanffy

3. Mi a WHO?

- Tudományos Világszervezet
- Társadalmi Orvosi Szervezet
- Egészségügyi Világszervezet

4. A személyközpontú szemlélet megalapítója:

- C. Rogers
- O. Rank
- J. Bowlby
- A. Maslow

5. A következő, a segítő kapcsolat kialakításához szükséges feltételek melyikét nem C. Rogers határozta meg?

- Empátia
- Feltétel nélküli pozitív elfogadás
- Reziliencia
- Önazonosság, hitelesség

6. Munkaszövetség

- Alkalmazott és munkaadó közötti szerződéses megállapodásra utal
- Csak a csoporthoz van köze, az egyénhez nincs
- A segítő kapcsolatban a kívánatos együttműködési forma
- A szakember által lefektetett szabályok, amelyeket a szolgáltatás igénybevevőjének be kell tartania

7. A segítő kapcsolatban az empátia hiánya

- a professzionalitásra utaló minőség
- segít annak jobb megértésében, amit a kliens mond
- javasolt a kiégés megelőzése érdekében
- ellehetetleníti a segítő kapcsolat hatékonyságát

8. Mi a komplex poszttraumás stressz zavar?

- Egy másik kifejezés a poszttraumás stressz zavarra
- Krónikusan traumatikus élmények miatt létrejövő kórkép
- Akkor használatos kifejezés, ha a poszttraumás stressz zavar tünetei több, mint 6 hónapja fennállnak
- Csoportos trauma által kiváltott rendellenesség

9. A következő jellemzők közül melyek nem kívánatosak egy traumatudatos ellátórendszerben?

- A páciens értékelése az ellátás minden aspektusában
- Semleges és támogató nyelvezet használata
- Megfelelő szűrés elvégzése annak megállapítására, hogy mely élményeket lehet traumatikusként meghatározni
- A munkatársak képzése a traumáról és annak hatásairól

10. Melyek a pszichés trauma létrejöttében szerepet játszó leggyakoribb kórtörténeti tényezők?

- A gondviselők általi fizikai és pszichés elhanyagolás ismételt élménye
- Természeti katasztrófák átélése
- Váratlan elhalálozás az illető közvetlen közelében
- Gyermekkori szexuális bántalmazás átélése

11. A tudatos traumaellátás jelentése:

- Egy sor olyan technika, amely kiegészíti az EMDR traumaátdolgozást
- A pszichoterápia egy típusa
- A traumát átélt személyek ellátására és kezelésére vonatkozó rendszerszintű szemlélet
- A taumát átélt személyek részére fenntartott külön kórházi részleg

12. Az asszisztált erőszak definíciója:

- Katasztrófák átéléséből fakadó trauma
- Olyan helyzet, amely során egy kiskorú közvetlenül vagy közvetetten részt vesz számára érzelmileg fontos személyek elleni erőszakos cselekményekben, vagy szemtanúja annak
- Az erőszak azon típusa, amelyet az egyik szülő követ el a másik ellen, a gyermek (pszichés manipuláció útján elért) pszichológiai és/vagy materiális támogatásával
- Abból fakadó trauma, ha valaki általános erőszakos jelenségek szemtanúja

13. Mik a javasolt intervenciós lépések akkor, ha valaki erőszak szemtanúja lesz?

- Felismerés, védelem, értékelés, kezelés
- Megfigyelés, értékelés, kezelés, családi közvetítés
- Felismerés, család elhelyezése, kezelés, családi közvetítés, család áthelyezése
- A családból való eltávolítás, családi közvetítés, család áthelyezése

14. A 2013-ban megjelent, a gyermekbántalmazás ellen Európában témájú WHO jelentés szerint hány 15 év alatti gyermek hal meg gyermekbántalmazás következtében?

- 800-900
- 500-600
- 900-1000
- 400-500

15. A komplex PTSD a PTSD-től a következőkben különbözik:

- A komplex PTSD a gyermekkorra jellemző
- A bizalmi kapcsolatokban fellépő erőszak esetében alakul ki
- Akkor van szó komplex PTSD-ről, ha a pszichés tünetek mellett motoros tünetek is jelentkeznek
- A komplex PTSD kizárólag nőknél és kiskorúaknál jelentkezik

Invia You have used 0 of 5 attempts

Salva Show Answer

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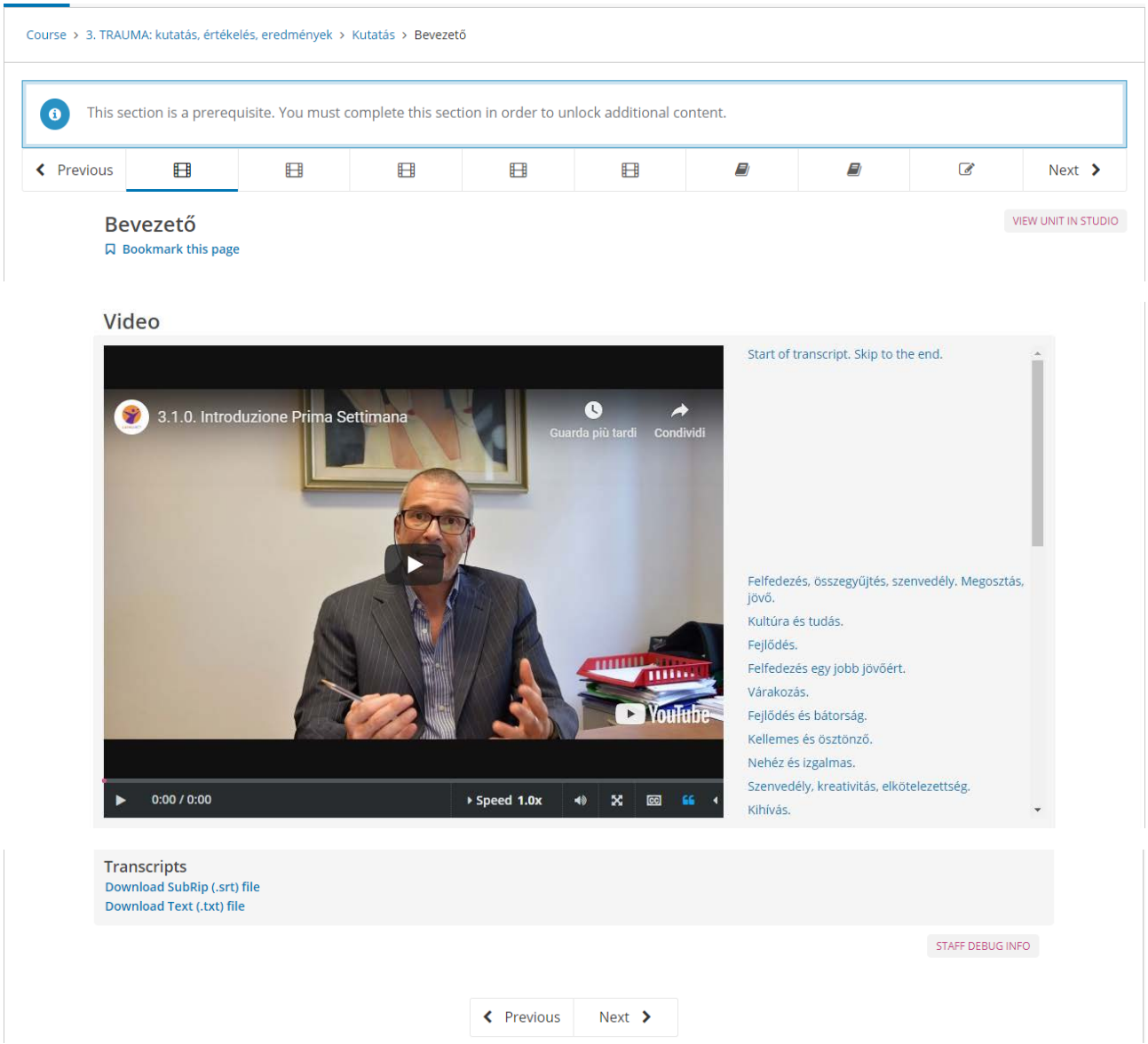


Transcript

Felfedezés, összegyűjtés, szenvedély. Megosztás, jövő.

Kultúra és tudás.

Fejlődés.

Felfedezés egy jobb jövőért.

Várakozás.

Fejlődés és bátorság.

Kellemes és ösztönző.

Nehéz és izgalmas.

Szenvedély, kreativitás, elkötelezettség.

Kihívás.

Haladás.

Jövő. Innováció, kitartás.

Áldozat és beteljesülés.

Lehetőség.

Fejlődés.

Megértés.

Kemény munka, szabadság és tanulás.

Ambíció.

Továbbfejlődés.

Erőfeszítés.

És egy kis játék.

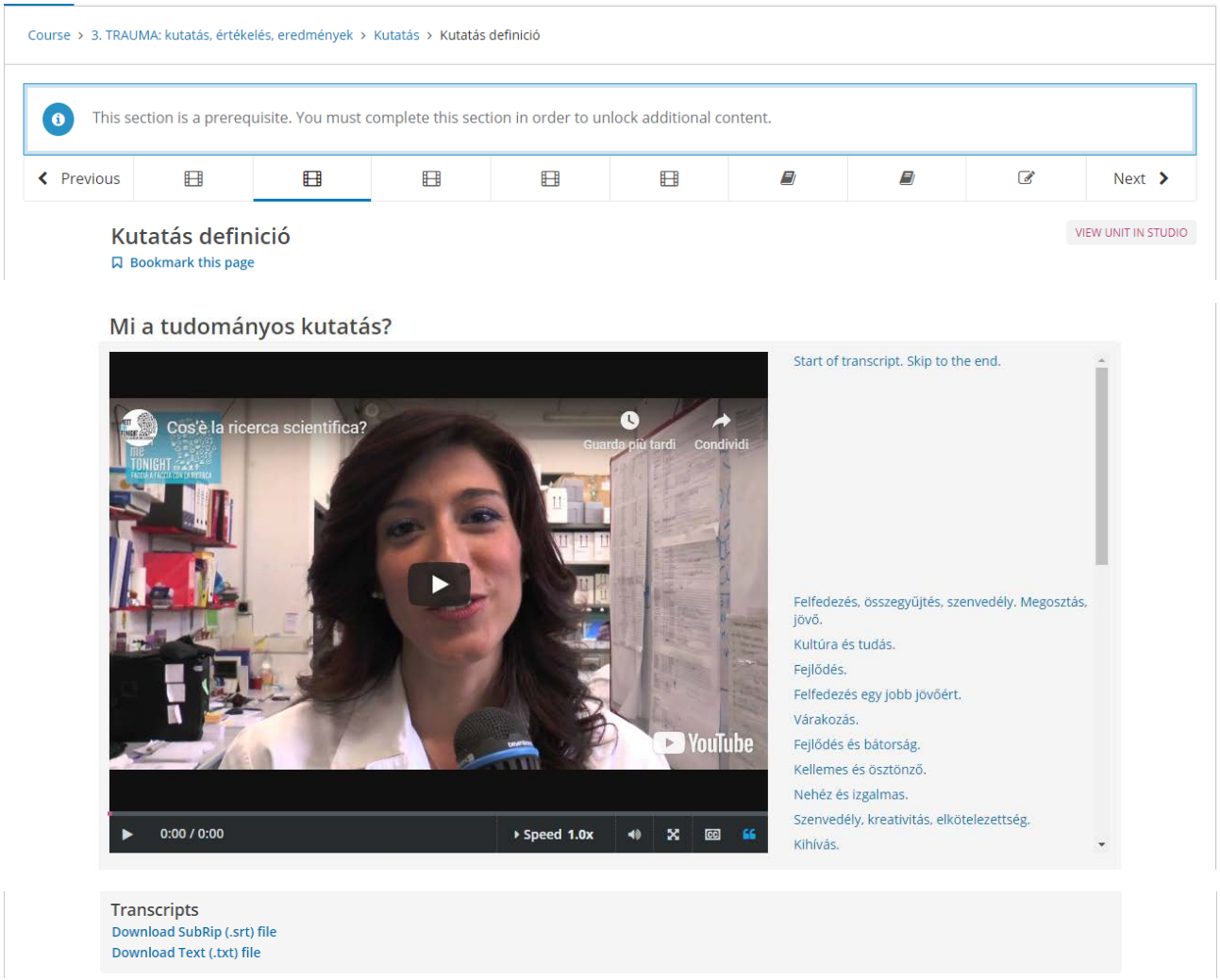
Kíváncsiság, innováció, felvirágzás.

A kutatás az emberi természet szerves része.

Aki nem kutat, az nem old meg problémákat, és szinte nem is létezik.

A kutatás kíváncsiság, vágy a valóság megismerésére, és azoknak,

akik csinálják, a felfedezés végtelen öröme.



Transcript

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akik csinálják, a felfedezés végtelen öröme.

Nem könnyű definiálni a határait annak, hogy mi a kutatás és mi nem az. Az idők során sok definíció született. Nézzünk néhányat az utóbbiak közül:

A kutatás egyszerűen keresi a választ bizonyos kérdésekre, amikre eddig nem volt válasz és a válaszok emberi erőfeszítéstől függenek (.....) Valójában a kutatás az a folyamat, amíg megérkezünk egy probléma megbízható megoldásaihoz az adatok tervezett és szisztematikus gyűjtésén, analizálásán és értelmezésén keresztül. „ (Singh, 2006.1.o.).

A kutatás a felfedezés kreatív folyamata, ami egy előre megállapított utiterv alapján fejlődik ki, , amely a tudományos közösségen belül konszolidálódott (szilárdult meg).” (Corbetta, 2015,15.o.)

Általában kutatást végeznek „amikor kíváncsiságot és intuíciót alkalmaznak szisztematikus megközelítéssel, hogy mindennapi jelenségekkel kapcsolatos kérdéseket megválaszoljanak, kihasználva a tapasztalatok és tudás előnyeit, melyek már összegyűltek. (Reseach Italy, 2013)

Különböző típusú kutatások vannak, melyek különbözhetnek alkalmazásukban, a vizsgálat célkitűzéseiben és módszereiben. A kutatás valójában lehet „alkalmazott” vagy „tiszta”. Az alkalmazott kutatás célja, hogy megoldást találjon egy alkalmazási problémára, amit szükséges megnevezni, míg a tiszta kutatás főleg általánosításokra és elméleti megállapításokra vonatkozik. (Kothary, 2004; Singh & Masuku, 2013). Célkitűzéseitől függően a kutatás lehet leíró, felderítő, korrelációs és magyarázó. A leíró kutatás célja, hogy meghatározzon egy jelenséget, egy problémát, egy szituációt.

A korrelációs kutatás célja, hogy megfigyelje a kapcsolatot két vagy több változó között.

A felderítő kutatás célja, hogy megmagyarázza, miért történnek bizonyos dolgok.

A magyarázó kutatás célja egy tanulmány használhatóságát megvizsgálni vagy felfedezni egy kevéssé ismert területet.

A vizsgálat megkezdéséhez szükség van egy munkatervre, meghatározott eljárási lépésekkel, amelyeket a vizsgálattal magával kell kivitelezni. Ezeket a fázisokat úgy nevezzük, hogy „kutatási terv".

Attól függően, hogy milyen technikát alkalmazunk, a kutatás szétválasztható:

> Kvantitatív kutatásra: mely strukturált megközelítést használ, célja számszerűsíteni egy jelenség, egy szituáció vagy attitűd variációit és sokféleségét egy jól strukturált kutatási terven keresztül. Ezzel számszerű adatokat kaphatunk, melyeket analizálva igazolhatunk hipotéziseket és tesztelhetünk változók közti kapcsolatokat.
>
> Kvalitatív kutatásra: mely nem strukturált megközelítést alkalmaz, magyarázó, leíró és következtetéses természetű, különös figyelemmel a tartalomra és a célra. Meghatároz és leír annyi lehetséges változót, amennyit csak lehet a jelenséggel, szituációval vagy attitűddel kapcsolatban. Megértésre törekszik a változók hátterében lévő okokkal. Az utóbbi magában foglalja „a világ értelmező és naturalisztikus szemléletét, ami azt jelenti, hogy a kvalitatív kutatók a jelenséget a saját természetes környezetében tanulmányozzák, megpróbálnak neki jelentést adni vagy az emberek által adott jelentést kifejezésekben értelmezik." (Denzin & Lincoln, 2011,3.o.) A kvalitatív kutatás célja, hogy inkább leírja és megértse a jelenségeket, minthogy megjósolja és/vagy kontrollálja őket. (Streubert &Carpenter, 2005)
>
> A kevert megközelítés másrészről, kombinálja a kvalitatív és a kvantitatív kutatási módszert. „A szociális kutatás a változók definícióján alapszik, keresi a kapcsolatokat közöttük, és megkísérli megérteni, hogy egy dolog változtatása okoz-e és hogyan változást a másik dologban. Néhány gyakori változó, amit szociális kutatásokban találni lehet a kor, a nem, az etnikai faj, a tanulmányok, a bevételek, a családi állapot, a foglalkoztatottság." (Bernard, 2006, 28-29.o.) Először kitaláljuk a változás koncepcióját: valamit, aminek több mint egy értéke van. Másodszor van a „mérés" koncepciója: valójában a változók a saját indikátoraik szerint lesznek mérve, amik a változók értékei szerint definiáltak. A mérés magában foglalja, hogy melyik értéket jegyzi meg. Minden kutatásnak tiszteletben kell tartani az érvényesség (validitás) és megbízhatóság elveit. Az érvényesség azt jelenti, hogy a kutatásnak pontos mérőeszközzel, adatokkal és eredményekkel kell rendelkeznie. Míg a megbízhatóság jelentése, hogy ugyanolyan eredményekhez jutunk, ha több alkalommal, ugyanazzal az eszközzel mérünk.

Bernard (2006) megmagyarázza a négy alappontot, amit a kutatás folyamata követ:

1. Először egy teoretikus probléma fogalmazódik meg (tudományos elmélet és irodalom)

2. Aztán kiválasztódik a megfelelő módszer és analizálási egység

3. Aztán összegyűlnek és analizálódnak az adatok

4. Végül az elméleti javaslat, amivel a kutatás indult, vagy támogatódik, vagy elvetődik.

(Bernard, 2006.69.o.)

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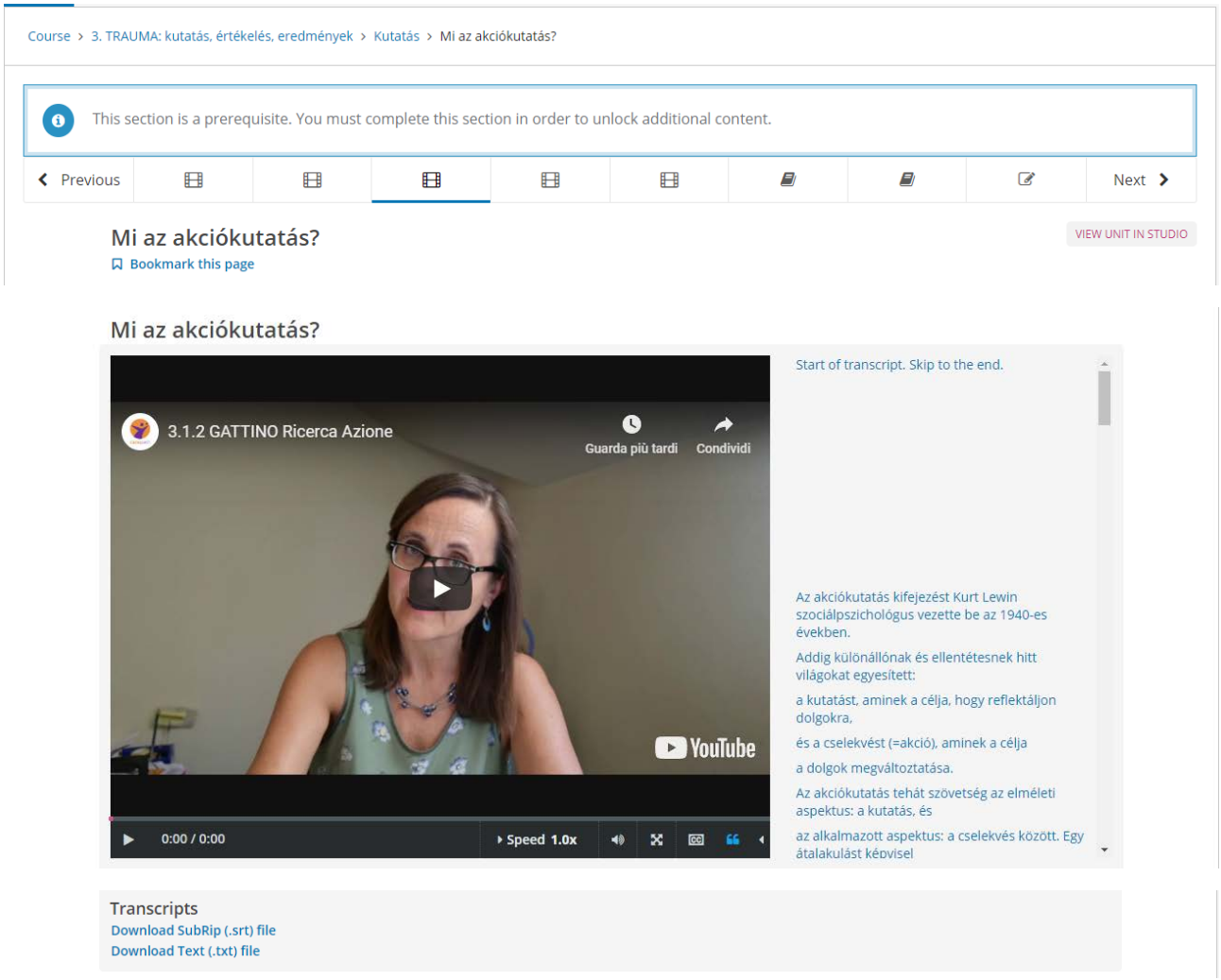


Transcript

Az akciókutatás kifejezést Kurt Lewin szociálpszichológus vezette be az 1940-es években.

Addig különállónak és ellentétesnek hitt világokat egyesített:

a kutatást, aminek a célja, hogy reflektáljon dolgokra,

és a cselekvést (=akció), aminek a célja

a dolgok megváltoztatása.

Az akciókutatás tehát szövetség az elméleti aspektus: a kutatás, és

az alkalmazott aspektus: a cselekvés között. Egy átalakulást képvisel

abban, ahogy a humántudományok terén a kutatásokat elképzeljük, eltervezzük és végezzük - a tanulmányozott jelenségek

összetettségének leegyszerűsítése nélkül, azok elfogadásával, figyelembevételével.

Az akciókutatást Lewin mindig csoportban végezte,

mivel a csoport az a pszichoszociális tér,

amelyben az emberek cselekedeteket hajtanak végre, és egyben egy eszköz a változási folyamatok

előmozdítására.

Az akciókutatás leírható a kutatási módszerek azon csoportjaként, amelyeknek célja,

ahogy már említettük, hogy egyszerre aktiváljon utakat, lehetőségeket a cselekvés

(más szóval: változás) és a kutatás (más szóval: jelenségek megértése) számára.

Ez az út egy spirálisan váltakozó ciklusokból álló rugalmas folyamaton át vezet,

és minden ciklus három egymást követő szakaszból áll: tervezés, végrehajtás

és vizsgálat: az utóbbi célja az egyes fázisok eredményeinek kiértékelése,

a következő fázis racionális alapjának előkészítése, és, ha szükséges, az eredeti cselekvési terv

megváltoztatása.

Mi történik az akciókutatás első ciklusa után?

Az eredmények kiértékelése után (és az eredeti kiindulópont esetleges megváltoztatásának

mérlegelése után) a folyamat új ciklusa kezdődik,

amelybe beépítjük a korábban elvégzett tevékenységek

nyomán felmerülő új elemeket is; majd ezeket a ciklusokat addig ismételjük, amíg a problémás helyzet meg nem oldódik.

A tervezést, kivitelezést és vizsgálatot támogatja, ha a résztvevők

kritikusan felmérik, hogy mi működött jól, mi nem, mit tanultak,

és mit lehetne másképp csinálni.

Az egyes ciklusok kritikus kiértékelése lehetővé teszi a kutatónak az esetleg hibák kijavítását,

és hogy a tevékenységeket a kutatás során felmerült konkrét szükségletekhez igazítsa.

Mi az akciókutatás célja?

Az akciókutatás célja a változás elősegítése:

változás a viselkedésben, szokásokban,

kontextusokban, stb.

Az alapfeltevés az, hogy a jelenlegi helyzet nem támogatja az emberek jóllétét,

és hogy a helyzeten csak változtatással lehet javítani.

A változást tehát elő kell idézni, azután elemezni és megérteni,

és tartósnak kell lennie.

Lewin szerint ahhoz, hogy a változás tartós legyen, három fázison kell átmennie:

a "kiolvasztás", ami a változásnak ellenálló tényezők kezelését jelenti,

melyek gyakran köthetőek társadalmi normákhoz;

az "elmozdulási fázis", például hiedelmek, értékrendek és attitűdök megváltoztatása

és újak kifejlesztése új információk alapján, illetve

a régi helyzetből az újba való elmozdulás;

harmadrészt, az "újjáépítő fázis" vagy "újrafagyasztás", amelyben az újonnan létrehozott helyzet

egy új egyensúlyi állapotban stabilizálódik, vagyis az új értékrendet, attitűdöket

és viselkedéseket megszilárdítjuk és beépítjük a teljes rendszer egészébe.

Az akciókutatás egyik fontos aspektusa az intervenciót igénybevevő fél aktív részvétele;

ő tulajdonképpen az intervenció befogadója és cselekvője is

egy személyben, és olyan helyzetbe kell őt helyezni, hogy megoszthassa magának a kutatásnak a céljait.

Az akciókutatás alapfeltevése az, hogy az emberek, akikkel dolgozunk, aktív személyek,

olyan készségekkel és kompetenciákkal, amiket be kell vonnunk a kutatási folyamatba.

Ha akciókutatási szemlélettel dolgozunk, aktívan be kell vonnunk azokat az embereket is,

akiknek az intervenció szól, és egy olyan helyzetet kell létrehozni, amelyben

az intervenció befogadói-cselekvői együttműködnek és konfrontálódnak.

Az akciókutatási módszer másik jellemző eleme az,

hogy nincs előre meghatározott intervenciós metódus.

Ezt a módszert a csoporttal együtt építjük fel bizonyos lényegi alapelvekből kiindulva,

és a munka során megfigyelt reakciókra alapozva.

Gyakran előfordul, hogy az eredeti elképzelés útközben változik, mivel a kivitelezendő módszereket

és tevékenységeket a folyamat közben rakjuk össze.

Végigvettük tehát, mi jellemzi az akciókutatást.

Most vizsgáljuk meg, mik azok az elemek, amelyek megkülönböztetik a kísérleti módszertől.

Ahogy már említettük, az akciókutatásban nincs fix intervenció.

Akik tehát ezzel a szemlélettel dolgoznak, hagyják, hogy a hipotézis magától jelenjen meg a folyamat közben,

és akár változtassa az irányát, ha a megfigyelések szerint szükséges.

Egy másik különbség, hogy az akciókutatásban nem akarunk ok-okozati kapcsolatokat felállítani,

a szakirodalomban szereplő hipotéziseket bizonyítani, vagy kezelések eredményességét vizsgálni reprezentatív mintákon

azért, hogy általános elméleteket erősítsünk vagy

cáfoljunk meg.

Az akciókutatásban, minden ciklus során inkább arra a jelenségre fókuszálunk, amire az intervencióval

szeretnénk reagálni.

Nem foglalkozunk a változók mérhetőségével, és a cél az, hogy olyan, előre nem látható különböző utak vizsgálatával próbáljunk problémákat megoldani, amelyek a csoport eredményévé és egyszersmind eszközévé válnak.

Végezetül, további különbség található abban, ahogy a kutatás eredményei bemutatásra kerülnek; az akciókutatás esetén azokat megosztjuk az egész csoporttal, közösséggel, bevonva őket, a kísérleti kutatások beszámolóira jellemző bonyolult tudományos szakzsargon helyett egyszerű, könnyen érthető nyelvezettel.

Az adatok bemutatásának célja egy olyan reflexió, értékelés, amely elősegíti a lehetséges fejlődési, javítási irányok meghatározását.

Foglaljuk akkor össze az eddig elhangzottak alapján az akciókutatás alapvetéseit:

Az akciókutatás praktikus és kontextushoz igazodó.

Célja egy csoport vagy közösség problémáinak kezelése; tehát ez egy kontextusfüggő, az adott környezethez, helyzethez, közösséghez igazodó kutatási forma; célja a változás előmozdítása, fókusza pedig az egyén helyett a csoport szinten van, mind a folyamatok elemzésekor, mind a feltáruló eredmények és megoldások meghatározásakor.

Továbbá az akciókutatás több szakaszból áll, és kialakításából fakadóan ciklikus, mivel a tudás és a cselekvés fázisai váltogatják egymást benne. Központjában a részvétel áll, valamint a kutató és a csoport, a közösség közötti együttműködés és kölcsönös egymásra utaltság.

Hagyományosan a kutatás témája, hogy objektíven analizáljon jelenségeket a világ lejegyzett természeti törvényeinek következtetéseivel. A kutatónak teljesen semlegesen kell az általa tanulmányozott jelenséghez állnia. A kutatás definíciója szerint az elmélethez tartozik, az általánosítás felé tart és annyira univerzális modelleket épít, amennyire csak lehetséges. Az akció másrészről, az általános tapasztalat szerint át van itatva motivációkkal, vágyakkal, érzelmekkel és tudással, ami sokszor nem logikus, ellentmondásos és a célja a cselekvés, a teremtés és a változás. Az akció a gyakorlatra irányul, kapcsolódik a különlegeshez és egyedülállóhoz, lokális és szituációs, történetileg kezelt, nem mindig kiszámítható az eredete és a kimenetele. (Amerio, 2000) Az akciókutatás azzal a szándékkal született, hogy kombinálja ezt a két dimenziót, ami hagyományosan elválasztott és összeegyeztethetetlen. A két sarokpont, ami megkülönbözteti az akciókutatást a hagyományos kutatástól, a részvétel és a kooperáció. Elliot így határozza meg:

„Az akciókutatás egy szociális szituáció tanulmányozásaként definiálható, melynek célja, hogy fejlessze a benne lévő akciók minőségét. Más szavakkal, az a célja, hogy bevezessen egy praktikus értékelést a konkrét szituációkba; az „elméletek" érvényessége vagy a hipotézisek, amiket generál nem annyira az igazság „tudományos" érvényességétől függ, inkább attól, hogy mennyire használható segítség az emberek számára, hogy intelligensebben és ügyesebben cselekedjenek. Az akciókutatásban az „elméletek" nem függetlenül értékelhetők, hanem gyakorlatban alkalmazottak és a gyakorlatban értékelődnek. (Elliot, 1994, 97.o.)

És újra:

„A helyzet-problémát diagnosztizálni kell és a gyógyító cselekvést meg kell tervezni és végre kell hajtani, a hatásokat kontrollálni kell, ha előrelépés következett be. Ez a teljes folyamat, Analízis-Diagnózis-Tervezés-Cselekvés-Hatás ellenőrzés, amit úgy hívunk akciókutatás (.....) . (Elliot, 1994, 96.o.)

Az akciókutatás eredeti modelljét Lewin fejlesztette ki (1946), azzal a céllal, hogy megértse azokat a problémákat, amik speciális összefüggésekben merültek fel, mikor megosztották tapasztalataikat azok az emberek, akik egyben kutatók és a vizsgálat alanyai is voltak. Az akció egyre több és több értéket képvisel, mert eljön a pillanat, mikor a probléma megismerése felépül. A változás folyamata három fázisban megy végbe:

1. Felolvasztás: a kezdeti egyensúly felborul a szociális normákhoz való ragaszkodásnak ellenálló cselekvéseken keresztül.

2. Mozdulás: új és meglévő elemek cselekvési erőt kapnak a területen belül.

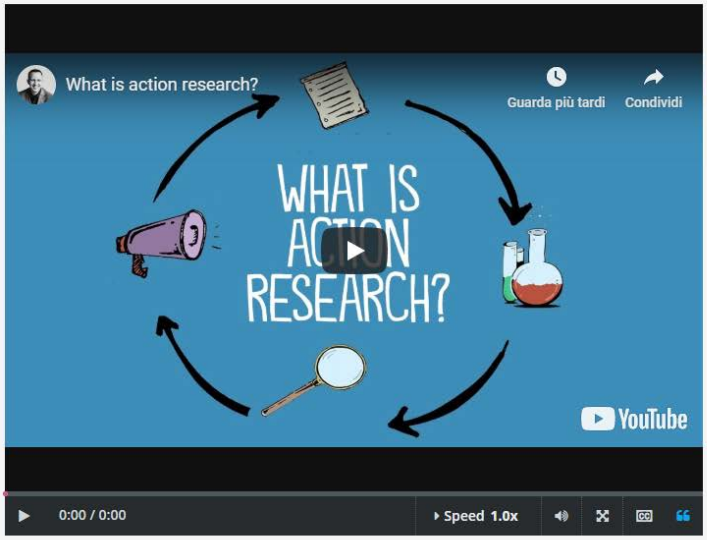
3. Megszilárdulás: az új szituáció stabilizálódik az új egyensúly körül.

Az akciókutatás ezért egy „szisztematikus adatgyűjtés és analizálás, abból a célból, hogy cselekedjünk és változást hozzunk létre", megosztható, gyakorlati ismereteket generáljunk. (Gillis & Jackson, 2002, 264.o.)

Bármilyen akciókutatás célja, hogy szociális változást produkáljon a cselekvés (vagy cselekvések) által, ami megfordítva a végső eredménye a kutatásnak. (Greenwood & Levin, 1998, McNiff & Whitehead, 2006, MacDonald, 2012).

A kutatók, akik elkezdték az akciókutatást, észben tartják a feltevést, hogy a valóság egy folyamatos szociális folyamat által teremtődik és újrateremtődik. Felismerik, Argyris (1982) alapján, hogy egy kutatási megközelítésnek, ami egy szociális szituációban működik, alapvető elemei: az együttműködés a kutatók és a résztvevő közösségek között, kritikus vizsgálati folyamat, fókusz a szociális gyakorlaton és reflektív tanulási folyamat. Ez szükségszerűen magában foglalja a különböző típusú kutatásokat a hipotézisek igazolásától, ami több figyelmet fordít a kutatás témáira, természetesen kifejtve és megvitatva, megengedvén bárkinek, akit érdekel, hogy előterjesszen egy kritikai vizsgálatot (Checkland & Holwell, 1998)

Definition of Action Research



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A tanítás külön mesterség. Egyszerre művészet és tudomány. A kitűnő tanárok sokat kísérleteznek,

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Az egyik opció az akciókutatás, amivel azonosíthatjuk a kérdést, tesztelhetjük

a stratégiát, adatot gyűjthetünk és megnézhetjük, hogy működik-e. A végeredmény

egy dinamikus, innovatív, közvetlenül a tanteremhez kötődő dolog.

Az akciókutatás lebontja a falat a résztvevők és a kutatók között.

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Az akciókutatás lebontja a falat a résztvevők és a kutatók között.

Más szóval a tanár aktívan részt vesz a vizsgált helyzetben, miközben a kutatást

végzi. Sok különböző akciókutatási keretrendszer létezik,

de általában hasonló folyamatra épülnek. Az első szakasz a kutatás előkészítése.

Itt vizsgálódással kezdünk, és meghatározunk egy konkrét kutatási kérdést.

Ennek olyasminek kell lennie, amit lehet tesztelni.

Következő lépésként egy szakirodalmi áttekintést végzünk el, hogy mélyebb rálátást szerezzünk a témára.

Végül következik a tervezési folyamat, amely során meghatározzuk az adatgyűjtési módszereket,

etikai kérdéseket fontolunk meg, ha kell, engedélyeket szerzünk be, határidőket tűzünk ki, és felállítjuk a rendszert.

Ezután következik az akció-szakasz. Itt kezdünk bele a kísérletezés és adatgyűjtés

több ciklusból álló folyamatába. Az adatgyűjtés vonatkozhat

kvalitatív adatokra, úgymint megfigyelések, tárgyak, interjúk; vagy

kvantitatív adatokra, mint kategóriapontos kérdőívek vagy teljesítményadatok. Ezek után

következik az elemzés. Az adatokat gyakran rendezzük

grafikonokba vagy táblázatokba, hogy konkrét tendenciákat állapíthassunk meg.

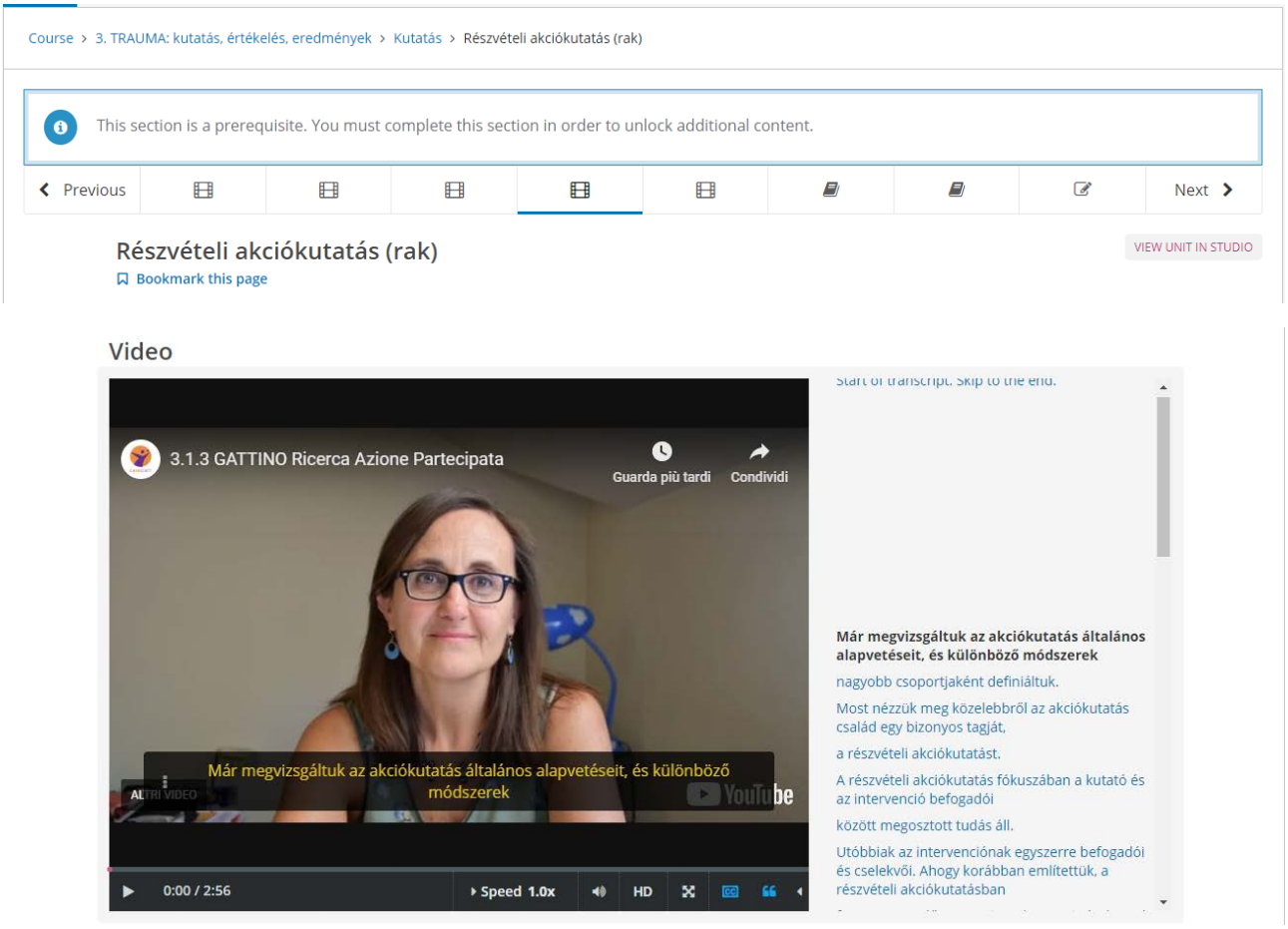
Meg is tárgyalhatjuk más szakmabeliekkel, szabadon írhatunk róla naplót, vagy klasztertérképet is

készíthetünk, mielőtt leírjuk a végleges eredményeket. Végezetül elértünk az összegzéshez.

Itt osztjuk meg a világgal a kutatásunkat, és reflektálunk a gyakorlatunkra.

Ez végül újabb kérdésekhez fog vezetni, és egy újabb ciklus indul, miközben

folyamatosan finomítjuk mesterségünket, és egyre jobb és kreatívabb tanárokká válunk.



Transcript

Már megvizsgáltuk az akciókutatás általános alapvetéseit, és különböző módszerek

nagyobb csoportjaként definiáltuk.

Most nézzük meg közelebbről az akciókutatás család egy bizonyos tagját,

a részvételi akciókutatást.

A részvételi akciókutatás fókuszában a kutató és az intervenció befogadói

között megosztott tudás áll.

Utóbbiak az intervenciónak egyszerre befogadói és cselekvői. Ahogy korábban említettük, a részvételi akciókutatásban

fontos szem előtt tartani azt, hogy mind a kutató, mind a résztvevők

hozzájárulnak a közös cselekvés megtervezéséhez és értelmének visszaállításához.

Tehát a részvételi akciókutatásban fontos, hogy az akciókutatást együtt tervezze meg és végezze el

a szakember az intervenció célját képező közösség/csoport tagjaival,

akik kontextusspecifikus, a helyzetet tekintve szakértői tudással járulhatnak hozzá a kutatáshoz azáltal,

hogy hozzáteszik az adott kontextusban jelen lévő

sokféle különböző szempontot és meglátást.

A részvételi akciókutatás intervencióiban az egyik alapelv a részvétel,

ami egyszerre funkcionál eszközként és a társadalmi változást előidézni hivatott intervenció céljaként.

A részvételi akciókutatás felismeri azt, hogy az adott probléma a csoportban egy konkrét kontextusban

és egy konkrét, jól definiálható időpillanatban jelentkezik.

A kutató tehát a problémára csak felhívja a figyelmet, nem generálja, és a szerepe az, hogy segítsen a csoportnak/közösségnek

megálapítani azokat a legfőbb tényezőket, amik

segíthetnek nekik cselekvéssel továbblépni.

Így hát azoknak, akik a részvételi akciókutatás szemléletével szeretnének dolgozni, egy kollaborációs, együttműködésen alapuló helyzetet kell teremteniük,

amelyben párbeszéd zajlik a közösség tagjai és a szakemberek között a megvizsgálandó

problémák, a kutatás módja, és a változás

előkészítése tekintetében.

Ahogy Vargiu (2008) kiemeli, Az akciókutatás területe nagyon különböző tapasztalatokat hoz létre, de ezeket egyesíti a tény, hogy két fő tárgyra törekszenek: a megértésre és a változásra. Az irodalmat elemezve, lehetséges úgy definiálni az akciókutatást, mint a „megközelítések családját" (Reason 1994, Reason – Bradbury 2006), mely arra irányul, hogy a kutatást a közösség szolgálatába helyezze. Aktiválja a részvételi gyakorlatot, hogy szociális változást érjen el. Ez lényeges különbségeket foglal magában, amellett hogy tiszteletben tartja a kutatás más formáit, tekintettel a célkitűzésekre, ahová a kutató irányítja magát, ismeretelméleti hipotéziseit és gyakorlatát. (p.206). A szerző szerint ez a „család" összekapcsolódik olyan megközelítésekkel és gyakorlattal, mint:

1) akciókutatás, 2) részvételi kutatás, 3) részvételi akciókutatás, 4) akció tudomány, 5) akció vizsgálat, 6) az akció szociológiája vagy sociologie de l'action (Bartoletto, 2006). Vargiu (2008) szintén hozzátette, azokat a tapasztalatokat, amik visszavezethetők a Közösség Alapú Kutatáshoz, a Közösség Alapú (Részvételi) Akciókutatáshoz és megfigyelte, hogy a részvételi kutatás és a részvételi akciókutatás behozható abba a kutatási kategóriába, amit Capecchi (2006) úgy definiál, mint "con-ricerca" (209.o.) A szerző szerint, ami hasznos megkülönböztetés lehet, az hogy a részvétel szintje előre látható a kutatási folyamatban, hogy a tárgyak definíciójában mennyi az eljárási elem és eszköz, a szubjektív és kollektív dimenziónak adott tér.

A részvételi kutatás és az akciókutatás egyre inkább központi paradigmájává válik a szociális tudományoknak (Brydon-Miller et al. 2004, Greenwood & ílevin, 1998, Kindon, Pain & Kesby, 2007, Jason et al., 2004, Park et al., 1993, Reason & Bradbury, 2006, Selener, 1997; Taggart, 1997). Ahogy jelezték Kindon, Pain and Kesby (2007) és Mackenzie és kollegái (2012), a Részvételi Akciókutatás (RAK) magában foglalja a kutatókat és résztvevőket a teljes projectben, célja megvizsgálni a problematikus feltételeket vagy akciókat és jobb irányba módosítani őket. (Wadsworth, 1998). Ez egy együttműködő kutatási, tanítási és akciós folyamat (Hall, 1981), szociális transzformáció felé irányul (McTaggart, 1997), kezdve a sokféle tudás jelenlétének felismerésétől, változó szervezetekben és kontextusokban (Kindon, Pain and Kesby, 2007). A folyamat ciklikus (reflekció-akció ciklusokon alapszik): a kutatók és a résztvevők meghatároznak egy problémát vagy szituációt, ami változást igényel és kezdeményeznek egy kutatást, amely készségeket és forrásokat hív fel, hogy felgyorsítsa a megfelelő cselekvést. A kutatók és a résztvevők is reflektálnak erre az akcióra, tanulnak belőle és tovább mozdulnak a kutatás/akció/reflekció új ciklusára. Ahogy Kindon, Pain and Kesby (2007) meghatározza, ők kooperálnak is a kontextus-specifikus módszerek fejlődésében, hogy facilitálják ezeket a ciklusokat. Összefoglalva, a RAK a párbeszédre fókuszál a kutatók között (Kindon, Pain és Kesby, 2007) és a RAK ezért egy orientáció a kutatás végzése során (Reason 2004; Kesby et al, 2005), ami módszertani fejlesztést igényel és a kutatási folyamatot úgy tekinti, mint az eredményét: a hatékonysága nem csak vele jár az összegyűjtött információk minőségével, de a résztvevők készségeinek, tudásának, képességeinek mértéke határozza meg, amik a kutatási tapasztalat alatt fejlődtek. (Cornwall és Jewkes 1995; Kesby et al., 2005, 2007; Maguire 1987).

Reason and Bradbury (2006) érvelnek egy részvételi perspektíva vagy világ szemlélet adoptálásának szükségessége mellett, ami „arra kér minket, hogy legyünk helyben lévők és reflektívek együttal, legyünk határozottak a perspektívával kapcsolatban, ahonnan az ismeret létre jött, a vizsgálatot tekintsük a tudás folyamatának, hogy szolgáljuk az akciókutatás demokratikus és praktikus erkölcsi világképét." (7.o.) Összhangban Kindonnal és kollegáival (2007), a kulcs egy ontológiai nézet, mely azt vallja, hogy az emberi lények dinamikus tényezők, felruházva reflektív készségekkel és személyes változással, és egy ismeretelmélet, mely megragadja ezeket a készségeket a kutatási folyamaton belül.

Egy alapvetően részvételi perspektiva alapján, a RAK-ban a részvétel módjának és szintjének kiválasztása nem csak elsődlegesen a kutatók által történhet, hanem megtárgyalják a társ-kutatókkal és a résztvevőkkel. A leggyakrabban használt módszerek a RAK-ban a párbeszédre, a történetmesélésre és a közösségi akciókra fókuszálnak. A leggyakrabban használt módszerek (Kindon, Pain and Kesby, 2007):

- Felmérések
- Résztvevő megfigyelés
- Másodlagos adat analízis
- Csinálva tanulás
- Párbeszéd
- Politikai akció
- Csoport munka és megbeszélés
- Interjú
- Történetmesélés
- Leképezés
- Közösségi művészet és média
- Diagram készítés
- Oktató táborok
- Csere programok
- Besorolás és pontozás
- Megosztott analízis, írás és prezentációk

Ahogy már kiemelték, az akciókutatás részvételi akciókutatássá válik, attól függően, hogy ki vesz részt az egyes fázisokban és milyen mértékben. A résztvevők és a társkutatók tájékoztathatják a tervezést, javasolhatnak módszereket, facilitálhatnak néhány aktivitást és mindenekfelett áttekinthetik és értékelhetik az egész folyamatot. (Mackenzie et al., 2012). A tervezési fázistól kezdve a RAK igyekszik használni a megalapozott kutatási technikákat, adaptálni a szituációhoz és úgy véli lényeges felépíteni egy stratégiát (az akció előtt), hogy monitorozni és értékelni lehessen az akció hatékonyságát. Ennek meg kell engedni az a változás mértékének felismerését, de ugyanakkor ki kell fejtenie egy erős ismeretelméleti tudást azzal szemben, ami a kapcsolat az érvényesség és kiugrás az új vagy feltörekvő tudásban, hasonlóan a szisztematikus gondolkodási szisztémához (Ison, 2008). A hatékony monitorozás és az értékelő eljárások biztosítják a folyamat szigorát, hogy értékelje az akciókutatás közbenjárásának hatékonyságát, alkalmasságát és jelentőségét. Ez egy keretmunkát is biztosít az okozati összefüggések megállapításához, hogy meghatározza a szituációban vágyott változások kutatás „okozta" vagy „hozzájárult" mértékét. (McAllister és Vernooy, 1999)". (12-13.o.). A résztvevők értékelése a folyamatról és a kimenetről egy további utat biztosít arra, hogy az érdekelt felek bevonását megszilárdítsa és lehetőséget ajánljon kollektíven arra, hogy közösen hozzanak létre egy aktív és kritikus szerződést, amiben alternatív hangok nélkülözhetetlenek és gazdagítóak. A RAK ezért azt kívánja a kutatótól, hogy adja fel az irányítást és a folyamat facilitátorának szerepét vegye fel. (Kindon, Pain és Kesby, 2007; Janssen et al., 2013).

Ahogy Kangovi és kollegái kiemelték (2014), a mentális egészség területén a RAK jó stratégiának bizonyult, hogy működőképesen vonják be a pácienseket a tervezésbe. A RAK kooperatív és ismétlődő természete megengedi a kutatóknak, az egészségügyi stábnak és a pácienseknek, hogy együttműködjenek a beavatkozások tervezésében, amit a végső felhasználók értékelnek. Arra is használható, hogy adaptálják egy meglévő beavatkozásra speciális igényekhez, és amikor elterjedt, új beállításokhoz és/vagy páciens csoportokhoz. Fiatal populáción való alkalmazás területén, ahogy Shamrova és Cummings (2017) mondják, a gyermekjogok paradigma nagy ösztönző erővel bírt a kutatók számára, hogy felismerjék a gyerekeket, mint a jelentés felépítésében lévő aktív résztvevőket. Ebben a RAK egy olyan mechanizmus, amin keresztül a képviseletet kiosztották a résztvevőknek, támogatva a gyermekjogok végrehajtását. (Checkoway, 2011; Quijada Cerecer, Cahill és Bradley, 2013; Shamrova és Cummings, 2017). Továbbá az irodalomban, az eredmények alkalmazásának vonatkozásában, a szervezési szinten is jelentik, hogy a leggyakoribb változást a szervezési kultúrában érték el: a részvételi lehetőségek növelésével, a gyerek bevonódási szintjének növelésével és nagyobb figyelmet fordítottak arra, hogy a programok jobban illeszkedjenek a gyerekek és a fiatalok igényeihez. (Shamrova és Cummings, 2017). Ebben a szerzők leírnak néhány módszertani választást, ami segíthet a gyerekek hatékony részvételének támogatásában:

- tréning
- gyerekbarát adatgyűjtési módszerek kidolgozása és használata
- gyerekek aktív bevonása az adatok analizálásába és az eredmények értelmezésébe
- szignifikáns helyszínek választása a kutatás eredményeinek terjesztésére

Sérülékeny csoportokkal végzett kutatás tekintetében, amint azt Lushey és Munro (2015) jelzi a RAK a gyerekek részvételi jogát hirdetheti és azokét akik elvesztették a gondozásukat, egyúttal informálhat a tapasztalati alap eredményekről a tanulmányokból, melyeket ezzel a populációval végeztek.

Egy konceptuális szinten különösen érdekes a Fiatalok Részvételi Akciókutatása (FRAK) (Anyon et al., 2018; Rodriguez és Brown, 2009), amely magában foglalja a következő alapelveket:

1. vizsgálaton alapszik

2. a megfigyelt területek a fiatal emberek által megélt tapasztalatok

3. részvételi

4. átváltoztató természete van

A kulcs folyamatok a következőek:

a) az erő megosztás a fiatalok és a felnőttek között az egész folyamat alatt

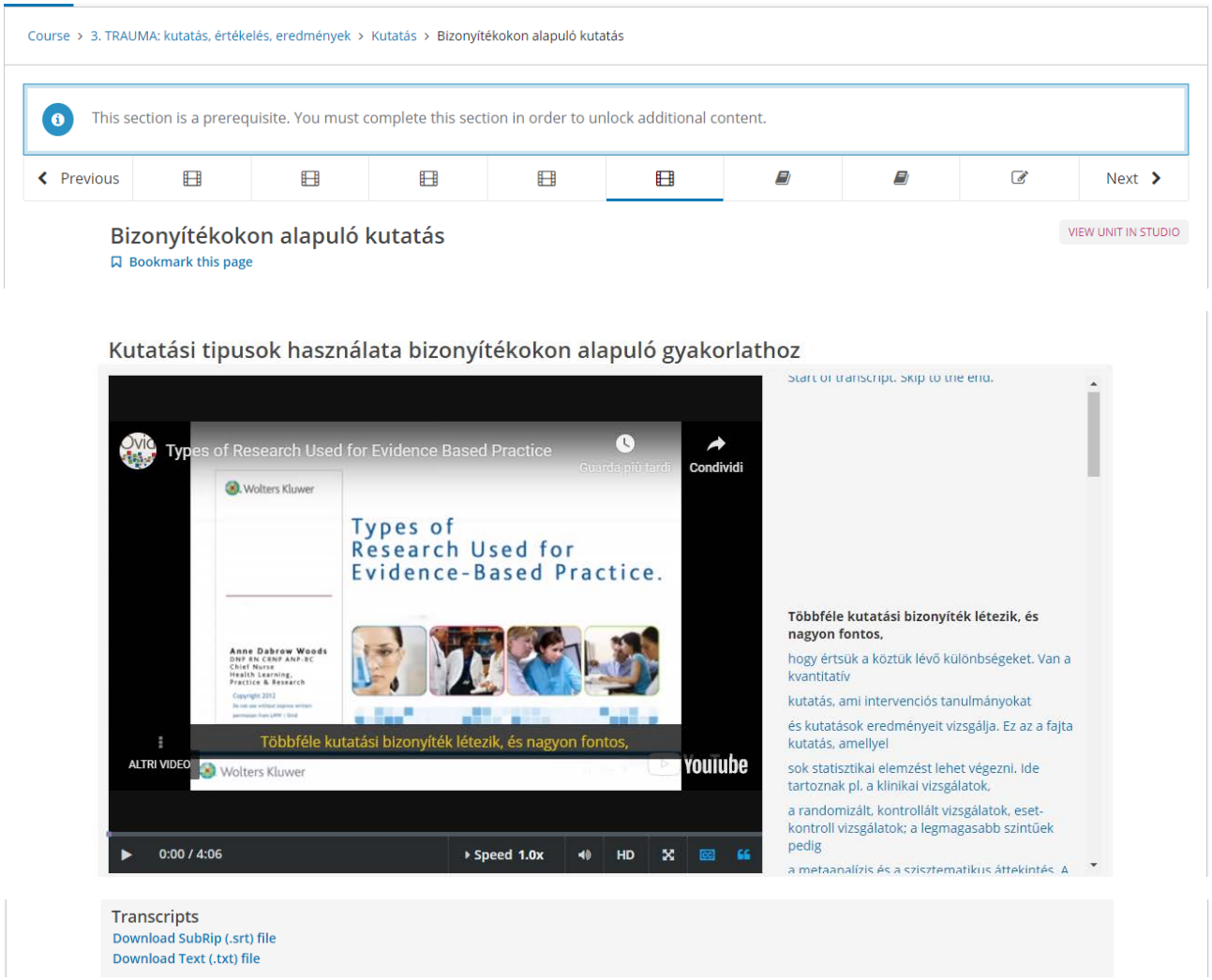
b) tréning és a kutatás és az érdekképviseleti módszerek alkalmazása

c) a stratégiai gondolkodás kritikai használata azon, hogy szociális változást hogyan lehet elérni

d) szövetségek kiépítése minden érdekelttel

Végül egy RAK paradigmán alapuló kutatási példa, amit Törrönen és Vornanen (2014) végzett ápolás-elhagyókkal. A fenti elvek sorrendjében, ahogy a szerzők jelzik, a szakmabeliek és a kutatók bevonódtak egy támogató szerepbe, míg a fiatalok lefolytatták az interjúkat, összegyűjtötték az adatokat a párjaiktól és bátorították a vélemények megosztását a tapasztalatokról (Törrönen & Vauhkonen, 2012). A központi aspektus valójában a figyelem a segédkutatók csekély bevonódásának a víziójára, ezért ők teljesen bevonódtak a kutatási folyamatba.

STAFF DEBUG INFO



Transcript

Többféle kutatási bizonyíték létezik, és nagyon fontos,

hogy értsük a köztük lévő különbségeket. Van a kvantitatív

kutatás, ami intervenciós tanulmányokat

és kutatások eredményeit vizsgálja. Ez az a fajta kutatás, amellyel

sok statisztikai elemzést lehet végezni. Ide tartoznak pl. a klinikai vizsgálatok,

a randomizált, kontrollált vizsgálatok, eset-kontroll vizsgálatok; a legmagasabb szintűek pedig

a metaanalízis és a szisztematikus áttekintés. A klinikai gyakorlat irányelveit a legtöbb

esetben a kvantitatív kutatások eredményeire alapozzák. A másik típusú kutatás

a kvalitatív kutatás, aminek a célja

az emberi viselkedés megértése, hogy az emberek hogyan

reagálnak egy-egy helyzetre. A leggyakrabban olyan területeken

találkozunk ezzel a típussal, mint az ápolás és a társadalomtudányok,

pl. fenomenológiai tanulmányok formájában, ahol azt a jelenséget vizsgálják, hogy az ember beteg,

vagy valamilyen egészségi gonddal küzd. Beletartozik ebbe az etnográfiai
csoportok tanulmányozása, ami az antropológiában gyökerezik. Tehát megvizsgálunk egy csoportot,
akik egy bizonyos egészségügyi gonddal küzdenek. A kvalitatív kutatás nagyon fontos ahhoz,
hogy hogyan végezzük a segítő foglalkozásokat, mert biztosítanunk kell azt, hogy
a páciensek jó élményben részesüljenek azáltal a segítő szolgáltatás által, amit kapnak.
A legmagasabb szintű kutatásnak a szekunder kutatást tartják, ami
a szisztematikus áttekintés vagy metaanalízis. Amik ebben mások, az többek között az, hogy
egyformán szigorú szempontok alapján
tekinti át egy bizonyos tudományos témában elvégzett összes kutatási tanulmányt.
Mindegyiket egyforma szigorral ellenőrzi és elemzik.
Egy szisztematikus áttekintés egészen más, mint egy
szakirodalmi áttekintés, mivel a szisztematikus áttekintésnek és a metaanalízisnek
át kell mennie szakértői felülvizgálaton, vagyis két vagy három másik embernek is
értékelnie kell a szisztematikus áttekintésben vagy meta-analízben szereplő tanulmányokat.
Szisztematikus áttekintés készítésekor továbbá néhány más dolgot is
biztosítani kell annak érdekében, hogy a pácienseknek a megfelelő ellátást
biztosítsuk. Meg kell vizsgálni, hogy az áttekintés eredményei valóban
kivitelezhetőek-e. Valóban meg lehet valósítani az adott, konkrét páciensállományon?
Megfelelő lesz? Értelmezhető az általam kezelt betegek esetén,
az én egészségügyi szolgáltatási gyakorlatomban? És valóban hatásos lesz?
Valóban segíteni fog? Azt is tudni kell, hogy nem minden kutatási eredmény egyforma,
ezért nagyon fontos, hogy egy egészségügyi szolgáltatásnyújtó
alaposan megnézze az általa talált tanulmányokat. Meg kell vizsgálnia, hogy
milyen szintű kutatásról van szó. Az alap szinten vannak az eredeti
kutatási tanulmányok, mint például a randomizált, kontrollált tanulmányok
és a hasonló dolgok. A következő szint a szisztematikus áttekintések
a metaanalízisekben: mint mondtam, ez úgy készül, hogy a kutató
az összes, egy adott témában készült kutatási anyagot áttekinti,
kritikusan értékeli és szintetizálja őket, majd mindezt szisztematikus
áttekintésként illeszti össze egy egésszé. Ezt egy magasabb szintű kutatásnak
tekintjük a bizonyítékok hiararchikus sorában. A legmagasabb szintű pedig a klinkai
döntéstámogatás. Ezek olyan eszközök, amelyeket az egészségügyi

szolgáltatásnyújtók azonnal használni tudnak, azonnal gyakorlatba ültethetnek, miután elolvasták őket. Ez miért fontos? Mert az egészségügyi szolgáltatásnyújtóknak legtöbbször nincs idejük elvolasni száz, kétszáz, háromszáz oldalas szisztematikus áttekintéseket és metaanalíziseket, mielőtt döntést hoznak egy páciensről: a bizonyítékokat kell elolvasniuk, és azt azonnal gyakorlatba ültetniük. Ebben segítenek a klinikai döntéstámogató eszközök.
A klinikai döntéstámogató eszközöknek szisztematikus áttekintéseken, metaanalíziseken, bizonyítékösszegzéseken, vagy az elérhető legjobb bizonyítékon kell alapulniuk.

A bizonyítékokon alapuló kutatás terminus (BAK) 2009-ben jött létre, hogy jelezze a megközelítést, ami ellensúlyozza a biomedikai kutatás jelentős veszteségforrását (Robinson, 2009), ami az elsődleges tanulmányok következtében jelentek meg, a rendelkezésre álló bizonyítékok szisztematikus áttekintése nélkül. Ez sem etikus sem tudományos nem volt. (Lund, H. et al., 2017) A bizonyítékokon alapuló kutatás mindig szisztematikus áttekintéssel (SÁ) kezdődik, amely magában foglalja aez lőre meghatározott kutatási kérdéseket, bevonási kritériumokat, kutatási módszereket, kiválasztási eljárásokat, minőség értékelést, adat kivonást és statisztikai analízist (Lund, H. et al., 2017). Az SÁ-eket használják a kutatások megértésére és rangsorolására és hogy valyon szükséges és hasznos a közösség számára vagy lehetséges forrása az elvesztegetett erőforrásoknak, mert nem hoz létre új tudományos ismeretet. A vezérfonalakat a Bizonyíték irányítja, ezt a GIMBE Alapítvány nyitott hozzáférésű újságja (Bizonyítékokon Alapuló Orvostudomány Olasz Csoportja) mutatja be a következő bizonyítékokon alapuló kutatási projektben:

1. Kialakítja az előzetes kutatási kérdéseket és azonosítja a megfelelő szisztematikus áttekintéseket

2. Értékeli a cél adekvátságát, minőségét és a kutatás időszerűségét

3. Részleteiben értékeli: a populációt, a beavatkozásokat, összevetéseket, kimeneteleket éa az időtartományt (PICOT/PBÖKI)

4. Értékeli a módszert és az eredményeket

Végül a kutatóknak a tanulmány végső kérdésének megfogalmazásához is alkalmazniuk kell a SÁ-t, amit szeretnének hirdetni, igazolni a szükségességét a támogatás kéréséhez és az etikai bizottság jóváhagyásához, az új tanulmány eredményeinek értelmezéséhez a rendelkezésre álló bizonyítékok kontextusában , és a jövőbeli kutatások ajánlásában. Az idők során egy exponenciális növekedés történt a bizonyítékokon alapuló kutatásban, ami oda vezetett, hogy körülbelül 2 millió cikk jelent meg, több mint 20 ezer újságban. Sok oka van ennek a növekedésnek, egyik oldalról az oktatási hivatás (JAMA, 1992) és a paradigma váltás (Pagliaro & Colli, 2014) ami ehheza gyakorlathoz vezetett, másrészről a bizonyítékokon alapuló kutatás erősségének jelenléte:

- olyan területeken is, aholnagyobb a bizonytalanság az értelmezésben, elérhető tudást és iránymutatást hozhat létre a szakmai gyakorlatban, mint a klinikusi gyakorlat
- csökkenti a veszteséget, mert definiálja a kutatási kérdések fontossági sorrendjét az előzetes szisztematikus áttekintés használata által.
- a kutatási tervek tiszta megfogalmazását hozza (célpopuláció, értelmezések, összevetések, kimenetelek)
- frissítéseket hoz létre és elterjeszti a szisztematikus áttekintéseket
- integrálja a bizonyítékokat a klinikai gyakorlatban

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Kutatási példák

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A következő példa egy felmérési módszerről Bean & Creswell (1980, 321-322.o.) által:

„A tanulmány helyszine egy kis (1000-es felvétel), vallásos, koedukált, liberális művészeti főiskola volt egy 175 ezres lakosú Közép-nyugati városban. Az előző év lemorzsolódási aránya 25% volt. A lemorzsolódási arány legmagasabb szokott lenni a gólyák és a másodévesek között, így megpróbáltak elérni annyi gólyát és másodévest, amennyit csak lehetett, amikor szétosztották a kérdőíveket az osztályok között. A veszteség vizsgálata azt mutatta, hogy a főiskolai lemorzsolódás okai különbözőek férfiaknál és nőknél (Bean, 1978; Spady 1971). Ezért ebben a tanulmányban csak nőket analizáltak. 1979 áprilisban 169 nő küldte vissza a kérdőívet. 135 nőből álló homogén csoportot választottak ki közűlük erre a vizsgálatra, akik 25 éves vagy fiatalabb, hajadon, teljes idős, amerikai állampolgár és kaukázusi volt. Közűlük 71 volt gólya, 55 másodéves és 9 harmadéves. A tanulók 95 %-a 18 és 21 év közötti volt. Ez a példa elfogult a magasabb képességű diákok irányában, ahogy az ACT teszt értékei mutatják. Az adatokat egy 116 elemből álló kérdőív segítségével gyűjtötték össze [...] ezek nagy többsége Likert-szerű elem volt, ami egy skálán alapult a „nagyon kis mértékben"-től a „nagyon nagy mértékben"-ig. Más kérdések tényekre kérdeztek rá, mint az ACT pontszámok, gimnáziumi jegyek és szülők iskolai végzettsége. Minden információ, amit az analízisben használtak a kérdőívek adataiból származott. A kérdőívet három másik intézménynél fejlesztették ki és tesztelték, mielőtt ebben a főiskolában használták. [A szerzők megtárgyalták az eszközt.] [...] Többszörös regressziós elemzést és út analízist használtak az adatok elemzésére [...]"

(Creswell, 2014,181-182.o.)

A következő egy kvalitatív kutatás példája (Cardano, Ortalda, 242-243.o.)

„ A kutatás célja a pre-adolescensek bevezetése a dohányzásba volt. (Frohlich, Potvin, Chabot, Corin, 2002). Miután rekonstruálták a pre-adolescensek közt a dohányzás elterjedtségét Quebec 32 tartományában és szereztek releváns információkat a fizikai kényszerről és „strukturális" forrásokról, amik hol akadályozzák, hol engedélyezik a dohányzási szokást ebben a populációban – a dohányboltok jelenléte, olyan közterületek jelenléte, ahol nem engedett meg a dohányzás, olyanok jelenléte, akik monitorozzák a kormányzati szabályozás betartását, ami a fiatalok számára árusított cigarettára és a közterületen való dohányzásra vonatkozik – a szerzők figyelmüket 8 tartományra fordították, melyekben fókusz csoportokat vezettek. Minden tartományban a helyi iskolák tanárainak közvetítésével toborozták a résztvevőket, ők tettek be őket, fiúkat és lányokat egy csoportba, ahol a tagok – lehetőség szerint – ismerték egymást és gyakran találkoztak a fókusz csoport előtt. Ebben a tanulmánybana résztvevők közös tudása egy forrássá vált, nem egy korláttá, felajánlva a kutatóknak a lehetőséget, hogy hozzáférjenek a beszélgetésekhez, amik talán kevésbé szelídek, a résztvevők életének kontextusában formálódtak. Az utóbbi ráadásul erősödött a közösségi támogatástól, képes volt kezelni a témát – a dohányzási szokást – amit nehéz volt megtárgyalni egy felnőtt résztvevő előtt, nagyobb nyugalommal. Az etnográfiai kontextus ismerete, a tartományban elterjedt nyelvi kódok a szociális gyakorlatban voltak azok a fókusz csoportok, lehorgonyzások, amik lehetővé tették a kutatók számára, hogy szembe nézzenek a nehézségekkel. Általában társították a főkusz csoportok megvalósulását a természetes csoportokkal: a felhívás a tapasztalatok megosztására nem volt teljesen megmagyarázva a beszélgetésben, a szleng kifejezések használata, index kifejezések használata.

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Teszt 3.1

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Q3.1

4 points possible (graded)

1. Egy tudományos kutatás....

- Adat gyűjtéssel kezdődik
- Mindig lehetőséget ad a realitás hiteles vizsgálatára
- Mindig egy egyszerű módszert használ
- Mindig be kell számoljon a korábban megszerzett ismeretekről

2. Az akciókutatásban....

- A kutatónak teljesen semlegesnek kell lennie a kutatás tárgya iránt
- Megpróbáltak természeti törvényeket kikövetkeztetni a jelenség objektív analízisén keresztül.
- Nem kell szociális változást produkálni a kutatási kontextusban
- Bátorítják a kutatók részvételét és kooperációját

3. Mely lépések NEM részei minden bizonyítékon alapuló kutatási projektnek?

- Az eredmények értékelése.
- Az elmélet értékelése a gyakorlaton keresztül.
- Kutatási hipotézisek megszövegezése
- Az irodalom szisztematikus áttekintése

4. A központi eleme a Részvételi Akciókutatásnak:

- A fókusz a megosztott ismeret gondolatán van a kutató és a beavatkozás kedvezményezettje között.
- A fókusz a nem megosztott ismeret gondolatán van a kutató és a beavatkozás kedvezményezettje között.
- A tiszta és teljes elkülönítés az Akció és a kutatás között.
- A megvizsgálandó problémák és a használandó eszközök eleve kiválasztottsága

Invia You have used 0 of 2 attempts

Salva Show Answer

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Bizonyítékokon alapuló kutatás a tic/tip-ben: nemzetközi perspektíva

A traumatizált kiskorúakkal foglakozó szervezetek egyik fő témája és az egyik legnagyobb kérdése az, hogyan garantáljon adekvát és hatékony tréninget a szakmabelieknek a bizonyítékokon alapuló értelmezések alapján (Ruzek & Rosen, 2009). Amikor megfigyeljük a kezelések végrehajtásának helyzetét és a bizonyítékokon alapuló vezérelveket egy általános perspektívából, annak ellenére, hogy ez a téma nagyon fontos a közegészségügy területén, a megvalósítás egyenlőtlen, korlátozott figyelem a szisztémás értékelésen, és a tréning programok hosszú távú hatásai vonhatók le. (Ruzek & Rosen, 2009). Ráadásul egy összehasonlító perspektívából Delaney (2006) kiemelt egy másik lényeges aspektust: nemzetközi szinten a vezérelvek és megvalósításaik a klinikai gyakorlat választható kezeléseiben nagymértékben változatos a nemzetek szintjén és a különböző népeknél (beleértve a közegészségügyi szabályozásokat). Weiner, Schneider & Lyons (2009) a traumatizált kiskorúak kezelésének bizonyítékokon alapuló módszereinek analízisét tanulmányozták. Ahogy a szerzők meghatározták, néhány ezek közül a tapasztalati vagy kvázi-tapasztalati módon tesztelt módszer, de a legtöbb módszer felnőtt populációra lett kialakítva, bár kiskorúak számára is használták őket és az értékelésben nem vagy kevéssé vették figyelembe a kulturális különbségeket és változatosságot az alcsoportokban, mint a kimenetelt befolyásoló faktorokat.

Ezekből a megfigyelésekből a kezelések kultúrközi értékelésének egy érdekes gyűjteménye származott, ami nem csak a hatékonyság növelését tette lehetővé, hanem megmagyarázza azt is, hogy milyen korlátok akadályozzák a kezelések kivitelezését és a rugalmas adaptációs követelményeket a speciális alcsoportok vagy alkalmazások körülményei közt. Courtois & Gold (2009) és Layne & kollegái (2014) kiemelték azt az igényt, hogy bevegyenek egy speciális fókuszt a trauma és következményei vonatkozásában a kezelők tréningjébe, kezdve azzal, hogy tudatosítsák a tényt, hogy a trauma és annak hatásai befolyással vannak a kezelés minden részére, különösen a páciens elköteleződésére, az értékelésre, és a kezelésre való reagálásra. Továbbá aláhúzzák, hogy ebben a tekintetben, hogyan játszik jelentős szerepet a nemzetközi standardok alkotása és a megosztott tréning módszerek a Bizonyítékokon Alapuló Gyakorlat kezelői számára. (BAG, Lyon et al., 2011). A BAG lehetővé teszi a kezelő számára, hogy a legműködőképesebb megoldást válassza, speciális szituációra érvényesítve és alkalmassá téve, a kliens speciális igényeire, erősségeire és körülményeire alapozva. (Layne et al., 2014). Azért, hogy a megfelelő tréninget tudják garantálni, ebben a tekintetben, szükségszerű a tudományos közösség számára, hogy létrehozzanak egy definíciót a központi kompetenciák számára, ami egy alaptudás arról, amit a trauma történetének kezelésében alkalmazni kell. Ennek a fajta figyelemnek különösképpen lehetővé kell tennie, hogy az ajánlott szolgáltatások jó minőségűek legyenek, a kezelők felelőssége növekedjen és terjedjen a tudás, amit megosztanak, gyakran protokollokon keresztül, vagy különböző csoportokon keresztül (pszichológia, pszichoterápia, szociális tudományok, pszichiátria, stb.) A Nemzeti Gyermek Traumás Stressz Network (NGTSN/NCTSN) egy szakmabelieknek, családtagoknak, kutatóknak és nemzetközi partnereknek szánt honlap, ami a gondozási standardok javulásával foglalkozik és hozzáférést biztosít a gyerekekkel és családokkal foglalkozó szolgáltatóknak. Az NTCSN létrehozott egy tréning protokollt CCCT (Gyermekkori Trauma Alap Tanterv/Curriculum) (Layne et al., 2011), amely tisztázza a beavatkozások főbb elemeit (egy integrált, bizonyítékokon alapuló mátrixba foglalva őket), a trauma alap koncepcióit, a tervezéshez szükséges lényegi terápiás készségeket, és egy hatékony beavatkozás végrehajtása traumatizált gyerekek és családjaik számára. Alapvetően két elem tűnik fel: a beavatkozás célja (azok a célkitűzések, amelyek várhatóan megfelelnek majd a beavatkozással kapcsolatos elvárásoknak) és a gyakorlati elemek (a ténylegesen alkalmazott folyamatok az eredmények eléréséhez). Az alapkompetenciákra összpontosuló figyelem a kezelők tréningjében, a specifikus „arany standardokban" definiálódik, az EBP tréninghez és a bizonyítékokon alapuló kezelésekhez képest.

A CCCT 5 szintet tartalmaz: a) empirikus bizonyítékok alapja; b) a gyermekek és családjaik traumatikus stresszválaszának megértésére alkotott 12 alapkoncepció; c) a beavatkozás céljai; d) gyakorlati elemek (a ténylegesen alkalmazott folyamatok az eredménynek eléréséhez); e) terápiás készségek és képességek (két alkategória: 1) procedurális és folyamatorientált; 2) kiértékelő). A fent említett modell támogatja a bizonyítékon alapuló gyakorlatokat és kompetenciákat, a rutinszerű kiértékelést és információgyűjtést, a gyakorlat elméletét, a tudományos irodalomból származó eredmények egyéni szituációkban való alkalmazását, az esetek konceptualizálását, és a beavatkozás megtervezését. A CCCT modell vizsgálata és alkalmazása során az egyik munkacsoport külön alkalmat tervezett a statisztikai analitikai készségek fejlesztésére és olyan tanulási protokollok létrehozására, amelyek hasznosak a klinikai gyakorlatban való értékeléshez. Ami a leginkább hansúlyozható ezzel kapcsolatban, az a mind az elméleti aspektusok, mind a kiértékelési módszerek (multidimenzionális) fejlesztése, valamint a bizonyíték hozzáférhetősége a beavatkozások kiértékelése és érvényesítése során (különösen figyelembe véve azok kimenetelét, a beavatkozó tényezőket, a személyek speciális helyzetére fókuszáló beavatkozások hatékonyságát). Briggs és kollégái (2012) továbbá prioritásként jelölik meg a standardek emelését a „[...] bizonyítékokon alapuló módszerek fejlesztésén, alkalmazásán és elterjesztésén" keresztül (p.1). A beavatkozás vezérfonalainak struktúrálása – azonosítani és a módszereket (mi a lehető legjobb beavatkozás a speciális körülmények között), és a kimenetel értékelése – alapvető és hasznos a kezelők számára és azoknak, akik a szolgáltatások kialakításával foglalkoznak. A kutatás tervezés hasznos lehet azoknak, akik fontolgatják, hogy összekapcsolják a rizikó faktorokat és különböző kimeneteket, abból a célból, hogy tisztázzák a beavatkozás mely elemeire lehetne fókuszálni, továbbá, ismétlődően, bevonjanak új aspektusokat a trauma teoretikus megértésébe és a tudományos keretrendszert tágítsák. Különösen érdekes tény, az a megfigyelés, hogy a PTSD-vel összefüggő tünetek enyhítését célzó kezelések a funkcionális nehézségek csökkentésében is hatékonyak, nem közvetlenül kapcsolódva a kezelés tárgyához. Ez megvilágítja, hogy a traumára fókuszált kezelés pozitív, széles körű hatást tud generálni. (Layne et al., 2010).

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Tic-vel foglalkozó szervezetek tréning igénye

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Bryson és kollegái (2017) lefektettek egy érdekes premisszát, hogy hasznos megkülönböztetni a visszatükrözés két szintjét. A modul témáinak analízisére és értékelésére alkalmazva a szerzők külön választják a trauma-specifikus kezeléseket (ezek a traumával kapcsolatos tünetek csökkentését célzó beavatkozások) a TIC-től, ami egy általános perspektíva, aminek a célja a gondozói rendszer átváltozása, a TIC magában foglalja a traumával kapcsolatos stressz válaszok minden szinten való megértését a szolgáltatások szervezetének minden aspektusában. A széles körű kérés ellenére, hogy a TIC elveit alkalmazzák a szolgáltatások, az előnyök ellenére, amivel ez járhatna, a tudományos hozzájárulás a TIC végrehajtására fiatalkorúaknál, sajnos korlátozott. (Bryson et al., 2017). Ruzek & Rosen, 2009-ben, már megfigyelte, hogy a PTSD-vel kapcsolatos tünetekre fókuszáló, bizonyítékokon alapuló kezelések elterjesztése volt az egyik kulcs elem, amihez a traumát átélt embereket támogató szervezetek elköteleződtek. Ezt, mint eredményt mi is tanúsítottuk a tudományos irodalom növekedésével, ami a szervezeti faktorokkal foglalkozik és ez együtt járt a legjobb gyakorlatok megvalósításával és elterjesztésével. Ennek ellenére egy korábbi analízis, amit Delaney (2006) mutatott be, megerősítve Ruzek & Rosen (2009) és Bryson és kollégái (2017) által, egy erős bizonytalanságú tényező jelent meg a gyakorlatban, mint a korlátozás és az izoláció. Továbbá, ahogy Valenkamp és kollégái (2014) és szintén Bryson és kollégái (2017), néhány tanulmány tesztelte ezeknek a beavatkozásoknak a hatékonyságát, mikor összevetették más alternatív elfogadó módszerekkel. A beavatkozási módszerek bizonytalansága, Ruzek & Rosen (2009) szerint, feltárja egy összehasonlító analízis eljárásának szükségességét, a vezérelvekről és a legjobb nemzetközi gyakorlatokról, azért, hogy még inkább megalapozzák a szervezeti változtatási javaslatokat a területen és az irányelvek szintjén még inkább bizonyítékokon alapulóak legyenek. Bryson & kollégái (2017) a tudományos irodalom szisztematikus áttekintésén keresztül megpróbálták kiemelni, hogy milyen faktorok teszik lehetővé a TIC alkalmazásának működését. Milyen felhasználók, milyen körülmények között, milyen irányban, és miért.

A legszélesebb körben figyelembe vett stratégiák, amiket megosztottak tudományos leírásokban: 1) változás-orientált vezetés, 2) kutatási adatok használata a gyakorlat informálásában, 3) stáb fejlesztés, 4) eszközök használata a korlátozás és izoláció megelőzése érdekében, 5) a felhasználók szerepe a tartózkodásuk kontextusában, 6) kérdezési technikák. Figyelembe véve a szükségletet , hogy analizálják ezeknek az elemeknek a működési komplexitását, miközben össze is kapcsolják őket helyi és szervezeti sajátosságokkal, a szerzők meghívása a TIC alkalmazással foglalkozó szolgáltatók számára, megelőlegezve a demonstráció megkísérlését, a tudományos kutatás folyamatán keresztül, egy hosszú távú perspektívában, az erőfeszítés és a változás hatékonyságát alkalmazták a páciensek biztonságának javulásáért, úgy mint a kezelések hosszú távú kimenetele. Összefüggően ezzel a perspektívával, Lang és kollégái (2016) aláhúzzák, hogy milyen fontos egy konszenzust elérni abban, hogy mi minősül egy trauma- fókuszú szolgáltatásnak és hogyan lehet hatékonyan mérni a bevonódott faktorokat. Mindenekelőtt, a központi kérdések: hogyan lehet elérni egy optimális titoktartási folyamatot, hogyan lehet legjobban működésbe hozni a TIC alap princípiumait a napi munkában a potenciálisan vagy biztosan traumának kitett alanyokkal és mik lehetnek a legjobb módszerek arra, hogy fejlesszék a szolgáltatókat, akik ezzel a populációval foglalkoznak. Jelenleg kevés kutatás foglalkozik a változások hatékonyságával a TIC alapú szervezetekbe bekerülő pácienseknél, és hogy ezeknek a változásoknak milyen része hasznos az egészségre nézve a résztvevő felhasználóknál. A kutatók kihangsúlyozták, hogy valójában egy kihívás lehetne a EBP (bizonyítékokon alapuló gyakorlat) kutatás és a legjobb gyakorlatok integrációja, acélból, hogy a szolgáltatók által felajánlott beavatkozások minősége javuljon (miközben figyelembe veszik ezeknek a kezdeményezéseknek a gazdasági hatás elemzését is), a stáb kompetenciáinak fejlődésén keresztül, a szűrési eljárásokon és az irányelvek változási képességein át. Ez irányban a vezetőség játszhat kritikus szerepet, amely támogathatja a változás folyamatát, néha radikálisan, még a szervezeti kultúra szintjén is (kihangsúlyozva, például a TIC fontosságát).

A trauma tréning egy központi alkotóelem, de ez nem elégséges, hogy egy szervezet trauma-érzékeny legyen. Egy másik fontos aspektus, ahogy Kramer és kollégái (2013) meghatározták, a különböző szervezetek együttműködése, amelyek a kiskorúakkal és családjaikkal foglalkoznak, akiknek meg kell egyezniük a TIC alapelveiben. Ebben az utolsó aspektusban a szerzők analizálták a tréning hatékonyságát, mely speciális tudás megszerzésére törekszik adekvát felmérési eszközök hosszútávú alkalmazásáról (tréning előtt és után), úgy mint egy követő felmérés, hogy analizálják mennyire voltak eredményesek ezek a szerzett képességek változást eredményezni a kérdéses szolgáltatónál. Ennél a speciális aspektusnál, egy érdekes téma a korlátok analízise, melyek az egész stábot érintették. Az összehasonlító kutatási struktúra (randomizált csoportokkal), azt akarta megvizsgálni, hogy mennyire hasznosak az alkalmazott stratégiák és vannak e további tréning igények hosszú távon.

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A trauma kutatás elterjesztése szervezeti helyzetekben

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Amikor a kutatás elterjesztéséről beszélünk, szervezeti körülmények között, Ruzek & Rosen (2009) aláhúzza ennek komplexitását: mikor a modellek az elterjesztéssel foglalkoznak, kiemelik hogyan függ ez sokféle faktor interakciójától, különböző szinteken (egyénilag és szervezetileg). Briggs és kollégái (2012) bemutatják hogyan ismerhető fel, ha a tudásban történt változás megjelenik az első lépésben a szervezeti változás felé, de annak az értékelése, hogy ez hogyan mutat tovább vagy fordítódik át aktuális viselkedésbeli változásba ugyanolyan alapvető. Két aspektus tűnik fontosnak: a tudományos tartalom elterjedésének szisztémás és többszintű komplexitása a szervezetekben, és az a folyamat, ami összeköti a tudást és a gyakorlatot az egyéni és szervezeti változás komplex mechanizmusán keresztül. Ez a folyamat előhozza az egyik leggyakoribb ellenállást az új, legjobb gyakorlatok alkalmazásával szemben: a tény, hogy az alkalmazásukat választották a szervezetben gyakran „felülről lefele"-ként tapasztalják, és ezért a klinikusok nem nagyon támogatják. (Rohrbach et al., 2006; Ruzek & Rosen, 2009). Valójában ebben az esetben a kezelők elköteleződése a szervezeti praxisukban történő változáshoz egy központi dimenzió. Ahogy a tudósok hozzájárulása javasolja, a változásról történő megegyezést megtárgyalása a vezetőség és a beosztottak között, szem előtt tartva a helyi igényeket, hozzájárul a sikeres alkalmazáshoz. (Durlak & DuPre, 2008; Ruzek & Rosen, 2009). Egy másik központi téma az a tény, hogy az egészségügyi szervezetekben sokszor nincs speciális EBP (bizonyítékokon alapuló kutatás)-ban jártas személy a stábban, hogy tanulmányozza a legjobb gyakorlatokat és stratégiákat az alkalmazásban, és különösen, hogy analizálja és rendszerezze a tudományos kutatások eredményeinek folyamatos integrációját. (Berwick, 2003; Ruzek & Rosen, 2009).

Erre tekintettel, Marvin & Volino Robinson (2018) kiemelték a szervezetek szükségletét arra, hogy legyen egy elképzelésük, mely úgy szemléli az intézmény vagy szolgáltató analízisét magát, mint a képességet vagy készséget a változtató beavatkozás befogadására és fenntartására (az irodalom ezt „szervezeti felkészültségnek" hívja, és mérni lehet, szervezeti, csoport vagy egyéni szinten). Ezzel a dimenzióval foglalkozni a tervezési fázisban teljesen helyénvaló, hogy fenntartsák az új gyakorlatok alkalmazását, hogy analizálják a korlátokat a folyamatban és fenntartsák a hitet és a pozitív attitűdöt a szervezeti változás iránt. Egy széleskörű megfontolása ennek a témának a központiság, hozzá kell rendelni az ajánláshoz, mikor a célzott változási stratégiát felépítik egy speciális szervezetnél (Augustsson et al., 2017; Marvin & Volino Robinson, 2018). A kutatás bizonyítja, hogy a vezetői és manageri elképzelések közös konstrukciója milyen fontos a változás útján, szinkronban a szakemberekkel és kultura-orientált módon megosztva a TIC alkalmazást, először is a stáb igények

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Kutatás a trauma-fókuszált szolgálatoknál

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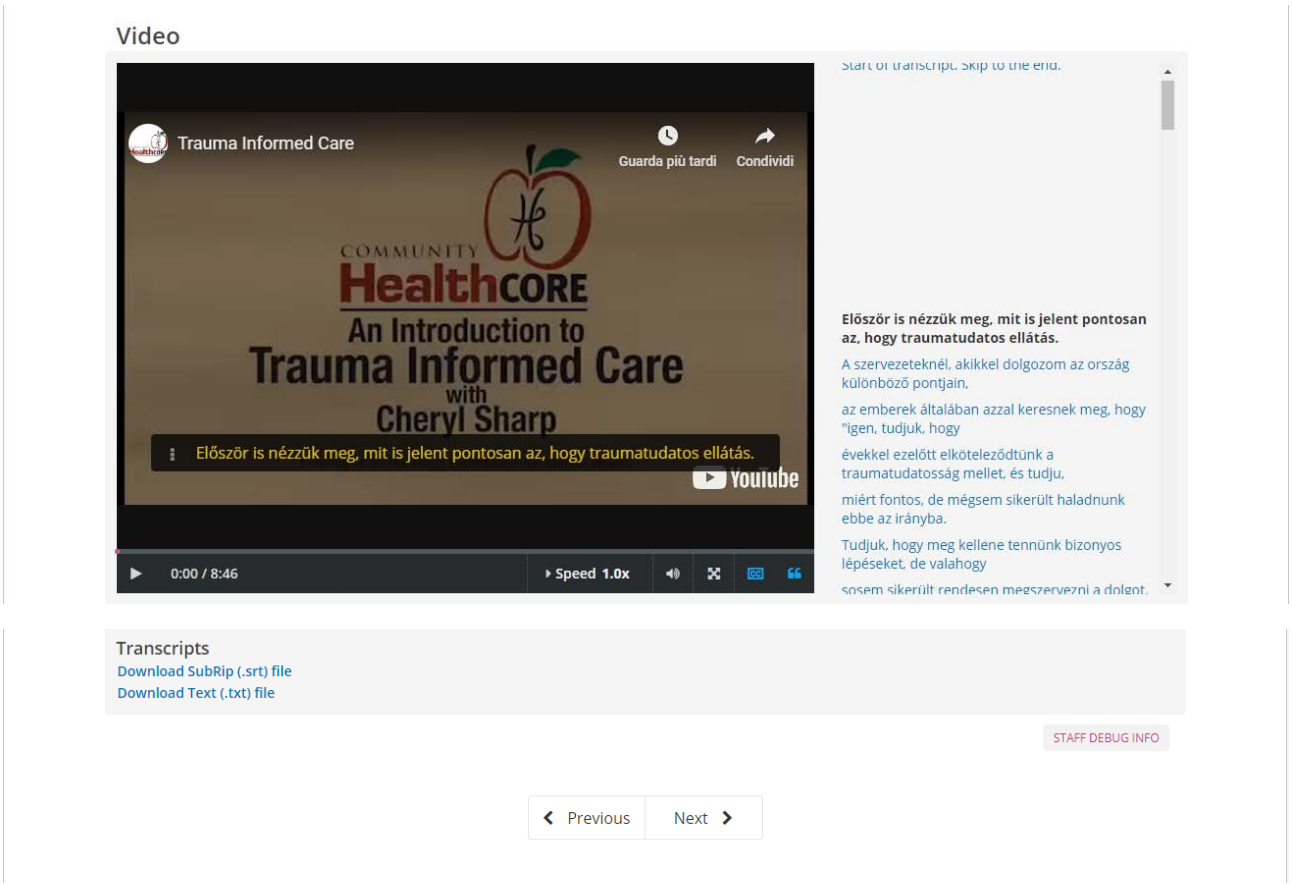
A TIC-et lehet úgy definiálni, mint egy bizonyítékokon alapuló megközelítést a traumára való reagálásban, ami a stábtagok képességeire (vagy képtelenségeire) fókuszál, akik részt vesznek a traumatizált páciensek kezelésének elképzelésében. Egy kritikus előjele az adoptált startégiák sikerének vagy a kudarcának, az hogy lecsökkentsék a kliens újra traumatizálódásának kockázatát.(Marvin & Volino Robinson, 2018). Ebben alap, hogy óvatosan tárjuk fel a történetek komplexitását, amiben a trauma történt, a különböző és egyéni tapasztalatokat. Az irányelvek, eljárások és a napi működés lehet egy hozzáadott traumatizáló élmény vagy a traumatizált személynél olyan egyéni funkcionális kapcsolt reakciókat provokálhat, ami megakadályozza, hogy a számára szükséges gondozást elfogadja. Azért, hogy megelőzzük ezeket a szituációkat és hogy stresszt generáljunk a stáb tagokban, hasznos lehet, ha speciálisan strukturált és nemzetközileg kipróbált legjobb gyakorlatokra váltunk. (lásd például SAMHSA által 2014-ben ajánlott stratégiák). Szinergikus kapcsolatban ezzel, a TIC megközelítés arra invitálja a szervezeteket, hogy vegyék figyelembe azt a hatást, amit a klinikai szolgálatokba ömlő traumatikus történetek gyakorolnak a tagokra (SAMHSA, 2014; Knight, 2015) és hogy a kezelők hogyan kaphatnak segítséget tréningeken keresztül és trauma-érzékeny vezetőség által, hogy egy magas szintű jóllétet és a munkában hatékony beavatkozásokat tudjanak elérni. (Manderscheid, 2009). Ruzek & Rosen (2009) mélységében vizsgálták azokat a faktorokat, amik hatással vannak annak a módjára, ahogy a szervezetek megkapják a kutatási eredményeket a a trauma kezeléshez kapcsolódó, bizonyítékokon alapuló gyakorlatokról. Egy gondos értékelés mind a gyakorlat elterjedéséről, mind a kutatásról magában foglalja a sokrétű faktorok elemzési területének összefoglalását, melyek hatással lehetnek a gondozási folyamat fejlődésére, a páciensek vagy potenciális felhasználók kapcsolatára a szolgáltatóval, a klinikusok új kezelési technikákat tanuló szokásaira, a szervezeti változásokra kapcsolódva a viselkedésbeli átalakulásra.

Bizonyára, a szerzők elképzeléseinek megfelelően, egy egyre sürgetőbb prioritás a tapasztalati kutatás alkalmazása ezen a területen, az értékelés vagy támogatás a kezelési módok alkalmazására, egy gazdaságilag megfelelő módon. A kutatók, általában, a kezelőkhöz kapcsolódó faktorok szerepét analizálták, amit a kutatás kiemelt a kimenetelhez kapcsolódóan. Megfigyelték, hogy a kezelők értékelései, különösen a traumához kapcsolódó stresszben (különösen, akik PTSD-vel foglalkoznak) egy speciális gyakorlatról, a kompetenciáik és jellemzőik (pl. a hatékonysági szintjük) a hajlandóságuk a változásra a konkrét gyakorlatban (pl. adoptálni egy legjobb gyakorlatot és bevezetni a napi működésbe) a befolyásoló tényezők, de alig tanulmányozzák őket empirikus szinten. Az EBP-s tréning programok megközelíthetősége és az aggodalom a fejlesztés alkalmazhatóságát illetően, hogy a kutatási terület megfeleő-e a ő speciális populációjára (az eredmények generalizálásának problémája) látszik a leg befolyásolóbb tényezőnek a bizonyítékokon alapuló gyakorlatok iránti attitúdjeikben, függetlenül az elméleti keretrendszerüktől. A tréning módszer, ami különösen hatékonynak tűnik, hogy változtasson a gondozói viselkedésen, az intenzív tréning kurzus, különösen, amikor a szükséges kompetenciák demonstrálásáról van szó, és amikor megkívánják ezek letesztelését az interaktív részvételen keresztűl az órákon (rendszeresen elérhető szuperízió mellett, a tréning eseményeken túl, és tréningezd a trénert- eseményeken). Üdvözölve az újítási faktorokat, a szerzők kiemelik, hogy a kliensek és kezelők észlelése a kezelésről egy lényegi eleme az adoptációnak, különösen vonatkoztatva ezt a bizonyított hatékonyságukra (összehasonlítva más módszerekkel). Üdvözölve a szisztémás tényezőket, megfigyelték hogy mennyire fontos a szupervízió elérhetősége és az adminisztratív-szervezeti támogatás egy jó gyakorlat sikeres alkalmazásához. (Fixsen et al., 2005) Még fontosabb szükséglet a tapasztalati támogatás a trauma-érzékeny gondozói rendszerek megalkotásában. (Ko et al., 2008; Ruzek & Rosen, 2009) Továbbiakban a kezelés alkalmazásának monitorozása egy másik kulcspontja az elterjedésnek, hatékonyságnak, a bizalomnak az EBP-s eljárás kiteljesedésében (Rosenheck, 2001b; DuFrene, Noell, Gilbertson & Duhon, 2005; Durlak & DuPre, 2008; Ruzek e Rosen, 2009). Egy különösen érdekes aspektus, amit Rosenheck elemzett (2001a), aki kiemelte a kölcsönösen rekurzív folyamatot a EBP-s interakciókban (az általános és előíró dimenzióiban) és a helyi tapasztalatokat/szükségleteket a kivitelezésben. A monitorozás célja, még annak a költségeivel szemben is, gazdasági és idő befektetési értelemben erőforrások a szolgálatok számára, ezért meg kell engedni a szolgálatoknak, hogy a kezelések kimenetelének lényegi elemeire és a hatékonyságára fókuszáljanak. (Ruzek & Rosen, 2009). Az egyik kulcskérdés lehet, hogy a klinikusok módosult válasza a speciális igényekre hogyan áshatja alá, növelheti vagy hagyhatja érintetlenűl a beavatkozás hatásait. (Ruzek & Rosen, 2009).



Transcript

Először is nézzük meg, mit is jelent pontosan az, hogy traumatudatos ellátás.

A szervezeteknél, akikkel dolgozom az ország különböző pontjain,

az emberek általában azzal keresnek meg, hogy "igen, tudjuk, hogy

évekkel ezelőtt elköteleződtünk a traumatudatosság mellet, és tudju,

miért fontos, de mégsem sikerült haladnunk ebbe az irányba.

Tudjuk, hogy meg kellene tennünk bizonyos lépéseket, de valahogy

sosem sikerült rendesen megszervezni a dolgot, megtenni azt a következő lépést."

A Nemzeti Tanácsnál kifejlesztettünk egy eszközt,

amit "szervezeti önfelmérésnek" neveztünk el.

Vettük a terület vezető szakembereinek ötleteit, olyan emberekét, mint

például Roger Fowler, Maxine Harris, Judith Herman és Sandy Blum,

és próbáltuk a munkásságukat oly módon szintetizálni, hogy az bemutassa, mik valójában

a traumatudatosságot képviselő gyakorlatok és alapelvek. Például az

"első a biztonság", az őszinteség, a kölcsönösség, a választás lehetősége,

a véleményalkotás, az irányítás, a közös munka, az, hogy az életük feletti kontrollt visszaadjuk az

emberek kezébe. Tehát összegyúrtunk egy "szervezeti önfelmérés" nevű eszközt

ezekből a gyakorlatokból és alapelvekből annak érdekében,
hogy a működés szintjére lehozzuk, hogyan is néz ki, ha egy szervezet elkezd mozdulni
a traumatudatosság irányába. Ez az önfelmérés egy 1-4 közötti Likert skálával dolgozik,
és van benne "nem alkalmazható" opció is. A traumatudatos ellátás
hét területét különítettük el, és ezen a hét területen belül lehet követni az
alapelveket. Minden területhez több szabvány, irányelv tartozik, de
ezek nem kizárólagosak; az önfelmérés lényege az, hogy a szervezetek
elkezdjenek kicsit másképp gondolkodni a munkáról, amit végeznek.
A hét terület közül az első a "szűrés és felmérés", amivel a célunk az,
hogy a kliensek, amikor egy szervezethez
fordulnak, akkor menjenek át egy szűrésen, de ugyanakkor
legyen lehetőségük bármiről beszélni,
bármilyen élményükről, kényes dologról, bizalmas módon. Ha valaki segítségért fordul
egy szervezethez, és nagyon fél, akkor lehet, hogy nem bízik az
ott dolgozókban. A célunk az, azt szeretnénk elérni, hogy
olyan környezetbe érkezzenek a segítséget kérő emberek, ahol nem kellemetlen nekik
egyes kérdések megválaszolása. A szakembereket pedig képezni kell arra,
hogy hogyan tegyék fel ezeket a kérdéseket, hogyan alakítsanak ki egy kapcsolatot
valakivel, a legelső alkalommal, amint az illető belép ajtón.
A második terület a "kliens-központú ellátás és szolgáltatások".
Nagyon örülök a Community HealthCore-nak, annak, ahogy az általuk végzett munkáról
gondolkodnak, annak, hogy sok embert képeznek ki és alkalmaznak
azok közül az közösségek közül, akiknek a szolgáltatás szól, ami igazán nagyszerű,
de nem ez az egyetlen eleme. Az ilyen segítők egész más szemmel látják a szolgáltatást:
tudják, milyen érzés átmenni a szűrési és felmérési folyamaton,
hogy milyen érzés, ha egy olyan csoportba teszik be az embert, ami nagyon nem neki való,
hogy milyen az, amikor maga a rendszer újratraumatizálja őket.
Az ő nézőpontjuk és véleményük fontos része ennek a munkának,
a kiensközpontú ellátásnak és szolgáltatásoknak. Akkor lesz valami igazán kliensközpontú,
ha felépülés-orientált és emberközpontú szemlélettel dolgozik,
ha a szolgáltatás igénybevevőinek van lehetősége elmondani,
hogy mi az, ami működik, jó nekik, és mi nem. Nagyon fontos az ő véleményük,

hogy biztosítva legyen az, hogy a célcsoport, a felhasználók, igénybevevők, kliensek
lehetőséget kapjanak elmondani, hogy mi az, amiben jól működik a szervezet,
és miben nem. Beszéltünk a munkaerőfejlesztésről is,
hogy a segítők megfelelően képzettek legyenek a taumatudatosság területén.
Ebbe beletartozik a klinikai képzés is, az orvosoknak megfelelő képzésre van szükségük,
hogy a munkájukat végezhessék, de pl. a recepciós számára mit jelent
egy traumatudatos szervezetnél dolgozni? Minden ember számít,
a gépkocsivezető, a karbantartó, a gondnok; mind hozzájárulnak
egy olyan közösség létrehozásához, amelyben az emberek azt érzik, hogy
elkezdhetnek gyógyulni. De gondolni kell a munkatársak érzelmi kimerülésére is.
Korábban ma már beszéltünk a belső ügyfélszolgálatról, hogy
a szervezetnél dolgozó minden ember így kezelje egymást. Nem lehet
traumatudatos szervezetet létrehozni, ha a dolgozók annyira túlterheltek,
hogy érzelmileg ki vannak égve. Tehát gondolni kell a dolgozók szükségleteire is,
és arra, hogy ha saját magamról nem gondoskodom kellőképpen,
hogyan tudnék igazán segíteni egy másik embernek? A klinikai szupervíziót
is meg kell vizsgálni: traumatudatos módon végezzük a szupervíziót, vagy
büntető módon? A 4. terület a bizonyítékokon alapuló jó gyakorlatok,
ami azt jelenti, hogy az ember nyitott szemmel jár, nem az a hozzállása, hogy "mi ezt így és így csináljuk,
mert ez bizonyítottan működik, és soha nem nézzük meg a szakmán belül
történő új dolgokat." Azt jelenti, hogy nyitottak vagyunk a jól működő dolgokra,
és képzést biztosítunk a dolgozók számára, és a célcsoport által jóváhagyott,
bizonyítékokon alapuló jó gyakorlatokat használunk, mint pl. a “WHAM” Wellness,
Whole Health Action Management, ahol a célcsoport tagjai segítenek egymásnak, és
kezükbe veszik a fizikai egészségük irányítását. Vagy a “WRAP”: Wellness Recovery Action Planning,
ami szintén egy remekül használható, bizonyíték-alapú traumatudatos eszköz,
a biztonságos környezet létrehozásához. Az emberek nem tudnak úgy gyógyulni, ha
nam érzik magukat biztonságban. Ha az ember folyamatosan kiélezett figyelemmel figyeli a környezetét,
ha olyan környezetbe érkezik, ami nem látja szívesen, és nem érzi magát biztonságban,
abból nem fog semmi jó kisülni. Valaki elmesélte, hogy a szervezeténél átfestették
és kicsit megszépítették a recepció területét, és az egyik kliens
ezt látva megkérdezte: "Mennünk kell, költözünk?" Válaszoltak neki, "Nem, miért?"

"Azt gondoltam, hogy ha ilyen szépre megcsinálják a helyet,
akkor biztos el kell mennünk innen." Ez nagyon jól jelzi, hogy
az emberek, a kliensek nem érezték igazán értékelve magukat, ami jó lecke volt
a szervezetnek. Az emberek megérdemlik, hogy olyan környezetben és módon foglalkozzanak velük, ami
azt üzeni: "Tisztellek, értékes vagy". Nem kezdődhet el a gyógyulás addig,
amíg az ember nem érzi ezt. A hatodik terület a közösségi partneri kapcsolatok építése.
Bárkik is legyünk, dolgoznunk kell a közösségek kialakításán.
A traumatudatos gyógyulás nem vákuumban történik. Lehet, hogy a te programodban
remek szolgáltatást kapok, de ha átmenve az XY részlegre
méltatlanul bánnak velem, akkor az sajnos visszafordítja mindannak
a jó munkának a hatását, amit veled elértünk. Ezért fontos felvenni a kapcsolatot
a közösséggel, és segíteni nekik megérteni, mit jelent a traumatudatosság.
Végezetül, a hetedik terület a "teljesítményjavítás".
Honnan tudhatjuk, hogy valóban van hatása a munkánknak?
Hogy ha csinálok egy bizonyos dolgot, az működni fog számomra és az emberek számára, akikkel dolgozom?
Kérek visszajelzést kérdőív formájában a kliensektől? Megkérdezem a klienseket, mennyire
érzik magukat biztonságban? Kérek ugyanígy visszajelzést a dolgozóimtól? És ha igen,
teszek-e bármit az eredmények alapján? A szervezeti önfelmérést
úgy végezzük, hogy az első felmérés után, ami a kiindulópont,
egy idő után megkérjük őket, hogy végezzék el újra,
hogy láthassák a fejlődést, a haladást. Használunk még más eszközöket is,
egy teljesítményellenőrző eszközt, és egy megvalósítási útmutatót, ami
segít a szervezeteknek a haladásban. Röviden ezt jelenti a szervezeti önfelmérés,
dióhéjba sűrítve, hiszen ez egy hosszabb folyamat. A szervezeti önfelmérés
lényege nem az, hogy a szervezetek elmondhassák, hogy "oké, megvolt",
nem csak egy kipipálandó feladat, hanem egy irány a beszélgetések számára,
hogy jelentős változások indulhassanak el a szervezetben.

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Teszt 3.2

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Q3.2

3 points possible (graded)

1. Ruzek és Rosen (2009) tanulmánya megmutatta, hogy a traumával kapcsolatos kezelések nemzetközi kontextusában:

- A kezeléseket egységesen végezték a különböző országokban, kiemelve a használt megközelítés hatékonyságát
- A speciális alcsoportok igényeit adekvátan kezelték.
- Ugyanaz a kezelés egyformán hatékony volt felnőtteknél és gyerekeknél
- A tréning programokat különböző módokon hajtották végre, kiemelve a központi kompetenciák definíciójának szükségességét

2. Trauma-érzékeny gondozás...

- Célja csak a traumához kapcsolódó tünetek enyhítése, beavatkozó technikákra fókuszál.
- Megvalósít olyan technikákat, mint a korlátozás és elkülönítés
- Különösen fiataloknál alkalmazzák.
- Célja átalakítani a gondozási szisztémát, a stáb képességére fókuszálni, hogy részt vegyenek a traumatizált páciensek gondozásának elképzelésében.

3. Az egyik előnye a tudományos elterjesztésnek a traumával foglalkozó szervezeteknél:

- Lehetőség különleges érdeklődést kifejezni dolgozó csoportokkal kapcsolatos témákban.
- A lehetőség, hogy a legújabb bizonyítékokon alapuló gyakorlatok alapján kezdjenek meg egy végrehajtási folyamatot, célja a stáb és a páciens jóllétének növelése.
- A bizonyíték végrehajtása, mint egy felülről-lefelé döntés a vezetőség részéről.
- Az átmenet a generikus kezelésekre, ami minden páciensnél működik.

Invia You have used 0 of 2 attempts

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Definíciók és premisszák

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Guyadeen & Seasons (2018) kiemelik hogy, hasonlóan sok más tudományhoz, „a tervezés területének megvan a maga saját értékelési minősége" (98. o.) ami két csoportra osztható: „ a terv kiértékelése és tervezési értékelés". Hagyományosan, az értékelés a tervezésben független volt a program értékeléstől és speciális értékelési megközelítéseket foglalt magában. A tervezési disciplina jelenleg vitatja, hogy előnyös lenne, ha szorosabb kapcsolat épülne a program értékelés és a tervezési értékelés között. (98.o.) A közegészségügyi rendszerben, az értékelés fontos szerepet játszik az alapelvek kifejlesztésében és az elvi tervezésben. „Mindkét folyamat egy probléma azonosító és definiáló fázist követ" (99.o.) ezután a megszövegezés, megvalósítás fázisai és végül az értékelés következik. Az utolsó fázis célja, hogy felmérje a beavatkozás sikerességét és azonosítsa a program javulási területeit (Pal, 2014; Guyadeen & Seasons, 2018). Ahogy Guyadeen and Seasons (2018) meghatározták: „Ez egy struktúrált folyamat, aminek a célja, hogy a beavatkozásokról szóló információkat hozzon létre és szintetizáljon, azért, hogy megítélhesse az okozott változásokat, a beavatkozás kívánatosságát, és az alkalmazhatóság mértékét a szándékos és szándéktalan kimenetelek közt. (McDavid & Hawthorn, 2006)" (99.o.) Az értékelési folyamat fókuszálhat a programok és tervek költséghatékonyságára is, és ez különleges jelentőségű lehet az állami szektor szervezeteinél: a politikai és törvényhozói felelősség okai magukban foglalják, hogy a tervezőknek demonstrálniuk kel a cselekedeteik vagy javaslataik előnyeit a nyilvánosság és a közösség számára. (Vedung, 2010; Guyadeen & Seasons, 2018). Craig és kollegái (2008) kiemelik „hogy a komplex beavatkozások széles körben használatosak az egészségügyi szolgáltatók körében, a népegészségügyi gyakorlatban, a szociálpolitika területein, ami fontos következményekkel jár az egészségre" (1.o.). Ezek a kezdeményezések kihívást jelentenek az értékelést végző kezelők számára, ami túlmegy az értékelési folyamat alkalmazási és módszertani nehézségein a sikerről, amit a kezdeményezésnek érintenie kell. Ami azt illeti, „a komplex beavatkozásokat úgy írják le, mint olyan beavatkozásokat, amik sok interakciós komponenst tartalmaznak" és „sokféle karaktervonásuk van, amiket az értékelőknek számba kell venniük" (Craig at al., 2008, 1.o.). Ebben például kulcskérdés tud lenni a komplex beavatkozások értékelésében: - az ilyen beavatkozások hatékonyak a mindennapi praxisban? - Tud a hatékonyság változni a célcsoport vagy a tartalom vonatkozásában? - Hogyan működik a beavatkozás? - Mik a kulcs elemek és hogyan fejtik ki hatásukat?

Általában egy eljárási és folyamatbeli nézőpontból a legjobb gyakorlat állandóan szisztematikusan fejlődik a beavatkozásokban. Ez azt jelenti, hogy „a legjobb gyakorlat szisztematikusan fejleszti a beavatkozásokat, használja a legjobb, elérhető bizonyítékokat és megfelelő elméletet, aztán teszteli őket egy gondosan szakaszolt megközelítésben, kezdve egy kísérleti tanulmány sorozattal, megcélozva minden egyes bizonytalanságot a tervezésben, és továbbmenve egy felderítői és később egy végleges értékeléssel. Az eredményeket olyan széles körben é.s meggyőzően kell elterjeszteni, ahogy csak lehetséges további kutatással segíteni és monitorozni a végrehajtás folyamatát" (Craig et al., 2008, 2.o.).

Elkezdve tisztázni az elemeket, amik ebben a komplex folyamatban szerepelnek Rychetnik, Frommer, Hawe & Shiell (2002) ellátnak minket a következő definíciókkal:

- BEAVATKOZÁS: úgy lehet gondolni rá, mint egy cselekvési csomag, melynek célja az a tárgy, mely magában foglalja a változást vagy azonosítható kimenetelt hoz létre. Nagyobb jóllétet mozdítani elő vagy támogatni az egészségügyi státuszt a közegészségügyi beavatkozások fő tárgya, ami különbözik a klinikai beavatkozásoktól, amiknek általában az a célja, hogy megelőzze vagy kezelje az egyéni distresszt.
- KONTEXTUS: ez a szociális, politikai és/vagy szervezeti helyzetre utal, melyben a beavatkozásokat tervezik, végrehajtják és értékelik. A kontextuális vonások, melyek relevánsnak tekinthetők egy beavatkozásnál, a beavatkozás tipusa szerint változnak. A közegészségügyi beavatkozásoknál a politikai, szervezeti, szocio-ökonomikus, demografikus és környezeti faktorok fontosak.
- ÉRTÉKELÉS: ez az a folyamat, mely meghatározza az értékeket, melyek alapján a beavatkozások összehasonlíthatóak az előre meghatározott és definiált standardokkal.
- BIZONYÍTÉK: ez magában foglalja az adatok értelmező olvasását, melyeket a hagyományos kutatással gyűjtöttek össze vagy speciálisan végrehajtott vizsgálatokkal a tudományos módszerek standarjaival. A Bizonyítékokon-alapuló gyakorlat kiemeli és foglalkozik a beavatkozás vágyott következményeivel és gondol a központi hatékonyságra (a költségeket tekintve is), figyelembe véve a beavatkozás végrehajtásának és kimenetelének adatait is.

Ráadásul, a PROGRAMOK olyan aktivitás csoportokból vannak összeállítva, melyeknek célja egy speciális eredmény elérése vagy célkitűzések halmaza (McDavid & Hawthorn, 2006; Pal, 2014; Guyadeen & Seasons, 2018). A programokat általában olyan eszköznek tervezik, ami a forrásokat cselekvésbe fordítja, hogy a kívánt eredményt elérjék. (McDavid & Hawthorn, 2006; Guyadeen & Seasons, 2018). A TERVEK, amik betölthetik az irányító funkciót, egyfajta programozást és tervezési elképzelést, uralkodó szerepük van a a beavatkozások vagy kezdeményezések szervezésében a közösség számára. (Baer 1997; Ryan, 2011; Guyadeen & Seasons, 2018). Nekik lehetnek átfogó céljaik, ahogy felajánlják a jövőbeli fejlődés felé irányuló elképzeléseiket: egyesítik a tényeket, tárgyakat és irányelveket, ami lefordítható egy fizikai vagy kézzel fogható fejlődési modellre és megérint sokrétű közösségi problémát. (Berke et al., 2006). A programok egy terv végrehajtási stratégiáinak részei lehetnek. (Guyadeen & Seasons, 2018). Ahogy ők írják: „Fontos megjegyezni, hogy a tervek fejlődő eszközök, melyeket folyamatosan szükséges áttekinteni és felújítani a fejlődő szükségleteknek, tudásnak és tapasztalatoknak megfelelően. (Brody 2003). Ebben a vonatkozásban, az értékelésnek kulcsszerepet kell játszania a tervek és programok alkalmazhatóságának és megfelelőségének erősítésében." (99.o.)

Először, az értékelés megfontolható „egy tapasztalat orientált elvként, ami információkat hoz létre a programról" (Guyadeen & Seasons, 2018, 99.o.) fejlesztési céllal és/vagy a jövőbeli döntések irányadójaként. Másodszor, nyomaték van mindkettőn, a program működésén és az eredményeken. Tehát, az értékelés nem csak a program hatékonyságáról szól, de a folyamatról is. Ami azt illeti, ez arra a módra fókuszál, ahogy a programokat kezelik, ez magában foglal egy szervezeti módszertani analízist, amit a program fejlesztésére, a használt inputokra (pl. források), az eredményekre (pl. kézzelfogható mérések) és a költséghatékonyságra használnak (Howlett, Ramesh & Perl, 2009; Guyadeen & Seasons, 2018). Végül, a program értékelés arra is használható, hogy megpróbálják a programot hatékonyabbá és eredményesebbé tenni (Weiss, 1998; Guyadeen & Seasons, 2018), és mint a biztosíték, kiszámíthatóság és minőségbiztosítás eszközeként is (Cousins et al., 2014; Pal, 2014; Guyadeen & Seasons, 2018).

Ezen okok miatt a közegészségügyi területen a beavatkozásokról szóló döntéseknek a fejlesztések által javasolt, mély értékelés erős pontjain kell alapulniuk, de ugyanúgy a csapdákon és a gyengeségi aspektusokonis, a bizonyíték támogatott alkalmazásaikban (Rychetnik et al., 2002). Kritikus útmutatók a beavatkozás értékelésének területén, amik azonosíthatók és és értékelhetők a többdimenziós bizonyítékok mentén, lehetővé teszi olyan kérdések megfelelő figyelembevételét, mint a fontosság és az átadhatóság, speciális és igazolt gyakorlati javaslatokról gondoskodik (Rychetnik et al., 2002). Bár ugyanolyan fontos kiegyensúlyozni a szigorú értékelést és az átívelő célokat, és különbséget tenni az elérhető bizonyítékok szisztematikus értékelése és a komplex szociál-politikai folyamat között, mely meghatározza a politikai és gyakorlati döntéseket (Rychetnik et al., 2002).

Továbbá, Rychetnik, Frommer, Hawe és Shiell (2002) aláhúzzák „a különbségtevést a bizonyíték értékelése és a politikai döntéshozatal vagy operatív döntések között, a beavatkozások megvalósításakor. A kutatás-alapú bizonyíték csak egy a számtalan faktor között, amire számítanak az ilyen döntéseknél" (119.o.) A szerzők tovább részletezik:

„A közegészségügyi beavatkozások általában komplexek, programozottak, és tartalom függőek. A hatékonyságuk bizonyítékának kellően átfogónak kell lennie, hogy megerősítse ezt a komplexitást. A bizonyíték értékelésének különbséget kell tenni aközött, hogy az értékelési folyamat ragaszkodik a beavatkozás sikerének vagy kudarcának észleléséhez és a beavatkozásnak magának a relatív sikere vagy kudarca között. Továbbá, ha egy beavatkozás sikertelen, a bizonyítéknak segíteni kell a megértésben, hogy vajon a beavatkozás eredendően hibás (ez a koncepció vagy elmélet hibája), vagy rosszul lett kivitelezve (az alkalmazás hibája). Mégtovább, a bizonyíték helyes értelmezése az adekvát leírt információk elérhetőségétől függ, a beavatkozásról és annak tartalmáról, tehát meghatározhatja a bizonyíték átruházhatóságát. (119.o.)

Ahogy Craig and kollegái (2008) kimutatták, a gyakorlatban, az értékelés számos megközelítésen keresztül kerül kivitelezésre és ez hatással van a választási lehetőségekre a beavatkozások és értékelési módszerek között. Továbbá, a komplex beavatkozások területén, különböző források (pl. politikai elfogadhatóság) jelentősen tudja tájékoztatni és befolyásolni a kutatókat, hogy az ideális értékelési programot fogadják el. Mégtovább, a tapasztalati modellek sokkal jobban elfogadottak az értékelési módszertanban, de politikai vagy etikai dolgok limitálhatják a használatukat. Az értékelésnek központi szerepet kell játszania a beavatkozások kritikai megközelítésében. Ha a tervezők úgy döntenek, hogy egy nem-tapasztalati módszert alkalmaznak, akkor tudatában kell lenniük a módszertani korlátaiknak és konzekvensen óvatosan kell értelmezni és terjeszteni az eredményeket. Ebben a kutatóknak „felkészültnek kell lenniük, hogy megmagyarázzák a döntéshozóknak a megfelelő fejlesztési munka szükségességét, a tapasztalati és nem-tapasztalati megközelítések előnyeit és hátrányait, és a kompromisszumokat a gyengébb módszerek alkalmazásakor. Fel kell készíteniük a döntéshozókat arra a kihívásra, hogy ha a beavatkozások bizonytalan eredményeket hoznak egy módon, akkor egy szigorú értékelési módszerrel erősíteni a bizonyítékot nehéz lesz, vagy a végrehajtási stratégia módosítása feltárhatja a lehetőségét egy sokkal informatívabb értékelésnek." (Craig et al., 2008. 2.o.).

Még pontosabban, a kutatók (Craig et al., 2008) hangsúlyozzák hogyegy komplex beavatkozás kifejlesztéséhez az értékelési folyamatnak speciális lépéseket kell követnie:

1. A meglévő bizonyítékok azonosítása a témában: amit már publikáltak vagy megosztottak a tudományos közösségben a hasonló beavatkozásokról (szisztematikus és magas minőségű beszámoló az ide vonatkozó bizonyítékokról, beleértve az értékelési módszert a folyamatról és az eredményekről)

2. Az elmélet azonosítása és fejlesztése: a beavatkozás komplex programjának indoklása, az elvárt kimenetel, és az a mód, ahogy a változás elérhetővé válik talán nem teljesen tiszta a kezdettől fogva. Az egyik első kulcs feladat „kifejleszteni egy elméleti megértést a kedvelt változási folyamatról a létező bizonyítékok és elméletek segítségével, kiegészítve, ha szükséges, új, elsődleges kutatással. Ezt meg kell csinálni akkor is, ha a kutató fejleszt ki egy beavatkozást vagy értékel egy már kifejlesztettet." (2.o.)

3. Modellezési folyamat: egy komplex beavatkozás megfelelő modelljének kialakítása mielőtt egy teljes értékelést csinálnának, a kutatóknak lehetővé teszi, hogy hasznos információkat gyűjtsenek és vegyenek bele mind a beavatkozás tervezésébe, mind az értékelésbe. Több tanulmánynak szüksége lenne fokozatosan finomítani a projektet, mielőtt egy teljes értékelést csinálnak. Egy másik hasznos aspektus a tervezési szakaszban a gazdasági értékelés, ami segíthet a projekt ajánlóinak, hogy azonosítsák a gyengeségeket és kitöltsék a hiányosságokat.

Végül a kutatóknak figyelmet kell fordítaniuk az általános kijelentésekre, hogy melyik modell illeszkedik a beavatkozás tipusához a különböző kérdések és körülmények terén, és választani egy tanulmány tervet a speciális karakterek alapján. Ilyen az elvárt hatás mértéke és a kiválasztás valószínűsége vagy az eloszlási hajlam. „A tapasztalati és nem-tapasztalati megközelítések teljes tárházának ismerete megfelelőbb módszertani választásokhoz fog vezetni."(Craig et al., 2008, 3.o.).

A program értékelések területén a főbb tipusok a formatív és összegző értékelési tipus. a program teljesítményének javítására fókuszáló értékelés formatív, mert ők abból a célból adnak visszajelzést, hogy a program eredményei javuljanak vagy a hatékonyság nőjön. (McDavid & Hawthorn, 2006; Posavac & Carey, 2007; Guyadeen & Seasons, 2018). Képzési értékelések hasznos információkat produkálnak a programról való azonnali döntésekhez, úgy mint fejleszteni néhány részt és/vagy módosítani folyamatokat (Shadish, Cook & Leviton, 1991; Guyadeen & Seasons, 2018). Az értékelések az eredményekre fókuszálnak, amik akkor jönnek létre mikor a program véglegesítődik és majdnem teljes, információt ad arról, hogy a program elérte-e a célját és/vagy vajon a folyamat érdemes-e a folytatásra (McDavid & Hawthorn, 2006; Posavac & Carey 2007; Shadish, Cook & Leviton, 1991; Guyadeen & Seasons, 2018).

Összefoglalva, ahogy Wandersman és kollégái 2000-ben jelezték, az értékelési folyamat komplex és összetett (1. ábra)

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Hatékonyság és tapasztalat értékelése (eredmények)

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Guyadeen & Seasons (2018) szerint, „a történelmileg domináns értékelési modell tudomány-vezérelt és technikailag magas minőségű, eerős hangsúllyal a kvantitatív módszereken.". A tudományos kutatási módszerek és technikák, mint a szisztematikus randomizált kutatás tervek és tapasztalatok az értékelési folyamat szerves részeinek tekinthetők. (Alkin 2013). Ez az értékelési megközelítés a hatékonyság és az eredményesség mérésére fókuszál (Greene 1994)" 100.o.

A tudósok hosszú ideje dolgoznak azon, és nem nézeteltérések nélkül, hogy hogyan értékeljenek, célokat, tartalmakat és indikátorokat (Jacobson et al., 1999). Például széleskörű gyakorlat az értékelési területen annak analízise, hogy a programok hogyan (főleg kvantitatív terminusokban) segítik elő vagy akadályozzák a célkitűzések elérését. Ez a megközelítés tisztán megfogalmazott célokat és kongruens indikátorokat kíván meg. A hatékonyság értékelése egy komplex folyamat és nem mentes a vonatkozó döntések felvállalásának felelősségétől: ahogy Craig és kollégái (2008) kimutatták, egy beavatkozás hatékonyságának értékelésében a randomizálást, mint módszert mindig választani kell (pl. hogy elkerüljük a kiválasztási hibákat). Ha egy hagyományos randomizált vizsgálat két párhuzamos csoport között nem megfelelő, akkor más randomizált módszerű tanulmány tervezetet kell megfontolni, vagy ha egy tapasztalati megközelítés nem megvalósítható, akkor kvázi-tapasztalati vagy megfigyelési projektek jöhetnek szóba.

Tekintettel a beavatkozás eredményének analízisére, ha a kutatási tervet kivitelezték, összhangban a tudományos módszerrel, aminek célja, hogy megerősítse vagy elvesse az ok-okozati összefüggés létezését a beavatkozás és az eredmény között és megértse az okokat a hatékonyság vagy a hiánya mögött. A kutatási terv is meghatározza a bizonyíték szintjét, ami ebből keletkezik. A randomizált, kontrollált vizsgálatok szisztematikus felülvizsgálata a legszéleskörűbben használt és elismert módszerek, amik a legjobb szintű bizonyítékokat hozzák létre a megelőzés hatásain és/vagy a kezelési beavatkozásokon. (Rychetnik, Frommer, Hawe & Shiell, 2002). hosszútávú követés szükséges lehet, annak meghatározásához, hogy vajon a várt eredmények születtek vagy vajon a rövid távú változások tartanak: „bár nem gyakori, de ilyen tanulmányok nagyon informatívak" (Craig et al., 2008, 3.o.).

A közegészségügyi beavatkozások értékelésében a bizonyítékok szintjéről további tanulmányok vannak a tudományos irodalomban, mert ezek kritérium függősége megalapozta a hitelességüket. Ebben a tekintetben a vita folytatódik a randomizált, kontrollált vizsgálatok (RKV) területén, aközegészségügyi beavatkozások analízisénél. Ez főleg a nehézségeket érinti ezeknek a kutatásoknak a véghez vitelében, a beavatkozások programadó komplexitása következtében, az eredmények analízise és a megfigyelő kutatások közreműködésének alábecsülése. A természetük következtében, sok közéleti beavatkozás sokrétű és rugalmas analizis stratégiát igényel, amihez a kutatások a a „Klasszikus RKV modellekre alapoznak - a szerzők alapján – nehéz alkalmazni (különösen mert nagyon rigid standardizálási eljárást igényelnek és a randomizálás feltételezése az alapja az egyedi egységeknek).A kutatók analízisének egyik fontos pontja, hogy hangsúlyozzák a nem randomizált módszerek alkalmazását, ahol lehetséges, különben szignifikáns és fenntarthatatlan veszteséghez jutnak, de Rychetnik és kollégái (2002) szavait követve:

„ a kutatás tervezése egyedül nem lehet elégséges, mint a bizonyítékok hitelességének fő kritériuma a közegészségügyi beavatkozásoknál" (121.o.)

Az eredmények értelmezése

Az értékelési folyamat egy központi aspektusa a beavatkozás tervezésének és alkalmazásának, tekintet nélkül arra, hogy vajon a hatékonysági eredmények pozitívak vagy negatívak. Valójában, egy adekvát alkalmazás bizonyítéka a beavatkozási program által előírt eljárásoknál és a hatékony indikátorok használata a folyamat monitorozásában központi szerepet játszik a tudományos irodalomban (Rychetnik et al., 2002).

A beavatkozások mögött húzódó elméletek, a specialitásaik (magyarázat és valószínűség) kapcsolatban a mögöttes feltételezésekkel (hipotézisek) kapcsolódnak az eredmények és hatások mérésének hatékonyságához és működőképességéhez, a kulcs kritériumok az értékelés és értelmezés minőségét tekinteve a közegészségügy területén.(Rychetnik et al., 2002).

Rychetnik kollégái (2002) analízisét követve többdimenziós megközelítések érhetők el az irodalomban, hogy értékeljük a kutatást és az eredményeit. Három fontos dimenzió van a beavatkozás hatékonysági bizonyítékainak értékelésében:

1. „a bizonyíték erőssége,a kutatás tervezés kombinációja által meghatározva, módszertani minőség és statisztikai precizitás” (122.o.)
2. „a mért hatások nagyságrendje” (122.o.)
3. a „mért hatások jelentősége (ahogy az értékelésben megfigyelt) az alkalmazás kontextusában” (122.o.)

Empirikus minőségi értékelések szükségesek, mivel tudják befolyásolni a döntéseket a politikai vagy gyakorlati szinteken a közegészségügyi területen. Óvatosan ki kell emelni, hogy a nem megfelelő értékelési protokollok nem eredményeznek irreális vagy túl sok költséggel járó igényeket. Az értékelési szempontoknak támogatniuk kell a döntéshozói folyamatot, segíteniük kell meghatározni, hogy vajon a mért eredmények magukban foglalják-e (a) azok érdeklődését, akik bevonódhatnak a döntésbe vagy javasolhatnak beavatkozást és a célközönség; (b) vajon a beavatkozás vártlan és várt hatásai előnyökkel járnak vagy sem; és (c) a beavatkozás eredményessége és hatékonysága. Az első dimenzióról, az összes érdekelt fél hozzájárulása alapvető, adott a közegészségügy szociális és politikai természete. Ezen okok miatt, az értékelési folyamatban fontos szereplők a döntéshozók és a célcsoportok.

Ahogy Guyadeen & Seasons (2018) kimutatták, vannak értékelési folyamatok, melyek erős hangsúlyt helyeznek a pluralizmusra és az analízisre, ahol különböző érdekel felek bevonódnak az értékelésbe. Továbbá kvalitatív módszereket gyakran használnak, hogy fejlesszék a programok elképzeléseit az érdekelt felek közvetlen nézőpontjából (Greene, 1994); ami azt illeti, kritikusak is tudnak lenni, ha közvetlenül bevonódnak (pl. anyagi és személyes érdekeltségek) az értékelésbe.

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Az intervenciók hatékonyságának értékelése: folyamatok értékelése

Ahogy eddig is hangsúlyoztuk, az értékelési folyamatnak központi szerepet kellene játszania annak biztosításában, hogy a tervek mind elméleti, mind gyakorlati szempontból a lehető legjobb minőségűek legyenek (Guyadeen & Seasons, 2018; Berke and Godschalk, 2009; Baer, 1997). Ez nagyban hozzájárulhat az objektivitáshoz és a szisztematikussághoz az intervenció tervezésében és elemzésében, javítva ezáltal a rendszerszintű előkészületi folyamatot, és lehetőséget nyújt a projekt szándékolt terve (az elérni kívánt célkitűzések) és az elért eredmények összhangjának vizsgálatára (Guyadeen & Seasons, 2018). Az értékelésen keresztül továbbá dokumentálni és empirikusan azonosítani lehet a hiányosságokat és/vagy erősségeket (Berke, Smith & Lyles 2012; Guyadeen & Seasons, 2018). Az alapvető kiindulási pont az, hogy ahhoz, hogy a tervek hatékonyak és értékelhetőek legyenek, egyértelmű kapcsolatnak kell lennie a terv fő elemei (pl. célkitűzései és a benne foglalt szabályzatok) és a megvalósítási mechanizmusok között (Oliveira & Pinho 2010b; Guyadeen & Seasons, 2018). Összességében két általános értékelési mód létezik a tervezésben: (a) a terv értékelése (pl. a terv színvonalának értékelése, a terv megvalósításának értékelése és a terv eredményeinek értékelése) és (b) a tervezés értékelése (pl. a tervezési folyamat és tervezési gyakorlat értékelése) (Guyadeen & Seasons, 2018). Míg a tervezés értékelésébe beletartozik a tervezési folyamat hatékonyságának megállapítása, az intervenciós terv és annak eredményeinek értékelése a terv színvonalának, a megvalósítás sikerének, és a kitűzött célok elérésének értékelését jelenti (Morckel, 2010; Guyadeen & Seasons, 2018). Az értékelés ezen formái hasonlóak a programértékeléshez, mivel a céljuk a döntéshozatal javítása, ám különböznek is attól, mivel itt a hangsúly a terven van: hogy azt hogyan hozták létre, illetve hogy a tervezés tevékenysége milyen eredményeket ért el (Guyadeen & Seasons, 2018). Ezen kívül általában három értékelési típus létezik a tervezés területén: előzetes, folyamatos és utólagos (Guyadeen & Seasons, 2018). Oliveira & Pinho (2010) szerint ezek az értékelési típusok megfeleltethetőek a tervezés különböző fázisainak, úgymint a terv előkészítése, megvalósítása és értékelése (a megvalósítás után).

A bizonyítékokon alapuló egészségügyi ellátás célja, hogy figyelembe vegye a hatékonyságot és eredményességet, habár a hatékonysági problémákra a bizonyítékokon alapuló orvoslás eddig nem fektetett nagy hangsúlyt. A közegészségügyi intervenciókra vonatkozó bizonyítékok értékelésének elkerülhetetlenül meg kell állapítania, hogy hatékony-e a vizsgálat tárgya, és ha igen, mennyire (Rychetnik, Frommer, Hawe & Shiell, 2002). Továbbá „egy adott intervenció értékére és alkalmazhatóságára vonatkozó, bizonyítékokon alapuló döntéseket, amelyeket azzal megegyező, hasonló vagy azzal rokon intervenciók ismeretére alapoznak, általában más környezetben és más időben visznek véghez és értékelnek. Ahhoz, hogy értékeljük egy adott intervencióra vonatkozó bizonyítékok átvehetőségét, információkra van szükség (a) magáról az intervencióról, (b) a értékelési kontextusról, és (c) az intervenció és a kontextus közötti interakciókról" (Rychetnik, Frommer, Hawe & Shiell, 2002, 123. o.). Komplex intervenciók esetén az eredetihez való hűség nem könnyű kérdés. Az egyik tényező, amely összetetté teszi a kérdést az, hogy az eljárások szigorú szabványosítása olykor megakadályozza az intervenció igényre szabását, amelyet a konkrét helyi szükségletek tehetnek szükségessé (Craig et al., 2008). Az egyik fő dolog, amelyet egyértelművé kell tenni az, hogy milyen mértékben megengedettek a változtatások és az intervenciók egyedi igényekre szabása, illetve hogy miként/mennyire szükséges a megvalósításbeli változásokat nyilvántartani ahhoz, hogy az eredetihez való hűséget értékelni lehessen a szabványosság kutatási terv által előírt mértékéhez képest. A megvalósítás változékonysága - ha tervezett, ha nem - még fontosabbá teszi azt, hogy a folyamat- és eredményértékelő eljárásokról teljes körű beszámolók készüljenek, és hogy egy-egy intervenció reprodukálásának engedélyezéséhez szükség legyen az intervenció egyértelmű leírására (Craig et al., 2008).

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Teszt 3.3

VIEW UNIT IN STUDIO

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Q3.3

3 points possible (graded)

1. Rychetnik, Frommer, Hawe és Shiell (2002) szerint az értékelést a következőképpen lehet definiálni:

- Egy sor olyan változtatás és eredmény, amelyeket előre meg lehet határozni
- Hivatalos kutatás vagy specifikus kérdőívek formájában gyűjtött adatok értelmező kiértékelése
- Egy intervenció értékének megállapítása, előre meghatározott, konkrét szabványokkal való összevetés által
- Az a társadalmi, politikai és/vagy szervezeti környezet, amelyben az intervenciót megvalósítani tervezik

2. Egy intervenció hatékonyságának kiértékelésekor a következők közül melyik NEM fontos tényező? (Rychetnik et al., 2002)

- A mért hatások relevanciája a megvalósítási kontextusban
- A mért hatások mértéke
- A szervezet által megvalósított intervenciók száma
- A bizonyíték erőssége, amelyet a kutatás tervének, a módszertan színvonalának és a statisztikák pontosságának kombinációja határoz meg

3. Az értékelésre igaz a következő:

- Lehetővé teszi az intervenciós tervek gyengeségeinek és erősségeinek empirikus dokumentálását
- Nem követeli meg, hogy az értékelési módszerek a kiértékelni kívánt tervhez igazodjanak
- Kerülnie kell az intervenciókkal kapcsolatos döntésekben részt vevő emberek érdekeinek figyelembevételét
- Kizárólag az eredményeket kell kiértékelni

Invia You have used 0 of 2 attempts

Salva Show Answer

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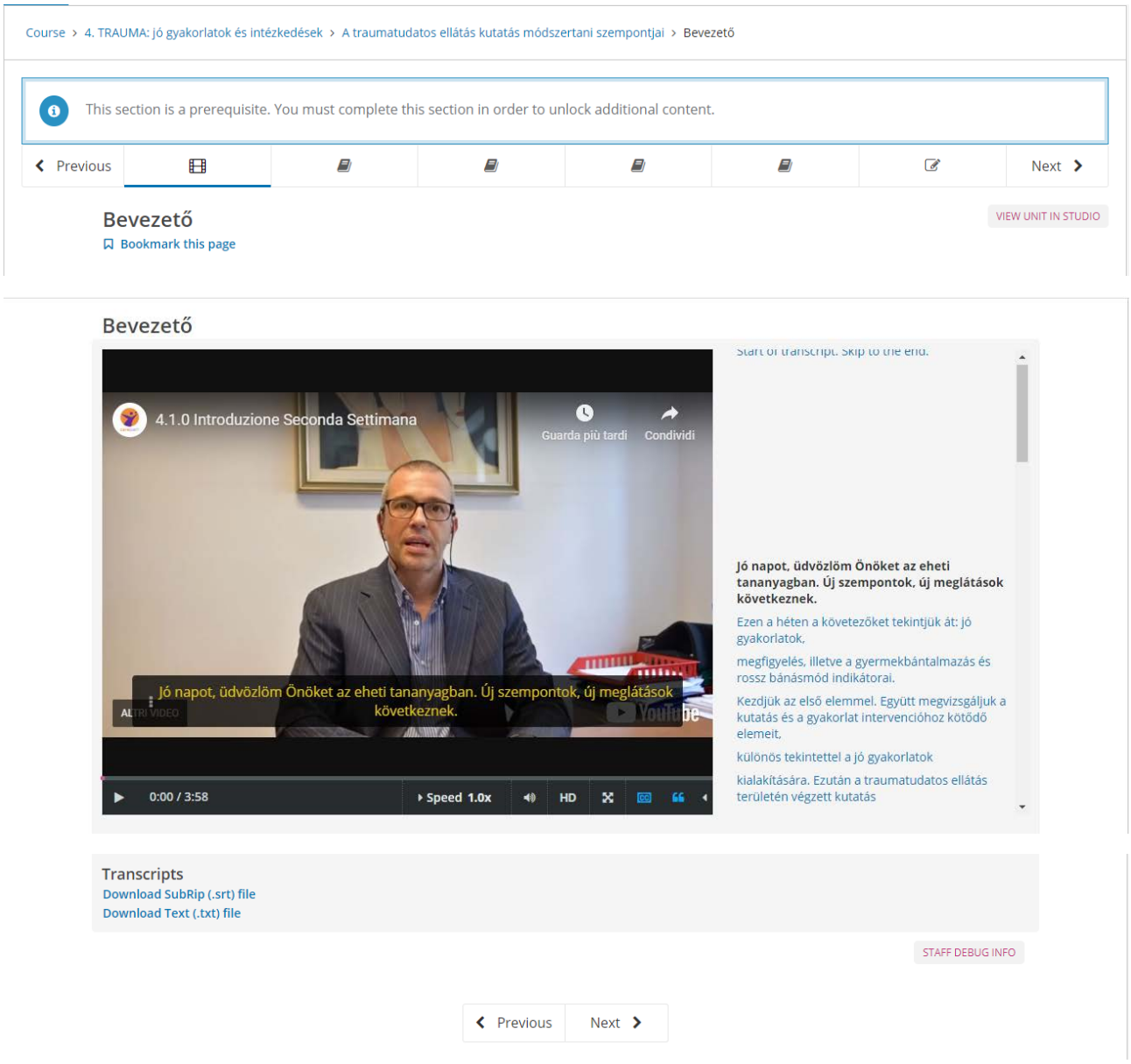

Transcript

Jó napot, üdvözlöm Önöket az eheti tananyagban. Új szempontok, új meglátások következnek.

Ezen a héten a követezőket tekintjük át: jó gyakorlatok,

megfigyelés, illetve a gyermekbántalmazás és rossz bánásmód indikátorai.

Kezdjük az első elemmel. Együtt megvizsgáljuk a kutatás és a gyakorlat intervencióhoz kötődő elemeit,

különös tekintettel a jó gyakorlatok

kialakítására. Ezután a traumatudatos ellátás területén végzett kutatás

metodológiai aspektusait vizsgáljuk meg, amit már megtanultunk

megérteni és felismerni, illetve még jobban kifejtjük, hogy mindezek hogyan

alkalmazhatóak a kutatástervezésre, hogy hogyan használjuk a

traumatudatos ellátás formátumát a kutatásban. Végül megnézzük az elmélet és a gyakorlat közötti kapcsolatot.

Ezután megpróbáljuk meghatározni, hogy mitől

lesz jó egy kutatási pályázat, azáltal, hogy megvizsgáljuk, mik egy jó módszer, mint pl. a megfigyelés jellemzői.

A megfigyelés klinikai eszköz. A megfigyelés lehetővé teszi az olyan szakember számára,

aki a traumatudatos ellátás szemléletével dolgozik, tervez dolgozni vagy hajlandó azt mélyebben megismerni,

hogy a megfigyelést módszerként használja, és megértse az embert, akivel az

adott kontextusban dolga van

(tartsuk szem előtt a traumatudatos ellátás jelentését).

Itt pedig szemügyre vesszük a klinikai megfigyelés követelményeit és lehetséges alkalmazási területeit, egyebek mellett.

Ezután korábban tárgyalt fogalmak, úgymint

a jó gyakorlatok és a megfigyelés példáival és meghatározásával folytatjuk,

és megnézzük, mindezt hogyan lehet a gyermekbántalmazás és rossz bánásmód esetén alkalmazni. Továbbá megpróbáljuk

azonosítani ezeknek az indikátorait, szem előtt tartva, hogy az indikátor nem több, mint indikátor, és nem a bántalmazás

és rossz bánásmód alapvető és biztos jele/eleme. Ugyanakkor

az indikátorok jelenléte érdekes lehet számunkra, mert olyasmit jelölhetnek, amit érdemes közelebbről megvizsgálni.

Ezután következnek a trauma felméréséhez kapcsolódó

szűrési módszerek, és kollégáimmal együtt megpróbáljuk megérteni, hogy a tudás szempontjából milyen fontos

az esetleges trauma kiszűrése, észrevétele.

A hetet a traumatudatos ellátás és annak a kutatással való kapcsolata vizsgálatával zárjuk, illetve annak feltárásával, miként lehet

létrehozni egy olyan szisztematikus rendszert különböző folyamatokból, ami az elmélettől a gyakorlat felé vezet.

Az első részben, az első két hétben kollégáimmal együtt megvizsgáltuk a traumának talán a leginkább elméleti

aspektusát, az elmúlt két hétben

megnéztük a bizonyítékokon alapuló kutatást és az akciókutatást a traumatudatos ellátás területén,

mostantól pedig továbbra is a traumára és a

traumatudatos ellátásra fókuszálunk, ám egy kissé más nézőpontból.

Ez pedig a jogi szabályozás kérdése. Tehát megvizsgáljuk a terület jogi, kutatási és szakpolitikai aspektusait.

Saját és kollégáim nevében kívánok

további jó tanulást Önöknek; már több, mint a felét átvettük a tananyagnak,

és hamarosan az online kurzus végéhez érünk.

További minden jót kívánok, és újra találkozunk majd a kurzus végén.

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Bevezetés a traumatudatos ellátás kutatási módszertanának szempontjaiba

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Newman és Ridenour (1998) kiemelik, hogy a kutatók nagyban eltérő módszerekkel végeznek tanulmányokat és vonnak le belőlük következtetéseket, amelyeket jelentősen befolyásol a valósághoz való hozzáállásuk. Ezen túl, míg az ismeretelmélet (episztemológia) a dolgok megismerésének lehetséges változataival foglalkozik, addig a módszer azknak az eljárásmódoknak a kiválasztására fókuszál, amiken keresztül jobban megismerhetünk egy adott jelenséget (Bernard, 2006).

Ahogyan Lastrucci (1963) megfogalmazta, a tudomány "objektív, logikus és szisztematikus eszköz a jelenségek elemzésére, célja a megbízható tudás felhalmozása" (6. oldal). Mindez három célkitűzés mentén valósul meg, amik a kutatói munka során meghozott döntéseket irányítják (Bernard, 2006):

- Objektivitás: explicit mérések végzése, módszertan figyelembevétele, hivatkozás a tudományos közösségen belüli kollegiális lektorálásra
- Tudományos módszerek
- Megbízhatóság

Az etikai dimenzió a tudományos módszer egy része. A humántudományok kutatására hivatkozva felmerül a központi kérdés, miszerint miként lehet a természetüknél fogva összetett jelenségeket működőképessé tenni. Ez a fajta folyamat a változók meghatározásán, a közöttük levő asszociációk és kapcsolatok keresésén, valamint annak megkísérlésén alapul, hogy valamely dolog variációja okoz-e variációt egy másikban (Bernard, 2006). A fenti szempontokkal összefügg, hogy a kutatások egyik alapelve az érvényes és megbízható mutatók felmérése és beazonosítása, valamint a szoros kapcsolódás az operatív meghatározások strukturálásához. Ezek a meghatározások "utasításokból állnak, amelyek a fogalmilag meghatározott változó mérésére szolgálnak" (38. o.).

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A traumatudatos ellátás kutatása

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A traumatudatos ellátás esetében kimondottan fontos a tudományosan bizonyított eljárások és elméletek használata. Ebből a szempontból elengedhetetlen a klinikai munka és a kutatások közötti szinergikus kölcsönhatás elősegítése. Mindez azért fontos, hogy a kezelések eredményeit tanulmányozni lehessen a szolgáltatások működő modelljeinek hatékonyságának és eredményességének értékelésével együtt, konkrét iránymutatásokon keresztül szabályozva a fenti szempontokat és/

vagy annak figyelembevételével, hogy a speciális protokoll milyen mértékben ragaszkodik a területen végzett nemzetközi kutatás bevett elemeihez (Schäfer et al., 2018).

Ebből a szempontból kiemelten fontos az olyan tudományos kutatásokban való részvétel, amelyeknek célja a traumatudatos ellátás meghatározásainak és alapvető tényezőinek elemzése.

E tekintetben Becker-Blease (2017), Hanson & Lang (2016) és Johnson (2017) számos kritikus szempontot emelnek ki a traumatudatos ellátással és annak alkalmazási problémáival kapcsolatban. Ide érthetjük például a tudományos irodalomban az elméleti szempontokról alkotott, kizárólag a jelenre irányuló fókusz meglétét, valamint azkat az alapelveket, amelyek szerint a figyelmet negatívan befolyásolják az alávető elemek és a gyakorlati alkalmazásuk: „szakadék van a gyakorló szakemberek munkájában az elméleti alapelvek és a mindennapi gyakorlat között, és abban, ahogy a saját eredményességüket felmérik" (Becker-Blease, 2017, 3. o.). A kutatási fókusz ezért igazán hasznos a traumatudatosság módszerét alkalmazó kezdeményezések, programok és szolgáltatások értékeléséhez, valamint annak megállapításához, hogy vajon mindez összefüggésbe hozható-e a jelentős számú pozitív eredménnyel.

Annak érdekében, hogy a fogalmi, elméleti és a használati szempontok között hasznos és működőképes váltást lehessen végrehajtani, nagy figyelmet kellene fordítani a szabványosított eljárások és mutatók alkalmazásának vizsgálatára, mind a folyamat elemei, mind a kapott eredmények szempontjából. A témával kapcsolatos tudományos irodalom arra készteti a szervezeteket és az intézményeket, hogy fontolják meg a különösen releváns kutatási projektek alapvető és alkalmazható strukturálását, amelyeknek célja a szűrési eljárások (bizonyítékokon alapuló szűrés) kezelése, valamint a traumatikus események és azok jellemzőinek beazonosítását célzó értékelési eljárások elemzése. Ezen túlmenően fontos, hogy a véletlenszerű, ellenőrzött tanulmányokat kísérleti alapon hajtsák végre, hogy tesztelhessék a trauma-orientált beavatkozások hatékonyságát.

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A jó kutatási pályázatok alapelemei

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A szociális és az egészségügy területén különböző lehetőségek vannak(Leone & Prezza, 1999) egy projekt felépítésére: a) szinoptikus-racionális (a tartalom lényegénekelőzetes felépítése), b) összehangolt-részvétel vagy párbeszédes tervezés (a szakértők és a résztvevőkfolyamatosan egyeztetnek a célkitűzésekről); c) heurisztikus (a célkitűzések minimális előzetes strukturálása).

Legtöbbször a következő lépéseket kell követni egy kutatási folyamat során:

1. Először meg kell fogalmazni egy elméleti problémát (ami a tudományos elmélet és az irodalom elemzéséből származik);
2. Meg kell határozni a megfelelő elemzési egységeket és a metodológiát;
3. Adatgyűjtés és elemzés;
4. A kutatást elindító javaslatot vagy megcáfolják, vagy elfogadják.

Ahogyan azt Lanzara (1985) is írja: „Mindenki, aki az innováció problémájával találkozik, vagy egyszerűencsak változtatni szeretne rajta, a tervezés problémájával szembesül" (336 o.). A tervezés a rendszerezés folyamata. A kutatási projekt felépítése kritikus, mégis elengedhetetlen szakasz. Fontos döntéseket kell ilyenkor meghozni, amik befolyásolhatják a kutatás végkimenetelét. Leone és Prezza (1999) is hangsúlyozza, hogy: „Egy projekt kiemelése a különféle témák közül, valamint az összefüggések megtalálása a különböző részek (célok, idő, rendelkezésre álló személyek...) között azt jelenti, hogy problémának minősítjük a gyakorlatot, valamint szembe kell nézni a korlátokkal, elfogultsággal. És pontosan ez az a probléma, amelyet bizonyos összefüggésekben hajlamosak vagyunk figyelmen kívül hagyni"(23. o.), vagy alkalmazhatósági szempontból túl bonyolultnak ítélni.

Transzverzális szempontból, a szerzők részletezik egy társadalomtudományi projekt felépítésének alapvető szakaszait:

1. Ötletelés: a projekt kivitelezése vagy tervezése.
2. Aktiválás: erőforrások, szerepek, problémák és stratégiák felülvizsgálata, igények (kliensek) lehetséges elemzése.
3. Tervezés: a projekt kidolgozása, a projekt szakaszainak megállapítása, az idő és a módszertan meghatározása.
4. Kivitelezés: a kutatás megkezdése, a hipotézisek első ellenőrzése, folyamatban lévő változások követése.
5. Ellenőrzés: az eredmények végső elemzése.

Ezenkívül a tudományos kutatás területén, az alkalmazás szempontjából további fontos elemek a következők

- A kutatás tárgyának meghatározása és tudományos irodalmi elemzése, az elméleti váz magyarázata,
- A tanulmány általános és konkrét céljainak meghatározása és magyarázata (a kutatás kérdése feltáró, értékelő vagy magyarázó),
- Hipotézisek felépítése,
- A célcsoport beazonosítása, részvevők toborzása és mintavétel,
- Értékelési eljárások, a mutatók, az összegyűjtött adatok elemzésére szolgáló eszközök és technikák meghatározása,
- Időtervezés (ütemterv) és megvalósíthatósági elemzés (a kritikákat és a korlátozásokat is beleértve).

Mindezek során – a kutatási kérdéstől függően – kvantitatív, kvalitatív vagy kevert mátrixú módszertani alkalmazást lehet használni.

A tervezési folyamat minden szakaszában a kutató fontos kérdéseket tesz fel, amelyek fogalmi és gyakorlati szempontból is figyelembe veszik a kritikus elemeket. A kutatás körülményei és a források is ide sorolhatók.

A fentiek összetettsége miatt alapvető, hogy ebből a szempontból is figyelmet fordítsunk a munkatársak képzésére, valamint a klinikai munkában részt vevő szakemberek és a kutatásban részt vevő kutatók közötti kapcsolattartásra.

Központi fontosságú azoknak az eszközöknek a strukturálása és érvényesítése, amik mind a beavatkozási, mind a kutatási célkitűzéstől kezdve felhasználhatóak. Ezeknek különböző formái lehetnek, és sajátos célokra alkalmazhatóak. Ezért alapvető, hogy a projekt megtervezésében és végrehajtásában részt vevő összes szereplő szinergikusan alakítsa ki a projektterv minden egyes szakaszát, beleértve a módszertani döntéseket is.

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Teszt 4.1

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Q4.1

3 points possible (graded)

1. Az operatív meghatározás:

- A változó fogalmi meghatározása előtt kerül megállapításra
- A változó fogalmi meghatározása után kerül megállapítása
- Nem lehet használni a változó mérésére
- A változó mérése során dolgozzák ki

2. A traumatudatos ellátás területén fontos:

- A beavatkozási módszertan előírása az irányítók részére
- A tudományos kutatások hozzájárulásának figyelmen kívül hagyása
- Kritikus szempontok és alkalmazási nehézségek figyelmen kívül hagyása
- A klinikai munka és a kutatás közötti szinergikus interakció előmozdítása

3. A tervezési folyamat minden egyes szakaszában:

- A kutatónak fel kell tenni magának olyan fontos kérdéseket, amelyek fogalmi és gyakorlati szempontból is figyelembe veszik a kritikus elemeket
- A kutatónak nem kell feltennie magának olyan fontos kérdéseket, amelyek fogalmi és gyakorlati szempontból is figyelembe veszik a kritikus elemeket
- Az adatokat mindig elemezni kell
- Az időzítést tervezni kell

Invia You have used 0 of 2 attempts

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Jó gyakorlatok a trauma tudatos ellátásban

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Mivel a traumatikus események (ártalmas gyermekkori élmények) nagy mértékben veszélyeztethetik a fizikai és pszichés egészséget, az évek során számos intervenció született a traumatikus hátterű embereknek segítséget nyújtó intézmények és szakemberek támogatására, illetve, hogy ezzel a traumatudatos szemlélet alkalmazásának előnyei előtérbe kerüljenek (Baker et al., 2016). Kiemelendő az, hogy „a traumatudatos szemlélet holisztikusan szemléli az embert, nem csak az általa tapasztalt problémák halmazának" (Hepburn, 2017, p. 7) látja. Ahogy azt számos szerző megfogalmazta (Bryson et al., 2017; Bridgett, Valentino & Hayden, 2012; Ellis & Boyce, 2011; Perry, 2002; Rothbart, Ziaie, O'Boyle, 1992), a jó ellátás, valamint a figyelmes és proaktív ellátó szakemberek által létrehozott támogató kapcsolatok védő hatással (pufferhatással) bírnak: a kapcsolati biztonság csökkenti a trauma hatásait a gyermekeknél. A traumatikus stressz gyakori velejárója az ártalmas gyermekkori élményeknek, és sok esetben okoz olyan komoly klinikai problémákat (internalizáció és/vagy tünetek externalizációja), amik rendszeresen megtalálhatóak mind a felnőtteket, mind a gyermekeket ellátó kórházakban és bentlakásos intézményekben (Bryson et al., 2017; Greenwald et al, 2012; Hummer, Dollard & Robst, 2010; Ko et al., 2008). Elliott és társai (2005) szerint: „a traumatudatos ellátás olyan ellátás, amely tisztában van az interperszonális erőszak és a viktimizáció az ember életére és fejlődésére tett hatásával", illetve: „az ellátási környezetben megtalálható számos elterjedt eljárás és gyakorlat újraaktiválja a traumatikus reakciókat, illetve a biztonság hiánya és a gyengeség érzéseit váltja ki a traumatúlélőkből" (p. 446).

Tovább kell hangsúlyoznunk, hogy a jó gyakorlatokat a szakirodalomban meghatározott, és a traumatikus történeteket alkotó komplex tényezők elemzését magukban foglaló konkrét kritériumok alapján kell értékelni. Ha a szolgálat vagy szervezet traumát elszenvedett emberekkel dolgozik, kockázatcsökkentésen és -megelőzésen alapuló szemlélet javasolt a közegészségügyben és szociális ellátási rendszerben. Ezen a területen a traumatudatos szemlélet központi fontosságú: a traumatudatos ellátás és gyakorlat a javasolt paradigma, mivel ezek célja teljes ellátási rendszerek átalakítása a traumára adott stresszválasz figyelembevételének beépítése által, melyet a szolgáltatási rendszer minden szintjébe és részébe be kell építeni, a biztonságos környezet és a választás lehetőségének előtérbe helyezésével párhuzamosan. Ez a megközelítés továbbá egy erőszakellenességen, tanuláson és együttműködésen alapuló kezelési kultúrát is kíván létrehozni, amelyben egyformán hangsúlyos minden környezeti és interperszonális interakció (Bryson et al., 2017). A szakirodalom szisztematikus áttekintése során Bryson és kollégái (2017) fontos konklúziókat találtak:

· A „fizikai kényszerítés csökkentése az általános és bentlakásos pszichiátriai ellátásban" (11. o.)

hangsúlyos; az elzárási, kontrolláló és kényszerítési stratégiák csökkentésének/elhagyásának fontossága;

· A traumatudatos ellátás egyik legjelentősebb aspektusa az, hogy „alapvető fontosságú, hogy a vezetők előnyben részesítsék a traumatudatos ellátást [...], főként, ha a munkatársaknak új munkamódokat kell elsajátítaniuk" (11. o.);
· a kutatók nagyban hangsúlyozzák annak fontosságát, hogy a munkatársak haladó képzésekben részesüljenek (főleg a traumára adott reakciók tekintetében), illetve a folyamatos szupervíziót, coachingot és beszámolókat;
· elengedhetetlen, hogy meghallgassuk a pácienseket és családjukat, különös figyelmet fordítva a kezelési folyamattal kapcsolatos élményeikre, szükségleteikre, prioritásaikra;
· a kutatási adatok folyamatos frissítésének és az eredményindikátorok elemzésének fontossága, melyek olyan transzverzális tengelyek, amelyek célja a szolgáltatásnyújtás motiválása, kutatási alapokra helyezése, és hatékonyságának növelése;
· a szakirodalom rengeteget foglalkozik „annak szükségességével, hogy a formális és informális szabályok és gyakorlat összhangba kerüljenek a traumatudatos gyakorlat általános alapelveivel" (11. o.).

Annak ellenére, hogy egyre szélesebb körben alkalmazzák, még mindig kevés a traumatudatos szemlélet hatékonyságát vizsgáló tudományos kutatás (Bryson et al., 2017); ahogy azt Valenkamp, Delaney & Verheij (2014), valamint Chandler (2008) kiemelik, kevés az olyan ellenőrzött, randomizált vizsgálat, amely az intervenciókat teszteli, és a traumatudatos személeten alapuló kezeléseket meghatározó legfontosabb tényezőket vizsgálja. Ám ahogy az jelenleg nemzetközi szinten előtérbe kerül, empirikus kutatások bizonyítják a szakemberek részvételének fontosságát olyan képzésekben, amelyek a páciensek élményeit leíró egységes nyelvezettel, valamint a traumatizált pácienseknél alkalmazható konkrét intervenciós lehetőségekkel látják el őket (Bryson et al., 2017). Ennek a központi fontosságát korábban Le Bel, Huckshorn & Caldwell (2008), valamint Brown, Baker & Wilcox (2012) is hangsúlyozták. Ezen kívül a jó gyakorlatokat bemutató képzések, és páciensek részvétele a képzésekben (pl. beszámolók az élményeikről) is hasznosnak bizonyult (Holstead, Lamond, Dalton, Horne & Crick, 2010), ahogy a gyermekek bevonása az ellátásnyújtás kritikus tényezőinek vagy szakaszainak beszámolóiba (Lebel et al., 2008), az adatmegosztás, valamint a teljesítmény/folyamatok folyamatos ellenőrzése is (egyéni, kollektív és osztály-szinteken egyaránt) (Bryson et al., 2017).

A szakirodalom egy másik újonnan fókuszba kerülő témája a hatékony traumatudatos stratégiák területén a szervezetek képessége arra, hogy szabályzataikat és gyakorlataikat összehangolják a tájékozott traumaellátással (Bryson et al., 2017). E szerint a szemlélet szerint a szervezetek belső környezete és kultúrája önmagukban is terápiás eszközként funkcionálnak, és hozzájárulnak a „terápiás közösség" felépítéséhez. Különösen relevánsak:
1) a biztonságos kezelési tér létrehozásának fontossága mind a páciensek, mind a munkatársak számára, valamint 2) a traumatudatos ellátás alapelveinek belefoglalása a szervezet küldetési és jövőkép-nyilatkozatába. Összefoglalva, a Bryson és kollégái (2017) által kiemelt fő traumatudatos ellátási stratégiák összhangban vannak a NASMHPD (National Association of State Mental Health Program Directors - Állami Mentális Egészségügyi Programigazgatók Nemzeti Szövetsége) alapelveivel; mindkettő megtalálható az alábbi 1. táblázatban.

Bryson és kollégái (2017)
Közösségi befogadás
Vezetőség elköteleződése
Modell kiválasztása
Munkaerő átalakítása
Eredmény-orientáltság
Közös fenntartás

NASMHPD
Vezetés a szervezeti változás felé
Információ-alapú gyakorlat
Korlátozás és elzárás alkalmazását csökkentő eszközök használata
Munkaerő fejlesztése
A felhasználó szerepének fejlesztése a bentlakásos környezetekben
Alapos beszámolási technikák

1. táblázat - A traumatudatos ellátás alapstratégiái

Ezen kívül egy Azeem és kollégái (2011) által elvégzett kutatásban ezeket a stratégiai fontosságú elemeket hosszú távon is tesztelték, a korlátozás és elzárás alkalmazásának csökkentését elemezendő. A szerzők főként a következőket emelték ki:

- a vezetésnek kulcsszerepe van a kulturális átalakulás megvalósításában, főleg, ha a traumatudatos szemléleten az összes munkatárs osztozik;
- az adatgyűjtésnek és -megosztásnak „kulcsszerepe van a teljesítmény javítását célzó projektekben" (12. o.) és az ellenőrzési folyamatokban;
- a munkatársak képzése és folyamatos oktatása a felépülés-orientált ellátás, a kliensközpontú ellátás és a traumatudatos ellátás területein jelentős pozitív hatással bírt a kapcsolódó teljesítményértékelések szerint;
- fontos fókuszpontnak kellene lenniük az elsődleges megelőzés alapelveinek, a traumatikus hátteret, valamint a páciens, annak családja és a munkatársak stratégiáit magába foglaló egyéni kezelési tervek alkalmazása által;
- a traumatudatos ellátás gyakorlatának egy jó alapelve a páciens és a család bevonása;
- beszámolótevékenységek támogatása, különös tekintettel az érzelmi aspektusokra és a kezelési terv szükséges változtatásaira: úgymint - a megfelelő alkalmazás mellett - a traumatizációt és annak hatásait csökkentő intervenciókra.

A traumatudatos ellátás különböző megközelítéseit vizsgálva Hanson és Lang (2016) illetve Johnson (2017) azonosított néhány fontosnak tekinthető, vizsgálandó kérdést a gyermekeknek nyújtott szolgáltatások megközelítése terén, és konklúzióként a traumatudatos ellátás 15 alapvető összetevőjét határozták meg:

Az azonosított összetevőket három szintbe/kategóriába sorolták be (Hanson & Lang, 2016, 98. o.):

1. Munkaerő fejlesztése:

- A munkatársak kötelező képzése a bántalmazás és trauma hatásainak területén;
    - A munkatársak kompetenciáinak meghatározott kritériumok szerinti mérése, a traumához kapcsolódó tudás / megfelelő gyakorlat ellenőrzése;
    - Stratégiák / eljárások a munkatársak másodlagos traumából eredő stresszének kezelésére / csökkentésére;
    - Tudás/készségek annak terén, hogy hogyan érhetőek el és alkalmazhatóak a traumához kapcsolódó, bizonyíték alapú jó gyakorlatok;

2. Traumaorientált szolgáltatások:

- Szabványosított szűrési eljárások / bizonyítékokon alapuló felmérési folyamatok alkalmazása a traumatikus előélet, valamint a traumához kapcsolódó tünetek és problémák azonosítása érdekében;

- A gyermek traumatikus előéletének belefoglalása a dokumentációkba / aktákba / ellátási tervbe;

- Traumafókuszú, bizonyítékokon alapuló gyakorlatokban képzett és megfelelő végzettséggel rendelkező klinikus szakemberek elérhetősége;

3. Szervezeti kivitelezés

- Együttműködés, a szolgáltatások koordinációja, és információmegosztás a szervezet szakemberei között, a traumatudatos ellátással kapcsolatosan;
- Együttműködés, a szolgáltatások koordinációja, és információmegosztás a különböző szervezetek szakemberei között, a traumatudatos ellátással kapcsolatosan;

- A kliensek újratraumatizációjának kockázatát csökkentő eljárások;

- A kliensek bevonását, a szolgáltatások tervezésében és a traumatudatos rendszer kialakításában való részvételét célzó eljárások;

- Az erősségekre fókuszáló, a pozitív fejlődést elősegítő szolgáltatások nyújtása;

- Pozitív és biztonságos fizikai környezet biztosítása;

- Olyan írott szabályzatok, melyek kifejezetten tartalmazzák és támogatják a traumatudatos alapelveket;

- Egy olyan fontos vezetői szerepkör/pozíció, amely kifejezetten a taumatudos ellátáshoz kapcsolódik.

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A bevált gyakorlatok alapvető elemei

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A traumatudatos ellátás gyakorlatainak értékeléséhez az irodalom és a különböző protokollok elemzéséből arra lehet következtetni, hogy a bevált gyakorlatok (amik különböző kontextusokba potenciálisan áthelyezhetők) magukba foglalják a következőket:

1) Az alkalmazottak állandó képzése a traumákról és azok kölcsönhatásairól. Ezt a képzést nemcsak azoknak a szakembereknek kell biztosítani, akik közvetlenül klinikai szinten dolgoznak a felhasználókkal, hanem azoknak is, akik a szervezetben különböző pozíciókban különféle feladatokat látnak el;

2) a belső személyzet naprakészen tartása a bizonyítékokon alapuló gyakorlatokról a trauma kezelésében, valamint figyelmet kell fordítani a szakemberek véleményére a bizonyítékokon alapuló gyakorlatokról;

3) együttműködés a terület szakértőivel, hogy növelhessék a képzett klinikai szolgáltatók rendelkezésre állását;

4) a szabványosított és a bizonyítékokon alapuló szűrési eljárások beépítése a klinikai gyakorlatba, valamint speciális és érvényesített értékelési intézkedések/eszközök használata a traumatikus események azonosítására;

5) figyelmet kell fordítani a felhasználók személyes múltjára, és hogy annak milyen összefüggései lehetnek a traumához köthető tünetekkel és nehézségekkel;

6) az előző ponttal összhangban, a munkatársak aktív, empatikus ésfigyelmes meghallgatása szükséges a felhasználók egyéni múltjának megismeréséhez;

7) a gyermekkori trauma történeteinek beépítése és körültekintő megosztása a beavatkozás tervezése vagy az esetek megfogalmazása során;

8) a munkatársak készségeinek alapos értékelése és folyamatos megfigyelése (kifejezetten erre a célra kialakított eljárások használata);

9) a megfelelő traumatudatos ellátási szolgáltatásra vonatkozó előírások fenntartásának alapos megfigyelése, hogy ki lehessen javítani az esetlegesen felmerülő hiányosságokat;

10) eljárások kivitelezése a másodlagos trauma okozta stressz csökkentése és a munkatársak jólétének növelése érdekében;

11) megfelelő együttműködési hálózat kiépítése és fenntartása a szolgáltatókon belül és a területen működő más ügynökségekkel is;

12) odafigyelés a kommunikációs dimenzió központi elemére: a legmagasabb szintű célkitűzések elérése, valamint a megosztott és közösen kialakított eljárások használatának érdekében szükség van az odafigyelő és együttműködő munkatársak alkalmazására;

13) olyan eljárások alkalmazása, amelyek csökkentik a felhasználók újbóli traumatizálásának kockázatát;

14) a páciensek ösztönzése, hogy részt vegyenek a kezelési terv kidolgozásában;

15) a felhasználók bevonása a szolgáltatás tervezésébe: figyelemmel kell kísérni a visszajelzéseiket és javaslataikat a szervezet és a kínált szolgáltatások javítása érdekében;

16) kiemelt figyelmet kell fordítani az erősségeken alapuló szolgáltatások nyújtására, amelyek célja a pozitív fejlődés tényezőinek (például ellenálló képesség, felhatalmazás) előmozdítása;

17) stratégiai képzések, amelyek célja a pozitív környezet kialakítása a felhasználók és a munkatársak részére;

18) különös figyelmet kell fordítani a szolgáltatás fizikai és szerkezeti dimenzióira;

19) a traumatudatos ellátás alapelveinek betartása és előmozdítása konkrét és világos irányelvekkel;

20) a vezetés dimenziójának és funkcióinak központi szerepet kell betölteni a szolgáltatás szervezésében.

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Kritikai elemek és kihívások

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Annak ellenére, hogy bizonyítékokon alapuló gyakorlatok kiemelt téma a bevált gyakorlatok alkalmazásának szorgalmazásában, egyes szakértőkben, szervezetekben és kutatókban még mindig ellenállást váltanak ki (Gray, Elhai, Schmidt, 2007). Mindezt a traumás esetek klinikai kezelését végző szervezeteknek kell elemezni, megvitatni és figyelemmel kísérni, amelyek , azért, hogy a szabványokat kooperatívan meg tudják határozni.

Bár a traumatudatos megközelítés jelenleg fontos szerepet játszik a traumatizált személyek ellátásában és aszolgáltatások kialakításában, még mindig vannak problémák azokhasználatában és – mindenekelőtt – a megfogalmazásában (Baker, 2016). Különös hiányosságok vannak e tekintetben:

- az egyértelmű működés meghatározásában,
- pszichometrikus eszközök jelenlétében a traumatudatos ellátás dimenzióinak értékeléséhez.

Ennek a hiányosságnak akitöltésére például Baker és munkatársai (2016) egy olyan eszközt készítettek és validáltak- traumatudatos ellátáshoz való hozzáállás (ARTIC) skála -, amivel felmérhető az olyan munkatársak állásfoglalása a traumatudatos ellátásról, akik különböző területeken dolgoznak, vagy traumatikus kórtörténettel rendelkezőket kezelnek. Egy korábbi publikációjukban, melynek címe Creating cultures of trauma-informed care (CCTIC): a self-assessment and planning protocol (A traumatudatos ellátás kultúrájának létrehozása: önfelmérési és tervezési protokoll), Fallot és Harris (2009) önértékelési és tervezési protokollt hoztak létre. Ezek hat olyan területetölelnek fel, amelyek szolgáltatási, adminisztrációs vagy rendszerszintű változtatásokatjelentenek. A traumatudatos ellátás alkalmazásának összetettségére való figyelem egyre inkább kihívást jelentő célkitűzéssé válik mind az egyes üzemeltetők, mind a szociális és egészségügyi szolgáltatások szempontjából, nemcsak a mindennapi interakcióikban, de a referenciaként szolgáló tudományos közösséggel fenntartott kapcsolataikban is.

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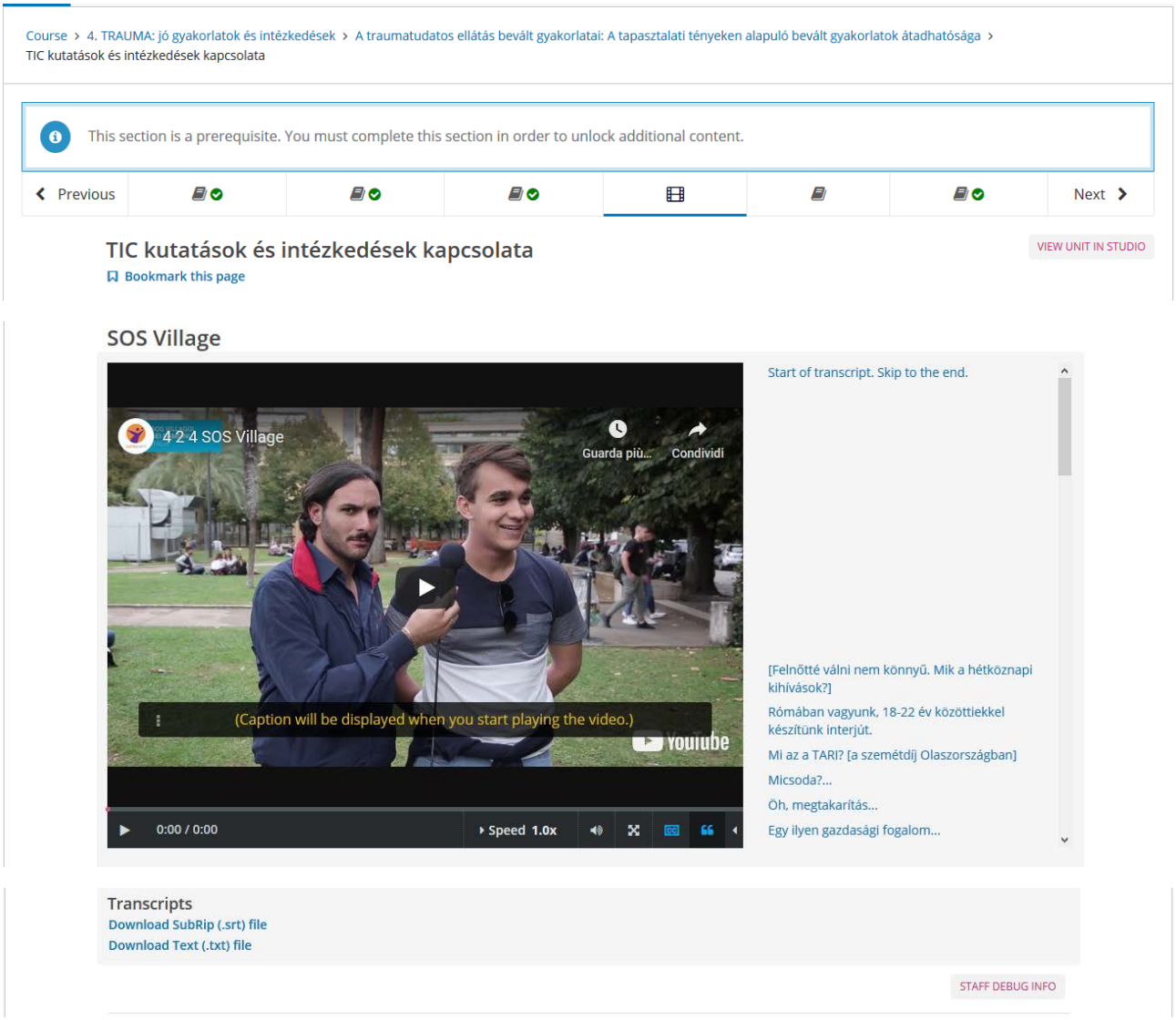

Transcript

[Felnőtté válni nem könnyű. Mik a hétköznapi kihívások?]

Rómában vagyunk, 18-22 év közöttiekkel készítünk interjút.

Mi az a TARI? [a szemétdíj Olaszországban]

Micsoda?...

Öh, megtakarítás...

Egy ilyen gazdasági fogalom...

A TARI egy ilyen politikai valami...

Igen, igen.

Mi az TARI?

A TARI? Az egy adó?

Ha házat keresel, hogy fogsz neki?

Mit csinálsz, mihez kezdesz?

Tömegközlekedéssel...

Giulia megtalálta.

Egy ingatlanirodával.

Otthon élek, anyukámmal,

oda mindig visszamehetek.

Milyen szerződést írsz alá?

Hát, fizetek, ki kell fizetnem...

Szerződés, oké, határozatlan idejű,

hosszú távú...

Most kezdtem el jogot tanulni...

Csak most kezdtem!

A négyest csinálod? [4+4, elterjedt ingatlanszerződés]

4 hónap?

Plusz 5

Az albérleti díj kidobott pénz.

A víz és az áram ugye benne van az árban?

4?

A bankszámla...

Ennél egy latin vizsga is könnyebb!

Ön, nemtom.

Ahova berakod a pénzt...

Inkább beszélgessünk Senecáról.

Ha valami gondod van, kit hívsz fel?

Giuliát.

Apát.

Senecát, aki halott... anyát

vagy apát.

Vannak nehéz kérdések, és vannak olyan fiatalok,

akik 18 évesen egyedül állnak szembe velük.

Ellátásból kilépők

Nem tudom, mi az.

Ilyen... egészségügyi dolog?

Kik azok?

Liverpool játékosok.

Nem tudom, sosem hallottam róluk.

Nem értem a kérdést.

Egyházi személyek?

Olyan fiatalok, akik nevelőotthonban élnek,

és amikor betöltik a 18-at, el kell onnan költözniük, és önálló lakhatást találni maguknak.

Remek!

[A jövő napról napra épül]

Mit mondhatnánk ezeknek a fiataloknak?!

Hát... A legjobbat kívánjuk, mégis mondhatnánk nekik?!

A TRAUMATUDATOS ELLÁTÁS KUTATÁSA ÉS ANNAK SZAKPOLITIKAI VONATKOZÁSAI

A szolgáltatások strukturálása céljából készített modellként a traumatudatos ellátást igen sokféle kontextusban alkalmazzák. Bowen és Murshid (2016) hangsúlyozzák, miként lehet ennek a paradigmának az alapvetéseit (biztonság, megbízhatóság és átláthatóság, együttműködés, megerősítés, választás és interszekcionalitás) a szociálpolitika területén egyaránt alkalmazni.. A szerzők felvetése szerint mivel a traumatudatos ellátás a mentális egészségügyi szakembereknek (főként a közszférában dolgozóknak) egyfajta egyenlőtlen felszámolását célzó utat kínál a klinikai-szervezeti cselekvésen keresztüli, így az etikai és deontológiai rétegei által tágabb, politikai vonatkozással is rendelkezik. Reeves (2015) már korábban kiemelte, hogy a traumatudatosság-orientált ellátási modellek széles körű alkalmazása miként helyezi a beavatkozás középpontjába a rehabilitációs szolgáltatásokat vezető személyek egyedi és különleges szükségleteire való válaszadást, csökkentve ennek a sérülékeny csoportnak a korábban elszenvedett egyenlőtlenségeket.

Nemrég Levy-Carrick és munkatársai (2019) hangsúlyozták az állami egészségügyi szolgáltatást nyújtó szervezetekben - a trauma kontextusában - az egyenlőtlen ellátást, amelyet a traumatudatos ellátás megvalósítása, ha nem is teljesen, de nagy részben orvosolhat. A szerzők központi fontosságúnak tartják, hogy ennek a paradigmának a hatékony alkalmazását az garantálná, ha az ellátást közvetlenül nyújtó személyeket a tevékenységek tervezésébe és megvalósításába minden lépésnél teljeskörűen bevonnák. „Caring for the vulnerable: Perspectives in nursing theory, practice, and research" c. könyvükben De Chesnay és Anderson (2019) szintén kiemelik, hogy a mentális egészségügynek van politikai és részvételi vonatkozása is (főként a felhasználók részéről). Ezzel összhangban, az Egészségügyi Világszervezet (WHO) azt szorgalmazza, hogy a szakpolitikák olyan, kölcsönös együttműködésen alapuló terek létrehozását tegyék lehetővé, amelyekben a szakemberek és a mentális egészségügyi szolgáltatásokat igénybe vevő személyek jogait védő csoportok (érdekérvényesítési csoportok), illetve az érdekelt felek széles köre együtt tehetnek lépéseket a szinergia felé, kölcsönös tekintettel egymás szükségleteire.

Fontos politikailag hozzájárulni a döntéshez – ahogy ez néhol meg is valósul - , a tapasztalati tényeken alapuló gyakorlatokat elemző és előmozdító tanulmányok finanszírozásával, a közös szabványok létrehozásával és elterjesztésével az ellátási modellek nyújtásában részt vevő szervezetek és intézmények szervezeti arányának és közösségi célkitűzéseinek meghatározása érdekében (Ko et al., 2008; Bateman & Anderson, 2013; Levy-Carrick et al., 2019).

Az eddig leírtak vonatkoznak általánosságban az egészségügyi szakpolitikákra, de a konkrét területi igényeket megválaszoló helyi kontextusokra is, illetve, még ennél is konkrétabb szinten, az egyes szervezetek vagy szolgáltatások szakpolitikáira is. A traumatudatos ellátással foglalkozó szakirodalom szerint „a trauma esetén adható tájékozott segítségnyújtás megvalósításához elékőkészületre, felmérésre és szervezeti változásokra van szükség (Harris & Fallot, 2001, Rivard, Bloom, McCorkle, & Abramovitz, 2005) […]. Tehát a trauma esetén adható tájékozott segítségnyújtás megvalósítása az egyedi szervezeti adatokon alapszik, ennek kell a tervezés és a megvalósítás alapjának lennie" (Hummer et al., 2010, p. 82). A szakpolitikák hatékony kutatási létesítményektől származó adatokkal való megtámogatása tehát kétségkívül kiemelten fontos és kívánatos stratégiai elem (Levy-Carrick et al., 2019). Például az olyan eszközök tekintetében, amelyek annak elemzésében hasznosak, hogy a szervezeti politikák mennyire traumatudatos ellátás-orientáltak. A Fallot és Harris (2009) által kifejlesztett CCTIC protokoll különösen érdekes lehet, mivel ez a traumaellátás szférájában működő szervezeti szolgáltatások és kezdeményezések felmérésében részt vevő területeket és alterületeket azonosítja.

Összegezve az eddigieket, tehát a traumatudatos ellátás-orientált nézőpont magába foglalja az érzékenységet arra, amit Levy-Carrick és munkatársai hangsúlyoztak (2019): „Ahhoz, hogy segíthessünk betegeinken és saját magunkon, elengedhetetlen a nézőpontváltás, amelyet a képzés elején kell bevezetni, mindenkiben meg kell erősíteni, az idősebb szakembereknek kell ezt formálniuk, a jövő generációinak pedig elő kell mozdítaniuk" (107. o.).

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Teszt 4.2

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Teszt 4.2

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A megfigyelés fontossága

A klinikusok és a kutatók folyamatosan keresik a tudást egy bizonyos jelenséggel kapcsolatban, többé-kevésbé szisztematikus módon. Ez a tudásvágy érdeklődésből vagy kíváncsiságból táplálkozik, szabad szemmel vagy eszközök segítségével veszi gondosan szemügyre tárgyát - nem más, mint a megfigyelés.

Mantovani (1995) a megfigyelést a következőképpen definiálja: „[...] a felderítés egy formája, melynek célja egy adott jelenség feltárása (84. o.)".

A megfigyelés összetett és erőfeszítést igénylő tevékenység, amihez a következőkkellenek:

- idő;
- intellektuális szabadság;
- az előítéletektől és prekoncepcióktól való mentesség;
- önismeret;
- részvételre való képesség;
- képesség az ítélkezés felfüggesztésére.

Klinikai és kutatási kontextusokban a megfigyelés kiemelt fontosságú; egy egyszerű és tudománytalan módszerből rugalmas, strukturált és megbízható módszerré válik. Például a gyermekeken végzett kutatások fejlődésével a „gyermekbiográfiák" alkalmazását elhagyták, hogy teret adjanak a szisztematikus megfigyelésnek és kísérletezésnek (Bornstein, 2001). Majd idővel a naturalisztikus megfigyeléseket felváltották a szabványosított megfigyelések (Bornstein, 2001). Úgy is fogalmazhatnánk, Venuti (2001) szavaival élve, a megfigyelés „[...] hídként köti össze a magyarázó referenciamodellt és az utána következő elemzési folyamatot és adatértelmezést" (58. o.). Tehát a megfigyeléshez immár nem elég pusztán az, ha interakció közben nézünk egy gyerekcsoportot, vagy egy anya és gyermeke közti viselkedésről készült felvételt, mivel a megfigyelésnek mindig egy elméleti és magyarázati modell vonatkozásában kell történnie, ami segíti a kutatót hipotézisek megfogalmazásában és az adatelemzésben (Venuti, 2001). Az, hogy mit, hogyan, mikor és hol figyelünk meg, a kutatás céljától és a referenciaként szolgáló elméleti megközelítéstől függ.

Különböző típusú megfigyelések vannak:

- pszichoanalitikus megfigyelés, aminek az elméleti modellje a pszichoanalízis;
- piaget-i megfigyelés, aminek az elméleti modellje a fejlődés pszichológia;
- etológiai megfigyelés, aminek az elméleti modellje az etológia.

A piaget-i megfigyelés egy kvázi-kísérleti megfigyeléstípus. Elméleti gyökerei az interakcionizmus, a strukturalizmus és a kognitivizmus, és a mentális élet útjának a fejlődés során való tanulmányozását mélyíti el (Vigna, 2002). Nem merül ki mindennek a feljegyzésében, amit a gyermek tesz, hanem a piaget-i elmélet alapját képező hipotézisek vezérlik. A megfigyelő természetes kontextusban próbál interakciót kialakítani a megfigyelttel (Petter, 1984; Vigna, 2002). Ennek a fajta megfigyelésnek két fő alapvetése van:

1. A megfigyelő alkalmazkodik a gyermek fejlődési stádiumához, és interakció által módosítja magának a megfigyelésnek a körülményeit;

2. A megfigyelő ismételten újrateremti ugyanazt a játékhelyzetet a megfigyelés során, hogy felmérje, hogy a gyermek reakciója megismétlődik-e ugyanazon ingerek jelenlétében, és nem véletlenszerű-e.

Ennek a típusú megfigyelésnek a fő alkalmazási kontextusa az óvoda.

Ezzel szemben az etológiai megközelítést Darwin evolúciós elmélete, és az etológus, Lorenz munkássága inspirálta. Itt a megfigyelés akkor definiálható etológiaiként, ha a megfigyelő semmilyen módon nem befolyásolja a tanulmányozni kívánt viselkedést, és amennyire csak lehet, kizárja szubjektivitását. Ezt a technikát általában a természeti környezetben alkalmazzák, ahol a viselkedés spontán módon mutatkozik meg. Ám lehet a laboratóriumot is környezetként használni, ha az úgy van berendezve és kialakítva, hogy a gyermek számára ismerős környezetet reprodukál (pl. játszószoba).

Ez a módszer a korai évek tanulmányozásában hasznos, amikor a verbális nyelv még hiányzik vagy hiányos, két okból:

1. a kisgyermekek természetes életterét könnyebb meghatározni;

2. a kisgyermekek nem mindig veszik észre, ha megfigyelik őket, és ha esetleg mégis, akkor sem reagálnak a viselkedésük megváltoztatásával.

Ennek a fajta megfigyelésnek a célja a szubjektivitás kizárása és az objektivitás elérése, és pusztán az utóbbi segítségével kerülhetjük el a félrevezető következtetéseket (Lis & Venuti, 1986). Az ilyen típusú megfigyelés során olyan eljárásokat alkalmaznak, amelyek lehetővé teszik a viselkedések rögzítését és objektív, szisztematikus katalogizálását, hogy aztán később a kezdeti hipotézis tükrében értelmezni lehessen őket. Az etológiai megfigyelés erősségei többek között:

- a gyermekkori viselkedés leíró tanulmányai számának növekedése;
- fontosságot tulajdonít a hosszú távú kutatásnak, melyet a legmegfelelőbbnek tartanak a változás folyamatának és annak evolúciós jelentésének megértéséhez.

Ám az objektív leíráson való fókusz elfeledtetheti velünk azt, hogy megfigyelés közben elkerülhetetlenül döntéseket is hozunk. Továbbá az objektíven leírható - mikroviselkedések felderítésének fontossága miatt ne veszítsük szem elől az egyes viselkedésekben rejlő, egy adott pillanathoz és kontextushoz kötődő jelentéseket.

Ezzel szemben a pszichoanalitikus megfigyelés a megfigyelés közvetlen típusa, olyan módszer, ami nem használ semmilyen eszközt magán a megfigyelőn kívül. A pszichoanalitikus modell szerint, amelyben nincsenek egy adott elmélet alapján előre látott jelenségek, „a nem várt" (Bion, 1962) válik relevánssá. A megfigyelés funkciója ebben az esetben egy olyan tér létrehozása, amelyben a nem várt kifejeződhet. Ebben a kontextusban a megfigyelő részéről nincsen semmilyen szándékoltság, lehetővé téve, hogy megragadjuk a megfigyelt személy tudatos és tudattalan szándékoltságát. Alkalmazási területei a következők:

- pszichológiai kutatás;

- klinikai munka;

- gyermek-pszichoterapeuták és -pszichoanalitikusok képzése.

A megfigyelő a helyzet szerves része, viselkedéseket és verbalizációkat, valamint hangulatokat és érzelmeket is megfigyel. Saját pszichológiai állapotait is a megfigyelt alanyról szóló információforrásként kell gondosan elbírálnia; saját hasonlóságát arra használja, hogy az alanyt megkülönböztesse magától, és elfogadja saját jelenlétét.

Végezetül, a teljes családmagot meg lehet figyelni strukturált feladatok segítségével, klinikai kontextusban, vagy az illető saját természetes környezetében. Ennél a típusú megfigyelésnél interjút vesznek fel a családdal, és célja a családmag tagjainak egymással való viselkedésének, illetve a kommunikáció verbális és preverbális szintjeinek (az implicit interszubjektivitás formáinak) megértése.

Végső soron a megfigyelés az oktatásban és a képzésben dolgozók szakmaiságának egyik sarokköve, ami segít egy olyan „alaphozzáállás" kialakításában, amely a professzionális viselkedés szerves részéve, az oktatási kompetenciák alapelemévé válik. Nem egy egyszerű eszköz, hanem attitűdök, metodológiák és eszközök készlete. Ezek lehetnek strukturáltak (videofelvételek, hálózatok, ellenőrzőlisták, stb.) vagy strukturálatlanok (pl. napló). A megfigyelőnek egy képzést kell teljesítenie, el kell sajátítania a megfelelő készségeket és tudást, hogy használni tudja ezeket az eszközöket, és fel tudja tárni a tanulmányozni kívánt jelenségeket (Venuti, 2001). A megfigyelés során nyert adat lehet kvalitatív és kvantitatív is. A kvalitatív adatok narratív struktúrával rendelkeznek (Hilliard, 1993), míg a kvantitatív adatokat különböző felmérések és elemzések során lehet felhasználni (pl. gyakorisági és időtartamfelmérések, szekvenciális elemzések, stb.).

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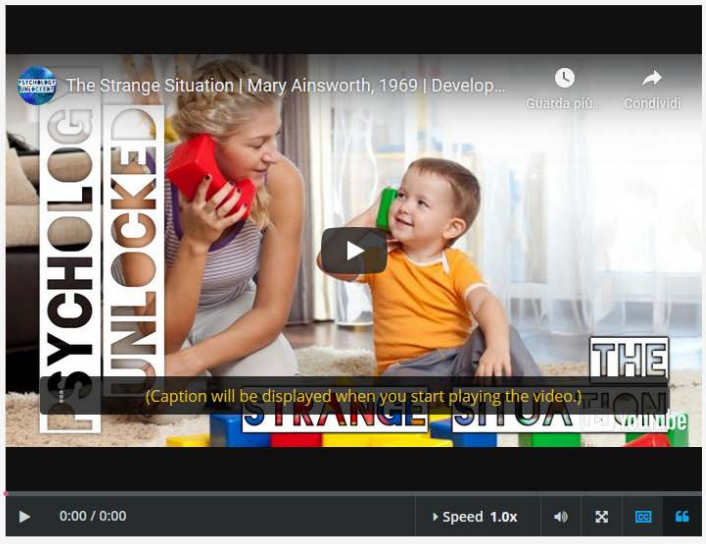

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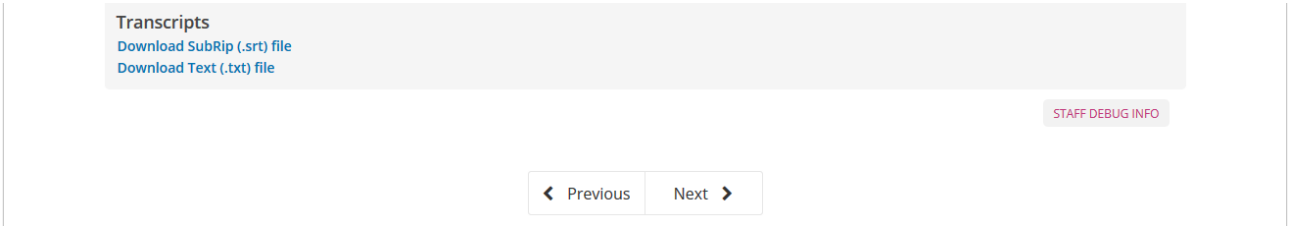
1969-ben Mary Ainsworth pszichológus egy új eljárással gazdagította a pszichológia eszközeinek

tárházát a kötődés vizsgálatára csecsemőknél.

Az "idegen helyzet teszt" nevet adta neki; általában csak az "idegen helyzetként"

hivatkoznak rá. Felnőttként tudunk róla, ha kötődést alakítunk ki valakivel.

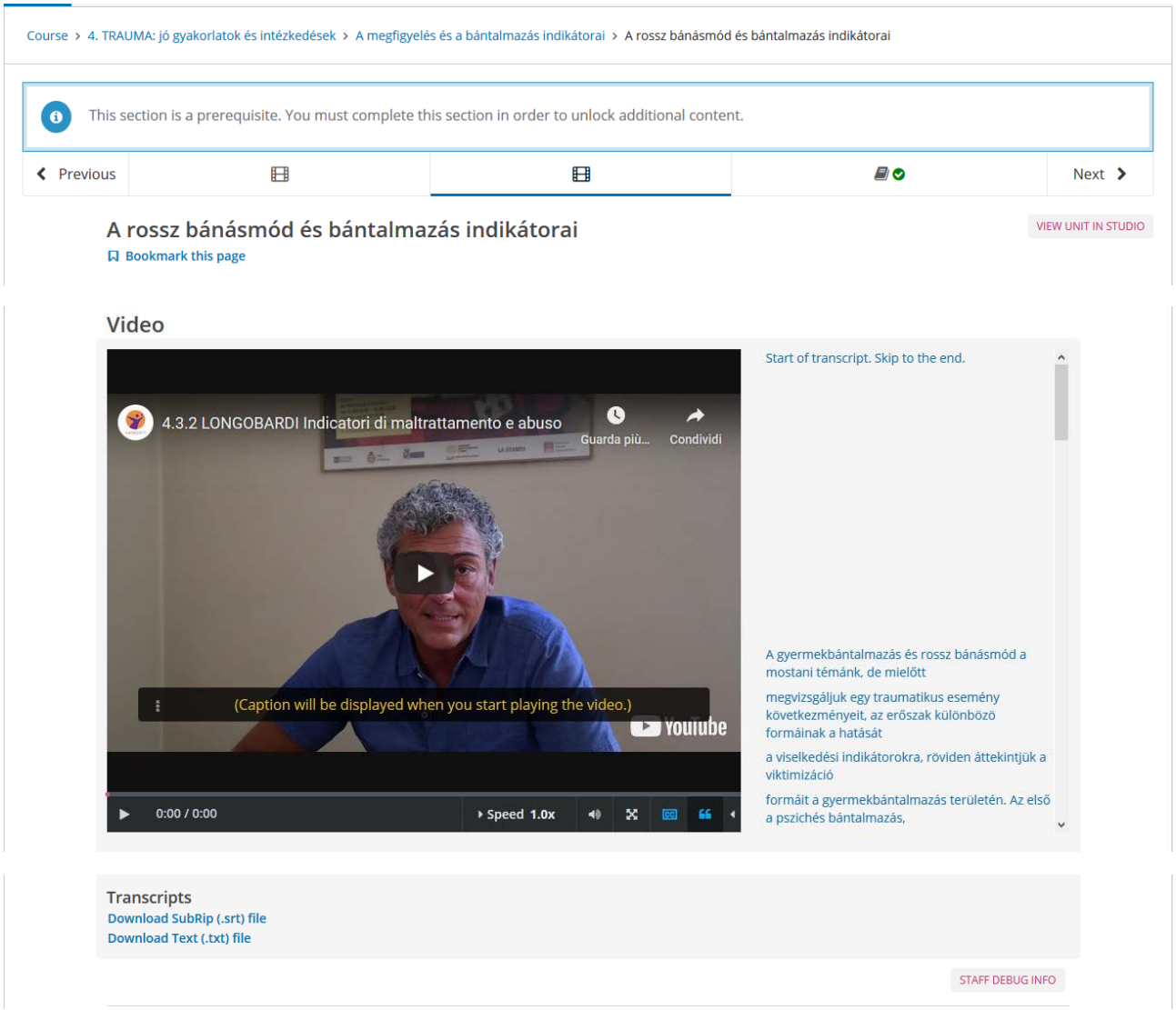
Tudjuk, hogy ez milyen érzés, és tudjuk, hogyan



Transcript

1969-ben Mary Ainsworth pszichológus egy új eljárással gazdagította a pszichológia eszközeinek tárházát a kötődés vizsgálatára csecsemőknél.
Az "idegen helyzet teszt" nevet adta neki; általában csak az "idegen helyzetként" hivatkoznak rá. Felnőttként tudunk róla, ha kötődést alakítunk ki valakivel.
Tudjuk, hogy ez milyen érzés, és tudjuk, hogyan fejezzük ki az érzéseinket szavakkal. Ám a csecsemők és kisgyermekek esetén,
akiknek még nem fejlődtek ki ezek a készségeik,
a kutatóknak más módszereket kell alkalmazniuk.
Ilyen pl. az idegen helyzet, ami a kötődés biztonságosságát méri
1-2 éves gyermekeknél. A kísérlet során egy 20 perces résztvevő megfigyelés formájában
a kutató megfigyeli a csecsemő viselkedési reakcióit több különböző szituációra.
Az ainsworth-i idegen helyzet 8 szakaszból áll, aminek mindegyike kb. 3 perces.
Kezdésképpen az anyuka, a csecsemő és a kutató hárman együtt vannak egy szobában,
egy kicsi, semleges színekkel festett térben, ahol játékok is vannak, amikkel a gyermek játszhat.
A kutató kb. egy perc után távozik, és az anyuka és a gyermek kettesben maradnak
a szobában kb. 3 percre. Ebben a szakaszban
a kutatók azt figyelik, hogy a gyermek elég magabiztos-e ahhoz, hogy elinduljon felfedezni a környezetét, vagy sem. Ezután egy idegen csatlakozik az anyához
és a gyermekhez a szobában. A kutatók feljegyzik a baba reakcióit az új jövevényre,
aki nemsokkal ezután egyedül marad a gyermekkel, és az anya kimegy a szobából.
A kutatók ekkor szeparációs szorongás jeleit keresik a gyermek viselkedésében.
Három perc múlva az anya visszatér,
a kutatók a gyermek az újratalálkozásra adott reakcióit figyelik. Az idegen kimegy a szobából.
Pár perc múlva az anya is kimegy, ezzel a gyermeket, a kísérlet során először,
teljesen egyedül hagyja. Következőnek az idegen megy be a szobába,
majd végül, három perc után az anya visszatér és az idegen kimegy.
Az egész egy igen idegen és szokatlan helyzet az összes résztvevő számára.

Mit mérnek eközben a kutatók? Amikor az anya bent van a szobában a gyermekkel,
négy szempont szerint osztályozzák a csecsemő viselkedését:
"Közelség és kontaktuskeresés". "Kontaktus fenntartása."
"Közelség és kontaktus elkerülése." és "Kontaktusnak és vigasztalásnak való ellenállás".
A gyermek felfedező viselkedését szintén rögzítik, miközben a környezettel ismerkedik.
Ainsworth arra jött rá, hogy a csecsemők három kötődési stílus egyikét mutatják:
A biztonságosan kötődő csecscemők distresszt mutatnak, amikor elszakítják őket az anyjuktól,
jobban kerülik az idegent, amikor egyedül vannak, de barátságosak vele, amikor az anyjuk is velük van,
és örülnek, amikor az anyjuk visszatér a szobába.
A tanulmányozott gyermekek 70%-a esett ebbe a kategóriába. A gyermekek 15%-a ambivalens kötődést
mutatott az anyja felé. Ezek a gyermekek intenzív distresszt mutatnak, amikor az anyjuk elhagyja
a szobát, és jelentős félelmet mutatnak az idegen irányába.
Amikor az anya visszatér a szobába, az ambivalens csecsemők elindulnak az anya felé,
de elutasítják a kontaktust. A maradék 15%-ot Ainsworth
az elkerülő kötődési stílusba sorolta. Az ilyen csecsemők nem mutatnak érdeklődést,
amikor az anya elhagyja a szobát, és örömmel játszanak az idegennel.
Amikor az anya visszatér, a gyermek alig veszi észre.
1990-ben Maine és Solomon mindezt kiegészítették azzal, hogy a gyermekek nagyon kis hányada
következetlenül viselkedik, ez lett a negyedik, "dezorganizált" kötődési stílus.
Ainsworth "gondozói érzékenység hipotézise" szerint a csecsemők kötődési stílusa
attól függ, hogy az anya a fejlődéskritikus szakaszában
milyen viselkedést tanúsít irányukba.



Transcript

A gyermekbántalmazás és rossz bánásmód a mostani témánk, de mielőtt
megvizsgáljuk egy traumatikus esemény következményeit, az erőszak különböző formáinak a hatását
a viselkedési indikátorokra, röviden áttekintjük a viktimizáció
formáit a gyermekbántalmazás területén. Az első a pszichés bántalmazás,
amit érzelmi bántalmazásnak is neveznek;
a következő a fizikai bántalmazás; végül a szexuális bántalmazás.
Fizikai bántalmazás az, amikor a gyermek fizikai, testi erőszakot szenved el,
ami egy igen erős traumatikus élmény.
Kihatással van a fejlődésére, hamarosan megnézzük,
pontosan hogyan. Ami a pszichés bántalmazást illeti,
ennek a megjelenési formái a gyermek szidalmazása, gúnyolása, társas elszigetelése,
egy fajta elhanyagolása. Az erőszaknak ezen formái kevésbé láthatóak,

de ettől még van pszichés hatásuk, és hosszú távon traumatikus élménynek számítanak.

Az utolsó a szexuális bántalmazás. Ide tartozik minden olyan viktimizáció,

ami szexuális erőszak fizikai elszenvedésével jár, úgymint vérfertőzés,

a gyermek gondozói által egy védett környezetben elkövetett helytelen érintések.

Most pedig nézzük, mik lehetnek

a gyermek ellen elkövetett erőszak különböző formáinak következményei.

A viselkedési és érzelmi indikátorokat általánosságban határozzuk meg. A fejlődésben lévő gyermek által

elszenvedett következmények lehetnek többek között

a saját testének észlelési zavarai, azaz testképzavar,

mivel nem érti, hogy a teste egy gyermeki test vagy felnőtt test, hiszen gyermekkorától erotikus szemmel néztek rá.

Ide tartoznak az ismétlődő alvási nehézségek, tehát a taumatikus eseménynek hatása van

az alvás-ébrenlét ciklus szabályozására is. Szintén ide tartoznak a figyelemzavarok,

és az iskolában a koncentrációs nehézségek.

Ha a gyermek 3-5 évesnél fiatalabb, akkor székletürítési rendellenességek is felléphetnek.

Kamaszkorban más kellemetlen tünetek

jelentkezhetnek, úgymint evészavarok:

anorexia és bulimia, kifejezett agresszió

mindenki ellen, aki figyelemteli viselkedést mutat a gyermek irányába;

a gyermek agresszióval védi magát. Végül ide tartozik az önbántalmazás,

mivel a gyermek magában hordoz egy belső szenvedést,

amit a traumatikus esemény okozott, és erre úgy reagál, hogy fizikailag károsítja, bántalmazza magát és/vagy másokat.

Ezek tehát többek között a traumatikus események elszenvedésének következményei

csecsemőkorban, gyermekkorban és kamaszkorban, de a szakirodalomban

még többet találunk: tanulási zavarok, elszigetelődés, antiszociális viselkedés,

úgymint alkoholfogyasztás és drogok használata, kicsapongó szexuális viselkedés,

nemi betegségeknek való kitettség.

Így látható, hogy sajnos nem jön létre egy normális fejlődési folyamat,

mivel a gondozók, akiknek a feladata az lenne, hogy gondoskodjanak a gyermekről,

a korábban taglalt fizikai bántalmazásnak teszik ki őt,

úgymint verés, szándékos fájdalomokozás vagy szexuális bántalmazás,

azaz a gyermek testének eroticizálása személyes impulzusok kiszolgálására, avagy pszichés bántalmazás, úgymint megalázás, elszigetelés és szidalmazás. Mindez traumatikus hatással van a gyermekre, aminek a következményeit az imént részleteztük. Ezek a következmények tehát viselkedési és érzelmi indikátorokként jelentkeznek, és jelzik azt a diszkomfortot, amit a gyermek az adott pillanatban érez. Ezekre fontos minél korábban a megfelelő intervencióval válaszolni, mielőtt a következmények egyre traumatikusabbá válnak, és az illető személyiségfejlődését is meghatározzák, különböző pszichopatológiák formájában.

Schimmenti (2018) azt hangsúlyozza, hogy az elszenvedett trauma hogyan okoz nagy szenvedést az egyének számára, amely több szinten kihathat a pszichológiai kondicionálási folyamataikra, és a világban való funkcionálásukra. Különösképpen hatással van az éntudatra, énképre, a kapcsolati lehetőségekre és módozatokra, valamint a hitrendszerekre. A szerző arra is rámutat, hogy bizonyos tanulmányok szerint a traumatikusnak nevezhető események gyakran összefüggnek egymással, és hogy a többszörös traumának való kitettség növeli a pszichopatológiák (halmozódó traumák) kialakulásának esélyét, főként ha ez gyermekkorban, és leginkább, ha a családi kapcsolatok kontextusában történik. Curran és kollégái (2018) kiemelik ezt a tudományos irodalom kontextusában is, és rámutatnak, hogy hogyan kapcsolódik a következőkhöz:

1. Azoknál a gyermekeknél, akik többszörös traumatikus élményeknek voltak kitéve, nő a depresszió és impotencia kockázata (Arata et al, 2007);

2. hosszú távon felnőttkorban a fizikai és pszichikai bántalmazást elszenvedett személyeknél nőaz alacsony önértékelés kockázata, csökken az érzelmekkel (főként a haraggal és agresszióval) való megküzdési képesség , jellemzőbb a deviáns szexuális viselkedés, és gyakoribbak a pszichoszociális alkalmazkodási nehézségek (Sesar és mások., 2010);

3. a szexuális vagy fizikai erőszakot, bántalmazást elszenvedett egyéneknél magasabb a pszichoszociális nehézségek, az aszociális vagy antiszociális viselkedés, a krónikus tünetek és a szorongó vagy depresszív zavarok kockázata, és a traumával vagy disszociációval kapcsolatos tünetek gyakorisága (Higgins & McCabe, 2000);

4. illetve a kamaszkort illetően, tudományos kutatások mutatták ki, hogy nő a delikvens (bűnöző hajlamú) viselkedés, valamint a drogfüggőség és önbántalmazás kockázata, főleg ha az illető előtörténetében megtalálható a PTSD vagy a többszörös viktimizáció.

Általánosságban elmondható, hogy a tanulmányok epidemiológiai szempontból kimutatják a trauma és a sérülés súlyosságának kapcsolatát; továbbá, ha ezt gyermekkorban szenvedték el, komoly és maradandó hatása lehet a kognitív, érzelmi és szociális készségek fejlődésére (Curran és mások., 2018). Az egyik aspektus, amelynek kifejezetten jelentős hatása van a gyerekkori traumatikus élmények létrejöttére és kimenetelére, az a legközelebbi kötődési szerepben lévők – főként a szülői szerepet betöltők – általi érzelmi elhanyagolás (Schimmenti, 2018). A traumára adott, egyéntől függően változó pszichológiai reakciók mögötti mechanizmus megértése azért fontos, hogy felismerjük azokat a gyerekeket, akik hosszútávú stressznek vannak kitéve, és hogy megfelelő és hatékony beavatkozási módszereket tudjunk kidolgozni (Ozer és mások., 2003; Alisic és mások, 2011). Különösen fontos hangsúlyozni, hogy a gyermekek a felnőttektől eltérő módon reagálnak a traumára, részben, mert más fejlettségi és készségszinten vannak, és másként kezelik az emlékezeti tartalmaikat és az eseményekre adott érzelmi reakcióikat. Lonigan és kollégái (1998) már hangsúlyozták a gyermekek traumára adott reakcióit és az ehhez társuló tényezőket vizsgáló tudományos kutatás szükségességét. Az egyik általuk felvetett kérdés az volt, hogy meg kell vizsgálni a gyerekek nemkívánatos eseményekre adott normális reakcióinak indikátorait a pszichopatológiás reakciókkal szemben – kifejezetten a gyermekpopulációra vonatkozó indikátorokat, amelyeket nem csupán a felnőttekkel végzett kutatások alapján vettek át. A kutatás egy izgalmas területe az a vizsgálat, hogy mik a tipikus válaszok a traumára, és melyek azok a lehetőségek, állapotok, amelyekben pszichopatológiás választ találunk – különös tekintettel az olyan tünetekre, melyek lehetővé teszik, hogy differenciáltan tekintsünk a két állapotra, és hogy növeljük a klinikai szakemberek számára a hatékony felismerés lehetőségeit (Lonigan et al., 1998). Az irodalom sok információt közöl a rossz bánásmód és a bántalmazás indikátorairól, kimutatván, hogy ezek gyakran nem specifikus jelek, amiet körültekintően és kellő figyelemmel kell értelmezni, mert nem mindig kizárólagosan a bántalmazásra utalnak. Sőt, szükséges a kezelőszemélyek olyan képességének a fejlesztése, hogy meg tudják ragadni a gyermekek szenvedését a saját kontextusukun belül, olyan feltételeket teremtve a számukra, amiben kellően elfogadva és támogatva érzik magukat ahhoz, hogy kifejezzék az érzelmeiket és a nehézségeiket. A segítők megfigyelési technikák és indikátor-táblázatok kombinációját tudják alkalmazni a probléma lehető legjobb feltárása érdekében. Lásd például a C.E.S.P.IM (Centro Servizi per il volontariato Provincia di Imperia) által kidolgozott dokumentumot az alábbi címen: "Il Silenzio dei Passerotti. Project for combating and recovering abuse and mistreatment of children", amelyben a bántalmazás és a rossz bánásmód néhány indikátorára találhatóak példák.

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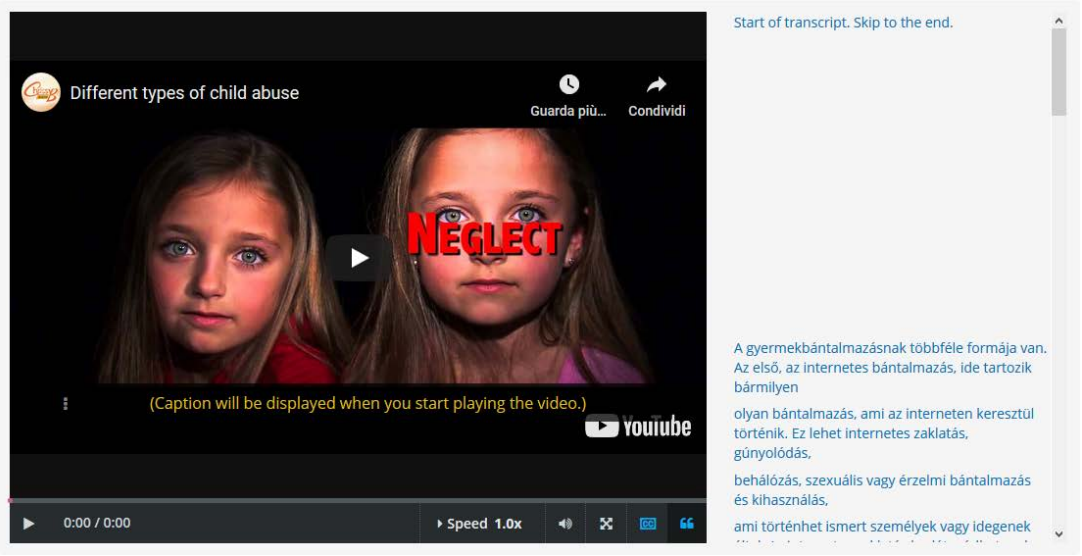
Video



Transcript

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Teszt 4.3

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Kurzus célja

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1. megismerni röviden a szocio-kulturális és jogi folyamatokat, amelyek világszerte és Európában elvezettek a gyermekek, mint jogokat megillető entitások felismeréséhez, és kötelezővé vált az államok számára megfelelően és hatékonyan közbelépni védelmükben, abúzus, erőszak és elhanyagolás esetén

2. alapvető jogok és elvek megismerése, amelyben a TIC alkalmazható. Különleges tekintettel a meghallgatáshoz és tájékoztatáshoz való jog, döntéshozatal gondozásuk és jövőjükkel kapcsolatban

3. megismerni a törvényes eszközöket, amelyek garantálják a traumatizált gyermekek részvételét a folyamatokban, hatósági és bírósági eljárásokban, amelyek védelmükről szólnak (pl. véleménynyilvánításhoz való jog, beleegyezés)

4. megismerni a gyermekjogi megközelítések (leginkább a gyermekek részvételét hangsúlyozó jogok) hatását a szociálpolitikára

5. jogi terminológiák elsajátítása

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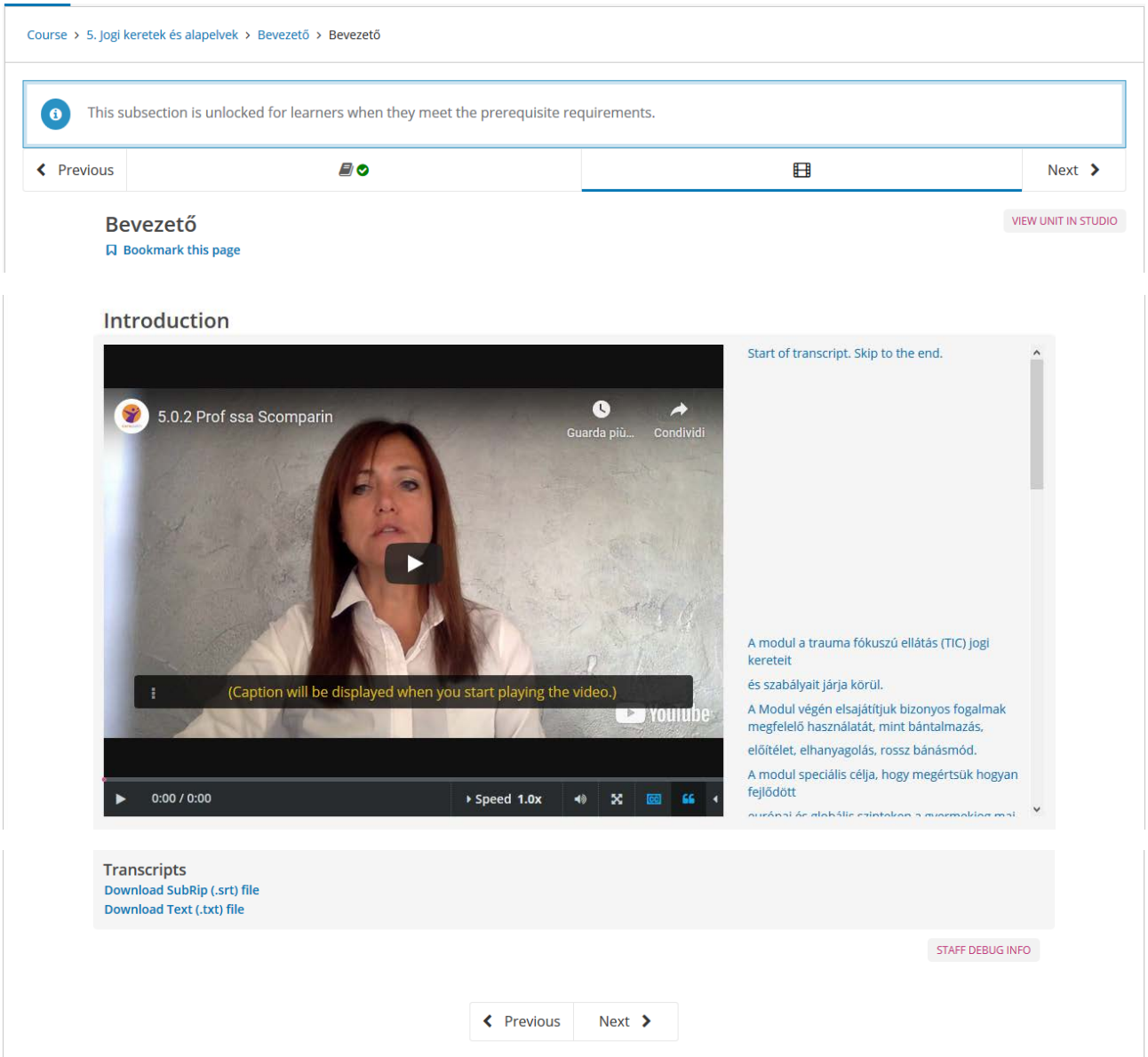

Transcript

A modul a trauma fókuszú ellátás (TIC) jogi kereteit

és szabályait járja körül.

A Modul végén elsajátítjuk bizonyos fogalmak megfelelő használatát, mint bántalmazás,

előítélet, elhanyagolás, rossz bánásmód.

A modul speciális célja, hogy megértsük hogyan fejlődött

európai és globális szinteken a gyermekjog mai napjainkig,

amely kialakította az államok felelősségét hogyan avatkozzanak be

hatékonyan és gyorsan a gyermekek védelme érdekében.

Megtanuljuk az Európai szabályozás hogyan alakította ki

az alapvető szabadságjogok a gyermekjogok területén

ami a TIC alapjainak kerete.
Megfigyeljük hogyan képesek saját jogaikat érvényesíteni a fiatalkorúak
bizonyos eljárások és állami gondoskodások területén.

Intézkedések során
hogyan garantálja bántalmazott fiatalkorúak részvételét a jogrendszer
bíróságokon és egyéb döntéshozatali folyamatokban

arra helyezzük a hangsúlyt hogyan érvényesül a gyermekek joga
ezekben a helyzetekben s más
védelmi intézkedések során.
Végül a gyermekjogok érvényesülését vizsgáljuk meg
szociális és egészségügyi szolgáltatások során,
általánosságban és
esetbemutatások által, pl. megvizsgáljuk
a női nemiszervek eltávolítására vonatkozó tiltásokat és családon belüli testi fenyítés tiltását,
intézkedéseket különböző országokban
gyám kijelölésére kisérő nélküli kiskorúak számára.

This section is a prerequisite. You must complete this section in order to unlock additional content.

Gyermekkori trauma jogi megközelítése

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Jogi szaknyelv a trauma kifejezését nem használja.

Az ENSZ Gyermekek jogairól szóló nemzetközi egyezménye (CRC) például kimondja, hogy "Az Egyezményben részes államok megtesznek minden arra alkalmas, törvényhozási, közigazgatási, szociális és nevelési intézkedést, hogy megvédjék a gyermeket az erőszak, a támadás, a fizikai és lelki durvaság, az elhagyás vagy az elhanyagolás, a rossz bánásmód vagy a kizsákmányolás - ideértve a nemi erőszakot is - bármilyen formájától mindaddig, amíg szüleinek vagy valamelyik szülőjének, illetőleg törvényes képviselőjének vagy képviselőinek, vagy bármely más olyan személynek, akinél elhelyezték, felügyelete alatt áll." (19. Cikk, CRC)

Bántalmazás és Családon belüli erőszak, rossz bánásmód

Az Európa Tanács a gyerek bántalmazást az alábbi szerint definiálja:

"Gyermekeket komolyan veszélyeztető magatartás vagy cselekvés, amely fenyegeti testi épségét, fizikai, értelmi és érzelmi fejlődését, amely elhanyagoláshoz vezethet, és családon belül vagy mások által fizikai/mentális/szexuális sérüléseket okoz" (IV Kriminológiai Konferencia - Strasbourg, 1978)

Az Egészségügyi Világszervezet (WHO) kijelenti, hogy " gyermekbántalmazás fizikai vagy érzelmi rossz bánásmód minden formája, szexuális bántalmazás, elhanyagolás és gondatlanság (hanyag bánásmód) vagy gazdasági kizsákmányolás, vagy egyéb kizsákmányolás minden formáját, mely a gyermek egész¬ségének, túlélésének, fejlődésének vagy méltóságának tényleges vagy potenciális sérelmét eredményezi egy olyan kapcsolat keretében, amely a felelősségen, bizalmon vagy hatalmon alapul."

Bántalmazás formái:

- aktív viselkedés (pl. verés, sérülések, szexuális, kizsákmányolás)
- passzív viselkedés (pl. elhanyagolás, gondatlanság)

A fizikai traumatikus bizonyíték hiánya nem zárja ki a bántalmazás lehetőségét. Pl., Érzelmi bántalmazás az, amikor egy tanár vagy szülő megalázó, leértékelő, rágalmazó magatartása sérülést okoz a gyermek érzelmi és fizikai egészségében és aláássa méltóságát.

Az erőszak és kizsákmányolás kifjezés a gyermek ellen irányuló aktív cselekvés.

Kizsákmányolás lehet gazdasági és szexuális irányultságú.

• 32. Cikk (CRC) – "Az Egyezményben részes államok elismerik a gyermeknek azt a jogát, hogy védelemben részesüljön a gazdasági kizsákmányolás ellen, és ne legyen kényszeríthető semmiféle kockázattal járó, iskoláztatást veszélyeztető, egészségére, fizikai, szellemi, lelki, erkölcsi vagy társadalmi fejlődésére ártalmas munkára."

• 34. Cikk (CRC) – "Az Egyezményben részes államok kötelezik magukat arra, hogy megvédik a gyermeket a nemi kizsákmányolás és a nemi erőszak minden formájától."

Az ENSZ Gyermek Jogi Bizottsága kimondja, hogy erőszaknak nevezzük, ha " fizikai és érzelmi erőszak minden formáját, sérülés vagy abúzús, elhanyagolás vagy hanyag bánásmód, kizsákmányolás, rossz bánásmód, szexuális bántalmazást beleértve.A köznyelvben az erőszak kifejezését szándékos, sérülést okozó cselekvésként értelmezzük. A Bizottság hangsúlyozza, hogy az erőszak kifejezését semmiféleképpen nem szabad úgy értelmezni, hogy az csökkentse a nem szándékos és/vagy nem fizikai formáinak értelmezését (többek között pl, elhagyás (?), érzelmi bántalmazás) (A gyermekek joga minden erőszaktól mentes élethez, Általános kiegészítés, 13., 2011, CRC / C / GC / 13, 2011. április 18.)

Az elhagyás kifejezése azt takarja, amikor a szülő tartós és súlyos hiányát éli meg a gyermek elhanyagolás, erőszak vagy kizsákmányolás miatt.

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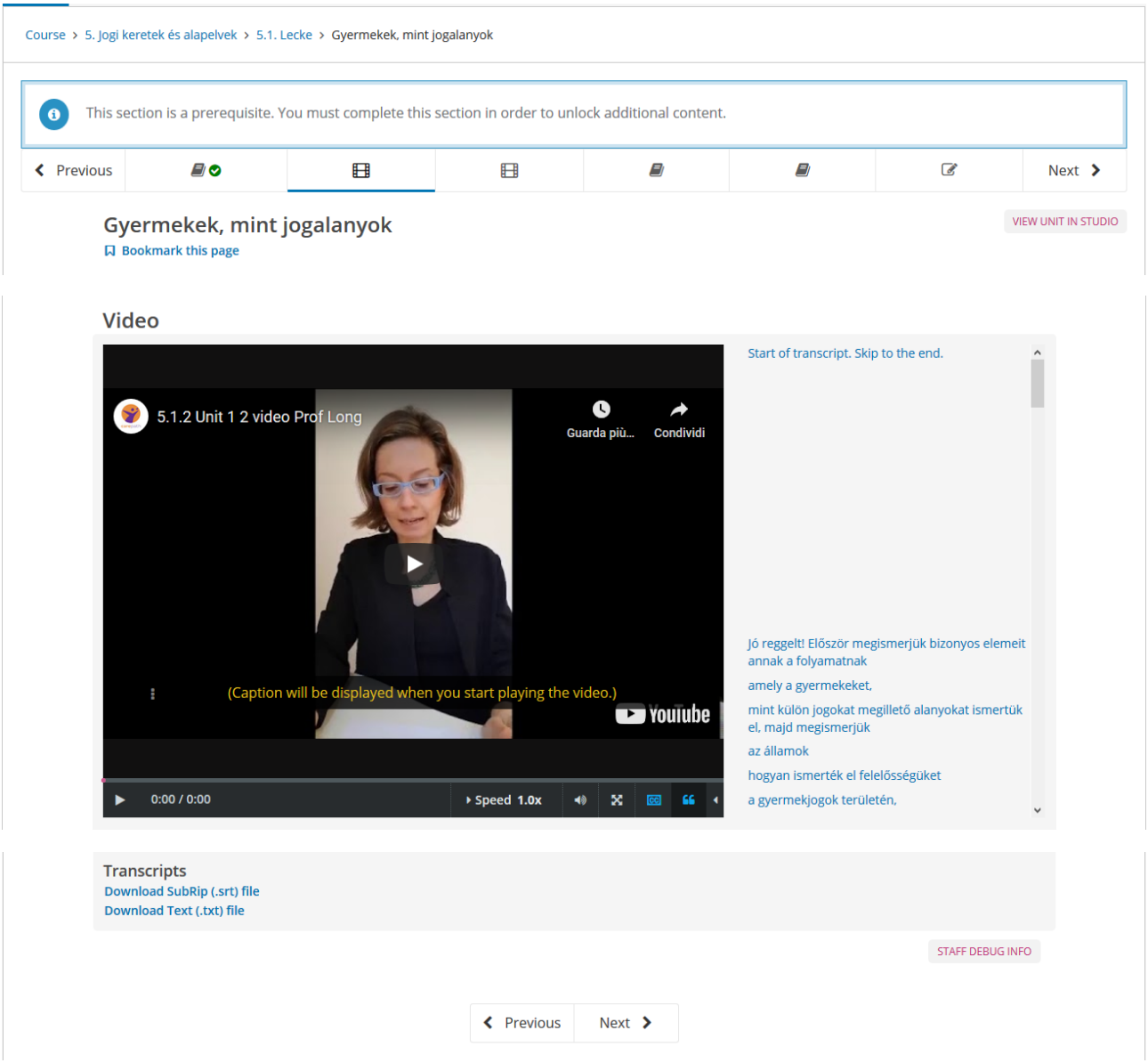

Transcript

Jó reggelt! Először megismerjük bizonyos elemeit annak a folyamatnak

amely a gyermekeket,

mint külön jogokat megillető alanyokat ismertük el, majd megismerjük

az államok

hogyan ismerték el felelősségüket

a gyermekjogok területén,

gyermekek védelmében hogyan léptek fel a

gyermekbántalmazás és rossz bánásmód ellen. a téma konceptualizálásához

Felolvasok pár sort „Élet és szabályok” című könyvből Feltrinellitől, 2006-ból

A szerző Stefano Rodotr, olasz politikus és jogász, aki

az Európai Alapjogok szerzője is. Rodotr írja:
a jog nem
nem gyógyítja be a világ sebeit, de meghatározza
személyes és társadalmi határait”
Ez az írás megvilágítja számunkra, hogy az állam lehetősége
a gyermekbántalmazás terén nem
omnipotens. Ez azt jelenti, hogy még ha van is jogi keret
a gyermekbántalmzás és erőszak ellen,
sajnálatos módon ez nem jelenti azt, hogy a gyakorlatban ez megakadályozza annak előfordulását.
Sőt, hozzá kell tennünk, hogy a való életben sajnos, amennyiben gyermekbántalmazás fordul elő az
állam nem mindig képes időben és hatékonyan fellépni az esetekben.
Rodotr sorai többek között segítenek számunkra megvilágítani az állam határait
viszontagságon keresztüleső emberek védelmét illetően
és a rossz bánásmódban részesülő gyermekek védelmét
illetően. A küszöböt megkülönböztethetjük az emberi méltóság elleni küzdelemben.
Az államnak kötelessége közbelépni, ha a fájdalomküszöb eléri
az emberi méltóság határait,
az állami beavatkozás ebben az esetben általános kötelessége, ami
szolidaritás és az individuum védelme
érdekében történik.
Vizsgáljuk meg az alapvető államomásait annak a folymatnak
amely elvezetett az államok a gyermekbántalmazás áldozatai védelmének felelősségét
felismerni.
az első kiinduló dátum
1874. New York városában folyt
Mary Ellen Wilson pere.
Mary Ellen Wilson ügye hívta fel a figyelmet
először a gyermekek védelmének rendszerszintű hiányára és ez az ügy
vezetett el az első jótékony szervezet megalakulásához: New York közössége a
gyermekbántalmazás ellen. Mik voltak az ügy körülményei?
A szomszédok mesélték
el Etta Wheeler metodista lelkésznek az 5 évesnek hitt

(valójában 10 éves) Mary Ellen esetét, akit az anyja bántalmazott.
Etta Wheeler azzal az ürüggyel kéredzkedett a házba,
hogy segítséget kér egy krónikus beteg szomszéd számára. Ezzel az ürüggyel bejutva
a házba személyesen igazolta a
gyermekbántalmazás jeleit,
amely testi tüneteket is mutatott, sebek, hegek, égések, vágások voltak a testén, öltözete
nem megfelelő volt, emellett a gyermeket pszichés bántalmazásnak is kitették,
bezárták egy szekrénybe és nem engedték
ki az épületből csak pár órára.
Etta Wheeler felvette a kapcsolatot a helyi hatóságokkal és kérte a gyermek kiemelését
a családból. a helyi hatóságok ezt nem tették meg, arra hivatkozva, hogy nincs
hogy nincs törvényes eszköz a kezükben erre. Etta Wheeler nem adta fel és megbízott egy ügyvédet,
aki állatkínzás ügyekben jártas volt, hogy
használja a jogi kereteket erre az esetre is.
és elérte, hogy a gyermeket kiemeljék a családból. 1874-ben az ügy végén
az anyát egy év börtönre ítélték Mary Ellen bántalmazásával.
Később újabb fontos ügyre került sor
gyermekbántalmazás területén 1924-ben. Most Genfbe megyünk.
Az ENSZ létrehozta a Genfi Egyezményt,
amely kimondja a gyermekek jogainak védelmét. Az Egyezmény a gyermekek
materiális szükségleteire helyezte a figyelmet és a jogok
passzív szenvedőinek tekintette őket. Példaképpen az egyezmény kijelentette:
„Az éhes gyermeket meg kell etetni, a beteg gyermeket gyógyítani kell”
Pár évtizedet várnunk kell, hogy megszülessen
az ENSZ új fejezete az Emberi Jogok Egyetemes Nyilatkozata, 1959-ben New Yorkban.
Ebben a dokumentumban a gyermekeket a törvény
alanyainak ismeri el, és közvetlen
gyakorolhatják jogaikat. Az első elvnél
olvashatjuk, miszerint „a gyermek minden jogot élvez, amely
ebben a nyilatkozatban szerepel”. A harmadik elv szerint: „a gyermeket
a születési joga szerint megilleti a név és állampolgárság” Ez az alapja az

1989-es ENSZ Gyermekek jogairól szóló egyezménynek.

Hangsúlyozom az egyezmény kifjezését,

mivel ez nagy változás az 1924-es

es és 1959 bírósági határozathoz képest. Az 1989-es Egyezmény minden azt aláíró államot köt

ellentétben a bírósági határozattal, amely csak arra az

államra vonatkozik, amelynek bírósága meghozta az ítéletet.

Az 1989-es Egyezmény létrehozta a

Gyermekek jogairól szóló Bizottságot is Genfben, amely

ellenőrizte az Egyezmény végrehajtását és megvizsgálta az államok

által benyújtott riportokat évente. Az Egyezmény összességében

kiterjeszttette nemzetközi emberi jogokat a gyermekekre,

kiegészítve pár speciális joggal.

A gyermekbántalmazáshoz fontos megemlíteni a 19. Cikk tartalmát,

amely az összes gyermeket védi minden erőszaktól a családban,

majd a 34. cikk tartalmát, amely „ a szexuális erőszak és kizsákmányolás ellen véd”, a 35. cikk tartalmát,

amely a gyermeket védi az emberkereskedelmtől, a 37. cikket, amely a kínzás, kegyetlen és embertelen bánásmód ellen véd,

a 39 cikk,

amely fontos, mert kijelenti, hogy

„minden államnak kötelessége minden intézkedést megtenni, hogy a gyermekbántalmazások áldozatait pszichés és fizikai ellátásban

részesítse és szociális integrációját elősegítse.

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Mary Ellen ügye

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The Mary Ellen case

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Olvasmányok

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Z és mások esete Nagy Brittaniában ellen

2001, Május 10, Bíróság

Tények

Az eset 1995, Október 9-én, Nagy-Brittania ellen benyújtott keresetből.

Z, A, B, C felperesek testvérek, 7 és 13 éves között, gyermekbántalmazás elszenvedése miatt a helyi hatóságokat perelik az emberi jogok európa egyezménye 3, 6, 8 és 13 cikk alapján.

1987, Októberében látogatta először a helyi szociális intézmény egészségügyi munkatársa a gyermekek és házastársak közötti probléma jelzése miatt.

1988, márciusában újabb találkozásra került sor, amely alapján az esetet lezártnak tekintették, mivel már nem álltak fenn az előző problémák.

A szomszéd rendszeresen jelentette, hogy a gyermekeket bezárták otthon. A rendőrség és a gyermekorvos jelezte, hogy a gyermekek szobája koszos volt és az orvos szerint a szobájuk ajtaját gyakran zárva tartották.

1989, Október 4-én szociális szervezet, a gyermekek tanára, egészségügyi szakember és általános szakember közösen szakmaközi esetkonferencián eldöntötték nem jelölnek ki szocális szakembert a gyermekek számára. Az iskola továbbra is figyelte a gyermekek súlyát és az egészségügyi szakember rendszeresen látogatta tovább a családot. A problémát a szülői feladatok hanyag és nem megfelelő ellátásában látták, nem a fizikai bántalmazás fennállásában és szülői feladataikhoz segítségnyújtást javasoltak.

1989, December 13-án az egészségügyi szakember javasolta a gyermekek védelembe vételét, mivel az anya nem tudta ellátni megfelelően feladatait. A javaslatot elutasították, de kirendeltek szociális munkást, Ms M.-et.

1990, Október 3-án szakmaközi esetkonferencián Ms. M. aggodalmát fejezte ki a gyermekek fejlődése és az anya érdeklődés hiánya miatt. Látszólag a gyermekek hálószobájukban ürítették székletüket, mellyel bemaszatolták az ablakokat.

1990, December 5-én szakmaközi konferencia során esetkonferenciát hívtak össze 1991 Januárra.

1991, Január 28-án Ms M. kijelentette, hogy a gyermekek szobájában nincs se világítás, se játékok, függönyök, ágyneműjük nedves, büdös és koszos. Tanáruk kijelentette, hogy Z visszahúzódó és gyakran sír, A gyakran koszos és kukákat rongál az iskolában, B nagyon visszahúzódó, figyelemre vágyik és farkaséhes.

Több vélemény ellenére, amely a szülői alkalmasságot és a megfelelő otthont megkérdeőjelezte, végeredményben úgy döntöttek kevés bizonyíték áll rendelkezésre, hogy bíróságra vigyék az ügyet.

Úgy érezték a szülők nem szándékosan hanyagolják el a gyermekeket, saját szegény előéletük ellenére mindent megtesznek és folyamatos támogatással javíthatnak helyzetükön. Úgy döntöttek nem veszik védelembe a gyermekeket.

1992, Június 10-én a gyermekek anyja kérte gyermekvédelmi elhelyezésüket, mert nem tudja ellátni feladatait és kijelentette, ha tovább maradnak nála ütni fogja őket.Nevelőszülőnél elhelyezték a gyermekeket. 1992 Június 22-I esetkonferencia után a gyermekeket elhanyagolás és érzelmi bántalmazás miatt védelembe vették. 1992, Október 8-án a helyi hatóság úgy döntött, gondozási helyet keres védelmük érdekében. 1992 December 7-én átmeneti gondozásba vételt határoztak.

1993, Januárjában Dr. Dora Black pszichiáter megviszgálta a gyermekeket. Kijelentette, hogy három gyermek pszichés zavarokat mutat. Z súlyos depresszió jeleit mutatta, mely feltételezhetően családja miatt alakult ki. Anyja viselkedését felé kegyetlennek és érzelmileg bántalmazóként írta le.

A és B rémálmoktól szenvedtek és PTSD jeleit mutatták, A krónikus kötődéshiány jeleit mutatta.

Dr. Black kijelentette, hogy mindegyik gyermek fizikai gondoskodás és szeretet hiányától szenved.

Helyzetüket nyersen fogalmazva horribilisnek írta le és hozzátette, ez volt a legsúlyosabb elhanyagolás és érzelmi abúzús, melyet egész karrierje során tapasztalt eddig.

1993, Júniusban a kijelölt ügyvéd eljárást indított a helyi hatóságok ellen, állami kötelesség mulasztás és elhanyagolás vádjával, mivel a elmulasztották a gyermekek jóllétének figyelembe vételét, mely állami kötelességük és nem intézkedtek elé gyorsan és hatékonyan. A helyi hatóságok hibás intézkedése pszichológiai sérüléseket okozott a gyermekek számára.

A kérelmet elutasította az első és a másodfokú bíróság is.

A felperesek ezután a Lordok Házához fellebbeztek.

1995, Június 29-én, a Lordok Háza elutasította a kérelmet, tekintettel arra, hogy a helyi hatóságokat ellen elhanyagolás és állami kötelességmulasztás miatt nem lehet felelősségre vonni az 1989 gyermekvédelmi törvény alapján.

A bíróság döntése

A bíróság egyöntetűen kijelentette, hogy az Egyezmény (CRC) 3 cikk alapján mulasztás történt, 8 Cikk értelmében nem történt mulasztás, 12 szavazattal az 5 ellen a 6. cikk alapján sem történt mulasztás, végül 15 szavazattal a 2 ellen szintén úgy határoztak, hogy nem történt mulasztás a 13. cikk alapján sem.

A Bíróság véleményének ismertetése

Az Egyezmény 3 Cikk megsértése (“gyermeket ne lehessen sem kínzásnak, sem kegyetlen, embertelen, megalázó büntetésnek vagy bánásmódnak alávetni”)

A felperesek kijelentették, hogy a helyi hatóságok a 3. Cikk alapján felelősségüket elmulasztották.

A bíróság megismételte a 3. Cikk jelentőségét, amely a demokratikus értékek alapjogait védi.

Tiltja, hogy gyermeket ne lehessen sem kínzásnak, sem kegyetlen, embertelen, megalázó büntetésnek vagy bánásmódnak alávetni.

Magas szerződő felek közelezettsége az Egyezmény 1. Cikk szerint biztosítani mindenki számára az Egyezményben megfogalmazott jogokat, 3. Cikk értelmében és összefüggésében, előírja, hogy az államok hozzanak intézkedéseket, annak biztosítására, hogy gyermekek nem tehetők ki kínzásnak vagy kegyetlen, embertelen vagy megalázó bánásmódnak, beleértve az egyének által jelzett rossz bánásmódot.

Megfelelő védelmet nyújtanak gyermekek és egyéb veszélyeztetett csoportok számára eme rendelkezések, melyek előírják az intézkedéseket, hogyan előzzük meg a rossz bánásmódot, melyről a hatóságoknak tudomásuk volt.

Nincs vita afelől, hogy a bántalmazás, melyet a négy gyermek elsznevedett átlépi az embertelenség és kegyetlen bánásmód határait (melyet már előzőleg leírtunk). Ez a bánásmód már 1987 Októberében tudomására jutott a helyi hatóságoknak. Állami kötelességük let volna megvédeni a gyermekeket, melyre számtalan eszköz áll rendelkezésükre, beleértve kivételüket a családból. Ennek ellenére csupán átmeneti gondozásba kerültek 1992 Április 30 anyjuk követelésére.

A négy és fél év hatósági jelenlét alatt a gyermekek folyamatosan ki voltak téve, a pszichiáter szavaival élve horribilis bánásmódnak és körülményeknek.

A Bíróság elismeri a szociális szolgálat döntésének súlyát és érzékenyégét és a családhoz való jog védelmét. Ebben az esetben azonban semi kétség afelől, hogy a rendszer hibázott a gyermekek megóvásában bántalmazástól és elhanyagolástól. A Bíróság az Egyezmény 3. cikkben szereplő felelősség mulasztásnak eleget ad.

AZ EGYEZMÉNY 13. CIKK MEGSÉRTÉSE (JOGORVOSLATHOZ VALÓ JOG)

A felperesek jogorvoslathoz való jogukat követelték a helyi hatóságok védelmének elmúlasztása okán. A Bíróság ebben az esetben megállapította, hogy a felpereseknek nem volt döntő bizonyítéka a mulasztásokra, mely szerint a helyi hatóságok nem vétték meg őket az embertelen és megalázó körülményektől és joguk van az elszenvedett károk megtérítésére. Következésképpen nem jogosultak kártérítésre a 3 Cikk szerint elszenvedett kárékért a 13 Cikk értelmében.

A 3 Cikk megsértése ellenére nem áll fenn a 8 Cikk megsértése (A magán és családi élet védelméhez való jog)

Úgyszintén nem áll fenn a 6 cikk megsértése (a tisztességes eljáráshoz való jog), mivel a felperesek ügyében mind az első és másodfokú bíróság, mind pedig a Lordok Háza törvényesen eljárt.

Z és mások esete Nagy Brittaniában ellen

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Olvasmányok

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Az ENSZ Gyermekjogi egyezménye gyerekbarát nyelven:

A „jogok" olyan dolgok, amik minden gyereknek vannak, vagy legalábbis kellene, hogy legyenek. Valamennyi gyermeknek ugyanazok a jogai. Ezek a jogok az ENSZ Gyermekjogi Egyezményében vannak felsorolva. Majdnem minden ország egyetért ezekkel a jogokkal. Az összes jog egymáshoz kapcsolódik, és mindegyik ugyanolyan fontos. Néha a jogok alatt azt értjük, hogy mi a legjobb egy gyermek számára egy adott helyzetben és mi a legfontosabb a gyermek élete szempontjából, mi védi meg a sérüléstől. Ahogy nősz fel, egyre több felelősséged van a döntések meghozatalában és a jogaid gyakorlásában.

1. cikk

Minden 18 év alatti gyermeket megilletnek ezek a jogok.

2. cikk

Minden gyermeknek vannak ilyen jogai, nem fontos, hogy hol lakik, mit dolgoznak a szülei, milyen nyelvet beszél, milyen vallású, fiú vagy lány, milyen a kultúrája, van-e fogyatékossága, gazdag vagy szegény. Egy gyermekkel sem szabad méltánytalanul bánni semmilyen alapon.

3. cikk

Minden felnőttnek úgy kell veled bánnia, hogy neked a legjobb legyen. Amikor a felnőttek döntéseket hoznak, gondolniuk kell arra, hogy döntéseiknek milyen hatása van a gyermekekre.

4. cikk

Az állam felelőssége, hogy a jogaid védve legyenek. Segítenie kell a családodat a jogaid védelmében és egy olyan környezetet kell kialakítania, ahol jó felnőni és ahol kiteljesedhetsz.

5. cikk

A családod felelős azért, hogy segítsen neked jogaid gyakorlásában és biztosítsa, hogy a jogaid védve legyenek.

6. cikk

Jogod van élni.

7. cikk

Jogod van ahhoz, hogy neved legyen és ezt az állam hivatalosan is elismerje. Jogod van az állampolgársághoz (ahhoz, hogy egy országhoz tartozzál).

8. cikk

Jogod van a személyazonossághoz – egy olyan hivatalos papírhoz, ami megmondja, ki vagy. Ezt senki sem veheti el tőled.

9. cikk

Jogod van ahhoz, hogy a szüleiddel élj, kivéve ha ez számodra rossz. Jogod van egy olyan családban élni, ahol gondoskodnak rólad.

10. cikk

Ha egy másik országban élsz, mint ahol a szüleid élnek, jogod van ahhoz, hogy egy helyen legyetek.

11. cikk

Jogod van arra, hogy ne raboljanak el a szüleidtől.

12. cikk

Jogod van arra, hogy elmondd a véleményed, és hogy a felnőttek azt meghallgassák és komolyan vegyék.

13. cikk

Jogod van arra, hogy kitalálj dolgokat és megoszd az elképzeléseidet másokkal akár beszélgetve, akár rajzolva, írva vagy bármilyen más módon, kivéve, ha ezzel másoknak ártasz vagy másokat megsértesz.

14. cikk

Jogod van megválasztani a vallásodat és a meggyőződésedet. A szüleidnek segíteniük kell téged abban, hogy el tudd dönteni mi a jó és mi a rossz, és mi számodra a legjobb.

15. cikk

Jogod van megválasztani a barátaidat és csatlakozni csoportokhoz vagy létrehozni csoportokat, amennyiben ezzel másoknak nem ártasz.

16. cikk

Jogod van a magánéleted tiszteletben tartásához.

17. cikk

Jogod van ahhoz, hogy tájékoztatást kapj a jólléted szempontjából fontos dolgokról a rádióból, az újságokból, a könyvekből, a számítógépekből vagy más forrásokból. A felnőtteknek meg kell győződniük arról, hogy a tájékoztatás számodra nem ártalmas és segíteniük kell neked abban, hogy megértsd az információkat, amikre szükséged van.

18. cikk

Jogod van ahhoz, hogy lehetőség szerint a szüleid neveljenek fel.

19. cikk

Jogod van ahhoz, hogy megvédjenek attól, hogy a tested vagy a lelked bántsák.

20. cikk

Jogod van speciális gondozáshoz és segítséghez, ha nem tudsz a szüleiddel együtt élni.

21. cikk

Jogod van a gondozáshoz és a védelemhez, ha örökbe fogadtak vagy nevelőszülőknél nevelkedsz.

22. cikk

Ha menekült vagy (ha el kellett hagynod az otthonod és egy másik országban élsz), jogod van a speciális védelemhez és segítséghez és az ebben az egyezményben foglalt jogokhoz is.

23. cikk

Ha fogyatékkal élsz, jogod van a speciális oktatáshoz és az ebben az egyezményben foglalt jogokhoz, hogy teljes életet tudj élni.

24. cikk

Jogod van a legmagasabb szintű egészséghez, biztonságos ivóvízhez, tápláló ételhez, tiszta és biztonságos környezethez és a jóllétedet elősegítő tájékoztatáshoz.

25. cikk

Ha gyermekvédelmi szakellátásban élsz vagy más helyzetekben, amikor az otthonodtól távol élsz, jogod van ahhoz, hogy az életkörülményeidet rendszeresen megvizsgálják annak érdekében, hogy eldöntsék, megfelelőek-e számodra.

26. cikk

Jogod van ahhoz, hogy segítséget kapj az államtól, ha szegény vagy illetve nélkülözöl.

27. cikk

Jogod van az ételhez, a ruházkodáshoz, egy biztonságos helyen élni és az alapvető szükségleteid kielégítéséhez. Nem szabad, hogy hátrányosan megkülönböztessenek (ez akkor van, ha nem tudsz megcsinálni sok olyan dolgot, amit más gyerekek meg tudnak csinálni).

28. cikk

Jogod van a jó minőségű oktatáshoz. Arra kell, hogy bátorítsanak, hogy minél tovább járj iskolába.

29. cikk

Az iskola segít abban, hogy használd és továbbfejleszd a tehetségedet és a képességeidet. Arra is segít megtanítani, hogy békésen élj, védd a környezeted és tiszteld a többi embert.

30. cikk

Jogod van a saját kultúrád, nyelved és vallásod gyakorlásához. A kisebbségeket és az őslakos csoportokat speciális védelem illeti meg e jog gyakorlásában.

31. cikk

Jogod van a játékhoz és a pihenéshez.

32. cikk

Jogod van ahhoz, hogy megvédjenek az olyan munkától, ami fájdalmat okoz és hátrányos az egészségedre és a tanulmányaidra. Ha dolgozol, jogod van a biztonsághoz és ahhoz, hogy tisztességesen megfizessenek.

33. cikk

Jogod van a káros kábítószerektől való védelemhez és a drogkereskedelemmel szembeni védelemhez.

34. cikk

Jogod van ahhoz, hogy szexuálisan ne bántalmazzon senki.

35. cikk

Senkinek nincs joga elrabolni vagy eladni téged.

36. cikk

Jogod van a kizsákmányolás valamennyi formája elleni védelemhez (nem használhatnak ki)

37. cikk

Senki sem büntethet meg kegyetlen vagy számodra káros módon.

38. cikk

Jogod van a védelemhez és a háborúmentes élethez. 15 éven aluli gyermekeket nem kényszeríthetnek arra, hogy háborúba menjenek vagy részt vegyenek a háborúban.

39. cikk

Jogod van ahhoz, hogy segítséget kapjál, ha bántottak vagy elhanyagoltak.

40. cikk

Jogod van jogi segítséget kapni és tisztességes bánásmódban részesülni egy olyan jogrendszerben, amely tiszteletben tartja a jogaidat.

41. cikk

Ha az országod jogszabályai kedvezőbb védelmet biztosítanak számodra, mint az ebben az egyezményben foglalt jogok, akkor azokat a jogszabályokat kell alkalmazni.

42. cikk

Jogod van ismerni a jogaidat! A felnőtteknek tudnia kell a jogaidról és segíteniük kell téged e jogok megismerésében.

43. – 54. cikkek

Ezek a cikkek elmagyarázzák, hogy az államok és a nemzetközi szervezetek, mint pl. az UNICEF azon dolgoznak, hogy a gyermekek jogait megvédjék.

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Teszt 5.1

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T5.1

5 points possible (graded)

1. Jogilag melyik a megfelelő terminológia a "gyermekkori trauma" kefejezésére?:

- csak fizikai erőszak, szándékos
- fizikai és nem fizikai erőszak, szándékos
- a fizikai és nem fizikai erőszak minden formája, még abban az esetben is, ha nem szándékos
- csak fizikai erőszak, nem szándékos

2. Mary Ellen Wilson gyermekbántalmazás áldozata mivel szemben kapott védelmet?

- embertelen vagy megalázó bánásmód tilalma
- gyermekbántalmazás tilalma
- fizikai erőszak tilalma
- állatkínzás tilalma

3. Melyik az igaz állítás?

- Children hold specific rights granted to them as trainees
- Children are not subject to rights
- Children have only rights recognised to every human person as such
- Children are subject to rights if they have the ability to discern

4. Melyik rendelkezést vezette be az Európa Tanácsa, mint speciális eszközt a gyermekek védelmére?

- Lanzarote Egyezmény
- ECHR -
- European Social Charter – Európai Szociális Karta
- Charter of Nice – Nizzai Egyezmény

5. In the judgment of the ECHR Z. AND OTHERS against UNITED KINGDOM, which of the following is recognised?:

- Article 5 of the ECHR (Right to freedom and security)
- Article 3 of the ECHR (Prohibition of Torture)
- Article 8 of the ECHR (Right to respect for private and family life)
- Article 6 of the ECHR (Right to a fair trial)

Invia You have used 0 of 2 attempts

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Európai Uniós szervezetek és egyezmények jogi megközelítése

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Európai Uniós szervezetek és egyezmények jogi megközelítése

Egyesült Nemzetek Szervezete (ENSZ) = egy nemzetközi szervezet, amely az államok közti együttműködést hivatott elősegíteni a nemzetközi jog és biztonság, a gazdasági fejlődés, a szociális ügyek és az emberi jogok terén, valamint a világbéke elérésében. Tagjai szuverén államok, az ENSZ nem felettük álló szerv. A második világháború után, 1945-ben a Nemzetek Szövetsége utódjaként azzal a céllal alapították, hogy megelőzzék a háborúkat és lehetőséget adjanak az országoknak problémáik megtárgyalására.

ENSZ Gyermekek jogairól szóló egyezménye (CRC) – nemzetközi egyezményt 1989-ben fogadta el az ENSZ Közgyűlése, amelyben minden állam és nemzetközi közösség először ismeri el a gyermekek "mindenek felett álló érdekét", polgári, szocális, politikai, kulturális és gazdasági érdekeit.

ENSZ Gyermekjogi Bizottság = ENSZ Gyermekjogi Egyezménye hozta létre 44 . cikkelyében, az egyezmény betartásának ellenőrzésére, 18 rangos, szakterületen elismert szakértőből áll. A Bizottság véleményezi a részes tagállamok által készített riportokat az Egyezmény végrehajtásáról, melyet a 44. cikkely ír elő számukra.

Emberi Jogok Európai Egyezménye (ECHR) – nemzetközi szerződésben a magas szerződő felek garantálják az európai jogok és alapvető szabadságjogokat nem csupán állampolgáraik, hanem joghatóságuk alatt álló minden személy számára. 1950 novemberében Rómában írták alá és 1953-ban lépett hatályba.

Emberi Jogok Európai Bírósága (Strasbourg Bíróság, EJEB) – Az Emberi Jogok Európai Bírósága nemzetközi bíróság, amely 1959 óta működik. Feladata eljárni az Emberi Jogok Európai Egyezményében garantált jogok egyéni és államközi beadványokban állított sérelmének ügyeiben.

1998 óta folyamatosan működik, és minden magánszemély számára hozzáférhető.

Európa Tanács –nemzetközi szervezet szószólója a demokráciának, emberi jogoknak, európai értékeknek és megoldást keres az európai szociális problémákra. 1949 Május 5-én alapították Londoban, Strasbourgi székhellyel működik 47 tagállamban, amely 28 Európai Uniós tagállamot foglal magában. Figyelem! Az Európa Tanács nem az EU része és nem szabad annak szervezeteivel összekeverni!

Az Európa Tanács Egyezménye a gyermekek védelméről a szexuális kizsákmányolás és a szexuális bántalmazás ellen (Lanzarote-i Egyezmény) – az egyezményben a tagállamok büntetik a gyermekek szexuális kizsákmányolását. Az első egyezmény, amely gyermekek családon belüli szexuális bántalmazásával foglalkozik.

Európa Tanács egyezménye a nőkkel szembeni erőszak és a kapcsolati erőszak elleni küzdelemről és azok megelőzéséről (Isztambuli Egyezmény) - Az Európa Tanács 2011-ben elfogadott Isztambuli Egyezménye a nők elleni erőszak és a családon belüli erőszak megelőzését és felszámolását célozza. Az első nemzetközi jogalap a nőkkel szembeni erőszak minden formája ellen.

Európai Unió – Az Európai Unió egyedülálló gazdasági és politikai unió, melyet jelenleg 28 európai ország alkot, második világháború után alakult a gazdasági növekedést fejlesztése érdekében a tagállamok között. Idővel, az Unió apaljává vált az európai országok poltikai egységét megőrizni, fenntartani a békét, garantálja közös gazdasági és szociális fejlesztésekkel az európai piacot és szociális kohéziót erősíteni.

Európai Unió Alapjogi Kartája – (Nizzai szerződés) – 2000 December 20-án írta alá az Európai Tanács tagjai Nizzában, összegyűjti az alapvető szabadság és emberi jogokat és kiterjeszti az EU tagállamainak állampolgáraira. A Lisszaboni szerződéssel lépett ugyan cask hatályba, de az Európai Parlamentet befolyásolta. A Lisszaboni szerződés jogerőre emelte minden európai intézmény és tagállam számára.

Európai Unió Bírósága (Luxemburgi Bíróság, EUB) – 1952-ben alakult Luxemburgban, jogértelmezést ad ki az uniós jogszabályokról annak érdekében, hogy azokat az összes uniós országban azonos módon alkalmazzák, ezen túlmenően pedig rendezi a tagállami kormányok és az uniós intézmények közötti jogvitákat.

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Olvasmányok

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célok:

- a nemzetközi és európai jogi keretrendszerben lefektetett alapvető jogok és jogelvek ismerete, amelynek keretein belül a trauma tudatos ellátás alkalmazható.

- a gyermekek részvételi jogának megértése

Kit tekintünk gyermeknek?

Az ENSZ Nemzetközi Gyermekjogi Egyezmény vonatkozásában gyermek az a személy, aki tizennyolcadik életévét nem töltötte be (1. cikk).

Hasonlóképpen az Európa Tanács legtöbb gyermekekkel kapcsolatos jogi eszköze átvette a Gyermekjogi Egyezmény fogalom meghatározását.

Az Európai Unión belül nincs elfogadott definíció arra vonatkozóan, hogy kit tekintünk gyermeknek, ezért a Gyermekjogi Egyezmény fogalom meghatározását használják.

Jogi keretrendszer

Nemzetközi szint: ENSZ (Egyesült Nemzetek Szövetsége) – Nemzetközi Gyermekjogi Egyezmény

Európai szint:

- Európa Tanács – Emberi Jogok Európai Egyezménye (Emberi Jogok Európai Bírósága- strasbourgi bíróság), Lanzarote Egyezmény, Isztambul Egyezmény
- Európai Unió – az Európai Unió Alapjogi Chartája (Nizzai Charta), Európai Unió Bírósága (luxemburgi bíróság)

Gyermeki jogok és szabadságok

Minden egyént, beleértve a gyermekeket is, megilletnek az emberi jogi eszközökben – különösen az Európai Unió Alapjogi Chartájában (Nizzai Charta) és az Emberi Jogok Európai Egyezményében (EJEE) – elismert jogok és szabadságok.

Alapvető jogok és szabadságok:

- polgári jogok
- gazdasági, politikai, kulturális jogok

Alapvető polgári jogok és szabadságok:

- ún. első generációs jogok, alapvető fontosságúak, hiszen megsértésük súlyosan károsítja az egyén életét.
- megkövetelik, hogy az államok beavatkozhassanak az egyén magánszférájába és aktívan hozzájáruljanak ezen alapvető jog hatékony érvényesüléséhez.
- pl.: a családi élet tiszteletben tartásához való jog (EJEE 8. cikk) felhívja a tagállamokat, hogy csak abban az esetben szakítsák el a gyermekeket családjuktól (szüleiktől), amennyiben ez a gyermekek védelme érdekében feltétlenül szükséges. Továbbá az EJEE vonatkozó cikke azt is leszögezi, hogy a tagállamok tegyék meg a szükséges intézkedéseket a szülők és a gyermekek közötti zavartalan kapcsolattartások érdekében, támogatva a különélő szülőt a gyermekével való kapcsolattartása gyakorlásában és kezeljék megfelelően a gyermekkel együtt élő szülőnek a másik szülő kapcsolattartását indokolatlanul akadályozó magatartását.

- **a családi élet tiszteletben tartásához való jog:**
    - mindenkinek joga van a **családi élete** tiszteletben tartásához a gyakorlatban (pl. a gyermeknek joga van családban felnőni és a válást követően kapcsolatot tartani mindkét szülőjével)
    - irányadó cikkek:
        - § Nizzai Charta 7. cikke (a családi élet tiszteletben tartásához való jog)
        - § EJEE 8. cikke (a családi élet tiszteletben tartásához való jog)
        - § Gyermekjogi Egyezmény 8. és 9. cikkek

- **a magánélet tiszteletben tartásához való jog:**
    - a magánélet fogalmát a strasbourgi bíróság joggyakorlata fejlesztette ki, amely tágan értelmezendő és magában foglalja az egyén identitásának számos aspektusát. (pl. testi és erkölcsi integritás, az egyén neve, képmása, személyes adatainak védelme)
    - irányadó cikkek:
        - § Nizzai Charta 7. cikke (a magánélet tiszteletben tartásához való jog)
        - § EJEE 8. cikke (a magánélet tiszteletben tartásához való jog)
        - § Gyermekjogi Egyezmény 16. cikke

- **a hátrányos megkülönböztetés (diszkrimináció) tilalma**
    - a nem, faj, bőrszín, etnikai vagy társadalmi származás, genetikai sajátosságok, nyelv, meggyőződés vagy vallás, politikai vagy más vélemény, nemzeti kisebbséghez tartozás, pénzügyi helyzet, születés, fogyatékosság, életkor vagy szexuális irányultságon alapuló eltérő bánásmód diszkriminatív és tilos, hacsak nem egy legitim célt szolgál.
    - irányadó cikkek: Nizzai Charta 7. cikk (magánélet tiszteletben tartásához való jog), 20. cikk (törvény előtti egyenlőség), 21. cikk (hátrányos megkülönböztetés tilalma)
    - EJEE 14. cikk; EJEE 12. számú kiegészítő jegyzőkönyvének 1. cikke
    - Európai Szociális Charta E cikke (hátrányos megkülönböztetés tilalma)
    - EJEE 8. cikk (a magánélet tiszteletben tartásához való jog)
    - Gyermekjogi Egyezmény 2. cikke

- **gyermek legfőbb érdekét szem előtt tartó alapelv**
    - a gyermekeknek és a fiataloknak életkorukra való tekintettel joguk van a különleges védelemhez és az életkoruk szerinti megkülönböztetett bánásmódhoz
    - irányadó cikk: Gyermekjogi Egyezmény 3. cikk

1. példa: a válás/különválás után a szülői felügyeleti jogról döntést hozó bíró csak és kizárólag az alapján kell döntést hozzon, hogy mi szolgálja leginkább a gyermek érdekét, és nem pedig szüleiét.

- **véleménynyilvánítás szabadsága**
    - mindenkinek joga van a szabad véleménynyilvánításhoz. A jog tartalma magába foglalja a vélemény szabad kifejtését, és azt is, hogy a gyermek az állami hatóságok beavatkozása nélkül és határokra tekintet nélkül továbbíthasson és fogadhasson információt és fejezhesse ki gondolatait.
    - EJEE 10. cikk (1) bekezdés
    - irányadó cikkek: Nizzai Charta 11. és 24. cikk (1) bekezdése, EJEE 10. cikk, Gyermekjogi Egyezmény 12. cikk (1) bekezdés

- **a gyermek meghallgatáshoz való joga**
    - „A gyermeknek lehetőséget kell adni arra, hogy bármely olyan bírói vagy közigazgatási eljárásban, amelyben érdekelt, közvetlenül vagy képviselője, illetőleg arra alkalmas szerv útján, a hazai jogszabályokban foglalt eljárási szabályoknak megfelelően meghallgassák." (Gyermekjogi Egyezmény 12. cikk)
    - a gyermek meghallgatáshoz való jogával kapcsolatos bővebb információért lásd Long professzor videóját 2. fejezet 3. lecke
    - irányadó cikkek: Gyermekjogi Egyezmény 12. cikk, a gyermekek jogainak gyakorlásáról szóló Európa Tanácsi egyezmény 3. és 6. cikke
- **a gyermek joga az erőszakkal és a kizsákmányolással szembeni védelemhez**
    - „Az Egyezményben részes államok megtesznek minden arra alkalmas törvényhozási, közigazgatási, szociális és oktatási intézkedést, hogy megvédjék a gyermeket a sérülés vagy visszaélés, a támadás, a fizikai vagy lelki bántalmazás, az elhanyagolás vagy gondatlan bánásmód, a bántalmazás vagy a kizsákmányolás - ideértve a szexuális erőszakot is - bármilyen formájától." (ENSZ Gyermekjogi Egyezmény 19. cikk (1) bekezdése)
    - Z és mások esete kontra Nagy Britannia
    - irányadó cikkek:
        - § EJEE 2. cikk (élethez való jog), EJEE 3. cikk (embertelen vagy megalázó bánásmód) és EJEE 8. cikk (testi integritáshoz való jog); EJEE 1. számú kiegészítő jegyzőkönyvének 2. cikke (oktatáshoz való jog)
        - § Európai Szociális Charta 7. cikk (fizikai és morális veszélyekkel szembeni speciális védelem) és 17. cikk (védelemhez való jog)
        - § az Európa Tanácsnak a gyermekek szexuális kizsákmányolással és szexuális visszaélésekkel szembeni védelméről szóló egyezménye (Lanzarote Egyezmény)
        - § a nők elleni erőszak és a családon belüli erőszak megelőzéséről és az azzal szembeni küzdelemről szóló egyezmény (Isztambul Egyezmény)
        - § a gyermekek szexuális bántalmazása, szexuális kizsákmányolása és a gyermekpornográfia elleni küzdelemről szóló 2011/93/EU irányelv

2. példa: A gyermek tanúja a bántalmazásnak

A bántalmazás nem csak akkor okoz kárt, amikor megtörténik, hanem akkor is, amikor annak egy gyermek tanújává válik.

A bántalmazás szemtanújaként a gyermek a bántalmazást (erőszakot) látja, végighallgatja, fájdalmat érez emiatt, érzelmileg elárasztva érzi magát anélkül, hogy bármit is képes lenne tenni. A gyermek ezáltal a bántalmazás valamely formájának van kitéve, amely fizikai, szóbeli, érzelmi, szexuális vagy gazdasági erőszak formájában ölt testet. A bántalmazás családi környezetben zajlik és közvetlenül a gyermek számára kulcsfontosságú személyek, vagy más érzelmileg hozzá közel álló személyek ellen irányul. Ezekben a helyzetekben a gyermek a bántalmazás tanúja.

Ez a jelenség a mai napig „láthatatlan", számos jele van, melyek végzetes hatással lehetnek a gyermek fizikai, kognitív és viselkedésbeli fejlődésére.

(Save the Children https://www.savethechildren.it/campagne/abbattiamo-il-muro-del-silenzio)

Irányadó cikkek: Gyermekjogi egyezmény 19. cikk, Európai Szociális Charta 17. cikk

Kapcsolódó videók: A gyermekek akik szemtanúi a bántalmazásnak, egyben elszenvedői is: https://www.youtube.com/

watch?v=aNbVwD86JqU

A gyermek szemtanú története: https://www.youtube.com/watch?v=hYX8cRkiklE

3. példa: Testi fenyítés

Az alábbi cselekvések minősülnek testi fenyítésnek:

- minden olyan büntetés, amihez fizikai erőt használnak annak érdekében, hogy valamilyen mértékű fájdalmat vagy szenvedést idézzenek elő, tekintet nélkül arra, hogy az milyen gyenge mértékű.
- az ugyanolyan megalázó és kegyetlen nem fizikai büntetés, pl. olyan büntetések, amelyek célja a gyermek lekicsinylése, megalázása, megvetése, bűnbakká tétele, fenyegetése, megijesztése, a rajta való gúnyolódás (ENSZ Gyermekjogi Bizottság 8. sz. átfogó kommentárja, 2006 https://resourcecentre.savethechildren.net/library/general-comment-no-8-2006-right-child-protection-corporal-punishment-and-other-cruel-or)
- irányadó cikkek: EJEE 3. cikke, Gyermekjogi Egyezmény 19. cikk, 28. cikk (2) bekezdés és 37. cikk

4. példa: Szexuális erőszak/bántalmazás

Szexuális erőszaknak/bántalmazásnak minősül egy gyermekkel szexuális cselekmény folytatása

- kényszer, erőszak vagy fenyegetés alkalmazásával; vagy elismert bizalmi helyzettel, tekintéllyel vagy a gyermek befolyásolásával történő visszaéléssel, ideértve a családon belüli eseteket is;

- a gyermek különösen veszélyeztetett helyzetével történő visszaéléssel, nevezetesen a testi vagy szellemi fogyatékossága vagy függőségi helyzete miatt.

(Az Európa Tanácsnak a gyermekek szexuális kizsákmányolással és szexuális visszaélésekkel szembeni védelméről szóló egyezménye (Lanzarote Egyezmény) 18. cikk (1) bekezdése

Irányadó cikkek: Gyermekjogi Egyezmény 32. és 34. cikkek, Lanzarote Egyezmény

Kapcsolódó videó: Nem érhetsz hozzám! https://www.youtube.com

/watch?v=ZNmu7plH5c8

Gazdasági, kulturális és szociális jogok

Az ún. második generációs jogok, melyek tiszteletben tartása minden részes állam feladata, a természet, életkor stb. által okozott társadalmi egyenlőtlenségek, gazdasági egyenlőtlenségek, hátrányok leküzdése érdekében.

A konkrét megvalósításuk (sajnos!) fokozatosan és a részes államok által tapasztalt gazdasági-strukturális problémák mentén zajlik.

- **az egészséghez való jog**
    - „Az egészség egy komplex fizikai, mentális és társadalmi jólléti állapot, nem egyszerűen a betegség vagy fogyatékosság hiánya." (WHO Egészségügyi Világszervezet, 1948)
    - irányadó cikkek:
        - § Nizzai Charta 3. cikk (egészségügyi ellátáshoz való hozzáférés)
        - § Emberi Jogok Egyetemes Nyilatkozata 25. cikk
        - § Gyermekjogi Egyezmény 24. , 25. és 26. cikkek
        - § EJEE 2. cikk (élethez való jog) és 3. cikk (fizikai integritáshoz való jog)
        - § Európai Szociális Charta 11. cikk (egészség védelméhez való jog) és 13. cikk (a társadalombiztosítási ellátáshoz és az egészségügyi ellátáshoz való jog)
        - § az emberi jogokról és a biogyógyászatról szóló egyezmény (az Oviedói Egyezmény) 6. cikke
- **az oktatáshoz való jog**
    - § „Minden személynek joga van az oktatáshoz. Az oktatásnak, legalábbis az elemi és alapvető oktatást illetően, ingyenesnek kell lennie. Az elemi oktatás kötelező. A technikai és szakoktatást általánossá kell tenni; a felsőbb tanulmányokra való felvételnek mindenki előtt - érdeméhez képest - egyenlő feltételek mellett nyitva kell állnia." (Emberi Jogok Egyetemes Nyilatkozata 26. cikk)
    - § Az oktatáshoz való jog nem korlátozódik az alap iskolai tantárgyak elsajátítására, ennél sokkal tágabban értelmezendő. Az oktatásnak elő kell segítenie a gyermek személyiségének, értelmi és fizikai képességeinek és hozzáállásának kibontakoztatását. (Gyermekjogi Egyezmény 29. cikk)
    - § irányadó cikkek: Nizzai Charta 14. cikk, Gyermekjogi egyezmény 28. és 29. cikk, EJEE 17. cikk, EJEE 1. számú kiegészítő jegyzőkönyvének 2. cikke

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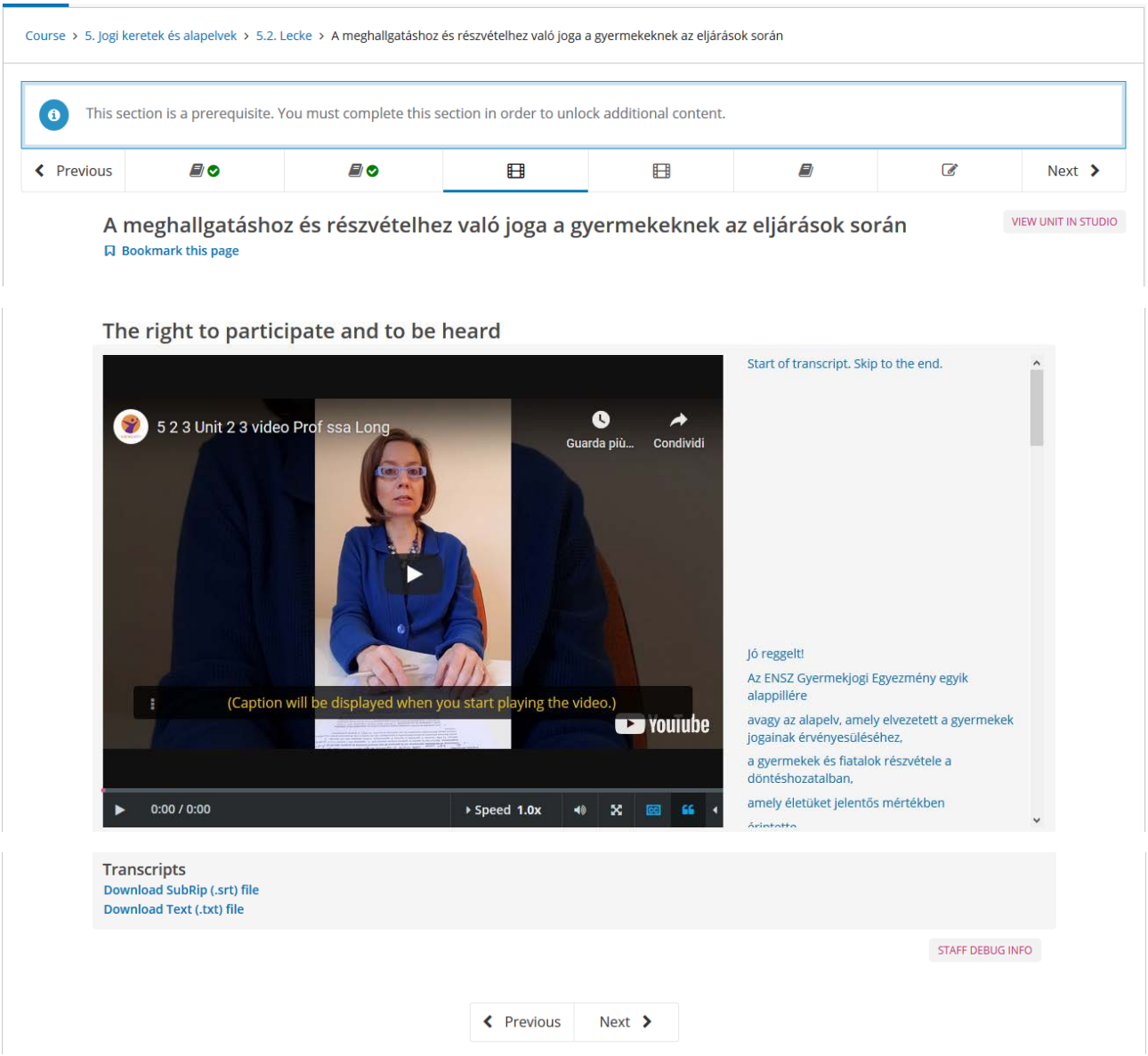

Transcript

Jó reggelt!

Az ENSZ Gyermekjogi Egyezmény egyik alappillére

avagy az alapelv, amely elvezetett a gyermekek jogainak érvényesüléséhez,

a gyermekek és fiatalok részvétele a döntéshozatalban,

amely életüket jelentős mértékben

érintette.

Az ENSZ Gyermekjogi Egyezménye elismeri a gyermekek jogait,

mint alapvető emberi jogokat, 12. Cikkely első és második paragrafusában

megnevezi az eszközöket, amelyek garantálják a gyermekek részvételét

a döntéshozatali folyamatokban, a meghallgatáshoz való jogot bíróságokon

és más hatóságok eljárásaiban, amelyek a gyermekek ügyét érintik.

Meghallgatáshoz való jog nem az egyedüli garancia a gyermekek

jogait illetően.

Az európai egyezmény gyermekek jogainak gyakorlásáról

szóló 3 Cikkelyben –melyben a bírósági eljárásokat részletezi - elismeri a gyermek „minden releváns információval rendelkezés jogát”

és a 4. cikkelyben elismeri a gyermek

különleges képviselethez való jogát és amennyiben érdekkülönbség áll fenn

a szülő és gyermek között az eljárás során

kirendelt képviselőhöz való jogát.

Mit jelent a gyakorlatban a gyermek véleménynyilvánítás szabadsága?

A döntéshozó számára is fontos információkat tartalmazhat,

ugyanakkor az előzetes meghallgatás során

a meghallgatáshoz való joga

jelentősége a véleménnyilvánításban rejlik

saját sorsát illetően.

A gyermek meghallgatáshoz való jogának érvényesülésének következményeként

ez a folyamat nem tekinthető vallatásnak sem

tanú kihallgatásnak.

A gyermek visszautasíthatja

a bíró általi meghallgatást

és a meghallgatáshoz való jogát is.

A gyermek meghallgatáshoz való jogát nem utasíthatják el

azzal az érvvel, hogy

felesleges az adott ügy menetelében.

Egyetlen egy esetben lehet a gyermek meghallgatáshoz való jogát elutasítani,

amennyiben az a gyermek érdekeivel ütközik.

Másik alappillére az ENSZ Gyermekjogi Egyezményének

a gyermekek védelemhez való joga, amelynek összhangban kell lennie a gyermekek

részvétel és meghallgatáshoz való jogával.

A gyermek akarata szerepet játszik

a végső döntésnél.

A hatóságot a döntéshozatali folyamatban a gyermek akarata nem köti kizárólag.

Sőt, előfordulhat, hogy a gyermek akarata
ellentétben áll a gyermek érdekeivel.
Vegyünk például egy fiatalt,
aki ragaszkodik a szülők láthatásához, annak ellenére, hogy rossz bánásmódban részesült általuk,
azaz a bántalmazó szülők láthatásához.
Ebben az esetben a hatóság a gyermek akarata ellen dönt
és megtagadja a bántalmazó szülők láthatását.
Felnőttek esetében különbözik egy hasonló helyzet.
Felnőttek megtagadhatják az orvosi ellátást,
abban az esetben is, ha az halálos kimenetelű.
Fiatalkorú esetében ez a helyzet másképp áll fenn, mert a gyermek véleménynyilvánításának joga
és akarata összhangban kell legyen
mindenek felett álló érdekével.
Az összhang megteremtése érdekében bíróság részvétele szükséges,
akik a fiatal életéről döntenek és tájékoztatják
a gyermeket a döntés okairól, hogy miért nem
az ő akarata szerint történik.

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The children act - film

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Bevezetés a filmhez: "The Children Act" (nincs magyar címe) – könyv alapján készült

A film főhőse, Adam, 17 éves tinidzsér, aki visszautasítja az életet jelentő vérátömlesztést vallási okokból, szülei beleegyezésével. Fiona Maye, gyerekjogok területén jártas bírónőt kirendelik az ügyhöz, hogy döntse el kaphat e a fiú vérátömlesztést. A film betekintést enged számunkra a CRC, Gyerekjogi Egyezmény 12. cikkelyébe a meghallgatás során.

- **A meghallgatás a fiatal számára ad lehetőséget jogai gyakorlására.** Fiona azért találkozik Adammal, mert nem csupán a kihallgatási felvételekről szeretné hallani álláspontját, hanem személyesen is. Beszélgetésük során más témákat is érintenek, mint zene, művészet.
- **A meghallgatás nem köti a bírót a fiatalkorú akaratának elismeréséhez. Épp ellenkezőleg, a filmben Fiona a fiatal akaratának ellen megy.** A felnőttek jogaival szemben a gyermeknek, fiatalkorúnak nem áll jogában saját haláláról dönteni (pl. ilyen esetben), a 12. Cikkely CRC-ben elmondja, hogy a biro figyelembe veheti a fiatal döntését és akaratát, de nem köti őt. Sőt, kimondja, hogy amennyiben úgy véli, hogy a fiatal érdekeit nem képviseli annak saját döntése, ellenkezőleg is dönthet.

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The children act

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Kézikönyv a gyermekjogokra vonatkozó európai jogról

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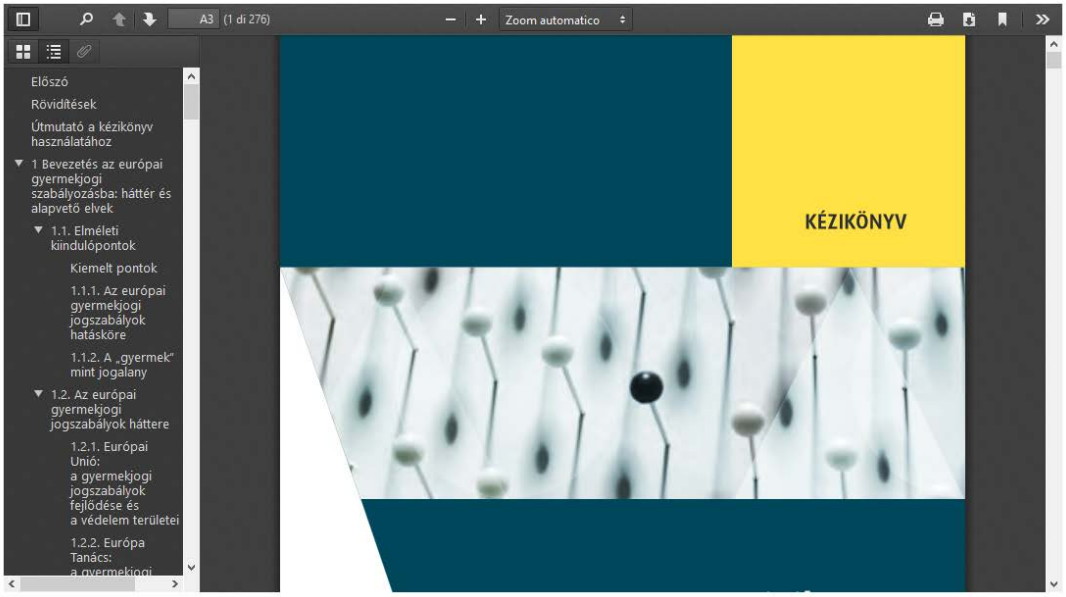
Handbook



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Teszt 5.2

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T5.2

5 points possible (graded)

1. Mi tartozik a testi fenyítések közé, amely kart okozhat a gyermekben?

- ○ A nem fizikai tettek is, mint fenyegetés vagy bármi, ami a gyermeket megalázza
- ○ Kizárólag fizikai büntetések, amelyek fájdalmat és kellemetlenséget okoznak a gyermeknek
- ○ Minden fizikai és nem fizikai tett, kivéve, ha nevelési célzattal tesszük
- ○ Csak fizikai büntetések, amely fájdalmat okoz a gyermeknek

2. Melyik a hamis állítás?

- ○ Igazságtalan kor szerinti megkülönböztetett bánásmód tilos
- ○ A gyermekkel való bánásmódot a gyermek mindenek felett álló érdeke határozza meg
- ○ Fiatalkorúaknak joga van kor szerint megkülönböztetett bánásmódhoz
- ○ Minden kor szerint megkülönböztetett bánásmód tilos

3. Melyik álltás igaz a gyermekek meghallgatása során?

- ○ Kizárható, amennyiben a gyermek véleménye felesleges
- ○ Végrehajtható mint egy tanúmeghallgatás, de nem mint egy kihallgatás
- ○ Csak gyermeket érintő bírósági eljárások során kell garantálni, hatósági eljárások során nem
- ○ Csak azokban a bírósági vagy más hatósági eljárások esetében kell biztosítani számukra, amely érinti őket

4. Köti a döntéshozókat a döntésben a gyermek véleménye azokban az esetekben ahol a gyermek meghallgatása kerül sor?

- ○ Nem, a döntéshozó semmisnek tekintheti
- ○ Igen
- ○ Nem, de a döntéshozó figyeleme kell, hogy vegye
- ○ Igen, ha a gyermek elég érett

5. Melyik az a speciális eszköz, amelyet az Európa Tanács hozott létre családon belüli és kapcsolati erőszak terén?

- ○ Lanzarote-i Egyezmény
- ○ Egyezmény személyek közötti kapcsolatok terén gyermekeket kiemelve
- ○ Isztambuli Egyezmény
- ○ Nemzetközi Gyermekjogi Egyezmény (CRC)

Invia You have used 0 of 2 attempts

Salva Show Answer

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Jogi fogalmak a gyermekek részvételéről

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Jogi fogalmak traumatizált gyermekek büntetőgoji és polgári eljárásokban való részvételéről

Elsődleges „viktimizáció/áldozattá válás" = abúzus vagy erőszak, ami fizikai és pszichés sebeket okoz

Másodlagos „viktimization"/áldozattá válás = további szenvedések, amelyet az eljárások során ért stressz okoz, az abúzus felidézése, az elkövetővel való találkozás, találkozás az ügyvédekkel és bíróval

Büntetjogi eljárások = igazságügyi eljárás, amelyben az elkövetőt megbüntetik bűnéért.

Polgárjogi eljárás = igazságügyi eljárás, amelyben a bíró megvizsgálja a gyermek családi körülményeit és intézkedésekről dönt, ha szükséges

Gyermek meghallgatása = a polgárjogi és büntetjogi eljárás része, amelyben a gyermek tényeket mesél el a bírónak

Gyermekkel való konzultáció = leginkább a polgárjogi eljárás részeként a gyermek kifejezi nézeteit a bírói döntés előtt

Gyermek beleegyezése = további garancia, melyben a gyermek véleményét a bíró meghallgatja különleges döntésekkel kapcsolatban (pl. elhelyezés, örökbefogadás)

Törvényes képviselő = szülők hiányában, amennyiben nem elérhetőek vagy érdekellentét áll fen, kijelölnek egy törvényes képviselőt, aki a gyermek érdekeit képviseli az eljárás alatt

Ügyvéd = képzett szakember, aki a bírói döntést a gyermek érdeke felé befolyásolja, amennyire lehetséges

Szociális és egészségügyi szakember = képzett pszichológia, pszichiátria vagy szociológia területén, aki segít a traumatizált gyermeknek a polgárjogi és büntetőjogi eljárások során szükségleteit és pszicho-fizikai állapotát védeni

Óvintézkedések = bíró által javasolt előzetes intézkedések, amelyek a gyermek pszicho-fizikai állapotát óvják az eljárás során

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Olvasmányok

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A traumatizált gyermekek hangja a polgári és büntető eljárásokban

3. fejezet, elsajátítandó célok:

megismerni a traumatizált gyermeket érintő polgári és büntető eljárásokban a részvételben rejlő erőt és azokat az intézkedéseket, melyek célja, hogy garantálják a gyermek biztonságát, valamint pszichés és fizikai jóllétét.

Főbb nemzetközi és európai jogforrások

ENSZ Egyezmény:

- a Gyermekjogi Egyezmény

Európa Tanácsi Egyezmények:

- a gyermekek jogainak gyakorlásáról szóló Európa Tanácsi Egyezmény (Strasbourgi Egyezmény)
- Lanzarote Egyezmény
- Emberi Jogok Európai Egyezménye (EJEE)

Európai Uniós jogszabályok:

- Európai Unió Alapjogi Chartája
- az emberkereskedelemről szóló 2011/36/EU irányelv
- a bűncselekmények áldozatainak jogairól szóló 2012/29/EU irányelv
- a gyermekek szexuális bántalmazása és a gyermekpornográfia elleni küzdelemről szóló 2011/93/EU irányelv

Eljárások, melyekben a gyermek érintett lehet

1. Büntető eljárások

- Az államok kötelessége megelőzni és megbüntetni a gyermekekkel szembeni erőszakot (elsődleges áldozattá válás) *Gyermekjogi Egyezmény 3-7. cikkek, EJEE 3. cikk, Lanzarote Egyezmény 18. cikk, 2011/36/EU irányelv 2.-10. cikkek, 2011/93/EU irányelv 3-17. cikkek*
- **Megelőzés**: a gyermekekkel szembeni erőszakos cselekményekkel kapcsolatban bűncselekményi kategóriák bevezetése
- **Büntetés**: a gyermekekkel szembeni erőszakot elkövetők megbüntetése

2. Polgári eljárások

- amikor a szülők valamelyike (vagy mindkét szülő) az erőszak elkövetője, vagy egyébként engedte az erőszak bekövetkezését
- a gyermek számára biztonságos és békés családi környezet biztosítása *(Gyermekjogi Egyezmény 9. cikk, EJEE 8. cikk)*

- szülőkkel szembeni korlátozások (Baldelli videó, Ceccarelli videó, Cibinel videó)
- a gyermekre vonatkozó felügyeleti jogot egy másik család gyakorolja
- a gyermek a traumatizált gyermekek elhelyezésére szolgáló intézményben kell elhelyezni
- a gyermek örökbefogadása

A polgári és büntető eljárások közötti kapcsolatok:

- büntető eljárások célja: a gyermekekkel szembeni erőszakot elkövető személy beazonosítása és megbüntetése, amennyiben cselekménye bűncselekménynek minősül
- polgári eljárások célja: a gyermek családja alkalmasságának ellenőrzése és további sérülések megelőzése

Ezek az eljárások egymástól függetlenek és elkülönülnek: olyan cselekmény is veszélyeztetheti a családi környezetet, amely nem minősül bűncselekménynek és megalapozhatja a bíró beavatkozását.

Cibinel videó és Baldelli videó

3. Jogon kívüli eljárások

Amennyiben az erőszak elkövetője és a gyermek közötti kapcsolat helyreállíthatónak tűnik (*strasbourgi egyezmény 13. cikk, 2012/29/EU irányelv 12. cikk)*

Ilyen esetekben a cél a kapcsolat helyreállíthatóságát egyértelműen veszélyeztető, túlzottan beavatkozó eljárások elkerülése mediációval, békéltetési kísérlettel, vagy egyéb, a közeledést szolgáló intézkedések segítségével.

A gyermek legfőbb érdeke

Ez az alapelv valamennyi eljárásra vonatkozik és megköveteli, hogy a gyermek pszichés és fizikai jóllétét minden más védelmet igénylő érdek elé helyezzünk *(Gyermekjogi egyezmény 3. cikk, Strasbourgi egyezmény 6. cikk)*

- a bírónak minden információt be kell gyűjtenie annak érdekében, hogy az ügyben releváns tényeket és a gyermek családi környezetét megismerje.
- a bíró döntése mindig a gyermek érdekeinek védelmét kell, hogy szolgálja

A gyermek meghallgatáshoz való joga

A bírónak ismernie kell a gyermek véleményét és azt figyelembe kell vennie döntése meghozatala során. *(Gyermekjogi Egyezmény 12. cikk, Strasbourgi Egyezmény 3. cikk)*

A gyermeknek részvételi lehetőséget kell biztosítani, UGYANAKKOR védelmi intézkedéseket kell meghozni a másodlagos áldozattá válás elkerülése érdekében.

Ceccarelli videó és Long videó

A gyermek számára biztosított részvételi garanciák

1. a gyermek tájékoztatáshoz való joga (Lanzarote egyezmény 31. cikk, Strasbourgi Egyezmény 3. cikk, 2012/29/EU irányelv 3-4. cikkek)

A gyermek csak a megfelelő tudás birtokában tud érdemben részt venni a döntéshozatali eljárásokban

Miről?

- az eljárások jelentése
- az ügyben releváns tények
- jogok és védelmi lehetőségek
- a gyermek szerepe
- véleményének lehetséges következményei

Ki?

- a bíróság
- jogi képviselő
- eseti gondnok/ügygondnok
- szakértő

Hogyan?

- a gyermek életkorának és érettségi szintjének megfelelő nyelv- és fogalom használat.

2. A gyermeket meg kell hallgatni az adott ügyben releváns tényekkel kapcsolatban

Szükségessé válhat a gyermek meghallgatása a döntés meghozatala szempontjából fontos tényekkel kapcsolatban.

büntető ügyekben: amennyiben a gyermek az erőszak elszenvedője, a vádlott bűnösségének bizonyítására

polgári ügyekben: amennyiben a gyermek erőszak szemtanúja volt, a család alkalmasságának megállapítására.

Ezekben az esetekben magas fokú a másodlagos áldozattá válás veszélye!

3. A gyermeket meg kell hallgatni a bíró döntésének meghozatala előtt

A döntés meghozatala előtt a gyermeknek joga van ahhoz, hogy kinyilvánítsa a véleményét az eljárással összefüggő kérdésekkel kapcsolatban *(Gyermekjogi Egyezmény 12. cikk, Strasbourgi egyezmény 3. cikk)*

Büntető eljárások:

- az eljárások elején
- megelőző intézkedések
- próbára bocsátás és egyéb speciális eljárások
- bizonyítékok értékelése

Polgári eljárások:

- családból történő kiemelés
- az egyik szülőtől való kiemelés
- gyermek feletti szülői felügyeleti jog
- örökbefogadás

Jogon kívüli eljárások:

- mediációhoz való hozzájárulás, békéltetési kísérlet

A vélemény súlya a gyermek érettségi szintjétől függ!

Védelmi intézkedések az eljárások során

1. támogató személyek *(Gyermekjogi Egyezmény 12. cikk, Lanzarote egyezmény 31. cikk, Strasbourgi egyezmény 9-10. cikkek, 2012/29/EU irányelv 24. cikk)*

- eseti gondnok/ügygondnok (amennyiben a szülők nem elérhetők, vagy közöttük érdekellentét áll fenn): ő azonosítja be és képviseli a gyermek érdekeit

- jogi képviselő: a legmegfelelőbb jogi stratégiát választja annak érdekében, hogy egy olyan döntés szülessen, amely a gyermek érdekeivel összhangban áll.

- **szociális szektorban vagy egészségügyben dolgozók** (pszichológusok, pszichiáterek, szociális munkások):

    - a másodlagos áldozattá válással szembeni védelem

    - a bíró, a szülők és a jogi képviselők támogatása annak érdekében, hogy megértsék a gyermek érdekeit és sérülékenységét

- hozzájárul az erőszak következtében elszenvedett traumák meghaladásához

2. magánélet tiszteletben tartásához való jog *(Gyermekjogi Egyezmény 16. cikk, EJEE 8. cikk, 2012/29/EU irányelv 29. cikk)*

Zárt tárgyalást kell tartani, a közönség jelenléte nélkül.

Korlátozni kell a fényképek és az információk terjesztését.

Korlátozni kell a magánélettel kapcsolatos kérdéseket, melyeket a tárgyalás során a gyermeknek feltehetnek.

3. Az eljárások ésszerű időn belül való befejezése

A másodlagos áldozattá válás az eljárások hosszához is köthető (Strasbourgi Egyezmény 7. cikke)

A különböző érdekek közötti konfliktus:

- a döntéseket a lehető leghamarabb időn belül meg kell hozni annak érdekében, hogy a hosszan tartó stresszt elkerüljük.
- a gyermek egyéb érdekeit és a döntésben érintettek érdekeit nem lehet teljes mértékben feláldozni.

Ezeket a különféle érdekeket kell összhangba hozni.

4. A tárgyalás alatti védelmi intézkedések

Amikor a gyermek tanúskodik a bántalmazásról, az elkövetővel való kapcsolatáról, a családjáról. *(Lanzarote egyezmény 31. cikk, 2012/29/EU irányelv 18. cikk, S.N.c. kontra Svédország Emberi Jogok Európai Bírósága esetjoga, 2002.07.02.)*

A másodlagos áldozattá válást megelőző intézkedések

- A tárgyalás helyszíne: a tárgyalást a bírósági üléstermen kívül is meg lehet tartani: a gyermek házában, a bíró irodájában, a jogi képviselő irodájában, egy speciális erre a célra kialakított szobában
- Ki teszi fel a kérdéseket? A kérdéseket nem közvetlenül a felek jogi képviselői teszik fel, hanem a bíró, vagy egy másik szakértő. A jogi szakértők sokszor erőszakosak lehetnek, vagy egyszerűen nincs megfelelő tapasztalatuk a gyermekekkel kapcsolatos meghallgatásokkal
- A lehető leghamarabb szükséges elkezdeni a tárgyalást és kerülni kell az ismétléseket:
    - a tárgyalásra való várakozás és az ismétlések fokozzák a stresszt
    - a gyermeket az eljárás korai szakaszában kell meghallgatni, azt követően a meghallgatást nem szabad megismételni.
- A vádlottal, az érdekellentétben lévő szülőkkel és jogi képviselőikkel ne legyen kapcsolat
    - a szemkontaktus stresszt generálhat a gyermekben és megfélemlítheti
    - távbeszélő rendszer létesítése üvegfallal
    - videó konferencia használata
    - a kérdéseket a jogi képviselők készítik elő, de azokat a bíró vagy egy szakértő teszik fel egy speciális helyiségben

A gyermek érdekeit és a védelem jogait összhangba kell hozni.

A gyermek meghallgatásával kapcsolatos videók:

Egy speciális meghallgató szoba példája Olaszországban: https://www.youtube.com/watch?v=HSrAuM2otjQ

A gyermek felkészítése a tanúkénti meghallgatásra (https://www.youtube.com/watch?v=FbxKri2-_eM https://www.youtube.com/watch?v=WKhKVoQfG5Y)

A gyermek tanúvallomása nővére haláláról (https://www.youtube.com/watch?v=jaTb5xmCdUg)

5. A gyermek véleményének kifejezését vagy a hozzájárulás megadását szolgáló védelmi intézkedések *(strasbourgi egyezmény 6. cikk)*

A véleménynyilvánítás szabadságát vagy a hozzájárulás szabad megadását veszélyeztetheti bizonyos személyek, mint pl. a szülők, a vádlott vagy a jogi képviselők jelenléte. Ezért a bíró dönthet úgy, hogy a gyermeket a bírósági termen kívül, vagy e személyek jelenléte nélkül hallgatja meg.

Ceccarelli videó és Long videó

6. A gyermek jóllétének védelme az eljárások során *(Gyermekjogi Egyezmény 20-21. cikk, Lanzarote egyezmény 31. cikk, 2012/29/EU irányelv 18. cikke)*

A végső döntés meghozatala előtt ideiglenes védelmi intézkedéseket fogadhatnak el a gyermek védelme érdekében:

Az elkövetővel szembeni intézkedések:

- megelőző őrizet/házi őrizet
- szülőkkel szembeni korlátozások
- a családból történő kiemelés
- a gyermek megközelítésének tilalma

A gyermekkel kapcsolatos intézkedések:

- ideiglenes elhelyezés egy másik családnál
- a családból történő kiemelés

Baldelli videó és Cibinel videó

7. Támogatás az eljárásokon kívül *(Gyermekjogi egyezmény 39. cikk, Lanzarote egyezmény 31. cikk, 2012/29/EU irányelv 8. és 9. cikkek)*

Pszichológiai és érzelmi támogatás az eljárásokon kívül:

- meg kell előzni a másodlagos áldozattá válást a tárgyalás előtt és azt követően is
- a bűnös megbüntetése és a családi élet nyugalmának helyreállítása nem elég – a gyermeket támogatni kell az erőszak miatt elszenvedett trauma meghaladásában (elsődleges áldozattá válás)

Ezeket az igényeket a legtöbb esetben a szociális szolgáltatók biztosítják.

Összefoglaló a szociális és egészségügyi szakemberek szerepéről

Az eljárásokon belül:

- a speciális védelmi igények egyéni vizsgálata
- a jogi eljárásokban való részvétele során a gyermek támogatása
- a gyermek megbízhatóságának vizsgálata
- békéltető eljárásokban való részvétel
- a gyermek érettségi fokának vizsgálata
- a családi körülmények felmérése

Fő cél: a másodlagos áldozattá válás megelőzése és a bíró számára hasznos információk nyújtása

Az eljárásokon kívül:

- a gyermek pszichológiai és érzelmi támogatása
- az új család körülményeinek felülvizsgálata

Fő cél: az erőszak okozta trauma meghaladása és a családi élet nyugalmának helyreállítása

Egyéb hasznos források:

Európa Tanács: A gyermekbarát igazságszolgáltatással kapcsolatos irányelvek: https://www.coe.int/en/web/children/child-friendly-justice

ENSZ Kézikönyv szakemberek és döntéshozók számára a gyermek áldozatokat és a bűncselekmények gyermek szemtanúit érintő esetekkel kapcsolatos igazságszolgáltatásról https://www.un.org/ruleoflaw/blog/document/handbook-for-professionals-and-policymakers-on-justice-in-matters-involving-child-victims-and-witnesses-of-crime/

A bírósági rendszerrel kapcsolatba kerülő gyermekekkel kapcsolatos irányelvek (Családjogi bírák nemzetközi szövetsége) http://www.aimjf.org/download/Documentation_EN/AIMJF/Guidelines_-_ENG_-_Ratified_17.04.26.pdf

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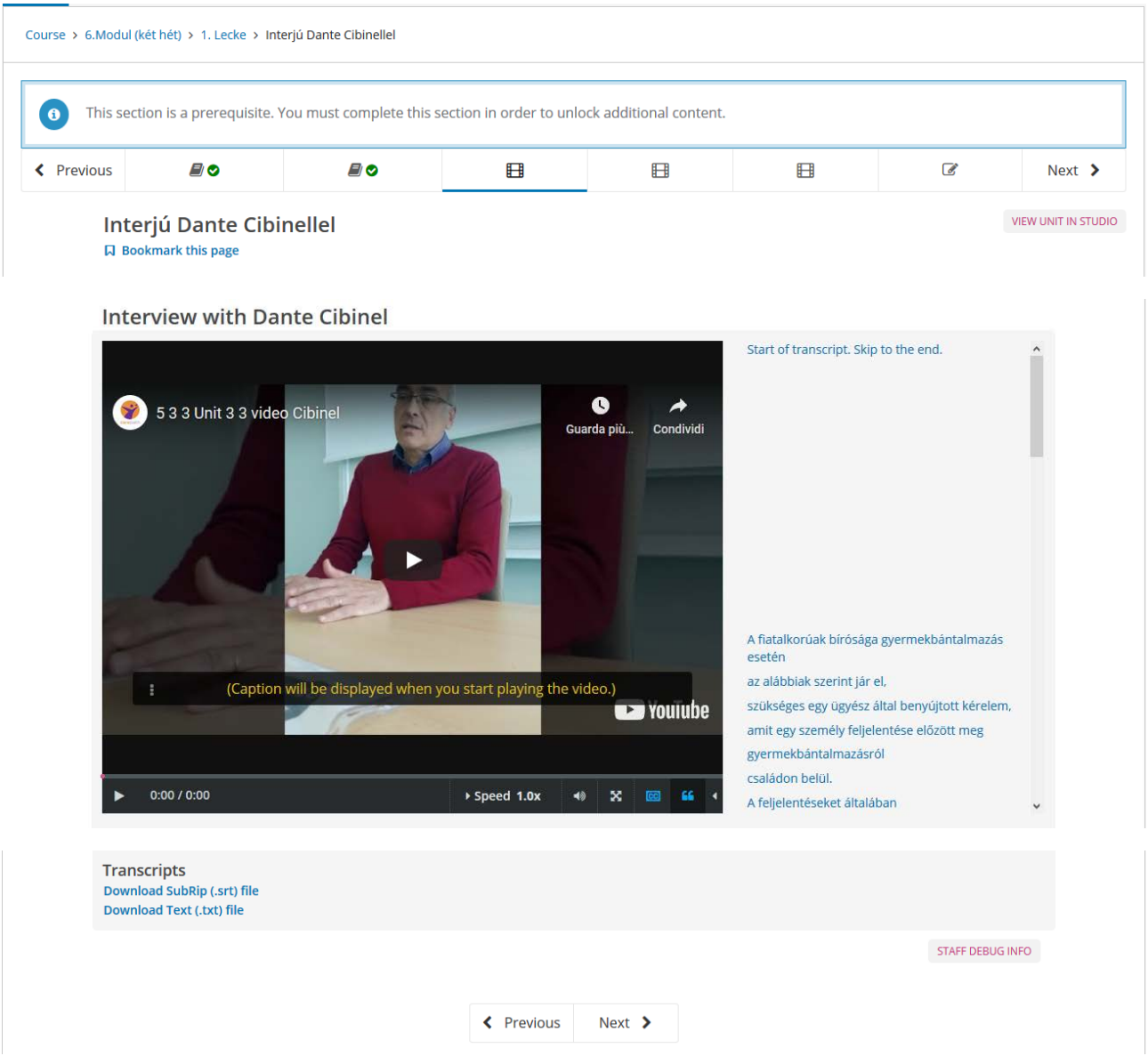


Transcript

A fiatalkorúak bírósága gyermekbántalmazás esetén

az alábbiak szerint jár el,

szükséges egy ügyész által benyújtott kérelem,

amit egy személy feljelentése előzött meg

gyermekbántalmazásról

családon belül.

A feljelentéseket általában

szociális szolgáltatók,

iskolák vagy rendőrség

teszi meg.

Ezután lép be a büntetőjogi bíróság, melyben

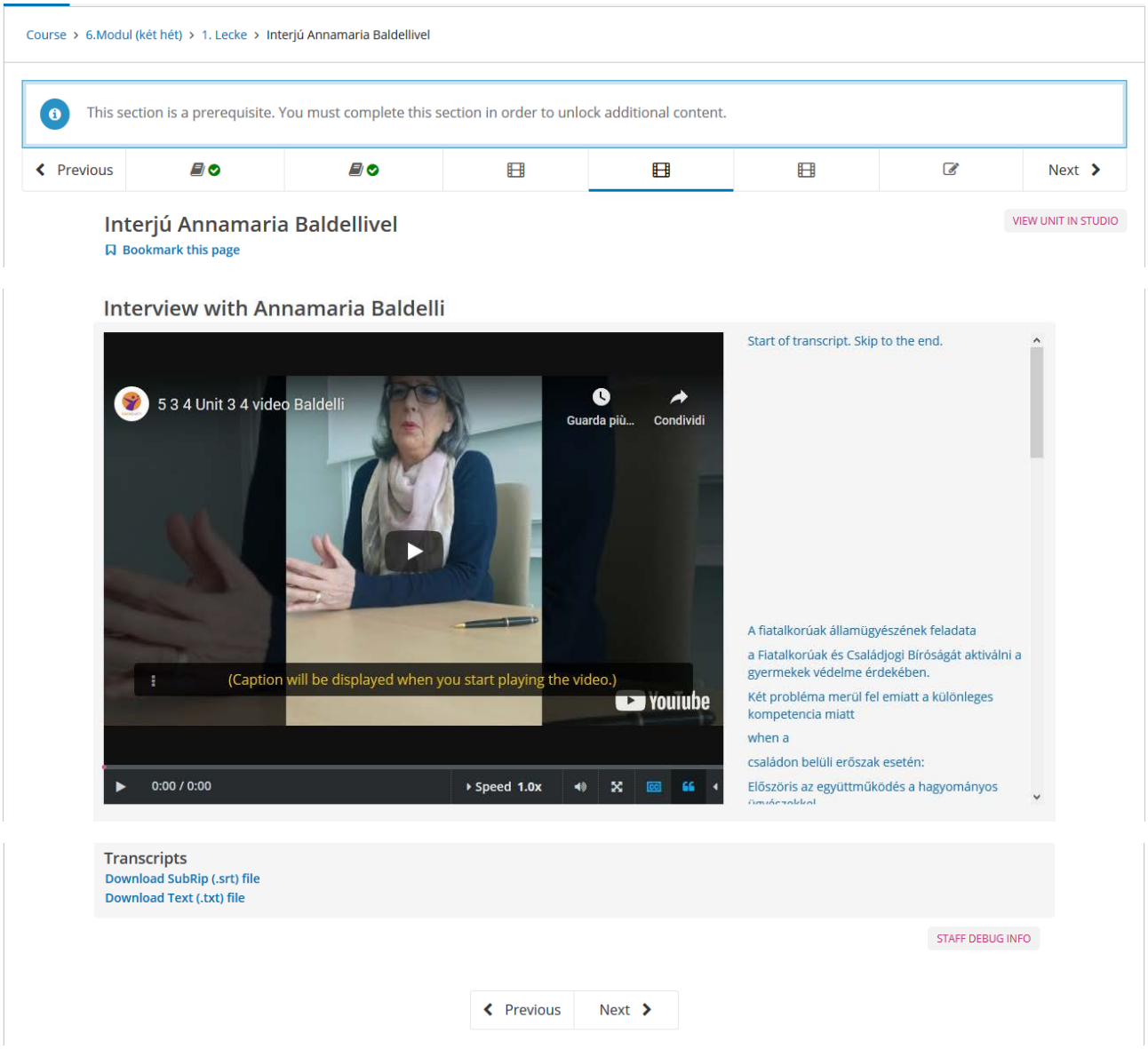
gyakran, ha a vád nyilvánvaló, csupán szimultán avatkozik közbe s a fiatalkorúak bírósága
rendeli el a védelemmel kapcsolatos intézkedéseket,
melyeket a büntetjogi bíróság megerősít.
A Bíróság eljárása az ügyész kérelmétől függ.

Bizonyos esetekben az ügyész azonnali közbeavatkozást kér,
hogy a gyermeket emeljék ki családjából
vagy más esetekben az államügyész
nyomozást kér a bíróságtól,
hogy a feljelentés vádjáról megbizonyosodjon,
és megfelelő intézkedéseket tehessenek a gyermek védelme érdekében.
A nyomozások során
vagy a kiemelés után
- amennyiben a bíróság jóváhagyta –
nem csupán a feljelentést tett hatóságokat vonják be az eljárásba,
hanem más speciális pszichológiai szervezeteket
és természetesen a szülőket.
A törvény ugyanakkor lehetőséget ad arra,
hogy a szülőket az ügyész kérésére a bíróság a tárgyalás előtt meghallgathatja
a gyermek védelme érdekében, amely limitálja
szülői jogait,
amennyiben az állami ügyész is ezt a módot alkalmazza
a döntéshez.
A gyermeket 12 év felett hallgatják meg a tárgyalásokon,
amennyiben a bíró úgy dönt képes
kifejezni saját nézőpontját,
helyzetét illetően.
A bíró saját belátása szerint dönthet
mérlegelve a fiatal pszichés állapotát.
Ismétlem: A fiatalt előtte speciális pszichológiai szakértő vizsgálja meg
és mérlegeli állapotát
és tájékoztatja a bírót

és függ életkorától is.

Ezt a meghallgatási formát „közvetített” meghallgatásnak nevezhetjük, amelyben egy szakértő vesz részt és segít a bírói

döntés meghozatalában.



Transcript

A fiatalkorúak államügyészének feladata

a Fiatalkorúak és Családjogi Bíróságát aktiválni a gyermekek védelme érdekében.

Két probléma merül fel emiatt a különleges kompetencia miatt

when a

családon belüli erőszak esetén:

Először is az együttműködés a hagyományos ügyészekkel,

akik a büntetőeljárásban részt vettek, ellenérdekek elkerülése végett

sérülhet a nyomozás,

másodszor információgyűjtés közben

az előítéletek kiszűrése,

and the

amely addigra érte a gyermeket és az egész családot,

ezután készíti el a kérelmet a Fiatalkorúak és Családjogi Bíróság számára.

Legnagyobb kihívás az eljárás időigényét felmérni,

mivel a fiatalkorúak esetében az eljárások külön időigénnyel működnek,

de a büntetőeljárások időigénye is eltérő lehet. Amit ebben az esetben tehetünk,

hogy a megfelelő eljárás éredekében, már az elejétől kezdve, megkérjük a rendőrséget, hogy szimultán jelentsen, mind az államügyész felé,

aki a vádlottak eljárását viszi,

mint pedig a fiatalkorúak kirendelt ügyésze felé, aki a gyermeket képviseli.

Ez a módszer

segíti az ügyészséget a valós történések

időbeli meghatározására és védi a nyomozás kimenetelét

és a gyermek érdekeit.

Gyakran előfordul különösen abban az esetekben, amikor a gyermekkórházban van

és nincs a szülőkkel véleménykülönbség,

hogy a védelembe vétel késik,

emiatt a bírósági eljárás is késik, mivel a kórházi ellátás már biztosítja

a gyermek védelmét, így az államügyész

a vádlottak vizsgálatát titokban és hatékony tudja végigvinni.

Amennyiben a védelembe vételi döntést

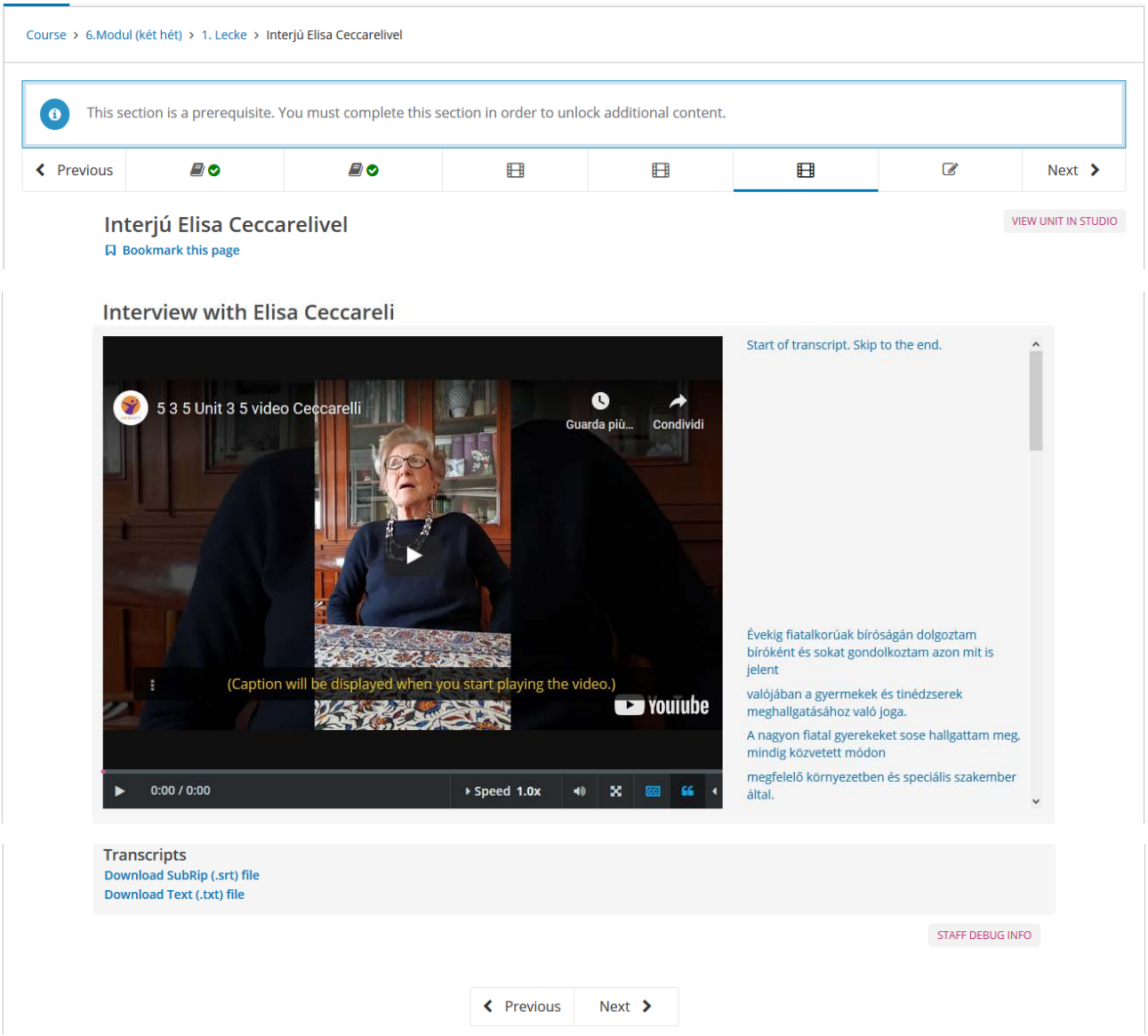
nem tudjuk elhalasztani, úgy használhatjuk

rendőrségi kapcsolatainkat, akik

a 403-as eljárás alapján elrendelhetik csupán papíron a

védelmét a gyermeknek, annak érdekében,

ez ideiglenes védelembe vétel, amelyet a bíróság jogilag megerősít kérelmünkre.



Transcript

Évekig fiatalkorúak bíróságán dolgoztam bíróként és sokat gondolkoztam azon mit is jelent

valójában a gyermekek és tinédzserek meghallgatásához való joga.

A nagyon fiatal gyerekeket sose hallgattam meg, mindig közvetett módon

megfelelő környezetben és speciális szakember által.

Azonban sok 7-8-10-11 éves gyermeket hallgattam meg.

elsősorban olyan gyermekek voltak, akiknek a szülei ugyan elváltak, mégis konfliktusaikat

a gyermekük kárára továbbgörgették.

Amit mindig próbáltam a gyermekek felé közvetíteni

az, hogy létezik olyan ember,

aki meghallgatja őket,
egy személy, aki az ő legjobb érdekük szerint dönt
és ez a döntés
még az is lehet külöbözik az ő vágyuktól
amit kifejeztek.

A döntés a bíróságon és a bírón múlik. A bíró dönt,
ezért figyelembe vesz mindent, amit mondasz neki
és mindent megpróbálok megtenni azért,
hogy neked a legjobb legyen.
Ugyanakkor, a döntés nem mindig
esik egybe a vágyaiddal. Ez az, ami az életben is megtörténik
amihez hozzá kell szoknod.
Mindig próbáltam a gyermekek szüleikhez való kapcsolatának pozitív aspektusait nézni.
Általánosságban, az apák
agresszívabban próbálják gyermekeiket
rávenni olyan dolgokra,
amik szerintük hasznos lehet számukra előző kapcsolatuk szempontjából.
Megpróbálom
elmondani a gyereknek, hogy nézd, az apukádnak semmi baja veled és természetes, hogy szereted.
Ugyanakkor tudjuk, hogy nehézségei vannak azzal, hogy elfogadja a a jelenlegi helyzetet.
Röviden fontos, hogy megőrizzük a gyermek számára az egészséges apaképet.
Fontos, hogy a bíró a gyermek lázadását megfelelően kezelje,
ne bátorítsa, ugyanakkor
a gyermek mondhat
attól még nemet arra,
hogy apjával maradjon.

Emlékszem egy esetre, ahol 10 éves volt a lány két szülővel,
az apa teljesen patologikus eset volt, a döntés szerint
az apának lehetősége van változtatni helyzetének,
ám amennyiben ez nem sikerül a gyermek nem viselheti ennek minden terhét.

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Teszt 6.1

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T6.1

7 points possible (graded)

1. Másodlagos viktimizációt okozza:

- ○ a bírósági eljárás során elszenvedett bántalmazás/stressz
- ○ A fiatalkorút érő stressz az eljárások során
- ○ az új családba helyezés során elszenvedett stressz
- ○ az eredetileg elszenvedett abúzus ismétlése

2. A „gyermek mindenek felett álló érdekének" jelentése:

- ○ a bírónak minden egyéb érdekkel szemben a gyermek fizikai-pszichés jóllétét kell szem előtt tartania
- ○ az államokat arra kötelezi, hogy kerüljék a fiatalkorú részvételét az eljárásokban abúzus után
- ○ csak büntető eljárásban érvényes
- ○ csak polgárjogi eljárásokra érvényes

3. A gyermek kihallgatása, mint tanú:

- ○ a bírónak kell kihallgatnia
- ○ kétszer is meg kell ismételni, hogy a gyermek megbizhatóságát teszteljük
- ○ Az eljárás végén ajánlott
- ○ az eljárás elején ajánlott

4. A fiatalkorú véleménye az eljárás során:

- ○ köti a bírót a döntésben
- ○ nem köti a bírót, de kötelező a döntéshozatalban figyelembe vennie
- ○ csak abban az esetben köti a bírót, ha a fiatalkorú külön hozzájárul
- ○ csak abban az esetben köti a bírót, ha a fiatalkorú 14 felett van

5. gyermekbántalmazás büntetjogi és polgárjogi eljárásokban:

- ○ külön eljárás, de a polgárjogi csak azután kezdődhet, miután a büntetjogi eljárás során a szülőket elítélték
- ○ külön eljárás, de a polgárjogi eljárás csak a büntetjogi után kezdődhet
- ○ ugyanaz a célja és tárgya
- ○ különböző okokat és tényeket vesznek figyelembe

6. Mikor rendel el a bíró óvintézkedéseket?

- ○ a gyermek fizikai és pszichés jólléte védelmében az eljárás során
- ○ az eljárás végén
- ○ az eljárás ésszerű időkerete érdekében, az eljárás ideje alatt
- ○ az eljárás elején

7. Bíróságon kívüli eljárások:

- ○ mindig alkalmazni kell
- ○ amennyiben súlyos az abúzus
- ○ amennyiben az elkövető és az áldozat közötti kapcsolat helyreállíthatónak tűnik
- ○ abban az esetben alkalmazható, ha a rossz bánásmód nem súlyos

Invia You have used 0 of 2 attempts

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Jogi fogalmak a gyermeket érintő intézkedésekről

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Gyermekekről szóló szakpolitikákkal kapcsolatos jogi kifejezések gyűjteménye és magyarázata

Szociális szolgáltatások = magán vagy állami intézmények által nyújtott szolgáltatások, melyek közösségi és személyes szükségleteket elégítenek ki. A „szolgáltatások" kifejezés szabványosított szolgáltatásokat takar, melyeket széleskörűen biztosítanak egy meghatározott kategória alá tartozó személyek számára. A „szociális szolgáltatások" ezzel szemben a kedvezményezettek speciális igényeire szabott szolgáltatások.

Gyermekek és családok számára nyújtott szociális szolgáltatások = egy sor intézkedés és tevékenység, amely igazodik a gyermekek és/vagy családjaik egyéni vagy általános szükségleteihez. Az ilyen típusú szolgáltatások – mint a speciális és átfogó szolgáltatások – célja a gyermekek és családjaik különböző szükségleteinek kielégítése.

Gyermekbarát szociális szolgáltatások = olyan szociális szolgáltatások, melyek tiszteletben tartják, védik és segítik érvényesülni minden gyermek jogait, ideértve a juttatásokhoz való hozzáférés jogát, a részvételhez és a védelemhez, valamint a gyermek legfőbb érdekét figyelembe vevő eljáráshoz való jogot (A gyermekek jogairól és a gyermekek és családjaik számára nyújtandó szociális szolgáltatásokról szóló 12. számú 2011. november 16-i Európa Tanácsi ajánlás).

Gyermekbarát igazságszolgáltatás = olyan igazságszolgáltatási rendszerek, melyek biztosítják valamennyi gyermek számára a gyermeki jogoknak a lehető legmagasabb színvonalon történő hatékony érvényesülését. E rendszerek figyelembe veszik a gyermek érettségi szintjét és megértési képességét. Ez a gyermekek számára hozzáférhető igazságszolgáltatás, amely igazodik a gyermek életkorához és igényeihez, gyermekközpontú, gyors, alapos, tiszteletben tartja a gyermekek jogait, ideértve a tisztességes eljáráshoz való jogot, a részvételhez való jogot, a magán és családi élethez való jogot, valamint az emberi méltóságot és sérthetetlenséget.

Koragyermekkori Oktatás és Ellátás (Early Childhood Education and Care -ECEC) = a gyermekek számára születésüktől kezdve általános iskolás korukig nyújtott szolgáltatás, amelyet nemzeti szabályozási keretek határoznak meg és minimumszabályoknak és/vagy akkreditálási eljárásoknak kell megfelelnie. A szolgáltatás magán, állami és önkéntes szolgáltatásokat is magában foglal. Az európai tagállamok különböző megoldásokat irányoznak elő a kötelező iskolakezdési korhatár alatti gyermekek oktatására és gondozására. Az ECEC ennek ellenére egyre inkább az európai oktatási rendszerek integráns részévé válik.

(Bővebben lásd: https://eur-lex.europa.eu/legal-content/HU/TXT/PDF/?uri=CELEX:52011DC0066&from=EN)

Európai Felsőoktatási Térség European (European Higher Education Area - EHEA) = a projekt célja a felsőoktatási rendszerek illetve az egyetemi oktatás közelítése (konvergenciája) és megerősítése Európában. Ez a folyamat összhangban van az Európai Bizottság és a tagállamok által a közelmúltban közösen elindított stratégiájával, amelynek célja egy valóban tudásközpontú Európa létrehozása, a mobilitás és a diákok foglalkoztatásának elősegítése, az oktatási rendszerek minőségének javítása és versenyképességének fokozása, továbbá az Európából és a világ más tájáról érkező diákok (és tanárok) számára az európai felsőoktatási rendszerek vonzóvá tétele. E célok eléréséhez növelni kell az eltérő oktatási rendszerek és az Európai Felsőoktatási Térség különböző intézményei közötti összehasonlíthatóságot és megfeleltethetőséget.

(Bővebben: https://ec.europa.eu/education/education-in-the-eu/european-education-area_hu)

Gyermekbarát egészségügy = olyan egészségügyi szakpolitikák és gyakorlatok, amelyek figyelemmel vannak a gyermekek fejlődésben lévő jogaira, szükségleteire, jellegzetességeire, erőforrásaira és képességeire, tiszteletben tartva a véleményüket. (lásd https://rm.coe.int/168046ccef)

Gyermekbarát megközelítés az egészségügyben = integrált koncepcionális és működőképes keret, amely teljesen tiszteletben tartja a gyermekek jogait és szükségleteit az egészségügyben. (Lásd https://rm.coe.int/168046ccef)

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Olvasmányok

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A gyermekjogi megközelítés hatása a szociális és egészségügyi szakpolitikákra

4. lecke, Elsajátítandó célok:

Megérteni, hogy az alapvető gyermeki jogokat – és különösen a gyermek részvételi jogokat – középpontba helyező megközelítés milyen konkrét hatással van a szociális és egészségügyi szakpolitikákra.

Jogi keretrendszer versus szakpolitikák

A szakpolitikák a gyermekekkel szembeni erőszak elleni küzdelem keretrendszerének lényeges elemét képezik. Önmagában a gyermekekkel szembeni erőszakot tiltó megfelelő jogi szabályozás megléte NEM elég!

„Túl sok esetben látjuk, hogy a jogi szabályozás a könyvekben létezik, de sok gyermek a társadalom perifériájára szorul (...), egyre inkább kiszolgáltatva az erőszaknak és a visszaéléseknek (írja Rima Salah, az UNICEF helyettes igazgatója, az ENSZ főtitkár a gyermekekkel szembeni erőszakkal kapcsolatos tanulmányában)"

Szociális és egészségügyi szakpolitikák és részvételi jogok

A gyermekek hozzájárulnak a szakpolitikák kialakításához:

- aktívan részt vesznek az **őket érintő ügyek** döntéshozatali folyamataiban (pl. interjúkkal, vagy a szociális munkásnak, a bírónak címzett leveleikkel, közvetlenül részt vesznek találkozókon, melyeken az ő ügyeikben születik döntés, egy speciális képviselő jelenlétében.)
- **csoportként** részt vesznek a gyermekekkel szembeni erőszakkal szembeni küzdelem során fontosnak tartott prioritások és cselekvések meghatározásában (pl. gyermekek számára tanácsadó bizottságok létrehozása, a fiatalok bevonása a gyermekvédelmi szakemberek képzésébe, a gyermekek bevonása a gyermekvédelmi szolgálatok működésével kapcsolatos tanulmányokba és kutatásokba)

A családban

„Egy olyan család, amelyben a gyermekek szabadon véleményt nyilváníthatnak és korai életkoruktól kezdve komolyan veszik őket... **ez a fajta hozzáállás megelőző hatással van a családban vagy otthon előforduló bántalmazás valamennyi formájára."**

Olyan szülői edukációs programok, melyek:

- a szülők és a gyermekek közötti kölcsönös tiszteleten alapuló kapcsolatokat részesítik előnyben
- ösztönzik a gyermekek bevonását a döntéshozatalba
- hangsúlyozzák a családon belüli eltérő véleményekkel kapcsolatos hozzáállásokat

(Forrás: ENSZ Gyermekjogi Egyezménynek a gyermek meghallgatáshoz való jogáról szóló 12. sz. átfogó kommentárja: https://www.refworld.org/docid/4ae562c52.html)

1. példa:

Globális (https://endcorporalpunishment.org/) és európai szinten (https://www.coe.int/en/web/children/corporal-punishment) számos figyelemfelkeltő kezdeményezés létezik, amely kifejezetten a szülőkre fókuszál és kinyilvánítja a gyermekekkel szembeni testi fenyítéssel kapcsolatos zéró toleranciát.

A gyermekvédelmi szakellátásban (alternatív gondoskodásban):

„Olyan mechanizmusokat kell létrehozni, melyek biztosítják, hogy az alternatív gondoskodásban élő gyermekek – ideértve az intézményeket – képesek legyenek kifejezni véleményüket és azoknak kellő súlyt adjanak az elhelyezésük során, a nevelőszülőknél vagy gyermekotthonban lévő szabályzatok kialakítása során és a mindennapi életük során." (ENSZ Gyermekjogi Egyezménynek a gyermek meghallgatáshoz való jogáról szóló 12. sz. átfogó kommentárja, 2009: https://www.refworld.org/docid/4ae562c52.html)

Pl. meg kell hallgatni őket az alábbi döntések meghozatala előtt:

- az alternatív gondoskodásban történő elhelyezés időpontjának és az elhelyezés módjának kiválasztásakor
- döntés azokról a családtagokról, akikkel az alternatív gondoskodás ideje alatt szeretné tartani a kapcsolatot, a kapcsolattartások gyakorisága és azok módja
- a gyermek jövőjét érintő kérdések
- a gyermek helyzetének időszakos felülvizsgálata

(Lásd Nemzetközi SOS Gyermekfalvak, Az alternatív gondoskodásban élő gyermekekkel kapcsolatos irányelvek: egy ENSZ keretrendszer, Genf, 2009: https://resourcecentre.savethechildren.net/library/united-nations-guidelines-alternative-care-children)

Az általános mechanizmusok lehetnek:

- **monitorozó intézmények** (pl. gyermekjogi *ombudsman*), a gyermek elhelyezésére szolgáló intézményekhez való korlátlan hozzáféréssel annak érdekében, hogy a gyermek véleményét és aggályait közvetlenül meghallgathassák.
- **gyermekek érdekképviseleti tanácsa** a bentlakásos intézményekben, amely lehetőséget kap arra, hogy részt vegyen az intézmény szabályzatának kialakításában és végrehajtásában.
- **szakemberek speciális képzése**, melybe a gyermekeket is bevonják, mint trénereket.

2. példa

Számos európai országban a korábban intézményekben vagy nevelőszülőknél elhelyezett, az alternatív gondoskodást elhagyók és korábban elhagyók informális hálózata jött létre azzal a céllal, hogy erősítsék a részvételi jogok és az aktív állampolgárság érvényesülését:

- összejövetelek szervezése, beszélgetések és kölcsönös tudásgazdagodás a résztvevők között
- hozzájárulás az alternatív gondoskodással kapcsolatos szociális szakpolitikák előmozdításához és az állami gondoskodást elhagyó fiatalok speciális támogatásának ösztönzése.

Az alternatív gondoskodást elhagyók európai hálózata jelenleg kialakítás alatt áll.

Forrás: http://www.agevolando.org/leavecare-livelife/

Az alternatív gondoskodásban élő gyermekek legfőbb aggálya, hogy **18. életévük betöltését követően milyen jövő** vár rájuk. Ez az időpont általában egybeesik az államnak az alternatív gondoskodásban élő gyermekkel szembeni speciális gondoskodási kötelezettségének megszűnésével.

Az olasz alternatív gondoskodást elhagyók hálózatának konkrét akciója felhívja a figyelmet arra, hogy milyen nehézségeket okoz a gyermekvédelmi szakellátásból kikerülő 18. életévüket betöltött fiatalok számára a függetlenné válás. (Lásd az alábbi videót: https://www.youtube.com/watch?v=4hZYGVNLIIY)

Egy ombudsman konkrét akciója, az ír ombudsman videója: bentlakásos intézményben lakó fiatal panasszal él a gyermekjogi ombudsmanhoz: https://www.youtube.com/watch?v=Nt2YcFHkdqA)

Egészségügy

A gyermekeket mindig be kell vonni az egészségüket érintő döntések meghozatalába (UNICEF- Save The Children, Minden gyermeknek joga van a véleménye meghallgatásához, 2009: https://www.refworld.org/docid/4ae562c52.html)

Jogod van ahhoz, hogy az életkorodnak és az érettségi fokodnak megfelelően tájékoztassanak (A kórházban lévő gyermekek európai szövetsége Chartájának 4. cikke https://www.each-for-sick-children.org/each-charter/the-10-articles-of-the-each-charter

„Abban az esetben, amikor a törvény szerint egy kiskorú nem rendelkezik a beavatkozásba való beleegyezés képességével, a beavatkozást csak **képviselője**, hatóság vagy a törvény által kijelölt személy vagy testület **engedélyével** lehet végrehajtani.

A **kiskorú véleményét** korának és érettségi fokának megfelelően egyre meghatározóbb mértékű tényezőként kell figyelembe venni. (Az emberi lény emberi jogainak és méltóságának a biológia és az orvostudomány alkalmazására való tekintettel történő védelméről szóló egyezménye 6. cikk (2) bekezdése: https://www.coe.int/en/web/bioethics/oviedo-convention)

Amikor a gyermekek bántalmazást szenvednek el otthon, biztosítani kell számukra a **bizalmas orvosi ellátáshoz és tanácsadáshoz** való hozzáférést, szülői beleegyezés nélkül, a gyermek életkorától függetlenül. (Gyermekjogi Bizottság 12. sz. átfogó kommentárja a gyermek meghallgatáshoz való jogáról)

A gyermek részvétele az egészségét érintő döntések meghozatalában nem csak a személyes jóllétét mozdítja elő, hanem fejleszti az egészségügyi szakpolitikákat és az egészséggel kapcsolatos biztonságos gyakorlatokat is.

Az általános mechanizmusok az alábbiakat foglalják magukban:

- visszajelzés a szolgáltatások felhasználóinak
- kutatások és konzultációs eljárások, melyekben a gyermekek kutatók és/vagy válaszadók
- a gyermekek tanácsainak részvétele az egészségügyi szolgáltatásokkal kapcsolatos olyan indikátorok és sztenderdek kidolgozásában, melyek tiszteletben tartják a gyermekek jogait
- a gyermekek bevonása a kutatásokba és azok monitorozásába

(Unicef – Save the Children, Minden gyermeknek joga van a véleménye meghallgatásához, 2009, 98. oldal https://www.refworld.org/docid/4ae562c52.html)

Erőszakos helyzetekben:

Az államokat arra bátorítják, hogy:

- az erőszakkal szembeni fellépést szolgáló jogi, oktatási és egyéb intézkedések meghozatala és végrehajtása során beszéljenek a gyermekekkel, ideértve a marginalizált és hátrányos helyzetű csoportokat (ENSZ Gyermekjogi Bizottság 12. számú átfogó kommentárja, A gyermek meghallgatáshoz való joga 2009 https://www.refworld.org/docid/4ae562c52.html)
- tegyék lehetővé a gördülékeny hozzáférést az olyan egyénekhez és szervezetekhez, amelyekhez a gyermekek bizalommal és biztonsággal fordulhatnak (ENSZ Gyermekjogi Bizottság 12. számú átfogó kommentárja, A gyermek meghallgatáshoz való joga 2009 https://www.refworld.org/docid/4ae562c52.html)
- hozzanak létre független hatóságokat annak érdekében, hogy valamennyi kiskorú jogai érvényesüljenek, különösen az erőszakot elszenvedetteké (ENSZ Gyermekjogi Bizottság 13. számú átfogó kommentárja (2011), A gyermek joga az erőszak minden formájától való védelemhez)

3. példa

Az Európa Tanács „Mondd el valakinek, akiben megbízol!" (https://www.coe.int/en/web/children/tell-someone-you-trust[BJ1]) című videója gyermekközpontú nyelvezettel közelíti meg a szexuális bántalmazás jelenségét, **arra bátorítva a gyermekeket, hogy mondják el valakinek, ha erőszakot szenvedtek el.**

4. példa

Az Európa Tanács „az Italianaire" (https://www.youtube.com/watch?v=wiQ3hTqyPos[BJ2]) című rajzfilm videóját öt fiatal felnőtt részvételével készült, akik Egyiptomból származnak és Olaszországban élnek. A videó – melynek létrejöttét a Save the Children segítette elő – célja, hogy felhívja a figyelmet és tájékoztassa a magas elvándorlási rátájú térségekben élő egyiptomi gyermekeket az Olaszországban élő egyiptomi hátterű migráns gyermekek **valódi életkörülményeiről**.

5. példa

Az Európa Tanács „Beat Bullying" elnevezésű videója (https://www.youtube.com/watch?v=e5sB7mndfrQ[BJ3]) gyermekbarát tartalommal és nyelvezettel mutatja be a „bullying" jelenség hatásait és arra bátorítja a gyermekeket, hogy vállaljanak vezető szerepet a bullying elleni küzdelemben.

„A gyermekek és a fiatalok meghallgatáshoz való joga megelőző szerepet játszhat az erőszak bármely formájának kialakulásában akár otthon, a családban, az iskolákban vagy az intézményekben."

(Európai Gyermekjogi Ombudsmanok Hálózata (ENOC), Állásfoglalás a gyermekekkel szembeni erőszakról, 2015: http://enoc.eu/wp-content/uploads/2014/12/ENOC-position-statement-on-Violence-against-children-2015-FV.pdf)

A felnőtteknek garantálni kell a gyermekek részvételét a döntéshozatali eljárásokban, és minden lehetséges óvintézkedést meg kell hozniuk annak érdekében, hogy csökkentsék az erőszak kockázatát vagy bármely más negatív következményt, amely magából a részvételből fakad. (ENSZ Gyermekjogi Bizottság 12. számú átfogó kommentárja, 2009, A gyermek meghallgatáshoz való joga https://www.refworld.org/docid/4ae562c52.html)

Következtetések

Integrált megközelítés szükséges, amely magában foglalja:

- a gyermekekkel szembeni erőszak megelőzését (nem kizárólag a már megtörtént erőszak elleni intézkedéseket)
- a gyermekjogok tiszteletben tartásának előmozdítását
- a gyermekekkel kapcsolatba kerülő szakemberek számára a védelemről és a részvételi jogokról szóló speciális képzéseket
- a gyermekek számára gyermekbarát szolgáltatások létrehozását és működtetését
- a help line-ok és help deskek könnyen hozzáférhetővé tételét az erőszakot átélt gyermekek számára

Forrás: Európa Tanács, A gyermekek elleni erőszakkal szembeni védelemre irányuló integrált nemzeti stratégiákkal kapcsolatos szakpolitikai irányelvek, 2009 (https://www.coe.int/en/web/children/integrated-strategies) Lásd még: Európai Gyermekjogi Ombudsmanok Hálózata (ENOC), Állásfoglalás a gyermekekkel szembeni erőszakról, 2015: (http://enoc.eu/wp-content/uploads/2014/12/ENOC-position-statement-on-Violence-against-children-2015-FV.pdf)

„A gyermekeknek egyedülálló tudásuk van az életükről, a szükségleteikről és aggodalmaikról és közvetlen tapasztalataikból is leszűrnek gondolatokat és véleményeket. Azok a döntések lesznek hitelesebbek, hatékonyabbak és fenntarthatóbbak, amelyeket a gyermekek tudatosan, saját elhatározásukból hoznak."

Forrás: Save the Children Alapítvány, Minden gyermeknek joga van a véleménye meghallgatásához, az ENSZ Gyermekjogi Bizottság 12. számú átfogó kommentárjával kapcsolatos iránymutatás, London, 2011: https://www.refworld.org/docid/4ae562c52.html)

[BJ1]rossz link volt, javítottam, de magyarul nincs meg, csak angolul.

[BJ2]csak olaszul van meg, angol felirat sincs hozzá.

[BJ3]Nem volt link, ezt találtam , de nincs meg magyarul a videó.

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Ombudsman szerepe és működése

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GYERMEKJOGI OMBUDSMAN

A gyermekjogi ombudsman kompetenciáját számos törvény határozza meg, amely számos intézkedésre jogosítja fel: meghallgatás, részvétel, tájékoztatás és figyelemfelkeltés, együttműködés, véleményezések, javaslatok és rendeletek előkészítése. A gyermekjogi ombudsmanok vezető szerepet töltenek be a gyermekjogi intézkedések terén és hallatják a gyermekek hangját, akik gyakran láthatatlanok/némák maradnak.

https://www.youtube.com/watch?v=jWiE2jHX5yE.

Gyermekjogi ombudsman összefoglalva:

- ellenőrzi a gyermekjogi egyezmény kapcsán beadott kérelmeket az országban
- segíti a gyermekjogok terjesztését
- gyermekjogi sérelmét vélve jelenti az illetékes hatóságoknak
- biztosítja a fiatalkorúak jogaikhoz való hozzáférését
- véleményt nyilvánít szabályalkotási javaslatok kapcsán fiatalkorúak jogainak védelmében és a téma fejlesztése éreékben ebben a fejlődő korszakban

Még pontosabban a garanciális hatóság (gyermekjogi ombudsman) hatásköre két területre bontható: 1) Az első általános jellegű intervenciós tevékenység a gyermekjogok terjesztése. A gyermekjogi ombudsman, pl. támogatja az általános szabadságjogok megerősítését gyermekek és fiatalok számára, támogat minden kezdeményezést, ami felismeri ennek szükségességét, az ENSZ gyermekek jogairól szóló egyezményhez benyújtott kérelmeket ellenőrzi, a helyi hatóságok kérésére véleményt nyilvánít, javaslatokat és megfigyeléseket tesz a törvények, rendelkezések és egyéb hatósági intézkedések során, amelyek hatással lehetnek gyermekekre és fiatalokra.

2) A második intervenciós tevékenység speciálisan a bajba jutott gyermekek helyzetére reflektál.

A gyermekjogi ombudsman elfogad bejelentéseket fiatalkorúaktól is (https://www.youtube.com/watch?v=Nt2YcFHkdqA), családoktól, iskoláktól, szervezetektől, intézményektől, olyan ügyekben, amely gyermekek jogait sértheti, jelenti az illetékes hatóságoknak az esetet, kapcsolódó tényeket begyűjti, nem hagyományos eszközökkel is, amelyhez hozzájárult, közintézmény, magánszemély és a gyermek is.

A gyermekjogi ombudsman modus operandi nem vezet nyomozásokat, nem szankcionál és nem ír elő intézkedéseket. A „Guarantorok" szerepe a morális meggyőzésben rejlik, amelyet kifejt a közvéleményre (politikai döntéshozókra, helyi hatóságokra, szociális szevezetekre, igazságügyi szolgáltatókra) és privát entitásokra (szülők, 3. szektor képviselői), mint garanciális hatóság. Ezáltal a gyermekjogi ombudsman javasolhat az illetékes hatóságoknak támogató és helyreállító intézkedéseket,

A gyermekjogi ombudsman működhet nemzeti és lokális szinteken is.

Európában az Európai összefogás gyerekek és serdülők védelmében hálózata („guarantorok") évente találkozik, hogy megvitassa a közös érdekeket és megossza a mintákat.

(https://enoc.eu/?page_id=174)

A nemzeti hatóságok folyamatosan együttműködnek a nemzetközi hálózattal a gyermekek védelméért, nemzetközi civil szervezetekkel és intézményekkel együtt a gyermekek jogait érvényesítik. A közös együttműködés különböző alanyokkal segíti a hatóságokat gyermekek szükségleteinek megfelelő beadványokat készíteni.

A „Guarantorok" az erőszak, rossz bánásmód jelenségére fókuszálnak és avatkoznak közbe fiatalkorúak esetén (pszichés rossz bánásmód, fizikai abúzus, erőszak, szexuális abúzus, elhanyagolás, asszisztált erőszak), ENOC álláspontja a „gyermekek elleni erőszakról".

http://enoc.eu/wp-content/uploads/2014/12/ENOC-position-statement-on-Violence-against-children-2015-FV.pdf

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Gyermekek részvétele

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Egy önkéntes gyám tapasztalata

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Önkéntes gyám, mint a kísérő nélküli kiskorú hangja

Sok gyermek kényszerül arra, hogy elhagyja országát és távol otthonától élje meg a gyermekkort, családjától elszakítva, család nélkül, ami nem grantálja biztonságát.

Nagy részük a menekülés során vagy családjukat elhagyva traumatikus élményeket élt át.

Az Európai Parlament és Tanács rendelete, 2011/95/EU, a kísérő nélküli kiskorúakat az alábbi szerint határozza meg: kísérő nélküli kiskorú az, aki felnőtt kíséret nélkül érkezik egy adott tagállamba, függetlenül a tagállam elfogadja törvényesen vagy se, amíg nem veszi gondjaiba felnőtt gondviselő, addig kísérő nélküli kiskorú, aki kíséret nélkül érkezett a tagállamba.

Egyre több európai országban tapasztalható az önkéntes gyám. Önálló állampolgár, aki magasan képzett és felkérték, hogy legyen az országba érkező kísérő nélküli kiskorúak törvényes képviselője, hogy védelmezze érdekeiket, meghallgatásukat biztosítsa és szükségleteiket kielégítse. Az önkéntes gyám intézménye más szavakkal képviseli az aktív állampolgárságot, így a fiatalkorúak szociálpolitikai eszköze.

Carlo Infuso, torinoi ügyvéd leírja tapasztalatait, mint önkéntes gyám:

"V-vel, a gyámoltammal, teljesen hétköznapi helyzetben lettem bemutatva vendéglátói által.

Az első bemutatkozás után fogalmam sem volt miről beszélgethetnénk. Elvittem a motoromon egy körre, kicsit beszélgettünk majd szép lassan felépült köztünk mára egy kapcsolat, ami kellemes, élvezhető és bizalmon alapul. V. elkezdheti életét Olaszországban végre. Megkapta a menekültjogot két évre, ezzel maradhat 18 éves kora után is. Engedélyt kérünk tanulmányai befejezésére. Végre megértette az olasz nyelvtanulás szükségességét saját maga és kapcsolatai számára, akiket rajtam keresztül jobban megismert. Felismerte a fontosságát pincér munkájának. Megtanulta pincérként hogyan hozza ki az ételt az asztalokhoz, hogyan készítsen el egy cappuccinot rajzzal a tetején, hogyan készítse ki az evőeszközöket jobbról és balról, készítse ki a vizet, borospoharakat, szalvétákat és így tovább. Szép lassan felfedezi a tanulás örömét.

Nagyon mókás fiatal tinédzser, aki megőrül a zenéért. Fülbevalót hord és trendi haja van, mint minden más fiúnak. Ami megdöbbentett gyámként, az hogy nem ellenkezett gyámkodó feladatommal. Amikor dönteni kellett, pl. abban, hogy mit tanuljon, V ezt mondta: Nincsenek szüleim, te vagy az olasz apám. Te döntöd el, mit tanuljak, mert tudom az biztos jó lesz, amit te döntesz. Pár hónappal később örülök annak, hogy V elmondhatja: Örülök, hogy ezt az iskolát választottuk, nagyon szeretem.

Képes voltam kis apró mindennapi dolgokkal magabiztosságát mások felé erősíteni, ami önbizalmat adott számára és ma V képes döntéseket hozni, több figyelemmel, tudatossággal és elkötelezettséggel, mint ezelőtt. Ez egy kapcsolat (gyám és gyámoltja között), ami alakulhat jól és rosszul is. Mi esetünkben jól alakult és fel tudtunk építeni valamit. Örömmel mondhatom, hogy most hétvégén V. a vendégünk otthonunkban és ő főz nekünk, nagyon örülünk neki.

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Teszt 6.2

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T6.2

5 points possible (graded)

1. Családon belüli erőszak esetén, tinédzser gyermek és szülők közötti konfliktusban:

- ○ bizalmas orvosi vizsgálathoz a hozzáférést biztosítani kell szülői beleegyezéssel, kortól függetlenül
- ○ bizalmas orvosi vizsgálathoz a hozzáférést biztosítani kell szülői beleegyezéssel, ha elég érett már
- ○ bizalmas orvosi vizsgálathoz a hozzáférést biztosítani kell szülői beleegyezés nélkül, függetlenül korától
- ○ bizalmas orvosi vizsgálathoz a hozzáférést biztosítani kell szülői beleegyezés nélkül, 14 év felett

2. EU-s gyermekek bukaresti nyilatkozata eszköz a gyermekek részvételét az európai intézményeknél és tagállamoknál ösztönözni:

- ○ meghallgatáshoz való jogot bírósági és más hatósági
- ○ részesülhessenek bizonyos védelemben, amit kor szerint megkülönböztetnek
- ○ részt vehessen az EU döntéshozatalában
- ○ információkat kommunikál határok nélkül, hatósági intézkedések nélkül

3. Amikor, a gyermek törvényesen nem képes egészségügyi beavatkozásokhoz nyilatkozni:

- ○ nem szabad eljárni
- ○ eljárhatunk törvényes képviselő nyilatkozata nélkül is
- ○ eljárhatunk törvényes képviselő nélkül, amennyiben a gyermek akaratával az megegyezik
- ○ nem szabad eljárni, amíg törvényes képviselője beleegyezik

4. Az Európa Tanács videója: „Oszd meg azzal, akiben megbízol" gyermekbarát módon foglalkozik az alábbi témával:

- ○ bully – kortárs erőszak
- ○ testi fenyítés
- ○ szexuális abúzus
- ○ erőszak tanúja

5. A gyermekjogi ombudsman hatásköre:

- ○ morális meggyőzés
- ○ nyomozás indítása
- ○ szankciók és megszorítások elrendelése
- ○ szabályozások

Invia You have used 0 of 2 attempts

Salva Show Answer

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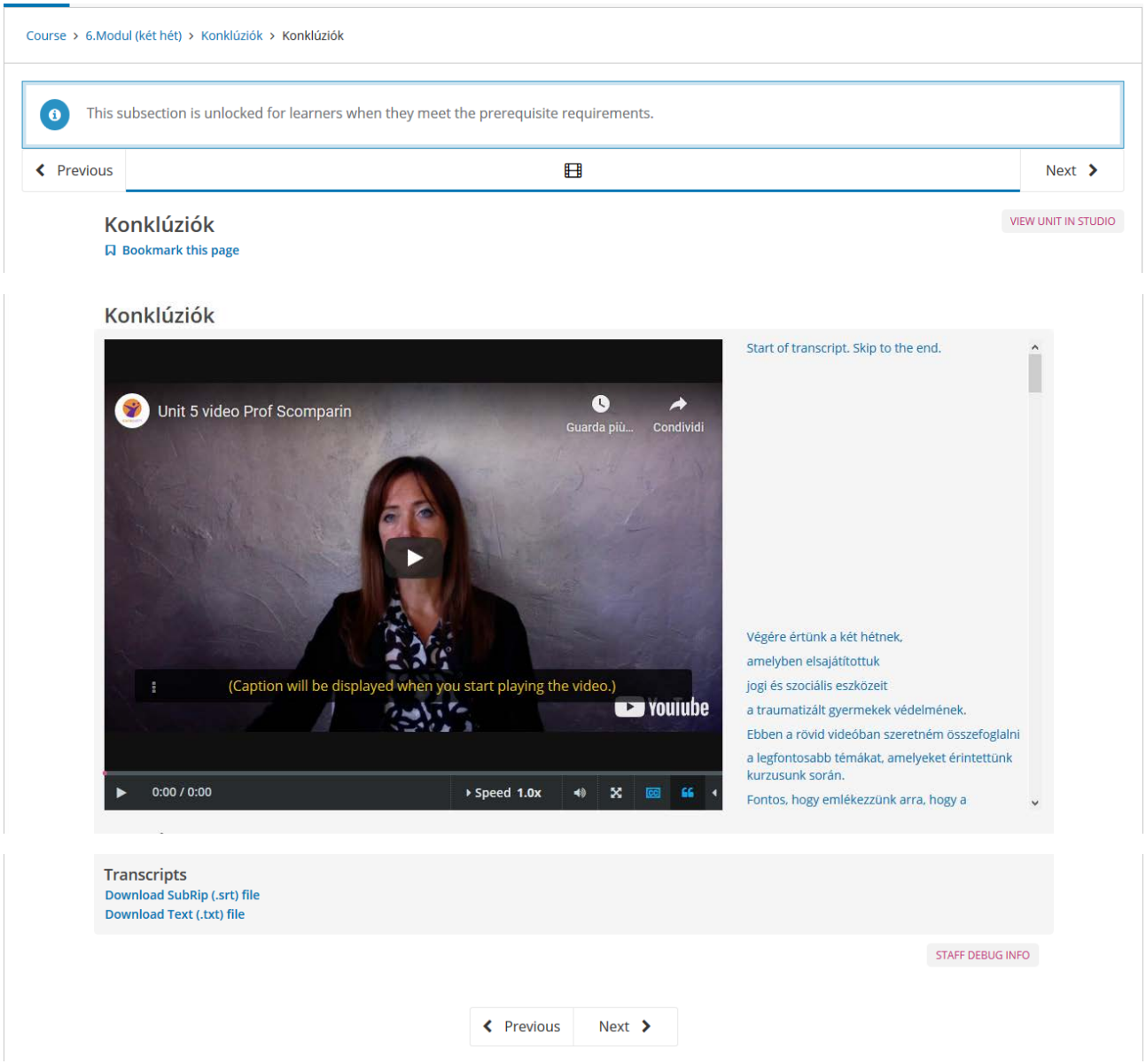

Transcript

Végére értünk a két hétnek,

amelyben elsajátítottuk

jogi és szociális eszközeit

a traumatizált gyermekek védelmének.

Ebben a rövid videóban szeretném összefoglalni

a legfontosabb témákat, amelyeket érintettünk kurzusunk során.

Fontos, hogy emlékezzünk arra, hogy a gyermekek jogainak elismeréséhez

rögös út vezetett.

Ennek világos bizonyítéka Mary Ellen Wilson esete,

amelynek pozitív kimenetele egy metodista misszionárius kitartásának

és egy ügyvéd intuíciójának köszönhetõ,
melyben a gyermeket úgy tudták
nem megfelelõ családi környezetébõl kiemelni,
hogy az állatkínzásra vonatkozó törvényi kereteket használták fel.
Eképesztõ!
Még megdöbbentõbb ugyanakkor
az Emberi Jogok Európai Bíróságának ügye a Brit Állammal,

amely 100 évvel késõbb történt.
Még
a 90-es évek elején sem volt törvényileg beágyazott egy államban,
hogy megfelelõen orvosolja a gyermek jóllétét problémás családi környezetben,

ezért az Európai Bíróság bírója az ügyet
az Egyetem Emberi Jogok Nyilatkozata alapján folytatta le, amely
kimondja az embertelen és méltatlan bánásmód tilalmát 3. cikkelyében.
Emlékezzünk arra,
hogy a nemzetközi és a nemzetek felett álló jog
hogyan mutatott rá államok törvényi hiányosságaira.

Emlékezzünk a New York- Egyezményre
vagy az Európa Tanács által létrehozott egyezményekre
vagy az Európai Unió intézkedéseire.
Csupán ezen intézkedéseknek köszönhetõ, hogy a gyermekek és fiatalkorúak
független autonóm joga és annak gyakorlása
elterjedt,
így ma,
már elmondhatjuk, hogy minden jogrendszerben általánossá vált.
Szintúgy megalapozottá vált,
hogy az állam felelõssége és kötelessége
minden gyermekbántalmazás során eljárni,

azt megakadályozni és az áldozatokat megfelelõ ellátásban részesíteni
a teljes pszicho-szociális felépülés érdekében.
Szükséges hangsúlyozni,
hogy a fiatal különleges jellemzõkkel bíró individuum:

személyisége még fejlõdésben van,
amit egy felnõtt általában nem,
ez a különleges bánásmód és figyelem kifejezetten
fontos, amikor gyermekbántalmazás vagy családon belüli erõszak áldozatáról
beszélünk.
Általánosságban elmondható,
hogy az általános emberi jogokat kiterjedtek a fiatalkorúakra
figyelembe véve azok speciális
igényeit.
Igaz, hogy a gyermek
véleménynyilvánításhoz való joga megvan.
Ugyanakkor az is igaz, hogy mégis a döntés eltérhet attól,
may
amit a gyermek akarataként kifejezett.

A negyedik fontos téma.
A traumatizált gyermek
felépülése néha ugyanolyan
fájdalmas, mint az
erõszak, amely érte az abúzus során.
Büntetjogi és polgárjogi eljárások
során több fontos célt is
figyelembe kell venni: megbüntetni az elkövetõket,
amennyiben az ítélet megszületik,
megakadályozni az újabb abúzust,
kompenzálni a kárt,
helyrehozni a megfelelõ családi környezetet.

Nem szabad elfelejteni, hogy az éremek van egy másik oldala is,
mégpedig,
hogy a gyermeknek minden fázison keresztül kell esnie
az eljárás során.
Elengedhetetlen a gyermek részvétele
az eljárások során
hiszen nem csupán részvételhez való joga érvényesül,
hanem fontos eszköze az igazságszolgáltatásnak is,
mivel véleményét kifejezve segítheti a
bíró döntését végsõ döntés meghozatalában.
Ugyanakkor, ahogy láttuk,
fenáll a másodlagos viktimizáció/retraumatizáció veszélye,
mivel
az eljárások során,
gyermek újra hallja és emlékezni kell a bántalmazás részleteire,

a nyilvánosság felé kiszolgáltatott

és a tárgyalás során közvetlen kapcsolat éri az elkövetõvel.
Mindezek releváns rizikót jelentenek.
Azt se felejtsük el, hogy miután elrendelték az örökbefogadást vagy
védelembe vették a gyermeket
milyen nehéz az új családhoz kapcsolódnia.
Paradox módon az elsõ trauma túllépéséhez a gyermeknek

megvan a veszélye annak, hogy szembe kell néznie
rengeteg új kisebb traumával.
A legfontosabb feladat maradt hátra.
Gyakran elõfordul, hogy az új jogok
érvényesüléséhez idõ és energia szükséges,
ez történt a gyermekek esetében is.
Ugyanakkor most,

hogy ezek a jogok már garantáltak
egy újabb épést szükséges megtennünk,
be kell látnunk, hogy a jog,
a nemzetközi és nemzetek felett álló jogok
egyedül nem elegendõek.
Ez csupán a kezdet,
az alap,
amelyre építkezhetünk.
A legfontosabb – ezen a területen
még inkább, mint máshol – hogyan alkalmazzuk a jogot
hatékony szociális intézkedések során.
A központi és helyi hatóságoknak
konkrét intézkedésekkel kell
a gyermekek jogait érvényesíteni.
Speciális szolgáltatásokba kell belefektetniük
a fiatalok számára,
mint ügyfélszolgálatok, támogató körök,
ellenõrzõ hatóságok.
Nem szabad elfelejtenünk
az önkéntesség fontos szerepét és a gyermekek jogait terjesztõ
szervezetek szükségességét sem,
amelyek alapjai
a hatékony és hatásos szociálpolitikai intézkedéseknek.
Központi intézkedéseknek megfelelõ
érzékenységgel kell kezelnie
a másodlagos viktimizáció csökkentését,
például, állítsanak fel
speciális meghallgató szobákat,
alkalmazzanak érzékeny ügyvédeket és bírókat,
biztosítsák a gyermek megfelelõ körülményeit a meghallgatásra
és nyújtsanak állandó pszichés segítségnyújtás
az eljárások során.

Természetesen a legfontosabb alapvetõ segítség ebben

ezen kurzus résztvevõi is, azok a szakemberek, akik kapcsolatban állnak

a gyermekekkel.

Ti

vagytok

a gyermekek védelmezõi,

akik segítenek az elsõdleges traumán kereszül jutni számunkra,

ti vagytok ott az eljárások során,

ti vagytok azok,

akik elviselhetõvé teszik azt,

ami sohasem lehet egyszerû vagy hétköznapi,

ti vagytok azok, akik ott vannak a gyermek számára az eljárások után,

akik biztosítják a csodálatos

felépülés lehetõségét ezen a nehéz úton

elérni a végsõ célt!

Végezetül, sok nehézség vár a gyermekre

bántalmazás során,

de ahogy próbáltuk megvilágítani

több eszköz áll rendelkezésünkre ahhoz, hogy túljuthasson ezeken a kihívásokon.

Kívánok sok sikert munkájuk során!

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Áttekintés

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Instrukciók a szakértői értékeléshez

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Könyvjelzőbe

Ebben a gyakorlatban a feladat, hogy elemezzen egy esetet (válasszon tetszés szerint) jogi, pszichológiai és/vagy tudomány kutatás szempontból. A válaszait a traumatudatos ellátás alapelvei tükrében tett meglátásai alapján adja meg.

1. Válaszait elkészítheti

• szövegként (csak adja meg válaszát a megfelelő területen) VAGY

• válaszait feltöltheti fájl formájában. Fontos megjegyzés – a fájl legyen .pdf formátumban, mérete legyen maximum 5 MB.

Amennyiben videóban válaszol, adja meg a videó linkjét, ahol értékelésre elérhető.

2. Minden tanulónak, miután leadta a saját válaszát, értékelnie kell más tanulóktól legalább egy választ. Ez szükséges része a gyakorlat elvégzésének.

Fontos megjegyzés – Ha fájlként feltöltött választ kell értékelnie, töltse azt le, és nyissa meg számítógépén vagy mobileszközén. A fájl legyen .pdf formátumú. Ha nem az, nevezze át a fájl, adjon neki .pdf végződést.

3. Utolsó lépésként munkatársaink értékelik a válaszait. Amint végeztek ezzel, az osztályzata azonnal elérhető lesz.

A feladat ehhez a részhez:

Elemezzen egy esetet (válasszon tetszés szerint) jogi, pszichológiai és/vagy tudomány kutatás szempontból.

Készítsen egy választ a választott esetről (ami lehet szöveges, videó, prezentáció, vagy egyéb formájú), a traumatudatos ellátás alapelvei szem előtt tartásával.

Fontos megjegyzés: Csak .pdf formátumú, maximum 5 MB méretű fájlokat töltsön fel.

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1. Esettanulmány

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A 13 éves R.-t a bíróság a helyi egészségügyi intézménybe küldi.

Általános iskolába jár, és 9 éves kora óra nevelőotthonban él.

Az első találkozóra az otthon nevelőjével jön. Érdeklődő, nyitott afelé, hogy megismerje az embereket, akikhez azért jött interjúra, hogy felvegyük kliensként, és igénybe vehesse a szolgáltatásunkat. Eleinte szociális, válaszol a kérdésekre, kapcsolódik az emberekhez, viccelődik és szimpatikus. Amikor elkezdünk beszélni arról, hogy miért jött az interjúra, összezavarodottnak tűnik: nem tudja, miért van itt, mit kéne csinálnia, hogy mit akarunk tőle, és válaszokat vár ezekre a kérdésekre. Zavarodottságot és különböző félelmeket fejez ki, pl. hogy még távolabb fog kerülni a szüleitől, hogy megbántja őket, vagy hogy valaki majd úgy dönt, hogy nem láthatja őket többé, stb.

A szülei némi külön töltött idő után ismét együtt élnek, csakúgy, mint amikor R. kikerült a családból. A fiú a szülei több veszekedésére emlékszik: nem jöttek ki jól egymással, és az anya, aki egy másik országból származik, többször megpróbált visszatérni a származási családjához. Amikor az anyja elment, R. sajnálta ezt, de örült is annak, hogy a szülei veszekedései egy időre így elcsitultak. Szereti a szüleit, és most is szívesen tölt időt velük.

Minden nap beszél velük telefonon, és hetente egyszer találkoznak, amikor a szülők meglátogatják őt a lakóotthonban.

Egy pár éve lakik ott, és jól van; habár szeretne hazamenni, nem tudja, hogy ez lehetséges-e.

Nem emlékszik jól arra a napra, amikor ideköltözött, de azt tudja, hogy az apja jött vele. Az anyja otthon maradt, sírt, R. pedig nagyon sajnálta őt. Az apa erősebb volt, ő kísérte el, és mint mindig, sok szóval látta el, de nem sírt.

R. először félt, amikor a lakóotthonba költözött, de kedves és vicces embereket ismert ott meg, akik segítettek neki, hogy kevésbé féljen, és hogy a többiekkel is könnyen összebarátkozzon.

R. akkor költözött az otthonba, miután a szülei egyik barátja szexuális erőszakot követett el ellene. Nem mondta el senkinek, de valahogy mégis kitudódott (R. nem tudja, hogyan), és a bíróságra került. Az illető férfi a szülei barátja volt, és gyakran látogatta a szülei lakását. A férfi kedvelte R.-t, és ő is fontos volt R.-nek; esténként a férfi gyakran olvasott neki meséket, és néha R. apja megkérte, hogy fektesse le ő R.-t.

Amikor azok a szörnyű dolgok történtek, és kiderültek, az apa elhozta R.-t a lakóotthonba, azért, hogy megvédje attól a férfitól.

R. nem igazán tudja, hogy is érez az egésszel kapcsolatban, csak annyit mond, hogy nagyon össze van zavarodva.

A lakóotthonban jól van, de néha kényszernek érzi, hogy betartson egyes szigorú szabályokat, amiktől mérges lesz, rosszul viselkedik, és megrongál tárgyakat; de embereket sosem bánt. R. főleg azt nem tudja elviselni, hogy ahhoz, beszélni tudjon a szüleivel, vagy találkozhasson velük, olyan szabályokat kell betartania, amiket nem ért. Ugyanakkor az otthonban érdekes dolgokat csinál (sportol is), és úgy érzi, jól kapcsolódik a többiekhez. Szereti, hogy ott vannak körülötte a barátai, de néha szeretne csak egyedül lenni és több személyes térrel rendelkezni.

R. különleges kapcsolatot alakított ki az egyik nevelővel, aki odafigyel rá, ami nagyon tetszik R.-nek.

R.-nek sok félelme van azzal kapcsolatban, hogy mi lesz, ha otthagyja a nevelőotthont. Nnem azért, mert már el kéne mennie, hanem mert tudja, hogy az előbb-utóbb el fog jönni. Nem akarja, hogy a szülei megtudják, hogy fél ettől, mert attól fél, ezzel elszomorítaná őket, és azt gondolnák, hogy nem szereti őket.

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2. Esettanulmány

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B. 15 éves tanuló, van egy fiatalabb testvére; az anyja üzletasszony, az apja munkanélküli; egy nagyváros külvárosában él a négy tagú család.

B. súlyos, elviselhetetlen, a teste alsó részét (lábak és alhas) érintő fizikai fájdalom miatt jön konzultációra, amire nem találtak semmilyen szervi, orvosi indokot (a szülei több szakorvossal is kivizsgáltatták).

A fájdalom ellehetetleníti, hogy kielégítő, a korának megfelelő életet éljen: nem tud bejárni az iskolába, ezért fenn áll a veszélye, hogy megbukik, és évet kell ismételnie; illetve nagyon nehéz megoldania, hogy időt töltsön a barátaival vagy részt vegyen valamilyen sporttevékenységben, mert a terveit bármikor keresztülhúzhatja a hirtelen fellépő éles fájdalom.

Az első találkozásunkkor rendetlennek, nagyon befelé fordulónak tűnik (szemét lesüti, csak pár szót suttog), görnyedten ül (az együtt töltött időnk során végig összekuporodva ül a széken). Azt mondja, azért döntött úgy, hogy segítséget kér, mert tudja, hogy rendeznie kell ezt a problémát, ami “a házba bezárva tartja”.

Igen nagy tudást mutat dolgokról, nagyon kíváncsi, intelligenciája éles – mindez valahogy kontrasztban van a merev, görnyedt testtartása kisugárzásával.

Azt mondja, fogalma sincs, mi okozhatja a tüneteit, amik körülbelül az első menstruációja óta kínozzák.

Elmondása szerint nagyon jó kapcsolata van a családtagjaival, viszont kevés barátja van, és nehézséget okoz neki csoportokban, közösségben lenni, legyen szó kortársairól vagy felnőttekről. Nagyon szeret olvasni, zenét hallgatni és autodidakta módon több nyelvet tanul.

A pszichoterápia első évében a súlyos tünetei okának feltárásán dolgozunk és arra fókuszálunk, hogy megerősítsük őt. A fájdalom csökken és enyhül, egy idő után már csak a menstruációja előtt jelentkezik, és így csak havi 2-3 napot veszít az iskolából. De továbbra sem tudunk semmit a tünet okáról, illetve gyakori pánikrohamoktól is szenved.

A B.-vel való személyes munka mellett rendszeresen találkozom az egész családdal, akik, habár még mindig nagyon aggódnak B. miatt, elismerik, hogy nagy fejlődésen ment keresztül, és képes volt erőt meríteni magából ahhoz, hogy újra kielégítő életet élhessen.

Két év pszichoterápia után B. megtanulja kezelni a pánikrohamait, amik egyre ritkábbak, és többféle stratégiája is van a fájdalom kezelésére (autogén tréning, jóga, vezetett vizualizációk, légzéstechnikák).

Ám egy alkalommal, amikor olyan filmet néz, aminek az egyik jelenetében valaki ellen szexuális erőszakot követnek el, hirtelen erős fájdalmat érez, amit a következő ülésünkön úgy ír le, mint egy “belső áramszünet”.

Elkezdjük feltárni ezt az érzést, és megközelíteni azokat a képeket, amiket ő eleinte “álomfoszlányokként” ír le; amik később homályos képekké válnak, és nehéz eldönteni, hogy emlékek, vagy könyvekből, filmekből vett fantáziák.

B. belső időzítését és kapacitását tiszteletben tartva, erőltetés nélkül haladva, a védőmechanizmusai és érthető félelmei tiszteletben tartásával, de mindeközben őt és belső erőforrásait folyamatosan támogatva, B. lassan visszaemlékszik valakire, akire a szülei kiskorában (3-7 éves kora között) rábízták, hogy vigyázzon rá – aki szexuálisan bántalmazta őt.

Az emlék megjelenése lehetővé teszi nem csak azt, hogy a bántalmazó ellen eljárást indíthassanak és biztonságos környezetet hozhassanak létre a lány számára (a bántalmazó alkalmanként még mindig kapcsolatban volt a családdal), hanem azt is, hogy megértsük az addig csak kezelt, de nem értelmezett pszichés és fizikai szenvedésének az okát.

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3. esettanulmány

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C. F. 15 éves, a helyi közösségi szolgálat utalta be a helyi kórházba.

Rendszertelenül jár az iskolába, eredményei rosszak, és nagy mennyiségű pszichotróp szer fogyasztása miatt került be a kórház sürgősségi osztályára.

Az elsősegély-beavatkozás után hazaküldték azzal a feltétellel, hogy az egész családnak részt kell vennie egy támogatási, segítségnyújtási programban.

A fiatal dühös, nem akar részt venni az interjúban, sem beszélni a helyzetéről, és nem érti, miért lett ide beutalva. Azt belátja, hogy hülyeséget csináltak a barátjával, de azt mondja, biztosan nem fogják megismételni.

Miután empatikus, megértő módon állunk hozzá a félelemhez, amit a nagy mennyiségű gyógyszer bevételekor érzett (az esetre ő "nagy baromságként" utal), és elmondjuk neki az általunk felajánlott szolgáltatás feltételeit, a lány megnyílik, és megosztja velünk a történetét, a törékenységét. Elmondja, hogy a szülei pár hónappal korábban szétváltak – ugyan még nem hivatalosan – és az anyja elköltözött otthonról.

C. elmondja, hogy az anya távozása számára pozitív fejlemény, mivel nagyon nehéz vele a kapcsolata, és az, hogy az anyja nincs ott, megnyugtatóan hat rá; ugyanakkor ez azt is jelenti, hogy többé nincs senki, aki segítsen neki megcsinálni dolgokat. Sokáig, amikor C. általános és középiskolába járt, az anyja mindig mérges volt vele, verte és inzultálta, ha C. valamit nem jól csinált. Az anya pszichés és fizikai erőszakkal büntette őt, a tipikus inzultusok a következők voltak: "hülye", "te kurva", stb. Ám az utóbbi egy évben C. már nem csak passzívan elszenvedte a rossz bánásmódot, hanem reagált az anyja támadásaira, vitába szállt vele, sőt, olykor fizikai verekedésbe is bonyolódtak. Az anyjával szembeni új, aktív viselkedését kielégítőbbnek találta a korábbinál. Az apja egész nap munkában van, C. szerint jó ember, de csak este ér haza, és nem érdeklik a családban zajló dolgok, valószínűleg azért, mert nagyon fáradtan ér haza a munkából. A viszony a szülők között elhidegült. A családtagok nem végeznek együtt semmilyen közös tevékenységet. A vasárnapokat is otthon töltik, a nagynénivel (az apa nővére). C. számára a nagynéni fontos felnőtt, fontos viszonyítási pont.

Amikor C. 13 éves volt, egy barátjával együtt elkezdtek cigarettázni és marihuánát fogyasztani az iskolában. Tetszett neki az ellazulás és szórakozás érzése, amit a marihuána adott neki, és hamarosan egy olyan csoporttal kezdett időt tölteni, akiket szintén érdekelt a füvezés.

Több hónapos folyamatos otthoni nehézségek után az anya egyre kevésbé volt jelen, délutánonként elment otthonról, ami lehetővé tette C. számára, hogy áthívja barátait. Eleinte örült ennek az új helyzetnek, úgy érezte, ezzel javult az élete. Aztán egy nap, miközben egy barátjával épp mentek valahova, meglátta az anyját egy másik férfival egy bár előtt, egyértelműen intim kapcsolatot sugalló helyzetben.

Ezen a ponton, ahogy C. mondja, olyan helyzetben találta magát, hogy bármit kicsikarhat az anyjától, mert az nem térhet ki a kérései elől: pl. C. haza akarja vinni a barátját és egyedül akar maradni vele anélkül, hogy az anyja zavarná őket. Az anya eleinte nem akar belemenni, de amikor C. megzsarolja, hogy különben elmondja az apjának az anya házasságon kívüli viszonyát, az anya kénytelen eleget tenni a kéréseinek. C. követelései és az anya engedményei egyre nagyobbak: C. haza akar vinni bárkit, akit akar; otthon dohányzik és füvezik; szabadon vehet sört, és bármennyi pénzt megkap, amit kér. Az anya megadja, amiket kér, de ugyanakkor C. rengeteg haragot, szidalmat és utálatot is kap tőle.

Az apa nem tud semmiről. Miközben erről beszél, C. egy fajta szomorú diadal és nagy harag érzéseit mutatja.

Ez nagyjából egy évig így megy, szeptemberig, amikor az apa rájön, hogy a felesége megcsalja, és megkéri, költözzön el otthonról. Innentől C. még szabadabb, és az apja munkából hazatértéig minden nap egyedül van otthon; egyre többször késik az iskolából, vagy be sem megy, aztán egy nap, egy barátnőjénél a barátnővel együtt megtalálják a barátnő anyjának a gyógyszerét, és úgy döntenek, együtt beveszik. Ezután az apát a barátnő anyja telefonon hívja, hogy a lányát és C.-t mély alvásban, zavarodott állapotban találja, és a két lányt beviszik a sürgősségi osztályra.

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Peer review assessment

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FINAL EXAM

This assignment has several steps. In the first step, you'll provide a response to the prompt. The other steps appear below the **Your Response** field.

IN PROGRESS

1 Your Response

Enter your response to the prompt. You can save your progress and return to complete your response at any time. **After you submit your response, you cannot edit it.**

The prompt for this section

> Analyze the case (Choosing the Scenario you prefer) from a legal, psychological and/or scientific research point of view
>
> Prepare a contribution (which can take different forms such as: text, video, presentation .ppt) that contains the reflections of the participant in the light of the fundamental principles
>
> of Trauma Informed Care, about the chosen case.
>
> **Important note: Please upload only pdf files up to 5 mb**

Your response (optional)

Enter your response to the prompt above.

Save your progress THIS RESPONSE HAS NOT BEEN SAVED.

Sfoglia... Nessun file selezionato. Upload files

You may continue to work on your response until you submit it.

Submit your response and move to the next step

NOT AVAILABLE

2 Assess Peers

NOT AVAILABLE

3 Staff Grade

Your Grade: Not Started

MANAGE INDIVIDUAL LEARNERS VIEW ASSIGNMENT STATISTICS GRADE AVAILABLE RESPONSES

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Kérdőív

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KÉRDŐÍV

	0. Not at all	1	2	3	4. Very much	5. I do not know
1. Are the contents consistent with educational aims?	○	○	○	○	○	○
1. Are the contents of the lesson presented in an understandable way?	○	○	○	○	○	○
1. Is there enough time to read, listen and watch the educational materials?	○	○	○	○	○	○
1. How useful do you find the topics explored?	○	○	○	○	○	○
1. How applicable do you think the themes of the lesson are?	○	○	○	○	○	○
1. Would you suggest to a friend/colleague/friend/knower this lesson?	○	○	○	○	○	○
1. How would you assess the experience of this online training?	○	○	○	○	○	○
1. How would you rate the level of the CarePath course?	○	○	○	○	○	○

carepath

Empowering public authorities and professionals towards trauma-informed leaving care support

Training and assessment material
ANNEX 1
–
Hungarian Version

Co-funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

COUR EUROPÉENNE DES DROITS DE L'HOMME
EUROPEAN COURT OF HUMAN RIGHTS

CASE OF Z AND OTHERS v. THE UNITED KINGDOM

(Application no. 29392/95)

JUDGMENT

STRASBOURG

10 May 2001

In the case of Z and Others v. the United Kingdom,

The European Court of Human Rights, sitting as a Grand Chamber composed of the following judges:

Mr L. WILDHABER, *President*,
Mrs E. PALM,
Mr C.L. ROZAKIS,
Mr J.-P. COSTA,
Mr L. FERRARI BRAVO,
Mr L. CAFLISCH,
Mr P. KŪRIS,
Mr J. CASADEVALL,
Mr B. ZUPANČIČ,
Mrs N. VAJIĆ,
Mr J. HEDIGAN,
Mrs W. THOMASSEN,
Mrs M. TSATSA-NIKOLOVSKA,
Mr E. LEVITS,
Mr K. TRAJA,
Mr A. KOVLER,
Lady Justice ARDEN, ad hoc *judge*,

and also of Mr P.J. MAHONEY, *Deputy Registrar*,

Having deliberated in private on 28 June and 11 October 2000 and on 4 April 2001,

Delivers the following judgment, which was adopted on the last-mentioned date:

PROCEDURE

1. The case was referred to the Court, in accordance with the provisions applicable prior to the entry into force of Protocol No. 11 to the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention"), by the European Commission of Human Rights ("the Commission") on 25 October 1999 (Article 5 § 4 of Protocol No. 11 and former Articles 47 and 48 of the Convention).

2. The case originated in an application (no. 29392/95) against the United Kingdom of Great Britain and Northern Ireland lodged with the Commission under former Article 25 of the Convention by the applicants, Z, A, B, C and D, five British nationals, on 9 October 1995.

3. The applicants alleged that the local authority had failed to take adequate protective measures in respect of the severe neglect and abuse which they were known to be suffering due to their ill-treatment by their

parents and that they had no access to a court or effective remedy in respect of this. They relied on Articles 3, 6, 8 and 13 of the Convention.

4. The Commission declared the application admissible on 26 May 1998. On 6 September 1999, pursuant to the express wishes of D's adoptive parents, the Commission decided that D should no longer be an applicant. In its report of 10 September 1999 (former Article 31 of the Convention) [*Note by the Registry*. The report is obtainable from the Registry], it expressed the unanimous opinion that there had been a violation of Article 3 of the Convention, that no separate issue arose under Article 8, that there had been a violation of Article 6 and that no separate issue arose under Article 13.

5. Before the Court the applicants had been granted legal aid. The President of the Court acceded to their request not to have their names disclosed (Rule 47 § 3 of the Rules of Court).

6. On 6 December 1999 a panel of the Grand Chamber determined that the case should be decided by the Grand Chamber (Rule 100 § 1). The composition of the Grand Chamber was determined according to the provisions of Article 27 §§ 2 and 3 of the Convention and Rule 24. The President of the Court decided that in the interests of the proper administration of justice, the case should be assigned to the Grand Chamber that had been constituted to hear the case of *T.P. and K.M. v. the United Kingdom* ([GC], no. 28945/95, ECHR 2001-V) (Rules 24, 43 § 2, and 71). Sir Nicolas Bratza, the judge elected in respect of the United Kingdom, who had taken part in the Commission's examination of the case, withdrew from sitting in the Grand Chamber (Rule 28). The United Kingdom Government ("the Government") accordingly appointed Lady Justice Arden to sit as an *ad hoc* judge (Article 27 § 2 of the Convention and Rule 29 § 1).

7. The applicants and the Government each filed a memorial. Third-party comments were also received from Professor G. Van Bueren, Director of the Programme on International Rights of the Child, University of London, who had been given leave by the President to intervene in the written procedure (Article 36 § 2 of the Convention and Rule 61 § 3).

8. A hearing took place in public in the Human Rights Building, Strasbourg, on 28 June 2000 (Rule 59 § 2).

There appeared before the Court:

(a) *for the Government*

Ms S. McGRORY, Foreign and Commonwealth Office, *Agent*,
Mr D. ANDERSON QC, Foreign and Commonwealth Office,
Ms J. STRATFORD, Foreign and Commonwealth Office, *Counsel*,
Ms S. RYAN, Foreign and Commonwealth Office,
Ms J. GRAY, Foreign and Commonwealth Office,
Mr M. MURMANE, Foreign and Commonwealth Office, *Advisers*;

(b) *for the applicants*
Mr B. EMMERSON QC, *Counsel*,
Ms P. WOOD, Solicitor,
Mrs M. MAUGHAN, Solicitor,
Ms E. GUMBEL QC,
Ms N. MOLE, of the AIRE Centre, *Advisers*.

The Court heard addresses by Mr Emmerson and Mr Anderson.

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

9. The applicants are four full siblings:
– Z, a girl born in 1982;
– A, a boy born in 1984;
– B, a boy born in 1986;
– C, a girl born in 1988.

10. The applicants' parents were married in November 1981.

11. The family was first referred to social services in October 1987 by their health visitor due to concerns about the children and marital problems. Z was reported to be stealing food at night. Following the referral, a professionals' meeting, involving the relevant agencies, was held on 24 November 1987, at which it was decided that a social worker and health visitor should visit. The family were reviewed at a further meeting in March 1988 and as it appeared that concerns had diminished, the file was closed.

12. In September 1988 a neighbour reported that the children were locked outside the house for most of the day.

13. In April 1989 the police reported that the children's bedrooms were filthy. The family's general practitioner also reported that the children's bedrooms were filthy and that their doors were locked. The children's head-teacher, Mrs Armstrong, expressed concern in May 1989 and requested a case conference. In June 1989 the NSPCC (National Society for the Prevention of Cruelty to Children) and the emergency team made a referral after complaints by neighbours that the house was filthy and that the children spent most of the day in their bedrooms, rarely being allowed out to play, and crying frequently. In August 1989 the maternal grandmother complained to the social services about the mother's care and discipline of the children.

14. At a professionals' meeting on 4 October 1989, at which the social services, the applicants' head-teacher, the applicants' general practitioner

and health visitor attended, it was decided that no social worker would be allocated to the family. The school was to monitor the older children's weight and the health visitor was to continue to visit the family regularly. It was agreed that the problem was one of limited and neglectful parenting rather than a risk of physical abuse, and that the parents should be assisted to manage their responsibilities better.

15. In October 1989, whilst the applicants were on holiday, their house was burgled. On entering, the police found it in a filthy state. Used sanitary towels and dirty nappies were discarded in a cupboard and the children's mattresses were sodden with urine. At a professionals' meeting on 13 December 1989, the health visitor requested that the four older children be placed on the Child Protection Register as she felt that their mother could not offer consistent care. This suggestion was rejected. However, a social-work assistant, Ms M., was assigned to the family. It was not considered appropriate to convene a case conference at this stage. Prior to the meeting, Z and A had mentioned to the head-teacher that A had been hit with a poker. It was decided that this statement would be investigated.

16. At a professionals' meeting on 23 March 1990, an improvement was noted in respect of the cleanliness of the house, the children's bedding being clean save on two occasions. However, it was reported that Z and A were taking food from bins at the school. There was still considered to be cause for concern, especially since the birth of another child was expected.

17. At a professionals' meeting on 11 July 1990, the applicants' headmistress reported a deterioration in the children's well-being; Z and A were still taking food from bins and A was soiling himself. Ms M. was visiting weekly at this stage and said that she was checking the children's bedrooms. She had noted that the children ate at 4 or 4.30 p.m. and then did not eat again until the morning. The children were also sent to bed at 6 p.m. It was planned to give the applicant's mother further assistance through a voluntary agency.

18. In or about September 1990, A and B were both reported to have bruising on their faces. The police investigated after neighbours had reported screaming at the applicants' home but apparently found no signs of bruising. They reported to the social services that "the conditions of the house were appalling and not fit for [the] children to live in".

19. At a further professionals' meeting on 3 October 1990, the assistant social worker, Ms M., stated that she was concerned about the applicants' soiling and their mother's lack of interest. Apparently, the children were defecating in their bedroom and smearing excrement on their windows. The head-teacher expressed concern, particularly concerning the boys A and B, and stated that the children had described blocks of wood being placed against their bedroom doors. It was decided to continue monitoring the children.

20. At a professionals' meeting on 5 December 1990, a decision was made to arrange a case conference for January 1991 as a result of concern regarding the applicants' care and the state of their bedroom. Ms M. considered that standards in the boys' bedroom had dramatically dropped. She found the room to be damp and smelly. A's bed was broken and had a metal bar protruding from it. The bedding was damp and grubby with soil marks.

21. In a report dated 24 January 1991, the headmistress stated that A was shabby, ill-kempt and often dirty and that he had been raiding the playground bins for apple cores. Z was pathetic, lacking in vitality and frequently and inexplicably tearful, becoming increasingly isolated from the other girls in her peer group with unfortunate incidents in which detrimental remarks were made about her appearance. B presented as withdrawn, pathetic and bedraggled. He regularly arrived cold, was frequently tearful and craved physical contact from adult helpers. He also appeared to crave for food. She concluded that they were still concerned that the children's needs were not being adequately met and that home conditions and family dynamics were giving reasons for concern.

22. At the case conference held on 28 January 1991, Ms M. stated that the boys' bedroom had no light, carpet or toys and that their bedding was wet, smelly and soil-stained. Their mother did not change the beds. Their head-teacher stated that Z was tearful and withdrawn, A had been raiding school bins and was often dirty, and B was very withdrawn, craved attention and was ravenously hungry. The chairman of the conference concluded that, despite the many concerns about the parenting of the applicants and the conditions in the home, there was little evidence to support going to court. It was felt that the parents were not wilfully neglecting their children and, bearing in mind their own poor upbringing, it was considered that the applicants' parents were doing what they could and that continued support was required to try and improve the situation. It was decided not to place the children on the Child Protection Register.

23. On 5 March 1991 B was found to have “unusual” bruises on his back.

24. At a later social services meeting in April 1991, no change to the children's living conditions was noted. The head-teacher stated that Z and A were still taking food from bins and that A was becoming more withdrawn. Ms M. reported that the mother had stated that the children were taking food from the park bins on the way to school.

25. In July 1991 the applicants' mother informed social services that the children would be better off living in care. On 12 August 1991 the social services received a phone call from a neighbour who stated that the children were frequently locked outside in a filthy back garden, that they constantly screamed and that they were kept for long periods in their bedrooms where they smeared faeces on their windows. The maternal grandparents later told

the guardian *ad litem* that Z, who was treated by her mother as a little servant, was expected to clean the excrement from the windows.

26. From 19 to 28 August 1991, the three older children spent some time with foster carers in respite care. The foster carers reported that A did not know how to wash, bathe or clean his teeth on arrival. He wet his bed every night and stole food from his brother. B was described as being "very frightened. He could not understand how he could play in the garden and the door was left open for him to come back in, he expected to be locked out". He also had to be taught to use the toilet properly and to clean himself.

27. At a professionals' meeting on 18 September 1991, Ms M. stated that the conditions in which the boys were sleeping were deteriorating. The mattresses in the boys' bedroom were ripped and the springs were coming through. The boys were stealing food, and C had also been seen to do this. Their mother stated that she could not control them. It was decided not to arrange a child-protection meeting but to carry out a monthly weight check on the three older children at school, and for the health visitor to check the weight of the two younger children. It was also decided to arrange respite care for Z, A and B in the holidays as well as on one weekend in four.

28. In November-December 1991 C was found to have developed a squint. His mother failed to keep appointments at the eye-clinic over the following months.

29. At a professionals' meeting on 21 November 1991, it was reported that the applicants' mother had said that she could not control the applicants' behaviour which consisted of refusing to go to bed when asked and stealing food. It was considered that the home was in an acceptable condition, though the boys' room still needed attention. The children's weights were recorded. It was noted that Z had put on 2 lb in the previous two months whereas she had only put on 2.5 lb in the preceding two years. A had only put on 3 lb in a year. B had put on 0.5 lb in a year and was on the 50th centile for height. C was on the 25th centile for weight. There was a discussion about the three elder children being accommodated by the local authority to allow the mother "to get back on her feet". The social services considered a six-week period whilst the general practitioner envisaged a period of eighteen to twenty-four months.

30. In December 1991 a social worker was introduced to the applicants' mother with a view to assisting her with shopping, budgeting and cooking.

31. Z, A and B were accommodated by volunteers between January and March 1992, and showed to have gained weight. In March and again in April, their mother asked if the boys, A and B, could be placed for adoption.

32. On 14 January 1992 C started to attend a nursery group at a family centre. She was noted to be unsocialised, lacking in confidence, unable to share, and with poor speech.

33. At a further professionals' meeting on 9 March 1992, it was decided that further respite care would be considered. The children's weights were noted, increases being seen for Z, A and B.

34. The children's parents divorced in April 1992.

35. At another professionals' meeting on 30 April 1992 it was decided that the applicants' mother's request that A and B be placed for adoption be followed up. The headmistress voiced concern over the fundamental pattern of the mother's care of the children, in particular in relation to Z's role in the home and the mothering role which she played. Ms M. reported that conditions were deteriorating for A and B.

36. On 10 June 1992 the applicants' mother demanded that the children be placed in care as she could not cope. She stated that if they were not removed from her care she would batter them. The applicants were placed in emergency foster care. The applicants were entered onto the Child Protection Register under the categories of neglect and emotional abuse after a child-protection meeting on 22 June 1992.

37. The applicants were all fostered separately. Initially, Z was noted to have dirty, ill-fitting clothes. She stated that she did not like living with her siblings as she did not like having to look after them all the time. A wet the bed every night, shunned physical contact and suffered from nightmares. B did not know how to use the toilet or toilet paper. C bonded very quickly with her foster parents.

38. On 8 October 1992 the local authority decided to seek care orders in respect of the children. Interim care orders were made on 7 December 1992.

39. A guardian *ad litem*, who was appointed on 18 January 1993, recommended that all the applicants should be the subject of care orders in order to protect them from further harm. She stated that there was "an abundance of evidence that the children have been subjected to physical and mental ill-treatment". She noted that their health had also been neglected by their parents who frequently missed appointments with opticians and doctors.

40. All the applicants were seen by Dr Dora Black, a consultant child psychiatrist, in January 1993. Dr Black stated that the three older children were all showing signs of psychological disturbance. Z was exhibiting signs of serious depressive illness and had assumed responsibility for her family and for its breakdown. Her mother's behaviour towards her was described as cruel and emotionally abusive. A and B, who suffered from nightmares, were both identified as showing signs of post-traumatic stress disorder and A was also chronically under-attached. Dr Black noted that all children had been deprived of affection and physical care. She described their experiences as "to put it bluntly, horrific", and added that the case was the worst case of neglect and emotional abuse that she had seen in her professional career. In her opinion, social services had "leaned over backwards to avoid putting these children on the Child Protection Register

and had delayed too long, leaving at least three of the children with serious psychological disturbance as a result".

41. Full care orders were made in respect of the applicants on 14 April 1993 by Judge Tyrer sitting at Milton Keynes County Court.

42. In June 1993 the Official Solicitor, acting as the applicants' next friend, commenced proceedings against the local authority claiming damages for negligence and/or breach of statutory duty arguing that the authority had failed to have regard to their welfare as was required by statute and should have acted more quickly and more effectively when apprised of their condition. It was argued that the local authority's failure to act had resulted in psychological damage. The application was struck out as revealing no cause of action, by Mr Justice Turner on 12 November 1993.

43. The applicants appealed to the Court of Appeal, which, on 28 February 1994, upheld the decision of Mr Justice Turner to strike out the application.

44. The applicants appealed to the House of Lords. On 29 June 1995 the House of Lords rejected their appeal, finding that no action lay against the local authority in negligence or breach of statutory duty concerning the discharge of their duties relating to the welfare of children under the Children Act 1989 in respect of child care. The case is reported as *X and Others v. Bedfordshire County Council* [1995] 3 All England Law Reports 353.

45. Lord Browne-Wilkinson gave the leading judgment. In respect of claims for breach of statutory duty, he stated, *inter alia*:

> "... My starting point is that the Acts in question are all concerned to establish an administrative system designed to promote the social welfare of the community. The welfare sector involved is one of peculiar sensitivity, involving very difficult decisions how to strike the balance between protecting the child from immediate feared harm and disrupting the relationship between the child and its parents. In my judgment in such a context it would require exceptionally clear statutory language to show a parliamentary intention that those responsible for carrying out these difficult functions should be liable in damages if, on subsequent investigation with the benefit of hindsight, it was shown that they had reached an erroneous conclusion and therefore failed to discharge their statutory duties. ...
>
> When one turns to the actual words used in the primary legislation to create the duties relied upon in my judgment they are inconsistent with any intention to create a private law cause of action."

46. As regards the claims that the local authority owed a duty of care to the applicants pursuant to the tort of negligence, Lord Browne-Wilkinson stated, *inter alia*:

> "I turn then to consider whether, in accordance with the ordinary principles laid down in *Caparo* [1990] 2 AC 605, the local authority ... owed a direct duty of care to the plaintiffs. The local authority accepts that they could foresee damage to the plaintiffs if they carried out their statutory duties negligently and that the relationship between the authority and the plaintiffs is sufficiently proximate. The third

requirement laid down in *Caparo* is that it must be just and reasonable to impose a common law duty of care in all the circumstances ...

The Master of the Rolls took the view, with which I agree, that the public policy consideration that has first claim on the loyalty of the law is that wrongs should be remedied and that very potent counter considerations are required to override that policy (see [1994] 4 AER 602 at 619). However, in my judgment there are such considerations in this case.

First, in my judgment a common law duty of care would cut across the whole statutory system set up for the protection of children at risk. As a result of the ministerial directions contained in 'Working Together' the protection of such children is not the exclusive territory of the local authority's social services. The system is inter-disciplinary, involving the participation of the police, educational bodies, doctors and others. At all stages the system involves joint discussions, joint recommendations and joint decisions. The key organisation is the Child Protection Conference, a multi-disciplinary body which decides whether to place the child on the Child Protection Register. This procedure by way of joint action takes place, not merely because it is good practice, but because it is required by guidance having statutory force binding on the local authority. The guidance is extremely detailed and extensive: the current edition of 'Working Together' runs to 126 pages. To introduce into such a system a common law duty of care enforceable against only one of the participant bodies would be manifestly unfair. To impose such liability on all the participant bodies would lead to almost impossible problems of disentangling as between the respective bodies the liability, both primary and by way of contribution, of each for reaching a decision found to be negligent.

Second, the task of the local authority and its servants in dealing with children at risk is extraordinarily delicate. Legislation requires the local authority to have regard not only to the physical well-being of the child but also to the advantages of not disrupting the child's family environment. ... In one of the child abuse cases, the local authority is blamed for removing the child precipitately; in the other for failing to remove the children from their mother. As the Report of the Inquiry into Child Abuse in Cleveland 1987 (Cmnd. 412) ('Cleveland Report 1987') said, at p. 244:

> '... It is a delicate and difficult line to tread between taking action too soon and not taking it soon enough. Social services whilst putting the needs of the child first must respect the rights of the parents; they also must work if possible with the parents for the benefit of the children. These parents themselves are often in need of help. Inevitably a degree of conflict develops between those objectives.'

Next, if liability in damages were to be imposed, it might well be that local authorities would adopt a more cautious and defensive approach to their duties. For example, as the Cleveland Report makes clear, on occasions the speedy decision to remove the child is sometimes vital. If the authority is to be made liable in damages for a negligent decision to remove a child (such negligence lying in the failure properly first to investigate the allegations) there would be a substantial temptation to postpone making such a decision until further inquiries have been made in the hope of getting more concrete facts. Not only would the child in fact being abused be prejudiced by such delay, the increased workload inherent in making such investigations would reduce the time available to deal with other cases and other children.

> The relationship between the social worker and the child's parents is frequently one of conflict, the parent wishing to retain care of the child, the social worker having to consider whether to remove it. This is fertile ground in which to breed ill-feeling and litigation, often hopeless, the cost of which both in terms of money and human resources will be diverted from the performance of the social service for which they were provided. The spectre of vexatious and costly litigation is often urged as a reason for not imposing a legal duty. But the circumstances surrounding cases of child abuse make the risk a very high one which cannot be ignored.
>
> If there were no other remedy for maladministration of the statutory system for the protection of children, it would provide substantial argument for imposing a duty of care. But the statutory complaints procedures contained in section 76 of the 1980 Act and the much fuller procedures now available under the 1989 Act provide a means to have grievances investigated though not to recover compensation. Further, it was submitted (and not controverted) that the local authorities Ombudsman would have power to investigate cases such as these.
>
> Finally, your Lordships' decision in *Caparo* [1990] 2 AC 605 lays down that in deciding whether to develop novel categories of negligence the court should proceed incrementally and by analogy with decided categories. We were not referred to any category of case in which a duty of care has been held to exist which is in any way analogous to the present cases. Here, for the first time, the plaintiffs are seeking to erect a common law duty of care in relation to the administration of a statutory social welfare scheme. Such a scheme is designed to protect weaker members of society (children) from harm done to them by others. The scheme involves the administrators in exercising discretion and powers which could not exist in the private sector and which in many cases bring them into conflict with those who, under the general law, are responsible for the child's welfare. To my mind, the nearest analogies are the cases where a common law duty of care has been sought to be imposed upon the police (in seeking to protect vulnerable members of society from wrongs done to them by others) or statutory regulators of financial dealing who are seeking to protect investors from dishonesty. In neither of these cases has it been thought appropriate to superimpose on a statutory regime a common law duty of care giving rise to a claim in damages for failure to protect the weak against the wrongdoer. ... In my judgment, the courts should proceed with great care before holding liable in negligence those who have been charged by Parliament with the task of protecting society from the wrong doings of others."

47. Z and C, the two girls, were meanwhile adopted. The boys, A and B, were initially in foster care. Following the breakdown of B's adoptive placement, he was placed in a therapeutic residential placement in July 1995. After two years, he was again placed with foster parents where he remained, attending school in a special-needs group. In January 1996, A was placed in a therapeutic community, where he stayed for two years. He apparently had a number of foster placements which broke down. Records indicated that he had been in twelve different placements in eight years. He is currently in a children's home.

48. In March 1996, applications were made to the Criminal Injuries Compensation Board (CICB) on behalf of all the children by the adoption society to whom the local authority had delegated certain responsibilities. It was claimed on behalf of Z that she had suffered severe neglect and chronic

deprivation which rendered it likely that specialist care would be necessary during her adolescence, a time where emotional repercussions of the abuse might become apparent; on behalf of A that he had suffered physical deprivation, emotional abuse, physical abuse and possible sexual abuse – he had suffered permanent physical scarring and was still receiving treatment from a child psychiatrist; on behalf of B that he had suffered extreme physical and emotional deprivation and shown signs of sexual abuse – he also had suffered permanent physical scarring and was receiving therapy; and on behalf of C that she had suffered extreme physical and emotional deprivation, and in addition that her need for eye treatment was not being met by her parents.

49. In February 1997, the CICB awarded 1,000 pounds sterling (GBP) to Z, GBP 3,000 to A and GBP 3,000 to B for injuries suffered between 1987 and 1992; it awarded GBP 2,000 to C for injuries suffered between 1988 and 1992. In a letter dated 20 May 1998 from the CICB to the Official Solicitor, it was stated:

> "The Board Member who assessed these cases recognised that the children were exposed to appalling neglect over an extended period but explained to their advisers that the Board could not make an award unless it was satisfied on the whole available evidence that an applicant had suffered an injury – physical or psychological – directly attributable to a crime of violence ... He was nevertheless satisfied, that setting aside 'neglect' the children had some physical and psychological injury inflicted upon them as enabled him to make an award to each child ..."

II. RELEVANT DOMESTIC LAW

A. Local authority's duties in respect of child care

50. Prior to the coming into force of the current legislation, the Children Act 1989, on 14 October 1991, the local authority's duty in respect of child care was governed by the Child Care Act 1980.

Sections 1 and 2 of the Child Care Act 1980 provided that:

> "1. It shall be the duty of every local authority to make available such advice, guidance and assistance as may promote the welfare of children by diminishing the need to receive or keep them in care.
>
> 2. (1) Where it appears to a local authority with respect to a child in their area appearing to them to be under the age of seventeen -
>
> (a) that he has neither parent nor guardian or has been and remains abandoned by his parents or guardian or is lost;
>
> (b) that his parents or guardian are, for the time being or permanently, prevented by reason of mental or bodily disease or infirmity or other incapacity or any other

circumstances from providing for his proper accommodation, maintenance and upbringing; and

(c) in either case, that the intervention of the local authority under this section is necessary in the interests of the welfare of the child, it shall be the duty of the local authority to receive the child into their care under this section."

51. Section 17 of the Children Act 1989 has since provided, *inter alia*:

"17. Provision of services for children in need, their families and others

(1) It shall be the general duty of every local authority (in addition to the other duties imposed on them by this Part) -

(a) to safeguard and promote the welfare of children within their area who are in need; and

(b) so far as is consistent with that duty, to promote the upbringing of such children by their families,

by providing a range and level of services appropriate to those children's needs.

(2) For the purpose principally of facilitating the discharge of their general duty under this section, every local authority shall have the specific duties and powers set out in Part I of Schedule 2.

...

(10) For the purposes of this Part a child shall be taken to be in need if -

(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him of services by a local authority under this Part;

(b) his health or development is likely to be significantly impaired or further impaired, without the provision for him of such services; or

(c) he is disabled ...

(11) ...; and in this Part

'development' means physical, intellectual, emotional, social or behavioural development; and

'health' means physical or mental health."

52. Part III of the Children Act 1989 deals with local authority support for children and families. The policy of the Act is made clear by paragraph 7 of Part I of Schedule 2, which requires local authorities to take reasonable steps designed to reduce the need to bring proceedings relating to children.

53. Section 20 provides that

"20(1) Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of -

(a) there being no person who has parental responsibility for him;

(b) his being lost or having been abandoned; or

(c) the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.

...

(4) A local authority may provide accommodation for any child within their area (even though a person who has parental responsibility for him is able to provide him with accommodation) if they consider that to do so would safeguard or promote the child's welfare."

54. Part V of the Children Act 1989 deals with the protection of children. Section 47 provides as follows:

"47(1) Where a local authority -

...

(b) have reasonable cause to suspect that a child who lives or is found, in their area is suffering, or is likely to suffer, significant harm,

the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

...

(8) Where, as a result of complying with this section, a local authority conclude that they should take action to safeguard or promote the child's welfare they shall take action (so far as it is within their power and reasonably practicable for them to do so)."

B. Complaints procedure

55. The complaints procedure is provided by section 26 of the Children Act 1989:

"Review of cases and inquiries into representations

...

(3) Every local authority shall establish a procedure for considering any representations (including any complaint) made to them by -

(a) any child ... who is not being looked after by them but is in need;

(b) a parent of his;

...

(e) such other person as the authority consider has a sufficient interest in the child's welfare to warrant his representations being considered by them,

about the discharge by the authority of any of their functions under this Part in relation to the child.

(4) The procedure shall ensure that at least one person who is not a member or officer of the authority takes part in -

(a) the consideration; and

(b) any discussions which are held by the local authority about the action (if any) to be taken in relation to the child in the light of this consideration.

...

(7) Where any representation has been considered under the procedure established by the local authority under this section, the authority shall -

(a) have due regard to the findings of those considering the representation; and

(b) take such steps as are reasonably practicable to notify (in writing) -

(i) the person making the representation;

(ii) the child (if the authority consider that he has sufficient understanding); and

(iii) such other persons (if any) as appear to the authority to be likely to be affected,

of the authority's decision in the matter and their reasons for taking that decision and of any action which they have taken, or propose to take.

(8) Every local authority shall give such publicity to their procedure for considering representations under this section as they consider appropriate."

56. The powers of the Secretary of State to investigate the actions of the local authority are set out in sections 81 and 84 of the Children Act 1989.

"81. (1) The Secretary of State may cause an inquiry to be held into any matter connected with -

(a) the function of the social services committee of a local authority, in so far as those functions relate to children;

...

84. Local authority failure to comply with statutory duty: default power of Secretary of State

(1) If the Secretary of State is satisfied that any local authority has failed, without reasonable excuse, to comply with any of the duties imposed on them by or under this Act he may make an order declaring that authority to be in default with respect to that duty.

...

(3) Any order under subsection (1) may contain such directions for the purpose of ensuring that the duty is complied with, within such period as may be specified in the order, as appears to the Secretary of State to be necessary.

(4) Any such directions shall, on the application of the Secretary of State, be enforceable by mandamus."

C. Actions for damages against the local authority

57. In England and Wales there is no single tort which imposes liability to pay compensation for civil wrongs. Instead there is a series of separate torts, for example, trespass, conversion, conspiracy, negligence and defamation.

58. Negligence arises in specific categories of situations. These categories are capable of being extended. There are three elements to the tort of negligence: a duty of care, breach of the duty of care, and damage. The duty of care may be described as the concept which defines the categories of relationships in which the law may impose liability on a defendant in damages if he or she is shown to have acted carelessly. To show a duty of care, the claimant must show that the situation comes within an existing established category of cases where a duty of care has been held to exist. In novel situations, in order to show a duty of care, the claimant must satisfy a threefold test, establishing:

– that damage to the claimant was foreseeable;

– that the claimant was in an appropriate relationship of proximity to the defendant; and,

– that it is fair, just and reasonable to impose liability on the defendant.

These criteria apply to claims against private persons as well as claims against public bodies. The leading case is *Caparo Industries plc v. Dickman* ([1990] 2 Appeal Cases 605).

59. If the courts decide that as a matter of law there is no duty of care owed in a particular situation, that decision will (subject to the doctrine of precedent) apply in future cases where the parties are in the same relationship.

60. The decision in *X and Others v. Bedfordshire County Council* ([1995] 3 All England Law Reports 353) is the leading authority in the United Kingdom in this area. It held that local authorities could not be sued for negligence or for breach of statutory duty in respect of the discharge of

their functions concerning the welfare of children. The leading judgment is reported at length in the facts above (see paragraphs 45-46 above).

61. Since *X and Others v. Bedfordshire County Council*, there have been two further significant judgments regarding the extent of liability of local authorities in child care matters.

62. The Court of Appeal gave judgment in *W. and Others v. Essex County Council* ([1998] 3 All England Law Reports 111). This case concerned the claims by a mother and father (first and second plaintiffs), who had agreed to act as foster parents, that the defendant local authority placed G., a 15-year-old boy, in their home although they knew that he was a suspect or known sexual abuser. During G.'s stay in their home, the plaintiffs' three children (fourth to sixth plaintiffs) were all sexually abused and suffered psychiatric illness. The plaintiffs brought an action against the local authority and the social worker involved, claiming damages for negligence and for negligent misstatement. On the defendants' application to strike out the statement of claim as disclosing no reasonable cause of action, the judges struck out the parents' claims but refused to strike out the claims of the children. The Court of Appeal upheld his decision. The headnote for the judgment summarised the Court of Appeal's findings as follows:

> "(1) Although no claim in damages lay in respect of decisions by a local authority in the exercise of a statutory discretion, if the decision complained of was so unreasonable that it fell outside the ambit of the discretion conferred, there was no *a priori* reason for excluding common law liability. In the instant case, the giving of information to the parents was part and parcel of the defendants' performance of their statutory powers and duties, and it had been conceded that it was arguable that those decisions fell outside the ambit of their discretion. Accordingly, since it had also been conceded that the damage to the children was reasonably foreseeable and that there was sufficient proximity, the question for the court was whether it was just and reasonable to impose a duty of care on the council or the social worker. Having regard to the fact that common law duty of care would cut across the whole statutory set up for the protection of children at risk, that the task of the local authority and its servants in dealing with such children was extraordinarily difficult and delicate, that local authorities might adopt a more defensive approach to their duties if liability in damages were imposed, that the relationship between parents and social workers was frequently one of conflict and that the plaintiff children's injuries were compensatable under the Criminal Injuries Compensation Scheme, it was not just and reasonable to do so. It followed that no duty of care was owed to the plaintiff parents who in any event were secondary victims in respect of their claim for psychiatric illness ...
>
> (2) (Stuart-Smith LJ dissenting) It was arguable that the policy considerations against imposing a common law duty of care on a local authority in relation to the performance of its statutory duties to protect children did not apply when the children whose safety was under consideration were those in respect of whom it was not performing any statutory duty. Accordingly, since in the instant case, the plaintiff children were not children for whom the council had carried out any immediate caring responsibilities under the child welfare system but were living at home with their parents, and express assurances had been given that a sexual abuser would not be placed in their home, their claim should proceed ..."

63. On further appeal by the parents, the House of Lords on 16 March 2000 held that it was impossible to say that the psychiatric injury allegedly suffered by the parents, flowing from a feeling that they had brought the abuser and their children together or from a feeling of responsibility for not having detected the abuse earlier, was outside the range of psychiatric injury recognised by the law, nor was it unarguable that the local authority had owed a duty of care to the parents. The parents' claim could not be said to be so certainly or clearly bad that they should be barred from pursuing it to trial and their appeal was allowed.

64. The House of Lords gave judgment on 17 June 1999 in *Barrett v. London Borough of Enfield* ([1999] 3 Weekly Law Reports 79). That case concerned the claims of the plaintiff, who had been in care from the age of ten months to 17 years, that the local authority had negligently failed to safeguard his welfare causing him deep-seated psychiatric problems. The local authority had applied to strike out the case as disclosing no cause of action. The House of Lords, upholding the plaintiff's appeal, unanimously held that the judgment in *X and Others v. Bedfordshire County Council* did not in the circumstances of this case prevent a claim of negligence being brought against a local authority by a child formerly in its care.

65. Lord Browne-Wilkinson, in his judgment in that case, commented as follows on the operation of the duty of care:

> "(1) Although the word 'immunity' is sometimes incorrectly used, a holding that it is not fair, just and reasonable to hold liable a particular class of defendants whether generally or in relation to a particular type of activity is not to give immunity from a liability to which the rest of the world is subject. It is a prerequisite to there being any liability in negligence at all that as a matter of policy it is fair, just and reasonable in those circumstances to impose liability in negligence. (2) In a wide range of cases public policy has led to the decision that the imposition of liability would not be fair and reasonable in the circumstances, e.g. some activities of financial regulators, building inspectors, ship surveyors, social workers dealing with sex abuse cases. In all these cases and many others the view has been taken that the proper performance of the defendant's primary functions for the benefit of society as a whole will be inhibited if they are required to look over their shoulder to avoid liability in negligence. In English law the decision as to whether it is fair, just and reasonable to impose a liability in negligence on a particular class of would-be defendants depends on weighing in the balance the total detriment to the public interest in all cases from holding such class liable in negligence as against the total loss to all would-be plaintiffs if they are not to have a cause of action in respect of the loss they have individually suffered. (3) In English law, questions of public policy and the question whether it is fair and reasonable to impose liability in negligence are decided as questions of law. Once the decision is taken that, say, company auditors though liable to shareholders for negligent auditing are not liable to those proposing to invest in the company (see *Caparo Industries plc v. Dickman* [1990] 1 All ER 568, [1990] 2 AC 605), that decision will apply to all future cases of the same kind. The decision does not depend on weighing the balance between the extent of the damage to the plaintiff and the damage to the public in each particular case."

D. Striking-out procedure

66. At the relevant time, Order 18, Rule 19 of the Rules of the Supreme Court provided that a claim could be struck out if it disclosed no reasonable cause of action. This jurisdiction has been described as being reserved for "plain and obvious cases", in which a claim was "obviously unsustainable".

67. In applications to strike out, the courts proceeded on the basis that all the allegations set out in the claimant's pleadings were true. The question for the courts was whether, assuming that the claimant could substantiate all factual allegations at trial, the claim disclosed a reasonable cause of action.

68. The striking out procedure, now contained in Part 3.4(2) of the Civil Procedure Rules in force since 1999, is regarded as an important feature of English civil procedure, performing the function of securing speedy and effective justice, *inter alia*, by allowing a court to decide promptly which issues need full investigation and trial, and disposing summarily of the others. By means of this procedure, it can be determined at an early stage, with minimal cost to the parties, whether the facts as pleaded reveal a claim existing in law.

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION

69. The applicants alleged that the local authority had failed to protect them from inhuman and degrading treatment contrary to Article 3 of the Convention, which provides:

> "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

70. In its report the Commission expressed the unanimous opinion that there had been a violation of Article 3 of the Convention. It considered that there was a positive obligation on the Government to protect children from treatment contrary to this provision. The authorities had been aware of the serious ill-treatment and neglect suffered by the four children over a period of years at the hands of their parents and failed, despite the means reasonably available to them, to take any effective steps to bring it to an end.

71. The applicants requested the Court to confirm this finding of a violation.

72. The Government did not contest the Commission's finding that the treatment suffered by the four applicants reached the level of severity prohibited by Article 3 and that the State failed in its positive obligation,

under Article 3 of the Convention, to provide the applicants with adequate protection against inhuman and degrading treatment.

73. The Court reiterates that Article 3 enshrines one of the most fundamental values of democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment. The obligation on High Contracting Parties under Article 1 of the Convention to secure to everyone within their jurisdiction the rights and freedoms defined in the Convention, taken in conjunction with Article 3, requires States to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman or degrading treatment, including such ill-treatment administered by private individuals (see *A. v. the United Kingdom*, judgment of 23 September 1998, *Reports of Judgments and Decisions* 1998-VI, p. 2699, § 22). These measures should provide effective protection, in particular, of children and other vulnerable persons and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge (see, *mutatis mutandis*, *Osman v. the United Kingdom*, judgment of 28 October 1998, *Reports* 1998-VIII, pp. 3159-60, § 116).

74. There is no dispute in the present case that the neglect and abuse suffered by the four applicant children reached the threshold of inhuman and degrading treatment (as recounted in paragraphs 11-36 above). This treatment was brought to the local authority's attention, at the earliest in October 1987. It was under a statutory duty to protect the children and had a range of powers available to them, including the removal of the children from their home. These were, however, only taken into emergency care, at the insistence of the mother, on 30 April 1992. Over the intervening period of four and a half years, they had been subjected in their home to what the consultant child psychiatrist who examined them referred as horrific experiences (see paragraph 40 above). The Criminal Injuries Compensation Board had also found that the children had been subject to appalling neglect over an extended period and suffered physical and psychological injury directly attributable to a crime of violence (see paragraph 49 above). The Court acknowledges the difficult and sensitive decisions facing social services and the important countervailing principle of respecting and preserving family life. The present case, however, leaves no doubt as to the failure of the system to protect these applicant children from serious, long-term neglect and abuse.

75. Accordingly, there has been a violation of Article 3 of the Convention.

II. ALLEGED VIOLATION OF ARTICLE 8 OF THE CONVENTION

76. The applicants alleged, in the alternative to their complaints under Article 3 of the Convention, that the circumstances in which they suffered

ill-treatment, causing them physical and psychological injury, disclosed a breach of Article 8 of the Convention, which under the principle of respect for private life, protected physical and moral integrity.

77. Having regard to its finding of a violation of Article 3, the Court considers that no separate issue arises under Article 8 of the Convention.

III. ALLEGED VIOLATION OF ARTICLE 6 OF THE CONVENTION

78. The applicants complained that they had been denied access to a court to determine their claims against the local authority in negligence. They relied on Article 6 of the Convention.

79. Article 6 § 1 provides in its first sentence:

> "In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law."

80. The Government denied that there was any civil right in issue in the case or any restriction on access, while the Commission found unanimously that there had been a breach of Article 6, in that the House of Lords had applied an exclusionary rule concerning the liability of local authorities in child care matters which constituted in the circumstances a disproportionate restriction on the applicants' access to a court.

A. Submissions of the parties

1. The applicants

81. The applicants submitted that their negligence claim was plainly arguable as a matter of domestic law, relying, *inter alia*, on *Osman*, cited above. The right to sue in negligence, a cause of action framed in general terms, was an established civil right in domestic law. The local authority had conceded that they could have foreseen damage to the applicants if they carried out their duties negligently and that there was a proximate relationship, thereby satisfying the first two limbs of the test for the duty of care. There was a strong argument that public policy considerations required a duty of care to be imposed and there was no prior decision excluding liability. The applicants also pointed to the fact that the judge who made the care orders specifically released the case papers to the Official Solicitor so that he could investigate and, if appropriate, pursue negligence claims; that the Official Solicitor considered that there were arguable claims in negligence; that the Legal Aid Board granted legal aid to pursue the claims to the House of Lords; and that the Court of Appeal which rejected the claims by a majority granted leave to appeal to the House of Lords, the precondition for such leave being that the claim was arguable in domestic

law; that the Master of the Rolls, in the Court of Appeal, found that there was duty of care, stating the contrary to be "an affront to common sense"; and that in previous cases, local authorities had paid settlements in negligence cases, on the basis that they were potentially liable. There was a serious dispute in domestic law, therefore, as to the existence of any exclusionary principle, which has continued since, and Article 6 was applicable.

82. The exclusionary rule applied by the House of Lords permitted the applicants' claims to be struck out without determining the facts and without a trial. This applied regardless of the merits or the seriousness of the harm suffered. Designed to protect local authorities from wasting resources on having to defend an action at all, this amounted in practical effect to an immunity and acted as a restriction on access to a court.

83. The application of a blanket rule which excluded the determination of the applicants' claims irrespective of the seriousness of the harm suffered, the nature and extent of negligence involved, or the fundamental rights which were at stake, constituted a disproportionate restriction on their right of access to a court. They emphasised the severity of the damage suffered by them due to prolonged exposure to abuse and neglect against which the public policy arguments against imposition of liability had little weight, namely, the alleged risk of frivolous litigation, the increased caution of social services in fulfilling their functions or the difficulty or sensitivity of the issues. Indeed, the requirement to investigate effectively cases of treatment contrary to Article 3 pointed strongly to the recognition of a right of access to a court where the State's responsibility had been engaged for inhuman or degrading treatment of vulnerable children. They referred to the Court's finding in *Osman* (cited above, p. 3170, § 151) that the domestic courts should be able to distinguish between degrees of negligence or harm and give consideration to the justice of a particular case. An exclusionary rule on that basis should be capable of yielding to competing human rights considerations on the facts of a particular case.

2. The Government

84. The Government submitted that Article 6 guaranteed a fair trial in the determination only of such civil rights and obligations as are (at least arguably) recognised in national law. It does not bear on the substantive question of whether a right to compensation exists in any given situation. The proceedings brought by the applicants established that no right existed. The decision to strike out their claim touched on the scope of the domestic law. By ruling that a right of action did not exist in a particular set of circumstances, the courts were applying substantive limits to tort liability, as the legislature might do in statute (see, for example, *Powell and Rayner v. the United Kingdom*, judgment of 21 February 1990, Series A no. 172,

pp. 16-17, § 36). There was no established cause of action which was restricted. Accordingly, they claimed that Article 6 § 1 was not applicable.

85. The Government argued in the alternative that there was no immunity applied which could be regarded as a restriction on access to a court. Even assuming that there was an arguable issue, there could in their view be no doubt that the dispute was subject to a fair and public hearing in compliance with the guarantees of Article 6. The striking-out procedure was an important way of securing the speedy and cost-effective determination of cases that were hopeless in law. It achieved those aims without inhibiting claimants' rights to present any arguments in their favour to a court. Thus, as factual matters were assumed to be those pleaded, the claimants were not prejudiced by the lack of hearing of evidence, while they could put forward any arguments in their favour to persuade the court that their claim was sustainable as a matter of law.

86. Assuming that their arguments on the above failed, the Government argued that any restriction on access to a court nonetheless pursued a legitimate aim and was proportionate. It aimed to preserve the efficiency of a vital sector of public service. The exclusion of liability was strictly limited in scope to the category of cases to which it applied, actions for misfeasance, vicarious liability for employees remaining unaffected. The domestic courts had themselves weighed up the public policy issues for and against liability in light of the principles of English tort law and the social and political philosophy underlying those principles. A very substantial margin of appreciation would therefore be appropriate in any international adjudication.

B. The Court's assessment

1. Applicability of Article 6 of the Convention

87. The Court recalls its constant case-law to the effect that "Article 6 § 1 extends only to '*contestations*' (disputes) over (civil) 'rights and obligations' which can be said, at least on arguable grounds, to be recognised under domestic law; it does not itself guarantee any particular content for (civil) 'rights and obligations' in the substantive law of the Contracting States" (see *James and Others v. the United Kingdom*, judgment of 21 February 1986, Series A no. 98, pp. 46-47, § 81; *Lithgow and Others v. the United Kingdom*, judgment of 8 July 1986, Series A no. 102, p. 70, § 192; and *The Holy Monasteries v. Greece*, judgment of 9 December 1994, Series A no. 301-A, pp. 36-37, § 80). It will however apply to disputes of a "genuine and serious nature" concerning the actual existence of the right as well as to the scope or manner in which it is exercised (see *Benthem v. the Netherlands*, judgment of 23 October 1985, Series A no. 97, pp. 14-15, § 32).

88. In the present case, the applicants were claiming damages on the basis of alleged negligence, a tort in English law which is largely developed through the case-law of the domestic courts. It is agreed by the parties that there was no previous court decision which indicated that liability existed in respect of damage caused negligently by a local authority in carrying out its child protection duties. It was in the applicants' case that the domestic courts were called on to rule whether this situation fell within one of the existing categories of negligence liability, or whether any of the categories should be extended to this situation (see paragraphs 57-65 above).

89. The Court is satisfied that at the outset of the proceedings there was a serious and genuine dispute about the existence of the right asserted by the applicants under the domestic law of negligence as shown, *inter alia*, by the grant of legal aid to the applicants and the decision of the Court of Appeal that their claims merited leave to appeal to the House of Lords. The Government's submission that there was no arguable (civil) "right" for the purposes of Article 6 once the House of Lords had ruled that no duty of care arose has relevance rather to any claims which were lodged or pursued subsequently by other plaintiffs. The House of Lords' decision did not remove, retrospectively, the arguability of the applicants' claims (see *Le Calvez v. France*, judgment of 29 July 1998, *Reports* 1998-V, pp. 1899-900, § 56). In such circumstances, the Court finds that the applicants had, on at least arguable grounds, a claim under domestic law.

90. Article 6 was, therefore, applicable to the proceedings brought by these applicants alleging negligence by the local authority. The Court must, therefore, examine whether the requirements of Article 6 were complied with in those proceedings.

2. Compliance with Article 6 of the Convention

91. The Court, in *Golder v. the United Kingdom* (judgment of 21 February 1975, Series A no. 18, pp. 13-18, §§ 28-36), held that the procedural guarantees laid down in Article 6 concerning fairness, publicity and expeditiousness would be meaningless if there were no protection of the pre-condition for the enjoyment of those guarantees, namely, access to a court. It established this as an inherent aspect of the safeguards enshrined in Article 6, referring to the principles of the rule of law and the avoidance of arbitrary power which underlie much of the Convention.

92. Article 6 § 1 "may ... be relied on by anyone who considers that an interference with the exercise of one of his (civil) rights is unlawful and complains that he has not had the possibility of submitting that claim to a tribunal meeting the requirements of Article 6 § 1" (see *Le Compte, Van Leuven and De Meyere v. Belgium*, judgment of 23 June 1981, Series A no. 43, p. 20, § 44). Where there is a serious and genuine dispute as to the lawfulness of such an interference, going either to the very existence or the scope of the asserted civil right, Article 6 § 1 entitles the individual "to have

this question of domestic law determined by a tribunal" (see *Sporrong and Lönnroth v. Sweden*, judgment of 23 September 1982, Series A no. 52, p. 30, § 81; see also *Tre Traktörer AB v. Sweden*, judgment of 7 July 1989, Series A no. 159, p. 18, § 40).

93. The right is not absolute, however. It may be subject to legitimate restrictions such as statutory limitation periods, security for costs orders, regulations concerning minors and persons of unsound mind (see *Stubbings and Others v. the United Kingdom*, judgment of 22 October 1996, *Reports* 1996-IV, pp. 1502-03, §§ 51-52; *Tolstoy Miloslavsky v. the United Kingdom*, judgment of 13 July 1995, Series A no. 316-B, pp. 80-81, §§ 62-67; and *Golder*, cited above, p. 19, § 39). Where the individual's access is limited either by operation of law or in fact, the Court will examine whether the limitation imposed impaired the essence of the right and, in particular, whether it pursued a legitimate aim and there was a reasonable relationship of proportionality between the means employed and the aim sought to be achieved (see *Ashingdane v. the United Kingdom*, judgment of 28 May 1985, Series A no. 93, pp. 24-25, § 57). If the restriction is compatible with these principles, no violation of Article 6 will arise.

94. It is contended by the applicants in this case that the decision of the House of Lords, finding that the local authority owed no duty of care, deprived them of access to a court as it was effectively an exclusionary rule, or an immunity from liability, which prevented their claims from being decided on the facts.

95. The Court observes, firstly, that the applicants were not prevented in any practical manner from bringing their claims before the domestic courts. Indeed, the case was litigated with vigour up to the House of Lords, the applicants being provided with legal aid for that purpose. Nor is it that any procedural rules or limitation periods had been relied on. The domestic courts were concerned with the application brought by the defendants to have the case struck out as disclosing no reasonable cause of action. This involved the pre-trial determination of whether, assuming the facts of the applicants' case as pleaded were true, there was a sustainable claim in law. The arguments before the courts were, therefore, concentrated on the legal issues, primarily whether a duty of care in negligence was owed to the applicants by the local authority.

96. Moreover, the Court is not persuaded that the House of Lords' decision that, as a matter of law, there was no duty of care in the applicants' case may be characterised as either an exclusionary rule or an immunity which deprived them of access to a court. As Lord Browne-Wilkinson explained in his leading speech, the House of Lords was concerned with the issue whether a novel category of negligence, that is a category of cases in which a duty of care had not previously been held to exist, should be developed by the courts in their law-making role under the common law

(see paragraph 46 above). The House of Lords, after weighing in the balance the competing considerations of public policy, decided not to extend liability in negligence into a new area. In so doing, it circumscribed the range of liability under tort law.

97. That decision did end the case, without the factual matters being determined on the evidence. However, if as a matter of law, there was no basis for the claim, the hearing of evidence would have been an expensive and time-consuming process which would not have provided the applicants with any remedy at its conclusion. There is no reason to consider the striking-out procedure which rules on the existence of sustainable causes of action as *per se* offending the principle of access to a court. In such a procedure, the plaintiff is generally able to submit to the court the arguments supporting his or her claims on the law and the court will rule on those issues at the conclusion of an adversarial procedure (see paragraphs 66-68 above).

98. Nor is the Court persuaded by the suggestion that, irrespective of the position in domestic law, the decision disclosed an immunity in fact or practical effect due to its allegedly sweeping or blanket nature. That decision concerned only one aspect of the exercise of local authorities' powers and duties and cannot be regarded as an arbitrary removal of the courts' jurisdiction to determine a whole range of civil claims (see *Fayed v. the United Kingdom*, judgment of 21 September 1994, Series A no. 294-B, pp. 49-50, § 65). As it has recalled above in paragraph 87, it is a principle of Convention case-law that Article 6 does not in itself guarantee any particular content for civil rights and obligations in national law, although other Articles such as those protecting the right to respect for family life (Article 8) and the right to property (Article 1 of Protocol No. 1) may do so. It is not enough to bring Article 6 § 1 into play that the non-existence of a cause of action under domestic law may be described as having the same effect as an immunity, in the sense of not enabling the applicant to sue for a given category of harm.

99. Furthermore, it cannot be said that the House of Lords came to its conclusion without carefully balancing the policy reasons for and against the imposition of liability on the local authority in the circumstances of the applicants' case. Lord Browne-Wilkinson, in his leading judgment in the House of Lords, acknowledged that the public policy principle that wrongs should be remedied required very potent counter-considerations to be overridden (see paragraph 46 above). He weighed that principle against the other public policy concerns in reaching the conclusion that it was not fair, just or reasonable to impose a duty of care on the local authority in the applicants' case. It may be noted that in subsequent cases the domestic courts have further defined this area of law concerning the liability of local authorities in child-care matters, holding that a duty of care may arise in other factual situations, where, for example, a child has suffered harm once

in local authority care, or a foster family has suffered harm as a result of the placement in their home by the local authority of an adolescent with a history of abusing younger children (see *W. and Others v. Essex County Council* and *Barrett*, both cited above, paragraphs 62-65 above).

100. The applicants, and the Commission in its report, relied on *Osman* (cited above) as indicating that the exclusion of liability in negligence, in that case concerning the acts or omissions of the police in the investigation and prevention of crime, acted as a restriction on access to a court. The Court considers that its reasoning in *Osman* was based on an understanding of the law of negligence (see, in particular, *Osman*, cited above, pp. 3166-67, §§ 138-39) which has to be reviewed in the light of the clarifications subsequently made by the domestic courts and notably by the House of Lords. The Court is satisfied that the law of negligence as developed in the domestic courts since the case of *Caparo Industries plc* (cited above) and as recently analysed in the case of *Barrett* (cited above, loc. cit.) includes the fair, just and reasonable criterion as an intrinsic element of the duty of care and that the ruling of law concerning that element in this case does not disclose the operation of an immunity. In the present case, the Court is led to the conclusion that the inability of the applicants to sue the local authority flowed not from an immunity but from the applicable principles governing the substantive right of action in domestic law. There was no restriction on access to a court of the kind contemplated in *Ashingdane* (cited above, loc. cit.).

101. The applicants may not, therefore, claim that they were deprived of any right to a determination on the merits of their negligence claims. Their claims were properly and fairly examined in light of the applicable domestic legal principles concerning the tort of negligence. Once the House of Lords had ruled on the arguable legal issues that brought into play the applicability of Article 6 § 1 of the Convention (see paragraphs 87-89 above), the applicants could no longer claim any entitlement under Article 6 § 1 to obtain any hearing concerning the facts. As pointed out above, such a hearing would have served no purpose, unless a duty of care in negligence had been held to exist in their case. It is not for this Court to find that this should have been the outcome of the striking-out proceedings since this would effectively involve substituting its own views as to the proper interpretation and content of domestic law.

102. It is nonetheless the case that the interpretation of domestic law by the House of Lords resulted in the applicants' case being struck out. The tort of negligence was held not to impose a duty of care on the local authority in the exercise of its statutory powers. Their experiences were described as "horrific" by a psychiatrist (see paragraph 40 above) and the Court has found that they were victims of a violation of Article 3 (see paragraph 74 above). Yet the outcome of the domestic proceedings they brought is that they, and any children with complaints such as theirs, cannot sue the local

authority in negligence for compensation, however foreseeable – and severe – the harm suffered and however unreasonable the conduct of the local authority in failing to take steps to prevent that harm. The applicants are correct in their assertions that the gap they have identified in domestic law is one that gives rise to an issue under the Convention, but in the Court's view it is an issue under Article 13, not Article 6 § 1.

103. The Court emphasises that the object and purpose underlying the Convention, as set out in Article 1, is that the rights and freedoms should be secured by the Contracting State within its jurisdiction. It is fundamental to the machinery of protection established by the Convention that the national systems themselves provide redress for breaches of its provisions, the Court exerting its supervisory role subject to the principle of subsidiarity. In that context, Article 13, which requires an effective remedy in respect of violations of the Convention, takes on a crucial function. The applicants' complaints are essentially that that they have not been afforded a remedy in the courts for the failure to ensure them the level of protection against abuse to which they were entitled under Article 3 of the Convention. The domestic courts referred to "the public-policy consideration that has first claim on the loyalty of the law" as being that "wrongs should be remedied" (see paragraph 46 above). As far as Convention wrongs are concerned, that principle is embodied in Article 13 (see, *inter alia*, *Kudła v. Poland* [GC], no. 30210/96, § 152, ECHR 2000-XI). It is under Article 13 that the applicants' right to a remedy should be examined and, if appropriate, vindicated.

104. Accordingly, the Court finds that there has been no violation of Article 6 of the Convention.

IV. ALLEGED VIOLATION OF ARTICLE 13 OF THE CONVENTION

105. The applicants submitted that they had not been afforded any remedy for the damage which they had suffered as a result of the failure of the local authority to protect them, relying on Article 13 of the Convention, which provides:

> "Everyone whose rights and freedoms as set forth in [the] Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."

106. The applicants argued that the exclusionary rule established by the House of Lords in their case deprived them of any effective remedy within the national legal system for the violation of Article 3 which they suffered. While the remedy required by Article 13 need not always be judicial in character, in their case a judicial determination was required. This was because the tort of negligence was the only remedy in national law capable of determining the substance of their complaint and which (but for the

alleged immunity) would closely match the requirements of the Convention. Also the accountability of public officials, central to both Articles 3 and 13, required a right of access to a court whereby the individual could hold the responsible officials to account in adversarial proceedings and obtain an enforceable order for compensation if the claim was substantiated. The wording of Article 13 also prohibited the creation of immunities for public officials and any such immunity must be regarded as contrary to the object and purpose of the Convention.

107. The Government pointed out that there were a number of remedies available to the applicants which went some way towards providing effective redress. This included the payment of compensation from the Criminal Injuries Compensation Board (CICB), the possibility of complaining to the Local Government Ombudsman, and the complaints procedure under the Children Act 1989. However, the Government accepted that in the particular circumstances of this case, the remedies were insufficient, alone or cumulatively, to satisfy the requirements of Article 13. They conceded that there had been a serious violation of one of the most important Convention rights, that the CICB could only award compensation for criminal acts, not for the consequences of neglect, and that any recommendation by the Ombudsman would not have been legally enforceable. They had been under the obligation, in this case, to ensure that some form of compensation was made available for damage caused by the breach of Article 3, whether by a broader statutory compensation scheme, an enforceable Ombudsman's award, or through the courts. They pointed out that from October 2000, when the Human Rights Act 1998 came into force, a victim would be able to bring proceedings in the courts against a public authority for a breach of a substantive right, and the courts would be empowered to award damages.

108. As the Court has stated on many occasions, Article 13 of the Convention guarantees the availability at the national level of a remedy to enforce the substance of the Convention rights and freedoms in whatever form they might happen to be secured in the domestic legal order. Article 13 thus requires the provision of a domestic remedy to deal with the substance of an "arguable complaint" under the Convention and to grant appropriate relief, although the Contracting States are afforded some discretion as to the manner in which they conform to their Convention obligations under this provision. The scope of the obligation under Article 13 also varies depending on the nature of the applicant's complaint under the Convention. Nevertheless, the remedy required by Article 13 must be "effective" in practice as well as in law (see, among other authorities, *Aydın v. Turkey*, judgment of 25 September 1997, *Reports* 1997-VI, pp. 1895-96, § 103).

109. The Court has previously held that where a right with as fundamental an importance as the right to life or the prohibition against torture, inhuman and degrading treatment is at stake, Article 13 requires, in

addition to the payment of compensation where appropriate, a thorough and effective investigation capable of leading to the identification and punishment of those responsible, including effective access for the complainant to the investigation procedure (see *Kaya v. Turkey*, judgment of 19 February 1998, *Reports* 1998-I, pp. 330-31, § 107). These cases, however, concerned alleged killings or infliction of treatment contrary to Article 3 involving potential criminal responsibility on the part of security force officials. Where alleged failure by the authorities to protect persons from the acts of others is concerned, Article 13 may not always require that the authorities undertake the responsibility for investigating the allegations. There should, however, be available to the victim or the victim's family a mechanism for establishing any liability of State officials or bodies for acts or omissions involving the breach of their rights under the Convention. Furthermore, in the case of a breach of Articles 2 and 3 of the Convention, which rank as the most fundamental provisions of the Convention, compensation for the non-pecuniary damage flowing from the breach should in principle be part of the range of available remedies.

110. The applicants have argued that in their case an effective remedy could only be provided by adversarial court proceedings against the public body responsible for the breach. The Court notes that the Government have conceded that the range of remedies at the disposal of the applicants was insufficiently effective. They have pointed out that in the future, under the Human Rights Act 1998, victims of human rights breaches will be able to bring proceedings in courts empowered to award damages. The Court does not consider it appropriate in this case to make any findings as to whether only court proceedings could have furnished effective redress, though judicial remedies indeed furnish strong guarantees of independence, access for the victim and family, and enforceability of awards in compliance with the requirements of Article 13 (see, *mutatis mutandis*, *Klass and Others v. Germany*, judgment of 6 September 1978, Series A no. 28, p. 30, § 67).

111. The Court finds that in this case the applicants did not have available to them an appropriate means of obtaining a determination of their allegations that the local authority failed to protect them from inhuman and degrading treatment and the possibility of obtaining an enforceable award of compensation for the damage suffered thereby. Consequently, they were not afforded an effective remedy in respect of the breach of Article 3 and there has, accordingly, been a violation of Article 13 of the Convention.

V. APPLICATION OF ARTICLE 41 OF THE CONVENTION

112. Article 41 of the Convention provides:

> "If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party."

A. Pecuniary damage

1. The applicants

113. The applicants submitted that they should be compensated for loss of future earnings and the costs of future medical expenses. Their experiences have, in different ways and to differing extents, blighted their lives. A substantial award should be made to enable them to enter life with a modicum of financial security, the potential to build an independent existence and the means to pay for therapeutic treatment and support.

114. The applicants provided updated medical reports dated 16 May 2000 by Dr Jean Harris-Hendriks concerning their progress and prognosis for the future.

(i) Z was described as having made a recovery from the serious depressive illness suffered at the time of her removal into care. While she was no longer suffering from any psychiatric illness, she had emotional, social and practical difficulties far beyond those normally affecting a girl of her age and was statistically vulnerable to anxiety and perhaps depressive illness in adult life. Her problems were classified as being of moderate severity. It was estimated that she would need psychotherapeutic treatment, outside the National Health Service, estimated at 60 to 100 sessions costing 70 to 90 pounds sterling (GBP) per session, to cope with her vulnerability, particularly at periods of transition. She was likely to remain vulnerable on the labour market, though it was anticipated that she would be able to take on further education, sustain her own mental health and enter the workforce. On her behalf, her representatives claimed GBP 9,000 for the cost of future psychiatric treatment, and GBP 40,000 to offset her handicap on the labour market, a total of GBP 49,000.

(ii) A had failed to appear for an interview with Dr Harris-Hendriks, who also commented on the lack of detailed information concerning periods spent by A in care. She had, however, interviewed him on behalf of the local authority in May 1993 and had some records concerning his past treatment and problems. On that basis, she concluded that he was suffering from long-term psychiatric illness and had a poor prognosis for recovery. His chances of fitting into the normal school system remained very poor. He

was prone to aggressiveness and had difficulty with everyday tasks. He was currently suffering from a reactive attachment disorder, resulting directly from severe parental neglect and abuse. The prognosis for the future was extremely bleak and he was likely to require intermittent hospitalisation. He was seriously handicapped on the labour market and was unlikely ever to be able to hold down a job. Assuming that he might otherwise have been able to obtain low-paid manual employment earning GBP 15,000 per year, and a normal working life to age 65, and taking into account uncertainties and early settlement, he claimed GBP 150,000 in loss of future earnings. As he had a substantial and continuing need for psychiatric treatment outside the National Health Service (NHS), he claimed GBP 50,000 as a minimum estimate for future treatment. This made a total of GBP 200,000.

(iii) B was still suffering from untreated post-traumatic stress disorder and a chronic, generalised anxiety disorder. He had horrific nightmares and, if left untreated, was likely to continue in the same disturbed emotional state. He required open-ended psychiatric treatment into adult life, outside the limited provision of the NHS. This was estimated at a cost of GBP 50,000 minimum. He is vulnerable in terms of both schooling and employment opportunities because of a chronic psychiatric disorder and limited social skills. His prospects of future employment were not as bleak as those of A, but he was likely to have substantial interruptions in his employment. On the assumption of six gaps of one year, on an average labourer's wage of GBP 15,000 per year, he claimed GBP 90,000. This made a total of GBP 140,000.

(iv) C was described as happy in her adoptive home, though carrying a substantial burden about her origins and reminders of them. She was recurrently angry and anxious about her natural mother. She had some remaining behavioural problems which were likely to be containable with good substitute parenting. She was, however, more liable than other children to anxiety and there was a statistical risk of depression in adult life. She did not currently require psychiatric treatment although provision should be made for treatment in adolescence and adulthood. At a recommended 30 to 50 sessions at GBP 70 to 90, a claim was made for GBP 4,500 for future psychiatric treatment. GBP 10,000 was claimed for loss of future earnings, making a total of GBP 14,500.

The reports commented that all the children would have benefited from compensation for their claims in 1994 as this would have allowed additional psychotherapeutic help, improving their prognosis. In A's case, his difficulties had been exacerbated by this lack of help while appropriate psychiatric, educational and environmental help might have substantially improved his prognosis. In B's case, more psychotherapeutic help could have reduced his current vulnerability and given a less gloomy prognosis. The reports also deplored that the psychotherapeutic referrals recommended for A and B in 1993 (for both) and 1998 (for B) had not been pursued by the

local authority on their behalf, and noted that one of the social workers had been told that there was no time or money for this work to be done.

2. The Government

115. The Government submitted that it was wrong to rely on domestic case-law and scales of assessment in just-satisfaction claims under Article 41 as the Court made its own assessment in accordance with principles in its own case-law. They emphasised that it must also be taken into account that the ill-treatment and neglect suffered by the applicants was not inflicted by the local authority but by their parents. It was also relevant that the breach of Article 3 arose only after there had been a failure to take effective steps when the situation in the home failed to show significant improvement – there was no ground for assuming that the children should have been removed from their home immediately. Nor should any award be made in respect of any alleged violation of Article 13 as that damage would be compensated by the award made under Article 3. In assessing what compensation would be equitable, it should also be taken into account that a number of compensatory remedies were available to the applicant, in particular, they received awards from the CICB.

116. As regards the recent medical reports, the Government considered that these were framed in largely identical terms with no attempt to distinguish the children's condition by reference to their age at the time of the violation, their sex and the duration of the treatment. No consideration was given either to what part was played by the temperament of the applicants, and by environmental factors including the care which they had received since 1992. Nor was any regard given to any harm which they might have suffered since being taken into care.

117. Turning to the specific claims made, the Government noted that Z had recovered from her depressive illness and had been doing remarkably well during her schooling, with no significant problems. There was nothing to substantiate the asserted claim for 60 to 100 sessions of psychotherapeutic treatment. Given her positive progress, the claim of statistical vulnerability to future anxiety and depressive illness was not substantiated either.

The report on A was in their view particularly unsatisfactory as it was issued without A having appeared for interview and without full information about his history. While he was not referred to a special clinic as suggested, he did receive therapeutic work in the community where he lived between 1996 and 1998. There was no or little basis for the assumption that his difficulties were exacerbated by the failure of his earlier compensation claim.

The report on B was similarly highly speculative and unsubstantiated, with regard to the alleged adverse impact of the lack of compensation. Its comments on his educational difficulties were inconsistent.

The report on C indicated that she was not psychiatrically ill and was coping well, rendering the conclusion that she had emotional and practical difficulties beyond the average girl of her age difficult to understand. The statements concerning likely future need and alleged impact of the failure of the compensation claim were unsupported by the evidence.

118. The Government submitted that in light of these considerations a reasonable sum of GBP 20,000 for Z, GBP 40,000 for A, GBP 30,000 for B, and GBP 10,000 for C would afford the applicants just satisfaction for both pecuniary and non-pecuniary damage.

3. The Court's assessment

119. As regards the applicants' claims for pecuniary loss, the Court's case-law establishes that there must be a clear causal connection between the damage claimed by the applicant and the violation of the Convention and that this may, in the appropriate case, include compensation in respect of loss of earnings (see, among other authorities, *Barberà, Messegué and Jabardo v. Spain* (Article 50), judgment of 13 June 1994, Series A no. 285-C, pp. 57-58, §§ 16-20, and *Çakıcı v. Turkey* [GC], no. 23657/94, § 127, ECHR 1999-IV).

120. A precise calculation of the sums necessary to make complete reparation (*restitutio in integrum*) in respect of the pecuniary losses suffered by the applicants may be prevented by the inherently uncertain character of the damage flowing from the violation (see *Young, James and Webster v. the United Kingdom* (Article 50), judgment of 18 October 1982, Series A no. 55, pp. 6-7, § 11). An award may still be made notwithstanding the large number of imponderables involved in the assessment of future losses, though the greater the lapse of time involved, the more uncertain the link becomes between the breach and the damage. The question to be decided in such cases is the level of just satisfaction, in respect of both past and future pecuniary losses, which it is necessary to award each applicant, the matter to be determined by the Court at its discretion, having regard to what is equitable (see The Sunday Times *v. the United Kingdom (no. 1)* (Article 50), judgment of 6 November 1980, Series A no. 38, p. 9, § 15, and *Smith and Grady v. the United Kingdom* (just satisfaction), nos. 33985/96 and 33986/96, §§ 18-19, ECHR 2000-IX). In that determination, the awards made in comparable domestic cases is a relevant but not decisive consideration.

121. Turning to the present case, the Court recalls that all four children suffered psychological and physical damage resulting from the abuse and neglect of their parents over a period of more than four years (see paragraphs 11-40 above). The breach of Article 3 concerned the failure of the local authority to take reasonable steps available to them to protect them from that damage. There is a direct causal link, therefore, between the breach and the damage suffered by the children. While it is correct, as

asserted by the Government, that there is no finding that the children should have immediately been taken into care and that they might have suffered damage even if effective steps had been taken at an earlier stage, the Court notes that the severity of the damage suffered by the children is inextricably linked to the long period of time over which the abuse persisted, which factor is also at the heart of the violation of Article 3 in this case.

122. The Court has taken into consideration the points made by the Government concerning the medical reports provided by the applicants, in particular, the lack of any attempt to compare the children's prospects in education and employment prior to their being taken into care. It cannot be excluded, for example, that A and B, who were identified as having educational difficulties, would have experienced some problems in any event. However, such assessments would inevitably be imprecise and based on some degree of speculation, as were the views expressed by Dr Harris-Hendriks concerning the future prognosis and effect on the educational and employment prospects. It may also be noted that the medical reports have not been tested in adversarial proceedings.

123. It is nonetheless possible, on the basis of the information available to the Court, to conclude that the four children will, in all probability, suffer from the effects of their experiences for the rest of their lives. Their capacity to cope with this past trauma will depend on their own personal abilities and the support to which they may have access.

124. It is clear that Z has made an excellent recovery from her depressive illness and, receiving support from her new family, is expected to do well at school and in the future in general. C, who, due to her young age, was less damaged by events, has also successfully integrated into a new family and is attending school without problem. In their case, the Court finds that it is not possible with any degree of certainty to draw conclusions as to future difficulties in the employment sphere. Notwithstanding their current positive prognosis, it may be considered as reasonably possible that in the future they will have some need of professional help in coping with problems which may arise as they grow older and in coming to terms with their childhood experience. An award to cover future psychotherapeutic care will assist in providing them with the support necessary to that process.

125. A was the most severely damaged of the children and suffers an ongoing psychiatric illness. Therapeutic care would help him now and will be necessary in the future. The Court is satisfied that the medical report may be relied on in this respect, Dr Harris-Hendriks having previously examined A and having access to sufficient information to support her opinion. Having integrated neither into a family nor into the education system, the prognosis for A may reasonably be described as bleak. In his case, it may be claimed that the damage suffered from the abuse will in all probability affect his prospects of gaining employment in the future. An award is appropriate to reflect this loss.

126. B is suffering from post-traumatic stress and anxiety disorders, which are likely to continue to affect him for some time to come. He requires both current and future psychiatric treatment. He is attending school, in a special-needs group. It is also probable, though to a lesser extent than A, that he will have problems in obtaining and sustaining employment in later life. An award is appropriate to reflect this.

127. Bearing in mind the uncertainties of the applicants' situations, and making an assessment on an equitable basis, the Court awards Z the sum of GBP 8,000 for future medical costs; A the sum of GBP 50,000 for future medical costs and GBP 50,000 for loss of employment opportunities; B the sum of GBP 50,000 for future medical costs and GBP 30,000 for loss of employment opportunities; and C the sum of GBP 4,000 for future medical costs.

B. Non-pecuniary damage

1. The applicants

128. The applicants claimed non-pecuniary damage in respect of the physical and psychiatric damage sustained. Z had suffered a serious depressive illness and severe malnutrition, and it was predicted that she would need long-term psychiatric care, probably into adulthood. A had suffered from post-traumatic stress disorder and was chronically under-attached. There was evidence to suggest that his father had hit him with a poker and that he had been sexually abused. He had suffered permanent scarring and was expected to require long-term psychiatric care. B had also suffered post-traumatic stress disorder, with some evidence of being beaten by a poker and being sexually abused. He suffered very bad nightmares and would wake up screaming. He was expected to require long-term psychiatric care. C had been less seriously damaged but was also expected to require some psychiatric treatment. Her health had been neglected by her mother and she had a squint as a result.

According to the assessment of Dr Black, Z, A and B had suffered psychiatric damage falling at the upper end of the severe bracket. They exhibited "marked problems" in their ability to cope with life and in their relationships with family, friends and those with whom they came into contact. A and B in particular had a poor prognosis and there was a likelihood of future vulnerability. C had suffered damage in the "moderately severe" bracket. Although she presented significant problems in the areas above, she had a more favourable prognosis.

Having regard to the levels of awards in such cases in the domestic courts, the applicants considered that a reasonable sum would be GBP 35,000 for Z, GBP 45,000 for A, GBP 40,000 for B, and GBP 25,000 for C.

2. The Government

129. As stated above, the Government considered that sums of GBP 20,000 for Z, GBP 40,000 for A, GBP 30,000 for B, and GBP 10,000 for C would afford the applicants just satisfaction for both pecuniary and non-pecuniary damage.

3. The Court's assessment

130. The children in this case suffered very serious abuse and neglect over a period of more than four years. Z, A and B suffered, and in the case of the two boys, still suffer psychiatric illness as a result. A and B also suffered physical injury and C suffered neglect in respect of an eye condition. The description of the conditions which they endured and the traumatic effects which this had on the children leave the Court with no doubt that a substantial award to reflect their pain and suffering is appropriate.

131. In making this assessment, the Court recalls that the rates applied in domestic cases, though relevant, are not decisive. It does not consider it appropriate or desirable to attempt to distinguish between the children in this context. Making an assessment on an equitable basis, the Court awards each child the sum of GBP 32,000.

C. Costs and expenses

132. The applicants claimed GBP 52,781.28 inclusive of value-added tax (VAT) by way of legal costs and expenses, which included fees for attendance at hearings before the Commission and the Court, fees for Dr Harris-Hendriks and submissions on Article 41 of the Convention.

133. The Government did not dispute the hourly rate or number of hours claimed by the applicants' principal legal advisers. They did query the involvement of a leading counsel as an expert on negligence law in addition to the leading counsel with human rights expertise. They also queried the involvement of the AIRE Centre in addition to an experienced counsel and solicitor, and noted that the AIRE Centre's fees for attending the hearing had also been billed in full in the second case, *T.P. and K.M. v. the United Kingdom* [GC], no. 28945/95, ECHR 2001-V, heard before the Court on the same day. They proposed that GBP 43,000 was a reasonable sum, taking these deductions into account. However, if no violation of Articles 6 and 8 of the Convention was found, they disputed the necessity for any of the fees incurred after April 2000 when the Government conceded a breach of Articles 3 and 13 of the Convention. In those circumstances, a reasonable sum would be GBP 36,000.

134. The Court recalls that only legal costs and expenses found to have been actually and necessarily incurred and which are reasonable as to

quantum are recoverable under Article 41 of the Convention (see, among other authorities, *Nikolova v. Bulgaria* [GC], no. 31195/96, § 79, ECHR 1999-II). It observes that the case involved important and complex issues, both concerning the facts which were established by the Commission, and the legal aspects. It does not consider that the costs incurred after April 2000 should be disallowed as such, as there were outstanding issues to be determined, including the claims of pecuniary and non-pecuniary damage arising out of the breaches conceded by the Government. As, however, the complaint made under Article 6, which was a significant part of the application, was unsuccessful, the costs and expenses allowed should be reduced. The Court has had regard to the fact that the Article 6 complaint was to some extent interconnected with the complaint about the inadequacy of remedies under Article 13.

135. In light of these matters, the Court awards the global sum of GBP 39,000 for legal costs and expenses, inclusive of VAT.

D. Default interest

136. According to the information available to the Court, the statutory rate of interest applicable in the United Kingdom at the date of adoption of the present judgment is 7.5% per annum.

FOR THESE REASONS, THE COURT

1. *Holds* unanimously that there has been a violation of Article 3 of the Convention.

2. *Holds* unanimously that no separate issue arises under Article 8 of the Convention.

3. *Holds* by twelve votes to five that there has been no violation of Article 6 of the Convention.

4. *Holds* by fifteen votes to two that there has been a violation of Article 13 of the Convention.

5. *Holds* unanimously
   (a) that the respondent State is to pay the applicants, within three months, the following amounts:
      (i) GBP 8,000 (eight thousand pounds sterling) to Z, GBP 100,000 (one hundred thousand pounds sterling) to A, GBP 80,000 (eighty

thousand pounds sterling) to B, and GBP 4,000 (four thousand pounds sterling) to C in respect of pecuniary damage;

(ii) GBP 32,000 (thirty-two thousand pounds sterling) to each applicant for non-pecuniary damage;

(iii) GBP 39,000 (thirty-nine thousand pounds sterling) in respect of costs and expenses, inclusive of VAT;

(b) that simple interest at an annual rate of 7.5% shall be payable from the expiry of the above-mentioned three months until settlement;

6. *Dismisses* unanimously the remainder of the applicants' claims for just satisfaction.

Done in English and in French, and delivered at a public hearing in the Human Rights Building, Strasbourg, on 10 May 2001.

Luzius WILDHABER
President

Paul MAHONEY
Deputy Registrar

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the following separate opinions are annexed to this judgment:

(a) concurring opinion of Lady Justice Arden as to Article 6;

(b) concurring opinion of Lady Justice Arden as to Article 41, joined by Mr Kovler;

(c) partly dissenting opinion of Mr Rozakis joined by Mrs Palm;

(d) partly dissenting opinion of Mrs Thomassen joined by Mr Casadevall and Mr Kovler.

L.W.
P.J.M.

CONCURRING OPINION OF LADY JUSTICE ARDEN AS TO ARTICLE 6

I agree that Article 6 of the Convention is applicable in this case and that it is not violated for the reasons given by the majority. I attach particular importance to the majority's affirmation of the well-established principle of Convention case-law that Article 6 does not guarantee any particular content for civil rights and obligations (see paragraphs 87, 98, 100 and 101 of the judgment). In the present case the applicants failed to obtain any remedy under the domestic law because the domestic courts held that they had no cause of action in English law (*X v. Bedfordshire County Council* [1995] 2 Appeal Cases 633).

Founding themselves upon the erroneous proposition as a matter of domestic law that they had some general right to sue in negligence where the defendant's act had caused damage and there was sufficient proximity, the applicants sought to argue that the decision of the English courts amounted to a sweeping or blanket immunity. I agree with the conclusion, in paragraph 98 of the judgment, that the facts of this case do not support that argument. In my view, when the courts in England, proceeding incrementally under the common law system of judicial law-making, hold that a hitherto unconsidered category of harm does not, as a matter of law, fall within the scope of the tort of negligence, they cannot properly be described as creating an "immunity", whether blanket or limited (see the speech of Lord Browne-Wilkinson in *Barrett v. the London Borough of Enfield* [1999] 3 Weekly Law Reports 79, paragraph 65 of the judgment in the present case). What the decision of the House of Lords in the present case did was to determine a legal issue fixing the limits on the substantive content of a domestic "civil right". In any event the decision was fully and carefully reasoned. It could not be regarded as the product of arbitrariness and it applied only to closely defined circumstances (see paragraphs 98-99 of the judgment).

Paragraph 98 of the judgment refers to *Fayed v. the United Kingdom* (judgment of 21 September 1994, Series A no. 294-B). In that case the Court contemplated the possibility that there might be a violation of the right of access to a court if, for example, a State could remove from the jurisdiction of the courts a whole range of civil claims, or confer immunities from civil liability on large groups or categories of persons (ibid., pp. 49-50, § 65). At the same time, however, the Court also stated that the Convention enforcement bodies could not create, by way of interpretation of Article 6, a substantive civil right which had no legal basis in the State concerned. Yet that is what the applicants are inviting the Court to do in the present case. Once the conclusion is reached that the right on which the applicants seek to rely has no legal basis in national law, the question of whether there was an

"immunity" such as to rely on the principle referred to in *Fayed* strictly does not arise.

In *Fayed* the Court did not settle the question whether the operation of a defence to a claim in defamation conferred by English law on a public officer was such as to attract the application of the right of access to a court under Article 6 § 1 or, rather, the substantive right to respect for one's private life under Article 8. Instead, it chose to "proceed on the basis that Article 6 § 1 [was] applicable to the facts of the case" (ibid., pp. 50-51, § 67). It explained that it did so as a matter of procedural convenience because the same central issues of legitimate aim and proportionality would have been raised under Article 8, and because the parties' arguments had been directed solely to Article 6 § 1. The result in that case does not, therefore, set any precedent for the applicability of Article 6 § 1 or detract from the principle to which, as stated, I attach particular importance, namely that Article 6 does not guarantee any particular content for civil rights and obligations (see paragraphs 87, 98, 100 and 101 of the present judgment).

CONCURRING OPINION OF LADY JUSTICE ARDEN AS TO ARTICLE 41, JOINED BY JUDGE KOVLER

Article 41 of the Convention enables the Court in appropriate cases to "afford just satisfaction to the injured party". The judgment of the Court awards two sums to each applicant by way of just satisfaction: one sum in respect of pecuniary damage and the other sum in respect of non-pecuniary damage. In the case of pecuniary damage, each applicant is awarded a different sum. However, in respect of non-pecuniary damage, each applicant is awarded an identical amount. Thus, with regard to non-pecuniary damage, the applicants' cases are not assessed individually. The applicants are treated as having suffered equal distress. In addition, no distinction is drawn between the suffering of any one applicant as against that of any other applicant, despite the differences between the cases of the applicants.

I agree that the just satisfaction which the Court awards to the applicants for the violation of Article 13 should include a sum on account of non-pecuniary damage in addition to the sums awarded in respect of pecuniary damage. I have no doubt that such an award is justified. However, in my opinion, the Court should not award the same sum to each applicant but rather should make a separate award to each applicant, reflecting the suffering of that applicant.

As paragraph 128 of the judgment shows, the applicants themselves have sought different amounts: GBP 35,000 for Z, GBP 45,000 for A, GBP 40,000 for B, and GBP 25,000 for C.

All the applicants endured suffering before they were taken into care. After they were taken into care they were assessed by consultant child psychiatrists: in 1993 by Dr Black, and in 2000 by Dr Harris-Hendriks. The diagnosis of A indicates that his case is the most serious. In 1993 he was diagnosed as suffering from post-traumatic stress disorder, and in 2000 he was diagnosed as suffering from a personality disorder for which the prognosis was unfavourable. B was considered to have a post-traumatic stress disorder in both 1993 and 2000, as well as social difficulties, and in addition in 2000 a generalised anxiety disorder, but the prognosis for him was uncertain rather than unfavourable. On the other hand, the initial diagnosis in 1993 of Z as suffering from a severe depressive illness has not been borne out, though it is considered that she may suffer anxiety and perhaps depressive illness in later life. In 2000 C's difficulties were described as moderate; she was regarded as vulnerable to anxiety and likely to need psychotherapeutic help in the future, but she had not suffered any psychiatric disorder.

In the circumstances my preferred course would have been to have performed a separate assessment of the amount to be awarded for non-pecuniary damage to each applicant. Having considered the evidence on the Article 41 issue, I consider that an appropriate amount would have been

GBP 25,000 for Z, GBP 40,000 for A, GBP 35,000 for B, and GBP 15,000 for C.

PARTLY DISSENTING OPINION OF JUDGE ROZAKIS JOINED BY JUDGE PALM

With great regret I am unable to follow the assessment and the conclusions of the majority of the Court that, in the instant case, there has been no violation of Article 6 § 1 of the Convention in so far as access of the applicants to a court of law is concerned. The reasons which have led me to depart from the majority's findings are as follows:

1. The majority is satisfied that the proceedings before the national courts, which culminated in a decision of the House of Lords, met the requirements of Article 6 § 1 as regards the applicants' right to have access to a court for the determination of their civil rights. As the Court observes in paragraph 101 of the judgment, the applicants may not "claim that they were deprived of any right to a determination on their merits of their negligence claims. Their claims were properly and fairly examined in the light of the applicable domestic principle concerning the tort of negligence". And, as it is also stated in paragraph 95, "[t]he arguments before the courts were, therefore, concentrated on the legal issues, primarily whether a duty of care in negligence was owed to the applicants by the local authority". It is difficult for one to accept this approach. The applicants' claims before the national courts did not, of course, refer to this preliminary issue. Their complaint was that the local authorities acted with gross negligence in a case involving a statutory duty of care and that, because of the damage inflicted on them by the failure of the authorities to properly discharge their responsibilities, compensation was due. They submitted this civil right to the courts and nurtured the legitimate expectation that it would be dealt with by the courts through an examination on the merits following an adversarial procedure that would enable them to prove the veracity of their claims. If it may be asserted that, as a general rule the question of access to a court is determined by the subject matter of the claims before the national courts, then the applicants never enjoyed access: at all stages of the domestic examination of their case, the national courts solely examined the jurisdictional problem of whether they could entertain the merits of the case before them, thus confining themselves to the preliminary question of whether an exclusionary rule exists, preventing them from examining the merits. An exclusionary rule which was eventually established by them, not on the basis of statutory requirements or specific precedents that were binding on them, but on the basis of a particular interpretation by them of the requirements of English law in the light of the circumstances of the case before them.

2. It is one matter, of course, to accept that there was no access to a court – which, unfortunately, the majority did not clearly accept – and another to say that, in the circumstances of a particular case, the absence of access is justified because it serves a particular purpose which is proportionate to the

damage done to an individual not enjoying the protection otherwise afforded to him by Article 6 of the Convention.

I am prepared to subscribe to this alternative approach, on which the majority has also embarked – without, however, making a clear distinction between the absence of access and the circumstances justifying a proportional denial of it. However, I am not prepared to accept that the facts of the case may lead us to the conclusion that the applicants were correctly and proportionately deprived of their right because the public-interest considerations prevailed over their legitimate expectation to have their claims examined on the merits.

First of all, it transpires clearly from the facts of the case that the right to sue in negligence was an established civil right in domestic law, that the public-care authorities accepted that they had been negligent in their behaviour, and that there was a proximate relationship in accordance with the criteria determined by national law. Further, the way that the judicial authorities dealt with the matter shows that the case presented serious issues that warranted serious examination: as the applicants pointed out, the judge who made the care orders specifically released the case papers to the Official Solicitor so that he could investigate and, if appropriate, pursue negligence claims; the Official Solicitor considered that there were arguable claims in negligence; the Legal Aid Board granted legal aid to pursue the claims to the House of Lords; and the Court of Appeal, which rejected the claims by a majority, granted leave to appeal to the House of Lords, the precondition for such leave being that the claim was arguable in domestic law; the Master of the Rolls in the Court of Appeal found that there was a duty of care, stating the contrary to be "an affront to common sense"; and, in previous cases, local authorities had settled negligence claims on the basis that they were potentially liable.

So, the only reason which eventually led to this case being struck out was an interpretation by the national courts, and particularly the House of Lords, based on an argument of expediency and as a matter of policy. Indeed, by applying the third test of the English law of torts on negligence – namely, whether it was fair, just and reasonable to impose liability on the public-care authorities in the circumstances of the case, the House of Lords found that it would be detrimental to the exercise of the duties of the public body in question to impose upon them the excessive burden of tortious liability for acts or omissions in the discharge of their duties. The position taken by the House of Lords in this matter was novel and tantamount to a refusal to extend tortious liability for civil wrongs arising out of a duty of care by local authorities for child care.

It is not the Court's task to enter into an examination of the social-policy considerations which led the national courts to interpret the third test in the way they did. Yet, it is its task to look at the circumstances surrounding the particular decisions taken and to assess their significance when applying its

own test of proportionality; and it seems difficult for me to accept that in view of the importance attached to the facts of the case by the various judicial and other bodies, and the novel character of the House of Lords' ruling, the creation of new case-law barring the examination of the case on its merits was proportionate to the need for adequate protection of individuals (and society generally) against negligence by public authorities.

Secondly, and more importantly, this Court has found a violation of Article 3 of the Convention on the basis of a finding that "the neglect and abuse suffered by the four applicant children reached the threshold of inhuman and degrading treatment" (see paragraph 74 of the judgment). Again it is difficult for me to accept that serious matters of public concern – as are all matters involving a violation of Article 3 – may be left outside the protection of independent and impartial tribunals established by law, and providing all the guarantees required by Article 6 of the Convention. The majority, however, holds a different view since it accepts that, even in circumstances where there has been a violation of the substance of Article 3, the Contracting States "are afforded some discretion as to the manner in which they conform to their Convention obligations ..." provided that some effective remedy exists to deal with individual complaints concerning inhuman and degrading treatment. Hence, they conclude that, in the present situation, Article 13, but not Article 6, has been violated.

It seems to me that the present case may be considered as the *locus classicus* of the limits afforded to States by the Convention to determine the modalities of access to domestic courts. Our case-law has repeatedly underlined the fact that the right to a tribunal is not unlimited – and rightly so. Yet, the Court is free to determine in which instances a Contracting State oversteps its freedom of choice and becomes liable under Article 6; and one criterion which can readily assist the Court in drawing the line between instances where a State retains its discretion, and instances where a State is bound to offer judicial guarantees to those falling under its jurisdiction, is the severity of the complaint before the national authorities. If the complaint may involve a violation of core Convention rights – such as Articles 2 and 3 – the Court is bound, to my mind, to find that the States are obliged not simply to offer an effective remedy (as required by Article 13), but a judicial remedy covering all the requirements of Article 6.

3. Most of the ideas put forward in the previous lines have as their source of inspiration *Osman v. the United Kingdom* (judgment of 28 October 1998, *Reports of Judgments and Decisions* 1998-VIII) which the majority has not followed in the present judgment. The main reason which has led the majority to depart from the established case-law is explained in paragraph 100 of the present judgment:

> "... The Court considers that its reasoning in *Osman* was based on an understanding of the law of negligence ... which has to be reviewed in the light of the clarifications subsequently made by the domestic courts and by notably the House of Lords. The

> Court is satisfied that the law of negligence as developed in the domestic courts since the case of *Caparo Industries plc* ... and as recently analysed in the case of *Barrett* ... includes the fair, just and reasonable criterion as an intrinsic element of the duty of care and that the ruling of law concerning that element in this case does not disclose the operation of an immunity. In the present case, the Court is led to the conclusion that the inability of the applicants to sue the local authority flowed not from an immunity but from the applicable principles governing the substantive right of action in domestic law. ..."

I do not think that in *Osman* the Court was very much concerned with this subtle issue raised by this judgment in the above-mentioned paragraph. The Court in *Osman* never said that the jurisdictional bar was an immunity to be distinguished from the applicable principles governing the substantive right of action in domestic law. It simply considered that "the application of the [exclusionary] rule in this manner without further enquiry into the existence of competing public interest considerations only serves *to confer a blanket immunity* on the police for their acts and omissions during the investigation and suppression of crime and amounts to an unjustifiable restriction on an applicant's right to have a determination on the merits of his or her claim against the police in deserving cases" (see *Osman*, cited above, p. 3170, § 151 – emphasis added). It went on to express the opinion that, in cases where the harm sustained by a complainant was of the most serious nature, examination of the merits could not be automatically excluded by the application of a rule which "*amounts to the grant of an immunity to the police*". In conclusion, the Court in *Osman* was mainly concerned with the fact that the applicants in a very serious case of possible substantive human-rights violations did not have the opportunity to air their grievances before a court of law; it was not concerned with whether the reason behind it being impossible to examine the case on the merits was or was not the result of an immunity provided for by national law acting as a procedural bar having such an effect. It simply found that the impossibility amounted to a grant of an immunity. Under these circumstances how can we distinguish between *Osman* and the present case?

For all the above reasons I believe that Article 6 (access to a court) has been violated and, hence, I consider that Article 13 does not raise a separate ground for violation, Article 6 being the *lex specialis* in this case.

PARTLY DISSENTING OPINION OF JUDGE THOMASSEN JOINED BY JUDGES CASADEVALL AND KOVLER

I am unable to agree with the majority that there has been no violation of Article 6 of the Convention in this case.

The Court is unanimous that the authorities failed to protect the applicants, young children, from inhuman and degrading treatment and its majority observes that the applicants were denied "a determination of their allegations that the local authority failed to protect them from inhuman and degrading treatment and the possibility of obtaining an enforceable award of compensation for the damage suffered thereby" (see paragraph 111 of the judgment).

Despite the severe negligence by the authorities, which allowed the ill-treatment of the applicants to continue for so many years and caused the applicants physical and psychiatric injuries amounting to a violation of Article 3, the applicants could not hold the authorities accountable in domestic court proceedings. By reference to policy factors (for example, difficulties of attributing responsibility between different agencies, sensitivity of decisions, risk of inculcating in local authorities a cautious and defensive approach to exercise of their duties, risk of costly and vexatious litigation) the domestic courts decided that the local authority could not be held liable in negligence in the exercise of their statutory powers to protect children. *De facto*, the local authority was thus declared to be immune for claims because they had acted in the exercise of their statutory powers to protect children.

In my view the applicants' rights under Article 6 were thereby violated as they had no access to a court in order to have a decision on their claims, which were arguable under national law. The facts of this case and the way in which domestic law operated are very similar to those in *Osman v. the United Kingdom* (judgment of 28 October 1998, *Reports of Judgments and Decisions* 1998-VIII) where the applicants' claims for negligence against the police were struck out for policy reasons relating to the perceived interests in preventing the efficiency of the police service being undermined by litigation. In *Osman* the Court found that the application of an exclusionary rule barring liability of the police for negligence in the exercise of their functions of investigating and preventing crime constituted a disproportionate restriction on access to a court for the applicants. The majority's reasons for not following the decisions in *Osman* (see paragraph 100 of the judgment) are not, to my mind, convincing. There seem to have been no striking or significant changes in the law of negligence since that case and all relevant matters concerning the content of domestic law had been brought to the attention of the Court by the parties in *Osman*. I am of the opinion that the conclusion under Article 6 in this case must be the same.

It is true that, as the majority observes in paragraph 95 of the judgment, the applicants were not prevented in any practical manner from bringing their claims before the domestic courts. The case was litigated up to the House of Lords, the applicants being provided with legal aid for that purpose. Nor is it the case that any procedural rules of limitation had been relied on. However, the notion of "access to a court" under Article 6 guarantees not only that the applicants have their claims brought before the courts, but implies also the right to have those claims examined on the basis of the facts before the courts and to have them decided on.

I agree with the majority saying in paragraph 98 that Article 6 does not in itself guarantee any particular content for civil rights and obligations in national law. But where there is an arguable claim under domestic tort law as in this case (see paragraph 89 of the judgment), requiring that the applicants obtain a decision by a court on the liability of those responsible for allowing their ill-treatment to continue for many years, cannot, in my opinion, be said to determine the content of domestic law.

I would observe that the Court's supervision of the activities of national courts in defining "access" or "liability" seems to take place on a wider basis. In *Fayed v. the United Kingdom* (judgment of 21 September 1994, Series A no. 294-B, pp. 49-50, § 65), the Court said:

> "Certainly the Convention enforcement bodies may not create by way of interpretation of Article 6 § 1 a substantive civil right which has no legal basis in the State concerned. However, it would not be consistent with the rule of law in a democratic society or with the basic principle underlying Article 6 § 1 – namely that civil claims must be capable of being submitted to a judge for adjudication – if, for example, a State could, without restraint or control by the Convention enforcement bodies, remove from the jurisdiction of the courts a whole range of civil claims or confer immunities from civil liability on large groups or categories of persons ..."

To reach its conclusion that the decision by the House of Lords did not amount to the granting of an immunity, the Court's majority observes, in paragraph 99, that in cases concerning the liability of local authorities in child-care matters brought after the applicants' case, the domestic courts have held that a duty of care may arise. But this does not change the fact that an immunity was conferred on the authorities in the applicants' case. Apparently the immunity applied in the applicants' case was found no longer appropriate in subsequent cases, the national courts taking into account, amongst other factors, the Court's approach in *Osman*, cited above.

While it has been alleged by the Government that a finding of a violation in this case would undermine the striking-out procedure used to avoid pointless litigation of baseless claims, I consider that this argument has not been substantiated by the material placed before the Court. The domestic courts have continued to strike cases out after the Court's judgment in *Osman*. A finding of a violation in this case would mean only that these applicants' claims, which involved serious ill-treatment contrary to a

fundamental human right, should not have been struck out on the basis of general policy arguments. This Court has found no denial of access to a court where judges have struck out cases where there has been no proximity or foreseeability (see, for example, *Powell v. the United Kingdom* (dec.), no. 45305/99, ECHR 2000-V, and *Bromiley v. the United Kingdom* (dec.), no. 33747/96, 23 November 1999, unreported).

The majority of the Court finds that the applicants were not afforded an effective remedy in respect of the breach of Article 3 and they conclude that Article 13, not Article 6, was violated.

My conclusion would be that the "remedy" to which the applicants were entitled should have been access to a court in order to have their damages settled. Restrictions to access to a court in order to protect the interests of the local authority exercising their powers to protect children may be necessary and justified under Article 6. However, I would say that in this case, where it is agreed that the child applicants were victims of the failure of the system to protect them from serious, long-term neglect and abuse, the immunity conferred on the local authority because of policy reasons cannot be seen as proportionate.

Therefore, I believe that Article 6 was violated.

I voted for a violation of Article 13 because I agree with the majority that the applicants, whose rights under Article 3 of the Convention were violated, had no effective remedy before the national authorities.

KÉZIKÖNYV

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Előszó

Ezt a gyermekjogokra vonatkozó európai jogról szóló kézikönyvet az Európai Unió Alapjogi Ügynöksége (FRA) és az Európa Tanács az Emberi Jogok Európai Bíróságának Hivatalával közösen készítette. Ez a szervezeteink által közösen kidolgozott európai jogi kézikönyvek sorozatának negyedik tagja. A korábbi kézikönyvek az anti-diszkriminációs jogszabályokra, a menekültügyre, a határvédelemre és a bevándorlásra, valamint az adatvédelemre vonatkozó európai jogot tárgyalták.

Ezt az új közös projektünket a Gyermek Jogairól szóló – valamennyi európai állam által ratifikált – ENSZ egyezmény (továbbiakban: Gyermekjogi egyezmény) 25. évfordulója alkalmából tartott ünnepségekhez kapcsolódóan indítottuk el, hogy megvilágítsuk, milyen szerepet játszanak az európai jogi normák annak biztosításában, hogy a gyermekek élvezhessék egyetemes jogaikat.

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Az Európai Unió Alapjogi
Ügynökségének igazgatója

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CRD	A fogyasztók jogairól szóló irányelv
CRPD	A Fogyatékossággal élő személyek jogairól szóló ENSZ egyezmény
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ECPT	Európai egyezmény a kínzás és az embertelen vagy megalázó büntetések vagy bánásmód megelőzéséről
ECSR	Szociális Jogok Európai Bizottsága
EGT	Európai Gazdasági Térség
EGK	Európai Gazdasági Közösség
EJEB	Az Emberi Jogok Európai Bírósága
EJEE	Egyezmény az emberi jogok és alapvető szabadságok védelméről (ismert nevén: az Emberi Jogok Európai Egyezménye)
ENSZ	Egyesült Nemzetek Szervezete
ESC	Európai Szociális Karta
ET	Európa Tanács
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FRA	Az Európai Unió Alapjogi Ügynöksége
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GRETA	Az Emberkereskedelem Elleni Küzdelem Szakértői Csoportja
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ICESCR	A Gazdasági, Szociális és Kulturális Jogok Nemzetközi Egyezségokmánya
ILO	Nemzetközi Munkaügyi Szervezet
PACE	Az Európa Tanács Parlamenti Közgyűlése
TCN	Harmadik országok állampolgárai
TSD	A játékok biztonságáról szóló irányelv
UCPD	A belső piacon az üzleti vállalkozások fogyasztókkal szemben folytatott tisztességtelen kereskedelmi gyakorlatairól szóló irányelv
UNHCR	Az ENSZ Menekültügyi Főbiztosa

Útmutató a kézikönyv használatához

Ez a kézikönyv áttekintést ad arról, hogy milyen alapvető jogokkal rendelkeznek a gyermekek az Európai Unió (EU) és az Európa Tanács (ET) tagállamaiban. Az áttekintés széles körű. A gyermekeket valamennyi emberi/alapvető jog alanyának tekinti, akikre ezenkívül – sajátos jellemzőikből adódóan – külön rendelkezések is vonatkoznak. A gyermekek jogai átívelnek a jog különböző területein. E kézikönyv a gyermekek szempontjából különösen fontos jogterületekre helyezi a hangsúlyt.

A kézikönyv olyan jogászoknak és más szakembereknek hivatott segítséget nyújtani, akik nem a gyermekjogok területére szakosodtak. Ügyvédeknek, bíráknak, ügyészeknek, szociális munkásoknak, valamint a nemzeti hatóságok és intézmények, illetve civil és nem-kormányzati szervezetek munkatársainak szól, akik ezekhez a témákhoz kapcsolódó jogi kérdésekkel találkozhatnak. A kézikönyv referenciaként szolgál az EU és az ET e területekkel kapcsolatos joganyagának vonatkozásában, és bemutatja, miként szabályozza az egyes kérdéseket az uniós jog, valamint az Emberi Jogok Európai Egyezménye (EJEE), az Európai Szociális Karta (ESC) és az Európa Tanács más jogi aktusai. Minden egyes fejezet táblázatot tartalmaz, amely összefoglalja a két különálló európai jogrendszer szerint alkalmazandó jogot. Ezt az egyes rendszerek szerint az adott témakör vonatkozásában alkalmazandó jog bemutatása követi. Az olvasó ezáltal megismerheti a két joganyag hasonlóságait és különbségeit. A kézikönyv adott esetben hivatkozik az Egyesült Nemzetek Szervezetének (ENSZ) a Gyermek jogairól szóló egyezményére (Gyermekjogi egyezmény) és egyéb nemzetközi jogi aktusokra is.

Azon nem uniós államok szakemberei, amelyek tagjai az Európa Tanácsnak és ezáltal részes felei az EJEE-nek, a saját országukra vonatkozó információkat az ET-ről szóló részekben találják meg. Az uniós tagállamok szakembereinek mindkét részt tanulmányozniuk kell, mivel ezekre az államokra mindkét jogrend érvényes. Aki egy bizonyos kérdésről szeretne többet megtudni, annak a kézikönyv „Ajánlott szakirodalom" című szakaszában szereplő, speciálisabb anyagokat is tartalmazó irodalomjegyzéket érdemes tanulmányoznia.

Az EJEE szerinti jog ismertetéséhez röviden bemutatjuk az Emberi Jogok Európai Bíróságának (EJEB) a kézikönyvben tárgyalt témákkal kapcsolatos válogatott ügyeit, amelyek az EJEB gyermekjogi kérdésekben született ítéletei és határozatai közül kerültek ki.

Az uniós jog az eddig elfogadott jogalkotási intézkedésekben, valamint a Szerződések és különösen az Európai Unió Alapjogi Chartája idevágó rendelkezéseiben foglaltatik benne, amelyek értelmezésénél az Európai Unió Bíróságának (EUB – a 2009. december előtti megnevezés szerint Európai Bíróság) ítélkezési gyakorlata az irányadó.

A kézikönyvben bemutatott vagy idézett ítélkezési gyakorlat az EJEB és az EUB jelentős esetjogi korpuszából hoz példákat. Amennyire azt a áttekintő jelleg és a korlátozott keretek lehetővé teszik, a kézikönyv 2015. január 1-jéig terjedően tárgyalja a jogi fejleményeket, noha lehetőség szerint későbbi fejleményekről is említést tesz.

A kézikönyv a bevezető fejezetben röviden bemutatja az ET és az EU joga által létrehozott két jogrendszer szerepét, majd 10 érdemi fejezetben foglalkozik a következő kérdésekkel:

- polgári jogok és szabadságok;
- egyenlő bánásmód és a hátrányos megkülönböztetés tilalma;
- identitáshoz fűződő kérdések;
- családi élet;
- gyermekvédelmi szakellátás (alternatív gondoskodás) és örökbefogadás;
- a gyermekek erőszakkal és kizsákmányolással szembeni védelme;
- gazdasági, szociális és kulturális jogok;
- migráció és menekültügy;
- fogyasztóvédelem és adatvédelem;
- a gyermekek jogai a büntető igazságszolgáltatás keretében.

Mindegyik fejezet egy különálló témát jár körül, a más témákra és fejezetekre vonatkozó kereszthivatkozások pedig megkönnyítik az alkalmazandó jogi keret átfogóbb megértését. Az egyes szakaszok elején ismertetjük a Kiemelt pontokat.

1

Bevezetés az európai gyermekjogi szabályozásba: háttér és alapvető elvek

EU	Tárgyalt kérdések	ET
A szabad mozgásról szóló irányelv (2004/38/EK), a 2. cikk (2) bekezdésének c) pontja	A „gyermek" mint jogalany	Az emberkereskedelem elleni fellépésről szóló egyezmény, a 4. cikk d) pontja A gyermekek szexuális kizsákmányolás és szexuális zaklatás elleni védelméről szóló egyezmény (Lanzarote-i Egyezmény), a 3. cikk a) pontja EJEB, *Marckx kontra Belgium*, (6833/74), 1979 (a bírósági ítélet meghozatalakor a kérelmező gyermek hatéves volt)
A fiatal munkavállalók védelméről szóló irányelv (94/33/EK), 3. cikk	A fiatal munkavállalók munkahelyi védelme	(Módosított) Európai Szociális Karta, 7. cikk (a gyermekek és fiatalok védelemhez való joga)
Alapjogi Charta, a 14. cikk (2) bekezdése (az oktatáshoz való jog)	A kötelező oktatásban való ingyenes részvételhez való jog	
Alapjogi Charta, 21. cikk (a hátrányos megkülönböztetés tilalma)	Az életkor alapján történő hátrányos megkülönböztetés tilalma	

EU	Tárgyalt kérdések	ET
Alapjogi Charta, 32. cikk (a gyermekmunka tilalma és a fiatalok munkahelyi védelme) A gyermekek szexuális bántalmazása, szexuális kizsákmányolása és a gyermekpornográfia elleni küzdelemről szóló irányelv (2011/93/EU) Az emberkereskedelem elleni küzdelemről szóló irányelv (2011/36/EU)	A kizsákmányoló gyermekmunka tilalma	(Módosított) Európai Szociális Karta, 7. cikk (a gyermekek és fiatalok védelemhez való joga)
Alapjogi Charta, 24. cikk (a gyermekek jogai) Az Európai Unióról szóló szerződés, a 3. cikk (3) bekezdése	A gyermekek jogainak (általános) védelme	
Alapjogi Charta, 7. cikk (a magán- és a családi élet tiszteletben tartása)	A magán- és családi élet tiszteletben tartásához való jog	EJEE, 8. cikk (a magán- és családi élet tiszteletben tartásához való jog) A házasságon kívül született gyermekek jogi helyzetéről szóló egyezmény A gyermekek örökbefogadásáról szóló (felülvizsgált) egyezmény A gyermekekkel való kapcsolattartásról szóló egyezmény A gyermekek jogainak gyakorlásáról szóló egyezmény EJEB, *Maslov kontra Ausztria* [Nagykamara], (1638/03), 2008 (a gyermekként bűncselekmények miatt elítélt kérelmező kitoloncolása)
EUB, C-413/99. sz. ügy, *Baumbast és R. kontra Secretary of State for the Home Department*, 2002 EUB, C-200/02. sz. ügy, *Kunqian Catherine Zhu és Man Lavette Chen kontra Secretary of State for the Home Department*, 2004 EUB, C-148/02. sz. ügy, *Carlos Garcia Avello kontra belga állam*, 2003 EUB, C-310/08. sz. ügy, *London Borough of Harrow kontra Nimco Hassan Ibrahim és Secretary of State for the Home Department*, 2010	A személyek szabad mozgása	

EU	Tárgyalt kérdések	ET
EUB, C-480/08. sz. ügy, *Maria Teixeira kontra London Borough of Lambeth és Secretary of State for the Home Department*, 2010		

Ez a bevezető fejezet bemutatja, hogyan fejlődött európai szinten a gyermekjogi szabályozás, mely alapelvek vezérlik annak alkalmazását, és melyek azok az alapvető gyermekjogi kérdéskörök, amelyekkel az európai jog foglalkozik. Mindez háttérként szolgál a következő fejezetek egyes területekre vonatkozó elemzéséhez.

1.1. Elméleti kiindulópontok

Kiemelt pontok

- Az európai gyermekjogi jogszabályok a nemzeti és nemzetközi szinten már létező rendelkezésekre épülnek.

1.1.1. Az európai gyermekjogi jogszabályok hatásköre

Az „európai gyermekjogi jogszabályok” említésekor az Európa Tanács (ET) és az Európai Unió (EU) által bevezetett elsődleges jogforrásokra (szerződések, egyezmények) és a másodlagos jogforrásokra, valamint az esetjogra gondolunk. Adott esetben hivatkozunk egyéb olyan európai forrásokra, amelyek hatással voltak az európai gyermekjogi jogszabályok fejlődésére, ideértve a kulcsfontosságú szakpolitikai dokumentumokat, az iránymutatásokat és más, nem kötelező érvényű, illetve puha jogi eszközöket.

A gyermekek elsősorban jogaik birtokosai, s nem pusztán védelem tárgyát képező személyek. Valamennyi emberi/alapvető jog megilleti őket, emellett – sajátos jellemzőikből adódóan – külön rendelkezések is vonatkoznak rájuk. A gyermekek korlátozott cselekvőképességéből adódóan az európai esetjog jelentős része a szülők vagy a gyermekek egyéb törvényes képviselői által kezdeményezett peres ügyekből származik. Miközben e kézkönyv azt hivatott bemutatni, hogy miként jelennek meg a jogban a gyermekek speciális érdekei és szükségletei,

emellett a szülők/gyámok és más törvényes képviselők fontosságára is rávilágít, és adott esetben utal arra, hogy milyen körülmények esetén ruházzák a jogokat és kötelezettségeket a gyermekek gondozóira. Ilyen esetekben az ENSZ Gyermek jogairól szóló egyezményében (Gyermekjogi egyezmény)[1] foglalt megközelítés érvényesül, nevezetesen a szülői kötelezettségek teljesítésekor a gyermek legfőbb (mindenek felett álló) érdekeit kell elsődleges szempontnak tekinteni, és a gyermek kibontakozó képességének megfelelően kell eljárni[2].

1.1.2. A „gyermek" mint jogalany

A nemzetközi jogban a Gyermekjogi egyezmény 1. cikkében kimondja, hogy „gyermek az a személy, aki tizennyolcadik életévét nem töltötte be". Ez jelenleg az az Európában is alkalmazott jogi paraméter, amelynek alapján meghatározzák, hogy ki a gyermek.

Az uniós jogban nem létezik egységes, formális meghatározása a „gyermek" fogalmának, sem a Szerződésekben, sem pedig az alacsonyabb rendű jogszabályokban vagy az ítélkezési gyakorlatban. A gyermek fogalommeghatározása a szabályozási háttértől függően jelentős eltéréseket mutathat az uniós jogon belül. Így például az uniós polgárok és családtagjaik szabad mozgáshoz való jogára nézve irányadó uniós jogszabály meghatározása szerint „gyermekek" azok az egyenes ági leszármazottak, „akik 21. életévüket nem töltötték be vagy eltartottak"[3], ami alapvetően biológiai és gazdasági fogalom, nem pedig a kiskorúság tényén alapul.

Néhány uniós jogszabály életkortól függően különböző jogokat tulajdonít a gyermekeknek. A fiatal személyek munkahelyi védelméről szóló 94/33/EK irányelv (a fiatal munkavállalók védelméről szóló irányelv)[4] például, amely a gyermekek

1 Az ENSZ Közgyűlése (1989), Egyezmény a Gyermek Jogairól, 1989. november 20.

2 Jelen magyar fordítás a Gyermekjogi egyezmény hivatalos magyar fordításában alkalmazott és más kapcsolódó jogszabályokban is meghonosodott „mindenek felett álló érdek" kifejezés mellé, az angol „best interests of the child" kifejezésnek, tartalmát tekintve jobban megfelelő „legfőbb érdek" kifejezést is használja.

3 Az Európai Parlament és a Tanács 2004. április 29-i 2004/38/EK irányelve az Unió polgárainak és családtagjaiknak a tagállamok területén történő szabad mozgáshoz és tartózkodáshoz való jogáról, valamint az 1612/68/EGK rendelet módosításáról, továbbá a 64/221/EGK, a 68/360/EGK, a 72/194/EGK, a 73/148/EGK, a 75/34/EGK, a 75/35/EGK, a 90/364/EGK, a 90/365/EGK és a 93/96/EGK irányelv hatályon kívül helyezéséről, HL L 158., 2004. április 30. és HL L 158., 2004. április 29., 2. cikk (2) bekezdés c) pont.

4 Az 1994. június 22-i 94/33/EK irányelv a fiatal személyek munkahelyi védelméről, HL L 216., 1994, 3. cikk.

uniós tagállamokon belüli formális foglalkoztatáshoz való hozzáférését és annak feltételeit szabályozza, különbséget tesz a „fiatal személy" (a 18 évesnél fiatalabb személyekre alkalmazott általános fogalom), valamint a „serdülő" (a legalább 15. életévét betöltött, de 18 évesnél fiatalabb, már nem tanköteles személy) és a „gyermek" (a 15 év alatti, a formális foglalkoztatásból nagyrészt kizárandó személy) között.

Az uniós jog más területein, különösen ahol az uniós fellépés kiegészíti a tagállami fellépést (ideértve a szociális biztonságot, a migrációt és az oktatást) a „gyermek" fogalmának meghatározása a nemzeti jogra hárul. Ezekben az esetekben a Gyermekjogi egyezmény fogalommeghatározása az általánosan elfogadott.

Az Európa Tanács joganyagában a gyermekekkel kapcsolatos jogi eszközök elsősorban a „gyermek" Gyermekjogi egyezmény szerinti fogalommeghatározását alkalmazzák. Példa erre az Európa Tanács emberkereskedelem elleni fellépésről szóló egyezménye[5] 4. cikkének d) pontja, valamint az Európa Tanács gyermekek szexuális kizsákmányolás és szexuális zaklatás elleni védelméről szóló egyezménye (Lanzarote-i Egyezmény)[6] 3. cikkének a) pontja.

Az Emberi Jogok Európai Egyezménye (EJEE) nem tartalmaz fogalommeghatározást a gyermekre vonatkozóan, 1. cikke azonban előírja az államok számára, hogy a joghatóságuk alatt álló „minden személy számára" biztosítsák az egyezmény szerinti jogokat. Az EJEE 14. cikke rendelkezik az egyezményben meghatározott jogok „minden hátrányos megkülönböztetés", így például életkor alapján történő hátrányos megkülönböztetés nélküli élvezetének biztosításáról.[7] Az Emberi Jogok Európai Bírósága (EJEB) életkortól függetlenül fogad be gyermekek által, illetve nevében benyújtott kérelmeket.[8] Ítélkezési gyakorlatában a Gyermekjogi egyezmény gyermekre vonatkozó fogalommeghatározását alkalmazza[9], a tizennyolcadik életév be nem töltésére vonatkozó kitételt támogatva.

5 Európa Tanács, Egyezmény az emberkereskedelem elleni fellépésről, CETS 197., 2005. május 15.

6 Európa Tanács, Egyezmény a gyermekek szexuális kizsákmányolás és szexuális zaklatás elleni védelméről, CETS 201., 2007. október 25.

7 EJEB, *Schwizgebel kontra Svájc* (25762/07), 2010. június 10. Lásd még FRA és EJEB (2010), 102. o.

8 Lásd például EJEB, *Marckx kontra Belgium* (6833/74), 1979. június 13., ahol a bírósági ítélet meghozatalakor a kérelmező gyermek hatéves volt.

9 EJEB, *Güveç kontra Törökország* (70337/01), 2009. január 20.; *Çoşelav kontra Törökország* (1413/07), 2012. október 9.

Ugyanez érvényes az Európai Szociális Kartára (ESC) és annak a Szociális Jogok Európai Bizottsága (ECSR) általi értelmezésére.[10]

1.2. Az európai gyermekjogi jogszabályok háttere

A legtöbb eddigi európai gyermekjogi jogszabályt az EU és az ET dolgozta ki. Az ENSZ mellett több más nemzetközi intézmény, köztük a Hágai Nemzetközi Magánjogi Konferencia is fontos jogi aktusokat fogadott el, amelyek tovább segítik az európai jogfejlődést. Noha ezek a nemzetközi keretszabályozások egymástól függetlenül működnek, egyre több kapcsolat jön létre közöttük.[11] Különösen erőteljes az intézményközi együttműködés az ET és az EU között.

1.2.1. Európai Unió: a gyermekjogi jogszabályok fejlődése és a védelem területei

A gyermekjogok Unión belüli fejlődése fokozatosan, egy-egy területen változó ütemben ment végbe. Az európai gyermekjog hagyományosan elsősorban a tágabb, gazdasági és politikai indíttatású kezdeményezések gyermekekkel kapcsolatos egyes vonatkozásainak kezelését célozta, például a fogyasztóvédelem[12] és a személyek szabad mozgása területén.[13] Újabban azonban a gyermekjogok kezelése összehangoltabb uniós menetrend részét képezi, három kulcsfontosságú mérföldkőre alapozva:

- az Európai Unió Alapjogi Chartájának bevezetése;
- a Lisszaboni Szerződés 2009. decemberi hatálybalépése;
- „A gyermekek különleges helyzetének figyelembevétele az Európai Unió külső fellépéseiben” című európai bizottsági közlemény, valamint

10 Szociális Jogok Európai Bizottsága, *Defence for Children International (DCI) kontra Hollandia* (47/2008), 2009. október 20., 25. pont.

11 Lásd például az 5. fejezetet, amely bemutatja, hogyan működik a gyermekek határokon átnyúló jogellenes elvitelére vonatkozó uniós családjog a gyermekek jogellenes külföldre vitelének polgári jogi vonatkozásairól szóló 1980. október 25-i egyezménnyel (Hágai Egyezmény).

12 Például az Európai Parlament és a Tanács 2009. június 18-i 2009/48/EK irányelve a játékok biztonságáról (HL L 170., 2009), amely biztonsági intézkedéseket érvényesít a gyermekjátékok vonatkozásában.

13 Például a 2004/38/EK irányelv.

a gyermek jogainak előmozdítására és védelmére vonatkozó uniós tanácsi iránymutatások elfogadása.

Az első mérföldkövet az Európai Unió Alapjogi Chartájának 2000. évi bevezetése jelentette.[14] A Lisszaboni Szerződés 2009. december 1-jei hatálybalépése óta a Charta az uniós Szerződésekkel azonos jogi státuszt élvez (az Európai Unióról szóló szerződés (EUSZ) 6. cikke). A Charta kötelezi az Uniót és tagállamait, hogy az uniós jog végrehajtásakor védelmezzék az abban rögzített jogokat. Az Európai Unió Alapjogi Chartája első ízben hivatkozik részletesen, uniós alkotmányos szinten a gyermekek jogaira, elismerve többek között a gyermekek kötelező oktatásban való ingyenes részvételhez való jogát (a 14. cikk (2) bekezdése), az életkoron alapuló hátrányos megkülönböztetés tilalmát (21. cikk), valamint a kizsákmányoló gyermekmunka tilalmát (32. cikk). Jelentős elem, hogy a Charta külön rendelkezést tartalmaz a gyermekek jogaira vonatkozóan (24. cikk). Ez a cikk három kulcsfontosságú elvet rögzít a gyermekek jogainak tekintetében: a véleményük életkoruknak és érettségüknek megfelelő, szabad kifejezéséhez való jog (a 24. cikk (1) bekezdése); a legfőbb (mindenek felett álló) érdekük elsődleges szempontként való figyelembevételéhez való jog valamennyi, velük kapcsolatos tevékenység során (a 24. cikk (2) bekezdése); valamint a mindkét szülővel való rendszeres, személyes és közvetlen kapcsolattartáshoz való jog (a 24. cikk (3) bekezdése).

A második kulcsfontosságú mérföldkő a Lisszaboni Szerződés volt, amely, mint az már fentebb említésre került, 2009. december 1-jén lépett hatályba.[15] Ez az eszköz az EUSZ és a korábbi Európai Közösséget létrehozó szerződés (mai nevén az Európai Unió működéséről szóló szerződés) módosítása révén jelentős intézményi, eljárási és alkotmányos változásokat hozott az Unióban.[16] Ezek a változások erősítették az EU képességét a gyermekjogok védelmének előmozdítására, nem utolsósorban azáltal, hogy az EU egyik általános kinyilvánított célkitűzéseként (az EUSZ 3. cikkének (3) bekezdése) és az EU külkapcsolati politikájának fontos tényezőjeként határozza meg (az EUSZ 3. cikkének (5) bekezdése) „a gyermekek jogainak védelmét".Az EUMSZ is további konkrét utalásokat tartalmaz a gyermekekre vonatkozóan, amely lehetővé teszi az Unió számára, hogy intézkedéseket

14 EU (2012), Az Európai Unió Alapjogi Chartája, HL C 326., 2012.

15 EU (2007), Az Európai Unióról szóló szerződés és az Európai Közösséget létrehozó szerződés módosításáról szóló, Lisszabonban aláírt Lisszaboni Szerződés, HL C 306., 2007., 1–271 o.

16 Lásd: Európai Közösségek (2012), Az Európai Unióról szóló szerződés (EUSZ) és az Európai Unió működéséről szóló szerződés (EUMSZ) egységes szerkezetbe foglalt változata, HL C 326., 2012.

tegyen a szexuális kizsákmányolás és az emberkereskedelem elleni küzdelem céljából (79. cikk (2) bekezdésének d) pontja és a 83. cikk (1) bekezdése).

Ennek nyomán került elfogadásra a gyermekek szexuális bántalmazásával, szexuális kizsákmányolásával és a gyermekpornográfiával szembeni küzdelemről[17], valamint az emberkereskedelem megelőzéséről és az ellene folytatott küzdelemről szóló irányelv[18], amely a gyermek áldozatok speciális szükségleteit érintő rendelkezéseket is tartalmaz. A bűncselekmények áldozatainak jogaira, támogatására és védelmére vonatkozó minimumszabályok megállapításáról szóló újabb irányelv hasonlóképpen számos rendelkezést szentel a gyermekeknek[19].

A harmadik fontos mérföldkő stratégiaibb, politikai szinten következett, eredetileg az EU külső együttműködési menetrendjével összefüggésben, majd később belső ügyekhez kapcsolódóan. Ennek keretében az Európai Unió Tanácsa elfogadta a gyermek jogainak előmozdítására és védelmére vonatkozó uniós iránymutatásokat[20], az Európai Bizottság pedig *„A gyermekek különleges helyzetének figyelembevétele az Európai Unió külső fellépéseiben”* című közleményt[21], amelyek célja a gyermekek jogainak általános érvényesítése az EU valamennyi, nem uniós tagállamokkal kapcsolatos tevékenységében. Ehhez hasonlóan az Európai Bizottság 2011-ben elfogadta az EU gyermekjogi ütemtervét, amely meghatározza a gyermekjogi szabályozás és szakpolitika uniós tagállamokon belüli fejlesztésének kulcsfontosságú prioritásait.[22] Az ütemterv a gyermekek védelme szempontjából releváns jogalkotási eljárásokat is előirányzott, ideértve az áldozatok jogairól szóló említett irányelv elfogadását.

Nemrégiben mindez kiegészült azzal, hogy a Bizottság átfogó stratégiát fogadott el, amelynek célja a tagállamok támogatása a szegénység és a társadalmi kirekesztés kezelésében egy sor, a koragyermekkori (6 éves kor alatti és általános

17 2011/93/EU irányelv, HL L 335., 2011, 1. o.

18 2011/36/EU irányelv, HL L 101., 2011, 1. o.

19 2012/29/EU irányelv, HL L 315., 2012, 57. o.

20 Az Európai Unió Tanácsa (2007), *A gyermek jogainak előmozdítására és védelmére vonatkozó uniós iránymutatások*, Brüsszel, 2007. december 10.

21 Európai Bizottság (2008), *A gyermekek különleges helyzetének figyelembevétele az Európai Unió külső fellépéseiben: A Bizottság közleménye a Tanácsnak, az Európai Parlamentnek, az Európai gazdasági és Szociális bizottságnak és a Régiók Bizottságának*, COM(2008) 55 final, Brüsszel, 2008. február 5.

22 Európai Bizottság (2011), *Az EU gyermekjogi ütemterve: A Bizottság közleménye az Európai Parlamentnek, a Tanácsnak, az Európai Gazdasági és Szociális Bizottságnak és a Régiók Bizottságának*, COM(2011)0060 final, Brüsszel, 2011. február 15.

iskolás korú gyermekekre irányuló) fellépés révén.[23] Ez a kezdeményezés, az ütemtervhez hasonlóan nem bír jogi kötőerővel, ugyanakkor mindkettő jelentőséggel bír abban a vonatkozásban, hogy meghatározzák az EU gyermekjogi szabályozással kapcsolatos normatív és módszertani megközelítésmódjának kívánatos módját, amely szorosan kapcsolódik a Gyermekjogi egyezményhez, és amely a gyermekek védelme, a részvételhez való jog és a hátrányos megkülönböztetés tilalmának étoszán alapul.

Az EU csak abban az esetben alkothat jogszabályokat, ha ahhoz a Szerződések hatáskört ruháznak rá (az EUMSZ 2–4. cikke). Mivel a gyermekjogok ágazatokon átívelnek, az EU hatáskörét eseti alapon kell meghatározni. Mindeddig az EU az alábbi, a gyermekjogok szempontjából fontos területeken végzett kiterjedt jogalkotási tevékenységet:

- adatvédelem és fogyasztóvédelem;
- menekültügy és migráció;
- polgári és büntetőügyekben folytatott együttműködés.

Az EUSZ 6. cikkének (1) bekezdése és az Európai Unió Alapjogi Chartája 51. cikkének (2) bekezdése kimondja, hogy a Charta nem terjeszti ki az Unió hatásköreit, valamint nem hoz létre új hatásköröket vagy feladatokat az Unió számára, és nem módosítja azokat. A Charta rendelkezéseinek címzettjei az uniós intézmények és a tagállamok annyiban, amennyiben az Unió jogát hajtják végre. Miközben a Charta rendelkezései az Unióra nézve mindig kötelező érvényűek, a tagállamokra nézve csak akkor kötelezőek jogilag, ha az uniós jog hatályán belül járnak el.

A következő fejezetek mindegyike rövid áttekintést ad az EU adott fejezetben tárgyalt területen fennálló hatásköréről.

1.2.2. Európa Tanács: a gyermekjogi jogszabályok fejlődése és a védelem területei

Az Európai Unióval szemben, az ET már létrejötte óta egyértelmű mandátummal rendelkezik az emberi jogok védelmére és előmozdítására vonatkozóan. Legfontosabb emberi jogi szerződése, az Emberi jogok és alapvető szabadságok

23 Európai Bizottság (2013), *Beruházások a gyermekek érdekében: a hátrányos helyzetből való kitörés*, 2013/112/EU ajánlás, Brüsszel.

védelméről szóló egyezmény vagy más néven az Emberi Jogok Európai Egyezménye (EJEE), amelyet az ET valamennyi tagállama ratifikált, és amely konkrét rendelkezéseket tartalmaz a gyermekekre vonatkozóan. Ezek közül a legfontosabbak a következők: az 5. cikk (1) bekezdésének d) pontja rendelkezik a gyermek nevelési felügyelet céljából történő törvényes őrizetbe vételéről; a 6. cikk (1) bekezdése korlátozza a tisztességes és nyilvános tárgyaláshoz való jogot abban az esetben, ha ez kiskorúak érdekei szempontjából szükséges; az EJEE-hez csatolt 1. Kiegészítő Jegyzőkönyv 2. cikke pedig kimondja az oktatáshoz való jogot, és előírja, hogy a tagállamoknak tiszteletben kell tartaniuk a szülők vallási és világnézeti meggyőződését gyermekeik oktatása tekintetében. Emellett az EJEE valamennyi általános rendelkezése minden emberre, köztük a gyermekekre is alkalmazandó. Ezek közül számos különösen fontos a gyermekek szempontjából, így például a 8. cikk, amely biztosítja a magán- és családi élet tiszteletben tartásához való jogot, valamint a 3. cikk, amely tiltja a kínzást és az embertelen, megalázó bánásmódot és büntetést. Az EJEB az EJEE rendelkezéseiben megfogalmazott pozitív kötelezettségekre összpontosító értelmező megközelítéseket alkalmazva kiterjedt ítélkezési gyakorlatot alakított ki a gyermekek jogaira vonatkozóan, amelyben gyakran utal Gyermekjogi egyezményére. Mindazonáltal az EJEB eseti alapon vizsgálja meg a kérelmeket, és ezért nem nyújt átfogó áttekintést az EJEE értelmében a gyermekeket megillető jogokról.

Az ET másik fő emberi jogi szerződése, az Európai Szociális Karta (ESC[24] – 1996-ban felülvizsgálva[25]) rendelkezik a szociális jogok védelméről, külön kitérve a gyermekek jogaira. Két rendelkezése különösen fontos a gyermekek jogai szempontjából. A 7. cikk előírja a gyermekek gazdasági kizsákmányolással szembeni védelmét, a 17. cikk pedig kimondja, hogy az államoknak valamennyi megfelelő és szükséges intézkedést meg kell tenniük annak biztosítása érdekében, hogy a gyermekek részesüljenek a számukra szükséges gondozásban, támogatásban, oktatásban és képzésben (beleértve az ingyenes alap- és középfokú oktatást), valamint hogy védjék a gyermekeket és a fiatalokat az elhanyagolás, az erőszak és a kizsákmányolás minden formájától, és biztosítsanak védelmet azon gyermekek számára, akik nem kapnak támogatást a családjuktól. Az Európai Szociális Karta végrehajtását a Szociális Jogok Európai Bizottsága (ECSR) felügyeli, amely független szakértőkből ál és kollektív panasztételi eljárás vagy nemzeti jelentéstételi eljárás útján ítélkezik a nemzeti jog és gyakorlat Európai Szociális Kartának való megfelelőségéről.

24 Európa Tanács, Európai Szociális Karta, CETS 35., 1961. október 18.

25 Európa Tanács, (Módosított) Európai Szociális Karta, CETS 163., 1996. május 3.

Emellett az ET számos más szerződést is elfogadott, amelyek különféle egyedi gyermekjogi kérdéseket tárgyalnak. Ide tartoznak az alábbiak:

- a házasságon kívül született gyermekek jogi helyzetéről szóló egyezmény;[26]
- a gyermekek örökbefogadásáról szóló, 2008-ban felülvizsgált egyezmény;[27]
- a gyermekekkel való kapcsolattartásról szóló egyezmény;[28]
- a gyermekek jogainak gyakorlásáról szóló egyezmény;[29]
- az Európa Tanácsnak a gyermekek szexuális kizsákmányolás és szexuális zaklatás elleni védelméről szóló egyezménye (Lanzarote-i Egyezmény).[30]

Végezetül a politikai szintet tekintve meg kell jegyezni, hogy az ET 2006-ban elindította az „Építsük Európát a gyermekekért a gyermekekkel" elnevezésű programját, amely transzverzális cselekvési tervként gyermekjogi kérdések kezelését szolgálja, ideértve normaalkotási eszközök elfogadását számos területre kiterjedően.[31] A jelenlegi prioritások négy kulcsfontosságú területre összpontosulnak:[32]

- a gyermekbarát szolgáltatások és rendszerek előmozdítása;
- a gyermekekkel szembeni erőszak valamennyi formájának felszámolása;
- a kiszolgáltatott helyzetben lévő, sérülékeny (különösen védendő) gyermekek jogainak szavatolása;
- a gyermekek részvételének előmozdítása.

26 Európa Tanács, Európai egyezmény a házasságon kívül született gyermekek jogi helyzetéről, CETS 85., 1975. október 15.

27 Európa Tanács, (Felülvizsgált) Európai egyezmény a gyermekek örökbefogadásáról, CETS 202., 2008. november 27.

28 Európa Tanács, Egyezmény a gyermekekkel való kapcsolattartásról, CETS 192., 2003. május 15.

29 Európa Tanács, Európai egyezmény a gyermekek jogainak gyakorlásáról, CETS 160., 1996. január 25.

30 Európa Tanács, Egyezmény a gyermekek szexuális kizsákmányolás és szexuális zaklatás elleni védelméről, CETS 201., 2007. október 25.

31 Bővebb információért lásd: http://www.coe.int/t/dg3/children/.

32 Európa Tanács, Miniszteri Bizottság (2011), Az Európa Tanács gyermekjogi stratégiája (2012–2015), CM (2011)171 final, 2012. február 15.

Az ET gyermekjogi programjának fő célja a nemzetközi gyermekjogi normák valamennyi ET-tagállam általi végrehajtásának támogatása és különösen a Gyermekjogi egyezmény végrehajtásának előmozdítása, rámutatva annak legfontosabb elveire: a hátrányos megkülönböztetés tilalma, az élethez és a fejlődéshez való jog, a gyermek legfőbb (mindenek felett álló) érdeke mint a döntéshozók által elsődlegesen figyelembe veendő szempont, valamint a gyermekek meghallgatáshoz való joga.[33]

A program több gyermekjogi eszköz elfogadását követte nyomon, gyakorlati iránymutatást adva a kötelező érvényű európai jogi eszközök kiegészítése céljából, ideértve az alábbiakat:

- a gyermekbarát igazságszolgáltatásról szóló iránymutatás;[34]
- a gyermekbarát egészségügyi ellátásról szóló iránymutatás;[35]
- a gyermekek erőszakkal szembeni védelmét célzó integrált nemzeti stratégiákról szóló ajánlás;[36]
- a gyermekek jogairól és a gyermek- és családbarát szociális szolgáltatásokról szóló ajánlás;[37]
- a 18 év alatti gyermekek és fiatalok részvételéről szóló ajánlás.[38]

A program így biztosította, hogy Európa központi szerepet játsszon a gyermekjogi normák meghatározásában, emellett különböző eszközök révén éllovasa volt annak, hogy a gyermekek véleménye középpontban álljon ebben a folyamatban. A program célja továbbá az EJEE és az Európai Szociális Karta végrehajtásának támogatása, valamint az ET gyermekekkel (részvételükkel, védelmükkel

33 *Uo.*

34 Európa Tanács, Miniszteri Bizottság (2010), *Iránymutatás a gyermekbarát igazságszolgáltatásról*, 2010. november 17.

35 Európa Tanács, Miniszteri Bizottság (2011), *Iránymutatás a gyermekbarát egészségügyi ellátásról*, 2011. szeptember 21.

36 Európa Tanács, Miniszteri Bizottság (2009), A Miniszteri Bizottság CM/Rec(2009)10. sz. ajánlása a tagállamok számára a gyermekek erőszakkal szembeni védelmét célzó integrált nemzeti stratégiákról, 2009. november 18.

37 Európa Tanács, Miniszteri Bizottság (2011), Rec (2011)12. sz. ajánlás a gyermekek jogairól és a gyermek- és családbarát szociális szolgáltatásokról, 2011. november 16.

38 Európa Tanács, Miniszteri Bizottság (2012), Rec (2012)2. sz. ajánlás a 18 év alatti gyermekek és fiatalok részvételéről, 2012. március 28.

és jogaikkal), fiatalokkal és családdal kapcsolatos további meglévő jogi eszközeinek előmozdítása.[39]

1.3. Az európai gyermekjogi szabályozás és az ENSZ Gyermek Jogairól szóló Egyezménye

Kiemelt pontok

- Az európai gyermekjogi szabályozás jelentős részben az ENSZ Gyermek Jogairól szóló egyezményén (Gyermekjogi egyezmény) alapul.

Mivel az EU és az ET valamennyi tagállama részes fele a Gyermekjogi egyezménynek, az egyezmény fontos szerepet tölt be európai szinten. Közös jogi kötelezettségeket ró az európai államokra, és hatással van arra, hogy miként biztosítják és fejlesztik az európai intézmények a gyermekek jogainak védelmét.

Ezáltal a Gyermekjogi egyezmény az európai gyermekjogi szabályozás fejlődésének alapkövévé vált, amelynek következtében az ET és az EU egyre inkább támaszkodik annak befolyására. Azzal, hogy a Gyermekjogi egyezmény elvei és rendelkezései európai szinten beépülnek a kötelező erejű eszközökbe és az ítélkezési gyakorlatba, a Gyermekjogi egyezmény erőteljesebbé válik, és hatékonyabb jogérvényesítési csatornákat nyit meg mindazok előtt, akik Európában hivatkozni kívánnak a gyermekek jogaira. Erre a kézikönyv számos helyen szolgál konkrét példákkal.

Az EU nem részes fele a Gyermekjogi egyezménynek és nem is válhat azzá, mivel a Gyermekjogi egyezmény keretén belül nem létezik olyan jogi mechanizmus, amely lehetővé tenné az államtól eltérő jogalanyok csatlakozását. Az EU azonban az uniós Szerződések értelmezésének kiegészítése és az ezzel kapcsolatos iránymutatás céljából az uniós jog „általános elveire" (a tagállamok közös alkotmányos hagyományaiból következő írott és íratlan elvekre) támaszkodik (az EUSZ 6. cikkének (3) bekezdése). Az Európai Unió Bíróságának (EUB) ítéletei

39 Európa Tanács, Miniszteri Bizottság (2011), *Az Európa Tanács gyermekjogi stratégiája (2012–2015)*, CM (2011)171 final, 2012. február 15.

megerősítették, hogy az uniós tagságból eredő kötelezettségek nem ütközhetnek a tagállamok saját alkotmányukból és nemzetközi emberi jogi kötelezettségvállalásaikból adódó kötelezettségeivel.[40] Mivel a Gyermekjogi egyezményt valamennyi uniós tagállam ratifikálta, az Uniónak legalább az (uniós Szerződések által meghatározott) uniós hatáskörbe tartozó kérdések vonatkozásában tartania kell magát az abban rögzített elvekhez és rendelkezésekhez.

Ezt a kötelezettséget erősítik más uniós szerződések, és különösen az Európai Unió Alapjogi Chartája. A Charta 24. cikkét közvetlenül a Gyermekjogi egyezmény rendelkezései ihlették, ideértve néhány, a „Gyermekjogi egyezmény alapelveinek" rangjára emelkedett rendelkezést, nevezetesen a gyermek legfőbb (mindenek felett álló) érdekének elvét (Gyermekjogi egyezmény 3. cikk), a gyermek részvételének jogát (Gyermekjogi egyezmény 12. cikk), valamint a gyermek azon jogát, hogy szüleivel éljen és/vagy kapcsolatot tartson (Gyermekjogi egyezmény 9. cikk).

Arra, hogy milyen fontos szerepet játszik a Gyermekjogi egyezmény az uniós gyermekjogok fejlődésében, az Európai Bizottság gyermekjogi ütemterve is rámutatott, amely leszögezi, hogy „a Gyermekjogi egyezmény normáinak és elveinek továbbra is iránymutatásul kell szolgálniuk a gyermekek jogait érintő uniós politikák és fellépések számára".[41] Ennek szellemében a gyermekekkel kapcsolatos jogalkotási eszközök szinte kivétel nélkül kifejezetten hivatkoznak a Gyermekjogi egyezményre, vagy implicitebb módon utalnak az olyan gyermekjogi elvekre, mint a legfőbb (mindenek felett álló) érdek, a gyermek alapvető joga az őt érintő döntések meghozatalában való részvételhez, vagy a hátrányos megkülönböztetés tilalma.

Az Európai Unióhoz hasonlóan az Európa Tanácsot, mint szervezetet nem köti jogilag a Gyermekjogi egyezmény, noha az ET valamennyi tagállama külön-külön részes fele az egyezménynek. Az EJEE sem értelmezhető azonban légüres térben, hanem azt a nemzetközi jog általános elveivel összhangban kell értelmezni. Minden esetben figyelembe kell venni az EJEE részes államai közötti kapcsolatokra alkalmazandó nemzetközi jogi szabályokat, különös tekintettel az emberi jogok egyetemes védelmével kapcsolatos szabályokra. Az EJEE által a gyermekek jogai területén a részes államokra rótt konkrétabb kötelezettségeket a Gyermekjogi egyezmény

40 Például EUB, C-4/73. sz. ügy, *J. Nold, Kohlen- und Baustoffgroßhandlung kontra az Európai Közösségek Bizottsága*, 1974. május 14.

41 Európai Bizottság (2011), *Az EU gyermekjogi ütemterve*, COM(2011)0060 final, Brüsszel.

fényében kell értelmezni.[42] A Szociális Jogok Európai Bizottsága ugyancsak kifejezetten hivatkozik határozataiban a Gyermekjogi egyezményre.[43] Emellett az ET normaalkotási és szerződéskidolgozási tevékenységeire hatnak a Gyermekjogi egyezmény elvei és rendelkezései. Így például a gyermekbarát igazságszolgáltatásról szóló iránymutatás[44] közvetlenül merített a Gyermekjogi egyezmény számos rendelkezéséből, nem szólva az ENSZ Gyermekjogi Bizottságának azt kísérő, a gyermek jogairól szóló Átfogó Kommentárjairól.[45]

1.4. Az európai bíróságok szerepe az európai gyermekjogok értelmezésében és érvényre juttatásában

1.4.1. Az Európai Unió Bírósága

Az EUB számos különféle jogi keresetre vonatkozóan ad ki határozatokat. Gyermekjogi kérdésekben az EUB mindeddig elsősorban előzetes döntéshozatali ügyeket vizsgált felül (az EUMSZ 267. cikke).[46] Ezek olyan eljárások, amelyek során egy nemzeti bíróság vagy törvényszék kéri az Európai Bíróságtól az elsődleges uniós jog (azaz a Szerződések) vagy a másodlagos uniós jog (azaz határozatok és más jogszabályok) értelmezését egy, az adott nemzeti bíróság vagy törvényszék előtt folyamatban lévő ügy vonatkozásában.

42 EJEB, *Harroudj kontra Franciaország* (43631/09), 2012. október 4., 42. pont.

43 Szociális Jogok Európai Bizottsága, *World Organisation against Torture (OMCT) kontra Írország*, 18/2003. sz. panasz, 2004. december 7., 61–63. pont; Szociális Jogok Európai Bizottsága, *Defence for Children International (DCI) kontra Hollandia*, 47/2008. sz. panasz, 2009. október 20.

44 Európa Tanács, Miniszteri Bizottság (2010), *Iránymutatás a gyermekbarát igazságszolgáltatásról*, 2010. november 17.

45 Lásd: ENSZ, Gyermekjogi Bizottság (2007), *10. számú Átfogó Kommentár (2007): A gyermekek jogai a fiatalkorúakra vonatkozó igazságszolgáltatásban*, CRC/C/GC/10, 2007. április 25.; ENSZ, Gyermekjogi Bizottság (2009), *12. számú Átfogó Kommentár (2009): A gyermek meghallgatáshoz való joga*, CRC/C/GC/12, 2009. július 1.; valamint ENSZ, Gyermekjogi Bizottság (2013), *14. számú Átfogó Kommentár (2013) a gyermekek legfőbb (mindenek felett álló) érdekük elsődleges szempontként történő figyelembevételéhez való jogáról (3. cikk (1) bekezdés)*, CRC/C/GC/14, 2013. május 29.

46 Az egyetlen kivétel egy megsemmisítés iránti kereset: EUB, C-540/03. sz. ügy, *Európai Parlament kontra az Európai Unió Tanácsa* [Nagytanács], 2006. június 27.

A legutóbbi évekig az EUB csak néhány gyermekjogi ügyben hozott ítéletet. A gyermekjogokra vonatkozó kifejezettebb jogalkotási intézkedések és a hangsúlyosabb gyermekjogi ütemterv elfogadása nyomán azonban valószínűsíthető, hogy a jövőben a gyermekek jogai nagyobb rendszerességgel fognak megjelenni az EUB tárgyalási jegyzékeiben.

Az EUB a legtöbb, gyermekjogokat érintő ítéletét a szabad mozgással és az uniós polgársággal összefüggésben hozta, amely területeken az EU régóta rendelkezik hatáskörrel. Ezek vonatkozásában az EUB kifejezetten elismerte, hogy a gyermekeket saját jogukon megilletik az uniós polgársággal járó előnyök, az uniós állampolgárság alapján a gyermekekre is kiterjesztve ezáltal az önálló tartózkodási jogot, valamint a szociális és oktatási jogosultságokat.[47]

Egyetlen olyan eset volt, amelyben az EUB közvetlenül felhasználta az ENSZ gyermekjogi egyezményét annak megállapításához, hogy miként kell értelmezni az uniós jogot a gyermekek vonatkozásában, nevezetesen a *Dynamic Medien GmbH kontra Avides Media AG* ügyben. Az ügy az azokra az importált DVD-kre és videokazettákra vonatkozó német címkézési korlátozások jogszerűségét tárgyalja, amelyek az Egyesült Királyságban már hasonló ellenőrzések tárgyát képezték. Az EUB arra a megállapításra jutott, hogy a címkézéssel kapcsolatos német ellenőrzések jogszerűen korlátozzák az áruk Unión belüli szabad mozgását (amely egyéb esetben kizárja az ilyen jellegű kettős szabályozói eljárásokat), mivel azok célja a gyermekek jólétének védelme. Az EUB határozatát a Gyermekjogi egyezmény 17. cikkére hivatkozva támasztotta alá, amely ösztönzi a részes államokat, hogy dolgozzanak ki megfelelő iránymutatásokat a gyermekek médiából származó, a jólétükre nézve ártalmas információkkal és anyagokkal szembeni védelme érdekében.[48] Az arányosság követelménye alkalmazandó ugyanakkor a gyermekek védelme céljából bevezetett ellenőrzési eljárást illetően, amelynek könnyen hozzáférhetőnek és ésszerű időn belül lefolytathatónak kell lennie.[49]

47 Lásd: EUB, C-413/99. sz. ügy, *Baumbast és R. kontra Secretary of State for the Home Department*, 2002. szeptember 17.; EUB, C-200/02. sz. ügy, *Kunqian Catherine Zhu és Man Lavette Chen kontra Secretary of State for the Home Department*, 2004. október 19.; EUB, C-148/02. sz. ügy, *Carlos Garcia Avello kontra belga állam*, 2003. október 2.; EUB, C-310/08. sz. ügy, *London Borough of Harrow kontra Nimco Hassan Ibrahim és Secretary of State for the Home Department* [Nagytanács], 2010. február 23.; EUB, C-480/08. sz. ügy, *Maria Teixeira kontra London Borough of Lambeth és Secretary of State for the Home Department*, 2010. február 23. Ezeket az ügyeket a 8. és a 9. fejezet tekinti át.

48 EUB, C-244/06. sz. ügy, *Dynamic Medien Vertriebs GmbH kontra Avides Media AG*, 2008. február 14., 42. és 52. pont.

49 *Uo.*, 49. és 50. pont.

Más esetekben az EUB ítéletei alátámasztásához utalt a gyermekjogi egyezmény rendelkezéseiben is benne foglalt általános gyermekjogi elvekre (így például a gyermek legfőbb (mindenek felett álló) érdekére és a meghallgatáshoz való jogára), különösen a gyermekek külföldre történő jogellenes elvitelével kapcsolatos ügyekkel összefüggésben.[50]

Ettől eltekintve az EU hagyományosan körültekintően jár el a tekintetben, hogy döntő erőt tulajdonítson a Gyermekjogi egyezménynek, különösen a migráció ellenőrzéséhez hasonló, politikai szempontból érzékenyebb területeken[51], noha ez a legújabb ítélkezési gyakorlatot tekintve változóban van, amint azt a következő fejezetek bemutatják. Az Európai Unió Alapjogi Chartájának elfogadása óta az Európai Unió Bíróságának a Charta gyermekjogokat érintő cikkeire utaló hivatkozásai gyakran összecsengenek a gyermekjogi egyezményre való hivatkozásokkal, tekintettel a rendelkezések közötti hasonlóságokra.

1.4.2. Az Emberi Jogok Európai Bírósága

Az EJEB elsősorban az EJEE 34. és 35. cikkével összhangban benyújtott egyéni kérelmekről határoz. Az EJEB joghatósága az EJEE és jegyzőkönyvei értelmezésével és alkalmazásával kapcsolatos valamennyi ügyre kiterjed (az EJEE 32. cikke).

Az Európai Unió Bíróságával szemben az Emberi Jogok Európai Bírósága kiterjedt ítélkezési gyakorlattal rendelkezik a gyermekek jogai területén. Noha az EJEE a magán- és családi élet tiszteletben tartásához való jogról szóló 8. cikke alá eső eseteket sokszor nem a gyermekek, hanem a szülők jogainak szempontjából bírálja el, más anyagi jogi rendelkezések alá eső eseteknél a szülők nem szükségszerűen érintettek, és így azok egyértelműbben az adott gyermekek jogaira összpontosítanak, ideértve az embertelen és megalázó bánásmóddal szembeni védelemhez való jogot (az EJEE 3. cikke) vagy a tisztességes tárgyaláshoz való jogot (az EJEE 6. cikke).

Bár az EJEB a gyermekek által vagy nevében benyújtott panaszok kezelésekor gyakran hivatkozik a Gyermekjogi egyezményre, nem tulajdonít neki szisztematikusan döntő súlyt. Egyes esetekben a Gyermekjogi egyezményben rögzített gyermekjogi elvek jelentős hatással voltak az EJEB érvelésére, különösen annak

50 EUB, C-491/10. PPU. sz. ügy, *Joseba Andoni Aguirre Zarraga kontra Simone Pelz*, 2010. december 22. Lásd még az 5. fejezetet.

51 EUB, C-540/03. sz. ügy, *Európai Parlament kontra az Európai Unió Tanácsa* [Nagytanács], 2006. június 27.

vonatkozásában, ahogyan az EJEB az EJEE 6. cikkét (tisztességes tárgyaláshoz való jog) a joggal összetűzésbe kerülő gyermekekkel való bánásmód vonatkozásában értelmezte (lásd a 11. fejezetet). Más területeken, például a gyermekek bírósági meghallgatásának vonatkozásában (lásd a 2. fejezetet) az EJEB megközelítésmódja kismértékben eltérhet a Gyermekjogi egyezmény megközelítésmódjától. Egyes esetekben viszont az EJEB kifejezetten a Gyermekjogi egyezményre támaszkodott.

Példa: A *Maslov kontra Ausztria*[52] ügy tárgya a kiskorúként több bűncselekmény miatt elítélt kérelmező kitoloncolása. Az EJEB úgy ítélte meg, hogy a fiatalkorú elkövetővel szembeni kitoloncolási intézkedések tekintetében a gyermek legfőbb (mindenek felett álló) érdekének figyelembevételével kapcsolatos kötelezettség a Gyermekjogi egyezmény 40. cikkével összhangban magában foglalja azt a kötelezettséget, hogy elő kell segíteni a gyermek újbóli beilleszkedését a társadalomba. Az EJEB véleménye szerint a társadalmi reintegráció nem valósulna meg, ha kitoloncolás révén elvágják a gyermek családi vagy társadalmi kötelékeit.[53] A Gyermekjogi egyezmény szolgált tehát az egyik hivatkozási alapként annak megállapításához, hogy a kitoloncolás aránytalan mértékben sérti azokat a jogokat, amelyek a kérelmezőt az EJEE 8. cikke alapján megilletik (a családi élet tiszteletben tartásához való jog).

1.5. A Szociális Jogok Európai Bizottsága

A Szociális Jogok Európai Bizottsága 15 független és pártatlan szakértőből áll, akik kollektív panasztételi eljárás vagy nemzeti jelentéstételi eljárás útján ítélkeznek a nemzeti jog és gyakorlat Európai Szociális Kartának való megfelelőségéről.[54] Kijelölt nemzeti és nemzetközi szervezetek kollektív panaszt emelhetnek az Európai Szociális Karta azon részes államaival szemben, amelyek elfogadták a panasztételi eljárást. Az eddigi panaszok arra vonatkoztak, hogy megsértették-e egyes államok a gyermekek Európai Szociális Karta szerinti jogait a gyermekek

52 EJEB, *Maslov kontra Ausztria* [Nagykamara] (1638/0323), 2008. június 23.

53 *Uo.*, 83. pont.

54 További információkért kérjük, látogasson el az EJEB honlapjára: www.coe.int/t/dghl/monitoring/socialcharter/ECSR/ECSRdefault_en.asp.

gazdasági kizsákmányolásával[55], a gyermekek testi épségével[56], a migráns gyermekek egészséget érintő jogaival[57] és a fogyatékossággal élő gyermekek oktatáshoz való hozzáférésével kapcsolatos ügyekben[58].

Példa: Az *International Commission of Jurists (ICJ) kontra Portugália* ügyben[59] azt kifogásolták, hogy bár a portugál jogszabályok tiszteletben tartják az Európai Szociális Karta 7. cikkének (1) bekezdésében rögzített rendelkezést, amely szerint a munkavállalás legalacsonyabb életkori határa 15 év, mindezt nem hajtják végre megfelelően. A Szociális Jogok Európai Bizottsága úgy ítélte meg, hogy az Európai Szociális Karta célja és tárgya a jogok nem csupán elméleti, hanem a gyakorlatban is megvalósuló védelme, és ezért a kérdéses jogszabályt hatékonyan kell alkalmazni. Utalva arra, hogy számos gyermeket foglalkoztatnak Portugáliában illegálisan, a Szociális Jogok Európai Bizottsága megállapította, hogy ez a helyzet sérti az Európai Szociális Karta 7. cikkének (1) bekezdését.

55 Szociális Jogok Európai Bizottsága, *International Commission of Jurists (ICJ) kontra Portugália*, 1/1998. sz. panasz, 1999. szeptember 9.

56 Szociális Jogok Európai Bizottsága, *World Organisation Against Torture (OMCT) kontra Görögország*, 17/2003. sz. panasz, 2004. december 7.

57 Szociális Jogok Európai Bizottsága, *Defence for Children International (DCI) kontra Belgium*, 69/2011. sz. panasz, 2012. október 23.

58 Szociális Jogok Európai Bizottsága, *Mental Disability Advocacy Center (MDAC) kontra Bulgária*, 41/2007.sz. panasz, 2008. június 3., 35. pont.

59 Szociális Jogok Európai Bizottsága, *International Commission of Jurists (ICJ) kontra Portugália*, 1/1998. sz. panasz, 1999. szeptember 9.

2 Alapvető polgári jogok és szabadságok

EU	Tárgyalt kérdések	ET
Alapjogi Charta, 10. cikk (vallásszabadság) és 14. cikk (az oktatáshoz való jog)	**Gondolat-, lelkiismeret- és vallásszabadság**	EJEE, 9. cikk (vallásszabadság) és 14. cikk (a hátrányos megkülönböztetés tilalma); az 1. jegyzőkönyv 2. cikke (a szülők azon joga, hogy biztosítsák gyermekük meggyőződésükkel összhangban álló oktatását) EJEB, *Dogru kontra Franciaország* (27058/05), 2008 (iszlám fejkendő viselése egy állami középiskolában) EJEB, *Kervanci kontra Franciaország* (31645/04), 2008 (iszlám fejkendő viselése egy állami középiskolában) EJEB, *Grzelak kontra Lengyelország* (7710/02), 2010 (a hitoktatás alternatívái általános és középiskolákban) EJEB, *Lautsi és társai kontra Olaszország* [Nagykamara] (30814/06), 2011 (feszületek kifüggesztése állami iskolákban)
Alapjogi Charta, 11. cikk (a véleménynyilvánítás szabadsága)	**A véleménynyilvánítás és az információ szabadsága**	EJEE, 10. cikk (a véleménynyilvánítás szabadsága) EJEB, *Handyside kontra Egyesült Királyság* (5493/72), 1976 (egy gyermekkönyv betiltása) EJEB, *Gaskin kontra Egyesült Királyság* (10454/83), 1989 (a gyermekkor folyamán vezetett aktához való hozzáférés)

EU	Tárgyalt kérdések	ET
Alapjogi Charta, 24. cikk (a gyermekek jogai) EUB, C-491/10. PPU. sz. ügy, *Joseba Andoni Aguirre Zarraga kontra Simone Pelz* ügy, 2010 (a meghallgatáshoz való jog, a gyermek jogellenes külföldre vitele).	**A meghallgatáshoz való jog**	EJEE, 6. cikk (tisztességes tárgyalás) A gyermekek jogainak gyakorlásáról szóló egyezmény, 3., 4., 6. és 7. cikk EJEB, *Sahin kontra Németország* [Nagykamara] (30943/96), 2003 (gyermek bírósági meghallgatása láthatással kapcsolatos eljárásokban)
Alapjogi Charta, 12. cikk (a békés gyülekezés és az egyesülés szabadsága)	**A békés gyülekezéshez való jog és az egyesülés szabadsága**	EJEE, 11. cikk (a békés gyülekezéshez való jog és az egyesülés szabadsága) EJEB, *Christian Democratic People's Party kontra Moldova* (28793/02), 2006 (közterületeken tartott gyűléseken való részvétel)

Minden embert megilletik a különböző jogi eszközökben – különösen az Európai Unió Alapjogi Chartájában és az Emberi Jogok Európai Egyezményében (EJEE) – meghatározott, az Emberi Jogok Európai Bírósága (EJEB) értelmezése szerinti polgári jogok és szabadságok. A Chartán kívül egyetlen uniós jogi eszköz sem foglalkozik kifejezetten a gyermekek vonatkozásában az e fejezetben tárgyalt polgári jogokkal. Az ET szintjén azonban az évek során – különösen az EJEB ítélkezési gyakorlata nyomán – jelentős mértékben fejlődött e polgári jogok hatálya és értelmezése.

Ez a fejezet áttekintést ad az Európai Unió Alapjogi Chartájának II. címében felsorolt szabadságokról annyiban, amennyiben azok hatással vannak a gyermekek jogaira. Elemzi a gyermek gondolat-, lelkiismeret- és vallásszabadsághoz való jogát (2.1. szakasz), a véleménynyilvánításhoz és az információ szabadságához való jogát (2.3. szakasz), a gyermek meghallgatáshoz való jogát (2.4. szakasz), valamint a békés gyülekezés és az egyesülés szabadságához való jogot (2.5. szakasz).

2.1. Gondolat-, lelkiismeret- és vallásszabadság

Kiemelt pontok

- Az Európai Unió Alapjogi Chartájában és az Emberi Jogok Európai Egyezményében biztosított gondolat-, lelkiismeret- és vallásszabadság magában foglalja a vallás vagy a meggyőződés megváltoztatásának szabadságát, valamint a vallás vagy a meggyőződés istentisztelet, oktatás, gyakorlás és szertartások végzése útján való kifejezésre juttatásának szabadságát.
- A szülőknek joguk van ahhoz, hogy biztosítsák gyermekeik vallási, világnézeti és pedagógiai meggyőződésükkel összhangban álló oktatását és nevelését.
- A szülőknek joga és kötelessége, hogy képességei fejlettségének megfelelően irányítsák a gyermeket a gondolat-, lelkiismeret- és vallásszabadsághoz való jogának gyakorlásában.

2.1.1. A gyermek vallásszabadsághoz való joga

Az uniós jogban az Európai Unió Alapjogi Chartájának 10. cikke mindenki számára biztosítja a gondolat-, lelkiismeret- és vallásszabadságot. Ez a jog magában foglalja a vallás vagy a meggyőződés megváltoztatásának szabadságát, valamint a vallás vagy meggyőződés kifejezésre juttatásának jogát mind egyénileg, mind együttesen, mind a nyilvánosság előtt, mind a magánéletben, istentisztelet, oktatás, gyakorlás és szertartások keretében történő kifejezésre juttatását. A katonai szolgálat lelkiismereti okból történő megtagadásához való jogot a nemzeti törvények szerint el kell ismerni (a Charta 10. cikkének (2) bekezdése).

Az ET joganyagában az EJEE 9. cikke mindenki számára biztosítja a gondolat-, lelkiismeret- és vallásszabadságot. Az EJEB ítélkezési gyakorlata nyomán a vallásszabadsághoz való jognak három dimenziója kristályosodott ki: a belső dimenzió; a vallás vagy meggyőződés megváltoztatásának szabadsága; valamint a vallás vagy meggyőződés kifejezésre juttatásának szabadsága. Az első két dimenzió abszolút, és azokat az államok semmilyen körülmények között nem korlátozhatják.[60] A vallás vagy meggyőződés kifejezésre juttatásának szabadsága korlátozható, amennyiben a korlátozások törvényben vannak meghatározva,

60 EJEB, *Darby kontra Svédország* (11581/85), 1990. október 23.

legitim (és törvényes) célt szolgálnak és egy demokratikus társadalomban szükségesek (az EJEE 9. cikkének (2) bekezdése).

Ítélkezési gyakorlatában az EJEB elsősorban az oktatáshoz való jog és az állami iskolarendszer vonatkozásában tárgyalta a gyermekek gondolat-, lelkiismeret- és vallásszabadságát. Az európai országokban sok nyilvános vita zajlik a vallás iskolákban való jelenlétéről.

Példa: A *Dogru kontra Franciaország* és a *Kervanci kontra Franciaország* ügy[61] tárgya az, hogy két, 11, illetve 12 éves lányt eltanácsoltak egy francia állami középiskola első osztályából, amiért testnevelés órán nem voltak hajlandóak levenni fejkendőjüket. Az EJEB megállapította, hogy a kérelmezők vallási meggyőződésük kifejezésre juttatásához való jogát abból a célból korlátozták, hogy megfeleljenek az állami iskolák vallási semlegességéhez kapcsolódó követelményeknek. A nemzeti hatóságok szerint a fátyol, például az iszlám fejkendő viselése egészségügyi és biztonsági okokból nem egyeztethető össze a testnevelésórákkal. Az EJEB ezt ésszerűnek ítélte meg, mivel az iskola egyensúlyba hozta egymással a kérelmezők vallási meggyőződését és a mások jogai és szabadságai, valamint a közrend védelméhez kapcsolódó előírásokat. Ennek megfelelően arra a megállapításra jutott, hogy a tanulók vallásuk kifejezésre juttatásával kapcsolatos szabadságába való beavatkozás indokolt volt és arányban állt az elérni kívánt céllal. A bíróság ezért nem állapította meg az EJEE 9. cikkének megsértését.

Példa: A *Grzelak kontra Lengyelország* ügy[62] tárgya az, hogy egy hitoktatás alól felmentett tanuló számára nem biztosítottak etikaoktatást és ehhez kapcsolódó érdemjegyeket. Magukat agnosztikusnak valló szülei kívánságának megfelelően a kérelmező az alap- és középfokú tanulmányai egészének ideje alatt (hét és 18 éves kora között) nem részesült hitoktatásban. Mivel túl kevés tanuló érdeklődött, soha nem szerveztek meg etikaoktatást, és bizonyítványaiban a „hittan/etika" tantárgy mellett minden esetben egy egyenes vonal szerepelt érdemjegy helyett. Az EJEB szerint az, hogy a fiú bizonyítványaiban nem szerepel hittan-, illetve etikajegy, a gondolat-, lelkiismeret- és vallásszabadság negatív aspektusát

61 EJEB, *Dogru kontra Franciaország* (27058/05), 2008. december 4.; EJEB, *Kervanci kontra Franciaország* (31645/04), 2008. december 4. (elérhető francia nyelven).

62 EJEB, *Grzelak kontra Lengyelország* (7710/02), 2010. június 15.

érinti, mivel a bizonyítványok rámutathattak vallási hovatartozásának hiányára. Ezért ez az indokolatlan megbélyegzés egy formájának minősül. Az etikaoktatásban részesülni kívánó nemhívőkkel és a hittanoktatásban részt vevő tanulókkal szembeni eltérő bánásmód tehát nem volt objektíven és ésszerűen indokolt, emellett nem állt fenn ésszerű arányosság az alkalmazott eszközök és az elérni kívánt célok között. Az állam az ügyben túllépett mérlegelési jogkörén, mivel lényegében sérült a kérelmező ahhoz való joga, hogy ne nyilvánítsa ki vallását vagy meggyőződését, ami az EJEE 9. cikkével összefüggésben sérti az EJEE 14. cikkét.

2.2. A szülők jogai és a gyermekek vallásszabadsága

A szülőknek a gyermekeik vallásszabadságával kapcsolatos jogait az európai jog a Gyermekjogi egyezményhez képest eltérően kezeli.

Az uniós jogban tiszteletben kell tartani a szülők azon jogát, hogy gyermekeik számára vallási, világnézeti vagy pedagógiai meggyőződésüknek megfelelő nevelést és oktatást biztosítsanak, különös tekintettel az oktatási intézmények alapításának szabadságára (a Charta 14. cikkének (3) bekezdése).

Az ET joganyagában és különösen az EJEE Kiegészítő Jegyzőkönyvének 2. cikke szerint állam az oktatás és tanítás terén vállalt feladatkörök gyakorlása során köteles tiszteletben tartani a szülők (vallási) meggyőződését. Az EJEB szerint ezt a kötelezettséget tágan kell értelmezni, mivel nemcsak az iskolai tantervek tartalmára és végrehajtására alkalmazandó, hanem valamennyi, az állam által vállalt feladat ellátására.[63] Magában foglalja az állami oktatás megszervezését és finanszírozását, a tanterv meghatározását és megtervezését, a tantervben foglalt információk vagy ismeretek objektív, kritikus és pluralista szellemben történő átadását (tiltva ezáltal, hogy az állam indoktrinációra törekedjen, ezáltal esetlegesen nem tartva tiszteletben a szülők vallási és világnézeti meggyőződését), valamint az iskolai környezet megszervezését, beleértve a feszületek állami iskolák tantermeiben való jelenlétét.

63 Lásd az EJEB vonatkozó ítélkezési gyakorlatát: EJEB, *Kjeldsen, Busk Madsen és Pedersen kontra Dánia* (5095/71, 5920/72 és 5926/72), 1976. december 7.; EJEB, *Valsamis kontra Görögország* (21787/93), 1996. december 18.; EJEB, *Folgerø és társai kontra Norvégia* [Nagykamara] (15472/02), 2007. június 29.; EJEB, *Hasan és Eylem Zengin kontra Törökország* (1448/04), 2007. október 9.; EJEB, *Lautsi és társai kontra Olaszország* [Nagykamara] (30814/06), 2011. március 18.

Példa: A *Lautsi és társai kontra Olaszország* ügy[64] tárgya a feszületek állami iskolák tantermeiben való kifüggesztése. Egy szülő panaszt tett, mivel szerinte a gyermekei által látogatott állami iskola tantermeiben kihelyezett feszületek sértik a szekularizmus elvét, amelynek megfelelően gyermekeit nevelni kívánja. Az EJEB Nagykamarája megállapította, hogy az oktatással és tanítással kapcsolatos feladatköreinek részeként az állam feladata annak eldöntése, hogy az állami iskolák tantermeiben legyenek-e feszületek vagy sem, és hogy minderre az EJEE Kiegészítő Jegyzőkönyve 2. cikkének második mondata alkalmazandó. A bíróság érvelése szerint ez a döntés alapvetően az alperes állam mérlegelési jogkörébe tartozik, és nincs európai konszenzus arra vonatkozóan, hogy legyenek-e jelen vallási szimbólumok az állami iskolákban. Igaz, hogy a feszületeknek – mint a kereszténységre egyértelműen utaló jelnek – az állami iskolák tantermeiben való jelenléte láthatóan hangsúlyozza az iskolai környezetben az ország többségi vallását. Ez azonban önmagában véve nem elegendő annak megállapításához, hogy az alperes tagállam indoktrinációt folytatna. Az EJEB véleménye szerint a falon elhelyezett feszület alapvetően passzív szimbólum, amely nem gyakorol ahhoz fogható befolyást a tanulókra, mint egy beszéd vagy a vallási tevékenységekben való részvétel. A Nagykamara ennek megfelelően arra a következtetésre jutott, hogy a hatóságok akkor, amikor úgy döntöttek, megtartják a feszületeket a kérelmező gyermekei által látogatott állami iskola tantermeiben, mérlegelési jogkörük keretein belül jártak el, és ezáltal tiszteletben tartották a szülők azon jogát, hogy saját vallási vagy világnézeti meggyőződésüknek megfelelő oktatást és nevelést biztosítsanak gyermekeik számára.

A nemzetközi jogban a Gyermekjogi egyezmény 14. cikkének (2) bekezdése előírja a részes államok számára, hogy tiszteletben tartsák a szülőknek azt a jogát és kötelességét, hogy a gyermeket kibontakozó képességeinek megfelelően iránymutatást adjanak a gondolat-, lelkiismeret- és vallásszabadsághoz való jogának gyakorlásában. A Gyermekjogi egyezmény tehát – szemben az Európai Unió Alapjogi Chartája 14. cikkének (3) bekezdésével – maga a gyermek szabadságának gyakorlását helyezi középpontba. A Gyermekjogi egyezmény értelmében a szülőknek nem saját meggyőződésüknek megfelelően, hanem a gyermekeik meggyőződésének megfelelően van joguk iránymutatást és tanácsokat adni. A Gyermekjogi egyezmény 14. cikke (2) bekezdésének megfogalmazása összhangban áll a Gyermekjogi egyezmény szülői felelősségekre vonatkozó általános felfogásával: a szülői feladatokat a gyermek kibontakozó képességeinek megfelelően (Gyermekjogi egyezmény 5. cikk) és a gyermek legfőbb (mindenek felett álló) érdeke alapján kell ellátni (a Gyermekjogi egyezmény 18. cikk (1) bekezdése).

64 EJEB, *Lautsi és társai kontra Olaszország* [Nagykamara] (30814/06), 2011. március 18.

2.3. A véleménynyilvánítás és az információ szabadsága

Kiemelt pontok

- Az Európai Unió Alapjogi Chartája és az EJEE egyaránt biztosítja a véleménynyilvánítás szabadságát, amely magában foglalja a véleményalkotás szabadságát, valamint az információk és eszmék megismerésének és közlésének szabadságát anélkül, hogy ebbe állami szerv beavatkozhatna.
- Az információ szabadsága nem foglalja magában a gyermekvédelmi iratokhoz való hozzáférés jogát.
- A gyermekvédelmi nyilvántartáshoz való hozzáférésnek az információ szolgáltatója által adott beleegyezéstől való függővé tétele összeegyeztethető lehet az EJEE 8. cikkével (a magán- és családi élet tiszteletben tartásához való jog), amennyiben egy független hatóság mondja ki a döntő szót arra vonatkozóan, hogy biztosítani kell-e a hozzáférést.

Az uniós jogban a véleménynyilvánítás szabadsága magában foglalja a véleményalkotás szabadságát, valamint az információk és eszmék megismerésének és közlésének szabadságát anélkül, hogy ebbe állami szerv beavatkozhatna, továbbá országhatárokra való tekintet nélkül (az Európai Unió Alapjogi Chartájának 11. cikke).

Az ET jogi rendszerében a véleménynyilvánítás szabadságát az EJEE 10. cikke biztosítja, és ez a szabadság csak akkor korlátozható, ha azt törvény írja elő, és ha az a 10. cikk (2) bekezdésében felsorolt törvényes célok valamelyikét szolgálja és egy demokratikus társadalomban szükséges.

Ítélkezési gyakorlatában az EJEB rámutatott arra, hogy „a véleménynyilvánítás szabadsága a [demokratikus] társadalom egyik alappillére, mind a társadalmi haladásnak, mind az egyén kibontakozásának alapvető feltétele [...] nemcsak a kedvezően fogadott, a nem sértő vagy a közömbösnek tekintett „információkra" és „eszmékre" alkalmazandó, hanem azokra is, amelyek sértőek, meghökkentőek vagy felkavarják az államot vagy a lakosság bármely csoportját".[65]

65 Lásd például: EJEB, *Handyside kontra Egyesült Királyság* (5493/72), 1976. december 7., 49. pont.

Példa: A *Handyside kontra Egyesült Királyság* ügyben[66] az EJEB azt állapította meg, hogy a „*Little Red School Book*" („Kis Piros Iskolai Könyv") című könyv hatóságok általi betiltása összhangban áll az EJEE 10. cikkének (2) bekezdésében rögzített, az erkölcsök védelmére vonatkozó kivétellel. Az ügy a gyermek életkorának és érettségének megfelelő információk megismeréséhez való jogot tárgyalja - a véleménynyilvánítás szabadságának ezen aspektusa különösen fontos a gyermekek szempontjából. A dán nyelvből fordított könyv iskoláskorú gyermekek számára íródott, és egy sor társadalmi normát kérdőjelezett meg, többek között a szexualitásról és a kábítószerekről. A könyv egyes részeit a fiatalok fejlődésük kritikus szakaszában ösztönzésként értelmezhetik, amely arra indítja őket, hogy életkoruknak nem megfelelő, rájuk nézve káros tevékenységekbe fogjanak, sőt bizonyos bűncselekményeket kövessenek el. Az EJEB szerint ezért az eljáró angol bírók „mérlegelési jogkörüket gyakorolva az adott időpontban jogosan gondolhatták, hogy a könyv káros hatással lenne számos, azt olvasó gyermek és serdülő erkölcseire".[67]

Az EJEE 10. cikkére hivatkozó más gyermekjogi ügyek a gyermekvédelmi szakellátásba helyezett gyermekek információhoz való hozzáféréssel kapcsolatos jogát érintik.

Példa: A *Gaskin kontra Egyesült Királyság* ügy[68] tárgyát képező személy gyermekkora legnagyobb részében gyermekvédelmi szakellátásban élt, amelynek során a helyi önkormányzat bizalmas aktákat vezetett róla. Ezeknek részét képezték különböző orvosi jelentések, valamint tanárok, rendőrök és pártfogó felügyelők, szociális munkások, védőnők, nevelőszülők és a bentlakásos intézményben dolgozó alkalmazottak jelentései. Amikor a kérelmező hozzáférést kért ezekhez az aktákhoz, hogy személyi sérülés miatt eljárjon a helyi önkormányzattal szemben, elutasításban részesült. Az aktáták titkosságát a gyermekvédelmi szolgálat megfelelő működéséhez fűződő közérdek alapján biztosították, amelyet veszélyeztetne az, ha az aktákhoz információkat közlő személyek a jövőben nem lennének hajlandóak őszintén írni a jelentéseikben. Az EJEB elismerte, hogy a gyermekkorukban állami gondozásban élő személyeknek alapvető érdekük, hogy „megkapják a gyermekkoruk és korai fejlődésük megismeréséhez és megértéséhez szükséges információkat".[69] Miközben biztosítani kell az állami akták titkosságát,

66 *Uo.*

67 *Uo.*, 52. pont.

68 EJEB, *Gaskin kontra Egyesült Királyság* (10454/83), 1989. július 7.

69 *Uo.*, 49. pont.

a brithez hasonló rendszer, amely az információközlő beleegyezéséhez köti az aktákhoz való hozzáférést, elvben összeegyeztethető lehetne az EJEE 8. cikkével, amennyiben az aktákhoz hozzáférni kívánó személy érdekei akkor is biztosítottak lennének, ha az információközlő nem érhető el vagy rosszhiszeműen tagadta meg a beleegyezést. Ilyen esetben végső soron egy független hatóságnak kell döntést hoznia a hozzáférés megadásával kapcsolatban. A szóban forgó ügyben ilyen eljárás nem állt rendelkezésre a kérelmező számára, és a bíróság megállapította az EJEE 8. cikke szerint a kérelmezőt megillető jogok megsértését. Az EJEB ugyanakkor nem állapította meg az EJEE 10. cikkének megsértését, megismételve, hogy a tájékozódás szabadsága értelmében a kormányzat nem korlátozhatja az egyes személyeket az olyan információkhoz való hozzájutásban, amelyeket mások közölni kívánnak vagy hajlandóak lehetnek közölni, miközben nem is kötelezi az államot arra, hogy közölje az adott személlyel az adott információt.

2.4. A meghallgatáshoz való jog

Kiemelt pontok

- Az uniós jog szerint a gyermekeknek joguk van ahhoz, hogy szabadon kifejezzék véleményüket. Az őket érintő ügyekben véleményüket életkoruknak és érettségüknek megfelelően figyelembe kell venni.
- Az EJEE nem írja elő abszolút követelményként a gyermek bírósági meghallgatását. Azt, hogy erre sor kerül-e, az adott eset egyedi körülményeinek figyelembevételével kell mérlegelni, a gyermek életkorától és érettségétől is függően.
- Az ENSZ, a Gyermekjogi egyezménye nyomán egyik általános elveként ismerte el a gyermekek ahhoz való jogát, hogy az őket érintő valamennyi kérdésben szabadon kifejezzék saját véleményüket.

Az uniós jogban az Európai Unió Alapjogi Chartája 24. cikkének (1) bekezdése kimondja, hogy a gyermekek véleményüket szabadon kifejezhetik, és hogy az őket érintő ügyekben véleményüket életkoruknak és érettségüknek megfelelően figyelembe kell venni. Ez a rendelkezés általánosan alkalmazandó, és nem korlátozódik konkrét eljárásokra. Az EUB ezt a rendelkezést a Brüsszel IIa. rendelettel együttesen értelmezte.

Példa: A *Joseba Andoni Aguirre Zarraga kontra Simone Pelz* ügy[70] tárgya egy kiskorú gyermek szülői felügyeleti jogával kapcsolatos határozatba ütköző, Spanyolországból Németországba történő elvitele. Az Európai Unió Bíróságát annak megállapítására kérték, hogy a német bíróság (azaz azon ország bírósága, ahová a gyermeket elvitték) elutasíthatja-e a spanyol (azaz a származási ország szerinti) bíróság végrehajtási határozatát azon az alapon, hogy a gyermeket nem hallgatták meg, megsértve ezzel a 2201/2003/EK rendelet (Brüsszel IIa. rendelet) 42. cikke (2) bekezdésének a) pontját, valamint az Európai Unió Alapjogi Chartájának 24. cikkét. A gyermek ellenezte a visszatérést, amikor a német bíróság előtt kifejtette véleményét. Az EUB szerint a gyermek meghallgatása nem abszolút jog, amennyiben azonban ezt egy bíróság szükségesnek ítéli, valós és tényleges lehetőséget kell biztosítania a gyermek számára a véleménynyilvánításra. Az EUB azt is megállapította, hogy a gyermeknek a Charta és a Brüsszel IIa. rendelet szerinti, meghallgatáshoz való joga olyan jogi eljárásokat és feltételeket tesz szükségessé, amelyek lehetővé teszik a gyermek számára, hogy véleményét szabadon kifejezhesse, és hogy azt a bíróság figyelembe vegye. A bíróságnak emellett e meghallgatások céljából minden szükséges intézkedést meg kell tennie, figyelembe véve a gyermek legfőbb (mindenek felett álló) érdekét és az adott egyedi ügy körülményeit. Az EUB ítélete szerint azonban azon ország hatóságai, ahová a gyermeket elvitték (Németország) nem tagadhatták meg a gyermek visszatérését azon az alapon, hogy a származási országban (Spanyolország) sérült a meghallgatáshoz való jog.

Az ET jogi rendszerében az EJEB nem úgy értelmezi a magán- és családi élet tiszteletben tartásához való jogot (az EJEE 8. cikke), mint amely mindig megkívánná a gyermek bírósági meghallgatását. Általános szabályként a nemzeti bíróságok feladata a rendelkezésükre álló bizonyítékok értékelése, beleértve a vonatkozó tények megállapításához alkalmazott eszközöket. A hazai bíróságoknak nem minden esetben kell meghallgatniuk a bíróságon a gyermeket a szülői felügyeleti joggal nem rendelkező szülővel való kapcsolattartás kérdésében. Ezt a kérdést az egyes esetek egyedi körülményeinek figyelembevételével kell mérlegelni, kellő tekintettel az érintett gyerek életkorára és érettségére. Ezenkívül az EJEB a 8. cikk eljárásjogi követelményei alapján gyakran megbizonyosodik arról, hogy

70 EUB, C-491/10 PPU. sz. ügy, *Joseba Andoni Aguirre Zarraga kontra Simone Pelz*, 2010. december 22.; lásd még az 5.4. szakaszt, amely ezen ítélet további részleteit és a Brüsszel IIa. rendelet működését tárgyalja.

a hatóságok megtették a megfelelő lépéseket annak érdekében, hogy a szükséges biztosítékok kísérjék a határozataikat.

Példa: A *Sahin kontra Németország* ügyben[71] az anya megtiltott minden kapcsolatot a kérelmező apa és négyéves lánya között. A német regionális bíróság úgy határozott, hogy a szülők közötti súlyos feszültségek miatt a gyermekre nézve káros lenne, ha biztosítanák az apa számára a láthatást. A bíróság a határozat meghozatala előtt nem hallgatta meg a gyermeket azzal kapcsolatban, hogy szeretné-e továbbra is látni az apját. A gyermek bírósági meghallgatását illetően az EJEB hivatkozott a szakértőnek a német regionális bíróság előtt kifejtett magyarázatára. A szakértő, miután több alkalommal találkozott a gyermekkel, anyjával és a kérelmezővel, úgy vélte, hogy a gyermek kikérdezésének folyamata olyan kockázatokat vonhatott volna maga után, amelyeket nem lehetett volna különleges bírósági rendelkezésekkel elkerülni. Az EJEB úgy ítélte meg, hogy ilyen körülmények között az EJEE 8. cikkében implicit módon benne rejlő eljárásjogi követelmény – a gyermek bírósági meghallgatása – nem jelent olyan kötelezettséget, hogy közvetlenül ki kellene kérdezni a gyermeket az apjához fűződő kapcsolatáról.

Példa: A *Sommerfeld kontra Németország* ügyben[72] a kérelmező 13 éves lánya egyértelműen kinyilvánította, hogy nem kívánja látni a kérelmezőt, és éveken át tartotta is magát ehhez. A hazai bíróságok úgy ítélték meg, hogy súlyosan megzavarná a lány érzelmi és lelki egyensúlyát, ha arra kényszerítenék, hogy találkozzon a kérelmezővel. Az EJEB elfogadta, hogy a döntéshozatali folyamat során biztosították a kérelmező számára érdekeinek előírt védelmét.[73]

A gyermekek jogainak gyakorlásáról szóló egyezmény foglalkozik a gyermekek szabad véleménynyilvánításhoz való jogával.[74] Az egyezmény célja a gyermekek jogainak azáltal történő előmozdítása, hogy egyedi eljárási jogokat biztosít

71 EJEB, *Sahin kontra Németország* [Nagykamara] (30943/96), 2003. július 8., 73. pont. Azon egyedi vonatkozással kapcsolatban, hogy a nemzeti bíróságoknak értékelniük kell a rendelkezésükre álló bizonyítékokat, valamint azt, hogy milyen jelentőséggel bírnak az alperesek által felhozni kívánt bizonyítékok, lásd még: EJEB, *Vidal kontra Belgium* (12351/86), 1992. április 22., 33. pont.

72 EJEB, *Sommerfeld kontra Németország* [Nagykamara] (31871/96), 2003. július 8.

73 *Uo.*, 72. és 88. pont.

74 Európa Tanács, Európai egyezmény a gyermekek jogainak gyakorlásáról, CETS 160., 1996.

számukra az igazságügyi hatóságok előtti családjogi eljárásokban, különös tekintettel a szülői felelősség gyakorlásával kapcsolatos, például a lakóhelyet és a láthatást érintő eljárásokra. Az egyezmény 3. cikke eljárási jogként biztosítja a gyermekek számára az eljárások során a tájékoztatáshoz és a véleménynyilvánításhoz való jogot. A 4. cikk biztosítja a gyermek számára az ahhoz való jogot, hogy külön képviselő kijelölését kérje az igazságügyi hatóságok előtt folyamatban lévő, őt érintő eljárásokban. A 6. cikk értelmében a hatóságoknak biztosítaniuk kell, hogy a gyermek minden vonatkozó tájékoztatást megkapjon, adott esetben személyesen kell vele konzultálniuk, és lehetővé kell tenniük a gyermek számára véleményének kinyilvánítását.

A nemzetközi jogban a Gyermekjogi egyezmény 12. cikkének (1) bekezdése kimondja, hogy az ítélőképessége birtokában lévő gyermeknek jogában áll minden őt érdeklő kérdésben szabadon kinyilvánítania véleményét. A gyermek véleményét korára és érettségére figyelemmel kellően tekintetbe kell venni. A Gyermekjogi egyezmény 12. cikkének (2) bekezdése emellett előírja, hogy lehetőséget kell adni a gyermeknek arra, hogy bármely olyan bírósági vagy közigazgatási eljárásban, amelyben érdekelt, közvetlenül vagy képviselője, illetőleg arra alkalmas szerv útján, a hazai jogszabályokban foglalt eljárási szabályoknak megfelelően meghallgassák.

Az ENSZ Gyermekjogi Bizottsága rámutatott arra, hogy a részes államoknak vagy közvetlenül kell biztosítaniuk ezt a jogot, vagy olyan jogszabályokat kell elfogadniuk, illetve olyan módon kell felülvizsgálniuk a jogszabályokat, hogy a gyermek teljes körűen élhessen ezzel a joggal.[75] Ezenkívül biztosítaniuk kell, hogy a gyermek minden szükséges információt és tanácsot megkapjon a legfőbb (mindenek felett álló) érdekének megfelelő döntés meghozatala érdekében. A Bizottság azt is megjegyzi, hogy a gyermeknek jogában áll nem élni ezzel a joggal: a véleménynyilvánítás egy lehetőség és nem kötelesség.

75 ENSZ, Gyermekjogi Bizottság, *14. számú Átfogó Kommentár (2013) a gyermek ahhoz való jogáról, hogy a legfőbb (mindenek felett álló) érdeke elsődleges szempont legyen (3. cikk, (1) bekezdés)*, CRC/C/GC/14, 2013. május 29.

2.5. A békés gyülekezés és az egyesülés szabadsága

Kiemelt pontok

- Mind az Európai Unió Alapjogi Chartája, mind az EJEE biztosítja a békés gyülekezés és az egyesülés szabadságát.
- Ez a jog lehetőséget és védelmet biztosít az egyén számára ügyeinek másokkal közösen történő előmozdításához.

Az uniós jogban az Európai Unió Alapjogi Chartájának 12. cikke kimondja, hogy mindenkinek joga van a békés gyülekezés szabadságához és a másokkal való bármilyen szintű, különösen politikai, szakszervezeti és polgári célú egyesüléshez. Ez magában foglalja mindenkinek a jogát ahhoz, hogy érdekei védelmére szakszervezetet alapítson, vagy azokhoz csatlakozzon.

Az ET jogrendszerében az EJEE 11. cikkének (1) bekezdése biztosítja a békés gyülekezés és az egyesülés szabadságát, a 11. cikk (2) bekezdésében rögzített korlátozások mellett.

Az EJEB kifejezetten rámutatott arra, hogy a gyermekeknek jogukban áll közterületeken tartott gyűléseken részt venni. Amint azt a bíróság a *Christian Democratic People's Party kontra Moldova* ügyben megállapította, ellentétes lenne a szülők és a gyermekek gyülekezési szabadságával, ha nem vehetnének részt bizonyos rendezvényeken, különös tekintettel az iskoláztatással kapcsolatos kormányzati politikával szembeni tiltakozásokra.

A nemzetközi jogban az egyes gyermekek, csakúgy, mint a gyermekek szervezetei a Gyermekjogi egyezmény 15. cikkében kínált védelemre támaszkodhatnak, amely kimondja az egyesüléshez és a békés gyülekezéshez való jogot. E rendelkezés alapján számos, gyermekek részvételével megvalósuló szervezeti forma kapott nemzetközi védelmet.

3

Egyenlő bánásmód és a hátrányos megkülönböztetés tilalma

EU	Tárgyalt kérdések	ET
Alapjogi Charta, III. cím (Egyenlőség), beleértve a 20. (a törvény előtti egyenlőség), a 21. (a hátrányos megkülönböztetés tilalma) és a 23. cikket (a nők és férfiak közötti egyenlőség)	**Egyenlő bánásmód és a hátrányos megkülönböztetés tilalma**	EJEE, 14. cikk; az EJEE 12. Kiegészítő Jegyzőkönyvének 1. cikke (a hátrányos megkülönböztetés tilalma) (Módosított) Európai Szociális Karta, E. cikk (a hátrányos megkülönböztetés tilalma)
A faji egyenlőségről szóló irányelv (2000/43/EK)	**A faj és az etnikai származás alapján történő hátrányos megkülönböztetés tilalma**	EJEB, *D.H. és társai kontra Cseh Köztársaság* [Nagykamara] (57325/00), 2007 (roma gyermekek külön iskolákban történő elhelyezése) EJEB, *Oršuš és társai kontra Horvátország* (15766/03), 2010 (kizárólag roma osztályok általános iskolákban) A nemzeti kisebbségek védelméről szóló keretegyezmény (FCNM), 4. és 12. cikk

EU	Tárgyalt kérdések	ET
Alapjogi Charta, 45. cikk (a mozgás és a tartózkodás szabadsága) EUB, C-200/02. sz. ügy, *Kunqian Catherine Zhu és Man Lavette Chen kontra Secretary of State for the Home Department*, 2004 (harmadik országbeli állampolgár szülők tartózkodási joga)	**A nemzetiség és a menekültügyi státusz alapján történő hátrányos megkülönböztetés tilalma**	EJEB, *Ponomaryovi kontra Bulgária* (5335/05), 2011 (ideiglenes lakosok által fizetendő tandíjak) A nemzeti kisebbségek védelméről szóló keretegyezmény 4. cikke, valamint 12. cikkének (3) bekezdése
A foglalkoztatási egyenlőségről szóló irányelv (2000/78/EK)	**Az életkor alapján történő hátrányos megkülönböztetés tilalma**	EJEE, 14. cikk; az EJEE 12. Kiegészítő Jegyzőkönyvének 1. cikke (a hátrányos megkülönböztetés tilalma)
EUB, C-303/06. sz. ügy, *S. Coleman kontra Attridge Law és Steve Law* [Nagytanács], 2008	**Az egyéb védett tulajdonság alapján történő hátrányos megkülönböztetés tilalma**	EJEB, *Fabris kontra Franciaország* [Nagykamara] (16574/08), 2013 (házasságon kívül született gyermekek öröklési joga)

A hátrányos megkülönböztetés tilalma demokratikus társadalmak egyik alapelve. Mind az EU, mind az ET fontos szerepet játszott ezen elv értelmezésében. Az uniós intézmények számos irányelvet fogadtak el, amelyek rendkívül fontosak a gyermekeket érintő kérdések szempontjából. Az Emberi Jogok Európai Bírósága (EJEB) jelentős ítélkezési gyakorlatot alakított ki az EJEE hátrányos megkülönböztetés tilalmáról szóló 14. cikke vonatkozásában, az egyezmény más cikkeivel összefüggésben.

A Szociális Jogok Európai Bizottsága (ECSR) úgy tekinti, hogy az Európai Szociális Karta (ESC) hátrányos megkülönböztetés tilalmáról szóló E. cikke hasonló funkciót tölt be, mint az Emberi Jogok Európai Egyezményének (EJEE) 14. cikke: nem független rendelkezés, és azt az Európai Szociális Karta adott érdemi rendelkezésével összefüggésben kell alkalmazni.[76]

Ez a fejezet az egyenlő bánásmód és hátrányos megkülönböztetés tilalmának elvével foglalkozik, azon indokokra összpontosítva, amelyek tekintetében gyermekekre vonatkozó ítélkezési gyakorlat alakult ki. Először általános információkat nyújt az európai anti-diszkriminációs jogról (3.1. szakasz), majd bemutatja a gyermekek egyenlőségének és hátrányos megkülönböztetésük tilalmának kérdését az etnikai származás (3.2. szakasz), a nemzetiség és a menekültügyi státusz (3.3. szakasz), az életkor (3.4. szakasz), valamint egyéb védett tulajdonság, köztük a nem, a nyelv és a személyazonosság (3.5. szakasz) vonatkozásában.

76 Szociális Jogok Európai Bizottsága, *Syndicat des Agrégés de l'Enseignement Supérieur (SAGES) kontra Franciaország*, 26/2004. sz. panasz, 2015. június 15., 34. pont.

3.1. Az európai anti-diszkriminációs jog

Kiemelt pontok

- Az EU joga és az ET joganyaga tiltja a nemi vagy faji alapon, bőrszínen, etnikai hovatartozáson vagy társadalmi származáson, genetikai jellemzőkön, anyanyelven, valláson vagy meggyőződésen, politikai vagy bármilyen egyéb véleményen, nemzeti kisebbséghez való tartozáson, vagyoni helyzeten, születésen, fogyatékosságon, életkoron vagy szexuális orientáción alapuló hátrányos megkülönböztetést[77].
- Ha az EJEB megállapítja, hogy egyes személyeket alapvetően hasonló helyzetben eltérő bánásmódban részesítettek, megvizsgálja, hogy fennáll-e objektív és ésszerű indok. Amennyiben nem, megállapítja, hogy az EJEE hátrányos megkülönböztetés tilalmáról szóló 14. cikkét sértő bánásmódot alkalmaztak.

Az uniós jogban a hátrányos megkülönböztetés tilalma, amelyről az Európai Unió Alapjogi Chartájának 21. cikke rendelkezik, önálló elv, amely a Charta egyéb rendelkezései által nem érintett helyzetekre is alkalmazandó. A rendelkezés kifejezetten tiltja a nemi vagy faji alapon, bőrszínen, etnikai hovatartozáson vagy társadalmi származáson, genetikai tulajdonságon, nyelv, vallás vagy meggyőződés, politikai vagy más vélemény, nemzeti kisebbséghez tartozás, vagyoni helyzet, születés, fogyatékosság, életkor vagy szexuális orientáció alapján történő hátrányos megkülönböztetést. Ezzel szemben az EUMSZ 19. cikke csak a nem, faji alapon vagy etnikai hovatartozáson, vallás vagy meggyőződés, fogyatékosság, kor és szexuális irányultság alapján történő hátrányos megkülönböztetés tilalmát említi.

Számos uniós irányelv tiltja a foglalkoztatás, a jóléti ellátások, valamint az áruk és szolgáltatások területén történő hátrányos megkülönböztetést, melyek mindegyike érintheti a gyermekeket. A 2000/78/EK tanácsi irányelv, amely megteremtette a foglalkoztatás és a munkavégzés során alkalmazott egyenlő bánásmód általános kereteit (a foglalkoztatási egyenlőségről szóló irányelv)[78] tiltja a vallás vagy meggyőződés, fogyatékosság, életkor vagy szexuális irányultság alapján történő hátrányos megkülönböztetést. A személyek közötti, faji vagy etnikai származásra való tekintet nélküli

77 A hátrányos megkülönböztetés elleni uniós irányelveken, valamint az EJEE 14. cikkén és 12. Kiegészítő Jegyzőkönyvén alapuló európai anti-diszkriminációs jog áttekintését lásd: FRA és EJEB (2011), valamint az ahhoz kapcsolódó, ítélkezési gyakorlatra vonatkozó frissített tájékoztató (2010. július – 2011. december).

78 2000/78/EK tanácsi irányelv, HL L 303., 2000. Valamennyi uniós jogi eszköz elérhető az „EUR-Lex" oldalon, az EU uniós jogszabályokhoz való hozzáférést lehetővé tévő online portálján: http://eur-lex.europa.eu/homepage.html.

egyenlő bánásmód elvének alkalmazásáról szóló 2000/43/EK tanácsi irányelv (a faji egyenlőségről szóló irányelv) nemcsak a foglalkoztatás, valamint az árukhoz és szolgáltatásokhoz való hozzáférés vonatkozásában tiltja a faji vagy etnikai származáson alapuló hátrányos megkülönböztetést, hanem a jóléti rendszer (és azon belül a szociális védelem, a szociális biztonság és az egészségügyi ellátás), valamint az oktatás tekintetében is.[79] További irányelvek rendelkeznek a férfiak és nők közötti egyenlő bánásmód elvének a foglalkoztatás és munkavégzés területén (a nemek közötti egyenlőségről szóló irányelv)[80], továbbá az árukhoz és szolgáltatásokhoz való hozzáférés, valamint azok értékesítése, illetve nyújtása tekintetében történő végrehajtásáról (az árukhoz és szolgáltatásokhoz való egyenlő hozzáférésről szóló irányelv).[81]

Az ET joganyagában a hátrányos megkülönböztetés tilalma az Emberi Jogok Európai Egyezményében meghatározott anyagi jogok és szabadságok élvezetére (14. cikk), valamint a nemzeti jog vagy valamely állami hatóság bármely aktusa révén biztosított jogok gyakorlására vonatkozik (az EJEE 12. Kiegészítő Jegyzőkönyvének 1. cikke). A 12. Kiegészítő Jegyzőkönyv azonban korlátozottan alkalmazható, mivel azt csupán kevés ország ratifikálta, és a jegyzőkönyv alapján mindeddig nem született határozat gyermekekkel kapcsolatos ügyekben. A két jogi eszközben foglalt rendelkezések tartalmazzák azon ok nem teljeskörű listáját, amelyek alapján tilos hátrányos megkülönböztetést alkalmazni: nem, faj, bőrszín, nyelv, vallás, politikai vagy egyéb vélemény, nemzeti hovatartozás vagy társadalmi származás, nemzeti kisebbséghez tartozás, vagyoni helyzet, születés vagy egyéb helyzet. Amennyiben az EJEB úgy találja, hogy egyes személyeket alapvetően hasonló helyzetben eltérő bánásmódban részesítettek, megvizsgálja, hogy ez objektív módon és ésszerűen indokolható-e.[82]

Az Európai Szociális Karta E. cikke szintén tartalmazza azon indokok nem teljeskörű listáját, amelyek alapján tilos hátrányos megkülönböztetést alkalmazni: faj, bőrszín, nem, nyelv, vallás, politikai vagy más vélemény, nemzeti vagy társadalmi származás, egészség, nemzeti kisebbséghez fűződő kapcsolat vagy születés. E cikk függeléke egyértelműsíti, hogy az objektív és ésszerű indokoláson alapuló differenciált bánásmód magában foglalja a bizonyos életkor vagy képesség

79 A Tanács 2000. június 29-i 2000/43/EK irányelve a személyek közötti, faji vagy etnikai származásra való tekintet nélküli egyenlő bánásmód elvének alkalmazásáról, HL L 180., 2000.6.29.

80 2006/54/EK irányelv (átdolgozott szöveg), HL L 204., 2006.

81 2004/113/EK tanácsi irányelv, HL L 373., 2004, 37. o.

82 Az EJEB ítélkezési gyakorlatának áttekintését lásd: FRA és EJEB (2011), valamint az ahhoz kapcsolódó, ítélkezési gyakorlatra vonatkozó frissített tájékoztató (2010. július – 2011. december).

előírását a bizonyos oktatási formákhoz való hozzáférés tekintetében[83] – ezért ez nem minősül hátrányos megkülönböztetésnek.

A nemzeti kisebbségek védelméről szóló keretegyezmény[84] (FCNM) 4. cikke értelmében a részes államok biztosítják a valamely nemzeti kisebbséghez tartozó személyek számára a törvény előtti egyenlőséget és a törvény általi egyenlő védelem jogát, és tiltják a nemzeti kisebbséghez tartozáson alapuló hátrányos megkülönböztetést. Emellett vállalják, hogy szükség esetén megfelelő intézkedéseket hoznak a gazdasági, a társadalmi, a politikai és a kulturális élet minden területén a nemzeti kisebbségekhez tartozó személyek és a többséghez tartozók közötti teljes és tényleges egyenlőség előmozdítása érdekében.

A következő szakaszok elemzik a hátrányos megkülönböztetés azon konkrét okait, amelyek különösen fontosnak bizonyultak a gyermekek szempontjából.

3.2. A faji vagy etnikai származás alapján történő hátrányos megkülönböztetés tilalma

Kiemelt pontok

- Faji vagy etnikai származás alapján tilos hátrányos megkülönböztetést alkalmazni.
- Az EU és az ET egyaránt foglalkozik az oktatás, a foglalkoztatás, az egészségügyi ellátás és a lakhatás területén tapasztalható, romákkal szembeni hátrányos megkülönböztetés problémájával.
- A valamely etnikai csoporthoz tartozó gyermekek speciális iskolákban vagy osztályokban való felülreprezentáltsága vagy elkülönítése csak akkor indokolható objektíven, ha megfelelő biztosítékok vonatkoznak a gyermekek ilyen iskolákba vagy osztályokba utalására.

Az uniós jog szerint a faji egyenlőségről szóló irányelv nemcsak a foglalkoztatás, valamint az árukhoz és szolgáltatásokhoz való hozzáférés vonatkozásában tiltja a faji vagy etnikai származáson alapuló hátrányos megkülönböztetést, hanem a jóléti ellátások, az oktatás és a szociális biztonság tekintetében is. A romák különösen

83 Európa Tanács, (Módosított) Európai Szociális Karta (1996), Magyarázó jelentés, 136. pont.

84 Európa Tanács, Keretegyezmény a nemzeti kisebbségek védelméről (FCNM), CETS 157., 1995.

jelentős és kiszolgáltatott etnikai csoportként egyértelműen az irányelv hatálya alá tartoznak. A romákkal szembeni hátrányos megkülönböztetés uniós szintű kezelésére irányuló törekvések kulcsfontosságú eleme volt a nemzeti romaintegrációs stratégiák 2020-ig tartó uniós keretrendszerének elfogadása.[85] Ezt az uniós tagállamok által kidolgozott nemzeti stratégiák Európai Bizottság általi évenkénti ellenőrzése követte. A faji egyenlőségről szóló irányelv legalább négy olyan kulcsfontosságú területet ölel fel, amely fontos a roma gyermekek szempontjából: ezek az oktatás, a foglalkoztatás, az egészségügyi ellátás és a lakhatás. A teljes egyenlőség gyakorlati megvalósítása bizonyos körülmények között indokolhatja a romákra irányuló pozitív fellépéseket, különösen a négy említett területen.[86]

Az ET joganyagában az EJEB több alapvető jelentőségű ügyben hozott ítéletet a roma gyermekekkel szembeni, oktatási rendszeren belül alkalmazott eltérő bánásmódot illetően. Ezeket az ügyeket az EJEE 1. Kiegészítő Jegyzőkönyvének 2. cikkével együttesen értelmezett 14. cikk alapján vizsgálták meg. Az EJEB úgy ítélte meg, hogy a roma gyermekek speciális iskolákban vagy osztályokban való felülreprezentáltsága vagy szegregációja csak akkor indokolható objektíven, ha megfelelő biztosítékokat alkalmaznak a gyermekek ilyen iskolákba vagy osztályokba irányításánál, ideértve a kifejezetten a roma gyermekek szükségleteire szabott és azokra érzékeny teszteket; az előrehaladás megfelelő értékelését és nyomon követését annak érdekében, hogy a tanulási nehézségek leküzdését követően a gyermekeket integrálják a hagyományos osztályokba; továbbá a tanulási nehézségek orvoslására irányuló pozitív intézkedéseket. A szegregációval szembeni hatékony intézkedések hiányában tehát nem indokolható a roma gyermekek többségi tantervvel működő, normál iskolákon belüli oktatási szegregációja.[87]

Példa: A *D.H. és társai kontra Cseh Köztársaság* ügyben[88] az EJEB megállapította, hogy aránytalanul sok roma gyermeket helyeztek el indokolatlanul a tanulási nehézségekkel küzdő gyermekek számára fenntartott speciális

85 Európai Bizottság (2011), *A nemzeti romaintegrációs stratégiák uniós keretrendszere 2020-ig: A Bizottság közleménye az Európai Parlamentnek, a Tanácsnak, az Európai Gazdasági és Szociális Bizottságnak és a Régiók Bizottságának*, COM(2011)173 final, Brüsszel, 2011. április 5.

86 Európai Bizottság (2014), *Közös jelentés a személyek közötti, faji vagy etnikai származásra való tekintet nélküli egyenlő bánásmód elvének alkalmazásáról szóló, 2000. június 29-i 2000/43/EK tanácsi irányelv és a foglalkoztatás és a munkavégzés során alkalmazott egyenlő bánásmód általános kereteinek létrehozásáról szóló, 2000. november 27-i 2000/78/EK tanácsi irányelv alkalmazásáról*, A Bizottság jelentése az Európai Parlamentnek és a Tanácsnak, COM(2014) 2 final, Brüsszel, 2014. január 17.

87 EJEB, *Lavida és társai kontra Görögország* (7973/10), 2013. május 30. (elérhető francia nyelven).

88 EJEB, *D.H. és társai kontra Cseh Köztársaság* [Nagykamara] (57325/00), 2007. november 13., 206–210. pont.

iskolákban. A bíróság aggályosnak tartotta, hogy ezek az iskolák alacsonyabb szintű tantervet kínálnak, és hogy ez a rendszer szegregációhoz vezet. A roma gyermekek tehát olyan oktatásban részesültek, amely fokozza nehézségeiket és hátrányos a későbbi személyes fejlődésükre nézve, ahelyett, hogy segítené őket a normál iskolarendszerbe való beilleszkedésben és azon készségek fejlesztésében, amelyek megkönnyítenék életüket a többségi társadalom körében. Következésképpen az EJEB megállapította az EJEE 14. cikkének az EJEE 1. jegyzőkönyve 2. cikkével összefüggésben történő megsértését.

Példa: Az *Oršuš és társai kontra Horvátország* ügyben[89] az EJEB a többségi általános iskolákon belüli roma osztályok meglétét vizsgálta. Az, ha a gyermekeket az oktatás nyelvének nem megfelelő ismerete miatt ideiglenesen külön osztályban helyezik el, alapvetően nem minősül önmagában véve hátrányos megkülönböztetésnek. Úgy tekinthető, hogy az ilyen intézkedéssel az oktatási rendszer igazodik a nyelvi nehézségekkel küzdő gyermekek speciális szükségleteihez. Mindazonáltal amint ez az intézkedés aránytalan mértékben vagy kizárólagosan egy bizonyos etnikai csoport tagjait érinti, biztosítékokra van szükség. A külön osztályokban való kezdeti elhelyezés tekintetében az EJEB megállapította, hogy az intézkedés nem egy, a nyelvet nem megfelelően beszélő gyermekek problémáinak kezelését célzó általános gyakorlat részét képezte, és hogy a gyermekek nyelvismeretének külön felmérésére nem került sor. Ami a kínált tantervet illeti, egyes gyermekek számára semmiféle speciális programot (például külön nyelvórát) nem biztosítottak annak érdekében, hogy a lehető legrövidebb idő alatt szert tegyenek a szükséges nyelvi készségekre. Sem áthelyezési, sem nyomonkövetési eljárást nem alkalmaztak annak biztosítása érdekében, hogy a megfelelő nyelvismeret megszerzését követően a roma gyermekeket azonnal és automatikusan áthelyezzék a vegyes osztályokba. Következésképpen az EJEB megállapította, hogy ez az EJEE 1. Kiegészítő Jegyzőkönyvének 2. cikkével összefüggésben sértette az EJEE 14. cikkét.

Az EJEB véleménye szerint a roma gyermekekre vonatkozó oktatáspolitikákat kísérhetik rugalmas struktúrák, megfelelve a csoport sokszínűségének, és figyelembe lehet venni, hogy egyes csoportok vándorló vagy részben vándorló életmódot folytatnak, elkülönített roma iskolák azonban nem működhetnek.[90]

89 EJEB, *Oršuš és társai kontra Horvátország* [Nagykamara] (15766/03), 2010. március 16., 157. pont.

90 Szociális Jogok Európai Bizottsága, (Módosított) Európai Szociális Karta – Következtetések 2003 (Bulgária), 17. cikk, 2. pont, 53. o.

A nemzeti kisebbségek védelméről szóló keretegyezmény 4. cikkének (2) és (3) bekezdése értelmében nem tekinthetők hátrányosan megkülönböztető jellegűnek azon intézkedések, amelyek célja a nemzeti kisebbségekhez tartozók tényleges egyenlőségének előmozdítása. A nemzeti kisebbségek védelméről szóló keretegyezmény 12. cikkének (3) bekezdése alapján emellett a részes államok kifejezetten kötelezettséget vállalnak arra, hogy minden szinten előmozdítják az esélyegyenlőséget a nemzeti kisebbségekhez tartozó személyek oktatáshoz való hozzáférése tekintetében. A nemzeti kisebbségek védelméről szóló keretegyezmény tanácsadó bizottsága rendszeresen vizsgálja a roma gyermekek oktatáshoz való, e rendelkezés szerinti egyenlő hozzáférését.[91]

3.3. A nemzetiségi hovatartozás és a menekültügyi státusz alapján történő hátrányos megkülönböztetés tilalma

Kiemelt pontok

- A nemzetiségi hovatartozás alapján történő hátrányos megkülönböztetéssel szembeni védelem az uniós jogban az ET jogához képest korlátozottabb.
- Az uniós jogban a nemzetiségi hovatartozás alapján történő hátrányos megkülönböztetéssel szembeni védelem csak az uniós tagállamok polgárait illeti meg, amint azt az Európai Unió Alapjogi Chartájának 45. cikke (a mozgás és a tartózkodás szabadsága) rögzíti.
- Az EJEE az adott tagállam joghatósága alatti valamennyi személy számára biztosítja a jogok gyakorlását.

Az uniós jogban a nemzetiségi hovatartozáson nyugvó hátrányos megkülönböztetéssel szembeni védelem különösen fontos kérdés a személyek szabad mozgása vonatkozásában. A harmadik országok állampolgárait (azaz azon személyeket, akik nem uniós tagállam állampolgárai) nagyjából ugyanazokon a területeken illeti meg az egyenlő bánásmódhoz való jog, mint amelyeket az anti-diszkriminációs

91 Lásd: Európa Tanács, A nemzeti kisebbségek védelméről szóló keretegyezmény tanácsadó bizottsága, *Kommentár a nemzeti kisebbségek védelméről szóló keretegyezménynek megfelelő oktatásról* (2006), ACFC/25DOC(2006)002.

irányelvek lefednek, amennyiben „huzamos tartózkodási engedéllyel rendelkezőnek" minősülnek. Ahhoz, hogy ennek minősüljenek, a harmadik országok állampolgárairól szóló irányelv értelmében egyéb feltételek teljesülése mellett ötéves jogszerű tartózkodás szükséges.[92] Emellett a családegyesítési jogról szóló 2003/86/EK irányelv (családegyesítési irányelv)[93] lehetővé teszi a harmadik országok valamely tagállamban jogszerűen tartózkodó állampolgárai számára, hogy családtagjaik bizonyos feltételek mellett csatlakozzanak hozzájuk (lásd még a 9.5. szakaszt).

Példa: A *Chen*-ügy[94] azt a kérdést tárgyalja, hogy egy harmadik ország állampolgárának gyermeke jogosult-e valamely uniós tagállamban tartózkodni, ha egy attól eltérő tagállamban született és annak az állampolgára. Anyja, aki gondviselője volt, harmadik ország állampolgára volt. Az EUB úgy ítélte meg, hogy amennyiben egy tagállam feltételeket szab az állampolgárságot szerezni kívánó személyek számára, és ezek a feltételek teljesülnek, egy másik tagállam nem kérdőjelezheti meg ezt a jogosultságot, amennyiben az anya és a gyermek tartózkodási engedélyért folyamodik. Az EUB megerősítette, hogy egy tagállam nem tagadhatja meg a tartózkodáshoz való jogot azon szülőtől, aki uniós állampolgár gyermek gondviselője, mivel ezáltal a gyermeket megfosztanák tartózkodási jogának mindenfajta hatékony érvényesülésétől.

Az ET joganyagában az EJEE a valamely tagállam joghatósága alatt élő valamennyi személy számára szavatolja a jogok gyakorlását, függetlenül attól, hogy rendelkeznek-e állampolgársággal, ideértve azokat is, akik az adott ország területén kívül, valamely tagállam tényleges ellenőrzése alatt álló területeken élnek. Az oktatás tekintetében ezért az EJEB úgy ítéli meg, hogy a nemzetiségi hovatartozás és a menekültügyi státusz alapján alkalmazott eltérő bánásmód hátrányos megkülönböztetésnek minősülhet.

Példa: A *Ponomaryovi kontra Bulgária* ügy[95] azt a kérdést tárgyalja, hogy az állandó tartózkodási engedéllyel nem rendelkező külföldi állampolgároknak tandíjat kell fizetniük a középfokú oktatásért. Főszabály szerint a gazdasági vagy társadalmi stratégiával kapcsolatos általános

92 A harmadik országok huzamos tartózkodási engedéllyel rendelkező állampolgárainak jogállásáról szóló, 2004. január 23-i 2003/109/EK irányelv, HL L 16., 2004, 44. o.

93 A családegyesítési jogról szóló, 2003. október 3-i 2003/86/EK irányelv, HL L 251., 2003, 12. o.

94 EUB, C-200/02. sz. ügy, *Kunqian Catherine Zhu és Man Lavette Chen kontra Secretary of State for the Home Department*, 2004. október 19.

95 EJEB, *Ponomaryovi kontra Bulgária* (5335/05), 2011. június 21., 60. pont.

intézkedések esetében fennálló, rendszerint széles mérlegelési jogkört az oktatás területén két okból korlátozni kell:

- az oktatáshoz való jog az EJEE értelmében közvetlen védelmet élvez;
- az oktatás a közszolgáltatások egyedi típusa, amely széles körű társadalmi funkciókat tölt be.

Az EJEB szerint minél magasabb oktatási szintről van szó, annál inkább szélesedik a mérlegelési jogkör, fordított arányban az adott oktatás érintett személyek és a széles társadalom szempontjából fennálló jelentőségével. Így miközben az alapfokú oktatás esetében nehezen indokolható a külföldiek által fizetendő (magasabb) tandíj, egyetemi szinten ez teljes mértékben indokolható lehet. Tekintettel a középfokú oktatásnak a személyes fejlődés, valamint a társadalmi és szakmai beilleszkedés szempontjából fennálló jelentőségére, az eltérő bánásmód arányosságát ezen oktatási szint vonatkozásában is szigorúbban kell ellenőrizni. Az EJEB világossá tette, hogy nem foglal állást abban a kérdésben, hogy egy államnak jogában áll-e megfosztani valamennyi irreguláris migránst az állampolgárai és a külföldiek bizonyos kategóriái számára nyújtott oktatási előnyöktől. Az eset egyedi körülményeit megvizsgálva arra a megállapításra jutott „az irreguláris migrációs hullám mérséklésének vagy visszafordításának szükségességével kapcsolatos megfontolások nem alkalmazandók". A kérelmezők nem próbáltak visszaélni a bolgár oktatási rendszerrel, mivel – miután anyjuk egy bolgárhoz ment férjhez – nagyon fiatal korukban kellett Bulgáriába jönniük, és így nem volt más választásuk, mint hogy Bulgáriában járjanak iskolába. Következésképpen az EJEE 1. Kiegészítő Jegyzőkönyvének 2. cikkével összefüggésben sérült az EJEE 14. cikke.

3.4. Az életkor alapján történő hátrányos megkülönböztetés tilalma

Kiemelt pontok

- Az uniós jog és az EJEE értelmében egyaránt tilos az életkor alapján történő hátrányos megkülönböztetés.

Az uniós jogban az Európai Unió Alapjogi Chartájának 21. cikke kifejezetten megemlíti a „kort" mint olyan indokot, amely alapján tilos a hátrányos megkülönböztetés.

A 24. cikk a védelmet élvező alapvető jogok között rögzíti a gyermekek jogait. A jelenlegi, európai anti-diszkriminációs jogszabályok értelmében az életkor alapján történő hátrányos megkülönböztetéssel szembeni védelem korlátozottabb, mint a faj vagy etnikai származás, illetve a nem alapján történő hátrányos megkülönböztetés esetében. Az életkor jelenleg csupán a foglalkoztatáshoz való hozzáférés vonatkozásában élvez védelmet, hasonlóan a szexuális irányultsághoz, a fogyatékossághoz, a valláshoz és a meggyőződéshez.

A foglalkoztatási egyenlőségről szóló irányelv a törvényesen munkavállalásra jogosult gyermekekre alkalmazandó. Míg a Nemzetközi Munkaügyi Szervezetnek (ILO) a foglalkoztatás alsó korhatáráról szóló egyezménye[96], amelyet valamennyi uniós tagállam ratifikált, az alsó korhatárt 15 évben állapítja meg, az uniós tagállamok között továbbra is vannak különbségek e korhatár tekintetében.[97] A foglalkoztatási egyenlőségről szóló irányelv 6. cikke értelmében a tagállamok indokolhatják az életkoron alapuló eltérő bánásmódot. Az eltérő bánásmód nem jelent hátrányos megkülönböztetést, ha egy törvényes cél által objektíven és ésszerűen igazolt, és ha a cél elérésének eszközei megfelelőek és szükségesek. A gyermekek és a fiatalok tekintetében ilyen eltérő bánásmód lehet például a foglalkoztatáshoz és a szakképzéshez történő hozzájutás külön feltételekhez kötése, valamint külön foglalkoztatási és munkafeltételek meghatározása szakmai beilleszkedésük elősegítése vagy védelmük biztosítása céljából.

Az ET joganyagában az EJEE 14. cikke és 12. Kiegészítő Jegyzőkönyvének 1. cikke nem említi külön az életkort mint olyan indokot, amely alapján tilos megkülönböztetést alkalmazni. Az EJEB azonban több, az EJEE által védett joggal összefüggésben vizsgált olyan ügyeket, amelyek az életkoron alapuló hátrányos megkülönböztetéshez kapcsolódtak, és ezáltal az életkort implicit módon „egyéb helyzetként" elemezte. A *D.G. kontra Írország*[98] és a *Bouamar kontra Belgium* ügyben[99] például az EJEB úgy ítélte meg, hogy a szóban forgó országok igazságszolgáltatási rendszere az egyezmény alkalmazása szempontjából releváns eltérő bánásmódot alkalmaz a felnőttekkel és a gyermekekkel szemben az őrizet tekintetében. Ez az eltérő bánásmód abból adódott, hogy az őrizet célja

96 Nemzetközi Munkaügyi Szervezet (ILO) (1973), 138. sz. egyezmény a foglalkoztatás alsó korhatáráról.

97 A hátrányos megkülönböztetés tilalmával foglalkozó jogi szakértők európai hálózata, O'Dempsey, D. és Beale, A. (2011), *Age and employment [Életkor és foglalkoztatás]*, Európai Bizottság, Jogérvényesülési Főigazgatóság, Luxembourg, Kiadóhivatal.

98 EJEB, *D.G. kontra Írország* (39474/98), 2002. május 16. (lásd még a 11.2.2. szakaszt).

99 EJEB, *Bouamar kontra Belgium* (9106/80), 1988. február 29. (lásd még a 11.2.2. szakaszt).

a felnőttek esetében a büntetés, míg a gyermekek tekintetében a megelőzés. A bíróság ezért elfogadta, hogy az „életkor" indokolhatja a megkülönböztetést.

3.5. Az egyéb védett tulajdonságok alapján történő hátrányos megkülönböztetés tilalma

Kiemelt pontok

- A gyermekekkel kapcsolatos európai ítélkezési gyakorlat a hátrányos megkülönböztetés további okait, köztük a fogyatékosságot és a születést is tárgyalta.

Az uniós jogban az Európai Unió Alapjogi Chartájának 21. cikke a gyermekek szempontjából különösen fontos egyéb okok – köztük a nem, a genetikai tulajdonságok, a nyelv, a fogyatékosság és a szexuális irányultság – alapján történő hátrányos megkülönböztetést is tiltja. Az EUB a fogyatékosság vonatkozásában elismerte, hogy az uniós jog az úgynevezett „járulékos hátrányos megkülönböztetéssel", azaz az olyan személy tekintetében alkalmazott hátrányos megkülönböztetéssel szemben is védelmet biztosít, akit egy védett tulajdonsággal rendelkező másik személlyel kapcsolnak össze (ilyen lehet például egy fogyatékossággal élő gyermek anyja).

Példa: Az *S. Coleman kontra Attridge Law és Steve Law* ügyben[100] az EUB megállapította, hogy a foglalkoztatási egyenlőségről szóló irányelv tartalmaz olyan rendelkezéseket, amelyek kifejezetten a fogyatékossággal élők igényeihez való alkalmazkodást célozzák. Ebből azonban nem következik, hogy az egyenlő bánásmód irányelvben rögzített elvét szorosan kell értelmezni, mintha az csupán a fogyatékosságon alapuló, és kizárólag a fogyatékossággal élő személyeket érintő közvetlen hátrányos megkülönböztetést tiltaná. Az EUB szerint az irányelv nem a személyek egy konkrét kategóriájára alkalmazandó, hanem magára a hátrányos megkülönböztetés jellegére. Egy olyan értelmezés, amely az irányelv alkalmazását a fogyatékossággal élő személyekre korlátozná, jelentős mértékben

100 EUB, C-303/06. sz. ügy, *S. Coleman kontra Attridge Law és Steve Law* [Nagytanács], 2008. július 17.

csorbítaná az irányelv hatékonyságát és csökkentené az általa szavatolni kívánt védelmet. Az EUB következtetése szerint az irányelvet úgy kell értelmezni, hogy a közvetlen hátrányos megkülönböztetés abban rögzített tilalma nem korlátozódik a fogyatékossággal élő személyekre. Ebből adódóan ha egy munkáltató egy fogyatékossággal nem rendelkező munkavállalóval szemben kevésbé kedvező bánásmódot alkalmazott, mint egy másik munkavállalóval szemben egy hasonló helyzetben, és ennek oka a volt munkavállaló gyermekének fogyatékossága volt, amely gyermek elsődleges gondviselője a szóban forgó alkalmazott, akkor ez ellentétben állt a közvetlen hátrányos megkülönböztetés irányelvben rögzített tilalmával.

Az ET jogi rendszerében az EJEB számos különböző, a már említettektől eltérő helyzettel kapcsolatban foglalkozott a gyermekekkel szembeni hátrányos megkülönböztetéssel, ideértve a nyelven[101] és a származáson alapuló hátrányos megkülönböztetést[102].

Példa: A *Fabris kontra Franciaország* ügyben[103] a kérelmező amiatt tett panaszt, hogy nem élhetett azon 2001-ben bevezetett törvény előnyeivel, amely a törvényes gyermekekéivel azonos öröklési jogokat biztosít a házasságon kívül született gyermekek számára, és amely törvény az EJEB *Mazurek kontra Franciaország* ügyben[104] 2000-ben hozott ítélete nyomán került elfogadásra. Az EJEB úgy ítélte meg, hogy a kérelmező féltestvéreit megillető öröklési jog védelmének törvényes célja nem nyom többet a latba, mint a kérelmező azon igénye, hogy részesüljön anyja örökségéből. Ebben az esetben az eltérő bánásmód hátrányos megkülönböztetésnek minősült, mivel nem volt objektív és ésszerű indoka. A bíróság megállapította, hogy ez az EJEE 1. Kiegészítő Jegyzőkönyvének 1. cikkével összefüggésben sértette az EJEE 14. cikkét.[105]

A fogyatékossággal élő gyermekek tekintetében az EJEB megállapította, hogy az Európai Szociális Karta 17. cikkének (2) bekezdése alkalmazásában a fogyatékossággal élő és a nem fogyatékos gyermekek közötti különbségtétel elfogadható.

101 EJEB, *„Relating to certain aspects of the laws on the use of languages in education in Belgium" kontra Belgium* (1474/62, 1677/62, 1691/62, 1769/63, 1994/63 és 2126/64), 1968. július 23.

102 EJEB, *Fabris kontra Franciaország* [Nagykamara] (16574/08), 2013. február 7.

103 *Uo.*

104 EJEB, *Mazurek kontra Franciaország* (34406/97), 2000. február 1.

105 EJEB, *Fabris kontra Franciaország* [Nagykamara] (16574/08), 2013. február 7.

Főszabályként azonban a fogyatékossággal élő gyermekeket integrálni kell a többségi iskolákba, ahol gondoskodni kell sajátos igényeik kielégítéséről, a speciális iskoláknak pedig a kivételt kell jelenteniük.[106] Emellett az Európai Szociális Karta 17. cikke (2) bekezdésének megfelelő speciális iskolákba járó gyermekeket elégséges oktatásban és képzésben kell részesíteni ahhoz, hogy arányaiban egyenlő számú gyermek szerezzen iskolai végzettséget a speciális iskolákban és a többségi iskolákban.[107] A gyermekek oktatással kapcsolatos jogait a 8.2. szakasz is tárgyalja.

A Gyermekjogi egyezmény 2. cikke tiltja a gyermekekkel szembeni hátrányos megkülönböztetést számos, nem teljeskörűen felsorolt tulajdonság vonatkozásában, amelyek között kifejezetten szerepel a születés. A 2. cikk a következőképpen rendelkezik:

> *1. Az Egyezményben részes államok tiszteletben tartják és biztosítják a joghatóságuk alá tartozó gyermekek számára az Egyezményben lefektetett jogokat minden hátrányos megkülönböztetés, nevezetesen a gyermeknek vagy szüleinek vagy törvényes képviselőjének faja, színe, neme, nyelve, vallása, politikai vagy más véleménye, nemzeti, nemzetiségi vagy társadalmi származása, vagyoni helyzete, cselekvőképtelensége, születési vagy egyéb helyzete szerinti különbségtétel nélkül.*
>
> *2. Az Egyezményben részes államok megteszik a megfelelő intézkedéseket arra, hogy a gyermeket hatékonyan megvédjék minden, bármely formában jelentkező hátrányos megkülönböztetéstől és megtorlástól, amely szülei, törvényes képviselői vagy családtagjai jogi helyzete, tevékenysége, véleménynyilvánítása vagy meggyőződése miatt érhetné őt.*

106 Szociális Jogok Európai Bizottsága, *International Association Autism Europe (IAAE) kontra Franciaország*, 13/2002. sz. panasz, 2003. november 4.

107 Szociális Jogok Európai Bizottsága, *Mental Disability Advocacy Center (MDAC) kontra Bulgária*, 41/2007. sz. panasz, 2008. június 3.

4

Személyazonossággal kapcsolatos kérdések

EU	Tárgyalt kérdések	ET
	Születési anyakönyvezés és a névhez való jog	EJEB, *Johansson kontra Finnország* (10163/02), 2007 (egy korábban más személyeknek engedélyezett név anyakönyvezésének elutasítása) A nemzeti kisebbségek védelméről szóló keretegyezmény, 11. cikk (az eredeti nyelvű vezetéknév viseléséhez való jog) A gyermekek örökbefogadásáról szóló (felülvizsgált) európai egyezmény, 11. cikk (3) bekezdés (örökbe fogadott gyermek eredeti nevének megtartása)
	A személyazonossághoz való jog	EJEE, 6. cikk (tisztességes tárgyaláshoz való jog) és 8. cikk (a magán- és családi élet tiszteletben tartásához való jog) EJEB, *Gaskin kontra Egyesült Királyság* (10454/83), 1989 (a gyermekgondozási aktához való hozzáférés megtagadása) EJEB, *Mizzi kontra Málta* (26111/02), 2006 (az apaság vitatásának lehetetlensége) EJEB, *Mennesson kontra Franciaország* (65192/11), 2014 (béranyaság a biológiai apával mint jövendő apával) EJEB, *Godelli kontra Olaszország* (33783/09), 2012 (a szülőanyával kapcsolatos, az azonosítást lehetővé nem tévő információk) A gyermekek örökbefogadásáról szóló (felülvizsgált) európai egyezmény, 22. cikk.

EU	Tárgyalt kérdések	ET
	Személyazonosság-lopás	EJEB, *K.U. kontra Finnország* (2872/02), 2008 (hirdetés közzététele az interneten a sértett tudomása nélkül)
EUB, C-200/02. sz. ügy, *Kunqian Catherine Zhu és Man Lavette Chen kontra Secretary of State for the Home Department*, 2004 (uniós állampolgár gyermek elsődleges gondviselőjének tartózkodási joga) EUB, C-34/09. sz. ügy, *Gerardo Ruiz Zambrano kontra Office National de l'Emploi (ONEm)*, 2011 (kiskorú uniós állampolgár gyermekkel rendelkező harmadik országbeli állampolgár tartózkodási joga)	Állampolgárság	EJEB, *Genovese kontra Málta* (53124/09), 2011 (házasságon kívül született gyermekek állampolgárságának önkényes megtagadása) Az állampolgárságról szóló európai egyezmény Az Európa Tanács államutódlás esetén bekövetkező hontalanság elkerüléséről szóló egyezménye
	Nemzeti kisebbség tagjának identitása	A nemzeti kisebbségek védelméről szóló keretegyezmény 5. cikkének (1) bekezdése (az identitás alapvető elemeinek megőrzése)

Tekintettel arra, hogy az EU korlátozott hatáskörrel rendelkezik ezen a területen, a személyazonossággal kapcsolatos kérdéseket általában nem uniós szinten tárgyalják. Az EUB azonban a mozgás szabadságának szempontjából mellékesen a névhez való jogról is hozott ítéletet (különös tekintettel azon jogra, hogy a valamely tagállamban elismert nevet a többi tagállamban is elismerjék). Az EUMSZ 20. cikke alapján az állampolgársággal és a tartózkodással kapcsolatos szempontokról is születtek ítéletek. Az ET ugyanakkor – különösen az EJEB ítélkezési gyakorlata révén – több, a személyazonossággal kapcsolatos alapvető jog alkalmazását értelmezte és fejlesztette. A következő szakaszok ezért – néhány olyan terület kivételével, ahol uniós szinten foglalkoztak a személyazonossági kérdésekkel – kizárólag az ET jogát tárgyalják.

Ez a fejezet nem egy konkrét alapvető jogra vonatkozik, hanem olyan, a személyazonossághoz kapcsolódó alapjogi kérdések keresztmetszetét adja, mint a születési anyakönyvezés és a névhez való jog (4.1. szakasz); a személyazonossághoz való jog (4.2. szakasz); a személyazonosság-lopás (4.4. szakasz); az

állampolgársághoz való jog (4.5. szakasz); valamint a nemzeti kisebbségekhez tartozó gyermekek identitása (4.6. szakasz). Több vonatkozó kérdést más fejezetek tárgyalnak, különösen a szexuális erőszakhoz (7.1.3. fejezet) és az adatvédelemhez kapcsolódóan (10. fejezet). Egyes vonatkozó jogokat, köztük a névhez való jogot elsősorban a szülők jogaiként érvényesítik, a megközelítést azonban könnyen át lehet ültetni a gyermekekre, tekintettel a saját jogaikra gyakorolt következményekre.

4.1. Születési anyakönyvezés és a névhez való jog

Kiemelt pontok

- Az olyan utónév anyakönyvezésének megtagadása, amely már elfogadott és nem minősül egy gyermek számára nem megfelelőnek, ellentétes lehet az EJEE 8. cikkével (a magán- és családi élet tiszteletben tartásához való jog).

Szemben az ENSZ egyezményekkel (például A Polgári és Politikai Jogok Nemzetközi Egyezségokmánya 24. cikkének (2) bekezdése, a Gyermekjogi egyezmény 7. cikkének (1) bekezdése, valamint a Fogyatékossággal élő személyek jogairól szóló egyezmény 18. cikke) az európai alapjogi eszközök nem rendelkeznek kifejezetten a közvetlenül a születést követő születési anyakönyvezéshez való jogról vagy a születéstől kezdődő névviseléshez való jogról.

Az uniós jogban a névhez való jogot a mozgás szabadságának szempontjából vizsgálták. Az EUB szerint a mozgás szabadsága kizárja, hogy valamely uniós tagállam megtagadja egy gyermek azon másik tagállamban bejegyzett vezetéknevének elismerését, amelynek a gyermek állampolgára, vagy ahol a gyermek született és tartózkodott.[108]

Az ET joganyagában a gyermek születési anyakönyvezésének megtagadása az EJEE 8. cikkének vonatkozásában problémát vethet fel.

108 Lásd: EUB, C-148/02. sz. ügy, *Carlos Garcia Avello kontra belga állam*, 2003. október 2.; EUB, C-353/06. sz. ügy, *Stefan Grunkin és Dorothee Regina Paul* [Nagytanács], 2008. október 14.

Először is, az EJEB úgy ítélte meg, hogy a név mint „a személyek családjukon és közösségükön belüli azonosításának eszköze" a magán- és családi élet tiszteletben tartásához való jog hatókörébe tartozik, amelyet az EJEE 8. cikke rögzít.[109] A gyermek utónevének[110] és családi nevének[111] szülők általi megválasztása a magánélet része. A bíróság megítélése szerint amikor az állami hatóságok azzal az indokkal tagadták meg a választott utónév anyakönyvezését, hogy a név valószínűsíthetően káros vagy hátrányos lenne a gyermekre nézve, nem sértették meg az EJEE 8. cikkét.[112] Az olyan utónév anyakönyvezésének megtagadása azonban, amely már elfogadott és nem minősül egy gyermek számára nem megfelelőnek, ellentétes lehet az EJEE 8. cikkével.

Példa: A *Johansson kontra Finnország* ügyben[113] a hatóságok megtagadták az „Axl Mick" utónév anyakönyvezését, mivel annak helyesírása nem felelt meg a finn névadási gyakorlatnak. Az EJEB elfogadta, hogy kellően tekintettel kell lenni a gyermek legfőbb (mindenek felett álló) érdekére, és hogy a nemzeti névadási gyakorlat megőrzése közérdek. Ugyanakkor megállapította, hogy más esetekben a nevet a hivatalos anyakönyvezésnél elfogadhatónak találták, és ezért nem tekinthető egy gyermek számára nem megfelelőnek. Mivel a név már elfogadott Finnországban, és mivel nem nyert megállapítást, hogy ez a név kedvezőtlenül érintette az állam kulturális és nyelvi identitását, az EJEB arra a következtetésre jutott, hogy a közérdekkel kapcsolatos megfontolások nem előrébb valók, mint a gyermek választott néven történő anyakönyvezéséhez fűződő érdek. A bíróság ezért megállapította az EJEE 8. cikkének megsértését.

Az EJEB azt is megállapította, hogy az a szabály, amely szerint a férj családi nevét kell adni a törvényes gyermeknek születése pillanatában, önmagában véve nem sérti az Emberi Jogok Európai Egyezményét. Azt azonban, hogy ettől az általános szabálytól nem lehet eltérni, az EJEB túlságosan merevnek és a nőkkel szemben diszkriminatívnak ítélte, megállapítva az EJEB 8. cikkel együtt értelmezett 14. cikkének megsértését.[114]

109 EJEB, *Guillot kontra Franciaország* (22500/93), 1993. október 24., 21. pont.

110 EJEB, *Johansson kontra Finnország* (10163/02), 2007. szeptember 6., 28. pont.; EJEB, *Guillot kontra Franciaország* (22500/93), 1993. október 24., 22. pont.

111 EJEB, *Cusan és Fazzo kontra Olaszország* (77/07), 2014. január 7., 56. pont.

112 EJEB, *Guillot kontra Franciaország* (22500/93), 1993. október 24., 27. pont.

113 EJEB, *Johansson kontra Finnország* (10163/02), 2007. szeptember 6.

114 EJEB, *Cusan és Fazzo kontra Olaszország* (77/07), 2014. január 7., 67. pont.

A nemzeti kisebbségek védelméről szóló keretegyezmény 11. cikke kimondja, hogy minden, valamely nemzeti kisebbséghez tartozó személynek joga van családi és utónevét kisebbségi nyelvén használni, továbbá joga van ahhoz, hogy nevét a jogrendszerben szabályozottaknak megfelelően hivatalosan elismerjék.

A gyermekek örökbefogadásáról szóló felülvizsgált európai egyezmény 11. cikkének (3) bekezdése rendelkezik arról, hogy a részes államoknak lehetőségük van megtartani az örökbe fogadott gyermek eredeti családi nevét (örökbefogadásról szóló egyezmény).[115] Ez kivételt jelent azon általános szabály alól, amely szerint az örökbe fogadott gyermek és eredeti családja közötti jogi kapcsolatot meg kell szüntetni.

4.2. A személyazonossághoz való jog

Kiemelt pontok

- A saját származás ismeretéhez való jog a gyermek magánéletének körébe tartozik.
- Az apaság megállapításánál gondos egyensúlyt kell teremteni a gyermek saját személyazonosságának ismeretéhez fűződő érdeke, a vélt vagy feltételezett apa érdeke, valamint a közérdek között.
- A titkos (anonim) szülés az EJEE 8. cikke értelmében (a magán- és családi élet tiszteletben tartásához való jog) megengedhető lehet, amennyiben a gyermek legalább azonosítást lehetővé nem tévő információkat kaphat az anyáról, és az anya kérelmezheti a titkosság feloldását.
- Az örökbe fogadott gyermeknek joga van hozzájutni a származásával kapcsolatos információkhoz. A vér szerinti szülők számára biztosítható az a törvényes jog, hogy ne fedjék fel személyazonosságukat, de ez nem minősül abszolút vétójognak.

Az ET jogát tekintve az EJEB szerint az EJEE 8. cikke magában foglalja a személyazonossághoz és a személyes fejlődéshez való jogot. A bíróság úgy ítélte meg, hogy a személyes fejlődés szempontjából fontosak az egyén személyazonosságának részletei, valamint az ahhoz fűződő érdek, hogy „az egyén megkapja a szükséges információkat annak feltárásához, hogy mi az igazság személyazonosságának fontos aspektusait tekintve, ideértve szüleinek személyazonosságát”[116]. A születés és a születési körülmények a gyermek magánéletének részét képezik.

115 Európa Tanács, (Felülvizsgált) Európai egyezmény a gyermekek örökbefogadásáról, CETS 202., 2008.

116 EJEB, *Odièvre kontra Franciaország* [Nagykamara] (42326/98), 2003. február 13., 29. pont.

Az egyén gyermekkorának, fejlődésének és történetének „messzemenően személyes aspektusaival kapcsolatos információk alapvető információforrást jelenthetnek az egyén múltjára és meghatározó első éveire vonatkozóan”[117], ezért az EJEE 8. cikke alapján kérdést vet fel, ha a gyermek nem fér hozzá ezekhez az információkhoz.

A nemzetközi jogban a Gyermekjogi egyezmény 8. cikke magas szinten és meglehetősen részletesen védi a gyermek személyazonosságának megtartásához fűződő jogot. A rendelkezés védelmet biztosít a gyermek saját személyazonossága – azon belül állampolgársága, neve és családi kapcsolatai – megtartásához fűződő, a törvényben elismert jogába való törvénysértő beavatkozással szemben. Emellett a személyazonosság lehető legrövidebb időn belül történő helyreállítása érdekében biztosítja a „megfelelő segítséget és védelmet” arra az esetre, ha a gyermeket törvénytelen módon megfosztják személyazonossága alkotóelemeitől vagy azoknak egy részétől.

4.2.1. Az apaság megállapítása

Az ET joganyagában az Emberi Jogok Európai Bíróságához panaszok érkeztek gyermekek részéről amiatt, hogy nem lehet megállapítani vérszerinti apjuk személyazonosságát. Az EJEB megállapította, hogy a gyermek és a vélt vér szerinti apa közötti jogi kapcsolat a magánélet körébe tartozik (az EJEE 8. cikke). A származás az identitás alapvető tényezője.[118] A gyermeknek az apaság megállapításához fűződő érdekét azonban egyensúlyba kell hozni a feltételezett apa érdekeivel és a közérdekkel. A gyermek ahhoz fűződő érdeke, hogy jogilag bizonyosságot szerezzen apai származásáról, nem előrébb való, mint az apa ahhoz fűződő érdeke, hogy visszautasítsa az apaság jogi vélelmét.

Példa: A *Mikulić kontra Horvátország* ügyben[119] a kérelmező házasságon kívül született, és eljárásokat kezdeményezett feltételezett apjával szemben az apaság megállapítására irányulóan. Az alperes többször is megtagadta a bíróság által elrendelt DNS-vizsgálaton való megjelenést, ami miatt az apasági eljárás szükségtelen módon több mint öt éven át elhúzódott. Az EJEB megállapította, hogy amennyiben a vélt apát a hazai jogszabályok alapján nem lehet kényszeríteni az orvosi vizsgálatra, az államnak alternatív eszközöket kell biztosítania, amelyek lehetővé teszik a vér szerinti apa független hatóság általi gyors azonosítását. A bíróság a kérelmező ügyében megállapította az EJEE 8. cikkének megsértését.

117 EJEB, *Gaskin kontra Egyesült Királyság* (10454/83), 1989. július 7., 36. pont

118 EJEB, *Mennesson kontra Franciaország* (65192/11), 2014. június 26., 96. pont.

119 EJEB, *Mikulić kontra Horvátország* (53176/99), 2002. február 7., 64–65. pont.

Példa: A *Mizzi kontra Málta* ügyben[120] a feltételezett apa nem tudta vitatni apaságát a felesége által szült gyermek tekintetében, mivel letelt a jogszabályban előírt hat hónapos határidő. Az EJEB az ügyet az EJEE 6. cikke (tisztességes tárgyaláshoz való jog) és 8. cikke (a magán- és családi élet tiszteletben tartásához való jog) alapján vizsgálta. A bíróság megállapította, hogy a gyermek feltételezett apa általi el nem ismerésére rendelkezésre álló határidő előírásának célja a jogbiztonság szavatolása, valamint a gyermek személyazonossága ismeretéhez fűződő jogának védelme. E célok azonban nem nyomnak többet a latba, mint az apa azon joga, hogy lehetőséget kapjon az apaság vitatására. A szóban forgó ügyben a születés óta gyakorlatilag lehetetlen volt vitatni az apaságot, ami túlzott terhet rótt a feltételezett apára, sértve a bírósághoz forduláshoz és a tisztességes tárgyaláshoz való, az EJEE 6. cikkében rögzített jogát. Az intézkedés emellett az EJEE 8. cikke szerinti jogait is aránytalan mértékben sértette.[121]

Az apaság kiderítésére törekvő gyermek és a biológiai apa érdekei időnként egybeeshetnek. Ez történt egy olyan esetben, amikor az apa jogképességének hiánya miatt nem tudott nemzeti szinten eljárást kezdeményezni a gyermekével való kapcsolat megállapítása érdekében. Az EJEB megállapította, hogy nem szolgálta a házasságon kívül született gyermek legfőbb (mindenek felett álló) érdekét, hogy vér szerinti apja nem tudott eljárást kezdeményezni az apaság megállapítása érdekében, és hogy ezért a gyermek teljes mértékben arra volt utalva, hogy az állami szervek mérlegeljék származásának megállapítását.[122]

A hatóságoknak pozitív kötelességük lehet a gyermek legfőbb (mindenek felett álló) érdekére tekintettel beavatkozni az apaság megállapítására irányuló eljárásokba, amennyiben a gyermek jogi képviselője (a szóban forgó esetben az anya) például súlyos fogyatékosság miatt nem képes megfelelően képviselni a gyermeket.[123]

A jövendő szülők és a béranyától született gyermek közötti kapcsolat elismerésének egyedi esetében az EJEB alapvetően elfogadta, hogy az államok széles mérlegelési jogkörrel rendelkeznek, mivel nincs európai konszenzus a leszármazás béranyaság keretében történő engedélyezése, illetve elismerése tekintetében. Az azonban, hogy a származás a gyermek identitásának alapvető tényezője, szűkíti a mérlegelési jogkört.

120 EJEB, *Mizzi kontra Málta* (26111/02), 2006. január 12.

121 *Uo.*, 112–114. pont.

122 EJEB, *Krušković kontra Horvátország* (46185/08), 2011. június 21., 38–41. pont.

123 EJEB, *A.M.M. kontra Románia* (2151/10), 2012. február 14., 58–65. pont (elérhető francia nyelven).

Példa: A *Mennesson kontra Franciaország* ügy[124] tárgya, hogy a francia hatóságok közpolitikai okokból megtagadták az Egyesült Államokban béranyától született gyermekek franciaországi anyakönyvezését. Az EJEB nem tudta megállapítani a kérelmezők családi életük tiszteletben tartásához való jogának megsértését, mivel semmilyen tekintetben nem akadályozták őket abban, hogy Franciaországban családi életet éljenek, és az esetlegesen felmerült adminisztratív akadályok nem voltak leküzdhetetlenek. A gyermekek magánéletének tiszteletben tartásához való jog tekintetében a bíróság nagy jelentőséget tulajdonított a gyermekek legfőbb (mindenek felett álló) érdekének. Hangsúlyozta különösen, hogy az a férfi, akit a gyermekek apjaként kívántak anyakönyveztetni, egyben a biológiai apjuk is volt. Abban az esetben, ha a biológiai leszármazás megállapítást nyer és az érintett szülő teljes körű elismerést kér, a gyermekek törvényes leszármazásának el nem ismerése nem tekinthető a gyermekek legfőbb (mindenek felett álló) érdeke szerinti intézkedésnek. A bíróság ezért a gyermekek magánéletük tiszteletben tartására vonatkozó panasza tekintetében megállapította az EJEE 8. cikkének megsértését.[125]

4.2.2. Az anyaság megállapítása: titkos (anonim) szülés

Az ET jogrendszerében a gyermek ahhoz fűződő érdekét, hogy megismerje származását és különösen anyját, egyensúlyba kell hozni olyan egyéb magán- és közérdekekkel, mint az érintett család vagy családok érdekei, az illegális abortuszok és a gyermekelhagyás megelőzéséhez fűződő közérdek, illetve az egészség védelme. Azon esetek, amelyekben a szülőanya a titkosság (anonimitás) mellett dönt, a gyermek azonban legalább az azonosítást lehetővé nem tévő információkat kaphat szülőanyjáról és kérheti az anyától a titkosság feloldását, összhangban állhatnak az EJEE 8. cikkével.[126]

Példa: A *Godelli kontra Olaszország* ügyben[127] a kérelmezőt születésekor elhagyta az anyja, aki nem adta beleegyezését ahhoz, hogy nevét a születési anyakönyvi kivonaton feltüntessék. A kérelmező nem tudott az azonosítást lehetővé nem tévő információkhoz hozzáférni származását illetően,

124 EJEB, *Mennesson kontra Franciaország* (65192/11), 2014. június 26.

125 *Uo.*, 100. pont; lásd még: EJEB, *Labassee kontra Franciaország* (65941/11), 2014. június 26., 79. pont.

126 EJEB, *Odièvre kontra Franciaország* [Nagykamara] (42326/98), 2003. február 13., 48-49. pont.

127 EJEB, *Godelli kontra Olaszország* (33783/09), 2012. szeptember 25., 58. pont

és nem tudta elérni anyja személyazonosságának feltárását. Az EJEB megállapította az EJEE 8. cikkének megsértését, mivel az állam nem törekedett a szülőanya és a gyermek egymással szemben álló érdekei közötti megfelelő egyensúly megteremtésére.

4.3. A származás megállapítása: örökbefogadás

A gyermek származásának ismeretéhez fűződő joga különös jelentőséggel bír az örökbefogadással összefüggésben. Az örökbefogadással kapcsolatos – a saját származás ismeretéhez való jogon kívüli – anyagi jogi garanciákkal a 6.3. szakasz foglalkozik.

Az ET jogi rendszerében a gyermekek örökbefogadásáról szóló felülvizsgált európai egyezmény 22. cikkének (3) bekezdése meglehetősen erőteljesen rendelkezik az örökbe fogadott gyermek azon jogáról, hogy hozzáférhessen a hatóságoknál meglévő, származásával kapcsolatos információkhoz. Lehetővé teszi a részes államok számára, hogy törvényes jogot biztosítsanak a származás szerinti szülők számára személyazonosságuk fel nem fedésére, amennyiben ez nem minősül abszolút vétójognak. Az illetékes hatóságnak meg kell tudnia állapítani, hogy a körülmények fényében és a szóban forgó jogokra tekintettel felülírja-e a származási szülők jogát, és kiadhat-e azonosítást lehetővé tévő információkat. Teljes örökbefogadás esetén lehetővé kell tenni, hogy az örökbe fogadott gyermek legalább egy olyan dokumentumot kaphasson, amely igazolja születésének helyét és idejét.[128]

A nemzetközi jogban a nemzetközi örökbefogadásról szóló Hágai Egyezmény lehetővé teszi, hogy az örökbe fogadott gyermek „megfelelő iránymutatással" hozzáférhessen a szülei kilétére vonatkozó információkhoz, de az egyes részes államokra hagyja annak eldöntését, hogy engedélyezik-e ezt.[129]

128 Európa Tanács, (Felülvizsgált) Európai egyezmény a gyermekek örökbefogadásáról, CETS 202., 2008, 22. cikk.

129 Hágai Nemzetközi Magánjogi Konferencia, Egyezmény a gyermekeknek a nemzetközi örökbefogadások terén való védelméről és az ilyen ügyekben történő együttműködésről, 1993. május 29., 30. cikk, (2) bekezdés.

4.4. Személyazonosság-lopás

Kiemelt pontok

- Gyakorlati és hatékony védelmet kell biztosítani a gyermekek sérelmére elkövetett személyazonosság-lopással szemben.

Személyazonosság-lopás olyan helyzetekben merül fel, amikor a gyermek tudtán kívül használják a nevét.

Az ET joganyagában az EJEB az EJEE magán- és családi élet tiszteletben tartásához való jogról szóló 8. cikkének vonatkozásában foglalkozott a személyazonosság-lopással. Megállapította, hogy az államoknak kötelességük biztosítani a gyermekek személyazonosság-lopással szembeni gyakorlati és hatékony védelmét, és hogy az államoknak hathatós lépéseket kell tenniük az elkövető azonosítása és eljárás alá vonása érdekében.[130]

Példa: A *K.U. kontra Finnország* ügyben[131] egy 12 éves fiú nevében tudtán kívül hirdetést helyeztek el egy internetes társkereső oldalon. A hirdetés tartalmazta a fiú életkorát, telefonszámát, külsejének leírását, valamint egy, a fényképét tartalmazó weboldalra mutató hivatkozást. A hirdetés szexuális jellegű volt, és azt sugallta, hogy a fiú egy vele egyidős vagy nála idősebb fiúval szeretne intim kapcsolatot létesíteni, amivel pedofilok céltáblájává tette őt. A hatályos jogszabályok miatt az internetszolgáltatótól nem lehetett megszerezni a hirdetés feladójának személyazonosságát. Az EJEB megállapította, hogy az EJEE 8. cikke szerinti azon pozitív kötelezettség, amely szerint a bűncselekményeket nemcsak büntetendővé kell tenni, hanem ténylegesen ki is kell vizsgálni és büntetőeljárás alá kell vonni, még fontosabbá válik, ha egy gyermek testi és erkölcsi jóléte van veszélyben. A szóban forgó ügyben a bíróság úgy ítélte meg, hogy azáltal, hogy a gyermeket pedofilok közeledésének tették ki az interneten, veszélyeztették a testi és erkölcsi jólétét. Következésképpen fennállt az EJEE 8. cikkének megsértése.

130 EJEB, *K.U. kontra Finnország* (2872/02), 2008. december 2., 49. pont.

131 EJEB, *K.U. kontra Finnország* (2872/02), 2008. december 2.

A személyazonosság-lopás egyes vonatkozásai szorosan összefüggnek a gyermekpornográfiával és a gyermekek elcsábításával. Ezeket a 7.2. szakasz tárgyalja.

4.5. Az állampolgársághoz való jog

Kiemelt pontok

- Az uniós állampolgárságú gyermekeket, az Unión belüli tartózkodáshoz való joguk mindenfajta hatékony érvényesülésétől nem lehet megfosztani azáltal, hogy megtagadják szülőjüktől vagy szüleiktől a tartózkodáshoz való jogot.
- Az EJEB nem biztosítja az állampolgársághoz való jogot, az állampolgárság önkényes megtagadása azonban az EJEE 8. cikkének (a magán- és családi élet tiszteletben tartásához való jog) hatálya alá tartozhat, mivel hatással van az egyén magánéletére.

Az uniós jogban az EUMSZ 20. cikkének (1) bekezdése az uniós tagállamok valamennyi állampolgára számára biztosítja az uniós polgárságot. Az EUB egy ítéletében foglalkozott azon uniós állampolgár gyermekek tartózkodási jogának hatékony érvényesülésével, akik nem rendelkeznek a lakóhelyük szerinti uniós tagállam állampolgárságával. Az ügy tárgya az volt, hogy megtagadhatóak-e a tartózkodási jogok az Unión belül egy olyan szülőtől, aki egy uniós állampolgár gyermek gondviselője. Az EUB úgy ítélte meg, hogy a gyermek elsődleges gondviselőjének minősülő szülő tartózkodási jogainak megtagadása megfosztja a gyermek tartózkodási jogát mindenfajta hatékony érvényesüléstől. Ezért az elsődleges gondviselő szülőnek joga van a gyermekkel együtt a fogadó államban tartózkodni.[132] Ezekkel a vonatkozásokkal a 9.5. szakasz foglalkozik részletesebben.

Az ET jogrendszerében az EJEE nem biztosítja az állampolgársághoz való jogot.[133] Az állampolgárság önkényes megtagadása azonban az EJEE 8. cikkének hatálya alá tartozhat, mivel hatással van az egyén magánéletére, amely magában foglalja a gyermek társadalmi identitásának aspektusait[134], ami ebben az esetben a gyermek társadalmon belüli identitását jelenti.

132 EUB, C-200/02. sz. ügy, *Kunqian Catherine Zhu és Man Lavette Chen kontra Secretary of State for the Home Department*, 2004. október 19., 45–46. pont.

133 EJEB, *Slivenko és társai kontra Lettország* [Nagykamara], határozat az elfogadhatóságról (48321/99), 2002. január 23., 77. pont.

134 EJEB, *Genovese kontra Málta* (53124/09), 2011. október 11., 33. pont.

Példa: A *Genovese kontra Málta* ügyben egy nem máltai anyától és egy, a bíróság által elismert máltai apától, nem Máltán, házasságon kívül született gyermektől megtagadták a máltai állampolgárságot. Az állampolgárság megtagadása önmagában véve nem sérti az EJEE 8. cikkét. Az állampolgárság házasságon kívüli születés alapján történő önkényes megtagadása azonban felvetette a hátrányos megkülönböztetés kérdését. Az ilyen alapon alkalmazott önkényes eltérő bánásmódot nyomós indokokkal kell igazolni. Ilyen indokok hiányában megállapítást nyert az EJEE 8. cikkének és 14. cikkének együttes megsértése.[135]

Az állampolgárság megszerzéséhez való joggal kapcsolatos szerződéses rendelkezések tekintetében kulcsfontosságú kérdés a hontalanság elkerülése. Az állampolgárságról szóló európai egyezmény részletes rendelkezéseket tartalmaz a gyermek törvényes állampolgársághoz jutására vonatkozóan, és korlátozza a gyermekek tekintetében az állampolgárság elvesztésének lehetőségeit.[136] Az Európa Tanács államutódlás esetén bekövetkező hontalanság elkerüléséről szóló egyezménye előírja a hontalanság születéskor történő elkerülését (10. cikk), és hontalanság esetére rendelkezik a jogutód állam állampolgárságához való jogról (2. cikk).[137] A hontalanság elkerülésére való törekvés a gyermekek örökbefogadásáról szóló felülvizsgált európai egyezmény 12. cikkében is megjelenik: az államoknak elő kell segíteniük, hogy a valamely állampolgáruk által örökbe fogadott gyermek megszerezze az adott állam állampolgárságát és az állampolgárság örökbefogadás következtében történő elvesztésének feltétele egy másik állampolgárság megléte vagy megszerzése.

A nemzetközi jogban a Gyermekjogi egyezmény 7. cikke szavatolja az állampolgárság megszerzéséhez való jogot, csakúgy, mint a Polgári és Politikai Jogok Nemzetközi Egyezségokmánya 24. cikkének (3) bekezdése.

135 *Uo.*, 43-49. pont.

136 Európa Tanács, Európai egyezmény az állampolgárságról, CETS 166., 1997, 6. és 7. cikk.

137 Európa Tanács, Egyezmény az államutódlás esetén bekövetkező hontalanság elkerüléséről, CETS 200., 2006.

4.6. A nemzeti kisebbségekhez tartozó gyermekek identitása138

Kiemelt pontok

- A nemzeti kisebbséghez tartozó gyermeknek jogában áll saját kulturális életét élni, saját vallását megvallani és gyakorolni, valamint saját nyelvét használni.[138]

Az uniós jog mindeddig nem fordított különös figyelmet alapjogi szempontból a nemzeti kisebbségekhez tartozó gyermekek identitására. Emellett az Unióban nincs olyan irányadó ítélkezési gyakorlat, amely hozzáadna az ET normáihoz.

Az ET joganyagában a nemzeti kisebbségek védelméről szóló keretegyezmény 5. cikkének (1) bekezdése kifejezetten rögzíti a részes államok azon kötelezettségvállalását, hogy megőrzik a nemzeti kisebbségekhez tartozó személyek identitásának alapvető elemeit, nevezetesen vallásukat, nyelvüket, hagyományaikat és kulturális örökségüket. A nemzeti kisebbségek védelméről szóló keretegyezmény nem tartalmaz kifejezetten a gyermekekre vonatkozó rendelkezést. Az oktatáson belüli nyelvhasználat kérdését a 8.2. szakasz tárgyalja.

A nemzetközi jogban a Gyermekjogi egyezmény 30. cikke biztosítja a nemzeti kisebbséghez tartozó vagy őslakos gyermek számára azt a jogot, hogy „saját kulturális életét élje, vallását vallja és gyakorolja, illetőleg csoportjának többi tagjával együtt saját nyelvét használja”.

138 A gazdasági, szociális és kulturális jogok egyéb vonatkozásaival kapcsolatban lásd még a 8. fejezetet.

5 Családi élet

EU	Tárgyalt kérdések	ET
Alapjogi Charta, 7. cikk (a magán- és a családi élet tiszteletben tartása)	A családi élet tiszteletben tartásához való jog	EJEE, 8. cikk (a magán- és családi élet tiszteletben tartásához való jog)
Alapjogi Charta, 24. cikk (a gyermekek jogai) Tartási rendelet (4/2009/EK)	A szülők általi gondozáshoz való jog	EJEB, *R.M.S. kontra Spanyolország* (28775/12), 2013 (lánygyermekkel való kapcsolattartás megtagadása)
Alapjogi Charta, a 24. cikk (3) bekezdése (a mindkét szülővel való kapcsolattartás joga) Brüsszel IIa. rendelet (2201/2003/EK) A közvetítésről szóló irányelv (2008/52/EK)	A mindkét szülővel való kapcsolattartás joga	A gyermekekkel való kapcsolattartásról szóló egyezmény

EU	Tárgyalt kérdések	ET
Az igazságszolgáltatáshoz való hozzáférésről szóló irányelv (2003/8/EK) (az igazságszolgáltatáshoz való hozzáférés határokon átnyúló jogviták esetén)	**A szülőktől való elválasztás**	EJEB, *Levin kontra Svédország* (35141/06), 2012 (a kapcsolattartás jogának korlátozása) EJEB, *Schneider kontra Németország* (17080/07), 2011 (kapcsolattartás a gyermek és a jogilag el nem ismert apa között) EJEB, *Sommerfeld kontra Németország* [Nagykamara] (31871/96), 2003 (kapcsolattartás apa és lánya között) EJEB, *Mustafa és Armağan Akin kontra Törökország* (4694/03), 2010 (testvérek közötti kapcsolattartás a felügyeleti jog megítélése után) EJEB, *Vojnity kontra Magyarország* (29617/07), 2013 (a láthatás vallási meggyőződés alapján történő korlátozása)
Alapjogi Charta, 24. cikk (a gyermekek jogai) Brüsszel IIa. rendelet (2201/2003/EK) EUB, C-211/10. PPU. sz. ügy, *Doris Povse kontra Mauro Alpago*, 2010 (végrehajtási igazolás)	**A gyermek jogellenes elvitele**	A gyermekekkel való kapcsolattartásról szóló egyezmény EJEB, *Neulinger és Shuruk kontra Svájc* [Nagykamara] (41615/07), 2010 (a gyermek anya általi elvitele) EJEB, *X kontra Lettország* [Nagykamara] (27853/09), 2013 (súlyos kockázat a gyermek Hágai Egyezmény szerinti visszavitele esetén)

Az európai jog – mind az EU, mind az ET joganyaga – biztosítja a családi élet tiszteletben tartásához való jogot (az Európai Unió Alapjogi Chartájának 7. cikke; az EJEE 8. cikke). A családi életet érintő ügyekben az EU hatásköre a határokon átnyúló jogvitákhoz kapcsolódik, ideértve a bírósági határozatok tagállamok közötti elismerését és végrehajtását. Az EUB olyan kérdésekkel foglalkozik, mint a gyermek legfőbb (mindenek felett álló) érdeke és a családi élethez való jog, amint azt az Európai Unió Alapjogi Chartája rögzíti, a Brüsszel IIa. rendeletet érintően. Az EJEB családi élettel kapcsolatos ítélkezési gyakorlata elismeri az olyan, egymástól kölcsönösen függő jogokat, mint a családi élethez való jog és a gyermek ahhoz való joga, hogy legfőbb (mindenek felett álló) érdekét elsődleges szempontként vegyék figyelembe. A bíróság elismeri, hogy a gyermekek jogai olykor ütköznek egymással. A gyermek családi életének tiszteletben tartásához való joga például a legfőbb (mindenek felett álló) érdekének biztosítása érdekében korlátozható. Emellett az ET

több egyéb eszközt is elfogadott, amelyek a kapcsolattartással, a felügyeleti joggal és a gyermekek jogainak gyakorlásával kapcsolatos kérdésekkel foglalkoznak.

Ez a fejezet megvizsgálja a gyermek családi életének tiszteletben tartásához való jogát és a kapcsolódó jogokat, különös tekintettel e jogok tartalmára és hatókörére, valamint a kapcsolódó jogi kötelezettségekre és az egyéb jogokkal fennálló kölcsönhatásukra. Olyan konkrét vonatkozások bemutatására kerül sor, mint a családi élet tiszteletben tartásához való jog és annak korlátai (5.1. szakasz), a gyermek szülei általi gondozáshoz való joga (5.2. szakasz), a mindkét szülővel való kapcsolattartás joga (5.3. szakasz) és a gyermek jogellenes elvitele (5.4. szakasz).

5.1. A családi élet tiszteletben tartásához való jog

Kiemelt pontok

- Az államoknak pozitív kötelezettségeik vannak annak biztosítása tekintetében, hogy a gyermekek ténylegesen élvezhessék a családi élet tiszteletben tartásához való jogukat.
- Az igazságügyi és a közigazgatási szerveknek mind az EU, mind az ET joganyaga szerint valamennyi, a gyermek családi életének tiszteletben tartásához való jogát érintő döntésüknél figyelembe kell venniük a gyermek legfőbb (mindenek felett álló) érdekét.

A gyermek családi életének tiszteletben tartásához való joga több különféle jogot foglal magában, ideértve a gyermek szülei általi gondozáshoz való jogát (5.2. szakasz); a mindkét szülővel való kapcsolattartás jogát (5.3. szakasz); az ahhoz fűződő jogot, hogy a gyermeket kizárólag akkor szakítsák el szüleitől, ha ez a legfőbb (mindenek felett álló) érdekét szolgálja (5.4. szakasz és 6. fejezet); valamint a családegyesítéshez való jogot (9. fejezet).

Az EU és az ET joganyagában a családi élet tiszteletben tartásához való jog nem abszolút jog, és számos korlátozás tárgyát képezi. E korlátozások – amint azt az Európai Unió Alapjogi Chartájához fűzött magyarázatok[139] egyértelműsítik –

139 Európai Parlament, Az Európai Unió Tanácsa, Európai Bizottság (2007), *Magyarázatok az Alapjogi Chartához*, 2007/C 303/02, HL C 303/02., 2007.12.14., 17–35. o., lásd a 7. cikkhez tartozó magyarázatot.

azonosak az EJEE vonatkozó rendelkezéséhez kapcsolódó korlátozásokkal, konkrétan a 8. cikk (2) bekezdésében foglaltakkal, azaz a törvényben meghatározott, olyan esetekben alkalmazandók, amikor az egy demokratikus társadalomban a nemzetbiztonság, a közbiztonság vagy az ország gazdasági jóléte érdekében, zavargás vagy bűncselekmény megelőzése, a közegészség vagy az erkölcsök védelme, avagy mások jogainak és szabadságainak védelme érdekében szükséges.[140]

Az Európai Unió Alapjogi Chartája e jogba kifejezetten belefoglalja a gyermek legfőbb (mindenek felett álló) érdeke figyelembevételének kötelezettségét (a 24. cikk (2) bekezdése).[141] Noha az EJEE nem teszi kifejezetten kötelezővé a gyermek legfőbb (mindenek felett álló) érdekének szem előtt tartását, az EJEB ítélkezési gyakorlatában megjelenik ez a kötelezettség.[142]

5.2. A gyermek szülei általi gondozáshoz való joga

Kiemelt pontok

- Az uniós jog szabályozza a gyermek szülei általi gondozáshoz való jogának eljárási vonatkozásait.
- Az EJEE értelmében az államoknak negatív és pozitív kötelezettségeik vannak a gyermekek és a szülők családi életének tiszteletben tartásával kapcsolatban.

A gyermek családi élete tiszteletben tartásához fűződő jogának két fő összetevője a gyermek szülei személyazonosságának ismeretéhez való joga, valamint a szülei általi gondozásához való joga. Ezek bizonyos mértékben kölcsönösen összefüggenek: a gyermek azon jogát, hogy ismerje szüleit, a szülői gondozás biztosítja. Olykor azonban – például az örökbe fogadott gyermekek vagy az orvosi technikákkal segített reprodukció útján született gyermekek esetében – ezek a jogok eltérőek. Esetükben ez a jog szorosabban kapcsolódik a gyermek személyazonossághoz való jogához, ami vér szerinti szüleinek ismeretében nyilvánul

140 Európa Tanács, Egyezmény az emberi jogok és alapvető szabadságok védelméről, CETS 5., 1950, 8. cikk.

141 EUB, C-400/10 PPU. sz. ügy, *J. McB. kontra L. E.*, 2010. október 5.

142 Lásd például: EJEB, *Ignaccolo-Zenide kontra Románia* (31679/96), 2000. január 25., 94. pont.

meg, és ezért ezt a kérdést a 4. fejezet tárgyalja. E szakasz a második jogra, azaz a gyermekek szüleik általi gondozáshoz való jogára összpontosít.

Az uniós jog nem rendelkezik a szülők általi gondozáshoz való jog tárgyi hatályáról. Az uniós eszközök foglalkozhatnak olyan határokon átnyúló vonatkozásokkal, mint a bírósági határozatok tagállamok közötti elismerése és végrehajtása. A tartással kapcsolatos ügyekben a joghatóságról, az alkalmazandó jogról, a határozatok elismeréséről és végrehajtásáról, valamint az e területen folytatott együttműködésről szóló 4/2009/EK rendelet (tartási rendelet) például kiterjed a családi kapcsolatokból adódó, határokon átnyúló tartási kérelmekre.[143] Egységes szabályokat állapít meg az EU egésze tekintetében azzal a céllal, hogy a tartási követelések akkor is behajthatóak legyenek, ha a kötelezett vagy a jogosult más tagállamban tartózkodik.

Az ET joganyagában az EJEB rámutatott, hogy az EJEE 8. cikke elsődlegesen a családi életbe való be nem avatkozás (negatív) kötelességét írja elő az államok számára.[144] Az államnak azonban pozitív kötelezettsége is van a tekintetben, hogy meg kell hoznia a szükséges intézkedéseket egyrészt a szülők és a családok támogatása, másrészt a gyermekek esetleges bántalmazással szembeni védelme érdekében.[145] A gyermekeket csak kivételes esetekben lehet elválasztani szüleiktől. Ilyen esetekben mindent meg kell tenni a személyes kapcsolatok megőrzése és adott esetben a család „újraépítése" érdekében. Az államok a gyermekek szüleiktől való elválasztására vonatkozó első határozathozatalnál széles mérlegelési jogkörrel rendelkeznek.[146] Szigorúbb ellenőrzésre van azonban szükség a további korlátozások tekintetében, ideértve a szülők láthatási jogának korlátozását, valamint a szülők és a gyermekek családi életének tiszteletben tartásához való jog hathatós védelmét szavatolni hivatott jogi biztosítékok korlátozását. E további korlátozások azt a veszélyt hordozzák magukban, hogy ténylegesen fellazulnak a fiatal gyermek és egyik vagy mindkét szülője közötti családi kapcsolatok. Hasonlóképpen az anyák újszülött csecsemőiktől való

143 Az Európai Unió Tanácsa (2009), A Tanács 2008. december 18-i 4/2009/EK tanácsi rendelete a tartással kapcsolatos ügyekben a joghatóságról, az alkalmazandó jogról, a határozatok elismeréséről és végrehajtásáról, valamint az e területen folytatott együttműködésről, HL L 7., 2009 (tartási rendelet).

144 EJEB, *R.M.S. kontra Spanyolország* (28775/12), 2013. június 18., 69. pont.

145 *Uo.*, 69 skk. pont.

146 EJEB, *Y.C. kontra Egyesült Királyság* (4547/10), 2012. március 13., 137. pont.

elválasztása esetén az államnak rendkívüli mértékben meggyőző és kényszerítő indokokat kell felhoznia.[147]

A mérlegelési jogkör annál kisebb, minél hosszabb ideig vannak a gyermekek elválasztva szüleiktől, és az állami szerveknek erős érvekkel kell alátámasztaniuk a különválasztás fenntartására irányuló határozatukat.[148] Az EJEB megvizsgálja, hogy tisztességes volt-e a döntéshozatali folyamat, és valamennyi érintett fél számára lehetőséget biztosítottak-e ügyük előterjesztésére.

Példa: Az *R.M.S. kontra Spanyolország* ügyben[149] a kérelmező azt sérelmezte, hogy szociális-gazdasági helyzete miatt semmiféle kapcsolatot nem tarthat fenn lányával annak három éves és 10 hónapos kora óta. A bíróság az EJEE 8. cikkének megsértését megállapítva hangsúlyozta, hogy „a spanyol közigazgatási hatóságoknak a gyermek állami gondozásba vételénél kevésbé drasztikus intézkedéseket kellett volna mérlegelniük". A bíróság emellett megállapította, hogy: „A szociális jóléti szervek szerepe éppen az, hogy segítsék a nehézségekkel küzdőket [...], iránymutatást adjanak nekik és tanácsokkal lássák el őket olyan kérdésekben, mint a különféle rendelkezésre álló juttatások, a szociális lakáshoz jutás lehetősége, valamint a nehézségek leküzdésének egyéb módjai, ideértve azokat, amelyekkel a kérelmező eredetileg élni kívánt." Ennek megfelelően az EJEB úgy ítélte meg, hogy „a spanyol hatóságok nem tették meg a megfelelő és elégséges erőfeszítéseket azon jog biztosítása érdekében, hogy a kérelmező együtt élhessen gyermekével".[150]

A nemzetközi jogban a Gyermekjogi egyezmény 5. cikke kimondja, hogy a részes államok „tiszteletben tartják a szülőknek [...] azt a felelősségét, jogát és kötelességét, hogy a gyermeknek az Egyezményben elismert jogai gyakorlásához, kibontakozó képességeinek megfelelően, iránymutatást és tanácsokat adjanak". Emellett a Gyermekjogi egyezmény 9. cikke rögzíti, hogy a gyermeket nem szabad akarata ellenére elválasztani szüleitől, és hogy valamennyi érdekelt félnek lehetőséget kell adni az ezzel kapcsolatos eljárásokban való részvételre. Az alternatív gondoskodásról szóló ENSZ iránymutatások még inkább

147 EJEB, *K. és T. kontra Finnország* [Nagykamara] (25702/94), 2001. július 12., 168. pont.

148 EJEB, *Y.C. kontra Egyesült Királyság* (4547/10), 2012. március 13., 137. pont.

149 EJEB, *R.M.S. kontra Spanyolország* (28775/12), 2013. június 18.

150 *Uo.*, 86. és 93. pont.

megerősítik a gyermekek ilyen helyzetekben fennálló jogait és az államok vonatkozó kötelességeit.[151]

5.3. A mindkét szülővel való kapcsolattartás joga

Kiemelt pontok

- A gyermek azon joga, hogy mindkét szülőjével kapcsolatot tartson, a szülőktől való elválasztás valamennyi – akár családi eredetű, akár az állam által elrendelt – formájánál megjelenik.
- A gyermek szülőkkel való kapcsolattartáshoz való jogának és a családegyesítésnek a biztosításakor elsődleges szempontként kell figyelembe venni a gyermek legfőbb (mindenek felett álló) érdekét, korának és érettségének megfelelően kellő súlyt fektetve a gyermek véleményére.

A szülőkkel való kapcsolattartás jogának hatálya a körülményektől függ. Amennyiben a szülők döntenek úgy, hogy különválnak egymástól, a jog hatóköre tágabb, és alapvetően csak a gyermek legfőbb (mindenek felett álló) érdeke korlátozza. Az állam által elrendelt – például valamely szülő kitoloncolásából vagy szabadságvesztéséből következő – különválasztás esetén az állami hatóságok egy védett érdek előmozdítása céljából járnak el, és megfelelő egyensúlyt kell teremteniük a felek érdekei és a gyermek legfőbb (mindenek felett álló) érdekének biztosításával kapcsolatos kötelezettség között. A gyermek azon joga, hogy mindkét szülőjével kapcsolatot tartson, mindkét esetben alkalmazandó.

Az uniós jogban az Európai Unió Alapjogi Chartája 24. cikkének (3) bekezdése kifejezetten elismeri minden gyermeknek ahhoz való jogát, hogy *mindkét* szülőjével kapcsolatot tartson fenn. A rendelkezés megszövegezése egyértelművé teszi a jog tartalmát, különösen a kapcsolattartás jelentését: a kapcsolattartásnak *rendszeresnek* kell lennie, lehetővé kell tennie a *személyes kapcsolat* kialakulását, és *közvetlen kapcsolat* formájában kell megvalósulnia. Van azonban

151 ENSZ, Emberi Jogi Tanács (2009), *Az ENSZ iránymutatásai a gyermekek alternatív gondozásához*, A/HRC/11/L.13. sz. ENSZ-dokumentum, 2009. június 15. A bővített, kommentárral ellátott magyar változat elérhető: SOS Nemzetközi Gyermekfalvak (2010), *Alternatív gondoskodás a gyermekekről – útmutató, Az Egyesült Nemzetek Szervezete által kidolgozott feltételrendszer*, Innsbruck, SOS Children's Villages International.

egy kikötés: a gyermek azon joga, hogy kapcsolatot tartson fenn szülőjével, kifejezetten arra korlátozódik, ami megfelel a gyermek legfőbb (mindenek felett álló) érdekének. Ez a rendelkezés – amint azt a Chartához fűzött magyarázatok egyértelműsítik – kifejezetten a Gyermekjogi egyezmény 9. cikkén alapul.

Az EU hatásköreinek megfelelően (lásd az 1. fejezetet) külön hangsúlyt kapott az igazságügyi együttműködés (amelynek célja a szabadságon, a biztonságon és a jog érvényesülésén alapuló térség megvalósítása, ahol biztosított a személyek szabad mozgása). Ki kell emelni két uniós jogi eszközt: a 2201/2003/EK tanácsi rendeletet[152] (Brüsszel IIa.), valamint a 2008/52/EK európai parlamenti és tanácsi irányelvet (a közvetítésről szóló irányelv)[153]. A jogok szempontjából jelentős a Brüsszel IIa. rendelet. Először is, a szülői felelősséggel kapcsolatos *valamennyi* határozatra alkalmazandó, függetlenül a családi állapottól. Másrészt a joghatóságra vonatkozó szabályok (amelyeket többnyire a gyermek szokásos tartózkodási helye határozza meg) kifejezetten a gyermek legfőbb (mindenek felett álló) érdekén alapulnak; harmadrészt pedig különös hangsúlyt kap a gyermek véleményének tiszteletben tartása.[154]

A gyermek valamely szülő egyoldalú döntését követő jogellenes elvitelével kapcsolatos ügyekben az EUB ítélkezési gyakorlatának elsődleges célja a gyermek azon alapvető jogának megőrzése, hogy rendszeres, személyes és közvetlen kapcsolatot tartson fenn mindkét szülőjével (a Charta 24. cikkének (3) bekezdése), mivel a Bíróság megítélése szerint ez a jog tagadhatatlanul egybevág a gyermek legfőbb (mindenek felett álló) érdekével. Az EUB véleménye szerint egy olyan intézkedés, amely megakadályozza, hogy a gyermek mindkét szülőjével rendszeres, személyes és közvetlen kapcsolatot tartson fenn, csak a gyermek olyan egyéb érdekével igazolható, amely előrébb való, mint a szóban forgó alapvető jogot alátámasztó érdek.[155] Ez magában foglalja a Brüsszel IIa. rendelet 20. cikke szerinti ideiglenes intézkedéseket, beleértve a védelmi intézkedéseket

152 Az Európai Unió Tanácsa (2003), A Tanács 2003. november 27-i 2201/2003/EK rendelete a házassági ügyekben és a szülői felelősségre vonatkozó eljárásokban a joghatóságról, valamint a határozatok elismeréséről és végrehajtásáról, illetve az 1347/2000/EK rendelet hatályon kívül helyezéséről, HL L 338., 2003 (Brüsszel IIa.).

153 Európai Parlament, az Európai Unió Tanácsa (2008), Az Európai Parlament és a Tanács 2008. május 21-i 2008/52/EK irányelve a polgári és kereskedelmi ügyekben végzett közvetítés egyes szempontjairól, HL L 136/3., 2008. (a közvetítésről szóló irányelv).

154 Lásd például a 2201/2003/EK tanácsi rendelet preambulumát (5., 12., 13. és 19. preambulumbekezdés), valamint 8. cikkét, 41. cikke (2) bekezdésének c) pontját és 42. cikke (2) bekezdésének a) pontját.

155 EUB, C-403/09 PPU. sz. ügy, *Jasna Detiček kontra Maurizio Sgueglia*, 2009. december 23., 59. pont.

is. A Bíróság úgy ítélte meg, hogy a Brüsszel IIa. rendelet rendelkezései szerinti eljárások során el kell végezni a összes vonatkozó érdekének kiegyensúlyozott és méltányos, magára a gyermek személyére és az őt körülvevő társadalmi környezetre vonatkozó objektív megfontolásokon alapuló értékelését.[156]

Példa: Az *E. kontra B.* ügy[157] az E. (az apa) és B. (az anya) közötti eljárást érinti, amelynek tárgya az Egyesült Királyság bíróságainak joghatósága a felek gyermeke, S. szokásos tartózkodási helyének, valamint az apa láthatási jogainak meghatározását illetően. A szülők egy spanyol bíróság előtt megállapodást írtak alá arról, hogy a felügyeleti jog az anyát illeti meg, az apának pedig láthatási joga van. Ezt követően az anya kérelmezte, hogy csökkentsék az e megállapodás által az apa számára biztosított láthatási jogokat. Az apa kérelmet nyújtott be a fellebbviteli bíróságnál a spanyol megállapodás végrehajtására irányulóan. Az anya kijelentette, hogy elfogadta a spanyol bíróság joghatóságát, és kérte a kikötött joghatóságnak az angliai és walesi bíróságokhoz való áthelyezését. Az apa fellebbezése nyomán a Fellebbviteli Bíróság kérdéseket terjesztett az EUB elé a Brüsszel IIa. rendelet 12. cikke (3) bekezdésének értelmezését illetően. Az EUB megállapította, hogy ha valamely bírósághoz fordulnak a Brüsszel IIa. rendelet 12. cikkének (3) bekezdése alapján, a gyermek legfőbb (mindenek felett álló) érdeke kizárólag úgy védhető, ha a bíróság minden egyes esetben megvizsgálja, hogy a kívánt joghatóságra vonatkozó megállapodás összhangban van-e ezzel a legfőbb (mindenek felett álló) érdekkel. A joghatóságról való megállapodás kizárólag arra az adott eljárásra vonatkozik, amely céljából ahhoz a bírósághoz fordultak, amelynek joghatósága tekintetében megállapodtak. Ez a joghatóság a joghatóságról való megállapodás alapján indult eljárás végleges befejezésével megszűnik a Brüsszel IIa. rendelet 8. cikke (1) bekezdésének értelmében általános joghatósággal rendelkező bíróság javára.

A szülői felelősség tekintetében a Brüsszel IIa. rendelettel párhuzamosan fennáll a szülői felelősséggel és a gyermekek védelmét szolgáló intézkedésekkel kapcsolatos együttműködésről, valamint az ilyen ügyekre irányadó joghatóságról,

156 *Uo.*, 60. pont.

157 EUB, C-436/13. sz. ügy, *E. kontra B.*, 2014. október 1. (kiigazított összefoglalás a http://cases.iclr.co.uk oldalról).

alkalmazandó jogról, elismerésről és végrehajtásról szóló Hágai Egyezmény[158]. A 61. cikk értelmében a Brüsszel IIa. rendelet elsőbbséget élvez a Hágai Egyezménnyel szemben: a) amennyiben az érintett gyermek valamely tagállam területén rendelkezik szokásos tartózkodási hellyel; vagy b) valamely tagállam bírósága által hozott határozatnak egy másik tagállam területén történő elismerését és végrehajtását illetően, még akkor is, ha az érintett gyermek olyan harmadik állam területén rendelkezik szokásos tartózkodási hellyel, amely a Hágai Egyezmény szerződő fele. A Brüsszel IIa. rendelet értelmében ezért kulcsfontosságú kérdés a gyermek szokásos tartózkodási helyének megállapítása.

Példa: A *Mercredi kontra Chaffe* ügyben[159] Anglia és Wales Fellebbviteli Bírósága az Európai Unió Bíróságához fordult egy két hónapos gyermek Egyesült Királyságból Réunion francia szigetre történő elvitele tárgyában. Az EUB úgy ítélte meg, hogy a szokásos tartózkodási hely fogalma a Brüsszel IIa. rendelet 8. és 10. cikke alkalmazásában megfelel annak a helynek, amely tükrözi a gyermek szociális és családi környezetbe való, bizonyos fokú beilleszkedését. Amennyiben egy olyan csecsemő az érintett, aki csupán néhány napot tartózkodott anyjával valamely – a szokásos tartózkodási helye szerinti tagállamtól eltérő – tagállamban, ahová elvitték, a figyelembe veendő tényezők között szerepel először is az adott tagállam területén való tartózkodás időtartama, szabályszerűsége, az ezen uniós tagállam területén való tartózkodásnak, illetve az anya e tagállamba való költözésének a körülményei és indokai, továbbá másodsorban – különös tekintettel a gyermek életkorára – az anya földrajzi és családi származása, valamint az anyának és a gyermeknek az adott tagállamban meglévő családi és társadalmi kapcsolatait.

A határokon átnyúló jogvitákban a mindkét szülővel való kapcsolattartáshoz fűződő jog érvényesülése tekintetében különösen fontosak azok az igazságszolgáltatáshoz való jogot szabályozó eszközök is, amelyek világossá teszik, miként kell eljárni az összetett jogvitákban: ilyen a 2002/8/EK irányelv (az igazságszolgáltatáshoz való hozzáférésről szóló irányelv), amely „a határon átnyúló vonatkozású jogviták esetén az igazságszolgáltatáshoz való hozzáférés" megkönnyítésére

158 A polgári és kereskedelmi ügyekben történő határokon átnyúló együttműködés világszervezete (1996), Hágai Nemzetközi Magánjogi Konferencia, Egyezmény a szülői felelősséggel és a gyermekek védelmét szolgáló intézkedésekkel kapcsolatos együttműködésről, valamint az ilyen ügyekre irányadó joghatóságról, alkalmazandó jogról, elismerésről és végrehajtásról, 1996. október 19.

159 EUB, C-497/10. PPU. sz. ügy, *Barbara Mercredi kontra Richard Chaffe*, 2010. december 22.

irányul, „az e jogvitákkal kapcsolatos költségmentességre vonatkozó közös minimumszabályok megállapításán keresztül”.[160] Az irányelv célja a határon átnyúló vonatkozású polgári ügyekben az igazságszolgáltatáshoz való hozzáférés megkönnyítése a költségmentességre vonatkozó közös minimumszabályok megállapításán keresztül; annak biztosítása, hogy bizonyos feltételek mellett megfelelő költségmentességben részesüljenek azon személyek, akik pénzügyi helyzetükből adódóan nem tudják viselni az eljárási költségeket; továbbá a vonatkozó nemzeti jogszabályok összeegyeztethetőségének elősegítése és a tagállami hatóságok közötti együttműködést célzó mechanizmusok biztosítása.

Az ET joganyagában a gyermekek mindkét szülővel való kapcsolattartáshoz fűződő joga implicit módon benne rejlik az EJEE 8. cikkében. Az EJEB szerint „a családi élet alapvető eleme, hogy a szülő és a gyermek kölcsönösen élvezzék egymás társaságát”.[161] A bíróság azonban arra is rámutat, hogy ez a jog a gyermek legfőbb (mindenek felett álló) érdeke alapján korlátozható (lásd az 5.4. szakaszt és a 6. fejezetet). Ez a jog a láthatást és a gyermekkel való kapcsolattartást érintő bírósági döntéshozatal központi eleme.

Az EJEB a láthatás és a kapcsolattartás vonatkozásában egy sor ügyben utalt kifejezetten vagy implicit módon a gyermek legfőbb (mindenek felett álló) érdekére.

Példa: A *Schneider kontra Németország* ügyben[162] a kérelmező egy férjezett nővel tartott fenn viszonyt, és azt állította, hogy ő a vér szerinti apja a nő fiának, akinek jogilag elismert apja a nő férje volt. A kérelmező úgy érvelt, hogy a hazai bíróság határozata, amely azon az alapon utasítja el a gyermekkel való kapcsolattartásra és a gyermek fejlődésével kapcsolatos tájékoztatásra irányuló kérelmét, hogy se nem a gyermek törvényes apja, se nem állt kapcsolatban a gyermekkel, sértette az EJEE 8. cikke értelmében fennálló jogait. A jogsértés megállapításánál az EJEB azt állította középpontba, hogy a hazai bíróságok nem mérlegelték, hogy az eset egyedi körülményeit tekintve nem felelne-e meg a gyermek legfőbb (mindenek felett álló) érdekének a gyermek és a kérelmező közötti

160 Az Európai Unió Tanácsa (2003), A Tanács 2003. január 27-i 2003/8/EK irányelve a határon átnyúló vonatkozású jogviták esetén az igazságszolgáltatáshoz való jog megkönnyítése érdekében az ilyen ügyekben alkalmazandó költségmentességre vonatkozó közös minimumszabályok megállapításáról, HL L 26., 2003 (az igazságszolgáltatáshoz való hozzáférésről szóló irányelv).

161 EJEB, *K. és T. kontra Finnország* [Nagykamara] (25702/94), 2001. július 12., 151. pont.

162 EJEB, *Schneider kontra Németország* (17080/07), 2011. szeptember 15.

kapcsolattartás.[163] Ami a kérelmezőnek a gyermek személyes fejlődésével kapcsolatos tájékoztatásra irányuló kérését illeti, a bíróság megállapította, hogy a hazai bíróságok nem indokolták meg kellően a 8. cikk (2) bekezdése alkalmazásában történő beavatkozásukat[164], és ezért a beavatkozás nem volt „egy demokratikus társadalomban szükséges".

Példa: A *Levin kontra Svédország* ügyben[165] a kérelmező, egy háromgyermekes anya, akinek gyermekei gyermekvédelmi szakellátásban élnek, azt sérelmezte, hogy a gyermekeivel való kapcsolattartás jogának korlátozása sérti a családi élet tiszteletben tartásához való jogát. Az EJEB a kapcsolattartás korlátozásának célját, nevezetesen a gyermekek legfőbb (mindenek felett álló) érdekének védelmét helyezte a középpontba. A konkrét esetben a gyermekek el voltak hanyagolva, amíg a kérelmező gondozása alatt álltak, és az anyával való kapcsolattartás igen negatív reakciókat váltott ki a gyermekekből. A bíróság úgy ítélte meg, hogy nem sérült az EJEE 8. cikke, és megállapította, hogy a kérelmező jogainak korlátozása „arányban állt az elérni kívánt törvényes céllal [a gyermekek legfőbb (mindenek felett álló) érdekével], és nem ment túl a hazai hatóságok mérlegelési jogkörén".

Példa: A *Sommerfeld kontra Németország* ügyben[166] a kérelmező azon jogának korlátozása miatt emelt panaszt, hogy kapcsolatot tartson fenn lányával, aki következetesen kinyilvánította, hogy nem kíván kapcsolatban lenni vele. A kérelmező különösen azzal érvelt, hogy a hazai bíróságok nem kértek pszichológiai szakvéleményt, ami eljárási hibának minősül. Az EJEB nem találta megállapíthatónak az EJEE 8. cikkének megsértését, és kimondta, hogy a hazai bíróság alkalmas volt arra, hogy mérlegelje a lány nyilatkozatait és megállapítsa, hogy képes volt-e önálló döntést hozni.

Példa: A *Mustafa és Armağan Akin kontra Törökország* ügyben[167] a kérelmezők – apa és fia – sérelmezték, hogy a hazai bíróság felügyeleti jogról szóló határozata sértette az EJEE 8. cikke szerinti jogaikat. A határozat feltételei miatt a fiú nem tudott kapcsolatot tartani lánytestvérével, aki

163 Lásd még: EJEB, *Anayo kontra Németország* (20578/07), 2010. december 21., 67. és 71. pont.

164 EJEB, *Schneider kontra Németország* (17080/07), 2011. szeptember 15., 104.pont.

165 EJEB, *Levin kontra Svédország* (35141/06), 2012. március 15., 57. és 69. pont; EJEB, *K. és T. kontra Finnország* [Nagykamara] (25702/94), 2001. július 12., 151. pont.

166 EJEB, *Sommerfeld kontra Németország* [Nagykamara] (31871/96), 2003. július 8., 72. pont.

167 EJEB, *Mustafa és Armağan Akin kontra Törökország* (4694/03), 2010. április 6.

felett anyja gyakorolt felügyeleti jogot. Emellett az apa nem találkozhatott mindkét gyermekével egyszerre, mert fia ugyanabban az időben találkozott az anyjával, amikor ő a lányával. Az EJEB megállapította, hogy a hazai bíróság testvéreket szétválasztó határozata sértette a kérelmezőknek a családi életük tiszteletben tartásához való jogát, mivel amellett, hogy megakadályozta, hogy a két testvér lássa egymást, azt is ellehetetlenítette, hogy az apa mindkét gyermekével egyszerre találkozhasson.

A szülői felügyeleti jogot és a kapcsolattartást érintő döntéshozatal vonatkozásában az EJEB az EJEE 14. cikkével összeegyeztethetetlen hátrányos megkülönböztetést is tiltja.

Példa: A *Vojnity kontra Magyarország* ügyben[168] a kérelmező sérelmezte, hogy vallási meggyőződése miatt megvonták tőle fia láthatásának jogát.[169] Az EJEB megállapította az EJEE 14. cikkének a 8. cikkel összefüggésben történő megsértését, és nem találta bizonyítottnak, hogy a kérelmező vallási meggyőződése veszélyes gyakorlatokkal járt együtt, illetve fizikai vagy lelki sérülésnek tette volna ki a fiút.[170] A hazai bíróságok azon határozatai, amellyel megvonták a kérelmező láthatási jogát, lehetetlenné tettek mindenfajta kapcsolattartást és megakadályozták bármiféle további családi élet kialakítását, noha a kapcsolattartás teljes megszüntetése csak kivételes körülmények fennállása esetén indokolható.[171] Az EJEB ezért megállapította, hogy nem állt fenn ésszerű arányosság a kérelmező láthatási jogának teljes körű megvonása és az elérni kívánt cél, nevezetesen a gyermek legfőbb (mindenek felett álló) érdekének védelme között.[172]

Példa: A *Salgueiro da Silva Mouta kontra Portugália* ügyet[173] egy apa kezdeményezte annak érdekében, hogy szülői felügyeletet gyakorolhasson gyermeke fölött. Állítása szerint a nemzeti eljárás során a portugál hatóságok elutasították igényét, és szexuális irányultsága miatt az anyának ítélték meg a szülői felügyeleti jogot. Az EJEB megállapította, hogy a hazai hatóságok

168 EJEB, *Vojnity kontra Magyarország* (29617/07), 2013. február 12.; lásd még: EJEB, *P.V. kontra Spanyolország* (35159/09), 2010. november 30. (elérhető francia és spanyol nyelven).

169 EJEB, *Vojnity kontra Magyarország* (29617/07), 2013. február 12., 22. pont.

170 *Uo.*, 38. pont.

171 *Uo.*, 41. pont.

172 *Uo.*, 43. pont.

173 EJEB, *Salgueiro da Silva Mouta kontra Portugália* (33290/96), 1999. december 21.

valóban homoszexualitása alapján tagadták meg tőle a felügyeleti jogot, amely határozat nincs objektíven és ésszerűen indokolva. A bíróság arra a következtetésre jutott, hogy sérült az EJEE 14. cikkel együttesen értelmezett 8. cikke.

Mindezeken túlmenően, az ET gyermekekkel való kapcsolattartásról szóló egyezménye kifejezetten hivatkozik a gyermek azon jogára, hogy mindkét szülőjével kapcsolatot tartson fenn.[174] Az egyezmény 4. cikkének (1) bekezdése kimondja, hogy „a gyermeknek és szüleinek jogában áll rendszeres kapcsolatot létesíteni és fenntartani egymással". A kapcsolattartásra vonatkozó ítélkezési gyakorlatban alkalmazandó általános elvek rámutatnak a gyermek tájékoztatáshoz, megkérdezéshez és véleménynyilvánításhoz való jogára, valamint e vélemény kellő figyelembevételére. Az Európa Tanács gyermekek jogainak gyakorlásáról szóló egyezménye[175] 6. cikkében azonosítja az igazságügyi döntéshozatal további feltételeit, ideértve az alábbiakra vonatkozó jogi kötelezettségeket: annak mérlegelése, hogy elegendő információval rendelkezik-e az igazságügyi hatóság a gyermek legfőbb (mindenek felett álló) érdekének meghatározásához; a gyermek eljárással és annak kimenetelével kapcsolatos tájékoztatáshoz való jogának biztosítása; valamint biztonságos hely biztosítása az érintett gyermekek számára ahhoz, hogy életkoruknak, illetve érettségüknek megfelelő módon, szabadon kifejtsék véleményüket.

Előfordulhatnak olyan helyzetek, amelyekben a gyermeket más módon, például a szülő szabadságvesztése következtében választják el valamely szülőjétől. Az EJEB a *Horych kontra Lengyelország* ügyben[176] találkozott ilyen helyzettel, azt vizsgálva, hogy milyen körülmények között látogathatták meg kiskorú lányai a veszélyes fogvatartottnak minősített kérelmezőt. Az EJEB megállapította, hogy „a gyermekek [...] börtönben tett látogatásához különös szabályokra van szükség, és életkoruktól, az érzelmi állapotukra vagy jóllétükre gyakorolt lehetséges hatásoktól, valamint a látogatott személy személyes körülményeitől függően egyedi feltételeket lehet előírni".[177] A bíróság emellett rámutatott, hogy „az állam 8. cikk szerinti pozitív kötelezettségei [...] magukban foglalják a megfelelő, a látogatók számára a lehető leginkább stresszmentes körülmények biztosításának

174 Európa Tanács, Egyezmény a gyermekekkel való kapcsolattartásról, CETS 192., 2003. Lásd még: A polgári és kereskedelmi ügyekben történő határokon átnyúló együttműködés világszervezete (1996), Hágai Nemzetközi Magánjogi Konferencia, Egyezmény a szülői felelősséggel és a gyermekek védelmét szolgáló intézkedésekkel kapcsolatos együttműködésről, valamint az ilyen ügyekre irányadó joghatóságról, alkalmazandó jogról, elismerésről és végrehajtásról.

175 Európa Tanács, Európai egyezmény a gyermekek jogainak gyakorlásáról, CETS 160., 1996.

176 EJEB, *Horych kontra Lengyelország* (13621/08), 2012. április 17.

177 *Uo.*, 131. pont.

kötelességét a gyermekek fogadása során, szem előtt tartva a szabadságvesztés gyakorlati következményeit”.[178]

Végezetül, a szabadságuktól megfosztott gyermekek szüleikkel való kapcsolattartáshoz fűződő jogát az ET gyermekbarát igazságszolgáltatásról szóló iránymutatásának egyes rendelkezései is megerősítik.[179] Az iránymutatás kifejezetten rögzíti a szabadságuktól megfosztott gyermekek ahhoz való jogát, hogy „rendszeres és érdemi kapcsolatot tartsanak fenn szüleikkel [és] családtagjaikkal” (a 21. cikk a) pontja) (lásd még a 11. fejezetet).

A nemzetközi jogban a mindkét szülővel való kapcsolattartáshoz fűződő jogot a Gyermekjogi egyezmény 9. cikkének (3) bekezdése rögzíti: „Az Egyezményben részes államok tiszteletben tartják a mindkét szülőjétől vagy ezek egyikétől külön élő gyermeknek azt a jogát, hogy személyes kapcsolatot és közvetlen érintkezést tarthasson fenn mindkét szülőjével, kivéve, ha ez a gyermek legfőbb (mindenek felett álló) érdekeivel ellenkezik.”

5.4. Gyermekek határokon átnyúló jogellenes elvitele

Kiemelt pontok

- Az EJEB a gyermekek jogain alapuló megközelítést követel meg a felügyeleti joggal kapcsolatos megállapodásokat sértő jogellenes elvitel esetén: Az EJEE 8. cikkét (a magán- és családi élet tiszteletben tartásához való jog) a Hágai Egyezménnyel és a Gyermekjogi egyezménnyel összefüggésben kell értelmezni.
- Az uniós jog konkrétabban előírja, hogy a gyermeket meg kell hallgatni jogellenes elvitelét vagy visszatartását követő visszatérésével kapcsolatos eljárások során.

A gyermek jogellenes elvitele olyan helyzetet jelent, amelyben egy gyermeket a felügyeleti jogra vonatkozó hatályos megállapodásokat megsértve jogellenesen a nemzeti határokon túlra visznek vagy ott visszatartanak (a gyermekek

178 *Uo.*, 131. pont.

179 Európa Tanács, Miniszteri Bizottság (2010), *Iránymutatás a gyermekbarát igazságszolgáltatásról*.

jogellenes külföldre vitelének polgári jogi vonatkozásairól szóló Hágai Egyezmény[180] (Hágai Egyezmény) 3. cikke. A Hágai Egyezmény értelmében a jogellenesen külföldre vitt vagy visszatartott gyermekeket mihamarabb vissza kell vinni a szokásos tartózkodási helyük szerinti országba (a 11. cikk (1) bekezdése). A szülői felügyeleti joggal kapcsolatos jogvita érdemi eldöntése a szokásos tartózkodási hely szerinti ország bíróságainak feladata. Azon ország bíróságainak, ahonnan a gyermeket külföldre vitték, a visszavitelre irányuló kérelem benyújtásától számított hat héten belül el kell rendelniük a gyermek visszavitelét (11. cikk). A Hágai Egyezmény a gyermek legfőbb (mindenek felett álló) érdekének elvére támaszkodik. Az egyezménnyel összefüggésben abból kell kiindulni, hogy a gyermek jogellenes elvitele önmagában véve káros, és a jogellenes helyzetek jogi megszilárdulásának elkerülése érdekében a lehető leghamarabb vissza kell állítani a korábbi status quót. A szülői felügyeleti joggal és a láthatással kapcsolatos kérdésekben azon bíróságoknak kell dönteniük, amelyek a gyermek szokásos tartózkodási helyén joghatósággal rendelkeznek, nem pedig azon ország bíróságainak, ahová a gyermeket jogellenesen elvitték. A visszaviteli mechanizmus alól van néhány korlátozott kivétel, amelyeket a Hágai Egyezmény 12., 13. és 20. cikke rögzít. A legtöbb jogvitát a 13. cikkben foglalt rendelkezések váltották ki, mind hazai, mind nemzetközi szinten. A cikk értelmében azon ország, ahová a gyermeket elvitték, megtagadhatja a gyermek visszavitelének elrendelését, amennyiben a gyermeket visszavitele súlyos károsodásnak tenné ki vagy bármi más módon elviselhetetlen helyzetet teremtene számára (a 13. cikk b) pontja). A visszavitel abban az esetben is megtagadható, ha a gyermek ellenzi a visszavitelét és elérte már az érettségnek azt a fokát, hogy kifejtse véleményét (a 13. cikk (2) bekezdése).

Az uniós jogban a gyermekek uniós tagállamok közötti jogellenes elvitelére vonatkozó legfontosabb eszköz a Brüsszel IIa. rendelet,[181] amely nagyban a Hágai Egyezmény rendelkezésein alapul. A rendelet az Unión belüli jogellenes elvitelek vonatkozásában kiegészíti a Hágai Egyezményt és elsőbbséget élvez vele szemben ((17) preambulumbekezdés és a 60. cikk e) pontja). Bár a gyermekek jogellenes elvitele tekintetében továbbra is a Hágai Egyezmény a legfontosabb eszköz, a Brüsszel IIa. rendelet bizonyos vonatkozásokban „szűkítette" a joghatósági sza-

180 A polgári és kereskedelmi ügyekben történő határokon átnyúló együttműködés világszervezete (1980), Hágai Nemzetközi Magánjogi Konferencia, A gyermekek jogellenes külföldre vitelének polgári jogi vonatkozásairól szóló. 1980. október 25-i Hágai Egyezmény, 1980. október 25.

181 Az Európai Unió Tanácsa (2003), A Tanács 2003. november 27-i 2201/2003/EK rendelete a házassági ügyekben és a szülői felelősségre vonatkozó eljárásokban a joghatóságról, valamint a határozatok elismeréséről és végrehajtásáról, illetve az 1347/2000/EK rendelet hatályon kívül helyezéséről, HL L 338., 2003.

bályokat a származási/szokásos tartózkodási hely szerinti ország bíróságai javára. A Hágai Egyezményhez hasonlóan azon állam bíróságai, ahol a gyermek közvetlenül a jogellenes elvitelt/visszatartást megelőzően szokásosan tartózkodott, továbbra is joghatósággal rendelkeznek a gyermekek jogellenes elvitelét érintő ügyekben. A rendelet fenntartja azokat a visszavitel alóli kivételeket, amelyeket a gyermekek jogellenes külföldre viteléről szóló egyezmény rögzít.

A Brüsszel IIa. rendelet értelmében azonban – a Hágai Egyezménnyel szemben – a szokásos tartózkodási hely szerinti állam azt követően is joghatósággal rendelkezik a felügyeleti joggal kapcsolatos jogvita érdemi eldöntése tekintetében, hogy a Hágai Egyezmény 13. cikke b) pontjának és a Brüsszel IIa. rendelet 11. cikke (6)–(8) bekezdésének alkalmazásában a visszavitelt elutasító határozat került kiadásra. A joghatóság csak a Brüsszel IIa. rendelet 10. cikkében meghatározott két helyzetben szállhat át azon államra, amelybe a gyermeket elvitték. Az első helyzetben a fogadó állam bíróságai akkor szereznek joghatóságot, ha az adott tagállam a gyermek szokásos tartózkodási helyévé vált, és minden felügyeleti joggal rendelkező személy elfogadja az elvitelt, illetve visszatartást.[182] A második helyzet akkor merül fel, ha a gyermek szokásos tartózkodási helyet szerzett abban a tagállamban, ahová elvitték; legalább egy év telt el azóta, hogy a hátrahagyott szülő tudomást szerzett, illetve tudomást szerezhetett a gyermek tartózkodási helyéről; a gyermek beilleszkedett új környezetében; valamint a Brüsszel IIa. rendelet 10. cikkének b) pontjában felsorolt további négy feltétel legalább egyike teljesül.[183]

Az összes többi uniós jogi eszközhöz hasonlóan a Brüsszel IIa. rendeletet is az Európai Unió Alapjogi Chartájának rendelkezéseivel, különösen 24. cikkével összhangban kell értelmezni. Az Európai Unió Bíróságának alkalma volt arra, hogy gyermekek jogellenes elvitelével összefüggésben egyértelműsítse a 24. cikk értelmezését. Amint azt a 2.4. szakaszban bemutattuk, az EUB az Aguirre Zarraga-ügyben

182 A Brüsszel IIa. rendelet 10. cikkének a) pontja.

183 A Brüsszel IIa. rendelet 10. cikkének b) pontja a következő négy alternatív feltételt határozza meg: i. egy éven belül azt követően, hogy a felügyeleti jog gyakorlója tudomást szerzett vagy tudomást kellett szereznie a gyermek tartózkodási helyéről, nem nyújtottak be a visszavitel iránti kérelmet annak a tagállamnak az illetékes hatóságaihoz, ahová a gyermeket elvitték, illetve amelyben visszatartották; ii. a felügyeleti jogok gyakorlója által benyújtott visszaviteli kérelmet visszavonták és nem nyújtottak be új kérelmet az i. bekezdésben meghatározott határidőn belül; iii. a 11. cikk (7) bekezdése alapján lezárták azt az ügyet, amelyet azon tagállam bírósága előtt folytattak, ahol a gyermek közvetlenül a jogellenes elvitel, illetve visszatartás előtt szokásos tartózkodási hellyel rendelkezett; iv. a gyermek visszaviteléről nem rendelkező, felügyeletről szóló határozatot hoztak annak a tagállamnak a bíróságai, ahol a gyermek közvetlenül a jogellenes elvitel, illetve visszatartás előtt szokásos tartózkodási hellyel rendelkezett.

megállapította, hogy a gyermeknek a Charta 24. cikke szerinti, meghallgatáshoz való joga olyan jogi eljárások és feltételek biztosítását tesz szükségessé, amelyek lehetővé teszik a gyermek számára, hogy véleményét szabadon kifejezhesse, és hogy azt a bíróság figyelembe vegye.[184] Az EUB szerint ugyanakkor kizárólag a gyermek szokásos tartózkodási helye szerinti tagállam bírósága vizsgálhatja saját határozatainak a jogszerűségét az Európai Unió Alapjogi Chartája és a Brüsszel IIa. rendelet fényében. A kölcsönös bizalom elvével összhangban a tagállamok jogrendjeinek egyenértékű és tényleges védelmet kell biztosítaniuk az alapjogok tekintetében. Az érdekelt feleknek tehát az emberi jogokon alapuló kifogásaikat azon bíróságok előtt kell megtenniük, amelyek a rendelet értelmében joghatósággal rendelkeznek a felügyeleti joggal kapcsolatos jogvita érdemi eldöntése tekintetében. Az EUB megállapította, hogy azon tagállam bírósága, ahová a gyermeket jogellenesen elvitték, nem tagadhatta meg a gyermek visszavitelét elrendelő, igazolt határozat végrehajtását, mivel a jogsértés fennállásának értékelése azon tagállam kizárólagos joghatóságába tartozik, ahonnan a gyermeket elvitték.

Példa: A *Povse kontra Alpago* ügy[185] tárgya egy lány Ausztriába történő jogellenes elvitele anyja részéről. Az osztrák bíróságok azzal az indokkal utasították el az apa által lánya Olaszországba való visszavitelére irányulóan benyújtott kérelmet, hogy fennáll a gyermeknek okozott sérelem súlyos kockázata. Mindeközben az apa kérésére az olasz bíróság megállapította, hogy továbbra is joghatósággal rendelkezik a szülői felügyeleti joggal kapcsolatos jogvita érdemi eldöntése tekintetében, és határozatot adott ki, elrendelve a gyermek Olaszországba történő visszavitelét, valamint végrehajtási igazolást bocsátott ki a Brüsszel IIa. rendelet 42. cikke alapján. Az ügyet egy osztrák bíróság az EUB elé utalta, miután az anya fellebbezett az igazolás végrehajtására irányuló kérelemmel és a gyermek Olaszországba való visszavitelét elrendelő határozattal szemben. Az EUB megállapította, hogy a végrehajtási igazolás kibocsátását követően abban az országban, ahová a gyermeket elvitték, (a szóban forgó esetben Ausztriában) nincs lehetőség a visszavitel megtámadására, mivel a határozat automatikusan végrehajtható. Az EUB ezenkívül úgy határozott, hogy ebben az esetben csak az olasz bíróságok illetékesek eldönteni, hogy súlyos

184 EUB, C-491/10. PPU. sz. ügy, *Joseba Andoni Aguirre Zarraga kontra Simone Pelz*, 2010. december 22. A gyermek ezen ügyben való részvételével kapcsolatos vonatkozásokkal kapcsolatban lásd még a 2.4. szakaszban található elemzést.

185 EUB, C-211/10. PPU. sz. ügy, *Doris Povse kontra Mauro Alpago*, 2010. július 1.

kockázattal járna-e a visszavitel a gyermek legfőbb (mindenek felett álló) érdekére nézve. Amennyiben ezek a bíróságok indokoltnak tekintenék ezt a kockázatot, kizárólagos hatáskörrel rendelkeznének saját végrehajtási határozatuk felfüggesztése tekintetében[186].

Az ET jogrendszerében a gyermekek feletti felügyeleti jogot érintő határozatok elismeréséről és végrehajtásáról, valamint a felügyeleti viszonyok helyreállításáról szóló európai egyezmény[187] és a gyermekekkel való kapcsolattartásról szóló egyezmény[188] biztosítékokat tartalmaz a gyermekek jogellenes elvitelének megelőzése és a gyermekek visszavitelének biztosítása érdekében.[189]

Az EJEB gyakran foglalkozik a gyermekek jogellenes elvitelével kapcsolatos ügyekkel, és ezek esetében általában a Hágai Egyezmény rendelkezései alapján értelmezi az EJEE 8. cikkét. Az EJEB azonban ezekben az esetekben elkerülhetetlenül megvizsgálja a gyermek legfőbb (mindenek felett álló) érdekét. A kérdéssel kapcsolatban két kiemelt nagykamarai ítélet világítja meg a bíróság álláspontját.

Példa: A *Neulinger és Shuruk kontra Svájc* ügyet[190] egy anya kezdeményezte, aki a hatályos gyámsági megállapodásokat megsértve Izraelből Svájcba vitte a fiát. Az apa Hágai Egyezmény alapján benyújtott kérelme nyomán a svájci hatóságok elrendelték a gyermek Izraelbe történő visszavitelét. A nemzeti bíróságok és szakértők véleménye szerint a gyermek Izraelbe való visszavitelére csak úgy kerülhetett sor, hogy anyja elkíséri őt. A kérdéses intézkedés a nemzeti hatóságok ilyen ügyekben fennálló mérlegelési jogkörén belül maradt. Az EJEE 8. cikkének való megfelelés értékeléséhez azonban figyelembe kellett venni azt is, hogy milyen fejlemények történtek azóta, hogy a szövetségi bíróság elrendelte a gyermek visszatérését. A szóban forgó ügyben a gyermek svájci állampolgár volt és jól beilleszkedett az országban, ahol mintegy négy éven át élt megszakítás

186 Később ugyanezen tényállások alapján kérelmet nyújtottak be az Emberi Jogok Európai Bíróságához, amelyet elfogadhatatlannak nyilvánítottak. Lásd: EJEB, *Povse kontra Ausztria*, határozat az elfogadhatatlanságról (3890/11), 2013. június 18.

187 Európa Tanács, Európai egyezmény a gyermekek feletti felügyeleti jogot érintő határozatok elismeréséről és végrehajtásáról, valamint a felügyeleti viszonyok helyreállításáról, CETS 105., 1980.

188 Európa Tanács, Egyezmény a gyermekekkel való kapcsolattartásról, CETS 192., 2003.

189 *Uo.*, 10. cikk b) pont, illetve 16. cikk; Európa Tanács, Európai egyezmény a gyermekek feletti felügyeleti jogot érintő határozatok elismeréséről és végrehajtásáról, valamint a felügyeleti viszonyok helyreállításáról, CETS 105., 1980., 8. cikk.

190 EJEB, *Neulinger és Shuruk kontra Svájc* [Nagykamara] (41615/07), 2010. július 6.

nélkül. Bár olyan korban volt, amikor még jelentős mértékben képes az alkalmazkodásra, a környezetéből való újbóli kiszakítás valószínűleg súlyos következményekkel járt volna rá nézve, és ezért ezt össze kellett vetni azzal, hogy milyen előnyökkel járhatna számára az intézkedés. Meg kell említeni azt is, hogy a gyermek jogellenes elvitelét megelőzően korlátozták az apa láthatási jogát. Emellett az apa azóta kétszer újraházasodott és ismét gyermeke született, lánya után azonban nem fizetett tartásdíjat. Az EJEB kétségesnek tartotta, hogy ezek a körülmények kedvezőek lennének a gyermek jólléte és fejlődése szempontjából. Ami az anyát illeti, Izraelbe való visszatérése esetén büntetőjogi szankciók kockázatának lenne kitéve, beleértve a börtönbüntetést. Világos volt, hogy egy ilyen helyzet nem lenne a gyermek legfőbb (mindenek felett álló) érdeke szerint való, tekintettel arra, hogy valószínűsíthetően anyja volt az egyetlen személy, akihez kapcsolat fűzte. Így tehát az, hogy az anya megtagadta az Izraelbe való visszatérést, nem volt teljes mértékben indokolatlan. Emellett az apa sosem élt egyedül a gyermekkel, és azóta nem látta őt, hogy a gyermek kétéves korában elkerült onnan. Az EJEB ezért nem volt meggyőződve arról, hogy az Izraelbe való visszatérés megfelelne a gyermek legfőbb (mindenek felett álló) érdekének. Ami az anyát illeti, az Izraelbe való visszatérés aránytalanul sértené a családi életének tiszteletben tartásához való jogát. Következésképpen mindkét kérelmező vonatkozásában sértené az EJEE 8. cikkét, ha a második kérelmező Izraelbe való visszavitelére irányuló határozatot végrehajtanák.

Példa: Az *X kontra Lettország* ügyben[191] az anya azzal érvelt, hogy lánya súlyos ártalmaknak lenne kitéve, ha visszatérne Ausztráliába, ahonnan jogellenesen elvitték. Annak megállapításakor, hogy – az államok számára ilyen ügyekben biztosított mérlegelési jogkörön belül – megfelelő egyensúlyt teremtett-e a nemzeti bíróság határozata az egymással ütköző érdekek között, a gyermek legfőbb (mindenek felett álló) érdekének kell lennie az elsődleges szempontnak. Az EJEE és a Hágai Egyezmény harmonikus értelmezése érdekében a megkeresett államnak ténylegesen figyelembe kellett vennie azokat a tényezőket, amelyek a Hágai Egyezmény 12., 13. és 20. cikke értelmében kivételt képezhetnek a gyermek azonnali visszavitele alól, és ezen államnak olyan határozatot kellett kiadnia, amely kellő indokolást tartalmazott erre vonatkozóan, és az EJEE 8. cikke tekintetében

191 EJEB, *X kontra Lettország* [Nagykamara] (27853/09), 2013. november 26., 101., 106., 107. és 115–119. pont.

értékelés tárgyát képezte. Ez a cikk eljárási kötelezettséget rótt a hazai hatóságokra, előírva, hogy a gyermek visszavitelére irányuló kérelmek értékelésekor mérlegeljék a visszavitel esetén a gyermeket fenyegető „súlyos kockázatra" vonatkozó, nem megalapozatlan állításokat, és határozatukba foglaljanak bele konkrét indokokat. A „súlyos kockázat" pontos természetét tekintve a Hágai Egyezmény 13. cikkének b) pontjában rögzített kivétel csak az olyan helyzetekre vonatkozik, amelyek túlmennek azon, ami a gyermek számára ésszerűen elviselhető. A szóban forgó ügyben a kérelmező pszichológusi igazolást nyújtott be a lett fellebbviteli bírósághoz, amely megállapítja, hogy az anyjától való azonnali különválasztás esetén a gyermeket a trauma veszélye fenyegeti. Noha a nemzeti bíróságok feladata annak ellenőrzése, hogy „súlyos kockázat" áll fenn a gyermek esetében, és a pszichológusi jelentés közvetlenül kapcsolódott a gyermek legfőbb (mindenek felett álló) érdekéhez, a regionális bíróság megtagadta e jelentés megállapításainak a Hágai Egyezmény 13. cikkének b) pontja alapján történő vizsgálatát. Egyidejűleg a nemzeti bíróságok azzal a kérdéssel sem foglalkoztak, hogy lehetséges lenne-e az anya számára, hogy kövesse lányát, és kapcsolatot tartson vele. Mivel a nemzeti bíróságok elmulasztották a kérelmező állításainak tényleges kivizsgálását, a hazai jog szerinti döntéshozatali folyamat nem felelt meg az EJEE 8. cikkében benne rejlő eljárási követelményeknek, és ezért aránytalan mértékben sérült a kérelmező családi életének tiszteletben tartásához való joga.

6

A családi gondozással szembeni gyermekvédelmi szakellátás (alternatív gondoskodás) és örökbefogadás

EU	Tárgyalt kérdések	ET
Alapjogi Charta, 7. cikk (családi élet) és 24. cikk (a gyermekek jogai) Brüsszel IIa. rendelet (2201/2003/EK)	**A családi gondozással szembeni gyermekvédelmi szakellátás (alternatív gondoskodás)**	EJEE, 8. cikk (a magán- és családi élet tiszteletben tartásához való jog) (Módosított) Európai Szociális Karta, 17. cikk (a gyermekek és fiatalok szociális, jogi és gazdasági védelemhez való joga) EJEB, *Wallová és Walla kontra Cseh Köztársaság* (23848/04), 2006 (nem megfelelő lakhatás miatti gondoskodásba vétel) EJEB, *Saviny kontra Ukrajna* (39948/06), 2008 (szociális-gazdasági okok miatti gondoskodás vétel) EJEB, *B. kontra Románia (2.)* (1285/03), 2013 (a szülők döntéshozatalba való bevonása) EJEB, *B.B. és F.B. kontra Németország* (18734/09 és 9424/11), 2013 (eljárási hibák a döntéshozatali folyamat során) EJEB, *Olsson kontra Svédország (1.)* (10465/83), 1988 (gondozási határozat végrehajtása) EJEB, *T. kontra Cseh Köztársaság* (19315/11), 2014 (a kapcsolattartás fontossága)

EU	Tárgyalt kérdések	ET
Alapjogi Charta, 24. cikk (a gyermekek jogai)	Örökbefogadás	A gyermekek örökbefogadásáról szóló (felülvizsgált) egyezmény EJEB, *Pini és társai kontra Románia* (78028/01 és 78030/01), 2004 (a gyermek érdekeinek elsődlegessége az örökbefogadásnál) EJEB, *Kearns kontra Franciaország* (35991/04), 2008 (az örökbefogadáshoz adott szülői beleegyezés) EJEB, *E.B. kontra Franciaország* [Nagykamara] (43546/02), 2008 (leszbikus nő örökbefogadásra való jogosultsága) EJEB, *Gas és Dubois kontra Franciaország* (25951/07), 2012 (meleg pár örökbefogadásra való jogosultsága) EJEB, *X és társai kontra Ausztria* [Nagykamara] (19010/07), 2013 (társszülős örökbefogadás azonos nemű pár esetén) EJEB, *Harroudj kontra Franciaország* (43631/09), 2012 (kafala-rendszer és örökbefogadás)

Minden gyermeknek joga van a családi életének tiszteletben tartásához, amely jogot az Európai Unió Alapjogi Chartájának 7. cikke és az Emberi Jogok Európai Egyezményének (EJEE) 8. cikke is elismer (lásd az 5. fejezetet). Az EU és az Európa Tanács joganyaga egyaránt tükrözi a családi kapcsolatok gyermek tekintetében fennálló jelentőségét, és ez magában foglalja a gyermek ahhoz való jogát, hogy ne fosszák meg a szüleivel való kapcsolattartástól, kivéve ha az ellentétes lenne a gyermek legfőbb (mindenek felett álló) érdekével.[192] Megtalálni az egyensúlyt annak biztosítása között, hogy a gyermek – a családi élet tiszteletben tartásához való joggal összhangban – családjával maradjon, valamint hogy a gyermeket megvédjék az ártalmaktól, nem könnyű. Ha a gyermeket kiemelik családjából, nevelőszülőkhöz vagy gyermekotthonba kerülhet. Ezzel a különválasztással nem szakad vége a családi életnek, és szükséges, hogy – amennyiben az megfelel a gyermek legfőbb (mindenek felett álló) érdekének – az újbóli családegyesítés elősegítése érdekében is fennmaradjon a kapcsolat. Bizonyos körülmények esetén a gyermeket örökbefogadás révén véglegesen kiemelik családjából. Az örökbefogadás végleges volta miatt szigorú követelményeknek kell megfelelni.

E fejezet célja a gyermekvédelmi szakellátással (alternatív gondoskodással) kapcsolatos európai jog áttekintése. Az uniós jog – elsősorban a Brüsszel IIa. rendelet

192 EU (2012), Az Európai Unió Alapjogi Chartája, HL C 326., 2012, 24. cikk (3) bekezdés.

révén – a gyermekek alternatív gondozásba vételének határokon átnyúló eljárási vonatkozásaival foglalkozik. A rendeletet az Európai Unió Alapjogi Chartájával, különösen annak 24. cikkével összhangban kell értelmezni. Az EJEB is jelentős ítélkezési gyakorlatot alakított ki, amely a gyermekek alternatív gondozásba vételének anyagi és eljárásjogi kérdéseit egyaránt tárgyalja.

A 6.1. szakasz először bemutat néhány, a családi gondozást nélkülöző gyermekek helyzetére nézve irányadó általános elvet, a 6.2. szakasz felvázolja a gyermekek gyermekvédelmi szakellátásba (alternatív gondoskodásba) vételre vonatkozó jogszabályokat, a 6.3. szakasz pedig áttekinti az örökbefogadásra vonatkozó európai normákat.

6.1. Gyermekvédelmi szakellátás (alternatív gondoskodás): általános elvek

Kiemelt pontok

- Az alternatív gondoskodás ideiglenes jellegű védelmi intézkedés.
- A nemzetközi jog megerősíti, hogy az intézeti gondozással szemben előnyben kell részesíteni a családi jellegű gondozást.
- A gyermekek gyermekvédelmi szakellátásba (alternatív gondoskodásba) vétele vonatkozásában is joguk van a tájékoztatáshoz és véleményük kinyilvánításához.

Az uniós jogban, az ET jogában és a nemzetközi jogban összességében hat átfogó elv merül fel a gyermekvédelmi szakellátás (alternatív gondoskodás) tekintetében.

Az első elv az, hogy az alternatív gondoskodásba vétel olyan védelmi intézkedés, amely biztosítja a gyermekek ideiglenes biztonságos elhelyezését, és a lehetőség szerint a gyermekek számára a családjukba való visszahelyezést.[193] Ideális esetben tehát ez egy ideiglenes megoldás. Olykor ez a családegyesítésig alkal-

193 Az ENSZ Közgyűlése, *Iránymutatások a gyermekek alternatív gondozásához*, A/RES/64/142, 2010. február 24., 48–51. pont; A bővített, kommentárral ellátott magyar változat elérhető: SOS Nemzetközi Gyermekfalvak (2010), *Alternatív gondoskodás a gyermekekről – útmutató, Az Egyesült Nemzetek Szervezete által kidolgozott feltételrendszer*, Innsbruck, SOS Children's Villages International; ENSZ, Gyermekjogi Bizottság (2013), *14. számú Átfogó Kommentár a gyermek ahhoz való jogáról, hogy a legfőbb (mindenek felett álló) érdeke elsődleges szempont legyen (3. cikk, (1) bekezdés)*, CRC/C/GC/14. sz. ENSZ-dokumentum, 2013. május 29., 58–70. pont.

mazott védelmi intézkedést jelent, például a kísérő nélküli kiskorú migránsok esetében.[194] Máskor a védelmi intézkedésre a családi életben bekövetkező változásig, például valamely szülő egészségi állapotának javulásáig vagy a szülők számára történő segítségnyújtásig van szükség.

A második elv a nemzetközi jog értelmében az, hogy a gyermek védelmének és fejlődésének biztosítása tekintetében a gyermekvédelmi szakellátás (alternatív gondoskodás) optimális formája a családi jellegű (például nevelőszülői) gondoskodás. Ezt a gyermekek alternatív gondoskodásával kapcsolatos ENSZ-iránymutatások is megerősítik, csakúgy, mint a Fogyatékossággal élő személyek jogairól szóló ENSZ-egyezmény (CRPD), amelynek az EU részes fele.[195] A Fogyatékossággal élő személyek jogairól szóló egyezmény kifejezetten rögzíti, hogy amennyiben a közvetlen család „nem tudja ellátni a fogyatékossággal élő gyermeket, a részes államok minden erőfeszítést megtesznek annak érdekében, hogy alternatív gondozást biztosítsanak a gyermek számára a szélesebb családi körben, ennek hiányában pedig a közösségen belül családi környezetben".[196] A nem családi jellegű (például intézetben történő) gondozást „azon esetekre kell korlátozni, amikor ez a környezet az adott gyermekre és legfőbb (mindenek felett álló) érdekeire nézve kifejezetten megfelelő, szükséges és konstruktív".[197]

A harmadik elv az, hogy a gyermek gyámhoz vagy törvényes képviselőhöz való joga kulcsfontosságú a szélesebb körű jogainak biztosításához.[198] Bár az uniós jog nem írja elő általános jelleggel és kifejezetten a gyám kijelölését a szülői gondoskodás nélkül élő gyermekek számára, legalább hét uniós irányelv előírja, hogy a tagállamok bizonyos esetekben – amelyek némelyike közvetlenül kapcsolódik a szülői gondoskodás nélkül élő gyermekekhez – gyámot jelöljenek

194 Az ENSZ Közgyűlése, Egyezmény a Gyermek Jogairól, 1989. november 20., 22. cikk; Gyermekjogi Bizottság (2005), *6. számú Átfogó Kommentár (2005): A kísérő nélküli kiskorúak kezelése származási országukon kívül*, CRC/GC/2005/6. sz. ENSZ-dokumentum, 2005. szeptember 1., 81–83. pont.

195 Az ENSZ Közgyűlése, *Iránymutatások a gyermekek alternatív gondozásához*, A/RES/64/142, 2010. február 24., 20–22. pont; ENSZ, Gyermekjogi Bizottság (2006), *7. számú Átfogó Kommentár (2005): A gyermekjogok kisgyermekkori érvényesítése*, CRC/C/GC/7/Rev.136 (b). sz. ENSZ-dokumentum, 2006. szeptember 20., 18. pont; ENSZ, Egyezmény a fogyatékossággal élő személyek jogairól (CRPD), 2006. december 13., 23. cikk (5) bekezdés (lásd még a 7. cikket).

196 ENSZ, Egyezmény a fogyatékossággal élő személyek jogairól (CRPD), 2006. december 13., 23. cikk (5) bekezdés.

197 Az ENSZ Közgyűlése, *Iránymutatások a gyermekek alternatív gondozásához*, 2010. február 24., A/RES/64/142, 21. pont.

198 FRA (2014a), 31. o.

ki a gyermekek számára.[199] Ezt a joganyagot alátámasztják továbbá (általában véve a szülői gondoskodás nélkül élő gyermekek vonatkozásában) a gyermekek alternatív gondozásáról szóló ENSZ-iránymutatások, (kifejezetten a kísérő nélküli kiskorúak vonatkozásában) a Gyermekjogi egyezmény, valamint az Európa Tanács emberkereskedelem elleni fellépésről szóló egyezménye[200] is. A gyám feladata leggyakrabban a gyermek legfőbb (mindenek felett álló) érdekének védelme, általános jóllétének biztosítása, valamint korlátozott jogképességének kiegészítése (és olykor a jogi képviselet ellátása).[201]

A negyedik elv szerint, amely implicit módon megjelenik az Európai Unió Alapjogi Chartájának 24. cikkében, jogi kötelezettség az olyan pozitív intézkedések megtétele, amelyek biztosítják, hogy a gyermek elhelyezésével kapcsolatos döntéshozatalt a gyermek legfőbb (mindenek felett álló) érdeke[202] és véleménye[203] vezérelje. Az ENSZ Gyermekjogi Bizottságának 5. és 14. számú Átfogó Kommentárja[204], valamint a gyermekek alternatív gondozásáról szóló ENSZ-iránymutatások rámutatnak arra, hogy biztosítani kell a gyermek tájékoztatáshoz való jogát, beleértve a jogairól és választási lehetőségről való tájékoztatást is, valamint szavatolni kell a gyermek ahhoz való jogát, hogy „megkérdezzék és véleményét kibontakozó képességeinek megfelelően kellően figyelembe vegyék".[205]

Az ötödik elv értelmében a gyermekeket az Európai Unió Alapjogi Chartája, az EJEE és az ENSZ gyermekjogi egyezménye keretében megillető, szélesebb körű jogok az alternatív gondoskodás (nevelőszülői hálózatban vagy intézetben történő gondozás) esetében is alkalmazandók. Ez magában foglalja a polgári és politikai jogokat (például a magánélethez való jogot, a véleménynyilvánítás szabadságát

199 *Uo.*, 14. o.

200 Az ENSZ Közgyűlése, *Iránymutatások a gyermekek alternatív gondozásához*, 2010. február 24., A/RES/64/142, 100–103. pont; ENSZ, Gyermekjogi Bizottság, *6. számú Átfogó Kommentár (2005): A kísérő nélküli kiskorúak kezelése származási országukon kívül*, CRC/GC/2005/6. sz. ENSZ-dokumentum, 2005. szeptember 1., 33–38. pont; Európa Tanács, Egyezmény az emberkereskedelem elleni fellépésről, CETS 197., 2005, 10. cikk (4) bekezdés.

201 FRA (2014a), 15. o.

202 ENSZ, Gyermekjogi Bizottság (2013), *14. számú Átfogó Kommentár (2013) a gyermek ahhoz való jogáról, hogy a legfőbb (mindenek felett álló) érdeke elsődleges szempont legyen (3. cikk, (1) bekezdés)*, CRC/C/GC/14. sz. ENSZ-dokumentum, 2013. május 29.

203 ENSZ, Gyermekjogi Bizottság (2009), *12. számú Átfogó Kommentár (2009): A gyermek meghallgatáshoz való joga*, CRC/C/GC/12. sz. ENSZ-dokumentum, 2009. július 20., 97. pont.

204 ENSZ, Gyermekjogi Bizottság, *14. számú Átfogó Kommentár*, 15. pont g) alpont, 2013. május 29.; *5. számú Átfogó Kommentár*, 24. pont, 2003. november 27.

205 Az ENSZ Közgyűlése (2010), *Iránymutatások a gyermekek alternatív gondozásához*, 2010. február 24., A/RES/64/142, 6. pont.

és a vallásszabadságot, továbbá az erőszak valamennyi formájával szembeni védelmet) és a társadalmi-gazdasági jogokat (beleértve az oktatáshoz, az egészségügyi ellátáshoz és a kulturális életben való részvételhez fűződő jogokat).[206]

Végezetül, a Gyermekjogi egyezmény 4. cikke értelmében az államoknak meg kell hozniuk „minden olyan törvényhozási, közigazgatási vagy egyéb intézkedést", amelyek az egyezmény végrehajtásához szükségesek. Ez ugyanúgy érvényes az alternatív gondoskodás vonatkozásában is. A (Módosított) Európai Szociális Karta 17. cikke (1) bekezdésének c) pontja hasonlóan előírja az államok számára az összes megfelelő és szükséges intézkedés megtételét annak érdekében, hogy védelmet és különleges segítséget nyújtsanak azon gyermekeknek és fiataloknak, akik ideiglenesen vagy véglegesen nélkülözik családjuk támogatását.

Az uniós jogban az EUB ítélete szerint a Brüsszel IIa. rendelet vonatkozik a gyermek gyermekvédelmi szakellátásba (alternatív gondoskodásba) vételével kapcsolatos határozatokra. Amint azt az 5. fejezet említi, a Brüsszel IIa. rendelet megközelítése magában foglalja a gyermekjogi elveket, hangsúlyozva, hogy figyelembe kell venni egyebek mellett minden gyermek egyenlőségét, a gyermek legfőbb (mindenek felett álló) érdekét, valamint a meghallgatáshoz való jogot.[207] Ebben a tekintetben iránymutatással szolgálnak a Brüsszel IIa. rendelet 23. cikkében rögzített, „a szülői felelősségére vonatkozó határozatok elismerését kizáró okok". A 23. cikk kimondja, hogy a határozatok nem ismerhetők el, amennyiben:

> *„a) az ilyen elismerés – a gyermek érdekeit figyelembe véve – nyilvánvalóan ellentétes azon tagállam közrendjével, ahol az elismerést kérik;*
>
> *b) ha – a sürgős eseteket kivéve – a határozatot úgy hozták meg, hogy nem adtak lehetőséget a gyermek meghallgatására, megsértve ezzel annak a tagállamnak az eljárási alapelveit, ahol az elismerést kérik […]."*

A rendelet értelmében a joghatóságot a gyermek szokásos tartózkodási helye alapján kell megállapítani, néhány korlátozott kivétellel, ideértve a gyermek legfőbb (mindenek felett álló) érdekét (a Brüsszel IIa. rendelet 8., 12. és 15. cikke).

206 Az Európai Unió Alapjogi Chartája, 3–4., 7., 10–11., 14. és 24. cikk; EJEE, különösen 8. cikk; valamint az ENSZ gyermekjogi egyezménye, 13–14., 16., 19., 28., 29., 24., 31. és 37. cikk; Az ENSZ Közgyűlése (2010), *Iránymutatások a gyermekek alternatív gondozásához*, 2010. február 24., A/RES/64/142, 2. szakasz.

207 Brüsszel IIa., preambulum. Lásd még az 5. fejezetet.

Az ET joganyagában az EJEB megerősíti, hogy a családot tartja szükséges és természetes közegnek a gyermekek növekedéséhez és jóllétéhez. Amennyiben azonban a család nem tudja biztosítani a gyermek számára a szükséges gondoskodást és védelmet, szükségessé válhat az alternatív gondozásba vétel. Az ilyen kiemelés ütközik a családi élet tiszteletben tartásához való joggal. Az EJEB kifejtette, hogy a gyermek szakellátásba (alternatív gondoskodásba) vételét a legtöbb esetben ideiglenes intézkedésként kell előirányozni, és a gyermeket végül vissza kell helyezni családjába, megfelelve az EJEE 8. cikkében rögzített, a magán- és családi élet tiszteletben tartásához való jognak.[208]

Bár az EJEE nem ró kifejezett kötelességet az államokra arra vonatkozóan, hogy biztosítsák a gyermekek számára a gondoskodást és a védelmet, az Európai Szociális Karta 17. cikke értelmében az államok „megteszik az összes megfelelő és szükséges intézkedést, melynek célja az állami védelem és speciális segítség nyújtása azon gyermekeknek és fiataloknak, akik ideiglenesen vagy véglegesen nélkülözik családjuk támogatását”.[209]

6.2. Gyermekek gyermekvédelmi szakellátásba (alternatív gondoskodásba) vétele

Kiemelt pontok

- Az ET joganyagában a gyermek gyermekvédelmi szakellátásba (alternatív gondoskodásba) vételének egy demokratikus társadalomban törvényen kell alapulnia, törvényes célt kell szolgálnia és szükségesnek kell lennie. Az illetékes hatóságnak elégséges és releváns indokokat kell felhoznia.
- Az ET joganyagában a döntéshozatali folyamat során eleget kell tenni bizonyos garanciáknak.

208 EJEB, *K.A. kontra Finnország* (27751/95), 2003. január 14. Az Európa Tanács Miniszteri Bizottsága a bentlakásos intézményekben élő gyermekek jogairól szóló, 2005. március 16-án elfogadott ajánlásában támogatta ezt a megközelítést.

209 Európa Tanács, (Módosított) Európai Szociális Karta, CETS 163., 1996, 17. cikk (1) bekezdés c) pont.

Az ET jogi rendszerében[210] a gyermek szakellátásba (alternatív gondoskodásba) vétele csak akkor egyeztethető össze az EJEE 8. cikkével egy demokratikus társadalomban, ha az összhangban van a jogszabályokkal, törvényes célt szolgál (ideértve például a gyermek legfőbb (mindenek felett álló) érdekének védelmét) és szükségesnek tekinthető. Ez utóbbi szempont megkívánja, hogy a bíróságok olyan indokokat jelöljenek meg, amelyek relevánsak és elégségesek az elérni kívánt cél megvalósítása érdekében alkalmazott eszközök alátámasztásához.

Példa: Az *Olsson kontra Svédország (1.)* ügyben[211] a kérelmezők sérelmezték a három gyermekük szakellátásba (alternatív gondoskodásba) vételéről szóló határozatot. Az EJEB, miután úgy találta, hogy a gondozásba vételről szóló határozat az állam mérlegelési jogkörébe tartozott, arra összpontosított, hogy miként hajtották végre a határozatot. A bíróság szerint a határozatot ideiglenes intézkedésnek kellett volna tekinteni, amelynek véget kell vetni, amint azt a körülmények lehetővé teszik, tekintve, hogy nem mérlegeltek örökbeadást. A meghozott intézkedések tehát nem álltak összhangban a vér szerinti család újraegyesítésének végső céljával. Erre tekintettel az EJEB megjegyezte, hogy a nemzeti hatóságok a gyermekeket különböző nevelőcsaládoknál helyezték el, jelentős távolságra egymástól és szüleiktől. Bár a hatóságok a határozat végrehajtásakor jóhiszeműen jártak el, az EJEB elfogadhatatlannak minősítette, hogy az igazgatási nehézségek – köztük a megfelelő nevelőcsaládok vagy helyek hiánya – határozzák meg, hogy hova kerülnek a gyermekek. Egy olyan alapvető területen, mint a családi élet tiszteletben tartásához való jog, az ilyen megfontolások legfeljebb másodlagos szerepet kaphatnak. Az EJEB ezért – megállapítva az EJEE 8. cikkének megsértését – rámutatott arra, hogy a hatóságok által a határozat végrehajtása során hozott intézkedések nem voltak elégséges okokkal alátámasztva ahhoz, hogy arányban álljanak a 8. cikk értelmében elérni kívánt törvényes céllal.

Egy frissebb határozatában az EJEB a gyermekek szakellátásba (alternatív gondozásba) vételére irányuló határozatok érdemi részét vizsgálta az EJEE 8. cikke alapján.

210 A gyermekek alternatív gondozásba vétele sok éven át politikai vita tárgyát is képezte az Európa Tanácsban. Lásd például a Miniszteri Bizottság gyermekek elhelyezéséről szóló, 1977. november 3-án elfogadott (77) 33. sz. határozatát.

211 EJEB, *Olsson kontra Svédország (1.)* (10465/83), 1988. március 24.

Példa: A *Wallová és Walla kontra Cseh Köztársaság* ügyben[212] a kérelmezők azt sérelmezték, hogy rossz lakáskörülményeik miatt öt gyermeküket két különböző gyermekotthonban helyezték el. A gyermekek feletti felügyeleti jogot 2002-ben a szülők bizonytalan gazdasági helyzete miatt a gyermekotthonokra ruházták, majd később, gazdasági helyzetük és lakáskörülményeik javulását követően a határozatot megszüntették. Az EJEB megállapította, hogy a gyermekek gondozásba vételére irányuló határozat alapjául szolgáló indok a megfelelő lakhatás hiánya volt, és ily módon kevésbé drasztikus intézkedést is lehetett volna alkalmazni a helyzet kezelésére. A cseh jog alapján lehetséges lett volna a család higiéniás és életkörülményeinek nyomon követése és tanácsadás biztosítása arra vonatkozóan, hogy miként lehetne javítani a helyzeten, ezzel a lehetőséggel azonban nem éltek. A gyermekek gondozásba adásának indokai relevánsak voltak ugyan, de nem voltak elégségesek, és a hatóságok nem tettek elegendő erőfeszítést annak érdekében, hogy alternatív intézkedések révén segítsék a kérelmezőket nehézségeik leküzdésében. Az EJEB emellett az EJEE 8. cikkének megsértésének megállapításakor figyelembe vette az ENSZ Gyermekjogi Bizottságának észrevételeit is, amelyek szerint a gyermek legfőbb (mindenek felett álló) érdekének elsődleges szempontként történő mérlegelésére vonatkozó elv még nincsen megfelelően meghatározva és átültetve valamennyi, gyermekeket érintő cseh jogszabályban, bírósági határozatban és szakpolitikai döntésben.

Példa: A *Saviny kontra Ukrajna* ügyben[213] a kérelmezők gyermekeit azért vették szakellátásba, mert a szülőknek nem volt megfelelő pénzügyi hátterük, anyagi eszközeik és a hazai bíróság arra a megállapításra jutott, hogy személyes tulajdonságaik veszélyeztették a gyermekek életét, egészségét és erkölcsi nevelését. Az ügy vizsgálatakor az EJEB megkérdőjelezte azon bizonyítékok megfelelőségét, amelyekre a hazai hatóságok megállapításaikat alapozták, és úgy ítélte meg, hogy nem áll rendelkezésre elegendő információ a biztosított szociális támogatás mértékét illetően. Ez lényeges lett volna annak értékeléséhez, hogy a hatóságok teljesítették-e a család egyben tartásával kapcsolatos kötelességüket, és kellően mérlegelték-e a kevésbé drasztikus alternatívák hatékonyságát, mielőtt a gyermekek szüleiktől való elválasztásához folyamodtak. Ezenkívül a bírák az eljárás

212 EJEB, *Wallová és Walla kontra Cseh Köztársaság* (23848/04), 2006. október 26. (elérhető francia nyelven).

213 EJEB, *Saviny kontra Ukrajna* (39948/06), 2008. december 18.

egyik szakaszában sem hallgatták meg a gyermekeket. Összességében bár a nemzeti hatóságok által a kérelmezők gyermekeinek kiemelésére vonatkozóan megjelölt indokok relevánsak voltak, nem voltak elegendőek ahhoz, hogy indokolják a kérelmezők családi életébe történő ilyen súlyos beavatkozást. A bíróság ezért megállapította az EJEE 8. cikkének megsértését.

Az EJEB az EJEE 8. cikke alapján megkívánja, hogy a családi élet tiszteletben tartásával kapcsolatos döntéshozatal feleljen meg bizonyos eljárási biztosítékoknak. A családi életbe való beavatkozást jelentő intézkedésekhez vezető döntéshozatali folyamatnak (közigazgatási és bírósági eljárásnak) tisztességesnek kell lennie, és kellően tiszteletben kell tartania a 8. cikk által védett érdekeket. A 8. cikk alapján azt kell mérlegelni, hogy „elegendő mértékben bevonták-e a szülőket a döntéshozatali folyamatba [...] ahhoz, hogy biztosított legyen érdekeik előírt védelme".[214] Ez magában foglalja, hogy tájékoztatni kell őket a fejleményekről, lehetővé kell tenni számukra a velük kapcsolatos döntéshozatalban való részvételt[215], valamint bizonyos esetekben meg kell hallgatni az érintett gyermekeket[216].

Példa: A *B. kontra Románia (2.)* ügyben[217] a kérelmezőnél paranoid skizofréniát diagnosztizáltak, és a rendőrség több alkalommal pszichiátriai intézetbe vitte őt kezelés céljából. Gyermekei már nem éltek vele, anyjuk betegsége miatt gondozásba vették őket. Az EJEB azt vizsgálta, hogy a gyermekek gondozásba vételével kapcsolatban meghozandó döntések súlyos voltára tekintettel összességében kellő mértékben biztosított volt-e a döntéshozatali folyamat során a szülők számára érdekeik előírt védelme. Ezzel kapcsolatban a bíróság megállapította, hogy a súlyos mentális zavarral küzdő kérelmező mellé nem rendeltek ki jogi képviselőt vagy eseti gondnokot, hogy képviselje őt az eljárások során, így nem tudott részt venni a kiskorú gyermekeit érintő döntéshozatali folyamatban. Emellett a kérelmező helyzetét és gyermekeinek helyzetét a bíróság 12 év alatt, mindkét gyermek nagykorúságáig csak két alkalommal vizsgálta, és nem volt arra utaló bizonyíték, hogy rendszeres kapcsolat lett volna a szociális munkások és a kérelmező között, ami egyébként megfelelő eszközt kínált volna arra, hogy képviseljék véleményét a hatóságoknál. Mindezek fényében a bíróság

214 EJEB, *W. kontra Egyesült Királyság* (9749/82), 1987. július 8., 64. pont.

215 EJEB, *McMichael kontra Egyesült Királyság* (16424/90), 1995. február 24.

216 EJEB, *B. kontra Románia (2.)* (1285/03), 2013. február 19.; EJEB, *B.B. és F.B. kontra Németország* (8734/09 és 9424/11), 2013. március 14.

217 EJEB, *B. kontra Románia (2.)* (1285/03), 2013. február 19.

megállapította, hogy a gyermekek gondozásba vételével kapcsolatos döntéshozatali folyamat során nem védték megfelelően a kérelmező érdekeit, és ezáltal megsértették az EJEE 8. cikke szerinti jogait.

Példa: A *B.B. és F.B. kontra Németország* ügy[218] tárgya, hogy miután a kérelmező 12 éves lánya azt állította, hogy apja ismétlődően verte őt és 8 éves öccsét, a két gyermek vonatkozásában a szülői felügyeleti jogokat a fiatalkorúak bíróságára ruházták át, és a gyermekeket gyermekotthonban helyezték el. A kerületi bíróság a szülői felügyeletet a kérelmezőkről az ifjúságvédelmi hivatalra ruházta át, a gyermekektől szerzett közvetlen bizonyítékra alapozva határozatát. Amikor a lány ezt követően, körülbelül egy évvel később először találkozott szüleivel, bevallotta, hogy hazudott, amikor azt állította, hogy verték, és végül a gyermekeket visszaadták szüleiknek. A kérelmezők arra vonatkozó panaszát illetően, hogy a hatóságok nem vizsgálták meg megfelelően a vonatkozó tényeket, az EJEB rámutatott, hogy a szakemberek téves értékelése nem szükségszerűen jelenti azt, hogy a hozott intézkedések nem voltak összeegyeztethetőek az EJEE 8. cikkével. Az elhelyezésről szóló határozatot csak azon helyzet alapján lehetett megítélni, amelyet akkoriban a hazai hatóságok elé tártak. Az EJEB véleménye szerint lényeges elem az, hogy a kerületi bíróság kizárólag a gyermek állításaira hagyatkozott, miközben a kérelmezők orvosi igazolásokat nyújtottak be arról, hogy nem látszik jele a bántalmazásnak, és mindemellett a fellebbviteli bíróság nem vizsgálta meg újból a gyermekeket. Mivel a gyermekek az érdemi meghallgatás idején biztonságos helyen voltak, nem volt szükség sietségre, és a bíróságok hivatalból kivizsgálhatták volna a tényállást, amit azonban nem tettek meg. Összegezve, a német bíróságok nem szolgáltak elégséges indokkal a kérelmezők szülői felügyeletének megvonására vonatkozóan, sértve az EJEE 8. cikkét.

A gyermekeknek szakellátásba (alternatív gondoskodásba) kerülésüket követően is joguk van kapcsolatot tartani szüleikkel. Ezt a jogot az EJEE is elismeri,[219] mivel az EJEB szerint a szülők és a gyermekek közötti kölcsönös kapcsolattartás a 8. cikk szerinti családi élet alapvető eleme. Mivel a gyermekvédelmi szakellátásba (alternatív gondoskodásba) vételnek alapesetben ideiglenes intézkedésnek kell lennie, a családi kapcsolatok fenntartása elengedhetetlen annak

218 EJEB, *B.B. és F.B. kontra Németország* (18734/09 és 9424/11), 2013. március 14.

219 EJEB, *Olsson kontra Svédország (1.)* (10465/83), 1988. március 24.

biztosításához, hogy a gyermek sikeresen visszatérjen családjához.[220] Az EJEE értelmében ezen elvekből pozitív kötelességek következnek, amint azt a következő esetek szemléltetik.

Példa: A *T. kontra Cseh Köztársaság* ügyben[221] az EJEB azt vizsgálta, hogy megsértették-e egy apa és lánya (a kérelmezők) jogait a gyermek gondozásba vételével, valamint azzal, hogy a hatóságok nem támogatták a kettőjük közötti kapcsolattartást. A gyermeket anyja halálát követően, és miután az apa lánya feletti felügyeleti jogra irányuló kérelmeit a személyiségével kapcsolatos aggályok miatt elutasították, speciális intézményben helyezték el. Később elutasították arra irányuló kéréseit is, hogy szabadságát lányával tölthesse, és egy terápiás központ megállapította, hogy látogatásai nem válnak a gyermek javára, mivel félelmet vált ki belőle; ekkor valamennyi kapcsolat megszűnt közöttük. A későbbiekben a bíróságok úgy határoztak, hogy a két kérelmező a gyermek kérésének megfelelően csak írásban tarthat kapcsolatot egymással. Az EJEB egyebek mellett kiemelte, hogy a gyermeknek érdeke fenntartani a kapcsolatot családjával, kivéve azokat a különösen szélsőséges eseteket, amikor ez nem szolgálja a gyermek legfőbb (mindenek felett álló) érdekét. A gyermek gondozásba vételéről szóló határozatot vizsgálva az EJEB egyetértően állapította meg, hogy a hazai hatóságok gondosan mérlegelték döntésüket, amelyet a pszichológiai és pszichiátriai szakvélemények meghallgatását követően és a gyermek kívánságait figyelembe véve hoztak meg. Ezért a gyermek gondozásba vétele vonatkozásában az EJEE 8. cikke nem sérült. A bíróság ugyanakkor megállapította, hogy a kérelmezők közötti kapcsolattartás korlátozásából fakadóan megsértették a 8. cikket, különös tekintettel arra, hogy nem ellenőrizték a gyermekotthon kapcsolattartás megtagadására vonatkozó határozatait, amely határozatok végső soron csökkentették a család újraegyesítésének esélyét.

Példa: A *K.A. kontra Finnország* ügyben[222] a kérelmező gyermekeit amiatt vették szakellátásba (alternatív gondoskodásba), mert állítások szerint szexuálisan zaklatták őket. Mialatt a gyermekek állami gondoskodásban éltek, kevés kapcsolat volt közöttük és szüleik között, és csekély erőfeszítéseket tettek a család újbóli egyesítésére irányulóan. Az ügyet vizsgálva

220 EJEB, *Eriksson kontra Svédország* (11373/85), 1989. június 22.

221 EJEB, *T. kontra Cseh Köztársaság* (19315/11), 2014. július 17. (elérhető francia nyelven).

222 EJEB, *K.A. kontra Finnország* (27751/95), 2003. január 14.

az EJEB megállapította, hogy az államnak pozitív kötelessége elősegíteni a család újraegyesítését, mihelyt az ésszerűen megvalósítható, szem előtt tartva a gyermek legfőbb (mindenek felett álló) érdekének védelmére vonatkozó kötelezettséget. Az EJEB szerint azért korlátozták szigorúan a kérelmező azon jogát, hogy látogassa gyermekeit, mert a gyermekvédelmi hatóság a gyermek és a nevelőcsalád közötti kötelékeket kívánta erősíteni az eredeti család újraegyesítése helyett. Ez annak ellenére történt, hogy az apa körülményei észlelhetően javultak. Így tehát megállapítható az EJEE 8. cikkének megsértése.

6.3. Örökbefogadás

Kiemelt pontok

- Az örökbefogadás biztosítja az alternatív gondozást azon gyermekek számára, akik nem maradhattak vér szerinti családjuknál.
- Az örökbefogadásnál kiemelten fontos a gyermek legfőbb (mindenek felett álló) érdekének mérlegelése.
- Az EU és az ET joganyagában nem létezik örökbefogadáshoz való jog, az örökbefogadási eljárásnak azonban eleget kell tennie néhány kritériumnak, biztosítandó, hogy az a gyermek legfőbb (mindenek felett álló) érdekét szolgálja.[223]

A nemzetközi jogban örökbefogadás esetén kiemelten fontos a gyermek legfőbb (mindenek felett álló) érdekének mérlegelése. A legfőbb (mindenek felett álló) érdek elve mellett a Gyermekjogi egyezmény más általános elvei is iránymutatást adnak és alapul szolgálnak annak örökbefogadással összefüggésben történő végrehajtásához: ezek a hátrányos megkülönböztetés tilalma, az élethez, az életben maradáshoz és a fejlődéshez való jog, valamint a gyermek véleményének tiszteletben tartása.[224] Különösen fontos az ENSZ Gyermekjogi Bizottságának

223 A gyermek örökbefogadás vonatkozásában fennálló, származásának ismeretéhez fűződő érdekével kapcsolatban lásd a 4. fejezetet.

224 Gyermekjogi egyezmény 2., 3., 6. és 12. cikk. Lásd még: ENSZ, Gyermekjogi Bizottság (2010), Szerződésspecifikus iránymutatások a részes államok által a Gyermek Jogairól szóló Egyezmény 44. cikke (1) bekezdésének b) pontja szerint benyújtandó időszakos jelentések formájára és tartalmára vonatkozóan, CRC/C/58/Rev.2. sz. ENSZ-dokumentum, 2010. november 23., 23–27. pont.

14. sz. Átfogó Kommentárja „a gyermek ahhoz való jogáról, hogy a legfőbb (mindenek felett álló) érdeke elsődleges szempont legyen”[225].

Hasonlóképpen a gyermekeknek a nemzetközi örökbefogadások terén való védelméről és az ilyen ügyekben történő együttműködésről szóló Hágai Egyezmény egyik célja is „kidolgozni olyan garanciákat, amelyek biztosítják, hogy a nemzetközi örökbefogadások a gyermekek legfőbb (mindenek felett álló) érdekeinek és a nemzetközi jog által elismert alapvető jogaik tiszteletben tartásával történnek”.[226]

Az uniós jogban az Európai Unió Alapjogi Chartájának 24. cikke szerinti kapcsolódó jogi kötelezettségek alkalmazandók az örökbefogadásra, amennyiben azt az Unió vizsgálja.

Az ET joganyagában az EJEE 8. cikkében rögzített családi élet tiszteletben tartásához való jog alkalmazandó és követendő az örökbefogadás eseteiben. E tárgyban az Európa Tanácsnak létezik két külön egyezménye is: a gyermekek örökbefogadásáról szóló egyezmény[227] és a gyermekek örökbefogadásáról szóló (felülvizsgált) egyezmény.[228] Ezen egyezmények a gyermekek jogain alapuló megközelítést írnak elő az örökbefogadás vonatkozásában. A gyermekek örökbefogadásáról szóló (felülvizsgált) egyezmény például kimondja, hogy „az illetékes hatóság csak akkor engedélyezheti az örökbefogadást, ha meggyőződött arról, hogy az örökbefogadás a gyermek legfőbb (mindenek felett álló) érdekét szolgálja”.[229] Hasonlóképpen az EJEB is hangsúlyozza, hogy a gyermek legfőbb (mindenek felett álló) érdeke bizonyos körülmények között, például örökbefogadás esetén felülírhatja a szülők érdekeit.[230] A gyermekek örökbefogadásáról szóló (felülvizsgált) egyezmény azt is előírja, hogy az illetékes hatóság nem engedélyezheti az örökbefogadást anélkül, hogy ahhoz „a jogszabályok megítélése

225 ENSZ, Gyermekjogi Bizottság (2013), *14. számú Átfogó Kommentár a gyermek ahhoz való jogáról, hogy a legfőbb (mindenek felett álló) érdeke elsődleges szempont legyen*, CRC/C/GC/14, 3. cikk (1) bekezdés.

226 Hágai Nemzetközi Magánjogi Konferencia, Egyezmény a gyermekeknek a nemzetközi örökbefogadások terén való védelméről és az ilyen ügyekben történő együttműködésről, 1993. május 29., 1. cikk, a) pont.

227 Európa Tanács, (Felülvizsgált) Európai egyezmény a gyermekek örökbefogadásáról, CETS 202., 2008.

228 *Uo.* Az egyezményt 2008-ban nyitották meg aláírásra, majd 2011-ben lépett hatályba.

229 *Uo.*, 4. cikk (1) bekezdés.

230 EJEB, *Pini és társai kontra Románia* (78028/01 és 78030/01), 2004. június 22.

szerint kellő értelemmel rendelkező gyermek beleegyezését adná".[231] Ezenkívül azt a gyermeket, aki a megítélés szerint nem rendelkezik ehhez kellő érettséggel, „lehetőség szerint meg kell kérdezni, és véleményét, illetve kívánságait érettségi fokának szem előtt tartásával figyelembe kell venni".[232]

Példa: A *Pini és társai kontra Románia* ügyben[233] két olasz pár tett panaszt amiatt, hogy a román hatóságok nem hajtották végre egy romániai bíróság határozatát két román gyermek általuk történő örökbefogadását illetően. A román magánintézmény, ahol a gyermekek éltek, a bírósági végzést megsértve megtagadta a gyermekek kérelmezőknek történő kiadását. Az EJEB úgy ítélte meg, hogy a kérelmezők és örökbe fogadott gyermekeik közötti kapcsolat az EJEE 8. cikke szerinti családi élet körébe tartozott, még akkor is, ha soha nem éltek együtt, és nem jöttek létre közöttük érzelmi kötelékek. Az ügyet vizsgálva az EJEB a 8. cikket a Gyermekjogi egyezmény és a Hágai Egyezmény fényében értelmezte, és megállapította, hogy a hatóságok azon pozitív kötelezettségét, hogy lehetővé tegyék a kérelmezők számára családi kötelékek kialakítását az örökbe fogadott gyermekeikkel, behatárolja a gyermek legfőbb (mindenek felett álló) érdeke.[234] Ennek vonatkozásában az EJEB úgy ítélte meg, hogy a gyermek érdekei – jellegüktől és súlyuktól függően – felülírhatják a szülő érdekeit. Emellett a bíróság – megállapítva, hogy a 8. cikk nem sérült – hangsúlyozta, hogy egy örökbefogadáson alapuló kapcsolatban fontos, hogy a gyermek érdekei elsőbbséget élvezzenek a szülők érdekeivel szemben, mivel az örökbefogadás célja egy gyermek családhoz juttatása, nem pedig egy család gyermekhez juttatása.[235]

Példa: A *Kearns kontra Franciaország* ügyben[236] az EJEB az Emberi Jogok Európai Egyezményével összeegyeztethetőnek találta, hogy egy ír nő, aki Franciaországban örökbefogadásra kínálta fel lányát, a két hónapos időszak lejártát követően nem vonhatta vissza az örökbefogadáshoz adott hivatalos hozzájárulását. Az EJEB elsőként azt hangsúlyozta, hogy az, hogy

231 Európa Tanács, (Felülvizsgált) Európai egyezmény a gyermekek örökbefogadásáról, CETS 202., 2008, 5. cikk (1) bekezdés b) pont.

232 *Uo.*, 6. cikk.

233 EJEB, *Pini és társai kontra Románia* (78028/01 és 78030/01), 2004. június 22.

234 *Uo.*, 155. pont.

235 *Uo.*, 156. pont.

236 EJEB, *Kearns kontra Franciaország* (35991/04), 2008. január 10.

a nemzeti hatóságok elutasították a gyermek visszavitelére irányuló kérelmet, a mások – ebben az esetben a gyermek – jogainak és szabadságainak védelmére irányuló törvényes célt szolgált.[237] A hozzájárulás visszavonásának határidőhöz kötése tekintetében a francia jog megfelelő egyensúlyra törekedett, és igyekezett biztosítani a vér szerinti anya, a gyermek és az örökbe fogadó család egymással ütköző érdekei közötti arányosságot. E folyamatban kiemelt szempontnak kellett lennie a gyermek legfőbb (mindenek felett álló) érdekének.[238] Az EJEB elé tárt bizonyítékok alapján a gyermek legfőbb (mindenek felett álló) érdekét szolgálta az, hogy a lehető leghamarabb stabil kapcsolatai legyenek egy új családon belül, és minden szükséges lépést megtettek annak érdekében, hogy a kérelmező tisztában legyen lépésének pontos következményeivel. E megfontolások alapján az EJEB megállapította, hogy Franciaország nem mulasztotta el a kérelmezővel szembeni, az EJEE 8. cikke szerinti pozitív kötelezettségeinek teljesítését.

Az EJEB azt is leszögezi, hogy az örökbefogadással kapcsolatos döntéshozatalnak összhangban kell állnia a hátrányos megkülönböztetés tilalmával, melyet az EJEE 14. cikke rögzít. Így az EJEB megvizsgálta, hogy összeegyeztethető-e a 8. cikkel együtt értelmezett 14. cikkel az, ha a kérelmezőket szexuális irányultságuk vagy életkoruk alapján kizárják az örökbefogadásra jogosultak köréből. Ennek vonatkozásában a bíróság rámutat arra, hogy kiemelt jelentőséggel bír a gyermek legfőbb (mindenek felett álló) érdekének védelmében történő arányos fellépés kötelessége.

Példa: A *Schwizgebel kontra Svájc* ügyben[239] a kérelmező, egy 47 éves egyedülálló nő a közötte és az általa örökbe fogadni kívánt gyermek között fennálló korkülönbség miatt nem fogadhatott örökbe egy második gyermeket. A kérelmező azt állította, hogy életkor alapján történő hátrányos megkülönböztetés áldozata. Az EJEB megítélése szerint a kérelmező esetében az, hogy nem engedélyezték egy gyermek örökbefogadás céljából történő fogadását, a gyermek jólétének és jogainak védelmére irányuló törvényes célt szolgált.[240] Mivel arra vonatkozóan nincs európai konszenzus, hogy joga van-e valakinek egyedülálló szülőként örökbe fogadni,

237 *Uo.*, 73. pont.

238 *Uo.*, 79. pont.

239 EJEB, *Schwizgebel kontra Svájc* (25762/07), 2010. június 10.

240 *Uo.*, 86. pont.

illetve hogy mi az örökbefogadás alsó és felső korhatára és mekkora korkülönbség lehet az örökbe fogadó és a gyermek között, és ebből adódóan az államnak széles mérlegelési jogköre van ezen a téren, továbbá mivel védeni kell a gyermek legfőbb (mindenek felett álló) érdekét, a második gyermek elhelyezésére vonatkozó engedély megtagadása nem volt ellentétes az arányosság elvével.[241] Az EJEB ezért úgy ítélte meg, hogy a kormányzat által adott indokolás objektívnek és ésszerűnek tekinthető, a sérelmezett eltérő bánásmód pedig nem volt az EJEE 14. cikke értelmében hátrányosan megkülönböztető jellegű.

Példa: Az *E.B. kontra Franciaország* ügy[242] tárgya, hogy a kérelmező – egy egyedülállóként örökbe fogadni kívánó, partnerével élő leszbikus nő – számára a nemzeti hatóságok nem adták meg jóváhagyásukat az örökbefogadáshoz.[243] Az EJEB emlékeztetett arra, hogy az EJEE 8. cikke önmagában véve nem jelent családalapításhoz vagy örökbefogadáshoz való jogot. A hátrányos megkülönböztetésre vonatkozó panaszok azonban egy adott jog tágabb hatálya alá tartozhatnak, még akkor is, ha az adott kérdés nem az EJEE által biztosított egyedi jogosultságok valamelyikéhez kapcsolódik.[244] Mivel a francia jog lehetővé teszi az egyedülállók számára az örökbefogadást, ezt a jogot nem lehet megkülönböztető jellegű okok miatt megtagadni valamely egyéntől. Amint azt a hazai bíróságok megállapították, a kérelmező kétségtelen személyes kvalitásokkal rendelkezett és alkalmas volt a gyermeknevelésre, ami biztosíthatóan a gyermek legfőbb (mindenek felett álló) érdekét szolgálta, amely kulcsfogalom a vonatkozó nemzetközi eszközökben.[245] Az EJEB álláspontja szerint a kérelmező szexuális irányultsága döntő szerepet játszott abban, hogy a hatóságok nem engedélyezték számára az örökbefogadást, ami a nemzeti jog alapján örökbe fogadni jogosult többi egyedülálló személyhez képest hátrányosan megkülönböztető jellegű bánásmódnak minősül.[246]

241 *Uo.*, 97. pont.

242 EJEB, *E.B. kontra Franciaország* [Nagykamara] (43546/02), 2008. január 22.

243 *Uo.*, 49. pont.

244 *Uo.*, 41–48. pont.

245 *Uo.*, 95. pont.

246 *Uo.*, 96. pont.

Példa: A *Gas és Dubois kontra Franciaország* ügy[247] azt tárgyalja, hogy az azonos nemű párok a heteroszexuális párokkal egyformán jogosultak-e társszülős örökbefogadásra. A kérelmezők azonos nemű párként élettársi kapcsolatot létesítettek. Együtt felneveltek egy lányt, aki mesterséges megtermékenyítéssel fogant, és akit egyikőjük hordott ki 2000-ben. A másik partner egyszerű örökbefogadásra irányuló kérelmét azzal az indokkal utasították el, hogy az örökbefogadás megfosztaná szülői jogaitól a vér szerinti anyát, ami mind a kérelmező szándékaival, mind a gyermek legfőbb (mindenek felett álló) érdekével ellentétes lenne. A francia jogban az egyetlen olyan helyzet, amelyben az egyszerű örökbefogadás nem eredményezi a vér szerinti szülők jogainak az örökbe fogadó szülőre való átszállását, az, amikor az adott személy a házastársa gyermekét fogadja örökbe. A kérelmezők azt állították, hogy hátrányos megkülönböztetést alkalmaztak velük szemben a házasságban élő és a nem házasságban élő heteroszexuális párokhoz képest. Az EJEB annak vizsgálatakor, hogy történt-e hátrányos megkülönböztetés egy házasságban élő házaspárhoz képest, megállapította, hogy a házasság különleges jogállást keletkeztet, és társadalmi, személyes és jogi következményekkel jár; ezért nem állítható, hogy a kérelmezők lényegében a házasságban élő párokhoz hasonló helyzetben lennének. Az ellenkező nemű, nem házasságban élő párokkal való összehasonlítást illetően a bíróság rámutatott, hogy egy élettársi kapcsolatban élő hasonló, heteroszexuális pár egyszerű örökbefogadásra irányuló kérelmét a francia jog rendelkezései alapján szintén elutasították volna. Következésképpen az EJEB megállapította, hogy nem alkalmaztak eltérő bánásmódot a szexuális irányultság alapján, és így nem sérültek a kérelmezők egyezmény szerinti jogai.

Példa: Az *X és társai kontra Ausztria* ügy[248] tárgya egy azonos nemű pár azzal kapcsolatos panasza, hogy a különböző nemű párokhoz képest hátrányos megkülönböztetést alkalmaztak velük szemben a társszülős örökbefogadás vonatkozásában. Az első és a harmadik kérelmező tartós kapcsolatban élt, és az első kérelmező örökbe kívánta fogadni a második kérelmezőt, aki a harmadik kérelmező fia. Amint a *Gas és Dubois* ügyben, az EJEB itt is visszautasította azt, hogy a kérelmezők hasonló helyzetben lennének, mint egy házasságban élő pár, amelyben valamely fél a másik házastárs gyermekét kívánja örökbe fogadni. Ugyanakkor az EJEB elfogadta, hogy a kérelmezők hasonló helyzetben voltak, mint egy

247 EJEB, *Gas és Dubois kontra Franciaország* (25951/07), 2012. március 15.

248 EJEB, *X és társai kontra Ausztria* [Nagykamara] (19010/07), 2013. február 19.

nem házasságban élő heteroszexuális pár. Miközben az osztrák jog a nem házasságban élő heteroszexuális párok esetében lehetővé teszi a társszülős örökbefogadást, az osztrák polgári törvénykönyv kimondja, hogy aki gyermeket fogad örökbe, az azonos nemű vér szerinti szülő helyébe lép, ami azt jelenti, hogy az azonos nemű párok esetében a társszülős örökbefogadás jogilag lehetetlen. Az EJEB megállapította, hogy ilyen körülmények között eltérő bánásmódot alkalmaztak a kérelmezőkkel szemben szexuális irányultságuk alapján, és hogy a kormány az EJEE 8. cikkével együtt értelmezett 14. cikkét megsértve nem hozott fel nyomós és meggyőző indokokat ennek igazolására.

Végezetül, az EJEB a nemzetközi jog szellemiségének és céljának való érdemi megfelelést is szem előtt tartja az örökbefogadással kapcsolatos döntéshozatal vonatkozásában.

Példa: A *Harroudj kontra Franciaország* ügyben[249] a francia hatóságok elutasították a kérelmező arra irányuló kérelmét, hogy teljes körűen örökbe fogadjon egy algériai lányt, akit születésekor elhagytak és az iszlám jog szerinti gyámság, a *kafala* keretében a kérelmező gondozásába helyeztek. Az elutasítás oka az volt, hogy a francia polgári törvénykönyv nem teszi lehetővé olyan gyermek örökbefogadását, akinek örökbefogadása a származási országának joga (ez esetben az algériai jog) alapján tilos lenne, valamint hogy a *kafala* már szülői felügyeletet biztosított a kérelmező számára, lehetővé téve számára, hogy döntéseket hozzon a gyermek legfőbb (mindenek felett álló) érdekében. Az ezt követő fellebbezést annak alapján utasították el, hogy a hazai jog összhangban állt a gyermekeknek a nemzetközi örökbefogadások terén való védelméről és az ilyen ügyekben történő együttműködésről szóló Hágai Egyezménnyel, és hogy a Gyermekjogi egyezmény 20. cikke a *kafalát* az örökbefogadással egyenértékűnek ismeri el a gyermek legfőbb (mindenek felett álló) érdekének védelme tekintetében. A kérelmező panaszát vizsgálva az EJEB emlékeztetett azon elvre, hogy miután családi kötelék jött létre, az államnak úgy kell eljárnia, hogy az biztosítsa e kötelék fejlődését, és olyan jogi biztosítékokat kell bevezetnie, amelyek lehetővé teszik a gyermek családba való beilleszkedését, továbbá rámutatott arra, hogy az Emberi Jogok Európai Egyezményét a nemzetközi jog általános elveivel összhangban kell értelmezni. Értékelésében az EJEB rámutatott a francia bíróságok azon törekvésére, hogy

249 EJEB, *Harroudj kontra Franciaország* (43631/09), 2012. október 4.

megfeleljenek a nemzetközi egyezmények – köztük a Gyermekjogi egyezmény – szellemének és céljának. A francia jog elismeri a *kafalát*, és a kérelmező szülői felügyeletet gyakorolhatott és döntéseket hozhatott a gyermek érdekében. Így például végrendeletet készíthetett a gyermek javára, felülkerekedve az örökbefogadással kapcsolatos korlátozásból adódó nehézségeken. Összegezve, az örökbefogadás tilalmának ily módon történő fokozatos megkerülésével az alperes tagállam, amely arra törekedett, hogy anélkül ösztönözze a külföldi származású gyermek integrációját, hogy azonnal elvágná őt származási országának szabályaitól, tiszteletet tanúsított a kulturális pluralizmus iránt, és megfelelő egyensúlyt teremtett a közérdek és a kérelmező érdeke között. Az EJEB tehát nem állapította meg a kérelmező jogainak megsértését.

7

A gyermekek erőszakkal és kizsákmányolással szembeni védelme

EU	Tárgyalt kérdések	ET
A gyermekek szexuális bántalmazása, szexuális kizsákmányolása és a gyermekpornográfia elleni küzdelemről szóló irányelv (2011/93/EU)	**Iskolai, otthoni és egyéb környezetben előforduló erőszak**	EJEE, 2. cikk (élethez való jog), 3. cikk (embertelen és megalázó bánásmód) és 8. cikk (testi épség); az EJEE 1. jegyzőkönyve, 2. cikk (oktatáshoz való jog) EJEB, *Kayak kontra Törökország* (60444/08), 2012 (késelés egy iskola közelében) EJEB, *O'Keeffe kontra Írország* [Nagykamara] (35810/09), 2014 (szexuális zaklatás iskolában) EJEB, *Campbell és Cosans kontra Egyesült Királyság* (7511/76 és 7743/76), 1982 (testi fenyítés) (Módosított) Európai Szociális Karta, 7. cikk (a fizikai és erkölcsi veszélyekkel szembeni különös védelemhez való jog) és 17. cikk (védelemhez való jog) Szociális Jogok Európai Bizottsága, *World Organisation against Torture (OMCT) kontra Belgium*, 21/2003. sz. panasz, 2004 (a testi fenyítés tilalma Belgiumban) A gyermekek szexuális kizsákmányolás és szexuális zaklatás elleni védelméről szóló egyezmény (Lanzarote-i Egyezmény) A nők elleni és a családon belüli erőszak megelőzéséről és felszámolásáról szóló egyezmény (Isztambuli Egyezmény)

EU	Tárgyalt kérdések	ET
Alapjogi Charta, az 5. cikk (2) bekezdése (kényszermunka és kötelező munka) A fiatal munkavállalókról szóló irányelv (94/33/EK) Az emberkereskedelem elleni küzdelemről szóló irányelv (2011/36/EU)	**Kényszermunka**	EJEE, 4. cikk (a szolgaság, a kényszermunka és a kötelező munka tilalma) EJEB, *C.N. és V. kontra Franciaország* (67724/09), 2012 (szolgaság; az állam pozitív kötelezettségei) (Módosított) Európai Szociális Karta, a 7. cikk (10) bekezdése (a gyermekek védelme a fizikai és erkölcsi veszélyekkel szemben) Az Európa Tanácsnak a gyermekek szexuális kizsákmányolás és szexuális zaklatás elleni védelméről szóló egyezménye (Lanzarote-i Egyezmény)
Alapjogi Charta, az 5. cikk (3) bekezdése (az emberkereskedelem tilalma) Az emberkereskedelemről szóló irányelv (2011/36/EU)	**Gyermekkereskedelem**	EJEE, 4. cikk (a szolgaság tilalma) EJEB, *Rantsev kontra Ciprus és Oroszország* (25965/04), 2010 (az emberkereskedelem vádjának állam általi ki nem vizsgálása) Az Európa Tanács emberkereskedelem elleni fellépésről szóló egyezménye
Az emberkereskedelemről szóló irányelv (2011/36/EU)	**Gyermekpornográfia**	EJEE, 8. cikk (a magánélet tiszteletben tartásához való jog) EJEB, *Söderman kontra Svédország* [Nagykamara] (5786/08), 2013 (gyermek titokban történő filmezése) (Módosított) Európai Szociális Karta, a 7. cikk (10) bekezdése (különleges védelem a fizikai és erkölcsi veszélyekkel szemben) A gyermekek szexuális kizsákmányolás és szexuális zaklatás elleni védelméről szóló egyezmény (Lanzarote-i Egyezmény) A számítástechnikai (cyber crime) bűnözésről szóló egyezmény
	Kisebbséghez tartozó gyermekek	EJEB, *Valentin Câmpeanu részéről eljáró Centre for Legal Resources kontra Románia* [Nagykamara]*Centre of Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC] (47848/08), 2014 (súlyos fogyatékossággal élő fiatalember halála egy állami intézményben)
A Tanács 2010/48/EK határozata	**Fogyatékossággal élő gyermekek**	EJEB, *Nencheva és társai kontra Bulgária* (48609/06), 2013 (gyermekek halála egy állami intézményben)
A Bizottság 2007/698/EK határozata	**Eltűnt gyermekek**	EJEB, *Zorica Jovanović kontra Szerbia* (21794/08), 2013 (tájékoztatáshoz való jog)

A gyermekek széles értelemben vett védelme valamennyi olyan intézkedésre vonatkozik, amelyek célja a gyermekjogok gyakorlásának biztosítása. Szűk értelemben a gyermekek mindenfajta erőszaktól való mentességhez fűződő jogához kapcsolódik. A nemzetközi jog értelmében az államoknak intézkedéseket kell hozniuk annak biztosítása érdekében, hogy a gyermekek megfelelő védelemben részesüljenek, és a testi épséghez és méltósághoz való joguk hatékonyan érvényesüljön. Az állam védelemre vonatkozó kötelessége különböző formákat ölthet, attól függően, hogy az erőszak milyen konkrét kockázatának van kitéve a gyermek, és ki az elkövető. Így az államok kötelességei nyilvánvalóbbak azokban az esetekben, amikor a gyermekek az állam felügyelete és ellenőrzése alatt állnak, például ha állami intézményekben vannak elhelyezve. Erre akkor kerül sor, ha nagy az erőszak kockázata. Az állam védelemre vonatkozó kötelessége nehezebbnek bizonyulhat azon esetekben, amikor a gyermekek magánemberek, például családtagjaik részéről vannak kitéve erőszaknak.

Az Európai Unió fő hatásköre ezen a területen a határokon átnyúló bűncselekményekhez kapcsolódik (az Európai Unió működéséről szóló szerződés (EUMSZ) 83. cikke). Ezért külön jogalkotási intézkedések kerültek elfogadásra a gyermekpornográfia és az emberkereskedelem vonatkozásában. Az EU emellett olyan jogszabályt is elfogadott, amely előírja a tagállamok számára a szexuális zaklatás számos formájának büntetendővé tételét. Az Európa Tanács (ET) szintjén az emberi jogok európai egyezménye (EJEE) – különösen annak 2., 3. és 8. cikke – rendelkezik az államok kötelességeiről számos, gyermekekkel szembeni erőszaknak minősülő cselekmény tekintetében. A Szociális Jogok Európai Bizottsága ugyancsak tevékenyen lépett fel ezen a területen, egyrészt jelentéstételi eljárása, másrészt kollektív panasztételi mechanizmusa révén. Emellett ma már az Európa Tanácsnak külön egyezményei vannak érvényben, amelyek közül ki kell emelni a gyermekek szexuális kizsákmányolás és szexuális zaklatás elleni védelméről szóló egyezményt (Lanzarote-i Egyezmény)[250]; ezek végrehajtását ellenőrző szervek felügyelik.

Ez a fejezet a gyermekek elleni erőszak egyes vonatkozásait és a nemzetközi közösség azokra adott válaszát elemzi. A 7.1. szakasz az otthoni, iskolai és egyéb környezetben előforduló erőszakot vizsgálja meg, és olyan kérdésekre összpontosít, mint a testi fenyítés, a gyermekek bántalmazása és elhanyagolása, valamint a szexuális erőszak. A 7.2. szakasz a gyermekek kizsákmányolásának egyértelműen határokon átnyúló dimenzióval rendelkező eseteit járja körül, beleértve

250 Európa Tanács, Az Európa Tanács egyezménye a gyermekek szexuális kizsákmányolás és szexuális zaklatás elleni védelméről, CETS 201., 2007.

a kényszermunka és szexuális kizsákmányolás céljából folytatott emberkereskedelmet, a gyermekpornográfiát és a gyermekek becserkészését (grooming). Végezetül a 7.3. szakasz a bántalmazás olyan eseteit vizsgálja, amikor a gyermekek különösen kiszolgáltatott helyzetben vannak.

7.1. Iskolai, otthoni és egyéb környezetben előforduló erőszak

Kiemelt pontok

- Az államok kötelesek biztosítani, hogy a gyermekek mindenhol hathatós védelemben részesüljenek az erőszakkal és más ártalmakkal szemben.
- Az államoknak megfelelő jogi keretet kell biztosítaniuk a gyermekek védelmére irányulóan.
- Az államoknak hatékonyan ki kell vizsgálniuk a gyermekbántalmazással, a gyermekekkel szembeni erőszakkal és a gyermekeknek okozott ártalmakkal kapcsolatos állításokat.

Az uniós jogban[251] a legfontosabb jogi eszköz ezen a területen a gyermekek szexuális bántalmazása, szexuális kizsákmányolása és a gyermekpornográfia elleni küzdelemről szóló, az EUMSZ 82. és 83. cikke alapján elfogadott 2011/93/EU irányelv.[252]

Az ET joganyagában az EJEB és a Szociális Jogok Európai Bizottsága jelentős ítélkezési gyakorlatot alakított ki a gyermekek környezetében előforduló erőszakkal szembeni védelmére vonatkozóan. Emellett az ET külön egyezményei (például a Lanzarote-i Egyezmény) részletes biztosítékokat nyújtanak a gyermekekkel szembeni erőszak bizonyos formáival szembeni védelemhez.

251 Az Európai Parlament és a Tanács 2011. december 13-i 2011/93/EU irányelve a gyermekek szexuális bántalmazása, szexuális kizsákmányolása és a gyermekpornográfia elleni küzdelemről, HL L 335/1., 2011.

252 *Uo.*

7.1.1. Az állam felelősségi köre

Az ET joganyagában keretében az EJEB az EJEE különböző cikkei, különösen a 2. és a 3. cikk alapján elemezte a gyermekekkel szembeni erőszak legsúlyosabb formáit. A bíróság megállapította, hogy az államokra egyértelmű kötelességek hárulnak, ha gyermekeket a felügyeletük alá tartozó intézményekben helyeznek el.[253] Hasonlóképpen abban az esetben, ha bizonyos magatartás vagy helyzet olyan súlyossági fokot ér el, amely már a 3. cikk szerinti embertelen vagy megalázó bánásmódnak minősül, az államnak pozitív kötelezettségei vannak a gyermekek bántalmazással szembeni védelme tekintetében, beleértve a magánszemélyek által alkalmazott bánásmódot is. A bíróság megállapította hatáskörét olyan elé kerülő ügyekben,mint a szülők általi tartós elhanyagolás,[254] egy pedagógusok által elkövetett, ismételt szexuális zaklatás,[255] erőszakos közösülés,[256] vagy testi fenyítés[257] esetei, amelyek mind az EJEE 3. cikkének hatálya alá tartoznak.

Halált okozó gyermekbántalmazás esetén az állam az EJEE 2. cikke értelmében felelősségre vonható, még akkor is, ha a halálesetet egy magánszemély idézte elő, nem pedig valamely állami alkalmazott. Az államok pozitív kötelezettségei esettől függően változnak, alapvető kötelesség azonban a gyermekek erőszakkal szembeni *hatékony* védelmének biztosítása. A bántalmazás súlyos formái esetében a pozitív kötelezettségek közé tartozik a bűnüldözési rendszer által támogatott hatékony büntetőjogi rendelkezések elfogadása.[258] Az államoknak ezenkívül külön intézkedéseket és garanciákat kell elfogadniuk a gyermekek védelmére.[259]

Az EJEB elé többször kerültek olyan ügyek, amelyek tárgyát magánszemélyek által gyermekekkel szemben iskolákban, otthon vagy egyéb, nem állami szereplők által működtetett intézményekben elkövetett erőszak képezte, amely esetekben kérdéses volt, hogy felmerülhet-e az állam felelőssége. Ennél is fontosabb, hogy az EJEB ítélete szerint az állam nem mentheti fel magát a gyermekek védelmének kötelezettsége alól azáltal, hogy fontos közszolgáltatások – például

253 EJEB, *Nencheva és társai kontra Bulgária* (48609/06), 2013. június 18. (elérhető francia nyelven).
254 EJEB, *Z. és társai kontra Egyesült Királyság* [Nagykamara] (29392/95), 2001. május 10.
255 EJEB, *O'Keeffe kontra Írország* [Nagykamara] (35810/09), 2014. január 28.
256 EJEB, *M.C. kontra Bulgária* (39272/98), 2003. december 4.
257 EJEB, *Tyrer kontra Egyesült Királyság* (5856/72), 1978. április 25.
258 EJEB, *M.C. kontra Bulgária* (39272/98), 2003. december 4., 150. pont.
259 EJEB, *O'Keeffe kontra Írország* [Nagykamara] (35810/09), 2014. január 28., 146. pont.

az oktatás – igazgatását magánszemélyekre ruházza át.[260] Az állam felelősségének megállapítását érintő esetekben az EJEB általában különbséget tett az állam, konkrétan nem azonosítható kockázat esetén fennálló általános védelmi kötelezettsége, valamint az áldozat egyértelmű azonosíthatósága esetén a konkrét védelem kötelezettsége között. Az előbbi esetben az EJEB azt vizsgálta, hogy az állam be nem avatkozása következtében tényleges kockázat fenyegette-e a gyermek áldozatot.

Példa: A *Kayak kontra Törökország* ügy[261] tárgya, hogy egy iskola közelében egy tinédzser halálra késelt egy 15 éves fiút. Az EJEB megállapította, hogy az iskoláknak kötelességük az erőszak minden formájával szemben védelmet biztosítani a tanulóik számára. E konkrét esetben az EJEB úgy ítélte meg, hogy Törökország az EJEE 2. cikke értelmében felelős azért, hogy nem védte meg a kérelmezők fia, illetve fivére élethez való jogát, mivel akkoriban nem létezett hatékony felügyeleti rendszer. E rendszer hiányában egy tizenéves fiatal magához vehetett egy kést az iskolai konyhából, amellyel megkéselte az áldozatot.

Példa: Az *O'Keeffe kontra Írország* ügy[262] egy Ír Nemzeti Iskolában az 1970-es években elkövetett bántalmazásokat érint. Akkoriban Írországban a nemzeti iskolák az állam által elismert és finanszírozott iskolák voltak, melyek irányítását és igazgatását az egyházra bízták. A kérelmező, egy akkori diák mintegy 20 alkalommal szenvedett el szexuális erőszakot az iskola egyik tanára részéről. A történtekkel kapcsolatban csak 1998-ban tett panaszt az állami hatóságoknak, miután tudomást szerzett arról, hogy ugyanaz a tanár más esetekben is elkövetett szexuális erőszakot. Az Emberi Jogok Európai Bíróságának azt kellett megállapítania, hogy felelősségre vonható-e az állam olyan bántalmazási esetek miatt, amelyeket akkoriban nem jelentettek a hatóságoknak. Az EJEB először is megállapította, hogy a kérelmező által elszenvedett bántalmazás az EJEE 3. cikkének hatálya alá tartozik. Ezután az EJEB megállapította, hogy az államnak figyelemmel kellett volna lennie az iskolai szexuális erőszak potenciális veszélyére. Akkoriban nem létezett megfelelő eljárás, amely lehetővé tette volna egy gyermek vagy szülő számára, hogy közvetlenül az állam felé jelezze

260 *Uo.*, 150. pont; EJEB, *Costello-Roberts kontra Egyesült Királyság* (13134/87), 1993. március 25., 27. pont.

261 EJEB, *Kayak kontra Törökország* (60444/08), 2012. július 10. (elérhető francia nyelven).

262 EJEB, *O'Keeffe kontra Írország* [Nagykamara] (35810/09), 2014. január 28.

a bántalmazást. Emellett nem voltak felügyeleti, szupervíziós mechanizmusok, amellyel ellenőrizték volna a tanárok gyermekekkel szembeni bánásmódját. Az EJEB ezért megállapította, hogy Írország nem teljesítette az EJEE 3. cikke szerinti pozitív kötelezettségeit, mivel nem gondoskodott hatékony védelmi mechanizmusról a kiskorúakkal szembeni, iskolákban elkövetett bántalmazások ellen.

Az EJEB szerint az államnak emellett hatékonyan ki kell vizsgálnia a bántalmazások vagy halálesetek gyanúját, függetlenül attól, hogy az elkövetők állami alkalmazottak-e[263] vagy magánszemélyek. A vizsgálat akkor hatékony, ha az áldozatok vagy jogutódaik által benyújtott panasz beérkezésekor az állam olyan eljárást indít el, amelynek nyomán azonosítható és megbüntethető az EJEE 2. vagy 3. cikkébe ütköző erőszakos cselekményekért felelős személy.

Az Európai Szociális Karta értelmében a gyermekek bántalmazással szembeni védelemhez való joga elsősorban a 7. és a 17. cikk alá tartozik.

Emellett a Lanzarote-i Egyezmény szerint az államoknak büntetendővé kell tenniük a gyermekekkel szemben elkövetett szexuális erőszak és szexuális kizsákmányolás különböző formáit.[264] Az egyezmény azt is előírja az államok számára, hogy hozzanak jogalkotási vagy egyéb intézkedéseket a gyermekekkel szembeni szexuális erőszak megelőzése érdekében, ideértve figyelemfelkeltő kampányok megszervezését, szakemberek képzését, a gyermekeknek a bántalmazás veszélyeivel kapcsolatos tájékoztatását, valamint szakértői segítségnyújtást azon személyek számára, akik esetében fennáll a gyermekbántalmazás elkövetésének veszélye. Ezenkívül a Nők elleni és a családon belüli erőszak megelőzéséről és felszámolásáról szóló egyezmény (Isztambuli Egyezmény)[265] 4. és 5. cikke értelmében az államok vállalják, hogy külön jogalkotási intézkedéseket hoznak és kivizsgálják a nőkkel szembeni erőszak eseteit. Az Isztambuli Egyezmény 22. cikke alapján az államoknak kötelességük szakértői támogató szolgáltatásokat biztosítani a családon belüli erőszak áldozataivá vált nők és gyermekek számára.

A nemzetközi jogban a gyermekek állami szintű védelme biztosításának kulcsfontosságú jogi eszköze a Gyermekjogi egyezmény, amelynek 19. cikke értelmében

263 EJEB, *Assenov és társai kontra Bulgária* (24760/94), 1998. október 28.

264 Európa Tanács, Az Európa Tanács egyezménye a gyermekek szexuális kizsákmányolás és szexuális zaklatás elleni védelméről, CETS 201., 2007.

265 Európa Tanács, Az Európa Tanács egyezménye a nők elleni és a családon belüli erőszak megelőzéséről és felszámolásáról, CETS 210., 2011.

a részes államok megtesznek minden arra alkalmas törvényhozási, közigazgatási, szociális és nevelési intézkedést, hogy megvédjék a gyermeket az erőszak bármilyen formájától. Az ENSZ Gyermekjogi Bizottsága jelentős számú Átfogó Kommentárt és ajánlást adott ki, amelyben értelmezte az államoknak a Gyermekjogi egyezmény értelmében fennálló kötelezettségeit. Így például a 13. számú Átfogó Kommentár leírja a gyermekeknek az erőszak valamennyi formájával szembeni védelmére irányuló intézkedéseket.[266] Az 5. számú Átfogó Kommentár pedig a Gyermekjogi egyezmény nemzeti jogba és szakpolitikákba való átültetésére és nyomon követésére irányuló intézkedéseket tárgyalja.[267]

7.1.2. Testi fenyítés

A testi fenyítés általában a fizikai büntetés minden olyan formáját jelenti, amelynek célja fájdalom vagy kellemetlenség okozása valaki számára. Legtöbbször a gyermekek kézzel vagy valamely tárggyal történő verésére vonatkozik, de olyan nem fizikai cselekedeteket is magában foglalhat, mint a fenyegetés, amely ugyanazzal a végeredménnyel, nevezetesen a gyermek megalázásával jár.[268]

Az ET joganyagában az EJEB legtöbbször az EJEE 3. cikke alapján vizsgálta a testi fenyítéssel mint a fegyelmezés egy formájával kapcsolatos panaszokat. Amennyiben a fegyelmezésre irányuló intézkedés elérte a 3. cikk szerinti súlyossági fokot, az EJEB megállapította, hogy a bánásmód e rendelkezésbe ütközött.[269] Amennyiben a testi fenyítés nem éri el a 3. cikkben meghatározott súlyossági küszöböt, a testi és erkölcsi integritáshoz való jog részeként a 8. cikk hatálya alá tartozhat. Mindeddig azonban az EJEB testi fenyítéssel kapcsolatos ügyekben nem állapította meg a 8. cikk érdemi megsértését. A testi fenyítés állami iskolákban történő alkalmazása emellett a szülők azon jogát is sértheti, hogy gyermekeiket világnézeti meggyőződésüknek megfelelően neveljék, amint arról az EJEE 1. Kiegészítő Jegyzőkönyvének 2. cikke rendelkezik.[270]

266 ENSZ, Gyermekjogi Bizottság (2011), *13. számú Átfogó Kommentár*, CRC/C/GC/13, 2011. április 18.

267 ENSZ, Gyermekjogi Bizottság (2003), *5. számú Átfogó Kommentár*, CRC/C/GC/5, 2003. november 27.

268 ENSZ, Gyermekjogi Bizottság (2007), 8. számú Átfogó Kommentár (2006): *A gyermek joga a testi fenyítéssel és a büntetés egyéb kegyetlen vagy megalázó formáival szembeni védelemhez* (többek között 19. cikk; 28. cikk (2) bekezdés; valamint 37. cikk), CRC/C/GC/8, 2007. március 2.

269 EJEB, *Tyrer kontra Egyesült Királyság* (5856/72), 1978. április 25.

270 EJEB, *Campbell és Cosans kontra Egyesült Királyság* (7511/76 és 7743/76), 1982. február 25., 38. pont.

Példa: A *Campbell és Cosans kontra Egyesült Királyság* ügyek[271] tárgya, hogy két fiút eltanácsoltak egy iskolából, miután nem voltak hajlandóak elfogadni a testi fenyítést. Az EJEB nem állapította meg az EJEE 3. cikkének megsértését, mivel a gyermekek nem voltak tényleges testi fenyítésnek alávetve. Megállapította ugyanakkor az EJEE 1. Kiegészítő Jegyzőkönyve 2. cikkének megsértését, mivel az alperes állam azáltal, hogy lehetővé tette a testi fenyítést, nem tartotta tiszteletben a szülők világnézeti meggyőződését. Az EJEB emellett megállapította, hogy az iskolából történő eltanácsolás révén sérült az egyik fiú oktatáshoz való joga, amelyről az EJEE 1. Kiegészítő Jegyzőkönyvének 2. cikke rendelkezik.

Az Európai Szociális Karta nem tartalmaz közvetlen tiltást a testi fenyítésre vonatkozóan. A Szociális Jogok Európai Bizottsága azonban úgy értelmezte, hogy az Európai Szociális Karta 17. cikkében benne foglaltatik az erre vonatkozó kötelezettség.[272] A jelentéstételi eljárás és a kollektív panasztételi eljárás révén a Szociális Jogok Európai Bizottsága ellenőrzi, hogy az államok eleget tesznek-e az Európai Szociális Karta 17. cikkének, és ennek keretében megállapította, hogy több részes állam megsértette ezt a rendelkezést azáltal, hogy nem tiltotta meg a testi fenyítés valamennyi formáját. Három hasonló ügyben, amelyeket az *Association for the Protection of All Children (APPROACH) Ltd. Belgium*[273], a Cseh Köztársaság[274], illetve Szlovénia[275] ellen indított, az EJEB megállapította az Európai Szociális Karta 17. cikkének megsértését, mivel a három említett állam nem rendelkezett olyan jogszabállyal, amely „kifejezetten és átfogóan tiltotta volna a gyermekek testi fenyítésének valamennyi olyan formáját, amely sértheti testi épségüket, méltóságukat, fejlődésüket vagy lelki jólétüket".[276] Az EJEB emellett azt is megállapította, hogy a gyermekek testi fenyítését tiltó jogszabályokat a gyermekvédelmi szakellátás (alternatív gondoskodás) olyan formáira is alkalmazni kell, mint az intézetben történő gondozás, a nevelőszülőknél való elhelyezés és az óvo-

271 EJEB, *Campbell és Cosans kontra Egyesült Királyság* (7511/76 és 7743/76), 1982. február 25.

272 Lásd például: Szociális Jogok Európai Bizottsága, *World Organisation against Torture (OMCT) kontra Belgium*, 21/2003. sz. panasz, 2004 december 7; Szociális Jogok Európai Bizottsága, Következtetések XVI-2, Lengyelország, 17. cikk, 65. o.

273 Szociális Jogok Európai Bizottsága, *Association for the Protection of All Children (APPROACH) kontra Belgium*, 98/2013. sz. panasz, 2015. május 29., 49. pont.

274 Szociális Jogok Európai Bizottsága, *Association for the Protection of All Children (APPROACH) kontra Cseh Köztársaság*, 96/2013. sz. panasz, 2015. május 29.

275 Szociális Jogok Európai Bizottsága, *Association for the Protection of All Children (APPROACH) kontra Szlovénia*, 95/2013. sz. panasz, 2015. május 27.

276 Szociális Jogok Európai Bizottsága, *Association for the Protection of All Children (APPROACH) kontra Szlovénia*, 95/2013. sz. panasz, 2015. május 27., 51. pont.

dák. E tekintetben emlékeztetni kell arra is, hogy az Európa Tanács Parlamenti Közgyűlése 2004-ben ajánlást adott ki, amelyben felkérte az összes szerződő államot a testi fenyítés teljes betiltására.[277]

A nemzetközi jog a testi fenyítést közvetve a gyermekekkel szembeni erőszak egyik formájának tekinti, ami az Gyermekjogi egyezmény 19. cikke, 28. cikkének (2) bekezdése és 37. cikke alá tartozik. Emellett az ENSZ Gyermekjogi Bizottsága 2006-ban kiadta a 8. számú Átfogó Kommentárt, amelyben felhívta az államokat, hogy tegyenek megfelelő intézkedéseket a testi fenyítés valamennyi formájával szemben.[278]

7.1.3. Szexuális bántalmazás

Az emberkereskedelem és a gyermekpornográfia kérdését a 7.2.2., illetve a 7.2.3. szakasz tárgyalja.

A gyermekek szexuális bántalmazása számos formát ölthet, ideértve a zaklatást, az érintést, a vérfertőzést és az erőszakos közösülést. A gyermekek szexuális bántalmazására különféle helyeken kerülhet sor, így például otthonukban, iskolákban, különféle ellátást nyújtó intézményekben, templomokban stb. A gyermekek különösen ki vannak szolgáltatva a szexuális bántalmazásnak, mivel gyakran hierarchikus viszonyban, felnőttek hatalma és ellenőrzése alatt állnak, és kevésbé férnek hozzá a panasztételi mechanizmusokhoz is.

Az uniós jogban a 2011/93/EU irányelv – amely nagyrészt a Lanzarote-i Egyezmény megközelítését tükrözi – a gyermekek szexuális bántalmazásával kapcsolatos különféle bűncselekmények esetében minimálisan alkalmazandó büntetőjogi szankciók tagállamok közötti harmonizálását célozza.[279] Az irányelv 3. cikke értelmében a tagállamoknak büntetőjogi intézkedéseket kell hozniuk a szexuális bántalmazás különböző formáinak szankcionálása érdekében, ideértve az olyan bűncselekményeket, mint a gyermek arra történő késztetése, hogy szexuális

277 Európa Tanács, Parlamenti Közgyűlés (2004), 1666 (2004). sz. ajánlás a gyermekek testi fenyítésének Európa-szerte történő betiltásáról, 2004. június 23.

278 ENSZ, Gyermekjogi Bizottság (2008), *8. számú Átfogó Kommentár (2006): A gyermek joga a testi fenyítéssel és a büntetés egyéb kegyetlen vagy megalázó formáival szembeni védelemhez* (többek között 19. cikk; 28. cikk (2) bekezdés; valamint 37. cikk), CRC/C/GC/8, 2007. március 2.

279 Az Európai Parlament és a Tanács 2011. december 13-i 2011/93/EU irányelve a gyermekek szexuális bántalmazása, szexuális kizsákmányolása és a gyermekpornográfia elleni küzdelemről, HL L 335/1., 2011.

tevékenység tanúja legyen, valamint a gyermekkel folytatott szexuális tevékenység. Az irányelv súlyosabb büntetési tételekről rendelkezik arra az esetre, ha a cselekményeket bizalmi helyzettel visszaélő személyek követik el különösen kiszolgáltatott gyermekekkel szemben és/vagy kényszer alkalmazásával. Emellett a tagállamoknak biztosítaniuk kell, hogy a gyermekek bántalmazásával gyanúsított személyeket automatikusan eljárás alá vonják, és hogy a szexuális bántalmazással kapcsolatos bűncselekmények miatt elítélt személyek semmiféle olyan szakmai tevékenységet ne gyakorolhassanak, amelyek gyermekekkel való közvetlen vagy rendszeres kapcsolattartással jár. Az irányelv rendelkezéseket tartalmaz a gyermekbarát eljárásokra irányulóan is, valamint biztosítja a gyermek áldozatok bíróságok előtti védelmét.

A 2011/93/EU irányelv kapcsolódik a bűnügyi nyilvántartásból származó információk tagállamok közötti cseréjének megszervezéséről és azok tartalmáról szóló 2009/315/IB kerethatározathoz[280]. Bár a kerethatározat nem kifejezetten a gyermekekre vonatkozik, megszünteti a védelmi rendszer egy fontos hiányosságát, biztosítva, hogy a tagállami hatóságok hozzáférhessenek az elítélt személyek bűnügyi nyilvántartásban szereplő adataihoz. Ez lehetővé teszi azoknak a szexuális bántalmazás miatt elítélt személyeknek az azonosítását, akik más tagállamokban keresnek állást gyermekekkel foglalkozó intézményekben.

Az ET joganyagában az EJEB az EJEE 3. és 8. cikke alapján vizsgált szexuális bántalmazással kapcsolatos ügyeket. A panaszok általában arra vonatkoztak, hogy az államok nem hoztak megfelelő intézkedéseket a gyermekek bántalmazással szembeni védelmére irányulóan. A 3. cikkel összefüggésben az EJEB azt is vizsgálta, hogy az államok hatékonyan kivizsgálták-e a szexuális bántalmazás alapos gyanúját. A 8. cikken alapuló, gyermekbántalmazással kapcsolatos panaszok tárgya e cselekményeknek az áldozat testi épségére és a családi élet tiszteletben tartásához való jogra gyakorolt hatása. Az államok 3. és 8. cikk szerinti kötelezettségeit időnként nem lehet élesen elkülöníteni egymástól; az EJEB mindkét cikk esetében hasonló érvelést alkalmaz a jogsértések megállapításához. Meg kell ugyanakkor jegyezni, hogy a 8. cikken alapuló ügyek gyakoribbak a jogtalan kiemeléssel/gondozásba vétellel kapcsolatos helyzetekben és a gyermekbántalmazás alapos gyanújának a családra gyakorolt hatását érintő esetekben. Ezeket a helyzeteket az 5. fejezet vizsgálja.

280 A Tanács 2009. február 26-i 2009/315/IB kerethatározata a bűnügyi nyilvántartásból származó információk tagállamok közötti cseréjének megszervezéséről és azok tartalmáról, HL L 93., 2009, 23–32. o.

Példa: Az *M.C. kontra Bulgária* ügyben[281] a kérelmező egy 14 éves lány volt, aki azt állította, hogy két ember megerőszakolta, amikor egy este szórakozni ment. A hazai hatóságokhoz benyújtott panaszát elsősorban amiatt utasították el, mert a fizikai erőszak semmilyen formáját nem állapították meg. Az EJEB megjegyezte, hogy az erőszakos közösülés gyanúja az EJEE 3. cikke alá tartozik, és az alperes államnak hatékonyan ki kellett vizsgálnia az erre vonatkozó állításokat. Annak megállapításakor, hogy a bolgár hatóságok nem végeztek ilyen vizsgálatot, az EJEB arra a bizonyítékra támaszkodott, hogy a hatóságok általában elutasították azokat az ügyeket, amelyekben az áldozat nem tudott fizikai ellenállást tanúsítani az erőszakos közösüléssel szemben. A bíróság úgy ítélte meg, hogy egy ilyen bizonyítási küszöb nem felel meg az erőszakos közösülés áldozatai esetében fennálló ténybeli realitásoknak, ami az EJEE 3. cikkébe ütközően alááshatta a hatósági vizsgálat hatékonyságát.

Ezen túlmenően a Lanzarote-i Egyezmény részletesen szabályozza a gyermekek szexuális bántalmazással szembeni védelemhez való jogát. Az egyezményt az ET keretében fogadták el, de Európán kívüli államok is ratifikálhatják. Ezt a kötelező érvényű eszközt számtalan nem kötelező érvényű eszköz támogatja, melyek célja annak további biztosítása, hogy az államok hatékony intézkedéseket hozzanak a gyermekek szexuális bántalmazásával szemben.[282]

7.1.4. Családon belüli erőszak és a gyermek elhanyagolása

A családon belüli erőszakkal kapcsolatos esetekben sokszor áll fenn a szexuális erőszak gyanúja. Ebben az összefüggésben az államok nemzetközi jog szerinti kötelezettségei hasonlóak a fenti 7.1.3. szakaszban felsoroltakhoz.

Az ET joganyagában legtöbbször anyák tettek panaszt az Emberi Jogok Európai Bíróságánál amiatt, hogy az állam nem teljesítette megfelelően a sérelem okozással szembeni védelemre vonatkozó, EJEE szerinti kötelezettségét. A családon

281 EJEB, *M.C. kontra Bulgária* (39272/98), 2003. december 4.

282 Ide tartoznak például a következők: Európa Tanács, Miniszteri Bizottság (2001), Rec (2001) 16. sz. ajánlás a gyermekek szexuális kizsákmányolással szembeni védelméről, 2001. október 31.; Európa Tanács, Parlamenti Közgyűlés (1996), 1099 (1996) sz. határozat a gyermekek szexuális kizsákmányolásáról, 1996. szeptember 25.; Európa Tanács, Parlamenti Közgyűlés (2000), 1212 (2000) sz. határozat a fegyveres konfliktusok során elkövetett nemi erőszakról, 2000. április 3.; Európa Tanács, Parlamenti Közgyűlés (2002), 1307 (2002) sz. határozat a gyermekek szexuális kizsákmányolásáról: zéró tolerancia, 2002. szeptember 27.

belüli erőszak esetei az egyezmény 2., 3. és 8. cikke alapján vetettek fel kérdéseket. Az államoknak eleget kell tenniük azon pozitív kötelezettségüknek, hogy hatékony intézkedéseket hozzanak a családon belüli erőszakkal szemben, és hatékonyan kivizsgálják a családon belüli erőszakkal illetve a gyermekek elhanyagolásával kapcsolatos alapos gyanúkat.

Példa: A *Kontrová kontra Szlovákia* ügyben[283] a kérelmezőt férje többször fizikailag bántalmazta. Panaszt tett a rendőrségen, de panaszát később visszavonta. Ezt követően férje gyermekeik megölésével fenyegette. Ezt egy rokon jelentette a rendőrségnek. Az eset után néhány nappal azonban a kérelmező férje lelőtte két gyermeküket, és magával is végzett. Az EJEB megállapította, hogy az államnak pozitív kötelezettségei merülnek fel az EJEE 2. cikke vonatkozásában, amennyiben a hatóságoknak tudomásuk van vagy tudniuk kellene arról, hogy egy azonosított személy élete ténylegesen és közvetlenül veszélyben van. A szóban forgó esetben a szlovák hatóságoknak tudniuk kellett volna e veszély fennállásáról, mivel a kérelmező és a rendőrség között előzőleg volt kommunikáció. A rendőrség pozitív kötelezettségeiből adódóan nyilvántartásba kellett volna venni a kérelmező büntetőjogi panaszát, bűnügyi nyomozást kellett volna indítani és büntetőjogi eljárást kellett volna kezdeményezni, megfelelően nyilvántartva a segélyhívásokat, és lépéseket téve azon állítások igazolása vonatkozásában, hogy a kérelmező férje lőfegyverrel rendelkezik. A rendőrség azonban nem tett eleget kötelezettségeinek, és ennek közvetlen következménye volt a kérelmező gyermekeinek halála, ami az EJEE 2. cikkének megsértését jelenti.

Példa: Az *Eremia kontra Moldovai Köztársaság* ügy[284] tárgya egy anya és két lánya azzal kapcsolatos panasza, hogy a hatóságok nem védték meg őket a férj és apa erőszakos és bántalmazó magatartásával szemben. Az EJEB megállapította, hogy a hatóságok, bár tudtak a bántalmazásról, nem tettek hatékony intézkedéseket annak érdekében, hogy megvédjék az anyát a további, családon belüli erőszaktól. Emellett arra is rámutatott, hogy bár a lányokra nézve káros pszichés következményekkel járt az, hogy otthonukban tanúi voltak apjuk anyjukkal szembeni erőszakos cselekedeteinek, e magatartás megismétlődésének megelőzésére alig, vagy egyáltalán nem tettek lépéseket. A bíróság kimondta, hogy a moldovai hatóságok nem teljesítették megfelelően az EJEE 8. cikke szerinti kötelezettségeiket.

283 EJEB, *Kontrová kontra Szlovákia* (7510/04), 2007. május 31.

284 EJEB, *Eremia kontra Moldovai Köztársaság* (3564/11), 2013. május 28.

Gyermekek ellátást nyújtó állami intézményekben történő vagy családon belüli elhanyagolásával kapcsolatos ügyek is kerültek az EJEB elé. A hatóságokat a gyermekek szülők általi elhanyagolásával kapcsolatos helyzetekben hasonló kötelezettségek terhelik, mint a fent bemutatott esetekben. Az államnak egyrészről hatékony gyermekvédelmi mechanizmusokat kell felállítania, másrészről az állami szerveknek intézkedéseket kell tenniük a gyermekek védelme érdekében, amennyiben bejelentés érkezik gyermekek elhanyagolásáról, vagy elegendő bizonyíték áll rendelkezésükre egy gyermek elhanyagolására vonatkozóan, történjék az akár otthon, akár magánintézményekben.[285] Az állami intézményekben előforduló elhanyagolás közvetlen gyermekvédelmi kötelezettségeket ró a hatóságokra és állami szervekre, amelyek keretében biztosítaniuk kell, hogy a gyermekek megfelelő (orvosi) ellátásban részesüljenek, a nekik otthont adó létesítmények megfelelőek legyenek és/vagy a személyzet kellően képzett legyen, hogy biztosítani tudja a gyermekek szükségleteinek megfelelő ellátást.[286]

Kiemelten fontos e tárgyban az Isztambuli Egyezmény,[287] amely bár nem kifejezetten a gyermekekre vonatkozik, többször utal a gyermekekre. Először is, a 3. cikk f) pontja értelmében a 18 év alatti lányokat nőknek kell tekinteni, és ezért az egyezmény valamennyi rendelkezése vonatkozik rájuk. Másrészt a 2. cikk (2) bekezdése ösztönzi a részes államokat, hogy az egyezményt a családi erőszak valamennyi áldozatára alkalmazzák, ami gyermekekre is vonatkozhat. Nyilvánvaló, hogy a legtöbb esetben a gyermekek tanúi a családon belüli erőszaknak, és az súlyosan érinti őket.[288] Végezetül az egyezmény gyermekekre vonatkozó rendelkezései között szerepel, hogy az államok kötelesek intézkedéseket hozni a gyermek áldozatok szükségleteinek kielégítése, a gyermekek körében történő figyelemfelkeltés és ismeretterjesztés, valamint a gyermek tanúk védelme érdekében.

Hasonlóképpen az Európai Szociális Karta 17. cikke értelmében az államok kötelesek tiltani a gyermekekkel szembeni erőszak valamennyi formáját, valamint megfelelő büntetőjogi és polgári jogi rendelkezéseket elfogadni.

285 EJEB, *Z. és társai kontra Egyesült Királyság* [Nagykamara] (29392/95), 2001. május 10.

286 EJEB, *Nencheva és társai kontra Bulgária* (48609/06), 2013. június 18. (elérhető francia nyelven).

287 Európa Tanács, Az Európa Tanács egyezménye a nők elleni és a családon belüli erőszak megelőzéséről és felszámolásáról, CETS 210., 2011.

288 FRA (2014c), 134–135. o. Lásd még: UNICEF (2006).

A családon belüli erőszak és a gyermekek elhanyagolásának kérdésköre több, az Európa Tanács által elfogadott nem kötelező erejű jogi eszköz tárgyát képezte.[289]

7.2. A gyermekek kizsákmányolása, pornográfia és gyermekek becserkészése (grooming)

Kiemelt pontok

- Az állami hatóságoknak és szerveknek kötelességük együttműködni és hatékonyan együtt munkálkodni a gyermekek erőszakkal szembeni védelme érdekében, a vizsgálatok lefolytatása során is.

7.2.1. Kényszermunka

Az uniós jogban tilos a rabszolgaság, a szolgaság a kényszermunka és a kötelező munka (az Európai Unió Alapjogi Chartája 5. cikkének (2) bekezdése). Tilos továbbá a gyermekek foglalkoztatása is (a Charta 32. cikke). A gyermekmunka tilalmára vonatkozó legfontosabb jogi eszköz a 94/33/EK irányelv.[290] A foglalkoztatás alsó korhatárát a tagállamok csak kivételes esetekben határozhatják meg a tankötelezettség felső határa alatt (a 4. cikk (2) bekezdése). Az államoknak biztosítaniuk kell, hogy azok a fiatalok, akik munkát vállalhatnak, megfelelő munkakörülmények között dolgozhassanak (6. és 7. cikk). Ezenkívül gyermekeket csak bizonyos tevékenységekre, például könnyű háztartási munkára vagy társadalmi és kulturális tevékenységekre lehet alkalmazni (a 2. cikk(2) bekezdése és 5. cikk). Az irányelv emellett a gyermekmunka esetén alkalmazandó egyedi védelmi intézkedéseket is meghatároz (III. szakasz).

289 Ide tartoznak például a következők: Európa Tanács, Miniszteri Bizottság (1985), R (85) 4. sz. ajánlás a családon belüli erőszakról, 1985. március 26.; Európa Tanács, Miniszteri Bizottság (1990), R (90) 2. sz. ajánlás a családon belüli erőszakkal kapcsolatos szociális intézkedésekről, 1990. január 15.; Európa Tanács, Parlamenti Közgyűlés (1998), 1371 (1998) sz. ajánlás a gyermekek bántalmazásáról és elhanyagolásáról, 1998. április 23.

290 A Tanács 1994. június 22-i 94/33/EK irányelve a fiatal személyek munkahelyi védelméről, HL L 216., 1994.

A gyermekek kényszermunkája sok esetben kapcsolódik a gyermekkereskedelemhez.[291] Az emberkereskedelem megelőzéséről és az ellene folytatott küzdelemről szóló 2011/36/EU irányelv a kényszermunkát a gyermekek kizsákmányolásának egyik formájaként határozza meg (a 2. cikk (3) bekezdése).[292] A kényszermunka céljából gyermekkereskedelem áldozatává váló gyermekeket az irányelv ugyanúgy védi, mint a más célból folytatott emberkereskedelem áldozatait (ideértve a szexuális kizsákmányolást, lásd a 7.1.3. szakaszt).[293]

Az ET jogi rendszerében az EJEE 4. cikke teljes egészében tiltja a rabszolgaság, a szolgaság, a kényszermunka és a kötelező munka minden formáját. Az EJEB a „kényszer- vagy kötelező munka" alatt az olyan munkát vagy szolgálatot érti, „amelyet valamely személy büntetés terhe mellett, akarata ellenére végez, és amelyre az adott személy nem önként jelentkezett".[294] A szolgaság emellett magában foglalja azt a kötelezettséget, hogy a „szolgálónak" egy más személy ingatlanában kell élnie, és nem változtathat körülményein.[295] A szolgaság tehát a kötelező munka minősített esete.

Kényszermunkával kapcsolatos állítások esetén az EJEB elsőként azt állapítja meg, hogy az állítások az EJEE 4. cikke alá tartoznak-e.[296] Ezt követően megvizsgálja, hogy az államok eleget tettek-e azon jogalkotási és igazgatási keret létrehozására vonatkozó kötelezettségüknek, amely tiltja és bünteti a kötelező munka, a szolgaság és a rabszolgaság eseteit, valamint hatékonyan eljár velük szemben.[297] A 4. cikk eljárási vonatkozásai tekintetében az EJEB elemzi, hogy a hazai hatóságok hatékonyan kivizsgálták-e a kényszermunkára vagy a szolgaságra vonatkozó gyanúkat.[298]

291 Az Európai Parlament és a Tanács 2011. április 15-i 2011/36/EU irányelve az emberkereskedelem megelőzéséről és az ellene folytatott küzdelemről, valamint az áldozatok védelméről, OJ L 101., 2011, 1. o., (11) preambulumbekezdés.

292 Az Európai Parlament és a Tanács 2011. április 15-i 2011/36/EU irányelve az emberkereskedelem megelőzéséről és az ellene folytatott küzdelemről, valamint az áldozatok védelméről, OJ L 101., 2011, 1. o.

293 Lásd még: FRA (2015c), 40–41. o.

294 EJEB, *Siliadin kontra Franciaország* (73316/01), 2005. július 26., 116. pont.

295 *Uo.*, 123. pont.

296 EJEB, *C.N. és V. kontra Franciaország* (67724/09), 2012. október 11., 70. pont.

297 *Uo.*, 104skk. pont.

298 EJEB, *C.N. kontra Egyesült Királyság* (4239/08), 2012. november 13., 70–82. pont.

Példa: A *C.N. és V. kontra Franciaország* ügy[299] tárgya két, burundi származású lánytestvér kényszermunkára vonatkozó állítása. Szüleik halála után nagynénjük vette őket magához, hogy vele és családjával éljenek Franciaországban. Négy éven át a ház alagsorában voltak elszállásolva, állítólag nagyon rossz körülmények között. Az idősebbik lány nem járt iskolába, és egész idejét háztartási munkákkal töltötte, valamint nagynénje fogyatékossággal élő fiára vigyázott. A fiatalabbik lány járt iskolába, és az iskola után dolgozott nagynénjének, miután kapott időt házi feladatainak elkészítésére. Mindkét lány panaszt nyújtott be az Emberi Jogok Európai Bíróságához, amiért szolgaságban tartották és kényszermunkának vetették alá őket. Az EJEB megállapította, hogy az első kérelmezőt valóban kényszermunkának vetették alá, mivel heti hét napon át kellett dolgoznia fizetség és szabadság nélkül. Sőt, szolgaságban tartották, mivel az volt az érzése, hogy helyzete állandó, és nincs valószínűsége a változásnak. Az EJEB emellett kimondta, hogy az állam nem teljesítette pozitív kötelezettségeit, mivel a hatályos jogi keret nem biztosított hatékony védelmet a kötelező munka áldozatai számára. A kivizsgálással kapcsolatos eljárási kötelezettség vonatkozásában az EJEB megállapította, hogy az EJEE 4. cikkének előírásai teljesültek, mivel a hatóságok gyors és független vizsgálatot végeztek, amelynek nyomán azonosították és megbüntették a felelősöket. Az EJEB elutasította a második kérelmező kényszermunkával kapcsolatos állításait, azzal érvelve, hogy a lány járhatott iskolába és kapott időt házi feladatai elvégzésére.

Az Európai Szociális Karta biztosítja a gyermekek munkakörnyezeten belüli és azon kívüli fizikai és erkölcsi veszélyekkel szembeni védelemhez való jogát (a 7. cikk (10) bekezdése). A Szociális Jogok Európai Bizottsága megállapította, hogy állami szinten tiltani kell a gyermekek otthoni, illetve munkaerőként történő kizsákmányolását, beleértve a munkaerő-kizsákmányolás céljából történő emberkereskedelmet.[300] Az Európai Szociális Karta részes államainak nemcsak azt kell biztosítaniuk, hogy rendelkezzenek a megfelelő jogszabályokkal a kizsákmányolás megelőzéséhez és a gyermekek és fiatalok védelméhez, hanem azt is, hogy e jogszabályokat a gyakorlatban hatékonyan alkalmazzák.[301]

A Lanzarote-i Egyezmény is rögzíti, hogy az államoknak fel kell lépni és büntetendővé kell tenni a gyermekek szexuális kizsákmányolásának valamennyi formáját.

299 EJEB, *C.N. és V. kontra Franciaország* (67724/09), 2012. október 11.

300 Szociális Jogok Európai Bizottsága, Következtetések 2004, Bulgária, 57. o.

301 Szociális Jogok Európai Bizottsága, Következtetések 2006, Albánia, 61. o.; Szociális Jogok Európai Bizottsága, Következtetések 2006, Bulgária, 113. o.

7.2.2. Gyermekkereskedelem

Az uniós jogban az EUMSZ 83. cikke az emberkereskedelmet olyan területként jelöli meg, ahol az Európai Parlament és a Tanács jogalkotási hatáskörökkel rendelkezik. Az Európai Unió Alapjogi Chartája 5.cikkének (3) bekezdése kifejezetten tiltja az emberekkereskedelmet. A határokon átnyúló vonatkozások miatt ezen a területen különösen fontos az EU hatáskörének megléte.

Az emberkereskedelem megelőzéséről és az ellene folytatott küzdelemről, valamint az áldozatok védelméről szóló 2011/36/EU irányelv az első olyan eszköz, amelyet az Európai Parlament és a Tanács az EUMSZ 83. cikke alapján fogadott el.[302] Az irányelv 2. cikkének (1) bekezdése értelmében az emberkereskedelem „személyek kizsákmányolás céljából való toborzása, szállítása, átadása, rejtegetése vagy fogadása – az adott személyek feletti ellenőrzés megváltoztatását vagy átadását is ideértve – fenyegetéssel, erőszakkal vagy egyéb kényszer alkalmazásával, emberrablással, csalással, megtévesztéssel, hatalommal vagy a kiszolgáltatott helyzettel való visszaélés révén, illetve anyagi ellenszolgáltatásnak vagy előnyöknek valamely személy felett ellenőrzést gyakorló személy beleegyezésének megszerzése érdekében történő nyújtásával vagy elfogadásával". Az irányelv célja minimumszabályok megállapítása az emberkereskedelem területén a bűncselekményi tényállások és szankciók meghatározására vonatkozóan (1. cikk). Az irányelv egésze releváns a gyermekek szempontjából, és több, kifejezetten a gyermekeket érintő rendelkezést is tartalmaz az emberkereskedelem gyermek áldozatainak segítésére és támogatására, valamint a nyomozás alatti védelmére vonatkozóan (13–16. cikk).[303] Az egyes áldozatok körülményeinek szakértői értékelése alapján egyedi támogatási intézkedéseket kell hozni (a 14. cikk (1) bekezdése). Az államoknak gyámot kell kijelölniük, aki képviseli a gyermek legfőbb (mindenek felett álló) érdekét (a 14. cikk (2) bekezdése), továbbá támogatást kell nyújtaniuk a gyermek családja számára (a 14. cikk (3) bekezdése). A büntetőeljárás során a gyermekeknek joguk van megfelelő jogi képviseletre, az ingyenes jogi tanácsadáshoz, valamint ahhoz, hogy megfelelő helyiségben, képzett szakemberek kihallgassák őket (a 15. cikk (1)–(3) bekezdése). A további védelmi intézkedések közé tartozik az a lehetőség, hogy a tárgyalásra a nyilvánosság kizárásával kerüljön sor, valamint hogy a gyermeket kommunikációs technológiák felhasználásával, közvetve hallgassák meg (a 15. cikk (5) bekezdése).[304]

302 Az Európai Parlament és a Tanács 2011. április 15-i 2011/36/EU irányelve az emberkereskedelem megelőzéséről és az ellene folytatott küzdelemről, valamint az áldozatok védelméről, OJ L 101., 2011, 1. o.

303 A rendelkezésekről részletesen lásd: FRA és EJEB (2014), 222. o.

304 Lásd: FRA (2015b), 79. o.

Az emberkereskedelem áldozatává vált gyermekek szempontjából fontos még a 2004/81/EK irányelv is.[305] Ezen eszköz értelmében az emberkereskedelem áldozatai számára a fogadó tagállam tartózkodási engedélyt adhat ki, amennyiben együttműködnek a büntetőjogi eljárás során. Az irányelv azonban csak annyiban alkalmazandó a gyermekekre, ahogyan azt a tagállamok meghatározzák.[306]

A végrehajtás tekintetében az EU bűnüldözési ügynöksége (Europol) és az EU igazságügyi együttműködési egysége (Eurojust) fontos szerepet játszik a szervezett emberkereskedő-hálózatok azonosítására és a velük szembeni fellépésre irányuló, tagállamok közötti együttműködés biztosításában. A gyermek áldozatok uniós szintű védelmét célzó vonatkozó rendelkezéseket e kézikönyv 11.3. szakasza tárgyalja.

Az ET jogában az EJEE nem tartalmaz kifejezett rendelkezést az emberkereskedelemre vonatkozóan. Az EJEB azonban az EJEE 4.cikkét úgy értelmezi, hogy az az emberkereskedelem tilalmát is magában foglalja.[307] A bíróság az emberkereskedelemnek ugyanazt a fogalommeghatározását fogadta el, amelyet a nemzetközi szervezett bűnözés elleni ENSZ-egyezménynek az emberkereskedelem, különösen a nő- és gyermekkereskedelem megelőzéséről, felszámolásáról és megbüntetéséről szóló jegyzőkönyve (Palermói Jegyzőkönyv) 3. cikkének a) pontja és az Európa Tanács emberkereskedelem elleni fellépésről szóló egyezménye 4. cikkének a) pontja rögzít.[308] Az EJEB először azt határozza meg, hogy az adott helyzet vonatkozásában utalnak-e hiteles állítások emberkereskedelemre, mely esetben az a 4. cikk alá tartozik. Amennyiben ez fennáll, az EJEB az elemzés során a 7.2.1. szakaszban leírt eljárást követi: a bíróság megvizsgálja, hogy az alperes állam jogi kerete hatékony védelmet biztosít-e az emberkereskedelemmel szemben, eleget tett-e az állam pozitív kötelezettségeinek az eset konkrét körülményeit tekintve, valamint hogy a hatóságok hatékonyan kivizsgálták-e az emberkereskedelemre vonatkozó alapos gyanúkat.

305 A Tanács 2004. április 29-i 2004/81/EK irányelve a harmadik országok emberkereskedelem áldozatává vált vagy az illegális bevándorlás megkönnyítésére irányuló cselekményekkel érintett, a hatáskörrel rendelkező hatóságokkal együttműködő állampolgárai részére kiállított tartózkodási engedélyről, HL L 261., 2004, 19–23. o.

306 *Uo.*, 3. cikk.

307 EJEB, *Rantsev kontra Ciprus és Oroszország* (25965/04), 2010. január 7., 282. pont.

308 ENSZ, A nemzetközi szervezett bűnözés elleni ENSZ-egyezmény (UNCTOC) jegyzőkönyve az emberkereskedelem, különösen a nő- és gyermekkereskedelem megelőzéséről, felszámolásáról és megbüntetéséről, New York, 2000. november 15.; Európa Tanács, Az Európa Tanács egyezménye az emberkereskedelem elleni fellépésről, CETS 197., 2005.

Példa: A *Rantsev kontra Ciprus és Oroszország* ügyet[309] egy gyanús körülmények között Cipruson elhunyt fiatal orosz lány apja kezdeményezte. A lány előadóművészi vízummal érkezett Ciprusra. Egy valószínűsíthető menekülési kísérletet követően kiesett a munkáltatója ismerőseinek lakása erkélyéről, és meghalt. Apja Oroszország és Ciprus ellen is panaszt nyújtott be, alapvetően azt állítva, hogy a hatóságok nem vizsgálták ki megfelelően lánya halálát. Az EJEB elsőként megállapította, hogy az emberkereskedelem az EJEE 4. cikkének hatálya alá tartozik. Bár Ciprus megfelelő jogi kerettel rendelkezik az emberkereskedelem elleni fellépés terén, a 4. cikket megsértették, mivel az a közigazgatási gyakorlat, hogy a munkáltatóknak pénzügyi garanciákat kell adniuk a revütáncosok számára, nem biztosított hatékony védelmet az emberkereskedelemmel és a kizsákmányolással szemben. Továbbá az eset konkrét körülményeit tekintve a ciprusi hatóságoknak tudniuk kellett volna, hogy a kérelmező lánya emberkereskedelem kockázatának volt kitéve. A bíróság úgy ítélte meg, hogy a rendőrség nem tett lépéseket a lány kizsákmányolással szembeni védelme érdekében. Végezetül az EJEB megállapította a 4. cikk Oroszország általi megsértését, mivel az orosz hatóságok nem vizsgálták ki megfelelően az emberkereskedelemmel kapcsolatos állításokat.

A Szociális Jogok Európai Bizottsága úgy tekinti, hogy az emberkereskedelem az emberi jogok és az emberi méltóság súlyos megsértésének minősül, és a rabszolgaság egyik új formájának tekinthető.[310] A 7. cikk (10) bekezdése értelmében az államoknak jogszabályokat kell hozniuk annak büntetendővé tétele érdekében.[311] E jogszabályokat megfelelő felügyeleti mechanizmusokkal, szankciókkal, valamint a gyermekkereskedelem és a gyermekek szexuális kizsákmányolás elleni cselekvési tervvel kell alátámasztani.[312]

Szerződéses szinten az ET emberkereskedelem elleni fellépésről szóló egyezménye az emberkereskedelem kezelésének kulcsfontosságú eszköze.[313] Tekintettel

309 EJEB, *Rantsev kontra Ciprus és Oroszország* (25965/04), 2010. január 7. Az ügy tárgya nem egy gyermek halála, mégis érdemes megemlíteni, mivel az EJEB elé nem kerültek gyermekeket érintő emberkereskedelemmel kapcsolatos esetek, és mivel az emberkereskedelem különös veszélyeket jelent a gyermekekre nézve.

310 Szociális Jogok Európai Bizottsága, *Federation of Catholic Family Associations in Europe (FAFCE) kontra Írország*, 89/2013. sz. panasz, 2014. szeptember 12., 56. pont.

311 Szociális Jogok Európai Bizottsága, Következtetések XVII-2 2005, Lengyelország, 638. o.

312 Szociális Jogok Európai Bizottsága, *Federation of Catholic Family Associations in Europe (FAFCE) kontra Írország*, 89/2013. sz. panasz, 2014. szeptember 12., 57. pont.

313 Európa Tanács, Az Európa Tanács egyezménye az emberkereskedelem elleni fellépésről, CETS 197., 2005.

az ET szélesebb körű tagságára és arra, hogy az emberkereskedelem elleni fellépésről szóló egyezményhez az ET tagállamain kívüli országok is csatlakozhatnak,[314] az egyezmény kiegészíti a 2011/36/EU irányelvet, és rendkívül fontos az emberkereskedelem elleni, közös normákon és kötelezettségeken alapuló fellépéshez az egyezmény részes államaiban, legyenek azok akár uniós tagállamok, akár nem. Az egyezmény végrehajtását egy független szakértőkből álló csoport felügyeli (az Emberkereskedelem Elleni Küzdelem Szakértői Csoportja, GRETA), amely rendszeresen értékeli az egyes országok helyzetét, és jelentéseket tesz közzé. E jelentések alapján az egyezmény részes feleinek bizottsága, az egyezmény szerinti felügyeleti mechanizmus politikai pillére ajánlásokat fogad el a részes államok számára a GRETA következtetéseinek végrehajtásához meghozandó intézkedésekre vonatkozóan, és nyomon követi az előrehaladást.

7.2.3. Gyermekpornográfia és a gyermekek becserkészése (grooming)

Az uniós jogban a gyermekpornográfia kezelésének legfontosabb jogi eszköze a 2011/93/EU irányelv.[315] Fogalommeghatározása szerint pornográfia: „i. minden olyan anyag, amely vizuálisan ábrázolja a kifejezetten szexuális magatartást tanúsító vagy ilyen magatartást színlelő gyermeket; vagy ii. gyermek nemi szerveit mutatja be, elsődlegesen szexuális céllal; vagy iii. minden olyan anyag, amely vizuálisan ábrázolja a kifejezetten szexuális magatartást tanúsító vagy ilyen magatartást színlelő gyermeknek tűnő személyt, vagy amely gyermeknek tűnő személy nemi szerveit mutatja be, elsődlegesen szexuális céllal; vagy iv. kifejezetten szexuális magatartást tanúsító gyermek valósághű képei, vagy gyermek nemi szerveinek valósághű képei, elsődlegesen szexuális céllal."[316] Az irányelv 5. cikke kötelezi az uniós tagállamokat, hogy tegyenek meg minden szükséges intézkedést annak biztosítása érdekében, hogy a gyermekpornográfia szándékos készítése, megszerzése vagy birtoklása, megosztása, terjesztése vagy továbbítása, felajánlása, nyújtása vagy hozzáférhetővé tétele, továbbá az ilyen jellegű tartalomhoz való tudatos hozzáférés büntetendő legyen.

314 Belarusz például 2013. november 26-án csatlakozott az egyezményhez.

315 Az Európai Parlament és a Tanács 2011. december 13-i 2011/93/EU irányelve a gyermekek szexuális bántalmazása, szexuális kizsákmányolása és a gyermekpornográfia elleni küzdelemről, HL L 335/1., 2011., 1–14. o.

316 *Uo.*, a 2. cikk c) pontja.

Az ET joganyagában az EJEB többször vizsgált gyermekpornográfiával kapcsolatos ügyeket az EJEE 8. cikke alapján.

> Példa: A *Söderman kontra Svédország* ügyet egy lány kezdeményezte, akiről mostohaapja megkísérelt filmfelvételt készíteni, miközben zuhanyzott.[317] A lány állítása szerint a svéd jogszabályi keretrendszer nem védi megfelelően a magánéletét. Az EJEB megállapította, hogy az államnak pozitív kötelezettsége olyan jogszabályi keretrendszert kialakítani, amely megfelelő védelmet nyújt a kérelmezőhöz hasonló sértettek számára. Mivel az ügy tárgya csak a kérelmező lefilmezésére irányuló kísérlet, az EJEB úgy ítélte meg, hogy a vonatkozó jogszabályi keretnek nem feltétlenül kell büntetőjogi szankciókat tartalmaznia. A sértett számára biztosított – akár polgári jogi, akár büntetőjogi – jogorvoslatnak hatékonynak kell lennie. Az ügy tényállását tekintve az EJEB megállapította, hogy a kérelmező nem részesült hatékony polgári jogi vagy büntetőjogi jogorvoslatban a róla filmfelvételt készíteni megkísérlő mostohaapjával szemben, ami által sérült az EJEE 8. cikke.

Az ET számítástechnikai (cyber crime) bűnözésről szóló egyezményének[318] 9. cikke előírja a részes államok számára, hogy tegyék büntetendővé a gyermekpornográfia számítástechnikai rendszer útján történő felajánlását, hozzáférhetővé tételét, továbbítását, forgalomba hozatalát, megszerzését vagy birtoklását, illetve az ilyen tartalmak számítástechnikai rendszer útján történő létrehozását. Fontos követelmény, hogy e cselekményt szándékosan kell elkövetni. Az egyezményhez fűzött magyarázó jelentés kimondja, hogy a „pornográf anyag" fogalma az „obszcénnek, közerkölcsbe ütközőnek vagy hasonlóan erkölcstelennek" minősülő anyagokra vonatkozó nemzeti előírások függvénye.[319] Ez a büntetendővé tételre vonatkozó kötelezettség ugyanakkor nemcsak azon anyagokra alkalmazandó, amelyek vizuálisan ábrázolnak egy gyermeket, hanem azokra is, amelyek gyermeknek tűnő személyt ábrázolnak vagy valósághű képeket mutatnak be egy kifejezetten szexuális magatartást tanúsító gyermekről.[320]

317 EJEB, *Söderman kontra Svédország* [Nagykamara] (5786/08), 2013. november 12.

318 Európa Tanács, Egyezmény a számítástechnikai (cyber crime) bűnözésről, CETS 185., 2001.

319 Magyarázó jelentés az Európa Tanács számítástechnikai (cyber crime) bűnözésről szóló egyezményéhez, 99. pont.

320 Európa Tanács, Egyezmény a számítástechnikai (cyber crime) bűnözésről, CETS 185., 2001, a 9. cikk (2) bekezdése.

Ezenkívül a Lanzarote-i Egyezmény 21–23. cikke szerint az államoknak jogalkotási intézkedéseket kell hozniuk a gyermekpornográfia különböző formáinak büntetendővé tétele érdekében. A 21. cikk értelmében büntetendővé kell tenni a gyermekpornográfiához való toborzást, az arra való kényszerítést és az abban való részvételt. A 22. cikk értelmében szintén büntetendővé kell tenni annak elősegítését, hogy gyermekek szexuális (erőszak-)cselekmények tanúivá váljanak. Végezetül a 23. cikk előírja, hogy büntetőjogi jogszabályokat kell hozni a gyermekek információs és kommunikációs technológiák segítségével történő, szexuális célú megszólítására vonatkozóan. A Lanzarote-i Bizottság véleményt fogadott el erről a rendelkezésről, amelyben felkéri az egyezmény részes államait, hogy mérlegeljék a gyermekek olyan esetekre is kiterjedő büntetését, amelyekben a szexuális bántalmazás nem személyes találkozás következménye, hanem online történik.[321]

7.3. Sérülékeny (különösen védendő) csoportok

Kiemelt pontok

- Az erőszakos eltűnés (amely a nemzetközi jogban mint „erőszakos eltüntetés” ismert) gyermekáldozatainak joguk van ahhoz, hogy megőrizzék vagy újra létrehozzák személyazonosságukat, identitásukat.

7.3.1. Kisebbségekhez tartozó gyermekek

Az Európa Tanács joganyagában meglehetősen ritkák a kifejezetten a kisebbségi gyermekek elleni erőszakkal foglalkozó – az emberkereskedelemmel és a kényszermunkával nem összefüggő – ügyek. Ezek főként iskolai szegregációval és diszkriminációval kapcsolatosak, amit a 3.2. szakasz elemez.

Példa: A *Valentin Câmpeanu részéről eljáró Centre for Legal Resources kontra Románia* ügyben egy civil szervezet nyújtott be keresetet egy fiatal roma, HIV-pozitív és súlyos értelmi fogyatékos fiú nevében, aki egy állami intézetben

321 A Lanzarote-i Bizottság véleménye a Lanzarote-i Egyezmény 23. cikkéről, magyarázó feljegyzéssel, 2015. június 17.

halt meg.[322]. Az intézetben, ahol élt, gyalázatos körülmények uralkodtak: nem volt fűtés, nem voltak ágyneműk és ruhák, nem kapott támogatást a személyzettől stb. Mivel az áldozatnak nem voltak közeli rokonai, a nevében egy civil szervezet nyújtott be panaszt az EJEE 2., 3., 5., 8., 13. és 14. cikkében megállapított jogok megsértése miatt. A Nagykamara úgy döntött, hogy az ügy kivételes körülményeire (a fiatal roma rendkívüli kiszolgáltatottságára és ismert hozzátartozóinak hiányára) tekintettel a nem kormányzati szervezetnek jogában áll, hogy képviselje az elhunyt kérelmezőt. Az EJEB az ügy érdemi részét illetően megállapította a 2. cikk érdemi szempontjainak megsértését. Megállapítást nyert, hogy a belföldi hatóságok felelősek Valentin Câmpeanu haláláért, mert egy olyan intézetben helyezték el, ahol a megfelelő élelmezés, az elhelyezési körülmények és orvosi ellátás hiánya miatt halt meg. Az EJEB megállapította a 2. cikk megsértését is, mert a román hatóságok nem folytattak eredményes vizsgálatot Valentin Câmpeanu halálával kapcsolatban.

Ami az intézetekben élő gyermekeket illeti, az Európa Tanács Rec(2005)5 ajánlása támogatja azt a döntést, hogy a gyermekek elhelyezése nem alapulhat hátrányos megkülönböztetésen.[323]

7.3.2. Fogyatékossággal élő gyermekek

Ami az **uniós jogot** illeti, az EU aláírta a Fogyatékossággal élő személyek jogairól szóló egyezményt, amely az első olyan nemzetközi szerződés az emberi jogok területén, amelyhez az EU is csatlakozott.[324] A Fogyatékossággal élő személyek jogairól szóló egyezmény a gyermekekkel kapcsolatban külön rendelkezéseket tartalmaz. Az uniós tagállamok és az EU vállalták, hogy biztosítják a fogyatékossággal élő gyermekek számára, hogy más gyermekekkel egyenlő módon gyakorolhassák emberi jogaikat. A Fogyatékossággal élő személyek jogairól szóló egyezmény 16. cikke alapján konkrét intézkedéseket kell hozniuk, hogy megvédjék a fogyatékossággal élő gyermekeket a visszaéléssel és a kizsákmányolással szemben.[325]

322 EJEB, *Valentin Câmpeanu részéről eljáró Centre for Legal Resources kontra Románia* [Nagykamara] (47848/08), 2014. július 17.

323 Európa Tanács, Miniszteri Bizottság (2005), Rec(2005)5 ajánlás a bentlakásos intézetekben élő gyermekek jogairól, 2005. március 16.

324 Az Európai Unió Tanácsa (2009), a Tanács 2009. november 26-i 2010/48/EK határozata a fogyatékossággal élő személyek jogairól szóló ENSZ-egyezménynek az Európai Közösség általi megkötéséről, HL L 23., 2010.1.27., 35. o.

325 Lásd még: 3.5. szakasz.

Az Európa Tanács joganyagában a fogyatékossággal élő gyermekekkel kapcsolatos EJEB-ügyek különféle kérdéseket vetettek fel: foglalkoztak a beleegyezéssel, az államok halállal és rossz bánásmóddal szembeni védelem biztosítására vonatkozó pozitív kötelezettségeivel és az állami működtetésű létesítményekben fennálló életkörülményekkel.

Példa: A *Nencheva és társai kontra Bulgária* ügy[326] 15 gyermek és fiatal felnőtt halálával foglalkozik, amely egy szellemi és testi fogyatékossággokkal élő személyek elhelyezésére szolgáló otthonban következett be. Az EJEB megállapította, hogy a gyermekeket egy olyan szakosított állami ellátó intézményben helyezték el, amely kizárólag állami ellenőrzés alatt állt. A gyermekek gyalázatos körülmények között éltek az intézetben: nem kaptak elegendő élelmet, gyógyszert, ruhát, és nem volt fűtés. Az illetékes hatóságokat többször figyelmeztették erre a helyzetre, következésképpen tisztában voltak azzal, illetve tisztában kellett volna lenniük azzal, hogy fennáll a halálesetek veszélye. Az EJEB megállapította az EJEE 2. cikke érdemi szempontjainak megsértését, mivel a hatóságok nem hoztak intézkedéseket, hogy megvédjék a felügyeletük alá helyezett gyermekek életét. Továbbá, a bolgár hatóságok nem folytattak tényleges vizsgálatot a kérelmezők gyermekeinek halálával kapcsolatban. Az ügy konkrét körülményeire tekintettel a bolgár hatóságoknak hivatalból bűnügyi nyomozást kellett volna indítaniuk. Az általuk végzett vizsgálatot több okból nyilvánították eredménytelennek: a gyermekek halála után kér évvel indult, ésszerűtlenül elhúzódott, nem terjedt ki az összes gyermek halálára, és nem tisztázta az üggyel kapcsolatos összes lényeges tényezőt.

7.4. Eltűnt gyermekek

Az uniós jog alapján az Európai Bizottság inysegélyvonalat hozott létre az eltűnt gyermekek felkutatására (116000).[327] Ez a szolgálat eltűnt gyermekek bejelentésére vonatkozó hívásokat fogad, és ezeket a bejelentéseket továbbítja a rendőri hatóságoknak, útmutatást és támogatást nyújt az eltűnt gyermekért felelős személyeknek, és segíti a nyomozást.

326 EJEB, *Nencheva és társai kontra Bulgária* (48609/06), 2013. június 18. (elérhető francia nyelven).

327 Bizottsági határozat (2007), a Bizottság 2007. október 29-i 2007/698/EK határozata a 2007/116/EK határozatnak a további, 116-tal kezdődő, fenntartott hívószámok bevezetése tekintetében történő módosításáról, HL L 284., 2007.10.30., 31. o.

Az Európa Tanács joganyagában a gyermekek erőszakos eltüntetésével az EJEE 8. cikke alapján foglalkoznak.

> Példa: A *Zorica Jovanović kontra Szerbia* ügyben[328] egy újszülött állítólag röviddel a születése után meghalt a kórházban, de a holttestét soha nem adták át a szülőknek. Az anya azt kifogásolja, hogy az állam semmilyen tájékoztatást nem adott neki fia sorsáról, ezen belül állítólagos halálának okáról, valamint temetésének időpontjáról és helyéről. Az EJEB megállapította, hogy az állam azáltal, hogy „folyamatosan elmulasztotta hiteles információkkal ellátni [az anyát] fiának sorsával kapcsolatban", megsértette a családi élet tiszteletben tartásához való jogát.[329]

Ami a nemzetközi jogot illeti, a Minden egyénnek az erőszakos eltüntetéssel szembeni védelméről szóló nemzetközi egyezmény[330] 25. cikke (1) bekezdésének b) pontja kimondja, hogy az államoknak meg kell akadályozniuk és büntetniük kell az olyan gyermekek „valós személyazonosságát igazoló dokumentumok meghamisítását, eltitkolását vagy megsemmisítését", akik maguk vagy akiknek a szülei erőszakos eltüntetés áldozatává válnak. Az államoknak meg kell hozniuk az ahhoz szükséges intézkedéseket is, hogy felkutassák és azonosítsák ezeket a gyermekeket, és visszajuttassák őket családjukhoz. Tekintettel e gyermekek azon – a jog által elismert – jogára, hogy megőrizzék vagy újra létrehozzák személyazonosságukat, ezen belül állampolgárságukat, nevüket és családi kapcsolataikat, az államoknak jogi eljárásokkal kell rendelkezniük az erőszakos eltüntetés áldozatává váló gyermekek esetleges örökbefogadásának vagy elhelyezésének felülvizsgálata és megsemmisítése céljából (25. cikk (4) bekezdés). Az egyezmény a gyermekek jogait alátámasztó általános elvek közül kettőt ismétel meg: ezek a gyermek legfőbb (mindenek felett álló) érdeke mint elsődleges megfontolás és a gyermek véleménynyilvánításhoz való joga (a 25. cikk (5) bekezdése). Noha ezt az egyezményt viszonylag kis számú európai állam ratifikálta, nem szabad figyelmen kívül hagyni a jelentőségét az európai normatív keret szempontjából.[331]

328 EJEB, *Zorica Jovanović kontra Szerbia* (21794/08), 2013. március 26.

329 *Uo.*, 74. bek.

330 ENSZ, Nemzetközi egyezmény minden személy erőszakos eltűnéssel szembeni védelméről, 2006. december 20.

331 2015. február 19-ig a 28 uniós tagállamból kilenc ratifikálta az egyezményt (Ausztria, Belgium, Spanyolország, Franciaország, Németország, Litvánia, Hollandia, Portugália és Szlovákia). Ezen túlmenően az Európa Tanács következő tagállamai ratifikálták az egyezményt: Szerbia, Montenegró, Bosznia és Hercegovina, Örményország és Albánia.

8

Gazdasági, szociális és kulturális jogok, valamint a megfelelő életszínvonalhoz való jog

EU	Tárgyalt kérdések	ET
Alapjogi Charta, 14. cikk (oktatás) Az elismerésről szóló irányelv (2011/95/EU) EUB, C-413/99. sz. ügy, *Baumbast és R. kontra Secretary of State for the Home Department*, 2002 (migráns gyermekek oktatása)	**Az oktatáshoz való jog**	EJEE, az 1. Kiegészítő Jegyzőkönyv 2. cikke (oktatáshoz való jog) (Módosított) Európai Szociális Karta, 17. cikk (oktatáshoz való jog) EJEB, *Catan és társai kontra Moldova és Oroszország* [Nagykamara] (43370/04, 8252/05 és 18454/06), 2012 (nyelv az iskolákban) EJEB, *D.H. és társai kontra Cseh Köztársaság* [Nagykamara], (57325/00), 2007; EJEB, *Oršuš és társai kontra Horvátország* [Nagykamara], (15766/03), 2010 (a roma gyermekekkel szembeni iskolai hátrányos megkülönböztetés) EJEB, *Ponomaryovi kontra Bulgária*, (5335/05), 2011 (menekültügyi státuszon alapuló hátrányos megkülönböztetés) A nemzeti kisebbségek védelmét szolgáló európai keretegyezmény, a 12. cikk (3) bekezdése és a 14. cikk A migráns munkavállalók jogállásáról szóló európai egyezmény

EU	Tárgyalt kérdések	ET
Alapjogi Charta, 35. cikk (egészségügyi ellátáshoz való hozzáférés) Az elismerésről szóló irányelv (2011/95/EU), 29. cikk (a migráns gyermekeknek járó alapellátások)	**Az egészséghez való jog**	(Módosított) Európai Szociális Karta, 11. cikk (az egészség védelméhez való jog) és 13. cikk (a szociális és egészségügyi segítségre való jog) EJEE, 2. cikk (élethez való jog) és 8. cikk (testi épséghez való jog) EJEB, *Oyal kontra Törökország* (4864/05), 2010 (újszülött HIV-fertőzése) EJEB, *Iliya Petrov kontra Bulgária* (19202/03), 2012 (sérülés egy villamos alállomáson) EJEB, *Valentin Câmpeanu részéről eljáró Centre for Legal Resources kontra Románia* [Nagykamara] (47848/08), 2014 (egy intézetben bekövetkezett haláleset) EJEB, *Glass kontra Egyesült Királyság* (62617/00), 2004 (beleegyező nyilatkozat) EJEB, *M.A.K. és R.K. kontra Egyesült Királyság* (45901/05 és 40146/06), 2010 (szülői beleegyezés nélkül elvégzett vizsgálat) Szociális jogok Európai Bizottsága, *International Federation of Human Rights Leagues (FIDH) kontra Franciaország*, 14/2003. sz. panasz, 2004 (orvosi ellátás migráns gyermekek számára). Szociális Jogok Európai Bizottsága, *Defence for Children International (DCI) kontra Belgium*, 69/2011. sz. panasz, 2012 (rendezetlen helyzetű gyermekek) Egyezmény az emberi jogokról és a biomedicináról (Oviedói Egyezmény), 6 és 8. cikk
Az EU Alapjogi Chartája, 34. cikk (3) bekezdés (szociális támogatáshoz és lakástámogatáshoz való jog)	**Lakhatáshoz való jog**	(Módosított) Európai Szociális Karta, 16. cikk (a család joga a szociális, jogi és gazdasági védelemhez), 17. cikk (a gyermekek és fiatalok szociális, jogi és gazdasági védelemhez való joga) és 31. cikk (a lakhatáshoz való jog). EJEB, *Bah kontra Egyesült Királyság* (56328/07), 2011 EJEB, *Connors kontra Egyesült Királyság* (66746/01), 2004

EU	Tárgyalt kérdések	ET
Az EU Alapjogi Chartájának 34. cikke (szociális biztonság és szociális segítségnyújtás)	**A megfelelő életszínvonalhoz való jog és a szociális biztonsághoz való jog**	(Módosított) Európai Szociális Karta, 12–14. cikk (a társadalombiztosításhoz való jog, a szociális és egészségügyi segítségre való jog és a szociális jóléti szolgáltatásokból való részesülés joga), 16. cikk (a család joga a szociális, jogi és gazdasági védelemhez) és 30. cikk (a szegénység és a társadalmi kirekesztés elleni védelemhez való jog) Szociális Jogok Európai Bizottsága, *European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) kontra Franciaország*, 82/2012. sz. panasz, 2013 (családtámogatások felfüggesztése iskolakerülés miatt) EJEB, *Konstantin Markin kontra Oroszország* [Nagykamara](30078/06), 2012 (szülői szabadság)

A gazdasági, szociális és kulturális jogok, amelyeket európai összefüggésben gyakrabban említenek a szociális-gazdasági jogokként vagy szociális jogokként, a munkával kapcsolatos jogokat, valamint az oktatáshoz, az egészséghez, a lakhatáshoz, a szociális biztonsághoz és általánosabban a megfelelő életszínvonalhoz való jogot foglalják magukban. A kulturális jogok a tudomány és a peres eljárások területén egyelőre kevéssé szabályozottak. E jogok egyes szempontjaival a kisebbséghez tartozó gyermekek identitásáról szóló 4.6. szakasz, illetve az oktatáshoz való jog keretében a 8.2. szakasz foglalkozik.

Európai összefüggésben a gazdasági, szociális és kulturális jogok tekintetében explicit normák főként az Európai Szociális Kartában és az EU Alapjogi Chartájában találhatók, noha az EJEE és jegyzőkönyvei szintén tartalmaznak több idevágó rendelkezést, mint amilyen például a kényszermunka tilalma és az oktatáshoz való jog. Ezenfelül az EJEB amellett érvelt, hogy „nincs olyan átjárhatatlan választóvonal, amely elválasztaná a [szociális és gazdasági jogok területét] az egyezmény által lefedett területtől”[332], és az EJEE által garantált polgári jogok közé tartozó jogként értelmezi a gazdasági, szociális és kulturális jogokat. Ily módon például az egészségügyi ellátáshoz való hozzáféréssel a kínzás, embertelen vagy megalázó bánásmód vagy büntetés tilalmának keretében foglalkoznak (az EJEE 3. cikke).[333]

Ez a fejezet a gyermekek szempontjából különösen fontos gazdasági, szociális és kulturális jogokat elemzi: az oktatáshoz való jogot (8.2. szakasz); az egészséghez

332 EJEB, *Airey kontra Írország* (6289/73), 1979. október 9., 26. bek.

333 Lásd például az EJEB bebörtönzöttek egészséggel kapcsolatos jogairól szóló 2015. februári tájékoztatóját *(Factsheet on Prisoners' health-related rights)* és az egészségről szóló 2015. áprilisi tájékoztatóját *(Factsheet on Health)*.

való jogot (8.3. szakasz); a lakhatáshoz való jogot (8.4. szakasz); és a megfelelő életszínvonalhoz és szociális biztonsághoz való jogot (8.5. szakasz).

8.1. A gazdasági, szociális és kulturális jogok megközelítései

Kiemelt pontok

- A szociális jogok védelmének biztosításához kulcsfontosságú a megfelelő erőforrások rendelkezésre állásának biztosítása.
- A szociális jogok alapvető elemei a rendelkezésre állás, a hozzáférhetőség, az adaptálhatóság és az elfogadhatóság.

Ami az uniós jogot illeti, az Európai Unió Alapjogi Chartájában a polgári és politikai jogokkal azonos szinten szerepelnek a gazdasági, szociális és kulturális jogok. A Charta 52. cikke azonban különbséget tesz jogok és elvek között, amely utóbbiak „bíróság előtti elfogadhatóságukat" tekintve korlátozottak.

Az Európa Tanács égisze alatt a Szociális Jogok Európai Bizottsága megállapította, hogy amennyiben valamely jog megvalósítása „kivételesen összetett és különösen költségesen oldható meg", a fokozatos megvalósítást értékeli, három kritérium alapján: „intézkedéseket kell tenni, hogy ésszerű időn belül elérjék az Európai Szociális Karta célkitűzéseit, mérhető előrehaladás mellett, a rendelkezésre álló erőforrások maximális kihasználásával összhangban álló mértékben".[334] Priorizálást is bevezetett, minthogy emlékeztette az államokat, hogy „választásaik milyen hatással lesznek a kiemelten kiszolgáltatott csoportokra és más érintett személyekre nézve".[335]

A Szociális Jogok Európai Bizottsága, jóllehet a szociális biztonsághoz való joggal konkrét összefüggésben, amellett érvel, hogy „a meglévő szociális biztonsági rendszer fenntartásának és fenntarthatóságának biztosítása érdekében" megengedhetők

334 Szociális Jogok Európai Bizottsága, *International Association Autism Europe (IAAE) kontra Franciaország*, 13/2002. sz. panasz, 2003. november 4., 53. bek.; alkalmazták: Szociális Jogok Európai Bizottsága, *European Action of the Disabled (AEH) kontra Franciaország*, 81/2012. sz. panasz, 2013. szeptember 11., 94–99. bek.

335 Szociális Jogok Európai Bizottsága, *International Association Autism Europe (IAAE) kontra Franciaország*, 13/2002. sz. panasz, 2003. november 4., 53. bek.

a visszalépések, feltéve hogy nem „ássák alá a nemzeti szociális biztonsági rendszer alapvető keretét, vagy nem fosztanak meg egyéneket a súlyos szociális és gazdasági kockázat elleni védelem igénybevételének lehetőségétől”.[336] Az EJEB szintén elfogadja a visszalépések lehetőségét, de megvizsgálja, hogy a választott módszer ésszerű-e és alkalmas-e az elérni kívánt jogos cél elérésére.[337]

A Szociális Jogok Európai Bizottsága az oktatáshoz való joggal összefüggésben a rendelkezésre állás, hozzáférhetőség, elfogadhatóság és adaptálhatóság elemzési keretét vezette be, összhangban az ENSZ gazdasági, szociális és kulturális jogokkal foglalkozó bizottságának megközelítésével.[338] A rendelkezésre állás és a hozzáférhetőség közötti különbségtétel az EJEB ítélkezési gyakorlatában is megjelenik. A következő elemzést a rendelkezésre állás, hozzáférhetőség, elfogadhatóság és adaptálhatóság kritériumai vagy alapvető elemei vezérlik, amennyiben rendelkezésre áll idevágó ítélkezési gyakorlat.

8.2. Az oktatáshoz való jog

Kiemelt pontok

- Az oktatás hozzáférhetőségét korlátozó intézkedéseknek indokoltnak és előre láthatónak kell lenniük, törvényes és legitim célt kell szem előtt tartaniuk és nem lehetnek diszkriminatívak.
- Az elfogadható oktatás megköveteli a szülők vallási és világnézeti meggyőződéseinek a tiszteletben tartását is, de nem zárja ki, hogy az iskolákban vallási nevelés és szexuális edukáció folyjon.
- Az adaptálhatóság külön intézkedéseket tesz szükségessé a fogyatékossággal élő gyermekek érdekében, valamint megköveteli, hogy a kisebbséghez tartozó gyermekek lehetőséget kapjanak arra, hogy saját nyelvükön részesüljenek oktatásban.
- A gyermekeket állampolgárságuktól és menekültügyi jogállásuktól függetlenül megilleti az oktatáshoz való jog.

336 Szociális jogok Európai Bizottsága, *General Federation of Employees of the National Electric Power Corporation (GENOP-DEI) és Confederation of Greek Civil Servants' Trade Unions (ADEDY) kontra Görögország*, 66/2011. sz. panasz, 2012. május 23., 47. bek.

337 EJEB, *Markovics és társai kontra Magyarország*, elfogadhatatlansági határozat, (77575/11, 19828/13 és 19829/13), 2014. június 24., 37. és 39. bek.

338 Szociális Jogok Európai Bizottsága, *Mental Disability Advocacy Center (MDAC) kontra Bulgária*, 41/2007. sz. panasz, 2008. június 3., 37. bek.

Az uniós jogban az EU Alapjogi Chartája 14. cikkének (2) bekezdése garantálja az oktatáshoz való jogot, amely magában foglalja „a kötelező oktatásban való ingyenes részvétel lehetőségét". A 14. cikk (3) bekezdése biztosítja az oktatási intézmények demokratikus elvek figyelembevételével történő alapításának szabadságát, valamint a szülők azon jogát, hogy gyermekeik számára vallási, világnézeti vagy pedagógiai meggyőződésüknek megfelelő nevelést biztosítsanak.

Az Európa Tanács szerint, az EJEE 1. Kiegészítő Jegyzőkönyvének 2. cikke garantálja az oktatáshoz való jogot. Az EJEB tisztázza, hogy ez a cikk nem kötelezi az államokat arra, hogy elérhetővé tegyék az oktatást, hanem „a bármely adott időpontban létező oktatási intézményekhez való hozzáférés jogát" határozza meg.[339] Ezen túlmenően az oktatáshoz való jog úgyszintén magában foglalja „annak a lehetőségét, hogy hasznosítani tudják az oktatás során tanultakat, azaz hogy az elvégzett [...] tanulmányokról ilyen vagy olyan formában hivatalos elismerést kapjanak, összhangban az egyes államokban érvényben lévő szabályokkal".[340] Ez azonban nem korlátlan jog; az érintettek tekintetében korlátozásoknak kell meghatározhatónak lenniük, amelyeknek törvényes és legitim célt kell szolgálniuk. Megengedettek a fegyelmi intézkedések, ideértve a felfüggesztést és az oktatási intézményből való kizárást, feltéve hogy megfelelnek a megengedhető korlátozások feltételeinek. Annak értékelése érdekében, hogy az oktatásból való kizárás e formái az oktatáshoz való jog megtagadását eredményezik-e, olyan tényezőket vesznek figyelembe, mint az eljárási garanciák, a kizárás időtartama, az újbóli beilleszkedés érdekében tett erőfeszítések és a nyújtott alternatív oktatás megfelelősége.[341]

Példa: A *Catan és társai kontra Moldova és Oroszország* ügyben[342] az EJEB a Dnyeszteren túli terület szeparatista hatóságai által az iskolákban bevezetett nyelvi politikát vizsgálta. E nyelvpolitika célja az oroszosítás volt. A moldáv nyelvű (latin betűs írást használó) iskolák erőszakos bezárását követően a szülőknek arról kellett dönteniük, hogy olyan iskolába küldik gyermekeiket, ahol a nyelv és a cirill ábécé mesterséges kombinációjában tanítják őket, a szovjet időkben előállított tananyagból, vagy rosszabbul felszerelt és kevésbé jól megközelíthető helyen lévő iskolába küldik őket, amelyek

339 EJEB, *„Relating to certain aspects of the laws on the use of languages in education in Belgium" kontra Belgium* (1474/62, 1677/62, 1691/62, 1769/63, 1994/63 és 2126/64), 1968. július 23., 4. bek.

340 *Uo.*

341 EJEB, *Ali kontra Egyesült Királyság* (40385/06), 2011. január 11., 58. bek.

342 EJEB, *Catan és társai kontra Moldova és Oroszország* [Nagykamara] (43370/04, 8252/05 és 18454/06), 2012. október 19.

megközelítésekor zaklatásnak és megfélemlítésnek lesznek kitéve. Az iskolák erőszakos bezárását és a későbbi zaklatást a bíróság a gyermekek oktatáshoz való jogába való indokolatlan beavatkozásnak minősítette, amely sérti az EJEE 1. jegyzőkönyvének 2. cikkét.[343]

Az oktatáshoz való jog részeként a szülőknek joguk van vallási és világnézeti meggyőződéseik tiszteletben tartásához. „A tananyag meghatározása és megtervezése" azonban „elvben" az állam „hatásköre".[344] Vallási és világnézeti jellegű információ vagy ismeret is beépíthető az iskolai tananyagba, azzal a feltétellel, hogy azt „tárgyilagos, kritikus és pluralista módon" közvetítik.[345] A pluralizmus biztosítása érdekében a meghatározott vallás vagy világnézet tanításában fennálló mennyiségi és minőségi különbségeket egyensúlyba kell hozni oly módon, hogy felajánlják a szülőknek annak a lehetőségét, hogy részben vagy teljes mértékben felmentsék gyermekeiket az ilyen tanítás alól, azaz lehetőséget adnak nekik arra, hogy ne vegyenek részt bizonyos órákon vagy egyáltalán ne vegyenek részt a vallás tantárgy oktatásában.[346] Azzal kapcsolatban, hogy az EJEB hogyan kezeli ezt a kérdést a hátrányos megkülönböztetés tilalma szempontjából, lásd a 2.1. szakaszban.[347]

A módosított Európai Szociális Karta 17. cikkének (2) bekezdése szerint az államok vállalják, hogy „megteszik az összes megfelelő és szükséges intézkedést, melynek célja [...] biztosítani a gyermekek és fiatalok ingyenes elemi és középfokú iskoláztatását, valamint azt, hogy rendszeresen járjanak iskolába".[348] A Szociális Jogok Európai Bizottsága ezen túlmenően megállapította, hogy a szerződő államoknak e rendelkezés alapján biztosítaniuk kell, hogy menekültügyi jogállásuktól függetlenül a területükön tartózkodó gyermekeknek ugyancsak biztosítsák az oktatáshoz való hozzáférést.[349]

Ezenfelül az oktatási intézményeknek hátrányos megkülönböztetés nélkül mindenki számára hozzáférhetőnek kell lenniük.[350] A Szociális Jogok Európai Bizottsága leszögezte, hogy „a fogyatékossággal élő gyermekek többségi iskolába való

343 *Uo.*, 141–144. bek.

344 EJEB, *Folgerø és társai kontra Norvégia* [Nagykamara] (15472/02), 2007. június 29., 84. bek.

345 *Uo.*, 84. bek.

346 *Uo.*, 85–102. bek. és eltérő vélemény.

347 EJEB, *Grzelak kontra Lengyelország* (7710/02), 2010. június 15.

348 Az 1961. évi Európai Szociális Karta nem tartalmaz az oktatáshoz való jogra vonatkozó rendelkezést.

349 Szociális Jogok Európai Bizottsága, *Médecins du Monde – International kontra Franciaország*, 67/2011. sz. panasz, 2012. szeptember 11.

350 A fogyatékossággal élő gyermekek kérdését illetően lásd még a 3. fejezetet és a 7. fejezetet.

integrálásának kell a normát jelentenie, és a speciális iskolákban való tanításuknak kivételt kell képeznie".[351] Az államoknak nincs széles mérlegelési jogkörük a fogyatékossággal élő személyek rendelkezésére álló iskolák típusát illetően; ennek többségi iskolának kell lennie.[352]

Az oktatásban alkalmazott – például állampolgárságon, migrációs jogálláson vagy etnikai származáson alapuló – eltérő bánásmóddal kapcsolatos helyzetekkel a 3. fejezet foglalkozik.

A Szociális Jogok Európai Bizottságának ítélkezési gyakorlata alapján a szexuális és reproduktív egészség oktatásának a rendes tananyag részét kell képeznie.[353] Miközben az államok széles mérlegelési jogkört élveznek a használt oktatási anyag kulturális megfelelőségének eldöntése terén, biztosítaniuk kell a nem diszkriminatív szexuális és reproduktív egészségügyi oktatást, amely „nem tartósítja vagy erősíti meg a társadalmi kirekesztést és az emberi méltóság megtagadását". Az oktatási anyagok nem „erősíthetik meg a lealacsonyító sztereotípiákat", például a nem heteroszexuális irányultságú személyeket illetően.[354]

Végezetül az oktatás adaptálhatósága megköveteli például, hogy azon fogyatékossággal élő gyermekek számára, akiket többségi iskolába integráltak, „intézkedéseket hozzanak különleges szükségleteik kielégítése céljából"[355] (lásd még: 3.5. szakasz).

Ezen túlmenően a nemzeti kisebbségek védelmét szolgáló európai keretegyezmény 12. cikkének (3) bekezdése alapján a részes államok vállalják, hogy előmozdítják a nemzeti kisebbségekhez tartozó személyek számára az oktatáshoz minden szinten a hozzájutás esélyegyenlőségét (lásd még:3. fejezet).[356] A nemzeti

351 Szociális Jogok Európai Bizottsága, *Mental Disability Advocacy Center (MDAC) kontra Bulgária*, 41/2007. sz. panasz, 2008. június 3., 35. bek.

352 Szociális Jogok Európai Bizottsága, *European Action of the Disabled (AEH) kontra Franciaország*, 81/2012. sz. panasz, 2013. szeptember 11., 78. bek.

353 Szociális Jogok Európai Bizottsága, *International Centre for the Legal Protection of Human Rights (INTERIGHTS) kontra Horvátország*, 45/2007. sz. panasz, 2009. március 30., 47. bek.

354 *Uo.*, 59. és 61. bek.

355 Szociális Jogok Európai Bizottsága, *Mental Disability Advocacy Center (MDAC) kontra Bulgária*, 41/2007. sz. panasz, 2008. június 3., 35. bek.

356 Lásd továbbá: Európa Tanács, a nemzeti kisebbségek védelmét szolgáló európai keretegyezmény tanácsadó bizottsága, Észrevételek az oktatással kapcsolatban a nemzeti kisebbségek védelmét szolgáló európai keretegyezmény alapján *(Commentary on Education under the Framework Convention for the Protection of National Minorities)*, 2006, ACFC/25DOC(2006)002, 2.1. rész.

kisebbségekhez tartozó gyermekek esetében a nemzeti kisebbségek védelmét szolgáló európai keretegyezmény 14. cikke magában foglalja azt a jogot, hogy saját nyelvüket megtanulhassák vagy ezen a nyelven tanulhassanak.[357] Az EJEB megerősítette, hogy az oktatáshoz való jog magában foglalja annak a jogát, hogy a nemzeti nyelven (a nemzeti nyelvek egyikén) részesülhessenek oktatásban.[358]

8.2.1. A migráns gyermekek oktatáshoz való joga

Az uniós jogban a gyermekek oktatáshoz való alapvető –menekültügyi státuszuktól független – jogát lényegében az uniós migrációs jog minden vonatkozásában elismerik.[359] Az EU mindazonáltal nem rendelkezik olyan hatáskörrel, amelynek keretében meghatározhatná a nemzeti oktatásügyi rendelkezések tartalmát vagy hatályát. Az EU ehelyett a migráns gyermekek oktatáshoz való hozzáférésének az állampolgárokkal azonos vagy – jogállásuktól függően – hasonló jogát védi. A diákokról szóló 2004/114/EK irányelv[360] a harmadik országok állampolgárai tanulmányok folytatása, diákcsere, javadalmazás nélküli gyakorlat, illetve önkéntes szolgálat céljából történő beutazásának feltételeit szabályozza. Ez a beutazás a harmadik országbeli állampolgár belépését és három hónapot meghaladó időn át tartó tartózkodását öleli fel. A gyermekek beutazásának általános feltételei az érvényes útiokmány, a tervezett tartózkodásra vonatkozó szülői engedély bemutatását, az egészségbiztosítást és – ha a tagállam kéri – a beutazási kérelem eljárási díjának befizetését foglalják magukban.[361] A tanulóknak például igazolniuk kell, hogy a tagállam által elismert szervezet által működtetett

357 Ha további pontosításra van szüksége, lásd: Európa Tanács, a nemzeti kisebbségek védelmét szolgáló európai keretegyezmény tanácsadó bizottsága, Észrevételek az oktatással kapcsolatban a nemzeti kisebbségek védelmét szolgáló európai keretegyezmény alapján, 2006, ACFC/25DOC(2006)002, 2.3. rész és 3. tematikus észrevétel: A nemzeti kisebbségekhez tartozó személyek nyelvi jogai a keretegyezmény alapján *(The language rights of persons belonging to national minorities under the Framework Convention)*, 2012, ACFC/44DOC(2012)001 rev, VI. rész, Nyelvi jogok és oktatás.

358 EJEB, *Catan és társai kontra Moldova és Oroszország* [Nagykamara] (43370/04, 8252/05 és 18454/06), 2012. október 19., 137. bek.

359 Pl. A harmadik országbeli állampolgárok és hontalan személyek nemzetközi védelemre jogosultként való elismerésére, az egységes menekült- vagy kiegészítő védelmet biztosító jogállásra, valamint a nyújtott védelem tartalmára vonatkozó szabályokról (átdolgozás) szóló, 2011. december 13-i 2011/95/EU európai parlamenti és tanácsi irányelv (HL L 337., 2011.12.20., 9–26. o.) 27. cikke.

360 A Tanács 2004/114/EK irányelve a harmadik országok állampolgárai tanulmányok folytatása, diákcsere, javadalmazás nélküli gyakorlat, illetve önkéntes szolgálat céljából történő beutazásának feltételeiről (a diákokról szóló irányelv).

361 *Uo.*, 6. cikk.

diákcsere-programban vesznek részt.[362] A javadalmazásban nem részesülő gyakornokoknak a tagállam által kért módon igazolniuk kell, hogy tartózkodásuk folyamán rendelkezni fognak a megélhetésük, képzésük és visszautazásuk költségeihez szükséges anyagi fedezettel.[363] A jövedelemszerző tevékenység – ezen belül a foglalkoztatás – felsőoktatásban részt vevő hallgatók általi folytatásának lehetősége korlátozott.[364]

Azoknak az Unión belüli migránsoknak a gyermekei, akik a szabad mozgáshoz való jog alapján egy másik uniós tagállamba költöznek, ezzel összefüggésben a legkedvezőbb jogosultságot élvezik, és az állam saját állampolgáraiéval azonos feltételekkel nyernek felvételt általános oktatási intézménybe, szakmunkás- és egyéb szakképzésre.[365] Ez magában foglalja az állami és magán, illetve a kötelező és nem kötelező oktatást. Az EUB e jogosultságot mindig tágan értelmezte, hogy biztosítsa az oktatáshoz való egyenlő hozzáférést, valamint a tágabb, oktatással összefüggő szociális ellátásokhoz és az oktatásban való részvételt segítő bármely ellátáshoz való hozzáférést is. A *Casagrande*-ügyben például egy migráns munkavállaló gyermeke hozzájuthatott egy rászorultságon alapuló oktatási támogatáshoz a szabad mozgáshoz való uniós jog alapján.[366]

Ezenfelül az 1970-es években bevezetett jogszabályok előírják a tagállamoknak, hogy kiegészítő nyelvoktatást biztosítsanak az uniós migráns munkavállalók gyermekeinek, mind a fogadó állam nyelvén, mind anyanyelvükön, azzal a céllal, hogy megkönnyítsék a fogadó államban és – amennyiben a későbbiekben hazatérnek – származási országukban való beilleszkedésüket.[367] Jóllehet ez úgy tűnik, hogy meglehetősen nagyvonalú és értékes kiegészítő támogatást kínál a gyermekek-

362 *Uo.*, 7. cikk.

363 *Uo.*, 10. cikk.

364 *Uo.*, 17. cikk.

365 Az Európai Parlament és a Tanács 2011. április 5-i 492/2011/EU rendelete a munkavállalók Unión belüli szabad mozgásáról (HL L 141., 2011.5.27., 1–12. o.), 10. cikk; valamint az Európai Parlament és a Tanács 2004. április 29-i 2004/38/EK irányelve az Unió polgárainak és családtagjaiknak a tagállamok területén történő szabad mozgáshoz és tartózkodáshoz való jogáról, valamint az 1612/68/EGK rendelet módosításáról, továbbá a 64/221/EGK, a 68/360/EGK, a 72/194/EGK, a 73/148/EGK, a 75/34/EGK, a 75/35/EGK, a 90/364/EGK, a 90/365/EGK és a 93/96/EGK irányelv hatályon kívül helyezéséről (HL L 158., 2004.4.30., 77–123. o.), 24. cikk (1) bekezdés.

366 EUB, C-9/74. sz. ügy, *Donato Casagrande kontra Landeshauptstadt München*, 1974. július 3. A későbbiekben ezt más ügyekben is megerősítették, pl.: EUB, C-3/90. sz. ügy, *M.J.E. Bernini kontra Minister van Onderwijs en Wetenschappen*, 1992. február 26.

367 A Tanács 1977. július 25-i 77/486/EGK irányelve a migráns munkavállalók gyermekeinek oktatásáról, HL L 199., 1977.8.6., 32–33. o. Felhívjuk a figyelmet arra, hogy a harmadik országbeli állampolgár migráns gyermekek nem tartoznak e jogi aktus hatálya alá.

nek, miután felvették őket a fogadó állam valamely iskolájába, a különböző országokbeli végrehajtása hírhedten ellentmondásos és a gyakorlatban egyre kevésbé megvalósítható, tekintve a figyelembe veendő különböző nyelvek körét.[368]

Példa: A *Baumbast és R kontra Secretary of State for the Home Department* ügyben[369] az a kérdésvetődött fel, hogy egy kolumbiai feleségével és lányaival az Egyesült Királyságba költöző német migráns munkavállaló két lánya folytathatja-e az Egyesült Királyságban az iskolát, miután az apa az Egyesült Királyságból egy nem uniós tagállamba távozott, hátrahagyva feleségét és lányait. Az EUB azzal a kérdéssel szembesült, hogy a migráns munkavállaló felesége és lányai függetlenül is a fogadó államban maradhatnak-e, annak ellenére, hogy Baumbast úr (akitől a család tartózkodása joga eredetileg származott) ténylegesen lemondott az uniós migráns munkavállalói jogállásáról. Az EUB számára az volt a döntő tényező, hogy a gyermekek beilleszkedtek a fogadó állam oktatási rendszerébe, és káros és aránytalan is lett volna, ha kiszakították volna őket onnan, tanulmányaik ilyen kritikus pontján. A Bíróság megerősítette, hogy a gyermekek oktatásában a folyamatosság biztosítása annyira fontos, hogy ténylegesen megalapozhatja a(z egyébként nem jogosult) család fogadó állambeli tartózkodását a migráns gyermekek tanulmányainak időtartamára.

A *Baumbast*-határozatot későbbi ügyekben[370] is követték, és a 2004/38/EK irányelv[371] (a szabad mozgásról szóló irányelv) 12. cikkének (3) bekezdésében kodifikálták.

A harmadik országbeli állampolgár gyermekek általában csak az állami finanszírozású oktatáshoz férhetnek hozzá az állampolgárokkal azonos feltételek mellett,

368 A 77/486/EGK irányelv végrehajtásáról szóló bizottsági jelentések: COM(84) 54 végleges és COM(88) 787 végleges.

369 EUB, C-413/99. sz. ügy, *Baumbast és R. kontra Secretary of State for the Home Department*, 2002. szeptember 17.

370 EUB, C-480/08. sz. ügy, *Maria Teixeira kontra London Borough of Lambeth és Secretary of State for the Home Department*, 2010. február 23.; EUB, C-310/08. sz. ügy, *London Borough of Harrow kontra Nimco Hassan Ibrahim és Secretary of State for the Home Department* [Nagytanács], 2010. február 23.

371 Az Európai Parlament és a Tanács 2004. április 29-i 2004/38/EK irányelve az Unió polgárainak és családtagjaiknak a tagállamok területén történő szabad mozgáshoz és tartózkodáshoz való jogáról, valamint az 1612/68/EGK rendelet módosításáról, továbbá a 64/221/EGK, a 68/360/EGK, a 72/194/EGK, a 73/148/EGK, a 75/34/EGK, a 75/35/EGK, a 90/364/EGK, a 90/365/EGK és a 93/96/EGK irányelv hatályon kívül helyezéséről (HL L 158., 2004. április 30., 3. o.), a 2. cikk (2) bekezdésének c) pontja és a 12. cikk (3) bekezdése.

és kizárják őket a társuló ellátásokból, például a szociális támogatásokból.[372] Egyes uniós migrációs jogi eszközök azonban továbblépnek azon, hogy pusztán egyenlő hozzáférést adjanak, és előírják a tagállamoknak, hogy vezessenek be olyan mechanizmusokat, amelyek biztosítják a külföldi képesítések kellő elismerését és elfogadhatóságát, akár igazoló dokumentumok hiányában is (az elismerésről szóló irányelv 28. cikke).[373]

A menedékkérő gyermekek oktatási jogai még mindig gyengébbek; *hasonló*, de nem szükségszerűen *azonos* feltételek mellett kell számukra biztosítani a fogadó állam oktatási rendszeréhez való hozzáférést, mint amelyek az állampolgárokra vonatkoznak.[374] Így az oktatást iskolák helyett befogadóállomásokon is biztosíthatják, és a hatóságok akár a menedékjog iránti kérelem dátumához képest három hónappal is elhalaszthatják a menedékkérő gyermekek iskolához való teljes körű hozzáférését. Amennyiben az oktatási rendszerhez való hozzáférés a gyermek egyedi helyzete miatt lehetetlen, a tagállamok kötelesek más oktatási módozatokat felajánlani (a befogadási szabályokról szóló irányelv 14. cikkének (3) bekezdése).[375]

Az Európa Tanács égisze alatt az EJEE 1. Kiegészítő Jegyzőkönyvének 2. cikkét használják fel a 14. cikkel együtt értelmezve arra, hogy biztosítsák a migráns gyermekek oktatáshoz való hozzáférését (lásd még: 3.3. szakasz).

372 A menekültek elismeréséről szóló 2011/95/EU irányelv, 11. cikk; a huzamos tartózkodási engedéllyel rendelkező állampolgárokkal kapcsolatos 2003/109/EK irányelv, 14. cikk; a családegyesítési jogról szóló 2003/86/EK irányelv, 14. cikk; az átmeneti védelemről szóló 2001/55/EK irányelv; a befogadásról szóló 2013/33/EU irányelv, 14. cikk c) pont; és a visszatérési irányelv (2008/115/EK).

373 Az Európai Parlament és a Tanács 2011. december 13-i 2011/95/EU irányelve a harmadik országbeli állampolgárok és hontalan személyek nemzetközi védelemre jogosultként való elismerésére, az egységes menekült- vagy kiegészítő védelmet biztosító jogállásra, valamint a nyújtott védelem tartalmára vonatkozó szabályokról (átdolgozás) (az elismerésről szóló irányelv), HL L 337., 2011.12.20., 9. o.

374 A befogadási szabályokról szóló 2013/33/EU irányelv. Meg kell említeni, hogy a menekültek elismeréséről szóló irányelv alapján (2011/95/EU, 27. cikk), a menekült gyermekek (akik huzamos tartózkodáshoz való jogot kaptak) az állampolgárokkal azonos feltételek mellett vehetnek részt az oktatásban.

375 Az Európai Parlament és a Tanács 2013. június 26-i 2013/33/EU irányelve a nemzetközi védelmet kérelmezők befogadására vonatkozó szabályok megállapításáról (átdolgozás) (a befogadásról szóló irányelv), HL L 180., 2013.6.29., 96–116. o.

Példa: A *Ponomaryovi kontra Bulgária* ügyben[376] az EJEB azt mérlegelte, hogy két orosz, állandó tartózkodási engedéllyel nem rendelkező iskolás gyermek számára előírták, hogy középiskolai díjat fizessenek. A bíróság megállapította, hogy a középiskolai díjak kiszabása esetükben diszkriminatív volt, és így ellentétes volt az EJEE 14. cikkével, azt az EJEE 1. Kiegészítő Jegyzőkönyvének 2. cikkével együtt olvasva.[377]

Az Európai Szociális Karta közvetlenül (17. cikk (2) bekezdés) és közvetetten is védi a migráns gyermekek oktatáshoz való jogát, oly módon, hogy korlátozásokat határoz meg a gyermekek foglalkoztatáshoz való joga tekintetében, azzal a céllal, hogy lehetővé tegye számukra a kötelező oktatás valamennyi előnyének kihasználását (7. cikk).

Továbbá, a migráns munkavállalók jogállásáról szóló európai egyezmény[378] megerősíti a migráns gyermekeknek azt a jogát, hogy a fogadó államban „az állampolgárokkal azonos alapon, velük azonos feltételek mellett" vehetnek részt az általános oktatásban és a szakképzésben(14. cikk (1) bekezdés).

A nemzetközi jog keretében a migráns gyermekek oktatáshoz való egyenlő hozzáférését a migráns munkavállalók és családtagjaik jogainak védelméről szóló nemzetközi ENSZ-egyezmény (30. cikk) támogatja.[379]

A Gyermekjogi egyezmény 28. cikke kimondja, hogy minden gyermeknek joga van az ingyenes kötelező oktatáshoz. A 29. cikk (1) bekezdésének c) pontja szerint ez a jog messze túlmutat az oktatáshoz való hozzáférés egyenlőségén, és a gyermek kulturális azonosságának fejlődésével, a gyermek származási országának nyelvével és értékeivel kapcsolatos rendelkezéseket foglal magában.

376 EJEB, *Ponomaryovi kontra Bulgária* (5335/05), 2011. június 21.

377 Lásd még: 3.3. szakasz.

378 Európa Tanács, Európai egyezmény a vendégmunkások jogállásáról, CETS 93, 1977.

379 ENSZ, Nemzetközi egyezmény a migráns munkavállalók és családtagjaik jogainak védelméről, 1990. december 18.

8.3. Az egészséghez való jog

Kiemelt pontok

- Az államokat pozitív kötelezettség terheli, hogy intézkedéseket tegyenek az életet veszélyeztető olyan egészségügyi kockázatokkal szemben, amelyekről a hatóságoknak tudomása van vagy tudomása kell hogy legyen.
- Az állami hatóságoknak elhalálozás esetén hatékony nyomozást kell folytatniuk.
- Az Európai Szociális Karta szerint az országban tartózkodó gyermekek, menekültügyi státuszuktól függetlenül a sürgős egészségügyi segítségnyújtáson túlmenően is jogosultak egészségügyi ellátásra.
- Az elfogadható egészségügyi ellátás megfelelő tájékoztatáson nyugvó beleegyező nyilatkozatot vagy engedélyezést tesz szükségessé.
- Az uniós jog és az Európai Szociális Karta alapján a migráns gyermekek – különböző korlátozásokat figyelembe vevő – szociális és egészségügyi ellátásra jogosultak.

Az uniós jog keretében az EU Alapjogi Chartájának 35. cikke garantálja az egészségügyi ellátás igénybevételének jogát.

Az uniós állampolgár migránsok gyermekei a fogadó államban való három hónapos tartózkodást követően, állampolgáraival azonos módon vehetnek igénybe szociális jóléti és egészségügyi támogatást.[380] Hasonló jogokkal rendelkeznek azoknak a harmadik országbeli állampolgároknak a gyermekei, akik állandó tartózkodási engedélyt szereztek valamely tagállamban, jóllehet ezek az úgynevezett „alapellátásokra" korlátozódhatnak.[381] Ami a menekült és menedékkérő gyermekeket illeti, a tagállamoknak a fogadó állam állampolgáraival azonos módon biztosítaniuk kell a megfelelő szociális segítségnyújtáshoz való hozzáférést, ez azonban ismét az „alapellátásokra" korlátozódhat (az elismerésről szóló irányelv 29. cikke). A jogszabályok előírják a tagállamoknak, hogy elégséges egészségügyi ellátáshoz való hozzáférést biztosítsanak a különösen sérülékeny csoporthoz tartozó migráns gyermekek számára. Azokat a gyermekeket például, akik erőszakot vagy kínzást szenvedtek el, megfelelő támogatást kell nyújtani, hogy kielégíthessék testi és szellemi szükségleteiket (a befogadásról szóló irányelv IV. fejezetének 21. cikke, 23. cikkének (4) bekezdé-

380 A szabad mozgásról szóló irányelv 24. cikke.

381 A harmadik országok huzamos tartózkodási engedéllyel rendelkező állampolgárainak jogállásáról szóló, 2003. november 25-i 2003/109/EK irányelv (HL L 16., 2004.01.23.) 11. cikkének 4. bekezdése.

se és 25. cikke). Az elismerésről szóló irányelv hasonló rendelkezéseket tartalmaz a különösen sérülékeny csoportokhoz tartozó migráns gyermekek tekintetében.

Az Európa Tanács égisze alatt az EJEE nem rendelkezik külön az egészségügyi ellátáshoz való jogról vagy az egészséghez való jogról. Az EJEB azonban számos, különféle körülményeket érintő, egészséggel kapcsolatos üggyel foglalkozott. Először is, a bíróság vizsgálja a gyermekekkel kapcsolatos, életet veszélyeztető egészségügyi problémákat. Az államra háruló pozitív kötelezettségeket állapít meg arra vonatkozóan, hogy megelőző intézkedéseket kell tennie az olyan életet veszélyeztető egészségügyi kockázatokkal szemben, amelyekről tudomása van, illetve amelyeket ismernie kell.

Példa: Az *Oyal kontra Törökország* ügyben megállapításra került, hogy az állam nem tett megelőző intézkedéseket a HIV fertőzés vérátömlesztés révén történő terjedése ellen. Ennek következményeképpen egy újszülöttet HIV-vírussal fertőztek meg vérátömlesztés során egy állami kórházban. Jóllehet felajánlottak bizonyos jogorvoslatot, az EJEB megállapította, hogy az érintett gyermek egész élete alatti kezelést és gyógyszerelést felölelő egészségügyi ellátás hiányában az állam elmulasztott kielégítő jogorvoslatot felajánlani, és ezáltal megsértette az élethez való jogot (az EJEE 2. cikke).[382] Ezenfelül elrendelte, hogy a török állam az áldozat számára élete végéig biztosítson ingyenes és teljes körű egészségügyi ellátást.

Példa: Az *Iliya Petrov kontra Bulgária* ügyben[383] egy 12 éves fiú súlyosan megsérült egy villamos alállomáson (az alállomások a 120 kV-os nagyfeszültség átalakítását végzik). Az alállomást egy kültéri parkban helyezték el, ahol gyakran találkoztak gyermekek és fiatalok, és az ajtó nem volt zárva. Az EJEB úgy vélekedett, hogy a villamoshálózat használata olyan tevékenység, amely kiemelt kockázatot jelent a létesítmények közelében tartózkodó személyek számára. Az államnak kötelessége, hogy megfelelő szabályozást vezessen be, ideértve a biztonsági szabályok megfelelő alkalmazásának ellenőrzésére szolgáló rendszert is. A bíróság úgy ítélkezett, hogy az állam azzal, hogy nem biztosította a villamos alállomás biztonságát, annak ellenére, hogy tudomása volt a biztonsági problémákról, az élethez való jog megsértésével ér fel (az EJEE 2. cikke).[384]

382 EJEB, *Oyal kontra Törökország* (4864/05), 2010. március 23., 71–72. bek.

383 EJEB, *Iliya Petrov kontra Bulgária* (19202/03), 2012. április 24. (elérhető francia nyelven).

384 *Uo.*

Ezenfelül az államokra hárul az a pozitív kötelezettség, hogy felelősséget vállaljon azoknak a kiszolgáltatott helyzetben lévő gyermekekért, akikről gyermekvédelmi szakellátásban gondoskodnak (lásd még: 6. fejezet és 7.3. szakasz).

Példa: A *Valentin Campeanu részéről eljáró Center for Legal Resources kontra Románia* ügy[385] egy HIV-pozitív, súlyos értelmi fogyatékossággal élő roma tizenévest érintett, aki emellett tuberkulózisban, tüdőgyulladásban és hepatitiszben is szenvedett, majd 18 évesen meghalt. Egész életében állami gondozásban volt. Az EJEB súlyos hiányosságokat állapított meg a gyógyszerezés és ellátás biztosításával kapcsolatos döntéshozatalban, és megállapította, hogy az orvosi személyzet folyamatosan elmulasztotta biztosítani számára a megfelelő ápolást és kezelést. Ily módon megsértették az EJEE 2. cikkét.[386]

Az EJEB azt is megállapította, hogy egészségügyi vészhelyzet hiányában, a szülői beleegyezés nélküli orvosi kezelés sérti az EJEE 8. cikkét.

Példa: A *Glass kontra Egyesült Királyság* ügyben[387] egy súlyos fogyatékossággal élő gyermeknek diamorfint adtak be, anyjának határozott tiltakozása ellenére. Az EJEB megállapította, hogy a kórházi hatóságoknak a döntése, hogy az anya javasolt kezelés elleni tiltakozását bírósági engedély nélkül figyelmen kívül hagyják, az EJEE 8. cikkének megsértéséhez vezetett.[388]

Példa: Az *M.A.K. és R.K. kontra Egyesült Királyság* ügyben[389] egy kilencéves kislánytól vért vettek és fényképeket készítettek róla, szülői beleegyezés nélkül, annak ellenére, hogy az apja kifejezetten utasítást adott arra, hogy ne végezzenek további vizsgálatokat, amíg a kislány egyedül van a kórházban. Egészségügyi hiányában ezekről a szülői beleegyezés nélkül végzett orvosi beavatkozásokról megállapították, hogy az EJEE 8. cikke alapján sértették a kislány testi épséghez való jogát.[390]

385 EJEB, *Valentin Câmpeanu részéről eljáró Centre for Legal Resources kontra Románia* [Nagykamara] (47848/08), 2014. július 17. Ezen EJEB-ítélet további leírását lásd a 7. fejezetben.

386 Lásd még a 7. szakaszt.

387 EJEB, *Glass kontra Egyesült Királyság* (61827/00), 2004. március 9.

388 *Uo.*, 83. bek.

389 EJEB, *M.A.K. és R.K. kontra Egyesült Királyság* (45901/05 és 40146/06), 2010. március 23.

390 *Uo.*, 79. bek.

Ha egy gyermek nem rendelkezik kellő cselekvőképességgel ahhoz, hogy beleegyezzen egy orvosi beavatkozásba, úgy ezt a beavatkozást az emberi jogokról és a biomedicináról szóló egyezmény[391] 6. és 8. cikkével összhangban csak törvényes képviselőjének az engedélyével szabad elvégezni, kivéve egészségügyi vészhelyzetben. Noha ez az egyezmény nem követeli meg a gyermek beleegyezését, ha jogilag nem képes beleegyezését adni, de rögzíti, hogy a gyermek véleményét „életkorának és érettségének megfelelően meghatározó tényezőként" figyelembe kell venni (6. cikk (2) bekezdés).

Továbbá, az Európai Szociális Karta 11. cikke alapján a részes államok megállapodnak abban, hogy tanácsadói és oktatási lehetőségeket biztosítsanak az egészségvédelemre és az egészségügyi kérdések iránti egyéni felelősség növelésére.[392] Az Európai Szociális Karta 13. cikke orvosi segítségnyújtást és ellátást garantál mindenkinek, aki nem rendelkezik megfelelő anyagi eszközökkel és aki nem képes ezeket az anyagi eszközöket megteremteni sem saját erőfeszítései révén, sem másképpen. Végül 2011-ben az ET Miniszterek Bizottsága a gyermekbarát egészségügyi ellátásra vonatkozó gyermekspecifikus iránymutatásokat fogadott el.[393]

Mint a következő példák jelzik, a Szociális Jogok Európai Bizottsága kimondja, hogy menekültügyi státuszuktól függetlenül, a valamely országban tartózkodó gyermekek a sürgősségi orvosi segítségnyújtáson túl is jogosultak egészségügyi ellátásra. Az Európai Szociális Karta sok helyen utal a gyermekek szociális jóléthez és egészségügyi szolgáltatásokhoz való jogaira (11., 12., 13., 14., 16. és 17. cikk), amelyek a menekültügyi státuszukra tekintet nélkül alkalmazandók.

Példa: Az EJEB *International Federation of Human Rights Leagues (FIDH) kontra Franciaország* ügyben[394] hozott határozata azzal kapcsolatos, hogy Franciaország olyan törvényt fogadott el, amely véget vetett a nagyon alacsony jövedelmű, rendezetlen jogállású migránsok orvosi ellátás

391 Európa Tanács, Egyezmény az emberi lény emberi jogainak és méltóságának a biológia és az orvostudomány alkalmazására tekintettel történő védelméről: Egyezmény az emberi jogokról és a biomedicináról, CETS 164, 1997.

392 Ami a szexuális és reproduktív egészségügyi felvilágosítást illeti, lásd még az oktatásról szóló részt is (8.2. szakasz).

393 Európa Tanács, Miniszterek Tanácsa (2011), Iránymutatás a gyermekbarát egészségügyi ellátásról, 2011. szeptember 21.

394 Szociális Jogok Európai Bizottsága, *International Federation of Human Rights Leagues (FIDH) kontra Franciaország*, 14/2003. sz. panasz, 2004. szeptember 8., 35–37. bek.

kifizetése alóli mentességének, és egészségügyi díjakat vetett ki. A Szociális Jogok Európai Bizottsága határozatában megállapította, hogy azon személyek számára, akik még nem érték el a nagykorúság határát, köztük a kísérő nélküli kiskorúak számára, ingyenes orvosi ellátást kell biztosítani.

Példa: A *Defence for Children International (DCI) kontra Belgium* ügyben[395] a Szociális Jogok Európai Bizottsága megállapította, hogy a hivatalos okmányokkal nem rendelkező migráns gyermekeknek nyújtott orvosi segítségre vonatkozó korlátozásokkal megsértették az Európai Szociális Karta 17. cikkét. A Bizottság megerősítette, hogy „a valamely országban jogellenesen tartózkodó kiskorúaknak joguk van ahhoz, hogy a sürgős orvosi segítségnyújtáson túlmenően, az elsődleges és másodlagos ellátást, valamint a pszichológiai segítségnyújtást is beleértve egészségügyi ellátásban részesüljenek”.[396] Azt is megállapította, hogy a menekültügyi státuszuktól függetlenül, az országban tartózkodó kiskorú külföldiek számára létrehozott befogadó létesítmények hiánya megnehezítette az egészségügyi ellátáshoz való hozzáférést. Ezenfelül megállapította, hogy a rossz egészségi állapot okai csak akkor szüntethetők meg, ha a gyermekek számára megfelelő lakhatást és gyermekvédelmi szakellátást biztosítanak. Ennek megfelelően megállapította, hogy a lakhatás és a gyermekvédelmi szakellátás intézményeihez való hozzáférés hiányával megsértették az Európai Szociális Karta 11 cikkének (1) és (3) bekezdését.[397]

A vendégmunkások jogállásáról szóló európai egyezmény[398] hasonlóképpen úgy rendelkezik, hogy a valamely másik állam területén jogszerűen alkalmazott migráns munkavállalóknak és családjuknak egyenlő hozzáférést kell kapniuk a szociális és orvosi segítségnyújtáshoz (19. cikk).

A nemzetközi jogban az egészséghez való jogra vonatkozóan átfogóbb rendelkezések találhatók a Gazdasági, Szociális és Kulturális Jogok Nemzetközi Egyezségokmányának[399] (ICESCR) 12. cikkében és a Gyermekjogi egyezmény 24. cikkében. Ezek az eszközök a megelőzést és a kezelést hangsúlyozzák.

395 Szociális Jogok Európai Bizottsága, *Defence for Children International (DCI) kontra Belgium*, 69/2011. sz. panasz, 2012. október 23.

396 *Uo.*, 128. bek.

397 *Uo.*, 116-118. bek.

398 Európa Tanács, Európai egyezmény a vendégmunkások jogállásáról, CETS 93, 1977.

399 Az ENSZ Közgyűlése, a Gazdasági, Szociális és Kulturális Jogok Nemzetközi Egyezségokmánya, 1966. december 16., az ENSZ szerződéssorozatának 993. kötete, 3. o.

Az ENSZ Gyermekjogi Bizottsága az elérhető legmagasabb színvonalú egészségügyi ellátáshoz és táplálkozáshoz való kisgyermekkori hozzáférés fontosságát[400], valamint a serdülők szexuális és reproduktív információkhoz való hozzáférésének fontosságát[401] hangsúlyozza. Azt is tisztázta, hogy a gyermekek egészséghez való joga maga után vonja „a saját egészsége és teste felleti ellenőrzés jogát is, ideértve a szexuális és reproduktív szabadságot, hogy felelős döntéseket lehessen hozni".[402] Arra bíztatja az államokat, hogy „mérlegeljék annak lehetővé tételét, hogy a gyermekek bizonyos orvosi kezelésekbe és beavatkozásokba – így a HIV-teszt elvégzésébe és a szexuális és reproduktív egészségügyi szolgáltatásokba, ezen belül a szexuális egészséggel kapcsolatos felvilágosításba és a fogamzásgátlásról, a biztonságos terhességmegszakításról szóló tájékoztatásba – a szülő, törvényes képviselő vagy gyám engedélye nélkül beleegyezhessenek".[403]

8.4. Lakhatáshoz való jog

Kiemelt pontok

- A megfelelő lakhatáshoz való jogot az Európai Szociális Karta 31. cikke garantálja.
- A Szociális Jogok Európai Bizottsága kimondja, hogy menekültügyi státuszuktól függetlenül, a valamely országban irregulárisan tartózkodó gyermekek számára megfelelő menedékhelyet kell biztosítani, és a menedékhelyek életkörülményeinek összhangban kell lenniük az emberi méltósággal.
- Az EJEB szerint a nem megfelelő lakhatás nem indokolja az állami gondozásba vételt.

Az uniós jogban az Unió Alapjogi Chartája 34. cikkének (3) bekezdése utal a társadalmi kirekesztés és a szegénység elleni küzdelem részeként a lakástámogatáshoz való jogra. A faji egyenlőségről szóló irányelv a nyilvánosság rendelkezésére álló azon áruk és szolgáltatások között emeli ki a lakhatást, amelynek tekintetében

400 Az ENSZ Gyermekjogi Bizottsága (2006), 7. általános észrevétel (2005): *Implementing child rights in early childhood*, CRC/C/GC/7/Rev.1 sz. ENSZ-dokumentum, 27. bek.

401 Az ENSZ Gyermekjogi Bizottsága (2003), 4. általános észrevétel: *Adolescent health and development in the context of the Convention on the Rights of the Child*, CRC/GC/2003/4. sz. ENSZ-dokumentum, 28. bek.

402 Az ENSZ Gyermekjogi Bizottsága (2013), *15. általános észrevétel a gyermek lehető legjobb egészségi állapothoz való jogáról (24. cikk)*, CRC/C/GC/15 ENSZ-dokumentum, 24. bek.

403 *Uo.*, 31. bek.

hátrányos megkülönböztetésmentes hozzáférést és ellátást kell biztosítani.[404] A lakhatási támogatással kapcsolatos hátrányos megkülönböztetésmentes bánásmód a huzamos tartózkodási engedéllyel rendelkezőkre alkalmazandó. Az uniós jog azonban megpróbálja biztosítani, például családegyesítés esetén, hogy a családtagok ne jelentsenek terhet a tagállamok szociális ellátó rendszerei számára.[405] A családegyesítési jogról szóló irányelv előírja, hogy a családegyesítésre irányuló kérelem szolgáltasson bizonyítékot arra nézve, hogy a családegyesítő (azaz olyan harmadik országbeli állampolgár, akinek megengedték, hogy egy éven át vagy ennél hosszabb időn át tartózkodjon a tagállamban, és akinek ésszerű esélye van arra, hogy megszerezze a huzamos tartózkodás jogát) rendelkezik az ugyanabban a régióban egy hasonló család számára szabványosnak tekintett szálláshellyel. A szálláshelynek meg kell felelnie az érintett tagállamban hatályos általános egészségügyi és biztonsági előírásoknak.[406]

Az Európa Tanács égisze alatt, az EJEE-ben nem szerepel a lakhatás biztosítására vonatkozó jog, de ha valamely állam úgy dönt, hogy lakhatást biztosít, azt hátrányos megkülönböztetésmentesen kell tennie.

Példa: A *Bah kontra Egyesült Királyság* ügyben[407] megengedték a kérelmezőnek, aki jogszerűen tartózkodott az Egyesült Királyságban, hogy csatlakozzon hozzá a fia, azzal a feltétellel, hogy nem folyamodik állami támogatásért. A kérelmező röviddel fia megérkezése után segítséget kért ahhoz, hogy lakást kapjon. Mivel azonban a fia menekültügyi eljárás alatt állt, megtagadták tőle azt az soronkívüliséget, amely az önhibáján kívül hajléktalan, kiskorú gyermekkel együtt élő személyt megilletett volna. A hatóságok végül segítettek új lakást találni, és később szociális lakhatást biztosítottak számára. A kérelmező azt kifogásolta, hogy azáltal, hogy megtagadták tőle a soronkívüliséget, hátrányos megkülönböztetést alkalmaztak vele szemben. Az EJEB megállapította, hogy jogszerű kritériumokat lehet szabni az olyan korlátozott erőforrások elosztása tekintetében, mint a szociális lakhatás, feltéve, hogy ezek a kritériumok nem önkényesek és nem diszkriminatívak. Az elsőbbség kérelmezőtől való megtagadása nem

404 A Tanács 2000/43/EK irányelve (2000. június 29.) a személyek közötti, faji- vagy etnikai származásra való tekintet nélküli egyenlő bánásmód elvének alkalmazásáról,3. cikk.

405 Lásd még: FRA és EJEB (2014), 201. o.

406 A Tanács 2003. szeptember 22-i 2003/86/EK irányelve a családegyesítési jogról (családegyesítési irányelv), a 7. cikk (1) bekezdésének a) pontja.

407 EJEB, *Bah kontra Egyesült Királyság* (56328/07), 2011. szeptember 27.

volt önkényes; a kérelmező úgy hozta be az országba a fiát, hogy teljes mértékben tisztában volt a fia belépésének engedélyezéséhez kapcsolt feltétellel. Ezenfelül a kérelmező ténylegesen soha nem volt hajléktalan, és léteztek más jogszabályi kötelességek, amelyek megkövetelték volna a helyi hatóságtól, hogy segítsen neki és a fiának, ha a hajléktalanság veszélye ténylegesen fenn állt volna. Ebből következik, hogy nem sértették meg az EJEE 14. cikkét a 8. cikkel összefüggésben.

Az EJEB roma családok lakókocsitelepekről való kilakoltatásával kapcsolatos ügyeket is vizsgál.[408] Az EJEB közvetetten foglalkozott a lakhatás minőségének kérdésével, és kimondta, hogy a nem megfelelő lakhatás nem indokolja a gyermekek családból való kiemelését.[409] (lásd még: 5.2 szakasz és 6.2. szakasz).

A megfelelő lakhatáshoz való jogot az Európai Szociális Karta 31. cikke garantálja. A Szociális Jogok Európai Bizottsága megállapítja, hogy „a 31. cikk (1) bekezdése szerinti megfelelő színvonalú lakás olyan lakást jelent, amely higiéniai és egészségügyi szempontból biztonságos, azaz rendelkezik minden alapvető komforttal, például vízzel, fűtéssel, hulladékelszállítással, tisztálkodási lehetőséggel és elektromos árammal, és szerkezetileg biztonságos, nem túlzsúfolt és a törvény által támogatott biztonságos lakáshasználatot tesz lehetővé".[410] A kilakoltatás indokolt esetben megengedett, az emberi méltóságot tiszteletben tartó feltételek melletti végrehajtással, és ha más szálláslehetőséget bocsátanak rendelkezésre.[411] A menedékhelyen olyan életkörülményeket kell biztosítani, „amelyek lehetővé teszik az emberi méltósággal összhangban lévő életet [...], [és] e körülményeknek meg kell felelniük a biztonság, az egészség és a higiénia követelményeinek, ideértve az alapvető komfortot, azaz a tiszta vizet, az elégséges világítást és a fűtést. Az ideiglenes lakhatás alapvető követelményei magukban foglalják a közvetlen környék biztonságát is.[412]

408 EJEB, *Connors kontra Egyesült Királyság* (66746/01), 2004. május 27.

409 EJEB, *Wallová és Walla kontra Cseh Köztársaság* (23848/04), 2006. október 26., 73–74. bek. (elérhető francia nyelven); EJEB, *Havelka és társai kontra Cseh Köztársaság* (23499/06), 2007. június 21., 57–59. bek. (elérhető francia nyelven).

410 Szociális Jogok Európai Bizottsága, *Defence for Children International (DCI) kontra Hollandia*, 47/2008. sz. panasz, 2009. október 20., 43. bek.

411 Szociális Jogok Európai Bizottsága, *European Roma Rights Centre (ERRC) kontra Olaszország*, 27/2004. sz. panasz, 2005. december 7., 41. bek.; Szociális Jogok Európai Bizottsága, *Médecins du Monde – International kontra Franciaország*, 67/2011. sz. panasz, 2012. szeptember 11., 74–75. bek. és 80. bek.

412 Szociális Jogok Európai Bizottsága, *Defence for Children International (DCI) kontra Hollandia*, 47/2008 sz. panasz, 2009. október 20., 62. bek.

A rendezetlen jogállású külföldi gyermekek lakhatását illetően a Szociális Jogok Európai Bizottsága megállapítja, hogy mind a bármilyenfajta szállás biztosításának elmulasztása, mind a szállodákban történő, nem megfelelő elhelyezés sérti az Európai Szociális Karta 17. cikkének (1) bekezdését.[413] Ezenfelül az Európai Szociális Karta 31. cikkének (2) bekezdése alapján, amely a hajléktalanság megelőzéséről szól, az államok kötelesek megfelelő menedékhelyet biztosítani a rendezetlen jogállású gyermekek számára, fogvatartáshoz folyamodás nélkül.[414]

8.5. A megfelelő életszínvonalhoz való jog és a szociális biztonsághoz való jog

Kiemelt pontok

- A gyermekek után járó támogatásokhoz és a szülői szabadsághoz való hozzáférés nem lehet diszkriminatív.
- A tanulószerződéses fiatal munkavállalók társadalombiztosítási fedezete az uniós jog szerint nem lehet olyan alacsony, hogy kizárja őket a védelem általános köréből.
- Az Európai Szociális Karta alapján a családi támogatások igazolatlan iskolai hiányzás esetén történő felfüggesztése aránytalanul korlátozza a család gazdasági, szociális és jogi védelemhez való jogát.

Ami az uniós jogot illeti, az Unió Alapjogi Chartája 34. cikkének (1) bekezdése meghatározza, hogy az „ Unió [...] elismeri és tiszteletben tartja a szociális biztonsági ellátásokra és szociális szolgáltatásokra való jogosultságot" a szociális biztonság hagyományos ágainak megfelelő esetekben (anyaság, betegség, munkahelyi baleset, rászorultság vagy idős kor és a munkahely elvesztése). A jogosultság az Unión belül jogszerűen lakóhellyel rendelkező és tartózkodási helyét jogszerűen megváltoztató minden személyt megillet. Elismerik a szociális segítségnyújtáshoz való jogot, hogy tisztességes megélhetést biztosítsanak azoknak, akik nem rendelkeznek elegendő forrással a társadalmi kirekesztés és a szegénység megelőzéséhez. Mindezeket a szempontokat „az uniós jog,

413 Szociális Jogok Európai Bizottsága, *Defence for Children International (DCI) kontra Belgium*, 69/2011. sz. panasz, 2012. október 23., 82–83. bek. Lásd még: FRA (2010), 30. o.

414 Szociális Jogok Európai Bizottsága, *Defence for Children International (DCI) kontra Hollandia*, 47/2008. sz. panasz, 2009. október 20., 64. bek.

valamint a nemzeti jogszabályok és gyakorlat által megállapított szabályok" minősítik (a Charta 34. cikkének (1) bekezdése).

Az EUB kimondja, hogy amennyiben valamely tagállam saját állampolgárainak ahhoz, hogy gyermeknevelési támogatásban részesülhessenek, csak azt írják elő, hogy a tagállamban kell tartózkodniuk, nem írható elő más uniós tagállamok állampolgárai számára, hogy hivatalos tartózkodási engedélyt mutassanak be ahhoz, hogy hozzáférhessenek ugyanezen ellátásokhoz.[415] A szülői szabadság kiadásának megtagadása bizonyos kategóriába tartozó személyeknek, például a béranyaságról szóló megállapodás keretében gyermek felnevelését vállaló (a kihordásra megbízást adó) anyáknak, diszkriminatív.[416] Ugyanez vonatkozik azokra a férfi közalkalmazottakra, akik nem kapnak szülői szabadságot, ha a feleségük nem dolgozik vagy nem gyakorolja hivatását, kivéve akkor, ha a feleség súlyos betegség vagy sérülés miatt képtelen eleget tenni a gyermek nevelésével járó feladatoknak.[417] Hasonlóképpen a tagállamoknak a szülői szabadság olyan rendszerét kell kialakítaniuk ikrek születése esetén, amely biztosítja, hogy a szülők a szükségleteiknek megfelelő bánásmódban részesüljenek. Ez biztosítható oly módon, hogy a szülői szabadság időtartamát a született gyermekek száma alapján állapítják meg, valamint egyéb intézkedések, például tárgyi segítségnyújtás vagy pénzügyi támogatás biztosításával.[418]

Az Európa Tanács égisze alatt az EJEB vizsgálta a szülői szabadság és szülői támogatások oroszországi odaítélése során vélelmezhetően megvalósuló hátrányos megkülönböztetést.

Példa: A *Konstantin Markin kontra Oroszország* ügyben[419] megtagadták a szülői szabadságot egy orosz hadseregben szolgáló katonától, miközben a katonanők jogosultak ilyen szabadságra. A Bíróság véleménye szerint a katonák szülői szabadságra való jogosultságból való kizárása ésszerűen nem indokolható meg. Megállapítást nyert, hogy sem a fegyveres erők

415 EUB, C-85/96. sz. ügy, *María Martínez Sala kontra Freistaat Bayern*, 1998. május 12., 60–65. pont.

416 EUB, C-363/12. sz. ügy, *Z. kontra A Government Department és The Board of Management of a Community School* [Nagytanács], 2014. március 18.

417 EUB, C-222/14. sz. ügy, *Konstantinos Maïstrellis kontra Ypourgos Dikaiosynis, Diafaneias kai Anthropinon Dikaiomaton*, 2015. július 16., 53. pont.

418 EUB, C-149/10. sz. ügy, *Zoi Chatzi kontra Ypourgos Oikonomikon*, 2010. szeptember 16., 72–75. pont.

419 EJEB, *Konstantin Markin kontra Oroszország* [Nagykamara] (30078/06), 2012. március 22.

különleges környezete, sem a sikeres működés eredményességének veszélyeztetése, sem a nők gyermekek nevelésében betöltött különleges szerepével kapcsolatos érvek vagy az országban fennálló hagyományok nem támasztják alá az eltérő bánásmódot. A Bíróság megállapította, hogy megsértették az EJEE 14. cikkét a 8. cikkel összefüggésben.

Az Európai Szociális Karta 12–14. cikkében a társadalombiztosításra, a szociális és egészségügyi segítségre és a szociális jóléti szolgáltatásokból való részesülés jogára vonatkozó szélesebb körű rendelkezések találhatók. Az Európai Szociális Karta 16. cikke kifejezetten úgy említi a szociális és családtámogatásokat, mint amelyekkel előmozdítható a család gazdasági, jogi és szociális védelme. Az Európai Szociális Karta 30. cikke rendelkezik a szegénység és társadalmi kirekesztés elleni védelemhez való jogról. Bizonyos szociális biztonsághoz kapcsolódó igények az EJEE 1. Kiegészítő Jegyzőkönyve 1. cikkének hatálya alá tartozhatnak, feltéve, hogy ha a jogszabály valamely jóléti ellátáshoz való jogot alapvető jogként határozza meg, akár függővé teszi azt járulékok előzetes befizetésétől, akár nem.[420]

Az Európai Szociális Karta 12. cikke előírja az államoknak, hogy társadalombiztosítási rendszert kell létrehozniuk vagy fenntartaniuk, és erőfeszítéseket kell tenniük a társadalombiztosítási rendszer fokozatosan magasabb szintre történő emelése érdekében.

Az Európai Szociális Karta 16. cikke előírja az államoknak, hogy megfelelő eszközökkel biztosítsák a család gazdasági, jogi és szociális védelmét. Az elsődleges eszközöknek a családi vagy gyermekek után járó ellátásoknak kell lenniük, amelyeket a társadalombiztosítás részeként nyújtanak, és amelyek vagy alanyi jogon elérhetők, vagy rászorultsági alapon járnak. Ezeknek az ellátásoknak jelentős számú család számára megfelelő jövedelemkiegészítést kell jelenteniük. A Szociális Jogok Európai Bizottsága az ekvivalens mediánjövedelem (Eurostat) alapján értékeli a családi (szülői) ellátások megfelelőségét.[421] A Szociális Jogok Európai Bizottsága megállapítja, hogy a családi ellátások általános rendszerének hiánya nincs összhangban az Európai Szociális Kartával.[422]

420 EJEB, *Stummer kontra Ausztria* [Nagykamara] (37452/02), 2011. július 7., 82. bek.

421 Szociális Jogok Európai Bizottsága, 2006-os következtetések, Észtország, 215. o.

422 Szociális Jogok Európai Bizottsága, 2011-es következtetések, Törökország, 16. cikk.

A Szociális Jogok Európai Bizottsága azonban elfogadja, hogy a gyermekek után járó ellátások fizetését a gyermek tartózkodási helyétől tehetik függővé.[423] Megállapítja, hogy a különleges tanulószerződésekben a gyermekek (15–18 évesek) számára nyújtott, szociális és gazdasági kockázatokkal szembeni csupán nagyon korlátozott védelem bevezetése (csak természetbeni betegségi ellátásokra és 1%-os munkahelyi baleseti fedezetre voltak jogosultak) a (kiskorú) munkavállalók egy elkülönülő csoportját ténylegesen kizárta a „szociális védelmi rendszer egésze által nyújtott védelem általános köréből". Emiatt ez a társadalombiztosítási rendszer fokozatosan magasabb szintre történő emelésére vonatkozó, államot terhelő kötelezettség megsértésének tekinthető.[424]

A családi támogatások igazolatlan iskolai hiányzás esetén történő felfüggesztése szintén aránytalanul korlátozza a család gazdasági, szociális és jogi védelemhez való jogát.

> Példa: Egy Franciaországgal szembeni panaszban a European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) amellett érvelt, hogy a családi támogatások igazolatlan iskolai hiányzások kezelése céljából való felfüggesztése sérti a családok szociális, jogi és gazdasági védelemhez való jogát, amelyet az Európai Szociális Karta 16. cikke határoz meg. A Bizottság, amely az elérni kívánt céllal aránytalannak találta az intézkedést, megjegyezte, hogy „a családi támogatások felfüggesztését és esetleges csökkentését magában foglaló, vitatott intézkedés kizárólag a szülőket teszi felelőssé az igazolatlan iskolai hiányzás visszaszorítására vonatkozó cél eléréséért, és növeli az érintett családok gazdasági és szociális kiszolgáltatottságát".[425]

A vendégmunkások jogállásáról szóló európai egyezmény[426] meghatározza, hogy a másik államban jogszerűen alkalmazott migráns munkavállalóknak és családtagjaiknak egyenlő hozzáférést kell biztosítani a társadalombiztosításhoz (18. cikk) és egyéb „szociális szolgáltatásokhoz", amelyek megkönnyítik befogadásukat

423 Szociális jogok Európai Bizottsága, XVIII-1-es következtetések, Általános bevezető, 11. o.

424 Szociális jogok Európai Bizottsága, *General Federation of Employees of the National Electric Power Corporation (GENOP-DEI) és Confederation of Greek Civil Servants' Trade Unions (ADEDY) kontra Görögország*, 66/2011. sz. panasz, 2012. május 23., 48. bek.

425 Szociális Jogok Európai Bizottsága, *European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) kontra Franciaország*, 82/2012. sz. panasz, 2013. március 19., 42. bek.

426 Európa Tanács, Európai egyezmény a vendégmunkások jogállásáról, CETS 93, 1977.

a fogadó államban (10. cikk). Hasonlóképpen, a szociális biztonságról szóló európai egyezmény védi a menekültek és a hontalan személyek fogadó állambeli társadalombiztonsághoz való hozzáférésre vonatkozó jogát (ideértve a gyermekek után járó családi támogatásokat is).[427]

Ami a nemzetközi jogot illeti, a megfelelő életszínvonalhoz való jogot az ICESCR 11. cikke és a Gyermekjogi egyezmény 27. cikke garantálja.

427 Európa Tanács, Európai egyezmény a szociális biztonságról CETS 78, 1972.

9 Migráció és menekültügy

EU	Tárgyalt kérdések	ET
EUMSZ, 21. cikk Alapjogi Charta, 45. cikk (a mozgás szabadsága) A befogadásra vonatkozó szabályokról szóló irányelv (2013/33/EU) Visszatérési irányelv (2008/115/EK) A menekültügyi eljárásokról szóló irányelv (2013/32/EU) Dublini rendelet (604/2013/EU) Az elismerésről szóló irányelv (2011/95/EU) A szabad mozgásról szóló irányelv (2004/38/EK) EUB, C-648/11. sz. ügy, *The Queen, MA és társai kérelme alapján kontra Secretary of State for the Home Department*, 2013 (dublini eljárás szerinti átadások) Schengeni Határ-ellenőrzési Kódex, 562/2006/EK rendelet, VII. melléklet, 6. pont	Belépés és tartózkodás	EJEE, 8. cikk (családi élet)
A menekültügyi eljárásokról szóló irányelv (2013/32/EK) 25. cikkének (5) bekezdése	Az életkor meghatározása	

EU	Tárgyalt kérdések	ET
Az EUMSZ 67. és 73. cikke, valamint 79. cikke (2) bekezdésének a) pontja Családegyesítési irányelv (2003/86/EK) Az elismerésről szóló irányelv (2011/95/EU), 31. cikk A befogadásra vonatkozó szabályokról szóló 2013/33/EU irányelv Az átmeneti védelemről szóló irányelv (2001/55/EK) Dublini rendelet (604/2013/EU) A visszatérési irányelv (2008/115/EK) 13. cikke	**Családegyesítés és családjuktól elszakított gyermekek**	EJEE, 8. cikk (magán- és családi élet tiszteletben tartásához való jog) EJEB, Şen kontra Hollandia, (31465/96), 2001 (jogok egyensúlyba hozása) EJEB, *Jeunesse kontra Hollandia* [Nagykamara], (12738/10), 2014 (családi élet, a gyermek legfőbb (mindenek felett álló) érdeke)
A befogadásra vonatkozó szabályokról szóló 2013/33/EU irányelv 11. cikke A visszatérési irányelv (2008/115/EK) 15. cikke	**Gyermekek őrizetbe vétele, fogvatartása**	EJEB, *Mubilanzila Mayeka és Kaniki Mitunga kontra Belgium* (13178/03), 2006 (őrizetben tartás kitoloncolás céljából) EJEB, *Popov kontra Franciaország* (39472/07 és 39474/07), 2012 (őrizetben tartás kitoloncolás céljából) EJEB, *Kanagaratnam kontra Belgium* (15297/09), 2011 (őrizetben tartás kitoloncolás céljából)
A szabad mozgásról szóló irányelv (2004/38/EK), Preambulum ((24) preambulumbekezdés), 7., 12. és13. cikk, valamint a 28. cikk (3) bekezdésének b) pontja	**Kitoloncolás**	EJEB, *Gül kontra Svájc* (23218/94), 1996 (család kiutasítása) EJEB, *Boultif kontra Svájc* (54273/00), 2001 (gyermekek kiutasítása) EJEB, *Tarakhel kontra Svájc* [Nagykamara],(29217/12), 2014 (gyermekek kiutasítása)
Az EU Alapjogi Chartájának 47–48. cikke (a hatékony jogorvoslathoz és a tisztességes eljáráshoz való jog, valamint az ártatlanság vélelme és a védelemhez való jog) A menekültügyi eljárásokról szóló irányelv (2013/32/EK) 7. és 25. cikke Az áldozatokról szóló irányelv (2012/29/EU), 8. cikk	**Az igazságszolgáltatáshoz való jog**	EJEE, 13. cikk (hatékony jogorvoslathoz való jog) EJEB, *Rahimi kontra Görögország*, (8687/08), 2011 (hatékony jogorvoslatok az őrizet feltételeinek megtámadása céljából)

Az EU-nak egyértelmű hatásköre, hogy jogot alkosson a migráció és a menekültügy területén. A migráns gyermekekre vonatkozó rendelkezések a migrációs helyzetek széles körét – ezen belül a munkával összefüggő hosszú távú migrációt, a menedékjogot és a kiegészítő védelmet – szabályozzák, és a rendezetlen jogállású migránsok helyzetével és foglalkoznak. Az Unió Alapjogi Chartájának 24. cikke alapján a migráns gyermekeket megillető védelmen túlmenően a Charta 18. és 19. cikke a menedékjoggal és a kitoloncolással, kiutasítással és kiadatással szembeni védelemmel is foglalkozik. Az EU figyelmet fordít a kísérő nélküli kiskorúak különleges szükségleteire is, többek között az olyan jogi szempontokkal kapcsolatban, mint a törvényes gyámság és törvényes képviselet, az életkor meghatározása, a család felkutatása és egyesítése, a menekültügyi eljárások, az őrizetben tartás és a kiutasítás, valamint a gyermekek életkörülményeivel összefüggő szempontokkal kapcsolatban, ideértve a szállást, az egészségügyi ellátást, az oktatást és képzést, a vallást, a kulturális normákat és értékeket, a szórakozást és szabadidős tevékenységeket, a szociális interakciót és a rasszizmussal kapcsolatos tapasztalatokat.[428]

Az Európa Tanács rendszerében különösen négy egyezmény támogatja a migráns gyermekek jogait, különféle összefüggésekben: az EJEB, az Európai Szociális Karta, a vendégmunkások jogállásáról szóló európai egyezmény és az állampolgárságról szóló európai egyezmény. Ez a fejezet főként az EJEB rendelkezéseinek végrehajtására összpontosít, nevezetesen a 3. cikk (az embertelen, megalázó bánásmóddal szembeni védelem), az 5. cikk (szabadságtól való megfosztás) és a 8. cikk (a magán- és családi élet tiszteletben tartásához való jog) végrehajtására, önmagukban véve vagy a 14. cikkel (a hátrányos megkülönböztetés tilalma) összefüggésben. E rendelkezéseket használják a migráns, menekült és menedékjogot kérelmező gyermekek és családtagjaik családegyesítéshez való jogának, igazságszolgáltatáshoz való jogának és a fogadó államban való folyamatos tartózkodáshoz való jogának alátámasztására.

Nemzetközi szinten a Gyermekjogi egyezmény több rendelkezése védi a gyermekek jogait a migráció és menekültügy összefüggésében, és ezek szolgálnak európai szinten a jogi intézkedések alakításának alapjául. A 7. cikk védi a gyermekek születéskori anyakönyvezéshez, állampolgársághoz és a szülők általi gondozáshoz való jogát; a 8. cikk védi a gyermek identitáshoz – ezen belül az állampolgársághoz, névhez és családi kapcsolatokhoz – való jogát; a 9. cikk biztosítja a szüleitől elszakított gyermek számára, hogy mindkét szülőjével kapcsolatot

428 Lásd még: FRA (2010); FRA (2011a), 27–38. o.; FRA (2011b), 26–30. o.

tartson, amennyiben ez a legfőbb (mindenek felett álló) érdeke; a 22. cikk pedig külön védelemhez és segítséghez való jogot biztosít a menekült gyermekek számára. Továbbá, általánosan a nemzetközi menekültvédelem központi elemének tekintik a menekültek jogállásáról szóló ENSZ-egyezményt[429], valamint annak 1967-es jegyzőkönyvét.

A következő részek középpontjában a belépés és tartózkodás (9.1. szakasz); az életkor meghatározás (9.2. szakasz); a családjuktól elszakított gyermekek családegyesítése (9.3. szakasz); a fogva tartás (9.4. szakasz); a kiutasítás (9.5. szakasz) és az igazságszolgáltatáshoz való hozzáférés (9.6. szakasz) áll.

9.1. Belépés és tartózkodás

Kiemelt pontok

- Az uniós állampolgárokat megilleti az Unión belüli szabad mozgás joga.
- A gyermekek belépésére és tartózkodására vonatkozó döntéseket megfelelő mechanizmusok és eljárások keretében, a gyermek legfőbb (mindenek felett álló) érdekét szem előtt tartva kell meghozni.

Az uniós jogban a gyermekek jogainak jellege és hatálya nagyrészt a gyermek és szülei állampolgárságának megfelelően változik, valamint annak megfelelően változik, hogy a gyermek szüleivel vagy önállóan érkezik-e migrációs céllal egy országba.

Az uniós állampolgárok migrációját különféle jogi eszközök szabályozzák. Az uniós állampolgároknak adott jogok kiterjedtek, és céljuk az EU-n belüli optimális mobilitás ösztönzése. Először is, az EUMSZ 21. cikke úgy rendelkezik, hogy az uniós polgároknak és családtagjaiknak joguk van a tagállamok területén való szabad mozgáshoz és tartózkodáshoz. Ezenfelül, miután megérkeztek a fogadó államba, joguk van ahhoz, hogy az adott állam állampolgáraival azonos bánásmódban részesüljenek a munkához való hozzáféréssel és a munkafeltételekkel, a szociális és jóléti juttatásokkal, az oktatással, az egészségügyi ellátással stb.

429 Az ENSZ Közgyűlése, *Egyezmény a menekültek jogállásáról*, 1951. július 28., az ENSZ szerződéssorozatának 189. kötete, 137. o.

kapcsolatban.[430] Az Unió Alapjogi Chartájának 45. cikke szintén garantálja az uniós polgárok szabad mozgását.

Továbbá, azoknak a gyermekeknek a jogait, akik uniós állampolgár szüleikkel,-gondviselőikkel költöznek, szintén a szabad mozgásról szóló irányelv[431] szabályozza. Ez kimondja, hogy a családtagoknak joguk van a fogadó államba beutazni és ott tartózkodni, akár az elsődleges uniós migráns költözésével egyidejűleg, akár azt követően (5. cikk (1) bekezdés). Ezen jogi eszköz alkalmazásában a családtag vagy az uniós migráns, vagy házastársának vagy élettársának a vér szerinti gyermeke, aki nem töltötte be a 21. életévét vagy eltartott (2. cikk (2) bekezdés). Lehet uniós vagy nem uniós állampolgár, feltéve hogy az elsődleges migráns, akivel költözik, uniós állampolgár. A költözést követő első három hónapban a család tartózkodási jogát nem kötik feltételekhez, de azt követően azoknak az uniós polgároknak, akik azt kívánják, hogy gyermekeik velük maradhassanak a fogadó államban, bizonyítaniuk kell, hogy elegendő forrással rendelkeznek, hogy eltartsák magukat, és teljes körű egészségbiztosítással rendelkeznek (7. cikk). A gyermekek és más családtagok, miután öt éven folyamatosan a fogadó államban tartózkodtak az uniós polgárral, automatikusan huzamos tartózkodási jogot szereznek (16. cikk (2) bekezdés és 18. cikk). E ponton már nem vonatkoznak rájuk a forrásokkal/egészségbiztosítással kapcsolatos feltételek.

Azoknak a harmadik országbeli állampolgároknak a mozgásszabadságára, akik nem uniós migráns családtagjai, több korlátozás vonatkozik. Ezt a területet részben az uniós jog, részben a nemzeti bevándorlási jogszabályok szabályozzák.

A nemzetközi védelmi eljárásokkal összefüggésben a gyermekek „sérülékeny személyeknek" minősülnek, akiknek sajátos, védendő helyzetét a tagállamok az uniós jog végrehajtása során kötelesek figyelembe venni.[432] Ez megköveteli az államoktól, hogy azonosítsanak és alkalmazzanak minden olyan speciális

430 Bizonyos korlátozásokat szabtak meg a Horvátországból érkező migránsok tekintetében, amely az EU-hoz utoljára csatlakozott ország, mégpedig a 2015. júniusig tartó átmeneti időszakra; a tagállamoknak lehetőségük van arra, hogy a korlátozások időtartamát 2020-ig meghosszabbítsák.

431 Felhívjuk a figyelmet arra, hogy az irányelv érintett rendelkezései az EGT-ben is alkalmazandók. Lásd még: Megállapodás az Európai Gazdasági Térségről, 1992. május 2., III. rész, A személyek, a szolgáltatások és a tőke szabad mozgása; az 1999. június 21-én Luxembourgban aláírt, 2002. június 1-jén hatályba lépett megállapodás egyrészről az Európai Közösség és tagállamai, másrészről a Svájci Államszövetség között a személyek szabad mozgásáról, HL L 114., 2002.4.30., 6. o.

432 Lásd különösen a befogadásra vonatkozó szabályokról szóló 2013/33/EU irányelv 21. cikkét és a visszatérésről szóló 2008/115/EK irányelv 3. cikkének (9) bekezdését.

rendelkezést, amelyre különösen a menedékkérelmet benyújtó gyermekeknek szükségük lehet a fogadó államba való beutazáskor. A menedékjoggal foglalkozó uniós jogszabályok beutazással és tartózkodással kapcsolatos, gyermekeket érintő követelményeire az Európai Unió Alapjogi Chartájának 24. cikke az alkalmazandó. Ez előírja, hogy az uniós tagállamoknak biztosítaniuk kell, hogy a hatóságok és a magánintézmények gyermekekkel kapcsolatos tevékenységében a gyermek legfőbb (mindenek fölött álló) érdeke legyen az elsődleges szempont. Konkrétabban, a gyermekekkel kapcsolatban a legfőbb (mindenek fölött álló) érdeken alapul a nemzetközi védelem megadására és visszavonására vonatkozó közös eljárásokról szóló 2013/32/EU irányelv, (a menekültügyi eljárásokról szóló irányelv)[433] és az egy harmadik országbeli állampolgár vagy egy hontalan személy által a tagállamok egyikében benyújtott nemzetközi védelem iránti kérelem megvizsgálásáért felelős tagállam meghatározására vonatkozó feltételek és eljárási szabályok megállapításáról szóló rendelet[434] (a dublini rendelet) végrehajtása. Mindkét szöveg tartalmaz a kísérő nélküli kiskorúakat – többek között jogi képviseletüket – érintő külön garanciákat is. A schengeni határ-ellenőrzési kódexről szóló 562/2006/EK rendelet előírja a határőröknek, hogy abban az esetben, ha a gyermeket felnőtt kíséri, ellenőrizzék, hogy a gyermeket kísérő személyek rendelkeznek-e szülői felügyeleti joggal, különösen ha a gyermeket csak egy felnőtt kíséri, és alapos a gyanúja annak, hogy a gyermeket jogellenesen vitték el a törvényes képviselőjének felügyelete alól. Ebben az esetben a határőrnek további vizsgálatot kell folytatnia az érintettek által adott információk közötti ellentmondások kiderítése érdekében. Ha a gyermekek kísérő nélkül utaznak, a határőröknek az úti okmányok és az igazoló okmányok alapos ellenőrzésével biztosítaniuk kell, hogy a gyermekek a szülői felügyeletet gyakorló személy(ek) akarata ellenére ne hagyják el a tagállamok területét.[435]

Az Európa Tanács joganyagában az államoknak az állandó nemzetközi jog alapján és a szerződéses kötelezettségeiktől (köztük az EJEE-től) függően joguk van

433 Az Európai Parlament és a Tanács 2013. június 26-i 2013/32/EU irányelve a nemzetközi védelem megadására és visszavonására vonatkozó közös eljárásokról (átdolgozás) HL L 180., 2013.6.29, 60. o.), 25. cikk (6) bekezdés.

434 Az Európai Parlament és a Tanács 2013. június 26-i 604/2013/EU rendelete egy harmadik országbeli állampolgár vagy egy hontalan személy által a tagállamok egyikében benyújtott nemzetközi védelem iránti kérelem megvizsgálásáért felelős tagállam meghatározására vonatkozó feltételek és eljárási szabályok megállapításáról (átdolgozás) (HL L 180., 2013.6.29., 31–59. o.), 6. cikk.

435 Az Európai Parlament és a Tanács 2006. március 15-i 562/2006/EK rendelete a személyek határátlépésére irányadó szabályok közösségi kódexének (Schengeni határ-ellenőrzési kódex) létrehozásáról, VII. melléklet, 6. pont.

ellenőrizni a külföldi állampolgárok beutazását, tartózkodását és kiutasítását. A magán- és családi élet tiszteletben tartásához való jogra, amelyet az EJEE 8. cikke határoz meg, gyakran hivatkoznak a kiutasítás elleni biztosítékként olyan gyermekeket érintő ügyekben, akiknek az esetében máskülönben úgy ítélnék meg, hogy nincs szükségük nemzetközi védelemre, ezen belül kiegészítő védelemre. Gyermekeket érintő ügyekben megállapították a 8. cikk megsértését, mivel a közeli családtagoktól való kényszerű elszakítás valószínűsíthetően súlyos következményekkel jár oktatásukra, szociális és érzelmi stabilitásukra valamint identitásukra is befolyással bír.[436]

9.2. Az életkor meghatározása[437]

Kiemelt pontok

- Az életkor meghatározására irányuló eljárások során figyelembe kell venni a gyermekek jogait.
- Az életkor meghatározása azokat az eljárásokat jelenti, amelyek révén a hatóságok megpróbálják megállapítani a migráns gyermek életkorát, hogy el tudják dönteni, mely menekültügyi vagy idegenrendészeti eljárást és szabályt kell követniük.

Az uniós jog keretében a menekültügyi eljárásokról szóló irányelv 25. cikkének (5) bekezdése lehetővé teszi a tagállamoknak, hogy orvosi vizsgálatokhoz folyamodjanak, de előírja, hogy ezeket „az egyén emberi méltóságának teljes mértékű tiszteletben tartása mellett kell elvégezni, az orvosi vizsgálatoknak a legkevésbé invazív jellegűnek kell lenniük, s amelyeket szakképzett egészségügyi dolgozóknak kell végrehajtani azokat". Ez a rendelkezés azt is előírja, hogy az érintetteket az általuk ismert nyelven tájékoztatni kell arról, hogy ez az életkor meghatározás elvégezhető, és hogy a vizsgálathoz meg kell szerezni a beleegyezésüket. Az orvosi vizsgálaton való részvétel kérelmező általi megtagadása nem vezethet a nemzetközi védelem iránti kérelem elutasításához.

436 EJEB, *Şen kontra Hollandia*, 31465/96, 2001. december 21. (elérhető francia nyelven); EJEB, *Tuquabo-Tekle és társai kontra Hollandia*, 60665/00, 2005. december 1.

437 Lásd még: FRA és EJEB (2014), 9.1.2. szakasz.

Az életkor meghatározására EU-szerte alkalmazott módszerek jellege és hatálya jelentősen változó.[438] Az Egyesült Királyságban például a bírói kar felülvizsgálta az életkor meghatározására irányuló belföldi eljárásokat, és a *Merton*-ügyben megállapította az életkor meghatározásának eljárási minimumkövetelményeit, ha egy személy azt állítja, hogy kísérő nélküli kiskorú.[439] Ezek a követelmények magukban foglalják többek között, hogy a menedékkérőnek joga van ahhoz, hogy tájékoztatást kapjon az elutasítás okairól vagy a vizsgálatot végző kifogásairól.[440] A nemzeti bíróságok azt is kinyilvánították, hogy az életkor-meghatározási ügyekben kétség esetén a kérelmező javára kell dönteni, jóllehet ezt egyes nemzeti bíróságok egyszerűen „a bizonyítékok jószándékú értékeléseként" értelmezik, nem pedig a „kedvezőbb elbírálás" formális elveként.[441]

Az Európa Tanács joganyagában nincsenek külön rendelkezések és nem áll rendelkezésre EJEB ítélkezési gyakorlat a gyermekeket az életkor meghatározására irányuló eljárásokkal összefüggésben megillető jogokkal kapcsolatban. Az e célból alkalmazott különösen invazív gyakorlatok azonban az EJEE 3. cikke vagy 8. cikke alapján kérdéseket vethetnek fel. A 3. cikket úgy értelmezik, hogy az embertelennek vagy megalázónak tekinthető forgatókönyvek széles körét foglalja magában, ideértve a gyermekek invazív fizikális vizsgálatát.[442] A 8. cikk alapján, azt a migrációval összefüggésben alkalmazva, a hatóságok jogszerűen beavatkozhatnak a gyermek magánélethez való jogába és elvégezhetik az életkor meghatározását, ha az összhangban van a joggal és az EJEE 8. cikkének (2) bekezdésében felsorolt jogos célok egyikének védelmében szükséges.

Ami a nemzetközi jogot illeti, a Gyermekjogi egyezmény 8. cikke kötelezi az államokat arra, hogy tartsák tiszteletben a gyermek személyazonossághoz és identitáshoz való jogát. Ennek része az a kötelezettség, hogy segítsenek a gyermeknek abban, hogy megerősítse identitátását, ami magával vonhatja a gyermek

438 Az egyes országokban alkalmazott különféle módszerek áttekintését lásd: European Asylum Support Office: Iránymutatások az életkor meghatározásának gyakorlataihoz, Luxemburg, 2014. Lásd még: FRA (2010), 53–55. o.

439 Egyesült Királyság, Court of Appeal, *R. (B. kérelme alapján) kontra The Mayor and Burgesses of the London Borough of Merton* [2003] EWHC 1689, 2003. július 14.

440 Lásd még: FRA (2010), 61–66. o.

441 Egyesült Királyság, Court of Appeal, *R. (CJ. kérelme alapján) kontra Cardiff County Council* [2011] EWCA Civ 1590, 2011. december 20., megerősítette: Egyesült Királyság, Upper Tribunal, *R. (MK. kérelme alapján) kontra Wolverhampton City Council* [2013] UKUT 00177 (IAC), 2013. március 26.

442 EJEB, *Yazgül Yilmaz kontra Törökország* (36369/06), 2011. február 1. (elérhető francia nyelven).

életkorának megerősítését is. Az életkor meghatározását célzó eljárásokhoz azonban csak végső esetben szabad folyamodni.

Az életkor meghatározását célzó nemzeti eljárásoknak mindenesetre a gyermek legfőbb (mindenek felett álló) érdekének az elvén kell alapulniuk. Az ENSZ Gyermekjogi Bizottsága megállapítja, hogy az életkor meghatározásakor figyelembe kell venni a gyermek fizikai megjelenését és pszichés érettségét. Az életkort tudományos, biztonságos módon, a gyermekek érdekeinek és a nemi szempontoknak a figyelembevételével, tisztességes módon kell meghatározni, és ennek során kerülni kell a gyermek testi épségének megsértését, és tiszteletben kell tartani az emberi méltóságot.[443]

9.3. Családegyesítés a családjuktól elszakított gyermekek esetében[444]

Kiemelt pontok

- A családegyesítésre vonatkozó európai szintű rendelkezések főként a gyermekekre és szüleikre összpontosulnak, akár a befogadó országban, akár származási országukban.
- A családegyesítéskor a családtagok közül elsőbbséget élveznek a gyermek szülei és/vagy elsődleges gondviselői.
- A családegyesítési ügyekben alapelvként a gyermek legfőbb (mindenek felett álló) érdekét kell szem előtt tartani.

Az uniós jogban a legfontosabb eszköz a családegyesítési irányelv, amely előírja a tagállamoknak, hogy engedélyezzék a kísérő nélküli kiskorú harmadik országbeli állampolgár szüleinek beutazását és tartózkodását – amennyiben nem szolgálná jobban a gyermek legfőbb (mindenek felett álló) érdekét, ha külföldön csatlakozna a szüleihez. Szülő hiányában a tagállamok mérlegelhetik a gyermek törvényes gyámja vagy más családtagja beutazásának és tartózkodásának

443 ENSZ Gyermekjogi Bizottság 6. számú Általános Kommentár (2005) „Treatment of Unaccompanied and Separated Children outside their Country of Origin" [A kísérő nélküli és felnőtt hozzátartozóiktól elszakított gyermekek kezelése származási országuk területén kívül], (V)(a)(31)(A). pont.

444 Lásd még: FRA és EJEB (2014), a családegyesítésről szóló 5.3. szakasz.

engedélyezését.[445] A „család" fogalommeghatározása és a hozzá kapcsolódó jogok ezért a kíséret nélküli kiskorúakkal kapcsolatban nagyvonalúbbak, mint a migráns gyermekek legtöbb egyéb kategóriája esetében.

Ami a menedékkérő gyermekeket illeti, az elismerésről szóló irányelv hangsúlyozza annak szükségességét, hogy a kísérő nélküli kiskorúakat a fogadó államban felnőtt hozzátartozóknál helyezzék el, együtt maradjanak a testvéreikkel, és hogy a távollévő családtagokat kellően körültekintő és biztonságos módon, a lehető leggyorsabban megkeressék (31. cikk). A befogadásra vonatkozó szabályokról szóló irányelv hasonló rendelkezéseket tartalmaz az olyan, kísérő nélküli kiskorúak tekintetében, akik még nem szereztek menekült jogállást (24. cikk).

A lakóhelyüket elhagyni kényszerült személyek tömeges beáramlása esetén nyújtandó átmeneti védelem minimumszabályairól, valamint a tagállamoknak e személyek befogadása és a befogadás következményeinek viselése tekintetében tett erőfeszítései közötti egyensúly előmozdítására irányuló intézkedésekről szóló 2001/55/EK tanácsi irányelv (az átmeneti védelemről szóló irányelv) szintén igyekszik meggyorsítani azon családtagok (köztük gyermekek) egyesítését, akik a származási országukból való hirtelen kitelepítést követően szakadtak el egymástól (15. cikk).[446] Ezt az irányelvet azonban egyelőre nem alkalmazzák; ahhoz, hogy megkezdődjön az alkalmazása, egy tanácsi határozat szükséges – ezt a határozatot azonban egyelőre nem hozták meg.

A befogadásra vonatkozó szabályokról szóló irányelv (átdolgozás) 24. cikkének (3) bekezdése ugyancsak előírja, hogy a tagállamok szükség esetén kezdjék meg a kísérő nélküli gyermek családtagjainak felkutatását. Ezt a kísérő nélküli kiskorú legfőbb (mindenek felett álló) érdekének védelme mellett, a nemzetközi védelem iránti kérelem benyújtását követően a lehető leghamarabb teszik, szükség esetén nemzetközi vagy egyéb kapcsolódó szervezetek segítségével. Azokban az esetekben, ha a gyermek, illetve közeli rokonai életét vagy testi épségét veszély fenyegetheti, különösen, ha az érintettek a származási országban maradtak, biztonságuk veszélyeztetésének elkerülése érdekében gondoskodni kell annak biztosításáról, hogy az e személyekre vonatkozó információk beszerzése,

445 A 10. cikk (3) bekezdésének a), illetve b) pontja.

446 A Tanács 2001. július 20-i 2001/55/EK irányelve a lakóhelyüket elhagyni kényszerült személyek tömeges beáramlása esetén nyújtandó átmeneti védelem minimumszabályairól, valamint a tagállamoknak e személyek befogadása és a befogadás következményeinek viselése tekintetében tett erőfeszítései közötti egyensúly előmozdítására irányuló intézkedésekről, HL L 212.,.2001.8.7., 12–23. o.

feldolgozása és terjesztése bizalmas keretek között történjen. Továbbá, az elismerésről szóló irányelv (átdolgozás) 31. cikkének (5) bekezdésével összhangban a gyermek nemzetközi védelemben való részesítése nem zavarhatja a felkutatási folyamat megkezdését vagy folytatását.

Ezen túlmenően a dublini rendelet meghatározza, hogy ha a kiskorú gyermeknek másik tagállamban élő hozzátartozója van, aki képes gondoskodni a gyermekről, a tagállamok – amennyiben lehetséges – kötelesek a családegyesítést elősegíteni a gyermek hozzátartozójával, kivéve ha ez nem szolgálja a gyermek legfőbb (mindenek felett álló) érdekét (8. cikk). Ezenfelül a rendelet arra vonatkozó kötelezettséget tartalmaz, hogy fel kell kutatni a hozzátartozókat a tagállamok területén, a gyermek legfőbb (mindenek felett álló) érdekének védelme mellett (6. cikk). Továbbá, a befogadásra vonatkozó szabályokról szóló irányelv kötelezettséget tartalmaz, amely szerint meg kell kezdeni a gyermek családtagjainak felkutatását, szükség esetén nemzetközi vagy egyéb kapcsolódó szervezetek segítségével (24. cikk). Az utóbbi típusú segítségnyújtást a dublini rendelet is tervbe veszi (6. cikk).

A családegyesítésre vonatkozó határozatok mérlegelésekor mindig a gyermek legfőbb (mindenek felett álló) érdekének az elvét kell alkalmazni. A szülőknek bizonyítaniuk kell például, hogy képesek megfelelően ellátni szülői feladataikat. A nemzeti hatóságok jogszerűtlennek minősítik a gyermek származási országába való kiutasítását, ha a hatóságok nem gyűjtöttek bizonyítékokat arra vonatkozóan, hogy az adott országban megfelelően tudják fogadni és ellátni a gyermeket (visszatérési irányelv, 10. cikk (2) bekezdés).

Ami az Európa Tanács jogát illeti, az EJEE 8. cikke nem ad korlátlan jogot a migráns szülők és gyermekeik számára annak megválasztására, hogy hol kívánnak élni. A nemzeti hatóságok jogszerűen kitoloncolhatnak családtagokat vagy megtagadhatják családtagok beutazását, feltéve hogy nem állnak leküzdhetetlen akadályok annak az útjában, hogy a család máshol telepedjen le.[447] Az ilyen döntéseknek mindig tágabb közrenddel kapcsolatos aggályokra adott, arányos válaszintézkedésnek kell lenniük, ideértve az olyan szülő kitoloncolásának vagy beutazása megtagadásának kívánatosságát, aki bűncselekményt követett el.

447 EJEB, *Bajsultanov kontra Ausztria* (54131/10), 2012. június 12.; EJEB, *Latifa Benamar és társai kontra Hollandia*, 43786/04. sz. elfogadhatatlansági határozat, 2005. április 5.

Példa: A *Şen kontra Hollandia* ügyben az EJEB megerősítette, hogy a gyermek/család jogainak és a tágabb közrendi érdekeknek az egyensúlyba hozása során három kulcsfontosságú tényezőt kell figyelembe venni: a gyermekek életkorát; a származási országbeli helyzetüket; és azt, hogy valójában milyen mértékben függnek a szülői gondoskodástól.

Példa: A *Jeunesse kontra Hollandia* ügy[448] abból indult ki, hogy a holland hatóságok megtagadták egy holland állampolgárral összeházasodott Suriname-i asszonytól, akinek e házasságból három gyermeke is született, hogy az országban folytatott korábbi családi élete alapján Hollandiában tartózkodhasson. Az EJEB úgy ítélte meg, hogy a hatóságok nem fordítottak kellő figyelmet az elutasítás kérelmező gyermekeire és legfőbb (mindenek felett álló) érdekeikre gyakorolt hatására. Az EJEB megállapította az EJEE 8. cikkének megsértését, azon az alapon, hogy nem találtak megfelelő egyensúlyt a kérelmezőnek és családjának ahhoz fűződő személyes érdeke között, hogy Hollandiában éljen családi életet, illetve a kormány bevándorlás szabályozásával kapcsolatos közrendi érdekei között.

A nemzetközi jog alapján a gyermeknek joga van ahhoz, hogy ne válasszák el a családjától, kivéve, ha ez az elválasztás a gyermek legfőbb (mindenek felett álló) érdekében szükséges (Gyermekjogi egyezmény 9. cikkének (1) bekezdése). A Gyermekjogi egyezmény 10. cikke kimondja, hogy annak a gyermeknek, akinek szülei különböző államokban élnek, lehetővé kell tenni, hogy ezen országok között mozogjon, és így mindkét szülőjével rendszeresen személyes kapcsolatot tartson fenn, vagy – a nemzeti migrációs jogra figyelemmel – lehetővé kell tenni számára a családegyesítést. A gyermekek vagy kísérő nélküli kiskorúak családjainak az egyesítésére vonatkozó minden döntést a Gyermekjogi egyezmény 3. cikkében foglalt legfőbb (mindenek felett álló) érdek elve vezérel.[449]

448 EJEB, *Jeunesse kontra Hollandia* [Nagykamara] (12738/10), 2014. október 3.

449 Az UNICEF szerint a nemzeti bíróságoknak a gyermek családjával való, fogadó állambeli egyesítésére vonatkozó kérelmekkel kapcsolatban biztosítaniuk kell, hogy a szülők ne használják fel gyermekeiket annak érdekében, hogy az adott országban tartózkodási engedélyt szerezzenek. Lásd: UNICEF, Judicial implementation of Art. 3 of the CRC in Europe (A gyermekjogi egyezmény 3. cikkének végrehajtása az európai igazságszolgáltatásban), 104. o. Lásd még: UNHCR-UNICEF, *Guidelines on Determining the Best Interests of the Child* (Iránymutatások a gyermek legfőbb (mindenek felett álló) érdekének megállapításához), 2008. május.

9.4. Fogvatartás

Kiemelt pontok

- Az európai jog a gyermekek fogvatartását a migrációval összefüggésben csak végső eszközként engedélyezi.
- A nemzeti hatóságok kötelesek a gyermekek számára megfelelő elhelyezést biztosítani.

Az uniós jogban a befogadásra vonatkozó szabályokról szóló (átdolgozott) irányelv 11. cikke előírja, hogy gyermekeket kizárólag végső esetben lehet fogva tartani, és csak akkor, ha kevésbé kényszerítő jellegű intézkedések alkalmazása nem lenne hatékony. A fogvatartást a lehető legrövidebb időtartamra kell elrendelni, és mindent meg kell tenni a fogva tartott kiskorú szabadon bocsátása és megfelelő szálláshelyen történő elhelyezése érdekében. Amennyiben gyermekeket tartanak őrizetben, biztosítani kell számukra a szabadidős tevékenységekben történő részvétel lehetőségét – ideértve a koruknak megfelelő játékokat és szabadidős tevékenységeket. Ugyanezen cikk szerint a kísérő nélküli kiskorúakat kizárólag kivételes körülmények között lehet fogva tartani, és mindent meg kell tenni mielőbbi szabadon bocsátásuk érdekében. Soha nem szabad őket büntetés-végrehajtási intézményben fogva tartani, hanem olyan intézményekben kell elhelyezni, amelyek személyzete és felszereltsége az említett korosztály szükségleteit figyelembe veszi. A gyermekeket a felnőttektől elkülönítve kell elszállásolni.

A visszatérési irányelv 17. cikke bizonyos feltételekre figyelemmel tervbe veszi az olyan gyermekek és családok őrizetben tartását, akik menedékjog iránti kérelmét elutasították. Ami a kísérő nélküli kiskorúakat illeti, előírja azonban, hogy őket olyan intézményekben kell elhelyezni, amelyek személyzete és felszereltsége az említett korosztály szükségleteit figyelembe veszi. Egyelőre nem áll rendelkezésre kifejezetten gyermekek fogva tartásával kapcsolatos EUB ítélkezési gyakorlat.

Az Európa Tanács joganyagában a migráns gyermekek fogvatartásával az EJEE 3. és 5. cikkével összefüggésben foglalkoznak.

Példa: A *Mubilanzila Mayeka és Kaniki Mitunga kontra Belgium* ügy[450] egy fogva tartott kísérő nélküli gyermeket érint. Egy ötéves gyermeket két hónapon át egy felnőttek számára működtetett tranzitközpontban tartottak őrizetben, megfelelő támogatás nélkül. A gyermek a Kongói Demokratikus Köztársaságból utazott a szükséges útiokmányok nélkül, abban reménykedve, hogy újra anyjához kerülhet, aki Kanadában menekült jogállást kapott. A gyermeket ezt követően visszatoloncolták a Kongói Demokratikus Köztársaságba, annak ellenére, hogy ott nem várta semmilyen családtag, aki gondoskodott volna róla. Az EJEB megállapította, hogy mivel nem állt fenn annak a kockázata, hogy a gyermek megpróbál kikerülni a belga hatóságok felügyelete alól, a felnőttek számára működtetett zárt központban való őrizetben tartása szükségtelen volt. Az EJEB azt is megállapította, hogy más intézkedések – például gyermekvédelmi szakellátásban való elhelyezése – meghozatalára is lehetőség lett volna, amelyek jobban szolgálták volna a gyermek legfőbb (mindenek felett álló) érdekét, amelyet a Gyermekjogi egyezmény 3. cikke rögzít. Az EJEB megállapította az EJEE 3., 5. és 8. cikkének megsértését.

Más ügyek arra világítottak rá, hogy a fogvatartás akkor is jogellenes, ha az érintett gyermeket szülő kíséri.

Példa: A *Muskhadzhiyeva és társai kontra Belgium* ügyben[451] az EJEB megállapította, hogy egy anya és négy, hét hónap és hét év közötti életkorú gyermekének zárt tranzitközpontban való, egyhónapos fogva tartása sértette az EJEE 3. cikkét. Következtetéseinek levonása során a bíróság felhívta a figyelmet arra, hogy a központot „felszereltsége nem tette alkalmassá gyermekek fogadására”, ami súlyos következményekkel járt mentális egészségükre nézve.

Példa: A *Popov kontra Franciaország* ügy[452], amelynek témája egy család Kazahsztánba történő kiutasítását megelőző, kéthetes adminisztratív őrizetben tartása volt, megerősíti ezt az ítéletet. Az EJEB megállapította az EJEE 3. cikkének megsértését, minthogy a francia hatóságok nem vették számításba a két (öthónapos és hároméves) gyermekre azáltal gyakorolt

450 EJEB, *Mubilanzila Mayeka és Kaniki Mitunga kontra Belgium* (13178/03), 2006. október 12.

451 EJEB, *Muskhadzhiyeva és társai kontra Belgium* (41442/07), 2010. január 19. (elérhető francia nyelven).

452 EJEB, *Popov kontra Franciaország* (39472/07 és 39474/07), 2012. január 19.

káros hatásokat, hogy egy fogdában tartották őket, olyan körülmények között, amelyek „alkalmatlanok voltak gyermekek számára”.[453] A bíróság az egész családra vonatkozóan megállapította az 5. és a 8. cikk megsértését is, és utalt a Gyermekjogi egyezmény 37. cikkére, amely előírja, hogy „a szabadságától megfosztott gyermekkel emberségesen és az emberi méltóságnak kijáró tisztelettel, életkorának megfelelő szükségleteinek figyelembevételével bánjanak”.[454]

Példa: Hasonlóképpen, a *Kanagaratnam kontra Belgium* ügyben[455] egy menedékjog iránt folyamodó anyának és három gyermekének egy rendezetlen jogállású külföldiek számára kialakított zárt központban való, négy hónapon át tartó fogva tartása az EJEE 3. és 5. cikke megsértésének minősült. Annak ellenére, hogy a gyermekeket anyjuk kísérte, a bíróság úgy ítélte meg, hogy a belga hatóságok – azáltal, hogy a gyermekeket zárt központban helyezték el – szorongást és kisebbségi érzést keltettek a gyermekekben, és a tények teljes körű ismeretében veszélybe sodorták a gyermekek fejlődését. [456]

A nemzetközi jog keretében a Gyermekjogi egyezmény 9. cikkének (4) bekezdése kimondja, hogy ha egy gyermeket fogva tartanak, az állami hatóságoknak tájékoztatniuk kell a gyermek szüleit a gyermek hollétéről.[457]

453 *Uo.*, 95. bek.

454 *Uo.*, 90. bek.

455 EJEB, *Kanagaratnam kontra Belgium* (15297/09), 2011. december 13. (elérhető francia nyelven).

456 A Kínzás, Embertelen vagy Megalázó Bánásmód vagy Büntetések Megelőzésére Létrehozott Európai Bizottság (az Európa Tanács kínzás megelőzésével foglalkozó bizottsága) 19. általános jelentésében védőintézkedéseket írt le a szabadságuktól megfosztott rendezetlen jogállású migránsok tekintetében, illetve további védőintézkedéseket írt le a gyermekek tekintetében; lásd még: *20 years of combating torture [A kínzás elleni küzdelem 20 éve], A Kínzás, Embertelen vagy Megalázó Bánásmód vagy Büntetések Megelőzésére Létrehozott Európai Bizottság 19. általános jelentése*, 2008. augusztus 1–2009. július 31.

457 Az őrizetben tartott gyermekek védelmét szolgáló nemzetközi biztosítékokat illetően lásd: *a kínzás és más kegyetlen, embertelen és megalázó bánásmód és büntetés területével foglalkozó különleges előadó jelentése (Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment)*, 2015. március 5., A/HRC/28/68.

9.5. Kiutasítás[458]

Kiemelt pontok

- A migráns gyermekek kiutasításának veszélye eredendően összefügg szüleik fogadó állambeli tartózkodási jogállásával.
- A migráns gyermekek és családjuk/elsődleges gondviselőik kiutasításával kapcsolatban minden döntést a legfőbb (mindenek felett álló) érdekek elvének kell vezérelnie.
- Az uniós jog alapján léteznek olyan körülmények, amelyek között a migráns gyermekek a fogadó államban maradhatnak, szüleik jogállásától függetlenül, különösen az iskola befejezését szem előtt tartva, vagy amennyiben a családi élet megteremtése másutt nehéz lenne.

Az uniós jog keretében az uniós migrációs jog más területeihez hasonlóan a gyermekek kiutasítására irányadó szabályok állampolgárságuktól, szüleik állampolgárságától és migrációjuk kontextusától függően változnak. Miután egy gyermek a szabad mozgásra vonatkozó uniós jog alapján bejutott egy tagállamba, valószínű, hogy ott is maradhat, még akkor is, ha az uniós migráns szülő, akivel eredetileg odaköltözött, már nem jogosult a folyamatos tartózkodásra vagy úgy dönt, hogy elhagyja a tagállamot.

A szabad mozgásról szóló irányelv alapján a gyermekek és más családtagok a fogadó államban maradhatnak annak az uniós polgár szülőnek a halála után, akivel együtt eredetileg a tagállamba költöztek (12. cikk (2) bekezdés), feltéve hogy a szülő halála előtt legalább 12 hónapon át a fogadó államban éltek. Hasonlóképpen, elviekben a fogadó államban maradhatnak a szülő elutazása után is. Ha azonban a gyermek/családtag harmadik országbeli állampolgár, úgy további tartózkodásának feltétele mindkét esetben, hogy képes legyen bizonyítani, hogy egészségbiztosítással, valamint elegendő pénzzel rendelkezik ahhoz, hogy eltartsa magát. (7. cikk).

458 Másképp visszatérés, kitoloncolás, hazaszállítás, kiadatás vagy áttelepítés, a jogi szövegkörnyezettől függően. E fejezet alkalmazásában a kiutasítás kifejezést egy nem állampolgár vagy más személy valamely államból való jogszerű eltávolításának meghatározására fogjuk használni. Lásd még: FRA és EJEB (2014), 5.4. szakasz a család fenntartásáról – védelem a kiutasítással szemben.

A szabályok még megengedőbbek a fogadó állambeli oktatási intézményekbe beiratkozott gyermekek esetében. Ilyen esetekben a gyermekek és szüleik vagy gondviselőjük jogosult arra, hogy az elsődleges migráns uniós polgár halála után a fogadó államban maradjanak, függetlenül a gyermek állampolgárságától (12. cikk (3) bekezdés). Jóllehet eredetileg úgy gondolták, hogy ez az oktatással összefüggő engedmény csak az eltartásukhoz elegendő pénzzel rendelkező családokban élő gyermekekre vonatkozik[459], a későbbi ítélkezési gyakorlat megerősítette, hogy azokra az oktatásban részt vevő gyermekekre is vonatkozik, akik szociális jóléti támogatásra szorulnak.[460]

Továbbá, a családtagok és különösen a harmadik országbeli állampolgár szülők is jogosultak a fogadó államban maradni az uniós polgár házastárstól történő válást követően, ha a pár gyermekeit illetően elsődleges felügyeleti jog illeti meg őket vagy a gyermekeket illetően olyan láthatási jogokat kaptak, amelyeket a fogadó államban kell gyakorolniuk (a 13. cikk (2) bekezdésének b) és d) pontja).

Az EUB egy gyermek mint az EUMSZ 20. cikke szerinti uniós polgár jogállására hivatkozott, hogy a gyermek harmadik országbeli állampolgár szüleinek munkavállalási engedélyt és tartózkodási engedélyt adjon a gyermek állampolgársága szerinti uniós tagállamban. Ez lehetővé teszi a gyermek számára, hogy éljen az uniós polgárként őt megillető jogokkal, amennyiben a gyermeknek máskülönben el kellene hagynia az EU-t, hogy csatlakozzon szüleihez.[461] Az Európai Unió Bíróságának későbbi ítélkezési gyakorlata azonban jelzi, hogy „pusztán az a tény, hogy gazdasági okokból vagy a család egységének az Unió területén történő biztosítása érdekében valamely tagállami állampolgár számára kívánatosnak tűnhet, ha családtagjai, akik nem rendelkeznek egyetlen tagállam állampolgárságával sem, vele együtt az Unió területén tartózkodnának, önmagában nem elegendő annak megállapításához, hogy az uniós polgár kénytelen volna elhagyni az Unió területét e tartózkodási jog megtagadása esetén”.[462]

459 EUB, C-413/99. sz. ügy, *Baumbast és R. kontra Secretary of State for the Home Department*, 2002. szeptember 17.

460 EUB, C-480/08. sz. ügy, *Maria Teixeira kontra London Borough of Lambeth és Secretary of State for the Home Department*, 2010. február 23.; EUB, C-310/08. sz. ügy, *London Borough of Harrow kontra Nimco Hassan Ibrahim és Secretary of State for the Home Department* [Nagytanács], 2010. február 23. A migráns gyermekek oktatásával a 8.2. szakasz foglalkozik részletesebben.

461 EUB, C-34/09. sz. ügy, *Gerardo Ruiz Zambrano kontra Office National de l’Emploi (ONEm)*, 2011. március 8.

462 EUB, C-256/11. sz. ügy, *Murat Dereci és társai kontra Bundesministerium für Inneres*, 2011. november 15., 68. pont. Lásd még: EUB, C-40/11. sz. ügy, *Yoshikazu Iida kontra Stadt Ulm*, 2012. november 8. Lásd még: FRA és EJEB (2014), 125–127. o.

A szabad mozgásról szóló irányelv kifejezetten úgy rendelkezik, hogy a gyermekek kivételes kiutasításának összhangban kell lennie a Gyermekjogi egyezmény rendelkezéseivel ((24) preambulumbekezdés). Ezenfelül a 28. cikk (3) bekezdésének b) pontja megerősíti a gyermekek kiutasítással szembeni mentességét, kivéve akkor, ha úgy ítélik meg, hogy a kiutasítás szolgálja a gyermek legfőbb (mindenek felett álló) érdekét, és összhangban van a Gyermekjogi egyezménnyel.

Ami azokat a menedékkérő gyermekeket illeti, akiknek a kérelmét elutasították, a visszatérési irányelv meghatározza, hogy a kísérő nélküli kiskorúak kiutasításával kapcsolatos döntéseket a gyermek legfőbb (mindenek felett álló) érdekének kell vezérelnie (10. cikk). Ezenfelül a kísérő nélküli kiskorúak a tagállam területéről történő kitoloncolása előtt a tagállam hatóságainak meg kell győződniük arról, hogy a gyermek egy családtagjához, kinevezett gondviselőhöz vagy a fogadó állam megfelelő befogadó intézménybe kerül (10. cikk (2) bekezdés).

Amennyiben menedékkérő gyermekeket küldenek vissza egy másik tagállamba, hogy ott értékeljék menedékkérelmüket, a dublini rendelet meghatározza, hogy az ilyen határozatok alkalmazását a legfőbb (mindenek felett álló) érdek elvének kell vezérelnie (6. cikk). Továbbá, a rendelet meghatározza azoknak a tényezőknek az ellenőrző listáját, amelyek segítenek a hatóságoknak annak eldöntésében, hogy mi a gyermek érdeke. Ez magában foglalja a következők kellő figyelembevételét: a gyermek családegyesítési lehetőségei; a gyermek jólléte és fejlődése; biztonsági megfontolások, különösen ha fennáll annak a veszélye, hogy a gyermek emberkereskedelem áldozatává válik; a gyermek véleménye életkorának és érettségének megfelelően.

Példa: A *The Queen, MA. és társai kérelme alapján kontra Secretary of State for the Home Department* ügyben[463] az EUB-nek azt kellett eldöntenie, hogy melyik állam a felelős egy olyan, kísérő nélküli gyermek esetében, aki különböző uniós tagállamokban nyújtott be menedékjog iránti kérelmet, és akinek nincsenek családtagjai vagy rokonai más uniós tagállamokban. Az EUB tisztázta, hogy a tagállamok valamelyikének területén jogszerűen tartózkodó családtag hiányában az ilyen kérelem megvizsgálásáért az az állam felelős, amelyben a gyermek fizikailag tartózkodik. Ebben az Európai Unió Alapjogi Chartája 24. cikkének (2) bekezdését vette alapul, miszerint minden, a gyermekekkel kapcsolatos tevékenységben a gyermek legfőbb (mindenek felett álló) érdekének kell az elsődleges szempontnak lennie.

463 EUB, C-648/11. sz. ügy, *The Queen, MA és társai kérelme alapján kontra Secretary of State for the Home Department*, 2013. június 6.

Az Európa Tanács joganyagában az államok számára az EJEE 8. cikkének (2) bekezdésével összhangban elvileg megengedett, hogy beavatkozzanak a családi élet tiszteletben tartásához való jogba.

Példa: A *Gül kontra Svájc* ügy[464] egy olyan kérelmezőt érint, aki feleségével és lányával Svájcban élt; az összes családtag humanitárius okból kapott tartózkodási engedélyt. A kérelmező Svájcba kívánta vinni kiskorú fiát is, akit Törökországban hagytak hátra, de a svájci hatóságok elutasították e kérésének teljesítését, főként azon az alapon, hogy nem rendelkezik elégséges eszközökkel ahhoz, hogy eltartsa a családját. Az EJEB megállapította, hogy Törökország elhagyásával a kérelmező maga idézte elő a fiától való különválást. A Törökországban tett közelmúltbeli látogatásai bizonyították, hogy a politikai menedékjog iránti svájci kérelmének eredeti okai már nem érvényesek. Nem állt fenn semmilyen akadálya annak, hogy a család származási országában telepedjen le, ahol kiskorú fiúk mindig is élt. Annak elismerése mellett, hogy családjuk helyzete emberi szempontból nagyon nehéz, a bíróság megállapította, hogy nem sértették meg az EJEE 8. cikkét.

Példa: Az *Üner kontra Hollandia* ügyben[465] megerősítették, hogy annak eldöntésekor, hogy a kiutasítás arányos válaszintézkedés-e, figyelembe kell venni, hogy a kiutasítás milyen hatással lenne a családban élő gyermekekre. Ez a következők mérlegelését foglalja magában: „a gyermekek legfőbb (mindenek felett álló) érdeke és jólléte, különösen azoknak a nehézségeknek a súlyossága, amelyekkel bármely gyermeknek […] valószínűleg szembe kell néznie abban az országban, amelybe a kérelmezőt ki kívánják toloncolni; valamint a fogadó országban és a célországban aktuálisan meglévő szociális, kulturális és családi kötelékek szilárdsága”.

Példa: A *Tarakhel kontra Svájc* ügyben[466], a svájci hatóságok elutasították egy afgán pár és hat gyermekük menedékjog iránti kérelmének megvizsgálását, és úgy határoztak, hogy visszaküldik őket Olaszországba. Az EJEB megállapította, hogy tekintettel az olaszországi befogadási rendszer jelenlegi helyzetére és mivel hiányoztak a konkrét céllétesítményre vonatkozó részletes és megbízható információk, a svájci hatóságok nem rendelkeztek elegendő biztosítékkal

464 EJEB, *Gül kontra Svájc* (23218/94), 1996. február 19.

465 EJEB, *Üner kontra Hollandia* [Nagykamara] (46410/99), 2006. október 18., 57–58. bek. Lásd még: *Boultif kontra Svájc* (54273/00), 2001. augusztus 2.

466 EJEB, *Tarakhel kontra Svájc* [Nagykamara] (29217/12), 2014. november 4.

arra nézve, hogy a kérelmezőkről – ha visszaküldik őket Olaszországba – a gyermekek életkorának megfelelő módon fognak gondoskodni. Az EJEB ezért megállapította, hogy sértené az EJEE 3. cikkét, ha a svájci hatóságok a Dublin II rendelet alapján úgy küldenék vissza a kérelmezőket Olaszországba, hogy előtte nem szereznének be az olasz hatóságoktól megfelelő biztosítékokat arra vonatkozóan, hogy a kérelmezőkről a gyermekek életkorának megfelelő módon fognak gondoskodni, és hogy a családot együtt fogják tartani.

A nemzetközi jog alapján az államok letartóztatás, szabadságvesztés-büntetés, száműzetés, kiutasítás vagy halál esetén kérelemre közlik a szülőkkel vagy a gyermekkel a hiányzó családtag vagy családtagok tartózkodási helyére vonatkozó lényeges adatokat, kivéve, ha ez hátrányos lenne a gyermek jóllétére nézve (Gyermekjogi egyezmény 9. cikkének (4) bekezdése).

9.6. Az igazságszolgáltatáshoz való jog[467]

Kiemelt pontok

- A migráns gyermekeknek is joguk van a hatékony jogorvoslathoz.

Az uniós jogban a gyermekek igazságszolgáltatáshoz való hozzáférési jogait a bevándorlással összefüggésben több különböző jogi eszköz határozza meg. Mindenekelőtt a hatékony jogorvoslathoz és a tisztességes eljáráshoz való jogot az Európai Unió Alapjogi Chartájának 47. cikke határozza meg. Ez tartalmazza az ahhoz való jogot, hogy mindenkinek az ügyét független és pártatlan bíróság tisztességesen, nyilvánosan és ésszerű időn belül megtárgyalja, a tanácsadás, védelem és képviselet igénybevételének lehetősége valamint a 48. cikk szerinti megfelelő jogi képviselet mellett. A migráns gyermekek esetében mindezt több másodlagos jogi rendelkezés erősíti meg. A dublini rendelet kötelezi a tagállamokat annak biztosítására, hogy a kísérő nélküli gyermeket megfelelően képzett szakember képviselje, akinek hozzáférése van a gyermek aktájában szereplő, releváns dokumentumok tartalmához (6. cikk). Ezzel párhuzamos rendelkezéseket tartalmaz az elismerésről szóló irányelv (31. cikk) és a menekültügyi eljárásokról szóló irányelv (25. cikk). A gyermekek jogi képviselethez való jogát a különleges, bizalmasan működő áldozatsegítő

467 Lásd még: FRA és EJEB (2014), 4.5. szakasz (Jogi segítségnyújtás menekültügyi és kiutasítási eljárások során).

szolgáltatások igénybevételéhez való joguk is támogatja, amelyet a bűncselekmények áldozatainak jogaira, támogatására és védelmére vonatkozó minimumszabályok megállapításáról szóló 2012/29/EU irányelv[468] (az áldozatokról szóló irányelv) 8. cikke határoz meg.

Az igazságszolgáltatáshoz való hozzáféréshez kapcsolódó jogok azonban nem korlátlanok, és bizonyos életkori feltételekhez lehetnek kötöttek. A menekültügyi eljárásokról szóló irányelv például előírja a tagállamoknak, hogy „nem kell [jogi] képviselőt kijelölniük, ha a kísérő nélküli kiskorú minden valószínűség szerint betölti a 18. életévét, mielőtt az elsőfokú határozat meghozatalára sor kerül" (25. cikk (2) bekezdés).

Ami az Európa Tanács joganyagát illeti, az EJEB a külföldiek beutazására, tartózkodására és kitoloncolására vonatkozó döntésekkel kapcsolatos ügyekben kizárta a 6. cikk (tisztességes tárgyaláshoz való jog) alkalmazandóságát.[469] Az EJEE 13. cikkére (hatékony jogorvoslathoz való jog) azonban bizonyos körülmények között lehet támaszkodni.

Példa: A *Rahimi kontra Görögország* ügy[470] azokat a feltételeket érinti, amelyek mellett egy afganisztáni migráns gyermeket, aki irregulárisan utazott be Görögországba, egy fogdában tartották, majd később elengedték, hogy kiutasítsák. Az EJEB, amely megállapította az EJEE 13. cikkének megsértését, megjegyzi, hogy a kérelmezőnek adott tájékoztató füzet nem tüntette fel, hogy milyen eljárást kell követni, ha panaszt kíván tenni a rendőrkapitányságon. Ráadásul a kérelmezőt nem tájékoztatták az általa értett nyelven a rendelkezésre álló jogorvoslatokról sem, amelyekkel élhetett volna, hogy panaszt tegyen fogva tartásának körülményeivel kapcsolatban. Az EJEB – az Európa Tanács kínzás megelőzésével foglalkozó bizottságának jelentéseire támaszkodva – megállapította, hogy Görögországban nincs olyan független hatóság, amely a büntetés-végrehajtási szervek idegenrendészeti fogdáit ellenőrizné. Azt is megállapította, hogy nem volt olyan pártatlan hatóság, amely biztosította volna a jogorvoslat hatékonyságát. Ennek megfelelően megállapította az EJEE 3. cikkének, 5. cikke (1) és (4) bekezdésének, valamint 13. cikkének megsértését.

468 Az Európai Parlament és a Tanács 2012. október 25-i 2012/29/EU irányelve a bűncselekmények áldozatainak jogaira, támogatására és védelmére vonatkozó minimumszabályok megállapításáról, HL L 315., 2012.11.14., 55. o.

469 EJEB, *Maaouia kontra Franciaország* [Nagykamara] (39652/98), 2000. október 5.

470 EJEB, *Rahimi kontra Görögország* (8687/08), 2011. április 5. (elérhető francia nyelven).

Az Európai Szociális Karta előírja az államoknak a családjogi (valamint szociális és gazdasági) fejlődésének az előmozdítását (16. cikk). Ezenfelül a 19. cikk (1) bekezdése előírja az államoknak, hogy „megfelelő és ingyenes" szolgáltatásokat tartsanak fenn, és hogy biztosítsák, hogy a migráns munkavállalók és családjaik pontos információkat kapjanak a kivándorlással és bevándorlással kapcsolatban. Hasonló „tájékoztatási" követelményt tartalmaz (amely központi eleme a migránsok igazságszolgáltatáshoz való hozzáférésének) a vendégmunkások jogállásáról szóló európai egyezmény 6. cikke, de a „bíróságokhoz és közigazgatási hatóságokhoz való fordulás jogát" szabályozó tágabb rendelkezések (26. cikk) kizárólag a migráns munkavállalóknak szólnak, nem pedig családtagjaiknak.[471]

Ezen túlmenően fontos megjegyezni, hogy az Európa Tanács nagyon átfogó iránymutatásokat dolgozott ki a gyermekbarát igazságszolgáltatásról, amelyek meghatározzák, hogy hogyan kell valamennyi igazságügyi és közigazgatási eljárást – ezen belül menekültügyi eljárást – a gyermekek szükségleteihez igazítani.[472]

Ami a nemzetközi jogot illeti, a Gyermekjogi egyezmény 37. cikke különösen lényeges a szabadságuktól megfosztott migráns gyermekek számára, mivel biztosítja e gyermekek jogát a rövid időn belüli jogsegély vagy bármely más alkalmas segítség igénybe vételéhez, valamint azt a jogot, hogy szabadságelvonásuk törvényességével kapcsolatban bírósághoz vagy más illetékes, független és pártatlan hatósághoz forduljanak, akiknek az ügyben sürgősen dönteniük kell.

471 Európa Tanács, Európai egyezmény a vendégmunkások jogállásáról, CETS 93, 1977.

472 Európa Tanács, Miniszterek Tanácsa (2010), *Iránymutatás a gyermekbarát igazságszolgáltatásról*, 2010. november 17, http://birosag.hu/sites/default/files/allomanyok/stat-tart-file/gyerekbarat_igazsagszolgaltatas_iranymutatas.pdf.

10 Fogyasztóvédelem és a személyes adatok védelme

EU	Tárgyalt kérdések	ET
Az Európai Unió Alapjogi Chartája, 38. cikk EUMSZ, 169. cikk A fogyasztók jogairól szóló irányelv (2011/83/EU) A tisztességtelen kereskedelmi gyakorlatokról szóló irányelv (2005/29/EK) Általános termékbiztonsági irányelv (2001/95/EK) A klinikai vizsgálatokról szóló irányelv (2001/20/EK) EUB, C-244/06. sz. ügy, *Dynamic Medien Vertriebs GmbH kontra Avides Media AG*, 2008 (DVD-k internetes értékesítése) EUB, C-36/02. sz. ügy, *Omega Spielhallen- und Automatenaufstellungs-GmbH kontra Oberbürgermeisterin der Bundesstadt Bonn*, 2004 (játék játszására szóló licenc) Az emberi felhasználásra szánt gyógyszerek klinikai vizsgálatairól szóló 536/2014/EU rendelet A különleges táplálkozási célú élelmiszerekről szóló irányelv (2009/39/EK) Játékbiztonsági irányelv (2009/48/EK) A másnak látszó, és ezáltal a fogyasztók egészségét vagy biztonságát veszélyeztető termékekről szóló irányelv (87/357/EGK)	A gyermekek, mint fogyasztók védelme	Európai egyezmény a határokat átnyúló televíziózásról

EU	Tárgyalt kérdések	ET
A határok nélküli televíziózásról szóló irányelv (89/552/EGK) Az audiovizuális médiaszolgáltatásokról szóló irányelv (2010/13/EU)		
Alapjogi Charta, 7. cikk (a magán- és a családi élet tiszteletben tartása), 8. cikk (a személyes adatok védelme) és 52. cikk (a jogok és elvek hatálya és értelmezése) EUMSZ, 16. cikk Az adatvédelmi irányelv (95/46/EK)	**A gyermekek és az adatvédelem**	EJEE, 8. cikk (A magán- és családi élet tiszteletben tartásához való jog) EJEB, *K.U. kontra Finnország* (2872/02), 2008 (Internetes hirdetés) EJEB, *Avilkina és társai kontra Oroszország* (1585/09), 2013 (orvosi nyilvántartások kiadása) Egyezmény az egyének védelméről a személyes adatok gépi feldolgozása során

Ez a fejezet a fogyasztóvédelem és az adatvédelem terén hatályos európai jogszabályokat és ítélkezési gyakorlatot taglalja. Mivel az EUMSZ kifejezetten megállapítja ezen ügyekben az EU hatáskörét, uniós szinten bőséges mennyiségű jogszabály és ítélkezési gyakorlat áll rendelkezésre. Az Európa Tanács e területen kevésbé aktív. A szerződések szintjén két fő egyezmény van a médiáról, illetve az adatvédelemről. Az EJEB szintén hozott döntést számos, magánszemélyek adatainak védelmét érintő ügyben.

A következő részek középpontjában a fogyasztóvédelmi jog gyermekekkel kapcsolatos sajátos szempontjai (10.1. szakasz) és az adatvédelem (10.2. szakasz) állnak. E kérdések mindegyike esetében elemezzük az általános jogi keretet és annak a gyermekekre való alkalmazhatóságát, valamint adott esetben a gyermekek védelmét szolgáló külön normákat.

10.1. A gyermekek, mint fogyasztók védelme

Kiemelt pontok

- Az EUB szerint a gyermekkorú fogyasztók legfőbb (mindenek felett álló) érdekei és jogaik védelme felülírják a közérdek követelményeit, és alapot adnak az áruk, személyek, szolgáltatások és tőke szabad mozgásának korlátozására.
- A gyermekeket mint fogyasztókat releváns információkkal kell ellátni, hogy képesek legyenek minden lényeges tényt mérlegelni, és tájékozottan dönteni.
- Tisztességtelen kereskedelmi gyakorlatok azok a gyakorlatok, amelyek nem felelnek meg a szakmai gondosság elvének, és befolyásolhatják a felnőtt- és a gyermekkorú fogyasztók ügyleti döntéseit.
- Gyermekek csak akkor vonhatók be klinikai vizsgálatba, ha a beadott gyógyszer várhatóan közvetlen kedvező hatást fejt ki rájuk, amely túlsúlyban van a kockázatokkal szemben.
- Az uniós jog és az Európa Tanács joga korlátozza a gyermekekre irányuló marketing mennyiségét, anélkül azonban, hogy azt teljességgel tiltaná.
- A gyermekek külön védelemre jogosultak, amely magában foglalja az olyan reklámokkal és televíziós vásárlási műsorokkal szembeni védelmet, amelyek erkölcsi vagy fizikai kárt okozhatnának a gyermekekben.
- A gyermekműsorokban tilos termékhirdetéseket elhelyezni.

10.1.1. Fogyasztói jogok

Az uniós jogban a fogyasztóvédelem fő pilléreit az EUMSZ 169. cikkének (1) bekezdése és az Unió Alapjogi Chartájának 38. cikke állapítja meg. Az EUB elismeri, hogy a gyermek legfőbb (mindenek felett álló) érdekei felülírják a közérdek követelményeit, és indokolttá teszik a szokásos piaci szabadságok korlátozását.

Példa: A *Dynamic Medien* ügy[473] japán rajzfilmeket tartalmazó DVD-k németországi internetes értékesítését érinti. A rajzfilmeket az Egyesült Királyságban 15 éven felüli gyermekek számára hagyták jóvá. Az illetékes német hatóság ezeket nem minősítette megfelelőnek. Az EUB által eldöntendő fő kérdés az volt, hogy a németországi tiltás ellentétes-e az áruk szabad mozgásának elvével. Az EUB megállapította, hogy a német jogszabály fő célja a gyermekek olyan információktól való megvédése, amelyek károsak lennének a jóllétükre. Úgy ítélkezett, hogy az áruk szabad mozgására vonatkozó korlátozás mindaddig nem aránytalan, amíg nem lép túl a gyermekek védelmére vonatkozó, az érintett tagállam által szem előtt tartott célkitűzés eléréséhez szükséges mértéken.

Példa: Az *Omega* ügy[474] egy „lézerharc pálya" németországi működtetését érinti. A „lézerharc pályán" játszott játék része volt, hogy a játékosok által viselt kabátokon elhelyezett szenzoros célpontokat kellett megütni. A játékhoz szükséges felszerelést egy brit vállalat szállította, és az Egyesült Királyságban a játékot és a felszerelést egyaránt jogszerűen forgalmazták. Németországban megtiltották a játékot azon az alapon, hogy az ellentétes olyan alapvető értékekkel, mint az emberi méltóság. Az EUB megállapította, hogy a német hatóságok által megszabott korlátozás nem ellentétes az uniós joggal, mivel azt közpolitikával kapcsolatos megfontolásokkal kellően megindokolták.

Az uniós fogyasztóvédelmi jog legutóbbi átdolgozásának eredményeképpen elfogadták a fogyasztói jogokról szóló 2011/83/EU irányelvet, amelynek célja a távértékesítésre és az üzlethelyiségen kívül kötött szerződésekre, valamint a fogyasztói szerződések más típusaira vonatkozó nemzeti jogszabályok teljes körű harmonizálása.[475] A cél a fogyasztóvédelem magas szintje és a vállalkozások versenyképessége közötti megfelelő egyensúly megteremtése. A fogyasztói jogokról szóló irányelv a 3. cikk (3) bekezdésének a) pontja szerint nem alkalmazandó azon szerződésekre, amelyek tárgya többek között a szociális lakáshoz juttatással, a gyermekgondozással és az arra állandó vagy ideiglenes jelleggel rászoruló családoknak

473 EUB, C-244/06. sz. ügy, *Dynamic Medien Vertriebs GmbH kontra Avides Media AG*, 2008. február 14.

474 EUB, C-36/02. sz. ügy, *Omega Spielhallen- und Automatenaufstellungs-GmbH kontra Oberbürgermeisterin der Bundesstadt Bonn*, 2004. október 14.

475 Az Európai Parlament és a Tanács 2011. október 25-i 2011/83/EU irányelve a fogyasztók jogairól, a 93/13/EGK tanácsi irányelv és az 1999/44/EK európai parlamenti és tanácsi irányelv módosításáról, valamint a 85/577/EGK tanácsi irányelv és a 97/7/EK európai parlamenti és tanácsi irányelv hatályon kívül helyezéséről, HL L 304., 2011.11.22., 64. o. (2013. december 13-ig kellett volna végrehajtani).

vagy személyeknek nyújtott támogatással – ezen belül a tartós ápolással-gondozással – kapcsolatos szociális szolgáltatás. A szociális szolgáltatások közé többek között a gyermekek és a fiatalok részére nyújtott szolgáltatások, a családok, az egyedülálló szülők és az időskorú személyek részére biztosított segítségnyújtási szolgáltatások, valamint a migránsok részére nyújtott szolgáltatások tartoznak. A fogyasztói jogokról szóló irányelv külön figyelmet fordít a szerződéskötést megelőző tájékoztatásra. „Tájékoztatási követelményeit" arra a feltevésre alapozza, hogy ha a fogyasztók, köztük a gyermekek megfelelő tájékoztatást kapnak, képesek lesznek valamennyi lényeges tényt mérlegelni, és tájékozott döntést hozni.

10.1.2. Tisztességtelen kereskedelmi gyakorlatok gyermekekkel szemben

Az uniós jogban a belső piacon az üzleti vállalkozások fogyasztókkal szemben folytatott tisztességtelen kereskedelmi gyakorlatairól szóló 2005/29/EK irányelv[476] (UCPD) a vállalkozások és fogyasztók közötti mindenfajta ügyletet lefed (legyen szó offline vagy online lebonyolított, akár árukat, akár szolgáltatásokat érintő ügyletekről). A tisztességtelen kereskedelmi gyakorlatokról szóló irányelvben a gyermekek a „sérülékeny fogyasztók" kategóriájában szerepelnek (5. cikk (3) bekezdés). Az ügyleti döntések nem hozhatók meg zaklatást, kényszerítést vagy nem megengedett befolyásolást vagy megtévesztő tájékoztatást követően, és a gyermek fogyasztóknak jogukban áll, hogy ezeket a döntéseket szabadon hozzák meg. Az irányelv tiltja az olyan marketing- és hirdetési tevékenységeket, amelyek a termék más termékkel vagy egy versenytárs védjegyével való összetévesztését eredményezik, és előírja, hogy a fogyasztók számára minden szükséges információt világos és érthető módon kell biztosítani, alkalmas időben ahhoz, hogy képesek legyenek meghozni az ügyleti döntést (6. és 7. cikk)

10.1.3. Termékbiztonság

Az uniós jogban egy átfogó keretrendszer szolgál annak biztosítására, hogy csak biztonságos és a jogszabályoknak máskülönben megfelelő termékek kerülhessenek forgalomba. Az általános termékbiztonságról szóló 2001/95/EK irányelv (termékbiztonsági irányelv) külön figyelmet szentel a gyermekek biztonságának

476 Az Európai Parlament és a Tanács 2005. május 11-i 2005/29/EK irányelve a belső piacon az üzleti vállalkozások fogyasztókkal szemben folytatott tisztességtelen kereskedelmi gyakorlatairól, valamint a 84/450/EGK tanácsi irányelv, a 97/7/EK, a 98/27/EK és a 2002/65/EK európai parlamenti és tanácsi irányelvek, valamint a 2006/2004/EK európai parlamenti és tanácsi rendelet módosításáról, HL L 149., 2005.6.11., 22. o.

azáltal, hogy az érintett termékek által jelentett kockázatoknak nagyobb mértékben kitett fogyasztói csoportokba sorolja be őket (a termékbiztonsági irányelv (8) preambulum bekezdése). Ezért a termékek biztonságát valamennyi jelentős szempont – különösen a fogyasztók azon csoportjainak – figyelembevételével kell értékelni, amelyeknek a terméket szánják.

A 87/357/EGK tanácsi irányelv[477] a másnak látszó, és ezáltal a fogyasztók egészségét vagy biztonságát veszélyeztető termékekre vonatkozó tagállami jogszabályok közelítéséről szóló, külön termékbiztonsági irányelv. Tiltja az élelmiszernek látszó, de nem ehető termékek forgalmazását, behozatalát és előállítását. A tagállamoknak ellenőrzéseket kell végezniük annak biztosítása céljából, hogy ne lehessen ilyen termékeket forgalmazni. Ha valamely tagállam ezen irányelv alapján betilt egy terméket, tájékoztatnia kell a Bizottságot, és részletes adatokkal kell szolgálnia, hogy a többi tagállamot is tájékoztatni tudják. A játékok biztonságának kérdését részletesebben a 10.1.6. szakasz tárgyalja.

10.1.4. Gyermekeken végzett klinikai vizsgálatok

Ami az uniós jogot illeti, az emberi felhasználásra szánt gyógyszerekkel végzett klinikai vizsgálatok során alkalmazandó helyes klinikai gyakorlat bevezetésére vonatkozó tagállami törvényi, rendeleti és közigazgatási rendelkezések közelítéséről szóló 2001/20/EK irányelv[478] azok közé a sérülékeny személyek közé sorolja be a gyermekeket, akik nem képesek törvényes beleegyezésüket adni a klinikai vizsgálatokhoz ((3) preambulum bekezdés). Gyermekek csak akkor vonhatók be klinikai vizsgálatokba, ha a gyógyszer beadása közvetlen előnnyel jár számukra, és ha ez az előny felülmúlja a kockázatokat ((3) preambulum bekezdés). A klinikai vizsgálatok során a lehető legjobb védelmet kell biztosítani a vizsgálati alanyok számára (4. cikk).

Hasonlóképpen, az emberi felhasználásra szánt gyógyszerek klinikai vizsgálatairól szóló 536/2014/EU rendelet a lakosság sérülékeny csoportjainak kategóriájában tartalmaz a gyermekekre vonatkozó különrendelkezéseket (10. cikk

477 A Tanács 1987. június 25-i 87/357/EGK irányelve a másnak látszó, és ezáltal a fogyasztók egészségét vagy biztonságát veszélyeztető termékekre vonatkozó tagállami jogszabályok közelítéséről, HL L 192., 1987.7.11., 49. o.

478 Az Európai Parlamenti és a Tanács 2001. április 4-i 2001/20/EK irányelve az emberi felhasználásra szánt gyógyszerekkel végzett klinikai vizsgálatok során alkalmazandó helyes klinikai gyakorlat bevezetésére vonatkozó tagállami törvényi, rendeleti és közigazgatási rendelkezések közelítéséről, HL L 121., 2001.5.1., 34–44. o.

(1) bekezdés). E rendelet célja, hogy fokozatosan a 2001/20/EK irányelv[479] helyébe lépjen. Előírja a gyermekek bevonásával elvégzendő klinikai vizsgálat engedélyezése iránti kérelem gondos kiértékelését. A klinikai vizsgálat lefolytatásához beleegyezését kell adnia a gyermek törvényes képviselőjének, valamint – a véleményalkotásra képes gyermekek esetében – a gyermeknek is (29. cikk (1) és (8) bekezdés). A rendelet különfeltételeket állapít meg a biztonságos klinikai vizsgálatok gyermekeken való elvégzése és tájékoztatáson alapuló beleegyező nyilatkozatuk biztosítása tekintetében (32. cikk). E feltételek a következők: a klinikai vizsgálatban való részvételért a vizsgálati alanyoknak a vizsgálatban való részvételhez közvetlenül kapcsolódóan felmerült költségek vagy bevételkiesés miatt juttatott kártalanításon kívül egyéb ösztönzőket nem alkalmaznak; a klinikai vizsgálat csak gyermekek esetében előforduló, orvosi kezelésre szoruló állapot kezelési módjait kívánja kutatni; és tudományos alapon feltételezhető, hogy a klinikai vizsgálatban való részvétel: a kockázatokat és a megterheléseket meghaladó mértékű közvetlen kedvező hatásokkal jár az érintett kiskorú számára, vagy kedvező hatással jár a népesség érintett kiskorú által képviselt csoportja számára, továbbá az ilyen klinikai vizsgálat az esetében alkalmazott standard kezeléshez képest minimális kockázattal és megterheléssel jár a kiskorú számára. Anélkül hogy előzőleg megszerezték volna beleegyezését vagy törvényes képviselőinek beleegyezését, csak sürgősségi esetben végezhető gyermekeken klinikai vizsgálat (35. cikk (1) bekezdés).

10.1.5. Csecsemőknek és gyermekeknek szánt élelmiszerek

Az uniós jog keretében a különleges táplálkozási célú élelmiszerekről szóló 2009/39/EK irányelv[480] összpontosít a kifejezetten csecsemők és 12 hónaposnál kisebb gyermekek számára gyártott élelmiszerek tápanyag-összetételére és biztonságára. Szabályai az anyatej-helyettesítő és anyatej-kiegészítő tápszerekre, a csecsemők és a kisgyermekek számára készült feldolgozott gabonaalapú élelmiszerekre, bébiételekre és élelmiszer-adalékanyagokra irányulnak. Az irányelv célja a termékbiztonság garantálása és a fogyasztó megfelelő termékekkel és megfelelő információkkal való ellátása. Többek között meghatározza, hogy

479 Az Európai Parlament és a Tanács 2014. április 16-i 536/2014/EU rendelete az emberi felhasználásra szánt gyógyszerek klinikai vizsgálatairól és a 2001/20/EK irányelv hatályon kívül helyezéséről, HL L 158., 2014.5.27., 1. o.

480 Az Európai Parlament és a Tanács 2009. május 6-i 2009/39/EK irányelve a különleges táplálkozási célú élelmiszerekről, HL L 124., 2002.1.15., 21. o.

a különleges táplálkozási célnak ki kell elégítenie a személyek egyes csoportjainak – köztük az egészséges csecsemőknek és gyermekeknek – a táplálkozási szükségleteit (1. cikk (3) bekezdés c) pont).

10.1.6. Játékbiztonság

Az uniós jog keretében a játékok biztonságáról szóló 2009/48/EK irányelv[481] 2. cikke úgy határozza meg a játékokat, mint „14 év alatti gyermekek részére – kizárólag vagy nem kizárólag – játék céljára tervezett vagy szánt termékeket".[482] Az I. melléklet tartalmazza azoknak a termékeknek a nem teljeskörű listáját, amelyek nem minősülnek játéknak, de összekeverhetők a játékokkal. A 2. cikk (2) bekezdése szintén felsorol néhány olyan játékot, amelyre az irányelv nem alkalmazható. A játékbiztonsági irányelv azáltal is megerősíti az egészségügyi és biztonsági színvonalat, hogy korlátozza bizonyos vegyi anyagoknak azt a mennyiségét, amely a játékokhoz felhasznált anyagokban előfordulhat (10. cikk).[483]

10.1.7. A gyermekek és a reklám

Az uniós jog keretében az audiovizuális médiaszolgáltatásokról szóló 2010/13/EU irányelv[484] bővítette a tagállamok törvényi, rendeleti vagy közigazgatási intézkedésekben megállapított, televíziós műsorszolgáltató tevékenységre vonatkozó egyes rendelkezéseinek összehangolásáról szóló 89/552/EGK irányelv (A határok nélküli televíziózásról szóló irányelv) hatályát. Az audiovizuális médiaszolgáltatásokról szóló irányelv foglalkozik azon marketing mennyiségének korlátozásával, minőségével és tartalmával, amelynek a gyermekek kitehetők, szabályozva a reklám időtartamát (20., 24. és 27. cikk). Az irányelv a gyermekműsorokban megtiltja a termékmegjelenítést (11. cikk), és felhatalmazza a tagállamokat, hogy megtiltsák a támogatói logó megjelenítését a gyermekműsorok

481 Az Európai Parlament és a Tanács 2009. június 18-i 2009/48/EK irányelve a játékok biztonságáról, HL L 170., 2009.6.30., 1. o.

482 *Uo.*, 2. cikk (1) bek.

483 Az Európai Bizottság „önkéntes megállapodásokat" is kötött európai játékgyártókkal/-kereskedőkkel, hogy javítsa a játékok biztonságát. A részletekért lásd: http://ec.europa.eu/growth/sectors/toys/safety/index_en.htm.

484 Az Európai Parlament és a Tanács 2010. március 10-i 2010/13/EU irányelve a tagállamok audiovizuális médiaszolgáltatások nyújtására vonatkozó egyes törvényi, rendeleti vagy közigazgatási rendelkezéseinek összehangolásáról (Audiovizuális médiaszolgáltatásokról szóló irányelv), HL L 95., 2010.4.15., 1. o.

közben (10. cikk (4) bekezdés).[485] Az audiovizuális médiaszolgáltatásokról szóló irányelv egyensúlyt teremt a gyermekek védelme és más fontos demokratikus értékek – így a véleménynyilvánítás szabadsága – között, alátámasztva azt az elképzelést, hogy ez a védelem a szülői felelősség alapvető bevonásával lehetséges ((48) és (59) preambulum bekezdés).

Az audiovizuális médiaszolgáltatásokról szóló irányelv eredményes végrehajtását a gyermekek és az emberi méltóság védelméről szóló 1998-es[486] és 2006-os[487] ajánlás egészíti ki.

Az Európa Tanács joganyagában a határokat átlépő televíziózásról szóló európai egyezmény[488] volt az első nemzetközi szerződés, amely jogi keretet teremtett a határokat átlépő televíziós műsorok Európán belüli szabad mozgása számára. Ez kifejezetten védi a gyermekeket és a fiatalokat (7. cikk (2) bekezdés), például tiltva a pornográf és erőszakos tartalmak, valamint a fajgyűlöletet keltő műsorok sugárzását. Hirdetési szabványokat azonosít, valamint szabályozza a reklámidőt és a reklámszüneteket.

485 Az audiovizuális médiaszolgáltatásokról szóló irányelv működésének általánosabb áttekintése megtalálható a következő helyen: COM(2012) 203 final, A Bizottság jelentése az Európai Parlamentnek, a Tanácsnak, az Európai Gazdasági és Szociális Bizottságnak és a Régiók Bizottságának az audiovizuális médiaszolgáltatásokról szóló 2010/13/EU irányelv (Audiovizuális médiaszolgáltatásokról szóló irányelv) alkalmazásáról, Brüsszel, 2012. május 4. és SWD(2012) 125 final, az audiovizuális médiaszolgáltatásokról szóló 2010/13/EU irányelv alkalmazásáról szóló, az Európai Parlamentnek, a Tanácsnak, az Európai Gazdasági és Szociális Bizottságnak és a Régiók Bizottságának címzett első bizottsági jelentéshez csatolt bizottsági szolgálati munkadokumentum, Brüsszel, 2012. május 4.

486 A Tanács 1998. szeptember 24-i 98/560/EK ajánlása a kiskorúak és az emberi méltóság összehasonlítható és hatékony védelmének megvalósítását célzó nemzeti keretek elősegítése által az európai audiovizuális és információs szolgáltatási ágazat versenyképességének fejlesztéséről, HL L 270., 1998.10.7., 48. o.

487 Az Európai Parlament és a Tanács 2006. december 20-i 2006/952/EK ajánlása a kiskorúak és az emberi méltóság védelméről és a válaszadás jogáról az európai audiovizuális és on-line információs szolgáltatási ipar versenyképességével összefüggésben, HL L 378., 2006.12.27., 72–77. o.

488 Európa Tanács, Európai egyezmény a határokat átlépő televíziózásról, CETS 132, 1989. Módosították a Jegyzőkönyv rendelkezései szerint, CETS 171, 2002.

10.2. A gyermekek és a személyes adatok védelme

Kiemelt pontok

- Az uniós jogban és az Európa Tanács joganyagában alapvető jognak ismerik el a személyes adatok védelmét.
- A magán- és családi élet tiszteletben tartásához való jog (az EJEE 8. cikke) magában foglalja a személyes adatok védelméhez való jogot.
- A gyermekeket – a személyes adataikkal kapcsolatos egyéb jogok mellett – megilleti az adataik feldolgozása elleni tiltakozás joga, kivéve kényszerítő erejű, jogos indokok esetén.

10.2.1. Az Európai Unió adatvédelmi joga

Az uniós jog keretében az EU jogalkotási hatáskörrel rendelkezik adatvédelmi kérdésekben (az EUMSZ 16. cikke).[489] Az Unió Alapjogi Chartája 8. cikkének (2) bekezdése kulcsfontosságú adatvédelmi elveket tartalmaz (tisztességes adatfeldolgozás, hozzájárulás vagy törvényben rögzített jogos cél, hozzáférési jog és a kijavíttatáshoz való jog), a 8. cikk (3) bekezdése pedig előírja, hogy az adatvédelmi szabályok tiszteletben tartását független hatóságnak kell ellenőriznie. A személyes adatok védelméhez való, 8. cikkben megállapított jog a törvényekkel összhangban és a demokratikus társadalom elveinek – így mások szabadságainak és jogainak – tiszteletben tartása érdekében korlátozható (a Charta 52. cikke).[490]

A személyes adatok védelme a magánélet védelmével kapcsolatos európai jog egyik kulcsfontosságú területévé vált. E terület legfontosabb jogi eszköze a személyes adatok feldolgozása vonatkozásában az egyének védelméről és az ilyen adatok szabad áramlásáról szóló 95/46/EK irányelv (adatvédelmi irányelv)[491].

489 Az európai adatvédelmi jog általános áttekintését lásd: FRA és Európa Tanács (2014).

490 EUB, C-468/10. és C-469/10. sz. egyesített ügyek, *Asociación Nacional de Establecimientos Financieros de Crédito (ASNEF) és Federación de Comercio Electrónico y Marketing Directo (FECEMD) kontra Administración del Estado*, 2011. november 24., 48. pont; EUB, C-275/06. sz. ügy, *Productores de Música de España (Promusicae) kontra Telefónica de España SAU* [Nagytanács], 2008. január 29., 68. pont.

491 Az Európai Parlament és a Tanács 1995. október 24-i 95/46/EK irányelve a személyes adatok feldolgozása vonatkozásában az egyének védelméről és az ilyen adatok szabad áramlásáról (adatvédelmi irányelv), HL L 281., 1995.11.23., 31. o.

Mivel az adatfeldolgozás a nyilvánosság számára nem nyitott, zárt helyeken folyik, a gyermekek és más érintettek rendszerint nem tudnak saját személyes adataik feldolgozásáról. Az érintettek sérülékenységét ellensúlyozandó, az európai jog konkrét egyéni jogokat garantál a gyermekek (és más érintettek) számára, amelyek szerint joguk van tájékoztatást kapni arról, hogy az adataikat gyűjtik, joguk van a tárolt adatokba betekinteni és megismerni a feldolgozási művelet részleteit, jogellenes feldolgozás esetén joguk van tiltakozni, joguk van az adatok helyesbítéséhez, törléséhez és zárolásához.

A feldolgozási műveletek adatkezelőinek megfelelő tájékoztatást kell adniuk az adatok feldolgozásával kapcsolatban (az adatvédelmi irányelv 10. és 11. cikke). Mindez gyermekbarát értelmezésben azt jelenti, hogy a tájékoztatás nyelvezetét és formáját hozzá kell igazítani a gyermekek érettségéhez és felfogó képességéhez. A tájékoztatásnak minimális követelményként ki kell térnie az adatfeldolgozás céljára, valamint az adatkezelő személyére és elérhetőségi adataira (az adatvédelmi irányelv 10. cikkének a) és b) pontja).

Az adatvédelmi irányelv meghatározza az érintettek beleegyezését, tekintet nélkül a feldolgozott adatok érzékenységére (7., 8. és 14. cikk). A gyermekbarát hozzájárulási eljárás maga után vonná a gyermek kibontakozó képességeinek figyelembevételét és fokozatos bevonását. Az első lépés az jelenti, hogy a gyermek törvényes képviselője a hozzájárulás megadása előtt egyeztet a gyermekkel, majd következő lépésben a gyermek és törvényes képviselője párhuzamos hozzájárulást ad, végül pedig a serdülő gyermek egyedül ad hozzájárulást.

Az érintetteknek joguk van az adatok törléséhez, ami azt jelenti, hogy lehetőségük van arra, hogy kérésükre eltávolítsák vagy töröljék személyes adataikat, valamint ahhoz is joguk van, hogy tiltakozzanak személyes adataik feldolgozása ellen. Ez utóbbi egyre fontosabbá válik a gyermekek számára, a gyermekek személyes adatainak a közösségi médiában forgó és elérhető óriási mennyisége miatt. Jóllehet az EUB még nem foglalkozott gyermekeket érintő ügyekkel, egy felnőtt felperest érintő, közelmúltbeli ügyben megállapította, hogy a tiltakozás joga vonatkozik az adatokra és információkra „többek között akkor, ha az adatok e célokra és az eltelt időre tekintettel nem megfelelőek, nem, vagy már nem relevánsak, illetve túlzó mértékűek”.[492] Az EUB azt is megállapította, hogy a tiltakozási jog alkalmazandóságát egyensúlyba kell hozni az egyéb alapvető jogokkal.

492 EUB, C-131/12. sz. ügy, *Google Spain SL és Google Inc. kontra Agencia Española de Protección de Datos (AEPD) és Mario Costeja González* [Nagytanács], 2014. május 13., 93. bek.

Az Európai Tanács joganyagában az EJEB az EJEE 8. cikkét értelmezi a személyes adatok védelméhez való jogként. A bíróság vizsgál olyan helyzeteket, amelyekben felmerül az adatvédelem kérdése, ideértve a beszélgetések lehallgatását[493], a felügyelet különféle formáit[494] és a személyes adatok hatóságok általi tárolásával szembeni védelmet[495]. Továbbá, az EJEB úgy ítélte meg, hogy a nemzeti jognak megfelelő intézkedéseket kell meghatároznia, hogy bírósági jogorvoslatokat biztosítson az adatvédelmi jogok megsértésével szemben.

Példa: A *K.U. kontra Finnország* ügyben[496] a kérelmező egy gyermek volt, aki azért tett panaszt, mert egy internetes társkereső oldalon szexuális tartalmú hirdetést tettek közzé a nevében. A szolgáltató a finn jog által előírt titoktartási kötelezettségek miatt megtagadta azon személy adatainak a kiadását, aki közzétette az információkat. A kérelmező azt állította, hogy a finn jog nem nyújt elegendő védelmet a kérelmezőről az interneten terhelő adatokat elhelyező magánszemély ilyen jellegű cselekményeivel szemben. Az EJEB úgy ítélte meg, hogy az államokat pozitív kötelezettségek terhelik, amelyek magukban foglalják olyan intézkedések elfogadását, amelyek célja a magánélet tiszteletben tartásának biztosítása, még a magánszemélyek közötti kapcsolatok területén is. A kérelmező esetében a gyakorlati és hatékony védelem megkövetelte volna, hogy tegyenek tényleges lépéseket az elkövető azonosítására és vád alá helyezésére. Az állam azonban nem biztosított ilyen védelmet, ezért a Bíróság megállapította, hogy megsértették az EJEE 8. cikkét.[497]

Példa: Az *Avilkina és társai kontra Oroszország* ügy[498] arról szól, hogy egy kétéves kislány orvosi aktáját kiadták az ügyészségnek, miután az tájékoztatást kért a Jehova tanúi által elutasított vérátömlesztésekkel kapcsolatban. Annak elismerése mellett, hogy előfordulhat, hogy a beteg és valamely közösség egészének az orvosi adatok titokban tartásához fűződő érdekénél nagyobb súllyal eshetnek latba a bűncselekmények kivizsgá-

493 Lásd például: EJEB, *Malone kontra Egyesült Királyság* (8691/79), 1984. augusztus 2.; EJEB, *Copland kontra Egyesült Királyság* (62617/00), 2007. április 3.

494 Lásd például: EJEB, *Klass és társai kontra Németország* (5029/71), 1978. szeptember 6.; EJEB, *Uzun kontra Németország* (35623/05), 2010. szeptember 2.

495 Lásd például: EJEB, *Leander kontra Svédország* (9248/81), 1987. március 26.; EJEB, *S. és Marper kontra Egyesült Királyság* [Nagykamara] (30562/04 és 30566/04), 2008. december 4.

496 EJEB, *K.U. kontra Finnország* (2872/02), 2008. december 2. Lásd még: 4. fejezet.

497 FRA és Európa Tanács (2014), 122. o.

498 EJEB, *Avilkina és társai kontra Oroszország* (1585/09), 2013. június 6.

lásával kapcsolatos érdekek, a bíróság megállapította, hogy a kérelmező nem gyanúsítottja vagy vádlottja semmilyen büntetőeljárásnak. Ezen túlmenően a kérelmező számára kezelést nyújtó egészségügyi szakemberek kérelmezhették volna a vérátömlesztés bíróság általi engedélyezését, ha úgy gondolták volna, hogy a beteg életveszélyes állapotban van. Mivel semmilyen sürgető társadalmi szükséglet nem állt fenn, amely indokolta volna, hogy kérjék a kérelmezőre vonatkozó bizalmas orvosi adatok kiadását, az EJEB megállapította, hogy megsértették az EJEE 8. cikkét.

Példa: Az *S. és Marper kontra Egyesült Királyság* ügyben[499] időkorlát nélkül megőrizték egy tizenegy éves ujjlenyomatait és DNA-ját, amelyet egy rablási kísérlet gyanúja kapcsán vettek le, annak ellenére, hogy végül felmentették. A sejtmintákban és a DNA-profilokban foglalt személyes információk jellegére és mennyiségére tekintettel már önmagukban ezek megőrzése is az első kérelmező magánélet tiszteletben tartásához való jogába való beavatkozásnak minősül. Az Európa Tanács vonatkozó eszközeinek alapelvei, valamint a többi szerződő fél joga és gyakorlata előírja, hogy az adatmegőrzésnek az adatgyűjtés céljával arányosnak és időben korlátozottnak kell lennie, különösen a rendőrségi ágazatban. Az EJEE 8. cikke által nyújtott védelem elfogadhatatlanul gyengülne, ha bármilyen áron, potenciális előnyeik és a fontos magánéleti érdekek gondos egyensúlyba hozása nélkül megengednék a korszerű tudományos technológiák alkalmazását a büntetőjogi eljárás során. E tekintetben különösen szembeszökő volt Angliában és Walesben a megőrzés hatáskörének általános és válogatás nélküli jellege, mivel ez lehetővé tette az adatok korlátlan időn át történő megőrzését, tekintet nélkül a bűncselekmény jellegére és súlyosságára, valamint a gyanúsított életkorára. Az adatok megőrzése különösen káros lehet a kiskorúak esetében, tekintve különleges helyzetüket, valamint fejlődésük és a társadalomba való beilleszkedésük fontosságát. Összefoglalva, az adatok megőrzése a kérelmező magánélet tiszteletben tartásához való jogába való aránytalan beavatkozásnak minősült.

A személyes adatok gépi feldolgozása során az egyének védelméről szóló európa tanácsi egyezmény[500] (108. egyezmény) a magán- és az állami szférában végrehajtott valamennyi adatfeldolgozásra alkalmazandó, és a személyes ada-

499 EJEB, *S. és Marper kontra Egyesült Királyság* [Nagykamara] (30562/04 és 30566/04), 2008. december 4.

500 Európa Tanács, Egyezmény az egyének védelméről a személyes adatok gépi feldolgozása soránCETS 108, 1981.

tok feldolgozását esetlegesen kísérő visszaélésekkel szemben nyújt védelmet a magánszemélyek, köztük a gyermekek számára. A 108. egyezményhez egy kiegészítő jegyzőkönyv is tartozik, amely a felügyeleti hatóságok létrehozását és a személyes adatoknak az egyezményben nem részes felek felé történő, határokon átnyúló áramlását szabályozza.[501]

A 108. egyezményben a személyes adatok feldolgozásával kapcsolatban megállapított elvek a tisztességes és jogszerű adatgyűjtést és az adatok automatikus feldolgozását érintik, amelyeket meghatározott, jogszerű célra tárolnak, nem pedig az e célokkal nem összeegyeztethető felhasználás céljából, és amelyeket a szükségesnél hosszabb ideig nem szabad megőrizni. Az említett elvek az adatok minőségét is érintik. Megfelelő jogi garanciák hiányában tilos a „szenzitív" adatok – azaz a fajra, politikai nézetre, egészségi állapotra, vallásra, szexuális életre vagy büntetett előéletre vonatkozó adatok – feldolgozása. Az egyezmény az egyén – többek között a gyermek – azon jogáról is rendelkezik, hogy tudomást szerezhessen a róla tárolt adatokról, továbbá szükség esetén helyesbíttethesse azokat. Az egyezményben megállapított jogok korlátozása csak magasabb rendű érdekek, például az állambiztonság vagy -védelem érintettsége esetén lehetséges.

A nemzetközi jog szerint az adatvédelemhez való jog a gyermek magánélethez való jogának a része, amelyet a gyermekjogi egyezmény 16. cikke rögzít. E cikk úgy rendelkezik, hogy a gyermeket nem szabad alávetni magánéletével, családjával, lakásával vagy levelezésével kapcsolatban önkényes vagy törvénytelen beavatkozásnak, sem pedig becsülete vagy jó hírneve elleni jogtalan támadásnak. E jogot mindenkinek tiszteletben kell tartania, többek között a gyermek törvényes képviselőjének is.

501 Európa Tanács, Kiegészítő jegyzőkönyv a személyes adatok gépi feldolgozása során az egyének védelméről szóló egyezményhez, az adatvédelmi hatóságokra és az országhatárokat átlépő adatáramlásra vonatkozóan, CETS 181, 2001.

11

A gyermekek büntető igazságszolgáltatáson és alternatív (nem bírósági) eljárásokon belüli jogai

EU	Tárgyalt kérdések	ET
Alapjogi Charta, 47. cikk (a hatékony jogorvoslathoz és a tisztességes eljáráshoz való jog), 48. cikk (az ártatlanság vélelme és a védelemhez való jog) és 49. cikk (a bűncselekmények és büntetések törvényességének és arányosságának elvei) A tolmácsoláshoz és fordításhoz való jogról szóló irányelv (2010/64/EU) A tájékoztatáshoz való jogról szóló irányelv (2012/13/EU) Az ügyvédi segítségről szóló irányelv (2013/48/EU)	A tisztességes eljárás garanciái	EJEE, 6. cikk (tisztességes eljárás) EJEB, *T. kontra Egyesült Királyság* [Nagykamara] (24724/94), 1999 (gyermekek a bíróságon) EJEB, *Panovits kontra Ciprus* (4268/04), 2008 (ügyvédi segítség igénybevétele)

EU	Tárgyalt kérdések	ET
Alapjogi Charta, 4. cikk (kínzás, embertelen vagy megalázó bánásmód vagy büntetés) és 6. cikk (a szabadsághoz való jog)	Őrizet	EJEE, 3. cikk (kínzás, embertelen vagy megalázó bánásmód vagy büntetés) és 5. cikk (a szabadsághoz való jog) EJEB, *Bouamar kontra Belgium* (9106/80), 1988 (őrizetben tartás nevelési felügyelet céljából) EJEB, *D.G. kontra Írország* (39474/98), 2002 (őrizetben tartás nevelési felügyelet céljából) EJEB, *Nart kontra Törökország* (20817/04), 2008 (előzetes letartóztatás) EJEB, *Güveç kontra Törökország* (70337/01), 2009 (őrizet körülményei)
Az áldozatokról szóló irányelv (2012/29/EU) EUB, C-105/03. sz. ügy, *Maria Pupino elleni büntetőeljárás* [Nagytanács], 2005 (a gyermekkorú tanúk helyzete a bíróságon)	Gyermekkorú tanúk és áldozatok	EJEE, 3. cikk (kínzás, embertelen vagy megalázó bánásmód vagy büntetés) és 8. cikk (magánélet) EJEB, *Kovač kontra Horvátország* (503/05), 2007 (gyermekkorú tanú) EJEB, *S.N. kontra Svédország* (34209/96), 2002 (gyermekkorú tanú) EJEB, *R.R. és társai kontra Magyarország* (19400/11), 2012 (család kizárása a tanúvédelmi programból)

A gyermekek jogai a fiatalkorúakra vonatkozó igazságszolgáltatási eljárásokkal összefüggésben azokat a gyermekeket érintik, akiket bűncselekmény elkövetésével vádolnak, akik ellen bűncselekmény elkövetése miatt eljárás folyik vagy akiket bűncselekmény elkövetése miatt elítélnek, illetve olyan gyermekeket, akik igazságügyi vagy ehhez kapcsolódó eljárásokban áldozatként és/vagy tanúként vesznek részt. A fiatalkorúakra vonatkozó igazságszolgáltatásban a gyermekek helyzetét az általános – a felnőttekre és a gyermekekre egyaránt vonatkozó – emberi jogi rendelkezések szabályozzák.

Ez a fejezet áttekintést ad a bírósági és a bíróságon kívüli, alternatív eljárásokban részt vevő gyermekekre vonatkozó európai normákról. Foglalkozik a tisztességes eljárás garanciáival, beleértve a hatékony részvételt és az ügyvédi segítség igénybevételét, a fogva tartott fiatalkorú bűnelkövetők jogaival, ezen belül az előzetes letartóztatással (anyagi és eljárási biztosítékok), az őrizetben tartás körülményeivel

és a rossz bánásmóddal szembeni védelemmel, valamint a gyermekkorú tanúk és áldozatok védelmével. A védelmi szempontok különösen lényegesek a nem peres, alternatív eljárások esetében, amelyeket minden esetben alkalmazni kell, ha ez szolgálja a gyermek legfőbb (mindenek felett álló) érdekét.[502] A gyermekek esetében a büntető igazságszolgáltatás célkitűzései, például a társadalmi beilleszkedés, reintegráció, az oktatás és a visszaesés megelőzése azok az alapelvek, amelyek értékelésére sor kerül[503]

11.1. A tisztességes eljárás garanciái

Kiemelt pontok

- A gyermekeket megilleti az a jog, hogy a büntetőeljárásokban tisztességes és gyermekbarát bánásmódban részesüljenek.
- A bírósági eljárásokat hozzá kell igazítani a gyermekek szükségleteihez, hogy biztosítsák hatékony részvételüket.
- A gyermekeknek joguk van ahhoz, hogy a büntetőeljárás kezdeti szakaszaitól és az első rendőrségi kihallgatástól kezdődően ügyvédi segítséget vegyenek igénybe.

Ez a szakasz – a tisztességes eljárásra vonatkozó általános, az EU és az Európa Tanács szintjén megfogalmazott követelmények rövid körvonalazása mellett – külön hangsúlyt helyez a tisztességes eljárás kifejezetten a gyermekeket érintő biztosítékaira.

A tisztességes eljáráshoz való jog a demokratikus társadalmak alapvető pillére. A bűncselekménnyel gyanúsított vagy vádolt gyermekeket megilleti a tisztességes eljáráshoz való jog, és ugyanolyan garanciákat vehetnek igénybe, mint bárki más, a törvénnyel összeütközésbe kerülő személy. A tisztességes eljárásra vonatkozó garanciák a gyermek első kihallgatásától alkalmazandók, és az eljárás egésze alatt fennállnak. A törvénnyel összeütközésbe kerülő gyermekek azonban különösen sérülékenyek, és ezért további védelemre szorulhatnak. Az európai szervek külön követelményeket dolgoztak ki annak biztosítására, hogy eredményesen kielégítsék e gyermekek szükségleteit.

502 Európa Tanács, Miniszterek Tanácsa (2010), *Iránymutatás a gyermekbarát igazságszolgáltatásról*, 2010. november 17., 24. bek.

503 Lásd még: Európa Tanács, Miniszterek Tanácsa (2008), A Miniszterek Tanácsa CM/Rec (2008)11 ajánlása a tagállamoknak a szankciók vagy intézkedések hatálya alá helyezett fiatalkorú bűnelkövetőkre vonatkozó európai szabályokról, 2008. november 5., I.A.2. rész.

Az uniós jogban az Unió Alapjogi Chartájának több rendelkezése is megállapítja az igazságszolgáltatáshoz való hozzáférés alapvető jogát, és határoz meg tisztességes eljárásra vonatkozó garanciákat a felnőttek és a gyermekek számára. A 47. cikk kifejezetten a hatékony jogorvoslathoz és a tisztességes eljáráshoz való joggal foglalkozik, és a gyermekek számára különösen lényeges követelményeket állapít meg, mint amilyen például az ésszerű időn belül megtartott, tisztességes és nyilvános tárgyalás, a tanácsadáshoz, védelemhez és képviselethez, valamint a költségmentességhez való jog. Hasonlóképpen, különösen lényegesek a gyermekek számára a bűncselekmények és büntetések törvényességének és arányosságának a 49. cikkben megállapított elvei. Ezen túlmenően több uniós irányelv is megállapít a tisztességes büntetőeljárásra vonatkozó külön garanciákat: a tolmácsoláshoz és fordításhoz való jogról szóló irányelv[504], a tájékoztatáshoz való jogról szóló irányelv[505] és az ügyvédi segítségről szóló irányelv[506]. Az első két irányelv nem tartalmaz kifejezetten a gyermekekre vonatkozó garanciákat, jóllehet a tájékoztatáshoz való jogról szóló irányelv meghatároz az általában a sérülékeny gyanúsítottak vagy bűncselekménnyel vádolt személyek helyzetével foglalkozó rendelkezéseket. Az ügyvédi segítségről szóló irányelv gyermekekkel kapcsolatos rendelkezéseivel a 11.2.2. szakasz foglalkozik részletesen.

A tagállamoknak a fent említett irányelvek rendelkezéseinek végrehajtásakor a kifejezetten a gyermekekre vonatkozó rendelkezések hiányában is be kell tartaniuk az Európai Unió Alapjogi Chartáját. Ebből következően az olyan esetekben, amikor az irányelvek bármely rendelkezéseinek tárgyai gyermekek, kellő súlyt kell helyezni a gyermek mindenek fölött álló érdekének a 24. cikkben rögzített elvére. Eddig nem került az EUB elé a Charta 24. cikkének az említett irányelvek valamelyikével összefüggésben történő értelmezésével kapcsolatos ügy.[507]

Különösen fontos a büntetőeljárás során gyanúsított vagy vádlott gyermekek részére nyújtandó eljárási garanciákról szóló irányelvre irányuló európai bizottsági

504 Az Európai Parlament és a Tanács 2010. október 20-i 2010/64/EU irányelve a büntetőeljárás során igénybe vehető tolmácsoláshoz és fordításhoz való jogról, HL L 280., 2010.10.26., 1–7. o.

505 Az Európai Parlament és a Tanács 2012. május 22-i 2012/13/EU irányelve a büntetőeljárás során a tájékoztatáshoz való jogról, HL L 142., 2012.6.1., 1–10. o.

506 Az Európai Parlament és a Tanács 2013. október 22-i 2013/48/EU irányelve a büntetőeljárás során és az európai elfogatóparancshoz kapcsolódó eljárásokban ügyvédi segítség igénybevételéhez való jogról, valamint valamely harmadik félnek a szabadságelvonáskor történő tájékoztatásához való jogról és a szabadságelvonás ideje alatt harmadik felekkel és a konzuli hatóságokkal való kommunikációhoz való jogról, HL L 294., 2013.11.6., 1–12. o.

507 Az EUB a gyermekek jogellenes külföldre vitelével kapcsolatos eljárásokban foglalkozott a 24. cikk értelmezésével (lásd: 5.4. szakasz).

javaslat[508], amelynek célja az ügyvédi segítség kötelező igénybevételének biztosítása a büntetőeljárás valamennyi szakaszában. Azt is meghatározza, hogy a gyermekeket haladéktalanul tájékoztatni kell jogaikról, biztosítani kell számukra szüleik (vagy más megfelelő személyek) támogatását és a zárt ajtók mögötti kihallgatást. Ezen túlmenően a szabadságuktól megfosztott gyermekeknek jogosultnak kell lenniük arra, hogy megfelelő oktatásban, nevelésben, képzésben és orvosi ellátásban részesüljenek, és hogy a felnőttektől elkülönítve kerüljenek elhelyezésre.[509]

Az Európai Tanács joganyagában az EJEE tisztességes eljárásra vonatkozó garanciáit a 6. cikk állapítja meg, amelyen az EJEB legbőségesebb ítélkezési gyakorlata alapul. Az EJEB 6. cikkének (1) bekezdése tartalmaz néhány, kifejezetten a tisztességes eljárásra vonatkozó garanciát: a tisztességes nyilvános tárgyaláshoz/ítélethirdetéshez való jog (kivéve ha az ellentétes többek között a fiatalkorúak érdekeivel); az ésszerű időn belül megtörténő tárgyaláshoz való jog; a független és pártatlan bíróság által lefolytatott eljáráshoz való jog[510] és a törvény által létrehozott bíróság általi tárgyaláshoz való jog. A tisztességes eljárás fogalmából eredendően adódó módon az EJEB garanciákat dolgozott ki: a védelmi lehetőségek egyenlősége és kontradiktórius eljárások; a hallgatáshoz való jog; az ügyvédi segítség igénybevétele; hatékony részvétel; a tárgyaláson való jelenlét; és indokolással ellátott határozatok. Ezen túlmenően alapvetésként, mindenkit mindaddig ártatlannak kell vélelmezni, amíg bűnösségét a törvénynek megfelelően meg nem állapították (az EJEE 6. cikkének (2) bekezdése)

Minden bűncselekménnyel vádolt személyt megilletnek minimálisan a következő jogok: az a jog, hogy a legrövidebb időn belül tájékoztassák az ellene felhozott vádról olyan nyelven, amelyet megért (az EJEE 6. cikke (3) bekezdésének a) pontja); annak a joga, hogy rendelkezzék a védekezésének előkészítéséhez szükséges idővel és eszközökkel (az EJEE 6. cikke (3) bekezdésének b) pontja); az általa választott védő igénybevételének joga (az EJEE 6. cikke (3) bekezdésének

508 Európai Bizottság (2013), A büntetőeljárás során gyanúsított vagy vádlott gyermekek részére nyújtandó eljárási biztosítékokról szóló európai parlamenti és tanácsi irányelvre irányuló javaslat, COM(2013) 822 final, Brüsszel, 2013. november 27.

509 Lásd még: 11.2. szakasz. A gyermekek védelme szempontjából lényeges lehet még: Európai Bizottság (2013), A szabadságuktól megfosztott gyanúsítottak és vádlottak ideiglenes költségmentességéről, valamint az európai elfogatóparancshoz kapcsolódó eljárásokban biztosított költségmentességről szóló európai parlamenti és tanácsi irányelvre irányuló javaslat, COM(2013) 824 final, Brüsszel, 2013. november 27.

510 EJEB, *Nortier kontra Hollandia* (13924/88), 1993. augusztus 24.; EJEB, *Adamkiewicz kontra Lengyelország* (54729/00), 2010. március 2.

c) pontja); az a jog, hogy kérdéseket intézzen vagy intéztessen a vád tanúihoz (az EJEE 6. cikke (3) bekezdésének d) pontja); és az a jog, hogy ingyenes tolmács álljon rendelkezésére (az EJEE 6. cikke (3) bekezdésének e) pontja). Ezek a garanciák a felnőttekre és a gyermekekre egyformán vonatkoznak. A hatékony részvételhez való jog és az ügyvédi segítség igénybevételéhez való jog azonban olyan, a gyermekek számára különösen fontos szempontok, amelyek nyomán kifejezetten a gyermekeket érintő ítélkezési gyakorlat született. E fejezetben ezért részletesebben foglalkozunk a tisztességes eljárás e két konkrét garanciájával.

A gyermekkorú gyanúsítottak/vádlottak számára különösen fontos az Európa Tanács *gyermekbarát igazságszolgáltatásról szóló iránymutatása*[511]. Még ha az iránymutatások nem is bírnak jogi kötőerővel, átmenetet jelentenek annak biztosítása felé, hogy az igazságszolgáltatási eljárások – többek között a büntető igazságszolgáltatási rendszer részét alkotó eljárások – figyelembe vegyék a gyermekek sajátos szükségleteit. Az iránymutatás az EJEB fennálló ítélkezési gyakorlatára és más európai és nemzetközi jogi normákra épül, így például a Gyermekjogi egyezményre. Hasznos eszközként szolgál a gyermekekkel foglalkozó szakemberek számára is. Az I. szakasz (1) bekezdése szerint az iránymutatás a bírósági (büntető vagy nem büntető) eljárásokban vagy az ilyen eljárásokat helyettesítő, bíróságon kívüli, alternatív eljárásokban részt vevő gyermekekre alkalmazandó. A büntetőeljárásban részt vevő gyermekek számára különösen fontos az a jog, hogy a gyermeket és a szülőket egyaránt olyan módon kell tájékoztatni a vádakról, hogy azokat pontosan megértsék (IV.A.1.5. szakasz); az a jog, hogy a gyermeket csak ügyvéd/szülők vagy a gyermek bizalmát élvező személy jelenlétében szabad kikérdezni (C. szakasz 30. pont); a gyors eljáráshoz való jog (D. szakasz 4. pont) és a gyermek szempontjaira érzékeny kikérdezésekhez és kihallgatásokhoz való jog (D. szakasz 5. pont).

Az Európa Tanács Parlamenti Közgyűlése (PACE) 2014 júniusában állásfoglalást fogadott el a fiatalkorúakkal foglalkozó gyermekbarát igazságszolgáltatásról, amely aláhúzza a törvénnyel ütközésbe kerülő gyermekekkel szembeni, jogokon alapuló és gyermekspecifikus bánásmód szükségességét.[512] A PACE felhívja a tagállamokat, hogy vezessenek be a fiatalkorúakkal foglalkozó igazságszolgáltatás tekintetében nemzetközi emberi jogi normákat, köztük az Európa Tanács gyermekbarát igazságszolgáltatásról szóló iránymutatását, és harmonizálják nemzeti

511 Európa Tanács, Miniszterek Tanácsa (2010), Iránymutatás a gyermekbarát igazságszolgáltatásról, 2010. november 17.

512 Az Európa Tanács Parlamenti Közgyűlése, 2010 (2014) határozat, „Child-friendly juvenile justice: from rhetoric to reality".

jogszabályaikat és gyakorlataikat e normákkal. A PACE azt javasolja, hogy a szabadságtól való megfosztást csak végső esetben és a lehető legrövidebb időre alkalmazzák, 14 évben szabva meg a büntetőjogi felelősség alsó korhatárát, anélkül, hogy a súlyos bűncselekmények esetében kivételt tenne lehetővé, továbbá a fiatalkorúakkal foglalkozó szakosodott igazságszolgáltatási rendszert határoz meg, amely elterelési (diverziós) mechanizmusokat, szabadságelvonással nem járó intézkedéseket és szakembereket foglal magában.

A nemzetközi jog keretében a Gyermekjogi egyezmény 40. cikke elismeri a bűncselekmény elkövetésével gyanúsított, vádolt vagy abban bűnösnek nyilvánított gyermeknek a tisztességes és olyan bánásmódhoz való jogát, amely figyelembe veszi korát. A Gyermekjogi egyezmény 40. cikke szerint a fiatalkorúakkal foglalkozó igazságszolgáltatás fő célkitűzése, hogy a gyermekek újra beilleszkedjenek a társadalomba, amelynek hasznos tagjai lehetnek. A Gyermekjogi egyezmény 40. cikkének (2) bekezdése elismeri a gyermek tisztességes eljáráshoz való jogát, amely magában foglalja az ahhoz való jogát, hogy szülei segíthessék, a fellebbezéshez való jogot és az ahhoz való jogot, hogy magánéletét teljes mértékben tiszteletben tartsák az eljárás minden szakaszában.

Más jogi eszközök is fejlesztették tovább a tisztességes eljárás Gyermekjogi egyezményben megfogalmazott elvét és a gyermekspecifikus bánásmódhoz való jogot, ideértve a szabadságelvonás végső esetben és a megfelelő legrövidebb időn át tartó alkalmazását (Gyermekjogi egyezmény 37. cikkének b) pontját). Különösen fontosak az ENSZ fiatalkorúak igazságszolgáltatási rendszerére vonatkozó minimumszabályai (pekingi szabályok)[513], az ENSZ fiatalkori bűnözés megelőzéséről szóló iránymutatásai (rijadi iránymutatások)[514] és a szabadságuktól megfosztott fiatalkorúak védelmére vonatkozó (havannai szabályok) ENSZ-szabályok[515]. A pekingi szabályok részletes útmutatást adnak a Gyermekjogi egyezmény 40. cikkében foglalt, tisztességes eljárásra vonatkozó követelmények végrehajtásához és a gyermekspecifikus bánásmódhoz, ideértve a fiatalkorúakra vonatkozó igazságszolgáltatás céljait, a magánélet védelmét, a vizsgálatot és a büntetőeljárást, az előzetes letartóztatást, az ítélethozatalt és rendelkezést, valamint az intézményi és nem intézményi bánásmódot. A havannai szabályok

513 ENSZ Közgyűlés (GA) (1985), *UN Standard Minimum Rules for the Administration of Juvenile Justice*, GA Res. 40/33. sz. ENSZ-dokumentum,1985. november 19.

514 ENSZ Közgyűlés (GA) (1990), *UN Guidelines for the Prevention of Juvenile Delinquency*, GA Res. 45/112. sz. ENSZ-dokumentum, 1990. december 14.

515 ENSZ Közgyűlés (GA) (1990), UN Rules for the Protection of Juveniles Deprived of their Liberty, GA Res. 45/113. sz. ENSZ-dokumentum, 1990. december 14.

a szabadságuktól megfosztott fiatalkorúakkal szembeni bánásmóddal foglalkoznak, és a szabadságelvonás fogalommeghatározására, a rendőrségi őrizetre és az előzetes letartóztatásra, a fiatalkorúaknak kialakított intézmények körülményeire, a fegyelmi eljárásokra, a szűrési módszerekre és az erőszak vagy kényszer alkalmazására, a panasztételi mechanizmusokra, az ellenőrzési és nyomon követési mechanizmusokra, valamint a fiatalkorúak beilleszkedésére vonatkozó szabályokat tartalmaznak. Végezetül a rijadi iránymutatások részletes iránymutatást nyújtanak a fiatalkori bűnözés megelőzését célzó politikák tekintetében.

Az ENSZ Gyermekjogi Bizottsága egy átfogó kommentárt adott ki (10. számú Átfogó Kommentár)[516] a gyermekekkel és fiatalkorúakkal foglalkozó igazságszolgáltatásról, amely részletes útmutatást nyújt arra vonatkozóan, hogy a fiatalkorúakkal foglalkozó igazságszolgáltatást illetően hogyan kell értelmezni a végrehajtani a Gyermekjogi egyezményt. Ez az észrevétel a fiatalkorúakkal foglalkozó igazságszolgáltatás fontos elveivel foglalkozik, így a hatékony részvételhez való – a tisztességes eljáráshoz való jog részét alkotó – joggal (lásd még: 11.1.1. szakasz), a szabadságelvonás végső esetben és a megfelelő lehető legrövidebb időt át tartó alkalmazásával, az elterelés (diverzió) alkalmazásával és a fiatalkori bűnözés megelőzésével, a gyermek legfőbb (mindenek felett álló) érdeke elvének és a hátrányos megkülönböztetés tilalmának elvének a fiatalkorúakkal foglalkozó igazságszolgáltatás rendszerébe való integrálásával, valamint a korhatárokkal. Az ENSZ Gyermekjogi Bizottsága a büntetőjogi felelősségre vonás minimum alsó korhatárát 12. életévben vagy lehetőleg ennél magasabb életkorban ajánlja megszabni. Azt is ajánlja, hogy minden gyermek kapjon jogot arra, hogy a fiatalkorúakkal foglalkozó igazságszolgáltatás keretében kezeljék az ügyét, és tiltja, hogy súlyos bűncselekmények esetében a 16–17 éves elkövetőket a felnőttek büntetőigazságszolgáltatási rendszerébe helyezzék át. A fiatalkorúakkal foglalkozó igazságszolgáltatás szempontjából szintén lényegesek egyéb általános észrevételek, pl. a meghallgatáshoz való jogot (amely az igazságszolgáltatási eljárásokban való hatékony részvételhez való joghoz kapcsolódik) és az erőszak valamennyi formája elleni védelmet illetően.[517]

516 Az ENSZ Gyermekjogi Bizottsága (2007), 10. számú Átfogó Kommentár: A gyermekek jogai a fiatalkorúak igazságszolgáltatásában (Children's rights in juvenile justice), CRC/C/GC/07, 2007. április 25.

517 Az ENSZ Gyermekjogi Bizottsága (2009), *12. számú Átfogó Kommentár: A gyermek meghallgatáshoz való joga* (*The right of the child to be heard*, CRC/C/GC/12, 2009. július 1.; Az ENSZ Gyermekjogi Bizottsága (2011), *13. számú Átfogó Kommentár (2011): A gyermek joga az erőszak minden formájától való védelemhez (The right of the child to freedom from all forms of violence)*, CRC/C/GC/13, 2011. április 18.

11.1.1. Hatékony részvétel

Az uniós jogban az Európai Unió Alapjogi Chartájának 47. cikke az EJEB 6. cikkében meghatározottakhoz hasonló garanciákat állapít meg: ilyen a független és pártatlan bíróság általi tisztességes, nyilvános és ésszerű időn belüli tárgyaláshoz való jog, a jogi képviselethez való jog és a hatékony jogorvoslathoz való jog. A büntetőeljárás során gyanúsított vagy vádlott gyermekek részére nyújtandó eljárási biztosítékokról szóló irányelvre irányuló javaslat magában foglalja a hatékony részvétel jogát, valamint a jogi képviselethez való jogot.[518]

Az Európai Tanács joganyagában az EJEB a 6. cikk alapján konkrét követelményeket dolgozott ki a gyermekek büntetőeljárásokban való hatékony részvételének biztosítása céljából. Az eljárások során általános szabályként biztosítani kell, hogy figyelembe vegyék a gyermek életkorát, érettségének szintjét és érzelmi állapotát.[519] A „hatékony részvételre" vonatkozó követelmények konkrét példái közé tartozik a gyermek tárgyalásokon való részvétele, a zárt tárgyalások tartása, a nyilvánosság korlátozása, annak biztosítása, hogy a gyermek megértse az eljárás célját, lényegét és tétjét, valamint a bírósági tárgyalások korlátozott formalitása. Az EJEB eddig nem ítélkezett úgy, miszerint a büntetőjogi felelősség alsó korhatárának a túl alacsony életkorban való meghatározása önmagában sértené az EJEE 6. cikkét. Annak értékelésekor, hogy egy gyermek képes volt-e hatékonyan részt venni a nemzeti eljárásban, az EJEB az egyes ügyek konkrét körülményeit vizsgálja.

Példa: A *T. kontra Egyesült Királyság* ügyben[520] egy kétéves gyermeket meggyilkolt két tízéves. Nyilvános tárgyaláson, nagy médiafigyelem mellett tárgyalták az ügyüket. A bírósági eljárást részben módosították, így rövidebb üléseket tartottak, a kérelmező szüleit a kérelmezőhöz közel helyezték el, a szünetek alatt játszóterület állt rendelkezésre, stb. A kérelmező és a másik vádlott ellen mindazonáltal egy felnőtt bíróságon folyt eljárás, és a büntetőeljárás szigorú formaságait többségében megtartották. Az EJEB megállapította, hogy a kérelmező az ülések nyilvánossága, a magas fokú médiafigyelem, valamint amiatt nem volt képes hatékonyan részt venni az eljárásban, hogy korlátozottan volt képes ügyvédjeivel érdemben együttműködni, őket instruálni és megfelelő vallomást tenni. Ebből következően megsértették az EJEE 6. cikke szerinti jogait.

518 Európai Bizottság (2013), A büntetőeljárás során gyanúsított vagy vádlott gyermekek részére nyújtandó eljárási biztosítékokról szóló európai parlamenti és tanácsi irányelvre irányuló javaslat, COM(2013) 822 final, Brüsszel, 2013. november 27.

519 EJEB, *T. kontra Egyesült Királyság* [Nagykamara] (24724/94), 1999. december 16., 61. bek.

520 EJEB, *T. kontra Egyesült Királyság* [Nagykamara] (24724/94), 1999. december 16.

A hatékony részvételhez való jog elismerése az Európa Tanács gyermekbarát igazságszolgáltatásról szóló iránymutatásainak is központi eleme. A gyermekeknek, ezen belül a fiatalkorúaknak nyújtott igazságszolgáltatással szemben követelmény, hogy legyen „hozzáférhető, az életkornak megfelelő, gyors, gondos, a gyermekek jogaihoz és szükségleteihez igazodó és azokra koncentrál, tiszteletben tartja a gyermekek jogait, beleértve a tisztességes eljáráshoz való jogot, az eljárásban való részvétel és az eljárás megértésének jogát, a magánélet, a családi élet, az integritás és a méltóság tiszteletben tartásához fűződő jogot.”.[521] Az iránymutatás külön útmutatást ad arra vonatkozóan, hogy hogyan kell kezelni a gyermekeket a fiatalkorúakkal foglalkozó igazságszolgáltatási, illetve egyéb igazságszolgáltatási eljárások során. A gyermekeknek hozzá kell férniük a bírósági és igazságügyi eljárásokhoz,és védeni kell a jogi tanácsadáshoz és képviselethez, valamint a meghallgatásukhoz és véleményük kinyilvánításához való jogukat; el kell kerülni az indokolatlan késedelmet, az eljárást gyermekbarát módon kell megszervezni (ami a környezetet és a nyelvezetet illeti), és külön biztosítékokat kell beépíteni a gyermekek által tett vallomás és nyilatkozatok felvétele és az azokra adott válaszadás tekintetében.[522]

11.1.2. Az ügyvédi segítség igénybevételéhez való jog

Az uniós jogban az ügyvédi segítség igénybevételéhez való jogról szóló 2013/48/EU irányelv[523], amelyet 2016. november 27-ig kell végrehajtani, a preambulum (52) és (55) preambulum bekezdésében, valamint az 5. cikk (2)–(4) bekezdésében közvetlenül utal a gyermekekre. Az (55) preambulum bekezdés és az 5. cikk (2) bekezdése szerint ha gyermeket fosztanak meg a szabadságától, értesíteni kell a szülői felügyelet gyakorló személyt, akinek meg kell adni a szabadságelvonás indokait is, kivéve akkor, ha ez ellentétes a gyermek legfőbb (mindenek felett álló) érdekével. Ez utóbbi esetben egy másik megfelelő felnőttet kell értesíteni. A 2. cikk szerint az irányelvet attól az időponttól kezdve kell alkalmazni, amikor a gyanúsított vagy vádlott tudomására hozzák, hogy bűncselekmény elkövetésével gyanúsítják vagy

521 Európa Tanács, Miniszterek Tanácsa (2010), *Iránymutatás a gyermekbarát igazságszolgáltatásról*, 2010. november 17., II. c. bek.

522 *Uo.*, D. szakasz.

523 Az Európai Parlament és a Tanács 2013. október 22-i 2013/48/EU irányelve a büntetőeljárás során és az európai elfogatóparancshoz kapcsolódó eljárásokban ügyvédi segítség igénybevételéhez való jogról, valamint valamely harmadik félnek a szabadságelvonáskor történő tájékoztatásához való jogról és a szabadságelvonás ideje alatt harmadik felekkel és a konzuli hatóságokkal való kommunikációhoz való jogról, HL L 294., 2013.11.6., 1–12. o.

vádolják, az eljárás befejezéséig, azaz a bűnösség vagy ártatlanság végső megállapításáig. Továbbá, a 3. cikk (3) bekezdése megállapítja, hogy az ügyvédi segítség igénybevételéhez való jog magában foglalja, hogy a gyanúsítottnak vagy vádlottnak joga legyen az ügyvéddel négyszemközt találkozni és kommunikálni, többek között az első meghallgatás előtt is, az ügyvéd kihallgatáson való jelenlétének és hatékony részvételének jogát, valamint az ügyvéd különféle nyomozási vagy bizonyításfelvételi cselekményeknél való jelenlétének jogát.

Az Európa Tanács joganyagában az EJEB az ügyvédi segítség igénybevételét a tisztességes eljáráshoz való jog egyik alapvető elemének tartja.[524] A bűncselekménnyel vádolt személyeknek joguk van ahhoz, hogy a rendőrségi nyomozás kezdeti szakaszától ügyvédi segítséget vegyenek igénybe. Ezt a jogot kivételes körülmények között korlátozhatják, feltéve hogy ez a korlátozás nem sérti indokolatlanul a vádlott jogait. Az EJEB megállapította, hogy ez fordulhat elő, amikor az elmarasztaló ítélethez az ügyvédi segítség igénybevétele nélkül tett nyilatkozatokat használnak fel.[525] A gyermekeket érintő ügyekben az EJEB szigorúbban vizsgálja, hogy a kérelmező ténylegesen igénybe vehetett-e ügyvédi segítséget.[526]

Példa: A *Panovits kontra Ciprus* ügy[527] egy gyilkossággal és rablással vádolt 17 évest érint, akit apjának kíséretében vittek be a rendőrségre. Ezután letartóztatták, és egy külön szobába vitték kihallgatás céljából, az apja és ügyvéd nélkül. Miközben a kérelmezőt kikérdezték, az apját tájékoztatták arról, hogy a kérelmezőnek jogában áll, hogy ügyvéddel vegye fel a kapcsolatot. Az apával néhány perccel később közölték, hogy a fia időközben bevallotta a bűncselekmény elkövetését. Az EJEB megállapította, hogy a kérelmező életkoránál fogva nem feltételezhettek, hogy tisztában van azzal, hogy mielőtt nyilatkozna, joga van jogi képviselethez. Az is valószínűtlen, hogy ésszerűen képes lett volna felmérni, hogy egy gyilkosságot érintő büntetőeljárásban milyen következményekkel jár, hogy ügyvéd segítsége nélkül hallgatják ki. Noha a hatóságok láthatólag bármikor hajlandók voltak megengedni a kérelmezőnek, hogy amennyiben kéri, ügyvédi segítséget vegyen igénybe, elmulasztották felhívni a figyelmét arra a jogára, hogy szükség esetén ügyvéd ingyenes kijelölését kérheti. Nem volt bizonyíték arra, hogy a kérelmező vagy az apja kifejezetten és egyhangúlag lemondtak volna a jogi képviselethez

524 EJEB, *Salduz kontra Törökország* (36391/02), 2008. november 27., 51. bek.

525 *Uo.*, 62. bek.

526 *Uo.*, 60. bek.

527 EJEB, *Panovits kontra Ciprus* (4268/04), 2008. december 11.

való jogukról. Ebből következően a bíróság megállapította, hogy megsértették az EJEE 6. cikke (3) bekezdésének c) pontját a 6. cikk (1) bekezdésével összefüggésben.

11.2. A fiatal bűnelkövetők fogvatartással kapcsolatos jogai

Kiemelt pontok

- Gyermekek csak legvégső esetben és a lehető legrövidebb ideig sújthatók szabadságelvonással.
- Fogvatartásuk esetén a gyermekeket a koruknak megfelelően, emberi méltóságukat tiszteletben kell tartva kell kezelni.
- A gyermekeket nem szabad felnőttekkel együtt fogva tartani.

Minden személyt megillet a szabadsághoz való jog. A szabadságelvonás tehát kivételt képez ez alól, és bíróság vagy közigazgatási hatóság határozata révén olyan intézményben történő elhelyezés bármely formáját magában foglalja, amelyet a fiatalkorú nem hagyhat el önszántából.[528] Tekintettel arra, hogy kiemelten fontos a gyermek jogainak, ezen belül legfőbb (mindenek felett álló) érdekének védelme, a szabadságelvonás intézményét ebből a szempontból is vizsgálni kell, ha gyermekekről van szó.

Jóllehet fogvatartásra különféle körülmények között kerülhet sor, ez a fejezetrész a büntető igazságszolgáltatási rendszerekkel érintkezésbe kerülő gyermekekre összpontosít.

A vonatkozó nemzetközi jogi eszközök minden esetben megerősítik, hogy a fogvatartáshoz csak végső eszközként szabad folyamodni. Ez azt jelenti, hogy az állami hatóságoknak, ha egy gyermek fogvatartásának kérdésével szembesülnek, először megfelelő módon és körültekintően mérlegelniük kell az elzáráshoz képesti alternatív megoldásokat, hogy védjék a gyermek legfőbb (mindenek felett álló)

528 Az Európa Tanács, Miniszterek Tanácsa 21.5. szabálya (2008), CM/Rec (2008)11. sz. ajánlás a szankciók vagy intézkedések hatálya alatt álló fiatalkorú elkövetőkre vonatkozó európai szabályokról2008. november 5.

érdekét, és előmozdítsák a gyermek társadalmi beilleszkedését (a Gyermekjogi egyezmény 40. cikkének (1) bekezdése). Alternatív megoldásként szóba jöhetnek például a következők: a gyermekvédelmi szakellátásba vétel, a pártfogó felügyelet, a tanácsadás, a próbára bocsátás, az oktatási és szakképzési programok (a Gyermekjogi egyezmény 40. cikke (4) bekezdésének. Az fogvatartást csak abban az esetben szabad lehetőségként mérlegelni, ha az alternatív megoldások nem megvalósíthatók. Ezenfelül a szabadság elvonását csak a lehető legrövidebb időre és megfelelő anyagi és eljárási garanciák mellett szabad elrendelni. A gyermekeket fogvatartásuk esetén – tekintettel életkorukra és sérülékenységükre – különleges jogok és biztosítékok illetik meg.

11.2.1. A fogvatartás formái (anyagi és eljárási biztosítékok)

Az uniós jogban a büntető igazságszolgáltatási eljárások jelenlegi jogi keretrendszere nem tartalmaz a gyermekek fogvatartása tekintetében jogi kötőerővel bíró eszközt.

Az Európa Tanács joganyagában az EJEE 5. cikke kimondja, hogy mindenkinek joga van a szabadsághoz. A fogva tartás, a szabadság megvonás büntetése olya kivétel, amelyről a nemzeti jogszabálynak kell rendelkeznie, és amely nem lehet önkényes. Ezen túlmenően a fogva tartást az 5. cikk (1) bekezdésének a)–f) pontjában kimerítően felsorolt helyzetek egyike alapján indokolni kell. A büntető igazságszolgáltatási rendszerrel érintkezésbe kerülő gyermekek fogva tartása az a) pont (fogvatartás az illetékes bíróság által történt elítélést követően), a c) pont (előzetes letartóztatás) vagy a d) pont (különösen nevelési felügyelet céljából történő fogva tartás) alapján indokolható. A két utóbbi esetet elemezzük, mivel azok az állami hatóságok részéről különleges feladatok ellátását teszik szükségessé.

Előzetes letartóztatás

Az előzetes letartóztatás azt a helyzetet jelenti, amikor valakit rendőri őrizetbe vesznek annak gyanúja miatt, hogy bűncselekményt követett el, vagy vizsgálati fogságban tartanak. Az egyén őrizetbe vételével kezdődik és az elsőfokú bíróság által az ügy érdeme tekintetében hozott döntéssel ér véget.[529] Jóllehet a gyermekeket a felnőttekkel azonos garanciák illetik meg, az EJEB több kiegészítő elvet állapított meg, hogy erősítse a gyermekek helyzetét a belföldi büntetőeljárásokban.

529 EJEB, *Idalov kontra Oroszország* (5826/03), 2012. május 22., 112. bek.

Az EJEB általánosan úgy értelmezi az 5. cikk (2) bekezdésének c) pontját és az 5. cikk (3) bekezdését, mint amely előírja, hogy egy személy csak akkor helyezhető előzetes letartóztatásba, ha ésszerűen fennáll annak a gyanúja, hogy bűncselekményt követett el. Továbbá, az előzetes letartóztatás nem haladhatja meg az ésszerű időtartamot, és azt ésszerű időközönként felül kell vizsgálni. Minél hosszabb az őrizetben tartás időtartama, annál határozottabb indokokkal kell azt a hatóságoknak alátámasztaniuk. Az EJEB ítélkezési gyakorlata szerint a bűncselekménnyel vádolt személyt a tárgyalásig mindig szabadon kell engedni, kivéve akkor, ha az állam bizonyítani tudja, hogy „releváns és elégséges" indok áll fenn, amely alátámasztja a folytatódó őrizetben tartást.[530]

Az EJEB az előzetes letartóztatási ügyekben négy alapvető és elfogadható indokot határozott meg a szabadon bocsátás elutasítására: a szökés kockázata, az eljárás más módon történő veszélyeztetése, további bűncselekmények elkövetésének veszélye és a közrend megzavarásának veszélye. Ezen túlmenően az előzetes letartóztatás folytatásának szigorúan szükségesnek kell lennie, és az államnak meg kell vizsgálnia minden körülményt, amely a szabadságelvonás folytatását indokoló tényleges közérdekű követelmény létezése mellett vagy ellen szól.[531]

A gyermekeket érintő ügyekben az EJEB megköveteli az állami hatóságoktól, hogy az előzetes letartóztatás mellett és ellen szóló érvek mérlegelésekor fordítsanak külön figyelmet a gyermek életkorára; ezt csak végső esetben és a lehető legrövidebb időn át szabad alkalmazni.[532] Ez azt jelenti, hogy a hatóságoknak meg kell vizsgálniuk az előzetes letartóztatás alternatíváit.[533] Ezenfelül az állami hatóságoknak különösen ügyelniük kell arra, hogy a gyermekeket érintő ügyeket ésszerű időn belül megtárgyalják.[534]

Példa: A *Nart kontra Törökország* ügyben[535] a 17 éves felperest annak gyanúja alapján tartóztatták le, hogy kirabolt egy élelmiszerboltot. 48 napra előzetes letartóztatásba helyezték, egy felnőtt börtönben. Külön kiemelve,

530 EJEB, *Smirnova kontra Oroszország* (46133/99 és 48183/99), 2003. július 24., 58. bek.

531 *Uo.*, 58–59. bek.; EJEB, *Ladent kontra Lengyelország* (11036/03), 2008. március 18., 55. bek.

532 EJEB, *Korneykova kontra Ukrajna* (39884/05), 2012. január 19., 43–44. bek. Lásd még: *Selçuk kontra Törökország* (21768/02), 2006. január 10., 35–36. bek.; EJEB, *J.M. kontra Dánia* (34421/09), 2012. november 13., 63. bek.

533 EJEB, *Dinç és Çakır kontra Törökország* (66066/09), 2013. július 9., 63. bek. (elérhető francia nyelven); EJEB, *Güveç kontra Törökország* (70337/01), 2009. január 20., 108. bek.

534 EJEB, *Kuptsov és Kuptsova kontra Oroszország* (6110/03), 2011. március 3., 91. bek.

535 EJEB, *Nart kontra Törökország* (20817/04), 2008. május 6.

hogy a felperes gyermek, az EJEB kijelentette, hogy „a kiskorúak előzetes letartóztatása csak végső esetben alkalmazható; annak a lehető legrövidebb ideig szabad csak tartania, és amennyiben az őrizetben tartás szigorúan szükséges, a kiskorúakat a felnőttektől elkülönítve kell elhelyezni”.[536] A hatóságok ebben a konkrét esetben a „bizonyítékok természetével” igyekeztek indokolni az előzetes letartóztatást, az EJEB azonban megállapította, hogy ez az indok önmagában nem alapozhatta meg a kérelmező fogvatartásának időtartamát. Az EJEB ebből következően megállapította az EJEE 5. cikke (3) bekezdésének megsértését.

Nevelési felügyelet céljából történő fogva tartás

A fogva tartás e formáját olyan helyzetekben rendelik el, amikor a gyermeknek zavart személyisége és erőszakos magatartása miatt nevelési felügyeletre van szüksége. Az EJEE 5. cikke (1) bekezdésének d) pontja elsősorban a fiatalkorúakkal foglalkozó igazságszolgáltatási rendszer hatáskörén kívül eső őrizeti formákra irányul.

Példa: A *Bouamar kontra Belgium* ügy[537] egy olyan gyermeket érint, akit kilenc alkalommal, körülbelül 15 napos időtartamokra helyeztek vizsgálati fogságba. A serdülő korú kérelmezőnél személyiségzavart és erőszakos viselkedést állapítottak meg. A belga kormány azt állította, hogy nevelési felügyelet céljából helyezték vizsgálati fogságba. Az EJEB megállapította, hogy az ideiglenes vizsgálati fogságba helyezés önmagában nem ellentétes az 5. cikk (1) bekezdésének d) pontjával, amennyiben a hatóságoknak az a célja, hogy nevelési felügyelet alá helyezzék a fiatalkorút. Az EJEB azonban megállapította, hogy a kérelmező esetében a hatóságok elmulasztották bizonyítani, hogy szándékukban állt vagy lehetőségük volt arra, hogy a fiatalt olyan intézményben helyezzék el, ahol nevelési felügyeletben részesülhetett volna. Az EJEB ebből következően megállapította az EJEE 5. cikke (1) bekezdése d) pontjának megsértését.

Példa: A *D.G. kontra Írország* ügy[538] egy erőszakos gyermek fogdában való elhelyezését érinti. Az EJEB kifejtette, hogy a „nevelési felügyelet” fogalma nem tekinthető egyenlőnek a tantermi oktatással. A nevelési felügyelet

536 *Uo.*, 31. bek.

537 EJEB, *Bouamar kontra Belgium* (9106/80), 1988. február 29.

538 EJEB, *D.G. kontra Írország* (39474/98), 2002. május 16.

a szülői felügyeleti jogok helyi hatóság általi – az érintett személy javára és védelme érdekében történő – gyakorlásának több elemét is tartalmazza. Az EJEB kijelentette, hogy megengedhető, hogy a belföldi hatóságok ideiglenesen fogvatartási helyen helyezzenek el fiatalkorúakat, amíg nem találnak megfelelő elhelyezést, amennyiben ez gyorsan megtörténik. A kérelmező esetében a gyorsaság követelményének nem tettek eleget, mert az őrizetből való szabadon bocsátása után csak több mint hat hónappal kapott megfelelő elhelyezést. Az EJEB emiatt megállapította az EJEE 5. cikke (1) bekezdése d) pontjának megsértését.

Fellebbezés a fogvatartással szemben, a felülvizsgálat gyorsasága és ügyvédi segítség igénybevétele

Az EJEB a fogvatartott gyermekeket érintő esetekben különös gondosságot vár el a nemzeti hatóságoktól. A fent említett garanciákon túlmenően az állami hatóságoknak biztosítaniuk kell, hogy a gyermekeknek joguk legyen ésszerű időközönként megtámadni a fogvatartás jogszerűségét, és hogy ügyvédi segítséget vehessenek igénybe a fogvatartásuk jogszerűségét megállapító eljárás során. Ezenfelül a belföldi hatóságoknak gyorsan kell dönteniük ezekről a jogi kifogásokról. Az EJEB ezen eljárási biztosítékokat az EJEE 5. cikke (4) bekezdésének a szövegéből származtatja.

Példa: A *Bouamar kontra Belgium* ügyben[539] az EJEB megállapította az 5. cikk (4) bekezdésének megsértését, mert a kérelmező szabadságának megvonásáról döntő tárgyalásokra ügyvédjeinek távollétében került sor; az eljárás során nem születtek gyors döntések; s nem született tényleges döntés a fogvatartás „ jogszerűségéről" sem, mivel a belföldi bíróságok a kérelmező fellebbezéseit okafogyottként elutasították.

11.2.2. A fogvatartás körülményei

Az uniós jog keretében az Európai Unió Alapjogi Chartájának 4. cikke tiltja a kínzást és az embertelen vagy megalázó bánásmódot. Mivel azonban a Charta csak az uniós jog keretében alkalmazandó, ezt a rendelkezést egy másik, fogvatartással foglalkozó uniós jogi eszközzel kell összekapcsolni, hogy e tekintetben kötelező legyen a tagállamokra nézve. Az EUB elé eddig nem került a Charta 4. cikkével kapcsolatos ügy.

539 EJEB, *Bouamar kontra Belgium* (9106/80), 1988. február 29.

Az Európa Tanács joganyagában az EJEB megállapította, hogy a gyermekek felnőttekkel való közös fogva tartása az EJEE 3. cikkének[540] vagy 5. cikkének[541] a megsértéséhez vezethet. Továbbá, a fogvatartás időtartama alatt a megfelelő orvosi ellátás hiánya szintén problémákat vethet fel a 3. cikk alapján.[542] Azok az egyéb szempontok, amelyek potenciálisan problémákat vethetnek fel a 3. cikk alapján, a rendelkezésre álló teret, a világítást és a rekreációs tevékenységeket foglalják magukban.[543] Annak értékelése során, hogy az őrizet körülményei összeegyeztethetők-e az EJEE 3. cikkében megfogalmazott normákkal, az EJEB gyakran támaszkodik a Kínzás, Embertelen vagy Megalázó Bánásmód vagy Büntetések Megelőzésére Létrehozott Európai Bizottság (az Európa Tanács kínzás megelőzésével foglalkozó bizottsága) által kidolgozott normakészletre, amely bizottság a kínzás és az embertelen vagy megalázó büntetések vagy bánásmód megelőzéséről szóló európai egyezmény keretében az Európa Tanács tagállamaiban végzett helyszíni ellenőrzésekkel követi nyomon a börtönkörülményeket.[544]

Példa: A *Güveç kontra Törökország* ügyben[545] egy tizenöt éves fiút tartóztattak le annak gyanúja miatt, hogy a Kurd Munkáspárt (PKK) tagja. Az állambiztonsági bíróság öt év szabadságvesztésre ítélte egy felnőtt büntetés-végrehajtási intézményben. Az EJEB megállapította, hogy a fogvatartás ellentétes volt a török jogszabályokkal és a nemzetközi szerződések szerinti kötelezettségekkel, többek között a Gyermekjogi egyezmény 37. cikkének c) pontjával, amely előírja, hogy a gyermekeket a felnőttektől elkülönítve kell elhelyezni. A bíróság azt is megállapította, hogy a kérelmezőnek a börtönben pszichés problémái kezdődtek, amelyek miatt többször is öngyilkosságot próbált meg elkövetni. Ezen túlmenően a hatóságok nem nyújtottak a kérelmező számára megfelelő egészségügyi ellátást. Következésképpen, tekintettel a kérelmező életkorára, a börtönben, felnőttekkel közösen való fogvatartásának időtartamára, arra, hogy a hatóságok nem biztosítottak számára megfelelő orvosi ellátást pszichés problémáival kapcsolatban, és hogy nem tettek lépéseket, hogy megakadályozzák ismétlődő öngyilkossági kísérleteit, az EJEB-nek kétsége sem volt afelől,

540 EJEB, *Güveç kontra Törökország* (70337/01), 2009. január 20.

541 EJEB, *Nart kontra Törökország* (20817/04), 2008. május 6.

542 EJEB, *Güveç kontra Törökország* (70337/01), 2009. január 20.; EJEB, *Blokhin kontra Oroszország* (47152/06), 2013. november 14. (a Nagykamara elé utalva 2014. március 24-én).

543 EJEB, *Kuptsov és Kuptsova kontra Oroszország* (6110/03), 2011. március 3., 70. bek.

544 Lásd például: EJEB, *Güveç kontra Törökország* (70337/01), 2009. január 20.

545 *Uo.*

hogy a kérelmezőt embertelen és megalázó bánásmódnak tették ki. A bíróság ennek megfelelően megállapította az EJEE 3. cikkének megsértését.

A Szociális Jogok Európai Bizottsága következetesen úgy értelmezi az Európai Szociális Karta 17. cikkét, hogy amennyiben gyermekeket tartanak fogva, el kell őket különíteni a felnőttektől.

Az Európa Tanács szankciók vagy intézkedések hatálya alatt álló fiatalkorú elkövetőkre vonatkozó európai szabályai részletes útmutatást adnak a fogvatartás körülményeivel kapcsolatban. Azt is meghatározzák, hogy a fiatalkorúak nem helyezhetőek el felnőttek számára kialakított intézményekben, hanem csak kifejezetten számukra kialakított intézményekben.[546]

Ami a nemzetközi jogot illeti, a Gyermekjogi egyezmény tartalmaz egy külön rendelkezést a gyermekek szabadságtól való megfosztásáról, amely kimondja, hogy a gyermekeket el kell különíteni a felnőttektől, kivéve, ha a gyermek legfőbb (mindenek felett álló) érdekében ennek ellenkezője tűnik kívánatosabbnak (a Gyermekjogi egyezmény 37. cikkének c) pontja). E cikk azt is kimondja, hogy a gyermeknek joga van levelezés és látogatások útján kapcsolatban maradni családjával.

11.2.3. A bántalmazással és rossz bánásmóddal szembeni védelem

Az Európa Tanács joganyagában az EJEB többször leszögezte, hogy a fogvatartott személyek más fogvatartottak vagy maguk a hatóságok által okozott elhalálozásával, a velük szembeni visszaéléssel vagy rossz bánásmóddal szembeni védelméért a belföldi hatóságok a felelősek. Az államok ezzel kapcsolatos kötelezettségei különösen szigorúak, mivel a fogvatartottak az állam felügyelete és ellenőrzése alatt állnak.[547] A fogvatartottak védelmét szolgáló ésszerű intézkedések meghozatalán túlmenően az állami hatóságoknak eredményes nyomozást kell folytatniuk a rossz bánásmódra vagy a halálesetekre vonatkozó, megalapozott állításokkal kapcsolatban.

546 Európa Tanács, Miniszterek Tanácsa (2008), CM/Rec (2008)11 ajánlás a szankciók vagy intézkedések hatálya alatt álló fiatalkorú elkövetőkre vonatkozó európai szabályokról, 2008. november 5., 59.1. szabály.

547 EJEB, *Anguelova kontra Bulgária* (38361/97), 2002. június 13.; EJEB, *H.Y. és Hü.Y. kontra Törökország* (40262/98), 2005. október 6.

Példa: A *Çoşelav kontra Törökország* ügy egy serdülő által a börtönben elkövetett öngyilkosságot érint,[548] aki korábban több alkalommal kísérelt meg sikertelenül öngyilkosságot. E kísérleteket követően a hatóságok áthelyezték a fiatalkorúaknak fenntartott szárnyból egy felnőttek számára fenntartott fogdába. Miután a bíróság először megállapította, hogy a hatóságok előtt ismert volt vagy ismertnek kellett volna lennie, hogy a kérelmező fiának életét valós és közvetlen veszély fenyegeti, azt állapította meg, hogy a hatóságok nem tették meg az öngyilkosság veszélyének megelőzéséhez szükséges ésszerű intézkedéseket. Az EJEB erőteljes hangsúlyt helyezett az elhunyt életkorára, és arra, hogy felnőttekkel együtt tartották fogva. Ennek alapján az EJEB megállapította a 2. cikk érdemi szempontjainak megsértését. Ezen túlmenően a bíróság a 2. cikk eljárási részének megsértését is megállapította, mivel a hatóságok nem folytattak eredményes vizsgálatot a kérelmező fiának halálával kapcsolatban. Az e megállapításokat alátámasztó okok a következők voltak: a hatóságok elmulasztották haladéktalanul értesíteni a kérelmezőket fiuk haláláról; az ügyészség nem vizsgálta ki az öngyilkosság megelőzése tekintetében elkövetett vélelmezett mulasztásokat; a rákövetkező közigazgatási eljárás túlzott elhúzódása.

11.3. A gyermekkorú áldozatok és tanúk védelme

Kiemelt pontok

- A gyermek áldozatokat és tanúkat megilleti az újbóli áldozattá válással (reviktimizáció) szembeni védelem, a rehabilitáció és a reintegráció joga, valamint a büntető- és alternatív eljárásokban való hatékony részvétel joga.

A gyermek áldozatok és tanúk speciális helyzetét mind az **uniós jog**, mind **az Európa Tanács joganyaga** elismeri.

548 EJEB, *Çoşelav kontra Törökország* (1413/07), 2012. október 9.

Az uniós jogban az áldozatok jogairól szóló 2012/29/EU irányelv[549] kifejezetten foglalkozik a gyermek áldozatok helyzetével. Kimondja, hogy amennyiben az áldozat gyermek, elsődlegesen a gyermek legfőbb (mindenek felett álló) érdekét vegyék figyelembe, amelyet egyénre szabottan kell értékelni. Ezen túlmenően gyermekközpontú szemléletnek kell érvényesülnie, ami azt jelenti, hogy figyelembe kell venni a gyermek életkorát, érettségét, valamint véleményét, szükségleteit és aggályait. Ezenfelül az irányelv célja annak biztosítása, hogy a gyermeket és a szülői felügyeleti jogot gyakorló személyt (vagy a gyermek más törvényes képviselőjét) tájékoztassák azokról az intézkedésekről vagy jogokról, amelyek középpontjában kifejezetten a gyermek áll (a 1. cikk (2) bekezdése). A gyermek áldozatokat is megilleti a büntetőeljárás során a meghallgatáshoz való jog, és a tagállamoknak biztosítaniuk kell, hogy bizonyítékot szolgáltathassanak. Kellően figyelembe kell venni a gyermek életkorát és érettségét (a 10. cikk (1) bekezdése). Továbbá, az irányelv igyekszik védeni a gyermek áldozatok magánéletét és identitását a büntetőeljárás alatt, többek között a másodlagos áldozattá válás megelőzése érdekében (a 21. cikk (1) bekezdése; lásd a 26. cikket is). Ezenfelül az irányelv külön rendelkezést állapít meg a büntetőeljárás során a gyermek áldozatok védelemhez való joga tekintetében (24. cikk), amely a gyermek áldozatok audiovizuális eszközök útján történő meghallgatásának és a felvétel bizonyítékként való értékelésének jogával, a speciális képviselők kinevezésével, valamint a gyermek áldozat és a szülői felügyeleti jogot gyakorló személyek közötti érdekellentét esetén, a gyermek saját nevében eljáró jogi képviselethez való joggal foglalkozik. Az irányelv továbbá különféle rendelkezéseket tartalmaz általában az áldozatok védelmére vonatkozóan, így például az áldozatsegítő szolgáltatások igénybevételével kapcsolatban. A gyermekek és más sérülékeny csoportok esetében segítő szakszolgáltatásokat kell biztosítani (lásd az irányelvet kísérő állásfoglalás 38. szakaszát).[550]

Mielőtt az áldoztvédelmi irányelv, a büntetőeljárásban a sértett jogállásáról szóló 2001/220/IB kerethatározat helyébe lépett volna, ennek hatálya alá tartozott többek között az áldozatok részvétele, jogaik és a tisztességes bánásmód kérdése. E kerethatározat elismerte a sérülékeny sértettek különleges helyzetét, jóllehet, nem utalt kifejezetten a gyermekekre. Az EUB e kerethatározat alapján úgy ítélkezett, hogy a gyermekek sérülékenynek minősülhetnek, ha figyelembe veszik életkorukat és azokat a bűncselekményeket, amelyek áldozatának tartják

549 Az Európai Parlament és a Tanács 2012. október 25-i 2012/29/EU irányelve a bűncselekmények áldozatainak jogaira, támogatására és védelmére vonatkozó minimumszabályok megállapításáról, HL L 315., 2012.11.14., 55. o.

550 Lásd: FRA (2014b), 36. o.

magukat. Ebből fakadóan különleges védelmi intézkedésekre jogosítja fel őket, így például arra, hogy a tárgyaló bíróságon kívül, illetve a tárgyalás előtt hallgassák meg őket.[551] Az EUB azt is kimondta, hogy az áldozatok védelme érdekében minden védőintézkedést úgy kell meghozni, hogy ezek mellett a vádlott vonatkozásában is tisztességes eljárás folyjon. Más szavakkal, az áldozatok és tanúk védelme nem veszélyeztetheti a megvádolt személy tisztességes eljáráshoz való jogát sem (lásd még az EJEB ítélkezési gyakorlatából vett példákat is).[552]

Példa: A *Pupino* ügyben[553] egy olasz pedagógus ellen folyt eljárás, amiért egy tanulót bántalmazott. Az olasz büntetőeljárási törvénykönyv szerint a tanúknak általános szabályként a tárgyalás során a bíróság előtt kell tanúskodniuk. Bizonyos körülmények között azonban vallomást tehetnek egy bíró előtt a tárgyalást megelőzően is, egy különleges eljárás keretében (*incidente probatorio*). Az ügyész ebben az ügyben azt kérte a nemzeti bíróságtól, hogy a fiatal gyermek előzetes vallomást tehessen, ám a nemzeti bíróság elutasította ezt a kérést. Az EUB első alkalommal értelmezett néhány, a gyermekek mint büntetőeljárásban részt vevő áldozatok és tanúk jogállása szempontjából lényeges rendelkezést. Hangsúlyozta, hogy a 2001/220/IB kerethatározat előírja a tagállamok számára a sérülékeny áldozatok különleges védelmének biztosítását, ami azt jelenti, hogy a nemzeti bíróság számára biztosítani kell azt a lehetőséget, hogy a sérülékeny áldozatok részére engedélyezze, hogy olyan módon tegyenek tanúvallomást, amely garantálja védelmüket, például a nyilvános tárgyaláson kívül és azt megelőzően. Az EUB kimondta: „Azonban – függetlenül a kérdéstől, hogy a bűncselekmény sértettjének a kerethatározat szerinti különösen sérülékennyé minősítéséhez főszabály szerint elegendő-e, ha kiskorú – nem vitatható, hogy amennyiben, mint az alapügyben, gyermekek azt állítják, hogy a pedagógus bántalmazta őket, e gyermekek, tekintettel többek között korukra, valamint az általuk megfogalmazottan a sérelmükre elkövetett bűncselekmények jellegére és következményeire [...] megfelelnek e minősítésnek."[554] Az EUB kimondta továbbá, hogy a védelemmel és a másodlagos áldozattá válás megelőzésével kapcsolatos

551 EUB, C-105/03. sz. ügy, *Maria Pupino elleni büntetőeljárás* [Nagytanács], 2005. június 16., 53. pont.

552 EUB, C-105/03. sz. ügy, *Maria Pupino elleni büntetőeljárás* [Nagytanács], 2005. június 16. Lásd még: EUB, C-507/10. sz. ügy, *X elleni büntetőeljárás* [Nagytanács], 2011. december 21.

553 EUB, C-105/03. sz. ügy, *Maria Pupino elleni büntetőeljárás* [Nagytanács], 2005. június 16.

554 *Uo.*, 53. bek.

mindenfajta intézkedést úgy kell kialakítani, hogy a vádlott továbbra is tisztességes eljárásban részesüljön.[555]

Az Európa Tanács joganyagában az EJEB kimondta, hogy az államnak kötelessége, hogy védje az áldozatok érdekeit. Ez igaz a büntetőeljárásban tanúként részt vevő áldozatokra. Az EJEE rendelkezései, például a 2. cikk és a 8. cikk szerinti érdekeiket egyensúlyba kell hozni a vádlott védelmének érdekeivel.[556] Az EJEB számos szexuális bűncselekménnyel kapcsolatos ítéletet hozott, amelyben gyermekek tanúskodtak a gyanúsított elkövetők ellen. Ez az ítélkezési gyakorlat azt mutatja, hogy a bíróság elismerte, hogy a szexuális bűncselekményekkel kapcsolatos büntetőeljárásokat „az áldozat gyakran megpróbáltatásként éli meg, különösen ha akarata ellenére szembesítették a vádlottal", és hogy ez még nyilvánvalóbb, ha gyermekekről van szó.[557] A bíróság következésképpen elfogadta, hogy ilyen esetekben bizonyos intézkedések hozhatók a gyermek áldozatok védelme céljából. Azt is megállapította azonban, hogy ezek az intézkedések nem veszélyeztethetik a védelem jogainak megfelelő és hatékony gyakorlását, és az igazságügyi hatóságok számára emiatt előírható, hogy olyan intézkedéseket hozzanak, amelyek ellensúlyozzák azokat a hátrányokat, amelyek mellett a védelem működik.[558]

Példa: A *Kovač kontra Horvátország* ügyben[559] egy 12 éves lány azt vallotta a nyomozási bíró előtt, hogy a kérelmező illetlenül viselkedett vele. A kérelmező nem volt jelen vagy képviselve az említett vallomástétel alatt, és nem kapott lehetőséget arra sem, hogy megtámadja az áldozat állítását. Az EJEB megismételte, hogy általános szabályként minden bizonyítékot a vádlott jelenlétében be kell mutatni a nyilvános tárgyaláson, hogy azokkal szemben érveket lehessen felsorakoztatni. Ha a rendőrségi nyomozás alatt vagy a bírósági szakban tett nyilatkozatokat használnak fel bizonyítékként, ez önmagában véve nem összeegyeztethetetlen az EJEE 6. cikkével, feltéve hogy a vádlott megfelelő lehetőséget kap arra, hogy megtámadja és kérdezzen az érintett tanútól, vagy a nyilatkozattétel idő-

555 *Uo.*, 59. bek.

556 EJEB, *Doorson kontra Hollandia* (20524/92), 1996. március 26.

557 EJEB, *S.N. kontra Svédország* (34209/96), 2002. július 2., 47. bek.

558 EJEB, *Bocos-Cuesta kontra Hollandia* (54789/00), 2005. november 10.; EJEB, *A.L. kontra Finnország* (23220/04), 2009. január 27.; EJEB, *W. kontra Finnország* (14151/02), 2007. április 24.; EJEB, *Kovač kontra Horvátország* (503/05), 2007. július 12.

559 EJEB, *Kovač kontra Horvátország* (503/05), 2007. július 12.

pontjában, vagy az eljárás későbbi szakaszában. A kérelmező esetében az áldozat nyilatkozata volt a kérelmezővel szemben felsorakoztatott tények egyedüli közvetlen bizonyítéka, és e bizonyíték döntő szerepet játszott abban, hogy a bíróság elmarasztaló ítéletet hozott. A kérelmező azonban nem tudott kifogást emelni vagy választ kapni a belföldi bíróságoktól az ezzel kapcsolatos panaszára. Sőt, az áldozat tényleges nyilatkozatát egyszer sem olvasták fel a tárgyalást lefolytató bíróságon. A bíró ehelyett csupán megjegyezte, hogy az áldozat fenntartja a vizsgálóbíró előtt tett nyilatkozatát. Az EJEB ezért megállapította, hogy a kérelmező számára nem biztosítottak tisztességes eljárást, ami sértette az EJEE 6. cikkének (1) bekezdését a 6. cikk (3) bekezdésének d) pontjával összefüggésben.

Példa: Az *S.N. kontra Svédország* ügyben[560] egy tízéves fiú azt vallotta a rendőrségnek, hogy a kérelmező szexuális visszaélést követett el ellene. A fiút kétszer kihallgatta egy gyermekekkel szembeni visszaélési ügyekben jelentős tapasztalattal rendelkező rendőr. Az első kihallgatást videoszalagon, a másodikat pedig hangszalagon rögzítették. A kérelmező ügyvédje nem vett részt a második kihallgatáson, de megegyezett a rendőr arról, hogy milyen kérdéseket szükséges megvitatni. A tárgyalás során a kerületi bíróság lejátszotta a gyermek kihallgatásairól készült felvételeket, de személyesen nem hallgatta meg a gyermeket. A bíróság végül elítélte a kérelmezőt, szinte kizárólag a gyermek vallomására támaszkodva. A fellebbviteli bíróság megerősítette az elmarasztaló ítéletet. Megállapította, hogy a rendőrségi kihallgatások elégséges bizonyítékkal szolgáltak a kérelmező bűnösségének megállapításához, noha elismerte, hogy semmilyen technikai bizonyíték nem támasztotta alá a gyermek állításait, amelyek helyenként pontatlanok voltak. Az EJEB elfogadta, hogy a szexuális bűncselekmények esetében nem mindig lehetséges a tanúk szembesítése, és hogy ilyen esetekben a tanúvallomásokat rendkívül óvatosan kell kezelni. Noha a gyermek által tett nyilatkozat volt lényegében a vádlott elleni egyedüli bizonyíték, az eljárás egészében véve tisztességes volt. A tárgyalás és a fellebbviteli tárgyalás során lejátszották a videófelvételt és a kerületi bíróság előtt felolvasták a második kihallgatás átiratát; a hangfelvételt a fellebbviteli bíróság előtt is lejátszották. Ez elegendő lehetőséget adott a kérelmezőnek arra, hogy megtámadja a gyermek vallomását és szavahihetőségét a büntetőeljárás során. Ebből következik, hogy nem sértették meg az EJEE 6. cikke (3) bekezdésének d) pontját.

560 EJEB, *S.N. kontra Svédország* (34209/96), 2002. július 2.

Az EJEB ítélkezési gyakorlata nemcsak a gyermekkorú áldozatok védelmének és a vádlott tisztességes eljáráshoz való jogának az egyensúlyba hozásával foglalkozik, hanem az áldozatok és családjuk, ezen belül a gyermekek élethez való jogának az EJEE 2. cikke szerinti védelmével is, mint azt a következő példa mutatja.

Példa: Az *R.R. és társai kontra Magyarország* ügy[561] egy fogvatartottat érint, aki nyilvános tárgyaláson tett vallomást kábítószer-kereskedelmi tevékenységeiről, és akit a megtorlás kockázata miatt feleségével és két gyermekével együtt felvettek a hivatalos tanúvédelmi programba. Amikor a hatóságok észlelték, hogy a fogvatartott továbbra is kapcsolatban van bűnözői körökkel, a feltételek megszegése miatt kivették őt és családját a tanúvédelmi programból. A család az EJEE 2. cikke alapján azt állította, hogy a tanúvédelmi programból való kizárása a bűnszervezet általi megtorlás veszélyébe sodorta. A bíróság elfogadta, hogy a felperesek tanúvédelmi programba való felvétele és az apa hatóságokkal való együttműködése azt jelentette, hogy a felperesek élete az intézkedés eredeti végrehajtásakor veszélyben forgott. Mivel a program által nyújtott védelemből való kizárásukat nem e veszély csökkenése indokolta, hanem a program feltételeinek a megsértése, a bíróság nem volt meggyőződve arról, hogy a hatóságok bizonyították a veszély megszűnését. Továbbá, nem volt ésszerűtlen feltételezni, hogy a család fedő személyazonosságainak visszavonása után személyazonosságuk és hollétük bárki számára hozzáférhetővé vált, aki ártani kívánt nekik. A hatóságok ilyen módon potenciálisan életveszélyes helyzetbe hozták a családot, megsértve ezzel az EJEE 2. cikkét.

A Lanzarote-i Egyezmény 31. cikkében szerepel, hogy a tagállamoknak milyen átfogó intézkedéseket kell tenniük az áldozatok jogainak és érdekeinek – ezen belül mint tanúknak fennálló különleges szükségleteiknek a – védelme érdekében a nyomozások és büntetőeljárások valamennyi szakaszában (a 31. cikk (1) bekezdése). Ezen intézkedések közé tartozik az áldozatként őket megillető jogokról, a szolgáltatások rendelkezésre állásáról és a nyomozás vagy eljárás általános előrehaladásáról való tájékoztatás, magánéletük és biztonságuk védelme (ideértve a megvádolt vagy elítélt személy szabadon bocsátásáról való tájékoztatást). valamint az áldozatok és elkövetők közötti érintkezés elkerülése a bíróságon és a bűnüldöző szerv helyiségeiben. A 31. cikken ezen túlmenően meghatározza, hogy az áldozatoknak igénybe kell tudniuk venni ügyvédi segítséget (31. cikk

561 EJEB, *R.R. és társai kontra Magyarország* (19400/11), 2012. december 4.

(3) bekezdés). A nyújtott tájékoztatásnak igazodnia kell a gyermek életkorához és érettségéhez, és azt olyan nyelven kell nyújtani, amelyet a gyermek megért (31. cikk (6) bekezdés).

Az Európa Tanács *gyermekbarát igazságszolgáltatásról szóló iránymutatása*[562] szintén figyelmet fordít a gyermekkorú áldozat és tanú helyzetére, különösen ha bizonyítékot szolgáltat bírósági eljárásban. Az iránymutatás felhívja a tagállamokat, hogy tegyenek meg „minden erőfeszítést […] annak érdekében, hogy a gyermek a legkedvezőbb környezetben és a legmegfelelőbb körülmények között tudjon vallomást tenni, tekintettel életkorára, érettségére, értelmi szintjére és lehetséges kommunikációs nehézségeire."[563]. E célból képzett szakembereket kell bevonni, és ösztönözni kell például az audiovizuális nyilatkozatokat. A gyermekeknek arra is lehetőséget kell kapniuk, hogy a gyanúsított elkövető jelenléte nélkül szolgáltassanak büntetőeljárás során bizonyítékot. Az iránymutatás azt is elismeri, hogy e gyermekbarát megközelítésnek tiszteletben kell tartania más felek ahhoz való jogát, hogy megtámadják a gyermek nyilatkozatainak a tartalmát. Ezen túlmenően az iránymutatás meghatározza, hogy a gyermek magánéletét és családi életét védeni kell (IV.A.9. pont), és az eljárást lehetőleg zárt tárgyalás keretében kell lefolytatni.

A nemzetközi jogban a gyermek áldozatok helyzetét a gyermekjogi egyezmény 39. cikke kifejezetten elismeri. A rendelkezés kimondja, hogy egyezményben részes államok megtesznek minden alkalmas intézkedést arra, hogy megkönnyítsék a gyermekkorú áldozatok testi és szellemi rehabilitációját és a társadalomba való beilleszkedését. Ennek a rehabilitációnak és a társadalomba való beilleszkedésnek a gyermek egészségét, önbecsülését és emberi méltóságát támogató, védő körülmények között kell történnie.

Azt is fontos megjegyezni, hogy az ENSZ elfogadta a gyermekkorú áldozatokra és a bűncselekmények tanúira vonatkozó igazságszolgáltatásra vonatkozó iránymutatást.[564] Ezek az iránymutatások arra szólítanak fel, hogy a gyermekkorú áldozatokat „gyermekekre érzékeny módon" kezeljék, ami „olyan megközelítést jelent, amely mérlegeli a gyermek védelemhez való jogát, és figyelembe

562 Európa Tanács, Miniszterek Tanácsa (2010), *Iránymutatás a gyermekbarát igazságszolgáltatásról*, 2010. november 17. Lásd még: FRA (2015b).

563 Európa Tanács, Miniszterek Tanácsa (2010), *Iránymutatás a gyermekbarát igazságszolgáltatásról*, 2010. november 17. 64. bek.

564 Az ENSZ Gazdasági és Szociális Tanácsa (ECOSOC), 2005/20 határozat, *Guidelines on Justice in Matters involving Child Victims and Witnesses of Crime*, 2005. július 22.

veszi a gyermek egyéni szükségleteit és nézeteit".[565] Az iránymutatások nagyon részletes útmutatást adnak e szempontok megvalósítása tekintetében. Az ENSZ Gyermekjogi Bizottsága Átfogó Kommentárjában szintén hangsúlyozta ezen – a Gyermekjogi egyezmény 12. cikkén alapuló (a meghallgatáshoz való jog) – ENSZ-iránymutatások fontosságát.[566] A Bizottság szerint a bűncselekmények gyermek áldozatainak és gyermek tanúinak lehetőséget kell adni arra, hogy maradéktalanul gyakorolhassák a nézeteik szabad kinyilvánításához való jogukat, ami különösen „azt jelenti, hogy mindent meg kell tenni annak biztosítása érdekében, hogy a gyermekkorú áldozattal és/vagy tanúval egyeztessenek a vizsgált ügybe való részvétel szempontjából lényeges kérdésekről, és képessé tegyék őt arra, hogy szabadon, a maga módján kinyilvánítsa a bírósági eljárásban való részvételével kapcsolatos nézeteit és aggályait".[567] A Bizottság amellett is érvel, hogy „a gyermek áldozat és tanú joga összefügg az olyan kérdésekkel kapcsolatos tájékoztatás jogával, mint az egészségügyi, pszichológiai és szociális szolgáltatások elérhetősége, a gyermek áldozat és/vagy tanú szerepe, hogy milyen módon folytatják le a kihallgatást, a gyermek számára a panasz benyújtásakor és a nyomozásban és a bírósági eljárásban való részvételekor elérhető, meglévő támogatási mechanizmusok, a tárgyalások konkrét helye és időpontja, a védelmi intézkedések elérhetősége, a jóvátétel lehetőségei és a fellebbezésre vonatkozó rendelkezések".[568]

565 *Uo.*, 9(d) pont

566 Az ENSZ Gyermekjogi Bizottsága (2009), *12. számú Átfogó Kommentár*: *A gyermek meghallgatáshoz való joga*, CRC/C/GC/12, 2009. július 1., 62–64. bek.

567 *Uo.*, 63. bek.

568 *Uo.*, 64. bek.

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Útmutató az európai bíróságok ítélkezési gyakorlatának kereséséhez

Emberi Jogok Európai Bírósága: HUDOC esetjogi adatbázis

A **HUDOC adatbázis** ingyenes hozzáférést nyújt az EJEB ítélkezési gyakorlatához: http://HUDOC.echr.coe.int.

Az adatbázis angolul és franciául érhető el, felhasználóbarát keresőprogramja pedig megkönnyíti az ítélkezési gyakorlat megtalálását.

A HUDOC **Help** oldalán ? oktatóvideók és felhasználói kézikönyvek segítik a keresést. Ha a keresési területek és szűrök használatával kapcsolatban további részletekre vagy szemléltető példákra van szüksége, álljon a kurzorral az ikonra, amely minden keresési eszköz jobb oldalán megtalálható a Hudoc felületén.

A Kézikönyvben szereplő esetjogi hivatkozások átfogó tájékoztatást nyújtanak az olvasónak, amelynek segítségével könnyen megtalálja az idézett ítélet vagy határozat teljes szövegét.

Mielőtt megkezdi a keresést, felhívjuk a figyelmét, hogy az alapbeállítás a nagytanács és a tanács ítéleteit mutatja, a legutoljára megjelent ítélettel kezdve. Ha más gyűjteményekben, például a határozatok között szeretne keresni, a képernyő bal felső oldalán megjelenő „**Document Collections**" részben jelölje be a megfelelő négyzetet.

A keresés legegyszerűbb módja, ha a képernyő jobb felső részén található **Advanced Search** funkció alatt megjelenő „Application Number" mezőbe beírja a kérelem számát, majd a kék „Search" gombra kattint.

Ha más kérdésekkel, például gyermekjogi kérdésekkel foglalkozó további ítélkezési gyakorlatot keres, használhatja a képernyő jobb felső részén található, nagyítóval jelzett „**Search**" mezőt. A keresés mezőben a következők szerint kereshet a szövegben:

- egy szóra (pl. gyermek)
- kifejezésre (pl. migráns gyermekek)
- ügy címére
- államra
- logikai műveletekkel kombinált kifejezésre (pl. szakellátásban ÉLŐ gyermekek)

A felhasználót segíti keresése végrehajtásának az egyszerű logikai keresés, amelyet **Search** mezőn belül megjelenő nyílra kattintva indíthat el. Az egyszerű logikai keresés hat keresési lehetőséget kínál fel: pontos szó vagy kifejezés, ezek a szavak mind, bármelyik e szavak közül, e szavak közül egyik sem, hasonló ezekhez a szavakhoz, szabad logikai keresés.

Amikor megjelenik a keresés eredménye, a képernyő bal oldalán található „**Filters**" mezőben könnyen leszűkítheti a találatokat, például nyelv vagy állam szerint. A szűrőket használhatja egyesével vagy többet egyszerre, hogy tovább szűkítse a találatok körét. Hasznos eszköz lehet a „Keywords" szűrő, mivel ez gyakran az EJEE szövegében szereplő kifejezéseket tartalmaz, és közvetlenül kapcsolódik a bíróság érveléséhez és következtetéseihez.

Példa: Keressük meg a bíróság ítélkezési gyakorlatát az olyan menedékkérők kiutasításáról, akik ezáltal az EJEE 3. cikke szerinti kínzás, embertelen vagy megalázó bánásmód vagy büntetés veszélyének lennének kitéve:

1) Először írjuk be az „asylum seekers" (menedékkérők) szót a Search mezőbe, majd kattintsunk a kék „Search" gombra.

2) A keresési eredmények megjelenése után a „Filters" mezőben a „Violation" szűrő alatt válasszuk ki a „3" számot, hogy az eredményeket leszűkítsük a 3. cikk megsértésével kapcsolatosakra.

3) Ezután a „Keywords" szűrő alatt kiválasztott releváns kulcsszavakkal tovább szűkíthetjük az eredményeket a 3. cikk szempontjából relevánsakra, például az „(Art. 3) Prohibition of torture" („3. cikk, a kínzás tilalma") kulcsszavakkal.

A HUDOC adatbázis a jelentősebb ügyekről jogi összefoglalót is tartalmaz. Az összefoglaló az ügyet bemutató bevezetőből, a tényállás és a jogszabály rövid ismertetéséből áll, a jogi szempontból érdekes pontokra helyezve a hangsúlyt. Ha van összefoglaló, az ítélet vagy határozat szövegéhez vezető linkkel együtt ennek a linkje is megjelenik az eredményekben. A jogi összefoglalókra külön is rá lehet keresni, ehhez a „**Document Collections**" mezőben kizárólag a „**Legal Summaries**" négyzetet kell megjelölni.

Ha egy adott ügyről nem hivatalos fordítás is készült, az ítélet vagy határozat szövegéhez vezető linkkel együtt ennek a linkje is megjelenik az eredményekben. A HUDOC oldalán olyan, harmadik felek által üzemeltetett oldalak linkjei is megtalálhatók, amelyek más fordításokat közölnek az EJEB ítélkezési gyakorlatából. Bővebb felvilágosítást a HUDOC „Help" menüpontja alatt megjelenő „Language versions" pontban talál.

Az Európai Unió Bírósága: CURIA esetjogi adatbázis

A **CURIA esetjogi adatbázis** ingyenes hozzáférést nyújt az EB/EUB ítélkezési gyakorlatához: http://curia.europa.eu.

A kereső az EU összes hivatalos nyelvén használható.[569] A nyelv a képernyő jobb felső sarkában választható ki. A kereső a Bíróság, a Törvényszék és a Közszolgálati Törvényszék lezárt és folyamatban lévő ügyeire vonatkozó összes dokumentumban keresi a kért információt.

A „**Help**" rovat itt érhető el: http://curia.europa.eu/common/juris/en/aideGlobale.pdf. Minden keresési mezőnek külön segítség oldala van, amelyet az ikonra kattintva érhet el. Itt az adott eszköz lehető legjobb használatához kaphat hasznos információkat.

Egy konkrét ügyet legkönnyebben úgy lehet megtalálni, ha beírjuk az ügy teljes számát az „**Ügyszám**" keresőablakba, majd a zöld „Keresés" gombra kattintunk. Ügyet keresni az ügyszám egy részével is lehet. Ha például az „Ügyszám" ablakba a 122-es számot írjuk be, minden évből és mindhárom bíróságtól (Bíróság, Törvényszék, Közszolgálati Törvényszék) láthatjuk a 122-es számú ügyeket.

569 2004. április 30. óta elérhető nyelvek: spanyol, dán, német, görög, angol, francia, olasz, holland, portugál, finn és svéd; 2004. május 1-jétől: cseh, észt, lett, litván, magyar, lengyel, szlovák és szlovén; 2007. január 1-jétől: bolgár és román; 2007. április 30-tól: máltai; 2011. december 31-től: ír; az ideiglenes eltérési lehetőségeket a 920/2005/EK és 1257/2010/EK tanácsi rendelet rendelet állapította meg. Az Európai Unió Hivatalos Lapjában Horvátország csatlakozása után publikálásra kerül az a különleges kiadás, amely tartalmazni fogja a horvát nyelvű hivatalos fordítást is.

Kereshetünk az ügy köznapi neve szerint is, „**A felek neve**” keresőablak segítségével. Ez általában az ügyben érintett felek nevének egyszerűsített formáját jelenti.

A találatok szűkítéséhez összesen 16 többfunkciós keresési mező áll rendelkezésre. A különböző keresőablakok felhasználóbarát kialakításúak, és többféle kombinációban is használhatók. A keresőablakokhoz gyakran keresési listák is tartoznak; ezeket az ikonra kattintva lehet előhívni, hogy válasszunk a rendelkezésre álló kereső kifejezések közül.

Általánosabb kereséshez „**A szöveg szavai**” mező alkalmazásával kulcsszó alapján kereshetünk az 1954 óta az Európai Bírósági Határozatok Tárában és az 1994 óta az Európai Bírósági Határozatok Tárában – személyzeti ügyek (EBHT-KSZ) megjelent összes dokumentumban.

Ha a keresés inkább témához kötődik, érdemes a „**Tárgy**” mezőt használni. Ehhez kattintsunk a mező jobb oldalán található ikonra, és a felsorolásból válasszuk ki a megfelelő tárgya(ka)t. A keresés eredményeképpen megkapjuk a Bíróság, a Törvényszék, a Közszolgálati Törvényszék határozataiban és a főtanácsnoki indítványokban tárgyalt jogi kérdésekre vonatkozó válogatott dokumentumok ábécésorrendbe rendezett listáját.

A CURIA weboldalnak további esetjogi eszközei is vannak:

„**Ügyszám szerinti hozzáférés**”: ez a rész a három bíróság valamelyike elé került ügyekre vonatkozó információkat gyűjti össze. Az ügyeket a hivatalba történt érkezésüknek megfelelően, ügyszám szerinti sorrendben mutatja be. Az ügyek tanulmányozásához kattintson az ügyszámra. Az „Ügyszám szerinti hozzáférés” itt érhető el: http://curia.europa.eu/jcms/jcms/Jo2_7045/.

„**Rendszerezett ítélkezési gyakorlat**”: ebben a részben az adott határozat jogi szempontból legfontosabb részeiről szóló esetjogi összefoglalók rendszerezett csoportosítását találjuk. Ezek az összefoglalók a lehető legnagyobb mértékben támaszkodnak magára a határozat szövegére. A „Rendszerezés” itt érhető el: http://curia.europa.eu/jcms/jcms/Jo2_7046/.

„**Az ítéletekhez kapcsolódó kommentárok jegyzéke**”: ez a rovat a három bíróság fennállása óta hozott ítéleteihez kapcsolódó tanulmányokra vonatkozó hivatkozásokat tartalmazza. Az ítéletek mindhárom bíróság esetében időrendben, az ügyszám szerinti sorrendben, míg a tanulmányokra vonatkozó hivatkozások

a megjelenésük időrendi sorrendjében szerepelnek. A hivatkozások az eredeti nyelvükön szerepelnek. „Az ítéletekhez kapcsolódó kommentárok jegyzéke" itt érhető el: http://curia.europa.eu/jcms/jcms/Jo2_7083/.

„**A nemzeti ítélkezési gyakorlat adatbázisa**": ez a külső adatbázis a CURIA weboldalon keresztül érhető el. Az uniós joggal kapcsolatos releváns nemzeti ítélkezési gyakorlathoz nyújt hozzáférést. Az adatbázis a tagállami nemzeti bíróságok ítélkezési gyakorlatának gyűjteményén alapul. Az információk összeállítása a jogi folyóiratok szelektív figyelemmel kísérése és számos tagállami bírósággal fennálló közvetlen kapcsolatok révén történt A „Nemzeti ítélkezési gyakorlat adatbázisa" angolul és franciául érhető el, itt: http://curia.europa.eu/jcms/jcms/Jo2_7062/.

Hivatkozott jogforrások

Az ENSZ joganyagához kapcsolódó jogforrások

Az ENSZ alapvető szerződéseit, ezen belül a Gyermekjogi egyezményt és ellenőrző szervezeteiket illetően lásd: www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx.

A gyermekek védelméről, a családról és a tulajdonviszonyokról szóló nemzetközi magánjogi egyezményekkel foglalkozó hágai konferenciát illetően lásd: https://www.hcch.net/en/instruments/conventions.

Az Európa Tanács jogforrásai

Az Európa Tanács valamennyi jogi eszköze elérhető az interneten a http://conventions.coe.int/Treaty/ címen. Az Európa Tanács jogi eszközei uniós tagállamok általi elfogadásának helyzetére vonatkozó információkat illetően lásd az FRA honlapján a „Nemzetközi kötelezettségek" (International obligations) című részt, a következő címen: http://fra.europa.eu/en/publications-and-resources/data-and-maps/int-obligations.

	Cím
A gyermekek jogai/polgári jogok	
Egyezmény az emberi jogok és alapvető szabadságok védelméről	A 11. és 14. Kiegészítő Jegyzőkönyv által módosított Emberi Jogok Európai Egyezménye, CETS 005, Róma, 1950.11.4., 1–15. o.
Jegyzőkönyv az emberi jogok és alapvető szabadságok védelméről szóló európai egyezményhez	A 11. Kiegészítő Jegyzőkönyv által módosított kiegészítő jegyzőkönyv az emberi jogok és alapvető szabadságok védelméről szóló egyezményhez, CETS 009, Párizs, 1952.3.20., 1–3. o.
12. jegyzőkönyv az emberi jogok és alapvető szabadságok védelméről szóló európai egyezményhez	12. Kiegészítő Jegyzőkönyv az emberi jogok és alapvető szabadságok védelméről szóló egyezményhez, CETS 177, Róma, 2000.11.4., 1–3. o.
Európai egyezmény a gyermekek jogainak gyakorlásáról	Európai egyezmény a gyermekek jogainak gyakorlásáról, CETS 160, Strasbourg, 1996.1.25., 1–10. o.
Európai egyezmény a házasságon kívül született gyermekek jogállásáról	Európai egyezmény a házasságon kívül született gyermekek jogállásáról, CETS 085, Strasbourg, 1975.10.15., 1–5. o.
Egyezmény az emberi jogokról és a biomedicináról	Egyezmény az emberi lény emberi jogainak és méltóságának a biológia és az orvostudomány alkalmazására tekintettel történő védelméről: Egyezmény az emberi jogokról és a biomedicináról, CETS 164, Oviedo, 1997.4.4., 1–12. o.
Identitáshoz kapcsolódó, és személyazonossági kérdések	
Keretegyezmény a nemzeti kisebbségek védelméről	Keretegyezmény a nemzeti kisebbségek védelméről, CETS 157, Strasbourg, 1995.2.1., 1–10. o.
Európai egyezmény az állampolgárságról	Európai egyezmény az állampolgárságról, CETS 166, Strasbourg, 1997.11.6., 1–13. o.
Az Európa Tanács egyezménye az utódállamokban létrejövő hontalanság elkerüléséről	Az Európa Tanács egyezménye az utódállamokban létrejövő hontalanság elkerüléséről, CETS 200, Strasbourg, 2006.5.19., 1–7. o.
Családi élet és szülői felügyelet	
Egyezmény a gyermekekkel való kapcsolattartásról	Egyezmény a gyermekekkel való kapcsolattartásról, CETS 192, Strasbourg, 2003.5.15., 1–13. o.
Európai egyezmény a gyermekek örökbefogadásáról	Európai egyezmény a gyermekek örökbefogadásáról, CETS 202, Strasbourg, 2008.11.27., 1–11. o.
Európai egyezmény a gyermekek feletti felügyeleti jogot érintő határozatok elismeréséről és végrehajtásáról, valamint a felügyeleti viszonyok helyreállításáról	Európai egyezmény a gyermekek feletti felügyeleti jogot érintő határozatok elismeréséről és végrehajtásáról, valamint a felügyeleti viszonyok helyreállításáról, CETS 105, Luxembourg, 1980.5.20., 1–12. o.

A gyermekek erőszakkal és kizsákmányolással szembeni védelme	
Az Európa Tanács egyezménye a gyermekek szexuális kizsákmányolással és szexuális visszaéléssel szembeni védelméről	Az Európa Tanács egyezménye a gyermekek szexuális kizsákmányolással és szexuális visszaéléssel szembeni védelméről, CETS 201, Lanzarote, 2007.10.25., 1–21. o.
Európai Egyezmény a kínzás és az embertelen vagy megalázó büntetések vagy bánásmód megelőzéséről	Európai egyezmény a kínzás és az embertelen vagy megalázó büntetések vagy bánásmód megelőzéséről, CETS 126, Strasbourg, 1987.11.26., 1–9. o.
Egyezmény a számítástechnikai bűnözésről	Egyezmény a számítástechnikai bűnözésről, CETS 185, Budapest, 2001.11.23., 1–27. o.
Az Európa Tanács Egyezménye az emberkereskedelem elleni fellépésről	Az Európa Tanács Egyezménye az emberkereskedelem elleni fellépésről, CETS 197., 2005.5.16., 1–21. o.
Az Európa Tanács egyezménye a nők elleni erőszak és a családon belüli erőszak megelőzéséről és felszámolásáról	Az Európa Tanács egyezménye a nők elleni erőszak és a családon belüli erőszak megelőzéséről és felszámolásáról, CETS 210, Isztanbul, 2011.5.11., 1–31. o.
Gazdasági, szociális és kulturális jogok	
Európai Szociális Karta	Európai Szociális Karta, CETS 035, Torino, 1961.10.18., 1–18. o.
Európai Szociális Charta	(Módosított) Európai Szociális Karta, CETS 163, Strasbourg, 1996.5.3., 1–29. o.
Migrációval és menekültüggyel kapcsolatos kérdések	
Európai egyezmény a kiskorúak kiutasításáról	Európai egyezmény a kiskorúak kiutasításáról, CETS 071, Hága, 1970.5.28., 1–9. o.
Európai egyezmény a vendégmunkások jogállásáról	Európai egyezmény a vendégmunkások jogállásáról, CETS 93, Strasbourg, 1977.11.24., 1–14. o.
Európai egyezmény a társadalombiztosításról	Európai egyezmény a társadalombiztosításról, CETS 078, Párizs, 1972.12.14., 1–42. o.
Európai társadalombiztosítási kódex	Európai társadalombiztosítási kódex, CETS 048, Strasbourg, 1968.4.16., 1–33. o.
Fogyasztó- és adatvédelem	
Egyezmény az egyének védelméről a személyes adatok gépi feldolgozása során	Egyezmény az egyének védelméről a személyes adatok gépi feldolgozása során, CETS 108, Strasbourg, 1981.1.28., 1–10. o.
Európai egyezmény a határokat átlépő televíziózásról	Európai egyezmény a határokat átlépő televíziózásról, CETS 132, Strasbourg, 1989.5.5., 1–20. o.

Uniós jogi eszközök

Valamennyi uniós jogi eszköz elérhető az interneten a http://eur-lex.europa.eu címen.

Rövid megnevezés	Cím
A hátrányos megkülönböztetés tilalma	
A faji egyenlőségről szóló 2000/43/EK irányelv	A Tanács 2000. június 29-i 2000/43/EK irányelve a személyek közötti, faji vagy etnikai származásra való tekintet nélküli egyenlő bánásmód elvének alkalmazásáról, HL L 180., 2000.7.19., 22–26. o.
A munkavégzés során alkalmazott egyenlő bánásmódról szóló 2000/78/EK irányelv	A Tanács 2000. november 27-i 2000/78/EK irányelve a foglalkoztatás és a munkavégzés során alkalmazott egyenlő bánásmód általános kereteinek létrehozásáról, HL L 303., 2000.12.2., 16–22. o.
Az árukhoz és szolgáltatásokhoz való egyenlő hozzáférésről szóló 2004/113/EK irányelv	A Tanács 2004. december 13-i 2004/113/EK irányelve a nők és férfiak közötti egyenlő bánásmód elvének az árukhoz és szolgáltatásokhoz való hozzáférés, valamint azok értékesítése, illetve nyújtása tekintetében történő végrehajtásáról, HL L 373., 2004.12.21., 37–43. o.
Családi élet és szülői felügyelet	
Brüsszel IIa. rendelet (2201/2003/EK)	A Tanács 2003. november 27-i 2201/2003/EK rendelete a házassági ügyekben és a szülői felelősségre vonatkozó eljárásokban a joghatóságról, valamint a határozatok elismeréséről és végrehajtásáról, illetve az 1347/2000/EK rendelet hatályon kívül helyezéséről, HL L 338., 2003.12.23., 1–29. o.
A tartásról szóló 4/2009/EU rendelet	A Tanács 2008. december 18-i 4/2009/EK rendelete a tartással kapcsolatos ügyekben a joghatóságról, az alkalmazandó jogról, a határozatok elismeréséről és végrehajtásáról, valamint az e területen folytatott együttműködésről, HL L 7., 2009.1.10., 1–79. o.
A közvetítésről szóló 2008/52/EK irányelv	Az Európai Parlament és a Tanács 2008. május 21-i 2008/52/EK irányelve a polgári és kereskedelmi ügyekben végzett közvetítés egyes szempontjairól, HL L 136., 2008.5.24., 3–8. o.
Az igazságszolgáltatáshoz való jogról szóló 2002/8/EU irányelv	A Tanács 2003. január 27-i 2003/8/EK irányelve a határon átnyúló vonatkozású jogviták esetén az igazságszolgáltatáshoz való jog megkönnyítése érdekében az ilyen ügyekben alkalmazandó költségmentességre vonatkozó közös minimumszabályok megállapításáról, HL L 26., 2003.1.31., 41–47. o.

A gyermekek erőszakkal és kizsákmányolással szembeni védelme	
A fiatal munkavállalókról szóló 94/33/EK irányelv	A Tanács 1994. július 22-i 94/33/EK irányelve a fiatal személyek munkahelyi védelméről, HL L 216., 1994.8.20., 12–20. o.
Az emberkereskedelemről szóló 2011/36/EU irányelv	Az Európai Parlament és a Tanács 2011. április 5-i 2011/36/EU irányelve az emberkereskedelem megelőzéséről, és az ellene folytatott küzdelemről, az áldozatok védelméről, valamint a 2002/629/IB tanácsi kerethatározat felváltásáról, HL L 101., 2011.4.15., 1–11. o.
A gyermekek szexuális bántalmazása, szexuális kizsákmányolása és a gyermekpornográfia elleni küzdelemről szóló 2011/93/EU irányelv	Az Európai Parlament és a Tanács 2011. december 13-i 2011/92/EU irányelve a gyermekek szexuális bántalmazása, szexuális kizsákmányolása és a gyermekpornográfia elleni küzdelemről, valamint a 2004/68/IB tanácsi kerethatározat felváltásáról, HL L 335., 2011.12.17., 1-14. o.
Az áldozatokról szóló 2012/29/EU irányelv	Az Európai Parlament és a Tanács 2012. október 25-i 2012/29/EU irányelve a bűncselekmények áldozatainak jogaira, támogatására és védelmére vonatkozó minimumszabályok megállapításáról és a 2001/220/IB tanácsi kerethatározat felváltásáról, HL L 315., 2012.11.14., 57-73. o.
Az emberkereskedelem áldozatainak kiállított tartózkodási engedélyekről szóló irányelv (2004/81/EK)	A Tanács 2004. április 29-i 2004/81/EK irányelve a harmadik országok emberkereskedelem áldozatává vált vagy az illegális bevándorlás megkönnyítésére irányuló cselekményekkel érintett, a hatáskörrel rendelkező hatóságokkal együttműködő állampolgárai részére kiállított tartózkodási engedélyről, HL L 261., 2004.8.6., 19–23. o.
A 2007/698/EK bizottsági határozat	A Bizottság 2007. október 29-i határozata a 2007/116/EK határozatnak a további, 116-tal kezdődő, fenntartott hívószámok bevezetése tekintetében történő módosításáról (az értesítés a C(2007) 5139. számú dokumentummal történt) (EGT-vonatkozású szöveg), HL L 284., 2007.10.30., 31–32. o.
Migráció és menekültügy, ezen belül a migráns gyermekek szociális jogai	
A menekültügyi eljárásokról szóló 2013/32/EU irányelv	Az Európai Parlament és a Tanács 2013. június 26-i 2013/32/EU irányelve a nemzetközi védelem megadására és visszavonására vonatkozó közös eljárásokról, HL L 180., 2013.6.29., 60–95. o.
Dublini rendelet (604/2013/EU).	Az Európai Parlament és a Tanács 2013. június 26-i 604/2013/EU rendelete egy harmadik országbeli állampolgár vagy egy hontalan személy által a tagállamok egyikében benyújtott nemzetközi védelem iránti kérelem megvizsgálásáért felelős tagállam meghatározására vonatkozó feltételek és eljárási szabályok megállapításáról, HL L 180., 2013.6.29., 31–59. o.

Az elismerésről szóló irányelv (2011/95/EU)	Az Európai Parlament és a Tanács 2011. december 13-i 2011/95/EU irányelve a harmadik országbeli állampolgárok és hontalan személyek nemzetközi védelemre jogosultként való elismerésére, az egységes menekült- vagy kiegészítő védelmet biztosító jogállásra, valamint a nyújtott védelem tartalmára vonatkozó szabályokról, HL L 337., 2011.12.20., 9–26. o.
492/2011/EU rendelet.	Az Európai Parlament és a Tanács 2011. április 5-i 492/2011/EU rendelete a munkavállalók Unión belüli szabad mozgásáról (EGT-vonatkozású szöveg), HL L 141., 2011.5.27., 1–12. o.
A szabad mozgásról szóló irányelv (2004/38/EK)	Az Európai Parlament és a Tanács 2004. április 29-i 2004/38/EK irányelve az Unió polgárainak és családtagjaiknak a tagállamok területén történő szabad mozgáshoz és tartózkodáshoz való jogáról, valamint az 1612/68/EGK rendelet módosításáról, továbbá a 64/221/EGK, a 68/360/EGK, a 72/194/EGK, a 73/148/EGK, a 75/34/EGK, a 75/35/EGK, a 90/364/EGK, a 90/365/EGK és a 93/96/EGK irányelv hatályon kívül helyezéséről (EGT-vonatkozású szöveg), HL L 158., 2004.4.30., 77–123. o.
A migráns munkavállalók gyermekeinek oktatásáról szóló 77/486/EGK tanácsi irányelv	A Tanács 1977. július 25-i 77/486/EGK irányelve a migráns munkavállalók gyermekeinek oktatásáról, HL L 199., 1977.8.6., 32–33. o.
Családegyesítési irányelv (2003/86/EK)	A Tanács 2003. szeptember 22-i 2003/86/EK irányelve a családegyesítési jogról, HL L 251., 2003.10.3., 12–18. o.
Az átmeneti védelemről szóló irányelv (2001/55/EK)	A Tanács 2001. július 20-i 2001/55/EK irányelve a lakóhelyüket elhagyni kényszerült személyek tömeges beáramlása esetén nyújtandó átmeneti védelem minimumszabályairól, valamint a tagállamoknak e személyek befogadása és a befogadás következményeinek viselése tekintetében tett erőfeszítései közötti egyensúly előmozdítására irányuló intézkedésekről, HL L 212., 2001.8.7., 12–23. o.
A befogadásra vonatkozó szabályokról szóló 2013/33/EU irányelv	Az Európai Parlament és a Tanács 2013. június 26-i 2013/33/EU irányelve a nemzetközi védelmet kérelmezők befogadására vonatkozó szabályok megállapításáról, HL L 180., 2013.6.29., 96–116. o.
Visszatérési irányelv (2008/115/EK)	Az Európai Parlament és a Tanács 2008. december 16-i 2008/115/EK irányelve a harmadik országok illegálisan tartózkodó állampolgárainak visszatérésével kapcsolatban a tagállamokban használt közös normákról és eljárásokról, HL L 348., 2008.12.24., 98–107. o.
A huzamos tartózkodási engedéllyel rendelkezőkről szóló 2003/109/EK irányelv	A Tanács 2003. november 25-i 2003/109/EK irányelve a harmadik országok huzamos tartózkodási engedéllyel rendelkező állampolgárainak jogállásáról, HL L 16., 2004.01.23., 44–53. o.

Schengeni Határ-ellenőrzési Kódex, 562/2006/EK rendelet	Az Európai Parlament és a Tanács 2006. március 15-i 562/2006/EK rendelete a személyek határátlépésére irányadó szabályok közösségi kódexének (Schengeni határ-ellenőrzési kódex) létrehozásáról, HL L 105., 2006.4.13., 1–32. o.
Fogyasztóvédelem és a személyes adatok védelme	
A fogyasztók jogairól szóló irányelv (2011/83/EU)	Az Európai Parlament és a Tanács 2011. október 25-i 2011/83/EU irányelve a fogyasztók jogairól, a 93/13/EGK tanácsi irányelv és az 1999/44/EK európai parlamenti és tanácsi irányelv módosításáról, valamint a 85/577/EGK tanácsi irányelv és a 97/7/EK európai parlamenti és tanácsi irányelv hatályon kívül helyezéséről (EGT-vonatkozású szöveg), HL L 304., 2011.11.22., 64–88. o.
A másnak látszó, és ezáltal a fogyasztók egészségét vagy biztonságát veszélyeztető termékekről szóló 87/357/EGK irányelv	A Tanács 1987. június 25-i 87/357/EGK irányelve a másnak látszó, és ezáltal a fogyasztók egészségét vagy biztonságát veszélyeztető termékekre vonatkozó tagállami jogszabályok közelítéséről, HL L 192., 1987.7.11., 49–50. o.
A távértékesítésről szóló 97/7/EK irányelv	Az Európai Parlament és a Tanács 1997. május 20-i 97/7/EK irányelve a távollevők között kötött szerződések esetén a fogyasztók védelméről, HL L 144., 1997.6.4., 19–27. o.
Általános termékbiztonsági irányelv (2001/95/EK)	Az Európai Parlament és a Tanács 2001. december 3-i 2001/95/EK irányelve az általános termékbiztonságról (EGT vonatkozású szöveg), HL L 11., 2002.1.15., 4–17. o.
A különleges táplálkozási célú élelmiszerekről szóló 2009/39/EK irányelv	Az Európai Parlament és a Tanács 2009. május 6-i 2009/39/EK irányelve a különleges táplálkozási célú élelmiszerekről (átdolgozás) (EGT-vonatkozású szöveg), HL L 124., 2002.1.15., 21–29. o.
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AZ EURÓPAI UNIÓ ALAPJOGI ÜGYNÖKSÉGE
Schwarzenbergplatz 11 – 1040 Bécs – Ausztria
Tel.: +43 (1) 580 30-60 – Fax: +43 (1) 580 30-693
fra.europa.eu – info@fra.europa.eu

EURÓPA TANÁCS
67075 Strasbourg Cedex – Franciaország

EMBERI JOGOK EURÓPAI BÍRÓSÁGA
Tel.: +33 (0) 3 88 41 20 18 – Fax: +33 (0) 3 88 41 27 30
echr.coe.int – publishing@echr.coe.int

ET GYERMEKJOGI OSZTÁLY
Tel. +33 (0) 388 41 25 07 – Fax +33 (0) 90 21 52 85
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Practice Guidelines

Third edition

August 2017

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Preface

This Third Edition of the Practice Guidelines replaces the second edition published in 2009. Legislation, practice and technology have moved on since then and these changes are captured in the new guidance.

This edition of the guidelines was produced through the British Psychological Society's Professional Practice Board by a working group drawn from the range of Member Networks across The Society whose members are engaged in professional practice, as well as representatives from relevant expert reference groups of The Society, in particular areas of practice. Further information is available in ***Appendix 3: How this document has been developed.***

These Practice Guidelines aim to define good practice for all psychologists whether registered, chartered or in training and offer guidance for decision making. The Guidelines have been designed for broad application across the full range of applied psychology.

The first part of the guidance (sections 1–3) set out considerations for psychologists on different contexts of practice. The second part of the guidance (sections 4–8) sets out guidance for psychologists on how to manage work with clients.

It is recognised that in addition psychologists may require more detailed guidance for some particular roles and responsibilities or for particular situations in which they work. Further information is available in the ***Appendices***.

The Society expects that the guidelines will be used to form a basis for consideration, with the principles being taken into account in the process of decision-making, together with the needs of others and the specific circumstances. No guidance can replace the need for psychologists to use their own professional judgement. Effective practice means exercising this professional judgement in a defensible way that does not put clients or the public at risk, or undermine, or call into question the reputation of the profession as a whole.

The Guidelines will be reviewed in accordance with Society policy within a maximum period of five years in order to reflect current legislation, evidence and practice contexts. Psychologists using the Practice Guidelines should do so in conjunction with the ***BPS Code of Ethics and Conduct*** and the ***BPS Code of Human Research Ethics***, as necessary.

Glossary of terms

Client

The Society's *Code of Ethics and Conduct* uses the term person or people throughout, this is in recognition of the fact that the document is generic and may be used by all psychologists; academics, researchers, students and practitioners alike.

Throughout this Practice Guidelines document the term 'client' is used and refers to any person or persons with whom a psychologist interacts on a professional basis.

For example, the 'client' may be a couple, a family group, an educational institution, a community organisation or group or a private or public organisation including a court, an individual (sometimes referred to as, for example, athlete, child/young person, patient, prisoner, coachee, service user, stakeholder, leader, or student), who are in receipt of the services of the psychologist.

Psychologist

Throughout this Practice Guidelines document the term 'psychologist' is used and refers to all psychologists whether registered, chartered or in training who provide psychological services across the full range of applied psychology, in any context of practice.

1. How psychologists work

1.1 Legal and professional obligations of psychologists

Psychologists' professional practice is impacted upon and governed by a range of legislation and regulation. Particular psychological disciplines may also need to consider additional legislation, regulation and guidelines. It is the psychologist's responsibility to ensure they are aware of the legislation and guidelines that govern their particular area of practice as well as the terms of their employment or terms contracted with a commissioner of their services.

Psychologists are also advised to consider membership of a union or similar body to ensure they have access to appropriate representation, support and legal advice should they be subject to a complaint or disciplinary action, or require support for example with an employment grievance, which may be related to concerns over quality and standards of psychological service provision.

Further information is available in the ***Appendices***. Important examples to note are:

Health and Care Professions Council (HCPC) Registration

It is a statutory requirement for all psychologists wishing to practice using one of the titles protected by the HCPC to register with the HCPC. Unregistered psychologists offering services to the public in any of the domains regulated by the HCPC may commit an offence by doing so, even if they refrain from using protected titles, provided intent to deceive can be proved. The Society's position is that it is in the interests of both the public and the profession for all psychologists providing services in a regulated domain to be registered with the HCPC.

Professional competence

Psychologists should value the continuing development and maintenance of high standards of competence in their practice and the importance of working within the recognised limits of their knowledge, skill, training, education, and experience. Psychologists should consider advances in the evidence base, the need to maintain technical and practical skills and knowledge and the limits of their competence. This is stipulated in both the ***BPS Code of Ethics and Conduct*** and the ***HCPC Standards of Proficiency***.

Professional indemnity insurance

The UK Government has introduced legislation (The Health Care and Associated Professions (Indemnity Arrangements) Order 2014) which now makes it mandatory for health professionals to have a professional indemnity arrangement in place. The HCPC has made having such an arrangement in place a condition of registration.

This may be achieved either through the employer or through a privately arranged policy. An employer's insurance may provide cover only for a negligence claim but not for the costs of a disciplinary hearing. It is the psychologist's responsibility to check carefully that

they have cover in place that meets their personal/professional needs. Further information is available in the ***Society document: Career Support and Development***

Disclosure and Barring Service (DBS) Checks

Psychologists working in certain fields, for example with children or in healthcare, will need to demonstrate they have had a satisfactory criminal records check at the appropriate level for the nature of the work undertaken.

Applicants will be provided with a certificate to demonstrate this. Applicants cannot request a check personally, this can be requested by a psychologist's employer. For psychologists practising independently the Society offers this as a service to members. Further information is available on the ***Society Website: https://beta.bps.org.uk/Practice-Guidelines***

Equality Act 2010

This Act protects people against unfair treatment, promotes equality and prevents discrimination against any of nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. Respect is a core ethical value for psychologists and a commitment to equality of opportunity is embedded in all aspects of psychological practice. Psychologists, where they operate in an organisational context, must also seek to encourage and influence others in ensuring that equality of opportunity is embedded in all thinking and all practice relating to access to services for client groups and recruitment and employment practices.

Providers of service to the public must also make reasonable adjustments for people who have a disability under the Act. This requirement is anticipatory so requires consideration, and adjustment where reasonable, of any barriers which may prevent a person with a disability from using a service.

Data Protection Act 1998

The Data Protection Act defines personal and sensitive personal data, and data must be processed in accordance with eight principles. It gives individuals the right to know what information is held about them and provides a framework to ensure that personal information is handled properly.

Good information governance is at the heart of safe practice. It encompasses physical data security, access controls and acceptable use, data quality, and records management, among other things. Psychologists must have appropriate security to prevent any personal data held from being accidentally or deliberately compromised. In most circumstances, independent practitioners will also need to register as a data controller with the Information Commissioner's Office.

Further information is available in ***Section 7.1: Information governance, Appendix 1: Relevant legislation*** and ***Society Document: Data Protection Act 1998 – Guidelines for Psychologists.***

Freedom of Information Act 2000

The Freedom of Information Act 2000 provides public access to information held by public authorities. Public authorities include government departments, local authorities, the NHS, State schools and police forces.

It does this in two ways:

- public authorities are obliged to publish certain information about their activities; and
- members of the public are entitled to request information from public authorities.

The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland, and by UK-wide public authorities based in Scotland. Information held by Scottish public authorities is covered by Scotland's own Freedom of Information (Scotland) Act 2002.

This legislation permits information to be withheld from disclosure in certain prescribed circumstances, for example information provided in confidence, related to law enforcement or where it relates to personal matters.

Health and Safety at Work Act 1974

This Act places a duty on all employers 'to ensure, so far as is reasonably practicable, the health, safety and welfare at work' (Part 1, Section 2.1) of all their employees. Employees themselves also have obligations under the legislation.

Working together to safeguard children guidance

The Government website provides statutory guidance on inter-agency working to safeguard and promote the welfare of children. Statutory guidance is issued by law; it must be followed unless there is a good reason not to. All organisations, including charities, are expected to comply with this government inter-agency statutory guidance. Psychologists have a duty of care to both their clients and the public. Any allegations of abuse, either ongoing or historic, must be taken seriously and consideration must be given about breaking confidentiality especially in cases where other vulnerable people may be at risk. Further information is available in ***Section 4: Safeguarding***.

Mental Capacity Act 2005

The Mental Capacity Act (2005) provides a clear and comprehensive framework with regard to capacity and consent for all individuals aged 16 years and above in England and Wales.

There are five key principles set out in the Act which underpin practice (quoted from legislative source):

(i) A person must be assumed to have capacity unless it is established that he lacks capacity.

(ii) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(iii) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(iv) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
(v) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

In Scotland the Adults with Incapacity (Scotland) Act 2000 applies and in Northern Ireland the Mental Capacity Act (Northern Ireland) 2016 is used.

Mental Health Act 1983 as amended 2007

The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

The Act sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients. The Code of Practice[1] provides statutory guidance for mental health professionals on how they should carry out their responsibilities in practice under the MHA. Although the Act allows for people to be compulsorily detained and treated without their consent if required, empowerment and involvement of patients as far as is possible is required by the Code of Practice.

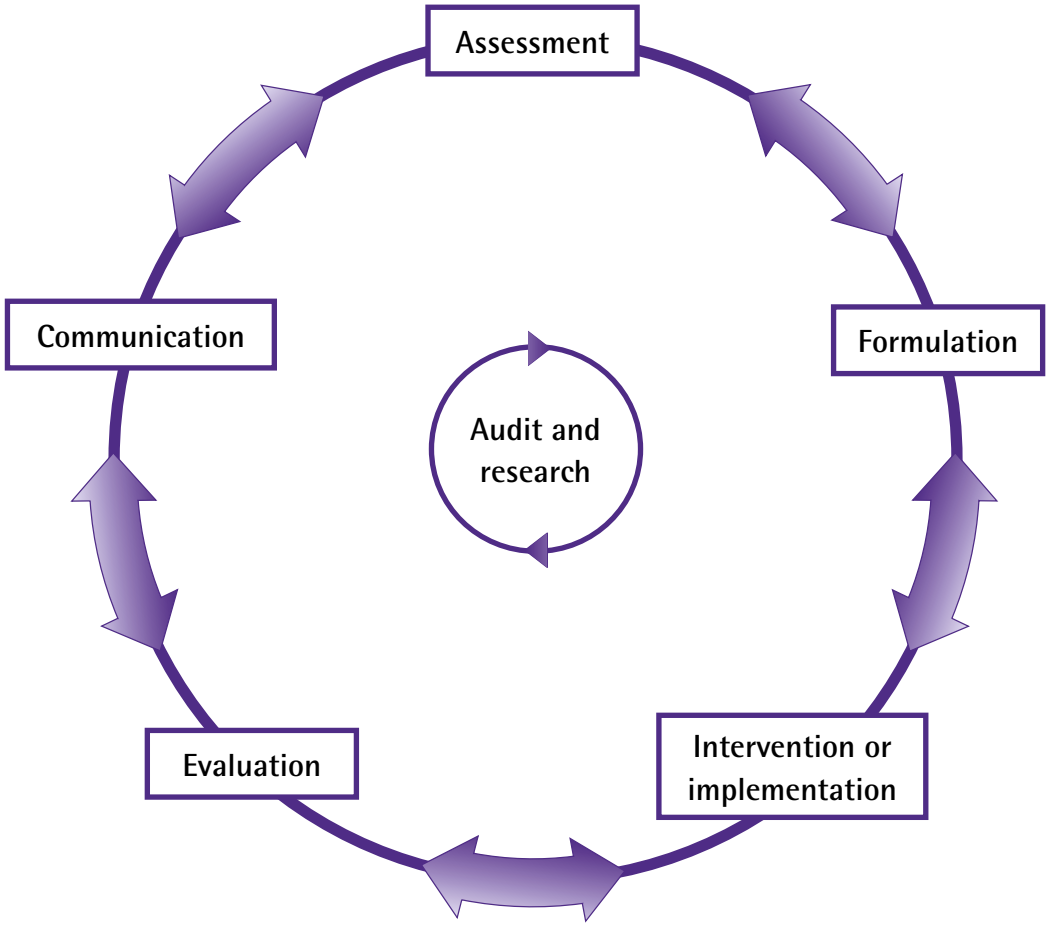
Those involved in working with people subject to provisions of the MHA, including psychologists, must understand and give consideration to the five key principles set out in the Code:
(i) least restrictive option and maximising independence;
(ii) empowerment and involvement;
(iii) respect and dignity;
(iv) purpose and effectiveness; and
(v) efficiency and equity.

1.2 Cycle of professional practice

The professional practice of psychologists is underpinned by four key ethical values – Respect, Competence, Responsibility and Integrity – and five core skills:

- **assessment** and establishment of agreements with the client;
- **formulation** of client needs and problems;
- **intervention or implementation** of solutions;
- **evaluation** of outcomes; and
- **communication** through reporting and reflecting on outcomes.

These core competencies flow and inform each other as illustrated below.



Assessment and establishment of agreements with the client

Assessment of psychological processes and behaviour is derived from the theory and practice of both academic and applied psychology. It includes both assessing change and stability, and comparison with others. Assessment procedures used will depend heavily on the practice context and may include:

- the development and use of psychometric tests following best practice;
- the application of systematic observation and measurement of behaviour in a range of contexts and settings;
- devising structured assessment strategies for individual clients, teams and organisations; and
- the use of a range of interview processes with clients, carers, other stakeholders and other professionals.

Results of these assessments are integrated within the context of the historical, dynamic and developmental processes that will have shaped the client as well as future aspirations or needs. Psychologists have the ability to assess the suitability of different measurement procedures, depending on the purpose for which the assessment is needed, as well as being competent to devise and use context-specific procedures.

Formulation of client needs and problems

Formulation is the summation and integration of the knowledge that is acquired by the assessment process. This will draw on psychological theory and research to provide a framework for describing a client's needs. Because of their particular training in the relationship of theory to practice, psychologists will be able to draw on a number of models to meet needs or support decision-making. This process provides the foundation from which actions derive. What makes this activity unique to psychologists is the knowledge base, experience and information on which they draw. The ability to access, review, critically evaluate, analyse and synthesise data and knowledge from a psychological perspective is one that is distinct to psychologists, both academic and applied.

Intervention or implementation of solutions

This will be the stage where the client's needs, as described by formulation, begin to be met. This may involve the use of psychological models or approaches to, for example, facilitate change, solve a problem or improve the quality of a relationship. All these interventions, or implementation of solutions, are tests of the provisional hypotheses contained in the formulation, and are subject to repeated modification in the light of experience and new data.

Evaluation of and reflecting on outcomes

Evaluation is used to measure the effectiveness of activities and interventions both during and after their implementation. The results of any evaluation and reflection will impact the next steps taken by a psychologist.

Although employers and others may demand certainty about outcomes, psychologists should always be careful to make it clear that they are able to provide only interpretations of behaviour, and advice and guidance, rather than necessarily predicting future behaviours.

Communication through reporting

Communication skills are integral to all aspects of a psychologist's role. Effective communication skills are essential in relation to all aspects of work with others. Communication skills include communication with clients, all forms of electronic and verbal communication, professional letters and reports, and the dissemination of research findings.

Audit and research

Audit and research underpin the cycle, as they help to inform all stages of professional practice.

Audit aims to evaluate how close assessment, formulation, intervention and implementation are against a set of previously given standards of practice. Audit also evaluates how protocols and procedures, for example related to consent or recording of activity, have been followed.

Research provides the evidence base for the practice of psychology. Research methods in psychology vary from qualitative observation to quantitative scientific method, so it is important to distinguish the nature and quality of the evidence underpinning any knowledge or techniques being applied. In general, basic research develops theories, models and data to describe and explain psychological processes and structures, while primary research develops and evaluates ways of using psychological knowledge to intervene with people, organisations, processes or technologies to achieve desired effects. Secondary research consolidates other research to identify higher order trends and directions.

1.3 Reflective practice

One of the key processes that should be encouraged for psychologists is having a complex understanding of self in the context of others. The HCPC requires reflection in the record of continued professional development in order to retain continued registration.

Psychologists will need to make decisions about clients which may have a profound impact on their lives. Decision-making is often subject to various competing biases. Psychologists should be aware of the possibility that they may be influenced by considerations which are not driven by professional knowledge, skills or experience. Maintaining awareness of these biases is important when trying to think through dilemmas.

Sources of influence and bias may include:

- **Cognitive Biases –** Over 150 have been described[2,3,4] including salience (how readily something comes to mind), confirmation bias (the human tendency to look for evidence that confirms their belief and to ignore other evidence), loss aversion (risky behaviour to avoid loss), beliefs about disclosure (tendency to be more honest when they believe their actions will be known by others), and dissonance reduction (justifying actions if consequences are considered worth it).
- **Personal Experience –** the experience of the psychologist may affect how they view or treat a client or situation. This may include current or historical trauma, or the kind of organisation and culture with which they are most familiar. Interventions which may be appropriate in one context may be ineffective and cause distress in another.
- **Motivation –** the original reasons for undertaking the profession may change or be challenged due to fatigue or experience within the profession which may affect the psychologist's viewpoint.
- **Health –** psychologists should be mindful of the potential effect of health conditions or medications which they may be taking, on their practice.
- **Control over the psychologist's own practice –** this refers to clarity and openness in the management of the psychologist's business and maintaining the professional's autonomy in their interactions with clients.
- **Pro bono public work –** psychologists are encouraged, and personally motivated to

engage with such work, while being mindful of impact on the value that is placed on the profession as a whole.

- **An unethical environment –** maintaining self-recognition of what the appropriate ethical standard should be, irrespective of the prevailing situation.
- **Environment –** political realities may lead the psychologist to make compromises; while there is nothing wrong with compromises, their constant use may mean a decline in overall standards.

The literature is generally pessimistic about the ability of practitioners to overcome some of these biases, considering them to be inherent in human thinking patterns. By being aware of and acknowledging them, it can be possible to manage their influence. For example, biases can be levelled out by presenting information in different ways, by engaging the perspectives of people with different experiences and expectations, or by priming thinking with different examples.

A key factor in developing and maintaining these skills is the use of consultation or supervision and having a space where it is possible to open up thinking to the mind of another with a view to extending knowledge about the self.

It is important that psychologists from all disciplines look after their own wellbeing. This is not only important for them as individuals, but also for the quality of the care they give their clients. In their practice and, for example, within their CPD plans and supervision psychologists should consider self-care and how they can maintain their own wellbeing.

It is also important for psychologists to evaluate effectiveness of practice, by welcoming feedback from clients. This can be difficult due to fears of criticism but reflective practitioners are eager to improve and welcome any feedback that will support this process.

1.4 Continuing professional development

Continuing professional development (CPD) is the professional and work-related aspect of lifelong learning. It is an integral part of the process of adapting to change, and essential for maintaining and enhancing professionalism and competence. The Society provides an online facility to record CPD, further information is available on the ***Society website: http://beta.bps.org.uk/Practice-Guidelines***.

- CPD is both a professional expectation and an individual responsibility to taking a structured and self-managed approach to further learning through:
  - actively engaging in a range of CPD
  - maintaining a record of CPD
  - applying learning from CPD to professional practice.
- There is a range of formal and informal learning activities that may be used for CPD and it is recommended that psychologists engage in a mix of CPD activities.
- Professional development is not purely about inputs (i.e. undertaking CPD activities); it also requires a reflective, outcomes-based approach which focuses on the learning gained from CPD and its application to current or future practice, together with the associated benefits for clients and the services provided.

- All members who are registered with the HCPC are required to comply with their CPD requirements as a condition of continued professional registration. Further information is available in ***Appendix 2: Websites and further information***

Mentoring

Psychologists may seek a mentoring relationship with colleagues in order to focus their attention on skills to add to their competencies. Psychologists taking on the role of mentor often support the psychologist with their career path. Early career psychologists may find it beneficial to be mentored by a more experienced psychologist.

1.5 Consultation/supervision

Consultation or supervision is considered an essential part of good practice as a psychologist. There is no legal requirement for supervision, although it is considered an ethical and professional expectation to engage in appropriate consultation in order to support effective practice. Provision of this is therefore an important underpinning to good quality service delivery. The Society's position is, for safe and effective practice in clinical and mental health settings, or with other vulnerable groups, supervision is a requirement of practice.

The objectives of consultation/supervision are:

- to provide practitioners with consultation on their work with clients;
- to enhance the quality and competence of practice offered to all clients;
- to offer psychologists intellectual challenge enabling reflection, transformational learning and psychological support to maximise their responsibility for appropriate self-care; and
- to contribute to the CPD of both psychologist and supervisor by developing competence in the use and practise of supervision.

All aspects of practice are appropriate for discussion in supervision, including research activity, administrative and managerial work, service developments, team working, teaching and the process of supervising others. Supervision is not personal therapy and nor is it a form of, or substitute for, line management or appropriate training.

For psychologists working in a wide range of settings such as therapeutic and organisational settings, supervision is a core component of the psychologist's CPD. For some areas of practice, the nature of supervision changes over time. This may be unique to each psychologist and the context of their application. Expectations should be agreed from the outset and reviewed at appropriate intervals.

Forms of consultation/supervision

Supervision may take the form of clinical supervision, mentoring, coaching, supervision on placement/work setting, tutorials and peer support. Psychologists may engage in one to one supervision; group supervision (facilitated or non-facilitated) or peer supervision and any of these may be face to face or virtual. Whilst it should not be a substitute for line management, a psychologist's supervisor may also be their line manager.

Those working in independent practice, or in the absence of service-based supervision, should seek supervision from appropriately qualified and experienced personnel as appropriate. Peer supervision (individual or group) may be an appropriate way to find collegial support.

Psychologists may select different supervisors, depending on their preferred supervisory style, nature, orientation and their needs at the time. Particularly for experienced psychologists, this may be from an experienced colleague from outside their profession, professional specialty or organisation. Psychologists could also invite supervision from experts by experience for whom they provide services, where appropriate to the context of practice.

The Society maintains the Register of Applied Psychology Practice Supervisors (RAPPS), which recognises psychologists with special expertise in supervision and supervisory practice. Further information is available on the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines***.

Amount of supervision

While there is a specified number of supervision sessions for trainees (e.g. for their Chartered status) which varies across different sub-disciplines of psychology, no definitive amount of supervision is specified as part of CPD. To determine both the quantity and nature of the supervision, the psychologist may consider their need for supervision from various perspectives: their own assessment of need, the competencies required for their practice; the context of their work; organisational requirements; and the support available. For psychologists in employment the arrangements for consultation/supervision should be agreed after considering these factors in consultation with the employer.

Roles and responsibilities of the supervisor

Psychologists undertaking supervision should ensure that they are sufficiently experienced, competent and appropriately trained to provide supervision. Psychologists are often called upon to supervise non-psychologists, in which case these guidelines would also apply.

In supervision, the psychologist as supervisor needs be aware of their own competence in relation to the work of the psychologist and, where necessary, recommend additional supervisors who may have the appropriate level of expertise. Psychologists may offer consultancy supervision to professional colleagues, organisations and stakeholders in line with their competencies.

Psychologists should avoid personal relationships between the supervisor and psychologist which could adversely affect integrity and objectivity.

Psychologists providing consultation/supervision should do so in line with the guidance in other relevant sections of these Practice Guidelines.

Issues of power and control

The nature of supervision itself creates a power imbalance, even between peers. Both the person providing supervision and the person receiving it need to be aware of this.

The supervisory leadership relationship should be both informative and reflective. Psychologists in leadership roles as supervisors should provide regular, informative feedback to the psychologist as well as motivating them to reflect on their own practice, continue to self-assess and improve self-awareness.

1.6 Leadership

Psychologists at any stage of their career are likely to find themselves in a position where they are required to demonstrate or model leadership. This may be an integral part of their practitioner work or may arise through being a leader of a team, including leading in Society work. Leadership is widely quoted and described in the context of leading change as, *'accepting responsibility to create conditions that enable others to achieve shared purpose in the face of uncertainty'*[5]. Furthermore, leaders 'can create conditions interpersonally, structurally, and/or procedurally'[6]. These descriptors highlight the often complex process of psychological change through clinical intervention and also through leading others.

Contemporary leadership styles are generally more aligned to working *within* a team or a system rather than being directive. Leading as a psychologist is likely to include dealing with highly complex information and systems whatever the context. Leading in this way demands high levels of skill in developing, managing and maintaining professional relationships. This may include communicating complex and sensitive information, and reflexivity to enable individuals and teams to co-formulate around difficulty and challenge.

2. Where psychologists work

2.1 Working environment

When undertaking work with clients, psychologists need to give consideration to providing an environment which is welcoming, accessible, safe, and offers privacy. Although choice of workspace is not always available, it is important wherever work takes place with clients that psychologists consider:

- whether lighting, acoustics, heating and seating are comfortable;
- whether confidential conversations may be audible to others;
- whether there are arrangements to ensure client and practitioner safety, for example through easy access to another member of staff if a difficulty arises;
- whether access and exits are safe, well-lit and in areas which are likely to be overseen;
- that reasonable adjustments can be made to support effects of special needs and/or disability;
- whether the setting is culturally acceptable to clients; and
- whether there are facilities and equipment suitable for the clients, for example lavatories, play materials for children.

Where context of practice allows, psychologists could seek the assistance of relevant workplace representatives, for example their trade union representative or human resources staff, in situations where appropriate workplace conditions are not being provided. However, it is acknowledged that sometimes the ideal workspace may not be available or that psychologists may not have access to these workplace representatives due to their context of practice and psychologists should, within the limits of safe practice, be able to adapt to situations within local constraints in order to provide the best service for clients.

Sometimes, it is important to work with clients in representative environments in order to understand behavioural drivers. This will apply if the psychologist's task is to understand behaviours in such environments and provide support, for example through the use of technology, design of procedures, training or team design. Psychologists should consider carefully how to create representative conditions without causing harm. Equally it may sometimes be necessary for psychologists to work in a client's own context as that is where any intervention may be formulated or put in place. Psychologists should ensure they follow the relevant health and safety guidelines in place at their working location even if that location is not their usual place of work.

There may be a temptation to make assumptions about what sort of environment is most suitable, comfortable and culturally appropriate for clients, however it is helpful to ask them and endeavour to make appropriate adjustments to meet their needs.

Lone working

Many psychologists practise in a lone worker workplace and on occasion visit clients in their own homes. When working at home, it is necessary to ensure the proper insurance

and protocols for this type of work, as well as manage boundaries between personal and private space. When working alone, the Suzy Lamplugh Trust recommends always ensuring that someone else has access to schedules and contact details for clients. Psychologists may also want to put in place a 'code word call', where should they fail to answer or speak the correct code word, the police are alerted. This is just an example of an additional safety practice, and there may be different ideas for ensuring personal safety when lone working. However, the important point is to think about keeping safe, have a plan and stick to it. Further information is available in ***Appendix 2: Websites and further information.***

Harassment and bullying

Bullying is behaviour that may take the form of actions or comments that are offensive, which are intended to humiliate, undermine, demean or injure the recipient. It may target an individual or group of individuals and is a form or abuse that may be explicit and therefore obvious, or it may be insidious, an experience recognised only by the recipient and harder to notice by others. Bullying may be vertical (i.e. between managers/supervisors and staff) or horizontal (i.e. between colleagues). Clients may also experience bullying by professionals. While bullying may involve a misuse of power and be committed in the workplace by a manager, supervisor or senior colleagues (sometimes known as downwards bullying), it should be borne in mind that it is not uncommon for senior staff to be bullied by those whose work they oversee.[7] What can be legitimately classified as bullying may take into account the particular personal sensitivities and characteristics of the person suffering the alleged bullying.

Harassment can be defined as actions or comments that are unwanted and which may be related to age, disability, gender reassignment, race, sex, sexual orientation, religion or belief or any other personal characteristic of the recipient. Harassment occurs when someone engages in unwanted conduct in relation to the aforementioned characteristics and that conduct has the purpose or effect of violating the other person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for the other person.

The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Psychologists with concerns over the above behaviour should seek the support of their supervisor, line manager or other appropriate senior staff member, accredited trade union workplace representative or human resources department. Further information is available in ***Appendix 2: Websites and further information.***

Whistleblowing

Whistleblowing is the disclosure of wrong doing (beyond normal managerial channels) and is important as it is a critical way not only of seeking justice for the individual or individuals affected, but also of developing inside information within organisations about incorrect or unfair practices,[8] thereby increasing the evidence required for corrective action to take place.

A whistle-blower is protected by law (the Public Interest (Disclosure) Act 1998) if:

1. They are a worker (this includes trainees and can include self-employed personnel servicing an organisation in certain circumstances).
2. They are acting in the public interest.
3. The disclosure relates to past, present or likely future wrongdoing which involves one or more of the following:
    - criminal offences (which may include fraudulent actions);
    - a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
    - a miscarriage of justice has occurred, is occurring or is likely to occur;
    - the health or safety of any individual has been, is being or is likely to be endangered;
    - the environment has been, is being or is likely to be damaged; or
    - information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

If the individual has been victimised or if they have lost their job due to whistleblowing, the legislation provides them with the right to take a case to an employment tribunal. Whistleblowing is a complex legal area and it is important that anyone considering it considers appropriate advice, for example from an accredited trade union workplace representative or helpline. The relevant human resources department which will have a policy relating to this, or it may be appropriate to seek formal legal advice. Some organisations such as NHS Trusts have a nominated Director responsible for dealing with disclosure issues who may be contacted directly. The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Further information is available in ***Appendix 2: Websites and further information.***

Psychologists can inform on all aspects of the establishment of workplace cultural norms that promote positive managerial and leadership behaviour and can help facilitate the development of cultures that support the disclosure of inappropriate practices. Psychologists are also appropriately qualified to support workers who have been subject to bullying or harassment or who are contemplating or indeed have already 'blown the whistle'. Whistleblowing, and even the prospect of such, can create traumatic responses in workers[9] and can lead to retaliation as a consequence. Empirical evidence highlights the link between whistleblowing and the devastating effects on health that may follow, such as depression, anxiety and symptoms relating to post-traumatic stress[10]. Psychologists are able to work with affected employees and in a consultative capacity with organisations to manage work-related stress disorders caused by these incidents of bullying, harassment and whistleblowing to lessen the risk of absenteeism and to facilitate a return to work following a period of absence. Further information is available in ***Section 8: How to respond when things go wrong.***

2.2 Working in the digital age

Digital media continues to advance in terms of choice and functionality. It is becoming increasingly common for psychologists in particular when working with clients to make use of the internet and/audio-visual technology. These technologies require the psychologist to ensure that the network used is as secure as reasonably possible and, as far as is feasible, assures privacy to their clients.

There can be no guarantee of security when using the internet, and voice over internet protocol (VOIP) services such as 'Skype' or 'FaceTime' are no different, as they use the same data infrastructure as the rest of the internet.

Most, if not all, VOIP systems encrypt the voice into waveforms during digital transit across the internet, and it would be impossible to eavesdrop on these data packets in real time. However, the information is potentially vulnerable to eavesdropping/compromise before encryption by the speaker's system, and after decryption by the listener's system. This will depend upon the security measures in place for the end user's (speaker and listener) own networking infrastructures, be that a company, institution or home user. If an end user's computer has been compromised by any form of malware, then there will be a risk of eavesdropping, data theft and/or denial of service.

The risk for eavesdropping on VOIP systems is no more or less than that of traditional analogue phone systems, and both would require specialist knowledge, equipment and software to be achieved. However, it is recommended that only fit-for-purpose VOIP systems are used, and that public networks, such as Social Media sites, are avoided for VOIP communications. Further information is available on the ***Society website: http://beta.bps.org.uk/Practice-Guidelines***.

Some employers may have their own rules about which media are acceptable to use. The USA has the Health Insurance Portability and Accountability Act (HIPAA) which sets standards for security for electronic data. There is no such provision in the UK to date, and so psychologists must satisfy themselves that any media used to communicate personal data is secure. This is a rapidly changing area and so technology-specific guidance has not been provided in this document. Further information is available in ***Section 7.1: Information governance*** and ***Appendix 2: Websites and further information.***

The use of online 'Apps', computer assisted decision-making and artificial intelligence in psychological practice and research is evolving rapidly. When recommending or using computerised systems psychologists should pay due regard to peoples' health, wellbeing and safety being mindful of Clinical Safety Evaluations, Medical Device Evaluations and other relevant guidance such as NICE.

Use of social media

Many psychologists are using social media, networking sites or blogs to communicate with friends, family, professionals, colleagues and clients. This specific guidance therefore addresses the use of social media by psychologists, and provides practical advice for using them responsibly. Further information is available in ***Appendix 2: Websites and further information.***

Psychologists should:

- Remember that social networking sites are generally public and permanent. Once something is posted online, it remains traceable even if it is later deleted.
- Keep their professional and personal life as separate as possible. This may be best achieved by having separate accounts for work-related communications to those for friends/family.
- Consider whether, in their context of practice, it is appropriate to accept 'friend' requests from current or past clients, if necessary, decline the request via more formal means of communication. It is highly unlikely to be appropriate to accept in a clinical or forensic context.
- Be minded to act responsibly at all times and uphold the reputation of the profession, whether identified as a psychologist or not on the social media platform.
- Be aware that social networking sites may update their services and that privacy settings can be reset to a default that deletes personalised settings.
- Remember that images posted online by family or friends may be accessible, as they may not have set privacy settings as tightly.
- Be minded that social networking sites can make it easier to engage (intentionally or unintentionally) in professional misconduct.
- Report the misconduct of other psychologists on such social networking sites to any relevant parties (such as the employer or the HCPC).
- Be aware of their employer's social media policy.

Psychologists should not:

- Establish inappropriate relationships with clients online.
- Discuss work-related or confidential issues online in any non-secure medium.
- Publish pictures of clients online, where they are classified as clinical records.
- Use social networking sites for whistle-blowing or raising concerns.
- Post defamatory comments about individuals or institutions. Defamation law can apply to any comments posted on the web, irrespective of whether they are made in a personal or professional capacity.

2.3 Working for the court

Psychologists may be asked to act as professional or expert witnesses in court. The main difference between an expert witness and an ordinary witness (i.e. a witness to fact), is that the former are able to give an opinion, whereas ordinary witnesses can give only factual evidence. A professional witnesses' remit can cross the boundary of both fact and opinion.

Psychologists are responsible for ensuring they are sufficiently competent and expert in offering an opinion. It is not appropriate for trainee or assistant psychologists to act as expert witnesses. Indications of competence in respect of the knowledge required by the court, and expertise within a specialised field, may include:

- qualifications and/or degree(s) in the areas(s) in question;
- a number of years of post-doctoral/post-qualification experience;
- academic, professional and scientific publications in relevant areas;
- demonstrations of professional practice, competence, specialist knowledge and expertise with a bearing upon the issues in the case; and

- current experience in applying psychology in the area of claimed expertise.

It follows that a psychologist with trainee or assistant status is unlikely to have the necessary experience and qualifications to be retained as an expert witness by a legal firm. However, trainees or assistants who have written reports on individuals in the course of their employment may be required to give evidence (for example, at a tribunal). If so, they should bear in mind that only qualified psychologists should give evidence of opinion, and that their supervisor is responsible for the professional quality of their work in this situation as in all others.

Psychologists instructed as experts need to ensure that they can provide an independent and impartial opinion, and that their independence is clear to all. Any potential conflicts of interest should be made explicit and should be reported as soon as they arise. This can extend to being asked to provide an expert report on someone the psychologist is providing with therapy as an 'Applicant', 'Claimant' or 'Complainer'. This dual relationship is an unacceptable conflict.

When lawyers seek to introduce expert psychological evidence, it is the judge in the case who decides whether an individual has the requisite expertise to give evidence with the potential to be relevant to the case. The judge also decides whether what the expert asserts is relevant and, therefore, admissible in law.

Expert evidence in civil court proceedings is governed by Part 35 of the Civil Procedure Rules 1998, and its associated practice direction. This rule makes clear that an expert's overriding duty is to help the court on matters within their expertise and that this duty overrides the expert's duty to the person from whom they are receiving instructions. Any report must be written in accordance with the criteria in Practice Direction 35.

Further information is available in ***Society documents: Psychologists as Expert Witnesses: Guidelines and Procedure*** and ***Psychologists as Expert Witnesses in the Family courts in England and Wales.***

2.4 Working for defence and security organisations

Psychologists may work with defence and security interests in many different capacities. This may include supporting military or security personnel to perform their roles through the development of skills and behaviours, supporting the mental health and wellbeing of people affected by threats, activities and events in this context, and offering advice and consultancy. It is also UK Defence practice to enlist uniformed psychologists for roles associated with psychology. However, in general, psychologists in defence will be in a civilian role and therefore not under military command.

While there is a strong sense of common culture within the defence and security sectors, there are also important variations. For example, each of the armed forces has its own organisational culture resulting in different attitudes and behaviours. There are also differences within different sectors of each organisation. All these differences are very important to the individuals concerned, forming a large part of their sense of identity.

Psychologists working with these populations should ensure they investigate and acknowledge cultural differences, particularly when working with other national cultures. They should also take careful account of the environments in which people are living and working. Psychologists can be working with civilians and/or members of the armed forces who are operating in life threatening environments and are required to make decisions under extraordinary pressure. It is usually invalid to extrapolate from behaviour in benign conditions to behaviour under threat, hardship and stress.

3. Who psychologists work with

3.1 Working with Experts by Experience

In relevant services it is best practice for psychologists to work collaboratively with clients and Experts by Experience in developing and delivering all aspects of psychological services. In mental health, the Government is committed to shared decision-making and the principle 'no decision about me without me'[11]. This applies from work with an individual client through to changes in government policy relevant to the services provided by psychologists. Psychologists should develop services, policies and guidelines in collaboration with the people who use their services.

In professional practice it is important and helpful to work collaboratively with clients and, where relevant, others in order to ensure that the application of psychological research and theory is understood by and adapted appropriately to the client group and context, which may differ from the populations on which the research was based.

3.2 Working with assistants/interns

Many graduate psychologists take up assistant psychologist positions on either a paid or an unpaid basis.

The following (non-exhaustive) list provides examples of activities which can be carried out by assistant psychologists/interns. This list can guide those who are working as assistant psychologists/interns to request or refuse a task or assignment, as well as assist those who are practising and supervising to observe boundaries and limitations:

- research, audit and service evaluation;
- literature searches, developing and maintaining training packs, information leaflets, libraries of equipment, and other tasks necessary to the efficient running of the service;
- assessment of individuals and groups, for example, direct observations, formal psychometric testing, semi-structured interviews, and writing appropriate reports;
- delivery of interventions with individuals, groups and organisations;
- undertaking supportive work with carers, family members, employers, human resources professionals, team members, health staff and other professionals;
- delivering training for other professionals (if and when competent to do so); or
- promoting applied psychology services by providing relevant information to referrers, commissioners and others.

An assistant psychologist/intern should not be employed to:

- substitute for qualified applied psychologists; or
- undertake solely administrative or clerical duties for which a clerical assistant should be employed.

In occupational settings, the issue of appropriate supervision and guidance is of particular importance when the needs of individuals and organisational demands need to be balanced. Appropriate mechanisms need to be in place to ensure that no assistant psychologist/intern is, for instance, put in a position where they have to design or decide on any materials or processes which could have a potential harmful impact on individuals or groups or to an organisation (such as potential loss of profit or revenue).

In clinical and forensic settings, there are some additional limitations, related to the clear delineation between qualified and assistant psychologist/intern, as follows:

- An assistant psychologist should carry out only prescribed interventions with individuals or in groups, and should write reports only when under close supervision of the primary, qualified psychologist. Any report should be signed as having been written 'under the supervision of' followed by the name, registration status and job title of the qualified psychologist.
- When an assistant psychologist is called to give evidence in a legal setting, such as a tribunal, the qualified psychologist remains responsible for the professional quality of the assistant's work. This means the qualified psychologist should attend the hearing also, as there may be questions which an assistant cannot answer. Both should bear in mind that an assistant is not qualified to give evidence of opinion.
- An assistant psychologist should not undertake tasks in areas where there is not a competent supervisor.
- An assistant psychologist should not carry out the duties of a care assistant.

The managing or supervising psychologist has a responsibility to ensure that assistant psychologists are not given work to do that is over and above their level of competence. Further information is available in ***Society Document: Applied practitioner psychologist internship programmes and unpaid voluntary assistant psychologist posts.***

3.3 Working with trainee psychologists

The Society's standards related to working with trainees across the domains of applied psychology are set out in the Standards for accreditation of training programmes. These set out: the required core competencies that trainees need to develop, the curriculum and assessment requirements that programme providers need to deliver against, and the requirements of supervised practice; expectations around trainees' understanding of and ability to work ethically and legally; selection and recruitment of trainees; personal and professional development of trainees whilst in training; academic staffing and leadership for accredited programmes; and expectations in relation to quality management. Psychologists working with trainees as practice educators should familiarise themselves with these standards and adhere to them in their work with trainees. Further information is available on the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines.***

3.4 Working with multiple clients

Psychologists will sometimes be in situations where their client will not be one clear individual or group, for example, a psychologist may be employed by an organisation to

provide assessment or psychological support for employees. Psychologists need to consider and be mindful of the demands that this might place on their ethical practice and how this might lead to conflicts of interest.

Identification of the following client hierarchy may be considered[12],[13]:

- Primary client – the person or persons with whom the psychologist is interacting directly: the recipient of a psychological service.
- Commissioning stakeholders – the organisation or overall commissioning body that has sought the psychologist.
- Others affected by the primary client's actions – the customers of the organisation or service, or the personal acquaintances, friends and family of the primary client. In some circumstances, this will be the general public or larger groups interested in the outcomes of the intervention.

The psychologist's role will be mainly to the primary client and then the commissioning stakeholder. It is paramount that issues around boundaries and sharing of information are made explicit and addressed appropriately through a clear contracting agreement. Further information is available in ***Section 3.5: Working with other professionals***, ***Section 5: Making and maintaining agreements*** and ***Section 7: Managing data and confidentiality.***

Within each of the levels of the hierarchy, varying allegiances to associates (friends, family, acquaintances, colleagues) will need to be attended to, as will consideration of the impact of professional activity on the reputation of the profession and all those concerned.

3.5 Working with other professionals (including in multi-agency settings)

In order to meet the complex needs of clients fully, psychologists will often be required to work collaboratively with other professionals from their own or other agencies.

Such collaborative working will be for the benefit of clients and/or the promotion of the safety and protection of the public or the benefit of the organisation, and is required by national policy and legislation in a number of areas in which psychologists work. Engaging in partnerships drawing on a wide range of services and agencies enables psychologists to address identified community issues with the optimum use of resources.

Where appropriate to their context of practice, and consistent with the requirements of psychological practice, psychologists should:

- Work together with colleagues to develop a shared view of the aims and objectives of work at all levels. They should respect the professional standing and views of other colleagues and commit themselves to joint working.
- Make it clear to other professional colleagues what can be expected of them in collaborative work, the work that will be done, and the point at which the work will be terminated.
- Ensure that there are explicit agreements about information-sharing and confidentiality and its limits, and that these are adhered to.

- Practise and encourage in others full and open communication with colleagues/ agencies to support effective collaboration within the boundaries of the agreed limits on information-sharing and confidentiality,
- Demonstrate their commitment to involving clients in multi-agency work, finding ways to engage them and retaining the central principle of better outcomes for clients as the rationale for multi-professional and multi-agency work, as long as this is consistent with public safety.
- Be sensitive to the effects of clients receiving contradictory advice from different professionals or agencies and should work towards a co-ordinated view wherever possible.

3.6 Boundaries in professional relationships

Psychologists seek to establish good relationships and trust with their clients, other professionals, organisations and the community. They are aware of the complexity of professional relationships and the need to observe their boundaries. Multiple relationships occur when a psychologist is in a professional role with a client or colleague and at the same time is in another role with the same person or group e.g. as a supervisor, sports club member or co-author in a publication or where a psychologist is asked to work at a school where their child is a pupil.

Psychologists should:

- Ensure that the relationship reflects the appropriate context within which the practice is taking place.
- Be aware of the issues of multiple relationships and professional boundaries which may lead to (real or perceived) conflicts of interest or ethical considerations.
- Clarify for clients and other relevant stakeholders when these issues might arise.

When acting as leaders in practitioner or managerial roles, psychologists should maintain an awareness of the importance of respect for boundary and power issues within leadership relationships. In particular, an awareness of the possible abuse of these relationships should be maintained at all times. It is important that psychologists explicitly define the boundary of the relationship and negotiate and respect the responsibility that each holds in relation to it. Where psychologists are in a position of power/leadership with individuals, it is particularly important that they exercise caution and consider the possible issues which may arise from developing a personal relationship with these individuals. It may be necessary to seek further supervision where appropriate, with additional peers as necessary.

Psychologists have a duty of care towards their clients, who may be vulnerable, and should maintain a professional emotional distance from clients, services users or relatives and should not enter into an intimate or sexual relationship with any clients, service users or relatives they come into contact with as part of practice. Psychologists should also be aware that their duty of care can continue after a client practitioner relationship has ended.

As far as is reasonably practical, psychologists should not enter into a professional relationship with someone with whom they already have, or have had, a close personal

relationship. This includes family members and friends. Where there is no reasonable alternative, such as a lack of availability of other professionals, and it is acceptable in the particular context of practice, the psychologist should make every effort to remain professional and objective while working with the individual they know or have known. In such circumstances, at the earliest possible opportunity, this should be disclosed and discussed with a manager, where there is one, and supervisor and a note should be made in client records.

A range of psychologists work with people who initially have accessed the services in a dependent position, and have then transitioned to becoming partners and colleagues in service and policy development and design. The nature of the work becomes more collegiate and the psychologist holds multiple roles including facilitating participation, adapting communication and advocacy.

3.7 Working with children and young people

When seeking to work with children and young people, psychologists should consider how they can develop ways of communicating with the child or young person that will be most effective in ensuring they can express their views and feelings.

In most instances psychologists will use their specialist professional training and experience working with children, young people and families in order to understand the developmental needs of the child or young person in question; where a psychologist does not have specialist training that has included children and young people then there would be an expectation that advice or supervision should be sought before working with a child, young person, or their family. Similarly, work with children, young people and their families should take account of wider systemic factors outside of the child or young person; this will usually involve the child's family and may also include their school, and other settings.

As with adult clients, there can be misunderstandings and confusions about the role of a psychologist, the nature of the work being undertaken, and the possible outcomes of the work. It is essential to ask the children and young people about their understanding of what is happening on a regular basis (this may be appropriate at each session) and address any confusion that has arisen.

When working with children and young people, psychologists are advised to ensure that they have ascertained who has parental responsibility and that those with parental responsibility are aware of their planned involvement, if this is appropriate. Psychologists working with children, young people and families need to be aware that young people who are deemed to be competent to make their own decisions: 'Gillick competent'[14] can give their own consent to involvement with a psychologist, and that if a young person gives consent under these circumstances, then parental consent is not required. Similarly, a young person who is 'Gillick competent' can give consent even if parents have declined to give consent; such young people can also ask that parents are not informed of any involvement, and this should be respected by the psychologist; an example here would be in a school setting where a young person may give their own consent to see a psychologist

and may ask for parents not to be informed. Psychologists also need to be aware that where separated or divorced parents share parental responsibility, one parent can give consent.

3.8 Working with people with intellectual disabilities and impaired cognitive abilities

Psychologists are likely to work at some point with a range of people whose cognitive abilities are either temporarily or permanently altered, either by organic or developmental changes. Appropriate assessment of the abilities and skills is required, so that adaptions can be made to further interventions, treatments or management. The implications of the cognitive abilities on the person, their family and the reason for psychology involvement, will need to be considered.

Psychologists working with people with intellectual (learning) disabilities will need to consider adaptations to their approach to ensure the service they are offering is clearly understood, and is adapted to the individual's preferences, strengths and needs. This can include considering adaptations to oral or written communication, psychological assessment, intervention, and outcome evaluation.

Psychologists will need to be flexible and to make reasonable adjustments to their usual practice to ensure an appropriate service is offered. Psychologists should ensure their work is person-centred and respectful of the individual's needs, whether that work involves working with the individual with intellectual disabilities directly, or whether it also includes, or even may predominantly involve, working indirectly with family, carer or professional systems around the individual.

Psychologists will need to be mindful of the range of complex factors that often affect people with intellectual disabilities (e.g. communication needs, poorer mental and physical health outcomes and healthcare service experiences, unemployment, disempowerment, social isolation and exclusion, including experiences of bullying, abuse and hate crime, being overrepresented in the prison population, among others) and, therefore, the specific policy and practice guidance that applies. Further information is available in ***Section 4.2: Safeguarding adults at risk of harm*** and ***Section 6.3: Informed consent with people who may lack capacity.***

3.9 Working with detained people

Where clients are detained involuntarily there will always be a legal framework within which professionals must practise, and they should be aware of how their work fits into that framework. Involuntary detention is not only covered by professional rules and national legislation, but also by international agreements.

Psychologists should be aware that having the approval of one's employer is not necessarily a guarantee that practice is either ethical or legal, as described for example in the Hoffman report[15]. Where practitioners have doubts about the legal or ethical acceptability of employer demands, they should seek advice from an accredited workplace trade union representative, a human resources department, or appropriate helpline. They should

follow their organisation's guidelines on raising concerns at work. Seeking advice outside the immediate setting is helpful as colleagues within the workplace may be subject to the same pressures as they are.

Under the headings below, the role of the practitioner can be seen to be key to the way that detained persons are understood, and this can have a great impact on the way that their cases are handled by the detaining authority. The practitioner therefore has considerable power, whereas the client has very little. This power imbalance should always be borne in mind by practitioners dealing with detained persons. They should also bear in mind that the imbalance can be implicit as well as explicit.

Prisoners

Putting psychological pressure on detained persons to obtain a confession to an offence is illegal under the UN Convention on Torture[16]. In this context, 'psychological pressure' could well include such things as telling indeterminate-sentence prisoners who maintain innocence that they are unlikely to be released unless they engage with an intervention that relies on acknowledgement of guilt. Decisions about release are not the role of the practitioner, unless they are directly involved with, or are a member of the release authority, with a delegated role in the formal decision-making process. An approach to engagement such as this would not be considered beneficial to the client. However, those instructed by any party to the formal Parole Board decision-making process may properly be asked to give an opinion on suitability for release.

Practitioners dealing with detained offenders who have committed violent or sexual offences should guard against being morally judgemental. It is routine for practitioners in this field to encounter offenders who have committed very unpleasant acts with whose victims they can readily identify. Psychologists should be mindful that their own views about a client do not impact on their work.

Care should be taken when working with detained persons whose literacy is poor or whose first language is not English, and who cannot read a report which has been written about them. Even clients who are literate in English will probably not be familiar with psychological terminology, and may need considerable time to read and fully digest a report. People who are detained can also have cognitive challenges or intellectual disabilities which might make this process more difficult.

Persons detained under immigration legislation

Detained people may be afraid of raising a particular topic in case it is misunderstood, or too embarrassed because of cultural standards. For example, in some cultures it is difficult or unacceptable to discuss sexual matters, but sexual violence has been suffered by many asylum seekers in conflict zones, and some discussion of it may be essential in assessing their case. Even within the same culture there can be considerable generational differences.

Psychologists should guard against unwarranted interpretations of psychological evidence by commissioners or authority figures. For example, reporting that someone's story shows inconsistencies may give the impression that they are lying. This may be the case, but inconsistencies alone are insufficient proof of this. It is commonplace for evidence to be

inconsistently reported when people have been through traumatising experiences in areas of conflict, as is often the case with persons detained under immigration legislation.

Practitioners should take particular care in dealing with detained persons whose first language is not English. The opportunities for misunderstanding in both directions should be obvious, and in many cases the correct procedure will be to interview with the help of an interpreter. Failing to use interpreters when it was clearly appropriate to do so could inappropriately compromise the quality of the psychologist's work.

Mental Health Detentions

Mental Health Act 1983 as amended 2007 (England and Wales)
Under the Mental Health Act (MHA) a person can only be detained for treatment if that person is suffering from a mental disorder of a nature of degree that makes it appropriate for them to receive medical treatment in hospital. In the Act 'mental disorder' is defined as 'any disorder or disability of mind'. This definition is very broad but the *Code of Practice* provides guidance on clinically recognised conditions that fall within its meaning. Major categories of mental illness (e.g. affective disorders, schizophrenia and organic mental disorders) are included along with personality disorders, autistic spectrum disorders and learning disabilities (the latter only if accompanied by abnormally aggressive or seriously irresponsible behaviour). Dependence on alcohol or drugs is not considered a mental disorder under the MHA.

In the Act, all 'medical treatment' including psychological interventions is for the purpose of alleviating, or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations. The medical treatment must be required for the health and safety of the client or for the protection of others. This means that the primary purpose of psychological interventions offered and provided to detained persons has to be to reduce the risks that their mental disorder presents to the detained person or others; as once those risks are reduced or minimised the client will no longer require detention and can progress to a less restrictive environment. This requirement points to the importance of an individualised formulation of a client's treatment needs that includes a careful assessment of the risks to self and others (see section on Risk Assessment, p.32).

Under the MHA appropriate medical treatment must be available. This is described as the 'appropriate medical treatment test' in the *Code of Practice*. Such treatment must have the *purpose* of alleviating or preventing a worsening of the disorder or its symptoms or manifestations, even if it cannot be shown in advance that the treatment is likely to have an effect for a particular patient. Thus, appropriate medical treatment need not be likely to achieve those purposes. That is, purpose is not the same as likelihood. The nature and degree of the patient's mental disorder and all the patient's particular circumstances are all relevant to whether the treatment is appropriate.

The appropriate medical treatment test is designed to ensure that patients are not detained for treatment unless they are actually to be offered appropriate treatment for their mental disorder. Thus, the MHA requires only that appropriate treatment is available to a detained patient. The patient's refusal to accept treatment is not an obstacle to detention, so long as appropriate treatment is available.

This has particular relevance for psychological therapies. The Code at chapter 23.20 states:

> *In particular, psychological therapies and other forms of medical treatments which, to be effective, require the patient's cooperation are not automatically inappropriate simply because a patient does not currently wish to engage with them. Such treatments can potentially remain appropriate and available as long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to engage.*

Whilst the availability test of appropriate medical treatment applies to psychological interventions in the same way as for other forms of treatment, it is important for psychologists to avoid placing pressure on clients to participate in such treatment. In order for there to be an effective therapeutic alliance there needs to be trust and this only develops in the absence of coercion. Psychological therapy works when the client decides they are ready for therapy and freely consents to it. There is an inevitable power differential in favour of the clinician. Thus, every attempt should be made to emphasise patient involvement and choice and to avoid coercion in a manner consistent with the *Code of Practice* empowerment and involvement and respect and dignity principles. Further information is available in ***Section 6: Obtaining informed consent.***

The Mental Health Act 2007, which amended the MHA 1983, introduced approved clinicians (AC) who may be drawn from a defined group of professions, including practitioner psychologists listed in the register maintained by the Health and Care Professions Council. ACs are approved by the appropriate national authority to act as an approved clinician for the purposes of the MHA 1983. Responsible clinicians (RC) are ACs who have overall responsibility for an allocated patient's case. The Code of Practice at chapter 36.3 says that a patient's RC should be the available AC with the most appropriate expertise to meet the patient's main assessment and treatment needs. At chapter 36.5 the Code says that where psychological therapies are central to a patient's treatment then it may be appropriate for a professional with particular expertise in this area to act as the RC.

Chapter 39 of the *Code of Practice* provides guidance on the circumstances in which potential conflicts of interest may prevent designated professionals from making an application for or recommendations supporting a patient's detention or guardianship. The potential conflicts of interest dealt with in the Code involve financial, business, professional and personal issues.

The Mental Health (Scotland) Act 2015.

This act, together with the Mental Health (Care and Treatment) (Scotland) Act 2003 sets out the law for detaining patients and restricting patients. For patients to be detained, this has to be considered by the Mental Health Tribunal for Scotland. This applies, for example, to those detained in the NHS who are not subject to a court (forensic) decision.

Restricted patients are 'detained in hospital under a compulsion order with a restriction order'. They have usually committed an offence punishable by imprisonment but as a result of mental disorder are not imprisoned but ordered to be detained in hospital for treatment, without limit of time. They are dealt with through a programme of treatment and rehabilitation – the aim being to prevent recurrence of offending by dealing with the mental disorder'.

Risk assessment

When dealing with detained people seeking release, such as parole applicants or patients seeking release from a mental health tribunal, risk assessment (usually for violence risk) will be a prime consideration. Psychologists should bear in mind that risk assessment is not prediction. Risk assessment instruments are rarely more than about 70 per cent accurate when predicting reconviction and many items on commonly used risk-assessment schedules are of poor predictive value.[17] Psychologists should also bear in mind that risk-assessment instruments are better at identifying low-risk than high-risk individuals[18],[19]. A statement of risk is not a prediction about an individual, but a statement based on the behaviour of a criterion group with which that individual is being compared. Risk is statistical by its very nature, and the value of such comparisons depends upon the individual's similarity to the criterion group upon which the risk assessment instrument was developed. Accuracy may be greatly reduced if the similarity is low[20]. It may be better to think of risk assessment as a process of identifying those risk factors which need to be monitored and controlled if supervision of the individual is to be reduced or withdrawn.

3.10 Working with people who are, or would like to be employed

Psychologists are sometimes commissioned to deliver psychological assessment or training with employees and potential employees. Psychologists should take particular care over the advice provided in follow-up reports, as employers are not trained professionals and may misinterpret advice or psychometric testing results. For example, citing a reading ability level using age is misleading, and could be interpreted as incompetent for the role, when in reality the role does not require a high reading level or a reasonable adjustment could be provided.

Similarly, psychologists should ensure that the tools they are using to assess competence or suitability are appropriate for the role, and have good reliability and validity. Any tools devised by the psychologist are likely to be interpreted by the employer as professional and authoritative, where there is ambiguity or multiple interpretations, this must be made clear, so that decisions about peoples' employment are not made in error.

There are people who work or who would like to work, who may experience cognitive difficulties caused by a range of factors, for example intellectual disabilities, dementia, acquired brain injury. Sometimes this information is known and needs to be considered when assessing and advising. At other times, this possibility of a cognitive or intellectual impairment needs to be considered. The impact of this can be far reaching, in terms of ongoing or future employment, access to benefits and of course associated psychological adjustments for the person and the people around them. Further information is available in ***Section 7: Managing data and confidentiality*** and ***Society Document: Psychological Assessment of Adults with Specific Performance Difficulties at Work.***

3.11 Working with cultural difference

It is expected that all psychologists will have the necessary skills and abilities to work with all sections of the community.

Psychologists need to be aware of stereotypical beliefs and assumptions which manifest in thinking about culture and ethnic groups. Psychologists should bear in mind the history of racism and the early development of Western psychology[21] and culturally biased testing in favour of white, middle-class children. Psychologists need to recognise that multi-ethnic groups are not homogenous groups and there are wide regional and local differences among these groups which can be split by language, dialect and regional variations. Each ethnic community has a distinct identity and religious focus may also vary within and across communities.

Race is not a biologically meaningful concept to apply to people, and even the artificial divisions between the so-called racial groups are nebulous and unstable, biologically, socially and physically.[22]

Psychologists need to understand the discrimination suffered by people from diverse and/or minority ethnic and religious backgrounds as a result of:

- the interchangeable use of the terms race, culture and ethnicity leading either to the perception of black and minority culture, race and ethnicity as unitary or an assumption that knowing about these cultures solves the problem of equality, fairness and availability of services;
- the maintenance of the colour-blind approach in service where 'one size fits all', resulting in a lack of formal recognition of the varied diverse needs as well as these needs being ignored, unacknowledged or assumed to be the same;
- the lack of appropriate culturally relevant psychological therapy available to certain Black and Minority Ethnic (BME) communities;
- being discriminated against on grounds of 'special' needs, effectively considered as 'cultural pathology'; and
- experiencing instances of indirect, subtle, or unintentional discrimination often called 'micro-aggressions'.

It would be expected that all practising psychologists should develop a productive working relationship with culturally and linguistically diverse groups of people by:

- avoiding different types of biases and find new ways (verbally and non-verbally) to build rapport and respect;
- using and working with trained interpreters in assessment, formulation and intervention work as well as research work;
- being aware of the impact of culture, ethnicity and religion in assessment, formulation and intervention processes and the use of norm-referenced tests which do not include minority ethnic groups as part of their standardisation;
- pre-assessing and pre-incorporating ethnic identity (including its fine gradations, region, class and generation) which can have impacts on processes and outcomes of psychological work;
- acknowledging their own ethnocentricity and possible underlying socially conditioned prejudice to people who are 'different'; psychologists need to acknowledge that people can change, irrespective of their differences and psychological distress;
- relooking at current models of mental health which traditionally reflect Western

constructions, and incorporating other world views of psychological wellbeing; and
- understanding and respecting the different concepts of health and illness that exist within different ethnicities, including newly arrived people from Europe and refugees from Syria, Turkey, Somalia etc.

Psychologists need to: address the different life situations and life circumstances experienced by users who wish to use mental health services; hear their voices based on their personal experiences; and act and respond accordingly in a human way.

3.12 Working with people of faith, religion and spirituality

In working with clients who hold a variety of values and religious and spiritual beliefs which may be different from their own, psychologists should consider the following:

- Psychologists should respect clients' values and spiritual beliefs and need to be mindful that their personal beliefs should not be an impediment to engaging with the client.
- Spiritual beliefs are very often beneficial to the client's wellbeing and may be helpful to be incorporated into any intervention to achieve a positive impact where appropriate.
- In some circumstances the client's faith belief may be harmful or detrimental to themselves or others.

3.13 Working with sexual and gender minorities

Psychologists are committed to the fair treatment and inclusion of people who are intersex, people who do not identify as heterosexual and/or people who do not identify with their natally-assigned sex. This section provides guidance to address specific issues in support of these heterogeneous populations. In these guidelines we use the term 'sexual minority(ies)' to refer to individuals whose romantic attraction or sexual attraction is other than heterosexual (different from the majority in the surrounding society), and the term 'gender minorities' to refer to transgender, genderqueer and intersex individuals.

When working with gender and sexual minorities, psychologists are encouraged to:

- remember that sexual and gender minority identities are not indicative of mental health disorders;
- understand that attitudes towards sex, sexuality and gender are located in a changing social, cultural, and political context, and to reflect on their own understanding of these concepts and how it may impact their practice;
- reflect on the limits of their practice when working with certain sexual and gender minority clients, and to consider appropriate referral and training when necessary;
- understand how social stigmatisation (e.g. prejudice, discrimination and violence) poses risks to gender and sexual minority clients;
- consider engaging with the wider socio-political context regarding sexual and gender minorities in order to reduce social stigma;
- be knowledgeable about the diversity of sexual and gender minority identities and practices;

- use the preferred language of the sexual and gender minority individuals;
- understand the unique and particular circumstances and challenges facing clients with diverse gender and sexual identities and practices;
- understand the diversity of forms of relationships and families in gender and sexual minority clients;
- be aware of the potential challenges facing sexual and gender minority clients in their relationships and families;
- be mindful of the intersections between sexual and gender minority and socio-cultural/economic status;
- recognise the particular challenges experienced by gender and sexual minorities with physical and/or mental health difficulties;
- recognise the diversity of developmental pathways for sexual and gender minority children and adults;
- recognise the needs and issues of young people from gender and sexual minorities, and their particular vulnerabilities;
- support the self-determination of their clients in the development of their identities and practices; and
- avoid attempting to change gender or sexual minorities on the basis that they can be 'cured' or because of stigmatising theory, personal, religious and/or socio-cultural beliefs.

Working with racially and ethnically diverse Lesbian, Bisexual, Gay, Trans*, Queer (LGBTQ) populations

Black and minority ethnic (BME) LGBTQ people have to negotiate between the values and beliefs of the mainstream and minority ethnic cultures. Cultural differences in norms, beliefs, and values can be a source of psychological stress[23],[24],[25]. There may be no particular sexual and ethnic minority group to which a BME LGBTQ person can anchor their identity and obtain acceptance and support. This may be a particular issue for BME LGBTQ youth who are exploring their sexuality and sexual identity.

When offering psychological services to racially and ethnically diverse LGBTQ populations, it is not sufficient for a psychologist simply to identify the racial and ethnic identity and background of the client. Ethnic minority status can complicate and exacerbate the issues, challenges and difficulties the client experiences. The client can be affected by the way their ethno-culture community view and understand sex, sexuality and gender. The issue of racism within the LGBTQ community is also an important issue to consider[26],[27],[28],[29]. Sensitivity to the complex dynamics associated with factors such as cultural values about gender roles, religious and procreative beliefs, degree of individual and family acculturation, and the personal and cultural history of discrimination or oppression is also important. All of these factors may have a significant impact on identity integration and psychological and social functioning[30],[31],[32],[33],[34].

Further information is available in ***Society Document: Guidelines and Literature Review for Psychologists Working Therapeutically with Sexual and Gender Minority Clients.***

3.14 Working with people who may be socially excluded

Social exclusion refers to the extent to which individuals are denied access to the prevailing social system and the right to participate in key areas of social, economic and cultural life. This exclusion occurs due to constraints and restrictions rather than as a matter of choice. Exclusion is typically a result of poverty and/or belonging to a social minority group. The impact of social exclusion has been well documented and leads to the perpetuation of cycles of inequality for individuals and groups. These cycles of inequality are perpetuated in terms of income, health, opportunity, relationships and life-span. Further information is available in ***Society Document: Socially inclusive practice.***

Social inclusion is the process where the needs of all members of communities and the groups which constitute them are recognised, prioritised and met, resulting in these individuals feeling valued and respected. Promoting social inclusion is a broader task than promoting equality and tackling discrimination and stigma. It requires psychology professionals to address wider structural issues in society which maintain excluding processes and power differentials.

The range of individuals and groups who may experience disadvantage and exclusion is not limited to the protected characteristics outlined in the Equality Act. For example, people may also experience exclusion because of their age, they are a carer or are in care, they have a low income or low educational achievement, or their cognitive ability is compromised.

When working towards social inclusion psychologists are encouraged to:

- acknowledge, understand and respect the diversity of the communities in which they practise;
- make adjustments where possible and needed, to enable people to fully participate, e.g. to communication, access to services, adaptation to materials and psychological assessment and interventions;
- recognise that they have a professional duty actively to promote equality and opportunity;
- recognise the shame and distress caused by discrimination, and the impact of discrimination on wellbeing;
- acknowledge and respond to the trauma and distress caused by exclusion;
- move beyond the level of the individual and recognise that social exclusion is a structural issue, and that inclusion will be achieved only by structural changes in society and broad policy initiatives;
- acknowledge that there is a responsibility to highlight the links between structural societal factors and mental health problems;
- make employers, policy-makers, clients and the general public aware of situations where policies, practice and the distribution of resources are oppressive, unfair, harmful or illegal;
- challenge social conditions, both as individuals and collectively, that contribute to social exclusion and stigmatisation;
- make services accessible in terms of time, space, familiarity and comfort; make reasonable adjustments to services to meet individuals' needs; people need to be able

to get to places, get into places, feel welcomed to places and feel that they belong in places;

- recognise that inclusive services reflect the communities they serve in terms of the identities and diversity of the staff team;
- recognise the range of interventions that can improve clinical and social outcomes and use influence to ensure these services are commissioned;
- emphasise social outcomes and participation alongside clinical outcomes;
- maintain an emphasis on empowering clients to achieve their social goals; and
- identify natural sources of support and reciprocal relationships for individuals within their communities, and seek out opportunities to help individuals transition out of formal mental health services.

4. Safeguarding

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect[35]. This guidance addresses safeguarding of both children and adults.

Abuse takes many forms and cuts through various domains of life. The categories below are often referred to in investigation/legislation context and are not mutually exclusive with e.g. emotional abuse featuring in the other domains of abuse. Abuse can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

- Physical abuse – is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This could include hitting, poisoning, deprivation of food, water or liberty, rough handling or exposure to heat or cold, amongst other things.
- Sexual violence and abuse – sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding. Sexual violence and abuse can take many forms and may include non-contact sexual activities such as: indecent exposure, stalking, grooming or being made to look at, or be involved in the production of sexually abusive material, or being made to watch sexual activities.
- Psychological/emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, blaming, controlling, intimidation or coercion amongst other things.
- Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not, or could not, consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property of inheritance.
- Institutional abuse is the mistreatment or neglect by a regime or individuals, in settings which people who may be at risk reside in or use. Institutional abuse may occur when routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. It may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services and includes a failure to ensure the necessary preventative and/or protective measures are in place.
- Neglect is the persistent failure to meet basic physical and/or psychological needs. It may involve a parent or carer failing to provide adequate food, clothing and shelter, failing to provide or unresponsiveness to, basic emotional needs or failing to protect from physical harm.

Psychologists are in a particularly relevant position to identify interactions or circumstances that affect health and development. This applies not only to psychologists who undertake direct work with children and vulnerable adults in a variety of settings; but also to those who work with clients, seen for instance in clinics, hospitals or prisons, who may make historical disclosures of abuse or raise concerns about child protection or the welfare of people within their families or communities. Safeguarding is thus the responsibility of all psychologists whatever their role.

4.1 Safeguarding children

The Society endorses *Working Together to Safeguard Children* – A guide to inter-agency working to safeguard and promote the welfare of children[36]. Safeguarding children is the responsibility of everyone.

The guidance defines safeguarding children as protecting children from maltreatment and preventing impairment of children's physical or mental health or development (physical, intellectual, emotional, social and behavioural). Promotion of welfare is defined as ensuring that children grow up in circumstances consistent with the provision of safe and effective care, and taking action to enable all children to have the best life chances.

Child protection within safeguarding refers to the activity that is undertaken to protect specific children who are suffering or likely to suffer significant harm. For the purposes of child protection legislation children are those who have not yet reached their 18th birthday. The child's needs are paramount, and the needs and wishes of each child be they a baby or infant or an older child, should be put first, so every child receives the support they need before a problem escalates.

The policy of Working Together is underpinned by two key principles: (a) safeguarding is everyone's responsibility and for services to be effective each professional and organisation should play their full part; and (b) safeguarding requires a child-centred approach based on a clear understanding of the needs and views of children.

Where there are concerns that a child is at risk of harm, such concerns should normally be communicated following the psychologist's work-place safeguarding protocol. Where this is not applicable, concerns about a child's welfare can be made directly to the local authority children's social care team.

Psychologists should:

- be alert to the heightened vulnerability/possible need for early intervention support for a child who: has a disability, has additional needs (including special educational needs), is a young carer, is showing signs of engaging in anti-social or criminal behaviour, has returned home from care and/or is showing early signs of abuse and/or neglect.
- be alert to heightened vulnerability where a child is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence.
- consider the potential impacts of parental/carer ill-health on the family and whether this creates any significant negative impacts or risks for children within that family;

- be aware that if an adult has responsibilities for children outside the home setting, such as working with children, their mental ill-health and/or their health more generally upon the adult's capacity to work safely;
- be aware that children within the same family can be treated differently (one child may be singled out for abuse);
- be aware/seek to understand how children can come to abuse other children;
- recognise that some professionals use their position to abuse children and vulnerable people; and
- challenge institutional abuse in its many forms.

Psychologists should be aware of situations of risk which require additional consideration, notably:

- sexual exploitation, which involves exploitative situations, contexts and relationships without the child recognising the harm on account of their age/understanding, social/economic and/or emotional vulnerability;
- internet abuse, which can involve cyber bullying, exposure to pornography or violence and exploitation of young people;
- domestic violence which may expose a child to violence directly or indirectly;
- shame-based abuse where children or young people may be physically assaulted or murdered because of bringing perceived 'shame' to their families or breaking cultural expectations of 'honour'; and
- Trafficking, any child transported for exploitative reasons is considered to be a trafficking victim, whether or not they have been forced or deceived. This is partly because it is not considered possible for children to give informed consent. Even when a child understands what has happened they may still appear to submit willingly to what they believe to be the will of their parents or accompanying adults.

Psychologists should have a knowledge and understanding of services for children in need and how to access them. Psychologists confronted with child abuse in any form should contribute to whatever actions are needed to safeguard children and promote their welfare. The needs/interests of adults should not be allowed to take precedence ahead of the needs of the child. Psychologists should work co-operatively with parents/carers unless this is inconsistent with ensuring the child's safety and ensure that the child's view is sought, heard and communicated. Psychologists should share appropriate information in a timely way, discuss any concerns and help analyse information so that an assessment can be made of the child's needs and circumstances. Psychologists should contact the children's services or social services department at the appropriate local authority (in some cases this role has been delegated to a multi-agency safeguarding hub) if they are concerned about a child or a vulnerable adult.

Managing cases of alleged historical abuse

There is a growing recognition that a disclosure of non-recent abuse may reveal current risks to others from an alleged perpetrator. Psychologists have a duty of care to their clients, and in the safeguarding of others. This may place psychologists in complex positions when trying to negotiate and balance their duties and responsibilities.

Psychologists who work with adult clients who disclose non-recent sexual abuse, should recognise that there may be current and ongoing risks posed by the alleged perpetrator to others. Not sharing concerns beyond the consulting room could mean that other children and young people could be at risk.

A client's allegations should be taken seriously, regardless of their presenting problems or mental health diagnosis.

Lack of access to children identified through familial relationships, work or volunteering roles should not eliminate concerns about risk, given opportunities for abuse to occur within communities.

It is crucial that psychologists seek advice from colleagues, particularly colleagues in safeguarding services, within the organisation and also from other agencies tasked with leading on safeguarding (i.e. social services). Psychologists working with clients without a referral and where no stakeholder agency is involved should seek advice from senior experienced colleagues on how to proceed. Psychologists need to be alert to the possibility that abuse may be organised, severe and complex.

There may be times when, in the interests of supporting a client's psychological readiness for disclosure, consultation may continue without requiring identifying details to be provided to the psychologist. It is important that a clients' lack of readiness to disclose does not become an obstacle to receiving psychological help. Further information is available in ***Society Document: Guidance document on the management of disclosures of non-recent (historic) child sexual abuse.***

Where the disclosure is made by the perpetrator of the abuse, risk assessment should be made regarding the context of the setting of the disclosure but there may be a professional obligation to disclose the criminal offence in order to safeguard other potential victims as above.

4.2 Safeguarding adults at risk of harm

The Care Act 2014 brought in new legislation regarding the safeguarding of all vulnerable adults. In some regions there is a move away from the term 'vulnerable adult' towards the concept of an adult at risk of harm.

An adult at risk of harm is a person aged 18 or over with need for care or support, who is experiencing, or is at risk of, abuse or neglect, and as a result of their needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The needs referred to here may cover a variety of personal or life circumstances including (but not limited to) cognitive impairment, age, disability, illness, injury or mental health condition.

The legal context

There is no set piece of legislation for adult safeguarding. It is a mix of criminal law, case law and welfare law. The Care Act 2014, updated in 2016, brought in the first legal framework for safeguarding adults in a single act. It contains a range of regulations and statutory guidance, which form the base upon how social care will develop in the future.

It enshrines the new statutory principle of wellbeing and it makes it the responsibility of local authorities to promote wellbeing when carrying out any of their care and support functions. The act specifies the rights of those who need care and support, their carers, and the funding system for care and support. It recognises that this cannot be achieved by any single agency. Every organisation and person who comes into contact with a child or adult has a responsibility and a role to play to help to keep children and adults safe. Further information is available in ***Appendix 1: Relevant legislation.***

Modern slavery

An important area of concern is modern slavery. The Government website provides details about the government's work to end modern slavery, including details about how to refer victims into the national referral mechanism (NRM). Modern slavery is a serious crime. It encompasses slavery, servitude, and forced or compulsory labour and human trafficking. Modern slavery victims can often face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation.

A person is trafficked if they are brought to (or moved around) a country by others who threaten, frighten, hurt and force them to do work or other things they don't want to do.

A victim of slavery is entitled to help and protection from the UK Government (this is called the National Referral Mechanism), all support is provided on a confidential basis, and support to talk to the police. The National Referral Mechanism has been put in place to identify victims of trafficking and refer them to organisations that will offer help and support. Further information is available in ***Appendix 2: Websites and further information.***

Responding to concerns

Safeguarding adults means:

- Protecting the rights of adults to live in safety, free from abuse and neglect.
- People and organisations working together to prevent and stop both the risks and experience of abuse or neglect.
- People and organisations making sure that the adult's wellbeing is promoted including, where appropriate, taking fully into account their views, feelings and beliefs in deciding on any action.
- Recognising that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances and therefore potential risks to their safety and wellbeing.

Providers' safeguarding arrangements should always promote the adult's wellbeing. Being safe is only one of many things that adults want for themselves and there can be challenges in balancing safety and freedom in a way which protects and fulfils human rights. Providers, and other professionals where relevant, should work with the adult to establish what being safe means to them and how that can be best achieved.

Care and support means different things in every case. The fundamental standard on safeguarding is that children and adults using services must be protected from abuse and improper treatment. Providers should establish and operate systems and processes

effectively to ensure this protection and to investigate allegations of abuse as soon as they are aware of them.

The standard states that care or treatment must not:

- Discriminate on the grounds of any of the protected characteristics of the Equality Act 2010;
- Include acts intended to control or restrain an adult or a child that are not necessary to prevent, or not a proportionate response to, a risk of harm to them or another person if the adult or child was not subject to control or restraint;
- Be degrading to the adult or the child;
- Significantly disregard the needs of the adult or the child for care or treatment.

The standard goes on to state that no adult or child must be deprived of their liberty for the purposes of receiving care or treatment without lawful authority.

Safeguarding Adults Boards were established to help and safeguard adults with care and support needs The Safeguarding Adult Board must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies, according to the values of 'Making Safeguarding Personal' Guide 2014[37]. Making safeguarding personal is not just for people with capacity, it is just as important for people who lack capacity. The Guide specifies outcomes that people might want including to be and to feel safe, to maintain or get friends, to know that this won't happen to anyone else or to be able to protect self in the future.

The following are not outcomes:

- Harm or abuse is substantiated/unsubstantiated.
- The person is receiving increased monitoring or care.

The role of the Care Quality Commission[38] is to monitor, inspect and regulate services to make sure that they meet the fundamental standards of quality and care. The Commission works alongside Safeguarding Adults Boards and Safeguarding Children Boards to share information and intelligence where appropriate to help them identify risks. This includes providing appropriate advice and support to people at risk of radicalisation in sectors such as healthcare and education.

4.3 Terrorism and extremism

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ('specified authorities' listed in Schedule 6 to the Act), in the exercise of their functions, to have 'due regard to the need to prevent people from being drawn into terrorism'. Depending on where the psychologist works, these duties may have relevance in the course of their employment. The term 'due regard' as used in the Act means that the authorities should place an appropriate amount of weight on the need to prevent people being drawn into terrorism when they consider all the other factors relevant to how they carry out their usual functions.

The current UK definition of 'terrorism' is given in the Terrorism Act 2000. In summary, this defines terrorism as an action that endangers or causes serious violence to a person/ people; causes serious damage to property; or seriously interferes or disrupts an electronic system. The use or threat must be designed to influence the government or to intimidate the public and is made for the purpose of advancing a political, religious or ideological cause. People suspected of being involved in such activity must be referred to the police.

'Extremism' is defined in the Prevent Strategy[39] as vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty, and mutual respect and tolerance of different faiths and beliefs. Definitions of extremism can also include calls for the death of members of our armed forces, whether in this country or overseas.

While it is recognised there is no single profile associated with extremism, identity is considered to be central, and risk screening is based on assessment in relation to two general pathways into extremism – criminal and non-criminal. Disengagement follows a similar process. This is a contentious area of practice. Psychologists should ensure they focus on their core role, working in a non-stigmatising way, and avoiding profiling based on characteristics such as race, religion, ethnicity or any other aspect. The psychologist should carefully weigh relevant professional obligations and seek and follow appropriate local and employer guidance. Further information is available in ***Appendix 2: Websites and further information.***

5. Making and maintaining agreements

Both client and psychologist benefit by having arrangements for the work clearly set out from the start. Psychologists should be aware that all professional engagements are ultimately governed by the law of contract. A legally enforceable contract can arise as a result of the parties' entering into a written agreement, but can also arise as a result of a verbal agreement between the contracting parties.

A contract arises if the following are present:

- one of the parties (the offeror) had made an offer to the other party (the offeree);
- the offeree accepts the offeror's offer;
- there is consideration (i.e. something of value) passing from each party to the other, e.g. the offeror provide services to the offeree; the offeree pays the offeror;
- the parties intended to create a legal binding arrangement; and
- the terms of the contract are sufficiently certain.

While this does not mean that all client engagements are made subject to an agreed contract document, it does mean that in the worst-case scenario of a complaint against a psychologist being made, it will be very helpful for the psychologist to be able to demonstrate that they have met their professional obligations to their client. This will be best done by demonstrating that an agreement was made by both parties who knew what they were agreeing to, that the parties had the legal capacity to make such an agreement and that what they were agreeing to is permitted under the law. Where the client does not have the capacity, best interest decisions need to be made in accordance with the Mental Capacity Act. Further information is available in ***Section 6: Obtaining informed consent***.

Psychologists may wish to include the following when making agreements:

- the role and function of the psychologist;
- the psychologist's relevant qualifications, areas of expertise and ways of working;
- relevant limitations of the psychologist's practice, e.g. assessments not accepted or types of activity not undertaken;
- where the psychologist is appointed to work with a third party, the psychologist should make clear their obligations to each of the clients concerned and each client's obligations under the agreement and ensure that there are no conflicts or ambiguities;
- the extent of the psychologist's power and responsibilities when acting on behalf of other agencies;
- obligations in relation to duty of care and safeguarding, and related limitations to confidentiality;
- how confidentiality of client information and data is assured and any limitations to that confidentiality;
- how conflicts of interest will be managed if applicable;
- the client's, or other party's, rights of access to stored information;
- the use of any one-way viewing screens or video or audio recording and the security of any recorded material;

- the nature of psychological activities involved, the reasons for undertaking them and information about the likely outcomes;
- the availability of the psychologist to the client;
- details of fees, together with application of VAT if non-clinical services, or expenses to be billed in connection with the work undertaken;
- what is expected from the client as their contribution to the engagement with the psychologist, expectations for payment and consequences of non-payment;
- ownership of intellectual property rights;
- what might cause a breach of the agreement;
- the rights of each party to withdraw from the agreement and the consequences to any financial agreement;
- recourse to dispute resolution or law;
- the equality and justice aspects of social policies and their possible impact;
- external ethical scrutiny and approval of the engagement, where appropriate; and
- arrangements to terminate the retainer.

In advance of any psychological assessment, the client should be made aware of the availability of services, and the existence of any waiting lists for intervention.

For some approaches, intervention follows an evolving path, unique to each client and his or her life circumstances, which cannot be precisely predicted in advance. Clients should be made aware of this uncertainty, and predictions should be made on the best judgments. It is recognised that it is sometimes unrealistic and undesirable to provide detailed information on all aspects of psychological intervention, and consent should be obtained to a general strategy rather than specific procedures. Further information is available in this document or the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines.***

5.1 The practitioner's right to withdraw their service

There are circumstances in which a psychologist may decide to terminate the agreement for provision of psychological services. The circumstances may be personal or professional.

The personal circumstances may include but will not be restricted to leaving employment in a psychological service, incidences of illness or family commitments.

The professional issues may relate to service structural changes, safety, or provision of most appropriate service.

In these circumstances, psychologists will, as far as possible, work to ease the transition of service provision and give as much notice as is practical in the particular situation.

5.2 Referrals

Where a psychologist finds themselves unable to come to an agreement with a client, the psychologist may refer the client to a suitably qualified colleague. Psychologists will both make and receive referrals when working in services with other professionals.

In making referrals, psychologists should consider the needs of the client and to the best of their knowledge refer to another professional with the appropriate skills and experience.

In receiving referrals, the psychologist should consider whether the referral is appropriate for psychology, establish the client's understanding of the purpose of the referral, and consider as far as possible prior to meeting the client whether the referral falls appropriately within their own areas of practice.

5.3 Representation of the qualifications and status of the psychologist

HCPC registration and BPS Chartered Status

Psychologists are encouraged to state their registration with the HCPC and protected title(s). This will provide assurance that the psychologist meets national standards of training and professional skills.

Use of the 'consultant' title

The term 'consultant' generally does not have a formal definition. Within the medical field it is used by doctors who have considerable experience and proven expertise demonstrated through examination within their respective Royal Colleges.

While there is no clear comparable grading structure for psychologists outside the NHS (within the NHS, the consultant title is used by psychologists who are employed in Band 8C, 8D and 9 positions), the use of this title would be seen to reflect both seniority and specialist expertise.

There is a difference between a 'consultant' psychologist and a psychologist who provides consultations in their context of practice. The Society expects that psychologists should be honest and accurate in representing their professional affiliations and qualifications, including such matters as knowledge, skill, training, education and experience.

The Society's position is that this would be applicable in any situation where expert knowledge or skills is being marketed or promoted, whether or not this is for financial gain. Further information is available in ***Society Document: Guidance on the use of the title 'Consultant Psychologist'.***

6. Obtaining informed consent

Psychologists should always ensure that they have sought and received the consent of those they work with, given of their own free will, without undue influence.

The concept of informed consent relates to the client's right to choose whether to receive psychological services, and to make this choice on the basis of the best information available presented in the most appropriate way. The principles apply, whether the psychologist works in the public, private or voluntary sector or in independent practice.

Psychologists should obtain the informed consent of the client in an appropriate manner prior to undertaking any assessment, intervention or research activities. In all circumstances, common sense and ethical practice should apply when considering the approach to gaining informed consent from those with whom the psychologist is working.

This section refers, in the main, to consent with adults with capacity. Further information on informed consent with discrete communities where further consideration may be needed is available in ***Sections 6.1 to 6.4***.

Obtaining informed consent involves a process which is dynamic and is relevant to the specific assessment, intervention or decision being made at that time. When there are substantive changes in the intervention or when the psychologist has reason to consider the client may no longer consent, consent should be reviewed. Psychologists should ensure that their clients are enabled to play an active role in this process. Clients should be encouraged to ask questions whenever they are in doubt.

Psychologists should be aware that a client's desire for help, and the immediate impact of the psychologist's supportive listening, may affect the client's ability to make informed choices about the help they wish to receive. They should also be aware that their own desires to help a client may bias their presentation of information, such as the probability of successful outcomes.

Psychologists should be aware of the complexities of obtaining informed consent to treatment due to the perceived power, status and authority of the professional psychologist. It may not be clear if the consent given is freely given by the client or, for example, is part of a pattern of compliance towards authority figures. Equally, a client may say that they understand the explanation given by the psychologist, and accept a plan for intervention, in order to avoid the discomfort of being seen not to understand the psychologist's complex language and ideas.

Obtaining informed consent is particularly difficult when the client is obliged to undertake the psychological intervention as part of an employment process or performance measure where they may have obligations under their employment contract; or when detained.

There should ideally be an ongoing dialogue between client and psychologist, as part of the process of joint decision-making. At any point, the client should feel free to ask questions about the impact of the treatment and withdraw consent to continue.

Psychologists should attempt to intervene against the express wish of a client only after careful consideration and in line with relevant legislation, policies and professional practice.

Provision of information for informed consent

In order to ensure that the client has all the information necessary to make an informed decision about whether to take part or not in a psychological activity, they must be provided with relevant information, such as that listed below, in a format that is designed to meet their specific needs.

The psychologist should consider providing information about the following:

- what the psychological activity involves, as far as this is consistent with the model of interaction, e.g. there will be limits in the use of some non-directive therapies and psychometric assessments;
- the benefits of the activity, either directly to the client in the case of assessment or intervention, or indirectly in the case of systemic intervention, or to potential theoretical advances or service improvement;
- any alternative assessment or treatment options and their known availability;
- foreseeable risks and how minor or serious they may be, for example the potential to feel worse at stages during therapeutic interventions;
- what might be the benefits and potential costs and risks to them of engaging or not engaging in the proposed psychological activity; and
- the client's right to withdraw their consent from assessment, treatment or intervention at any stage, along with information about any likely consequences of such withdrawal.

Consent to involvement of others

Psychologists have an obligation to ensure that prospective clients are informed of the extent and limitations of confidentiality with respect to anticipated services, the purposes of any assessment, the nature of the procedures to be employed or the intended uses of any product such as notes or recordings, before the assessment or intervention starts. Further information is available in ***Section 7: Managing data and confidentiality.***

The psychologist should ask the prospective client: whom they would wish to be informed of their assessment or treatment, if anyone; and the information they are willing to share where communication is essential, for example to the referring agent or organisation, management or court. Wherever appropriate, including in the law, the client should have copies of reports or letters or be given feedback so that they are kept fully informed.

If it is deemed necessary to move from individual contact to include others this should where possible be done with the client's prior consent.

Psychologists may be asked to provide consultancy or advice to colleagues about an identified client, without that person's knowledge or when the client has indicated that they do not want to have direct contact with the psychologist. In these circumstances, the psychologist will need to consider their potential involvement and the need for consent.

A psychologist who draws upon the work of other professionals in preparing a report, should seek their consent, where possible and if not already in disclosed records, to include that material and should acknowledge its source in the report.

If a report is requested which draws upon previous or concurrent investigations of a client in other contexts, for example NHS records in the preparation of a report for the court, the client's consent or relevant authority's consent for that information to be used should be sought.

If psychologists wish to use reports on clients which have been compiled by other professionals, they should do so only with the consent of those professionals and use the reports only in the context for which the report was specifically provided.

Information on and consent to record-keeping

Express consent must be sought in advance for the use of video, audio recording or one-way screens, with a clear explanation of the purpose of these. Further information is available in ***Section 7.1: Information governance***

6.1 Informed consent for court

When a psychologist is instructed to give evidence in court, it is the court that should be informed and whose authority should be sought for the work undertaken. When serving as a witness in the legal arena, the psychologist is responsible to the court, rather than to either party.

6.2 Informed consent with children and young people

All children and young people, whatever their age or status, have a right to express their views freely and be involved in any decision-making that affects their lives, which includes judicial and administrative proceedings[40]. Therefore, psychologists who seek to work with children or young people must gain their informed consent. This applies whether the child or young person or another agent with legitimate responsibility for the child or young person has made the request for involvement. Any direction or guidance provided by parents or other caregivers must be 'in accordance with the child's evolving capabilities' and support the 'exercise by the child of his or her rights'[41]. The onus is then on the adults to provide appropriate support to enable the child or young person to express their views and contribute to decision-making.

Every psychologist should consider how they can:

- provide an accessible explanation to the child or young person about their work as a psychologist;
- offer a clear reason for their possible involvement;
- provide an opportunity for the child or young person to talk about what working with the psychologist might involve.
- discuss and agree how information is recorded and possibly shared with others with an awareness that young people who are 'Gillick competent' can consent to information not being shared with parents;

- discuss how the child or young person will be kept safe;
- ensure that the child or young person has understood the psychologist's role and has given their informed consent;
- ensure the child or young person understands they can withdraw their consent at any point;
- ensure their practice acknowledges and respects the culture, community and context of the child or young person.

Occasionally, a disagreement over consent may arise between parent/carer and child or young person and/or between parents/carers. The psychologist would make every effort to resolve the difference of views, perhaps seeking, with agreement, involvement of an appropriate family member and/or a colleague, although as discussed above, a young person who is 'Gillick competent' can legitimately request that family members (including parents) are not involved or informed of any involvement. If the disagreement is not resolved, the psychologist should draw on their professional experience to act in the best interest of the child or young person seeking consultation and support through appropriate channels, including safeguarding and legal departments, and consultation with appropriate colleagues including other professionals.

6.3 Informed consent with people who may lack capacity

It is likely that psychologists at some stage within their careers will be working with people who lack capacity to consent to assessment or treatment. This could be because of a wide range of difficulties such as intellectual disability, brain injury, dementia, severe mental health difficulties, and neurological conditions. As a result, it will often be necessary to make a judgment about a client's ability to give informed consent. This should include whether the person is able to:

- understand the information relevant to the decision (e.g. psychological treatment);
- retain that information;
- use or weigh that information as part of the process of making the decision; and
- communicate their decision (whether by talking, using sign language or any other means.)

The Mental Capacity Act 2005 contains 5 key principles which it is important to understand:

1. A presumption of capacity;
2. Individuals being supported to make their own decisions;
3. Individuals have the right to make 'unwise' decisions;
4. Anything done on behalf of a person with a mental capacity issue should be in their best interests; and
5. An intervention should be on the basis of the 'less restrictive option' weighed up in the particular circumstances of the case.

The Mental Capacity Act Code of Practice[42] expands upon these points (and indeed all aspects of the Act), highlighting the need to assist a client in making a decision for

themselves (with the use, for example, of memory aids, simplified resources, etc.). It should also be noted that the fact that a person is able to retain the information relevant to a decision for a short period does not prevent them from being regarded as able to make the decision.

The Mental Capacity Act (2005) provides a clear framework for what to do if a person lacks capacity to make a range of decisions, including consenting to treatment. The principle of 'best interest' must be followed, and the Act states clearly who needs to be consulted in relation to making such a decision and ensuring that the individual's wishes are considered.

It is good practice to give full information (possibly using adapted resources) to clients even when they are not deemed able to give informed consent. The psychologist must, so far as reasonably practicable, permit and encourage the client to participate, or to improve their clients' ability to participate, as fully as possible in any act done for the client and in any decision affecting them.

In some circumstances, it is possible that there may be others who have been given legal authority for decision-making on behalf of others, such as Power of Attorney for Health and Welfare or Deputyships for Health and Welfare. It is important to note that patients might also have created Property and Affairs Lasting Powers of Attorney. Those acting under a Property and Affairs power alone will not have authority to make decisions in relation to a patient's treatment. If someone is a Health and Welfare Attorney or Deputy, those persons will be able to make those decisions on behalf of others. It is also necessary to ensure that the client has not made an Advance Decision to refuse treatment prior to the loss of capacity, although this is unusual in relation to psychological treatment.

In some clinical contexts, particularly relating to brain injury, intellectual disabilities and dementia, issues related to capacity and best interest are particularly prevalent. Psychologists practising in these areas need to ensure sufficient knowledge and expertise. Further information is available in ***Society Document: Guidance on determining the best interests of adults who lack the capacity to make a decision for themselves.***

6.4 Informed consent with people as employees

Tripartite arrangements where an employer commissions and pays for an assessment or intervention, such as diagnostic assessments for neurodiversity and cognitive functioning return to work assessments, or coaching, potentially give the employer access to data that they will struggle to interpret, or may misinterpret, for example test scores and details of personal life. It is important that the psychologist protects the employee by giving the employer only what they need to know and can reasonably require for the purpose of employment.

The Psychologist should consider whether they will be gathering information that is not usually held by an employer, or is not held routinely for all employees, for example IQ scores and childhood experiences. If so, the psychologist should consider abridging documentation so that the employer receives only the information they 'need to know',

and the employee can if necessary hold a full copy for future reference. This prevents discrimination against employees who are subject to in depth assessment for reasons related to illness, neurodiversity or disability from being unfairly compared to their peers. It also prevents complex psychological information from being held by those who are not qualified to interpret it.

Agreements should be made explicitly about the information which can be shared with the commissioning organisation. In order to aid transparency, information should normally be sent to the client prior to being shared with the organisation.

6.5 Informed consent with detained persons

Prisoners

Informed consent may be harder to obtain when a client is detained. Psychologists working with detained persons should be aware that, as well as UK law, the UK is signatory to a number of conventions on the treatment of detained persons. These conventions not only outlaw physical ill-treatment, but also certain kinds of psychological pressure. For example, it is contrary to the UN Convention on Torture to apply psychological pressure to elicit a confession, or compliance with a regime. In this context, 'psychological pressure' could include making progression contingent on compliance with a particular aspect of the regime. Practitioners should be particularly mindful of the power imbalance in forensic contexts, which is far more acute than is generally found in non-justice system based settings. Only offenders detained in secure hospitals can be required to comply with assessments or treatments under involuntary detention sections of the Mental Health Act.

Mental Health Detentions

For psychologists there can be potential conflicts of interest or what could be better termed 'competing duties of care' between the roles of Responsible Clinician (RC) (for further information on this role see Section 3.5) (including the duty to detain or otherwise compel participation in treatment) and that of psychologist (including, principally, the duty to establish freely-given consent wherever possible to enhance the efficacy of the therapeutic intervention). The MHA Code at chapter 24.34 (medical treatment) states that permission given by a patient to a particular treatment 'under any unfair or undue pressure' is not consent (p.257).

Good outcomes for psychological therapies are associated with positive therapeutic alliances and good working relationships between therapists and patients. The potential for even perceived abuse of power and the inherent power differential between an RC and a detained patient subject to the MHA runs a risk of rupturing this relationship or it becoming coercive. Psychologist RCs must therefore remain aware of and give full consideration to any potential competing duties of care between the RC and psychological therapist roles when providing psychological treatments to patients over whom they have compulsory powers.

The main issues to be considered by psychologist RCs when addressing potential competing duties of care in this context include the following:

1. Psychological treatments (with the possible exception of indirect interventions delivered by proxies such as paid staff and carers) are more likely to be effective when informed consent is obtained. As such, RCs acting as psychological therapists should utilise all reasonable and ethical attempts to obtain consent from patients before proceeding with psychological treatment. The *Code* at chapter 24.34–24.39 (p.257) provides guidance on obtaining consent.
2. The Act permits psychological treatment to be given without consent and the Code provides guidance on how to proceed with treatment in these circumstances (chapter 24.40–24.44, pp.257–258). There may be circumstances, especially when significant risks to others or self have been identified, when it is considered to be necessary for a psychologist RC to proceed with providing psychological treatment without consent. In such circumstances then there should be, where practicable, prior discussion with the MDT involved in the patient's treatment and care about the risks involved. Careful consideration should be given to the availability and merits of another suitably qualified member of the team providing the psychological treatment required with the RC remaining in overall charge of the client's care.
3. There may be situations where it is judged that informed consent cannot be clearly obtained, or where it would appear another available practitioner would be more likely to achieve a more effective outcome (perhaps due to the power differential between patient and RC). In such situations the psychologist RC is advised to refer on to other members of the treatment team who are able to provide the psychological treatment needed, while the RC remains in charge of overall care.

7. Managing data and confidentiality

7.1 Information governance

Psychologists should follow local and national guidance and statutory responsibilities regarding management of data. Psychologists should make, keep and disclose information in records only in accordance with national policy and legislation, and the policies and procedures of the organisation(s) they are employed by/working in collaboration with. Further information is available in ***Section 1.1: Legal and professional obligations of psychologists, Appendix 1: Relevant legislation*** and ***Appendix 2: Websites and further information.***

Psychologists must bear in mind the potential impact of the information in their records on all who may have access to such records, for example, the client, other professionals, managers, authorised carers, etc. Where possible, distinction should be made between fact, observation and opinion, and judgemental comments should be avoided. Psychologists are responsible for holding their records securely to ensure the confidentiality of the information contained within them and to control access to them. Further information is available in ***Society Guidance: Guidelines on the use of Electronic Health Records.***

This guidance applies to all record-keeping on clients, their relatives, carers and/or associates, and their organisations, regardless of the media in which information is held, e.g. written notes and reports, audio- and video-recordings, paper and electronic records, etc.

Records made, kept or accessed by psychologists should be:

- systematic and appropriately detailed;
- in clear language/format;
- accurate;
- up to date; and
- relevant to professional work and to the purpose for which they were collected.

Clients have a legal right to access records concerning them, and this right is enshrined in legislation. Additionally, it is good practice for clients to be given feedback on their content. Sharing records with clients supports the collaborative approach of psychologists and enables clients to have full and effective involvement. Client access to records will be restricted to information about themselves and not third parties. Restrictions will also apply when disclosure would place the clients or others at risk of serious harm.

In tripartite arrangements involving an employer access to information should be governed by agreements made explicitly about the information which can be shared with the commissioning organisation.

Shared records

In some organisations in which psychologists work single, multi-professional, client-based records are held. Such records are designed as shared documents (paper or electronic),

the function of which is primarily to facilitate inter-professional communication to ensure the safe and effective delivery of high quality services. Such records may be shared among organisations/agencies to facilitate care and/or exceptionally, to safeguard the client or others, including the general public. In some contexts, clients have the right to object to their data being disclosed to a third party even someone who might provide essential healthcare. Psychologists should be aware of local codes and policies. Further information is available in ***Section 3.5: Working with other professionals***, ***Section 7: Managing data and confidentiality*** and ***Appendix 2: Websites and further information.***

Psychologists should include in the shared record all information about their work with clients and related others which is required to ensure appropriate multi-professional care and to safeguard the client and relevant others, including the general public.

Third-party and sensitive material should be clearly marked. There should be clarity/clear communication within the multi-professional team about what is and is not shared with the client if there are safeguarding concerns. A system needs to be established about how suspicions and causes of concern are recorded and/or shared.

Where shared records are held, other professionals involved with the clients will have access to such records. This should be explained to the clients at the onset of engagement with them.

The use of sealed envelopes is no longer considered good practice following the findings from serious untoward incident investigations where the existence of sealed envelopes compromised care.

Assessment materials

Psychologists should be mindful at all times of the confidential nature of assessment materials. Many assessment measures are invalidated by prior knowledge of their specific content and objectives. Psychologists who use these materials are required to respect their confidentiality and to avoid their release into the public domain (unless this is explicitly allowed in the nature of the instrument and by the test publisher). Psychologists should, therefore, take reasonable steps to prevent misuse of test data and materials by others. Further information is available from ***Appendix 2: Websites and further information.***

In many organisations, there is only one shared records system. In these cases, it is necessary for psychologists to be able to use the shared records system to hold raw data from psychometric assessment. The results of psychometric assessment will be incorporated into reports which explain their context and appropriate interpretation, and which are included in the shared institutional record. In relation to the visibility of the psychometric instrument and the raw data to other members of the multidisciplinary team who are not psychologists, the onus is on the other professionals not to interpret information where they are unqualified to do so, just as the psychologist would not interpret, for example, physical healthcare test results they are unqualified to interpret. Psychologists may consider whether it is appropriate to mark assessment materials so their nature is clear.

Additional data

Psychologists may wish to keep separate notes to aid their work but which are not intended for sharing with others or to be part of the permanent client record. These notes, often called process notes, which are written for the purposes of reflection on practice, should be anonymised with no other identifying links e.g. initials, appointment time, so that these notes therefore are clearly not part of the client record. Process notes may, for example, be used for reflection and supervision. If process notes are made to assist in compilation of a report, the material should be incorporated, as relevant, into the final report and the process notes then destroyed.

Long-term illness, incapacity or death of a psychologist

Most organisations will have procedures in place in the event of illness, incapacity or death of a psychologist. Psychologists in independent practice are advised to make a professional will and to appoint a professional executor, probably an experienced colleague, whose role it would be to take charge of client records, to inform the clients involved and, where appropriate and practicable, to make provision for continuity of the service provided.

Retention and destruction of records

Psychologists' records should be held securely for as long as they are required for the purpose of psychological work. Psychologists must follow legal requirements, national and local policy frameworks and procedures regarding the retention or disposal of records after the psychologist's work is concluded. Psychologists should ensure that they keep up to date with requirements.

For independent practitioners general guidance is that many independent psychologists keep records relating to contact with adults for 7 years, and follow NHS guidance in relation to children. Where the records derive from work undertaken within an organisation, the maintenance of these records is determined by the organisation's policies and legal requirements.

Retention and destruction of health records, both paper and electronic, is covered in the NHS code of practice for records management. Generally speaking, retention is until age 26 for people seen as children; 20 years after the last contact for adults, and 8 years after death if the death occurred while the person was in the care of the NHS. There are specific requirements for mental health services depending on the nature of the contact.

In education settings, Local authorities generally retain Education Health and Care Plans for 35 years after the case has been closed. Other records are retained until the child is 25.

All records must be destroyed under confidential conditions following organisational procedures or for independent practitioners using a destruction service or process which meets industry standards for document management and can provide the appropriate certification.

7.2 Confidentiality

Clients are entitled to expect that the information they give to psychologists about themselves and others will remain confidential. Psychologists have a duty not to disclose

such information except as discussed below and to bring their confidentiality practice to the attention of their clients, employers, managers and any other professionals involved.

Psychologists have a duty to inform involved parties of their confidentiality standards and practice at the point of first contact. Clients should be informed of the limits of confidentiality where information about them may be shared and confidentiality breached, for example for reasons of safeguarding, requirements of the law, and public protection.

Psychologists have a duty to be aware of the content of any other relevant guidelines and of any other policy guidelines which set out local expectations.

Use of client data for audit must follow the Caldicott principles, which, designed for the NHS, provide helpful guidance for any setting in terms of when it is appropriate to use with client-identifiable data and when anonymised data should be used[43]. Generally under data protection legislation, it is necessary to obtain specific informed consent for the use of client data for particular purposes, and to inform clients of the purposes for which their data is being collected and how it will be used. Further information is available in ***Appendix 2: Websites and further information.***

Disclosure of information

If disclosure of information is deemed necessary, psychologists should obtain specific informed consent from their clients, making the consequences of disclosure as clear and unbiased as possible. There are a number of circumstances where this might not be possible or may not apply: for example where the health, safety, security or welfare of the client or someone else may otherwise be put at risk; and if there are legal or safeguarding responsibilities, such as the need to avoid 'tipping off'. If confidentiality is broken without consent, the client should be told what has been said and to whom, unless such disclosure may expose the client or others to serious harm or is contrary to legal or safeguarding obligations.

Psychologists who are faced with the difficult decision as to whether to disclose information without a client's consent must weigh carefully the arguments for and against disclosure. The responsibility for this decision lies with the individual psychologist although they may seek advice and guidance from appropriate sources such as their employing organisation's Information Governance or Data Protection Lead, Clinical Governance Lead, Caldicott Guardian, Safeguarding named and designated professionals, or legal departments. These other professionals can be the most helpful sources of advice in difficult disclosure situations. Independent practitioners may wish to consult the legal helpline of their professional indemnity insurer.

Circumstances may emerge where clients may present a risk to others or to themselves, or be at risk from others whom they wish to protect. It is then necessary to discuss the importance of disclosure and to encourage it, for example to partners of HIV positive clients, and to employers if a client's mental health status presents a risk to others via driving, handling machinery or interaction in a working situation, for example, flight deck crew. Disclosure without consent, or against the client's expressed wish may be necessary in situations in which failure to disclose appropriate information would expose the client, or

someone else, to a risk of serious harm (including physical or sexual abuse) or death.

The psychologist must weigh up the needs and interests of their own client against the wider welfare, protection and safeguarding of the public.

Disclosure to clients' employers, insurance companies and others

Psychologists have a duty to ensure, at first contact, that clients understand the purpose of any assessment undertaken at the request of employers, the DVLA or insurance companies, and of the psychologist's obligation to disclose the results of that assessment. In the case of assessment for fitness to work or to drive, they should obtain the client's written consent.

Psychologists should consider what each party involved needs to know, gaining understanding and agreement on which aspects will be fed back, in advance. For example, the full detailed and raw scores obtained by a psychologist in recruitment assessment processes may be unsuitable for an employer to receive in full. The commissioning body should be made aware of the decision-making data that they originally requested, in the case of an employer this could include strengths and weaknesses, and recommendations for employer actions, for example.

Primary clients should be advised about and able to preview, with opportunity to ask questions first, any data that will be sent to an employer about them. Bear in mind that the informed consent difficulties still stand and that an employee or potential employee can withdraw consent for the employer to be informed of any part of their results.

This can be very difficult to manage in practice, and requires psychologists to make these agreements with their commissioners before they start the work, so that all are informed of the risks in the service delivery. Further information is available in ***Section 3.4: Working with multiple clients.***

Disclosure after a client's death

After a client's death, relatives or other authorities may seek access to the psychologist's records. In the first instance, the psychologist is advised to follow organisational procedures where they exist which usually deal with the administrative proofs required such as proof of death, proof of kinship and right to access the material requested.

A psychologist's duty of confidentiality continues after a client has died. The psychologist will need to weigh up the circumstances around the request for disclosure and what personal information is being sought. If there has been a specific request by the client for their information to remain confidential, their wishes should usually be respected. If the psychologist is unaware of any instructions from the client, when considering requests for information the following should be taken into account:

- the purpose of the disclosure;
- whether the disclosure of information is likely to cause distress to, or be of benefit to, the client's partner or families;
- the permission of a surviving relative or next of kin is not required, and does not authorise disclosure of confidential information, although the views of those who were close to the client may help the psychologist decide if disclosure is appropriate;

- whether the disclosure will also disclose information about the client's family or anyone else; and
- whether the information is already public knowledge or can be anonymised or coded.

There may be circumstances where the disclosure of information is required, for example:
- to support an inquest or fatal accident inquiry;
- where the disclosure is required by law, is authorised under section 251 of the NHS Act 2006, or is justified in the public interest, such as for education or research;
- in the case of national confidential inquiries or for local clinical audit; and
- when a person has a right of access to records under the Access to Health Records Act 1990 or Access to Health Records (Northern Ireland) Order 1993.

7.3 Confidentiality when safeguarding

In exceptional circumstances it may be necessary to breach the client's confidentiality with or without their immediate knowledge or consent. This would be the case where there are significant risks to the client's psychological wellbeing; where the alleged perpetrator may be a current risk to others or where there is risk of jeopardising a potential investigation. Any decision to breach confidentiality cannot be taken lightly, but can be justified and accounted for if made in good faith because of safeguarding concerns. This is supported by professional guidance. The focus of any intervention including any breach of confidentiality must be on promoting a proportionate, measured approach to balancing the risk of harm with respecting the client's capacity to consent, their choices and preferred outcome for their own life circumstances.

Specified authorities may need to share personal information to ensure, for example, that a person at risk of radicalisation is given appropriate support. When considering sharing personal information, the specified authority should take account of the following:
- necessity and proportionality: personal information should be shared only where it is strictly necessary to the intended outcome and proportionate to it. Key to determining the necessity and proportionality of sharing information will be the professional judgement of the risks to an individual or the public;
- consent: wherever possible the consent of the person concerned should be obtained before sharing any information about them;
- power to share: the sharing of data by public sector bodies requires the existence of the power to do so, in addition to satisfying the requirements of the Data Protection Act 1998 and the Human Rights Act 1998; and
- Data Protection Act and the Common Law Duty of Confidentiality: in engaging with non-public bodies, the specified authority should ensure that they are aware of their own responsibilities under the Data Protection Act and any confidentiality obligations that exist.

In relation to health sector staff, government guidance states it is important that staff understand how to balance client confidentiality with the duty to report. They should also be made aware of the information-sharing agreements in place for sharing information with other sectors, and get advice and support on confidentiality issues when responding

to potential evidence that someone is being drawn into terrorism, either during informal contact or consultation and treatment.

7.4 Confidentiality for the court

Psychologists acting as expert or professional witnesses have a duty to disclose all of the evidence used to reach their opinion where directed by the court to do so.

This could include:

- the details of any tests and assessments administered with professional colleagues;
- notes made during report writing; and
- referenced academic articles or studies.

No information relating to an assessment or report should be disclosed outside the relevant proceedings without agreement. Psychologists should normally seek permission from the instructing party to disclose any information to another health care professional.

Where instructed directly by the court, the Crown Prosecution Service, Procurator Fiscal or a solicitor, the psychologist is required to report or comment on any or all aspects of the case that appear to the psychologist, as an expert in the field, to be relevant or pertinent. In such circumstances, the psychologist is not in a position to offer confidentiality to any person, and should make this position clear to any party with whom they have contact during psychological investigations or assessment.

In these circumstances, it will be important that the psychologist makes sure they are up to date with the legislation and policy guidance regarding public and media access to information available to whichever court or tribunal their instruction arises from. The psychologist will need this awareness so that they can explain to the adult or child concerned what the limits of privacy are in these legal circumstances. They will need to make clear to the client which information needs to be made accessible, by whom and under what circumstances. Only when the client understands this, can they give informed consent.

There are different levels of access to sensitive information in different legal contexts; this will include testimony, documents and professional and expert reports. Many proceedings typically take place in open court, to which the public has access. In these cases, there is a presumption in favour of providing information and documents to third parties which were relied upon by the court in reaching its decision, though not the entire court file.

Where court papers and other materials are received in electronic format, psychologists should ensure that these are stored in a secure, password-protected format. This may require the addition of additional security for documents that arrive in an unsecured form. Where psychologists submit reports in an electronic format they should ensure that these are in a secure, password-protected format.

Psychologists working with clients who are the subject of court proceedings may need to be careful to ensure that they keep all records which may be of relevance to the court process until it is clear that the court has reached a final conclusion, including any appeal that may have been heard.

With few exceptions, applications in the family court are heard in private, with only those immediately involved being allowed to attend and access information. It is possible, however, for duly accredited members of the media to attend hearings in the family court, subject to the power to exclude them on specified grounds.

In most family court proceedings, media representatives have no entitlement to receive or peruse court documents referred to in the course of evidence, submissions or judgment. If media representatives wish to see documents referred to in the family court they may apply to the judge for disclosure but they are subject to strict guidance in terms of what information they can divulge into the public domain.

7.5 Confidentiality with children and young people

When beginning direct work with a child or young person, the psychologist should discuss and agree who will have access to the information arising from the work, with direct reference to principles of 'Gillick competence'. In undertaking this discussion it is helpful to acknowledge that there may be those adults (e.g. parents/carers, other relevant professionals such as teachers, social workers, counsellors) who may have a supportive interest in the work and may wish to have appropriate access to information but the wishes of a 'Gillick competent' young person should take precedence unless there are safeguarding concerns.

Parents or those with legal responsibility may be made aware of this agreement if appropriate, although a young person deemed to be Gillick competent is able to agree to work with a psychologist independently. Those with parental responsibility do not have an automatic right of access to the psychologist's records by making a subject access request under data protection legislation.

The nature and purposes of any work will vary and this will determine how and to whom information will be shared, however the child or young person should always be made aware of who will have access to what and for what purpose and due consideration given to the wishes of a 'Gillick competent' young person about who can have access to information about any involvement with a psychologist. The child or young person should be fully aware of the content of any shared information, including as appropriate, copies of the documents. Whatever is agreed about information sharing including work where information is confidential, the psychologist must ensure the child or young person knows and understands that if there is a risk of harm the psychologist must follow safeguarding procedures.

7.6 Confidentiality with detained persons

When detained persons give informed consent to the collection of information, they do so for a specific purpose and for use by specific people. The use of such information for a different purpose or for use by different people would require separate consent. Thus, although a psychologist may interview and write a report on a detained person, consent for that purpose cannot be taken as allowing a third party access to the psychologist's records on that person, such as notes on (or recordings of) the interview. If psychologists are

put under pressure to reveal such information, they should seek the advice of colleagues including for example those responsible for governance or data protection. They should bear in mind that they have a legal duty to be aware of and comply with data protection legislation and professional confidentiality rules.

7.7 Confidentiality obligations during training

During training, no academic/training documents should identify clients to whom they relate (even by means for example of initials, service name or date of appointment) as any such potential identifiers could be used to trace the client and therefore make the document a part of the clinical record and subject to the relevant provisions of data protection legislation. This includes published reports, case studies prepared for trainee assessments and any articles or publications. Tutors and supervisors should communicate this to their trainees. Trainees should be clearly instructed to both make and keep separately those records which are part of the provision of psychological service and which belong to the service organisation and are subject to its policies and procedures; and papers which are anonymised and are part of the trainee's academic learning, and belong to the trainee and are subject to the training provider's policies and procedures.

Express consent should be obtained by trainees before audio- or video-recording their interactions with clients. If the client is unable to give informed consent, it is unlikely to be appropriate for the recording to be made. Careful consideration should be given before any material is recorded if the client is party to any legal proceedings or family or employment disputes. If material is to be used for purposes other than client care (including teaching and research), the client should be informed of the purposes of the recording. It should be made clear to clients how the material will be used and to whom it will be disclosed, for example, trainee students, other researchers, and supervisors.

The trainee and the client should come to an agreement about how long recorded material should be kept. The general principle is that recordings will be kept for as long as needed to fulfil the purpose for which the client has given consent and no longer. The security of the material must be maintained, and it must be destroyed at the agreed time limit if no longer required.

Informed consent is required before client material in an identifiable format may be published in case studies, presentations or other research reports. It is becoming common practice for clinical material in professional doctorate portfolios to be stripped out before the thesis is placed in online institutional repositories.

8. How to respond when things go wrong

8.1 Managing conflict with a client

Conflict with a client suggests that someone's expectations are not being met. The first objective should be to restore agreement or agree to make changes. The well prepared psychologist will have a client agreement in place and will be able to review the experience against the agreement with the client to address this question. Further information is available in ***Section 5: Making and maintaining agreements***. Even in the absence of an agreement, the psychologist would be advised to enquire with the client where their expectations are unmet or raise their own unmet expectations with the client. This can be an opportunity to put a belated agreement in place.

It may be that the parties agree to set aside the agreement and bring it to an early close. Agreeing to disagree may be a better outcome for psychologist and client who cannot restore agreement. Take account of any need for onward referral either within the service or elsewhere or back to the original referrer, and depending on the nature of the work setting, any financial obligations in closing the work.

The psychologist may find it helpful to consult with appropriate colleagues in preparation for the conversations with the client, such as line or service managers, those with other relevant organisational responsibilities, and supervisors. There may be more general lessons to be drawn as part of reflective practice in relation to the quality of the client agreement for future use.

8.2 Transparency and duty of candour

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 duty of candour (regulation 20) requires all health and adult social care providers registered with the Care Quality Commission to be open with people when things go wrong. Psychologists need to be aware of the terminology relating to this regulation including:

- openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered;
- transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators; and
- candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Psychologists also have a responsibility to ensure that they engage in open and transparent communications with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. Guidance from the Care Quality Commission on duty of candour outlines the specific requirements that providers must follow when things go wrong with care and treatment, including informing people about

the incident, providing reasonable support, providing truthful information, and making an apology. Psychologists are instrumental in supporting organisations to promote a culture that encourages candour, openness and honesty at all levels. Further information is available in ***Appendix 2: Websites and further information.***

8.3 Managing conflict in team settings

Dealing with breakdowns in working relationships, professional disagreements and fitness to practise concerns

As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues (including relating to consultation/supervision or line management) by clear communication, relevant evidence and collaboratively working through the issues in reasoned argument within the context of respectful relationships.

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

Where there is serious or continual disagreement, both parties need to take whatever action is appropriate in their professional context, consulting other experienced professionals as necessary.

Supervisors and line managers have professional obligations concerning professional standards, ethical practice and 'fitness to practise' issues. If line managers or supervisors have any concerns regarding performance in these areas, they have a duty to discuss these with the psychologist and, if necessary, address the matters by in the first instance following appropriate employment policies and procedures, or in the case of an independent practitioner, making a report to the HCPC.

Working in multi-professional or multi-agency contexts

Psychologists may find themselves in conflict with the approaches to work taken by other individual colleagues or by the multi-professional team or agency.

Psychologists should bring to the awareness of the multi-professional team or agency any difficulty in the group working together which may impact on the psychologist's ability to function effectively and ethically in their role. Such issues are best addressed when guided by national and local policy and current legislation before proceeding with multi-professional/multi-agency collaboration. Further information is available in ***Appendix 1: Relevant legislation.***

The psychologist may also have cause for concern about the ability of the team to provide for the needs of the client owing to interpersonal difficulties between members of the multi-agency or multidisciplinary team that might have an indirect impact on the client. As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues by clear communication, relevant evidence and collaboratively

working through the issues in reasoned argument within the context of respectful relationships.

If the situation remains unresolved for any reason, for example because it is judged not to be an issue for active management, the psychologist must make a judgement about whether their involvement in the team is helpful to the client or the working of the team. If not, the psychologist should consult with an appropriate colleague about whether they should disengage from that team.

A psychologist may also experience concerns about the competence or ethical practice of individual colleagues involved in joint working. These concerns may relate to the competence of the colleague to carry out a particular intervention, the appropriateness of an intervention for a particular client or problem, the nature of the relationship between a colleague and his or her client (e.g. potential abuses of power).

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

If they conclude that misconduct has occurred, psychologists should bring the matter to the attention of those charged with the responsibility to investigate such concerns, generally in the first instance an employer or in the case of an independent practitioner, the HCPC. Further information is available in ***Section 2.1: Working environment.***

8.4 Supporting a colleague when a complaint has been made

The receipt of a complaint or allegation can be distressing for all concerned, not least for the person who is the subject of the complaint or allegation. It is important that they receive advice and support from appropriate persons. Any potential conflicts of interest should be considered. It may be that a psychologist is not best placed to offer support and guidance as they may be called as a witness in the complaints process. Encourage colleagues to seek advice from an experienced colleague or supervisor where appropriate.

The psychologist should also be encouraged to seek the support of an accredited workplace trade-union representative who is skilled at supporting people in these situations and can access legal advice if necessary. Legal advice can also be obtained from the professional indemnity insurance broker, and sometimes from household insurance policies where the householder has taken out the legal advice additional option.

Complaints are an increasingly normal occurrence and must be handled in a professional manner. The complaint investigator or professional body will need the psychologist's version of events and any evidence before any conclusions are reached. Psychologists should support colleagues to respond promptly, objectively, factually and honestly to the complaint. The content of the complaint should always be held in confidence.

8.5 If the client remains unhappy

If any conflict or issue as referred to in this section cannot be resolved, it may be appropriate to advise a client or other individual that that they have a right to raise any concerns about a psychologist with the Health and Care Professions Council, further details of which can be found at www.hcpc-uk.org

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Role	Name
Chair of the Practice Guidelines Working Group	Nicola Gale
Academics, Researchers and Teachers in Psychology	Simon Goodson
Children, Young People and their Families	Katie Hunt
Clinical Psychology	Tejinder Kondel and Ste Weatherhead
Coaching Psychology	Paul Philipps
Community Psychology	Ho Law
Counselling Psychology	Helen Nicholas
Crisis, Disaster & Trauma	John Durkin
Defence and Security	Fiona Butcher and Karen Carr
Education and Child Psychology	Charmian Hobbs
Ethics	Martin Fisher
Expert Witness Advisory Group	David Crighton
Forensic Psychology	Robert Forde
Health Psychology	Andrew Haig-Ferguson
Independent Practice	Sonya Wallbank and Jill Wilkinson
Informatics	Graham Fawcett
Intellectual Disabilities	Kate Theodore
Mental Capacity Advisory Group	Gemma Gray

Role	Name
Mental Health Act Advisory Group	John Taylor
Neuropsychology	Katherine Carpenter
Northern Ireland	Alison Clarke
Occupational Psychology	Nancy Doyle, Julie Freeborn, Almuth McDowell and Rainer Kurtz
Older People	Carolien Lamers
Prevent	Clare Fuller
Psychology of Sexualities	Jimmy Couzens
Psychotherapy	Ho Law
Race and Culture	Zenobia Nadirshaw
Safeguarding Advisory Group	Gill Evans, Liz McMonagle and Anne Peake
Scotland	Louise Richards
Social Inclusion	Anna Daiches
Sport and Exercise Psychology	Lee Ann Sharp
Wales	Nicola Massie
Experts by Experience	Joanne Hemmingfield and Simon Mudie
Legal Support	Stephen Pearson, Freeths LLP
Administrator	Emma Smith
Editorial Support	Sally Anderson
Policy Advisor (Professional Practice)	Hannah Farndon

Appendix 1 – Relevant legislation

Unless otherwise stated, Acts can be found on the government website http://www.legislation.gov.uk/

United Kingdom and England

Care Act 2014

An Act to make provision to reform the law relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding adults from abuse or neglect; to make provision about care standards; to establish and make provision about Health Education England; to establish and make provision about the Health Research Authority; to make provision about integrating care and support with health services; and for connected purposes.

Care Standards Act 2000

An Act to establish a National Care Standards Commission; to make provision for the registration and regulation of children's homes, independent hospitals, independent clinics, care homes, residential family centres, independent medical agencies, domiciliary care agencies, fostering agencies, nurses agencies and voluntary adoption agencies; to make provision for the regulation and inspection of local authority fostering and adoption services; to make provision for the registration, regulation and training of those providing child minding or day care' to make provision for the protection of children and vulnerable adults; to amend the law about children looked after in schools and colleges.

Children Act 1989

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Children and Families Act 2014

An Act to make provision about children, families, and people with special educational needs or disabilities; to make provision about the right to request flexible working; and for connected purposes.

Data Protection Act 1998

An Act to make new provision for the regulation of the processing of information relating to individuals, including the obtaining, holding, use or disclosure of such information. The Act states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- fairly and lawfully processed;

- processed for limited purposes;
- adequate, relevant and not excessive;
- accurate and up to date;
- not kept for longer than is necessary;
- processed in line with your rights;
- secure; and
- not transferred to other countries without adequate protection.

Equality Act 2010

An Act to make provision to require Ministers of the Crown and others when making strategic decisions about the exercise of their functions to have regard to the desirability of reducing socio-economic inequalities; to reform and harmonise equality law and restate the greater part of the enactments relating to discrimination and harassment related to certain personal characteristics; to enable certain employers to be required to publish information about the differences in pay between male and female employees; to prohibit victimisation in certain circumstances; to require the exercise of certain functions to be with regard to the need to eliminate discrimination and other prohibited conduct; to enable duties to be imposed in relation to the exercise of public procurement functions; to increase equality of opportunity; to amend the law relating to rights and responsibilities in family relationships; and for connected purposes.

Health and Social Care Act 2012

An Act to establish and make provision about a National Health Service Commissioning Board and clinical commissioning groups and to make other provision about the National Health Service in England; to make provision about public health in the United Kingdom; to make provision about regulating health and adult social care services; to make provision about regulating health and social care workers; to make provision about public involvement in health and social care matters, scrutiny of health matters by local authorities and co-operation of health care services; to make other provision about information relating to health or social care to make other provision about health care; and for connected purposes.

Mental Capacity Act 2005

An Act to make new provision relating to persons who lack capacity; to establish a superior court of record called the Court of Protection in place of the office of the Supreme Court called by that name; to make provision in connection with the Convention on the International Protection of Adults signed at the Hague on 13th January 2000; and for connected purposes.

Mental Health Act 1983 as amended 2007

An Act to consolidate the law relating to mentally disordered persons. The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

Offender Rehabilitation Act 2014

An Act to make provision about the release, and supervision after release, of offenders; to make provision about the extension period for extended sentence prisoners; to make provision about community orders and suspended sentence orders; and for connected purposes.

Official Secrets Act 1989

An Act to replace section 2 of the Official Secrets Act 1911 by provisions protecting more limited classes of official information.

Regulation of Investigatory Powers Act (RIPA) 2000/Investigatory Powers Act 2016

An Act to make provision for and about the interception of communications, the acquisitions and disclosure of data relating to communications, the carrying out of surveillance, the use of human intelligence sources and acquisitions of the means by which electronic data protected by encryption or passwords may be decrypted or accessed; equipment interference, bulk personal datasets and other information; to make provision about the treatment of material held as a result of such interception, equipment interference or acquisition or retention; to establish the Investigatory Powers Commissioner and other Judicial Commissioners and make provision about them and other oversight arrangements; to make further provision about investigatory powers and national security; to amend sections 3 and 5 of the Intelligence Services Act 1994.

Safeguarding Vulnerable Groups Act 2006

An Act to make provision in connection with the protection of children and vulnerable adults. Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.

Northern Ireland

Children Act 1989 – NI has a Criminal Justice Children's Order 1998

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Criminal Justice (Northern Ireland) Act 2013

An Act to amend the law relating to sex offender notification, sexual offences prevention orders and human trafficking; to provide for the destruction, retention, use and other regulation of certain fingerprints and DNA samples and profiles; to provide for the release on license of persons detained under Article 45(2) of the Criminal Justice (Children) (Northern Ireland) Order 1998.

Criminal Justice (Northern Ireland) Order 2008 and Public Protection Arrangements in Northern Ireland (PPANI)

The Criminal Justice (NI) Order 2008 introduced a new sentencing framework, including extended and indeterminate sentences for public protection to reduce the risk of dangerous sexual and violent offenders being released into the community until the risk they pose is considered by the parole commissioners to be at a manageable level. The Public Protection Arrangements in Northern Ireland (PPANI) contained within the Criminal Justice (NI) Order 2008, place a duty on a number of agencies, within the criminal justice sector and elsewhere, to cooperate in the interest of better assessment and management of risk posed by serious sexual and violent offenders.

Justice Act (Northern Ireland) 2015

An Act to provide for a single jurisdiction for county courts and magistrates' courts; to amend the law on committal for trial; to provide for prosecutorial fines; to make provision in relation to victims and witnesses in criminal proceedings and investigations; to amend the law on criminal records and live links; to provide for violent offences prevention orders; to make other amendments relating to the administration of civil and criminal justice; and for connected purposes.

Mental Capacity Act (Northern Ireland) 2016

This Act fused mental health and mental capacity law into a single piece of legislation. The Act provides a framework for broader decision-making which includes: a statutory presumption of capacity, a requirement to support decision-making, mechanisms to allow individuals to plan for times that they do not have capacity, and safeguards to protect the rights of individuals when compulsory interventions or substitute decisions are required. It will remove the ability for someone to be treated for a mental health condition against his or her wishes if he or she retains the capacity to refuse such treatment, thus putting it on a par with the rights that individuals currently enjoy to make decisions regarding physical health treatment.

The Parole Commissioners' Rules (Northern Ireland) 2009

The Parole Commissioners for Northern Ireland are an independent body responsible for making decisions on the release and recall of prisoners sentenced to life, indeterminate custodial sentences, and extended custodial sentences, as well as the recall of prisoners serving determinate sentences.

The Sexual Offences (Northern Ireland) Order 2008

The Sexual Offences (Northern Ireland) Order 2008 lowered the age of sexual consent from 17 to 16 and incorporated significant changes to the law in relation to sexual offences in Northern Ireland; better protection for young people and people with a mental disorder from sexual abuse and exploitation; and sought to clarify issues surrounding consent in sexual assault cases and rape.

Scotland

Adoption and Children (Scotland) Act 2007

An Act of the Scottish Parliament to restate and amend the law relating to adoption; to make other provision in relation to the care of children; to enable provision to be made in relation to allowances in respect of certain children; and for connected purposes.

Adults with Incapacity (Scotland) Act 2000

An Act of the Scottish Parliament to make provision as to the property, financial affairs and personal welfare of adults who are incapable by reason of mental disorder or inability to communicate; and for connected purposes.

Adult Support and Protection (Scotland) Act 2007

An Act of the Scottish Parliament to make provision for the purposes of protecting adults from harm; to require the establishment of committees with functions relating to the safeguarding of adults who are at risk of harm; to amend the law relating to incapable adults; to allow the Public Guardian to intervene in court proceedings; to amend the law relating to mentally disordered persons; and for connected purposes

Children (Scotland) Act 1995

An Act to reform the law of Scotland relating to children, to the adoption of children and to young persons who as children have been looked after by a local authority; to make new provision as respects the relationship between parent and child and guardian and child in the law of Scotland; to make provision as respects residential establishments for children and certain other residential establishments; and for connected purposes.

Children and Young People (Scotland) Act 2014

An Act of the Scottish Parliament to make provision about the rights of children and young people; to make provision about investigations by the Commissioner for Children and Young People in Scotland; to make provision for and about the provision of services and support for or in relation to children and young people; to make provision for an adoption register; to make provision about children's hearings, detention in secure accommodation and consultation on certain proposals in relation to schools; and for connected purposes.

Mental Health (Scotland) Act 2015

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

Mental Health (Care and Treatment) (Scotland) Act 2003

An Act of the Scottish Parliament to restate and amend the law relating to mentally disordered persons; and for connected purposes.

Protection from Abuse (Scotland) Act 2001

An Act of the Scottish Parliament to enable a power of arrest to be attached to interdicts

granted to protect individuals from abuse; to regulate the consequences of such attachment; and for connected purposes.

Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005

An Act of the Scottish Parliament to make it an offence to meet a child following certain preliminary contact and to make other provision for the purposes of protecting children from harm of a sexual nature, including provision for implementing in part Council Framework Decision 2004/68/JHA; and to make further provision about the prevention of sexual offences.

Protection of Vulnerable Groups (Scotland) Act 2007

An Act of the Scottish Parliament to bar certain individuals from working with children or certain adults; to require the Scottish Ministers to keep lists of those individuals; to make further provision in relation to those lists; to establish a scheme under which information about individuals working or seeking to work with children or certain adults is collated and disclosed; to amend Part 5 of the Police Act 1997; to amend the meaning of school care accommodation service in the Regulation of Care (Scotland) Act 2001; and for connected purposes

Public Bodies (Joint Working) (Scotland) Act 2014

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

Regulation of Care (Scotland) Act 2001

An Act of the Scottish Parliament to establish the Scottish Commission for the Regulation of Care and the Scottish Social Services Council; to make provision for the registration and regulation of care services and for the registration, regulation and training of social service workers; to enable local authorities to provide and maintain residential accommodation in which nursing is provided; to make further provision as respects persons who have been looked after by local authorities; to amend the definition of 'place of safety' in the Children (Scotland) Act 1995.

Smoking, Health and Social Care (Scotland) Act 2005

To amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council, the provision of information to the Council and the minimum frequency of inspection of care services by the Commission to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to amend the Public Health (Scotland) Act 1897 to introduce a right of appeal in certain cases under that Act; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland

Social Care (Self-directed Support) (Scotland) Act 2013

An Act of the Scottish Parliament to enable local authorities to provide support to certain carers; to make provision about the way in which certain social care services are provided by local authorities; and for connected purposes.

Vulnerable Witnesses (Scotland) Act 2004

An Act of the Scottish Parliament to make provision for the use of special measures for the purpose of taking the evidence of children and other vulnerable witnesses in criminal or civil proceedings; to make provision about the admissibility of expert psychological or psychiatric evidence as to subsequent behaviour of the complainer in criminal proceedings in respect of certain offences to make provision about the admissibility of certain evidence bearing on the character, conduct or condition of witnesses in proceedings before a sheriff relating to the establishment of grounds of referral to children's hearings; to abolish the competence test for witnesses in criminal and civil proceedings; and for connected purposes.

Wales

The Mental Health (Wales) Measure 2010

This measure places new legal duties on local health boards and local authorities in Wales in relation to the assessment and treatment of mental health problems. The Measure became law in December 2010 and there are 4 parts to it which are as follows:

- Part 1 ensures that there are more mental health services are available within primary care.
- Part 2 makes sure all patients in secondary services have a Care and Treatment plan.
- Part 3 enables all adults discharged from secondary services to refer themselves back to those services.
- Part 4 supports every in-patient to have help from an independent mental health advocate if wanted.

Social Services and Well-being (Wales) Act 2014

An Act of the National Assembly for Wales to reform social services law; to make provision about improving the wellbeing outcomes for people who need care and support and carers who need support; to make provision about co-operation and partnership by public authorities with a view to improving the wellbeing of people; to make provision about complaints relating to social care and palliative care; and for connected purposes.

Violence against women, Domestic Abuse and Sexual Violence (Wales) Act 2015

An Act of the National Assembly for Wales to improve arrangements for the prevention of gender-based violence, domestic abuse and sexual violence; to improve arrangements for the protection of victims of such abuse and violence; to improve support for people affected by such abuse and violence; and to require the appointment of a National Adviser on gender-based violence, domestic abuse and sexual violence.

Well-being of Future Generations (Wales) Act 2015

An Act of the National Assembly for Wales to make provision requiring public bodies to do things in pursuit of the economic, social, environmental and cultural wellbeing of Wales in

a way that accords with the sustainable development principle; to require public bodies to report on such action; to establish a Commissioner for Future Generations to advise and assist public bodies in doing things in accordance with this Act; to establish public services boards in local authority areas; to make provision requiring those boards to plan and take action in pursuit of economic, social, environmental and cultural wellbeing in their area; and for connected purposes.

Appendix 2 – Websites and further information

British Psychological Society – www.bps.org.uk

The Society website has guidance, advice and further information on many topics not covered in these guidelines as well as those mentioned.

Psychologists working in clinical fields will also need to take account of Clinical Guidelines produced by NICE in England and Wales https://www.nice.org.uk/ or SIGN in Scotland http://www.sign.ac.uk/

1.1 Legal and professional obligations of psychologists

HCPC – http://hcpc-uk.org
The Health and Care Professions Council website has lots of information about professional registration including the standards of proficiency for the seven protected titles and information about indemnity insurance

Information Commissioner's Office – https://ico.org.uk/
The ICO website contains lots of useful information for organisations, private practitioners and the public regarding the rights and responsibilities under the data protection and Freedom of Information Acts.

DBS Checks – https://www.gov.uk/disclosure-barring-service-check
The government website provides helpful information for employers regarding these checks.

1.2 Continuing professional development

The HCPC has provided guidance regarding CPD for registrants. http://www.hcpc-uk.org/cpd

2.1 Working environment

Lone Working

Suzy Lamplugh Trust – http://www.suzylamplugh.org/

The Suzy Lamplugh Trust campaigns for personal safety and has lots of advice for people working alone to help to keep safe. They have some good advices and resources available.

Harassment and Bullying

ACAS – http://www.acas.org.uk/
The Advisory, Conciliation and Arbitration Service (ACAS) is a statutory organisation providing help and advice for employers and employees. They have produced guidance on several topics including harassment and bullying aimed separately at employers and employees.

Whistleblowing

Whistleblowing for employees – https://www.gov.uk/whistleblowing

The government has produced some guidance for employees surrounding whistleblowing including what to do and what to expect.

2.2 Working in the digital age

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – http://www.hhs.gov/hipaa/

This American act makes provisions for health information privacy. The government website provides information for professionals regarding this act.

N.B This Act is ONLY law for practice in America.

Social Media

The HCPC has provided guidance regarding the use of social media by professional psychologists.

http://www.hcpc-uk.org/Assets/documents/100035B7Social_media_guidance.pdf

3. Safeguarding

Statutory guidance Working together to safeguard children – https://www.gov.uk/government/publications/working-together-to-safeguard-children–2
Statutory guidance on inter-agency working to safeguard and promote the welfare of children.

Getting it Right for Every Child (GIRFEC) and the Early Years Framework – http://www.maternal-and-early-years.org.uk/getting-it-right-for-every-child-principles-and-values
This is an NHS Scotland approach which establishes the principle of giving all children and young people the best possible start in life as a priority for all services.

UK Government Guidance – https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care
No Secrets sets out a code of practice for the protection of vulnerable adults.

It explains how commissioners and providers of health and social care services should work together to produce and implement local policies and procedures. They should collaborate with the public, voluntary and private sectors and they should also consult clients, their carers and representative groups. Local authority social services departments should co-ordinate the development of policies and procedures.

Protection of vulnerable adults scheme (POVA) – http://www.scie.org.uk/publications/guides/guide03/law/adults.asp
Individuals should be referred to, and included on, the POVA list if they have abused, neglected or otherwise harmed vulnerable adults in their care or placed vulnerable adults

in their care at risk of harm. By making statutory checks against the list, providers of care must ensure they do not offer such individuals employment in care positions. POVA checks are requested as part of disclosures from the Criminal Records Bureau.

Prevention and Protection in Partnership 2015 – https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf

This policy from Northern Ireland is for all organisations working with, or providing services to, adults across the statutory, voluntary, community, independent and faith sectors. It sets clear and proportionate safeguarding expectations across the range of organisations.

Modern Slavery and the national referral mechanism (NRM) – https://www.gov.uk/government/collections/modern-slavery
These pages provide details about the government's work to end modern slavery, including details about how to refer victims into the NRM.

Let's talk about it – http://www.ltai.info/about/
Let's Talk About It is an initiative designed to provide practical help and guidance to the public in order to stop people becoming terrorists or supporting terrorism.

4. Managing data and confidentiality

Information Commissioners Office – https://ico.org.uk/
The Information Commissioners Office produces guidance with regards to data sharing and the Data protection and Freedom of information Acts.

HCPC guidance on confidentiality – http://www.hcpc-uk.co.uk/assets/documents/100023F1GuidanceonconfidentialityFINAL.pdf
The HCPC has provided guidance on confidentiality for registrants.

NHS – https://digital.nhs.uk/article/402/Information-Governance
The NHS has produced guidance regarding Information Governance and security for NHS and partner organisations. The NHS has codes of practice for Records management and Confidentiality.

Caldicott Report – https://www.gov.uk/government/publications/the-information-governance-review
A review was commissioned in 1997 by the Chief Medical Officer of England owing to increasing concern about the ways in which patient information is being used in the NHS in England and Wales and the need to ensure that confidentiality is not undermined. Such concern was largely due to the development of information technology in the service, and its capacity to disseminate information about patients rapidly and extensively. A committee was established under the chairmanship of Dame Fiona Caldicott. The Caldicott Report highlighted six key principles, and made 16 specific recommendations. In 2012 Dame Caldicott produced a follow up report which made 26 further recommendations including the addition of a seventh principle.

Psychological Testing Centre – http://ptc.bps.org.uk/ptc/guidelines-and-information

The PTC website contains lots of guidance about psychometric testing and the management of data generated from those tests.

5. Transparency and duty of candour

Care Quality Commission – http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
The CQC has produced Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare with regards to duty of candour.

Appendix 3 – How this document has been developed

In developing these guidelines, the overall aim and scope of the guidelines was considered at length, and the decision arrived at that they should be applicable to all psychologists irrespective of registration status or practice context. The guidelines have therefore been written in a way which it is hoped is inclusive of the various contexts of practice. Drawing on a broad stakeholder group for the development work, the guidelines aim to cover all the important considerations for practice. It is however recognised they cannot cover every circumstance and also that new issues arise which will require careful consideration by the individual psychologist.

The Practice Guidelines development Working Group was constituted to include all of the member networks of the Society whose members engage in practice, including the HCPC registered practitioners. It included representatives of the Society's national branches in Scotland, Wales and Northern Ireland, in order to ensure applicability to the different national contexts. It also included representation from the expert working groups of the Society's Professional Practice Board and others on specialist topics of practice.

The content of the guidelines has been developed from a combination of revision of the previous edition in the light of professional consensus on current expectations of a good standard of practice of psychology; inclusion of key points from other Society guidance on specific topics with reference to further guidance; and in some cases development of new material drawing on the professional experience of our members or outside professionals in the field. The working group has not used systematic methods to search for or assess the evidence for the material included. Recommendations have been included based on working group consensus. Where there are known areas of professional difference of opinion this has been stated.

A draft of the guidelines was circulated for Society wide consultation and one month allowed for comment. This included circulation to Experts by Experience (psychology service user representatives) with whom the Society works in various contexts. The Guidelines were also sent for comment to the Health and Care Professions Council as the statutory regulator for practitioner psychologists. Comments received were considered carefully by the Working Group and changes made to the text of the guidelines where considered necessary. The annotated audit sheet of the comments received and disposal was provided to a meeting of the Society's Professional Practice Board to assist its consideration of the draft guidelines, by way of final peer scrutiny. The guidelines were reviewed by the Society's legal advisers prior to publication. Final approval of the guidelines was given by the Society's Board of Trustees.

The guidelines will be reviewed and updated in accordance with Society policy after five years or sooner if circumstances indicate this is needed.

To ensure clarity and presentation in a user friendly format, the Guidelines have been edited by professional staff within the Society and the format designed by the Society's Preparation for Print specialists. Where considered helpful, links have been made to

additional web based resources, both to assist practitioner development and to provide up to date information in areas where there is frequent change. Organisational providers of psychological services are encouraged to review how these guidelines are used in practice and feed back to the Society any barriers to application.

In ensuring an appropriate level of independence in the production of these Guidelines, the Society has ensured its conflict of interest policy has been complied with and that no member of the working group's input has been compromised by a conflict of interest. No member has received any form of remuneration other than reimbursement of travel and subsistence expenses in accordance with Society policy. The large size of the working group and peer scrutiny and challenge, as well as the robust consultation process, guards against the potential for any one member or small group of members inappropriately to bias the Guidelines.

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel: 0116 254 9568 Fax 0116 247 0787 E-mail: mail@bps.org.uk Website: www.bps.org.uk

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Principles of recovery oriented mental health practice

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.

> *It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment and connection—and external conditions that facilitate recovery—implementation of human rights, a positive culture of healing, and recovery-oriented services. (Jacobson and Greenley, 2001 p. 482)*

The purpose of principles of recovery oriented mental health practice is to ensure that mental health services are being delivered in a way that supports the recovery of mental health consumers.

1. UNIQUENESS OF THE INDIVIDUAL

Recovery oriented mental health practice:

- recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community
- accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life
- empowers individuals so they recognise that they are at the centre of the care they receive.

2. REAL CHOICES

Recovery oriented mental health practice:

- supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored
- supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time
- ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.

3. ATTITUDES AND RIGHTS

Recovery oriented mental health practice:

- involves listening to, learning from and acting upon communications from the individual and their carers about what is important to each individual
- promotes and protects individual's legal, citizenship and human rights
- supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual
- instils hope in an individual's future and ability to live a meaningful life.

4. DIGNITY AND RESPECT

Recovery oriented mental health practice:

- consists of being courteous, respectful and honest in all interactions
- involves sensitivity and respect for each individual, particularly for their values, beliefs and culture
- challenges discrimination and stigma wherever it exists within our own services or the broader community.

5. PARTNERSHIP AND COMMUNICATION

Recovery oriented mental health practice:

- acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them
- values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement
- involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

6. EVALUATING RECOVERY

Recovery oriented mental health practice:

- ensures and enables continuous evaluation of recovery based practice at several levels
- individuals and their carers can track their own progress
- services demonstrate that they use the individual's experiences of care to inform quality improvement activities
- the mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships as well as health and well being measures.

These Recovery Principles have been adapted from the Hertfordshire Partnership NHS Foundation Trust Recovery Principles in the UK.

SPECIAL ARTICLE

How important are the common factors in psychotherapy? An update

Bruce E. Wampold

Department of Counseling Psychology, University of Wisconsin, Madison, WI, USA; Modum Bad Psychiatric Center, Vikersund, Norway

The common factors have a long history in the field of psychotherapy theory, research and practice. To understand the evidence supporting them as important therapeutic elements, the contextual model of psychotherapy is outlined. Then the evidence, primarily from meta-analyses, is presented for particular common factors, including alliance, empathy, expectations, cultural adaptation, and therapist differences. Then the evidence for four factors related to specificity, including treatment differences, specific ingredients, adherence, and competence, is presented. The evidence supports the conclusion that the common factors are important for producing the benefits of psychotherapy.

Key words: Common factors, contextual model, psychotherapy, alliance, empathy, expectations, cultural adaptation, therapist differences, specific ingredients

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The so-called common factors have a long history in psychiatry, originating with a seminal article by S. Rosenzweig in 1936 (1) and popularized by J. Frank in the various editions of his book *Persuasion and Healing* (2-4). During this period, the common factors have been both embraced and dismissed, creating some tension (5-9). The purpose of this paper is not to review or discuss the debate, but to provide an update, summarizing the evidence related to these factors.

To understand the evidence for the common factors, it is important to keep in mind that these factors are more than a set of therapeutic elements that are common to all or most psychotherapies. They collectively shape a theoretical model about the mechanisms of change in psychotherapy.

A particular common factor model, called the contextual model, has been recently proposed (8,10). Although there are other common factor models (e.g., 4,11), based on different theoretical propositions, the predictions made about the importance of various common factors are similar and the choice of the model does not affect conclusions about the impact of these factors. The contextual model is presented below, followed by a review of the evidence for the common factors imbedded in the model.

THE CONTEXTUAL MODEL

The contextual model posits that there are three pathways through which psychotherapy produces benefits. That is, psychotherapy does not have a unitary influence on patients, but rather works through various mechanisms. The mechanisms underlying the three pathways entail evolved characteristics of humans as the ultimate social species; as such, psychotherapy is a special case of a social healing practice.

Thus, the contextual model provides an alternative explanation for the benefits of psychotherapy to ones that emphasize specific ingredients that are purportedly beneficial for particular disorders due to remediation of an identifiable deficit (8).

The three pathways of the contextual model involve: a) the real relationship, b) the creation of expectations through explanation of disorder and the treatment involved, and c) the enactment of health promoting actions. Before these pathways can be activated, an initial therapeutic relationship must be established.

Initial therapeutic relationship

Before the work of therapy can begin, an initial bond between therapist and patient needs to be created. E. Bordin stated in 1979 that "some basic level of trust surely marks all varieties of therapeutic relationships, but when attention is directed toward the more protected recesses of inner experience, deeper bonds of trust and attachment are required and developed" (12, p. 254). The initial meeting of patient and therapist is essentially the meeting of two strangers, with the patient making a determination of whether the therapist is trustworthy, has the necessary expertise, and will take the time and effort to understand both the problem and the context in which the patient and the problem are situated.

The formation of the initial bond is a combination of bottom-up and top-down processing. Humans make very rapid determination (within 100 ms), based on viewing the face of another human, of whether the other person is trustworthy or not (13), suggesting that patients make very rapid judgments about whether they can trust their therapist. More than likely, patients make rapid judgments about the dress of the therapist, the arrangement and decorations of the room (e.g., diplomas on the wall), and other features of the therapeutic setting (14). However, patients come to therapy with expectations about the nature of psychotherapy as

well, due to prior experiences, recommendations of intimate or influential others, cultural beliefs, and so forth. The initial interaction between patient and therapist is critical, it seems, because more patients prematurely terminate from therapy after the first session than at any other point (15).

Pathway 1: The real relationship

The real relationship, defined psychodynamically, is "the personal relationship between therapist and patient marked by the extent to which each is genuine with the other and perceives/experiences the other in ways that befit the other" (16, p. 119). Although the psychotherapeutic relationship is influenced by general social processes, it is an unusual social relationship in that: a) the interaction is confidential, with some statutory limits (e.g., child abuse reporting), and b) disclosure of difficult material (e.g., of infidelity to a spouse, of shameful affect, and so forth) does not disrupt the social bond. Indeed, in psychotherapy, the patient is able to talk about difficult material without the threat that the therapist will terminate the relationship.

The importance of human connection has been discussed for decades, whether is it called attachment (17), belongingness (18), social support (19), or the lack of loneliness (20,21). In fact, perceived loneliness is a significant risk factor for mortality, equal to or exceeding smoking, obesity, not exercising (for those with chronic cardiac disease or for healthy individuals), environmental pollution, or excessive drinking (22-24). Psychotherapy provides the patient a human connection with an empathic and caring individual, which should be health promoting, especially for patients who have impoverished or chaotic social relations.

Pathway 2: Expectations

Research in a number of areas documents that expectations have a strong influence on experience (25). Indeed, the purported price of a bottle of wine influences rating of pleasantness as well as neural representations (26). The burgeoning research on the effects of placebos documents the importance of expectations, as placebos have robustly shown to alter reported experience as well as demonstrating physiological and neural mechanisms (27,28).

Expectations in psychotherapy work in several possible ways. Frank (4) discussed how patients present to psychotherapy demoralized not only because of their distress, but also because they have attempted many times and in many ways to overcome their problems, always unsuccessfully. Participating in psychotherapy appears to be a form of remoralization.

However, therapy has more specific effects on expectations than simple remoralization. According to the contextual model, patients come to therapy with an explanation for their distress, formed from their own psychological beliefs, which is sometimes called "folk psychology" (29-31). These beliefs, which are influenced by cultural conceptualizations of mental disorder but also are idiosyncratic, are typically not adaptive, in the sense that they do not allow for solutions. Psychotherapy provides an explanation for the patient's difficulties that is adaptive, in the sense that it provides a means to overcome or cope with the difficulties. The patient comes to believe that participating in and successfully completing the tasks of therapy, whatever they may be, will be helpful in coping with his or her problems, which then furthers for the patient the expectation that he or she has ability to enact what is needed. The belief that one can do what is necessary to solve his or her problem has been discussed in various ways, including discussions of mastery (4,32), self-efficacy (33), or response expectancies (25).

Critical to the expectation pathway is that patients believe that the explanation provided and the concomitant treatment actions will be remedial for their problems. Consequently, the patient and therapist will need to be in agreement about the goals of therapy as well as the tasks, which are two critical components of the therapeutic alliance (34,35). Hatcher and Barends described the alliance as "the degree to which the therapy dyad is engaged in collaborative, purposive work" (36, p. 293). Creating expectations in psychotherapy depends on a cogent theoretical explanation, which is provided to the patient and which is accepted by the patient, as well as on therapeutic activities that are consistent with the explanation, and that the patient believes will lead to control over his or her problems. A strong alliance indicates that the patient accepts the treatment and is working together with the therapist, creating confidence in the patient that the treatment will be successful.

Pathway 3: Specific ingredients

The contextual model stipulates that there exists a treatment, particularly one that the patient finds acceptable and that he or she thinks will be remedial for his or her problems, creating the necessary expectations that the patient will experience less distress. Every treatment that meets the conditions of the contextual model will have specific ingredients, that is, each cogent treatment contains certain well-specified therapeutic actions.

The question is how the specific ingredients work to produce the benefits of psychotherapy. Advocates of specific treatments argue that these ingredients are needed to remediate a particular psychological deficit. The contextual model posits that the specific ingredients not only create expectations (pathway 2), but universally produce some salubrious actions. That is, the therapist induces the patient to enact some healthy actions, whether that may be thinking about the world in less maladaptive ways and relying less on dysfunctional schemas (cognitive-behavioral treatments), improving interpersonal relations (interpersonal psychotherapy and some dynamic therapies), being more accepting

of one's self (self-compassion therapies, acceptance and commitment therapy), expressing difficult emotions (emotion-focused and dynamic therapies), taking the perspective of others (mentalization therapies), and so forth. The effect of lifestyle variables on mental health has been understated (37). A strong alliance is necessary for the third pathway as well as the second, as without a strong collaborative work, particularly agreement about the tasks of therapy, the patient will not likely enact the healthy actions.

According to the contextual model, if the treatment elicits healthy patient actions, it will be effective, whereas proponents of specific ingredients as remedial for psychological deficits predict that some treatments – those with the most potent specific ingredients – will be more effective than others (8).

EVIDENCE FOR VARIOUS COMMON FACTORS

Now that the contextual model has been briefly presented, attention is turned toward an update of the evidence for the common factors. Each factor reviewed is imbedded in the contextual model, although each of them is more generically considered atheoretically as an important one. As will be apparent, many of the common factors are not theoretically or empirically distinct.

To present the evidence succinctly and with as little bias and error as possible, we rely on meta-analyses of primary studies. Studies that examine the association of levels of a common factor and outcome are typically reported by some type of correlation statistic (such as Pearson's product-moment correlation), whereas studies that experimentally manipulate and compare conditions typically report some standardized mean difference (such as Cohen's d). For comparison purposes, correlational statistics are converted to Cohen's d. All meta-analyses reported aggregate statistics, corrected for bias, based on the effects of individual studies appropriated weighted. To understand the importance of effects, Cohen (38) classified a d of 0.2 as small, 0.5 as medium, and 0.8 as large. The evidence is summarized in Figure 1, where the effects of various common factors are compared to those of various specific factors.

Alliance

The alliance is composed of three components: the bond, the agreement about the goals of therapy, and the agreement about the tasks of therapy (12). As discussed above, alliance is a critical common factor, instrumental in both pathway 2 and pathway 3.

Alliance is the most researched common factor. Typically the alliance is measured early in therapy (at session 3 or 4) and correlated with final outcome. The most recent meta-analysis of the alliance included nearly 200 studies involving over 14,000 patients and found that the aggregate correlation between alliance and outcome was about .27, which is equivalent to a Cohen's d of 0.57 (39), surpassing the threshold for a medium sized effect.

There have been a number of criticisms of the conclusion that alliance is an important factor in psychotherapy (40), most of which have focused on the correlational nature of alliance research. However, each of the criticisms has been considered and has been found not to attenuate the importance of the alliance (see 8).

First, it could well be that early symptom relief causes a strong alliance at the third or fourth session – that is, early responders report better alliances and have better outcomes. To address this threat, early therapy progress must be statistically controlled or longitudinal research is needed to examine the association of alliance and symptoms over the course of therapy. The studies that have examined this question have found evidence to support either interpretation, but the better designed and more sophisticated studies are converging on the conclusion that the alliance predicts future change in symptoms after controlling for already occurring change.

Second, it could be that the correlation between alliance and outcome is due to the patients' contributions to the alliance. According to this line of thinking, some patients may come to therapy well prepared to form a strong alliance and it is these patients who also have a better prognosis, so the alliance-outcome association is due to the characteristics of the patients rather than to something that therapists provide to the patients. Disentangling the patient and therapist contributions involves the use of multilevel modeling. Recently, Baldwin et al (41) performed such an analysis and found that it was the therapist contribution which was important: more effective therapists were able to form a strong alliance across a range of patients. Patients' contribution did not predict outcome: patients who are able to form better alliances, perhaps because they have secure attachment histories, do not have better prognoses. Indeed, patients with poor attachment histories and chaotic interpersonal relationships may well benefit from a therapist who is able to form alliances with difficult patients. These results have been corroborated by meta-analyses (42).

Third, there may be a halo effect if the patient rates both the alliance and the outcome. However, meta-analyses have shown that the alliance-outcome association is robust even when alliance and outcome are rated by different people. It also appears that the alliance is equally strong for cognitive-behavioral therapies as it is for experiential or dynamic treatments, whether a manual is used to guide treatment or not, and whether the outcomes are targeted symptoms or more global measures.

There are other threats to validity of the alliance as a potent therapeutic factor, but the evidence for each of them is nonexistent or weak (8). The research evidence, by and large, supports the importance of the alliance as an important aspect of psychotherapy, as predicted by the contextual model.

As mentioned above, distinctions between certain common factors are difficult to make. A distinction has been

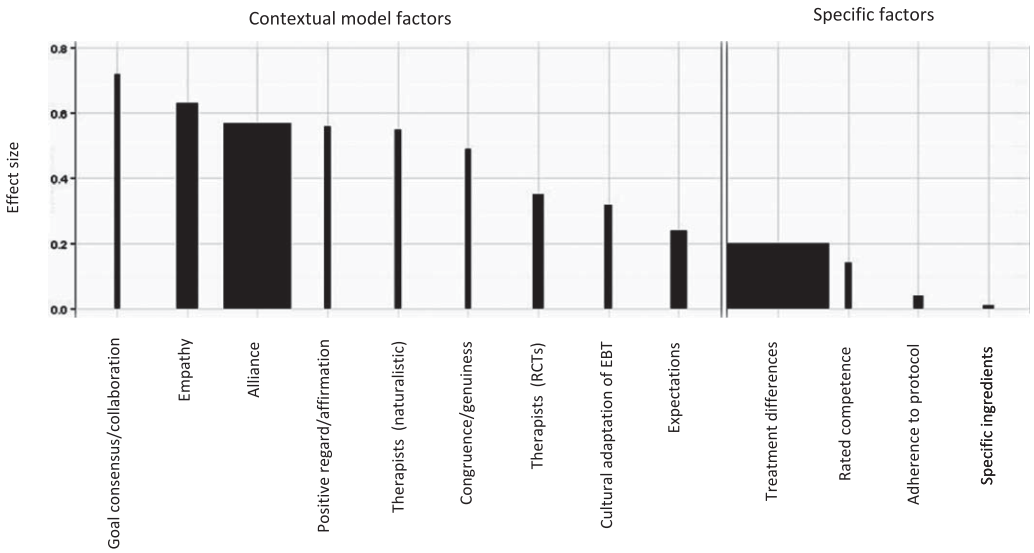

Figure 1 Effect sizes for common factors of the contextual model and specific factors. Width of bars is proportional to number of studies on which effect is based. RCTs – randomized controlled trials, EBT – evidence-based treatments

made between the bond, as defined as a component of the alliance, which is related to purposeful work, and the real relationship, which is focused on the transference-free genuine relationship (8,16). There is some evidence that the real relationship is related to outcome, after controlling for the alliance (16), and, although the evidence is not strong, it does support the first pathway of the contextual model.

A second construct related for the alliance is labeled goal consensus/collaboration. Although related to agreement about the goals and tasks for therapy, goal consensus/collaboration is measured with different instruments. As shown in Figure 1, the effect for goal consensus and collaboration is strong (d=0.72), based on a meta-analysis of 15 studies (43).

Empathy and related constructs

Empathy, a complex process by which an individual can be affected by and share the emotional state of another, assess the reasons for another's state, and identify with the other by adopting his or her perspective, is thought to be necessary for the cooperation, goal sharing, and regulation of social interaction. Such capacities are critical to infant and child rearing, as children, who are unable to care for themselves, signal to the caregiver that care is needed, a process that is then put to use to manage social relations among communities of adult individuals. Therapist expressed empathy is a primary common factor, critical to pathway 1 of the contextual model, but which also augments the effect of expectations.

The power of the empathy in healing was beautifully revealed in a study of placebo acupuncture for patients with irritable bowel syndrome (44). Patients with this syndrome were randomly assigned to a limited interaction condition, an augmented relationship condition, or treatment as usual (waiting list for acupuncture). In the limited interaction condition, the acupuncturist met with the patient briefly, but was not allowed to converse with him or her, and administered the sham acupuncture (a device that gives the sensation of having needles pierce the skin, but they do not). In the augmented relationship condition, the practitioner conversed with the patient about the symptoms, the relevance of lifestyle and relationships to irritable bowel syndrome, as well as the patient's understanding of the cause and meaning of her disorder. All this was done in a warm and friendly manner, using active listening, appropriate silences for reflection, and a communication of confidence and positive expectation. For the four dependent variables (global improvement, adequate relief, symptom severity, and quality of life), the two sham acupuncture conditions were superior to treatment as usual. However, the augmented relationship condition was superior to the limited interaction condition, particularly for quality of life.

The above study is noteworthy because it was an experimental demonstration of the importance of a warm, caring, empathic interaction within a healing setting. Unfortunately, experimental manipulation of empathy in psychotherapy studies is not possible, for design and ethical reasons. Nonetheless, there have been numerous studies (n=59) that have correlated ratings of therapist empathy with outcome, which have been meta-analytically summarized (45), resulting in a relatively large effect (d=0.63; see Figure 1). Constructs related to empathy have also been meta-analyzed and found to be related to outcome, including positive regard/affirmation (d=0.56, n=18; see Figure 1) (46) and congruence/genuineness (d=0.49, n=18; see Figure 1) (47).

It should be recognized that several of the threats to validity for the alliance are also present with regard to empathy. For example, it is clearly easier for a therapist to be warm and

caring toward a motivated, disclosing and cooperative patient than to one who is interpersonally aggressive, and the former types of patients will most likely have better outcomes than the latter, making the empathy/outcome correlation an artifact of patient characteristics rather than therapist action. Unfortunately, studies such as the ones conducted to rule out these threats to validity for the alliance have not been conducted for empathy and related constructs.

Expectations

Examining the role of expectations in psychotherapy is difficult. In medicine, expectations can be induced verbally and then physicochemical agents or procedures can be administered or not, making the two components (creation of expectations and the treatment) independent. In psychotherapy, creating the expectations, through explanation of the patient's disorder, presenting the rationale for the treatment, and participating in the therapeutic actions, is part of therapy. It is difficult to design experimental studies of expectations in psychotherapy (not impossible, but not yet accomplished in any important manner).

The typical way to assess the effect of expectations in psychotherapy is to correlate patient ratings of their expectations with outcomes, but we have seen that such correlational studies produce threats to validity. Furthermore, in many studies, expectations are measured *prior* to when the rationale for the treatment is provided to the patient, when it is the explanation given to the patient that is supposed to create the expectations. Assessing expectations after the explanation has been given (i.e., during the course of treatment) is also problematic, as those patients who have made significant progress in therapy will naturally respond that they think therapy will be helpful.

Despite the difficulties with investigating expectations in psychotherapy, this is a topic of much interest (48-50). Recently, a meta-analysis of expectations showed that there was a relatively small, but statistically significant, relationship between rated expectations and outcome ($d=0.24$, $n=46$; see Figure 1) (49). The best evidence for expectations in the context of healing is derived from studies of the placebo effect, where exquisite care has been taken to experimentally manipulate variables of interest and to control for threats to validity, by using physiological and neurological variables as well as subjective reports. A summary of this literature is beyond the scope of this article, but many excellent reviews are available (8,27,28).

Cultural adaptation of evidence-based treatments

The contextual model emphasizes that the explanation given for the patient's distress and the therapy actions must be acceptable to the patient. Acceptance is partly a function of consistency of the treatment with the patient's beliefs, particularly beliefs about the nature of mental illness and how to cope with the effects of the illness. This suggests that evidence-based treatments that are culturally adapted will be more effective for members of the cultural group for which the adapted treatment is designed. There are many ways to adapt treatments, including those involving language, cultural congruence of therapist and patient, cultural rituals, and explanations adapted to the "myth" of the group.

A recent meta-analysis demonstrated that adapting evidence-based treatments by using an explanation congruent with the cultural group's beliefs (i.e., using the cultural "myth" as the explanation) was more effective than unadapted evidence-based treatments, although the effect was modest ($d=0.32$, $n=21$; see Figure 1) (51).

Therapist effects

Therapist effects are said to exist if some therapists consistently achieve better outcomes with their patients than other therapists, regardless of the nature of the patients or the treatment delivered. Therapist effects have been studied in clinical trials and in naturalistic settings. In both designs, the measure of therapist effects is an intraclass correlation coefficient. Technically, this coefficient indexes the degree to which two patients from the same therapist have similar outcomes relative to two patients from two different therapists. To compare therapist effects to other common factors, the intraclass correlation coefficient is converted to Cohen's d.

The contextual model predicts that there will be differences among therapists *within* a treatment. That is, even though the therapists are delivering the same specific ingredients, some therapists will do so more skillfully and therefore achieve better outcomes than other therapists delivering the same treatment. Evidence for this conjecture is found in clinical trials. A meta-analysis of therapist effects in clinical trials found modest therapist effects ($d=0.35$, $n=29$; see Figure 1) (52). Keep in mind that the therapists in clinical trials generally are included because of their competence and then they are given extra training, supervised, and monitored. Moreover, the patients in such trials are homogeneous, as they have a designated diagnosis and are selected based on various inclusionary/exclusionary criteria. In such designs, patients are randomly assigned to therapists. Consequently, consistent differences among therapists in such trials, although modest, are instructive.

Not surprisingly, therapist effects in naturalistic settings are greater than in clinical trials. In the former settings, therapists are more heterogeneous, patients may not be randomly assigned to therapists, patients are heterogeneous, and so forth. A meta-analysis of therapist effects in such settings found a relatively large effect ($d=0.55$, $n=17$; see Figure 1) (52).

The finding of robust therapist effects raises the question about what are the characteristics or actions of more effective therapists. Recent research has begun to address this

question. Studies have shown that effective therapists (vis-à-vis less effective therapists) are able to form stronger alliances across a range of patients, have a greater level of facilitative interpersonal skills, express more professional self-doubt, and engage in more time outside of the actual therapy practicing various therapy skills (8).

SPECIFIC EFFECTS

Evidence for the common factors is also collected by examining the evidence for specific aspects of psychotherapy. The contextual model makes several predictions about specific effects, which will be discussed as each specific effect is considered.

Treatment differences

When pathway 3 of the contextual model was discussed earlier, it was emphasized that the model contends that all therapies with structure, given by empathic and caring therapists, and which facilitate the patient's engagement in behaviors that are salubrious, will have approximately equal effects. That is, the specific ingredients, discussed in pathway 3, are not critical because they remediate some psychological deficit.

The question of whether some treatments are superior to others has long been debated, with origins at the very beginning of the practice of psychotherapy (think about the disagreements amongst Freud, Adler and Jung, for example). Today, there are claims that some treatments, in general or for specific disorders, are more effective than others. Others, however, claim that there are no differences among psychotherapies, in terms of their outcomes.

The literature addressing this issue is immense and summarizing the results of relative efficacy is not possible. Nevertheless, the various meta-analyses for psychotherapies in general or for specific disorders, if they do find differences among various types of treatment, typically find at most differences of approximately d=0.20, the value shown in Figure 1.

Specific effects from dismantling studies

To many, the dismantling design is the most valid way to identify the effects of specific ingredients. In this design, a specific ingredient is removed from a treatment to determine how much more effective the treatment is in total compared to the treatment without the ingredient that is purportedly remedial for the psychological deficit.

Two meta-analyses have examined dismantling designs and both found minimal differences between the total treatment and the treatment without one or more critical ingredients (d=0.01, n=30, see Figure 1) (53,54). The most recent of these meta-analyses did find that adding an ingredient to an existing treatment increased the effect for targeted variables by a small amount (d=0.28) (53).

Adherence and competence

In clinical trials, it is required that adherence to the protocol and the competence at delivering the treatment are rated. This makes sense: if the goal is to make inferences about a particular treatment, then it is necessary to ensure that the treatment was delivered with the necessary components and not with extraneous components (i.e., with *adherence* to the protocol) and that the treatment components were delivered skillfully (i.e., given *competently*).

It would seem logical theoretically that adherence to the protocol and competence would be related to outcome. That is, for cases where the therapist followed the protocol and did so skillfully, there should be better outcomes. However, this is not the case. In a meta-analysis of adherence and competence (55), effects were small (d=0.04, n=28 for adherence; d=0.14, n=18 for competence; see Figure 1).

The results for adherence and competence demand further explanation. If the specific ingredients of a treatment are critical, then adherence should make a difference – actually delivering those ingredients should be related to outcome. There is evidence that rigid adherence to a protocol can attenuate the alliance and increase resistance to the treatment (i.e., failing to accept the treatment, a contextual model tenet) (8), and that flexibility in adherence is related to better outcomes (56), results consistent with prediction of the contextual model.

The findings for competence are a bit more difficult to understand. Competence in these trials typically is rated by experts in the treatment being given, based on watching therapy sessions. Why can't experts differentiate between "good" therapy and "bad" therapy? If this were indicative of experts' abilities to judge competence, then the notion of psychotherapy supervision would be turned upside down, because what is observed and evaluated would have no relation to outcomes – how could the supervisor then make a case for providing input to the supervisee? But the clue to the resolution of this mystery is found in the definition of competence. Most psychotherapy trials rate the competence *for a specific treatment*. That is, what is rated is the skill in providing the elements of the treatment protocol, rather than common factors, such as empathy, alliance, affirmation, and so forth – aspects of therapy that do predict outcome and seem to differentiate more effective therapists from less effective therapists.

CONCLUSIONS

Although the common factors have been discussed for almost a century, the focus of psychotherapy is typically on the development and dissemination of treatment models. If

not discounted, then the common factors are thought of as perhaps necessary, but clearly not sufficient. The evidence, however, strongly suggests that the common factors must be considered therapeutic and attention must be given to them, in terms of theory, research and practice.

One of the criticisms of the common factors is that they are an atheoretical collection of commonalities. In this paper, the contextual model was presented to convey a theoretical basis for these factors.

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REVIEW
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Trauma and Public Mental Health: A Focused Review

Rolf J. Kleber[1,2]*

[1] Utrecht University, Utrecht, Netherlands, [2] Arq Psychotrauma Expert Group, Diemen, Netherlands

Psychological trauma has developed into a very common concept in the scientific community, in mental health care, as well as in popular language and mass media. The purpose of this article is to show the relevance of the discipline of traumatic stress studies to the field of public mental health by examining central concepts and findings concerning trauma and its aftermath and examining implications for public mental health. Attention is paid to the diagnosis of posttraumatic stress disorder (PTSD) and the construct of resilience as well as to specific areas of public mental health activities. A public mental health perspective will help to develop preventive approaches to trauma and extend the impact of various forms of interventions. It will also make clear that trauma care will have to consider the community and the society at large.

Keywords: trauma, posttraumatic stress disorder, resilience, public mental health, war, disasters, violence

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Eva-Maria Pichler,
University of Zurich, Switzerland

***Correspondence:**
Rolf J. Kleber
r.kleber@uu.nl

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INTRODUCTION

Psychological trauma has developed into a very popular concept in the scientific community, in the world of mental health care, as well as in common language and mass media. The consequences of various shocking events—violence, disasters, acts of terrorism, accidents, and war—receive frequent and enduring attention. The number of scientific and clinical publications has increased enormously and in many media programs ample attention is paid to victims and others affected by these events. The purpose of this article is to show the relevance of the discipline of traumatic stress studies to the field of public mental health by examining central concepts and findings concerning trauma and its aftermath and examining implications for public mental health.

WHAT IS A TRAUMATIC EVENT?

Traumatic events involve the confrontation with war, violence, disasters, sudden loss, serious illness, and other overwhelming and disturbing events. According to the psychiatric classifications [of the *International Classification of Diseases* of the World Health Organization (ICD-11) and the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5)], a traumatic event is defined as the exposure to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (1, 2).

Phenomenologically such an event can be characterized by an extreme sense of powerlessness as well as a disruption of beliefs and expectations. The individual has lost control over the situation and is to a large extent a victim of the circumstances and/or other people (i.e. the perpetrator). In "Jenseits des Lustprinzips" (1920), Freud already posed: "the essence of a traumatic situation is an experience of helplessness that is brought about either externally or internally." At the same time, he or she is confronted with a shattering of basic assumptions. The self-evidence of one's life is gone. The sense of invulnerability,

the idea of the benevolence of the world, and the idea that other people can be trusted are devastated. The obvious certainties of life have disappeared. The images one holds of oneself and the environment no longer adequately fit the new situation. In the words of Janoff-Bulman (3), basic assumptions have been shattered.

Exposure to traumatic events is not rare, as has been consistently found in epidemiological studies. The World Mental Health Surveys of adults were carried out among nearly 70,000 participants from 24 countries ranging in economic status from low to high (4). These data showed that at some time in their life 70.4% of the respondents had experienced at least one type of a traumatic event. The specific rates were: 14% had experienced intimate partner or sexual violence, 34.3% accidents or injuries, 22.9% physical violence, 13.1% war-related events, 34.1% the unexpected or traumatic death of a loved one, and 35.7% experienced traumas that happened to loved ones (e.g., serious illness of a child). As Kessler et al. (4) stated, these findings make clear that it is rather normal to be exposed to a very upsetting event in one's lifetime.

RISE AND BLOOM OF THE CONCEPT OF POST-TRAUMATIC STRESS DISORDER

The concept of *posttraumatic stress disorder* (PTSD) is nowadays so much used that it dominates most thinking about the consequences of violence, disaster, and being a refugee. That development is quite unique as the attention for trauma was very meager just 40, 50 years ago. In the 1970s, the United States became increasingly confronted with the psychological and social difficulties of the nearly three million veterans who had fought in Vietnam. They suffered from nightmares, depression, relationship problems, et cetera. However, because of the ambivalent perspective on the Vietnam War, authorities and professionals were rather reluctant to acknowledge these difficulties, but the increasing concern led to the introduction of the term post-traumatic stress disorder in the anxiety disorders section of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) (5).

The diagnosis of PTSD is directly linked to experiencing or witnessing a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape, or other violent assault (criterion A). According to DSM-5 (1), PTSD consists of four categories of symptoms. Re-experiencing the traumatic event (criterion B) is manifested in symptoms such as intrusive memories, distressing dreams, flashbacks, or distress or physiological reactions upon exposure to cues of the trauma. The other categories are symptoms of avoidance of the reminders of the trauma (criterion C), alterations in memories or mood associated with the trauma (criterion D), and finally clear alterations in physiological arousal and reactivity [criterion E; see further Ref. (1)].

Recently a relatively different definition of PTSD has been introduced in the new version of the International Classification of Diseases of the World Health Organization (2018). It consists of three categories (reexperiencing, avoidance, hyperarousal) with only two core symptoms in each category. The definition may be more flexible to use (allowing for cultural variation and clinical judgment) but is less detailed and comprehensive. Empirical studies have found that prevalence rates may vary between the two classifications and there is often a lack of overlap (i.e., not the same individuals are classified as PTSD patients by the two classifications). This is a major concern for the field of traumatic stress studies. It is a challenge for future research to unravel the differences and to create order (6), as most research is conducted with the DSM definition while most countries in the world use instead ICD.

Prevalence figures for PTSD vary enormously, according to the nature of the events, various risk factors, the time of measurement, and the instruments used. In general, PTSD occurs more when an aggressor is involved (in the case interpersonal violence), for persistent and extended events (e.g., internment, sexual abuse) and for socially charged events (e.g., rape). Among Dutch veterans who were confronted with war violence during deployment in Iraq, the figures of current prevalence varied between 3 and 4% (7). Nine percent of American Vietnam veterans had current PTSD 20 years after the war (8). Figures on PTSD in studies of disasters (man-made, technological, as well as natural) varied mostly around 5% to 15% (9). The prevalence findings also fluctuated strongly in studies of sexual violence, although the rates are generally higher than after other events: between 3.7% and 65%. The already mentioned World Mental Health Surveys (4, 10) determined that intimate partner or sexual violence (such as rape) was a very frequent cause of PTSD. Nevertheless, the unexpected death of loved ones represented the most frequent cause of event-related psychopathology within the general population because of the high frequency with which people experience such a loss. About this last mentioned finding, it is relevant to remark that there is a close relationship between trauma and loss and consequently between PTSD and complicated grief, but they are not similar (11). The concepts of Persistent Complex Bereavement Disorder (1) and Prolonged Grief Disorder (2) as result of the death of a family member or a close friend are included in DSM-5 and ICD-11, respectively.

In a comprehensive and systematic analysis (12) prevalence rates of PTSD and depression were identified from 181 surveys comprising 81,866 refugees and other conflict-affected persons from 40 countries exposed to humanitarian emergencies. Again, rates of reported PTSD and depression showed large inter-survey variability. The prevalence estimates derived from the methodologically most robust surveys provided rates between 13% and 25% for PTSD, as assessed by Steel et al. (12). The risk of PTSD among refugees was increased by experiencing torture and sexual violence, having a higher age, being a woman, and through a long stay in different asylum seekers centers.

Despite the increased knowledge about PTSD and despite the positive results of therapeutic treatments for PTSD, there are various dilemmas and challenges. First, there is a large comorbidity, as most patients also suffer from depression, substance abuse, or other disorders (6). Furthermore, defining the borderline between normal and abnormal behavior after trauma is difficult. Moreover, although this is matter of heavy debate among researchers and clinicians, PTSD is sometimes an overstretched concept in the sense that normal responses to stressful life events are labelled as disorder. Difficulties of diverse groups—from refugees to veterans—are attributed too much or too easily to traumatic events and their resilience is underestimated (13).

IMPACT ON THE INDIVIDUAL

Regarding a public mental health perspective, it is highly relevant to understand that the majority of people exposed to serious live events does not develop disorders. However, this does not mean that they will not suffer from symptoms and difficulties. Most people will experience responses such as intrusions, nightmares, startle reactions, and numbness (14). Findings from large epidemiological studies of disaster victims have made this clear. In 2000 the Netherlands were confronted with a disastrous explosion of a fireworks container area in the middle of a neighborhood. A comprehensive and longitudinal study was conducted among the inhabitants. In the investigation of post-disaster reactions (15) it was found that most inhabitants suffered from various serious symptoms (especially depression, fears, re-experiences, physical symptoms) in the first 2 to 3 weeks after the explosion. At least 87% of the affected residents were highly affected in those first weeks after the disaster.

These responses can be considered functional and normal, as has been made clear in emotion theories (16). People are afraid that it will happen again. They do not feel safe anymore and are constantly alert for danger. They are angry because of the neglect of the responsible authorities or they feel rage in the direction of the perpetrator. They react easily irritated at remarks of other people. They blame themselves for being there at the moment of the disaster or having not done anything to prevent the situation. They feel despaired because of the death of loved ones and the loss of material goods. They have the impression that other people do not understand their distress and sorrow and feel estranged from others. Nevertheless, the intensity and frequency of these distressing and painful responses do not reach the level of disorder.

Although DSM-5 recognizes the possibility of the occurrence of Acute Stress Disorder (ASS) in the first days after an event, a diagnosis that overlaps with PTSD, this diagnosis is rarely used in clinical practice as well as research. Patients with ASS usually report numbness, problems with memory, sleep and concentration, irritability, fears, or anxiety and have frequent re-experiences of the event. The usefulness of acute stress disorder as a classification is controversial in the literature (17). The difference with normal reactions to a major life event and with PTSS, apart from the time criterion (ASS can only be used for disturbances in the first 4 weeks after the experience), is not yet confirmed adequately.

As mentioned above, the world does not make sense any more after such a traumatic experience. Already in the 1940s the psychiatrist and concentration camp survivor Victor Frankl stated that the search for meaning played a crucial role in adaptation to threatening events (18). Cognitive approaches to trauma (e.g., 19) state that successful processing of the traumatic experience takes place when new information (e.g., the implication of the traumatic experience) is assimilated into existing structures or models. Unsuccessful processing occurs when the trauma-related information is not integrated into existing beliefs concerning self-image and world views (20). In low control situations not amenable to direct repair or problem-solving, such as trauma, loss, and serious illness, meaning-making is often the most adaptive strategy. As Schok et al. (20) have argued, meaning can be created by answering the question why an event occurred and why it happened to the person. It can also be operationalized as considering the ways in which one's life changed because of the event and assessing the extent to which one has "made sense of" the experience. Research findings have indicated that these two processes of finding a cause for the extreme event and finding personal benefits in the traumatic experience play independent roles in adjustment after trauma (21, 22). Therefore, the attempt to find meaning discloses itself twofold: in searching for an answer to the question why it happened as well as in rethinking one's attitudes and priorities to restructure one's life along more satisfying lines (23).

IMPACT ON THE COMMUNITY

Violence, disasters, accidents, and war are also stressful events for the community. Consequently, the impact of traumatic events goes beyond those who are directly exposed to the event and affects close relationships, the social environment, and the society at large. A human being does not live in a vacuum. He or she is surrounded by others. And those others will be confronted with the traumatic event and its aftermath too. This holds true for an event that struck an individual, such as a rape. Others hear about the event, perceive the suffering of the victims, and must cope with the implications. Naturally, it holds also true for events that struck a large group of people. For instance, a disaster undermines the social fabric of a community. It can lead to dissolution of social networks and to forced or voluntary migration. Regarding the health care system, it can lead to a disruption of the provision of social services and an erosion of the health care infrastructure (24, 25).

On the other hand, the social environment can stimulate recovery after trauma. The perception of social support has been found to be an influential factor for the effects of traumatic events on the individual as well as the community. For instance, studies undertaken after disasters have shown that social support had a significant stress-buffering effect for post-traumatic problems. Furthermore, a comprehensive meta-analysis (26) has shown that lack of social support systems and lack of sharing of emotions are significant risk factors for mental health disturbances.

THE OTHER SIDE OF TRAUMA: RESILIENCE

The finding that most people confronted with extreme life events did not develop disturbances like PTSD created interest in the phenomenon of *resilience*. This concept has been widely used in recent years in the scientific and clinical world. Resilience refers to a dynamic process involving positive adaptation to one's circumstances in the face of significant adversity, as defined by Luthar and Cicchetti (27). However, there are various understandings of resilience [see Ref. (28)]. Resilience may be treated as a quality, a personal trait, a process, and an outcome. While, for example, some researchers conceive of resilience

as a multiply determined developmental process that is not fixed, others use measures of trait resilience, which favors the assumption that resilience is a personality attribute [see for the different views Ref. (29)].

Investigation of resilience can lead to useful avenues for intervention. The concept offers a different perspective on risk and protection. Focusing on what makes individuals strong rather that what makes them weak may aid to understand what helps them to maintain their mental health. Sleijpen and colleagues examined strategies of young refugees in dealing with negative experiences (28). Their findings revealed that young refugees living in the Netherlands were affected by memories of traumatic events experienced in their country of origin or during the flight, but that current stressors, especially for young people without a residence permit, played a more significant role in determining their psychological well-being. The participants in this study used the following four strategies to deal with traumatic experiences and current stressors: (1) acting autonomously, (2) performing at school, (3) perceiving support from peers and parents, and (4) participating in the new society. These strategies helped the young refugees to strengthen their sense of power and control, they gave them some distraction, and they supported or sustained their spirit within the family unit and the new society [see Ref. (28)].

PROLONGED AFTERMATH

For public mental health initiatives, it is important to realize on the one hand the significance of the resilience of people affected, but at the other hand also the fact that disturbances can last for a very long period. Difficulties do not always disappear in time. Sometimes they may last for a very long time. 10 years after the Enschede Fireworks disaster still 6.7% of a representative sample of the inhabitants of the neighborhood had an indication of chronic disaster-related PTSD (30). 40 years after the Vietnam War (31), prevalence rates of PTSD were 4.5% (male USA veterans) and 6.1% (female veterans). In the World Mental Health Surveys (4), it was also found that PTSD symptoms typically were quite persistent.

The long-term aftermath of trauma can be illustrated with the following research finding. A large community-based sample of child survivors from World War II was compared with a reference group from the Dutch population as well as with clinical groups (32). These children survived internment in the Japanese camps in the former colony of the Dutch East Indies (now Indonesia) during the period 1942–1945 (and afterwards). Most of them were forced to migrate to the Netherlands in the 1940s and 1950s. Long-term sequelae of the persecution were studied by standardized questionnaires on posttraumatic responses, general health, and dissociation. Compared with control individuals of the same age that lived through the German occupation in the Netherlands during World War II, the child survivors from the former Dutch Indies reported significantly more traumatic experiences and mental health disturbances approximately 50 years after the war. 23 percent of these now adult child survivors in the community sample had an indication of PTSD related to the events in World War II [see Ref. (32)].

These results underline the long-term aftermath of traumatic experiences. This conclusion is also relevant for the many war refugees who migrated to Europe in recent years. In the field of psychotraumatology, there has been a continuing debate about the extent to which diagnostic criteria for PTSD adequately cover the posttraumatic symptomatology experienced by individuals exposed to prolonged, repeated, and interpersonal traumatic events, such as occurring in situations of domestic violence, war, and torture (33). This symptomatology is more complex, more severe, and more invasive than that captured by the classic PTSD diagnosis. This manifestation of psychopathology is referred to as *complex PTSD* (CPTSD). In the 11th version of the ICD (2), this concept is added as a formal diagnosis comorbid to PTSD. It consists of impairments in three domains: difficulties in emotion regulation, negative beliefs about oneself, and difficulties in sustaining relationships. The concept is attractive as it focuses on personal changes due to the confrontation with enduring violence and oppression, but it is as such also rather (too) close to personality disorders while it is not clear whether the addition of this new diagnostic concept is really required beyond PTSD. Research is also still indecisive about these matters. Because of these reasons, a concept such as complex PTSD was not included in DSM-5.

PUBLIC HEALTH STRATEGIES

Public health strategies are aimed at preventing or diminishing mental health problems and addressing the causes of these conditions (see also 10). These strategies are active on multiple levels: individual, family, community, and society. Unfortunately, public health care of trauma is a rather underdeveloped area (see Magruder et al., 2107), especially in contrast to the field of treatment of trauma-related disorders, in particular PTSD. Psychotherapies of PTSD have been found successful, as has been shown by many RCT's (randomized controlled trials) and meta-analyses, in comparison with control groups and placebo treatments [e.g., Ref. (34)]. Most evidence has been found for trauma-focused cognitive behavioral therapy and Eye Movement Desensitization and Reprocessing (EMDR), and to a somewhat lesser extent Narrative Exposure Therapy and Brief Eclectic Psychotherapy for PTSD [e.g., Ref. (35)]. However, here we focus only on public health strategies relevant to trauma care. They are all explicitly aimed at preventing the emergence of health problems or preventing the aggravation of these difficulties.

Preventing adversity. First, although it is a truism, one should bear in mind that stopping or avoiding exposure to events that can be experienced as traumatic is a sensible public health strategy. If disasters, accidents, or wars can be prevented by concrete measures, the chance on traumatic experiences and on their negative consequences is, by definition, taken away.

Creating awareness and recognition. Secondly, creating awareness and acknowledgment concerning the impact of trauma on the population is a strategy by which difficulties can be prevented. Psycho-education with the help of brochures is an obvious example of this. Similarly, so-called silent journeys by a community after a violent crime in their neighborhood

and creating monuments ("lieux de memoire") are just as exemplary regarding recognition and appreciation for the people affected by trauma.

The increase of awareness through public health campaigns has been suggested for combatting child sexual abuse (36). Public health campaigns serve to help the identification of affected children and to facilitate the recognition of their difficulties by adults. Such services imply the awareness of the impact of traumatic experiences in diverse domains (individual, societal), the recognition of signs and symptoms, the integration of knowledge about trauma in public health programs, and the prevention of re-traumatization for their users. In this respect, technology-based interventions (e.g., online platforms, social media, mobile applications) can be advantageous. Such campaigns of awareness and recognition should be accompanied by mental health services with adequate interventions for abused persons looking for care. Nevertheless, despite their positive aims and effects, at the same time, all these campaigns may have a downside: they can lead to complications, such as the risks of promoting an unnecessary victim status and medicalizing complaints of the affected persons, resulting in a reduction of the potential for spontaneous recovery (36, 37).

Strengthening resilience. The third group of strategies is focused on bolstering resilience and stimulating self-efficacy. For example, training programs have been developed in the armies of the USA and several European countries to allow military soldiers to deal with the stress of war and to be more resistant to the intense and overwhelming events they will be confronted with.

Counseling. Fourth, counseling people confronted with traumatic events is a well-known intervention in the field of trauma care. Various forms of secondary preventive interventions providing practical care, support, and information have been designed for employees of organizations confronted with extreme events in the work setting, such as the police and banks, but also for victims of large-scale acts of terrorism. These interventions consist of a couple of protocolled sessions in the first 2 or 3 months after a calamity [see for an overview Ref. (38)]. They are considered as quite helpful, although controlled research is mostly lacking. This intervention should not be confused with so-called psychological debriefing, a typically single session of group counseling directly after a disaster or an act of violence. If this form of support is focused too much on the ventilation of emotions, debriefing has been found to have a negative impact: posttraumatic reactions and depressive feelings are worsened and very early exposure to the trauma material may interfere with natural recovery processes (9, 38).

Reconciliation. A related form of post-trauma care are large-scale programs to reconcile people after large-scale conflicts. For instance, a civil war divides families, communities, and nations, often pitting one neighbor against another. Distrust, resentment, and anger dominate post-war society, just as much as passivity and emotional numbness. That is why programs are designed to reconcile people (perpetrators and victims) and to restore trust, connectedness, and social cohesion.

Such truth and reconciliation efforts were conducted in Sierra Leone (39). Community-level forums in 200 villages were set up in which victims detailed war atrocities and perpetrators confessed to war crimes. Research using a randomized control trial among more than 2,000 individuals showed that reconciliation led to greater forgiveness of perpetrators and strengthened social capital: social networks were larger, and people contributed more to public goods in treated villages. However, there were also negative psychological costs next to the positive societal benefits. The reconciliation intervention also worsened psychological health, increasing depression, anxiety, and PTSD in the same villages. For a subset of villages, outcomes were measured 9 months and 31 months after the intervention. Results showed that both positive and negative effects persisted into the longer time horizon. These findings suggest that policy-makers should be careful with reconciliation processes and must find ways to restrict the emphasis on emotions.

Policy making. Finally, there is the overarching field of policy making, a rather underdeveloped topic in trauma care. As Magruder et al. (40) stated, public policies should be formulated to prevent traumatic events, to understand risk and protective factors, to provide early intervention services for individuals and communities at risk of post-trauma maladjustment, and to shape societal norms to eliminate stigma. Extra priorities for improving mental health include a focus on adequately training researchers and professionals, supporting international collaborations, and encouraging scientists to share their expertise with policymakers. Furthermore, integration of physical and mental health care is especially important, as trauma-exposed individuals often seek help in primary care rather than mental health settings. Consequently, posttraumatic disturbances may go undiagnosed.

FINALLY

A public mental health perspective will help to develop preventive approaches to trauma and extend the impact of various forms of interventions. It will also make clear that trauma care will have to consider the community and the society at large. The concept of trauma is an attractive concept. It refers to both spectacular and shocking events that receive huge attention, such as acts of terrorism and large-scale calamities. Something dramatic happens that could happen to anyone: the cause appears to be clear and the responsibility appears to lay elsewhere. One could argue that traumatic experiences show us the limits of our abilities to master our lives and that they defy our efforts to control the circumstances. However, the concept of trauma is also a dangerous concept. It is often used too easy and too quick. Not every stressful event is a traumatic experience and not every person confronted with war, disaster, or terror is traumatized. Overstretching the concept may create the risk of medicalization of regular difficulties of the afflicted people and ignoring the self-reliance and the adaptive skills of them.

AUTHOR CONTRIBUTIONS

I am the sole author. I designed and wrote the manuscript.

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APPLY

TRAUMA TYPES

ABOUT CHILD TRAUMA

TRAUMA TYPES

- Bullying
- Community Violence
- Complex Trauma
- Disasters
- Early Childhood Trauma

Intimate Partner Violence

Medical Trauma

Physical Abuse

Refugee Trauma

Sexual Abuse

Terrorism and Violence

Traumatic Grief

POPULATIONS AT RISK

When a child feels intensely threatened by an event he or she is involved in or witnesses, we call that event a trauma. There is a range of traumatic events or trauma types to which children and adolescents can be exposed.

Bullying

Bullying is a deliberate and unsolicited action that occurs with the intent of inflicting social, emotional, physical, and/or psychological harm to someone who often is perceived as being less powerful.

view

Community Violence

Community violence is exposure to intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim.

view

Complex Trauma

Complex trauma describes both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure.

view

Disasters

Natural disasters include hurricanes, earthquakes, tornadoes, wildfires, tsunamis, and floods, as well as extreme weather events such as blizzards, droughts, extreme heat, and wind storms.

view

Early Childhood Trauma

Early childhood trauma generally refers to the traumatic experiences that occur to children aged 0-6.

view

Intimate Partner Violence

Intimate Partner Violence (IPV), also referred to as domestic violence, occurs when an individual purposely causes harm or threatens the risk of harm to any past or current partner or spouse.

view

Medical Trauma

Pediatric medical traumatic stress refers to a set of psychological and physiological responses of children and their families to single or multiple medical events.

view

Physical Abuse

Physical abuse occurs when a parent or caregiver commits an act that results in physical injury to a child or adolescent.

view

Refugee Trauma

Many refugees, especially children, have experienced trauma related to war or persecution that may affect their mental and physical health long after the events have occurred.

view

Sexual Abuse

Child sexual abuse is any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer.

view

Terrorism and Violence

Families and children may be profoundly affected by mass violence, acts of terrorism, or community trauma in the form of shootings, bombings, or other types of attacks.

view

Traumatic Grief

While many children adjust well after a death, other children have ongoing difficulties that interfere with everyday life and make it difficult to recall positive memories of their loved ones.

view

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Traumatic stress: effects on the brain

J. Douglas Bremner, MD

Brain areas implicated in the stress response include the amygdala, hippocampus, and prefrontal cortex. Traumatic stress can be associated with lasting changes in these brain areas. Traumatic stress is associated with increased cortisol and norepinephrine responses to subsequent stressors. Antidepressants have effects on the hippocampus that counteract the effects of stress. Findings from animal studies have been extended to patients with post-traumatic stress disorder (PTSD) showing smaller hippocampal and anterior cingulate volumes, increased amygdala function, and decreased medial prefrontal/anterior cingulate function. In addition, patients with PTSD show increased cortisol and norepinephrine responses to stress. Treatments that are efficacious for PTSD show a promotion of neurogenesis in animal studies, as well as promotion of memory and increased hippocampal volume in PTSD.

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Author affiliations: Departments of Psychiatry and Behavioral Sciences and Radiology, and the Emory Center for Positron Emission Tomography, Emory University School of Medicine, Atlanta, Ga, and the Atlanta VAMC, Decatur, Ga, USA

Address for correspondence: J Douglas Bremner, MD, Emory University, 1256 Briarcliff Rd, Room 308e, Atlanta, GA 30306, USA
(e-mail: jdbremn@emory.edu)

Effects of traumatic stress

Traumatic stressors such as early trauma can lead to post-traumatic stress disorder (PTSD), which affects about 8% of Americans at some time in their lives,[1] as well as depression,[2,3] substance abuse,[1,4] dissociation,[5] personality disorders,[6,7] and health problems.[8] For many trauma victims, PTSD can be a lifelong problem.[9] The President's New Freedom Commission Report highlights the importance of providing services for mental disorders related to early trauma.[10-12] However, the development of effective treatments is limited by gaps in knowledge about the underlying neurobiological mechanisms that mediate symptoms of trauma-related disorders like PTSD. This paper reviews preclinical and clinical studies on the effects of traumatic stress on the brain.

Normal development of the brain across the lifespan

To understand how traumatic stress occurring at different stages of the life cycle interacts with the developing brain, it is useful to review normal brain development. The normal human brain undergoes changes in structure and function across the lifespan from early childhood to late life. Understanding these normal developmental changes is critical for determining the difference between normal development and pathology, and how normal development and pathology interact.

Although the bulk of brain development occurs in utero, the brain continues to develop after birth. In the first 5 years of life there is an overall expansion of brain volume related to development of both gray matter and white

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Selected abbreviations and acronyms

ACTH	*adrenocorticotropic hormone*
BDNF	*brain-derived neurotropic factor*
BPD	*bipolar disorder*
CRF	*corticotropin-releasing factor*
CS	*conditioned stimulus*
FDG	*fluorodeoxyglucose*
HPA	*hypothalamic-pituitary-adrenal*
MRI	*magnetic resonance imaging*
mRNA	*messenger ribonucleic acid*
NAA	N-*acetyl aspartate*
PET	*positron emission tomography*
PTSD	*post-traumatic stress disorder*
US	*unconditioned stimulus*

matter structures; however, from 7 to 17 years of age there is a progressive increase in white matter (felt to be related to ongoing myelination) and decrease in gray matter (felt to be related to neuronal pruning) while overall brain size stays the same.[13-16] Gray matter areas that undergo the greatest increases throughout this latter developmental epoch include frontal cortex and parietal cortex.[17,18] Basal ganglia decrease in size, while corpus callosum,[19,20] hippocampus, and amygdala[21-23] appear to increase in size during childhood, although there may be developmental sex-laterality effects for some of these structures.[24] Overall brain size is 10% larger in boys than girls during childhood.[24]

During the middle part of life (from age 20 to 70) there is a gradual decrease in caudate,[25] diencephalon,[25] and gray matter,[25,26] which is most pronounced in the temporal[27] and frontal cortex,[26] with enlargement of the ventricles[26,27] and no change in white matter.[25,26] Studies have not been able to document changes in hippocampal volume in normal populations during this period.[27] After menopause in women at about the age of 50, however, there are changes in reproductive hormones, such as decreased levels of estrogen. Since estrogen promotes neuronal branching in brain areas such as the hippocampus,[28] a loss of estrogen may lead to changes in neuronal structure. Although the effects of menopause on the brain have not been well studied, it is known that sex hormones also affect brain function and circuitry[29]; therefore, the changes in sex hormones with menopause will presumably affect brain function, as well as possibly structure. There is some evidence in super-elderly individuals (age >70) for modest reductions in hippocampal volume with late stages of aging.[27,30] More robust findings have included increased ventricular volume and reduction in gray matter, temporal lobe, and cerebellum volumes with normal aging, that begins before the age of 70.[25,27,31-33]

Therefore, trauma at different stages in life will presumably have different effects on brain development. The few studies that have looked at this issue do suggest that there are differences in the effects of trauma on neurobiology, depending on the stage of development at which the trauma occurs. Studies in this area, however, have been limited.

Neurobiology of PTSD

PTSD is characterized by specific symptoms, including intrusive thoughts, hyperarousal, flashbacks, nightmares, and sleep disturbances, changes in memory and concentration, and startle responses. Symptoms of PTSD are hypothesized to represent the behavioral manifestation of stress-induced changes in brain structure and function. Stress results in acute and chronic changes in neurochemical systems and specific brain regions, which result in long-term changes in brain "circuits," involved in the stress response.[34-37] Brain regions that are felt to play an important role in PTSD include hippocampus, amygdala, and medial prefrontal cortex. Cortisol and norepinephrine are two neurochemical systems that are critical in the stress response *(Figure 1)*.

The corticotropin-releasing factor (CRF)/hypothalamic-pituitary-adrenal (HPA) axis system plays an important role in the stress response. CRF is released from the hypothalamus, with stimulation of adrenocorticotropic hormone (ACTH) release from the pituitary, resulting in glucocorticoid (cortisol in man) release from the adrenal, which in turn has a negative feedback effect on the axis at the level of the pituitary, as well as central brain sites including hypothalamus and hippocampus. Cortisol has a number of effects which facilitate survival. In addition to its role in triggering the HPA axis, CRF acts centrally to mediate fear-related behaviors,[38] and triggers other neurochemical responses to stress, such as the noradrenergic system via the brain stem locus coeruleus.[39] Noradrenergic neurons release transmitter throughout the brain; this is associated with an increase in alerting and vigilance behaviors, critical for coping with acute threat.[40-42]

Studies in animals showed that early stress has lasting effects on the HPA axis and norepinephrine. A variety of early stressors resulted in increased glucocorticoid

response to subsequent stressors.[43-45] Maternally deprived rats had decreased numbers of glucocorticoid receptors in the hippocampus, hypothalamus, and frontal cortex.[46] Stressed animals demonstrated an inability to terminate the glucocorticoid response to stress,[47,48] as well as deficits in fast-feedback of glucocorticoids on the HPA axis, which could be related to decreased glucocorticoid receptor binding in the hippocampus.[49] Early postnatal adverse experiences increase hypothalamic CRF messenger ribonucleic acid (mRNA), median eminence CRF content, and stress-induced glucocorticoid[50] and ACTH release.[46] These effects could be mediated by an increase in synthesis of CRH mRNA following stress.[51] In nonhuman primates, adverse early experiences resulted in long-term effects on behaviors, as well as elevated levels of CRF in the cerebrospinal fluid.[52] Exposure to chronic stress results in potentiation of noradrenergic responsiveness to subsequent stressors and increased release of norepinephrine in the hippocampus and other brain regions.[42]

Preclinical and clinical studies have shown alterations in memory function following traumatic stress,[53] as well as changes in a circuit of brain areas, including hippocampus, amygdala, and medial prefrontal cortex, that mediate alterations in memory.[54] The hippocampus, a brain area involved in verbal declarative memory, is very sensitive to the effects of stress. Stress in animals is associated with damage to neurons in the CA3 region of the hippocampus (which may be mediated by hypercortisolemia, decreased brain-derived neurotrophic factor (BDNF), and/or elevated glutamate levels) and inhibition of neurogenesis.[55-60] High levels of glucocorticoids seen with stress were also associated with deficits in new learning.[61,62]

Antidepressant treatments have been shown to block the effects of stress and/or promote neurogenesis.[58,63-66] Animal studies have demonstrated several agents with

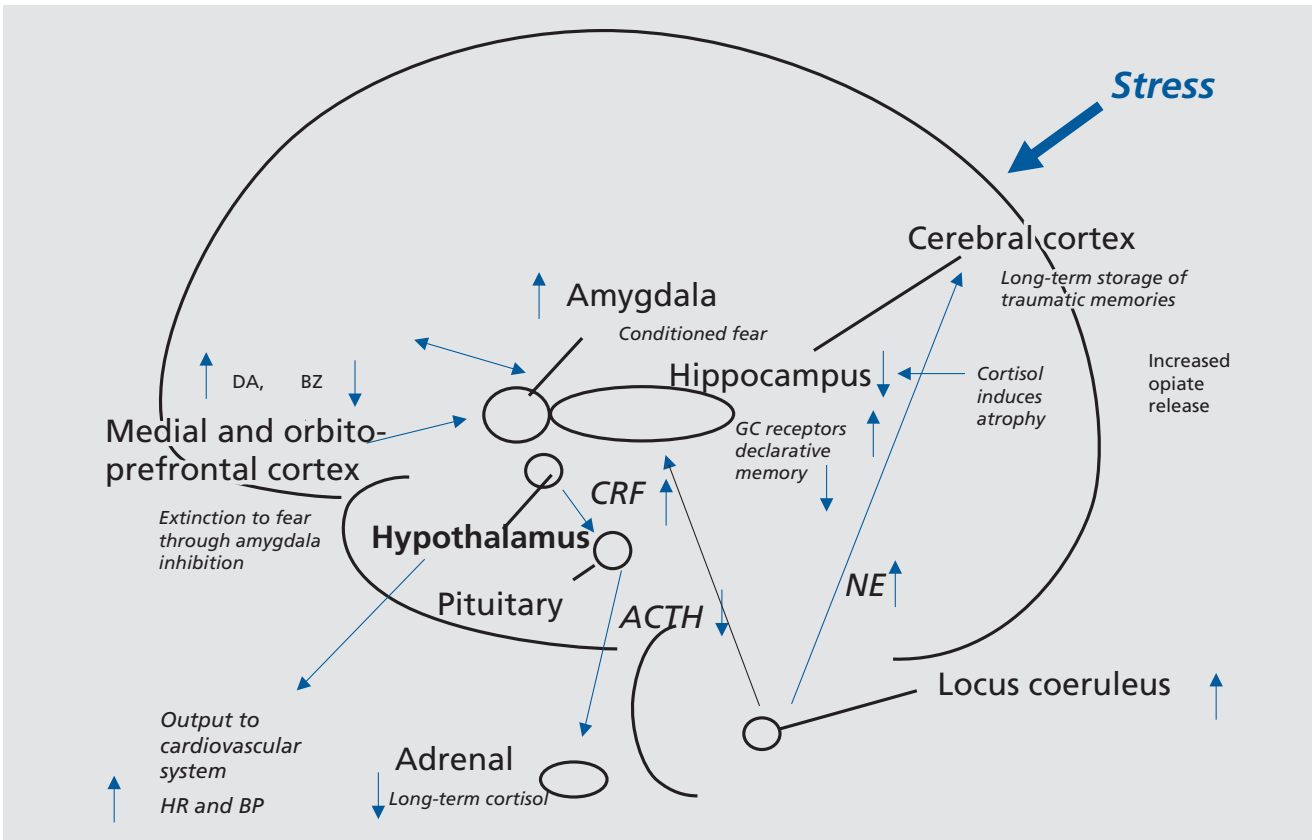

Figure 1. Lasting effects of trauma on the brain, showing long-term dysregulation of norepinephrine and cortisol systems, and vulnerable areas of hippocampus, amygdala, and medial prefrontal cortex that are affected by trauma. GC, glucocorticoid; CRF, corticotropin-releasing factor; ACTH, adrenocorticotropin hormone; NE, norepinephrine; HR, heart rate; BP, blood pressure; DA, dopamine; BZ, benzodiazapine; GC, glucocorticoid

potentially beneficial effects on stress-induced hippocampal damage. It has been found that phenytoin blocks the effects of stress on the hippocampus, probably through modulation of excitatory amino acid-induced neurotoxicity.[67] Other agents, including tianeptine, dihydroepiandosterone (DHEA), and fluoxetine have similar effects.[63,64,66,68-73] These medications may share a common mechanism of action through upregulation of cyclic adenosine monophosphate (cAMP) response element binding protein (CREB) that may lead to regulation of expression of specific target genes involved in structural modeling of the hippocampus. Such treatment effects on BDNF and trkB messenger ribonucleic acid (mRNA), can have long-term effects on brain structure and function. There is new evidence that neurogenesis is necessary for the behavioral effects of antidepressants,[74,75] although this continues to be a source of debate.[72,76]

The hippocampus demonstrates an unusual capacity for neuronal plasticity and regeneration. In addition to findings noted above related to the negative effects of stress on neurogenesis, it has recently been demonstrated that changes in the environment, eg, social enrichment or learning, can modulate neurogenesis in the dentate gyrus of the hippocampus, and slow the normal age-related decline in neurogenesis.[77,78] Rat pups that are handled frequently within the first few weeks of life (picking them up and then returning them to their mother) had increased type II glucocorticoid receptor binding which persisted throughout life, with increased feedback sensitivity to glucocorticoids, and reduced glucocorticoid-mediated hippocampal damage in later life.[79] These effects appear to be due to a type of "stress inoculation" from the mothers' repeated licking of the handled pups.[80] Considered together, these findings suggest that early in the postnatal period there is a naturally occurring brain plasticity in key neural systems that may "program" an organism's biological response to stressful stimuli. These findings may have implications for victims of childhood abuse.

Long-term dysregulation of the HPA axis is associated with PTSD, with low levels of cortisol found in chronic PTSD in many studies[81-86] and elevations in CRF.[82,87] Not all studies, however, have found lower cortisol levels in PTSD.[88-91] Exposure to a traumatic reminder appears to be associated with a potentiated release of cortisol in PTSD.[92]

The few studies of the effects of early stress on neurobiology conducted in clinical populations of traumatized children have generally been consistent with findings from animal studies. Research in traumatized children has been complicated by issues related to psychiatric diagnosis and assessment of trauma.[93] Some studies have not specifically examined psychiatric diagnosis, while others have focused on children with trauma and depression, and others on children with trauma and PTSD. Sexually abused girls (in which effects of specific psychiatric diagnosis were not examined) had normal baseline cortisol and blunted ACTH response to CRF,[94] while women with childhood abuse-related PTSD had hypercortisolemia.[95] Another study of traumatized children in which the diagnosis of PTSD was established showed increased levels of cortisol measured in 24-hour urines.[96] Emotionally neglected children from a Romanian orphanage had elevated cortisol levels over a diurnal period compared with controls.[97] Maltreated school-aged children with clinical-level internalizing problems had elevated cortisol compared with controls.[98] Depressed preschool children showed increased cortisol response to separation stress.[99] Adult women with a history of childhood abuse showed increased suppression of cortisol with low-dose (0.5 mg) dexamethasone.[100] Women with PTSD related to early childhood sexual abuse showed decreased baseline cortisol based on 24-hour diurnal assessments of plasma, and exaggerated cortisol response to stressors (traumatic stressors[101] more than neutral cognitive stressors).[102] We also found that patients with PTSD had less of an inhibition of memory function with synthetic cortisol (dexamethasone) than normal subjects.[103] Adult women with depression and a history of early childhood abuse had an increased cortisol response to a stressful cognitive challenge relative to controls,[104] and a blunted ACTH response to CRF challenge.[105] These findings show long-term changes in stress responsive systems. Early in development, stress is associated with increased cortisol and norepinephrine responsiveness, whereas with adulthood, resting cortisol may be normal or low, but there continues to be increased cortisol and norepinephrine responsiveness to stressors. In addition, early stress is associated with alterations in hippocampal morphology which may not manifest until adulthood, as well as increased amygdala function and decreased medial prefrontal function.

Cognitive function and brain structure in PTSD

Studies in PTSD are consistent with changes in cognition and brain structure. Multiple studies have demonstrated verbal declarative memory deficits in PTSD.[53,106-108]

Patients with PTSD secondary to combat[109-113] and childhood abuse[114,115] were found to have deficits in verbal declarative memory function based on neuropsychological testing. Studies, using a variety of measures (including the Wechsler Memory Scale, the visual and verbal components of the Selective Reminding Test, the Auditory Verbal Learning Test, Paired Associate Recall, the California Verbal New Learning Test, and the Rivermead Behavioral Memory Test), found specific deficits in verbal declarative memory function, with a relative sparing of visual memory and IQ.[109-113,115-124] These studies have been conducted in both patients with PTSD related to Vietnam combat,[109-113,116,119-121,123] rape,[117] the Holocaust,[124-126] adults with early childhood abuse,[115] and traumatized children.[118] One study in adult rape survivors showed that verbal declarative memory deficits are specifically associated with PTSD, and are not a nonspecific effect of trauma exposure.[117] Another study of women with early childhood sexual abuse in which some, but not all, of the patients had PTSD, showed no difference between abused and nonabused women,[127] while another study was not able to show a difference between Vietnam veterans with and without PTSD.[128] Other types of memory disturbances studied in PTSD include gaps in memory for everyday events (dissociative amnesia),[129] deficits in autobiographical memory,[130] an attentional bias for trauma-related material,[131-140] and frontal lobe-related impairments.[141] These studies suggest that traumas such as early abuse with associated PTSD result in deficits in verbal declarative memory. It is not clear if cognitive deficits in early abuse survivors are specific to PTSD and are not related to the nonspecific effects of abuse.

These effects were specific to verbal (not visual) memory, and were significant after controlling for IQ. Some of these studies used neuropsychological tests of declarative memory, such as the Wechsler Memory Scale (WMS) and Selective Reminding Test (SRT), that have been validated as sensitive to loss of neurons in the CA3 region of the hippocampus in epileptics who underwent hippocampal resection.[142,143] Vietnam veterans with PTSD were originally shown by us to have 8% smaller right hippocampal volume based on magnetic resonance imaging (MRI) relative to controls matched for a variety of factors such as alcohol abuse and education ($P<0.05$); smaller volume was correlated with deficits in verbal declarative memory function as measured with the Wechsler Memory Scale.[144] A second study from our group showed a 12% reduction in left hippocampal volume in 17 patients with childhood abuse-related PTSD compared with 17 case-matched controls, that was significant after controlling for confounding factors.[145] Smaller hippocampal volume was shown to be specific to PTSD within the anxiety disorders, and was not seen in panic disorder.[146] Gurvits et al[147] showed bilateral hippocampal volume reductions in combat-related PTSD compared with combat veterans without PTSD and normal controls. Combat severity was correlated with volume reduction. Stein et al[148] found a 5% reduction in left hippocampal volume. Other studies in PTSD have found smaller hippocampal volume and/or reductions in *N*-acetyl aspartate (NAA), a marker of neuronal integrity.[149-153] Studies in childhood[154-156] and new-onset[157,158] PTSD did not find hippocampal volume reduction, although reduced NAA (indicating loss of neuronal integrity) was found in medial prefrontal cortex in childhood PTSD.[159] In a recent meta-analysis we pooled data from all of the published studies and found smaller hippocampal volume for both the left and the right sides, equally in adult men and women with chronic PTSD, and no change in children.[160] More recent studies of holocaust survivors with PTSD did not find a reduction in hippocampal volume, although PTSD patients who developed PTSD in response to an initial trauma had smaller hippocampal volume compared with those who developed PTSD after repeated trauma, suggesting a possible vulnerability of smaller hippocampal volume.[161] Two independent studies have shown that PTSD patients have deficits in hippocampal activation while performing a verbal declarative memory task,[149,162] although it is unclear if this is a deficit in activation or higher hippocampal blood flow at baseline. Both hippocampal atrophy and hippocampal-based memory deficits reversed with treatment with the selective serotonin reuptake inhibitor (SSRI) paroxetine, which has been shown to promote neurogenesis (the growth of neurons) in the hippocampus in preclinical studies.[163] In addition, treatment with the anticonvulsant phenytoin led to an improvement in PTSD symptoms[164] and an increase in right hippocampal and right cerebral volume.[165] We hypothesize that stress-induced hippocampal dysfunction may mediate many of the symptoms of PTSD which are related to memory dysregulation, including both explicit memory deficits as well as fragmentation of memory in abuse survivors. It is unclear at the current time whether these changes are specific to PTSD, whether certain common environmental events (eg, stress) in different disorders lead to similar brain changes, or whether common genetic traits lead to similar outcomes.

The meaning of findings related to deficits in memory and the hippocampus in PTSD, and questions related to the relative contribution of genetic and environmental factors, has become an important topic in the field of PTSD and stress research. There are three possible models, taking into account genetic or environmental factors, which have been proposed to explain smaller hippocampal volume in PTSD: Model A (Environment), Model B (Environment and Genetic), and Model C (Genetic).[166-169] In Model C (Genetic), smaller hippocampal volume represents a premorbid risk factor for PTSD. In support of this model Pitman and colleagues[170] have demonstrated that lower premilitary IQ is associated with combat-related PTSD, as well as finding a correlation between PTSD symptoms and hippocampal volume in twin brothers.[151] Model A (Environment) states that stress leads to damage or inhibition of neurogenesis via hypercortisolemia, decreased BDNF, or increased glutamate. Model B (Environment/Genetic) states that a combination of environmental and genetic factors leads to deficits in hippocampal function and structure. Showing that an intervention like medication changes hippocampal volume and cognition would provide support for at least a partial contribution of the environment to the outcomes of interest.

In addition to the hippocampus, other brain structures have been implicated in a neural circuitry of stress, including the amygdala and prefrontal cortex. The amygdala is involved in memory for the emotional valence of events, and plays a critical role in the acquisition of fear responses. The medial prefrontal cortex includes the anterior cingulate gyrus (Brodmann's area [BA] 32) and subcallosal gyrus (area 25) as well as orbitofrontal cortex. Lesion studies demonstrated that the medial prefrontal cortex modulates emotional responsiveness through inhibition of amygdala function. Conditioned fear responses are extinguished following repeated exposure to the conditioned stimulus in the absence of the unconditioned (aversive, eg, electric shock) stimulus. This inhibition appears to be mediated by medial prefrontal cortical inhibition of amygdala responsiveness.

Animal studies also show that early stress is associated with a decrease in branching of neurons in the medial prefrontal cortex.[171] Rauch and colleagues found smaller volume of the anterior cingulate based on MRI measurements in PTSD[172]; we have replicated these findings in women with abuse and PTSD.[160] An important question is whether these effects are reversible with treatment.

Neural circuits in PTSD

Brain imaging studies have shown alterations in a circuit including medial prefrontal cortex (including anterior cingulate), hippocampus, and amygdala in PTSD. Many of these studies have used different methods to trigger PTSD symptoms (eg, using traumatic cues) and then look at brain function. Stimulation of the noradrenergic system with yohimbine resulted in a failure of activation in dorsolateral prefrontal, temporal, parietal, and orbitofrontal cortex, and decreased function in the hippocampus.[173] Exposure to traumatic reminders in the form of traumatic slides and/or sounds or traumatic scripts was associated with an increase in PTSD symptoms, decreased blood flow, and/or failure of activation in the medial prefrontal cortex/anterior cingulate, including Brodmann's area 25, or subcallosal gyrus, area 32 and 24, as measured with positron emission tomography (PET) or functional MRI (fMRI).[174-183] Other findings in studies of traumatic reminder exposure include decreased function in hippocampus,[176] visual association cortex,[176,180] parietal cortex,[176,179,180,184] and inferior frontal gyrus,[176,179,180,184] and increased function in amygdala,[181,184] posterior cingulate,[174,176,177,180] and parahippocampal gyrus.[174,176,178] Shin and colleagues found a correlation between increased amygdala function and decreased medial prefrontal function with traumatic reminders,[181] indicating a failure of inhibition of the amygdala by the medial prefrontal cortex that could account for increased PTSD symptoms with traumatic reminders. Other studies found increased amygdala and parahippocampal function and decreased medial prefrontal function during performance of an attention task,[182] increased posterior cingulate and parahippocampal gyrus and decreased medial prefrontal and dorsolateral prefrontal function during an emotional Stroop paradigm,[185] and increased amygdala function with exposure to masked fearful faces.[186] Retrieval of emotionally valenced words[187] (eg "rape-mutilate") in women with PTSD from early abuse resulted in decreases in blood flow in an extensive area which included orbitofrontal cortex, anterior cingulate, and medial prefrontal cortex (BA 25, 32, and 9), left hippocampus, and fusiform gyrus/inferior temporal gyrus, with increased activation in posterior cingulate, left inferior parietal cortex, left middle frontal gyrus, and visual association and motor cortex.[188] Another study found a failure of medial prefrontal cortical/anterior cingulate activation, and decreased visual association and parietal

cortex function, in women with abuse and PTSD relative to women with abuse without PTSD, during performance of the emotional Stroop task (ie, naming the color of a word such as "rape").[189] We recently found increased amygdala activation with classical fear conditioning (pairing a shock and a visual stimulus), and decreased medial prefrontal cortex function with extinction, in abuse-related PTSD.[190] The findings described above point to a network of related regions mediating symptoms of PTSD, including medial prefrontal cortex, anterior cingulate, hippocampus, amygdala, posterior cingulate, parietal, visual association, and dorsolateral prefrontal cortex.[191]

Fewer brain imaging studies have been performed in children with PTSD. Several studies have shown alterations in electroencephalogram (EEG) measures of brain activity in children with a variety of traumas who were not selected for diagnosis compared with healthy children. About half of the children in these studies had a psychiatric diagnosis. Abnormalities were located in the anterior frontal cortex and temporal lobe and were localized to the left hemisphere.[192,193] Two studies have found reductions in brain volume in children with trauma and PTSD symptoms.[154,155] One group did not find reductions in hippocampal volume, either at baseline or over a longitudinal period,[154,156] while another group found an 8.5% reduction in hippocampal volume that was not significant after controlling for smaller brain volumes in the PTSD group.[155] One study used single-voxel proton magnetic resonance spectroscopy (proton MRS) to measure relative concentration of NAA and creatinine (a marker of neuronal viability) in the anterior cingulate of 11 children with maltreatment-related PTSD and 11 controls. The authors found a reduction in the ratio of NAA to creatinine in PTSD relative to controls.[159] Studies have also found smaller size of the corpus callosum in children with abuse and PTSD relative to controls.[154] as well as larger volume of the superior temporal gyrus.[194] In a study of abused children in whom diagnosis was not specified, there was an increase in T2 relaxation time in the cerebellar vermis, suggesting dysfunction in this brain region.[195] The reason for differences in findings between adults and children are not clear; however, factors such as chronicity of illness or interaction between trauma and development may explain findings to date.

In summary, dysfunction of a circuit involving the medial prefrontal cortex, dorsolateral prefrontal cortex, and possibly hippocampus and amygdala during exposure to traumatic reminders may underlie symptoms of PTSD. These studies have primarily assessed neural correlates of traumatic remembrance, while little has been done in the way of utilizing cognitive tasks as probes of specific regions, such as memory tasks as probes of hippocampal function.

MRI assessment of brain abnormalities in PTSD and trauma spectrum disorders

Findings of smaller hippocampal volume appear to be associated with a range of trauma related psychiatric disorders, as long as there is the presence of psychological trauma. We have used MRI to show smaller hippocampal volume in PTSD,[144,145,149,196] depression,[197] depression with early abuse,[198] borderline personality disorder (BPD) with early abuse,[199] and Dissociative Identity Disorder (DID) with early abuse.[200] The greatest magnitude of difference was seen in the DID patients, who had unusually severe early childhood sexual abuse histories. We did not find changes in hippocampal volume in patients with panic disorder without a history of abuse (suggesting that findings are not generalized to other anxiety disorders).[201] We found smaller amygdala volume in BPD with early abuse[199] and increased amygdala volume in depression.[197,202] Patients with depression had smaller orbitofrontal cortex volume with no changes in anterior cingulate (BA 32) or medial prefrontal cortex (BA 25).[203] More recently, we found smaller anterior cingulate volume in women with abuse and PTSD relative to controls.[204]

Neural circuits in women with abuse and PTSD

We have used PET to study neural circuits of trauma-related disorders in women with early abuse and a variety of trauma spectrum mental disorders. Initially we studied women with abuse and PTSD.[54,205-208] We initially measured brain activation with a paragraph-encoding task in conjunction with PET O-15 water measurement of brain blood flow. Women with abuse and PTSD showed a failure of hippocampal activation during the memory task relative to controls.[149] Women with abuse and PTSD in this study also had smaller hippocampal volume measured with MRI relative to both women with abuse without PTSD and nonabused non-PTSD women. The failure of hippocampal activation was significant

after controlling differences in hippocampal volume as well as accuracy of encoding. In another study we measured neural correlates of exposure to a personalized script of childhood sexual abuse. Women with abuse and PTSD showed a failure of medial prefrontal and hippocampal activation relative to abused women without PTSD.[176] Women with abuse and PTSD also showed a failure of medial prefrontal and hippocampal function during recall of paired word associates with traumatic-emotional content (eg, "rape-mutilate"),[188] and decreased medial prefrontal function during an emotional Stroop task with trauma-content words.[209] Other studies showed a failure of medial prefrontal activation in women with BPD and early abuse during an abandonment script.[210] Women with BPD and abuse had increased psychophysiological responses to abandonment scripts relative to trauma scripts, while women with PTSD and abuse had the opposite pattern,[211] indicating differential responding in those two disorders in spite of the common exposure to early abuse.

In another project we studied 19 physically healthy women including women with a history of severe childhood sexual abuse and the diagnosis of current PTSD (N=8) and women without childhood abuse or PTSD (N=11).[212] All subjects underwent PET measurement of cerebral blood flow and psychophysiology measurement of heart rate and skin conductance during habituation, acquisition, and extinction conditions, on a single day, with scanning during a control condition on another day separated by 1 week from the active condition. Subjects were randomly assigned to undergo either the active condition or the control condition first (ie, active-control or control-active). Subjects were told at the beginning of the study that they would be exposed to electric shocks and viewing images on a screen during collection of PET and psychophysiology data. During habituation subjects were exposed to a blue square on a screen (conditioned stimulus [CS]), 4 seconds in duration, followed by 6 seconds of a blank screen. CS exposure was repeated eight times at regular intervals over 80 seconds in two separate blocks separated by 8 minutes. One PET image of brain blood flow was obtained starting from the beginning of each of the blocks. During active fear acquisition exposure to the blue square (CS) was paired with an electric shock to the forearm (unconditioned stimulus [UCS]). Subjects had 8 paired CS-UCS presentations at 10-second intervals for each of two blocks. With extinction subjects were again exposed to the blue squares (CS) without shock ("active" extinction). On a second day subjects went through the same procedure with electric shocks delivered randomly when the blue square was not present (unpaired CS-UCS) (an equal number as on day 1) during scans 3 and 4, which served as a control for active fear acquisition.

PTSD subjects had increased symptoms of anxiety, fear, dissociation, distress, substance use disorders (SUDs), and PTSD at all time points during both study days relative to non-PTSD. Acquisition of fear was associated with increased skin conductance (SC) responses to CS exposure during the active versus the control conditions in all subjects. There was increased SC for PTSD during the first CS-UCS presentation. Extinction of fear was associated with increased skin conductance (SC) responses to CS exposure during the active versus the control conditions in all subjects. When PTSD and non-PTSD subjects were examined separately, SC levels were significantly elevated in non-PTSD subjects undergoing extinction following the active compared with the control condition during session one.

PTSD subjects showed activation of the bilateral amygdala during fear acquisition compared with the control condition. Non-PTSD subjects showed an area of activation in the region of the left amygdala. When PTSD subjects and control subjects were directly compared, PTSD subjects showed greater activation of the left amygdala during the fear conditioning condition (pairing of US and CS) relative to the random shock control than healthy women. Other areas that showed increased activation with fear acquisition in PTSD included bilateral superior temporal gyrus (BA 22), cerebellum, bilateral inferior frontal gyrus (BA 44, 45), and posterior cingulate (BA 24). Fear acquisition was associated with decreased function in medial prefrontal cortex, visual association cortex, and medial temporal cortex, inferior parietal lobule function, and other areas. Extinction of fear responses was associated with decreased function in the orbitofrontal and medial prefrontal cortex (including subcallosal gyrus, BA 25, and anterior cingulate BA 32), visual association cortex, and other areas, in the PTSD subjects, but not in the controls. Amygdala blood flow with fear acquisition was negatively correlated with medial prefrontal blood flow with fear extinction (increased blood flow in amygdala correlated with decreased blood flow in medial prefrontal cortex) in all subjects (r=-0.48; P<0.05). Increased amygdala blood flow with fear acquisition was positively correlated with PTSD (r=0.45), anxiety (r=0.44) and disso-

ciative (r=0.80) symptom levels in PTSD (but not non-PTSD) subjects. There was a negative correlation between medial prefrontal blood flow during extinction and anxiety as measured with the Panic Attack Symptom Scale (PASS) during extinction in the PTSD group only, which was significant after correction for multiple comparisons (r=-0.90; P=0.006).[190] This study was consistent with increased amygdala function with fear acquisition, and decreased medial prefrontal (anterior cingulate) function during extinction in PTSD. This is consistent with the model of an overactive amygdala and a failure of medial prefrontal cortex to extinguish, or shut off, the amygdala, when the acute threat is no longer present.

Treatment of PTSD

Intervening soon after the trauma is critical for long-term outcomes, since with time traumatic memories become indelible and resistant to treatment.[213] Early treatments are not necessarily effective. For instance, studies have shown that Critical Incident Stress Debriefing (CISD) can be associated with a worsening of outcome relative to no treatment at all.[214] Pharmacological treatment of chronic PTSD has shown efficacy originally for imipramine,[215] amitriptyline,[216] and phenalzine,[215] and later for brofaramine,[217] paroxetine,[218,219] and sertraline.[220] Selective serotonin reuptake inhibitors (SSRIs) and tianeptine are now recommended as first-line treatment for PTSD.[221-226]

The utility of early treatment is also demonstrated by animal studies showing that pretreatment before stress with antidepressants reduces chronic behavioral deficits related to stress.[227,228] Antidepressants, including both norepinephrine and serotonin reuptake inhibitors, as well as gabapentine and phenytoin, promote nerve growth (neurogenesis) in the hippocampus, while stress inhibits neurogenesis.[63,64,66,69,71,75,229] This is important because hippocampal neurogenesis has been shown to be required for antidepressant response.[74]

Few studies have examined the effects of pharmacological treatment on brain structure and function in patients with trauma-related mental disorders. We studied a group of patients with depression and found no effect of fluoxetine on hippocampal volume, although there were increases in memory function[230] and hippocampal activation measured with PET during a memory encoding task. Depressed patients with a history of childhood trauma were excluded, and we subsequently have found hippocampal volume reductions at baseline in women with early abuse and depression but not in women with depression without early abuse;[198] this suggests that the study design of excluding patients with early trauma may account for the negative result. Other studies in depression showed that smaller hippocampal volume was a predictor of resistance to antidepressant treatment.[231] Smaller orbitofrontal cortex volume is associated with depression; one study in geriatric depression found smaller orbitofrontal cortex volume, while length of antidepressant exposure was correlated with larger orbitofrontal volume.[232]

Several studies have looked at functional brain imaging response to antidepressants in depression. Single photon-emission computed tomography (SPECT) blood flow studies in depression showed that antidepressants increased anterior cingulate, right putamen, and right thalamus function.[233] SPECT Xenon-133 studies showed reduced prefrontal function at baseline in depression, with treatment responders showing reduced perfusion in prefrontal cortex compared with nonresponders after treatment.[234] In a fluorodeoxyglucose (FDG) PET study of brain function patients with depression treated with fluoxetine who had a positive response to treatment had limbic and striatal decreases (subgenual cingulate, hippocampus, insula, and pallidum) and brain stem and dorsal cortical increases (prefrontal, parietal, anterior, and posterior cingulate) in function. Failed response was associated with a persistent 1-week pattern and absence of either subgenual cingulate or prefrontal changes.[235] Sertraline resulted in an increase in middle frontal gyrus activity in depression measured with PET FDG, as well as increased function in right parietal lobe and visual association cortex.[236] Successful paroxetine therapy of depression was associated with increased glucose metabolism measured with PET in dorsolateral, ventrolateral, and medial aspects of the prefrontal cortex, parietal cortex, and dorsal anterior cingulate. Areas of decreased metabolism were noted in both anterior and posterior insular regions (left) as well as right hippocampal and parahippocampal regions.[237] In another PET FDG study, at baseline, subjects with depression had higher normalized metabolism than controls in the prefrontal cortex (and caudate and thalamus), and lower metabolism in the temporal lobe. With treatment with paroxetine, subjects with depression had metabolic changes in the direction of normalization in these regions.[238] A PET FDG study of patients with depression and controls showed that at baseline, the mean metabolism was increased in the left and right lateral orbital cortex/ventrolateral prefrontal cortex (PFC), left amygdala,

and posterior cingulate cortex, and decreased in the subgenual anterior cingulate cortex (ACC) and dorsal medial/dorsal anterolateral PFC in depressives relative to controls. Following treatment with antidepressants, metabolism significantly decreased in the left amygdala and left subgenual ACC. The metabolic reduction in the amygdala and right subgenual ACC appeared largely limited to those subjects who both responded to treatment and remained well at 6 months' follow-up.[239] Another study showed that antidepressant treatment of depression resulted in a decrease in amygdala activation with emotional faces as measured with fMRI.[240] In summary, studies show changes in limbic and prefrontal cortical regions with successful antidepressant treatment of depression.

Fewer studies have looked at the effects of pharmacological treatment on the brain in anxiety disorders. One PET FDG study showed that caudate function decreased with treatment of obsessive compulsive disorder with antidepressants.[241] Paroxetine resulted in a decrease in glutamate/glutamine measured with magnetic resonance spectroscopy (MRS) in children with obsessive-compulsive disorder (OCD).[242] Patients with PTSD were shown to have an increase in hippocampal volume and memory function with paroxetine,[163] and increased right hippocampal and right cerebral volume with phenytoin.[165] No published studies have looked at the effects of pharmacological treatment on brain function in PTSD, or on sensitive markers of brain chemistry like NAA.

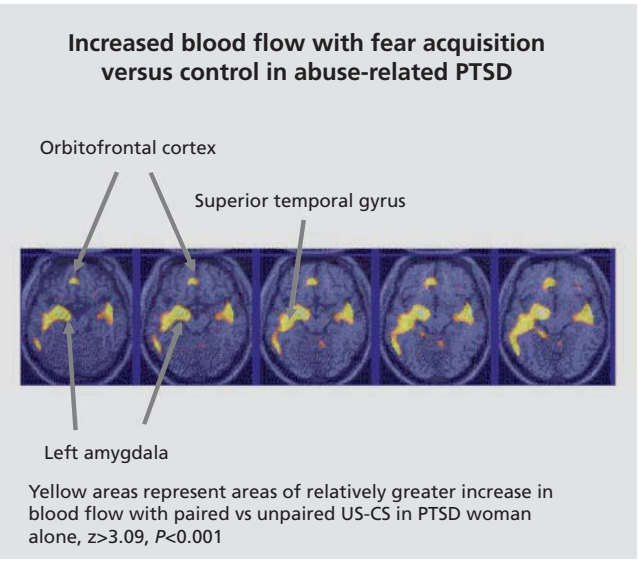

Figure 2. Neural correlates of fear conditioning in women with abuse and PTSD. There was increased amygdala activation with fear acquisition using a classical conditioning paradigm relative to non-PTSD abused women. PTSD, post-traumatic stress disorder

Brain biomarkers like NAA represent an objective marker of neural plasticity. To date psychiatry has relied on subjective reports as the gold standard. However, this is limited by self-reporting and the subjective interpretations of symptoms and response to treatment. Brain markers of antidepressant response may provide a complementary approach to assessing response to treatment, as well as providing insight into the mechanisms of treatment response. Our group is trying to look at mechanisms in the brain underlying treatment response in PTSD.

Effects of pharmacotherapy on brain function and structure in PTSD

We have begun to assess the effects of pharmacotherapy on brain structure and function in PTSD.[243] We recently assessed the effects of phenytoin on brain structure and function. Studies in animals show that phenytoin, which is used in the treatment of epilepsy and is known to modulate glutamatergic function, blocks the effects of stress on the hippocampus.[67] We studied nine patients with PTSD in an open-label function before and after treatment with phenytoin. Phenytoin resulted in a significant improvement in PTSD symptoms.[164] Phenytoin also resulted in increases in both right hippocampal volume and right hemisphere volume.[165] These findings indicate that phenytoin has an effects on PTSD symptoms as well as brain structure in PTSD patients.

We have assessed the effects of open-label paroxetine on memory and the hippocampus in PTSD. Male and female patients with symptoms of PTSD were medication-free for at least 4 weeks before participation in the study. Twenty-eight patients were found to be eligible and started the medication phase. Of the total patient sample five patients did not finish due to noncompliance; 23 patients completed the study.

Before patients started the medication phase, neuropsychological tests were administered, including the *Wechsler Adult Intelligence Scale – Revised*, WAIS-R (arithmetic, vocabulary, picture arrangement, and block design test), two subtests of the *Wechsler Memory Scale-Revised*, WMS-R, including logical memory (free recall of two story narratives, which represents verbal memory) and figural memory (which represents visual memory and involved reproduction of designs after a 6-second presentation); and the verbal and visual components of

the *Selective Reminding Test*, SRT.

Paroxetine was prescribed in the first visit after the pre-treatment assessments. All patients started open-label with a dose of 10 mg daily and were titrated up to 20 mg in 4 days.

Paroxetine treatment resulted in a mean 54% reduction in PTSD symptoms as measured with mean changes from baseline on the CAPS total score ($P<0.005$) among study completers. Improvement was equally strong on all symptom cluster scores (Re-experiencing, Avoidance/Numbing, Hyperarousal). Treatment also resulted in significant improvements in verbal declarative memory as measured with the WMS-R paragraph recall for delayed recall ($P<0.005$) and percent retention (80.2 to 91.1; $P=0.003$), but not immediate recall. Improvements were significant on all subscales of the Verbal Component of the SRT; including long-term recall and delayed recall.

Repeated measures ANOVA with side as the repeated measure showed a main effect for treatment related to a 4.6% increase in mean hippocampal volume (1857.3 mm^3 [SD 225.6] to 1906.2 mm^3, [SD 243.2]) with treatment (F=8.775 df=1. 36; $P=0.005$). Increased hippocampal volume was seen for both left (5.6%) (1807.6 mm^3 [SD 255.5] to 1909.3 mm^3 [SD 236.9]) and right (3.7%) (1906.9 mm^3 [SD 195.8] to 1976.7 mm^3 (SD 249.6]) hippocampus. There was no change in whole brain volume with treatment. Increase in hippocampal volume was significant after adding whole brain volume before and after treatment to the model.

Discussion

Traumatic stress has a broad range of effects on brain function and structure, as well as on neuropsychological components of memory. Brain areas implicated in the stress response include the amygdala, hippocampus, and prefrontal cortex. Neurochemical systems, including cortisol and norepinephrine, play a critical role in the stress response. These brain areas play an important role in the stress response. They also play a critical role in memory, highlighting the important interplay between memory and the traumatic stress response. Preclinical studies show that stress affects these brain areas. Furthermore, antidepressants have effects on the hippocampus that counteract the effects of stress. In fact, promotion of nerve growth (neurogenesis) in the hippocampus may be central to the efficacy of the antidepressants. Studies in patients with PTSD show alterations in brain areas implicated in animal studies, including the amygdala, hippocampus, and prefrontal cortex, as well as in neurochemical stress response systems, including cortisol and norepinephrine. Treatments that are efficacious for PTSD show a promotion of neurogenesis in animal studies, as well as promotion of memory and increased hippocampal volume in PTSD. Future studies are needed to assess neural mechanisms in treatment response in PTSD. ❑

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Estrés traumático: efectos en la cerebro

El estrés traumático surte efectos muy diversos sobre la función y la estructura cerebrales. Las regiones cerebrales implicadas en la respuesta al estrés son la amígdala (núcleo amigdalino), el hipocampo y la corteza prefrontal. Los sistemas neuroquímicos, como el cortisol y la noradrenalina, desempeñan una misión crítica en la respuesta al estrés. Estas regiones cerebrales influyen sobre la respuesta al estrés y sobre la memoria, lo que subraya la interrelación entre la memoria y la respuesta al estrés traumático. Los antidepresivos actúan sobre el hipocampo y contrarrestan el efecto del estrés. Los estudios sobre pacientes con trastorno por estrés postraumático (TEPT) revelan alteraciones en las regiones cerebrales implicadas en los estudios con animales como la amígdala, el hipocampo y la corteza prefrontal, así como en los sistemas neuroquímicos de respuesta al estrés, entre ellos el cortisol y la noradrenalina. Los tratamientos con eficacia frente al TEPT promueven la neurogénesis en los estudios con animales y también aumentan la memoria, y el volumen hipocámpico en el TEPT. Se requieren nuevos estudios para evaluar los mecanismos neurales de la respuesta terapéutica en el TEPT.

Effets du stress traumatique sur le cerveau

Le stress traumatique exerce une grande variété d'effets sur la fonction et la structure cérébrales. Les aires cérébrales impliquées dans la réponse au stress comprennent l'amygdale, l'hippocampe et le cortex préfrontal. Les systèmes neurochimiques, incluant le cortisol et la norépinéphrine, jouent un rôle critique dans la réponse au stress. Ces aires cérébrales influent sur la mémoire et sur la réponse au stress traumatique, soulignant ainsi les interactions existant entre les deux. Les effets des antidépresseurs sur l'hippocampe compensent les effets du stress. Les études chez les patients atteints de trouble stress post-traumatique (ESPT) montrent des modifications des aires cérébrales impliquées au cours des études animales, telles l'amygdale, l'hippocampe et le cortex préfrontal, ainsi que des modifications des systèmes neurochimiques de réponse au stress comme le cortisol et la noradrénaline. Les traitements efficaces dans l'ESPT entraînent une activation de la neurogenèse chez l'animal de même qu'une amélioration de la mémoire et une augmentation du volume de l'hippocampe dans l'ESPT. Il faudra d'autres études pour évaluer les mécanismes neuronaux dans la réponse thérapeutique au cours de l'ESPT.

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Child abuse and neglect

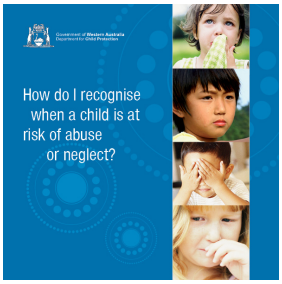
CHILD ABUSE AND NEGLECT

In Western Australia, under the *Children and Community Services Act 2004,* a child is a person under the age of 18 years.

There are generally five types of child abuse and neglect, which may co-exist:

- physical abuse
- sexual abuse
- emotional abuse
- psychological abuse
- child neglect.

Publication: How do I recognise when a child is at risk of abuse or neglect?



Child development and trauma guide

The *Child development and trauma guide* has been developed to assist practitioners to understand typical developmental pathways of children and recognise indicators of trauma at different ages and stages.

Importantly, the resource offers practical, age appropriate advice as to the needs of children, parents and carers when trauma has occurred, and ways in which children and families can be assisted in healing and recovery.

The *Child development and trauma guide* covers the following age groups:

- 0 to 12 months
- 12 months to 3 years
- 3 to 5 years
- 7 to 9 years
- 9 to 12 years
- 12 to 18 years.

Resources

What to do... when you are concerned that a child is being abused or neglected
A3 poster

How do I recognise when a child is at risk of abuse or neglect?
Outlines the five main types of child abuse and neglect.

What does it mean?
A guide for families and carers about how the Department for Child Protection helps keep children safe.

Protecting children
Information for parents, families and friends.

Keeping our kids safe
For aboriginal families and communities.

Become a Foster Carer

Promemoria sulla privacy di YouTube, una società di Google RICORDAMELO PIÙ TARDI LEGGI

SALTA LINK DI NAVIGAZIONE

ACCEDI

Orizzonti mediterranei, storie di migrazione e di violenza Subtitles english

119 visualizzazioni • 26 ago 2017 3 0 CONDIVIDI SALVA

Pina Mandolfo
5 iscritti

ISCRIVITI

Il calvario dei viaggi migratori di uomini e, soprattutto, donne vittime di violenza, narrato da alcuni e alcune protagonisti.

MOSTRA ALTRO

Prossimi video

RIPRODUZIONE AUTOMATICA

Fatima - Il segreto rivelato (Documentario)
Nicola Umile Preghiere Scuderi
Recommended for you

01 - Ascesa e caduta di Mussolini
Stefano Ticci
Recommended for you

Promemoria sulla privacy di YouTube, una società di Google RICORDAMELO PIÙ TARDI LEGGI

SALTA LINK DI NAVIGAZIONE

ACCEDI

EP.14 - Entrare da soli in Corea Del Nord KP|GUIDA DA NON SEGUIRE 😅
Progetto Happiness
Recommended for you

I NOSTRI Soldi e le Banche... (Mitico Enrico Brignano!)
jeanpy67@
Recommended for you

Momenti storici e sputtanate della tv italiana! - Parte Terza!
VideoBox
29.368 visualizzazioni
Nuovo

NON UNA DI MENO LE INVISIBILI
Pina Mandolfo
34 visualizzazioni

Piazzapulita - "E io pago" (Puntata 24/03/2014)
La7 Attualità
572.376 visualizzazioni

Carvilius, un enigma dall'antica Roma.avi
GA&A CHANNEL
Recommended for you

La crisi finanziaria e la grande recessione: origini e politiche economiche adottate (F. Sdogati)
PoliMi
913.600 visualizzazioni

Igor Sibaldi - Conosci Te Stesso
Nuova Civiltà - Cristianesimo Cosmico
Recommended for you

Come fare gli gnocchi di patate - ricetta facile - easy recipe of potato dumplings- Fabio Campoli
Fabio Campoli
Recommended for you

Anima e Alimentazione: Nutrirsi senza infiammarsi - Dott. Raffaele Fiore

Promemoria sulla privacy di YouTube, una società di Google RICORDAMELO PIÙ TARDI LEGGI

YouTube IT ACCEDI

Tv2000it
Recommended for you

Stanzani Racconta: L'impatto con le maniere di Lamborghini - Davide Cironi (SUBS)
Davide Cironi
Recommended for you

National Geographic:Il Vangelo di Giuda.flv
Loreto Renzi
Recommended for you

Documentario esperienze premorte - Near death experience documentary. By Lara Peviani
Lara Peviani Documentaries
Recommended for you

Felice Maniero, boss della Mala del Brenta - Kings of Crime
Gomorra Channel
2,1 Mln di visualizzazioni

Ilaria Capua, da scienziato simbolo dell'eccellenza italiana a trafficante di virus
La7 Attualità
81.822 visualizzazioni

LA MORTE NERA la grande peste del Trecento
giovanni cavalieri
Recommended for you

MOSTRA ALTRO

A TREATMENT IMPROVEMENT PROTOCOL

Trauma-Informed Care in Behavioral Health Services

TIP 57

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

A TREATMENT IMPROVEMENT PROTOCOL

Trauma-Informed Care in Behavioral Health Services

TIP 57

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

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Disclaimer

The views, opinions, and content expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of SAMHSA or HHS. No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described are intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

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Consensus Panel

Note: Each panelist's information reflects his or her affiliation at the time of the Consensus Panel meeting and may not reflect that person's most current affiliation.

Chair

Lisa M. Najavits, Ph.D.
Research Psychologist
Veterans Affairs Boston Healthcare System
Professor of Psychiatry
Boston University School of Medicine
Boston, MA

Co-Chair

Linda B. Cottler, Ph.D., M.P.H.
Professor of Epidemiology in Psychiatry
Department of Psychiatry
Washington University–St. Louis
St. Louis, MO

Workgroup Leaders

Stephanie S. Covington, Ph.D., LCSW, MFCC
Co-Director
Center for Gender and Justice
Institute for Relational Development
La Jolla, CA

Margaret Cramer, Ph.D.
Clinical Psychologist/Clinical Instructor
Harvard Medical School
Boston, MA

Anne M. Herron, M.S.
Director
Treatment Programming
New York State Office of Alcoholism and Substance Abuse Services
Albany, NY

Denise Hien, Ph.D.
Research Scholar
Social Intervention Group
School of Social Work
Columbia University
New York, NY

Dee S. Owens, M.P.A.
Director
Alcohol-Drug Information
Indiana University
Bloomington, IN

Panelists

Charlotte Chapman, M.S., LPC, CAC
Training Director
Division of Addiction Psychiatry
Mid-Atlantic Addiction Technology Transfer Center
Virginia Commonwealth University
Richmond, VA

Scott F. Coffey, Ph.D.
Associate Professor
Department of Psychiatry and Human Behavior
University of Mississippi Medical Center
Jackson, MS

Renee M. Cunningham-Williams, M.S.W., M.P.E., Ph.D.
Research Assistant/Professor of Social Work
Department of Psychiatry
Washington University
St. Louis, MO

Chad D. Emrick, Ph.D.
Administrative Director
Substance Abuse Treatment Program
Denver VA Medical Center (116A1)
Denver, CO

Charles R. Figley, Ph.D.
Professor
Director of the Traumatology Institute
Florida State University
Tallahassee, FL

Larry M. Gentilello, M.D., FACS
Professor and Chairman
Division of Burn, Trauma, and Critical Care
University of Texas Southwestern Medical School
Dallas, TX

Robert Grant, Ph.D.
Trauma Consultant
Oakland, CA

Anthony (Tony) Taiwai Ng, M.D.
Disaster Psychiatrist
Washington, DC

Pallavi Nishith, Ph.D.
Associate Research Professor
Center for Trauma
Department of Psychology
University of Missouri–St. Louis
St. Louis, MO

Joseph B. Stone, Ph.D., CACIII, ICADC
Program Manager and Clinical Supervisor
Confederated Tribes of Grand Ronde Behavioral Health Program
Grand Ronde, OR

Michael Villanueva, Ph.D.
Research Professor
Center on Alcoholism, Substance Abuse, and Addiction
Albuquerque, NM

KAP Expert Panel and Federal Government Participants

Barry S. Brown, Ph.D.
Adjunct Professor
University of North Carolina–Wilmington
Carolina Beach, NC

Jacqueline Butler, M.S.W., LISW, LPCC, CCDC III, CJS
Professor of Clinical Psychiatry
College of Medicine
University of Cincinnati
Cincinnati, OH

Deion Cash
Executive Director
Community Treatment and Correction Center, Inc.
Canton, OH

Debra A. Claymore, M.Ed.Adm.
Owner/Chief Executive Officer
WC Consulting, LLC
Loveland, CO

Carlo C. DiClemente, Ph.D.
Chair
Department of Psychology
University of Maryland–Baltimore County
Baltimore, MD

Catherine E. Dube, Ed.D.
Independent Consultant
Brown University
Providence, RI

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief, Services
Division of Clinical and Services Research
National Institute on Drug Abuse
Bethesda, MD

Michael Galer, D.B.A.
Independent Consultant
Westminster, MA

Renata J. Henry, M.Ed.
Director
Division of Alcoholism, Drug Abuse and Mental Health
Delaware Department of Health and Social Services
New Castle, DE

Joel Hochberg, M.A.
President
Asher & Partners
Los Angeles, CA

Jack Hollis, Ph.D.
Associate Director, Center for Health Research
Kaiser Permanente
Portland, OR

Mary Beth Johnson, M.S.W.
Director
Addiction Technology Transfer Center
University of Missouri–Kansas City
Kansas City, MO

Eduardo Lopez
Executive Producer
EVS Communications
Washington, DC

Holly A. Massett, Ph.D.
Academy for Educational Development
Washington, DC

Diane Miller
Chief
Scientific Communications Branch
National Institute on Alcohol Abuse and Alcoholism
Bethesda, MD

Harry B. Montoya, M.A.
President/Chief Executive Officer
Hands Across Cultures
Española, NM

Richard K. Ries, M.D.
Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, WA

Gloria M. Rodriguez, D.S.W.
Research Scientist
Division of Addiction Services
New Jersey Department of Health and Senior Services
Trenton, NJ

Everett Rogers, Ph.D.
Center for Communications Programs
Johns Hopkins University
Baltimore, MD

Jean R. Slutsky, P.A., M.S.P.H.
Senior Health Policy Analyst
Agency for Healthcare Research & Quality
Rockville, MD

Nedra Klein Weinreich, M.S.
President
Weinreich Communications
Canoga Park, CA

Clarissa Wittenberg
Director
Office of Communications and Public Liaison
National Institute of Mental Health
Bethesda, MD

Consulting Members of the KAP Expert Panel

Paul Purnell, M.A
Social Solutions, LLC
Potomac, MD

Scott Ratzan, M.D., M.P.A., M.A.
Academy for Educational Development
Washington, DC

Thomas W. Valente, Ph.D.
Director
Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Los Angeles, CA

Patricia A. Wright, Ed.D.
Independent Consultant
Baltimore, MD

What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://store.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

Pamela S. Hyde, J.D.
Administrator
Substance Abuse and Mental Health Services Administration

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Frances M. Harding
Director
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

How This TIP Is Organized

This Treatment Improvement Protocol (TIP) is divided into three parts:

- Part 1: *A Practical Guide for the Provision of Behavioral Health Services*
- Part 2: *An Implementation Guide for Behavioral Health Program Administrators*
- Part 3: *A Review of the Literature*

Part 1 is for behavioral health service providers and consists of six chapters. Recurring themes include the variety of ways that substance abuse, mental health, and trauma interact; the importance of context and culture in a person's response to trauma; trauma-informed screening and assessment tools, techniques, strategies, and approaches that help behavioral health professionals assist clients in recovery from mental and substance use disorders who have also been affected by acute or chronic traumas; and the significance of adhering to a strengths-based perspective that acknowledges the resilience within individual clients, providers, and communities.

Chapter 1 lays the groundwork and rationale for the implementation and provision of trauma-informed services. It provides an overview of specific trauma-informed intervention and treatment principles that guide clinicians, other behavioral health workers, and administrators in becoming trauma informed and in creating a trauma-informed organization and workforce. Chapter 2 provides an overview of traumatic experiences. It covers types of trauma; distinguishes among traumas that affect individuals, groups, and communities; describes trauma characteristics; and addresses the socioecological and cultural factors that influence the impact of trauma. Chapter 3 broadly focuses on understanding the impact of trauma, trauma-related stress reactions and associated symptoms, and common mental health and substance use disorders associated with trauma. Chapter 4 provides an introduction to screening and assessment as they relate to trauma and is devoted to screening and assessment processes and tools that are useful in evaluating trauma exposure, its effects, and client intervention and treatment needs. Chapter 5 covers clinical issues that counselors and other behavioral health professionals may need to know and address when treating clients who have histories of trauma. Chapter 6 presents information on specific treatment models for trauma, distinguishing integrated models (which address substance use disorders, mental disorders, and trauma simultaneously) from those that treat trauma alone.

Advice to Counselors and/or Administrators boxes in Part 1 provide practical information for providers. Case illustrations, exhibits, and text boxes further illustrate information in the text by offering practical examples.

Part 2 provides an overview of programmatic and administrative practices that will help behavioral health program administrators increase the capacity of their organizations to deliver

trauma-informed services. Chapter 1 examines the essential ingredients, challenges, and processes in creating and implementing trauma-informed services within an organization. Chapter 2 focuses on key development activities that support staff members, including trauma-informed training and supervision, ethics, and boundaries pertinent to responding to traumatic stress, secondary trauma, and counselor self-care.

Advice to Administrators and/or Supervisors boxes in Part 2 highlight more detailed information that supports the organizational implementation of trauma-informed care (TIC). In addition, case illustrations, organizational activities, and text boxes reinforce the material presented within this section.

Part 3 is a literature review on TIC and behavioral health services and is intended for use by clinical supervisors, interested providers, and administrators. Part 3 has three sections: an analysis of the literature, links to select abstracts of the references most central to the topic, and a general bibliography of the available literature. To facilitate ongoing updates (performed periodically for up to 3 years from first publication), the literature review is only available online at the Substance Abuse and Mental Health Services Administration (SAMHSA) Publications Ordering Web page (http://store.samhsa.gov).

Terminology

Behavioral health: Throughout the TIP, the term "behavioral health" is used. Behavioral health refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illness and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used in this TIP to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use and related problems, treatments and services for mental and substance use disorders, and recovery support. Because behavioral health conditions, taken together, are the leading causes of disability burden in North America, efforts to improve their prevention and treatment will benefit society as a whole. Efforts to reduce the impact of mental and substance use disorders on America's communities, such as those described in this TIP, will help achieve nationwide improvements in health.

Client/consumer: In this TIP, the term "client" means anyone who seeks or receives mental health or substance abuse services. The term "consumer" stands in place of "client" in content areas that address consumer participation and determination. It is not the intent of this document to ignore the relevance and historical origin of the term "consumer" among individuals who have received, been subject to, or are seeking mental health services. Instead, we choose the word "client," given that this terminology is also commonly used in substance abuse treatment services. Note: This TIP also uses the term "participant(s)" instead of "client(s)" for individuals, families, or communities seeking or receiving prevention services.

Complex trauma: This manual adopts the National Child Traumatic Stress Network (NCTSN) definition of complex trauma. The term refers to the pervasive impact, including developmental

consequences, of exposure to multiple or prolonged traumatic events. According to the NCTSN Web site (http://www.nctsn.org/trauma-types), complex trauma typically involves exposure to sequential or simultaneous occurrences of maltreatment, "including psychological maltreatment, neglect, physical and sexual abuse, and domestic violence…. Exposure to these initial traumatic experiences—and the resulting emotional dysregulation and the loss of safety, direction, and the ability to detect or respond to danger cues—often sets off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood" (NCTSN, 2013).

Co-occurring disorders: When an individual has one or more mental disorders as well as one or more substance use disorders (including substance abuse), the term "co-occurring" applies. Although people may have a number of health conditions that co-occur, including physical problems, the term "co-occurring disorders," in this TIP, refers to substance use and mental disorders.

Cultural responsiveness and cultural competence: This TIP uses these terms interchangeably, with "responsiveness" applied to services and systems and "competence" applied to people, to refer to "a set of behaviors, attitudes, and policies that…enable a system, agency, or group of professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 13). Culturally responsive behavioral health services and culturally competent providers "honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services…. [C]ultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time" (U.S. Department of Health and Human Services, 2003, p. 12).

Evidence-based practices: There are many different uses of the term "evidence-based practices." One of the most widely accepted is that of Chambless and Hollon (1998), who say that for a treatment to be considered evidence based, it must show evidence of positive outcomes based on peer-reviewed randomized controlled trials or other equivalent strong methodology. A treatment is labeled "strong" if criteria are met for what Chambless and Hollon term "well-established" treatments. To attain this level, rigorous treatment outcome studies conducted by independent investigators (not just the treatment developer) are necessary. Research support is labeled "modest" when treatments attain criteria for what Chambless and Hollon call "probably efficacious treatments." To meet this standard, one well-designed study or two or more adequately designed studies must support a treatment's efficacy. In addition, it is possible to meet the "strong" and "modest" thresholds through a series of carefully controlled single-case studies. An evidence-based practice derived from sound, science-based theories incorporates detailed and empirically supported procedures and implementation guidelines, including parameters of applications (such as for populations), inclusionary and exclusionary criteria for participation, and target interventions.

Promising practices: Even though current clinical wisdom, theories, and professional and expert consensus may support certain practices, these practices may lack support from studies that are scientifically rigorous in research design and statistical analysis; available studies may be limited in number or sample size, or they may not be applicable to the current setting or population. This TIP refers to such practices as "promising."

Recovery: This term denotes a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Major dimensions that support a life in recovery, as defined by SAMHSA, include:

- ***Health:*** overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.
- ***Home:*** a stable and safe place to live.
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- ***Community:*** relationships and social networks that provide support, friendship, love, and hope.

Resilience: This term refers to the ability to bounce back or rise above adversity as an individual, family, community, or provider. Well beyond individual characteristics of hardiness, resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events. This TIP applies the term "resilience" and its processes to individuals across the life span.

Retraumatization: In its more literal translation, "retraumatization" means the occurrence of traumatic stress reactions and symptoms after exposure to multiple events (Duckworth & Follette, 2011). This is a significant issue for trauma survivors, both because they are at increased risk for higher rates of retraumatization, and because people who are traumatized multiple times often have more serious and chronic trauma-related symptoms than those with single traumas. In this manual, the term not only refers to the effect of being exposed to multiple events, but also implies the process of reexperiencing traumatic stress as a result of a current situation that mirrors or replicates in some way the prior traumatic experiences (e.g., specific smells or other sensory input; interactions with others; responses to one's surroundings or interpersonal context, such as feeling emotionally or physically trapped).

Secondary trauma: Literature often uses the terms "secondary trauma," "compassion fatigue," and "vicarious traumatization" interchangeably. Although compassion fatigue and secondary trauma refer to similar physical, psychological, and cognitive changes and symptoms that behavioral health workers may encounter when they work specifically with clients who have histories of trauma, vicarious trauma usually refers more explicitly to specific cognitive changes, such as in worldview and sense of self (Newell & MacNeil, 2010). This publication uses "secondary trauma" to describe trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event. Secondary trauma can occur among behavioral health service providers across all behavioral health settings and among all professionals who provide services to those who have experienced trauma (e.g., healthcare providers, peer counselors, first responders, clergy, intake workers).

Substance abuse: Throughout the TIP, the term "substance abuse" has been used to refer to both substance abuse and substance dependence. This term was chosen partly because behavioral health professionals commonly use the term substance abuse to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs to determine what possible range of meanings it covers; in most cases, it will refer to all varieties of substance-related

disorders as found in *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (American Psychiatric Association, 2013a).

Trauma: In this text, the term "trauma" refers to experiences that cause intense physical and psychological stress reactions. It can refer to "a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Although many individuals report a single specific traumatic event, others, especially those seeking mental health or substance abuse services, have been exposed to multiple or chronic traumatic events. See the "What Is Trauma" section in Part 1, Chapter 1, for a more indepth definition and discussion of trauma.

Trauma-informed: A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. In May 2012, SAMHSA convened a group of national experts who identified three key elements of a trauma-informed approach: "(1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice" (SAMHSA, 2012, p 4).

Trauma-informed care: TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.

Trauma-specific treatment services: These services are evidence-based and promising practices that facilitate recovery from trauma. The term "trauma-specific services" refers to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.

Trauma survivor: This phrase can refer to anyone who has experienced trauma or has had a traumatic stress reaction. Knowing that the use of language and words can set the tone for recovery or contribute to further retraumatization, it is the intent of this manual to put forth a message of hope by avoiding the term "victim" and instead using the term "survivor" when appropriate.

Part 1: A Practical Guide for the Provision of Behavioral Health Services

1 Trauma-Informed Care: A Sociocultural Perspective

IN THIS CHAPTER

- Scope of the TIP
- Intended Audience
- Before You Begin
- Structure of the TIP
- What Is Trauma?
- Trauma Matters in Behavioral Health Services
- Trauma Informed Intervention and Treatment Principles
- As You Proceed

Many individuals who seek treatment in behavioral health settings have histories of trauma, but they often don't recognize the significant effects of trauma in their lives; either they don't draw connections between their trauma histories and their presenting problems, or they avoid the topic altogether. Likewise, treatment providers may not ask questions that elicit a client's history of trauma, may feel unprepared to address trauma-related issues proactively, or may struggle to address traumatic stress effectively within the constraints of their treatment program, the program's clinical orientation, or their agency's directives.

By recognizing that traumatic experiences and their sequelae tie closely into behavioral health problems, front-line professionals and community-based programs can begin to build a trauma-informed environment across the continuum of care. Key steps include meeting client needs in a safe, collaborative, and compassionate manner; preventing treatment practices that retraumatize people with histories of trauma who are seeking help or receiving services; building on the strengths and resilience of clients in the context of their environments and communities; and endorsing trauma-informed principles in agencies through support, consultation, and supervision of staff.

This Treatment Improvement Protocol (TIP) begins by introducing the scope, purpose, and organization of the topic and describing its intended audience. Along with defining trauma and trauma-informed care (TIC), the first chapter discusses the rationale for addressing trauma in behavioral health services and reviews trauma-informed intervention and treatment principles. These principles serve as the TIP's conceptual framework.

Scope of the TIP

Many individuals experience trauma during their lifetimes. Although many people exposed to trauma demonstrate few or no lingering symptoms, those individuals who have experienced repeated, chronic, or multiple traumas are more likely to exhibit pronounced symptoms and consequences, including substance abuse, mental illness, and health problems. Subsequently, trauma can significantly affect how an individual engages in major life areas as well as treatment.

This TIP provides evidence-based and best practice information for behavioral health service providers and administrators who want to work more effectively with people who have been exposed to acute and chronic traumas and/or are at risk of developing traumatic stress reactions. Using key trauma-informed principles, this TIP addresses trauma-related prevention, intervention, and treatment issues and strategies in behavioral health services. The content is adaptable across behavioral health settings that service individuals, families, and communities—placing emphasis on the importance of coordinating as well as integrating services.

Intended Audience

This TIP is for behavioral health service providers, prevention specialists, and program administrators—the professionals directly responsible for providing care to trauma survivors across behavioral health settings, including substance abuse and mental health services. This TIP also targets primary care professionals, including physicians; teams working with clients and communities who have experienced trauma; service providers in the criminal justice system; and researchers with an interest in this topic.

Before You Begin

This TIP endorses a trauma-informed model of care; this model emphasizes the need for behavioral health practitioners and organizations to recognize the prevalence and pervasive impact of trauma on the lives of the people they serve and develop trauma-sensitive or trauma-responsive services. This TIP provides key information to help behavioral health practitioners and program administrators become trauma aware and informed, improve screening and assessment processes, and implement science-informed intervention strategies across settings and modalities in behavioral health services. Whether provided by an agency or an individual provider, trauma-informed services may or may not include trauma-specific services or trauma specialists (individuals who have advanced training and education to provide specific treatment interventions to address traumatic stress reactions). Nonetheless, TIC anticipates the role that trauma can play across the continuum of care—establishing integrated and/or collaborative processes to address the needs of traumatized individuals and communities proactively.

Individuals who have experienced trauma are at an elevated risk for substance use disorders, including abuse and dependence; mental health problems (e.g., depression and anxiety symptoms or disorders, impairment in relational/social and other major life areas, other distressing symptoms); and physical disorders and conditions, such as sleep disorders. This TIP focuses on specific types of prevention (Institute of Medicine et al., 2009): selective prevention, which targets people who are at risk for developing social, psychological, or other conditions as a result of trauma or who are at greater risk for experiencing trauma due to behavioral health disorders or conditions; and indicated prevention, which targets people who display early signs of trauma-related

symptoms. This TIP identifies interventions, including trauma-informed and trauma-specific strategies, and perceives treatment as a means of prevention—building on resilience, developing safety and skills to negotiate the impact of trauma, and addressing mental and substance use disorders to enhance recovery.

This TIP's target population is adults. Beyond the context of family, this publication does not examine or address youth and adolescent responses to trauma, youth-tailored trauma-informed strategies, or trauma-specific interventions for youth or adolescents, because the developmental and contextual issues of these populations require specialized interventions. Providers who work with young clients who have experienced trauma should refer to the resource list in Appendix B. This TIP covers TIC, trauma characteristics, the impact of traumatic experiences, assessment, and interventions for persons who have had traumatic experiences. Considering the vast knowledge base and specificity of individual, repeated, and chronic forms of trauma, this TIP does not provide a comprehensive overview of the unique characteristics of each type of trauma (e.g., sexual abuse, torture, war-related trauma, murder). Instead, this TIP provides an overview supported by examples. For more information on several specific types of trauma, please refer to TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (Center for Substance Abuse Treatment [CSAT], 2000b), TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b), TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d), and the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (Substance Abuse and Mental Health Services Administration [SAMHSA], planned f).

This TIP, *Trauma-Informed Care in Behavioral Health Services*, is guided by SAMHSA's Strategic Initiatives described in *Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014* (SAMHSA, 2011b). Specific to Strategic Initiative #2, Trauma and Justice, this TIP addresses several goals, objectives, and actions outlined in this initiative by providing behavioral health practitioners, supervisors, and administrators with an introduction to culturally responsive TIC.

Specifically, the TIP presents fundamental concepts that behavioral health service providers can use to:

- Become trauma aware and knowledgeable about the impact and consequences of traumatic experiences for individuals, families, and communities.
- Evaluate and initiate use of appropriate trauma-related screening and assessment tools.
- Implement interventions from a collaborative, strengths-based approach, appreciating the resilience of trauma survivors.
- Learn the core principles and practices that reflect TIC.
- Anticipate the need for specific trauma-informed treatment planning strategies that support the individual's recovery.
- Decrease the inadvertent retraumatization that can occur from implementing standard organizational policies, procedures, and interventions with individuals, including clients and staff, who have experienced trauma or are exposed to secondary trauma.
- Evaluate and build a trauma-informed organization and workforce.

The consensus panelists, as well as other contributors to this TIP, have all had experience as substance abuse and mental health counselors, prevention and peer specialists, supervisors, clinical directors, researchers, or administrators working with individuals, families, and

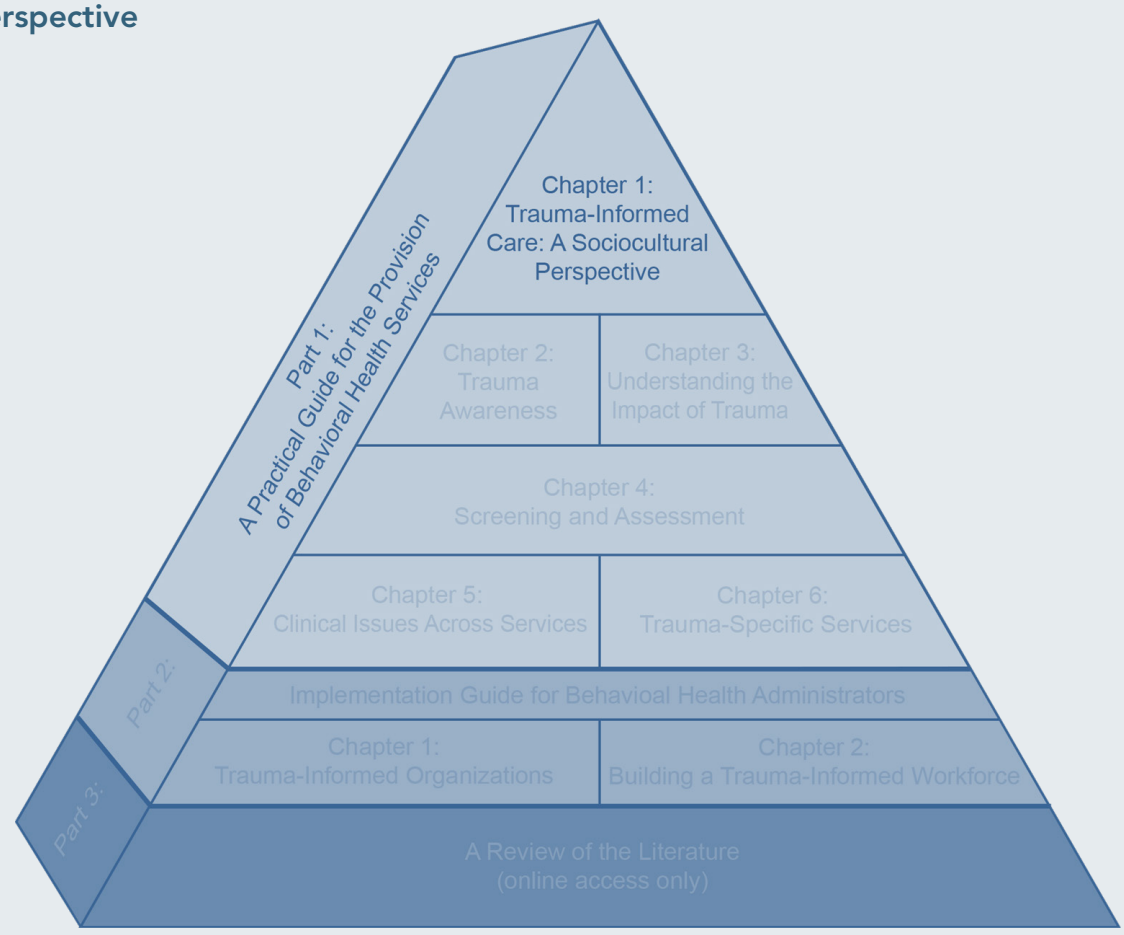
communities who have experienced trauma. The material presented in this TIP uses the wealth of their experience in addition to the available published resources and research relevant to this topic. Throughout the consensus process, the panel members were mindful of the strengths and resilience inherent in individuals, families, and communities affected by trauma and the challenges providers face in addressing trauma and implementing TIC.

Structure of the TIP

Using a TIC framework (Exhibit 1.1-1), this TIP provides information on key aspects of trauma, including what it is; its consequences; screening and assessment; effective prevention, intervention, and treatment approaches; trauma recovery; the impact of trauma on service providers; programmatic and administrative practices; and trauma resources.

Note: To produce a user-friendly but informed document, the first two parts of the TIP include minimal citations. If you are interested in the citations associated with topics covered in Parts 1 and 2, please consult the review of the literature provided in Part 3 (available online at http://store.samhsa.gov). Parts 1 and 2 are easily read and digested on their own, but it is highly recommended that you read the literature review as well.

Exhibit 1.1-1: TIC Framework in Behavioral Health Services—Sociocultural Perspective



What Is Trauma?

According to SAMHSA's Trauma and Justice Strategic Initiative, "trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Trauma can affect people of every race, ethnicity, age, sexual orientation, gender, psychosocial background, and geographic region. A traumatic experience can be a single event, a series of events, and/or a chronic condition (e.g., childhood neglect, domestic violence). Traumas can affect individuals, families, groups, communities, specific cultures, and generations. It generally overwhelms an individual's or community's resources to cope, and it often ignites the "fight, flight, or freeze" reaction at the time of the event(s). It frequently produces a sense of fear, vulnerability, and helplessness.

See Appendix C to read about the history of trauma and trauma interventions.

Often, traumatic events are unexpected. Individuals may experience the traumatic event directly, witness an event, feel threatened, or hear about an event that affects someone they know. Events may be human-made, such as a mechanical error that causes a disaster, war, terrorism, sexual abuse, or violence, or they can be the products of nature (e.g., flooding, hurricanes, tornadoes). Trauma can occur at any age or developmental stage, and often, events that occur outside expected life stages are perceived as traumatic (e.g., a child dying before a parent, cancer as a teen, personal illness, job loss before retirement).

It is not just the event itself that determines whether something is traumatic, but also the individual's experience of the event. Two people may be exposed to the same event or series of events but experience and interpret these events in vastly different ways. Various biopsychosocial and cultural factors influence an individual's immediate response and long-term reactions to trauma. For most, regardless of the severity of the trauma, the immediate or enduring effects of trauma are met with resilience—the ability to rise above the circumstances or to meet the challenges with fortitude.

For some people, reactions to a traumatic event are temporary, whereas others have prolonged reactions that move from acute symptoms to more severe, prolonged, or enduring mental health consequences (e.g., posttraumatic stress and other anxiety disorders, substance use and mood disorders) and medical problems (e.g., arthritis, headaches, chronic pain). Others do not meet established criteria for posttraumatic stress or other mental disorders but encounter significant trauma-related symptoms or culturally expressed symptoms of trauma (e.g., somatization, in which psychological stress is expressed through physical concerns). For that reason, even if an individual does not meet diagnostic criteria for trauma-related disorders, it is important to recognize that trauma may still affect his or her life in significant ways. For more information on traumatic events, trauma characteristics, traumatic stress reactions, and factors that heighten or decrease the impact of trauma, see Part 1, Chapter 2, "Trauma Awareness," and Part 1, Chapter 3, "Understanding the Impact of Trauma."

Trauma Matters in Behavioral Health Services

The past decade has seen an increased focus on the ways in which trauma, psychological distress, quality of life, health, mental illness,

and substance abuse are linked. With the attacks of September 11, 2001, and other acts of terror, the wars in Iraq and Afghanistan, disastrous hurricanes on the Gulf Coast, and sexual abuse scandals, trauma has moved to the forefront of national consciousness.

Trauma was once considered an abnormal experience. However, the first National Comorbidity Study established how prevalent traumas were in the lives of the general population of the United States. In the study, 61 percent of men and 51 percent of women reported experiencing at least one trauma in their lifetime, with witnessing a trauma, being involved in a natural disaster, and/or experiencing a life-threatening accident ranking as the most common events (Kessler et al., 1999). In Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions, 71.6 percent of the sample reported witnessing trauma, 30.7 percent experienced a trauma that resulted in injury, and 17.3 percent experienced psychological trauma (El-Gabalawy, 2012). For a thorough review of the impact of trauma on quality of life and health and among individuals with mental and substance use disorders, refer to Part 3 of this TIP, the online literature review.

Rationale for TIC

Integrating TIC into behavioral health services provides many benefits not only for clients, but also for their families and communities, for behavioral health service organizations, and for staff. Trauma-informed services bring to the forefront the belief that trauma can pervasively affect an individual's well-being, including physical and mental health. For behavioral health service providers, trauma-informed practice offers many opportunities. It reinforces the importance of acquiring trauma-specific knowledge and skills to meet the specific needs of clients; of recognizing that individuals may be affected by trauma regardless of its acknowledgment; of understanding that trauma likely affects many clients who are seeking behavioral health services; and of acknowledging that organizations and providers can retraumatize clients through standard or unexamined policies and practices. TIC stresses the importance of addressing the client individually rather than applying general treatment approaches.

TIC provides clients more opportunities to engage in services that reflect a compassionate perspective of their presenting problems. TIC can potentially provide a greater sense of safety for clients who have histories of trauma and a platform for preventing more serious consequences of traumatic stress (Fallot & Harris, 2001). Although many individuals may not identify the need to connect with their histories, trauma-informed services offer clients a chance to explore the impact of trauma, their strengths and creative adaptations in managing traumatic histories, their resilience, and the relationships among trauma, substance use, and psychological symptoms.

Two Influential Studies That Set the Stage for the Development of TIC

The Adverse Childhood Experiences Study (Centers for Disease Control and Prevention, 2013) was a large epidemiological study involving more than 17,000 individuals from United States; it analyzed the long-term effects of childhood and adolescent traumatic experiences on adult health risks, mental health, healthcare costs, and life expectancy.

The Women, Co-Occurring Disorders and Violence Study (SAMHSA, 2007) was a large multisite study focused on the role of interpersonal and other traumatic stressors among women; the interrelatedness of trauma, violence, and co-occurring substance use and mental disorders; and the incorporation of trauma-informed and trauma-specific principles, models, and services.

Implementing trauma-informed services can improve screening and assessment processes, treatment planning, and placement while also decreasing the risk for retraumatization. The implementation may enhance communication between the client and treatment provider, thus decreasing risks associated with misunderstanding the client's reactions and presenting problems or underestimating the need for appropriate referrals for evaluation or trauma-specific treatment. Organizational investment in developing or improving trauma-informed services may also translate to cost effectiveness, in that services are more appropriately matched to clients from the outset. TIC is an essential ingredient in organizational risk management; it ensures the implementation of decisions that will optimize therapeutic outcomes and minimize adverse effects on the client and, ultimately, the organization. A key principle is the engagement of community, clients, and staff. Clients and staff are more apt to be empowered, invested, and satisfied if they are involved in the ongoing development and delivery of trauma-informed services.

An organization also benefits from work development practices through planning for, attracting, and retaining a diverse workforce of individuals who are knowledgeable about trauma and its impact. Developing a trauma-informed organization involves hiring and promotional practices that attract and retain individuals who are educated and trained in trauma-informed practices on all levels of the organization, including board as well as peer support appointments. Trauma-informed organizations are invested in their staff and adopt similar trauma-informed principles, including establishing and providing ongoing support to promote TIC in practice and in addressing secondary trauma and implementing processes that reinforce the safety of the staff. Even though investing in a trauma-informed workforce does not necessarily guarantee trauma-informed practices, it is more likely that services will evolve more proficiently to meet client, staff, and community needs.

Advice to Counselors: The Importance of TIC

The history of trauma raises various clinical issues. Many counselors do not have extensive training in treating trauma or offering trauma-informed services and may be uncertain of how to respond to clients' trauma-related reactions or symptoms. Some counselors have experienced traumas themselves that may be triggered by clients' reports of trauma. Others are interested in helping clients with trauma but may unwittingly cause harm by moving too deeply or quickly into trauma material or by discounting or disregarding a client's report of trauma. Counselors must be aware of trauma-related symptoms and disorders and how they affect clients in behavioral health treatment.

Counselors with primary treatment responsibilities should also have an understanding of how to recognize trauma-related reactions, how to incorporate treatment interventions for trauma-related symptoms into clients' treatment plans, how to help clients build a safety net to prevent further trauma, how to conduct psychoeducational interventions, and when to make treatment referrals for further evaluations or trauma-specific treatment services. All treatment staff should recognize that traumatic stress symptoms or trauma-related disorders should not preclude an individual from mental health or substance abuse treatment and that all co-occurring disorders need to be addressed on some level in the treatment plan and setting. For example, helping a client in substance abuse treatment gain control over trauma-related symptoms can greatly improve the client's chances of substance abuse recovery and lower the possibility of relapse (Farley, Golding, Young, Mulligan, & Minkoff, 2004; Ouimette, Ahrens, Moos, & Finney, 1998). In addition, assisting a client in achieving abstinence builds a platform upon which recovery from traumatic stress can proceed.

Trauma and Substance Use Disorders

Many people who have substance use disorders have experienced trauma as children or adults (Koenen, Stellman, Sommer, & Stellman, 2008; Ompad et al., 2005). Substance abuse is known to predispose people to higher rates of traumas, such as dangerous situations and accidents, while under the influence (Stewart & Conrod, 2003; Zinzow, Resnick, Amstadter, McCauley, Ruggiero, & Kilpatrick, 2010) and as a result of the lifestyle associated with substance abuse (Reynolds et al., 2005). In addition, people who abuse substances and have experienced trauma have worse treatment outcomes than those without histories of trauma (Driessen et al., 2008; Najavits et al., 2007). Thus, the process of recovery is more difficult, and the counselor's role is more challenging, when clients have histories of trauma. A person presenting with both trauma and substance abuse issues can have a variety of other difficult life problems that commonly accompany these disorders, such as other psychological symptoms or mental disorders, poverty, homelessness, increased risk of HIV and other infections, and lack of social support (Mills, Teesson, Ross, & Peters, 2006; Najavits, Weiss, & Shaw, 1997). Many individuals who seek treatment for substance use disorders have histories of one or more traumas. More than half of women seeking substance abuse treatment report one or more lifetime traumas (Farley, Golding, Young, Mulligan, & Minkoff, 2004; Najavits et al., 1997), and a significant number of clients in inpatient treatment also have subclinical traumatic stress symptoms or posttraumatic stress disorder (PTSD; Falck, Wang, Siegal, & Carlson, 2004; Grant et al., 2004; Reynolds et al., 2005).

Trauma and Mental Disorders

People who are receiving treatment for severe mental disorders are more likely to have histories of trauma, including childhood physical and sexual abuse, serious accidents, homelessness, involuntary psychiatric hospitalizations, drug overdoses, interpersonal violence, and other forms of violence. Many clients with severe mental disorders meet criteria for PTSD; others with serious mental illness who have histories of trauma present with psychological symptoms or mental disorders that are commonly associated with a history of trauma, including anxiety symptoms and disorders, mood disorders (e.g., major depression, dysthymia, bipolar disorder; Mueser et al., 2004), impulse control disorders, and substance use disorders (Kessler, Chiu, Demler, & Walters, 2005).

Traumatic stress increases the risk for mental illness, and findings suggest that traumatic stress increases the symptom severity of mental illness (Spitzer, Vogel, Barnow, Freyberger & Grabe, 2007). These findings propose that traumatic stress plays a significant role in perpetuating and exacerbating mental illness and suggest that trauma often precedes the development of mental disorders. As with trauma and substance use disorders, there is a bidirectional relationship; mental illness increases the risk of experiencing trauma, and trauma increases the risk of developing psychological symptoms and mental disorders. For a more comprehensive review of the interactions among traumatic stress, mental illness, and substance use disorders, refer to Part 3 of this TIP, the online literature review.

Trauma-Informed Intervention and Treatment Principles

TIC is an intervention and organizational approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health services from prevention through treatment. There are many definitions of TIC and various models for incorporating it across organizations, but a "trauma-informed approach incorporates three key elements: (1) *realizing* the prevalence of trauma; (2) *recognizing* how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) *responding* by putting this knowledge into practice" (SAMHSA, 2012, p. 4).

TIC begins with the first contact a person has with an agency; it requires all staff members (e.g., receptionists, intake personnel, direct care staff, supervisors, administrators, peer supports, board members) to recognize that the individual's experience of trauma can greatly influence his or her receptivity to and engagement with services, interactions with staff and clients, and responsiveness to program guidelines, practices, and interventions. TIC includes program policies, procedures, and practices to protect the vulnerabilities of those who have experienced trauma and those who provide trauma-related services. TIC is created through a supportive environment and by redesigning organizational practices, with consumer participation, to prevent practices that could be retraumatizing (Harris & Fallot, 2001c; Hopper et al., 2010). The ethical principle, "first, do no harm," resonates strongly in the application of TIC.

> "A program, organization, or system that is trauma informed realizes the widespread impact of trauma and under stands poten tial paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings."
>
> (SAMHSA, 2012, p. 4)

TIC involves a commitment to building competence among staff and establishing programmatic standards and clinical guidelines that support the delivery of trauma-sensitive services. It encompasses recruiting, hiring, and retaining competent staff; involving consumers, trauma survivors, and peer support specialists in the planning, implementation, and evaluation of trauma-informed services; developing collaborations across service systems to streamline referral processes, thereby securing trauma-specific services when appropriate; and building a continuity of TIC as consumers move from one system or service to the next. TIC involves reevaluating each service delivery component through a trauma-aware lens.

The principles described in the following subsections serve as the TIP's conceptual

Advice to Counselors: Implementing Trauma-Informed Services

Recognizing that trauma affects a majority of clients served within public health systems, the National Center for Trauma-Informed Care (NCTIC) has sought to establish a comprehensive framework to guide systems of care in the development of trauma-informed services. If a system or program is to support the needs of trauma survivors, it must take a systematic approach that offers trauma-specific diagnostic and treatment services, as well as a trauma-informed environment that is able to sustain such services, while fostering positive outcomes for the clients it serves. NCTIC also offers technical assistance in the implementation of trauma-informed services. For specific administrative information on TIC implementation, refer to Part 2, Chapters 1 and 2, of this TIP.

framework. These principles comprise a compilation of resources, including research, theoretical papers, commentaries, and lessons learned from treatment facilities. Key elements are outlined for each principle in providing services to clients affected by trauma and to populations most likely to incur trauma. Although these principles are useful across all prevention and intervention services, settings, and populations, they are of the utmost importance in working with people who have had traumatic experiences.

Promote Trauma Awareness and Understanding

Foremost, a behavioral health service provider must recognize the prevalence of trauma and its possible role in an individual's emotional, behavioral, cognitive, spiritual, and/or physical development, presentation, and well-being. Being vigilant about the prevalence and potential consequences of traumatic events among clients allows counselors to tailor their presentation styles, theoretical approaches, and intervention strategies from the outset to plan for and be responsive to clients' specific needs. Although not every client has a history of trauma, those who have substance use and mental disorders are more likely to have experienced trauma. Being trauma aware does not mean that you must assume everyone has a history of trauma, but rather that you anticipate the possibility from your initial contact and interactions, intake processes, and screening and assessment procedures.

Even the most standard behavioral health practices can retraumatize an individual exposed to prior traumatic experiences if the provider implements them without recognizing or considering that they may do harm. For example, a counselor might develop a treatment plan recommending that a female client—who has been court mandated to substance abuse treatment and was raped as an adult—attend group therapy, but without considering the implications, for her, of the fact that the only available group at the facility is all male and has had a low historical rate of female participation. Trauma awareness is an essential strategy for preventing this type of retraumatization; it reinforces the need for providers to reevaluate their usual practices.

> "Trauma informed care embraces a perspective that highlights adaptation over symptoms and resilience over pathology."
>
> (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005, p. 467)

Becoming trauma aware does not stop with the recognition that trauma can affect clients; instead, it encompasses a broader awareness that traumatic experiences as well as the impact of an individual's trauma can extend to significant others, family members, first responders and other medical professionals, behavioral health workers, broader social networks, and even entire communities. Family members frequently experience the traumatic stress reactions of the individual family member who was traumatized (e.g., angry outbursts, nightmares, avoidant behavior, other symptoms of anxiety, overreactions or underreactions to stressful events). These repetitive experiences can increase the risk of secondary trauma and symptoms of mental illness among the family, heighten the risk for externalizing and internalizing behavior among children (e.g., bullying others, problems in social relationships, health-damaging behaviors), increase children's risk for developing posttraumatic stress later in life, and lead to a greater propensity for traumatic stress reactions across generations of the family. Hence, prevention and intervention services can provide education and age-appropriate programming tailored to develop coping skills and support systems.

So too, behavioral health service providers can be influenced by exposure to trauma-related affect and content when working with clients. A trauma-aware workplace supports supervision and program practices that educate all direct service staff members on secondary trauma, encourages the processing of trauma-related content through participation in peer-supported activities and clinical supervision, and provides them with professional development opportunities to learn about and engage in effective coping strategies that help prevent secondary trauma or trauma-related symptoms. It is important to generate trauma awareness in agencies through education across services and among all staff members who have any direct or indirect contact with clients (including receptionists or intake and admission personnel who engage clients for the first time within the agency). Agencies can maintain a trauma-aware environment through ongoing staff training, continued supervisory and administrative support, collaborative (i.e., involving consumer participation) trauma-responsive program design and implementation, and organizational policies and practices that reflect accommodation and flexibility in attending to the needs of clients affected by trauma.

Recognize That Trauma-Related Symptoms and Behaviors Originate From Adapting to Traumatic Experiences

A trauma-informed perspective views trauma-related symptoms and behaviors as an individual's best and most resilient attempt to manage, cope with, and rise above his or her experience of trauma. Some individuals' means of adapting and coping have produced little difficulty; the coping and adaptive strategies of others have worked in the past but are not working as well now. Some people have difficulties in one area of life but have effectively negotiated and functioned in other areas.

Individuals who have survived trauma vary widely in how they experience and express traumatic stress reactions. Traumatic stress reactions vary in severity; they are often measured by the level of impairment or distress that clients report and are determined by the multiple factors that characterize the trauma itself, individual history and characteristics, developmental factors, sociocultural attributes, and available resources. The characteristics of the trauma and the subsequent traumatic stress reactions can dramatically influence how individuals respond to the environment, relationships, interventions, and treatment services, and those same characteristics can also shape the assumptions that clients/consumers make about their world (e.g., their view of others, sense of safety), their future (e.g., hopefulness, fear of a foreshortened future), and themselves (e.g., feeling resilient, feeling incompetent in regulating emotions). The breadth of these effects may be observable or subtle.

Once you become aware of the significance of traumatic experiences in clients' lives and begin to view their presentation as adaptive, your identification and classification of their presenting symptoms and behaviors can shift from a "pathology" mindset (i.e., defining clients strictly from a diagnostic label, implying that something is wrong with them) to one of resilience—a mindset that views clients' presenting difficulties, behaviors, and emotions as responses to surviving trauma. In essence, you will come to view traumatic stress reactions as *normal* reactions to *abnormal* situations. In embracing the belief that trauma-related reactions are adaptive, you can begin relationships with clients from a hopeful, strengths-based stance that builds upon the belief that their responses to traumatic experiences reflect creativity, self-preservation, and determination.

This will help build mutual and collaborative therapeutic relationships, help clients identify what has worked and has not worked in their attempts to deal with the aftermath of trauma from a nonjudgmental stance, and develop intervention and coping strategies that are more likely to fit their strengths and resources. This view of trauma prevents further retraumatization by not defining traumatic stress reactions as pathological or as symptoms of pathology.

View Trauma in the Context of Individuals' Environments

Many factors contribute to a person's response to trauma, whether it is an individual, group, or community-based trauma. Individual attributes, developmental factors (including protective and risk factors), life history, type of trauma, specific characteristics of the trauma, amount and length of trauma exposure, cultural meaning of traumatic events, number of losses associated with the trauma, available resources (internal and external, such as coping skills and family support), and community reactions are a few of the determinants that influence a person's responses to trauma across time. Refer to the "View Trauma Through a Sociocultural Lens" section later in this chapter for more specific information highlighting the importance of culture in understanding and treating the effects of trauma.

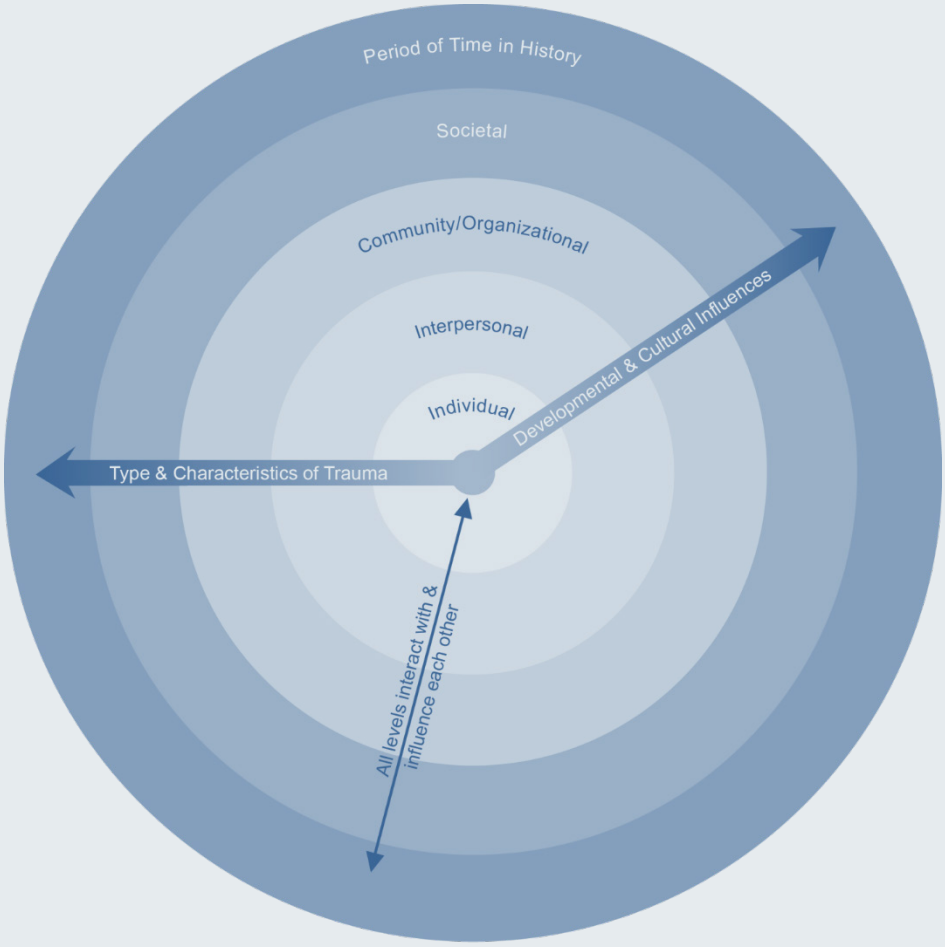
Trauma cannot be viewed narrowly; instead, it needs to be seen through a broader lens—a contextual lens integrating biopsychosocial, interpersonal, community, and societal (the degree of individualistic or collective cultural values) characteristics that are evident preceding and during the trauma, in the immediate and sustained response to the event(s), and in the short- and long-term effects of the traumatic event(s), which may include housing availability, community response, adherence to or maintenance of family routines and structure, and level of family support.

To more adequately understand trauma, you must also consider the contexts in which it occurred. Understanding trauma from this angle helps expand the focus beyond individual characteristics and effects to a broader systemic perspective that acknowledges the influences of social interactions, communities, governments, cultures, and so forth, while also examining the possible interactions among those various influences. Bronfenbrenner's (1979) and Bronfenbrenner and Ceci's (1994) work on ecological models sparked the development of other contextual models. In recent years, the social-ecological framework has been adopted in understanding trauma, in implementing health promotion and other prevention strategies, and in developing treatment interventions (Centers for Disease Control and Prevention, 2009). Here are the three main beliefs of a social-ecological approach (Stokols, 1996):

- Environmental factors greatly influence emotional, physical, and social well-being.
- A fundamental determinant of health versus illness is the degree of fit between individuals' biological, behavioral, and sociocultural needs and the resources available to them.
- Prevention, intervention, and treatment approaches integrate a combination of strategies targeting individual, interpersonal, and community systems.

This TIP uses a social-ecological model to explore trauma and its effects (Exhibit 1.1-2). The focus of this model is not only on negative attributes (risk factors) across each level, but also on positive ingredients (protective factors) that protect against or lessen the impact of trauma. This model also guides the inclusion of certain targeted interventions in this text, including selective and indicated

Exhibit 1.1-2: A Social-Ecological Model for Understanding Trauma and Its Effects



prevention activities. In addition, culture, developmental processes (including the developmental stage or characteristics of the individual and/or community), and the specific era when the trauma(s) occurred can significantly influence how a trauma is perceived and processed, how an individual or community engages in help-seeking, and the degree of accessibility, acceptability, and availability of individual and community resources.

Depending on the developmental stage and/or processes in play, children, adolescents, and adults will perceive, interpret, and cope with traumatic experiences differently. For example, a child may view a news story depicting a traumatic event on television and believe that the trauma is recurring every time they see the scene replayed. Similarly, the era in which one lives and the timing of the trauma can greatly influence an individual or community response. Take, for example, a pregnant woman who is abusing drugs and is wary of receiving medical treatment after being beaten in a domestic dispute. She may fear losing her children or being arrested for child neglect. Even though a number of States have adopted policies focused on the importance of treatment for pregnant women who are abusing drugs and of the accessibility of prenatal care, other States have approached this issue from a criminality standpoint (e.g., with child welfare and criminal laws) in the past few decades. Thus, the traumatic event's timing is a significant

component in understanding the context of trauma and trauma-related responses.

The social-ecological model depicted in Exhibit 1.1-2 provides a systemic framework for looking at individuals, families, and communities affected by trauma in general; it highlights the bidirectional influence that multiple contexts can have on the provision of behavioral health services to people who have experienced trauma (see thin arrow). Each ring represents a different system (refer to Exhibit 1.1-3 for examples of specific factors within each system). The innermost ring represents the individual and his or her biopsychosocial characteristics. The "Interpersonal" circle embodies all immediate relationships including family, friends, peers, and others. The "Community/Organizational" band represents social support networks, workplaces, neighborhoods, and institutions that directly influence the individual and his/her relationships. The "Societal" circle signifies the largest system—State and Federal policies and laws, such as economic and healthcare policies, social norms, governmental systems, and political ideologies. The outermost ring, "Period of Time in History," reflects the significance of the period of time during which the event occurred; it influences each other level represented in the circle. For example, making a comparison of society's attitudes and responses to veterans' homecomings across different wars and conflicts through time shows that homecoming environments can have either a protective or a negative effect on healing from the psychological and physical wounds of war, depending on the era in question. The thicker arrows in the figure represent the key influences of culture, developmental characteristics, and the type and characteristics of the trauma. All told, the context of traumatic events can significantly influence both initial and sustained responses to trauma; treatment needs; selection of prevention, intervention, and other treatment

Exhibit 1.1-3: Understanding the Levels Within the Social-Ecological Model of Trauma and Its Effects

Individual Factors	Interpersonal Factors	Community and Organizational Factors	Societal Factors	Cultural and Developmental Factors	Period of Time in History
Age, biophysical state, mental health status, temperament and other personality traits, education, gender, coping styles, socioeconomic status	Family, peer, and significant other interaction patterns, parent/family mental health, parents' history of trauma, social network	Neighborhood quality, school system and/or work environment, behavioral health system quality and accessibility, faith-based settings, transportation availability, community socioeconomic status, community employment rates	Laws, State and Federal economic and social policies, media, societal norms, judicial system	Collective or individualistic cultural norms, ethnicity, cultural subsystem norms, cognitive and maturational development	Societal attitudes related to military service members' homecomings, changes in diagnostic understanding between DSM-III-R* and DSM-5**

**Diagnostic and Statistical Manual of Mental Disorders,* Third Edition, Revised (American Psychiatric Association [APA], 1987)

***Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (APA, 2013a)

Case Illustration: Marisol

Marisol is a 28-year-old Latina woman working as a barista at a local coffee shop. One evening, she was driving home in the rain when a drunk driver crossed into her lane and hit her head on. Marisol remained conscious as she waited to be freed from the car and was then transported to the hospital. She sustained fractures to both legs. Her recovery involved two surgeries and nearly 6 months of rehabilitation, including initial hospitalization and outpatient physical therapy.

She described her friends and family as very supportive, saying that they often foresaw what she needed before she had to ask. She added that she had an incredible sense of gratitude for her employer and coworkers, who had taken turns visiting and driving her to appointments. Although she was able to return to work after 9 months, Marisol continued experiencing considerable distress about her inability to sleep well, which started just after the accident. Marisol describes repetitive dreams and memories of waiting to be transported to the hospital after the crash. The other driver was charged with driving under the influence (DUI), and it was reported that he had been convicted two other times for a DUI misdemeanor.

Answering the following questions will help you see how the different levels of influence affect the impact and outcome of the traumatic event Marisol experienced, as well as her responses to that event:

1. Based on the limited information provided in this illustration, how might Marisol's personality affect the responses of her family and friends, her coworkers, and the larger community?
2. In what ways could Marisol's ethnic and cultural background influence her recovery?
3. What societal factors could play a role in the car crash itself and the outcomes for Marisol and the other driver?

Explore the influence of the period of time in history during which the scenario occurs—compare the possible outcomes for both Marisol and the other driver if the crash occurred 40 years ago versus in the present day.

strategies; and ways of providing hope and promoting recovery.

Minimize the Risk of Retraumatization or Replicating Prior Trauma Dynamics

Trauma-informed treatment providers acknowledge that clients who have histories of trauma may be more likely to experience particular treatment procedures and practices as negative, reminiscent of specific characteristics of past trauma or abuse, or retraumatizing—feeling as if the past trauma is reoccurring or as if the treatment experience is as dangerous and unsafe as past traumas. For instance, clients may express feelings of powerlessness or being trapped if they are not actively involved in treatment decisions; if treatment processes or providers mirror specific behavior from the clients' past experiences with trauma, they may voice distress or respond in the same way as they did to the original trauma. Among the potentially retraumatizing elements of treatment are seclusion or "time-out" practices that isolate individuals, mislabeling client symptoms as personality or other mental disorders rather than as traumatic stress reactions, interactions that command authority, treatment assignments that could humiliate clients (such as asking a client to wear a sign in group that reflects one of their treatment issues, even if the assignment centers on positive attributes of the client), confronting clients as resistant, or presenting treatment as conditional upon conformity to the provider's beliefs and definitions of issues.

Clients' experiences are unique to the specific traumas they have faced and the surrounding

circumstances before, during, and after that trauma, so remember that even seemingly safe and standard treatment policies and procedures, including physical plant operations (e.g., maintenance, grounds, fire and safety procedures), may feel quite the contrary for a client if one or more of those elements is reminiscent of his or her experience of trauma in some way. Examples include having limited privacy or personal space, being interviewed in a room that feels too isolating or confining, undergoing physical examination by a medical professional of the same sex as the client's previous perpetrator of abuse, attending a group session in which another client expresses anger appropriately in a role play, or being directed not to talk about distressing experiences as a means of deescalating traumatic stress reactions.

Although some treatment policies or procedures are more obviously likely to solicit distress than others, *all* standard practices should be evaluated for their potential to retraumatize a client; this cannot be done without knowing the specific features of the individual's history of trauma. Consider, for instance, a treatment program that serves meals including entrees that combine more than one food group. Your client enters this program and refuses to eat most of the time; he expresses anger toward dietary staff and claims that food choices are limited. You may initially perceive your client's refusal to eat or to avoid certain foods as an eating disorder or a behavioral problem. However, a trauma-aware perspective might change your assumptions; consider that this client experienced neglect and abuse surrounding food throughout childhood (his mother forced him to eat meals prepared by combining anything in the refrigerator and cooking them together).

Advice to Counselors and Administrators: Sending the Right Message About Trauma

How often have you heard "We aren't equipped to handle trauma" or "We don't have time to deal with reactions that surface if traumatic experiences are discussed in treatment" from counselors and administrators in behavioral health services? For agencies, staff members, and clients, these statements present many difficulties and unwanted outcomes. For a client, such comments may replicate his or her earlier encounters with others (including family, friends, and previous behavioral health professionals) who had difficulty acknowledging or talking about traumatic experiences with him or her. A hands-off approach to trauma can also reinforce the client's own desire to avoid such discussions. Even when agencies and staff are motivated in these sentiments by a good intention—to contain clients' feelings of being overwhelmed—such a perspective sends strong messages to clients that their experiences are not important, that they are not capable of handling their trauma-associated feelings, and that dealing with traumatic experiences is simply too dangerous. Statements like these imply that recovery is not possible and provide no structured outlet to address memories of trauma or traumatic stress reactions.

Nevertheless, determining how and when to address traumatic stress in behavioral health services can be a real dilemma, especially if there are no trauma-specific philosophical, programmatic, or procedural processes in place. For example, it is difficult to provide an appropriate forum for a client to address past traumas if no forethought has been given to developing interagency and intra-agency collaborations for trauma-specific services. By anticipating the need for trauma-informed services and planning ahead to provide appropriate services to people who are affected by trauma, behavioral health service providers and program administrators can begin to develop informed intervention strategies that send a powerful, positive message:

- Both clients and providers can competently manage traumatic experiences and reactions.
- Providers are interested in hearing clients' stories and attending to their experiences.
- Recovery is possible.

As a treatment provider, you cannot consistently predict what may or may not be upsetting or retraumatizing to clients. Therefore, it is important to maintain vigilance and an attitude of curiosity with clients, inquiring about the concerns that they express and/or present in treatment. Remember that certain behaviors or emotional expressions can reflect what has happened to them in the past.

Foremost, a trauma-informed approach begins with taking practical steps to reexamine treatment strategies, program procedures, and organizational polices that could solicit distress or mirror common characteristics of traumatic experiences (loss of control, being trapped, or feeling disempowered). To better anticipate the interplay between various treatment elements and the more idiosyncratic aspects of a particular client's trauma history, you can:

- Work with the client to learn the cues he or she associates with past trauma.
- Obtain a good history.
- Maintain a supportive, empathetic, and collaborative relationship.
- Encourage ongoing dialog.
- Provide a clear message of availability and accessibility throughout treatment.

In sum, trauma-informed providers anticipate and respond to potential practices that may be perceived or experienced as retraumatizing to clients; they are able to forge new ways to respond to specific situations that trigger a trauma-related response, and they can provide clients with alternative ways of engaging in a particularly problematic element of treatment.

Create a Safe Environment

The need to create a safe environment is not new to providers; it involves an agency-wide effort supported by effective policies and procedures. However, creating safety within a trauma-informed framework far exceeds the standard expectations of physical plant safety (e.g., facility, environmental, and space-related concerns), security (of staff members, clients, and personal property), policies and procedures (including those specific to seclusion and restraint), emergency management and disaster planning, and adherence to client rights. Providers must be responsive and adapt the environment to establish and support clients' sense of physical and emotional safety.

Beyond anticipating that various environmental stimuli within a program may generate strong emotions and reactions in a trauma survivor (e.g., triggers such as lighting, access to exits, seating arrangements, emotionality within a group, or visual or auditory stimuli) and implementing strategies to help clients cope with triggers that evoke their experiences with trauma, other key elements in establishing a safe environment include consistency in client interactions and treatment processes, following through with what has been reviewed or agreed upon in sessions or meetings, and dependability. Mike's case illustration depicts ways in which the absence of these key elements could erode a client's sense of safety during the treatment process.

Neither providers nor service processes are always perfect. Sometimes, providers

Case Illustration: Mike

From the first time you provide outpatient counseling to Mike, you explain that he can call an agency number that will put him in direct contact with someone who can provide further assistance or support if he has emotional difficulty after the session or after agency hours. However, when he attempts to call one night, no one is available despite what you've described. Instead, Mike is directed by an operator to either use his local emergency room if he perceives his situation to be a crisis or to wait for someone on call to contact him. The inconsistency between what you told him in the session and what actually happens when he calls makes Mike feel unsafe and vulnerable.

unintentionally relay information inaccurately or inconsistently to clients or other staff members; other times, clients mishear something, or extenuating circumstances prevent providers from responding as promised. Creating safety is not about getting it right all the time; it's about how consistently and forthrightly you handle situations with a client when circumstances provoke feelings of being vulnerable or unsafe. Honest and compassionate communication that conveys a sense of handling the situation together generates safety. It is equally important that safety extends beyond the client. Counselors and other behavioral health staff members, including peer support specialists, need to be able to count on the agency to be responsive to and maintain their safety within the environment as well. By incorporating an organizational ethos that recognizes the importance of practices that promote physical safety and emotional well-being, behavioral health staff members may be more likely to seek support and supervision when needed and to comply with clinical and programmatic practices that minimize risks for themselves and their clients.

Beyond an attitudinal promotion of safety, organizational leaders need to consider and create avenues of professional development and assistance that will give their staff the means to seek support and process distressing circumstances or events that occur within the agency or among their clientele, such as case consultation and supervision, formal or informal processes to debrief service providers about difficult clinical issues, and referral processes for client psychological evaluations and employee assistance for staff. Organizational practices are only effective if supported by unswerving trauma awareness, training, and education among staff. Jane's case illustration shows the impact of a minor but necessary postponement in staff orientation for a new hire—not an unusual circumstance in behavioral health programs that have heavy caseloads and high staff turnover.

Identify Recovery From Trauma as a Primary Goal

Often, people who initiate or are receiving mental health or substance abuse services don't identify their experiences with trauma as a significant factor in their current challenges or problems. In part, this is because people who have been exposed to trauma, whether once or repeatedly, are generally reluctant to revisit it. They may already feel stuck in repetitive memories or experiences, which may add to their existing belief that any intervention will make matters worse or, at least, no better. For some clients, any introduction to their trauma-related memories or minor cues reminiscent of the trauma will cause them to experience strong, quick-to-surface emotions, supporting their belief that addressing trauma is dangerous and that they won't be able to handle the

Case Illustration: Jane

Jane, a newly hired female counselor, had a nephew who took his own life. The program that hired her was short of workers at the time; therefore, Jane did not have an opportunity to engage sufficiently in orientation outside of reviewing the policies and procedure manual. In an attempt to present well to her new employer and supervisor, she readily accepted client assignments without considering her recent loss. By not immersing herself in the program's perspective and policies on staff well-being, ethical and clinical considerations in client assignments, and how and when to seek supervision, Jane failed to engage in the practices, heavily supported by the agency, that promoted safety for herself and her clients. Subsequently, she felt emotionally overwhelmed at work and would often abruptly request psychiatric evaluation for clients who expressed any feelings of hopelessness out of sheer panic that they would attempt suicide.

emotions or thoughts that result from attempting to do so. Others readily view their experiences of trauma as being in the past; as a result, they engage in distraction, dissociation, and/or avoidance (as well as adaptation) due to a belief that trauma has little impact on their current lives and presenting problems. Even individuals who are quite aware of the impact that trauma has had on their lives may still struggle to translate or connect how these events continue to shape their choices, behaviors, and emotions. Many survivors draw no connection between trauma and their mental health or substance abuse problems, which makes it more difficult for them to see the value of trauma-informed or trauma-specific interventions, such as creating safety, engaging in psychoeducation, enhancing coping skills, and so forth.

As a trauma-informed provider, it is important that you help clients bridge the gap between their mental health and substance-related issues and the traumatic experiences they may have had. All too often, trauma occurs before substance use and mental disorders develop; then, such disorders and their associated symptoms and consequences create opportunities for additional traumatic events to occur. If individuals engage in mental health and substance abuse treatment without addressing the role that trauma has played in their lives, they are less likely to experience recovery in the long run. For example, a person with a history of trauma is more likely to have anxiety and depressive symptoms, use substances to self-medicate, and/or relapse after exposure to trauma-related cues. Thus, collaboration within and between behavioral health agencies is necessary to make integrated, timely, trauma-specific interventions available from the beginning to clients/consumers who engage in substance abuse and mental health services.

Support Control, Choice, and Autonomy

Not every client who has experienced trauma and is engaged in behavioral health services wants, or sees the need for, trauma-informed or trauma-specific treatment. Clients may think that they've already dealt with their trauma adequately, or they may believe that the effects of past trauma cause minimal distress for them. Other clients may voice the same sentiments, but without conviction—instead using avoidant behavior to deter distressing symptoms or reactions. Still others may struggle to see the role of trauma in their presenting challenges, not connecting their past traumatic experiences with other, more current difficulties (e.g., using substances to self-medicate strong emotions). Simply the idea of acknowledging trauma-related experiences and/or stress reactions may be too frightening or overwhelming for some clients, and others may fear that their reactions will be dismissed. On the other hand, some individuals want so much to dispense with their traumatic experiences and reactions that they hurriedly and repeatedly disclose their experiences before establishing a sufficiently safe environment or learning effective coping strategies to offset distress and other effects of retraumatization.

As these examples show, not everyone affected by trauma will approach trauma-informed services or recognize the impact of trauma in their lives in the same manner. This can be challenging to behavioral health service providers who are knowledgeable about the impact of trauma and who perceive the importance of addressing trauma and its effects with clients. As with knowing that different clients may be at different levels of awareness or stages of change in substance abuse treatment services, you should acknowledge that people affected by trauma

present an array of reactions, various levels of trauma awareness, and different degrees of urgency in their need to address trauma.

Appreciating clients' perception of their presenting problems and viewing their responses to the impact of trauma as adaptive—even when you believe their methods of dealing with trauma to be detrimental—are equally important elements of TIC. By taking the time to engage with clients and understand the ways they have perceived, adjusted to, and responded to traumatic experiences, providers are more likely to project the message that clients possess valuable personal expertise and knowledge about their own presenting problems. This shifts the viewpoint from "Providers know best" to the more collaborative "Together, we can find solutions."

How often have you heard from clients that they don't believe they can handle symptoms that emerge from reexperiencing traumatic cues or memories? Have you ever heard clients state that they can't trust themselves or their reactions, or that they never know when they are going to be triggered or how they are going to react? How confident would you feel about yourself if, at any time, a loud noise could initiate an immediate attempt to hide, duck, or dive behind something? Traumatic experiences have traditionally been described as exposure to events that cause intense fear, helplessness, horror, or feelings of loss of control. Participation in behavioral health services should not mirror these aspects of traumatic experience. Working collaboratively to facilitate clients' sense of control and to maximize clients' autonomy and choices throughout the treatment process, including treatment planning, is crucial in trauma-informed services.

For some individuals, gaining a sense of control and empowerment, along with understanding traumatic stress reactions, may be pivotal ingredients for recovery. By creating opportunities for empowerment, counselors and other behavioral health service providers help reinforce, clients' sense of competence, which is often eroded by trauma and prolonged traumatic stress reactions. Keep in mind that treatment strategies and procedures that prioritize client choice and control need not focus solely on major life decisions or treatment planning; you can apply such approaches to common tasks and everyday interactions between staff and consumers. Try asking your clients some of the following questions (which are only a sample of the types of questions that could be useful):

- What information would be helpful for us to know about what happened to you?
- Where/when would you like us to call you?
- How would you like to be addressed?
- Of the services I've described, which seem to match your present concerns and needs?
- From your experience, what responses from others appear to work best when you feel overwhelmed by your emotions?

Likewise, organizations need to reinforce the importance of staff autonomy, choice, and sense of control. What resources can staff members access, and what choices are available to them, in processing emotionally charged content or events in treatment? How often do administrators and supervisors seek out feedback on how to handle problematic situations (e.g., staff rotations for vacations, case consultations, changes in scheduling)? Think about the parallel between administration and staff members versus staff members and clients; often, the same philosophy, attitudes, and behaviors conveyed to staff members by administrative practices are mirrored in staff–client interactions. Simply stated, if staff members do not feel empowered, it will be a challenge for them to value the need for client empowerment. (For more information on administrative and workforce development issues, refer to Part 2, Chapters 1 and 2.)

Case Illustration: Mina

Mina initially sought counseling after her husband was admitted to an intensive outpatient drug and alcohol program. She was self-referred for low-grade depression, resentment toward her spouse, and codependency. When asked to define "codependency" and how the term applied to her, she responded that she always felt guilty and responsible for everyone in her family and for events that occurred even when she had little or no control over them.

After the intake and screening process, she expressed interest in attending group sessions that focused primarily on family issues and substance abuse, wherein her presenting concerns could be explored. In addition to describing dynamics and issues relating to substance abuse and its impact on her marriage, she referred to her low mood as frozen grief. During treatment, she reluctantly began to talk about an event that she described as life changing: the loss of her father. The story began to unfold in group; her father, who had been 62 years old, was driving her to visit a cousin. During the ride, he had a heart attack and drove off the road. As the car came to stop in a field, she remembered calling 911 and beginning cardiopulmonary resuscitation while waiting for the ambulance. She rode with the paramedics to the hospital, watching them work to save her father's life; however, he was pronounced dead soon after arrival.

She always felt that she never really said goodbye to her father. In group, she was asked what she would need to do or say to feel as if she had revisited that opportunity. She responded in quite a unique way, saying, "I can't really answer this question; the lighting isn't right for me to talk about my dad." The counselor encouraged her to adjust the lighting so that it felt "right" to her. Being invited to do so turned out to be pivotal in her ability to address her loss and to say goodbye to her father on her terms. She spent nearly 10 minutes moving the dimmer switch for the lighting as others in the group patiently waited for her to return to her chair. She then began to talk about what happened during the evening of her father's death, their relationship, the events leading up to that evening, what she had wanted to say to him at the hospital, and the things that she had been wanting to share with him since his death.

Weeks later, as the group was coming to a close, each member spoke about the most important experiences, tools, and insights that he or she had taken from participating. Mina disclosed that the group helped her establish boundaries and coping strategies within her marriage, but said that the event that made the most difference for her had been having the ability to adjust the lighting in the room. She explained that this had allowed her to control something over which she had been powerless during her father's death. To her, the lighting had seemed to stand out more than other details at the scene of the accident, during the ambulance ride, and at the hospital. She felt that the personal experience of losing her father and needing to be with him in the emergency room was marred by the obtrusiveness of staff, procedures, machines, and especially, the harsh lighting. She reflected that she now saw the lighting as a representation of this tragic event and the lack of privacy she had experienced when trying to say goodbye to her father. Mina stated that this moment in group had been the greatest gift: "…to be able to say my goodbyes the way I wanted… I was given an opportunity to have some control over a tragic event where I couldn't control the outcome no matter how hard I tried."

Create Collaborative Relationships and Participation Opportunities

This trauma-informed principle encompasses three main tenets. First, **ensure that the provider–client relationship is collaborative**, regardless of setting or service. Agency staff members cannot make decisions pertaining to interventions or involvement in community services autocratically; instead, they should develop trauma-informed, individualized care plans and/or treatment plans collaboratively with the client and, when appropriate, with family and caregivers. The nonauthoritarian approach that characterizes TIC views clients

as the experts in their own lives and current struggles, thereby emphasizing that clients and providers can learn from each other.

The second tenet is to **build collaboration beyond the provider–client relationship**. Building ongoing relationships across the service system, provider networks, and the local community enhances TIC continuity as clients move from one level of service to the next or when they are involved in multiple services at one time. It also allows you to learn about resources available to your clients in the service system or community and to connect with providers who have more advanced training in trauma-specific interventions and services.

The third tenet emphasizes the need to **ensure client/consumer representation and participation in behavioral health program development, planning, and evaluation as well as in the professional development of behavioral health workers**. To achieve trauma-informed competence in an organization or across systems, clients need to play an active role; this starts with providing program feedback. However, consumer involvement should not end there; rather, it should be encouraged throughout the implementation of trauma-informed services. So too, clients, potential clients, their families, and the community should be invited to participate in forming any behavioral health organization's plans to improve trauma-informed competence, provide TIC, and design relevant treatment services and organizational policies and procedures.

Trauma-informed principles and practices generated without the input of people affected by trauma are difficult to apply effectively. Likewise, staff trainings and presentations should include individuals who have felt the impact of trauma. Their participation reaches past the purely cognitive aspects of such education to offer a personal perspective on the strengths and resilience of people who have experienced trauma. The involvement of trauma survivors in behavioral health education lends a human face to subject matter that is all too easily made cerebral by some staff members in an attempt to avoid the emotionality of the topic.

Consumer participation also means giving clients/consumers the chance to obtain State training and certification, as well as employment in behavioral health settings as peer specialists. Programs that incorporate peer support services reinforce a powerful message—that provider–consumer partnership is important, and that consumers are valued. Peer support specialists are self-identified individuals who have progressed in their own recovery from alcohol dependence, drug addiction, and/or a mental disorder and work within behavioral health programs or at peer support centers to assist others with similar disorders and/or life experiences. Tasks and responsibilities may include leading a peer support group; modeling effective coping, help-seeking, and self-care strategies; helping clients practice new skills or monitor progress; promoting positive self-image to combat clients' potentially negative feelings about themselves and the discrimination they may perceive in the program or community; handling case management tasks; advocating for program changes; and representing a voice of hope that views recovery as possible.

Familiarize the Client With Trauma-Informed Services

Without thinking too much about it, you probably know the purpose of an intake process, the correct way to complete a screening device, the meaning of a lot of the jargon specific to behavioral health, and your program's expectations for client participation; in fact, maybe you're already involved in facilitating these processes in behavioral health services every day, and they've become almost

automatic for you. This can make it easy to forget that nearly everything clients and their families encounter in seeking behavioral health assistance is new to them. Thus, introducing clients to program services, activities, and interventions in a manner that *expects* them to be unfamiliar with these processes is essential, regardless of their clinical and treatment history. Beyond addressing the unfamiliarity of services, educating clients about each process—from first contact all the way through recovery services—gives them a chance to participate actively and make informed decisions across the continuum of care.

Familiarizing clients with trauma-informed services extends beyond explaining program services or treatment processes; it involves explaining the value and type of trauma-related questions that may be asked during an intake process, educating clients about trauma to help normalize traumatic stress reactions, and discussing trauma-specific interventions and other available services (including explanations of treatment methodologies and of the rationale behind specific interventions). Developmentally appropriate psychoeducation about trauma-informed services allows clients to be informed participants.

Incorporate Universal Routine Screenings for Trauma

Screening universally for client histories, experiences, and symptoms of trauma at intake can benefit clients and providers. Most providers know that clients can be affected by trauma, but universal screening provides a steady reminder to be watchful for past traumatic experiences and their potential influence upon a client's interactions and engagement with services across the continuum of care. Screening should guide treatment planning; it alerts the staff to potential issues and serves as a valuable tool to increase clients' awareness of the possible impact of trauma and the importance of addressing related issues during treatment.

Nonetheless, screenings are only as useful as the guidelines and processes established to address positive screens (which occur when clients respond to screening questions in a way that signifies possible trauma-related symptoms or histories). Staff should be trained to use screening tools consistently so that all clients are screened in the same way. Staff members also need to know how to score screenings and when specific variables (e.g., race/ethnicity, native language, gender, culture) may influence screening results. For example, a woman who has been sexually assaulted by a man may be wary of responding to questions if a male staff member or interpreter administers the screening or provides translation services. Likewise, a person in a current abusive or violent relationship may not acknowledge the interpersonal violence in fear of retaliation or as a result of disconnection or denial of his or her experience, and he or she may have difficulty in processing and then living between two worlds—what is acknowledged in treatment versus what is experienced at home.

In addition, staff training on using trauma-related screening tools needs to center on how and when to gather relevant information after the screening is complete. Organizational policies and procedures should guide staff members on how to respond to a positive screening, such as by making a referral for an indepth assessment of traumatic stress, providing the client with an introductory psychoeducational session on the typical biopsychosocial effects of trauma, and/or coordinating care so that the client gains access to trauma-specific services that meet his or her needs. Screening tool selection is an important ingredient in incorporating routine, universal screening practices into behavioral health services. Many screening tools are available, yet they differ in format

and in how they present questions. Select tools based not just on sound test properties, but also according to whether they encompass a broad range of experiences typically considered traumatic and are flexible enough to allow for an individual's own interpretation of traumatic events. For more information on screening and assessment of trauma and trauma-related symptoms and effects, see Chapter 4, "Screening and Assessment," in this TIP.

View Trauma Through a Sociocultural Lens

To understand how trauma affects an individual, family, or community, you must first understand life experiences and cultural background as key contextual elements for that trauma. As demonstrated in Exhibit 1.1-2, many factors shape traumatic experiences and individual and community responses to it; one of the most significant factors is culture. It influences the interpretation and meaning of traumatic events, individual beliefs regarding personal responsibility for the trauma and subsequent responses, and the meaning and acceptability of symptoms, support, and help-seeking behaviors. As this TIP proceeds to describe the differences among cultures pertaining to trauma, remember that there are numerous cross-cutting factors that can directly or indirectly influence the attitudes, beliefs, behaviors, resources, and opportunities within a given culture, subculture, or racial and/or ethnic group (Exhibit 1.1-4). For an indepth

Exhibit 1.1-4: Cross-Cutting Factors of Culture

Culture and Trauma

- Some populations and cultures are more likely than others to experience a traumatic event or a specific type of trauma.
- Rates of traumatic stress are high across all diverse populations and cultures that face military action and political violence.
- Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma.
- Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life.
- Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behavior, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased.
- Traumatic stress symptoms vary according to the type of trauma within the culture.
- Culture affects what qualifies as a legitimate health concern and which symptoms warrant help.
- In addition to shaping beliefs about acceptable forms of help-seeking behavior and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.

exploration of these cross-cutting cultural factors, refer to the planned TIP, *Improving Cultural Competence* (SAMHSA, planned c).

When establishing TIC, it is vital that behavioral health systems, service providers, licensing agencies, and accrediting bodies build culturally responsive practices into their curricula, standards, policies and procedures, and credentialing processes. The implementation of culturally responsive practices will further guide the treatment planning process so that trauma-informed services are more appropriate and likely to succeed.

Use a Strengths-Focused Perspective: Promote Resilience

Fostering individual strengths is a key step in prevention when working with people who have been exposed to trauma. It is also an essential intervention strategy—one that builds on the individual's existing resources and views him or her as a resourceful, resilient survivor. Individuals who have experienced trauma develop many strategies and/or behaviors to adapt to its emotional, cognitive, spiritual, and physical consequences. Some behaviors may be effective across time, whereas others may eventually produce difficulties and disrupt the healing process. Traditionally, behavioral health services have tended to focus on presenting problems, risk factors, and symptoms in an attempt to prevent negative outcomes, provide relief, increase clients' level of functioning, and facilitate healing. However, focusing too much on these areas can undermine clients' sense of competence and hope. Targeting only presenting problems and symptoms does not provide individuals with an opportunity to see their own resourcefulness in managing very stressful and difficult experiences. It is important for providers to engage in interventions using a balanced approach that targets the strengths clients have

> "Trauma informed care recognizes symptoms as originating from adaptations to the traumatic event(s) or context. Validating resilience is important even when past coping behaviors are now causing problems. Understanding a symptom as an adaptation reduces a survivor's guilt and shame, increases their self esteem and provides a guideline for developing new skills and resources to allow new and better adaptation to the current situation."
>
> (Elliot et al., 2005, p. 467)

Advice to Counselors and Administrators: Using Strengths-Oriented Questions

Knowing a client's strengths can help you understand, redefine, and reframe the client's presenting problems and challenges. By focusing and building on an individual's strengths, counselors and other behavioral health professionals can shift the focus from "What is wrong with you?" to "What has worked for you?" It moves attention away from trauma-related problems and toward a perspective that honors and uses adaptive behaviors and strengths to move clients along in recovery.

Potential strengths-oriented questions include:

- The history that you provided suggests that you've accomplished a great deal since the trauma. What are some of the accomplishments that give you the most pride?
- What would you say are your strengths?
- How do you manage your stress today?
- What behaviors have helped you survive your traumatic experiences (during and afterward)?
- What are some of the creative ways that you deal with painful feelings?
- You have survived trauma. What characteristics have helped you manage these experiences and the challenges that they have created in your life?
- If we were to ask someone in your life, who knew your history and experience with trauma, to name two positive characteristics that help you survive, what would they be?
- What coping tools have you learned from your _____ (fill in: cultural history, spiritual practices, athletic pursuits, etc.)?
- Imagine for a moment that a group of people are standing behind you showing you support in some way. Who would be standing there? It doesn't matter how briefly or when they showed up in your life, or whether or not they are currently in your life or alive.
- How do you gain support today? (Possible answers include family, friends, activities, coaches, counselors, other supports, etc.)
- What does recovery look like for you?

developed to survive their experiences and to thrive in recovery. A strengths-based, resilience-minded approach lets trauma survivors begin to acknowledge and appreciate their fortitude and the behaviors that help them survive.

Foster Trauma-Resistant Skills

Trauma-informed services build a foundation on which individuals can begin to explore the role of trauma in their lives; such services can also help determine how best to address and tailor interventions to meet their needs. Prevention, mental health, and substance abuse treatment services should include teaching clients about how trauma can affect their lives; these services should also focus on developing self-care skills, coping strategies, supportive networks, and a sense of competence. Building trauma-resistant skills begins with normalizing the symptoms of traumatic stress and helping clients who have experienced trauma connect the dots between current problems and past trauma when appropriate.

Nevertheless, TIC and trauma-specific interventions that focus on skill-building should not do so at the expense of acknowledging individual strengths, creativity in adapting to trauma, and inherent attributes and tools clients possesses to combat the effects of trauma. Some theoretical models that use skill-building strategies base the value of this approach on a deficit perspective; they assume that some individuals lack the necessary tools to manage specific situations and, because of this deficiency, they encounter problems that others with effective skills would not experience. This type of perspective further assumes that, to recover, these individuals must learn new coping skills and behavior. TIC, on the other hand, makes the assumption that clients

Advice to Administrators: Self-Assessment for Trauma-Informed Systems

NCTIC has developed a self-assessment package for trauma-informed systems to help administrators structurally incorporate trauma into programs and services. The self-assessment can be used by systems of care to guide quality improvement with the goal of establishing fully trauma-informed treatment and recovery efforts (NCTIC, Center for Mental Health Services, 2007). Behavioral health treatment program administrators can use these materials and NCTIC as resources for improvement in delivering TIC.

are the experts in their own lives and have learned to adapt and acquire skills to survive. The TIC approach honors each individual's adaptations and acquired skills, and it helps clients explore how these may not be working as well as they had in the past and how their current repertoire of responses may not be as effective as other strategies.

Demonstrate Organizational and Administrative Commitment to TIC

Becoming a trauma-informed organization requires administrative guidance and support across all levels of an agency. Behavioral health staff will not likely sustain TIC practices without the organization's ongoing commitment to support professional development and to allocate resources that promote these practices. An agency that wishes to commit to TIC will benefit from an organizational assessment of how staff members identify and manage trauma and trauma-related reactions in their clients. Are they trauma aware—do they recognize that trauma can significantly affect a client's ability to function in one or more areas of his or her life? Do the staff members understand that traumatic experiences and trauma-related reactions can greatly influence clients' engagement, participation, and response to services?

Agencies need to embrace specific strategies across each level of the organization to create trauma-informed services; this begins with staff education on the impact of trauma among clients. Other agency strategies that reflect a trauma-informed infrastructure include, but are not limited to:

- Universal screening and assessment procedures for trauma.
- Interagency and intra-agency collaboration to secure trauma-specific services.
- Referral agreements and networks to match clients' needs.
- Mission and value statements endorsing the importance of trauma recognition.
- Consumer- and community-supported committees and trauma response teams.
- Workforce development strategies, including hiring practices.
- Professional development plans, including staff training/supervision focused on TIC.
- Program policies and procedures that ensure trauma recognition and secure trauma-informed practices, trauma-specific services, and prevention of retraumatization.

TIC requires organizational commitment, and often, cultural change. For more information on implementing TIC in organizations, see Part 2, Chapter 1 of this TIP.

Develop Strategies To Address Secondary Trauma and Promote Self-Care

Secondary trauma is a normal occupational hazard for mental health and substance abuse professionals, particularly those who serve populations that are likely to include survivors of trauma (Figley, 1995; Klinic Community Health Centre, 2008). Behavioral health staff members who experience secondary trauma present a range of traumatic stress reactions

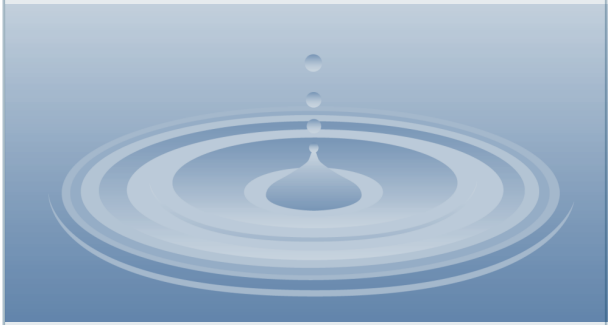
and effects from providing services focused on trauma or listening to clients recount traumatic experiences. So too, when a counselor has a history of personal trauma, working with trauma survivors may evoke memories of the counselor's own trauma history, which may increase the potential for secondary traumatization.

The range of reactions that manifest with secondary trauma can be, but are not necessarily, similar to the reactions presented by clients who have experienced primary trauma. Symptoms of secondary trauma can produce varying levels of difficulty, impairment, or distress in daily functioning; these may or may not meet diagnostic thresholds for acute stress, posttraumatic stress, or adjustment, anxiety, or mood disorders (Bober & Regehr, 2006). Symptoms may include physical or psychological reactions to traumatic memories clients have shared; avoidance behaviors during client interactions or when recalling emotional content in supervision; numbness, limited emotional expression, or diminished affect; somatic complaints; heightened arousal, including insomnia; negative thinking or depressed mood; and detachment from family, friends, and other supports (Maschi & Brown, 2010).

Working daily with individuals who have been traumatized can be a burden for counselors and other behavioral health service providers, but all too often, they blame the symptoms resulting from that burden on other stressors at work or at home. Only in the past 2 decades have literature and trainings begun paying attention to secondary trauma or compassion fatigue; even so, agencies often do not translate this knowledge into routine prevention practices. Counselors and other staff members may find it difficult to engage in activities that could ward off secondary trauma due to time constraints, workload, lack of agency resources, and/or an organizational culture that disapproves of help-seeking or provides inadequate staff support. The demands of providing care to trauma survivors cannot be ignored, lest the provider become increasingly impaired and less effective. Counselors with unacknowledged secondary trauma can cause harm to clients via poorly enforced boundaries, missed appointments, or even abandonment of clients and their needs (Pearlman & Saakvitne, 1995).

Essential components of TIC include organizational and personal strategies to address

The Impact of Trauma



Trauma is similar to a rock hitting the water's surface. The impact first creates the largest wave, which is followed by ever-expanding, but less intense, ripples. Likewise, the influence of a given trauma can be broad, but generally, its effects are less intense for individuals further removed from the trauma; eventually, its impact dissipates all around. For trauma survivors, the impact of trauma can be far-reaching and can affect life areas and relationships long after the trauma occurred. This analogy can also broadly describe the recovery process for individuals who have experienced trauma and for those who have the privilege of hearing their stories. As survivors reveal their trauma-related experiences and struggles to a counselor or another caregiver, the trauma becomes a shared experience, although it is not likely to be as intense for the caregiver as it was for the individual who experienced the trauma. The caregiver may hold onto the trauma's known and unknown effects or may consciously decide to engage in behaviors that provide support to further dissipate the impact of this trauma and the risk of secondary trauma.

Advice to Counselors: Decreasing the Risk of Secondary Trauma and Promoting Self-Care

- **Peer support.** Maintaining adequate social support will help prevent isolation and depression.
- **Supervision and consultation.** Seeking professional support will enable you to understand your own responses to clients and to work with them more effectively.
- **Training.** Ongoing professional training can improve your belief in your abilities to assist clients in their recoveries.
- **Personal therapy.** Obtaining treatment can help you manage specific problems and become better able to provide good treatment to your clients.
- **Maintaining balance.** A healthy, balanced lifestyle can make you more resilient in managing any difficult circumstances you may face.
- **Setting clear limits and boundaries with clients.** Clearly separating your personal and work life allows time to rejuvenate from stresses inherent in being a professional caregiver.

secondary trauma and its physical, cognitive, emotional, and spiritual consequences. In agencies and among individual providers, it is key for the culture to promote acceptability, accessibility, and accountability in seeking help, accessing support and supervision, and engaging in self-care behaviors in and outside of the agency or office. Agencies should involve staff members who work with trauma in developing informal and formal agency practices and procedures to prevent or address secondary trauma. Even though a number of community-based agencies face fiscal constraints, prevention strategies for secondary trauma can be intertwined with the current infrastructure (e.g., staff meetings, education, case consultations and group case discussions, group support, debriefing sessions as appropriate, supervision). For more information on strategies to address and prevent secondary trauma, see Part 2, Chapter 2 of this TIP.

Provide Hope—Recovery Is Possible

What defines recovery from trauma-related symptoms and traumatic stress disorders? Is it the total absence of symptoms or consequences? Does it mean that clients stop having nightmares or being reminded, by cues, of past trauma? When clients who have experienced trauma enter into a helping relationship to address trauma specifically, they are often looking for a cure, a remission of symptoms, or relief from the pain as quickly as possible. However, they often possess a history of unpredictable symptoms and symptom intensity that reinforces an underlying belief that recovery is not possible. On one hand, clients are looking for a message that they can be cured, while on the other hand, they have serious doubts about the likely success of any intervention.

Clients often express ambivalence about dealing with trauma even if they are fully aware of trauma's effects on their lives. The idea of living with more discomfort as they address the past or as they experiment with alternative ways of dealing with trauma-related symptoms or consequences is not an appealing prospect, and it typically elicits fear. Clients may interpret the uncomfortable feelings as dangerous or unsafe even in an environment and relationship that is safe and supportive.

How do you promote hope and relay a message that recovery is possible? First, maintain consistency in delivering services, promoting and providing safety for clients, and showing respect and compassion within the client–provider relationship. Along with clients' commitment to learning how to create safety for themselves, counselors and agencies need

to be aware of, and circumvent, practices that could retraumatize clients. Projecting hope and reinforcing the belief that recovery is possible extends well beyond the practice of establishing safety; it also encompasses discussing what recovery means and how it looks to clients, as well as identifying how they will know that they've entered into recovery in earnest.

Providing hope involves projecting an attitude that recovery is possible. This attitude also involves viewing clients as competent to make changes that will allow them to deal with trauma-related challenges, providing opportunities for them to practice dealing with difficult situations, and normalizing discomfort or difficult emotions and framing these as manageable rather than dangerous. If you convey this attitude consistently to your clients, they will begin to understand that discomfort is not a signal to avoid, but a sign to engage—and that behavioral, cognitive, and emotional responses to cues associated with previous traumas are a normal part of the recovery process. It's not the absence of responses to such triggers that mark recovery, but rather, how clients experience and manage those responses. Clients can also benefit from interacting with others who are further along in their recovery from trauma. Time spent with peer support staff or sharing stories with other trauma survivors who are well on their way to recovery is invaluable—it sends a powerful message that recovery is achievable, that there is no shame in being a trauma survivor, and that there is a future beyond the trauma.

As You Proceed

This chapter has established the foundation and rationale of this TIP, reviewed trauma-informed concepts and terminology, and provided an overview of TIC principles and a guiding framework for this text. As you proceed, be aware of the wide-ranging responses to trauma that occur not only across racially and ethnically diverse groups but also within specific communities, families, and individuals. Counselors, prevention specialists, other behavioral health workers, supervisors, and organizations all need to develop skills to create an environment that is responsive to the unique attributes and experiences of each client. As you read this TIP, remember that many cross-cutting factors influence the experiences, help-seeking behaviors, intervention responses, and outcomes of individuals, families, and populations who have survived trauma. Single, multiple, or chronic exposures to traumatic events, as well as the emotional, cognitive, behavioral, and spiritual responses to trauma, need to be understood within a social-ecological framework that recognizes the many ingredients prior to, during, and after traumatic experiences that set the stage for recovery.

2 Trauma Awareness

IN THIS CHAPTER

- Types of Trauma
- Characteristics of Trauma
- Individual and Sociocultural Features

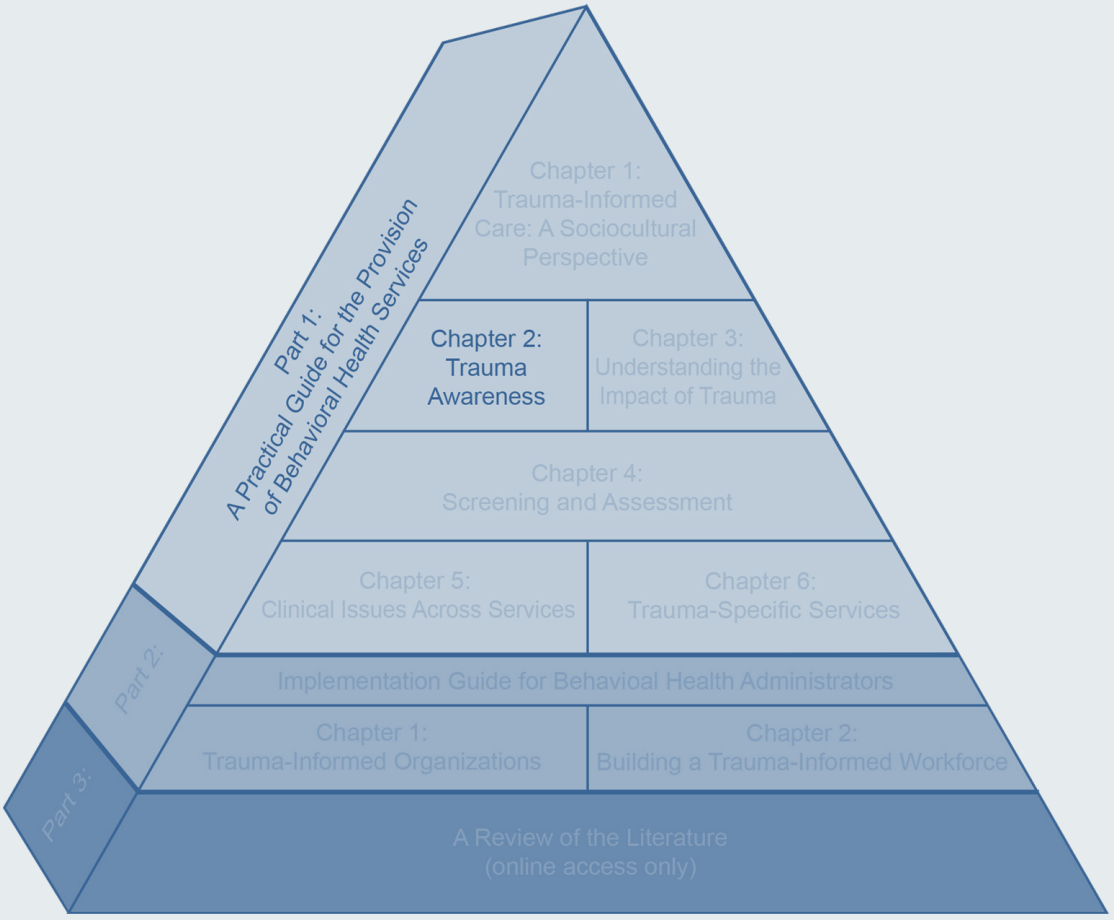
Traumatic experiences typically do not result in long-term impairment for most individuals. It is normal to experience such events across the lifespan; often, individuals, families, and communities respond to them with resilience. This chapter explores several main elements that influence why people respond differently to trauma. Using the social-ecological model outlined in Part 1, Chapter 1, this chapter explores some of the contextual and systemic dynamics that influence individual and community perceptions of trauma and its impact. The three main foci are: types of trauma, objective and subjective characteristics of trauma, and individual and sociocultural features that serve as risk or protective factors.

This chapter's main objective is to highlight the key characteristics of traumatic experiences. Trauma-informed behavioral health service providers understand that many influences shape the effects of trauma among individuals and communities—it is not just the event that determines the outcome, but also the event's context and the resultant interactions across systems.

Types of Trauma

The following section reviews various forms and types of trauma. It does not cover every conceivable trauma that an individual, group, or community may encounter. Specific traumas are reviewed only once, even when they could fit in multiple categories of trauma. Additionally, the order of appearance does not denote a specific trauma's importance or prevalence, and there is no lack of relevance implied if a given trauma is not specifically addressed in this Treatment Improvement Protocol (TIP). The intent is to give a broad perspective of the various categories and types of trauma to behavioral health workers who wish to be trauma informed.

TIC Framework in Behavioral Health Services—Trauma Awareness



Natural or Human-Caused Traumas

The classification of a trauma as natural or caused by humans can have a significant impact on the ways people react to it and on the types of assistance mobilized in its aftermath (see Exhibit 1.2-1 for trauma examples). Natural traumatic experiences can directly affect a small number of people, such as a tree falling on a car during a rainstorm, or many people and communities, as with a hurricane. Natural events, often referred to as "acts of God," are typically unavoidable. Human-caused traumas are caused by human failure (e.g., technological catastrophes, accidents, malevolence) or by human design (e.g., war). Although multiple factors contribute to the severity of a natural or human-caused trauma, traumas perceived as intentionally harmful often make the event more traumatic for people and communities.

For information on resources to prepare States, Territories, and local entities to deliver effective mental health and substance abuse responses during disasters, contact the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Disaster Technical Assistance Center:

4350 East West Hwy, Suite 1100
Bethesda, MD 20814 6233
Phone: 1 800 308 3515
Fax: 1 800 311 7691
Email: DTAC@samhsa.hhs.gov

Exhibit 1.2-1: Trauma Examples

Caused Naturally	Caused by People	
	Accidents, Technological Catastrophes	Intentional Acts
Tornado	Train derailment	Arson
Lightning strike	Roofing fall	Terrorism
Wildfire	Structural collapse	Sexual assault and abuse
Avalanche	Mountaineering accident	Homicides or suicides
Physical ailment or disease	Aircraft crash	Mob violence or rioting
Fallen tree	Car accident due to malfunction	Physical abuse and neglect
Earthquake	Mine collapse or fire	Stabbing or shooting
Dust storm	Radiation leak	Warfare
Volcanic eruption	Crane collapse	Domestic violence
Blizzard	Gas explosion	Poisoned water supply
Hurricane	Electrocution	Human trafficking
Cyclone	Machinery-related accident	School violence
Typhoon	Oil spill	Torture
Meteorite	Maritime accident	Home invasion
Flood	Accidental gun shooting	Bank robbery
Tsunami	Sports-related death	Genocide
Epidemic		Medical or food tampering
Famine		
Landslide or fallen boulder		

How survivors of natural trauma respond to the experience often depends on the degree of devastation, the extent of individual and community losses, and the amount of time it takes to reestablish daily routines, activities, and services (e.g., returning to school or work, being able to do laundry, having products to buy in a local store). The amount, accessibility, and duration of relief services can significantly influence the duration of traumatic stress reactions as well as the recovery process.

Alongside the disruption of daily routines, the presence of community members or outsiders in affected areas may add significant stress or create traumatic experiences in and of themselves. Examples include the threat of others stealing what remains of personal property, restrictions on travel or access to property or living quarters, disruption of privacy within shelters, media attention, and subsequent exposure to repetitive images reflecting the devastation. Therefore, it isn't just the natural disaster or event that can challenge an individual or community; often, the consequences of the event and behavioral responses from others within and outside the community play a role in pushing survivors away from effective coping or toward resilience and recovery.

Human-caused traumas are fundamentally different from natural disasters. They are either intentional, such as a convenience store robbery at gunpoint, or unintentional, such as the technological accident of a bridge collapse (as occurred in Minneapolis, Minnesota, in 2007; U.S. Fire Administration, 2007). The subsequent reactions to these traumas often depend on their intentionality. However, a person or group of people is typically the target of the survivors' anger and blame. Survivors of an unintentionally human-caused traumatic event may feel angry and frustrated because of the lack of protection or care offered by the responsible party or government, particularly if there has been a perceived act of omission. After intentional human-caused acts, survivors often struggle to understand the

Case Illustrations: Quecreek Mine Flood and Greensburg's Tornado

Quecreek Mine Flood

The year following the rescue of nine miners from the Quecreek mine in western Pennsylvania in 2002 was a difficult one for residents of Somerset County. The dazzle of publicity surrounding a handful of workers from a small town, tension between miners and rescuers, and animosity over money for movie and book deals, in addition to the trauma itself, resulted in a rescuer's suicide, a number of miners having trauma-related symptoms, and several rescuers needing to seek treatment for posttraumatic stress disorder (PTSD; Goodell, 2003).

Greensburg's Tornado

Greensburg, a small town in southern Kansas, was hit by a large tornado in 2007 that killed 11 residents and leveled 95 percent of the town while causing severe damage to the remaining 5 percent. Families and community members experienced significant grief and traumatic stress after the disaster. Yet today, Greensburg is rebuilding with a focus on being "green"—that is, environmentally responsible—from design to construction and all the way through demolition. This town has the highest number of Leadership in Energy and Environmental Design–certified buildings in the world. A reality television show about the town's reinvention ran for three seasons, demonstrating the town's residents and business owners working with local government and various corporations to make their home an even better place than it was before the tornado.

motives for performing the act, the calculated or random nature of the act, and the psychological makeup of the perpetrator(s).

Individual, Group, Community, and Mass Traumas

In recognizing the role of trauma and understanding responses to it, consider whether the trauma primarily affected an individual and perhaps his or her family (e.g., automobile accident, sexual or physical assault, severe illness); occurred within the context of a group (e.g., trauma experienced by first responders or those who have seen military combat) or community (e.g., gang-related shootings); transpired within a certain culture; or was a large-scale disaster (e.g., hurricane, terrorist attack). This context can have significant implications for whether (and how) people experience shame as a result of the trauma, the kinds of support and compassion they receive, whether their experiences are normalized or diminished by others, and even the kinds of services they are offered to help them recover and cope.

Individual trauma

An individual trauma refers to an event that only occurs to one person. It can be a single event (e.g., mugging, rape, physical attack, work-related physical injury) or multiple or prolonged events (e.g., a life-threatening illness, multiple sexual assaults). Although the trauma directly affects just one individual, others who know the person and/or are aware of the trauma will likely experience emotional repercussions from the event(s) as well, such as recounting what they said to the person before the event, reacting in disbelief, or thinking that it could just as easily have happened to them, too.

Survivors of individual trauma may not receive the environmental support and concern that members of collectively traumatized groups and communities receive. They are less likely to reveal their traumas or to receive validation of their experiences. Often, shame distorts their perception of responsibility for the trauma. Some survivors of individual traumas, especially those who have kept the trauma secret, may not receive needed comfort and

Advice to Counselors: Working With Clients Who Have Experienced Individual Traumas

In working with clients who have histories of individual trauma, counselors should consider that:

- Empathy, or putting oneself in the shoes of another, is more potent than sympathy (expressing a feeling of sorrow for another person).
- Some clients need to briefly describe the trauma(s) they have experienced, particularly in the early stages of recovery. Strategies that focus on reexperiencing the trauma, retrieving feelings related to the trauma, and bringing past experiences to the forefront should only be implemented if trauma-specific treatment planning and services are available.
- Understanding the trauma, especially in early recovery, should begin with educating the client about and normalizing trauma-related symptoms, creating a sense of safety within the treatment environment, and addressing how trauma symptoms may interfere with the client's life in the present.
- It is helpful to examine how the trauma affects opportunities to receive substance abuse and/or mental health treatment as well as treatment for and recovery from the trauma itself (e.g., by limiting one's willingness to share in or participate in group counseling).
- Identifying and exploring strengths in the client's history can help the client apply those strengths to his or her ability to function in the present.

acceptance from others; they are also are more likely to struggle with issues of causation (e.g., a young woman may feel unduly responsible for a sexual assault), to feel isolated by the trauma, and to experience repeated trauma that makes them feel victimized.

Physical injuries

Physical injuries are among the most prevalent individual traumas. Millions of emergency room (ER) visits each year relate directly to physical injuries. Most trauma patients are relatively young; about 70 percent of injury-related ER cases are people younger than 45 years old (McCaig & Burt, 2005). Dedicated ER hospital units, known as "trauma centers," specialize in physical traumas such as gunshot wounds, stabbings, and other immediate physical injuries. The term "trauma" in relation to ERs does not refer to psychological trauma, which is the focus of this TIP, yet physical injuries can be associated with psychological trauma. Sudden, unexpected, adverse health-related events can lead to extensive psychological trauma for patients and their families.

Excessive alcohol use is the leading risk factor for physical injuries; it's also the most promising target for injury prevention. Studies consistently connect injuries and substance use (Gentilello, Ebel, Wickizer, Salkever, & Rivara, 2005); nearly 50 percent of patients admitted to trauma centers have injuries attributable to alcohol abuse and dependence (Gentilello et al., 1999). One study found that two thirds of ambulatory assault victims presenting to an ER had positive substance use urinalysis results; more than half of all victims had PTSD 3 months later (Roy-Byrne et al.,

Acute stress disorder (ASD) prevalence among patients at medical trauma centers is very high, making trauma related disorders some of the most common complications seen in physically injured patients. Clients who have sustained serious injuries in car crashes, fires, stabbings, shootings, falls, and other events have an increased likelihood of developing trauma related mental disorders. Research suggests that PTSD and/or problem drinking is evident in nearly 50 percent of patients 1 year after discharge from trauma surgical units.

(Zatzick, Jurkovich, Gentilello, Wisner, & Rivara, 2002)

2004). Nearly 28 percent of patients whose drinking was identified as problematic during an ER visit for a physical injury will have a new injury within 1 year (Gentilello et al., 2005). For further information, see TIP 16, *Alcohol and Other Drug Screening of Hospitalized Trauma Patients* (Center for Substance Abuse Treatment [CSAT], 1995a).

Group trauma

The term "group trauma" refers to traumatic experiences that affect a particular group of people. This TIP intentionally distinguishes group trauma from mass trauma to highlight the unique experiences and characteristics of trauma-related reactions among small groups. These groups often share a common identity and history, as well as similar activities and concerns. They include vocational groups who specialize in managing traumas or who routinely place themselves in harm's way—for example, first responders, a group including police and emergency medical personnel. Some examples of group trauma include crews and their families who lose members from a commercial fishing accident, a gang whose members experience multiple deaths and injuries, teams of firefighters who lose members in a roof collapse, responders who attempt to save flood victims, and military service members in a specific theater of operation.

Survivors of group trauma can have different experiences and responses than survivors of individual or mass traumas. Survivors of group trauma, such as military service members and first responders, are likely to experience repeated trauma. They tend to keep the trauma experiences within the group, feeling that others outside the group will not understand; group outsiders are generally viewed as intruders. Members may encourage others in the group to shut down emotionally and repress their traumatic experiences—and there are some occupational roles that necessitate the repression of reactions to complete a mission or to be attentive to the needs at hand. Group members may not want to seek help and may discourage others from doing so out of fear that it may shame the entire group. In this environment, members may see it as a violation of group confidentiality when a member seeks assistance outside the group, such as by going to a counselor.

Group members who have had traumatic experiences in the past may not actively support traumatized colleagues for fear that acknowledging the trauma will increase the risk of repressed trauma-related emotions surfacing. However, groups with adequate resources for helping group members can develop a stronger and more supportive environment for handling subsequent traumas. These main group features influence the course of short- and long-term adjustments, including the development of traumatic stress symptoms associated with mental and substance use disorders.

Certain occupational groups are at greater risk of experiencing trauma—particularly multiple traumas. This TIP briefly reviews two main groups as examples in the following sections: first responders and military service members. For more detailed information on the impact of trauma and deployment, refer to the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (SAMHSA, planned f).

First responders

First responders are usually emergency medical technicians, disaster management personnel, police officers, rescue workers, medical and behavioral health professionals, journalists, and volunteers from various backgrounds. They also include lifeguards, military personnel, and clergy. Stressors associated with the kinds of traumatic events and/or disasters first responders are likely to experience include

exposure to toxic agents, feeling responsible for the lives of others, witnessing catastrophic devastation, potential exposure to gruesome images, observing human and animal suffering and/or death, working beyond physical exhaustion, and the external and internal pressure of working against the clock.

Military service members

Military personnel are likely to experience numerous stressors associated with trauma. Service members who have repeatedly deployed to a war zone are at a greater risk for traumatic stress reactions (also known as combat stress reaction or traumatic stress injury), other military personnel who provide support services are also at risk for traumatic stress and secondary trauma (refer to the glossary portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP). So too, service members who anticipate deployment or redeployment may exhibit psychological symptoms associated with traumatic stress. Some stressors that military service members may encounter include working while physically exhausted, exposure to gunfire, seeing or knowing someone who has been injured or killed, traveling in areas known for roadside bombs and rockets, extended hypervigilance, fear of being struck by an improvised explosive device, and so forth.

Trauma affecting communities and cultures

Trauma that affects communities and cultures covers a broad range of violence and atrocities that erode the sense of safety within a given community, including neighborhoods, schools, towns, and reservations. It may involve violence in the form of physical or sexual assaults, hate crimes, robberies, workplace or gang-related violence, threats, shootings, or stabbings—for example, the school shooting at Virginia Polytechnic Institute and State University in 2007. It also includes actions that attempt to dismantle systemic cultural practices, resources, and identities, such as making boarding school attendance mandatory for Native American children or placing them in non-Native foster homes. Cultural and/or community-based trauma can also occur via indifference or limited responsiveness to specific communities or cultures that are facing a potential catastrophe. Cultural traumas are events that, whether intentionally or not, erode the heritage of a culture—as with prejudice, disenfranchisement, and health inequities (e.g., late prenatal care, inability to afford medications, limited access to culturally appropriate health education, vicinity and quality of affordable medical services), among other examples.

"The excitement of the season had just begun, and then, we heard the news, oil in the water, lots of oil killing lots of water. It is too shocking to understand. Never in the millennium of our tradition have we thought it possible for the water to die, but it is true."

—Chief Walter Meganack, Port Graham, 1989

Of all the groups negatively affected by the Exxon Valdez oil spill, in many ways Alaska Natives were the most devastated. The oil spill destroyed more than economic resources; it shook the core cultural foundation of Native life. Alaska Native subsistence culture is based on an intimate relationship with the environment. Not only does the environment have sacred qualities for Alaska Natives; their survival also depends on the well-being of the ecosystem and the maintenance of cultural norms of subsistence. The spill directly threatened the well-being of the environment, disrupted subsistence behavior, and severely disturbed the sociocultural milieu of Alaska Natives.

Source: Gill & Picou, 1997, pp. 167–168.

Historical trauma

Historical trauma, known also as generational trauma, refers to events that are so widespread as to affect an entire culture; such events also have effects intense enough to influence generations of the culture beyond those who experienced them directly. The enslavement, torture, and lynching of African Americans; the forced assimilation and relocation of American Indians onto reservations; the extermination of millions of Jews and others in Europe during World War II; and the genocidal policies of the Hutus in Rwanda and the Khmer Rouge in Cambodia are examples of historical trauma.

In the past 50 years, research has explored the generational effects of the Holocaust upon survivors and their families. More recent literature has extended the concept of historical or generational trauma to the traumatic experiences of Native Americans. Reduced population, forced relocation, and acculturation are some examples of traumatic experiences that Native people have endured across centuries, beginning with the first European presence in the Americas. These tragic experiences have led to significant loss of cultural identity across generations and have had a significant impact on the well-being of Native communities (Whitbeck, Chen, Hoyt, & Adams, 2004). Data are limited on the association of mental and substance use disorders with historical trauma among Native people, but literature suggests that historical trauma has repercussions across generations, such as depression, grief, traumatic stress, domestic violence, and substance abuse, as well as significant loss of cultural knowledge, language, and identity (Gone, 2009). Historical trauma can increase the vulnerability of multiple generations to the effects of traumas that occur in their own lifetimes.

Mass trauma

Mass traumas or disasters affect large numbers of people either directly or indirectly. It is beyond the scope of this TIP to cover any specific disaster in detail; note, however, that mass traumas include large-scale natural and human-caused disasters (including intentional acts and accidents alike). Mass traumas may involve significant loss of property and lives as well as the widespread disruption of normal routines and services. Responding to such traumas often requires immediate and extensive resources that typically exceed the capacity of the affected communities, States, or countries in which they occur. Recent examples of such large-scale catastrophes include:

- In January 2010, a massive earthquake hit Haiti, killing hundreds of thousands of people and leaving over a million homeless.
- A nuclear reactor meltdown in the Ukraine in 1986 resulted in a technological and environmental disaster that affected tens of millions of people.
- The tsunami in the Indian Ocean in 2005 left hundreds of thousands dead in nine countries.

One factor that influences an individual's response to trauma is his or her ability to process one trauma before another trauma occurs. In mass traumas, the initial event causes considerable destruction, the consequences of which may spawn additional traumas and other stressful events that lead to more difficulties and greater need for adjustments among survivors, first responders, and disaster relief agencies. Often, a chain reaction occurs. Take, for example, Hurricane Katrina and its impact on the people of Louisiana and other coastal States. After the initial flooding, people struggled to obtain basic needs, including food, drinking water, safe shelter, clothing, medicines, personal hygiene items, and so forth, all as concern mounted about the safety of children and

other relatives, friends, and neighbors. In this and similar cases, the destruction from the initial flooding led to mass displacement of families and communities; many people had to relocate far from New Orleans and other badly affected areas, while also needing to gain financial assistance, reinitiate work to generate income, and obtain stable housing. People could not assimilate one stressor before another appeared.

Nevertheless, mass traumas can create an immediate sense of commonality—many people are "in the same boat," thus removing much of the isolation that can occur with other types of trauma. People can acknowledge their difficulties and receive support, even from strangers. It is easier to ask for help because blame is often externalized; large-scale disasters are often referred to as "acts of God" or, in cases of terrorism and other intentional events, as acts of "evil." Even so, survivors of mass trauma often encounter an initial rally of support followed by quickly diminishing services and dwindling care. When the disaster fades from the headlines, public attention and concern are likely to decrease, leaving survivors struggling to reestablish or reinvent their lives without much outside acknowledgment.

The experience of mass trauma can lead to the development of psychological symptoms and substance use at either a subclinical or a diagnostic level (refer to Part 3 of this TIP, available online, for more information highlighting the relationship between trauma and behavioral health problems). Likewise, one of the greatest risks for traumatic stress reactions after a mass tragedy is the presence of preexisting mental and co-occurring disorders, and individuals who are in early recovery from substance use disorders are at greater risk for such reactions as well. Nonetheless, people are amazingly resilient, and most will not develop long-term mental or substance use disorders after an event; in fact, most trauma-related symptoms will resolve in a matter of months (Keane & Piwowarczyk, 2006).

Interpersonal Traumas

Interpersonal traumas are events that occur (and typically continue to reoccur) between people who often know each other, such as spouses or parents and their children. Examples include physical and sexual abuse, sexual assault, domestic violence, and elder abuse.

Intimate partner violence

Intimate partner violence (IPV), often referred to as domestic violence, is a pattern of actual or threatened physical, sexual, and/or emotional abuse. It differs from simple assault in that multiple episodes often occur and the perpetrator is an intimate partner of the victim. Trauma associated with IPV is normally ongoing. Incidents of this form of violence are rarely isolated, and the client may still be in contact with and encountering abuse from the perpetrator while engaged in treatment.

Intimate partners include current and former spouses, boyfriends, and girlfriends. The majority of all nonfatal acts of violence and intimate partner homicides are committed against women; IPV accounts for over 20 percent of nonfatal violence against women but only 3.6 percent of that committed against men (Catalano, 2012). Children are the hidden casualties of IPV. They often witness the assaults or threats directly, within earshot, or by being exposed to the aftermath of the violence (e.g., seeing bruises and destruction of property, hearing the pleas for it to stop or the promises that it will never happen again).

Substance abuse, particularly involving alcohol, is frequently associated with IPV. It is the presence of alcohol-related problems in either partner, rather than the level of alcohol consumption itself, that is the important factor.

Drinking may or may not be the cause of the violence; that said, couples with alcohol-related disorders could have more tension and disagreement within the relationship in general, which leads to aggression and violence. The consumption of alcohol during a dispute is likely to decrease inhibitions and increase impulsivity, thus creating an opportunity for an argument to escalate into a physical altercation. More information on domestic violence and its effects on partners and families, as well as its connection with substance use and trauma-related disorders, is available in TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b), and from the National Online Resource Center on Violence Against Women (http://www.vawnet.org/).

Developmental Traumas

Developmental traumas include specific events or experiences that occur within a given developmental stage and influence later development, adjustment, and physical and mental health. Often, these traumas are related to adverse childhood experiences (ACEs), but they can also result from tragedies that occur outside an expected developmental or life stage (e.g., a child dying before a parent, being diagnosed with a life-threatening illness as a young adult) or from events at any point in the life cycle that create significant loss and have life-altering consequences (e.g., the death of a significant other in the later years that leads to displacement of the surviving partner).

Adverse childhood experiences

Some people experience trauma at a young age through sexual, physical, or emotional abuse and neglect. The Adverse Childhood Experiences Study (Felitti et al., 1998) examined the effects of several categories of ACEs on adult health, including physical and emotional abuse; sexual abuse; a substance-dependent parent; an incarcerated, mentally ill, or suicidal household member; spousal abuse between parents; and divorce or separation that meant one parent was absent during childhood. The National Comorbidity Studies examined the prevalence of trauma and defined childhood adversities as parental death, parental divorce/separation, life-threatening illness, or extreme economic hardship in addition to the childhood experiences included in the Adverse Childhood Experiences Study (Green et al., 2010).

ACEs can negatively affect a person's well-being into adulthood. Whether or not these experiences occur simultaneously, are time-limited, or recur, they set the stage for increased vulnerability to physical, mental, and substance use disorders and enhance the risk

Child Neglect

Child neglect occurs when a parent or caregiver does not give a child the care he or she needs according to his or her age, even though that adult can afford to give that care or is offered help to give that care. Neglect can mean not providing adequate nutrition, clothing, and/or shelter. It can mean that a parent or caregiver is not providing a child with medical or mental health treatment or is not giving prescribed medicines the child needs. Neglect can also mean neglecting the child's education. Keeping a child from school or from special education can be neglect. Neglect also includes exposing a child to dangerous environments (e.g., exposure to domestic violence). It can mean poor supervision for a child, including putting the child in the care of someone incapable of caring for children. It can mean abandoning a child or expelling him or her from home. Lack of psychological care, including emotional support, attention, or love, is also considered neglect—and it is the most common form of abuse reported to child welfare authorities.

Source: dePanfilis, 2006.

for repeated trauma exposure across the life span. Childhood abuse is highly associated with major depression, suicidal thoughts, PTSD, and dissociative symptoms. So too, ACEs are associated with a greater risk of adult alcohol use. When a person experiences several adverse events in childhood, the risk of his or her heavy drinking, self-reported alcohol dependence, and marrying a person who is alcohol dependent is two to four times greater than that of a person with no ACEs (Dube, Anda, Felitti, Edwards, & Croft, 2002).

A detailed examination of the issues involved in providing substance abuse treatment to survivors of child abuse and neglect is the subject of TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT, 2000b).

Political Terror and War

Political terror and war are likely to have lasting consequences for survivors. In essence, anything that threatens the existence, beliefs, well-being, or livelihood of a community is likely to be experienced as traumatic by community members. Whether counselors are working with an immigrant or refugee enclave in the United States or in another country, they should be aware of local events, local history, and the possibility that clients have endured trauma. (For international information about the clinical, historical, and theoretical aspects of trauma and terrorism, see Danieli, Brom, & Sills, 2005.) Terrorism is a unique subtype of human-caused disasters. The overall goal of terrorist attacks is to maximize the uncertainty, anxiety, and fear of a large community, so the responses are often epidemic and affect large numbers of people who have had direct or indirect exposure to an event (Silver et al., 2004; Suvak, Maguen, Litz, Silver, & Holman, 2008). Terrorism has a variety of results not common to other disasters, such as reminders of the unpredictability of terrorist acts; increases in security measures for the general population; intensified suspicion about a particular population, ethnicity, or culture; and heightened awareness and/or arousal.

Refugees

According to the World Refugee Survey, there are an estimated 12 million refugees and asylum seekers, 21 million internally displaced people, and nearly 35 million uprooted people (U.S. Committee for Refugees and Immigrants, 2006). Many of these people have survived horrendous ordeals with profound and lasting effects for individuals and whole populations. In addition to witnessing deaths by execution, starvation, or beatings, many survivors have experienced horrific torture.

Refugees are people who flee their homes because they have experienced or have a reasonable fear of experiencing persecution. They

Torture and Captivity

Torture traumatizes by taking away an individual's personhood. To survive, victims have to give up their sense of self and will. They become the person the torturer designs or a nonperson, simply existing. Inevitably, the shame of the victim is enormous, because the focus of torture is to humiliate and degrade. As a result, victims often seek to hide their trauma and significant parts of their selfhood long after torture has ended and freedom has been obtained. According to Judith Herman, "the methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma. They are organized techniques of disempowerment and disconnection. Methods of psychological control are designed to instill terror and helplessness and to destroy the victim's sense of self in relation to others."

Source: Herman, 1997, p. 77.

differ from immigrants who willingly leave their homes or homeland to seek better opportunities. Although immigrants may experience trauma before migrating to or after reaching their new destination, refugees will often have greater exposure to trauma before migration. Refugees typically come from war-torn countries and may have been persecuted or tortured. Consequently, greater exposure to trauma, such as torture, before migrating often leads to more adjustment-related difficulties and psychological symptoms after relocation (Steel et al., 2009).

Refugees typically face substantial difficulties in assimilating into new countries and cultures. Moreover, the environment can create a new set of challenges that may include additional exposure to trauma and social isolation (Miller et al., 2002). These as well as additional factors influence adjustment, the development of mental illness (including PTSD), and the occurrence of substance use disorders. Additional factors that influence outcomes after relocation include receptivity of the local community, along with opportunities for social support and culturally responsive services.

Among refugee populations in the United States, little research is available on rates of mental illness and co-occurring substance use disorders and traumatic stress among refugee populations. Substance use patterns vary based on cultural factors as well as assimilation, yet research suggests that trauma increases the risk for substance use among refugees after war-related experiences (Kozarić-Kovačić, Ljubin, & Grappe, 2000). Therefore, providers should expect to see trauma-related disorders among refugees who are seeking treatment for a substance use disorder and greater prevalence of substance use disorders among refugees who seek behavioral health services.

Vietnamese Refugees

"Wars always have consequences, both immediate and remote, and the consequences are often tragic. One tragic circumstance often caused by war is the forceful, disorganized, and uncontrollable mass movement of both civilians and soldiers trying to escape the horrors of the wars or of an oppressive regime.…

"Vietnamese communists, by taking power in the North in 1954 and then in the South in 1975, caused two major upheavals in the Land of the Small Dragon, as Vietnam was once called. The first Vietnam War led to the 1954 exodus during which 1 million people fled from the North to the South. The second Vietnam War resulted in the dispersion, from 1975-1992, of approximately 2 million Vietnamese all over the world. These significant, unplanned, and uncoordinated mass movements around the world not only dislocated millions of people, but also caused thousands upon thousands of deaths at sea.…

"The second and third wave of refugees from 1976 onward went through a more difficult time. They had to buy their way out and to hide from soldiers and the police who hunted them down. After catching them, the police either asked for brides or threw the escapees into jails. Those who evaded police still had to face engine failures, sea storms, pirates…They then had to survive overcrowded boats for days or weeks, during which food and water could not be replenished and living conditions were terrible… Many people died from exhaustion, dehydration, and hunger. Others suffered at the hands of terrifying pirates… After the sea ordeal came the overcrowded camps where living conditions were most often substandard and where security was painfully lacking.…

"In the United States, within less than 3 decades, the Vietnamese population grew from a minority of perhaps 1,000 persons to the second largest refugee group behind Cubans."

Source: Vo, 2006, pp. 1–4.

System-Oriented Traumas: Retraumatization

Retraumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma. Unfortunately, treatment settings and clinicians can create retraumatizing experiences, often without being aware of it, and sometimes clients themselves are not consciously aware that a clinical situation has actually triggered a traumatic stress reaction. Agencies that anticipate the risk for retraumatization and actively work on adjusting program policies and procedures to remain sensitive to the histories and needs of individuals who have undergone past trauma are likely to have more success in providing care, retaining clients, and achieving positive outcomes.

Staff and agency issues that can cause retraumatization include:

- Being unaware that the client's traumatic history significantly affects his or her life.
- Failing to screen for trauma history prior to treatment planning.
- Challenging or discounting reports of abuse or other traumatic events.
- Using isolation or physical restraints.
- Using experiential exercises that humiliate the individual.
- Endorsing a confrontational approach in counseling.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling behavior/feelings as pathological.
- Failing to provide adequate security and safety within the program.
- Limiting participation of the client in treatment decisions and planning processes.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate setting.

Advice to Counselors: Addressing Retraumatization

- Anticipate and be sensitive to the needs of clients who have experienced trauma regarding program policies and procedures in the treatment setting that might trigger memories of trauma, such as lack of privacy, feeling pushed to take psychotropic medications, perceiving that they have limited choices within the program or in the selection of the program, and so forth.
- Attend to clients' experiences. Ignoring clients' behavioral and emotional reactions to having their traumatic memories triggered is more likely to increase these responses than decrease them.
- Develop an individual coping plan in anticipation of triggers that the individual is likely to experience in treatment based on his or her history.
- Rehearse routinely the coping strategies highlighted in the coping plan. If the client does not practice strategies prior to being triggered, the likelihood of being able to use them effectively upon triggering is lessened. For example, it is far easier to practice grounding exercises in the absence of severe fear than to wait for that moment when the client is reexperiencing an aspect of a traumatic event. (For more information on grounding exercises, refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*; Najavits, 2002a, pp. 125–131.)
- Recognize that clinical and programmatic efforts to control or contain behavior in treatment can cause traumatic stress reactions, particularly for trauma survivors for whom being trapped was part of the trauma experience.
- Listen for the specific trigger that seems to be driving the client's reaction. It will typically help both the counselor and client understand the behavior and normalize the traumatic stress reactions.
- Make sure that staff and other clients do not shame the trauma survivor for his or her behavior, such as through teasing or joking about the situation.
- Respond with consistency. The client should not get conflicting information or responses from different staff members; this includes information and responses given by administrators.

- Having clients undress in the presence of others.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Imposing agency policies or rules without exceptions or an opportunity for clients to question them.
- Enforcing new restrictions within the program without staff–client communication.
- Limiting access to services for ethnically diverse populations.
- Accepting agency dysfunction, including lack of consistent, competent leadership.

Characteristics of Trauma

The following section highlights several selected characteristics of traumatic experiences that influence the effects of traumatic stress. Objective characteristics are those elements of a traumatic event that are tangible or factual; subjective characteristics include internal processes, such as perceptions of traumatic experiences and meanings assigned to them.

Objective Characteristics

Was it a single, repeated, or sustained trauma?

Trauma can involve a single event, numerous or repeated events, or sustained/chronic experiences. A *single trauma* is limited to a single point in time. A rape, an automobile accident, the sudden death of a loved one—all are examples of a single trauma. Some people who experience a single trauma recover without any specific intervention. But for others—especially those with histories of previous trauma or mental or substance use disorders, or those for whom the trauma experience is particularly horrific or overwhelming—a single trauma can result in traumatic stress symptoms and trauma- and stress-related disorders. Single traumas do not necessarily have a lesser psychological impact than repeated traumas. After the terrorist attacks on September 11, 2001—a significant single trauma—many Manhattan residents experienced intrusive memories and sleep disruption whether they were at the site of the attacks or watched television coverage of it (Ford & Fournier, 2007; Galea et al., 2002).

A series of traumas happening to the same person over time is known as *repeated trauma*. This can include repeated sexual or physical assaults, exposure to frequent injuries of others, or seemingly unrelated traumas. Military personnel, journalists covering stories of mass tragedies or prolonged conflicts, and first responders who handle hundreds of cases each year typify repeated trauma survivors. Repetitive exposure to traumas can have a cumulative effect over one's lifetime. A person who was assaulted during adolescence, diagnosed with a life-threatening illness in his or her thirties, and involved in a serious car accident later in life has experienced repeated trauma.

Some repeated traumas are sustained or chronic. Sustained trauma experiences tend to wear down resilience and the ability to adapt. Some examples include children who endure ongoing sexual abuse, physical neglect, or emotional abuse; people who are in violent relationships; and people who live in chronic poverty. Individuals in chronically stressful, traumatizing environments are particularly susceptible to traumatic stress reactions, substance use, and mental disorders.

Bidirectional relationships exist between trauma and substance use as well as trauma and mental illness. For example, abuse of alcohol and drugs increases the risk of a traumatic experience and creates greater vulnerability to the effects of trauma; substance abuse reduces a person's ability to take corrective and remedial actions that might reduce the impact of the trauma. Likewise, traumatic stress leads to a greater likelihood of

Case Illustration: Yourself

Think of a time that was particularly stressful (but not traumatic) in your life. Revisit this period as an observer watching the events unfold and then ask yourself, "What made this time particularly stressful?" It is likely that a part of your answer will include the difficulty of managing one situation before another circumstance came along demanding your time. Stressful times denote being bombarded with many things at one time, perceived or actual, without sufficient time or ability to address them emotionally, cognitively, spiritually, and/or physically. The same goes for trauma—rapid exposure to numerous traumas one after another lessens one's ability to process the event before the next onslaught. This creates a cumulative effect, making it more difficult to heal from any one trauma.

substance abuse that, in turn, increases the risk for additional exposure to trauma. Paralleling this bidirectional relationship, mental illness increases vulnerability to the effects of trauma and raises the risk for substance use disorders and for encountering additional traumatic events. So too, early exposure to ACEs is associated with traumatic stress reactions and subsequent exposure to trauma in adult years.

People who have encountered multiple and longer doses of trauma are at the greatest risk for developing traumatic stress. For example, military reservists and other military service members who have had multiple long tours of duty are at greater risk for traumatic stress reactions (see the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families;* SAMHSA, planned f). In addition, people are more likely to encounter greater impairment and distress from trauma if that trauma occurs with significant intensity and continues sporadically or unceasingly for extended periods.

Was there enough time to process the experience?

A particularly severe pattern of ongoing trauma, sometimes referred to as "cascading trauma," occurs when multiple traumas happen in a pattern that does not allow an individual to heal from one traumatic event before another occurs. Take, for example, California residents—they repeatedly face consecutive and/or simultaneous natural disasters including fires, landslides, floods, droughts, and earthquakes. In other cases, there is ample time to process an event, but processing is limited because people don't have supportive relationships or environments that model preventive practices. This can lead to greater vulnerability to traumas that occur later in life.

How many losses has the trauma caused?

Trauma itself can create significant distress, but often, the losses associated with a trauma have more far-reaching effects. For instance, a child may be forced to assume adult responsibilities, such as serving as a confidant for a parent who is sexually abusing him or her, and lose the opportunity of a childhood free from adult worries. In another scenario, a couple may initially feel grateful to have escaped a house fire, but they may nevertheless face significant community and financial losses months afterward. In evaluating the impact of trauma, it is helpful to access and discuss the losses associated with the initial trauma. The number of losses greatly influences an individual's ability to bounce back from the tragedy.

In the case illustration on the next page, Rasheed's losses cause him to disconnect from his wife, who loves and supports him. Successful confrontation of losses can be difficult if the losses compound each other, as with Rasheed's loss of his friend, his disability, his employment struggles, and the threats to his marriage and liberty. People can cite a specific

Case Illustration: Rasheed

Rasheed was referred to an employee assistance program by his employer. He considered quitting his job, but his wife insisted he talk to a counselor. He is a 41-year-old auto mechanic who, 4 years ago, caused a head-on collision while attempting to pass another vehicle. A close friend, riding in the passenger's seat, was killed, and two young people in the other vehicle were seriously injured and permanently disabled. Rasheed survived with a significant back injury and has only been able to work sporadically. He was convicted of negligent homicide and placed on probation because of his physical disability. He is on probation for another 4 years, and if he is convicted of another felony during that time, he will have to serve prison time for his prior offense.

While still in the hospital, Rasheed complained of feeling unreal, numb, and disinterested in the care he received. He did not remember the crash but remembers waking up in the hospital 2 days later. He had difficulty sleeping in the hospital and was aware of feelings of impending doom, although he was unaware of the legal charges he would later face. He was diagnosed with ASD.

He was discharged from the hospital with a variety of medications, including pain pills and a sleep aid. He rapidly became dependent on these medications, feeling he could not face the day without the pain medication and being unable to sleep without sleep medicine in larger doses than had been prescribed. Within 3 months of the accident, he was "doctor shopping" for pain pills and even had a friend obtain a prescription for the sleeping medication from that friend's doctor. In the 4 intervening years, Rasheed's drug use escalated, and his blunted emotions and detachment from friends became more profound. He became adept at obtaining pain pills from a variety of sources, most of them illegal. He fears that if he seeks treatment for the drug problem, he will have to admit to felony offenses and will probably be imprisoned. He also does not believe he can manage his life without the pain pills.

In the past 2 years, he has had recurring dreams of driving a car on the wrong side of the road and into the headlights of an oncoming vehicle. In the dream, he cannot control the car and wakes up just before the vehicles crash. At unusual times—for instance, when he is just awakening in the morning, taking a shower, or walking alone—he will feel profound guilt over the death of his friend in the accident. He becomes very anxious when driving in traffic or when he feels he is driving faster than he should. His marriage of 18 years has been marked by increasing emotional distance, and his wife has talked about separating if he does not do something about his problem. He has been unable to work consistently because of back pain and depression. He was laid off from one job because he could not concentrate and was making too many mistakes.

The counselor in the employee assistance program elicited information on Rasheed's drug use, although she suspected Rasheed was minimizing its extent and effects. Knowledgeable about psychological trauma, the counselor helped Rasheed feel safe enough to talk about the accident and how it had affected his life. She was struck by how little Rasheed connected his present difficulties to the accident and its aftermath. The counselor later commented that Rasheed talked about the accident as if it had happened to someone else. Rasheed agreed to continue seeing the counselor for five additional visits, during which time a plan would be made for Rasheed to begin treatment for drug dependence and PTSD.

event as precipitating their trauma, or, in other cases, the specific trauma can symbolize a series of disabling events in which the person felt his or her life was threatened or in which he or she felt emotionally overwhelmed, psychologically disorganized, or significantly disconnected from his or her surroundings. It will be important for Rasheed to understand how his losses played a part in his abuse of prescription medications to cope with symptoms associated with traumatic stress and loss, (e.g., guilt, depression, fear). If not addressed, his trauma could increase his risk for relapse.

Was the trauma expected or unexpected?

When talking about a trauma, people sometimes say they didn't see it coming. Being unprepared, unaware, and vulnerable often increases the risk of psychological injury, but these are common components of most traumas, given that most traumatic events do occur without warning (e.g., car crashes, terrorist attacks, sexual assaults). People with substance use disorders, mental illness, and/or cognitive disabilities may be especially vulnerable in that they may attend less or have competing concerns that diminish attention to what is going on around them, even in high-risk environments. However, most individuals attempt to gain some control over the tragedy by replaying the moments leading up to the event and processing how they could have anticipated it. Some people perseverate on these thoughts for months or years after the event.

Sometimes, a trauma is anticipated but has unexpected or unanticipated consequences, as in the case of Hurricane Katrina. Learning about what is likely to happen can reduce traumatization. For instance, training military personnel in advance of going to combat overseas prepares them to handle traumas and can reduce the impact of trauma.

Were the trauma's effects on the person's life isolated or pervasive?

When a trauma is isolated from the larger context of life, a person's response to it is more likely to be contained and limited. For instance, military personnel in combat situations can be significantly traumatized by what they experience. On return to civilian life or noncombat service, some are able to isolate the traumatic experience so that it does not invade ordinary, day-to-day living. This does not mean that the combat experience was not disturbing or that it will not resurface if the individual encounters an experience that triggers memories of the trauma; it just means that the person can more easily leave the trauma in the past and attend to the present.

Conversely, people who remain in the vicinity of the trauma may encounter greater challenges in recovery. The traumatic event intertwines with various aspects of the person's daily activities and interactions, thus increasing the possibility of being triggered by surrounding cues and experiencing subsequent psychological distress. However, another way to view this potential dilemma for the client is to reframe it as an opportunity—the repetitive exposure to trauma-related cues may provide vital guidance as to when and which treatment and coping techniques to use in the delivery of trauma-informed and trauma-specific behavioral health services.

Who was responsible for the trauma and was the act intentional?

If the severity of a trauma is judged solely by whether the act was intentional or not, events that reflect an intention to harm would be a primary indicator in predicting subsequent difficulties among individuals exposed to this form of trauma. For most survivors, there is an initial disbelief that someone would conceivably intend to harm others, followed by considerable emotional and, at times, behavioral investment in somehow making things right again or in making sense of a senseless, malicious act. For instance, in the wake of the World Trade Center attacks in New York City, people responded via renewed patriotism, impromptu candlelight vigils, attacks on people of Arab and Muslim descent, and unprecedented donations and willingness to wait in long lines to donate blood to the Red Cross. Each example is a response that in some way attempts to right the perceived wrong or attach new meaning to the event and subsequent consequences.

When terrible things happen, it is human nature to assign blame. Trauma survivors can become heavily invested in assigning blame or finding out who was at fault, regardless of the type of trauma. Often, this occurs as an attempt to make sense of, give meaning to, and reestablish a sense of predictability, control, and safety after an irrational or random act. It is far easier to accept that someone, including oneself, is at fault or could have done something different than it is to accept the fact that one was simply in the wrong place at the wrong time.

For some trauma survivors, needing to find out why a trauma occurred or who is at fault can become a significant block to growth when the individual would be better served by asking, "What do I need to do to heal?" Behavioral health professionals can help clients translate what they have learned about responsibility in recovery to other aspects of their lives. For instance, someone in treatment for co-occurring disorders who has internalized that becoming depressed or addicted was not his or her fault, but that recovery *is* a personal responsibility, can then apply the same principle to the experience of childhood abuse and thereby overcome negative judgments of self (e.g., thinking oneself to be a bad person who deserves abuse). The individual can then begin to reassign responsibility by attaching the blame to the perpetrator(s) while at the same time assuming responsibility for recovery.

Was the trauma experienced directly or indirectly?

Trauma that happens to someone directly seems to be more damaging than witnessing trauma that befalls others. For example, it is usually more traumatic to be robbed at gunpoint than to witness someone else being robbed or hearing someone tell a story about being robbed. Yet, sometimes, experiencing another's pain can be equally traumatic. For instance, parents often internalize the pain and suffering of their children when the children are undergoing traumatic circumstances (e.g., treatments for childhood cancer).

There are two ways to experience the trauma of others. An individual may witness the event, such as seeing someone killed or seriously injured in a car accident, or may learn of an event that happened to someone, such as a violent personal assault, suicide, serious accident, injury, or sudden or unexpected death. For many people, the impact of the trauma will depend on a host of variables, including their proximity to the event as eyewitnesses, the witnesses' response in the situation, their relationship to the victims, the degree of helplessness surrounding the experience, their exposure to subsequent consequences, and so on.

Case Illustration: Frank

Frank entered substance abuse treatment with diagnoses of co-occurring PTSD and substance use disorder. While on a whitewater kayak trip with his wife, her kayak became pinned on a rock, and Frank could only watch helplessly as she drowned. His drinking had increased markedly after the accident. He acknowledged a vicious cycle of sleep disturbance with intrusive nightmares followed by vivid memories and feelings of terror and helplessness after he awoke. He drank heavily at night to quiet the nightmares and memories, but heavy alcohol consumption perpetuated his trouble sleeping. He withdrew from contact with many of his old "couple friends" and his wife's family, with whom he had been close. At treatment entry, he described his life as "going to work and coming home." The trauma occurred 3 years before he sought treatment, but Frank continued to feel numb and disconnected from the world. His only emotion was anger, which he tried to keep in check. Integrated treatment for PTSD and substance abuse helped him sleep and taught him coping skills to use when the memories arose; it fostered his engagement and retention in long-term care for both disorders.

The effects of traumas such as genocide and internment in concentration camps can be felt across generations—stories, coping behaviors, and stress reactions can be passed across generational lines far removed from the actual events or firsthand accounts. Known as historical trauma, this type of trauma can affect the functioning of families, communities, and cultures for multiple generations.

What happened since the trauma?

In reviewing traumatic events, it is important to assess the degree of disruption after the initial trauma has passed, such as the loss of employment, assets, community events, behavioral health services, local stores, and recreational areas. There is typically an initial rally of services and support following a trauma, particularly if it is on a mass scale. However, the reality of the trauma's effects and their disruptiveness may have a more lasting impact. The deterioration of normalcy, including the disruption of day-to-day activities and the damage of structures that house these routines, will likely erode the common threads that provide a sense of safety in individual lives and communities. Hence, the degree of disruption in resuming normal daily activities is a significant risk factor for substance use disorders, subclinical psychological symptoms, and mental disorders. For example, adults displaced from their homes because of Hurricanes Katrina or Rita had significantly higher rates of past-month cigarette use, illicit drug use, and binge drinking than those who were not displaced (Office of Applied Studies, 2008).

Subjective Characteristics

Psychological meaning of trauma

An important clinical issue in understanding the impact of trauma is the meaning that the survivor has attached to the traumatic experience. Survivors' unique cognitive interpretations of an event—that is, their beliefs and assumptions—contribute to how they process, react to, cope with, and recover from the trauma. Does the event represent retribution for past deeds committed by the individual or his or her family? How does the individual attach meaning to his or her survival? Does he or she believe that it is a sign of a greater purpose not yet revealed? People who attempt to share their interpretation and meaning of the event can feel misunderstood and sometimes alienated (Paulson & Krippner, 2007; Schein, Spitz, Burlingame, & Muskin, 2006).

> It is important to remember that what happened is not nearly as important as what the trauma means to the individual.

People interpret traumatic events in vastly different ways, and many variables shape how an individual assigns meaning to the experience (framing the meaning through culture, family beliefs, prior life experiences and learning, personality and other psychological features, etc.). Even in an event that happens in a household, each family member may interpret the experience differently. Likewise, the same type of event can occur at two different times in a person's life, but his or her interpretation of the events may differ considerably because of developmental differences acquired between events, current cognitive and emotional processing skills, availability of and access to environmental resources, and so forth.

Disruption of core assumptions and beliefs

Trauma often engenders a crisis of faith (Frankl, 1992) that leads clients to question basic assumptions about life. Were the individual's core or life-organizing assumptions (e.g., about safety, perception of others, fairness, purpose of life, future dreams) challenged or disrupted during or after the traumatic event? (See the seminal work,

Resilience: Connection and Continuity

Research suggests that reestablishing ties to family, community, culture, and spiritual systems is not only vital to the individual, but it also influences the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of survivors of Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents directly affected by the purge experienced fewer negative effects than those who were emotionally or physically severed from their grandparents. Whether the grandparents survived was less important than the connection the grandchildren felt to their pasts.

Shattered Assumptions, by Janoff-Bulman, 1992.) For example, some trauma survivors see themselves as irreparably wounded or beyond the possibility of healing. The following case illustration (Sonja) explores not only the importance of meaning, but also the role that trauma plays in altering an individual's core assumptions—the very assumptions that provide meaning and a means to organize our lives and our interactions with the world and others.

Cultural meaning of trauma

Counselors should strive to appreciate the cultural meaning of a trauma. How do cultural interpretations, cultural support, and cultural responses affect the experience of trauma? It is critical that counselors do not presume to understand the meaning of a traumatic experience without considering the client's cultural context. Culture strongly influences the perceptions of trauma. For instance, a trauma involving shame can be more profound for a person from an Asian culture than for someone from a European culture. Likewise, an Alaska Native individual or community, depending upon their Tribal ancestry, may believe that the traumatic experience serves as a form of retribution. Similarly, the sudden death of a family member or loved one can be less traumatic in a culture that has a strong belief in a positive afterlife. It is important for counselors to recognize that their perceptions of a specific trauma could be very different from their clients' perceptions. Be careful not to judge a client's beliefs in light of your own value system. For more information on culture and how to achieve cultural competence in providing behavioral health services, see SAMHSA's planned TIP, *Improving Cultural Competence* (SAMHSA, planned c).

Individual and Sociocultural Features

A wide variety of social, demographic, environmental, and psychological factors influence a person's experience of trauma, the severity of traumatic stress reactions following the event, and his or her resilience in dealing with the short- and long-term environmental, physical, sociocultural, and emotional consequences. This section addresses a few known factors that influence the risk of trauma along with the development of subclinical and diagnostic traumatic stress symptoms, such as mood and anxiety symptoms and disorders. It is not meant to be an exhaustive exploration of these factors, but rather, a brief presentation to make counselors and other behavioral health professionals aware that various factors influence risk for and protection against traumatic stress and subsequent reactions. (For a broader perspective on such factors, refer to Part 1, Chapter 1.)

Individual Factors

Several factors influence one's ability to deal with trauma effectively and increase one's risk for traumatic stress reactions. Individual factors pertain to the individual's genetic, biological, and psychological makeup and history as they influence the person's experience and

Case Illustration: Sonja

Sonja began to talk about how her life was different after being physically assaulted and robbed in a parking lot at a local strip mall a year ago. She recounts that even though there were people in the parking lot, no one came to her aid until the assailant ran off with her purse. She sustained a cheekbone fracture and developed visual difficulties due to the inflammation from the fracture. She recently sought treatment for depressive symptoms and reported that she had lost interest in activities that typically gave her joy. She reported isolating herself from others and said that her perception of others had changed dramatically since the attack.

Sonja had received a diagnosis of major depression with psychotic features 10 years earlier and received group therapy at a local community mental health center for 3 years until her depression went into remission. She recently became afraid that her depression was becoming more pronounced, and she wanted to prevent another severe depressive episode as well as the use of psychotropic medications, which she felt made her lethargic. Thus, she sought out behavioral health counseling.

As the sessions progressed, and after a psychological evaluation, it was clear that Sonja had some depressive symptoms, but they were subclinical. She denied suicidal thoughts or intent, and her thought process was organized with no evidence of hallucinations or delusions. She described her isolation as a reluctance to shop at area stores. On one hand, Sonja was self-compassionate about her reasons for avoidance, but on the other hand, she was concerned that the traumatic event had altered how she saw life and others. "I don't see people as very caring or kind, like I used to prior to the event. I don't trust them, and I feel people are too self-absorbed. I don't feel safe, and this bothers me. I worry that I'm becoming paranoid again. I guess I know better, but I just want to have the freedom to do what I want and go where I want."

Two months after Sonja initiated counseling, she came to the office exclaiming that things can indeed change. "You won't believe it. I had to go to the grocery store, so I forced myself to go the shopping center that had a grocery store attached to a strip mall. I was walking by a coffee shop, quickly browsing the items in the front window, when a man comes out of the shop talking at me. He says, 'You look like you need a cup of coffee.' What he said didn't register immediately. I looked at him blankly, and he said it again. 'You look like you need a cup of coffee. I'm the owner of the shop, and I noticed you looking in the window, and we have plenty of brewed coffee left before we close the shop. Come on in, it's on the house.' So I did! From that moment on, I began to see people differently. He set it right for me—I feel as if I have myself back again, as if the assault was a sign that I shouldn't trust people, and now I see that there is some goodness in the world. As small as this kindness was, it gave me the hope that I had lost."

For Sonja, the assault changed her assumptions about safety and her view of others. She also attached meaning to the event. She believed that the event was a sign that she shouldn't trust people and that people are uncaring. Yet these beliefs bothered her and contradicted how she saw herself in the world, and she was afraid that her depressive symptoms were returning.

For an inexperienced professional, her presentation may have ignited suspicions that she was beginning to present with psychotic features. However, it is common for trauma survivors to experience changes in core assumptions immediately after the event and to attach meaning to the trauma. Often, a key ingredient in the recovery process is first identifying the meaning of the event and the beliefs that changed following the traumatic experience. So when you hear a client say "I will never see life the same," this expression should trigger further exploration into how life is different, what meaning has been assigned to the trauma, and how the individual has changed his or her perception of self, others, and the future.

(Continued on the next page.)

Case Illustration: Sonja (continued)

Sometimes, reworking the altered beliefs and assumptions occurs with no formal intervention, as with Sonja. In her situation, a random stranger provided a moment that challenged an assumption generated from the trauma. For others, counseling may be helpful in identifying how beliefs and thoughts about self, others, and the world have changed since the event and how to rework them to move beyond the trauma. It is important to understand that the meaning that an individual attaches to the event(s) can either undermine the healing process (e.g., believing that you should not have survived, feeling shame about the trauma, continuing to engage in high-risk activities) or pave the road to recovery (e.g., volunteering to protect victim rights after being sexually assaulted). The following questions can help behavioral health staff members introduce topics surrounding assumptions, beliefs, interpretations, and meanings related to trauma:

- In what ways has your life been different since the trauma?
- How do you understand your survival? (This is an important question for clients who have been exposed to ACEs or cumulative trauma and those who survived a tragedy when others did not.)
- Do you believe that there are reasons that this event happened to you? What are they?
- What meaning does this experience have for you?
- Do you feel that you are the same person as before the trauma? In what ways are you the same? In what ways do you feel different?
- How did this experience change you as a person? Would you like to return to the person you once were? What would you need to do, or what would need to happen, for this to occur?
- Did the traumatic experience change you in a way that you don't like? In what ways?
- How do you view others and your future differently since the trauma?
- What would you like to believe now about the experience?

interpretation of, as well as his or her reactions to, trauma. However, many factors influence individual responses to trauma; it is not just individual characteristics. Failing to recognize that multiple factors aside from individual attributes and history influence experiences during and after trauma can lead to blaming the victim for having traumatic stress.

History of prior psychological trauma

People with histories of prior psychological trauma appear to be the most susceptible to severe traumatic responses (Nishith, Mechanic, & Resick, 2000; Vogt, Bruce, Street, & Stafford, 2007), particularly if they have avoided addressing past traumas. Because minimization, dissociation, and avoidance are common defenses for many trauma survivors, prior traumas are not always consciously available, and when they are, memories can be distorted to avoid painful affects. Some survivors who have repressed their experiences deny a history of trauma or are unable to explain their strong reactions to present situations.

Remember that the effects of trauma are cumulative; therefore, a later trauma that outwardly appears less severe may have more impact upon an individual than a trauma that occurred years earlier. Conversely, individuals who have experienced earlier traumas may have developed effective coping strategies or report positive outcomes as they have learned to adjust to the consequences of the trauma(s). This outcome is often referred to as posttraumatic growth or psychological growth.

Clients in behavioral health treatment who have histories of trauma can respond negatively to or seem disinterested in treatment efforts. They may become uncomfortable in groups that emphasize personal sharing; likewise, an individual who experiences brief bouts of dissociation (a reaction of some trauma survivors) may be misunderstood by others in treatment and seen as uninterested. Providers need to

attend to histories, adjust treatment to avoid retraumatization, and steer clear of labeling clients' behavior as pathological.

History of resilience

Resilience—the ability to thrive despite negative life experiences and heal from traumatic events—is related to the internal strengths and environmental supports of an individual. Most individuals are resilient despite experiencing traumatic stress. The ability to thrive beyond the trauma is associated with individual factors as well as situational and contextual factors. There are not only one or two primary factors that make an individual resilient; many factors contribute to the development of resilience. There is little research to indicate that there are specific traits predictive of resilience; instead, it appears that more general characteristics influence resilience, including neurobiology (Feder, Charney, & Collins, 2011), flexibility in adapting to change, beliefs prior to trauma, sense of self-efficacy, and ability to experience positive emotions (Bonanno & Mancini, 2011).

History of mental disorders

The correlations among traumatic stress, substance use disorders, and co-occurring mental disorders are well known. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (American Psychiatric Association, 2013a), traumatic stress reactions are linked to higher rates of mood, substance-related, anxiety, trauma, stress-related, and other mental disorders, each of which can precede, follow, or emerge concurrently with trauma itself. A co-occurring mental disorder is a significant determinant of whether an individual can successfully address and resolve trauma as it emerges from the past or occurs in the present. Koenen, Stellman, Stellman, and Sommer (2003) found that the risk of developing PTSD following combat trauma was higher for individuals with preexisting conduct disorder, panic disorder, generalized anxiety disorder, and/or major depression than for those without preexisting mental disorders. For additional information on comorbidity of trauma and other mental disorders, see TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c).

Sociodemographic Factors

Demographic variables are not good predictors of who will experience trauma and subsequent traumatic stress reactions. Gender, age, race and ethnicity, sexual orientation, marital status, occupation, income, and education can all have some influence, but not enough to determine who should or should not receive screening for trauma and traumatic stress symptoms. The following sections cover a few selected variables. (For more information, please refer to Part 3 of this TIP, the online literature review.)

Gender

In the United States, men are at greater risk than women for being exposed to stressful events. Despite the higher prevalence among men, lifetime PTSD occurs at about twice the rate among women as it does in men. Less is known about gender differences with subclinical traumatic stress reactions. There are also other gender differences, such as the types of trauma experienced by men and women. Women are more likely to experience physical and sexual assault, whereas men are most likely to experience combat and crime victimization and to witness killings and serious injuries (Breslau, 2002; Kimerling, Ouimette, & Weitlauf, 2007; Tolin & Foa, 2006). Women in military service are subject to the same risks as men and are also at a greater risk for military sexual trauma. Men's traumas often occur in public; women's are more likely to take place in private settings. Perpetrators of traumas against men are often strangers, but women are more likely to know the perpetrator.

Age

In general, the older one becomes, the higher the risk of trauma—but the increase is not dramatic. Age is not particularly important in predicting exposure to trauma, yet at no age is one immune to the risk. However, trauma that occurs in the earlier and midlife years appears to have greater impact on people for different reasons. For younger individuals, the trauma can affect developmental processes, attachment, emotional regulation, life assumptions, cognitive interpretations of later experiences, and so forth (for additional resources, visit the National Child Traumatic Stress Network; http://www.nctsn.org/). For adults in midlife, trauma may have a greater impact due to the enhanced stress or burden of care that often characterizes this stage of life—caring for their children and their parents at the same time. Older adults are as likely as younger adults to recover quickly from trauma, yet they may have greater vulnerabilities, including their ability to survive without injury and their ability to address the current trauma without psychological interference from earlier stressful or traumatic events. Older people are naturally more likely to have had a history of trauma because they have lived longer, thus creating greater vulnerability to the effects of cumulative trauma.

Race, ethnicity, and culture

The potential for trauma exists in all major racial and ethnic groups in American society, yet few studies analyze the relationship of race and ethnicity to trauma exposure and/or traumatic stress reactions. Some studies show that certain racial and ethnic groups are at greater risk for specific traumas. For example, African Americans experienced higher rates of overall violence, aggravated assault, and robbery than Whites but were as likely to be victims of rape or sexual assault (Catalano, 2004). Literature reflects that diverse ethnic, racial, and cultural groups are more likely to experience adverse effects from various traumas and to meet criteria for posttraumatic stress (Bell, 2011).

Sexual orientation and gender identity

Lesbian, gay, bisexual, and transgender individuals are likely to experience various forms of trauma associated with their sexual orientation, including harsh consequences from families and faith traditions, higher risk of assault from casual sexual partners, hate crimes, lack of legal protection, and laws of exclusion (Brown, 2008). Gay and bisexual men as well as transgender people are more likely to experience victimization than lesbians and bisexual women. Dillon (2001) reported a trauma exposure rate of 94 percent among lesbian, gay,

Resilience: Cultural, Racial, and Ethnic Characteristics

The following list highlights characteristics that often nurture resilience among individuals from diverse cultural, racial, and ethnic groups:

- Strong kinship bonds
- Respect for elders and the importance of extended family
- Spirituality and religious practices (e.g., shrine visitations or the use of traditional healers)
- Value in friendships and warm personal relationships
- Expression of humor and creativity
- Instilling a sense of history, heritage, and historical traditions
- Community orientation, activities, and socialization
- Strong work ethic
- Philosophies and beliefs about life, suffering, and perseverance

"Fortune owes its existence to misfortune, and misfortune is hidden in fortune."

–Lao-Tzu teaching, Taoism (Wong & Wong, 2006)

and bisexual individuals; more than 40 percent of respondents experienced harassment due to their sexual orientation. Heterosexual orientation is also a risk for women, as women in relationships with men are at a greater risk of being physically and sexually abused.

People who are homeless

Homelessness is typically defined as the lack of an adequate or regular dwelling, or having a nighttime dwelling that is a publicly or privately supervised institution or a place not intended for use as a dwelling (e.g., a bus station). The U.S. Department of Housing and Urban Development (HUD) estimates that between 660,000 and 730,000 individuals were homeless on any given night in 2005 (HUD, 2007). Two thirds were unaccompanied persons; the other third were people in families. Adults who are homeless and unmarried are more likely to be male than female. About 40 percent of men who are homeless are veterans (National Coalition for the Homeless, 2002); this percentage has grown, including the number of veterans with dependent children (Kuhn & Nakashima, 2011).

Rates of trauma symptoms are high among people who are homeless (76 to 100 percent of women and 67 percent of men; Christensen et al., 2005; Jainchill, Hawke, & Yagelka, 2000), and the diagnosis of PTSD is among the most prevalent non-substance use Axis I disorders (Lester et al., 2007; McNamara, Schumacher, Milby, Wallace, & Usdan, 2001). People who are homeless report high levels of trauma (especially physical and sexual abuse in childhood or as adults) preceding their homeless status; assault, rape, and other traumas frequently happen while they are homeless. Research suggests that many women are homeless because they are fleeing domestic violence (National Coalition for the Homeless, 2002). Other studies suggest that women who are homeless are more likely to have histories of childhood physical and sexual abuse and to have experienced sexual assault as adults. A history of physical and/or sexual abuse is even more common among women who are homeless and have a serious mental illness.

Youth who are homeless, especially those who live without a parent, are likely to have experienced physical and/or sexual abuse. Between 21 and 42 percent of youth runaways report having been sexually abused before leaving their homes; for young women, rates range from 32 to 63 percent (Administration on Children, Youth and Families, 2002). Additionally, data reflect elevated rates of substance abuse for youth who are homeless and have histories of abuse.

More than half of people who are homeless have a lifetime prevalence of mental illness and substance use disorders. Those who are homeless have higher rates of substance abuse (84 percent of men and 58 percent of women), and substance use disorders, including alcohol and drug abuse/dependence, increase with longer lengths of homelessness (North, Eyrich, Pollio, & Spitznagel, 2004).

For more information on providing trauma-informed behavioral health services to clients who are homeless, and for further discussion of the incidence of trauma in this population, see TIP 55-R, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2013b).

3 Understanding the Impact of Trauma

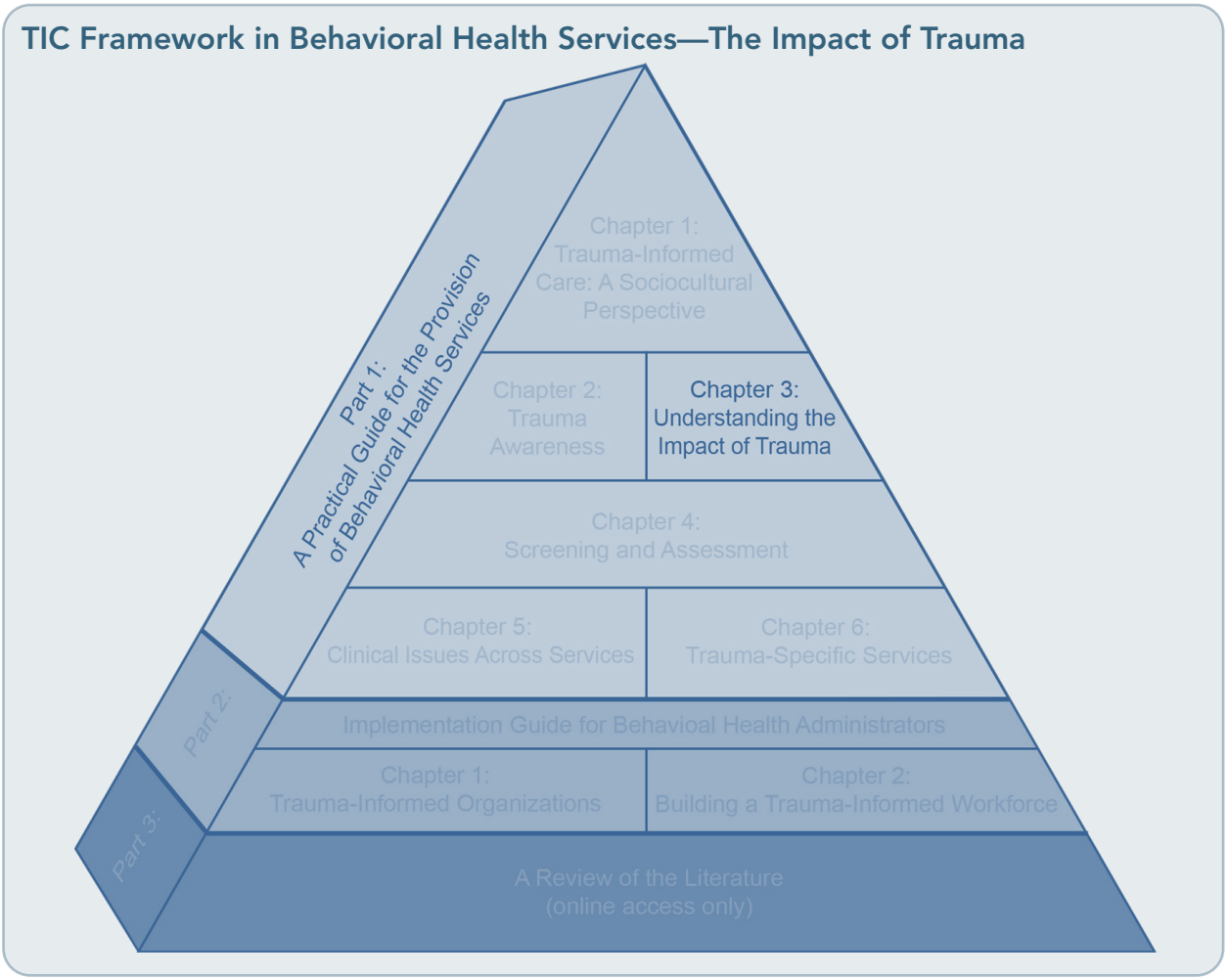
IN THIS CHAPTER

- Sequence of Trauma Reactions
- Common Experiences and Responses to Trauma
- Subthreshold Trauma Related Symptoms
- Specific Trauma Related Psychological Disorders
- Other Trauma Related and Co Occurring Disorders

Trauma-informed care (TIC) involves a broad understanding of traumatic stress reactions and common responses to trauma. Providers need to understand how trauma can affect treatment presentation, engagement, and the outcome of behavioral health services. This chapter examines common experiences survivors may encounter immediately following or long after a traumatic experience.

Trauma, including one-time, multiple, or long-lasting repetitive events, affects everyone differently. Some individuals may clearly display criteria associated with posttraumatic stress disorder (PTSD), but many more individuals will exhibit resilient responses or brief subclinical symptoms or consequences that fall outside of diagnostic criteria. The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors.

This chapter begins with an overview of common responses, emphasizing that traumatic stress reactions are normal reactions to abnormal circumstances. It highlights common short- and long-term responses to traumatic experiences in the context of individuals who may seek behavioral health services. This chapter discusses psychological symptoms not represented in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), and responses associated with trauma that either fall below the threshold of mental disorders or reflect resilience. It also addresses common disorders associated with traumatic stress. This chapter explores the role of culture in defining mental illness, particularly PTSD, and ends by addressing co-occurring mental and substance-related disorders.



Sequence of Trauma Reactions

Survivors' immediate reactions in the aftermath of trauma are quite complicated and are affected by their own experiences, the accessibility of natural supports and healers, their coping and life skills and those of immediate family, and the responses of the larger community in which they live. Although reactions range in severity, even the most acute responses are natural responses to manage trauma—they are not a sign of psychopathology. Coping styles vary from action oriented to reflective and from emotionally expressive to reticent. Clinically, a response style is less important than the degree to which coping efforts successfully allow one to continue necessary activities, regulate emotions, sustain self-esteem, and maintain and enjoy interpersonal contacts. Indeed, a past error in traumatic stress psychology, particularly regarding group or mass traumas, was the assumption that all survivors need to express emotions associated with trauma and talk about the trauma; more recent research indicates that survivors who choose not to process their trauma are just as psychologically healthy as

Foreshortened future: Trauma can affect one's beliefs about the future via loss of hope, limited expectations about life, fear that life will end abruptly or early, or anticipation that normal life events won't occur (e.g., access to education, ability to have a significant and committed relationship, good opportunities for work).

those who do. The most recent psychological debriefing approaches emphasize respecting the individual's style of coping and not valuing one type over another.

Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect. Most responses are normal in that they affect most survivors and are socially acceptable, psychologically effective, and self-limited. Indicators of more severe responses include continuous distress without periods of relative calm or rest, severe dissociation symptoms, and intense intrusive recollections that continue despite a return to safety. Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely. Exhibit 1.3-1 outlines some common reactions.

Common Experiences and Responses to Trauma

A variety of reactions are often reported and/or observed after trauma. Most survivors exhibit immediate reactions, yet these typically resolve without severe long-term consequences. This is because most trauma survivors are highly resilient and develop appropriate coping strategies, including the use of social supports, to deal with the aftermath and effects of trauma. Most recover with time, show minimal distress, and function effectively across major life areas and developmental stages. Even so, clients who show little impairment may still have subclinical symptoms or symptoms that do not fit diagnostic criteria for acute stress disorder (ASD) or PTSD. Only a small percentage of people with a history of trauma show impairment and symptoms that meet criteria for trauma-related stress disorders, including mood and anxiety disorders.

The following sections focus on some common reactions across domains (emotional, physical, cognitive, behavioral, social, and developmental) associated with singular, multiple, and enduring traumatic events. These reactions are often normal responses to trauma but can still be distressing to experience. Such responses are not signs of mental illness, nor do they indicate a mental disorder. Traumatic stress-related disorders comprise a specific constellation of symptoms and criteria.

Emotional

Emotional reactions to trauma can vary greatly and are significantly influenced by the individual's sociocultural history. Beyond the initial emotional reactions during the event, those most likely to surface include anger, fear, sadness, and shame. However, individuals may encounter difficulty in identifying any of these feelings for various reasons. They might lack experience with or prior exposure to emotional expression in their family or community. They may associate strong feelings with the past trauma, thus believing that emotional expression is too dangerous or will lead to feeling out of control (e.g., a sense of "losing it" or going crazy). Still others might deny that they have any feelings associated with their traumatic experiences and define their reactions as numbness or lack of emotions.

Emotional dysregulation

Some trauma survivors have difficulty regulating emotions such as anger, anxiety, sadness, and shame—this is more so when the trauma occurred at a young age (van der Kolk, Roth, Pelcovitz, & Mandel, 1993). In individuals who are older and functioning well

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma

Immediate Emotional Reactions	Delayed Emotional Reactions
Numbness and detachment Anxiety or severe fear Guilt (including survivor guilt) Exhilaration as a result of surviving Anger Sadness Helplessness Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself) Disorientation Feeling out of control Denial Constriction of feelings Feeling overwhelmed	Irritability and/or hostility Depression Mood swings, instability Anxiety (e.g., phobia, generalized anxiety) Fear of trauma recurrence Grief reactions Shame Feelings of fragility and/or vulnerability Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
Immediate Physical Reactions	**Delayed Physical Reactions**
Nausea and/or gastrointestinal distress Sweating or shivering Faintness Muscle tremors or uncontrollable shaking Elevated heartbeat, respiration, and blood pressure Extreme fatigue or exhaustion Greater startle responses Depersonalization	Sleep disturbances, nightmares Somatization (e.g., increased focus on and worry about body aches and pains) Appetite and digestive changes Lowered resistance to colds and infection Persistent fatigue Elevated cortisol levels Hyperarousal Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
Immediate Cognitive Reactions	**Delayed Cognitive Reactions**
Difficulty concentrating Rumination or racing thoughts (e.g., replaying the traumatic event over and over again) Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes) Memory problems (e.g., not being able to recall important aspects of the trauma) Strong identification with victims	Intrusive memories or flashbacks Reactivation of previous traumatic events Self-blame Preoccupation with event Difficulty making decisions Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma Belief that feelings or memories are dangerous Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day) Suicidal thinking
Immediate Behavioral Reactions	**Delayed Behavioral Reactions**
Startled reaction Restlessness Sleep and appetite disturbances Difficulty expressing oneself Argumentative behavior Increased use of alcohol, drugs, and tobacco Withdrawal and apathy Avoidant behaviors	Avoidance of event reminders Social relationship disturbances Decreased activity level Engagement in high-risk behaviors Increased use of alcohol and drugs Withdrawal

(Continued on the next page.)

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma (continued)

Immediate Existential Reactions	Delayed Existential Reactions
Intense use of prayer	Questioning (e.g., "Why me?")
Restoration of faith in the goodness of others (e.g., receiving help from others)	Increased cynicism, disillusionment
Loss of self-efficacy	Increased self-confidence (e.g., "If I can survive this, I can survive anything")
Despair about humanity, particularly if the event was intentional	Loss of purpose
Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)	Renewed faith
	Hopelessness
	Reestablishing priorities
	Redefining meaning and importance of life
	Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)

Sources: Briere & Scott, 2006b; Foa, Stein, & McFarlane, 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011.

prior to the trauma, such emotional dysregulation is usually short lived and represents an immediate reaction to the trauma, rather than an ongoing pattern. Self-medication—namely, substance abuse—is one of the methods that traumatized people use in an attempt to regain emotional control, although ultimately it causes even further emotional dysregulation (e.g., substance-induced changes in affect during and after use). Other efforts toward emotional regulation can include engagement in high-risk or self-injurious behaviors, disordered eating, compulsive behaviors such as gambling or overworking, and repression or denial of emotions; however, not all behaviors associated with self-regulation are considered negative. In fact, some individuals find creative, healthy, and industrious ways to manage strong affect generated by trauma, such as through renewed commitment to physical activity or by creating an organization to support survivors of a particular trauma.

Traumatic stress tends to evoke two emotional extremes: feeling either too much (overwhelmed) or too little (numb) emotion. Treatment can help the client find the optimal level of emotion and assist him or her with appropriately experiencing and regulating difficult emotions. In treatment, the goal is to help clients learn to regulate their emotions without the use of substances or other unsafe behavior. This will likely require learning new coping skills and how to tolerate distressing emotions; some clients may benefit from mindfulness practices, cognitive restructuring, and trauma-specific desensitization approaches, such as exposure therapy and eye movement desensitization and reprocessing (EMDR; refer to Part 1, Chapter 6, for more information on trauma-specific therapies).

Numbing

Numbing is a biological process whereby emotions are detached from thoughts, behaviors, and memories. In the following case illustration, Sadhanna's numbing is evidenced by her limited range of emotions associated with interpersonal interactions and her inability to associate any emotion with her history of abuse. She also possesses a belief in a foreshortened future. A prospective longitudinal study (Malta, Levitt, Martin, Davis, & Cloitre, 2009) that followed the development of PTSD in disaster workers highlighted the importance of understanding and appreciating numbing as a traumatic stress reaction. Because numbing

Case Illustration: Sadhanna

Sadhanna is a 22-year-old woman mandated to outpatient mental health and substance abuse treatment as the alternative to incarceration. She was arrested and charged with assault after arguing and fighting with another woman on the street. At intake, Sadhanna reported a 7-year history of alcohol abuse and one depressive episode at age 18. She was surprised that she got into a fight but admitted that she was drinking at the time of the incident. She also reported severe physical abuse at the hands of her mother's boyfriend between ages 4 and 15. Of particular note to the intake worker was Sadhanna's matter-of-fact way of presenting the abuse history. During the interview, she clearly indicated that she did not want to attend group therapy and hear other people talk about their feelings, saying, "I learned long ago not to wear emotions on my sleeve."

Sadhanna reported dropping out of 10th grade, saying she never liked school. She didn't expect much from life. In Sadhanna's first weeks in treatment, she reported feeling disconnected from other group members and questioned the purpose of the group. When asked about her own history, she denied that she had any difficulties and did not understand why she was mandated to treatment. She further denied having feelings about her abuse and did not believe that it affected her life now. Group members often commented that she did not show much empathy and maintained a flat affect, even when group discussions were emotionally charged.

symptoms hide what is going on inside emotionally, there can be a tendency for family members, counselors, and other behavioral health staff to assess levels of traumatic stress symptoms and the impact of trauma as less severe than they actually are.

Physical

Diagnostic criteria for PTSD place considerable emphasis on psychological symptoms, but some people who have experienced traumatic stress may present initially with physical symptoms. Thus, primary care may be the first and only door through which these individuals seek assistance for trauma-related symptoms. Moreover, there is a significant connection between trauma, including adverse childhood experiences (ACEs), and chronic health conditions. Common physical disorders and symptoms include somatic complaints; sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders.

Somatization

Somatization indicates a focus on bodily symptoms or dysfunctions to express emotional distress. Somatic symptoms are more likely to occur with individuals who have traumatic stress reactions, including PTSD. People from certain ethnic and cultural backgrounds may initially or solely present emotional distress via physical ailments or concerns. Many individuals who present with somatization are likely unaware of the connection between their emotions and the physical symptoms that they're experiencing. At times, clients may remain resistant to exploring emotional content and remain focused on bodily complaints as a means of avoidance. Some clients may insist that their primary problems are physical even when medical evaluations and tests fail to confirm ailments. In these situations, somatization may be a sign of a mental illness. However, various cultures approach emotional distress through the physical realm or view emotional and physical symptoms and well-being as one. It is important not to assume that clients with physical complaints are using somatization as a means to express emotional pain; they may have specific conditions or disorders that require medical attention. Foremost, counselors need to refer for medical evaluation.

Advice to Counselors: Using Information About Biology and Trauma

- Educate your clients:
  - Frame reexperiencing the event(s), hyperarousal, sleep disturbances, and other physical symptoms as physiological reactions to extreme stress.
  - Communicate that treatment and other wellness activities can improve both psychological and physiological symptoms (e.g., therapy, meditation, exercise, yoga). You may need to refer certain clients to a psychiatrist who can evaluate them and, if warranted, prescribe psychotropic medication to address severe symptoms.
  - Discuss traumatic stress symptoms and their physiological components.
  - Explain links between traumatic stress symptoms and substance use disorders, if appropriate.
  - Normalize trauma symptoms. For example, explain to clients that their symptoms are not a sign of weakness, a character flaw, being damaged, or going crazy.
- Support your clients and provide a message of hope—that they are not alone, they are not at fault, and recovery is possible and anticipated.

Biology of trauma

Trauma biology is an area of burgeoning research, with the promise of more complex and explanatory findings yet to come. Although a thorough presentation on the biological aspects of trauma is beyond the scope of this publication, what is currently known is that exposure to trauma leads to a cascade of biological changes and stress responses. These biological alterations are highly associated with PTSD, other mental illnesses, and substance use disorders. These include:

- Changes in limbic system functioning.
- Hypothalamic–pituitary–adrenal axis activity changes with variable cortisol levels.
- Neurotransmitter-related dysregulation of arousal and endogenous opioid systems.

As a clear example, early ACEs such as abuse, neglect, and other traumas affect brain development and increase a person's vulnerability to encountering interpersonal violence as an adult and to developing chronic diseases and other physical illnesses, mental illnesses, substance-related disorders, and impairment in other life areas (Centers for Disease Control and Prevention, 2012).

Hyperarousal and sleep disturbances

A common symptom that arises from traumatic experiences is hyperarousal (also called hypervigilance). Hyperarousal is the body's way of remaining prepared. It is characterized by sleep disturbances, muscle tension, and a lower threshold for startle responses and can persist years after trauma occurs. It is also one of the primary diagnostic criteria for PTSD.

Hyperarousal is a consequence of biological changes initiated by trauma. Although it

Case Illustration: Kimi

Kimi is a 35-year-old Native American woman who was group raped at the age of 16 on her walk home from a suburban high school. She recounts how her whole life changed on that day. "I never felt safe being alone after the rape. I used to enjoy walking everywhere. Afterward, I couldn't tolerate the fear that would arise when I walked in the neighborhood. It didn't matter whether I was alone or with friends—every sound that I heard would throw me into a state of fear. I felt like the same thing was going to happen again. It's gotten better with time, but I often feel as if I'm sitting on a tree limb waiting for it to break. I have a hard time relaxing. I can easily get startled if a leaf blows across my path or if my children scream while playing in the yard. The best way I can describe how I experience life is by comparing it to watching a scary, suspenseful movie—anxiously waiting for something to happen, palms sweating, heart pounding, on the edge of your chair."

serves as a means of self-protection after trauma, it can be detrimental. Hyperarousal can interfere with an individual's ability to take the necessary time to assess and appropriately respond to specific input, such as loud noises or sudden movements. Sometimes, hyperarousal can produce overreactions to situations perceived as dangerous when, in fact, the circumstances are safe.

Along with hyperarousal, sleep disturbances are very common in individuals who have experienced trauma. They can come in the form of early awakening, restless sleep, difficulty falling asleep, and nightmares. Sleep disturbances are most persistent among individuals who have trauma-related stress; the disturbances sometimes remain resistant to intervention long after other traumatic stress symptoms have been successfully treated. Numerous strategies are available beyond medication, including good sleep hygiene practices, cognitive rehearsals of nightmares, relaxation strategies, and nutrition.

Cognitive

Traumatic experiences can affect and alter cognitions. From the outset, trauma challenges the just-world or core life assumptions that

Cognitions and Trauma

The following examples reflect some of the types of cognitive or thought-process changes that can occur in response to traumatic stress.

Cognitive errors: Misinterpreting a current situation as dangerous because it resembles, even remotely, a previous trauma (e.g., a client overreacting to an overturned canoe in 8 inches of water, as if she and her paddle companion would drown, due to her previous experience of nearly drowning in a rip current 5 years earlier).

Excessive or inappropriate guilt: Attempting to make sense cognitively and gain control over a traumatic experience by assuming responsibility or possessing survivor's guilt, because others who experienced the same trauma did not survive.

Idealization: Demonstrating inaccurate rationalizations, idealizations, or justifications of the perpetrator's behavior, particularly if the perpetrator is or was a caregiver. Other similar reactions mirror idealization; traumatic bonding is an emotional attachment that develops (in part to secure survival) between perpetrators who engage in interpersonal trauma and their victims, and Stockholm syndrome involves compassion and loyalty toward hostage takers (de Fabrique, Van Hasselt, Vecchi, & Romano, 2007).

Trauma-induced hallucinations or delusions: Experiencing hallucinations and delusions that, although they are biological in origin, contain cognitions that are congruent with trauma content (e.g., a woman believes that a person stepping onto her bus is her father, who had sexually abused her repeatedly as child, because he wore shoes similar to those her father once wore).

Intrusive thoughts and memories: Experiencing, without warning or desire, thoughts and memories associated with the trauma. These intrusive thoughts and memories can easily trigger strong emotional and behavioral reactions, as if the trauma was recurring in the present. The intrusive thoughts and memories can come rapidly, referred to as flooding, and can be disruptive at the time of their occurrence. If an individual experiences a trigger, he or she may have an increase in intrusive thoughts and memories for a while. For instance, individuals who inadvertently are retraumatized due to program or clinical practices may have a surge of intrusive thoughts of past trauma, thus making it difficult for them to discern what is happening now versus what happened then. Whenever counseling focuses on trauma, it is likely that the client will experience some intrusive thoughts and memories. It is important to develop coping strategies before, as much as possible, and during the delivery of trauma-informed and trauma-specific treatment.

help individuals navigate daily life (Janoff-Bulman, 1992). For example, it would be difficult to leave the house in the morning if you believed that the world was not safe, that all people are dangerous, or that life holds no promise. Belief that one's efforts and intentions can protect oneself from bad things makes it less likely for an individual to perceive personal vulnerability. However, traumatic events—particularly if they are unexpected—can challenge such beliefs.

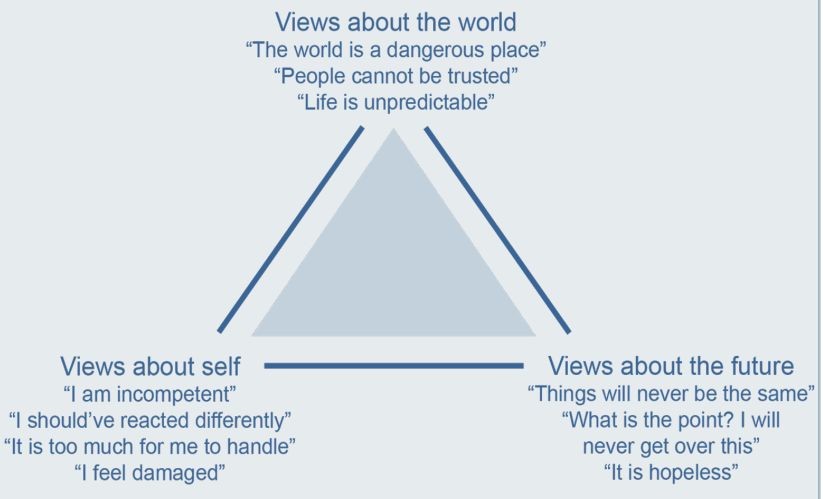
Let's say you always considered your driving time as "your time"—and your car as a safe place to spend that time. Then someone hits you from behind at a highway entrance. Almost immediately, the accident affects how you perceive the world, and from that moment onward, for months following the crash, you feel unsafe in any car. You become hypervigilant about other drivers and perceive that other cars are drifting into your lane or failing to stop at a safe distance behind you. For a time, your perception of safety is eroded, often leading to compensating behaviors (e.g., excessive glancing into the rearview mirror to see whether the vehicles behind you are stopping) until the belief is restored or reworked. Some individuals never return to their previous belief systems after a trauma, nor do they find a way to rework them—thus leading to a worldview that life is unsafe. Still, many other individuals are able to return to organizing core beliefs that support their perception of safety.

Many factors contribute to cognitive patterns prior to, during, and after a trauma. Adopting Beck and colleagues' cognitive triad model (1979), trauma can alter three main cognitive patterns: thoughts about self, the world (others/environment), and the future. To clarify, trauma can lead individuals to see themselves as incompetent or damaged, to see others and the world as unsafe and unpredictable, and to see the future as hopeless—believing that personal suffering will continue, or negative outcomes will preside for the foreseeable future (see Exhibit 1.3-2). Subsequently, this set of cognitions can greatly influence clients' belief in their ability to use internal resources and external support effectively. From a cognitive–behavioral perspective, these cognitions have a bidirectional relationship in sustaining or contributing to the development of depressive and anxiety symptoms after trauma. However, it is possible for cognitive patterns to help protect against debilitating psychological symptoms as well. Many factors contribute to cognitive patterns prior to, during, and after a trauma.

Feeling different

An integral part of experiencing trauma is feeling different from others, whether or not the trauma was an individual or group experience. Traumatic experiences typically feel surreal and challenge the necessity and value of mundane activities of daily life. Survivors

Exhibit 1.3-2: Cognitive Triad of Traumatic Stress



often believe that others will not fully understand their experiences, and they may think that sharing their feelings, thoughts, and reactions related to the trauma will fall short of expectations. However horrid the trauma may be, the *experience* of the trauma is typically profound.

The type of trauma can dictate how an individual feels different or believes that they are different from others. Traumas that generate shame will often lead survivors to feel more alienated from others—believing that they are "damaged goods." When individuals believe that their experiences are unique and incomprehensible, they are more likely to seek support, if they seek support at all, only with others who have experienced a similar trauma.

Triggers and flashbacks

Triggers

A trigger is a stimulus that sets off a memory of a trauma or a specific portion of a traumatic experience. Imagine you were trapped briefly in a car after an accident. Then, several years later, you were unable to unlatch a lock after using a restroom stall; you might have begun to feel a surge of panic reminiscent of the accident, even though there were other avenues of escape from the stall. Some triggers can be identified and anticipated easily, but many are subtle and inconspicuous, often surprising the individual or catching him or her off guard. In treatment, it is important to help clients identify potential triggers, draw a connection between strong emotional reactions and triggers, and develop coping strategies to manage those moments when a trigger occurs. A trigger is any sensory reminder of the traumatic event: a noise, smell, temperature, other physical sensation, or visual scene. Triggers can generalize to any characteristic, no matter how remote, that resembles or represents a previous trauma, such as revisiting the location where the trauma occurred, being alone, having your children reach the same age that you were when you experienced the trauma, seeing the same breed of dog that bit you, or hearing loud voices. Triggers are often associated with the time of day, season, holiday, or anniversary of the event.

Flashbacks

A flashback is reexperiencing a previous traumatic experience as if it were actually happening in that moment. It includes reactions that often resemble the client's reactions during the trauma. Flashback experiences are very brief and typically last only a few seconds, but the emotional aftereffects linger for hours or longer. Flashbacks are commonly initiated by a trigger, but not necessarily. Sometimes, they occur out of the blue. Other times, specific physical states increase a person's vulnerability to reexperiencing a trauma, (e.g., fatigue, high

Advice to Counselors: Helping Clients Manage Flashbacks and Triggers

If a client is triggered in a session or during some aspect of treatment, help the client focus on what is happening in the here and now; that is, use grounding techniques. Behavioral health service providers should be prepared to help the client get regrounded so that they can distinguish between what is happening now versus what had happened in the past (see Covington, 2008, and Najavits, 2002b, 2007b, for more grounding techniques). Offer education about the experience of triggers and flashbacks, and then normalize these events as common traumatic stress reactions. Afterward, some clients need to discuss the experience and understand why the flashback or trigger occurred. It often helps for the client to draw a connection between the trigger and the traumatic event(s). This can be a preventive strategy whereby the client can anticipate that a given situation places him or her at higher risk for retraumatization and requires use of coping strategies, including seeking support.

Source: Green Cross Academy of Traumatology, 2010.

stress levels). Flashbacks can feel like a brief movie scene that intrudes on the client. For example, hearing a car backfire on a hot, sunny day may be enough to cause a veteran to respond as if he or she were back on military patrol. Other ways people reexperience trauma, besides flashbacks, are via nightmares and intrusive thoughts of the trauma.

Dissociation, depersonalization, and derealization

Dissociation is a mental process that severs connections among a person's thoughts, memories, feelings, actions, and/or sense of identity. Most of us have experienced dissociation—losing the ability to recall or track a particular action (e.g., arriving at work but not remembering the last minutes of the drive). Dissociation happens because the person is engaged in an automatic activity and is not paying attention to his or her immediate environment. Dissociation can also occur during severe stress or trauma as a protective element whereby the individual incurs distortion of time, space, or identity. This is a common symptom in traumatic stress reactions.

Dissociation helps distance the experience from the individual. People who have experienced severe or developmental trauma may have learned to separate themselves from distress to survive. At times, dissociation can be very pervasive and symptomatic of a mental disorder, such as dissociative identity disorder (DID; formerly known as multiple personality disorder). According to the DSM-5, "dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (APA, 2013a, p. 291). Dissociative disorder diagnoses are closely associated with histories of severe childhood trauma or pervasive, human-caused, intentional trauma, such as that experienced by concentration camp survivors or victims of ongoing political imprisonment, torture, or long-term isolation. A mental health professional, preferably with significant training in working with dissociative disorders and with trauma, should be consulted when a dissociative disorder diagnosis is suspected.

Potential Signs of Dissociation

- Fixed or "glazed" eyes
- Sudden flattening of affect
- Long periods of silence
- Monotonous voice
- Stereotyped movements
- Responses not congruent with the present context or situation
- Excessive intellectualization

(Briere, 1996a)

The characteristics of DID can be commonly accepted experiences in other cultures, rather than being viewed as symptomatic of a traumatic experience. For example, in non-Western cultures, a sense of alternate beings within oneself may be interpreted as being inhabited by spirits or ancestors (Kirmayer, 1996). Other experiences associated with dissociation include depersonalization—psychologically "leaving one's body," as if watching oneself from a distance as an observer or through derealization, leading to a sense that what is taking place is unfamiliar or is not real.

If clients exhibit signs of dissociation, behavioral health service providers can use grounding techniques to help them reduce this defense strategy. One major long-term consequence of dissociation is the difficulty it causes in connecting strong emotional or physical reactions with an event. Often, individuals may believe that they are going crazy because they are not in touch with the nature of their reactions. By educating clients on the resilient qualities of dissociation while also emphasizing that it prevents them from addressing or

validating the trauma, individuals can begin to understand the role of dissociation. All in all, it is important when working with trauma survivors that the intensity level is not so great that it triggers a dissociative reaction and prevents the person from engaging in the process.

Behavioral

Traumatic stress reactions vary widely; often, people engage in behaviors to manage the aftereffects, the intensity of emotions, or the distressing aspects of the traumatic experience. Some people reduce tension or stress through avoidant, self-medicating (e.g., alcohol abuse), compulsive (e.g., overeating), impulsive (e.g., high-risk behaviors), and/or self-injurious behaviors. Others may try to gain control over their experiences by being aggressive or subconsciously reenacting aspects of the trauma.

Behavioral reactions are also the consequences of, or learned from, traumatic experiences. For example, some people act like they can't control their current environment, thus failing to take action or make decisions long after the trauma (learned helplessness). Other associate elements of the trauma with current activities, such as by reacting to an intimate moment in a significant relationship as dangerous or unsafe years after a date rape. The following sections discuss behavioral consequences of trauma and traumatic stress reactions.

Reenactments

A hallmark symptom of trauma is reexperiencing the trauma in various ways. Reexperiencing can occur through reenactments (literally, to "redo"), by which trauma survivors repetitively relive and recreate a past trauma in their present lives. This is very apparent in children, who play by mimicking what occurred during the trauma, such as by pretending to crash a toy airplane into a toy building after seeing televised images of the terrorist attacks on the World Trade Center on September 11, 2001. Attempts to understand reenactments are very complicated, as reenactments occur for a variety of reasons. Sometimes, individuals reenact past traumas to master them. Examples of reenactments include a variety of behaviors: self-injurious behaviors, hypersexuality, walking alone in unsafe areas or other high-risk behaviors, driving recklessly, or involvement in repetitive destructive relationships (e.g., repeatedly getting into romantic relationships with people who are abusive or violent), to name a few.

Self-harm and self-destructive behaviors

Self-harm is any type of intentionally self-inflicted harm, regardless of the severity of injury or whether suicide is intended. Often, self-harm is an attempt to cope with emotional or physical distress that seems overwhelming or to cope with a profound sense of dissociation or being trapped, helpless, and "damaged" (Herman, 1997; Santa Mina & Gallop, 1998). Self-harm is associated with past childhood sexual abuse and other forms of trauma as well as substance abuse. Thus,

Resilient Responses to Trauma

Many people find healthy ways to cope with, respond to, and heal from trauma. Often, people automatically reevaluate their values and redefine what is important after a trauma. Such resilient responses include:

- Increased bonding with family and community.
- Redefined or increased sense of purpose and meaning.
- Increased commitment to a personal mission.
- Revised priorities.
- Increased charitable giving and volunteerism.

Case Illustration: Marco

Marco, a 30-year-old man, sought treatment at a local mental health center after a 2-year bout of anxiety symptoms. He was an active member of his church for 12 years, but although he sought help from his pastor about a year ago, he reports that he has had no contact with his pastor or his church since that time. Approximately 3 years ago, his wife took her own life. He describes her as his soulmate and has had a difficult time understanding her actions or how he could have prevented them.

In the initial intake, he mentioned that he was the first person to find his wife after the suicide and reported feelings of betrayal, hurt, anger, and devastation since her death. He claimed that everyone leaves him or dies. He also talked about his difficulty sleeping, having repetitive dreams of his wife, and avoiding relationships. In his first session with the counselor, he initially rejected the counselor before the counselor had an opportunity to begin reviewing and talking about the events and discomfort that led him to treatment.

In this scenario, Marco is likely reenacting his feelings of abandonment by attempting to reject others before he experiences another rejection or abandonment. In this situation, the counselor will need to recognize the reenactment, explore the behavior, and examine how reenactments appear in other situations in Marco's life.

addressing self-harm requires attention to the client's reasons for self-harm. More than likely, the client needs help recognizing and coping with emotional or physical distress in manageable amounts and ways.

Among the self-harm behaviors reported in the literature are cutting, burning skin by heat (e.g., cigarettes) or caustic liquids, punching hard enough to self-bruise, head banging, hair pulling, self-poisoning, inserting foreign objects into bodily orifices, excessive nail biting, excessive scratching, bone breaking, gnawing at flesh, interfering with wound healing, tying off body parts to stop breathing or blood flow, swallowing sharp objects, and suicide. Cutting and burning are among the most common forms of self-harm.

Self-harm tends to occur most in people who have experienced repeated and/or early trauma (e.g., childhood sexual abuse) rather than in those who have undergone a single adult trauma (e.g., a community-wide disaster or a serious car accident). There are strong associations between eating disorders, self-harm, and substance abuse (Claes &Vandereycken, 2007; for discussion, see Harned, Najavits, & Weiss, 2006). Self-mutilation is also associated with (and part of the diagnostic criteria for) a number of personality disorders, including borderline and histrionic, as well as DID, depression, and some forms of schizophrenia; these disorders can co-occur with traumatic stress reactions and disorders.

It is important to distinguish self-harm that is suicidal from self-harm that is not suicidal and to assess and manage both of these very serious dangers carefully. Most people who engage in self-harm are not doing so with the intent to kill themselves (Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003)—although self-harm can be life threatening and can escalate into suicidality if not managed therapeutically. Self-harm can be a way of getting attention or manipulating others, but most often it is not. Self-destructive behaviors such as substance abuse, restrictive or binge eating, reckless automobile driving, or high-risk impulsive behavior are different from self-harming behaviors but are also seen in clients with a history of trauma. Self-destructive behaviors differ from self-harming behaviors in that there may be no immediate negative impact of the behavior on the individual; they differ from suicidal behavior in that there is no intent to cause death in the short term.

Advice to Counselors: Working With Clients Who Are Self-Injurious

Counselors who are unqualified or uncomfortable working with clients who demonstrate self-harming, self-destructive, or suicidal or homicidal ideation, intent, or behavior should work with their agencies and supervisors to refer such clients to other counselors. They should consider seeking specialized supervision on how to manage such clients effectively and safely and how to manage their feelings about these issues. The following suggestions assume that the counselor has had sufficient training and experience to work with clients who are self-injurious. To respond appropriately to a client who engages in self-harm, counselors should:

- Screen the client for self-harm and suicide risk at the initial evaluation and throughout treatment.
- Learn the client's perspective on self-harm and how it "helps."
- Understand that self-harm is often a coping strategy to manage the intensity of emotional and/or physical distress.
- Teach the client coping skills that improve his or her management of emotions without self-harm.
- Help the client obtain the level of care needed to manage genuine risk of suicide or severe self-injury. This might include hospitalization, more intensive programming (e.g., intensive outpatient, partial hospitalization, residential treatment), or more frequent treatment sessions. The goal is to stabilize the client as quickly as possible, and then, if possible, begin to focus treatment on developing coping strategies to manage self-injurious and other harmful impulses.
- Consult with other team members, supervisors, and, if necessary, legal experts to determine whether one's efforts with and conceptualization of the self-harming client fit best practice guidelines. See, for example, Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT], 2005c). Document such consultations and the decisions made as a result of them thoroughly and frequently.
- Help the client identify how substance use affects self-harm. In some cases, it can increase the behavior (e.g., alcohol disinhibits the client, who is then more likely to self-harm). In other cases, it can decrease the behavior (e.g., heroin evokes relaxation and, thus, can lessen the urge to self-harm). In either case, continue to help the client understand how abstinence from substances is necessary so that he or she can learn more adaptive coping.
- Work collaboratively with the client to develop a plan to create a sense of safety. Individuals are affected by trauma in different ways; therefore, safety or a safe environment may mean something entirely different from one person to the next. Allow the client to define what safety means to him or her.

Counselors can also help the client prepare a safety card that the client can carry at all times. The card might include the counselor's contact information, a 24-hour crisis number to call in emergencies, contact information for supportive individuals who can be contacted when needed, and, if appropriate, telephone numbers for emergency medical services. The counselor can discuss with the client the types of signs or crises that might warrant using the numbers on the card. Additionally, the counselor might check with the client from time to time to confirm that the information on the card is current.

TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a), has examples of safety agreements specifically for suicidal clients and discusses their uses in more detail. There is no credible evidence that a safety agreement is effective in preventing a suicide attempt or death. Safety agreements for clients with suicidal thoughts and behaviors should only be used as an adjunct support accompanying professional screening, assessment, and treatment for people with suicidal thoughts and behaviors. Keep in mind that safety plans or agreements may be perceived by the trauma survivor as a means of controlling behavior, subsequently replicating or triggering previous traumatic experiences.

All professionals—and in some States, anyone—could have ethical and legal responsibilities to those clients who pose an imminent danger to themselves or others. Clinicians should be aware of the pertinent State laws where they practice and the relevant Federal and professional regulations.

However, as with self-harming behavior, self-destructive behavior needs to be recognized and addressed and may persist—or worsen—without intervention.

Consumption of substances

Substance use often is initiated or increased after trauma. Clients in early recovery—especially those who develop PTSD or have it reactivated—have a higher relapse risk if they experience a trauma. In the first 2 months after September 11, 2001, more than a quarter of New Yorker residents who smoked cigarettes, drank alcohol, or used marijuana (about 265,000 people) increased their consumption. The increases continued 6 months after the attacks (Vlahov, Galea, Ahern, Resnick, & Kilpatrick, 2004). A study by the Substance Abuse and Mental Health Services Administration (SAMHSA, Office of Applied Studies, 2002) used National Survey on Drug Use and Health data to compare the first three quarters of 2001 with the last quarter and reported an increase in the prevalence rate for alcohol use among people 18 or older in the New York metropolitan area during the fourth quarter.

Interviews with New York City residents who were current or former cocaine or heroin users indicated that many who had been clean for 6 months or less relapsed after September 11, 2001. Others, who lost their income and could no longer support their habit, enrolled in methadone programs (Weiss et al., 2002). After the Oklahoma City bombing in 1995, Oklahomans reported double the normal rate of alcohol use, smoking more cigarettes, and a higher incidence of initiating smoking months and even years after the bombing (Smith, Christiansen, Vincent, & Hann, 1999).

Self-medication

Khantzian's self-medication theory (1985) suggests that drugs of abuse are selected for their specific effects. However, no definitive pattern has yet emerged of the use of particular substances in relation to PTSD or trauma symptoms. Use of substances can vary based on a variety of factors, including which trauma symptoms are most prominent for an individual and the individual's access to particular substances. Unresolved traumas sometimes lurk behind the emotions that clients cannot allow themselves to experience. Substance use and abuse in trauma survivors can be a way to self-medicate and thereby avoid or displace difficult emotions associated with traumatic experiences. When the substances are withdrawn, the survivor may use other behaviors to self-soothe, self-medicate, or avoid emotions. As likely, emotions can appear after abstinence in the form of anxiety and depression.

Avoidance

Avoidance often coincides with anxiety and the promotion of anxiety symptoms. Individuals begin to avoid people, places, or situations to alleviate unpleasant emotions, memories, or circumstances. Initially, the avoidance works, but over time, anxiety increases and the perception that the situation is unbearable or dangerous increases as well, leading to a greater need to avoid. Avoidance can be adaptive, but it is also a behavioral pattern that reinforces perceived danger without testing its validity, and it typically leads to greater problems across major life areas (e.g., avoiding emotionally oriented conversations in an intimate relationship). For many individuals who have traumatic stress reactions, avoidance is commonplace. A person may drive 5 miles longer to avoid the road where he or she had an accident. Another individual may avoid crowded places in fear of an assault or to circumvent strong emotional memories about an earlier assault that took place in a crowded area. Avoidance can come in many forms. When people can't tolerate strong affects associated with traumatic memories, they avoid, project,

deny, or distort their trauma-related emotional and cognitive experiences. A key ingredient in trauma recovery is learning to manage triggers, memories, and emotions without avoidance—in essence, becoming desensitized to traumatic memories and associated symptoms.

Social/Interpersonal

A key ingredient in the early stage of TIC is to establish, confirm, or reestablish a support system, including culturally appropriate activities, as soon as possible. Social supports and relationships can be protective factors against traumatic stress. However, trauma typically affects relationships significantly, regardless of whether the trauma is interpersonal or is of some other type. Relationships require emotional exchanges, which means that others who have close relationships or friendships with the individual who survived the trauma(s) are often affected as well—either through secondary traumatization or by directly experiencing the survivor's traumatic stress reactions. In natural disasters, social and community supports can be abruptly eroded and difficult to rebuild after the initial disaster relief efforts have waned.

Survivors may readily rely on family members, friends, or other social supports—or they may avoid support, either because they believe that no one will be understanding or trustworthy or because they perceive their own needs as a burden to others. Survivors who have strong emotional or physical reactions, including outbursts during nightmares, may pull away further in fear of being unable to predict their own reactions or to protect their own safety and that of others. Often, trauma survivors feel ashamed of their stress reactions, which further hampers their ability to use their support systems and resources adequately.

Many survivors of childhood abuse and interpersonal violence have experienced a significant sense of betrayal. They have often encountered trauma at the hands of trusted caregivers and family members or through significant relationships. This history of betrayal can disrupt forming or relying on supportive relationships in recovery, such as peer supports and counseling. Although this fear of trusting others is protective, it can lead to difficulty in connecting with others and greater vigilance in observing the behaviors of others, including behavioral health service providers. It is exceptionally difficult to override the feeling that someone is going to hurt you, take advantage of you, or, minimally, disappoint you. Early betrayal can affect one's ability to develop attachments, yet the formation of supportive relationships is an important antidote in the recovery from traumatic stress.

Developmental

Each age group is vulnerable in unique ways to the stresses of a disaster, with children and the elderly at greatest risk. Young children may display generalized fear, nightmares, heightened arousal and confusion, and physical symptoms, (e.g., stomachaches, headaches). School-age children may exhibit symptoms such as aggressive behavior and anger, regression to behavior seen at younger ages, repetitious traumatic play, loss of ability to concentrate, and worse school performance. Adolescents may display depression and social withdrawal, rebellion, increased risky activities such as sexual acting out, wish for revenge and action-oriented responses to trauma, and sleep and eating disturbances (Hamblen, 2001). Adults may display sleep problems, increased agitation, hypervigilance, isolation or withdrawal, and increased use of alcohol or drugs. Older adults may exhibit increased withdrawal and isolation, reluctance to leave home, worsening of chronic illnesses, confusion, depression, and fear (DeWolfe & Nordboe, 2000b).

Neurobiological Development: Consequences of Early Childhood Trauma

Findings in developmental psychobiology suggest that the consequences of early maltreatment produce enduring negative effects on brain development (DeBellis, 2002; Liu, Diorio, Day, Francis, & Meaney, 2000; Teicher, 2002). Research suggests that the first stage in a cascade of events produced by early trauma and/or maltreatment involves the disruption of chemicals that function as neurotransmitters (e.g., cortisol, norepinephrine, dopamine), causing escalation of the stress response (Heim, Mletzko, Purselle, Musselman, & Nemeroff, 2008; Heim, Newport, Mletzko, Miller, & Nemeroff, 2008; Teicher, 2002). These chemical responses can then negatively affect critical neural growth during specific sensitive periods of childhood development and can even lead to cell death.

Adverse brain development can also result from elevated levels of cortisol and catecholamines by contributing to maturational failures in other brain regions, such as the prefrontal cortex (Meaney, Brake, & Gratton, 2002). Heim, Mletzko et al. (2008) found that the neuropeptide oxytocin—important for social affiliation and support, attachment, trust, and management of stress and anxiety—was markedly decreased in the cerebrospinal fluid of women who had been exposed to childhood maltreatment, particularly those who had experienced emotional abuse. The more childhood traumas a person had experienced, and the longer their duration, the lower that person's current level of oxytocin was likely to be and the higher her rating of current anxiety was likely to be.

Using data from the Adverse Childhood Experiences Study, an analysis by Anda, Felitti, Brown et al. (2006) confirmed that the risk of negative outcomes in affective, somatic, substance abuse, memory, sexual, and aggression-related domains increased as scores on a measure of eight ACEs increased. The researchers concluded that the association of study scores with these outcomes can serve as a theoretical parallel for the effects of cumulative exposure to stress on the developing brain and for the resulting impairment seen in multiple brain structures and functions.

The National Child Traumatic Stress Network (http://www.nctsn.org) offers information about childhood abuse, stress, and physiological responses of children who are traumatized. Materials are available for counselors, educators, parents, and caregivers. There are special sections on the needs of children in military families and on the impact of natural disasters on children's mental health.

Subthreshold Trauma-Related Symptoms

Many trauma survivors experience symptoms that, although they do not meet the diagnostic criteria for ASD or PTSD, nonetheless limit their ability to function normally (e.g., regulate emotional states, maintain steady and rewarding social and family relationships, function competently at a job, maintain a steady pattern of abstinence in recovery). These symptoms can be transient, only arising in a specific context; intermittent, appearing for several weeks or months and then receding; or a part of the individual's regular pattern of functioning (but not to the level of DSM-5 diagnostic criteria). Often, these patterns are termed "subthreshold" trauma symptoms. Like PTSD, the symptoms can be misdiagnosed as depression, anxiety, or another mental illness. Likewise, clients who have experienced trauma may link some of their symptoms to their trauma and diagnose themselves as having PTSD, even though they do not meet all criteria for that disorder.

Combat Stress Reaction

A phenomenon unique to war, and one that counselors need to understand well, is combat stress reaction (CSR). CSR is an acute anxiety reaction occurring during or shortly after participating in military conflicts and wars as well as other operations within the war zone, known as the theater. CSR is not a formal diagnosis, nor is it included in the DSM-5 (APA, 2013a). It is similar to acute stress

Case Illustration: Frank

Frank is a 36-year-old man who was severely beaten in a fight outside a bar. He had multiple injuries, including broken bones, a concussion, and a stab wound in his lower abdomen. He was hospitalized for 3.5 weeks and was unable to return to work, thus losing his job as a warehouse forklift operator. For several years, when faced with situations in which he perceived himself as helpless and overwhelmed, Frank reacted with violent anger that, to others, appeared grossly out of proportion to the situation. He has not had a drink in almost 3 years, but the bouts of anger persist and occur three to five times a year. They leave Frank feeling even more isolated from others and alienated from those who love him. He reports that he cannot watch certain television shows that depict violent anger; he has to stop watching when such scenes occur. He sometimes daydreams about getting revenge on the people who assaulted him.

Psychiatric and neurological evaluations do not reveal a cause for Frank's anger attacks. Other than these symptoms, Frank has progressed well in his abstinence from alcohol. He attends a support group regularly, has acquired friends who are also abstinent, and has reconciled with his family of origin. His marriage is more stable, although the episodes of rage limit his wife's willingness to commit fully to the relationship. In recounting the traumatic event in counseling, Frank acknowledges that he thought he was going to die as a result of the fight, especially when he realized he had been stabbed. As he described his experience, he began to become very anxious, and the counselor observed the rage beginning to appear.

After his initial evaluation, Frank was referred to an outpatient program that provided trauma-specific interventions to address his subthreshold trauma symptoms. With a combination of cognitive–behavioral counseling, EMDR, and anger management techniques, he saw a gradual decrease in symptoms when he recalled the assault. He started having more control of his anger when memories of the trauma emerged. Today, when feeling trapped, helpless, or overwhelmed, Frank has resources for coping and does not allow his anger to interfere with his marriage or other relationships.

reaction, except that the precipitating event or events affect military personnel (and civilians exposed to the events) in an armed conflict situation. The terms "combat stress reaction" and "posttraumatic stress injury" are relatively new, and the intent of using these new terms is to call attention to the unique experiences of combat-related stress as well as to decrease the shame that can be associated with seeking behavioral health services for PTSD (for more information on veterans and combat stress reactions, see the planned TIP, *Reintegration-Related Behavioral Health Issues for Veterans and Military Families*; SAMHSA, planned f).

Although stress mobilizes an individual's physical and psychological resources to perform more effectively in combat, reactions to the stress may persist long after the actual danger has ended. As with other traumas, the nature of the event(s), the reactions of others, and the survivor's psychological history and resources affect the likelihood and severity of CSR. With combat veterans, this translates to the number, intensity, and duration of threat factors; the social support of peers in the veterans' unit; the emotional and cognitive resilience of the service members; and the quality of military leadership. CSR can vary from manageable and mild to debilitating and severe. Common, less severe symptoms of CSR include tension, hypervigilance, sleep problems, anger, and difficulty concentrating. If left untreated, CSR can lead to PTSD.

Common causes of CSR are events such as a direct attack from insurgent small arms fire or a military convoy being hit by an improvised explosive device, but combat stressors encompass a diverse array of traumatizing events, such as seeing grave injuries, watching others

Advice to Counselors: Understanding the Nature of Combat Stress

Several sources of information are available to help counselors deepen their understanding of combat stress and postdeployment adjustment. Friedman (2006) explains how a prolonged combat-ready stance, which is adaptive in a war zone, becomes hypervigilance and overprotectiveness at home. He makes the point that the "mutual interdependence, trust, and affection" (p. 587) that are so necessarily a part of a combat unit are different from relationships with family members and colleagues in a civilian workplace. This complicates the transition to civilian life. *Wheels Down: Adjusting to Life After Deployment* (Moore & Kennedy, 2011) provides practical advice for military service members, including inactive or active duty personnel and veterans, in transitioning from the theater to home.

The following are just a few of the many resources and reports focused on combat-related psychological and stress issues:

- *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Tanielian & Jaycox, 2008)
- *On Killing* (Grossman, 1995), an indepth analysis of the psychological dynamics of combat
- *Haunted by Combat* (Paulson & Krippner, 2007), which contains specific chapters on Reserve and National Guard troops and female veterans
- *Treating Young Veterans: Promoting Resilience Through Practice and Advocacy* (Kelly, Howe-Barksdale, & Gitelson, 2011)

die, and making on-the-spot decisions in ambiguous conditions (e.g., having to determine whether a vehicle speeding toward a military checkpoint contains insurgents with explosives or a family traveling to another area). Such circumstances can lead to combat stress. Military personnel also serve in noncombat positions (e.g., healthcare and administrative roles), and personnel filling these supportive roles can be exposed to combat situations by proximity or by witnessing their results.

Specific Trauma-Related Psychological Disorders

Part of the definition of trauma is that the individual responds with intense fear, helplessness, or horror. Beyond that, in both the short term and the long term, trauma comprises a range of reactions from normal (e.g., being unable to concentrate, feeling sad, having trouble sleeping) to warranting a diagnosis of a trauma-related mental disorder. Most people who experience trauma have no long-lasting disabling effects; their coping skills and the support of those around them are sufficient to help them overcome their difficulties, and their ability to function on a daily basis over time is unimpaired. For others, though, the symptoms of trauma are more severe and last longer. The most common diagnoses associated with trauma are PTSD and ASD, but trauma is also associated with the onset of other mental disorders—particularly substance use disorders, mood disorders, various anxiety disorders, and personality disorders. Trauma also typically exacerbates symptoms of preexisting disorders, and, for people who are predisposed to a mental disorder, trauma can precipitate its onset. Mental disorders can occur almost simultaneously with trauma exposure or manifest sometime thereafter.

Acute Stress Disorder

ASD represents a normal response to stress. Symptoms develop within 4 weeks of the trauma and can cause significant levels of distress. Most individuals who have acute stress reactions never develop further impairment or PTSD. Acute stress disorder is highly associated with the experience of one specific trauma rather than the experience of long-term exposure to chronic traumatic stress. Diagnostic criteria are presented in Exhibit 1.3-3.

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). **Note:** This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks), during which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood:
   5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms:
   6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
   7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors, such as head injury, alcohol, or drugs).

Avoidance Symptoms:
   8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   9. Efforts to avoid external reminders (e.g., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms:
   10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
   11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   12. Hypervigilance.
   13. Problems with concentration.
   14. Exaggerated startle response.

(Continued on the next page.)

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD (continued)

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure. **Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

Source: APA, 2013a, pp. 280–281.

The primary presentation of an individual with an acute stress reaction is often that of someone who appears overwhelmed by the traumatic experience. The need to talk about the experience can lead the client to seem self-centered and unconcerned about the needs of others. He or she may need to describe, in repetitive detail, what happened, or may seem obsessed with trying to understand what happened in an effort to make sense of the experience. The client is often hypervigilant and avoids circumstances that are reminders of the trauma. For instance, someone who was in a serious car crash in heavy traffic can become anxious and avoid riding in a car or driving in traffic for a finite time afterward. Partial amnesia for the trauma often accompanies ASD, and the individual may repetitively question others to fill in details. People with ASD symptoms sometimes seek assurance from others that the event happened in the way they remember, that they are not "going crazy" or "losing it," and that they could not have prevented the event. The next case illustration demonstrates the time-limited nature of ASD.

Differences between ASD and PTSD

It is important to consider the differences between ASD and PTSD when forming a diagnostic impression. The primary difference is the amount of time the symptoms have been present. ASD resolves 2 days to 4 weeks after an event, whereas PTSD continues beyond the 4-week period. The diagnosis of ASD can change to a diagnosis of PTSD if the condition is noted within the first 4 weeks after the event, but the symptoms persist past 4 weeks.

ASD also differs from PTSD in that the ASD diagnosis requires 9 out of 14 symptoms from five categories, including intrusion, negative mood, dissociation, avoidance, and arousal. These symptoms can occur at the time of the trauma or in the following month. Studies indicate that dissociation at the time of trauma is a good predictor of subsequent PTSD, so the inclusion of dissociative symptoms makes it more likely that those who develop ASD will later be diagnosed with PTSD (Bryant & Harvey, 2000). Additionally, ASD is a transient disorder, meaning that it is present in a person's life for a relatively short time and then passes. In contrast, PTSD typically becomes a primary feature of an individual's life. Over a lengthy period, PTSD can have profound effects on clients' perceptions of safety, their sense of hope for the future, their relationships with others, their physical health, the appearance of psychiatric symptoms, and their patterns of substance use and abuse.

There are common symptoms between PTSD and ASD, and untreated ASD is a possible predisposing factor to PTSD, but it is unknown whether most people with ASD are likely to develop PTSD. There is some suggestion that, as with PTSD, ASD is more

Case Illustration: Sheila

Two months ago, Sheila, a 55-year-old married woman, experienced a tornado in her home town. In the previous year, she had addressed a long-time marijuana use problem with the help of a treatment program and had been abstinent for about 6 months. Sheila was proud of her abstinence; it was something she wanted to continue. She regarded it as a mark of personal maturity; it improved her relationship with her husband, and their business had flourished as a result of her abstinence.

During the tornado, an employee reported that Sheila had become very agitated and had grabbed her assistant to drag him under a large table for cover. Sheila repeatedly yelled to her assistant that they were going to die. Following the storm, Sheila could not remember certain details of her behavior during the event. Furthermore, Sheila said that after the storm, she felt numb, as if she was floating out of her body and could watch herself from the outside. She stated that nothing felt real and it was all like a dream.

Following the tornado, Sheila experienced emotional numbness and detachment, even from people close to her, for about 2 weeks. The symptoms slowly decreased in intensity but still disrupted her life. Sheila reported experiencing disjointed or unconnected images and dreams of the storm that made no real sense to her. She was unwilling to return to the building where she had been during the storm, despite having maintained a business at this location for 15 years. In addition, she began smoking marijuana again because it helped her sleep. She had been very irritable and had uncharacteristic angry outbursts toward her husband, children, and other family members.

As a result of her earlier contact with a treatment program, Sheila returned to that program and engaged in psychoeducational, supportive counseling focused on her acute stress reaction. She regained abstinence from marijuana and returned shortly to a normal level of functioning. Her symptoms slowly diminished over a period of 3 weeks. With the help of her counselor, she came to understand the link between the trauma and her relapse, regained support from her spouse, and again felt in control of her life.

prevalent in women than in men (Bryant & Harvey, 2003). However, many people with PTSD do not have a diagnosis or recall a history of acute stress symptoms before seeking treatment for or receiving a diagnosis of PTSD.

Effective interventions for ASD can significantly reduce the possibility of the subsequent development of PTSD. Effective treatment of ASD can also reduce the incidence of other co-occurring problems, such as depression, anxiety, dissociative disorders, and compulsive behaviors (Bryant & Harvey, 2000). Intervention for ASD also helps the individual develop coping skills that can effectively prevent the recurrence of ASD after later traumas.

Although predictive science for ASD and PTSD will continue to evolve, both disorders are associated with increased substance use and mental disorders and increased risk of relapse; therefore, effective screening for ASD and PTSD is important for all clients with these disorders. Individuals in early recovery—lacking well-practiced coping skills, lacking environmental supports, and already operating at high levels of anxiety—are particularly susceptible to ASD. Events that would not normally be disabling can produce symptoms of intense helplessness and fear, numbing and depersonalization, disabling anxiety, and an inability to handle normal life events. Counselors should be able to recognize ASD and treat it rather than attributing the symptoms to a client's lack of motivation to change, being "dry drunk" (for those in substance abuse recovery), or being manipulative.

Posttraumatic Stress Disorder

The trauma-related disorder that receives the greatest attention is PTSD; it is the most

Case Illustration: Michael

Michael is a 62-year-old Vietnam veteran. He is a divorced father of two children and has four grandchildren. Both of his parents were dependent on alcohol. He describes his childhood as isolated. His father physically and psychologically abused him (e.g., he was beaten with a switch until he had welts on his legs, back, and buttocks). By age 10, his parents regarded him as incorrigible and sent him to a reformatory school for 6 months. By age 15, he was using marijuana, hallucinogens, and alcohol and was frequently truant from school.

At age 19, Michael was drafted and sent to Vietnam, where he witnessed the deaths of six American military personnel. In one incident, the soldier he was next to in a bunker was shot. Michael felt helpless as he talked to this soldier, who was still conscious. In Vietnam, Michael increased his use of both alcohol and marijuana. On his return to the United States, Michael continued to drink and use marijuana. He reenlisted in the military for another tour of duty.

His life stabilized in his early 30s, as he had a steady job, supportive friends, and a relatively stable family life. However, he divorced in his late 30s. Shortly thereafter, he married a second time, but that marriage ended in divorce as well. He was chronically anxious and depressed and had insomnia and frequent nightmares. He periodically binged on alcohol. He complained of feeling empty, had suicidal ideation, and frequently stated that he lacked purpose in his life.

In the 1980s, Michael received several years of mental health treatment for dysthymia. He was hospitalized twice and received 1 year of outpatient psychotherapy. In the mid-1990s, he returned to outpatient treatment for similar symptoms and was diagnosed with PTSD and dysthymia. He no longer used marijuana and rarely drank. He reported that he didn't like how alcohol or other substances made him feel anymore—he felt out of control with his emotions when he used them. Michael reported symptoms of hyperarousal, intrusion (intrusive memories, nightmares, and preoccupying thoughts about Vietnam), and avoidance (isolating himself from others and feeling "numb"). He reported that these symptoms seemed to relate to his childhood abuse and his experiences in Vietnam. In treatment, he expressed relief that he now understood the connection between his symptoms and his history.

commonly diagnosed trauma-related disorder, and its symptoms can be quite debilitating over time. Nonetheless, it is important to remember that PTSD symptoms are represented in a number of other mental illnesses, including major depressive disorder (MDD), anxiety disorders, and psychotic disorders (Foa et al., 2006). The DSM-5 (APA, 2013a) identifies four symptom clusters for PTSD: presence of intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. Individuals must have been exposed to actual or threatened death, serious injury, or sexual violence, and the symptoms must produce significant distress and impairment for more than 4 weeks (Exhibit 1.3-4).

Certain characteristics make people more susceptible to PTSD, including one's unique personal vulnerabilities at the time of the traumatic exposure, the support (or lack of support) received from others at the time of the trauma and at the onset of trauma-related symptoms, and the way others in the person's environment gauge the nature of the traumatic event (Brewin, Andrews, & Valentine, 2000).

People with PTSD often present varying clinical profiles and histories. They can experience symptoms that are activated by environmental triggers and then recede for a period of time. Some people with PTSD who show mostly psychiatric symptoms (particularly depression and anxiety) are misdiagnosed and go untreated for their primary condition. For many people, the trauma experience and diagnosis

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled "Posttraumatic Stress Disorder for Children 6 Years and Younger" (APA, 2013a).

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
   5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
   2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
   3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
   4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
   5. Markedly diminished interest or participation in significant activities.
   6. Feelings of detachment or estrangement from others.
   7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

(Continued on the next page.)

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD (continued)

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   2. Reckless or self-destructive behavior.
   3. Hypervigilance.
   4. Exaggerated startle response.
   5. Problems with concentration.
   6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify whether:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Source: APA, 2013a, pp. 271–272.

are obscured by co-occurring substance use disorder symptoms. The important feature of PTSD is that the disorder becomes an orienting feature of the individual's life. How well the person can work, with whom he or she associates, the nature of close and intimate relationships, the ability to have fun and rejuvenate, and the way in which an individual goes about confronting and solving problems in life are all affected by the client's trauma experiences and his or her struggle to recover.

Posttraumatic stress disorder: Timing of symptoms

Although symptoms of PTSD usually begin within 3 months of a trauma in adulthood, there can be a delay of months or even years before symptoms appear for some people. Some people may have minimal symptoms after a trauma but then experience a crisis later in life. Trauma symptoms can appear suddenly, even without conscious memory of the original trauma or without any overt provocation. Survivors of abuse in childhood can have a delayed response triggered by something that happens to them as adults. For example, seeing a movie about child abuse can trigger symptoms related

Advice to Counselors: Helping Clients With Delayed Trauma Responses

Clients who are experiencing a delayed trauma response can benefit if you help them to:

- Create an environment that allows acknowledgment of the traumatic event(s).
- Discuss their initial recall or first suspicion that they were having a traumatic response.
- Become educated on delayed trauma responses.
- Draw a connection between the trauma and presenting trauma-related symptoms.
- Create a safe environment.
- Explore their support systems and fortify them as needed.
- Understand that triggers can precede traumatic stress reactions, including delayed responses to trauma.
- Identify their triggers.
- Develop coping strategies to navigate and manage symptoms.

to the trauma. Other triggers include returning to the scene of the trauma, being reminded of it in some other way, or noting the anniversary of an event. Likewise, combat veterans and survivors of community-wide disasters may seem to be coping well shortly after a trauma, only to have symptoms emerge later when their life situations seem to have stabilized. Some clients in substance abuse recovery only begin to experience trauma symptoms when they maintain abstinence for some time. As individuals decrease tension-reducing or self-medicating behaviors, trauma memories and symptoms can emerge.

Culture and posttraumatic stress

Although research is limited across cultures, PTSD has been observed in Southeast Asian, South American, Middle Eastern, and Native American survivors (Osterman & de Jong, 2007; Wilson & Tang, 2007). As Stamm and Friedman (2000) point out, however, simply observing PTSD does not mean that it is the "best conceptual tool for characterizing posttraumatic distress among non-Western individuals" (p. 73). In fact, many trauma-related symptoms from other cultures do not fit the DSM-5 criteria. These include somatic and psychological symptoms and beliefs about the origins and nature of traumatic events. Moreover, religious and spiritual beliefs can affect how a survivor experiences a traumatic event and whether he or she reports the distress. For example, in societies where attitudes toward karma and the glorification of war veterans are predominant, it is harder for war veterans to come forward and disclose that they are emotionally overwhelmed or struggling. It would be perceived as inappropriate and possibly demoralizing to focus on the emotional distress that he or she still bears. (For a review of cultural competence in treating trauma, refer to Brown, 2008.)

Methods for measuring PTSD are also culturally specific. As part of a project begun in 1972, the World Health Organization (WHO) and the National Institutes of Health (NIH) embarked on a joint study to test the cross-cultural applicability of classification systems for various diagnoses. WHO and NIH identified apparently universal factors of psychological disorders and developed specific instruments to measure them. These instruments, the Composite International Diagnostic Interview and the Schedules for Clinical Assessment in Neuropsychiatry, include certain criteria from the DSM (Fourth Edition, Text Revision; APA, 2000a) as well as criteria from the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10; Exhibit 1.3-5).

Exhibit 1.3-5: ICD-10 Diagnostic Criteria for PTSD

A. The patient must have been exposed to a stressful event or situation (either brief or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.

B. There must be persistent remembering or "reliving" of the stressor in intrusive "flashbacks," vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.

D. Either of the following must be present:
   1. Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor.
   2. Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
      a. Difficulty in falling or staying asleep.
      b. Irritability or outbursts of anger.
      c. Difficulty in concentrating.
      d. Exaggerated startle response.

E. Criteria B, C, and D must all be met within 6 months of the stressful event or at the end of a period of stress. (For some purposes, onset delayed more than 6 months can be included, but this should be clearly specified.)

Source: WHO, 1992.

Complex trauma and complex traumatic stress

When individuals experience multiple traumas, prolonged and repeated trauma during childhood, or repetitive trauma in the context of significant interpersonal relationships, their reactions to trauma have unique characteristics (Herman, 1992). This unique constellation of reactions, called complex traumatic stress, is not recognized diagnostically in the DSM-5, but theoretical discussions and research have begun to highlight the similarities and differences in symptoms of posttraumatic stress versus complex traumatic stress (Courtois & Ford, 2009). Often, the symptoms generated from complex trauma do not fully match PTSD criteria and exceed the severity of PTSD. Overall, literature reflects that PTSD criteria or subthreshold symptoms do not fully account for the persistent and more impairing clinical presentation of complex trauma. Even though current research in the study of traumatology is prolific, it is still in the early stages of development. The idea that there may be more diagnostic variations or subtypes is forthcoming, and this will likely pave the way for more client-matching interventions to better serve those individuals who have been repeatedly exposed to multiple, early childhood, and/or interpersonal traumas.

Other Trauma-Related and Co-Occurring Disorders

The symptoms of PTSD and other mental disorders overlap considerably; these disorders often coexist and include mood, anxiety,

The term "**co occurring disorders**" refers to cases when a person has one or more mental disorders as well as one or more substance use disorders (including sub stance abuse). Co occurring disorders are common among individuals who have a history of trauma and are seeking help.

Advice to Counselors: Universal Screening and Assessment

Only people specifically trained and licensed in mental health assessment should make diagnoses; trauma can result in complicated cases, and many symptoms can be present, whether or not they meet full diagnostic criteria for a specific disorder. Only a trained assessor can distinguish accurately among various symptoms and in the presence of co-occurring disorders. However, behavioral health professionals without specific assessment training can still serve an important role in screening for possible mental disorders using established screening tools (CSAT, 2005c; see also Chapter 4 of this TIP). In agencies and clinics, it is critical to provide such screenings systematically—for each client—as PTSD and other co-occurring disorders are typically underdiagnosed or misdiagnosed.

substance use, and personality disorders. Thus, it's common for trauma survivors to be underdiagnosed or misdiagnosed. If they have not been identified as trauma survivors, their psychological distress is often not associated with previous trauma, and/or they are diagnosed with a disorder that marginally matches their presenting symptoms and psychological sequelae of trauma. The following sections present a brief overview of some mental disorders that can result from (or be worsened by) traumatic stress. PTSD is not the only diagnosis related to trauma nor its only psychological consequence; trauma can broadly influence mental and physical health in clients who already have behavioral health disorders.

People With Mental Disorders

MDD is the most common co-occurring disorder in people who have experienced trauma and are diagnosed with PTSD. A well-established causal relationship exists between stressful events and depression, and a prior history of MDD is predictive of PTSD after exposure to major trauma (Foa et al., 2006).

Many survivors with severe mental disorders function fairly well following trauma, including disasters, as long as essential services aren't interrupted. For others, additional mental health supports may be necessary. For more information, see *Responding to the Needs of People With Serious and Persistent Mental Illness in Times of Major Disaster* (Center for Mental Health Services, 1996).

Co-occurrence is also linked with greater impairment and more severe symptoms of both disorders, and the person is less likely to experience remission of symptoms within 6 months.

Generalized anxiety, obsessive–compulsive, and other anxiety disorders are also associated with PTSD. PTSD may exacerbate anxiety disorder symptoms, but it is also likely that preexisting anxiety symptoms and anxiety disorders increase vulnerability to PTSD. Preexisting anxiety primes survivors for greater hyperarousal and distress. Other disorders, such as personality and somatization disorders, are also associated with trauma, but the history of trauma is often overlooked as a significant factor or necessary target in treatment.

The relationship between PTSD and other disorders is complex. More research is now examining the multiple potential pathways among PTSD and other disorders and how various sequences affect clinical presentation. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c), is valuable in understanding the relationship of substance use to other mental disorders.

People With Substance Use Disorders

There is clearly a correlation between trauma (including individual, group, or mass trauma) and substance use as well as the presence of posttraumatic stress (and other trauma-related disorders) and substance use disorders. Alcohol and drug use can be, for some, an effort to

Co-Occurring PTSD and Other Mental Disorders

- Individuals with PTSD often have at least one additional diagnosis of a mental disorder.
- The presence of other disorders typically worsens and prolongs the course of PTSD and complicates clinical assessment, diagnosis, and treatment.
- The most common co-occurring disorders, in addition to substance use disorders, include mood disorders, various anxiety disorders, eating disorders, and personality disorders.
- Exposure to early, severe, and chronic trauma is linked to more complex symptoms, including impulse control deficits, greater difficulty in emotional regulation and establishing stable relationships, and disruptions in consciousness, memory, identity, and/or perception of the environment (Dom, De, Hulstijn, & Sabbe, 2007; Waldrop, Back, Verduin, & Brady, 2007).
- Certain diagnostic groups and at-risk populations (e.g., people with developmental disabilities, people who are homeless or incarcerated) are more susceptible to trauma exposure and to developing PTSD if exposed but less likely to receive appropriate diagnosis and treatment.
- Given the prevalence of traumatic events in clients who present for substance abuse treatment, counselors should assess all clients for possible trauma-related disorders.

manage traumatic stress and specific PTSD symptoms. Likewise, people with substance use disorders are at higher risk of developing PTSD than people who do not abuse substances. Counselors working with trauma survivors or clients who have substance use disorders have to be particularly aware of the possibility of the other disorder arising.

Timeframe: PTSD and the onset of substance use disorders

Knowing whether substance abuse or PTSD came first informs whether a causal relationship exists, but learning this requires thorough assessment of clients and access to complete data on PTSD; substance use, abuse, and dependence; and the onset of each. Much current research focuses solely on the age of onset of substance use (not abuse), so determining causal relationships can be difficult.

The relationship between PTSD and substance use disorders is thought to be bidirectional and cyclical: substance use increases trauma risk, and exposure to trauma escalates substance use to manage trauma-related symptoms. Three other causal pathways described by Chilcoat and Breslau's seminal work (1998) further explain the relationship between PTSD and substance use disorders:

1. The "self-medication" hypothesis suggests that clients with PTSD use substances to manage PTSD symptoms (e.g., intrusive memories, physical arousal). Substances such as alcohol, cocaine, barbiturates, opioids, and amphetamines are frequently abused in attempts to relieve or numb emotional pain or to forget the event.
2. The "high-risk" hypothesis states that drug and alcohol use places people who use substances in high-risk situations that increase their chances of being exposed to events that lead to PTSD.
3. The "susceptibility" hypothesis suggests that people who use substances are more susceptible to developing PTSD after exposure to trauma than people who do not. Increased vulnerability may result from failure to develop effective stress management strategies, changes in brain chemistry, or damage to neurophysiological systems due to extensive substance use.

PTSD and substance abuse treatment

PTSD can limit progress in substance abuse recovery, increase the potential for relapse, and complicate a client's ability to achieve success in various life areas. Each disorder can mask or hide the symptoms of the other, and both need

Case Illustration: Maria

Maria is a 31-year-old woman diagnosed with PTSD and alcohol dependence. From ages 8 to 12, she was sexually abused by an uncle. Maria never told anyone about the abuse for fear that she would not be believed. Her uncle remains close to the family, and Maria still sees him on certain holidays. When she came in for treatment, she described her emotions and thoughts as out of control. Maria often experiences intrusive memories of the abuse, which at times can be vivid and unrelenting. She cannot predict when the thoughts will come; efforts to distract herself from them do not always work. She often drinks in response to these thoughts or his presence, as she has found that alcohol can dull her level of distress. Maria also has difficulty falling asleep and is often awakened by nightmares. She does not usually remember the dreams, but she wakes up feeling frightened and alert and cannot go back to sleep.

Maria tries to avoid family gatherings but often feels pressured to go. Whenever she sees her uncle, she feels intense panic and anger but says she can usually "hold it together" if she avoids him. Afterward, however, she describes being overtaken by these feelings and unable to calm down. She also describes feeling physically ill and shaky. At these times, she often isolates herself, stays in her apartment, and drinks steadily for several days. Maria also reports distress pertaining to her relationship with her boyfriend. In the beginning of their relationship, she found him comforting and enjoyed his affection, but more recently, she has begun to feel anxious and unsettled around him. Maria tries to avoid sex with him, but she sometimes gives in for fear of losing the relationship. She finds it easier to have sex with him when she is drunk, but she often experiences strong feelings of dread and disgust reminiscent of her abuse. Maria feels guilty and confused about these feelings.

to be assessed and treated if the individual is to have a full recovery. There is a risk of misinterpreting trauma-related symptoms in substance abuse treatment settings. For example, avoidance symptoms in an individual with PTSD can be misinterpreted as lack of motivation or unwillingness to engage in substance abuse treatment; a counselor's efforts to address substance abuse–related behaviors in early recovery can likewise provoke an exaggerated response from a trauma survivor who has profound traumatic experiences of being trapped and controlled. Exhibit 1.3-6 lists important facts about PTSD and substance use disorders for counselors.

Sleep, PTSD, and substance use

Many people have trouble getting to sleep and/or staying asleep after a traumatic event; consequently, some have a drink or two to help them fall asleep. Unfortunately, any initially helpful effects are likely not only to wane quickly, but also to incur a negative rebound effect. When someone uses a substance before going to bed, "sleep becomes lighter and more easily disrupted," and rapid eye movement sleep (REM) "increases, with an associated increase in dreams and nightmares," as the effects wear off (Auerbach, 2003, p. 1185).

People with alcohol dependence report multiple types of sleep disturbances over time, and it is not unusual for clients to report that they cannot fall asleep without first having a drink. Both REM and slow wave sleep are reduced in clients with alcohol dependence, which is also associated with an increase in the amount of time it takes before sleep occurs, decreased overall sleep time, more nightmares, and reduced sleep efficiency. Sleep during withdrawal is "frequently marked by severe insomnia and sleep fragmentation…a loss of restful sleep and feelings of daytime fatigue. Nightmares and vivid dreams are not uncommon" (Auerbach, 2003, pp. 1185–1186).

Confounding changes in the biology of sleep that occur in clients with PTSD and substance use disorders often add to the problems of

Exhibit 1.3-6: PTSD and Substance Use Disorders: Important Treatment Facts

Profile Severity

- PTSD is one of the most common co-occurring mental disorders found in clients in substance abuse treatment (CSAT, 2005c).
- People in treatment for PTSD tend to abuse a wide range of substances, including opioids, cocaine, marijuana, alcohol, and prescription medications.
- People in treatment for PTSD and substance abuse have a more severe clinical profile than those with just one of these disorders.
- PTSD, with or without major depression, significantly increases risk for suicidality (CSAT, 2009a).

Gender Differences

- Rates of trauma-related disorders are high in men and women in substance abuse treatment.
- Women with PTSD and a substance use disorder most frequently experienced rape or witnessed a killing or injury; men with both disorders typically witnessed a killing or injury or were the victim of sudden injury or accident (Cottler, Nishith, & Compton, 2001).

Risk of Continued Cycle of Violence

- While under the influence of substances, a person is more vulnerable to traumatic events (e.g., automobile crashes, assaults).
- Perpetrators of violent assault often are under the influence of substances or test positive for substances at the time of arrest.

Treatment Complications

- It is important to recognize and help clients understand that becoming abstinent from substances does not resolve PTSD; in fact, some PTSD symptoms become worse with abstinence for some people. Both disorders must be addressed in treatment.
- Treatment outcomes for clients with PTSD and a substance use disorder are worse than for clients with other co-occurring disorders or who only abuse substances (Brown, Read, & Kahler, 2003).

recovery. Sleep can fail to return to normal for months or even years after abstinence, and the persistence of sleep disruptions appears related to the likelihood of relapse. Of particular clinical importance is the vicious cycle that can also begin during "slips"; relapse initially improves sleep, but continued drinking leads to sleep disruption. This cycle of initial reduction of an unpleasant symptom, which only ends up exacerbating the process as a whole, can take place for clients with PTSD as well as for clients with substance use disorders. There are effective cognitive–behavioral therapies and nonaddictive pharmacological interventions for sleep difficulties.

4 Screening and Assessment

IN THIS CHAPTER

- Screening and Assessment
- Barriers and Challenges to Trauma Informed Screening and Assessment
- Cross Cultural Screening and Assessment
- Choosing Instruments
- Trauma Informed Screening and Assessment
- Concluding Note

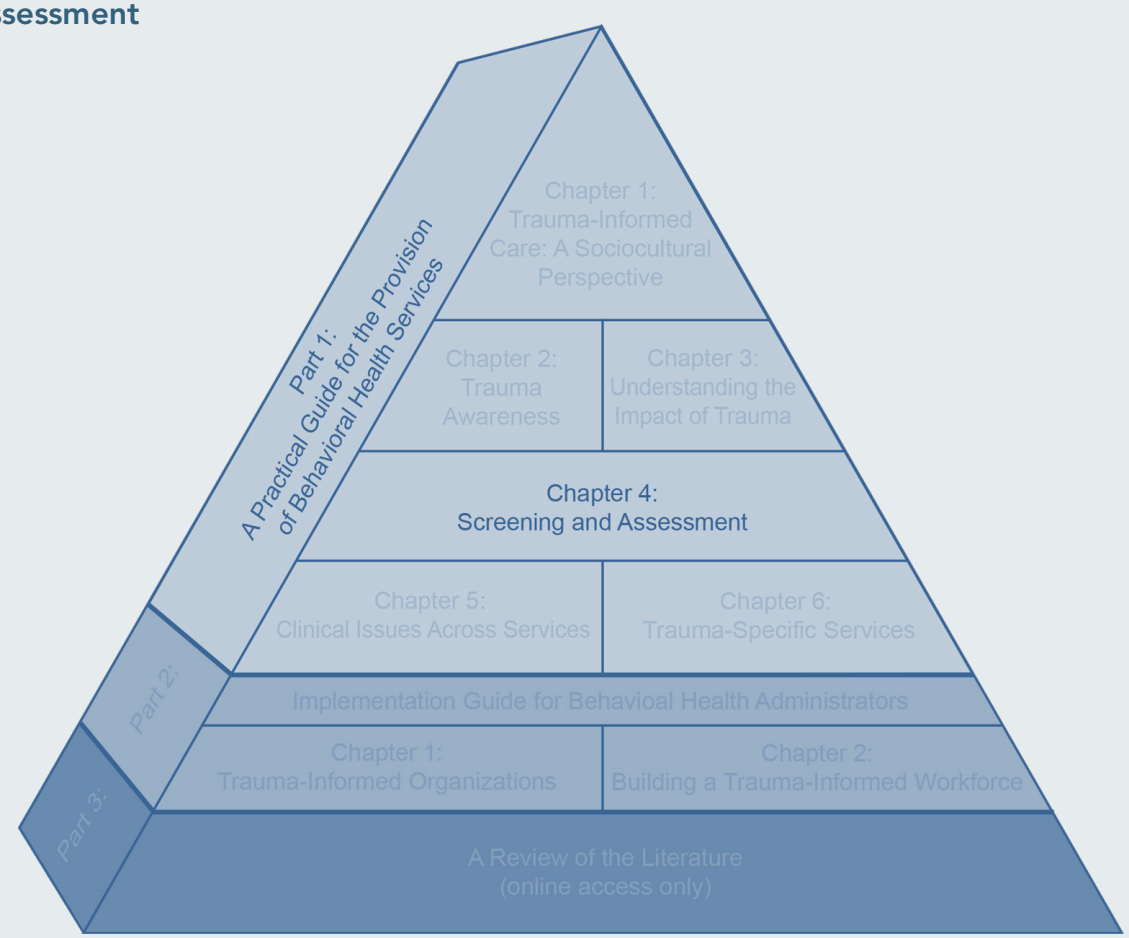
Why screen universally for trauma in behavioral health services? Exposure to trauma is common; in many surveys, more than half of respondents report a history of trauma, and the rates are even higher among clients with mental or substance use disorders. Furthermore, behavioral health problems, including substance use and mental disorders, are more difficult to treat if trauma-related symptoms and disorders aren't detected early and treated effectively (Part 3, Section 1, of this Treatment Improvement Protocol [TIP], available online, summarizes research on the prevalence of trauma and its relationship with other behavioral health problems).

Not addressing traumatic stress symptoms, trauma-specific disorders, and other symptoms/disorders related to trauma can impede successful mental health and substance abuse treatment. Unrecognized, unaddressed trauma symptoms can lead to poor engagement in treatment, premature termination, greater risk for relapse of psychological symptoms or substance use, and worse outcomes. Screening can also prevent misdiagnosis and inappropriate treatment planning. People with histories of trauma often display symptoms that meet criteria for other disorders.

Without screening, clients' trauma histories and related symptoms often go undetected, leading providers to direct services toward symptoms and disorders that may only partially explain client presentations and distress. Universal screening for trauma history and trauma-related symptoms can help behavioral health practitioners identify individuals at risk of developing more pervasive and severe symptoms of traumatic stress. Screening, early identification, and intervention serves as a prevention strategy.

Screening to identify clients who have histories of trauma and experience trauma related symptoms is a prevention strategy.

Trauma-Informed Care Framework in Behavioral Health Services—Screening and Assessment



The chapter begins with a discussion of screening and assessment concepts, with a particular focus on trauma-informed screening. It then highlights specific factors that influence screening and assessment, including timing and environment. Barriers and challenges in providing trauma-informed screening are discussed, along with culturally specific screening and assessment considerations and guidelines. Instrument selection, trauma-informed screening and assessment tools, and trauma-informed screening and assessment processes are reviewed as well. For a more research-oriented perspective on screening and assessment for traumatic stress disorders, please refer to the literature review provided in Part 3 of this TIP, which is available online.

Screening and Assessment

Screening

The first two steps in screening are to determine whether the person has a history of trauma and whether he or she has trauma-related symptoms. Screening mainly obtains answers to "yes" or "no" questions: "Has this client experienced a trauma in the past?" and "Does this client at this time warrant further assessment regarding trauma-related symptoms?" If someone acknowledges a trauma history, then further screening is necessary to determine whether trauma-related symptoms are present. However, the presence of such symptoms does not necessarily say anything about their severity, nor does a positive screen indicate that a disorder actually exists. Positive

Screening is often the first contact between the client and the treatment provider, and the client forms his or her first impression of treatment during this intake process. Thus, how screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client.

screens only indicate that assessment or further evaluation is warranted, and negative screens do not necessarily mean that an individual doesn't have symptoms that warrant intervention.

Screening procedures should always define the steps to take after a positive or negative screening. That is, the screening process establishes precisely how to score responses to screening tools or questions and clearly defines what constitutes a positive score (called a "cut-off score") for a particular potential problem. The screening procedures detail the actions to take after a client scores in the positive range. Clinical supervision is helpful—and sometimes necessary—in judging how to proceed.

Trauma-informed screening is an essential part of the intake evaluation and the treatment planning process, but it is not an end in itself. Screening processes can be developed that allow staff without advanced degrees or graduate-level training to conduct them, whereas assessments for trauma-related disorders require a mental health professional trained in assessment and evaluation processes. The most important domains to screen among individuals with trauma histories include:

- Trauma-related symptoms.
- Depressive or dissociative symptoms, sleep disturbances, and intrusive experiences.
- Past and present mental disorders, including typically trauma-related disorders (e.g., mood disorders).
- Severity or characteristics of a specific trauma type (e.g., forms of interpersonal violence, adverse childhood events, combat experiences).
- Substance abuse.
- Social support and coping styles.
- Availability of resources.
- Risks for self-harm, suicide, and violence.
- Health screenings.

Assessment

When a client screens positive for substance abuse, trauma-related symptoms, or mental disorders, the agency or counselor should follow up with an assessment. A positive screening calls for more action—an assessment that determines and defines presenting struggles to develop an appropriate treatment plan and to make an informed and collaborative decision about treatment placement. Assessment determines the nature and extent of the client's problems; it might require the client to respond to written questions, or it could involve a clinical interview by a mental health or substance abuse professional qualified to assess the client and arrive at a diagnosis. A clinical assessment delves into a client's past and current experiences, psychosocial and cultural history, and assets and resources.

Assessment protocols can require more than a single session to complete and should also use multiple avenues to obtain the necessary clinical information, including self-assessment tools, past and present clinical and medical records, structured clinical interviews, assessment measures, and collateral information from significant others, other behavioral health professionals, and agencies. Qualifications for conducting assessments and clinical interviews are more rigorous than for screening. Advanced degrees, licensing or certification, and special training in administration, scoring, and interpretation of specific assessment instruments and interviews are often

Advice to Counselors: Screening and Assessing Clients

- Ask all clients about any possible history of trauma; use a checklist to increase proper identification of such a history (see the online Adverse Childhood Experiences Study Score Calculator [http://acestudy.org/ace_score] for specific questions about adverse childhood experiences).
- Use only validated instruments for screening and assessment.
- Early in treatment, screen all clients who have histories of exposure to traumatic events for psychological symptoms and mental disorders related to trauma.
- When clients screen positive, also screen for suicidal thoughts and behaviors (see TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*; Center for Substance Abuse Treatment [CSAT], 2009a).
- Do not delay screening; do not wait for a period of abstinence or stabilization of symptoms.
- Be aware that some clients will not make the connection between trauma in their histories and their current patterns of behavior (e.g., alcohol and drug use and/or avoidant behavior).
- Do not require clients to describe emotionally overwhelming traumatic events in detail.
- Focus assessment on how trauma symptoms affect clients' current functioning.
- Consider using paper-and-pencil instruments for screening and assessment as well as self-report measures when appropriate; they are less threatening for some clients than a clinical interview.
- Talk about how you will use the findings to plan the client's treatment, and discuss any immediate action necessary, such as arranging for interpersonal support, referrals to community agencies, or moving directly into the active phase of treatment. It is helpful to explore the strategies clients have used in the past that have worked to relieve strong emotions (Fallot & Harris, 2001).
- At the end of the session, make sure the client is grounded and safe before leaving the interview room (Litz, Miller, Ruef, & McTeague, 2002). Readiness to leave can be assessed by checking on the degree to which the client is conscious of the current environment, what the client's plan is for maintaining personal safety, and what the client's plans are for the rest of the day.

required. Counselors must be familiar with (and obtain) the level of training required for any instruments they consider using.

For people with histories of traumatic life events who screen positive for possible trauma-related symptoms and disorders, thorough assessment gathers all relevant information necessary to understand the role of the trauma in their lives; appropriate treatment objectives, goals, planning, and placement; and any ongoing diagnostic and treatment considerations, including reevaluation or follow-up.

Overall, assessment may indicate symptoms that meet diagnostic criteria for a substance use or mental disorder or a milder form of symptomatology that doesn't reach a diagnostic level—or it may reveal that the positive screen was false and that there is no significant cause for concern. Information from an assessment is used to plan the client's treatment. The plan can include such domains as level of care, acute safety needs, diagnosis, disability, strengths and skills, support network, and cultural context. Assessments should reoccur throughout treatment. Ongoing assessment during treatment can provide valuable information by revealing further details of trauma history as clients' trust in staff members grows and by gauging clients' progress.

Timing of Screening and Assessment

As a trauma-informed counselor, you need to offer psychoeducation and support from the outset of service provision; this begins with explaining screening and assessment and with proper pacing of the initial intake and evaluation process. The client should understand the screening process, why the specific questions are important, and that he or she may choose to delay a response or to not answer a question

at all. Discussing the occurrence or consequences of traumatic events can feel as unsafe and dangerous to the client as if the event were reoccurring. It is important not to encourage avoidance of the topic or reinforce the belief that discussing trauma-related material is dangerous, but be sensitive when gathering information in the initial screening. Initial questions about trauma should be general and gradual. Taking the time to prepare and explain the screening and assessment process to the client gives him or her a greater sense of control and safety over the assessment process.

Clients with substance use disorders

No screening or assessment of trauma should occur when the client is under the influence of alcohol or drugs. Clients under the influence are more likely to give inaccurate information. Although it's likely that clients in an active phase of use (albeit not at the assessment itself) or undergoing substance withdrawal can provide consistent information to obtain a valid screening and assessment, there is insufficient data to know for sure. Some theorists state that no final assessment of trauma or posttraumatic stress disorder (PTSD) should occur during these early phases (Read, Bollinger, & Sharkansky, 2003), asserting that symptoms of withdrawal can mimic PTSD and thus result in overdiagnosis of PTSD and other trauma-related disorders. Alcohol or drugs can also cause memory impairment that clouds the client's history of trauma symptoms. However, Najavits (2004) and others note that underdiagnosis, not overdiagnosis, of trauma and PTSD has been a significant issue in the substance abuse field and thus claim that it is essential to obtain an initial assessment early, which can later be modified if needed (e.g., if the client's symptom pattern changes). Indeed, clinical observations suggest that assessments for both trauma and PTSD—even during active use or withdrawal—appear robust (Coffey, Schumacher, Brady, & Dansky, 2003). Although some PTSD symptoms and trauma memories can be dampened or increased to a degree, their overall presence or absence, as assessed early in treatment, appears accurate (Najavits, 2004).

Conduct Assessments Throughout Treatment

Ongoing assessments let counselors:

- Track changes in the presence, frequency, and intensity of symptoms.
- Learn the relationships among the client's trauma, presenting psychological symptoms, and substance abuse.
- Adjust diagnoses and treatment plans as needed.
- Select prevention strategies to avoid more pervasive traumatic stress symptoms.

The Setting for Trauma Screening and Assessment

Advances in the development of simple, brief, and public-domain screening tools mean that at least a basic screening for trauma can be done in almost any setting. Not only can clients be screened and assessed in behavioral health treatment settings; they can also be evaluated in the criminal justice system, educational settings, occupational settings, physicians' offices, hospital medical and trauma units, and emergency rooms. Wherever they occur, trauma-related screenings and subsequent assessments can reduce or eliminate wasted resources, relapses, and, ultimately, treatment failures among clients who have histories of trauma, mental illness, and/or substance use disorders.

Creating an effective screening and assessment environment

You can greatly enhance the success of treatment by paying careful attention to how you approach the screening and assessment process. Take into account the following points:

- ***Clarify for the client what to expect in the screening and assessment process.*** For example, tell the client that the screening and assessment phase focuses on identifying issues that might benefit from treatment. Inform him or her that during the trauma screening and assessment process, uncomfortable thoughts and feelings can arise. Provide reassurance that, if they do, you'll assist in dealing with this distress—but also let them know that, even with your assistance, some psychological and physical reactions to the interview may last for a few hours or perhaps as long as a few days after the interview, and be sure to highlight the fact that such reactions are normal (Read et al., 2003).
- ***Approach the client in a matter-of-fact, yet supportive, manner.*** Such an approach helps create an atmosphere of trust, respect, acceptance, and thoughtfulness (Melnick & Bassuk, 2000). Doing so helps to normalize symptoms and experiences generated by the trauma; consider informing clients that such events are common but can cause continued emotional distress if they are not treated. Clients may also find it helpful for you to explain the purpose of certain difficult questions. For example, you could say, "Many people have experienced troubling events as children, so some of my questions are about whether you experienced any such events while growing up." Demonstrate kindness and directness in equal measure when screening/assessing clients (Najavits, 2004).
- ***Respect the client's personal space.*** Cultural and ethnic factors vary greatly regarding the appropriate physical distance to maintain during the interview. You should respect the client's personal space, sitting neither too far from nor too close to the client; let your observations of the client's comfort level during the screening and assessment process guide the amount of distance. Clients with trauma may have particular sensitivity about their bodies, personal space, and boundaries.
- ***Adjust tone and volume of speech to suit the client's level of engagement and degree of comfort in the interview process.*** Strive to maintain a soothing, quiet demeanor. Be sensitive to how the client might hear what you have to say in response to personal disclosures. Clients who have been traumatized may be more reactive even to benign or well-intended questions.
- ***Provide culturally appropriate symbols of safety in the physical environment.*** These include paintings, posters, pottery, and other room decorations that symbolize the safety of the surroundings to the client population. Avoid culturally inappropriate or insensitive items in the physical environment.
- ***Be aware of one's own emotional responses to hearing clients' trauma histories.*** Hearing about clients' traumas may be very painful and can elicit strong emotions. The client may interpret your reaction to his or her revelations as disinterest, disgust for the client's behavior, or some other inaccurate interpretation. It is important for you to monitor your interactions and to check in with the client as necessary. You may also feel emotionally drained to the point that it interferes with your ability to accurately listen to or assess clients. This effect of exposure to traumatic stories, known as secondary traumatization, can result in symptoms similar to those experienced by the client (e.g., nightmares, emotional numbing); if necessary, refer to a colleague for assessment (Valent, 2002). Secondary traumatization is addressed in greater detail in Part 2, Chapter 2, of this TIP.
- ***Overcome linguistic barriers via an interpreter.*** Deciding when to add an interpreter requires careful judgment. The interpreter should be knowledgeable of behavioral

health terminology, be familiar with the concepts and purposes of the interview and treatment programming, be unknown to the client, and be part of the treatment team. Avoid asking family members or friends of the client to serve as interpreters.

- ***Elicit only the information necessary for determining a history of trauma and the possible existence and extent of traumatic stress symptoms and related disorders.*** There is no need to probe deeply into the details of a client's traumatic experiences at this stage in the treatment process. Given the lack of a therapeutic relationship in which to process the information safely, pursuing details of trauma can cause retraumatization or produce a level of response that neither you nor your client is prepared to handle. Even if a client wants to tell his or her trauma story, it's your job to serve as "gatekeeper" and preserve the client's safety. Your tone of voice when suggesting postponement of a discussion of trauma is very important. Avoid conveying the message, "I really don't want to hear about it." Examples of appropriate statements are:
  - "Your life experiences are very important, but at this early point in our work together, we should start with what's going on in your life currently rather than discussing past experiences in detail. If you feel that certain past experiences are having a big effect on your life now, it would be helpful for us to discuss them as long as we focus on your safety and recovery right now."
  - "Talking about your past at this point could arouse intense feelings—even more than you might be aware of right now. Later, if you choose to, you can talk with your counselor about how to work on exploring your past."
  - "Often, people who have a history of trauma want to move quickly into the details of the trauma to gain relief. I understand this desire, but my concern for you at this moment is to help you establish a sense of safety and support before moving into the traumatic experiences. We want to avoid retraumatization—meaning, we want to establish resources that weren't available to you at the time of the trauma before delving into more content."
- ***Give the client as much personal control as possible during the assessment by:***
  - Presenting a rationale for the interview and its stress-inducing potential, making clear that the client has the right to refuse to answer any and all questions.
  - Giving the client (where staffing permits) the option of being interviewed by someone of the gender with which he or she is most comfortable.
  - Postponing the interview if necessary (Fallot & Harris, 2001).
- ***Use self-administered, written checklists rather than interviews when possible to assess trauma.*** Traumas can evoke shame, guilt, anger, or other intense feelings that can make it difficult for the client to report them aloud to an interviewer. Clients are more likely to report trauma when they use self-administered screening tools; however, these types of screening instruments only guide the next step. Interviews should coincide with self-administered tools to create a sense of safety for the client (someone is present as he or she completes the screening) and to follow up with more indepth data gathering after a self-administered screening is complete. The Trauma History Questionnaire (THQ) is a self-administered tool (Green, 1996). It has been used successfully with clinical and nonclinical populations, including medical patients, women who have experienced domestic violence, and people with serious mental illness (Hooper, Stockton,

Krupnick, & Green, 2011). Screening instruments (including the THQ) are included in Appendix D of this TIP.

- ***Interview the client if he or she has trouble reading or writing or is otherwise unable to complete a checklist.*** Clients who are likely to minimize their trauma when using a checklist (e.g., those who exhibit significant symptoms of dissociation or repression) benefit from a clinical interview. A trained interviewer can elicit information that a self-administered checklist does not capture. Overall, using both a self-administered questionnaire and an interview can help achieve greater clarity and context.
- ***Allow time for the client to become calm and oriented to the present if he or she has very intense emotional responses when recalling or acknowledging a trauma.*** At such times, avoid responding with such exclamations as "I don't know how you survived that!" (Bernstein, 2000). If the client has difficulty self-soothing, guide him or her through grounding techniques (Exhibit 1.4-1), which are particularly useful—perhaps even critical—to achieving a successful

Exhibit 1.4-1: Grounding Techniques

Grounding techniques are important skills for assessors and all other behavioral health service providers who interact with traumatized clients (e.g., nurses, security, administrators, clinicians). Even if you do not directly conduct therapy, knowledge of grounding can help you defuse an escalating situation or calm a client who is triggered by the assessment process. Grounding strategies help a person who is overwhelmed by memories or strong emotions or is dissociating; they help the person become aware of the here and now. A useful metaphor is the experience of walking out of a movie theater. When the person dissociates or has a flashback, it's like watching a mental movie; grounding techniques help him or her step out of the movie theater into the daylight and the present environment. The client's task is not only to hold on to moments from the past, but also to acknowledge that what he or she was experiencing is from the past. Try the following techniques:

1. **Ask the client to state what he or she observes.**
   Guide the client through this exercise by using statements like, "You seem to feel very scared/angry right now. You're probably feeling things related to what happened in the past. Now, you're in a safe situation. Let's try to stay in the present. Take a slow deep breath, relax your shoulders, put your feet on the floor; let's talk about what day and time it is, notice what's on the wall, etc. What else can you do to feel okay in your body right now?"
2. **Help the client decrease the intensity of affect.**
   - "Emotion dial": A client imagines turning down the volume on his or her emotions.
   - Clenching fists can move the energy of an emotion into fists, which the client can then release.
   - Guided imagery can be used to visualize a safe place.
   - Distraction (see #3 below).
   - Use strengths-based questions (e.g., "How did you survive?" or "What strengths did you possess to survive the trauma?").
3. **Distract the client from unbearable emotional states.**
   - Have the client focus on the external environment (e.g., name red objects in the room).
   - Ask the client to focus on recent and future events (e.g., "to do" list for the day).
   - Help the client use self-talk to remind himself or herself of current safety.
   - Use distractions, such as counting, to return the focus to current reality.
   - Somatosensory techniques (toe-wiggling, touching a chair) can remind clients of current reality.
4. **Ask the client to use breathing techniques.**
   - Ask the client to inhale through the nose and exhale through the mouth.
   - Have the client place his or her hands on his or her abdomen and then watch the hands go up and down while the belly expands and contracts.

Source: Melnick & Bassuk, 2000.

interview when a client has dissociated or is experiencing intense feelings in response to screening and/or interview questions.

- ***Avoid phrases that imply judgment about the trauma.*** For example, don't say to a client who survived Hurricane Katrina and lost family members, "It was God's will," or "It was her time to pass," or "It was meant to be." Do not make assumptions about what a person has experienced. Rather, listen supportively without imposing personal views on the client's experience.
- ***Provide feedback about the results of the screening.*** Keep in mind the client's vulnerability, ability to access resources, strengths, and coping strategies. Present results in a synthesized manner, avoiding complicated, overly scientific jargon or explanations. Allow time to process client reactions during the feedback session. Answer client questions and concerns in a direct, honest, and compassionate manner. Failure to deliver feedback in this way can negatively affect clients' psychological status and severely weaken the potential for developing a therapeutic alliance with the client.
- ***Be aware of the possible legal implications of assessment.*** Information you gather during the screening and assessment process can necessitate mandatory reporting to authorities, even when the client does not want such information disclosed (Najavits, 2004). For example, you can be required to report a client's experience of child abuse even if it happened many years ago or the client doesn't want the information reported. Other legal issues can be quite complex, such as confidentiality of records, pursuing a case against a trauma perpetrator and divulging information to third parties while still protecting the legal status of information used in prosecution, and child custody issues (Najavits, 2004). It's essential that you know the laws in your State, have an expert legal consultant available, and access clinical supervision.

Barriers and Challenges to Trauma-Informed Screening and Assessment

Barriers

It is not necessarily easy or obvious to identify an individual who has survived trauma without screening. Moreover, some clients may deny that they have encountered trauma and its effects even after being screened or asked direct questions aimed at identifying the occurrence of traumatic events. The two main barriers to the evaluation of trauma and its related disorders in behavioral health settings are clients not reporting trauma and providers overlooking trauma and its effects.

Concerning the first main barrier, some events will be experienced as traumatic by one person but considered nontraumatic by another. A history of trauma encompasses not only the experience of a potentially traumatic event, but also the person's responses to it and the meanings he or she attaches to the event. Certain situations make it more likely that the client will not be forthcoming about traumatic events or his or her responses to those events. Some clients might not have ever thought of a particular event or their response to it as traumatic and thus might not report or even recall the event. Some clients might feel a reluctance to discuss something that they sense might bring up uncomfortable feelings (especially with a counselor whom they've only recently met). Clients may avoid openly discussing traumatic events or have difficulty recognizing or articulating their experience of trauma for other reasons, such as feelings of shame, guilt, or fear of retribution by others associated with the event (e.g., in cases of interpersonal or

Common Reasons Why Some Providers Avoid Screening Clients for Trauma

Treatment providers may avoid screening for traumatic events and trauma-related symptoms due to:

- A reluctance to inquire about traumatic events and symptoms because these questions are not a part of the counselor's or program's standard intake procedures.
- Underestimation of the impact of trauma on clients' physical and mental health.
- A belief that treatment of substance abuse issues needs to occur first and exclusively, before treating other behavioral health disorders.
- A belief that treatment should focus solely on presenting symptoms rather than exploring the potential origins or aggravators of symptoms.
- A lack of training and/or feelings of incompetence in effectively treating trauma-related problems (Salyers, Evans, Bond, & Meyer, 2004).
- Not knowing how to respond therapeutically to a client's report of trauma.
- Fear that a probing trauma inquiry will be too disturbing to clients.
- Not using common language with clients that will elicit a report of trauma (e.g., asking clients if they were abused as a child without describing what is meant by abuse).
- Concern that if disorders are identified, clients will require treatment that the counselor or program does not feel capable of providing (Fallot & Harris, 2001).
- Insufficient time for assessment to explore trauma histories or symptoms.
- Untreated trauma-related symptoms of the counselor, other staff members, and administrators.

domestic violence). Still others may deny their history because they are tired of being interviewed or asked to fill out forms and may believe it doesn't matter anyway.

A client may not report past trauma for many reasons, including:

- Concern for safety (e.g., fearing more abuse by a perpetrator for revealing the trauma).
- Fear of being judged by service providers.
- Shame about victimization.
- Reticence about talking with others in response to trauma.
- Not recalling past trauma through dissociation, denial, or repression (although genuine blockage of all trauma memory is rare among trauma survivors; McNally, 2003).
- Lack of trust in others, including behavioral health service providers.
- Not seeing a significant event as traumatic.

Regarding the second major barrier, counselors and other behavioral health service providers may lack awareness that trauma can significantly affect clients' presentations in treatment and functioning across major life areas, such as relationships and work. In addition, some counselors may believe that their role is to treat only the presenting psychological and/or substance abuse symptoms, and thus they may not be as sensitive to histories and effects of trauma. Other providers may believe that a client should abstain from alcohol and drugs for an extended period before exploring trauma symptoms. Perhaps you fear that addressing a clients' trauma history will only exacerbate symptoms and complicate treatment. Behavioral health service providers who hold biases may assume that a client doesn't have a history of trauma and thus fail to ask the "right" questions, or they may be uncomfortable with emotions that arise from listening to client experiences and, as a result, redirect the screening or counseling focus.

Challenges

Awareness of acculturation and language

Acculturation levels can affect screening and assessment results. Therefore, indepth discussions may be a more appropriate way to gain an understanding of trauma from the client's point of view. During the intake, prior to trauma screening, determine the client's history of

Common Assessment Myths

Several common myths contribute to underassessment of trauma-related disorders (Najavits, 2004):

- ***Myth #1: Substance abuse itself is a trauma.*** However devastating substance abuse is, it does not meet the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), criteria for trauma per se. Nevertheless, high-risk behaviors that are more likely to occur during addiction, such as interpersonal violence and self-harm, significantly increase the potential for traumatic injury.
- ***Myth #2: Assessment of trauma is enough.*** Thorough assessment is the best way to identify the existence and extent of trauma-related problems. However, simply identifying trauma-related symptoms and disorders is just the first step. Also needed are individualized treatment protocols and action to implement these protocols.
- ***Myth #3: It is best to wait until the client has ended substance use and withdrawal to assess for PTSD.*** Research does not provide a clear answer to the controversial question of when to assess for PTSD; however, Najavits (2004) and others note that underdiagnosis of trauma and PTSD has been more significant in the substance abuse field than overdiagnosis. Clinical experience shows that the PTSD diagnosis is rather stable during substance use or withdrawal, but symptoms can become more or less intense; memory impairment from alcohol or drugs can also cloud the symptom picture. Thus, it is advisable to establish a tentative diagnosis and then reassess after a period of abstinence, if possible.

migration, if applicable, and primary language. Questions about the client's country of birth, length of time in this country, events or reasons for migration, and ethnic self-identification are also appropriate at intake. Also be aware that even individuals who speak English well might have trouble understanding the subtleties of questions on standard screening and assessment tools. It is not adequate to translate items simply from English into another language; words, idioms, and examples often don't translate directly into other languages and therefore need to be adapted. Screening and assessment should be conducted in the client's preferred language by trained staff members who speak the language or by professional translators familiar with treatment jargon.

Awareness of co-occurring diagnoses

A trauma-informed assessor looks for psychological symptoms that are associated with trauma or simply occur alongside it. Symptom screening involves questions about past or present mental disorder symptoms that may indicate the need for a full mental health assessment. A variety of screening tools are available, including symptom checklists. However, you should only use symptom checklists when you need information about how your client is currently feeling; don't use them to screen for specific disorders. Responses will likely change from one administration of the checklist to the next.

Basic mental health screening tools are available. For example, the Mental Health Screening Form-III screens for present or past symptoms of most mental disorders (Carroll & McGinley, 2001); it is available at no charge from Project Return Foundation, Inc. and is also reproduced in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c). Other screening tools, such as the Beck Depression Inventory II and the Beck Anxiety Inventory (Beck, Wright, Newman, & Liese, 1993), also screen broadly for mental and substance use disorders, as well as for specific disorders often associated with trauma. For further screening information and resources on depression and suicide, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008), and TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a).

For screening substance use disorders, see TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT, 1994); TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT, 1997a); TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT, 1999c); TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c); and TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d).

A common dilemma in the assessment of trauma-related disorders is that certain trauma symptoms are also symptoms of other disorders. Clients with histories of trauma typically present a variety of symptoms; thus, it is important to determine the full scope of symptoms and/or disorders present to help improve treatment planning. Clients with trauma-related and substance use symptoms and disorders are at increased risk for additional Axis I and/or Axis II mental disorders (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Cottler, Nishith, & Compton, 2001). These symptoms need to be distinguished so that other presenting subclinical features or disorders do not go unidentified and untreated. To accomplish this, a comprehensive assessment of the client's mental health is recommended.

Misdiagnosis and underdiagnosis

Many trauma survivors are either misdiagnosed (i.e., given diagnoses that are not accurate) or underdiagnosed (i.e., have one or more diagnoses that have not been identified at all). Such diagnostic errors could result, in part, from the fact that many general instruments to evaluate mental disorders are not sufficiently sensitive to identify posttraumatic symptoms and can misclassify them as other disorders, including personality disorders or psychoses. Intrusive posttraumatic symptoms, for example, can show up on general measures as indicative of hallucinations or obsessions. Dissociative symptoms can be interpreted as indicative of schizophrenia. Trauma-based cognitive symptoms can be scored as evidence for paranoia or other delusional processes (Briere, 1997). Some of the most common misdiagnoses in clients with PTSD and substance abuse are:

- ***Mood and anxiety disorders.*** Overlapping symptoms with such disorders as major depression, generalized anxiety disorder, and bipolar disorder can lead to misdiagnosis.
- ***Borderline personality disorder.*** Historically, this has been more frequently diagnosed than PTSD. Many of the symptoms, including a pattern of intense interpersonal relationships, impulsivity, rapid and unpredictable mood swings, power struggles in the treatment environment, underlying anxiety and depressive symptoms, and transient, stress-related paranoid ideation or severe dissociative symptoms overlap. The effect of this misdiagnosis on treatment can be particularly negative; counselors often view clients with a borderline personality diagnosis as difficult to treat and unresponsive to treatment.
- ***Antisocial personality disorder.*** For men and women who have been traumatized in childhood, "acting out" behaviors, a lack of empathy and conscience, impulsivity, and self-centeredness can be functions of trauma and survival skills rather than true antisocial characteristics.
- ***Attention deficit hyperactivity disorder (ADHD).*** For children and adolescents, impulsive behaviors and concentration problems can be diagnosed as ADHD rather than PTSD.

It is possible, however, for clients to legitimately have any of these disorders in addition to trauma-related disorders. Given the overlap of posttraumatic symptoms with those of other disorders, a wide variety of diagnoses often needs to be considered to avoid misidentifying

other disorders as PTSD and vice versa. A trained and experienced mental health professional will be required to weigh differential diagnoses. TIP 42 (CSAT, 2005c) explores issues related to differential diagnosis.

Cross-Cultural Screening and Assessment

Many trauma-related symptoms and disorders are culture specific, and a client's cultural background must be considered in screening and assessment (for review of assessment and cultural considerations when working with trauma, see Wilson & Tang, 2007). Behavioral health service providers must approach screening and assessment processes with the influences of culture, ethnicity, and race firmly in mind. Cultural factors, such as norms for expressing psychological distress, defining trauma, and seeking help in dealing with trauma, can affect:

- How traumas are experienced.
- The meaning assigned to the event(s).
- How trauma-related symptoms are expressed (e.g., as somatic expressions of distress, level of emotionality, types of avoidant behavior).
- Willingness to express distress or identify trauma with a behavioral health service provider and sense of safety in doing so.
- Whether a specific pattern of behavior, emotional expression, or cognitive process is considered abnormal.
- Willingness to seek treatment inside and outside of one's own culture.
- Response to treatment.
- Treatment outcome.

When selecting assessment instruments, counselors and administrators need to choose,

Culture-Specific Stress Responses

Culture-bound concepts of distress exist that don't necessarily match diagnostic criteria. Culture-specific symptoms and syndromes can involve physical complaints, broad emotional reactions, or specific cognitive features. Many such syndromes are unique to a specific culture but can broaden to cultures that have similar beliefs or characteristics. Culture-bound syndromes are typically treated by traditional medicine and are known throughout the culture. Cultural concepts of distress include:

- ***Ataques de nervios.*** Recognized in Latin America and among individuals of Latino descent, the primary features of this syndrome include intense emotional upset (e.g., shouting, crying, trembling, dissociative or seizure-like episodes). It frequently occurs in response to a traumatic or stressful event in the family.
- ***Nervios.*** This is considered a common idiom of distress among Latinos; it includes a wide range of emotional distress symptoms including headaches, nervousness, tearfulness, stomach discomfort, difficulty sleeping, and dizziness. Symptoms can vary widely in intensity, as can impairment from them. This often occurs in response to stressful or difficult life events.
- ***Susto.*** This term, meaning "fright," refers to a concept found in Latin American cultures, but it is not recognized among Latinos from the Caribbean. *Susto* is attributed to a traumatic or frightening event that causes the soul to leave the body, thus resulting in illness and unhappiness; extreme cases may result in death. Symptoms include appetite or sleep disturbances, sadness, lack of motivation, low self-esteem, and somatic symptoms.
- ***Taijin kyofusho.*** Recognized in Japan and among some American Japanese, this "interpersonal fear" syndrome is characterized by anxiety about and avoidance of interpersonal circumstances. The individual presents worry or a conviction that his or her appearance or social interactions are inadequate or offensive. Other cultures have similar cultural descriptions or syndromes associated with social anxiety.

Sources: APA, 2013, pp. 833–837; Briere & Scott, 2006b.

whenever possible, instruments that are culturally appropriate for the client. Instruments that have been normed for, adapted to, and tested on specific cultural and linguistic groups should be used. Instruments that are not normed for the population are likely to contain cultural biases and produce misleading results. Subsequently, this can lead to misdiagnosis, overdiagnosis, inappropriate treatment plans, and ineffective interventions. Thus, it is important to interpret all test results cautiously and to discuss the limitations of instruments with clients from diverse ethnic populations and cultures. For a review of cross-cultural screening and assessment considerations, refer to the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration, planned c).

Choosing Instruments

Numerous instruments screen for trauma history, indicate symptoms, assess trauma-related and other mental disorders, and identify related clinical phenomena, such as dissociation. One instrument is unlikely to meet all screening or assessment needs or to determine the existence and full extent of trauma symptoms and traumatic experiences. The following sections present general considerations in selecting standardized instruments.

Purpose

Define your assessment needs. Do you need a standardized screening or assessment instrument for clinical purposes? Do you need information on a specific aspect of trauma, such as history, PTSD, or dissociation? Do you wish to make a formal diagnosis, such as PTSD? Do you need to determine quickly whether a client has experienced a trauma? Do you want an assessment that requires a clinician to administer it, or can the client complete the instrument himself or herself? Does the instrument match the current and specific diagnostic criteria established in the DSM-5?

Population

Consider the population to be assessed (e.g., women, children, adolescents, refugees, disaster survivors, survivors of physical or sexual violence, survivors of combat-related trauma, people whose native language is not English); some tools are appropriate only for certain populations. Is the assessment process developmentally and culturally appropriate for your client? Exhibit 1.4-2 lists considerations in choosing a screening or assessment instrument for trauma and/or PTSD.

Instrument Quality

An instrument should be psychometrically adequate in terms of sensitivity and specificity or reliability and validity as measured in several ways under varying conditions. Published research offers information on an instrument's psychometric properties as well as its utility in both research and clinical settings. For further information on a number of widely used trauma evaluation tools, see Appendix D and Antony, Orsillo, and Roemer's paper (2001).

The DSM-5 and Updates to Screening and Assessment Instruments

The recent publication of the DSM-5 (APA, 2013a) reflects changes to certain diagnostic criteria, which will affect screening tools and criteria for trauma-related disorders. Criterion A2 (specific to traumatic stress disorders, acute stress, and posttraumatic stress disorders), included in the fourth edition (text revision) of the DSM (DSM-IV-TR; APA, 2000a), has been eliminated; this criterion stated that the individual's response to the trauma needs to involve intense fear, helplessness, or horror. There are now four cluster symptoms, not three: reexperiencing, avoidance, arousal, and persistent negative alterations in cognitions and mood. Changes to the DSM-5 were made to symptoms within each cluster. Thus, screening will need modification to adjust to this change (APA, 2012b).

Exhibit 1.4-2: Key Areas of Trauma Screening and Assessment

Trauma
Key question: Did the client experience a trauma?

Examples of measures: Life Stressor Checklist-Revised (Wolfe & Kimerling, 1997); Trauma History Questionnaire (Green, 1996); Traumatic Life Events Questionnaire (Kubany et al., 2000).

Note: A good trauma measure identifies events a person experienced (e.g., rape, assault, accident) and also evaluates other trauma-related symptoms (e.g., presence of fear, helplessness, or horror).

Acute Stress Disorder (ASD) and PTSD
Key question: Does the client meet criteria for ASD or PTSD?

Examples of measures: Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990); Modified PTSD Symptom Scale (Falsetti, Resnick, Resnick, & Kilpatrick, 1993); PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993); Stanford Acute Stress Reaction Questionnaire (Cardena, Koopman, Classen, Waelde, & Spiegel, 2000).

Note: A PTSD diagnosis requires the person to meet criteria for having experienced a trauma; some measures include this, but others do not and require use of a separate trauma measure. The CAPS is an interview; the others listed are self-report questionnaires and take less time.

Other Trauma-Related Symptoms
Key question: Does the client have other symptoms related to trauma? These include depressive symptoms, self-harm, dissociation, sexuality problems, and relationship issues, such as distrust.

Examples of measures: Beck Depression Inventory II (Beck, 1993; Beck et al., 1993); Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993); Impact of Event Scale (measures intrusion and avoidance due to exposure to traumatic events; Horowitz, Wilner, & Alvarez, 1979; Weiss & Marmar, 1997); Trauma Symptom Inventory (Briere, 1995); Trauma Symptom Checklist for Children (Briere, 1996b); Modified PTSD Symptom Scale (Falsetti et al., 1993).

Note: These measures can be helpful for clinical purposes and for outcome assessment because they gauge *levels* of symptoms. Trauma-related symptoms are broader than diagnostic criteria and thus useful to measure, even if the patient doesn't meet criteria for any specific diagnoses.

Other Trauma-Related Diagnoses
Key question: Does the client have other disorders related to trauma? These include mood disorders, anxiety disorders besides traumatic stress disorders, and dissociative disorders.

Examples of measures: Mental Health Screening Form III (Carroll & McGinley, 2001); The Mini-International Neuropsychiatric Interview (M.I.N.I.) Structured Clinical Interview for DSM-IV-TR, Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011); Structured Clinical Interview for DSM-IV-TR, Non-Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011a).

Note: For complex symptoms and diagnoses such as dissociation and dissociative disorders, interviews are recommended. Look for measures that incorporate DSM-5 criteria.

Sources: Antony et al., 2001; Najavits, 2004.

Practical Issues

Is the instrument freely and readily available, or is there a fee? Is costly and extensive training required to administer it? Is the instrument too lengthy to be used in the clinical setting? Is it easily administered and scored with accompanying manuals and/or other training materials? How will results be presented to or used with the client? Is technical support available for difficulties in administration, scoring, or interpretation of results? Is special equipment required such as a microphone, a video camera, or a touch-screen computer with audio?

Trauma-Informed Screening and Assessment

The following sections focus on initial screening. For more information on screening and assessment tools, including structured interviews, see Exhibit 1.4-2. Screening is only as good as the actions taken afterward to address a positive screen (when clients acknowledge that they experience symptoms or have encountered events highlighted within the screening). Once a screening is complete and a positive screen is acquired, the client then needs referral for a more indepth assessment to ensure development of an appropriate treatment plan that matches his or her presenting problems.

Establish a History of Trauma

A person cannot have ASD, PTSD, or any trauma-related symptoms without experiencing trauma; therefore, it is necessary to inquire about painful, difficult, or overwhelming past experiences. Initial information should be gathered in a way that is minimally intrusive yet clear. Brief questionnaires can be less threatening to a client than face-to-face interviews, but interviews should be an integral part of any screening and assessment process. If the client initially denies a history of trauma (or minimizes it), administer the questionnaire later or delay additional trauma-related questions until the client has perhaps developed more trust in the treatment setting and feels safer with the thoughts and emotions that might arise in discussing his or her trauma experiences.

The Stressful Life Experiences (SLE) screen (Exhibit 1.4-3) is a checklist of traumas that also considers the client's view of the impact of those events on life functioning. Using the SLE can foster the client–counselor relationship. By going over the answers with the client, you can gain a deep understanding of your client, and the client receives a demonstration of your sensitivity and concern for what the client has experienced. The National Center for PTSD Web site offers similar instruments (http://www.ptsd.va.gov/professional/pages/assessments/assessment.asp).

In addition to broad screening tools that capture various traumatic experiences and symptoms, other screening tools, such as the Combat Exposure Scale (Keane et al., 1989) and the Intimate Partner Violence Screening Tool (Exhibit 1.4-4), focus on acknowledging a specific type of traumatic event.

Screen for Trauma-Related Symptoms and Disorders in Clients With Histories of Trauma

This step evaluates whether the client's trauma resulted in subclinical or diagnosable disorders. The counselor can ask such questions as, "Have you received any counseling or therapy? Have you ever been diagnosed or treated for a psychological disorder in the past? Have you ever been prescribed medications for your emotions in the past?" Screening is typically conducted by a wide variety of behavioral health service providers with different levels of training and education; however, all

Exhibit 1.4-3: SLE Screening

Please fill in the number that best represents how much the following statements describe your experiences. You will need to use two scales, one for how well the statement describes your experiences and one for how stressful you found this experience. The two scales are below.

Describes your Experience:

0	1	2	3	4	5	6	7	8	9	10
Did not experience this	a little like my experiences				somewhat like my experiences					exactly like my experiences

Stressfulness of Experience:

0	1	2	3	4	5	6	7	8	9	10
Not at all stressful	not very stressful				somewhat stressful					extremely stressful

Describes your Experience	Life Experience	Stressfulness Then		Stressfulness Now
	I have witnessed or experienced a natural disaster; like a hurricane or earthquake.			
	I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.			
	I have witnessed or experienced a serious accident or injury.			
	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.			
	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.			
	I have witnessed or experienced the death of my spouse or child.			
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).			
	I or a close friend or family member has been kidnapped or taken hostage.			
	I or a close friend or family member has been the victim of a terrorist attack or torture.			
	I have been involved in combat or a war or lived in a war affected area.			
	I have seen or handled dead bodies other than at a funeral.			
	I have felt responsible for the serious injury or death of another person.			
	I have witnessed or been attacked with a weapon other than in combat or family setting			
	As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury			
	As an adult, I was hit, choked or pushed hard enough to cause injury.			
	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.			
	As a child/teen I was forced to have unwanted sexual contact.			
	As an adult I was forced to have unwanted sexual contact.			
	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact			
	I have witnessed or experienced an extremely stressful event not already mentioned. Please Explain:_____ _____			

Sources: Hudnall Stamm, 1996, 1997. Used with permission.

Exhibit 1.4-4: STaT Intimate Partner Violence Screening Tool

1. Have you ever been in a relationship where your partner has pushed or **Slapped** you?
2. Have you ever been in a relationship where your partner **Threatened** you with violence?
3. Have you ever been in a relationship where your partner has thrown, broken, or punched **Things**?

Source: Paranjape & Liebschutz, 2003. Used with permission

individuals who administer screenings, regardless of education level and experience, should be aware of trauma-related symptoms, grounding techniques, ways of creating safety for the client, proper methods for introducing screening tools, and the protocol to follow when a positive screen is obtained. (See Appendix D for information on specific instruments.) Exhibit 1.4-5 is an example of a screening instrument for trauma symptoms, the Primary Care PTSD (PC-PTSD) Screen. Current research (Prins et al., 2004) suggests that the optimal cutoff score for the PC-PTSD is 3. If sensitivity is of greater concern than efficiency, a cutoff score of 2 is recommended.

Exhibit 1.4-5: PC-PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…

1. Have had nightmares about it or thought about it when you did not want to?
   YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES NO
3. Were constantly on guard, watchful, or easily startled?
   YES NO
4. Felt numb or detached from others, activities, or your surroundings?
   YES NO

Source: Prins et al., 2004. Material used is in the public domain.

Another instrument that can screen for traumatic stress symptoms is the four-item self-report SPAN, summarized in Exhibit 1.4-6, which is derived from the 17-item Davidson Trauma Scale (DTS). SPAN is an acronym for the four items the screening addresses: startle, physiological arousal, anger, and numbness. It was developed using a small, diverse sample of adult patients (N=243; 72 percent women; 17.4 percent African American; average age = 37 years) participating in several clinical studies, including a family study of rape trauma, combat veterans, and Hurricane Andrew survivors, among others.

The SPAN has a high diagnostic accuracy of 0.80 to 0.88, with sensitivity (percentage of true positive instances) of 0.84 and specificity (percentage of true negative instances) of 0.91 (Meltzer-Brody, Churchill, & Davidson, 1999). SPAN scores correlated highly with the full DTS (r = 0.96) and other measures, such as the Impact of Events Scale (r = 0.85) and the Sheehan Disability Scale (r = 0.87).

The PTSD Checklist (Exhibit 1.4-7), developed by the National Center for PTSD, is in the public domain. Originally developed for combat veterans of the Vietnam and Persian

Exhibit 1.4-6: The SPAN

The SPAN instrument is a brief screening tool that asks clients to identify the trauma in their past that is most disturbing to them currently. It then poses four questions that ask clients to rate the frequency and severity with which they have experienced, in the past week, different types of trauma-related symptoms (startle, physiological arousal, anger, and numbness).

To order this screening instrument, use the following contact information:
Multi-Health Systems, Inc.
P.O. Box 950
North Tonawanda, NY
14120-0950
Phone: 800-456-3003

Source: Meltzer-Brody et al., 1999.

Exhibit 1.4-7: The PTSD Checklist

Instructions to Client: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully and circle the number that indicates how much you have been bothered by that problem *in the past month*.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
2. Repeated, disturbing dreams of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
4. Feeling very upset when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
7. Avoiding activities or situations because they reminded you of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
8. Trouble remembering important parts of a stressful experience?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
9. Loss of interest in activities that you used to enjoy?
   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
10. Feeling distant or cut off from other people?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
12. Feeling as if your future will somehow be cut short?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
13. Trouble falling or staying asleep?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
14. Feeling irritable or having angry outbursts?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
15. Having difficulty concentrating?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
16. Being "super-alert" or watchful or on guard?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely
17. Feeling jumpy or easily startled?
    1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Source: Weathers et al., 1993. Material used is in the public domain.

Gulf Wars, it has since been validated on a variety of noncombat traumas (Keane, Brief, Pratt, & Miller, 2007). When using the checklist, identify a specific trauma first and then have the client answer questions in relation to that one specific trauma.

Other Screening and Resilience Measures

Along with identifying the presence of trauma-related symptoms that warrant assessment to determine the severity of symptoms as well as whether or not the individual possesses subclinical symptoms or has met criteria for a trauma-related disorder, clients should receive other screenings for symptoms associated with trauma (e.g., depression, suicidality). It is important that screenings address both external and internal resources (e.g., support systems, strengths, coping styles). Knowing the client's strengths can significantly shape the treatment planning process by allowing you to use strategies that have already worked for the client and incorporating strategies to build resilience (Exhibit 1.4-8).

Exhibit 1.4-8: Resilience Scales

A number of scales with good psychometric properties measure resilience:

- Resilience Scale (Wagnild & Young, 1993)
- Resilience Scale for Adults (Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003)
- Connor Davidson Resilience Scale, 25-,10-, and 2-Item (Connor & Davidson, 2003; Campbell-Sills & Stein, 2007; Vaishnavi, Connor, & Davidson, 2007, respectively)
- Dispositional Resilience Scale, 45-,30-, 15-item forms (Bartone, Roland, Picano, &Williams, 2008)

Preliminary research shows improvement of individual resilience through treatment interventions in other populations (Lavretsky, Siddarth, & Irwin, 2010).

Screen for suicidality

All clients—particularly those who have experienced trauma—should be screened for suicidality by asking, "In the past, have you ever had suicidal thoughts, had intention to commit suicide, or made a suicide attempt? Do you have any of those feelings now? Have you had any such feelings recently?" Behavioral health service providers should receive training to screen for suicide. Additionally, clients with substance use disorders and a history of psychological trauma are at heightened risk for suicidal thoughts and behaviors; thus, screening for suicidality is indicated. See TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a). For additional descriptions of screening processes for suicidality, see TIP 42 (CSAT, 2005c).

Concluding Note

Screenings are only beneficial if there are follow-up procedures and resources for handling positive screens, such as the ability to review results with and provide feedback to the individual after the screening, sufficient resources to complete a thorough assessment or to make an appropriate referral for an assessment, treatment planning processes that can easily incorporate additional trauma-informed care objectives and goals, and availability and access to trauma-specific services that match the client's needs. Screening is only the first step!

5 Clinical Issues Across Services

IN THIS CHAPTER

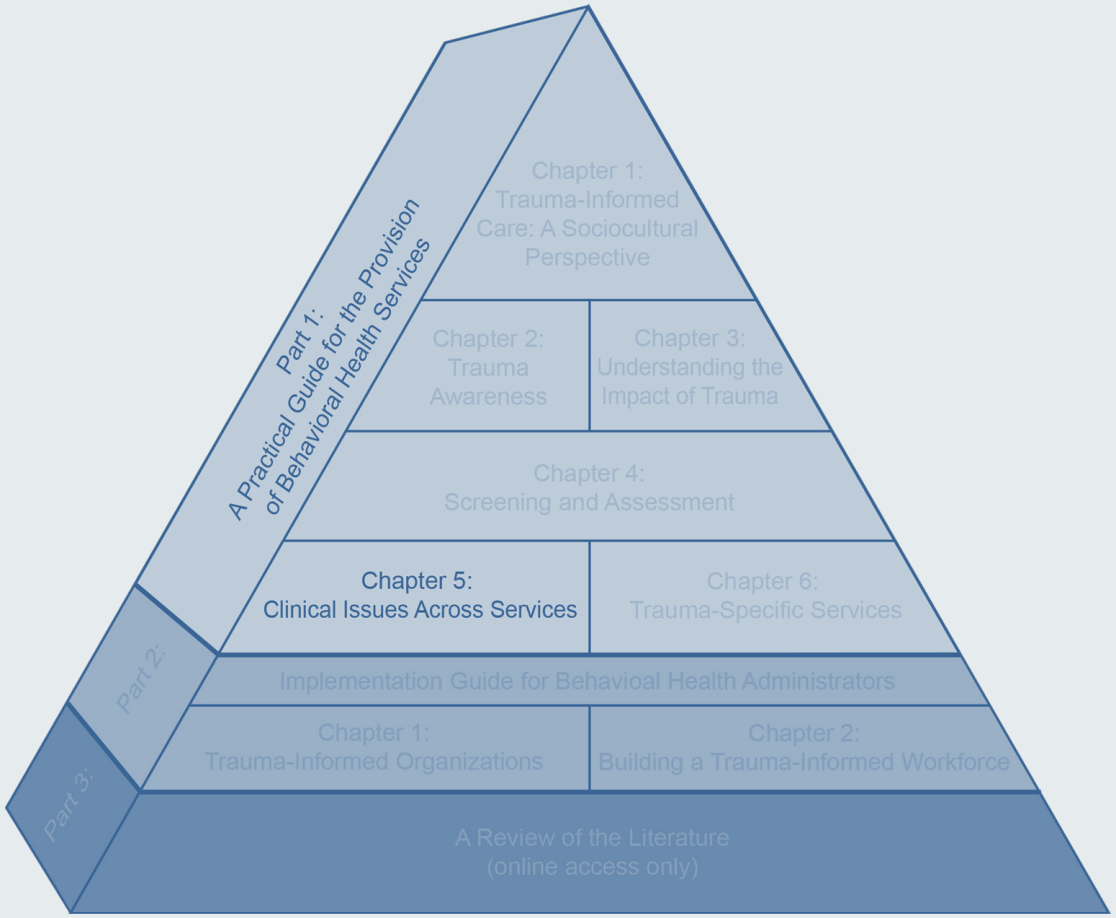
- Trauma Informed Prevention and Treatment Objectives
- Treatment Issues
- Making Referrals to Trauma Specific Services

Many clients in behavioral health treatment may have histories of trauma, so counselors should be prepared to help them address issues that arise from those histories. This chapter begins with a thorough discussion of trauma-informed prevention and treatment objectives along with practical counselor strategies. Specific treatment issues related to working with trauma survivors in a clinical setting are discussed as well, including client engagement, pacing and timing, traumatic memories, and culturally appropriate and gender-responsive services. The chapter ends with guidelines for making referrals to trauma-specific services.

Trauma-Informed Prevention and Treatment Objectives

Trauma-informed care (TIC) not only focuses on identifying individuals who have histories of trauma and traumatic stress symptoms; it also places considerable effort in creating an environment that helps them recognize the impact of trauma and determine the next course of action in a safe place. For some individuals, psychoeducation and development or reinforcement of coping strategies will be the most suitable and effective strategy, whereas others may request or warrant a referral for more trauma-specific interventions (see Part 1, Chapter 6, of this Treatment Improvement Protocol [TIP]). Although research is limited in the area of building resilience to prevent exacerbation of trauma symptoms and traumatic stress disorders, TIC also focuses on prevention strategies to avoid retraumatization in treatment, to promote resilience, and to prevent the development of trauma-related disorders. The following sections highlight key trauma-informed prevention and treatment objectives.

TIC Framework in Behavioral Health Services—Clinical Issues Across Services



Establish Safety

Beyond identifying trauma and trauma-related symptoms, the initial objective of TIC is establishing safety. Borrowing from Herman's (1992) conceptualization of trauma recovery, safety is the first goal of treatment. Establishing safety is especially crucial at the outset of trauma-informed treatment and often becomes a recurrent need when events or therapeutic changes raise safety issues, such as a change in treatment staffing due to vacations.

In the context of TIC, safety has a variety of meanings. Perhaps most importantly, the client has to have some degree of ***safety from trauma symptoms***. Recurring intrusive nightmares; painful memories that burst forth seemingly without provocation; feelings of sadness, anger, shame, or being overwhelmed; or not having control over sudden disconnections from others make moment-to-moment living feel unsafe. Clients might express feeling unsafe through statements such as, "I can't control my feelings," or, "I just space out and disconnect from the world for no reason," or, "I'm afraid to go to sleep because of the nightmares." The intense feelings that accompany trauma can also make clients feel unsafe. They may wake up in the morning feeling fine but become immobilized by depression as the day progresses. Clients with histories of trauma may experience panicky feelings of being trapped or abandoned. An early effort in trauma treatment is thus helping the client

Advice to Counselors: Strategies To Promote Safety

Strategy #1: Teach clients how and when to use grounding exercises when they feel unsafe or overwhelmed.

Strategy #2: Establish some specific routines in individual, group, or family therapy (e.g., have an opening ritual or routine when starting and ending a group session). A structured setting can provide a sense of safety and familiarity for clients with histories of trauma.

Strategy #3: Facilitate a discussion on safe and unsafe behaviors. Have clients identify, on paper, behaviors that promote safety and behaviors that feel unsafe for them today.

Strategy #4: Refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (Najavits, 2002a). This menu-based manual covers an array of treatment topics, including the core concept of safety. Each topic consists of several segments, including preparing for the session, session format, session content, handouts, and guidelines.

Strategy #5: Encourage the development of a safety plan. Depending on the type of trauma, personal safety can be an issue; work with the client to develop a plan that will help him or her feel in control and prepared for the unexpected. If the trauma was a natural or human-caused disaster, encourage thinking about how family and friends will respond and connect in the event of another crisis. If sexual abuse or rape was the event, encourage thinking about future steps that could help make the client safer. There is a delicate balance between preparation and the realization that one cannot prepare for all possible traumatic events. Nonetheless, an action plan can help the client regain a sense of environmental balance.

gain more control over trauma symptoms (and be able to label them as such) by learning more about the client and helping him or her develop new coping skills to handle symptoms when they arise and stay more grounded when flooded with feelings or memories.

A second aspect is ***safety in the environment***. Trauma reactions can be triggered by sudden loud sounds (e.g., television at high volume, raised voices), tension between people, certain smells, or casual touches that are perceived as invasions of physical boundaries. The vulnerability of exposing one's history in the treatment setting can manifest in the client as feeling physically vulnerable and unsafe in the treatment environment. Sudden or inadequately explained treatment transitions, such as moving from one level of treatment to another or changing counselors, can also evoke feelings of danger, abandonment, or instability. Early in treatment, trauma survivors generally value routine and predictability. The counselor should recognize these needs and respond appropriately by offering information in advance, providing nonshaming responses to a client's reactions to stimuli in his or her environment, and helping the client build a daily structure that feels safe.

A third aspect of safety is ***preventing a recurrence of trauma***. People with histories of trauma and substance abuse are more likely to engage in high-risk behaviors and to experience subsequent traumas. Early treatment should focus on helping clients stop using unsafe coping mechanisms, such as substance abuse, self-harm, and other self-destructive behaviors, and replacing them with safe and healthy coping strategies. Helping clients learn to protect themselves in reasonable ways is a positive goal of treatment.

Prevent Retraumatization

A key objective in TIC is to prevent retraumatization generated by intervention and treatment practices and policies. Unfortunately, treatment settings and clinicians can

Advice to Counselors: Strategies To Prevent Retraumatization

Strategy #1: Be sensitive to the needs of clients who have experienced trauma regarding behaviors in the treatment setting that might trigger memories of the trauma.

Strategy #2: Do not ignore clients' symptoms and demands when clients with trauma histories act out in response to triggered trauma memories; doing so may replicate the original traumatic experience.

Strategy #3: Be mindful that efforts to control and contain a client's behaviors in treatment can produce an abnormal reaction, particularly for trauma survivors for whom being trapped was part of the trauma experience.

Strategy #4: Listen for specific triggers that seem to be driving the client's reaction. An important step in recovery is helping the client identify these cues and thereby reach a better understanding of reactions and behaviors.

unintentionally create retraumatizing experiences (for a review of traumas that can occur when treating serious mental illness, see Frueh et al., 2005). For instance, compassionate inquiry into a client's history can seem similar to the interest shown by a perpetrator many years before. Direct confrontation by counselors about behaviors related to substance abuse can be seen, by someone who has been repeatedly physically assaulted, as provocation building up to assault. Counselor and program efforts to help clients constrain destructive behaviors can be interpreted as efforts to control and dominate the individual. Intrusive shaming or insensitive behavior demonstrated by another client in the program can threaten a trauma survivor whose boundaries have been disregarded in the past—thus making the experience of treatment feel dangerous rather than safe. Some staff and agency issues that can result in retraumatization include:

- Disrespectfully challenging reports of abuse or other traumatic events.
- Discounting a client's report of a traumatic event.
- Using isolation.
- Using physical restraints.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling intense rage and other feelings as pathological.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate and/or disrespectful manner.
- Having clients undress in the presence of others.
- Being insensitive to a client's physical or emotional boundaries.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Applying rigid agency policies or rules without an opportunity for clients to question them.
- Accepting agency dysfunction, including a lack of consistent, competent leadership.

Provide Psychoeducation

Trauma-informed education informs clients about traumatic stress and trauma-related symptoms and disorders as well as the related consequences of trauma exposure. It focuses on giving information to clients to help normalize presenting symptoms, to highlight potential short-term and long-term consequences of trauma and various paths to recovery, and to underscore the message that recovery is possible. Education frequently takes place prior to or immediately following an initial screening as a way to prepare clients

Advice to Counselors: Strategies To Implement Psychoeducation

Strategy #1: Remember that this may be the client's first experience with treatment. It's easy to use program or clinical jargon when you're around it every day, but most individuals who seek help are unfamiliar with clinical language, how the program works, and treatment objectives. Psychoeducation begins with understanding the client's expectations and reasons for seeking help, followed by educating the client and other family members about the program. Remember that this is all new for them.

Strategy #2: After obtaining acknowledgment of a trauma history, provide an overview of common symptoms and consequences of traumatic stress, regardless of whether the client affirms having trauma-related symptoms. It is equally important to educate the client on resilience factors associated with recovery from trauma (Wessely et al., 2008). A trauma-informed perspective provides a message that trauma reactions are normal responses to an abnormal situation.

Strategy #3: Develop a resource box that provides an array of printed or multimedia educational materials that address the program, specific symptoms and tools to combat trauma-related symptoms, treatment options and therapy approaches, advantages of peer support, and steps in developing specific coping strategies.

Strategy #4: Develop a rotating educational group that matches services and client schedules to complement treatment. Remember that education can play a pivotal role in enhancing motivation, in normalizing experiences, and in creating a sense of safety as individuals move further into treatment. For some survivors, education can be a powerful intervention or prevention strategy.

for hearing results or to place the screening and subsequent assessment findings in proper context. Education in and of itself, however, does not necessarily constitute a stand-alone treatment; rather, it can be conceptualized as a first step and/or component of more comprehensive treatment. Nonetheless, education may be a prevention and intervention strategy for individuals who have histories of trauma without current consequences or symptoms and/or those who have reported a resolution of past trauma(s). For example, some clients may have significantly delayed onset of traumatic stress symptoms. In this scenario, earlier education can enhance recognition of symptoms and ease the path of seeking treatment.

Some clients do not recognize the link between their current difficulties and their trauma histories; education can help them understand the possible origin of their difficulties. Psychoeducation presents trauma-related symptoms that follow a trauma as normal reactions. By identifying the source of clients' current difficulties and framing them as normal thoughts, emotions, and behaviors in response to trauma, many trauma survivors report a reduction in the intensity of the difficulties or symptoms. Often, a client will express relief that his or her reactions are normal. You may find the U.S. Department of Veterans Affairs (VA) National Center on PTSD's educational handouts on traumatic stress reactions useful.

Psychoeducation goes beyond the identification of traumatic stress symptoms and/or learning about the psychological, cognitive, and physical impacts of trauma. Numerous curricula are available that use psychoeducation as a first-line or complementary approach to trauma-specific therapies to enhance coping strategies in key areas, including safety, emotional regulation, help-seeking, avoidant behavior, and so forth. An example is S.E.L.F., a trauma-informed psychoeducational group curriculum with educational components related to trauma recovery in the following

Case Illustration: Linda

Linda served as an Army nurse in an evacuation hospital in Vietnam. She reported her postdeployment adjustment as difficult and isolating but denied any significant symptoms of traumatic stress throughout her life. Four years ago, Linda sought treatment for alcohol dependence; during the intake, she recalls denying trauma-related symptoms. "I distinctly remember the session," she recounts. "The counselor first took my history but then gave information on typical symptoms and reactions to trauma. I thought, 'Why do I need to hear this? I've survived the worst trauma in my life.' I didn't see the value of this information. Then 3 weeks ago, I began to have recurrent nightmares, the same graphic type I occasionally had when I was in Vietnam. Since then, I've been very anxious, reliving horrible scenes that I'd experienced as a nurse and postponing going to bed in fear of having the dreams again. I didn't understand it. I am 70 years old, and the war happened a long time ago. Then I began putting it together. Recently, the emergency helicopter flight pattern and approach to the area's hospital changed. I began hearing the helicopter periodically in my living room, and it reminded me of Vietnam. I knew then that I needed help; I couldn't stop shaking. I felt as if I was losing control of my emotions. I remembered how the intake counselor took the time to explain common symptoms of trauma. That's why I'm here today."

"This might not sound like a big deal, but for many people relationships have become all about getting: telling your problem story and then getting help with it. There is little, if any, emphasis placed on giving back. That's a big deal!!! Service relationships are like a one way street and both people's roles are clearly defined. But in 'regular' relationships in your community, people give and take all the time. No one is permanently on the taking side or the giving side. This exchange contributes to people feeling ok about being vulnerable (needing help) as well as confident about what they're offering. For many of us, being the role of 'getter' all the time has shaken our confidence, making us feel like we have nothing worthwhile to contribute. Peer support breaks that all down. It gets complicated somewhat when one of us is paid, but modeling this kind of relationship in which both of us learn, offers us the real practice we need to feel like a 'regular' community member as opposed to an 'integrated mental patient'."

(Mead, 2008, p.7)

areas: creating **S**afety, regulating **E**motions, addressing **L**oss, and redefining the **F**uture (Bloom, Foderaro, & Ryan, 2006).

Offer Trauma-Informed Peer Support

Living with a history of trauma can be isolating and consuming. The experience of trauma can reinforce beliefs about being different, alone, and marred by the experience. At times, behavioral health treatment for trauma-related effects can inadvertently reinforce these beliefs. Simply engaging in treatment or receiving specialized services (although warranted) can further strengthen clients' beliefs that there is something wrong with them. Formalized peer support can enhance the treatment experience. Treatment plus peer support can break the cycle of beliefs that reinforce traumatic stress (e.g., believing that one is permanently damaged; that nobody could understand; that no one should or could tolerate one's story). Peer support provides opportunities to form mutual relationships; to learn how one's history shapes perspectives of self, others, and the future; to move beyond trauma; and to mirror and learn alternate coping strategies. Peer support defines recovery as an

Advice to Counselors: Strategies To Enhance Peer Support

Strategy #1: Provide education on what peer support is and is not. Roles and expectations of peer support can be confusing, so providing clarification in the beginning can be quite useful. It is important to provide initial education about peer support and the value of using this resource.

Strategy #2: Use an established peer support curriculum to guide the peer support process. For example, *Intentional Peer Support: An Alternative Approach* (Mead, 2008) is a workbook that highlights four main tasks for peer support: building connections, understanding one's worldview, developing mutuality, and helping each other move toward set desires and goals. This curriculum provides extensive materials for peer support staff members as well as for the individuals seeking peer support.

interactive process, not as a definitive moment wherein someone fixes the "problem."

Normalize Symptoms

Symptoms of trauma can become serious barriers to recovery from substance use and mental disorders, including trauma-related ones. Counselors should be aware of how trauma symptoms can present and how to respond to them when they do appear. A significant step in addressing symptoms is normalizing them. People with traumatic stress symptoms need to know that their symptoms are not unique and that their reactions are common to their experience(s). Often, normalizing symptoms gives considerable relief to clients who may have thought that their symptoms signified some pervasive, untreatable mental disorder.

Advice to Counselors: Strategies To Normalize Symptoms

Strategy #1: Provide psychoeducation on the common symptoms of traumatic stress.

Strategy #2: Research the client's most prevalent symptoms specific to trauma, and then provide education to the client. For example, an individual who was conscious and trapped during or as a result of a traumatic event will more likely be hypervigilant about exits, plan escape routes even in safe environments, and have strong reactions to interpersonal and environmental situations that are perceived as having no options for avoidance or resolution (e.g., feeling stuck in a work environment where the boss is emotionally abusive).

Strategy #3: First, have the client list his or her symptoms. After each symptom, ask the client to list the negative and positive consequences of the symptom. Remember that symptoms serve a purpose, even if they may not appear to work well or work as well as they had in the past. Focus on how the symptoms have served the client in a positive way (see Case Illustration: Hector). This exercise can be difficult, because clients as well as counselors often don't focus on the value of symptoms.

Case Illustration: Hector

Hector was referred to a halfway house specializing in co-occurring disorders after inpatient treatment for methamphetamine dependence and posttraumatic stress disorder (PTSD). In the halfway house, he continued to feel overwhelmed with the frequency and intensity of flashbacks. He often became frustrated, expressing anger and a sense of hopelessness, followed by emotional withdrawal from others in the house. Normalization strategy #3 was introduced in the session. During this exercise, he began to identify many negative aspects of flashbacks. He felt that he couldn't control the occurrence of flashbacks even though he wanted to, and he realized that he often felt shame afterward. In the same exercise, he was also urged to identify positive aspects of flashbacks. Although this was difficult, he realized that flashbacks were clues about content that he needed to address in trauma-specific treatment. "I realized that a flashback, for me, was a billboard advertising what I needed to focus on in therapy."

Identify and Manage Trauma-Related Triggers

Many clients who have traumatic stress are caught off guard with intrusive thoughts, feelings, sensations, or environmental cues of the trauma. This experience can be quite disconcerting, but often, the individual does not draw an immediate connection between the internal or external trigger and his or her reactions. At other times, the trigger is so potent that the individual is unable to discern the present trigger from the past trauma and begins to respond as if the trauma is reoccurring.

Key steps in identifying triggers are to reflect back on the situation, surroundings, or sensations prior to the strong reaction. By doing so, you and your client may be able to determine the connections among these cues, the past trauma(s), and the client's reaction. Once the cue is identified, discuss the ways in which it is connected to past trauma. For some cues, there will be an obvious and immediate connection (e.g., having someone say "I love you" in a significant relationship as an adult and connecting this to an abuser who said the same thing prior to a sexual assault). Other

Advice to Counselors: Strategies To Identify and Manage Trauma-Related Triggers

Strategy #1: Use the Sorting the Past From the Present technique for cognitive realignment (Blackburn, 1995) to help separate the current situation from the past trauma. Identify one trigger at a time, and then discuss the following questions with the client:

- When and where did you begin to notice a reaction?
- How does this situation remind you of your past history or past trauma?
- How are your reactions to the current situation similar to your past reactions to the trauma(s)?
- How was this current situation different from the past trauma?
- How did you react differently to the current situation than to the previous trauma?
- How are you different today (e.g., factors such as age, abilities, strength, level of support)?
- What choices can you make that are different from the past and that can help you address the current situation (trigger)?

After reviewing this exercise several times in counseling, put the questions on a card for the client to carry and use outside of treatment. Clients with substance use disorders can benefit from using the same questions (slightly reworded) to address relapse triggers.

Strategy #2: After the individual identifies the trigger and draws connections between the trigger and past trauma, work with him or her to establish responses and coping strategies to deal with triggers as they occur. Initially, the planned responses will not immediately occur after a trigger, but with practice, the planned responses will move closer to the time of the trigger. Some strategies include an acronym that reflects coping strategies (Exhibit 1.5-1), positive self-talk generated by cognitive–behavioral covert modeling exercises (rehearsal of coping statements), breathing retraining, and use of support systems (e.g., calling someone).

Strategy #3: Self-monitoring is any strategy that asks a client to observe and record the number of times something happens, to note the intensity of specific experiences, or to describe a specific behavioral, emotional, or cognitive phenomenon each time it occurs. For individuals with histories of trauma, triggers and flashbacks can be quite frightening, intense, and powerful. Even if the client has had just one or two triggers or flashbacks, he or she may perceive flashbacks as happening constantly. Often, it takes time to recover from these experiences. Using self-monitoring and asking the client to record each time a trigger occurs, along with describing the trigger and its intensity level (using a scale from 1–10), clients and counselors will gain an understanding of the type of triggers present and the level of distress that each one produces. Moreover, the client may begin to see that the triggers don't actually happen all the time, even though they may seem to occur frequently.

Exhibit 1.5-1: The OBSERVATIONS Coping Strategy

- Take a moment to just ***Observe*** what is happening. Pay attention to your body, your senses, and your environment.
- Focus on your ***Breathing***. Allow your feelings and sensations to wash over you. Breathe.
- Name the ***Situation*** that initiated your response. In what way is this situation familiar to your past? How is it different?
- Remember that ***Emotions*** come and go. They may be intense now, but later they will be less so. Name your feelings.
- ***Recognize*** that this situation does not define you or your future. It does not dictate how things will be, nor is it a sign of things to come. Even if it is familiar, it is only one event.
- ***Validate*** your experience. State, at least internally, what you are feeling, thinking, and experiencing.
- ***Ask*** for help. You don't have to do this alone. Seek support. Other people care for you. Let them!
- ***This*** too shall pass. Remember: There are times that are good and times that are not so good. This hard time will pass.
- ***I*** can handle this. Name your strengths. Your strengths have helped you survive.
- Keep an ***Open*** mind. Look for and try out new solutions.
- ***Name*** strategies that have worked before. Choose one and apply it to this situation.
- Remember you have survived. You are a ***Survivor***!

cues will not be as obvious. With practice, the client can begin to track back through what occurred immediately before an emotional, physical, or behavioral reaction and then examine how that experience reminds him or her of the past.

Draw Connections

Mental health and substance abuse treatment providers have historically underestimated the effects of trauma on their clients for many reasons. Some held a belief that substance

Advice to Counselors: Strategies To Help Clients Draw Connections

Strategy #1: Writing about trauma can help clients gain awareness of their thoughts, feelings, and current experiences and can even improve physical health outcomes (Pennebaker, Kiecolt-Glaser, & Glaser, 1988; Smyth, Hockemeyer, & Tulloch, 2008). Although this tool may help some people draw connections between current experiences and past traumas, it should be used with caution; others may find that it brings up too much intense trauma material (especially among vulnerable trauma survivors with co-occuring substance abuse, psychosis, and current domestic violence). Journal writing is safest when you ask clients to write about present-day specific targets, such as logging their use of coping strategies or identifying strengths with examples. Writing about trauma can also be done via key questions or a workbook that provides questions centered upon trauma experiences and recovery.

Strategy #2: Encourage clients to explore the links among traumatic experiences and mental and substance use disorders. Recognition that a mental disorder or symptom developed after the trauma occurred can provide relief and hope that the symptoms may abate if the trauma is addressed. Ways to help clients connect substance use with trauma histories include (Najavits, 2002b; Najavits, Weiss, & Shaw, 1997):

- Identifying how substances have helped "solve" trauma or PTSD symptoms in the short term (e.g., drinking to get to sleep).
- Teaching clients how trauma, mental, and substance use disorders commonly co-occur so that they will not feel so alone and ashamed about these issues.
- Discussing how substance abuse has impeded healing from trauma (e.g., by blocking feelings and memories).
- Helping clients recognize trauma symptoms as triggers for relapse to substance use and mental distress.
- Working on new coping skills to recover from trauma and substance abuse at the same time.
- Recognizing how both trauma and substance abuse often occur in families through multiple generations.

abuse should be addressed before attending to any co-occurring conditions. Others did not have the knowledge and training to evaluate trauma issues or were uncomfortable or reluctant to discuss these sensitive issues with clients (Ouimette & Brown, 2003). Similarly, in other behavioral health settings, clinicians sometimes address trauma-related symptoms but do not have experience or training in the treatment of substance abuse.

So too, people who have histories of trauma will often be unaware of the connection between the traumas they've experienced and their traumatic stress reactions. They may notice depression, anger, or anxiety, or they may describe themselves as "going crazy" without being able to pinpoint a specific experience that produced the trauma symptoms. Even if clients recognize the events that precipitated their trauma symptoms, they may not understand how others with similar experiences can have different reactions. Thus, a treatment goal for trauma survivors is helping them gain awareness of the connections between their histories of trauma and subsequent consequences. Seeing the connections can improve clients' ability to work on recovery in an integrated fashion.

Teach Balance

You and your clients need to walk a thin line when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session whereby the client dissociates, shuts down, or becomes emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma. Several trauma-specific theories offer guidelines on acceptable levels of distress associated with the traumatic content that the therapy addresses. For example, some traditional desensitization processes start at a very low level of subjective distress, gradually working up through a hierarchy of trauma memories and experiences until those experiences produce minimal reactions when paired with some coping strategy, such as relaxation training. Other desensitization processes start at a higher level of intensity to provide more rapid extinction of traumatic associations and to decrease the risk of avoidance—a behavior that reinforces traumatic stress.

> The Subjective Units of Distress Scale (SUDS) uses a 0 10 rating scale, with 0 representing content that causes no or minimal distress and 10 representing content that is exceptionally distressing and overwhelming.
>
> (Wolpe & Abrams, 1991)

Working with trauma is a delicate balancing act between the development and/or use of coping strategies and the need to process the traumatic experiences. Individuals will choose different paths to recovery; it's a myth that every traumatic experience needs to be expressed and every story told. For some individuals, the use of coping skills, support, and spirituality are enough to recover. Regardless of theoretical beliefs, counselors must teach

Advice to Counselors: Strategy To Teach Balance

Strategy #1: Teach and use the SUDS in counseling. This scale can be useful from the outset as a barometer for the client and counselor to measure the level of distress during and outside of sessions. It provides a common language for the client and counselor, and it can also be used to guide the intensity of sessions. SUDS can tangibly show a client's progress in managing experiences. Without a scale, it is more difficult to grasp that a distressing symptom or circumstance is becoming less and less severe without some repeated measure.

coping strategies as soon as possible. Retraumatization is a risk whenever clients are exposed to their traumatic histories without sufficient tools, supports, and safety to manage emotional, behavioral, and physical reactions.

Build Resilience

Survivors are resilient! Often, counselors and clients who are trauma survivors focus on the negative consequences of trauma while failing to recognize the perseverance and attributes that have helped them survive. It is natural to focus on what's not working rather than what has worked. To promote growth after trauma and establish a strengths-based approach, focus on building on clients' resilience. Current resilience theories claim that building or reinforcing resilience prevents further development of trauma-related symptoms and disorders. The following *Advice to Counselors* box is adapted from the American Psychological Association's 2003 statement on resilience.

Advice to Counselors: Strategies To Build Resilience

Strategy #1: Help clients reestablish personal and social connections. Access community and cultural resources; reconnect the person to healing resources such as mutual-help groups and spiritual supports in the community.

Strategy #2: Encourage the client to take action. Recovery requires activity. Actively taking care of one's own needs early in treatment can evolve into assisting others later on, such as by volunteering at a community organization or helping military families.

Strategy #3: Encourage stability and predictability in the daily routine. Traumatic stress reactions can be debilitating. Keeping a daily routine of sleep, eating, work, errands, household chores, and hobbies can help the client see that life continues. Like exercise, daily living skills take time to take hold as the client learns to live through symptoms.

Strategy #4: Nurture a positive view of personal, social, and cultural resources. Help clients recall ways in which they successfully handled hardships in the past, such as the loss of a loved one, a divorce, or a major illness. Revisit how those crises were addressed.

Strategy #5: Help clients gain perspective. All things pass, even when facing very painful events. Foster a long-term outlook; help clients consider stress and suffering in a spiritual context.

Strategy #6: Help maintain a hopeful outlook. An optimistic outlook enables visions of good things in life and can keep people going even in the hardest times. There are positive aspects to everyone's life. Taking time to identify and appreciate these enhances the client's outlook and helps him or her persevere.

Strategy #7: Encourage participation in peer support, 12-Step, and other mutual-help programs.

Source: American Psychological Association, 2003.

Address Sleep Disturbances

Sleep disturbances are one of the most enduring symptoms of traumatic stress and are a particularly common outcome of severe and prolonged trauma. Sleep disturbances increase one's risk of developing traumatic stress; they significantly alter physical and psychological processes, thus causing problems in daytime functioning (e.g., fatigue, cognitive difficulty, excessive daytime sleepiness). People with sleep disturbances have worse general health and quality of life. The cardiovascular and immune systems, among others, may be affected as well. Sleep disturbances can worsen traumatic stress symptoms and interfere with healing by impeding the brain's ability to process and consolidate traumatic memories (Caldwell & Redeker, 2005).

Sleep disturbances vary among trauma survivors and can include decreased ability to stay asleep, frequent awakenings, early morning unintentional awakening, trouble falling asleep, poor quality of sleep, and disordered

Advice to Counselors: Strategies To Conduct a Sleep Intervention

Strategy #1: Conduct a sleep history assessment focused first on the client's perception of his or her sleep patterns. Assess whether there is difficulty initiating or staying asleep, a history of frequent or early morning awakenings, physically restless sleep, sleepwalking, bedtime aversion, and/or disruptive physical and emotional states upon awakening (e.g., confusion, agitation, feeling unrested). Also determine total sleep time, pattern of nightmares, and use of medications, alcohol, and/or caffeine (see Moul, Hall, Pikonis, & Buysse, 2004, for a review of self-report measures).

Strategy #2: Use a sleep hygiene measure to determine the presence of habits that typically interfere with sleep (e.g., falling asleep while watching television). The National Sleep Foundation Web site (http://www.sleepfoundation.org) provides simple steps for promoting good sleep hygiene.

Strategy #3: Provide education on sleep hygiene practices. Introduce clients to the idea that practicing good sleep hygiene is one step toward gaining control over their sleep disturbances.

Strategy #4: Reassess sleep patterns and history during the course of treatment. Sleep patterns often reflect current client status. For example, clients who are struggling are more likely to have disturbed sleep patterns; sleep disturbances significantly influence clients' mental health status.

Strategy #5: Use interventions such as nightmare rehearsals to target recurrent nightmares. There are numerous examples of imagery-based nightmare rehearsals. Clients may be instructed to rehearse repetitively the recurrent nightmare a few hours before bedtime. In this instruction, the client either rehearses the entire nightmare with someone or visualizes the nightmare several times to gain control over the material and become desensitized to the content. Other strategies involve imagining a change in the outcome of the nightmare (e.g., asking the client to picture getting assistance from others, even though his or her original nightmare reflects dealing with the experience alone).

breathing during sleep (Caldwell & Redeker, 2005). Most traumatic stress literature focuses on nightmares, insomnia, and frequent awakenings. These disturbances are connected to two main symptoms of traumatic stress: hyperarousal (which causes difficulty in falling and remaining asleep) and reexperiencing the trauma (e.g., through recurrent nightmares). Other sleep disturbances trauma survivors report include sleep avoidance or resistance to sleep (see Case Illustration: Selena), panic awakenings, and restless or unwanted body movements (e.g., hitting your spouse unintentionally in bed while asleep; Habukawa, Maeda, & Uchimura, 2010).

Case Illustration: Selena

Selena initially sought treatment for ongoing depression (dysthymia). During treatment, she identified being sexually assaulted while attending a party at college. At times, she blames herself for the incident because she didn't insist that she and her girlfriends stay together during the party and on the way back to their dorm afterward. Selena reported that she only had two drinks that night: "I could never manage more than two drinks before I wanted to just sleep, so I never drank much socially." She was assaulted by someone she barely knew but considered a "big brother" in the brother fraternity of her sorority. "I needed a ride home. During that ride, it happened," she said. For years thereafter, Selena reported mild bouts of depression that began lasting longer and increasing in number. She also reported nightmares and chronic difficulty in falling asleep. In therapy, she noted avoiding her bed until she's exhausted, saying, "I don't like going to sleep; I know what's going to happen." She describes fear of sleeping due to nightmares. "It's become a habit at night. I get very involved in playing computer games to lose track of time. I also leave the television on through the night because then I don't sleep as soundly and have fewer nightmares. But I'm always exhausted."

Build Trust

Some traumatic experiences result from trusting others (e.g., interpersonal trauma). In other cases, trust was violated during or after the traumatic experience, as in cases when help was late to arrive on the scene of a natural disaster. This lack of trust can leave individuals alienated, socially isolated, and terrified of developing relationships. Some feel that the trauma makes them different from others who haven't had similar experiences. Sometimes, a client's trust issues arise from a lack of trust in self—for instance, a lack of trust in one's perceptions, judgment, or memories. People who have also experienced severe mental or substance use disorders may have difficulty trusting others because, during the course of their illness, they felt alienated or discriminated against for behaviors and emotions generated by or associated with the disorders.

Some client groups (e.g., gay, lesbian, and bisexual clients; people from diverse cultures; those with serious mental illness) evidence significant mistrust because their trust has been repeatedly violated in the past. Traumatic experiences then compound this mistrust. Mistrust can come from various sources, is usually unstated, and, if left unaddressed, can impede treatment. For example, some clients leave treatment early or do not engage in potentially beneficial treatments. Others avoid issues of trust and commitment by leaving treatment when those issues begin to arise.

Establishing a safe, trusting relationship is paramount to healing—yet this takes time in the counseling process. Counselors and other behavioral health professionals need to be consistent throughout the course of treatment; this includes maintaining consistency in the parameters set for availability, attendance, and level of empathy. Trust is built on behavior shown inside and outside of treatment; you should immediately address any behavior that may even slightly injure the relationship (e.g., being 5 minutes late for an appointment, not responding to a phone message in a timely manner, being distracted in a session).

Advice to Counselors: Strategies To Build Trust

Strategy #1: Clients can benefit from a support or counseling group composed of other trauma survivors. By comparing themselves with others in the group, they can be inspired by those who are further along in the recovery process and helpful to those who are not faring as well as they are. These groups also motivate clients to trust others by experiencing acceptance and empathy.

Strategy #2: Use conflicts that arise in the program as opportunities. Successful negotiation of a conflict between the client and the counselor is a major milestone (van der Kolk, McFarlane, & Van der Hart, 1996). Helping clients understand that conflicts are healthy and inevitable in relationships (and that they can be resolved while retaining the dignity and respect of all involved) is a key lesson for those whose relationship conflicts have been beset by violence, bitterness, and humiliation.

Strategy #3: Prepare clients for staff changes, vacations, or other separations. Some clients may feel rejected or abandoned if a counselor goes on vacation or is absent due to illness, especially during a period of vulnerability or intense work. A phone call to the client during an unexpected absence can reinforce the importance of the relationship and the client's trust. You can use these opportunities in treatment to help the client understand that separation is part of relationships; work with the client to view separation in a new light.

Strategy #4: Honor the client–counselor relationship, and treat it as significant and mutual. You can support the development of trust by establishing clear boundaries, being dependable, working with the client to define explicit treatment goals and methods, and demonstrating respect for the client's difficulty in trusting you and the therapeutic setting.

Support Empowerment

Strong feelings of powerlessness can arise in trauma survivors seeking to regain some control of their lives. Whether a person has survived a single trauma or chronic trauma, the survivor can feel crushed by the weight of powerlessness. Mental illness and substance abuse, too, can be disempowering; clients may feel that they've lost control over their daily lives, over a behavior such as drug use, or over powerful emotions such as fear, sadness, or anger. Empowerment means helping clients feel greater power and control over their lives, as long as such control is within safe and healthy bounds. A key facet of empowerment is to help clients build on their strengths. Empowerment is more than helping clients discover what they "should" do; it is also helping them take the steps they feel ready to take.

Case Illustration: Abby

Abby, a 30-year-old, nervous-looking woman, is brought by her parents to a community mental health clinic near their home in rural Indiana. During the intake process, the counselor learns that Abby is an Army Reservist who returned from 12 months of combat duty 3 years ago. The war experience changed her in many ways. Her deployment pulled her away from veterinary school as well as the strong emotional support of family, friends, and fellow classmates. She got along with her unit in Iraq and had no disciplinary problems. While there, she served as a truck driver in the Sunni Triangle. Her convoy was attacked often by small arms fire and was once struck by an improvised explosive device. Although Abby sustained only minor injuries, two of her close friends were killed. With each successive convoy, her level of fear and foreboding grew, but she continued performing as a driver.

Since returning to the United States, she has mostly stayed at home and has not returned to school, although she is helping out on the farm with various chores. Abby has isolated herself from both family members and lifelong friends, saying she doesn't think others can understand what she went through and that she prefers being alone. She reports to her parents and the counselor that she is vaguely afraid to be in cars and feels most comfortable in her room or working alone, doing routine tasks, at home. Abby also says that she now understands how fragile life can be.

She has admitted to her parents that she drinks alcohol on a regular basis, something she did not do before her deployment, and that on occasion, she has experienced blackouts. Abby feels she needs a drink before talking with strangers or joining in groups of friends or family. She confided to her father that she isolates herself so that she can drink without having to explain her drinking to others.

The counselor recognizes Abby's general sense of lacking internal control and feeling powerless over what will happen to her in the future. He adopts a motivational interviewing style to establish rapport and a working alliance with Abby. During sessions, the counselor asks Abby to elaborate on her strengths; he reinforces strengths that involve taking action in life, positive self-statements, and comments that deal with future plans. He also introduces Abby to an Iraq War veteran who came home quite discouraged about putting his life together but has done well getting reintegrated. The counselor urges Abby go to the local VA center so that she can meet and bond with other recently returned veterans. He also encourages Abby to attend Alcoholics Anonymous meetings, emphasizing that she won't be pressured to talk or interact with others more than she chooses to.

The counselor continues to see Abby every week and begins using cognitive–behavioral techniques to help her examine some of her irrational fears about not being able to direct her life. He asks Abby to keep a daily diary of activities related to achieving her goals of getting back to school and reestablishing a social network. In each session, Abby reviews her progress using the diary as a memory aid, and the counselor reinforces these positive efforts. After 4 months of treatment, Abby reenrolls in college and is feeling optimistic about her ability to achieve her career plans.

Advice to Counselors: Strategies To Support Empowerment

Strategy #1: Offer clients information about treatment; help them make informed choices. Placing appropriate control for treatment choices in the hands of clients improves their chances of success.

Strategy #2: Give clients the chance to collaborate in the development of their initial treatment plan, in the evaluation of treatment progress, and in treatment plan updates. Incorporate client input into treatment case consultations and subsequent feedback.

Strategy #3: Encourage clients to assume an active role in how the delivery of treatment services occurs. An essential avenue is regularly scheduled and structured client feedback on program and clinical services (e.g., feedback surveys). Some of the most effective initiatives to reinforce client empowerment are the development of peer support services and the involvement of former clients in parts of the organizational structure, such as the advisory board or other board roles.

Strategy #4: Establish a sense of self-efficacy in clients; their belief in their own ability to carry out a specific task successfully—is key. You can help clients come to believe in the possibility of change and in the hope of alternative approaches to achieving change. Supporting clients in accepting increasing responsibility for choosing and carrying out personal change can facilitate their return to empowerment (Miller & Rollnick, 2002).

Acknowledge Grief and Bereavement

The experience of loss is common after traumas, whether the loss is psychological (e.g., no longer feeling safe) or physical (e.g., death of a loved one, destruction of community, physical impairment). Loss can cause public displays of grief, but it is more often a private experience. Grieving processes can be emotionally overwhelming and can lead to increased substance use and other impulsive behaviors as a way to manage grief and other feelings associated with the loss. Even for people who experienced trauma years prior to treatment, grief is still a common psychological issue. Delayed or absent reactions of acute grief can cause exhaustion, lack of strength, gastrointestinal symptoms, and avoidance of emotions.

Risk factors of chronic bereavement (grief lasting more than 6 months) can include:

- Perceived lack of social support.
- Concurrent crises or stressors (including reactivation of PTSD symptoms).
- High levels of ambivalence about the loss.
- An extremely dependent relationship prior to the loss.
- Loved one's death resulting from disaster: unexpected, untimely, sudden, and shocking (New South Wales Institute of Psychiatry & Centre for Mental Health, 2000).

Advice to Counselors: Strategies To Acknowledge and Address Grief

Strategy #1: Help the client grieve by being present, by normalizing the grief, and by assessing social supports and resources.

Strategy #2: When the client begins to discuss or express grief, focus on having him or her voice the losses he or she experienced due to trauma. Remember to clarify that losses include internal experiences, not just physical losses.

Strategy #3: For a client who has difficulty connecting feelings to experiences, assign a feelings journal in which he or she can log and name each feeling he or she experiences, rate the feeling's intensity numerically, and describe the situation during which the feeling occurred. The client may choose to share the journal in an individual or group session.

Strategy #4: Note that some clients benefit from developing a ritual or ceremony to honor their losses, whereas others prefer offering time or resources to an association that represents the loss.

Monitor and Facilitate Stability

Stability refers to an ongoing psychological and physical state whereby one is not overwhelmed by disruptive internal or external stimuli (Briere & Scott, 2006b). It's common for individuals to have an increase in symptoms, distress, or impairment when dealing with the impact of their trauma or talking about specific aspects of their trauma. There is a thin line that the client and counselor need to negotiate and then walk when addressing trauma. Too much work focused on highly distressing content can turn a desensitization process into a session that causes the client to dissociate, shut down, or become emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma.

Advice to Counselors: Strategies To Monitor and Facilitate Stability

Strategy #1: If destabilization occurs during the intake process or treatment, stop exploring the material that triggered the reaction, offer emotional support, and demonstrate ways for the client to self-soothe.

Strategy #2: Seek consultation from supervisors and/or colleagues (e.g., to explore whether a new case conceptualization is needed at this point).

Strategy #3: Refer the client for a further assessment to determine whether a referral is necessary for trauma-specific therapy or a higher level of care, or use of multiple levels of care (e.g., intensive outpatient care, partial hospitalization, residential treatment).

Strategy #4: Focus on coping skills and encourage participation in a peer support program.

Strategy #5: When a client becomes agitated and distressed, carefully explore with the client what is causing this state. When such feelings arise because of current threats in the client's life or environment, it is dangerous to halt or soothe away responses that act as warning signals (Pope & Brown, 1996). When a client is in a situation involving domestic violence, lives in a dangerous neighborhood, or has run out of money for food, he or she requires direct and concrete assistance rather than simple emotional support.

Source: Briere & Scott, 2006b.

Managing Destabilization

When a client becomes destabilized during a session, you can respond in the following manner: "Let's slow down and focus on helping you be and feel safe. What can we do to allow you to take care of yourself at this moment? Then, when you feel ready, we can decide what to focus on next."

Clients should have some psychological stability to engage in trauma-related work. An important distinction can be made between a normative increase in symptoms (e.g., the typical up-and-down course of traumatic stress reactions or substance abuse) and destabilization (dangerous, significant decrease in functioning). Signs of destabilization include (Green Cross Academy of Traumatology, 2007; Najavits, 2002b):

- Increased substance use or other unsafe behavior (e.g., self-harm).
- Increased psychiatric symptoms (e.g., depression, agitation, anxiety, withdrawal, anger).
- Increased symptoms of trauma (e.g., severe dissociation).
- Helplessness or hopelessness expressed verbally or behaviorally.
- Difficulty following through on commitments (e.g., commitment to attend treatment sessions).
- Isolation.
- Notable decline in daily activities (e.g., self-care, hygiene, care of children or pets, going to work).

Treatment Issues

The treatment environment itself can significantly affect how clients experience traumatic stress and how the client responds to treatment. Some specific issues related to working with trauma survivors in a clinical setting are discussed in the following sections.

Client Engagement

A lack of engagement in treatment is the client's inability to make progress toward treatment goals, deal with important topics in treatment, or complete treatment. Clients who have histories of trauma will express ambivalence about treatment similarly to others, except that clients who have traumatic stress can feel more "stuck" and perceive themselves as having fewer options. In addition, clients may be avoiding engagement in treatment because it is one step closer to addressing their trauma. You should attend to the client's motivation to change, implement strategies that address ambivalence toward treatment, and use approaches that help clients overcome avoidant behavior.

Advice to Counselors: Strategies To Foster Engagement

Strategy #1: According to Mahalik (2001), the standard method of handling clients' lack of engagement is exploring it with them, clarifying the situation through discussion with them, reinterpreting (e.g., from "can't" to "won't" to "willing"), and working through the situation toward progress.

Strategy #2: To improve engagement into treatment, try motivational interviewing and enhancement techniques. For additional information on such techniques, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT], 1999b).

Pacing and Timing

Although your training or role as a counselor may prohibit you from providing trauma-specific services, you must still be prepared for the fact that clients are not as focused on when or where it is most appropriate to address trauma—they want relief, and most lay and professional people have been taught that the only path to recovery is disclosure. Some clients are reluctant to talk about anything associated with their histories of trauma. Other clients immediately want to delve into the memories of their trauma without developing a safe environment. The need to gain any relief for the traumatic stress pushes some individuals to disclose too quickly, without having the necessary support and coping skills to manage the intensity of their memories. Clients who enter treatment and immediately disclose past trauma often don't return because the initial encounter was so intense or because they experienced considerable emotional distress for several days afterward and/or in anticipation of the next session.

Proper pacing of sessions, disclosure, and intensity is paramount. Clients who immediately disclose without proper safety nets are actually retraumatizing themselves by reliving the experience without adequate support—often placing themselves in the same circumstances that occurred during the actual traumas they experienced. Although you should not adamantly direct clients not to talk about what happened, it is important to discuss with the clients, even if you have to interrupt them empathically and respectfully, the potential consequences of disclosing too soon and too fast. Ask whether they have done this before, and then inquire about the outcome. Reinforce with clients that trauma heals when there are support, trust, and skills in place to manage the memories of the traumatic experiences. Ideally, disclosure begins after these elements are secured, but realistically, it is a

Advice to Counselors: Strategies To Establish Appropriate Pacing and Timing

Strategy #1: Frequently discuss and request feedback from clients about pacing and timing. Moving too quickly into discussion of the trauma can increase the risk of dissociation, overactivation of memories, and feeling overwhelmed.

Strategy #2: Use the SUDS as a barometer of intensity to determine the level of work.

Strategy #3: Slowly increase the speed of interventions and continually adjust the intensity of interventions; move in and out of very intense work, or use strategies that decrease the intensity when necessary. One approach that typically decreases the intensity of traumatic memories is to ask the individual to imagine that he or she is seeing the scene through a window or on a television screen. This helps decrease intensity and the risk of dissociation. It provides an opportunity for the client to view the trauma from a different perspective and a strategy to use outside of treatment to shift from reliving the trauma to observing it from a neutral position.

Strategy #4: Monitor clients to ensure that treatment does not overwhelm their internal capacities, retraumatize them, or result in excessive avoidance; make sure therapy occurs in the "therapeutic window" (Briere & Scott, 2006b).

Strategy #5: Be alert to signs that discussions of trauma, including screening, assessment, and intake processes, are going too fast. Mild to moderate signs are:
- Missing counseling appointments after discussions of important material.
- Periods of silence.
- Dissociation.
- Misunderstanding what are usually understandable concepts.
- Redirecting the focus of the discussion when certain issues arise.

Strategy #6: Observe the client's emotional state. Slow down; seek consultation if the client exhibits:
- Persistent resistance to addressing trauma symptoms.
- Repetitive flashbacks.
- Increase in dissociation.
- Regression.
- Difficulty in daily functioning (e.g., trouble maintaining everyday self-care tasks).
- Substance use relapses.
- Self-harm or suicidal thoughts/behaviors (e.g., talking about suicide).

Strategy #7: Use caution and avoid (Briere, 1996b, p. 115):
- Encouraging clients to describe traumatic material in detail before they can deal with the consequences of disclosure.
- Using overly stressful interventions (e.g., intensive role-plays, group confrontation, guided imagery).
- Confrontations or interpretations that are too challenging given the client's current functioning.
- Demanding that the client work harder and stop resisting.

Source: Strategies 1–6: Green Cross Academy of Traumatology, 2001. Adapted with permission.

balancing act for both the counselor and client as to when and how much should be addressed in any given session. Remember not to inadvertently give a message that it is too dangerous to talk about trauma; instead, reinforce the importance of addressing trauma without further retraumatization.

Length of Treatment

Many factors influence decisions regarding the length of treatment for a given client. Severity of addiction, type of substance abused, type of trauma, age at which the trauma occurred, level of social support, and the existence of

mental disorders all influence length of treatment. External factors, such as transportation and childcare, caps on insurance coverage, and limitations in professional resources, can also affect length of treatment. In general, longer treatment experiences should be expected for clients who have histories of multiple or early traumas, meet diagnostic criteria for multiple Axis I or Axis II diagnoses, and/or require intensive case management. Most of the empirically studied and/or manual-based models described in the next chapter are short-term models (e.g., lasting several months); however, ongoing care is indicated for clients with more complex co-occurring trauma disorders.

Traumatic Memories

One of the most controversial issues in the trauma field is the phenomenon of "recovered memories" or "traumatic amnesia" (Brewin, 2007). Practitioners working with traumatized individuals are particularly concerned about the possibility of new memories of the traumatic event emerging during the course of therapy and the possibility of these memories being induced by the clinician. Scientific reviews indicate that people can experience amnesia and delayed recall for some memories of a wide variety of traumas, including military combat and prisoner of war experiences, natural disasters and accidents, childhood sexual abuse, and political torture (Bowman & Mertz, 1996; Brewin, 2007; Karon & Widener, 1997; McNally, 2005). In some cases, the survivor will not remember some of what happened, and the counselor may need to help the client face the prospect of never knowing all there is to know about the past and accept moving on with what is known.

Legal Issues

Legal issues can emerge during treatment. A client, for instance, could seek to prosecute a perpetrator of trauma (e.g., for domestic violence) or to sue for damages sustained in an accident or natural disaster. The counselor's role is not to provide legal advice, but rather, to offer support during the process and, if needed, refer the client to appropriate legal help (see Advice to Counselors box on p. 131). A legal matter can dominate the treatment atmosphere for its duration. Some clients have difficulty making progress in treatment until most or all legal matters are resolved and no longer act as ongoing stressors.

Memories of Trauma

Points for counselors to remember are:

- Some people are not able to completely remember past events, particularly events that occurred during high-stress and destabilizing moments.
- In addition to exploring the memories themselves, it can be beneficial to explore how a memory of an event helps the client understand his or her feeling, thinking, and behaving in the present.
- Persistently trying to recall all the details of a traumatic event can impair focus on the present.

Forgiveness

Clients may have all sorts of reactions to what has happened to them. They may feel grateful for the help they received, joy at having survived, and dedication to their recovery. At the other extreme, they may have fantasies of revenge, a loss of belief that the world is a good place, and feelings of rage at what has happened. They may hold a wide variety of beliefs associated with these feelings.

One issue that comes up frequently among counselors is whether to encourage clients to forgive. The issue of forgiveness is a very delicate one. It is key to allow survivors their feelings, even if they conflict with the counselor's own responses. Some may choose to forgive the perpetrator, whereas others may remain angry or seek justice through the courts and other legal means. Early in recovery from

Advice to Counselors: Strategies To Manage Traumatic Memories

Strategy #1: Most people who were sexually abused as children remember all or part of what happened to them, although they do not necessarily fully understand or disclose it. Do not assume that the role of the clinician is to investigate, corroborate, or substantiate allegations or memories of abuse (American Psychiatric Association [APA], 2000b).

Strategy #2: Be aware that forgotten memories of childhood abuse can be remembered years later. Clinicians should maintain an empathic, nonjudgmental, neutral stance toward reported memories of sexual abuse or other trauma. Avoid prejudging the cause of the client's difficulties or the veracity of the client's reports. A counselor's prior belief that physical or sexual abuse, or other factors, are or are not the cause of the client's problems can interfere with appropriate assessment and treatment (APA, 2000b).

Strategy #3: Focus on assisting clients in coming to their own conclusions about the accuracy of their memories or in adapting to uncertainty regarding what actually occurred. The therapeutic goal is to help clients understand the impact of the memories or abuse experiences on their lives and to reduce their detrimental consequences in the present and future (APA, 2000b).

Strategy #4: Some clients have concerns about whether or not a certain traumatic event did or did not happen. In such circumstances, educate clients about traumatic memories, including the fact that memories aren't always exact representations of past events; subsequent events and emotions can have the effect of altering the original memory. Inform clients that it is not always possible to determine whether an event occurred but that treatment can still be effective in alleviating distress.

Strategy #5: There is evidence that suggestibility can be enhanced and pseudomemories can develop in some individuals when hypnosis is used as a memory enhancement or retrieval strategy. Hypnosis and guided imagery techniques can enhance relaxation and teach self-soothing strategies with some clients; however, use of these techniques is not recommended in the active exploration of memories of abuse (Academy of Traumatology, 2007).

Strategy #6: When clients are highly distressed by intrusive flashbacks of delayed memories, help them move through the distress. Teach coping strategies and techniques on how to tolerate strong affect and distress (e.g., mindfulness practices).

trauma, it is best to direct clients toward focusing on stabilization and a return to normal functioning; suggest that, if possible, they delay major decisions about forgiveness until they have a clearer mind for making decisions (Herman, 1997). Even in later stages of recovery, it's not essential for the client to forgive in order to recover. Forgiveness is a personal choice independent of recovery. Respect clients' personal beliefs and meanings; don't push clients to forgive or impose your own beliefs about forgiveness onto clients.

In the long-term healing process, typically months or years after the trauma(s), forgiveness may become part of the discussion for some people and some communities. For example, in South Africa, years after the bitter and bloody apartheid conflicts, a Truth and Reconciliation Commission was established by the Government. Public hearings created dialog and aired what had been experienced as a means, ultimately, to promote forgiveness and community healing. By addressing very difficult topics in public, all could potentially benefit from the discourse. Similarly, a parental survivor of the Oklahoma City bombing was, at first, bitter about his daughter's early, unfair, and untimely death. Today, he gives talks around the world about the abolition of the death penalty. He sat with convicted

Advice to Counselors: Strategies To Manage Legal Proceedings

Strategy #1: If you're aware of legal proceedings, you can play a key role in helping your client prepare emotionally for their impact, such as what it might be like to describe the trauma to a judge or jury, or how to cope with seeing the perpetrator in court. When helping a client prepare, however, be careful not to provide legal advice.

Strategy #2: Help clients separate a successful legal outcome from a successful treatment outcome. If clients connect these two outcomes, difficulties can arise. For example, a client may discontinue treatment after his or her assailant is sentenced to serve prison time, believing that the symptoms will abate without intervention.

Strategy #3: If clients express interest in initiating a civil or criminal suit, encourage them to consider the ways in which they are and are not prepared for this, including their own mental states, capacity for resilience, and inevitable loss of confidentiality (Pope & Brown, 1996). Inform clients coping with legal issues that involvement in the legal process can be retraumatizing.

Strategy #4: Emphasize, for trauma survivors who are involved in legal proceedings against an assailant, that "not guilty" is a legal finding—it is based on the degree of available evidence and is not a claim that certain events in question did not occur. They should also receive, from an attorney or other qualified individual, information on:

- The nature of the legal process as it pertains to the clients' specific cases.
- The estimated duration and cost of legal services, if applicable.
- What to expect during police investigations.
- Court procedures.
- Full information on all possible outcomes.
- What to expect during cross-examination.

Strategy #5: Counselors can be called on to assist with a legal case involving trauma. The court may require you to provide treatment records, to write a letter summarizing your client's progress, or to testify at a trial. Always seek supervisory and legal advice in such situations and discuss with the client the possible repercussions that this might have for the therapeutic relationship. As a general rule, it is best practice to avoid dual roles or relationships.

bomber Timothy McVeigh's father while the man's son was executed in Indiana at a Federal prison several years after the bombing. For this man, forgiveness and acceptance helped him attain personal peace. Other trauma survivors may choose never to forgive what happened, and this, too, is a legitimate response.

Culturally and Gender Responsive Services

Culture is the lens through which reality is interpreted. Without an understanding of culture, it is difficult to gauge how individuals organize, interpret, and resolve their traumas. The challenge is to define how culture affects individuals who have been traumatized.

Increased knowledge of PTSD (Wilson & Tang, 2007), mental illness, and substance use disorders and recovery (Westermeyer, 2004) requires behavioral health practitioners to consider the complicated interactions between culture, personality, mental illness, and substance abuse in adapting treatment protocols. This section offers some general guidelines for working with members of cultures other than one's own. Treatment for traumatic stress, mental illness, substance use disorders, and co-occurring trauma-related symptoms is more effective if it is culturally responsive.

The U.S. Department of Health and Human Services (2003) has defined the term "cultural competence" as follows:

> Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time (p. 12).

Cultural competence is a process that begins with an awareness of one's own culture and beliefs and includes an understanding of how those beliefs affect one's attitudes toward people of other cultures. It is rooted in respect, validation, and openness toward someone whose social and cultural background is different from one's own. For a thorough review of cultural competence, see the planned TIP, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration [SAMHSA], planned c).

Cultural Competence

Cultural competence includes a counselor's knowledge of:

- Whether the client is a survivor of cultural trauma (e.g., genocide, war, government oppression, torture, terrorism).
- How to use cultural brokers (i.e., authorities within the culture who can help interpret cultural patterns and serve as liaisons to those outside the culture).
- How trauma is viewed by an individual's sociocultural support network.
- How to differentiate PTSD, trauma-related symptoms, and other mental disorders in the culture.

For more specific information on cultural competence in trauma therapy, see Brown (2008).

In some cultures, an individual's needs take precedence over group needs (Hui & Triandis, 1986), and problems are seen as deriving from the self. In other cultures, however, complex family, kin, and community systems take precedence over individual needs. Considerable heterogeneity exists within and across most ethnic subcultures and across lines of gender, class, age, and political groups (CSAT, 1999b). Subcultures abound in every culture, such as gangs; populations that are homeless or use substances; orphaned or disenfranchised people; religious, ethnic, and sexual minorities; indigenous people; and refugee and immigrant populations. Some subcultures have more in common with similar subcultures in other countries than with their own cultures (e.g., nonheterosexual populations).

Trauma and substance abuse can themselves be a basis for affiliation with a subculture. De Girolamo (1993) reports that "disaster subcultures" exist within many cultures. These cultures of victimization, like all subcultures, have unique worldviews, codes of conduct, and perceptions of the larger society. In a disaster subculture, people are, to some extent, inured to disaster and heedless of warnings of impending disaster. For example, riverbank erosion in Bangladesh displaces thousands of people each year, yet few believe that it is a serious problem or that the displacement will be permanent (Hutton, 2000). Israelis who have lived with unpredictable violence for many years behave differently in public areas and have adapted to different norms than people who don't commonly experience violence (Young, 2001).

Many people identify with more than one subculture. Some identify with a particular culture or subculture, but not with all of its values. Individual identities are typically a mosaic of factors, including developmental achievements, life experiences, behavioral health histories, traumatic experiences, and

alcohol and illicit drug use; levels of acculturation and/or assimilation vary from one individual to the next as well.

Importance of the trauma aftermath

Counselors working in the immediate aftermath of trauma—whether individual, group, or community in nature—face many challenges. For example, survivors may be forced to adjust without access to other health services, employment, support, or insurance. In these instances, counselors must often work with individuals and communities coping with the trauma while struggling daily to meet basic needs. Research suggests that reestablishing ties to family, community, culture, and spiritual systems can not only be vital to the individual, but can also influence the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of people victimized by Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents affected by the purge experienced fewer negative effects than did those who were emotionally or physically severed from their grandparents. The researchers also found that whether the grandparents survived was less important than the connection the grandchildren managed to keep to their past. Ties to family and community can also have an adverse effect, especially if the family or community downplays the trauma or blames the victim. Counselors need to have a full understanding of available support before advocating a particular approach.

Treatment strategies

Many traditional healing ways have been damaged, forgotten, or lost—yet much wisdom remains. Drawing on the best traditional and contemporary approaches to human distress and defining culturally competent curricula regarding identity and healing (Huriwai, 2002; Wilson & Tang, 2007) both require respect and appreciation for the many ways in which various people characterize and resolve trauma and how they use addictive substances to bear the burdens of human distress.

Community-Based Treatment for Native American Historical Trauma

Key beliefs in community healing:

- Clients carry childhood pain that has led to adult dysfunction.
- Childhood pain must be confronted, confessed, and addressed, if relief is to be obtained.
- Cathartic expression is the initial step in the healing journey toward a lifelong pursuit of introspection and self-improvement.
- The healing journey entails reclamation of indigenous heritage, identity, spirituality, and practices to remedy the pathogenic effects of colonization and other sources of historical trauma.

Source: Gone, 2009.

It is not yet known how well existing PTSD treatments work for individuals who identify primarily with cultures other than mainstream American culture. It is possible that such treatments do work for clients of other cultures, though some cultural adaptation and translation may be required. For example, some PTSD treatments that have been used with subculture groups without adaptation other than language translation and that appear to be effective across cultures include eye movement desensitization and reprocessing (Bleich, Gelkopf, & Solomon, 2003) and Seeking Safety (Daouest et al., 2012).

Gender

Gender differences exist in traumatic stress, mental disorders, and substance use disorders. For example, women have higher rates of PTSD, whereas men have higher rates of substance abuse (Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Stewart, Ouimette, & Brown, 2002; Tolin & Foa, 2006).

Working With Clients From Diverse Cultures: Trauma and Substance Abuse

- In socially appropriate ways, educate clients, their loved ones, and possibly members of their extended community about the relationship between substance abuse and PTSD, how substance abuse is often used to cope with trauma, and what treatment entails.
- Make serious efforts to connect clients to supportive and understanding people (preferably within culturally identified groups).
- Help clients understand that many who have not experienced trauma or do not have substance use disorders will not understand the psychological, spiritual, and interpersonal insights that they have gained during their recovery processes.

The types of interpersonal trauma experienced by men and by women are often different. A number of studies (Kimerling, Ouimette, & Weitlauf, 2007) indicate that men experience more combat and crime victimization and women experience more physical and/or sexual assault—implying that men's traumas often occur in public, whereas the traumatization of women is more likely to take place in a private setting, such as a home. Men's abusers are more often strangers. Those who abuse women, on the other hand, are more often in a relationship with them. Women (and girls) often are told, "I love you," during the same time period when the abuse occurs. However, women now serve in the military and thus are increasingly subject to some of the same traumas as men and also to military sexual trauma, which is much more common for women to experience. Similarly, men can be subject to domestic violence or sexual abuse.

In treatment, gender considerations are relevant in a variety of ways, including, but not limited to, the role and impact of societal gender stereotypes upon assessment processes, treatment initiation, and engagement of services (e.g., peer support systems); the selection and implementation of gender-specific and gender-responsive approaches for both men and women at each level of intervention; and the best selection of trauma-related interventions that account for gender-specific differences related to traumatic stress. For an extensive review and discussion of gender-specific and gender-responsive care for traumatic stress and substance use, see the TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d), and TIP 56, *Addressing the Specific Behavioral Health Needs of Men* (SAMHSA, 2013a).

Beyond the complexities of gender considerations, one must also consider whether clients should be given the choice of working with a male or a female counselor. Some clients who have been traumatized have no preference, particularly if their trauma wasn't associated with gender (e.g., a natural disaster, act of terrorism, fire, serious accident). If gender did play a role in trauma (e.g., childhood sexual abuse), clients can have strong fears of working with a counselor who is the same gender as the perpetrator. Many women who experienced sexual abuse (whose perpetrators are typically men) feel uncomfortable being treated by men because of the intense emotions that can be evoked (e.g., anger, fear). Men who experienced sexual abuse (whose perpetrators are also typically men) can feel uncomfortable for the same reasons, or they may feel shame when talking to men due to feelings evoked about masculinity, homosexuality, and so forth. However, not all clients with trauma histories prefer female therapists.

Discuss with clients the possible risks (e.g., initial emotional discomfort) and benefits of being treated by a woman or man (e.g., developing a therapeutic relationship with a man might challenge a client's belief that all men are dangerous), and, if possible, let them then choose the gender of their counselor. Tell

them that if they experience initial emotional discomfort, and the discomfort does not decrease, they can switch to a counselor of the opposite gender. For group therapy that focuses on trauma, similar considerations apply. Generally, gender-specific groups are recommended when possible, but mixed-gender groups also work. Gender also comes into play in substance abuse treatment. Research and clinical observation indicate that significant gender differences occur in many facets of substance abuse and its treatment. For example, men and women experience different physical repercussions of substance use (e.g., women have more health problems), different trajectories (e.g., women become addicted more quickly), and different treatment considerations (e.g., traditional substance abuse treatment was designed for men).

Sexual orientation

Lesbian, gay, bisexual, and transgender (LGBT) clients face specific issues in behavioral health treatment settings, including histories of abuse and discrimination relating to sexual orientation, homophobia in treatment on the part of counselors or other clients, potential difficulty addressing traumatic experiences related to their sexuality or sexual orientation, and often, a significant lack of trust toward others. LGBT people sometimes think that others can't understand them and their specific needs and thus are reluctant to engage in treatment programs in which the clientele is predominantly heterosexual. Some clients react with judgment, anger, or embarrassment when an LGBT client attempts to describe sexual trauma relating to homosexual behavior, making it even harder for LGBT clients to describe their experiences.

Often, individual counseling can address issues the LGBT client isn't comfortable discussing in group treatment. "Providing one-on-one services may decrease the difficulty of mixing heterosexual and LGBT clients in treatment groups and decrease the likelihood that heterosexism or homophobia will become an issue" (CSAT, 2001, p. 56). For more on treating LGBT individuals, see *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT, 2001).

Making Referrals to Trauma-Specific Services

Many people who experience trauma do not exhibit persistent traumatic stress symptoms. In fact, people do recover on their own. So how do you determine who is at higher risk for developing more persistent symptoms of traumatic stress, trauma-related disorders, and traumatic stress disorders? One main factor is the severity of symptoms at the time of screening and assessment. Other factors, beyond trauma characteristics and pretrauma individual characteristics, to consider in making referrals include (Ehlers & Clark, 2003):

- Cognitive appraisals that are excessively negative regarding trauma sequelae, including consequences, changes after the event(s), responses of other people to the trauma, and symptoms.
- Acknowledgment of intrusive memories.
- Engagement in behaviors that reinforce or prevent resolution of trauma, including avoidance, dissociation, and substance use.
- History of physical consequences of trauma (e.g., chronic pain, disfigurement, health problems).
- Experiences of more traumas or stressful life events after the prior trauma.
- Identification of co-occurring mood disorders or serious mental illness.

The next chapter provides an overview of trauma-specific services to complement this chapter and to provide trauma-informed counselors with a general knowledge of trauma-specific treatment approaches.

6 Trauma-Specific Services

IN THIS CHAPTER

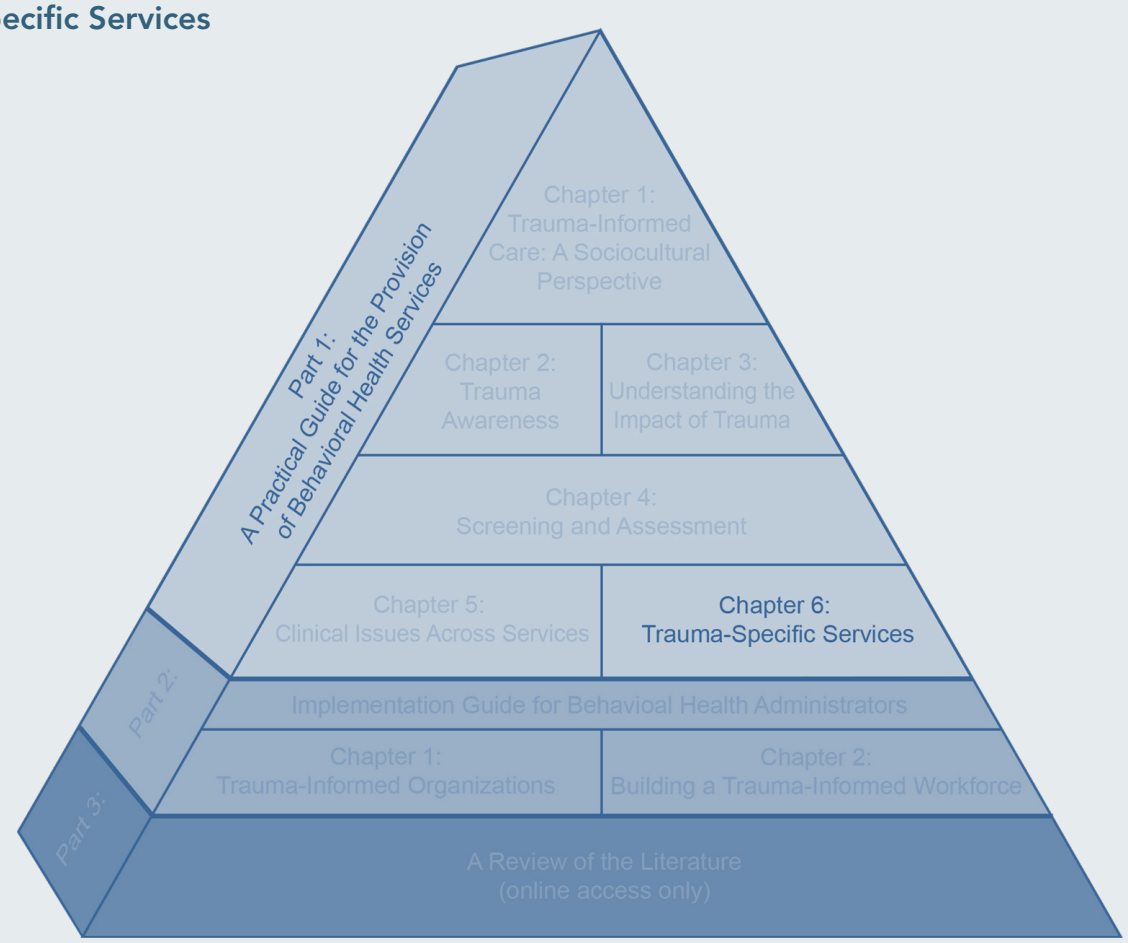
- Introduction
- Trauma Specific Treatment Models
- Integrated Models for Trauma
- Emerging Interventions
- Concluding Note

This chapter covers various treatment approaches designed specifically to treat trauma-related symptoms, trauma-related disorders, and specific disorders of traumatic stress. The models presented do not comprise an exhaustive list, but rather, serve as examples. These models require training and supervised experience to be conducted safely and effectively. The chapter begins with a section on trauma-specific treatment models, providing a brief overview of interventions that can be delivered immediately after a trauma, as well as trauma-specific interventions for use beyond the immediate crisis. The second segment focuses on integrated care that targets trauma-specific treatment for mental, substance use, and co-occurring disorders. Even though entry-level, trauma-informed behavioral health service providers are unlikely to be in a position to use these interventions, having some knowledge of them is nevertheless important. Currently, more research is needed to tease out the most important ingredients of early interventions and their role in the prevention of more pervasive traumatic stress symptoms. More science-based evidence is available for trauma-specific treatments that occur and extend well beyond the immediate reactions to trauma. The last part of the chapter provides a brief review of selected emerging interventions that have not been covered elsewhere in this Treatment Improvement Protocol (TIP).

Introduction

Trauma-specific therapies vary in their approaches and objectives. Some are present focused, some are past focused, and some are combinations (Najavits, 2007a). Present-focused approaches primarily address current coping skills, psychoeducation, and managing symptoms for better functioning. Past-focused approaches primarily focus on telling the trauma story to understand the impact of the trauma on how the person functions today, experiencing emotions that were too overwhelming to experience in the past, and helping clients more effectively cope in the present with their

Trauma-Informed Care Framework in Behavioral Health Services—Trauma-Specific Services



traumatic experiences. Clients participating in present-focused approaches may reveal some of their stories; past-focused approaches emphasize how understanding the past influences current behavior, emotion, and thinking, thereby helping clients cope more effectively with traumatic experiences in the present.

The distinction between these approaches lies in the primary emphasis of the approach. Depending on the nature of the trauma and the specific needs of the client, one approach may be more suitable than the other. For instance, in short-term treatment for clients in early recovery from mental illness and/or substance abuse, present-focused, cognitive–behavioral, or psychoeducational approaches are generally more appropriate. For clients who are stable in their recovery and have histories of developmental trauma where much of the trauma has been repressed, a past-focused orientation may be helpful. Some clients may benefit from both types, either concurrently or sequentially.

This chapter discusses a number of treatment models, general approaches, and techniques. A treatment model is a set of practices designed to alleviate symptoms, promote psychological well-being, or restore mental health. Treatment techniques are specific procedures that can be used as part of a variety of models. Some models and techniques described in this chapter can be used with groups, some with individuals, and some with both. This chapter is selective rather than comprehensive; additional models are described in the literature. See, for example, the PILOTS database on the Web site of the National Center for PTSD

(NCPTSD; http://www.ptsd.va.gov) for treatment literature related to trauma and posttraumatic stress disorder (PTSD). For an overview of models for use with both adult and child populations, refer to *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services* (Center for Mental Health Services, 2008).

Some treatments discussed in this chapter are described as evidence based. Because research on integrated treatment models is so new, many have only been examined in a few studies. Given these circumstances and the fact that an outcome study provides only limited evidence of efficacy, the term "evidence based" should be interpreted cautiously. Additional scientific study is needed to determine whether some treatments discussed herein are, in fact, evidence based. A good resource for evaluating evidence-based, trauma-specific treatment models is *Effective Treatments for PTSD* (Foa, Keane, Friedman, & Cohen, 2009). Although evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with symptoms of trauma that co-occur with mental and substance use disorders (see Allen, 2001, for an indepth discussion of trauma and serious mental illness), other factors must also be weighed, including the specific treatment needs of the client; his or her history of trauma, psychosocial and cultural background, and experiences in prior trauma treatment; the overall treatment plan for the client; and the competencies of the program's clinical staff. Although behavioral health counselors can prepare to help their clients address some of the issues discussed in Chapter 5, specialized training is necessary to provide treatment for co-occurring substance use and mental disorders related to trauma.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has created the National Registry of Evidence-Based Programs and Practices (NREPP) as a resource for reviewing and identifying effective treatment programs. Programs can be nominated for consideration as co-occurring disorders programs or substance abuse prevention or treatment programs, and their quality of evidence, readiness for dissemination, and training considerations are then reviewed. For more detailed information, including details about several evidence-based co-occurring trauma treatment programs, visit the NREPP Web site (http://www.nrepp.samhsa.gov). Program models for specialized groups, such as adolescents, can also be found on the NREPP Web site. For specific research-oriented information on trauma-specific treatments, refer to Part 3 of this TIP, which provides a literature review and links to select abstracts (available online).

Federal Agencies

Both the American Red Cross and the Federal Emergency Management Agency (FEMA) respond to disasters. Behavioral health service providers should understand the basics about these major emergency response agencies. For example, the Red Cross can respond rapidly with funding for food, shelter, and immediate needs, whereas FEMA assistance requires a period of gearing up but provides for longer-term needs. SAMHSA, along with other Federal agencies, assists FEMA in a number of areas of emergency response planning activities. See also SAMHSA's Disaster Technical Assistance Center Web site (http://www.samhsa.gov/dtac) and Technical Assistance Publication 34, *Disaster Planning Handbook for Behavioral Health Treatment Programs* (SAMHSA, 2013).

Trauma-Specific Treatment Models

Immediate Interventions

Intervention in the first 48 hours

The acute intervention period comprises the first 48 hours after a traumatic event. In a

"One day I was called out of bed at 5:00 a.m. to go to a town approximately 30 miles away because a levee had broken…. By 6:00 a.m., my colleagues and I were there with many of the townspeople, with helicopters flying overhead, with trucks going in and out by the main road trying to empty the factories. When we got there, as far as you could see was farmland. By 11 a.m., you could see a 'lake' in the distance. By 2 p.m., the water was on the edge of the town. Being there, at that town, before, during, and after the water came was probably the most valuable function we performed. We were able to share in the grief of the hundreds of people as we stayed with them while their fields, houses, and workplaces were flooded. We witnessed the death of a town, and the people reacted with disbelief, anger, sadness, and numbness. Each person had a different story, but all grieved, and we provided many an opportunity to express it. People cried as the water started rising into their houses. Some had to watch. Some had to leave. At times it was utterly silent as we all waited. There was a woman whose parents sent her away during the floods of '43 and she had been angry for 50 years about it. She was determined that her children and grandchildren would see everything. I spent 12 hours that day just giving support, listening, giving information, and sometimes shedding a tear or two myself."

—Rosemary Schwartzbard, Ph.D., responder to floods along the Mississippi River in 1993

Source: Schwartzbard, 1997.

disaster, rescue operations usually begin with local agencies prior to other organizations arriving on the scene. Law enforcement is likely to take a primary role on site. Whether it is a disaster, group trauma, or individual trauma (including a trauma that affects an entire family, such as a house fire), a hierarchy of needs should be established: survival, safety, security, food, shelter, health (physical and mental), orientation of survivors to immediate local services, and communication with family, friends, and community (National Institute of Mental Health, 2002). In this crucial time, appropriate interventions include educating survivors about resources; educating other providers, such as faith-based organizations and social service groups, to screen for increased psychological effects including use of substances; and use of a trauma response team that assists clients with their immediate needs. No formal interventions should be attempted at this time, but a professionally trained, empathic listener can offer solace and support (Litz & Gray, 2002).

Basic needs

Basic necessities, such as shelter, food, and water, are key to survival and a sense of safety. It is important to focus on meeting these basic needs and on providing a supportive environment. Clients' access to prescribed medications may be interrupted after a trauma, particularly a disaster, so providers should identify clients' medication needs for preexisting physical and mental disorders, including methadone or other pharmacological treatment for substance use. For example, after September 11, 2001, substance abuse treatment program administrators in New York had to seek alternative methadone administration options (Frank, Dewart, Schmeidler, & Demirjian, 2006).

Psychological first aid

The psychological first aid provided in the first 48 hours after a disaster is designed to ensure safety, provide an emotionally supportive environment and activities, identify those with high-risk reactions, and facilitate communication, including strong, reassuring leadership immediately after the event. The primary helping response of psychological first aid is to provide a calm, caring, and supportive environment to set the scene for psychological recovery. It is also essential that all those first responding to a trauma—rescue workers, medical professionals, behavioral health workers (including substance abuse counselors), journalists, and volunteers—be familiar with relevant aspects of traumatic stress. Approaching

Advice to Counselors: Core Actions in Preparing To Deliver Psychological First Aid

- Contact and engagement
- Safety and comfort
- Stabilization
- Information gathering: Current needs and concerns
- Practical assistance
- Connection with social supports
- Information on coping
- Linkage with collaborative services

Source: National Child Traumatic Stress Network & NCPTSD, 2012.

survivors with genuine respect, concern, and knowledge increases the likelihood that the caregiver can (NCPTSD, 2002):

- Answer questions about what survivors may be experiencing.
- Normalize their distress by affirming that what they are experiencing is normal.
- Help them learn to use effective coping strategies.
- Help them be aware of possible symptoms that may require additional assistance.
- Provide a positive experience that will increase their chances of seeking help if they need it in the future.

Clinical experience suggests that care be taken to respect a survivor's individual method of coping; some may want information, for example, whereas others do not. Similarly, some may want to talk about the event, but others won't. An excellent guide to providing psychological first aid is available online from the Terrorism and Disaster Branch of the National Child Traumatic Stress Network (http://www.nctsn.org/content/psychological-first-aid).

Critical incident stress debriefing

Initially developed for work with first responders and emergency personnel, critical incident stress debriefing (CISD; Mitchell & Everly, 2001) is now widely used and encompasses various group protocols used in a variety of settings. This facilitator-led group intervention is for use soon after a traumatic event with exposed people. The goal is to provide psychological closure by encouraging participants to talk about their experiences and then giving a didactic presentation on common stress reactions and management.

The widespread use of CISD has occurred despite the publication of conflicting results regarding its efficacy. Claims that single-session psychological debriefing can prevent development of chronic negative psychological sequelae are not empirically supported (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Some controlled studies suggest that it may impede natural recovery from trauma (McNally, Bryant, & Ehlers, 2003). Other research suggests emphasizing screening to determine the need for early interventions. Mitchell and Everly (2001) point out that many of the studies showing negative

Advice to Counselors: Evidence Related to Immediate Interventions

Evidence related to immediate interventions suggests that:

- Early, brief, focused psychotherapeutic intervention provided in an individual or group format can reduce distress in bereaved spouses, parents, and children.
- Selected cognitive–behavioral approaches may help reduce the incidence, duration, and severity of acute stress disorder (ASD), PTSD, and depression in trauma survivors.
- A one-session individual recital of events and expression of emotions evoked by a traumatic event does not consistently reduce risk of later developing PTSD. In fact, it may increase the risk for adverse outcomes. Perhaps CISD hinders the natural recovery mechanisms that restore pretrauma functioning (Bonanno, 2004).
- The focus initially should be upon screening with follow-up as indicated.

results were not conducted with first responders; that is, CISD may be appropriate for some, but not all, groups. A recent study of 952 U.S. peacekeepers and CISD by the U.S. Army Research Unit–Europe (Adler et al., 2008) found mixed results.

Interventions Beyond the Initial Response to Trauma

In the interest of increasing your overall familiarity with relevant approaches, the following sections review several traumatic stress treatment approaches that counselors will most likely encounter when collaborating with clinicians or agencies that specialize in trauma-specific services and treating traumatic stress.

Cognitive–behavioral therapies

Most PTSD models involve cognitive–behavioral therapy (CBT) that integrates cognitive and behavioral theories by incorporating two ideas: first, that cognitions (or thoughts) mediate between situational demands and one's attempts to respond to them effectively, and second, that behavioral change influences acceptance of altered cognitions about oneself or a situation and establishment of newly learned cognitive–behavioral interaction patterns. In practice, CBT uses a wide range of coping strategies.

There are many different varieties of CBT. CBT originated in the 1970s (Beck, Rush, Shaw & Emery, 1979; Ellis & Harper, 1975) and has expanded since then to address various populations, including people who use substances, people who experience anxiety, people with PTSD or personality disorders, children and adolescents, individuals involved in the criminal justice system, and many others. CBT has also been expanded to include various techniques, coping skills, and approaches, such as dialectical behavior therapy (DBT; Linehan, 1993), Seeking Safety (Najavits, 2002a), and mindfulness (Segal, Williams, & Teasdale, 2002). Traditional CBT emphasizes symptom reduction or resolution, but recent CBT approaches have also emphasized the therapeutic relationship, a particularly important dynamic in trauma treatment (Jackson, Nissenson, & Cloitre, 2009).

A widely accepted framework in treating trauma, substance use disorders, and mental illness categorizes therapies as single (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treatment of multiple disorders delivered by separate clinicians or in separate programs that do not necessarily address the interactions between symptoms and disorders).

CBT has been applied to the treatment of trauma and has also been widely and effectively used in the treatment of substance use. A review of efficacy research on CBT for PTSD is provided by Rothbaum, Meadows, Resick, and Foy (2000). Najavits and colleagues (2009) and O'Donnell and Cook (2006) offer an overview of CBT therapies for treating PTSD and substance abuse. In addition, a free online training resource incorporating CBT for traumatized children within the community, Trauma-Focused CBT, is available from the Medical University of South Carolina (http://tfcbt.musc.edu/).

Cognitive processing therapy

Cognitive processing therapy (CPT) is a manualized 12-session treatment approach that can be administered in a group or individual setting (Resick & Schnicke, 1992, 1993). CPT was developed for rape survivors and combines elements of existing treatments for PTSD, specifically exposure therapy (see the "Exposure Therapy" section later in this chapter) and cognitive therapy. The exposure therapy component of treatment consists of

Advice to Counselors: Relaxation Training, Biofeedback, and Breathing Retraining Strategies

Relaxation training, biofeedback, and breathing retraining strategies may help some clients cope with anxiety, a core symptom of traumatic stress. However, no evidence supports the use of relaxation and biofeedback as effective standalone PTSD treatment techniques (Cahill, Rothbaum, Resick, & Follete, 2009). Both are sometimes used as complementary strategies to manage anxiety symptoms elicited by trauma-related stimuli. Breathing retraining uses focused or controlled breathing to reduce arousal. Breathing retraining and relaxation, along with other interventions when necessary, can help clients with ASD. An important caution in the use of breath work with trauma clients is that it can sometimes act as a trigger—for example, given its focus on the body and its potential to remind them of heavy breathing that occurred during assault. Biofeedback, which requires specialized equipment, combines stress reduction strategies (e.g., progressive muscle relaxation, guided imagery) with feedback from biological system measures (e.g., heart rate, hand temperature) that gauge levels of stress or anxiety reduction. Relaxation training, which requires no specialized equipment, encourages clients to reduce anxiety responses (including physiological responses) to trauma-related stimuli; it is often part of more comprehensive PTSD treatments (e.g., prolonged exposure and stress inoculation training [SIT]).

clients writing a detailed account of their trauma, including thoughts, sensations, and emotions that were experienced during the event. The client then reads the narrative aloud during a session and at home. The cognitive therapy aspect of CPT uses six key PTSD themes identified by McCann and Pearlman (1990): safety, trust, power, control, esteem, and intimacy. The client is guided to identify cognitive distortions in these areas, such as maladaptive beliefs.

Results from randomized, placebo-controlled trials for the treatment of PTSD related to interpersonal violence (Resick, 2001; Resick, Nishith, Weaver, Astin, & Feuer, 2002) support the use of CPT. CPT and prolonged exposure therapy models are equally and highly positive in treating PTSD and depression in rape survivors; CPT is superior in reducing guilt (Nishith, Resick, & Griffin, 2002; Resick et al., 2002; Resick, Nishith, & Griffin, 2003). CPT has shown positive outcomes with refugees when administered in the refugees' native language (Schulz, Marovic-Johnson, & Huber, 2006) and with veterans (Monson et al., 2006). However, CPT has not been studied with high-complexity populations such as individuals with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. CPT requires a 3-day training plus consultation (Karlin et al., 2010). Resick and Schicke (1996) published a CPT treatment manual, *Cognitive Processing Therapy for Rape Victims: A Treatment Manual*.

Exposure therapy

Exposure therapy for PTSD asks clients to directly describe and explore trauma-related memories, objects, emotions, or places. Intense emotions are evoked (e.g., sadness, anxiety) but eventually decrease, desensitizing clients through repeated encounters with traumatic material. Careful monitoring of the pace and appropriateness of exposure-based interventions is necessary to prevent retraumatization (clients can become conditioned to fear the trauma-related material even more). Clients must have ample time to process their memories and integrate cognition and affect, so some sessions can last for 1.5 hours or more. For simple cases, exposure can work in as few as 9 sessions; more complex cases may require 20 or more sessions (Foa, Hembree, & Rothbaum, 2007). Various techniques can

Advice to Counselors: Steps for Introducing a Breathing Exercise

Use the following statements to lead clients through a breathing exercise:

- Place your hands on your stomach. As you inhale, breathe deeply but slowly so that your hands rise with your stomach. As you exhale slowly, practice breathing so that your hands drop with your stomach.
- Inhale slowly through your nose with your mouth closed; don't rush or force in the air.
- Exhale slowly through your mouth with your lips in the whistling position.
- Breathe out for twice as long as you breathe in.

expose the client to traumatic material. Two of the more common methods are exposure through imagery and in vivo ("real life") exposure.

The effectiveness of exposure therapy has been firmly established (Rothbaum et al., 2000); however, adverse reactions to exposure therapy have also been noted. Some individuals who have experienced trauma exhibit an exacerbation of symptoms during or following exposure treatments. Even so, the exacerbation may depend on counselor variables during administration. Practitioners of exposure therapy need comprehensive training to master its techniques (Karlin et al., 2010); a counselor unskilled in the methods of this treatment model can not only fail to help his or her clients, but also cause symptoms to worsen.

Exposure therapy is recommended as a first-line treatment option when the prominent trauma symptoms are intrusive thoughts, flashbacks, or trauma-related fears, panic, and avoidance. However, counselors should exercise caution when using exposure with clients who have not maintained stability in managing mental illness symptoms or abstinence from substance use disorders. Studies and routine use of exposure have consistently excluded high-complexity clients such as those with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. The only trial of exposure therapy with a substance dependence sample found that it did not outperform standard substance abuse treatment on most variables (Mills et al., 2012).

Prolonged exposure therapy for PTSD is listed in SAMHSA's NREPP. For reviews of exposure therapy, also see Najavits (2007a) and Institute of Medicine (2008). In addition to prolonged exposure therapy, other therapies incorporate exposure and desensitization techniques, including eye movement desensitization and reprocessing (EMDR; Shapiro, 2001), cognitive processing, and systematic desensitization therapies (Wolpe, 1958).

Eye movement desensitization and reprocessing

EMDR (Shapiro, 2001) is one of the most widely used therapies for trauma and PTSD. The treatment protocols of EMDR have evolved into sophisticated paradigms requiring training and, preferably, clinical supervision. EMDR draws on a variety of theoretical

A Brief Description of EMDR Therapy

Treatment involves three main concentrations (past memories, present disturbances, future actions) and eight phases. Counselors may work with several phases in one session. Each phase is meant to be revisited either in every session or when appropriate (e.g., the closure process is meant to be conducted at the end of every session, in preparation for the next).

- Phase 1: History and Treatment Planning (1-2 sessions)
- Phase 2: Preparation
- Phase 3: Assessment and Reprocessing
- Phase 4: Desensitization
- Phase 5: Installation
- Phase 6: Body Scan
- Phase 7: Closure
- Phase 8: Reevaluation

Source: EMDR Network, 2012.

frameworks, including psychoneurology, CBT, information processing, and nonverbal representation of traumatic memories. The goal of this therapy is to process the experiences that are causing problems and distress. It is an effective treatment for PTSD (Seidler & Wagner, 2006) and is accepted as an evidence-based practice by the U.S. Department of Veterans Affairs (VA), the Royal College of Psychiatrists, and the International Society for Traumatic Stress Studies (Najavits, 2007a); numerous reviews support its effectiveness (e.g., Mills et al., 2012). EMDR values the development of "resource installation" (calming procedures) and engages in exposure work to desensitize clients to traumatic material, using external tracking techniques across the visual field to assist in processing distressing material. Training in EMDR, available through the EMDR Institute, is required before counselors use this treatment. It is listed in SAMHSA's NREPP (EMDR Network, 2012). Thus far, there is no study examining the use of EMDR with clients in substance abuse treatment. See Part 3 of this TIP, available online, to review empirical work on EMDR.

Narrative therapy

Narrative therapy is an emerging approach to understanding human growth and change; it is founded on the premise that individuals are the experts on their own lives and can access their existing intrapsychic and interpersonal resources to reduce the impact of problems in their lives. Developed for the treatment of PTSD resulting from political or community violence, narrative therapy is based on CBT principles, particularly exposure therapy (Neuner, Schauer, Elbert, & Roth, 2002; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). This approach views psychotherapy not as a scientific practice, but as a natural extension of healing practices that have been present throughout human history. For a trauma survivor, the narrative, as it is told and retold, expresses the traumatic experience, puts the trauma in the context of the survivor's life, and defines the options he or she has for change. Narrative structure helps clients connect events in their lives, reveals strings of events, explores alternative expressions of trauma, evokes explanations for clients' behaviors, and identifies their knowledge and skills. The use of stories in therapy, with the client as the storyteller, generally helps lessen suffering (McLeod, 1997; White, 2004).

In the substance abuse treatment field, many clients will see a connection between narrative therapy and the process of telling their stories in 12 Step programs, in which reframing life stories of feeling trapped, despairing, and hopeless leads to stories of strength, joy, and hope. Key storytelling points at a 12 Step speaker meeting include describing what an experience was like, what happened, and what it is like now.

Skills training in affective and interpersonal regulation

Skills training in affective and interpersonal regulation (STAIR) is a two-phase cognitive–behavioral model that adapts therapies developed by others into a new package (Cloitre, Koenen, Cohen, & Han, 2002). Phase 1 consists of eight weekly sessions of skills training in affect and interpersonal regulation derived from general CBT and DBT (Linehan, 1993) and adapted to address trauma involving childhood abuse. Session topics are labeling and identifying feelings, emotion management, distress tolerance, acceptance of feelings, identifying trauma-based interpersonal schemas, identifying conflict between trauma-generated feelings and current interpersonal goals, role-plays on issues of power and control, and role-plays on developing flexibility in interpersonal situations. Phase 2 features eight

STAIR Steps

Phase 1, tailored to individual clients, is called Skills Training in Affect Regulation and consists of the following components:

- Psychoeducation: Describe the symptoms of PTSD and explain the treatment rationale.
- Training in experiencing and identifying feelings, triggers, and thoughts, as well as training in mood regulation strategies.
- Learning history: Ask the client the following questions—How did the client deal with traumas past and present? How did the client's family deal with feelings? How did the client's family life affect his or her present difficulty experiencing and identifying feeling?
- Emotion regulation skills: Identify the cognitive, behavioral, and social support modalities for coping. Use data gathered with self-monitoring forms to identify strengths and weaknesses in each coping modality. Teach skills such as breathing retraining, self-statements to reduce fear, and social skill training to improve social support.
- Acceptance and tolerance of negative affect: Motivate clients to face distressing situations related to the trauma that are important to them. Review negative repercussions of avoidance. Discuss tolerating negative affect as a step toward achieving specific goals.
- Schema therapy for improved relationships: Identify relevant schemas learned in childhood. Suggest alternative ways of viewing self and others in current relationships. Use role-playing to teach assertiveness, emphasizing response flexibility based on relative power in each relationship.

Once Phase 1 of STAIR is well learned, clients move to Phase 2, which involves exposure therapy.

Source: Mollick & Spett, 2002.

sessions of modified prolonged exposure using a narrative approach.

Cloitre and colleagues (2002) assigned women with PTSD related to childhood abuse randomly to STAIR or a minimal attention waitlist, excluding clients with current substance dependence as well as other complexities. STAIR participants showed significantly greater gains in affect regulation, interpersonal skills, and PTSD symptoms than the control participants. These gains were maintained through follow-up at 3 and 9 months. However, it is not clear from this study whether DBT and exposure were both needed. Phase 1 therapeutic alliance and negative mood regulation skills predicted Phase 2 exposure success in reducing PTSD, suggesting the importance of establishing a strong therapeutic relationship and emotion regulation skills before conducting exposure work with people who have chronic PTSD.

Stress inoculation training

SIT was originally developed to manage anxiety (Meichenbaum, 1994; Meichenbaum & Deffenbacher, 1988). Kilpatrick, Veronen, and Resick (1982) modified SIT to treat rape survivors based on the idea that the anxiety and fear that rape survivors experience during their trauma generalizes to other objectively safe situations. SIT treatment components include education, skills training (muscle relaxation training, breathing retraining, role-playing, guided self-talk, assertiveness training, and thought stopping [i.e., actively and forcefully ending negative thoughts by thinking

SIT has been used to help individuals cope with the aftermath of exposure to stressful events and on a preventative basis to "inoculate" individuals to future and ongoing stressors (Meichenbaum, 1996). This practice as a preventive strategy is similar to promoting disease resistance through immunizations.

Advice to Counselors: SIT Phases

SIT is a prevention and treatment approach that has three overlapping phases. It is often seen as a complementary approach to other interventions for traumatic stress.

Phase 1: Conceptualization and education. This phase has two main objectives. The initial goal is to develop a collaborative relationship that supports and encourages the client to confront stressors and learn new coping strategies. The next objective is to increase the client's understanding of the nature and impact of his or her stress and awareness of alternative coping skills. Many cognitive strategies are used to meet these objectives, including self-monitoring activities, Socratic questioning, identifying strengths and evidence of resilience, and modeling of coping strategies.

Phase 2: Skill acquisition and rehearsal. This phase focuses on developing coping skills and using coping skills that the individual already possesses. This process includes practice across settings, so that the individual begins to generalize the use of his or her skills across situations through rehearsal, rehearsal, and more rehearsal.

Phase 3: Implementation and following through. The main objective is to create more challenging circumstances that elicit higher stress levels for the client. By gradually increasing the challenge, the client can practice coping strategies that mimic more realistic circumstances. Through successful negotiation, the client builds a greater sense of self-efficacy. Common strategies in this phase include imagery and behavioral rehearsal, modeling, role-playing, and graded in vivo exposure.

Source: Meichenbaum, 2007.

"STOP" and then redirecting thoughts in a more positive direction]), and skills application. The goal is to help clients learn to manage their anxiety and to decrease avoidant behavior by using effective coping strategies. Randomized controlled clinical trials have indicated that SIT reduces the severity of PTSD compared with waitlist controls and shows comparable efficacy to exposure therapy. At follow-up (up to 12 months after treatment), gains were maintained (Foa et al., 1999; Foa, Rothbaum, Riggs, & Murdock, 1991).

Other therapies

Numerous interventions introduced in the past 20 years focus on traumatic stress. For some interventions, the evidence is limited, and for other others, it is evolving. One example is the traumatic incident reduction (TIR) approach. This brief memory-oriented intervention is designed for children, adolescents, and adults who have experienced traumatic stress (Valentine & Smith, 2001). Listed in SAMHSA's NREPP, the intervention is designed to process specific traumatic incidents or problematic themes related to the trauma, including specific feelings, emotions, sensations, attitudes, or pain. It involves having clients talk through the traumatic incident repeatedly with the anticipation that changes in affect will occur throughout the repetitions. TIR is a client-centered approach.

Integrated Models for Trauma

This section covers models specifically designed to treat trauma-related symptoms along with either mental or substance use disorders at the same time. Integrated treatments help clients work on several presenting problems simultaneously throughout the treatment, a promising and recommended strategy (Dass-Brailsford & Myrick, 2010; Najavits, 2002b; Nixon & Nearmy, 2011). Thus far, research is limited, but what is available suggests that integrated treatment models effectively reduce

substance abuse, PTSD symptoms, and other mental disorder symptoms. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment, 2005c), offers a detailed description of integrated treatment. In contrast with integrated models, other model types include single (treatment of only one disorder), sequential (treatment of one disorder first, then the other), or parallel (concurrent treatment of multiple disorders delivered by separate clinicians or in separate programs that do not necessarily address the interactions between symptoms and disorders).

Similar to single models, integrated treatment models are designed for use in a variety of settings (e.g., outpatient, day treatment, and/or residential substance abuse and mental health clinics/programs). Most models listed are manual-based treatments that address trauma-related symptoms, mental disorders, and substance use disorders at the same time. Additional approaches and further details on the selected approaches can be found at NREPP (http://www.nrepp.samhsa.gov).

Addiction and Trauma Recovery Integration Model

The Addiction and Trauma Recovery Integrated Model (ATRIUM; Miller & Guidry, 2001) integrates CBT and relational treatment through an emphasis on mental, physical, and spiritual health. This 12-week model for individuals and groups blends psychoeducational, process, and expressive activities, as well as information on the body's responses to addiction and traumatic stress and the impact of trauma and addiction on the mind and spirit. It helps clients explore anxiety, sexuality, self-harm, depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection. It was designed primarily for women and focuses on developmental (childhood) trauma and interpersonal violence, but it recognizes that other types of traumatic events occur.

The ATRIUM model consists of three phases of treatment. The first stage, or "outer circle," consists of the counselor collecting data from the client about his or her trauma history, offering psychoeducation on the nature of trauma, and helping the client assess personal strengths. ATRIUM actively discourages the evocation of memories of abuse or other trauma events in this phase. The second stage, or "middle circle," allows clients and counselors to address trauma symptoms more directly and specifically encourages clients to reach out to and engage with support resources in the community. The middle circle also emphasizes learning new information about trauma and developing additional coping skills. The third stage of the program, the "inner circle," focuses on challenging old beliefs that arose as a result of the trauma. For instance, the concept of "nonprotecting bystander" is used to represent the lack of support that the traumatized person experienced at the time of the trauma. This representation is replaced with the "protective presence" of supportive others today.

ATRIUM was used in one of the nine study sites of SAMHSA's Women, Co-Occurring Disorders and Violence Study. Across all sites, trauma-specific models achieved more favorable outcomes than control sites that did not use trauma-specific models (Morrissey et al., 2005). There has not yet been a study of ATRIUM per se, however. A manual describing the theory behind this model in greater depth, as well as how to implement it, is published under the title *Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit* (Miller & Guidry, 2001).

Beyond Trauma: A Healing Journey for Women

Beyond Trauma (Covington, 2003) is a curriculum for women's services based on theory, research, and clinical experience. It was developed for use in residential, outpatient, and correctional settings; domestic violence programs; and mental health clinics. It uses behavioral techniques and expressive arts and is based on relational therapy. Although the materials are designed for trauma treatment, the connection between trauma and substance abuse in women's lives is a theme throughout. Beyond Trauma has a psychoeducational component that defines trauma by way of its process as well as its impact on the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). Coping skills are emphasized; specific exercises develop emotional wellness.

Concurrent Treatment of PTSD and Cocaine Dependence

Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD) is a 16-session, twice-weekly individual outpatient psychotherapy model designed to treat women and men with co-occurring PTSD and cocaine dependence (Coffey, Schumacher, Brimo, & Brady, 2005). CTPCD combines imagery and in vivo exposure therapy (in which the client becomes desensitized to anxiety-producing stimuli through repeated exposure to them) for the treatment of PTSD with elements of CBT for substance dependence. To balance the dual needs of abstinence skill building and prompt trauma treatment, the first five sessions focus on coping skills for cocaine dependence. Session six transitions into exposure therapy, which begins in earnest in session seven and is combined with CBT for the treatment of substance abuse.

CTPCD helps reduce substance use and PTSD symptoms. The use of any illicit drug, as measured by urine screens, was quite low during the 16-week treatment trial and didn't escalate during the second half of treatment—when most exposure sessions occurred. PTSD symptoms dropped significantly over the course of treatment, as did self-reported depressive symptoms; however, the dropout rate was high (Coffey, Dansky, & Brady, 2003). CTPCD was reformulated into Concurrent Prolonged Exposure (COPE; Mills et al., 2012), which was compared with treatment as usual in a high-complexity clinical sample of individuals who had PTSD and substance dependence. Both treatment conditions resulted in improvements in PTSD with no difference at 3 months (though COPE showed significantly greater improvement at 9 months); moreover, the two conditions did not differ in impact on substance use outcomes, depression, or anxiety.

Integrated CBT

Integrated CBT is a 14-session individual therapy model designed for PTSD and substance use. It incorporates elements such as psychoeducation, cognitive restructuring, and breathing retraining (McGovern, Lamber-Harris, Alterman, Xie, & Meier, 2011). A randomized controlled trial showed that both integrated CBT and individual addiction treatment achieved improvements in substance use and other measures of psychiatric symptom severity with no difference between the treatments.

Seeking Safety

Seeking Safety is an empirically validated, present-focused treatment model that helps clients attain safety from trauma and substance abuse (Najavits, 2002a). The Seeking Safety manual (Najavits, 2002b) offers clinician guidelines and client handouts and is available in

several languages. Training videos and other implementation materials are available online (http://www.seekingsafety.org). Seeking Safety is flexible; it can be used for groups and individuals, with women and men, in all settings and levels of care, by all clinicians, for all types of trauma and substance abuse.

Seeking Safety covers 25 topics that address cognitive, behavioral, interpersonal, and case management domains. The topics can be conducted in any order, using as few or as many as are possible within a client's course of treatment. Each topic represents a coping skill relevant to both trauma and substance abuse, such as compassion, taking good care of yourself, healing from anger, coping with triggers, and asking for help. This treatment model builds hope through an emphasis on ideals and simple, emotionally evocative language and quotations. It attends to clinician processes and offers concrete strategies that are thought to be essential for clients dealing with concurrent substance use disorders and histories of trauma.

More than 20 published studies (which include pilot studies, randomized controlled trials, and multisite trials representing various investigators and populations) provide the evidence base for this treatment model. For more information, see SAMHSA's NREPP Web site (http://www.nrepp.samhsa.gov) as well as the "Outcomes" section of the Seeking Safety Web site (http://www.seekingsafety.org/3-03-06/studies.html). Study samples included people with chronic, severe trauma symptoms and substance dependence who were diverse in ethnicity and were treated in a range of settings (e.g., criminal justice, VA centers, adolescent treatment, homelessness services, public sector). Seeking Safety has shown positive outcomes on trauma symptoms, substance abuse, and other domains (e.g., suicidality, HIV risk, social functioning, problem-solving, sense of meaning); consistently outperformed treatment as usual; and achieved high satisfaction ratings from both clients and clinicians. It has been translated into seven languages, and a version for blind and/or dyslexic individuals is available.

The five key elements of Seeking Safety are:

1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
2. Integrated treatment (working on trauma and substance abuse at the same time).
3. A focus on ideals to counteract the loss of ideals in both trauma and substance abuse.
4. Four content areas: cognitive, behavioral, interpersonal, and case management.
5. Attention to clinician processes (addressing countertransference, self-care, and other issues).

Substance Dependence PTSD Therapy

Substance Dependence PTSD Therapy (Triffleman, 2000) was designed to help clients of both sexes cope with a broad range of traumas. It combines existing treatments for PTSD and substance abuse into a structured, 40-session (5-month, twice-weekly) individual therapy that occurs in two phases. Phase I is "Trauma-Informed, Addictions-Focused Treatment" and focuses on coping skills and cognitive interventions as well as creating a safe environment. Phase I draws on CBT models, anger management, relaxation training, HIV risk reduction, and motivational enhancement techniques. Phase II, "Trauma-Focused, Addictions-Informed Treatment," begins with psychoeducation about PTSD followed by "Anti-Avoidance I," in which a modified version of stress inoculation training is taught in two to four sessions. Following this is "Anti-Avoidance II," lasting 6 to 10 sessions, in which in vivo exposure is used.

Trauma Affect Regulation: Guide for Education and Therapy

Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford & Russo, 2006; Frisman, Ford, Lin, Mallon, & Chang, 2008) uses emotion and information processing in a present-focused, strengths-based approach to education and skills training for trauma survivors with severe mental, substance use, and co-occurring disorders across diverse populations. TARGET helps trauma survivors understand how trauma changes the brain's

TARGET: The Seven-Step FREEDOM Approach

Focus: Being focused helps a person pay attention and think about what's happening right now instead of just reacting based on alarm signals tied to past trauma. This step teaches participants to use the SOS skill (Slow down, Orient, Self-check) to pay attention to body signals and the immediate environment and to use a simple scale to measure stress and control levels.

Recognize triggers: Recognizing trauma triggers enables a person to anticipate and reset alarm signals as he or she learns to distinguish between a real threat and a reminder. This step helps participants identify personal triggers, take control, and short-circuit their alarm reactions.

Emotion self-check: The goal of this skill is to identify two types of emotions. The first are "alarm" or reactive emotions such as terror, rage, shame, hopelessness, and guilt. Because these emotions are the most noticeable after trauma, they are the alarm system's way of keeping a person primed and ready to fend off further danger. The second type of emotion, "main" emotions, include positive feelings (e.g., happiness, love, comfort, compassion) and feelings that represent positive strivings (e.g., hope, interest, confidence). By balancing both kinds of emotions, a person can reflect and draw on his or her own values and hopes even when the alarm is activated.

Evaluate thoughts: When the brain is in alarm mode, thinking tends to be rigid, global, and catastrophic. Evaluating thoughts, as with identifying emotions, is about achieving a healthier balance of positive as well as negative thinking. Through a two-part process, participants learn to evaluate the situation and their options with a focus on how they choose to act—moving from reactive thoughts to "main" thoughts. This is a fundamental change from the PTSD pattern, which causes problems by taking a person straight from alarm signals to automatic survival reactions.

Define goals: Reactive goals tend to be limited to just making it through the immediate situation or away from the source of danger. These reactive goals are necessary in true emergencies but don't reflect a person's "main" goals of doing worthwhile things and ultimately achieving a good and meaningful life. This step teaches one how to create "main" goals that reflect his or her deeper hopes and values.

Options: The only options that are available when the brain's alarm is turned on and won't turn off are automatic "flight/fight" or "freeze/submit" reactive behaviors that are necessary in emergencies but often unhelpful in ordinary living. This step helps identify positive intentions often hidden by the more extreme reactive options generated by the alarm system. This opens the possibility for a greater range of options that take into consideration one's own needs and goals as well as those of others.

Make a contribution: When the brain's alarm is turned on and reacting to ordinary stressors as if they were emergencies, it is very difficult for a person to come away from experiences with a feeling that they have made a positive difference. This can lead to feelings of alienation, worthlessness, or spiritual distress. The ultimate goal of TARGET is to empower adults and young people to think clearly enough to feel in control of their alarm reactions and, as a result, to be able to recognize the contribution they are making not only to their own lives, but to others' lives as well.

Source: Advanced Trauma Solutions, 2012.

normal stress response into an extreme survival-based alarm response that can lead to PTSD, and it teaches them a seven-step approach to making the PTSD alarm response less distressing and more adaptive (summarized by the acronym FREEDOM: Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution).

TARGET can be presented in individual therapy or gender-specific psychoeducational groups, and it has been adapted for individuals who are deaf; it has also been translated into Spanish and Dutch. TARGET is a resilience-building and recovery program not limited to individual or group psychotherapy; it is also designed to provide an educational curriculum and milieu intervention that affects all areas of practice in school, therapeutic, or correctional programs. TARGET is listed in SAMHSA's NREPP (http://www.nrepp.samhsa.gov).

Trauma Recovery and Empowerment Model

The trauma recovery and empowerment model (TREM) of therapy (Fallot & Harris, 2002; Harris & Community Connections Trauma Work Group, 1998) is a manualized group intervention designed for female trauma survivors with severe mental disorders. TREM addresses the complexity of long-term adaptation to trauma and attends to a range of difficulties common among survivors of sexual and physical abuse. TREM focuses mainly on developing specific recovery skills and current functioning and uses techniques that are effective in trauma recovery services. The model's content and structure, which cover 33 topics, are informed by the role of gender in women's experience of and coping with trauma.

TREM can be adapted for shorter-term residential settings and outpatient substance abuse treatment settings, among others. Adaptations of the model for men and adolescents are available. The model was used in SAMHSA's Women, Co-Occurring Disorders and Violence Study for three of the nine study sites and in SAMHSA's Homeless Families program, and it is listed in SAMHSA's NREPP. This model has been used with clients in substance abuse treatment; research by Toussaint, VanDeMark, Bornemann, and Graeber (2007) shows that women in a residential substance abuse treatment program showed significantly better trauma treatment outcomes using TREM than they did in treatment as usual, but no difference in substance use.

TREM Program Format

Each session includes an experiential exercise to promote group cohesiveness. The 33 sessions are divided into the following general topic areas:

- **Part I–empowerment** introduces gender identity concepts, interpersonal boundaries, and self-esteem.
- **Part II–trauma recovery** concentrates on sexual, physical, and emotional abuse and their relationship to psychiatric symptoms, substance abuse, and relational patterns and issues.
- **Part III–advanced trauma recovery issues** addresses additional trauma issues, such as blame and the role of forgiveness.
- **Part IV–closing rituals** allows participants to assess their progress and encourages them to plan for their continued healing, either on their own or as part of a community of other survivors.
- **Part V–modifications or supplements for special populations** provides modifications for subgroups such as women with serious mental illness, incarcerated women, women who are parents, women who abuse substances, and male survivors.

Source: Mental Health America Centers for Technical Assistance, 2012.

Triad Women's Project

The Triad Project was developed as a part of SAMHSA's Women, Co-Occurring Disorders and Violence Study. It is a comprehensive, trauma-informed, consumer-responsive integrated model designed for female trauma survivors with co-occurring substance use and mental disorders who live in semirural areas. Triad integrates motivational enhancement for substance use disorders, DBT, and intensive case management techniques for co-occurring mental disorders. This program is a 16-week group intervention for women that uses integrated case management services, a curriculum-based treatment group, and a peer support group (Clark & Fearday, 2003).

Emerging Interventions

New interventions are emerging to address traumatic stress symptoms and disorders. The following sections summarize a few interventions not highlighted in prior chapters; this is not an exhaustive list. In addition to specific interventions, technology is beginning to shape the delivery of care and to increase accessibility to tools that complement trauma-specific treatments. Numerous applications are available and evolving. For more information on the role of technology in the delivery of care, see the planned TIP, *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (SAMHSA, planned g).

Couple and Family Therapy

Trauma and traumatic stress affects significant relationships, including the survivor's family. Although minimal research has targeted the effectiveness of family therapy with trauma survivors, it is important to consider the needs of the individual in the context of their relationships. Family and couples therapy may be key to recovery. Family members may experience secondary traumatization silently, lack understanding of traumatic stress symptoms or treatment, and/or have their own histories of trauma that influence their willingness to support the client in the family or to talk about anything related to trauma and its effects. Family members can engage in similar patterns of avoidance and have their own triggers related to the trauma being addressed at the time. A range of couple and family therapies have addressed traumatic stress and PTSD, but few studies exist that support or refute their value. Current couple or family therapies that have some science-based evidence include behavioral family therapy, behavioral marital therapy, cognitive–behavioral couples treatment, and lifestyle management courses (Riggs, Monson, Glynn, & Canterino, 2009).

Mindfulness Interventions

Mindfulness is a process of learning to be present in the moment and observing internal experience (e.g., thoughts, bodily sensations) and external experience (e.g., interactions with others) in a nonjudgmental way. Mindfulness challenges limiting beliefs that arise from trauma, quells anxiety about future events, and simply helps one stay grounded in the present. It plays a significant role in helping individuals who have been traumatized observe their experiences, increase awareness, and tolerate uncomfortable emotions and cognitions.

To date, mindfulness-based interventions appear to be valuable as an adjunct to trauma-specific interventions and in decreasing arousal (Baer, 2003). It may also help individuals tolerate discomfort during exposure-oriented and trauma processing interventions. Overall, mindfulness practices can help clients in managing traumatic stress, coping, and resilience. In a study of firefighters, mindfulness was associated with fewer PTSD symptoms, depressive symptoms, physical symptoms, and alcohol problems when controlling for other variables (Smith et al., 2011).

Becoming an Observer and Learning To Tolerate Discomfort: The Leaf and Stream Metaphor

The following exercise, "leaves floating on a stream," is a classic. Many clinicians and authors provide renditions of this mindfulness practice. The main objectives are to stand back and observe thoughts rather than get caught up in them. Simply stated, thoughts are just thoughts. Thoughts come and go like water flowing down a stream. We don't need to react to the thoughts; instead, we can just notice them.

Conduct the mindfulness exercise for about 10 minutes, then process afterward. Take time to allow participants to visualize each sense as they imagine themselves sitting next to the stream. For example, what does it look like? What do they hear as they sit next to the stream? Don't rush the exercise. As you slowly make the statements detailed in the following two paragraphs, take time in between each statement for participants to be in the exercise without interruption; simply offer gentle guidance.

Begin to sit quietly, bringing your attention to your breath. If you feel comfortable, close your eyes. As you focus on breathing in and out, imagine that you are sitting next to a stream. In your imagination, you may clearly see and hear the stream, or you may have difficulty visualizing the stream. Follow along with the guided exercise; either way, it will work just as well.

Now begin to notice the thoughts that come into your mind. Some thoughts rush by, while others linger. Just allow yourself to notice your thoughts. As you begin to notice each thought, imagine putting those words onto a leaf as it floats by on the stream. Just let the thoughts come, watching them drift by on the leaves. If your thoughts briefly stop, continue to watch the water flow down the stream. Eventually, your thoughts will come again. Just let them come, and as they do, place them onto a leaf. Your attention may wander. Painful feelings may arise. You may feel uncomfortable or start to think that the exercise is "stupid." You may hook onto a thought—rehashing it repeatedly. That's okay; it's what our minds do. As soon as you notice your mind wandering or getting stuck, just gently bring your focus back to your thoughts, and place them onto the leaves. Now, bring your attention back to your breath for a moment, then open your eyes and become more aware of your environment.

Facilitated Questions:

- What was it like for you to observe your thoughts?
- Did you get distracted? Stuck?
- Were you able to bring yourself back to the exercise after getting distracted?
- In what ways was the exercise uncomfortable?
- In what ways was the exercise comforting?

For clients and practitioners who want to develop a greater capacity for mindfulness, see Kabat-Zinn's books *Wherever You Go, There You Are: Mindfulness Meditation In Everyday Life* (1994) and *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* (1990). For clinical applications of mindfulness, see *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse* (Segal et al., 2002) and *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors* (Marlatt & Donovan, 2005).

Pharmacological Therapy

Pharmacotherapy for people with mental, substance use, and traumatic stress disorders needs to be carefully managed by physicians who are well versed in the treatment of each condition. Medications can help manage and control symptoms; however, they are only a part of a comprehensive treatment plan. There

are no specific "antitrauma" drugs; rather, certain drugs target specific trauma symptoms. Clients receiving pharmacotherapy need careful assessment. Some clients with preexisting mental disorders may need further adjustment in medications due to the physiological effects of traumatic stress. In addition, sudden withdrawal from a pattern of self-administered substances can not only lead to dangerous levels of physical distress, but also exacerbate the emergence of more severe PTSD symptoms. Distress after trauma often lessens over time, which can sometimes make the use of medications unnecessary for some individuals. Some trauma survivors do not develop long-term psychological problems from their experiences that require medication; others may simply refuse the initiation of pharmacotherapy or the use of additional medications.

Concluding Note

Behavioral health counselors can best serve clients who have experienced trauma by providing integrated treatment that combines therapeutic models to target presenting symptoms and disorders. Doing so acknowledges that the disorders interact with each other. Some models have integrated curricula; others that address trauma alone can be combined with behavioral health techniques with which the counselor is already familiar.

In part, the choice of a treatment model or general approach will depend on the level of evidence for the model, the counselor's training, identified problems, the potential for prevention, and the client's goals and readiness for treatment. Are improved relationships with family members a goal? Will the client be satisfied if sleep problems decrease, or is the goal resolution of broader issues? Are there substance use or substance-related disorders? Is the goal abstinence? Collaborating with clients to decide on goals, eliciting what they would like from treatment, and determining what they expect to happen can provide some clues as to what treatment models or techniques might be successful in keeping clients engaged in recovery.

Part 2: An Implementation Guide for Behavioral Health Program Administrators

1 Trauma-Informed Organizations

IN THIS CHAPTER

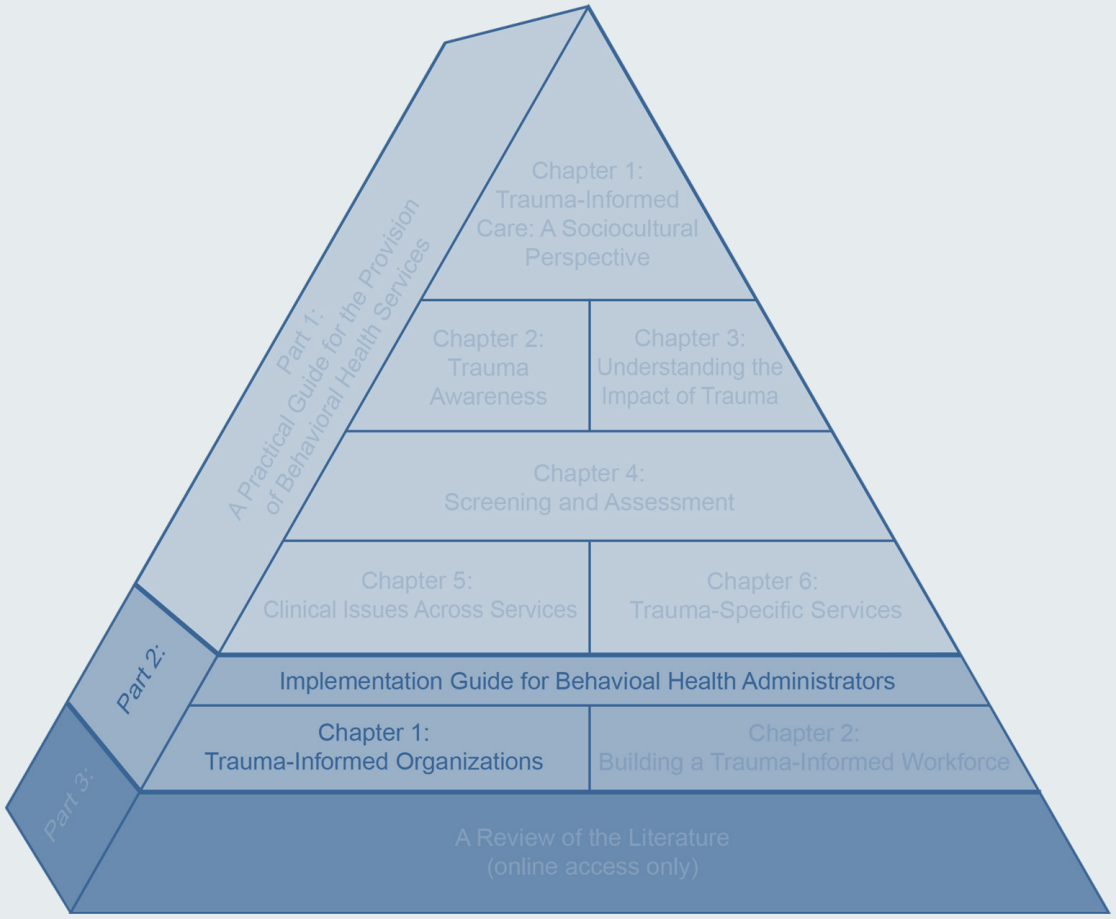
- Show Organizational and Administrative Commitment to TIC
- Use Trauma Informed Principles in Strategic Planning
- Review and Update Vision, Mission, and Value Statements
- Assign a Key Staff Member To Facilitate Change
- Create a Trauma Informed Oversight Committee
- Conduct an Organizational Self Assessment of Trauma Informed Services
- Develop an Implementation Plan
- Develop Policies and Procedures To Ensure Trauma Informed Practices and To Prevent Retraumatization
- Develop a Disaster Plan
- Incorporate Universal Routine Screenings
- Apply Culturally Responsive Principles
- Use Science Based Knowledge
- Create a Peer Support Environment
- Obtain Ongoing Feedback and Evaluations
- Change the Environment To Increase Safety
- Develop Trauma Informed Collaborations

Part 2 provides a broad overview of how to create and implement an institutional framework for trauma-informed services in program delivery and staff development, policies and procedures, administrative practices, and organizational infrastructure in behavioral health services. Chapter 1, "Trauma-Informed Organizations," focuses on specific organizational strategies that will help develop a trauma-informed culture in behavioral health settings. Numerous strategies are presented, including organizational commitment to trauma-informed care (TIC), trauma-informed organizational assessment, implementation of universal screening for trauma, and creation of a peer support environment.

Chapter 2, "Building a Trauma-Informed Workforce," focuses on organizational activities that foster the development of a trauma-informed workforce, including recruiting, hiring, and retaining trauma-informed staff; providing training on evidence-based and emerging trauma-informed best practices; developing competencies specific to TIC; addressing ethical considerations; providing trauma-informed supervision; and preventing and treating secondary trauma in behavioral health service providers.

The strategies described in the following sections can help supervisors and other administrative staff members create a trauma-informed behavioral health environment. As a starting point, the administration should identify key personnel and consumers to guide the organizational change process and the organizational assessment. Administrators and supervisors need to plan for and demonstrate an ongoing commitment to these strategies, or staff may perceive development activities as comprising yet another idea or demand from the agency that is short-lived beyond the initial thrust of training.

TIC Framework in Behavioral Health Services—Trauma-Informed Organizations



Creating a trauma-informed organization is a fluid, ongoing process; it has no completion date. Consumer demographics change across time, exposure to specific types of trauma may become more prevalent, and knowledge of best and evidence-based practices (EBPs) will continue to advance. A trauma-informed organization continues to demonstrate a commitment to compassionate and effective practices and organizational reassessments, and it changes to meet the needs of consumers with histories of trauma. It is encouraging that recent Substance Abuse and Mental Health Services Administration (SAMHSA) data indicates that the majority of over 10,000 programs they surveyed state that they provide trauma-related care (Capezza & Najavits, 2012). However, there remains a major need to make TIC consistently high-quality, routine, and pervasive across treatment systems.

The following stages form the basis of creating a trauma-informed organization:

1. Commit to creating a trauma-informed agency.
2. Create an initial infrastructure to initiate, support, and guide changes.
3. Involve key stakeholders, including consumers who have histories of trauma.
4. Assess whether and to what extent the organization's current policies, procedures, and operations either support TIC or interfere with the development of a trauma-informed approach.
5. Develop an organizational plan to implement and support the delivery of TIC within the agency.

Trauma-Informed Services and Service Systems

"A trauma-informed service system and/or organization is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence and trauma play in the lives of people seeking mental health and addiction services. A 'trauma-informed' organizational environment is capable of supporting and sustaining 'trauma-specific' services as they develop. A trauma-informed system recognizes that trauma results in multiple vulnerabilities and affects many aspects of a survivor's life over the lifespan, and therefore coordinates and integrates trauma-related activities and training with other systems of care serving trauma survivors. A basic understanding of trauma and trauma dynamics…should be held by all staff and should be used to design systems of services in a manner that accommodates the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid retraumatization and facilitate consumer participation in treatment. A trauma-informed service system is knowledgeable and competent to recognize and respond effectively to adults and children traumatically impacted by any of a range of overwhelming adverse experiences, both interpersonal in nature and caused by natural events and disasters. There should be written plans and procedures to develop a trauma-informed service system and/or trauma-informed organizations and facilities with methods to identify and monitor progress. Training programs for this purpose should be implemented."

Source: Jennings, 2009, pp. 111–112.

6. Create collaborations between providers and consumers and among service providers and various community agencies.
7. Put the organizational plan into action.
8. Reassess the implementation of the plan and its ability to meet the needs of consumers and to provide consistent TIC on an ongoing basis.
9. Implement quality improvement measures as needs and problem areas are identified.
10. Institute practices that support sustainability, such as ongoing training, clinical supervision, consumer participation and feedback, and resource allocation.

Strategy #1: Show Organizational and Administrative Commitment to TIC

Foremost, administrators need to understand the impact that trauma can have on people's lives. The consistent delivery of TIC is only as effective as the organization's commitment, which must extend to administrative practices with staff members, program policies and procedures, program design, staffing patterns, use of peer support, staff and peer training and supervision, organizational assessment and consumer feedback, and resources to uphold trauma-informed principles and practices. Even short-term change is not sustainable without the agency's continual commitment.

Typically, desirable organizational change doesn't occur by accident. It comes from steadfast leadership, a convincing message that change is necessary and beneficial for staff and consumers, and resources that support change. Many people naturally resist change; thus, an organization's commitment includes a willingness to discuss with staff members the impact and role of trauma in their service setting, patience in planning and implementation, and

Seminal Resource for Administrators

As you investigate how best to implement or improve trauma informed services within your organization or across systems, review the influential work, *Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services.*

(Harris & Fallot, 2001c)

Advice to Administrators: Managing Staff Reactions to Implementation of New Processes or Ideas

A common hurdle for administrators after introducing a new process or idea is the staff assumption that it will require more work. Frontline staff members are often inundated with many responsibilities beyond face-to-face time with clients. In addition, a common misperception is that if you begin to address trauma, you will have difficulty containing it.

In addition to administrative buy-in, administrators must promote rather than simply announce the implementation of trauma-informed services. Promotion includes educating staff about the rationale for trauma-informed services, offering opportunities for discussion and input from staff and consumers, providing training focused on trauma-informed skills, and so forth. For example, the San Diego Trauma-Informed Guide Team (2012) created a promotional brochure on how TIC can make staff jobs easier:

- Focuses on root problem
- Is preventative
- Increases support system
- Facilitates collaboration
- Shares workload
- Empowers client
- Provides consistency in agencies/systems
- Uses evidence-based best practices

TIC may be cost-effective, lead to less intensive services and less use of services, prevent undue stress for staff members and clients, and prevent client crises caused by old policies that could retraumatize trauma survivors.

the ability to tolerate the uncertainty that naturally accompanies transitions.

Strategy #2: Use Trauma-Informed Principles in Strategic Planning

Strategic planning provides an opportunity to explore and develop short- and long-term goals. The planning process often begins with reevaluating the organizations' values, mission, and vision, yet agencies cannot adequately develop a trauma-informed strategic plan without obtaining specific information about internal (staff, resources, processes) and external environmental (referral constellation, changes in health care, funding sources, State and Federal standards, community needs, consumer demographics, etc.) factors and influences. Data gathered through staff, consumer, organizational, and community assessments shapes the direction of the plan, including projected demands, challenges, obstacles, strengths, weaknesses, and resources. At the conclusion of this planning process, the organization will have specific goals, objectives, and tasks to meet the needs of their stakeholders and to address any anticipated challenges. Ideally, strategic planning should define key steps in developing or refining trauma-informed services within the organization.

Strategy #3: Review and Update Vision, Mission, and Value Statements

Vision, mission, and value statements provide a conceptual framework for TIC development and delivery. They should not be created in isolation; they should reflect voices from the community, populations, and other stakeholders that the organization serves. These statements develop through input, discussion, and assessment. They are not static; they evolve as needs, populations, or environments change.

Statement Example

As behavioral health service providers, we strive to be trauma aware—to understand the dynamics and impact of trauma on the lives of individuals, families, and communities. We strive to create a trauma-sensitive culture by demonstrating, through consumer empowerment, program design, and direct care, an understanding of the relationships among trauma, substance abuse, and mental illness.

Advice to Administrators: How To Create Vision, Value, and Mission Statements

Define the organization's vision, values, and mission to be compatible with TIC. Emphasize the organizational culture needed to provide TIC. An outgrowth of that cultural shift may include an enhanced working environment for employees and consumers that is noncoercive and reduces conflicts, restraint, and seclusion. Even if the current mission statement is appropriate, change it anyway to symbolize intended change within the organization. To define or redefine the vision, values, and mission:

- Involve consumers, all levels of staff, and leadership, including the director/CEO.
- Review:
  - Organizational priorities to identify and manage conflicting priorities.
  - Resources to assess whether reallocation is necessary for change (e.g., to hire peer support specialists, to furnish comfort rooms).
- Operationalize the vision, values, and mission at the level of individual departments
- Evaluate progress at regular staff meetings to ensure that changing the culture of care stays on the agenda.

Source: New Logic Organizational Learning, 2011.

Strategy #4: Assign a Key Staff Member To Facilitate Change

Prior to the development of an oversight committee, a senior staff member with the authority to initiate and implement changes should be assigned to oversee the developmental process. By assigning a trauma-aware senior staff member who is committed to trauma-informed services, it is more likely that the organization's and committee's goals, objectives, and plans will remain in focus. This senior staff member is responsible for ongoing development and facilitation of the oversight committee; management of the initial organizational assessment, reassessments, and other evaluative and feedback processes; and facilitation and oversight of the implementation plan and subsequent changes, including policies and procedures to ensure delivery of TIC.

Strategy #5: Create a Trauma-Informed Oversight Committee

The role of the oversight committee includes providing ongoing input and direction in the initial organizational assessment, strategic plan, plan implementation, reevaluation and development of trauma-informed policies and procedures, and future reassessments. The committee monitors progress and uses real-time data to forge a clear pathway to new processes that support TIC. The committee should involve stakeholders from the community, consumers, specialists, staff members, and administrators. Leadership involvement is necessary. Stakeholders may be alumni, family members, community-based organizations, and other institutions that interact with the agency or would benefit from trauma-informed services.

Initially, the agency must educate the committee on the organization's mission, values, and vision as well as the task at hand—developing trauma-informed services. To ease potential conflicts or confusion about the organization's structure, the guidelines, expectations, and roles of the committee need to be communicated directly to committee members as well as the organization as a whole, including board members, support and professional staff, supervisors, and so forth. The committee also needs to know the extent of their power and the necessary lines of communication before, during, and after evaluating and implementing changes in the organization.

Including consumers and/or those who have lived through trauma is vital. They have unique knowledge, experiences, and perspectives on the impact of treatment design, delivery, policies, and procedures. They offer firsthand information on practices that can potentially retraumatize clients in behavioral health settings and can suggest preventive, alternative practices and solutions. Consumer committee members keep staff and administrators aware of the goal of achieving TIC.

Strategy #6: Conduct an Organizational Self-Assessment of Trauma-Informed Services

An organizational self-assessment evaluates the presence and/or the effectiveness of current trauma-informed practices across each service and level of the organization. This assessment allows an organization to see how it functions within the context of trauma-informed principles and provides feedback to inform the development or revision of the implementation plan for TIC. In essence, this assessment process can serve as a blueprint for change and as a benchmark of compliance with and progress in implementing trauma-informed practices across time. Overall, it is a process of identifying organizational strengths, weaknesses, opportunities, and threats related to the implementation and maintenance of TIC. Refer to Appendix F for sample organizational assessment tools for the organization and the consumer.

The self-assessment should obtain feedback from key stakeholders, particularly consumers, family members, referral sources, community organizations, and all levels of the organization's staff, including nonclinical and clinical staff, supervisors, and administrative personnel. Similar to the universal screening process, an organizational self-assessment is only as effective as the steps taken after data are gathered and analyzed. From this assessment, an implementation plan should be established that highlights the goals, objectives, steps, timeframe, and personnel responsible in overseeing the specific objective. Assessment shouldn't be a once-and-done project. Timely and regularly scheduled organizational assessments should follow to assist in quality improvement. For an explanation of more detailed steps to take in conducting an organizational self-assessment, see Chapter 4 of the planned Treatment Improvement Protocol (TIP), *Improving Cultural Competence* (SAMHSA, planned c).

Advice to Administrators: Ten Steps to Quality Improvement

1. Identify new goals or problems.
2. Gather input from each level of the organization, including consumers and other key stakeholders.
3. Analyze the feedback.
4. Explore improvement options and the potential barriers associated with each.
5. Select the overall approach and specific strategies to address barriers (anticipate barriers, and try to address them before they occur).
6. Develop an implementation plan, and then present the plan to staff members and other key stakeholders not directly involved in the quality improvement process.
7. Implement the plan.
8. Reassess the new plan.
9. Evaluate the results and determine if new goals or additional problems or issues need to be addressed.
10. Repeat the first nine steps.

Strategy #7: Develop an Implementation Plan

Implementation plans should evolve from consumer participation, demographic profiles

Advice to Administrators: Implementation Plan Content

1. **Introduction and overview:** This includes the organization's history, the demographics that characterize its client base, the rationale for the implementation plan, and the incorporation of TIC. Focus on identification of strengths, weaknesses, opportunities, and threats. Provide an overview of goals and objectives.
2. **Specific goals and objectives:** Goals and objectives should address:
   - Workforce development strategies for recruiting, hiring, retaining, training, supervising, and promoting wellness of clinical and nonclinical staff members to support TIC.
   - Consumer participation and peer support development and implementation strategies.
   - Policies, procedures, and practices to support TIC and culturally responsive services, to promote safety, and to prevent retraumatization.
   - Specific evidence-based or best practice adoptions to support TIC.
   - Strategies to amend facility design or environment (plant) operations to reinforce safety.
   - Fiscal planning to ensure sustainability of the steps initiated in the organization.
3. **Guidelines for implementation:** Guidelines should highlight the specific steps, roles, responsibilities, and timeframes for each activity to meet TIC objectives.

of populations served, data from organizational self-assessment, and research on promising and evidence-based trauma-informed practices. Using the framework proposed in this TIP, the oversight committee is responsible for designing a plan that outlines the purpose, goals, objectives, timeframes, and personnel responsible for each objective (Exhibit 2.1-1).

Exhibit 2.1-1: TIC Planning Guidelines

The following publications provide samples of organizational guidelines for implementing TIC.

- Fallot, R. D. & Harris, M. (2009). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.* Washington, DC: Community Connections, 2009.
- Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-informed organizational toolkit.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W. K. Kellogg Foundation.
- Huckshorn, K. (2009). Transforming cultures of care toward recovery oriented services: Guidelines toward creating a trauma informed system of care. In *Trauma informed care (TIC) planning guidelines for use in developing an organizational action plan.* Alexandria, VA: National Association of State Mental Health Program Directors.
- Jennings, A. (2009). *Criteria for building a trauma-informed mental health service system.* Retrieved on May 21, 2013, from http://www.theannainstitute.org/CBTIMHSS.pdf
- Ohio Legal Rights Service (2007). *Trauma-informed treatment in behavioral health settings.* Columbus, OH: Ohio Legal Rights Service.
- Prescott, L., Soares, P., Konnath, K., & Bassuk, E. (2008). *A long journey home: A guide for creating trauma-informed services for mothers and children experiencing homelessness* [draft]. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W.K. Kellogg Foundation.

The following resource is a systemwide set of guidelines for implementing TIC.

- U.S. Department of Health and Human Services, Health Resources and Services Administration (2006). *Model trauma system: Planning and evaluation.* Rockville, MD: Health Resources and Services Administration.

Strategy #8: Develop Policies and Procedures To Ensure Trauma-Informed Practices and To Prevent Retraumatization

In the early stage of evaluating current services and planning for TIC, the committee needs to assess practices, procedures, and policies that may have been or could be retraumatizing to any individual, at any level of the organization, from consumers to administrators. Programs that are not trauma informed are as likely to be unaware of the impact of trauma on staff as they are to be unaware of its influence on consumers. In the initial review, careful scrutiny should be used to eliminate any practice that is potentially harmful, including seclusion and restraint practices, therapeutic activities that are shaming, treatment planning without collaboration, any medical inquiry without privacy, and so forth.

Policies and procedures are the building blocks of each agency. They guide the service process and, if followed, they provide an opportunity for the agency to deliver consistent responses and care. Policies and procedures must incorporate trauma-informed practices across all domains and standards, such as admissions, plant/environmental standards, screening and assessment processes, referrals (to other services, including hospitalization, or for further evaluations), treatment planning, confidentiality, discharge, and more. They also need to be updated periodically to incorporate new science and to meet the changing needs of consumers. By regularly reviewing and adapting administrative and clinical policies and procedures in response to ever-changing needs and evidence, the agency can provide staff members with good guidelines for providing trauma-informed services that are consistent yet flexible.

Program Curriculum: Roadmap to Seclusion-Free and Restraint-Free Mental Health Services

This curriculum, written from consumer perspectives, provides behavioral health staff with education, strategies, and hands-on tools to prevent and ultimately eliminate the use of seclusion and restraint. It includes many handouts for participants and consumers. This training package, available online (http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055), is divided into seven modules plus a resources section:

- Module 1: The Personal Experience of Seclusion and Restraint
- Module 2: Understanding the Impact of Trauma
- Module 3: Creating Cultural Change
- Module 4: Understanding Resilience and Recovery from the Consumer Perspective
- Module 5: Strategies to Prevent Seclusion and Restraint
- Module 6: Sustaining Change Through Consumer and Staff Involvement
- Module 7: Review and Action Plan
- Resource Section

Source: Center for Mental Health Services (CMHS), SAMHSA, 2005.

Strategy #9: Develop a Disaster Plan

Facilities are often required to develop disaster plans, but specific requirements vary from State to State. From the outset, developing a disaster plan in behavioral health services is essential. Many clients in behavioral health services have lived with trauma, so proactive steps that reduce the impact of a new trauma may prevent worsening of symptoms and decrease the risk for more pervasive effects. (See also Technical Assistance Publication 34, *Disaster Planning Handbook for Behavioral Health Treatment Programs* [SAMHSA, 2013].)

Most disaster events cannot be accurately anticipated. Even so, behavioral health organizations can take steps to reduce the impact of a disaster event on program functioning and on the lives of clients. Each service or program should develop a disaster response committee that meets regularly to develop, maintain, and adapt policies and procedures to respond to disasters affecting the program. Committee planning efforts may include:

1. Creating a disaster response team of program staff members tasked with coordinating program administration and services in a disaster event.
2. Establishing a communication process for informing staff and clients of the status of program functioning and for coordinating staff assignments during and shortly after the disaster event.
3. Outlining a process to inform clients and their families of available services, their location, and contact information for accessing services to meet clients' critical needs.
4. Developing plans for service provision during a disaster event and service implementation after the event.
5. Creating special plans for high-risk or special needs clients who need services during and shortly after the disaster. Examples of this are clients who are homeless, in detoxification services or methadone programs, on prescribed psychopharmaceuticals, or at risk for suicide.
6. Making plans for maintaining the security of client records, program records, and facilities during and shortly after the event.
7. Coordinating ahead with other community resources and services to ensure that clients at high risk or with special needs get the services they require as soon as possible.
8. Prioritizing how services will start back up after a disaster event.
9. Providing special services after the event to clients at high risk for trauma reactions and symptoms.
10. Establishing a postdisaster debriefing process to review disaster responses, services, and outcomes.

Some specific disaster events, such as hurricanes, may sometimes offer opportunities for planning and preparation in advance of the disaster event. This preparation time is usually just a few days, but it allows programs to make advance preparations and take advance action to establish lines of communication, stockpile resources, prepare for evacuation of clients, and protect client and program records.

Strategy #10: Incorporate Universal Routine Screenings

A key element of trauma-informed services is the institution of universal routine screening across all services, regardless of the individual's path in accessing services (e.g., primary care, hospitalization, outpatient). Considering the prevalence of trauma among individuals who seek services for mental and substance use disorders, the implementation of screening is paramount. Without screening, clients are not identified as trauma survivors. Subsequently, they miss recovery opportunities and treatment services that would be more likely to meet their needs, while also running a higher risk of being retraumatized by unexamined organizational policies, procedures, and practices. For more information on the rationale, processes, and instruments of universal screening for trauma, refer to Part 1, Chapter 4.

Strategy #11: Apply Culturally Responsive Principles

Providers must be culturally competent when incorporating evidence-based and best practices as well as trauma-informed treatment

models within the organization. Clients' views of behavioral health differ according to race, ethnicity, and culture (refer to the planned Treatment Improvement Protocol [TIP], *Improving Cultural Competence* [SAMHSA, planned c]). Likewise, cultures attach different meanings to trauma, and responses to trauma will vary considerable across cultures (see Part 3, the online literature review, for more information). For example, trauma survivors who come from a collective society or culture, in which the goals of the group take precedence over the goals of the individual, may be more focused on the well-being of their family or the family's response to the trauma survivors' experience. Often, this view runs in opposition to the individualistic perspective of many behavioral health services. Subsequently, treatment providers who are not culturally competent may interpret collective values as a sign of resistance or avoidance in dealing with traumatic stress. CMHS (2003) outlines principles of cultural competence in disaster work applicable across all forms of trauma:

1. ***Recognize the importance of culture and respect diversity.*** Those who value culture and diversity understand their own cultures, attitudes, values, and beliefs, and they work to understand the cultures of others. This includes being able to communicate effectively with those from other cultures, respecting others' feelings about personal space, knowing about others' social organization, understanding how time is viewed, and being aware of others' beliefs about the effects of their behaviors.
2. ***Maintain a current profile of the cultural composition of the community.*** This includes describing the community's population in terms of race and ethnicity, age, gender, religion, refugee and immigrant status, housing status, income levels, rural/urban balance, unemployment, languages spoken, literacy, schools, and businesses.
3. ***Recruit workers who are representative of the community or service area.*** If the workers who are available do not match the community, they should have the personal attributes, knowledge, and skills to develop cultural competence.
4. ***Provide ongoing cultural competence training to staff.*** Topics should include cultural values and traditions, family values, linguistics and literacy, immigration experiences and status, help-seeking behaviors, techniques and strategies for cross-cultural outreach, and the avoidance of stereotypes and labels (DeWolfe & Nordboe, 2000b).
5. ***Ensure that services are accessible, appropriate, and equitable.*** In planning disaster work or TIC, community associations and organizations are invaluable. Gaining their acceptance requires time and energy.
6. ***Recognize the role of help-seeking behaviors, traditions, and natural support networks.*** Culture includes traditions that dictate whom, or which groups, to seek in times of need; how to handle suffering and loss; and how healing takes place. These customs and traditions are respected by a culturally responsive disaster relief program.
7. ***Involve community leaders and organizations representing diverse cultural groups as "cultural brokers."*** Collaborating with community leaders is an effective means of learning about the community, establishing program credibility, and ensuring that services are culturally responsive.
8. ***Ensure that services and information are culturally and linguistically responsive.*** Communication with individuals who do not speak English, who are illiterate in all languages or have limited literacy, and who are deaf or hard of hearing is essential to service provision. Local radio stations, television outlets, and newspapers that are multicultural are an excellent venue for educational information after a disaster.

Using survivors' friends or relatives as interpreters is not recommended, as survivors may be uncomfortable discussing personal matters with family members or friends. Asking children to interpret can place too heavy a responsibility on them and reverses parents' and children's roles.

9. ***Assess and evaluate the program's level of cultural responsiveness.*** Self-assessment and process evaluation can help keep a program on track. A variety of strategies can be used for collecting data and communicating findings to stakeholders.

Strategy #12: Use Science-Based Knowledge

Along with culturally responsive services, trauma-informed organizations must use science-based knowledge to guide program development and the implementation of services, policies, procedures, and practices. This includes the adoption of EBPs (see Part 1, Chapter 6, and Part 3, Section 1, to review definition, treatments, and resources for EBPs). TIC research is quite new; interpret these limited studies and information cautiously. Chambless and Hollon's (1998) criteria, which are still the benchmark for EBPs, are valuable resources for administrators. Look closely at who was included—and excluded—from treatment studies. Often, the types of severe, chronic, and unstable cases seen in community settings are excluded from treatment studies. Evidence-based interventions should be a primary consideration in selecting appropriate treatment models for people with mental illness, substance use disorders, and co-occurring psychological trauma. Nonetheless, other variables must also be contemplated before adopting EBPs in an organization, including the cultural appropriateness of the practice; the strength of its clinical focus on strengths-based strategies; training and competence of clinical staff; the cost of training, materials, and implementation; and the ease of maintaining EBP fidelity amidst staff turnover.

For more detailed information on EBPs, visit the National Registry of Evidence Based Programs and Practices (NREPP) Web site (http://nrepp.samhsa.gov). For more specific research oriented information on trauma and trauma specific treatments, refer to the literature review in Part 3 of this TIP, available online.

Strategy #13: Create a Peer-Support Environment

The main purpose of peer support services is to provide consumer mentoring, support, and care coordination for clients with histories of mental illness or substance abuse. The goals are to help others deal with personal and environmental barriers that impede recovery and achieve wellness. Peer support accomplishes this through many activities, including advocacy, support during crises and recovery activities, modeling, education, and assistance in accessing available resources. Peer support programs send a powerful message to staff members, consumers, and the community—that recovery is possible through support, collaboration, and empowerment. These programs reinforce the trauma-informed premise that organizations need to reflect the populations that they serve and involve consumers in planning, implementing, monitoring, and delivering recovery services.

For an introduction to peer support services, see *What Are Peer Recovery Support Services?* (Center for Substance Abuse Treatment, 2009e).

Notably, peer support services have the potential to be considerably flexible to meet client needs at each stage of recovery. Specifically, peer support services can be incorporated

across the continuum of care, starting with outreach services and extending into long-term recovery services. Peer support specialists can enhance consumer motivation to change, to initiate services, and/or to engage in recovery activities. They can play powerful liaison roles by supporting clients entering treatment and explaining what to expect from services. They can ease the transition into treatment, from one service to the next, from one modality to another (e.g., inpatient group to outpatient group), and beyond formal treatment. Moreover, peer support services create an atmosphere focused on mutuality rather than pathology. They provide living models of resilience and promote hope—that recovery is possible and attainable.

Administrators should familiarize themselves with how other organizations have implemented peer support programs, current curricula, certifications and training processes, competencies and ethics, and peer support service State standards or recommendations, if applicable. The Carter Center's Summit in 2009, The Pillars of Peer Support Services, supported in part by SAMHSA and CMHS, highlighted the numerous elements necessary to develop a strong, vital peer workforce (Daniels et al., 2010). These elements include:

- Clear job and service descriptions.
- Job-related competencies and competence-based testing processes.
- Peer support certifications.
- Ongoing continuing education.
- Media and technology access for peer specialists.
- Sustainable funding.
- Research and evaluation components.
- Code of ethics and conduct.
- Competence-based training for supervisors.
- Multilevel support and program support teams.

> "Peer recovery support services are evidence based and have been demonstrated to promote positive health outcomes and control the cost of healthcare. These services are offered by a trained individual with lived experience and recovery from a mental illness, substance use and/or chronic health conditions. Peer recovery support services minimally include chronic illness self management, whole health and wellness promotion and engagement, relapse prevention, life skill coaching, and insurance and health systems navigation."
>
> (Daniels et al., 2012, p. 22)

Advice to Administrators: Sample Peer Support Staff Tasks

- Use active listening skills help peers identify areas of dissatisfaction and benefits of changing beliefs, thoughts, and behavior.
- Use problem-solving skills to help peers identify barriers to recovery and develop plans to meet peer-determined goals.
- Facilitate recovery support groups.
- Link clients with community resources.
- Work with the treatment team to advocate for clients and to remove recovery barriers.
- Participate in consumer panels to educate staff about the consumer perspective and about peer support.
- Participate in hospital-wide committees and workgroups

Source: New Logic Organizational Learning, 2011.

Strategy #14: Obtain Ongoing Feedback and Evaluations

Obtain feedback on and evaluations of organizational performance on a regular basis. Give consumers a clear avenue for offering feedback at any time, and make evaluations assessing the organization's progress toward providing trauma-informed services standard practice. Without feedback and further evaluation, organizations cannot assess whether they are

meeting trauma-informed objectives. A routine monitoring process for TIC implementation gives the organization additional information necessary to combat new obstacles and threats and to understand what works. Regular monitoring equips organizations with the ability to formulate different strategies to meet objectives as well as to respond to the changing needs of the population. Ongoing evaluation and consumer feedback are essential in improving the quality of services.

Strategy #15: Change the Environment To Increase Safety

Practices that generate emotional and physical safety are necessary. Another aspect of creating safety is reevaluating the physical facilities and environment to enhance safety and to circumvent preventable retraumatization. Think how traumatizing it would be if you were a female rape survivor and a night counselor was conducting a room check at 2:00 a.m., or a male security guard was walking the women's residential wing. What would it be like if you were sitting with your back to the door in a small office during an intake interview, if your history included a physical assault and robbery? For most, it would at least increase anxiety; for others it would be retraumatizing. Trauma-informed providers must carefully assess environmental safety. Although you are likely to identify some facility issues that could erode safety for trauma survivors, a safe environment will only be established if regular feedback is obtained from consumers about their experiences with the program.

Strategy #16: Develop Trauma-Informed Collaborations

TIC is about collaboration with consumers, staff members, key stakeholders, and other agencies. Collaborative relationships provide opportunities for consumers to access the most appropriate services as needs arise. Rather than waiting for a crisis or a dire need for a service to investigate available resources, it is far more efficient and compassionate to establish relationships within the agency and with other community resources before these needs arise. No agency can meet the needs of every client; referral agreements and/or collaborative arrangements that integrate the delivery of TIC, including support services (e.g., housing, legal, medical), are important.

Creating Sanctuary

The sanctuary model is a trauma-based therapeutic approach that has been used in inpatient, residential, therapeutic community, and outpatient settings with children, adolescents, and adults. It provides a template for changing social service delivery systems so that they are better equipped to respond to the complex needs of trauma survivors. Sanctuary is informed by four knowledge areas: "the psychobiology of trauma, the active creation of nonviolent environments, principles of social learning, and an understanding of the ways in which complex adaptive systems grow, change, and alter their course" (Bloom et al., 2003, p. 174).

The sanctuary model describes a stage-based approach to healing that is referred to as SAGE: safety, affect modulation, grieving, and emancipation. This model is nonlinear; an individual does not necessarily move from one stage to another in a straight path, but progress in one area does affect progress in other areas (Bloom, 1997; Bloom et al., 2003). SAGE is a cognitive–behavioral translation of the sanctuary model (Bills, 2003). Early in treatment, the focuses are typically on safety and affect management. Safety encompasses four domains: physical, psychological, social, and moral (Bloom, 1997; see http://www.sanctuaryweb.com for further details and a curriculum).

2 Building a Trauma-Informed Workforce

IN THIS CHAPTER

- Introduction
- Workforce Recruitment, Hiring, and Retention
- Training in TIC
- Trauma Informed Counselor Competencies
- Counselor Responsibilities and Ethics
- Clinical Supervision and Consultation
- Secondary Traumatization
- Counselor Self Care

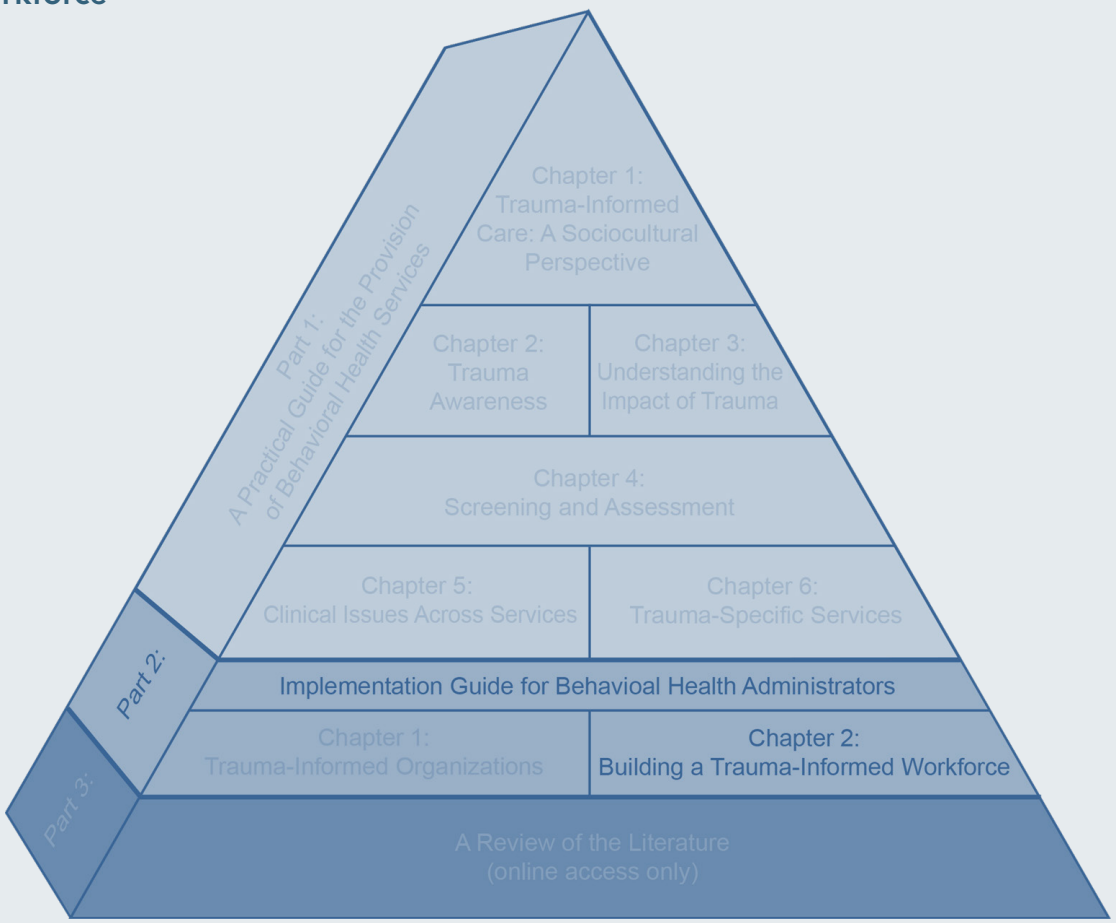
Introduction

For an organization to embrace a trauma-informed care (TIC) model fully, it must adopt a trauma-informed organizational mission and commit resources to support it. This entails implementing an agency-wide strategy for workforce development that is in alignment with the values and principles of TIC and the organization's mission statement. Without a fully trained staff, an organization will not be able to implement the TIC model. However, simply training behavioral health professionals in TIC is not enough. Counselors will not be able to sustain the kind of focus required to adopt and implement a trauma-informed philosophy and services without the ongoing support of administrators and clinical supervisors.

An organizational environment of care for the health, well-being, and safety of, as well as respect for, its staff will enhance the ability of counselors to provide the best possible trauma-informed behavioral health services to clients. This culture of care must permeate the organization from top to bottom. Behavioral health program administrators should aim to strengthen their workforce; doing so "requires creating environments that support the health and well-being, not only of persons with mental and substance use conditions, but of the workforce as well" (Hoge, 2007, p. 58). An organizational culture of care, safety, and respect demands activities that foster the development of trauma-informed counselors. This chapter focuses on key workforce development activities, such as:

- Recruiting, hiring, and retaining trauma-informed staff.
- Training behavioral health service providers on the principles of, and evidence-based and emerging best practices relevant to, TIC.
- Developing and promoting a set of counselor competencies specific to TIC.

TIC Framework in Behavioral Health Services—Building a Trauma-Informed Workforce



- Delineating the responsibilities of counselors and addressing ethical considerations specifically relevant to promoting TIC.
- Providing trauma-informed clinical supervision.
- Committing to prevention and treatment of secondary trauma of behavioral health professionals within the organization.

Addressing each of these areas is essential to building a trauma-informed workforce and an organizational culture that supports TIC.

Workforce Recruitment, Hiring, and Retention

An Action Plan for Behavioral Health Workforce Development (Hoge et al., 2007) emphasizes the importance of organization-wide support and active involvement in workforce recruitment, hiring, and retention in behavioral health systems. One of the key findings of this report is that the work environment itself in many behavioral health settings can be toxic to the workforce and may hinder the delivery of individualized, respectful, collaborative, and client-centered care to service recipients. Factors such as the downward pressure on organizations for higher productivity of counselors increase caseloads and decrease wages of behavioral health staff members and may create a high-stress environment that contributes to low morale and worker dissatisfaction. Other factors that often contribute to low retention of qualified counselors in behavioral health settings include the lack of professional career

ladders, fragile job security, the lack of clinical supervision, and an inability to influence the organization in which they are working (Hoge et al., 2007).

Added to this mix is the intensity of working with people with the co-occurring conditions of trauma-related mental and substance use disorders and the risk of secondary traumatization of counselors. In creating and sustaining a trauma-informed workforce, organizations need to foster a work environment that parallels the treatment philosophy of a trauma-informed system of care. Doing so allows counselors to count on a work environment that values safety, endorses collaboration in the making of decisions at all levels, and promotes counselor well-being.

Recruitment and Hiring in a Trauma-Informed System of Care

In a 2007 technical report (Jennings, 2007b), the National Center for Trauma-Informed Care identified several priorities for organizations with regard to recruitment and hiring trauma-informed staff, including:

- Active recruitment of and outreach to prospective employees who are trauma-informed or have formal education in providing trauma-informed or trauma-specific services in settings such as universities, professional organizations, professional training and conference sites, peer support groups, and consumer advocacy groups.
- Hiring counselors and peer support staff members with educational backgrounds and training in trauma-informed and/or trauma-specific services and/or lived experience of trauma and recovery.
- Providing incentives, bonuses, and promotions for staff members during recruitment and hiring that take into consideration prospective employees' trauma-related education, training, and job responsibilities.

In addition to hiring behavioral health professionals with formal professional education and training, organizations should also "routinely survey the demographics and other characteristics of the population served and recruit a workforce of similar composition" (Hoge et al., 2007, p. 297). Essentially, this means actively engaging in outreach to consumer advocacy groups, recovery-oriented programs, community and faith-based organizations, and former clients/consumers with the intention of recruiting potential employees whose knowledge and expertise comes from their lived experience of trauma, resilience, and recovery. Support staff members, peer support workers, counselors in training, and apprentices can be recruited from this population and offered incentives, such as tuition reimbursement, training stipends, and professional mentoring with the goal of developing a trauma-informed workforce from within the demographic served. Jennings (2007b) calls these staff members "trauma champions" who can provide needed expertise in a trauma-informed organization to promote trauma-informed policies, staff development, and trauma-based services consistent with the mission of the organization (p. 135).

Who Is a Trauma Champion?

"A champion understands the impact of violence and victimization on the lives of people seeking mental health or addiction services and is a front-line worker who thinks 'trauma first.' When trying to understand a person's behavior, the champion will ask, 'is this related to abuse and violence?' A champion will also think about whether his or her own behavior is hurtful or insensitive to the needs of a trauma survivor. The champion is there to do an identified job—he is a case manager or a counselor or a residential specialist—but in addition to his or her job, a champion is there to shine the spotlight on trauma issues."

Source: Harris & Fallot, 2001a, p. 8.

As with hiring behavioral health professionals who are in recovery from substance use disorders, the organization should be transparent and explicit in its recruitment and hiring practices of trauma survivors in recovery. The organization can be transparent by advertising the mission statement of the organization as part of the recruitment process and inviting applicants who are in recovery from trauma to apply. The needs of behavioral health staff members who are in recovery from both substance use and trauma-related conditions and working in a trauma-informed system of care should be addressed in the organization's ongoing training, clinical supervision, and staff development policies and practices.

Workforce Retention

Staff turnover is rampant in behavioral health settings. It is costly to the organization, and as a result, it is costly to clients. A strong therapeutic relationship with a counselor is one of the largest factors in an individual's ability to recover from the overwhelming effects of trauma. When behavioral health professionals leave an organization prematurely or in crisis as a result of chronic levels of high stress or secondary traumatization, clients must deal with disruptions in their relationships with counselors. Some of the organizational factors that contribute to chronic levels of high stress and often lead to high staff turnover include expecting counselors to maintain high caseloads of clients who have experienced trauma; not providing trauma-informed clinical supervision and training to counselors; and failing to provide adequate vacation, health insurance, and other reasonable benefits that support counselors' well-being. Other factors that may have a more profound impact on staff retention include failing to acknowledge the reality of secondary traumatization, promoting the view that counselors' stress reactions are a personal failure instead of a normal response to engaging with clients' traumatic material, and not supporting personal psychotherapy for counselors (Saakvitne, Pearlman, & Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy, 1996).

Research on promoting counselor retention in behavioral health settings demonstrates that

Advice to Administrators: Preventing Turnover and Increasing Workforce Retention

To prevent behavioral health staff turnover and increase retention of qualified, satisfied, and highly committed trauma-informed counselors, consider:

- Offering competitive wages, benefits, and performance incentives that take into account education, training, and levels of responsibility in providing trauma-informed or trauma-specific services.
- Creating a safe working environment that includes both the physical plant and policies and procedures to prevent harassment, stalking, and/or violence in the workplace and to promote respectful interactions amongst staff at all levels of the organization.
- Establishing an organizational policy that normalizes secondary trauma as an accepted part of working in behavioral health settings and views the problem as systemic—not the result of individual pathology or a deficit on the part of the counselor.
- Instituting reasonable, manageable caseloads that mix clients with and without trauma-related concerns.
- Letting staff offer input into clinical and administrative policies that directly affect their work experience.
- Providing vacation, health insurance (which includes coverage for psychotherapy/personal counseling), and other benefits that promote the well-being of the staff.
- Implementing regular, consistent clinical supervision for all clinical staff members.
- Providing ongoing training in trauma-informed services offered by the organization.

behavioral health staff members are interested in the same kind of work environment and benefits as employees in many other fields. They include a "living wage with healthcare benefits; opportunities to grow and advance; clarity in a job role; some autonomy and input into decisions; manageable workloads; administrative support without crushing administrative burden; basic orientation and training for assigned responsibilities; a decent and safe physical work environment; a competent and cohesive team of coworkers; the support of a supervisor; and rewards for exceptional performance" (Hoge et al., 2007, p. 18).

When an organization's administration values its staff by providing competitive salaries and benefits, a safe working environment, a reasonable and manageable workload, input into the making of clinical and administrative policy decisions, and performance incentives, it helps behavioral health workers feel connected to the mission of the organization and become dedicated to its sustainability and growth. This type of work environment demonstrates both a level of respect for counselors (similar to the level of respect a trauma-informed organization displays toward clients) and an appreciation for the complexity of their job responsibilities and the stress they face when working with people who have experienced trauma in their lives. To retain behavioral health professionals working in a trauma-informed setting, wages and performance incentives should be tied not only to education, training, and work experience, but also to levels of responsibility in working with clients who have experienced trauma.

Training in TIC

Training for all staff members is essential in creating a trauma-informed organization. It may seem that training should simply focus on new counselors or on enhancing the skill level of those who have no prior experience in working with trauma, but training should, in fact, be more systematic across the organization to develop fully sustainable trauma-informed services. All employees, including administrative staff members, should receive an orientation and basic education about the prevalence of trauma and its impact on the organization's clients. To ensure safety and reduction of harm, training should cover dynamics of retraumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. Training for all employees must also educate them "about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socioeconomic status on individuals' experiences of trauma" (Jennings, 2007a, p. 5).

All clinical and direct service staff members, regardless of level of experience, should receive more indepth training in screening and assessment of substance use and trauma-related disorders; the relationships among trauma, substance use disorders, and mental disorders; how to understand difficult client behaviors through a trauma-informed lens; how to avoid retraumatizing clients in a clinical setting; the development of personal and professional boundaries unique to clinical work with traumatized clients; how to identify the signs of secondary traumatization in themselves; and how to develop a comprehensive personal and professional self-care plan to prevent and/or ameliorate the effects of secondary traumatization in the workplace. All clinical staff members who work with traumatized clients should receive additional training in evidence-based and promising practices for the treatment of trauma (for information on locating training, see Appendix B.) This might include training done within the agency by experts in the field or training received by attending advanced trauma trainings. Administrators

should provide the time and financial resources to clinical staff members for this professional development activity. Jennings (2007a) suggests that, whenever possible, "trainings should be multi-system, inclusive of staff in mental health and substance abuse, health care, educational, criminal justice, social services systems and agencies, and promoting systems integration and coordination" (p. 5).

Moreover, criminal justice settings, schools, military/veteran programs, and other places in which behavioral health services are provided may benefit from approaches that are sensitive to the special circumstances and cultures of these environments. For example, in exploring trauma-informed correctional care, Miller and Najavits (2012, p. 1) observe:

> Prisons are challenging settings for trauma-informed care. Prisons are designed to house perpetrators, not victims. Inmates arrive shackled and are crammed into overcrowded housing units; lights are on all night, loud speakers blare without warning and privacy is severely limited. Security staff is focused on maintaining order and must assume each inmate is potentially violent. The correctional environment is full of unavoidable triggers, such as pat downs and strip searches, frequent discipline from authority figures, and restricted movement….This is likely to increase trauma-related behaviors and symptoms that can be difficult for prison staff to manage….Yet, if trauma-informed principles are introduced, all staff can play a major role in minimizing triggers, stabilizing offenders, reducing critical incidents, deescalating situations, and avoiding restraint, seclusion or other measures that may repeat aspects of past abuse.

The Need for Training

Behavioral health service providers working with clients who have mental, substance use, and trauma-related disorders need to have the best knowledge, skills, and abilities. Substance abuse counselors, in particular, require additional training and skill development to be able to extend trauma-informed services (within the

Case Illustration: Larry

Larry is a 28-year-old clinical social worker who just finished his master's program in social work and is working in a trauma-informed outpatient program for people with substance use disorders. He is recovering from alcohol use disorder and previously worked in a residential rehabilitation program as a recovery support counselor. There, his primary responsibilities were to take residents to Alcoholics Anonymous (AA) meetings, monitor their participation, and confront them about their substance use issues and noncompliance with the program's requirement of attendance at 12-Step meetings.

In Larry's new position as a counselor, he confronts a client in his group regarding her discomfort with attending AA meetings. The client reports that she feels uncomfortable with the idea that she has to admit that she is powerless over alcohol to be accepted by the group of mostly men. She was sexually abused by her stepfather when she was a child and began drinking heavily and smoking pot when she was 11 years old. The client reacts angrily to Larry's intervention.

In supervision, Larry discusses his concerns regarding the client's resistance to AA and the feedback that he provided to her in group. Beyond focusing supervision on Larry's new role as a counselor in a trauma-informed program, the clinical supervisor recommends that Larry take an interactive, multisession, computer-assisted training on the 12-Step facilitation (TSF) model. The TSF model introduces clients to and assists them with engaging in 12-Step recovery support groups. The agency has the computer-based training available in the office, and Larry agrees to use follow-up coaching sessions with his supervisor to work on implementation of the approach. The supervisor recognizes that Larry is falling back on his own recovery experience and the strategies he relied on in his previous counseling role. He will benefit from further training and coaching in an evidence-based practice that provides a nonaggressive, focused, and structured way to facilitate participation in recovery support groups with clients who have trauma histories.

limits of their professional licensure and scope of practice) to clients who have co-occurring substance use, trauma-related, or mental disorders. Many clinical practice issues in traditional substance abuse treatment are inconsistent with trauma-informed practice, which needs to be addressed with further training. Similarly, mental health clinicians often need training in substance abuse treatment, as they typically do not have backgrounds or experience in that domain. Moreover, several surveys indicate that clinicians consistently perceive the combination of trauma and substance abuse as harder to treat than either one alone (Najavits, Norman, Kivlahan, & Kosten, 2010). It is thus key to emphasize cross-training as part of TIC. Exhibit 2.2-1 addresses these issues and offers suggestions for additional training.

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings

- Some substance abuse counseling strategies commonly used to work through clients' denial and minimization of their substance use issues may be inappropriate when working with trauma survivors (e.g., highly confrontational models can remind trauma survivors of emotional abuse).

  Training: The Stages of Change model of addiction treatment can help counselors shift from the traditional confrontation of denial to conceptualizing clients' ambivalence about changing substance use patterns as a normal part of the precontemplation stage of change. This method is a respectful cognitive–behavioral approach that helps counselors match counseling strategies to their assessment of where each client is in each stage of change, with the ultimate goal of helping clients make changes to health risk behaviors. (Connors, Donovan, & DiClemente, 2001).

- The 12-Step concept of powerlessness (Step 1) may seem unhelpful to trauma survivors for whom the emotional reaction to powerlessness is a major part of their trauma (particularly for victims of repetitive trauma, such as child abuse or intimate partner violence). It can be confusing and counterproductive to dwell on this concept of powerlessness regarding trauma when the therapeutic objective for trauma-informed counseling methods should be to help clients empower themselves. For people in recovery, powerlessness is a paradox, sometimes misunderstood by both counselors and clients, in that the acknowledgment of powerlessness often creates a sense of empowerment. Most clients, with support and respectful guidance from a counselor, will come to understand that powerlessness (as used in 12-Step programs) is not an inability to stand up for oneself or express a need, and it does not mean for one to be powerless in the face of abuse. With this understanding, clients may become more open to participating in 12-Step groups as a resource for their recovery from substance use disorders. When clients continue to struggle with this concept and decline to participate in 12-Step recovery efforts, they may benefit from referral to other forms of mutual-help programs or recovery support groups in which the concept of powerlessness over the substance of abuse is not such a significant issue.

  Training: The TSF model can help counselors develop a more supportive and understanding approach to facilitating clients' involvement in 12-Step recovery groups (if this is a client-generated recovery goal). "Although based on standard counseling models, TSF differs from them in several ways. These differences include TSF's strong emphasis on therapist support, discouragement of aggressive 'confrontation of denial' and therapist self-disclosure, and highly focused and structured format" (Sholomskas & Carroll, 2006, p. 939).

  Another well-intentioned, but often misguided, approach by counselors who have not had formal or extensive training is "digging" for trauma memories without a clear therapeutic rationale or understanding of client readiness. In doing so, the counselor may unintentionally retraumatize the client or produce other harmful effects. In early intervention, it is sufficient simply to acknowledge and validate the pain and suffering of the client without uncovering or exploring specific trauma memories. The counselor who is insufficiently trained in trauma-informed clinical

(Continued on the next page.)

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings (continued)

practice may also press agendas that are ultimately unhelpful, such as insisting that the client forgive an abuser, pursue a legal case against a perpetrator, or engage in trauma treatment, even when the client may not be ready for such steps. These efforts are particularly inappropriate for clients in early recovery from substance use disorders. The first goal in treatment is stabilization

Training: The Seeking Safety model of treating substance abuse and posttraumatic stress disorder (PTSD) can help counselors focus on the primary goal of stabilization and safety in TIC. This model emphasizes safety as the target goal, humanistic themes such as honesty and compassion, and making cognitive–behavioral therapy accessible and interesting to clients who may otherwise be difficult to engage (Najavits, 2002a).

- Treatment should be client-centered; it should acknowledge the client's right to refuse counseling for trauma-related issues. It is important to discuss the advantages and disadvantages of exploring trauma-related concerns, and then, following an open discussion, to allow clients the right to choose their path. This discussion should be part of the informed consent process at the start of treatment. Clients also have the right to change their minds.

  Training: Motivational interviewing, a client-centered, nonpathologizing counseling method, can aid clients in resolving ambivalence about and committing to changing health risk behaviors including substance use, eating disorders, self-injury, avoidant and aggressive behaviors associated with PTSD, suicidality, and medication compliance (Arkowitz, Miller, Westra, & Rollnick, 2008; Kress & Hoffman, 2008). Training in MI can help counselors remain focused on the client's agenda for change, discuss the pros and cons of treatment options, and emphasize the personal choice and autonomy of clients.

In addition to the training needs of substance abuse counselors, all direct care workers in mental health settings, community-based programs, crisis intervention settings, and criminal justice environments should receive training in TIC. Guidelines for training in assisting trauma-exposed populations are presented in Exhibit 2.2-2.

Continuing Education

Research on the effectiveness of single-session didactic and/or skill-building workshops

Exhibit 2.2-2: Guidelines for Training in Mental Health Interventions for Trauma-Exposed Populations

After a year of collaboration in 2002, the Task Force on International Trauma Training of the International Society for Traumatic Stress Studies published a consensus-based set of recommendations for training. Core curricular elements of the recommended training include:

- Competence in listening.
- Recognition of psychosocial and mental problems to promote appropriate assessment.
- Familiarity with established interventions in the client population.
- Full understanding of the local context, including help-seeking expectations, duration of treatment, attitudes toward intervention, cost-effectiveness of intervention, and family attitudes and involvement.
- Strategies for solving problems on the individual, family, and community levels.
- Treatment approaches for medically unexplained somatic pain.
- Collaboration with existing local resources and change agents (e.g., clergy, traditional healers, informal leaders).
- Self-care components.

Source: Weine et al., 2002.

Advice to Administrators: Trauma-Informed Staff Training

- Establish training standards for the evidence-based and promising trauma-informed practice models (such as Seeking Safety) adopted by your organization.
- Bring expert trainers with well-developed curricula in TIC and trauma-specific practices into your organization.
- Select a core group of clinical supervisors and senior counselors to attend multisession training or certification programs. These clinicians can then train the rest of the staff.
- Use sequenced, longitudinal training experiences instead of single-session seminars or workshops.
- Emphasize interactive and experiential learning activities over purely didactic training.
- Provide ongoing mentoring/coaching to behavioral health professionals in addition to regular clinical supervision to enhance compliance with the principles and practices of TIC and to foster counselor mastery of trauma-specific practice models.
- Build organization-wide support for the ongoing integration of new attitudes and counselor skills to sustain constructive, TIC-consistent changes in practice patterns.
- Provide adequate and ongoing training for clinical supervisors in the theory and practice of clinical supervision and the principles and practices of TIC.
- Include information and interactive exercises on how counselors can identify, prevent, and ameliorate secondary traumatic stress (STS) reactions in staff trainings.
- Offer cross-training opportunities to enhance knowledge of trauma-informed processes throughout the system.

demonstrates that immediate gains in counselor knowledge and skills diminish quickly after the training event (Martino, Canning-Ball, Carroll, & Rounsaville, 2011). Consequently, organizations may be spending their scarce financial resources on sending counselors to this kind of training but may not be reaping adequate returns with regard to long-lasting changes in counselor skills and the development of trauma-informed and trauma-specific counselor competencies. Hoge et al. (2007) suggest the implementation of training strategies for behavioral health professionals that have proven to be effective in improving counselor skills, attitudes, and practice approaches. These strategies include: "interactive approaches; sequenced, longitudinal learning experiences; outreach visits, known as academic detailing; auditing of practice with feedback to the learner; reminders; the use of opinion leaders to influence practice; and patient-mediated interventions, such as providing information on treatment options to persons in recovery, which in turn influences the practice patterns of their providers" (p. 124).

Trauma-Informed Counselor Competencies

Hoge et al. (2007) identified a number of counselor competencies in behavioral health practices that are consistent with the skills needed to be effective in a trauma-informed system of care. They include person-centered planning, culturally competent care, development of therapeutic alliances, shared responsibility for decisions, collaboratively developed recovery plans, evidence-based practices, recovery- and resilience-oriented care, interdisciplinary- and team-based practice, and consumer/client advocacy. In addition, counselor competencies critical to the effective delivery of services to clients with trauma-related disorders include:

- Screening for and assessment of trauma history and trauma-related disorders, such as mood and anxiety disorders.
- Awareness of differences between trauma-informed and trauma-specific services.

- Understanding the bidirectional relationships among substance use and mental disorders and trauma.
- Engagement in person-centered counseling.
- Competence in delivering trauma-informed and trauma-specific evidence-based interventions that lessen the symptoms associated with trauma and improve quality of life for clients.
- Awareness of and commitment to counselor self-care practices that prevent or lessen the impact of secondary traumatization on behavioral health workers.

Exhibit 2.2-3 provides a checklist of competencies for counselors working in trauma-informed behavioral health settings. Administrators and clinical supervisors can use this checklist to assess behavioral health professionals' understanding of trauma awareness and counseling skills and determine the need for additional training and clinical supervision.

Counselor Responsibilities and Ethics

Treating all clients in an ethical manner is an expectation of all healthcare providers. It is of special importance when working with clients who have trauma-related disorders, as their trust in others may have been severely shaken. Counselors who work with traumatized individuals on a regular basis have special responsibilities to their clients because of the nature of this work. Administrators and clinical supervisors in trauma-informed organizations should develop policies that clearly define the counselors' job and should provide education about the role of counselors in the organization and their responsibilities to clients.

General Principles Regarding Counselor Responsibilities

The following are some general principles governing the responsibilities of counselors who provide behavioral health services for clients with histories of trauma:

- Counselors are responsible for routinely screening clients for traumatic experiences and trauma-related symptoms (Ouimette & Brown, 2003; see also Treatment Improvement Protocol [TIP] 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Center for Substance Abuse Treatment [CSAT], 2005c).
- Counselors should offer clients with substance use and trauma-related disorders continuing mental health services if it is within their professional license and scope of practice to do so.
- Counselors are responsible for referring clients with substance use disorders and co-occurring trauma-related disorders to treatment that addresses both disorders when the treatment falls outside of the counselor's professional license and scope of practice (Ouimette & Brown, 2003).
- Counselors should refer clients with substance use disorders and co-occurring trauma-related disorders to concurrent participation in mutual-help groups if appropriate (Ouimette & Brown, 2003).
- Counselors have a responsibility to practice the principles of confidentiality in all interactions with clients and to respect clients' wishes not to give up their right to privileged communication.
- Counselors are responsible for educating clients about the limits of confidentiality and what happens to protected health information, along with the client's privilege, when the client signs a release of information or agrees to assign insurance benefits to the provider.
- Counselors must inform clients that treatment for trauma-related disorders is always voluntary.
- Counselors are responsible for being aware of their own secondary trauma and

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist

Trauma Awareness

___ Understands the difference between trauma-informed and trauma-specific services

___ Understands the differences among various kinds of abuse and trauma, including: physical, emotional, and sexual abuse; domestic violence; experiences of war for both combat veterans and survivors of war; natural disasters; and community violence

___ Understands the different effects that various kinds of trauma have on human development and the development of psychological and substance use issues

___ Understands how protective factors, such as strong emotional connections to safe and nonjudgmental people and individual resilience, can prevent and ameliorate the negative impact trauma has on both human development and the development of psychological and substance use issues

___ Understands the importance of ensuring the physical and emotional safety of clients

___ Understands the importance of not engaging in behaviors, such as confrontation of substance use or other seemingly unhealthy client behaviors, that might activate trauma symptoms or acute stress reactions

___ Demonstrates knowledge of how trauma affects diverse people throughout their lifespans and with different mental health problems, cognitive and physical disabilities, and substance use issues

___ Demonstrates knowledge of the impact of trauma on diverse cultures with regard to the meanings various cultures attach to trauma and the attitudes they have regarding behavioral health treatment

___ Demonstrates knowledge of the variety of ways clients express stress reactions both behaviorally (e.g., avoidance, aggression, passivity) and psychologically/emotionally (e.g., hyperarousal, avoidance, intrusive memories)

Counseling Skills

___ Expedites client-directed choice and demonstrates a willingness to work within a mutually empowering (as opposed to a hierarchical) power structure in the therapeutic relationship

___ Maintains clarity of roles and boundaries in the therapeutic relationship

___ Demonstrates competence in screening and assessment of trauma history (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Shows competence in screening and assessment of substance use disorders (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Demonstrates an ability to identify clients' strengths, coping resources, and resilience

___ Facilitates collaborative treatment and recovery planning with an emphasis on personal choice and a focus on clients' goals and knowledge of what has previously worked for them

___ Respects clients' ways of managing stress reactions while supporting and facilitating taking risks to acquire different coping skills that are consistent with clients' values and preferred identity and way of being in the world

___ Demonstrates knowledge and skill in general trauma-informed counseling strategies, including, but not limited to, grounding techniques that manage dissociative experiences, cognitive–behavioral tools that focus on both anxiety reduction and distress tolerance, and stress management and relaxation tools that reduce hyperarousal

(Continued on the next page.)

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist (continued)

___ Identifies signs of STS reactions and takes steps to engage in appropriate self-care activities that lessen the impact of these reactions on clinical work with clients

___ Recognizes when the needs of clients are beyond his or her scope of practice and/or when clients' trauma material activates persistent secondary trauma or countertransference reactions that cannot be resolved in clinical supervision; makes appropriate referrals to other behavioral health professionals

Source: Abrahams et al., 2010.

countertransference reactions and seeking appropriate help in responding to these reactions so that they do not interfere with the best possible treatment for clients.

TIC organizations have responsibilities to clients in their care, including:

- Protecting client confidentiality, particularly in relation to clients' trauma histories. Organizations should comply with the State and Federal laws that protect the confidentiality of clients being treated for mental and substance use disorders.
- Providing clients with an easy-to-read statement of their rights as consumers of mental health and substance abuse services, including the right to confidentiality (Exhibit 2.2-4).
- Providing quality clinical supervision to all counselors and direct-service workers, with an emphasis on TIC. Organizations should, at minimum, comply with State licensing requirements for the provision of clinical supervision to behavioral health workers.
- Establishing and maintaining appropriate guidelines and boundaries for client and counselor behavior in the program setting.
- Creating and maintaining a trauma-informed treatment environment that respects the clients' right to self-determination and need to be treated with dignity and respect.
- Maintaining a work environment that reinforces and supports counselor self-care.

All behavioral health professionals are responsible for abiding by professional standards of care that protect the client. Breaches of confidentiality, inappropriate conduct, and other violations of trust can do further harm to clients who already have histories of trauma. Many treatment facilities have a Client Bill of Rights (or a similar document) that describes the rights and responsibilities of both the counselors and the participants; it often is part of the orientation and informed consent process when a client enters treatment. However, simply reading and acknowledging the receipt of a piece of paper is not a substitute for the dialog that needs to happen in a collaborative therapeutic partnership. Administrators are responsible for providing clients with easy-to-read information describing counselor responsibilities and client rights. Clinical supervisors are responsible for helping counselors engage in a respectful dialog with clients about those rights and responsibilities as part of a comprehensive informed consent process.

Exhibit 2.2-4 is an excerpt from a Client Bill of Rights that outlines clients' right to confidentiality in plain language that is readable and easily understood.

Exhibit 2.2-4: Sample Statement of the Client's Right to Confidentiality From a Client Bill of Rights

Tri-County Mental Health Services is a trauma-informed mental health and substance abuse treatment agency in Maine. Below is a statement regarding clients' right to confidentiality and staff responsibility to protect that privilege; this statement is provided in a brochure outlining consumer rights that is easily accessible to service recipients at the agency and online.

Confidentiality

We will not give out information about you to anyone without your knowledge and permission. This includes written information from your record and verbal information from your providers. Additionally, we will not request any information about you without your knowledge and permission. A Release of Information Form allows you to say what information can be shared and with whom. You determine the length of time this is valid, up to one year.

Tri-County policies prevent any employee of the agency who does not have a direct need to know from having access to any information about you. The penalty for violation can include immediate dismissal.

Exceptions to this rule of confidentiality include times when a client is at immediate risk of harm to self or others, or when ordered by the court. We will make every effort to notify you in these instances.

Source: Tri-County Mental Health Services, 2008, pp. 6-7.

Ethics in Treating Traumatized Clients

All behavioral health professionals must conform to the ethical guidelines established by their profession's State licensing boards and/or certifying organizations. State licensing boards for substance abuse counseling, psychiatry, social work, psychology, professional counseling, and other behavioral health professions provide regulatory standards for ethical practice in these professions. These boards also have specific procedures for responding to complaints regarding the actions of professional caregivers. Additionally, national professional societies have standards for ethical practices. Members of these organizations are expected to practice within the boundaries and scope of these standards. Some of these standards are quite explicit, whereas others are more general; most approach professional ethics not as a rigid set of rules, but rather, as a process of making ethical decisions.

Clinical supervisors are responsible for informing counselors of their ethical responsibilities with regard to their own organization's policies and procedures, monitoring supervisees' reading and understanding the codes of ethics of professional organizations and State licensing boards, and promoting counselor understanding of ethics and how to make decisions ethically as a regular part of clinical supervision, team meetings, and counselor training. Administrators can support high ethical standards by creating an organization-wide ethics task group consisting of counselors, supervisors, and administrators who meet regularly to review and revise clinical policies in line with State and Federal law and professional codes of ethics. Administrators may also act as a support mechanism for counselors who need additional consultation regarding potential ethical dilemmas with clients. The Green Cross Academy of Traumatology provides ethical guidelines for the treatment of clients who have experienced trauma; these guidelines are adapted in Exhibit 2.2-5.

Exhibit 2.2-5: Green Cross Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized

Respect for the dignity of clients

- Recognize and value the personal, social, spiritual, and cultural diversity present in society, without judgment. As a primary ethical commitment, make every effort to provide interventions with respect for the dignity of those served.

Responsible caring

- Take the utmost care to ensure that interventions do no harm.
- Have a commitment to the care of those served until the need for care ends or the responsibility for care is accepted by another qualified service provider.
- Support colleagues in their work and respond promptly to their requests for help.
- Recognize that service to survivors of trauma can exact a toll in stress on providers. Maintain vigilance for signs in self and colleagues of such stress effects, and accept that dedication to the service of others imposes an obligation to sufficient self-care to prevent impaired functioning.
- Engage in continuing education in the appropriate areas of trauma response. Remain current in the field and ensure that interventions meet current standards of care.

Integrity in relationships

- Clearly and accurately represent your training, competence, and credentials. Limit your practice to methods and problems for which you are appropriately trained and qualified. Readily refer to or consult with colleagues who have appropriate expertise; support requests for such referrals or consultations from clients.
- Maintain a commitment to confidentiality, ensuring that the rights of confidentiality and privacy are maintained for all clients.
- Do not provide professional services to people with whom you already have either emotional ties or extraneous relationships of responsibility. The one exception is in the event of an emergency in which no other qualified person is available.
- Refrain from entering other relationships with present or former clients, especially sexual relationships or relationships that normally entail accountability.
- Within agencies, ensure that confidentiality is consistent with organizational policies; explicitly inform individuals of the legal limits of confidentiality.

Responsibility to society

- Be committed to responding to the needs generated by traumatic events, not only at the individual level, but also at the level of community and community organizations in ways that are consistent with your qualifications, training, and competence.
- Recognize that professions exist by virtue of societal charters in expectation of their functioning as socially valuable resources. Seek to educate government agencies and consumer groups about your expertise, services, and standards; support efforts by these agencies and groups to ensure social benefit and consumer protection.
- If you become aware of activities of colleagues that may indicate ethical violations or impairment of functioning, seek first to resolve the matter through direct expression of concern and offers of help to those colleagues. Failing a satisfactory resolution in this manner, bring the matter to the attention of the officers of professional societies and of governments with jurisdiction over professional misconduct.

Clients' universal rights

All clients have the right to:

- Not be judged for any behaviors they used to cope, either at the time of the trauma or after the trauma.
- Be treated at all times with respect, dignity, and concern for their well-being.
- Refuse treatment, unless failure to receive treatment places them at risk of harm to self or others.

(Continued on the next page.)

Exhibit 2.2-5: Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized (continued)

- Be regarded as collaborators in their own treatment plans.
- Provide their informed consent before receiving any treatment.
- Not be discriminated against based on race, culture, sex, religion, sexual orientation, socioeconomic status, disability, or age.
- Have promises kept, particularly regarding issues related to the treatment contract, role of counselor, and program rules and expectations.

Procedures for introducing clients to treatment

Obtain informed consent, providing clients with information on what they can expect while receiving professional services. In addition to general information provided to all new clients, clients presenting for treatment who have histories of trauma should also receive information on:

- The possible short-term and long-term effects of trauma treatment on the client and the client's relationships with others.
- The amount of distress typically experienced with any particular trauma treatment.
- Possible negative effects of a particular trauma treatment.
- The possibility of lapses and relapses when doing trauma work, and the fact that these are a normal and expected part of healing.

Reaching counseling goals through consensus

Collaborate with clients in the design of a clearly defined contract that articulates a specific goal in a specific time period or a contract that allows for a more open-ended process with periodic evaluations of progress and goals.

Informing clients about the healing process

- Clearly explain to clients the nature of the healing process, making sure clients understand.
- Encourage clients to ask questions about any and all aspects of treatment and the therapeutic relationship. Provide clients with answers in a manner they can understand.
- Encourage clients to inform you if the material discussed becomes overwhelming or intolerable.
- Inform clients of the necessity of contacting you or emergency services if they feel suicidal or homicidal, are at risk of self-injury, or have a sense of being out of touch with reality.
- Give clients written contact information about available crisis or emergency services.
- Inform clients about what constitutes growth and recovery and about the fact that some trauma symptoms may not be fully treatable.
- Address unrealistic expectations clients may have about counseling and/or the recovery process.

Level of functioning

- Inform clients that they may not be able to function at the highest level of their ability—or even at their usual level—when working with traumatic material.
- Prepare clients to experience trauma-related symptoms, such as intrusive memories, dissociative reactions, reexperiencing, avoidance behaviors, hypervigilance, or unusual emotional reactivity.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

Boundaries in therapeutic relationships

Maintaining appropriate therapeutic boundaries is a primary ethical concern for behavioral health professionals. Counselors working with clients who have substance use, trauma-related, and other mental disorders may feel challenged at times to maintain boundaries that create a safe therapeutic container. Some clients, especially those with longstanding disorders, bring a history of client–counselor relationships to counseling. Clients who have been traumatized may need help understanding the roles and responsibilities of both the counselor and the client. Clients with trauma-related conditions may also have special needs

Advice to Clinical Supervisors: Recognizing Boundary Confusion

Clinical supervisors should be aware of the following counselor behaviors that can indicate boundary confusion with clients:

- The counselor feels reluctant or embarrassed to discuss specific interactions with a client or details of the client's treatment in supervision or team meetings.
- The counselor feels possessive of the client, advocates with unusual and excessive vehemence for the client, or expresses an unreasonable sense of overresponsibility for the client.
- The counselor becomes defensive and closed to hearing ideas from the supervisor or the treatment team members about approaches to working with a client and/or exploring his or her own emotional reactions to a client.
- The clinician begins or increases personal self-disclosure to the client and is not able to identify legitimate clinical reasons for the self-disclosure.

in establishing appropriate boundaries in the counseling setting; they may be particularly vulnerable and not understand or appreciate the need for professional boundaries, including not engaging in dual relationships. For example, some clients might experience a counselor's boundary around not giving the client his or her personal phone number for emergency calls as a rejection or abandonment. Cultural considerations also influence therapeutic boundaries.

Administrators, in collaboration with clinical supervisors, are responsible for creating policies regarding counselor and client boundaries for various issues (e.g., giving and receiving gifts, counselor personal disclosure, and counselor roles and responsibilities when attending the same 12-Step meetings as clients); policies should be specific to their organization and conform to State and Federal law and behavioral health professional codes of ethics. Clinical supervisors are responsible for training counselors in the informed consent process and effective ways to discuss boundaries with clients when they enter treatment.

Guidelines for establishing and maintaining boundaries in therapeutic relationships, adapted from the Green Cross Academy of Traumatology, are given in Exhibit 2.2-6.

Clients with trauma histories may be especially vulnerable to counselor behaviors that are inconsistent or that are experienced by the client as boundary violations. Examples of such behavior include: being late for appointments, ending counseling sessions early, repeatedly and excessively extending the session time, canceling or "forgetting" appointments multiple times, spending time in the session talking about their own needs and life experiences, exploring opportunities for contact outside the therapeutic relationship (including making arrangements to meet at AA or other 12-Step recovery group meetings), and enforcing rules differently for one client than for another.

Due to the complex dynamics that can arise in the treatment of clients with trauma histories, regularly scheduled clinical supervision, where issues of ethics and boundaries can be discussed, is recommended for counselors. For more information on how clinical supervision can be effectively used, see TIP 52, *Clinical Supervision and the Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Boundary crossing and boundary violation

Although guidelines and codes of ethics are useful tools in helping clinical supervisors and counselors understand the boundaries between counselors and clients, they are open to interpretation and are context-bound. Given these limitations, it is crucial to educate counselors

Exhibit 2.2-6: Boundaries in Therapeutic Relationships

Procedures for Establishing Safety

Roles and boundaries
Counselor roles and boundaries should be established at the start of the counseling relationship and reinforced periodically, particularly at times when the client is experiencing high stress.

Ongoing Relationships and the Issue of Boundaries

Dual relationships
Dual relationships and inappropriate interactions with clients are to be avoided. It is important to tell clients at the beginning of counseling that contact between the counselor and the client can only occur within the boundaries of the professional relationship. This information is part of the informed consent process. Relationships outside these boundaries include sexual or romantic relationships, a counselor also serving as a client's sponsor in 12-Step programs, and any kind of relationship in which the counselor exploits the client for financial gain.

Sexual contact
- Never engage in any form of sexual contact with clients.
- Do not reward sexualized behaviors with attention or reactivity.
- Directly clarify the boundaries of the therapeutic relationship, and address the underlying motivations of persisting sexualized behavior.
- Set limits on a client's inappropriate behaviors while maintaining an ethos of care. Maintain respect for the dignity and worth of the client at all times.
- Understand that a client's attempt to sexualize a therapeutic relationship may reflect an early history of abuse, difficulty understanding social norms, or a variety of psychological problems.
- Readdress the absolute inappropriateness of sexual and/or romantic behavior in a nonlecturing, nonpunitive manner.
- If sexual behavior between clients occurs in a treatment program, counselors should consult with a clinical supervisor. Document the nature of the contact and how the issue is addressed.
- If a counselor has sexual contact with a client, he or she should take responsibility by ceasing counseling practice, referring clients to other treatment providers, and notifying legal and professional authorities. If a counselor is at risk for engaging with a client sexually but has not acted on it, the counselor should immediately consult with a supervisor, colleague, or psychotherapist.

Boundaries
Counselors should use care with self-disclosure or any behaviors that may be experienced as intrusive by the client, including:
- Personal disclosures made for the counselor's own gratification.
- Sexualized behavior with the client.
- Excessively intrusive questions or statements.
- Interrupting the client frequently.
- Violating the client's personal space.
- Interpersonal touch, which might activate intrusive memories or dissociative reactions or be experienced as a boundary violation by the client.
- Being consistently late for appointments or allowing outside influences (such as telephone calls) to interrupt the client's time in a counseling session.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

in TIC settings regarding the boundary issues that may arise for clients who have been traumatized and to give counselors a conceptual framework for understanding the contextual nature of boundaries. For example, it would be useful for clinical supervisors to discuss with

counselors the distinction between boundary crossings and boundary violations in clinical practice. Gutheil and Brodsky (2008) define boundary crossing as a departure from the customary norms of counseling practice in relation to psychological, physical, or social space "that are harmless, are nonexploitative, and may even support or advance the therapy" (p. 20). Examples of boundary crossings include taking phone calls from a client between sessions if the client is in crisis or telling a client a story about the counselor's recovery from trauma (without offering specific personal information or graphic/detailed description of the trauma) with the intention of offering hope that it is possible to recover.

Gutheil and Brodsky (2008) define boundary violations as boundary crossings that are unwanted and dangerous and which exploit the client, stating that "some boundary crossings are inadvisable because of their intent (i.e., they are not done in the service of the patient's well-being and growth, involve extra therapeutic gratification for the therapist) and/or their effect (i.e., they are not likely to benefit the patient and entail a significant risk of harming the patient)" (pp. 20–21). An example of a boundary violation would be when a counselor invites a client to attend the same AA meetings the counselor attends or shares drinking and drugging "war stories" for the counselor's own gratification. Two key elements in understanding when a boundary crossing becomes a boundary violation are the intent of the counselor and the damaging effect on the client. Maintaining a standard of practice of nonexploitation of the client is the primary focus for clinical supervisors and counselors in determining when boundary crossings become boundary violations.

Context is also an important consideration in determining the acceptability of boundary crossings. For example, it may be acceptable for a counselor in a partial hospitalization program for serious mental illness to have a cup of coffee at the kitchen table with a resident, whereas for a counselor in an outpatient mental health program, having a cup of coffee with a client at the local coffee shop would be a much more questionable boundary crossing.

Case Illustration: Denise

Denise is a 40-year-old licensed professional counselor working in an inpatient eating disorder program. She has had extensive training in trauma and eating disorder counseling approaches and has been working as a clinician in mental health settings for 15 years. Denise is usually open to suggestions from her supervisor and other treatment team members about specific strategies to use with clients who have trauma histories and eating disorders. However, in the past week, her supervisor has noticed that she has become defensive in team meetings and individual supervision when discussing a recently admitted young adult who was beaten and raped by her boyfriend; subsequently, the client was diagnosed with PTSD and anorexia. When the clinical supervisor makes note of the change in Denise's attitude and behavior in team meetings since this young woman was admitted, initially Denise becomes defensive, saying that the team just doesn't understand this young woman and that the client has repeatedly told Denise, "You're the only counselor I trust."

The clinical supervisor recognizes that Denise may be experiencing secondary traumatization and boundary confusion due to working with this young woman and to the recent increase in the number of clients with co-occurring trauma-related disorders on her caseload. After further exploration, Denise reveals that her own daughter was raped at the same age as the young woman and that hearing her story has activated an STS reaction in Denise. Her way of coping has been to become overly responsible for and overprotective of the young woman. With the nonjudgmental support of her supervisor, Denise is able to gain perspective, recognize that this young woman is not her daughter, and reestablish boundaries with her that are appropriate to the inpatient treatment setting.

Clinical Supervision and Consultation

Organizational change toward a TIC model doesn't happen in isolation. Ongoing support, supervision, and consultation are key ingredients that reinforce behavioral health professionals' training in trauma-informed and trauma-specific counseling methods and ensure compliance with practice standards and consistency over time. Often, considerable energy and resources are spent on the transition to new clinical and programmatic approaches, but without long-range planning to support those changes over time. The new treatment approach fades quickly, making it hard to recognize and lessening its reliability.

Advice to Clinical Supervisors and Administrators: Adopting an Evidence-Based Model of Clinical Supervision and Training

Just as adopting evidence-based clinical practices in a trauma-informed organization is important in providing cost-effective and outcome-relevant services to clients, adopting an evidence-based model of clinical supervision and training clinical supervisors in that model can enhance the quality and effectiveness of clinical supervision for counselors. This will ultimately enhance client care.

One of the most commonly used and researched integrative models of supervision is the discrimination model, originally published by Janine Bernard in 1979 and since updated (Bernard & Goodyear, 2009). This model is considered a competence-based and social role model of supervision; it includes three areas of focus on counselor competencies (intervention, conceptualization, and personalization) and three possible supervisor roles (teacher, counselor, and consultant).

Counselor competencies:

- Intervention: The supervisor focuses on the supervisee's intervention skills and counseling strategies used with a particular client in a given session.
- Conceptualization: The supervisor focuses on how the supervisee understands what is happening in a session with the client.
- Personalization: The supervisor focuses on the personal style of the counselor and countertransference responses (i.e., personal reactions) of the counselor to the client.

Supervisor roles:

- Teacher: The supervisor teaches the supervisee specific counseling theory and skills and guides the supervisee in the use of specific counseling strategies in sessions with clients. The supervisor as teacher is generally task-oriented. The supervisor is more likely to act as a teacher with beginning counselors.
- Counselor: The supervisor does not act as the counselor's therapist, but helps the counselor reflect on his or her counseling style and personal reactions to specific clients. The supervisor as counselor is interpersonally sensitive and focuses on the process and relational aspects of counseling.
- Consultant: The supervisor is more of a guide, offering the supervisee advice on specific clinical situations. The supervisor as consultant invites the counselor to identify topics and set the agenda for the supervision. The supervisor is more likely to act as a consultant with more advanced counselors.

This model of supervision may be particularly useful in working with counselors in TIC settings, because the supervisor's response to the supervisee is flexible and specific to the supervisee's needs. In essence, it is a counselor-centered model of supervision in which the supervisor can meet the most relevant needs of the supervisee in any given moment.

For a review of other theories and methods of clinical supervision, refer to TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Ongoing supervision and consultation supports the organizational message that TIC is the standard of practice. It normalizes secondary traumatization as a systemic issue (not the individual pathology of the counselor) and reinforces the need for counselor self-care to prevent and lessen the impact of secondary traumatization. Quality clinical supervision for direct care staff demonstrates the organization's commitment to implementing a fully integrated, trauma-informed system of care.

Supervision and Consultation

Historically, there was an administrative belief that counselors who had extensive clinical experience and training would naturally be the best clinical supervisors. However, research does not support this idea (Falender & Shafranske, 2004). Although a competent clinical supervisor needs to have an extensive clinical background in the treatment of substance use, trauma-related, and other mental disorders, it is also essential for any counselor moving into a supervisory role to have extensive training in the theory and practice of clinical supervision before taking on this role. In particular, clinical supervisors in trauma-informed behavioral health settings should be educated in how to perform clinical supervision (not just administrative supervision) of direct service staff and in the importance of providing continuous clinical supervision and support for staff members working with individuals affected by trauma. Clinical

Case Illustration: Arlene

Arlene is a 50-year-old licensed substance abuse counselor who has a personal history of trauma, and she is actively engaged in her own recovery from trauma. She is an experienced counselor who has several years of training in trauma-informed and trauma-specific counseling practices. Her clinical supervisor, acting in the role of consultant, begins the supervision session by inviting her to set the agenda. Arlene brings up a clinical situation in which she feels stuck with a client who is acting out in her Seeking Safety group (for more information on Seeking Safety, see Najavits, 2002a).

Arlene reports that her client gets up suddenly and storms out of the group room two or three times during the session. The supervisor, acting in the role of the counselor and focusing on personalization, asks Arlene to reflect on the client's behavior and what feelings are activated in her in response to the client's anger. Arlene is able to identify her own experience of hyperarousal and then paralysis as a stress reaction related to her prior experience of domestic violence in her first marriage. The supervisor, acting in the role of teacher and focusing on conceptualization, reminds Arlene that her client is experiencing a "fight-or-flight" response to some experience in the group that reminds her of her own trauma experience. The supervisor then suggests to Arlene that her own reactions are normal responses to her previous history of trauma, and that when her client is angry, Arlene is not reexperiencing her own trauma but is being activated by the client's traumatic stress reaction to being in group. In this way, the supervisor highlights the parallel process of the client–counselor's stress reactions to a perceived threat based on prior trauma experiences.

The supervisor, acting again as a consultant and focusing on personalization this time, invites Arlene to reflect on the internal and external resources she might be able to bring to this situation that will help remind her to ground herself so she can lessen the impact of her stress reactions on her counseling strategy with this client. Arlene states that she can create a list of safe people in her life and place this list in her pocket before group. She can use this list as a touchstone to remind her that she is safe and has learned many recovery skills that can help her stay grounded, maintain her boundaries, and deal with her client's behavior. The clinical supervisor, acting as a consultant and now focusing on intervention, asks Arlene if she has some specific ideas about how she can address the client's behavior in group. Arlene and the clinical supervisor spend the remainder of the session discussing different options for addressing the client's behavior and helping her feel safer in group.

supervision in a TIC organization should focus on the following priorities:

- General case consultation
- Specialized consultation in specific and unusual cases
- Opportunities to process clients' traumatic material
- Boundaries in the therapeutic and supervisory relationship
- Assessment of secondary traumatization
- Counselor self-care and stress management
- Personal growth and professional development of the counselor

Supervision of counselors working with traumatized clients should be regularly scheduled, with identified goals and with a supervisor who is trained and experienced in working with trauma survivors. The styles and types of supervision and consultation may vary according to the kind of trauma work and its context. For instance, trauma counseling in a major natural disaster would require a different approach to supervision and consultation than would counseling adults who experienced childhood developmental trauma or counseling clients in an intensive early recovery treatment program using a manualized trauma-specific counseling protocol.

Competence-based clinical supervision is recommended for trauma-informed organizations. Competence-based clinical supervision models identify the knowledge and clinical skills each counselor needs to master, and they use targeted learning strategies and evaluation procedures, such as direct observation of counselor sessions with clients, individualized coaching, and performance-based feedback. Studies on competence-based supervision approaches have demonstrated that these models improve counselor treatment skills and proficiency (Martino et al., 2011).

Whichever model of clinical supervision an organization adopts, the key to successful trauma-informed clinical supervision is the recognition that interactions between the supervisor and the counselor may parallel those between the counselor and the client. Clinical supervisors need to recognize counselors' trauma reactions (whether they are primary or secondary to the work with survivors of trauma) and understand that a confrontational or punitive approach will be ineffective and likely retraumatize counselors.

Clinical supervisors should adopt a respectful and collaborative working relationship with counselors in which role expectations are clearly defined in an informed consent process similar to that used in the beginning of the counselor–client relationship and in which exploring the nature of boundaries in both client–counselor and counselor–supervisor relationships is standard practice. Clear role boundaries, performance expectations, open dialog, and supervisor transparency can go a long way toward creating a safe and respectful relationship container for the supervisor and supervisee and set the stage for a mutually enhancing, collaborative relationship. This respectful, collaborative supervisory relationship is the main source of training and professional growth for the counselor and for the provision of quality care to people with behavioral health disorders.

Secondary Traumatization

The demands of caregiving exact a price from behavioral health professionals that cannot be ignored; otherwise, they may become ineffective in their jobs or, worse, emotionally or psychologically impaired. In a study of Master's level licensed social workers, 15.2 percent of respondents to a survey reported STS as a result of indirect exposure to trauma material at a level that meets the diagnostic criteria for PTSD. This rate is almost twice the rate of PTSD in the general population. The author

STS is a trauma related stress reaction and set of symptoms resulting from exposure to another individual's traumatic experiences rather than from exposure directly to a traumatic event.

concluded that behavioral health professionals' experience of STS is a contributing factor in staff turnover and one reason why many behavioral health service professionals leave the field (Bride, 2007). Secondary traumatization of behavioral health workers is a significant organizational issue for clinical supervisors and administrators in substance abuse and mental health treatment programs to address.

To prevent or lessen the impact of secondary traumatization on behavioral health professionals, clinical supervisors and administrators need to understand secondary trauma from the ecological perspective described in Part 1, Chapter 1 of this TIP. The organization itself creates a social context with risk factors that can increase the likelihood of counselors experiencing STS reactions, but it also contains protective factors that can lessen the risk and impact of STS reactions on staff members. Organizations can lessen the impact of the risk factors associated with working in trauma-informed organizations by mixing caseloads to contain clients both with and without trauma-related issues, supporting ongoing counselor training, providing regular clinical supervision, recognizing counselors' efforts, and offering an empowering work environment in which counselors share in the responsibility of making decisions and can offer input into clinical and program policies that affect their work lives.

When organizations support their counselors in their work with clients who are traumatized, counselors can be more effective, more productive, and feel greater personal and professional satisfaction. In addition, counselors develop a sense of allegiance toward the organization, thus decreasing staff turnover. If organizations do not provide this support, counselors can become demoralized and have fewer emotional and psychological resources to manage the impact of clients' traumatic material and outward behavioral expressions of trauma on their own well-being. Providing counselors with the resources to help them build resilience and prevent feeling overwhelmed should be a high priority for administrators and clinical supervisors in TIC organizations.

Risk and Protective Factors Associated With Secondary Traumatization

Clinical and research literature on trauma describes a number of factors related to the development of secondary trauma reactions and psychological distress in behavioral health professionals across a wide range of practice settings, as well as individual and organizational factors that can prevent or lessen the impact of STS on staff. The risk and protective factors model of understanding secondary trauma is based on the ecological perspective

Advice to Clinical Supervisors: Recognizing Secondary Traumatization

Some counselor behaviors that demonstrate inconsistency to clients may be outward manifestations of secondary traumatization, and they should be discussed with counselors through a trauma-informed lens. It is imperative that clinical supervisors provide a nonjudgmental, safe context in which counselors can discuss these behaviors without fear of reprisal or reprimand. Clinical supervisors should work collaboratively with supervisees to help them understand their behavior and engage in self-care activities that lessen the stress that may be contributing to these behaviors.

outlined in Part 1, Chapter 1 of this TIP. The terms "compassion fatigue," "vicarious traumatization," "secondary traumatization," and "burnout" are used in the literature, sometimes interchangeably and sometimes as distinct constructs. As stated in the terminology portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP, the term "secondary traumatization" refers to traumatic stress reactions and psychological distress from exposure to another individual's traumatic experiences; this term will be used throughout this section, although the studies cited may use other terms.

Risk factors

Individual risk factors that may contribute to the development of STS in behavioral health professionals include preexisting anxiety or mood disorders; a prior history of personal trauma; high caseloads of clients with trauma-related disorders; being younger in age and new to the field with little clinical experience or training in treating trauma-related conditions; unhealthy coping styles, including distancing and detachment from clients and co-workers; and a lack of tolerance for strong emotions (Newall & MacNeil, 2010). Other negative coping strategies include substance abuse, other addictive behaviors, a lack of recreational activities not related to work, and a lack of engagement with social support. A recent study of trauma nurses found that low use of support systems, use of substances, and a lack of hobbies were among the coping strategies that differed between nurses with and without STS (Von Rueden et al., 2010). Other researchers found that clinicians who engaged in negative coping strategies, such as alcohol and illicit drug use, were more likely to experience intrusive trauma symptoms (Way, Van Deusen, Martin, Applegate, & Janle, 2004).

Numerous organizational factors can contribute to the development of STS in counselors who work with clients with trauma-related disorders. These risk factors include organizational constraints, such as lack of resources for clients, lack of clinical supervision for counselors, lack of support from colleagues, and lack of acknowledgment by the organizational culture that secondary traumatization exists and is a normal reaction of counselors to client trauma (Newall & MacNeil, 2010). In a study of 259 individuals providing mental health counseling services, counselors who spent more time in session with clients with trauma-related disorders reported higher levels of traumatic stress symptoms (Bober & Regehr, 2006). Counselors may be more at risk for developing secondary traumatization if the organization does not allow for balancing the distribution of trauma and nontrauma cases amongst staff members.

Protective factors

Much of the clinical and research literature focuses on individual factors that may lessen the impact of STS on behavioral health professionals, including male gender, being older, having more years of professional experience,

Advice to Clinical Supervisors: Recognizing STS in Counselors Who Are In Recovery

For counselors who are in recovery from a substance use or mental disorder, the development of STS may be a potential relapse concern. As Burke, Carruth, and Prichard (2006) point out, "a return to drinking or illicit drug use as a strategy for dealing with secondary trauma reactions would have a profoundly detrimental effect on the recovering counselor" (p. 292). So too, secondary trauma may ignite the reappearance of depressive or anxiety symptoms associated with a previous mental disorder. Clinical supervisors can address these risk factors with counselors and support them in engaging with their own recovery support network (which might include a peer support group or an individual counselor) to develop a relapse prevention plan.

having specialized training in trauma-informed and trauma-specific counseling practices, lacking a personal trauma history, exhibiting personal autonomy in the workplace, using positive personal coping styles, and possessing resilience or the ability to find meaning in stressful life events and to rebound from adversity (Sprang, Clark, & Whitt-Woosley, 2007). Some of these factors, like positive personal coping styles and the ability to find meaning in adversity, can be developed and enhanced through personal growth work, psychotherapy, engagement with spiritual practices and involvement in the spiritual community, and stress reduction strategies like mindfulness meditation. A recent multimethod study of an 8-week workplace mindfulness training group for social workers and other social service workers found that mindfulness meditation increased coping strategies, reduced stress, and enhanced self-care of the participants; findings suggested that workers were more likely to practice stress management techniques like mindfulness at their place of work than at home (McGarrigle & Walsh, 2011). Organizations can support counselors' individual efforts to enhance positive personal coping styles, find meaning in adversity, and reduce stress by providing time for workers during the workday for personal self-care activities, like mindfulness meditation and other stress reduction practices.

One of the organizational protective factors identified in the literature that may lessen the negative impact of secondary traumatization on behavioral health professionals is providing adequate training in trauma-specific counseling strategies, which increases providers' sense of efficacy in helping clients with trauma-related disorders and reduces the sense of hopelessness that is often a part of the work (Bober & Regehr 2006). One study found that specialized trauma training enhanced job satisfaction and reduced levels of compassion fatigue, suggesting that "knowledge and training might provide some protection against the deleterious effects of trauma exposure" (Sprang et al., 2007, p. 272). Another protective factor that may lessen the chances of developing secondary traumatization is having a diverse caseload of clients. Organizations "must determine ways of distributing workload in order to limit the traumatic exposure of any one worker. This may not only serve to reduce the impact of immediate symptoms but may also address the potential longitudinal effects" (Bober & Regehr, 2006, p. 8).

Emotional support from professional colleagues can be a protective factor. A study of substance abuse counselors working with clients who were HIV positive found that workplace support from colleagues and supervisors most effectively prevented burnout (Shoptaw, Stein, & Rawson, 2000). This support was associated with less emotional fatigue and depersonalization, along with a sense of greater personal accomplishment. In a study of domestic violence advocates, workers who received more support from professional peers were less likely to experience secondary traumatization (Slattery & Goodman, 2009).

In addition, counselor engagement in relationally based clinical supervision with a trauma-informed supervisor acts as a protective agent. Slattery and Goodman (2009) note that "for the trauma worker, good supervision can normalize the feelings and experiences, provide support and information about the nature and course of the traumatic reaction, help in the identification of transference and countertransference issues, and reveal feelings or symptoms associated with the trauma" (p. 1362). Workers who reported "engaging, authentic, and empowering relationships with their supervisors" were less likely to experience STS (p. 1369). Thus, it is not simply the frequency and regularity of clinical supervision,

but also the quality of the supervision and the quality of the supervisor–counselor relationship that can lessen the impact of STS on behavioral health professionals.

Engagement with a personal practice of spirituality that provides a sense of connection to a larger perspective and meaning in life is another protective factor that can lessen the impact of STS on counselors (Trippany, Kress, & Wilcoxon, 2004). Although recovering counselors may look to support groups for connection to a spiritual community, other behavioral health professionals might find support for enhancing spiritual meaning and connection in church, a meditation group, creative endeavors, or even volunteer work. The key is for counselors to develop their own unique resources and practices to enhance a sense of meaningful spirituality in their lives. Clinical supervisors should be aware of spiritual engagement as a protective factor in preventing and lessening the impact of STS and should support clinicians in including it in their self-care plans, but they should take care not to promote or reject any particular religious belief system or spiritual practice.

Another protective factor that may lessen the impact of workers' STS is a culture of empowerment in the organization that offers counselors a sense of autonomy, a greater ability to participate in making decisions about clinical and organizational policies, and obtaining support and resources that further their professional development. Slattery & Goodman (2009) surveyed 148 domestic violence advocates working in a range of settings. The authors found that those workers "who reported a high level of shared power were less likely to report posttraumatic stress symptoms, despite their own personal abuse history or degree of exposure to trauma" (p. 1370). To the degree that organizations can provide a cultural context within which behavioral health professionals have autonomy and feel empowered, they will be able to lessen the impact of STS on their professional and personal lives. Self-efficacy and empowerment are antidotes to the experience of powerlessness that often accompanies trauma.

Strategies for Preventing Secondary Traumatization

The key to prevention of secondary traumatization for behavioral health professionals in a trauma-informed organization is to reduce risk and enhance protective factors. Organizational strategies to prevent secondary traumatization include:

- Normalize STS throughout all levels of the organization as a way to help counselors feel safe and respected, enhancing the likelihood that they will talk openly about their experiences in team meetings, peer supervision, and clinical supervision.
- Implement clinical workload policies and practices that maintain reasonable standards for direct-care hours and emphasize balancing trauma-related and nontrauma-related counselor caseloads.
- Increase the availability of opportunities for supportive professional relationships by promoting activities such as team meetings, peer supervision groups, staff retreats, and counselor training that focuses on understanding secondary traumatization and self-care. Administrators and clinical supervisors should provide time at work for counselors to engage in these activities.
- Provide regular trauma-informed clinical supervision that is relationally based. Supervisors should be experienced and trained in trauma-informed and trauma-specific practices and provide a competence-based model of clinical supervision that promotes counselors' professional and personal development. Supervision limited to case consultation or case management is insufficient to

reduce the risk for secondary traumatization and promote counselor resilience.

- Provide opportunities for behavioral health professionals to enhance their sense of autonomy and feel empowered within the organization. Some of these activities include soliciting input from counselors on clinical and administrative policies that affect their work lives, including how to best balance caseloads of clients with and without histories of trauma; inviting representatives of the counseling staff to attend selected agency board of directors and/or management team meetings to offer input on workforce development; and inviting counselors to participate in organizational task forces that develop trauma-informed services, plan staff retreats, or create mechanisms to discuss self-care in team meetings. Administrators and clinical supervisors should assess the organization's unique culture and develop avenues for counselor participation in activities that will enhance their sense of empowerment and efficacy within the organization.

Exhibit 2.2-7 highlights some specific strategies that individual counselors can engage in to prevent secondary traumatization.

Assessment of Secondary Traumatization

Counselors with unacknowledged STS can harm clients, self, and family and friends by becoming unable to focus on and attend to their needs or those of others. They may feel helpless or cynical and withdraw from support systems. Exhibit 2.2-8 describes some emotional, cognitive, and behavioral signs that may indicate that a counselor is experiencing secondary traumatization. Clinical supervisors should be familiar with the manifestations of STS in their counselors and should address signs of STS immediately.

Stamm (2009–2012) has developed and revised a self-assessment tool, the Professional Quality of Life Scale (ProQOL), that measures indicators of counselor compassion fatigue and compassion satisfaction. Compassion fatigue "is best defined as a syndrome consisting of a combination of the symptoms

Exhibit 2.2-7: Counselor Strategies To Prevent Secondary Traumatization

Strategies that counselors can use (with the support and encouragement of supervisors and administrators) to prevent secondary traumatization include:

- ***Peer support*:** Maintaining adequate social support, both personally and professionally, helps prevent isolation and helps counselors share the emotional distress of working with traumatized individuals.
- ***Supervision and consultation*:** Professional consultation will help counselors understand secondary traumatization, their own personal risks, the protective factors that can help them prevent or lessen its impact, and their countertransference reactions to specific clients.
- ***Training*:** Ongoing professional training can improve counselors' understanding of trauma and enhance a sense of mastery and self-efficacy in their work.
- ***Personal psychotherapy or counseling*:** Being in counseling can help counselors become more self-aware and assist them in managing the psychological and emotional distress that often accompanies working with clients who have trauma histories in a number of behavioral health settings.
- ***Maintaining balance in one's life*:** Balancing work and personal life, developing positive coping styles, and maintaining a healthy lifestyle can enhance resilience and the ability to manage stress.
- ***Engaging in spiritual activities that provide meaning and perspective*:** Connection to a spiritual community and spiritual practices (such as meditation) can help counselors gain a larger perspective on trauma and enhance resilience.

Exhibit 2.2-8: Secondary Traumatization Signs

The following are some indicators that counselors may be experiencing secondary traumatization.

Psychological distress
- Distressing emotions: grief, depression, anxiety, dread, fear, rage, shame
- Intrusive imagery of client's traumatic material: nightmares, flooding, flashbacks of client disclosures
- Numbing or avoidance: avoidance of working with client's traumatic material
- Somatic issues: sleep disturbances, headaches, gastrointestinal distress, heart palpitations, chronic physiological arousal
- Addictive/compulsive behaviors: substance abuse, compulsive eating, compulsive working
- Impaired functioning: missed or canceled appointments, decreased use of supervision, decreased ability to engage in self-care, isolation and alienation

Cognitive shifts
- Chronic suspicion about others
- Heightened sense of vulnerability
- Extreme sense of helplessness or exaggerated sense of control over others or situations
- Loss of personal control or freedom
- Bitterness or cynicism
- Blaming the victim or seeing everyone as a victim
- Witness or clinician guilt if client reexperiences trauma or reenacts trauma in counseling
- Feeling victimized by client

Relational disturbances
- Decreased intimacy and trust in personal/professional relationships
- Distancing or detachment from client, which may include labeling clients, pathologizing them, judging them, canceling appointments, or avoiding exploring traumatic material
- Overidentification with the client, which may include a sense of being paralyzed by one's own responses to the client's traumatic material or becoming overly responsible for the client's life

Frame of reference
- Disconnection from one's sense of identity
- Dramatic change in fundamental beliefs about the world
- Loss or distortion of values or principles
- A previous sense of spirituality as comfort or resource decreases or becomes nonexistent
- Loss of faith in something greater
- Existential despair and loneliness

Sources: Figley, 1995; Newall & MacNeil, 2010; Saakvitne et al., 1996.

of secondary traumatic stress and professional burnout" (Newall & MacNeil, 2010, p. 61). Although secondary traumatization as a reaction to exposure to clients' trauma material is similar to PTSD, burnout is a more general type of psychological distress related to the pressures of working in high-stress environments over time. Burnout may be a result of secondary traumatization and/or a contributing factor in the development of secondary traumatization. The ProQOL includes STS and burnout scales that have been validated in research studies (Adams, Figley, & Boscarino, 2008; Newall & MacNeil, 2010).

This tool can be used in individual and group clinical supervision, trainings on self-care, and team meetings as a way for counselors to check in with themselves on their levels of stress and potential signs of secondary traumatization.

Case Illustration: Gui

Gui is a 48-year-old licensed substance abuse counselor who has worked in a methadone maintenance clinic for 12 years. He originally decided to get his degree and become a counselor because he wanted to help people and make a difference in the world. Over the past 6 months, he has felt fatigued a great deal, gets annoyed easily with both clients and coworkers, and has developed a cynical attitude about the world and the people who come to the clinic for help. During this time, the clinic has been forced to lay off a number of counselors due to funding cutbacks. As a result, Gui and the remaining counselors have had a 20 percent increase in the number of weekly client contact hours required as part of their job duties. In addition, the level and severity of clients' trauma-related and other co-occurring disorders, poverty, joblessness, and homelessness has increased.

Gui is a valued employee, and when Gui discusses his thoughts that he might want to leave the clinic with his clinical supervisor, the supervisor listens to Gui's concerns and explores the possibility of having him fill out the ProQOL to get a pulse on his stress level. Gui agrees and is willing to discuss the results with his supervisor. He is not surprised to see that he scores above average on the burnout scale of the instrument but is very surprised to see that he scores below average on the secondary traumatic stress scale and above average on the compassion satisfaction scale. He begins to feel more hopeful that he still finds satisfaction in his job and sees that he is resilient in many ways that he did not acknowledge before.

Gui and the clinical supervisor discuss ways that the supervisor and the organization can lessen the impact of the stress of the work environment on Gui and support the development of a self-care plan that emphasizes his own ability to rebound from adversity and take charge of his self-care.

The compassion satisfaction scale allows counselors to reflect on their resilience and reminds them of why they choose to work with people with substance use and trauma-related disorders, despite the fact that this work can lead to secondary traumatization. The compassion satisfaction subscale reminds counselors that they are compassionate, that one of the reasons they are in a helping profession is that they value service to others, and that helping brings meaning and fulfillment to their lives. Exhibits 2.2-9 through 2.2-11 present the most recent version of the ProQOL.

Addressing Secondary Traumatization

If a counselor is experiencing STS, the organization should address it immediately. Clinical supervisors can collaborate with counselors to devise an individualized plan that is accessible, acceptable, and appropriate for each counselor and that addresses the secondary stress reactions the counselor is experiencing, providing specific self-care strategies to counteract the stress. Decisions about strategies for addressing secondary traumatization should be based on the personal preferences of the counselor, the opportunity for an immediate intervention following a critical incident, and the counselor's level of awareness regarding his or her experience of STS. Counselors may need to talk about what they are experiencing, feeling, and thinking. These experiences can be processed in teams, in consultations with colleagues, and in debriefing meetings to integrate them effectively (Myers & Wee, 2002).

If a critical incident evokes secondary traumatization among staff—such as a client suicide, a violent assault in the treatment program, or another serious event—crisis intervention should be available for workers who would like to participate. Any intervention should be voluntary and tailored to each worker's individual needs (e.g., peer, group, or individual sessions); if possible, these services should be offered continuously instead of just one time.

Exhibit 2.2-9: PRoQOL Scale

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PRoQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *past 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I *[help]*.
___ 3. I get satisfaction from being able to *[help]* people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I *[help]*.
___ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
___ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
___ 10. I feel trapped by my job as a *[helper]*.
___ 11. Because of my *[helping]*, I have felt "on edge" about various things.
___ 12. I like my work as a *[helper]*.
___ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
___ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a *[helper]*.
___ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
___ 21. I feel overwhelmed because my case [work] load seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
___ 24. I am proud of what I can do to *[help]*.
___ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a *[helper]*.
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.

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Exhibit 2.2-10: Your Scores on the ProQOL: Professional Quality of Life Screening

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental healthcare professional.

Compassion Satisfaction _____
Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____
Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____
The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a healthcare professional.

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Source: Stamm, 2012. Used with permission.

Exhibit 2.2-11: What Is My Score and What Does It Mean?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

*You Wrote	Change to
1	5
2	4
3	3
4	2
5	1

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____
Total : _____

The sum of my Compassion Satisfaction questions is	So my score equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score.

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____
Total : _____

The sum of my Burnout questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add the[m] up. When you have added them up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____
Total : _____

The sum of my Secondary Trauma questions is	So my score equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

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The objective of debriefing a critical incident that evokes STS reactions in counselors is to help them dissipate the hyperarousal associated with traumatic stress and prevent long-term aftereffects that might eventually lead to counselor impairment. Because clinical supervisors may also be experiencing secondary traumatization, it is advisable for administrators to invite an outside trauma consultant into the organization to provide a safe space for all staff members (including clinical supervisors) to address and process the critical stress incident. For noncrisis situations, secondary traumatization should be addressed in clinical supervision. Clinical supervisors and counselors should work collaboratively to incorporate regular screening and self-assessment of STS into supervision sessions.

Advice to Clinical Supervisors: Advantages and Disadvantages of Using Psychometric Measures

Using a psychometric measure such as the ProQOL has advantages and disadvantages. It is important to understand that all tests measure averages and ranges but do not account for individual circumstances.

If you use the ProQOL in clinical supervision, present it as a self-assessment tool. Let counselors opt out of sharing their specific results with you and/or your team if it is administered in a group. If counselors choose to share scores on specific items or scales with you, work collaboratively and respectfully with them to explore their own understanding of and meanings attached to their scores. If this tool is not presented to supervisees in a nonjudgmental, mindful way, counselors may feel as if they have failed if their scores on the secondary traumatization scale are above average or if their scores on the compassion satisfaction scale are below average. High scores on the compassion fatigue and burnout scales do not mean that counselors don't care about their clients or that they aren't competent clinicians. The scores are simply one way for you and your supervisees to get a sense of whether they might be at risk for secondary traumatization, what they can do to prevent it, how to address it, and how you can support them.

The potential benefits of using a self-assessment tool like the ProQOL in clinical supervision are that it can help counselors:

- Reflect on their emotional reactions and behaviors and identify possible triggers for secondary traumatization.
- Assess their risk levels.
- Examine alternative coping strategies that may prevent secondary traumatization.
- Understand their own perceptions of themselves and their job satisfaction, affirming what they already know about their risk of secondary traumatization and their compassion satisfaction.
- Reflect on different factors that might contribute to unexpected low or high scores, such as the day of the week, the intensity of the workload, whether they have just come back from the weekend or a vacation, and so forth.
- Increase self-awareness and self-knowledge, because scores on specific items or scales bring to consciousness what is often outside of awareness.
- Realize how resilient they are emotionally, mentally, physically, and spiritually.
- Become aware of and open up conversations about self-care and self-care activities and resources, such as supportive coworkers, team members, and social networks outside of work.

If used regularly, self-assessment tools can help counselors and clinical supervisors monitor STS levels, indicate significant positive and negative changes, and suggest action toward self-care in specific areas. Clinical supervisors should fill out the ProQOL and review results with their own supervisors, a peer supervisor, or a colleague before administering it to supervisees. Doing so enables supervisors to gauge their own reactions to the self-assessment and anticipate potential reactions from supervisees.

Advice to Clinical Supervisors: Is it Supervision or Psychotherapy?

Although there are some aspects of clinical supervision that can be therapeutic and parallel the therapeutic and emotional support that occurs between the counselor and the client, clinical supervision is not therapy. As a result, it is important for clinical supervisors to maintain appropriate boundaries with supervisees when addressing their STS reactions at work.

When does the process in supervision cross over into the realm of practicing therapy with a supervisee? One clear indicator is if the supervisor begins to explore the personal history of the counselor and reflects directly on that history instead of bringing it back to how the counselor's history influences his or her work with a particular client or with clients with trauma histories in general. Clinical supervisors should focus only on counselor issues that may be directly affecting their clinical functioning with clients. If personal issues arise in clinical supervision, counselors should be encouraged to address them in their own counseling or psychotherapy.

Exhibit 2.2-12: Clinical Supervisor Guidelines for Addressing Secondary Traumatization

1. Engage counselors in regular screening/self-assessment of counselors' experience of STS.
2. Address signs of STS with counselors in clinical supervision.
3. Work collaboratively with counselors to develop a comprehensive self-care plan and evaluate its effectiveness on a regular basis.
4. Provide counselors a safe and nonjudgmental environment within which to process STS in individual and group supervision or team meetings.
5. Provide counselors with a safe and nonjudgmental place within which to debrief critical stress incidents at work; bring in an outside consultant if needed.
6. Support and encourage counselors to engage in individual counseling or psychotherapy, when needed, to explore personal issues that may be contributing to secondary traumatization at work.

When STS issues arise, the clinical supervisor should work with counselors to review and revise their self-care plans to determine what strategies are working and whether additional support, like individual psychotherapy or counseling, may be warranted.

Exhibit 2.2-12 outlines some guidelines for clinical supervisors in addressing secondary trauma in behavioral health professionals working with clients who have substance use, mental, and trauma-related disorders.

Counselor Self-Care

In light of the intensity of therapeutic work with clients with co-occurring substance use, mental, and trauma-related disorders and the vulnerability of counselors to secondary traumatization, a comprehensive, individualized self-care plan is highly recommended. Balance is the key to the development of a self-care plan—a balance between home and work, a balance between focusing on self and others, and a balance between rest and activity (Saakvitne, Perlman, & Traumatic Stress Institute/ Center for Adult & Adolescent Psychotherapy 1996). Counselor self-care is also about balancing vulnerability, which allows counselors to be present and available when clients address intensely painful content, with reasonable efforts to preserve their sense of integrity in situations that may threaten the counselors' faith or worldview (Burke et al., 2006). A comprehensive self-care plan should include activities that nourish the physical, psychological/mental, emotional/relational, and spiritual aspects of counselors' lives.

The literature on counselor self-care advocates for individual, team, and organizational strategies that support behavioral health professionals working with clients who have

Case Illustration: Carla

Carla is a 38-year-old case manager working in an integrated mental health and substance abuse agency. She provides in-home case management services to home-bound clients with chronic health and/or severe mental health and substance abuse problems. Many of her clients have PTSD and chronic, debilitating pain.

Both her parents had alcohol use disorders, and as a result, Carla became the caretaker in her family. She loves her job; however, she often works 50 to 60 hours per week and has difficulty leaving her work at work. She often dreams about her clients and wakes up early, feeling anxious. She sometimes has traumatic nightmares, even though she was never physically or sexually abused, and she has never experienced the trauma of violence or a natural disaster. She drinks five cups of coffee and three to four diet sodas every day and grabs burgers and sweets for snacks while she drives from one client to the next. She has gained 20 pounds in the past year and has few friends outside of her coworkers. She has not taken a vacation in more than 2 years. She belongs to the Catholic church down the street, but she has stopped going because she says she is too busy and exhausted by the time Sunday rolls around.

The agency brings in a trainer who meets with the case management department and guides the staff through a self-assessment of their current self-care practices and the development of a comprehensive self-care plan. During the training, Carla acknowledges that she has let her work take over the rest of her life and needs to make some changes to bring her back into balance. She writes out her self-care plan, which includes cutting back on the caffeine, calling a friend she knows from church to go to a movie, going to Mass on Sunday, dusting off her treadmill, and planning a short vacation to the beach. She also decides that she will discuss her plan with her supervisor and begin to ask around for a counselor for herself to talk about her anxiety and her nightmares. In the next supervision session, Carla's supervisor reviews her self-care plan with her and helps Carla evaluate the effectiveness of her self-care strategies. Her supervisor also begins to make plans for how to cover Carla's cases when she takes her vacation.

substance use and trauma-related disorders. Counselors are responsible for developing comprehensive self-care plans and committing to their plans, but clinical supervisors and administrators are responsible for promoting counselor self-care, supporting implementation of counselor self-care plans, and modeling self-care. Counselor self-care is an ethical imperative; just as the entire trauma-informed organization must commit to other ethical issues with regard to the delivery of services to clients with substance use, mental, and trauma-related disorders, it must also commit to the self-care of staff members who are at risk for secondary traumatization as an ethical concern. Saakvitne and colleagues (1996) suggest that when administrators support counselor-self-care, it is not only cost-effective in that it reduces the negative effects of secondary traumatization on counselors (and their clients), but also promotes "hope-sustaining behaviors" in counselors, making them more motivated and open to learning, and thereby improving job performance and client care.

A Comprehensive Self-Care Plan

A self-care plan should include a self-assessment of current coping skills and strategies and the development of a holistic, comprehensive self-care plan that addresses the following four domains:

1. Physical self-care
2. Psychological self-care (includes cognitive/mental aspects)
3. Emotional self-care (includes relational aspects)
4. Spiritual self-care

Activities that may help behavioral health workers find balance and cope with the stress

Advice to Clinical Supervisors: Spirituality

The word "spiritual" in this context is used broadly to denote finding a sense of meaning and purpose in life and/or a connection to something greater than the self. Spiritual meanings and faith experiences are highly individual and can be found within and outside of specific religious contexts.

Engaging in spiritual practices, creative endeavors, and group/community activities can foster a sense of meaning and connection that can counteract the harmful effects of loss of meaning, loss of faith in life, and cognitive shifts in worldview that can be part of secondary traumatization. Counselors whose clients have trauma-related disorders experience fewer disturbances in cognitive schemas regarding worldview and less hopelessness when they engage in spiritually oriented activities, such as meditation, mindfulness practices, being in nature, journaling, volunteer work, attending church, and finding a spiritual community (Burke et al., 2006). Clinical supervisors can encourage counselors to explore their own spirituality and spiritual resources by staying open and attuned to the multidimensional nature of spiritual meaning of supervisees and refraining from imposing any particular set of religious or spiritual beliefs on them. A strong sense of spiritual connection can enhance counselors' resilience and ability to cope with the sometimes overwhelming effects of clients' trauma material and trauma-related behavior (including suicidality) on counselors' faith in life and sense of meaning and purpose.

Modeling Self-Care

"Implementing interventions was not always easy, and one of the more difficult coping strategies to apply had to do with staff working long hours. Many of the staff working at the support center also had full-time jobs working for the Army. In addition, many staff chose to volunteer at the Family Assistance Center and worked 16- to 18-hour days. When we spoke with them about the importance of their own self-care, many barriers emerged: guilt over not working, worries about others being disappointed in them, fear of failure with respect to being unable to provide what the families might need, and a 'strong need to be there.' Talking with people about taking a break or time off proved problematic in that many of them insisted that time off was not needed, despite signs of fatigue, difficulty concentrating, and decreased productivity. Additionally, time off was not modeled. Management, not wanting to fail the families, continued to work long hours, despite our requests to do otherwise. Generally, individuals could see and understand the reasoning behind such endeavors. Actually making the commitment to do so, however, appeared to be an entirely different matter. In fact, our own team, although we kept reasonable hours (8 to 10 per day), did not take a day off in 27 days. Requiring time off as part of membership of a Disaster Response Team might be one way to solve this problem."

—Member of a Disaster Response Team at the Pentagon after September 11

Source: Walser, 2004, pp. 4–5.

of working with clients with trauma-related disorders include talking with colleagues about difficult clinical situations, attending workshops, participating in social activities with family and friends, exercising, limiting client sessions, balancing caseloads to include clients with and without trauma histories, making sure to take vacations, taking breaks during the workday, listening to music, walking in nature, and seeking emotional support in both their personal and professional lives (Saakvitne et al., 1996). In addition, regular clinical supervision and personal psychotherapy or counseling can be positive coping strategies for lessening the impact of STS on counselors. Still, each counselor is unique, and a self-care approach that is helpful to one counselor may not be helpful to another. Exhibits 2.2-13 and 2.2-14 offer tools for self-reflection to help counselors discover which specific self-care activities might best suit them. The worksheet can be used privately by counselors or by clinical supervisors as an exercise in individual supervision, group supervision, team meetings, or trainings on counselor self-care.

Exhibit 2.2-13: Comprehensive Self-Care Plan Worksheet

Name: Date:	Personal	Professional/Workspace
Physical		
Psychological/Mental		
Emotional/Relational		
Spiritual		

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Review the questions in Exhibit 2.2-14, and then write down specific self-care strategies in the form (given in Exhibit 2.2-13) that you're confident you will practice in both personal and professional realms.

The *Comprehensive Self-Care Worksheet* is a tool to help counselors (and clinical supervisors) develop awareness of their current coping strategies and where in the four domains they need to increase their engagement in self-care activities. Once completed, clinical supervisors should periodically review the plan with their supervisees for effectiveness in preventing and/or ameliorating secondary traumatization and then make adjustments as needed.

Essential Components of Self-Care

Saakvitne and colleagues (1996) describe three essential components, the "ABCs," of self-care that effectively address the negative impact of secondary traumatization on counselors:

1. **Awareness** of one's needs, limits, feelings, and internal/external resources. Awareness involves mindful/nonjudgmental attention to one's physical, psychological, emotional, and spiritual needs. Such attention requires quiet time and space that supports self-reflection.
2. **Balance** of activities at work, between work and play, between activity and rest, and between focusing on self and focusing on others. Balance provides stability and helps counselors be more grounded when stress levels are high.
3. **Connection** to oneself, to others, and to something greater than the self. Connection decreases isolation, increases hope, diffuses stress, and helps counselors share the burden of responsibility for client care. It provides an anchor that enhances counselors' ability to witness tremendous suffering without getting caught up in it.

Exhibit 2.2-14: Comprehensive Self-Care Plan Worksheet Instructions

Use the following questions to help you engage in a self-reflective process and develop your comprehensive self-care plan. Be specific and include strategies that are accessible, acceptable, and appropriate to your unique circumstances. Remember to evaluate and revise your plan regularly.

Physical
What are non-chemical things that help my body relax?
What supports my body to be healthy?

Psychological/Mental
What helps my mind relax?
What helps me see a bigger perspective?
What helps me break down big tasks into smaller steps?
What helps me counteract negative self-talk?
What helps me challenge negative beliefs?
What helps me build my theoretical understanding of trauma and addictions?
What helps me enhance my counseling/helping skills in working with traumatized clients?
What helps me become more self-reflective?

Emotional/Relational
What helps me feel grounded and able to tolerate strong feelings?
What helps me express my feelings in a healthy way?
Who helps me cope in positive ways and how do they help?
What helps me feel connected to others?
Who are at least three people I feel safe talking with about my reactions/feelings about clients?
How can I connect with those people on a regular basis?

Spiritual
What helps me find meaning in life?
What helps me feel hopeful?
What sustains me during difficult times?
What connects me to something greater?

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Clinical supervisors can help counselors review their self-care plans through the ABCs by reflecting on these questions:

1. Has the counselor accurately identified his or her needs, limits, feelings, and internal and external resources in the four domains (physical, psychological/mental, emotional/relational, spiritual)?
2. Has the counselor described self-care activities that provide a balance between work and leisure, activity and rest, and a focus on self and others?
3. Has the counselor identified self-care activities that enhance connection to self, others, and something greater than self (or a larger perspective on life)?

Supervisors should make their own self-care plans and review them periodically with their clinical supervisors, a peer supervisor, or a colleague.

Commitment to Self-Care

One of the major obstacles to self-care is giving in to the endless demands of others, both at work and at home. It is therefore essential for counselors with the support of clinical supervisors to become "guardians of [their] boundaries and limits" (Saakvitne et al., 1996, p 136). Creating a daily schedule that includes breaks for rest, exercise, connection with coworkers, and other self-care activities can support counselors in recognizing that they are valuable individuals who are worthy of taking the time to nourish and nurture themselves, thus increasing commitment to self-care. Another way to support counselors in committing to self-care is for supervisors and administrators to model self-care in their own professional and personal lives.

Understanding that counselor self-care is not simply a luxury or a selfish activity, but rather, an ethical imperative (Exhibit 2.2-15) can foster counselors' sense of connection to their own values and accountability to the people they serve as competent and compassionate caregivers. Clinical supervisors and administrators can reinforce this sense of accountability while supporting counselors by providing a caring, trauma-informed work environment

Exhibit 2.2-15: The Ethics of Self-Care

The Green Cross Academy of Traumatology was originally established to serve a need in Oklahoma City following the April 19, 1995, bombing of the Alfred P. Murrah Federal Building. Below are adapted examples of the Academy's code of ethics with regard to worker self-care.

Ethical Principles of Self-Care in Practice
These principles declare that it is unethical not to attend to your self-care as a practitioner, because sufficient self-care prevents harming those we serve.

Standards of self-care guidelines:
- Respect for the dignity and worth of self: A violation lowers your integrity and trust.
- Responsibility of self-care: Ultimately it is your responsibility to take care of yourself—and no situation or person can justify neglecting this duty.
- Self-care and duty to perform: There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care.

Standards of humane practice of self-care:
- Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self-care.
- Physical rest and nourishment: Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
- Emotional rest and nourishment: Every helper deserves emotional and spiritual renewal both in and outside the work context.
- Sustenance modulation: Every helper must utilize self-restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since improper consumption can compromise their competence as a helper.

Commitment to self-care:
- Make a formal, tangible commitment: Written, public, specific, measurable promises of self-care.
- Set deadlines and goals: The self-care plan should set deadlines and goals connected to specific activities of self-care.
- Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care.

Source: Green Cross Academy of Traumatology, 2010. Adapted with permission.

that acknowledges and normalizes secondary traumatization and by offering reasonable resources that make it possible for counselors to do their work and take care of themselves at the same time. Preventing secondary traumatization and lessening its impact on counselors once it occurs is not only cost-effective with regard to decreasing staff turnover and potential discontinuity of services to clients; it is also the ethical responsibility of a trauma-informed organization.

Appendices

Appendix A—Bibliography

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Appendix B—Trauma Resource List

Introduction

As it would be difficult to include every organization focused on trauma, the list of resources in this appendix is not exhaustive; consequently, this list does not include books or other materials concerning the vast nature of this topic, but rather, it concentrates solely on online resources accessible to the public for free or as part of an organization membership. The inclusion of selected resources does not necessarily signify endorsement by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Following these resources for adults is a list of resources focused on children and adolescents and a list of training opportunities.

Technology and Trauma: Using the Web To Treat PTSD

The role of the Internet in helping those who are experiencing posttraumatic stress disorder (PTSD) has expanded rapidly; there are numerous Web sites with toolkits and research publications for clinicians who treat clients with PTSD, as well as Web sites aimed at providing information and support for these individuals. The U.S. military has contributed to the field in developing these avenues—specifically, with interactive Web applications for use on home computers and smartphones.

- PTSD Coach is a smartphone application from the U.S. Department of Veterans Affairs (VA) to help people experiencing PTSD learn about and manage their symptoms (http://www.ptsd.va.gov/public/pages/ptsdcoach.asp).
- Afterdeployment.org is a Web site developed by the Defense Centers of Excellence project led by the National Center for Telehealth & Technology, with interactive workshops about PTSD, traumatic brain injury (TBI), anxiety, and depression, aimed at returning veterans (http://www.afterdeployment.org).
- T2 Virtual PTSD Experience, also developed by the National Center for Telehealth & Technology, is an application to be used within the popular online game Second Life as an interactive way of simulating how PTSD can be acquired within a combat environment, how PTSD may present itself to the person experiencing it, and how to seek effective treatment (http://www.t2health.org/vwproj).

Resources for Adults

Academy of Cognitive Therapy

http://www.academyofct.org
260 South Broad Street
18th Floor
Philadelphia, PA 19102
Phone: 267-350-7683
Email: info@academyofct.org

The Academy of Cognitive Therapy, a nonprofit organization, supports continuing education and research in cognitive therapy, provides a valuable resource in cognitive therapy for professionals and the public at large,

and actively works toward the identification and certification of clinicians skilled in cognitive therapy. Certification is awarded to those individuals who, based on an objective evaluation, have demonstrated an advanced level of expertise in cognitive therapy. The Academy includes physicians, psychologists, social workers, and other mental health professionals from around the world. The Academy formed a Trauma Task Force after September 11, 2001, to disseminate information (available on their Web site) to help people around the world receive the best help possible following trauma.

Addiction Technology Transfer Center Network

http://www.attcnetwork.org/index.asp
5100 Rockhill Road
Kansas City, MO 64110
Phone: 816-235-6888
Email: networkoffice@attcnetwork.org

The Addiction Technology Transfer Center (ATTC) Network serves as a resource for students and professionals to identify international distance education opportunities for the substance abuse treatment field and as a free marketing venue for ATTC-approved sponsors of distance education courses. The ATTC Web site provides trauma-related resources that include case studies, information on working with returning veterans who have been exposed to trauma, and links to various publications on PTSD and secondary traumatic stress.

Agency for Healthcare Research and Quality

http://www.innovations.ahrq.gov/index.aspx
540 Gaither Road
Suite 2000
Rockville, MD 20850
Phone: 301-427-1104

The Agency for Healthcare Research and Quality (AHRQ) is the research arm of HHS, specializing in patient safety and quality improvement, outcomes and effectiveness of care, clinical practice and technology assessment, and healthcare organization and delivery systems. AHRQ also provides funding and technical assistance to health research and research training programs at many universities and institutions. AHRQ's Web site provides links to research publications on PTSD and to other government publications and toolkits dealing with trauma-informed care.

The American Academy of Experts in Traumatic Stress

http://www.aaets.org
203 Deer Road
Ronkonkoma, NY 11779
Phone: 631-543-2217
Email: info@aaets.org

The American Academy of Experts in Traumatic Stress is a multidisciplinary network of professionals who are committed to the advancement of intervention for survivors of trauma. The Academy aims to identify expertise among professionals and across disciplines and to provide meaningful standards for those who work regularly with survivors. The Academy is committed to fostering a greater appreciation of the effects of common traumatic experiences (e.g., chronic illness, accidents, domestic violence, loss) in addition to large-scale disasters and catastrophes. The group's aim is to help all victims to become survivors and, ultimately, to thrive.

American Red Cross Disaster Services

http://www.redcross.org/what-we-do/disaster-relief
American Red Cross National Headquarters
2025 E Street, NW

Washington, DC 20006
Phone: 202-303-4498

Red Cross disaster relief focuses on meeting people's immediate emergency disaster-caused needs. When a disaster threatens or strikes, the Red Cross provides shelter, food, and health and mental health services to address basic human needs. In addition to these services, the core of Red Cross disaster relief is the assistance given to individuals and families affected by disaster to enable them to resume their normal daily activities independently. Training opportunities are also provided.

Anxiety and Depression Association of America

http://www.adaa.org
8701 Georgia Avenue #412
Silver Spring, MD 20910
Phone: 240-485-1001

The Anxiety and Depression Association of America (ADAA) is the only national, nonprofit membership organization dedicated to informing the public, healthcare professionals, and legislators that anxiety disorders are real, serious, and treatable. ADAA promotes the early diagnosis, treatment, and cure of anxiety disorders and is committed to improving the lives of the people who have them. The ADAA Web site provides information about the symptoms of PTSD and how it can be treated, in addition to offering a PTSD self-screening tool.

Association for Behavioral and Cognitive Therapies

http://www.abct.org
305 7th Avenue
16th Floor
New York, NY 10001
Phone: 212-647-1890
Fax: 212-647-1865

The Association for Behavioral and Cognitive Therapies is a professional, interdisciplinary organization concerned with the application of behavioral and cognitive science to understanding human behavior, developing interventions to enhance the human condition, and promoting the appropriate use of these interventions. The association's Web site includes resources for the public and for professionals on trauma and disaster-related problems, a clinical referral directory, and other resources and training opportunities in behavioral therapy.

Association of Traumatic Stress Specialists

http://www.atss.info
88 Pompton Avenue
Verona, NJ 07044
Phone: 973-559-9200
Email: Admin@atss.info

The Association of Traumatic Stress Specialists is an international membership organization that offers three distinct board certifications to qualified individuals who provide services, intervention, response, and/or treatment in the field of traumatic stress. The Association is dedicated to improving the quality of life of all individuals throughout the world who have been affected by traumatic events. Membership represents those who serve survivors of natural disasters, terrorist attacks, injuries and deaths related to serving in the line of duty or to school and workplace violence; veterans; refugees; victims of crime; Holocaust survivors; those affected and exploited by political persecution; and others who have experienced traumatic stress injuries.

Center for Anxiety and Related Disorders

http://www.bu.edu/card
648 Beacon Street
6th Floor

Boston, MA 02215
Phone: 617-353-9610

The Center for Anxiety and Related Disorders (CARD) at Boston University is a clinical and research center dedicated to advancing knowledge and providing care for anxiety, mood, eating, sleep, and related disorders. CARD's Web site offers information regarding PTSD and research publications on trauma and anxiety, in addition to linking to toolkits from the National Child Traumatic Stress Network's Adolescent Traumatic Stress and Substance Abuse Program.

Center for the Study of Traumatic Stress

http://www.cstsonline.org
Uniformed Services University of the Health Sciences
Department of Psychiatry
4301 Jones Bridge Road
Bethesda, MD 20814-4799
Phone: 301-295-2470
Fax: 301-319-6965

The Center for the Study of Traumatic Stress (CSTS) is a federally funded organization established by the Military Health System in 1987 to address Department of Defense concerns regarding health risks and concerns resulting from the traumatic impact of the use of weapons of mass destruction in combat, acts of terrorism and hostage events, combat and peacekeeping operations, natural disasters, and assaults or accidents occurring in both uniformed and civilian communities. CSTS primarily serves members of the armed forces, along with their children and families.

Center for Culture, Trauma and Mental Health Disparities

http://www.semel.ucla.edu/cctmhd
UCLA Semel Institute of Neuroscience & Biobehavioral Sciences
760 Westwood Plaza
Los Angeles, CA 90024
Phone: 310-794-9929

The Collaborative Center for Trauma and Mental Health Disparities at the University of California Los Angeles is a multiethnic and multidisciplinary group that focuses on conducting research and providing training that pertains to trauma in minority populations.

Council of State Governments Justice Center—Mental Health

http://csgjusticecenter.org/jc/category/mental-health
100 Wall Street
20th Floor
New York, NY 10005
Phone: 212-482-2320
Fax: 212-482-2344
Email: consensusproject@csg.org

The Consensus Project is part of the Council of State Governments Justice Center and partners with other organizations, such as SAMHSA's GAINS Center, working to improve outcomes for people, including juveniles, with mental illnesses involved with the criminal justice system. The Consensus Project offers a webinar on trauma services in the criminal justice system and on child trauma and juvenile justice, as well as a local programs database.

Dart Center for Journalism and Trauma

http://www.dartcenter.org
Columbia University
Graduate School of Journalism
2950 Broadway
New York, NY 10027
Phone: 212-854-8056

The Dart Center is dedicated to improving media coverage of trauma, conflict, and

tragedy. The Center also addresses the consequences of such coverage for those working in journalism and provides training and education via seminars, newsroom briefings and consultation on trauma issues, in addition to training for journalism educators and other trainers. The Dart Center Web site offers fact sheets, publications, and DVDs on request for use by journalists, educators, and clinicians.

David Baldwin's Trauma Information Pages

http://www.trauma-pages.com
Phone: 541-686-2598
Email: dvb@trauma-pages.com

This Web site focuses primarily on emotional trauma and traumatic stress, including PTSD and dissociation, whether following individual traumatic experience(s) or a large-scale disaster. The site's purpose is to provide information for clinicians and researchers in the traumatic stress field. Specifically, the focus is on both clinical and research aspects of trauma responses and their resolution.

Disaster Technical Assistance Center

http://www.samhsa.gov/dtac
9300 Lee Highway
Fairfax, VA 22031
Phone: 800-308-3515
Fax: 703-225-2338

SAMHSA has created the Disaster Technical Assistance Center (DTAC) to help States prepare for and respond to a wide range of potential catastrophes—both natural and human-caused disasters. DTAC primarily serves individuals and communities who are recovering from natural and human-caused disasters. It works in conjunction with the Federal Emergency Management Agency (FEMA) and SAMHSA's Emergency Mental Health and Traumatic Stress Services Branch, using strengths-based, outreach-oriented principles conducted in nontraditional settings, as a supplement to programs already in place on a local level.

EMDR Institute, Inc.

http://www.emdr.com
P.O. Box 750
Watsonville, CA 9507
Phone: 831-761-1040
Fax: 831-761-1204
Email: inst@emdr.com

Eye Movement Desensitization and Reprocessing (EMDR) is an information-processing therapy that uses an eight-phase approach. (See the description in Part 1, Chapter 6.) The Web site presents background and descriptive information about this approach to treatment and lists training opportunities, references, and networking groups.

The Federal Emergency Management Agency

http://www.fema.gov
500 C Street SW
Washington, DC 20472
Phone: 202-646-2500

The Federal Emergency Management Agency, a formerly independent agency that became part of the Department of Homeland Security in March 2003, is tasked with responding to, planning for, recovering from, and mitigating against disasters. FEMA can trace its beginnings to the Congressional Act of 1803. This Act, generally considered the first piece of disaster legislation, provided assistance to a New Hampshire town following an extensive fire. In the century that followed, ad hoc legislation was passed more than 100 times in response to hurricanes, earthquakes, floods, and other natural disasters.

The International Critical Incident Stress Foundation, Inc.

http://www.icisf.org
3290 Pine Orchard Lane
Suite 106
Ellicott City, MD 21042
Phone: 410-750-9600
Fax: 410-750-9601
Email: info@icisf.org

The International Critical Incident Stress Foundation, Inc., is a nonprofit, open-membership foundation dedicated to the prevention and mitigation of disabling stress through the provision of education, training, and support services for all emergency services professions; continuing education and training in emergency mental health services for psychologists, psychiatrists, social workers, and licensed professional counselors; and consultation in the establishment of crisis and disaster response programs for varied organizations and communities worldwide.

International Society for the Study of Trauma and Dissociation

http://www.issd.org
8400 Westpark Drive
Second Floor
McLean, VA 22102
Phone: 703-610-9037
Fax: 703-610-0234
Email: info@isst-d.org

The Society is a nonprofit professional association organized for the purposes of information sharing and international networking of clinicians and researchers; providing professional and public education; promoting research and theory about dissociation; and promoting research and training in the identification, treatment, and prevention of dissociative disorders. The Society offers courses in its Dissociative Disorders Psychotherapy Training Program.

The International Society for Traumatic Stress Studies

http://www.istss.org
111 Deer Lake Road
Suite 100
Deerfield, IL 60015
Phone: 847-480-9028
Fax: 847-480-9282

The International Society for Traumatic Stress Studies (ISTSS) was founded in 1985 for professionals to share information about the effects of trauma. ISTSS is dedicated to the discovery and dissemination of knowledge about policy, program, and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences. ISTSS provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma in the United States and around the world.

National Alliance on Mental Illness

http://www.nami.org
3803 N. Fairfax Dr.
Suite 100
Arlington, VA 22203
Phone: 703-524-7600
Fax: 703-524-9094

The National Alliance on Mental Illness (NAMI) is a nonprofit advocacy group founded in 1979 to raise awareness and provide essential and free education, advocacy, and support group programs for people living with mental illness and their loved ones. NAMI operates at the local, State, and national levels, with each level of the organizations providing education, information, support, and advocacy for those with mental illness and their support system. NAMI has developed a Trauma Toolkit and includes a series of lectures for mental health professionals about trauma.

National Association of State Alcohol and Drug Abuse Directors, Inc.

http://www.nasadad.org
1025 Connecticut Ave NW
Suite 605
Washington, DC 20036
Phone: 202-293-0090
Fax: 202-293-1250
Email: dcoffice@nasadad.org

The National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) is a private, not-for-profit educational, scientific, and informational organization. NASADAD's basic purpose is to foster and support the development of effective alcohol and drug abuse prevention and treatment programs throughout every State. NASADAD offers a policy brief with regards to trauma and substance use/abuse in the wake of natural or human-made disasters.

National Association of State Mental Health Program Directors

http://www.nasmhpd.org
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 703-739-9333
Fax: 703-548-9517

The National Association of State Mental Health Program Directors (NASMHPD; pronounced "NASH-pid") is a nonprofit organization dedicated to serving the needs of the Nation's public mental health system through policy development, information dissemination, and technical assistance. NASMHPD represents the $23 billion public mental health service delivery system. As a private, not-for-profit 501(c)(3) membership organization, NASMHPD helps set the agenda and determine the direction of State mental health agency interests across the country, historically including State mental health planning, service delivery, and evaluation. The principal programs operated, funded, and/or regulated by NASMHPD members serve people who have serious mental illnesses, developmental disabilities, and/or substance use disorders. NASMPHD has launched a Technical Assistance Coordinating Center in response to the Alternatives to Restraint and Seclusion State Infrastructure Grant Project, an initiative of SAMHSA's Center for Mental Health Services, designed to promote the implementation and evaluation of best practice approaches to preventing and reducing the use of seclusion and restraint in mental health settings.

National Center for Injury Prevention and Control

http://www.cdc.gov/injury
1600 Clifton Road
Atlanta, GA 30333
Phone: 800-232-4636
Email: cdcinfo@cdc.gov

The National Center for Injury Prevention and Control (NCIPC) was established by the Centers for Disease Control and Prevention in 1992. Through research, surveillance, implementation of evidence-based strategies, capacity building, and communication activities, NCIPC works to reduce morbidity, disability, mortality, and costs associated with injuries and violence. NCIPC is the lead U.S. Federal agency for nonoccupational injury prevention.

National Center for PTSD

http://www.ptsd.va.gov
810 Vermont Avenue NW
Washington, DC 20420
Phone: 802-296-6300
Email: ncptsd@va.gov

The National Center for PTSD (NCPTSD) was created within the Department of

Veterans Affairs in 1989 in response to a Congressional mandate to address the needs of veterans with military-related PTSD. Its mission is to advance the clinical care and social welfare of America's veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders. Its Web site is provided as an educational resource concerning PTSD and other enduring consequences of traumatic stress. The NCPTSD Web site has information about instruments to measure trauma exposure, risk and resilience factors for PTSD, self-report instruments, and interview schedules. Training opportunities are listed at http://www.ptsd.va.gov/about/training/training-programs.asp.

National Center for Telehealth and Technology

http://www.t2health.org
9933C West Hayes Street
Joint Base Lewis-McChord, WA 98431
Phone: 253-968-1914
Fax: 253-968-4192
Email: AskUs@t2health.org

The National Center for Telehealth and Technology is a Federal agency founded by the Department of Defense as part of the Military Health System. It primarily serves veterans and active-duty military personnel who are experiencing adverse health effects due to TBI and PTSD, as well as military children who are coping with their parents' deployment, through the use of technology (e.g., mobile phone applications, deployable telehealth centers).

National Center for Trauma-Informed Care

http://www.samhsa.gov/nctic
66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: 866-254-4819
Fax: 703-548-9517
Email: NCTIC@NASMHPD.org

The National Center for Trauma-Informed Care (NCTIC) is a Federal center established by SAMHSA in 2005 to offer consultation, technical assistance, education, outreach, and resources to support trauma-informed care in publicly-funded systems and programs. NCTIC primarily serves those who are already receiving services from the behavioral health system and is focused on helping behavioral health services and programs to become more aware of the impact of trauma among consumers, to adapt services to incorporate trauma-informed practices, and to help raise awareness of practices or processes that are more likely to retraumatize consumers.

National Center for Victims of Crime

http://www.victimsofcrime.org
2000 M Street NW
Suite 480
Washington, DC 20036
Phone: 202-467-8700
Fax: 202-467-8701
Email: webmaster@ncvc.org

The National Center for Victims of Crime (NCVC) is a nonprofit organization funded partially by Federal grants from the Department of Justice. It was founded in 1985 and originally known as the Sunny Von Bulow National Victim Advocacy Center. NCVC is a resource center for those affected by violent crimes and also provides training and education for behavioral health service providers.

National Center on Domestic Violence, Trauma & Mental Health

http://www.nationalcenterdvtraumamh.org/
Phone: 312-726-7020
Fax: 312-726-7022

The National Center on Domestic Violence, Trauma & Mental Health was established in 2005 through a grant from the Family Violence Prevention and Services Program, HHS. The Center's mission is to promote accessible, culturally relevant, and trauma-informed responses to domestic violence and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being; this is achieved by providing training and online resources to mental health and substance abuse treatment providers and developing policies to improve system responses to domestic violence survivors and their children.

National Center on Elder Abuse

http://www.ncea.aoa.gov
University of California–Irvine
Program in Geriatric Medicine
101 The City Drive South, 200 Building
Orange, CA 92868
Phone: 855-500-3537
Email: ncea-info@aoa.hhs.gov

The National Center on Elder Abuse (NCEA), part of the U.S. Administration on Aging, serves as a national resource center dedicated to the prevention of elder mistreatment. NCEA provides information to both mental health professionals and the general public and also provides technical assistance and training to States and community-based organizations.

National Center on Family Homelessness

http://www.familyhomelessness.org
200 Reservoir Street
Suite 200
Needham, MA 02494
Phone: 617-964-3834
Fax: 617-244-1758
Email: info@familyhomelessness.org

The National Center on Family Homelessness (NCFH) was founded in 1988 and is a nonprofit organization that conducts research and creates public awareness about the special needs of families experiencing homelessness. NCFH primarily serves veterans who are homeless and their families and young mothers who are homeless with their children. NCFH has developed a Trauma-Informed Organizational Toolkit for Homeless Services.

National Coalition Against Domestic Violence

http://www.ncadv.org
1 Broadway
Suite B210
Denver, CO 80203
Phone: 303-839-1852
Fax: 303-831-9251
Email: mainoffice@ncadv.org

The National Coalition Against Domestic Violence (NCADV) is an advocacy group founded in 1978 and acts as a national information and referral center for the general public, media, survivors of domestic violence and their children, and allied and member agencies and organizations. NCADV also works to influence legislation that would provide protection for survivors of domestic violence and their families and provide funding to shelters, healthcare centers, and other organizations.

National Council for Behavioral Health

http://www.thenationalcouncil.org
1701 K Street NW
Suite 400
Washington, DC 20006
Phone: 202-684-7457
Email: communications@thenationalcouncil.org

The National Council for Behavioral Health is a national community behavioral health

advocacy organization, formed in 1970, to conduct Federal advocacy activities, representing the industry on Capitol Hill and before Federal agencies. It also offers a national consulting service program, various publications, and an annual training conference. The National Council Magazine, 2011, Issue 2, focuses on trauma-informed behavioral health services. The National Council has offered a Learning Community for Adoption of Trauma-Informed Practices, funded by SAMHSA.

National Institute on Drug Abuse

http://drugabuse.gov
National Institute on Drug Abuse
National Institutes of Health
6001 Executive Boulevard
Room 5213, MSC 9561
Bethesda, MD 20892-9561
Phone: 301-443-1124
Email: information@nida.nih.gov

The National Institute on Drug Abuse's (NIDA) mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. NIDA's goal is to ensure that science, not ideology or anecdote, forms the foundation for all of the Nation's drug abuse reduction efforts. NIDA was established in 1974, and in October 1992 it became part of the National Institutes of Health (NIH), HHS. The Institute is organized into divisions and offices, each of which plays an important role in programs of drug abuse research. NIDA has an ongoing research program on women's health and sex/gender differences, including the gathering of information on trauma and substance abuse.

National Institute of Mental Health

http://www.nimh.nih.gov
National Institute of Mental Health
Science Writing, Press, and Dissemination Branch
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: 301-443-4513
Fax: 301-443-4279
Email: nimhinfo@mail.nih.gov

The National Institute of Mental Health (NIMH) is one of the 27 component institutes of NIH, the Federal Government's principal biomedical and behavioral research agency that is part of HHS. NIMH's mission is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior. This public health mandate demands that NIMH use science to achieve better understanding, treatment, and eventually, prevention of these disabling conditions that affect millions of Americans. NIMH offers publications and podcasts related to traumatic events and PTSD.

National Registry for Evidence-Based Programs and Practices

http://www.nrepp.samhsa.gov
Phone: 866-436-7377
Email: nrepp@samhsa.hhs.gov

SAMHSA's National Registry for Evidence-Based Programs and Practices (NREPP) is a searchable online registry of more than 300 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. NREPP offers several interventions that address trauma and PTSD.

National Sexual Violence Resource Center

http://www.nsvrc.org
123 North Enola Drive
Enola, PA 17025
Phone: 717-909-0710
Fax: 717-909-0714

The National Sexual Violence Resource Center (NSVRC) was founded by the Pennsylvania Coalition Against Rape in 2000 and is partially federally funded by grants from the Centers for Disease Control and Prevention. NSVRC advocates for changes in Federal and State legislation to further the goal of ending sexual violence in all communities, in addition to collecting and disseminating a wide range of resources on sexual violence, including statistics, research, position statements, statutes, training curricula, prevention initiatives and program information. NSVRC does not provide direct services to survivors of sexual violence but acts as a resource to support these services.

National Trauma Consortium

http://www.nationaltraumaconsortium.org
520 Ralph Street
Sarasota, FL 34242
Phone: 941-312-9795

The National Trauma Consortium (NTC) is a clearinghouse for information about trauma and emerging best practices in trauma treatment and services and, in addition, offers training and consultation services. NTC also provides resources in the form of downloadable publications and links to other organizations related to mental health and trauma.

National Voluntary Organizations Active in Disasters

http://www.nvoad.org
1501 Lee Highway
Suite 170
Arlington, VA 22209-1109
Phone: 703-778-5088
Fax: 703-778-5091
Email: info@nvoad.org

National Voluntary Organizations Active in Disasters (NVOAD) coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective service and less duplication by getting together before disasters strike. Once disasters occur, NVOAD or an affiliated State VOAD encourages members and other voluntary agencies to convene on site. This cooperative effort has proven to be the most effective way for a wide variety of volunteers and organizations to work together in a crisis. NVOAD's principles are cooperation, coordination, communication, education, mitigation, convening mechanisms, and outreach.

Office for Victims of Crime Training and Technical Assistance Center

https://www.ovcttac.gov/
9300 Lee Highway
Fairfax, VA 22031-6050
Phone: 866-682-8822
TTY: 866-682-8880
Fax: 703-279-4673
Email: TTAC@ovcttac.org

The Office for Victims of Crime Training and Technical Assistance Center provides comprehensive, quality technical assistance and training resources to victims' service providers and allied professionals. Its mission is to support the development of the field by increasing the Nation's capacity to provide crime victims with skilled, capable, and sensitive assistance. Its core functions are needs assessment, capacity building, evaluation, and reporting.

Rape, Abuse & Incest National Network

http://www.rainn.org
1220 L Street NW
Suite 505
Washington, DC 20005
Phone: 202-544-1034
Email: info@rainn.org

The Rape, Abuse & Incest National Network (RAINN) is a nonprofit organization, founded in 1994, that is partially funded by a grant from the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. RAINN provides support for survivors of sexual assault via a telephone hotline and an online hotline and works with the Department of Defense (DoD) to provide a hotline for members of the DoD community who have experienced sexual assault.

SAMHSA's Tribal Training and Technical Assistance Center

http://beta.samhsa.gov/tribal-ttac
201 Corporate Drive
Suite 800
Landover, MD 20785
Phone: 240-650-0257
Email: TA-Request@tribaltechllc.com

SAMHSA's Tribal Training and Technical Assistance Center (Tribal TTAC) is committed to providing comprehensive broad, focused, and/or intensive training and technical assistance to federally recognized Tribes and other American Indian and Alaska Native communities seeking to address and prevent mental and substance use disorders and suicide while promoting mental health. The goal of the Tribal TTAC is to use a culturally relevant, evidence-based, holistic approach to support Native communities in their self-determination efforts through infrastructure development, capacity building, and program planning and implementation.

Sanctuary Model

http://www.sanctuaryweb.com
Phone: 888-538-3124

The goals of the Sanctuary Model include increasing the perceived sense of community/cohesiveness; the degree of social immunity to the spread of violence; the capacity for social learning; the making of decisions democratically and the sharing of responsibility in solving problems and resolving conflicts; the ability to deal with complexity; opportunities for all clients and staff members to experience a truly safe and connected community; opportunities for troubled clients to have corrective emotional, relational, and environmental experiences; and recovery, healing, and growth.

Seeking Safety

http://www.seekingsafety.org
Treatment Innovations
28 Westbourne Road
Newton Centre, MA 02459
Phone: 617-299-1610
Fax: 617-701-1295
Email: info@seekingsafety.org

This Web site provides information about Seeking Safety, a psychotherapeutic intervention for treating trauma, PTSD, and substance abuse. Seeking Safety is a present-focused therapy to help people attain safety from both PTSD and substance abuse. The treatment is also available as a book, which provides both client handouts and guidance for clinicians. The site includes topics included in the treatment program, sample materials, relevant empirical studies, and supplementary articles.

Sidran Institute

http://www.sidran.org
P.O. Box 436
Brooklandville, MD 21022-0436
Phone: 410-825-8888
Fax: 410-560-0134
Email: info@sidran.org

The Sidran Institute is a nationally focused nonprofit organization devoted to helping people who have experienced traumatic life events through education and advocacy. The Institute's education and advocacy focuses on:

- The early recognition and treatment of trauma-related stress in children.
- The understanding of trauma and its long-term effect on adults.
- The strategies in engaging in mutual-help recovery for trauma survivors.
- The clinical methods and practices leading in aiding trauma victims.
- The development of public policy initiatives responsive to the needs of adult and child survivors of traumatic events.

Substance Abuse and Mental Health Services Administration

http://www.samhsa.gov
1 Choke Cherry Lane
Rockville, MD 20857
Phone: 877-726-4727
Fax: 240-221-4292
Email: SAMHSAInfo@samhsa.hhs.gov

SAMHSA is the Federal agency within HHS charged with improving the quality and availability of prevention, treatment, and rehabilitative services to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness. The Emergency Mental Health and Traumatic Stress Services Branch, a branch of SAMHSA's Center for Mental Health Services, works with FEMA to provide crisis counseling training and technical assistance to State and local mental health professionals. SAMHSA offers several publications regarding trauma and PTSD, as well as a publication focusing on creating a seclusion-free and restraint-free environment.

Traumatic Stress Institute

http://www.traumaticstressinstitute.org
Klingberg Family Centers
370 Linwood Street
New Britain, CT 06052
Phone: 860-224-9113

The Traumatic Stress Institute (TSI) works to increase understanding of the psychological impact of trauma and to help victims of violence restore meaning and wholeness to their lives. In meeting these goals, TSI is involved in clinical service, professional training, community education, and research. TSI offers forensic assessment and expert testimony, professional education, training opportunities, and publications. TSI developed the "Risking Connections" trauma treatment program and provides training in the use of this model.

Tulane University Traumatology Institute

http://sites.google.com/site/charlesfigley/Home/traumatologyinstitute
Tulane School of Social Work
6823 St. Charles Ave., Building 9
New Orleans, LA 70118
Phone: 800-631-8234
Email: figley@tulane.edu

The Traumatology Institute, founded in 1996, brings together health and mental health professionals from a wide array of disciplines from throughout the United States and around the world to develop cutting-edge research, treatment approaches, and training programs in the field of traumatology. The Institute facilitates the development of knowledge about the traumatization experience of victims, survivors, and the professionals who serve them. The Traumatology Institute conducts research, education, and service activities toward reducing the deleterious effects of trauma on individuals, families, communities, and entire societies.

Veterans Affairs PTSD Support Services

http://www.ptsdsupport.net/va.html
P.O. Box 5574
Woodland Park, CO 80866
Email: russ@ptsdsupport.net

The Department of Veterans Affairs Medical Centers provide a network of more than 100 specialized programs for veterans with PTSD, working closely in conjunction with the Veterans Web Site (http://www.vetcenter.va.gov) operated by VA's Readjustment Counseling Service. Each specialized PTSD program offers veterans education, evaluation, and treatment conducted by mental health professionals from a variety of disciplines (such as psychiatry, psychology, social work, counseling, and nursing). See also: National Center for PTSD.

White Bison Wellbriety Training Institute

http://www.whitebison.org
701 N. 20th Street
Colorado Springs, CO 80904
Phone: 877-871-1495
Email: info@whitebison.org

White Bison is an American Indian nonprofit charitable organization that focuses on offering sobriety, recovery, addictions prevention, and wellness/Wellbriety learning resources to the Native American community nationwide. White Bison's Wellbriety Training Institute provides training, tools, and resources for historical and intergenerational trauma to trainers and mental health professionals.

Resources for Children and Adolescents

The following section provides resources that address the needs of children and adolescents who are affected by traumatic stress.

American Academy of Child & Adolescent Psychiatry

http://www.aacap.org
3615 Wisconsin Avenue NW
Washington, DC 20016-3007
Phone: 202-966-7300
Fax: 202-966-2891

The American Academy of Child & Adolescent Psychiatry (AACAP) is a national professional medical association dedicated to treating and improving the quality of life for children, adolescents, and families affected by mental, behavioral, and developmental disorders. AACAP distributes information to promote an understanding of mental illnesses and remove the shame associated with them, to advance efforts in prevention of mental illnesses, and to ensure proper treatment and access to services for children and adolescents.

American Professional Society on the Abuse of Children

http://www.apsac.org
350 Poplar Avenue
Elmhurst, IL 60126
Phone: 630-941-1235
Fax: 630-359-4274
E-mail: apsac@apsac.org

The mission of the American Professional Society on the Abuse of Children (APSAC) is to enhance the ability of professionals to respond to children and families affected by abuse and violence. Among other initiatives, APSAC provides education and other sources of information to professionals who work in the child maltreatment and related fields.

Anna Institute

http://www.theannainstitute.org
21 Ocean Street
Rockland, ME 04841
Email: afj@gwi.net

The Anna Institute was founded in memory of artist Anna Caroline Jennings; it focuses on educating both the public and mental health professionals about the effects of sexual abuse and trauma on children. The Anna Institute's Web site provides articles on incorporating

trauma-informed care into existing behavioral health models, presentations on childhood trauma and retraumatization, and handouts for teachers at primary and secondary schools.

Caring for Every Child's Mental Health Campaign

http://www.samhsa.gov/children
P.O. Box 2345
Rockville, MD 20847-2345
Email: nmhic-info@samhsa.hhs.gov

SAMHSA's Caring for Every Child's Mental Health communications campaign is a national public information and education operation. Its goals are to increase public awareness about the importance of protecting the mental health of young people; foster the recognition that many children have mental health problems; and encourage caregivers to seek early, appropriate treatment and services. It also strives to reduce discrimination associated with mental health problems. The campaign is a technical assistance program that is part of the Comprehensive Community Mental Health Services Program for Children and Their Families.

Child Study Center

http://www.aboutourkids.org
One Park Avenue
7th Floor
New York, NY 10016
Phone: 212-263-6622
Email: webmaster@aboutourkids.org

The New York University Child Study Center Web site offers information to parents of children and adolescents with learning, behavioral, and emotional disorders, including PTSD and substance use disorders. An online newsletter is available. Its research initiatives advance understanding of the causes and treatments of child mental disorders, and these findings are integrated into clinical care to provide state-of-the-art service.

Child Trauma Academy

http://www.childtrauma.org
5161 San Felipe
Suite 320
Houston, TX 77056
Phone: 866-943-9779
Email: cta@childtrauma.org

The mission of the Child Trauma Academy is to help improve the lives of traumatized and maltreated children. Through education, service delivery, and program consultation, the academy seeks to advance systems that educate, nurture, protect, and enrich these children.

Child Trauma Institute

http://www.childtrauma.com
P.O. Box 544
Greenfield, MA 01302-0544
Phone: 413-774-2340
Email: cti@childtrauma.com

The Child Trauma Institute provides training, consultation, information, and resources for those who work with trauma-exposed children, adolescents, and adults. The Web site has information for parents, publications for parents and professionals, and links to other child trauma Web sites.

Child Welfare Information Gateway

http://www.childwelfare.gov
Children's Bureau/ACYF
1250 Maryland Avenue SW
Eighth Floor
Washington, DC 20024
Phone: 800-394-3366
Email: info@childwelfare.gov

The Child Welfare Information Gateway (CWIG) is a service of the Children's Bureau in the Administration for Children and Families, part of HHS, which provides information

to child welfare and mental health professionals about programs, research, laws and policies, training approaches, and statistics regarding child welfare, child abuse and neglect, and adoption. CWIG offers educators' toolkits for preventing and responding to child abuse and neglect, a function to search State statutes about child abuse and neglect, and logic model builder toolkits for program administrators.

Child Welfare League of America

http://www.cwla.org
1726 M Street NW
Suite 500
Washington DC, 20036
Phone: 202-688-4200
Fax: 202-833-1689

Through its member child welfare agencies, the Child Welfare League of America develops and disseminates practice standards as benchmarks for high-quality services that protect children and youth; promotes high-quality services through training, consultation, conferences, and publications; formulates and promotes public policies that contribute to the well-being of children and youth; ensures that all child welfare services are provided in a manner that demonstrates respect for cultural and ethnic diversity; and promotes open exchange of data, resources, and ideas within and across systems that serve children, youth, and families.

Eunice Kennedy Shriver National Institute of Child Health and Human Development

http://www.nichd.nih.gov/Pages/index.aspx
31 Center Drive
Building 31, Room 2A32
Bethesda, MD 20892-2425
Phone: 800-370-2943

Established in 1962, NIH's National Institute of Child Health and Human Development (NICHD) focuses on human development processes from conception to later years. The Institute implements, conducts, and supports laboratory research, clinical trials, epidemiological research, and other studies that explore health processes and the impact of disabilities, diseases, and variations on the lives of individuals. NICHD sponsors training for scientists and healthcare providers to promote the goals of the Institute.

National Center for Children Exposed to Violence

http://www.nccev.org
Yale Child Study Center
230 South Frontage Road
P.O. Box 207900
New Haven, CT 06520-7900
Phone: 877-496-2238
Email: colleen.vadala@yale.edu

The National Center for Children Exposed to Violence (NCCEV) seeks to increase the capacity of individuals and communities to reduce the incidence and impact of violence on children and families; to train and support the professionals who provide intervention and treatment; and to increase professional and public awareness of the effects of violence on children, families, communities, and society. The Center's Web site is a rich source of information. NCCEV is supported by grants from the Office of Juvenile Justice and Delinquency Prevention, the Department of Justice, SAMHSA, and the Department of Education.

National Center on Substance Abuse and Child Welfare

http://www.ncsacw.samhsa.gov
P.O. Box 2345
Rockville, MD 20847-2345
Phone: 866-493-2758
Email: ncsacw@cffutures.org

The National Center on Substance Abuse and Child Welfare (NCSACW) is an initiative of HHS and is jointly funded by SAMHSA's Center for Substance Abuse Treatment and the Administration on Children, Youth and Families, Children's Bureau's Office on Child Abuse and Neglect. NCSACW seeks to develop and implement a comprehensive program of information gathering and dissemination, to provide technical assistance, and to develop knowledge that promotes effective practical, organizational, and systemic changes at the local, State, and national levels. Its Web site includes PowerPoint presentations, online tutorials and training, technical assistance presentations, and additional print resources.

National Child Traumatic Stress Network

http://www.nctsnet.org
NCTSN—University of California, Los Angeles
11150 W. Olympic Boulevard
Suite 650
Los Angeles, CA 90064
Phone: 310-235-2633
Fax: 310-235-2612

The National Child Traumatic Stress Network (NCTSN), currently comprising 54 treatment centers nationwide, is funded by SAMHSA's Center for Mental Health Services through the Donald J. Cohen National Child Traumatic Stress Initiative and coordinated by Duke University and the University of California, Los Angeles. The purpose of this congressionally mandated initiative is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. NCTSN works with SAMHSA to raise public awareness of the effects of traumatic stress on children and families, and with other systems of care (including the health, mental health, education, law enforcement, child welfare, juvenile justice, and military family service systems) to ensure that there is a comprehensive trauma-informed continuum of accessible care. Additionally, NCTSN offers a list of evidence-based and promising practices.

National Institute for Trauma and Loss in Children

http://www.starrtraining.org/trauma-and-children
42855 Garfield Road
Suite 111
Clinton Township, MI 48038
Phone: 877-306-5256
Fax: 586-263-4915
Email: TLC@starrtraining.org

The National Institute for Trauma and Loss in Children provides school professionals, crisis intervention teams, medical and mental health professionals, child care professionals, and clinicians with trauma education, training, consultation, referral services, and trauma-specific intervention programs and resource materials needed to help those traumatized by violent or nonviolent trauma-inducing incidents.

National Native Children's Trauma Center

http://iers.umt.edu/National_Native_Childrens_Trauma_Center
Institute for Educational Research and Service
McGill Hall 026
The University of Montana
Missoula, MT 59812-6376
Phone: 406-243-5344
Fax: 406-243-2197
Email: iers@mso.umt.edu

The National Native Children's Trauma Center (NNCTC) is a federally funded organization created by SAMHSA and affiliated with the National Child Traumatic Stress Network. It

is run by the University of Montana. NNCTC offers trauma interventions and trainings to address trauma in American Indian/Alaska Native children, primarily through clinicians, Tribal programs, school systems, and community agencies.

Training Opportunities

The following resources highlight various training and credentialing opportunities for behavioral health professionals interested in gaining more education in treating and providing services to those affected by trauma. It is not an exhaustive list, but provides a starting place for service providers looking for further training.

The Web site of the ISTSS has posted a directory of trauma-related academic and training opportunities (http://www.istss.org/LearningAboutTrauma.htm). It includes links to the institutions providing the programs. The Association for Traumatic Stress Specialists (http://www.atss.info) offers three levels of recognition for education and experience:

- Certified Trauma Specialist (CTS)—designed for counselors, clinicians, and treatment specialists who provide intervention services or individual, group, and/or family counseling. This certification requires 240 hours of education and training in trauma treatment, plus 2,000 hours of trauma counseling and intervention experience.
- Certified Trauma Responder (CTR)—designed for those who provide immediate trauma interventions. It requires a minimum of 40 hours of experience on a crisis or critical incident response team, an associate degree or a high school diploma with successful completion of disaster or critical incident stress debriefing training, and 72 hours of crisis response training.
- Certified Trauma Services Specialist (CTSS)—designed for those who provide immediate trauma intervention, crisis support, advocacy, or victim assistance. It requires 1 year of experience in a trauma-related field, plus specific training.

Some colleges and universities, such as the International Trauma Studies Program at New York University and the Center for Anxiety and Related Disorders at Boston University, provide specialty trauma training for mental health practitioners. The University of Missouri at St. Louis offers specialized training in trauma therapy or research at its Center for Trauma Recovery to students in its Clinical Psychology graduate program. The Center for the Treatment and Study of Anxiety at the University of Pennsylvania provides training for health professionals. The Department of Counseling at the University of Nevada, Las Vegas offers a graduate and undergraduate course on Trauma and Addiction; graduate students can receive training in trauma and addictions as part of the Advanced Graduate Certificate in Addiction Studies. The Medical University of South Carolina offers Web-based courses in trauma-focused cognitive–behavioral therapy (TF-CBT) and in using TF-CBT for childhood traumatic grief. Many universities have faculty members with expertise in trauma and trauma-related subjects, so that training can be accessed through many graduate programs.

The Addiction Technology Transfer Center (ATTC) Network, a resource established in 1993 by the SAMHSA's Center for Substance Abuse Treatment, is a network of 14 independent regional centers with a national office. One of its programs provides long-distance education for clinicians on various topics. Among hundreds of self-paced, self-directed, and supervised courses available online (http://www.attcnetwork.org/learn/education/

dasp.asp) are Substance Abuse Treatment for Trauma Survivors, Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues, Chemical Dependency and Posttraumatic Stress Disorder, Clinical Self-Care for Addiction Counselors and Clinical Supervisors, Eye Movement Desensitization and Reprocessing, Battered Women and Addictions, and Posttraumatic Stress Disorder. ATTC training and educational opportunities are based on empirical research and are intended to bring science to service. Undoubtedly, more distance-learning courses in this specialized area of interest will be developed as professional attention to co-occurring disorders increases.

SAMHSA's Center for Mental Health Services provides training for FEMA-approved crisis counseling programs using Stafford Act funding. These funding resources are available to select agencies designated to provide crisis counseling in the wake of a Presidential Disaster Declaration. Other funding for trauma training may be found through special programs of funding for target groups, such as those who provide mental health services and case management for victims of crime (e.g., Office for Victims of Crime in the U.S. Department of Justice; see p. 257).

The American Red Cross provides limited disaster mental health training. The focus of this training is to orient licensed mental health professionals to the Red Cross Disaster services system and their roles as volunteers.

The National Center for Post-Traumatic Stress Disorder was originally created in 1989 within the U.S. Department of Veterans Affairs (VA) to address the needs of veterans with military-connected PTSD. Its focus has since broadened to include trauma in general. The Center provides a variety of training opportunities for both VA and non-VA mental health personnel, including a PTSD 101 course developed specifically for clinicians who provide services to clients who have experienced trauma (see http://www.ptsd.va.gov/professional/index.asp).

Seeking Safety offers training in trauma, PTSD, and co-occurring disorders to mental health professionals on all levels, from counselors to nurses to administrators. The EMDR International Association (EMDRIA) provides training to clinicians for certification in EMDR via a curriculum including instruction, supervised practicum, and consultation; EMDRIA additionally provides basic training in the field, separate from the certification process. EMDR training is also provided by the EMDR Humanitarian Assistance Program, a nonprofit organization with a training-focused model to assist clinicians in treating trauma.

ISTSS was founded in 1985 to bring attention to the study, assessment, and treatment of traumatized people (http://www.istss.org). ISTSS is a professional society and provides face-to-face training during its annual meeting, especially through the preconference institutes. The ISTSS Web site offers numerous video and audio trainings for continuing education credits. ISTSS and the Figley Institute (http://www.figleyinstitute.com) have established best practice standards. The American Academy of Experts in Traumatic Stress provides training and certification in several different areas (http://www.aaets.org). Similarly, the International Society for the Study of Dissociation (http://www.issd.org) specializes in promoting therapies for dissociative disorders. In 2002, the Green Cross Academy of Traumatology (http://www.greencross.org) established a Commission on Accreditation of Traumatology Education Programs to increase and maintain the high standards in the education and training of traumatologists.

Appendix C—Historical Account of Trauma

Historically, symptoms of traumatic stress have been recorded in both military and civilian populations (Lasiuk & Hegadoren, 2006). Early accounts described the effect of battle conditions on soldiers; "soldier's heart" and "nostalgia" were the terms for traumatic stress reactions used during the American Civil War. As warfare techniques and strategies changed, so did the depiction of soldiers' traumatic stress reactions. The advent of heavy explosives in World War I led to the attribution of symptoms to "shell shock," giving a more physiological description of the effects from explosions (Benedek & Ursano, 2009). On the civilian side, the industrial revolution gave rise to larger and more dramatic catastrophes, including industrial and railway accidents. These, as well as other disasters, are noted in occupational health histories, newspapers, and contemporary literature.

Even with a more physical explanation of traumatic stress (i.e., shell shock), a prevailing attitude remained that the traumatic stress response was due to a character flaw. For instance, a soldier's pain at that time was often seen as a symptom of homesickness. In spite of the efforts of Charcot, Janet, and Freud, who described the psychogenic origin of symptoms as a response to psychological trauma (Lasiuk & Hegadoren, 2006), World War II military recruits were screened in attempt to identify those "who were afflicted with moral weakness," which would prevent them from entering military service.

At the same time, there were new treatment innovations for war-related trauma during World War II. One approach treated soldiers in the field for what was then called "battle fatigue" by allowing some time for rest before returning to battle. During the Korean and Vietnam wars, approaches began to focus more on the use of talk therapy. It was not until the post-Vietnam era that interest in developing treatment alternatives started to take hold. During this time, the U.S. Department of Veterans Affairs (then called the Veterans Administration) developed group therapy for posttraumatic stress disorder (PTSD). Beyond being cost-effective, the technique was well suited to the symptoms of the veterans and fostered socialization and reintegration (Greene et al., 2004).

The publication of the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition (DSM-III), in 1980 marked the introduction of PTSD as a diagnosis, inspired by symptoms presented by veterans of the Vietnam War (Benedek & Ursano, 2009). The diagnosis in this iteration required the identification of a specific stressor—a catastrophic stressor that was outside the range of usual human experience (APA, 1980)—and classified PTSD as

Historical Approaches to Trauma Healing and Recovery

First Generation of Approaches to Trauma Healing and Recovery
The first generation approaches to trauma healing and recovery focused on individual and clinical interventions to address the symptoms of PTSD and moved toward integration of trauma effects into ongoing life activities. The rapidly developing recognition of additional groups with violence and trauma histories—beyond those with war and captivity experiences (e.g., survivors of natural disasters and terrorism, refugees and immigrants fleeing homeland violence and persecution)—presented issues and needs that incited a second generation of approaches to trauma healing and recovery.

Second Generation of Approaches to Trauma Healing and Recovery
The second generation approaches focused on psychosocial education and empowerment models designed to tap into self-healing forces to energize personal and social movement. These approaches often are based on group and peer support models, and provide both support and education on the management of trauma and its affects. These approaches are not designed to replace clinical or alternative therapies; rather, they provide a social context for care.

Concurrent to the development of psychosocial educational empowerment approaches, we also learned that if the approaches are not implemented in organizations or programs that are trauma-informed, they will not take root and may lose effectiveness.

Trauma-Informed Care: A New Paradigm for Public Health Services
Trauma-informed care is a new paradigm for organizing public mental health and human services. Trauma-informed care changes the opening question for those seeking services from "What is wrong with you?" (patient or consumer) to "What has happened to you?" (survivor). Trauma-informed care is initiated by assumption that every person seeking services is a trauma survivor who designs his or her own path to healing, facilitated by support and mentoring from the service provider.

In a trauma-informed environment, survivors are empowered to proactively set goals and to manage progress toward those goals. For most existing organizations or programs, that requires movement from a traditional "top down" hierarchical clinical model to a psychosocial empowerment partnership that embraces all possible tools and paths to healing. In a pluralistic public health system with many levels and types of services and treatment, this is coming to be accepted as a "sine qua non," or "without which not," for humane, dignified, cost-effective, genuinely person-centered support and assistance in moving forward.

Source: Salasin, 2011, p. 18.

an anxiety disorder (Lasiuk & Hegadoren, 2006). Beginning with this definition, the body of research grew, and the scope of application began to broaden, but not without considerable debate on what constituted a trauma.

The social revolution that began in the 1960s, combined with the women's movement and the call for more attention to diverse and disenfranchised groups, set the stage for an increase in the acknowledgement and treatment of victims of interpersonal violence and crime-related trauma (Figley, 2002). The introduction of rape trauma syndrome as a condition highlighted the psychological consequences of sexual assault and the subsequent lack of support from society and the social services system (Kramer & Green, 1997). Subsequently, research began to focus more on interpersonal violence, thus leading to the identification of risk factors and treatment approaches unique to this form of violence and trauma (Olff, Langeland, Drajer, & Gersons, 2007).

With input from international and national mental health organizations and research, the DSM-IV further modified the definition of trauma to include a broader interpretation of the identified stressor (Andreasen, 2010). DSM-5 has maintained the modified definition of trauma, but the criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly (APA, 2013b).

Paralleling the change in DSM criteria, cognitive–behavioral therapy for traumatic stress was developed along with other skills-based approaches (Greene et al., 2004).

Researchers, such as Foa, Resick, D'Zurilla, and Michenbaum, added to the body of knowledge and gave clinicians a variety of tools; these approaches continue to develop and show efficacy even today. There was also renewed interest in the long- and short-term effects of childhood sexual abuse and domestic violence. Interest in documenting the effects of trauma expanded further, including traumatic brain injury, significant orthopedic injuries, and multiple traumas (Starr et al., 2004). So too, the consumer movement in health care began. Consumers insisted on patient rights, humane treatment, and involvement in the treatment process; as a result, the paternalistic approach to health care began to change. As consumers set the initial stage and Federal agencies (e.g., the Substance Abuse and Mental Health Services Administration and its centers) and national organizations promoted the need for trauma-informed policies and care, national studies began to demonstrate the prevalence of traumatic experiences. Research including the Adverse Childhood Experiences and the Women, Co-Occurring, and Violence studies clearly demonstrated the pervasive long-term impact of trauma, reinforcing the call for trauma-informed policies and care. (For more information on the development of trauma-informed care, see Harris and Fallot, 2001b, as well as Jennings, 2004.)

Appendix D—Screening and Assessment Instruments

This appendix provides a selected sample of available tools for screening and assessment of traumatic events and trauma-related symptoms. This is not an exhaustive list, nor does this list focus on screening instruments that capture a broader range of symptoms related to trauma (such as sleep hygiene and dissociation) or other features important in providing trauma-informed care (e.g., resilience level, coping skill style, resource availability). For more information on a broad range of available instruments, refer back to Part 1, Chapter 4. Many of the instruments listed below use criteria found in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000), but with the release of the DSM-5 (APA, 2013a), instruments will evolve, and new versions will be available under the same contact information.

Screening and Assessment Measures

- Clinician Administered PTSD Scale (CAPS)
- Davidson Trauma Scale (DTS)
- Distressing Event Questionnaire (DEQ)
- Evaluation of Lifetime Stressors (ELS)
- Impacts of Event Scale Revised (IES-R)
- Mississippi Scale for Combat-Related PTSD (M-PTSD)
- Penn Inventory for Posttraumatic Stress Disorder
- Posttraumatic Diagnostic Scale (PDS)
- PTSD Symptom Scale-Interview (PSS-I)
- PTSD Symptom Scale: Self-Report Version (MPSS-SR)
- Screen for Posttraumatic Stress Symptoms (SPTSS)
- Structured Interview for PTSD (SI-PTSD)
- Trauma Assessment for Adults (TAA)
- Trauma Assessment for Adults (TAA)–Self Report
- Trauma History Questionnaire (THQ)
- Trauma Symptom Inventory (TSI)
- Traumatic Stress Schedule

Screening and Assessment Measures

Clinician Administered PTSD Scale (CAPS)

Domains:	Posttraumatic stress disorder (PTSD), acute stress disorder (ASD)
Timeframe:	CAPS-Sx: Lifetime and current (past week) CAPS-Dx: Current (past month)
Response format:	Other
Format of administration:	Structured
Number of items:	30
Completion time:	30–60 minutes
Qualifications to administer:	Administered by clinicians and clinical researchers who have a working knowledge of PTSD and by appropriately trained paraprofessionals
How to obtain scale:	Contact Danny G. Kaloupek, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: veterans, car accident survivors Reliability: alpha = .94, test-retest = .90–.98 Validity: sensitivity = .85, specificity = .95 (compared with Structured Clinical Interview for DSM Disorders [SCID]), r = .91 (with MS Scale for Combat-related PTSD) kappa = .77 against the SCID diagnosis; item-total correlations = .49–.82; internal consistency = .94
Author(s):	Dudley David Blake, Frank W. Weathers, Linda M. Nagy, Danny G. Kaloupe, Dennis S. Charney, and Terence M. Keane
Contact:	Danny G. Kaloupek, Ph.D. National Center for PTSD Boston VA Medical Center, 11B 150 South Huntington Avenue Boston, MA 02130
Relevant citations:	Blake, D. D. (1994). Rationale and development of the clinician-administered PTSD scales. *PTSD Research Quarterly, 5,* 1–2. Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8*, 75–90.

Gray, M., Litz, B., Hsu, J., & Lombardo, T. (2004). Psychometric properties of the Life Events Checklist. *Assessment, 11*, 330–341.

Weathers, F. W., Keane, T. M., & Davidson, J. R. (2001). Clinician-Administered PTSD Scale: A review of the first ten years of research. *Depression and Anxiety, 13*, 132–156.

Davidson Trauma Scale (DTS)

Domains:	PTSD symptoms
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument. Education/training requirements may be waived for those granted the right to administer tests at this level (B) in their jurisdiction.
How to obtain scale:	Contact Mental Health Systems, Inc.
Cost or public domain:	Cost: $15.00
Psychometrics:	Populations sampled: rape victims, veterans, hurricane victims, miscellaneous traumas Reliability: alpha = .99, test-retest = .86
Author(s):	Jonathan R.T. Davidson
Contact:	Mental Health Systems, Inc. 908 Niagara Falls Boulevard North Tonawanda, NY, 14120-2060 800-456-3003
Relevant citations:	Davidson, J. R. T., Book, S. W., Colket, J. T., Tupler, L. A., Roth, S., David, D., Hertzberg, M., Mellman, T., Beckham, J.C., Smith, R., Davison, R. M., Katz, R., & Feldman, M. (1997). Assessment of a new self-rating scale for posttraumatic stress disorder. *Psychological Medicine, 27,* 153–160. Davidson, J. R., Tharwani, H. M., & Connor, K. M. (2002). Davidson Trauma Scale (DTS): Normative scores in the general population and effect sizes in placebo-controlled SSRI trials. *Depression and Anxiety, 15*, 75–78.

Distressing Event Questionnaire (DEQ)

Domains:	Posttraumatic Stress Disorder (PTSD) for multiple events
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact Edward Kubany, Ph.D.
How to obtain scale:	Contact Edward Kubany, Ph.D.
Cost or public domain:	Contact Edward Kubany, Ph.D.
Psychometrics:	Population sampled: veterans, battered women Reliability: inter-item r = .93, test-retest = .95; validity: Pearson's r reliability coefficient = .83 (with Penn Inventory, Pearson's r reliability coefficient = .76 (with Beck Depression Inventory)
Author(s):	Edward Kubany, Mary Beth Leisen, Aaron S. Kaplan, Martin P. Kelly
Contact:	Edward Kubany, Ph.D. National Center for PTSD Pacific Islands Division Department of VA Suite 307 Honolulu, HI 96813 Kubany.Edward@honolulu.va.gov
Relevant citations:	Kubany, E. S., Leisen, M. B., Kaplan, A. S., & Kelly, M. P. (2000). Validation of a brief measure of posttraumatic stress disorder: The distressing event questionnaire (DEQ). *Psychological Assessment, 12*, 197–209.

Evaluation of Lifetime Stressors (ELS)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	56
Completion time:	10–20 minutes for screening, 1–3 hours for complete interview
Qualifications to administer:	Should be administered by trained clinicians only

How to obtain scale:	Contact Karen Krinsley, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: male veterans, female sexual abuse survivors Reliability: r = .4–1.0
Author(s):	Karen Krinsley, Frank W. Weathers, Elana Newman, Edward A. Walker, Danny G. Kaloupek, Rachel Kimerling
Relevant citations:	Corcoran, C. B., Green, B. L., Goodman, L. A., & Krinsley, K. E. (2000). Conceptual and methodological issues in trauma history assessment. In A. Y. Shalev, R. Yehuda, & A. C. McFarlane (Eds.), *International handbook of human response to trauma* (pp. 22–232). Dordrecht, Netherlands: Kluwer Academic Publishers. Krinsley, K. (1996). Psychometric review of the Evaluation of Lifetime Stressors (ELS) Questionnaire and Interview. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation (*pp. 160–162). Lutherville, MD: Sidran Press.

Impact of Event Scale Revised (IES-R)

Domains:	PTSD for a single event
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	22
Completion time:	5–10 minutes for screening
Qualifications to administer:	None
How to obtain scale:	http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: earthquake survivors, emergency disaster workers, Vietnam veterans, violence and sexual assault victims Reliability: alpha = .79–.92, test-retest = .89–.94, Pearson's r reliability coefficient = .74–.87
Author(s):	Daniel Weiss and Charles R. Marmar
Relevant citations:	Sundin, E. C. & Horowitz, M. J. (2002). Impact of Event Scale: Psychometric properties. *British Journal of Psychiatry, 180,* 205–209. Weiss, D. S. & Marmar, C. R. (1996).The Impact of Event Scale-Revised. In J. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399–411). New York: Guilford Press. (Includes measure in its entirety.)

Mississippi Scale for Combat-Related PTSD (M-PTSD)

Domains:	PTSD for multiple events
Timeframe:	Contact National Center for PTSD at ncptsd@ncptsd.org
Response format:	Self-administered
Format of administration:	Structured
Number of items:	35
Completion time:	10–15 minutes
Qualifications to administer:	Contact National Center for PTSD at ncptsd@va.gov
How to obtain scale:	To order the scale contact the National Center for PTSD
Cost or public domain:	Free (ncptsd@va.gov)
Psychometrics:	Population sampled: veterans Reliability: inter-item r = .94, test-retest = .97 Validity: sensitivity = .93, specificity = .89
Author(s):	Terence M. Keane
Contact:	National Center for PTSD (116D) VA Medical Center 215 N. Main St. White River Junction, VT 05009 http://www.ptsd.va.gov/
Relevant citations:	Engdahl, B. & Eberly, R. (1994). Assessing PTSD among veterans exposed to war trauma 40–50 years ago. *NCP Clinical Quarterly, 4,* 13–14. Keane, T. M., Caddell, J. M., & Taylor, K. L. (1988). Mississippi Scale for Combat-Related Posttraumatic Stress Disorder: Three studies in reliability and validity. *Journal of Consulting and Clinical Psychology, 56,* 85–90.

Penn Inventory for Posttraumatic Stress Disorder

Domains:	PTSD for multiple events
Timeframe:	Current (past week)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	26
Completion time:	5–15 minutes

Qualifications to administer:	Contact Melvyn Hammarberg, Ph.D.
How to obtain scale:	Contact Melvyn Hammarberg, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans, oil-rig disaster survivors Reliability: alpha = .94, test-retest = .96
Author(s):	Melvyn Hammarberg
Contact:	Melvyn Hammarberg, Ph.D. Department of Anthropology University of Pennsylvania 325 University Museum 33rd and Spruce Street Philadelphia, PA 19104-6398
Relevant citations:	Hammarberg, M. (1996). Psychometric review of the Penn Interview for Post Traumatic Stress Disorder. In B. H, Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 231–235). Lutherville, MD: Sidran Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Posttraumatic Diagnostic Scale (PDS)

Domains:	DSM-IV PTSD symptom clusters
Timeframe:	Current (past month)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	49
Completion time:	10–15 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and course work in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact National Computer Systems (NCS)
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: accident/fire, disaster, assault, sexual assault, sexual abuse, major illness Reliability: alpha = .92, test-retest = .83 Validity: sensitivity = .89, specificity = .75

Author(s):	Edna B. Foa, Ph.D.
Contact:	National Computer Systems (NCS) 5605 Green Circle Drive Minnetonka, MN 55343
Relevant citations:	Foa, E. (1996). *Post-traumatic Diagnostic Scale manual*. Minneapolis, MN: National Computer Systems. Foa, E., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of PTSD: The Post-traumatic Diagnostic Scale (PDS). *Psychological Assessment, 9*, 445–451. Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

PTSD Symptom Scale-Interview (PSS-I)

Domains:	PTSD single event
Timeframe:	Current (past 2 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17
Completion time:	20 minutes
Qualifications to administer:	Can be administered by a master's level interviewer after a few hours of training.
How to obtain scale:	Contact Edna B. Foa, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: female sexual assault victims, female assault victims Reliability: alpha = .85, test-retest = .80; validity: sensitivity = .88, specificity = .96 (compared with SCID); Pearson's r reliability coefficient = .48–.80 (with Impact of Events intrusion and avoidance, State portion of State-Trait Anxiety Inventory, and MPSS-SR)
Author(s):	Edna B. Foa and Gregory A. Leskin
Contact:	Edna B. Foa, Ph.D. Medical College of Pennsylvania Department of Psychiatry 3200 Henry Avenue Philadelphia, PA 19129-1137

Relevant citations:	Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6*, 459–474. Foa, E. & Tolin, D. F. (2005). Comparison of the PTSD Symptom Scale-Interview Version and the clinician administered PTSD Scale. *Journal of Traumatic Stress, 13*, 181–191. Leskin, G. A. (1999). Screening for trauma and PTSD in a primary care clinic. *NC-PTSD Clinical Quarterly, 8*, 68–69.

PTSD Symptom Scale: Self-Report Version (MPSS-SR)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	Contact Sherry Falsetti, Ph.D.
How to obtain scale:	Contact Sherry Falsetti, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: alpha = .96–.97 Validity: sensitivity = .89, specificity = .65
Author(s):	Sherry Falsetti, Patricia A. Resick, Heidi S. Resnick, Dean G. Kilpatrick
Contact:	Sherry Falsetti, Ph.D. University of Illinois College of Medicine Department of Family and Community Medicine 1601 Parkview Avenue Rockford, IL 61107-1897
Relevant citations:	Bonin, M. F., Norton, G. R., Asmundson, G. J., Dicurzio, S., & Pidlubney, S. (2000). Drinking away the hurt: The nature and prevalence of PTSD in substance abuse patients attending a community-based treatment program. *Journal of Behavior Therapy and Experimental Psychiatry, 31*, 55–66. Coffey, S. F., Dansky, B. S., Falsetti, S. A., Saladin, M. E., & Brady, K. T. (1998). Screening for PTSD in a substance abuse sample:

Psychometric properties of a modified version of the PTSD Symptom Scale Self-Report. *Journal of Traumatic Stress, 11,* 393–399.

Falsetti, S. A., Resnick, H. S., Resick, P. A., & Kilpatrick, D. (1993). The Modified PTSD Symptom Scale: A brief self-report measure of post-traumatic stress disorder. *The Behavioral Therapist, 16*, 161–162.

Screen for Posttraumatic Stress Symptoms (SPTSS)

Domains:	PTSD for multiple or unknown events
Timeframe:	Current (past 2 weeks)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	5 minutes
Qualifications to administer:	Contact Eve Carlson, Ph.D.
How to obtain scale:	Contact Eve Carlson, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: psychiatric inpatients Reliability: split half reliability = .91, test-retest = .82
Author(s):	Eve Carlson, Ph.D.
Contact:	Eve Carlson, Ph.D. National Center for PTSD (352-117-MP) Palo Alto Health Care System 795 Willow Road Menlo Park, CA 94025
Relevant citations:	Carlson, E. (2001). Psychometric study of a brief screen for PTSD: Assessing the impact of multiple traumatic events. *Assessment*, *8*, 431–441.

Structured Interview for PTSD (SI-PTSD)

Domains:	PTSD single event
Timeframe:	Current (past 4 weeks)
Response format:	Other
Format of administration:	Structured
Number of items:	17

Completion time:	20–30 minutes
Qualifications to administer:	Can be administered by mental health professionals or by paraprofessionals after some training.
How to obtain scale:	Contact Jonathan Davidson, M.D.
Cost or public domain:	Public domain
Psychometrics:	Population sampled: veterans Reliability: alpha = .94, test-retest = .71, intraclass r = .97 Validity: sensitivity = .96, specificity = .80 (compared with SCID), Pearson's r reliability coefficient = .61 (with IES), Pearson's r reliability coefficient = .51 (with Hamilton Anxiety Scale)
Author(s):	Jonathan Davidson
Contact:	Jonathan Davidson, M.D. Department of Psychiatry Box 3812 Duke University Medical Center Durham, NC 27710-3812
Relevant citations:	Davidson, J. R. T., Kudler, H. S., & Smith, R. D. (1990). Assessment and pharmacotherapy of posttraumatic stress disorder. In J. E. L. Giller (Ed.), *Biological assessment and treatment of post-traumatic stress disorder* (pp. 205–221). Washington, DC: American Psychiatric Press. (Includes measure in its entirety.) Steel, J. L., Dunlavy, A. C., Stillman, J., & Pape, H. C. (2011). Measuring depression and PTSD after trauma: Common scales and checklists. *Injury, 42,* 288–300.

Trauma Assessment for Adults (TAA)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Other
Format of administration:	Structured
Number of items:	13
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain

Psychometrics:	Populations sampled: adult mental health center clients; face validity established; feasible; validity established via archival records
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Cusack, K. J., Frueh, B. C., & Brady, K. T. (2004). Trauma history screening in a community mental health center. *Psychiatric Services, 55,* 157–162. Resnick, H. S. (1996). Psychometric review of Trauma Assessment for Adults (TAA). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 362–365). Lutherville, MD: Sidran Press.

Trauma Assessment for Adults (TAA)–Self Report

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured
Number of items:	17
Completion time:	10–15 minutes
Qualifications to administer:	None specified
How to obtain scale:	Contact Heidi Resnick, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	None to date
Author(s):	Connie L. Best, John R. Freedy, Sherry A. Falsetti, Dean G. Kilpatrick, Heidi S. Resnick
Relevant citations:	Resnick, H. S., Falsetti, S. A., Kilpatrick, D. G., & Freedy, J. R. (1996). Assessment of rape and other civilian trauma-related posttraumatic stress disorder: Emphasis on assessment of potentially traumatic events. In T. W. Miller (Ed.), *Stressful life events* (pp. 231–266). Madison, WI: International Universities Press.

Trauma History Questionnaire (THQ)

Domains:	Trauma history
Timeframe:	Lifetime
Response format:	Self-administered
Format of administration:	Structured

Number of items:	24
Completion time:	5–15 minutes
Qualifications to administer:	Contact Bonnie L. Green, Ph.D.
How to obtain scale:	Contact Bonnie L. Green, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Populations sampled: psychiatric outpatients, college students, women with breast cancer Reliability: r = 0.7–0.9, intraclass = .76
Author(s):	Bonnie L. Green
Relevant citations:	Hooper, L., Stockton, P., Krupnick, J., & Green, B., (2011). Development, use, and psychometric properties of the Trauma History Questionnaire. *Journal of Loss and Trauma, 16*, 258–283. Muesser, K. T., Salyers, M. P., Rosenberg, S. D., Ford, J. D., Fox, L., & Carty, P. (2001). Psychometric evaluation of trauma and posttraumatic stress disorder assessments in persons with severe mental illness. *Psychological Assessment, 13*, 110–117. Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Trauma Symptom Inventory (TSI)

Domains:	Trauma-related symptoms
Timeframe:	Current (last 6 months)
Response format:	Self-administered
Format of administration:	Structured
Number of items:	100
Completion time:	20 minutes
Qualifications to administer:	Bachelor's degree in psychology. Must have related field and courses in the use of assessment instruments or special training in the use of this instrument.
How to obtain scale:	Contact Psychological Assessment Resources
Cost or public domain:	Cost: $15.00
Psychometrics:	Population sampled: general population Reliability: alpha = .84–.87

Author(s):	John Briere
Contact:	Psychological Assessment Resources Box 998 Odessa, FL 33556
Relevant citations:	Briere, J. (1996). Psychometric review of Trauma Symptom Inventory (TSI). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 381–383). Lutherville, MD: Sidran Press. Briere, J. (1995). *Trauma Symptom Inventory professional manual.* Odessa, FL: Psychological Assessment Resources. Orsillo, S. M. (2001). Measures for acute stress disorder and post-traumatic stress disorder. In M. M. Antony & S. M. Orsillo (Eds.), *Practitioner's guide to empirically based measures of anxiety* (pp. 255–307). New York: KluwerAcademic/Plenum.

Traumatic Stress Schedule

Domains:	Trauma history
Timeframe:	Current (but author suggests any period)
Response format:	Other
Format of administration:	Semi-structured
Number of items:	10 (with 12 probes)
Completion time:	5–30 minutes
Qualifications to administer:	Can be administered by lay interviewer with training
How to obtain scale:	Contact Fran Norris, Ph.D.
Cost or public domain:	Public domain
Psychometrics:	Reliability: test-retest = .88, frequency of events equal to National Women's Study PTSD Module
Author(s):	Fran Norris
Relevant citations:	Norris, F. H. (1990). Screening for traumatic stress: A scale of use in the general population. *Journal of Applied Social Psychology*, *20*, 1704–1718. (Includes measure in its entirety.) Norris, F. H. & Hamblen, J. L. (2004). Standardized self-report measures of civilian trauma and PTSD. In J. P. Wilson, T. M. Keane & T. Martin (Eds.), *Assessing psychological trauma and PTSD* (pp. 63–102). New York: Guilford Press.

Appendix E—Consumer Materials

The following are samples of available consumer materials relating to trauma-informed care and traumatic stress. There is a plethora of consumer information available to meet the immediate and long-term needs of consumers of behavioral health services affected by trauma. In order to not waste effort creating new materials for your client's concerns, it is advisable to explore current science-informed resources. In most cases, consumer materials are already available and easily accessible for free.

AfterDeployment.org (2010). *Just the Facts: Resilience*. Available: http://afterdeployment.org/sites/default/files/pdfs/client-handouts/resilience-understanding.pdf

This Web site provides resources to address symptoms related to traumatic stress in addition to other postdeployment adjustment issues. This site provides information and handouts on resilience, triggers, and other trauma-related topics. It is appropriate for service members as well as civilians.

Blanch, A., Filson, B., & Penny, D. (2012). *Engaging Women in Trauma-Informed Peer Support: A Guidebook*. Available: http://www.nasmhpd.org/publications/engagingwomen.aspx

This draft technical assistance guide was created by the National Center for Trauma-Informed Care (NCTIC) and developed under contract with the National Association of State Mental Health Program Directors. This publication is designed to help make trauma-informed peer support available to women who are trauma survivors and who receive or have received behavioral health services. It is a resource for peers providing support in these or other settings who want to learn how to use trauma-informed principles in supporting women or in the peer support groups. It has been a resource used in the delivery of technical assistance through NCTIC.

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., et al. (2006). Appendix E: Handouts. *Psychological First Aid: Field Operations Guide.* Available: http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_Appx_E_handouts.pdf

Developed jointly with the National Child Traumatic Stress Network and the National Center for PTSD, this curriculum provides a science-informed approach to psychological first aid for response workers. The goals of this module are to assist survivors in the immediate aftermath of disaster and/or terrorism, reduce initial distress, and foster short- and long-term adaptive functioning. This link provides specific survivor-oriented material, such as strategies in seeking and giving support, education on common immediate reactions, and parental tips for children across developmental stages.

Center for Mental Health Services (2002). *Dealing with the Effects of Trauma-A Self-Help Guide.* Available: http://store.samhsa.gov/shin/content//SMA-3717/SMA-3717.pdf

This self-help guide gives practical information and tools to address and manage symptoms and other consequences of traumatic stress. It provides education on a variety of topics, including trauma-related symptoms, advice on the key ingredients of quality care, barriers to recovery, and practical strategies to enhance recovery and manage difficult emotions.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2005). *Roadmap to Seclusion and Restraint Free Mental Health Services*. Available: http://store.samhsa.gov/product/Roadmap-to-Seclusion-and-Restraint-Free-Mental-Health-Services-CD-/SMA06-4055

This curriculum concerns the elimination of seclusion and restraint. It provides numerous handouts for consumers as well as staff. Several consumer handouts include common reactions to trauma, a trauma screening tool, and strategies to de-escalate agitation and distress.

Mead, S. (2008). *Intentional Peer Support: An Alternative Approach*. Sherry Mead Consulting. Available: http://www.intentionalpeersupport.org/apps/webstore/products/show/3408520

This interactive workbook is designed for individuals who are in peer support roles and those who use peer support services. It provides goals, tasks, competencies, and skills associated with peer support relationships and guidelines for first interviews.

Najavits, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

This evidence-based practice for individuals who have a history of trauma and a substance use disorder provides not only guidelines for clinicians but handouts for individuals. The consumer materials include information on PTSD and substance abuse and their interrelationship, key principles of the Seeking Safety program, coping skills to support safety, and grounding exercises. For additional information and resources, go to http://www.seekingsafety.org.

National Center for PTSD, U.S. Department of Veterans Affairs (2010). *Understanding PTSD*. Available: http://www.ptsd.va.gov/public/understanding_ptsd/booklet.pdf

This booklet provides consumer information on posttraumatic stress, common traumatic stress symptoms, effective treatments, and resources. The National Center for PTSD also provides additional professional and public resources specific to trauma for veterans and civilians.

Sidran Institute (2012). *Healing Self-Injury*. Available: http://healingselfinjury.org/about.html

This Web site provides numerous resources for consumers and professionals to understand self-inflicted violence. It offers publication links, archived newsletters, and a current blog focused on self-harm.

Appendix F—Organizational Assessment for Trauma-Informed Care

The following two resources are organizational assessments, which represent a key strategy in developing or re-evaluating trauma-informed services. The first assessment, presented by the University of South Florida, College of Behavioral and Community Sciences (2012), is designed for staff or key stakeholders. The second assessment comes from the *Trauma-Informed Organizational Toolkit for Homeless Services* (Guarino, Soares, Konnath, Clervil & Bassuk, 2009) and is a consumer version. There are several other assessment tools available, including Fallot and Harris's *Creating Cultures of Trauma-Informed Care (CCTIC): A Self Assessment and Planning Protocol* (2009).

Staff or Key Stakeholder Organizational Assessment Tool
University of South Florida, College of Behavioral and Community Sciences (2012). *Creating Trauma-Informed Care Environments: An Organizational Self-Assessment*. Available: http://www.cfbhn.org/assets/TIC/youthresidentialself%20assess%20Fillable%20FORM%20%282%29.pdf

Consumer Version: Organizational Assessment Tool
Guarino, K., Soares, P., Konnath, K., Clervil, R., & Bassuk, E. (2009). *Trauma-Informed Organizational Toolkit for Homeless Services*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. See: pp. 82–93. Available: http://www.familyhomelessness.org/media/90.pdf

Appendix G—SAMHSA Resource Panel

John Bailey
Special Expert
Office of Policy, Planning, and Budget
Office of the Administrator
Substance Abuse and Mental Health Services Administration
Rockville, MD

Shirley Beckett, NCAC II
Certification Administrator
National Association of Alcohol and Drug Abuse Counselors
Washington, DC

Danny Brom, Ph.D.
Director
The Israel Center for the Treatment of Psychotrauma
Latner Institute for the Study of Social Psychiatry and Psychotherapy
Israel

Ling Chin, M.D.
Chief, Clinical Science
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Carol Coley, M.S., USPHS
Senior Program Management Officer
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Christina Currier
Public Health Analyst
Office of Evaluation, Scientific Analysis and Synthesis
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Marlene EchoHawk, Ph.D.
Health Science Administrator
Division of Health
Indian Health Service
U.S. Department of Health and Human Services
Rockville, MD

Jill Shepard Erickson, M.S.W., ACSW
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Angela M. Gonzalez, Ph.D., CDR, USPHS
Special Programs Development Branch-Refugee Mental Health Program
Division of Prevention, Traumatic Stress, and Special Programs
Substance Abuse and Mental Health Services Administration
Rockville, MD

Jacqueline Hendrickson, M.S.W., LCSW-C
Public Health Advisor
Division of Pharmacologic Therapies
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Michael Hilton, Ph.D.
Health Science Administrator
Division of Clinical and Prevention Research
National Institute of Alcohol Abuse and Alcoholism
National Institutes of Health
Bethesda, MD

Kenneth J. Hoffman, M.D., M.P.H.
Medical Director
TRICARE Management Activity
Military Health System-Population Health Programs
Department of Defense, Health Affairs
Falls Church, VA

Kirk E. James, M.D.
Special Expert
Systems Improvement Branch
Division of Services Improvement
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Hendree E. Jones, Ph.D.
Assistant Professor
Department of Psychiatry and Behavioral Sciences
Johns Hopkins University Center
Baltimore, MD

Cindy Kleppinger, M.D.
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

David Liu, M.D.
Center for the Clinical Trials Network
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Richard E. Lopez, J.D., Ph.D.
Social Science Analyst
Co-Occurring and Homeless Branch
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Sue Martone, M.P.A.
Public Health Advisor
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
Washington, DC

Dee S. Owens, M.P.A.
Director
Alcohol-Drug Information Center
Indiana University
Bloomington, IN

Harold I. Perl, Ph.D.
Chief, Health Services Research Branch
Division of Clinical and Prevention Research
National Institute of Alcohol Abuse and Alcoholism
National Institutes of Health
Bethesda, MD

Melissa V. Rael, USPHS
Senior Program Management Officer
Division of State and Community Assistance
Co-Occurring and Homeless Branch
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Lawrence D. Rickards, Ph.D.
Co-Occurring Disorders Program Manager
Homeless Programs Branch
Division of Knowledge Development and Systems Change
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Cecilia Rivera-Casale, Ph.D.
Senior Project Officer
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Terrence Schomburg, Ph.D.
Team Leader
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Richard T. Suchinsky, M.D.
Associate Chief for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC

Beth A. Weinman, M.A.
Coordinator
National Drug Abuse Programs
Correctional Programs Division-Services Branch
U.S. Department of Justice
Washington, DC

Penelope P. Ziegler, M.D.
Head, Treatment Section
American Academy of Addiction Psychiatry
Williamsburg, VA

Appendix H—Field Reviewers

Carol Ackley
Owner/Director
River Ridge Treatment Center
Burnsville, MN

Rosie Anderson-Harper, M.A.
Mental Health Manager
Division of Alcohol and Drug Abuse
Missouri Department of Mental Health
Jefferson City, MO

Reba Architzel
Director
Federal Relations and Policy Analysis
New York State Office of Alcoholism and Substance Abuse Services
Albany, NY

Larry L. Ashley, Ed.S., M.A.
Addictions Specialist
Department of Counseling
University of Nevada, Las Vegas
Las Vegas, NV

G.T. (Gigi) Belanger
Public Health Advisor
Homeless Programs Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Charles H. Bombardier, Ph.D.
Associate Professor
Department of Rehabilitation Medicine
Harborview Medical Center
University of Washington School of Medicine
Seattle, WA

Patricia T. Bowman
Probation Counselor
Fairfax Alcohol Safety Action Program
Fairfax, VA

Patricia Allen Bradford, LISW, LMFT, CTS
Program Manager
Health Care for Homeless Veterans
Columbia, SC

Kathy Brock
Director
Polytechnic University Counseling Center
Brooklyn, NY

Vivian B. Brown, Ph.D.
Chief Executive Officer
Mental Health and Social Services Centers for Innovation in Health
PROTOTYPES
Culver City, CA

Wilma J. Calvert, R.N., Ph.D.
Post-Doctoral Fellow
Department of Psychiatry
Washington University School of Medicine
St. Louis, MO

Jerome F.X. Carroll, Ph.D.
Consultant in private practice
Chair, Columbia University's Drugs & Society Seminar
Brooklyn, NY

Steven J. Chen, Ph.D.
Associate Director
Division of Substance Abuse and Mental Health
Utah Department of Human Services
Salt Lake City, UT

Colleen Clark, M.A., Ph.D.
Research Assistant Professor
Licensed Clinical Psychologist
Triad Women's Project
University of South Florida
Tampa, FL

R.T. Codd, III., Ed.S.
Certified Member of the Academy of Cognitive Therapy
Director/Owner
Cognitive–Behavioral Therapy Center of Western North Carolina
Asheville, NC

Carol Coley, M.S.
Senior Program Management Advisor
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Carol J. Colleran, CAP, ICADC
Director of Primary Programs
Center of Recovery for Older Adults
Hanley-Hazelden Center
West Palm Beach, FL

Stephanie S. Covington, M.S.W., Ph.D.
Co-Director
Center for Gender and Justice
Institute for Relational Development
La Jolla, CA

David A. Deitch, Ph.D.
Professor of Clinical Psychiatry
Director, CCARTA
Department of Clinical Psychiatry
University of California, San Diego
La Jolla, CA

Gail D. Dixon, M.A., CAPP
NIDA Project Manager
Southern Coast Addiction Technology Transfer Center
Tallahassee, FL

Jill Shepard Erickson, M.S.W., ACSW
Public Health Advisor
Child and Family Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Phil Erickson
Substance Abuse Program Manager
Loudoun County Community Services Board
Leesburg, VA

Kathleen J. Farkas, Ph.D., LISW
Mandel School of Applied Social Sciences
Case Western Reserve University
Cleveland, OH

Norma B. Finkelstein, M.S.W., Ph.D.
Executive Director
W.E.L.L. Project
Institute for Health and Recovery
Cambridge, MA

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief
Services Research Branch
National Institute on Drug Abuse
National Institutes of Health
Bethesda, MD

Judith Ford, M.A., MFT
Director of Women's Services
Community Services and Hospitals
Connecticut Department of Mental Health and Addiction Services
Hartford, CT

Julian D. Ford, Ph.D.
Associate Professor
Department of Psychiatry
University of Connecticut Health Center
Farmington, CT

Matthew Friedman, M.D., Ph.D.
Professor of Psychiatry and Pharmacology
Executive Director, National Center for PTSD
Dartmouth Medical School
VA Medical Center
White River Junction, VT

John Galea, M.A.
Deputy Director, New York City Relations
New York State Office of Alcoholism and Substance Abuse Services
New York, NY

Angela M. Gonzalez, Ph.D., CAPT., USPHS
Scientist Officer
Special Programs Development Branch-Refugee Mental Health Program
Division of Prevention, Traumatic Stress, and Special Programs
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Maya D. Hennessey
Women's Specialist
Supervisor, Quality Assurance, Technical Assistance & Training
Office of Special Programs
Division of Substance Abuse
Illinois Department of Human Services and Substance Abuse
Chicago, IL

Michael W. Herring, LCSW
Licensed Clinical Social Worker
Wayne Psychiatric Associates, P.A.
Goldsboro, NC

Nancy J. Hirzel
Clinic Director
Adult Services Division
Jefferson Addictive Disorders Clinic
Jefferson Parish Human Services Authority
Metairie, LA

Robert Holden, M.A.
Program Director
Partners in Drug Abuse Rehabilitation Counseling (PIDARC)
Washington, DC

Kay M. Johnson
Crime Victims Treatment Center - HIV Project
St. Luke's Roosevelt Hospital Center
New York, NY

Kimberly A. Johnson, M.A., NCAC II
Director
Augusta Mental Health Complex
Maine Office of Substance Abuse
Augusta, ME

Sharon D. Johnson, M.S.W., M.P.E., Ph.D.
Assistant Professor
Department of Social Work
University of Missouri-St. Louis
St. Louis, MO

Lorene Lake, M.A., Ed.D.
Executive Director
Chrysalis House, Inc.
Crownsville, MD

Michael S. Levy, Ph.D.
Director of Clinical Treatment Services
CAB Health and Recovery Services
Danvers, MA

T.K. Logan, Ph.D.
Associate Professor
Center on Drug & Alcohol Research
Department of Behavioral Science
University of Kentucky
Lexington, KY

James J. Manlandro, D.O., FAOAAM, FACOFP
Medical Director
Family Addiction Treatment Services, Inc.
Somers Point, NJ

Rozanne Marel, Ph.D.
Head of Epidemiology & Needs Assessment
New York State Office of Alcoholism and Substance Abuse Services
New York, NY

Pamela Martin, Ph.D.
Director
Behavioral Health Services Division
New Mexico Department of Health
Santa Fe, NM

Ruby J. Martinez, Ph.D., R.N., CS
Assistant Professor
School of Nursing
University of Colorado Health Sciences Center
Denver, CO

Sue Martone, M.P.A.
Public Health Advisor
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
Washington, DC

Beth Marty, M.S., LPC
Clinical Program Manager
WYSTAR
Sheridan, WY

Lisa A. Melchior, Ph.D.
Vice President
The Measurement Group, LLC
Culver City, CA

Candace Merritt
Social Worker
Veterans Administration Medical Center
Denver, CO

Pamela A. Mumby, C.N.S., F.N.P., M.S.N.
Adult Psychiatric Nurse Practitioner
Substance Abuse Treatment Program
Veterans Administration Medical Center
Denver, CO

Briana S. Nelson-Goff, Ph.D.
Associate Professor
Family Studies and Human Service
Kansas State University
Manhattan, KS

Sarah Niemeyer
Clinical Director
Amethyst, Inc.
Columbus, OH

Thomas A. Peltz, M.Ed.
Therapist/Licensed Mental Health Counselor
Certified Addiction Specialist
Private Practice
Beverly Farms, MA

Karen Pressman, M.S.W., CADAC, LACDI
Director, Planning and Development
Bureau of Substance Abuse Services
Massachusetts Department of Public Health
Boston, MA

Melissa V. Rael, USPHS
Senior Program Management Officer
Co-Occurring and Homeless Branch
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Lawrence D. Rickards, Ph.D.
Public Health Advisor
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Rockville, MD

Alice F. Roeling
OAD Inpatient Facility Manager
The Springs of Recovery Adolescent Program
Greenwall Springs, LA

James Rowan, M.A.
Program Manager
Case Management and Offender Services
Arapahoe House, Inc.
Thornton, CO

JoAnn Y. Sacks, Ph.D.
Deputy Director, CIRP
National Development and Research Institutes, Inc.
New York, NY

Darren C. Skinner, M.S.W., Ph.D., LSW
Division Director
Co-Occurring Program
Gaudenzia, Inc.
Philadelphia, PA

Mickey J.W. Smith, M.S.W.
Senior Policy Associate, Behavioral Health
Program, Policy & Practice Unit
Division of Professional Development & Advocacy
National Association of Social Workers
Washington, DC

Richard T. Suchinsky, M.D.
Associate Chief for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC

Wilbur Woodis, M.A.
Management Analyst
Office of Clinical and Preventive Services
Division of Behavioral Health
Indian Health Service
Office of Public Health
U.S. Department of Health and Human Services
Rockville, MD

Appendix I: Cultural Competency and Diversity Network Participants

Charles H. Bombardier, Ph.D.
Associate Professor
Department of Rehabilitation Medicine
Harborview Medical Center
University of Washington School of Medicine
Seattle, WA
Disability Workgroup

Carol S. D'Agostino, CSW, CASAC
Director
Geriatric Addictions Program
LIFESPAN of Greater Rochester, Inc.
Rochester, NY
Aging Workgroup

Thomas L. Geraty, M.S.W., Ph.D., LICSW
Private Practice
Jamaica Plain, MA
LGBT Workgroup

Wayne Lee Mitchell, M.D.
Indian Health Service
Phoenix, AZ
Aging Workgroup

Ann S. Yabusaki, M.Ed., M.A., Ph.D.
Substance Abuse Director
Psychologist
Substance Abuse Programs and Training
Coalition for a Drug-Free Hawaii
Kaneohe, HI
Asian and Pacific Islanders Workgroup and Aging Workgroup

Appendix J: Acknowledgments

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Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under the Substance Abuse and Mental Health Services Administration's Knowledge Application Program (KAP) to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

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A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

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TIP 17 Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System—*Replaced by TIP 44*

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Quick Guide for Clinicians and Administrators

TIP 22 LAAM in the Treatment of Opiate Addiction—*Replaced by TIP 43*

TIP 23 Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing
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TIP 24 A Guide to Substance Abuse Services for Primary Care Clinicians
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TIP 25 Substance Abuse Treatment and Domestic Violence
Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers
Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators
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Substance Abuse Among Older Adults: A Guide for Social Service Providers
Substance Abuse Among Older Adults: Physician's Guide
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Case Management for Substance Abuse Treatment: A Guide for Treatment Providers
Case Management for Substance Abuse Treatment: A Guide for Administrators
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TIP 28 Naltrexone and Alcoholism Treatment—*Replaced by TIP 49*

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TIP 30 Continuity of Offender Treatment for Substance Use Disorders From Institution to Community
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TIP 33 Treatment for Stimulant Use Disorders
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TIP 35 Enhancing Motivation for Change in Substance Abuse Treatment
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TIP 36 Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues
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TIP 37 Substance Abuse Treatment for Persons With HIV/AIDS
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TIP 39 Substance Abuse Treatment and Family Therapy
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Family Therapy Can Help: For People in Recovery From Mental Illness or Addiction

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TIP 42 Substance Abuse Treatment for Persons With Co-Occurring Disorders
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TIP 43 Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs
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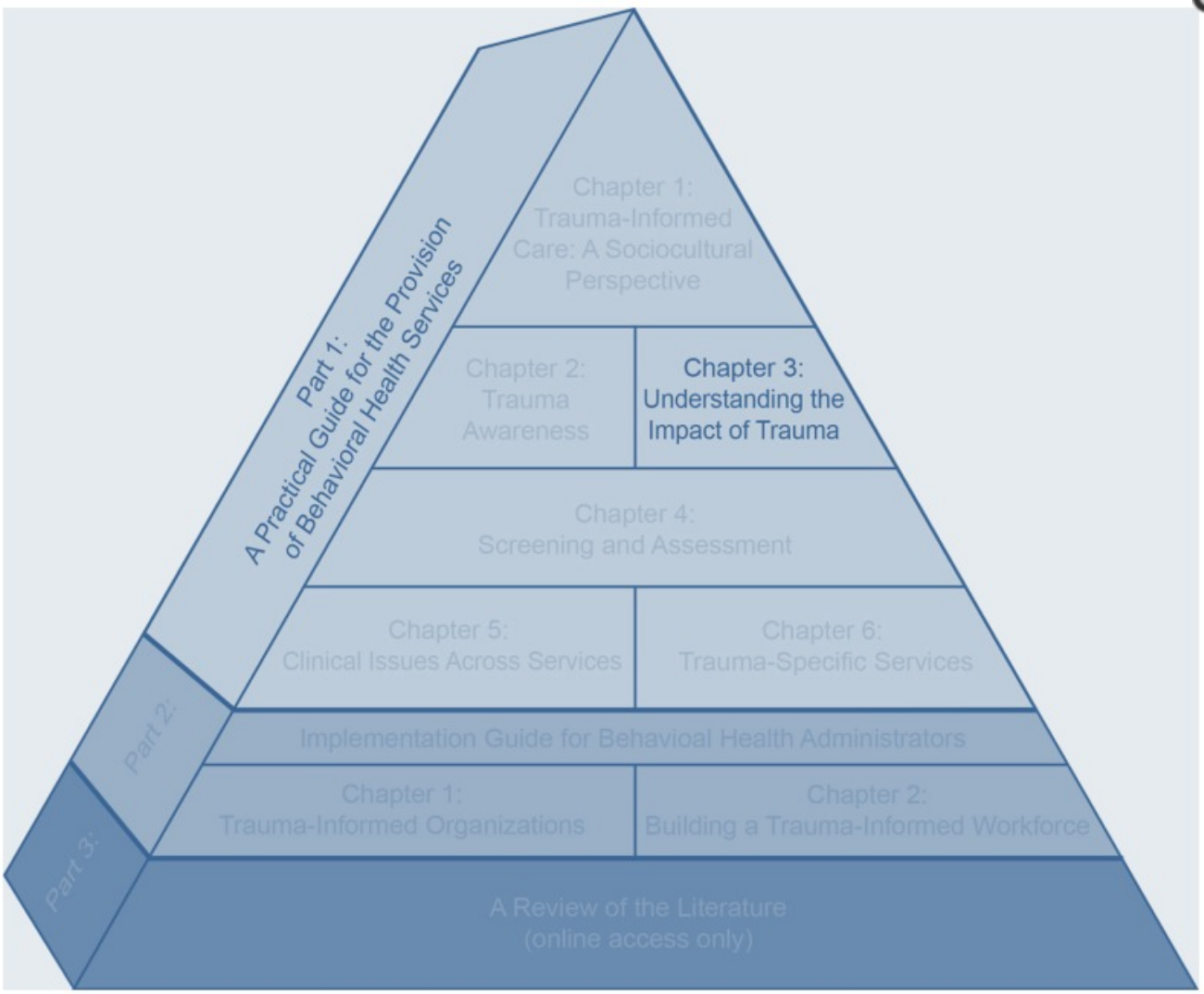
Chapter 3 Understanding the Impact of Trauma

Trauma-informed care (TIC) involves a broad understanding of traumatic stress reactions and common responses to trauma. Providers need to understand how trauma can affect treatment presentation, engagement, and the outcome of behavioral health services. This chapter examines common experiences survivors may encounter immediately following or long after a traumatic experience.

Trauma, including one-time, multiple, or long-lasting repetitive events, affects everyone differently. Some individuals may clearly display criteria associated with posttraumatic stress disorder (PTSD), but many more individuals will exhibit resilient responses or brief subclinical symptoms or consequences that fall outside of diagnostic criteria. The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors.

This chapter begins with an overview of common responses, emphasizing that traumatic stress reactions are normal reactions to abnormal circumstances. It highlights common short- and long-term responses to traumatic experiences in the context of individuals who may seek behavioral health services. This chapter discusses psychological symptoms not represented in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), and responses associated with trauma that either fall below the threshold of mental disorders or reflect resilience. It also addresses common disorders associated with traumatic stress. This chapter explores the role of culture in defining mental illness, particularly PTSD, and ends by addressing co-occurring mental and substance-related disorders.



TIC Framework in Behavioral Health Services—The Impact of Trauma

Sequence of Trauma Reactions

Survivors' immediate reactions in the aftermath of trauma are quite complicated and are affected by their own experiences, the accessibility of natural supports and healers, their coping and life skills and those of immediate family, and the responses of the larger community in which they live. Although reactions range in severity, even the most acute responses are natural responses to manage trauma— they are not a sign of psychopathology. Coping styles vary from action oriented to reflective and from emotionally expressive to reticent. Clinically, a response style is less important than the degree to which coping efforts successfully allow one to continue necessary activities, regulate emotions, sustain self-esteem, and maintain and enjoy interpersonal contacts. Indeed, a past error in traumatic stress psychology, particularly regarding group or mass traumas, was the assumption that all survivors need to express emotions associated with trauma and talk about the trauma; more recent research indicates that survivors who choose not to process their trauma are just as psychologically healthy as those who do. The most recent psychological debriefing approaches emphasize respecting the individual's style of coping and not valuing one type over another.

> **Foreshortened future:** Trauma can affect one's beliefs about the future via loss of hope, limited expectations about life, fear that life will end abruptly or early, or anticipation that normal life events won't occur (e.g., access to education, ability to have a significant and committed relationship, good opportunities for work).

Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect. Most responses are normal in that they affect most survivors and are socially acceptable, psychologically effective, and self-limited. Indicators of more severe responses include

continuous distress without periods of relative calm or rest, severe dissociation symptoms, and intense intrusive recollections that continue despite a return to safety. Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely. Exhibit 1.3-1 outlines some common reactions.

Common Experiences and Responses to Trauma

A variety of reactions are often reported and/or observed after trauma. Most survivors exhibit immediate reactions, yet these typically resolve without severe long-term consequences. This is because most trauma survivors are highly resilient and develop appropriate coping strategies, including the use of social supports, to deal with the aftermath and effects of trauma. Most recover with time, show minimal distress, and function effectively across major life areas and developmental stages. Even so, clients who show little impairment may still have subclinical symptoms or symptoms that do not fit diagnostic criteria for acute stress disorder (ASD) or PTSD. Only a small percentage of people with a history of trauma show impairment and symptoms that meet criteria for trauma-related stress disorders, including mood and anxiety disorders.

The following sections focus on some common reactions across domains (emotional, physical, cognitive, behavioral, social, and developmental) associated with singular, multiple, and enduring traumatic events. These reactions are often normal responses to trauma but can still be distressing to experience. Such responses are not signs of mental illness, nor do they indicate a mental disorder. Traumatic stress-related disorders comprise a specific constellation of symptoms and criteria.

Emotional

Emotional reactions to trauma can vary greatly and are significantly influenced by the individual's sociocultural history. Beyond the initial emotional reactions during the event, those most likely to surface include anger, fear, sadness, and shame. However, individuals may encounter difficulty in identifying any of these feelings for various reasons. They might lack experience with or prior exposure to emotional expression in their family or community. They may associate strong feelings with the past trauma, thus believing that emotional expression is too dangerous or will lead to feeling out of control (e.g., a sense of "losing it" or going crazy). Still others might deny that they have any feelings associated with their traumatic experiences and define their reactions as numbness or lack of emotions.

Emotional dysregulation

Some trauma survivors have difficulty regulating emotions such as anger, anxiety, sadness, and shame—this is more so when the trauma occurred at a young age (van der Kolk, Roth, Pelcovitz, & Mandel, 1993). In individuals who are older and functioning well prior to the trauma, such emotional dysregulation is usually short lived and represents an immediate reaction to the trauma, rather than an ongoing pattern. Self-medication—namely, substance abuse—is one of the methods that traumatized people use in an attempt to regain emotional control, although ultimately it causes even further emotional dysregulation (e.g., substance-induced changes in affect during and after use). Other efforts toward emotional regulation can include engagement in high-risk or self-injurious behaviors, disordered eating, compulsive behaviors such as gambling or overworking, and repression or denial of emotions; however, not all behaviors associated with self-regulation are considered negative. In fact, some individuals find creative, healthy, and industrious ways to manage strong affect generated by trauma, such as through renewed commitment to physical activity or by creating an organization to support survivors of a particular trauma.

Traumatic stress tends to evoke two emotional extremes: feeling either too much (overwhelmed) or too little (numb) emotion. Treatment can help the client find the optimal level of emotion and assist him or her with appropriately experiencing and regulating difficult emotions. In treatment, the goal is to help clients learn to regulate their emotions without the use of substances or other unsafe behavior. This will likely require learning new coping skills and how to tolerate distressing emotions; some clients may benefit from mindfulness practices, cognitive restructuring, and trauma-specific desensitization approaches, such as exposure therapy and eye movement desensitization and reprocessing (EMDR; refer to Part 1, Chapter 6, for more information on trauma-specific therapies).

Numbing

Numbing is a biological process whereby emotions are detached from thoughts, behaviors, and memories. In the following case illustration, Sadhanna's numbing is evidenced by her limited range of emotions associated with interpersonal interactions and her inability to associate any emotion with her history of abuse. She also possesses a belief in a foreshortened future. A prospective longitudinal study (Malta, Levitt, Martin, Davis, & Cloitre, 2009) that followed the development of PTSD in disaster workers highlighted the importance of understanding and appreciating numbing as a traumatic stress reaction. Because numbing symptoms hide what is going on inside emotionally, there can be a tendency for family members, counselors, and other behavioral health staff to assess levels of traumatic stress symptoms and the impact of trauma as less severe than they actually are.

Case Illustration: Sadhanna

Sadhanna is a 22-year-old woman mandated to outpatient mental health and substance abuse treatment as the alternative to incarceration. She was arrested and charged with assault after arguing and fighting with another woman on the street. At intake, Sadhanna reported a 7-year history of alcohol abuse and one depressive episode at age 18. She was surprised that she got into a fight but admitted that she was drinking at the time of the incident. She also reported severe physical abuse at the hands of her mother's boyfriend between ages 4 and 15. Of particular note to the intake worker was Sadhanna's matter-of-fact way of presenting the abuse history. During the interview, she clearly indicated that she did not want to attend group therapy and hear other people talk about their feelings, saying, "I learned long ago not to wear emotions on my sleeve."

Sadhanna reported dropping out of 10th grade, saying she never liked school. She didn't expect much from life. In Sadhanna's first weeks in treatment, she reported feeling disconnected from other group members and questioned the purpose of the group. When asked about her own history, she denied that she had any difficulties and did not understand why she was mandated to treatment. She further denied having feelings about her abuse and did not believe that it affected her life now. Group members often commented that she did not show much empathy and maintained a flat affect, even when group discussions were emotionally charged.

Physical

Diagnostic criteria for PTSD place considerable emphasis on psychological symptoms, but some people who have experienced traumatic stress may present initially with physical symptoms. Thus, primary care may be the first and only door through which these individuals seek assistance for trauma-related symptoms. Moreover, there is a significant connection between trauma, including adverse childhood experiences (ACEs), and chronic health conditions. Common physical disorders and symptoms include somatic complaints; sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders.

Somatization

Somatization indicates a focus on bodily symptoms or dysfunctions to express emotional distress. Somatic symptoms are more likely to occur with individuals who have traumatic stress reactions, including PTSD. People from certain ethnic and cultural backgrounds may initially or solely present emotional distress via physical ailments or concerns. Many individuals who present with somatization are likely unaware of the connection between their emotions and the physical symptoms that they're experiencing. At times, clients may remain resistant to exploring emotional content and remain focused on bodily complaints as a means of avoidance. Some clients may insist that their primary problems are physical even when medical evaluations and tests fail to confirm ailments. In these situations, somatization may be a sign of a mental illness. However, various cultures approach emotional distress through the physical realm or view emotional and physical symptoms and well-being as one. It is important not to assume that clients with physical complaints are using somatization as a means to express emotional pain; they may have specific conditions or disorders that require medical attention. Foremost, counselors need to refer for medical evaluation.

Advice to Counselors: Using Information About Biology and Trauma

- Educate your clients:

  - Frame reexperiencing the event(s), hyperarousal, sleep disturbances, and other physical symptoms as physiological reactions to extreme stress.
  - Communicate that treatment and other wellness activities can improve both psychological and physiological symptoms (e.g., therapy, meditation, exercise, yoga). You may need to refer certain clients to a psychiatrist who can evaluate them and, if warranted, prescribe psycho-tropic medication to address severe symptoms.
  - Discuss traumatic stress symptoms and their physiological components.
  - Explain links between traumatic stress symptoms and substance use disorders, if appropriate.
  - Normalize trauma symptoms. For example, explain to clients that their symptoms are not a sign of weakness, a character flaw, being damaged, or going crazy.

- Support your clients and provide a message of hope—that they are not alone, they are not at fault, and recovery is possible and anticipated.

Biology of trauma

Trauma biology is an area of burgeoning research, with the promise of more complex and explanatory findings yet to come. Although a thorough presentation on the biological aspects of trauma is beyond the scope of this publication, what is currently known is that exposure to trauma leads to a cascade of biological changes and stress responses. These biological alterations are highly associated with PTSD, other mental illnesses, and substance use disorders. These include:

- Changes in limbic system functioning.
- Hypothalamic–pituitary–adrenal axis activity changes with variable cortisol levels.
- Neurotransmitter-related dysregulation of arousal and endogenous opioid systems.

As a clear example, early ACEs such as abuse, neglect, and other traumas affect brain development and increase a person's vulnerability to encountering interpersonal violence as an adult and to developing chronic diseases and other physical illnesses, mental illnesses, substance-related disorders, and impairment in other life areas (Centers for Disease Control and Prevention, 2012).

Hyperarousal and sleep disturbances

A common symptom that arises from traumatic experiences is hyperarousal (also called hypervigilance). Hyperarousal is the body's way of remaining prepared. It is characterized by sleep disturbances, muscle tension, and a lower threshold for startle responses and can persist years after trauma occurs. It is also one of the primary diagnostic criteria for PTSD.

Hyperarousal is a consequence of biological changes initiated by trauma. Although it serves as a means of self-protection after trauma, it can be detrimental. Hyperarousal can interfere with an individual's ability to take the necessary time to assess and appropriately respond to specific input, such as loud noises or sudden movements. Sometimes, hyperarousal can produce overreactions to situations perceived as dangerous when, in fact, the circumstances are safe.

Case Illustration: Kimi

Kimi is a 35-year-old Native American woman who was group raped at the age of 16 on her walk home from a suburban high school. She recounts how her whole life changed on that day. "I never felt safe being alone after the rape. I used to enjoy walking everywhere. Afterward, I couldn't tolerate the fear that would arise when I walked in the neighborhood. It didn't matter whether I was alone or with friends—every sound that I heard would throw me into a state of fear. I felt like the same thing was going to happen again. It's gotten better with time, but I often feel as if I'm sitting on a tree limb waiting for it to break. I have a hard time relaxing. I can

easily get startled if a leaf blows across my path or if my children scream while playing in the yard. The best way I can describe how I experience life is by comparing it to watching a scary, suspenseful movie—anxiously waiting for something to happen, palms sweating, heart pounding, on the edge of your chair."

Along with hyperarousal, sleep disturbances are very common in individuals who have experienced trauma. They can come in the form of early awakening, restless sleep, difficulty falling asleep, and nightmares. Sleep disturbances are most persistent among individuals who have trauma-related stress; the disturbances sometimes remain resistant to intervention long after other traumatic stress symptoms have been successfully treated. Numerous strategies are available beyond medication, including good sleep hygiene practices, cognitive rehearsals of nightmares, relaxation strategies, and nutrition.

Cognitive

Traumatic experiences can affect and alter cognitions. From the outset, trauma challenges the just-world or core life assumptions that help individuals navigate daily life (Janoff-Bulman, 1992). For example, it would be difficult to leave the house in the morning if you believed that the world was not safe, that all people are dangerous, or that life holds no promise. Belief that one's efforts and intentions can protect oneself from bad things makes it less likely for an individual to perceive personal vulnerability. However, traumatic events—particularly if they are unexpected—can challenge such beliefs.

Cognitions and Trauma

The following examples reflect some of the types of cognitive or thought-process changes that can occur in response to traumatic stress.

Cognitive errors: Misinterpreting a current situation as dangerous because it resembles, even remotely, a previous trauma (e.g., a client overreacting to an overturned canoe in 8 inches of water, as if she and her paddle companion would drown, due to her previous experience of nearly drowning in a rip current 5 years earlier).

Excessive or inappropriate guilt: Attempting to make sense cognitively and gain control over a traumatic experience by assuming responsibility or possessing survivor's guilt, because others who experienced the same trauma did not survive.

Idealization: Demonstrating inaccurate rationalizations, idealizations, or justifications of the perpetrator's behavior, particularly if the perpetrator is or was a caregiver. Other similar reactions mirror idealization; traumatic bonding is an emotional attachment that develops (in part to secure survival) between perpetrators who engage in interpersonal trauma and their victims, and Stockholm syndrome involves compassion and loyalty toward hostage takers (de Fabrique, Van Hasselt, Vecchi, & Romano, 2007).

Trauma-induced hallucinations or delusions: Experiencing hallucinations and delusions that, although they are biological in origin, contain cognitions that are congruent with trauma content (e.g., a woman believes that a person stepping onto her bus is her father, who had sexually abused her repeatedly as child, because he wore shoes similar to those her father once wore).

Intrusive thoughts and memories: Experiencing, without warning or desire, thoughts and memories associated with the trauma. These intrusive thoughts and memories can easily trigger strong emotional and behavioral reactions, as if the trauma was recurring in the present. The intrusive thoughts and memories can come rapidly, referred to as flooding, and can be disruptive at the time of their occurrence. If an individual experiences a trigger, he or she may have an increase in intrusive thoughts and memories for a while. For instance, individuals who inadvertently are retraumatized due to program or clinical practices may have a surge of intrusive thoughts of past trauma, thus making it difficult for them to discern what is happening now versus what happened then. Whenever counseling focuses on trauma, it is likely that the client will experience some intrusive thoughts and memories. It is important to develop coping strategies before, as much as possible, and during the delivery of trauma-informed and trauma-specific treatment.

Let's say you always considered your driving time as "your time"—and your car as a safe place to spend that time. Then someone hits you from behind at a highway entrance. Almost immediately, the accident affects how you perceive the world, and from that moment onward, for months following the crash, you feel unsafe in any car. You become hypervigilant about other drivers and perceive that other cars are drifting into your lane or failing to stop at a safe distance behind you. For a time, your perception of safety is eroded, often leading to compensating behaviors (e.g., excessive glancing into the rearview mirror to see whether the vehicles behind you are stopping) until the belief is restored or reworked. Some individuals never return to their previous belief systems after a trauma, nor do they find a way to rework them—thus leading to a worldview that life is unsafe. Still, many other individuals are able to return to organizing core beliefs that support their perception of safety.

Many factors contribute to cognitive patterns prior to, during, and after a trauma. Adopting Beck and colleagues' cognitive triad model (1979), trauma can alter three main cognitive patterns: thoughts about self, the world (others/environment), and the future. To clarify, trauma can lead individuals to see themselves as incompetent or damaged, to see others and the world as unsafe and unpredictable, and to see the future as hopeless—believing that personal suffering will continue, or negative outcomes will preside for the foreseeable future (see Exhibit 1.3-2). Subsequently, this set of cognitions can greatly influence clients' belief in their ability to use internal resources and external support effectively. From a cognitive– behavioral perspective, these cognitions have a bidirectional relationship in sustaining or contributing to the development of depressive and anxiety symptoms after trauma. However, it is possible for cognitive patterns to help protect against debilitating psychological symptoms as well. Many factors contribute to cognitive patterns prior to, during, and after a trauma.

Feeling different

An integral part of experiencing trauma is feeling different from others, whether or not the trauma was an individual or group experience. Traumatic experiences typically feel surreal and challenge the necessity and value of mundane activities of daily life. Survivors often believe that others will not fully understand their experiences, and they may think that sharing their feelings, thoughts, and reactions related to the trauma will fall short of expectations. However horrid the trauma may be, the *experience* of the trauma is typically profound.

The type of trauma can dictate how an individual feels different or believes that they are different from others. Traumas that generate shame will often lead survivors to feel more alienated from others—believing that they are "damaged goods." When individuals believe that their experiences are unique and incomprehensible, they are more likely to seek support, if they seek support at all, only with others who have experienced a similar trauma.

Triggers and flashbacks

Triggers

A trigger is a stimulus that sets off a memory of a trauma or a specific portion of a traumatic experience. Imagine you were trapped briefly in a car after an accident. Then, several years later, you were unable to unlatch a lock after using a restroom stall; you might have begun to feel a surge of panic reminiscent of the accident, even though there were other avenues of escape from the stall. Some triggers can be identified and anticipated easily, but many are subtle and inconspicuous, often surprising the individual or catching him or her off guard. In treatment, it is important to help clients identify potential triggers, draw a connection between strong emotional reactions and triggers, and develop coping strategies to manage those moments when a trigger occurs. A trigger is any sensory reminder of the traumatic event: a noise, smell, temperature, other physical sensation, or visual scene. Triggers can generalize to any characteristic, no matter how remote, that resembles or represents a previous trauma, such as revisiting the location where the trauma occurred, being alone, having your children reach the same age that you were when you experienced the trauma, seeing the same breed of dog that bit you, or hearing loud voices. Triggers are often associated with the time of day, season, holiday, or anniversary of the event.

Flashbacks

A flashback is reexperiencing a previous traumatic experience as if it were actually happening in that moment. It includes reactions that often resemble the client's reactions during the trauma. Flashback experiences are very brief and typically last only a few seconds, but the emotional aftereffects linger for hours or longer. Flashbacks are commonly initiated by a trigger, but not necessarily. Sometimes, they occur out of the blue. Other times, specific physical states increase a person's vulnerability to reexperiencing a trauma, (e.g., fatigue, high stress levels).

Flashbacks can feel like a brief movie scene that intrudes on the client. For example, hearing a car backfire on a hot, sunny day may be enough to cause a veteran to respond as if he or she were back on military patrol. Other ways people reexperience trauma, besides flashbacks, are via nightmares and intrusive thoughts of the trauma.

Advice to Counselors: Helping Clients Manage Flashbacks and Triggers

If a client is triggered in a session or during some aspect of treatment, help the client focus on what is happening in the here and now; that is, use grounding techniques. Behavioral health service providers should be prepared to help the client get regrounded so that they can distinguish between what is happening now versus what had happened in the past (see Covington, 2008, and Najavits, 2002b, 2007b, for more grounding techniques). Offer education about the experience of triggers and flashbacks, and then normalize these events as common traumatic stress reactions. Afterward, some clients need to discuss the experience and understand why the flashback or trigger occurred. It often helps for the client to draw a connection between the trigger and the traumatic event(s). This can be a preventive strategy whereby the client can anticipate that a given situation places him or her at higher risk for retraumatization and requires use of coping strategies, including seeking support.

Source: Green Cross Academy of Traumatology, 2010.

Dissociation, depersonalization, and derealization

Dissociation is a mental process that severs connections among a person's thoughts, memories, feelings, actions, and/or sense of identity. Most of us have experienced dissociation—losing the ability to recall or track a particular action (e.g., arriving at work but not remembering the last minutes of the drive). Dissociation happens because the person is engaged in an automatic activity and is not paying attention to his or her immediate environment. Dissociation can also occur during severe stress or trauma as a protective element whereby the individual incurs distortion of time, space, or identity. This is a common symptom in traumatic stress reactions.

Dissociation helps distance the experience from the individual. People who have experienced severe or developmental trauma may have learned to separate themselves from distress to survive. At times, dissociation can be very pervasive and symptomatic of a mental disorder, such as dissociative identity disorder (DID; formerly known as multiple personality disorder). According to the DSM-5, "dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (APA, 2013a, p. 291). Dissociative disorder diagnoses are closely associated with histories of severe childhood trauma or pervasive, human-caused, intentional trauma, such as that experienced by concentration camp survivors or victims of ongoing political imprisonment, torture, or long-term isolation. A mental health professional, preferably with significant training in working with dissociative disorders and with trauma, should be consulted when a dissociative disorder diagnosis is suspected.

Potential Signs of Dissociation

- Fixed or "glazed" eyes
- Sudden flattening of affect
- Long periods of silence
- Monotonous voice
- Stereotyped movements
- Responses not congruent with the present context or situation
- Excessive intellectualization

(Briere, 1996a)

The characteristics of DID can be commonly accepted experiences in other cultures, rather than being viewed as symptomatic of a traumatic experience. For example, in non-Western cultures, a sense of alternate beings within oneself may be interpreted as being inhabited by spirits or ancestors (Kirmayer, 1996). Other experiences associated with dissociation include depersonalization—psychologically "leaving one's body," as if watching oneself from a distance as an observer or through derealization, leading to a sense that what is taking place is unfamiliar or is not real.

If clients exhibit signs of dissociation, behavioral health service providers can use grounding techniques to help them reduce this defense strategy. One major long-term consequence of dissociation is the difficulty it causes in connecting strong emotional or physical reactions with an event. Often, individuals may believe that they are going crazy because they are not in touch with the nature of their reactions. By educating clients on the resilient qualities of dissociation while also emphasizing that it prevents them from addressing or validating the trauma, individuals can begin to understand the role of dissociation. All in all, it is important when working with trauma survivors that the intensity level is not so great that it triggers a dissociative reaction and prevents the person from engaging in the process.

Behavioral

Traumatic stress reactions vary widely; often, people engage in behaviors to manage the aftereffects, the intensity of emotions, or the distressing aspects of the traumatic experience. Some people reduce tension or stress through avoidant, self-medicating (e.g., alcohol abuse), compulsive (e.g., overeating), impulsive (e.g., high-risk behaviors), and/or self-injurious behaviors. Others may try to gain control over their experiences by being aggressive or subconsciously reenacting aspects of the trauma.

Behavioral reactions are also the consequences of, or learned from, traumatic experiences. For example, some people act like they can't control their current environment, thus failing to take action or make decisions long after the trauma (learned helplessness). Other associate elements of the trauma with current activities, such as by reacting to an intimate moment in a significant relationship as dangerous or unsafe years after a date rape. The following sections discuss behavioral consequences of trauma and traumatic stress reactions.

Reenactments

A hallmark symptom of trauma is reexperiencing the trauma in various ways. Reexperiencing can occur through reenactments (literally, to "redo"), by which trauma survivors repetitively relive and recreate a past trauma in their present lives. This is very apparent in children, who play by mimicking what occurred during the trauma, such as by pretending to crash a toy airplane into a toy building after seeing televised images of the terrorist attacks on the World Trade Center on September 11, 2001. Attempts to understand reenactments are very complicated, as reenactments occur for a variety of reasons. Sometimes, individuals reenact past traumas to master them. Examples of reenactments include a variety of behaviors: self-injurious behaviors, hypersexuality, walking alone in unsafe areas or other high-risk behaviors, driving recklessly, or involvement in repetitive destructive relationships (e.g., repeatedly getting into romantic relationships with people who are abusive or violent), to name a few.

Self-harm and self-destructive behaviors

Self-harm is any type of intentionally self-inflicted harm, regardless of the severity of injury or whether suicide is intended. Often, self-harm is an attempt to cope with emotional or physical distress that seems overwhelming or to cope with a profound sense of dissociation or being trapped, helpless, and "damaged" (Herman, 1997; Santa Mina & Gallop, 1998). Self-harm is associated with past childhood sexual abuse and other forms of trauma as well as substance abuse. Thus, addressing self-harm requires attention to the client's reasons for self-harm. More than likely, the client needs help recognizing and coping with emotional or physical distress in manageable amounts and ways.

Resilient Responses to Trauma

Many people find healthy ways to cope with, respond to, and heal from trauma. Often, people automatically reevaluate their values and redefine what is important after a trauma. Such resilient responses include:

- Increased bonding with family and community.
- Redefined or increased sense of purpose and meaning.

- Increased commitment to a personal mission.
- Revised priorities.
- Increased charitable giving and volunteerism.

Case Illustration: Marco

Marco, a 30-year-old man, sought treatment at a local mental health center after a 2-year bout of anxiety symptoms. He was an active member of his church for 12 years, but although he sought help from his pastor about a year ago, he reports that he has had no contact with his pastor or his church since that time. Approximately 3 years ago, his wife took her own life. He describes her as his soul-mate and has had a difficult time understanding her actions or how he could have prevented them.

In the initial intake, he mentioned that he was the first person to find his wife after the suicide and reported feelings of betrayal, hurt, anger, and devastation since her death. He claimed that everyone leaves him or dies. He also talked about his difficulty sleeping, having repetitive dreams of his wife, and avoiding relationships. In his first session with the counselor, he initially rejected the counselor before the counselor had an opportunity to begin reviewing and talking about the events and discomfort that led him to treatment.

In this scenario, Marco is likely reenacting his feelings of abandonment by attempting to reject others before he experiences another rejection or abandonment. In this situation, the counselor will need to recognize the reenactment, explore the behavior, and examine how reenactments appear in other situations in Marco's life.

Among the self-harm behaviors reported in the literature are cutting, burning skin by heat (e.g., cigarettes) or caustic liquids, punching hard enough to self-bruise, head banging, hair pulling, self-poisoning, inserting foreign objects into bodily orifices, excessive nail biting, excessive scratching, bone breaking, gnawing at flesh, interfering with wound healing, tying off body parts to stop breathing or blood flow, swallowing sharp objects, and suicide. Cutting and burning are among the most common forms of self-harm.

Self-harm tends to occur most in people who have experienced repeated and/or early trauma (e.g., childhood sexual abuse) rather than in those who have undergone a single adult trauma (e.g., a community-wide disaster or a serious car accident). There are strong associations between eating disorders, self-harm, and substance abuse (Claes & Vandereycken, 2007; for discussion, see Harned, Najavits, & Weiss, 2006). Self-mutilation is also associated with (and part of the diagnostic criteria for) a number of personality disorders, including borderline and histrionic, as well as DID, depression, and some forms of schizophrenia; these disorders can co-occur with traumatic stress reactions and disorders.

It is important to distinguish self-harm that is suicidal from self-harm that is not suicidal and to assess and manage both of these very serious dangers carefully. Most people who engage in self-harm are not doing so with the intent to kill themselves (Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003)—although self-harm can be life threatening and can escalate into suicidality if not managed therapeutically. Self-harm can be a way of getting attention or manipulating others, but most often it is not. Self-destructive behaviors such as substance abuse, restrictive or binge eating, reckless automobile driving, or high-risk impulsive behavior are different from self-harming behaviors but are also seen in clients with a history of trauma. Self-destructive behaviors differ from self-harming behaviors in that there may be no immediate negative impact of the behavior on the individual; they differ from suicidal behavior in that there is no intent to cause death in the short term.

Advice to Counselors: Working With Clients Who Are Self-Injurious

Counselors who are unqualified or uncomfortable working with clients who demonstrate self-harming, self-destructive, or suicidal or homicidal ideation, intent, or behavior should work with their agencies and supervisors to refer such clients to other counselors. They should consider seeking specialized supervision on how to manage such clients effectively and safely and how to manage their feelings about these issues. The following

suggestions assume that the counselor has had sufficient training and experience to work with clients who are self-injurious. To respond appropriately to a client who engages in self-harm, counselors should:

- Screen the client for self-harm and suicide risk at the initial evaluation and throughout treatment.
- Learn the client's perspective on self-harm and how it "helps."
- Understand that self-harm is often a coping strategy to manage the intensity of emotional and/or physical distress.
- Teach the client coping skills that improve his or her management of emotions without self-harm.
- Help the client obtain the level of care needed to manage genuine risk of suicide or severe self-injury. This might include hospitalization, more intensive programming (e.g., intensive outpatient, partial hospitalization, residential treatment), or more frequent treatment sessions. The goal is to stabilize the client as quickly as possible, and then, if possible, begin to focus treatment on developing coping strategies to manage self-injurious and other harmful impulses.
- Consult with other team members, supervisors, and, if necessary, legal experts to determine whether one's efforts with and conceptualization of the self-harming client fit best practice guidelines. See, for example, Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT], 2005c). Document such consultations and the decisions made as a result of them thoroughly and frequently.
- Help the client identify how substance use affects self-harm. In some cases, it can increase the behavior (e.g., alcohol disinhibits the client, who is then more likely to self-harm). In other cases, it can decrease the behavior (e.g., heroin evokes relaxation and, thus, can lessen the urge to self-harm). In either case, continue to help the client understand how abstinence from substances is necessary so that he or she can learn more adaptive coping.
- Work collaboratively with the client to develop a plan to create a sense of safety. Individuals are affected by trauma in different ways; therefore, safety or a safe environment may mean something entirely different from one person to the next. Allow the client to define what safety means to him or her.

Counselors can also help the client prepare a safety card that the client can carry at all times. The card might include the counselor's contact information, a 24-hour crisis number to call in emergencies, contact information for supportive individuals who can be contacted when needed, and, if appropriate, telephone numbers for emergency medical services. The counselor can discuss with the client the types of signs or crises that might warrant using the numbers on the card. Additionally, the counselor might check with the client from time to time to confirm that the information on the card is current.

TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a), has examples of safety agreements specifically for suicidal clients and discusses their uses in more detail. There is no credible evidence that a safety agreement is effective in preventing a suicide attempt or death. Safety agreements for clients with suicidal thoughts and behaviors should only be used as an adjunct support accompanying professional screening, assessment, and treatment for people with suicidal thoughts and behaviors. Keep in mind that safety plans or agreements may be perceived by the trauma survivor as a means of controlling behavior, subsequently replicating or triggering previous traumatic experiences.

All professionals—and in some States, anyone—could have ethical and legal responsibilities to those clients who pose an imminent danger to themselves or others. Clinicians should be aware of the pertinent State laws where they practice and the relevant Federal and professional regulations.

However, as with self-harming behavior, self-destructive behavior needs to be recognized and addressed and may persist—or worsen—without intervention.

Consumption of substances

Substance use often is initiated or increased after trauma. Clients in early recovery— especially those who develop PTSD or have it reactivated—have a higher relapse risk if they experience a trauma. In the first 2 months after

September 11, 2001, more than a quarter of New Yorker residents who smoked cigarettes, drank alcohol, or used marijuana (about 265,000 people) increased their consumption. The increases continued 6 months after the attacks (Vlahov, Galea, Ahern, Resnick, & Kilpatrick, 2004). A study by the Substance Abuse and Mental Health Services Administration (SAMHSA, Office of Applied Studies, 2002) used National Survey on Drug Use and Health data to compare the first three quarters of 2001 with the last quarter and reported an increase in the prevalence rate for alcohol use among people 18 or older in the New York metropolitan area during the fourth quarter.

Interviews with New York City residents who were current or former cocaine or heroin users indicated that many who had been clean for 6 months or less relapsed after September 11, 2001. Others, who lost their income and could no longer support their habit, enrolled in methadone programs (Weiss et al., 2002). After the Oklahoma City bombing in 1995, Oklahomans reported double the normal rate of alcohol use, smoking more cigarettes, and a higher incidence of initiating smoking months and even years after the bombing (Smith, Christiansen, Vincent, & Hann, 1999).

Self-medication

Khantzian's self-medication theory (1985) suggests that drugs of abuse are selected for their specific effects. However, no definitive pattern has yet emerged of the use of particular substances in relation to PTSD or trauma symptoms. Use of substances can vary based on a variety of factors, including which trauma symptoms are most prominent for an individual and the individual's access to particular substances. Unresolved traumas sometimes lurk behind the emotions that clients cannot allow themselves to experience. Substance use and abuse in trauma survivors can be a way to self-medicate and thereby avoid or displace difficult emotions associated with traumatic experiences. When the substances are withdrawn, the survivor may use other behaviors to self-soothe, self-medicate, or avoid emotions. As likely, emotions can appear after abstinence in the form of anxiety and depression.

Avoidance

Avoidance often coincides with anxiety and the promotion of anxiety symptoms. Individuals begin to avoid people, places, or situations to alleviate unpleasant emotions, memories, or circumstances. Initially, the avoidance works, but over time, anxiety increases and the perception that the situation is unbearable or dangerous increases as well, leading to a greater need to avoid. Avoidance can be adaptive, but it is also a behavioral pattern that reinforces perceived danger without testing its validity, and it typically leads to greater problems across major life areas (e.g., avoiding emotionally oriented conversations in an intimate relationship). For many individuals who have traumatic stress reactions, avoidance is commonplace. A person may drive 5 miles longer to avoid the road where he or she had an accident. Another individual may avoid crowded places in fear of an assault or to circumvent strong emotional memories about an earlier assault that took place in a crowded area. Avoidance can come in many forms. When people can't tolerate strong affects associated with traumatic memories, they avoid, project, deny, or distort their trauma-related emotional and cognitive experiences. A key ingredient in trauma recovery is learning to manage triggers, memories, and emotions without avoidance—in essence, becoming desensitized to traumatic memories and associated symptoms.

Social/Interpersonal

A key ingredient in the early stage of TIC is to establish, confirm, or reestablish a support system, including culturally appropriate activities, as soon as possible. Social supports and relationships can be protective factors against traumatic stress. However, trauma typically affects relationships significantly, regardless of whether the trauma is interpersonal or is of some other type. Relationships require emotional exchanges, which means that others who have close relationships or friendships with the individual who survived the trauma(s) are often affected as well—either through secondary traumatization or by directly experiencing the survivor's traumatic stress reactions. In natural disasters, social and community supports can be abruptly eroded and difficult to rebuild after the initial disaster relief efforts have waned.

Survivors may readily rely on family members, friends, or other social supports—or they may avoid support, either because they believe that no one will be understanding or trustworthy or because they perceive their own needs as a burden to others. Survivors who have strong emotional or physical reactions, including outbursts during nightmares, may pull away further in fear of being unable to predict their own reactions or to protect their own safety and that of others. Often, trauma survivors feel ashamed of their stress reactions, which further hampers their ability to use their support systems and resources adequately.

Many survivors of childhood abuse and interpersonal violence have experienced a significant sense of betrayal. They have often encountered trauma at the hands of trusted caregivers and family members or through significant relationships. This history of betrayal can disrupt forming or relying on supportive relationships in recovery, such as peer supports and counseling. Although this fear of trusting others is protective, it can lead to difficulty in connecting with others and greater vigilance in observing the behaviors of others, including behavioral health service providers. It is exceptionally difficult to override the feeling that someone is going to hurt you, take advantage of you, or, minimally, disappoint you. Early betrayal can affect one's ability to develop attachments, yet the formation of supportive relationships is an important antidote in the recovery from traumatic stress.

Developmental

Each age group is vulnerable in unique ways to the stresses of a disaster, with children and the elderly at greatest risk. Young children may display generalized fear, nightmares, heightened arousal and confusion, and physical symptoms, (e.g., stomachaches, headaches). School-age children may exhibit symptoms such as aggressive behavior and anger, regression to behavior seen at younger ages, repetitious traumatic play, loss of ability to concentrate, and worse school performance. Adolescents may display depression and social withdrawal, rebellion, increased risky activities such as sexual acting out, wish for revenge and action-oriented responses to trauma, and sleep and eating disturbances (Hamblen, 2001). Adults may display sleep problems, increased agitation, hypervigilance, isolation or withdrawal, and increased use of alcohol or drugs. Older adults may exhibit increased withdrawal and isolation, reluctance to leave home, worsening of chronic illnesses, confusion, depression, and fear (DeWolfe & Nordboe, 2000b).

Neurobiological Development: Consequences of Early Childhood Trauma

Findings in developmental psychobiology suggest that the consequences of early maltreatment produce enduring negative effects on brain development (De Bellis, 2002; Liu, Diorio, Day, Francis, & Meaney, 2000; Teicher, 2002). Research suggests that the first stage in a cascade of events produced by early trauma and/or maltreatment involves the disruption of chemicals that function as neurotransmitters (e.g., cortisol, norepinephrine, dopamine), causing escalation of the stress response (Heim, Mletzko, Purselle, Musselman, & Nemeroff, 2008; Heim, Newport, Mletzko, Miller, & Nemeroff, 2008; Teicher, 2002). These chemical responses can then negatively affect critical neural growth during specific sensitive periods of childhood development and can even lead to cell death.

Adverse brain development can also result from elevated levels of cortisol and catecholamines by contributing to maturational failures in other brain regions, such as the prefrontal cortex (Meaney, Brake, & Gratton, 2002). Heim, Mletzko et al. (2008) found that the neuropeptide oxytocin— important for social affiliation and support, attachment, trust, and management of stress and anxiety—was markedly decreased in the cerebrospinal fluid of women who had been exposed to childhood maltreatment, particularly those who had experienced emotional abuse. The more childhood traumas a person had experienced, and the longer their duration, the lower that person's current level of oxytocin was likely to be and the higher her rating of current anxiety was likely to be.

Using data from the Adverse Childhood Experiences Study, an analysis by Anda, Felitti, Brown et al. (2006) confirmed that the risk of negative outcomes in affective, somatic, substance abuse, memory, sexual, and aggression-related domains increased as scores on a measure of eight ACEs increased. The researchers concluded that the association of study scores with these outcomes can serve as a theoretical parallel for the effects of cumulative exposure to stress on the developing brain and for the resulting impairment seen in multiple brain structures and functions.

The National Child Traumatic Stress Network (http://www.nctsn.org) offers information about childhood abuse, stress, and physiological responses of children who are traumatized. Materials are available for counselors, educators, parents, and caregivers. There are special sections on the needs of children in military families and on the impact of natural disasters on children's mental health.

Subthreshold Trauma-Related Symptoms

Many trauma survivors experience symptoms that, although they do not meet the diagnostic criteria for ASD or PTSD, nonetheless limit their ability to function normally (e.g., regulate emotional states, maintain steady and

rewarding social and family relationships, function competently at a job, maintain a steady pattern of abstinence in recovery). These symptoms can be transient, only arising in a specific context; intermittent, appearing for several weeks or months and then receding; or a part of the individual's regular pattern of functioning (but not to the level of DSM-5 diagnostic criteria). Often, these patterns are termed "subthreshold" trauma symptoms. Like PTSD, the symptoms can be misdiagnosed as depression, anxiety, oran other mental illness. Likewise, clients who have experienced trauma may link some of their symptoms to their trauma and diagnose themselves as having PTSD, even though they do not meet all criteria for that disorder.

Combat Stress Reaction

A phenomenon unique to war, and one that counselors need to understand well, is combat stress reaction (CSR). CSR is an acute anxiety reaction occurring during or shortly after participating in military conflicts and wars as well as other operations within the war zone, known as the theater. CSR is not a formal diagnosis, nor is it included in the DSM-5 (APA, 2013a). It is similar to acute stress reaction, except that the precipitating event or events affect military personnel (and civilians exposed to the events) in an armed conflict situation. The terms "combat stress reaction" and "posttraumatic stress injury" are relatively new, and the intent of using these new terms is to call attention to the unique experiences of combat-related stress as well as to decrease the shame that can be associated with seeking behavioral health services for PTSD (for more information on veterans and combat stress reactions, see the planned TIP, *Reintegration-Related Behavioral Health Issues for Veterans and Military Families*; SAMHSA, planned f).

Case Illustration: Frank

Frank is a 36-year-old man who was severely beaten in a fight outside a bar. He had multiple injuries, including broken bones, a concussion, and a stab wound in his lower abdomen. He was hospitalized for 3.5 weeks and was unable to return to work, thus losing his job as a warehouse forklift operator. For several years, when faced with situations in which he perceived himself as helpless and overwhelmed, Frank reacted with violent anger that, to others, appeared grossly out of proportion to the situation. He has not had a drink in almost 3 years, but the bouts of anger persist and occur three to five times a year. They leave Frank feeling even more isolated from others and alienated from those who love him. He reports that he cannot watch certain television shows that depict violent anger; he has to stop watching when such scenes occur. He sometimes daydreams about getting revenge on the people who assaulted him.

Psychiatric and neurological evaluations do not reveal a cause for Frank's anger attacks. Other than these symptoms, Frank has progressed well in his abstinence from alcohol. He attends a support group regularly, has acquired friends who are also abstinent, and has reconciled with his family of origin. His marriage is more stable, although the episodes of rage limit his wife's willingness to commit fully to the relationship. In recounting the traumatic event in counseling, Frank acknowledges that he thought he was going to die as a result of the fight, especially when he realized he had been stabbed. As he described his experience, he began to become very anxious, and the counselor observed the rage beginning to appear.

After his initial evaluation, Frank was referred to an outpatient program that provided trauma-specific interventions to address his subthreshold trauma symptoms. With a combination of cognitive– behavioral counseling, EMDR, and anger management techniques, he saw a gradual decrease in symptoms when he recalled the assault. He started having more control of his anger when memories of the trauma emerged. Today, when feeling trapped, helpless, or overwhelmed, Frank has resources for coping and does not allow his anger to interfere with his marriage or other relationships.

Although stress mobilizes an individual's physical and psychological resources to perform more effectively in combat, reactions to the stress may persist long after the actual danger has ended. As with other traumas, the nature of the event(s), the reactions of others, and the survivor's psychological history and resources affect the likelihood and severity of CSR. With combat veterans, this translates to the number, intensity, and duration of threat factors; the social support of peers in the veterans' unit; the emotional and cognitive resilience of the service members; and the quality of military leadership. CSR can vary from manageable and mild to debilitating and severe. Common, less severe symptoms of CSR include tension, hypervigilance, sleep problems, anger, and difficulty concentrating. If left untreated, CSR can lead to PTSD.

Common causes of CSR are events such as a direct attack from insurgent small arms fire or a military convoy being hit by an improvised explosive device, but combat stressors encompass a diverse array of traumatizing events, such as seeing grave injuries, watching others die, and making on-the-spot decisions in ambiguous conditions (e.g., having to determine whether a vehicle speeding toward a military checkpoint contains insurgents with explosives or a family traveling to another area). Such circumstances can lead to combat stress. Military personnel also serve in noncombat positions (e.g., healthcare and administrative roles), and personnel filling these supportive roles can be exposed to combat situations by proximity or by witnessing their results.

Advice to Counselors: Understanding the Nature of Combat Stress

Several sources of information are available to help counselors deepen their understanding of combat stress and postdeployment adjustment. Friedman (2006) explains how a prolonged combat-ready stance, which is adaptive in a war zone, becomes hypervigilance and overprotectiveness at home. He makes the point that the "mutual interdependence, trust, and affection" (p. 587) that are so necessarily a part of a combat unit are different from relationships with family members and colleagues in a civilian workplace. This complicates the transition to civilian life. *Wheels Down: Adjusting to Life After Deployment* (Moore & Kennedy, 2011) provides practical advice for military service members, including inactive or active duty personnel and veterans, in transitioning from the theater to home.

The following are just a few of the many resources and reports focused on combat-related psychological and stress issues:

- *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Tanielian & Jaycox, 2008)
- *On Killing* (Grossman, 1995), an indepth analysis of the psychological dynamics of combat
- *Haunted by Combat* (Paulson & Krippner, 2007), which contains specific chapters on Reserve and National Guard troops and female veterans
- *Treating Young Veterans: Promoting Resilience Through Practice and Advocacy* (Kelly, Howe-Barksdale, & Gitelson, 2011)

Specific Trauma-Related Psychological Disorders

Part of the definition of trauma is that the individual responds with intense fear, helplessness, or horror. Beyond that, in both the short term and the long term, trauma comprises a range of reactions from normal (e.g., being unable to concentrate, feeling sad, having trouble sleeping) to warranting a diagnosis of a trauma-related mental disorder. Most people who experience trauma have no long-lasting disabling effects; their coping skills and the support of those around them are sufficient to help them overcome their difficulties, and their ability to function on a daily basis over time is unimpaired. For others, though, the symptoms of trauma are more severe and last longer. The most common diagnoses associated with trauma are PTSD and ASD, but trauma is also associated with the onset of other mental disorders—particularly substance use disorders, mood disorders, various anxiety disorders, and personality disorders. Trauma also typically exacerbates symptoms of preexisting disorders, and, for people who are predisposed to a mental disorder, trauma can precipitate its onset. Mental disorders can occur almost simultaneously with trauma exposure or manifest sometime thereafter.

Acute Stress Disorder

ASD represents a normal response to stress. Symptoms develop within 4 weeks of the trauma and can cause significant levels of distress. Most individuals who have acute stress reactions never develop further impairment or PTSD. Acute stress disorder is highly associated with the experience of one specific trauma rather than the experience of long-term exposure to chronic traumatic stress. Diagnostic criteria are presented in Exhibit 1.3-3.

The primary presentation of an individual with an acute stress reaction is often that of someone who appears overwhelmed by the traumatic experience. The need to talk about the experience can lead the client to seem self-centered and unconcerned about the needs of others. He or she may need to describe, in repetitive detail, what

happened, or may seem obsessed with trying to understand what happened in an effort to make sense of the experience. The client is often hypervigilant and avoids circumstances that are reminders of the trauma. For instance, someone who was in a serious car crash in heavy traffic can become anxious and avoid riding in a car or driving in traffic for a finite time afterward. Partial amnesia for the trauma often accompanies ASD, and the individual may repetitively question others to fill in details. People with ASD symptoms sometimes seek assurance from others that the event happened in the way they remember, that they are not "going crazy" or "losing it," and that they could not have prevented the event. The next case illustration demonstrates the time-limited nature of ASD.

Differences between ASD and PTSD

It is important to consider the differences between ASD and PTSD when forming a diagnostic impression. The primary difference is the amount of time the symptoms have been present. ASD resolves 2 days to 4 weeks after an event, whereas PTSD continues beyond the 4-week period. The diagnosis of ASD can change to a diagnosis of PTSD if the condition is noted within the first 4 weeks after the event, but the symptoms persist past 4 weeks.

ASD also differs from PTSD in that the ASD diagnosis requires 9 out of 14 symptoms from five categories, including intrusion, negative mood, dissociation, avoidance, and arousal. These symptoms can occur at the time of the trauma or in the following month. Studies indicate that dissociation at the time of trauma is a good predictor of subsequent PTSD, so the inclusion of dissociative symptoms makes it more likely that those who develop ASD will later be diagnosed with PTSD (Bryant & Harvey, 2000). Additionally, ASD is a transient disorder, meaning that it is present in a person's life for a relatively short time and then passes. In contrast, PTSD typically becomes a primary feature of an individual's life. Over a lengthy period, PTSD can have profound effects on clients' perceptions of safety, their sense of hope for the future, their relationships with others, their physical health, the appearance of psychiatric symptoms, and their patterns of substance use and abuse.

There are common symptoms between PTSD and ASD, and untreated ASD is a possible predisposing factor to PTSD, but it is unknown whether most people with ASD are likely to develop PTSD. There is some suggestion that, as with PTSD, ASD is more prevalent in women than in men (Bryant & Harvey, 2003). However, many people with PTSD do not have a diagnosis or recall a history of acute stress symptoms before seeking treatment for or receiving a diagnosis of PTSD.

Case Illustration: Sheila

Two months ago, Sheila, a 55-year-old married woman, experienced a tornado in her home town. In the previous year, she had addressed a long-time marijuana use problem with the help of a treatment program and had been abstinent for about 6 months. Sheila was proud of her abstinence; it was something she wanted to continue. She regarded it as a mark of personal maturity; it improved her relationship with her husband, and their business had flourished as a result of her abstinence.

During the tornado, an employee reported that Sheila had become very agitated and had grabbed her assistant to drag him under a large table for cover. Sheila repeatedly yelled to her assistant that they were going to die. Following the storm, Sheila could not remember certain details of her behavior during the event. Furthermore, Sheila said that after the storm, she felt numb, as if she was floating out of her body and could watch herself from the outside. She stated that nothing felt real and it was all like a dream.

Following the tornado, Sheila experienced emotional numbness and detachment, even from people close to her, for about 2 weeks. The symptoms slowly decreased in intensity but still disrupted her life. Sheila reported experiencing disjointed or unconnected images and dreams of the storm that made no real sense to her. She was unwilling to return to the building where she had been during the storm, despite having maintained a business at this location for 15 years. In addition, she began smoking marijuana again because it helped her sleep. She had been very irritable and had uncharacteristic angry outbursts toward her husband, children, and other family members.

As a result of her earlier contact with a treatment program, Sheila returned to that program and engaged in psychoeducational, supportive counseling focused on her acute stress reaction. She regained abstinence from marijuana and returned shortly to a normal level of functioning. Her symptoms slowly diminished over a period

of 3 weeks. With the help of her counselor, she came to understand the link between the trauma and her relapse, regained support from her spouse, and again felt in control of her life.

Effective interventions for ASD can significantly reduce the possibility of the subsequent development of PTSD. Effective treatment of ASD can also reduce the incidence of other co-occurring problems, such as depression, anxiety, dissociative disorders, and compulsive behaviors (Bryant & Harvey, 2000). Intervention for ASD also helps the individual develop coping skills that can effectively prevent the recurrence of ASD after later traumas.

Although predictive science for ASD and PTSD will continue to evolve, both disorders are associated with increased substance use and mental disorders and increased risk of relapse; therefore, effective screening for ASD and PTSD is important for all clients with these disorders. Individuals in early recovery—lacking well-practiced coping skills, lacking environmental supports, and already operating at high levels of anxiety—are particularly susceptible to ASD. Events that would not normally be disabling can produce symptoms of intense helplessness and fear, numbing and depersonalization, disabling anxiety, and an inability to handle normal life events. Counselors should be able to recognize ASD and treat it rather than attributing the symptoms to a client's lack of motivation to change, being "dry drunk" (for those in substance abuse recovery), or being manipulative.

Posttraumatic Stress Disorder

The trauma-related disorder that receives the greatest attention is PTSD; it is the most commonly diagnosed trauma-related disorder, and its symptoms can be quite debilitating over time. Nonetheless, it is important to remember that PTSD symptoms are represented in a number of other mental illnesses, including major depressive disorder (MDD), anxiety disorders, and psychotic disorders (Foa et al., 2006). The DSM-5 (APA, 2013a) identifies four symptom clusters for PTSD: presence of intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. Individuals must have been exposed to actual or threatened death, serious injury, or sexual violence, and the symptoms must produce significant distress and impairment for more than 4 weeks (Exhibit 1.3-4).

Case Illustration: Michael

Michael is a 62-year-old Vietnam veteran. He is a divorced father of two children and has four grandchildren. Both of his parents were dependent on alcohol. He describes his childhood as isolated. His father physically and psychologically abused him (e.g., he was beaten with a switch until he had welts on his legs, back, and buttocks). By age 10, his parents regarded him as incorrigible and sent him to a reformatory school for 6 months. By age 15, he was using marijuana, hallucinogens, and alcohol and was frequently truant from school.

At age 19, Michael was drafted and sent to Vietnam, where he witnessed the deaths of six American military personnel. In one incident, the soldier he was next to in a bunker was shot. Michael felt helpless as he talked to this soldier, who was still conscious. In Vietnam, Michael increased his use of both alcohol and marijuana. On his return to the United States, Michael continued to drink and use marijuana. He reenlisted in the military for another tour of duty.

His life stabilized in his early 30s, as he had a steady job, supportive friends, and a relatively stable family life. However, he divorced in his late 30s. Shortly thereafter, he married a second time, but that marriage ended in divorce as well. He was chronically anxious and depressed and had insomnia and frequent nightmares. He periodically binged on alcohol. He complained of feeling empty, had suicidal ideation, and frequently stated that he lacked purpose in his life.

In the 1980s, Michael received several years of mental health treatment for dysthymia. He was hospitalized twice and received 1 year of outpatient psychotherapy. In the mid-1990s, he returned to outpatient treatment for similar symptoms and was diagnosed with PTSD and dysthymia. He no longer used marijuana and rarely drank. He reported that he didn't like how alcohol or other substances made him feel anymore—he felt out of control with his emotions when he used them. Michael reported symptoms of hyperarousal, intrusion (intrusive memories, nightmares, and preoccupying thoughts about Vietnam), and avoidance (isolating himself from others and feeling "numb"). He reported that these symptoms seemed to relate to his childhood abuse and his experiences in

Vietnam. In treatment, he expressed relief that he now understood the connection between his symptoms and his history.

Certain characteristics make people more susceptible to PTSD, including one's unique personal vulnerabilities at the time of the traumatic exposure, the support (or lack of support) received from others at the time of the trauma and at the onset of trauma-related symptoms, and the way others in the person's environment gauge the nature of the traumatic event (Brewin, Andrews, & Valentine, 2000).

People with PTSD often present varying clinical profiles and histories. They can experience symptoms that are activated by environmental triggers and then recede for a period of time. Some people with PTSD who show mostly psychiatric symptoms (particularly depression and anxiety) are misdiagnosed and go untreated for their primary condition. For many people, the trauma experience and diagnosis are obscured by co-occurring substance use disorder symptoms. The important feature of PTSD is that the disorder becomes an orienting feature of the individual's life. How well the person can work, with whom he or she associates, the nature of close and intimate relationships, the ability to have fun and rejuvenate, and the way in which an individual goes about confronting and solving problems in life are all affected by the client's trauma experiences and his or her struggle to recover.

Posttraumatic stress disorder: Timing of symptoms

Although symptoms of PTSD usually begin within 3 months of a trauma in adulthood, there can be a delay of months or even years before symptoms appear for some people. Some people may have minimal symptoms after a trauma but then experience a crisis later in life. Trauma symptoms can appear suddenly, even without conscious memory of the original trauma or without any overt provocation. Survivors of abuse in childhood can have a delayed response triggered by something that happens to them as adults. For example, seeing a movie about child abuse can trigger symptoms related to the trauma. Other triggers include returning to the scene of the trauma, being reminded of it in some other way, or noting the anniversary of an event. Likewise, combat veterans and survivors of community-wide disasters may seem to be coping well shortly after a trauma, only to have symptoms emerge later when their life situations seem to have stabilized. Some clients in substance abuse recovery only begin to experience trauma symptoms when they maintain abstinence for some time. As individuals decrease tension-reducing or self-medicating behaviors, trauma memories and symptoms can emerge.

Advice to Counselors: Helping Clients With Delayed Trauma Responses

Clients who are experiencing a delayed trauma response can benefit if you help them to:

- Create an environment that allows acknowledgment of the traumatic event(s).
- Discuss their initial recall or first suspicion that they were having a traumatic response.
- Become educated on delayed trauma responses.
- Draw a connection between the trauma and presenting trauma-related symptoms.
- Create a safe environment.
- Explore their support systems and fortify them as needed.
- Understand that triggers can precede traumatic stress reactions, including delayed responses to trauma.
- Identify their triggers.
- Develop coping strategies to navigate and manage symptoms.

Culture and posttraumatic stress

Although research is limited across cultures, PTSD has been observed in Southeast Asian, South American, Middle Eastern, and Native American survivors (Osterman & de Jong, 2007; Wilson & Tang, 2007). As Stamm and Friedman (2000) point out, however, simply observing PTSD does not mean that it is the "best conceptual tool for

characterizing post-traumatic distress among non-Western individuals" (p. 73). In fact, many trauma-related symptoms from other cultures do not fit the DSM-5 criteria. These include somatic and psychological symptoms and beliefs about the origins and nature of traumatic events. Moreover, religious and spiritual beliefs can affect how a survivor experiences a traumatic event and whether he or she reports the distress. For example, in societies where attitudes toward karma and the glorification of war veterans are predominant, it is harder for war veterans to come forward and disclose that they are emotionally overwhelmed or struggling. It would be perceived as inappropriate and possibly demoralizing to focus on the emotional distress that he or she still bears. (For a review of cultural competence in treating trauma, refer to Brown, 2008.)

Methods for measuring PTSD are also culturally specific. As part of a project begun in 1972, the World Health Organization (WHO) and the National Institutes of Health (NIH) embarked on a joint study to test the cross-cultural applicability of classification systems for various diagnoses. WHO and NIH identified apparently universal factors of psychological disorders and developed specific instruments to measure them. These instruments, the Composite International Diagnostic Interview and the Schedules for Clinical Assessment in Neuropsychiatry, include certain criteria from the DSM (Fourth Edition, Text Revision; APA, 2000a) as well as criteria from the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10; Exhibit 1.3-5).

Complex trauma and complex traumatic stress

When individuals experience multiple traumas, prolonged and repeated trauma during childhood, or repetitive trauma in the context of significant interpersonal relationships, their reactions to trauma have unique characteristics (Herman, 1992). This unique constellation of reactions, called complex traumatic stress, is not recognized diagnostically in the DSM-5, but theoretical discussions and research have begun to highlight the similarities and differences in symptoms of posttraumatic stress versus complex traumatic stress (Courtois & Ford, 2009). Often, the symptoms generated from complex trauma do not fully match PTSD criteria and exceed the severity of PTSD. Overall, literature reflects that PTSD criteria or subthreshold symptoms do not fully account for the persistent and more impairing clinical presentation of complex trauma. Even though current research in the study of traumatology is prolific, it is still in the early stages of development. The idea that there may be more diagnostic variations or subtypes is forthcoming, and this will likely pave the way for more client-matching interventions to better serve those individuals who have been repeatedly exposed to multiple, early childhood, and/or interpersonal traumas.

Other Trauma-Related and Co-Occurring Disorders

The symptoms of PTSD and other mental disorders overlap considerably; these disorders often coexist and in clude mood, anxiety, substance use, and personality disorders. Thus, it's common for trauma survivors to be underdiagnosed or misdiagnosed. If they have not been identified as trauma survivors, their psychological distress is often not associated with previous trauma, and/or they are diagnosed with a disorder that marginally matches their presenting symptoms and psychological sequelae of trauma. The following sections present a brief overview of some mental disorders that can result from (or be worsened by) traumatic stress. PTSD is not the only diagnosis related to trauma nor its only psychological consequence; trauma can broadly influence mental and physical health in clients who already have behavioral health disorders.

The term "**co-occurring disorders**" refers to cases when a person has one or more mental disorders as well as one or more substance use disorders (including substance abuse). Co-occurring disorders are common among individuals who have a history of trauma and are seeking help.

Advice to Counselors: Universal Screening and Assessment

Only people specifically trained and licensed in mental health assessment should make diagnoses; trauma can result in complicated cases, and many symptoms can be present, whether or not they meet full diagnostic criteria for a specific disorder. Only a trained assessor can distinguish accurately among various symptoms and in the presence of co-occurring disorders. However, behavioral health professionals without specific assessment training can still serve an important role in screening for possible mental disorders using established screening tools (CSAT, 2005c; see also Chapter 4 of this TIP). In agencies and clinics, it is critical to provide such

screenings systematically—for each client—as PTSD and other co-occurring disorders are typically under diagnosed or misdiagnosed.

People With Mental Disorders

MDD is the most common co-occurring disorder in people who have experienced trauma and are diagnosed with PTSD. A well-established causal relationship exists between stressful events and depression, and a prior history of MDD is predictive of PTSD after exposure to major trauma (Foa et al., 2006).

Many survivors with severe mental disorders function fairly well following trauma, including disasters, as long as essential services aren't interrupted. For others, additional mental health supports may be necessary. For more information, see *Responding to the Needs of People With Serious and Persistent Mental Illness in Times of Major Disaster* (Center for Mental Health Services, 1996).

Co-occurrence is also linked with greater impairment and more severe symptoms of both disorders, and the person is less likely to experience remission of symptoms within 6 months.

Generalized anxiety, obsessive–compulsive, and other anxiety disorders are also associated with PTSD. PTSD may exacerbate anxiety disorder symptoms, but it is also likely that preexisting anxiety symptoms and anxiety disorders increase vulnerability to PTSD. Preexisting anxiety primes survivors for greater hyperarousal and distress. Other disorders, such as personality and somatization disorders, are also associated with trauma, but the history of trauma is often overlooked as a significant factor or necessary target in treatment.

The relationship between PTSD and other disorders is complex. More research is now examining the multiple potential pathways among PTSD and other disorders and how various sequences affect clinical presentation. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c), is valuable in understanding the relationship of substance use to other mental disorders.

People With Substance Use Disorders

There is clearly a correlation between trauma (including individual, group, or mass trauma) and substance use as well as the presence of posttraumatic stress (and other trauma-related disorders) and substance use disorders. Alcohol and drug use can be, for some, an effort to manage traumatic stress and specific PTSD symptoms. Likewise, people with substance use disorders are at higher risk of developing PTSD than people who do not abuse substances. Counselors working with trauma survivors or clients who have substance use disorders have to be particularly aware of the possibility of the other disorder arising.

Co-Occurring PTSD and Other Mental Disorders

- Individuals with PTSD often have at least one additional diagnosis of a mental disorder.
- The presence of other disorders typically worsens and prolongs the course of PTSD and complicates clinical assessment, diagnosis, and treatment.
- The most common co-occurring disorders, in addition to substance use disorders, include mood disorders, various anxiety disorders, eating disorders, and personality disorders.
- Exposure to early, severe, and chronic trauma is linked to more complex symptoms, including impulse control deficits, greater difficulty in emotional regulation and establishing stable relationships, and disruptions in consciousness, memory, identity, and/or perception of the environment (Dom, De, Hulstijn, & Sabbe, 2007; Waldrop, Back, Verduin, & Brady, 2007).
- Certain diagnostic groups and at-risk populations (e.g., people with developmental disabilities, people who are homeless or incarcerated) are more susceptible to trauma exposure and to developing PTSD if exposed but less likely to receive appropriate diagnosis and treatment.

- Given the prevalence of traumatic events in clients who present for substance abuse treatment, counselors should assess all clients for possible trauma-related disorders.

Timeframe: PTSD and the onset of substance use disorders

Knowing whether substance abuse or PTSD came first informs whether a causal relationship exists, but learning this requires thorough assessment of clients and access to complete data on PTSD; substance use, abuse, and dependence; and the onset of each. Much current research focuses solely on the age of onset of substance use (not abuse), so determining causal relationships can be difficult. The relationship between PTSD and substance use disorders is thought to be bidirectional and cyclical: substance use increases trauma risk, and exposure to trauma escalates substance use to manage trauma-related symptoms. Three other causal pathways described by Chilcoat and Breslau's seminal work (1998) further explain the relationship between PTSD and substance use disorders:

1. The "self-medication" hypothesis suggests that clients with PTSD use substances to manage PTSD symptoms (e.g., intrusive memories, physical arousal). Substances such as alcohol, cocaine, barbiturates, opioids, and amphetamines are frequently abused in attempts to relieve or numb emotional pain or to forget the event.
2. The "high-risk" hypothesis states that drug and alcohol use places people who use substances in high-risk situations that increase their chances of being exposed to events that lead to PTSD.
3. The "susceptibility" hypothesis suggests that people who use substances are more susceptible to developing PTSD after exposure to trauma than people who do not. Increased vulnerability may result from failure to develop effective stress management strategies, changes in brain chemistry, or damage to neurophysiological systems due to extensive substance use.

PTSD and substance abuse treatment

PTSD can limit progress in substance abuse recovery, increase the potential for relapse, and complicate a client's ability to achieve success in various life areas. Each disorder can mask or hide the symptoms of the other, and both need to be assessed and treated if the individual is to have a full recovery. There is a risk of misinterpreting trauma-related symptoms in substance abuse treatment settings. For example, avoidance symptoms in an individual with PTSD can be misinterpreted as lack of motivation or unwillingness to engage in substance abuse treatment; a counselor's efforts to address substance abuse–related behaviors in early recovery can likewise provoke an exaggerated response from a trauma survivor who has profound traumatic experiences of being trapped and controlled. Exhibit 1.3-6 lists important facts about PTSD and substance use disorders for counselors.

Case Illustration: Maria

Maria is a 31-year-old woman diagnosed with PTSD and alcohol dependence. From ages 8 to 12, she was sexually abused by an uncle. Maria never told anyone about the abuse for fear that she would not be believed. Her uncle remains close to the family, and Maria still sees him on certain holidays. When she came in for treatment, she described her emotions and thoughts as out of control. Maria often experiences intrusive memories of the abuse, which at times can be vivid and unrelenting. She cannot predict when the thoughts will come; efforts to distract herself from them do not always work. She often drinks in response to these thoughts or his presence, as she has found that alcohol can dull her level of distress. Maria also has difficulty falling asleep and is often awakened by nightmares. She does not usually remember the dreams, but she wakes up feeling frightened and alert and cannot go back to sleep.

Maria tries to avoid family gatherings but often feels pressured to go. Whenever she sees her uncle, she feels intense panic and anger but says she can usually "hold it together" if she avoids him. Afterward, however, she describes being overtaken by these feelings and unable to calm down. She also describes feeling physically ill and shaky. At these times, she often isolates herself, stays in her apartment, and drinks steadily for several days. Maria also reports distress pertaining to her relationship with her boyfriend. In the beginning of their relationship, she found him comforting and enjoyed his affection, but more recently, she has begun to feel anxious and unsettled around him. Maria tries to avoid sex with him, but she sometimes gives in for fear of losing the relationship. She finds it easier to have sex with him when she is drunk, but she often experiences

strong feelings of dread and disgust reminiscent of her abuse. Maria feels guilty and confused about these feelings.

Sleep, PTSD, and substance use

Many people have trouble getting to sleep and/or staying asleep after a traumatic event; consequently, some have a drink or two to help them fall asleep. Unfortunately, any initially helpful effects are likely not only to wane quickly, but also to incur a negative rebound effect. When someone uses a substance before going to bed, "sleep becomes lighter and more easily disrupted," and rapid eye movement sleep (REM) "increases, with an associated increase in dreams and nightmares," as the effects wear off (Auerbach, 2003, p. 1185).

People with alcohol dependence report multiple types of sleep disturbances over time, and it is not unusual for clients to report that they cannot fall asleep without first having a drink. Both REM and slow wave sleep are reduced in clients with alcohol dependence, which is also associated with an increase in the amount of time it takes before sleep occurs, decreased overall sleep time, more nightmares, and reduced sleep efficiency. Sleep during withdrawal is "frequently marked by severe insomnia and sleep fragmentation…a loss of restful sleep and feelings of daytime fatigue. Nightmares and vivid dreams are not uncommon" (Auerbach, 2003, pp. 1185–1186).

Confounding changes in the biology of sleep that occur in clients with PTSD and substance use disorders often add to the problems of recovery. Sleep can fail to return to normal for months or even years after abstinence, and the persistence of sleep disruptions appears related to the likelihood of relapse. Of particular clinical importance is the vicious cycle that can also begin during "slips"; relapse initially improves sleep, but continued drinking leads to sleep disruption. This cycle of initial reduction of an unpleasant symptom, which only ends up exacerbating the process as a whole, can take place for clients with PTSD as well as for clients with substance use disorders. There are effective cognitive–behavioral therapies and nonaddictive pharmacological interventions for sleep difficulties.

Figures

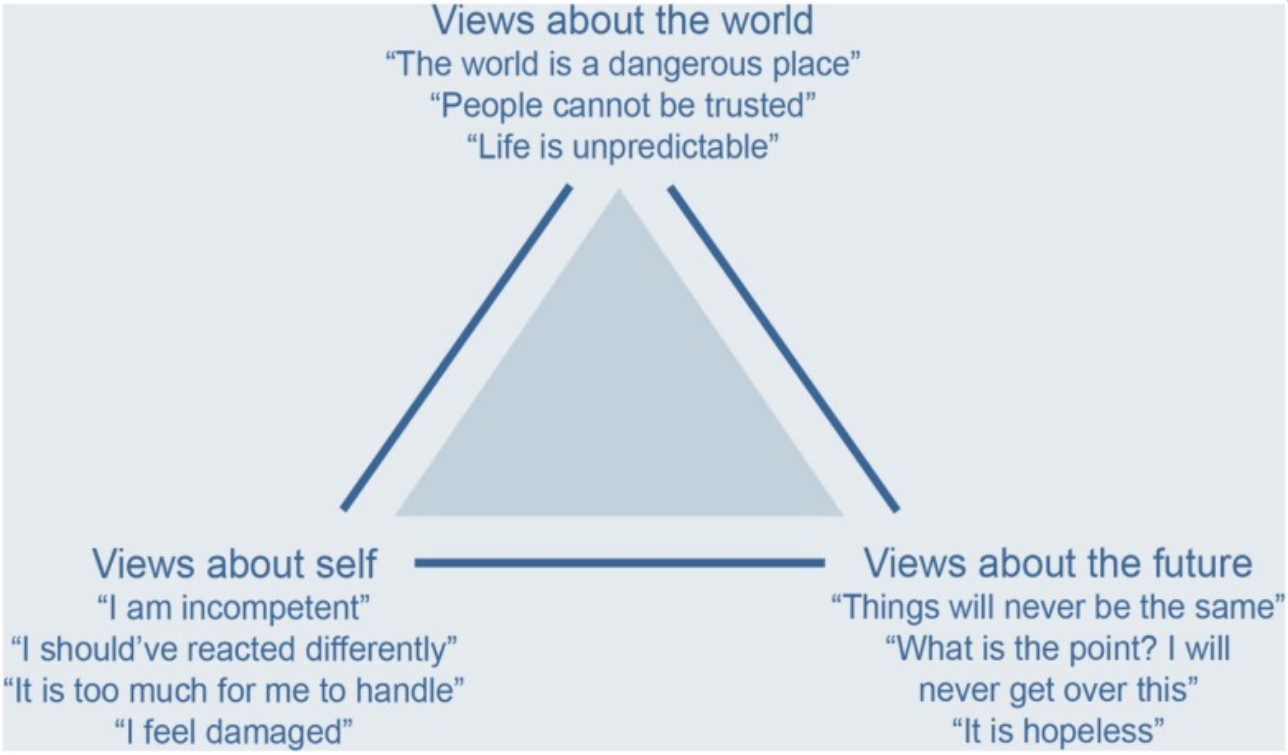


Exhibit 1.3-2 Cognitive Triad of Traumatic Stress

Tables

Exhibit 1.3-1 Immediate and Delayed Reactions to Trauma

Immediate Emotional Reactions Numbness and detachment Anxiety or severe fear Guilt (including survivor guilt) Exhilaration as a result of surviving Anger Sadness Helplessness Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself) Disorientation Feeling out of control Denial Constriction of feelings Feeling overwhelmed	**Delayed Emotional Reactions** Irritability and/or hostility Depression Mood swings, instability Anxiety (e.g., phobia, generalized anxiety) Fear of trauma recurrence Grief reactions Shame Feelings of fragility and/or vulnerability Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
Immediate Physical Reactions Nausea and/or gastrointestinal distress Sweating or shivering Faintness Muscle tremors or uncontrollable shaking Elevated heartbeat, respiration, and blood pressure Extreme fatigue or exhaustion Greater startle responses Depersonalization	**Delayed Physical Reactions** Sleep disturbances, nightmares Somatization (e.g., increased focus on and worry about body aches and pains) Appetite and digestive changes Lowered resistance to colds and infection Persistent fatigue Elevated cortisol levels Hyperarousal Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
Immediate Cognitive Reactions Difficulty concentrating Rumination or racing thoughts (e.g., replaying the traumatic event over and over again) Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes) Memory problems (e.g., not being able to recall important aspects of the trauma) Strong identification with victims	**Delayed Cognitive Reactions** Intrusive memories or flashbacks Reactivation of previous traumatic events Self-blame Preoccupation with event Difficulty making decisions Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma Belief that feelings or memories are dangerous Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day) Suicidal thinking
Immediate Behavioral Reactions Startled reaction Restlessness Sleep and appetite disturbances Difficulty expressing oneself Argumentative behavior Increased use of alcohol, drugs, and tobacco Withdrawal and apathy Avoidant behaviors	**Delayed Behavioral Reactions** Avoidance of event reminders Social relationship disturbances Decreased activity level Engagement in high-risk behaviors Increased use of alcohol and drugs Withdrawal
Immediate Existential Reactions	**Delayed Existential Reactions**

Intense use of prayer Restoration of faith in the goodness of others (e.g., receiving help from others) Loss of self-efficacy Despair about humanity, particularly if the event was intentional Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)	Questioning (e.g., “Why me?”) Increased cynicism, disillusionment Increased self-confidence (e.g., “If I can survive this, I can survive anything”) Loss of purpose Renewed faith Hopelessness Reestablishing priorities Redefining meaning and importance of life Reworking life’s assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)

Sources: Briere & Scott, 2006b; Foa, Stein, & McFarlane, 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011.

Boxes

Exhibit 1.3-3 DSM-5 Diagnostic Criteria for ASD

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). **Note:** This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks), during which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. **Note:** In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms

6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors, such as head injury, alcohol, or drugs).

Avoidance Symptoms

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
9. Efforts to avoid external reminders (e.g., people, places, conversations, activities, objects, situations) that

arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
12. Hypervigilance.
13. Problems with concentration.
14. Exaggerated startle response.

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure. **Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

Source: APA, 2013a, pp. 280–281.

Exhibit 1.3-4 DSM-5 Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled "Posttraumatic Stress Disorder for Children 6 Years and Younger" (APA, 2013a).

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify whether:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Source: APA, 2013a, pp. 271–272.

Exhibit 1.3-5 ICD-10 Diagnostic Criteria for PTSD

A. The patient must have been exposed to a stressful event or situation (either brief or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.

B. There must be persistent remembering or "reliving" of the stressor in intrusive "flashbacks," vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.

D. Either of the following must be present:

   1. Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor.
   2. Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
      a. Difficulty in falling or staying asleep.
      b. Irritability or outbursts of anger.
      c. Difficulty in concentrating.
      d. Exaggerated startle response.

E. Criteria B, C, and D must all be met within 6 months of the stressful event or at the end of a period of stress. (For some purposes, onset delayed more than 6 months can be included, but this should be clearly specified.)

Source: WHO, 1992.

Exhibit 1.3-6 PTSD and Substance Use Disorders: Important Treatment Facts

Profile Severity

- PTSD is one of the most common co-occurring mental disorders found in clients in substance abuse treatment (CSAT, 2005c).
- People in treatment for PTSD tend to abuse a wide range of substances, including opioids, cocaine, marijuana, alcohol, and prescription medications.
- People in treatment for PTSD and substance abuse have a more severe clinical profile than those with just one of these disorders.
- PTSD, with or without major depression, significantly increases risk for suicidality (CSAT, 2009a).

Gender Differences

- Rates of trauma-related disorders are high in men and women in substance abuse treatment.
- Women with PTSD and a substance use disorder most frequently experienced rape or witnessed a killing or injury; men with both disorders typically witnessed a killing or injury or were the victim of sudden injury or accident (Cottler, Nishith, & Compton, 2001).

Risk of Continued Cycle of Violence

- While under the influence of substances, a person is more vulnerable to traumatic events (e.g., automobile crashes, assaults).
- Perpetrators of violent assault often are under the influence of substances or test positive for substances at the time of arrest.

Treatment Complications

- It is important to recognize and help clients understand that becoming abstinent from substances does not resolve PTSD; in fact, some PTSD symptoms become worse with abstinence for some people. Both disorders must be addressed in treatment.
- Treatment outcomes for clients with PTSD and a substance use disorder are worse than for clients with other co-occurring disorders or who only abuse substances (Brown, Read, & Kahler, 2003).

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Violence Prevention

About the CDC-Kaiser ACE Study

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being.

The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors.

More detailed information about the study can be found in the links below or in the article, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults ,".

The ACE Pyramid +

Study Questionnaires +

Data and Statistics +

Major Findings +

Page last reviewed: April 2, 2019

Implementing a Trauma-Informed Approach for Youth across Service Sectors

This brief is based on a webinar, ***Implementing a Trauma-Informed Approach for Youth Across Service Sectors***, held Tuesday, May 21, 2013, 2:00 p.m. to 3:30 p.m. EDT. The webinar was sponsored by the Interagency Working Group on Youth Programs (IWGYP), a collaboration of 18 Federal departments and agencies that support programs and services focusing on youth and promote the goal of positive, healthy outcomes for youth. The webinar was planned jointly by the IWGYP and the Substance Abuse and Mental Health Services Administration (SAMHSA). The webinar slides are housed on the IWGYP website, FindYouthInfo.gov, under the Mental Health Youth Topic. The webinar featured three content experts nationally known in their field: Eugene Griffin, J.D., Ph.D., Northwestern University, Feinberg School of Medicine; Julian Ford, Ph.D., University of Connecticut, School of Medicine; and Charles Wilson, MSSW, Chadwick Center for Children and Families Rady Children's Hospital - San Diego, California; all of whom have been supported by SAMHSA trauma-focused grants. Additionally, the webinar included two youth presenters, NC and LS, who spoke about their own lived experience and the importance of trauma-informed care. Both youth are referred to only by initials to protect their privacy. NC is a peer specialist and LS is a law student.

Introduction

Trauma affects youth in all communities, and responses to those experiences by child-serving systems are critical. It is important for providers serving youth to understand how best to respond and support healing.

Service providers and policymakers in the youth-serving field are continually learning more from research[i] about trauma, traumatic experiences, and the various responses to traumatic events. It is important for youth serving systems to develop a greater understanding of the association between trauma and mental health and substance use disorders, and how it can derail the healthy development of youth. The field recognizes the importance of addressing trauma and using a trauma-informed approach in prevention, treatment, and recovery efforts.

This brief discusses the concept and prevalence of trauma; techniques for coping with, and recovering from trauma at an individual and systems level; the core principles for building a framework for understanding trauma; and implementation of elements essential for a trauma-informed system as presented by the featured experts.

Recognizing the effects of trauma and understanding how to address trauma are fundamental to the Trauma and Justice Strategic Initiative at the Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services (HHS). The focus of SAMHSA's Trauma and Justice Strategic Initiative is on integrating a trauma-informed approach throughout health, behavioral health, and related systems to reduce the harmful effects of trauma and violence on individuals, families, and communities and using innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.

As part of this Initiative, with the help of experts, SAMHSA will be releasing a concept paper outlining a framework for trauma and guidance for developing and implementing a trauma-informed approach.

What Do We Mean by Trauma?

After an introduction by Dr. Larke Huang from the Substance Abuse and Mental Health Services Administration (SAMHSA), Dr. Eugene Griffin provided a framework for understanding trauma.

Trauma is a complex experience that affects youth and the systems that serve them in a variety of ways. The experience of trauma can be described through some common elements: event, experience, and effects, also known as "Three E's."[ii] These elements address the uniqueness of an individual's response to an event and how an event affects one's future behavior and well-being.

An **Event** is objective and measurable. Traumatic events include abuse (physical, emotional, sexual); domestic or community violence; an accident or natural disaster; and war or terrorism.

1. An **Experience** is subjective and difficult to measure because it relates to how someone reacts to an event. It is often thought to be life threatening or physically or emotionally overwhelming, and intensity can vary among people and over time. The way one person experiences an event might differ from the way another person does; culture, gender, and age all influence one's experience of the event. Additionally, people experience events in different ways. Resilience, risk and protective factors, and supports may contribute to this experience.
2. **Effects** are the reactions a person has to an event and the ways an experience changes or alters that person's ongoing and future behavior. Classic symptoms include experiencing hyperarousal, such as overreacting or being hypervigilant; re-experiencing an event as nightmares or flashbacks; and avoiding a situation by having a fight, flight, or freeze reaction. The effects of a traumatic event can have a long-term impact on neurobiological development and contribute to negative physical, hormonal, and chemical changes due to stress responses.

Building on this "Three E's" concept of trauma, SAMHSA frames its concept of trauma as: an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[iii] Researchers[iv] report that traumatic stress occurs when an extreme experience overwhelms and alters an individual's stress-related physiological systems and compromises the functioning of stress-response systems (e.g., neuroimmune, neuroendocrine, autonomic, and central nervous system networks).

"What I found worked best is when I was surrounded by people who really got it, who really understood trauma." — LS

Prevalence of Trauma

Many youth are exposed to traumatic events, including those in the juvenile justice and child welfare systems, as well as those who experience homelessness. Building on the three E's concept, we know that the experience of trauma is complex and particular to each individual's life circumstances, which can make quantifying the extent difficult. Some people experience multiple traumas; for example, a youth who has been separated from his or her family and then experiences assault or abuse in a foster home. As many as half of all children that have been involved with the mental health, child welfare, and juvenile justice systems have experienced multiple traumas.[v] LS and NC, two young people formerly involved with the foster care system, comment in the box above on their experiences with multiple traumas.

"When I was seven years old…my brothers and I were placed in foster care…We were immediately separated, and so I felt like that was probably the first traumatic event that I experienced." — LS

"While I was at my foster home, I had gotten into altercations with my foster brother and before he hit me, I felt scared…" — NC

Coping with and Reactions to Trauma

Dr. Julian Ford provided an overview of strategies for youth, families, and communities to recover from trauma. Recovery from the adverse effects of trauma begins with the recognition that the experience of survival threat caused by traumatic events has caused some major changes in the way a person now copes with stress. These ways of coping are necessary and effective in emergencies such as traumatic events, but they interfere with ordinary day-to-day life. Youth who have experienced trauma may develop coping strategies to help them survive.

Chronic Survival Coping

Trauma affects a youth's relationships, sense of survival, and sense of trust and security with people. The reaction to terrible shock, stressors, challenges, and loss is chronic survival coping. An individual trying to cope or recover from serious challenges and stressors will learn techniques to survive, such as staying on edge; being vigilant, watchful, or even distrustful (hypervigilance); or using indifference to mask hopelessness.

Posttraumatic Survival Coping

Physically, posttraumatic survival coping reflects a change in the body, not just a mental and psychological change. It changes how a person's brain works. The brain helps a person learn, explore, try activities, and experience different ways of living. However, a person cannot experience life freely when trying to survive trauma. Instead, that person must put everything else aside and concentrate only on basic survival needs. Some common survival modes or hypervigilance practices are scanning the environment and being on guard for danger; attempting to block out or not think about upsetting things; being ready to fight or flee; experiencing elevated heart rate and adrenalin rush; and being unable to regulate aggression or use anger management techniques.

"I wish that the people who I was working with in my school were more trauma informed and that they were focused - instead of on the disruptive behavior - on what was causing the disruptive behavior." — LS

Hypervigilance can make it difficult to set and accomplish goals even for the most persistent and high achieving person; all goals are trumped by the larger objective of staying safe. This type of coping can lead to difficulties trusting, including parents, caregivers, friends, teachers, and other adults.

Neurobiological Brain Research

Neuroscience indicates that a person's response to stress and use of coping techniques have three components. Dr. Ford provided a metaphor for understanding these complex brain processes:

- The ***"alarm"*** in the brain tells a person to wake up and pay attention. It also tells the body when there is a crisis and to be ready to react and survive.
- The ***"librarian"*** and ***"search engine"*** file and retrieve memories. When the alarm goes off, the memory filing center pulls information from all parts of the brain to figure out what is going on.
- The ***"computer hard drive"*** is the thinking center where all the information is put together and decisions are made.

If the three above components are working well, the thinking center is activated and a person can handle the stressful situation, not worry about survival, and come up with good ideas and plans for handling the situation, thus the alarm is turned off. However, if the alarm is so strong because of extreme stress (e.g., a threat to survival), it can crash the memory filing center and the hard drive in the brain. At that point, survival coping tactics take over. These activities take place in the part of the brain that helps a person survive and be safe. Operating in survival mode is not the ideal way to live because it leads to difficulty relaxing, trusting, focusing, and handling things appropriately.

Recovery from Trauma

A trauma-informed approach is a framework for providing services that should be integrated into everything that a program and system does. Dr. Ford noted that the goal of recovery from trauma is to tap into an existing strength to reset the brain's alarm to not be in persistent survival mode. Resetting the alarm requires strategies to resume thinking clearly. Evidence-based trauma-informed and trauma-specific therapy programs provide youth and their caregivers with strategies to focus their minds and deal with not feeling safe. Learning the strategies for regulating emotions and controlling anxiety is vital to everyday functioning in society. A trauma-informed approach includes youth and caretakers

in future planning. Trauma takes away control of a person's body or life. Reintroducing some control can tap into resiliency, and planning for the future provides hope.[vi]

Strategies for recovery from trauma include recognizing one's own and others' alarm reactions, sweeping one's mind clear before judging and acting, focusing on what is most important and positive, and being aware of stress and personal control levels. These strategies activate the thinking center and reset the alarm.

Many Paths to Recovery: Evidence-Based Models

- Cognitive-behavioral therapies
- Emotion regulation therapies
- Relational-interpersonal therapies
- Psychotherapies for dissociation
- Parent-child and family system therapies
- Social/helping network therapies
- Peer-to-peer support programs

The webinar presenters acknowledged that there are many paths to recovery and recommended common therapeutic approaches implemented by mental health professionals that can assist individuals who have experienced trauma. It is important to understand that trauma-informed care principles can be implemented by people who are not mental health professionals and work in various systems that provide services for individuals who have experienced trauma.

Trauma at the Systems Level

Mr. Charles Wilson provided a discussion of the child welfare system, and its role in addressing youth and families who have experienced trauma. The experience of trauma is complex and personal, and youth and families who have experienced trauma receive services within a variety of community systems. Providers and systems have the ability to help or potentially re-traumatize. A trauma-informed system aligns interactions among youth-serving agencies, such as the child protection systems, lawyers, juvenile judges, law enforcement, schools, and mental health providers so that they better understand how youth, families, and adults respond to trauma.

A trauma-informed system is not just about raising awareness, but changing behavior, actions, and responses. The approach requires doing things differently so as not to re-traumatize or introduce additional trauma. Systems need to support the natural resiliency of children and youth and assist them in identifying their unique strengths.

In a trauma-informed system, caregivers play a central role in recovery, help promote youth's natural resiliency, and give youth tools for managing stress. A strengths-based approach considers and includes the assistance given to caregivers within the system. This approach considers how the system helps caregivers deal with both current and past traumatic stress. The trauma-informed system assists caregivers understand the significant trauma histories of the children and youth that are in their care. Child welfare workers, mental health therapists, foster parents, juvenile judges, and all those working with children who have experienced significant traumatic events are influenced and touched by the trauma and can experience secondary or vicarious traumatic reactions. Therefore, the trauma-informed system responds to the varying impacts of traumatic stress on children, caregivers, and all those who are in contact with the system. Practitioners take this thinking and awareness about trauma and use it in everyday practice.

"The aftercare team also took a lot of time to do safety planning and future planning with me, and that is important because a lot of young people who experience trauma, they express feelings of hopelessness and they are in a constant state of anxiety, and so their ability to project into the future and plan for the future can be seriously impaired." — LS

Core Principles of a Trauma-Informed Approach

Given the presence of trauma in the lives of many youth and the need for systems and providers to support healing, a trauma-informed approach to providing services is critical. According to SAMHSA's concept of trauma[vii], a program, an organization, or a system that is trauma informed is based on four key assumptions:

- ***Realizes*** the widespread impact of trauma and understands potential paths for recovery.
- ***Recognizes*** the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
- ***Responds*** by fully integrating knowledge about trauma into policies, procedures, practices, and settings.
- ***Resists re-traumatization*** of clients as well as staff***.***

The Chadwick Trauma-Informed Systems Project (CTISP)[viii] National Advisory Committee says that in a trauma-informed child welfare system, all parties recognize and respond to the varying impact of traumatic stress on children, caregivers, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness, and skill into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery.

"I was 13 years old in my first foster home, and I must admit I did not want to be there at first because I was at home with people who I was unfamiliar with…" — NC

SAMHSA's six principles[ix] support a framework for understanding trauma and developing a trauma-informed approach:

- ***Safety:*** Throughout the organization, the staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.
- ***Trustworthiness and transparency:*** Organizational operations and decisions are conducted with transparency and with the goal of building and maintaining trust among clients, family members, staff, and others involved with the organization.
- ***Collaboration and mutuality:*** There is true partnering and leveling of power differences between staff and clients and among organizational staff, from direct care staff to administrators; they recognize that healing happens in relationships and in the meaningful sharing of power and decision making.
- ***Empowerment:*** Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills are developed as needed.
- ***Voice and choice:*** The organization aims to strengthen the experience of choice for clients, family members, and staff and recognizes that every person's experience is unique and requires an individualized approach.
- ***Culture, historical and gender issues:*** The organization incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; are gender-responsive; and incorporate a focus on historical trauma.

These principles underlie the values, beliefs, and attitudes of individuals and organizations offering a trauma-informed approach. Using this approach, organizations foster a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. Trauma-informed organizations build on strengths and assets of clients, staff, and communities instead of responding only to their perceived deficits. They recognize that everyone has a role to play. They address cultural, historical, and gender issues; actively move past cultural stereotypes and biases; offer gender-responsive services; promote the value of cultural connections; and recognize and address historical trauma. In the words of Dr. Ford, "A person does not have to be a therapist to be therapeutic."

Implementation

In his presentation, Mr. Charles Wilson shared the following central elements of providing trauma-informed care within programs, policies, services, and systems as outlined by the child welfare committee of the National Child Traumatic Stress Network. Sources with additional information are provided in the resources section of this brief.

Element 1: Maximize Physical and Psychological Safety for Children and Families

- Safety is a priority. Children and families who have experienced trauma may still feel unsafe even when they are no longer in danger. In addition to ensuring physical safety, it is important to help children and families feel psychologically safe.
- Sometimes even a noise or smell can trigger the feeling of being unsafe and elicit a reaction that a caretaker might not expect or understand. Being aware of and understanding these triggers and changing something seemingly small or insignificant in a daily routine can change behavior from negative to positive.

Element 2: Identify the Trauma-Related Needs of Children

- One of the first steps in helping trauma-exposed children and families is to understand how they have been impacted by trauma.
- Trauma-related needs can be identified through trauma screening and assessment.
- It is important to consider the type(s) of trauma children have experienced when making service referrals and developing service plans. All children need individualized services that are based on their unique circumstances, strengths, and challenges.

"I had reported a child abuse and neglect incident with social services and they did not come and take us out of our home. It was a form of betrayal of trust because you are expecting someone to help you and when that help does not come, then your relationship with the institutions that you need to rely on in order to get out of a bad situation, the relationship is broken." — LS

Element 3: Enhance Child Well-Being and Resilience

- Many children are naturally resilient.
- Systems must recognize and build on children's existing strengths.
- Both individual caseworkers and overall agency policies should support the continuity of children's relationships.
- Staff and agencies should also ensure that children who have been traumatized have access to evidence-based treatments and services.

Element 4: Enhance Family Well-Being and Resilience

- Families are a critical part of both protecting children from harm and enhancing their natural resilience.
- Providing trauma-informed education and services to parents and other caregivers enhances protective capacities.
- Agencies should recognize and assist caregivers to understand the significant trauma histories of the children and youth that are in their care.
- Agencies should assist caregivers to understand their own trauma histories.

"We need to do some self-esteem building and work with young people to acknowledge their strengths. I think when you have experienced trauma, you have a lot of thoughts, beliefs, or feelings of being unworthy or ashamed and you feel a lot of guilt and sometimes that leads to hopelessness. You are not going to work hard to achieve goals if you do not believe you can achieve them, if you do not believe you are worthy of achieving them…" — LS

Element 5: Enhance the Well-Being and Resilience of Those Working in the System

- Staff play important roles in supporting children, but working with people who have experienced abuse, neglect, violence, and other trauma can cause staff to develop secondary traumatic stress reactions.
- Agencies should collect information about trauma and secondary trauma experienced by staff, implement strategies and practices that build resilience and help staff manage stress, and address the impact of secondary traumatic stress on both individuals and on the system as a whole.

> **"The aftercare team was most useful because they worked across the systems…I did not have to do the work that a lot of young people are burdened with, which is finding a way to get our systems to work with one another." — LS**

Element 6: Partner with Youth and Families

- Youth and families should have choices and an active voice in decision making on individual, agency, and systemic levels.
- Youth and family members who have been in the system have a unique perspective and can provide valuable feedback.
- Partnerships with youth and families should occur at all levels.

Element 7: Partner with Agencies and Systems That Interact with Children and Families

- Agencies need to establish strong partnerships with other child- and family-serving systems.
- Service providers should develop common protocols and frameworks.
- Cross-system collaboration enables all helping professionals to see the child as a whole person, thus preventing potentially competing priorities and messages.
- Collaboration between systems promotes cohesive care and better outcomes.

Conclusion

This brief provides an overview of the webinar content as presented by experts in the field regarding the concepts and prevalence of trauma, principles for understanding trauma, and practices for addressing trauma and working with youth who have experienced trauma.

LS and NC, two young people formerly involved with the foster care system, provided much insight on their experiences with multiple traumas. Their shared comments provide important information and practice-based evidence and strategies that child and youth serving systems could incorporate into their work with children and youth who have experienced trauma. Some of the practical applications they described as beneficial to them include:

- Staff working in schools need to be aware of, educated and informed on the effects of trauma for children and youth, and trained in the causes of disruptive behaviors and ways to address these behaviors that do not re-traumatize children and youth;
- Aftercare teams need to provide consistent and ongoing planning with youth to address the after effects of trauma, (e.g., anxiety, sadness, depressions, feelings of hopelessness, anger, shame, guilt) and to build upon their strengths to instill good self-esteem and a belief that they are worthy of and can achieve goals in their life;

- Aftercare teams need to provide ongoing assistance for children and youth to learn skills for daily life, safety planning to address potential re-traumatization, and development of goals for the "here and now" and in their future;
- Aftercare teams need to provide quick response for children and youth who have been traumatized when reports or incidents of child abuse and/or neglect occur. Teams need to remember that these children and youth have been placed in unfamiliar surroundings and they do not feel safe or trust the people or environment immediately. They must rely on the aftercare teams to provide a trusting relationship with staff that will provide safety, protection and security in their lives;
- Aftercare teams need to work across systems to advocate for children and youth who have experienced trauma, and to assist them with the work needed for their daily care and consistent planning for life transitions.

Many strategies for coping with trauma have been noted in this brief, as well as the experiences of LS and NC which can inform child and youth serving systems on the successful practices and strategies that could improve the experience of children and youth who are coping with and healing from trauma. The resources noted below offer a starting point for deeper understanding of trauma and trauma-informed approaches.

Resources

Helping Children and Adolescents Cope with Violence and Disasters: What Community Members Can Do, National Institute of Mental Health, 2013 website information
http://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-violence-and-disasters-community-members/index.shtml

National Child Traumatic Stress Network, Learning Center for Child and Adolescent Trauma, Resources and Training
http://learn.nctsn.org/index.php

National Council for Behavioral Health; Trauma Informed Care
http://www.thenationalcouncil.org/topics/trauma-informed-care/

National Council for Behavioral Health; How to Manage Trauma
http://www.thenationalcouncil.org/wp-content/uploads/2013/05/Trauma-infographic.pdf

Cady, D., & Lulow, E. (2012.) Trauma-Informed Method of Engagement [Flyer]. Washington, DC: National Technical Assistance Center for Children's Mental Health.

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Green, J. G., McLaughlin, K. A., Kessler, R. C., et al. (2010). Childhood adversities and adult psychopathology in the National Comorbidity Survey Replication (NCS-R) III: Associations with functional impairment related to DSM-IV disorders;

McLaughlin, K. A., Green, J. G., Kessler R. C., et al. (2010). Childhood adversity and adult psychiatric disorder in the U.S. National Comorbidity Survey;

Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2009). Collaborative treatment of traumatized children and teens: The Trauma Systems Therapy Approach;

Mollica, R. F. (2006). Healing invisible wounds: Paths to hope and recovery in a violent world.

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SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

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Introduction

Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. ***In order to maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.***

The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.[1,2,3,4,5] Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences.[6,7,8,9] However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical diseases.[1,10,11]

With appropriate supports and intervention, people can overcome traumatic experiences.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.[12,13] Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems.[5,14] Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.[15,16,17]

In addition, the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

Thus, the pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing "business as usual." In public institutions and service systems, there is increasing recognition that many of the individuals have extensive histories of trauma that, left unaddressed, can get in the way of achieving good health and well-being. For example, a child who suffers from maltreatment or neglect in the home may not be able to concentrate on school work and be successful in school; a women victimized by domestic violence may have trouble performing in the work setting; a jail inmate repeatedly exposed to violence on the street may have difficulty refraining from retaliatory violence and re-offending; a sexually abused homeless youth may engage in self-injury and high risk behaviors to cope with the effects of sexual abuse; and, a veteran may use substances to mask the traumatic memories of combat. The experiences of these individuals are compelling and, unfortunately, all too common. Yet, until recently, gaining a better understanding of how to address the trauma experienced by these individuals and how to mitigate the re-traumatizing effect of many of our public institutions and service settings was not an integral part of the work of these systems. Now, however, there is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their "business" under the framework of a trauma-informed approach.

There is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their business under the framework of a trauma-informed approach.

Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach

PURPOSE

The purpose of this paper is to develop a working concept of trauma and a trauma-informed approach and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups. SAMHSA puts forth a framework for the behavioral health specialty sectors, that can be adapted to other sectors such as child welfare, education, criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual's capacity to cope with traumatic experiences. In fact, many people with behavioral health problems receive treatment and services in these non-specialty behavioral health systems. SAMHSA intends this framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families and communities. The desired goal is to build a framework that helps systems "talk" to each other, to understand better the connections between trauma and behavioral health issues, and to guide systems to become trauma-informed.

APPROACH

SAMHSA approached this task by integrating three significant threads of work: trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors

of traumatic experiences who have had involvement in multiple service sectors. It was expected that this blending of the research, practice and survivor knowledge would generate a framework for improving the capacity of our service systems and public institutions to better address the trauma-related issues of their constituents.

To begin this work, SAMHSA conducted an environmental scan of trauma definitions and models of trauma informed care. SAMHSA convened a group of national experts who had done extensive work in this area. This included trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of trauma-specific interventions; and policymakers in the field of behavioral health.

From this meeting, SAMHSA developed a working document summarizing the discussions among these experts. The document was then vetted among federal agencies that conduct work in the field of trauma. Simultaneously, it was placed on a SAMHSA website for public comment. Federal agency experts provided rich comments and suggestions; the public comment site drew just over 2,000 respondents and 20,000 comments or endorsements of others' comments. SAMHSA reviewed all of these comments, made revisions to the document and developed the framework and guidance presented in this paper.

The key questions addressed in this paper are:

- **What do we mean by trauma?**
- **What do we mean by a trauma-informed approach?**
- **What are the key principles of a trauma-informed approach?**
- **What is the suggested guidance for implementing a trauma-informed approach?**
- **How do we understand trauma in the context of community?**

SAMHSA's approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA's trauma-focused grants and initiatives, such as SAMHSA's National Child Traumatic Stress Initiative, SAMHSA's National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA's: Jail Diversion Trauma Recovery grant program; Children's Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Reentry and Adult Treatment Drug Court Programs.

Background: Trauma — Where We Are and How We Got Here

The concept of traumatic stress emerged in the field of mental health at least four decades ago. Over the last 20 years, SAMHSA has been a leader in recognizing the need to address trauma as a fundamental obligation for public mental health and substance abuse service delivery and has supported the development and promulgation of trauma-informed systems of care. In 1994, SAMHSA convened the Dare to Vision Conference, an event designed to bring trauma to the foreground and the first national conference in which women trauma survivors talked about their experiences and ways in which standard practices in hospitals re-traumatized and often, triggered memories of previous abuse. In 1998, SAMHSA funded the Women, Co-Occurring Disorders and Violence Study to generate knowledge on the development and evaluation of integrated services approaches for women with co-occurring mental and substance use disorders who also had histories of physical and or sexual abuse. In 2001, SAMHSA funded the National Child Traumatic Stress Initiative to increase understanding of child trauma and develop effective interventions for children exposed to different types of traumatic events.

The American Psychiatric Association (APA) played an important role in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the recently released DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970's.[18,19,20,21] National trauma research and practice centers have conducted significant work in the past few decades, further refining the concept of trauma, and developing effective trauma assessments and treatments.[22,23,24,25] With the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.[3,25]

Simultaneously, an emerging trauma survivors movement has provided another perspective on the understanding of traumatic experiences. Trauma survivors, that is, people with lived experience of trauma, have powerfully and systematically documented their paths to recovery.[26] Traumatic experiences complicate a child's or an adult's capacity to make sense of their lives and to create meaningful consistent relationships in their families and communities.

Trauma survivors have powerfully and systematically documented their paths to recovery.

The convergence of the trauma survivor's perspective with research and clinical work has underscored the central role of traumatic experiences in the lives of people with mental and substance use conditions. The connection between trauma and these conditions offers a potential explanatory model for what has happened to individuals, both children and adults, who come to the attention of the behavioral health and other service systems.[25,27]

People with traumatic experiences, however, do not show up only in behavioral health systems. Responses to these experiences often manifest in behaviors or conditions that result in involvement with the child welfare and the criminal and juvenile justice system or in difficulties in the education, employment or primary care system. Recently, there has also been a focus on individuals in the military and increasing rates of posttraumatic stress disorders.[28,29,30,31]

With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed. Federal research agencies, academic institutions and practice-research partnerships have generated empirically-supported interventions. In SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) alone there are over 15 interventions focusing on the treatment or screening for trauma.

These interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough. Building on lessons learned from SAMHSA's Women, Co-Occurring Disorders and Violence Study; SAMHSA's National Child Traumatic Stress Network; and SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions in which services are provided played a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served. SAMHSA's National Center for Trauma-Informed Care has continued to advance this effort, starting first in the behavioral health sector, but increasingly responding to technical assistance requests for organizational change in the criminal justice, education, and primary care sectors.

FEDERAL, STATE AND LOCAL LEVEL TRAUMA-FOCUSED ACTIVITIES

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

States are elevating a focus on trauma. For example, Oregon Health Authority is looking at different types of trauma across the age span and different population groups. Maine's "Thrive Initiative" incorporates a trauma-informed care focus in their children's systems of care. New York is introducing a trauma-informed initiative in the juvenile justice system. Missouri is exploring a trauma-informed approach for their adult mental health system. In Massachusetts, the Child Trauma Project is focused on taking trauma-informed care statewide in child welfare practice. In Connecticut the Child Health and Development Institute with the state Department of Children and Families is building a trauma-informed system of care throughout the state through policy and workforce development. SAMHSA has supported the further development of trauma-informed approaches through its Mental Health Transformation Grant program directed to State and local governments.

Increasing examples of local level efforts are being documented. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the wellbeing of the community. The Family Policy Council in Washington State convened groups to focus on the impact of adverse childhood experiences on the health and well-being of its local communities and tribal communities. Philadelphia held a summit to further its understanding of the impact of trauma and violence on the psychological and physical health of its communities.

SAMHSA continues its support of grant programs that specifically address trauma.

At the federal level, SAMHSA continues its support of grant programs that specifically address trauma and technical assistance centers that focus on prevention, treatment and recovery from trauma.

Other federal agencies have increased their focus on trauma. The Administration on Children Youth and Families (ACYF) has focused on the complex trauma of children in the child welfare system and how screening and assessing for severity of trauma and linkage with trauma treatments can contribute to improved well-being for these youth. In a joint effort among ACYF, SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the three agencies developed and issued through the CMS State Directors' mechanism, a letter to all State Child Welfare Administrators, Mental Health Commissioners, Single State Agency Directors for Substance Abuse and State Medicaid Directors discussing trauma, its impact on children, screening, assessment and treatment interventions and strategies for paying for such care. The Office of Juvenile Justice and Delinquency Prevention has specific recommendations to address trauma in their Children Exposed to Violence Initiative. The Office of Women's Health has developed a curriculum to train providers in primary care on how to address trauma issues in health care for women. The Department of Labor is examining trauma and the workplace through a federal interagency workgroup. The Department of Defense is honing in on prevention of sexual violence and trauma in the military.

As multiple federal agencies representing varied sectors have recognized the impact of traumatic experiences on the children, adults, and families they serve, they have requested collaboration with SAMHSA in addressing these issues. The widespread recognition of the impact of trauma and the burgeoning interest in developing capacity to respond through trauma-informed approaches compelled SAMHSA to revisit its conceptual framework and approach to trauma, as well as its applicability not only to behavioral health but also to other related fields.

SAMHSA's Concept of Trauma

Decades of work in the field of trauma have generated multiple definitions of trauma. Combing through this work, SAMHSA developed an inventory of trauma definitions and recognized that there were subtle nuances and differences in these definitions.

Desiring a concept that could be shared among its constituencies — practitioners, researchers, and trauma survivors, SAMHSA turned to its expert panel to help craft a concept that would be relevant to public health agencies and service systems. SAMHSA aims to provide a viable framework that can be used to support people receiving services, communities, and stakeholders in the work they do. A review of the existing definitions and discussions of the expert panel generated the following concept:

> ***Individual trauma results from an* event*, series of events, or set of circumstances that is* experienced *by an individual as physically or emotionally harmful or life threatening and that has lasting adverse* effects *on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.***

THE THREE "E'S" OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as "trauma and stressor-related disorders" to include exposure to a traumatic or stressful event as a diagnostic criterion.

The individual's **experience** of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one's country differently from another refugee; one military veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of "why me?" The individual's experience of these events or circumstances is shaped in the context of this powerlessness and questioning. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When a person experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal, shattering a person's trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

How the event is experienced may be linked to a range of factors including the individual's cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure), or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty).[1]

The long-lasting adverse **effects** of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one's neurobiological make-up and ongoing health and well-being. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.[1,3] Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

SAMHSA's Trauma-Informed Approach: Key Assumptions and Principles

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to influence how service systems conduct their business.

The context in which trauma is addressed or treatments deployed contributes to the outcomes for the trauma survivors, the people receiving services, and the individuals staffing the systems. Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.[22,32,33] SAMHSA's concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles.

A program, organization, or system that is trauma-informed* realizes *the widespread impact of trauma and understands potential paths for recovery;* recognizes *the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and* responds *by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively* resist re-traumatization*.

A trauma informed approach is distinct from trauma-specific services or trauma systems. A trauma informed approach is inclusive of trauma-specific interventions, whether assessment, treatment or recovery supports, yet it also incorporates key trauma principles into the organizational culture.

Referred to variably as "trauma-informed care" or "trauma-informed approach" this framework is regarded as essential to the context of care.

THE FOUR "R'S: KEY ASSUMPTIONS IN A TRAUMA-INFORMED APPROACH

In a trauma-informed approach, all people at all levels of the organization or system have a basic **realization** about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People's experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional).There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in prevention, treatment, and recovery settings. Similarly, there is a realization that trauma is not confined to the behavioral health specialty service sector, but is integral to other systems (e.g., child welfare, criminal justice, primary health care, peer–run and community organizations) and is often a barrier to effective outcomes in those systems as well.

People in the organization or system are also able to **recognize** the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

The program, organization, or system **responds** by applying the principles of a trauma-informed approach to all areas of functioning. The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma practices. Policies of the organization, such as mission statements, staff handbooks and manuals promote a culture based on beliefs about resilience, recovery, and healing from trauma. For instance, the agency's mission may include an intentional statement on the organization's commitment to promote trauma recovery; agency policies demonstrate a commitment to incorporating perspectives of people served through the establishment of client advisory boards or inclusion of people who have received services on the agency's board of directors; or agency training includes resources for mentoring supervisors on helping staff address secondary traumatic stress. The organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes trust, fairness and transparency. The program's, organization's, or system's response involves a universal precautions approach in which one expects the presence of trauma in lives of individuals being served, ensuring not to replicate it.

A trauma-informed approach seeks to **resist re-traumatization** of clients as well as staff. Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission.[27] Staff who work within a trauma-informed environment are taught to recognize how organizational practices may trigger painful memories and re-traumatize clients with trauma histories. For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

1. **Safety**
2. **Trustworthiness and Transparency**
3. **Peer Support**
4. **Collaboration and Mutuality**
5. **Empowerment, Voice and Choice**
6. **Cultural, Historical, and Gender Issues**

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

The six key principles fundamental to a trauma-informed approach include:[24,36]

1. **Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. **Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.

3. **Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term "Peers" refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as "trauma survivors."

4. **Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: "one does not have to be a therapist to be therapeutic."[12]

5. **Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.[34] Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.

6. **Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Guidance for Implementing a Trauma-Informed Approach

Developing a trauma-informed approach requires change at multiples levels of an organization and systematic alignment with the six key principles described above. The guidance provided here builds upon the work of Harris and Fallot and in conjunction with the key principles, provides a starting point for developing an organizational trauma-informed approach.[20] While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives. Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a "checklist" or a prescriptive step-by-step process. These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care.[35,36,37,38] What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content.

TEN IMPLEMENTATION DOMAINS

1. **Governance and Leadership**
2. **Policy**
3. **Physical Environment**
4. **Engagement and Involvement**
5. **Cross Sector Collaboration**
6. **Screening, Assessment, Treatment Services**
7. **Training and Workforce Development**
8. **Progress Monitoring and Quality Assurance**
9. **Financing**
10. **Evaluation**

GOVERNANCE AND LEADERSHIP: The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within the organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

POLICY: There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be "hard-wired" into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

PHYSICAL ENVIRONMENT OF THE ORGANIZATION: The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of a trauma informed approach through openness, transparency, and shared spaces.

ENGAGEMENT AND INVOLVEMENT OF PEOPLE IN RECOVERY, TRAUMA SURVIVORS, PEOPLE RECEIVING SERVICES, AND FAMILY MEMBERS RECEIVING SERVICES: These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach that differentiates it from the usual approaches to services and care.

CROSS SECTOR COLLABORATION: Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization's mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

SCREENING, ASSESSMENT, AND TREATMENT SERVICES: Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach. Trauma screening and assessment are an essential part of the work. Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

TRAINING AND WORKFORCE DEVELOPMENT: On-going training on trauma and peer-support are essential. The organization's human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals with complex trauma.

PROGRESS MONITORING AND QUALITY ASSURANCE: There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments and treatment.

FINANCING: Financing structures are designed to support a trauma-informed approach which includes resources for: staff training on trauma, key principles of a trauma-informed approach; development of appropriate and safe facilities; establishment of peer-support; provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and development of trauma-informed cross-agency collaborations.

EVALUATION: Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

To further guide implementation, the chart on the next page provides sample questions in each of the ten domains to stimulate change-focused discussion. The questions address examples of the work to be done in any particular domain yet also reflect the six key principles of a trauma-informed approach. Many of these questions and concepts were adapted from the work of Fallot and Harris, Henry, Black-Pond, Richardson, & Vandervort, Hummer and Dollard, and Penney and Cave.[39, 40, 41,42]

While the language in the chart may seem more familiar to behavioral health settings, organizations across systems are encouraged to adapt the sample questions to best fit the needs of the agency, staff, and individuals being served. For example, a juvenile justice agency may want to ask how it would incorporate the principle of safety when examining its physical environment. A primary care setting may explore how it can use empowerment, voice, and choice when developing policies and procedures to provide trauma-informed services (e.g. explaining step by step a potentially invasive procedure to a patient at an OBGYN office).

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

KEY PRINCIPLES					
Safety	**Trustworthiness and Transparency**	**Peer Support**	**Collaboration and Mutuality**	**Empowerment, Voice, and Choice**	**Cultural, Historical, and Gender Issues**
10 IMPLEMENTATION DOMAINS					
Governance and Leadership	• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? • How do the agency's mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? • How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?				
Policy	• How do the agency's written policies and procedures include a focus on trauma and issues of safety and confidentiality? • How do the agency's written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery? • How do the agency's staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training? • How do human resources policies attend to the impact of working with people who have experienced trauma? • What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?				

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Physical Environment	• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? • In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this? • How has the agency provided space that both staff and people receiving services can use to practice self-care? • How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).
Engagement and Involvement	• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services? • How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information? • How is transparency and trust among staff and clients promoted? • What strategies are used to reduce the sense of power differentials among staff and clients? • How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
Cross Sector Collaboration	• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions? • Are collaborative partners trauma-informed? • How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services? • What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?
Screening, Assessment, Treatment Services	• Is an individual's own definition of emotional safety included in treatment plans? • Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? • Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? • How are peer supports integrated into the service delivery approach? • How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women? • Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding? • How are these trauma-specific practices incorporated into the organization's ongoing operations?

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH *(continued)*

10 IMPLEMENTATION DOMAINS *continued*	
Training and Workforce Development	• How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences? • How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? • How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? • How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety? • How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors. • What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? • What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?
Progress Monitoring and Quality Assurance	• Is there a system in place that monitors the agency's progress in being trauma-informed? • Does the agency solicit feedback from both staff and individuals receiving services? • What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency? • How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes? • What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?
Financing	• How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? • What funding exists for cross-sector training on trauma and trauma-informed approaches? • What funding exists for peer specialists? • How does the budget support provision of a safe physical environment?
Evaluation	• How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach? • How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? • What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality? • What measures or indicators are used to assess the organizational progress in becoming trauma-informed?

Next Steps: Trauma in the Context of Community

Delving into the work on community trauma is beyond the scope of this document and will be done in the next phase of this work. However, recognizing that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process.

Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.

Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not. The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

Conclusion

As the concept of a trauma-informed approach has become a central focus in multiple service sectors, SAMHSA desires to promote a shared understanding of this concept. The working definitions, key principles, and guidance presented in this document represent a beginning step toward clarifying the meaning of this concept. This document builds upon the extensive work of researchers, practitioners, policymakers, and people with lived experience in the field. A standard, unified working concept will serve to advance the understanding of trauma and a trauma-informed approach for public institutions and service sectors.

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Trauma-informed care in child/family welfare services

Liz Wall, Daryl Higgins and Cathryn Hunter

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This paper aims to define and clarify what trauma-informed service delivery means in the context of delivering child/family welfare services in Australia. Exposure to traumatic life events such as child abuse, neglect and domestic violence is a driver of service need. Policies and service providers must respond appropriately to people who are dealing with trauma and its effects in order to ensure best outcomes for individuals and families using these services. In addition to evidence-based programs or clinical interventions that are specific to addressing trauma symptoms, such as trauma-focused cognitive behaviour therapy, there is a need for broader organisational- or service-level systems of care that respond to the needs of clients with a lived experience of trauma that go beyond a clinical response. Some of the challenges identified in implementing and embedding trauma-informed care across services and systems are discussed.

KEY MESSAGES

- Traumatic experiences are common, with people often having multiple adverse experiences across their life. There are many serious and deleterious outcomes associated with exposure to them.
- Clients often present to child/family welfare services with a complex range of symptoms and behaviours related to prior and/or past trauma, which neither they nor those working with them have linked to this previous trauma exposure. As a result they may face an uninformed and fragmented response that is potentially re-traumatising.
- There are a small number of trauma-specific interventions that have been evaluated using a rigorous scientific standard and been shown to be effective—however, the research is often based on populations who have experienced a single traumatic event rather than complex trauma.
- Trauma-informed care is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.
- With the lack of an overarching framework in Australia, there is a danger of inconsistent or piecemeal development of trauma-informed models and practices that do not share a consistent language or framework for implementing trauma-informed systems of care in child/family services.
- As trauma affects a large proportion of the population, survivors are clients in a broad range of human services, and organisations across all settings should consider how a trauma-informed approach could benefit stakeholders, regardless of whether or not the organisation also provides evidence-based trauma-specific interventions.
- Challenges to implementing a trauma-informed approach to care include: a lack of clearly articulated definitions (e.g. of trauma-specific interventions vs the concept and principles of trauma-informed care); translating trauma-informed care to specific practice and service settings; consistency across service settings and systems; care-coordination; a lack of guidance for facilitating complex system change; and a lack of evaluation of models of trauma-informed care.
- Research is needed to explore whether different trauma-informed approaches are required for different population groups, including children, adolescents and adults, or for males and females.

Understanding the experiences of adversity in childhood such as sexual or other abuse as trauma is now recognised to be an important concept for human service delivery sectors. The USA has led efforts to incorporate trauma theory into mental health and other service delivery, largely driven by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA funds two major trauma-related resources, the National Center for Trauma-Informed Care (NCTIC) and the National Child Traumatic Stress Initiative (NCTSI), to provide a focus for developing a shared language and evidence base around trauma and trauma-informed approaches to service. Emerging

efforts in Australia are now contributing to our knowledge of effective practice for children, young people and adults who have experienced trauma from events such as child maltreatment, sexual assault, military service, forced adoption and past family separation practices.

This paper aims to define and clarify what trauma-informed service delivery means in an Australian context. Australia is not as far down the track as the USA in terms of implementing a trauma-informed approach to human service provision in systems such as mental health and child and family services. There is, however, a recognition that exposure to traumatic life events is a driver of service need and that policies and service providers must address and respond to trauma appropriately to ensure best outcomes for individuals and families using these services.

Trauma terminology

There has been extensive debate around the classification and terminology for describing the effects of trauma, as well as the relationship to specific diagnostic terms such as post-traumatic stress disorder (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005; Wall & Quadara, 2014). The latest iteration of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), an international classification system for mental health disorders, has taken a broad approach to the terminology with a category of "Trauma and Stressor Related Disorders" rather than specifically including complex trauma as a diagnostic term.

Any discussion of trauma-informed service delivery requires consideration of the vast array of definitions and terminology that arises around trauma. This section explains some of the different terms, phrases and concepts that are used in the literature to describe trauma and trauma-related service provision.

Recently, there have been attempts to provide consistency in definitions and a shared language around trauma and a trauma-informed approach to care. SAMHSA's (2014) *Concept of Trauma and Guidance for a Trauma-Informed Approach* puts forward definitions and a working concept of trauma and a trauma-informed approach in order to develop a shared understanding of these concepts for service systems and stakeholders. SAMHSA is a key resource for trauma-informed approaches to care and these definitions are likely to be widely adopted.

What is trauma?

Traumatic events have been described as those that "overwhelm the ordinary human adaptations to life [and] … generally involve threats to life or bodily integrity, or a close personal encounter with violence and death" (Herman, 1992, p. 33). SAMHSA's concept of trauma provides a comprehensive definition that encompasses trauma related to one-off events as well as ongoing adversity:

> Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing. (SAMHSA, 2014, p. 7)

Although not diagnostic terms, *complex trauma* and *complex post-traumatic stress disorder* are often used to describe trauma that is the result of stressors that are interpersonal—usually severe, sustained and perpetrated by one human being on another—and where clients may not meet all of the specific diagnostic criteria for post-traumatic stress disorder (PTSD) or where the primary clinical presentation is the associated features due to the global effects of trauma on the person's functioning (Connor & Higgins, 2008a, 2008b). Trauma is particularly damaging when it occurs in childhood. Complex, interpersonally generated trauma is severely disruptive of a person's capacity to manage internal states (Kezelman & Stavropoulos, 2012). Complex trauma symptoms include problems with mood regulation, impulse control, self-perception, attention, memory and somatic disorders (Briere & Jordan, 2004; Burstow, 2003; van der Kolk et al., 2005).

Trauma-informed interventions occur at two levels: trauma-specific interventions and trauma-informed models of care. Organisational responses to trauma tend to occur on a continuum from basic trauma awareness, to trauma sensitivity, trauma responsivity and through to trauma-informed and/or trauma-specific interventions. We argue here that it is helpful for organisations providing services in the child/family welfare domain, and human services more broadly, to think about their organisational responses to trauma based on their particular service and client needs.

Trauma-specific interventions

Trauma-specific interventions refer to clinical services or programs designed to treat and ameliorate the actual symptoms and presentations of trauma. While it is possible for individual practitioners to deliver trauma-specific interventions (such as trauma-focused cognitive behaviour therapy [CBT]) within the context of a service delivery model or agency that is not trauma-informed at a system level, this is far from ideal. Elements of a service may not be consistent with a trauma-informed approach—such as the waiting room design and operation, interactions with administrative staff or the absence of adjunct services to address other presenting issues for which the trauma-specific intervention might not be effective. Trauma-specific services are best delivered as part of a trauma-informed system of care operating within a trauma-aware organisational context (Elliot, Bjelajac, Fallor, Markoff, & Reed, 2005; Kezelman & Stavropoulos, 2012).

Funded by the Department of Veterans' Affairs, Phoenix Australia (previously known at the Australian Centre for Posttraumatic Mental Health) has developed a database that summarises the evidence for effective trauma-specific interventions related to military and veteran families and communities (see *What Emerging Interventions are Effective for the Treatment of Adults with PTSD?* <www.evidencecompass.dva.gov.au/home/question/10>). Regarding adults suffering from PTSD, they found a paucity of evidence in relation to the efficacy of emerging therapies.[1] Phoenix Australia have also published a variety of resources for practitioners working with people affected by trauma, including fact sheets, clinical guidelines, booklets for clients and a smartphone app for clients with post-traumatic stress symptoms <phoenixaustralia.org/for-practitioners/practitioner-resources>.

Trauma-focused cognitive behaviour therapy (TF-CBT) is an evidence-based treatment approach for children who have experienced sexual abuse, exposure to domestic violence or similar traumas.[2] TF-CBT features on a range of databases of evidence-based practices, including the California Evidence-Based Clearinghouse for Child Welfare (CEBC) Program Registry: <www.cebc4cw.org>. Training in TF-CBT is available online from the Medical University of South Carolina website: <tfcbt.musc.edu>. However, a full discussion of evidence-based trauma-specific interventions is beyond the scope of this paper.[3]

Similarly, in relation to adults affected by childhood trauma, Connor and Higgins (2008a, 2008b) outlined a model of trauma-specific intervention for clients who experience complex trauma (who may not meet the criteria for PTSD). Evaluating the model, they found qualitative and quantitative evidence from a small-scale pilot study of the effectiveness of their combined individual and group therapy approach focused on the following elements (using the mnemonic "HEALTH"):

- having a supportive therapist;
- ensuring personal safety;
- assisting with daily functioning;
- learning to manage core PTSD symptoms (self-regulation);
- treating complex PTSD symptoms; and
- having patience and persistence to enable "ego strengthening".

1 The emerging interventions included in their review were: mindfulness, acceptance and commitment therapy, meditation, transcendental meditation, acupuncture, power therapies, and experiential psychotherapies including adventure therapy, art therapy, music therapy, and canine- and equine-assisted psychotherapy. See: <evidencecompass.dva.gov.au/home/question/10>.

2 See: *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma* (Child Welfare Information Gateway, 2012) <www.childwelfare.gov/pubpdfs/trauma.pdf>.

3 See *Approaches Targeting Outcomes for Children Exposed to Trauma Arising From Abuse and Neglect: Evidence, Practice and Implications* (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2014) for a discussion of the evidence of the effectiveness of trauma-specific and trauma-informed practices pertaining specifically to children who have experienced abuse and neglect.

However, there have been criticisms made of trauma-specific interventions. For example:

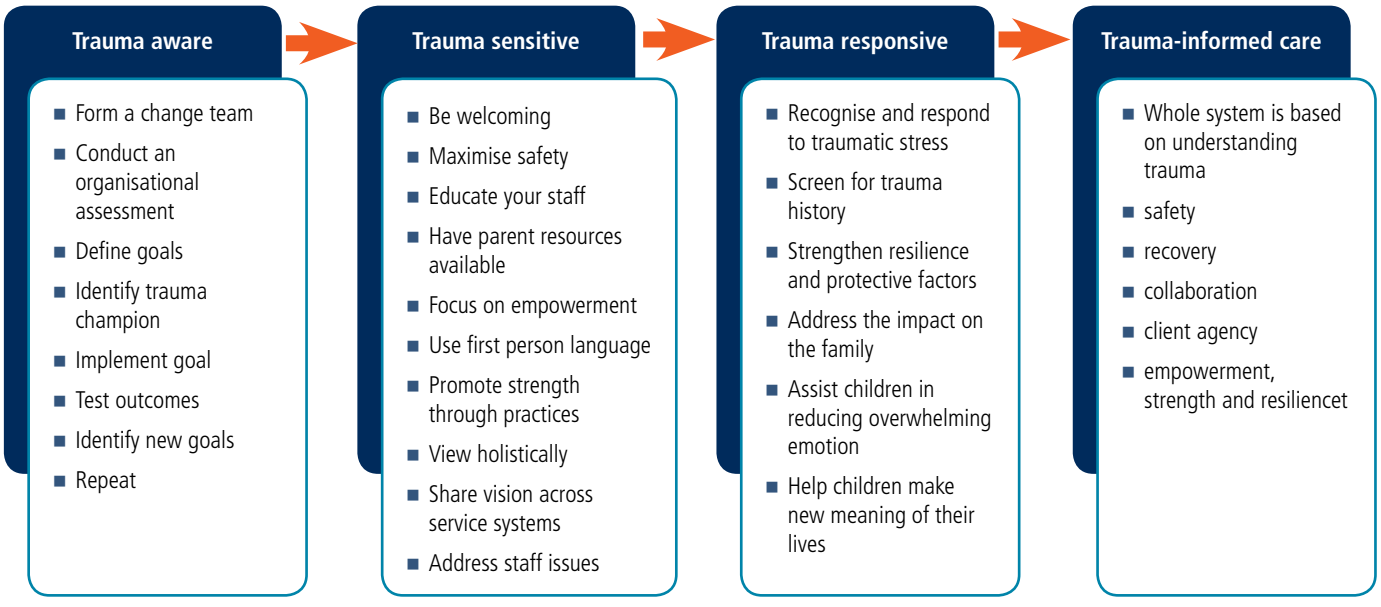
- complex trauma is often inter-relational in nature, so the degree to which research on the treatment of combat-related PSTD applies in these circumstances has been questioned (e.g. for those exposed to prolonged child sexual abuse, particularly if it has resulted in personality or dissociative disorders and is associated with disturbances to affect regulation, self-concept and interpersonal relationships);
- treatment sessions may need to be more frequent and over a longer duration than typical structured programs;
- evaluations of cognitive-based interventions often focus on statistically significant effect sizes rather than clinically meaningful symptom reduction; and
- the value of non-cognitively based interventions, which have been poorly evaluated or not evaluated, are easily overlooked (see: van der Kolk, 2014).

The primary purpose of the paper is not to review the effectiveness—or limitations—of trauma-specific interventions, or even to look specifically at complex trauma and complex PTSD (see: Wall & Quadara, 2014); but rather to explore the broader issue of the value and role of trauma-informed care in child and family welfare service provision.

Trauma-informed model of care

The available literature suggests that there is a continuum from being *trauma aware* (seeking information out about trauma and its implications for organisations) to being *trauma-informed* (a cultural shift at the systemic level). One useful resource sets out the progression in four stages (see Figure 1):

- *trauma aware*: seek information out about trauma;[4]
- *trauma sensitive*: operationalise concepts of trauma within the organisation's work practice;
- *trauma responsive*: respond differently, making changes in behaviour;
- *trauma informed*: entire culture has shifted to reflect a trauma approach in all work practices and settings.



Source: Adapted by Antonia Quadara from Mieseler & Myers (2013)

Figure 1: Practical steps to get from trauma aware to trauma informed

4 At its most basic level, organisations that are trauma aware incorporate trauma awareness into their work. Staff have an understanding of trauma and how symptoms and behavioural presentations in individuals may be responses to traumatic experiences so that behaviours that appear self-destructive or self-defeating can be acknowledged as being adaptive behaviours to trauma that have become maladaptive over time (Hopper, Bassuk, & Olivet, 2010; Markoff, Fallot, Reed, & Elliot, 2005). This applies particularly to broader human service delivery agencies (beyond child/family welfare), particularly if they are not primarily focused on delivering trauma-specific interventions and/or trauma-informed models of care.

SAMHSA's definition of a trauma-informed approach to service is:

> A program, organisation or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff and others involved with the system and responds by fully integrating knowledge about trauma into policies, procedures and practices and seeks to actively resist retraumatisation (SAMHSA, 2014, p. 9)

The main aim of this paper is to explore trauma-informed approaches to care and service delivery specifically in the child and family welfare sectors. While the focus is on how child/family welfare services can be trauma informed, the need extends to other service delivery areas. The trauma literature indicates that trauma survivors are clients in a very broad range of human services such as:

- homelessness (Hopper et al., 2010; Morrison 2009);
- mental health (Kezelman & Stavropoulos, 2012; Muskett, 2014);
- substance abuse treatment; and
- correctional systems (Stathopoulos, 2012).

These types of services have a clear connection to the impacts of trauma, particularly trauma arising from interpersonal victimisation, which has been identified as a driver of human service use (Huntington, Moses, & Veysey, 2005). The term "complex needs" is sometimes used to describe the span of need for an array of services required over a lifetime (Wall & Quadara, 2014). These agencies and services would benefit from being—at a minimum—"trauma aware".

What is the evidence that a trauma-informed approach is needed?

Research suggests that exposure to adverse, potentially traumatic events in childhood is not uncommon (Anda et al., 2006). For example, the Adverse Childhood Experiences (ACE) study in the USA showed that of 17,337 respondents, 64% had experienced at least one adverse experience[5] and approximately 12% had experienced four or more in the first 18 years of life (Anda et al., 2006). Further to this, a recent report suggested that childhood trauma affects an estimated five million Australian adults (Kezelman, Hossack, Stavropoulos, & Burley, 2015). There is also a great deal of evidence associating traumatic experiences with a broad range of deleterious outcomes in childhood, adolescence and adulthood (e.g. Anda et al., 2006; CFCA, 2014a, 2014b; Dube et al., 2001; Hahn Fox, Perez, Cass, Baglivio, & Epps, 2015; Johnson-Reid, Kohl, & Drake, 2012; Nurius, Green, Logan-Greene, & Borja, 2015).

Individual responses to traumatic experiences vary widely, with not all exposure leading to negative outcomes. It is the individual response to the experience that determines whether it is considered traumatic or not (SAMHSA, 2014). If effects occur they can be short- or long-term and may occur immediately following exposure to adversity or have a delayed onset (SAMHSA, 2014).

Multiple studies have reported negative effects associated with experiencing trauma across all facets of life. Mental ill-health, physical illness, social and relational difficulties, and poor academic and employment outcomes have all been linked to previous traumatic experiences. Anda and colleagues (2006) found a strong relationship between increased numbers of adverse childhood experiences and increased prevalence and risk of:

- affective disturbances (e.g. panic attacks, anxiety, hallucinations);
- somatic disturbances (e.g. sleep disturbance, severe obesity);
- smoking, illicit drug use, injected drug use, alcoholism (for people with four or more adverse childhood experiences);
- early intercourse, promiscuity and sexual dissatisfaction;
- impaired memory of childhood; and

5 The adverse childhood experiences measured were three types of childhood abuse: emotional abuse, physical abuse, and contact sexual abuse; and five measures of household dysfunction during childhood: exposure to alcohol or other substance abuse, mental illness, violent treatment of mother or step-mother, criminal behaviour in the household, and parental separation or divorce (Anda et al., 2006, p. 176).

- high perceived stress, difficulty controlling anger and risk of perpetrating intimate partner violence (for people with four or more adverse childhood experiences).

Further to this, the study found that as the number of adverse childhood experiences increased so too did the average number of co-occurring negative outcomes (Anda et al., 2006). There is strong evidence to indicate that certain types of trauma rarely occur in isolation. Research suggests, for example, that the different child maltreatment types are interrelated: sexual abuse, physical abuse, psychological maltreatment, neglect and exposure to domestic and family violence typically occur in combination with each other. A large proportion of children and young people who experience childhood abuse or neglect are exposed to more than one type of abuse (known as "multi-type maltreatment"; Price-Robertson, Higgins, & Vasallo, 2013). Further to this, other forms of victimisation such as bullying or assault by a peer have often been found to co-occur with child maltreatment (known as "poly-victimisation"; see Finkelhor, Ormrod, & Turner, 2007).

Multiple victimisation experiences across different domains are consistently associated with poorer outcomes than a single adverse or maltreatment experience. Those who experience multi-type maltreatment or poly-victimisation are more likely to experience high levels of trauma symptoms and worse outcomes than those who are exposed to no maltreatment or only one type (Finkelhor et al., 2007; Higgins & McCabe, 2001). Supporting these findings, a recent large scale US study of children in the Illinois child welfare system found that children who experienced both violent interpersonal *and* attachment-based ("non-violent") traumas within the caregiver system experienced greater difficulties across several areas of impairment (including attention/behavioural dysregulation and self/relational dysregulation) and were significantly more likely to exhibit PTSD-like symptoms compared to children who had experienced neither type of trauma, violent trauma only or non-violent trauma only (Kisiel et al., 2014).

Co-occurring mental health issues and disorders such as conduct disorder and oppositional defiant disorder (in children), PTSD, depression and other affective disorders, borderline personality disorder, somatoform disorders, psychotic and dissociative disorders have commonly been associated with traumatic experiences (Bateman, Henderson, & Kezelman, 2013; Breslaue, 2009; CFCA, 2014a, 2014b; Nurius et al., 2015; van der Kolk et al., 2005). Self-harm and suicide attempts have also been linked with previous traumatic experiences (Bateman et al., 2013; Cozolino, 2010; Dube et al., 2001; Herman, 1992; Johnson-Reid et al., 2012). In one study, Dube and colleagues (2001) reported that any adverse childhood experience increased the risk of attempted suicide by 2–5 fold with the relationship being partially mediated by illicit drug use, depressed affect and self-reported alcoholism.

Those who have had previous traumatic experiences also commonly report physical health issues. For example, in summarising research on the potential effects of trauma exposure, Bateman and colleagues (2013) found that "survivors of child maltreatment were at increased risk of hepatitis, diabetes, heart disease, cancer, a stroke, are more likely to have surgery and are at increased risk of having one or more chronic pain symptoms" (p. 19). The same authors also noted a range of conditions that child sexual abuse survivors were at increased risk of, including irritable bowel syndrome, asthma, arthritis and digestive problems.

In addition, childhood trauma exposure has been linked to involvement with the criminal justice system. A large study exploring adverse childhood experiences of serious, chronic and violent juvenile offenders and juveniles referred to the justice system for single non-violent offences found that every additional adverse childhood event experienced increased the risk of becoming a serious, chronic and violent juvenile offender by more than 35%, even when other known risk factors for violent behaviour were accounted for (Hahn Fox et al., 2015).

Lastly, difficulties in interpersonal relationships are often reported as a result of experiencing trauma (Bateman et al., 2013; Briere & Spinazzola, 2005; Evans & Coccoma, 2014; van der Kolk, 2005).

Although individual responses to traumatic experiences may vary widely, research has found a strong relationship between the degree of risk of experiencing multiple and complex negative outcomes following traumatic experiences and factors such as the age at which the experience/s occurred, the nature of the experience/s (with negative effects being particularly associated with

trauma of an interpersonal nature such as child abuse and neglect), and the severity and chronicity of the experiences (Cozolino, 2010; Herman, 1992; Kisiel et al., 2014; National Scientific Council on the Developing Child, 2014 [NSCDC]; Resick et al., 2012; van der Kolk et al., 2005). As noted by Cozolino (2010):

> The impact of trauma depends on a complex interaction of the physical and psychological stages of development during which it occurs, the length and degree of the trauma, and the presence of vulnerabilities or past traumas. The impact of chronic trauma becomes woven into the structure of personality and is hidden behind other symptoms, making it difficult to identify, diagnose and treat. (p. 266)

Traumatic events experienced early in life can be extremely damaging to the developing brain. Neural development relies on the interplay of genes and environmental inputs (particularly interaction with primary carers) and early adversity or disrupted attachment relationships that lead to chronic high levels of stress can interfere with key neurobiological development (NSCDC, 2014). Pamela Alexander (2013) suggested that "affective synchronization between mother and child" (p. 45) in carer–infant interactions is crucial for brain development, social development and stress regulation. Early onset, sustained trauma that interferes with this can lead to deficits in multiple domains: dysfunction in fear extinction; affect or emotional regulation; behaviour regulation; learning, cognition and attention; and self and relational dysregulation (Cook et al., 2005; Courtois & Ford, 2009; Evans & Coccoma, 2014; Kisiel et al., 2014; NSCDC, 2014; van der Kolk et al., 2005).

Research has also highlighted that experiencing traumatic events tends to increase the chances of experiencing further traumatic events across the life course. Cozolino (2010) argued that:

> Enduring personality traits and coping strategies that emerge in these situations [experiencing early onset, sustained trauma] tend to decrease positive adaptation and increase an individual's vulnerability to future trauma. This can manifest through engagement in abusive relationships, poor judgement, or a lack of self-protection. (pp. 268–9)

Finally, in examining the need for a trauma-informed approach to care it is pertinent to note that in many cases, due to the co-occurrence of problems resulting from experiencing trauma, individuals may find themselves in multiple systems, cycling in and out of specific services over many years to access, for example, treatment for drug and alcohol addictions, support for employment opportunities and therapeutic services for mental illness.

Historically, the underlying factor often linking a constellation of needs together—the history of abuse and its impacts—has not been adequately acknowledged or integrated into these service systems' service responses to individuals (Harris & Fallot, 2001). Further, populations with complex needs are at high risk of falling through the gaps of service delivery systems due to a lack of service co-ordination and the related barriers to service integration (Whiteford & McKeon, 2012). This can mean that clients: are deemed ineligible for services (e.g. cannot engage in mental health treatment until they have "dealt with" their substance abuse issue or vice versa); are expected to separate out their trauma experiences from their service or treatment needs ("we don't deal with trauma in this parenting class"); and experience services systems' responses as re-traumatising.

The SAMHSA-funded *Women With Co-Occurring Disorders and Violence Study* was a comprehensive 5-year project (1998–2003) across multiple sites, which provided evidence that integrating different services, such as mental health and substance abuse services where there was client need for both, was effective. This study showed that trauma-informed approaches could enhance the effectiveness of mental health and substance abuse services for women with co-occurring mental health and substance abuse disorders (Huntington et al., 2005; Morrisey et al., 2005). A trauma committee for this study also developed an understanding of trauma-informed principles and ways in which mental health and substance abuse service providers could use the approach (Elliot et al., 2005). In the years since the study, further development, debate and discussion has resulted in an expanded evidence base about the effects of trauma and appropriate approaches for services.

What is trauma-informed care?

Trauma-informed care could be described as a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs (Harris & Fallot, 2001). This requires consideration of a person's environment beyond the immediate service being provided and of how their symptoms and presentations may be seen as adaptations to trauma rather than as pathologies (Herman, 1992). At the broadest level, trauma-informed care means that services have an awareness and sensitivity to the way in which clients' presentation and service needs can be understood in the context of their trauma history (Knight, 2015). Kezelman and Stavropoulos (2012) noted that trauma-informed health and welfare settings and systems contrast dramatically with traditional settings and systems as they require different ways of operating, and without this understanding, risk re-traumatising service users. Trauma-informed approaches to care could be described as a strengths-based framework that is responsive to the effects of trauma (Bateman et al., 2013).

Principles of trauma-informed care

Principles of trauma-informed care have been articulated in a range of academic literature and guidance publications (Elliot et al., 2005; Hopper et al., 2010; Jennings, 2004; Kezelman & Stavropoulos, 2012; SAMHSA, 2014). These principles vary in length and number depending on the publication but essentially have the same underlying philosophies, that trauma-informed care means services are trauma aware, safe, strengths-based and integrated.

At the very minimum, trauma-informed services aim to do no further harm through re-traumatising individuals by acknowledging that usual operations may be an inadvertent trigger for exacerbating trauma symptoms. SAMHSA's (2014) approach to trauma-informed care makes four key assumptions that must be present as a basis of implementation for trauma-informed care, with a further six key principles to then be applied.

The key assumptions that SAMHSA has identified as needing to be inherent in any trauma-informed approach are based on four "R"s:

- *Realisation* at all levels of an organisation or system about trauma and its impacts on individuals, families and communities;
- *Recognition* of the signs of trauma;
- *Response*—program, organisation or system responds by applying the principles of a trauma-informed approach; and
- *Resist* re-traumatisation—of clients as well as staff.

In addition to these assumptions, SAMHSA (2014) then described six key principles of a trauma-informed approach:

- *Safety*—Staff and the people they serve feel physically and psychologically safe.
- *Trustworthiness and transparency*—Organisational operations and decisions are transparent and trust is built.
- *Peer support*—Peers is the terminology SAMHSA use for individuals with lived experience of trauma or their caregivers. Peers are also known as "trauma survivors".
- *Collaboration and mutuality*—This principle is about levelling power differentials between staff and clients and amongst organisational staff to ensure a collaborative approach to healing.
- *Empowerment, voice and choice*—This principle emphasises the strengths-based nature of trauma-informed care. The organisation—and ideally the whole service delivery system—fosters recovery and healing.
- *Cultural, historical and gender issues*—A trauma-informed approach incorporates processes that move past cultural stereotypes and biases, and incorporates policies, protocols and processes that are responsive to the cultural needs of clients.

For an example of an Australian model of trauma-informed care, see Tucci and Mitchell's (2015) outline of the basic understanding of trauma that informs appropriate care underpinning the services and training provided by the Australian Childhood Foundation: *9 Plain English Principles of Trauma Informed Care* <www.childhood.org.au/blog/home/2015/april/trauma-informed-care>.

The Berry Street Childhood Institute also provides a number of resources and training on trauma-informed care for children: <www.childhoodinstitute.org.au/Resources>.

Achieving trauma-informed services: Reflection questions for service managers

- What is the likelihood of clients who have experienced trauma accessing our service?
- Do we provide access to trauma-specific evidence-based treatments for current psychological difficulties that result from that trauma (e.g. Trauma-focused cognitive-behaviour therapy)?
  - See *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma* <www.childwelfare.gov/pubpdfs/trauma.pdf>
- Do we provide access to effective treatments for complex trauma and complex PTSD (for which trauma-specific treatments may not be as effective)?
  - (See: Connor & Higgins, 2008a, 2008b; Kezelman & Stavropoulos, 2012).
- Are these trauma-specific interventions provided inhouse, in collaboration with other agencies, or via referral to an external agency (and if so, do we provide active/warm referral)? See:
  - *Interagency collaboration: Part A. What is it, what does it look like, when is it needed and what supports it?* <aifs.gov.au/cfca/publications/interagency-collaboration-part-what-it-what-does-it>
  - *Interagency collaboration: Part B. Does collaboration benefit children and families? Exploring the evidence.* <aifs.gov.au/cfca/publications/interagency-collaboration-part-b-does-collaboration-benefi>
  - *Effective practices for service delivery coordination in Indigenous communities*. <www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2011/ctgc-rs-08.pdf>
- How do we incorporate restorative justice principles?
  - According to Higgins et al. (2014), restorative justice activities might include:
    - addressing trauma and other mental health consequences through evidence-based therapeutic interventions;
    - repairing the injuries caused to relationships, especially between sons/daughters and parents;
    - providing opportunities for truth-telling, storytelling and acknowledgement; and
    - overcoming shame and recognising past actions through public activities and community awareness campaigns.
  - See: Higgins et al., 2014, pp. 41–46: *Forced Adoption Support Services Scoping Study* <www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/forced-adoption-support-services-scoping-study>
- Who in the organisation is likely to come into contact with individuals who have experienced trauma, or be providing information to, or receiving communications from clients experiencing trauma? Thinking from a "client journey" perspective, this might include:
  - phone/intake staff;
  - web/staff with online monitoring;
  - reception;
  - office manager;
  - media and communications staff;
  - other staff or contractors on the premises (e.g. catering, cleaning, security); and
  - project/service delivery professionals and support staff.

- Who is less likely to be interacting with trauma survivors but who need to understand, and who need to support "front-line" workers and other support staff who do?
  - executive staff (who create the authorising environment);
  - managers and team leaders; and
  - mentors and supervisors.

This suggests the value of whole-of-organisation approaches to trauma-informed service delivery, directed at every level to ensure a focus on what helps clients feel safe.

- What should training encompass? Training should include:
  - skills in de-escalation or "holding" clients who are experiencing an acute episode of trauma or re-traumatisation;
  - debriefing and staff protocols for responding to difficult situations and clients presenting with complex circumstances and trauma histories;
  - information on staff care and preventing/responding to secondary or vicarious trauma—the psychological term for changes that can occur to people when they are repeatedly exposed to traumatic material (see <aifs.gov.au/publications/feeling-heavy>);
  - organisational supports to prevent or address vicarious trauma for staff including: clinician self-care skills and reflective practice, caseload management, supervision, debriefing, staff and peer support, workplace safety, comfort and supportive work culture that acknowledges the reality of vicarious trauma (Morrison, 2007);
  - types of events/circumstances in clients' lives that may be traumatising;
  - typical modes of reacting—events/triggers for re-traumatisation; and
  - understanding the impacts of trauma (such as behavioural symptoms typical of PTSD, as well as the developmental impacts of victimisation and trauma on an individual's beliefs—about the self, the world, and the future—e.g. see: Janoff-Bulman & Frieze, 1983).

Further to this, SAMHSA also provide a range of sample questions to consider when implementing a trauma-informed approach <store.samhsa.gov/shin/content//SMA14–4884/SMA14–4884.pdf> (p.14–16).

Which services should be delivering trauma-informed care?

Most of the US literature about trauma-informed care is directed at change in behavioural health services. In Australia there appears to be an emphasis on driving change in the mental health sector. This has the potential to cause confusion about the pathway to providing trauma-informed care in the child, family and community sectors and about what being trauma-informed actually means. One aspect of clarifying these questions is to understand which services should be adopting a trauma-informed approach to human service delivery.

In addition, there are communities and populations for whom violence and intergenerational trauma are a constant reality. Some Indigenous communities, for example, experience the phenomenon of trans-generational trauma whereby trauma is transmitted across a number of generations (Atkinson, 2002). The historical impacts of colonisation on Aboriginal people in Australia have played out in a history of disadvantage and discrimination as traditional Aboriginal life was gradually disrupted and dismantled (Atkinson, 2002; Keel, 2004). The effectiveness of the full range of health and human services in such communities could be enhanced by a trauma-informed approach (Atkinson, 2013).

As outlined in the earlier discussion on principles of trauma-informed care, it is important for services to be culturally attuned and relevant (Atkinson, 2013). This is described by SAMHSA as the principle that the trauma-informed organisation actively moves past cultural and gendered stereotypes and incorporates policies and processes that are responsive to the cultural needs of individuals served, including addressing historical trauma (SAMHSA, 2014) or collective trauma (Atkinson, 2013).

Building on the work of Harris and Fallot, SAMHSA's (2014) *Concept of Trauma and Guidance for a Trauma-Informed Approach* outlined ten implementation domains:

- governance and leadership;
- policy;
- physical environment;
- engagement and involvement;
- cross-sector collaboration;
- screening, assessment, treatment services;
- training and workforce development;
- progress monitoring and quality assurance;
- financing; and
- evaluation (p. 12).

This guidance information is designed to provide a starting point for an organisational approach to implementing trauma-informed care. It also indicates that organisations across *all* settings should consider how trauma-informed approaches could benefit stakeholders regardless of whether they deal with trauma in their day-to-day business. The reality of the prevalence of traumatic experiences in the general population indicates that trauma is not confined to prevention, treatment and recovery settings but is integral in other systems as well (SAMHSA, 2014).

It is important to note that many practices that service providers currently use are likely to already be consistent with a trauma-informed approach, such as conveying empathy and validating the client's experiences (Knight, 2015). What is different about identifying as a trauma-informed service is that there is a paradigm shift in service delivery culture to acknowledge and clearly articulate the importance of trauma in understanding and responding to client presentation.

With the lack of an overarching framework in Australia, there is a danger of developing trauma-informed models and practices that are not sharing a consistent language about what being trauma-informed entails. This issue is discussed in more depth in the section about challenges to implementation later in this paper.

The need for a systems approach to trauma-informed care

Following the lead of the USA, Australian health agencies are moving towards a trauma-informed paradigm for considering health and human service delivery systems (Kezelman & Stavropoulos, 2012) in preference to a medical model of individual illness (DeCanandia, Guarino, & Clervil, 2014).

The effects of traumatic experience often manifest in behaviours that result in people being involved in human service systems that go beyond mental health, such as the criminal justice system (SAMHSA, 2014). A systems approach to trauma-informed care means that implementation goes beyond individual practitioner and service organisation change to extend to whole systems that people who have experienced trauma are likely to interact with. A system, for example, could include the justice, homelessness or child welfare systems. These systems may not include treatment settings but can still affect the people who experience them. In the USA, a range of systems are in the process of adopting a cross-sectoral approach to implementing trauma-informed care and trauma-specific services to support service users (DeCanandia et al., 2014). For example, the behavioural health and health care, veterans' administration, homelessness and education sectors are just a few of the systems that are shifting to a trauma-informed approach (DeCanandia et al., 2014).

The differences between trauma-informed services and trauma-specific services are described in the definitions outlined earlier. It is important to distinguish between them but acknowledge the intersection of the two types. Trauma-specific services are designed to treat the symptoms or manifestations of the effect of a trauma on an individual but these interventions must be delivered in a trauma-informed context. This emphasises an overall philosophy of trauma as a central concept in understanding the presentation of clients within a range of health and welfare settings (Kezelman & Stavropoulos, 2012).

Challenges in implementing a trauma-informed approach to care

As noted previously, implementing trauma-informed care requires a paradigm shift in service delivery (Hopper et al., 2010; Jennings, 2004). The literature around trauma-informed care indicates that there are still some challenges to implementing this approach for systems and services, as well as the need for research to evaluate the approach's effect on client wellbeing and other service delivery outcomes (Ashmore, 2013; Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Hopper et al., 2010; Muskett, 2014). These challenges are discussed in the following sections.

Inconsistent understandings of what it means to be trauma-informed

The most identifiable challenges across the literature are in the need to create shared understandings, and current inconsistencies in education regarding trauma-informed care (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Hopper et al., 2010). It is difficult to align organisational change to a specific practice without a shared understanding or vision of what trauma-informed care actually is. In a comparative study of trauma-informed care in acute mental health inpatient units, Ashmore (2013) identified this as an issue in the implementation of trauma-informed care in an acute patient environment. A lack of definition and of a shared framework, as well as a lack of information specific to an acute mental health inpatient setting, were associated with challenges and inconsistency in implementation.

In their review of the literature, the Parenting Research Centre and the Australian Centre for Post-traumatic Health (2013, now Phoenix Australia) found that although participants within the child and family services sector who worked with children exposed to trauma were familiar with terminology such as "trauma-informed care", they argued that:

- the field still lacked clear definitions or understandings of concepts;
- there were assumptions that children's social and behavioural difficulties were necessarily trauma-related without clear assessment; and
- there was a lack of guidelines for assessment and treatment of trauma.

SAMHSA's (2014) recent guidance document is clearly aimed at addressing this lack of consistency in definitions and the 2012 document by Adults Surviving Child Abuse provides some practice guidelines (Kezelman & Stavropoulos, 2012). However, an aspect of trauma-informed care is that it must be culturally relevant to the populations it serves (Elliot et al., 2005; Jennings, 2004) and any broad level articulation of policy approaches or frameworks must be applicable in a range of systems and settings and for a variety of cohorts.

Translating trauma-informed care to specific practice and service settings

In addition to the array of terminology and concepts that are sometimes used interchangeably and inconsistently, there is a lack of evidence-based guidance for specific settings and systems to assist with coordinating how trauma-informed practice should be provided for particular service settings and specific populations of service users. This issue was identified by Muskett (2013) and Ashmore (2013) in relation to mental health nursing, where the need to remove the use of seclusion and restraint is emphasised but, beyond this, little has been articulated to support the use of specific practices for service settings to adopt to improve service delivery consistent with principles of trauma-informed care. Dealing with survivors of trauma, particularly in a mental health or child protection setting, may require individuals to use their prior experience to respond to specific situations. In such stressful and potentially dangerous settings, crisis management could lead to a de-prioritisation of trauma-informed responses (Conners-Burrow et al., 2013). Training and guidance for staff on how to respond to acute situations appropriately and feel confident that they are acting in accordance with the principles of trauma-informed care is recommended (Knight, 2015; Muskett, 2014).

Facilitating complex system change

As noted by the American Institute for Research, in order to build a trauma-informed system, commitment at all system levels is required. This includes a commitment to ongoing training and service transformation (DeCanandia et al., 2014). Australia is behind the USA and Canada in developing models and systemwide responses to children and other service users impacted by trauma (Bateman et al., 2013). For example, the USA has the National Child Traumatic Stress Network, funded by SAMHSA, which brings a singular and comprehensive focus to responding to childhood trauma. Australia is arguably still at the stage of requiring policy change to articulate a clear direction for moving towards systems of trauma-informed care in a range of different service delivery areas relating to child/family wellbeing (Bateman et al., 2013).

Systemic change is important because it enables people to receive services that are sensitive to the impact of trauma regardless of whether they enter through any particular service setting or intervention.

Large-scale systems change is also logistically difficult and time-consuming and requires commitment and resources (Hopper et al., 2010). Philosophical differences between sectors that need to work together to integrate care can also impede systemic change (Hopper et al., 2010). Ashmore (2013) identified particular features of systems change for systems such as mental health that are challenging. These challenges include that hierarchical systems such as health may encounter resistance and that there is an inherent power inequality between service users and professionals in such environments.

Creating change at a systemic level is more than providing practitioners and organisations with tools. It requires changes to funding models to support outcomes rather than outputs, and changes to education for mental health practitioners, social workers and other specialists. Essentially, this is about a move towards a more holistic understanding of the inter-related biological, psychological and social dimensions of trauma.

Evaluating a trauma-informed approach to care

Studies from the USA, particularly following the Women With Co-Occurring Disorders Study, have found that trauma-informed, integrated services are judged to be cost-effective when compared with treatment as usual in the comparison sites of that particular study (Domino, Morrisey, Chung, Huntington, & Larson, 2005). Although this study is regularly cited in the literature as evidence of the cost-effectiveness of trauma-informed care (DeCanandia et al., 2014, Hopper et al., 2010; Kezelman & Stavropoulos, 2012); in reality, there is a lack of evaluation about cost-effectiveness and other aspects of trauma-informed care approaches, including its effectiveness in improving outcomes for service users (Quadara, 2015). There is also a lack of evaluation tools to measure the extent to which an organisation is trauma-informed, and the lack of consistent definitions further translates into difficulties in identifying a clear method to indicate the degree to which a service or program is trauma-informed (Hopper et al., 2010).

Other challenges identified in evaluating trauma-informed care, highlighted by Hopper et al. (2010), include the difficulty in measuring cultural change and sustainability of change and whether changes in outcome are attributable to trauma-informed environments or trauma-specific interventions. In addition, the need for cross-system collaboration and assessing human service interactions to establish the extent of trauma-informed care practice implementation further complicates evaluation in this area (Kramer et al., 2015).

Applying trauma-informed care principles

To illustrate how trauma-informed care principles can be applied to respond to different trauma issues, we briefly look at service delivery in the context of people affected by the policies that created the Stolen Generation, past adoption practices and humanitarian migration.

The Stolen Generation

In their program logic, the Aboriginal and Torres Strait Islander Healing Foundation (2014, p. 25) explain how a collective healing process for members of the Stolen Generation and their descendants can occur, and the mechanisms that underlie this process. Central to this model is an understanding of an Aboriginal world view and the pervasive trauma of colonisation, and the need for specific strategies to address ongoing, collective trauma. A common element of collective healing projects is that they are based on a trauma-informed or recovery framework. According to the Healing Foundation (2014):

> Trauma-informed practice is a strengths-based approach to healing that: is based on an understanding of, and responsiveness to, the impact of trauma; emphasises physical, psychological, and emotional safety for people seeking help and for the helpers; and creates opportunities for people affected by trauma to rebuild a sense of control and empowerment. It recognises the prevalence of trauma and is sensitive to and informed by the impacts of trauma on the wellbeing of individuals and communities. (p. 47)

Forced adoption and past family removal practices

An example of an issue that has only recently received public acknowledgement of its role in traumatising a large number of Australians is the former practice of forced adoption, or separation from family due to past family removal practices. In their exploration of good practice principles for services addressing the needs of people affected by forced adoption and past family removal practices, Kenny, Higgins, and Morley (2015) noted:

> There is increasing recognition of the potential for trauma for individuals who have been subjected to forced adoption policies and practices, and the value of a "trauma-informed" or "trauma-aware" approach to service delivery. Good practice suggests that service providers should approach all clients with a forced adoption experience as if they might be trauma survivors (p. 8).

In their overview of good practice principles, Kenny et al. (2015, p. 8) outlined the key elements of trauma-informed service delivery. Being a trauma-informed service ensures the provision of:

- a safe and supportive environment that protects against physical harm and re-traumatisation;
- an understanding of clients and their symptoms in relation to their overall life background, experiences and culture;
- continued collaboration between service provider and client throughout all stages of service delivery and treatment;
- an emphasis on skill building rather than managing symptoms;
- an understanding of the symptoms and survival responses required to cope;
- a view of trauma as a fundamental experience that influences an individual's identity rather than a single discrete event; and
- a focus on what has happened to a person rather than what is wrong with a person.[6]

Humanitarian migrants surviving torture and trauma

The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) outline the program logic for their service model as systemic and based on an ecological model of factors that influence and support healing for survivors (see *How We Work* <www.startts.org.au/about-us/how-we-work>).

They aim to provide a range of services that reflect the bio-psycho-social model, such as:

- complementary therapies or neurofeedback to address biological impacts;
- counselling to address psychological impacts; and
- community development projects to support social changes.

6 See Forced Adoptions Community of Practice <aifs.gov.au/projects/forced-adoptions-community-practice>.

"There is nothing more practical than a good theory": The theoretical basis of trauma-informed models of care

(a) Attachment—developing a secure base

Attachment theory (Bowlby, 1988) has been used by developmental psychologists to explain positive, secure relationships between infants and caregivers, and how this forms the template for secure adult interpersonal relationships. Disruption to the relationship or insecure attachment is seen as a fundamental mechanism by which childhood trauma affects adult self-concept, wellbeing and interpersonal relationships. Trauma-informed care systems provide a safe environment to expose disruption to the attachment relationship, and build new internal models and "scripts" of the self and relationships.

(b) Self-regulation and control

Social cognitive theories of self-regulation help explain how individuals respond to threatening events. Key components of many trauma-specific treatments are to help individuals to improve self-regulation, safety, security, sense of control and mastery of their environment, and modulate their emotional reactions to traumatic stimuli. Trauma-informed systems of care are aware of the ways in which programs and organisations can trigger traumatic reactions—or even inadvertently replicate the dynamics of the traumatic events/relationships—and seek to minimise them, and promote environments that facilitate positive affect regulation or "modulation".

(c) Fundamental attribution error—overestimating the personal characteristics, underestimating situational factors

Theories of social psychology have identified that humans often make what is termed the "fundamental attribution error", whereby we over-emphasise a person's personality, or internal characteristics, in explaining their behaviour, and underestimate the environmental, or situational factors, that are external influences on their behaviours (e.g. see: Jones & Harris, 1967). For clients who have experienced trauma—particularly complex trauma involving multiple injuries in the interpersonal domain—it is likely that those around them, including their families, their work colleagues and even their health/mental health professionals, are likely to attribute their interpersonal difficulties and deficits in functioning and wellbeing to an inherent personality flaw, rather than having been shaped by their environment (i.e. the external traumatic events they have endured). Creating new environments of support, and opportunities for "reprograming" life scripts are important. But practitioners need to be open to seeing the external influences and specifically target intervention strategies to remediate the long-standing negative consequences.

Source: The title is a quote from Lewin (1952, p. 169)

Moving forward

Much of the literature identified that the paradigm shift towards implementation of a trauma-informed approach to care needed to include commitment from political leadership at all levels (Ashmore, 2013; Bateman et al., 2013; Kramer et al., 2015).

In Australia, the Mental Health Coordinating Council (Bateman et al., 2013) has articulated the requirement for a policy statement from national and state leaders endorsing the concept of trauma as a priority mental health issue and supporting the transition to a trauma-informed service system. This would ensure that there is an identifiable commitment from governments to support the need for trauma-informed service systems.

The broad dissemination of information about trauma-informed, evidence-based best practice has been identified as an important feature of developing the evidence base around trauma (Kramer et al., 2015). Development of a nationally based resource, such as SAMHSA's National Center for Trauma-Informed Care and the National Child Traumatic Stress Network, would provide an Australian-based network of information to support policy development and service delivery and to enable the use of what is currently known about trauma-informed services in different health and human service sectors. Having central resources such as these, is instrumental in shifting human service systems towards a trauma-informed approach to service delivery.[7] Australia does not yet have a body with such a specific focus but extensive work has been undertaken by organisations such as the Mental Health Coordinating Council and Adults Surviving Child Abuse, among others, to help shape behavioural health policy towards incorporating an understanding of the damaging effects of trauma into policy and service delivery approaches.

Although there are some resources and tools now available to support guidance towards trauma-informed systems of care in Australia (Bateman et. al., 2013), there does not appear to be an overarching trauma framework to support a shift in a consistent way. As noted earlier, organisations in Australia have recognised the need for trauma-informed services and

7 See National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint <www.samhsa.gov/nctic>

interventions but the current array of methods, models and interventions on offer and in use do not support a coordinated and common approach that would ensure trauma-informed has a consistent meaning and interpretation in service delivery.

Conclusion

There is growing awareness of the need, and a strong rationale for the value, of implementing a trauma-informed approach to human service delivery. Such an approach has been adopted and implemented extensively in the USA. In Australia, there is a strong push towards trauma-informed approaches to care, and recognition of the impacts of child abuse and other traumas as a driver of service need. However, there is confusion with the array of terminology used and a lack of reference to specific trauma-informed frameworks to guide the introduction of trauma-informed care in a systemic way. Despite the need, and the conceptual/theoretical rationale, it is important to acknowledge that there is limited empirical evidence to show that working systemically to be trauma aware and providing trauma-informed systems of care leads to reductions in trauma symptoms or other positive outcomes for clients.

Currently, there is no overarching policy to mandate trauma-informed care and no framework to guide evidence-based practice to transition in a systematic way to trauma-informed care in Australia. In addition, improvements to collection of research data and adoption of standardised outcome measures for evaluation would support a more systemic approach to evaluating the implementation of trauma-informed care.

There is value in capturing practice-based evidence; however, this is beyond the scope of the current paper, and would be best carried out via a systematic and rigorous approach to gathering and synthesising information from practitioners working with traumatised clients in a variety of fields—as well as the views of those in service delivery systems that are not yet trauma-informed to examine the barriers and enablers of system change. Similarly, there is a need to articulate findings from the emerging field of trauma-informed practice into concrete policy statements or frameworks that can be applied to different client groups within and across a range of service systems and settings.

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At the time of writing **Liz Wall** was a Senior Research Officer at the Australian Institute of Family Studies. **Daryl Higgins** is Deputy Director (Research) and **Cathryn Hunter** is a Senior Research Officer with the Child Family Community Australia information exchange at the Australian Institute of Family Studies.

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Australian Institute of Family Studies
Level 20, 485 La Trobe Street, Melbourne VIC 3000 Australia
Phone: (03) 9214 7888 Fax: (03) 9214 7839 Internet: <www.aifs.gov.au>

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GLBTQDVP

GLBTQ Domestic Violence Project

TRAUMA-INFORMED APPROACHES FOR LGBQT* SURVIVORS OF INTIMATE PARTNER VIOLENCE

A Review of Literature and a Set of Practice Observations

June 2016

Authors:

Erin C. Miller, M.P.S., M.D.V.
Domestic Violence/ Sexual Assault Programs; Newton-Wellesley Hospital

Lisa A. Goodman, Ph.D.
Boston College

Kristie A. Thomas, Ph.D.
Simmons College

Alex Peterson
University of British Columbia

Jillian R. Scheer, M.A.
Boston College

Julie M. Woulfe, M.A.
Boston College

Carole Warshaw, M.D.
National Center on Domestic Violence, Mental Health, and Trauma

Principal Investigator:

Curt Rogers, M.P.A.
GLBTQ Domestic Violence Project

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Produced by
The GLBTQ Domestic Violence Project

For more information on supporting LGBQT* survivors of intimate partner violence, contact one of the organizations below:

The LGBTQ DV Capacity Building Learning Center
c/o The Northwest Network
A program focused on improving research, practice and policy regarding domestic violence in LGBTQ communities.
1-206-568-777 | info@nwnetwork.org | www.nwnetwork.org

FORGE
A transgender anti-violence organization, specializing in technical assistance for victim service agencies, with a focus on domestic violence, sexual assault, dating violence, stalking, and hate crimes.
1-414-559-2123 | AskFORGE@forge-forward.org | www.forge-forward.org

If you would like more information about accessible, culturally relevant trauma-informed approaches for survivors, contact:

The National Center on Domestic Violence, Trauma & Mental Health
A program providing training, support, and consultation to advocates, clinicians, attorneys and policymakers as they work to improve agency and systems-level responses to survivors and their children.
1-312-726-7020 | info@nationalcenterdvtraumamh.org | www.nationalcenterdvtraumamh.org

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Executive Summary

In 2013, the Administration for Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services, awarded a grant to the GLBTQ Domestic Violence Project in Boston, Massachusetts to help improve trauma-informed work with lesbian, gay, bisexual, queer and transgender (LGBQT*) survivors of intimate partner violence (IPV). The following document is a literature review that sets the context for thinking about trauma-informed practice (TIP) for these communities. We developed this review over the course of 2015, supported along the way by an Advisory Board comprised of the NorthEast Two-Spirit Society, Queer Muslims of Boston, Fenway Community Health, the Hispanic Black Gay Coalition, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, and Massachusetts Asian & Pacific Islanders for Health.

This document helps inform a set of practice-based observations that are included in the Appendix (page 40) and are also available as a separate document. At present, there are few, if any, documented LGBQT*-specific models of trauma-informed practice. This literature review and the accompanying practice observations make a clear case for the need for such models, and for the implementation of culturally competent LGBQT* trauma-informed services.

Key takeaways from the literature review include:

- IPV occurs in LGBQT* relationships at rates equal to or higher than rates in heterosexual relationships. Different subgroups within the community may experience different rates or types of IPV, with bisexual and transgender individuals at particularly high risk.

- Although LGBQT* IPV shares many underlying dynamics with IPV in heterosexual couples, it also has unique characteristics, including the types of abusive tactics used and the context of discrimination and social stigma faced by LGBQT* individuals. Within LGBQT* subgroups, there may be additional complexities.

- LGBQT* survivors who are also part of other oppressed groups often face homophobia within their own cultural communities as well as racism, ableism, xenophobia, and colonialism in mainstream communities. Moreover, LGBQT* IPV often occurs in a landscape that includes other forms of abuse and trauma, including family violence, sexual violence, hate crimes, and police brutality. Such overlapping forms of trauma are often interrelated, rendering some members of the LGBQT* communities subject to abuse by more than one person at a time and at more than one point in their lifespans. In the face of these overlapping forms of oppression, LGBQT* survivors are forced to make particularly constrained choices about safety, often trading one kind of safety for another.

- Mental health difficulties are major concerns among LGBQT* people in general. LGBQT* individuals experience higher rates of traumatic events, and may be at greater risk for developing symptoms of PTSD, depression, and anxiety as well as experiencing suicidality and isolation. These concerns are amplified for LGBQT* survivors of IPV, especially transgender individuals and survivors of color. Nonetheless, LGBQT* survivors find strength and resilience through identity affirmation and social support.

- LGBQT* survivors exhibit unique help-seeking behaviors. Overall, they are less likely to seek services from law enforcement and mainstream providers and more likely to rely on informal social support and LGBQT*-focused programs. There also are differences in help-seeking *within* LGBQT* subgroups. For instance, trans individuals may have an especially difficult time accessing culturally competent and non-traumatizing services. For LGBQT* people of color, stigma, economic constraints, and the absence of community outreach are barriers to services.

- Service provision that is not rooted in an expansive understanding of the intersecting oppressions that LGBQT* survivors face may do more harm than good. The kind of harm done by those in a social service system designed to help has been referred to as *sanctuary harm*, which is antithetical to trauma-informed practice.

- Despite growing awareness of the impact of sanctuary harm on clients who experience multiple forms of oppression and of the unique needs of LGBQT* survivors, trauma-informed approaches tailored to LGBQT* communities have been slow to develop. To our knowledge, there are none in the academic literature. It was our Advisory Board that pointed to an alternative model of trauma-informed practice – transformative justice.[1] While the roots of trauma-informed practice grew out of mental health and substance abuse services, transformative justice emerged from activist communities and seeks to uproot the conditions that created traumatic experiences, ending oppression even (if not especially) within helping systems.

We hope that this document will facilitate thinking about how the core principles of trauma-informed practice can be applied to working with LGBQT* survivors and to ameliorating vicarious traumatization among service providers who do their best in difficult circumstances.
Although this document is intended primarily for staff in domestic and sexual violence organizations, it has broad applicability. The information provided can be used to enhance the work of practitioners, advocates, and administrators in other anti-abuse disciplines, homelessness services, mental health and healthcare circles, criminal legal systems, youth services, and an array of other human services disciplines and social change initiatives that seek to serve and ensure the inclusion of LGBQT* communities. The practice-based observations in the Appendix provide further framing for this important endeavor.

[1] The authors wish to thank Hales Burton, at the Fenway Violence Recovery Program, for first suggesting this conceptual shift.

Introduction

IPV refers to the physical and/or emotional abuse of an individual by a current or former intimate partner. It includes the full range of tactics used to create and maintain power and control over another person, including financial abuse, verbal abuse and intimidation, and cultural abuse. In this document, the phrases *intimate partner violence* and *domestic violence* are used interchangeably to denote partner violence. However, it is important to note that domestic violence (DV) is sometimes defined more broadly to include violence and abuse perpetrated by relatives. Although many LGBQT* individuals experience abuse and/or rejection from family and relatives, the dynamics of partner violence versus family violence may differ dramatically. When we discuss the latter, we use the term *family violence* to distinguish it from violence by an intimate partner.

Following a note on language, the literature review is organized into five sections. Section One focuses on the prevalence and dynamics of IPV in LGBQT* communities. Section Two focuses on trauma, mental health, and resilience among LGBQT* individuals to contextualize the critical need for trauma-informed practices for these survivors. Section Three focuses on the range of systemic, institutional, and individual-level barriers that thwart LGBQT* peoples' access to informal and formal support services. Finally, the last section reviews the core principles of a trauma-informed approach to practice, with attention to the needs of service providers who work with LGBQT* survivors, and provides examples of community-specific approaches to trauma.

A Note on Language

The authors wish to acknowledge at the outset the deep complexities of language. LGBQT* stands for lesbian, gay, bisexual, queer, and transgender. It is often used interchangeably with GLBTQ, LGBQT-TS, and similar acronyms to broadly refer to sexual and gender minorities. This document honors the current practice of including an asterisk after the "T" to signify the broad diversity of trans communities, including trans women – transgender individuals who identify as women, though assigned male at birth; trans men – transgender individuals who identify as men, though assigned female at birth; those transitioning from female to male (FTM); those transitioning from male to female (MTF); cross dressers; gender non-conforming individuals; and others who might self-identify as being members of trans communities. In this paper, transgender and trans are used interchangeably.

These definitions belie the complexity of the terms, however. The words *lesbian*, *gay*, *bisexual*, *transgender*, and *queer* all carry particular historical, political and cultural meanings. To a great extent, these words have been shaped in white, Western contexts. Words such as lesbian, gay, and bisexual, for example, are uniquely English. There are seldom translations into other languages that carry the same understanding of LGBQT* identity as being an identity rather than a set of behaviors. Literal translations, into Spanish or Haitian Creole as but two examples, carry few if any of the presumptions that are inherent in English. In many parts of the Latin and Spanish-speaking world, men who engage in sex with

same sex partners are only considered "gay" in the English sense of the word if they are the receptive partner. It is not engaging in the acts that is the determinant of identity, so much as the role that an individual plays (traditionally read as *masculine* or *feminine*) in the conduct of that act. Similarly, men who marry women, but engage in same sex acts with other men, are frequently identified as heterosexual. In short, they are defined by their social role, rather than by their private, intimate acts. Hence the conception of *gay*, as defined in U.S. contexts, frequently fails to apply.

Precisely because identifiers such as LGBQT* were defined in white middle class and academic contexts, the limitations of LGBQT* labels and identifiers may be particularly acute in communities of color, Indigenous communities, and immigrant communities, among others. During the course of crafting this literature review, members of our Advisory Board taught us a tremendous amount. The Hispanic Black Gay Coalition (HBGC) suggested use of the term *same gender loving*, a community-specific phrase coined by Cleo Manago to distinguish African Americans, and in particular African American men, who do not self-identify as being part of the predominantly white gay movement in the U.S., but who nonetheless wish to affirm their same sex intimate relationships. Corey Yarbrough, one of the founding Executive Directors of HBGC, suggested that, for some same gender loving people, this language may be a form of racialized resistance to the racism of the mainstream LGBQT* movement in the U.S. In the alternative, Corey stated, some members of African American communities may be on the *down low*, engaging in same sex sexual activity, but rejecting LGBQT* identifiers as a result of internalized homo- and bi-phobia.

The NorthEast Two-Spirit Society (NETSS) in part echoed Corey's thoughts about the racism of the mainstream LGBQT* movement. In addition, Harlan Pruden, one of co-founders of NETSS, spoke about an "internal muddiness" that some Native peoples may experience when seeking to find language for their experience. Speaking of his own Cree inheritance as a registered member of the Saddle Indian Reservation, Harlan said that when he asked something of an elder, he knew to offer them tobacco, but never understood the spiritual dimension of the ceremony. Having been separated from too much of their own history by colonialism, genocide, and forced assimilation, Harlan stated, many Native people may use the words *Two-Spirit* when what they really mean is gay Indian.[2]

Harlan also spoke at length about the contextual nature of Native Two-Spirit identities. As Harlan put it, "When I am out on a Friday night in a gay club, I am a gay man. Yet when I am in rural Oklahoma at a Two-Spirit gathering, I am a proud Two-Spirit man." Alluding to the unique role and cultural responsibilities that Two-Spirit people often held (and may still hold) in the life of Native communities, Harlan pointed out the obvious differences in the spiritual role of Two-Spirit peoples, and

[2] Two-spirit is a contemporary term, adopted from the Northern Algonquin, and meant to signify the embodiment of both masculine and feminine within one person. Now embraced by many Native peoples as a pan-Indigenous umbrella term connoting both diverse gender expressions and sexual orientations, two-spirit (TS) generally speaks to the respect that Native peoples held for diversity, and the unique sacred and ceremonial roles that TS people held (and may still hold) within their own communities. Herein the phrase TS speaks not simply to a third gender, or to same gender attraction, but more broadly to the history of compulsory Christianization that sought to erase two-spirit peoples within their own nations. Notably, there is no single consensus definition of two-spirit, and the term means different things to different Native peoples.

the political and social function of people claiming LGBQT* identities in mainstream communities. Several members of the project's advisory board echoed this point,
speaking about the complex layering of cultural and spiritual value systems that accompanied their choice to self-identify in, with, and outside of their own communities.

These same Advisory Board members also acknowledged the landscape in which such decisions are made, and stated that individuals in their communities may shift how they self identify as a means of preserving their safety. As the rest of this literature review discusses, LGB, transgender, same gender loving, Two-Spirit, and queer-identified peoples make choices about how, when, and if to "out" themselves in a complex social and political landscape that is too often unsafe, if not violent. Hence, how any individual self-identifies may shift depending on who is asking, why, and in what context. As one Advisory Board member stated, "identities have to be fluid in order to be protective."

Finally, the leadership of HarborCOV, an LGBQT*-affirming DV organization in Boston that specializes in serving communities facing cultural or linguistic barriers, has noted that some cultures may not have the variety or depth of language that words such as LGB, transgender, same gender loving, and Two-Spirit convey. Indeed, Kourou Pich, Co-Executive Director of HarborCOV has observed that people from some cultures and communities may have difficulty finding language for themselves in their own communities, and that that invisibility is intentional – a function both of denial of the existence of sexual minorities in those communities, but also perhaps protectiveness of gender queer and same gender attracted people.

Language is power. We authors, therefore, have put a great deal of thought into the words we use to name peoples' experiences. At the same time, we know that we can never be as inclusive or sensitive as we want to be. We have done our best to honor the range of experiences we are writing about in this document.

Intimate Partner Violence in LGBQT* Communities

Prevalence of IPV in LGBQT Communities*

Historically, DV has been seen primarily as a problem of cisgender[3], heterosexual men abusing cisgender, heterosexual women. Because of this limited framework, research on the prevalence of DV and IPV among LGBQT* and non-female-identified individuals has been scarce and often limited by the use of non-probability sampling, cross-sectional data that precludes causal inference, and inconsistent definitions of IPV and sexual orientation (Brown & Herman, 2015; Finneran & Stephenson, 2012). Recently, however, there has been an increase in studies that provide more rigorous estimates of IPV in LGBQT* communities. The majority of these studies suggest that IPV occurs in LGBQT* relationships at rates equal to or higher than heterosexual, cisgender relationships (Balsam, Rothblum, & Beauchaine, 2005; Duke & Davidson, 2009; Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016; Messinger, 2011; Walters, Chen, & Breiding, 2013). Herein, we briefly present prevalence estimates of LGB IPV before turning to the limited research on prevalence among trans individuals. For a more detailed review of IPV prevalence in LGBQT* communities, see Brown and Herman (2015).

Currently, the best prevalence estimates on partner abuse in LGB communities come from the nationally representative 2010 National Intimate Partner and Sexual Violence Survey (NISVS) conducted by the U.S. Center for Disease Control & Prevention (Walters et al., 2013). Findings suggest higher rates of lifetime IPV experiences (defined as physical violence, sexual violence, or stalking) among lesbians (43.8%), bisexual women (61.1%), and bisexual men (37.3%) – but not gay men (26%) – compared to heterosexual women (35.0%) and heterosexual men (29%). In addition, findings from the California Health Interview warrant mention. Based on a probability sample of California residents ages 18 to 70, this study found that lifetime and 1-year IPV prevalence was higher in sexual minorities compared with heterosexuals, but this was significant only for bisexual women and gay men.

Determining IPV prevalence based on gender identity is difficult due to a lack of studies with representative or even large samples. The National Transgender Discrimination Survey is one of the largest studies of transgender individuals' experience of discrimination with 6,456 participants (Grant, Mottet, & Tanis, 2011). This study did not focus on IPV in particular, but did measure related phenomena. The researchers found that 19% of respondents reported experiences of violence at the hands of a family member specifically due to their gender identity. This statistic is likely an underestimate because it excluded DV perpetrated by non-family intimate partners as well as DV unrelated to gender identity. A much higher percentage of participants reported experiencing actions that may or may not be part of abusive behavior: 29% reported an ex-partner limiting their contact with their children, 45% reported having a relationship end when they came out as trans to their partner, and 57% experienced family rejection (Grant et al., 2011). However, these are unreliable proxies for IPV.

[3] Cisgender is a term that refers to individuals for whom the gender they were assigned at birth matches their gender identity. It can be thought of as meaning "not transgender."

Only one study to date has compared IPV among transgender to IPV among cisgender individuals. Analysis of data from One Colorado's anonymous 2011 LGBT Health Survey (n= 1,193) found that 31.1% of trans respondents reported experiencing IPV, compared to 20.4% of cisgender respondents (Langenderfer-Magruder et al., 2016) – findings that suggest transgender individuals experience higher rates of IPV than their cisgender, LGB counterparts. Furthermore, preliminary evidence suggests that different subgroups within transgender communities experience different rates or types of IPV (Chestnut, Jindasurat, & Varathan, 2012; Clements, Katz, & Marx, 1999). Future studies should examine these differences, particularly with regard to differences between trans men and trans women and with attention to intersecting identities for all participants (e.g., race, sexual orientation, disability, socioeconomic status).

Similarities of LGBQT and Heterosexual IPV*

In general, IPV experienced by LGBQT* individuals follows patterns similar to heterosexual and cisgender individuals (Ristock, 2005). Specifically, abuse can take the form of physical or sexual violence as well as emotional, financial, or verbal abuse. Messinger's (2011) analysis of the National Violence Against Women Survey revealed that the prevalence of various types of abuse in GLB communities mirrored prevalence rates among heterosexuals: Both groups reported prevalence rates that went in descending order from verbal abuse to controlling behavior to physical violence to sexual abuse. However, as described next, there are also unique aspects of IPV in LGBQT* communities, and potentially important differences among LGBQT* subgroups.

Unique Characteristics of IPV in LGB communities

IPV occurs in a larger societal and systemic context of homo-, bi-, and transphobia, heterosexism, misogyny, and patriarchy. These factors can influence abuse tactics and relationship dynamics for LGBQT* survivors, making their experiences different from those of heterosexual survivors. For example, sexual minority victims of IPV may be subject to abusive tactics that leverage systemic and cultural discrimination (i.e., identity abuse; Ard & Makadon, 2011; Balsam, 2001; Balsam & Szymanski, 2005; FORGE, 2014; Gay Men's Domestic Violence Project, 2014; National Center on Domestic & Sexual Violence, 2014; West, 2012). Examples of identity abuse include denying or belittling an individual's LGBQT* identity (e.g., refusing to use preferred gender pronouns), restricting access to a supportive LGBQT* community (NCDSV, 2014), or threatening to disclose a survivor's sexual orientation, gender identity, or HIV/AIDS status (Ristock, 2005). People who use violence against their LGBQT* partners may also use threats to authenticity as a method of control, making survivors feel that they are not "queer enough" or do not understand how LGBQT* relationships are supposed to be (Bornstein, Fawcett, Sullivan, Senturia, & Shiu-Thornton, 2006). Controlling behavior, in general, may be a particularly important aspect of DV among LGBQT* couples, and may result in even higher levels of psychological harm than physical abuse alone (Frankland & Brown, 2014).

IPV in LGBQT* survivors can also be minimized in a variety of ways: For example, common portrayals of DV in the media – usually depicting heterosexual relationships, specifically men abusing women – can render invisible even to themselves experiences of underrepresented survivors (Holt, 2011). Pervasive beliefs that LGBQT* relationships are more egalitarian or that gay and lesbian individuals are better able to defend themselves against partners who use violence also serve to render IPV invisible in these communities (Bornstein et al., 2006; Holt, 2011; Walters, 2011).

Finally, although isolation is a commonly used tactic in heterosexual as well as in LGBQT* relationships, it may be more difficult to overcome in tight-knit LGBQT* communities in which relationships and resources are often shared with the abusive partner (Bornstein et al., 2006). The level of isolation is even more pronounced for LGBQT* survivors from rural and immigrant communities (Ristock, 2005).

Unique Characteristics of IPV among Transgender People

There is limited research on the characteristics of IPV in transgender communities. The National Coalition of Anti-Violence Programs 2014 annual survey of its member programs reported that, compared to people who did not identify as transgender, transgender survivors were two times more likely to face threats/intimidation, nearly two times more likely to experience harassment, and over four times more likely to face police violence in response to reporting IPV (National Coalition of Anti-Violence Program, 2015b). Transgender women were at highest risk of experiencing threats/intimidation, harassment, and injury (NCAVP, 2015a), and transgender people of color were the most likely to report experiencing threats of intimidation in their intimate partnerships.

Generally high rates of violence, trauma, and discrimination in the lives of transgender individuals may have a compounding effect, influencing transgender IPV survivors' willingness to identify abuse or seek help. FORGE's safety planning guide remarks that transgender individuals may feel unwanted, or "believe that they are lucky to ever find love, even if that love turns violent" (Guadalupe-Diaz, 2013, p. 3). In a study of transgender relationship violence, some participants could not even conceptualize their trans partner's behavior as abusive because they viewed these partners as being so oppressed themselves (Ristock, 2011).

Multiple Experiences of Violence in LGBQT Communities*

Because of the fragmented nature of research on violence and abuse in the lives of LGBQT* individuals, the prevalence of "polyvictimization"[4] – that is, multiple kinds of violence and abuse committed by different people – in this community is still unknown. However, evidence suggests that LGBQT* individuals are more likely to experience multiple types of violence (e.g. sexual abuse, physical abuse, and exposure to domestic violence during childhood; sexual assault, physical assault, and stalking during adulthood) at the hands of many different types of individuals (family, partners, community members, legal actors, strangers) and at multiple points in their lifetime (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Grant et al., 2011; Stotzer, 2009).

Specific subgroups of LGBQT* survivors are at especially high risk for multiple forms of victimization. One notable example is LGBQT* homeless youth, highly overrepresented among homeless populations (Durso & Gates, 2012; Grant et al., 2011; Hunter, 2008). Evidence indicates that family and partner violence are major drivers of such homelessness (Cochran et al., 2002; Durso & Gates, 2012; Grant et al., 2011; Risser & Shelton, 2002). Homelessness in turn may render LGBQT* peoples increasingly vulnerable to other forms of violence including harassment, hate crimes, police brutality, and sexual exploitation (Amnesty International, 2005; Durso & Gates, 2012; Keuroghlian et al., 2014; Mogul, Ritchie, & Whitlock, 2012; NCAVP, 2015a; NCAVP, 2015b; Reck, 2009). Layered onto these experiences are other types of oppression such as housing, employment, and healthcare, which are themselves traumatogenic and which also act as barriers to help seeking (D'Augelli, 1998; Durso & Gates, 2012; Grant et al., 2011; Tyler, 2008).

Unique Experiences of IPV among Specific Subgroups of LGBQT Survivors*

The experience of IPV for specific subgroups may be quite different than that of White, middle-class LGBQT* survivors (Chavis & Hill, 2009). The intersections of various identities result in unique social contexts shaped by multiple systems of power and oppression (Chavis & Hill, 2009; Feltey, 2001). These systems may shape the way that IPV is enacted and experienced, and the way it is addressed by service providers. Although attention to all intersections would be beyond the scope of this document, here we focus on three subgroups that have received especially scant attention: sexual minorities in Native communities, immigrant and refugee communities, and faith-based communities. Although there is virtually no research on IPV within these subgroups, it is nevertheless instructive to understand this context when considering the experience of IPV for people within these communities. Later sections touch on specific aspects of the help-seeking experience of African-American and Latin@ LGBQT* survivors.

[4] "Polyvictimization" refers to experiences of multiple kinds of violence and abuse, at the hands of multiple people at multiple points in the lifespan. The authors have chosen to put this word in quotes because some have understood it to imply that the victim is somehow responsible for for these experiences. This would obviously be inaccurate and inappropriate. Indeed, there is now a rich literature on the ways that people who use abusive behaviors target individuals with prior trauma histories.

Two-Spirit and LGBT Native Peoples. In general, there is scant research on the experiences of Two-Spirit and LGBT Native individuals. However, the fact that rates of violence and abuse against cisgender, heterosexual Native women are so high suggests that Two-Spirit Native women might be at especially high risk compared to their non-Native sexual minority counterparts (Lehavot, Walters, Simoni, 2009). Consistent with this view, one study showed that 78% of Two-Spirit women reported experiencing physical assault and 85% reported experiencing sexual assault (Lehavot et al. 2009).

These statistics are all the more alarming given that Native women, regardless of Two-Spirit or LBT status, are more likely to experience physical brutality, and therefore injury, during rapes and sexual assaults (Amnesty International, 2007). Further, some Native researchers have noted the disproportionate impact of homo/transphobia that occurs within the Native community given that Two-Spirit survivors may need cultural support from their own people in the face of violence and trauma (Frazer, Somjen, & Pruden, 2010). Not surprisingly then, violence against Two-Spirit and Native LGBQT* individuals also contributes to the development of a range of health and mental health conditions, such as liver disease, substance abuse, PTSD, as well as to behaviors that increase the risk for HIV (Balsam, Huang, Fieland, Simoni, & Walters, 2004; Centers for Disease Control and Prevention, 2001; Evans-Campbell, Lindhorst, Huang, & Walters, 2006; Simoni, Seghal, Walters, 2004). Clearly, more research is needed on IPV in the lives of Two-Spirit and LGBQT* Native peoples.

Immigrants and Refugees. The experiences of LGBQT* immigrant and refugee survivors of IPV are largely invisible in the academic literature. The broader research on DV in heterosexual, cisgender immigrant communities is complex, indicating that they experience lower rates of IPV, but higher rates of IPV homicide compared to non-immigrants (Bohn, 2003; Tjaden & Thoennes, 1998).

Although there is a need for more prevalence research, it is well documented that sexual minority immigrants face challenges resulting from historically homophobic immigration policies (Chung & Lee, 1999). Under the Immigration and Nationality Act of 1917, LGBQT* immigrants were strictly prohibited from entering the United States on the grounds that they were "mentally or physically defective." The Immigration & Naturalization Act of 1952 similarly prevented LGBQT* immigrants from entering the U.S. based on the idea that they were "afflicted with psychopathic personality" (Foss, 1994). Even up to 1990, Public Health Service physicians barred entrance to those immigrants suspected to be LGBQT*, labeling them as "sexual psychopaths." In addition to contending with these oppressive policies, LGBQT* immigrants were also isolated within their own communities and shunned by white, non-immigrant LGBQT* communities because of their immigration status (Cantú, Hurtado, & Anzaldúa, 2012; Moraga & Anzaldúa, 1981). Even today these interpersonal and institutional challenges echo in the lives of sexual minority immigrants and likely create unique challenges for LGBQT* immigrant and refugee survivors of IPV.

Religious or Spiritual LGBQT Survivors*. LGBQT* people have both positive and negative experiences of faith, possibly even simultaneously. Researchers and practitioners highlight the healing value of religious communities and practices for this community (e.g., Queer Muslims of Boston,

FaithTrust Institute; Ryan, Huebner, Diaz, & Sanchez, 2009). Yet, institutionalized religious policies and principles continue to be a major source of social oppression for many LGBQT* people (Clarke, Brown, & Hochstein, 1989; Davidson, 2000; Hilton, 1992; McNeill, 1993; Morrow & Gill, 2003; Spong, 1991; Spong, 1998). For example, many religious practices condemn non-heterosexual behavior (Bouhdiba, 1998; Jaspal & Cinnirella, 2010) and view LGBQT* people as immoral and spiritually corrupt (Morrow & Gill, 2003). For many religious LGBQT* people, family and societal rejection is therefore compounded by the loss of religious communities (Mahaffy, 1996).

Sources of conflict for religious LGBQT* people include anti-gay religious teachings and scriptural interpretations, homo/bi/transphobic church atmospheres, fear of being "outed" in non-affirming religious settings, and microaggressions (i.e., subtle forms of oppression) from people within their religious communities (Brown & Pantalone, 2011; Shuck & Liddle, 2001). Not surprisingly, receiving homophobic messages through a religious medium has been found to be associated with internalized shame among LGBQT* individuals (Herek, 1987; Ream, 2001).

The challenges of participating in a faith community that is not LGBQT*-affirming may be particularly acute for LGBQT* individuals of color and immigrants since the support role of faith-institutions is particularly crucial in these communities due to the lack of other available social supports. For example, Christian religious institutions have served a range of healing functions within African American communities, where faith has been an important source of strength in the face of ongoing racialized violence and oppression (Billingsley, 2003; Cone, 1997; Cone, 2010; Higginbotham, 1994; Lincoln & Mamiya, 1990). Yet, for African American young men, churches are the primary source of anti-gay messages in their communities (Stokes & Peterson, 1998). The loss of access to one's faith community under such circumstances may be particularly wounding. These challenges are real and ongoing, but their effects on LGBQT* survivors of IPV remain unexplored. Most research on the experience of IPV survivors in relation to their faith communities focuses on the spiritual lives of heterosexual, cisgender women. Clearly, more research is needed in this area.

In sum, violence – be it by intimate partners, family and community members, or society at large – is a common occurrence in the lives of many LGBQT* individuals. Because such polyvictimization is rooted in and exacerbated by the larger context of homophobia and transphobia, the experiences of LGBQT* survivors differ in many ways from those of heterosexual, cisgender survivors. Given that experiences differ, so too does the impact of experiencing IPV. We turn next to the research on the mental health consequences of IPV among LGBQT* survivors as well as protective factors that promote resilience.

Trauma and Mental Health in LGBQT* Communities

The emerging literature on how IPV affects the mental health of LGBQT* survivors is mixed, with some studies indicating that the impact is similar for LGBQT* and non-LGBQT* survivors, and others indicating that adverse effects are more common among LGBQT* survivors (Edwards, Sylaska, & Neal, 2015). This section reviews that literature, focusing especially on depression and PTSD – two common mental effects of abuse. As this section will show, emerging research indicates that bisexual and transgender survivors may be at particularly high risk for experiencing adverse mental health effects.

Depression. LGBQT* survivors of IPV, similar to their heterosexual and cisgender counterparts, are particularly at risk of depression. One longitudinal study examining data from a nationally representative survey of adolescents between the ages of 18 and 27 (227 gay and lesbian, 345 bisexual, and 13,490 heterosexual) found that across all three groups, exposure to IPV was significantly related to increased depression – even after controlling for exposure to childhood physical or sexual abuse and homelessness or expulsion from one's home by caregivers (McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012). This is consistent with a more recent meta-analysis examining 19 studies, which found that men who are victims of IPV at the hands of other men are more likely to use substances, suffer from depressive symptoms, have an HIV positive diagnosis, and engage in unprotected sex (Buller, Devries, Howard, & Bacchus, 2014). As a whole, this body of literature suggests that LGBQT* IPV survivors are at greater risk for experiencing depression than LGBQT* individuals without IPV experience.

Looking more closely within the LGBQT* community, there is some evidence indicating that bisexual individuals may have disproportionately high rates of depression as compared to gay and lesbian individuals (Bostwick, Boyd, Hughes, & McCabe, 2010). Interestingly, theoretical work has posited that the relatively high mental health difficulties within the bisexual community may be attributable to the additional stressors of experiencing bi-negative attitudes from both heterosexual and LGTQ communities. The National Epidemiologic Survey on Alcohol and Related Conditions, which compared rates of major depression among lesbian, gay, bisexual and heterosexual adults (*n*=34,653), found that both male and female individuals who reported bisexual behavior had higher lifetime rates of all mood disorders, including depression (Bostwick et al., 2010). By extension, one might expect bisexual survivors of IPV to be at particular risk for depression.

Likewise, there is scant research on depression and other mental health effects of IPV for transgender survivors. There is, however, literature on the relationship between interpersonal violence more generally and symptoms of depression in this community. For example, in one cross-sectional study of over 591 MTF participants from the New York City area, 63% had depression scores in the clinical range. Further, in this same sample, violence that was related to one's gender identity, or gender abuse, was predictive of depression (Nuttbrock et al., 2014). These findings are consistent with another study of 6,436 transgender-identified individuals, in which 19% of respondents had experienced violence at the hands of a family member because of their chosen gender identity. This exposure was associated with over twice the rate of suicidality, with 65% of those who experienced family violence also reporting

having attempted suicide, compared to 32% of those who did not experience family violence (Grant et al., 2011). Overall, though the literature remains inconclusive, it raises questions about whether transgender survivors of IPV could be at increased risk for depression.

PTSD. IPV exposure also increases the risk of PTSD symptoms in the LGBQT* community. According to the CDC's 2010 IPV report described previously (i.e., NISVS) 19.5% of lesbian women, 46.2% of bisexual women and 22.1% of heterosexual women report experiencing at least one symptom of PTSD – defined as having nightmares and intrusive thoughts of the traumatic experience; feeling constantly on guard, watchful or easily startled; and feeling numb or detached in response to an experience of IPV (Walters et al., 2013). Data from bisexual, gay, and heterosexual men were excluded from the analysis due to small sample sizes. Evidence from other research, however, suggests that that the relationship between IPV and PTSD may extend to gay and bisexual male survivors (Pantalone, Hessler, & Simoni, 2010).

Consistent with the findings on IPV and depression, there is initial evidence that bisexual survivors of IPV have higher rates of PTSD than gay and lesbian survivors. According the CDC's NISVS, more than half of bisexual women (57.4%) who experienced physical or sexual violence or stalking reported at least some form of negative impact (e.g., experiencing PTSD symptoms, missing a day of school or work, feeling fearful or concerned for their safety) as compared to a third of lesbian women (33.5%), and a fourth of heterosexual women (28.2%) (Walters et al., 2013). Significantly more bisexual women (46.2%) reported experiencing at least one symptom of PTSD as compared to lesbian (19.5%) and heterosexual women (22.1%) (Walters et al., 2013). These results suggest that bisexual women may be at disproportionately high risk for developing PTSD after experiencing IPV.

Again, literature on the relationship between IPV and PTSD in transgender communities is limited. As noted earlier, transgender individuals are especially likely to experience violence and discrimination in the domains of education, health, family life, and work which may shape their responses to partner violence (Grant et al., 2011). These risks are not equally distributed among trans individuals. Trans women experience higher rates of violence than trans men, probably because they are less able to "pass" (i.e., be perceived as the gender they identify as) (Dean et al., 2000; Mizock & Lewis, 2008). The risks may also be explained by the concept of trans-misogyny: the idea that there is a particular brand of discrimination that combines transphobia with sexism and applies specifically to trans women (Serano, 2007).

In addition, trans people of color are at particularly high risk (Richmond, Burnes, & Carroll, 2012). In a study of MTF youth of color in Chicago, major life stressors included lack of transportation, difficulty finding a job, sex in exchange for resources, being frequently bothered by police, forced sexual activity, difficulty finding a safe place to sleep, difficulty accessing healthcare, and history of incarceration and homelessness (Stieglitz, 2010). Given that multiple experiences of trauma are more likely to result in the development of clinical PTSD (Scott, 2007), it is not surprising that in one study of MTF transgender individuals, 17.8% reported clinically significant symptoms of PTSD (Shipherd, Maguen, Skidmore, &

Abramovitz, 2011). As a whole, the literature on bisexual and transgender communities makes clear the need for researchers to continue to investigate the distinct experiences of subgroups of the LGBQT* community.

The mental health consequences of IPV among LGBQT* survivors must also be understood within the broader context of historical trauma. Historical trauma is a term used to describe repeated communal traumatic events that exist across time, are embedded throughout culture, and can result in an intergenerational cycle of traumatic stress (Sotero, 2007). Oppressed communities subjected to historical trauma are at heightened risk for mental and physical health consequences compared to communities not exposed to such trauma (Danieli, 1998; McMichael, 1999; Sotero, 2007). Not only have LGBQT* people endured such historical trauma as a group, but many such individuals have also experienced intergenerational trauma originating from other identities such as those based on race or religion (DeGruy, 2005; Franklin, Boyd-Franklin, & Kelly, 2006; Jaimes & Halsey, 1992). Studies have shown that cumulative historical traumatic events actually increase survivors' risk for lifetime trauma and interpersonal violence (Chae & Walters, 2009). These forces are critical to understand when considering the mental health impact of violence against various subgroups of the LGBQT* communities.

Resilience in LGBQT Communities*

Research has identified several important factors that contribute to strength and resilience among LGBQT* survivors. In particular, a positive LGBQT* identity, or *identity affirmation,* and social support from friends can profoundly influence survivors' mental health.

Regarding the first of these two factors, LGBQT* identity affirmation has been well documented as critical to positive mental health outcomes. For example, one study investigating 165 lesbian, gay, and bisexual youth found that family support and self-acceptance mediated the relationship between victimization and mental health (Hershberger & D'Augelli. 1995). Another study surveyed 613 lesbian, gay, and bisexual individuals and found that LGB individuals who have positive appraisals of their LGB identity and do not anticipate rejection from others had lower psychological distress (Balsam & Mohr, 2007). In a subsequent study, the same authors found that higher identity acceptance negatively correlated with measures of depression, guilt, fear, hostility, and sadness, and positively correlated with measures of general life satisfaction, self-assurance, and social self-esteem (Mohr & Kendra, 2011). Finally, in a study of trans people of color who were survivors of traumatic events, participants named pride in one's gender and ethnic identity as critical to resilience (Singh & McKleroy, 2011). In short, LGBQT* individuals who feel more positive about being LGBQT* or their ethnicity are able to cope more successfully with the challenges they face.

Social support from friends and family also serves a critical protective role. Moody and Smith (2013), for example, found that perceived support from friends was associated with reduced suicidality among trans individuals. For transgender youth of color, identifying other youth and adults with similar identities helped to validate their experiences of racism within the LGBQT* community (Singh, 2013).

And in one study of MTF youth of color, friends were the most frequently cited source of support, and physicians or case managers were perceived as at least somewhat helpful (Stieglitz, 2010).

Social media has become a critical conduit for accessing social support within the LGBQT* community (Singh, 2013). Online communities have become sites of community organizing, cultural empowerment, and education for LGBQT* people, enhancing both a sense of identity and a sense of social support and community (Mehra, Merkel, & Bishop, 2004). Religion and spirituality may also contribute to resilience, particularly as these become sources of social support (Potter, 2007).

In sum, there is a clear need for supportive mental health and trauma-informed approaches for LGBQT* individuals. Furthermore, these services must recognize the societal factors that contribute to individual mental health concerns. LGB individuals, and transgender individuals in particular, experience high rates of traumatic experiences that stem from social isolation, prejudice, and discrimination. These experiences can have many negative mental health outcomes, and are exacerbated by multiple forms of oppression. Nonetheless, LGBQT* individuals show remarkable resilience by developing strong social support networks, creating and engaging with online and activist LGBQT* communities, and developing a positive LGBQT* identity. Trauma-informed approaches must allow providers to understand the context in which survivors have experienced abuse, identify sources of individual and communal strength and resilience, and support healing. Unfortunately, the current reality for sexual minorities who seek help from informal and formal supports is far different.

Help-Seeking Among LGBQT* Survivors

A range of systemic, institutional, and individual-level barriers uniquely thwart LGBQT* peoples' access to informal and formal support services (Edwards, Sylaska, & Neal, 2015; Helfrich & Simpson, 2006). At the broadest level, pervasive heterosexism renders violence between same sex partners invisible. The myth that IPV occurs only between men and women contributes to the profound difficulty that service professionals have even identifying IPV among LGBQT* couples (Blasko, Winek, & Bieschke, 2007; Brown & Groscup, 2008; Helfrich & Simpson, 2006; Seelau & Seelau, 2005). Brown and Groscup (2008) studied 120 crisis center workers' perceptions of same-sex DV by presenting scenarios in which only the gender of the abuser and survivor were changed, and found that participants ranked same-sex DV as less severe and less likely to get worse than the same scenario among heterosexual pairs. Although service providers may recognize that LGBQT* survivors deserve protection from IPV just as heterosexual survivors do (Sorenson & Thomas, 2009), these kinds of biases may affect their ability even to identify IPV in this community (Basow & Thompson, 2012).

Beyond the invisibility of LGBQT* IPV, a range of factors cause well-meaning social services systems to harm members of marginalized communities, including sexual minorities. Forms of oppression such as racism, colonialism, ableism, heterosexism, sexism, and transphobia that are often implicit in our helping systems can render these systems traumatogenic, especially when these oppressive dynamics are not acknowledged (Buzawa & Buzawa, 2003; Dirks, 2004; Herman, 2003; Walters, Simoni, & Evans-Campbell, 2002). The kind of harm done by institutions designed to provide support has been termed "sanctuary harm" (Bloom 2011; Bloom 2013).

A primary example of a system that causes this kind of sanctuary harm is the healthcare system. Historically, medicine and the health sciences were central to the effort to pathologize same sex relationships and transgenderism. Being gay or lesbian was classified as a mental disorder by the American Psychological Association until 1973, and conceptions of gender dysphoria as a mental health condition did not undergo a similar revolution until 2013 (Bayer, 1987; Drescher & Merlino, 2007).

The continuing impact of this history is evident in the experiences of LGBQT* patients in healthcare settings. Lambda Legal (2010) found that more than half of all sexual minority survey participants had experienced at least one of the following types of discrimination in a healthcare setting: being refused needed care; being blamed for their health status; seeing healthcare professionals refuse to touch them or use excessive precautions; hearing healthcare professionals use harsh or abusive language; or experiencing healthcare professionals being physically rough or abusive. Similarly, Shires and Jaffee (2015) found that over 40 percent of transgender men reported verbal harassment, physical assault, or denial of equal treatment in a doctor's office or hospital. Grant et al. (2011) reported that over one-quarter of respondents in a survey for the National Center for Transgender Equality experienced verbal harassment in medical settings, and that the likelihood of discrimination, abuse, or assault of transgender patients by their provider actually increased with the provider's awareness of their patient's transgender status. Such experiences of discrimination are far more likely to affect

LGBQT* patients of color, financially-oppressed patients, and undocumented patients (Grant et al., 2011; Lambda Legal, 2010).

Other examples of sanctuary harm abound across systems. For example, between 2010 and 2011, LGBQT* survivors reported an increase of incidences in which the police arrested both the abuser and victim when called (28.4% up from 21.9%), an increase in the percentage of LGBQT* survivors seeking shelter who were denied (61.6% up from 44.6%), and a decrease in the percentage of LGBQT* survivors who received requested orders of protection (78.1% down from 83.7%; NCAVP, 2015b). The same study found that transgender IPV survivors were over six times more likely to experience physical violence while interacting with the police than other survivors, and more likely to experience hate violence in shelters than other survivors (notably, trans men were 3.5 times more likely; whereas, trans women 1.3 times more likely) (NCAVP, 2015b). In short, transgender survivors may experience even more re-traumatization and less access to formal support systems than LGB survivors.

Mainstream programs may use heterosexist language in program materials, or have ambiguous or poorly defined policies regarding service provision for LGBQT* survivors (Helfrich & Simpson, 2006). LGBQT* survivors may well anticipate discrimination both from staff members and the heterosexual survivors using these services and may worry that their sexual orientation (and one could assume, gender identity) will be revealed should they actually seek help (Bornstein et al., 2006; McClennen, 2005; Helfrich & Simpson, 2006).

Low-income LGBQT* survivors of color experience another set of barriers: A community needs assessment of Black and Latin@ LGBQT* communities in the greater Boston area (Tod@s, The Hispanic Black Gay Coalition, The Violence Recovery Program at Fenway Health, The Network/La Red, & Renewal House, 2013) found that a lack of outreach to these communities limited their knowledge of IPV resources. In addition, geographic isolation, lack of transportation options, and the cost of making phone calls were major challenges to finding formal help. Similar to Black and Latin@ communities, Two-Spirit individuals identified lack of financial resources, transportation, and geographic inaccessibility as barriers to seeking support (Walters, Horwath, & Simoni, 2001). In addition, the lack of programming specifically aimed at Two-Spirit people and fear of what other Native community members might think were consistently ranked as barriers.

In the context of these institutional barriers, sexual minority survivors describe a range of personal reasons for not seeking support. Many feel that the need to educate a provider about one's identity and experiences would be overwhelming, particularly during a time of crisis (Turrell & Herrmann, 2008). Others worry about further victimization by providers who lack training on LGBQT* issues, and by other clients accessing the same services (Bornstein et al., 2006). Talking about abuse in one's intimate relationship almost always means coming out about one's sexual orientation or possibly one's gender identity. Further, gossip in insular or tight-knit communities raises concerns of confidentiality and retaliation – not just by the abuser but also by the community at large. Gay male survivors may keep silent about abuse and be more reluctant to seek help because they do not see doing so as consistent

with notions of masculinity (Seidler, 2006). According to Spiegel (2003), the abuse thrusts male survivors into "confrontation between two disparate psychosocial processes: the realities of abuse and the mythology of masculinity" (p. 133). Notably, although LGBQT* individuals may be hesitant to contact mainstream domestic violence programs, one survey reported that 86.2% of LGBQT* respondents *would* contact a domestic violence program if it was LGBQT*-specific (Holt, 2011).

Although the majority of LGBQT* survivors do not immediately seek help from the formal service system, they do rely on their informal social support systems; that is, their friends and families (Edwards et al., 2015). And yet, here too, LGBQT* survivors face a range of barriers to support. For example, LGBQT* survivors may be reluctant to seek help from friends and family given their own or their community's gendered beliefs about violence (e.g., women cannot be violent and men cannot be victimized) (Seelau & Seelau, 2005; Walters, 2011). They may be particularly hesitant to seek help from heterosexual friends or family members if they have had previous experiences of heterosexism and cissexism from their peers (Ard & Makadon, 2011). Survivors may have received messages that LGBQT* relationships themselves are "wrong" or "sick." Consequently, they may feel that admitting violence will only confirm these messages, conferring a sense of stigma on the victim, the relationship, and the LGBQT* community in general. Alternately, survivors who feel as though they are representing the LGBQT* community may feel that admitting IPV will harm the LGBQT* community at large (Balsam, 2001). Also, friends and resources may be shared between the survivor and perpetrator to an even greater degree than in heterosexual relationships, further making it difficult to access support (Bornstein et al., 2006).

In sum, a range of factors hinder LGBQT* survivors from seeking formal and informal assistance. Some survivors choose not to seek help from anyone; however, many survivors will make at least an initial attempt, and how they are treated can affect likelihood of seeking help in the future. Formal systems such as DV programs, hospitals, and law enforcement have a responsibility to ensure that they are facilitating help-seeking, not preventing it. To that end, the next section reviews the literature on a trauma-informed approach to practice, with attention to the needs of service providers who work with LGBQT* survivors, and provides examples of community-specific approaches to trauma.

Trauma-Informed Practices

A growing body of literature suggests that incorporating trauma-informed approaches into work with survivors is beneficial for the participant, staff, and overall organization. In this section we review the definition and core principles of a trauma-informed approach. Next, we discuss the need for LGBQT*-specific trauma-informed models and the role of transformative justice in developing such models.[5]

The term trauma-informed services was first used by Maxine Harris and Roger Fallot (2001a) in the context of mental health and addictions treatment programs. They noticed that many individuals seeking these services had experienced high rates of physical and sexual abuse, yet few providers were knowledgeable about trauma and the effects of such violence. As a result, services were not designed with trauma survivors in mind, increasing the possibility of retraumatization by the very services that were supposed to help them.

In response, Harris and Fallot (2001b) proposed creating trauma-informed service systems. This meant recognizing that the majority of people seeking services are likely to have experienced trauma; and that the effects of trauma impact many life domains, including people's experience of services. Thus, they argued, services had to be redesigned to incorporate an understanding of the pervasiveness of trauma and its impact on every aspect of their work. That is, programs and practices needed to be welcoming and appropriate for individuals with a history of trauma; and they needed to minimize retraumatization and promote healing and recovery. This, in turn, required an organizational commitment to trauma-informed practice, and ensuring that the necessary training for staff was in place.

In their initial work, Harris and Fallot (2001a) identified five requirements for creating trauma-informed services: (1) administrative commitment to change; (2) universal screening for trauma history among participants/clients;[6] (3) training and education on trauma for all staff; (4) hiring staff with a deep knowledge of trauma, referred to as "trauma champions;" and (5) reviewing policies and procedures to ensure they do not replicate abusive dynamics.

Although Harris and Fallot's approach was developed in the context of mental health and addictions services, its underlying principles have been adapted and applied to several different service contexts. These contexts include correctional facilities (Hodas, 2006), psychiatric and hospital settings (Jennings, 2004), homelessness services (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009), addiction

[5] While the terms trauma-informed care and a trauma-informed approach are sometimes used interchangeably, the use of these terms has evolved over time. Trauma-informed care while perhaps still applicable in settings that provide health or mental health care, is actually inconsistent with the spirit/principles of a trauma-informed approach which involves service relationships that are fully collaborative rather than one person providing and the other receiving care.

[6] The requirement for universal trauma screening emerged in the context of mental health and addictions treatment services and are not necessarily applicable to other service settings such as DV programs.

services (Covington, 2008), services for children who have experienced abuse (Hodas, 2006; Ko et al., 2008), and DV organizations (Warshaw, Sullivan, & Rivera, 2013; Warshaw 2014; Wilson, Fauci, & Goodman, 2015).

These adaptations have not fundamentally altered the original principles, but have offered more expanded and nuanced interpretations of how they work in practice. In their excellent review, Hopper, Bassuk, and Olivet (2010) identified core principles that cut across different service contexts. These include: trauma awareness (e.g., staff training, consultation, supervision and self-care); safety (e.g., physical and emotional safety for all, awareness of potential triggers, clear roles and boundaries, and cultural diversity); opportunities to rebuild control (e.g., predictable environments, rebuilding efficacy, and personal control over lives); and a strengths-based approach (e.g., focus on future and skills-building).

Furthermore, Elliot, Bjelajac, Fallot, Markoff and Reed (2005) placed trauma-informed principles in the context of the entire service system and environment. For example, in a trauma-informed system, survivors engage with staff as collaborative partners rather than as passive recipients of services, and organizations actively solicit survivor input. In trauma-informed organizations, providers also strive to understand each survivor within the context of their background and life experiences and in terms of what is meaningful to them. Such contextualizing is essential. Because survivors experience trauma and seek support in a social, historical, and political context, healing must also include recognition of this context.

In order to do this difficult work, staff must themselves be supported. A fundamental aspect of a trauma-informed approach, therefore, involves creating an organizational environment that facilitates providers' capacity to do their work well. Clients interact with individual providers, who themselves interact with supervisors and the organization. When providers are subject to stressful organizational dynamics, those stresses interfere with their ability to be effective (Bloom, 2010). One consequence of problematic organizational dynamics is vicarious traumatization (synonymous with secondary traumatic stress or compassion fatigue) among service providers. Vicarious traumatization has been defined by Charles Figley (1995) as "the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7), and symptoms may mimic those of PTSD. Vicarious traumatization has been linked to burnout in several studies (Bemiller & Williams, 2011; Brown & O'Brien, 1998; Ortlepp & Friedman, 2002; Ullman & Townsend, 2007).

Vicarious traumatization is widespread. Findings from a study of 148 advocates working in a range of types of DV organizations indicate that 47.3% of participants met criteria for clinical levels of PTSD symptoms (Slattery & Goodman, 2009). Organizational factors that may contribute to vicarious traumatization include a lack of involvement or influence on decision making, feeling like one's abilities are not being used, being exposed to danger at work, and too much focus on fixed regulations, procedures, and paperwork (Brown & O'Brien, 1998). Indeed, Slattery and Goodman (2009) found that lack of access to power (i.e., equality, voice, representation, shared leadership, and respect) in the

workplace significantly predicted vicarious traumatization above and beyond individual factors (e.g., personal history of trauma and exposure to traumatized clients). They recommended creating a workplace that emphasizes support, cooperation, effective communication, and conflict resolution skills and asserted that efforts to "flatten the hierarchy" and address power differences at the organization may also help minimize vicarious traumatization.

Creating a trauma-informed service system, then, occurs on three levels. The first is focused on the needs of survivors. The second is focused on changing an organization's culture to support staff and fully integrate trauma-informed practices into its service delivery; and the third level acknowledges the larger societal context in which survivors seek services and organizations operate. This level emphasizes not only engagement with the individual as part of a community, but also with community change itself in order to transform the conditions that produce abuse, violence, and trauma in the first place (Warshaw, 2014; Wilson et al., 2015).

These overarching principles have been applied across trauma-informed service systems. However, the particular language used to describe specific practices that arise from them may vary substantially depending on the service setting. The appendix provides a table of six trauma-informed models that have been identified as having some relevance for this project either because of the communities being served (LGBQT* or IPV survivors), the popularity of the model, or the credibility of the organization. See also Wilson and colleagues' (2015) recent qualitative content analysis of key documents – publications, manuals, and training guides – that describe an emerging consensus on trauma-informed practices in the domestic violence context, as well as points of difference and tension.

It is important to note that trauma-*informed* services are different from, but related to, trauma-*specific* services. Whereas trauma-informed services are designed to be implemented at all levels of an organization and focus on limiting the potential for retraumatization among participants, trauma-specific services are aimed at treating actual trauma symptoms (Harris & Fallot, 2001a). Examples of trauma-specific services include grounding techniques, psychoeducation, mind-body approaches and body-based therapies, cognitive behavioral therapy, and complex trauma treatment (Courtois & Ford, 2009; Courtois & Ford, 2015; Jennings, 2004; Resick, 2003; Warshaw & Brashler, 2009). A number of trauma-specific interventions have been tested in experimental or quasi-experimental research designs. Several studies have also attempted to document the effectiveness of trauma-specific services for female survivors of domestic violence. For a systematic review of evidence-based, trauma-specific services for survivors of domestic violence, see Warshaw et al. (2013). It is important to note, however, that none of these studies focused on LGBQT* survivors.

Trauma-informed service models are inherently more difficult to study because they focus less on specific practices and more on general principles, and they rely on change at the organizational level. Nonetheless, the Women, Co-Occurring Disorders, and Violence Study (WCDVS) attempted to evaluate the impact of this approach. As the only longitudinal study of a trauma-informed approach, the WCVDS indicated that women who received trauma-informed services showed small but significant

improvements on mental health outcomes and trauma symptoms relative to treatment as usual, but no effect for substance abuse (e.g., Morrissey et al., 2005). Since then, researchers have developed several tools to measure the presence of trauma-informed principles and practices as experienced by survivors (see, Accessing Safety and Recovery Initiative & the National Center on Domestic Violence, Trauma, & Mental Health, 2012; Goodman et al., in press;), and are testing new measures of the effects of trauma-informed practices on survivor wellbeing (National Center on Domestic Violence, Trauma, & Mental Health, in development), yielding new possibilities for exploring this important approach.

Trauma-Informed Practices with LGBQT Survivors of IPV*

Despite the high rates of IPV and trauma in LGBQT* communities, trauma-informed approaches tailored to LGBQT* communities have been slow to develop. Some non-IPV trauma-specific interventions have been designed with input from LGBQT* individuals and with concern for LGBQT* cultural competence (e.g., de Arrellano, Ko, Danielson, & Sprague, 2008; Real Life Heroes and Target-A). In addition, the Technical Assistance Partnership for Child and Family Mental Health created a webinar that discusses trauma-informed care for LGBQT* homeless youth. However, there are few well developed trauma-informed approaches for LGBQT* clients in service settings generally, and none in the field of IPV services.

Because of the barriers and difficulties faced by LGBQT* survivors, providers who work with these particular communities may face unique challenges, including lack of resources both within and outside of the service organization, exposure to homo-, bi-, and transphobia through hotline prank callers, experiences of discrimination while attempting to connect survivors with resources, and the possibility of increased vicarious trauma through shared LGBQT* identities.

At the same time, advocates may find strength and resiliency through a shared LGBQT* identity, a strong sense of LGBQT* community, and increased work satisfaction in serving marginalized community members. Advocates who identify as LGBQT* also may be able to draw upon their own experiences of discrimination as a source of resilience in the face of hardship. However, these hypotheses, which are informed by the authors' extensive practice experiences, have not been explored in the literature; considerable research is needed to determine the strengths and job stressors for providers who work with LGBQT* survivors.

Examples of Community-Specific Approaches to Trauma

Although there are no well-developed LGBQT*-specific practices, several community-specific approaches that have been developed by members of culturally-specific communities that have experienced multiple and overlapping forms of oppression may serve as guides.

One example, "Indigenist coping," which was first posited by Walters and colleagues (2002), is a Native-specific model that asks providers to abandon a focus on individual pathology, and instead center the historical trauma, ongoing discrimination, and experiences as a colonized people within a first world nation that are the norm for Native peoples in the U.S. (Walters et al., 2002). The multiple traumas experienced by Native peoples both individually and collectively are the foundation of service provision.

Walters and colleagues interpret the disproportionate rates of substance use, mental health challenges, and HIV risk behaviors among Native people, as conditions that might best be addressed and healed within the context of reconnection to the history and spiritual and healing practices of the Native community. Perhaps the most interesting aspect of the Indigenist coping model is its focus on uprooting internalized colonization and integrating identity along political, ethnic, racial, cultural, and spiritual dimensions. Although this model is not specific to Two-Spirit peoples, it is Two-Spirit-inclusive, and provides a conceptual framework that is responsive to the layered traumas experienced by too many Two-Spirit individuals (Walters, et al., 2002).

Similarly, the National Latin@ Network for Healthy Families and Communities has long used human rights and social justice frameworks to interpret trauma. Specifically, they view trauma through an understanding of multiple kinds of historical & collective trauma, the traumatogenic impact of "non-traditional" traumas such as racism, nativism, poverty, and discrimination and unjust denial of services from helping systems currently and historically experienced by Latin peoples. The National Latin@ Network correspondingly looks to identity cultural traditions and collective knowledge and wisdom, as sources of resilience and post-traumatic growth, both for individuals and for entire communities. Much like the Indigenist coping model (Walters et al., 2002), the approach of the National Latin@ Network looks to the community for both healing and leadership (Serrata, 2012).

Transformative Justice as a Trauma-Informed Practice

Transformative justice analyses recognize systemic oppression as contributing to and exacerbating the impact of interpersonal and community violence and seeks justice at every level (Hairston & Oliver, 2006; Generation Five, 2007). Whereas trauma-informed practice was conceptualized in clinical and academic contexts, transformative justice grew out of a community-based intervention model. It moves away from criminalizing and pathologizing those who use violence and toward transforming organizations, conditions, and systems that perpetuate violence. It is critical that trauma-informed practices include transformative justice as an additional lens in service delivery and system reform.

Generation Five (2007), an advocacy-based project working to end childhood sexual abuse, has helped shape a practice-oriented understanding of transformative justice by offering several goals and principles needed to build greater capacity of communities to challenge traumatogenic systems. According to Generation Five, there are four specific goals of transformative justice: safety, healing, and agency for survivors; accountability and transformation for people who use violence; community action,

healing, and accountability among those in positions of power; and, transformation of the social conditions that perpetuate violence. Notably, these goals build on a set of core principles: 1) liberation, 2) shifting power, 3) safety, 4) accountability, 5) collective action, 6) honoring diversity and 7) sustainability. Here, we explain these principles by providing possible ways in which they could be applied to work with LGBQT* survivors.

Liberation refers to ending long-standing intergenerational cycles of systemic and family violence, which can be partly achieved by shifting power away from those whose power has been achieved through domination, oppression, and violence. In the case of LGBQT* survivors, shifting power includes listening and responding to survivors' articulation of their stories and needs in order to promote self-determination. Liberation and shifting power also applies to LGBQT* individuals who use violence: To end intergenerational cycles of violence, it is important to understand their violent behaviors within the context of institutions and norms that perpetuate violence against them. For example, DV organizations can adopt more fluid and nuanced definitions of "victim" and "perpetrator"; that is, definitions that allow for someone to be (or have been) both a victim of violence and someone who used violence. Doing so invites people's full trauma history into the conversation for consideration and healing.

Safety is conceptualized on three intersecting levels. First, on an individual level, LGBQT* survivors must be protected from immediate and future acts of violence via intervention and prevention efforts. Second, within individual communities, action must be taken to foster norms and practices that condemn violence and support conditions for healing. Finally, at the macro level, communities must be accountable to one other in order to challenge institutional power. Part of that accountability includes acknowledging the prevalence and impact of interpersonal and historical trauma on individuals and communities as well as committing to survivor empowerment and healing. For example, mainstream DV programs can develop relationships with LGBQT* community members and programs to work toward long-term accountability of culturally sensitive service provision. They also can engage in ongoing program evaluation, including open discussion of policies, procedures, and staff profiles, in an effort to transform trauma-inducing organizational norms. Futures Without Violence (n.d.) has developed a series of "Program Personnel Policy Questions" for DV organizations to assess their readiness to work with children and teens; many of these questions can be amended to assess readiness to work with LGBQT* survivors. The National Center on Domestic Violence, Trauma & Mental Health's Accessible, Culturally Relevant, DV & Trauma-Informed (ACDVTI) Agency Self-Assessment Tool also provides guidance on organizational readiness and LGBTQ* inclusiveness.

Collective action highlights the need to address cycles of isolation and shame resulting from traumatic experiences by building alliances with communities to transform structures that perpetuate abuse. Additionally, honoring diversity includes creating and implementing interventions that respond to the unique needs of each community. Finally, sustainability refers to building internal capacity of intimate and community networks to support and maintain survivor-centered safety and healing. These last three principles highlight how social service organizations must incorporate advocacy efforts into

their work and cannot operate in isolation. Instead, they must learn from and collaborate with other organizations, specifically culturally specific organizations. Such collaboration includes not only LGBQT* organizations but also organizations that reflect the range of identities that LGBQT* survivors possess. Incorporating a diversity of expertise and perspective into programs and policies is critical for providing a more trauma-informed approach.

Conclusion

This literature review documents the need for LGBQT*-specific trauma-informed practices with survivors of IPV. IPV is at least as common among LGBQT* individuals as heterosexuals, and may be highest in bisexual and transgender communities. Furthermore, although LGBQT* IPV shares many underlying dynamics with IPV in heterosexual couples, it also has unique characteristics, including the types of abusive tactics used and the context of discrimination and social stigma faced by LGBQT* individuals. Moreover, there are additional complexities within LGBQT* subgroups.

LGBQT* survivors also face unique barriers to help-seeking. Overall, LGBQT* individuals are less likely to seek services from law enforcement and mainstream providers and more likely to rely on informal social support and LGBQT*-focused programs. There are also differences in help-seeking *within* LGBQT* subgroups. For instance, trans individuals may have an especially difficult time accessing culturally competent and non-traumatizing services. For LGBQT* people of color, stigma, economic constraints, and the absence of community outreach are barriers to accessing services.

Trauma and mental health are major concerns in LGBQT* communities in general, and for LGBQT* survivors specifically. LGBQT* individuals experience higher rates of traumatic events, and may be more susceptible to developing symptoms of PTSD, depression, isolation, suicidality, and anxiety. These concerns, which must be viewed in the context of historical trauma, are amplified for LGBQT* people of color and transgender individuals. Nonetheless, LGBQT* individuals find strength and resilience through identity affirmation and social support. More research focused on the strengths and sources of resilience of LGBQT* people is needed to complement and inform existing research on pathology and barriers.

Despite the high rates of IPV and trauma that LGBQT* communities experience, trauma-informed approaches tailored to LGBQT* survivors have been slow to develop. We hope that this document will facilitate thinking about how the core principles of trauma-informed practice can be applied to working with this community and to ameliorating vicarious traumatization among service-providers who do their best in difficult circumstances. The practice-based observations in the Appendix provide further framing for this important endeavor.

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Appendix A: Existing Trauma-Informed Approaches

Trauma-informed Approach	Trauma-informed Care with LGBQT* Homeless Youth
Community	LGBQT* Homeless Youth

Principles	Examples of Practices
• Recovery is possible • Healing happens in relationships • Sharing power and governance • Understanding trauma and its impact • Promoting safety • Supporting client control, choice, autonomy • Focus on strengths • Integrating cultural awareness	• Organizational commitment to nondiscrimination and cultural competence • Involve LGBQT* youth in decisions about services • Provide positive LGBQT* role models • Coordinate with LGBQT* service and advocacy organizations • Collaborate with other organizations • Outreach to change public awareness • Include LGBQT* youth in outreach • Assess staff for knowledge, attitudes, skills

Poirier, J., Murphy, C., Shelton, J., & Costello, S. (2013). Ending LGBT youth homelessness: A call to action. Retrieved from http://tapartnership.org/events/webinars/webinarArchives/presentationSlides/20130710_LGBThomelessness_FINAL.pdf

Trauma-informed Approach	Trauma-Informed or Trauma-Denied
Community	Female Survivors of Trauma

Principles	Examples of Practices
• Recognize the impact of violence and victimization on development and coping • Identify recovery from trauma as primary goal • Employ an empowerment model • Strive to maximize women's choice and control over recovery • Services are based in relational collaboration • Create an atmosphere respectful of survivors' need for safety, respect and acceptance • Emphasize women's strengths, adaptations and resiliency • Minimize retraumatization • Services are culturally competent and understand each woman in context • Solicit participant input and involve participants in designing and evaluating services	• Outreach and Engagement: prioritize safety, ask permission, follow client's lead • Screening and Assessment: screen all clients for trauma history, understand survivor's unwillingness to answer certain questions, only ask for necessary information, balance usefulness of information against client needs, clearly communicate reason for asking questions • Resource Coordination and Advocacy: focus on empowering clients, identify strengths, emphasize skill-building • Crisis Intervention: plan for crises in advance, avoid using restraints or forced hospitalizations, make sure clients know their options • Trauma-Specific Services: offered in trauma-informed environment by individuals trained in trauma and its treatment • Parenting Services: build on parents' strengths • Mental Health and Substance Abuse: treat trauma and substance abuse in integrated way, emphasize physical and emotional safety, collaborate on treatment • Healthcare: prepare clients for medical appointments that might be triggering, debrief and review information provided during exam

Elliot, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477.

Trauma-informed Approach	The Sanctuary Model
Community	Originally for adults who experienced abuse as children, adapted to domestic violence settings

Principles	Examples of Practices
• Core Concepts: nonviolence, viewing organization as whole entity, parallel processes • 7 Commitments: • Nonviolence: physical and psychological nonviolence at all organizational levels • Emotional Intelligence: staff must cultivate awareness of emotional responses and be able to manage and talk about them • Social Learning: organization must be dynamic and constantly identify and respond to changing needs of communities being served • Open Communication: organization should espouse transparency, nonviolent language, and effectively manage conflicts • Democracy: everyone at the agency, clients and staff, should have a voice that is heard • Social Responsibility: create a just and safe organization • Growth and Change: focus should be on the future, with goal of changing and growing over time	

The Sanctuary Model. Accessed 7/2014, from http://www.sanctuaryweb.com/

Trauma-informed Approach	National Center for Domestic Violence, Trauma & Mental Health's Accessible, Culturally Relevant, Domestic Violence-and Trauma-Informed (ACDVTI) Agency Self-Assessment Tool
Community	Domestic violence survivors and programs

Principles	Examples of Practices
• ACDVTI Approach • Be sensitive to the pervasiveness of trauma and its impact on survivors, staff and organizations including historical trauma and ongoing experiences of discrimination and oppression • Recognize the role of coercive control and DV-related safety and confidentiality concerns • Ensure services are welcoming, inclusive, accessible and culturally responsive • Work to minimize retraumatization • Support resilience, healing and well-being • Employ a collaborative strength-based approach • Attend to the quality of interactions for people using services and staff • Involve people using services and communities being served in shaping and evaluating services • Maintain a commitment to changing the conditions that contribute to abuse, violence, discrimination & oppression • Key tenets include recognizing the importance of • Physical and emotional safety • Relationship & connection • Respect, empowerment, transparency, collaboration & choice • Hope & resilience • A survivor-defined approach	The ACDVTI tool provides guidance on engaging in a reflective organization-wide self-assessment process. It is structured to walk agencies through a process of considering what an ACDVTI approach would look like in each of the following 7 domains. • Organizational Commitment and Infrastructure • Staff Support • Physical, Sensory and Relational Environment • Intake Process • Programs and Services • Community Partnership • Evaluation and Feedback It also includes a section on organizational readiness.

National Center on Domestic Violence, Trauma & Mental Health. *Becoming Accessible, Culturally Relevant, Domestic Violence- and Trauma-Informed Organizations: An Organizational Reflection Tool*. National Center on Domestic Violence, Trauma & Mental Health. Chicago, IL. 2015 in press. National Coalition of Anti-Violence Programs.(2012). Hate Violence Against Lesbian, Gay, Bisexual, Transgender, Queer, and HIV- affected Communities In the United States in 2011: A Report from the National Coalition of Anti-Violence Programs. New York City: NCAVP. Retrieved 8/22/2015 from: http://www.cuav.org/wp-content/uploads/2012/08/4379_NCAVPHVReport2011Final_Updated.pdf.

Trauma-informed Approach	SAMHSA TIC in Behavioral Health Services Guide	
Community	Behavioral health service organizations	
Principles		**Examples of Practices**
6 Initial Chapters: • Trauma-informed care: A sociocultural perspective • Trauma awareness • Understanding the impact of trauma • Screening and assessment • Clinical issues across services • Trauma-specific services		• Show organizational and administrative commitment to TIC • Use trauma-informed principles in strategic planning • Review and update vision, mission and value statements • Assign a key staff member to facilitate change • Create a TIC oversight committee • Conduct and organizational self-assessment • Develop an implementation plan • Develop policies and procedures to ensure trauma-informed practices and prevent retraumatization • Develop a disaster plan • Incorporate universal routine screenings • Apply culturally responsive principles • Use science-based knowledge • Create a peer-support environment • Obtain ongoing feedback and evaluations • Change the environment to increase safety • Develop trauma-informed collaborations
Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioral health services*. Rockville, MD: Substance Abuse and Mental Health Services Administration.		

Trauma-informed Approach	Developing Trauma-Informed Organizations Toolkit	
Community	Women with co-occurring disorders and histories of violence	
Principles		**Examples of Practices**
• A comprehensive, continuous, integrated service system • Person-centered services • Trauma • Safety • Family-focused • Diversity		• Establish open dialogue among providers, recipients, and systems • Increase capacity through cross-training, modification and addition of services as necessary • Increase access to peer support • Use respectful, gender-neutral, non-violent language • Recognize and understand cultural differences and how they impact the healing process • Provide co-ed and gender specific services • Staff should be knowledgeable about trauma • Provide access to trauma-specific services • Work with participants to develop calming skills • Validate participant experiences • Allow participant to define their family and support them in their role as parent • Cultural differences should be viewed as community resources and incorporated into service planning
Institute for Health and Recovery. (2012). *Developing Trauma-Informed Organizations: A Tool Kit* (Second ed.). Cambridge, MA: Institute for Health and Recovery.		

Appendix B: A Set of Practice-Based Observations for Trauma-Informed Practice with LGBQT* Survivors of Intimate Partner Violence

GLBTQDVP

GLBTQ Domestic Violence Project

TRAUMA-INFORMED APPROACHES FOR LGBQT* SURVIVORS OF INTIMATE PARTNER VIOLENCE

A Set of Practice Observations
June 2016

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Authors:

Erin C. Miller, M.P.S., M.D.V.
Domestic Violence/ Sexual Assault Programs;
Newton-Wellesley Hospital

Lisa A. Goodman, Ph.D.
Boston College

Kristie A. Thomas, Ph.D.
Simmons College

Carole Warshaw, M.D.
National Center on Domestic Violence, Mental Health, and Trauma

Principal Investigator:

Curt Rogers, M.P.A.
GLBTQ Domestic Violence Project

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Produced by
The GLBTQ Domestic Violence Project

GLBTQDVP

For more information on supporting LGBQT* survivors of intimate partner violence, contact one of the organizations below:

The LGBTQ DV Capacity Building Learning Center
c/o The Northwest Network
A program focused on improving research, practice and policy regarding domestic violence in LGBTQ communities.
1-206-568-777 | info@nwnetwork.org | www.nwnetwork.org

FORGE
A transgender anti-violence organization, specializing in technical assistance for victim service agencies, with a focus on domestic violence, sexual assault, dating violence, stalking, and hate crimes.
1-414-559-2123 | AskFORGE@forge-forward.org | www.forge-forward.org

If you would like more information about accessible, culturally relevant trauma-informed approaches for survivors, contact:

The National Center on Domestic Violence, Trauma & Mental Health
A program providing training, support, and consultation to advocates, clinicians, attorneys and policymakers as they work to improve agency and systems-level responses to survivors and their children.
1-312-726-7020 | info@nationalcenterdvtraumamh.org | www.nationalcenterdvtraumamh.org

Introduction and Project Overview

This document contains a set of preliminary practice observations from the field, which are intended to inform the development of a trauma-informed transformative justice approach specific to lesbian, gay, bisexual, queer, and transgender (LGBQT*) survivors of intimate partner violence (IPV). These observations are the result of a research project that was led by the GLBTQ Domestic Violence Project (GLBTQ-DVP) and funded by the Administration for Children, Youth and Families, Family and Youth Services Bureau, US Department of Health and Human Services.

The goal of the project was to help develop a culturally-specific, trauma-informed approach to working with LGBQT* survivors with support and input from a range of stakeholders. To meet this goal, the following activities[1] were conducted over the course of two years (2013-2015):

- A substantive literature review on intimate partner violence in the LGBQT* communities (page 1), which is intended to be read in tandem with the observations
- Input from an advisory committee that included Queer Muslims of Boston, the Hispanic Black Gay Coalition, the Northeast Two Spirit Society, the Massachusetts Alliance of Portuguese Speakers, HarborCOV, Massachusetts Asian & Pacific Islanders for Health, and Fenway Health
- Two focus groups with survivors participating in one GLBTQ DVP program, the goal of which was to explore their experiences seeking help
- Three separate focus groups and multiple individual conversations with staff of one GLBTQ DVP program to assess their perceptions, experiences, and ideas about trauma-informed organizations and providing trauma-informed services
- Surveys of the program's staff as well as LGBQT* practitioners nationally to assess knowledge and experience of trauma-informed practices
- Informal conversations with staff and leadership of LGBQT* culturally-specific organizations across the country
- The authors' own collective experience working with LGBQT* organizations and communities over the past 30 years
- Considerable guidance from the National Center on Domestic Violence, Trauma, & Mental Health

From these multiple sources of data, a set of six observations emerged, which then were simplified and distilled in the hopes that they will be broadly applicable. They are listed here and explained in detail in the subsequent pages.

- Observation 1: The majority of LGBQT* survivors have experienced multiple forms of violence and abuse in their lives. Experiences of historical trauma and ongoing discrimination can compound these multiple experiences of victimization.

[1] The Simmons College Institutional Review Board approved the research activities involving human subjects (i.e., interviews and focus groups with practitioners and program participants).

- Observation 2: Organizations that work with LGBQT* survivors must operate from a place of understanding that perceived "challenges" may actually be creative strengths.

- Observation 3: Organizations that work with LGBQT* survivors must operate from the premise that if LGBQT* communities, staff, board members, organizations, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their family of choice, not merely as a service provider or colleague.

- Observation 4: If practitioners are to truly be of service, a social justice and anti-oppression framework must become the cornerstone of their individual work, their organization's work, and their organization's interactions with the community.

- Observation 5: Staff self-care (and organizational support for self-care) is critical.

- Observation 6: There is a profound need for transformative justice[2] approaches to working with LGBQT* and other multiply oppressed communities.

It is important to note that the authors view these observations as dynamic and evolving, and we are hopeful that LGBQT*organizations, practitioners, activists, and researchers will expand upon them as part of their own trauma-informed, anti-oppression, transformative justice work. Some sections of this addendum tie directly to the literature review (e.g., observations 1 and 5), and others do not. Also, although these observations grew in tandem with the literature review – and should be read together – some of the ideas are not yet supported by a body of literature. Rather, they reflect the practice wisdom and lived experience of LGBQT* practitioners and LGBQT* survivors who contributed to this project.

The practice observations and companion literature review are intended primarily for staff in domestic and sexual violence organizations; however, they are applicable to practitioners in other anti-abuse disciplines, homelessness services, mental health and healthcare circles, criminal legal systems, youth services, and an array of other human services disciplines and social change endeavors that seek to serve and ensure the inclusion of LGBQT* communities.

[2] The authors wish to thank Hales Burton at the Fenway Violence Recovery Program for first suggesting this conceptual shift.

A Note on Language[3]

Before describing the observations, the authors wish to acknowledge the deep complexities of language. In this document, IPV refers to the physical and/or emotional abuse of an individual by a current or former intimate partner. It includes the full range of tactics used to create and maintain power and control over another person, including financial abuse, verbal abuse and intimidation, and cultural abuse. In this document, the phrases *intimate partner violence* and *domestic violence* are used interchangeably to denote partner violence. However, it is important to note that domestic violence (DV) is sometimes defined more broadly to include violence and abuse perpetrated by relatives. Although many LGBQT* individuals experience abuse and/or rejection from family and relatives, the dynamics of partner violence versus family violence may differ dramatically. When we discuss the latter, we use the phrase *family violence* to distinguish it from violence by an intimate partner.

LGBQT* stands for lesbian, gay, bisexual, queer, and transgender. It is often used interchangeably with GLBTQ, LGBQT-TS, and similar acronyms to broadly refer to sexual and gender minorities. This document honors the current practice of including an asterisk after the "T" to signify the broad diversity of trans communities, including trans women – transgender individuals who identify as women, though assigned male at birth; trans men – transgender individuals who identify as men, though assigned female at birth; those transitioning from female to male (FTM); those transitioning from male to female (MTF); cross dressers; gender non-conforming individuals; and others who might self-identify as being members of trans communities. In this paper, transgender and trans are used interchangeably.

These definitions belie the complexity of the terms, however. The words *lesbian*, *gay*, *bisexual*, *transgender*, and *queer* all carry particular historical, political and cultural meanings. To a great extent, these words have been shaped in white, Western contexts. Words such as lesbian, gay, and bisexual, for example, are uniquely English. There are seldom translations into other languages that carry the same understanding of LGBQT* identity as being an identity rather than a set of behaviors. Literal translations, into Spanish or Haitian Creole as but two examples, carry few if any of the presumptions that are inherent in English. In many parts of the Latin and Spanish-speaking world, men who engage in sex with same sex partners are only considered "gay" in the English sense of the word if they are the receptive partner. It is not engaging in the acts that is the determinant of identity, so much as the role that an individual plays (traditionally read as *masculine* or *feminine*) in the conduct of that act. Similarly, men who marry women, but engage in same sex acts with other men, are frequently identified as heterosexual. In short, they are defined by their social role, rather than by their private, intimate acts. Hence the conception of *gay*, as defined in U.S. contexts, frequently fails to apply.

Precisely because identifiers such as LGBQT* were defined in white middle class and academic contexts, the limitations of LGBQT* labels and identifiers may be particularly acute in communities of

[3] For those of you who are reading the literature and practice observations in tandem, please note that this "note on language" section is identical to the "note on language" section in the literature review.

color, Indigenous communities, and immigrant communities, among others. During the course of crafting this literature review, members of our Advisory Board taught us a tremendous amount. The Hispanic Black Gay Coalition (HBGC) suggested use of the term *same gender loving*, a community-specific phrase coined by Cleo Manago to distinguish African Americans, and in particular African American men, who do not self-identify as being part of the predominantly white gay movement in the U.S., but who nonetheless wish to affirm their same sex intimate relationships. Corey Yarbrough, one of the founding Executive Directors of HBGC, suggested that for some same gender loving people this language may be a form of racialized resistance to the racism of the mainstream LGBQT* movement in the U.S. In the alternative, Corey stated, some members of African American communities may be on the *down low*, engaging in same sex sexual activity, but rejecting LGBQT* identifiers as a result of internalized homo and biphobia.

The NorthEast Two-Spirit Society (NETSS) in part echoed Corey's thoughts about the racism of the mainstream LGBQT* movement. In addition, Harlan Pruden, one of co-founders of NETSS, spoke about an "internal muddiness" that some Native peoples may experience when seeking to find language for their experience. Speaking of his own Cree inheritance as a registered member of the Saddle Indian Reservation, Harlan said that when he asked something of an elder, he knew to offer them tobacco, but never understood the spiritual dimension of the ceremony. Having been separated from too much of their own history by colonialism, genocide and forced assimilation, Harlan stated, many Native people may use the words *Two-Spirit* when what they really mean is gay Indian.[4]

Harlan also spoke at length about the contextual nature of Native Two-Spirit identities. As Harlan put it, "When I am out on a Friday night in a gay club, I am a gay man. Yet when I am in rural Oklahoma at a Two-Spirit gathering, I am a proud Two-Spirit man." Alluding to the unique role and cultural responsibilities that Two-Spirit people often held (and may still hold) in the life of Native communities, Harlan pointed out the obvious differences in the spiritual role of Two-Spirit peoples, and the political and social function of people claiming LGBQT* identities in mainstream communities. Several members of the project's advisory board echoed this point,
speaking about the complex layering of cultural and spiritual value systems that accompanied their choice to self-identify in, with, and outside of their own communities.

These same Advisory Board members also acknowledged the landscape in which such decisions are made, and stated that individuals in their communities may shift how they self identify as a means of preserving their safety. As the rest of this literature review discusses, LGB, transgender, same gender loving, Two-Spirit, and queer-identified peoples make choices about how, when, and if to "out" themselves in a complex social and political landscape that is too often unsafe, if not violent. Hence how

[4] Two-Spirit is a contemporary term, adopted from the Northern Algonquin, and meant to signify the embodiment of both masculine and feminine within one person. Now embraced by many Native peoples as a pan-Indigenous umbrella term connoting both diverse gender expressions and sexual orientations, Two-Spirit generally speaks to the respect that Native peoples held for diversity, and the unique sacred and ceremonial roles that Two-Spirit people held (and may still hold) within their own communities. Herein the phrase Two Spirit speaks not simply to a third gender, or to same gender attraction, but more broadly to the history of compulsory Christianization that sought to erase Two-Spirit peoples within their own nations. Notably, there is no single consensus definition of Two-Spirit, and the term means different things to different Native peoples.

any individual self-identifies may shift depending on who is asking, why, and in what context. As one Advisory Board member stated, "identities have to be fluid in order to be protective."

Finally, the leadership of HarborCOV, an LGBQT*-affirming DV organization in Boston that specializes in serving communities facing cultural or linguistic barriers, has noted that some cultures may not have the variety or depth of language that words such as LGB, transgender, same gender loving, and Two-Spirit convey. Indeed, Kourou Pich, Co-Executive Director of HarborCOV has observed that people from some cultures and communities may have difficulty finding language for themselves in their own communities, and that that invisibility is intentional – a function both of denial of the existence of sexual minorities in those communities, but also perhaps protectiveness of gender queer and same gender attracted people.

Language is power. We authors, therefore, have put a great deal of thought into the words we use to name peoples' experiences. At the same time, we know that we can never be as inclusive or sensitive as we want to be. We have done our best to honor the range of experiences we are writing about in this document.

Notes from the Field: A Set of Practice-Base Observations

Observation 1: The majority of LGBQT survivors have experienced multiple forms of violence and abuse in their lives. Experiences of historical trauma and ongoing discrimination can compound these multiple experiences of victimization.*

A trauma-informed approach, at its core, asks that practitioners assume that everyone they serve has experienced some form of violence, abuse, or other trauma in their lives and to see these experiences as the norm, rather than the exception (Felitti et al., 1998; Harris & Fallot, 2001).

Given the prevalence and overlapping nature of violence and abuse in the lives of LGBQT* peoples, it might be more prudent to suggest that practitioners build practices and systems that presume *multiple* forms of victimization among the people they serve. It is not unusual for LGBQT* peoples to be targets of many different forms of violence and abuse at the hands of multiple individuals, at numerous points throughout the lifespan (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Grant, Mottet, & Tanis, 2011; Stotzer, 2009).[5] Indeed, traumatic experiences such as intimate partner

[5] To date, the fragmented nature of the research into violence and abuse in the lives of LGBQT* individuals means that, although there is a broad practice consensus about the prevalence of "polyvictimization" in the lives of LGBQT* peoples, there is little peer-reviewed research examining the phenomenon. However, there is abundant evidence that LGBQT* people, and in particular LGBQT* people of color, are more likely to be targeted for multiple forms of violence and abuse, in multiple contexts (family, partnerships, community) over the course of their lifetime. For example, LGBQT* peoples are disproportionately subject to childhood sexual abuse, bullying by peers, sexual violence in adolescence and adulthood, intimate partner violence, hate crimes, and police brutality (Roberts et al., 2010; Grant et al., 2011; Stotzer, 2009). Again, the authors wish to encourage individuals to read these observations in tandem with the literature review to learn more about these siloed areas of research.

violence, family violence, and other types of trauma that occur over the course of the lifespan, including childhood sexual assault, bullying, hate crimes, or police brutality, may intersect and compound each other in the lives of LGBQT* survivors in ways that create unique challenges for survivors themselves, and unique opportunities for control by future perpetrators.

These interpersonal traumas are often further compounded by experiences of oppression and historical trauma in LGBQT* communities. LGBQT* peoples have historically experienced discrimination at the hands of helping professionals in a range of systems (e.g., healthcare, mental health, criminal-legal, child protection, public assistance, and sexual and domestic violence organizations) – if LGBQT* peoples have been visible in those systems at all.[6] In addition, many of these systems (in particular mental health and criminal-legal systems) have not only pathologized, labeled, isolated, and detained LGBQT* individuals, but also intentionally fractured LGBQT* partnerships, families, and communities. Such treatment is especially the case for multiply marginalized LGBQT* communities, such as communities of color, immigrants and refugees, Two Spirit communities, and people with disabilities.

It is important to understand, however, that these forms of oppression are not merely historical artifact in the lives of LGBQT* survivors, but ongoing and continuing realities, especially for those who are multiply marginalized. This ongoing oppression then exacerbates experiences of current and historical trauma.

A trauma-informed approach encourages practitioners, and indeed entire systems, to minimize the possibilities for retraumatization by creating an atmosphere that prioritizes survivor's need for safety, respect, and acceptance (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Jennings, 2004; Substance Abuse and Mental Health Services Administration, 2014; Warshaw, 2014; Wilson, Fauci & Goodman, 2015). In short, a trauma-informed approach asks first and foremost that practitioners – as well as the systems in which they work – do no harm.

However, for LGBQT* survivors in particular, the mandate to do no harm requires that practitioners understand the concept of *sanctuary harm* – the idea that institutions and institutional gatekeepers can inflict enormous damage on the very people whose healing, empowerment, and safety they are supposed to nurture and protect (Bloom & Farragher, 2011; Smith & Freyd, 2014). Survivors who participated in the focus groups for this project spoke of blatant discrimination, noting, for example, institutions and practitioners who had at times openly refused services to male and LGBQT* survivors. And, in the staff focus groups, participants spoke about the challenges of advocating with organizations that had a funder mandate to be LGBQT* inclusive, but who were still actively resistant to accepting some members of this diverse community.

[6] The authors are mindful that historical trauma means different things in different communities. Many members of First Nation communities frame historical trauma in terms of colonization, genocide, and boarding-school trauma. Members of Jewish communities may frame historical trauma in terms of the intergenerational impact of the Holocaust. And members of the African Diaspora may think of the Middle Passage and the enslavement of African peoples when referencing historical traumas. The specific nature of the historical influences the way it continues to affect the lives of individuals and entire communities.

Conversations with LGBQT* practitioners across the country, especially those from mainstream organizations, surfaced deep ethical tensions over their own roles as institutional actors in organizations and agencies that they believed too often inflicted sanctuary harm. Consciousness of the harm they were doing – and the good they were prevented from doing – was a significant source of mental, emotional, and ethical distress for many practitioners, especially when contrasted with their larger awareness of the needs of the communities and people they were serving.

Observation 2: Organizations that work with LGBQT survivors must operate from a place of understanding that perceived "challenges" may actually be creative strengths.*

Recognizing the potentially significant impact of violence and abuse on development and coping strategies, a trauma-informed approach aims to contextualize coping strategies such as substance use, cutting, eating disorders, "promiscuous" sex, and dissociation as adaptive responses to otherwise intolerable situations (Elliot et al, 2005; Guarino et al., 2009; Jennings, 2004; SAMHSA, 2014, Warshaw 2014). Because it is rooted in clinical frameworks, trauma-informed practice approaches often frame such strategies as necessary within the context of abuse, but no longer adaptive once relative safety had been achieved. Following the examples of Kate Bornstein and Sylvia Rivera, the LGBQT*-specific practitioners who participated in the survey and informal conversations spoke about celebrating survivors' coping strategies as not merely adaptive, but indeed creative, even when such strategies are not on the surface immediately conducive to health or perceived well-being. Given the multiple forms of victimization, ongoing discrimination, and historical trauma that shape the LGBQT* experience, it may be that there is no safety anywhere. In that context, any strategy that allows people to survive – internally or externally – is to be celebrated. As one practitioner put it, "It isn't about coping, it is about surviving. We celebrate survival, because it is so uncertain." Such a response should not preclude practitioners from expressing concern or helping survivors to develop alternative survival strategies in parallel; however, it does require that practitioners fully embrace survivors and honor and respect their own strategies.

Observation 3: Organizations that work with LGBQT survivors must operate from the premise that if LGBQT* communities, staff, board members, organizations, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their family of choice, not merely as a service provider or colleague.*

A trauma-informed approach asks that practitioners base everything they do in relational collaboration. In fact, one of the core principles of a trauma-informed approach is to ensure that goals and strategies are collaboratively defined, and that the partnership between survivor and practitioner is itself a place of healing (Elliot, et al, 2005; SAMHSA, 2014; Warshaw, 2014; Davies & Lyon, 2014; Wilson et al., 2015).

Just as with other historically oppressed communities, the complexities of the LGBQT* experience may be such that a traditional relationship between service provider and client is not sufficient to fully support the person's healing. Instead, a different and more porous set of boundaries may be required – or at least expected. As several LGBQT* practitioners put it, when LGBQT* communities, staff, co-workers, and individual survivors lend you their trust, they are often accepting you as a community member, and possibly even as their "family of choice," not merely as a service provider. Program participants supported this sentiment, describing how one of the most important and helpful aspects of the services they received was the staff's willingness to go "above and beyond their job descriptions." Providing the sort of attention that a friend might provide (e.g., calling to check in or going along to doctor's appointments) was important because, as one survivor expressed, "I had never been treated that way in my life, not even by my family." Although this can raise complex ethical issues for both survivors and practitioners in navigating this important but complicated terrain, recognizing it is critical in working with LGBQT* survivors and working within LGBQT* communities.

Observation 4: If practitioners are to truly be of service, a social justice and anti-oppression framework must become the cornerstone of their individual work, their organization's work, and their organization's interactions with the community.

Another principle of trauma-informed practice is to respond to all people in ways that are sensitive to their individual social locations and contexts (Wilson et al., 2015; see also Elliot, et al, 2005; Jennings, 2004; Guarino et al., 2009; SAMHSA, 2014; National Center on Domestic Violence, Trauma & Mental Health, in press). At a minimum, this principle sets forth an expectation of cultural sensitivity across multiple aspects of identity. Given the chronic and cascading traumas, ongoing oppression and historical trauma referenced above, cultural sensitivity is essential but not sufficient for responding to the experiences of LGBQT* survivors. Instead, attention to individual social locations and contexts must be situated within a broader anti-oppression framework.

LGBQT* practitioners from across the country observed that the broader movements against sexual and domestic violence sometimes minimized the ways in which violence and abuse intersect with other forms of oppression. They took note not simply of the ways in which this lack of proactive attention shaped direct services, but also how it shaped their organization's hiring practices, the tokenization of staff members from historically marginalized communities, the narrow makeup of their organization's governing board, the focus on quantity over holistic quality of services, and the lack of input particularly from transgender community members and community members of color in strategic planning and other organizational activities.

By contrast, they called on practitioners to build organizations that are integrated into and learn from the historically marginalized communities they serve (or should be serving) and that center the knowledge and experiences of those communities. Historically oppressed communities, including LGBQT* communities, are at the leading edge of anti-violence work, not a set of "minority communities" requiring special logistics or uniquely special care. What organizations learn from historically oppressed communities should serve as the foundation of their organizational philosophy, practices, and policies.

Observation 5: Staff self-care (and organizational support for self-care) is critical.

Empathic engagement and bearing witness to other people's pain can affect us deeply. To be effective, it is important for service providers and activists serving people in pain and crisis to be mindful of how they have been affected by their own experiences of trauma *and* how they are affected when they open themselves up to other people's experiences (Saakvitne, Gamble, Pearlman, & Lev, 2000; Hopper, Bassuk, & Olivet, 2010; Bloom & Farragher, 2013; SAMHSA, 2014). Hence, an understanding of vicarious trauma and encouragement to develop strong habits of self-care have become foundational principles in trauma-informed practice (Bloom & Farragher, 2011; Bloom & Farragher, 2013). Thus, to be truly trauma-informed, organizations need to institute programmatic supports for self-care at all levels of the organization (Bloom & Farragher, 2011; Bloom & Farragher, 2013, Warshaw 2014).

Conversations with LGBQT* practitioners across the country led to an additional observation: There is a particular weight that accompanies serving LGBQT* people experiencing violence, abuse, and discrimination while simultaneously identifying with those same communities. Trauma, vicarious trauma, organizational trauma, and historical trauma compounded one another in the lives of the LGBQT* practitioners who contributed to this project, just as they do for the survivors who participate in their programs. Moreover, the impact of compounding trauma was one each group articulated virtually unanimously. Their experiences underscore the need for self-care at the individual level. They also point to need for organizational policies that enable self-care, provide LGBQT*-affirming workspaces, and facilitate connection with the larger community of providers and activists that support and depend upon the work and health of that organization. Essentially, caring for each other individually and as a collective is a critical element of any trauma-informed approach.

Observation 6: There is a profound need for transformative justice[7] approaches to working with LGBQT and other multiply oppressed communities.*

Because the companion literature review focused largely on peer-reviewed, published literature, it did not consider the enormous array of activist literature and art that historically oppressed communities have often used to express their communal strategies for survival and resistance. The work of Incite!, Creative Interventions, Black & Pink, and Break Out, along with broader bodies of art, music, dance, autobiography, fiction, and oral history attest to this creative communal drive.

One innovation that has emerged from this kind of activist energy is the concept of *transformative justice* (Generation Five, 2007; Creative Interventions, 2012). Transformative justice recognizes the profound harm and trauma that mainstream approaches have inflicted on LGBQT* peoples, particularly those who face multiple forms of oppression. Its practitioners argue for an approach that understands these historical harms and seeks to create new and innovative responses that avoid replicating them. Rather than work within the framework of social services, it aims for the liberation of oppressed people as communities not just as individuals, under the fundamental

[7] The authors wish to thank Hales Burton at the Fenway Violence Recovery Program for first suggesting this conceptual shift.

assumption that “individual justice and collective liberation are equally important, mutually supportive, and fundamentally intertwined” (Generation Five, 2007, p.1). In other words, transformative justice seeks to transform the political and cultural conditions that allow violence, abuse and oppression to exist in the first place. It is critical that trauma-informed practices include transformative justice as an additional lens in service delivery and system reform.

Conclusion

In summary, these six observations underscore the ways in which individual, interpersonal, and structural factors coalesce in the lives of LGBQT* survivors of domestic violence, creating a unique context, that affects their experiences and needs. Future trauma-informed approaches for LGBQT* survivors of domestic violence should consider the multi-layered context that surrounds LGBQT* survivors and use that knowledge to inform not only client-level practices, but also organizational-level policies.

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FEATURE

Growth after trauma

Why are some people more resilient than others—and can it be taught?

By Lorna Collier

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As Kay Wilson struggled to make her way through a Jerusalem forest after being repeatedly stabbed by a Palestinian terrorist, she distracted herself from her agony by playing the song "Somewhere Over the Rainbow" in her mind, composing a new piano arrangement while she fought for breath and forced herself to put one bare foot in front of the other.

Wilson, then 46, had been working as a tour guide when, on Dec. 18, 2010, she and a friend were ambushed by terrorists. Wilson witnessed her friend's murder and was herself viciously stabbed with a machete, ultimately playing dead as her attacker plunged his knife into her chest a final time.

She eventually recovered from her severe physical wounds and is healing from her psychological trauma. She now speaks to global audiences about her survival, hoping to "dispel hatred, whether toward Arabs or Jews."

The work "helps me make meaning out of something so senseless," says Wilson, who is also writing a book about her experiences.

After the attack, Wilson had flashbacks and deep survivor's guilt. But like many people who have survived trauma, she has found positive change as well—a new appreciation for life, a newfound sense of personal strength and a new focus on helping others.

Post-traumatic growth (PTG) is a theory that explains this kind of transformation following trauma. It was developed by psychologists Richard Tedeschi, PhD, and Lawrence Calhoun, PhD, in the mid-1990s, and holds that people who endure psychological struggle following adversity can often see positive growth afterward.

"People develop new understandings of themselves, the world they live in, how to relate to other people, the kind of future they might have and a better understanding of how to live life," says Tedeschi.

How can clinicians use PTG theory to help patients? How has new research helped refine understanding of it? Here's a look at developments in the field.

Signs of post-traumatic growth

PTG can be confused with resilience, but the two are different constructs (see "The post-traumatic growth inventory" below).

"PTG is sometimes considered synonymous with resilience because becoming more resilient as a result of struggle with trauma can be an example of PTG—but PTG is different from resilience, says Kanako Taku, PhD, associate professor of psychology at Oakland University, who has both researched PTG and experienced it as a survivor of the 1995 Kobe earthquake in Japan.

"Resiliency is the personal attribute or ability to bounce back," says Taku. PTG, on the other hand, refers to what can happen when someone who has difficulty bouncing back experiences a traumatic event that challenges his or her core beliefs, endures psychological struggle (even a mental illness such as post-traumatic stress disorder), and then ultimately finds a sense of personal growth. It's a process that "takes a lot of time, energy and struggle," Taku says.

Someone who is already resilient when trauma occurs won't experience PTG because a resilient person isn't rocked to the core by an event and doesn't have to seek a new belief system, explains Tedeschi. Less resilient people, on the other hand, may go through distress and confusion as they try to understand why this terrible thing happened to them and what it means for their world view.

To evaluate whether and to what extent someone has achieved growth after a trauma, psychologists use a variety of self-report scales. One that was developed by Tedeschi and Calhoun is the Post-Traumatic Growth Inventory (PTGI) (*Journal of Traumatic Stress*

(http://www.ncbi.nlm.nih.gov/pubmed/?term=the+posttraumatic+growth+inventory%3A+measuring+the+positive+legacy+of+trauma)

, 1996). It looks for positive responses in five areas:

Appreciation of life.

Relationships with others.

New possibilities in life.

Personal strength.

Spiritual change.

The scale is being revised to add new items that will expand the "spiritual change" domain, says Tedeschi. This is being done "to incorporate more existential themes that should resonate with those who are more secular" as well as reflect cross-cultural differences in perceptions of spirituality.

A predisposition for growth?

How many people experience PTG? Tedeschi prefers not to put a hard number on it.

"It all depends on the trauma, the circumstances, the timing of the measurement ... [and] on how you define growth using the PTGI, looking at total score, means, factors or individual items," he says. However, he estimates that about one-half to two-thirds of people show PTG.

Some PTG researchers have tried to corroborate self-reported growth by questioning friends and family members about whether growth "sticks."

"We are getting more studies that show that PTG is generally stable over time, with a few people showing increases and a few showing decreases," Tedeschi says. "It is now up to us to learn what is going on with those who change over time, but the evidence is for stability in general, and also corroboration by others."

There appear to be two traits that make some more likely to experience PTG, says Tedeschi: openness to experience and extraversion. That's because people who are more open are more likely to reconsider their belief systems, says Tedeschi, and extroverts are more likely to be more active in response to trauma and seek out connections with others.

Women also tend to report more growth than men, says Tedeschi, but the difference is relatively small.

Age also can be a factor, with children under 8 less likely to have the cognitive capacity to experience PTG, while those in late adolescence and early adulthood—who may already be trying to determine their world view—are more open to the type of change that such growth reflects, says Tedeschi.

There also may be genetic underpinnings for PTG, but researchers are just beginning to tease this out. In a 2014 study in the *Journal of Affective Disorders* (http://www.ncbi.nlm.nih.gov/pubmed/24161451) , for example, Harvard social and psychiatric epidemiologist Erin Dunn, ScD, and a team of researchers examined data previously collected from over 200 Hurricane Katrina survivors and found that variants in the gene RGS2 significantly interacted with levels of exposure to the hurricane to predict PTG. RGS2 is linked to fear-related disorders, such as post-traumatic stress disorder, panic disorder and anxiety.

Dunn calls the results "very interesting" but notes that "we have to be somewhat cautious in interpreting it because we were unable to find a similar sample to replicate that finding."

Sarah Lowe, PhD, of Montclair State University, who worked with Dunn on the research, says one difficulty with gene studies for PTG is the concept's complexity. "If you look at what predicts PTG, it is often psychological stress and dysfunction—but also more positive personality traits like optimism and future orientation, which you'd expect would have a very different genetic basis," she says.

Theory into practice

Is it possible to prepare people for PTG, to pave the way should tragedy or trauma strike? Yes, says Tedeschi, noting that psychologists can "allow people to understand that this may be a possibility for themselves" and is a "fairly normal process" if and when trauma occurs.

More often, though, therapists will become involved not before adversity has occurred, but afterward. In this context, they can introduce PTG concepts but need to take care doing so.

H'Sien Hayward, PhD, cautions that therapists should not "jump right into the possibility of growth," which she says can "often be construed as minimizing someone's pain and suffering and minimizing the impact of the loss."

Hayward, who works with veterans at VA Long Beach Medical Center in Long Beach, California, knows about such growth firsthand: She was paralyzed in a car accident when she was 16, ending a competitive athletic career. She overcame that trauma through the help of supportive family and friends, went on to study social psychology at Harvard and has traveled to more than 42 countries, often on humanitarian missions providing counseling and other support to trauma victims. Today, she credits the accident for increasing her strength of character "exponentially" by forcing her to overcome challenges. She also appreciates life and relationships with others—including the near-daily support in the small tasks of daily living that she gets from friends and strangers alike: "those interactions warm my heart."

Yet Hayward is careful not to preach the potential for upside to her patients before they are ready. Instead, she waits for them to express "some positive reaction to the event."

She also helps patients discover what's meaningful in their lives and then helps them schedule activities involving these interests, such as spending more time with family members or doing volunteer work.

Tedeschi says sometimes traditional therapy for trauma patients gives people short-fix solutions to help them resume daily functions, such as sleep or work, but may not provide them with a way of living "beyond just getting by .... We've got to attend to their experience of life and how meaningful, satisfied and fulfilling it is."

One veterans' care facility that takes a nontraditional, PTG approach to trauma treatment is Boulder Crest Retreat in Bluemont, Virginia. The private, donor-supported institute provides free, weeklong nonclinical exercises and activities for vets seeking recovery from combat stress. The treatment is led primarily by veterans who have themselves gone through trauma and achieved growth. Vets are encouraged to deal with past traumas while also discovering their underlying strengths, as well as forging connections with others and ultimately finding ways to give back.

After the intensive program, vets are followed for 18 months with regular Skype check-ins.

Kevin Sakaki, a former Marine and intelligence/special operations veteran, entered Boulder Crest's Warrior program last September and found it transformative. He's noticed such changes in himself as better communication with his family, less anger ("Things don't get to me as much"), a deeper appreciation of "the little things," more generosity and a stronger connection to other people.

Tedeschi is among the psychologists studying the Boulder Crest program's efficacy as part of a research grant funded by the Marcus Foundation.

He hopes that as vets go through the process at Boulder Crest, they "develop new principles for living that involve altruistic behavior, having a mission in life and purpose that goes beyond oneself, so that trauma is transformed into something that's useful not only for oneself but for others."

For further references go to our digital edition to connect directly to the research cited in this article: www.apa.org/monitor/digital (http://www.apamonitor-digital.org/apamonitor/201611?pg=1#pg1) .

The post-traumatic growth inventory

To evaluate whether and to what extent someone has achieved growth after a trauma, psychologists look for positive responses in five areas.

1: Appreciation of life

2: Relationships with others

3: New possibilities in life

4: Personal strength

5: Spiritual change

Source: Richard Tedeschi, PhD, and Lawrence Calhoun, PhD, *Journal of Traumatic Stress*, 1996

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